e-MDs Solution Series™

Chart User Guide

Version 8.0

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Table of Contents

1 Welcome

Welcome to e-MDs' premier suite of office automation tools! **e-MDs Chart** is our full-featured longitudinal electronic medical record, offering rapid, complete clinical documentation (with integrated ICD, CPT, and HCPCS coding), prescription and medication management, referral/consult letter generation, and automated E&M coding. Your practice management needs are exceeded with the **e-MDs Bill** and **e-MDs Schedule** applications. All applications reside in a common database, with no data bridges, affording remarkable flow of information from one module to another.

In addition to those fundamental programs, other modules improve workflow processes, enhance communication, and enable the office to truly operate in a paperless environment.

Because of their tight integration with Chart module functionality, Fast Forms, Tracking Board, and the Rules Engine are described in the this user guide. See the *e-MDs Solution Series Utilities Guide* for information on using the following tools:

- DocMan
- TaskMan
- Snapshot (Digicam)
- Forms/Letter Builder
- Spell Checker
- Signatures
- Continuity of Care Records (CCR)
- Continuity of Care Documents (CCD)

Visit us at http://www.e-MDs.com to check out our latest product offerings!

Continued on the next page...

Using This Guide

This guide leads you from the beginning of an office visit through the visit conclusion when billing is enabled. Using Chart you can track and code a patients medical information and provide prenatal, maternity and postnatal care. This guide also details Chart's prescription processing, lab interfaces, and telephone interactions with patients.

As you go through this guide, you will notice that each set of steps to perform a task begins with an indented heading starting with "To" and ending with a colon (:). That heading is then followed by indented steps to be performed in a prescribed sequence. For example, after a brief overview of why you will add a health problem from a template to a patient's chart, the procedure looks like the contents of the following box:

To add a problem from a template:

1. With a visit note open, click the template launch icon to the right of the **Current Problems** header in the note.
2. Select the **Current Problems** template from the Template Link window.

   The template is organized by body system (for example Heart, Lungs, Bones/Joints, etc.). A question that has a Current Problem Extended Attribute linked to it will display a stethoscope icon at the right.
3. Navigate to the diagnosis you want and select it by clicking the question.
   OR
   Select multiple problems, if needed.
4. Close the template and the diagnosis will drop into the Current Problems list.

Related Documentation

Documentation for Solution Series modules is provided in PDF (Portable Document Format) files for viewing and printing individually, and in Help format for easy access from each product module. Both formats and access methods provide the same information. The documentation library is updated extensively for each major product release as well as updated and corrected periodically, as needed. For the latest version of any Solution Series documentation, go to the documentation section of the e-MDs Support site at **Online Support** > **Downloads** > **Documentation**.

The following documents are available to all Solution Series users:

- *e-MDs Solution Series Administration Guide* is your starting point for initializing and customizing Solution Series modules for use in your organization. This guide provides step-by-step instructions for licensing your software, adding system users and defining access levels, adding and modifying user groups, and setting up default handling of various module tasks.
- *e-MDs Solution Series Bill User Guide* provides instructions for working with insurance codes and electronic claims, setting fee schedules and rules, defining policies, posting and billing transactions and reversals, and performing numerous other practice management tasks.
- *e-MDs Solution Series Formulary Benefits User Guide* describes how to determine the pharmacy benefits and drug copays for a patient's health plan, determine if a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to mail order pharmacies, and download a historic list of all *medications prescribed for a patient by any provider.*

- *e-MDs Solution Series Installation and Upgrade Guide* leads you through the preparation of your site for Solution Series, the database and application installation steps, and post-installation configuration. If Solution Series is already installed at your facility, use the update instructions provided to update your system.
- *e-MDs Solution Series Schedule User Guide* leads you through scheduling and tracking appointments, setting up and modifying patient accounts, blocking time on the calendar to restrict appointment scheduling, checking patients into the facility and tracking their progress through each encounter with a provider, and checking eligibility.
- *e-MDs Solution Series Reports User Guide* lists the reports available through Solution Series. A description of each report is provided, along with the location of the report within Solution Series modules, the available fields and filters used to select specific data for the report, and samples of most reports, illustrating what you can expect when running a report at your facility.
- *e-MDs Solution Series Utilities Guide* covers tools and utilities that may be used with various Solution Series modules. This includes using:
    - **DocMan** to graph lab results, process incoming faxes, and generate and send documents to patients and external resources such as specialist referrals and labs.
    - **TaskMan** to automatically send messages, implement secure e-mail, and track tasks to be performed within Solution Series.
    - **Snapshot/Digicam** to capture images of patients/staff and add them to patient and user records.
    - **Forms/Letter Builder** to generate, print and send forms and letters from within Solution Series. This includes the use of Microsoft Word and the e-MDs database to create customized/merged letters and documents.
    - **Registry Processor** to create, view, distribute and print customized reports based on patient demographics and healthcare records.

Additional documentation is also available on the e-MDs Support site for performing specific tasks and for using e-MDs interface products for working with labs and other organizations. See the e-MDs Support site for access to the latest versions of these documents.

Getting Additional Help and Information

e-MDs realizes that one of the most important elements of any software system is the support services backing it up. There are a number of support resources available to help you optimize the use of your system and participate in the e-MDs community.

Help Screens

Help is accessible on each Solution Series application and module by going to **Help** > **Search Topic** on each application's top toolbar. Related help files, such as this guide, the Utilities Guide, and the Reports User Guide, are generally accessible from the same help screen. After opening each help file, you can use the table of contents, index or search function to locate the specific information you need.

Online Help files are also available through the application toolbar for Portal applications by clicking the question mark. The following Help is available for the Portal application:

- *e-MDs Patient Portal: The Clinic's Guide to Using the Portal* provides instructions for maintaining user access on a Patient Portal, working with patient appointments scheduled through the Portal, communicating with patients through a Portal e-mail interface, processing prescription refill requests, and auditing Patient Portal usage.

- *e-MDs Patient Portal: The Patient's Guide to Using the Portal* instructs patients on the use of the Patient Portal to communicate with their healthcare provider, view their own healthcare information, and submit requests for appointments and prescription refills. This HTML file is provided on your Patient Portal for easy online viewing or printing by patients.

User Guides

The e-MDs Solution Series user guides contain comprehensive information about all standard product functions. This includes dealing with many of the complex situations that can arise in a medical office. Use the table of contents, index or search option to locate items of particular interest. These guides are very similar to the application help screens. See Related Documentation for a brief description of the Solution Series user guides available.

Solution Series guides are always available in electronic format (Adobe .pdf files). You can put copies on each computer in the network. You can download the Adobe Acrobat Reader for free from www.adobe.com Updated user guides are included on the CD-ROMs you will receive with each upgrade, as well as on the support pages at www.e-mds.com.

To download files from the e-MDs Support site, you will need your clinic password. Instructions on how to apply for a password are on the Web site. Only one password is issued per customer account, so please ensure you communicate this to your staff.

Using the e-MDs Support Center

The e-MDs Support Center is an online customer meeting place for clients with an active account. It is accessed from the Support pages at www.e-MDs.com or http://supportcenteronline.com/ics/support/default.asp?deptID=3222 . If you don't have an account, you can request one by using the Request New Account button on the login page. We strongly encourage each staff member in a clinic to have their own logins instead of one generic one for all people. The primary reason for this is that when we need to push information such as update notifications it is sent to everyone meaning there is a smaller chance that the information will not be disseminated such as if someone is sick or ignores the message.

Support Center includes the following tools that can be of great assistance to helping your practice work more efficiently with the e-MDs Software:

- **Forums/Newsgroups:** The online forums are an e-MDs User Community where you can post messages related to support, general discussions, suggestions, tips and more. It is a great non-urgent support tool and is also searchable. You can subscribe to various forums that interest you and get an e-mail notification if someone posts to them. You can also elect to get an e-mail if someone posts to a specific message. This is really useful if you post a question and want to know when it is answered. Support forums are monitored by the e-MDs support team and a number of our customers also chip in with their knowledge.
- **Downloads:** Downloads include shared templates for Chart, Word Forms, reports, updates to content such as ICD and CPT codes, bug patches, etc.
- **Knowledge Base:** The knowledge base includes an extensive list of articles that you can use for troubleshooting, setup and so on. These are generally posted based on questions from customers.
- **Troubleshooter:** This search utility makes it easy to quickly locate the information you're looking for. It cross-references multiple parts of the support center and returns hyperlinks to articles, downloads and the like.
- **Surveys:** Occasionally e-MDs will gauge your opinions about something via surveys which can be distributed via Support Center.
- **"Push" e-mails:** If we want to let you know about something, we can push information to you from Support Center.

2
Getting Started with Chart

The Solution Series applications work together to perform your healthcare record management and practice management tasks. For that reason, it may sometimes be difficult for newcomers to understand where one application ends and another begins. Sometimes you may not know exactly where to go for the information you need to perform specific tasks. To help you get started, we are dedicating this chapter to an overview of Chart and how you can begin working with patient charts. We will not try to tell you everything in one short chapter, but you should have a better idea of what you are dealing with after reading through this information.

After reading this chapter and looking at the corresponding Solution Series screens, you should be able to log on, open Tracking Board and Chart, add a new patient account, check a patient into the facility, open and update a Visit or Order Note, and check a patient out.

Note that the overview provided in this chapter does not take the place of formal training in Chart or related modules. It just lays some very basic groundwork for the remaining chapters in this guide. After you have dipped your toe in the water, you should be ready to forge ahead with instructions for performing the specific tasks described in later chapters and other e-MDs Solution Series documentation.

Continued on the next page...

Using the Dashboard

The Solution Series Dashboard is a platform that hosts applications/modules. You do not have to use it, but there are several advantages.

- **User Application and Toolbar Preferences:** Dashboard remembers your preferred applications, whether to open them automatically or not, and your preferences for where buttons should be located on the Dashboard toolbar.
- **Multiple User Sessions:** Dashboard also permits multiple sessions of certain applications to be run on the same computer for different logins. This accommodates the workflow in many practices where multiple users share a computer. One user can log in and start working on his/her set of tasks, use various modules, and then log out. When the next user logs in on the same computer, that user will see his/her own set of preferences and, in some cases, can be using exactly the same module but for a different task. It is worth noting that, because multiple instances of modules may be started, this can affect memory. If that happens, Dashboard will notify the user trying to log in that there is not enough free memory to run modules optimally. Dashboard does not know what effect third-party applications have so, if you have a lot of system sharing with many users, consider adding more than the minimum memory required per workstation.

Logging in and Setting Application Preferences

Dashboard is the default entry point for any e-MDs Solution Series environment. The e-MDs shortcut icon on the desktop automatically loads Dashboard.

To log in to and out of Dashboard:

1. Double-click the **e-MDs** desktop shortcut.
2. Enter your **user name** and **password**.
3. If necessary, verify that you are pointed to the correct login group (database and server) by clicking the button with the downward arrows.
4. Click **OK**. Dashboard starts.

There are several ways to log out:

- **Simple Log Out:** Click the button at the top-left of the Dashboard bar with a gold key icon, or click the minimize button at top-right. This minimizes everything and presents a login window. It does not close modules so, if the same user logs in again, the system returns to the last place that user worked for most applications. If another user logs in, the new user's preferences are loaded in a different session.
- **Close Session Applications Without Shutting Down:** To log out of a session completely and close all the modules you're using, click the button next to it with the gold key with boxes behind it. The system attempts to close all modules correctly. In some cases a particular task will prevent it from doing this. When this happens, a window appears showing the logged in user sessions and the applications they are running. It is best to note the ones in your user "tree", then click "Do not shutdown", then go into the different modules and close them

correctly. Once all modules are closed down, the system minimizes and shows the login window again.

- **Exit**: To close Dashboard completely, click the X at top right. Dashboard attempts to close all modules gracefully. If it cannot close them, it shows which are still running so you can complete any processes and then try to close again.

Note that setting the **Run** > **Options** timeout value is a way to execute a simple logout and preserve security should a user forget to minimize or log out.

To set up Dashboard applications and preferences:

1. Click **Run**. A menu of applications appears. The list is determined by how many of the Dashboard security privileges were added for the user. If applications are on the list but are grayed out, it usually means that the program file was not installed.
2. Click an application to add a button for it to the Dashboard bar. Repeat for additional modules. You can add any modules you wish but may have to scroll to see the buttons for these in the Dashboard bar depending on the number and your screen resolution.
3. When you add applications from the Run menu they are also started at the same time. The next time you log in, you will see this application button on the bar too. You can click a button at any time to toggle to the module.
4. You can right click a Dashboard application button to load a menu that provides further customization options.

   Dashboard Button Options:

   - **Button Order**: The Move option lets you set the order of applications in the bar.
   - **Auto Run**: To start the application automatically when you log in to Dashboard, click this option. A check mark appears to the left of the Auto Run option for those with this property. Click it again to undo. If you typically use several applications during a session, it's a good idea to set this for all of them. Although it will take slightly longer to open the system it saves you from waiting a few seconds the first time you click each button to go into the application. The application you typically use first should be moved to the right of the bar since Dashboard opens them left to right. It's also a good idea to open any modules that have task counters (e.g. TaskMan, Order Tracking, Refill Requests, Phone In Scripts) since the counters are only displayed when the application is running.
   - **To remove an application from the bar**, make sure it is closed. (Buttons for open applications have a yellowish background.) Then right-click the button and click **Remove**.

To set Dashboard options:

To set the Dashboard options, click **Run** then **Options**. There are four options that can be set.

- **Time Out:** The timeout feature for Dashboard minimizes the application after a user defined period of inactivity. This period of inactivity is based on the time (in seconds) entered into the timeout field. Once the application minimized the user is required to log back in to reopen the application. This is a security feature to prevent viewing or manipulation of information when the machine is not being used.

  Note: This setting overrides the timeout settings for the other modules that run in the Dashboard.

- **Dashboard Button Colors:** This option lets you set the background color for Dashboard buttons so they are more apparent than the pale yellow color that is used by default. Be aware that the color you select does not affect the red or black button label colors so you'll need to find a color that works with them.

- **SmartID**: This is a special interface that is being used on a very limited basis. You can disregard it unless you have installed and are implementing that interface. If you are implementing SmartID, follow the instructions in the documentation provided at the time of installation.
- **Search Bar**: This option allows you to enable or disable an Internet search from the Dashboard. This Search Bar allows you to search a designated online repository for medical information. By default, the **Search Bar Enabled** check box has been selected (activated). To disable this option, click the check box to deselect it. The Search Bar will appear on the Dashboard only if it is enabled on this screen.

  The **UpToDate** option is set as the default search engine. If you prefer a different option, click the down-arrow in the **Default Search Engine** field and select a different search engine.

  Click **Save** to retain any changes made on this screen. For instructions on using the Search Bar after it is enabled, see Searching External Databases for Medical Information.

Understanding Dashboard Sessions

As explained previously, you can run multiple sessions of Dashboard for different users on the same computer. In some cases, different instances of the specific modules are run in system memory, but for most of the clinical modules this is not the case. Depending on the number of users logging in on a computer as well as the number of modules they like to run, this can obviously take up memory. Eventually the system will notify a user trying to log in that there is not enough free memory to operate optimally. If some modules have been swapped to disk for a logged out user, it may take a little longer to start up again but that is temporary. Of course, this is not really an issue for users with a dedicated computer or tablet.

The log out options described about can optimize the system. For example, logging out and closing applications frees up resources for the next user faster.

You can see which users are logged into a computer as well as the number of modules that they have open and memory usage by clicking **Run** > **Sessions**. Shared Memory indicates modules that don't have separate sessions for each login.

It is very important that you close all your applications correctly when decide to completely end your session. This means you must click the button for each application, then close any open processes. To be sure, use the Exit function within the module. If another user has an open session on the computer, it can be closed by going to the **Run** > **Sessions** window, selecting the user and clicking the button with the red X.

To see the details of the sessions for a user, select the line then click the **View Details** button. This shows the specific module and how much memory it is using.

Searching External Databases for Medical Information

The Solution Series Dashboard provides a method of accessing online resources for medical information without leaving the application. This option is enabled by default, but can be suppressed if a user prefers or if your facility does not have an account that allows you to access those sites. The following resources are currently supported through this feature:

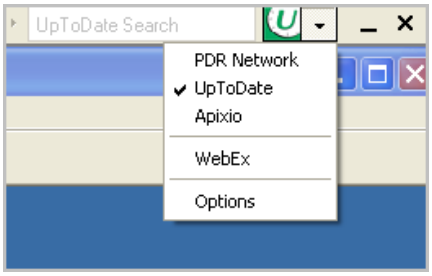
- **UpToDate** is an online repository of medical information that has been submitted, peer-reviewed and is maintained by expert clinicians. See http://www.uptodate.com/home/about/index.html for more information.
- **Physician's Desk Reference (PDR)** is a commercially published compilation of manufacturers' prescribing information on prescription drugs, updated annually. The PDR Network is the online source for that guide. See http://www.PDR.net for more information.
- **Apixio**: See http://www.apixio.com/ for more information.

Note: You must have an active membership to access these databases. When you use the search function to go to those sites through the Dashboard for the first time, you will be prompted to provide your account information.

- **WebEx** option will open a web browser to the e-MDs Webex website conveniently from within the Solution Series application. This allows you to quickly begin a Webex session with the e-MDs Support Team if necessary.

To search an online resource through Dashboard:

1. With Dashboard active on your desktop, locate the **Search Bar** in the upper-right corner of the Dashboard.
2. If you prefer to search a different resource rather than the default search engine, click the down-arrow next to the search engine icon and select a different option. Note that the search engine icon will change to reflect the currently-selected search engine.



3. Type your search string in the field and click the search engine icon immediately after the search field (or press **Enter** on your keyboard).

   Using your default Internet browser, a new window will open at the selected site.

   Note: If this is the first time you have accessed the site, you will be asked to enter your account information to register.

4. Review the information that is returned or begin a new search on the site, as needed.
5. When you have completed viewing the information, close the browser window.

Note: If you want to disable the Search Bar, select **Options** from this drop-down list to go directly to the Chart Options screen. To disable this option, click the check box next to **Search Bar Enabled** to deselect it, then click **Save**. The Search Bar will disappear from the Dashboard.

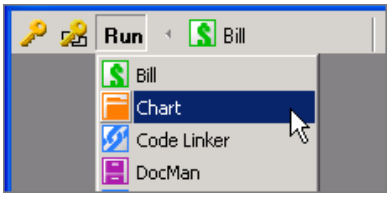
Opening Chart from the Dashboard

Before performing the tasks in this guide, you must log in to Chart. This is most frequently done from the Dashboard (or from the Tracking Board, as described below).

1. Double-click the desktop shortcut.
2. Log in using your Solution Series user name and password.
3. Click **OK**. Dashboard starts.
4. Click the **Chart** tab on the toolbar.

OR

If the Chart tab does not currently appear on the toolbar, click **Run** and select **Chart** from the drop-down list.



Opening a Patient's Chart from Tracking Board

If a patient's name appears anywhere within Tracking Board (such as in the Waiting Room, in an exam room, or Checked Out), click it and select **Open Chart**.

To open any other patient, click **File** and then select **Open Patient Chart**. Or, click the **Open Patient Chart** button (the first button on the toolbar, with the yellow chart icon). Search for the patient, select the name from the search results, and click **Select**.

Adding New Patient Accounts

Note: Because patient records may already exist in your system for individuals that indicate they are new patients, you must *always* search the database for potential existing accounts before adding a new patient. Therefore, when adding a new patient, first follow the patient search procedure below and then, if a match is not found, perform the new patient addition steps that follow. Failure to search for an existing patient before adding a new account may result in duplicate accounts that will ripple through the system, affecting everything from patient health records to lab reports and financial accounting.

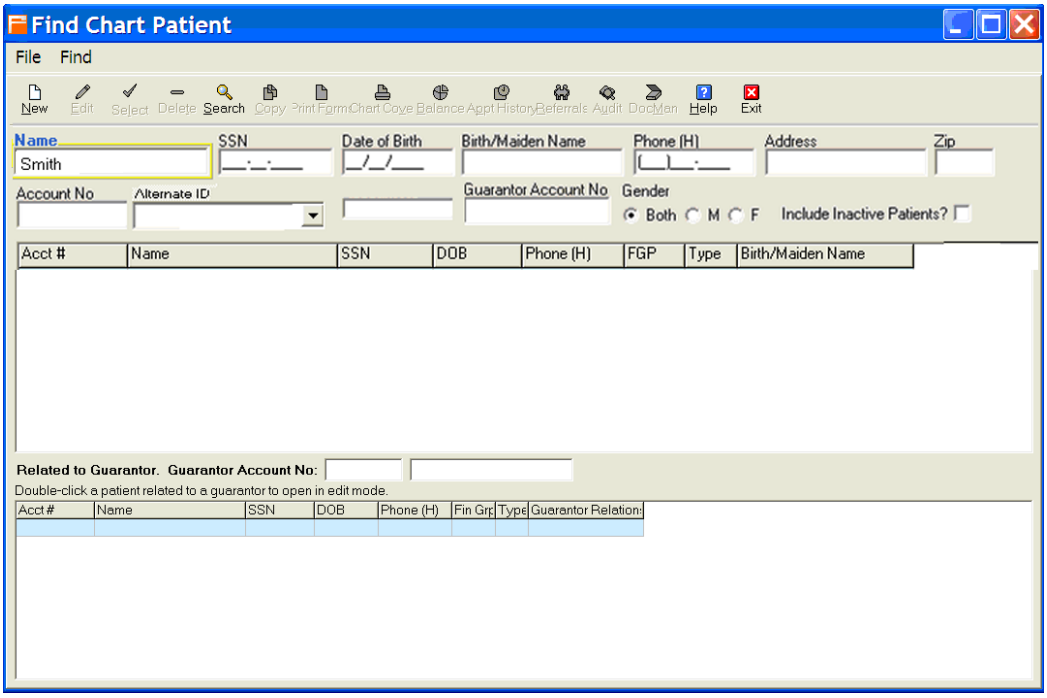
To search before adding a new patient:

1. On the main e-MDs Chart toolbar, click **Demographics** and then select the **Patients** menu option.

   OR

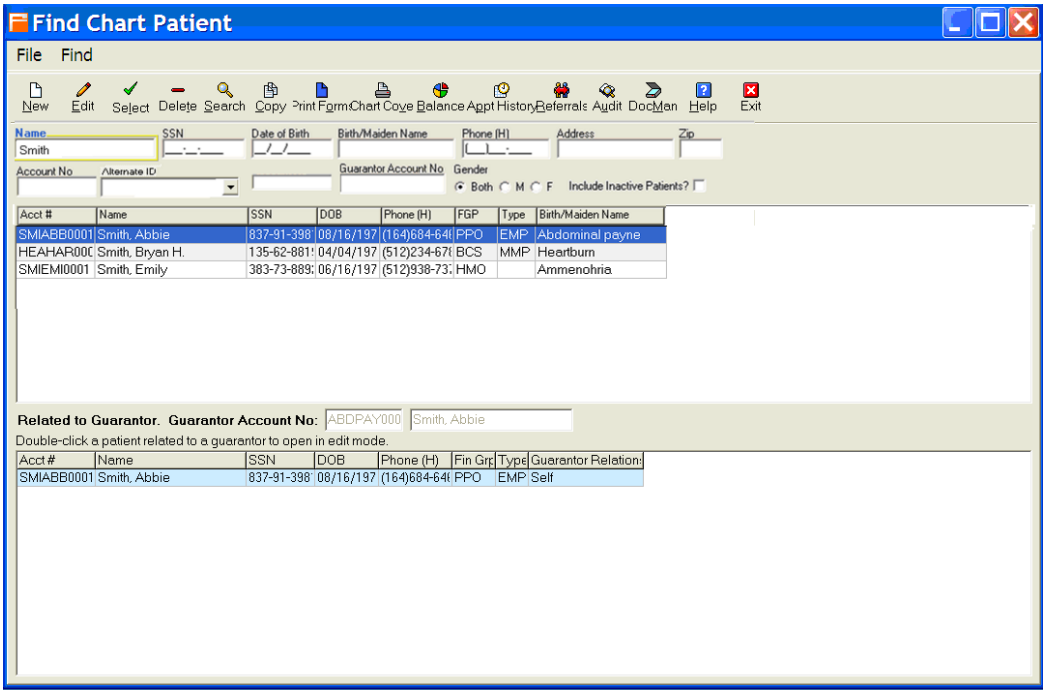
   Click the yellow folder icon near the upper left corner of e-MDs Chart. Either method will open the Find Chart Patient window.

   Note: Pressing **Cancel** at any time during the search process will return you to the Find Chart Patient window.



2. Type at least the first few characters of the patient's last name in the **Name** field. This can be as little as one letter (A, C, F, etc.) or as much as the patient's full last (Smith, Jones, Rodriguez, etc.).

3. Click **Search** to list any patients that match the search criteria. The names of matches that are found display on the screen in the top patient list.



Note: When searching for a patient, you may prefer to select a value in the **Alternate ID** field to list only patients that have a specific Alternate ID assigned to them.

4. *If possible matches are found,* review the list to determine if the patient may already have an account in the system. Since Social Security numbers are unique, check that column first. If you find a close match, select that name and then click **Edit** to open the Patient Maintenance window to view that patient's information.
   - *If the selected chart appears to be a valid match,* verify the chart information with the patient to ensure it is indeed the same person. If it is the same person, update the Patient Maintenance screen as necessary and save the changes. Since a valid match was found, it will not be necessary to create a new account.
   - *If the selected chart is not a valid match upon further investigation*, close that window to return to the Find Chart Patient window and repeat this step for any other possible matches. Continue with step 5 below.
5. If no valid matches were found on your system, continue with "To add a new patient after searching."

To add a new patient after searching:

1. Return to the Find Chart Patient window and click **New** to open the Patient Maintenance window.
2. Begin to enter a first or last name on the screen.

   At this time, Chart will automatically perform a secondary search to determine if another person already in the system may match the information appearing on this screen.
3. *If a matching person **is found***, you will be prompted to accept or reject the matching person's information. If you accept that information, the Patient Maintenance screen will be updated with the found person's information, overwriting any information in prepopulated fields.

   OR

   *If a matching person **is not found***, or if you reject a found person's information, nothing will be changed on the screen.
4. Continue inserting information in any blank fields on the Patient Maintenance screen. *The only required fields (under all tabs) are the patient's name, date of birth, and gender*. For an overview of the fields of note for this screen, see Patient Maintenance Window Options.
5. Click **Save** to update and close the Patient Maintenance window.

Patient Maintenance Window Options

General Tab	
Prefix, Suffix	Form of address and following letters.
Last, First, Middle	If a last-first name combination that already exists for another person entity is entered, a system prompt asks if you wish to view matches.
Display	This is for nicknames or other names by which the person prefers to be addressed and is displayed in e-MDs Chart and on patient super bills.
Birth/Maiden Name	Self explanatory; searchable field containing patient's birth name.
Date of Birth	Self explanatory. If a patient is less than 2 years old, additional fields appear for Time of Birth, Normal Birth and Premature check box options, and fields to enter Gestational age at birth. These values are used for plotting preemie growth charts in e-MDs Chart.
Gender	Self explanatory. The gender is set automatically if one has been designated under the Options tab for the internal medical facility in which the patient is added.
Race	Use this field to select the patient's race. This information is particularly helpful in diagnosing conditions that are prevalent with some races and for gathering statistical information for various reports. See To designate a patient's race as multi-racial for instructions on specifying more than one race for this option.

Ethnic Group	Select the main ethnic origin that the patient associates with his/her heritage. To select Hispanic subgroups, select **Hispanic or Latino**, click the **Search** button, then select the appropriate subgroup. If an appropriate option is not listed, you can leave the field blank (<none>) or select **Declined**.
Language	Select the language most commonly spoken by the patient. This will help identify the need for an interpreter if the patient's primary language is not normally spoken in the clinic.
Account Number	Set automatically based on the internal medical facility account numbering options.
SSN`	Other than a blank field, duplicates are not permitted for person records. A warning appears if a duplicate is entered.
Guarantor	Click **Self** to automatically create a guarantor account with the same information contained in the patient's demographics. This automatically sets the relationship field to **Self**. If the guarantor is someone other than the patient, click the magnifying glass to search for or create a different guarantor, then set the correct relationship. It should be noted that the guarantor is not always the policyholder, although it is used as a default to save time when adding insurance for the patient. For billing purposes, this is the financially responsible party in the event that insurance does not pay. It may be the patient, or a child's parent, or an elderly adult's child. It might also be a legal entity for personal injury patients, or an employer for corporate patients.
Relationship to Guarantor	If the patient is the Guarantor, leave this option with **Self** selected. However, if the Guarantor is someone other than the patient, use the drop-down list to select a different relationship.
Primary Provider	If the appointment is being made for a provider resource, the provider should be set to that person's name. Otherwise, select a default for the patient either by typing letters to filter the list, or clicking the magnifying glass to search. The system adds this person automatically as the DOS Provider when generating invoices that are not from Chart.
Address Lines 1 & 2	Self explanatory.
Zip	Upon entering a known zip code, the system automatically fills in the City and State.
Phone Numbers	Solution Series provides space for up to three phone numbers for each account. To designate one of these phone numbers as the favorite/preferred phone number, click the star-shaped button next to the field. Only one phone number can be designated as the favorite phone number. By default, the first phone number entered will become the "favorite" phone number or, if only one number is provided for the account, that number will be the favorite phone number. If additional phone numbers are added to the account, the option to select a favorite number will be activated and a different number can be selected, if desired. • **Phone (H):** If a number is entered that is already in the system for other person entities, the address details are filled automatically. • **Phone (Cell):** Self explanatory. • **Phone (Work):** Self explanatory.
E-Mail	An e-mail account is required for access to the e-MDs Patient Portal. This e-mail address will receive messages that are sent from the portal regarding appointment reminders, appointment confirmation and history forms needed prior to the next appointment.
Preferred Contact Method	Use this option to designate a patient's preferred contact method. The available options are **Phone**, **Text Message**, **Mail**, **Email**, **Secure Email**, and **Patient Portal**. When a contact method is selected here, the corresponding information field must already be populated with the appropriate information. For example, if **Phone** is selected as the preferred method, at least one phone number must be provided for this account. If the related information is missing for a method selected here, an error message will display when this option is selected. **Note:** If the patient is not an active Portal patient, the **Patient Portal** method will be unavailable for selection here.

Preferred Reminder Method	Use this option to designate a patient's preferred contact method for reminders. The available options are **Cell Phone**, **Cell Phone Only**, **Home Phone**, **Home Phone Only**, **Office Phone**, **Office Phone Only**, **Mail**, **Mail Only**, **Email**, **Email Only**, **Patient Portal**, and **Patient Portal Only**. As with the Preferred Contact Method option, the corresponding information field must be complete for the method selected and the Patient Portal methods will be disabled for patients who do not have active Portal accounts. **Note:** The available methods listed for this option are very specific to avoid excessive reminders going to patients using multiple methods. If a method indicating "Only" is selected, no alternative method should be used to remind the patient of upcoming appointments or procedures.
Financial Group	Extremely important field for e-MDs Bill users. Select the Financial Group Code (such as MDC, PPO, HMO) that identifies the type of financial resource being used. This code is also used when filtering accounts for reporting purposes.
Type of Patient	Patients can be assigned to one of the types set up in the Patient Type reference database. The background color of any appointment for the patient is filled with this to alerting users about any special conditions that apply to this type.
Default Referral	Set a default referral for a patient if required. If the patient is Medicare, and this is primary care clinic, the field should be set to the same person as the Provider to default on claims with lab or diagnostic tests. When the record is saved, a referral/authorization for the patient is created under the **Tools** > **Referral/Authorization** work list and appears in red for which there can only be one for a patient. The default referral is used on claims unless another one is created for a specific authorization, or the **User Provider as Referral if None Set** option in the **Bill** > **Options** window is checked.
Marital Status	Select from the list. A faster method is by starting to type the start letters of a known status and then pressing tab when it is highlighted.
Driver's License No, Date Expired, State	The driver's license information is useful for skip tracing in e-MDs Bill. To store an image of the driver's license, click the camera button at the end of the field. This loads a window in which the image(s) can be stored. You can capture the image directly from a scanner or camera using the scanner button above each image section (see the help on the Image Capture tool). You can also import an image by clicking the folder icon to open a window from which you can browse for and select a .jpg image previously scanned. To clear an image, click the button with the minus sign in the scans window. The Driver License Photos and the Patient Maintenance window can be positioned side by side so you can open the driver license image and then type the information into the demographics at the same time.
Insurance	To add an insurance company, click the **Add** button. A search window for insurance companies appears. Search for an insurance company and select a group to return to the Patient Insurance Maintenance window where the policy number, as well as effective dates and images of the insurance card can be added. Click **Save**. For expanded help, see the "Patient Insurance" section below.

Addresses Tab

Self explanatory. If necessary, insert additional addresses and phone numbers for the patient. The ones added in the **General** tab will appear here when the record is saved. Each one added here must be given a type. You can insert an unlimited number for any entity, although most reports will use specified types. If you add two addresses of phones for a patient of the same type, the one with the **Primary** flag set to **Y** will be used, where necessary, for reporting and other display purposes.

Misc. Tab	
External Medical Facility	The default external facility where the patient is treated should they be hospitalized, in a nursing home, etc. Having a default external facility set can save a great deal of time during daily operations. It will preset the facility for a patient when scheduling rounds visits, and is also used by e-MDs Bill to prefill insurance claim forms where the place of service is not home or office. In both cases, users can change the data for the round or claim if it is not the default.
Alternate FileID	A place to store a different record number such as a medical chart number, or a number used by a previous computer system.
Country of Origin	If the patient's country of birth is listed for this field, select that country. If no appropriate country is listed, leave this field blank (<none>).
First Visit Date, Last Visit Date, Release Date, Release Flag, Patient Signed Date	The first, release and signed dates are set automatically to the date of first registration, but can be overtyped. The Last Visit date is updated by e-MDs Bill every time and invoice is generated. The release flag relates to the level of release of information authorized by the patient and is used on claims. Most clinics typically make patients sign a release that authorizes them to supply all information required to pay a claim (Y). Otherwise, set the flags to N (No), or M (Conditional).
Account Status	Set to **Active**, **Hold**, **Collect** or **Inactive**. The **Active**/**Hold**/**Collect**/**Inactive** settings control statement printing in e-MDs Bill. When a patient is set to **Inactive**, the record is hidden from searches in the patient search window unless the **Include Inactive Patients?** flag is checked. Note that the system still performs duplication checks against inactive patients.
Super Bill ID	A special Superbill can be printed for patients who generally don't get the normal one. Setting the default here helps staff who don't have to remember to select the special one every time the patient is seen.
Super Bill Comment	Free text or lookup field. This prints in bold at the top of Superbills generated for the patient, as well as the top of the e-MDs Chart window. The purpose is to serve as an alert to the provider of care. Text can be added to a lookup comment. The comment group code must be SB in order to be stored in this field. You can add a combination of a comment and text by loading the comment then adding text.
Billing Block	This is used if a patient is on hold for accounting reasons. When set, it generates warnings in various e-MDs Solution Series applications as the patient is loaded and can be used in tandem with the account status and a patient alert to stop staff from scheduling such patients.
Marketing Referral	Is used in e-MDs Bill for a marketing tracking report that looks at business volume by referral. Link the marketing source for the patient such as word-of-mouth, Yellow Pages, advertisement, etc.
Poverty Level	These fields are used in Bill for indigent care billing. Enter the # Family Members and Family Income, then check the Set Poverty Level box. This cross references to the Sliding Scale and Poverty discount reference tables in Bill. If the box is checked, when generating an invoice for patients with no insurance, the discount adjustment and copay are automatically calculated.
Recall Dates	e-MDs Bill has a recall system including the Notice Processor which includes a list report, and the Patient Dates Roster reports based on recall dates. Click Add, then select the recall type and date. There is no limit to the number of recalls per patient. The same recall type with different dates can be linked multiple times to one patient. Note that although the purpose is similar, this is different to the clinical rules/preventive reminders created for patients by Rule Manager in Chart which can also be used for recall report printing. These fields can also be used for purposes other than recalls.

Contacts Tab

An unlimited number of family and emergency contacts can be linked to a patient. The primary contact can be free text typed and upon saving is added to the list at the bottom of the screen. Additional contacts must be added by clicking the + button at the top of the list at the bottom. A relationship is required. To edit the default contact whose information appears in expanded form at the top of the Contacts tab, select the record from the list and click Edit. The name information will be grayed out after it is saved for the first time making it ineditable.

Fax Contacts Tab

This is where a list of fax contacts related to the patient can be added. These f chart ax contacts show up in the Fax Recipient form when a user is faxing from within a patient or DocMan account. These contacts are people or organizations that you typically need to copy documentation to when you see the patient. For example, these could be insurance companies, specialists or referring physicians. Click the Add button then search for entities by Provider, Organization or Person. Make sure you have a fax number for the entity.

Note: The patient's default referral physician is added to this list automatically.

Facilities Tab

The facilities tab is used by Chart. Enter the External Medical Facility (i.e., hospital, nursing home, etc.) Registration Facility and any Pharmacies where a patient normally fills prescriptions. The pharmacies will appear on a short list for doctors when prescribing medications, making it quicker to fulfill the prescription electronically. Multiple pharmacies can be linked to a patient but only one can be designated as the Default.

Employment Tab

The current employment status as well as a complete employment history, sorted in date order can be added for a patient. Only the most recent one is used for claims. The default status is set to Unknown.

Note Tab

Used as an internal communication tool for billing and other messages between users. The check boxes above the note can be set to make this note appear as a warning in other e-MDs Solution Series modules. If the e-MDs Schedule option is checked, the note pops up automatically upon scheduling a patient, and the Edit Appointment window Alert button label is red. In e-MDs Bill, there is a red alert button in the invoicing module and in Chart there is a yellow triangle icon on the patient toolbar with an exclamation mark that turns red. Up to 5,000 characters are supported. An example of a note "Patient owes $20.00 copay from 10/02/2002 visit, transfer to billing office before scheduling an appointment!"

Aging Totals Tab

Shows current aged balances in e-MDs Bill.

File History Tab

This is where users can generate a report of any claim generated for the patient. The specific claims histories are located in the claims themselves. Click the Print button for a hard copy of the report.

Alternate IDs Tab

The alternate IDs tab is where you can add custom fields to the record. An administrator with appropriate security privileges can set up a list of available fields. To add one of these to the record, click Add, select the Alternate ID Type by clicking the list box to see the field names, then enter the Value specific to this record and click Save. You can use the alternate IDs in claims by setting up definitions. This option can also be used to filter groups of patients when performing a search.

Managing Patient Accounts

Here are a few useful tips to remember when working with patient accounts:

- Instead of giving established patients a blank intake form, print the Chart Cover report and ask the patient to verify the information on this report. That will save time for both you and patient.

- If you change a telephone number, be sure to read the prompts regarding guarantor linking or linking to other entities. Failure to do so can result in other entities with the same number or no number being updated. As part of being able to update family groups from one screen the system checks for other entities with the same number. If you have used a placeholder number, or have left it blank, you may be prompted to update other entities with the new number. Only do so if you are absolutely sure. In most cases you should select option to create a new one. You may have patients calling other patients because all entities linked will be affected (patients, organizations, etc.). If you need to clear a number, use the red X button. *Do not enter blanks.*
- Patients can only be deleted if they are not linked to other data. As soon as a medical record, invoice or appointment has been generated for a patient record, it cannot be deleted until the other data is deleted first. If any information for that patient has been locked such as signed off in e-MDs Chart, then it is impossible to delete the patient.
- To simplify the faxing and phoning of prescriptions or referrals to other providers, you can link one or many pharmacies or providers to the patient. When adding pharmacies to a patient account, you can designate a Default pharmacy that is the most commonly used by that patient.

To edit or delete a patient:

1. On the main e-MDs Chart toolbar, click **Demographics** and then select the **Patients** menu option.

   OR

   Click the yellow folder icon near the upper left corner of e-MDs Chart. Either method will open the **Find Patient** window
2. Enter search criteria into any of the fields (such as patient name, social security number, or account number) and then press **Enter** or click **Search**.
   - You can perform searches on either all or only part of a patient name.
   - To search on first and last name, type a few letters of the last name, followed by a comma, then a few letters of the first name.
3. To edit patient demographics, highlight the correct patient from the search results, and click **Edit**. Make changes as desired, and then click **Save**.
4. To delete a patient, highlight the correct patient from the search results, and click **Delete**. If Visit or Order Notes are attached to the patient, deletion is not allowed.

To designate a patient's race as multi-racial:

1. Click the down-arrow to the right of the **Race** field. A basic list of races appears.
2. Click **Other Race** to select that option.
3. Click the **Search** button (magnifying glass) to the right of the **Race** field to open the Select Race window.
4. Scroll down the screen to locate the first race to be selected.

   OR

   Type a search string in the **Description** field and click **Search** to locate the matching race(s).
5. *If the first race is to be specified as the Primary race*, click the check box in the second column (under the gold star) before the race name.
6. *If the first race is not the Primary race,* click the check box in the first column .
7. Continue to locate additional races to be specified and click the appropriate check box before each race. (There can be only one Primary race selected.)

8. After all appropriate races have been selected, click the **Save** button to save your selections and close the window.
9. When you return to the **Misc.** tab, notice that the **Race** field is no longer selectable. However, if you move the mouse over the field, the selected races will be listed in a hint box (for example, **Other Race, African American (Primary), American Indian**).
10. If you need to change the race designation after selecting multi-racial values, click the **Search** (magnifying glass) icon next to the **Race** field. From this screen you can:
    - Click the red X button at the bottom of the window to specify **Remove Selected Races**.
    - Click to clear one or more races selected earlier.
    - Click additional check boxes to add one or more races to the selection.
11. If you change anything on the Select Race window, click **Save** to keep your changes and close the window.

To add a provider fax contact to a patient account:

1. On the main e-MDs Chart toolbar, click **Demographics** and then select the **Patients** menu option.

   OR

   Click the yellow folder icon near the upper left corner of e-MDs Chart. Either method will open the Find Patient window
2. Enter the search criteria into any of the fields (such as patient name, social security number, or account number) and then press **Enter** or click **Search**.
3. Select the desired patient from the search results and click **Edit.**
4. Click the **Fax Contacts** tab and click **+ Add**.
5. Type the provider contact information in the appropriate fields.
6. Click **Save** to retain the changes and close the window.

To add a pharmacy/default pharmacy to a patient account:

1. On the main e-MDs Chart toolbar, click **Demographics** and then select the **Patients** menu option.

   OR

   Click the yellow folder icon near the upper left corner of e-MDs Chart. Either method will open the **Find Patient** window
2. Enter the search criteria into any of the fields (such as patient name, social security number, or account number) and then press **Enter** or click **Search**.
3. Select the desired patient from the search results and click **Edit.**
4. Click the **Facilities** tab and click + **Add**.

   The Find Pharmacy window will open.
5. Type the name of pharmacy in the **Organization Name** field and search, search results will show
6. Click the desired pharmacy name and click **Select *OR*** double-click the pharmacy name
7. In the Patient Pharmacy Maintenance screen the pharmacy name will populate the Pharmacy field

8. Add some information into **Mail Order Text** field if this is a mail order pharmacy. Typically this information would be a patient account number or some other insurance identifier required by the mail order pharmacy to identify the patient.

   Note: Information entered here will show up on the prescription if the prescription is faxed using this mail order pharmacy.

9. Click the check box labeled **Default** to make the pharmacy the default for the patient.

Copying Patient Records

The Copy feature is used to speed up data entry for new patients that share demographic information with others already in the system. The fields that are not copied are: First, Middle, Prefix, Suffix, Display, Maiden, DOB, Gender, SSN, Marital Status, Account Number and relationship to Guarantor. All insurance information is also copied, although the policyholder relationship must also be edited.

To create patient records using the copy key:

1. Click **Demographics** > **Patient** (Alt+D, P).
2. Search for the patient already in the database and highlight the record.
3. Click **Copy** (Alt+C). A new patient data entry screen appears with many fields already filled.
4. Enter missing information and overtype fields in which the information needs to be altered.
5. Open each insurance on the file and change the policy holder relationship.
6. Click **Save** (Alt+S).

3
Managing Patient Chart Information

This section provides detailed instructions for performing the day-to-day tasks required for managing, tracking, and reporting patient chart information. Many of the tasks described in this chapter can also be accessed from the Tracking Board application. See the Tracking Board section for information on that module.

Continued on the next page ...

Opening and Closing Patient Charts

The following instructions apply only when running e-MDs Chart as a standalone application or in the Dashboard, but *not when launching e-MDs Chart from the Tracking Board application.*

To open a patient chart from the e-MDs Chart application:

1. Open the Chart module as described in Opening Chart from the Dashboard.
2. Locate the patient. There are three ways to get to the Patient Search window:

   Click **Demographics** on the main Chart toolbar and select **Patients** from the menu

   OR

   Click the yellow folder icon just below the main toolbar.

   OR

   Click the white text on the desktop that indicates **Click "Open Patient Chart" in the File Menu to Begin**.

   Note: This option only works when no charts open, such as when the e-MDs Chart application is first launched.

   After using one of these methods, a Find Chart Patient form opens.
3. Type a few letters of the patient's last name (or part of the last name, a comma, and then a few letters of the first name), and click the **Search** button at the top of the screen (or simply press **Enter** on the keyboard).

   A list of patient names matching the search criteria displays.
4. Click to select the desired patient and click **Select** (or double-click the patient's name) to open the chart.

See the Tracking Board section for information on opening a patient chart from within the Tracking Board application.

To open multiple patient charts:

1. Open the first patient chart as described above.
2. With the first chart still open, select the second patient chart in the same manner, and so on.
3. To quickly switch between charts when more than one chart is open, click the **Current Chart** drop-down menu (located just below the main application toolbar). This drop-down menu displays the names of all patients with open charts.
4. Click to select any name in the drop-down menu to jump directly to that patient's chart.

   Note: This functionality is not supported with Tracking Board because the charts for all patients seen on a given day are already easily accessed from the main Tracking Board window.

To close a patient's chart:

Close any patient chart by simply clicking the **X** in the blue patient identification bar (to the far right of the patient's name and demographic information).

Important! Be careful that you click the correct **X**. Clicking the uppermost **X** will close the application, as well as all open patient charts.

To close* all *open charts:

Click the **Close All Charts** button (this button is located to the right of the Current Chart drop-down box and is identified by the black outline of two intersecting boxes).

OR

Click **File** and select the **Close All Charts** menu option.

OR

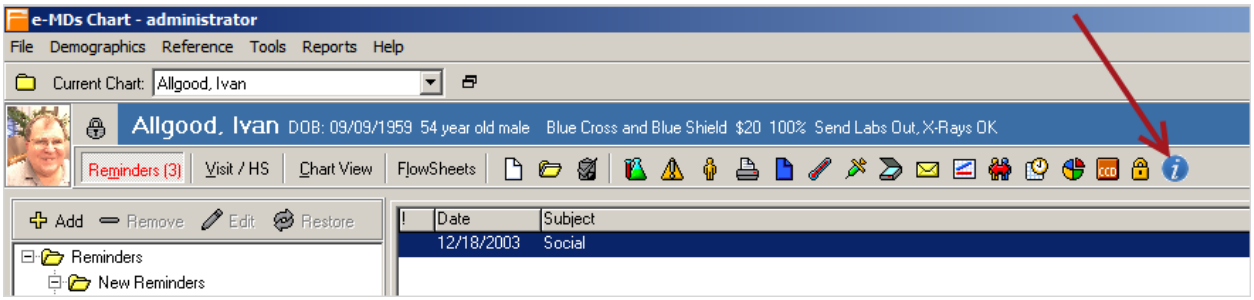
Select the **Log Off and Close All Charts** item.

Understanding the Chart Interface

The following pages provide an overview of the various screens in the Chart application. The individual tasks performed in those sections are described in detail later in this chapter.

MedlinePlus Information for Providers

The toolbar in a patient's chart contains an Info button (the letter *i* in a blue circle).

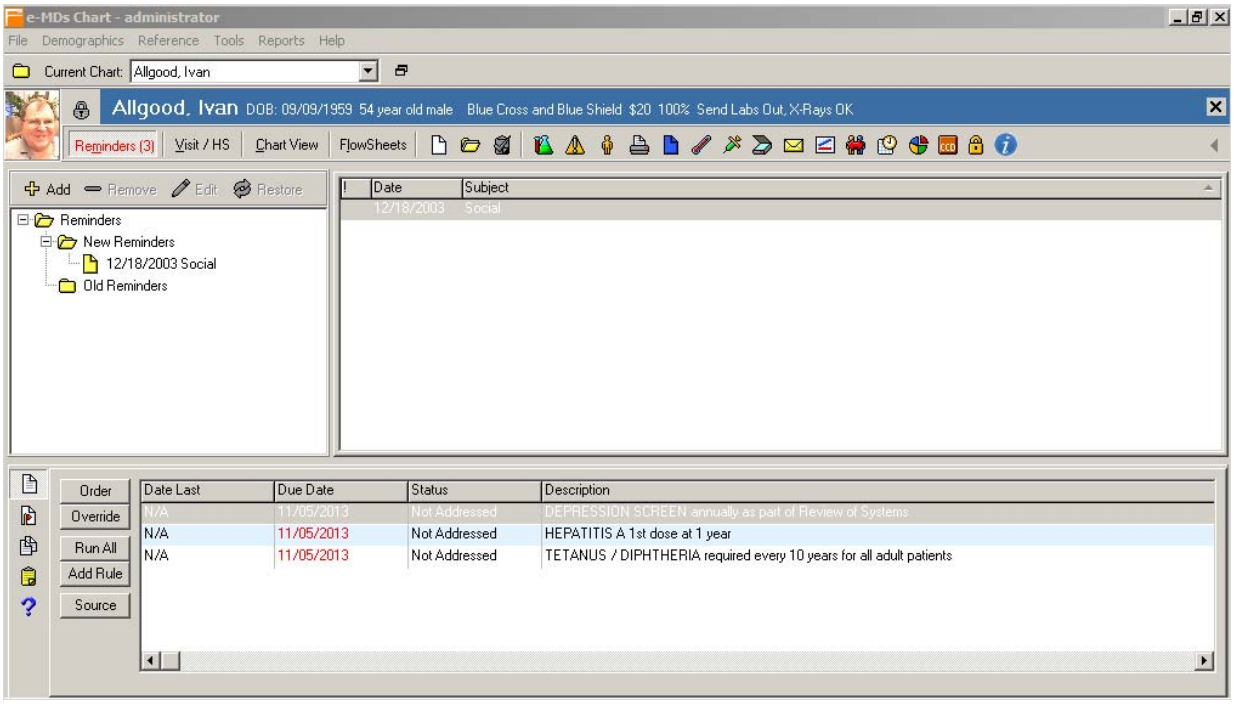


The Info button provides quick access to MedlinePlus information for all current problems, medications, and lab orders/results included in the patient's chart. MedlinePlus information can be viewed, saved, or printed. This button is visible only if the chart_infobutton privilege has been added to the users login account.

Note: The Info button is designed to support provider education rather than patient education. Viewing, printing, or saving the information accessed using this button does NOT meet the MU certification criteria for patient education.

Primary Chart Screen – Reminders

Upon opening a patient's chart, the **Reminders** tab is displayed. Basic reminders appear at the top of the tab and the rule-based reminders appear at the bottom of the tab.



Reminders

The **Reminders** section is intended to allow "sticky" type notes to be attached to the chart. Use these notes to temporarily document information that can be deleted at a later date (if desired). You can return to this section at any time by clicking the **Reminders** tab, located just below the blue patient identification bar.)

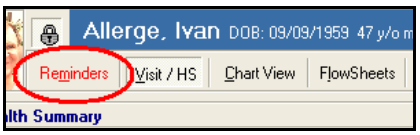
The **Reminders** screen is split into two sections:

- The left side displays a tree view of all New and Old Reminders, along with their priority levels, dates generated, and subject lines.
- The right side displays the full text of the selected reminder. After a New ("active") Reminder is acted on, it can be moved to the **Old Reminders** section. Old ("inactive") Reminders can either be maintained in the Old Reminder folder or permanently deleted.

Use the toolbar located immediately above the Reminders pane to add, delete, edit and restore reminders, as needed. For detailed information on this feature, see Using Reminders.

Rule-Based Reminders

The automatically generated **rule-based reminders** section is located across the bottom third of the window. (You can return to this section at any time by clicking the **Reminders** tab, located just below the blue patient identification bar.)



Clinical Rules are reminders for overdue (or soon due) items including preventive care, disease management, drug management, and immunizations. Rather than batch reports, these are patient-specific reminders, presented to the clinician at the point of care.

The rule description and due date are displayed in this section. A rule is satisfied by ordering the test in question in a Visit or Order Note. In addition, you can choose other options, such as **Deferred**, **Waived**,

or **Refused**. To learn more about addressing rules in the patient record, see the Clinical Rules Engine section

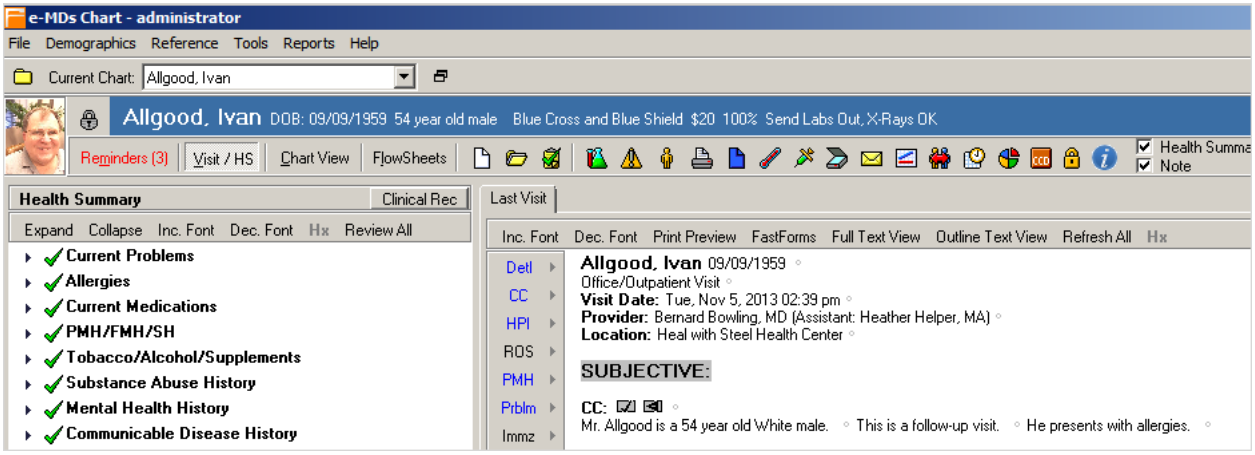
Note: If there are clinical rules that are due for a patient, the **Reminders** tab in Chart will display the word **Reminders** in red text as a visual cue that there are clinical rules that need addressing.

Visit and Health Summary

This window provides information about the selected patient's current health and related history. The Health Summary consists of:

- Current Problem List
- Current Medication List
- Allergies/Adverse Reactions
- Past Medical History
- Surgical History
- Family Medical History
- Social History
- Tobacco/Alcohol/Supplements
- Substance Abuse History
- Mental Health History
- Communicable Disease History.

To access this section, click the **Visit / HS** (Health Summary) tab, located just below the blue patient identification bar.



Health Summary

The Health Summary is displayed in the left window pane with details from the most recent visit in the right pane. (To view the Health Summary in full screen mode, un-check the **Note** check box on the toolbar located in the upper-right corner below the blue patient identification bar.)

Note: If the patient is currently an obstetrical patient, the patient's OB Module overview will be displayed in the right pane by default if the OB Module if installed at your facility. If the patient is not currently an obstetrical patient, or OB Module is not installed, the **Last Visit** tab will be displayed by default.

To display hidden information:

1. Click anywhere on a section bar in the Health Summary to open that section.
2. Click the bar again to close the section.
3. Click **Expand All** on the gray toolbar in the Health Summary to open every section.

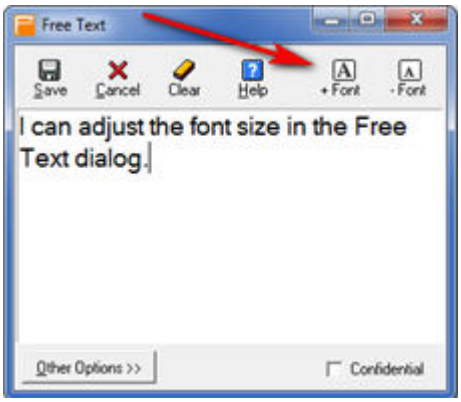
4. Click **Collapse All** to close all sections.

To change screen font size:

1. Click the **down-arrow** to the right of Health Summary and select **Font Size**. The Font Size adjustment box will open.

2. Click **+ Font** repeatedly to increase the size of the displayed text. Click **- Font** to decrease the size.
3. Click the **X** to close the Font box.

*In a Free Text window, font size is also controlled by the **+** and **–** Font buttons*.



Note: Changes in font are only reflected in the on-screen display, and not in the printed version of the Health Summary.

Last or Current Visit

To navigate to this section of a patient's chart, click the **Visit Note/HS** (Health Summary) tab, located just below the blue patient identification bar. The most recent Visit Note is displayed in the right pane. (To view the Visit Note full screen, hide the Health Summary by un-checking the Health Summary check box in the toolbar located below the blue patient identification bar.)

When a chart is initially opened, this screen will display the last Visit Note. That will be replaced with the current note when a new Visit Note is opened.

An active Visit or Order Note is displayed in typical SOAP format (**S**ubjective, **O**bjective, **A**ssessment, and **P**lan). Headers within each of those main four sections further subdivide the note (such as Chief Complaint, History of Present Illness, Review of Systems). Health Summary items can be included in a note under the appropriate headers (such as Current Medications, Allergies, Current Problem List). Click headers within the note for documentation options. Individual blue bars identify each of these sections. If information exists in a given section, a green check mark will be present on the blue bar.

Instead of scrolling through the note, you can click the central vertical row of buttons to quickly jump from one section to another. The black text labels on the buttons turn blue as the corresponding chart sections are addressed.

Within the body of the note, gray squares with black check marks indicate areas where templates may be available. Click any square to see a list of linked templates appropriate for that section. To add free text to the note, click any tiny gray circle (which turns into a yellow square when the cursor runs over it). See Entering Data for more information.

Also see Health Summary Report Print Options.

Chart View

One of the most frequently used windows in e-MDs Chart is the Chart View. Access this window in an individual patient's chart by clicking the **Chart View** tab, located just below the blue patient identification bar.

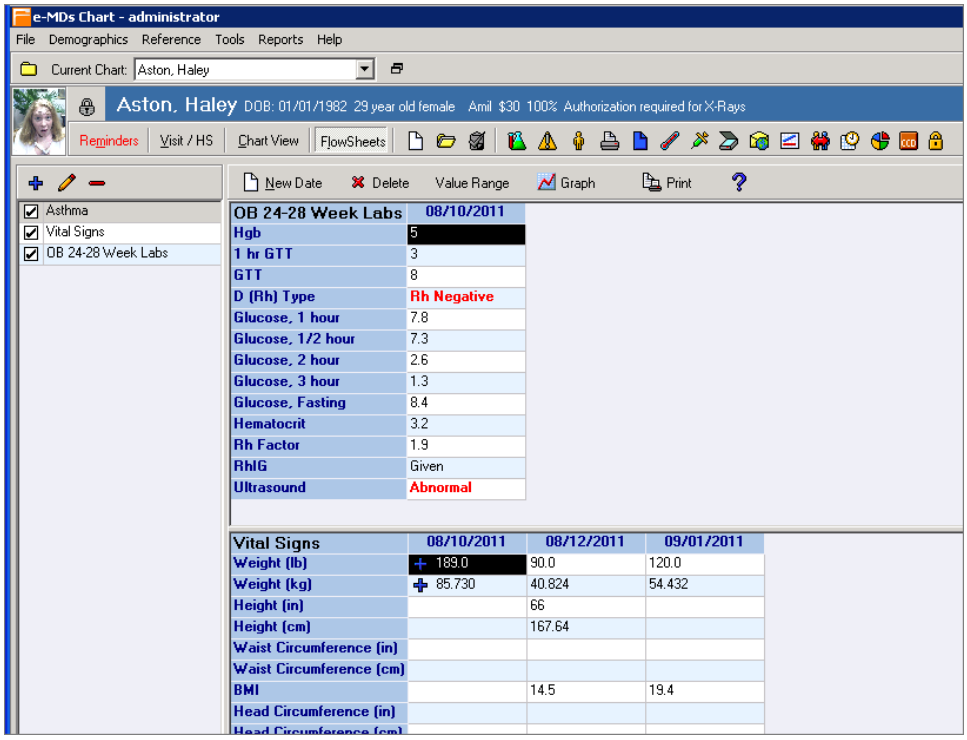
The Chart View, a subsection of an individual patient's chart, consists of ten different sections, which are described in the following table.

Chart View Tab	
Visit Notes	A reverse chronological view (most recent note on top) of all Doctor Visit, Nurse Visit and Order Notes. Notes can be viewed in their entirety or in a tree displaying the diagnoses, prescriptions, and orders associated with the visit or order. Order Notes may or may not be associated with an office visit and can be used to track and verify the completion of orders for patient care beyond an office visit. Order Notes must be signed off by the provider after completion of the order(s). See the Working with Visit and Order Notes section for details.
Telephone/Log/Rx Notes	A reverse chronological view of all telephone notes, log notes, prescription notes and TaskMan notes. Telephone notes document phone conversations with the patient. Log notes store any free-text chart documentation that is not related to a Visit Note or a Telephone Note, such as a notation that the patient's old records were reviewed, or a summary of a conversation with the patient's other physician(s). Prescription notes document any information related to prescriptions. TaskMan notes are internal e-mail messages that contain patient-specific information and have been saved to the patient's chart. Notes are displayed in a tree, identified by date and author. Select any note in the tree to view it in its entirety. See the Create a New Log/Phone Note section for details. When viewing a note and any associated addendums to that note, the original note appears in a pane at the top and the most recent addendum (if there are addendums) appears at the bottom of the pane below the note. When opening a note for viewing, the screen will automatically display the most recent note or addendum first. You can then scroll up and down to view other notations, or right-click anywhere in the addendum pane and select **Jump to Top** or **Jump to Bottom** to quickly move around to view other addendums or the original note.
Chronology	Lists all Visit Notes (Doctor and Nurse Visits), Order Notes, Telephone Notes, Log Notes, TaskMan notes and DocMan documents in reverse chronological order. Items are displayed in a tree, identified by date and author. Select any item in the tree to view it. See the View All Notes in Chronological Order section for details.
Labs/Tests	Lists all labs, tests, and procedures that have ever been ordered for the patient. Can be viewed in Grouped or Chronological fashion. Also hosts a view of Pending orders which works in conjunction with the Order Tracking module to provide a tracking mechanism for labs and tests (see Order Tracking Module for details). Orders are displayed in a tree, identified by the visit date and ordering physician. The associated Visit or Order Note can be displayed in its entirety. See the View Labs/Tests/Procedures section for details.
Diagnoses	Displays all diagnoses ever assigned to the patient, whether they came from the Assessment section of a Visit or Order Note or were added directly to the Current Problem list. Can be displayed in Grouped or Chronological fashion. Details such as Severity and Progression can be viewed. Diagnoses are displayed in a tree, identified by the visit date and physician (if applicable). Any associated Visit or Order Note can be displayed in its entirety. See the "View Diagnoses" section for details.

Medications	Displays all medications the patient has ever received, whether a prescription was written or the medication name was just added to the Current Medications list (i.e. prescribed by another physician or over-the-counter medications). Can be displayed in Grouped or Chronological fashion. Details such as Prescriber, Start and Stop Dates and Reason for Discontinuation can be viewed. Also hosts a view of Refill Requests. This view works in conjunction with the Refill Request module to provide a workflow for dealing with refills (see the Refill Request Module for details). Medications are displayed in a tree, identified by the visit date and physician (if applicable). Any associated Visit Note can be displayed in its entirety. See the "View Medications" section for details.
Consults/Referrals	Displays all Consuls and or Referral Letters that were generated through the Consults/Referrals section. Information available includes the initiating and consulting physician's names. Besides viewing of the information this is also the site in which new letters are generated. See the Create a Referral/Consult Letter section for details.
Documents	This section hosts the scanned or imported documents that are stored in the DocMan module. Access to these documents from the Chart View section allows for faster and easier access to important clinical information (see the Documents section of Chart View for more details).
Cases	This option allows users to view Patient cases. Patient case management is a component of the Bill application and it allows users to link multiple visits together to achieve billing, clinical, and other efficiencies. Cases can link together many different items such as appointments, chart notes and invoices for each encounter related to a case as well as any DocMan scans/forms. This information is available from within a single interactive window as well as a report. This ability to access all information without having to bounce around to different modules is extremely efficient. See Patient Case Management for details.
Legend	This option provides a legend for each of the icons that are used in the Chart View section.

FlowSheets

The FlowSheet module of e-MDs Chart is a very powerful and flexible component that allows you to define, capture and track virtually any type of clinical information. This information is displayed in a grid format much like a spreadsheet that allows you to view large amounts of data in a single, consolidated view.



To access this section of an patient's chart, click the **FlowSheets** tab, located just below the blue patient identification bar.

See FlowSheets for more information.

Basic Reminders

Reminders help keep chart information current and serve as memory joggers that assist in dealing with patients on a more personal level. This section provides instructions for adding, using, and removing basic reminders, which are reminders that are entered by users. (Rule-based reminders, which are automatically generated by rules defined in the Rules Manager, are covered in the next section of this chapter.)

To add a new reminder:

1. Within a patient's chart, click the **Reminders** tab (below the blue horizontal patient identification bar).
2. At the bottom of the **Reminders** left-side window, click **Add** to open the New Reminder form.
3. The current date, sender's name (person logged in at the time), patient's name, and a priority level of normal are filled in automatically.
4. Enter information into the subject line and change the priority level if desired. (The priority levels are High, Normal, and Low. Notes are sorted according to their date and priority level.)

5. Type the text message into the bottom part of the form.
6. Click **Save**.

To edit a reminder:

1. Within a patient's chart, click the **Reminders** tab (below the blue horizontal patient identification bar.)
2. Highlight the note to be edited, and click **Edit** (at the bottom of the left-sided Reminders window).
3. The Reminder window will open and changes can be made to the text message. Once changes have been made, click **Save**.

To move a reminder to the Old Reminders folder:

1. Within a patient's chart, click the **Reminders** tab (below the blue horizontal patient identification bar.)
2. Highlight the note to be moved, and click **Remove** (at the bottom of the left-sided Reminders window). This will move the item to the Old Reminders folder, making it an inactive reminder.
3. To move an Old Reminder back into the New Reminder folder, highlight the note and click the **Restore** button.
4. To permanently delete the note, see "Delete a Reminder."

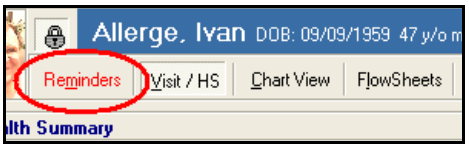
To delete a reminder:

1. Within a patient's chart, click the **Reminders** tab (below the blue horizontal patient identification bar.)
2. Reminders can only be deleted from the Old Reminders folder. (See "Move a Reminder to the Old Reminders Folder.") Highlight the Old Reminder to be deleted, and click **Remove** (at the bottom of the left-sided Reminders window).
3. In the pop-up Warning window, click **Yes** to confirm the decision to delete. This permanently deletes the reminder and it cannot be restored.

Rule-Based Reminders (Automated)

Rule-based reminders are automatically generated by the Rule Manager when defined conditions are met. Rule-based reminders generally focus on health care items that need attention, such as recommended preventive care screenings or best practice procedures for diagnosis-based disease management. (See Using the Rule Manager for more information about how rules work.)

If rule-based reminders have been generated for a patient, the **Reminders** tab in Chart will display the word **Reminders** in red text as a visual cue that there are clinical rules that need to be addressed.



The reminders generated by clinical rules are displayed in the lower third of the Reminders tab.

Views and Action Buttons

To the left of the rule-based reminders is a set of icons (shown below). Hold the mouse over an icon to see the icon label.

- Current view

 - Pending view

 - History view

 - Patient Rules view

 - Legend view

Clicking either of the first two icons (Current or Pending) displays a particular view of rule-based reminders. Clicking the third icon (History) displays an audit trail of actions that have been performed on rule-based reminders for the specific patient. Clicking the fourth icon (Patient Rules) displays any rules that apply only to the specific patient.

The fifth icon displays a legend, which provides information about the color coding of Due Dates for rule-based reminders. Dates are displayed in three colors:

- **Black**: Dates displayed in black are dates for items that are not expired.
- **Green**: Dates displayed in green denote items that are not overdue but that are coming due within a short period of time.
- **Red**: Dates displayed in red denote items that are overdue.

Note: To adjust the width of the columns in the first four views, position the cursor over the vertical splitter bar between the column headers until a left/right arrow appears, and then drag the column in either direction while holding down the left mouse button.

Action buttons are associated with several of these views. More detailed information about views and action buttons is included in the following paragraphs.

The Current View

The Current view is the default view and is represented by a white paper icon  . This view is displayed automatically when a user clicks the Reminders tab in the chart. The Current view includes four columns, which are described below.

Columns	
Date Last	This column displays the last date that actions, tests or documentation dictated by this clinical rule were performed. If the necessary action, test or documentation has never been performed, N/A will display.
Due Date	This column displays the Due Date for the displayed rule. Red text indicates the required action, test or documentation is overdue. Rules can be set to display in advance of the due date, so it is possible to view rules that are "coming due" but not yet overdue. These rules will be displayed in green text.
Status	This column displays the Order Status. When a new reminder is generated, the status will read "Not Addressed." If action is taken during that patient encounter (i.e. the appropriate CPT code is ordered to satisfy the rule), this rule reminder will disappear the next time the Rules Engine runs. The provider may choose to document the action as "Do Now" or "Order."
Description	This column displays the text that is entered in the rule when it is created; this will typically be the name of the lab or test that is needed. The descriptions can also describe the parameters of the rule. For example, a rule description might simply state "Mammogram" or may offer more details, such as "Mammogram to be performed annually in women >/= age 40." See Rule-Based Reminders for more information about these items.

Along the left side of the Current view are five action buttons labeled **Order**, **Override**, **Run All**, **Add Rule**, and **Source**. Use these buttons to perform and/or document actions taken with regard to the rule-based reminders listed for the patient.

Action Buttons	
Order	This button is intended to document that the user is going to order a test or procedure *OR* is requesting that someone else order the item related to the reminder. Clicking this button loads any ICD and CPT codes that are linked to the rule into the Cached CPT Code module and thereafter when a note is opened a warning message will be displayed to give the user an opportunity to add these linked codes to the note for both documentation and billing reasons. For example if the reminder showed that a patient was overdue for a mammogram, the user could mark the rule using the Ordered button and then when the note for the encounter was finally opened a warning message would be displayed explaining that there was a pending CPT code that needed to be dealt with. The user could then drop that CPT code into the note to ensure that the visit was correctly documented.
Override	This button opens the Edit Rule Result window, in which a user can document that the test or procedure indicated in the reminder has been refused, deferred, or waived, and by whom. The user can also indicate the reason for the override, and can change the Due Date (the date change causes the reminder to reappear at a later date determined by the user).
Run All	This button runs the entire rule set. It can be used after a visit so that the clinician can see if any new alerts have appeared, based on new data entered.
Add Rule	This button gives the user the ability to add a patient-specific iteration of the selected rule. This allows for refinements to accommodate special situations with patients.
Source	Selecting a reminder and then clicking the Source button displays a window that contains information about the source of the clinical guidelines on which the rule is based.

See the Addressing Rule-Based Reminders section to read more about the use of these buttons to take action on rule-based reminders during the patient encounter.

The Pending View

This view includes a list of all rule-based reminders for which a user clicked the Override option and then changed the Due Date. This causes the reminder to be removed from the Current view and to reappear at that later date. Until the date is reached and the reminder reappears in the Current view, the reminder will be displayed in the Pending view. In other words the Due Date has changed and the reminder is in a "pending" mode until that date is reached.

Rule-based reminders in the Pending view are displayed in four columns: **Due Date**, **Description**, **Status**, and **Override By**.

Along the side of this view are three action buttons labeled **Edit**, **Reset**, and **Delete**.

Action Buttons	
Edit	This button allows the user to edit the pending reminder and change the Due Date.
Reset	This button allows the user to reset a rule when a reminder has been refused, waived, or deferred, and remove it from the Pending view and return it to the Current view.
Delete	This button allows the user to delete a pending reminder.

The History View

This view provides an audit trail of actions that have been performed on rule-based reminders for the specific patient. Any action that is taken by clicking one of the buttons (except the Run All button) in the Current or Pending views is documented in this view. Clicking any of the reminders listed in this section will display any associated note in the gray area at the bottom of the section.

The History view displays information in 5 columns labeled **Last Date**, **Log Date**, **Due Date**, **Status** and **Override By**. Last Date, Due Date, and Status columns are the same as those described in "The Current View" section. The **Log Date** column displays the date that the action was taken on the rule-based

reminder. The **Override By** column indicates who deferred, refused, or waived the reminder. (Information is pulled from the Edit Rule Result window that is displayed when user clicks the Override button in the Current or Pending view.)

There are no action buttons associated with the History view.

The Patient Rules View

This view includes reminders generated by any patient-specific rules created for the patient.

Action buttons associated with this view are described below.

Action Buttons	
Run	Runs all the patient specific rules.
Edit	Allows the user to edit the patient specific rule.
Delete	Allows the user to delete the patient specific rule.

Addressing Rule-Based Reminders

Rule-base reminders for individual patients are displayed in the Tracking Board and on the Reminders tab of the patients' chart in e-MDs Chart. Instructions for addressing the reminders are identical, regardless of which application is used.

You can address most rule-based reminders in three ways:

- You can "satisfy" the rule by ordering the lab or test (CPT code) required by the rule.
- You can override the reminder (when the lab or test is refused, deferred or waived).
- You can take no action.

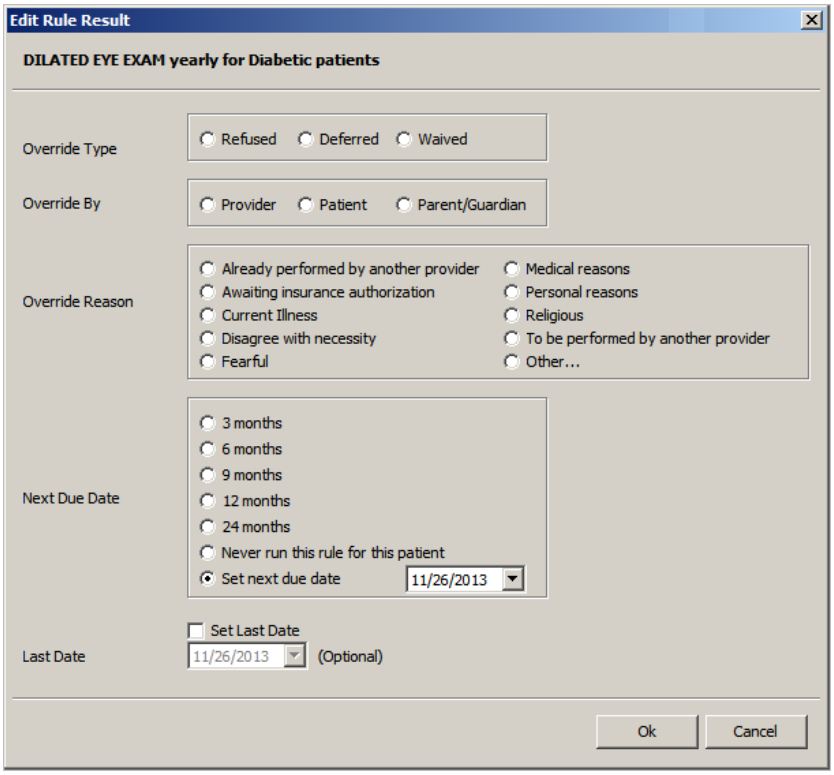
To address a rule-based reminder by ordering the recommended lab or test :

In the current Visit or Order Note, add the appropriate CPT to the Orders section (in the Plan). For example, if the rule-based reminder indicates that the patient is overdue for a mammogram, add a mammogram CPT to the Orders.

- Orders must be added within a note.
- Ordering the lab or test adds the corresponding CPT to the database. The next time the rule runs, this CPT will be recognized as satisfying the rule. Therefore, the next time the patient's chart is opened, that particular reminder will no longer be displayed.

To override a rule-based reminder:

1. Click the **Override** button at the top of the Current view. The **Edit Rule Result** window opens.



2. Select (click) the applicable option in the **Override Type**, **Override By**, and **Override Reason** sections.
3. Select (click) one of the options in the **Next Due Date** section. (If you select **Set next due date**, click the down arrow to pick a new date for when the reminder should reappear in the Current view.
4. Optional: If you want to document the last time the test or procedure was done, click the **Set Last Date** check box and then click the down arrow to select the date.
5. Click **OK** to save the changes.

   The next time the rule runs, the Refused, Deferred, or Waived flag will be recognized, and that particular rule will not appear again until the new Due Date is reached.

Note: Even though the patient refuses the recommended item at this visit, the provider may want to revisit the issue at a later date. To do so, reset the Due Date to a date in the near future (example a year from now). On the other hand, although it is not recommended to do so, a provider may decide that it is not worth revisiting the issue and may choose to select the **never run this rule for this patient** option (in the Next Due Date section) so that the warning does not reappear.

Important! When a reminder is marked as Refused, Deferred or Waived, it is displayed in the **Pending** view. (See the "Rule-Based Reminder Views" information provided previously in this chapter. If a reminder generated by a rule is inadvertently marked as **Deferred** or **Waived** *OR* if the Due Date for a pending item needs to be changed (for example the wrong Due Date was chosen), this can be done by selecting the item in the **Pending** section and clicking the **Reset** button.

To take no action:

If no action is taken on a rule-based reminder, the next time the patient's chart is accessed the reminder will again be displayed in the patient's chart with the status of ***Not Addressed****.*

To reset a rule-based reminder:

1. Click the **Pending** button to view rules that have been Refused, Waived or Deferred.
2. Click the rule to be reset.
3. Click the **Reset** button. A confirmation window asking if you want to reset the rule will appear.
4. Answer **Yes** at the confirmation window. The rule will be reset and the reminder will be removed from the Pending view and returned to the Current view.

Recording Information with Fast Forms

Fast Forms are paper forms derived from existing templates that allow patients to record their own Review of Systems (ROS).

- Using the Fast Form Editor, an existing template is converted into a Fast Form. In this conversion, the user may choose to delete any items within the original template. In addition, any medical terminology can be converted into layman's terms (or into a foreign language).
- Using the Fast Form Processor, the Fast Form is printed onto paper, along with a barcode identifying the patient and the template. The paper lists the template data elements with "bubbles" next to each answer option.
- After the patient answers the questions by filling in the "bubbles" with pencil, the Fast Form is scanned. The scanning process will check for errors, such as no answer (if desired) or both "yes" and "no" answers to a single question.
- The template check boxes are automatically clicked, according to the patient's answer set. With a Visit or Order Note open, the healthcare provider can click a button to drop the "pre-answered" template into the note. At that point, the provider can add additional information or change any answers as appropriate.

Creating a Fast Form Template

The Fast Form Editor uses existing ROS (Review of Systems) templates to create and/or edit Fast Forms for use in the Fast Form Processor.

To create a new Fast Form:

1. Open the Fast Form Editor. A shortcut to this module is not automatically created when the application is installed.

   To create a shortcut:
   a. Browse the computer's Program Files to find the e-MDs directory.
   b. Open the e-MDs Chart folder.
   c. Right-click the Fast Form Editor menu item.
   d. Select **Send To** > **Desktop** (create shortcut).

   The Login Name and Password are the same as for e-MDs Chart.

2. Click **Create**.

   The Editor window will display a tree node labeled **Review of Systems**.

3. Click the plus sign located to the left of the **Review of Systems** label.

   This expands the tree to show the four core ROS templates (Adult Female, Adult Male, Pediatric Female, Pediatric Male), plus any other ROS templates created by the user. These templates are exactly as they appear in e-MDs Chart.

4. Click the title of the template that is being converted to a Fast Form.

5. In the pop-up menu, choose whether this template will be two or three levels deep.

   A two-level ROS template lists the organ system (i.e. Cardiovascular) in the first level and the symptom (i.e. chest pain) in the second level. A three-level template may expound on that symptom (i.e. at rest, with exertion, etc.)

6. In the next pop-up window, supply a descriptive label for the Fast Form.

   This title prints on the form. Any text enclosed by `<brackets>` will not print. If several physicians are each creating personalized Fast Forms from the same core template, it is helpful to type the physician's name in brackets, so that the correct Fast Form is chosen at the time of use.

   The full template expands to the third level, with a check mark next to every data element.

7. Clear the box next to any data element that should not appear in the final Fast Form.

   Notes:

   - If a two-level template was chosen, the third level is still visible at this point. Do not be concerned about this. It *is not* necessary to clear all of the third-level boxes.
   - Be sure that all desired changes are made prior to the next step, as there is some limitation to the types of changes that can be made at the next level (see below).
   - When in Create mode, you can click the Fast Form title at any time to reset the check boxes back to default (all boxes checked).

8. Click **Edit** and then click the plus sign next to the appropriate Fast Form.

   At this point, any medical terminology in the Fast Form can be converted to layman's terms.

9. Click the word to change, and then click the **Edit Node Text** menu option.
10. Edit the text and press the **Enter** key.
11. After making edits, click the title of the Fast Form to either **Save** the template, **Save As** a different title, **Delete** the Fast Form template, or perform additional edits to the text.

    If the template is *NOT* saved in this manner, when the Fast Form Editor is closed, you will be prompted to **Save Fast Form**, **Save Fast Form As…**, **Abandon Changes**, or **Cancel Exit**.

    The newly created Fast Form is now available for the Fast Form Processor. (There is no **Save** button.)

To edit an existing Fast Form:

There is no way to return an existing Fast Form to the "Create" step, in which nodes are chosen to be included or excluded. However, the text of the existing nodes can be edited.

1. Click **Edit** for a list of all existing Fast Forms.
2. Click any node to edit the text, as described above.
3. To delete any item from the Fast Form, click the item to be deleted and select **Exclude Answer** from Template.

   If this is a "parent" item, the subsequent level "children" items will be deleted as well. The title of the Fast Form will now appear in red text, prompting the user to save the edited Fast Form.

4. Once in Edit mode, new items cannot be added to the Fast Form. But, in a newly created Fast Form (if the Fast Form Editor has not yet been closed), click the **Create** button.

   This step should show the previously selected "checked boxes" of the Fast Form.

5. Add the new item(s) and then click **Edit** again if further editing is desired.
6. When finished, click the title of the Fast Form and select the **Save Fast Form Template** option to replace the original Fast Form.

OR

Select the **Save Fast Form Template As…** option (and supply a title) to retain both the original and the newly edited Fast Form.

To delete a Fast Form:

1. Click **Edit** for a list of all existing Fast Forms.
2. Click the title of the Fast Form to be deleted and select the **Delete Fast Form Template** option.
3. Click **Yes** in the Delete Confirmation window.

Setting Up the Fast Form Processor

The Fast Form Processor prints ROS (Review of Systems) Fast Forms (created in the Fast Form Editor) with a barcode identifying the template and the patient. After the patient fills in the answers, the Processor then accepts scanned Fast Forms and identifies potential problems, such as questions with both a "yes" and "no" response selected. Several steps are required before the initial use of the Processor.

To set up a temporary file to hold Fast Forms:

1. After a patient has completed a Fast Form, and it has been scanned, it is temporarily stored in a file until the Fast Form is used in a Visit or Order Note.

   Create this temporary if one does not exist.
2. On the computer that will be storing scanned Fast Forms, set up a C:/temp directory.

   After the temporary file is available, the Fast Form program will create an additional directory folder called C:/temp/FastForm for storage of processing files.
3. *Do not* delete this directory. If deleted by mistake, simply recreate that directory.

To open the Fast Form Processor:

1. Open the FastForm Processor.

   A shortcut to this module *is not* automatically created when the application is installed.
2. To create a shortcut for the machine that will typically be used to print Fast Forms, browse the computer's Program Files to find the e-MDs directory.
3. Open the e-MDs Chart folder.
4. Right-click the **FastFormProcessor.exe** file and select **Send To > Desktop** (create shortcut).

   The Login Name and Password are the same as for e-MDs Chart.

To set up the scanner and printer:

1. Click **Select** and choose the **Scanner** menu option.
2. In the Select Source window, highlight the correct printer driver and click **Select**.
3. If no scanner drivers appear in this window, install the appropriate drivers for your scanner.

   Note: If other hardware (such as other scanners or digital camera) is installed on this computer, each time the FastForm Processor is launched, you must reselect the driver for the scanner that processes the Fast Forms.
4. Click **Select** on the tool bar again, and choose the **Printer** menu option.

   The Fast Form Processor automatically selects the computer's Windows default printer.
5. If necessary, change the printer in the Print Setup window.
6. Click **OK**.

To validate ambiguous answers:

1. Click **Setup.**
2. Select the **Options** menu item. By default, the **Validate** button is active.

   The Fast Form Processor is designed to handle ambiguous answers ("yes" and "no" selected for a single question) and non-answers (questions the patient did not answer). If the Validate button is pressed (highlighted green), the Processor automatically disregards ambiguous answers (the final template will have neither answer checked).

To manually review ambiguous answers:

1. Click the **Validate** button again to disable it (the button will now be gray/black).
2. After scanning the Fast Form, under **Scan and Score** in the Fast Form Processor, review the ambiguous and unanswered items. Ambiguous answers are colored **RED** and non-answers are **PURPLE**.
3. Click any item to launch another screen displaying an image of the patient's responses. A menu next to the image provides the option to save the answer as **YES** or **NO** or to **DISCARD** it.

To generate a thumbnail view of Fast Forms:

1. Click **Setup** and select the **Options** menu item. By default, the **Thumbs** button is inactive.
2. To present a thumbnail of a scanned Fast Form, click the **Thumb** button to activate it (highlighted green). Click the corresponding size of the thumbnail to select your preference.
3. Now, whenever a Fast Form is scanned, a thumbnail will be displayed on screen. To enlarge the thumbnail, double click it. This launches the Image Review screen, allowing review of the patient's responses.

Calibrating the Scanning Processor

Currently Fast Forms have default settings for scanning that include the position of the barcode and the four corner points. The processor uses one corner point as a reference to assist in identifying the remaining points and the barcode. Therefore, these default settings should not need to be adjusted.

The Answer Sets also come with default settings, but you cannot adjust their position and sensitivity at this point. These settings can be reviewed following the scanning/processing of the first Fast Form.

To test the settings of the Answer Set position and sensitivity:

1. Create a Fast Form for a sample patient and fill it out.

   After printing the Fast Form, a *pending* Fast Form for that patient should be visible under the **Scan & Score** tab.

2. Go to **Setup** > **Options** and click the **Validate** button to active (highlighted green). *The Thumbs activation is optional.*

   Note: The **Calibrate** option will *not* be active at this point.

3. Place the completed Fast Form sheet in the scanner tray and click the **Scan** button.

   This will open the Scan & Score Progress Monitor which shows processing details. If the initial Fast Form is "read" successfully (including the barcode and four corner points), the following message should be displayed: "*FastForm: "[name of FastForm]" scored and stored successfully."*

   If an error message appears stating that "*BARCODE NOT READ*, or *LESS THAN 3 POINTS IDENTIFIED*," re-scan the Fast Form.

4. Make sure that the Fast Form is facing *DOWN* in the scanner feeder tray, that all four corner points are printed and visible, and that the barcode is printed and visible as well.

After the Fast Form is scanned/processed successfully, the calibration functionality should be active.

5. To review the position and sensitivity settings, go to **Setup** > **Options** > **Calibrate**.

   This launches the Fast Form Setup – Mark Sense Calibration screen along with the Thumbnail if it was not previously active.

6. Double-click the thumbnail to launch the Image Review For Arbitrating window.

   This window displays the position of the CIRCULAR data point in relation to the computer's associated SQUARE data point. The blackened circles need to be as close to the center position of the square as possible. This ensures that the scanner will read the data correctly.

7. Make adjustments through the Setup Mark Sense Calibration window, which should be still be open on the desktop.

8. Click the window's title bar to make it active.

   Horizontal arrows move the position of the circle left or right and Vertical arrows move the position of the circle up or down.

9. Sensitivity determines the amount of coloring required to fill the circle.

   Move the pointer to the right to require less shading of the circle in order to be accepted as a valid data point. Move the pointer to the left to require more shading to be present in the circle and still be acceptable as a valid data point. In other words, if the pointer is moved to the right, the patient will be required to fill in the circle less, and, if moved left, more pencil mark will be acceptable.

10. After appropriate changes are made to the Horizontal, Vertical, and Sensitivity fields, click the **Reprocess** button in the calibration window to rerun the processing of this Fast Form.

    The Image Review window will close and new results will be displayed in the Scan and Score Progress Monitor.

11. Review these results to make sure that the data was captured correctly. If still not capturing the data correctly, repeat the steps to adjust the position and sensitivity settings.

12. Click **Store Settings** to save these new settings.

    OR

    Click **Restore Defaults** to return to the preset position and sensitivity defaults.

13. Click **Close** to end the calibration process. This closes all windows except the Fast Form Processor Window.

Printing and Scanning Fast Forms

To begin using Fast Forms to capture patient information, you must select and print the appropriate Fast Form template. You will then give this printed form to the patient to complete.

To print and scan the Fast Form template:

1. Open the FastForm Processor.

   Note: If a shortcut to this module is not on the desktop, browse the computer's Program Files to find the e-MDs directory.

2. Open the e-MDs Chart folder.

3. Right-click the **FastFormProcessor.exe** file and go to **Send To > Desktop** (create shortcut).

   The *Login Name* and *Password* are the same as for e-MDs Chart.

The Processor opens defaulted to the Scan & Score tab to alert you to any pending Fast Forms that have yet to be entered into e-MDs Chart. The Processor window can be resized and moved to anywhere on the desktop.

Note: The Fast Form Processor will not allow creation of a new Fast Form for a patient who currently has one **DONE** (scanned, but not yet dropped into a Visit or Order Note) or **PENDING** (awaiting scanning).

4. Click the **Fast Form Templates** tab.
5. Click the plus sign next to the **Review of Systems** label to expand the tree and view all available ROS Fast Forms.
6. Select the desired Fast Form by clicking the check box to the left of the title.
7. Click **Patient** (the first button, with the yellow folder icon).
8. Enter the search criteria and press the **Enter** key or click **Search**.
9. Highlight the correct patient's name from the search results and click **Select**.

   Note: If the Fast Form selected is either age or gender specific, and the patient does not match the criteria defined for one or both demographics, an error message will appear indicating the mismatch and printing will be cancelled. This will allow you to return to the earlier step and select a Fast Form more appropriate for the selected patient.
10. Click **Print** (the second button, with the printer icon).

    This will print a Fast Form for the patient to complete. The barcode on the left side identifies the patient and the template.
11. Instruct the patient to complete the Fast Form with a pencil, answering either **Yes** or **No** for each question.

    Note: Questions may be left unanswered. Remind the patient to fill in the circle as completely as possible. Avoid check marks, dots, or filling outside of the circle as this may increase errors while collecting the data by scanner.

    When a Fast Form has been printed, a notice is sent to the Scan & Score tab as a reminder that a Fast Form has been generated and is PENDING (awaiting scanning).
12. If a pending Fast Form is no longer needed, it can be deleted (and a new one generated, if desired).

    To delete a pending Fast Form:

    a. Click the Patient Name data line.

    b. Select the **Delete Pending Fast Form** menu option.

    Note: When the first Fast Form is printed, it is possible to select **Print** prior to **Patient**; in this case, you are prompted to do a patient search. After that first Fast Form, however, clicking **Print** will automatically print the Fast Form for the previously selected patient, and not give the option to search for a different patient.

To scan in a completed Fast Form:

1. With the **Scan & Score** tab selected, place the completed Fast Form in the scanner and click **Scan** (the third button, with the scanner icon).

   If the scanner is able to read all four corner points correctly, the light buttons turn to green on the left side of the Fast Form Scan & Score Monitor. The Monitor displays a message with the patient name and Fast Form title, stating that the form was scored and stored successfully.

Under the **Scan & Score** tab, the Patient Data line will now show the Fast Form as **DONE**. It remains at this status until the Fast Form is used in a e-MDs Chart Visit or Order Note.

Notes:

- No more Fast Forms for this patient can be created until the current form is added to a Visit or Order Note in e-MDs Chart.
- If the Fast Form Processor application is closed and re-opened, only the **PENDING** Fast Forms will be displayed in the Fast Form Processor. The **DONE** Fast Forms, however, are still available.

If the scanner fails to identify any of the four corner points on any page of the Fast Form, it will not complete the task, and the form must be re-scanned.

Under the **Scan & Score** tab, the Patient Data line will still show the Fast Form as **PENDING**. The Fast Form Scan & Score Monitor will display an error message similar to: "*ERROR: No BitMap for 604661750000006421. Process TERMINATED!"* **OR** "*Less than 3 points Identified"* **OR** "*Image Discarded! Missing Page! Image Discarded!"*

2. Place the entire Fast Form back in the scanner.
3. Verify that the **Scan & Score** tab is clicked.
4. Click **Scan**.

Remember, with Validate activated (see the "Set Up the Fast Form Processor" section for details), the Fast Form Processor automatically disregards ambiguous answers. If Validate is turned off, ambiguous answers must be manually corrected.

The Fast Form Scan & Score Monitor displays a summary of non-answers and of ambiguous answers. Ambiguous answers (those with both a "yes" and "no" response) are shown in **RED**. Non-answers (questions left blank by the patient) are shown in **PURPLE**.

To validate ambiguous answers:

1. Click any red (ambiguous answer) or purple (non-answer) item to display a menu with three choices.
2. Mark as **YES**, **NO**, or **DISCARD**.

   Another window opens with a scanned image of the Fast Form, showing the "actual pencil error."
3. Review the error circled in red, and either correct the information with the patient (mark **YES** or **NO**) or **DISCARD** the item entirely for review by the provider in the exam room.

   After all ambiguous items have been corrected, the Patient Data line under the Scan & Score tab will show the Fast Form as DONE.

To use a Fast Form template in a Visit or Order Note:

1. Print the appropriate ROS (Review of Systems) Fast Form.
2. Have the patient fill in the answers and scan the form back into the system.
3. Ensure that the scanning process was completed without errors
4. In an active note, click the **Add Fast Form** button located on the toolbar directly above the Visit or Order Note. This will open the ROS template, with the patient's answers checked off.

   Note: If no Fast Forms are available for that patient, a pop-up window will indicate that fact.
5. At this point, you can add additional information to the template and change any of the patient answers, as appropriate.
6. Close the template when finished.

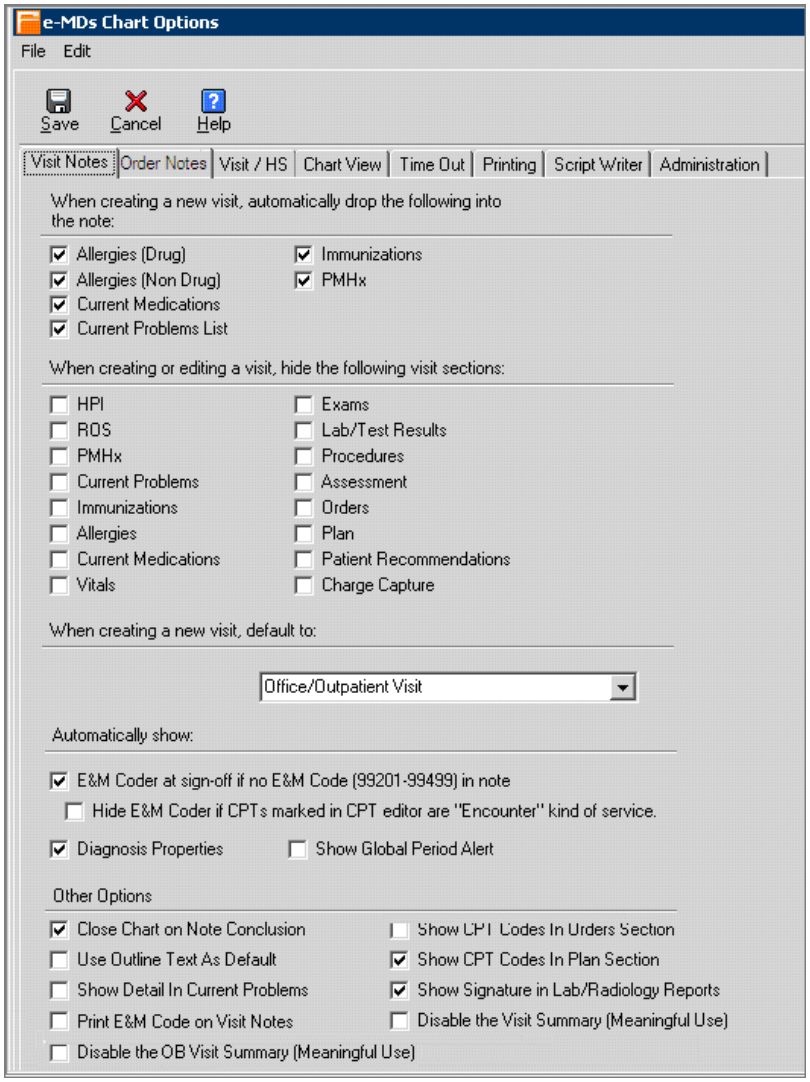
After the Fast Form has been dropped into the note, it is deleted from the database and cannot be reused. There *is no indication* in the Visit or Order Note that the information was collected via a Fast Form.

Note: If any existing template is *edited* in the Template Editor, all Fast Forms derived from that template will be *deleted*. See the "Association between Templates and Fast Forms" section for details.

Setting Preferences for Visit and Order Notes

As a user preference, a provider can choose to automatically add certain elements of the Health Summary to new Visit and Order Notes. These items drop into the note as soon as the Visit Details window is completed. Alternatively, other elements can be hidden based on user preferences.

In order to set preferences for a specific provider, the provider must first log in to e-MDs Chart and perform the steps described below. This login step links the preferences selected to the correct provider. (However, in actual use, the preferences used will be those of the provider whose name appears in the **Health Care Professional** field of the Visit Details window. This allows other clinical staff to be logged into e-MDs Chart to initiate the note, and still maintain the doctor's preferences.)

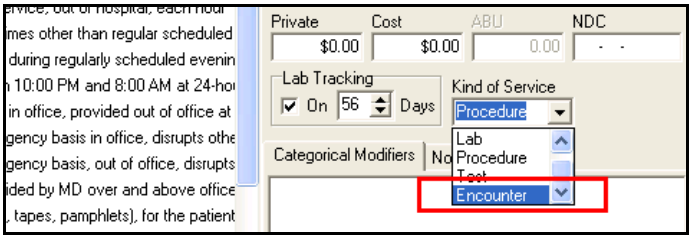


Note: The steps described below are basically the same for both Visit Notes and Order Notes. Just select the appropriate tab in the Chart Options window to set preferences for each type note.

To create user preferences for new Visit Notes and Order Notes:

1. Click **File** and select the **Options** menu option.
2. In the e-MDs Chart Options window, click the **Visit Notes** (or **Order Notes**) tab.
3. In each section, click to select the check box before each desired option as described in the Visit Notes and Order Notes Options table.
4. Click **Save** to retain the settings.

Visit Notes and Order Notes Options	
When creating a new [visit|order note], automatically drop the following into the note:	• **Allergies (Drug)** • **Allergies (Non Drug)** • **Current Medications** • **Current Problem List** • **Immunizations** • **PMHx**: Selecting **PMHx** will add the entire history to the note, including: Past Medical History, Surgical History, Family History, Social History, Tobacco/Alcohol/Supplements, Substance Abuse History, Mental Health History, and Communicable Disease History. *Currently, there is no way to add a subset of that history.*
When creating or editing [a visit|an order note], hide the following visit sections:	A new Visit Note or Order Note includes headers for all possible sections of a SOAP note (such as HPI, ROS, PMHx, Current Problems, etc.). This allows you to hide note headers for sections that you rarely address. These headers can be hidden, but the associated button in the vertical button column will still be visible. Therefore, if a particular section is hidden, it can still be accessed. **Note:** There is some crossover between sections that can be set to automatically drop into the note and those that can hidden. In those cases, if data exists, it will be added to the note. For example, if a user sets Allergies to automatically drop into the note, but he also has selected to hide that section, the patient's allergies will show up in the note.
When creating a new [visit|order note], default to:	The **Type of Encounter** is a required field in the Visit Details window. This information prints in the header of the note and is also used in calculating the E&M code. If you typically see a single type of encounter, you may set that type as a default. The default setting is **Office/Outpatient Visit**. Click the down-arrow to show the other options in a drop-down list.  **Note:** Those selections displayed in blue text are used by the E&M Coder. Options in black text either represent E&M codes that are purely time-based (and, therefore, are not used by the E&M Coder) or are main Encounter Type categories. For example, the "Consultations" Type of Encounter is not specific enough to be used by the E&M Coder; it is better to select a more specific (blue) Encounter Type, such as "Confirmatory Consultations" or "Initial Inpatient Consultations."

Automatically show:	• **E&M Codes at sign-off if no E&M Code (99201-99499) in note:** e-MDs Chart includes an E&M Code Calculator; this calculation is an automated process provided that templates are used for documentation, rather then free text. *The results of the calculation (i.e. the E&M code) will not be automatically added to the Visit or Order Note until authorized by the user*. At any time, the user can open the E&M Coder (by clicking the Plan header and choosing the E&M Coder menu option) to see the progress of the code calculation. While in the E&M Coder, the user can click Accept to add the E&M code to the Orders section of the note. There is a mechanism built in to remind the user to check this calculation and either accept the suggested E&M code or choose an alternate code. This feature is a user preference, and can be turned either on or off. If turned on, when the user clicks the Note Conclusion button and an E&M code has not yet been added to the note, the E&M Coder will automatically pop up. • **Hide E&M Codes if CPTs marked in CPT editor are "Encounter" kind of service**: This option is used to accommodate specific situations that arise with some CPT codes that do not fall into the official range for an E&M code but which ARE considered to be usable as E&M codes (for example 99024 is used for postoperative visits and considered as a replacement for a typical E&M code but does not exist in the "official" range of E&M codes). In cases where these non-typical E&M codes are present in a note the user may not want the E&M wizard to automatically pop up at the end of the visit since the non-typical code satisfies the E&M requirement. To avoid having the E&M Coder pop up in these situations, check the box labeled "**Hide E&M Coder if CPTs marked in CPT editor are "Encounter" kind of service.**" If this option is checked then the E&M coder will treat any CPT codes that are marked as "Encounter" as if they were official E&M codes. **Note:** This feature is designed to work with CPT codes whose Kind of Service type is marked as "Encounter" in the CPT details. To set a CPT code as an "Encounter" kind of service, click Reference in the Chart module. Search for the CPT code, click the description of the code then click Select. Click the Details button on the main toolbar to show the detailed information for the selected code. Select Encounter from the Kind of Service dropdown list in the CPT Search screen (see screen shot below).  • **Diagnosis Properties:** e-MDs Chart includes an E&M Code Calculator (see the Automation of the E&M Coder section for details); this calculation is an automated process. Part of the Medical Decision Making component of the E&M code is based on the number of diagnoses and their properties. For example, a new (acute) problem gets more 'points' than a single, stable chronic problem. There are three types of Diagnosis Properties: Severity (mild, moderate, or severe), Progress (improving, stable, or worsening), and Course (acute or chronic).

	To calculate the correct E&M code, therefore, it is critical that the properties of diagnoses in the Visit or Order Note are set correctly. At any time, you can select a diagnosis (in Assessment) and choose the Properties (severity) menu option to check these properties. Better yet, there is a mechanism built in to remind the user to check the diagnosis properties prior to closing the note. This reminder is a user preference, and can be turned on or off. If turned on, when the user clicks the Note Conclusion button, a pop up window will display all of the ICD codes and their properties. Any of the properties can be changed directly from that window. • **Show Global Period Alert:** The Global Period is the number of days that apply to a code being used for a patient. If the code is used again within this period with the same primary diagnosis, then the other global rules are invoked. A global alert is triggered if the patient is in a global period for any code. The detail of the alert can be viewed to see the codes and date of service that triggered it, what the global period end date is, the physician who did the procedure and the diagnosis.
Other Options:	• **Close Chart on Note Conclusion:** For security purposes the patient chart can be set to automatically close when the note is signed-off. Any time the note is closed through the Note Conclusion window, whether the provider chooses to Close Note/Edit Later or Close Note/Permanent Sign Off, the chart will automatically close if this option is chosen. **Note:** To prevent the chart from closing automatically, clear the **Close Chart on Note Conclusion** option. • **Use Outline Text As Default:** This option sets the default view of the HPI section of any Visit or Order Note to **Outline**. In the HPI section, with the full generated text, it can sometimes be challenging to quickly pick out pertinent information. The outline text feature allows you to decide if you want to see the HPI information with all the grammar and wording or just an outline of the pertinent information. By default, for a new install, the setting is to show the full text view. Clicking the check box next to the **Use Outline Text as Default** field will change the default view to **Outline**. **Note:** The view can be turned off and on "on the fly" by clicking a button at the top of the note (**Outline View** or **Full Text View**). • **Show Detail In Current Problems:** The Current Problems list shows diagnoses descriptions by default. There is a button in the Current Problems list that allows you to show a detailed view that adds the name of the person that added the problem to the list and the date it was added. • **Print E&M Code on [Visit|Order] Notes:** This will print the E&M code on whether the note is faxed or printed. • **Show CPT Codes In Order Section:** This option allows users to hide the CPT and HCPCS codes in the Orders section of all Visit an Order Notes. This allows the note to be saved and printed with just the descriptions for these items showing. The default setting is to *not* show codes in the note. If you want codes to show up simply click add a check mark to the check box next to the choice. **Note:** This option is user specific and can be set differently for each provider in the clinic. When a note is created, the option for showing or not showing the codes is based on the preferences of the provider listed in the Visit Details. Therefore, no matter who starts the note (provider or assistant) the preference will be that of the provider of note.

	• **Show CPT Codes In Plan Section:** This option allows users to hide the CPT and HCPCS codes in the PLAN section of all Visit and Order Notes. This allows the note to be saved and printed with just the descriptions for these items showing. The default setting is to NOT show codes in the note. If you want codes to show up simply click add a check mark to the check box next to the choice. This option is user specific and can be set differently for each provider in the clinic. When a note is created, the option for showing or not showing the codes is based on the preferences of the provider listed in the Visit Details. Therefore, no matter who starts the note (provider or assistant) the preference will be that of the provider of note. • **Show Signature in Lab/Radiology Reports:** Some Lab and Radiology test centers require a physician signature on the order forms that are sent to them. If this option is checked, the same signature that is used for signing faxed prescriptions will be added to any printed or faxed lab/radiology report that is created under the user's name. **Note:** In order for this option to work the user must have scanned signatures in the system (see the Utilities Guide: "Signatures" chapter for details). • **Disable the Visit Summary (Meaningful Use):** This user-specific setting gives users who are not participating in Meaningful Use an option to disable the Visit Summary. If the check box is selected, Visit Summary features that allow printing, exporting and sending a Visit Summary from the Note Conclusion screen will be disabled. This will also *disable* the export of the Visit Summary into DocMan at note signoff. Upon saving this setting, whether disabling or re-enabling, a TaskMan message will be sent to the Administrator/User that is set for Break Security notification in the Administration Section of Chart Options. The disabling or enabling of this option will also be tracked and reported in the Chart Audit Log. See *e-MDs Solution Series Reports User Guide* for information on that report. When upgrading to a new version of Solution Series, the Options setting saved in the previous application version is retained. New installs default to an enabled (clear check box) Visit Summary status. • **Disable the OB Visit Summary (Meaningful Use):** This user-specific setting gives users who are not participating in Meaningful Use an option to disable the OB Visit Summary. This works the same as the **Disable the Visit Summary (Meaningful Use)** option, except for OB visits.

Visit/HS Options

You can set options to auto expand specified sections of the Health Summary on a patient chart (blue header bars) whenever the chart is opened. This allows providers to always have certain information open and available whenever they are in a chart. For example, the provider might want to set the Current Problems and Current Medications sections to always be open when the chart is open.

Notes:

- It is probably best to keep these choices down to a minimum number because of the limited desktop space. If you choose to open too many of the Health Summary sections you will have to scroll to see most of the information.
- Before performing the steps below, the provider must first be logged into e-MDs Chart. This login links the preferences to the correct provider.

To set the Health Summary options:

1. Click **File**, and choose the **Options** menu option.
2. In the e-MDs Chart Options window, click the **Visit/HS** tab.

   In the tab, a list of Health Summary items will be shown with check boxes to the left of each one.

3. Place a check mark in the box next to those sections of the Health Summary that you want to default to open.

Chart View Options

The Chart View section of a patient's chart has many different views of patient information. Some users want to default to a certain view of Chart View whenever they open that section. For example, some users want to see the Visit Notes pane, while others prefer to see the Chronology view. This default view can be set as a user preference.

Note: The provider must first be logged into e-MDs Chart. This login links the preferences to the correct provider.

To set the Health Summary options:

1. Click **File**, and choose the **Options** menu option.
2. In the e-MDs Chart Options window, click the **Chart View** tab.
3. In the dropdown field, choose the desired default view for Chart View by clicking the selection you want.

   The chosen selection will show up in the field.

Health Summary Report Print Options

In addition to the Current Problems, Allergies, Current Medications, Past Medical, Family and Social History information, the Health Summary report also prints upcoming tests/health maintenance items that are due for the patient and tests and procedures that have been performed on the patient. These last two choices are optional and users can choose not to print them.

To set the Health Summary report print options:

1. Click **File** then **Options**
2. Select the **Printing** tab.
3. Under the section labeled **Health Summary Printing Options** are two check boxes labeled "Print upcoming Tests/Health Maintenance items with Health Summary" and "Print Tests and Procedures with Health Summary." If you don't want these new sections to print with the Health Summary, clear the check box next the option or options you want.

When you print all or part of the Health Summary, the clinic and patient demographics information will be inserted automatically in the printout.

Entering Data

e-MDs Solution Series provides several methods to streamline the entry of data in Chart. Those methods are described in detail below.

Fast Forms

Fast Forms offload some of the burden of data entry onto the patient. Because most offices would not be equipped to offer electronic data entry in the waiting room, and because all patients are familiar with filling out paper forms, e-MDs' first attempt at patient-generated data is in the form of paper. Our patent-pending process converts these paper forms into electronic data.

For more information, read about Fast Forms in general in Recording Information With Fast Forms. Also read that section to learn how to create a Fast Form, how to print and scan it, and how to add the patient-generated data to a note.

Templates

Templates are documentation tools used in nearly every portion of Visit and Order Notes. A template is an organized series of data points preceded by check boxes. Only those items that the user checks are added to the note. Sometimes checking a box causes another "level" of the template to open, allowing more detailed documentation. For example, in an HPI template, if you check that the patient has had a cough, the next level may ask for details such as duration and character. For the most part, these details are not required documentation elements; answer them if desired, or ignore them.

For detailed information on using templates in a note, see Accessing Templates in Visit and Order Notes.

Entering Free Text

Because every possible situation cannot be anticipated, Chart also provides free-text areas where you can enter your unique detailed information.

To add free text:

1. Click the **Free Text** icon.

   Free text can be added in the Health Summary, Visit Note, or Order Note at any place with a Free Text icon, which is represented as a small gray circle that turns into a yellow square when the cursor hovers over it.

2. Type into the Free Text window and then click **Save**.

To edit or delete free text:

1. As the cursor is run over the free text in a Visit or Order Note, text fragments highlight red. With any red-highlighted text fragment, perform a single left mouse click to reopen the Free Text window.
2. *To edit free text,* simply make changes as necessary in the Free Text window, and then click **Save**.

   OR

   To delete the entire text from a Free Text window, click **Clear** and then click **Yes** in the Delete Confirmation window.

Paste Text from Another Source into a Patient's Chart

Electronic text copied from another source can be pasted into the Health Summary, Visit Note, or Order Note at any place with a Free Text icon, which is represented as a small gray circle. When the cursor is run over a Free Text icon, it turns into a yellow square.

To paste text from another source:

1. Click the **Free Text** icon.
2. Paste text into the Free Text window and then click **Save**.

   Hint! Highlight text to be copied and then press **Ctrl+C**. This copies the text to the computer's clipboard. When the Free Text window is open, paste the copied material by pressing **Ctrl+V**.

Use Voice Recognition in a Visit or Order Note

e-MDs does not warrant that any speech recognition software will work within e-MDs Chart, and no application-specific voice commands have been developed. However, most voice recognition software is designed to work within any Windows-based product. In limited testing, most of the typical voice-to-text functions appear to work within the Free Text windows of e-MDs Chart. Expanded functionality, such as voice correction of misrecognitions may not be possible. Another option is to dictate into the speech

recognition product's dictation window (with it's full functionality), and then copy and paste the text into e-MDs Chart as described above.

To add speech recognition-generated text to the chart:

1. Click any **Free Text** icon.

   In the Health Summary, a Visit Note or an Order Note, Free Text icons are represented as small gray circles that turn into yellow squares when the cursor is run over them.

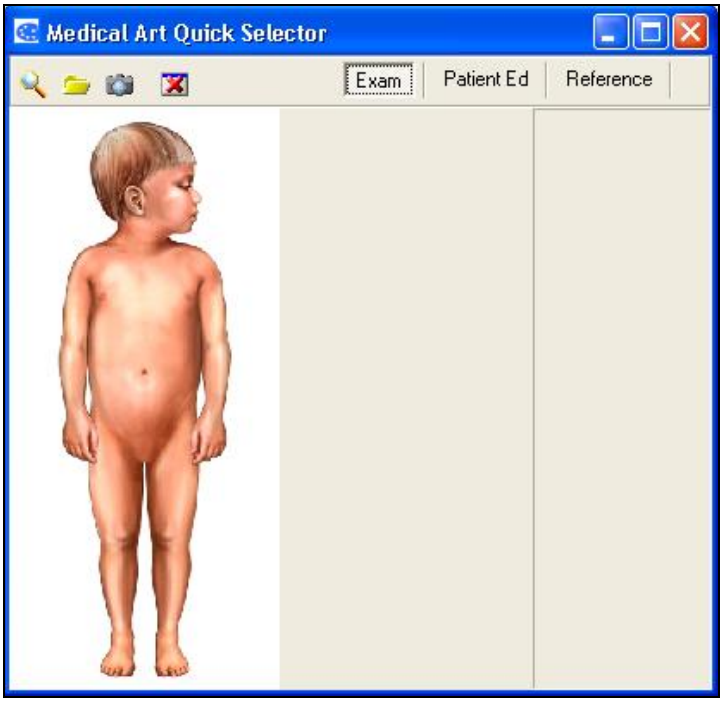
2. With the Free Text window open, turn on the microphone and begin speaking. Text will appear in this window.

3. When finished, turn off the microphone and click **Save**.

To add medical art to a note:

1. With a Visit or Order Note open, click the **Art** button at the bottom of the Chart navigation bar.

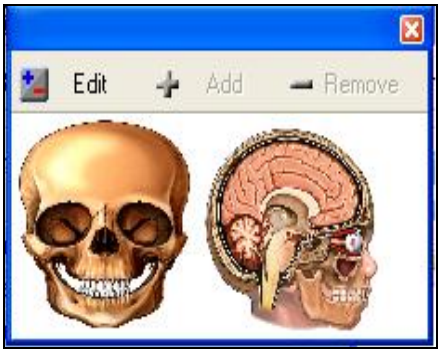
   This navigation bar runs vertically between the Health Summary and the note. This opens the Medical Art Quick Selector window. The age and gender of the patient will determine the body figure that is displayed.



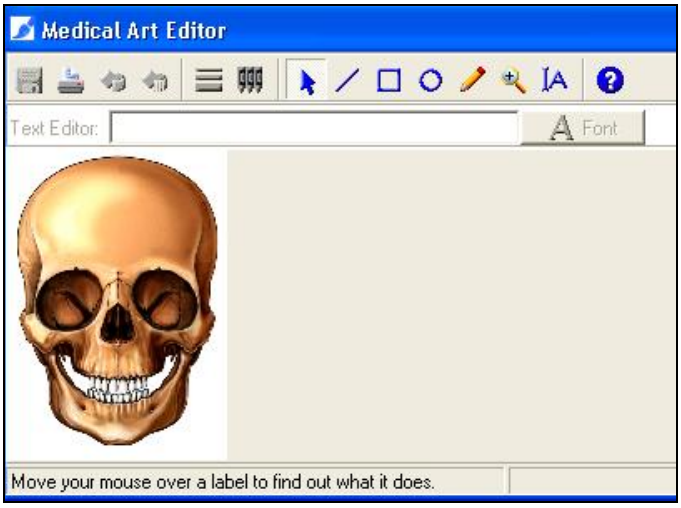
2. To view and select art associated with a specific area of the body or "Hotspot", select the type of art desired by clicking one of the tabs at the top right. Choices include **Exam**, **Patient Ed**, or **Reference**.

3. To view linked images after selecting the type of art, click the area of the body for which medical art is needed.

4. Click the Hotspot area to open the thumbnails window. This displays all linked Medical Art images.

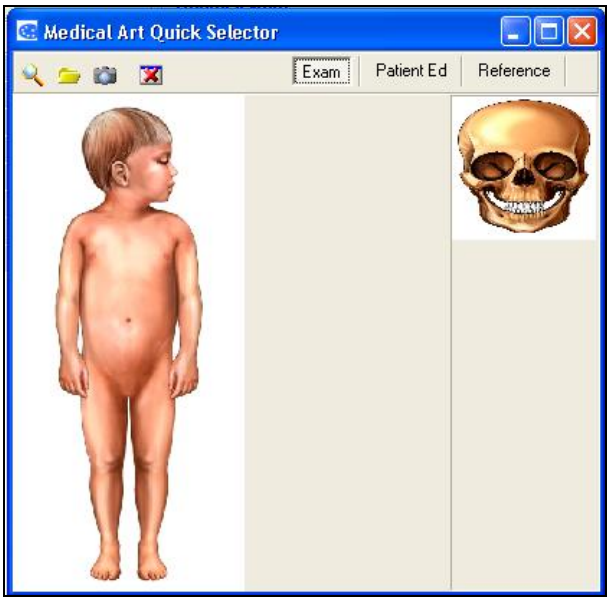


5. Click the image desired to open the image in the Medical Art Editor window.

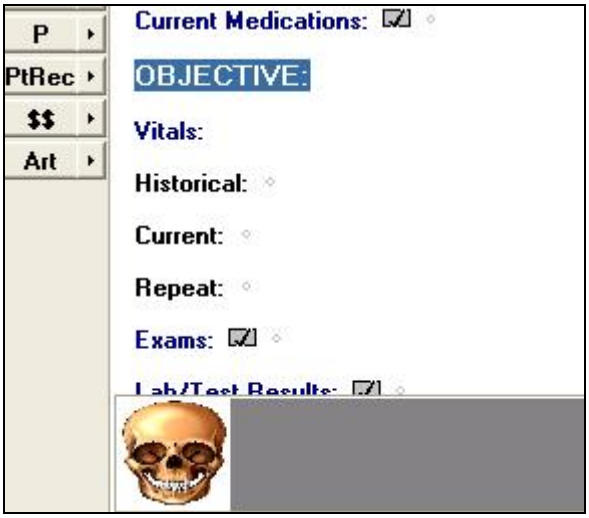


6. Close the Medical Art Editor window by clicking the **X** in the top-right corner.

   The image will be added to the Medical Art Quick Selector Thumbnail Strip prior to its addition to the note.



7. If desired, repeat the above steps to insert additional linked medical art images in the Thumbnail Strip that will also be added to the note.
8. When done, close the Medical Art Quick Selector window. This adds the art displayed on the Thumbnail Strip to the bottom of the note.



Beginning a New Note

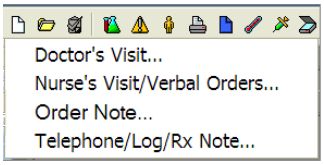
Use the following procedure to start any new Visit or Order Note in Chart.

To open a new Visit or Order Note:

1. Use one of the following methods to select the patient:
   - *If using e-MDs Chart as a standalone application,* click **Demographics** on the main toolbar and then select the **Patients** menu option.

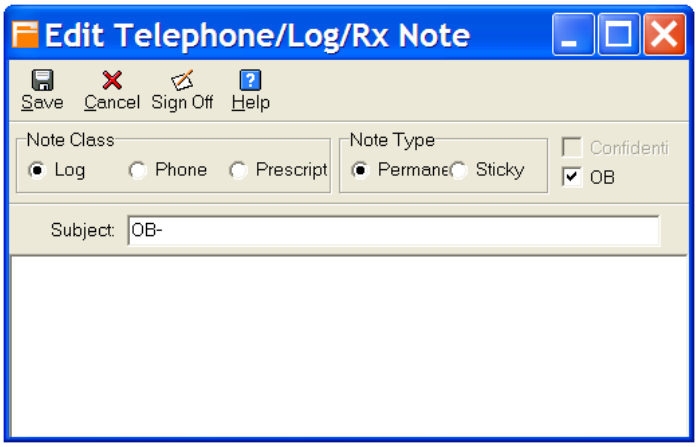
     Additional options to access a patient chart include clicking the *yellow folder* icon near the upper-left corner of e-MDs Chart or clicking the white prompt indicating **Click Open Patient Chart in the File Menu to Begin**. Either method will open the Find Patient window.
   - *If launching e-MDs Chart from Tracking Board* with the patient's name appearing anywhere in that window, click the name and select either the **Collect Vitals/Visit Note**, **Physician/Provider Start**, or **Show Chart** menu option.

     If the patient's name does not appear within the Tracking Board window, use one of the methods described in the above item (clicking Demographics, the yellow folder icon, or the white text prompt).
2. Enter the search criteria into any of the fields (such as patient name, social security number, or account number) and press **Enter** or click **Search**.
3. Select the correct patient from the search criteria and either double-click the name or click **Select**.
4. Click the **New Note** icon on the gray toolbar below the blue patient identifier bar. This icon is a white sheet of paper (immediately to the right of the **FlowSheets** tab).



5. Select the **Doctor's Visit**, **Nurse's Visit/Verbal Orders**, **Order Note**, or **Telephone/Log/Rx Note** menu item. The only difference between a **Doctor's Visit** and **Nurse's Visit/Verbal Orders** is the Visit Details window. These two notes are generally referred to as "Visit Notes." Selecting a Nurse Visit allows the nurse to be the primary healthcare provider for the visit, including the responsibility of permanently signing the note.

   Order Notes may or may not be associated with an office visit and can be used to track and verify the completion of orders for patient care beyond an office visit. Order Notes must be signed off by the provider after completion of the order(s).The **Telephone/Log/Rx Note** provides an option to make notes of patient's calls, to log information that is not related to a specific clinic visit, and to make notes regarding prescription handling.

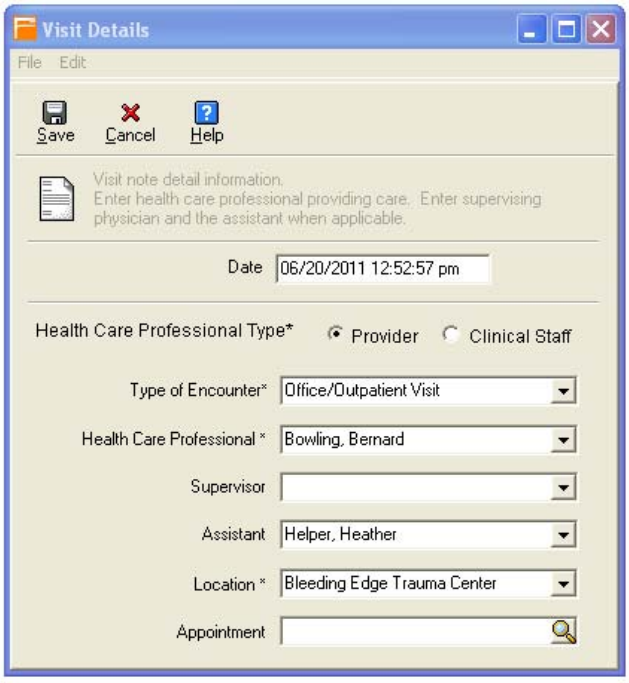


Notice that this note also includes an OB check box that is checked automatically when the patient has been identified as pregnant. The **OB-** notation is also added to the subject line automatically to highlight any logged information as being related to a pregnant patient. When the OB check box is selected, the **Confidential** check box is also disabled, giving priority to the OB status.

6. Complete the fields in the Visit Details window. See Visit Details Options for more information.

Visit Details Options

The Visit Details window of the Visit Note or Order Note must be completed prior to initiating a new note.



For a description of available Visit Details options, see the following table.

Doctor's Visits, Nurse's Visits/Verbal Orders and Order Note Options	
Date and Time	The current Date and Time that a note is initiated is automatically recorded. At any point prior to signing the note, the date can be changed. Time can be changed, but cannot be erased. Note that although the note date may change, any prescriptions written or CPTs ordered will retain the actual date.
Healthcare Professional Type *(Order Note Only)*	Two options are available: • **Provider:** Selecting this option will cause a drop-down list of *active* staff providers to be displayed. • **Clinical Staff:** Selecting this option will cause a drop-down list of clinical staff members to be displayed.
Type of Encounter	***Doctor:*** **Type of Encounter** is a required field. This information is recorded at the top of the note and is used in calculating the E&M code for the visit or order. If you typically have one type of encounter, such as Office or Other Outpatient Services, this can be set as a default. ***Nurse:*** This includes a wide range of nursing and non-nursing services such as emergency room, home services, rest home, and so forth.
Health Care Professional	Click the down-arrow in the **Health Care Professional** field and select the primary care provider for the current Visit or Order Note. **Note:** Physician Assistants and Nurse Practitioners should perform "Doctor's Visit" notes rather than Nurse Notes.
Supervisor	***Doctor:*** If the Health Care Professional is a Physician Assistant or Nurse Practitioner, his or her Supervising Physician should be entered in the Supervisor field. If a default Supervisor was specified, this field will automatically be filled in. (See Physician Assistant and Nurse Practitioner set-up instructions in *e-MDs Solution Series Administration Guide* for information on selecting a default Supervisor). If no default Supervisor has been selected, click the down arrow in that field to choose a supervising physician. ***Nurse:*** The Nurse or Medical Assistant responsible for the Nurse Visit can document his/her Supervising Physician in the Supervisor field. Click the down arrow in that field to choose a physician. ***Order:*** If the Healthcare Professional Type selected in an Order Note is a clinical staff member, the **Supervisor** field is a required field and a value must be selected. This is to ensure that any lab order forms resulting from the Order Note will list the correct ordering provider.
Assistant	***Doctor:*** If desired, an Assistant (such as a nurse or medical assistant) can be documented in the third field. Click the down arrow for a list of all Clinical Staff members. ***Nurse:*** If the primary provider was assisted by another Nurse or Medical Assistant, that assistant's name can be documented in the third field. Click the down arrow for a list of all Clinical Staff members.
Location	Document the location of the visit in this field. If a default location has been assigned to the computer, this field will already be filled in. (For details on setting a default location, see *e-MDs Solution Series Administration Guide*s.) If a default location has not been assigned, click the down-arrow for a list of all facilities.
Appointment	This field shows the appointment that corresponds with the current day's visit note. This field should be filled out automatically, but you can click the **Search** button (magnifying glass icon) to search for and select an appointment to link to the visit.

Telephone/Log/ Rx Notes	
Note Class	The classification of the note – **Log**, **Phone** or **Prescription**.
Note Type	**Permanent** (which requires a signature) and **Sticky** (no signature required).
Confidential	Follows standard Chart handling of confidential information.
Subject	A brief identification of the purpose of the note.
Text Field	The body of the note itself.

Using Past Visits and Shortcuts

A Past Visit loads the information contained in a previous visit into the current visit. This includes all templates, medications, orders, and patient education handouts. The only items that do not transfer are vital signs and health summary data (such as past medical history, allergies, current medications, current problem list, and immunizations).

To load a past visit:

1. In an active Visit or Order Note, click the **CC** heading (Chief Complaint) and select the **Past Visit** menu item.

   OR

   Click the **black arrow** next to the **CC** button in the vertical button column and select the **Past Visit** option.

   Note: To use a past visit, it must be loaded prior to documenting any section of the note that carries forward from the prior visit. This means that only vital signs and health summary data (such as Past Medical History, Current Problem List, Immunizations, Allergies, Current Medications) can be documented prior to loading the past visit. If any other section of the current note (i.e., Chief Complaint, HPI) contains data, the past visit cannot be loaded (the **Past Visit** menu item will be disabled).

   This opens the Load Visit window. Past Visits are identified by date, provider, and diagnoses. Every prior visit for this patient that has been signed off will appear in this window.

   Note: If a Doctor's Visit is initiated, the Load Visit window will show only prior physician encounters and not any Nurse Visits (and vice versa).

2. Click to select and load the desired past visit.

   OR

   Click **Cancel** to close the window without loading a past visit.

   Note: Template-generated text from the past visit is a grayish-blue color. This serves as a visual clue that the documentation came from a past visit. If any template is reopened (possibly for editing or deleting information), the templated text in the note will then turn black.

3. After the past visit is loaded, you can edit, delete, or augment any portion of that documentation. You can also add other items to the note at this point.

Loading a Shortcut Visit

Shortcuts offer rapid documentation by loading the majority of the note with one click, and allowing the physician to concentrate on "documenting by exception." Documentation from a shortcut can include templates, free text, prescriptions, orders, E&M coding, and patient education handouts. The only items that cannot be included in a shortcut are vital signs and health summary data (such as past medical history, allergies, current medications, current problem list, and immunizations).

To load a shortcut visit:

1. In an active Visit or Order Note, click the **CC** heading and select the **Shortcut** menu item.

   OR

   Click the black arrow next to the **CC** button in the vertical button column and select the **Shortcut** option.

   To use a shortcut visit, it must be loaded prior to documenting any section of the new note that might be included in a shortcut. That means that vital signs and health summary data (such as Past Medical History, Current Problem List, Immunizations, Allergies, Current Medications) can be documented prior to loading the shortcut. If any other section of the current note (i.e. Chief Complaint, HPI) contains data, the shortcut visit cannot be loaded (the shortcut menu item will be disabled).

   This opens the Load Shortcut window. Shortcuts are listed by title, and the window includes a search field.

   Note: Shortcuts may involve templates that are age or gender specific, and they may not be available for all patients. For example, a shortcut visit created on a male patient that uses the Male Exam template will not be available in female patients' charts. The user must either create shortcut visits for both sexes, or create gender-neutral templates for use with shortcuts.

2. Click the desired shortcut to load it.

   OR

   Click **Cancel** to close the window without loading a shortcut.

   Note: Template-generated text from the shortcut is a grayish-blue color. This serves as a visual clue that the documentation came from a shortcut. If any template is reopened (possibly for editing or deleting information), the templated text in the note will then turn black.

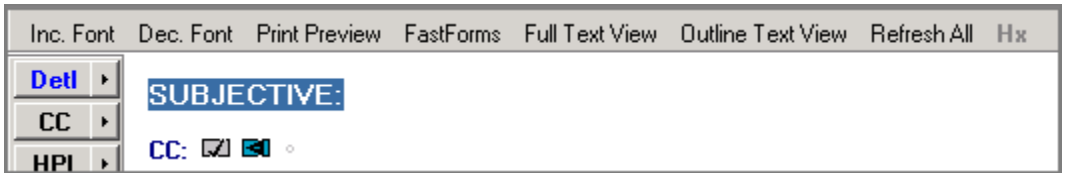
3. After the shortcut is loaded, go ahead and edit, delete or augment any portion of that documentation. You can also add other items to the note at this point.

Documenting the Visit

The information included in the Visit and Order Notes provides a comprehensive description of the patient's overall health status.

Adding the Chief Complaint

In an active Visit Note or Order Note, scroll to the **CC** (Chief Complaint) heading, or click the **CC** button in the vertical navigation button row.



The best option for documenting the Chief Complaint is through a template. There are two specific advantages of using a template. First, Chief Complaint templates can automatically drop the patient's age, gender, and race (if this has been entered in the demographics) into the note. Second, these templates can be built to automatically add the correct ICD-9 code to the visit based on the chief complaint(s) selected.

Another option is to type the Chief Complaint as free text.

To use a CC template:

1. Click the template icon (a gray square with a black check mark) located next to the **CC** heading to see a list of available CC templates.
2. Click the title of the desired template.
3. When the template opens, select the appropriate answers.

   Note: In e-MDs' template, the chief complaint may be a symptom, a disease, or a specific type of visit, such as "Annual Physical." The patient demographics are added automatically by virtue of using the template, so there is no need to click any check boxes for this to occur.
4. To close the template, click anywhere outside the template levels

   OR

   Close the template when finished by clicking the **X** in the upper-right corner of Level One (the first template window). There is no need to close each window individually because closing Level One will close the entire template.

   See Accessing Templates in Notes for more information.

To use free text:

1. Click the free text icon (the white circle with a gray outline, located to the right of the template icon). This opens a Free Text window.
2. Type in this window and click **Save**.

Using Automatic ICD-9 Coding with Templates

Items in the CC (Chief Complaint) templates can be linked to ICD-9 codes. Linking structured pieces of data to template items is done using components called *Extended Attributes* in the Template Editor.

With a CC template containing ICD-9 Extended Attributes, as you click off the reason for the visit (such as "sore throat", "annual physical"), the corresponding ICD-9 code is automatically added to the Assessment section in the note. (A *diagnosis* is not required; ICD-9 codes exist for symptoms and other complaints, as well.)

In addition, the reason for the visit is added to the **HPI** (History of Present Illness) section, along with the ICD code, although the code is not visible on screen. This eliminates the ICD search that was required there in prior versions of e-MDs Chart. Remember that templates are linked to ICD codes, so in order to find the corresponding HPI template(s), ICD-9 code(s) need to be present in the HPI. Therefore, selecting a complaint in a CC template eliminates the need for a manual ICD search in the HPI, and automates the process of presenting the appropriate template(s) in the HPI.

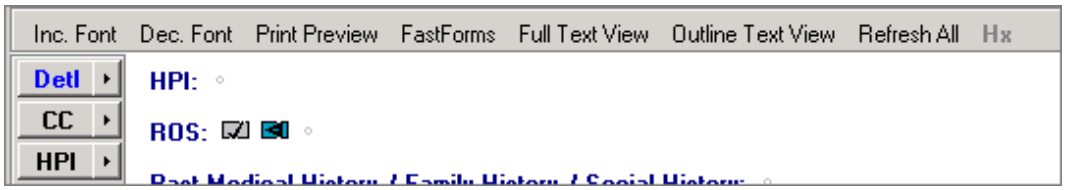
The primary Chief Complaint template created by e-MDs already has ICD-9 codes linked to it. You can, however, easily change it in the Template Editor if necessary (see the "ICD-9 Extended Attributes" section in *e-MDs Solution Series Administration Guide* in the Template Editor chapter for details). ICD-9 Extended Attributes can be incorporated into any new CC templates created by the user.

Any ICD-9 codes added in the HPI can be changed in the Assessment section. This is helpful when the patient presents with a symptom and, after a thorough history and examination, a more specific diagnosis can be made. For example, if the presenting complaint is "earache", the ICD-9 code for that symptom can be changed to the code for "Otitis Media" in Assessment. Changing the ICD-9 code in Assessment will not affect any of the text in the CC or HPI sections.

Documenting the History of Present Illness (HPI)

The easiest way to add a problem to the HPI is to select it in the CC (Chief Complaint) template. The complaints in the CC template are linked to ICD codes, eliminating the need to do a separate ICD search. See Using Automatic ICD-9 Coding with Templates for more information.

A diagnosis, symptom or other reason for the visit can also be selected in the History of Present Illness (HPI) section.



Note: If the reason for the visit is for follow up of an established diagnosis, see the To add a follow-up diagnosis procedure for steps to document the visit follow up.

To add new problems:

1. In an active note, click the **HPI** (History of Present Illness) heading and select the **New** menu option.

   OR

   Click the black arrow next to the **HPI** button in the vertical button column, and select **New**.

   Medicapaedia search option: *Medicapaedia is a database of clinical terminology. It includes diagnosis/symptom descriptions and associated codes.*

2. In the Search field, type the first few letters of a diagnosis or symptom (or type the ICD code) and then click the **Search** button located on the toolbar at the top of the Medicapaedia Search window (or just press the Enter key).
3. In the search results, select (click) the check box next to each description to be entered in the note and then click the **Select** button on the toolbar.

   This action adds the diagnosis code to the Assessment section of the note and adds the diagnosis description to the HPI and Plan sections.

If the patient is returning with an established diagnosis, the diagnosis can be added to the HPI section as a follow-up. (The user still has the option to choose that diagnosis in the Chief Complaint template instead.)

To add follow-up problems:

1. In an active Visit or Order Note, click the **HPI** (History of Present Illness) heading and then select the **Follow Up** menu option.

   OR

   Click the black arrow next to the **HPI** button in the vertical button column, and then select **Follow Up**. This displays the patient's Current Problem List.

2. Click any problem in the list to add it to the note.

   OR

   If the problem is not listed in the Current Problem List, click **All Problems** at the bottom of that window for a list of all diagnoses ever assigned to that patient. Then click any problem from that list to add it to the note.

   This action adds the diagnosis code to the Assessment section and the diagnosis description to the HPI and Plan sections.

Problems can be removed from the note from either the HPI or Assessment section.

To remove a problem:

1. Click the bold black diagnosis description and select the **Delete** menu option.

2. Click **Yes** in the Delete Confirmation window.

Notes:

- If a diagnosis is deleted from HPI, it will automatically be removed from the Assessment and Plan sections. Associated HPI and Plan templates and free text will also be deleted. Any existing orders and prescriptions will be moved to the non-linked Other Orders and Other Prescriptions section of Plan.
- If a diagnosis is deleted from the Assessment section, it will automatically be removed from the Plan. Information gathered in the HPI section, however, will not be affected. Associated Plan templates and free text will also be deleted. Any existing orders and prescriptions will be moved to the non-linked Other Orders and Other Prescriptions section of Plan.

To document the HPI:

1. In an active Visit or Order Note, click the **HPI** (History of Present Illness) heading.

   OR

   Click the **HPI** button in the vertical button column to "jump" to that section of the note.

   Note: Complaints, Symptoms, or Diagnoses must first be entered in the HPI section. This can be done through the CC (Chief Complaint) template, an ICD search, or by choosing a Follow Up problem from the Current Problem List. Then, the history itself can be documented.

   The template icon (a gray square with a black check mark) will appear to the right of the bold black diagnosis heading.

2. Click the template icon to see if any linked HPI templates are available for the given diagnosis. For information about the template icon and the Template Links, see the Accessing Templates in a Visit or Order Note section.

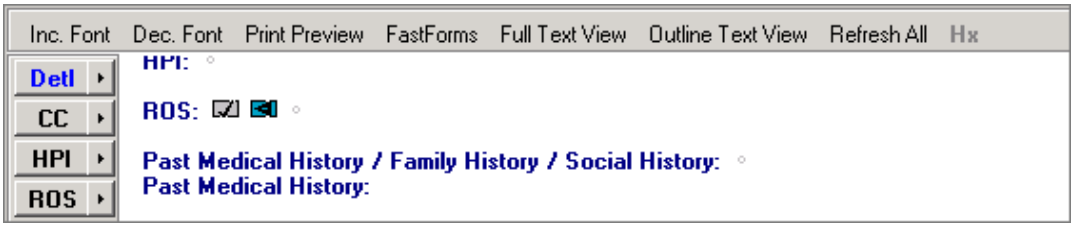
3. *If a linked template is available*, choose whether to use the blank template, a pre-clicked template, or a past template (see Accessing Templates in Visit and Order Notes section for information).

   Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the chart. In addition, free text can be typed to document any information not covered in the template.

4. *If no linked templates are available,* you can choose to use either a generic HPI template or free text (typing) to document basic information. Note that calculation of the E&M Code depends, in part, on the number of questions asked in the HPI. The automatic calculation of the E&M Code will be inaccurate if a template is not used to document this history.

Documenting the Review of Systems (ROS)

As with other sections, Review of Systems supports the use of both Fast Forms and Templates to document information.



To document the ROS:

1. In an active Visit or Order Note, scroll to the **ROS** (Review of Systems) heading.

   OR

Click the ROS button in the vertical button column to "jump" to that part of the note.

2. You can choose to use a Fast Form to document the Review of Systems (ROS). To drop a Fast Form answer set into a given note, click the **Fast Form** option, located on the gray bar just above the note.
3. Another option is to use a template. The template icon (a gray square with a black check mark) will appear to the right of the bold blue ROS heading. Click it for a list of age and gender-linked ROS templates. (See the Accessing Templates in Visit and Order Notes section for information about the template icon and the Template Links.)

   When using a template, you can choose whether to use the blank template, a pre-clicked template, or a past template (see the Accessing Templates in Visit and Order Notes section for information).
4. Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the chart.
5. In addition, free text can be typed to document any information not covered in the template. Note that calculation of the E&M Code depends, in part, on the number of systems reviewed in the ROS; the automatic calculation of the E&M Code will be inaccurate if a template is not used to document the ROS.

Recording Past Medical, Family Medical, Social Histories

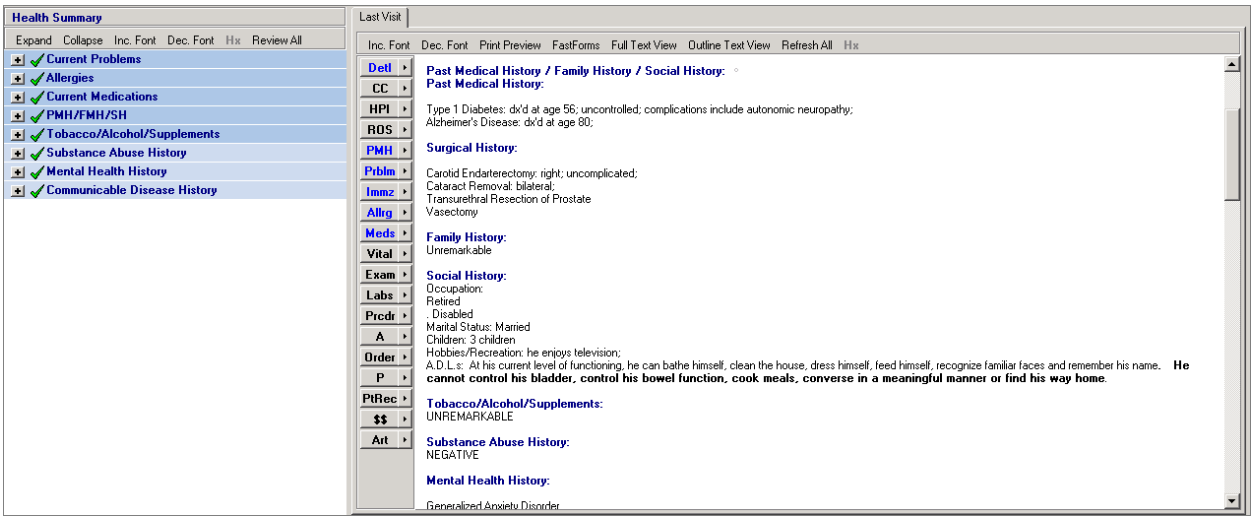
If this is the patient's first visit, you will need to add information about the patient's current and past health, along with family medical and social histories. Medical History refers to the following sections:

- Past Medical History
- Surgical History
- Family History
- Social History
- Tobacco/Alcohol/Supplements
- Substance Abuse History
- Mental Health History
- Communicable Disease History

Updates to any of these sections should be made in the Health Summary.

Note: Using SNOMED codes to document history for a first degree relative is a Stage 2 Meaningful Use requirement. The diseases in the *FMH by Individual (positive/negative responses)* template have been linked to the required codes. Family Medical History will display in a C-CDA file only if you use the *FMH by Individual (positive/negative responses)* template.

You can choose to *automatically* add the Medical History to every new Visit or Order Note (see Automatically Add Health Summary to Note for details). Note that if this automated option is chosen, the *entire* Medical History will be added to the note. The non-automated process described below permits inclusion and exclusion of the various subsections of Medical History.



To add medical history items to the current note:

1. In an active note, click the **PMH/FMH/SH** (Past Medical History/ Family Medical History/ Social History) heading and select the **Add** option.

   OR

   Click the black arrow to the right of the **PMH** button in the vertical button column, and then select **Add**.

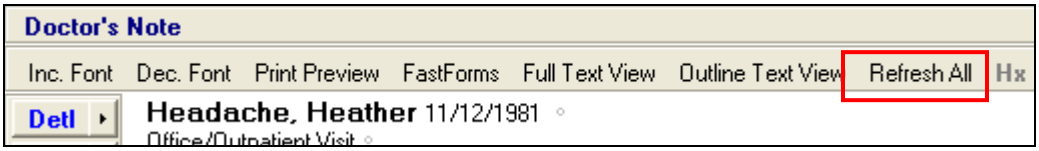
2. This will open the Past Medical History Options window.
3. Click the check box next to each blue history element that is to be added to the note.
   - Click **Select All** to automatically check every check box and add the complete History to the note. **Deselect All** will clear every check box.
   - Legacy Data is clinical history converted from e-MDs Chart 3.0 into e-MDs Chart 4.0 or 4.1. If no conversion was run, or if the patient did not have clinical data recorded in e-MDs Chart 3.0, there will be no Legacy Data.
4. Decide whether the note will merely indicate that the selected History items were reviewed or whether the entire History text itself will be displayed.
   - Click the **Reviewed Notation** button under any History item to add the quote "Reviewed" to the note. (For example: "Past Medical History: Reviewed.") Click **Set Selected to Reviewed Notation** to automatically click this button for every checked History item.
   - Click the **Complete Text** button under any History item to add the entire History text to the note. Click **Set Selected to Complete Text** to automatically click this button for every checked History item.
5. Click **Save**.
6. *If the Medical History has not yet been added to the note,* edit the History in the Health Summary (see the "Add/Edit/Delete History Items" section for details), and then add the History to the note (see the To add medical history items to the current note procedure for details.)
7. *If the Medical History has already been added to the note,* it can still be updated (in both the Health Summary and the note) by following the steps outlined below.

To edit medical history and refresh the note:

1. In an active Visit or Order Note, scroll to the **PMH/FMH/SH** (Past Medical History/ Family Medical History/ Social History) section, or click the **PMH** button in the vertical button column to 'jump' to that part of the note. View the History that has been added to the note.
2. Click the **PMH/FMH/SH** heading or the black arrow next to the **PMH** button (in the vertical button column), and select **Edit**. This opens the Medical History sections of the Health Summary. Make edits just as you would in the Health Summary (see the Add/Edit/Delete History Items section for details).
3. Close the Past Medical History Maintenance window by clicking the **X** in the upper right corner.
4. At this point, the changes have only been made in the Health Summary, not in the note. To update the note with these changes, click the **PMH/FMH/SH** heading or the **PMH** button and then select **Refresh**.

   OR

   Click the **Refresh All** button on the toolbar above the note



Note: The **Refresh All** will refresh ANY Health Summary items that are in the note. It *will not* add Health summary information that was not previously added to the note.

To delete medical history from a Visit or Order Note:

In an active note, click the **PMH/FMH/SH** (Past Medical History/ Family Medical History/ Social History) heading and select **Remove**.

OR

Click the **black arrow** next to the PMH button in the vertical button column, and then select **Remove**. This removes the History from the note, but not from the Health Summary.

Updating the Current Problem List

Updates to the Current Problem List should be made in the Health Summary (see "Add a Problem Directly to the List" for details.) Follow the directions below to add the Current Problem List to a Visit or Order Note.

Users may choose to automatically add the Current Problem List to every new Visit or Order Note (see the "Automatically Add Health Summary to Note" section for details). The following instructions describe how to add that information to the note in the case that auto-population is not chosen.

To add current problem list to a Visit or Order Note:

In an active Visit or Order Note, click the **Current Problems** header in the note and select the **Add** option.

OR

Click the **black arrow** next to the **Prblm** button in the vertical button column, and then select **Add**.

Notes:

- Additional free text can be added to any of the Current Problems by clicking the free text icon following the problem description.
- The entire Current Problem List must be added to the note; it is not possible to add only a portion of the list.

To edit current problems and refresh the note:

If the Current Problem List has been added to the note (see the To add current problem list to a Visit or Order Note procedure for details), and then the list is updated in the Health Summary, those updates can be reflected in the Note.

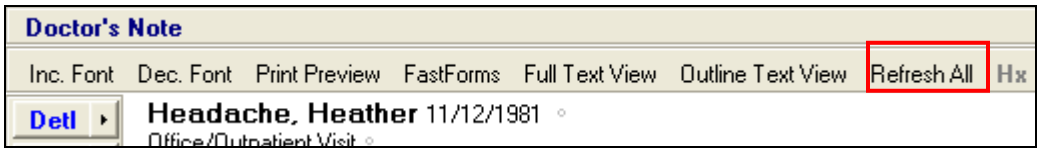
In an active Visit or Order Note, click the **Current Problems** header in the note and select the **Refresh** option.

OR

Click the **black arrow** next to the Prblm button in the vertical button column, and then select **Refresh**. This will update the note with the changes recently made in the Current Problem List.

OR

Click the **Refresh All** button on the toolbar above the note.



Note: The **Refresh All** will refresh ANY Health Summary items that are in the note. It *WILL NOT* add Health summary information that was not previously added to the note.

To delete current problem list from a Visit or Order Note:

In an active Visit or Order Note, click the **Current Problems** header in the note and select the **Remove** option.

OR

Click the black arrow next to the Prblm button in the vertical button column, and then select Remove. This removes the Current Problem List from the note, but not from the Health Summary.

Tracking Immunizations

Updates to the Immunization Log should be made in the Log directly (see Document an Immunization for details.) Follow the directions below to add the Immunization Log to a Visit or Order Note.

Users may choose to *automatically* add the Immunization Log to every new Visit or Order Note (see Setting Preferences for Visit and Order Notes for details). The following instructions detail how to add that information to the note in the case that auto-population is not chosen.

To add immunization log to a Visit or Order Note:

In an active Visit or Order Note, click the **Immunizations** header in the note and choose the **Add** option.

OR

Click the **black arrow** next to the **Immz** button in the vertical button column, and then select **Add**.

Notes:

- Additional free text can be added to any of the immunizations by clicking the free text icon following the vaccination description.
- The entire Immunization Log must be added to the note; it is not possible to add only a portion of the log.

To edit immunization log and refresh the note:

If the Immunization Log has been added to the Visit or Order Note (see the To add Immunization Log to a Visit or Order Note procedure for details), and then the log is updated, those updates can be reflected in the note.

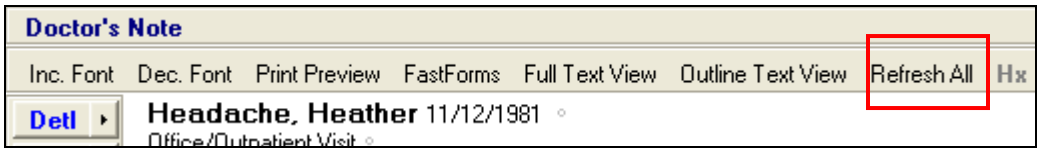
In an active Visit or Order Note, click the **Immunizations** header in the note and select the **Refresh** option.

OR

Click the **black arrow** next to the **Immz** button in the vertical button column, and then select **Refresh**. This will update the note with the changes recently made in the Immunization Log.

OR

Click the **Refresh All** button on the toolbar above the note.



Note: The **Refresh All** will refresh ANY Health Summary items that are in the note. It WILL NOT add Health summary information that was not previously added to the note.

To delete immunization log from a Visit or Order Note:

In an active Visit or Order Note, click the **Immunizations** header in the note and select the **Remove** option.

OR

Click the black arrow next to the **Immz** button in the vertical button column, and then select **Remove**. This removes the Immunization Log from the note, but otherwise does not affect the original Immunization Log.

Tracking Allergies

Updates to Allergies or Adverse Reactions should be made in the Health Summary (see Add an Allergy or Adverse Reaction section for details.)

Users may choose to *automatically* add Allergies to every new Visit or Order Note (see Setting Preferences for Visit and Order Notes for details). Note that if this automated option is chosen, only the *Drug* Allergies will be added to the note. The non-automated process described below permits inclusion of the *Non-Drug* Allergies, if desired.

The following instructions describe how to add that information to the note in the case that auto-population is not chosen.

To add allergies to a Visit or Order Note:

1. In an active Visit or Order Note, click the **Allergies** header in the note or click the **black arrow** next to the **Allrg** button in the vertical button column.
2. Select **Add** to add just the Drug Allergies to the Note.

   OR

   Select **Add Details** to be choose either both **Drug and Non-Drug Allergies** or just Non-**Drug Allergies**.

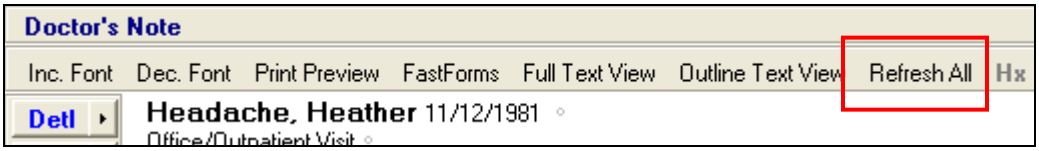
Notes:

- Additional free text can be added to any of the allergies (or adverse reactions) by clicking the free text icon following the allergen name.
- The entire list of Drug (and/or Non-Drug) Allergy/Adverse Reactions must be added to the Visit or Order Note; it is not possible to add only a portion of either list.

If the Allergy/Adverse Reaction list has been added to the Visit or Order Note (see the To add allergies to a Visit or Order Note procedure for details), and then the Allergy List is updated in the Health Summary, those updates can be reflected in the Note.

To edit allergies and refresh the Visit or Order Note:

1. In an active Visit or Order Note, click the **Allergies** header in the note or click the **black arrow** next to the **Allrg** button in the vertical button column.
2. Click the **Refresh All** button on the toolbar above the note.



Note: The **Refresh All** will refresh *any* Health Summary items that are in the note. It *WILL NOT* add Health summary information that was not previously added to the note.

To delete allergies from a Visit or Order Note:

1. In an active Visit or Order Note, click the **Allergies** header in the note or click the **black arrow** next to the **Allrg** button in the vertical button column.
2. Click **Remove**. This removes the Allergies from the note only, and does not affect the Health Summary.

Updating the Current Medication List

Updates to the Current Medications should be made in the Current Medications section of the Health Summary (see “Add a Drug to the Current Medication List” for details). To expedite entry of this information, the Current Medication template can also be used.

Users may choose to *automatically* add Current Medications to every new Visit or Order Note (see Setting Preferences for Visit and Order Notes for details).

The following instructions describe how to add that information to the note in the case that auto-population is not chosen.

To add current medications to a Visit or Order Note:

1. In an active Visit or Order Note, click the **Current Medications** header in the note or click the black arrow next to the **Meds** button in the vertical button column.
2. Click **Add**.

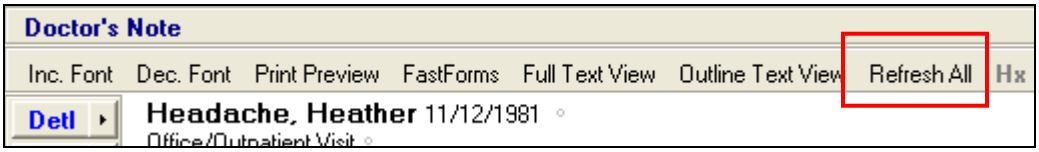
Notes:

- Additional free text can be added to any of the medications by clicking the free text icon following the medication.
- The entire Current Medication List must be added to the note; it is not possible to add only a portion of the List.
- If there are no medications in the Current Medication list and the user chooses to add Current Medications to the note (automatically or manually) a notation of “None” will appear in the note.

If the Current Medication List has been added to the note (see the To add current medications to a Visit or Order Note procedure for details) and then the list is updated in the Health Summary, those updates can be reflected in the Visit or Order Note.

To edit current medications and refresh Visit or Order Note:

1. In an active Visit or Order Note, click the **Current Medications** header in the note or click the **black arrow** next to the **Meds** button in the vertical button column.
2. Click the **Refresh All** button on the toolbar above the note.



Note: The **Refresh All** will refresh ANY Health Summary items that are in the note. It WILL NOT add Health summary information that was not previously added to the note.

To delete current medications from a Visit or Order Note:

1. In an active Visit or Order Note, click the **Current Medications** header in the note or click the black arrow next to the **Meds** button in the vertical button column.
2. Click **Remove**. This removes the Current Meds from the note only, and does not affect the Current Medications in the Health Summary.

Documenting Lab and Test Results

To document lab or test results in a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Lab/Test Results** section, or click the **Labs** button in the vertical button column.

   Note: This section is meant to document lab or test results that are available during the visit, not results that come in at a later date.
2. Use a template to document results. The template icon (a gray square with a black check mark) will appear to the right of the bold blue **Lab/Test Results** heading. Click it for a list of available templates. (See the Accessing Templates in a Visit or Order Note section for information about the template icon and the Template Links.)
3. Choose whether to use the blank template, a pre-clicked template, or a past template (click any of the underlined items for further information). Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the Chart.
4. If needed, type free text to document any information not covered in the template.

Note: Also see Accessing FlowSheets in Templates for information on capturing lab and test results in FlowSheets for inclusion in notes.

Collecting Vital Signs

Setting User Preferences in Vitals

With no user preferences set, the Vital Signs window displays General Vitals, consisting of weight, height, body mass index, waist circumference, temperature, respiration, blood pressure, and pulse. The default data entry mode units of measurement are: Weight = lb, Height = ft and in, Waist circ = in, Head circ = cm, Temp = F, Fundal Ht = cm. In the Vitals module, the user can enter standard or metric data into the fields based on their preferences. The corresponding unit per field will be Read Only.

User Preferences allow the user to add other types of Vitals, such as Respiratory (peak flow and oxygen saturation), OB-Gyn, Ophthalmology, Pain Index, and Intensive Care Vitals. The data entry mode can be changed to Metric or Standard combinations. As User preferences are saved, the corresponding field will be disabled/Read Only. The User Preferences are tied to the current user's login, and only that user will see the changes.

To set user preferences:

1. Open the Vital Signs window. To do that, either:

   Click the **Vitals** button on the Chart toolbar (with the red thermometer icon).

   OR

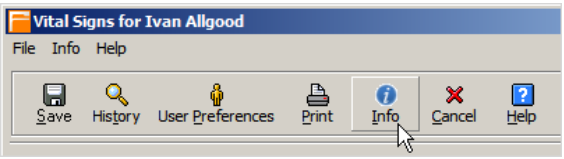
   In an active Visit or Order Note, click either the **Vitals** heading or the **Vital** button (in the vertical button column), and then click the **Edit Vitals** button.

2. In the Vital Signs window, click the **User Preferences** button.
3. In the Vitals User Preferences window, be sure that **A Permanent Change** is checked. (Check **This Instance Only** to make changes to User Preferences on the fly. These changes will apply only to the current visit, after which the Preferences will revert back to the user's original settings.)
4. Select **Standard** or **Metric combinations**. Note that if a standard measurement is entered, its metric equivalent is also displayed, and vice versa. Selecting the mode determines which fields will allow data entry or become disabled/Read Only.
5. Click the check boxes next to the desired Vital Signs types to add them to the User Preferences.
6. Click **Save**.

Note that the additional Respiratory Vitals and the Pain Index appear under the General tab. OB-Gyn and Intensive Care Vitals appear under their own tabs. Ophthalmology and Auditory vitals appear on a shared tab labeled. Visual/Auditory. OB-Gyn Vitals will not appear for male patients.

Adding, Editing, and Deleting Vital Signs

Note: To view information about the source of vital sign ranges or calculations, click the Info button located in the Vital Signs window and then select an option to display the respective source information.



If the physical layout of the clinic includes a separate vital sign station (prior to the patient being checked into an examination room), vital signs may be entered into the patient's chart *prior to the note being opened*.

To add vitals outside of a Visit or Order Note:

1. Open the patient's chart.
2. Click the **Vitals** button on the Chart toolbar (with the red thermometer icon).
3. Enter values for any vital signs and click **Save**.
4. Later, after the current note has been opened, click either the **Vitals** heading in the Visit or Order Note, or the black arrow next to the **Vital** button in the vertical button column, then select the **Add Existing Vitals** menu option. This will add the previously recorded vital signs to the current note.

   Notes:

   - Once Existing Vitals are added to a Visit or Order Note, those vitals are deleted from the original Vitals window (the window that opens from clicking Vitals on the Chart toolbar).

- Do not use the Vitals entry from the toolbar to enter any vital signs that will not eventually be dropped into a Visit or Oder Note, as they will not be saved in the Vitals History.
- If the user is unaware that Existing Vitals have been done, and mistakenly enters new vitals in the note, the original set of vitals can still be used. Click **Add Existing Vitals** and the original (first) vitals will appear in the **Current Vitals** section, and the second set of values will be displayed as Repeat Vitals.
- If the user preference for height units has been set for feet and inches, the user can enter the total feet and additional inches separately, or can convert the feet to inches and insert the total height in the inches field if preferred. In either case, the height will be retained in the database as total inches for use in computing the Body Mass Index.

To add vitals directly to a Visit or Order Note:

1. In an active Visit or Order Note, click either the **Vitals** heading or the black arrow next to the **Vitals** button in the vertical button column.
2. Select the **Edit** menu option to open the Vital Signs window.
3. Enter the desired vital sign values and click **Save**.

For additional information, see the following related sections for managing note information.

To edit or delete vital signs:

1. In an active Visit or Order Note, click either the **Vitals** heading or the black arrow next to the **Vital** button in the vertical button column.
2. Click **Edit** to open the current Vital Signs window.
3. To change any existing vital sign, highlight the value in its data entry field and type in the correct value.

   OR

   To delete a value, highlight it and press the **Delete** key.

   Note: Historical vital signs cannot be edited or deleted from the note.
4. Click **Save**.

Verifying Abnormal Vital Signs (Error Checking)

If the values entered in the vital sign module are outside of a normal range for the patient a visual feedback for most of the vital signs will be provided. This visual feedback consists of displaying the entered values in red text.

This feature addresses two issues. The first issue is to provide a warning when a patient's vitals are too high or too low. A visual cue to the user prevents issues from slipping thought the cracks or being ignored. In addition to the red text cue in the vital sign window, these out of range values appear in **bold** text in the note to alert the provider to the situation.

The second issue addressed by this feature is to catch data entry errors that may occur inadvertently. For example when entering a weight of 200 pounds for a patient a slip of the keyboard could produce a weight of 2000 pounds instead. Many times errors like this can go unnoticed but since the value is outside of the normal range for a patient it will appear in red and should be easily noticed and corrected.

Vitals history

To view historical vitals:

1. Open the Vital Signs window.
2. In an active Visit or Order Note, click either the **Vitals** heading or the black arrow next to the **Vitals** button in the vertical button column, and then select **Edit**.

3. In the Vital Signs window, click the **History** button.
4. In the Vital Sign History window, click the down arrow in the **Type of Vital** field.
5. Click the desired vital sign type in the list.

   Note: Only those vital types that have previous values recorded will appear in this list.

   All previously recorded values for that vital type will appear, in reverse chronological order (most recent first).

If desired, historical vitals can be added to a note as a point of reference, or comparison, to current vital sign values. See the following procedure for detailed steps.

To add historical vitals to a current Visit or Order Note:

1. In the Vital Signs window, click the **History** button.
2. In the Vital Sign History window, click the down arrow in the **Type of Vital** field.
3. Click the desired vital sign type in the list.

   Note: Only those vital types that have previous values recorded will appear in this list.

   All previously recorded values for that vital type will appear, in reverse chronological order (most recent first).
4. Highlight any item in that list and then click **Note** (there will be no visual confirmation that the value was added.)
5. Continue highlighting and clicking **Note** until all desired values have been added.
6. Click **Exit**.

   The selected values will appear under the Historical Vitals header in the Vitals section of the note.

Repeating Vital Signs

Occasionally, repeat vital signs will be recorded within a single Visit or Order Note. For example, a high blood pressure reading may prompt another reading.

To record additional (or repeat) vitals:

1. In the Vital Signs window, any vital type preceded by a blue plus sign will allow the recording of a repeat value.

   Record the initial value normally (see To add vitals directly to a Visit or Order Note for details).
2. For the next reading, click the blue plus sign preceding the vital type.

   The Additional window will display the initial value.
3. Press the **Enter** key or click the **New** button in the middle of the window.
4. Enter the vital sign value into the appropriate field(s).
5. If desired, attach a comment to the value. (For example, it may be helpful to note the circumstances of the reading, such as a temperature taken after Tylenol was given, or a peak flow recorded after a nebulizer treatment.)
6. Click the **Save** button in the middle of the screen to save that value and keep the Additional window open for entering another value.

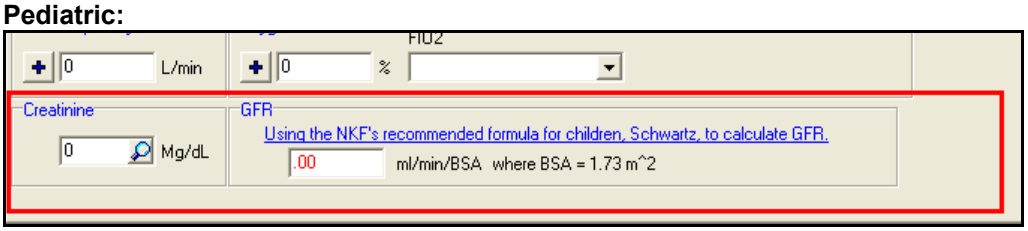
   OR

   Click the **Save** button in the upper left corner to save that value and close the window.

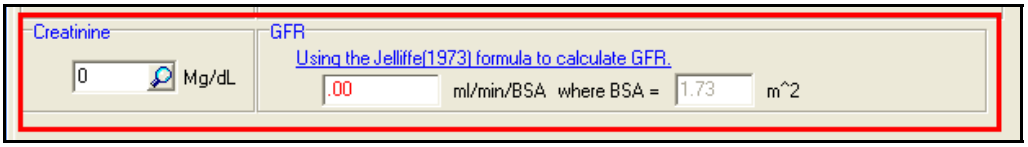
Tracking the Calculated GFR

Automatic calculation of the Glomerular Filtration Rate (GFR) for patients is available as part of the vitals section. The calculation occurs automatically if the patient chart has a recent value for a Creatinine level. This Creatinine must be stored in a patient FlowSheet and linked to a Master Lab Code in order for the application to be able to use it. If a patient does not have a Creatinine level then the user can manually enter one into the Creatinine field. The GFR value is calculated for both adult and pediatric patient (using a different formula for each). Below are screenshots of what the GFR section of Vitals looks like for both a pediatric and adult patient.

Pediatric:



Adult:



Notes:

- Clicking the blue underlined text in the GFR section will display the formula that is used to calculate the GFR.
- Adjustments are made to the calculation based on gender but the formulas used do not adjust for race.

Viewing Growth Charts

Growth charts can be accessed directly from the Chart toolbar or within the Vital Signs window. In either location, click the Growth Charts button (with the pink and blue icon of two people).

Depending on the age and gender of the selected patient, appropriate growth charts will be displayed. Growth Charts are based on the Centers for Disease Control (CDC) data published in 2000 and show the percentile curves for the 3rd, 5th, 10th, 25th, 50th, 75th, 90th, 95th, and 97th percentiles.

Children from birth through age 20 years will have graphs for Weight, Height (Length), and Weight-for-Length. Birth through age 3 years will also display Head Circumference. Ages 20-20 will also graph Body Mass Index.

Red dots (and a red connecting line) show the child's placement on the curve, and yellow label boxes display the actual values. In addition, a grid in the right windowpane displays the age, date, value, and percentile of each point that has been plotted.

See the following related sections for additional information: "Plot Points Directly from Vital Signs," "Plot Historical Points" and "Print Growth Charts."

Plotting Points Directly from Vital Signs

In an active Visit or Order Note, when a child's height, weight, and/or head circumference is entered into the Vital Signs window, that value is automatically plotted on the appropriate growth chart.

In addition, the value's percentile (i.e. where is falls on the standard growth chart curves) is returned to the Vital Signs window. (The percentile is displayed in the last field of the Weight, Height, and Head Circumference data entry lines, marked with a percent sign.)

See the "View the Growth Charts" section for more information about the Growth Charts.

Plotting Historical Points

Height, weight, and head circumference entered in Vital Signs as part of a current visit are automatically plotted on the Growth Charts (see the "Plot Points Directly from Vital Signs" section for details).

To plot past points:

1. Open the patient's chart.
2. Open Growth Charts.

   These can be accessed directly from the Chart toolbar or within the Vital Signs window. In either location, click the **Growth Charts** button (with the pink and blue icon of two people).
3. Over the grid in the right windowpane, click **Add**.
4. Enter the date of the prior vitals and their values and click **Save**.
5. Repeat the process to enter another set of values, and so on.

Using Preemie Growth Charts

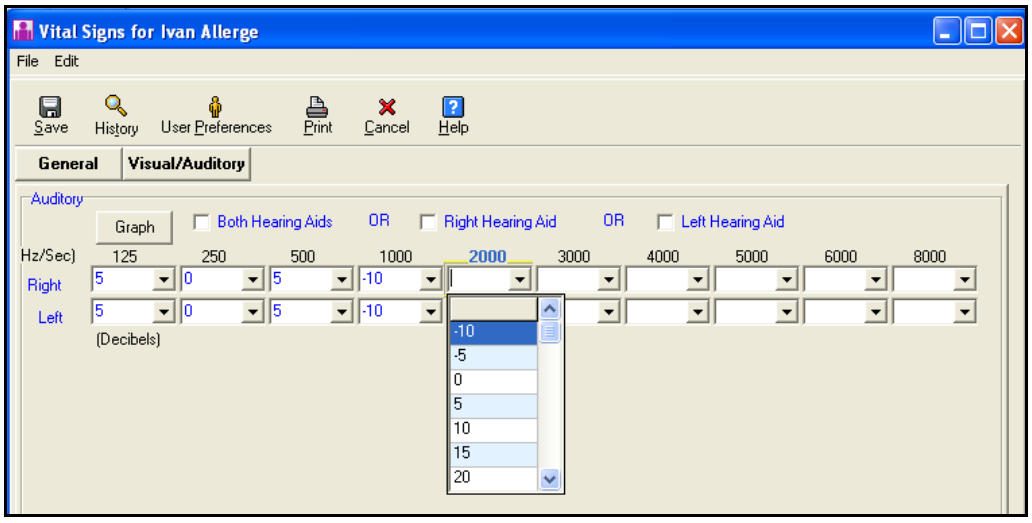
- If an infant is documented in the demographics module as being premature and a gestational age is also documented then the growth charts for that patient will change to display an additional line on each chart that will document the patient's status on the growth chart based on their gestational age. The preemie line is colored blue while the normal birth line is colored red.
- Fields in the Demographics and Vitals Signs forms of patients up to the age of 36 months allow for the documentation of **Normal Birth**, **Premature** and **Gestational Age** (in weeks and days). For a new patient the Normal Birth field is set by default and the Gestational Age fields are set to 0 weeks and 0 days. The user can document that an infant was born prematurely by checking the check box in the Premature field and then filling out the Gestational Age. If the documentation indicates that the infant was premature the gestational age values will be used to supplement the growth charts by displaying a premie growth line.

Recording Auditory Vitals

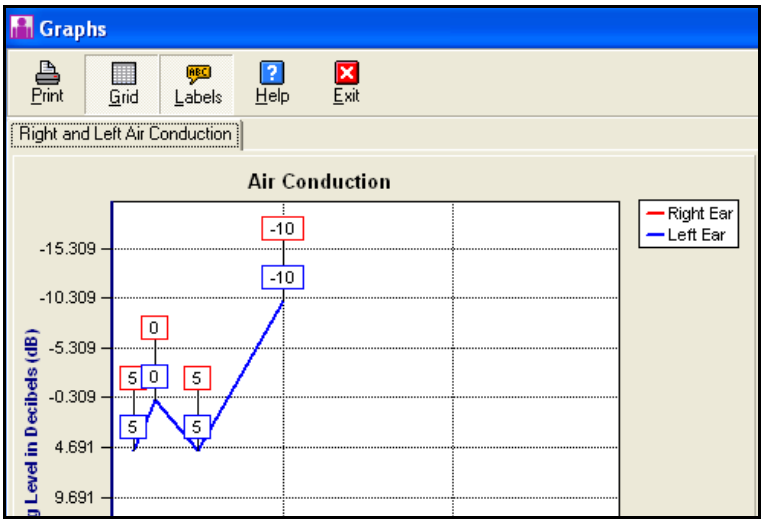
Auditory vitals can be documented in the Vital Sign section. The auditory vitals are not part of the vital signs that appear by default. To show the auditory vitals you must set your User Preferences to show them. Once set to show they appear in a tab labeled Visual/Auditory and appear with the Ophthalmology vitals if they are set to show.

In the User Preference window, you have the ability to customize the auditory vitals to suit your needs. For example, you can choose what range of Hz/sec that displays in the section.

To document results, select a value from the drop-down list for each range that you want to document. In addition users can also document whether a patient uses hearing aids (left, right or both). See image below for an example.



The information that is captured in the Auditory Vitals section can be graphed and printed if desired. On the graph the right ear values will be shown in Red and the left ear values in Blue. See image below for an example.



Documenting the Exam

To document the physical exam:

1. In an active Visit or Order Note, click either the **Exams** heading in the note, or the **Exam** button in the vertical button column.
2. Use a template to document results. The template icon (a gray square with a black check mark) will appear to the right of the bold blue **Exams:** heading. Click it for a list of available templates.
3. A General (full body) Exam template appropriate for age and gender will always be available as a choice. In addition, depending on the complaints listed in HPI, specific exams (i.e. Knee Exam, Mental Status Exam) linked to those diagnoses may be listed (see the Accessing Templates in a Visit or Order Note section for information about the template icon and the Template Links),

   Another way to access the Complaint-Specific Exam templates is to use Generic Templates. Typically, if the complaint in HPI (for example, Knee Pain) warrants a Complaint-Specific Exam (Knee Exam, in this example), that exam template will appear in the Template Links window. But, for example, if there is a reason to use the General (full body) Exam template, a Complaint-

Specific Exam template can be inserted anywhere within the General Exam by using Generic Templates. (In this example, open the Knee Exam template within the General Exam, at the musculoskeletal portion of that template.)

4. Choose whether to use the blank template, a pre-clicked template, or a past template. Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the Chart.
5. In addition, free text can be typed to document any information not covered in the template. Note that calculation of the E&M Code depends, in part, on how comprehensive the Exam is; the automatic calculation of the E&M Code will be inaccurate if a template is not used to document the exam.
6. If necessary, use Medical Art to illustrate significant findings.

Adding Procedures to a Note

To add a procedure note to a visit:

1. In an active Visit or Order Note, scroll to the Procedures heading in the note, or click the **Prcdr** button in the vertical button column to 'jump' to that section of the note.
2. Note that each diagnosis in Assessment also appears as a bold, black subheading under Procedures. As Procedure templates are linked by ICD-9 codes, document the Procedure next to the appropriate diagnosis header. A template icon (a gray square with a black check mark) will appear to the right of each diagnosis subheading. Click it for a list of available templates. For information about the template icon and the Template Links, see Accessing Templates in a Visit or Order Note.
3. Choose whether to use the blank template, a pre-clicked template, or a past template. Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the Chart.

   If templates are created correctly, the corresponding CPT code for the procedure documented will automatically drop into the Orders section of the Plan. See "CPT Extended Attributes" for information about embedding CPT Extended Attributes into templates.
4. In addition, free text can be typed to document any information not covered in the template.

Documenting the Assessment

Entering the Diagnoses from the History of Present Illness

The reason for the visit as documented in the HPI (History of Present Illness) will automatically appear as a diagnosis (with an associated ICD-9 code) in the Assessment. (This is true whether the diagnosis was added directly to the HPI or came from a Chief Complaint template.) If multiple complaints are documented in the HPI, each one will appear in the Assessment.

At that point, these diagnoses can be deleted, the descriptions can be edited, or the associated ICD-9 code can be changed. Click any of the underlined topics for more details.

Adding a New Diagnosis

If a complaint was entered in CC (Chief Complaint) or HPI (History of Present Illness), the Assessment will already contain a diagnosis, with an associated ICD-9 code. However, additional diagnoses can be added directly to the Assessment.

To add a diagnosis to the assessment:

1. In an active Visit or Order Note, click either the **Assessment** heading in the note, or the black arrow next to the **A** button in the vertical button column.

Medicapaedia search option: *Medicapaedia is a database of clinical terminology. It includes diagnosis/symptom descriptions and associated codes.*

2. In the Search field, type the first few letters of a diagnosis or symptom (or type the ICD code) and then click the **Search** button located on the toolbar at the top of the Medicapaedia Search window (or just press the Enter key).
3. In the search results, select (click) the check box next to each description to be entered in the note and then click the **Select** button on the toolbar.

   This action adds the diagnosis code to the Assessment section of the note and adds the diagnosis description to the HPI and Plan sections.

Adding a Follow-Up Diagnosis

If a complaint was entered in the CC (Chief Complaint) or HPI (History of Present Illness), the Assessment will already contain a diagnosis, with an associated ICD-9 code. However, additional diagnoses can be added directly to the Assessment.

If the patient is returning with an established diagnosis, add the diagnosis to HPI as a follow-up.

To add a follow-up diagnosis:

1. In an active Visit or Order Note, click either the **Assessment** heading in the note, or the black arrow next to the **A** button in the vertical button column.
2. Click **Follow Up** to view the patient's Current Problem List.
3. Click any problem in the list to add it to the **Assessment** section of the current Visit or Order Note. If the problem is not listed in the Current Problem List, click **All Problems** at the bottom of that window for a list of all diagnoses ever assigned to that patient. Click any problem from that list to add it to the note.

To delete a diagnosis:

Problems can be removed from the Visit or Order Note in either the HPI or Assessment section. Simply click the bold black diagnosis description and select the **Delete** menu option. Click **Yes** in the Delete Confirmation window.

- *If a diagnosis is deleted from HPI*, it will automatically be removed from Assessment and Plan. Associated HPI and Plan templates and free text will also be deleted. Any existing orders and prescriptions will be moved to the non-linked Other Orders and Other Prescriptions section of Plan.
- *If a diagnosis is deleted from Assessment*, it will automatically be removed from the Plan. Information gathered in HPI, however, will not be affected. Associated Plan templates and free text will also be deleted. Any existing orders and prescriptions will be moved to the non-linked Other Orders and Other Prescriptions section of Plan.

Documenting Diagnosis Properties

Editing the Properties of a Diagnosis

The Properties of a diagnosis include: description, date of onset, severity, progression, and chronicity.

Some of these properties are needed to determine the E&M Code for the visit. Because e-MDs Chart offers automation of the E&M Coding and because the diagnosis properties are critical in determining the correct E&M Code, Visit and Order Notes can be set to automatically pop up a screen detailing the diagnosis properties (and permitting changes) prior to note sign-off. It is strongly recommended that users select this option. See "Show Diagnosis Properties" for more information.

However, the properties can also be addressed in the note prior to note sign-off, as described below.

To edit the diagnosis properties:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Click any bold black diagnosis description and select the **Properties** menu option.
3. Select the option values described in the "Code Properties Window Options" table below.
4. Click **Save**.

Code Properties Window Options	
Code	Numerical ICD-9 code selected.
Description	Change the diagnosis description, if desired, by typing directly into that field.
Confidential	The **Confidential** check box can be checked.
Date of Onset	The **Date of Onset** field defaults to the current date, but can be changed by clicking the down arrow in that field to open a calendar.
Location	Change the Location by clicking the appropriate buttons. The default setting is **None** but can be changed to **Left**, **Right** or **Bilateral** for those diagnoses that have a location that needs to be documented. If a follow-up diagnosis is selected, these settings will reflect the last changes made to their properties by any user.
Severity	Change the severity by clicking the appropriate buttons. The default settings for **Severity** is **Moderate**. Other choices are **Mild** and **Severe**. If a follow-up diagnosis is selected, these settings will reflect the last changes made to their properties by any user.
Progress	Change the progress by clicking the appropriate buttons. The default setting **Progress** is **Stable**. Other choices are **Improving** and **Worsening**. If a follow-up diagnosis is selected, these settings will reflect the last changes made to their properties by any user.
Course	Change the course by clicking the appropriate buttons. The default setting for the **Course** field is determined by a setting in the ICD data. If a follow-up diagnosis is selected, these settings will reflect the last changes made to their properties by any user.
Add to Current Problems	When checked, this code information will be added to the Health Summary Current Problems section.
Auto Age	When a problem is recovered from the Resolved list, you have the option to auto age the problem so that it resolves itself after a specified number of days. If you do not want the problem to be automatically resolved *do not* check the **Auto Age** check box.
Resolve in (days)	If the **Auto Age** option is checked, the number of days for resolution will default to **30**. If you prefer, you can specify a different numerical value in this field.

To edit the description of a diagnosis:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Click any bold black diagnosis description and select the **Change Text** menu option.
3. Type the desired descriptive phrase in the Text Maintenance window, and click **Save**.

   Note: The new text will still be linked to the original ICD-9 code. To change the ICD-9 code, click **Change Code** instead of **Change Text**. See "Change the ICD Code of a Diagnosis" for details.

Changing the ICD Code of a Diagnosis

The ICD Code associated with a Diagnosis can be changed in the Assessment section of a Visit or Order Note. There are two ways to accomplish this. One way to change the code is by using the ICD Search

module to select another code. The second way is to use the Differential Diagnosis (DDx) module to substitute a code from a pre-existing list (see What is the DDx module? for details). Both methods are valid however the DDx module is a faster and simpler process (provided the DDx module is pre-populated appropriately).

To change the diagnosis code using the ICD search:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Click any bold black diagnosis description and select the **Change Code** menu option.

   This launches the ICD search with the current code already in the search results. Options at this point include conversion to a Full Search (rather than a Short Search of favorite codes), expanding the current code (if it is a "red" code that can be further expanded to four or five digits), or using the Parent button. See Searching for an ICD-9 Code for detailed instructions regarding the ICD search.
3. Highlight the correct diagnosis from the search results and either double-click or click **Accept**. This action adds the diagnosis code to **Assessment** and the diagnosis description to the **HPI** and **Plan** sections.

If the search does not return an acceptable diagnosis, it is recommended that you type in a different search term. However, at that point, you may choose to click **No Code** to type in a free-text diagnosis. This button is disabled until the first search is run. This is obviously not recommended since the correct ICD code is required for billing.

To change the diagnosis code using the DDx:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. In the Assessment section, click the text labeled **DDx** under the desired ICD code.
3. The DDx window will open with the selected ICD code highlighted in the left pane.
4. A list of differential diagnoses will appear in the right pane.

   Note: Not all diagnosis codes have differentials linked to them, however links can easily be created. For details on linking differentials to a diagnosis code, see Editing Differentials Linked to Diagnosis Codes.
5. Click the check box next to the diagnosis that should replace the highlighted diagnosis in the left pane. More than one diagnosis can be added by clicking the check box next to multiple differentials, but only the first diagnosis in the list will replace the highlighted code. The others will be added to the list.
6. When all the diagnoses are selected, click the **Sub** button located between the left and right panes.

   The selected diagnosis will replace the highlighted diagnosis in the left pane.
7. Click the **OK** button to save the changes and return to the note. The substituted diagnosis will replace the previous diagnosis in the Assessment section of the note.

Moving the Position of a Diagnosis

If using e-MDs Solution Series, the order of diagnoses in the Assessment section is important. The first diagnosis listed will be transferred to the billing invoice as the primary diagnosis (that is, the primary reason for the visit or most serious diagnosis).

To move a diagnosis to the first position:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Click the bold black diagnosis description of the diagnosis to be moved and select the **Move First** menu option.

   The remainder of the diagnoses can be reshuffled, if desired, by using a combination of the **Move Before** (another diagnosis), **Move Up**, and **Move Down** menu options.

Tracking the Differential Diagnosis (DDx)

The Differential Diagnosis (DDx) module, in its most basic usage, provides a simple method to document possible other diagnoses to consider for each diagnosis listed in the Assessment section of the Visit or Order Note. This can be helpful in dealing with undifferentiated problems over a period of several visits. An additional powerful feature of the DDx module allows for the addition or substitution of more specific diagnosis codes to the Assessment. This gives the user the option to drop a non-specific diagnosis into the Visit or Order Note when starting the documentation and then, as information is collected from the patient, to add or substitute one (or many) more specific diagnoses into the note.

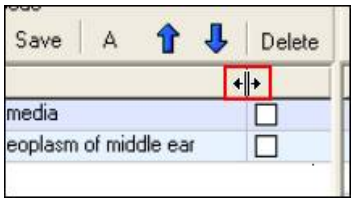
Accessing the DDx

The DDx module can only be accessed from the Assessment section of an **OPEN** Visit or Order Note. It cannot be accessed in a note that has been permanently signed off. Within the Assessment section ICD-9 codes and descriptions are listed as diagnoses and under every diagnosis code will appear wording labeled DDx. Clicking the text labeled DDx will open the module.

Customizing the DDx Window

Users can set up the DDx module to suit their own workflow and preferences by resizing the columns in module. DDx window itself can also be resized to fit in Portrait mode on a tablet with 1024 x 768 minimum screen resolution.

To resize the columns, place the cursor on the dividing line between the column headers and the cursor will change from an arrow to double arrowed icon. When this icon appears, click and hold the mouse button while moving your mouse left or right (depending on whether you are widening or narrowing the column). Any changes made to the column widths will be saved as the preference of the user that is logged in at the time the change is made.



The entire DDx window can also be resized as a user preference. To resize the window, place the cursor on the left, right, top or bottom border and the cursor will change to a double headed arrow. Click and hold the mouse button while dragging the mouse left, right, up or down to resize the window.

Updating the Diagnosis Section

- When the DDx window opens, any diagnosis code that is listed in the Assessment will appear in the left pane of the window. These diagnoses will be listed in the order they are shown in the Assessment section and are displayed in columns labeled **Code** and **Description**.
- This pane also includes a **Delete** button which can be used to remove a diagnosis from the DDx window and the Visit or Order Note.

Using the Substitution Short List and DDx List

The next two sections are labeled the **Substitution Short List** and the **DDx List**. The Substitution Short List is used to substitute more specific diagnoses for the diagnosis in the note while the DDx List shows a list of true differentials. There are two lists for just for organization purposes. Additions of differentials and substations of more specific codes can be done from either list but for organization purposes there are two lists.

Both sections have the same layout and functionality and are described below.

- Highlight one of the diagnoses in the left pane, by clicking it, to display the substitution list and a list of differentials and/or more specific diagnoses in the middle and right panes of the window. Each item in the two lists will have a check box in front of it. If the check box is clicked the diagnosis will be marked as selected.
- The text at the top of these panes is the ICD-9 code and description for the diagnosis that is highlighted in the left pane.

  Note: A list of substitutions and differentials will only appear for those diagnoses that have differentials linked to them. e-MDs has pre-linked common differentials to many of the more general ICD-9 codes that are used in Chart but not all ICD codes have these links. Users can easily add substitutions and differentials to any codes that do not have links or edit those that do (see Editing Differentials Linked to Diagnosis Codes for details).
- Across the top and bottom of both panes is a row of check boxes and buttons as shown in "Substitution Short List and DDx List Options."

Updating the Differential Text Section

Running horizontally across the middle part of the window is a gray section with radio buttons. Each radio button has specific wording associated with it (the differential text). Clicking a radio button will drop its associated text into the DDx section of the Assessment once the DDx window is closed. There are four radio buttons in the section with the following differential text as choices:

- Differential: A, B, C
- INCLUDES - Differential includes A, B, C. Based on current evaluation, there is insufficient information to make a more definitive diagnosis. If additional signs or symptoms manifest over time, a definitive diagnosis may become possible.
- EXCLUDES - Differential considered and excluded includes A, B, C. Current evaluation does not support a life or limb threatening condition.
- CO-MORBID - Associated co-morbid conditions considered include A, B, C.

Note: The A, B, C listed in each of differential text choices represents place holders for the differential descriptions that will appear in the text. The differentials will be inserted in the same order they are listed in the right pane. For example, choosing the INCLUDES selection above for a chest pain diagnosis and then selecting Acute MI and Unstable Angina as differentials would generate text that reads: Differential includes Acute MI, Unstable angina. Based on current evaluation etc. where Acute MI and Unstable Angina are substituted for A and B in the text. Note that Acute MI appeared in the list ahead of Unstable Angina so it is inserted into the text first. Keep in mind that although only 3 letters are shown as place holders (A, B, C) the differential text can handle more than 3 differential substitutions.

Updating the Differential Text Preview Section

At the very bottom of the DDx window is a section where the DDx text that is chosen by clicking a radio button is previewed. This allows the user to see the actual text that will drop into the note. For example, in the example listed above for chest pain, the actual text that would drop into the note would be shown in this section as: Differential includes Acute MI, Unstable angina. Based on current evaluation, there is insufficient information to make a more definitive diagnosis. If additional signs or symptoms manifest over time, a definitive diagnosis may become possible.

To add diagnosis substitutions and differentials to notes:

1. Select the diagnosis in the list on the left in the **Diagnosis** section
2. Click the **Insert List from Other ICD** button under the **Substitution** or **DDx list**.

   The ICD search will open.
3. Search for and select the ICD code from which you want to copy the list.

4. Close the ICD search and the list will be populated from the selected ICDs list.

Substitution Short List and DDx List Options

Top Check Boxes and Buttons	
Show ICD Code	Checking this check box will show the ICD code in parenthesis after the diagnosis description.
Check/Uncheck All Items	This check box will toggle the status of all the check boxes to the left of the differentials (Select boxes). It will also clear any check marks in the Delete column to the right of each differential (Delete boxes). **Note:** If more than half the select boxes in either list are checked when this button is pressed then all the boxes will clear. If more than half the boxes are cleared when this button is pressed then all the boxes will check. In the event that exactly half the boxes are checked when this button is pressed then all the boxes will be checked.
Add To List	Clicking this opens the ICD-9 Search module to allow adding more differentials to the list.
Save	Clicking this button saves any changes that have been made to the differential list.
A	Clicking this button toggles the differential descriptions between a user specified sequence and an alphabetical sequence. When the A button is depressed the sequence is alphabetical and the Up and Down arrows are grayed out and disabled.
Up Arrow	This button is only enabled when the A button is off (not depressed). Clicking this button will move the highlighted differential up one position in the list.
Down Arrow	This button is only enabled when the A button is off (not depressed). Clicking this button will move the selected differential down one position in the list.
Delete	Clicking this button will remove any differential codes that have a check mark in the Delete column.

Bottom Check Boxes and Buttons	
Move To	These buttons will move the selected diagnoses from the one list to the other. For example if you have a diagnosis in the Substitution list that you want moved to the DDx list you can click the check box for that diagnosis and then click the Move To > button under the Substitution list to move the item. To move from the DDx to the Substitution list select the diagnosis and click the < Move To button under the DDx list.
Copy To	These buttons work the same as the Move To buttons but instead of moving from one list to the other the diagnoses are COPIED.
Insert List from Other ICD	In some situations a diagnosis may have a Substitution or DDx list that could be used for another diagnosis. For example heartburn may have a list of differentials that would be useful to use with a GERD diagnosis. The Insert List from Other ICD button allows a user to select an ICD and have the Substitution or DDx list copied from that diagnosis (heartburn) to the diagnosis in question (GERD).

Vertical Buttons	
Add	Adds any differentials in the right **Differential** pane that are marked with checks over to the **Diagnosis** section.
Sub	Replaces the highlighted code in the left **Diagnosis** pane with the first checked item in the right pane and then adds any additional checked ICD9s in the right pane to the list of codes in the left pane.

Bottom DDx Buttons	
OK	Closes the DDx window and applies any changes to the note.
Cancel	Opens a confirmation window if any changes have been made in the DDx window but not saved. If no changes have been made or the **Save** button was pressed after any changes were made then clicking the **Cancel** button simply closes the DDx window and returns the program to the note.

Editing Differentials Linked to Diagnosis Codes

e-MDs has pre-linked common differentials to many of the more general ICD-9 codes that are used in Chart but not all ICD codes have these links. However, users can easily add differentials to any codes that do not have links or edit and make changes to those that do.

There is no editor to link Differential Diagnoses to ICDs so the linking must be done from within a Visit or Order Note. The user can choose to either create these links "on the fly" in a real patient's note or in a note created for a fake patient. In a busy practice it may be better to use a fake patient and do the linking during off hours.

To add linked differential diagnoses to an ICD:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Add the desired ICD code to the **Assessment** section of the note.
3. Click the DDx text that appears under the diagnosis code.

   The DDx window will open with the selected ICD-9 code highlighted in the left pane.
4. A list of Substitutions and Differential Diagnoses linked to that ICD-9 code will appear in the middle and right panes (in those cases where there are no linked differentials the panes will be empty).
5. To add a link, click the **Add to List** button at the top of the appropriate pane.

   The ICD-9 Search module will open.
6. In the Keywords field type in part of the name of the diagnosis code to be searched for and click the **Search** button. (see Searching for an ICD-9 Code for details)
7. In the search results highlight the desired code and click **Accept**.

   The code will drop into the appropriate pane at the bottom of the list.
8. The code can be repositioned in the list by clicking the **Up** or **Down Arrow** buttons at the top of the list.

There may be cases where users want to remove a differential that is linked to an ICD-9.

To delete a linked differential diagnosis from an ICD:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. Add the desired ICD code to the Assessment section of the note.
3. Click the DDx text that appears under the diagnosis code.

   The DDx window will open with the selected ICD-9 code highlighted in the left pane. A list of Substitutions and Differential Diagnoses linked to that ICD-9 code will appear in the middle and right panes.
4. Click the **Delete** check box to the right of the differential or differentials to be removed.
5. Click the **Save** button at the top of the right pane to delete the differential(s)

Note: To clear any Delete boxes that are checked by mistake, click the **Check/Uncheck All Items** button at the top left of the right pane. This will check (or clear) the Select check boxes to the left of each differential as well as clear the Delete check box of all differentials. It may require clicking this button twice to clear out all check boxes.

Differential Diagnoses are listed in the right pane in the order that they will drop into the note if they are added to the Assessment or listed as DDx. Because of this it may become necessary to reorder the list to place certain differentials before or after others.

To customize the order of differentials in the list:

1. Highlight the differential to be moved in the right pane.
2. Click the **Up Arrow** button at the top of the right pane to move the item up a level. Click the button as many times as necessary to move the item to the desired location.

   OR

   Click the **Down Arrow** button at the top of the right pane to move the item *down* a level. Click the button as many times as necessary to move the item to the desired location.
3. Click the **Save** button at the top of the right pane to Save the changes made to the order of the differentials in the list.

There may be times when the differential list needs to be listed in alphabetical order. For example, listing these items in alphabetical order can make it easier to find a specific item.

To list the differentials in alphabetical order:

1. With the DDx window open and a differential list showing in the right pane, click the **A** button at the top of the right pane to reorder the list alphabetically.
2. Click the **A** button again to revert the list to the original order.

   Note: When the **A** button is pressed it will appear depressed. As long as the button is depressed the list will remain in alphabetical order however this is not a permanent state. Once the DDx window is closed, the differential list will revert back to its original order.

Use the following procedure to document other possible diagnoses to consider for each diagnosis listed in the Assessment section of the note.

To add differential diagnoses to the Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.
2. In the **Assessment** section, click the text labeled **DDx** under the desired ICD code.
3. The DDx window will open with the selected ICD code highlighted in the left pane.
4. A list of Substitutions and Differential Diagnoses linked to that ICD-9 code will appear in the middle and right panes.

   Note: Not all diagnosis codes have differentials linked to them however links can easily be created. For details on linking differentials to a diagnosis code see Editing Differentials Linked to Diagnosis Codes.
5. Click the check box to the left of the substitution or differential to be added. More than one differential can be documented by clicking the check box next to multiple differentials.
6. Note that an asterisk (*) will appear in front of the diagnosis code in the left pane when a differential has been selected for it. This asterisk denotes that a differential has been selected for that diagnosis.

7. Select the Differential Text that will drop into the note by clicking the radio button next to the desired choice. There are four choices of that can be selected for Differential Text.
   - Differential: A, B, C
   - INCLUDES - Differential includes A, B, C. Based on current evaluation, there is insufficient information to make a more definitive diagnosis. If additional signs or symptoms manifest over time, a definitive diagnosis may become possible.
   - EXCLUDES - Differential considered and excluded includes A, B, C. Current evaluation does not support a life or limb threatening condition.
   - CO-MORBID - Associated co-morbid conditions considered include A, B, C.

   Note: The A, B, C listed in each of differential text choices represents place holders for the differential descriptions that will appear in the text. The differentials will be inserted in the same order they are listed in the right pane. For example, choosing the INCLUDES selection above for a chest pain diagnosis and then selecting Acute MI and Unstable Angina as differentials would generate text that reads: **Differential includes Acute MI, Unstable angina. Based on current evaluation** etc. where Acute MI and Unstable Angina are substituted for A and B in the text. Note that Acute MI appeared in the list ahead of Unstable Angina so it is inserted into the text first. Keep in mind that although only 3 letters are shown as place holders (A, B, C) the differential text can handle more than 3 differential substitutions.

   After a choice has been made for the Differential Text, a preview of the text that will show up in the note will appear in the Preview field at the bottom of the DDx window.
8. Once the differentials have been chosen and the text selected, click **OK** to save the changes and return to the note.
9. The Differential Text will appear directly under the appropriate diagnosis code in the Assessment section of the note.

Editing the Differential Text

The Differential Diagnosis appears in the Assessment section of the note directly under its ICD-9 code. The text cannot be edited directly but the differential that is documented for a specific ICD code can be changed or additional text can be added to the documentation.

To change the differential diagnosis:

1. In an open Visit or Order Note that has Differential Diagnoses associated with an ICD-9, click the text describing the differential. It will be located directly below the appropriate ICD in the **Assessment** section of the note.

   The DDx window will open. The selected ICD will be highlighted in the left pane. The substitutions or differentials attached to the ICD will appear in the right pane marked with a check in the check box to the left of the description.
2. Clear any differentials that are to be removed or add checks next to items to add to the differential.
3. Click **OK** to save the changes and return to the note.

Including Additional Diagnoses

One of the more powerful features of the DDx module is that it can be used for more than just documenting the Differential Diagnoses. It can also be used to quickly and easily add additional ICD codes to the Assessment section of the note.

To insert additional diagnosis codes:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A button** in the vertical button column to 'jump' to that part of the note.

2. In the Assessment section, click the text labeled **DDx** under the desired ICD code.

   The DDx window will open with the selected ICD code highlighted in the left pane.

3. A list of Substitutions and Differential Diagnoses linked to that ICD-9 code will appear in the middle and right panes.

   Note: Not all diagnosis codes have differentials linked to them; however, links can easily be created. For details on linking differentials to a diagnosis code, see Editing Differentials Linked to Diagnosis Codes.

4. Click the check box to the left of the diagnosis to be added. More than one diagnosis can be added by clicking the check box next to multiple differentials.

5. When all the diagnoses are selected, click the **Add** button that is between the left and right panes.

6. The selected diagnoses will be added to the list in the left pane.

7. Click the **OK** button to save the changes and return to the note. The selected diagnoses will now be added to the list of ICD codes in the Assessment section of the note.

Substituting More Specific Diagnoses

One of the more powerful features of the DDx module is that it can be used for more than just documenting the Differential Diagnoses. It can also be used to quickly and easily substitute more specific ICD codes to the Assessment section of the Visit or Order Note in place of non-specific codes.

To substitute a more specific diagnosis:

1. In an active Visit or Order Note, scroll to the **Assessment** section or click the **A** button in the vertical button column to 'jump' to that part of the note.

2. In the **Assessment** section, click the text labeled **DDx** under the desired ICD code.

3. The DDx window will open with the selected ICD code highlighted in the left pane.

4. A list of Substitutions and Differential Diagnoses linked to that ICD-9 code will appear in the middle and right panes.

   Note: Not all diagnosis codes have differentials linked to them; however, links can easily be created. For details on linking differentials to a diagnosis code see Editing Differentials Linked to Diagnosis Codes.

5. Click the check box to the left of the diagnosis that will replace the diagnosis that is highlighted in the left pane. More than one diagnosis can be added by clicking the check box next to multiple differentials but only the first diagnosis in the list will replace the highlighted code. The others will be added to the list.

6. When all the diagnoses are selected, click the **Sub** button that is between the left and right panes.

7. The selected diagnosis will replace the highlighted diagnosis in the left pane.

8. Click the **OK** button to save the changes and return to the note. The substituted diagnosis will replace the previous diagnosis in the Assessment section of the note.

Deleting Diagnosis Codes

Diagnosis codes that are inadvertently added to the left pane of the DDx window can be deleted.

To delete a diagnosis:

1. Highlight the code in the left pane that is to be deleted.

2. Click the **Delete** button at the top of the left pane.

3. Click **Yes** in the confirmation screen.
4. Click **OK** to save the changes and return to the note.

Updating the Orders Section

The Orders section aggregates all the Meds Prescribed, Radiology/Tests Orders, Lab Orders, Procedure Orders and Other Orders that are associated with the note. This is the same information that is listed in the Plan section but in the Plan section each item is placed in a subsection under the diagnosis that it was prescribed or ordered to treat. This can make it difficult to get an overall view of all the treatments that have been ordered for the patient in a single consolidated view. In the Orders section this information appears without being segregated by diagnosis so that all the Meds are listed together, the Labs together, etc.

This section is strictly for display purposes. No entering or editing of data occurs in this section. All inserts, edits and deletions of medications, tests or procedures occurs in the Plan section and the resulting information is simply displayed in this section.

Note: As with other sections of the Visit or Order Note, the Orders section can be hidden, if desired.

Managing the Plan Section

Each diagnosis that shows up in the PLAN section of a Visit or Order Note has text generated from templates listed below it and in addition there are sub-headers for Prescriptions, Orders and Patient Education underneath it. Each of these can also contain information. This can make it difficult to easily get from one diagnosis to another without using the scrollbar. The Diagnosis Navigation feature in the Plan allows users to quickly navigate between these diagnoses. The feature is accessible from a menu that lists the diagnoses that are part of the current note. (see images below for example)

To access this menu:

Right-click anywhere in the PLAN section of the Visit or Order Note,

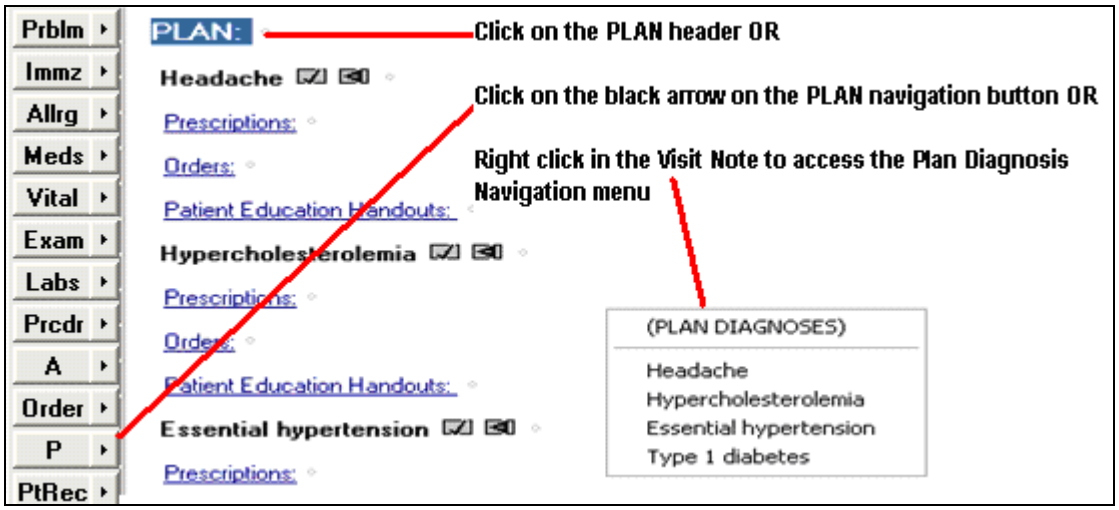
OR

Click the black arrow on the navigation button labeled **P** (for PLAN section).

OR

Click the **PLAN** header in the Visit or Order Note.

Each of these actions will pop up a menu that lists all available diagnoses that are part of the current note. Clicking a diagnosis will bring that diagnosis to the top of the note page. This allows for quick navigation when there are several diagnoses in the note.



To document the plan:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.
2. Each diagnosis (from Assessment) will have its own section in Plan. The diagnosis will appear in bold black text, followed by a template icon and a free text icon.
3. Use a template to document the treatment plan. The template icon will appear to the right of each bold black diagnosis heading. Click it for a list of linked templates. For information about the template icon and the Template Links, see Accessing Templates in a Visit or Order Note.
    a. If a linked template is available, choose whether to use the blank template, a pre-clicked template, or a past template. Open the appropriate template type, document by clicking the check boxes, and close the template. Template-generated text will drop into the Chart. In addition, free text can be typed to document any information not covered in the template.

        Note: It is preferable to use a template rather than free text to document the Plan, so that CPT codes linked to Labs, Tests, and Procedures can be automatically added to Orders simply by clicking off these items in the Plan template. See "Add Orders Directly from Plan Templates" for more information.

    b. *If no linked templates are available,* the user may choose to use either a Generic Plan template or free text (typing) to document basic information.

    Three sections, labeled **Prescriptions**, **Orders**, and **Patient Education**, follow each diagnosis heading. (See "Write a Prescription Linked to a Diagnosis", "Add an Order to a Note Manually" and "Add Patient Education to a Visit or Order Note" to read more about those sections.)

Note: A Care Plan template is available in the Plan section of a note. This template allows users to select general and diagnosis-specific guidelines for the patient. These guidelines are displayed in the visit note and are also included in C-CDA files. Inclusion of a care plan in the C-CDA provides the patient with ready access to individualized guidelines for healthier living and better outcomes.

Writing Prescriptions

To write a prescription linked to a diagnosis:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

    The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Prescriptions are linked to diagnoses.

2. Choose the correct diagnosis header (displayed in bold black text), and click the **Prescriptions** subheading (displayed in blue text and underlined).

   This opens the Refill Grid window. For detailed information about selecting a drug and writing a prescription, see Prescription Writing Basics.

   After the prescription is completed, it will appear in the Scripts Written windowpane of the Prescribe a Drug window. Additional prescriptions written for the same diagnosis can be written before closing this window.

Note: Another option is to write all of the prescriptions for the visit while in this window, and then move the prescriptions to the correct diagnoses later.

Important! It is important to keep in mind that *NO ONE* can write a prescription unless they have the correct privileges. Even if a provider has all script writing privileges, no prescriptions can be written under their name unless the person logged in *also* has script writing privileges.

The Medical Assistants security group is given ScripWriter Non-Schedule privileges by default. If a provider wants to limit the ability of a Medical Assistant to write ANY scripts this privilege needs to be removed from this particular security group. Additionally, if a provider wishes to delegate authority to Medical Assistants to write ALL types of prescriptions the ScriptWriter Schedule 3-5 and ScriptWriter Schedule 2 privileges need to be added to this security group. See Edit a Security Group.

Prescriptions can be written directly from templates if the template item has an Extended Attribute of Prescription linked to it (see Prescription Extended Attributes for details).

To write a prescription from a template:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.
2. The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment.
3. Choose the correct diagnosis header (displayed in bold black text), and open the template for that diagnosis.
4. Most PLAN templates have a Medications section. Click the medications question and select the desired drug from the following levels.

   When the template is closed a modified Refill Grid will open.
5. Change the prescription information, if necessary, and the click **Save.**

   The prescriptions will be added to the Prescription header under the appropriate diagnosis

Note: For detailed information about writing a prescription from a template, see Prescriptions from Templates.

When new prescriptions are written, they should be linked to an appropriate diagnosis. However, it is possible to write a new prescription in a Visit or Order Note without linking it to a diagnosis.

To write a prescription without a linked diagnosis:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.
2. At the bottom of the Plan section, click the bold blue heading labeled **Other Prescriptions** (rather than clicking any of the Prescriptions subheadings, displayed in blue text and underlined).

   This opens the Prescribe a Drug window. For detailed information about selecting a drug and writing a prescription, see Prescription Writing Basics.

Important! It is important to keep in mind that *NO ONE* can write a prescription unless they have the correct privileges. Even if a provider has all script writing privileges, no prescriptions can be written under their name unless the person logged in **also** has script writing privileges.

The Medical Assistants security group is given ScripWriter Non-Schedule privileges by default. If a provider wants to limit the ability of a Medical Assistant to write ANY scripts this privilege needs to be removed from this particular security group. Additionally if a provider wishes to delegate authority to Medical Assistants to write ALL types of prescriptions the ScriptWriter Schedule 3-5 and ScriptWriter Schedule 2 privileges need to be added to this security group. See Edit a Security Group for details.

To move a prescription to a different diagnosis:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Prescriptions are linked to diagnoses and are listed under the Prescriptions subheadings (displayed in blue text and underlined).

2. Click any prescription and select the **Move to Another Diagnosis** menu option.
3. This opens a window listing all of the diagnoses for the current visit. Select any one to move the prescription to that diagnosis.

To edit a prescription in a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Prescriptions are linked to diagnoses and are listed under the Prescriptions subheadings (displayed in blue text and underlined).

2. Click any prescription and select the **Edit** menu option. This opens the Write a Prescription window.
3. Make desired changes and click **Save**. For detailed information on writing a prescription, see Prescription Writing Basics.

To delete a prescription from a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The Plan section of the Visit or Order Note will display each diagnosis from Assessment. Prescriptions are linked to diagnoses and are listed under the Prescriptions subheadings (displayed in blue text and underlined).

2. Click any prescription and select the **Delete** menu option.
3. Click **Yes** in the Delete Confirmation window.

Documenting Orders

Add Orders Directly from Plan Templates

Items in the Plan templates can be linked to CPT codes. Linking structured pieces of data to template items is done via a process called "Extended Attributes" in the Template Editor.

With a Plan template containing CPT Extended Attributes, as the user clicks off Orders in the template (such as for Labs, Tests, and Procedures) the corresponding CPT code is automatically added to the Orders section of the Plan. This eliminates the CPT search that was required in prior versions of e-MDs Chart.

A Few Rules:

- A CPT can be deleted from the note by reopening the Plan template and clearing the associated order in the template. However, it is much faster to delete a CPT directly from the Orders. When

this occurs, the item will automatically be cleared in the template, correcting the generated template text as well.

- A given CPT can be added to the note more than one time. If the same CPT is checked off in two separate templates, a warning message will appear telling the user that the code already exists in the note and asking if they want to add a duplicate. This gives the user the ability to add duplicate CPT codes when desired.

Plan templates created by e-MDs already have CPT codes linked to them, although these can easily be changed in the Template Editor (see CPT Extended Attributes for details). CPT Extended Attributes can be incorporated into any new Plan (as well as Procedure and Exam) templates created by the user.

The easiest way to add Orders to the note is automatically, via the Plan templates. However, in cases where an appropriate Plan template does not exist, one could either use a Generic Plan template or add the Order manually, as described below.

To add an order to a note manually:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Orders are linked to diagnoses.

2. Select the correct diagnosis header (displayed in bold black text), and click the **Orders** subheading (displayed in blue text and underlined).

   This opens the Linked CPTs window, listing orders appropriate for the given diagnosis (as determined by the users).

3. Click all desired orders and then click **Accept**. (Once an order is selected, it can be clicked a second time to clear it.)

   Note: e-MDs Chart comes preloaded with a few linked orders as an example. Users can create ICD-to-CPT links in the Code Linker. In addition, orders can be added to the Linked CPTs window, on the fly, in a note. See "Add an Order to a Note Manually" for details.

Adding a CPT Code to the Linked Orders Window

The easiest way to add Orders to the note is automatically, via the Plan templates. However, in cases where an appropriate Plan template does not exist, the Order can be added manually from the Linked Orders window.

Appropriate orders can be linked to diagnoses via the Linked CPTs window. For the most common diagnoses, appropriate ICD-to-CPT links should be made ahead of time in the Code Linker. However, if the desired order does not appear in the Linked Orders window, it can be added on the fly, in the Visit or Order Note.

To add a linked order to a diagnosis in a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Orders are linked to diagnoses.

2. Select the correct diagnosis header (displayed in bold black text), and click the **Orders** subheading (displayed in blue text and underlined).

   This opens the Linked CPTs window, listing orders appropriate for the given diagnosis (as determined by the users).

3. To add another CPT to this window, click **Add CPT** to launch the CPT search.

4. Highlight the correct CPT from the search results and either double-click or click **Accept**. (For detailed instructions regarding the CPT search, see "Search for a CPT Code.")

   This permanently adds the CPT to the Linked CPTs window, and that order is now linked to the selected diagnosis.

   Note: Removal of an inappropriately linked order can only be performed in the Code Linker.

5. Highlight the newly added order and click **Accept** to add the CPT to the note.

Deleting a CPT Code from the Linked Orders Window

Appropriate orders can be linked to diagnoses via the Linked CPTs window. For the most common diagnoses, appropriate ICD-to-CPT links should be made ahead of time in the Code Linker. However, if the desired order does not appear in the Linked Orders window, it can be added on the fly, in the Visit or Order Note. Sometimes, an inappropriate CPT code will be linked to a diagnosis. This link can be broken in the Code Linker, but it is much faster to delete it on-the-fly in a note.

To delete an incorrectly linked order:

1. The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Orders are linked to diagnoses. Select the correct diagnosis header (displayed in bold black text), and click the **Orders** subheading (displayed in blue text and underlined).
2. This opens the Linked CPTs window, listing orders for the given diagnosis (as determined by the users).
3. To delete any CPT(s) from this window, highlight those to be unlinked and click **Delete**.

   Note: This breaks that ICD-CPT link for ALL users.

To delete an order from a note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Orders are linked to diagnoses and are listed under the Orders subheadings (displayed in blue text and underlined).

2. Click the order to be removed and select the **Delete** menu option.
3. Click **Yes** in the Delete Confirmation window.

   Note: If the Order was added directly, via a template, deleting the CPT from the Orders section will also automatically clear that item in the Plan template, correcting the generated template text.

Updating Order Properties

Orders are found in the **Plan** section of an active Visit or Order Note, linked to diagnoses and listed under the diagnosis' **Orders** subheading (displayed in blue text and underlined).

To edit the properties of an order:

1. Click the order and select the **Properties** menu option. (Alternatively, click directly on the **"In House"** or **"Send Out"** statement that follows the order in parentheses.)
2. Select the values for the properties as described in the Order Properties Options table.
3. When editing is complete, click **Save**.

Order Properties Options	
Description	This description can be changed. Note that the new text will still be linked to the original CPT code, so if the wrong order was entered, it must be deleted.
Number of Occurrences	The default is **1**, but this can be changed by typing directly into that field or clicking the up/down arrows. This value is the number of times the order should be performed (the quantity reflected on the Lab or Radiology Order Form).
Quantity	The default is **1**, but this can be changed by typing directly into that field or clicking the up/down arrows. There are some CPT codes that can be charged multiple times. For example, CPT code 90472 is billed for "each additional immunization administered" beyond the first injection. So, if 3 immunizations are given, code 90472 is billed with a quantity of "2".
In House	This box should be checked if the order will be performed in-house and billed. If checked, the CPT code for the order will appear on the Superbill/Charge Capture form. For labs or procedures that will be done elsewhere (and billed for by another party), make sure that this box is not checked. **Note:** Orders routinely done in-house can be defaulted to always check the **In House** box. See "View the Billing Details of a CPT Code" for details. *If the In House box is not checked*, a **Billable** check box will appear. If this box is checked, the CPT code for the order will appear on the Superbill/Charge Capture form, even though it is a "send out" test. This allows appropriate billing for those labs done elsewhere and charged to the clinic, where the clinic then, in turn, bills the patient.
Stat	Check this box for orders that are to be performed immediately. The "stat" designation will appear in the note as well as on the Laboratory Orders form. See "Lab Tracking" for details.
Comments	Use this free-text field to add specific information about each order in the note.
Print Comment	By default, this check box will be selected to print the **Comments** field text on the order. To avoid inclusion of the comments on the order output, deselect this check box.
Track	Check this box to mark an item to be tracked through the Lab Tracking module *for this instance only*. Or clear the box to mark and item to *NOT* be tracked.
Urgent	Check this box to change the priority of the Overdue Message generated and sent by TaskMan. Once received in TaskMan, a RED “P” flag is added to this message if the Urgent box is checked. See "Notification of Overdue Labs" for details.
Due After	Enter a value in this field to note to specify the number of days after which the item will be considered overdue. If there is a default value already set for this item the field will be prepopulated with this value. See "Setup Tracked Items" for details.
Due Date	This field is a calculated date based on the value in the **Due After** field and represents the date after which the item will be considered overdue.
Confidential	Check this box if the item is to be hidden for privacy reasons.
Print Separately	Check this box to generate a lab or radiology order with only the displayed CPT code and its details. All other CPT codes ordered in the Visit or Order Note will print together on a lab or radiology order form.
Print Each Occurrence Separately	Check this box to print an individual order form for the quality of that order. For example, if an INR is ordered with a quality of 6 (see **Number of Occurrences** field above), checking this option will generate 6 separate Lab Order Forms.

Editing the Description of an Order

Orders are found in the **Plan** section of an active Visit or Order Note, linked to diagnoses and listed under the diagnosis’ Orders subheading (displayed in blue text and underlined).

The Linked CPTs window (which displays orders appropriate for the given diagnosis) automatically displays the "official description" for any CPT. This process cannot be changed. However, once an order is dropped into a Visit or Order Note, the description can then be altered.

Order descriptions that drop into the note directly from a Plan template can be permanently changed, by editing the description assigned to the Extended Attribute. See "CPT Extended Attributes" for details.

To edit the description of an order in the note:

One way to modify the text description of an order is by editing the order's properties. See Updating Order Properties for details.

OR

Another way is to choose an Alternate Description. For that method, click the order in the right pane and select the **Alternate Descriptions** menu option. In the pop-up window, click the desired description to select it.

To learn how to create additional Alternate Descriptions for CPT codes, see "Add an Alternate Description for a CPT Code."

Orders are found in the Plan section of an active Visit or Order Note, linked to diagnoses and listed under the diagnosis' Orders subheading (displayed in blue text and underlined).

To add a modifier to a CPT code:

1. Click the order and select the **Modifiers** menu option. (Alternately, click directly on the five-digit numerical CPT code of the order.)
2. Highlight the appropriate modifiers from the Linked CPT Modifiers window and then click **Accept**.
3. If the appropriate modifiers do not appear in the Linked CPT Modifiers window, click **Add Modifiers**.
4. In the CPT Modifiers window, highlight correct modifiers and then click **Accept**. This will permanently add the modifiers to the Linked CPT Modifiers window. Then, proceed as outlined in step 2 above.

Managing CPT Codes Linked to an Order

Occasionally, when selecting one order, it is appropriate to also bill for a related order. For example, when billing the CPT code 90657 (Influenza vaccine), the user should also bill CPT code 90471 (Immunization administration). To aid charge capture and minimize lost billing opportunities, e-MDs has created CPT-to-CPT links.

Note: Orders are found in the Plan section of an active Visit or Order Note, linked to diagnoses and listed under the diagnosis' Orders subheading (displayed in blue text and underlined).

To add CPT codes to the visit charges:

1. Click the order and select the Linked CPTs menu option.

   The Linked CPTs window will show all CPTs linked to the selected order.

2. Highlight any CPT(s) in the list and click **Accept** to add them to the current Visit or Order Note.

   Note: e-MDs has pre-linked a few related orders, but the responsibility for creating the CPT-to-CPT links rests with the user. If the Linked CPTs window does not show the desired order, click Add CPT. Select the appropriate CPT from the full CPT search and click Accept. This will add the order to the Linked CPT window. Then, select the order from that window and click Accept to add the order to the current note.

Managing HCPCS Codes Linked to an Order

Occasionally, when selecting an order (i.e. a CPT code), it is appropriate to also bill for related supplies (i.e. HCPCS codes). For example, when billing for serum laboratory tests, it may be appropriate to also

charge for the syringe and needle. To aid charge capture and minimize lost billing opportunities, e-MDs has created CPT-to-HCPCS links.

It is assumed that these supplies are only used when an Order is performed "in house." Therefore, whenever an in-house CPT is added to a note, an automatic pop-up window will prompt the user to charge for supplies. This happens regardless of whether the Order was added via a template or directly from the Linked Orders window. In addition, this Linked HCPCS window can be viewed at any time by clicking an order in the note and selecting the HCPCS menu option.

Note: There is no way to prevent this pop up reminder from appearing. Currently, the window will appear even if there are no linked HCPCS. This will be handled differently in a future version of e-MDs Chart.

To add HCPCS to the visit charges:

1. The Linked HCPCSs window will show all HCPCS codes linked to the selected order (CPT). Highlight any HCPCS(s) in the list and click **Accept** to add them to the current Visit or Order Note.

   OR

   Click **Accept All** to choose all of the HCPCS in the list.

   The selected HCPCS code(s) will be added to the Orders section of the note, following the CPT code to which they are linked. Both the HCPCS code and description will appear, along with a quantity which defaults to 1 and is displayed as "(x1)" following the description.

2. To change the quantity, click "**(x1)**" and type into that field or use the up/down arrows to change the number.

   Note: e-MDs has pre-linked a few HCPCS, but the responsibility for creating the CPT-to-HCPCS links rests with the user. If the Linked HCPCSs window does not show the desired supply, click **Add HCPCS**. Select the appropriate HCPCS from the full HCPCS search and click **Accept**. This will add the supply to the Linked HCPCSs window. Then, select the supply code from that window and click **Accept** to add the HCPCS code to the current note.

   If any HCPCS codes are linked incorrectly, simply highlight the code(s) in the Linked HCPCS window and click **Delete**. This breaks the CPT-HCPCS link for ALL users.

Orders are found in the **Plan** section of an active Visit or Order Note, linked to diagnoses and listed under the diagnosis' Orders subheading (displayed in blue text and underlined).

To move an order to a different diagnosis:

1. Click any order and select the **Move to Another Diagnosis** menu option. (The Move to Another Diagnosis option is only active if the order was entered manually. Due to the linking created, an order entered via a template will not have this option available.)
2. This opens a window listing all of the diagnoses for the current visit. Select any one to move the prescription to that diagnosis.

   Note: Currently, it is not possible to link a single order (CPT) to more than one diagnosis (ICD) in either the note display or the Superbill/Charge Capture.

Using Cached CPT Codes

The Cached CPT Code module works in conjunction with the Clinical Rules Engine (Rule Manager) and the Rule-Based Reminders window to assist in automating the documentation and/or billing of CPT codes for tests or procedures that are deemed necessary during the process of a visit. The module does this by presenting a window that contains linked ICD and CPT codes appropriate for the selected rule. If codes exist in the **CPT Cache** window it will appear whenever a note is opened or closed and also on demand (see Accessing Cached CPT Codes for details). Once the window opens the user has the option of dropping these codes into the note for documentation and/or billing purposes.

Rules are created in the Rule Manager and these rules query the database to provide information about a patient's status concerning preventive health, disease management, medication management, and immunizations. As part of the process of creating these rules, CPT codes that represent the test or procedure identified by the rule can be associated with the rule. Reminders generated by the rule provide the user with information about tests or procedures that are overdue (or coming due in the near future), and these reminders are visible within the individual patients' chart. Once the reminders are displayed in the patient's chart, the user then has the option of addressing those reminders in several ways (see Addressing Rule-Based Reminders for details). One of the options for addressing a rule-based reminder is to use the **Ordered** button. Clicking this button inserts ICD and CPT codes into the Cached CPT Code module and when the note is opened the user has the option to drop these codes into the note.

Accessing Cached CPT Codes

The Cached CPT Code module presents the user with a **CPT Cache** window that contains ICD and CPT codes that are linked to specific rule-based reminders. This window is populated whenever a rule-based reminder is addressed by using the **Ordered** button in the Rule-Based Reminders section of a patient's chart and if the rule has codes linked to it (see Create a New Rule for details). The CPT Cache window can be accessed in 3 ways; automatically on the opening of a Visit or Order Note, automatically on the closing of a Visit or Order Note and manually on demand.

To access cached CPT codes:

1. Access CPT Cache upon opening a Visit or Order Note.
2. Whenever a Visit or Order Note is created or opened, a warning message is presented *if Cached CPT codes exist* for that patient. This message reads:

   ```
   There are outstanding orders (CPT codes) for this patient that have not been
   dealt with.  Please evaluate these "Cached CPT Codes" and handle as
   appropriate.

   Display "Cached CPT Codes"?
   ```

3. If you select **Yes**, the CPT Cache window opens and you are given the opportunity to drop the codes into the note or to cancel.

   OR

   If you select **No**, the CPT Cache window will not open and the note can be documented as necessary.

   Note: *If a shortcut or past visit is going to be used, you should choose **No** or the CPT Cache window should be canceled*. Dropping cached codes into the note at this point will prevent the loading of a shortcut or past visit. If the CPT Cache window is canceled, you will be reminded again at the note conclusion.

To access CPT cache on Visit or Order Note conclusion:

1. Anytime the **Note Conclusion** icon is clicked, a warning message is presented *if Cached CPT codes exist* for that patient. The message reads:

   ```
   There are outstanding orders (CPT codes) for this patient that have not been
   dealt with.  Please evaluate these "Cached CPT Codes" and handle as
   appropriate.

   Stop the conclusion of this note and display "Cached CPT Codes"?
   ```

2. If you select **Yes**, the CPT Cache window will open and you will be given the opportunity to drop the codes into the note or to cancel.
3. If you select **No**, the CPT Cache window will not open and the note conclusion will proceed as usual.

   Note: If you click the **X** at the top right of the patient chart or at the top right of the Chart application window, the CPT Cache window will *NOT* be displayed.

To access CPT cache manually:

1. Click the **Plan** header and select **Cached CPT Codes** from the pop-up menu.

   OR

   Click the arrow to the right of the **Plan** button (one of the navigation buttons on the left side of the note) and select **Cached CPT Codes** from the pop-up menu

   The CPT Cache window will open.

2. If any codes exist, drop them into the note now.

Dropping Cached CPT Codes into a Note

The Cached CPT Code module presents the user with a **CPT Cache** window that contains ICD and CPT codes (and the date they were generated) that are linked to specific rule-based reminders. This window is populated whenever a reminder is satisfied by using the **Ordered** button in the "Rule-Based Reminders section of a patient chart and if the Rule has codes linked to it (see Create a New Rule for details). Selection of one of these two methods inserts ICD and CPT codes into the Cached CPT Code module and when the note is opened the user has the option to drop these codes into the note.

Dropping Cached CPT codes into a Visit or Order Note serves two purposes. One is to satisfy the Rule that it was generated from so that the rule will no longer show up in the Rules Result window (until it becomes due again). The other is to ensure that reimbursement occurs for those items that are performed in-house.

To drop cached CPT codes into a note:

1. With the Cached CPT window open (see Accessing Cached CPT Codes for details).
2. Select the desired code to highlight it.
3. Click additional codes to drop multiple codes into the note (to clear a code, click it a second time).
4. After all codes are selected, click the **Drop Into Note** button.
5. The ICD code will be added to the note as a diagnosis under the PLAN section and the CPT will be added under that diagnosis under the **Orders** subhead.

   Note: If a CPT is cached without an associated ICD code the CPT will be added to the note under the Other Orders header. From there it can be move to an appropriate diagnosis if one exists (see Move an Order to Another Diagnosis for details).

Deleting Codes from the Cached CPT Window

Cached CPT codes are generated when a user clicks the **Ordered** button to address a rule-based reminder on the Reminders tab of a patient's chart (provided the rule has ICD or CPT codes linked to it). If the cached codes are not dropped into a Visit or Order Note they will remain in the Cached CPT window and will appear whenever a note is opened or closed for that patient. To avoid this problem it is always best to drop the cached codes into a note at the time of the visit. However if this does not happen the codes can be removed from the Cached CPT window at any time.

To delete codes from the cached CPT window:

1. With the Cached CPT window open (see Accessing Cached CPT Codes for details).
2. Select the code to be deleted to highlight it.
3. Click additional codes to delete multiple codes at one time (to clear a code, click it a second time).
4. Once all codes are selected, click the **Delete From Cache** button.

Updating E&M Coding

Automating Coding with the E&M Coder

e-MDs Chart offers an automated E&M (Evaluation and Management) coding wizard. To see the current status of the E&M documentation at any point during a note, click the **Plan** heading and then click E&M Coder. Alternately, click the black arrow next to the P button in the vertical button column, and then select E&M Coder.

Although the E&M Coder will suggest an E&M code based on the level of documentation, it will not automatically add that code to the note. The healthcare provider is required to view the E&M Coder and Accept the suggested code (or change it) in order to drop an E&M code into the note. (Alternately, the user can bypass the E&M Coder altogether and select an E&M code from a list.) So that the physician does not forget to include an E&M code, the system can be set to pop-up the E&M Coder at the time of note conclusion if a code has not already been added to the Orders.

Follow the steps in the next sections to understand the automation and how the code is calculated.

1. Service Type and Patient Type
2. History
3. Examination
4. Medical Decision Making
5. Accept or Change the Code

   Note: There are inherent difficulties in automating the determination of the E&M Code. This includes (but is not limited to) the amount of time that may be spent in counseling and coordination of care and the subjective nature of determining the level of risk in "Medical Decision Making" section. Therefore, e-MDs does not warrant the validity of any calculated E&M code. The calculated code is meant to merely be a guide, and the physician must use his or her best judgment in adjusting that code, if necessary.

E&M Coder: Service Type and Patient Type

1. **Service Type:** This field is located at the uppermost portion of the E&M Coder window. It will already be filled in based on information from the Visit Details window. This identifies the setting of the patient encounter, which determines the appropriate subset of E&M codes.
2. **Patient Type:** The Patient Type- New or Established- will already be filled in, based on an automated check of the database for any prior Visit or Order Notes. This information is very important as the amount of documentation required to reach a particular code level depends upon this status.

E&M Coder: History

3. **History Data:** This is recorded on the first horizontal row of the E&M Coder. There are 3 questions that must be answered to obtain a History Summary. Filling out this data automatically calculates the level of detail of the History and displays this in the History Summary field (located to the right of the arrow in the first row).
4. **History of Present Illness:** The number of questions asked in the History of Present Illness (HPI) - either 1-3 questions or 4+ questions.

   If this history is documented via HPI templates with E&M Extended Attributes, the number of questions will automatically be tallied. If some or all of the history is documented via free text (typing or voice recognition), the user must manually select the correct check box in the E&M Coder.
5. **Review of Systems:** The number of organ systems addressed in the Review of Systems (ROS) - either 1, 2-9, or 10+ systems.

If this history is documented via an ROS template (or Fast Form) with E&M Extended Attributes, the number of systems addressed will automatically be tallied. If some or all of the ROS is documented via free text (typing or voice recognition), the user must manually select the correct check box in the E&M Coder.

6. **Past Medical/Family/Social Histories:** Documents whether Past Medical History, Family Medical History, and/or Social History are addressed.

   If these various sections have been added to the note, they will automatically be counted.

If *ANY* of the following sections are added to the note, credit is given for Past Medical History: Current Problem List, Allergies, Current Medication List, Past Medical History, Surgical History, Mental Health History, and/or Communicable Disease History.

If *ANY* of the following sections are added to the note, credit is given for Social History: Social History, Tobacco/Alcohol/Supplements, and/or Substance Abuse History

E&M Coder: Examination

7. **Examination Data:** This is recorded on the second horizontal row of the E&M Coder, to the right of the text window. The only data field asks for the number of exam items performed—choose either 1-5, 6-11, 12+, or 18+ (which must involve at least 9 organ systems).

   If the exam is documented via a Plan template whose title begins with **"Exam with E/M Coding: __"**, the number of qualifying "exam items" will automatically be tallied. If any other template is used, or if all or part of the exam is documented via free text, the user must manually select the correct number of exam items.

8. When the number of exam items is selected (either automatically or manually), the level of detail of the Exam is calculated and displayed in the **Exam Summary** field (located to the right of the arrow in the second row).

E&M Coder: Medical Decision Making

Medical Decision Making Data is documented on the bottom horizontal row of the E&M Coder. There are 3 questions that must be answered to obtain a Summary. These items will be calculated automatically, but can be changed by the user. When the check boxes for each of the 3 questions are addressed, the level of complexity of the Medical Decision Making is automatically calculated and is displayed in the Medical Decision Making Summary field (located to the right of the arrow in the third row).

9. **Number of Diagnoses or Management Options:** Choices include minimal, limited, multiple , or extensive. *Click the bold header in that box to learn more about how this decision is made*. "Points" are assigned based on the total number of diagnoses in Assessment, as well as whether the problems are acute or chronic, and stable or worsening. For this reason, it is critical that the user record the diagnosis properties accurately.

   Note that a limitation of the E&M Coder is the inability to distinguish between a "new problem not needing further workup" (which is worth 3 points) and a "new problem requiring additional work-up" (worth 4 points). Therefore, if the Assessment includes a diagnosis that does need further work-up, and the "Multiple" option is automatically selected, the user will need to manually change that to "Extensive."

10. **Amount and Complexity of Data to Review:** Choices are none/minimal, limited, moderate, or extensive. *Click the bold header in that box to learn more about how this decision is made.*

    "Points" are assigned, in part, based on whether lab, radiology, and/or other tests are ordered. These points are counted automatically, based on the **Orders** section of the Visit or Order Note.

    (CPTs are divided into categories of "lab", "radiology" and "other." Note that one point is assigned for lab, regardless of the number of labs ordered. Similarly, one point is allowed for "other" orders, regardless of the number. But, there is no maximum number of points for "radiology.")

    Additional points can be counted if the physician discusses results with a specialist, decides to obtain old records, and/or reviews old records or obtains a history from someone other than the

patient. There is no way to automatically tally these points. So, if the user performs any of these actions, the check box may need to be changed manually.

11. **Risk of Complications:** The third field assesses the risk of complications and/or morbidity or mortality. *Click the bold header in that box to learn more about how this decision is made*.

    Three categories are used to determine the risk: the *types of problems* (acute/chronic, stable/worsening, etc.), the *types of procedures ordered* (and their relative risks), and the *types of management* (prescription medications, IV fluids, surgery, etc.) The highest level of risk in any one of the three categories determines the overall risk.

    Because the *type of problem* contributes to the determination of risk, it is critical that the user record the diagnosis properties accurately.

    In regard to the risk for each *type of procedure*, e-MDs has internally coded each CPT with a risk level, from 1 to 4. This level is not visible to the user or editable.

    One important aspect of the *type of management* is that prescription drugs are considered a moderate risk. Therefore, if any prescriptions are written through the Script Writer, the system will automatically score (at least) a moderate level risk. If, for some reason, a prescription is not written in the Script Writer (i.e. it is hand-written or samples are given), the user will need to manually mark the Moderate risk level.

E&M Coder: Accept or Change the Code

12. **The Calculated E&M Code:** Based upon the History, Exam, and Medical Decision Making Summaries, the E&M code is calculated and displayed in blue at the bottom of the E&M Coder window. If the user chooses to override a result in the Summary column, the calculated code will appear in red. The answers to any of the data fields may be changed at any time, which may automatically change a particular section's summary, and, ultimately, the final E&M code.
    - Click **Accept** to drop the calculated E&M code into the current Visit or Order Note and close the window.
    - Click **Reset** to clear all of the fields and calculate another E&M code.
    - Click **Cancel** to close the window.

Selecting a Code Without the E&M Coder

13. In an active Visit or Order Note, either click the **Plan** heading or the small black arrow next to the **P** button in the vertical button column, and then click the **Select E&M Code** option.

    This opens a Linked CPT window, displaying E&M codes that are in the user's "short list " of favorite codes.

14. If the desired code is in that window, click it to highlight it, and then click **Accept**. This will add the E&M code to the **Orders** section of the note, linked to the primary (first) diagnosis.

15. If the desired code is not present in the Linked CPT window:
    a. Click **Add CPT**. This opens the CPT search.
    b. Click the **Outline** button, and then click the plus sign next to the **Evaluation and Management** folder.
    c. Continue drilling down to open subfolders. Check the "short list" check box next to *every* E&M code to be displayed in e-MDs Chart.
    d. When finished with all selections, click **Exit**.

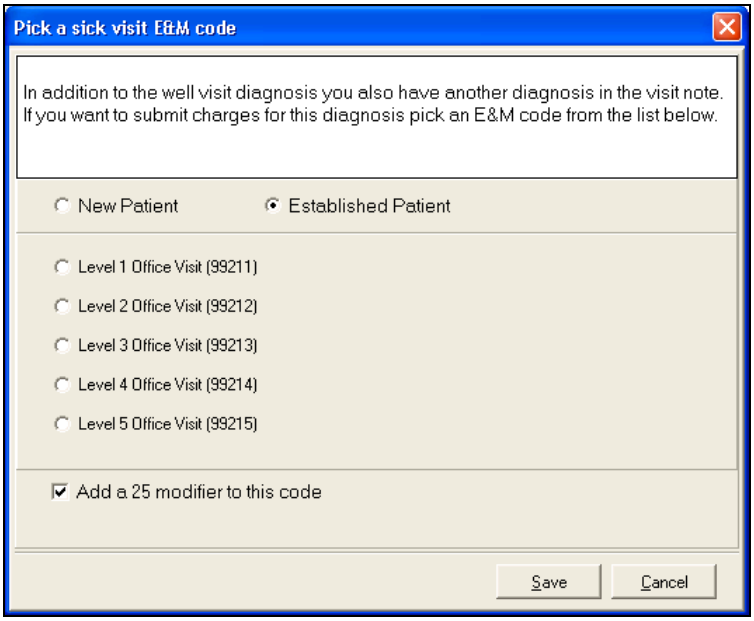
Dropping Preventive Care E&M Codes Into Notes

Preventive Care E&M codes are automatically dropped into the Visit or Order Note when the appropriate ICD is added. For example, when V20.2 is added to a Well Child visit, the patient's age will be assessed along with whether they are new or established and then the appropriate preventive E&M will automatically drop into the note without any intervention from the user. The preventive code will also be

available in the E&M wizard *IF* the **Type of Encounter** for the Visit or Order Note is set to **Preventive Medicine Services**.

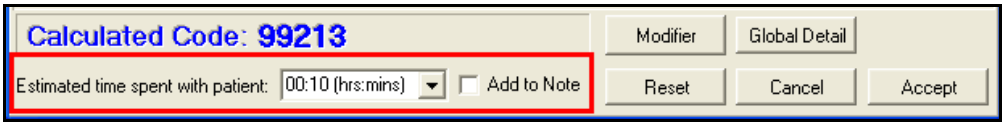
Note: If a well visit diagnosis is added to a note the preventive E&M will be added automatically whether the Type of Encounter in the visit details is set to Preventive Medicine Services or not. For example even for a visit marked as Office/Outpatient Visit if a well diagnosis is added to the note the preventive E&M will be dropped in automatically.

An feature related to the Preventive E&M code is that if there is a "sick" diagnosis code in the note as well as a "well visit" diagnosis then an additional window will pop up at Note Conclusion (in lieu of the E&M Wizard) prompting the user to add a second E&M code (along with a 25 modifier) to the note IF desired (see screenshot below for an example). This new screen is similar to the E&M wizard in that it provides codes based on whether the patient is a New or Established patient. e-MDs will not try to calculate an E&M level for the sick visit. The decision for picking an appropriate sick visit code is left up to the user.

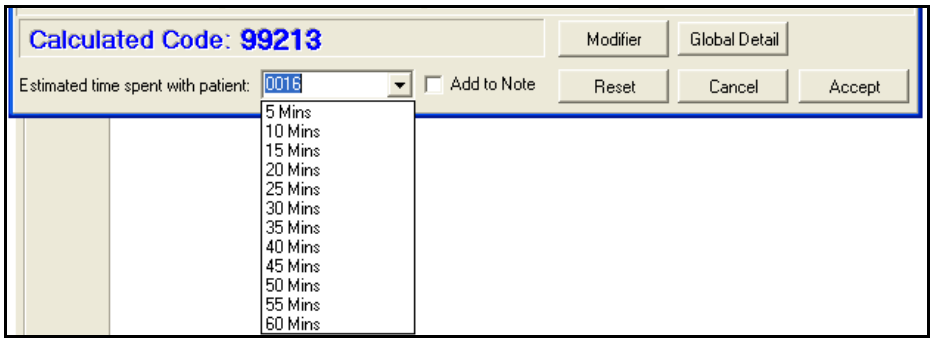


Tracking Time with the E&M Coder

To enhance the process of generating E&M codes there is a time tracking component available in the E&M Coder as seen in the screenshot below.



Time for a visit is tracked based on a timeframe that starts when the provider part of the note is started in Tracking Board and ending when the E&M wizard is opened or when the patient is checked out of the exam room in Tracking Board. This timeframe is an estimate and may not reflect the exact amount of time that is spent with the patient. Because this is an estimate an amount of time can also be chosen from a dropdown list so that the user can adjust the time to more accurately reflect time that was spent with the patient (see screenshot below for an example).

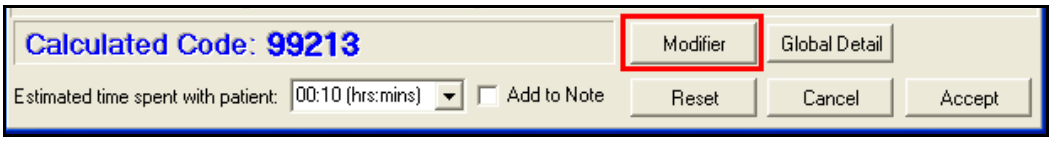


Whether you choose to use the calculate time or pick a time from the list, you can choose to add documentation to the Visit or Order Note that reflects the time spent with the patient. To do this simply click the check box labeled **Add to Note** to the right of the time field. If this check box is checked the time of the visit will be added to the description of the E&M code in parenthesis. For example documentation in the note would read: Office/outpatient visit; established patient, level 3 (15 minutes).

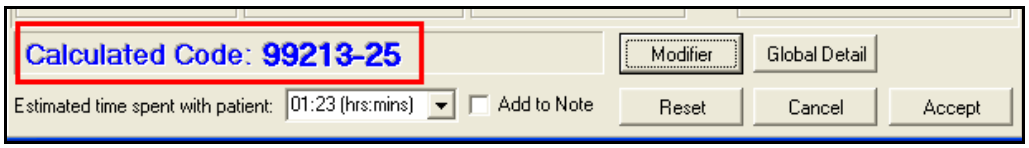
Note: Changes in the E&M code are not automatically calculated using the time documented. That is to say that e-MDs does not recalculate the E&M code at a higher or lower level based on the estimated time spent with the patient. The time is provided as a convenience and if the user wishes to make changes to the code based on time spent with the patient they must do so manually.

Adding a Modifier in the E&M Coder

To enhance the process of generating E&M codes there is a Modifier button available in the E&M Coder window.

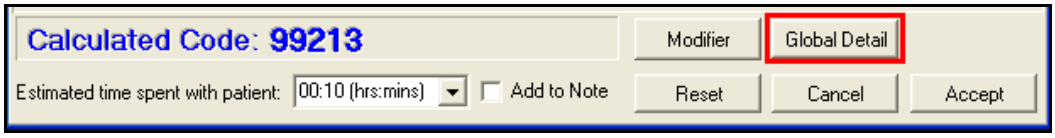


This button allows users to access the Linked CPT Modifiers window where the user can choose to add one or more modifiers (to a maximum of 4) to the E&M code that is displayed in the E&M Coder window. Once one or more modifiers are chosen they will be reflected in the E&M Coder window appended to the E&M code (see screenshot below for an example) and dropped into the Visit or Order Note.



Using the Global Detail View in E&M Coder

The E&M coder has a Global Detail button which opens a summary of the CPTs for which a patient is in a global period. The button label is red if the patient is in a global period.



Providing Patient Education

A wide variety of Patient Education materials are included in e-MDs Chart, including information about diseases, symptoms, procedures, preventive health measures, and alternative therapies. To enable quick searches of the material, each document is linked to one or more diagnosis (ICD) and/or procedure (CPT) codes. When these codes are used in a Visit or Order Note, the linked Patient Education documents are presented. (To read about editing these documents, see Edit a Patient Education Document.) Patient education resources from Krames and MedlinePlus are also available.

Adding Patient Education to a Visit or Order Note

In the Plan section of the Visit Note, you can add patient education for diagnoses, lab orders or results, and medications. Instructions are provided below.

To add patient education (e-MDs or Krames) to a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the note will display each diagnosis from Assessment. Patient Education documents are linked to diagnoses.

2. Select the correct diagnosis header (displayed in bold black text) and click the **Patient Education Handouts** subheading (displayed in blue text and underlined).

3. Select **Print e-MDs Patient Education** to print the related documentation available in e-MDs Chart. In the Linked Patient Education window, highlight the title(s) of appropriate handout(s) and click **Accept**. The selected documentation queues the handouts in the printer.

   OR

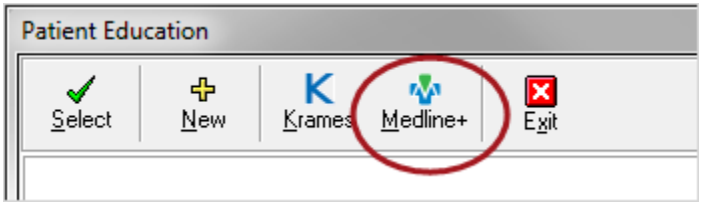
   Select **Krames** to review the available Krames patient education documentation. An Internet browser window will open at the Krames website and a list of appropriate patient education material will be displayed. Select the desired item(s) and click the Web browser **Print** option. The items selected will print after you close this window.

   This step adds documentation to the Visit and Order Note indicating that those specific handouts were given to the patient on that date. For more information about printing the handouts, see the To print and fax visit related items procedure.

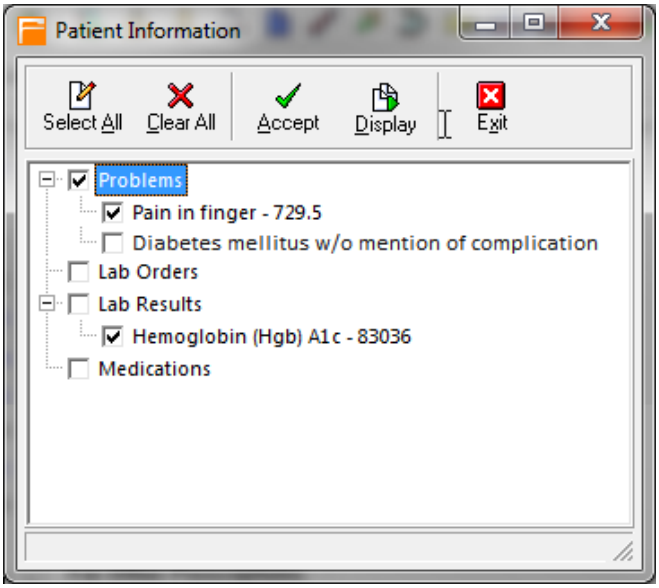
4. If an appropriate handout does not appear in the Linked Patient Education window, click **Add Patient Ed** for the full Patient Education search. If a document is found in that search, highlight its title and click **Accept**. This will add that document to the Linked Patient Education window, linking the document to the corresponding diagnosis.

To add patient education (MedlinePlus) to a Visit or Order Note

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.
2. Click the Patient Education Handouts link to open the Patient Education window.
3. At the top of the window are several buttons. Click the **Medline+** button to display a list of the problems, lab orders, lab results, and medications included in the Visit Note.



4. Click the check box next to each item for which you want to view or print MedlinePlus information. (To view information for all problems, lab orders, lab results, and medications, click the Select All button.)



5. To view information for the selected items:
   - Click the Display button. MedlinePlus Connect opens in a web browser, and each selected item is displayed as a link.
   - Click a link to display the related MedlinePlus information in a web browser. (You can print the information from the web browser.)
6. To add information to the Chart Note:
   - Click the Accept button. A list of the selected MedlinePlus patient education items is added to the note.

Adding Drug Education to a Visit or Order Note

Drug Education materials for the most commonly prescribed medications are included in e-MDs Chart. Handouts discuss indications, contraindications, common and serious side effects, general directions for taking the medication, drug interactions, and warnings. To enable quick searches of the material, each document can be linked to one or more diagnosis (ICD) codes. When these codes are used in a Visit or Order Note, the linked Drug Education documents are presented. To read about editing these documents, see Edit a Drug Education Document.

To add drug education to a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.
2. The Plan section of the Visit or Order Note will display each diagnosis from Assessment. Drug Education documents are linked to diagnoses. Choose the correct diagnosis header (displayed in bold black text), click the Patient Education Handouts subheading (displayed in blue text and underlined), and then select the Drug Education menu option.
3. In the Linked Drug Education window, highlight the title(s) of appropriate handout(s) and click **Accept**. This adds documentation to the Visit or Order Note that those specific handouts were given and queues up the handouts in the printer. (See the To print and fax visit related items procedure for details about printing the handouts).
4. If an appropriate handout does not appear in the Linked Drug Education window, click Add Drug Ed for the full Drug Education search. If a document is found in that search, highlight its title and click Accept. This will add that document to the Linked Drug Education window, linking the document to the corresponding diagnosis.

Using Spanish-Language Patient Education Handouts

Both the Patient Education and Drug Education handouts are available in Spanish. Follow the instructions for locating the appropriate document in English and dropping it into the Visit or Order Note (see Add Patient Education to a Visit or Order Note for details).

To use Spanish patient education handouts:

1. After the document has been added to the **Plan** section of the active Visit or Order Note, click the title of the handout, and select the **Properties** menu option.
2. In the Properties window, change the **Language** field selection from **English** to **Spanish**.
3. Click **Save**.

Note: When the Patient (or Drug) Education material is printed, the Spanish version will print. The Visit or Order Note documentation includes a notation that the Spanish version was given to the patient.

The following scenario should not happen frequently, since Patient Education Handouts are linked to diagnoses.

To move a patient education handout to another diagnosis:

1. Drop a linked Patient (or Drug) Education handout into a Visit or Order Note. (See Add Patient Education to a Visit or Order Note for instructions.)
2. Click the title of the handout and select the Move to Another Diagnosis menu option.
3. This opens a window listing all of the diagnoses for the current visit. Select any one to move the Patient Education handout to that diagnosis.

   Note: If the document is linked to the wrong diagnosis, it must be removed from that link window in the Code Linker module.

To delete a patient education handout from a Visit or Order Note:

1. The **Plan** section of the Visit or Order Note will display each diagnosis from Assessment. Patient (and Drug) Education documents are linked to diagnoses, and are displayed under the Patient Education Handouts subheading (displayed in blue text and underlined).
2. Click the title of the document to remove, and select the **Delete** menu option.
3. Click **Yes** in the Delete Confirmation window.

Documenting Patient Recommendations

To add recommendations related to a diagnosis:

1. In an active Visit or Order Note, scroll to the Patient Recommendations heading or click the PtRec button in the vertical button column to ‘jump’ to that section of the note. Patient Recommendations print separately from the note and can be given to the patient to take home.
2. Patient Recommendation text can come directly from templates. Note that many of the Plan templates include a section titled Patient Recommendations. Clicking off items in this part of the template will document the checked recommendations in both the Plan and in the Patient Recommendations.
   - Like any template-generated text, this information cannot be edited directly. See the Template Editor instructions to learn how to add, edit, or delete this Patient Recommendation text.
   - The only way to remove this text from Patient Recommendations is to reopen the corresponding template and clear the boxes.

3. Patient Recommendations can also be typed. The Patient Recommendations of the note will be subdivided with headers for each diagnosis. Click the free text icon (the gray circle that becomes a yellow square when the cursor hovers over it) to the right of any of these headers. Type recommendations in the Free Text window and click Save.

To add recommendations related to a medication:

1. In an active Visit or Order Note, scroll to the **Patient Recommendations** heading or click the **PtRec** button in the vertical button column to 'jump' to that section of the note. Patient Recommendations print separately from the note and can be given to the patient to take home.
2. Medication Recommendations can be typed into the Patient Recommendations section of the note. The Patient Recommendations of the note will be subdivided with headers for each prescription written. Click the free text icon (the gray circle that becomes a yellow square when the cursor hovers over it) to the right of any of these headers. Type recommendations in the Free Text window and click Save.

Capturing Charges with the Superbill

To display the Superbill:

1. In an active Visit or Order Note, click the blue **Charge Capture** heading.

   OR

   Click the $$ button in the vertical button column to 'jump' to that section of the note. The Superbill (or Charge Capture form) prints separately from the note.
2. The Superbill is built automatically as a result of ICD, CPT (including E&M), and HCPCS codes being added to the Assessment and Plan. Information that is not correct in the Superbill must be corrected in the Assessment and Plan.
3. All diagnoses (along with their ICD-9 codes) will transfer from Assessment to the Superbill.
4. All orders (along with their CPT codes) *that are marked as either "In House" or "Send Out/Billable"* will transfer from Plan.
5. All supplies (along with their HCPCS codes) *that are attached to either "In House" or "Send Out/Billable" orders* will transfer from Plan.
6. The black $$ on the Charge Capture button in the vertical button column turn blue as codes begin to appear in the Superbill. If red dollar signs ($$) appear instead, it indicates one or more of the following problems:
   - A "no code" diagnosis (without an ICD-9 code) exists,
   - A "red code" diagnosis (requiring the addition of a fourth or fifth digit) exists,
   - One or more orders (CPTs) appear in the Other Orders section, rather than linked to appropriate diagnoses (ICD-9s).

Using Laboratory and Radiology Order Forms

Laboratory Order Forms and Radiology Order Forms are automatically generated whenever lab or radiology procedures are ordered in the Plan section of a Visit or Order Note, but are only printed (or faxed) if the user decides to do so. To assist with workflow, these order forms can be routed to a printer or fax machine in the lab. (See the To print and fax visit related items procedure for details.)

The header of these forms include the clinic name, address, phone and fax numbers, the patient name and date of birth, the ordering healthcare provider, and the date. The orders contain the test description and CPT code, the ICD code (diagnosis) for which the procedure is being ordered, whether the procedure is to be done in-house or sent out, and whether the procedure is to be performed immediately.

Laboratory Order Forms and Radiology Order Forms follow e-MDs format, and this format cannot be altered.

Concluding the Visit Note

When note documentation is complete, click the **Note Conclusion** button (the yellow clipboard with the green check mark located on the toolbar above the note). Normally, this action will open the Note Conclusion window, allowing you to choose which items to print (or fax) and permits sign-off of the note. However, you can choose to have two pop-up reminder windows appear prior to the Note Conclusion window.

Setting User Preferences for Pop-Up Reminders

The first window allows verification of the diagnosis properties (severity, course, chronicity), which is important for accurate E&M code calculation.

The second window is a reminder to select an E&M code. This window appears only if an E&M code has not already been added to the note. It displays the automatically calculated code, allowing the user to accept that code or make changes.

Whether or not these windows appear is a *user preference*. Each user must choose to show these windows under his or her user preference options.

To set user preferences:

The provider must first be logged into e-MDs Chart. This login links the preferences to the correct provider.

1. Click **File**, and choose the **Options** menu option.
2. In the e-MDs Chart Options window, click the **Visit Notes** or **Order Notes** tab.
3. In the lower-left corner of the e-MDs Chart Options window, click either or both of the check boxes next to **Automatically show: Diagnosis Properties** and/or **Automatically show: EM Coder**.

Verifying Diagnosis Properties

For accurate E&M coding, it is very important that the diagnosis properties (severity, course, and chronicity) be recorded. This can be done at any time from the Assessment section of the note. However, because the physician may frequently forget to address this, it is recommended that user preferences be set to allow a pop-up reminder at the time of note conclusion.

If the user preference is activated, when the provider clicks **Conclude Visit Note**, the All Visit ICDs window opens. This window lists every diagnosis from the note, by ICD code and description. Columns display the Severity, Progress, and Course of each diagnosis.

- Choices for Severity include Mild, Moderate, or Severe. *All problems will default to Moderate*. (Except if a follow-up diagnosis was selected; in that case, the last recorded Severity for that problem will be displayed.)

  To change the Severity, click the radio button next to the desired severity choice.

- Choices for Progress include Improving, Stable, or Worsening. *All problems will default to Stable*. (Except if a follow-up diagnosis was selected; in that case, the last recorded Progress for that problem will be displayed.)

  To change the Progress, click the radio button next to the desired progress choice.

- Choices for Course include Acute or Chronic. *All ICDs in the database have been set to either Acute or Chronic by e-MDs, and the diagnosis will display that default setting*. (Except if a follow-up diagnosis was selected; in that case, the last recorded Course will be displayed.)

To change the Course, click the radio button next to the desired course choice.

- When all diagnosis properties have been set correctly, click **Save**.

Selecting the E&M Code

At any point during documentation of the Visit or Order Note, you can either manually select an E&M code or view the progress of the automated code calculation in the E&M Coder.

However, if no E&M code has been added to the note (and preferences have been set to be prompted for an E&M code), when you click **Conclude Visit Note**, the E&M Coder window will open. (Depending on your preferences, the window used to verify diagnosis properties may open first, and then the E&M Coder window.)

In the e-MDs E&M Coder window, view the calculated E&M code displayed in blue text in the lower left corner. Depending on whether structured templates were used to collect data (versus free text typing), this data may or may not be accurate. At this point, the user can manually change the data in any of the seven data collection fields (the boxes located to the left of the arrows).

Overriding any of the three Summary fields (to the right of the arrows) will turn the calculated code red, indicating that the code may be incorrect. It is better to instead correct any of the check boxes in the 7 data collection fields, allowing the E&M Coder to then recalculate the summary.

If the Calculated Code is deemed to be accurate, click Accept to add this E&M code to the note. It will automatically be tied to the primary (first) diagnosis.

Click **Reset** to clear all the data fields.

Click **Cancel** to close the E&M Coder without adding the E&M code to the note.

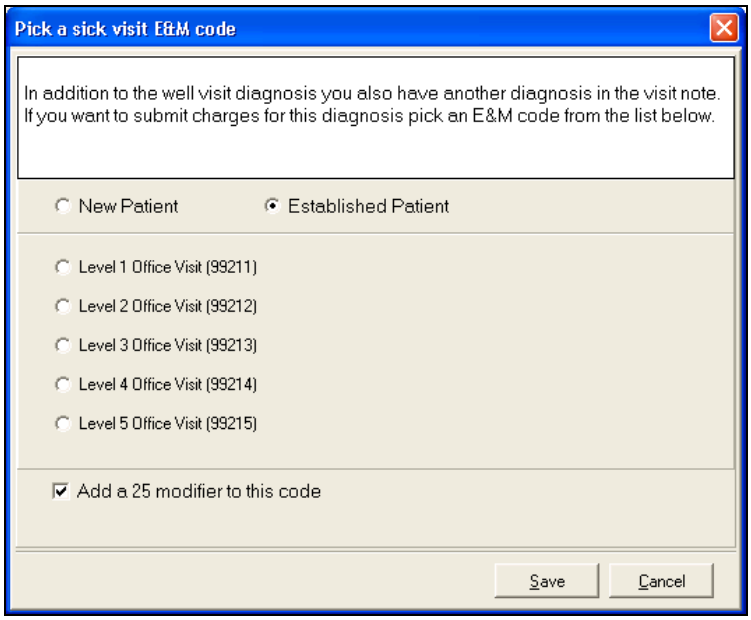
Note: There are inherent difficulties in automating the determination of the E&M Code. This includes (but is not limited to) the amount of time that may be spent in counseling and coordination of care and the subjective nature of determining the level of risk in "Medical Decision Making" section. Therefore, e-MDs does not warrant the validity of any calculated E&M code. The calculated code is meant to merely be a guide, and the physician must use his or her best judgment in adjusting that code, if necessary.

Using Automated Preventive Care E&M Coding

Preventive Care E&M codes are automatically dropped into the Visit and Order Notes when the appropriate ICD is added. For example, when V20.2 is added to a Well Child visit, the patient's age will be assessed along with whether they are new or established and then the appropriate preventive E&M will automatically drop into the note without any intervention from the user. The preventive code will also be available in the E&M wizard *IF* the **Type of Encounter** for the note is set to **Preventive Medicine Services**.

Note: If a well visit diagnosis is added to a note the preventive E&M will be added automatically whether the Type of Encounter in the visit details is set to Preventive Medicine Services or not. For example even for a visit marked as Office/Outpatient Visit if a well diagnosis is added to the note the preventive E&M will be dropped in automatically.

An feature related to the Preventive E&M code is that if there is a "sick" diagnosis code in the note as well as a "well visit" diagnosis then an additional window will pop up at Note Conclusion (in lieu of the E&M Wizard) prompting the user to add a second E&M code (along with a 25 modifier) to the note, *if desired* (see screenshot below for an example). This new screen is similar to the E&M wizard in that it provides codes based on whether the patient is a New or Established patient. e-MDs will not try to calculate an E&M level for the sick visit. The decision for picking an appropriate sick visit code is left up to the user.



Printing or Faxing Visit-Related Items

To print and fax visit related items:

1. At the conclusion of a Visit or Order Note, click the **Conclude Note** button, located on the Chart toolbar (clipboard with a green check mark button).
2. The Note Conclusion window contains two columns labeled **Print** and **Fax** with check boxes in each column corresponding to each report type that can be printed or faxed (EXAMPLE: Visit Notes, Patient Ed, Superbill, etc.).
3. To print or fax a report, click the check boxes in the **Print** column next to those items to be printed **AND/OR** in the **Fax** column for those items to be faxed. Anything not checked will not be printed (or faxed).

   Important! The exception to the Print and Fax column check boxes is the Prescription report. It only has one check box which is under the Print column. This check box represents that the prescriptions will be *PROCESSED* (either printed or faxed depending on the way prescriptions were designated when they were created). It is important that this check box ALWAYS be checked; otherwise the prescriptions will not be printed or faxed.
4. *If the item is to be faxed,* click the **Edit** button (pencil icon) in the Edit column to the right of the report name
5. A compact version of the Fax Monitor will open and you can enter information such as **Title**, **To**, **From** and the **Phone** (Fax) number.
6. After the information is entered, click the **OK** button to save the information into the Note Conclusion window.
7. *If the item is to be printed,* each report type (i.e. Visit Note, Order Note, Prescriptions, etc.) can be routed to any printer. This is typically set up in advance in Print Options, but can be changed on the fly by clicking the **Print Options** button in the Note Conclusion window **OR** by clicking the **Printer Icon** in the **Options** column. The Printer Icon in the Options column provides for faster access to the print options of the specific report chosen.
8. After all print and fax issues have been dealt with, address the Conclude Note portion of this window. See “To sign off a Visit or Order Note” below for details.
9. Click **OK**.

Successive messages will appear on screen as each report is routed as a print job to the appropriate printer(s).

Signing Off the Note

To sign off a Visit or Order Note:

1. At the conclusion of a Visit or Order Note, click the **Conclude Note** button, located on the Chart toolbar (yellow clipboard with a green check mark button).
2. Address the Print Options in the top half of the Note Conclusion window. (See the To print and fax visit related items procedure for details.)
3. Decide whether the documentation is complete or needs editing at a later point in time.
   - If incomplete, check **Close Note/Edit Later**. This enables printing or faxing of reports (such as Prescriptions and Patient Education), while permitting later editing of the note.
   - If the note is finished, check **Close Note/Permanent Sign Off**. Enter your application password. Permanent sign off requires that the note's author: 1.) be logged in, 2.) be designated as the Healthcare Provider in the Visit Details section of the Note, and 3.) use his/her password as a signature.

     Note: After a note is permanently signed, it cannot be edited with out un-signing it. However, a time-stamped addendum can be added to the bottom of the note. See "Add an Addendum to a Signed Off Note" for details. See the "Un-sign Note Feature" section for details on un-signing a note.
4. Choose whether or not to flag the note as **Ready to Bill**.
   - If a note is permanently signed, it is considered "ready to bill." Because the note cannot be edited, it is assumed that no further billing charges will be added. So, if the **Close Note/Permanent Sign Off** option is selected, the **Ready to Bill** check box is disabled.
   - On the other hand, a common scenario is that the note documentation is not complete, but all of the billing codes have been added. In this case, select **Close Note/Edit Later** and put a check mark next to **Ready to Bill**. If this is done, e-MDs Bill will display the visit in red text to identify the fact that the note is unsigned, and a check mark will appear in the **Ready to Bill?** column, informing billing personnel that the final invoice can be built.

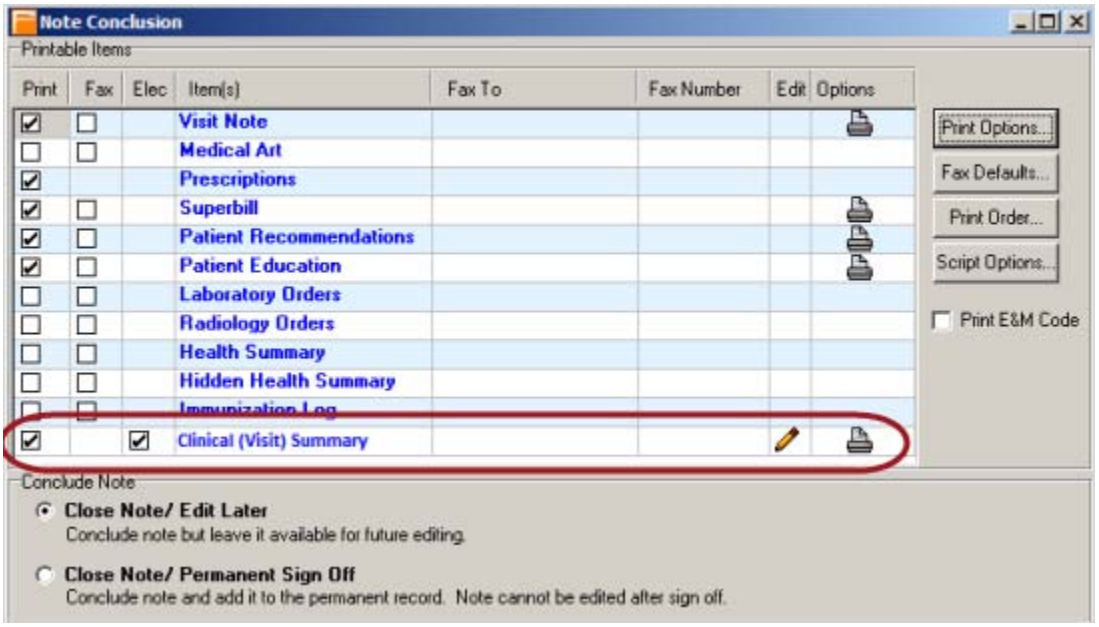
   Note: In order to identify all unsigned patient notes that have been designated as "ready to bill," you can select that filter in the "Unsigned Notes (Crystal Reports Version)" in *e-MDs Reports User Guide*.
5. When finished, click **OK**, or click **Cancel** to close this window and return to the note.

Customizing, Printing, or Exporting the Clinical (Visit) Summary

During each patient visit, information about that visit is automatically compiled to create a summary document that can be printed or exported for the patient. This summary includes, among other things:

- Provider's contact information
- Reason(s) for the visit
- Instructions based on clinical discussions that took place during the visit
- Information on immunizations and medications administered during the visit
- Time and location of next appointment, testing, or recommended appointment schedule

You can access the summary document by selecting it for printing or electronic transmission (exporting) on the Note Conclusion screen that is displayed during the Visit and Order Note sign off process.



Users have the option of excluding certain sections of the summary from the Note Conclusion screen. (HIPAA requirements allow healthcare providers to exclude patient information the provider deems as harmful for the patient.)

To select sections to include or exclude in the Clinical (Visit) Summary:

1. Select (click) the check box in the **Print** or **Elec** column for the Clinical (Visit) Summary. The pencil icon in the **Edit** column will become active.
2. Click the **Edit** (pencil) icon in the Clinical (Visit) Summary row to open the Clinical (Visit) Summary Options window.
3. Click the check box before each section you want to include, or deselect sections to be excluded if sections are already checked.
4. To keep these settings for all future patients, click the check box before the **Save as Default Settings** option at the top of the screen. When this window opens in the future, your saved settings will be preselected. If you do not check this option, you will need to select and/or deselect sections for each patient.

   Note: If you save these options as your default settings, they will affect only *your* Clinical (Visit) Summary output. Other users will need to set their own default settings when logged in under their own login names. *These are not global defaults for your facility*.
5. Click **OK** to save your choices and continue the Note Conclusion process.

Printing and Saving a Clinical (Visit) Summary

If **Print** is selected on the Note Conclusion screen, the summary will print on the default printer. If **Elec** (electronic transmission) is selected, a **Save CCD file** check box will be displayed to allow you to save the Clinical (Visit) Summary as a C-CDA (XML) file. See *e-MDs Solution Series Utilities Guide* for information about C-CDA files.

- If the patient is a Portal user, a pop-up window will be displayed, and you will have the option to send the Clinical (Visit) Summary to the patient's account on the Portal. (The patient would then be able to view the summary, save the summary to a location outside the Portal, or send the summary to another provider using Direct messaging.) Click Yes to add the summary document to the patient's Portal account. Click No to skip this step.

- After the Visit or Order Note is concluded (by selecting Close Note/Edit Later or Close Note/Permanent Sign Off), the Clinical (Visit) Summary is automatically saved to the Visit Notes folder in DocMan for future reference, as needed.

  Note: The Clinical (Visit) Summary C-CDA can be viewed in a browser window. If your browser is Internet Explorer version 9, the browser Security Setting "Access data sources across domains" must be selected in order to view the C-CDA in human readable format.

- To print the Clinical (Visit) Summary from DocMan, locate the summary in the Visit Notes folder, right-click the summary, and select Print.

  See e-MDs Solution Series Utilities Guide for more information on printing documents from DocMan.

- A record of the Clinical (Visit) Summary creation and distribution will be tracked and listed on the Chart Audits report. See e-MDs Reports User Guide for information on how to list and view this logged information.

Generating and Exporting a Transition of Care file (Chart Summary)

When you need to export a summary of the information documented in all Visit Notes (this would essentially be the information in the Health Summary), you can use the Export Transition of Care (C-CDA) option that is available when you click the CCD icon in the patient-specific toolbar in Chart. This export option is available in the Chart and DocMan modules.

See *e-MDs Solution Series Utilities Guide* for instructions on importing and exporting Transition of Care (C-CDA) files.

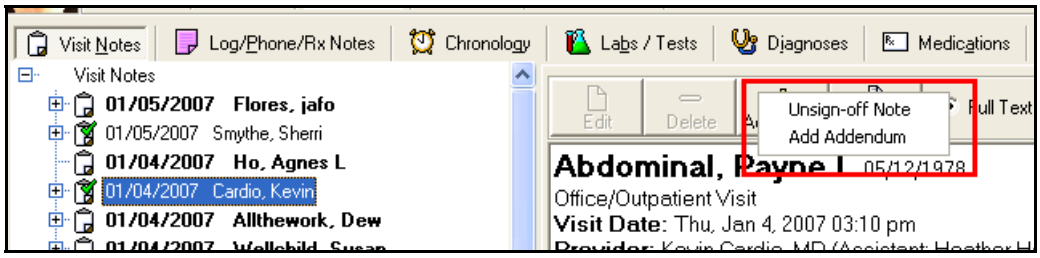
Using the Un-Sign Note Feature

This feature allows users to un-sign a note. This feature allows the provider that signed a note off (and *only* that provider) to un-sign the note and make changes before re-signing it. *Notes can only be un-signed within 24 hours* of when the note was originally signed. The feature was added to allow users to make simple changes within 24 hours of the end of a visit. This can be for items such as adding additional orders or prescriptions that may have been forgotten or overlooked during the visit.

To un-sign a note:

1. Go to Chart View and select the note to be edited.
2. Click the **Addendum** button on the right side of the screen and choose **Unsign-off Note** from the pop-up menu.

   If the choice is not available, then it has been more than 24 hours since the note was signed off.



Reopening a Previous Note

To reopen an unsigned note for editing:

1. First, select the patient. (On either the main e-MDs Chart or Tracking Board toolbar, click **File** and then select the **Open Patient Chart** menu option. Or, click the yellow folder icon near the upper left corner of either application. Either method will open the Find Patient window.)

2. Enter search criteria into any of the fields (such as patient name, social security number, or account number) and then press **Enter** or click **Search**.
3. Either double-click the correct patient name from the search results screen or select the patient from the results screen and click **Select**.
4. Click the **Edit Prior Note** icon on the gray toolbar below the blue patient identifier bar. This icon is an open yellow folder located to the right of the word "Note:".
5. Select either a **Doctor's Note, Nurse's Note** or **Order Note** to list unsigned notes.

   The Load Visit window displays all unsigned notes of that type (doctor, nurse or order note), identified by date, healthcare provider, and diagnoses.
6. Click to select the appropriate note.

   Notes:
   - Completed (signed) visits will not show up in the Load Visit window. This window only displays incomplete (unsigned) notes.
   - If a padlock icon appears next to any visit in the Load Visit window, that visit is "locked" and cannot currently be opened. This means that some user is currently working in that note, and the message "Locked by: __" identifies that user.

Health Summary

Current Problem List

All diagnoses that are added in a note are automatically added to the patient's Current Problem list. Chronic problems are shown in bold text and do not automatically get removed from the list. Acute problems will "age" and fall off the list based on a global option. This global option is set to 60 days by default but can be changed in the Administration Options section of Chart.

Current Problem List Interface

The Current Problem list has a toolbar that runs along the top of the window. This toolbar allows users to view the list in a Detail view. They can also view the Current list (default setting) as well as the Resolved list (list of historical problems for the patient).

In addition there is a button toolbar that runs down the right side of the list. These buttons allows users to Add a problem, Edit the properties of a problem, Resolve a problem and Delete a problem.

Detail View of Current Problems

In the default setting the Current Problem list shows only the description of the problem. In the Detail view the diagnosis code (ICD-9 code), the date of onset of the problem, when the problem was added and the person's name that added the problem are also shown.

You can always choose to turn the detailed view on or off.

To turn on the Detail View on the fly:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Problems** to open that section.
3. Click the check box labeled **Detail View.**

   The display will change to a detailed view

You can choose to set your default preference to always show the detailed view.

To turn on the Detail View as a default:

1. Within a patient's chart, click **File** then **Options**
2. Click the **Visit Notes** tab.
3. At the bottom of the form in the section labeled **Other Options**, click the check box labeled **Show Detail in Current Problems.**

   This sets the default setting to show detail.

The default setting for the Current Problems list is to show only the current problems for the patient. Users can select to view the resolved problems.

To view resolved problems:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled Current Problems to open that section.
3. Click the radio button labeled Resolved
4. The view will switch to showing only the patient's prior problems.

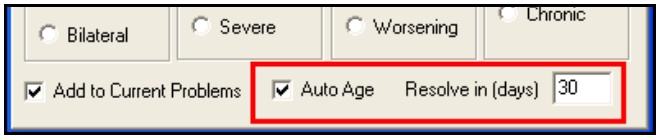
Recover Resolved Problems

Items that have been "resolved" and removed from the Current Problems list can be recovered and brought back to the current problems list. This is handy for when a patient presents with an acute problem that was resolved in the past or when a diagnosis is mistakenly resolved.

To recover a resolved problem:

1. Click the **Resolved** radio button in the Current Problems.
2. Highlight the problem.
3. Click the **Edit** button (pencil icon).
4. The Properties window for that diagnosis will open and at the bottom of the screen is a check box labeled Add to Current Problems. Placing a check mark in the check box will return the diagnosis to the Current Problems list.

   Note: When a problem is recovered from the Resolved list the user has the option to Auto Age the problem so that it resolves itself after a specified number of days. If you do not want the problem to be automatically resolved do not check the Auto Age check box. If the Auto Age box is checked the "Resolve in (days)" field will default to 30 days but can be changed to suit the user.



To add a problem directly to the list:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Problems** to open that section.
3. Click the yellow plus sign

   Medicapaedia search option: *Medicapaedia is a database of clinical terminology. It includes diagnosis/symptom descriptions and associated codes.*

4. In the Search field, type the first few letters of a diagnosis or symptom (or type the ICD code) and then click the **Search** button located on the toolbar at the top of the Medicapaedia Search window (or just press the Enter key).
5. In the search results, select (click) the check box next to each description to be entered in the note and then click the **Select** button on the toolbar.
6. The Properties of a diagnosis include its Description, Date of Onset, Location, Severity, Progression, Course and Confidential status. To edit any of these properties, right-click the diagnosis and select the **Properties** menu option. See the Edit the Properties of a Diagnosis section for detailed information about the Properties.

   Note: Problems marked as **Severe** will be displayed in Red. Problems marked as **Chronic** will be displayed in **Bold**.

All problems added to a Visit or Order Note, whether added from the HPI or the Assessment, are automatically added to the Current Problems list unless the option is turned off. To turn the option off:

To turn off the option to add a problem from the visit assessment:

7. Click **File**, then **Options**
8. Click the **Administration** tab.

   You must have the correct privilege in order to see the Administration tab.
9. Clear the box labeled Automatically add new problems to the current problems list.

   This is a Global option and will effect *ALL* users.

Adding a Problem from Current Problem Template

The Current Problem template allows for users to quickly document a patient's list of diagnoses. Items in this template that have an Extended Attribute of type Current Problem will populate the Current Problem list when chosen. See Current Problem Extended Attributes for details.

This allows a nurse or medical assistant to quickly and easily gather the patient's medical history information and populate the Current Problem list without having to do a search of the ICD-9 database, which can be confusing and time-consuming.

To add a problem from a template:

1. With a Visit Note or Order Note open, click the template launch icon to the right of the **Current Problems** header in the note.
2. Select the Current Problems template from the Template Link window.

   The template is organized by body system (for example Heart, Lungs, Bones/Joints, etc.).

   A question that has a Current Problem Extended Attribute linked to it will display a stethoscope icon at the right.
3. Navigate to the diagnosis you want and choose it by clicking the question.
4. Select multiple problems, if needed.
5. When the template is closed, the diagnosis will drop into the Current Problems list.

Current Problems

To edit the properties of a problem:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Problems** to open that section.

3. Highlight the problem that requires editing.
4. Click the **Edit** button .

   OR

   Right-click the problem and select the **Properties** menu option.
5. The Properties of a diagnosis include its Description, Date of Onset, Location, Severity, Progression, Course and Confidential status. See the Edit the Properties of a Diagnosis section for detailed information about the Properties.

   Notes:

   - Problems marked as **Severe** will be displayed in Red. Problems marked as **Chronic** will be displayed in **Bold**.
   - When a patient returns with an established diagnosis, it is very important to add that problem to the Visit or Order Note as a Follow-Up (see "Add Follow-Up Problems" for details). This way, changes in severity or progression can be tracked over time.

Resolving a Diagnosis

If a problem in the Current Problems list has resolved, it can be moved to the Resolved list. This merely removes the diagnosis from the Current Problems list, but not from the database. That problem can still be found under the Diagnoses tab in Chart View as well as the Resolved view in the Health Summary Current Problems section.

To resolve a diagnosis:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Problems** to open that section.
3. Click the problem to be resolved and select then click the **Resolve** button .
4. Click **Yes** in the confirmation window.

   Note: The Delete option is only available for problems that were not added to a note. To remove problems from a Visit or Order Note, edit the note and remove the problem.

Deleting a Problem

Diagnoses added in error to the Current Problems list can be deleted only if they come from a note that has not been signed off.

To delete a problem:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Problems** to open that section.
3. Highlight the problem to be deleted and click the **Delete** button .
4. Select a reason for deleting the diagnosis.
   - Dx in error
   - Not Relevant
   - No Reason

   There will be no confirmation number.

   Note: If the diagnosis is a permanent part of the patient record (for example, is part of a Visit Note or Order Note), it cannot be deleted.

Specifying No Current Problems (NCP)

Using the No current problems (NCP) check box under the Current Problem List section in Health Summary, shows how many patients were queried for current problems and did not have any problems. Once the NCP box is checked, the Current Problems header in Health Summary will display as *Current Problems – No Current Problems*. No Current Problems (NCP) will also display in the Visit or Order Note based on the auto-drop preference set in Chart Options.

Note: If an acute illness, such as a URI ages off of the Current Problem list to the Resolved list, the system will ensure that the NCP check box is selected for a patient.

Clearing the NCP check box yields the following prompt: *"Are you sure you want to uncheck this box?"* Click **Yes** to remove the check mark and *No Current Problems* text from the header. Or click **No** to leave the check mark and *No Current Problems* text in the header.

Reviewing the Health Summary

To view information about the last known reviewer, click the **Review** button within all categories of Health Summary. Doing so will populate the category with the last known reviewer's Name and the last Date/Time reviewed. The Review All button will allow all categories to be populated with one click (excluding Pregnancy Summary).

To Review or Review All in Health Summary:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. To populate ALL health Summary categories at once, click **Review All.**

Identifying Allergies/Adverse Reactions

To mark a Visit or Order Note as No Known Drug Allergies:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Allergies** to open that section.
3. Check the **NKDA** (No Known Drug Allergies) box.

   Notes:

   - If allergies have already been documented, they must be deleted before NKDA can be checked.
   - It is possible to document *non-drug* allergies and still check the NKDA box.

To add an allergy or adverse reaction:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Allergies** to open that section.
3. Click the **Add Allergy** button (the yellow plus sign) to open the Add Allergy window.

   Note: Users have the choice of adding Drug or Non Drug allergies or adverse reactions.

To add a Drug Allergy/Adverse Reaction:

1. When the Add Allergy screen opens, determine whether the patient has a true *allergy* or merely an *adverse reaction* to the allergen, and select the appropriate choice. (The default selection is **Allergy**.)
2. Select a **Severity** level, if desired. (The default selection is **Moderate**.)

3. To activate the **Date/Time of Occurrence (if known)** fields:
    a. Click the box before the **Date** field to activate that option. A calendar will open with today's date selected by default.
    b. Select a past or current date on the calendar. When a past or the current date is selected, the time field will also activate.
    c. Click the box before the **Time** field and type in a time/time of day (AM or PM). A time can only be entered if a date has been previously selected on the calendar.
4. If you want to document one of the most common drug allergies, under Drug, click the desired drug choice.
5. In addition to the common drug allergy choices, there is a radio button labeled "Other Common Drug Allergy." Selecting this radio button gives you a choice of a much larger list of common allergies in a search screen window. By using the search field or by scrolling down the list of choices, you can select the other common allergy that you want to document by clicking the drug name and then clicking Select or by double-clicking the drug name. Once the drug is selected, the drug name will become a selection on the Common list on the first screen.

    There is also another radio button labeled "Other Drug" that allows you to search for and select ANY drug in the database. When this choice is selected, the Select a Drug window will open and you can search and select any drug in the database. Once the drug is selected, the drug name will become a selection on the Common list.
6. Click the **Other Common Allergy** radio button to open the **Other Common Drug Allergy** list.
7. Search for the drug and click **Select** or double-click the drug name. After the drug is selected, the drug name will become a selection on the Common list.
8. After your choice is made (common, other common or other drug), you can choose to add further information about the allergy, if desired.

    If desired, the actual Reaction (e.g. nausea, hives) can be recorded in a structured manner.
9. Click the yellow plus sign in the **Reaction** section to open the Select Allergy Reaction window.

    The Reaction window will open pre-populated with a list of the most common reactions.
10. Type a few letters of the reaction type and either press **Enter** or click **Search *OR*** browse the list using the scrollbar on the right.

    Search options for reactions including Common drug reactions (the default setting), Drug Specific reactions (those reported to have occurred with the drug in question), or All reactions. If you do not find the reaction you are looking for in the common list, try changing the search filters by clicking the radio button next to Drug Specific or All and searching again.
11. Multiple reactions can be added at the same time by selecting them in the search results. When a reaction is selected it will be added to the pane at the bottom of the screen.
12. Click **Save** to add the reactions to the allergy.

    Any extra information can be typed in the Notes field if desired.
13. Click **Save** to save your changes back to the **Allergy** section of the Health Summary.

To add a non-drug allergy/adverse reaction:

1. In the Add Allergy screen, just below the Drug section is a field labeled Non Drug. This field is a drop down list of allergens that can be chosen to document non-drug allergies or adverse reactions.
2. In the dropdown box, type a few letters of the allergen or click the down arrow to view the full list.

Note: Non-drug allergens can now be added to the list of allergen available (see Adding Non-Drug Allergens for details)

3. Select the allergen from the search list by highlighting it.
4. To activate the Date/Time of Occurrence (if known) fields:
   a. Click **Date** to activate the Date field. A calendar will open with today's date selected by default.
   b. Select a past or current **date** on the calendar. When a past or the current date is selected, the time field will activate.
   c. Click **Time** to open the field and type in a **time**/**time of day** (AM or PM). A time can only be entered if a date has been previously selected on the calendar.
5. Determine whether the patient has a true allergy or merely an adverse reaction to the allergen, and select the appropriate choice. (The default selection is **Allergy**.)
6. Select a severity level, if desired. (The default selection is **Moderate**.)

   If desired, the actual reaction (e.g. nausea, hives) can be recorded in a structured manner.
7. Click the yellow plus sign in the **Reaction** section to open the Select Allergy Reaction window.

   The Reaction window will open pre-populated with a list of the most common reactions.
8. Type in a few letters of the reaction type and either press **Enter** or click **Search**.

   OR

   Browse the list using the scrollbar on the right.
9. Search options for reactions include Common drug reactions (the default setting), Drug Specific reactions (those reported to have occurred with the drug in question), or All reactions. If you do not find the reaction you are looking for in the common list, try changing the search filters by clicking the radio button next to **Drug Specific** or **All** and searching again.

   Multiple reactions can be added at the same time by selecting them in the search results. When a reaction is selected it will be added to the pane at the bottom of the screen.
10. Click **Save** to add the reactions to the allergy.
11. Any extra information can be typed in the Notes field, if desired.
12. Click **Save** to save your changes back to the **Allergy** section of the Health Summary.

    Note: Once the newly added allergy (or adverse reaction) appears in the **Allergies** section, details such as the allergen, reaction, user name, date entered, and date/time occurred can be viewed by using the cursor to hover the **Allergies** section. Details can also be viewed by double-clicking specific allergen or by highlighting it and clicking the **Edit Allergy** button (with the pencil icon).

To edit/delete an allergy or adverse reaction:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary appears in the left pane.
2. Click anywhere on the blue bar labeled **Allergies** to open that section.
3. To edit allergies/adverse reactions:
   a. Highlight an allergy/adverse reaction and click the **Edit Allergy** button (with the pencil icon) to open the Edit Allergy window.
   b. Make changes to the **Date/Time of Occurrence**, **Type**, **Severity**, **Reactions** and **Notes** fields, as needed.

c. Click **Save**.

To delete allergies/adverse reactions:

a. Highlight an allergy/adverse reaction and click the **Delete Allergy** button (with the red minus sign).

b. The Stop Allergy window will open,

c. Select a stop reason and click **Save**.

Stopped allergies are moved to the **Past Allergies** section and are documented with a stop reason, date deleted, and the name of the person that deleted the allergy.

To undelete allergy/adverse reaction (move past allergies back to current allergies):

a. Select the **Past allergies** radio button.

b. Highlight a past allergy/adverse reaction and click **Undelete Allergy** (yellow + icon).

c. Click **Yes** in the Undelete Confirmation window.

The allergy/adverse reaction will be returned to the **Current Allergies** view.

If non-drug allergies have been recorded, you can decide whether or not to view these in the Allergies window.

To view/hide non-drug allergies:

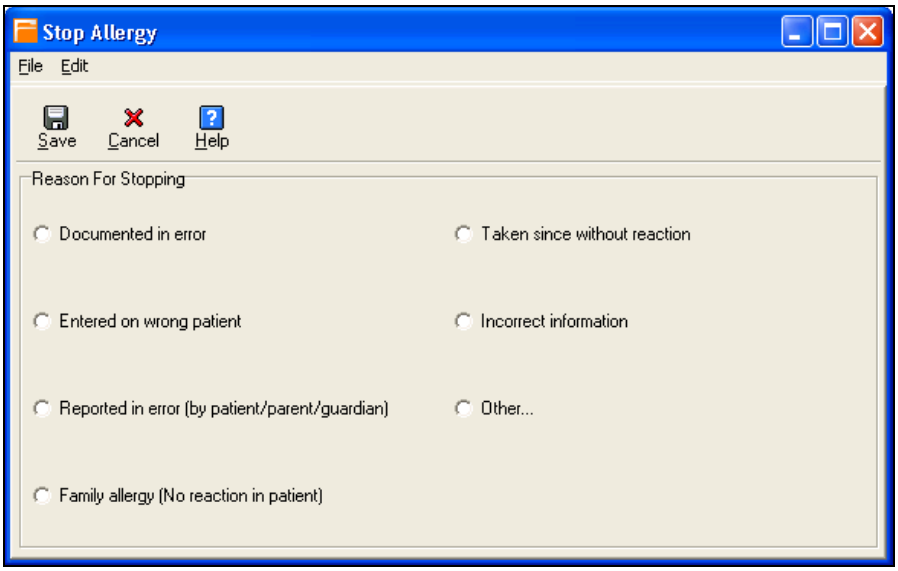
1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Allergies** to open that section. Using the cursor to hover the Allergies section will reveal details such as the allergen, reaction, user name, date entered, and date/time occurred.

   By default the Non-Drug Allergies show up in the **Allergies** section of the Health Summary.
3. Click the **Non-Drug Allergies** button in the bottom right corner of the **Allergies** section (the green spore icon) to toggle between showing and hiding Non-Drug Allergies.

Note: Non-drug allergies appear in red text to denote that they aren't included in automatic allergy checking.

Specifying Reasons for Stopping Allergy Notation

The Stop Allergy screen provides a quick pick list of reasons for stopping an allergy. This list consists of six specific reasons and one "other" reason. The list is pre-populated with reasons provided by e-MDs but the screen is a customizable to suit individual user. To select a reason for stopping an allergy simply click the radio button to the left of the desired reason. Use of the "other" button brings up the "Manage Medication and Allergies Stop Reasons" screen where the user can select a different reason or create a new one.



Users can choose to document a reason that is not in the list of quick pick Stop reasons by clicking the Other button choice. This will bring up a list of other reasons that can be chosen. This change is temporary and will not permanently become a choice in the list.

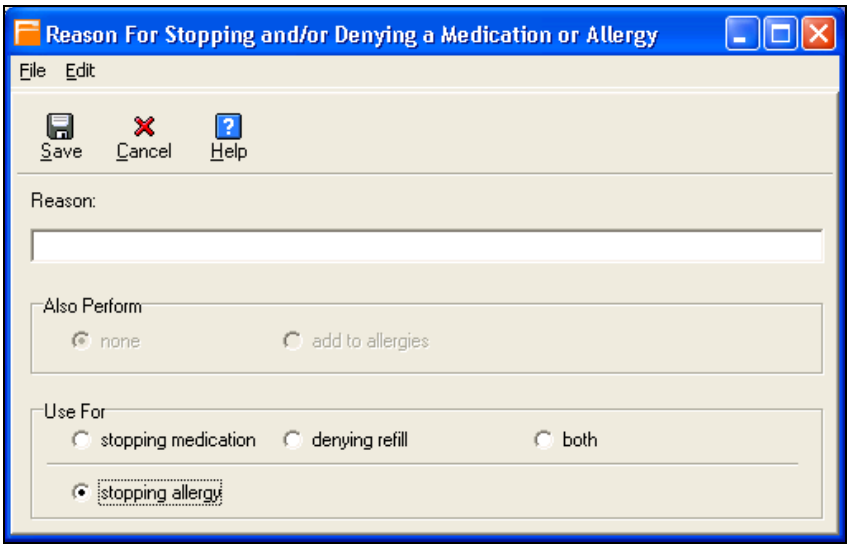
To choose an "other" stop allergy reason:

1. Click the radio button to the left of the choice labeled Other…
2. The Manage Medication and Allergy Stop Reasons maintenance screen will open.
3. The window will populate with Allergy stop reasons.
4. If the list is too long you can type in some search criteria in the Reason Text field and click Search to narrow your choices.
5. Pick a reason from the list and click the Select button or double click the selected reason.

To create a new stop allergy reason:

1. With the Manage Medication and Allergy Stop Reasons maintenance screen open click the New button on the toolbar.
2. The Reason for Stopping and/or denying a Medication or Allergy maintenance screen will open.
3. Type in a description for the stop reason in the Reason field.
4. In the Also Perform section leave the radio button labeled None checked.
5. In the Use For section select "stopping allergy"
6. Click Save when finished.

   The newly created reason will appear in the Manage Medication and Allergy Stop Reasons list.



Users can customize the Stop Allergy Reason screen to suit their individual needs. New reasons can be substituted for the reasons that ship with the product be default.

To customize the Stop Allergy Reason screen:

1. In the Stop Allergy screen, right-click to select a reason that you want to substitute another reason for.
2. A menu item labeled Change Selected Option will pop up, click the menu selection.
3. The Manage Medication and Allergy Stop Reasons maintenance screen will open.
4. Select a reason from the list of stop reasons (or create a new reason) and double click or click the Select button.
5. The newly selected reason will appear in place of the original stop reason.
6. This change will now become the default setting for the person making the change.

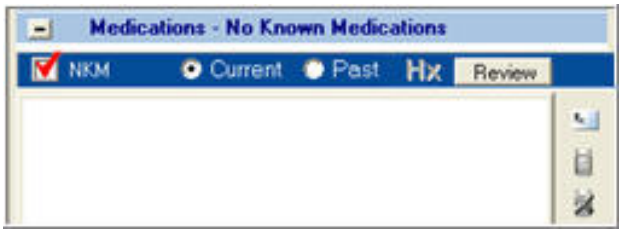
To document that allergies have been reviewed:

In the Allergies section of the Health Summary, click the **Review** button to document the date that allergies/adverse reactions were last reviewed and by whom. This feature is useful for providing notification to users whether this section has been reviewed recently.

Current Medication List

Note "No Known Medications"

Much like the No Known Allergies feature in the Allergy section, users can choose to mark a patient's Current Medication list as having No Known Medications. This is a proactive approach to documenting that a patient is not on any medications. An empty Current Medication list does not necessarily denote that the patient is not on any medications. It could be that no one has asked. With the No Known Medications choice, there is an active notation in the chart that the patient is not on any meds. See screenshot below for an example.



To mark a chart as No Known Medications:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Check the **NKM** (No Known Medications) box.

Note: If medications have already been documented, they must be deleted before NKM can be checked.

Write a New Prescription

If a patient is present for an appointment, any prescriptions written during that visit should be initiated in the **Plan** section of the active Visit or Order Note (see "Write a Prescription Linked to a Diagnosis" for details), *not* in the **Current Medications** section of the Health Summary. However, sometimes there is a need to write a prescription outside of a Visit or Order Note. In that situation, follow the steps outlined below.

To write a new prescription outside a Visit or Order Note:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Within the Current Medications window, click the **Write New Script** button (the uppermost button on the vertical toolbar, with the Rx pad icon).
4. A provider (doctor, nurse practitioner, physician assistant) must be responsible for the prescription. If the user is a provider, the Drug Search (aka Choose Medications window) screen opens immediately.
    - If the user is a non-provider (nurse, medical assistant, etc.), a pop-up window states that a provider responsible for the prescription must be selected. It will then ask if the selected provider will be responsible for ALL prescriptions written during that session that the Script Writer is open.
    - Click **No** to write a single prescription under that provider's name. The provider search will then be required for each prescription written. Click **Yes** to assign multiple prescriptions to the provider.

    Note: An audit trail records which logged-in users prescribe medications under a physician's name. In the current version of e-MDs Chart, a SQL query is needed to extract that information, but a future version of e-MDs Chart will include a report of that audit log.
5. In the Find Staff Provider window, type a few letters of the provider's name and press Enter or click Search.
6. Highlight the correct name from the search results and click Select.
7. This opens the Drug Search window. Proceed with writing the prescription (see "Write a New Prescription from the Current Med List" for details).

Refilling Prescriptions

Medications that have been previously prescribed or added for documentation purposes to the Current Medications list can be refilled. Users can choose to refill one, some or all prescriptions at one time by using the Refill Grid. See Refill Grid for details.

To refill prescriptions:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Within the Current Medications window, highlight the drug to refill and click **Refill Medication** (the second button on the vertical toolbar, with the pill bottle icon).

   The **Refill List** (Refill Grid) window will open. This window lists all the medications in the Current Med List in a grid format.
4. Click the check box next to each medication that is to be refilled.

   After a medication is checked to be refilled, the fields associated with the medication become editable.
5. You can change the Form Strength, Sig, Quantity, Units, Refills, Substitution, Print Separately, Send Method, Pharmacy and Notes fields, if needed. See the Refill Grid section for details on each field.
6. When, and if, changes to any selected medications have been made, click the **Save** button on the toolbar to process the prescriptions
7. If faxing or printing or electronically transmitting the prescriptions, a Sending confirmation window will open
8. Click **Send** to print or fax or electronically transmit the prescriptions.

Note: Medications that have been **Added** to the Current Med List will appear in the Refill Grid but may not necessarily have a form/strength or sig associated with them. To refill those medications simple check the refill check box and then complete the prescription by filling out the appropriate fields. See the Add a Drug to the Current Medication List for details on adding drugs.

Refills of medications that have been previously prescribed or added to the Current Medications list can be denied. This feature keeps an accurate record of the number of times that a patient requests a refill, even if that request is denied.

To deny a prescription refill:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.
3. Within the Current Medications window, highlight the drug to deny and click **Deny Refill of Medication** (the third button on the vertical toolbar, with the red X through the pill bottle).

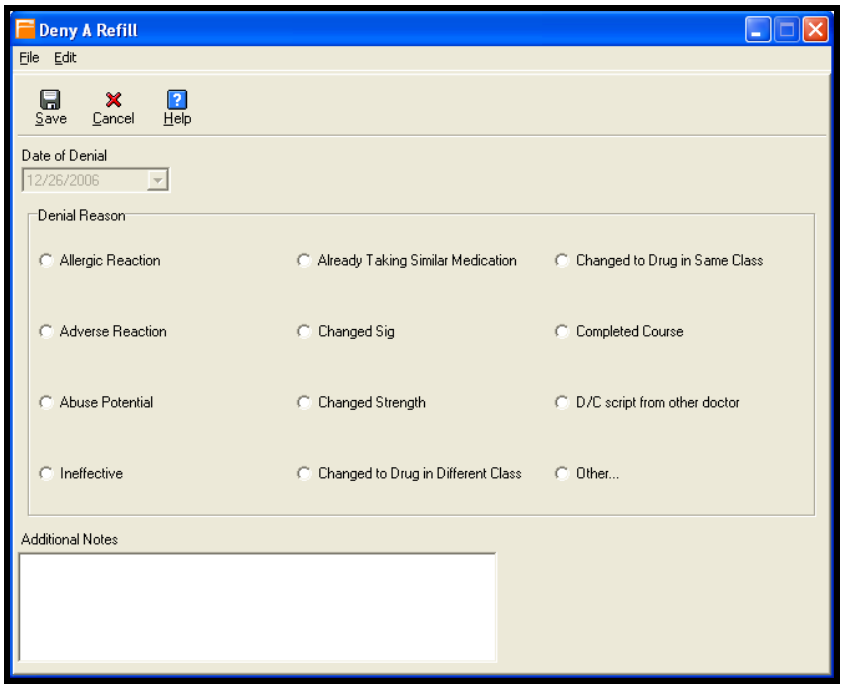
   OR
4. Within the Refill Grid, highlight the desired medication and click the **Deny** button on the toolbar.
5. If desired, select a **Denial Reason** and type **Additional Notes**.
6. Click **Save**.

   In Current Medications, click the plus sign next to the medication to review the prescription history of that drug, listed in reverse chronological order (most recent first). When a refill is denied, it will be in that list, preceded with the words DENIED REFILL. Discontinued and denied prescriptions

appear in red text. Double click the yellow notepad icon next to any denied refill to view the reason for denial.

Deny Medication Reasons

The Deny a Refill screen provides a quick pick list of reasons for denying a refill. This list consists of eleven specific reasons and one "other" reason. The list is pre-populated with reasons provided by e-MDs but the screen is a customizable to suit individual user. To select a reason for denying a refill simply click the radio button to the left of the desired reason. Use of the "other" button brings up the "Manage Medication and Allergies Stop Reasons" screen where the user can select a different reason or create a new one.



Users can choose to document a reason that is not in the list of quick pick Deny reasons by clicking the Other button choice. This will bring up a list of other reasons that can be chosen. This change is temporary and will not permanently become a choice in the list.

To choose an "Other" refill denial reason:

1. Click the radio button to the left of the choice labeled **Other…**

   The Manage Medication and Allergy Stop Reasons maintenance screen will open. The window will populate with **Deny a Refill** reasons.

2. If the list is too long, you can type in some search criteria in the **Reason Text** field and click **Search** to narrow your choices.

3. Pick a reason from the list and click the **Select** button or double-click the selected reason.

To create a new refill denial reason:

1. With the Manage Medication and Allergy Stop Reasons maintenance screen open, click the **New** button on the toolbar.

   The Reason for Stopping and/or denying a Medication or Allergy maintenance screen will open.

2. Type in a description for the stop reason in the Reason field.

3. In the **Also Perform** section, leave the radio button labeled **None** checked unless the deny a refill reason is one associated with the patient having a allergy or adverse reaction to the medication.

In that instance you might want to choose “add to allergy as the action performed when this reason is chosen. This choice will automatically give the user the option to add the medication to the patient’s allergy list if the reason is chosen.

4. In the **Use For** section, select **Denying Refill**.
5. Click **Save** when finished.

   The newly created reason will appear in the Manage Medication and Allergy Stop Reasons list.

Users can customize the Deny a Refill Reason screen to suit their individual needs. New reasons can be substituted for the reasons that ship with the product be default.

To customize the Deny a Refill Reason screen:

1. In the Deny a Refill screen, right-click a reason that you want to substitute another reason for.
2. Click the pop-up **Change Selected Option** menu selection

   The Manage Medication and Allergy Stop Reasons maintenance screen will open
3. Select a reason from the list of stop reasons (or create a new reason) and double click or click the **Select** button

   The newly selected reason will appear in place of the original stop reason. This change will now become the default setting for the person making the change.

Patients may be on a number of medications that are prescribed by other physicians or are available over-the-counter. Even though the patient gets these drugs from another source, they are important to add to the chart so that Allergy and Drug-Drug Interaction checking is complete. In these cases, add the medications directly to the Current Medications list, without writing a prescription. The user may choose to add just the drug name, or add as much detailed information (e.g. date initiated, strength, sig, etc.) as desired. The user can also write samples from this screen.

To add a drug to the Current Medication list:

1. Within a patient’s chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.
3. Within the Current Medications window, click **Add Current Medication** (the fourth button on the vertical toolbar, with the yellow plus sign).
4. From the menu, select either **Drug** (to launch the Drug Search) or **Free Text** (to type). It is strongly recommended that the **Drug Search** be chosen. Drug Allergy and Interaction checking cannot be run on Free Text additions.
   - *If **Drug** is chosen:*
     a. Type a few letters of drug name and press **Enter** or click **Search**.
     b. Highlight the correct drug from the search results and click **Select**.
     c. If desired, select a prescriber, change the prescribe date, pick a form strength, and choose a Sig (or edit an existing Sig, or create a new Sig).
     d. Click **Save**.
   - *If **Free Text** is chosen:*
     a. Type the drug name and directions into the **Free Text** window.
     b. If desired, search for and select a provider and change the prescribe date if needed.
     c. Click **Save**.

- *If **Sample** is chosen:*
  a. Type a few letters of the drug name and press Enter or click Search.
  b. Highlight the correct drug from the search results and click Select.
  c. Enter the form/strength and, if desired, enter the Sig, quantity, lot number and expiration date.

Add a Current Medication from a Template

Medications can be added from the Current Medication Template. This is the same functionality as described in the section above (medications that are prescribed by other physicians or are available over-the-counter) but the data entry is via template. Any questions that have an Extended Attribute type of Current Medication will populate the Current Med list when checked (see Current Medication Extended Attributes for details). This feature allows a nurse or medical assistant to quickly and easily gather the patient's medication information and populate the Current Medication list without having to do a search of the drug database.

To add a current medication from a template:

1. With a Visit or Order Note open, click the template launch icon to the right of the **Current Medications** header in the note.
2. Choose the **Current Medication** template from the Template Link window.

   The template is organized by therapeutic class (for example Anti-depressants, Antibiotics, Asthma medications, etc.).

   A question that has a structured medication linked to it will display a button labeled FS (for form strength) at the right. A question that has a Free Text medication linked to it will display a button labeled FT (for free text) at the right.

   Note: A Free Text medication could be a notation that the patient is on a medication but cannot remember the name (Example: An unknown blood pressure medicine). This allows documentation with a placeholder until the patient can bring in or remember the name of the actual medication.
3. Navigate to the medication you want and choose it by clicking the question.
4. Pick multiple medications, if needed.

   When the template is closed the medications will drop into the Current Medications list.

Occasionally, a patient's medication will change. For example, a different strength or new directions for taking the drug may be ordered. In this case, the drug can be edited in the Current Medications list.

To edit a current medication:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open this section.
3. Within the Current Medications window, select the medication to edit and click **Edit Current Medication** (the sixth button on the vertical toolbar denoted by the pencil icon).
4. Change information in the Edit Current Medication window as desired, and then click **Save**.

   This method of editing a Current Medication can be used when documenting medication changes that take place outside of an office visit (i.e. telephone call after reviewing lab, telephone call from patient to report adverse effects).

Discontinue (Stop) a Current Medication

Medications can be stopped from either the Current Medications List or from the Refill Grid.

To discontinue (stop) a medication from the Current Medications list:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Highlight the medication to discontinue and click **Stop Medication** (the seventh button in the vertical toolbar denoted by a red stop sign icon).
4. The current date will be entered as the default Discontinuation Date. To change the date, click the down arrow in the date field to access a calendar.
5. If desired, choose a **Reason for Stopping**.
6. Click **Save**.

To discontinue a medication from the Refill Grid:

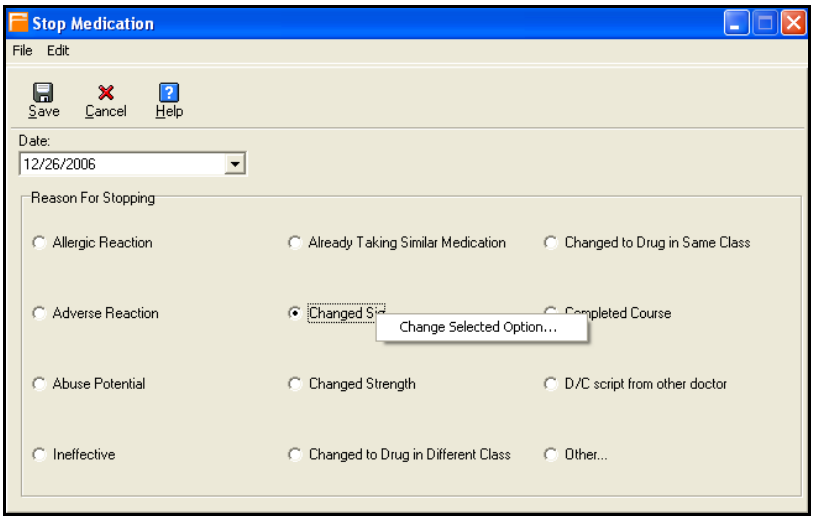
1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Within the Current Medications window, highlight the drug to refill and click **Refill Medication** (the second button on the vertical toolbar, with the pill bottle icon).

   The Refill List (Refill Grid) window will open. This window lists all the medications in the Current Med List in a grid format.
4. Select the medication to be discontinued and click the **Stop Medication** (stop sign) button.
5. The current date will be entered as the default Discontinuation Date. To change the date, click the down arrow in the date field to bring up a calendar.
6. If desired, select a **Reason for Stopping**.
7. Click **Save**.

Note: When a prescription is discontinued, it will move from the Current Medications list to the Past Medications list. To see Past Medications, while in the Current Medications section, click the **Past** button at the top. All discontinued medications will appear in the Medication History list, in red text, along with their discontinuation dates.

Stop Medication Reasons

The Stop Medication screen provides a quick pick list of reasons for stopping or discontinuing a medication. This list consists of eleven specific reasons and one "other" reason. The list is pre-populated with reasons provided by e-MDs but the screen is a customizable to suit individual user. To select a reason for stopping a medication simply click the radio button to the left of the desired reason. Use of the "other" button brings up the "Manage Medication and Allergies Stop Reasons" screen where the user can select a different reason or create a new one.



Users can choose to document a reason that is not in the list of quick pick Stop Medication reasons by clicking the Other button choice. This will bring up a list of other reasons that can be chosen. This change is temporary and will not permanently become a choice in the list.

To choose an "Other" Stop a Medication reason:

1. Click the radio button to the left of the choice labeled **Other**…

   The Manage Medication and Allergy Stop Reasons maintenance screen will open. The window will populate with Stop a Medication reasons.

2. If the list is too long, you can type in some search criteria in the **Reason Text** field and click **Search** to narrow your choices.

3. Pick a reason from the list and click the **Select** button or double-click the selected reason.

To create a new Stop a Medication reason:

1. With the **Manage Medication and Allergy Stop Reasons** maintenance screen open click the **New** button on the toolbar.

   The Reason for Stopping and/or denying a Medication or Allergy maintenance screen will open.

2. Type in a description for the stop reason in the **Reason** field.

3. In the **Also Perform** section, leave the radio button labeled **None** checked unless the stop medication reason is one associated with the patient having an allergy or adverse reaction to the medication. In that instance you might want to choose **Add to allergy** as the action performed when this reason is chosen. This choice will automatically give the user the option to add the medication to the patient's allergy list if the reason is chosen.

4. In the **Use For** section, select **Stopping a medication**.

5. Click **Save** when finished.

   The newly created reason will appear in the Manage Medication and Allergy Stop Reasons list.

Users can customize the Stop a Medication Reason screen to suit their individual needs. New reasons can be substituted for the reasons that ship with the product be default.

To customize the Stop a Medication Reason screen:

1. In the **Stop a Medication** screen, right-click a reason that you want to replace with another reason.

2. When the menu item labeled **Change Selected Option** pops up, click the menu selection

3. The Manage Medication and Allergy Stop Reasons maintenance screen will open
4. Select a reason from the list of stop reasons (or create a new reason) and double click or click the **Select** button.

   The newly selected reason will appear in place of the original stop reason. This change will now become the default setting for the person making the change.

If a prescription is lost or misplaced, it can be resent (reprinted, re-faxed, re-sent electronically or phoned in).

To resend (reprint) a prescription:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. Highlight the medication to be re-sent and click **Resend Script** (the fourth button in the vertical toolbar, with the printer icon).

   A pop-up menu with choices for **As Is** and **With Changes** will appear
4. Select **As Is** if you want to resend the prescriptions just like the first time it was sent.

   OR

   Select **With Changes** if you want to change the SEND method. You can choose to send the prescription by a different method (from print to fax, etc.) but you cannot change anything else about the prescription.

   Note: For print, fax and electronic, you will get the Sending confirmation screen. Clicking **Send** will *re-process* the prescription.

View Prior 'Send Methods' for Prescriptions

When a prescription is written, the physician chooses a Send Method in the Script Writer (e.g. Print, Phone-In, Fax or Electronic). When reviewing a prescription at a later date, this information can be easily retrieved in the Current Medications list by placing the cursor in the blank space just to the left of the prescription. (**Note:** The cursor should be placed very close to the prescription. If too far to the left – in the space reserved for allergy and drug interaction icons-- that hover hint will not appear.)

When the cursor hovers over this space, a blue highlighted hint will appear in place of the prescription, that will read either PRINT, PHONE, FAX or ELECTRONIC. For Phoned-In, Faxed or Electronic prescriptions, the name of the pharmacy will also be displayed.

For medications that have been refilled multiple times, click the plus sign (to the left of the prescription in the Current Medications list) to expand the entire refill history. Now, hover the cursor to the left of each of those refills to view the "send method" of each one.

Medication history can be reviewed in either Chart View (see "View Medications" for details) or in the Health Summary (as described below).

To view the entire history of a single medication:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.

   Note: The Current Medications will be displayed. To review the history of a discontinued medication, click the **Past** button at the top of the Current Medication list.
3. Within the Current Medications (or Medication History) window, click the plus sign next to the medication to review those medications.

The prescription history of that drug is displayed in a tree, listed in reverse chronological order (most recent first). When a refill is ordered, the current iteration of the prescription is automatically discontinued. Discontinued prescriptions (and denied refills) appear in red text.

The end of each medication line shows the initiation and discontinuation dates.

4. Double click the yellow notepad icon next to any prescription to view notes, such as the reasons for discontinuation or denial of refill.

Medication history can be reviewed in either Chart View (see "View Medications" for details) or in the Health Summary (as described below).

To view all discontinued medications:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.

   The Current Medications will be displayed.
3. To review Discontinued Medication, click the **Past** button at the top of the Current Medication list.

   This opens the Medication History window. All discontinued medications appear in red text. The end of each medication line shows the initiation and discontinuation dates.
4. Double-click the yellow notepad icon next to any prescription to view notes, such as the reason for discontinuation.

Notation of Allergies and Drug Interactions

When a medication is prescribed or a drug is added to the Current Medications list, an automated check for drug allergies, drug-drug and drug-disease interactions, and duplicate therapy is run, and appropriate warning icons are displayed in the Health Summary.

These icons appear to the left of the medication name in the Current Medications list or in the **Itx** or **AI** columns of the Refill Grid.

- A yellow triangle indicates a reported adverse reaction to that medication (or to another medication in the same class).
- A red triangle indicates a reported Allergy to that medication (or to another medication in the same class).
- Colored circles represent drug-drug interactions, the color signifying the severity: green is mild, yellow is moderate and red is major. Note that both medications that are part of the drug-drug interaction will display the interaction icon. Double click any drug interaction icon to read more detailed information regarding the interaction.
- A red "X" indicates a contraindicated drug combination. Double click the icon for further information.
- A blue circle signifies duplicate therapy. Double click the icon for further information.

To view the icon legend:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.
3. Click the last button on the vertical toolbar in Current Medications.

   The legend displays icons for allergies, adverse reactions, and drug interactions. In addition, icons related to formulary information appear.

Past Medical/Family/Social Histories

To add, edit or delete history items:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bars labeled **PMH/FMH/SH** (Past Medical History -- including Surgical History/ Family Medical History/ Social History), Tobacco/ Alcohol/ Supplements, Substance Abuse History, Mental Health History, or Communicable Disease History to open those sections.

   Information is added to these sections via templates or free text.
3. Within any section, click the **Edit** button to open the Past Medical History Maintenance window.
4. Click the template icon (the gray square with a check mark) to find appropriate templates.

   See "Blank Templates" for details about using templates.

Alternately, click any free text icon (tiny gray circles that turn into yellow squares when the cursor hovers over) to type information (See "Add/Edit/Delete Free Text" for details).

Record Locking on the Health Summary Templates

When a user has a patient's PMH template open it will "lock" the Health Summary section (templates for PMH, Social, Family, etc.) so that only one user at a time can EDIT the info. Multiple users can VIEW the info at the same time but if you try to edit it when another user has it open you get a message that is similar to the chart message that says the record is locked by the person that is editing the information (see screenshot below).

This locking of the section is to prevent the loss of information that could happen if more than one person had one of the Health Summary templates (Past Medical, Social, Family, Tobacco/Alcohol, Substance Abuse, etc.) open at the same time. This can and has lead to the problem of the "last person to close wins" where a Health Summary that was incomplete or blank could overwrite a full Health Summary template.

To prevent this, the Health Summary templates cannot be opened by clicking the text in the section. Each section of the Health Summary that uses templates for data input now has an Edit button at the top of the section. To add new information or to edit existing information you have to click the Edit button to open a window that allows you to access the templates by clicking the text or the template link icon.

View Legacy History after Data Conversion

Note: The following information *does not* apply to users whose original purchase of e-MDs Chart was *version 4.0 or later*.

e-MDs Chart *version 3.0* (and earlier versions) were based on a non-SQL database, limiting the ability to convert the Past Medical History data to the newer SQL database. When converting a database from e-MDs Chart 3.0 to e-MDs Chart 4.0 (or later), legacy history data (Past Medical History, Family Medical History, and Social History) will be recovered and displayed in the form of a non-editable image. To find this legacy data:

To view legacy history after data conversion:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar). The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **PMH/FMH/SH** (Past Medical History -- including Surgical History/ Family Medical History/ Social History) to open that section.

   At the bottom of the section, there is a blue heading labeled **Legacy Data**. (If no legacy data exists for the selected patient, the heading will not appear). The previously recorded history appears under this heading.

   - Free text additions to the Legacy Data are not permitted. All new information must be entered into the templates or free text areas of the various PMH/FMH/SH sections.
   - Once Legacy Data has been re-entered into the new templates, the Legacy Data can be deleted. To do this, right-click the **Legacy Data** heading and choose the **Delete** menu option.

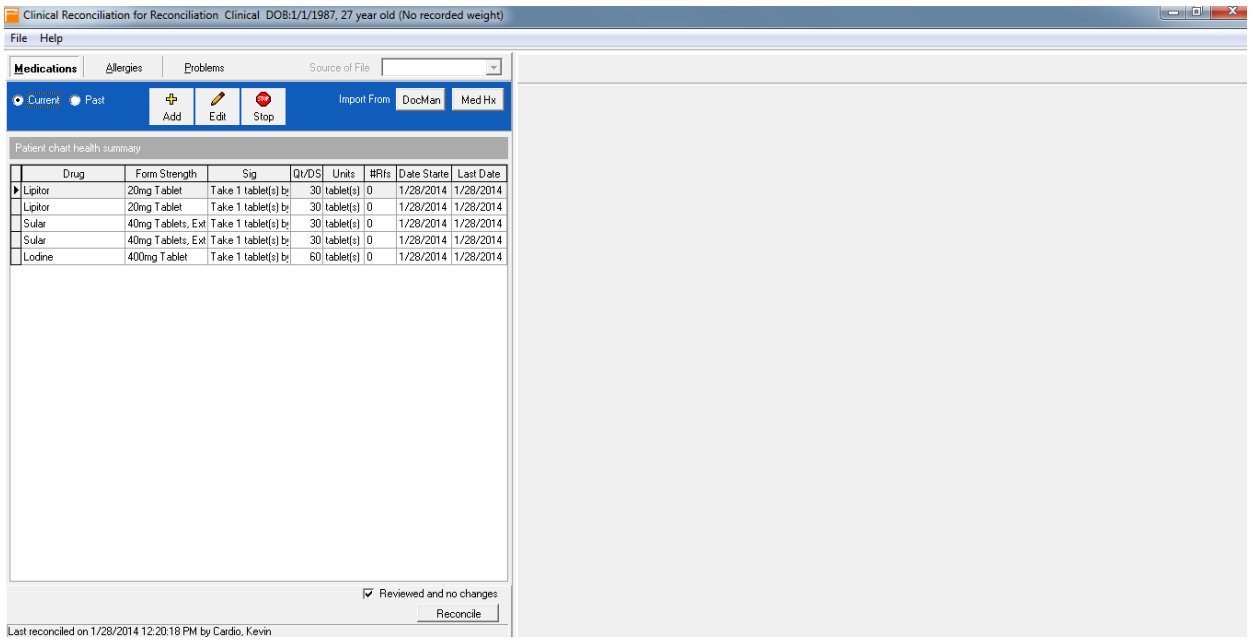
Clinical Reconciliation (Transition of Care)

You can import allergies, medications, and current problems directly from an imported transition of care document.

To perform clinical reconciliation:

1. In the Health Summary area of the Visit/HS tab, click dropdown arrow and choose Clinical Reconciliation.

A Clinical Reconciliation window opens (Example shown below). On the left side of the window are three tabs: Medications, Allergies, and Problems. On the right side of the window is a display area for transition of care documents.



2. To open a transition of care document, click the DocMan button in the Clinical Reconciliation window.

   An Importing from DocMan window opens and displays a list of all documents available in the patient's DocMan.

3. Click the desired transition of care document and then click the Select button located above the list of documents.

   The system compares the patient information in the selected document with the patient information in the chart and displays a message indicating whether the document matches the patient.

4. Click the OK button to display the transition of care document.

   When a DocMan document is displayed in the Clinical Reconciliation window, the Source of File field becomes available. The purpose of this field is to identify the source of the transition of care document (such as Emergency Dept., Inpatient Hospital, Specialist, etc.), and it is a required field when you perform reconciliation using a document from DocMan

   Click the down arrow in the Source of File field to display source options, and then click an option to select it. e-MDs has selected Patient by default but this can easily be changed by using the drop down options.

5. Click the down arrow in the Source of File field to display source options, and then click an option to select it.

   Note: If the transition of care document contains structured information (as in a C-CDA) about medications, allergies, or problems that are not included in the patient's Health Summary, that information will be listed in the Pending for Approval area located in the lower part of the respective tab in the Clinical Reconciliation window. You can then perform reconciliation by importing the information directly into the patient's Health Summary.

   For all reconciliations, now the Reviewed and No Changes check box will default to selected. Once a user makes any edits to the patient information, it will automatically deselect the box leaving the Reconcile button available.

6. To reconcile Medications:

   - In the Clinical Reconciliation window, click the Medications tab.

- In the Pending for Approval area, click the check box next to the medications that you want to add to the Health Summary and then click the Accept button.
- Click the check box next to the medications that you do not want to add and then click the Decline button.
- To add a medication not listed in the Pending for Approval area, click the Add button located at the top of the Medications tab.
- To edit or stop a medication, select the medication and then click the respective button located at the top of the Medications tab.
- When you have completed all desired changes, click the Reconcile button located below the Pending for Approval area. (Or, if there are no changes, click the “Reviewed and no changes” check box and then click the Reconcile button.)

7. To reconcile Allergies:
   - Click the Allergies tab.
   - In the Pending for Approval area, click the check box next to any allergies that you want to add to the Health Summary and then click the Accept button.
   - Click the check box next to any allergies that you do not want to add and then click the Decline button.
   - To add an allergy not listed in the Pending for Approval area, click the Add button located at the top of the Allergies tab.
   - To edit or remove an allergy, select the allergy and then click the respective button located at the top of the Allergies tab
   - When you have completed all desired changes, click the Reconcile button located below the Pending for Approval area. (Or, if there are no changes, click the “Reviewed and no changes” check box and then click the Reconcile button.)
8. To reconcile problems:
   - Click the Problems tab.
   - In the Pending for Approval area, click the check box next to any problems that you want to add to the Health Summary and then click the Accept button.
   - Click the check box next to any problems that you do not want to add and then click the Decline button.
   - To add a problem not listed in the Pending for Approval area, click the Add button located at the top of the Problems tab.
   - To edit, resolve, or delete a problem, select the problem and then click the respective button located at the top of the Problems tab.
   - When you have completed all desired changes, click the Reconcile button located below the Pending for Approval area. (Or, if there are no changes, click the “Reviewed and no changes” check box and then click the Reconcile button.)

Using the Chart View

The Chart View is probably the most frequently accessed screen in the Chart module. It is used each and every time a patient visits the office, calls for consultation, or a prescription is modified.

Working with Visit and Order Notes

A *Visit Note* tracks everything that happens during an office consultation. Order Notes may or may not be associated with an office visit and can be used to track and verify the completion of orders for patient care beyond an office visit. Order Notes must be signed off by the provider after completion of the order(s). Both types of notes can be started and completed by several members of the medical staff during or after a consultation.

To view notes in a tree:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Visit Notes** tab.

   The left pane lists all Doctor Visit Notes, Nurse Visit Notes, and Order Notes in a tree format, in reverse chronological order (most recent date first). Each note is represented by an icon (a clipboard for Doctor Notes, a clipboard with a red cross for Nurse Notes, and a clipboard with a beaker for Order Notes), and is identified by the visit or order date and the healthcare provider's name.
3. Click the plus sign next to any note to expand the tree. The expanded tree view lists items associated with that visit or order, such as all diagnoses (identified with a stethoscope icon), prescriptions (script pad icon), CPT codes/orders (test tube icon), and medical art (paintbrush icon). Click any of these items to display detailed information about the selected item in the right pane.
4. Click to select a note in the left pane (with the date and provider name) to view the entire note in the right pane.

   Note: Double-click this main tree node to simultaneously expand the tree and display the note.

To view notes in a grid:

1. In Chart View, click the **Visit Notes** tab.
2. In the left pane, click the first tree node, labeled **Visit Notes**.

   This will display a grid in the right pane with a summary of information about every note, including the visit or order date, whether the note has been permanently signed, the provider name, the location (clinic name), and the diagnoses from that visit.

To edit or delete a note:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Visit Notes** tab.
3. Click to select the note in the left pane (with the date and provider name) to view the entire note in the right pane. At the top of the note on the right is a small toolbar with buttons, labeled **Edit**, **Delete**, **Addendum** and **Print**.
4. Click **Edit** to reopen the note to make changes. If the note has been permanently signed off, it cannot be edited but you can add an addendum.

   OR

   Click **Delete** to delete the note, then click **Yes** in the Delete Confirmation window. If the note has been permanently signed off, you cannot delete it.

To add an addendum to a signed off note:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Visit Notes** tab.
3. Click to select the note in the left pane (with the date and provider name) to view the entire note in the right pane. At the top of the note on the right is a small toolbar with buttons, labeled **Edit**, **Delete**, **Addendum** and **Print**.
4. Click the **Addendum** button located at the top of the note on the right.
5. In the Free Text window, type the addendum and click **Save**.

   The addendum will be identified by the author, date, and time, and it will appear appended to the bottom of the note.

To view full text of a note:

Click the **Full Text** radio button to the right of the **Print** icon when viewing a note to see all of the information associated with a visit or order. All sections of the note that contain information will appear and all information that is in those sections will appear with all associated grammar. This is the default setting.

Note: As with the other choices on this screen, whatever is selected when the **Print** button is pressed is what will print. Therefore, if you have the **Full Text** view selected, that is what will print.

To view outline text of a note:

Click the **Outline Text** radio button to the right of the **Full Text** choice when viewing a note to see a "bullet" list of just the pertinent information associated with the note. All sections of the note that contain information will appear but the information will be displayed without much of the associated grammar that is available in the Full Text view.

Note: As with the other choices on this screen, whatever is selected when the **Print** button is pressed is what will print. So if you have the **Outline** view selected, that is what will print.

To view the summary of a note:

Click the **Summary** radio button to the right of the **Outline Text** choice when viewing a note to see a summary view that just displays the information in the Assessment, Orders (if set to view) and Plan sections. This view is intended to give the user a quick view of pertinent information, such as why the patient was seen (diagnoses in the Assessment section) and what was done about it (tests, procedures and medications in the Plan section).

Note: As with the other choices on this screen (Full Text and Outline Text), whatever is selected when the **Print** button is pressed is what will print. So if you have the **Summary** view selected, that is what will print.

Log/Phone/Rx Notes

Log, Phone and Rx Notes are used to attach medical or other pertinent information to the patient chart outside of a Visit Note. Phone Notes are intended to document telephone conversations while Log Notes are used to document medical information that is collected outside a visit or a phone call. Prescription notes are intended to document information related to prescriptions. Any user can create a Log or Phone or Rx Note. *The original author of the note is the only person authorized to edit or delete it, but any other user can add an addendum to another's note. Only providers (doctors, nurse practitioners, physician assistants) can permanently sign notes.* Once a note is permanently signed, it cannot be edited or deleted.

To add a new Log/Phone/Rx Note:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Log/Phone/Rx Notes** tab.
3. Click **New** in the gray toolbar located above the left windowpane.
4. In the Edit Chart Note window, assign a Note Class – either **Log Note**, **Phone Note** or **Prescription Note**.
5. Assign a Note Type – either **Permanent** or **Sticky**. Permanent notes can be signed and permanently attached to a patient's chart while "sticky" notes are intended to be temporary. "Sticky" notes do not print when the entire chart is printed.
6. Type the message into the white free-text area.
7. Click **Save** to close the window and save the note. Or, click **Sign Off** to close the window and permanently sign the note.

   Note: Only providers (doctors, nurse practitioners, physician assistants) can permanently sign a Phone Note or Log Note. If the user logged in is not a provider, the **Sign Off** button will be disabled.

To view prior Log/Phone/Rx Notes:

1. In Chart View, click the **Log/Phone/Rx** Notes tab.

   A reverse chronological list of all notes appears in the left windowpane, identified by author and date. Permanent Log Notes display an icon of a pink sheet of paper. Permanent Phone Notes have an icon of a pink sheet of paper with a phone in the middle. Permanent Prescription Notes have an icon of a pink sheet of paper with a Rx in the middle. Sticky Log, Phone and Prescription notes look the same, except the paper is yellow.
2. Click any node in the left tree to display the full text of the note in the right windowpane.

   When viewing a note and any associated addendums to that note, the original note appears in a pane at the top and the most recent addendum (if there are addendums) appears at the bottom of the pane below the note. When opening a note for viewing, the screen will automatically display the most recent note or addendum first. You can then scroll up and down to view other notations.

To edit a Log/Phone/Rx Note:

The original author of the note is the only person authorized to edit or delete it, but any other user can add an addendum to another's note.

1. In Chart View, click the **Log/Phone/Rx Notes** tab.

   A reverse chronological list of all notes appears in the left windowpane, identified by author and date.
2. Click any node in the left tree to display the full text of the note in the right windowpane.
3. Click **Edit**, located above the note in the right windowpane, and select whether to edit the **Note** or an **Addendum** in the menu options. Make changes to the note and click **Save**.

   If the **Edit** button is disabled, either the user is not the author or a provider has permanently signed the note (and it is no longer editable).

While any user can create a Log or Phone or Prescription Note, only providers (doctors, nurse practitioners, physician assistants) can permanently sign notes. Once a note is permanently signed, it cannot be edited or deleted.

To sign off a Log/Phone/Rx Note:

1. In Chart View, click the **Log/Phone/Rx Notes** tab.

   A reverse chronological list of all notes appears in the left windowpane, identified by author and date.

2. Click any node in the left tree to display the full text of the note in the right windowpane.

3. Click **Sign Off**, located above the note in the right windowpane.

   If the **Sign Off** button is disabled, either the note has already been signed, the user is not a provider, or the note type is sticky (only permanent notes can be signed).

Any user can create a Log or Phone or Prescription Note. The original author of the note is the only person authorized to edit or delete it, but any other user can add an addendum to another's note.

To add an addendum to a Signed Log/Phone/Rx Note:

1. In Chart View, click the **Log/Phone/Rx Notes** tab.

   A reverse chronological list of all notes appears in the left windowpane, identified by author and date.

2. Click any node in the left tree to display the full text of the note in the right windowpane.

3. Click **Sign Off**, located above the note in the right windowpane.

4. Type the addendum and click **Save**.

   Up until the point that the note is signed off, the author can still Edit the addendum.

The original author of the Log or Phone or Prescription Note is the only person authorized to delete it. Once a note is permanently signed, it cannot be deleted

To delete a Log/Phone/Rx Note:

1. In Chart View, click the **Log/Phone/Rx Notes** tab.

   A reverse chronological list of all notes appears in the left windowpane, identified by author and date.

2. Click any node in the left tree to display the full text of the note in the right windowpane.

3. Click **Delete**, located above the note in the right windowpane, and select whether to delete the **Note** or an **Addendum** in the menu options.

4. Click **Yes** in the Delete Confirmation window.

   Note: If the Delete button is disabled, either the user is not the original author of the note, or the note has been signed off.

Chronological View

The chronology section of Chart View combines all notes and documents (Provider and Nurse Visits, Log, Phone Notes, TaskMan notes and DocMan documents) into one list.

To view all notes in chronological order:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).

2. In Chart View, click the **Chronology** tab.

   The left windowpane displays a list of all items, identified by author and by date (in reverse chronological order). Icons identify the note type: clipboard for Provider Visit, clipboard with red

cross for Nurse Visit, piece of Pink or yellow paper for Log Note (permanent vs. sticky), and piece of pink or yellow paper with a blue phone for Phone Note (permanent vs. sticky).

3. Click the date and author of any note or the description of a document to display the note or document in the right windowpane.
4. If the note is a Visit or Order Note, click the plus sign to the left of the icon to display additional information about the visit such as diagnoses, labs ordered, prescriptions written, and any medical art that is attached to the visit. Click any of these additional items will display detailed information about those items in the right windowpane.
5. For a different view, click the **All Notes** header in the left windowpane to display a grid with summary information about every note in the right windowpane. This detail includes the note date, author, whether the note has been permanently signed, who signed the note, and, if it is a Visit or Order Note, the diagnoses from that encounter.

Labs/Tests/Procedures

To view labs/tests/procedures:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Labs/Tests** tab.
3. Choose **Grouped View** or **Chronological View**. Make this selection in the gray toolbar at the top of the left windowpane. Note that this is merely a display of CPTs which have been ordered, not necessarily of test results. Although results can be entered here manually, most users choose to scan or import results directly into DocMan.
4. **Grouped View:** This default view lists all items that have ever been ordered, sorted by CPT code. Items are grouped together so that only one instance of any unique lab, test or procedure is shown.
    - Click any CPT Code/Description in the tree to display a grid in the right windowpane. The grid lists the CPT code, description, every date that CPT has been ordered, and the ordering physician.
    - Click the plus sign next to any CPT Code/Description in the tree to expand a list of Visit and Order Notes from which the orders were generated, along with the date of the visit and the provider. Click any Visit or Order Note in the tree to display the full text of the note in the right windowpane.
5. **Chronological View**: This view lists every instance of a lab, test or procedure that has been ordered in reverse chronological order.
    - Click any CPT Code/Description in the tree to view the Visit or Order Note that generated the order in the right windowpane. Click the plus sign next to any CPT Code/Description to expand the tree to the diagnosis to which the order was linked.
    - Click the first tree node, labeled Labs, Tests, & Procedures to display a grid in the right windowpane. The grid lists every CPT code, description, date ordered, and the ordering physician.
        - **Pending**: In this view users can see a list of all notes that have at least one CPT or HCPCS code that is marked as "Tracked." Users can view the ''tracked" labs/tests and if a result has been linked to the code they can also see that result.

Notations regarding lab results can be entered manually, as described below. This is labor-intensive and is not the recommended method. It is far preferable to scan or import labs into DocMan.

To enter lab/test/procedure results:

1. Within a patient's chart, click the Chart View tab (below the blue horizontal patient identification bar).
2. In Chart View, click the Labs/ Tests tab.
3. Choose Chronological View. Make this selection in the gray toolbar at the top of the left windowpane.
4. Select the correct CPT Code/Description in the left windowpane. This will open the right windowpane, with a blue results field on top and a copy of the associated Visit or Order Note on the bottom.
5. In the blue windowpane, place the cursor after the Results and Notes heading. Type results or notes.
6. Click Save.

   Note: These free text notes are not permanent and can be deleted or edited at any time.

Diagnoses

To view diagnoses:

1. Within a patient's chart, click the Chart View tab (below the blue horizontal patient identification bar).
2. In Chart View, click the Diagnoses tab.
3. Choose Grouped or Chronological View. Make this selection in the gray toolbar at the top of the left windowpane.
4. **Grouped View**: This default view lists all diagnoses that have ever been given, arranged alphabetically. Items are grouped together so that only one instance of any unique diagnosis is shown.
   - Click any ICD-9 Code/Description in the tree to display a grid in the right windowpane. The grid lists the ICD-9 code, description, every date that diagnosis has been used, its severity and progression, and the diagnosing physician.

     Note: "Moderate" severity and "Stable" progression will not show. Mild or Severe and Improving or Worsening will be displayed. For more information about these diagnosis properties, see "Edit the Properties of a Problem."
   - Click the plus sign next to any ICD-9 Code/Description in the tree to expand a list of Visit and Order Notes from which the diagnoses were generated, along with the date of the visit and the provider. Click any Visit or Order Note in the tree to display the full text of the note in the right windowpane.

     Note: If the diagnosis was added directly to the Current Problems list, there will not be an associated Visit.
5. **Chronological View**: This view lists every instance of a diagnosis in reverse chronological order.
   - Click any ICD-9 Code/Description in the tree to view the Visit or Order Note that generated the diagnosis in the right windowpane. (Note: If a diagnosis was added directly to the Current Problems list, there will not be an associated Visit.) Click the plus sign next to any ICD-9 Code/Description to expand the tree to the orders and medications to which the diagnosis was linked.
   - Click the first tree node, labeled Diagnoses to display a grid in the right windowpane. The grid lists the ICD-9 code, description, every date that diagnosis has been used, its severity and progression, and the diagnosing physician.

Note: "Moderate" severity and "Stable" progression will not show. Mild or Severe and Improving or Worsening will be displayed. For more information about these diagnosis properties, see "Edit the Properties of a Problem."

Medications

The easiest way to review the medication history is directly from the Current Medications list in the Health Summary; from this location, the entire history of a single drug can be reviewed and all discontinued medications can be displayed. However, information can also be retrieved from Chart View, as described below.

To view medications:

1. Within a patient's chart, click the Chart View tab (below the blue horizontal patient identification bar).
2. In Chart View, click the Medications tab.
3. Choose Grouped or Chronological View. Make this selection in the gray toolbar at the top of the left windowpane.
4. **Grouped View:** This default view lists all medications that the patient has taken, arranged alphabetically. Medications are grouped together so that only one instance of any unique medication is shown.
    - Click any medication in the tree to display a grid in the right windowpane. The grid lists the medication, initiation and discontinuation dates, strength, sig, and prescribing physician. A check box marked Script is checked if an actual prescription was written. If the box is not checked, the medication was added directly to the Current Medications, without a prescription.
    - Click the plus sign next to any medication in the tree to expand a list of dates that the medication was used. This may reflect the date of the Visit or Order Note in which the medication was prescribed, or the date that the drug was added to Current Medications. Click the date of any Visit or Order Note in the tree to display the associated diagnosis for which the medication was prescribed.
5. **Chronological View**: This view lists every instance of the medication in reverse chronological order.
    - Click any medication in the tree to view the Visit or Order Note that generated the prescription in the right windowpane. Note that medications added directly to the Current Medications list are identified by an asterisk and do not have an associated Visit. Click the plus sign next to any medication to expand the tree to the associated diagnosis.
    - Click the first tree node, labeled Medications to display a grid in the right windowpane The grid lists the medication, initiation and discontinuation dates, strength, sig, and prescribing physician. A check box marked Script is checked if an actual prescription was written. If the box is not checked, the medication was added directly to the Current Medications, without a prescription.
        - **Refill/Refill Request**: This view lists the patient's modified current medication list. This view is used to show Refill Requests for the patient (see the Refill Request Module for details)

Consults and Referrals

The Referrals module allows structured data to be inserted from a Visit or Order Note into a letter that can be sent or faxed to another physician. Because the information comes from a Visit or Order Note, this module can generate both Referral Letters from generalist to sub-specialist, as well as Consultation Letters from the specialist back to the referring physician.

To create a referral/consult letter:

1. Within a patient's chart, click the Chart View tab (below the blue horizontal patient identification bar).
2. In Chart View, click the Referrals tab.
3. The left windowpane displays a tree with two primary nodes, Referrals (if any exist), Visit Notes and Order Notes. To create a new note, first click the plus sign next to Visit or Order Notes. Notes are displayed by visit/orderdate and provider. Click any line to view the entire note in the right windowpane. Select the correct Visit or Order Note and click **New** (in the gray toolbar at the top of the left windowpane).
4. In the Edit Referral window:
    a. Select the Letter Template to be used. This template is created ahead of time and determines which pieces of information will be pulled from the Visit or Order Note into the Referral Letter (see "Create a Letter Template for Referrals/Consults" for details).

       The provider listed in the **Visit Details** section of the note will be recorded as the Referring (or Consulting) Provider.

    b. Click the magnifying glass in that field to change this name, if desired.
    c. Select who to **Refer To** (i.e. the physician that will be receiving this letter). Click the magnifying glass in this field to search for the correct physician.

       Note: *If the physician does not exist in the database,* click **New**. Add information in the NonStaff Provider Maintenance window. The only required fields are the First and Last Names. But remember, if the Letter Template being used inserts the physician's address and phone/fax numbers, you will want to add this information here. When finished, click Save.

    d. If desired, select the Primary ICD (the primary reason for the referral; e.g. Chest Pain) and/or Primary CPT (the test that the consulting physician performs; e.g. Stress Test). Click the small down arrow in each field for a list of all diagnoses and orders from that visit.

       Primary ICD and **Primary CPT** are structured insert fields. They will not show up in the Referral Letter if these fields are not included in the Letter Template.

    e. Add Comments, if desired.

       Comments is a structured insert field. It will not show up in the Referral Letter if this field is not included in the Letter Template.

    f. Click **Save**.
5. In the left windowpane, click the **Referrals** node. The newly generated letter will appear at the top of the list, identified by the date, the Primary ICD/CPT (if included), and the physician to whom the letter is being sent. Click anywhere on this line to view the Referral Letter in the right windowpane.
6. At this point, the letter can be edited, if needed. When finished, print or fax the letter. Click the underlined topics for details.

To edit or delete a referral/consult letter:

1. Within a patient's chart, click the Chart View tab (below the blue horizontal patient identification bar).
2. In Chart View, click the Referrals tab.
3. The left windowpane displays a tree with two primary nodes, Referrals and Visit Notes. To edit an existing Referral Letter, first click the plus sign next to Referrals. Letters are displayed by create date and by provider to whom the letter is addressed.
4. Click any line to view the entire letter in the right windowpane.

5. Click Edit (in the gray toolbar at the top of the left windowpane).
6. In the Letter Template creator, make changes to the letter as desired. When finished, click Save.
7. At this point, the letter can be printed or faxed (see "Print or Fax a Referral/Consult Letter" for details).

To print or fax a referral/consultation letter:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Consults/Referrals** tab.

   The left windowpane displays a tree with two primary nodes, **Referrals** and **Visit Notes**.
3. To print or fax an existing referral letter, first click the plus sign next to **Referrals** in the left pane. Letters are displayed by creation date and by provider to whom the letter is addressed.
4. Click the line to view the entire referral letter in the right window pane.
5. *To print the letter,* click **Print** (in the gray toolbar at the top of the left windowpane), select the appropriate printer in the Print window, and click **OK**.

   OR

   To fax the letter, while holding down the **Shift** key, click **Print** to open the e-MDs Fax Monitor window.
6. Complete the required fields, including the fax recipient, and then click **Submit**.

The fax machine must be set up before performing the above steps. See "Setting Up Print and Fax Options" for more information.

Documents

Documents stored in the DocMan module are also available for viewing in the Chart View section of the patient's chart. This allows users to access pertinent patient information without having to open DocMan. There is a DocMan tab with an orange document icon to show the patient's DocMan folders. The complete Chronology view also includes documents (also using an orange document icon) so you can access everything from one view. Just clicking the heading on the left shows the image on the right.

The display of documents in Chart View provides some but not all of the functions of DocMan. Users can view documents, sign them off, edit the descriptions, etc. but this module does not include the ability to scan documents or import them directly into Chart View. Scanning and importing of documents needs to occur in the DocMan application.

DocMan documents can be attached to TaskMan messages. When the recipient opens the attachment the document will be displayed in the Chart View section of the patient's chart. This feature allows users to easily access and review additional pertinent patient information if necessary.

To view a document in Chart View:

1. Open the patient chart.
2. Click the **Chart View** button.
3. Click the **Documents** tab in Chart View.

   On the left side of the **Documents** section is a tree view of DocMan folders.
4. Double-click the desired folder to expand the tree.
5. Select the desired document description.

   The document will be displayed in the right pane.

Case Management

A full blown case management system is accessible from the Cases tab in Chart View. It can also be accessed in other applications including Schedule and Bill. If a case has particular forms required, DocMan also comes in to play. In Chart View the Cases tab shows visits grouped by case. You can also open cases from within the Misc. tab of the patient file. More details about the case management system are described in the Case Maintenance section of this document. A brief synopsis:

- Cases make it much easier to manage treatment based cases such as for workers comp, motor vehicle accident, corporate and other “non-normal” billing scenarios where there are demographics that override the patient’s normal guarantor and insurance. You can also set up policies, rules and a host of other information related to the case that will change the information in and routing of a claim, as well as affects how the system prompts the user to follow the correct case pathway from appointments through charting and billing.
- A patient can have multiple concurrent cases with separate descriptors. The last one used is remembered, but it’s easy to pick a different one as needed.

Legend

The Legend tab is represented by a question mark icon. The legend section of Chart View displays a list of icons that are used in the various sections of Chart View and give descriptions of what they represent.

Immunizations

In addition to documenting immunizations to provide a complete record for a patient, this information can also be captured, reported, and printed for external organization and agency requirements, such as school admission and state registries.

See the "Setting Chart Administration Options" section in *e-MDs Solution Series Administration Guide* for information on customizing the immunization functionality to meet your specific requirements.

Immunization Registries

An Immunization Registry module is provided to address the need to submit information to immunization registries at a state level. This new module queries the database and generates a file that contains the appropriate immunization information. This file can then be uploaded to the state registry.

This module works with the CDC recommended HL7 format for immunization information. Contact your local immunization registry for information about the format that they use.

Documenting Immunizations for Patients

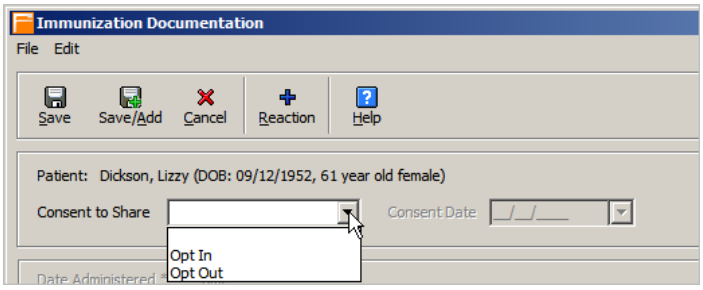
All immunization documentation is performed from the Chart **Visit/HS**, **Chart View**, or **FlowSheets** tab for the selected patient. You can document that an immunization was administered or deferred, and you can document presumed immunity based on history of disease.

To document administration of an immunization:

1. Click the **Immunization** button (with the green syringe icon) on the chart toolbar to open the Immunizations window.
2. All immunization information documented for the patient is displayed in the Immunizations window. If no immunization information has been added, the window will be blank.

   Note: You can change the order of the columns in the Immunizations window by clicking a column header and dragging the column to the desired location.
3. On the toolbar at the top of the Immunizations window, click **New**.

   The Immunization Documentation window is displayed.
4. In the **Consent to Share** field, click the down arrow and select the consent status.



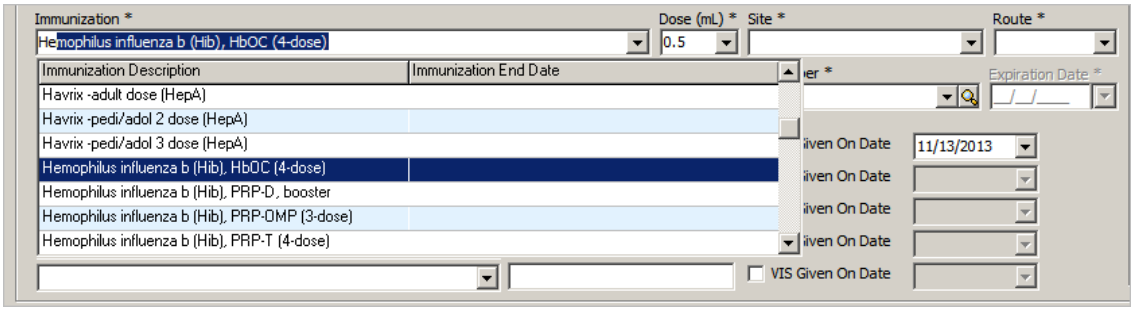
Opt In indicates that the patient has **consented** to have personal and health information transmitted to the state immunization registry.

Opt Out indicates that the patient has **denied consent** to have personal and health information transmitted to the state immunization registry.

When you select the consent status, the **Consent Date** field is activated: Enter the date the patient signed the consent.

5. If the immunization was given at a different location and you are just documenting the information, click the **Given at other location** check box. Clicking that check box activates the **Location** field: Click the down-arrow in that field to select the location. (If you select the **Free Text** option, you can type directly into the Location field.)

6. In the **Immunization** field, click the down arrow to select the immunization from a comprehensive list. (Or, you can type the first few letters of the immunization name to display matching immunizations.) Example shown below.



When you select the immunization, the system will automatically populate many of the remaining fields, including Date Administered, Time, Dose, Route, and Administered By, but you can change the information by clicking the down arrow or the magnifying glass next to the field.

7. To enter the **Manufacturer**, click the down arrow and select a manufacturer – or click the magnifying glass to search for a manufacturer.

   Note: Clicking the magnifying glass in the Manufacturer field opens the Find Vaccine Manufacturer window. In that window, you can access the Vaccine Manufacturer Maintenance window by selecting the manufacturer and clicking the Edit button. (In the Vaccine Manufacturer Maintenance window, you can add or remove a vaccine from the list of vaccines associated with a manufacturer, and you can add or remove manufacturers.)

8. Enter the **Lot Number** and **Expiration Date**. You can type directly into the Lot Number field, or you can click the down arrow to select a lot number that has been entered previously.

   Note: If you want to delete a lot number, click the magnifying glass in the Lot Number field to access the Lot Number Maintenance window. In that window, search for the lot number. In the search results, click the lot number to be deleted and then click the Delete button. Note that the lot number and expiration date are linked.

9. Enter the **VIS information**. (For combination vaccines, you can add VIS information for each component of the vaccine.)

   If a VIS Revision Date has been linked to the vaccine, the VIS Revision Date field will display the revision date, language and a comment (if one exists).

   The VIS Given On check box will be auto-checked and today's date will be displayed. If this field is checked the Immunization Detail report will include the date the VIS was given. If you do not provide the VIS information, clear the check box. If you want to change the date it was given, click the down arrow and select a different date.

10. Select the VFC eligibility and funding information. (VFC stands for the Vaccines for Children program, and the VFC eligibility status is used to designate a funding source for this immunization program.)

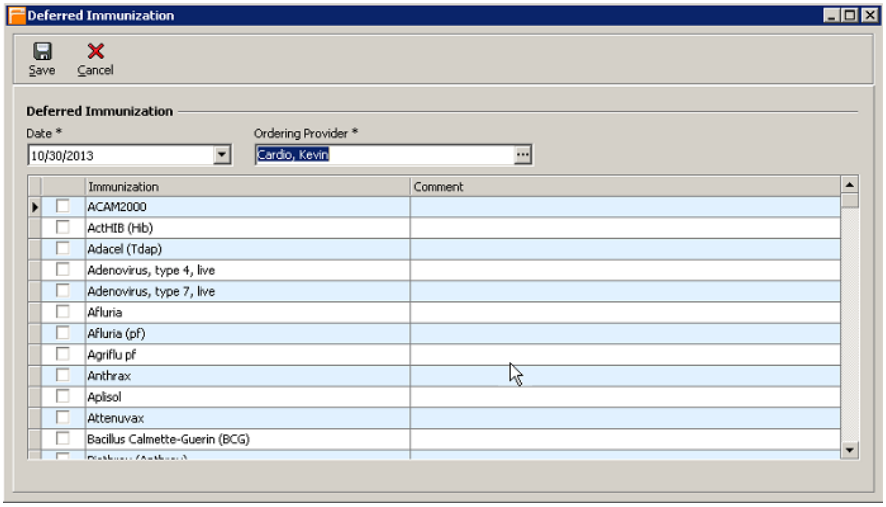
11. Click **Save** to add the immunization to the patient's chart. (To exit the window without saving any of the information, click the **Cancel** button.)

    Note: If you are adding multiple immunizations and want to bundle them into one VXU message to be sent to the registry, click the **Save/Add** button, then add the next immunization.

To document a deferred immunization:

9. Click the **Immunization** button (with the green syringe icon) on the chart toolbar to open the Immunizations window.
10. On the toolbar at the top of the Immunizations window, click **Deferred**.

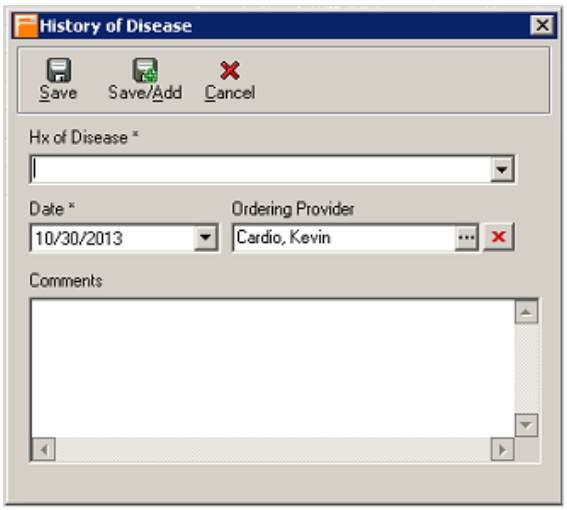
The Deferred Immunization window is displayed.



11. Click the check box next to each immunization that was deferred.
12. When you select an immunization, a **Refusal/Deferral Details** window is displayed. In that window, click the applicable radio buttons to indicate whether the immunization was refused, deferred, or waived, by whom, and the reason.
13. Click **Save** to save the information.

To document presumed immunity based on history of disease

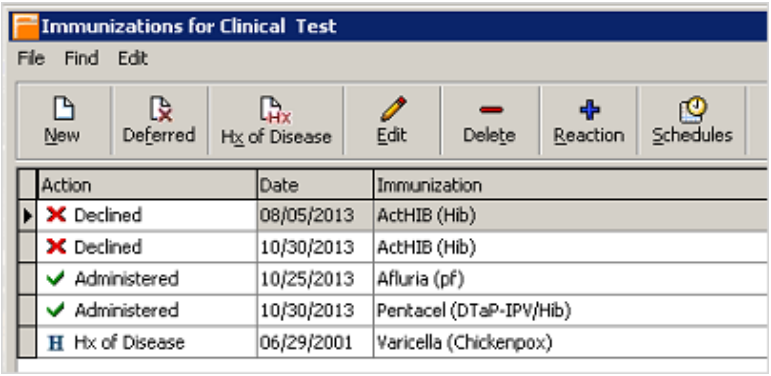
1. Click the **Immunization** button (with the green syringe icon) on the chart toolbar to open the Immunizations window.
2. On the toolbar at the top of the Immunizations window, click **Hx of Disease**.to display the History of Disease window.



3. Click the down arrow in the Hx of Disease field to display a list of diseases and then click a disease to select it.

4. If the date the patient had the disease is known, click the down arrow and select that date. (Otherwise, leave today's date in the field and note in the comments field that the patient is unsure of the date.)
5. Click Save to add the information to the Immunizations window.

All documented immunizations information is shown in the Immunizations window.



Viewing or Editing Immunization Details

To view or edit the details of an immunization, select (click) the immunization name and click the **Edit** button on the toolbar.

Note that you can add Administration Notes to an immunization record. Those notes are displayed in the Comments column of the Immunizations window and are *not* linked to the Reaction Memo.

Documenting an Immunization Adverse Reaction

IMPORTANT! There is only one Reaction Memo for any given patient: That memo is attached to the patient's entire immunization record and not to a specific vaccination. When you document a reaction, it is important to include the name(s) of the vaccine(s) in question and the date administered along with the type of reaction.

To add an immunization reaction:

1. Click the **Immunizations** button (with the green syringe icon) on the Chart toolbar.
2. On the Immunizations window toolbar, click the **Reaction** button.

   Note: If no reactions have been documented, a blue plus sign is displayed on the Reaction button. If reaction has been added to the Reaction Memo, a yellow triangle with a red exclamation mark is displayed on the Reaction button.
3. In the Reaction Memo, type the reaction information and click **Save**.

To edit an immunization reaction:

1. Click the **Immunizations** button (with the green syringe icon) on the Chart toolbar.
2. On the Immunizations window toolbar, click the **Reaction** button.
3. Change the information in the Reaction Memo window as appropriate and then click **Save**.

Deleting an Immunization

Deleting an immunization does not remove it from the patient's record; instead, it moves the immunization to deleted status. You can view deleted immunizations by clicking the *Display deleted immunization records* check box located at the top of the Immunizations window.

To delete an immunization:

1. Select the immunization and click the **Delete** button.
2. In the Delete Immunization Maintenance window, click the drop-down arrow located next to the **Delete Reason** field.
3. Click to select a reason from the list of default reasons and click **Save**.

Editing Immunization Delete Reasons

To access the Delete Reasons Editor:

1. Select an Immunization and click the Delete button.
2. In the Delete Immunization Maintenance window, click the magnifying glass icon button located next to the **Delete Reason** field.
3. At the Find Delete Reason window, click the **Search** button to list all of the current Delete Reasons.
4. Click the **Edit** button to make changes to the current Delete Reason.
5. Click the **Delete** button to remove any of the Delete Reasons.
6. Click the **New** button to create new Delete Reasons.
7. Click the **Select** button to add the reason to the **Delete Reason** field as well as select it from the drop down menu.
8. Click the **Exit** button to return to the Delete Immunization Maintenance window.

Viewing Schedules and Catch-up Schedule

To view the CDC recommended immunization schedules for Pediatric immunizations, Catch-up immunizations, and Adult immunizations, click the Schedules button located on the toolbar at the top of the Immunizations window.

Note: If the computer that is used to access the immunization module has an Abode PDF reader installed the documents will be displayed in .PDF format. If the computer has Word installed the documents will be displayed as Word documents. The computer must have one or the other of these applications installed in order to access the documents.

Printing the Immunization Log or Detail Report

The patient's Immunization Log or "shot record" can be printed or faxed if necessary. Two formats are available: Immunization Log and Detail Record. Both include the patient's name and date of birth, the immunization type, and the date administered. The Detail Record includes additional information.

Note: The printed record will be routed to the printer set up to print All Notes in Print Options.

Note: To fax an immunization record, hold the **Shift** key on the keyboard while clicking the Printer icon and selecting Immunization Log or Detail Record. In the Printing Explanation window, select the reason for printing and click OK. In the Select Fax Recipient window, fill in the information for faxing this report.

To print the immunization log:

1. Click the Immunizations button (with the green syringe icon) on the chart toolbar to open the Immunizations window.
2. Click the Print button on the Immunizations window toolbar and select Immunization Log or Detail Report.
3. In the Printing Explanation window, select the reason for printing and click OK.

4. A Print Preview window will be displayed. In that window, click the Printer icon to print the immunization information.

You can also print an immunization record from the patient's chart by clicking the Printer icon and selecting Immunization Log.

Linking Vaccines to Manufacturers

When you install e-MDs Solution Series, the vaccines available for selection have been associated with the manufacturer that makes the vaccine. However, in the event you need to link a vaccine to a different manufacturer, a mechanism is available.

To associate a vaccine to a manufacturer:

1. Click the **Edit** menu in the Immunization module and select **Manufacturer**.

   The Find Vaccine Manufacturer screen will open.

2. Search for the desired manufacturer, highlight it and click **Edit**.
3. At the bottom of the Vaccine Manufacturer Maintenance screen, click the **Add** button.

   The Immunization Type Vaccine Manufacturer Maintenance screen will open. The selected manufacturer will be displayed in the **Vaccine Manufacturer** field

4. Click the down-arrow and select a vaccine in the **Immunization Type** field.
5. To make this the default, click the **Default** check box.

VIS Revision Dates

As part of the Immunization module, you can document Vaccine Information Sheet (VIS) Revision Dates for vaccines given along with the date that the VIS was given. This allows you to document revision dates associated with a VIS at the time of documenting other information associated with a vaccination. The date associated with the VIS will be printed on the Immunization Detail Report. In order to document a VIS Revision date you must first add a revision date to a vaccine. The system allows you to add more than one VIS revision date to a vaccine and to designate one as the default VIS revision date. In addition, you can create VIS revision dates for VIS documents in languages other than English.

Note: In order to add a VIS revision date you must have the **Immunization: VIS Revision Date** privilege with at least Read/Write access.

When documenting an immunization, a VIS Revision date for the vaccine can be documented. If there is a default revision date it will automatically be inserted into the VIS Revision Date field. Sometimes there is no revision date associated with the vaccine and sometimes a different revision date needs to be chosen.

To select a VIS revision date:

Privileges Required: *Immunization: VIS Revision Date*

1. From within the Immunization module, click the magnifying glass in the **VIS Revision Date** field.
2. The **Find Revision Date** screen will open.

3. A list of vaccines and revision dates will be displayed.
4. Select the appropriate one and click **Select**.
5. If the desired revision date does not exist, click the **New** button and follow the directions in the next section.

To add a VIS revision date:

Privileges Required: *Immunization: VIS Revision Date*

1. From the main Chart menu click **Tools** then **VIS Revision Date**.
2. The **Find Revision Date** screen will open.
3. A list of vaccines and revision dates will be displayed.
4. To add a new revision date for a vaccine, type the name of the vaccine in the **Immunization Type** field.
5. Once the vaccine is selected in the Immunization Type field, click the **New** button on the toolbar.
6. The VIS Revision Date Maintenance screen will open with the vaccine name showing in the **Immunization Type** field.
7. Type a date in the **Revision Date** field. This is a required field.
8. Select a **Language** from the drop down list. The default language is English but can be changed. This is a required field.
9. In the **Comment** field you can type in additional information if needed. This field allows for a maximum of 650 characters.
10. Click the **Default** check box if this is to be the default revision date. Only one default revision date can be selected per vaccine.

Note: When a patient has a language other than English associated to their demographic account the VIS for that language will be selected by default in the VIS Revision Date field. If a VIS for that language does not exist then the English revision date will be selected.

Referral/Consult Letter Editor

This module is similar to a mail merge program. It allows templates to be built for various referral or consultation letters. The templates are created using structured fields from the database, such as demographic information for the patient and the physician, ICD-9 and CPT codes, and sections from a Visit or Order Note (HPI, Exam, Assessment, Plan, etc.).

See "Create a Referral/Consult Letter" for details about using the letter templates to create a referral letter in e-MDs Chart.

To create a new letter template:

1. In the main e-MDs Chart toolbar, click Tools and then select the Letter Editor menu option.

   The Select Letter window will open.
2. Click New to open the Letter Generator window.
3. Assign a title to the Letter Template by typing a descriptive name in the Letter Description field.
4. To insert any field into the Header, Body or Footer of the letter, highlight the desired field in the list on the right and click the Insert Field button.
5. Additional information can be added to the letter by typing directly into the Header, Body or Footer sections as necessary.

6. Format any text or inserted fields in the template as necessary by using the toolbar buttons (Undo, Cut, Copy, Paste, Font Size, Font Selection, Bold, Italic, Underline, Alignment and Bullet.)
7. Click the Save button
8. Click the Exit button or click the X in the upper right corner of the Select Letter window.

To edit an existing letter template:

1. In the Select Letter window, click Search for a list of all existing Letter Templates.
2. Highlight the correct Letter Template in the search results and click Edit.
3. Make changes as desired in the Letter Generator window, and click Save.

To delete a letter template:

1. In the Select Letter window, click Search for a list of all existing Letter Templates.
2. Highlight the Letter Template to be deleted in the search results and click Delete.
3. Click Yes in the Delete Confirmation window.

Printing and Faxing from e-MDs Chart

From virtually any place that you can print a job you can now also fax the same file. To do this, simply hold down the **Shift** key prior to clicking the print icon and this will launch a compact version of the Fax Monitor. The name of the end user logged in to the computer will be automatically filled in the **From** field. Use the **Title** field for the name of the document OR to add a note to the recipient. Click the magnifying glass icon to search for a Person or Organization fax number as described in the Phone Number Database section or enter a fax number manually.

Note: Please note that the fax phone number should be in the following format **(512)555-5555** to properly dial out. Not having this format may prevent the program from dial fax phone numbers correctly.

Once the fax number is entered, clicking OK will submit these faxes directly to the Fax Manager for processing.

Note: Unlike the full Fax Monitor, this compact version will only send **one** Fax print job to **one** recipient.

Print/Fax Items from Chart View

Visit Notes, Order Notes, Log Notes, Phone Notes, and Referral Letters can be printed or faxed from Chart View.

To print or fax Visit or Order Notes from Chart View:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the appropriate tab (**Visit Notes** or **Chronology**).
3. In the tree on the left, select the appropriate note.
4. When the full text of the note appears in the right windowpane, click **Print** (located on the toolbar directly above the note in the right windowpane).

   In the **Note Conclusion** window there are two columns with check boxes next to each report type (Visit Note, Medical Art, Superbill, etc.) one labeled **Print** and one labeled **Fax**.
5. *If the item is to be printed,* click the check box under the **Print** column.
6. Click **OK** to print the report

7. *If the item is to be faxed,* click the check box under the **Fax** column.
8. *If the item is to be faxed,* click the **Edit** button (pencil icon) in the **Edit** column to the right of the report name.

   A compact version of the Fax Monitor will open and you can enter information such as **Title**, **To**, **From** and the **Phone** (Fax) number. See Fax for details.
9. After the information is entered, click the **OK** button to save the information into the Note Conclusion window.
10. Click the **OK** button in the Note Conclusion window to print or fax the selected reports.

To print or fax log and phone notes from Chart View:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the appropriate tab (**Log/Phone/Rx Notes** or **Chronology**).
3. In the tree on the left, select the appropriate note.
4. When the full text of the note appears in the right windowpane, click the **Print** button to print the note.
5. To Fax the note hold down the shift key on the keyboard while clicking the **Print** button
6. A compact version of the Fax Monitor will open and you can enter information such as **Title**, **To**, **From** and the **Phone** (Fax) number. See Fax for details.
7. Click **OK** to fax the note.

To print or fax referral letters from Chart View:

1. Within a patient's chart, click the **Chart View** tab (below the blue horizontal patient identification bar).
2. In Chart View, click the **Referrals** tab.
3. In the tree on the left, select the appropriate letter to print.
4. When the full text of the note appears in the right windowpane, click the **Print** button to print the letter.
5. To Fax the letter hold down the shift key on the keyboard while clicking the **Print** button
6. A compact version of the Fax Monitor will open and you can enter information such as **Title**, **To**, **From** and the **Phone** (Fax) number. See Fax for details.
7. Click **OK** to fax the letter.

To print or fax Items when concluding a Visit or Order Note:

1. At the conclusion of a Visit or Order Note, click the **Conclude Note** button, located on the Chart toolbar (clipboard with a green check mark).
2. The Note Conclusion window contains two columns labeled **Print** and **Fax** with check boxes in each column corresponding to each report type that can be printed or faxed (EXAMPLE: Visit Notes, Order Notes, Patient Education, Superbill, etc.).
3. To print or fax a report, click the check boxes in the **Print** column next to those items to be printed **AND/OR** in the **Fax** column for those items to be faxed. Anything not checked will not be printed (or faxed).

   Important! The exception to the Print and Fax column check boxes is the Prescription report. It only has one check box which is under the Print column. This check box represents that the prescriptions will be *processed* (either printed or faxed depending on the way prescriptions were

designated when they were created). It is important that this check box *always* be checked; otherwise the prescriptions will not be printed or faxed.

4. *If the item is to be faxed*, click the **Edit** button (pencil icon) in the Edit column to the right of the report name
5. A compact version of the Fax Monitor will open and you can enter information such as **Title**, **To**, **From** and the **Phone** (Fax) number. See Faxing Documents for details.
6. Once the information is entered, click the **OK** button to save the information into the Note Conclusion window.
7. *If the item is to be printed*, each report type (i.e. Visit Note, Order Note, Prescriptions, etc.) can be routed to any printer. This is typically set up in advance in Print Options (see Print Options for details), but can be changed on the fly by clicking the **Print Options** button in the Note Conclusion window **OR** by clicking the **Printer Icon** in the **Options** column. The Printer Icon in the Options column provides quick access to the print options of the specific report chosen.
8. Once all print and fax issues have been dealt with, this Visit or Order Note can be closed without permanent sign off or it can be permanently signed off if the provider is completely finished with all visit documentation. See Visit and Order Note Sign Off for details.
9. Click **OK**.
10. Successive messages will appear on screen as each report is routed as a print job to the appropriate printer(s).

Print/Fax the Health Summary

The Health Summary can be printed or faxed at the conclusion of a Visit or Order Note (see Print/Fax Visit Related Items for details). Additionally, items can be printed independently by clicking the **Print Patient Reports** button on the chart toolbar (paper and printer icon). Select the **Health Summary** menu item to be printed. The Health Summary will be routed to the printer designated in the print options.

To Fax the Health Summary, hold down the **Shift** key on the keyboard while clicking the **Health Summary** menu item. A compact version of the Fax Monitor will open and information such as **Title**, **To**, **From** and **Phone or Fax** number can be entered. See Print Options for details.

Note: Growth Charts can only be printed or faxed from the Growth Chart module.

To print or fax growth charts:

1. Open the Growth Chart module by clicking the **Growth Charts** button on the chart toolbar (pink and blue people icon). Growth Charts can also be accessed from the Vital Signs window.
2. In patients over 20 years of age, Growth Charts are not available and the Growth Charts icon will not display.
3. Click the tabs across the top of the Growth Charts to view the desired chart (e.g. weight). Click the **Print** button to print the growth chart.
4. To print another chart (e.g. height), click the appropriate tab in Growth Charts, then click **Print**.
5. The actual Growth Chart curves and plotted data points will print. The grid listing the individual dates, values, and percentiles does not print.
6. The Growth Charts will be routed to the printer set up in print options (see Print Options for details)
7. To **Fax** Growth Charts use the same steps as outlined above. Holding down the **Shift** key on the keyboard while clicking the Print button brings up a compact version of the Fax Monitor. Information such as **Title**, **To**, **From** and the **Phone or Fax** number can be entered in this window. See Printing and Faxing from Chart for details.

To print, fax or create an electronic file when printing the entire chart:

1. Click the **Print Patient Reports** icon on the chart toolbar (paper and printer).
2. Select **Entire Patient Chart**.
3. Click **Yes** in the confirmation window(s).

   The Print or Fax Entire Chart Options window will open and display options to print, fax or create an electronic file.
4. *If faxing the selected item*, click the **Fax Options** button to select a recipient. See Print/Fax Options for details.
5. After the recipient is selected, click **Done** to save the information.
6. *If printing the selected item*, each report type (i.e. Visit Note, Order Note, Prescriptions, etc.) can be routed to any network printer. This is typically set up in advance in Print Options (see Print/Fax Options for details). These options can be changed "on the fly" by clicking **Print Options**.

   Successive messages will appear on screen as each report is routed as a print job to the appropriate printer(s).
7. *If an electronic file needs to be created,* select a file destination to save the text file.
8. Create a File Name.
9. Click **Save**.
10. **Limit by Date** will allow you to choose a date range for documents included in this file.
11. Choices include **Visit Notes**, **Order Note**, **Log/Telephone/Rx Notes**, **Health Summary**, **Hidden Health Summary, Immunization Log and Medical Art.** If all items need to be selected, place a check mark next to **Select All.**
12. Click **OK**.

Generating the Chart Audit Report

When you first access this screen, the results grid at the bottom of the screen will be blank. The following are some basic tasks you can perform from this screen.

To quickly view audited Chart activities for the current date:

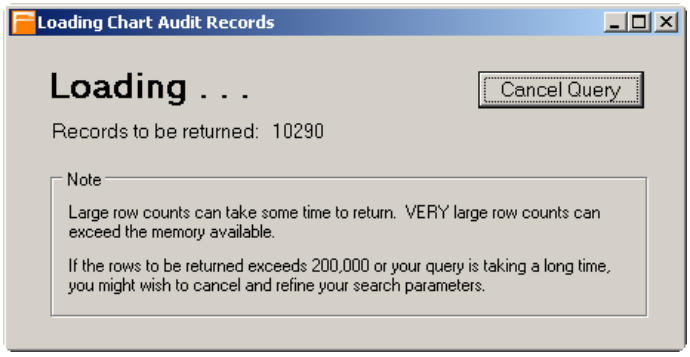
1. Click the **Today** button in the **Date of Activity** section. The current date will be selected for both begin and end dates.
2. Click **View** on the top toolbar to generate and view the results.

To view records for a set period of time:

1. Use the drop-down list after the **From** and **To** fields to select the date range you want to query.
2. Select any other filter options in the **User**, **Patient**, **Action** and/or **Type of Record** fields.

3. Click **View** on the top toolbar to generate and view the results in the lower portion of the screen and the following window opens:

If the number of records that match your filter selection exceeds 10,000 records, the following window will pop up instead:



Both windows indicate the system is in the process of obtaining the requested records from the database. If the database return is under 200 records, no window will pop up. Similarly, with a very fast database, it will be too fast to read.

4. When this window pops up, you have two choices:

   If you do not want to complete the query, click **Cancel Query**. The query will be cancelled and the bottom portion of the screen will remain unpopulated.

   OR

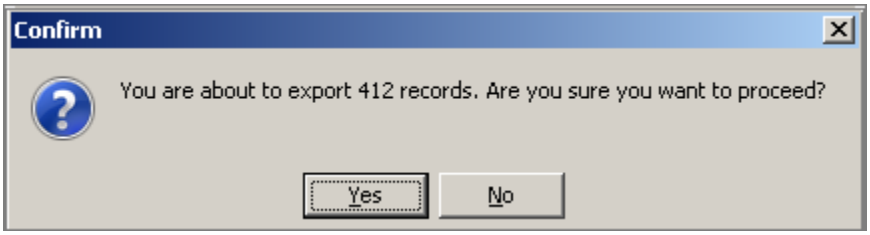
   If you want to continue the query and display all the returned records, this window will automatically close when the process is complete, and the returned results will display in the bottom portion of the Chart Audit Report screen.

To print query results:

1. Use either of the query methods above to list the required records.
2. Click **Print** to send the results to the report printer function.

To perform a query and export the results to a file:

1. Select the date(s) for the query as described above.
2. Select any other options on the screen to set additional filters.
3. Click the **Export** button in the top toolbar. The query will begin and the following screen will pop up to tell you how many records are being exported (in this case 412 records):

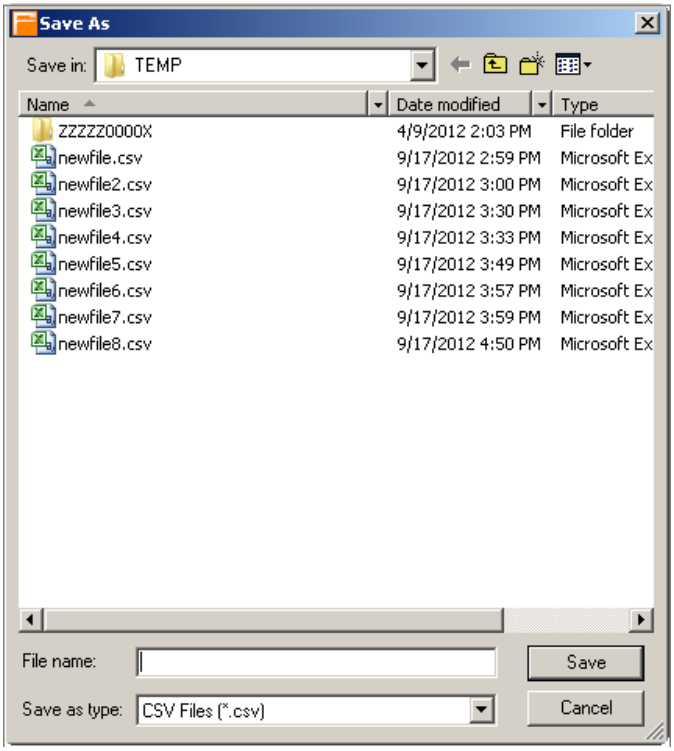


4. Click **Yes** to continue exporting the records to a text file. Continue with the next step below.

   OR

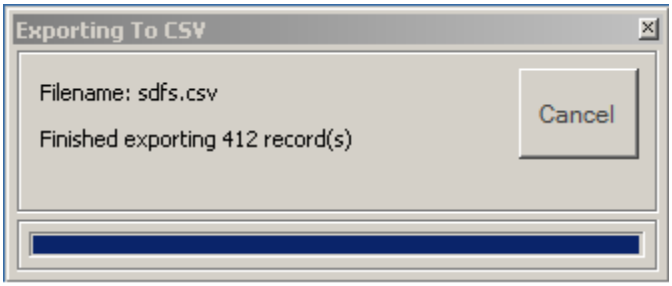
   Click **No** to end the query and export.

5. If you clicked **Yes**, the following window will appear for you to give the export file a name:



6. Enter the file name and click **Save**. (If you wish, you can also change the location for the file by changing the folder path in the **Save in** field at the top.)

   The following window appears, with the actual number of records reflected in the message.



7. If you decide to stop the export action, click the **Cancel** button. (Clicking the **Exit** button (**x**) will close the window but the file export will continue until complete.)
8. When the **Cancel** button on this window changes to **Close**, the export is complete and the text file is available for viewing, mailing or other processing.
9. Upon completion of the export, click the **Exit** button to close the window.

Generating the Demographics Audit Output

When you first access this screen, the results grid at the bottom of the screen will be blank. The following are some basic tasks you can perform from this screen.

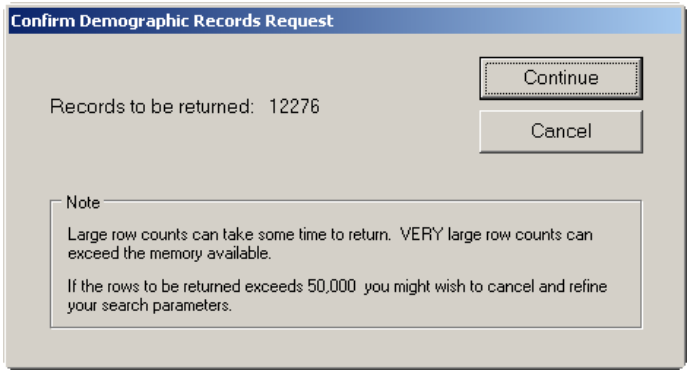
To quickly view audited Demographics activities for the current date:

1. Click the **Today** button in the **Date of Activity** section. The current date will be selected for both begin and end dates.
2. Click **View** on the top toolbar to generate and view the results.

To view records for a set period of time:

1. Use the drop-down list after the **From** and **To** fields to select the date range you want to query.
2. Select any other filter options in the **User**, **Patient**, **Transaction Type** and/or **Audit Alias Type** fields.
3. Click **View** on the top toolbar to generate and view the results in the lower portion of the screen and the following window opens:

If the number of records that match your filter selection exceeds 10,000 records, the following window will pop up instead:



4. When this window pops up, you have two choices:

   If you do not want to perform the query, click **Cancel**. The process will be cancelled and the bottom portion of the Demographics Audit Report screen will remain unpopulated.

   OR

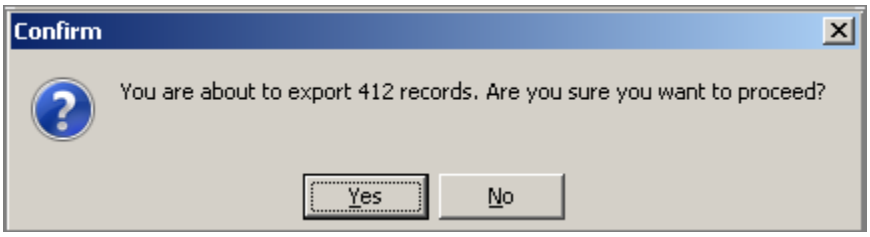
   If you want to run the query and display all the returned records, click Continue and this window will close when the process is complete, and the returned results will display in the bottom portion of the Demographics Audit Report screen.

To print query results:

1. Use either of the query methods above to list the required records.
2. Click **Print** to send the results to the report printer function.

To perform a query and export the found records to a file:

1. Select the date(s) for the query as described above.
2. Select any other options on the screen to set additional filters.
3. Click the **Export** button in the top toolbar. The query will begin and the following screen will pop up to tell you how many records are being exported (in this case 412 records):

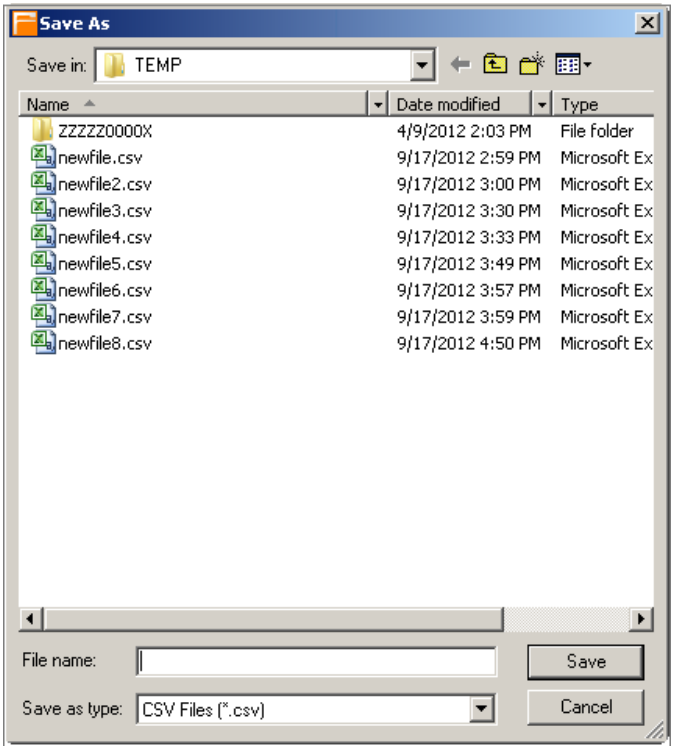


4. Click **Yes** to continue exporting the records to a text file. Continue with the next step below.

   OR

   Click **No** to end the query.

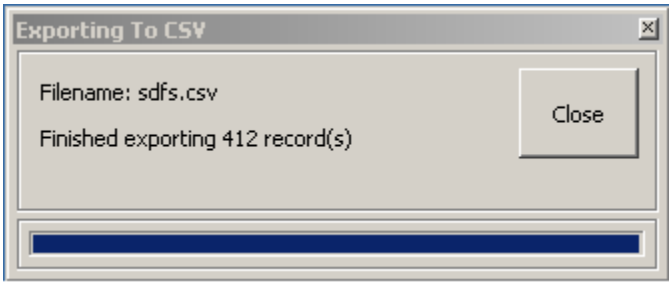
5. If you clicked **Yes**, the following window will appear for you to give the export file a name:



6. Enter the file name and click **Save**. (If you wish, you can also change the location for the file by changing the folder path in the **Save in** field at the top.)

   Note: **Note:** The only acceptable file type is .csv (Comma Separated Values).

   The following window appears, with the actual number of records reflected in the message.



7. If you decide to stop the export action, click the **Close** button. (Clicking the **Exit** button (**x**) will close the window but the file export will continue until complete.)
8. When the **Close** button on this window changes to **Complete**, the export is finished and the text file is available for viewing, mailing or other processing.

Upon completion of the export, click the **Exit** button to close the window.

Unsigned Notes Reports

The standard Unsigned Notes Report (described below) is available in the Chart module under the drop-down **Reports** menu. Another report named "Unsigned Reports (Crystal Reports Version)" expands the function of that report including the use of nurse notes, OB module notes, and "ready to bill" patient Visit or Order Notes. To learn more about this report, see the "Chart Reports" chapter of *e-MDs Reports User Guide*.

To generate reports of Unsigned Notes:

1. In the main e-MDs Chart menu, click **Tools** and select the **Unsigned Notes Report**.
2. Select the type of unsigned note report from the six choices:
   - **All Notes.** Displays all un-signed notes (Doctor Visits, Nurse Visits, Log and Phone Notes) for all authors. Select either **By Patient** or **By Author** to sort the report alphabetically by either patient's or author's last name.
   - **All Log/Phone/Rx Notes.** Displays all un-signed Log and Phone Notes for all authors. Select either **By Patient** or **By Author** to sort the report alphabetically by either patient's or author's last name.
   - **All Visit Notes.** Displays all un-signed Visit Notes (Doctor and Nurse notes). Select either **By Patient** or **By Author** to sort the report alphabetically by either patient's or author's last name.
   - **My Notes.** Displays all un-signed notes (Doctor or Nurse Visits, Order Notes, Log and Phone Notes) created by the user logged into the application at the time this module is accessed.
   - **My Log/Phone/Rx Notes.** Displays only the un-signed Log Notes and Phone Notes created by the user logged into the application at the time this module is accessed.
   - **My Visit Notes**. Displays only the un-signed Visit Notes created by the user logged into the application at the time this module is accessed.

   The Print Preview window will open.
3. To view the report on screen, use one of the sizing buttons on the toolbar (Whole Page, Page Width, 100%) or type in a % to enlarge or reduce the report to the best viewing size. Click one of the scroll buttons (First Page, Prior Page, Next Page, Last Page) or type in page # to go to a specific page if necessary.
4. To print the report, click the **Print** button.
5. Click **Close** to exit the window when finished.

Code Linker

Code Linker is a utility within e-MDs Chart that enables the user to link various data items together to help shortcut documentation. Items that can be linked include Billing Codes (ICD-9, CPT, HCPCS), Educational Documents (Patient Education, Drug Education, and Curbside Consults), Templates, and Medical Art.

Examples of how links are used in e-MDs Chart:

- **Template-to-ICD:** When a diagnosis (ICD) is chosen in History of Present Illness (e.g. abdominal pain), the appropriate templates (e.g. HPI: Abdominal Pain, PLAN: Abdominal Pain) are available. Although the user can search "all templates", it is quicker to present the linked templates so that a search is not required.
- **ICD-to-CPT:** For a specific diagnosis (ICD), appropriate orders (CPT codes) are available in the Plan section of the Visit and Order Notes. Again, the user can search "all CPTs", but it is helpful to display a list of linked orders first.
- **ICD-to-Patient Education:** Rather than search thousands of documents, the user is presented with a short list of Patient Education handouts linked to the diagnoses (ICDs) assigned in that visit.

Create/Delete Links

To create a link:

1. Click Tools on the main e-MDs Chart toolbar, and select the Code Linker menu option.
2. Log into Code Linker with the same username and password used in e-MDs Chart.
3. In the Code Linker, the left vertical sidebar presents the various linking options. These include ICDs, CPTs, HCPCS, Templates, Patient Ed., Drug Ed., Curbside Consults, and Art. Select one of these options as the primary item to which links will be made. For example, click ICDs.
4. Depending on which item was chosen, a search window will appear. In our example, the ICD-9 search opens. Perform a search, select an individual item (in this case, a single ICD-9 code), and click Accept.

   See the following topics for further search information:

   - Search for an ICD-9 Code
   - Search for a CPT Code
   - Search for a HCPCS Code
   - Search for Medical Art
   - Search for a Patient Education Document
   - Search for a Drug Education Document
   - Search for a Curbside Consult
   - Search for a Patient Instructions Document
5. This closes the search window and drops the individual item into the Code Linker. That item will appear at the top of the Code Linker window, highlighted in yellow.
6. Below the yellow highlighted item are several blue collapsible bars, representing data elements that can be linked to the highlighted item. In our example, an ICD-9 code is highlighted, and the blue bars are labeled CPTs, Curbside Consults, Patient Education Documents, Drug Education Documents, Templates, and Art.

7. Click the plus sign on the blue bar of the data element to be linked. In our example, click the plus sign next to CPTs to link CPT codes to the highlighted ICD-9 code.
8. When that section opens, click Add. This will launch an appropriate search. In this example, the CPT search is launched.
    - *To link a single item,* select it from the search results and click Accept.
    - *To link multiple items,* select items from search results by right clicking them and choosing the Add Code(s) to Select List menu option. This opens a Select List window, listing all chosen items. Additional searches can be performed at this time. When all desired items are in the Select List, click Accept.

    To select multiple codes at one time, click the first code to be linked, hold down the Shift key, and then click another code to select a contiguous series of codes. Or if the codes are not in a series, click the first code to be linked, and then while holding down the Ctrl key, click the other codes. When the group of codes is properly highlighted, right click and choose Add Code(s) to Select List.
9. The linked items (CPT codes, in this case) will now appear in the Code Linker window.

To delete a link:

1. Select one member of the link so that it is highlighted in the Code Linker. For example, to delete an ICD-to-CPT search, first select ICD in the left vertical sidebar and search for the correct ICD-9 code.
2. Highlight the link to be deleted. In this case, with the ICD highlighted yellow, click the blue CPT bar, and click the CPT link to be eliminated.

    Note: Hold down the Shift or Ctrl keys to select more than one item for deletion.
3. Click **Remove Selected**.

    Notes:
    - Links are not user-specific. Therefore, links made by any user will be visible to all users.
    - Links are two-way, or circular. For example, if a document is selected and an ICD-9 code is linked to it, a link is also made from the ICD-9 code to the document. The only exception is CPT-to-CPT links; these are one-way links, so carefully choose which CPT is primary (i.e. is highlighted in Code Linker).

A helpful feature is the ability to copy links. For example, suppose the user links multiple orders (CPTs), templates, and Patient Education handouts to a single ICD-9 code for diabetes. However, dozens of ICD-9 codes for diabetes exist, and the user does not want to manually recreate those links for every ICD-9 code. In this case, he simply copies the links, as described below.

To copy links from one item to another:

1. Open the Code Linker so that an item is highlighted and all of its links are visible.
2. To copy every link:
    a. Click **Select All** at the top of the Code Linker window (above the highlighted item).
    b. Click **Copy Selected**, and choose the correct menu item indicating to where the links will be copied. In the example above, the links to the ICD code are to be copied to another ICD code, so the ICD menu option is selected.
    c. Perform the search to find the correct item to copy the links to. In this case, perform a search for the correct ICD code.
        - *To copy the links to multiple items,* select items from search results by right clicking them and choosing the **Add Code(s) to Select List** menu option. This opens a Select List

window, listing all chosen items. Additional searches can be performed at this time. When all desired items are in the Select List, click **Accept**.

- *To select multiple codes at one time,* click the first code to be linked, hold down the **Shift** key, and then click another code to select a contiguous series of codes. Or, if the codes are not in a series, click the first code to be linked. Then, while holding down the **Ctrl** key, click the other codes. When the group of codes is properly highlighted, right-click and choose **Add Code(s) to Select List**.

3. To copy a subset of links:
   a. Click **Select All** in the subsection that is to be copied. For example, to copy only the CPT links, click **Select All** located below the blue bar labeled CPTs.
   b. Click **Copy Selected**, and choose the correct menu item indicating to where the links will be copied.
   c. Continue as outlined above.

Lab Tracking

Lab Tracking is a module that works with e-MDs Chart, DocMan and TaskMan to track labs, radiology tests, and procedures, and to notify the ordering provider when results for these items are overdue. It works like a tickler file to help providers keep track of outstanding items by their respective CPT and HCPCS codes. A pre-defined rule within Rule Manager determines if these items are overdue and automatically sends a message, using TaskMan, to the ordering physician and/or designated medical assistant. All CPT and HCPCS codes can now be set to "trackable" status, so that once they are selected within a Visit or Order Note in e-MDs Chart, a pre-defined "clock" is started.

To prepopulate the database, due dates for a select subset of codes were determined and loaded into the system based on the TYPE OF SERVICE parameter the code belongs to such as Diagnostic Labs, Diagnostic X-rays, and Medical Care (includes procedures). These due dates may or may not represent the actual expected due dates for individual users and are completely customizable.

Lab Tracking Interface - Overview of Lab Tab

The Lab Tracking Window provides a patient specific view of pending labs/tests/procedures and allows those items to be marked as complete. At the top of the window, identifying information including the patient's name, date of birth, gender and age are displayed. On the Lab tab, a split screen displays due dates, codes and descriptions for CPTs in the upper part and due dates, codes and descriptions for HCPCS in the lower part. The codes listed here represent items that were ordered for this particular patient and are currently being tracked. This list can include items that are both coming due and that are already overdue. A total of three messages identifying overdue items will be sent to the ordering provider (as well as the assistant designated in the Visit Details of the note) when items are determined to be overdue. Even after all messages have been sent the item will remain in this list until it is marked as done.

Pending items can be marked as complete (the results for these items have come in) by selecting the check box that appears next to each item in the list and then clicking the Save button. This marks the items as done and prevents overdue messages from being sent for those items.

To select all items in the list, click the check box located at the very top of the list (next to the column titles). Clicking that check box automatically checks all the remaining check boxes.

At the top of the window is a button labeled **Groups**. The Groups button opens a User Group window that allows the provider to identify additional people to be notified of overdue items. By default the provider and assistant specified in the visit details of a note are the only people notified unless otherwise indicated in the User Group window.

Accessing the Lab Tracking Window

The Lab Tracking window shows patient specific pending labs/tests/procedures and allows those items to be marked as complete. It can be accessed from within both Chart and DocMan.

To access the Lab Tracking window from Chart:

1. Open a patient chart and click the **Lab Tracking** icon which can be found on the gray patient specific tool bar that runs across the top of the patient's chart just below the blue demographic bar. 
2. To access the Lab Tracking window from DocMan:
3. Open a patient chart and click the **DocMan** icon to open DocMan. Then within the DocMan module, click the **Lab Tracking** icon on the main toolbar. 

   OR

   Open a patient record in the DocMan stand alone module. Then within the DocMan module click the Lab Tracking icon on the main toolbar.

   OR

   Open a patient record and click TOOLS then LAB TRACKING on the main DocMan toolbar.

   OR

   Open a patient record, select a specific category that is marked for tracking such as LABS, RADIOLOGY, etc… and click NEW DOCUMENT prior to scanning.

   OR

   Select a specific category that is marked for tracking such as LABS, RADIOLOGY, etc. and click TOOLS then IMPORT DOCUMENT from the main DocMan menu.

Mark Tracked Labs as Complete

CPT and HCPCS items that are ordered in a Visit or Order Note will be designated as pending and overdue messages will be sent, via TaskMan, unless the items are marked as complete (results are in).

The Lab Tracking Window provides a patient specific view of pending labs/tests/procedures and allows those items to be marked as complete. At the top of the window identifying information including the patient's name, date of birth, gender and age are displayed. At the bottom of the window a split screen displays due dates, codes and descriptions for CPTs in the upper part and due dates, codes and descriptions for HCPCS in the lower part. Next to each CPT and HCPCS code is a check box.

To mark items as complete in Chart:

1. Open the Lab Tracking window from within Chart by clicking the Lab Tracking icon 
2. Click the check box next to the item or items for which results have been obtained.
3. Click the Save button to activate the changes.
4. This marks the items as done and prevents overdue messages from being sent for those items.

To mark items as complete in DocMan:

1. Open the Lab Tracking window from within DocMan by clicking the **Lab Tracking** icon  or click Tools then Lab Tracking on the main DocMan menu toolbar.
2. Click the check box next to the item or items for which results have been obtained.

3. Click the Save button to activate the changes.
4. This marks the items as done and prevents overdue messages from being sent for those items.

OR

1. Open a patient record.
2. Scan an item into a Category in DocMan that is set up for tracking in DocMan such as Labs or Radiology (see Lab Tracking in DocMan for details on setting up tracking categories).
3. Click **New Document** prior to scanning.
4. This will launch the Lab Tracking screen so pending items can be marked as complete (this will prevent overdue messages from being sent).
5. Click the check box next to the item or items for which results have been obtained.
6. Click the Save button to activate the changes.
7. This marks the items as done and prevents overdue messages from being sent for those items.
8. To finish the scan, select a document type along with the option to send or not send a message (with the scanned image attached) to the ordering provider as notification that the results have arrived.

OR

1. Open a patient record
2. Import an item into a Category in DocMan that is set up for tracking in DocMan such as Labs or Radiology (see Lab Tracking in DocMan for details on setting up tracking categories).
3. Click **Tools** then **Import Document** on the main DocMan menu toolbar.
4. This will launch the Lab Tracking screen so pending items can be marked as complete (this will prevent overdue messages from being sent).
5. Click the check box next to the item or items for which results have been obtained.
6. Click the **Save** button to activate the changes.
7. This marks the items as done and prevents overdue messages from being sent for those items.
8. In the next window pick the document to be imported and click Open.
9. In the Document Info window click the **…** button and select a provider to be messaged.
10. This will send a message to notify the provider that the results are available.

Tracking Radiology Results

When a user imports a radiology result (narrative report or image), the result is listed on the Radiology tab in the Lab Tracking window. The user can then take various actions by clicking the drop-down button in the Document Type field, selecting an option, and then clicking Save.

Remove From Tracking Options

The Remove From Tracking options allow the user to document that no further result is expected and to indicate whether the result received is a narrative report or image or combination of both. When a user selects one of these options and then clicks Save, several things happen:

- The result is removed from the Lab Tracking window.
- The result is linked to the CPT code in the chart.
- The result is flagged as an image or narrative report. (This information is used for certain Meaningful Use reports.)
- A note indicating the type of result received is appended to the Orders Descriptions column in the Order Tracking window.

Leave On Tracking Options

The Leave On Tracking options allow the user to leave the result in the Lab Tracking window and to document that a narrative result has been received and the image is expected (or vice versa). Selecting one of these options and clicking Save also links the result to the CPT, flags the result as an image or narrative, and appends a note to the Orders Descriptions column in the Order Tracking window.

Notification of Overdue Labs

The Lab Tracking module tracks labs, radiology tests, and procedures, and notifies the ordering provider when results for these items are calculated to be overdue. These notifications are sent in the form of a TaskMan message that contains information about the patient that includes the patient name and date of birth, as well as information about the overdue item that includes the calculated due date and the CPT or HCPCS code and description.

A total of three messages identifying overdue items will be sent to the provider, as well as to the medical assistant designated in the Visit Details of the note, when items are determined to be overdue. These messages will be sent on 3 consecutive days as reminders to investigate the overdue item. After the third and final message is received no more messages will be sent. These messages will be stored in a message category in TaskMan labeled Lab Tracking and any messages marked as URGENT will be designated as such by a red ‘P’ flag.

Notifying Additional Staff

By default only the Provider and Assistant listed in the Visit Details window of a note are notified of an overdue item. The Provider is a required field in the Visit Details but the Assistant is not, so be sure to list an ASSISTANT if you would like someone other than the PROVIDER of the Visit or Order Note to be

notified of overdue labs, tests, procedures. Additionally, other staff members can be chosen to be notified by using the **Groups** button at the top of the Lab Tracking window.

Note: Additional staff can be added either permanently or temporarily. Adding names temporarily can be useful for coverage of absences such as vacation schedules.

To select additional staff for notification:

1. Click the **Groups** button at the top of the Lab Tracking window.
2. A window labeled User Group will open displaying a list of users for the facility.
3. Select the desired staff member by clicking their name in the left column.
4. Click the right-pointing arrow in the middle column to add the selected name to the **Group** list (multiple names can be added to the list).
5. Once the desired name or names have been added to the **Group** list click the **OK** button to save the changes.

   Note: To remove a name from the list highlight the name and click the left pointing arrow in the middle column and then click the OK button to save the changes.

Setup Tracked Items

The Lab Tracking module tracks labs, radiology tests and procedures based on their CPT and HCPCS codes and a number of days value associated with the codes. This number of day's value represents the number of days that an item will be considered pending before it becomes overdue. For example, if a CBC has a number of days value of 7 associated with it and it is ordered in a Visit or Order Note, it will be considered pending for 7 days and will become overdue as of day 8 if no results are available within that time.

As part of the content included in the database that ships with Solution Series products, e-MDs provides default values for most labs, radiology tests, and procedures. These values are set based on the specific TYPE OF SERVICE (TOS) under which the code is categorized. The following table denotes the default values set in the database.

CPT (TOS)	HCPCS (TOS)	Due Date
Diagnostic Labs	Diagnostic Labs	2 weeks
Diagnostic X-Rays*	Diagnostic X-Rays*	3 weeks
Medical Care	Medical Care	8 weeks

*Mammograms are set to 6 weeks.

The tracking values set for these codes can be left at the default setting or if they do not meet the user's requirements they can be edited to reflect values based on an individual clinic's preferences.

Permanent changes to tracking must be made in the Billing Details of either the CPT or HCPCS reference menu.

Lab Tracking Rule

Lab Tracking works in conjunction with Rule Manager to track overdue rules. A default rule named **Lab Tracking** is installed with Rule Manager to accomplish this. As with any other rule in Rule Manager this rule can be set to run daily, weekly or monthly. As part of the default setup the Lab Tracking rule is set to run on a daily basis although to have rules run automatically the Windows Scheduler needs to be set up work with the Rule Manager. To set up the Windows Scheduler to work with Rules Manager see Set Up the Rule Schedule for details.

Note: When setting up Lab Tracking to run automatically, it is recommended that this rule be run at night since it may need to query a large number of records in the database depending on the size of the practice.

To disable this rule so that Lab Tracking does not occur:

To turn off Lab Tracking:

1. Login in to Rule Manager using the same login and password used for Chart.
2. Select the Lab Tracking rule by clicking it.
3. Click the **Edit Rule** button on the main toolbar of Rule Manager.
4. In the Edit Rule, clear the **Rule Active** check box.

Note: There is a Reset Lab Tracking button in the Lab Tracking rule window. This button will set all labs to a status of NOT being tracked and will also delete any automated Overdue Lab TaskMan messages that were sent notify users of overdue labs. This feature allows users to reset the system to start lab tracking over. It is especially useful in cases where Lab Tracking is not turned on immediately after the Chart product is installed. In those cases a large number of Overdue lab messages can accumulate.

Tracked items (CPT and HCPCS codes) can be edited to change their expected due dates or to turn them off completely. Tracked items can only be changed permanently in the Billing Details section of either the CPT or HCPCS Search module.

To edit tracked items permanently:

1. Log into e-MDs Chart and click the **Reference** menu item on the main Chart menu toolbar then select **CPT Search** (or **HCPCS Search**) from the popup menu.
2. Once the Search module opens, select a code and then click the **Details** button on the main toolbar.
3. The Lab Tracking setup is found below the **Code Valid** section of the Details section.
4. Check the ON box to track this code and set day(s) time line for overdue notices.

Edit of a Tracked Item on the fly can only occur within an open Visit or Order Note. It is anticipated that this will most likely occur at the time the order is created but can occur at a later time as long as the note has not been permanently signed.

To edit tracked items on the fly:

1. In the **PLAN** section of an open Visit or Order Note, add a CPT or HCPCS code. This can be done by clicking a lab or test item in a PLAN template that has Extended Attributes linked to it. click here for details

   OR

   By adding a CPT or HCPCS code under the **Orders** header in the PLAN Section of an open note click here for details

2. Once a code (CPT or HCPCS) has been added to the Orders section, click the code and select **Properties** from the popup menu

   OR

   Click the (In-House) or (Send-Out) text at the end of the CPT code description (this is for CPT codes ONLY).

3. The Order Properties window will open.

4. There is a tracking section in the bottom of this screen consisting of 4 fields: a **Track** check box, an **Urgent** check box, **a Due Days** field and a **Date Due** date field.
    - If the **Track** box is checked the code is set to be tracked.
    - Check the **Urgent** box to change the priority of the Overdue Message generated and sent by TaskMan. Once received in TaskMan, a RED "P" flag is added to this message if the Urgent box is checked.
    - If the **Track** box is checked a default value will appear in the **Due After** days field section. This default value can be changed for this instance only by typing a different number into the field.

      Note: To receive an Overdue Message the very next time the Lab Tracking rule is run, set this value to 0 days.
    - The **Due Date** is calculated from the Visit or Order Note date by adding the Due After day's value.
    - If the **Track** box is NOT checked the item is not set to be tracked. To set it to be tracked for this instance only, simply check the box and complete the **Due After** days field as well. The program will automatically calculate the **Due Date** based on the Visit or Order Note date by adding the Due After day's value entered.

Note: The **Stat** check box is for the *Printed orders form only*. It is NOT currently being used in Lab Tracking.

Setting Up Tracking Categories in DocMan

Categories can be set up in DocMan so that when a document is scanned or imported into that category the Lab Tracking window will automatically open to allow pending items to be marked as completed.

To set up tracking categories:
Privileges Required: *Immunization: DocMan Control Panel*

1. Log in to DocMan.
2. Click the **Control Panel** button on the main DocMan toolbar and select **Category**.
3. Click a specialty in the left column and then select a category such as **Labs** in the middle column.
4. Click **Edit** then check the **Set Lab Tracking** check box.

   This will launch the Lab Tracking screen any time an item is scanned or imported into that category.

View Graphed Lab Results in Chart

e-MDs provides a Graphing module that can be accessed from within both DocMan and Chart. When lab results are scanned into a patient's record, an image of the lab report is saved and the numeric results are not recorded in a structured way. In response, e-MDs has added the ability to graph lab results. Manual data entry is required, but is very easy to accomplish and can be performed while viewing the scanned lab report on screen. We do not expect that the user will want to graph every lab, but may have a few key data types (such as cholesterol or HgbA1c) that are worth the effort. More information about graphing lab values is available in the Graphing Lab Results in DocMan section of the help and User Guide.

See the following sections for more information:

- Create Data Types to Graph
- Add Data Points to a Graph

- Edit or Delete Data Points from a Graph
- View All Graphed Labs for a Given Patient

To access graphing from within Chart:

1. Open Chart and open the appropriate patient's record.
2. Click the **Graph** button (with the yellow cog icon) on the patient-specific toolbar just below the blue bar with the patient's name and demographic information.

   This opens the Image Data/Graph window. All Data Types that have previously recorded values for the given patient are listed in the Patient Results window.
3. Highlight the desired **Data Type** in the Patient Results window.

   When a Data Type is selected, the upper right window displays all prior values for this Data Type as a graph, and the lower right window displays the results in a grid.

   The graph is titled with the Data Type and Patient Name, and represents numerical results over time. Red and blue horizontal bars represent expected maximum and minimum normal values, respectively. Plotted values are identified by black squares with yellow labels that display the individual numerical results. Successive values are connected with a black line. The horizontal axis, representing time, will lengthen or narrow depending on the number of plotted points.

Referral Authorization Window

The Referrals/Authorizations window provides the user with the ability to track multiple referrals per patient. It is designed to be an on-screen processing tool although a hard copy printout of data can also be generated.

Note: The Referrals/Authorizations window is a Practice Management module. Access to this module is dependent on the clinic having the billing component of the Solution Series. *If e-MDs Bill is not present, this module will not be accessible.*

Referral Authorization Window Options

Referral Authorization	
Retrieve	Retrieves a list of referrals based on filter settings.
New	Click this to create a new referral.
Edit	Opens the highlighted referral in edit mode.
Select	Used when selecting a referral from other parts of the system, such as when browsing from an invoice to link a referral to a claim.
Print	Prints the referral report.
Edit Patient	Opens the patient demographics form for the patient whose referral is currently highlighted.
Print Form	Opens the Word forms module. The system automatically selects the patient in the referral/authorization highlighted at the time the button is clicked.
Reset Filter and Filter	These are the buttons at the bottom left . If a work list has already been retrieved, the Reset Filter button can be used to return filter settings to their defaults. The Filter button is used to update the list if any filter criteria have been changed with a list already loaded.
The following filters are available for work list creation.	
Authorization Start Date Range and Authorization End Date Range	By default the system will use the start date as the search range so the box for this is checked. To use the end date range, check the box above that filter. You can use both at the same time. Enter date ranges.
Facility	Shows referrals for this facility, or all facilities to which the user has access rights.

Patient	Shows referrals for a specific patient.
PCP/Referring Physician	On the referral.
Specialty	The list can be filtered by the specialty of the PCP/Referring Physician on the referral.
Specialist	The first specialist on a referral.
Insurance	Patient primary insurance.
Provider	Patient's primary provider .
Show Default Referral	Default referrals are entered in the patient demographics file but are still stored in the authorizations tables. They are displayed in red in the referrals module but are excluded from the search list unless this box is checked.
# Days Until Expiration	Tracks against the authorized date range of a referral. This can be filtered for any number of days, referrals with at least or less than a number of days, and a specific count. This filter is useful for finding referrals that are expiring, but may have a high count of visits authorized remaining.
# of Remaining Visits	Tracks against the authorized visit count. This can also be filtered by any number of remaining visits, referrals with at least or less than a number of visits, or a specific visit count remaining.
Type	Filters by the inbound and outbound classifications.
Status	Filters by the Active, Inactive or Pending classifications.

Referral Workflow

This section is a brief explanation of how you might use the referral/authorization tool in your office.

- **Create a Referral "Order":** The office needs to get a referral for a patient (inbound, or on behalf of a patient being sent to another specialist). Nurse or other staff member goes to the referral tool and creates a pending referral.
- **Convert Pending Referrals by Getting Authorization:** The staff member assigned to this functional task creates a work list in the referrals window and calls the insurance companies listed for each pending referral. Information required by the insurance is looked up from within the window by opening the patient or the pending referral order. When the authorization is received, the number and other data is added to the referral, and the referral is changed to Active.
- **Notify Patient and Specialist:** When the authorization is received (or denied), the staff member can contact the patient and schedule an appointment, or tell them to contact a recommended specialist in their network. A referral authorization information sheet can be printed for the patient to take with him/her. It includes information about the patient, insurance and referral and is useful for staff members in other offices.
- **File Claims:** The active referral is linked to invoices and tracked automatically.
- **Ensure Compliance:** If necessary, someone can generate a referral work list to find referrals that are expiring but where there are still authorized visits remaining.

Adding a Referral/Authorization

An unlimited number of referrals can be added to a patient. Referrals are either inbound (applicable to this organization for tracking purposes), or outbound. They can also be tracked as pending, active or inactive. These classifications affect whether the referral is a work list for a user, tracked by the system, or historical.

To create a Referral Authorization:

1. Go to **Tools** > **Referral/Authorization** (Alt+T, R). Alternative methods of accessing the referrals module which may be more convenient depending on work flow are:
   - Click the **Referrals** button in the Schedule Check In module. This saves having to search for a patient when creating the new referral since the person is already known.
   - Double-click the **A** column in the Bill daily work list. This also filters for the patient, saving keystrokes.
   - From within an invoice, click the **Find** button next to the **Referral** field.
2. Click **New** (Alt+N). If loaded from the Tools menu, a patient must be searched for and selected first.
3. In the Patient Referral window, fill out fields as required. See Referral/Authorization Window Options for a description of available options.
4. Click **Save** to store the referral. The system will ask if this is the Active referral. If so, click **Yes**. Subsequent invoices for the patient will be tracked against it. If the referral status is **Not Active**, another pop-up asks for verification.

Referral/Authorization Window Options

Referral/Authorization	
Medical Facility	Referrals are facility specific for tracking purposes. The default is the facility in which you are working, but another can be selected if necessary.
Inbound/Internal, Outbound/External	Set this based upon whether the referral will be tracked for billing purposes in this office (internal) or by another clinic to which the patient is being referred (external). Only inbound referrals are tracked for warnings.
Status	Pending indicates a referral that needs to be authorized by insurance. Users can run a report of all pending referrals and use it as a work list. Active referrals are ones that can be used for billing and scheduling tracking. Inactive referrals are retained for historical tracking. The status type is summarized in the referral view with codes of A, I and P.
Authorization Number	The number issued by the insurance company for the treatment.
Referral Number	Additional referral identifier that may be assigned by the insurance company.
PCP/Referring Physician	The person that will be identified on claims as the referring physician.
Specialist, Second Specialist	Up to two physicians authorized to perform treatment can be entered, e.g. a surgeon and an anesthesiologist.
Approved Visit Count	Set to the number of visits authorized for the treatment. Based on the Setup Options to track authorizations by appointment or invoice, the **Remaining** field decrements by 1 for each invoice tagged to this referral. When the number remaining has expired, users get warnings when scheduling or invoicing patients.
Start and End Date	Enter the date range within which treatment must be rendered.
Allowed Amount	Enter the maximum allowed amount. If an invoice allowed balance exceeds the **Remaining** amount, a warning appears upon saving. If the remaining amount is <= 0.00, a warning will also be issued when trying to schedule an appointment.
Out Patient	Check the box. This is for information only.
Comment	Type a comment into the field to give more information about the referral, or click Find to select a standardized comment from the comment reference table. A combination of a standard comment and free text is permitted.

ICDs	Type ICD codes into the field then press Enter or click Add for the codes to appear in the list. When an invoice is created with codes that are not part of a referral linked to the invoice, the system warns users upon saving. To remove an ICD, click Remove.
CPTs	Enter CPT code ranges for the procedures authorized. For a single code, enter the same code in both the start and end fields, then click add. Custom sets of authorized codes can be created in a Referral Types support table (see Referral Types on page 48). Click Find to browse and select a type. To remove a CPT, click Remove.

The referral authorization sheet can be used by staff as a checklist for working a referral, or can be given to a patient to take to a specialist, etc. It prints all the patient, physician and insurance demographics, as well as details about the referral.

To print a referral/authorization:

1. Select the referral in the Referral/Authorization window and click **Edit**.
2. Click **Print** in the Patient Referral window.
3. Select a printer and click **OK**.

Note: A custom referral form can also be generated using Word forms and then printed by clicking the Print Form button in the Patient Referral window.

This feature allows users with the Chart: Secure Chart privilege to determine who can and cannot access a specific patient chart. Chart Security allows users access to charts in general, but can be set to block certain users from accessing particular patient charts. This feature is useful when there is a need to lock access to charts of staff members (who also happen to be patients), charts of a celebrity or other VIP patients, patients with privacy issues such as HIV, mental health, or other patient charts where there is a need to limit access.

To set security for specific patient charts:

Privileges Required: *Chart: Secure Chart*

1. Within a Patient chart, click the **Padlock** icon  .

   Users can be moved to the “Excluded Users” window on the right by highlighting the user’s name and using the middle arrows to move them. Multiple users can be selected by holding down CTRL on the keyboard or select all users by clicking the double black arrows.

2. Click **Close**.

4
Prescribing and Refilling Medications

This section provides instructions on how to use the Solution Series script tools to prepare and submit new prescriptions, approve and submit refills, check for drug-drug and drug-disease interactions, and work with a patient's formulary to ensure proper insurance coverage. The features covered are:

- Using Script Writer to search for drugs and their descriptions; write new prescriptions; and refill current and past prescriptions.
- Processing new prescriptions and refills through print, fax, phone and electronic transmission (using SureScripts).
- Using prescription tools to effectively support these requirements. Those tools include:
    - **Prescription Tracker** to follow and report the status of prescriptions (especially the processing of electronically submitted prescriptions).
    - **Dose Calculator** to compute the appropriate therapeutic dose range for a selected drug based on the patient's age, weight and diagnosis.
    - **Quick Picks** to list the most commonly prescribed drugs used in a particular practice.
    - **Phone-In Script** module to manage prescriptions to be called in to a pharmacy.
    - **Medication Reconciliation** to reconcile a list of medications from an external source with the medications previously or currently prescribed in the current facility.
    - **Refill Request** module to manage requests for refills received from pharmacies.

Continued on the next page ....

Understanding Script Writer

Script Writer is a prescription generator with the following features:

- A search mechanism to find a drug by name or by therapeutic class.
- Access to Drug Consults which consist of summary information about the medication's indications, contraindications, dosing, pregnancy and lactation warnings, adverse effects, drug interactions and precautionary information.
- Automatic Drug-Drug and Drug-Disease Interaction checking with warning messages and recommendations where appropriate.
- Automatic Drug Allergy and Drug Adverse reaction checking.
- Choice of printing, faxing, electronic or phoning in prescriptions.
- A Quick Pick generator, which creates a short list of complete prescriptions frequently used in the facility that enables one click generation of prescriptions.
- Ability to check for other available brands, forms or strengths of a drug.
- Ability to view list of similar drugs that exist within the same therapeutic class.
- Option to print Patient Recommendations specific to the medications prescribed.
- A Dose Calculator that indicates whether a selected sig for a medication falls within the daily Minimum and Maximum dose range based on diagnosis and patient weight.

e-MDs offers a Formulary Benefits add-on package that provides these additional functions:

- Ability to download a patient's Formulary Benefits Information (such as medication coverage, restrictions, and medication copay amounts) from Chart and Schedule applications.
- If a medication to be prescribed in ScriptWriter is non-formulary (not covered under patient's plan), provides a list of in formulary therapeutic alternatives for possible substitution.
- Ability to prescribe electronically to mail order pharmacies (if allowed by patient's plan).
- Ability to download a comprehensive list of all medications prescribed for a patient. The list includes prescriptions written by all providers and filled by any pharmacy, and that were processed through the PBM.

Contact e-MDs for more information or to purchase Formulary Benefits.

See *e-MDs Solution Series Formulary Benefits User Guide* for details about how these functions work within ScriptWriter.

Writing New Prescriptions

There are several ways to write new prescriptions, including:

- Searching for and selecting a drug in the Medications section of the **Visit Note/HS** (Health Summary) tab.
- From the Current Medications List and Visit Notes.
- From copies of new or existing prescriptions that are then changed to meet the patient's needs..
- From Quick Pick lists that identify frequently prescribed medications.

Searching for a Drug

When Script Writer is opened (as described below), the Prescribe a Drug window opens. This is the drug search window. Medications can be found in the database either by name (brand or generic) or by therapeutic class.

To search for a drug:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left windowpane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. In the Health Summary, under the **Medications** header, click the **Write New Script** button on the right side of the Current Medications window. It is the top button, with the **Rx** pad icon.

   OR

   In the Health Summary, under the **Medications** header, click the **Refill Medication** button on the right side of the Current Medications window. It is the second button, with the Rx bottle icon; this will open the Refill Grid (Medication List grid). Click the **New** button on the toolbar to open the drug search screen (Choose Medications).

   OR

   From within an active Visit or Order Note, in the **Plan** section, click the underlined text titled **Prescriptions** or **Other Prescriptions**. This will open the Refill Grid (Medication List grid). Click the **New** button on the toolbar to open the drug search screen and write a new prescription.
4. To find a drug by name, type a few letters of the drug name (brand or generic) in the search field labeled **Drug**. As soon as the first two letters are entered, the search will automatically begin. All medications matching the search criteria will appear in the **Drugs** section. Results may also appear in the **Quick Picks** section if any exist for that drug (see Add/Delete Quick Picks for details).
5. To find a drug by therapeutic class, click **Find** in the toolbar and select the **Find by Class** menu option. This will open a Find Drug by Class window. Type in a Class Description ("beta blocker" for example) and press **Enter** or click **Search**. All drug classes that match the search criteria will appear in the upper window.
6. Select a class in the upper window to display all member drugs in the lower window. Double-click a drug name in the list to open the Script Pad so that a prescription can be written.

   Note: The search criteria defaults to **Begins With**. To change the search criteria, click the buttons marked **Contains** or **Exact Match**.

Writing a New Prescription from the Current Medications List and Visit or Order Notes

New prescriptions can be written from the Current Medications list and from an active Visit or Order Note.

Important! Keep in mind that *no one* can write a prescription unless they have the correct privileges. Even if a provider has all script writing privileges, no prescriptions can be written under their name unless the person logged in *also* has script writing privileges.

The Medical Assistants security group is given ScriptWriter Non-Schedule privileges by default. If a provider wants to limit the ability of a Medical Assistant to write *any* scripts, this privilege needs to be removed from that particular security group. Additionally, if a provider wishes to delegate authority to Medical Assistants to write *all* types of prescriptions, the ScriptWriter Schedule 3-5 and ScriptWriter Schedule 2 privileges need to be added to the security group. See *e-MDs Solution Series Administration Guide* for more information about security groups and privileges.

Notes:

- Prescriptions written from the Current Medications list cannot be deleted, but they can be discontinued.
- Prescriptions written in a Visit or Order Note can be edited or deleted up until the point that the note is permanently signed off.

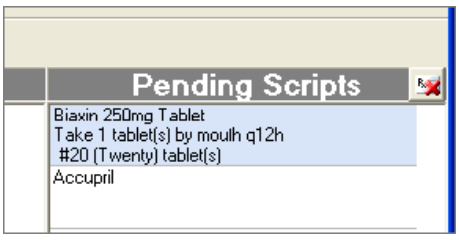
To write a new prescription from the Current Medications list:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left window pane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.
3. In the Health Summary, under the **Current Medications** header, click the **Write New Script** button on the right side of the Current Medications window. It is the top button, with the Rx pad icon.

   Note: If a message displays indicating you must select a provider responsible for this prescription, locate and select a provider on the Find Active Staff Provider screen and save that change.

   The Choose Medication screen appears.
4. To find a drug by name, type a few letters of the drug name (brand or generic) in the search field labeled **Drug**. As soon as the first two letters are entered, the search will automatically begin.

   All medications matching the search criteria will appear in the **Drugs** section. Results may also appear in the **Quick Picks** section if any exist for that drug (see Add/Delete Quick Picks for details).
5. If an appropriate Quick Pick exists, double-click the item in the **Quick Pick** section, or highlight it and click **Prescribe**.

   The Quick Pick information will appear in the **Pending Scripts** pane on the right side of the Prescribe a Drug window.

   Note: If you want to make changes to Quick Picks, you can do so in the Refill Grid (also known as the "Medication List grid") after the Choose Medications window closes
6. If no matching Quick Pick entry exists, double-click the medication name from the **Drugs** section, or highlight it and click **Prescribe** to add the selected drug to the **Pending Scripts** pane. See the example image below where Biaxin was chosen as a Quick Pick and Accupril was not.

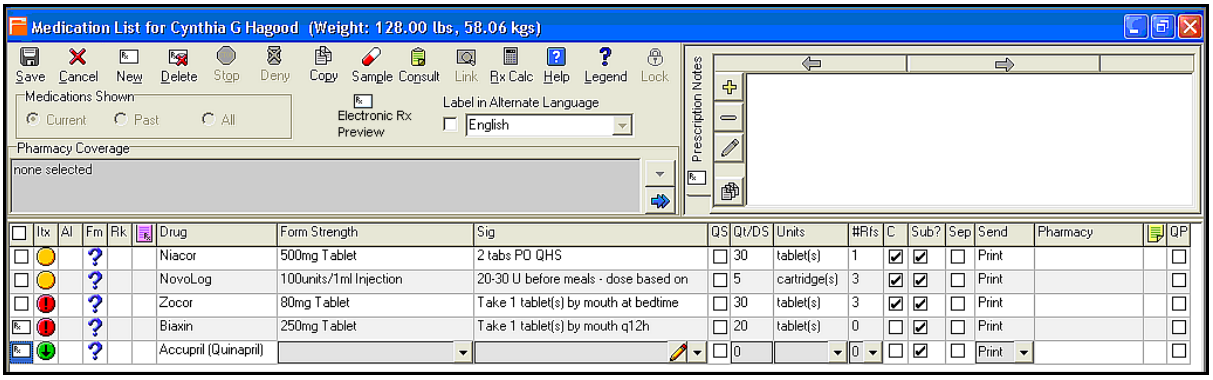
You will have the opportunity to complete the prescription in the Refill Grid window (see Refill Grid for an overview of the interface).

7. Repeat the process if you are prescribing more than one medication.

   Note: If a medication is inadvertently added to the **Pending Scripts** pane, you can click the button in the top-right corner to remove it from the pending scripts list.

8. Click the **Next** button and the Medication List/Refill Grid opens.

   This screen displays all Current Medications in a grid format. The new prescription(s) just written will appear at the bottom of the list and will be identified by a script pad icon in the first column.



Notes:

- The Quick Pick item (Biaxin, in this example) is completely filled out. If it does not need changes, you can click the **Save** button to prescribe the medication. If the Quick Pick item *does* need changes, you can make the changes by clicking the appropriate cell on the row of the medication that needs modification. For example, if you want to change the quantity, click in the cell under **Qty/DS**. The cell then becomes active and changes can be made (the cells are highlighted when active).
- The non-Quick Pick prescription (Accupril in this example) shows only the drug *name*. In this situation you *must* fill in the information for Form strength, Sig, QS OR Qty/DS, Units, #Rfs, C, Sub?, Sep, Send and possibly Pharmacy (if the Send method is Fax, Phone or Electronic).

If the patient is being given sample drugs, you can document that transaction by clicking the **Sample** icon to open the Select a Drug screen. From there you can search for and select the drug being given, then complete the Edit Medication Sample screen to describe the sample. After saving that information, the sample entry will appear in the Medication List with a light blue background and the **Sample** icon in the first column. Note that samples can be refilled like any other medication, if desired.

9. After all changes are made, click the **Save** button to complete the prescription writing process.

   If Electronic is selected as the Send method, and Surescripts has been implemented, an Electronic Rx Preview window is displayed so you can review all prescription details.

10. If all details are correct, click **OK** to save the prescription and proceed to the Sending Prescriptions dialog box. (If you click Cancel, you will return to the Medication List and nothing is saved.)

    If the prescription is to be printed, faxed or sent electronically, a Sending Prescriptions dialog window will open with **Send** and **Don't Send** choices.

Important! Some states allow controlled substances to be electronically faxed and others have more stringent requirements. By default, e-MDs software does not allow electronic faxing of

Schedule 2 (controlled substance) prescriptions. You must check individual state regulations to verify whether or not you can use the prescription faxing option for your controlled prescriptions.

11. Select Send to process the prescription,

    OR

    Select **Don't send** to just record the prescription in Chart.

    Note: Phone-In prescriptions will not have the Sending Prescriptions dialog because the prescriptions will automatically be listed on the phone-in list. See Phone-In Script Module.

To write a new prescription from a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

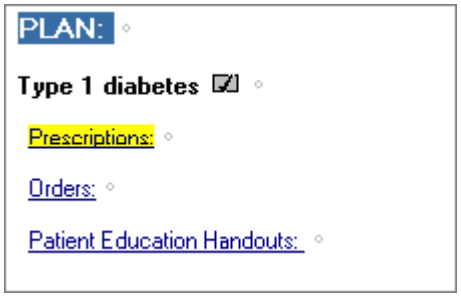
   The **Plan** section of the note will display each diagnosis from the **Assessment** section.

2. Select the correct diagnosis header (displayed in bold black text) and click the **Prescription** header that is listed below it. This will open the Refill Grid.

   Note: The Refill Grid opens so that you can write a new prescription or refill an existing one.

3. Click the **New** button on the toolbar of the Refill Grid to open the Choose Medications (the Drug Search) screen.

   The process for writing a prescription in this manner is the same as writing it from the Current Medication List. See Write a New Prescription from the Current Med List for details.



Prescriptions can be written directly from templates if the template item has an Extended Attribute of Prescription linked to it (see Prescription Extended Attributes for details)

To write a new prescription from a template:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

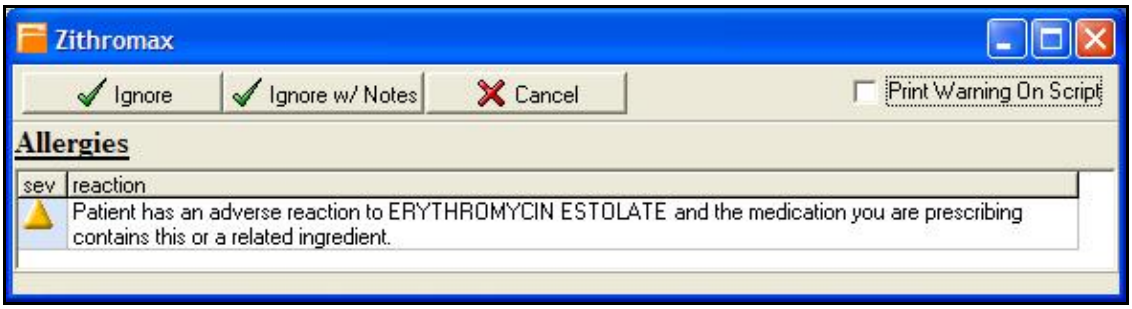
   The **Plan** section of the Visit or Order Note will display each diagnosis from the **Assessment** section.

2. Select the correct diagnosis header (displayed in bold black text), and open the template for that diagnosis

3. In the PLAN templates **Medication** section, click the medications question and select the desired drug from the following levels.

   Note: Questions that have a Prescription Extended Attribute linked to them will have a prescription pad icon on the right side of the question.

   At the time the question with a Prescription Extended Attribute is chosen, drug interaction and allergy checking will occur. If there are warning messages they will appear at this time.

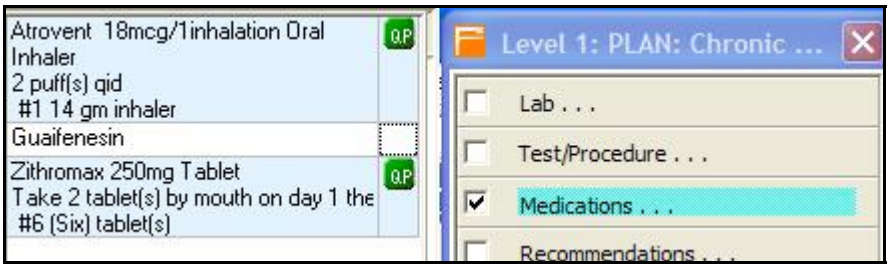


4. When a question with a Prescription Extended Attribute is chosen, the Diagnosis Navigator window (see Diagnosis Navigator for details) will change to display a list of the medications chosen in the template.

The list of medications will show the drug name on the left and a green Quick Pick icon QP on the right.

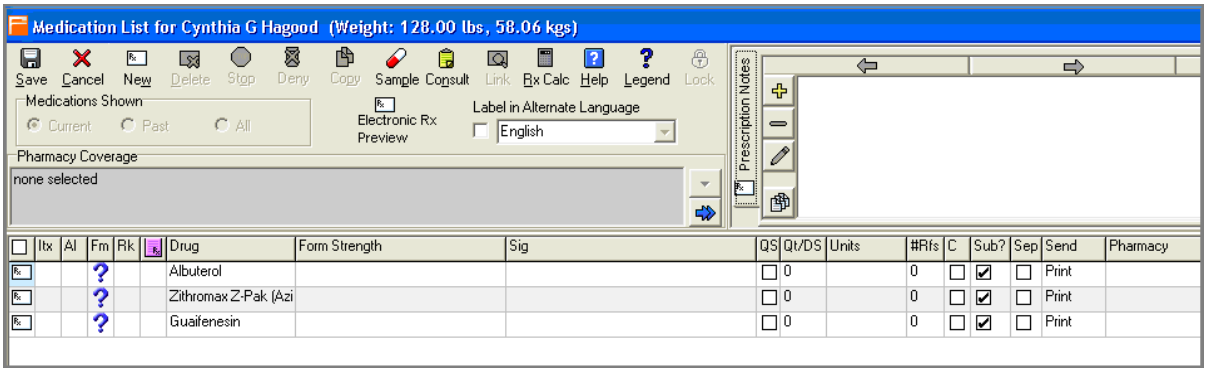
Note: The absence of a Quick Pick icon indicates that the medication does not have any associated Quick Picks. In the above example, the Guaifenesin does not have matching Quick Pick entries.

5. For those items that have Quick Picks, click the **QP** icon QP to access a list of Quick Picks entries.
6. Select the desired Quick Pick item from the list and double-click to select it. The medication list on the left will change to display the Quick Pick information.



7. When finished documenting the PLAN, close the template.

   A modified Refill Grid will open, displaying *only* those medications that were written in the template.



The medications with Quick Picks chosen will have all the information filled out while those without Quick Picks will only have the drug name.

Note: If the patient is being given sample drugs, you can document that transaction by clicking the **Sample** icon to open the Select a Drug screen. From there you can search for and select the drug being given, then complete the Edit Medication Sample screen to describe the sample. After saving that information, the sample entry will appear in the Medication List with a light blue background and the **Sample** icon in the first column. Note that samples can be refilled like any other medication, if desired.

8. Make any needed changes. For example, with Quick Picks you may want to change the send method and pick a pharmacy. Or, with the medications that do not have Quick Pick entries, you will need to fill out the pertinent information (such as form strength, sig, qty, etc.).
9. Click **Save** when finished

   The medications will appear under the **Prescription** header under the appropriate diagnosis.

Copying a Prescription

The copy feature enables a similar or duplicate prescription to be written without exiting the Script Pad or performing another drug search. This is helpful, for example, if a mail-in prescription is written for a three-month supply of a medication. In this case, the patient may also need a short-term prescription for the same medication to be filled at a local pharmacy.

To copy an existing prescription:

Note: From within the Refill Grid you can only copy prescriptions that are being refilled. See the "Refill Grid" section for details on the grid.

1. Click the refill check box to the left of the medication to be refilled.
2. After the medication is selected for refill, click the **Copy** button on the Refill Grid toolbar.

   The prescription will be copied and will be displayed at the bottom of the grid with a **Copy** icon (two pieces of white paper) replacing the refill check box
3. Make any desired changes to the original or the copy and, when finished, click the **Save** button.

To create a new prescription and then make a copy:

1. Write the first prescription as usual (see Write a New Prescription from the Current Med List for details).
2. When finished, click the **Copy** button (instead of clicking **Save).**

   The prescription will be copied and will be displayed at the bottom of the grid with a **Prescription Pad** icon replacing the refill check box
3. Make changes to the prescription, as needed.

4. Click the **Save** button when finished.

   Note: If the form and strength of the drug are identical in both prescriptions, the medication will appear only once in Current Medications. However, if the plus sign is clicked to expand the medication, both active prescriptions will be displayed.

Refilling Prescriptions

There are several ways to refill prescriptions, including from the:

- Current Medications List (in the Health Summary)
- Visit and Order Notes
- Past Medications List
- Refill Grid
- Refill Module

Refilling Prescriptions from the Current Medications List

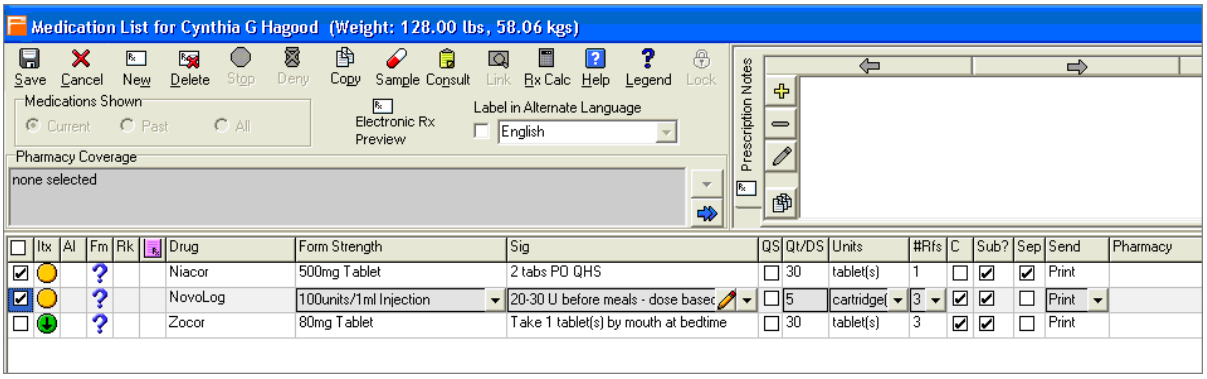
Prescriptions can be refilled from the Current Medications list (in the Health Summary) and from an active Visit or Order Note.

To refill a prescription from the Current Medications list:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left window pane.
2. Click anywhere on the blue bar labeled **Medications** to open that section.
3. In the Health Summary, under the **Medications** header, click the **Refill** button on the right side of the Current Medications window. It is the second button from the top and is a prescription bottle icon.

   The Refill Grid will open. It displays all current medications in a grid format.
4. To refill a medication, click the check box to the left of each medication that is to be refilled.

   Note: You can click the check box at the top of the first column to select *all* medications for refill.



5. Make changes to the medication by clicking in the cell that needs to be changed (the cells are highlighted when active). For example, if the quantity is changing, click the **Qty/DS** cell and change the quantity.
6. When all desired medications have been selected, and any changes have been made, click the **Save** button to refill the medications.

Notes:

- When the Refill Grid opens, it shows Current Medications by default. You can select the **Past** or **All** radio buttons to show the patient's past medication list or all medications. Refills for past medications are submitted using the same method as for Current Medications.

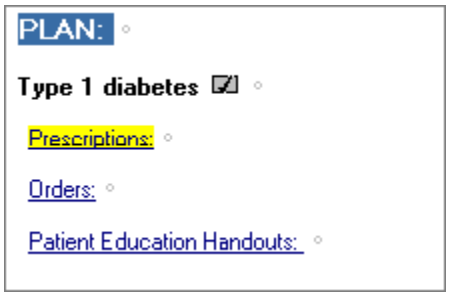
- If the patient is being given sample drugs, you can document that transaction by clicking the **Sample** icon to open the Select a Drug screen. From there you can search for and select the drug being given, then complete the Edit Medication Sample screen to describe the sample. After saving that information, the sample entry will appear in the Medication List with a light blue background and the **Sample** icon in the first column. Note that samples can be refilled like any other medication, if desired.

To refill a prescription from a Visit or Order Note:

1. In an active Visit or Order Note, scroll to the **Plan** heading or click the **P** button in the vertical button column to 'jump' to that section of the note.

   The **Plan** section of the note will display each diagnosis from the **Assessment** section.

2. Select the correct diagnosis header (displayed in bold black text) and click the **Prescription** header that is listed below it.

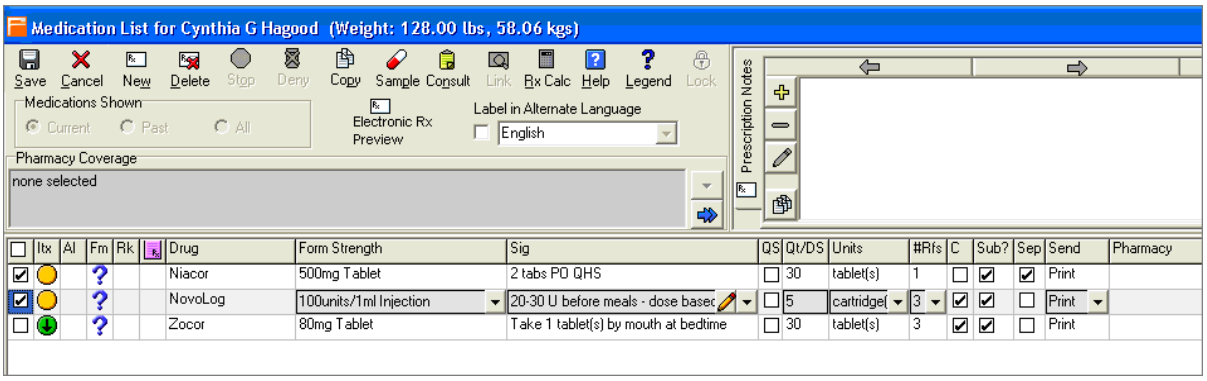
   

   This will open the Refill Grid which displays all Current Medications in a grid format.

   The Refill Grid opens so that you can refill medications or write a new prescription, as needed.

3. To refill a medication, click the check box to the left of each medication that is to be refilled.

   You can click the check box at the top of the check box column to select *all medications* for refill.



   You can make changes to the selected medication by clicking in the cell that needs to be changed (the cells are highlighted when active). For example, to change the quantity, click the **Qty/DS** cell and change the quantity.

4. When all of the desired medications have been selected, and any changes have been made, click the **Save** button to refill the medications.

   Note: When the Refill Grid opens, it defaults to show Current Medications. You can also select the **Past** or **All** radio buttons to show the patient's past medication list or all medications. Refills for past medications are submitted using the same method as for Current Medications.

Refilling Prescriptions from the Past Medications List

Medications that have been stopped are moved to the Past Medication List. These prescriptions can be refilled, if necessary. For refills, only the **With Changes** option can be selected. That option will open the Script Pad and allow you to make changes before filling.

To refill with changes/notes:

1. Within a patient's chart, click the **Visit Note/HS** (Health Summary) tab (below the blue horizontal patient identification bar.) The Health Summary is in the left window pane.
2. Click anywhere on the blue bar labeled **Current Medications** to open that section.
3. In the Health Summary, under the **Current Medications** header, click the **Past** button just below the **Current Medications** label.

   The display will change to show the past medications
4. Highlight the medication to be refilled and click the **Refill** button on the right.

   A menu item will appear with the options **As Is** (which is grayed out) and **With Changes/Notes**.
5. Select **With Changes/Notes**.

   The Script Pad will open with the prescription information fields already filled out.

6. Select a **Form Strength** (such as 250 mg tablets) from the drop-down list. All available Form Strengths for the selected drug should be in this list.
7. Select a **Sig** (such as 1 tab p.o. BID) from the drop-down list. Common Sigs for the selected drug will appear in the list.

   OR

   If an appropriate Sig is not in the list, either click **New** to create a new Sig or highlight an existing Sig and click **Edit**.
8. Select a quantity to be dispensed from the **Disp** drop-down list (quantities usually default to 30, 60 and 90-day supplies in the drop-down list) or type in a quantity to be dispensed. Select a unit to be dispensed (for example, Tablets, 30 gm tube, etc.)

   OR

   Alternatively, check **QS** (quantity sufficient) and select a number of days (for example, dispense QS 10 days).
9. Select the number of **Refills** authorized for the prescription.
10. Check or clear the **Allow Substitution** box. By default, every prescription is checked to allow (generic) substitution.
11. *OPTIONAL:* The **Label in Alternate Language** box can be changed. The default language is English and this message does not print on the label. This field is a message to the pharmacist to label the directions on the prescription in an alternate language (if possible) for the convenience of the patient.

12. Click **Save** when finished.

    If the prescription is to be printed, faxed or sent electronically, a Sending Prescriptions dialog window will open with **Send** and **Don't Send** choices.

    Important! Some states allow controlled substances to be electronically faxed and others have more stringent requirements. By default, e-MDs software does not allow electronic faxing of Schedule 2 (controlled substance) prescriptions. You must check individual state regulations to verify whether or not you can use the prescription faxing option for your controlled prescriptions.

13. Select **Send** to process the prescription.

    OR

    Select **Don't send** to just record the prescription in Chart.

    Note: Phone-In prescriptions will not have the Sending Prescriptions dialog because the prescriptions will automatically be listed on the phone-in list. See Phone-In Script Module.

Refilling Past Medications from the Refill Grid

In addition to refilling past medications directly from the Past Medications list, you can also refill past medications from the Refill Grid (Medication List grid).

To refill past medications from the Refill Grid:

1. Open the Refill Grid by clicking the **Refill** button. The Medication List grid (Refill Grid) will open.
2. In the section labeled **Medications shown**, click the radio button labeled **Past** to list past medications in the grid.

3. Select the past medication(s) to be refilled by clicking the check box at the left.
4. Make edits to the prescription(s), if desired.
5. Click **Save** when finished.

    Note: You can also choose to see *all* medications (current and past) in the same list by clicking the radio button labeled **All**.

Processing Prescriptions

There are a number of ways you can process a prescription with Solution Series:

- Print a prescription and give it to the patient.
- Call a prescription in to a pharmacy.
- Fax a prescription directly to a pharmacy.
- Transmit a prescription electronically.

The method you use will depend on a number of factors, including:

- The patient's current location – at the office or elsewhere. If the patient is in the office, he/she may prefer to have a written prescription to carry to the pharmacist or for another reason.
- The availability of pharmacies and what types of prescriptions they will accept – printed, telephone, faxed or electronic. The patient's preferred pharmacy may not accept all types of prescription submissions.
- If the prescription is for certain types of controlled medications, the prescription cannot be faxed in most states. Local, state and federal regulations play a part in how certain drugs are ordered, dispensed, and tracked.
- You may not currently have SureScripts installed at your facility. See Transmitting Prescriptions Electronically for more information on this interface module.

In the end, it all comes down to what works best for your organization in any given situation. Solution Series provides the flexibility to use the appropriate tool for each and every circumstance.

Printing Prescriptions from Script Writer

Before you ever write or refill a prescription in Solution Series, you must set up your preferences for all printed prescriptions. This is not only selecting a printer, but also includes identifying what should print o the prescription in addition to the drug-related information. This might include the name and address of your facility, specific license numbers and provider information, and much more. See the *e-MDs Solution Series Administration Guide* for instructions on setting user preferences for your facility for script printing.

After setting your user preferences, you can just select **Print** in the **Send** column of the Medication List grid.

Calling In Prescriptions to Pharmacies

One of the most frequently used methods of processing a prescription is to call it in to the patient's pharmacy of choice. If this is your preferred method, all the necessary information should have already been entered in the patient's chart.

If the pharmacy information is place for the patient, you can select Phone in the Send column of the Medication List grid. This will pass the necessary information to the Phone-In module for processing. This prescription information, along with other patients prescription information, will be queued for calling in on a scheduled basis. See Phone-In Script Module for how this feature works.

Faxing Prescriptions from Script Writer

A few things need to be set up in advance for seamless faxing from Script Writer. See the *e-MDs Solution Series Administration Guide* for how to:

- Add pharmacies to the database.
- Set up the faxing printer.

To write and fax a prescription in Script Writer:

1. Select **Fax** in the **Send Options** area of the script pad.

   A **Pharmacy** field will appear.

2. Begin typing the name of the pharmacy or click the small down arrow in the field to scroll the list.

3. Click the desired pharmacy to select it.

   There is nothing more to do! At the time of Note Conclusion, the prescription(s) will be routed to the fax printer and faxed.

If the prescription is faxed from Current Medications instead of inside a note, a Sending Prescriptions dialog window will open with **Send** and **Don't Send** choices. Selecting **Send** will process (fax) the prescription, **Don't send** will just record the prescription in the patient's chart.

Legal Issues with Faxing Prescriptions

Important! Some states do not allow faxed prescriptions at all and others have more stringent requirements. e-MDs software does not currently support electronic submission of Schedule 2 (controlled substance) prescriptions.

You must check individual state regulations to verify whether or not you can use the prescription faxing option. Faxes generated from e-MDs Chart include a printed line at the top allowing the pharmacy to verify that the fax did indeed originate from the physician's office as well a footer with information that includes the following statement:

> "This prescription has been electronically generated by e-MDs Solution Series and faxed to: <Pharmacy Name>, <Pharmacy Address>, <Pharmacy Phone Number>, <Pharmacy Fax Number> on <Fax Date and Time> by <Full Name of Person Logged In and Title>. "

This footer meets the requirements for faxed prescriptions in some specific states and, together with the signatures, should cover the majority of states that allow faxed prescriptions.

Signatures can be scanned and attached to faxed prescriptions (for faxed prescriptions only) in those states that allow this feature. See the Utilities Guide: "Signatures" chapter for details.

Transmitting Prescriptions Electronically

The ability to send prescriptions and receive refill requests electronically is included as part of the Script Writer functionality. The electronic transmission of prescriptions is performed through SureScripts, a third-party vendor. SureScripts acts as a "clearing house" for prescriptions and e-MDs works in conjunction with them to ensure compatibility with the Script Writer module. This functionality permits prescriptions to be sent through a very secure connection to the e-MDs server, then on to SureScripts. SureScripts then forwards the prescriptions to the designated pharmacy and an acknowledgement is sent back to the prescriber.

Refill requests can also be sent from the pharmacies to the clinic electronically. These electronic refill requests will show up in the Refill Request module and they will be designated as having come from SureScripts. See Refill Request Module for more information on electronic refill processing.

Important! While there is no licensing fee charged by e-MDs for the SureScripts functionality, there is a nominal setup fee that must be paid before this new feature can be used. Until you purchase the implementation service and e-MDs Support staff sets up your clinic for electronic prescriptions, you will not see any of the electronic features of the system. You can request information about implementing SureScripts by contacting the e-MDs Sales Department.

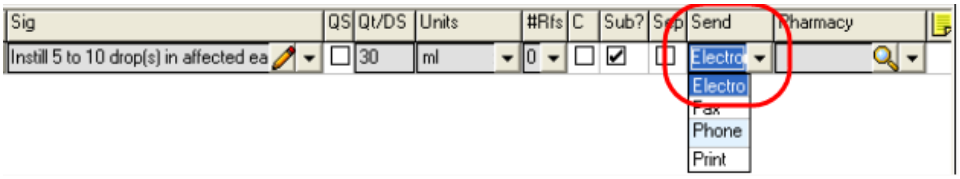
See the *e-MDs Solution Series Administration Guide* for information on setting up, maintaining and troubleshooting SureScripts for electronic prescription processing.

If you select **Electronic** in the **Send** column of the Medication List grid after SureScripts is implemented, Script Writer passes the prescription to SureScripts for processing.

Note: Recently the DEA approved the electronic prescribing of controlled substances (EPCS) for Schedule 2, 3, 4, and 5. However, there are some stringent requirements that must be met before that processing is allowed. e-MDs is currently working on requirements and business relationships that will be needed to support that functionality. At this time, Script Writer will not allow you to select the **Electronic** send method if the prescription is for a Scheduled medication. When this functionality has been fully implemented, e-MDs will publish that information to Solution Series users.

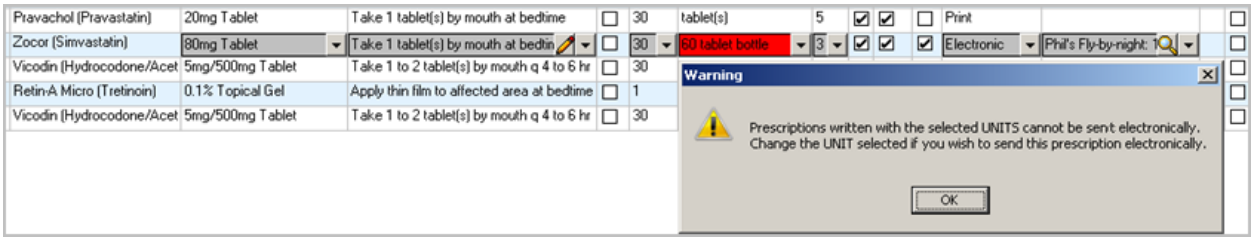
To send a prescription electronically using SureScripts:

1. When you complete a prescription in e-MDs Chart, select **Electronic** as the **Send** method.



Note: Accurate electronic transmission of the prescription requires selection of a specific quantity for a single unit. For example, to prescribe 20 ounces of a medication, you must select *Quantity: 20* and *Unit: ounce*, rather than *Quantity: 1* and *Unit: 20 ounce bottle*. See Writing New Prescriptions for more detailed information about entering prescriptions in the electronic medical record.

Important! Units that appear light grey are flagged Units that cannot be sent electronically. Those Units can be viewed for packaging and/or saved for Phone, Fax or Print transmission. Selecting a flagged Unit for electronic submission will change the Unit to red and incur a Warning message. The Unit or Send choice must be changed to save the prescription.



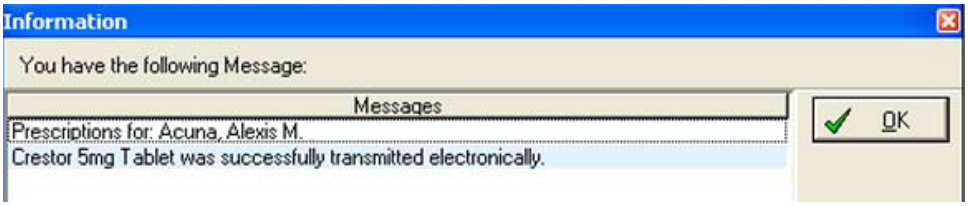
2. Click **Save**.

   If Electronic is selected as the Send method, and Surescripts has been implemented, an Electronic Rx Preview window is displayed so you can review all prescription details.

3. If all details are correct, click **OK** to save the prescription and proceed to the Sending Prescriptions dialog box. (If you click Cancel, you will return to the Medication List and nothing is saved.)

4. In the Sending Prescriptions dialog box, click **Send**.

Solution Series Chart processes the prescription for transmission and displays a message that *may* indicate successful electronic transmission. This message refers to transmission from Chart to SureScripts, but it *does not* indicate that it was successfully transmitted from SureScripts to the pharmacy.



For information about checking the status of transmission from SureScripts to the pharmacy, see To check a prescriptions electronic transmission status.

Important! Be aware that transmission status provides information about delivery of a prescription; it *does not* confirm that a pharmacist has reviewed the request or that the prescription is being filled.

Troubleshooting Electronic Prescription Processing Issues

If you encounter an issue when attempting to transmit a prescription electronically, please provide the prescription to the pharmacy via fax or telephone immediately to avoid a delay in filling the prescription for the patient. Then contact e-MDs Support within 24 hours. You can contact e-MDs Support at 800-565-5564 or https://supportcenter.e-mds.com.

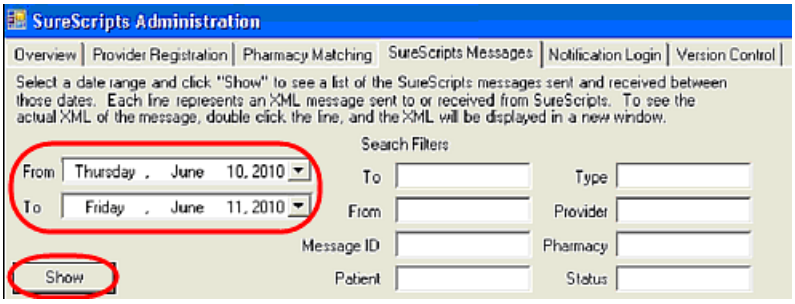
When you contact the Support Center, please provide the following information:

- Provider's SPI number (see To find a provider's SPI number)
- Message ID for the prescription (see procedure below)
- Name of the pharmacy to which the prescription was sent
- Date prescription was sent

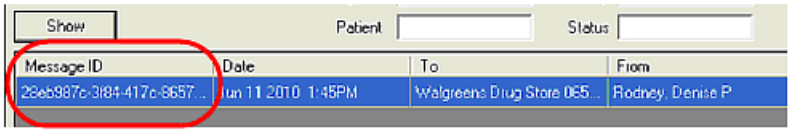
Important! To effectively troubleshoot an e-prescribing issue, e-MDs Support *must* have access to information contained in the message details. These details are retained in the system for *15 days from the date of transmission*.

To check electronic prescription details and transmission status:

1. In e-MDs Chart, access the SureScripts Administration module (**Tools > SureScripts Administration**) and click the **SureScripts Messages** tab.
2. Select the **From** and **To** dates, then click **Show**.



The message ID is shown in the first column, with message details to the right of the message ID.



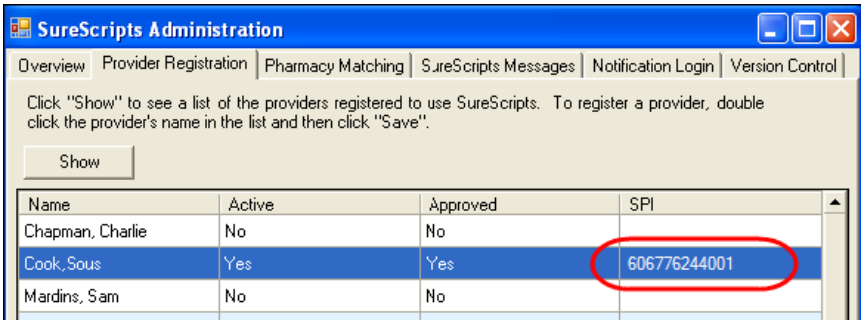
The last column in the message details shows the status of the message.

- A status of **Successful** means that SureScripts received the prescription and forwarded it to the pharmacy, and the pharmacy software confirmed delivery.
- A status of **Unknown** means that SureScripts received the prescription and forwarded it to the pharmacy, but the pharmacy software *did not* confirm delivery.

Note: If a pharmacy denies receipt of a prescription, but the transmission status shows **Successful** or **Unknown**, please contact e-MDs Support (800-565-5564 or https://supportcenter.e-mds.com) and provide the message ID for investigation. *The message ID is retained in the database for 15 calendar days from the date of transmission*.

To find a provider's SPI number:

1. In Chart, access the SureScripts Administration module (**Tools > SureScripts Administration**).
2. Click the **Provider Registration** tab, click **Show,** and scroll to find the provider's name. The number is shown in the SPI column to the right of the provider's name.



Removing Stuck SureScripts Refill Requests

From time to time, a clinic encounters a "stuck" refill request that cannot be approved or denied because it is linked to a medication that has already been fulfilled. Solution Series provides a utility to remove such requests from your system. Note that you can only remove this type of request if it is seven days (one week) or older. This restriction is to reduce the chances of accidentally removing current requests that are not stuck or have not been filled yet.

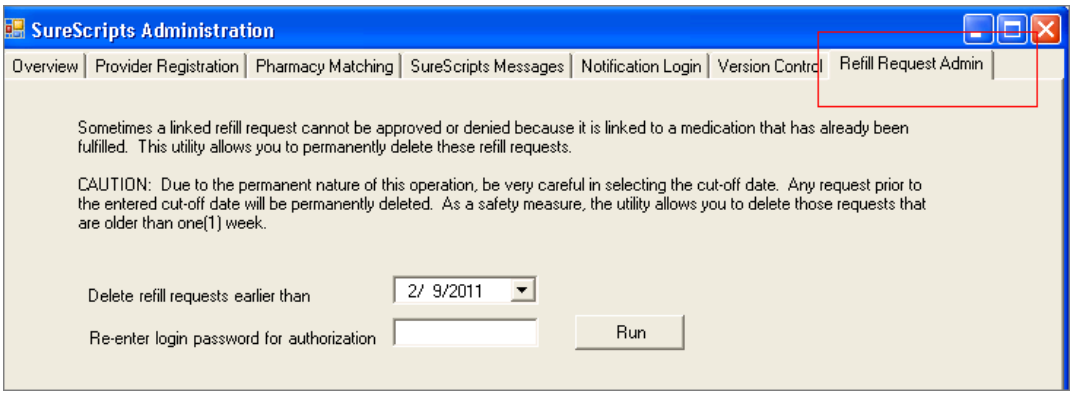
To remove stuck SureScripts refill requests:

Privileges Required: *SureScripts Administration*

1. In Chart, access the SureScripts Administration module (**Tools > SureScripts Administration**).
2. On the **Overview** tab, click **I want to remove stuck refill requests**.

   OR

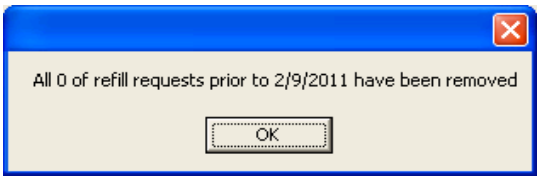
   Click the **Refill Request Admin** tab.



3. Click the down-arrow after the date field to display a calendar.

4. Select an appropriate date for when the refill requests should be removed. For example, by selecting a date of 12/21/2010, all refill requests dated before 12/21/2010 will be removed if this update is run. The date *must be* at least seven days prior to the current date.
5. Enter your login password to authorize the request removal process and click **Run**.

   A message screen, similar to the following example, will display indicating the number of requests prior to the selected date that have been removed (where *0* will be replaced with the actual number of requests that were removed and *2/9/2011* will be the date you selected on the Refill Request Admin screen).



A record of the transaction will be tracked and listed on the Chart Audits report. See *e-MDs Reports User Guide* for information on how to list and view this logged information.

Unlinking SureScripts Refill Requests

When electronic refill requests are received from a pharmacy, some refill requests are automatically linked by SureScripts and some will require manual linking. If a linking error occurs, use the following steps to manually unlink a refill request from a Chart patient or medication.

To unlink a SureScripts refill request:

Privileges Required: *Scriptwriter: SureScripts Patient Linking*

1. At the bottom of the patient's Medication List grid, right-click the linked medication and select **Unlink SureScripts Request**. The Unlink Refill Request dialog box will appear.
2. *To unlink the refill request from the medication only*, select the **Medication** radio button. The request will remain in the grid but will turn red to indicate the request is still linked to the patient but will require linking to a different medication.
3. *To unlink the refill request from both the medication and the patient*, select the **Patient & Medication** radio button The refill request will be removed from the patient's bottom grid and will appear in the Link Refill Request window.
4. To link the unlinked refill request to a different medication or patient, follow the instructions in "Linking Electronic Refill Requests."

A record of the unlinking action will be tracked and listed on the Chart Audits report. See *e-MDs Reports User Guide* for information on how to list and view this logged information.

Using Prescription Tools

To ensure efficient handling of prescriptions and refills, Solution Series provides a number of tools to:

- Track active prescriptions (Prescription Tracker)
- List details of all current prescriptions for each patient (Refill Grid)
- Check for allergies, drug-drug interactions, and drug-disease interactions (Automatic Allergy, Drug, and Drug-to-Disease Interaction Checking)
- Calculate the appropriate dosage for each medication based on the patient's age, weight and diagnosis (Dose Calculator)

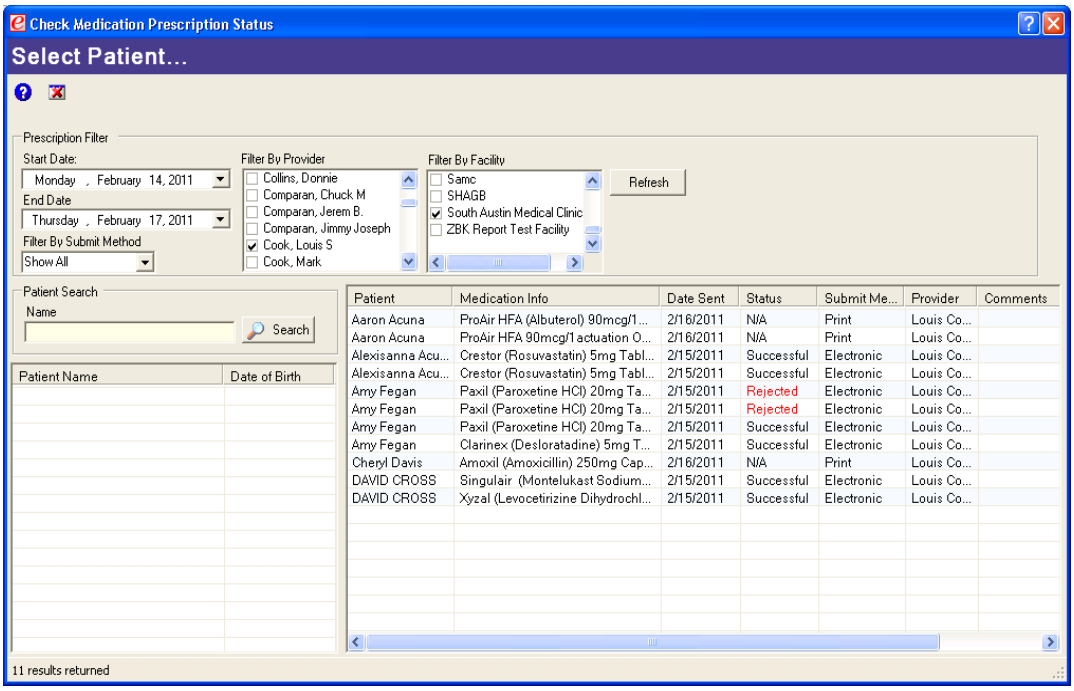
- List and view frequently prescribed medications (Quick Picks)
- List prescriptions to be phoned in (Phone-In Script Module)
- Reconcile medication lists (Medication Reconciliation)
- Manage workflow (Refill Request Module)

Prescription Tracker

The Prescription Tracker is a feature to help keep track of the status of prescriptions by patient. Specifically the feature was intended to provide status information for electronic prescriptions but the functionality was extended to provide *some* feedback on all prescriptions no matter the send method.

This module is opened by clicking the **Tools** menu in Chart and then selecting **Prescription Tracker** from the menu. If you are in a patient chart when you open the Tracker the current patient's information will be displayed in a grid as shown below. If you are not in a patient chart when the Tracker is opened the grid will be blank and you can search for a patient using the Patient Search field.

When the window opens the date range fields will default to today's date but can be changed to view prescriptions written on other dates. Information displayed in the grid includes the patient name, the prescription information (drug name, strength, sig, qty and refills), date, status and the submit method.

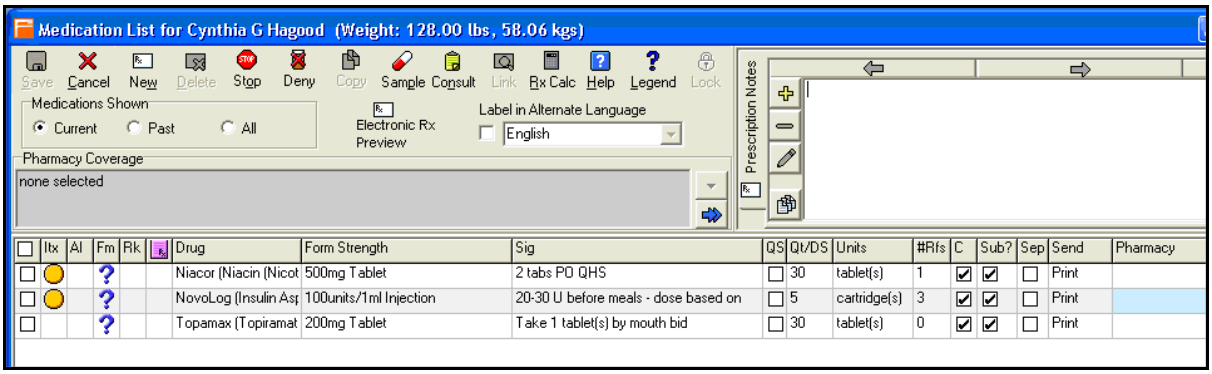


- **For Electronic prescriptions** the status will display Successful if a successful acknowledgement was received from the pharmacy and Rejected if there was an error.
- **For Phone-In prescriptions** the status will display Pending when the script is first sent to the Phone In module and Successful once the user (nurse or aide) has marked it as being phoned in to the pharmacy.
- **For Faxed prescriptions** the status will always display as N/A in this version. Currently, information on the status of faxes is not available.
- **For Printed prescriptions** the status will always display as N/A. While information that the script has been sent to the printer is available, information about whether the script actually printed is not (ex. the printer could be out of paper or have a paper jam).

Refill Grid

The Refill Grid (Medication List grid) displays all Current Medications in a grid format and allows users to easily and quickly refill one, some or all medications with a minimum of clicks.

The Refill List window buttons are described below. The window also lists the medications from the Current Med List. The medications are listed one per line in the grid. There are twenty different columns for each medication and each column contains different information related to refilling the medication. These columns are described below.



Medication List Window Options

Toolbar Buttons and Other Options	
Save	Saves and processes the medications that have been selected for refilling and any changes to the medications made in this module
Cancel	Cancels any refills and changes made to the medications in this module with the *exception* of discontinuing a med by using the **Stop** button. Using the Stop button discontinues the medication instantly and the cancel button does not reverse this action.
New	This button opens the Prescribe a Drug screen (aka Drug Search) and the user can search for and then write a new prescription.
Deny	Allows the user to deny a refill. This feature keeps an accurate record of the number of times that a patient requests a refill, even if that request is denied.
Stop	This button allows the user to discontinue a medication. Medications can also be discontinued from the Current Med List. To Stop a medication, highlight it by clicking the name and then click the Stop button. See Discontinue a Current Medication for details.
Copy	Allows the user to quickly and easily copy a med that is being refilled. This is useful when patients have mail order pharmacies and you need to quickly write a 90 day supply as well as a short term script to be filled locally. See the Copy a Prescription section for details.
Sample	Allows the user to document medication samples provided to the patient on the Medication List.
Consult	Opens the consult window for the selected medication. To select a medication, check the refill check box to the left of the medication and click the **Consult** button ***OR*** simply highlight the med (without checking the refill box) and click the Consult button.

Link	If an electronic refill request is received for a recognized patient, but a match cannot automatically be made to a drug in the patient's list, this button will be active. An unmatched medication can be caused by a difference in a drug dose or name, and so forth. Click this button to open the Link Refill Requests window where you can manually link the requested medication to a drug in the patient's medication list. **Note:** If no match exists (for example, the request is for a drug the patient is not on), then you have the option to deny the refill request from within the Link Refill Requests window.
Rx Calc	This button opens the Dose Calculator.
Help	This button opens the help file.
Legend	This button opens the list of associated icons with explanations of what the represent.
Padlock	The padlock button in the Refill Grid turns the confidentiality feature off. When this button is depressed (locked) any medications that are marked confidential will be blacked out and unreadable. If a user needs to see a hidden medication while in the Refill Grid they can use the padlock to reveal the med. Within the Refill grid, user can only unlock the Lock button to view the medications.
Medications Shown	By default, only current medications are shown in the grid. To view earlier prescriptions, select **Past**. Or, to view all prescriptions for the selected patient, select **All**.
Label in Alternate Language	This option allows you to select a different language for the label. To select a different language, click the check box, then use the drop-down list to select the language to be used.

Column Headings/ Options	
Refill Check Box	This is the first column and is represented by a check box or square at the top of the column. The check boxes in this column are used to select the medications that are to be refilled. You can select a single medication to be refilled by clicking the check box in that medication's row. You can select multiple medications by checking the check box next to each of the desired meds or you can select ALL meds to be refilled by checking the check box in the column header (at the top of the column). See the Refilling Prescriptions section for details.
Itx	Possible interactions or contraindications: If Drug Interactions between medications or between medications and a documented diagnosis exist an interaction icon will be displayed in this column next to the meds that interact. See Display of Allergies and Interactions in the List for details.
AI	If Allergies or Adverse Reactions exist for a medication an icon will be displayed in this column. See Display of Allergies and Interactions in the List for details.
Fm	Formulary Status (used by Formulary Benefits) Indicates whether the medication is part of the patient's formulary. Icons indicate if the drug is approved, preferred, not in formulary, not reimbursable or status cannot be determined.
Rk	Formulary Preference Level (used by Formulary Benefits) - There can be multiple therapeutic alternatives within a drug class. Alternatives are ranked from 1 to 99 - with higher values indicating a greater preference.
	Coverage or CoPay Information Available (used by Formulary Benefits) Indicates that Formulary Coverage and/or CoPay information is available for this medication for this patient.
Drug	This column contains the brand or generic name of the medication. For over-the-counter medications, the drug name will have a prefix of **OTC**.
Form Strength	This column contains the Form Strength of the drug. This information includes the form of the drug (ex. Tablet, Capsule, Syrup, etc.) as well as the strength (Example: 250mg, 5mg/ml, etc.).
Sig	The directions or sig for the prescription is listed in this column.`

QS	This column represents Quantity Sufficient which is an abbreviation for instructions to the pharmacist to calculate the quantity of medication to dispense. For example, QS for 10 days tells the pharmacist to calculate (based on the number of tablets or mls given according to the sig) a quantity of the medication sufficient to last 10 days. This field can be used in lieu of a quantity for the prescription. It is used in conjunction with the Days Supply column.
Qty/DS	This column represents Quantity or Days Supply depending on whether the QS column is used. If the QS column is NOT CHECKED (used) this column represents the quantity of medication that is to be dispensed. For example, a Qty of 30 would represent that 30 capsules (or tablets, etc.) are to be dispensed. If the QS column IS CHECKED then this column represents the number of days that are used by the pharmacist to calculate how much to dispense. See the QS column description above for details.
Units	This column displays the either the units that are to be dispensed OR will display the word Days if QS is selected. Units are the form of the drug that is to be dispensed. For example a prescription for a 250mg Tablet could display tablet(s) as the units while an ophthalmic drop might have choices for a 5ml bottle, 10ml bottle or 15ml bottle as the unit.
#Rfs	This column represents the number of refills associated with the prescription.
C	This column denotes whether the prescription is Chronic or Acute. A check in the check box means the prescription is Chronic. The preloaded prescriptions that come with the product are already correctly marked as Chronic or Acute but if a change needs to be made it can be done in this column.
Sub?	This stands for Substitution and denotes whether the provider will allow the prescription to be generically substituted or requires a brand name medication to be dispensed. This field is always defaulted to allow substitution (the check box is checked).
Sep	This stands for Separate and denotes whether the prescription will print together with other prescriptions for the patient or on a separate sheet of paper. A check mark in this field denotes that the prescription will print separately. This can be set as a user option. See User Preferences for Script Printing and Faxing for details. **Note:** Some states require that ALL prescriptions be printed on separate pages.
Send	This column represents the send method for the prescription. Send method can be Print, Fax, Electronic or Phone.
Pharmacy	If the Send method is Fax or Phone or Electronic, this column is used to pick the pharmacy to which the script is to be phoned or faxed or sent electronically.
Note?	This column will contain a Note icon (yellow sheet of paper) if there is an interaction or allergy note associated with the prescription. Users can also add a note by clicking in the appropriate cell on the row of the medication that they want to add a note to. When the note field opens the user has a choice of adding a note to the pharmacist that is printed on the face of the prescription (middle section of the form OR adding a note that is attached to the prescription and is strictly for internal use (bottom section of the form). **Note:** If a note is being added to print on the prescription make sure the check box at the very top of the form labeled “Add the following warning message to the printed prescription” is checked.
QP	This column allows the user to create a new Quick Pick by clicking the check box. When the check box is clicked a menu appears that allows you to Add Personal Quick Pick, Add Organizational Quick Pick, Remove Quick Pick. (See Add/Edit Quick Picks for more details.)

Automatic Allergy, Drug, and Drug to Disease Interaction Checking

During the process of prescribing medications, e-MDs Chart automatically checks for relevant patient allergies (or adverse reactions) as well as the Current Medication and diagnosis list for potential interactions. Appropriate warning messages and icons appear, as described below.

Drug and Interaction Warning Messages

When initiating a new prescription, the user selects a medication in the Script Writer. If the chosen drug is problematic, appropriate Drug Allergy (or Adverse Reaction), Drug-Drug or Drug-Disease Interaction warning messages will pop up. The prescription cannot be completed until a decision is made in the Warning window.

Note: Each drug interaction is classified by a level of severity (minor, moderate, major, and contraindicated). You can decide which levels of interactions should prompt a warning message (see "User Preferences for Script Writer" section for details).

The warning message indicates the nature of the allergy, adverse reaction, or drug interaction. In many cases, if a drug interaction is the problem, precautionary measures are outlined. If you plan to prescribe the medication despite the warning, you can check the **Print Warning on Script** box. This informs the pharmacist that the prescriber is aware of the potential allergy or interaction, alleviating the need for a phone call.

In the drug interaction warning window you must select one of three buttons:

- **Cancel** to cancel the prescription.
- **Ignore** to ignore the warning and proceed with the prescription.
- **Ignore with Notes** to proceed with the prescription and attach an explanation justifying the decision.

Note: Because warning icons are always visible (see below), the pop-up warning message only appears with the patient's initial prescription, and not with refills.

Drug and Interaction Warning Icons

If a prescription is written despite a warning, it will appear in Current Medications preceded by an icon. At any time, users can click the icons to review the warning.

Drug-Drug and Drug-Disease interaction warnings use the same icons:

- A red or yellow triangle indicates an allergy or adverse reaction, respectively.
- A colored circled represents a drug interaction (green is minor, yellow is moderate, red is major).
- A red X identifies a contraindicated drug combination.
- A blue circle represents duplicate medication.

To review the meanings of the icons in Current Medications:

1. Click the **Display Legend** button (the last button, with the blue question mark).

   If a justification note was attached to the prescription, a yellow notepad icon will appear next to the medication in Current Medications.

2. Click the yellow notepad icon to read the note.

Note: So that all healthcare providers will be aware of potentially problematic medications or drug interactions, the icons in Current Medications cannot be hidden or turned off.

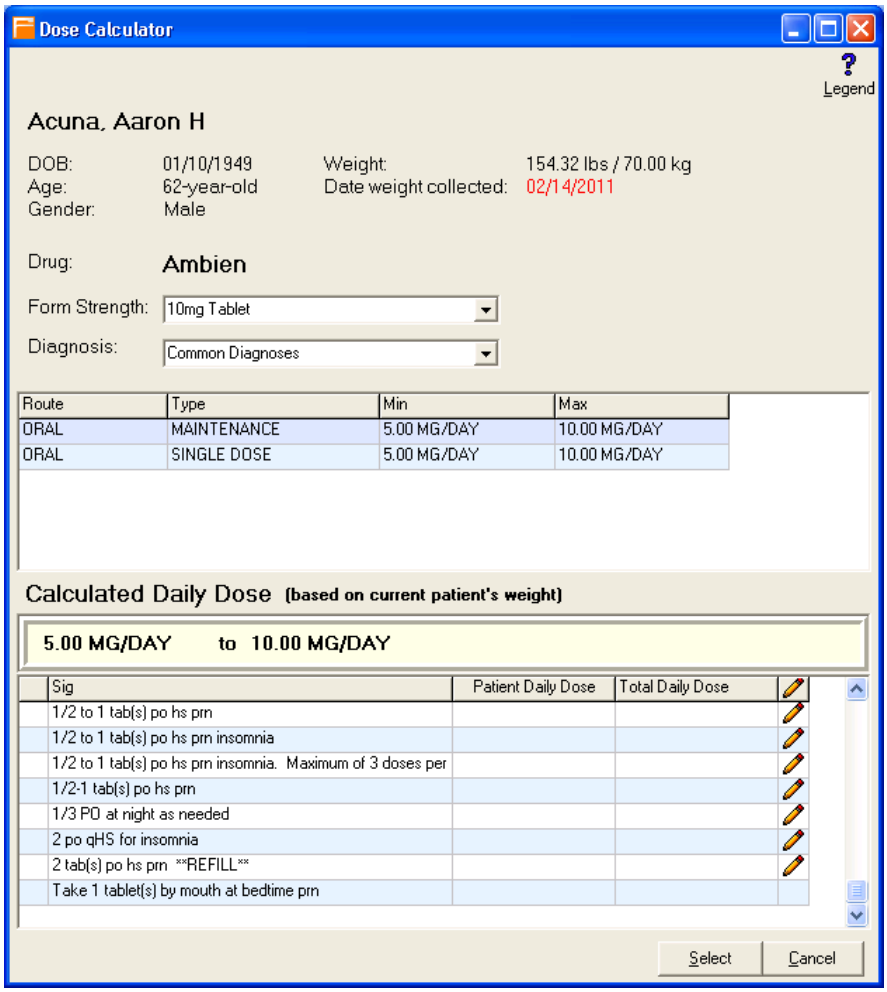
Dose Calculator (Rx Calc)

The Dose Calculator computes the therapeutic dose range for a selected drug (basing the calculation on age, weight, and diagnosis); displays minimum and maximum dose ranges based on the type of dose;

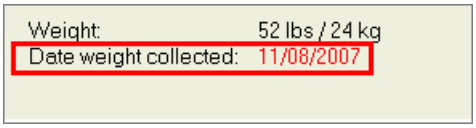
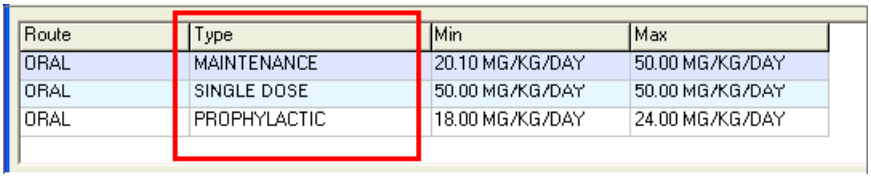
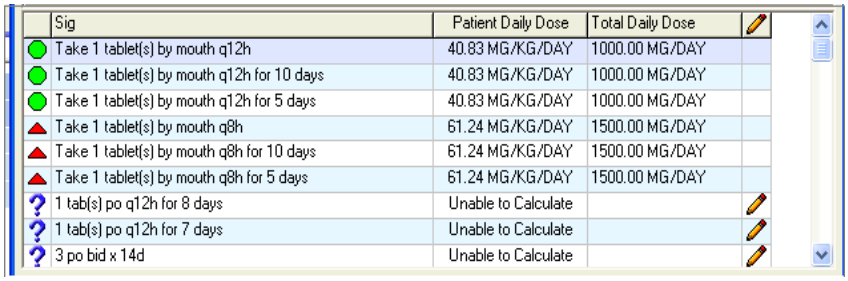
lists sigs linked to the selected drug, and indicates whether each selected sig falls within the therapeutic dose range calculated for that patient.

Note: Most pediatric drug dose range values are reported as **mg/kg/day** while ranges for many adult-prescribed medications are given as **mg/day**.

The Dose Calculator is accessed from the Medication List window of Script Writer.



Dose Calculator Options	
Demographics	These are retrieved from the patient's chart and include Patient Name, Date of Birth (DOB), Age, and Gender.
Weight	This is the most recent recorded weight for this patient. Not all dose calculations (especially adult doses) require a weight. If no patient weight has ever been recorded (and weight is required for a calculation), the user receives an error message stating that a weight must first be recorded. If a weight is required for a calculation and the displayed weight is not current (i.e. was not collected today), a warning message about the weight displays.

Date weight collected	Indicates when the weight used in calculation was collected. If the most recent weight was **not** collected **the same day** as the calculation, the Date appears in red text. 
Drug	Name of drug selected from the medication list to be used in dose calculation.
Form Strength	If a form/strength was selected on the Medication List, it displays here. The user can also select the form strength (or change it) from here by using the drop down list. A form strength must be selected to view dosing information. **Note:** If you select certain form strength and then a specific diagnosis where there is no dosing information for that diagnosis, you will receive a message indicating "Using All Common Indication Dose Range."
Diagnosis	The system defaults the Diagnosis field to the selection **Common Diagnoses**. Users can select a specific diagnosis from the drop down list to view different dosing information. Note that some dose range calculations do not require a specific diagnosis for computation. If the Script Writer Dose Calculator is accessed from within the Plan section of a Visit or Order Note, and a diagnosis was recorded in the note, the system attempts to match that diagnosis (if available) in the dose calculator. When a prescription is written under this diagnosis, that diagnosis will be linked to the prescription.
Dose Type Selection Grid	For the given diagnosis, select (click) the Type of Dosing (maintenance, prophylactic, etc.) for treatment using this medication. Note recommended dose ranges also display with each type. 
Calculated Daily Dose	This displays the minimum and maximum daily dose range for the selected dosing type, diagnosis, and current patient's weight.
Available Sigs Grid	Sigs displayed are those associated with the drug and Form/Strength selected. 

Route	Type	Min	Max
ORAL	MAINTENANCE	20.10 MG/KG/DAY	50.00 MG/KG/DAY
ORAL	SINGLE DOSE	50.00 MG/KG/DAY	50.00 MG/KG/DAY
ORAL	PROPHYLACTIC	18.00 MG/KG/DAY	24.00 MG/KG/DAY

Sig	Patient Daily Dose	Total Daily Dose
Take 1 tablet(s) by mouth q12h	40.83 MG/KG/DAY	1000.00 MG/DAY
Take 1 tablet(s) by mouth q12h for 10 days	40.83 MG/KG/DAY	1000.00 MG/DAY
Take 1 tablet(s) by mouth q12h for 5 days	40.83 MG/KG/DAY	1000.00 MG/DAY
Take 1 tablet(s) by mouth q8h	61.24 MG/KG/DAY	1500.00 MG/DAY
Take 1 tablet(s) by mouth q8h for 10 days	61.24 MG/KG/DAY	1500.00 MG/DAY
Take 1 tablet(s) by mouth q8h for 5 days	61.24 MG/KG/DAY	1500.00 MG/DAY
1 tab(s) po q12h for 8 days	Unable to Calculate	
1 tab(s) po q12h for 7 days	Unable to Calculate	
3 po bid x 14d	Unable to Calculate	

Sig Range Indication	Icons appearing in far left column of Available Sigs Grid indicate whether selecting that sig would provide the proper therapeutic dosing for that patient. Each sig is labeled as falling within, above, or below the Calculated Daily Dose; or, that the dose range cannot be determined from the information provided. The icons and their meanings are as follows: Sig Within Therapeutic Range Sig Below Therapeutic Range (sub-therapeutic dose) Sig Above Therapeutic Range (high dose) Unable to calculate. Any sig can be selected to prescribe whether it falls within, above, or below the therapeutic range.
Patient Daily Dose	This is the calculated daily dose in units/kg/day a patient would receive if that sig were selected. This value is based on weight.
Total Daily Dose	This is the total daily dose a patient would receive from the selected sig. Total Daily Dose is generally calculated by multiplying the selected drug strength by the dose frequency.

To use the Dose Calculator:

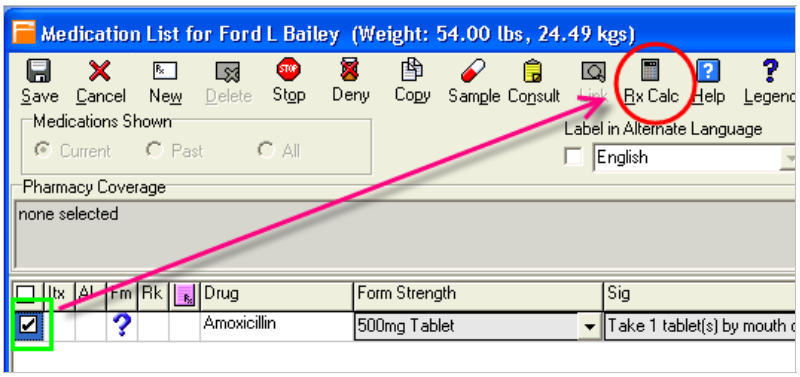
1. Confirm that a weight is documented in the patient record.

   If the most recent weight recorded for a patient is not current (i.e.: *was not* recorded the same day as the dose calculator is used), a warning displays. The user must decide if using a weight that was not collected today is appropriate. An old weight for adults or older children may or may not impact the dose calculation. For small children and infants, using an old weight could be significant if the patient's weight has changed since the most recently documented weight was collected.

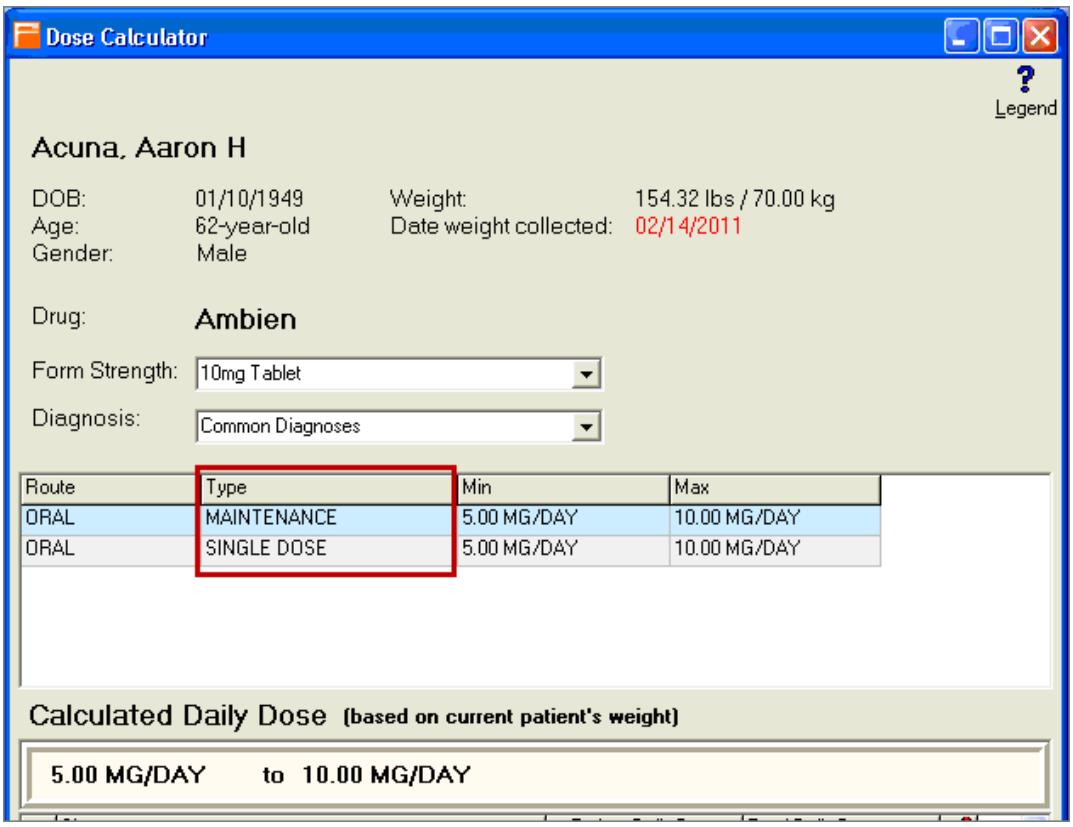
   If the provider chooses to continue, the most recent recorded weight is used in the calculation. If no weight has been recorded for the patient and the dose range calculation requires a weight, the same warning message appears. In this situation, the dose calculator still displays the Minimum and Maximum therapeutic dose range by dosing type, but cannot compute the Calculated Daily Dose nor display any sigs for selection.

2. In the Medication List window of Script Writer, select a **drug** and click the **Dose Calculator** icon.

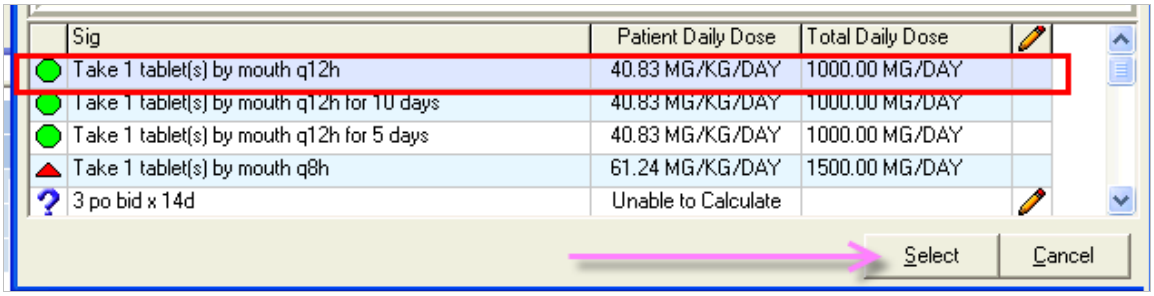
   A Form Strength must be selected in either the Medication List window or on the Dose Calculator before dosing information can display in the calculator.



3. If desired, select a different diagnosis (the default is “All Diagnoses”) in the Diagnosis field, then select the *type of dose* (single, maintenance, prophylactic, etc).



4. Sigs documented in e-MDs Solution Series that are linked to the selected form strength/type of dose for this drug are displayed in the Available Sigs Grid. To prescribe using one of these Sigs, click the desired **sig**, and then click **Select**.



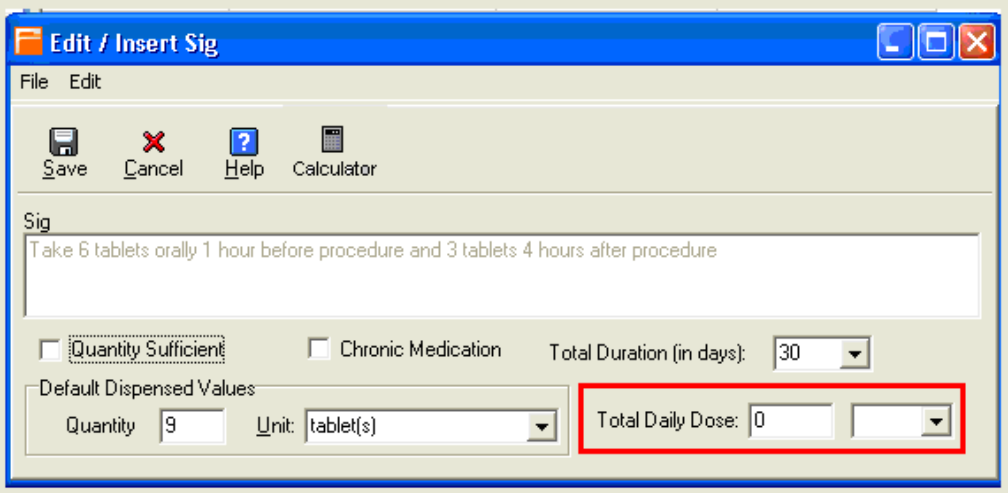
To edit/insert sig window:

Click the **Edit** icon on a line of the **Available Sigs** grid to open the Edit/Insert Sig window.

Note: While you cannot edit the selected sig, you can edit and save the **Total Daily Dose** for that sig. Only user-entered Sigs (not those provided by e-MDs) can be edited.

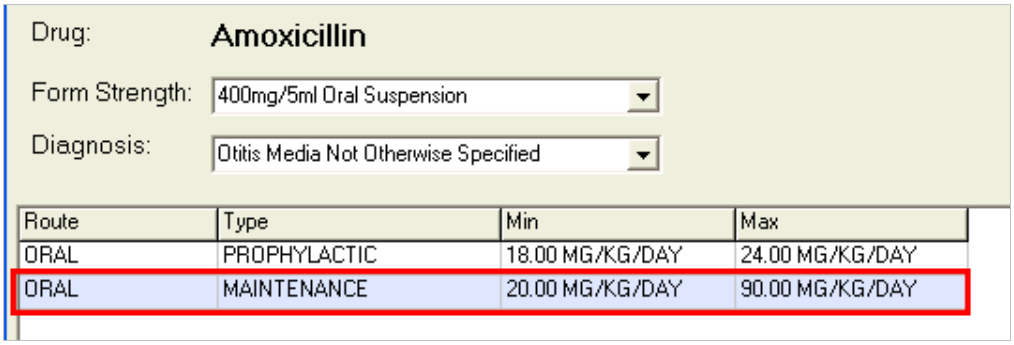
e-MDs is unable to calculate a Total Daily Dose (TDD) for user-entered sigs. Without a TDD, the dose calculation for these sigs cannot be performed. To display whether a user-entered sig is in range or not, the user must edit the sig and add a TDD.

To perform your own calculations without leaving this page, click the Calculator button to open another window containing a calculator to perform basic math functions. Click Exit on the Calculator screen when you are finished with it.

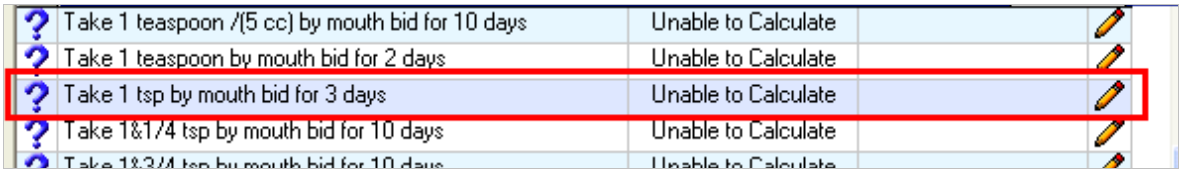


Example

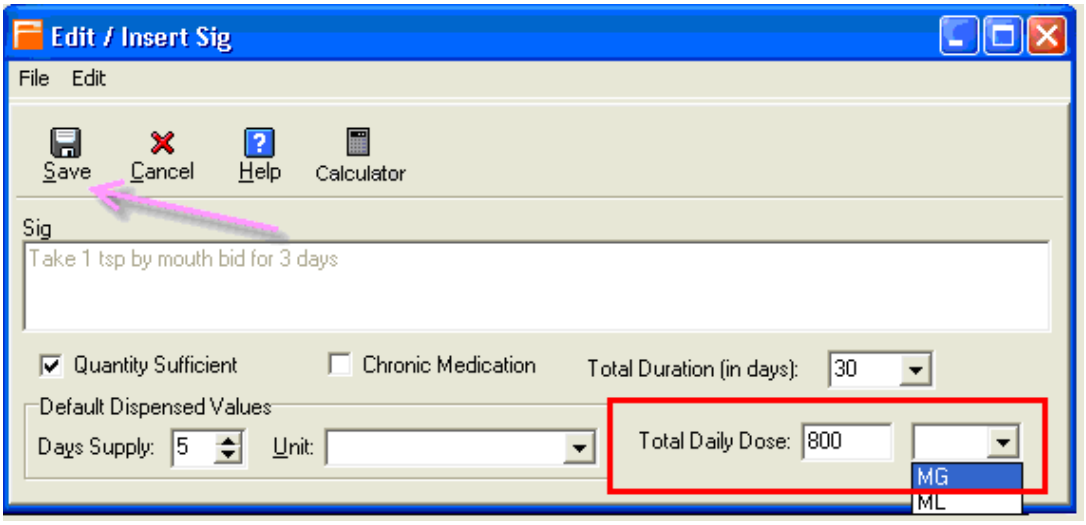
A 2 year old 20kg pediatric patient is being prescribed Amoxicillin 400mg/5ml for an ear infection (otitis media). On the Dose Calculator, the user selects a dose type of **Maintenance** which shows a therapeutic range of 20mg/kg/day to 90mg/kg/day.



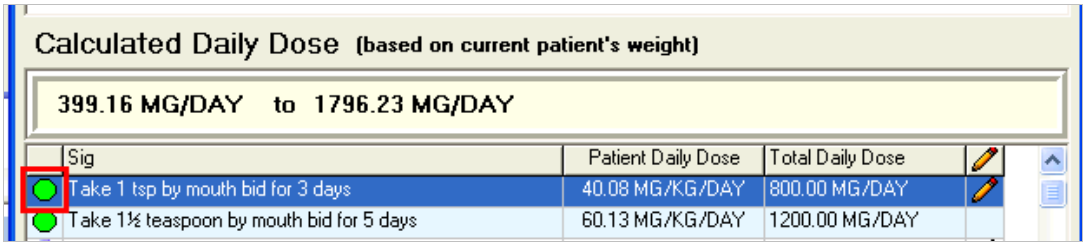
The user wants to select the sig “Take 1 tsp by mouth bid for 3 days” but the range indication icon shows ? (unable to calculate). The user clicks the **Edit** icon to open the **Edit / Insert sig** window.



Calculating the total daily dose for this sig yields 800 mg/day (400mg X 2 =800mg/day), which is entered in the first **Total Daily Dose field,** and **mg** is selected as the unit of measure. Clicking **Save** updates the sig on the Dose Calculator.



The selected sig now shows as within therapeutic range as indicated by the icon.



Quick Picks

Every provider has a list of most commonly prescribed drugs, and, in most cases, the prescription for a particular drug is written the same way every time. These common prescriptions can be saved ahead of time (or on the fly) as Quick Picks. A Quick Pick is a complete prescription, including directions (sig), amount dispensed, and refill authorization. A single drug can have multiple Quick Pick prescriptions, covering variations in dose or refills, for example.

Quick Picks are saved in the drug database. When performing a drug search to write a prescription, matching Quick Picks will also be displayed in the search results. A Quick Pick can be selected, enabling the user to write the prescription with just one click!

If a particular drug cannot be found in the drug search, the medication can be added by the user. Also keep in mind that only medications added by the user can be edited or deleted.

There are two types of Quick Pick: Personal and Organization. A Personal Quick Pick is available only to the person who created it and appears in regular black text. Organization Quick Picks can be accessed by all prescribers in the organization and are displayed in bold black text.

To create a Quick Pick ahead of time:

1. In the Drug Search (Choose Medications) window of the Script Writer, search for drug by brand or generic name.
2. Highlight the drug in the search results, click **File** in the toolbar, and select the **Create Quick Pick** menu option.
3. Write the complete prescription in the Script Pad.
4. Under Options, check either **Personal Quick Pick** or **Organization Quick Pick**. (By default, **Personal Quick Pick** will be checked, but this can be changed.)
5. Click **Save**.

To create a Quick Pick on the fly:

1. Write a prescription normally (see Script Writer for details).
2. Check the check box in the last column on the right labeled QP. Choices are
   - **Add Personal Quick Pick** (available only for your login)
   - **Add Organizational Quick Pick** (available to all users)
   - **Remove Quick Pick**

   Note: The **Remove Quick Pick** choice is used to remove a Quick Pick that was inadvertently created during the current session and will not to delete an existing Quick Pick. To delete an existing Quick Pick, see the next section.
3. Make the appropriate choice from the menu.
4. Click **Save.**

To delete a Quick Pick:

1. In the Drug Search (Choose Medications) window of the Script Writer, search for the Quick Pick drug by brand or generic name.
2. Highlight the Quick Pick and click **Delete** on the tool bar.
3. Click **Yes** in the Delete Confirmation window.

To view all strengths and forms of a medication:

1. In the Script Writer, search for a drug (see Search for a Drug for details). Drugs matching the search criteria are displayed in the middle of the window, under the Drugs heading.
2. Right-click to select a drug in the search results, and select the **Show All Forms and Brands** menu option.

To view all other drugs in the same class as a medication:

1. In the Script Writer, search for a drug (see Search for a Drug for details). Drugs matching the search criteria are displayed in the middle of the window, under the **Drugs** heading.
2. Right-click a drug in the search results, and select the **Show All Drugs in the Same Class** menu option.

To add a drug to the database:

1. In the Drug Search (Choose Medications) screen, click **File** and select the **Create Drug** menu option.
2. In the Add/Edit Drug window, type the drug name.

3. Click the yellow plus sign to add a Form/Strength (e.g. 250 mg tablet), a Dispensed Unit (e.g. tablets), and designate the schedule for a controlled/non-controlled substance. All fields are required.

   Note: To edit a Form/Strength, click the pencil icon. To delete one, click the red minus sign.

4. When finished, click **Save**.
5. Repeat this step to add additional Form/Strengths.
6. Click **Save**. Note that user-entered drugs will appear with an asterisk after the drug name- this cannot be changed.
7. When writing a prescription for the newly added drug, common sigs (directions for taking the medication) can be added in the Refill Grid.

To edit a user-added drug in the database:

1. In the Health Summary, under the Current Medications header, click the Write New Script button on the right side of the Current Medications window. It is the top button, with the Rx pad icon.
2. In the Drug Search (Choose Medications) screen, search for the drug to be edited.
3. Highlight the drug name.
4. Click **File** and select the **Edit Drug** menu option.

   The Add/Edit Drug window will open

5. Change the name, edit the form strength or add a new form strength, as necessary.
6. Click **Save** when finished.

To delete a user-added drug in the database:

1. In the Health Summary, under the **Medications** header, click the **Write New Script** button on the right side of the Current Medications window. It is the top button, with the Rx pad icon.
2. In the Drug Search (Choose Medications) screen, search for the drug to be deleted.
3. Highlight the drug name.
4. Click **File** and select the **Delete Drug** menu option.
5. Click **Yes** at the Delete confirmation warning.

Phone-In Script Module

The Phone-In Script module displays a list of prescriptions that were designated in Script Writer to be phoned in to a pharmacy. Sufficient information is presented to the user so that they can call a pharmacy and relay all the pertinent information that is needed to fill the prescription. This allows you to use the module as an electronic work list for prescriptions. The module can also display a record of past prescriptions that have been phoned or faxed to pharmacies.

File Menu	
Options	Options can be used to customize the behavior of the application to suit the needs of individual users. • **Display Phone In Prescriptions count in red if greater than**: This option can be used to set the behavior of the Phone In Scripts button in the Dashboard. When pending prescriptions are present for the selected provider (or providers) the Phone In Scripts Dashboard button will display the number of pending prescriptions for the selected provider(s). Ordinarily this number shows up in black however users can use this preference to show the number in red if it exceeds a specified number. For example a user can set this option to 10 and once the number of pending prescriptions reaches 11 the number displayed on the Dashboard button will appear in red. This feature can be used as a prompt to the user to deal with items when they reach a certain workload. • **Default HIPAA Compliance**: A user can decide to display No Patient Name, Initials Only or Full Patient Name in the Patient column of the grid. This is a common feature that is available in several of e-MDs applications and is useful for hiding or limiting the display of the patient name in situations where the computer screen can be seen by non-staff individuals such as visitors or other patients. This option sets the preference for the default behavior of this feature. The user can still temporarily change the setting "on the fly" by clicking the desired HIPAA icon on the toolbar (see Toolbar section) and this choice will be maintained as long as the current session of the application is open. But if the application is closed the setting will always return to the default the next time it is opened. The default setting for this feature is initially set to No Patient Name but can be changed by clicking the radio button next to the desired choice.
Exit	The exit menu choice will close the application.

Help Menu	
Search Topics	Selection of this choice will open the built in help files and allow users to search for help on specific topics.
About	Selection of this choice will display a screen that shows the current version number of the application. This information can be helpful when tracking down problems and may be asked for by the support department.

Toolbar Items	
Search	The search button will perform a search and return only the scripts that need the search criteria that has been entered into the Patient Last Name and/or the Pharmacy Name fields on the toolbar.
Exit	The exit button choice will close the application.
Help	Selection of this choice will open the built in help files and allow users to search for help on specific topics.
View	Users can choose to view Phone script, Fax scripts or Both by making a choice from the dropdown menu.
Status	Users can choose to view prescriptions that have note been dealt with (Not Done), that have been dealt with (Done) or Both.
Show Patients for	This field allows the user to select the provider or providers whose information will show up in the Phone In Scripts grid. See Set up Options for details.
Patient Last Name	Typing a patient's last name into this field and then pressing the Search button or the Refresh button will filter the records to only show prescriptions for that patient (if they exist).
Pharmacy Name	Typing a pharmacy name into this field and then pressing the Search button or the Refresh button will filter the records to only show prescriptions that are marked to be called in to that pharmacy (if they exist).

Filter by Date	If the check box in this field is checked, the date fields become enabled. Type in a Start and End date and then press the Search or Refresh buttons to only show prescriptions that fall into that date range.
HIPAA	This feature consists of a set of three icons that allow the user to select how the patient's name will be displayed in the grid. A user can decide to display No Patient Name, Initials Only or Full Patient Name by click the first, second or third icon respectively.
Refresh	Pressing this button will manually refresh the data in the grid.
Order By	This section determines how the grid is sorted. By default it is set to filter first by pharmacy name and then by patient's name. The Provider Name, Prescription Date, Submit Method and Status are additional filters that can be set. The filter that appears in the first drop down is the primary sort filter. For example with the default setting the grid sorts with the Pharmacy first so that all prescriptions for pharmacy A appear first and then pharmacy B, etc. The patient name is the secondary filter so that within pharmacy A's list the prescriptions are sorted by patient so that all of patient X's scripts are together. This makes it easier to work down the list so that users can call pharmacy A and give all the prescription information for patient X and then the next patient, etc. **Note:** In addition to sorting the grid by using the Order By fields, users can also click the header of each column to sort by that column. For example, click the column header labeled Patient to sort by patient name in alphabetical order starting with A (click the header again to sort in descending order starting with Z).

Grid Columns	
Done	This column displays information about whether the prescription has been dealt with or not. **Note:** The prescriptions marked as Fax do not display Done information at this time.
Date	This column displays the date the prescription was written
Prescription	Displays the complete information about the prescription (the drug name, quantity, directions, refills, etc.) that is needed to call it in to the pharmacy.
Brand	Displays whether the provider is requiring a Brand drug or not. If the column contains a check mark then the provider is requiring that the patient be given a brand rather than a generic drug.
Prescriber	Contains the name, license and DEA number (if required) of the provider prescribing the med.
Patient	Contains the patient's name and date of birth.
Pharmacy	Contains the pharmacy name, address, phone and fax number.
Notes	Displays any notes related to the prescription.

Setting Up Options

There are some options that need to be set up before using the Phone In Scripts module. These options will allow the application to be customized per user.

Show Patients For

- **Non-provider**: When a non-provider logs in to the Phone In Scripts module the "Show Patients For" field will default to (None) meaning that no providers are selected and the list of prescriptions designated to be phoned in to pharmacies will be empty. To monitor for phone in scripts the non-provider user must select one or more providers from the drop down list in the "Show Patients For" field. To do this, simply check the check box next to the name or names of the providers to be monitored. Once this has been done the changes will be retained the next time the user logs in.

- **Provider**: In the case of a provider logging into the Phone in Scripts module the "Show Patients For" field will be defaulted to the provider that is logged in. This allows providers to monitor their own list of phone in prescriptions. If the provider needs to monitor other providers lists they can choose the other providers to monitor by selecting the provider name(s) from the drop down list in the Show Patients For" field.

HIPAA Display

Users can set up the module display to not show patient names, to only show patient initials or to show the full patient name. To set up the default behavior of the HIPAA Compliance feature click File then Options and in the options screen select the appropriate compliance level. This will become the default setting whenever the user logs in. Changes can be made on the fly using the HIPAA buttons on the module toolbar but when the user logs out or when the system refreshes the setting will return to the default.

Workload Display

The Phone In Script module displays the number of pending scripts on its Dashboard button. Users have the option to display this number in red if it exceeds a specified number (for example if there are more than 15 Phone In Scripts for the provider being monitored the user can set the option to turn the number red). To set this up click File then Options and in the "Display Phone in Prescriptions Count in Red if greater than" field enter the desired number.

Search Criteria

When the Phone-In Scripts window is opened, the search criteria defaults to the settings listed below. These settings can be changed at any time.

- **Date Written** is set to today's date
- **Submit Method** is set to **Phone** (versus Fax or All)
- **Status** is set to **Not Done** (versus Done or All)
- **Order By** is set to filter first by pharmacy name and then by patient's name. The Prescriber Last Name, Patient Last Name and Pharmacy name are additional filters that can be set. For example, to search for a particular patient's prescription, type the patient's last name in the **Patient Last Name** box and then click **Search**. A list of scripts specific to that patient will be displayed.

To add a prescription to the Phone-In List:

1. When writing a prescription, select Phone in the Send Options. (see the Script Writer section for details.)
2. A pharmacy field will become enabled. Type a pharmacy name or click the down arrow to select the pharmacy to which the prescription will be phoned in.

   Note: If the patient has a DEFAULT pharmacy designated, the pharmacy field will be filled in automatically.
3. It helps to add frequently used pharmacies (and their phone numbers) to the database ahead of time (see the Add/Edit/Delete Pharmacies section for details about adding pharmacies to the database).
4. The prescription is then automatically routed to the Phone-In Script module.

To use the Phone-In Scripts module:

1. Click the **Phone In Scripts** button in the Dashboard

   OR

   In the main e-MDs Chart toolbar, click **Tools** and then select the **Phone-In Scripts** menu option.

The Phone-In Scripts window will open with a list of prescriptions written today and designated to be phoned in.

2. Review the information for each prescription, including the date the prescription was written, prescription information (drug name, strength, quantity, directions, and refills), prescriber's name, patient's name, pharmacy name, phone number and fax number (if included when adding the pharmacy to the database), and notes. This is the information you will give the pharmacy during the phone call.
3. To add an internal-use-only note to the prescription entry, click the note section of the prescription entry to pop up the Notes screen.
4. Type your comments in the bottom notes section and click **OK** to save the changes.

   The information entered in this section will be visible only at your facility and will not be printed on the outgoing prescription. This note is permanently attached to the prescription and can be viewed from the Current Medications list.
5. After calling in a prescription, click the check box in the **Done** column**.** If you click the **Search** button to refresh the screen, all prescriptions that are marked as **Done** will be removed from the active phone-in prescriptions list.
6. Click **Exit** to close the module when all tasks are complete.

Reconciling Medication Lists

When a patient is treated by providers from different facilities (specialists, other clinics, hospitals and so forth), different or additional medications may be prescribed for that patient. To ensure that medications do not overlap or result in conflicts, a medication reconciliation should be performed during any transition period when care changes from one provider to another. Solution Series provides a set of tools for importing external medical lists, comparing medications, adding medications to the patient's Current Medications list, discontinuing medications, and modifying medication strength and dosage, as needed.

Importing Different Types of Medication Lists

Because medication lists may come from multiple sources, multiple types of files can be captured and displayed for reconciliation. This includes text-based XML files from SureScripts and RxHub, CCD, C-CDA and CCR XML files. Imported files may also be image files that contain non-text information that can be displayed for viewing and printing. This includes files such as tiffs, MS Word files, PDFs and other images of documents or records that have been scanned into a system and transmitted.

After medication lists are imported, users can compare the current medication list and the imported list to determine what is different. This manual comparison is started by displaying the imported medication list in a viewer that is appropriate for the type of file imported (such as Acrobat for a .pdf file, MS Word for a .doc file, and so forth).

Tracking and Reporting Medication Reconciliation Activities

When you perform a Medication Reconciliation, the information will be captured in the Chart Audit trail. The Chart Audit trail includes information about the following:

- Medications that have been documented in the patient's Current Medication list as a drug selected from the database, a free-text drug, or a sample drug.
- Changes to dosage that occurred when existing prescriptions were edited.
- Medications that have been stopped.

Performing a Medication Reconciliation

The Medication Reconciliation is performed from the Clinical Reconciliation window.

To import a medication list from DocMan:

1. In the patient's chart, click the **Visit/Hs** tab to show the Health Summary.

2. Click the plus sign (+) before the blue **Current Medications** label to expand the patient's medication list.
3. Click the **Med Rec** button to open the Clinical Reconciliation window.

   The Clinical Reconciliation window will open to display the patient's current medications in the screen's left pane. You can click the column headings to sort the list.

   Note: To show past medications instead of current medications, click **Past.**
4. Choose **Import from DocMan** to open the DocMan Fax Filing window.
5. Click the **name** of the medication list file to be imported and click the green check mark icon to import the list.

   Depending on the type of file selected, the imported file will display in the right pane of the Clinical Reconciliation screen or a new window will open to display the file.
6. Review the list of imported medications to identify medications that should be added to or deleted from the Current Medications list and medications that need to have their strength, dosage, or directions changed.
7. Continue with To add, modify or discontinue drugs to make any necessary adjustments to reconcile the two medication lists.
8. If no changes are needed, click **Reconcile Medications** at the bottom of window to retain the Medication Reconciliation results and close the window.

To import a list from the Medication History:

1. In the patient's chart, click the **Visit/Hs** tab to show the Health Summary.
2. Click the plus sign (+) before the blue **Current Medications** label to expand the patient's medication list.
3. Click the **Med Rec** button to open the Clinical Reconciliation window.

   The Medication Reconciliation window opens, displaying the patient's current medications in the screen's left pane. You can click the column headings to sort the list.

   Note: To show past medications instead of current medications, click **Past.**
4. Choose **Import from Medication History** to open the RxHub window. The Consent Selection Form box opens.
5. Select the appropriate consent options and click **OK** to import the Medication History. The Medication History appears in the right pane of the Medication Reconciliation screen.
6. Review the list of imported medications to identify medications that should be added to or deleted from the Current Medications list and medications that need to have their strength, dosage, or directions changed.
7. Continue with To add, modify or discontinue drugs to make any necessary adjustments to reconcile the two medication lists.
8. If no changes are needed, click **Reconcile Medications** at the bottom of the window to retain the Medication Reconciliation results and close the window.

To add, modify or discontinue drugs:

1. After importing a medication list from either DocMan or the Medication History, review the list of imported medications.
2. To add a medication to the list, click the **Add** button.

   OR

To modify a current medication (such as the dosage or strength), select the drug name and click the **Edit button**.

OR

To stop a current medication, select the drug name and click the **Stop** button.

After selecting the icon, you will be taken to the Chart screen normally used to perform the selected task.

3. Use the normal procedure for documenting a drug in the Current Medication list. See Script Writer for more information.
4. Click **Reconcile Medications** to retain the changes and close the window.

Refill Request Module

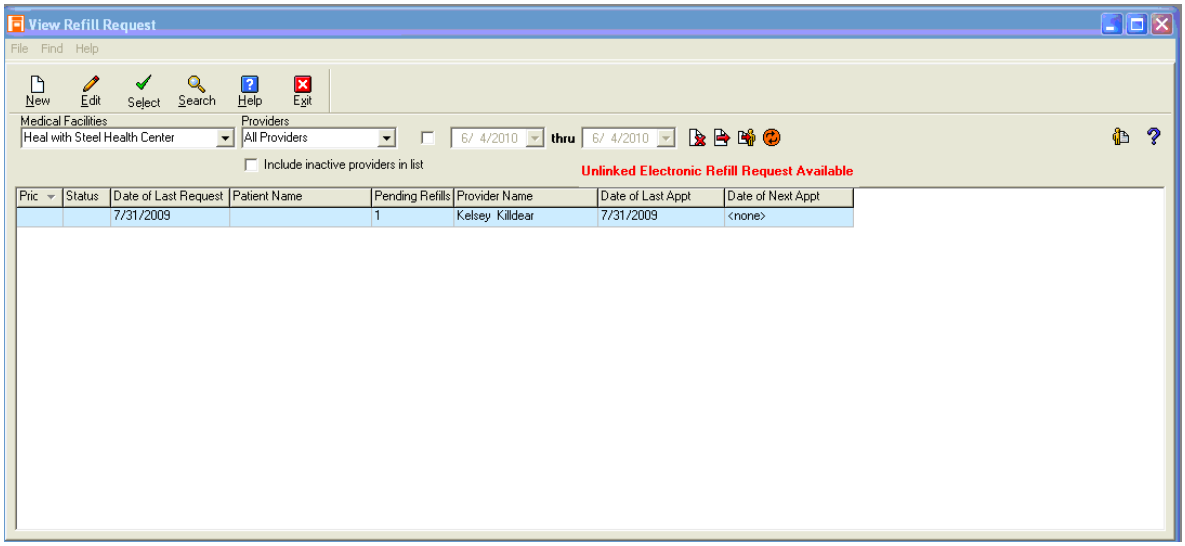
The Refill Request module is a workflow enhancement tool that provides an "at a glance" view of all prescription refill requests by one or more providers. The requests are displayed in a grid similar to a spreadsheet. Users are able to not only view requests but, by double-clicking a row, they can open the refill request and deal with it directly within the patient's chart.

Users can monitor lists for one or more providers at one time. This allows clinical staff to work with multiple providers and for providers to cover for each other during vacations or other times when providers are out of the office.

The Refill Request module also works in conjunction with the Chart View section of the patient's chart. Within the Chart View section the Medications subsection now contains information about refill requests. When a user deals with a refill request from within the Refill Request module, a link between the request and the patient chart take the user directly to the Chart View section and displays the current medication list along with a list of medications that are being requested for refill. Since the user is taken directly to the patient's chart, any additional information that needs to be reviewed is quickly available to the user.

Understanding the Refill Request Module Interface

The Refill Request module displays information about requested prescription refills in a grid display much like a spreadsheet. The information is displayed by patient per provider so that only one record per patient will be displayed for a single provider although a patient's name may appear more than once if they have made requests to more than one provider.



Menu Items

Menu items appear as words across the top of the application starting at the top left corner. Clicking a menu item will open a pop-up list of choices associated with the menu. The menu item choices for the Refill Request module are listed below.

File Menu	
Options	The options menu choice will open the options window to allow the user to set preferences for how they want the program to work. The choices for display options are listed below. **Note:** Changes to the options screen are login specific and will not affect other users display. • **Provider Setup:** In order to be able to add a refill request or refill a prescription, users MUST set up their list of providers (providers must set themselves up in this section as well). This option allows users to select the provider or providers that they work with and to provide a short name or nickname for the provider if desired. • **Display Refill Request Count in Red if greater than X:** This option can be used to set the behavior of the Refill Request button in the Dashboard. When requests are present for the selected provider (or providers), the Refill Request Dashboard button will display the number of refill request for the selected provider(s). Ordinarily the number of refill requests shows up in black however users can use this preference to show the number in red if it exceeds a specified number. For example a user can set this option to 10 and once the number of refill requests reaches 11 the number displayed on the Dashboard button will appear in red. This feature can be used as a prompt to the user to deal with items when they reach a certain workload. • **Automatic Refresh:** The information in the grid can be refreshed manually by clicking the Refresh button on the toolbar (see toolbar section) but the information is also set to refresh on an automated schedule. The default setting is for 2 minutes and cannot be set lower than that but it can be changed to a larger number. • **Default HIPAA Compliance:** A user can decide to display No Patient Name, Initials Only or Full Patient Name in the Patient column of the grid. This is a common feature that is available in several of e-MDs applications and is useful for hiding or limiting the display of the patient name in situations where the computer screen can be seen by non-staff individuals such as visitors or other patients. This option sets the preference for the default behavior of this feature. The user can still temporarily change the setting “on the fly” by clicking the desired HIPAA icon on the toolbar (see Toolbar section) and this choice will be maintained as long as the current session of the application is open. But if the application is closed the setting will always return to the default the next time it is opened. The default setting for this feature is initially set to No Patient Name but can be changed by clicking the radio button next to the desired choice.
Exit	The exit menu choice will close the application.

Find Menu	
Search	The Search function is not currently being used.
New	The New menu item will open the patient search screen to start a new request.
Edit	The Edit menu item will open the highlighted refill request in edit mode.
Select	The Select menu item will open the highlighted refill request and it will open in Refill mode.

Help Menu	
Search Topics	Selection of this choice will open the built in help files and allow users to search for help on specific topics.
About	Selection of this choice will display a screen that shows the current version number of the application. This information can be helpful when tracking down problems and may be asked for by the support department.

Toolbar Items	
New	The **New** button will open the patient search screen to start a new request.
Edit	The **Edit** button will open the highlighted refill request in edit mode.
Select	The **Select** button will open the highlighted refill request and it will open in Refill mode.
Search	The **Search** function is not currently being used.
Help	The **Help** button opens the built in help files
Exit	The **Exit** button choice will close the application.
Medical Facilities	This field lists the medical facilities the logged-in user is authorized to access.
Providers (Show Patients for)	This field allows the user to select the provider or providers whose information will show up in the Refill Request grid. When a provider logs in, this field should default to the name of the provider logged in. If a non-provider logs in the field will default to having no names selected. In either case, once the user is logged in they can select one or more providers from the dropdown list by checking the box to the left of the name. Once selection of the name(s) is completed clicking outside of the dropdown box will refresh the grid and show the refill requests for the selected provider or providers. A selection for All Providers is also available and may be handy for an administrator to monitor the information on a clinic wide basis. The selection of multiple providers allows users to monitor refill requests for multiple providers. In the case of non-providers, this may be necessary when a nurse or assistant is working with multiple providers and monitoring pending refill requests for them. In the case of providers this feature may be necessary when the provider is covering for another provider that is out of the clinic or when a provider is supervising physician extenders or residents.
Date Range Filter	By default the Refill Request grid displays ALL requests for the selected provider or providers. Use of the Date Range Filter allows users to choose to see only the requests for the selected date range.
HIPAA Patient Display	This feature consists of a set of three icons that allow the user to select how the patient's name will be displayed in the grid. A user can decide to display No Patient Name, Initials Only or Full Patient Name by click the first, second or third icon respectively. This is a common feature that is available in several of e-MDs applications and is useful for hiding or limiting the display of the patient name in situations where the computer screen can be seen by non-staff individuals such as visitors or other patients. **Note:** The use of the HIPAA Patient Display icons is an "on the fly" feature and will only change the display temporarily. The default setting for this feature is initially set to No Patient Name and changing the display via the buttons will only change the setting temporarily. The setting will revert to the default display setting on a refresh of the screen. The default setting can be changed permanently in the Options screen of the Refill Request module (see Options). Changes to the options screen are login specific and will not affect other user's display.

Refresh	The **Refresh** button redraws the screen and update any information that has changed since the module was opened or since the last refresh occurred. Most actions that are taken within the Refill Request module will cause a refresh of the screen automatically but there may be occasions when a manual refresh is desired. In addition there is an automatic refresh of the screen that occurs based on a user specified time period. The automatic refresh rate can be set in the Refill Request Options screen (see Options). Changes to the Automatic Refresh rate are login specific and will not affect other users refresh rate. The default refresh rate is set to 2 minutes and while this value can be changed to a longer time frame it cannot be changed to a setting less than 2 minutes.
Legend	The **Legend** button accesses a list of icons that appear in the application along with explanations of what those icons represent.
Unlinked Electronic Refill Request Available	This message appears in red when unlinked requests are available for processing. When no unlinked requests are active, the message will appear in gray. Click the red message or the **Link Refill Requests** button to open the Link Refill Request screen to manually link the available requests.
Link Refill Requests	This button opens the Link Refill Request window. This window allows users to manually link refill requests that cannot automatically be matched to a patient because of incomplete or contradictory information. This feature is only used in conjunction with electronic Refill Requests. These electronic refill requests are initiated by a pharmacy and sent over a secured connection via the Internet. Refill Requests sent in this manner may not have sufficient patient identifiers to allow e-MDs to positively identify the patient. Any requests received that cannot be matched to the patient will show up in this section and a message indicating **Unlinked Electronic Refill Requests Available** will appear on the View Refill Request screen. Click the message or the Link Refill Requests button to display the Link Refill Requests screen and manually match the patient on the request to a patient in the clinic database. **Note:** The unlinked refill message will appear in red and be clickable only when unlinked requests currently reside on the system. The **Link Refill Request** button is continuously active to allow you to open the Link Refill Requests screen at any time.
Include inactive providers in list	This option allows you to include inactive providers in your search to ensure that all possible providers can be found. This is particularly important when processing prescription refills that may have been issued by providers who are no longer active in the practice.

Grid Columns	
Priority	When a refill request is created users have the choice of setting a priority status to. This status defaults to Normal but can be changed to Urgent or Stat. When a priority setting other than normal is set an icon will be shown in the Priority column to draw attention to the request. If the priority status is Normal this column will not display an icon. If the priority is set to Urgent the column will display a single exclamation point icon  . If the priority is set to Stat the column will display a double exclamation point icon  .
Status	Requests can be marked as “Unfinished” to denote that more information needs to be collected or some other issue needs to be dealt with before the request is ready to be refilled. When a request is marked as “Unfinished” a clock icon will appear in the Status column of the request  .
Date	This column displays the date that the refill request was created.
Patient Name	This column displays the name of the patient.

Pending Refills	This column displays the number of medications that are queued up for refill for the patient listed. This number is based on the requests made by a patient from a specific provider. If a patient has requests for refill with different providers then the patient's name would appear in the grid more than once with the number of refills per provider showing in the column. For example if a patient has a request from Dr. Jones for one prescription and from Dr. Smith for two prescriptions then there would be two records in the refill request grid for the patient, one with the number one in the Pending Refills column and another with the number two displayed.
Provider Name	This column displays the name of the provider that the request is assigned to.
Date of Last Appointment	This column displays the date of the patient's last scheduled appointment.
Date of Next Appointment	This column displays the date of the patient's next scheduled appointment.

Legend Icons	
Urgent	A single exclamation point icon in the Priority column means that the request has an urgent status.
Stat	A double exclamation point icon in the Priority column means that the request has a stat priority status.
Note Attached	A yellow piece of paper icon means that the request has a note associated with it. These notes are generated by the pharmacy and are only associated with electronic refill requests. The icon only shows in the Request Medication and Refill Medication subsections of Chart View.
Unfinished Request	A clock icon means that the request requires that more information needs to be collected or some other issue needs to be dealt with before the request is ready to be refilled.
Refresh	The refresh icon on the toolbar will refresh all the information in the grid when pressed. There is a built in auto refresh function but at times a manual refresh may be desired.
Display without Patient Names	When this button is pressed the patient name will NOT be displayed in the Patient Name column of the grid. This is part of the HIPAA security module.
Display with Patient Initials	When this button is pressed the patient's initials will be displayed in the Patient Name column of the grid. This is part of the HIPAA security module.
Display with Patient Name	When this button is pressed the patient's full name will be displayed in the grid. This is part of the HIPAA security module.

Sorting the Columns in the Grid

The columns in the Refill Request grid are sorted by Priority, Status and then Date. If there are any items marked as Urgent or Stat then they will show up first. If there are no Priority items then any items marked with a Status will be listed first. If there are no Priority or Status items then the requests will be listed by date with the oldest listed first.

Columns can be sorted by the other columns as well in order to make information easier to locate. For example to sort patient names by alphabetical order click the column labeled Patient Name (the header). This will sort the patient last names in an ascending alphabetical order (from A to Z). Clicking the column header again will re-sort the list in descending alphabetical order (from Z to A). Each of the columns can be sorted in this way by clicking the header of the column.

Accessing the Refill Request Section of Chart View

With the advent of the Refill Request module new subsections under the Medication section of Chart View have been added. These new subsections of Medications are called Request Medication and Refill Medication and can be access on the Medications tab via radio button choices labeled Request Medication and Refill Medication. When a record in the Refill Request grid is double-clicked, the associated patient's chart is opened to the Refill Medication section of Chart View and when a new request is added or when request is edited the patient's chart is opened to the Request Medication section. In addition these new sections can be accessed anytime the user is in the Chart View section by

clicking the Medications tab and then selecting the Request Medication or Refill Medication radio button. When the Request Medication radio button is selected, it will display the patient's refill request list. When the Refill Medication radio button is selected, it will display the patient's current meds in the upper Grid and the request in the lower grid. All of the functionality of the Refill Grid is present in the Refill Medications section just as if you were filling prescriptions from the Current Medications list in the Health Summary section of the patient's chart.

Using the Refill Request Module

It is very important the all users set user preferences for themselves before beginning to use the Refill Request module. It is important to set up the Provider List, which lists the physicians under whose name the requests will be made. If this preference is not set up users will have to search for the provider name each time they add a request to the module. When the Provider List is filled out the user simply has to choose a provider from a drop down list. In addition to the Provider List users must set up the "Show Providers For" list. This list filters the requests and only shows those that are for the provider or providers set up in the Show Providers For list. If the user is a provider the list should default to their own name. However if the user is not a provider the list will default to show no names and will have to be set up. For details on setting up each of these lists, please see the next two sections.

Other items that may require setup are the Display Refill Request Count in Red if Greater Than X, the Refresh Rate and the HIPAA Compliance setup. All these items except for the Show Providers For preference are part of the Options section of the Refill Request module. See the Setting Up Options section for details about these preferences.

Setting Up a Provider List

The provider list is a short list of providers that can easily be selected to request a refill from. The Provider List is intended to be a fast and easy way for a user to pick a provider. It is very important that this list be set up *before* using the Refill Request module because otherwise the user submitting the request will have to search for a provider each time a request is made. The search process is much slower than just picking the provider from a short list.

Notes:

- Once the provider list is created it will only show up in the Request Medication subsection of the Chart View section of a patient's chart.
- All lists are user specific and the list will only be accessible by the person that created it.

To set up a provider list:

1. On the main menu bar of the Refill Request module, click **File** then select **Options** from the pop-up menu. The Primary provider s window will open.
2. Locate the six drop-down fields labeled **Provider 1** through **Provider 6** at the screen left.
3. To set up the first provider in the list, click the down arrow in the **Provider 1** drop-down list. A list of staff providers will appear.
4. Select the name of the desired provider and it will populate the field. Notice that, when the provider name is selected, the short name field to the right will also be populated by the same name.
5. *OPTIONAL:* To set up a short name (a nickname) for a provider, click in the **Short Name** field and type in a new name (for example: **Dr. B** for **Dr. Barnard**, etc.)
6. Set up the next provider by filling out the **Provider 2** field and so on. A total of six providers can be set up in this manner.
7. Click **Save** when finished.

Setting Up the Provider Field (Show Providers For List)

This field allows the user to select the provider or providers whose information will show up in the Refill Request grid. It is very important to set this list up since the Refill Request grid will only show requests for

those providers selected in the Show Providers For list. If at least one provider is not selected the refill request grid will remain empty.

By default, when a provider logs into the Refill Request module this field it default to show the name of the provider logged in. If a non-provider logs in, the field will default to having no names selected. In either case, once the user is logged in they can select one or more providers from the dropdown list by checking the box to the left of the name. Once selection of the name(s) is completed clicking outside of the dropdown box will refresh the grid and show the refill requests for the selected provider or providers. A selection for All Providers is also available and may be handy for an administrator to monitor the information on a clinic wide basis. The selection of multiple providers allows users to monitor refill requests for multiple providers. In the case of non-providers, this may be necessary when a nurse or assistant is working with multiple providers and monitoring pending refill requests for them. In the case of providers this feature may be necessary when the provider is covering for another provider that is out of the clinic or when a provider is supervising physician extenders or residents.

Note: All lists are user specific and the list will only be accessible by the person that created it.

To add providers to the Show Providers For list:

1. On the Main toolbar of the Refill Request module, click the drop-down labeled **Providers**.

   A list of all staff providers in the clinic will appear with a check box to the left of each name.

2. Click the check box next to the desired provider.

   Note: Multiple providers can be selected by clicking the check box next to more than one name.

3. A selection for **All Providers** is included to make it easy to monitor requests for all providers if necessary.

4. Once all desired provider names are selected click anywhere outside the list (or the **Refresh** button) to refresh the grid.

5. If refill requests exist for the provider or providers selected they will appear in the grid.

Setting Options

It is important to set up preferences for how the Refill Request module will perform. These preferences can be found in the Options section of the Refill Request module. It is not absolutely necessary to set up all of these preferences although it is highly recommended.

Refill Request Options	
Display Refill Request Count in Red if Greater Than	The Dashboard button for the Refill Request module will display the number of request that are pending for the providers set up in the Show Providers For field. This number can be set to display in red if the number exceeds a specified amount. This can provide a non-intrusive alert to a user about a possibly heavy workload.
Refresh Rate	There is an automatic refresh rate which will redraw the screen and update any information that has changed since the module was opened or since the last refresh occurred. This refresh rate is set to 2 minutes by default and cannot be changed to a lower number but can be changed to a higher one. Setting a higher refresh rate may be desired if there is a lot of traffic on the network and response times are slow. Constant refresh of any module that queries the database for a significant amount of information can case slowdowns in some cases.
Default HIPAA Setting	This feature allows the user to select how the patient's name will be displayed in the grid. The choices are to display No Patient Name, Initials Only or Full Patient Name. Settings can be changed on the fly using the buttons on the toolbar but a choice can be set as the default in the Options screen.

In order to filter your choices of providers for whom you will create a refill request, you should set up your Provider list as described below. If you do not set up this list, you will still be able to select a provider but it will be from an unfiltered list of *all providers*.

To set up the Display Refill Request Count in Red if Greater Than:

1. On the main menu bar of the Refill Request module, click **File** then select **Options** from the pop up menu. The Primary provider s window will open.

   Below the **Provider** drop-down list there is a section labeled **Display Refill Request Count in Red if greater than**. The default setting for this field is **0**, meaning that any refill request will cause the Dashboard button to display the count in red, so it is important to change the number.

2. Type the desired number in the field to set the count.
3. Click **Save** when finished.

To set up the refresh rate:

1. On the main menu of the Refill Request module, click **File** then select **Options** from the pop-up menu. The Primary provider s window will open.

   The second option from the bottom is the Refresh rate. The default setting is for the module to refresh every 2 minutes.

2. Type a number in the **Refresh** field to reset the rate.
3. Click **Save** when finished.

To set up the default HIPAA setting:

1. On the main menu of the Refill Request module, click **File** then select **Options** from the pop-up menu. The Primary provider s window will open.

   At the bottom of the window is the HIPAA compliance setting consisting of three radio buttons. The default setting is to not show any patient information but can be changed by clicking one of the other radio buttons.

2. Select the desired setting by clicking one of the radio button choices.
3. Click **Save** when finished.

Short Names

When setting up a Provider List for selection of provider name for refill requests, users have the choice of setting up Short Names. These are nicknames that will appear in the Primary Provider List instead of the provider's full name. When a provider is added from the provider dropdown in the Options window, the Short Name field will default to the same as the Provider field (which shows up in LastName, FirstName format). The Short Name feature allows users to reformat the name in any way they wish. For example with a provider named Dr. Christian Barnard the default format would be Barnard, Christian but could be changed to Dr. Barnard, Dr. B, Christian, etc.

To set up a short name:

1. Click **File** on the menu in the Refill Request module, then select **Options** from the pop-up menu.
2. Select a provider from the **Provider** drop-down list.
3. The **Short Name** field will default to the provider name in LastName, FirstName format.
4. To set the Short Name, type the desired name into the **Short Name** field to replace what is there.

Adding a New Request

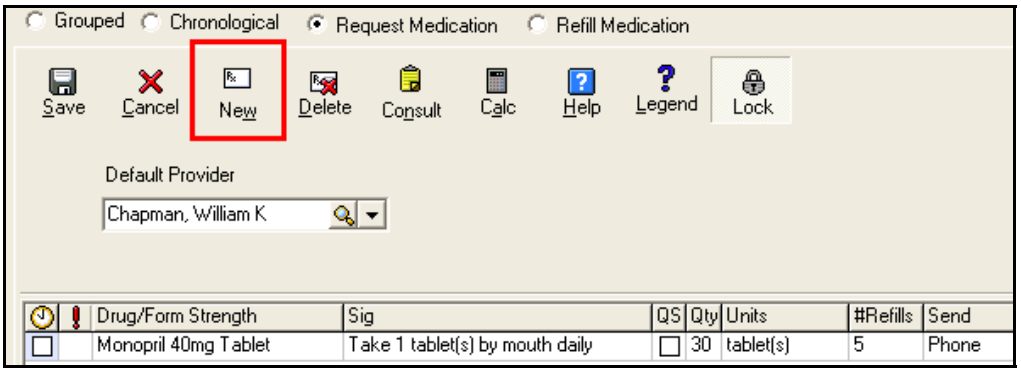
New requests for a refill can be added directly within the Refill Request module *OR* from within the DocMan application.

Some requests come in from pharmacies via fax. DocMan can be set up to receive faxes electronically and when that happens users may need to access the Refill Request module while viewing the fax. DocMan now has access to the Refill Request module in order to accommodate this need.

To add a request in the Refill Request Module:

1. On the main Refill Request toolbar, click the **New** button. A patient search screen will open.
2. Type in all or part of the patient's last name and press the **Enter** key or click the **Search** button.
3. In the Search results list, click the patient name and click the **Select** button ***OR*** double-click the patient name.
4. The patient's chart will open to the Request Medication subsection of Chart View.
5. Select the provider under whose name the request is being made. To do this, click the drop-down arrow at the **Primary provider** field to open the Provider list.

   Note: You must have your Provider List set up in order to see the provider names in this list. If you do not have a provider list set up you can still choose from a list of ALL providers in the clinic. This ALL list shows up in the request grid and is labeled **Provider**.
6. Click the **New** button on the toolbar to open the patient's Current Medications List. This form will default to the Current list, but you can select your request from the Past or All list by clicking the appropriate radio button.
7. Select a medication in the displayed list and click **Select** *OR* double-click the medication name. The medication list window will close and the medication will drop into the Request list.



8. After the medication has dropped into the request grid, you have the option to change the **# Refills**, **Send** method, **Provider** and **Last (date) Refilled** fields. The editable fields will be highlighted with a yellow background.
9. Set the priority of the request, if desired, by clicking the priority (!) column and select Normal, Urgent (!) or Stat (!!).

   The priority setting defaults to Normal but can be changed to Urgent or Stat if needed. The higher priority items appear with the respective icons in the Refill Request grid to draw attention to them.
10. The request can also be marked as **Unfinished**. Place a check mark in the unfinished column (denoted by a clock icon),
11. If this column is checked, an unfinished icon (clock icon) will appear in the Status column of the grid to show the item needs attention. This status can be used when other information needs to be gathered before the request is ready to be dealt with.
12. *OPTIONAL:* You can add a note to the patient chart but the note is not specific to any of the refills themselves. The note may refer to one or more of the requests. (See "Adding a Note to a Request" for details).
13. Click the **New** button and repeat the process if you need to add more requests.
14. When all of the information has been selected, click the **Save** button.

15. Click the **X** in the upper-right corner of the patient chart to close the chart and return to the Refill Request module.

To add a request from DocMan:

1. In DocMan, while viewing a faxed refill request, click the **Refill Request** button on the document viewer toolbar. A patient search screen will open.

   Note: You must either have the document open ***OR*** have the Filing Preview window showing at the bottom of the Fax Filing window in DocMan in order to access the viewer and associated toolbar.

2. Type all or part of the patient's last name and press the **Enter** key ***OR*** click the **Search** button.
3. In the Search results, click the patient name and click the **Select** button ***OR*** double-click the patient name.
4. The Refill Request form will open.

   Note: In this case the patient's chart will *NOT* open. Only the Refill Request form will open. This was done so that you can still see the faxed request at the same time as the form. The form can be moved around in order to be see the faxed request.

5. Select the Provider under whose name the request is being made. To do this, click the drop-down arrow at the **Primary provider** field to open the Provider list.

   Note: You must have your Provider List set up in order to see the provider names. If you do not have a provider list set up you can still choose from a list of ALL providers in the clinic. This ALL list shows up in the request grid and is labeled **Provider**.

6. Click the **New** button on the toolbar to open the patient's Current Medications List.

   Note: This form will default to the Current list but you can select your request from the Past or All list by clicking the appropriate radio button. Select a medication on list and click **Select** *OR* double-click the medication. The list window will close and the medication will drop into the Request list.

7. After the medication has dropped into the request grid, you have the option to change the **# Refills**, **Send** method, **Provider** and **Last (date) Refilled** fields. The editable fields will be highlighted with a yellow background.
8. If desired, click the priority (!) column and select **Normal**, **Urgent** (!) or **Stat** (!!) to set the priority of the request.

   The priority setting defaults to **Normal** but can be changed to **Urgent** or **Stat** if needed. The higher priority items appear with the respective icons in the Refill Request grid to draw attention to them.

9. To mark the request as **Unfinished**, place a check mark in the unfinished column (denoted by a clock icon),

   If this column is checked, an unfinished icon (clock icon) will appear in the Status column of the grid to show the item needs attention. This status can be used when other information needs to be gathered before the request is ready to be dealt with.

10. *OPTIONAL:* You can add a note to the patient chart but the note is not specific to any of the refills themselves. The note may refer to one or more of the requests. (See Adding a Note to a Request for details).
11. Click the **New** button and repeat the process if you need to add more requests.
12. When all of the information has been selected, click the **Save** button and the window will close.

Electronic Refill Requests (via SureScripts)

If a clinic has implemented electronic prescription functionality (via SureScripts), then electronic refill requests can also be sent from pharmacies through the same communication link. These electronic refill requests will automatically show up in the Refill Request module for processing. These requests come directly from the pharmacies and contain the same information as a faxed or manually entered request and they are processed in the same manner as manually input requests. Electronic requests will be designated by having SureScripts appear in the **Entered By** column of a request rather than a user name for manually entered requests.

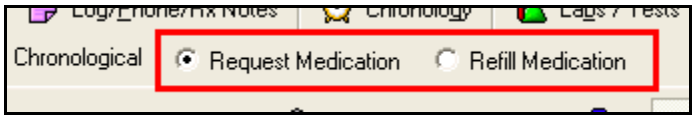
Note: SureScripts does not activate the refill request functionality until five new prescriptions per registered provider are sent from your e-MDs server.

Important! *SureScripts requires that electronic refill requests be acted upon within 48 hours.* If refill requests remain outstanding beyond that time frame, SureScripts may deactivate the electronic refill functionality. (e-MDs has no control over this process.) To retain the electronic refill functionality, it is important to address unlinked requests daily so providers can approve or deny the refill requests.

Request Mode

When in the Medication subsection of Chart View of a patient's chart, the chart can be in either a Request mode or a Refill mode. When in a request mode, the **Request Medication** radio button will be selected and the program is set to only allow a request to be made.

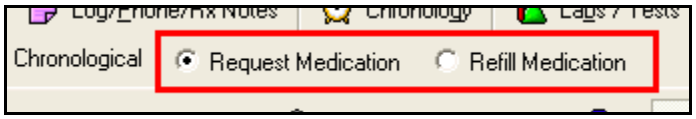
Note: The user can click the **Refill Medication** radio button at any time and switch the functionality to allow the refill of medications *IF* they have scriptwriter privileges.



Refill Mode

When in the Medication subsection of Chart View of a patient's chart, the chart can be in either a Request mode or a Refill mode. When in the Refill mode, the **Refill Medication** radio button will be selected and the program is set to only allow medications to be refilled.

Note: The **Request Medication** button can be clicked at any time in order to switch the module into Request mode.



At times the situation may arise where requests for a single patient come in under different providers at the same time. To deal with that situation, you should first set up refill requests for the first provider, save them and then add requests for the other provider.

To add requests for multiple providers:

1. On the main Refill Request toolbar, click the **New** button. A patient search screen will open.
2. Type in all or part of the patient's last name and press the **Enter** key ***OR*** click the **Search** button.
3. In the Search results list, click the patient name and click the **Select** button ***OR*** double-click the patient name. The patient's chart will open to the Request Medication section of Chart View.
4. Select the first Provider's name from the Provider List section by clicking the drop-down arrow in the **Primary provider** field to open the Provider list ***OR*** by choosing a provider from Provider drop-down in the refill request grid. This is an unfiltered list of ALL providers.
5. Click the **New** button on the toolbar to open the patient's Current Medications List.

6. This form will default to the Current list but you can select your request from the Past or All lists by clicking the appropriate radio button. Select a medication on list and click **Select** or double-click the medication, the list window will close and medication will drop into the Request list.
7. After the medication has dropped into the request grid, you have the option to change the **# Refills**, **Send** method, **Provider** and **Last (date) Refilled** fields. The editable fields will be highlighted with a yellow background.
8. Click the priority (!) column and select **Normal**, **Urgent** (!) or **Stat** (!!) to set the priority of the request, The priority setting defaults to **Normal** but can be changed to **Urgent** or **Stat** if needed. The higher priority items appear with the respective icons in the Refill Request grid to draw attention to them.
9. Mark any other information such as **Priority** or **Unfinished** status.
10. Click the **Save** button.
11. Select the second provider's name from the list and add requests for that provider as outlined above.
12. Continue in this manner until all requests are complete.
13. When all of the information has been selected, click the **Save** button.
14. Click the red **X** in the upper right corner of the patient chart to close the chart and return to the Refill Request module.

Linking Electronic Refill Requests

When a refill request is received from SureScripts, the system searches the e-MDs Solution Series database for a patient name and prescription that *exactly matches* the name and prescription from SureScripts. If no such match is found, the system cannot automatically link the refill request to the correct patient and prescription. (This may occur if the patient's name in the pharmacy records differs in some way from the patient's name in e-MDs Solution Series, or if the details in the refill request differ in some way from the prescription in e-MDs Solution Series.) Using the Link Refill Requests module, you can link an unmatched request to the correct patient and prescription, or you can deny the request.

Important! SureScripts requires that electronic refill requests be acted upon within 48 hours. If refill requests remain outstanding beyond that time frame, SureScripts may deactivate the electronic refill functionality. (e-MDs has no control over this process.) To retain the electronic refill functionality, it is important to address unlinked requests daily so providers can approve or deny the refill requests.

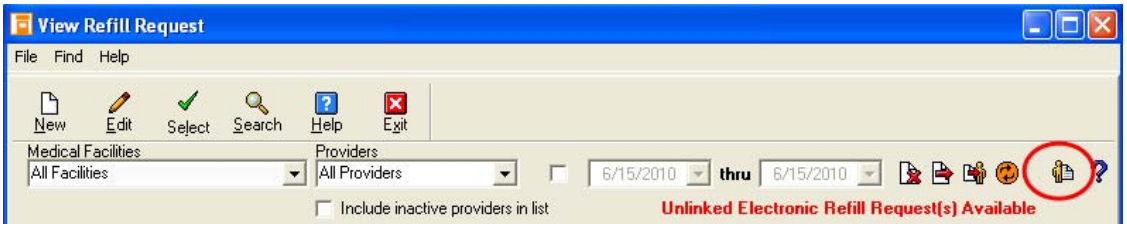
To link an unlinked refill request:

Privileges Required: *Scriptwriter: SureScripts Patient Linking*

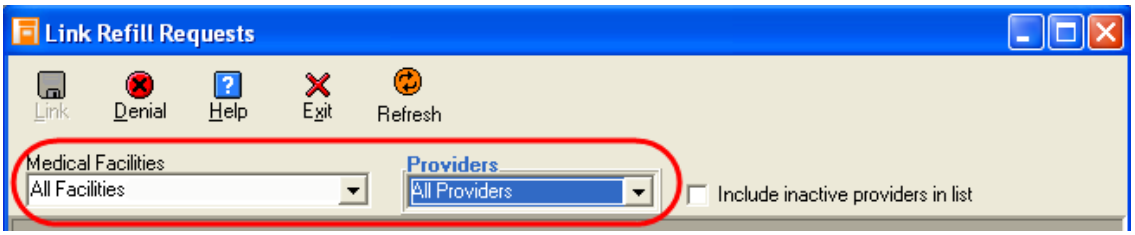
1. Access the Solution Series Dashboard and click **Run > Refill Request**. The Refill Request module opens and the refill request count is shown at the top of the Dashboard; the first number indicates the total number of refill requests, and the second number indicates the number of *unlinked requests* from SureScripts.

   If unlinked requests are in the queue, the **Unlinked Electronic Refill Requests Available** message will also on the View Refill Request screen. (If no unlinked electronic refill requests are available, the message text is gray and the link is not active.)

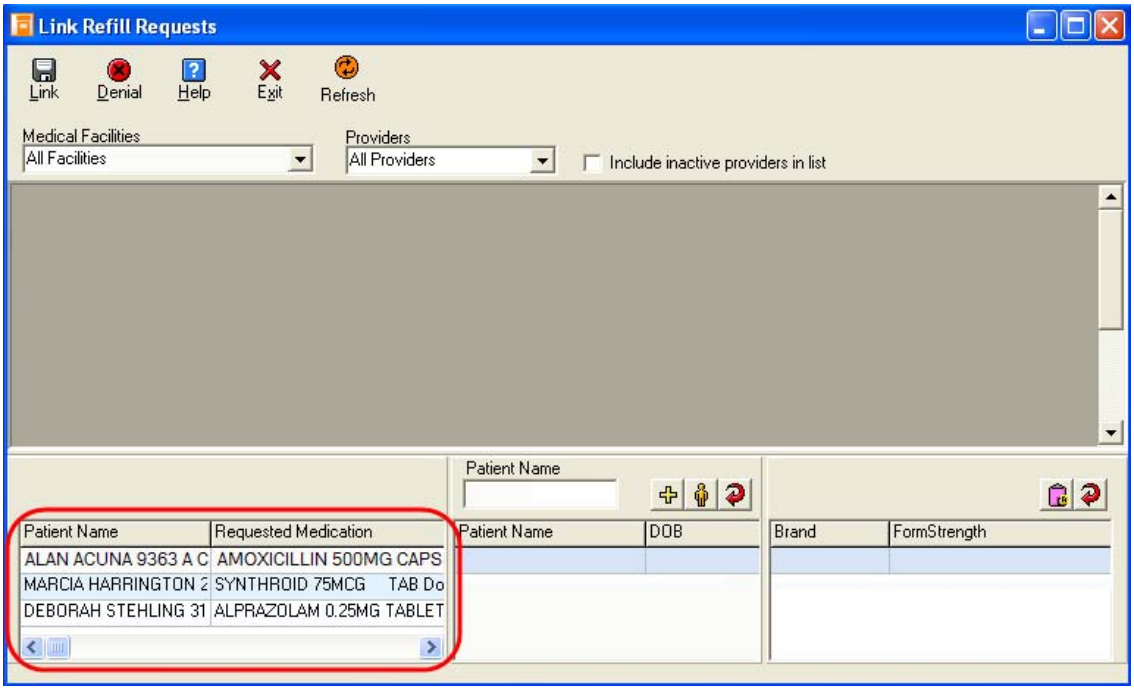
2. Click the **Link Refill Requests** button or the red message itself to display the Link Refill Requests screen.



Note: The Link Refill Requests screen automatically shows requests for **All Facilities** and **All Providers**. *To avoid missing a refill request, best practice is to leave this as the default setting.* However, if you want to see refill requests only for selected facilities or providers, click the down arrow in the **Medical Facilities** field or the **Providers** field, then click the checkbox next to the desired selection(s).

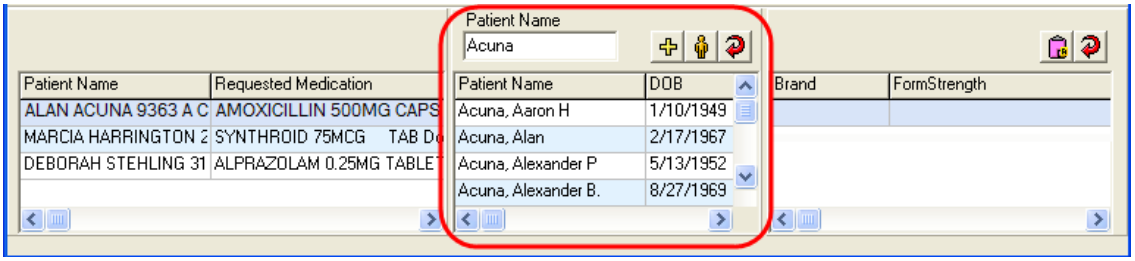


For each unlinked refill request, the system displays the patient name and requested medication.

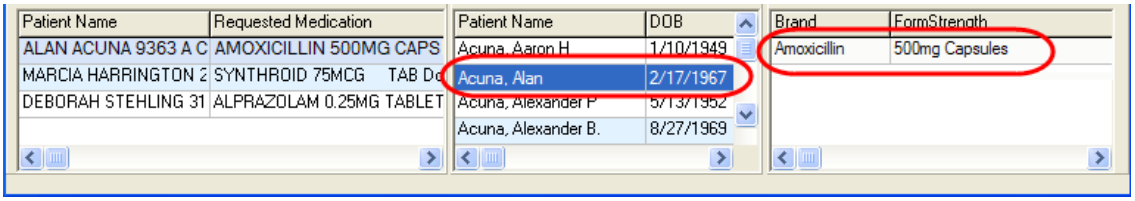


3. In the list of unlinked refill requests, click a request to select it. All information related to the selected request is displayed in the gray area above the list of request.
4. In the **Patient Name** field, type the last name (or the first few letters of the last name) of the patient for whom the selected refill is requested and press the **Enter** key.

The system displays a list of the patients in e-MDs Solution Series whose last name begins with the letters you typed.

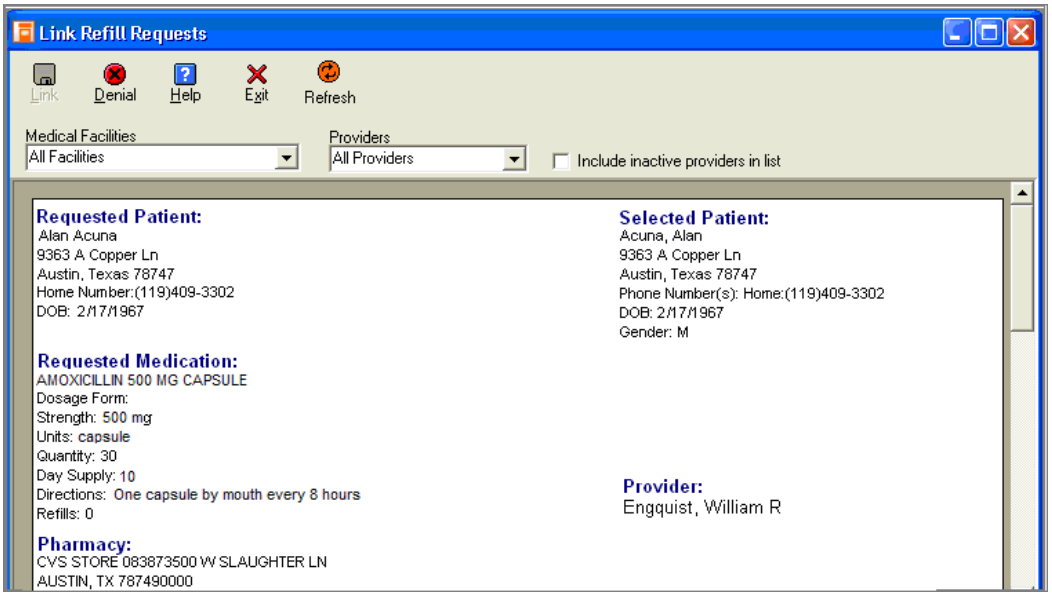


5. Click the name of a patient in the middle column to select the most likely match and a complete list of that patient's medications will appear in the far right column.



Note: If e-MDs Solution Series does not contain a record for the patient, but the provider has written a prescription for the patient, click the **yellow plus sign** (next to the **Patient Name** field) to access Chart Patient Maintenance screen and add the necessary demographic information. This scenario may occur when a provider sees a new patient in an emergency room and writes a prescription at that location.

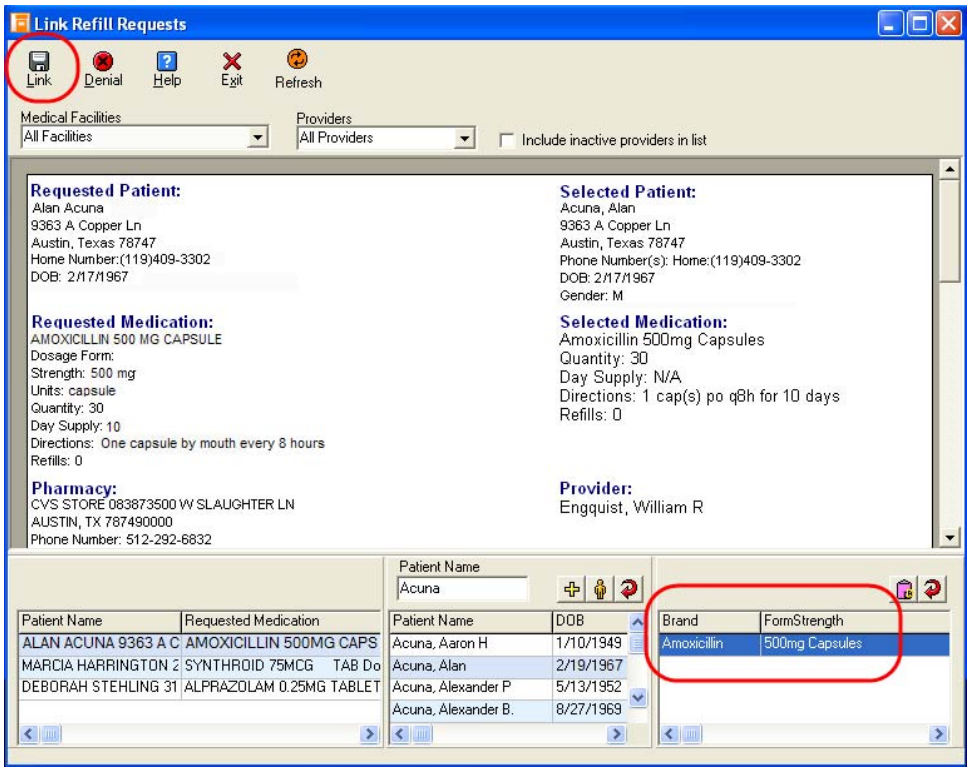
More information will be added to the top of the screen as the search results are narrowed.



Important! If you link a prescription to an incorrect patient name or medication, see Unlinking SureScripts Refill Requests for instructions on how to unlink the refill request.

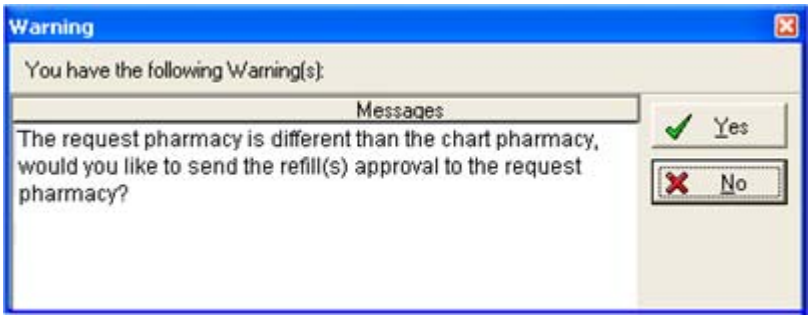
6. Do one of the following:

   - *If a prescription in e-MDs Solution Series matches the refill request*, click the prescription in e-MDs Solution Series that corresponds to the requested medication and then click **Link**.



Note: If the pharmacy requesting the refill is not the same pharmacy that is currently associated with the prescription in Chart, the system displays an alert message, which allows you to automatically update the pharmacy in Chart to the requesting pharmacy.

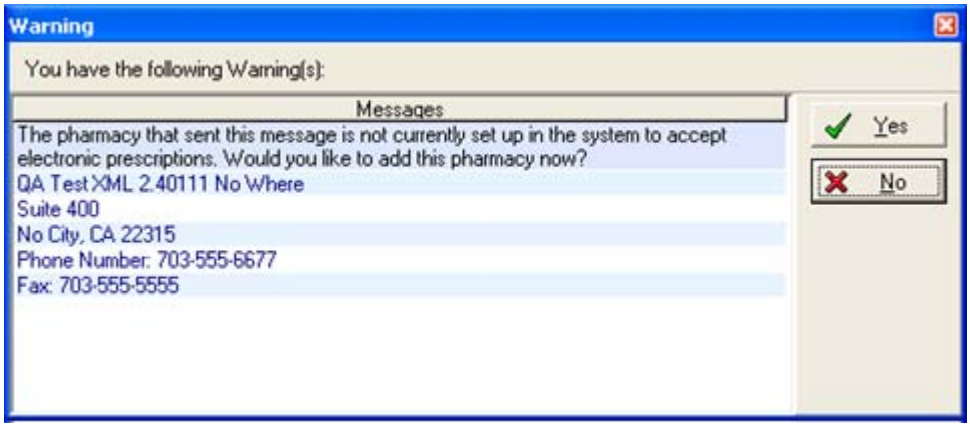
- *If Solution Series contains a Demographics record for the requesting pharmacy*, the message shown in the following image is displayed.



- Clicking Yes adds the requesting pharmacy to the patient's pharmacy list, changes the pharmacy associated with the prescription in Chart to the requesting pharmacy, and sends the approved refill to the requesting pharmacy.

- Clicking No sends the refill to the pharmacy that is currently associated with the prescription in Chart.

- *If Solution Series does* **not** *contain a Demographics record for the requesting pharmacy,* the message shown in the following image is displayed.



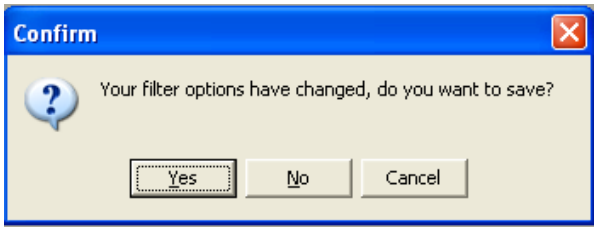
- Clicking Yes opens the Surescripts pharmacy matching screen. You can then search by pharmacy zip code or phone/fax number and then save the pharmacy as a new pharmacy.

- Clicking No sends the refill to the pharmacy that is currently associated with the prescription in Chart.

- *If* **no** *prescription in the e-MDs Solution Series list matches the requested medication*, do one of the following:
  - If a prescription in the e-MDs Solution Series list shows the brand name, and the requested medication shows the generic name of the drug, but all other components of the prescription match, link the two prescriptions.
  - If you want to add the drug to the patient's medication list and add the prescription to the Refill Request Module for review by the provider, click the **New Drug** button (the pink clipboard).
  - If you want to deny the refill, follow the steps in "To deny an unlinked refill request."

7. When the confirmation screen appears, click **Yes** to confirm that you are sure this information is correct. The completed refill request will appear in the View Review Request screen.
8. Process the newly linked refill request as you would any linked electronic refill request.

Note: If you used new filter values for the facility or provider to locate the correct patient, the following message may display when you start to close the screen:

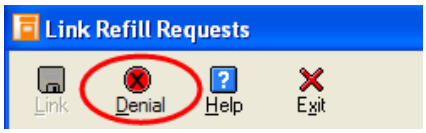


9. Click **Yes** to save your filter options for the entire Refill Request module, click **No** to discard the options and revert back to the default options, or click **Cancel** to return to the Link Refill Request screen without saving any changes. Note that saving your options on this screen will also make them the default filters for the View Refill Request screen as well.

To deny an unlinked refill request:

1. Access the Refill Request Module, select the refill request and search for the corresponding patient and prescription in e-MDs Solution Series as described in the "To link an unlinked refill request."

2. *If there is no corresponding* patient record *in e-MDs Solution Series*, do one of the following:
   - To deny the request, click **Denial**.



     The system notifies the requesting pharmacy that the patient is unknown.

     OR

   - *If e-MDs Solution Series does not contain a record for the patient, but the provider has written a prescription for the patient,* click the **yellow plus sign** (next to the **Patient Name** field) to access Chart Patient Maintenance and add demographic information. This scenario may occur when a provider sees a new patient in an emergency room and writes a prescription at that location.

     Note: Best practice is to notify the pharmacy by telephone if the patient is not part of your practice, so that they can identify the correct provider and resubmit the refill request.

3. *If there is no corresponding prescription for the patient in e-MDs Solution Series,* do one of the following:
   - *To deny the refill request,* click **Denial**.

     If you deny the refill request without first adding the drug to the patient's medication list in e-MDs Solution Series, the system transmits a denial message to the pharmacy. If that happens, the denial message indicates that the patient is unknown.

     OR

   - *To add the drug to the patient's medication list,* click the **New Drug** button (the pink clipboard). Then link the refill request and access the Refill Request Module to deny the request.

     This method adds a record of the request to the patient's chart, and sends the appropriate denial message to the pharmacy.

Adding a Note to a Request

Notes can be added to a refill request. These notes get saved as Prescription notes.

To add a note to a new request:

1. Add a new request as described in prior sections.
2. Once the request has been added, click the **Save** button.
3. In the note area at the top right of the Request screen, click the yellow plus (+) icon and select **Note** from the pop-up menu (if a note already exists, choices for **Note** and **Addendum** may be available).

   The Edit Telephone/Log/Rx Note window will open.
4. Select either Permanent or Sticky Prescription note
5. Type in your message.
6. Click Save.
7. The message will be displayed in the Note section.
8. Once the message has been saved, other icons will become enabled, allowing you to edit or delete the note (once a note is signed off, the Addendum button becomes enabled and you can add an addendum as well).

Notes:

- At the bottom left of the note section is a button that toggles from **Show All** to **Show Recent** when pressed. When this button is depressed it will only display the most recent notes associated with the current requests in the list. When toggled to **Show All** access to all the notes is provided.
- At the top of the note area are two arrows that point left and right.

These arrows allow users to browse and read past Prescription notes if they exist.

9. Close the chart by clicking the **X** in the red box  at the top right corner of the chart

   Note: *DO NOT* click the black **X** on the gray Dashboard toolbar unless you want to close the Dashboard and ALL applications.

To add a note to an existing request:

1. Click to select a request in the grid and click the **Edit** button. The patient's chart will open to the Request Medication section of Chart View.
2. Highlight the request and click the yellow plus (+) icon and then select **Note**

   The Edit Telephone/Log/Rx Note window, which allows you to create Rx notes, will open.
3. Select the type of note that you want to create -- **Sticky** or **Permanent**).
4. Type in your message.
5. Click **Save**. The message will be displayed in the Note section.
6. After the message has been saved, other icons will become enabled and these allow you to edit or delete the note (once a note is signed off the **Addendum** button becomes enabled and you can also add an addendum).
7. Close the chart by clicking the **X** in the red box at the top right corner of the chart

   Note: *DO NOT* click the black **X** on the gray Dashboard toolbar unless you want to close the Dashboard and ALL applications.

Refilling a Prescription

Prescriptions can be refilled by the provider they are assigned to. In addition, clinical staff can refill these prescriptions *IF* they have the correct scriptwriter privileges.

To refill a prescription:

1. Click the request to be refilled and click the **Select** button ✓ ***OR*** double-click the request.

   The patient's chart will open to Refill Medication section of Chart View and the request will be in Refill mode. The bottom grid will display the request(s) and the top grid will display patient's medication list.
2. Check the check box to the left of the requested medication(s) in bottom grid.

   This will cause the e medication that corresponds to the request to be highlighted and checked in the top grid (the patient's current medication list).

   Note: If the refill request was received electronically, and the substitution code in the request indicates that substitution should be acceptable, the "Sub?" check box is **automatically** selected in the bottom grid, but can be deselected by the user.
3. *If no changes are needed,* click the **Save** button to refill the prescriptions.

4. *If changes ARE needed,* make those changes by clicking in the field that needs changing (for example, the pharmacy field to change pharmacies) and change the value.

   Important! Requests will not always match the information in the medication list. Changes can be made to the number of refills, Send method, Pharmacy, etc. when the request is created. Providers have the last say in whether they want to make those changes so the changes are not automatically made to the actual medication. If the provider wants to accept the changes they need to make the change manually to the patient's medication.

5. When finished, click **Save**. A Sending Prescriptions dialog window will open with **Send** and **Don't Send** choices.

6. Click **Send** to send the prescription(s) ***OR*** click **Don't Send** to just record the prescription(s).

   After the prescription is processed the dialog exits and the request is removed from the bottom grid. This dialog will only appear if the prescription(s) are using Print, Fax or Electronic send methods. If the prescription refill is to be phoned-in, the prescription will process without the dialog and the request is removed from the bottom grid.

   Note: Depending on what is selected in the **Send** method field, sending could mean Printing, Faxing or Electronic)

7. Click the **X** in the red box in the upper right corner of the patient chart to close the chart and return to the Refill Request module.

Editing an Internal Refill Request

After a refill request has been added by clinic staff, and it appears in the Refill Request grid, it can be edited and information can be changed, if necessary. For example, if a request is initially marked as **Unfinished** and now needs to be changed, the request can be edited to do so. You can also change the Priority status, the Unfinished status, add a note, add a new request, remove a request, or change the request to another provider.

Note: You can only edit refill requests submitted within the clinic, not requests received through SureScripts.

To edit a request:

1. In the Refill Request grid, click the request to be edited and then click the **Edit** button.

   Note: *DO NOT* double-click the request. Double-clicking will open the request in REFILL mode and not in Request mode and you will not be able to edit. You can only refill without any changes.

   The patient's chart will open to the Request Medication section of Chart View.

2. The record will be in REQUEST mode; make the necessary changes.

3. When finished making changes, click the **Save** button.

Changing Providers on a Request

At times a request may be inadvertently assigned to the wrong provider or it may be that a provider is covering for another and the request needs to be changed to a different provider. The provider for a request can be changed by editing the request.

To change a provider:

1. In the Refill Request grid, click the request to be edited and then click the Edit button.

   Note: *DO NOT* double-click the request. Double-clicking will open the request in REFILL mode and not in Request mode and you will not be able to edit. You can only refill without any changes.

The patient's chart will open to the Request Medication section of Chart View. The record will be in REQUEST mode and the initial provider's name will be in the **Provider** field.

2. In the **Provider** field, select another provider to whom the request is going to be reassigned.
3. Click **Save** when finished.

Important! Currently the assigned provider cannot be changed for electronic refill requests.

Deleting a Request

Deleting a refill request will remove the request record for that patient.

To delete a request:

1. In the Refill Request grid, click the request to be edited and then click the **Edit** button.
2. The patient's chart will open to the Request Medication section of Chart View.
3. Click to highlight the request to be deleted.
4. Click the **Delete** button on the toolbar. The request will be removed from the grid.

Important! Electronic refill requests *CANNOT* be deleted. They must be *DENIED* so that a message is sent back to the pharmacy denoting that the request was denied.

Setting a Priority

A priority setting can be added to a request. This priority can be Urgent, which will place a single exclamation point icon ! in the Priority column of the grid, or it can be Stat, which will place a double exclamation point icon !! in the Priority column. Priority settings are useful to draw attention to a request that may need to be deal with quickly.

To set a priority level on a NEW request:

1. Add a new request as described in prior sections.
2. Select the **Priority** column and select a priority level (**Normal**, **Urgent** or **Stat**) from the pop-up menu
3. Click **Save** when all the information for the request has been added.

To add a priority level to an existing request:

1. In the Refill Request grid, click the request to be edited and then click the **Edit** button.
2. The patient's chart will open to Request Medication section of Chart View.
3. Click the **Priority** column and select a priority level (**Normal**, **Urgent** or **Stat**) from the pop-up menu.
4. Click **Save** when finished.

Mark as Unfinished

It may be necessary sometimes to mark a request as Unfinished. This status can be used when a request has been added but when there is more information that needs to be collected before the request is ready to be dealt with. For example when a request is added from DocMan the Refill Request form that opens does not contain the patient's chart (it just contains the Current Med list). In this case the user might want to mark the request as unfinished because there may be information from the chart that needs to be reviewed. Once marked as Unfinished the request will appear in the Refill Request grid with an icon in the Status column denoting it is unfinished. The user can then edit the record from the grid and access the patient's chart.

To mark a new request as unfinished:

1. Add a new request as described in prior sections.

2. Click the **Mark as Unfinished** check box (clock column).
3. Click **Save** when all the information for the request has been added.

To mark an existing *request as unfinished:*

1. In the Refill Request grid, click the request to be edited and then click the **Edit** button.

   The patient's chart will open to the Request Medication section of Chart View.

2. Click the **Mark as Unfinished** check box (clock column).
3. Click **Save** when finished.

Adding Refill Requests from DocMan

Some requests come in from pharmacies via fax. DocMan can be set up to receive faxes electronically and when that happens users may need to access the Refill Request module while viewing the fax. DocMan now has access to the Refill Request module in order to accommodate this need.

To add a request from DocMan:

1. In DocMan, while viewing a faxed refill request, click the **Refill Request** button on the document viewer toolbar. A patient search screen will open.

   Note: You must either have the document opened ***OR*** have the Filing Preview window showing at the bottom of the Fax Filing window in DocMan in order to access the viewer and associated toolbar.

2. Type all or part of the patient's last name and press the **Enter** key or click the **Search** button.
3. In the Search results list, click the patient name and click the **Select** button ***OR*** double-click the patient name. The Refill Request form will open.

   Note: In this case the patient's chart will *NOT* open. Only the Refill Request form will open. This was done so that you can still see the faxed request at the same time as the form. The form can be moved around in order to be able to see the faxed request.

4. Select the Provider under whose name the request is being made. To do this, click the drop-down arrow at the **Primary provider** field to open the Provider list.

   Note: You must have your Provider List set up in order to see the provider names. If you do not have a provider list set up you can still choose from a list of ALL providers in the clinic. This ALL list shows up in the request grid and is labeled Provider.

5. Click the **New** button on the toolbar to open the patient's Current Medications List.

   This form will default to the Current list but you can select your request from the Past or All lists by clicking the appropriate radio button. Select a medication on list and click **Select** or double-click the medication. The list window will close and the medication will drop into the Request list.

6. Once the medication has dropped into the request grid, you have the option to change the **# Refills**, **Send** method, **Provider** and **Last (date) Refilled** fields. The editable fields will be highlighted with a yellow background.
7. Set the priority of the request, if desired, by clicking the priority (!) column and select **Normal**, **Urgent** (!) or **Stat** (!!). The priority setting defaults to **Normal** but can be changed to **Urgent** or **Stat** if needed. The higher priority items appear with the respective icons in the Refill Request grid to draw attention to them.
8. The request can also be marked as **Unfinished**. Place a check mark in the unfinished column (denoted by a clock icon). If this column is checked, an unfinished icon (clock icon) will appear in the Status column of the grid to show the item needs attention. This status can be used when other information needs to be gathered before the request is ready to be dealt with.

9. *OPTIONAL:* A note can be added to the patient chart but the note is not specific to any of the refills themselves. The note may refer to one or more of the requests. (See “Adding a Note to a Request” for details).
10. Click the **New** button and repeat the process if you need to add more requests.
11. When all of the information has been selected, click the Save button and the window will close.

5
Using the OB Module

e-MDs OB module is designed to expedite the obstetric encounter. This module provides an efficient method for data collection and offers other OB-specific tools to streamline the documentation process for prenatal encounters.

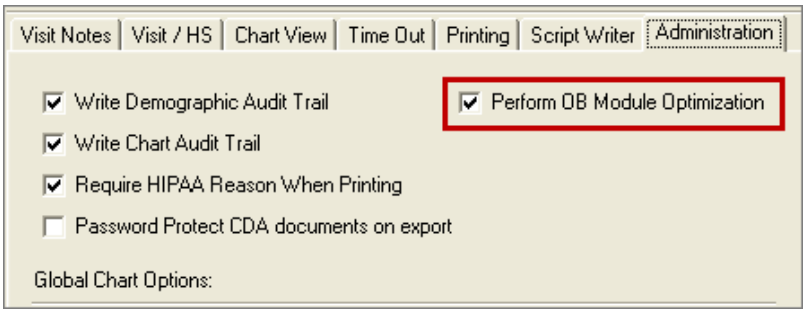
Continued on the next page ...

Optimizing Performance

Important! Before you use e-MDs OB module the first time, confirm that optimization has been activated in e-MDs Chart.

To activate optimization:

1. In the menu bar of e-MDs Chart, click **File** > **Options**.
2. On the **Administration** tab, select **Perform OB Module Optimization**.



3. Click **Save**.

Note: The first time you access the OB module on a workstation, you may see the following message:

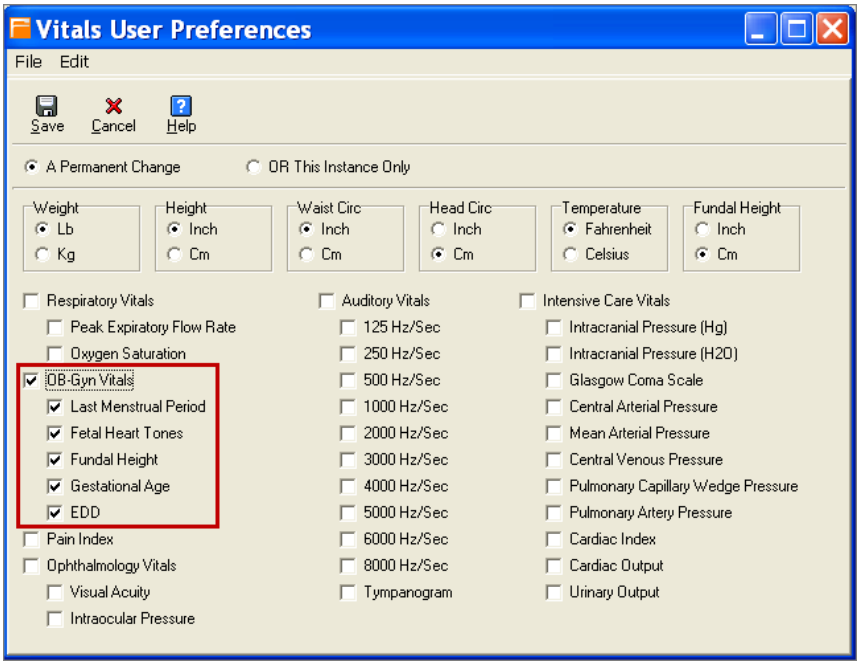
This is an informational message about the way the computer is set up to display pictures. If you click **OK**, the message will not appear again. However, if you close the message window without clicking **OK**, the message will continue to appear until you click **OK**.

Accessing the OB Module

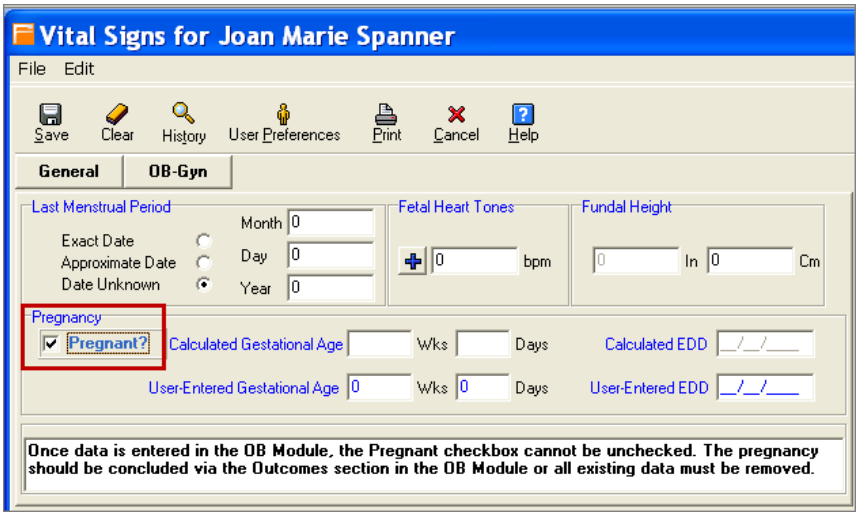
The OB module must be activated through the Vital Signs window in Chart before you use it the first time.

To activate the OB module:

1. Open the patient's chart.
2. Click the thermometer icon to access Vital Signs (or open from Visit or Order Note).
3. If the **OB-Gyn** tab is not visible on the Vital Signs screen:
    a. Select **User Preferences** from the top toolbar.
    b. Click **OB-Gyn Vitals**. then click **Save** to retain that setting and activate the **OB-Gyn** tab.



4. On the **Vital Signs** screen, click the **OB-Gyn** tab.
5. Check the box labeled **Pregnant?**. This is what activates the OB module.

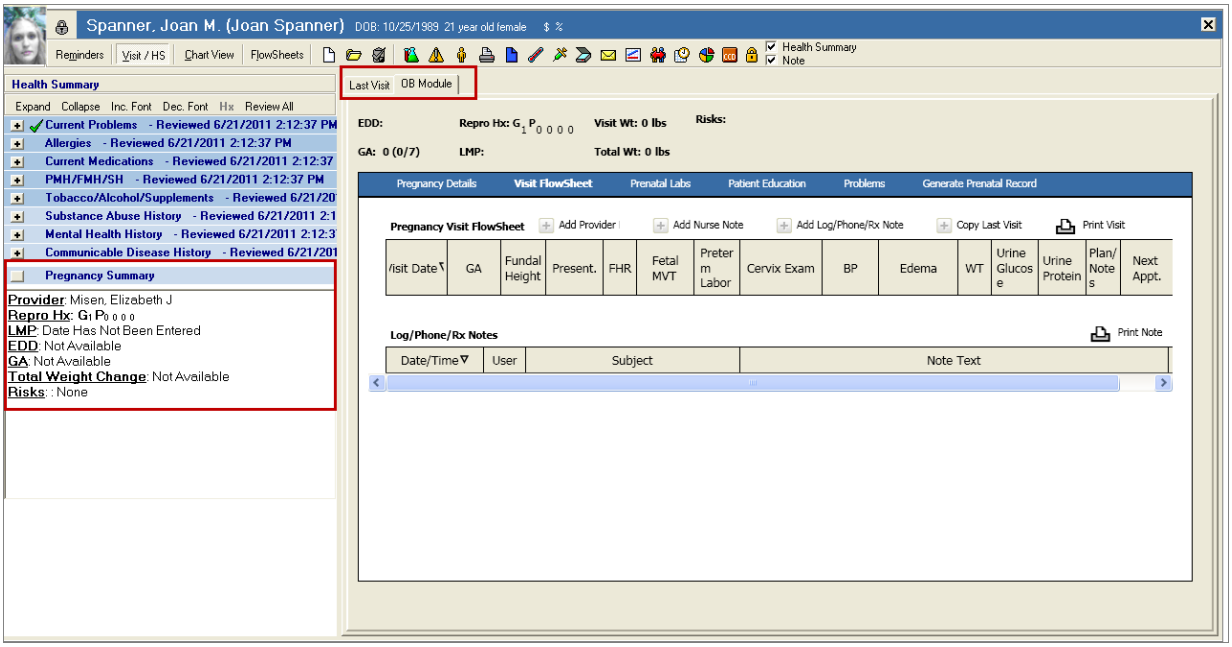


Notes:

- If a date for the last menstrual period is entered, gestational age and estimated delivery date are automatically calculated. Also, the date of the last menstrual period transfers to the Pregnancy Details Overview in the OB module. No other data entered in this window transfers to the OB module.
- After any data is entered in the OB module, the **Pregnant?** check box cannot be deselected. To cancel this selection, you must access the OB Module Outcomes section to conclude the pregnancy.

6. Click **Save**. The Pregnancy Summary section is added to the Chart Health Summary.

From this point on, as long as the patient is pregnant, the OB module overview page will display automatically whenever the **Visit/HS** tab is selected in Chart.



To toggle between the OB Module and Last Visit screens:

Click the **OB Module** or **Last Visit** tab at the top of the patient's Chart screen.

The Pregnancy Summary

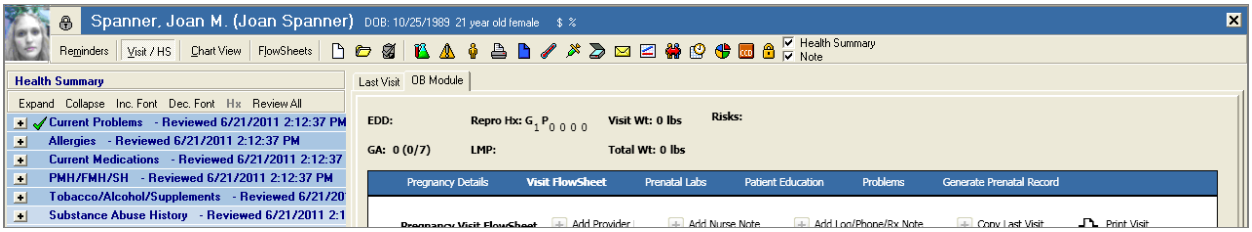
When a patient is marked pregnant on the OB-Gyn tab, a new section called Pregnancy Summary is added to the Health Summary in the patient's chart.

The Pregnancy Summary section displays:

- **Provider**: The Provider displayed in the Pregnancy Summary is pulled from the Primary Provider field in e-MDs Chart Patient Maintenance window unless an OB Provider is selected on the OB module Pregnancy Details screen. See the pregnancy details "Overview" for more information.
- **Repro Hx:** Reproductive history (based on data entered in e-MDs OB module).
- **LMP:** Last menstrual period date.
- **EDD:** Current estimated delivery date.
- **GA:** Gestational age.
- **Total weight change:** Amount of weight change to date.
- **Risks:** If risks are documented in the OB module, they are displayed in the Pregnancy Summary as well.

OB Module Interface Overview

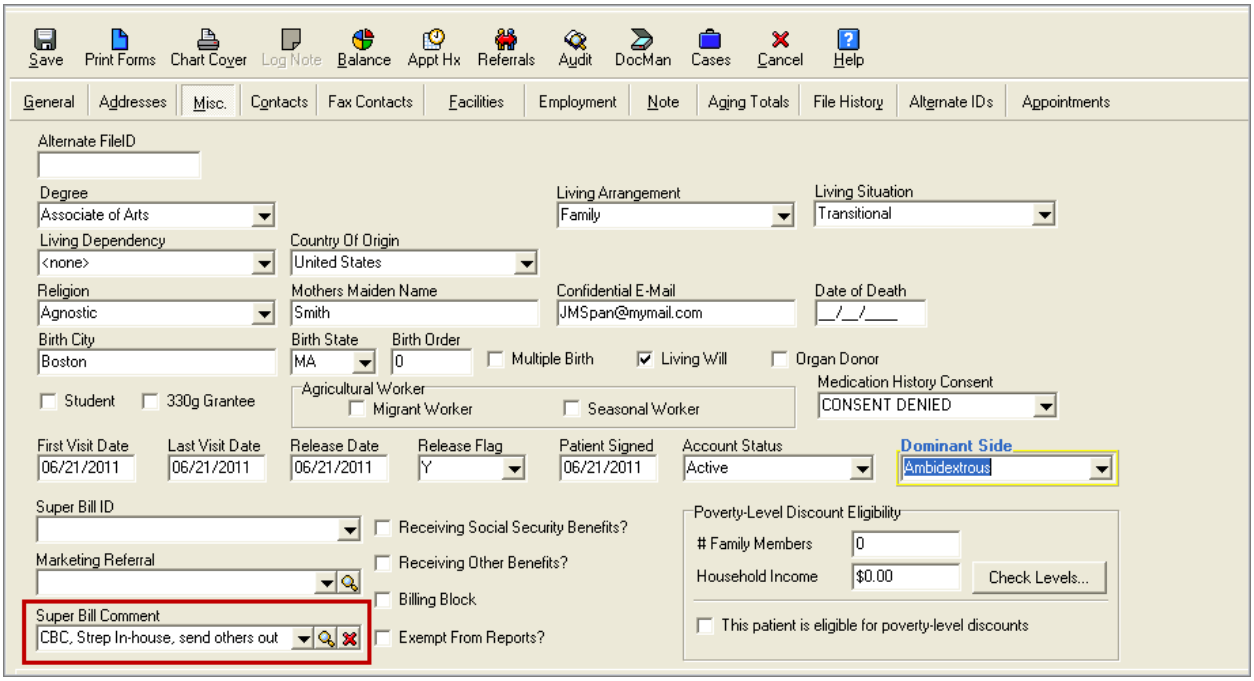
At the top of the OB module interface, the Patient Information header displays patient name, age, and date of birth, basic clinical data relative to the pregnancy, and certain insurance information. The Patient Information Header is visible from every section of the OB module.



Clinical information displayed in the Patient Information header includes:

- **EDD**: Current estimated delivery date.
- **GA**: Gestational age.
- **Reproductive History**: Presented in the following order: Gravida (total number of pregnancies), Para (number of full term births, number of preterm births, number of failed pregnancies, number of live children).
- **LMP**: Last menstrual period date.
- **Visit Weight**: Visit weight is calculated from the weight this visit and last visit.
- **Total Weight**: Total Weight is calculated from the pre-pregnancy weight and the weight this visit.
- **Risks**: When risks are added in the Risk Assessment section of the OB module, they are displayed here in red text.

In addition to clinical information, the following insurance information appears, including Insurance company name, co-pay amount, percent paid by insurance after co-pay, and Super Bill Comment. The Super Bill comment is fully customizable for each patient.



To customize this comment:

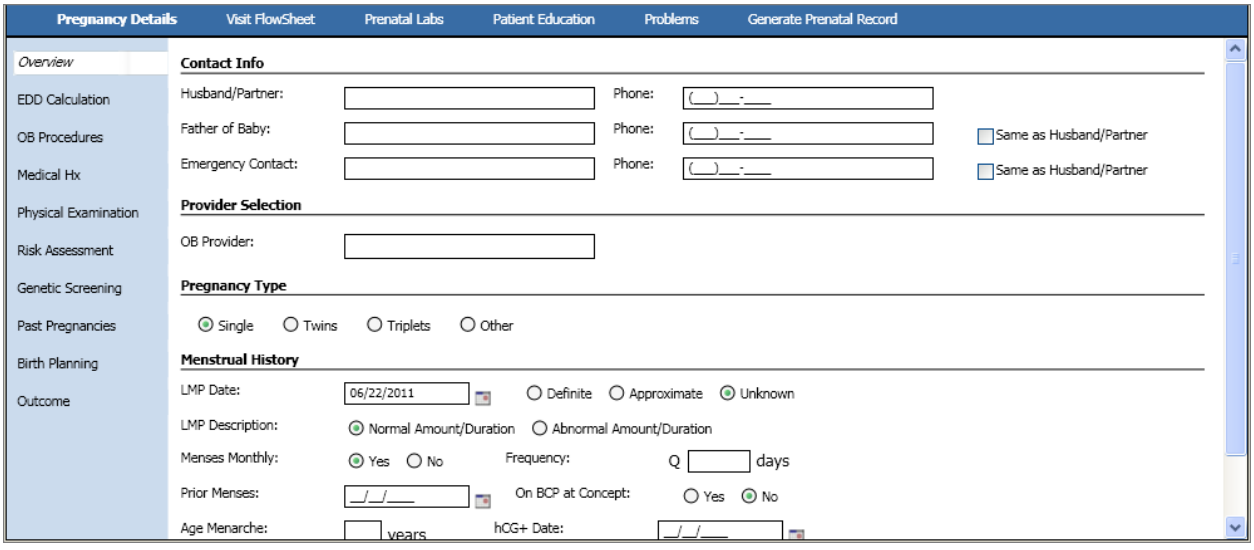
1. Go to **Chart** > **Demographics** > **Patients** and select a patient.
2. In the Chart Patient Maintenance window, click the **Misc.** tab.
3. Enter the comment in the **Super Bill Comment** field. (For more information on editing or creating Super Bill comments, see *e-MDs Bill User Guide*.)

Information in the OB module is presented in logical sections. Each section can be accessed from the OB module menu bar located directly below the Patient Information Header. Sections included in the OB module are:

- Pregnancy Details
- Visit FlowSheet
- Prenatal Labs
- Patient Education
- Problems
- Generate Prenatal Record

Documenting Pregnancy Details

The Pregnancy Details section of e-MDs OB module consists of a series of subsections that can be accessed via the Pregnancy Details menu on the left side of the OB module interface.

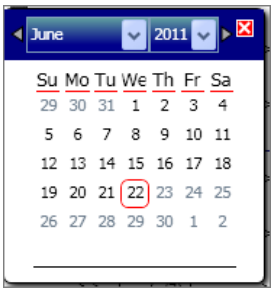


General Navigation

For more rapid data entry, the OB module interface allows the user to tab from field to field, enter dates by typing or using the calendar, enter numbers by typing or using a keypad, and select radio buttons or check boxes by pressing the spacebar.

For most fields with a dropdown list, the user can click in the field and type the first letters of the desired entry to display that entry, or simply click the dropdown list and select from the list.

To use the calendar to enter dates:



1. Click the calendar icon to open the calendar.
2. Select your date:
   - *To go forward or back by one month*, click the small grey arrow to left of month or right of year.
   - *To change month*, click the down arrow to right of month.
   - *To change year*, click the down arrow to right of year.
   - *To choose a date*, click that day on the calendar.
3. If the selected date is invalid for the field, the system displays a red exclamation point to indicate that the date is invalid.

A keypad appears when you click in a numeric field.

To use the keypad:

1. Click or tap on desired numbers and click **Next** when done.
2. Click **<** to clear a number.
3. Click the word **Next** to go the next field.

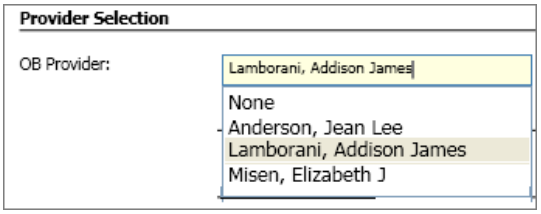
Overview

The Overview subsection of Pregnancy Details includes the following features:

- Documentation of individual contact information for husband/partner, father of baby, and emergency contact.

  Note: Contact information does *not* pull from any other fields in the system: The information must be entered here.

- The **Provider Selection** section allows you to select an OB Provider for the patient that is different than the patient's Primary Provider. This provider name will also appear in both the Pregnancy Summary section of the Visit/HS (Health Summary) pane of the patient's chart and the Prenatal Record report.

  Note that the OB Provider name will not appear in the Chart Visit/HS until the patient's chart has been closed and reopened after selecting that provider.

- Selection of multiple gestation automatically adds additional **FHR** (fetal heart rate) and **Presentation** fields to the OB Module Visit FlowSheet and adds a section for each baby to the Outcome subsection of Pregnancy Details.

  Note: Selection of **Other** (under **Pregnancy Type**) allows for documentation of quadruple pregnancy.

- Documentation of weight in Prepregnancy Vital Signs allows the system to calculate the total weight gained or lost each time a weight is entered in a new FlowSheet. (Total weight is displayed in the Patient Information Header at the top of the OB module.)

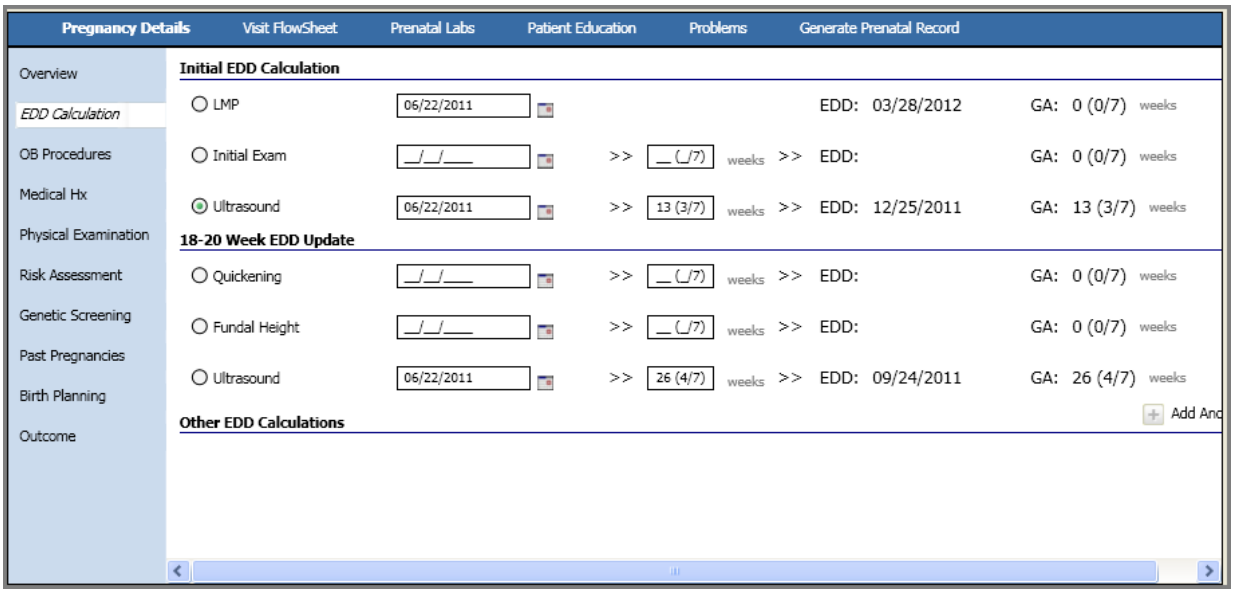
The system automatically populates the following fields but you can change the data:

- Pregnancy Type
- LMP Description
- Menses Monthly
- On BCP (birth control pills) at conception

You must enter all other data.

EDD Calculation

The EDD Calculation subsection offers automated calculation of initial EDD based on LMP, Initial Exam, or Ultrasound, and provides several options for 18-20 Week EDD update, including calculations based on Quickening, Fundal Height, or Ultrasound. Other EDD Calculations supports unlimited additional EDD calculations by ultrasound.



Note: If the LMP is entered on the **OB-Gyn** tab of Vital Signs in Chart, the initial EDD is calculated based on that date. This can be modified from the EDD Calculation subsection by changing the date.

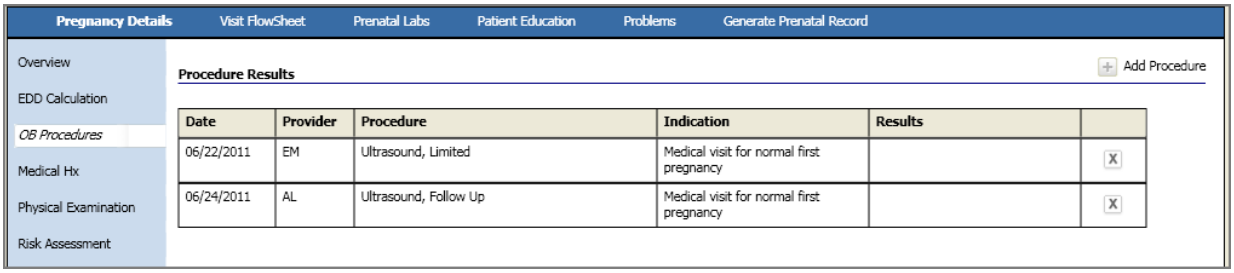
To update the EDD:

1. Select the calculation method.
2. Enter a new date.
3. Click in the GA field to open the keypad.
4. In the keypad, click the number of weeks and days, and then click Next.

   The EDD and GA as of current date are automatically calculated and displayed in the EDD Calculation window and in the Patient Information Header. EDD and current GA are then automatically updated throughout the chart. If the EDD is calculated based on anything other than LMP, a notation is displayed under the GA in the Patient Information Header.

OB Procedures

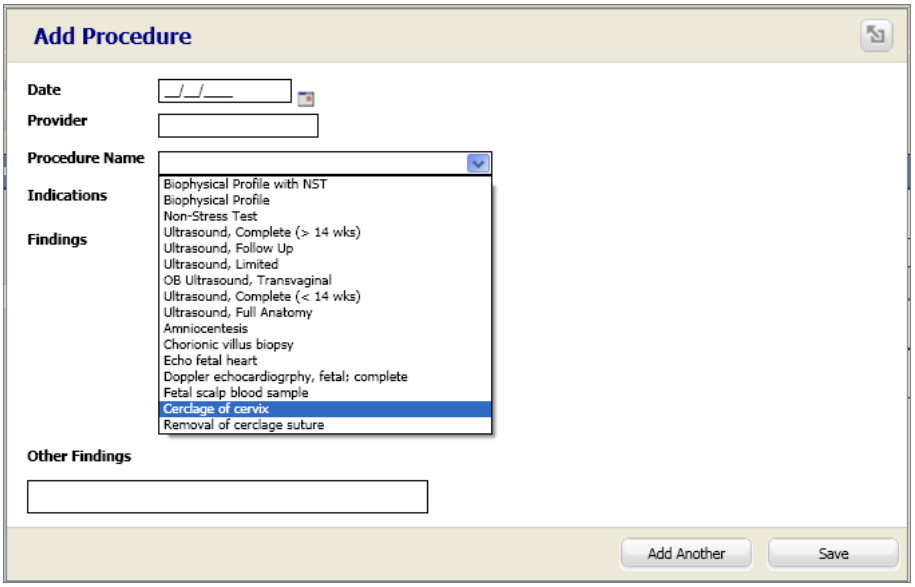
In the OB Procedures subsection of Pregnancy Details, you can document all procedures, whether performed in the office or off site.



Note: *Before you can document a procedure,* at least one diagnosis must be specified in the Problems list (or one complaint in the Visit FlowSheet).

To document a procedure:

1. In the OB Procedures window, click **Add Procedure**. The system displays the Add Procedure window.

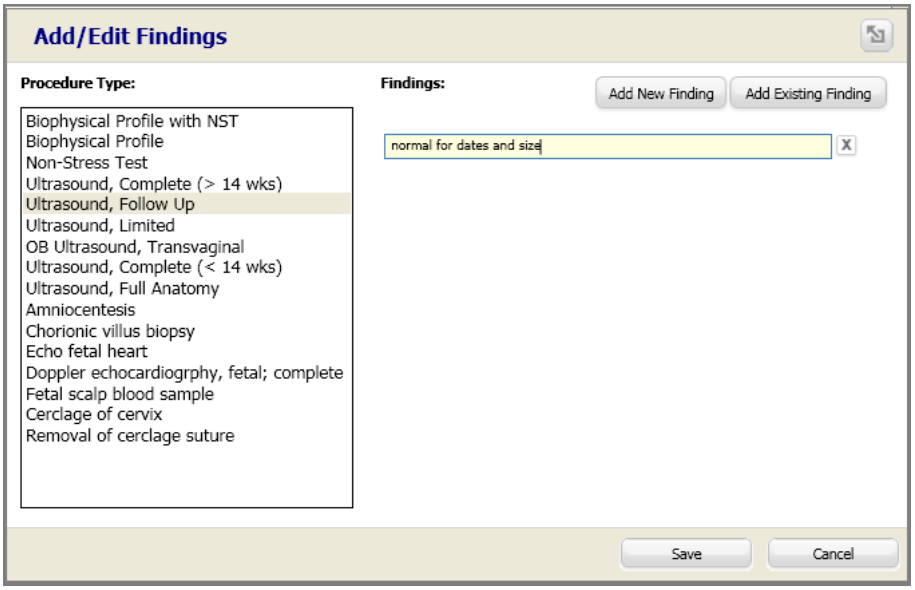


2. In the Add Procedure window:
   a. Enter the date.
   b. Enter the provider's name. (Type a few letters of the name or click the down arrow to select from the list. Both staff and non-staff providers can be selected.)
   c. Select the procedure.
   d. Select the indication for the procedure. (Selections for indications are auto-populated from the Problems section of e-MDs OB module, as well as from the Complaints list in the Plan section of the Visit FlowSheet.)

   Note: If no findings have been associated with this procedure, you must add new findings.

3. To access the Add/Edit Findings window, click the **Findings** icon.
4. To create a new procedure-specific finding, click **Add New Finding**.

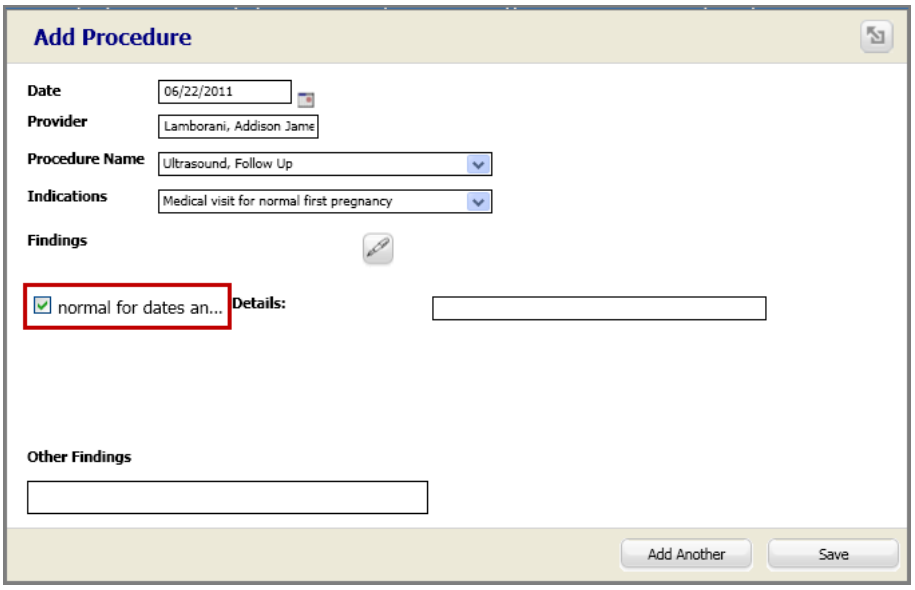
5. Type the finding in the blank field and then click **Save**.



The new finding is displayed in the Add Procedure window for the selected procedure type.

Note: After a new finding is added and saved for a specific procedure type, the finding is then available to all users when that specific procedure type is selected in the Add Procedure window.

6. In the Add Procedure window, click the check box next to the finding. (The finding will not display in the **Results** field of the OB Procedures window unless you select the finding by clicking in the check box.)



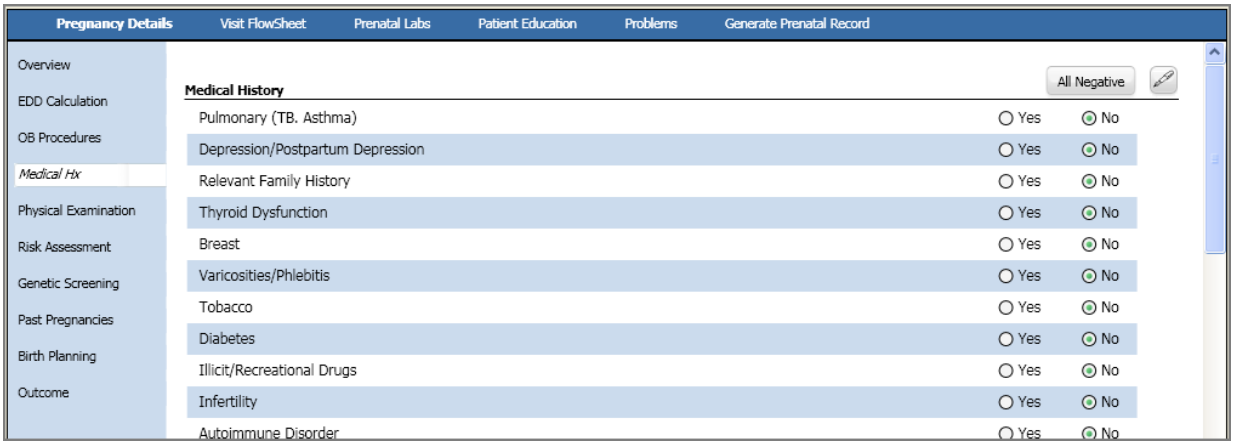
7. Add more details, as needed.
8. Click **Save**.

Note: The findings list must be created for each procedure. After a finding is entered using **Add New Finding**, you can add that finding to any procedure type by clicking **Add Existing Finding**.

Currently, there is *no edit feature for the Procedure Results list*. To change any information, you must delete the procedure and then add again.

Medical History

The Medical History subsection displays a list of common problems and issues that can be selected individually or marked **All Negative** with a single click. To clear a finding, click it again. You can add problems or issues and apply only to the current list or include as a default selection.

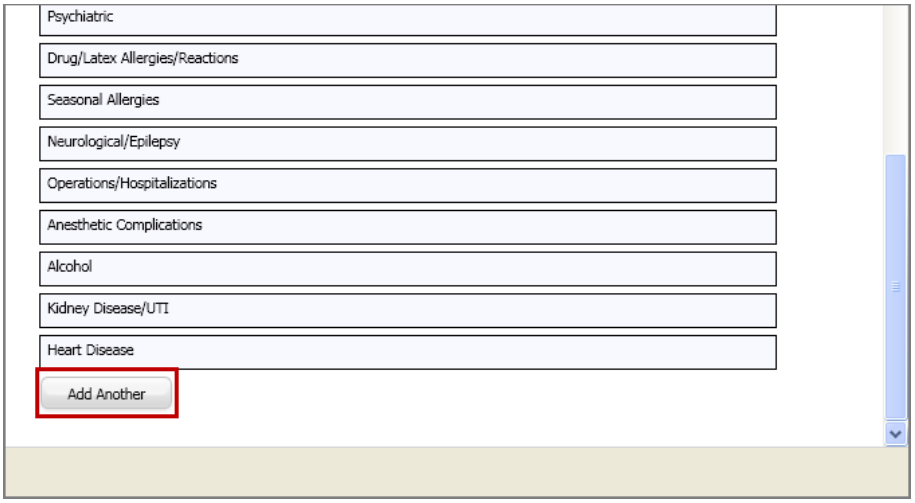


To change the sequence of items in the Medical History list:

1. Click the **Edit** icon located in upper right corner of the window.
2. In the Edit window, select the item to be moved.
3. Drag and drop the selected item to the desired sequence.

To add another Medical History item:

1. Click the **Edit** icon located in upper right corner of the window.
2. Scroll to the bottom of the Edit window and click **Add Another**. A blank field appears.



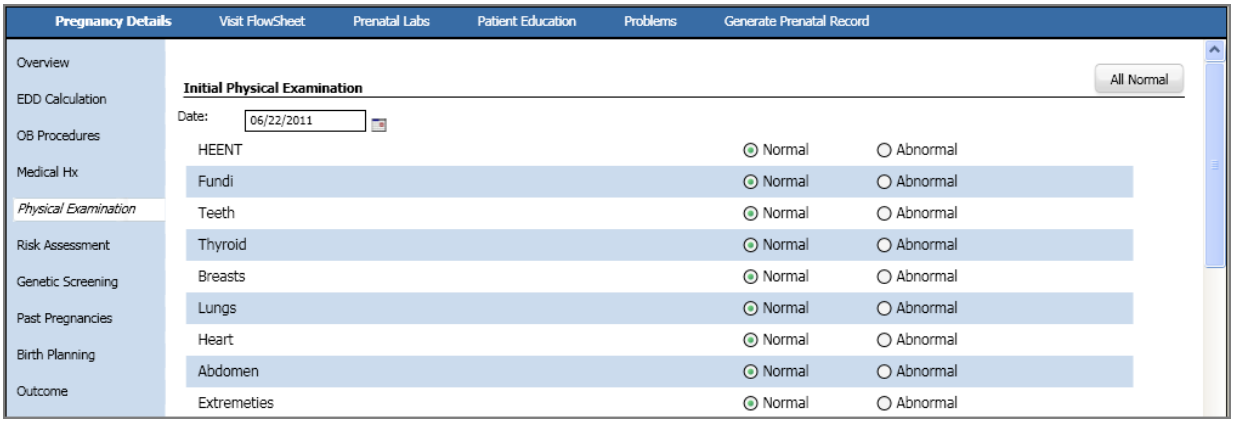
3. Type the new medical history item in the new field.
4. To designate an item a default selection, click in the check box labeled **Default Question**. (If **Default Question** is selected, the question will appear in the Medical History list of every patient's chart from this point forward. The question will not be specific to the user who entered it, but will appear for all users.)

5. Click **Add**.
6. Close the Edit window.

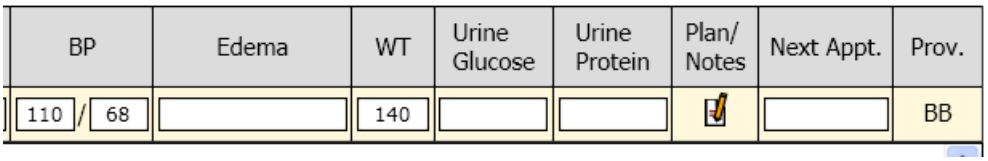
Note: The item can be deleted by clicking the red **X**.

Physical Examination

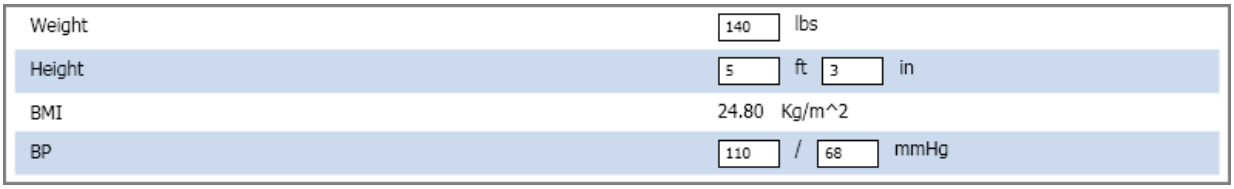
The Physical Examination subsection is provided for documentation of the *initial* physical exam for the pregnancy. The list of exam findings can be selected individually or marked **All Normal** with one click. To clear a finding, click it a second time. Some abnormal findings are listed and can be selected. Where abnormal findings are not listed, you can document details in the **Notes** field.



When vitals are taken and entered in the Visit FlowSheet section of the OB module on the same day as the OB physical exam, that data is captured and used to prepopulate the corresponding fields on the Physical Exam page. For example, when the patient's blood pressure and weight are entered in the Visit FlowSheet as shown here:



and the patient's height has already been entered in the patient's Chart, the information automatically appears in the OB Module Physical Exam screen:

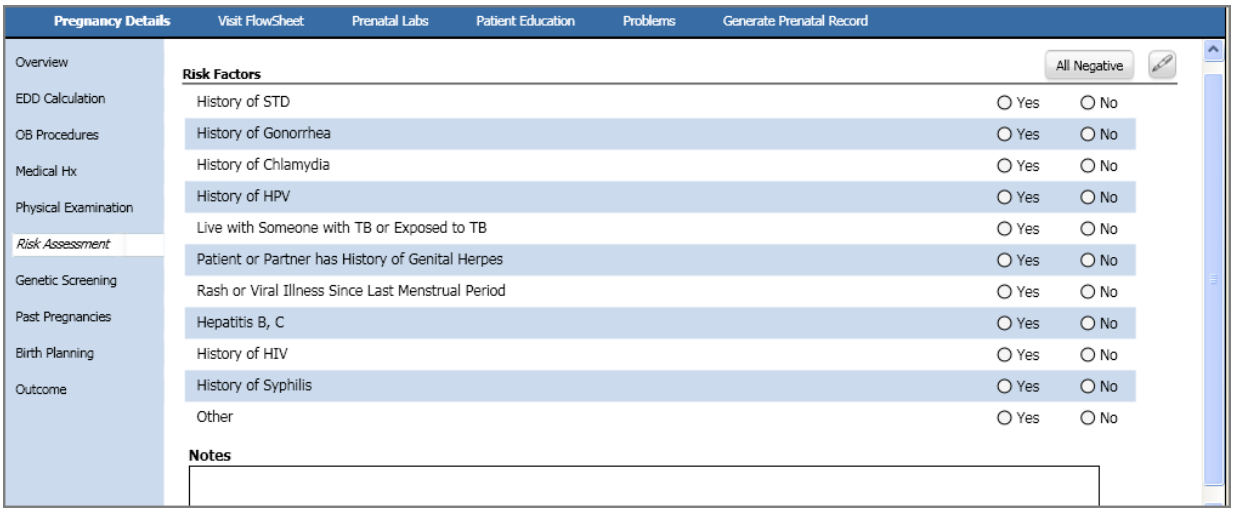


At the same time, the patient's Body Mass Index (BMI) is calculated from the patient's weight and height, and is also displayed on this screen.

Risk Assessment

Risk Assessment displays a list of risk factors that can be selected individually or marked All Negative with one click. A finding can be cleared by clicking it again. It is important to note that only risks added in this section are displayed in the Patient Information Header. When risks are added in the Risk Assessment, the risk data in the Patient Information Header displays in red.

General functionality for the Risk Assessment subsection is identical to that of the Medical History subsection. The user can change the order in which the risk factors appear and can add new risk factors.



To change the sequence of items in the list of risk factors:

1. Click the **Edit** icon located in upper right corner of the window.
2. In the Edit window, select the item to be moved.
3. Drag and drop the selected item to desired sequence.

To add another risk factor:

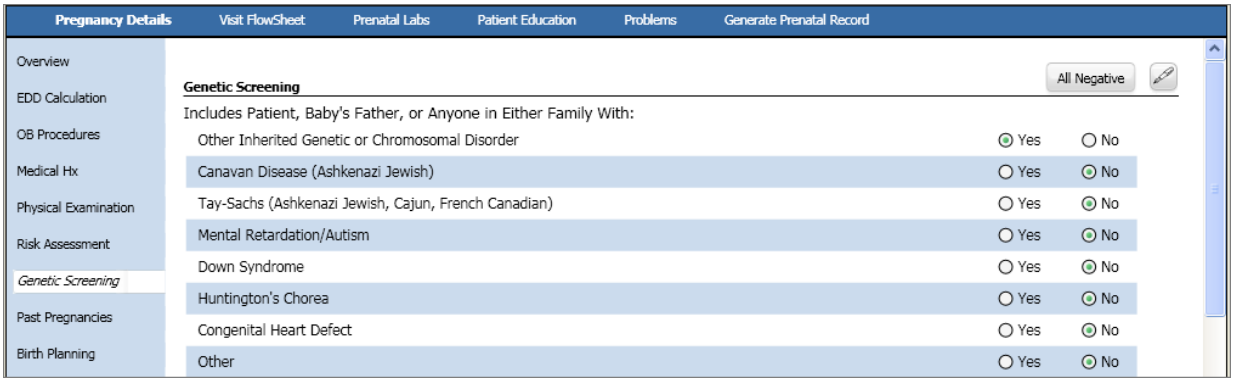
1. Click the **Edit** icon located in upper right corner of the window.
2. Scroll to the bottom of the Edit window and click **Add Another**. A blank field appears.
3. Type the new risk factor item in this field.
4. To include the item as a default selection, click the check box labeled **Default Question**.

   Note: If **Default Question** is selected, the item will appear in the Risk Assessment list of every patient's chart from this point forward. This is a global change and not user-specific.
5. Click **Add**.
6. Close the Edit window.

   Note: You can delete the item by clicking the red **x**.

Genetic Screening

The Genetic Screening subsection of Pregnancy Details offers the same general functionality as the Medical History and Risk Assessment subsections. See these sections for instructions for adding items to the Genetic Screening list or for changing item sequence.

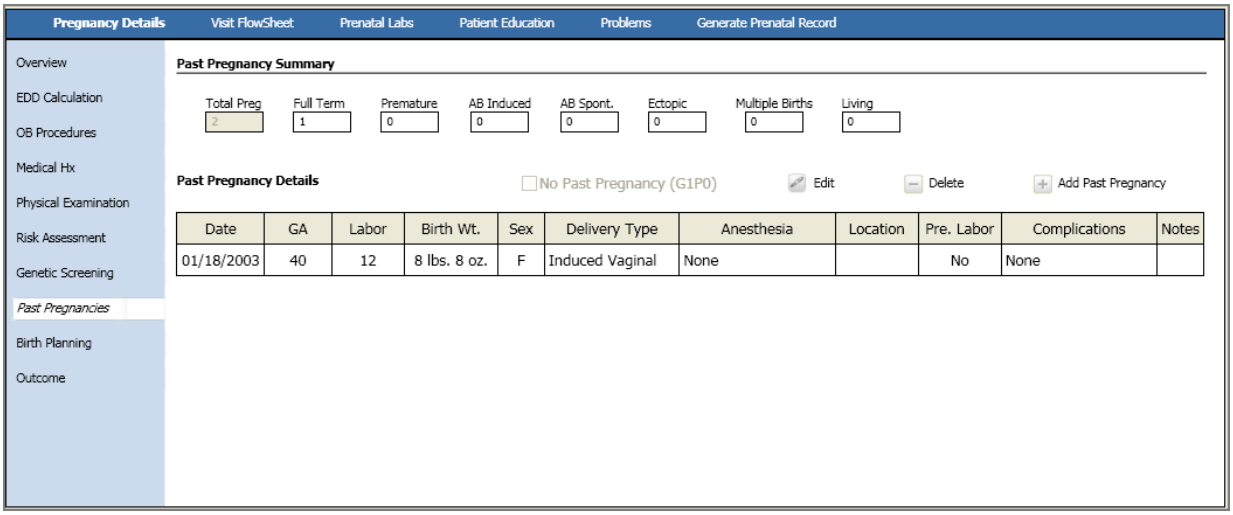


Past Pregnancies

The Past Pregnancies subsection provides a means for documenting details of previous pregnancies, including date, gestational age, delivery details, and complications. The system then displays a summary of pregnancy history information, along with the details of each pregnancy.

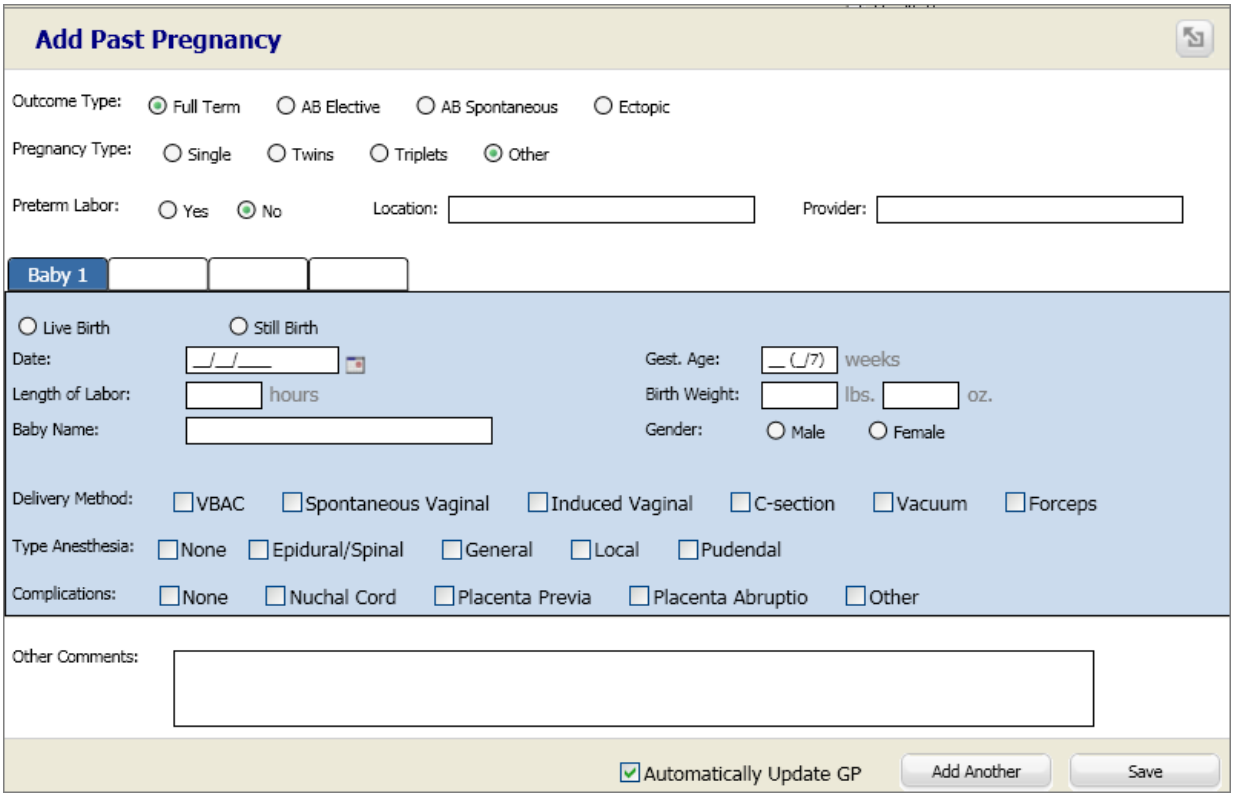
To document past pregnancies:

1. During the first visit for a new pregnancy, click the **No Past Pregnancy (G1P0)** check box if the patient indicates there have been no previous pregnancies.



OR

if the patient indicates there has been at least one past pregnancy, click **Add Past Pregnancy**.



2. In the Add Past Pregnancy window, click an item after **Outcome Type**. (For a preterm pregnancy, select **Full Term**, and the system will update to preterm based on gestational age.)
3. Click an item after **Pregnancy Type**. (The OB module supports documentation for up to a quadruplet pregnancy.)
4. Click the **Location** field to select the location and click the **Provider** field to select the attending provider.

   Note: Location pulls from the short list of external medical facilities, and **Provider** pulls both staff and non-staff providers. (The short list is created by navigating to **Chart** > **Demographics** > **Medical Facilities** > **External Facilities**.)
5. Complete the remaining details for each baby. (For multiple gestation, when data is entered for Baby 1, the date, gestational age, delivery method, and type of anesthesia are automatically populated for additional babies, but can be edited.)

   Note: Automatically Update GP is selected by default and allows the system to automatically update the patient's gravida/para status on the Patient Information Header as well as in the Summary and Details sections of the Past Pregnancies window.
6. Click **Save**.

To edit documented past pregnancies:

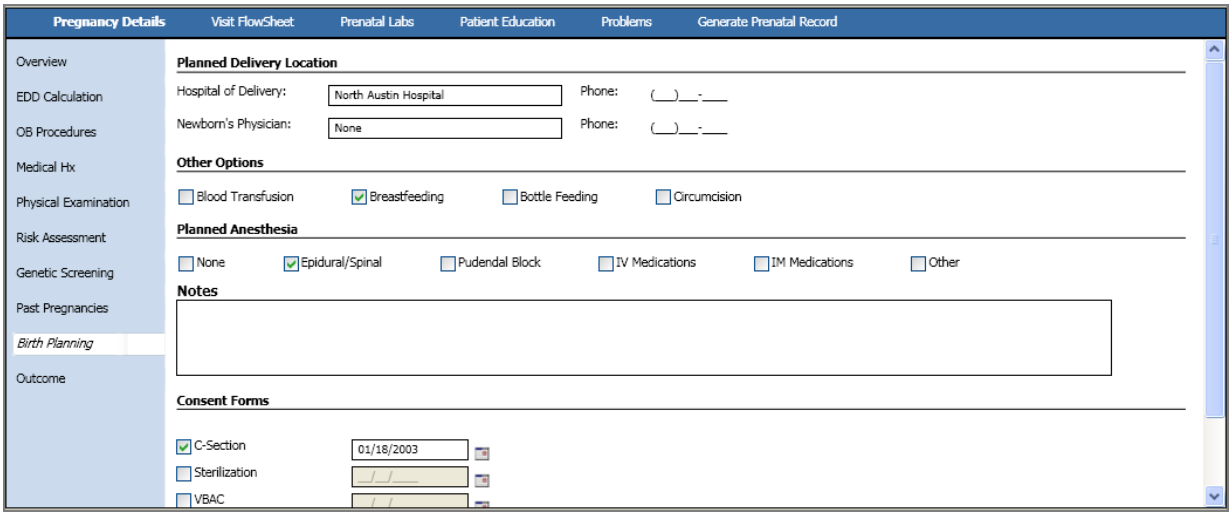
1. In the Past Pregnancies window, highlight the documented pregnancy to be edited.
2. Click **Edit**. The Add Past Pregnancy window appears.
3. Make your changes and then click **Save**.

To delete documented past pregnancies:

1. In the Past Pregnancies window, highlight the documented pregnancy to be deleted.
2. Click **Delete**.

Birth Planning

The Birth Planning subsection allows you to record information regarding delivery plans, including contact information for the hospital and the newborn's physician, status of consent form signatures, planned anesthesia, and other delivery details.



For the **Planned Delivery Location** field, the hospital selections are pulled from the short list of external facilities. (The short list is created in **Chart** > **Demographics** > **Medical Facilities** > **External Facilities.**)

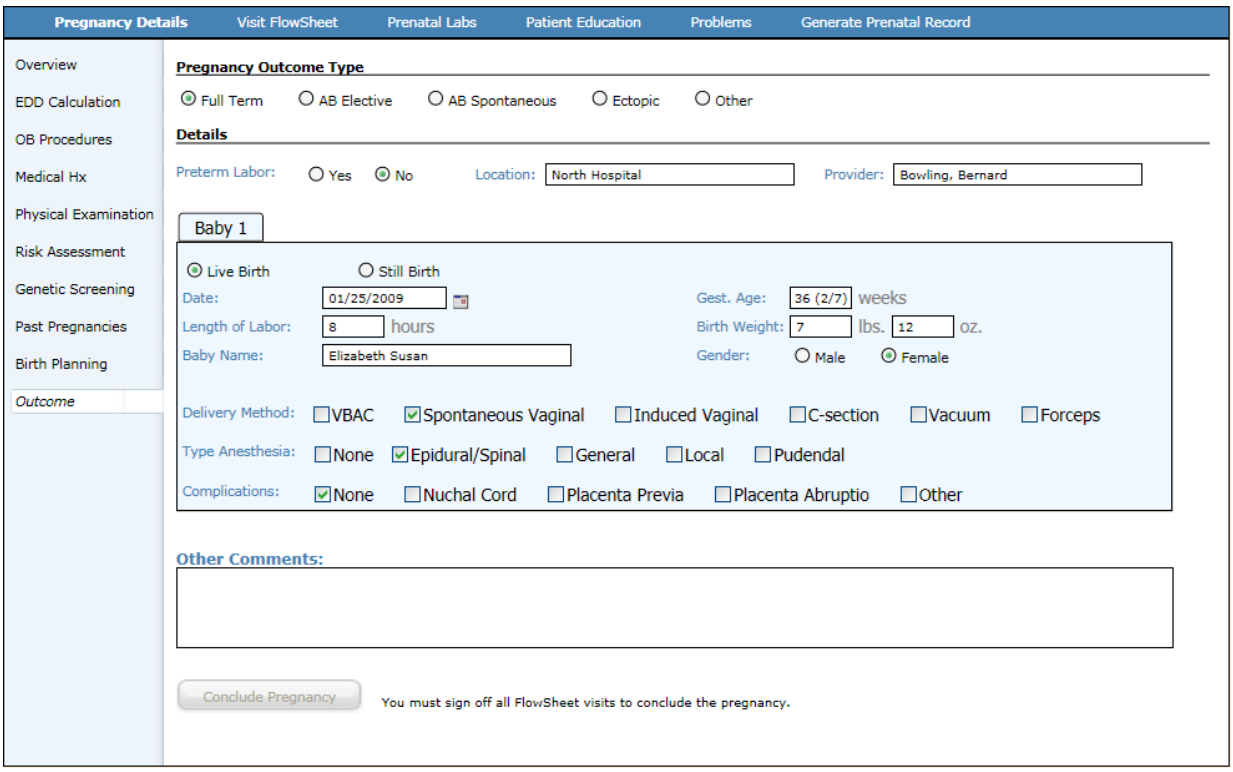
Selections for the physician include staff and non-staff providers. To select the hospital or physician, click in the field and select from the dropdown list, or type the first few letters of the name.

Note: In the Consent Forms list, the date for **HIV Release of Records** must be entered in order to include HIV results on the prenatal record. If there is no indication that the consent is signed, the system displays the following message when the user attempts to generate the prenatal record.

```
The current patient has not signed an HIV Consent Form. HIV information cannot
be printed to the Prenatal Record. Do you want to continue?
```

Outcome

The Outcome subsection provides an area to document details of the delivery. All fields in the **Add Past Pregnancy** window are also available in the Outcome window.



You can conclude a pregnancy record only if all Visit FlowSheets have been signed off for this patient. If you click **Outcome** while there are unsigned visits, a message indicating "You must sign off all FlowSheet visits to conclude the pregnancy" will appear at the bottom of this screen to the right of the **Conclude Pregnancy** button. The Provider identified for each unsigned visit must sign off any outstanding notes before you can continue with the following steps.

To document the pregnancy outcome:

1. In the Outcome window, select a type after **Pregnancy Outcome Type**. (For a preterm pregnancy, select **Full Term**, and the system will update to preterm based on gestational age.
2. Click in **Location** and **Attending Provider** fields to access available selections.

   Note: The **Location** value pulls from short list of external medical facilities and the **Provider** value pulls both staff and non-staff providers. (The short list is created in **Chart** > **Demographics** > **Medical Facilities** > **External Facilities**.)

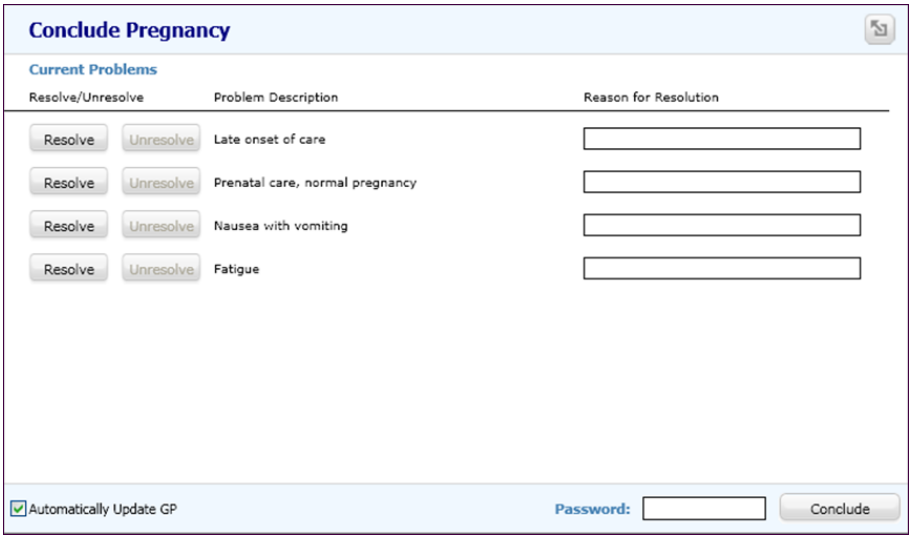
3. Complete the remaining details for each baby. (For multiple gestation, when data is entered for Baby 1, the date, gestational age, delivery method, and type of anesthesia are automatically populated for additional babies, but can be edited.)

   Note: Automatically Update GP is selected by default and allows the system to automatically update the patient's gravida/para status on the Patient Information Header as well as in the Summary and Details sections of the Past Pregnancies window.

4. Click **Save**.

   Note: Automatically Update GP is selected by default and allows the system to include this pregnancy in the Patient Information Header as well as in the Past Pregnancies summary and details.

When you click the **Conclude Pregnancy** button in the Outcome subsection, the Conclude Pregnancy window opens, and all diagnoses from the current Problems list are displayed in the window. You have the option to resolve each problem and include a reason for resolution. Any unresolved problems transfer to the Problems list in e-MDs Chart. Any staff provider can conclude the pregnancy.



When you click the **Conclude** button, the OB module closes for this pregnancy. A summary is stored in Chart and is available in Chart View, the Document folder, and the Other folder. A summary is also available in DocMan.

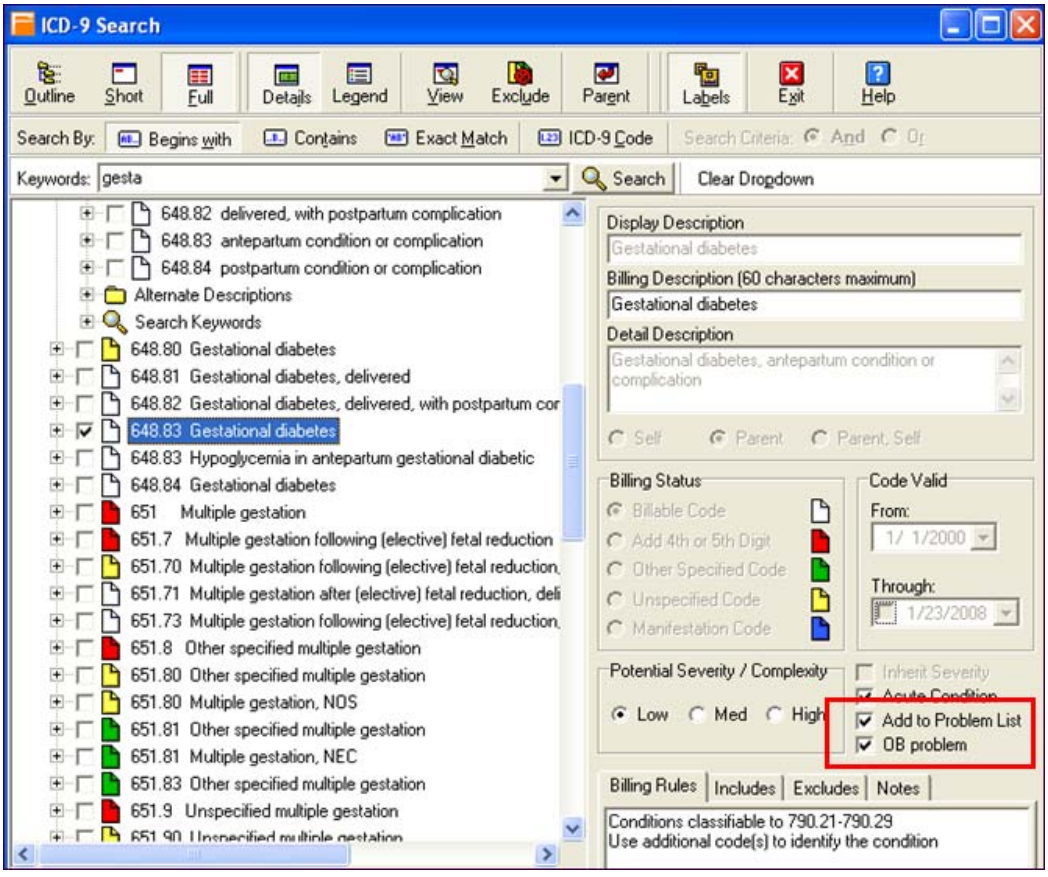
Modifying ICD and CPT Codes for Use in the OB Module

In both the **Problems** and **Visit FlowSheet** section, you can access ICD or CPT Common Lists. These lists are pre-populated by e-MDs, but can be modified by an authorized user. The following procedures describe how to add ICD codes to the OB module through Bill and Chart. You can also access non-pregnancy related ICD codes through the OB module.

In order to add individual CPT codes, you must exit the OB module and go to the Reference menu in Chart or Bill. See "To add CPT codes to the OB module" for more information. Regardless of the codes selected, the conditions or problems identified here will appear in the consolidated Chart and OB module problems list and will be accessible from both problem list screens.

To add ICD codes to the OB module:

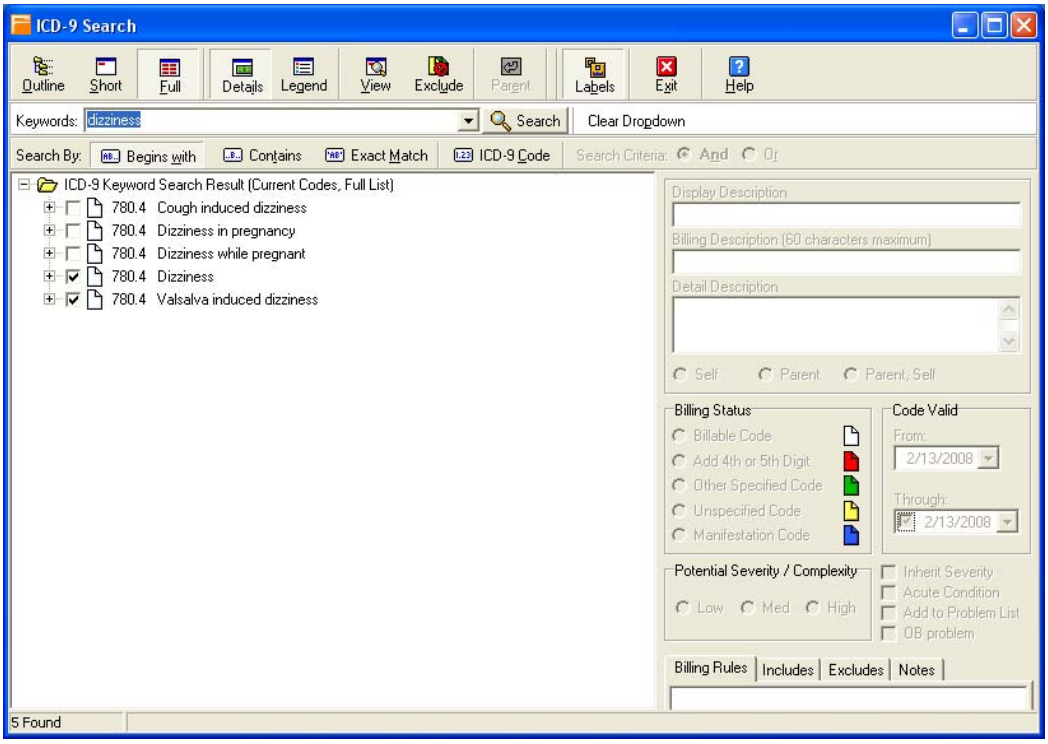
1. In e-MDs Chart menu bar, click **Reference**, and then select **ICD Search**.
2. In the ICD Search window, click **Details**.
3. Highlight the ICD code and select **OB Problem**.



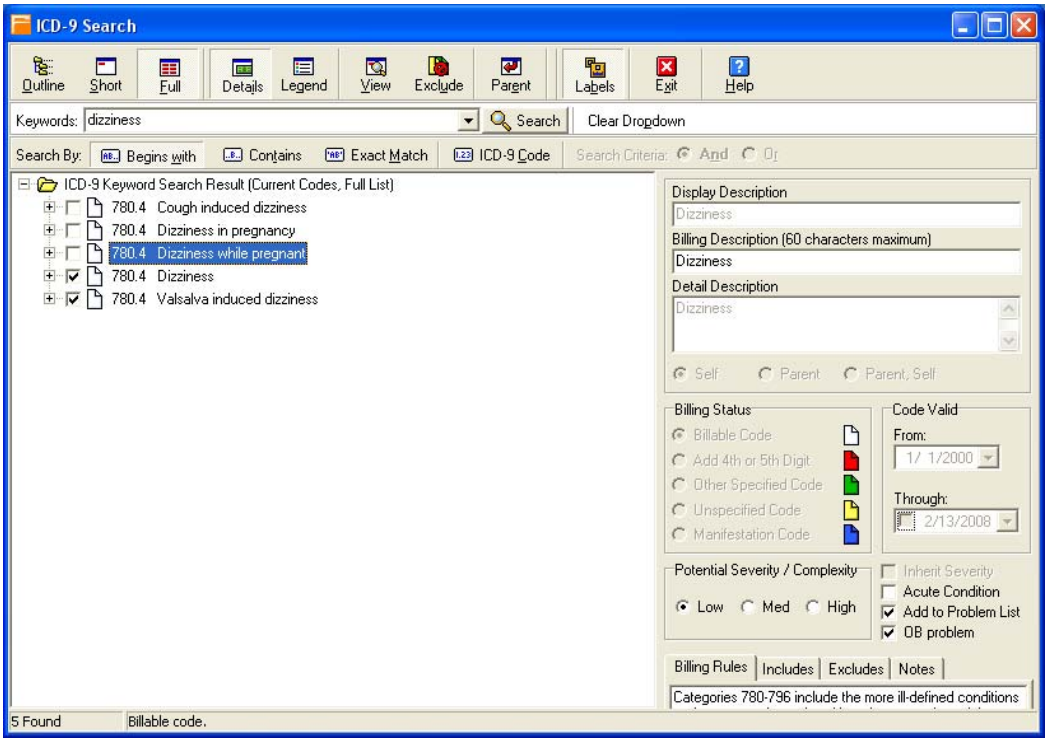
Alternate Descriptions

If you use the search function in ICD Search to find a particular symptom, the system displays a list containing the original ICD and all Alternate Descriptions, even if one of the Alternate Descriptions is selected, the system displays the Details pane for the original ICD.

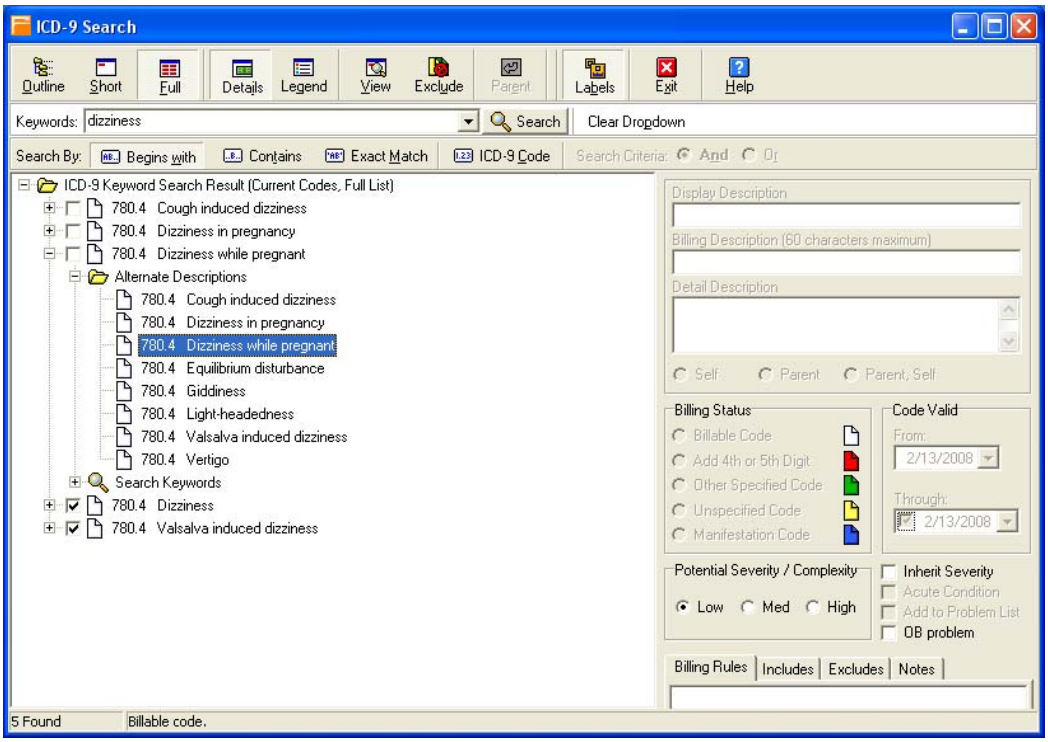
For example, if you search for “dizziness”, the system displays the following:



If you select **Dizziness while pregnant**, the Details pane is populated, but note that the **Display Description**, **Billing Description**, and **Detail Description** fields all specify “Dizziness.” If you select **OB problem** in this Detail pane, “Dizziness” appears as the description in the OB module, rather than “Dizziness while pregnant.” This is because “Dizziness while pregnant” is an Alternate Description of “Dizziness.”



To display the Alternate Description in the OB module, you must designate the description as an **OB Problem** in the Details pane specific to the Alternate Description. To display the correct Details pane, click the plus sign next to **Dizziness while pregnant**, open the Alternate Descriptions folder, and select **Dizziness while pregnant**. Note that all description fields are blank. To add this description to the OB module, place a check mark in the box next to **OB Problem**. (Click in the box to add a check mark.)

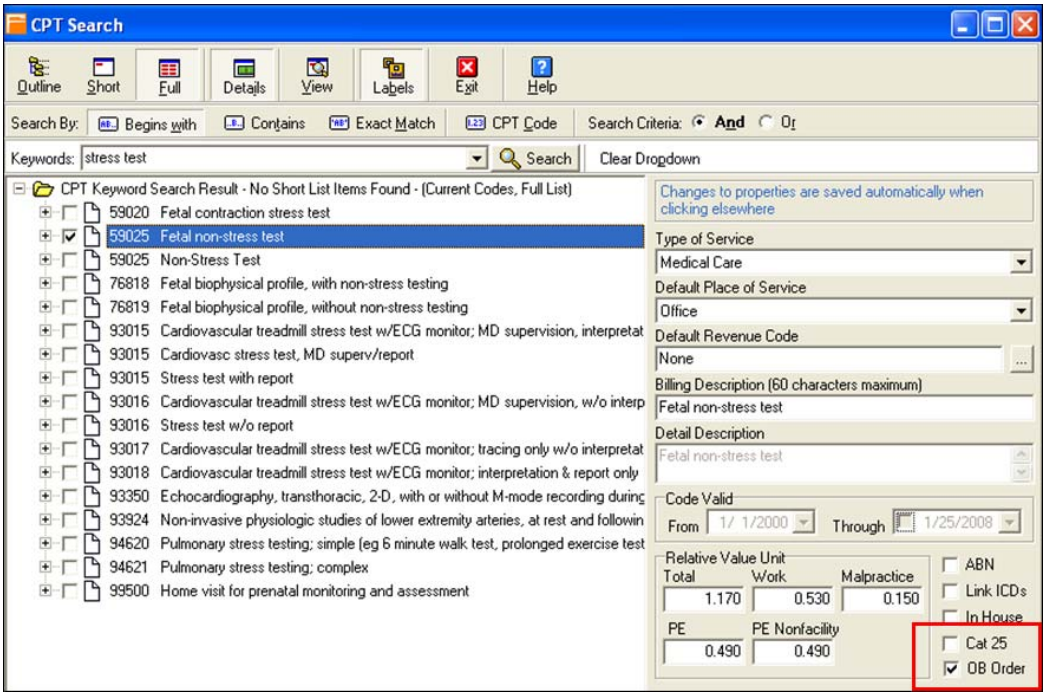


Note: This applies to any Alternate Descriptions for CPT codes as well.

An Alternate Description inherits all attributes of the original ICD when the Alternate Description is created, but if the original ICD is changed at a later time, the changes *are not* applied to the Alternate Description.

To add CPT codes to the OB module:

1. In e-MDs Chart menu bar, click **Reference**, and then select **CPT Search**.
2. In the CPT Search window, click **Details**.
3. Highlight the CPT code and select **OB Order** (located in the lower right corner of the details pane).

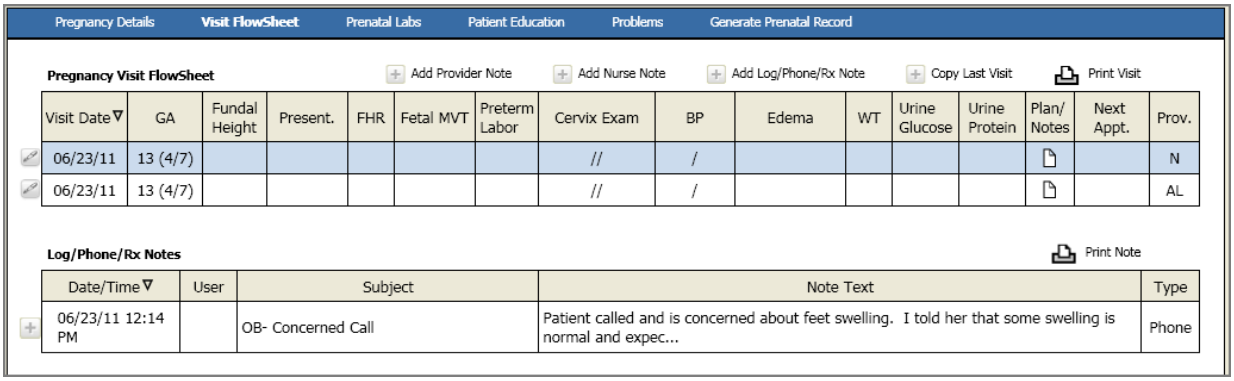


Creating and Using a Visit FlowSheet

The Visit FlowSheet supports rapid and consistent documentation of obstetric encounters. The e-MDs OB Module Visit FlowSheet:

- Provides a summary of each encounter in e-MDs Chart.
- Displays visual cues for abnormal values based on gestational age.
- Includes prompts for ordering appropriate labs and patient education based on gestational age.
- Populates the Prenatal Record which can be printed or faxed.
- Provides printing or faxing at note conclusion.

For each patient encounter, you create a new Visit FlowSheet. Creation of the FlowSheet automatically adds a Visit Note to e-MDs Chart in the Chart View section of the patient's chart.



To the left of each FlowSheet is a status icon.

- A padlock icon means the Visit Note is locked because another user is currently accessing it.

- A plus sign means the visit is signed off, but it is still possible to add an addendum.
- A pencil icon means that the visit is not signed and can be edited.

Note: To edit a visit, click the **Edit** icon.

To create a new provider or nurse visit note:

Note: This note will also appear on the **Visit Notes** tab in the patient's Chart view and the information will be added to the prenatal record.

1. Click **Add Provider Note** or **Add Nurse Note**.

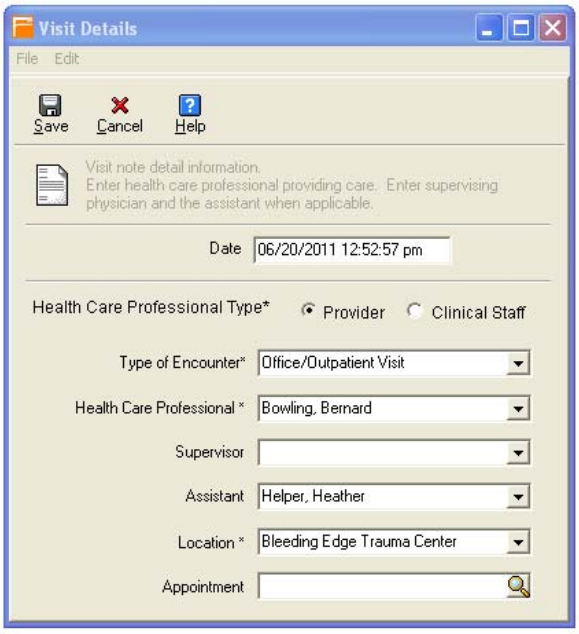
2. In the Visit Details window, enter the following values, then click **Save**:
   - Health Care Professional (Only this person will be allowed to sign off the visit note.)
   - Supervisor (if applicable)
   - Assistant
   - Location
   - Appointment

   Note: After a user adds this information once, it will default for that user. If the patient has an appointment for the current date in e-MDs Schedule, the appointment information will auto-populate.
3. In the Pregnancy Visit FlowSheet, enter the visit details. (Leave fields blank if measurements were not taken.)
   - Visit Date and GA are automatically entered.
   - Three fields in Cervix Exam: first field is dilation, second is effacement, and third is station.
   - For Edema, Urine Glucose, and Urine Protein, any result entered except negative will display as abnormal (displays text in red).
   - The reference range for abnormals for each field changes based on GA.

To create a new Order Note:

Note: This note will also appear on the **Visit Notes** tab in the patient's Chart view and the information will be added to the prenatal record.

1. Click **Add Order Note**.



2. In the Visit Details window, enter the following values, then click **Save**:
   - Health Care Professional Type
   - Type of Encounter
   - Health Care Professional (Only this person will be allowed to sign off the Order Note.)
   - Supervisor (if applicable)
   - Assistant
   - Location
   - Appointment

   Note: After a user adds this information once, it will default for that user. If the patient has an appointment for the current date in e-MDs Schedule, the appointment information will auto-populate.
3. In the Pregnancy Visit FlowSheet, enter the visit details. (Leave fields blank if measurements were not taken.)
   - Visit Date and GA are automatically entered.
   - Three fields in Cervix Exam: first field is dilation, second is effacement, and third is station.
   - For Edema, Urine Glucose, and Urine Protein, any result entered except negative will display as abnormal (displays text in red).
   - The reference range for abnormals for each field changes based on GA.

Notes:

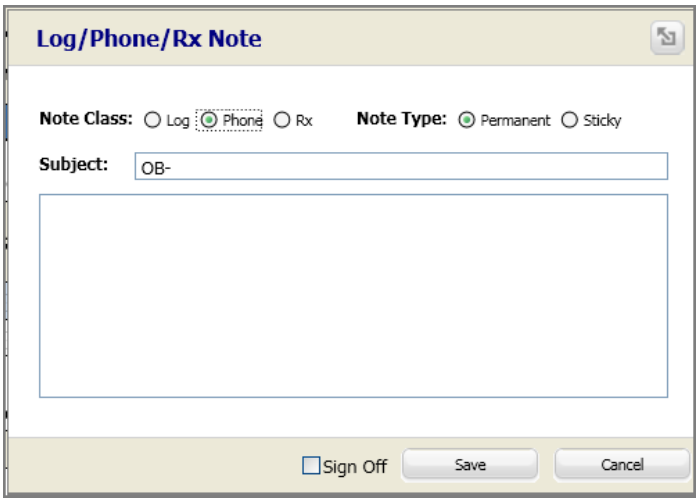
- The **Next Appt.** field allows you to indicate when the next appointment should be scheduled, but does not automatically schedule the appointment.

- When a Nurse Note is signed and saved on the Pregnancy Visit FlowSheet grid, the cells are shaded to distinguish Nurse Notes from Provider Notes at a glance.

To create a log, phone or prescription note:

Note: This note will also appear on the **Log/Phone/Rx Notes** tab in the patient's Chart view and the information will be added to the prenatal record.

1. Click **Add Log/Phone/Rx Note**.



2. Select the class of note – **Log**, **Phone**, or **Rx**.
3. Select the type of note – **Permanent** or **Sticky**. (A **Permanent** note can be signed off by the user creating it but a **Sticky** note never has to be signed off.)
4. Type the subject of the note. This should be something short but meaningful.

   Notice that an **OB-** notation is added to the subject line automatically to highlight any logged information as being related to a pregnant patient.
5. Type the note message.
6. Click **Save** to save and close the note.

   OR

   Click **Sign-Off** and then **Save** to both complete the note and save it.

   OR

   Click **Cancel** to discard the note without saving it.

To add an addendum to a note:

1. Click the plus sign to the left of a signed-off note or the icon to the left of an unsigned note.

   Note: After a note is signed off, more information can be added to the note as an addendum. Until it is signed off, the text of the original message can be modified as well.
2. In the note window, type the additional information in the bottom field (for addendums) or modify the text of the note (for unsigned notes).
3. Click **Save**.

Copying Visits

To save steps, you can click **Copy Last Visit** to have the system create an exact copy of the most recent Pregnancy Visit FlowSheet. You must then manually change the Visit Date, and then add visit information to the new Visit FlowSheet.

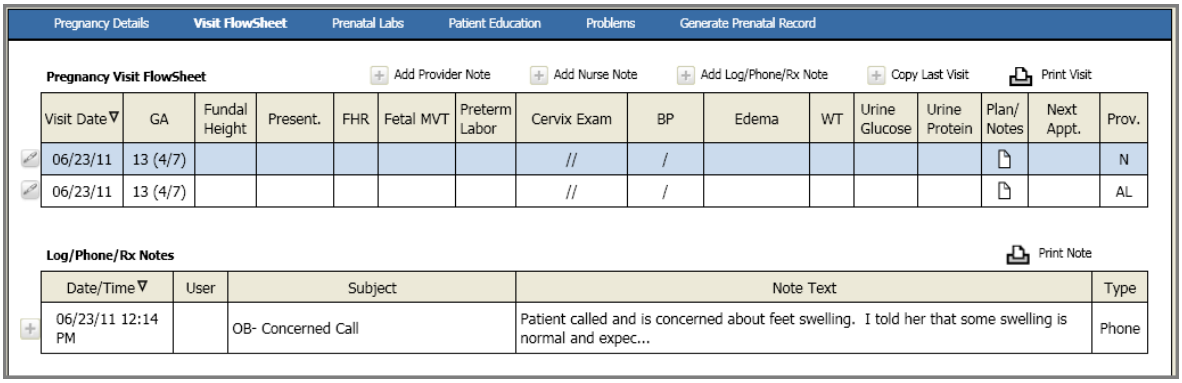
Creating a Plan for the Visit

After the Visit FlowSheet is created, you can then create a plan for the visit. The plan includes documentation of orders, patient education, complaints, and assessments. You can continue to enter data in the Visit FlowSheet while the Plan/Notes section is open.

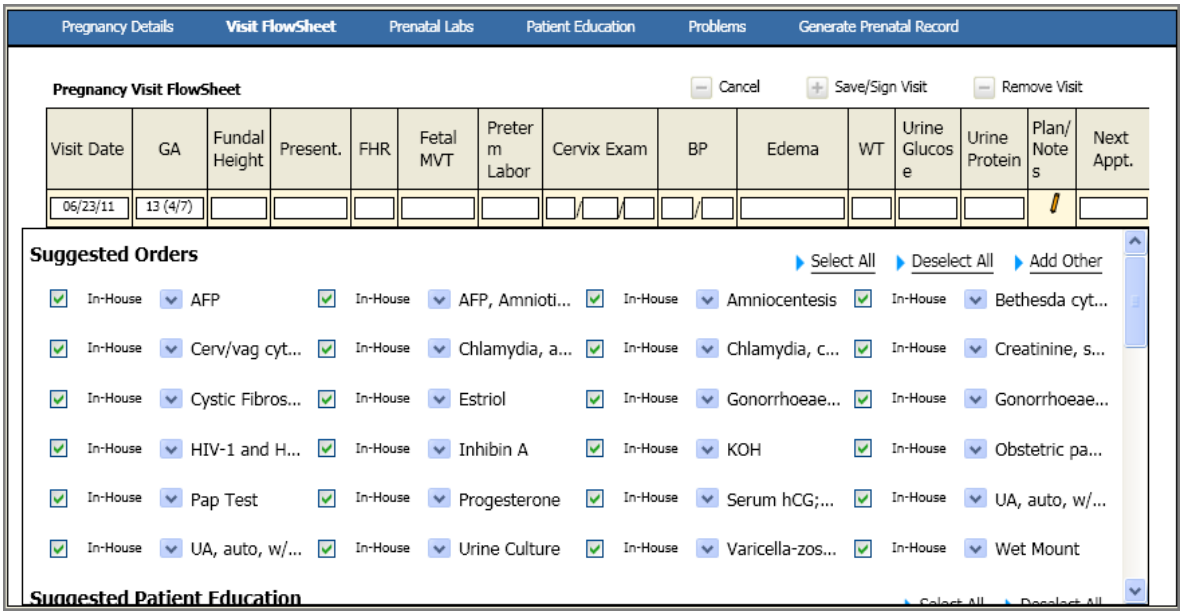
To add a plan:

1. In the Pregnancy Visit FlowSheet, click the pencil icon in the **Plan/Notes** field to display the plan.

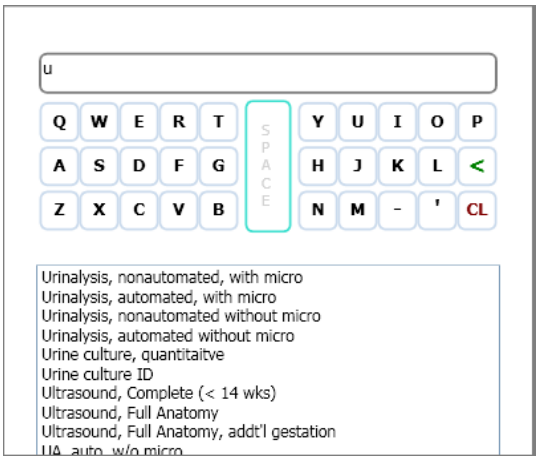
   Note: If the icon in the Plan/Notes field is a sheet of paper rather than a pencil, click the edit icon (grey pencil button) before the note entry to change the plan icon to a pencil. Then select the pencil in the **Plan/Notes** field.



2. Select the desired orders in the **Suggested Orders** section.



3. If the desired order is not shown under the **Suggested Orders**, click **Add Other** to access the **Add Labs** window.



4. In the Add Labs window:

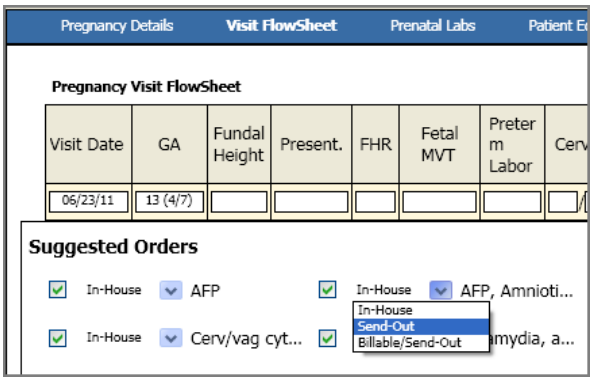
   a. Click the first letter of the desired order. The system displays a list of orders.

   b. Select a lab from the list, and click **Save**.

   Note: Orders will not display in the OB module list of orders unless the CPT code has been selected as an OB Order in the Details pane of the CPT Search window in e-MDs Chart.

5. To change the **In House/Send Out** status, click the down arrow to the right of the status, or change in the Visit Note Sign Off window when documentation is complete.

   Note: The **In House/Send Out** status is pulled from the fee schedule associated with the patient's insurance company. The status is not displayed until the order is selected.



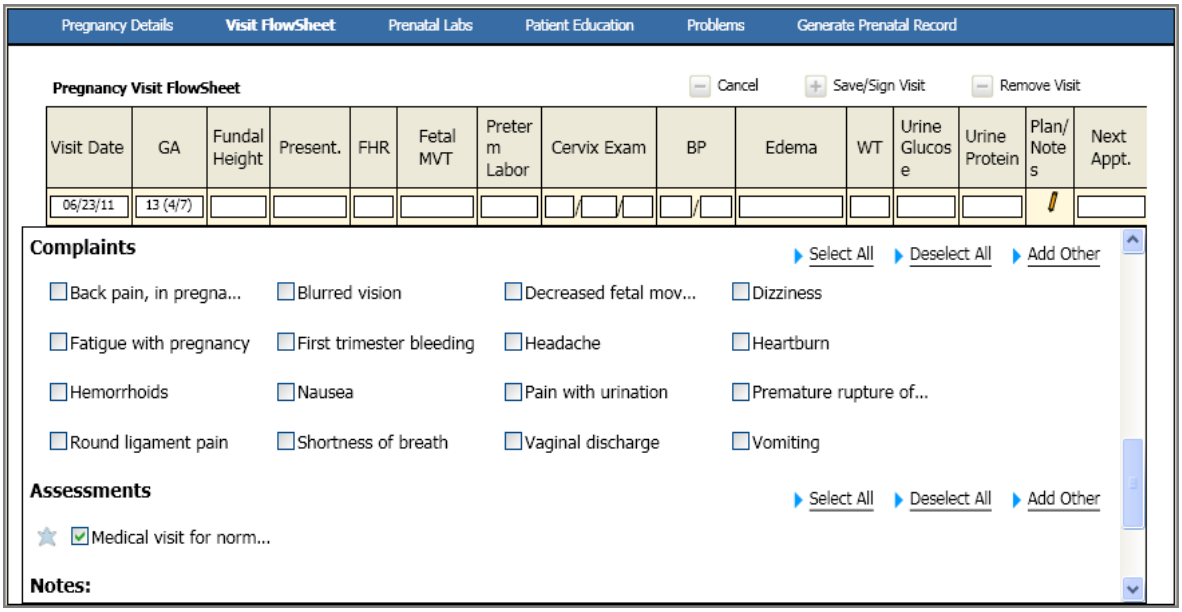
6. Select the Patient Education to be provided. Patient Education selections:

   - Are specific to gestational age.
   - Can be ordered more than once.
   - Can be printed at note conclusion. (Select in Visit Note Sign Off window.)
   - Automatically adds the date in the Patient Education section of OB module and indicates that the selected education was given.

   Note: Suggested Patient Education items that display in gray have been ordered for the patient previously, but can be ordered again.

7. Select complaints to be noted for this visit.

Complaints are common symptoms associated with pregnancy. Although pulled from the ICD list, these are not added to the Chart problem list and are not added as ICD for the visit, but are added to the Prenatal Record with the date of visit.



Note: To display more problems in the Complaints area:

a. Click **Add Other**.

b. In the Add Problem pop-up window, type the first letter of the desired complaint to display a list.

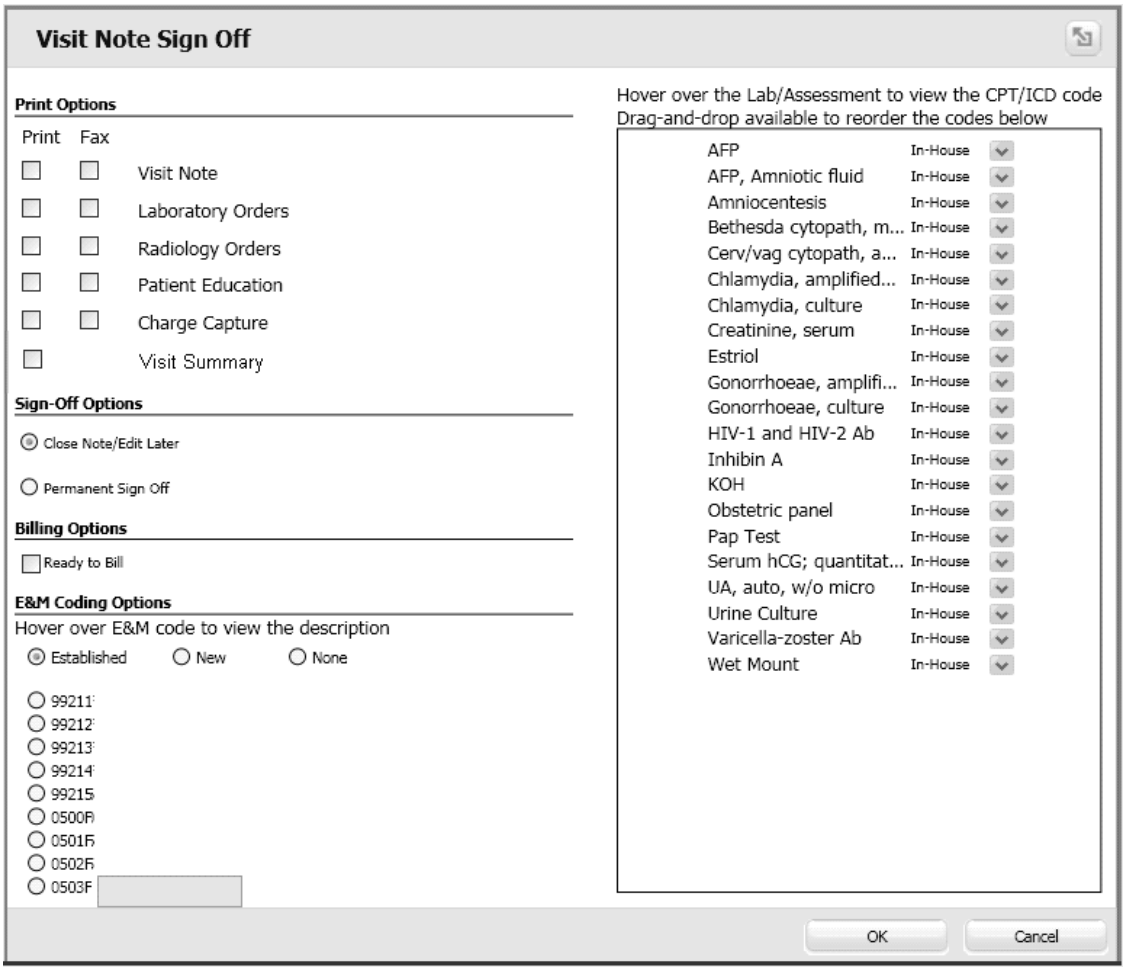
c. Select from the list. You can select both pregnancy and non-pregnancy codes from this list.

8. In the Assessments section, select all billable diagnoses and ongoing problems for the pregnancy.

   Assessments shown in this window are pulled from the Problems section of e-MDs OB module.

   Note: The first diagnosis listed is designated as the primary diagnosis for billing purposes. A blue star marks the diagnosis as primary. To change the primary diagnosis, select the new primary diagnosis and drag the blue star to that diagnosis.

9. Click **Save/Sign Visit** to save the visit and display the Visit Note Sign Off window.
   OR
   Click **Cancel** to delete information entered for this visit.



10. When the Visit Note Sign Off window appears, select the appropriate options:

    a. Under **Print Options**, select the appropriate check box for those items to be printed or faxed. Visit or Order Note will print or fax a summary of FlowSheet information. Note that selecting fax brings up the Fax Contacts list.

    Note: Clicking the **Visit Summary** check box will cause an OB Visit Summary to be generated for this visit. This output is the OB module version of the Visit Summary normally created by Chart when concluding a visit. The generation of this OB Visit Summary will also be tracked on the Audit Log. For instructions on enabling or disabling this option, see Setting Preferences for Visit and Order Notes. Also see Printing and Saving a Visit Summary for more information.

    b. Select the desired sign-off option. Permanent sign off is available only if the user currently logged in is the provider listed for the visit.

    c. If **Close Note/Edit Later** is selected, **Ready to Bill** is an option. If this option is selected, a check mark is automatically generated in e-MDs Bill to indicate that an invoice can be created for this visit.

    d. Select the appropriate **E&M Coding Options**.

    The E&M codes displayed in the far left column change based on selection of **Established** or **New**. (**None** clears the list.) The four codes in the second column (0500F, 0501F, 0502F and 0503F) are permanent codes that can be used to add frequently used codes at note conclusion. You can mouse over each of these four codes to see a short description of each code before selecting it.

Note: To add another E&M code that does not normally appear here, select **Other** and type the code number in the field that follows that selection.

e. Add the desired modifier to selected E&M codes.

f. In the list of assessments, change **In House** status to **Send Out** or **Send Out/Billable**, if necessary. (Note that you can move CPT codes to different ICD codes by dragging and dropping them.)

Note: To use the drag-and-drop functionality, left-click to select an item to move. Continue holding down the left mouse button and drag the item to its new location in the list. Release the mouse button to leave the item in its new position.

11. Click **OK**.

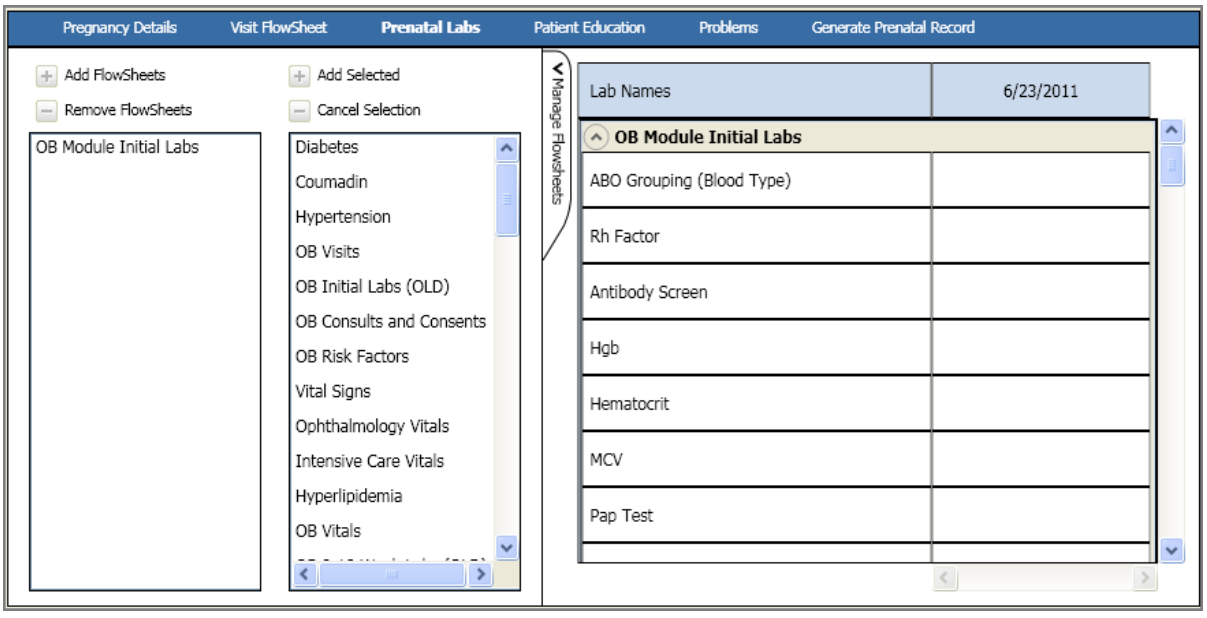
If **Permanent Sign Off** or **Ready to Bill** is selected, charges for this visit are immediately transferred to e-MDs Bill.

Monitoring Prenatal Labs

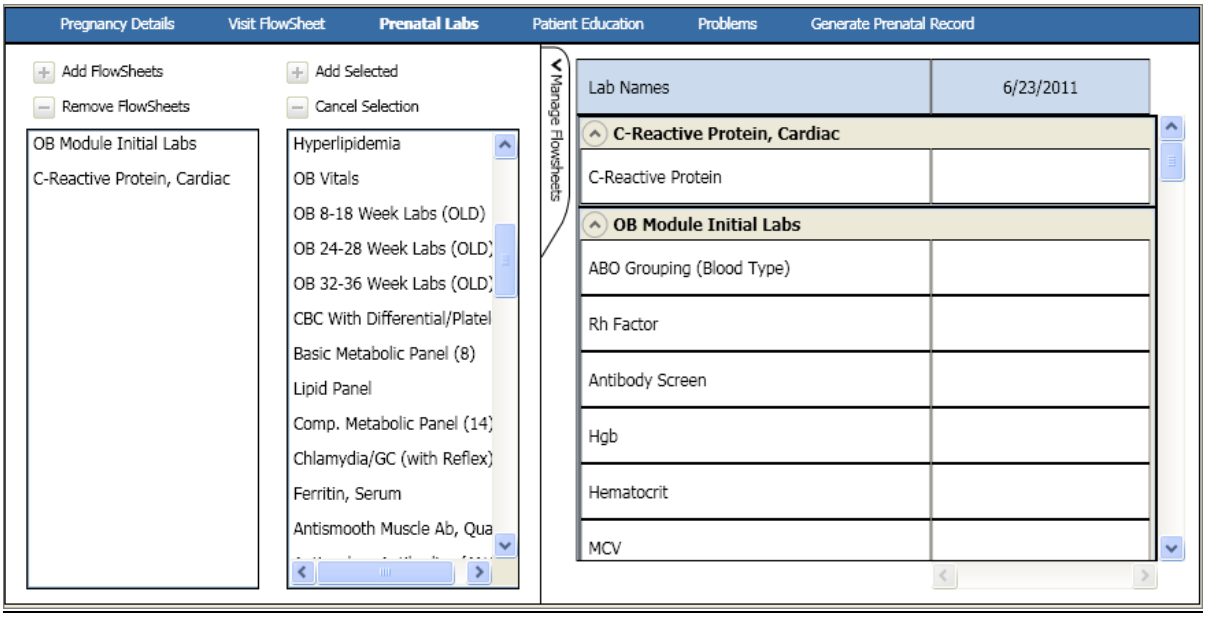
FlowSheets for pregnancy related labs, visit information, and vital signs are automatically displayed in the Prenatal Labs section of the OB module. Any FlowSheets selected in the patient's chart in e-MDs Chart will also be displayed in the Prenatal Labs section. To allow for inclusion of chronic problems during the prenatal visit, all other e-MDs FlowSheets are accessible from the Prenatal Labs tab. For offices using a Lab interface, lab results will automatically populate the appropriate FlowSheets.

To add a FlowSheet:

1. On the **OB Module** tab, select **Prenatal Labs**.
2. Click the **Manage FlowSheets** tab.



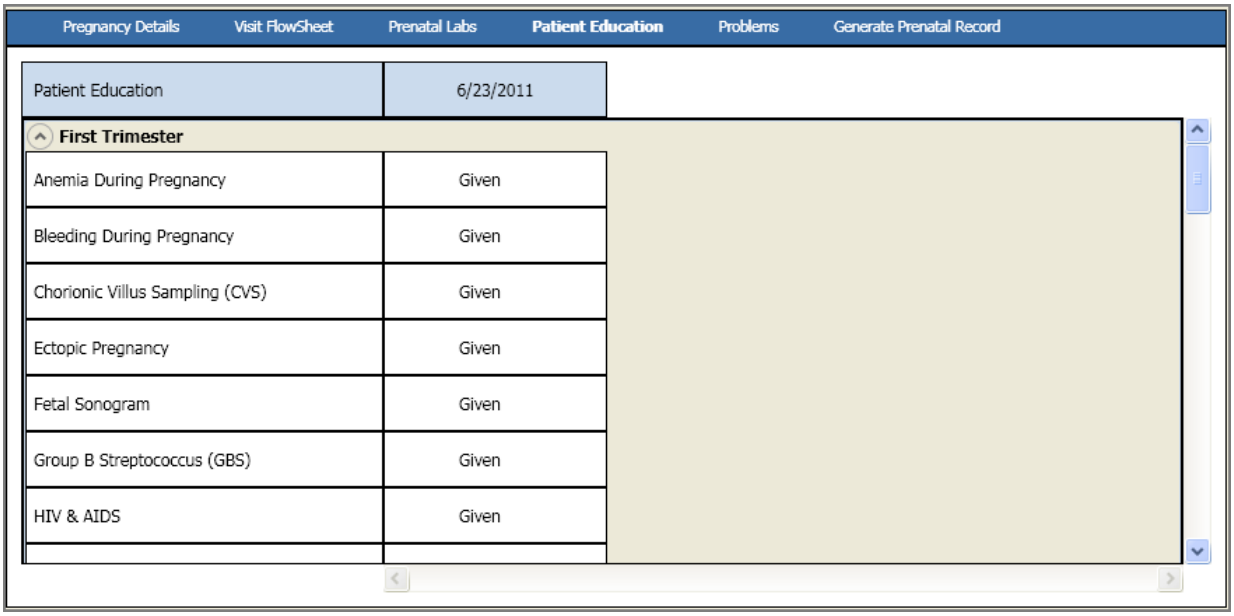
3. Click **Add FlowSheets** to display the list of available FlowSheets.
4. Select the desired FlowSheet and then click **Add Selected**. FlowSheets are added to current patient only.



Note: You cannot edit or create these FlowSheets from the OB module. Any edits to the FlowSheets must be done in e-MDs Chart. For instructions, see the FlowSheet section of this guide.

Tracking Patient Education

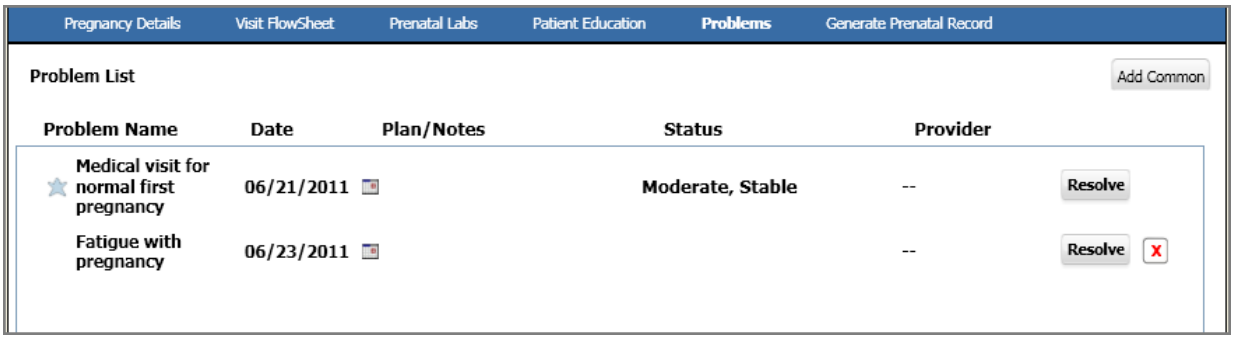
The Patient Education section lists the recommended education for each trimester and tracks the date on which education is provided.



Each time education is ordered in a Visit FlowSheet, a new column is displayed in the Patient Education window, with the date of the order at the top of the column. For all education items ordered, “Given” appears next to the item.

Working with the Problem List

The Problems section contains all current problems for this patient. Problems in e-MDs Chart flow to the Problems section in e-MDs OB module.



To add a problem:

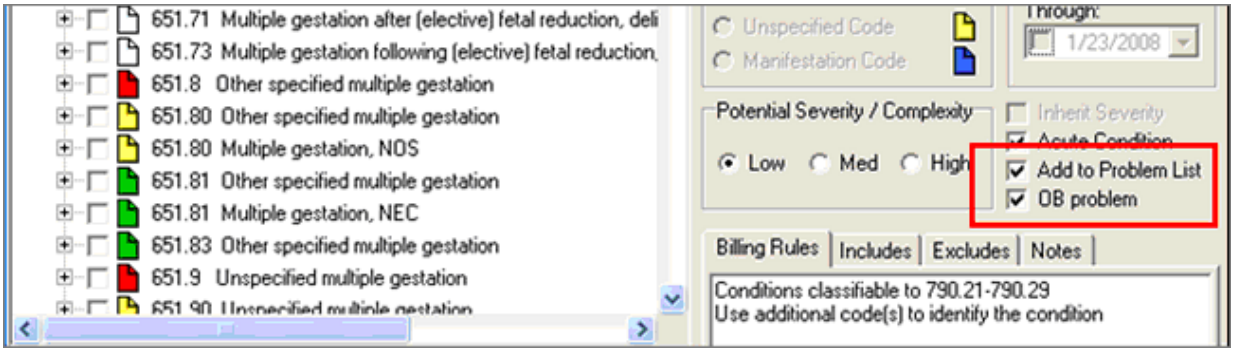
1. Click **Add Common**.
2. In the Add Problem window, type the first few letters of the problem to display a list of available problems.
3. Highlight the problem and click **Save**. (Use **Ctrl+click** to select multiple problems.)
4. Select the problem status and severity. *These fields are optional.*
5. To type any additional notes, click under **Plan/Notes** and enter your text.

Note: To change the order in which the problems appear, select the problem and drag and drop it to the desired location. The first problem in the list, designated with a blue star, is the primary.

Resolving or Deleting Problems

You can click the **Resolve** button to resolve a problem. When a problem is resolved, the problem turns gray and moves to the bottom of the problem list. You can also delete a problem by clicking the red x to the right of the **Resolve** button. However, once a problem is used in a note, the problem cannot be deleted, and the red x is no longer visible.

Note: Problems will not display in e-MDs OB module list of orders unless the ICD code has been selected as an OB Problem in the Details pane of the ICD Search window in e-MDs Chart.



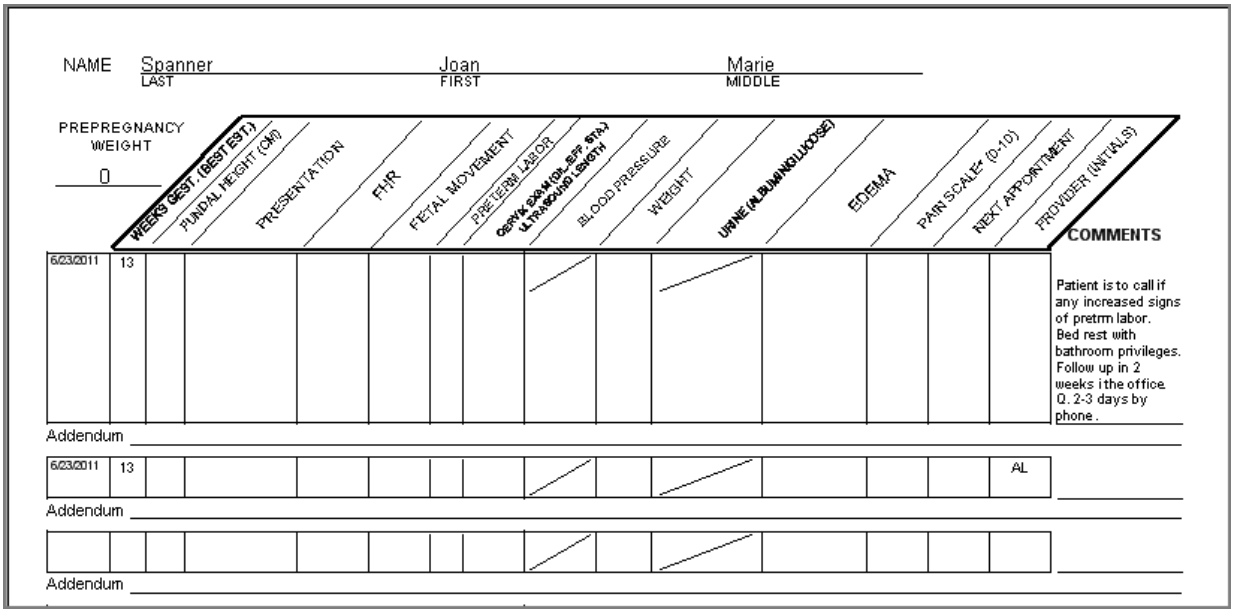
Generating Prenatal Records

At any time during the pregnancy you can generate a prenatal record modeled on the standardized forms commonly used by obstetricians. When the record is generated, the system automatically saves a copy to the patient's chart in DocMan (Prenatal HX category) and displays the copy in Chart View and Documents. The prenatal record can also be faxed from DocMan.

Notes:

- The **Referred By** field in the prenatal record will be populated based on the Default Referral entered in the General Tab of the Chart Patient Maintenance window.
- In the Consent Forms list (located in the Birth Planning section), the date for HIV Release of Records must be entered in order to include HIV results on the prenatal record. If there is no indication that the consent is signed, the system displays the following message when the user attempts to generate the prenatal record.

```
The current patient has not signed an HIV Consent Form. HIV information
cannot be printed to the Prenatal Record. Do you want to continue?
```

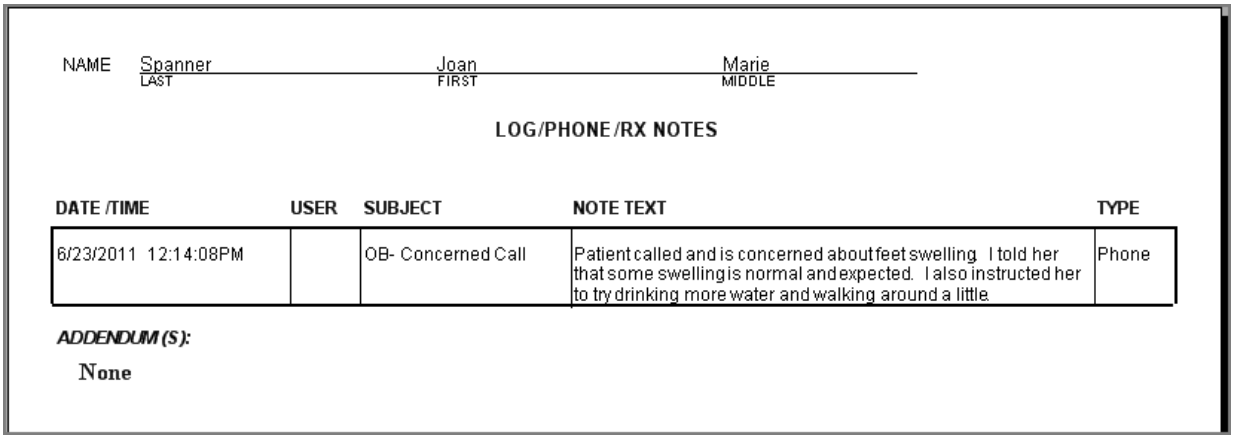

NAME Spanner (LAST) Joan (FIRST) Marie (MIDDLE)

PREPREGNANCY WEIGHT 0

WEEKS GEST. (BEST EST.) | FUNDAL HEIGHT (CM) | PRESENTATION | FHR | FETAL MOVEMENT | PRETERM LABOR | CERVIX EXAM (CM-EFF STA) ULTRASOUND LENGTH | BLOOD PRESSURE | WEIGHT | URINE (ALBUMIN/GLUCOSE) | EDEMA | PAIN SCALE (0-10) | NEXT APPOINTMENT | PROVIDER (INITIALS) | COMMENTS

6/23/2011	13													Patient is to call if any increased signs of pretrm labor. Bed rest with bathroom privileges. Follow up in 2 weeks i the office. Q. 2-3 days by phone.
Addendum														
6/23/2011	13												AL	
Addendum														
Addendum														

If a Log/Phone/Rx Note has been entered for this patient, that information will appear in the prenatal record, similar to the following example:


NAME Spanner (LAST) Joan (FIRST) Marie (MIDDLE)

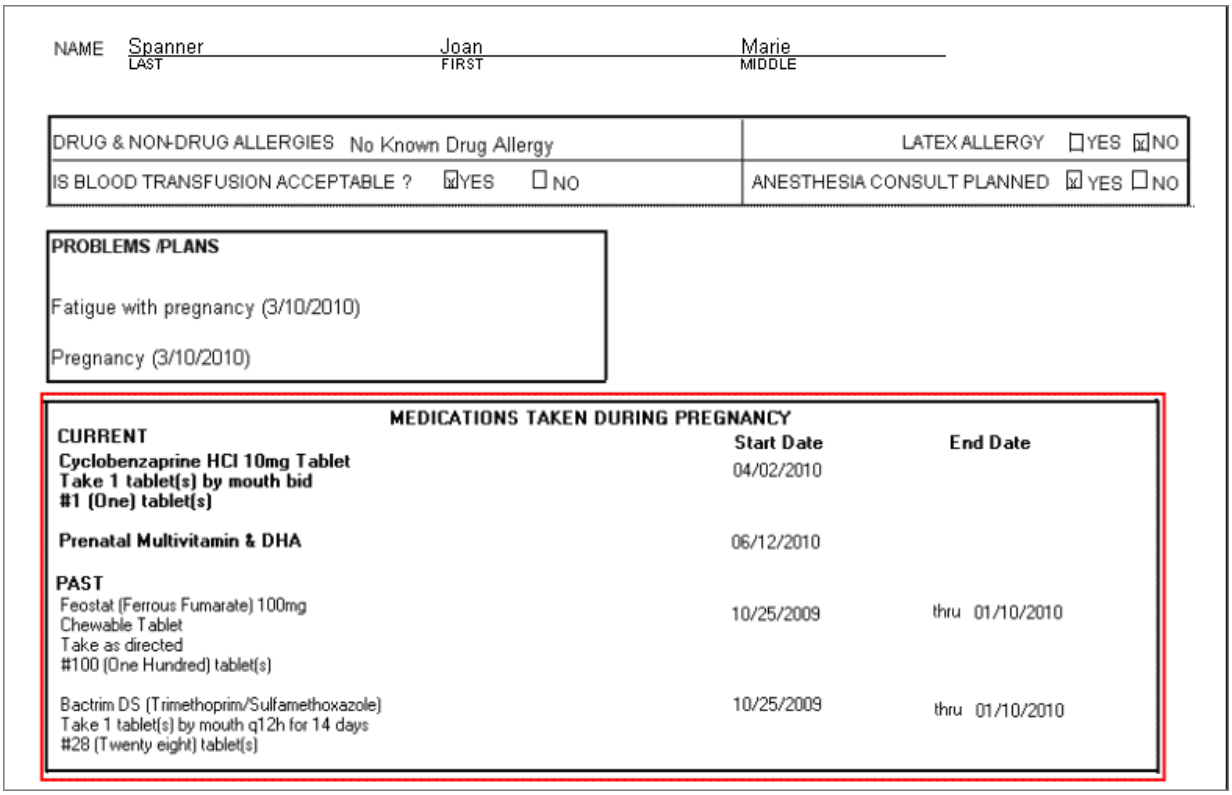
LOG/PHONE/RX NOTES

DATE /TIME	USER	SUBJECT	NOTE TEXT	TYPE
6/23/2011 12:14:08PM		OB- Concerned Call	Patient called and is concerned about feet swelling. I told her that some swelling is normal and expected. I also instructed her to try drinking more water and walking around a little.	Phone

ADDENDUM (S):

None

The medications taken by the mother can have a major effect on the health and well being of the unborn child. For that reason, the prenatal report includes an extensive record section tracking medications taken during pregnancy. That section looks similar to the following report:



NAME Spanner (LAST) Joan (FIRST) Marie (MIDDLE)

DRUG & NON-DRUG ALLERGIES No Known Drug Allergy	LATEX ALLERGY ☐YES ☒NO
IS BLOOD TRANSFUSION ACCEPTABLE ? ☒YES ☐NO	ANESTHESIA CONSULT PLANNED ☒YES ☐NO

PROBLEMS /PLANS

Fatigue with pregnancy (3/10/2010)

Pregnancy (3/10/2010)

MEDICATIONS TAKEN DURING PREGNANCY

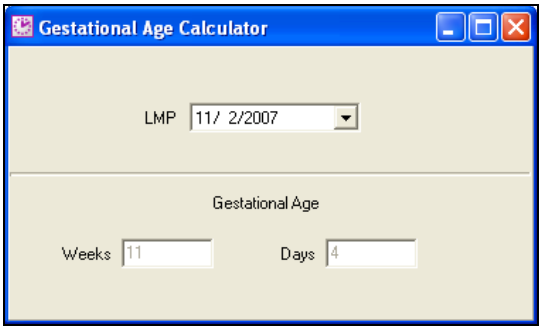
	Start Date	End Date
CURRENT		
Cyclobenzaprine HCl 10mg Tablet **Take 1 tablet(s) by mouth bid** **#1 (One) tablet(s)**	04/02/2010	
Prenatal Multivitamin & DHA	06/12/2010	
PAST		
Feostat (Ferrous Fumarate) 100mg Chewable Tablet Take as directed #100 (One Hundred) tablet(s)	10/25/2009	thru 01/10/2010
Bactrim DS (Trimethoprim/Sulfamethoxazole) Take 1 tablet(s) by mouth q12h for 14 days #28 (Twenty eight) tablet(s)	10/25/2009	thru 01/10/2010

Using Additional OB Module Features in Schedule and Chart

While most OB module features are accessible from the module itself, additional features are also available in Chart and Schedule.

Features in Schedule

To assist in setting appointments at the appropriate gestational age, a Gestational Age Calculator is available in the **Tools** menu in Schedule.



Features in Chart

The following OB-specific features are included in e-MDs Chart:

- An icon specific to OB appears in the Chart View.
- A summary of visit and order notes created in the OB module is automatically added to the Visit Notes section of Chart. (These OB-specific notes are denoted by a stork icon.)
- The audit function records every action (add, delete, etc.) taken in the OB module.
- Gestational Age rules are available in Chart.
- Two OB-specific Crystal Reports are available. These reports are *OB-Financial Analysis Report* and *OB-Monthly EDD Report.*

6
Using Templates

Templates are documentation tools used in nearly every portion of the Visit and Order Notes. A template is an organized series of data points preceded by check boxes. Only those items that the user checks are added to the note. Sometimes when a box is checked, another "level" of the template opens, allowing more detailed documentation. For example, in an HPI template, if the user checks that the patient has had a cough, the next level may ask for details such as duration and character. For the most part, these details are not required documentation elements; a user can answer them if desired, or ignore them entirely.

While e-MDs provides an extensive set of templates for use with Solution Series, you may find you need to create your own templates or customize existing templates. To facilitate that functionality, Solution Series Chart also includes a Template Editor. To learn more about how that tool works, see the *e-MDs Solution Series Administration Guide* for detailed instructions. Note that you must have the appropriate privileges assigned to your user access to use that editor.

Continued on the next page ...

Accessing Templates in Visit and Order Notes

Templates belong to "categories" that determine where a particular template will appear in e-MDs Chart. A History of Present Illness (HPI) template, for example, will only show up in the HPI section of a note. Sections of e-MDs Chart that use templates will display a small template icon (a gray box with a check mark ☑). When the cursor is held over the template icon, the gray box is highlighted in yellow. Click this icon to display a list of linked templates.

Templates may be linked to a patient based on the patient's age and gender, such as with the Review of Systems (ROS) and Exam templates. For example, questions relating to ovarian cancer will be found only in the Adult Female ROS or Past Medical History templates, and not in the corresponding Pediatric or Male templates. Templates are also linked to ICD and CPT codes. That is, if the complaint documented in HPI is "ankle pain", specific templates for ankle pain will show up in HPI, Exam, and Plan sections.

There could be a number of different reasons for being unable to find an appropriate template in the Template Links window.

- It is possible that a template for the given condition does not exist. To look for a related template that might have inadvertently not been linked, click the **Additional** button. This will list all templates of the appropriate category type, age, and gender. In addition, Generic templates are *always* available in the Template Links window for the HPI and PLAN sections and are developed in a way that makes them usable for documenting almost any condition.
- The template you are looking for may not be designated for the age or gender of the patient you are currently seeing. This can be resolved by editing the template to change the age and/or gender settings (this may not be appropriate in all cases since templates can be written to be very specific for age and gender).
- It could be that the template is set to draft status and cannot be accessed from the chart. To resolve this, you can edit the template and change the status to **Complete** (always verify that the template has truly been completed).

Quick Launch Templates

To the right of the Template Link icon there is a Quick Launch icon . With the Quick Launch feature you can designate a single template to be launched as the default choice for the diagnosis being documented in the particular section of the note that you are working in (HPI, ROS, Plan, etc.). All Quick Launch templates are age and gender-specific, meaning that one can be chosen for pediatric male, pediatric female, adult male, and adult female patients for each diagnosis and section of the note.

Notes:

- Complaint-Specific Exam templates cannot be set for Quick Launch use.
- If the template chosen is an Insurance-Specific Template, then the Quick Launch template will be insurance-specific as well (for more information, see the "Insurance-Specific Templates" section in the "Creating and Modifying Chart Templates" chapter of *e-MDs Solution Series Administration Guide*).

Quick Launch templates will be provider-specific. They can only be set up or changed by the provider, supervisor, or assistant listed in the visit details of an open note. After being set, the icon will turn blue to indicate the presence of a Quick Launch template.

To set a Quick Launch template:

- From an open Visit or Order Note, click the **Quick Launch** icon and select the name of the template to so designated.

  The template will open and become the Quick Launch template for the provider listed for this visit.

  OR

- From an open visit note:
  a. Click the **Template Link** icon.

     A column of check boxes will appear on the left side of the Template Launch window. If no Quick Launch template has been designated, no check mark will appear in the check boxes.

  b. Click the check box next to the template you want to select as the Quick Launch template.

  c. Click the template name to open it. This will set the selected template as the Quick Launch template for the current provider.

To change a Quick Launch template:

1. From an open Visit or Order Note, click the **Template Link** icon.

   A check mark will appear in the check box next to the template that is currently designated as the Quick Launch template. Additionally, text will appear after the name of the template indentifying it as the Quick Launch template.

2. Click the check box next to the template you want to designate as the Quick Launch template.

3. Click the template name to open it. This will change the Quick Launch designation to the selected template.

Blank Templates

Before a template is opened, you must choose between a blank template, a pre-clicked template (accessed via the computer mouse icon), or a past template (accessed via the alarm clock icon). A blank template is simply a template that has not had any check boxes checked.

After the template is open, click to select the appropriate check boxes. You can click either a check box or the words next to it.

In some templates, there is a check mark and an X, instead of just a check box. This allows for documentation of pertinent negatives. Clicking the check mark will document a positive (yes) response. Clicking the X will document a negative (no) response.

To close the template when finished, click the exit X in the upper-right corner of the first template window or click anywhere outside of the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top level window is closed.

Pre-Clicked Templates

Whenever you open a template you must choose between a blank template, a pre-clicked template, or a past template. A pre-clicked template is one where the answer set has already been created. For example, you can open a Review of Systems (ROS) template and check through the answers to generate a negative ROS. When the answer set is complete, give it a title and save it as a pre-clicked template. Later, when you want to use a ROS template in a note, you have the choice of dropping in that pre-clicked template.

A pre-clicked template should be treated as a "starting point" to assist in rapid documentation of common, repetitive data. If any pre-clicked answers do not apply to a given patient, the answer set can be rapidly amended to suit the situation, simply by clicking or un-clicking check boxes after the template has been dropped into the patient chart. *Changes made for that patient do not change the pre-clicked template.*

More About Pre-Clicked Templates

Keep these points in mind when working with pre-clicked templates:

- An unlimited number of pre-clicked templates can be created from a single template. For example, the Review of Systems (ROS) questions posed to an adolescent would be different than those asked of a geriatric patient. As a result, two different "Negative ROS" answer sets could be created.
- Templates of every category can be used to create pre-clicked templates. In addition to ROS, other common uses for pre-clicked templates include normal physical exams, procedure notes, and common treatment plans.
- Each pre-clicked template can be *Author only* (user specific) or *Clinic wide* (available to all users).

The following procedures guide you through using a pre-clicked template, and creating or editing pre-clicked templates on the fly.

To use a pre-clicked template:

1. To open a pre-clicked template, click the computer mouse icon, located to the left of the template title in the Template Links window. (See the Accessing Templates in a Visit or Order Note section for information about finding linked templates.)

   This opens a window displaying the titles of all pre-clicked versions of the selected template (plus a search field).

   Note: If the computer mouse icon is disabled (appears gray and is inactive), this indicates that no pre-clicked versions of the selected template exist.

2. Click the title of the desired pre-clicked template.

   Notes:

   - Pre-clicked templates are not user-specific; therefore, pre-clicked templates created by other users will be visible. It is wise to include your name or initials in the title of any pre-clicked templates that you create.
   - If none of the pre-clicked titles is appropriate, click **Template Links** at the bottom of the Pre-Clicks window to return to the original Template Links window.

3. The selected pre-clicked template will open. Make changes to the answer set, as necessary.
4. To close the template when finished, click the X in the upper-right corner of the first template window or click anywhere outside the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top level window is closed.

Pre-clicked versions of templates can be created in the Template Editor or created on the fly when a template is opened in a patient chart. The following instructions refer to creating a pre-clicked template in a patient chart. For information on creating them in the Template Editor, see the "Creating and Modifying Chart Templates" chapter in *e-MDs Solution Series Administration Guide*.

To create a pre-clicked template on the fly:

1. Open a template and check data points.
2. When finished, click the chart icon in the upper-left corner of the first template window to the left of the words "Level 1:" in the title bar of the template window.
3. Select **Save Pre-Clicks As** from the menu.
4. In the next window, supply a description for the pre-clicked template. If you want to be the only person to be able to use this pre-clicked template, select **Author only**. Be aware that no other

user will have access to view or use this pre-clicked template. If this pre-clicked template needs to be accessible to all users, select **Clinic-wide**.

5. Click **OK**.

   Note: When choosing **Clinic-wide**, all users will have access to the pre-clicked template. If multiple providers will be generating pre-clicks, it is helpful to include their names or initials in the titles to aid in rapidly identifying the correct template in e-MDs Chart.

6. When finished, close the template by clicking the **X** in the upper-right corner of the first template window or clicking anywhere outside the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top level window is closed

From time to time pre-clicked answer sets must be changed to suit the individual situation. To do so, click or un-click check boxes after the template has been dropped into the patient chart and then close the template. Changes made for that patient *do not* change the pre-clicked template. On the other hand, if you want to make *permanent* changes to the pre-clicked template, you must save the changes prior to closing the template.

To edit a pre-clicked template on the fly:

1. Open a pre-clicked template.
2. Make the appropriate changes by clicking or un-clicking check boxes in the template.
3. When finished, click the orange chart icon  in the upper-left corner of the first template window. It is located to the left of the words "Level 1:" in the title bar of the template window.
4. Select **Save Pre-Clicks** from the menu. This opens a window listing all pre-clicked versions of that template.
5. Highlight the name of the pre-clicked template that was just altered and click **Save**.
6. When finished, close the template by clicking the X in the upper-right corner of the first template window or click anywhere outside the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top level window is closed.

Past Templates

Before a template is opened, the user must choose between a blank template, a pre-clicked template, or a past template. A past template is an answer set from a prior time, when the selected template was used for the same patient. Answer sets are saved automatically whenever a template is used.

To open and close a past template:

1. Click the alarm clock icon , located to the left of the template title in the Template Links window. (See the Accessing Templates in a Visit or Order Note section for information about finding linked templates.)

   This opens a window displaying all previous dates that the selected template was used for this patient. Each date is followed by the diagnoses assigned at that visit.

   Note: If the alarm clock icon is disabled (appears gray and is inactive), no past versions of the selected template exist.

2. Click either the date or the associated diagnoses to open the past template. The selected past template will open.

   Note: If none of the past templates is appropriate, click **Template Links** at the bottom of the Pre-Clicks window to return to the original Template Links window.

3. Make changes to the answer set, as necessary.
4. To close the template when finished, click the X in the upper-right corner of the first template window or click anywhere outside the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top level window is closed.

Generic Templates

The History of Present Illness (HPI) and Plan templates are typically linked to ICD codes. Therefore, the Template Links windows in those sections of a note are populated with templates linked to the complaint(s) in HPI. If no templates exist for a complaint or diagnosis, a Generic Template can be used for basic documentation purposes. This usually reduces the amount of typing needed to complete the note.

For example, a Generic Plan template might include commonly ordered labs and procedures, an extensive list of sub-specialists for referral purposes, and generic follow-up instructions. Likewise, a Generic HPI template will ask questions such as duration and associated symptoms. Therefore, regardless of the patient's presentation, much of the template should be useful.

Generic templates appear in every Linked Templates window whether or not there are other linked templates. If there are diagnosis-specific templates linked to the diagnosis, the generic templates will appear at the bottom of the list after the diagnosis-specific templates. Otherwise they will appear at the top of the list.

To access generic templates:

1. Click any **Free Text** icon (they appear as small gray circles that turn into yellow squares when the cursor passes over them).
2. Select the **Other Options** button located in the bottom-left corner of the Free Text window.
3. Select the **Generic Template** menu option.

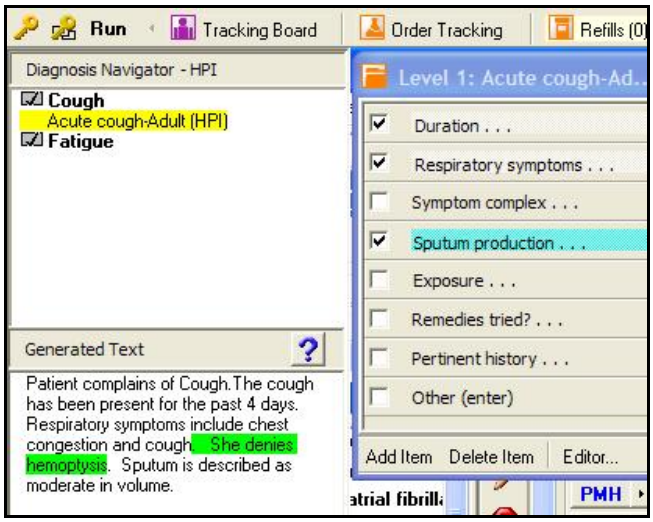
   Note: This menu option is only available in the HPI and Plan sections of a note for this usage. You may also notice that this menu option appears in Exam templates, but that option is for opening a "template within a template." See Nested Templates for details.

   A Template Links window will open, listing any available Generic Templates appropriate for the given section of the note. If this window is empty, no Generic Templates exist.

Working with Diagnosis Navigator

This feature takes the list of diagnoses that are in the Visit and Order Notes and presents them in a window that runs vertically down the left side of any open template. Users can easily and quickly jump from one diagnosis to another to access diagnosis-specific templates without having to close the template and then reopen another one.

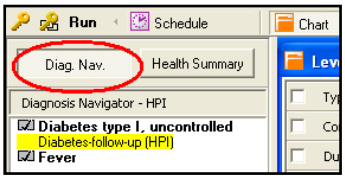
In the following sample screen, the patient presents with a cough and fatigue. Notice that both the complaints are listed in the Navigator window on the left. The cough complaint is highlighted in yellow to indicate it is the active template that is currently open (notice the template name on the header of the template). You can document as much as needed in the cough template and then, by clicking the word "fatigue" or the template launch icon ☑ in the left pane, open the fatigue template and begin documenting that complaint.

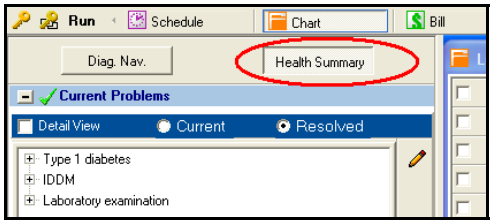


Note: In some cases the Diagnosis Navigator will appear with the wording “No Diagnosis Present in the Selection.” This happens with template categories that are not diagnosis dependent. For example, the CC, ROS and Exam templates are not dependent on a diagnosis. They show up as template choices in a note based on the patient’s age and gender, and not based on a complaint or diagnosis. On the other hand, HPI, PLAN and Procedure templates *do* have a dependency on a diagnosis or complaint and will always have complaints listed in the Diagnosis Navigator.

Turning Off the Diagnosis Navigator

The Diagnosis Navigator window displays when a template is opened. This window can be toggled off and on. When the Navigator is toggled off, the Health Summary will appear in the left pane. The state of the Diagnosis Navigator (off or on) is retained from the prior session. If the Navigator was displayed the last time you were in a patient chart, then it will display the next time. If you always want the Health Summary to be displayed, click the **Health Summary** button to hide the Navigator and leave it that way. Each time you log in you will see the Health Summary section instead of the Navigator. You can always toggle back and forth, but remember that the last setting will be the one that you see the next time. The sample screens below show the toggle buttons in both Navigator and Health Summary modes.





Generated Text

As part of the Diagnosis Navigator display, you will see the generated text from the template at the same time that the template items are being checked. As illustrated in the earlier example, this Generated Text pane runs vertically at the left of the template and just below the Diagnosis Navigator. Text appears in this pane as questions in the template are answered, providing a real-time view of what text in the note will look like as it is being generated. In addition, some text will show up highlighted in green to identify a "Nested" template (see Nested Templates for details). Clicking this highlighted text will launch a nested template just as if the nested template icon were clicked from within a template.

Note: The option to reopen a template to a specific question by clicking the text for the answer (a feature of templates available in the Visit or Order Note) *is not* available in the Diagnosis Navigator Generated Text window.

Legend

A Legend feature is built into the Diagnosis Navigator. It is found in the Generated Text section and is represented by a blue question mark ? icon. The legend describes the function of the icons that are available in the templates.

Navigating from Template to Template

The Diagnosis Navigator lists any diagnoses or complaints that exist in a Visit or Order Note when an HPI, PLAN or Procedure Template is open. You can navigate between the templates that are linked to these diagnoses or complaints without closing the templates and returning to the note.

To navigate between templates:

1. In a Visit or Order Note that contains more than one diagnosis or complaint, with a template for one of those diagnoses or complaints open (the complaint whose template is open should be highlighted in yellow), click one of the other complaints in the list.
2. *If there is only one template associated with that complaint,* the template will open and documentation can start.

   OR

   If there is more than one template associated, the Linked Template window will open and you can choose the appropriate template to start documentation.

Closing Templates

In most Windows-based programs, to close a window or form you must click the X in the top-right window corner or use a sequence of keystrokes (such as **File** and **Exit**). The resolution of some computer screens makes it difficult to hit the X and tablet computers do not have easy access to keyboard. That makes the closing of items that are used frequently, such as templates, more difficult and time consuming. To alleviate those issues, and to help speed documentation, the Template Launcher bypasses this requirement and allows a user to click anywhere outside of the template (and Diagnosis Navigator) to close the template.

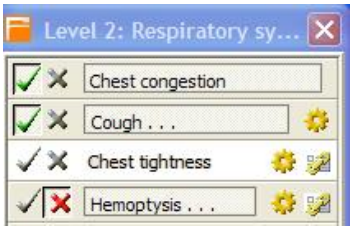
Nesting Templates

Nested Templates allow users to open a completely different template directly from within another template without closing the first template. For example, from within a "cough" template a user can document that a patient has an associated symptom of fever. The cough template only allows for a brief documentation of fever and, in order to document the fever in more detail, you might choose to open a complete fever template through a nested template. In other products this might require that you close the cough template and select a fever template. With e-MDs Chart you can click an icon within the cough template and access a fever (or other linked template) directly from the current template.

Note: Nested templates have a one-to-one relationship with template questions. In other words, only one template can be linked (or nested) to a template question.

Accessing Nested Templates in a Note

Nested Templates are launched directly from a template question. Nested Templates are linked to a template question in the Template Editor and are represented in the Template Launcher in Chart by an icon containing a piece of paper with a chain link across it. This sample screen segment shows a template containing multiple questions that are linked to a nested template. To launch a nested template, click the nested template icon and the linked template will open immediately.



Nested Template Text

Any text generated from a nested template will be embedded within the text of the original template. This text becomes part of the paragraph that appears under the original template's diagnosis. However, you also have an option to separate this text by dropping in a separate diagnosis for the nested template. For example, if you open a nested template for fever from within a cough template, you can choose to drop fever in as a diagnosis of its own (by clicking a **Process ICD** icon in the template). When you do that, all the text associated with the fever template will be moved into a new paragraph under the fever diagnosis.

To separate nested template text:

1. Open a template that has a Nested Template available.
2. Click the question with the nested template.

   If there is an ICD code associated with the question a gold cog icon will be displayed to the right of the question.
3. Click the **Gold Cog** icon to force the ICD to drop into the note as a separate diagnosis.
4. Click the **Nested Template** icon to open the nested template and document, as needed.
5. When the template is closed the ICD will appear in the note with the template-generated text under it.

Nested Templates are linked to a template question in the Template Editor. For more details on creating and editing templates in the Template Editor, see the "Individual Template Items" section of the "Creating and Modifying Chart Templates" chapter in *e-MDs Solution Series Administration Guide*. Note that you must have the appropriate user access level to open and use the Template Editor.

To add nested templates to a template item:

1. Open the Template Editor.
2. Edit a template.
3. Choose the question to which you want to link a Nested Template.

4. In the Template Editor, highlight any template item and click the arrow next to **Edit** (located at the bottom of that level's window). This opens the Edit Item Properties window.
5. In the Edit Item Properties window, click **Linked Template**.
6. Click the **Link a Template to Item** check box. The Template Catalog window will open.
7. Find the desired template, highlight the name and click the **Select** button at the bottom-right corner.

   OR

   Double-click the template name.

   The template name will be displayed in the **Linked Template** field.

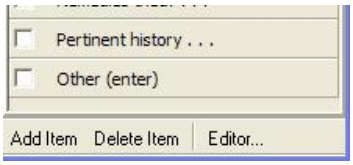
Editing Templates on the Fly

The Template Launcher is the module that presents and displays the templates in a Visit or Order Note. The Template Editor is the module used to create and edit templates that are displayed in the Template Launcher. You can switch between the functionality of the two on the fly while in a Visit or Order Note.

Note: Template editing on the fly is not available with ROS (Review of System) templates. This is due to their potential relationship to Fast Forms. If an ROS template that is linked to a Fast Form is edited, the linked Fast Forms will be deleted.

You can easily add a new item to a template without switching to Editor mode by clicking the **Add Item** button at the bottom of the template level to which the item is to be added. This is a quick and easy feature for adding template items that already exist in the Template Library. However, sometimes new items need to be added or existing items need to be edited or resequenced. Switching to Editor mode allows more flexibility in created and editing template items.

To access Editor Mode:



1. While in a Visit or Order Note with a template open, click the **Editor** button at the bottom-right corner of the template level.

   The template will switch from Launcher to Editor mode.
2. Make changes as necessary.

   Note: While most of the functionality of the Template Editor is available with this feature, not *all* functionality is available here. For example, you will not be able to create *new* templates in this manner.

   Important! If the template that is being edited is a Generic type (either HPI or PLAN), a copy of the template will be made and you will be prompted for a name to use for the template. This is done to prevent overwriting of Generic templates.

At times, the addition of an existing template item is all that is needed in order to deal with a template that is missing information.

To add an item to a template on the fly:

1. While in a Visit or Order Note with a template open, click the **Add Item** button at the bottom-left corner of the template level.

   The Template Library Browser will open. Categories of reusable items are listed in the left pane.
2. Click a category to display a list of reusable template items on the right.
3. Click to select the reusable item, then click the **Select** button at the bottom-right corner of the Template Library Browser window.

OR

Double-click the desired reusable item.

If a template item is inadvertently added to a template, or if you no longer need a template item, it can be deleted.

To delete an item from a template on the fly:

1. While in a Visit or Order Note with a template open, highlight the item to be deleted.
2. Click the **Delete Item** button at the bottom-left corner of the template level.

   A confirmation window will appear that asks “Do you really want to delete the question “*Item Name"*?
3. Click **Delete** to delete the item.

   OR

   Click **Keep** to cancel the deletion.

Accessing FlowSheets in Templates

To save time in capturing lab results from FlowSheets for inclusion in Visit or Order Notes, some templates contain links to the templates containing those FlowSheets. Use the following steps to capture those lab results and insert the information in a Visit or Order Note.

Note: The following procedure only works when the FlowSheets Extended Attributes have been implemented in a template. For details on how to set up this access, see "Adding Access to FlowSheets in Templates" in the "Creating and Modifying Chart Templates" chapter of the *e-MDs Solution Series Administration Guide*.

To access and extract lab results from a FlowSheet:

1. Open the appropriate template for the Chart task being performed.
2. If only one FlowSheet is associated with the template, that FlowSheet will display automatically.

   Note: If the single predefined FlowSheet is not currently in the patient's list of FlowSheets, all patient-specific FlowSheets will appear with the following message: *FlowSheet name* **is not currently in the patient's chart. Please add this FlowSheet using the Add a FlowSheet button (blue plus icon) as necessary.**

   If more than one patient-specific FlowSheet is available for access through the template, the entire list of FlowSheets displays, ready for you to access any listed templates to add or extract information.
3. When the Lab/Results: FlowSheet window opens, click to select a template in the left pane to display available information.
4. Perform any of the following tasks to add, modify or delete information in the FlowSheet and select it for inclusion in the note:
   - *To enter new data in an empty cell or modify existing data,* double-click the cell and type the new data.
   - *To add a new date to the FlowSheet,* click **New Date** in the screen toolbar and a new date column will be inserted. (This works the same as adding a new date in a FlowSheet outside templates.)
   - *To delete data in a cell where data was entered by a user,* click to highlight the cell and click **Delete**.

- *To set a date range preference for how far back the available lab results should be displayed,* click **Value Range** and specify the begin and end dates to be used.

When you perform any of the above tasks, the affected cell and value is automatically selected and a green check mark appears in the cell.

5. To drop the selected values into a Visit or Order Note, click **Select**. The data from the FlowSheet will be written to the note in the format similar to the following example:

```
Weight (lb): 220.0 (09/25/2003), 222 (09/28/2003), 222.0 (11/01/2003) 218.0
(11/05/2003); LDL: 130 (09/25/2003), 128 (09/28/2003), 99 (11/01/2003), 99
(11/05/2003)
```

Note that any abnormal results appear in bold font to highlight them in the V or Order Note.

Processing ICD and CPT Codes

Some templates, such as the HPI, have ICD codes linked to a question. Unlike a CC template where you *always* want the ICD to drop into the note if you choose the question, with an HPI template you might not want to drop an ICD in if you are only documenting a symptom. A similar situation exists with CPT codes. Process icons in the templates allow you to choose whether to add the codes or not.

With the **Assert EA as Default** option the cog is already displayed in the template as selected, thereby adding the code by default. You still have to option to deselect that cog to *not* add the ICD or CPT code.

HPI and Exam templates have a **Process ICD** option that is represented by a gold cog icon. This option allows you to choose whether to drop an EA associated with a template question into the note. Exam, Procedure, and Plan templates also have a **Process CPT** option that is represented by a red cog icon.

To process an ICD code:

1. Open an HPI or Exam template that has a question that has an associated ICD code.
2. Click the question with the ICD code. *If there is an ICD code associated with the question*, a gold cog icon will be displayed to the right of the question.
3. *If you want to drop the ICD code into the note,* click the gold cog icon if it is not already selected.

   OR

   If you do not want to drop the ICD code into the note, click the gold cog icon to clear (reset) the option.

To process a CPT code:

1. Open an Exam, Procedure or Plan template that has a question that has an associated CPT code.
2. Click the question with the CPT code. *If there is a CPT code associated with the question*, a red cog icon will be displayed to the right of the question.
3. *If you want to drop the CPT code into the note,* click the red cog icon if it is not already selected.

   OR

   If you do not want to drop the CPT code into the note, click the red cog icon to clear (reset) the option.

To add a process ICD or CPT code to a template:

1. Open the desired template from within a Visit or Order Note.
2. Click the **Extended Attributes** (rolodex card) icon next to the desired item. This will launch the Select Extended Attributes window.
3. Highlight either **CPT** or **ICD**, as applicable.
4. Click **OK** to launch the CPT or ICD Search screen.
5. Search for the desired code.
6. Highlight the code and click **Select**.

   OR

   Double-click the code.
7. If you want the code to be automatically added to the note *every time* (by default, the icon is depressed), click **Assert EA as Default**.
8. Click **OK**.
9. Click **Launcher** in the bottom-right corner to resume work in the note.

Designating Items as Confidential

Template questions can be designated as *Confidential*. Setting a question to the confidential state causes the generated text to be hidden when the **Confidential Item** button is selected to hide confidential information. When the information is hidden it will show up in the note but will be blacked out so that it cannot be identified. Questions in templates can be set up to default to **Confidential** from within the Template Editor and "on the fly" from within a Visit or Order Note.

Note: The ability to view confidential items is a privilege that is set up through security and associated with your login. If you are unable to view items set as confidential, see your administrator.

Setting an item as confidential on the fly, from within a note, only marks that item as confidential for *that* patient in *that* note. Items can also be set to be confidential permanently, but that must be done in the Template Editor.

To set confidential items on the fly:

1. While in a Visit or Order Note, open the template.
2. Right-click the item to be marked as confidential.
3. Select **Temporarily Set as Confidential** from the pop-up menu.

   Note: You can also choose to **Temporarily Set all items in this level as Confidential** to set every question on the level as confidential (for example, all of Level 2 in a template).
4. Questions marked as confidential will appear in green text in the template and will appear as *blacked out* items in the note itself (*if the **Confidentiality** option is turned on*).

Template items can be permanently set to Confidential in the Template Editor. Some template items such questions about HIV or mental illnesses are candidates for permanent confidentiality status. Marking the template questions in this manner assures that whenever the template is used the information will be set to confidential.

To permanently set items as confidential:

1. While in a Visit or Order Note, open the template.
2. Click the **Editor** button.

OR

In the Template Editor, open the template.

3. Select the question to be marked as confidential.
4. Click the **Edit** button at the bottom of the template level.
5. Select the **Set** *"Question Name"* **as Confidential Item** menu choice.

   Note: You can also choose to **Set all items in this level as confidential.**

Removing a setting of "Confidential" on-the-fly from within a Visit or Order Note only marks that item as public for *that* patient in *that* note. Items can also be permanently set to be public, but that must be done in the Template Editor.

To temporarily change Confidential status:

1. While in a Visit or Order Note, open the template.
2. Right-click the item to be marked as **Public**.
3. Select **Revert back to Public Item** from the pop-up menu.

   Note: You can also select **Revert back all items in this level as Public** to remove the Confidential status for all questions in that level (for example, all of Level 2 in a template).

Template items can be permanently set to Public in the Template Editor.

To permanently change Confidential status:

1. While in a Visit or Order Note, open the template and click the **Editor** button.

   OR

   While in the Template Editor, open the template.
2. Select the question to be marked as **Public**.
3. Click the **Edit** button at the bottom of the template level.
4. Select the **Set** *"Question Name"* **as Public Item** menu choice.

   Note: You can also select **Set all items in this level as public.**

Managing Template Text

In the HPI section, with the full generated text, it can sometimes be challenging to pick out pertinent information quickly. The Outline Text feature allows you to decide if you want to see the HPI information in a Full Text view or an Outline view. At its very basic level, the outline view places a carriage return after each sentence in the template for ease of viewing. You can also set the template questions to generate a shorter, more concise text for the outline view. For example, in Full Text view, generated text that reads:

```
The problem has been present for 2 weeks.
```

can be set to look like this:

```
DURATION: 2 weeks
```

By default the setting is to show the Full Text view that users are used to. But the Outline View can be turned off and on "on the fly" by clicking a button at the top of the Visit or Order Note (**Outline View** or **Full Text View**). In addition, there is a user preference setting that allows you to permanently set your default to **Outline View**.

Setting Text to Bold

This feature allows any template answer to be marked in bold text to draw attention to it. In many cases this can be used to denote abnormal or positive findings but it may also be used for ANY situation where attention needs to be directed to text in a Visit or Order Note. See "Individual Template Items" in the "Creating and Modifying Chart Templates" chapter of the *e-MDs Solution Series Administration Guide* for details.

Randomly Changing Opening Text

Templates have the option to randomly display opening paragraph text from templates in the HPI section. When the template is reopened, the text will change randomly to one of five phrases that were previously coded into the templates.

For example, a paragraph generated from a Chest Pain template in the HPI section might start out with the opening text indicating "Patient complains of chest pain." However, if the template is reopened for editing, the text might change to “Patient to be evaluated for chest pain” or “Chest pain noted.”

The random text feature works with opening text for Nested Templates as well. With Nested Templates the random set of text is slightly different. For example, in a nested template for depression the randomly generated text might be one of the following:

"Regarding depression"
"With regard to depression"
"Per complaint of depression"
"Per symptom of depression"
"Concerning depression”
“As for depression”

Note: This text is generated due to $OpeningSymptom and $OpeningCondition tokens being inserted into the **Opening Text** section of the HPI templates. To view or modify them, open the template in Template Editor and go to **Edit** > **Edit** (at the top) and click **Opening Text** on the left.

To remove some template text from a note:

1. Click the template text in the note. The template will open.
2. Clear any answers that are no longer needed.
3. Close the template, when finished.

To re-open a template to make changes:

1. As the cursor hovers over template-generated text, text fragments highlight in green. With the mouse over any green-highlighted text fragment, left-click the highlighted text.

   The template will reopen, and the text fragment that was selected at the time of reopening will be highlighted.
2. Make any desired changes.
3. When finished, close the template by clicking the X in the upper-right corner of the first template window or click anywhere outside the template. If multiple template windows are open (as in a multi-level template), it is not necessary to close each window. Subsequent level windows will automatically close when the top-level window is closed.

To completely remove a template from a note:

1. Click the template text in the note. The template will open.
2. Right-click any of the template questions. A pop-up menu will appear.
3. Select **Remove template from note**.

OR

As the cursor hovers over template-generated text, text fragments highlight in green. With the mouse over any green-highlighted text fragment, left-click the highlighted text.

4. Click the icon at the top-left of the first template window. Depending on how the chart was opened, the icon is a either an orange chart icon (opened in Chart) or a purple person icon (opened in Tracking Board). The icon it is located to the left of the words "Level 1:" in the title bar of the template window.

   A pop-up menu will appear.

5. Select the **Remove Template from Note** menu option.

Viewing Template Messages

Occasionally, when certain data elements are checked in templates, a yellow message box will appear in the lower-right portion of the screen. These messages are meant to be helpful hints for the healthcare provider and include items such as differential diagnosis hints or "best practices" guidelines.

The message boxes cannot be turned off, though it is possible to remove individual messages, one at a time, from templates in the Template Editor.

Caching and Flushing Templates

In prior versions of e-MDs Chart, there was a noticeable lag when opening some of the larger templates (such as Exam and PMH templates). Because template speed is crucial, e-MDs Chart includes "template caching" to improve performance.

Caching Templates

When a template is cached, a copy of the template is downloaded from the server and stored or “cached” on the local workstation. This provides a faster response time when opening a template because the information is stored locally and does not have to be fetched from the server. Flushing the template cache becomes necessary when changes have been made to a template and a version that is newer than the one stored on the local workstation exists on the server.

In previous versions users were required to manually flush the template cache any time a change to a template was made. In current versions of Chart, template caching has changed so that the application tracks the version of the template that is cached along with the version of the template that is stored on the database. Now, whenever a template is opened the application checks to see if a newer version exists on the database. If a newer version does exist, the application automatically flushes the cache and downloads the newer version. In most cases the addition of this feature eliminates the need to manually flush the cache when changes are made to a template. Since this flushing occurs whenever a version of a template that is newer than the version on the local workstation exists, it also eliminates the need to go to every workstation and flush the cache when changes are made.

Keep in mind that template caching is machine-specific, and a separate cache is saved to each computer, depending on which templates have been used on that machine.

Flushing Templates

After a template has been used on a particular computer, it resides in the template cache of that computer. Suppose that you now use the Template Editor to make edits to that template. If the cache is not flushed after the changes are made, the next time that particular template is called, the computer will display the old, unedited version that still resides in the cache.

Current versions of Chart have a template versioning feature that determines if a new version of a template exists anytime a template is opened. If a new version does exist the program automatically

deletes the template cache for the selected template *Only*. This avoids the need to flush the template cache manually. *However*, there may be times when it is necessary to flush the cache manually.

Note: If it becomes necessary to flush the cache manually, it must be flushed on *each machine*. Realize that this flushes the entire cache, not just a specific template. Also, the first time you open any large template after manually flushing the cache, there may be a delay.

To flush the template cache:

1. Open e-MDs Chart.
2. Click **Tools** on the main toolbar.
3. Click the **Flush Template Cache** menu option. This will flush the cache immediately, though there is no visual confirmation of that fact.

7
Tracking Patients and Workload with Tracking Board

Tracking Board allows healthcare providers and administrative staff to see an overview of their daily workload and track patients through the clinic all on a single screen.

Continued on the next page ...

Understanding the Tracking Board Interface

The following is a brief overview of the various components, along with links to detailed instructions for each part.

Main Page Menu	
File	User Preference Options are accessed via the File menu. Because Tracking Board involves e-MDs Schedule and tracking of patients through a facility, the Internal Facility must also be set. The charts of any patients who do not appear on screen can also be opened from the File menu.
Demographics	Provides access to demographic search and maintenance windows for Patients, Guarantors/Policyholders, Persons/Contacts, Providers & Staff, Organizations and Medical Facilities.
Reference	The Reference menu provides access to the Rooms maintenance, as well as the Clinical Reference Libraries which include the ICD-9 search, CPT search, HCPCS search, Medical Art, Patient Education, Curbside Consults, Drug Consults, Drug Education, Patient Instructions and Policies.
Tools	This provides access to several tools that are used in Tracking Board and also provides access to other workflow modules. The Tracking board specific tools are **Refresh** which refreshes the information in Tracking Board, **Hide/Show Rules** which turns the rule-based reminders section off or on and **Clear Rooms from Previous Day** which empties all rooms that may have had patients unintentionally left in them from previous days. Other modules that are available from this menu are Letter Editor, Phone-in Scripts, DocMan, FlowSheets, TaskMan, Order Tracking, HealthCare Visit Signoff (Unsigned Notes module), Referrals/Authorizations, Flush Template Cache, Memory Monitor and Spell Check Configuration.
Reports	This provides access to the Reporting functionality of Chart. This includes access to Unsigned Notes Report, Crystal Reports and Forms/Letters.
Help	This provides access to the Legend and the Help system.

Main Page Toolbar	
Open Patient Chart *(Yellow Chart)*	The first button on the toolbar allows the user to open a chart of any patient who does not appear on screen.
Log Off *(Gold Key)*	The second button allows the user to log off the application.
Refresh *(Gold Circle and Arrows)*	The third button is a Refresh. Because patients appear in the Waiting Room (in Tracking Board) once they are “checked in” in e-MDs Schedule, the Tracking Board screen must refresh periodically for these new patients to appear. The frequency of automatic refreshes can be set under Options, but a manual refresh will occur anytime this button is clicked.
TaskMan *(Envelop)*	The fourth button launches Task Man and opens the Inbox of the user who is logged in. Note that the number of unaddressed messages and tasks can be viewed in the Workload section of Tracking Board, and TaskMan can also be launched directly from that window.
Show Rules *(Person and Check mark)*	The fifth button is a toggle that will turn the rule-based reminders (automated clinical reminders) section off or on.
Show Patients For	This field allows users to select the resources to be monitored.
Custom Resource Filter	This button allows users to create a “Custom/Multiple” list of resources to monitor.

Patient Information Display Options	This option allows users to choose how patient names are displayed in Tracking Board. Choices are to not display the name, display as initials or as full name. The default setting is dependent on the choice made in the Options screen under the Patient Names tab (see User Preference Options for details). This prevents casual views of potentially sensitive protected health information (PHI). Click the desired button to toggle between views.
Legend	This button opens a window that illustrates what each of the items in the Tracking Board represents.
Help *(Blue Circle with Question Mark)*	The sixth button launches the electronic Help files.
Exit *(Red X)*	The last button closes the Tracking Board application.
The Waiting Room	Once a patient is "checked in" in e-MDs Schedule (see the Help files for that application), he or she will appear in the Waiting Room section of Tracking Board.
Room Status	Patients can be moved from the Waiting Room into a treatment room. The Room Status window displays a multiple of information, including various types of time tracking, the reason for visit, whether or not the patient is overdue for preventive care or disease/drug management issues, and the status of physician orders. See that section for full details.
Rules	The bottom of the Tracking Board screen displays rule-based reminders (i.e. overdue or coming due preventive care measures, disease or drug management issues, or immunizations) and a photo of the selected patient. This window can be turned off.
Checked Out	When a patient is checked out of a room, he or she will then appear in the Checked Out list. Color coding here identifies whether the note has been permanently signed, creating an end-of-day chart "clean-up" list for the physician.
Workload	This window displays outstanding TaskMan messages and tasks and also identifies any urgent or STAT messages. Clicking the message folder will automatically launch TaskMan.
Schedule	An overview of the monthly schedule is visible in the lower left corner. E-MDs Schedule can be launched directly from here as well (see "View of e-MDs Schedule from Tracking Board" for full details).

Selecting the Facility

Because Tracking Board deals with e-MDs Schedule and patient tracking through a facility, the application cannot be used until a facility has been selected.

To select a facility:

1. Click **File** and then select the **Change Internal Facilities** menu option.
2. Search for the desired facility in the Find Internal Facility window. Type part of the clinic name and hit **Enter**, or click **Search** for an entire list of available facilities.
3. Highlight the correct facility from the search results and click **Select**.
4. Click **File** and verify that the chosen facility name appears in parentheses after next to the **Internal Facilities** menu item.

Setting User Preference Options

As a user preference the column widths in the grid areas of Tracking Board (Waiting Room, Room Status, Checked Out, etc.) can be resized. These changes to the columns widths are saved as the preference for the user logged in when the changes are made. This allows users to customize the look of the application to better suit their workflow.

Note: To make changes to all of the options in Tracking Board, except Workload, a user MUST have the Tracking Board Administrator privilege.

To set user preference options:

Privileges Required: *Tracking Board Administrator*

1. Click **File** and then select the **Options** menu item.
2. Click the **Application** tab.
    - **Application Timeout:** This allows an automatic time-out that will log off the user after the set amount of seconds. This is a security feature that prevents unauthorized access to the application in the case that a user forgets to log off. If set to zero seconds (the default), there is no time-out.
    - **Auto-Refresh:** Because patients appear in the Waiting Room section after they have been checked in through e-MDs Schedule, it is important that the Tracking Board screen refresh at a fairly frequent interval so that these patients appear without delay. The user will notice a quick flash on screen every time a refresh occurs. The default setting is 120 seconds but can be changed.
    - **Show Appointments:** The typical clinic should choose For Today (the default setting), which ensures that all patients scheduled on a particular day will remain on screen in Tracking Board during that calendar day. However, the "day" ends at midnight, so for an urgent care facility that is open 24 hours a day, a "running schedule" should be set with any time span desired. For example, a facility may choose to show all patients scheduled "from 12 hours ago through 12 hours from now." Remember that patients who have been Checked Out will “disappear” from that window after this time period. So, if a physician’s shift is longer than 12 hours, adjust the running schedule accordingly so that all patients seen during the shift will still be visible at the end of the shift, allowing the physician to verify that all documentation is complete and all notes are signed.
3. Click the **Check In** tab.
    - The second column in the Room Status window displays the patient’s Check In time. Because the actual appointment time is not displayed, color-coding of this text is used to identify whether the patient arrived early, on time, or late. The user chooses what time frame is considered early or late. *The default setting is 15 minutes*. In this case, patients checked-in more than 15 minutes before the scheduled appointment time will appear in green text, and those checked in more than 15 minutes late will be in red.
4. Click the **Room Status** tab.
    - When a patient is taken to an examination room, the clock measures the wait time from that point up until treatment begins. Background color-coding of the In Room column gives a visual indication of how long each patient has been waiting. After a moderate wait, the background turns yellow, and after a long wait, the box turns red. The user can decide the number of minutes considered to be "moderate" and "long", and enter this into the Moderate Wait and Long Wait fields. *The default settings are 10 minutes for moderate, 20 minutes for long.*
    - Treatment Warning is visual indicator of how long the physician is spending with the patient in comparison to the time allotted for that appointment. The Treatment column identifies this with text and color. For example "15/20" indicates that treatment up to this point has taken 15

minutes, and the appointment is scheduled for 20 minutes. After a specified percentage of the appointment time has elapsed, the field will turn yellow, and if more than the allotted time has passed, the field turns red. *The default setting for the yellow treatment warning is 75% of the allotted time*.

5. Click the **Workload** tab.
   - The High Volume Warning refers to the number of unread messages and tasks waiting in the user's Inbox. The Workload window in Tracking Board shows the actual number of messages and tasks waiting, and folders give a visual indication of the volume, as well. The folders are blue when empty, and will turn yellow when at least one message exists and red when the High Volume number is reached.
   - There are three default folders that appear in the Workload window: The **Messages** folder is the "parent" folder and shows the total number of unread messages in TaskMan. The **Urgent** (urgent and/or STAT messages), **Overdue** (overdue tasks assigned to the user or that the user assigned to someone else) are the other two folders. These categories cannot be changed. However, unlimited additional categories can be added. (Remember that ALL messages will show up under the **Messages** folder, so it is not necessary to show specific message categories in all cases). Click the **down arrow** in the **Message/Task Categories** field for a list of all TaskMan categories. Place check marks next to those that are to be added to the Workload field in Tracking Board. Although an unlimited number can be chosen, for practical purposes, only two or three additional categories will show on screen at one time. Additional categories can be added and accessed by using the scroll bar.
6. Click the **Patient Names** tab.
   - This option allows users to choose how patient names are displayed in Tracking Board. This prevents casual views of potentially sensitive protected health information (PHI). Choices are to not display the name, display as initials or as full name. Click the desired button to toggle between views. The choice made here sets the default setting for this option. Users can change the setting on the fly by selecting one of the 3 buttons on the main Tracking Board toolbar but when they log into Tracking Board the choice will revert to the default setting.

Selecting Resources to View

The Tracking Board view can be set to show a single resource schedule (provider, service or equipment), a custom list of multiple resources or the entire clinic schedule. This option is helpful when nurses room patients for more than one provider and/or need to see patients who are scheduled for lab draws.

To select a single resource or all resources:

In the toolbar, click the **down arrow** in the "**Show Patients For"** field. Select a single resource name, the custom/multiple choice or All Providers.

To create a custom list of resources:

1. Click the **Groups** button to the right of the **Show Patients For** field.
2. This will open a window that displays a list of available resources (provider, service and equipment).
3. Select the desired resources by clicking the check box to the right of the resource.
4. When all the resources have been selected click the **Save/Edit Group** choice at the bottom of the list.
5. This will open a pane with a choices for saving the group as:

- **Only me in Tracking Board** (only the person logged in will see this group and only when in Tracking Board, not schedule)
- **Only me, All Applications** (only the person logged in will see this group in both Tracking Board and Schedule)
- **All users of Tracking Board** (this group will appear for all users in Tracking Board)
- **All users, All Applications** (this group will appear for all users of Tracking Board and Schedule)

6. Choose who will see the group
7. Next, type a name for the group in the **Save Group As** field.
8. Click the **Save Group As** button (floppy disk icon) when finished.
9. Click the **Groups** button again to close the window.

   This will save the selected resources as a custom group choice that will show up in the Show Patients For drop down list.

Both the Waiting Room and Room Status windows contain a **Provider** column. If the All Provider view is chosen, click the **Provider** column to sort all patients by resource.

The Appointment Schedule in the lower left window shows schedule density for either a single provider or for the entire clinic, depending on the view chosen. If the single physician view is selected, an additional graph below the calendar shows scheduling density *per hour* (for a 9-hour day).

Note that the Workload window displays TaskMan messages and tasks *for the person logged in,* regardless of which view is chosen. So, for example, a nurse may use the single provider view to see the patients scheduled for the physician, but still has access to her own TaskMan messages (not the physician's).

Opening a Patient Chart from Tracking Board

If a patient's name appears anywhere within Tracking Board (i.e. in the Waiting Room, in an exam room, or Checked Out), click it and select **Open Chart**.

To open any other patient, click **File** and then select **Open Patient Chart**. Or, click the **Open Patient Chart** button (the first button on the toolbar, with the yellow chart icon). Search for the patient, select the name from the search results, and click **Select**.

Using the Waiting Room

The upper left window in Tracking Board displays patients in the Waiting Room. Patients must be "checked in" in e-MDs Schedule in order to show up in the Waiting Room (see *e-MDs Solution Series Schedule User Guide* for detailed instructions).

1. There is some intelligence built into patient sorting in the Waiting Room. In most cases, the patient at the top of the grid should be taken back to an examination room first. By default, the grid will sort in the order that the patients check in. For late and early shows, check-in sort order will be modified with the following default times. For each 10 minutes early, 5 minutes is subtracted from the scheduled appointment time (maximum of 20 minutes subtracted). For each 10 minutes late, 10 minutes will be added to the scheduled appointment time (maximum of 30 minutes added).
2. Thus, if a patient has a 9:15 A.M. appointment and arrives at 9:05 (10 minutes early), for sorting purposes, his appointment will be seen as 9:10 (5 minutes subtracted). So, he will be put back

after a patient with a 9 A.M. appointment but before any other patients with a 9:15 A.M. appointment.

3. Likewise, if a patient has a 9:15 A.M. appointment and arrives at 9:30 (15 minutes late), his appointment time will be seen as 9:25 A.M. (10 minutes added). So, other patients with a 9:15 A.M. appointment who arrived on time will be moved into an exam room first, but he will still be put back before a 9:30 A.M. appointment.

The columns in the Waiting Rooms are as follows:

- **Age/Sex:** Displays patient demographics
- **Stat:** Displays urgency of visit: green is routine, yellow is urgent, red is emergent. This determination is based on the status recorded in e-MDs Schedule; however, it can be changed in Tracking Board by clicking in that field and picking another status from the menu.
- **Patient:** Shows patient name. Click the Patient column header to re-sort alphabetically. After 5 seconds, the order will revert to the automatic sorting.
- **Provider:** Displays the name of the provider the patient is scheduled to see (displayed as the first 3 letters of the last name followed by the first initial of first name). Click the Provider column header to re-sort patients, grouping them by provider. After 5 seconds, the order will revert to the automatic sorting.

Checking a Patient into a Room

Rooms (number and description) for each facility are created in e-MDs Schedule. See the Help files for that application for full instructions.

By a quick glance of the Room Status window, it is clear which rooms are available. Any rooms with a teal green background are empty. Brown rooms are those in which the patient has been checked out, but the room has not been cleaned.

To mark a dirty room as clean:

Click anywhere on the brown line and click the Room Clean menu option. (A patient can be checked into a room even if it is marked as Dirty.)

To move a patient into a room:

Click the patient name in the Waiting Room and select the In Room menu option. In the Select Room window, all room numbers and descriptions are displayed; rooms in red text are occupied. (However, it is possible to put more than one patient into a single room.) Highlight the desired room and click Select.

To move a patient back to the waiting room:

If a patient is inadvertently put into an exam room, they can be moved back to the waiting room. To do this, click the patient name (in the Room Status) and select the Back to Waiting Room menu option.

To move a patient to a different room:

Click the patient name (in the Room Status) and select the Move Patient menu option. In the Select Room window, all room numbers and descriptions are displayed; rooms in red text are occupied. (However, it is possible to put more than one patient into a single room.) Highlight the desired room and click Select.

Marking a Patient as Next/Ready

After a patient is checked into a room, initial information is collected and the patient is ready to be seen by the provider it is helpful to be able to mark that patient as next in line to be seen by the provider. To do this click the patient's name and select Ready for Provider from the pop up menu. The first patient marked this way will show up with the designation Next with a green background in their Treatment column. Any additional patients selected as Ready for Provider will show up with the designation Ready in their Treatment column.

Once treatment has been started on a patient the Next/Ready designation will change to the normal display for the Treatment column. The Treatment column displays two numbers separated by a forward slash. The first number represents the amount of time since treatment was started. The second number is the time allotted for that appointment. For example, "15/20" indicates that the physician has spent 15 minutes (and counting) with the patient and that the appointment is scheduled for a 20 minute slot.

When a patient is marked as Next and treatment is started, the next patient marked as Ready will change to Next. If multiple patients are marked as Ready, the one that is calculated to be next will be marked as Next. This calculation is based on the patient's appointment time and whether they were early or late being checked in. This allows patients to be seen in the order they are scheduled.

Understanding the Room Status Indicators

The Room Status window is located at the upper right section of the Tracking Board application. It tracks the status of the facility's rooms, patient wait times, and physician's orders, among other things. An explanation of each column is below.

Room Status Indicators	
Room	Lists room number. Click column header to sort by numerical order.
Orders	Displays status of any physician Orders from the associated Visit or Order Note. Various icons denote a variety of order statuses. In addition, click anywhere in the Order field and select the Show Orders menu option for a list of the Orders. To change the status of any order, click it for a status menu, and then click the appropriate menu option. The various order statuses are explained below: • **Not Yet Addressed:** Unaddressed Orders are noted by a black check mark icon. In the Show Orders window, these Orders are displayed as black text on a white background. • **STAT:** Orders with a "STAT" priority are noted by a red exclamation point icon. In the Show Orders window, these Orders are displayed as white text on a red background. • **Results Pending:** Orders with pending results are noted by a clock icon. In the Show Orders window, these Orders are displayed as black text on a yellow background. This status is for labs or tests that are done in-house and the results returned before the patient leaves. This status indicates that the nurse has addressed the order (and for example, obtained a blood or urine sample), but that the results are not back. • **Results Back:** Orders with results back, awaiting physician review, are noted by a green back-arrow icon. In the Show Orders window, these Orders are displayed as white text on a green background. • **Done:** If an Order is done, there is no icon representation. (If all Orders are addressed, the black check mark disappears.) In the Show Orders window, these orders are displayed as gray text on a white background.
Check In	Displays the time that the patient checked in at the front desk. Green text indicates an early arrival, and red is late. Click column header to sort by time.

In Room	Indicates the time that the patient was moved from the Waiting Room into an examination room. The background color of the cells is yellow if the patient has been waiting in the exam room for a moderate amount of time and red for a prolonged time. The number of minutes that determines a moderate or prolonged wait is a user preference (see the "User Preference Options" section of Tracking Board for details). Once treatment has begun, the background colors disappear for a less busy appearance on screen. Click column header to sort by time.
Provider	Displays the provider who the patient is scheduled to see (displayed as the first 3 letters of the last name followed by the first initial of the first name). Click column header to sort by provider.
Staff	Determines where the provider in question last "started treatment." This is not determined by which workstation the provider is logged into, so it is not a fool-proof way to locate the staff member, but it helps.
Age/Sex	Displays the patients' demographics. Click column header to sort by age.
Patient	Displays patients' names. Click column header to sort alphabetically by patient name. The background color of the patient name represents the Patient Type. Patient Type is a user customizable designation that can be set in Schedule. For example a patient can be marked as "Handle With Care" and the background of the patient's name will show up in the corresponding color. A legend that explains the meaning of the specific colors is available in Schedule.
Type	Shows the type of visit (i.e. PE for Physical Exam, etc.) This is determined in e-MDs Schedule and Visit Types are a user preference. See that application's Help files for details. Click column header to sort by type.
Diagnosis	Shows the reason for visit, as recorded in e-MDs Schedule. Click column header to sort alphabetically by diagnosis.
Due	Displays a red cell if the patient has outstanding rule-based reminders (i.e. overdue preventive care measures, disease or drug-management issues or immunizations). If the reminders window is turned on, these can be viewed at the bottom of the Tracking Board window.
Physician/Provider Start	After the patient is in the room and is marked as Next/Ready, the clinician clicks the patient's name and selects **Physician/Provider Start** to open the note started by the nurse. This action starts the clock running. At this point, the **Treatment** column will display two numbers separated by a forward slash. The first number represents the amount of time since treatment was started. The second number is the time allotted for that appointment. For example, "15/20" indicates that the physician has spent 15 minutes (and counting) with the patient and that the appointment is scheduled for a 20 minute slot. There is no background color if the physician is within the user defined "acceptable" time limits. It turns **yellow** near the end of the allotted appointment time. By default, the color turns yellow after 75% of the appointment time has elapsed, but this is a user specific option and can be changed. The background turns red once more time has elapsed than has been allotted for this appointment. For example, at 21 minutes into a 20 minute appointment. Currently, there is no way to "stop" or "pause" the clock. If patients are sent to x-ray, for example, they will appear to have a longer treatment time than what was actually spent in treatment time with the provider. It is up to each clinic to set a policy regarding which actions constitute "treatment." For example, a nurse may take the patient back to the room and collect vital signs, but the clinic may choose to start the clock counting when the physician opens the chart. In this case, the nurse should select the **Collect Vitals/Visit Note** option to document the vitals.

Checking Patients Out

When treatment is completed, a patient can be checked out by clicking his or her name in the Room Status window and selecting **Check Out** from the menu. If **Physician/Provider Start** was never selected, the **Check Out** option will not be visible.

The patient's name will then appear in the **Check Out** window of Tracking Board (on the left side). The name will not be highlighted if the note has been permanently signed off, but it will show up in **red** if it still needs to be signed.

The **Bill?** column indicates whether the user has marked the Visit or Order Note as **Ready to Bill**. This tells the billing staff that, even though the note is not permanently signed off, there will be no changes to the CPT or ICD-9 codes and an invoice can be created.

The **Orders** column displays status of any Physician orders from the associated note. This is the same column that shows the Room Status (clean or dirty). It enables tests and orders that may not have been completed prior to the patient being checked out to still be seen and dealt with from the Check Out window. As in the Room Status area, various icons denote a variety of order statuses. Users can click anywhere in the Order field and select the **Show Orders** menu option for a list of the Orders. To change the status of any order, click it for a status menu, and then click the appropriate menu option. The various order statuses are explained below:

This is a convenient end-of-day list for the physician. To reopen a note for signing, simply click the patient name and select the **Collect Vitals/Visit Note** menu option. There is no need to "move" the patient out of the Checked Out window (and no way to do so). At the end of the day (i.e. at midnight), this window will clear itself.

Viewing a Patient Photo

If a patient photograph has been saved with the Snapshot (Digicam) application, it will appear in the lower right corner of the Tracking Board window. See *e-MDs Solution Series Utilities Guide* for Snapshot (Digicam) instructions. Clicking the photo will cause it to appear in an enlarged format to make it easier to recognize the patient. In addition to the photo, the appointment details for the patient will appear beneath the photo.

Notes:

- If the Show Patient Names is set to not show the patient names or to only the patient's initials the patient photo will not appear. However the photo can still be seen by clicking in the photo area. As long as the mouse button is held down the photo stay in view.
- If Tracking Board is set to hide rule-based reminders, the photo will not appear. To view both, click the fifth toolbar icon that looks like a blue person with a check mark.

Viewing Rule-Based Reminders

In Tracking Board, reminders generated by clinical rules display in the lower third of the window. To view an individual patient's reminders, click the patient's name. Rules display must be activated in order to view rule-based reminders. (The Show Rules icon looks like a person with a check mark next to it.)

Rule-based reminders are displayed in several views, and a set of action buttons is provided with each view. These views and action buttons are also available on the Reminders tab of the patient's chart. For detailed information about the views and related action buttons, see the *Rule-Based Reminders (Automated)* section of chapter 3 in this user guide.

To read more about rules, see the Using the Rule Manager chapter of this user guide.

Using Messaging and Task Management in Tracking Board

The Workload window in Tracking Board (on the left side) displays visual indicators of the numbers of outstanding TaskMan messages and tasks to be addressed. The display reads from the Inbox of the logged-in user (not the Inbox of the physician selected at the top of the Tracking Board window).

There are three default folders that appear in the Workload window: The **Messages** folder is the “parent” folder and shows the total number of unread messages in TaskMan. The **Urgent** (urgent and/or STAT messages), **Overdue** (overdue tasks assigned to the user or that the user assigned to someone else) are the other two folders. These categories cannot be changed. However, unlimited additional categories can be added. (Remember that ALL messages will show up under the **Messages** folder, so it is not necessary to show specific message categories in all cases). See "User Preference Options" to learn how to add additional categories.

As the number of unread messages in each category increases the actual number of messages and tasks is displayed to the right of the folder. The numbers will be displayed in parentheses and followed by a letter M or T to denote whether the items are messages or tasks. The color of a folder will change from blue (denotes no messages exist) to yellow (at least one message exists) and then to red (denotes high volume based on User Preferences.

Double click any folder to open the inbox category in TaskMan.

Viewing e-MDs Schedule from Tracking Board

A monthly calendar overview is present in the lower left corner of Tracking Board. Days in the past are represented by dark gray squares. Light gray represents those days in the future in which the clinic is closed (i.e. weekends). Teal green represents blocked days (holidays, personal days off, etc). If a red "a" or "p" appears in any square, it indicates that the AM or PM schedule (respectively) for that day is completely booked.

Use the arrows and date fields at the top of the calendar to move forward or backward in time.

Double-click the calendar to launch e-MDs Schedule. Schedule will open to the selected date.

If the view of Tracking Board is set for a single provider, a status bar with 9 squares will appear below the calendar. This represents the schedule density (from green to yellow to red, with red being full) for each hour of the workday (for the current date).

To the right of the calendar block is the number of Patients Scheduled for today (**Sched**), the number that have not yet been seen (not including no shows) or Checked Out (**Left**), and the number who did not show up (**No Show**).

8
Tracking Orders

The Order Tracking module is a workflow enhancement tool that provides an “at a glance” view of all tracked items from Visit or Order Notes. These tracked items can be tests, labs, procedures, referrals, consults or any other item that can be represented by a CPT, Custom CPT or HCPCS code and that requires tracking. Order Tracking works with the Lab Tracking module from previous versions of Chart to initially identify items that have been ordered for patients and then to provide feedback about whether the results are available or not. In addition, information about abnormal and overdue results is available in order to provide the user with a mechanism to quickly identify and deal with situations that could affect patient safety. Other functionality allows the users (both providers and assistants) to communicate the status of the orders. For example assistants can change the status of a tracked order to notify the provider that the results are available, have been initially reviewed, any required additional information has been added and now the order is ready for the provider to review and deal with. The provider then can access the results, perform a final review, document pertinent clinical information and then set the status to notify the assistant to contact the patient. Other status indicators are available to mark the item to be held for review, if needed.

The Order Tracking module also works in conjunction with the Chart View section of the patient’s chart. Within the Chart View section, a Lab/Test subsection now contains information about these Pending Labs. When information needs to be reviewed from within the Order Tracking module, links with the patient chart take the user directly to the Chart View section and display the note, the tracked items and the results (when they become available). Since the user is taken directly to the patient’s chart, any additional information that needs to be reviewed is quickly available to the user.

Continued on the next page ...

Understanding the Order Tracking Interface

The Order Tracking module displays information about tracked orders in a grid display much like a spreadsheet. The information is displayed by patient per visit so that only one record per patient will be displayed for a single visit no matter how many orders are associated with that visit.

Menu Items

Menu items appear as words across the top of the application starting at the top left corner. Clicking a menu item will display a list of choices associated with the menu. The menu item choices for Order Tracking are listed below.

File Menu	
Options	See the Order Tracking Options section.

Edit Menu	
Hold for Review	This icon represents a status of Hold for Review and can be used anytime the record needs to be put on hold.
Contact Patient	A blue phone icon represents Contact Patient. This is used when the labs have been reviewed and are ready for the patient to be contacted with information concerning the results.
Ready for Provider	A green check mark icon represents that the record is Ready for Provider. This status can be used in situations where staff is tasked with reviewing information prior to a provider accessing it.
Clear Status	Choosing this option will remove any status indicated in Order Tracking.
Remove from list	This will remove a highlighted row from the Order Tracking list. However, results will still be present within DocMan and Chart View.
Open patient visit	Upon highlighting a patient row and clicking this option, the user will be granted access to view the corresponding visit for which the highlighted labs and/or imaging orders were initially placed. This allows a more comprehensive view of the circumstances and state of the patient leading to the placement of these orders.
Add note	This allows the user to make a note and attach it to the patient's order results. The Note Class allows for this to be categorized as a Log, Phone or Prescription Note and it can be permanent or temporary (sticky). The checkboxes to the right of this window allow the user to mark the Note Confidential. They can also Request and electronic copy of the Patient Summary or paper/fax versions of the patient's medical record. Once this note is signed-off by a provider, it will post within Order Tracking with the patient's results.
Refresh	The Refresh button will redraw the screen and update any order-related information that has changed since the module was opened or since the last refresh occurred. Most actions that are taken within the Order Tracking module will cause a refresh of the screen automatically but there may be occasions when a manual refresh is desired. In addition there is an automatic refresh of the screen that occurs based on a user specified time period. The automatic refresh rate can be set in the Order Tracking Options screen (see Options). Changes to the Automatic Refresh rate are login specific and will not affect other users' refresh rate. The default refresh rate is set to 2 minutes and while this value can be changed to a longer time frame it cannot be changed to a setting less than 2 minutes.

Message	
New Message	This opens a TaskMan window and allows the user to send a message to the staff or other providers.

New Message > Attach Chart	This opens a TaskMan window and allows the user to send a message to the staff or other providers, with a specific patient's chart attached.

Task	
New Task	This opens a TaskMan window and allows the user to send a task.
New Task > Attach Chart	This opens a TaskMan window and allows the user to send a task to the staff or other providers, with a specific patient's chart attached.

Tools	
Remove unmatched labs	Users can select a date to change the status of and remove all pending unmatched orders. This affects pending labs and radiology orders within the appropriate section of Chart View. The dropdown will reveal a calendar by which a date can be selected for the removal of these items.
Grid Settings	• **Restore Column Defaults:** This will restore the default settings of the Order Tracking columns. • **Apply Column Best Fit:** This option will help make the best use of space within the grid by auto-sizing the columns. • **Toggle Grouping Panel:** Sort the primary view by column headers. • **Toggle Filter Panel:** Add customized filters for the primary view. • **Export to MS Excel:** Save the primary view into an Excel spreadsheet.

Help Menu	
Search Topics	Selection of this choice will open the built in help files and allow users to search for help on specific topics.
Legend	The Legend button accesses a list of icons that appear in the application along with explanations of what those icons represent.
About	Selection of this choice will display a screen that shows the current version number of the application. This information can be helpful when tracking down problems and may be asked for by the support department.

Toolbar Items	
TaskMan	This button allows the user to create either a blank Message or Task, with or without a patient's chart attached. This can be useful in situations where issues arise that require a chart to be sent to another user in the clinic.
Refresh	The Refresh button will redraw the screen and update any order-related information that has changed since the module was opened or since the last refresh occurred. Most actions that are taken within the Order Tracking module will cause a refresh of the screen automatically but there may be occasions when a manual refresh is desired. In addition there is an automatic refresh of the screen that occurs based on a user specified time period. The automatic refresh rate can be set in the Order Tracking Options screen (see Options). Changes to the Automatic Refresh rate are login specific and will not affect other users refresh rate. The default refresh rate is set to 2 minutes and while this value can be changed to a longer time frame it cannot be changed to a setting less than 2 minutes.
Legend	The Legend button accesses a list of icons that appear in the application along with explanations of what those icons represent.
Help	The Help button accesses the built in e-MDs help files.

Patient Name Filter	This filter allows the user to search by name to identify the patient all other patients from appearing within the Order Tracking window.
Provider Filter	This field allows the user to select the provider or providers whose information will show up in the Order Tracking grid. When a provider logs in this field should default to the name of the provider logged in. If a non-provider logs in the field will default to having no names selected. In either case, once the user is logged in they can select one or more providers from the dropdown list by checking the box to the left of the name. Once selection of the name(s) is completed clicking outside of the dropdown box will refresh the grid and show the pending labs for the selected provider or providers. A selection for All Providers is also available and may be handy for an administrator to monitor the information on a clinic wide basis. The selection of multiple providers allows users to monitor pending labs for multiple providers. In the case of non-providers this may be necessary when nurse or assistant is working with multiple providers and monitoring pending labs for them. In the case of providers this feature may be necessary when the provider is covering for another provider that is out of the clinic or when a provider is supervising physician extenders or residents.
Status Filter	The Status filter allows the user to filter depending on different conditions associated with a patient's results. See the next table, "Grid Columns," for icon details.
Date Ordered Filter	The drop boxes within this section allow the user the ability to filter orders within the grid by a date range. Each dropdown will reveal a calendar. The first is for the user to select the beginning date in the range and the second (after the word 'thru') allows for the end range date to be specified. Once the desired time period has been indicated, click the Refresh button to see the filter results. The third 'Presets' dropdown allows for the quick selection of commonly used ranges.
Order Type Filter	If desired, this feature allows the user to filter their views. Filters include All, Lab, Procedure and Radiology.
HIPAA Patient Display	This feature consists of a set of three icons that allow the user to select how the patient's name will be displayed in the grid. A user can select to show No Patient Name, Initials Only or Full Patient Name by clicking the first, second or third icon, respectively. This is a common feature that is available in several e-MDs applications, useful for hiding or limiting the display of the patient name in situations where the computer screen can be seen by non-staff individuals such as visitors or other patients.

Grid Columns	
Date Ordered	This column displays the date that the pending orders were created.
Overdue	This column will display the Overdue icon IF at least one of the orders listed for the patient has not been marked as received, otherwise the cell will be empty. Determination of whether an order is overdue is based on information set up in the CPT and HCPCS search modules as described in the Lab Tracking help files (see Lab Tracking). For example, a CBC may be set to be considered overdue if results have not been received within 7 days. In this example on day 8 the cell in the Overdue column for that patient's visit would display the Overdue icon.
Abnormal	This column will display the Abnormal icon if abnormal results return for a patient. Specifically, if at least one of the results linked to the displayed visit for a patient is abnormal, a red triangle  will appear in this column. If the clinic is using an e-MDs lab interface, abnormal results will enter automatically, provided this data is sent by the lab processing the results. If the clinic is receiving lab results via paper or fax, the abnormal flag must be set manually in DocMan for this column to be populated. This usually occurs when the result is scanned into the patient's chart, but can also be set after the fact.

Priority	This column will display an icon if a priority has been indicated for one of the documents containing patient results. If the clinic is using an e-MDs lab interface, abnormal results will automatically result in a priority setting of Urgent (one red exclamation point ) if sent by the processing lab. Otherwise priority icons can be set manually in DocMan at the time of scanning, filing or after editing a document into a patient chart. Statuse choices are Urgent  or Stat 
Status	The Status column displays several different icons depending on different conditions associated with a patient's results. The status icons that can be seen in this column are shown below: • **No Icon:** A blank cell in this column represents the fact that no results have been received for this patient. •  **Clock Icon:** A clock icon represents the fact that SOME results have been received for the patient. •  **Green Arrow Icon:** A green arrow in the cell represents the fact that ALL results for this patient have been received. •  **Green Check Mark Icon:** A green check mark icon represents that the record is Ready for Provider. This status can be used in situations where staff is tasked with reviewing information prior to a provider accessing it. •  **Blue Phone Icon:** A blue phone icon represents Contact Patient. This is used when the labs have been reviewed and is ready for the patient to be contacted with information concerning the results. •  **Beaker with Clock Icon:** This icon represents a status of Hold for Review and can be used anytime the record needs to be put on hold, i.e. partial results awaiting final. •  **Beaker with Triangle Icon:** This icon represents that there are Unmatched Labs linked to the patient. An Unlinked Lab is a result that came in through one of the lab interfaces, but was not able to be automatically linked to a CPT code. These unlinked labs will be automatically linked to the correct patient and represented in the Order Tracking module with an Unmatched Lab icon.
Patient Name	The patient name is displayed in this column.
Note	If a note has been attached to the record a note icon  will be displayed in this column.
Number of Orders	A number representing the number of labs, tests or procedures that have been ordered for the patient (per a specific visit) will be displayed in this column.
Provider	The name of the ordering provider is displayed in this column.
Order Descriptions	Descriptions for each of the labs, tests or procedures that have been ordered for the patient will be displayed in this column.
Last Appt	This column displays the last valid appointment date for the patient.
Next Appt	This column displays the next scheduled appointment for the patient.
Customize	Located in the lower, right-hand corner, use this button to build your own filter. Simply click on each of the clauses, conditions or statements, pre-populated, and click apply and OK for the filter to be accessible.

Order Tracking Options

Options for Order Tracking can bet set to allow the user some customization of how they would like the application to display and perform. The choices for these options are described below.

Note: Changes to the options screen are login specific and will not affect other users' display

Order Tracking Options	
Display Order Tracking Count in Red if greater than X	This option can be used to set the behavior of the Order Tracking button in the Dashboard. When pending orders are present for the selected provider (or providers) the Order Tracking Dashboard button will display the number of pending orders for the selected provider(s). Ordinarily the number of pending orders shows up in black however users can use this preference to show the number in red if it exceeds a specified number. For example a user can set this option to 10 and once the number of pending orders reaches 11 the number displayed on the Dashboard button will appear in red. This feature can be used as a prompt to the user to deal with items when they reach a certain workload.
Automatic Refresh	The information in the grid can be refreshed manually by clicking the Refresh button on the toolbar (see toolbar section) but the information is also set to refresh on an automated schedule. The default setting is for 2 minutes and cannot be set lower than that but it can be changed to a larger number.
Refresh Interval:	Patient demographics touching Order Tracking update according to the Refresh Interval time settings. Privileged users can change the refresh interal minutes (See the *Administration Guide*, "Enabling Order Tracking Optimization" section.The automatic refresh default time is for 60 minutes and cannot be set lower than 5 minutes.
Default HIPAA Compliance	A user can decide to display the Patient name within the respective column and are given the following choices: Show no patient name, Show patient initials only or Show full patient name. This is useful for hiding or limiting the display of the patient name in situations where a computer screen may be visible by non-staff individuals, e.g. visitors or other patients. This option sets the preference for the default behavior of this feature and the default setting Show full patient name. This can be readily changed by clicking the radio button next to the desired choice. Selections will be maintained after the application is closed.
Sort Categories	Upon hovering over the column headings, a dropdown will display within the following categories: Date Ordered, Overdue, Abnormal, Priority, Status, Patient Name, Note and # Orders. Each dropdown has relevant filter options respective to the individual category, allowing for the inclusion, or exclusion, of data. By default the grid in Order Tracking sorts based on the Abnormal, Priority and Overdue columns. This means that Abnormal results are marked as a Priority items, followed by Overdue, and will always appear at the top of the list. This order sort can be changed to accommodate the needs of different types of users by using the filters.
Primary	The Primary sort order default is <NoSort>. To change the Primary sort order, click the dropdown to the right of the Primary category and choose another column to sort by.
Secondary	The Secondary sort order default is <NoSort>. To change the Secondary sort order, click the dropdown to the right of the Secondary category and choose another column to sort by.
Tertiary	The Tertiary sort order default is <NoSort>. To change the Tertiary sort order, click the dropdown to the right of the Tertiary category and choose another column to sort by.

To turn on optimization in Order Tracking:

1. Click **File**, then **Options**.

2. Click the **Administration** tab. *You must have the correct privilege in order to see the Administration tab.*
3. Under Order Tracking Options, click the **checkbox** for Enable Order Tracking Optimization. The default setting is 60 minutes with a minimum allowable setting of 5 minutes.
4. *To disable optimization, simply uncheck the box.*

Legend

The legend displays explanations of the different icons used in the Order Tracking module. These icons consist of items that represent the status of the pending order or the priority of the order.

Order Tracking Options

Status Icons	
No labs have been received	A blank cell in this column represents the fact that no results have been received for this patient.
Some labs have been received	A clock icon represents the fact that SOME results have been received for the patient.
All labs have been received	A green arrow in the cell represents the fact that ALL results for this patient have been received.
Ready for Provider	A green check mark icon represents that the record is Ready for Provider. This status can be used in situations where staff is tasked with reviewing information prior to a provider accessing it.
Hold for Review	This icon represents a status of Hold for Review and can be used anytime the record needs to be put on hold.
Contact Patient	A blue phone icon represents Contact Patient. This is used when the labs have been reviewed and is ready for the patient to be contacted with information concerning the results.
Unmatched labs exist for this patient	This icon represents that there are Unmatched Labs linked to the patient. An Unlinked Lab is a result that came in through one of the lab interfaces but was not able to be automatically linked to a CPT code. These unlinked labs will be automatically linked to the correct patient and represented in the Order Tracking module with an Unmatched Lab icon.
Priority Icons	
Normal Priority	A blank cell in the Priority column denotes that there is not a priority setting for the record.
Urgent Priority	A single exclamation icon represents an urgent priority.
Stat Priority	Two exclamation points represents a stat priority which is higher than an urgent status.
	A note icon represents the fact that a note exists for these labs.
Patient Name	If the patient's name appears in red in the Patient column it means that at least one of the patient's results in that particular record is abnormal.

Understanding the Pending Labs Section of Chart View

With the advent of Order Tracking a new section of Chart View has been added. This new section is a sub section of the Labs/Tests section of Chart View and it is called Pending Labs. On the Labs/Tests tab there is a new radio button choice labeled Pending Labs. When a record in the Order Tracking grid is double clicked the associated patient's chart is open to this new section of Chart View. In addition this new section can be accessed anytime the user is in the Chart View section by clicking the Labs/Tests tab and then selecting the Pending Labs radio button. This new section of Chart View displays CPT and HCPCS codes that are marked to be tracked as well as any associated Visit or Order Notes.

When in the Pending Labs section the tracked information will be displayed in a tree format with the date and ordering provider's name of the associated note displayed as the top level item. To the left of the

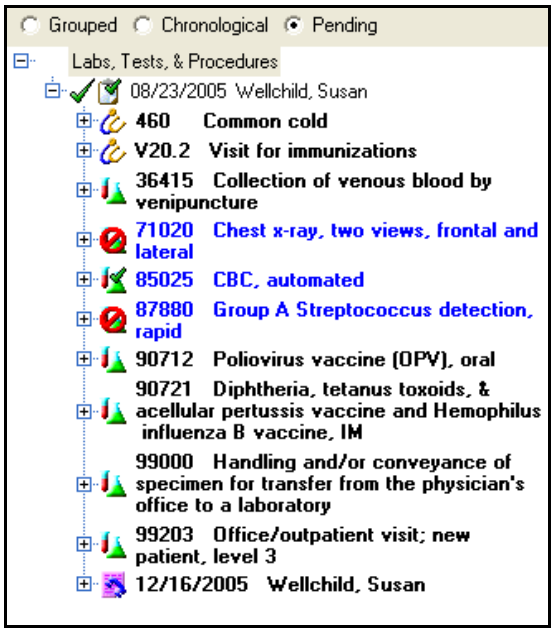
note information is a status icon that displays one of 4 different icons depending on the status of the order as displayed below:

Pending Lab Order Status	
Default	A green circle with a downward pointing arrow represents the default setting for a tracked order. This corresponds to there being no information associated with the order.
Ready for Provider	A green check mark icon represents that the record is Ready for Provider. This status can be used in situations where staff is tasked with reviewing information prior to a provider accessing it.
Hold for Review	This icon represents a status of Hold for Review and can be used anytime the record needs to be put on hold.
Contact Patient	A blue phone icon represents Contact Patient. This is used when the labs have been reviewed and is ready for the patient to be contacted with information concerning the results.

Beneath the note, any diagnoses, CPT codes and HCPCS codes associated with the visit are displayed. Icons and color coding denote the status of the individual orders. If there are linked items associated with an order, clicking the CPT or HCPCS code will display the linked image in the right pane of the **Pending Labs** section.

Individual Orders Status	
mm/dd/yyy ProviderLastName, ProviderFirstName	This is the top level item and represents the Visit or Order Note date and ordering provider's name.
	A stethoscope icon represents an ICD code that is associated with the Visit or Order Note.
	A test tube and beaker icon represent a CPT code associated with the Visit or Order Note. If the description of the CPT is not displayed in blue text the item is not a tracked item.
Items displayed in BLACK	Represents a regular item that is not being tracked.
Items displayed in BLUE	Represents a CPT or HCPCS code that is being tracked.
	If there is no result linked to the order the icon to the left of the code will be displayed as a test tube and beaker with a circle with a slash across it.
	If there ARE results linked to the order the icon to the left will be displayed as a test tube and beaker with a green check mark on top of it.
Items displayed in RED	Indicates there are abnormal results associated with the CPT or HCPCS code.
	A pink piece of paper icon represents that a Log Note is linked to the order.
	A yellow piece of paper icon represents that a Sticky Note is linked to the order.
	A pink piece of paper with a blue phone handset icon represents that a Phone Note is linked to the order.
	A yellow piece of piece of paper with a blue phone handset icon represents that a Sticky Phone Note is linked to the order.
Unmatched Labs	Lab results that come in through a lab interface and cannot be automatically linked to an order in the Visit or Order Note, will show up at the bottom of the tree view under a node labeled Unmatched Labs.

Example of the Pending Labs Section of Chart View



Accessing a Patient's Pending Labs

The rows of information displayed in the Order Tracking module represent a patient visit that contains tracked orders. The names of the orders can be seen in the Order Descriptions column but users will need to access the patient chart to see the Visit or Order Note and the actual CPT or HCPCS codes and any results that are available.

To access pending labs:

Double-click the record (row) that displays the patient that is of interest.

The patient's chart will open to the Chart View section and the following will display:

- The Pending Labs section which is a sub-section of the Labs/Test area of Chart View open.
- Along the left side there will be a tree display of all of the patient's visits that have tracked labs associated.
- The specific visit that was chosen in the Order Tracking module will be highlighted in the left tree and the note will be displayed in the right pane.
- Under the Visit or Order Note, any labs that were ordered in the note will be displayed and any order that is marked to be tracked will appear in Blue (unless there is an abnormal result linked to the order, in which case it will appear in Red).
- If there is no result linked to the order the icon to the left will be displayed as a test tube and . beaker with a circle with a slash across it .
- If there *ARE* results linked to the order the icon to the left will be displayed as a test tube and beaker with a green check mark on top of it .
- If the order has results the user can click the order description and the result will appear in the right pane.

Marking the Status of Orders

To provide feedback to users that are monitoring the Order Tracking module the status of the order can change based on information that obtained either automatically or manually. Lab results that are obtained via an electronic lab interface (Example: LabCorp, Quest, CPL, etc.) will cause the status to change automatically. Manual changes to the status could also be lab results but in this case they would be results obtain on paper and scanned into the system. Additional manual changes to the status would be performed by users such as providers and nurses. These changes provide feed information such as whether the results are "ready for provider" or ready to "contact patient." Changing the status of the order will change the icon that is displayed in the status column of Order Tracking (see Legend section for details about the status icons). More details about these manual status changes are explained below along with instruction on how to change the status.

Marking Orders as "Ready for Provider"

Depending on the workflow of the clinic, the provider may want to have the clinical staff review lab information and collect additional information prior to the provider themselves dealing with the results. The staff would then notify the provider that the results are ready to be dealt with. To accomplish this, the program was designed to allow the order status to be changed to "Ready for Provider." Changing the status of an order to Ready for Provider will place a green check mark icon in the status column. Providers would then monitor the Order Tracking module and look for orders that are marked as Ready for Provider.

To mark orders as Ready for Provider:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View

   On the left side of the Pending Lab section of Chart View, the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date a green circle icon with a downward pointing arrow icon will be displayed.

2. To change the status of the order, click the green circle icon and select **Ready for Provider** from the pop up menu.

   After the new status is selected, the icon to the left of the visit date will change to a green check mark icon. After the chart is closed, the icon in the status column will also change to a green check mark to denote that the order is ready for the provider to deal with.

Note: The icon will change depending on what is selected from the pop-up menu.

Marking Orders as Contact Patient

Depending on the workflow of the clinic, the clinical staff may be tasked with calling patients and letting them know what the results of their lab work is. To notify the clinical staff that the lab results are ready for notification to the patient the status of the order can be changed to "Contact Patient." Changing the status of an order to Contact Patient will place a blue phone handset icon in the status column. Staff would then monitor the Order Tracking module and look for orders that are marked as Contact Patient.

To mark items as Contact Patient:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View

   On the left side of the Pending Lab section of Chart View, the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date a green circle icon with a downward pointing arrow icon will be displayed.

2. To change the status of the order, click the green circle icon and select **Contact Patient** from the pop-up menu.

   After the new status is selected the icon to the left of the visit date will change to a blue phone handset icon. After the chart is closed the icon in the status column will also change to a blue phone to denote that the order is ready for the provider to deal with.

Note: The icon will change depending on what is selected from the pop up menu.

Marking Orders to Return to Default

Before any changes to an order status such as Ready for Provider, Contact Patient, Hold for Review, etc. are ever made the status of an order is blank and is represented by a green circle with a downward pointing icon. Once a status changes the icon will change to represent that status and the green circle will no longer be visible. If a status is mistakenly changed from the default status, it can be returned to the default.

To mark items as Default:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View

   On the left side of the Pending Lab section of Chart View the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date an icon will be displayed. This icon may be a green check mark, blue phone or other icon depending on the status of the order.

2. To change the status of the order back to the default setting click the displayed icon and select **Default** from the pop-up menu.

   Once the default status is selected the icon to the left of the visit date will change to a green circle with a downward pointing arrow icon. Once the chart is closed the icon in the status column will also change and no icon (or possibly an Unmatched Lab icon) will be displayed.

Note: If there are Unmatched Labs associated with the order an unmatched lab icon will be displayed even if the status is set to something else.

Adding a Note to a Pending Order

In some cases communication between the provider and staff concerning the pending labs may need to occur. In these cases a note can be added to the pending order. This note can be either a Log or Phone note and can be designated as either a permanent or sticky note. Adding a note in this manner creates a Log or Phone note that is listed in the Pending Labs section of Chart View as well as in the Log and Phone Notes Section. Once a note is added to a pending order a yellow note icon will appear in the Note column of the Order Tracking grid to show that a note is attached.

To add a note to an order:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View.

   On the left side of the Pending Lab section of Chart View the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date an icon will be displayed. This icon may be a green circle, green check mark, blue phone or other icon depending on the status of the order.

2. To add a note, click the displayed icon and choose **Add a Note** from the pop-up menu.

   The Edit Chart Note window will open allowing the user to create a new Log or Phone note.

3. After the note is created, click the **Save** button.

The Edit Chart Note will close and a new icon will be displayed at the bottom of the order tree. This note will be represented by one of four icons depending on the type of note that is added.

- A pink piece of paper icon represents a Log Note.
- A yellow piece of paper icon represents a Sticky Note.
- A pink piece of paper with a blue phone handset icon represents a Phone Note.
- A yellow piece of piece of paper with a blue phone handset icon represents a Sticky Phone Note.

When the chart is closed and the user is returned to the Order Tracking module a yellow note icon will appear in the Note column of the Order Tracking grid to show that a note is attached.

Marking Orders as Hold for Review

At times lab results for a patient may need to be put on hold (for example until more information is obtained or for some other reason). In order to do this in the Order Tracking module a record can be set with a status of "Hold for Review."

To mark an order as Hold for Review:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View.

   On the left side of the Pending Lab section of Chart View, the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date an icon will be displayed. This icon may be a green circle, green check mark, blue phone or other icon depending on the status of the order.

2. To change the status of the order, click the displayed icon and select **Hold for Review** from the pop up menu.

   After the new status is selected the icon to the left of the visit date will change to a test tube and beaker with a clock icon. After the chart is closed the icon in the status column will also change to a test tube and beaker with a clock to denote that the order is being held for review.

Removing Orders from Tracking List

Tracked Orders will remain the Order Tracking module until they are manually removed.

To remove orders from Order Tracking:

1. Double-click the desired row in Order Tracking to open the patient's chart to the Pending Lab section of Chart View

   On the left side of the Pending Lab section of Chart View the date and ordering provider's name for the Visit or Order Note, with all associated orders listed below it, will be displayed. To the left of the note date an icon will be displayed. This icon may be a green circle, green check mark, blue phone or other icon depending on the status of the order.

2. To remove the order from Order Tracking, click the displayed icon and select **Remove from List** from the pop-up menu.

   The Visit or Order Note and tracked orders will immediately be removed from the Pending Labs section of Chart View and when the chart is closed the Order Tracking module will no longer display the selected record.

Managing Unmatched Labs

The application will try to automatically match up orders in a Visit or Order Note with lab results that are received through an electronic lab interface. This automatic matching of lab results is not always possible. When a lab result comes in from a lab interface and it cannot be matched up to orders in a note, the application still will link to the patient. These "unmatched" labs show up in the Pending Labs section of Chart View (see the Overview of Pending Labs section for details about the Pending Labs section).

Note: If a lab order is submitted by any means other than entering a CPT code, the electronic results of that lab will be "unmatched" because automatic matches require CPT codes. When such electronic results are returned to the clinic, a TaskMan message is sent to the designated user, the results are entered in the patient's chart, and the results are also entered in the Order Tracking module to ensure they are tracked.

Unmatched labs can be linked to an order in a Visit or Order Note. Patients that have unmatched labs will have an unmatched lab  icon show up in the status column of the Order Tracking module.

To link unmatched labs:

1. Double-click the patient record in Order Tracking.
2. The patient's chart will open to the Pending Labs section of Chart View.
3. Click the **Unmatched labs** node of the tree on the left.
4. Click the unmatched lab. The results document will appear in the right pane.
5. With the document in view, click the **Lab Tracking icon**  on the toolbar.
6. Place a check mark in the check box next to the matching order.

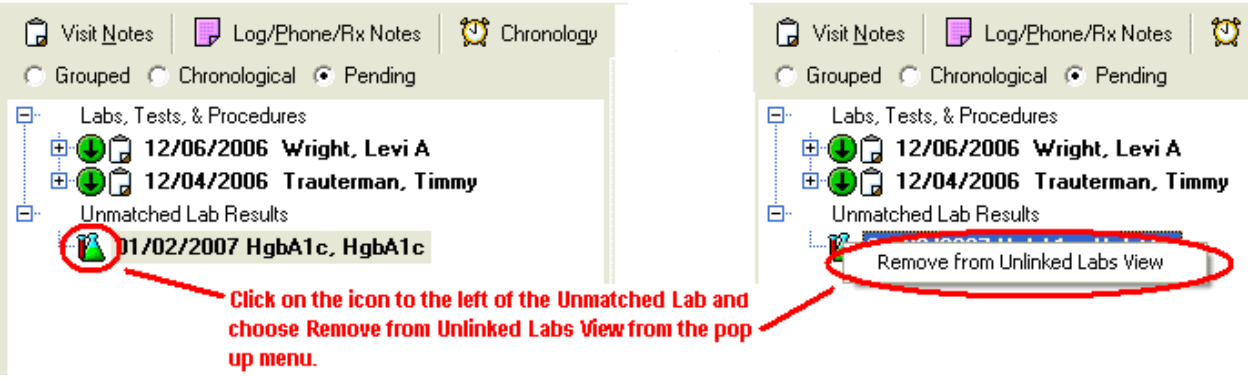
Removing Unmatched Labs

Sometime labs will show up as unmatched but will not have a corresponding order that they can be matched to. An example of this would be an order that was placed outside of a visit (on a paper requisition) or after a note has been signed off. Another example would be an unsolicited reflex test that is run by the lab based on a protocol. In these instances there will not be a corresponding order to link the results to. In these cases the user will need to remove the Unmatched lab from the Pending Labs area.

To remove unmatched labs:

1. In the **Pending** Labs subsection of Lab/Tests in Chart View, click the unmatched lab in the section at the bottom of the screen.
2. Click the icon to the left of the Unmatched Lab that you want to remove.
3. A pop-up menu item labeled **Remove from Unlinked Labs View** will appear.
4. Click the menu item to remove the Unmatched Lab (see image below for an example).

   Note: Removing an unmatched lab simply removes it from this view and prevents the Unmatched icon from masking other icons in Order Tracking (Ready for Provider, Contact Patient, etc.). The result itself is *NOT* deleted and is still accessible in the Documents section of Chart View and in DocMan.


Visit Notes
Log/Phone/Rx Notes
Chronology
Grouped
Chronological
Pending
Labs, Tests, & Procedures
12/06/2006 Wright, Levi A
12/04/2006 Trauterman, Timmy
Unmatched Lab Results
01/02/2007 HgbA1c, HgbA1c
Remove from Unlinked Labs View
Click on the icon to the left of the Unmatched Lab and choose Remove from Unlinked Labs View from the pop up menu.

9
FlowSheets

The FlowSheet module of e-MDs Chart is a very powerful and flexible component that allows users to define, capture and track virtually any type of clinical information. This information can represent dates, date/time, numeric values, Yes/No values and free text answers. The flexibility in the type of data values that can be entered allows for capture and display of virtually any type of data. This information is displayed in a grid format much like a spreadsheet. These grids display fields, that represent the type of information being tracked (vitals, labs, medications, etc), vertically down the left side of the grid and the date the information was collected horizontally across the top of the grid. This allows users to view large amounts of data in a single, consolidated view.

These FlowSheets and the fields that are used to represent clinical information are all fully customizable by the user. e-MDs provides several FlowSheets as well as a large number of fields with the product and users can edit those or create their own if needed. The ability to customize or create new FlowSheets makes this module a very flexible and useful component of the charting application.

Continued on the next page ...

Understanding Patient Specific FlowSheets

Patient specific FlowSheets are those FlowSheets that have been linked to a patient's chart. Once a FlowSheet has been linked to a patient the data contained in it will be specific to the patient. Patient specific FlowSheets can be edited to meet the needs of data capture for particular patients without changing the underlying original FlowSheet.

Viewing Patient Specific FlowSheets

FlowSheets can be added to any patient's chart to collect specific information about that patient. In addition the FlowSheets can be opened from within DocMan to allow for documentation of information, such as lab values, while viewing the scanned or electronically imported document that contains the information.

To view a patient-specific FlowSheet in Chart:

1. Open the patient's chart
2. Click the **FlowSheet** button to access the patient's FlowSheets. Just to the right of the patient's photo and below the blue patient specific header bar (where the patient's name and demographic info is displayed) there are four buttons labeled Reminders, Visit/HS (Visit Note/Health Summary view), Chart View and FlowSheets.
3. The FlowSheet view will open.
4. A list of FlowSheets that are linked to the patient will be displayed in the left pane. If no FlowSheets have been linked the pane will be empty.
5. If one or more FlowSheets have been linked to the patient the first one in the list will be displayed in the right pane. To view one of the other FlowSheets, click the name of the FlowSheet in the left pane and the view on the right will change to reflect the selected FlowSheet.

To view a patient-specific FlowSheet in DocMan:

1. Open the Patient's chart.
2. Click the **DocMan** button on the patient specific toolbar (just below the blue header bar that contains the patient's demographic information).
3. When DocMan opens, double-click the document that contains the information.
4. The selected document will open in the DocMan viewer.
5. Click the **FlowSheet** icon on the DocMan viewer toolbar  .
6. The FlowSheet module will open hosted at the bottom of the DocMan viewer.
7. Select the appropriate FlowSheet and enter data as necessary.

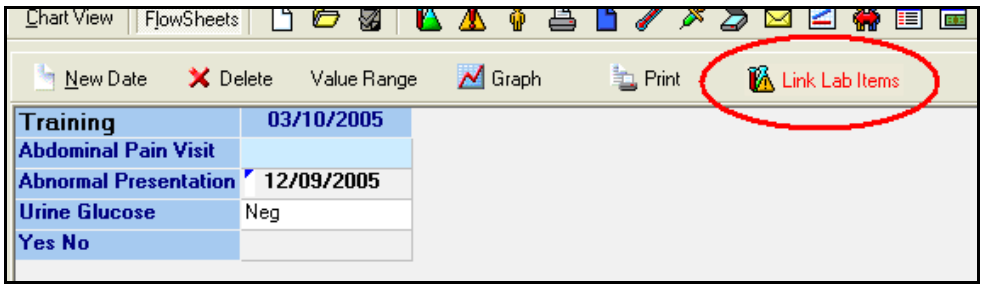
Lab Link Message

If a lab interface is being used in the clinic there is a chance that a warning message about lab results that are not linked to a FlowSheet existing in the system. This message allows the user to open the Lab Linker window and deal with any unlinked results. See image below for example of the warning message.

In some clinics these types of linking issues are dealt with by a designated person in the clinic. In those cases the physicians and nurses may not want to see the pop up warning message. If a user does not want to see the message that can choose to turn it off. A check box option to not show the message is available at the bottom of the screen. Click this check box to not show the message.

Note: This option is user specific and only effects the person logged on when the check box is clicked.

If you choose to *NOT* show this message you can still access the Lab Linker by clicking the Link Lab Items button on the FlowSheet toolbar (see image below). The text on this button turns red if unidentified labs exist so even if you choose to turn off the active warning message a passive visual cue is still available.



Adding a FlowSheet to a Patient's Chart

Initially no FlowSheet will be linked to any patient's chart if this is a new install of the application, if upgrading from a version that did not have FlowSheets or if the chart is that of a new patient. However users can easily add one or more FlowSheets to any patient's chart.

To add a FlowSheet to a patient:

1. Click the **FlowSheet** button within a patient's chart to open the FlowSheet view.
2. In the right pane, click the blue plus sign **Add** button at the top of the pane.
3. This will open the FlowSheet Select form.
4. Type in all or part of the desired FlowSheet name and click the **Search** button.

   OR

   Click the **Search** button without typing in a name to see ALL of the available FlowSheets.
5. From the search results, highlight the desired FlowSheet name and click the **Select** button or double click the desired FlowSheet name.
6. This will add the selected FlowSheet to the patient's chart.
7. To add multiple FlowSheets, repeat the steps listed above.

Deleting a FlowSheet from a Patient

Once a FlowSheet is linked to a patient it can be removed. For example if a FlowSheet were to be added to a patient by mistake the user can choose to delete it.

Note: Deleting a FlowSheet does not delete the information that is contained in the FlowSheet and if the FlowSheet is added again at some point, the values contained in it will still be available.

To delete a patient-specific FlowSheet:

1. Click the desired FlowSheet name in the left pane.
2. Click the red minus sign **Delete** button  at the top of the left pane.
3. The FlowSheet will be removed without requiring a confirmation from the user.

Editing a Patient's FlowSheet

FlowSheets that are created in the FlowSheet Editor are global in nature, that is to say they are not specific to any one patient until they are added to a patient's chart. However once a FlowSheet is added to a patient it can be edited and changed to reflect specific requirements of that patient without affecting the original "master" FlowSheet. This allows users to customize a FlowSheet to capture data for a particular patient's needs in a manner slightly different from that of other patients without causing any changes to the same FlowSheet that is linked to other patients. For example if a patient has hypertension and is also on Coumadin and the user wants to monitor information that is collected in both FlowSheets without having to display them separately they can edit one of the FlowSheets and simply add the desired fields from one to the other (ex. add the Coumadin dose field and the INR field to the Hypertension FlowSheet) to create a completely new FlowSheet *FOR THIS PATIENT ONLY*.

Note: Keep in mind that this action will not affect the original Hypertension FlowSheet that may be linked to other patients. To change a FlowSheet so that the changes are reflected for ALL patients linked to that FlowSheet use the FlowSheet Editor to make these changes.

In addition to adding fields other changes can also be made to the FlowSheets at the patient level. These changes include marking fields so that they do not show up in the FlowSheet (visible property), removing fields and re-sequencing or changing the order that the fields show up in the FlowSheet. Instructions on how to make these changes are described in other sections of the help files.

To edit a patient's FlowSheet:

1. Open the patient's chart.
2. Click the **FlowSheet** button.
3. Select the FlowSheet to be edited by highlighting the name in the left pane.
4. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open and changes can be made.

Adding Existing Fields to a Patient Specific FlowSheet

The FlowSheet module comes pre-populated with FlowSheet fields that can be used to augment existing FlowSheets or to create new ones. These fields cover a wide variety of data such as vital signs, lab tests, immunizations, best practice items, etc. These pre-existing fields can easily be added to an existing or new FlowSheet.

To add an existing field:

1. Click the desired FlowSheet name in the left pane.
2. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open in edit mode. The fields in the FlowSheet, along with details about each, will be listed in a grid on the right side of the form.
3. Click the **Add** button in the left pane of the window to add an existing field.

   The Field Select window will open.
4. Type the name of the field (full description or partial) that is to be added into the **Name** field.
5. Click the **Search** button on the toolbar.

   OR

   Press the **Enter** key on your keyboard.
6. Highlight the desired field from the search results and click the **Select** button on the toolbar

   OR

   Double-click the item.

   OR

   Press the **Enter** key on your keyboard to select the field.

   The field will be added to the list of fields already in the FlowSheet and placed in alphabetical order.
7. The order that the field shows up in the FlowSheet can be changed by clicking the **Sequence** button.

Adding New Fields to a Patient Specific FlowSheet

Although e-MDs supplies a large number of pre-existing fields along with the FlowSheet module, the user may want to capture data outside of the fields supplied. In anticipation of this and to make the module as flexible as possible e-MDs provides a mechanism for the user to create their own FlowSheet fields. Users can create fields to capture virtually any type of data. To learn how this feature works, seethe “Create a Field” section of the FlowSheet Editor chapter of *e-MDs Solution Series Administration Guide*.

Marking Fields as Visible or Invisible

When FlowSheets are created by e-MDs staff there are some instances where multiple fields that document the same information are added to FlowSheets. These are cases where information can be documented in more than one way. For example, there are Weight fields for documenting in both pounds and kilograms (some users prefer to document pediatric patients in grams and kilograms rather than pounds). Another example would be where an immunization can be documented by a Yes/No field to allow a user to simply mark that Yes the patient has had the immunization or No they have not *OR* by a date field to allow the user to mark an immunization as being given on a particular date, in this case the absence of a date denotes that the immunization was not given. In cases such as these, users may decide to use one method over another and in those cases may not want to see the alternate choice. To provide this flexibility the module allows the user the option of marking items as Visible or not. To mark an item as such:

To mark fields as visible or invisible:

1. Click the desired FlowSheet name in the left pane.
2. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open in edit mode. The fields in the FlowSheet, along with details about each, will be listed in a grid on the right side of the form. To the left of each field there are check boxes in a column labeled **Visible**. If a check mark appears in the check box, the field is set to be visible in the FlowSheet. If the check box is empty, the field will not show up.

   If there is no check mark in the check box, clicking in the box will add a check mark and if there is a check mark clicking in the box will remove it.
3. To set a field as visible or not click in the check box to add or remove the check mark.

Note: The visible property is only available for FlowSheets that are linked to a patient. The FlowSheet Editor does not have this functionality. In the FlowSheet Editor users can remove any fields that they do not want.

Removing Fields from a Patient-Specific FlowSheet

The only fields that can be removed from a FlowSheet *after it has been linked to a patient* are those that were added to the FlowSheet *after* it was linked to the patient, to remove other fields users must do so in the FlowSheet Editor.

To remove fields from a patient specific FlowSheet:

1. Click the desired FlowSheet name in the left pane.
2. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open in edit mode.
3. Highlight the field to be removed by clicking it.
4. Click the **Remove** button to delete the field from the FlowSheet.

   Notes:

   - If the **Remove** button is disabled (grayed out) the field is part of the original "master" FlowSheet and cannot be removed from this screen. Only fields that have been added AFTER the FlowSheet is linked to a patient can be removed. To remove a field that is part of the original master FlowSheet use the FlowSheet Editor.
   - Removing a field from a patient specific FlowSheet can only be done for items that have been added to the FlowSheet from within a patient's chart and this action only removes the field from that specific patient's FlowSheet. Removing fields under these conditions does not remove the field from the original "master" FlowSheet. To remove a field from the master FlowSheet use you must use the FlowSheet Editor.

Changing the Display Order of the Fields

When editing a FlowSheet please note that in edit mode the fields are displayed alphabetical order and not necessarily in the order they are displayed in the FlowSheet when it is being used. The order of the fields can be changed.

To change the display order of fields:

1. Click the desired FlowSheet name in the left pane.
2. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open in edit mode.
3. Click the **Sequence** button at the bottom of the left-side of the form.

   This will open the Field Sequence window with all the fields listed in the order that they display in the FlowSheet.
4. Select the field to reorder by clicking it to highlight.
5. Move the field to the desired location by using the blue up or down arrow at the top left side of the window.
6. Repeat the process for any fields that need to be re-ordered.
7. When finished, click the **Save** button to save changes.

Editing Fields in a Patient-Specific FlowSheet

The only FlowSheet Fields that can be edited in a FlowSheet once it has been linked to a patient are those that were added to the FlowSheet *after* it was linked to the patient, to edit other fields users must do so in the FlowSheet Editor.

Important! Currently the editing of *any* field, whether from the patient specific view OR from the FlowSheet Editor, will cause the changes that are made to be reflected in *all* FlowSheets that contain that field. In other words fields cannot be changed to reflect a specific need for only one patient. In cases where a patient specific field is required the user can create a completely *new* field and add it to the FlowSheet (see “Create and Add New Fields” in the FlowSheet Editor section for details). For example if the patient always runs a low grade fever and you want to change the temperature field to reflect a normal temperature of 99 instead of 98 and you change the field to reflect that then *every* temperature field for *every* patient would be changed to a normal temperature of 99. Instead you need to create a *new* field and name it something specific (Example: Low Grade Temp, Bob's Temp, etc.).

To edit fields in a patient-specific FlowSheet:

1. Click the desired FlowSheet name in the left pane.
2. Click the **Edit** button at the top of the left pane.

   The FlowSheet form will open in edit mode.
3. Click to highlight the field to be edited.
4. Click the **Edit** button to the left of the list of fields.

   Note: If the **Edit** button is disabled (grayed out) then the field is part of the original "master" FlowSheet and cannot be edited from this screen. Only fields that have been added AFTER the FlowSheet is linked to a patient can be edited. To edit a field that is part of the original master FlowSheet, use the FlowSheet Editor.

   The Field Maintenance form will open.

5. From the Field Maintenance form the user can edit any parts of the field including the Name of the field, the Display Name, the Data Element, the Note or the Validation (normal ranges). To learn more about editing these fields see “Edit a Field” in the FlowSheet Editor section of help. See the **IMPORTANT** note above for cautionary information about changing these fields.

Note: Editing a field from a patient specific FlowSheet can only be done for items that were added to the FlowSheet from within a patient's chart. To edit a field in the master FlowSheet use the FlowSheet Editor.

Adding Values to FlowSheet Fields

Data for FlowSheets gets input directly into the desired cell.

Note: Information entered into the vitals section of a visit will automatically populate the Vitals FlowSheet. In addition lab results that come in through an electronic lab interface will automatically populate lab FlowSheets. Future versions of Chart will automatically read additional information from the database into the FlowSheets but at the moment only vitals and lab results do so.

To add data to a FlowSheet:

1. Select the FlowSheet to add data to by clicking the name in the left pane.
2. If a column for the date under which you are entering data exists simply double click in the cell of the field that you want to add data to.
3. If the column for the date under which you are entering data *DOES NOT* exist, click the New Date button on the FlowSheet Toolbar. A New Date window will open.
4. Select the desired date from the calendar.

   Note: You can document information from the past by picking a date in the past but you cannot pick a future date.
5. Once the date column is picked simply double click in the cell of the field that you want to add data to
6. Depending on the type of data that the field represents you will be presented with a pick list, a calendar, a date/time mask or a field to type text or numbers into.
7. Enter the desired information into the cell and press enter or click into another cell to save the data.
8. Repeat for each cell where data is required.

Deleting Values from FlowSheet Fields

In this version users are able to delete any and all data from the FlowSheets. Future versions will restrict or prohibit deletions depending on the type of data entered. For example once automatic population of FlowSheets from database information occurs in a future version the user will not be able to delete that information from the FlowSheet itself.

To delete data from a FlowSheet:

1. Select the cell from which the data is to be deleted.
2. Click the **Delete** button on the FlowSheet toolbar.

   The cell will be cleared of information.

Auto-Populating FlowSheet Fields

Information entered into the vitals section of a visit will automatically populate the Vitals FlowSheet. In addition lab results that come in through an electronic lab interface will automatically populate lab FlowSheets. Future versions of Chart will automatically read additional information from the database into the FlowSheets but at the moment only vitals and lab results do so.

Setting the Value Range

The Value Range is a feature that allows the user to specify the number of days, months or years worth of data to display in the FlowSheet within any one patient session. The default value is set to 2 years worth of data but can be changed. To change the value range setting click the Value Range button on the FlowSheet toolbar to open the Past Value Results window and then change the range by changing the values in the # Day, # Months or # Years fields. Currently, changing the values of these fields will only cause the changes to be in effect as long as the patient's chart is open. Once the patient's chart is closed the Value Range will revert to the default setting of 2 years.

Initially use of this feature may not be necessary since most patients in a new installation will not have that much data entered. The FlowSheet grid can only display a limited amount of information horizontally anyway (depending on the resolution of the workstation monitor) so not all of the information associated with a patient can be displayed on screen at one time no matter what the Value Range is set to. However for purposes of browsing (using the scrollbars) or printing the data this feature can be used to limit the information that can be accessed in any one session.

Graphing a FlowSheet

FlowSheet data can be graphed to provide the user with a view of data that can be more easily understood. Graphs can sometimes provide an alternate view of data that allows the user to see relationships between items or progress of disease states that cannot easily be seen in a table view of the same data.

To graph data in a FlowSheet:

1. Select the FlowSheet to be graphed by highlighting it.
2. Click the Graph button on the FlowSheet toolbar.
3. The FlowSheet Graphing window will open.
4. A list of the fields that can be graphed will appear in the left pane of the window.
5. The first field in the list will be selected by default and a graph of that field will appear in the right pane.
6. To graph another field simply select it.
7. Any data points that fall outside the field's normal range (validation) will appear in red (or whatever color is selected to display out of range values in). See Set Validation for a Field for details on setting normal ranges.

Note: Only fields with at least two data points can be graphed. Fields with one data point or less will display a message reading "More than one data point must be available in order to create a graph" when selected.

Graphing Multiple Fields on One Graph

It is possible to graph multiple fields on one graph by clicking the check boxes for the results to be graphed. There are check boxes on the left and right of the results. If you check the box on the left the item will be graphed with its scale represented on the left axis. If you check the box on the right the item will be graphed with its scale represented on the right axis.

There is no limit to the number of multiple items that can be selected but it is prudent to consider keeping the number to a minimum. Too many items on one graph can make the information unreadable and unusable.

Note: It is best to keep results of like scale on the same axis. Items with drastically different scales can cause the graph to be difficult to read. For example, a HgbA1c value which can be in the range of 5 to 10 is not a good candidate to pair on the same axis with something like weight which can be in the range of 100 to 200 pounds. These types or results would be better displayed if one were displayed on the left axis and the other on the right axis. Systolic and Diastolic blood pressure readings on the other hand would be well suited to be graphed on the same axis since their scales are similar.

Printing a Graph

Graphed data from FlowSheets can be printed. The printed graph will look exactly like the screen version.

Important! To be able to print a graph, the FlowSheet Graphing window must be open.

To print a FlowSheet graph:

1. Select the FlowSheet to be graphed and click the **Graph** button on the FlowSheet toolbar.

   The FlowSheet Graphing window will open.

2. Select the item or items to be graphed (the limitation at this time is that only two data items can be graphed on one graph).

3. After the graphed items are displayed in the graph window, click the **Print** button on the main Graph toolbar.

   The graph will print to the default Windows printer set up on the current computer. The graph will print just as it is displayed on the screen.

Printing a FlowSheet

FlowSheets can be printed. The printed FlowSheet will look almost exactly like the screen version.

To print a FlowSheet:

1. Click the desired FlowSheet name in the left pane.

2. Click the **Print** button on the FlowSheet toolbar.

   The FlowSheet will print to the default Windows printer set up on the computer.

Using the FlowSheet Editor

The FlowSheet Editor is a module that is included with e-MDs Chart application. It can be used to edit the existing FlowSheets that are provided with the product or to create completely new ones.

Accessing the FlowSheet Editor

The FlowSheet Editor can be opened as a standalone application or as a module from within Chart.

To open the FlowSheet Editor in standalone mode:

1. Click the Windows **Start** menu at the bottom left corner of your desktop
2. Go to **Programs** > **e-MDs** > **e-MDs FlowSheet Editor.**

   The FlowSheet Editor will open

To open the FlowSheet Editor from Chart:

1. Login into Chart using your normal e-MDs username and password.
2. From the main Chart menu system, click **Tools** then select **FlowSheets** from the pop-up menu.

   The FlowSheet Editor will open.

To access a specific FlowSheet from a list of currently open FlowSheets:

1. Click the drop-down arrow at the right-side of the field.

   The drop-down will open and display all opened FlowSheets.
2. Click the desired FlowSheet to switch the view to that particular FlowSheet.

Understanding the FlowSheet Editor Interface

The main window of the FlowSheet Editor contains a **File** menu item in the top left corner, a **FlowSheet selection drop down field** and a **Close all FlowSheets** button.

The File menu item contains menu selections that allow the user to Open a Patient FlowSheet, Open a FlowSheet, access Categories, access Data Elements and access Fields.

File Menu	
Open Patient FlowSheet	Allows the user to open a specific patient's FlowSheet from within the FlowSheet Editor. The patient's chart does not have to be open to do this. **Note:** Data entered into any of the fields of a patient FlowSheet will associate that information to the patient just as if you were in the patient's chart. This IS NOT a test environment!
Open FlowSheet	Allows access to the **FlowSheet Select** window where you can search for and open a specific FlowSheet for editing purposes OR create a new FlowSheet from scratch.
Categories	Allows access to the **Categories Select** window. See the Categories section for details about categories.
Data Elements	Allows access to the **Data Element Select** window. See the Data Element section for details about data elements.
Fields	Allows access to the **Field Select** window. See the "Fields" section for details about FlowSheet fields.
Exit	Allows the user to close the FlowSheet Editor module. This performs the same action as the X in the upper right corner of the module.

Tools Menu	
Lab Linker	Accesses the Lab Linker module that allows users to link Data Elements to Master Lab Codes. See Link a Data Element to a Master Lab Code for details.
Merge Data Elements	Allows access to a module that merges Data Elements. Sometimes more than one Data Element that represents the same item will be created. Merging of these Data Elements takes all the information from the different elements and merges them into one.
FlowSheet Selection Dropdown	 Allows users to access any FlowSheets that have been opened in the current session. Multiple FlowSheets can be opened at one time within a session of the FlowSheet Editor and users can flip between them using the FlowSheet selection field.
Close All FlowSheets Button 	If multiple FlowSheets are opened within a session of the FlowSheet Editor they can all be closed at one time by clicking the **Close All FlowSheets** button

Editing the Details of a FlowSheet

There are details associated with each FlowSheet that can be edited. These details include the FlowSheet Name, Description and Category.

To edit the details of a FlowSheet:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop up menu.
3. The **FlowSheet Select** window will open.
4. Type the name of the FlowSheet to be edited into the **Name** search field
5. Click the **Search** button on the tool bar OR press the enter key on your keyboard.
6. A list of FlowSheets matching the search criteria will appear in the bottom part of the form.
7. Select the desired FlowSheet by clicking it and click the **Edit** button on the toolbar.
8. The **FlowSheet Maintenance** form will open
9. Make the desired changes to the **Name** or **Description** or change the designated Category.
10. Click the **Save** button when finished.

Editing a FlowSheet

Once a FlowSheet has been created they may be a reason to edit it. New FlowSheet fields may need to added or removed or the sequence of the fields may need to be changed.

To edit a FlowSheet:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop up menu.
3. The **FlowSheet Select** window will open.
4. Type the name of the FlowSheet to be edited into the **Name** search field
5. Click the **Search** button on the tool bar OR press the enter key on your keyboard.
6. A list of FlowSheets matching the search criteria will appear in the bottom part of the form.
7. Select the desired FlowSheet by clicking it and click the **Select** button on the toolbar OR press the Enter key on your keyboard.

OR

Double-click the name of the FlowSheet.

8. The **FlowSheet** form will open.
9. Changes to the FlowSheet or the FlowSheet Fields can be made. See the following sections for details.
10. When finished making changes simply close the FlowSheet by clicking the **X** on the blue FlowSheet header bar (the one where the FlowSheet name is displayed).

Note: Clicking the **X** and the top right corner (instead of the **X** on the blue FlowSheet header bar) will close the entire FlowSheet Editor module and not just the current FlowSheet.

Adding Existing Fields to a FlowSheet

The FlowSheet module comes pre-populated with FlowSheet fields that can be used to augment existing FlowSheets or to create new ones. These fields cover a wide variety of data such as vital signs, lab tests, immunizations, best practice items, etc. These pre-existing fields can easily be added to an existing or new FlowSheet.

To add an existing field to a FlowSheet:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop up menu.
3. The **FlowSheet Select** window will open.
4. Type the name of the FlowSheet to be edited into the **Name** search field
5. Click the **Search** button on the tool bar

   OR

   Press the **Enter** key on your keyboard.
6. A list of FlowSheets matching the search criteria will appear in the bottom part of the form.
7. Select the desired FlowSheet by clicking it and click the **Select** button on the toolbar ***OR*** press the Enter key on your keyboard ***OR*** double-click the name of the FlowSheet.
8. The **FlowSheet** form will open
9. The fields in the FlowSheet, along with details about each, will be listed in a grid on the right side of the form.
10. Click the **Add** button in the left pane of the window to add an *existing* field.
11. The **Field Select** window will open.
12. Type the name of the field (full description or partial) that is to be added into the **Name** field.
13. Click the **Search** button on the toolbar ***OR*** hit the **Enter** key on your keyboard.
14. Highlight the desired field from the search results and click the **Select** button on the toolbar ***OR*** double click the item ***OR*** hit the **Enter** key on your keyboard to select the field.
15. The field will be added to the list of fields already in the FlowSheet and placed in alphabetical order.
16. The sequence of items displayed in the FlowSheet can be changed by clicking the **Sequence** button (see "Change the Sequence of Fields" for details).

Changing the Sequence of Fields

When editing a FlowSheet please note that in edit mode the fields are displayed alphabetical order and not necessarily in the order they are displayed in the FlowSheet when it is being used. The order of the fields can be changed.

To change the FlowSheet field sequence:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop-up menu.
3. The **FlowSheet Select** window will open.
4. Type the name of the FlowSheet to be edited into the **Name** search field
5. Click the **Search** button on the tool bar.

   OR

   Press the enter key on your keyboard.

   A list of FlowSheets matching the search criteria will appear in the bottom part of the form.
6. Select the desired FlowSheet by clicking it and click the **Select** button on the toolbar.

   OR

   Press the Enter key on your keyboard.

   OR

   Double-click the name of the FlowSheet.

   The **FlowSheet** form will open. The fields in the FlowSheet, along with details about each, will be listed in a grid on the right side of the form.
7. Click the **Sequence** button at the bottom of the left side of the form.

   This will open the **Field Sequence** window with all the fields listed in the order that they display in the FlowSheet.
8. Select the field to reorder by clicking to highlight it.
9. Move the field to the desired location by using the blue up or down arrow at the top left side of the window.
10. Repeat the process for any fields that need to be re-ordered.
11. When finished, click the **Save** button to save changes.

Creating and Adding New Fields

Fields can be created from within a FlowSheet at the time the FlowSheet is being created (on the fly).

To add new fields:

1. Edit the desired FlowSheet.
2. Click the **New** button in the right pane.
3. A **New Field** form will open.

   There are five choices for add a new Field. These choices allow the user to create a completely new Field from scratch or to copy certain parts of existing Fields to create new ones. This functionality is intended to save time when creating FlowSheet Fields. The five choices are described below.

- **Create a New Field and New Data Element**: This choice is the same as creating a new Field outside of a FlowSheet. If this option is selected:
  - The Data Element Maintenance form will open and you can choose an existing Data Element or add a new one. See "Add a New Data Element" for details.
  - Once a Data Element is chosen the Field Maintenance form will open and you can finish creating the Field. See "Create a FlowSheet Field Outside a FlowSheet" for details.
- **Copy an Existing Field:** This choice allows the user to copy an existing field and then make changes as necessary. This can save time when creating a Field that is similar to an existing one but may only need small changes. For example if you have a patient whose normal temperature us 99 you might want to copy the temperature Field, rename it (ex. Low Grade Temp) and make changes to the Validation so that 99 will show up as a normal value for this patient. If this option is selected:

  The Field Select form will open and you can choose an existing Field to Edit. See "Edit a FlowSheet Field" for details.
- **Copy an Existing Field but create a New Data Element**: This choice can be used when you want keep the same Validation values (normal ranges or pick lists) but want to use a different Data Element. Copying of a Field that contains a Yes/No type Data Element is a good example of this choice. Rather than having to recreate the pick list for a Yes/No type question this option can be chosen and a different Yes/No type Data Element can be selected. If this option is chosen:
  - The Field Select form will open and you can search for and choose an existing Field to use.
  - After a field is selected the Field Maintenance form will open will all the information filled out EXCEPT the Data Element.
  - Pick an existing Data Element to use or create a new one. See "Add a New Data Element" for details.
- **Create a New Field Based on an Existing Data Element:** This option allows the user to pick a Data Element first and then enter information into the FlowSheet Field properties to create the Field. If this option is chosen:
  - The Data Element Select form will open.
  - Pick an existing Data Element or create a new one. See "Add a New Data Element" for details.
  - After a Data Element is chosen the Field Maintenance window will open with *ONLY* the Data Element field filled out.
  - Fill out the required information for the Field. See "Create a FlowSheet Field Outside a FlowSheet" for details.
- **Create a New Field based on an Existing Field's Data Element:** This option allows the user to select an existing Field and use ONLY its Data Element to create a new Field. For example a Pulse FlowSheet Field exists that has an underlying Data Element called Heart Rate. This is the same Data Element that would be used to create a Fetal Heart Rate FlowSheet Field. Use of this option would allow you to pick the FlowSheet Pulse field so that you can use the Heart Rate Data Element to create a completely new FlowSheet Field.

4. The **Field Select** form will open and you can search for and choose an existing Field that contains the Data Element you want to use.
5. After the field is selected, the Field Maintenance window will open with *ONLY* the Data Element field filled out.
6. Fill out the required information for the Field. See "Create a FlowSheet Field Outside a FlowSheet" for details.

7. After one of these options is selected, the Field Maintenance form will open. Depending on the choice made some, none or all of the fields on this form may be filled out.
8. Make changes or additions to the fields as desired. See the “General Tab” and “Validation Tab” sections for details.
9. Click **Save** when finished.

Editing Fields Associated with a FlowSheet

From within the FlowSheet Editor, FlowSheet Fields can be edited at any point after they have been created. However, from within a patient’s chart the only FlowSheet Fields that can be edited are those that have been specifically added to that patient’s chart.

To edit a FlowSheet field:

1. Edit the desired FlowSheet
2. Select the Field to be edited by clicking it.
3. Click the **Edit** button in the left pane.
4. The **Field Maintenance** window will open with the selected Field displayed in Edit mode.
5. Make desired changes to the items in the General tab (**Name**, **Display Name**, **Data Element** or **Note**) or to the items on the Validation tab (**Range From**, **Range To**, **Abnormal Color**, **Valid Values**, **Valid Color**, **Invalid Values** and **Invalid Color**). See The Field Maintenance Form.

Important! Editing of a FlowSheet Field may affect data that has already been collected in some patient specific FlowSheets if the Field is part of that FlowSheet and depending on the changes that have been made to the FlowSheet Field. Keep in mind that any changes to a field will b e transferred to every FlowSheet that the Field is linked to.

Removing Fields from a FlowSheet

Fields that are unneeded or unwanted can be removed from a FlowSheet.

To remove a field from a FlowSheet:

1. Edit the desired FlowSheet
2. Select the Field to be removed by clicking it.
3. Click the **Remove** button in the left pane.
4. In the Remove confirmation window click Yes to remove the field.
5. The field will be removed from the FlowSheet.

Notes:

- The field will be simply removed from the FlowSheet but NOT deleted. It will continue to exist in other FlowSheets and it can be added back to the FlowSheet it was deleted from if desired.
- Removing a field from an original or "master" FlowSheet will remove the field from every patient specific FlowSheet that the master FlowSheet is linked to. Keep this in mind when removing fields.

Adding a New FlowSheet

To add a new FlowSheet:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop up menu.

3. The **FlowSheet Select** window will open.
4. Click the New button on the toolbar.
5. The **FlowSheet Maintenance** window will open.
6. Enter a name in the **Name** field and a description into the **Description** field.
7. Select a **Category** from the Category drop down. The Name and Category are required fields.
8. Click **Save** when finished.

Deleting a FlowSheet

To delete a FlowSheet:

1. Open the FlowSheet Select window by clicking **File** in the main FlowSheet Editor module.
2. Select **Open FlowSheet** from the pop up menu.
3. The **FlowSheet Select** window will open.
4. Type the name of the FlowSheet to be deleted into the **Name** search field
5. Click the **Search** button on the tool bar ***OR*** press the enter key on your keyboard.
6. A list of FlowSheets matching the search criteria will appear in the bottom part of the form.
7. Select the desired FlowSheet by clicking it and click the **Delete** button on the toolbar.
8. Click Yes in the Deletion confirmation window.
9. The FlowSheet will be deleted.

Important! ***Use caution when deleting FlowSheets.*** Deletion of a FlowSheet will remove it from ALL patients' charts. The data associated with those patients will not be lost and may still be linked to the patient via other templates that have the same FlowSheet fields in them. To recover ALL data associated with the patient the FlowSheet might have to be recreated or the fields associated with the FlowSheet will need to be added to another FlowSheet.

Understanding FlowSheet and Category Linking

Each FlowSheet is required to be linked to a Category. This is required for future functionality to help in the organizing of FlowSheets. These categories are not currently being used but will be at a later date.

To add a new category:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Categories** from the menu.
3. The **Category Select** window will open.
4. Click the **New** button on the Category Select toolbar.
5. The Category Maintenance window will open.
6. Enter a name for the category in the **Name** field and a description of it (not required) in the **Description** field.
7. Click the Save button to save the new category.

To edit a category:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Categories** from the menu.
3. The **Category Select** window will open.
4. Enter the name of the Category in the **Name** field and click the **Search** button.
5. In the search results select the desired category by clicking it.
6. Click the **Edit** button on the Category Select toolbar.
7. The **Category Maintenance** window will open.
8. Make the desired changes to the **Name** and/or **Description** fields.
9. Click **Save** when finished.

To delete a category:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Categories** from the menu.
3. The **Category Select** window will open.
4. Enter the name of the Category in the **Name** field and click the **Search** button.
5. In the search results select the desired category by clicking it.
6. Click the **Delete** button on the Category Select toolbar.
1. Click Yes in the deletion confirmation window.

Using Data Elements with FlowSheets

Data Elements are the underlying data structures that contain information about what type of data is captured and stored in the database for any FlowSheet Field that is based on that particular Data Element. A Data Element can be used by any number of FlowSheet Fields but each Field can have one and only one Data Element associated with it. The reason for having multiple Fields for a Data Element is because the Fields can be set to hold different Validation or normal ranges for the same Data Element. For example, a Data Element called *Heart Rate* exists in the FlowSheet module that is used by both the Pulse and Fetal Heart Rate FlowSheet Fields. This allows the Pulse Field to have a normal Heart Rate range associated with adult patients and the Fetal Heart Rate to have a normal range associated with a fetus, yet both are stored as a single Heart Rate Data Element in the database. The concept of Data Elements in conjunction with FlowSheets Fields provides for a high level of flexibility to capture and track virtually any type of clinical data.

Data Elements can consist of seven different Data Types. See the Types of Data Elements section for details of these types.

Adding Lab Results in FlowSheets to Visit or Order Notes

Lab results that are listed in patient-specific FlowSheets can be copied to Chart Visit or Order Notes through templates that use the FlowSheets Extended Attributes. See the "Creating and Modifying Chart Templates" chapter in *e-MDs Solution Series Administration Guide* for information on how to add or modify those templates. For instructions on using those templates, also see Accessing FlowSheets in Templates.

Understanding Types of Data Elements (Data Types)

Data Elements can be designated as one of seven different **Data Types** depending on the kind of data to be tracked. These seven types of data consist of **Date**, **Date/Time, Decimal Number**, **Text**, **Time**, **Whole Number, Yes/No** and **Separator**. Each Data Type is defined below.

- **Date**: The Date Data Type is used when a FlowSheet Field is going to be used to capture a specific date. This can be used to document that a particular lab, test or immunization was performed on a specific date. This can be especially helpful when the date that the item was performed was not on the date the information was documented. Documentation today of an item such as an immunization, for example, that was performed in the past would by default have a date set to today but this date could easily be changed using the popup calendar associated with field.
- **Date/Time**: The Date/Time Data Type is used when you want to capture a time along with a date.
- **Decimal Number**: A decimal number is used when an expected value can but will not necessarily be a whole number. For example the value for a Hemoglobin A1c can be either 6 or 6.3. Use a decimal number when there is a possibility that the value will not be a whole number.
- **Text**: The Text Data Type is used to document free text information.
- **Time**: The Time Data Type is used to document a specific time that an item was performed.
- **Whole Number**: This Data Type is used to document an item that is ALWAYS expected to be a whole number. For example a Blood Pressure reading is never expected to be a decimal.
- **Yes/No**: This Data Type allows users to create a Data Element that expects a Yes or No as the value to be input into the FlowSheet Field that is linked to it. See the section on Validation for details about setting these labels.
- **Separator**: This Data Type is used to provide some organization to a FlowSheet by acting as a separator between FlowSheet fields.

To add a new data element:

1. Click the File menu in the main FlowSheet window.
2. Select **Data Elements** from the menu.
3. The **Data Elements Select** window will open.
4. Click **New** on the toolbar.
5. The **Data Element Maintenance** window will open.
6. Enter a Name and Description into the respective fields.
7. Pick a **Data Type** from the dropdown menu. See Types of Data Elements for details about the different selections in this field.
8. Click the search icon in the Associated Master Lab Code field if this is an element that needs to be linked to a Master Lab Code.

   Note: Skip this step if the element is not being linked to a Master Lab Code.

   A Select Master Lab Code window will open.
9. Search for and select the appropriate Master Lab Code.
10. Click **Save** when finished.

To edit a data element:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Data Elements** from the menu.
3. The **Data Elements Select** window will open.
4. Enter the name of the Data Element to be edited into the **Name** field and click **Search**.
5. Select the desired Data Element from the search results by clicking it.
6. Click the **Edit** button on the toolbar.
7. The **Data Element Maintenance** window will open.
8. Make any desired changes to the **Name**, **Description, Associated Master Lab Code** or **Data Type**.
9. Click **Save** when finished.

To delete a data element:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Data Elements** from the menu.
3. The **Data Elements Select** window will open.
4. Enter the name of the Data Element to be deleted into the **Name** field and click **Search**.
5. Select the desired Data Element from the search results by clicking it.
6. Click the **Delete** button on the toolbar.
7. Click **Yes** in the deletion confirmation window.

Important! Deletion of a Data Element can cause **DATA LOSS** if the Data Element is being used by FlowSheet Fields that contains patient data.

Linking a Data Element to a Master Lab Code

Lab tables that store lab results in the database have items call Master Lab Codes that identify lab tests. Lab companies throughout the country use different codes to identify lab tests. For example a CBC may have one ID code from laboratory A and a completely different one from Laboratory B even thought the ID codes are referring to the exact same order. This makes matching lab results that come in through a lab interface to a FlowSheet element difficult. Master Lab Codes were designed to deal with this dissimilar way of identifying the same lab test. One Master Lab code can be linked to many different laboratory ID codes (representing the same lab test) and acts as a single point of reference for those lab tests. This allows a FlowSheet Data Element to be linked to only one item rather than to different ID codes from different lab companies.

Note: A Data Element can only be linked to one Master Lab Code and vice versa.

To link a data element to a Master Lab Code:

1. In the FlowSheet Editor, click Tools then choose Lab Linker from the menu.
2. The Lab Linker window will open
3. Make sure the Link radio button is selected
4. The list of available Data Elements will be displayed down the left side and a list of available Master Lab Codes will be displayed down the right side.

5. Those Data Elements and Master Lab Codes that are already linked will appear with a chain link icon to the left of the description
6. Select an unlinked item in either column and then select the corresponding item in the other column
7. Click the Link button
8. If you are sure you want to link the items, answer Yes in the confirmation window

A Data Element or Master Lab Code can only be linked to one item. Sometimes these links are incorrect and an item needs to link to a different item. To do this you may first unlink the item.

To unlink a data element from a Master Lab Code:

1. In the FlowSheet Editor, click Tools then choose Lab Linker from the menu.
2. The Lab Linker window will open
3. Make sure the Unlink radio button is selected
4. The list of available Data Elements will be displayed down the left side and a list of available Master Lab Codes will be displayed down the right side
5. All the items will appear with a chain link icon since only the linked items will appear in this view
6. Click an item in either column and the linked item will be highlighted and will move to the top of it's respective list
7. Click the Unlink button
8. If you are sure you want to unlink these items, answer Yes at the confirmation window.

Merging Data Elements

Sometimes more than one Data Element that represents the same item can get created. For example two Data Elements for Sodium might be created. These two Data Elements contain the same information but users would have to create two FlowSheet fields to display this information. Merging of these Data Elements would take the all the information on Sodium and combine them into one Data Element.

Important! Merging of Data Elements *CANNOT BE REVERSED* and can cause LOSS OF DATA if done incorrectly. Be sure of what you are doing before deciding to merge Data Elements.

To merge data elements:

1. In the FlowSheet Editor, click Tools then choose Merge Data Elements from the menu.
2. The Merge Data Elements window will open
3. At the top is a pane that is labeled **Select Data Elements to Merge** and it contains an alphabetical list of all data elements
4. Next is a window labeled To Be Merged and it will be empty to start with
5. As you select items in the Data Elements list they get added to the To Be Merged section
6. For example if you had two items for Sodium called Sodium 1 and Sodium 2 you would see them in the Select Data Elements to Merge list and as you click one and then the other they would get added to the To Be Merged list
7. At the bottom of the window is a field labeled Merged Data Element Name
8. This field will default to the name of the first element that you select to be merged

9. In the example above with the Sodium 1 and 2, if you clicked on Sodium 1 first then that is what would default into the Merged Data Element Name field although you can type into the field to change the name if needed.

   Note: If you inadvertently select a Data Element that you do not want to merge, simply click it again to remove it from the list.

10. When you are finished selecting items to be merged, click the Merge button at the bottom.
11. You will be presented with three confirmation warning messages
12. If you are sure you want to merge these items click Yes to all three messages.

Important! Merging of Data Elements *CANNOT BE REVERSED* and can cause LOSS OF DATA if done incorrectly. Be sure of what you are doing before deciding to merge Data Elements.

Understanding FlowSheet Fields

FlowSheet Fields are the items that are displayed in the FlowSheets and that hold the data being captured. These Fields also contain Validation rules or normal ranges for the underlying Data Element that represents the data in the database.

The Field Maintenance Form

The FlowSheet Field Maintenance form is the screen where new FlowSheet fields are created or existing FlowSheet fields are edited. There are two tabs on this screen, a **General** tab and a **Validation** tab.

General Tab

The General tab contains information about the FlowSheet Field Name, Display Name, the underlying Data Element and a Note about the field.

General Tab	
Name	This is where the FlowSheet field name is entered. The Name is not what is displayed in the FlowSheet itself (that would be the Display Name) but instead is used for organizational purposes in the FlowSheet Editor. This is a **required** field.
Display Name	This is the name that is actually displayed in the FlowSheet. The display name can be the same as the FlowSheet field Name if desired and in fact the Display Name defaults to the same text as the Name field when creating a new FlowSheet field. This is a **required** field.
Data Element	This is the underlying data structure that contains information about what type of data is captured and stored in the database for any FlowSheet Field that is based on that particular Data Element. For more detailed information about Data Elements see "What are Data Elements?" This is a *required* field.
Note	This field can be used to provide information about what the FlowSheet field is being used to capture and track. This field is *NOT* a required field and can be left blank if desired.

Validation Tab

The Validation tab contains information about what the normal Range From and Range To of the values for the data entered into the FlowSheet field should be in addition to forms to enter Valid and Invalid expected values.

The Validation tab has a section for Range From and Range To values that allows the user to enter a normal expected range for the values that are input into the field and to pick an Abnormal Color to display out of range values. In addition the Validation tab contains sections for input of Valid Values and Invalid Values along with pick lists for Valid Color and Invalid Color. These fields allow the user to enter information about expected data input and abnormal input into FlowSheet fields that are not numeric *OR* where the values ARE numeric BUT they do not occur sequentially where they can be used in a range.

In other words, for text-based input (that does not fall into a normal range like a numeric value does) in FlowSheet fields you can still have information show up in a different color if the data is abnormal *OR* for numeric values that cannot be easily noted in a range (for example, a situation where the values expected are 10, 20, 30, etc). See below for specifics on using validation.

Validation Tab	
Range From and **Range To**	Enter a range of expected values into these two fields to define the normal range for the specific FlowSheet field. For example the normal range for Diastolic Blood Pressure could be considered to be from 40 mmHg to 80 mmHg. To set this range for a FlowSheet field you would enter 40 in the Range From field and 80 in the Range To field. **Note**: The system does not currently take into account units so do not enter anything other than numeric values into these fields.
Abnormal Color	This field allows the user to select a color for the value entered into the FlowSheet field if it falls outside the normal range. In the example above, the normal range for diastolic BP is set from 40 to 80. If the value 81 were entered into this field it would show up in whatever color is selected to denote an abnormal value. To set an Abnormal Color use the dropdown pick list and select the desired color. Red is the default color set for this field.
Valid Values	This field is used to enter expected normal values for a FlowSheet field if the values to be entered are NOT numeric OR they are numeric but do not occur in a sequence that would easily fit in a range (use Range From and Range To for that purpose). The function of this field creates pick lists of items that can be chosen when entering information into the FlowSheet field within a FlowSheet. For example for the FlowSheet field Karotype the expected values that can be entered are 46XX, 46XY, 46XO and 47XXY. These are a combination of alpha and numeric values and could not be documented in the Range From/Range To fields so they are entered into the Valid Values field. This allows the user that is entering data into the FlowSheet to choose one of these values from a pick list that is created as a result of entering this information into the Valid Values field. Another example would be any FlowSheet field that has a Data Element type of Yes/No. For these FlowSheet fields user would input both Yes and No (or Positive and Negative, True and False, On and Off, etc.) into the Valid Values field to create a dropdown pick list of those two answers.
Valid Color	Users can set a color for any value that is input into the Valid Values field. This field defaults to Black but can be changed if desired. To change the Valid Color use the dropdown pick list and select the desired color.
Invalid Values	This field can be used in conjunction with the Valid Values field to denote values that are considered abnormal or unwanted. For example in the example about the Karotype FlowSheet field given in the Valid Values section a list of expected values are created that consist of 46XX, 46XY, 46XO and 47XXY. All of these values will appear in the dropdown pick list for the Karotype field if it appears in a FlowSheet. Not all of these values are considered normal however. The values 46XO and 47XXY are considered abnormal values and if they are entered into the Invalid Values part of the validation field and then picked as a choice in a FlowSheet they will appear in whatever color is designated in the Invalid Color field. Another example is a Yes/No choice in a FlowSheet. For those FlowSheet fields with a Data Element of type Yes/No the Valid Values field would contain both Yes and No (or Positive and Negative, True and False, On and Off, etc.). Then the Invalid Values field would be populated with the choice that is the one considered as abnormal or unwanted. For example there is a Dilated Eye Exam field that can be used to denote whether a diabetic patient has had their expected yearly eye exam. This is a Yes/No FlowSheet field that has both Yes and No entered into the Valid Values field but only No is entered into the Invalid Values field so that a No answer will show up in the FlowSheet in red to draw attention to the fact that the patient has not had the exam. Other cases will exist where Yes would be the abnormal value and in those situations Yes would be entered into the Invalid Values field.

Invalid Color	Users can set a color for any value that is input into the Invalid Values field. This field defaults to Maroon but can be changed if desired. To change the Valid Color use the dropdown pick list and select the desired color. **Note:** The Invalid Color will default to Red in future versions.

To pick an existing data element:

1. Click the magnifying glass icon on the **Data Element** field.

   The Data Element Select form will open

2. Enter the name of the Data Element the **Name** field and click **Search**.
3. Select the desired Data Element from the search results by clicking it.
4. Click **Select** on the main toolbar OR press the Enter key on your keyboard OR double-click to add the Data Element to the Field.

To create a new data element:

1. Click the magnifying glass icon in the **Data Element** field.

   The Data Element Select form will open.

2. Click **New** on the toolbar.

   The Data Element Maintenance window will open.

3. Enter a Name and Description into the respective fields.
4. Pick a **Data Type** from the dropdown menu. See Types of Data Elements for details about the different selections in this field.
5. Click **Save** when finished.
6. Highlight the new Data Element and click **Select** on the main toolbar OR press the Enter key on your keyboard OR double-click to add the Data Element to the Field.

Creating a FlowSheet Field Outside a FlowSheet

Fields can be created from within a FlowSheet at the time the FlowSheet is being created (on the fly) or outside of a FlowSheet as part of the regular process of creating items to be used in FlowSheets.

To create a field outside a FlowSheet:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Fields** from the menu.
3. The **Field Select** window will open.
4. Click the **New** button on the toolbar.
5. The Field Maintenance window will open.
6. The **General** tab will be selected by default.
7. Fill out the **Name**, **Display Name**, **Data Element** and **Note fields**. See the General Tab section for details.

To pick an existing data element:

1. Click the magnifying glass icon in the **Data Element** field.
2. The **Data Element Select** form will open

3. Enter the name of the Data Element the **Name** field and click **Search**.
4. Select the desired Data Element from the search results by clicking it.
5. Click **Select** on the main toolbar OR press the Enter key on your keyboard OR double-click to add the Data Element to the Field.

To pick a new data element:

1. Click the magnifying glass icon in the **Data Element** field.

   The Data Element Select form will open

2. Click **New** on the toolbar.

   The Data Element Maintenance window will open.

3. Enter a Name and Description into the respective fields.
4. Pick a **Data Type** from the dropdown menu. See Types of Data Elements for details about the different selections in this field.
5. Click **Save** when finished.
6. Highlight the new Data Element and click **Select** on the main toolbar ***OR*** press the **Enter** key on your keyboard ***OR*** double-click to add the Data Element to the Field.
7. Click the **Validation** tab to enter information about normal/abnormal values or to create pick lists.
8. Fill out the **Range From**, **Range To**, **Abnormal Color**, **Valid Values**, **Valid Color**, **Invalid Values** and **Invalid Color** fields on the Validation tab if desired. See the Validation Tab section for details.
9. Click the **Save** button when finished.

Creating a FlowSheet Field on the Fly

Fields can be created from within a FlowSheet at the time the FlowSheet is being created (on the fly).

To add new fields:

1. Edit the desired FlowSheet.
2. Click the **New** button in the right pane.
3. A **New Field** form will open.

   There are five choices for add a new field. These choices allow the user to create a completely new Field from scratch or to copy certain parts of existing Fields to create new ones. This functionality is intended to save time when creating FlowSheet Fields. The five choices are described below.

   - **Create a New Field and New Data Element**: This choice is the same as creating a new Field outside of a FlowSheet. If this option is selected:
     - The Data Element Maintenance form will open and you can choose an existing Data Element or add a new one. See Add a New Data Element for details.
     - Once a Data Element is chosen the Field Maintenance form will open and you can finish creating the Field. See Create a FlowSheet Field Outside a FlowSheet for details.
   - **Copy an Existing Field:** This choice allows the user to copy an existing field and then make changes as necessary. This can save time when creating a Field that is similar to an existing one but may only need small changes. For example if you have a patient whose normal temperature us 99 you might want to copy the temperature Field, rename it (ex. Low Grade

Temp) and make changes to the Validation so that 99 will show up as a normal value for this patient. If this option is selected:

The Field Select form will open and you can choose an existing Field to Edit. See Edit a FlowSheet Field for details.

- **Copy an Existing Field but create a New Data Element**: This choice can be used when you want keep the same Validation values (normal ranges or pick lists) but want to use a different Data Element. Copying of a Field that contains a Yes/No type Data Element is a good example of this choice. Rather than having to recreate the pick list for a Yes/No type question this option can be chosen and a different Yes/No type Data Element can be selected. If this option is chosen:
  - The Field Select form will open and you can search for and choose an existing Field to use.
  - After a Field is selected the Field Maintenance form will open will all the information filled out EXCEPT the Data Element.
  - Pick an existing Data Element to use or create a new one. See Add a New Data Element for details.
- **Create a New Field Based on an Existing Data Element:** This option allows the user to pick a Data Element first and then enter information into the FlowSheet Field properties to create the Field. If this option is chosen:
  - The Data Element Select form will open.
  - Pick an existing Data Element or create a new one. See Add a New Data Element for details.
  - Once a Data Element is chosen the Field Maintenance window will open with ONLY the Data Element field filled out.
  - Fill out the required information for the Field. See "Create a FlowSheet Field Outside a FlowSheet" for details.
- **Create a New Field based on an Existing Field's Data Element:** This option allows the user to select an existing Field and use ONLY its Data Element to create a new Field. For example a Pulse FlowSheet Field exists that has an underlying Data Element called Heart Rate. This is the same Data Element that would be used to create a Fetal Heart Rate FlowSheet Field. Use of this option would allow you to pick the FlowSheet Pulse field so that you can use the Heart Rate Data Element to create a completely new FlowSheet Field.
  - The Field Select form will open and you can search for and choose an existing Field that contains the Data Element you want to use.
  - Once the Field is selected the Field Maintenance window will open with ONLY the Data Element field filled out.
  - Fill out the required information for the Field. See "Create a FlowSheet Field Outside a FlowSheet" for details.
  - Once one of these options is selected the Field Maintenance form will open. Depending on the choice made some, none or all of the fields on this form may be filled out.
  - Make changes or additions to the fields as desired. See the "General Tab" and "Validation Tab" sections for details.

4. Click **Save** when finished.

Editing a FlowSheet Field

FlowSheet Fields can be edited at any point after they have been created.

To edit a FlowSheet field:

1. Click the **File** menu in the main FlowSheet window.
2. Select **Fields** from the menu.
3. The **Field Select** window will open.
4. Enter the name of the Field to be edited into the Name field and click the **Search** button on the toolbar OR press the Enter key on your keyboard.
5. Highlight the desired Field in the search results and click the **Edit** button on the toolbar OR press the Enter key on your keyboard OR double-click the name of the Field.
6. The **Field Maintenance** window will open with the selected Field displayed in Edit mode.
7. Make desired changes to the items in the General tab (**Name**, **Display Name**, **Data Element** or **Note**) or to the items on the Validation tab (**Range From**, **Range To**, **Abnormal Color**, **Valid Values**, **Valid Color**, **Invalid Values** and **Invalid Color**). See "The Field Maintenance Form" section for details.

Important! Editing of a FlowSheet Field may affect data that has already been collected in some patient specific FlowSheets if the Field is part of that FlowSheet and depending on the changes that have been made to the FlowSheet Field. Keep in mind that any changes to a field will b e transferred to every FlowSheet that the Field is linked to.

Setting Validation for a Field

See Validation Tab for information on how to enter expected ranges for the values that are input in fields.

Creating Pick Lists for Fields

The **Valid Values** field lists possible Validation used to create pick lists of answers for a FlowSheet field. For example, for the FlowSheet field, Karotype, the expected values that can be entered are 46XX, 46XY, 46XO and 47XXY. These are a combination of alpha and numeric values that could not be documented in the Range From/Range To fields. Alpha numeric or text choices must be entered into the Valid Values field. This allows the user entering data into the FlowSheet to choose one of these values from a pick list. Another example would be any FlowSheet field that has a Data Element type of Yes/No. For these FlowSheet fields the user would input both Yes and No (or Positive and Negative, True and False, On and Off, etc.) into the Valid Values field to create a dropdown pick list of those two answers. From the Valid Values choices, items that indicate an abnormal result or outcome can be copied and pasted into Invalid Values. Invalid values display in red when appearing in a FlowSheet providing a visual indicator of an abnormal result or outcome. See the "Validation Tab" section for more details.

10
Managing Visit and Order Notes with the Unsigned Notes Module

Like the Unsigned Notes report the Healthcare Visit Sign Off module allows a provider to view all unsigned notes created under their name. Unlike the unsigned notes report this module allows providers to also sign off on these notes. Using this module a provider can either select notes individually or multiple selected them and permanently sign them off all at the same time. Additional functionality allows the user to edit any of the notes in the list of unsigned notes.

Note: As with all permanently signed notes a password is required. However the password needs only to be entered once.

Continued on the next page ...

Accessing the Unsigned Notes Module

The Healthcare Visit Sign Off module can be accessed from the Dashboard application and also from within the Chart application.

To access the Healthcare Visit Sign Off module:

1. With the Dashboard running, click **Run**.
2. Choose **Unsigned Notes** from the menu.

   OR

   From the main Chart menu toolbar, click **Tools** then select **Health Care Visit Sign Off** from the drop-down menu.

   A window labeled Multiple Sign Off will open.

Understanding the Unsigned Notes Module Interface

File Menu	
Exit	The exit menu choice will close the application.

Help Menu	
Search Topics	Selection of this choice will open the built in help files and allow users to search for help on specific topics.
About	Selection of this choice will display a screen that shows the current version number of the application. This information can be helpful when tracking down problems and may be asked for by the support department.

Toolbar Items	
Sign Off Button	This button will sign off any selected notes (notes that have check marks in the check box to the left).
Refresh Button	This button will refresh the screen and show new data if it exists.
Date Range Filter	The Date Range Filter allows the user to enter a date range and then only see the unsigned notes for that time period. To use the date range, click the check box and then enter a starting and ending date using the drop down calendar picker or by typing the date in the field. **Note:** The application is set to show all unsigned notes by default.
Visit Notes/Order Notes /Log/Rx Notes Choice	Users can choose to see unsigned Visit Notes, Order Notes, Unsigned Log/Phone/Rx Notes or Both. The default setting is to show Both but users can clear the check box next to the item the do not want to see.

Grid Columns	
Check Box	This column contains check boxes for each note. Users can check a box and then click the Sign Off button to permanently sign off the note.
Type	This column shows the Type of note with icons representing the type. Visit Notes, Order Notes, Permanent Log Notes, Permanent Phone Notes and Permanent Prescription Notes are the types currently available for sign off.
Patient	This column displays the name of the patient.

Description	This column displays a description of the note. Currently only the Visit or Order Notes will display a description. The description for the note is a list of the diagnoses that were documented in the note.
Date	Displays the date the note was created.
Unlabeled Column	The last column has no label. An Edit icon (pencil) is displayed in this column. Users can click the Edit button to open the note in edit mode. This allows the user to review the note and make changes, if necessary, prior to signing off.
Note: If any unsigned notes exist they will be listed by the date associated with the note with the oldest visits listed at the top and the more recent visits listed at the bottom of the list. The items listed in the grid can be reordered to show the visits alphabetically by patient or by date. To list the visits alphabetically by patient click the Patient label at the top of the patient column. To return to a list by date click the Date label at the top of the date column.	

Signing Off and Editing Unsigned Notes

Unsigned notes can be signed off either individually or in groups by multiple selecting from within the Unsigned Notes module.

To sign off an individual unsigned note:

1. Click the check box to the left of the note to be signed
2. Click the **Sign Off** button at the top left of the window
3. Enter the password used to login to e-MDs applications
4. Click the **OK** button

To sign off multiple-select unsigned notes:

1. Click the check box to the left of each of the notes to be signed.

   Note: To select or unselect ALL notes at one time, click the check box icon at the top of the check box column.
2. Once all the desired notes are marked with a check mark, click the **Sign Off** button at the top left of the window.
3. Enter the password used to login to Chart.
4. Click the **OK** button.

Unsigned notes can be also edited from within this module.

To edit an unsigned note:

1. Click the pencil icon to the right of the visit to be edited
2. The specified patient's chart will open to the appropriate visit
3. Make any changes as necessary

Co-Signature Tab

This feature is used when providers require supervisor review and sign off on their Visit or Order Notes. Under the **Supervisors** tab of Provider Demographics, check the box to the left of "Requires co-signature on visit notes" to activate this option. The check box is located at the bottom of the window. When set, all notes for this provider (resident, PA, NP, doctor, etc.) are routed to the supervisor designated in the note, as well as the rendering provider. The supervisor can view the note under the co-signature tab in the Unsigned Notes module. This tab will only display if notes requiring co-signature exist.

Toolbar Items	
Sign Off Button	This button will sign off any selected notes (designated by a marked check box on the left side).
Refresh Button	This button will refresh the screen and show new data if any exists.
Date Range Filter	The Date Range Filter allows the user to choose a date range for the display of unsigned notes. To indicate a date range, click the check box and enter a start/end date. Do this by using the drop down calendar display or by typing the date in the field. **Note:** The application is set to show all unsigned notes by default.

Grid Columns	
Check Box	This column contains check boxes for each note. Users can select the note for sign off by placing a check in the box and then click the Sign Off button. This note is now permanently signed off. This functions identically when co-signing the note.
Type	This icons displayed in this column indicate the Type of note requiring sign off. Visit Notes, Order Notes, Permanent Log Notes, Permanent Phone Notes and Permanent Prescription display in this module.
Red X	This column allows the supervisor to remove the note from their unsigned notes list without co-signing the note.
Patient	This column displays the name of the patient.
Description	This column displays a description of the note. Currently, only the Visit or Order Notes will display with a description. The description for the note is a list of the diagnoses that were documented in the Visit or Order Note.
Provider	This column displays the rendering provider.
Date	Displays the date the note was created.
Unlabeled Column	The last column has no label. A sunglasses icon (view) is displayed in this column. Users can click the View button to open the note. This allows the supervisor to review the note, add an addendum and co-sign the Visit or Order Note.
Note: The items listed in the grid can be sorted to show the visits alphabetically by patient or by date. To list the visits alphabetically by patient, click the Patient label at the top of the patient column. To return to a list by date, click the Date label at the top of the date column.	

Co-Signing Chart Notes

Unsigned notes can be co-signed either individually or in groups by multi-selecting from within the Unsigned Notes module.

To co-sign an individual unsigned note:

1. Click the check box to the left of the note to be signed.
2. Click the **Sign Off** button at the top left of the window.
3. Enter the password used to login to e-MDs applications.
4. Click the **OK** button.

To sign off multi-select unsigned notes:

1. Click the check box to the left of each of the notes to be signed.
2. To select or clear *all notes* at one time, click the check box icon at the top of the check box column.

3. Once all the desired notes are checked, click the **Sign Off** button at the top left of the window.
4. Enter the password used to login to Chart.
5. Click the **OK** button.

If the Visit or Order Note does not need co-signature or if only a percentage of the list requires co-signature, those notes can be removed from the unsigned notes list.

To remove Visit or Order Notes from your unsigned notes:

1. Check the box under the header with the Red X.
2. Once all the desired notes are marked with a Red X, click the **Sign Off** button at the top left of the window.
3. Enter the password used to login to Chart.
4. Click the **OK** button.

To review and add an addendum:

1. Click the sunglasses icon to the right of the note.
2. The specified patient's chart will open to the appropriate visit.
3. Click co-sign.
4. Select which addendum should be added to the visit. Free text can be used in this field.
5. Enter the password used to login to Chart.
6. Click the **Save** button.
7. Close the patient's chart.

11

Accessing Art with the Medical Art Quick Selector

The Medical Art Quick Selector is mechanism for accessing medical art images from the Medical Art Editor, from a directory on the user's computer or network, or from a camera, that can be annotated and added to a patient's chart record while generating a Visit or Order Note. The Medical Art Quick Selector displays the figure of a man or woman, adult or child depending on the age and gender of the patient. The figure contains "hotspots" that become enabled as the user passes the mouse cursor over them. Clicking the hotspot will open a window that displays thumbnails of linked images. These images are related to the body part represented by the hotspot. For example, clicking the heart area "hotspot" of the body figure will display linked cardiovascular related images. Users can select images from the link window to add to the note. Additionally users can annotate these images, e.g. adding text or drawings, to help illustrate points for the patient and/or provider.

Continued on the next page ...

Understanding the Quick Selector Interface

Toolbar Items	
Search (magnifying glass icon)	Opens the Medical Art Editor window so that the end user can search for and add medical art images to this note, not currently linked to the Hotspots.
Load (folder icon)	Opens a browser window on this computer so that the end user can search, select and import an image file to this note, not currently linked to the Hotspots.
Capture (camera icon)	Opens the Image Capture window so that the end user can take a picture, using an installed camera, and add it to the Visit or Order Note, outside of the linked images stored in the Hotspots.
Exit (boxed red X icon)	Closes the Medical Art Quick Selector window without making any selection.
Exam, Patient Ed, and Reference	Hotspot Categories for linked images.

Types of Linked Images

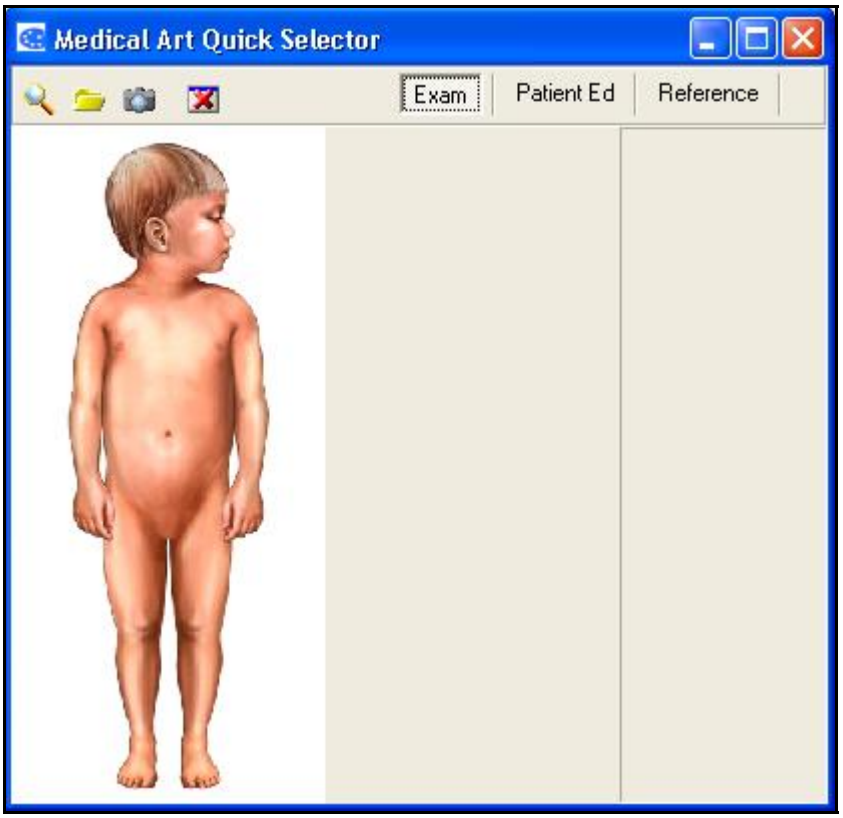
There are three different types of Categories for these Hotspots:

- **Exam**: Images that can be used by the medical staff to document a medical condition, e.g., noting the location of a lesion such as a tumor; to document the results of a procedure, e.g., noting the location of a laceration repair and sutures added; to document a planned procedure, e.g. noting the area on the liver to be biopsied; etc…
- **Patient Ed**: Images that can be used by the medical staff to provide additional information regarding the patient's medical condition, proposed therapies or instructions, exercises, anatomy information, etc…
- **Reference**: Images that can provide medical reference information for the medical staff.

Adding Medical Art to a Visit or Order Note

To add medical art images to a Visit or Order Note :

1. Log into Chart.
2. Search/select a patient record and start a Visit or Order Note.
3. Click the **Art** navigation button, located to the left of the Note.
4. This opens the Medical Art Selector window. The body figure launched is based on the patient's age and gender.

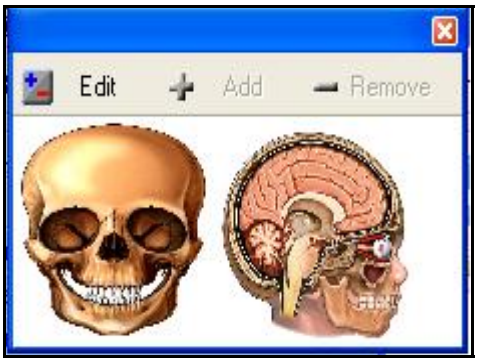


5. Choose the category that corresponds to the type of medical art to be viewed. Choices include Exam, Reference and Patient Ed. The category selected will determine what image thumbnails are displayed.

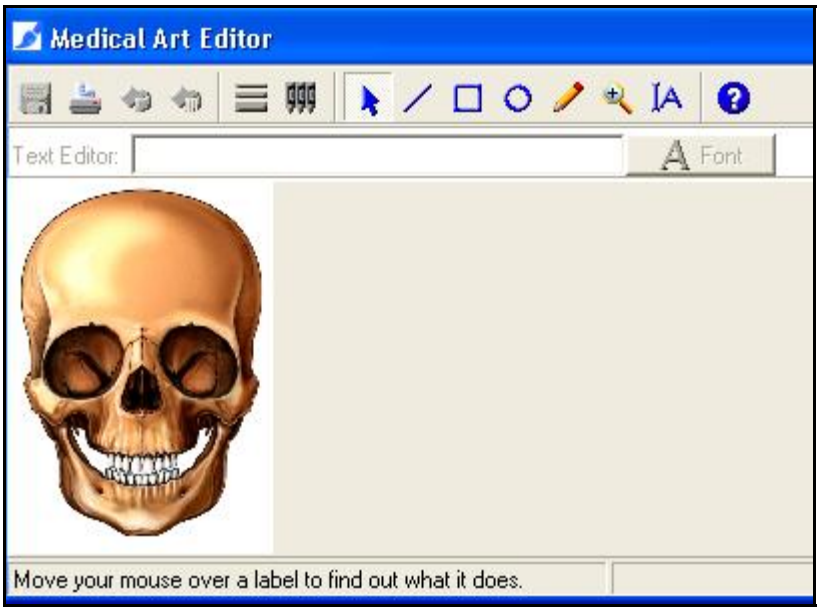
6. After the Category is selected, move the mouse cursor over the body of the figure.

   Note: This "enables" the Hotspot for this body region.

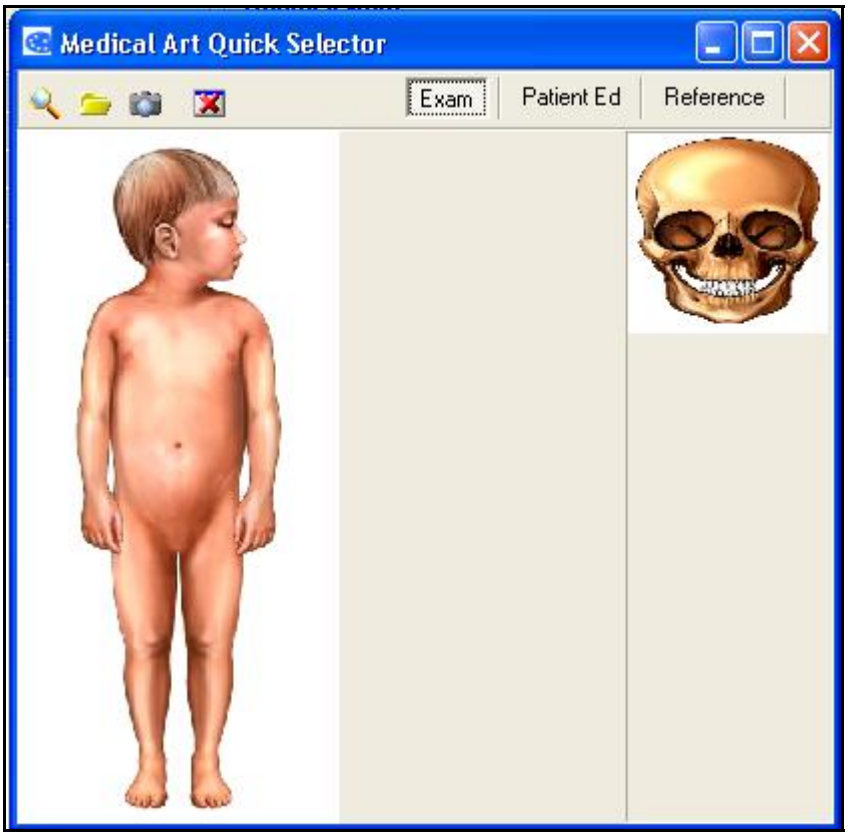
7. Click the "Hotspot" or body area associated with this medical art item to display all currently linked Medical Art Images.



8. Click the image desired. This opens the image in the Medical Art Editor window.



9. At this point, you can close the Medical Art Editor window (click the corner “X”) to add this image to the Medical Art Quick Selector Thumbnail Strip prior to adding it to the note.

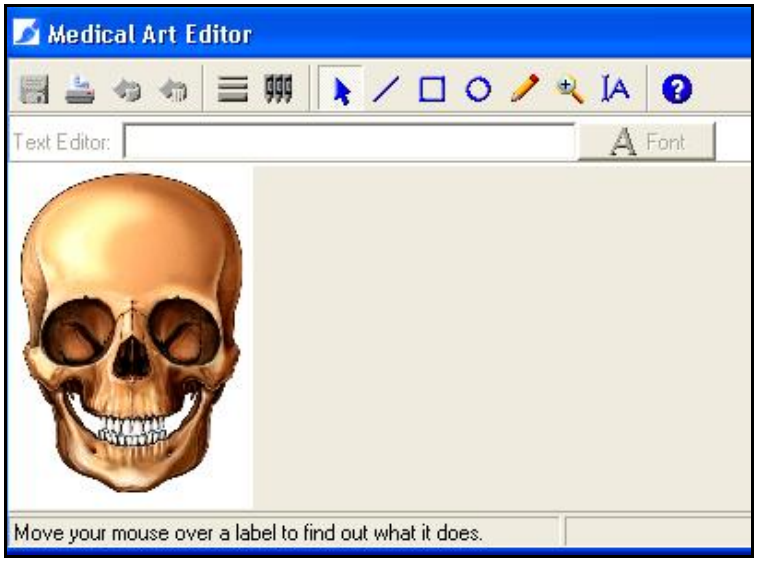


10. If desired, repeat the steps above to add additional linked medical art images to the Thumbnail Strip. These displayed images will also be added to the Visit or Order Note.
11. When done, close the Medical Art Quick Selector window. This adds the thumbnail(s) of the linked image(s) to a Strip at the bottom of the note.

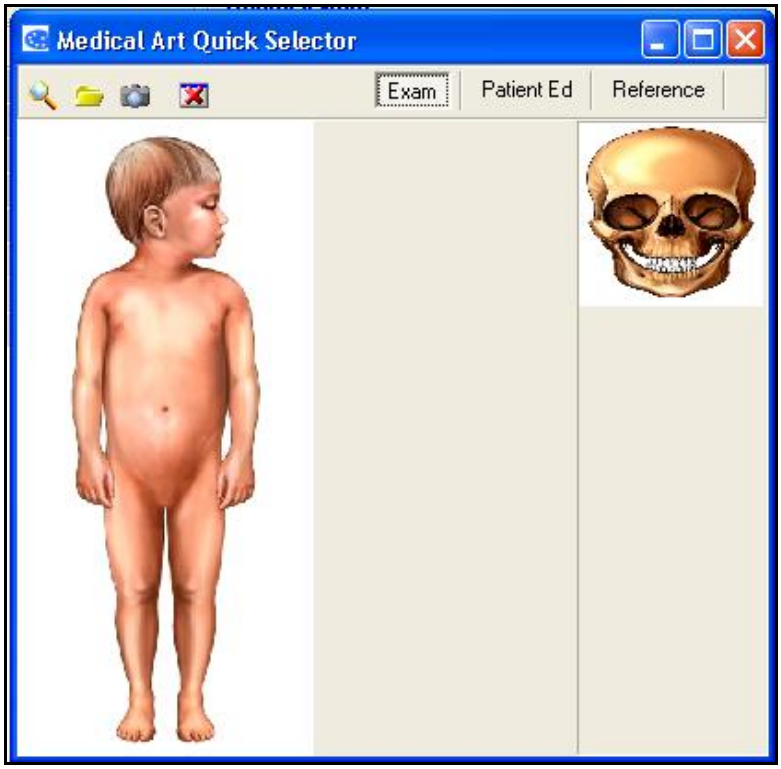
Annotating Medical Art

You can also make annotations to any of the linked medical art images either prior to adding them to the Visit or Order Note or afterwards, prior to sign-off.

Remember that when clicking a thumbnail of a linked image in the Thumbnails window, the image is opened in the Medical Art Editor window. At this point you can use the editing tools to add lines, squares, circles, to add text or to reduce/enlarge the image.



Closing the Medical Art Editor window adds this thumbnail to the Medical Art Quick Selector Thumbnail Strip. See “Medical Art Editor Help” section for more information regarding annotations.



Prior to closing the Medical Art Quick Selector window, you can click any of the listed thumbnails stored in the Thumbnail Strip. This again opens the thumbnail image in the Medical Art Editor.

When you close the Medical Art Quick Selector window, this adds the annotated image by thumbnail to the Visit or Order Note.

After the thumbnail has been added to the Visit or Order Note, prior to sign-off, you can click any of the these thumbnails. This opens the thumbnail image in the Medical Art Editor for annotations. Closing the Medical Art Editor returns the thumbnail to the Chart Thumbnail Strip.

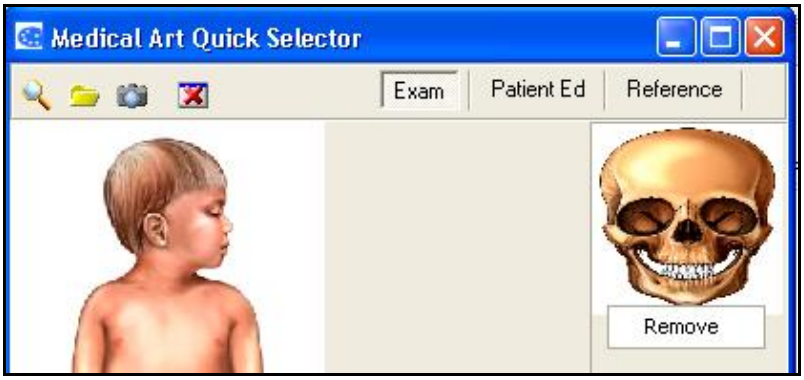
Note: If you re-open the Medical Art Quick Selector window, all thumbnails added to the note will be displayed here as well.

Using the Medical Art Quick Selector Thumbnail Strip

Located in the Medical Art Quick Selector Window and displays all of the medical art images that are to be added to the Visit or Order Note. You can annotate or remove the thumbnails through this strip.

Removing Images from Medical Art Quick Selector Thumbnail Strip

To remove any selected art from the Medical Art Quick Selector Thumbnail Strip, right-click over the thumbnail and select the **Remove** menu option.



Editing Images

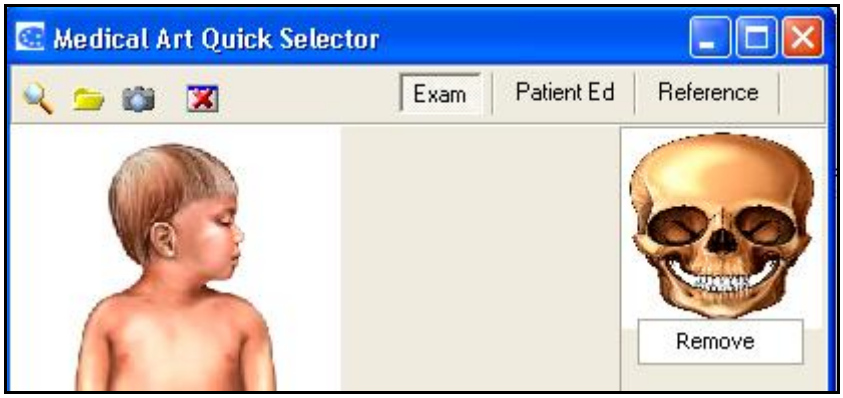
To edit any medical art images that have been either added to the Medical Art Quick Selector Thumbnail Strip or to a Visit or Order Note, simply click the Thumbnail to load it into the Medical Art Editor. See the Medical Art Editor Help for assistance with performing annotations and edits.

Removing Medical Art from a Visit or Order Note

Within the Chart Visit or Order Note, right-click the Thumbnail in the Chart Thumbnail Strip and select the **Remove** menu option.

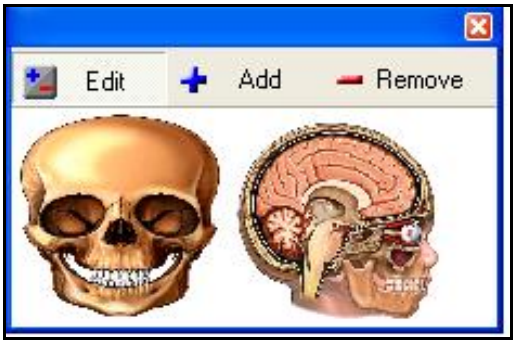
OR

Re-open the Medical Art Quick Selector Window and right-click the thumbnail listed in the Thumbnail Strip. This will also remove the thumbnail from the Visit or Order Note.



Adding/Removing Linked Images from the Medical Art Quick Selector

In the Thumbnails window, there is an **Edit** button that is used to add or remove images from the Hotspot categories. Click the **Edit** button and this makes both the Add and Remove buttons active.



Click one or more of the thumbnails listed. Notice now that they are highlighted. (To clear an image selection, simply re-click the thumbnail.)

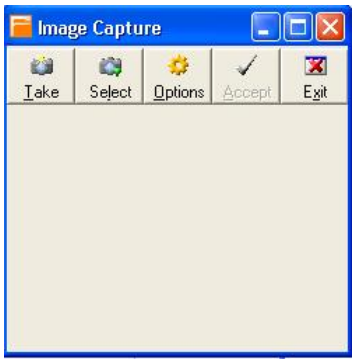
Clicking the **Add** button opens the Medical Art Editor. Search for desired medical art image and click Select button. This will add this medical art image as another thumbnail.

To delete any thumbnail, click the **Edit** button to make the Add or Remove buttons active. Then click the thumbnail of the medical art image to select it. Click Remove button. Click **Yes** to confirm the deletion and this will remove the thumbnail from the thumbnail window.

Note: This does not delete the medical art image from the Medical Art Editor. It only removes it from the Medical Art Quick Selector.

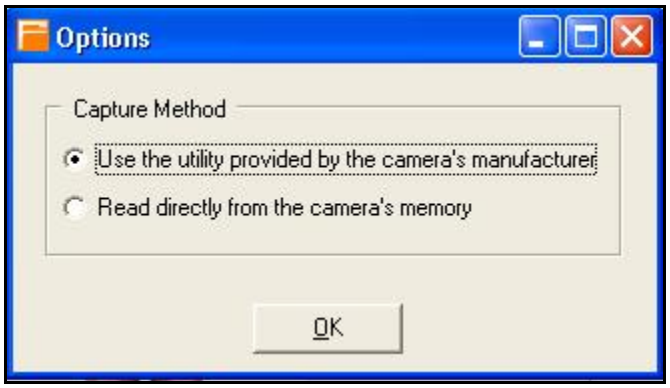
Capturing Images Using a Web Camera

To upload an image using a Web Camera, click the Camera **Capture** icon in the toolbar.



In the Image Capture window, first click the **Options** button.

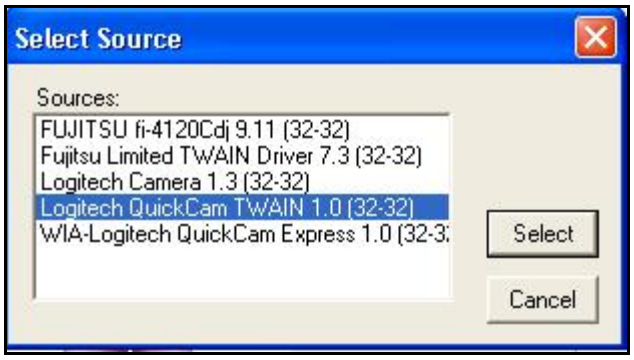
Select a preference as to how you would like to “capture” or upload the image. You can either choose to use the software utility used by the camera’s manufacture before uploading the image (allows you to use tools to edit image before uploading) or simply load the image from camera driver’s memory.



Note: The default setting is to use the utility provided by the camera's manufacturer. So if you change it to "read directly from the camera's memory", after capturing an image and uploading it, you will need to reset this preference prior to capturing a new image.

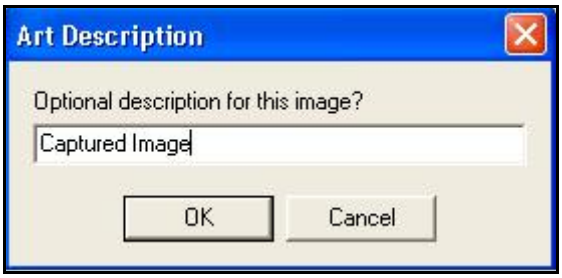
Next click the **Select** button. This preference is to select the correct Twain driver for your installed camera. Click the desired driver and click the **Select** button.

Note: This is very important as this computer may have multiple Twain drivers installed such as a scanner or other web camera on this computer. Once you have selected the desired Twain driver, it will remain selected while using the camera through the Medical Art Quick Selector utility. Remember to update this Twain preference when changing to another program that uses a different Twain driver such as DocMan or FastForm which uses a scanner Twain driver.

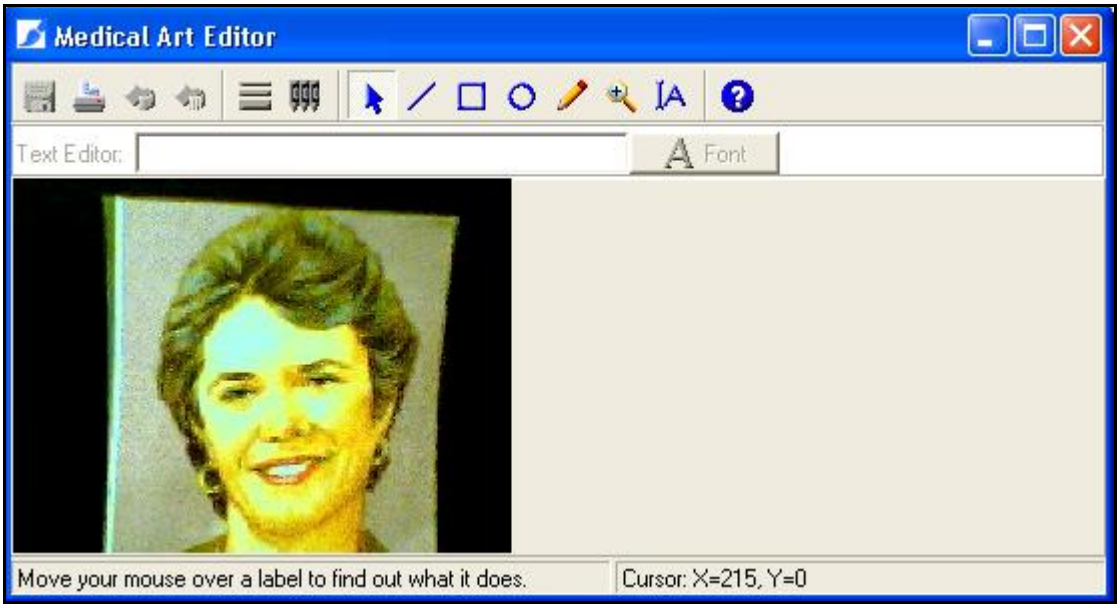


Finally, click the **Take** (Camera icon) button. If you chose to load the image from the camera driver's memory, then this will automatically display the image captured in the lower screen of the Image Capture window.

Click **Accept** (green check mark icon) button, add a description when prompted, and click OK button.



This then opens the image in the Medical Art Editor window. Make any annotations as desired and then close the Medical Art Editor Window.



The captured image is then added the Medical Art Quick Selector Thumbnails Strip. You can right-click the image to delete it or click it to annotate it again. Once done, close the Medical Art Quick Selector window to add this captured image to the Visit or Order Note.

Note: This process does not add this image to the Medical Art Editor library of images. See the Medical Art editor for help with adding images to its library.

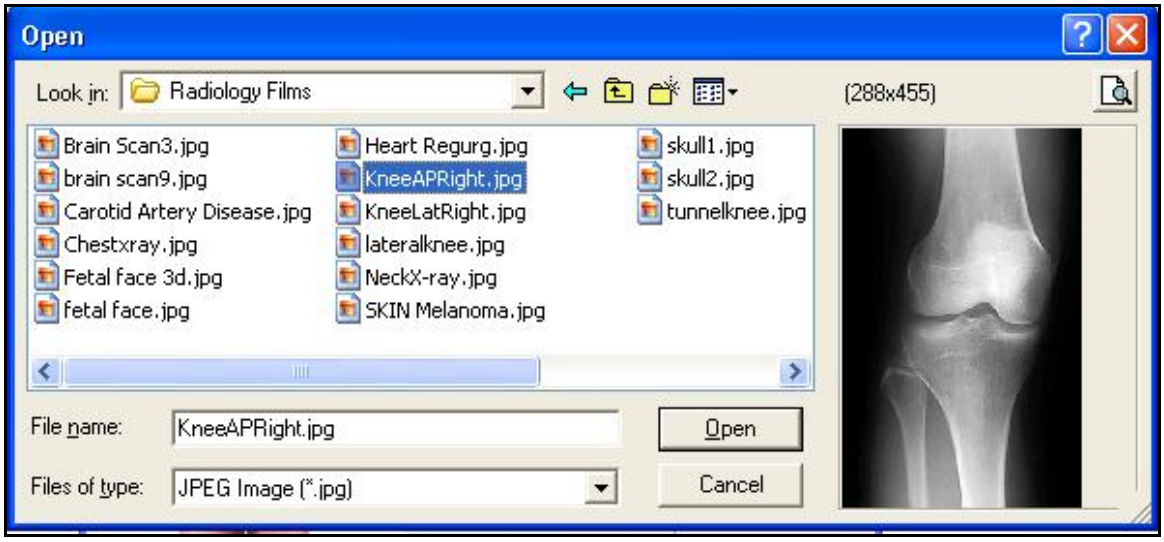
If you selected to "use the utility provided by the camera's manufacturer" the image will first be loaded into this utility's viewer. See your camera's Help guide for modifying the image and capturing the image through this utility. Once captured, the image will now be displayed in the lower half of the Image Capture window as when loading the image directly from the Camera driver's memory.

Note: If you cancel the process through the manufacturer's utility, this might generate an error message that an image could be retrieved from the camera or that there might be a problem with the camera installation or power resources.

Simply click OK button or whatever button is listed in the error message to close it. There is conflict between the manufacturer's utility cancel process and the Medical Art Quick Selector. This error message generally does not indicate that there is a problem with the camera. However, if you see this error message when attempting to capture the image, see your Camera manufacturer's Help guide or Windows Help for troubleshooting your camera's installation.

Importing Images into a Visit or Order Note

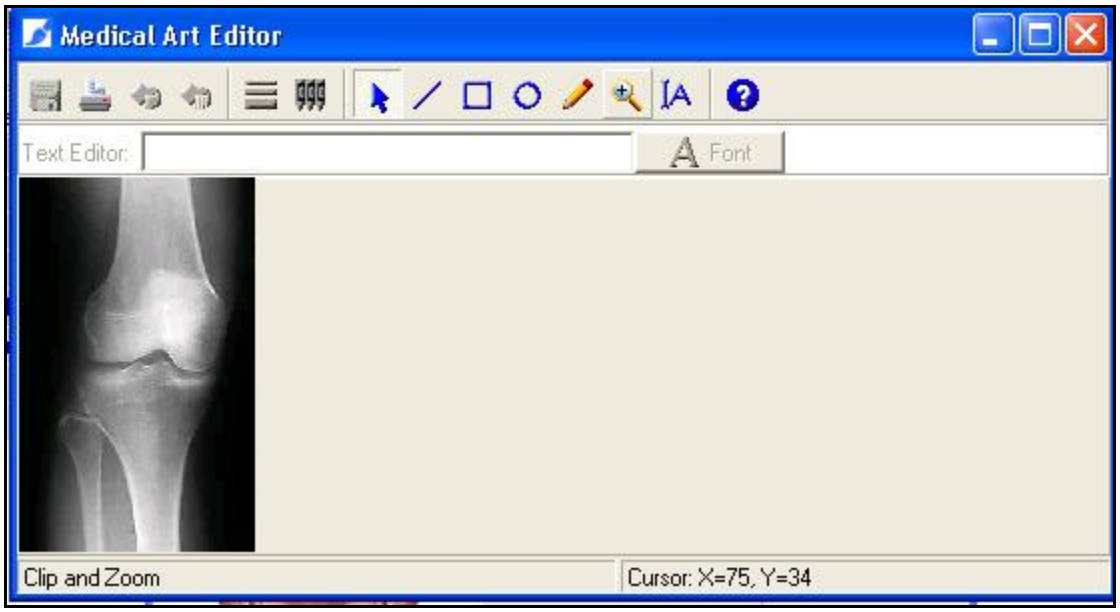
Medical Art Quick Selector also allows end users to import images stored on the hard drive of this computer or from any computer in this user's network. To import an image, click the **Load** button in the toolbar. This opens the Browser window to search and select an image file. Prior to importing the image, select it to preview its content in the viewer on the Right side of this Browser window.



Note: The user can import a variety of file types including .jpeg, .jpg, .bmp, .gif, .pox, .tiff, and .pang. The Medial Art Quick Selector converts these files to .jpg format prior to saving the image. This might affect the resolution display of the original file after it has been imported.

Once the correct image is located, click Open button and add a description to this image file.

Click the **OK** button and this will load this image into the Medical Art Editor window.

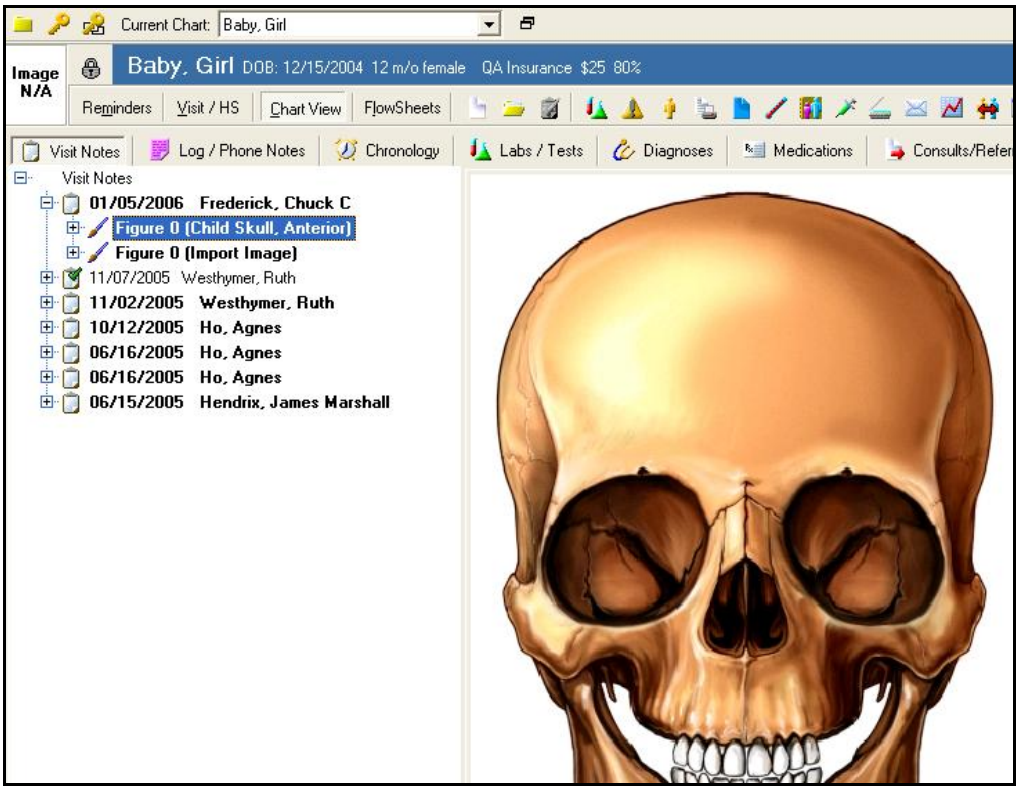


Perform any desired annotations and close this window. This adds this imported image to the Medical Art Quick Selector Thumbnail Strip. Close this window to add the imported image to the Visit or Order Note.

Note: This imported image file is not loaded into the Medical Art Editor library. It is only linked to this patient file. See the Medical Art Editor Help section for assistance with importing image files to its library.

Viewing Medical Art in Chart View

To view the medical art image added to a Visit or Order Note, search and select the patient. Click the **Chart View** button. Click the tree (+ sign) to expand the note. Any added medical art will be listed below the note as Figure 0 and the name of the medical art image. Click the description of this medical art to view the image on the Right screen.

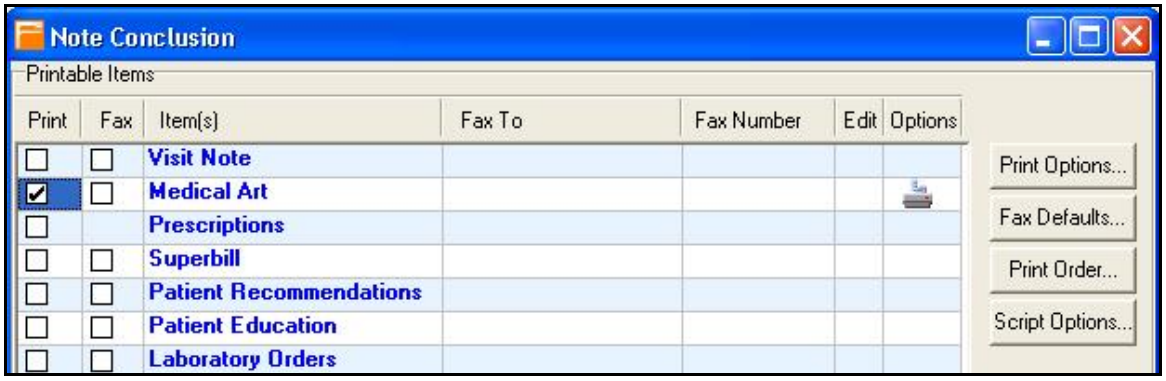


Printing Medical Art

To print the linked medical art image, when concluding or signing-off the Visit or Order Note, check the box next to Medical Art option.

OR

From Chart View, select the Visit or Order Note and click **Print**. Check the box next to **Medical Art** option to print all linked medical art images.



The medical art image can also be printed when it is loaded into the Medical Art Editor. Simply click the **Printer** icon located on the toolbar.

12
Using the Rule Manager

A rule is simply a set of parameters that allow the Solution Series software to automatically generate reminders. Those reminders contain information that alerts providers and clinical staff to such things as abnormal lab reports, best practices for preventive care and disease management, or forms to be completed. Reminders are displayed in the patient's chart and in the Schedule and Tracking Board applications. They can also be made available on the Patient Portal.

When rules are created, they run automatically (real-time) when the rule's parameters are met. For example, if a rule is designed to generate a reminder for routine hemoglobin A1c lab tests based on a diagnosis of diabetes, and a user adds that diagnosis to a patient's chart, the rule will run as soon as the diagnosis is saved to the patient's chart. Rules can also be run on demand or can be set up to run on a daily, weekly, or monthly schedule.

The Rule Manager also includes functionality that allows users to generate reports and task lists. For example, the Notice Processor rule (available on the Tasks tab of the Rule Manager) generates a list that can be sent automatically to a user's TaskMan inbox.

The Rule Manager includes a number of rules created by e-MDs, and users can easily add new rules.

Continued on the next page ...

Understanding Rule Types

e-MDs Chart contains the following types of rules: Disease Management, Gestational Age, Health Maintenance (based on CPT), Immunizations/ Repetitive Testing Scenarios, Lab result (FlowSheet), Lab Tracking rule for over due CPT/HCPCS, Medication rule by CPT, Medication rule by CPT and ICD, Require Form (HIPAA, Advanced Directive, Portal) and Script Audit rule for overdue reports. With the exception of the Script Audit and the Lab Tracking rule type, each of these rule modules can be used to generate an unlimited number of Rules.

- **Disease Management**: Disease Management rules track whether recommended tests or procedures are being performed regularly on a patient with a certain diagnosis. Rule parameters include the diagnosis (one or more ICD codes), the tests or procedures recommended for proper disease management (one or more CPT codes), the age and gender of the patient, and the frequency that the test needs to be ordered. For example, a rule created using this module could be used to track whether all diabetic patients are getting an HgbA1c test every 3 months as recommended.
- **Gestational Age**: This type of rule generates procedure/test reminders based on gestational age. Parameters include the patient's age, the diagnosis (one or more ICD codes), the gestational age and the test or procedure (one or more CPT codes) that is due.
- **Health Maintenance**: Health Maintenance rules determine whether the tests and procedures for detection or prevention of specific diseases are being performed regularly, according to recommended schedules. Parameters include the patient's age and gender, the tests or procedures that are recommended (one or more CPT codes), and the frequency that these tests should be performed. For example, a rule created using this module could be used to track whether all female patients over the age of 50 have had a mammogram annually.
- **Immunizations/Repetitive Testing Scenarios**: This type of rule is designed to track adherence to immunization schedules, but the rule could also be used to track other CPT related information. Parameters include the immunization type (one or more CPTs), the patient's age, and the cumulative number of immunizations (of a specific type) that should be given by that age. For example, one Immunization rule might check that all infants have a total of 2 DTaP vaccinations by the age of 4 months; a second rule would verify a total of 3 DTaP vaccinations by age 6 months, and so on.
- **Lab Result (FlowSheet):** This type of rule tracks abnormal lab results. Parameters include patient's age and gender, the diagnosis (one or more ICD codes), the specific lab test and lab value. Using the defined parameters, this rule searches the database for abnormal lab results and provides feedback within the patient's chart.
- **Lab Tracking**: This type of rule tracks whether results have been received for labs, tests or procedures that were ordered within Chart. CPT and HCPCS codes that are considered "trackable" have parameters associated with them that denote a time frame for when the results for a lab, test or procedure should be expected back. Using these parameters this rule searches the database and messages users when something is deemed to be overdue.
- **Medication Management**: Currently there are two types of rules that can be used for medications management.
    - **Medication Rule by CPT:** Patients on particular medications may need to have tests or procedures performed regularly. This rule type tracks whether these tests or procedures are being performed in adherence to a recommended schedule. Parameters include patient's age and gender, the medication, the recommended test or procedure (one or more CPT codes,) and the frequency with which the test or procedure should be performed. For example, this rule can be used to track whether a patient on Methotrexate has a liver and renal function test ordered at least every 3 months.

- **Medication Rule by CPT and ICD:** Patients with specific diagnoses AND on particular medications may need to have tests or procedures performed more frequently than those patients on the same medication but without the diagnosis. This type of rule tracks whether these tests or procedures are being performed in adherence to a recommended schedule. Parameters include patient's age and gender, the medication, the diagnosis (one or more ICD codes), the recommended test or procedure (one or more CPT codes) and the frequency with which the test or procedure should be performed. For example, a rule created using this module can be used to track whether a patient with Congestive Heart Failure (CHF) who is on Lotrel has a metabolic panel ordered at least every 2 months (patients without CHF who are on Lotrel are recommend to have the test every 6 months).

- **Require Form (HIPAA, Advanced Directive, Portal)**: If portal authorization, HIPAA authorization, or Advance Directives scanned into DocMan are expiring or not available, this rule allows users to get a message and/or populate the reminders section of their chart.
- **Script Audit:** Users in Ohio are required to print a report of faxed prescriptions on a regular basis. This rule acts as a tickler file by sending a TaskMan message if a report has not been printed in X number of days.

Creating a New Clinical Rule

To create a new rule:

1. Open the Rule Manager module. (Click **Run** > **Rules Manager**).
2. Click the **Clinic** tab located at the top of the Rule Manager window. A list of available Rules will be listed in the Rule Name column on the left side of window.
3. Click **New** on the main Rule Manager toolbar.
4. The **Select Rule Module** window will open. This window displays a list of all available rule types.
5. Highlight the applicable rule type and click **Select** to open the New Rule window.

   Note: To see a brief explanation of the general functionality of the selected rule type, click the **Info** tab in the New Rule window.
6. In the **Rule Name** field, type a name for the new rule. This name will be shown in the list of rules in the Rule Manager.
7. In the **Result Description** field, type a description that clearly describes the focus of the rule and any actions that need to be taken. (For example, a health maintenance rule for mammograms is shipped with e-MDs Chart. The description for that rule reads: “MAMMOGRAM yearly for all female patients 50 and older.”)

   Note: The Result Description is *the text that will appear in the rule-based reminder area of the Reminders tab in e-MDs Chart* and is different from the Rule Name (although the Rule Description and Rule Name can be the same, if desired).
8. Confirm that the **Rule Active** check box is checked. (If this check box does not contain a check mark, the rule will not run.)
9. If the rule requires a vitals value or Flowsheet data to satisfy the rule, click the **Require Flowsheet/Vitals to satisfy rule** check box. (Clicking this check box activates the Flowsheet/Vitals Satisfiers tab. On that tab you can add the type(s) of vitals or lab results that will satisfy the rule.)
10. Enter the remaining parameters for the rule.

    Various tabs are available in the New Rule window. On each tab, you can enter certain parameters for the rule. *The parameters you enter determine how the rule will function. Some*

parameters define the population for which the rule will run, some define the triggers that will cause the rule to generate a reminder, message, or report; and others define the action that needs to be taken to safisfy the rule. Tabs vary somewhat by rule type, and the parameters available on a tab also vary by rule type in a few instances. Most parameters are self-explanatory, but information about specific tabs and parameters is provided in the pages following these instructions.

11. After you enter all the necessary parameters for the rule, click the **Save** button on the toolbar to finish the process and save the rule.

Common Tabs and Parameters

The New Rule window and the Edit Rule window include various tabs that display rule parameters and other information. For most rule types, tabs and parameters are very similar. Those common tabs and parameters are described in the following pages. *However, two rule types (Lab Tracking and Script Audit) are significantly different, so tabs and parameters for those rule types are described separately.*

Note: Rule parameters define how a rule will function. Parameters must be defined completely in order for the rule to generate reminders and for the actions based on those reminders to "satisfy" the rule (i.e, remove the rule-based reminder from the list of current reminders).

Rule Tab

The Rule tab is present for all rule types. Common parameters are described in the following table. A few parameters are available only for certain rule types; those rule types are identified in the table.

Parameters	
Available to Portal	Click this check box to display the rule reminder in the patient's Portal.
Portal Description	If the reminder is to be displayed in the Portal, type the text to be displayed. (This parameter allows you to display reminder text in the Portal that is different from the reminder text that is displayed in Chart.)
Gender	Select the gender to which the rule applies.
Minimum Age Maximum Age	This parameter defines the age range for the patient population to which the rule will be applied. Type the applicable numbers in the Week, Months, and Years columns for Minimum Age and Maximum Age. **Note:** To create a rule that applies to patients of all ages leave all fields at zero except the "Max age in years" field. In that field fill in 100 (or older).
Frequency (*available only for certain rule types*)	This parameter defines how often the rule should run. Type the applicable numbers in the Weeks, Months, and Years columns. For example if a test or procedure is recommended to be run every 6 months, type "6" into the "Months" column for Frequency. The Frequency parameter is available for the following rule types: *Disease Management, Health Maintenance, Medication by CPT, Medication by CPT and ICD*
User Roles	The User Role parameter allows you to limit rule visibility to certain user roles. (Rule and rule reminders will be seen ONLY by the selected roles). Click the check box next to the role(s) for which the rule should be visible in Chart.
Rule Reminder *(not applicable to Lab Result rule type)*	This parameter defines the time period (number of days) that the automated reminder is to be generated and displayed before the related action is actually due. For example, if you type "90" in the Rule Reminder field, the reminder will be displayed in the patients' charts 90 days before the test or procedure is actually due.

Tracking, Type of Form, and Action (*available only in the Required Form rule type)*	The Tracking parameter includes two options: • The *Track only patients with expired forms* option tells the system to generate a reminder and/or taskman message **only if** the selected form type exists in the patient's DocMan and the current date is past the expiration date. • The *Track all patients (create rule results)* option tells the system to generate a reminder if the selected form type exists in the patient's DocMan, but is expired **or if** the selected form type does not exist in the patient's DocMan. The Type of Form parameter defines the type of form the rule will look for. Click the radio button next to the form name to select that form. Only one form can be selected per rule. The Action parameter determines whether the rule will generate a reminder or TaskMan message or both. If the rule is to send a TaskMan message, the user must also enter a recipient for the message.
Number of Times (*available only in the Immunizations rule type*)	This parameter allows you to define the total number of times a patient needs to have a test or immunization. When the applicable CPT or immunization has been ordered the defined number of time, reminders will no longer be generated for that CPT or immunization.
Lab Test Result and Lab Value (*available only in the Lab Result rule type*)	These parameters allow you to define a rule that will generate a notification if lab results are received that fall outside of a defined range (i.e., less than, equal to, or greater than a specified value). Click the **Lab** button to select the lab test result for which you want to receive notification if the result falls outside of the range defined in the Lab Value parameter. Select (click) one of the Lab Value range options (i.e., Less Than, Greater Than, etc.) and then type the number in the Value field. For example if you want to be notified if the selected lab result is >200, then select **> greater than** and type 200 in the **Value** field.
Gestational Age (*available only in the Gestational Age rule type*)	The rule will run only when a patient's gestational age falls within the selected time frame.
Medication (*available only in the two Medication rule types*)	When the selected medication is included in a patient's chart, the rule generates a reminder that the test or procedure selected on the CPT Satisfiers tab should be performed. Click the **Medication** button to open the Select a Drug screen in which you can search for and select the medication. **Note:** Only one medication can be selected for each rule written. All medications in the database that have the same ingredients will be included in the rule. For example, picking Proventil would cause the rule to be run for not only Proventil, but also Ventolin and all brands of albuterol. Also keep in mind that the drug rule is NOT form or strength specific. In the example above, a reminder would be generated for any patient on any form of albuterol (inhaler, nasal spray or tablets).
Patient Only (Optional) *(not applicable to Required Form rule type)*	This parameter allows you to create a rule that will be applied to ONLY one patient. In other words, if this field contains a patient name, then the rule becomes specific for that patient only and will no longer be run on all patients. Click the **Patient** button to launch the Find Patient window. Search for and select the correct patient. (For detailed instructions, see the *Creating a Patient-Specific Rule* section in this chapter of the user guide.) **Note:** Before you convert an existing rule to a patient specific rule, *ALWAYS COPY THE EXISTING RULE FIRST*. Otherwise the original rule will no longer be valid for *ALL* patients.

ICD Triggers Tab

This tab is available for Disease Management, Gestational Age, Lab Result, Medication by CPT and ICD, and Required Form rule types. The parameters on the ICD Triggers tab allow you to select the diagnoses that will cause a rule to run. You can select primary ICD codes and you can enter alternate descriptions.

Parameters	
PRIMARY Health Condition Lookup (ICD-9)	Click the **PRIMARY Health Condition Lookup ICD-9** radio button to activate the Add and Delete buttons for the Primary ICD. Then click the **Add** button (blue plus sign) to open the ICD Search window in which you can search for and select one or more ICD codes. **Note:** To add multiple codes at once: Search for a code. In the search results, highlight all codes that you want to add and then right-click on the highlighted codes. An "Add Code(s) to Select List" pop-up box will be displayed. Click that pop-up box. A "Select List" pop-up box will be displayed. This pop-up box contains all selected codes. To add the codes shown in that pop-up box, click the Select button at the top of the ICD Search window.
ICD Alt Description	This field allows for the input of an ICD alternate description. Alternate descriptions can be used to specify non-specific codes. For example code 281.9, which is officially described as Unspecified Deficiency Anemia, can become Megaloblastic Anemia by use of an alternate description. Use of alternate descriptions in Clinical Rules allows for tracking of diagnoses that would otherwise not be trackable. To enter an alternate description, click the **ICD Alt Description** radio button. This activates the ICD Alt Description field and associated buttons. Click the **Alt ICD** button to search for and select an alternate ID.

Drug Allergy Triggers Tab and Non-Drug Allergy Triggers Tab

These tabs are available for all rule types *except* Lab tracking and Script Audit. Allergy triggers can be used in a variety of ways. For example, suppose a certain type of immunization is contraindicated for patients who are allergic eggs. If you add eggs as a non-drug allergy trigger, and you enter the CPT code for the contraindicated immunization on the CPT Satisfier tab, the rule will look for charts in which an egg allergy is documented. If an egg allergy is documented, and the CPT code for the immunization does **not** exist in the order history, the rule will generate a reminder (warning) and display it on the Reminders tab of the chart.

The only parameter that can be defined on the Drug Allergy Triggers Tab and the Non-Drug Allergy Triggers tab are allergy triggers.

You can add multiple allergy triggers. To search for and select a drug or non-drug allergen to add, click the **Add** button (blue plus sign).

CPT Satisfiers Tab

This tab is available for Disease Management, Gestational Age, Health Maintenance, Immunizations, Medication by CPT, and Medication by CPT and ICD rule types. Certain rules are "satisfied" (i.e., are removed from the Current view on the Reminders tab of the patient's chart) by adding a CPT code to the chart. For example, if the trigger for a rule to run is a diagnosis of diabetes, and the rule is designed to generate a reminder that an A1c lab test needs to be ordered, adding the CPT code for that lab test will satisfy the rule. Multiple CPT codes can be selected, and adding any of them to the chart will satisfy the rule.

Click the **Add** button (blue plus sign) to search for and select CPT codes.

Flowsheet/Vitals Satisfiers Tab

This tab is available for Disease Management, Gestational Age, Health Maintenance, Medication by CPT, and Medication by CPT and ICD rule types, and is activated by clicking the *Require Flowsheet/Vitals to*

satisfy rule check box. On this tab, you can define a Flowsheet data element as the rule satisfier. When that data element is added to the patient's Flowsheets, the reminder generated by the rule is removed from the Current view on the Reminder's tab of the patient's chart.

To select a data element, click the **Add** button (blue plus sign) to open a window in which you can search for and select the data element that will satisfy the rule.

Result Tab

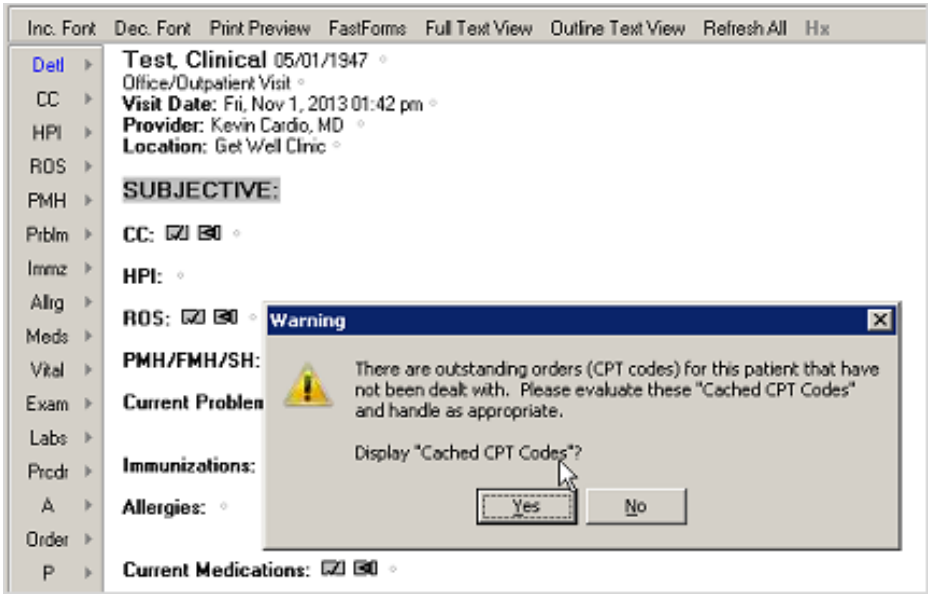
This tab is available for Disease Management, Gestational Age, Health Maintenance, Immunizations, Lab Result, Medication by CPT, and Medication by CPT and ICD rule types. On the Result tab, you can select a specific ICD code and CPT code. If the user clicks the Order button on the Reminders tab of the chart, the selected codes will be added to the Cached CPT list linked to the patient's chart. (Functionality described below.) This parameter is optional; you do not have to add these codes if you do not want to use the Cached CPT functionality to address reminders generated by the rule.

To search for and select an ICD code or a CPT code, click the **ICD** or **CPT** button, respectively.

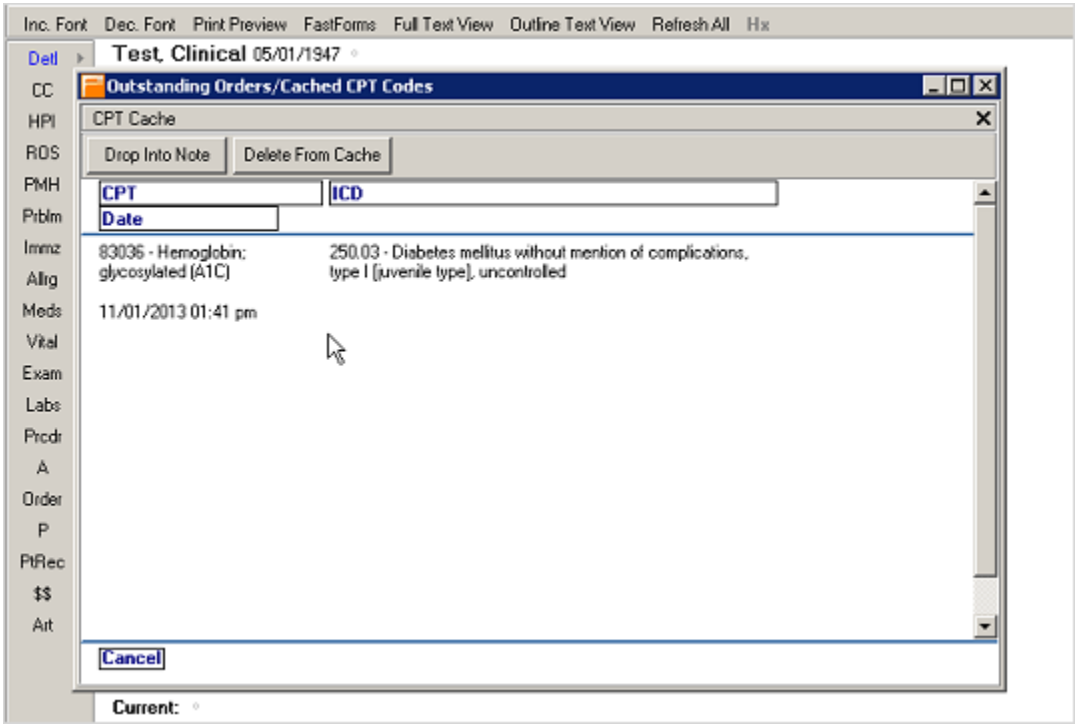
Note: Only one ICD/CPT combination can be defined. (The Clear button removes all selected codes.)

Cached CPT Functionality

- When the user selects a reminder and clicks the Order button, the ICD/CPT codes defined on the Result tab are added to the Cached CPT list.
- The next time the provider opens a note, the system will display a pop-up window indicating that CPT codes are pending for the patient. (See example below.)



- If the provider clicks Yes, the Outstanding Orders/Cached CPT Codes window will be displayed. (See example below.)



- The provider can then drop the order into the note, remove it from the list of outstanding orders/cached CPT codes, or click Cancel to leave the CPT in the list for future action.

Specialty Tab

This tab is available for all rule types *except* Lab Tracking. If you link a rule to a specific specialty, that specialty is displayed on this tab. (A rule can be linked to multiple specialties.) When a rule is linked to a specialty (or specialties), then *only providers and clinical staff that are associated with the linked specialty will be able to see (or act on) reminders that are generated by the rule*. Other specialties will not see the reminders.

For example, an Immunization rule for children could be linked to Pediatric and Family Practice specialties but not Cardiology. In this situation the Cardiologist (or any other specialty besides Pediatric or Family Practice) would not see any reminders generated by the immunization rule.

Instructions for linking rules to specialties are provided in the Making a Rule Specialty Specific section of this chapter of the user guide.

Note: No rules that ship with the product have been set up as specialty specific. Each practice or clinic can choose to make certain rules specialty specific.

Info Tab

This tab is available for all rule types. Click the **Info** tab to see a brief explanation of what the rule type is intended to do.

Source Tab

This tab is available for all rule types *except* Lab Tracking and Script Audit. On the Source tab, you can add information about the source of the clinical guidelines on which the rule is based.

Tabs and Paramaters Specific to Script Audit Rule Type

Rule Tab

The **Rule** tab for the **Script Audit** rule for overdue reports rule type includes only two parameters:

- Due Date (Days) – This parameter tells the TaskMan message recipient if the prescription audit report has been run within x days. For example, if you type “90” in theDue Date field, the TaskMan message will tell the recipient if the prescription audit report has been run within the past 90 days.
- Message To – Select the user who will receive the TaskMan message. Only one user can be selected.

Specialty Tab

The **Specialty** tab displays any specialties to which the rule has been linked.

A rule can be linked to multiple specialties. When a rule is linked to a specialty (or specialties), then only providers and clinical staff that are associated with the linked specialty will be able to see (or act on) reminders that are generated by the rule. Other specialties will not see the reminders.

For example, an Immunization rule for children could be linked to Pediatric and Family Practice specialties but not Cardiology. In this situation the Cardiologist (or any other specialty besides Pediatric or Family Practice) would not see any reminders generated by the immunization rule.

Instructions for linking rules to specialties are provided in the Making a Rule Specialty Specific section of this chapter of the user guide.

Note: No rules that ship with the product have been set up as specialty specific. Each practice or clinic can choose to make certain rules specialty specific

Info Tab

The **Info** tab displays a brief explanation of what the rule type is intended to do.

Tabs and Parameters Specific to Lab Tracking Rule Type

IMPORTANT! *The Lab Tracking Rule module CANNOT be used to create new rules.*

Rule Tab

On the **Rule** tab, there is a **Reset Lab Tracking** button. This button will set all labs to a status of NOT being tracked and will also delete any automated Overdue Lab TaskMan messages that were sent notify users of overdue labs. This feature allows users to reset the system to start lab tracking over. It is especially useful in cases where Lab Tracking is not turned on immediately after the Chart product is installed. In those cases a large number of Overdue lab messages can accumulate.

Info Tab

The **Info** tab displays a brief explanation of what the rule type is intended to do.

Creating a Patient-Specific Rule

Rules that are shipped with e-MDs Chart are not patient specific and will return results for ALL patients that meet the criteria set out in the rule. However, existing rules can be edited or new rules can be created to be specific for an individual patient. Reasons for making rules specific to individual patients include situations where patients with certain conditions require monitoring more frequently than patients without that condition. For example a patient that has had colon cancer may require a colonoscopy more frequently than patients without that diagnosis.

WARNING: When editing existing rules to make them patient specific, ALWAYS COPY the existing rule first. Making a change to an existing rule to make it patient specific will invalidate that rule for all other patients because the rule now will only be run for the specified patient.

To edit an existing rule to make it specific to an individual patient:

1. Open the Rule Manager.
2. Click **Start** > **Programs** > **e-MDs**. Select the **Rule Manager** menu item. Log in using the same user name and password used for e-MDs Chart.
3. With the Rule Manager module open, click any rule to select it and then click the **Rule** menu item and select **Copy Rule** from the popup menu or click the **Copy Rule** button on the toolbar.
4. Click **Yes** in the confirmation window.

   The **Edit Rule** window will open with all of the fields filled out with the values from the rule being copied. The Result Description name will be changed to "copy of" in front of the old rule name.
5. Make changes to the **Rule Name** and **Result Description** fields to reflect that this is rule will now be a patient specific one.
6. Make any other necessary changes to the other parameter. For example, make changes to the Frequency field to reflect that this patient requires monitoring more frequently than other patients.
7. *OPTIONAL:* In the **Run rule on this patient only** field, click the **Patient** button to open the Find Patient window.
8. In the Find Patient window, type all or part of the patient's last name in the **Name** field and click the **Search** button.
9. Highlight the desired patient's name from the search results and click the **Select** button.

   The Find Patient window will close and the program will return to the Edit Rule window with the selected patient's name filled out in the OPTIONAL field.
10. Click the **Save** button to save any changes.

To create a new rule for a specific patient:

1. Open the Rule Manager.
2. Click **Start** > **Programs** > **e-MDs**. Select the **Rule Manager** menu item. Log in using the same user name and password used for e-MDs Chart.

   After the Rule Manager window is open, a list of available Rules will be listed in the left windowpane.
3. Click **New Rule** on the main Rule Manager toolbar.

   A Select Rule module window will open. The window will open with all available rule modules listed.
4. Type part of the name of the rule module in the **Name** field and then click the **Search** icon (the magnifying glass) to find a specific rule module or click **Search** without typing any criteria into the Name field to display all available modules.
5. Highlight the appropriate rule module and click **Select** or double click to open the New Rule window.

   The **New Rule** window will open.
6. Fill out the Rule Name and other fields as appropriate (see "Create a New Rule" for details).
7. *OPTIONAL:* In the **Run rule on this patient only** field, click the **Patient** button to open the Find Patient window.
8. In the Find Patient window, type all or part of the patient's last name in the **Name** field and click the **Search** button.
9. Highlight the desired patient's name from the search results and click the **Select** button.

The Find Patient window will close and the program will return to the Edit Rule window with the selected patient's name filled out in the OPTIONAL field.

10. Click the **Save** button to save any changes.

Copying, Editing and Deleting a Rule

The Rule Manager module includes the capability to copy an existing rule. This simplifies the process of creating new rules from existing rules that have similar functionality.

To copy a rule:

1. Open the Rule Manager.
2. Click **Start** > **Programs** > **e-MDs**. Select the **Rule Manager** menu item. Log in using the same user name and password used for e-MDs Chart.
3. With the Rule Manager module open, click any rule to select it and then click the **Rule** menu item and select Copy Rule from the popup menu, or click Copy Rule button on toolbar.
4. Click **Yes** in the confirmation window.
5. The **Edit Rule** window will open with all of the fields filled out with the values from the rule being copied.
6. The Result Description name will be changed to "copy of" in front of the old rule name.
7. Make necessary changes to any of the fields.
8. Click the **Save** button to save any changes.

   Note: Before converting an existing rule to a patient specific rule *ALWAYS COPY AND RENAME THE EXISTING RULE FIRST*. Otherwise the original rule will no longer be valid for *ALL* patients.

To edit a rule:

1. Open the Rule Manager.
2. Click **Start** > **Programs** > **e-MDs**. Select the **Rule Manager** menu item. Log in using the same user name and password used for e-MDs Chart.
3. With the Rule Manager module open, click any rule to select it and then click the **Edit** button on the main Rule Manager toolbar.

   The **Edit Rule** window will open.
4. Make necessary changes to any of the fields.
5. Click the **Save** button to save any changes.

To delete a rule:

1. Open the Rule Manager.
2. Go to **Start** > **Programs** > **e-MDs** > **Rule Manager**.
3. Log in using the same user name and password used for e-MDs Chart.
4. With the Rule Manager module open, click any rule to select it and then click the **Delete** button on the main Rule Manager toolbar.
5. At the confirmation window, click **Yes**.

WARNING: *DO NOT DELETE THE LAB TRACKING RULE.* See the "Lab Tracking Rule" section for instructions on turning off Lab Tracking.

Making a Rule Specialty-Specific

Rules can be made specialty specific so that only providers (and other clinical staff) that are associated with the linked specialty will see the reminders generated by that rule.

To make a rule specialty-specific:

1. Create a new rule or edit an existing rule that you want to make specialty specific.
2. In the Edit Rule maintenance form for that rule, click the **Specialty** tab.

   If there are specialties already associated with the rule they will be listed in the **Linked Specialties** pane.
3. To add a specialty, click the **Specialty** button on the toolbar.

   The Select Specialty window will open.
4. In the **Subset** field, pick a subset of specialties.

   Note: This field groups specialties together to make it easier to add multiple specialties to a rule. For example a subset called Primary Care can contain Pediatrics, Family Practice and Internal Medicine specialties.
5. The list of specialties associated with the selected subset will appear in the left pane.

   Note: If no subsets appear or if you want to add new subsets, see To Create/Edit a Specialty Subset.
6. Select the desired specialty by clicking it. Select multiple specialties by clicking each one while holding down the **Control** key.
7. After all the specialties are highlighted, click the **Add** arrow to add them to the **Linked Rule Specialties** pane on the right.
8. Once all changes are made, click the **Exit** button to return to the **Specialty** tab of the Edit Rule screen.

   Note: There is no **Save** button so changes are saved automatically.

To create/edit a specialty subset:

1. In the Edit Rule maintenance form for the selected rule, click the **Specialty** tab.
2. Click the **Specialty** button on the toolbar.

   The Select Specialty window will open.
3. Click the **Subset** button on the toolbar.

   The Specialty Subset maintenance window will open.
4. To create a new subset, click the plus icon (+) and enter a subset name into the next screen.

   The new subset name will show up in the **Subset** pane at the top-left of the screen.
5. Highlight the appropriate specialties from the **Specialties** list at the bottom right and click the **Add** arrow to add them to the **Specialty Subset** pane at the right.
6. To edit a subset, highlight the subset in the **Subset** pane and then add or remove specialties by using the **Add** and **Delete** arrows.

7. After all changes are made, click the **Exit** button to return to the Select Specialty maintenance screen.

   Note: There is no Save button; changes are saved automatically.

8. The new (or edited) subset will appear in the **Subset** drop-down list.

Setting Up the Rule Schedule

Rules can be run manually "on demand" through the Rule Manager module or automatically at pre-specified times by using the Windows Scheduler.

To run rules manually:

1. Open the Rule Manager. Click **Start** > **Programs** > **e-MDs**. Select the Rule Manager menu item. Log in using the same user name and password used for e-MDs Chart.
2. With the Rule Manager module open, click any rule to select it and then click the Run button on the main Rule Manager toolbar. Or, run all rules simultaneously by clicking the Run All button. Depending on the number of patient records, running all of the rules at once can take awhile and cause a slow down of the other programs running on the server. Ideally, these reports should not be run during business hours.

Rule Manager has a "silent mode" that allows the program to run automatically through the Microsoft Window's Scheduler. This silent mode allows the program to run on at a scheduled interval without user intervention. For Rule Manager to run in silent mode, setup information must be input in both Rule Manager and in the Windows Scheduler. This setup needs to be done on one computer on the network; setting the silent mode on more than one computer can cause the program to fail to run.

To run rules automatically:

1. On the computer where the Windows Scheduler will be running, log in to Rule Manager using the same user name and password used for e-MDs Chart.
2. To set up the Windows Scheduler, open the scheduler by going to **Start** > **Programs** > **Accessories** > **System Tools** > **Scheduled Tasks**.
3. In the Scheduled Tasks window, click the **Add Scheduled Task** button. This will open a Scheduled Task Wizard.
4. Click **Next** in the first window.
5. In the second window, browse to the folder where **Rule Manager** is stored and select it (by default, the program is stored in Program Files\e-MDs\Solution Series\Apps\). Select the Rule Manager file and click **Next**.
6. In the next screen, type in a name for the task to be scheduled (The task name can be the same as the program name), and select how often the task should be run. It is highly suggested that these rules be run daily. Then click **Next**.
7. In the next screen, pick the start time and the frequency with which the task should be run (ex. Everyday, Weekdays, or Every x days) and the date the task should start running. Keep in mind that in clinics with a large patent population, the rules may take as long as 2 to 3 hours to run. Because of the amount of "processing time" that the rules demand from the computer, it is best to schedule these tasks to be run at night or during other off hours. Since these times are also when most businesses run their database backups and because the backups also require a lot of processing time, it is necessary to separate the scheduled times of these tasks. For example if a typical database backup starts at 10pm and takes about 2 hours, it would be necessary to either start the rule task after midnight or sometime well before 10PM, depending on the amount of time the rules take to run.

8. The next screen prompts for a username and password. The task will run as if it were started by that user. This username and password is the same one that would be used to log into the Windows network-- not one that is used to log into e-MDs Chart or Rule Manager.
9. Click **Finish** at the next screen.
10. There is one more step to be done before the setup is complete. In the Scheduled Task window there will now be an icon representing the task that was just created. Double-click this icon to open the Properties window of the scheduled task.
11. In the Properties window there will be a field labeled **Run:** with the path to the Rule Manager file and another field below it labeled **Start in:** that also shows the path but without the executable listed. The following is an example of what the two fields MIGHT look like (depending on your setup):

    ```
    Run:      "C:\Program Files\e-MDs\Solution Series\Apps\RuleManager.exe"
    Start in: "C:\Program Files\e-MDs\Solution Series\Apps"
    ```

    Important! For the Rule Manager to run in silent mode, a space, forward slash, and the letter "s" (/s) must be added to the end of the Run: path. This needs to be added OUTSIDE of the quotation marks. The following is an example of what the complete path should look like (depending on your setup):

    ```
    Run: "C:\Program Files\e-MDs\Solution Series\Apps\RuleManager.exe" /s
    ```

12. After the **/s** is added, the properties window can be closed and the Scheduler will run the rules automatically according to the time and frequency that were set up. This properties window can also be used to change the time and frequency of the scheduled task at a later date if necessary.

Addressing Rule-Based Reminders

Rule-based reminders are displayed on the Reminders tab in the patient's chart and also in the Tracking Board.

You can address most clinical rule-based reminders in three ways:

- You can satisfy the rule by ordering the lab or test (CPT code) required by the rule.
- You can override the reminder (when the lab or test is refused, deferred or waived).
- You can take no action.

For detailed information about addressing these reminders, see the *Rule-Based Reminders (Automated)* section in chapter 3 of this user guide.

13

Putting It All Together with Patient Case Management

The patient case management system gives you the ability to link multiple visits together to achieve billing, clinical, and other efficiencies. Cases can be set up to include demographics for other responsible parties (guarantors, and insurances).You can also link multiple referrals/authorizations to a case and switch them as each terminates. The case can also be set up with various rules including required providers, specialties and locations. You can also link policies with their associated requirements to a case so that staff can follow designated protocols to ensure appropriate standards of care, take care of paperwork and other requirements, and expedite billing. Appointments, chart notes and invoices for each encounter related to a case as well as any DocMan scans/forms are also available from within a single interactive window as well as a report. This ability to access all information without having to bounce around to different modules is extremely efficient.

Continued on the next page ...

Understanding Case Management

Some examples of the use of the case management system include:

- **Cross Billing**: The demographics elements that you can set up for a case will override the patient's defaults when invoices are generated. This makes it a useful tool for cross billing scenarios like workers comp (WC or WMC), motor vehicle accident (MVA), personal injury (PI) litigation or other scenarios. Defaults set up in a case override normal patient defaults. These include:
    - **Injury/Illness Date:** You do not have to look this up for each encounter.
    - **Guarantor and Insurance:** You do not have to switch this each time you generate an encounter for the case, and then back again for other encounter types.
    - **Referrals/Authorizations:** Can also be case based and override other patient defaults.
    - **Copay, Patient %:** This overrides the defaults from the insurance.
    - **Financial Group:** Depending on claims filing and reporting requirements, you may need a special financial group on an invoice.
    - **Clinical case grouping:** If you want to link visits of a particular type together so you have another dimension to track and view the case history. An example is for clinical research patients (drug trials) who may be receiving other medical care at your office. The multiple referral capability of a the case system also lends it to normal treatments where there may be multiple authorizations required for each visit (e.g. B12 shots).
- **Ensuring policy requirements are met:** If you have demanding administrative and clinical requirements associated with certain visit types, the requirements for the policy are tracked and will notify users when they have not been met. Requirements can be simple prompts, or can be forms based where a scan or Word Form must be linked to the requirement and saved in DocMan.

The case management system is accessible from many places in e-MDs Solution Series:

- **Schedule:** The current patient case for the encounter can be seen in the Edit Appointment window. You can also access the full case management system to view details for the patient or set up additional cases from this window, the Check In module and the Tools menu. Any case alerts are also presented when scheduling. These may be in the CPT/HCPCS alert window, or a case specific alert.
- **Chart:** All notes that were done for a specific case can be viewed together in the Cases tab under Chart View.
- **Bill:** The current case is seen when generating an invoice. As with appointments, you can access all cases from this field and case based alerts may appear when starting or saving the invoice. Cases are also available under the Tools menu.
- **Demographics:** This Misc. tab in the patient's demographics gives access to the complete case management system. This technically means you can review case information from anywhere that you can access a patient.
- **DocMan:** Although there is no direct link to cases in DocMan other than from the patient demographics, form or scan case requirements are added to the ABN/Forms Manager work list.

Linking Encounter Data and Satisfying Requirements

The case management system can link all information related to a case together so that you can review it all from one screen. Depending on where and how the data is entered, there are a few ways that it accomplishes this:

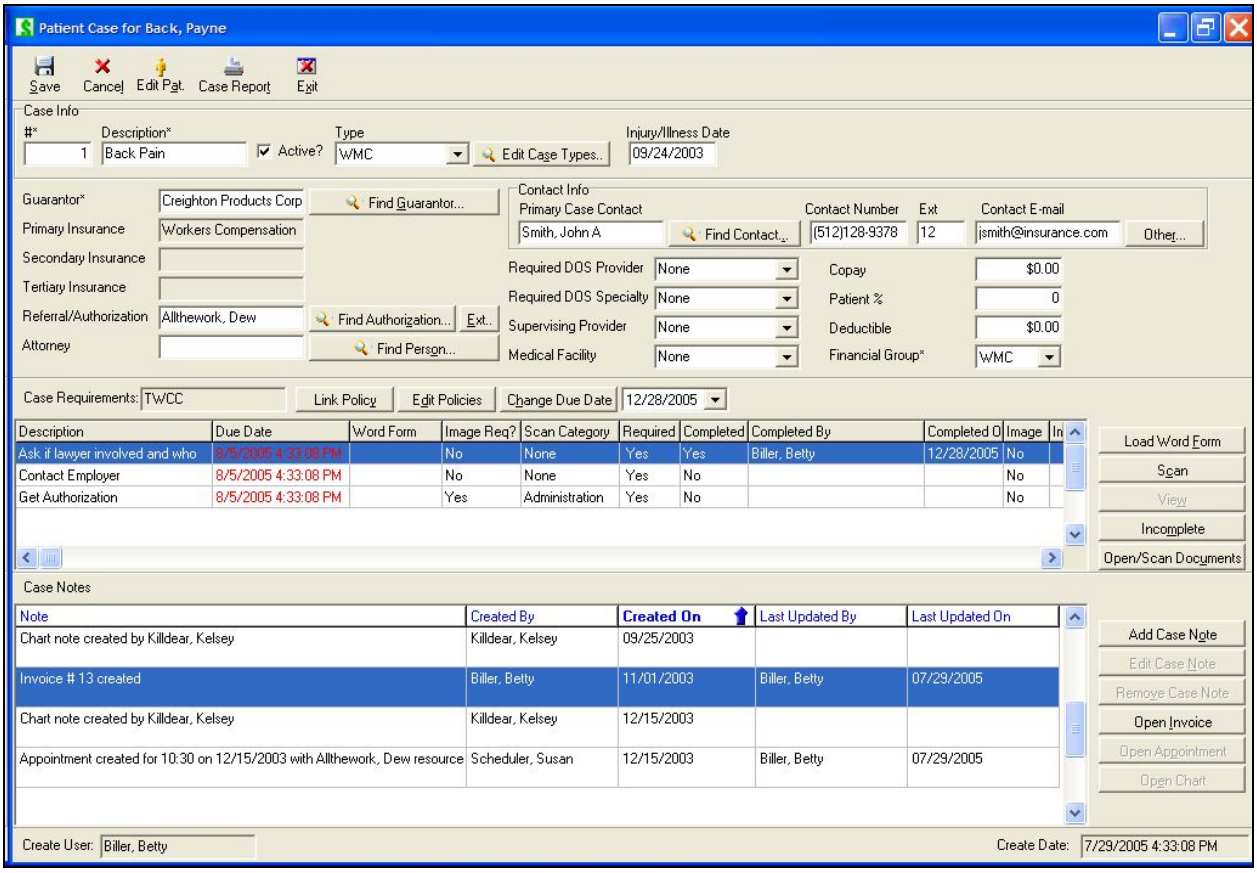
- **Appointments and Chart Notes:** An appointment has a field from which you can select the case for the encounter. When the appointment is saved the case ID is saved with it so this part is relatively simple. A chart progress note is linked to the case via the appointment. The Note Details window that is used to start a note and identify the provider also has a field to link an appointment. This is typically set automatically based on date and other parameters although you can change it. Thus, if you want to align cases to progress notes, you must create appointments in Schedule. Likewise, if you change the case for an appointment, you are also doing it for the linked chart note.
- **Invoices:** These also have a field that lets you select the case manually. However, if you build invoices from Chart or use the Daily Work List, the system automatically sets the case to one the one for the appointment.
- **Documents:** A case can have a number of requirements if you link it to a policy. When forms, scans or other files are linked to requirements that need these, they appear in the patient's DocMan folders in the specified category folders for those requirements. The case management window also gives you direct access to the forms via the requirements. You can fill out or print and scan forms from a case or from the ABN/Forms manager.

This appointment ID-based linking is important because of any requirements or other rules related to the case (including one that may be fee schedule based). By default, the system sets the case for a new appointment to the last active case used for the patient. When the case has requirements, they might be satisfied in Schedule, Chart or Bill, or using the ABN/Forms manager which is also available in DocMan. The common link means that users will not get prompted for rules and requirements when the flagged item has already been addressed.

Thus, if a scheduler or check in staff member managed to get a form filled out, the doctors and billers will not be prompted to get this information again. This obviously has significant ramifications for how you set up requirements and office work flow to accommodate the collection of information. In general, it is better to gather information in advance of a visit or at check. If clinicians are trying to get this information it is likely to take longer because they might not have access to the necessary forms, etc. Using physician time to take care of administrative tasks is also costly due to relative reimbursement rates. Likewise some requirements may require direct interaction with a patient (filling out a form, answering questions) so expecting a biller to do that makes that person's job much harder too and may delay claims processing.

Thus, having a good understanding of how the system tracks cases through an encounter and designing your policies, cases and workflow to optimize productivity and data collection is well worth the effort.

Patient Case Window



The Patient Case window is a single screen that gives you the ability to review and manage almost everything related to the case from one place.

Case Information Options	
#	The case number is set automatically by the system to the next case in the sequence for a patient, but you can overtype this with your own number. You can not duplicate an existing case number for a patient.
Description	This should tell you something about the case. For example: “Back Pain”, “Asthma Drug Trial.”
Active?	When the box is checked, the case is available on list boxes in appointments and invoices. Once a case is completed, this should be cleared so that it is not picked by mistake. By default, the system automatically links the last active case for the patient for new encounters.
Type	The type is an additional identifier which you can set up for reference and to classify a case. Examples are “WMC” or “WC” for workers comp, “MVA” for auto accident, “Research”, and so on. To set up your types, click the Edit Case Types button and add them in the editor that opens.
Injury/Illness Date	This is the first date for the case. This field is very important. It will save you from having to look up the injury date when billing because it sets this date in claims for the case.

General Information Options	
Guarantor & Insurance	For a new case these fields are defaulted to the patient's guarantor and insurance. If another party is responsible for the visits such as for workers comp or a third party auto accident, click Find Guarantor and select that person or organization. The insurances in the case are set to those for the guarantor. When a case is linked to an invoice, the guarantor and insurance override the patient defaults.
Referral/Authorization	You can link multiple referrals to a case. An example of this is where some insurances might authorize multiple encounters or procedures like B12 shots, but require a separate referral number to be sent on each claim for each one. The one used by default is the one in the Referral/Authorization. It overrides any other authorizations that the patient might have. See below for how to switch referrals for different encounters.
Attorney	If an attorney is involved in the case, link one here using the Find Person tool. This person is added as the Legal Referral in the claim prep for invoices generated under the case.
Required DOS Provider, Specialty, Supervising Provider and Medical Facility	If there are specific treating, supervising/billing physician, or location requirements on the case, select from the list. If users attempt to schedule appointments or generate claims for different providers, specialties or locations they will be warned about these requirements.
Copay, Patient %	These will override the defaults in the primary insurance on any claims generated under the case. This can save you from having to manually modify patient due responsibilities if they are not always the same.
Deductible	This is an information only field.
Financial Group	This will set the financial group for invoices under the case. Thus, it is extremely important that this is set correctly since many paper and electronic claims definitions are based on the financial group. It can also be used as a reports segregator.
Contact Info	You can set up one or more contacts on a case. These are used for both look up/reference purposes for your staff as well as by the case report faxing system. All contacts that have a work fax can be faxed with one click. Examples of case contacts are a claims adjuster or nurse manager.
Primary Case Contact	This is the person you will most frequently speak with about the case.
Other	A window where you can add and view a list of other contacts and their description can be accessed via this button.
Case Policy Requirements	A case can be linked to a policy which has one or more requirements.
Requirements	The requirements are listed in the middle section of the window. The list shows the requirement itself along with a due date, form or image scan requirements with the scan category; whether it is required (mandatory) or not; if it has been completed and by whom and when; and also the actual name of the image linked to the requirement.
Due Date	Each policy requirement can have a due date. This is set in the case by adding the number of days in the requirement master file to the date that the case is created. When the current date/time is after the Due Date, it is displayed in red. You can change the due date details for a specific requirement by selecting it, setting the date above the list and clicking Change Due Date.
Scanning/Forms Functions	If a requirement requires a Word Form or other image scan/file import, you can do this from within the case management window using the Load Word Form, Scan and View buttons.
Complete/Incomplete Requirements	When a requirement is satisfied, you can select it and click the Complete button at right. This changes the Completed setting to Yes and also adds the user name and date/time. The Complete button changes to Incomplete if a completed requirement is selected so you can reverse the status and clear this information.
DocMan Access	The Open/Scan Documents button opens the patient's complete document folders in DocMan if you have licensed this module.

Case Notes	The case notes section of the patient case window is where you can view appointments, chart notes and invoices that are linked to the case. These include the user who created or last updated the record and the activity date so you can sort by user, type, or chronologically. You can also create manual case notes. The list can be sorted ascending or descending by clicking any of the column headings.
Appointments	The note shows that made the appointment and the resource. For example: "Appointment created for 09:30am on 12/31/2005 for Smith, John resource." To open the actual Edit Appointment Detail window, click Open Appointment.
Chart Notes	Note shows the doctor. For example: "Chart note created by Smith, John." To open the patient chart with this specific note selected in Chart View, click Open Chart.
Invoices	Note shows the invoice number. For example: "Invoice #1234 created." To open the invoice, click Open Invoice.

Notes:

- Manual notes to document other activity on the case are added by clicking the Add Case Note button to the right. The window that appears permits up to 5,000 characters of free text. The window is also spell check and macro enabled.
- Depending on your screen resolution and personal preferences, you can size the whole Patient Case window. You can also set the requirements and case notes section columns by dragging the vertical bars between each column. After setting your preferences, click the X at the top right of the window to save the preference.

Maintaining Cases

Cases can be added for a patient from any of the access points described above. You can also add and edit cases on the fly where needed. Copy functions that speed up the process are also available.

For specific descriptions of each field, see the "Patient Case Window" section above.

To add or edit a case:

1. Go to **Tools** > **Patient Case Management**.
2. Search for and select the patient.
3. Click **New** in the Case Search window. If you are editing a case, select it from the list and click **Edit**.
4. Fill out the **Case Info**, **Guarantor** and **Insurance** fields.
5. Add any Referral/Authorization information necessary for the case by clicking the **Find Authorization** button and then adding and selecting a referral from the main authorizations window. Additional authorizations for the case are added using the **Ext** button and adding them to this list.
6. Add an attorney, if needed (for example, in personal injury cases).
7. Add case contact information. The primary contact is added by clicking **Find Contact** and selecting the person from the person search. The person's work phone and email are shown on screen.
8. To add additional contacts:
    a. Click the **Other** button.
    b. In the Contacts Manager window, click **New**.

c. Select **Find Person** and search. A description such as “Benefits Adjuster” can be added for each contact. If you think you are going to fax a case report to contacts, make sure they have an Office Fax in their files.

d. Add **Required DOS Provider**, **Specialty**, **Supervisor** or **Medical Facility** field values, if necessary, by selecting from the list boxes. Users are warned if they schedule or bill for invalid entries.

9. Add **Copay** and **Patient %** field values. These override the primary insurance on invoices.
10. Add a deductible amount if required. *This is for information only.*
11. Set a financial group that will be used on claims.
12. If you need to link a policy to the case, click **Link Policy** and select the appropriate one. Any requirements for the policy are listed in the middle of the screen. The due dates for each are set based on their default Days Due property from the current date. You can change this for a specific requirement by selecting it, setting the due date and clicking **Change Due Date**.
13. Click **Save**.

Copying Cases

The copy functions are very useful for adding new cases that are very similar to other ones. You can copy a case for the same patient, and from one patient to another. Examples of the usefulness of copying are treating patients for WC injuries where the employer is the same, or multiple patients for the same clinical trial.

The following elements of the case are copied:

- Description
- Injury/Illness date
- Guarantor and insurance
- Primary referral
- Lawyer
- Contacts
- Required providers and facility
- Copay, patient %, deductible and financial group

There are three ways you can copy:

- *To copy to same patient,* go to **Tools** > **Patient Case Management**, search for patient, select case and click Copy.
- *To copy to another patient,* go to **Tools** > **Patient Case Management**, search for patient who has case, click Copy To, search for other patient and select who needs the case.
- *To copy from another patient,* go to **Tools** > **Patient Case Management**, search for patient who needs the case setup, click Copy from, search for and select patient who has the case.

Reviewing Cases

There are multiple ways that you can review patient cases. These range from simply reviewing a list of cases for a patient to a complete detail with total access to all case related data. Bear in mind that you can access a patient’s cases from demographics (Misc. tab), the Tools menu in Bill & Schedule, appointments, invoices, and also Chart View. You can also open them from the CPT/HCPCS Alert warning window.

- **Simple list of cases for patient:** This uses the Case Search window for a patient. Go to **Tools** > **Patient Case Management**. You can filter the search by create date range, active or active and inactive cases, and description. The list includes the case #, description, create date, create user, active status and number of appointments and invoices on the case. Of course you can open each case in edit mode to see the detail.
- **Case Detail:** As described previously, the Patient Case window provides a complete detail of all case setup data as well as links to forms, scans, appointments, chart note and invoices generated under the case.
- **Chart View:** The **Cases** tab in Chart view groups displays progress notes by specific case. Each case has a gold "book" in the tree with the case description. Expanding the tree shows the progress notes, diagnoses, orders, etc. It's similar to the Visit Notes or Chronology views but you do not have to wade your way through any other data in the tree which is not pertinent to the case.

Receiving Case Alerts

If a patient has a case where certain requirements are not met, or other parameters or not met, users will get warnings at different places to let them know. Keep in mind that if a patient has multiple cases, the last one used is retrieved by the system.

- **Referral Warnings:** If the referral on the case has expired an alert appears when scheduling and appointment or saving an invoice. You can change the case from here too. Per an example described previously, it is possible to have multiple referrals on a case which need to be switched for each appointment. Because each referral is set up with a specific date or visit count parameter, the warning appears and lets you know that you need to set the correct one. You can do this by opening the case, then click the Ext button for the case Referral field and selecting the next one.
- **CPT/HCPCS Alert:** This appears when saving an appointment or invoice for the patient, or when an order is made in Chart where the P button (for Plan) gets a red border and/or the specific ICD or CPT entered is displayed with a yellow triangular icon. You can click the icon or the plan menu Process Alerts option. Any case alerts are displayed in the Case Match section. You can switch cases using the View Case button at the bottom of the alert window. The same window also shows and policy requirements. You can deal with these by opening the case from here.
- **Invoice Case Warning:** This may appear when you start a new invoice. It is a simple prompt that lists the problem. For example it may show that the referral is not set up correctly. You can continue, cancel or view and edit the case information from this prompt.

Generating Case Reports

There are two reports that can currently be used to show a case history for a patient:

- **Patient Case Report:** This report includes all the details of the case as well as case requirements and case notes. If the case notes include invoices, details such as ICD and CPT codes are shown. The report can be printed and also faxed automatically to all the contacts on a case. See the reports section.
- **Statement:** A statement for a patient can be filtered for a specific case. This is a good way to present billing only data for a case.

14

Doctor's Office Quality – Information Technology (DOQ-IT)

DOQ-IT stands for Doctor's Office Quality Information Technology and it is a project that is designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of Electronic Health Record (EHR) systems and information technology (IT) in small-to-medium sized primary care physician offices. This adoption push is part of a vision of enhancing access to patient information, decision support, and reference data, as well as improving patient-clinician communications.

The DOQ-IT project offers an integrated approach to improving care for Medicare beneficiaries in the areas of diabetes, heart failure, coronary artery disease, hypertension, and preventive care and is intended to educate physician offices on EHR system solutions and alternatives, as well as to provide implementation and quality improvement assistance. Quality measures developed in this project will be reported by participating practices to the Quality Improvement Organization (QIO) Clinical Warehouse. The QIO Clinical Warehouse will receive, review and validate electronically transmitted information regarding practitioner performance and identify opportunities for improvement.

This is a pilot project that promotes Pay for Performance (P4P) as a result of providing quality care to patients with the above specified diseases. In anticipation of widespread adoption of this type of program, e-MDs has developed the DOQ-IT module to help users track quality measurements.

You *must* register with your local QIO in order to participate in DOQ-IT. Once you are registered you will be given instructions on how to submit the reports generated by e-MDs DOQ-IT module. e-MDs is not responsible for the mechanism that is used to submit reports.

For more information you can visit the following web sites:
www.qualitynet.org
http://www.lumetra.com/doq-it/index.asp

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Tracking Patients and Quality Measurements

- Identifies patients meeting quality topic measurement criteria (HF, CAD, DM, HTN, PC,)
- Generates:
  - A file for upload to the QIO Clinical Warehouse
  - Internal pdf reports for topic compliance
- Tools for follow up include:
  - An interactive patient recall list
  - Ability to open a chart to document follow-up interaction
  - Ability to make appointment
  - Access to demographics
  - Access to forms/letters
- **Report Manager DOQ-IT Functionality:** The report manager tool is now accessible from the Schedule Reports menu and can be used to schedule DOQ-IT reports.

Configuring DOQ-IT

To register a facility:

1. Click the Configure button on the DOQ-IT toolbar.
2. Click the Change Facility button on the DOQ-IT Facility Registration window.
3. Search for and select the desired medical facility.
4. Select the quality measures the facility is registering for (at least one is required to register a facility).
5. In the Enrollment Information section enter a start date and stop date (Start Date defaults to today's date and the End Date defaults to indefinite).
6. Enter the facility group NPI in the Primary Clinic NPI field.
7. Click the **Search** icon (magnifying glass) in the DOQ-IT Admin field.
8. Search for and select a person to be the DOQ-IT administrator.
9. If desired, select a default output folder in the Configuration Options section.
10. Click Save to register the facility.

To change a facility:

1. Click the Configure button on the DOQ-IT toolbar.
2. Click the Change Facility button on the DOQ-IT Facility Registration window.
3. Search for and select the desired medical facility.

Creating a File

To create a file for a single patient:

1. Click the Create File button on the DOQ-IT toolbar.
2. To change Register facilities, you must go to the Configure screen.
3. In the Date Range section select a begin date and an end date.
4. Click the **Single Patient** check box.
5. Enter the name of an eligible patient (last name, first name format) and press the Enter key.
6. Select the patient in the Find Patient window.
7. Select a file location in the File Directory field (if this was not already set on the Configure screen).
8. Enter a file name in the File Name field (i.e. Jan2008).
9. Click the Go button to generate the DOQ-IT HL7 file.
10. Go to the file directory location to open the file.
11. The HL7 File is now ready to be uploaded to the QIO Warehouse via QualityNet.

To create a file for all eligible patients:

1. Click the Create File button on the DOQ-IT toolbar.
2. To change Register facilities, you must go to the Configure screen.
3. In the Date Range section select a begin date and an end date.
4. Select a file location in the File Directory field (if this was not already set on the Configure screen).
5. Enter a file name in the File Name field (i.e. Jan2008).
6. Click the Go button to generate the DOQ-IT HL7 file for all eligible patients in the system.
7. Go to the file directory location to open the file.
8. The HL7 File is now ready to be uploaded to the QIO Warehouse via QualityNet.

Creating a Report

To create a report for a single patient:

1. Click the Create Report button on the DOQ-IT toolbar.
2. To change Register facilities, you must go to the Configure screen.
3. In the Date Range section select a begin date and an end date.
4. Click the **Single Patient** check box.
5. Enter the name of an eligible patient (last name, first name format) and press the Enter key.
6. Select the patient in the Find Patient window.
7. In the Quality Topics section, select the quality topics to be reported (Notice that you only have access to those Quality Topics registered on the Configuration screen).
8. Select the Report Options to appear on the report.
9. Select a file location in the File Directory field (if this was not already set on the Configure screen).

10. Enter a file name in the File Name field.
11. Click the “Show file after creation” check box.
12. Click the Go button to generate the DOQ-IT report.
13. The report automatically displays on the screen.

To create a report for all eligible patients:

1. Click the Create Report button on the DOQ-IT toolbar.
2. To change Register facilities, you must go to the Configure screen.
3. In the Date Range section select a begin date and an end date.
4. In the Quality Topics section, select the quality topics to be reported (Notice that you only have access to those Quality Topics registered on the Configuration screen).
5. Select the Report Options to appear on the report.
6. Select a file location in the File Directory field (if this was not already set on the Configure screen).
7. Enter a file name in the File Name field.
8. Select the “Show file after creation” check box.
9. Click the Go button to generate the DOQ-IT report.
10. The report automatically displays on the screen.

Using the Patient Browser

To specify a registered facility:

- This is the registered facility set in the Configure screen of e-MDs DOQ-IT.
- To change facilities go to the Configure screen.

Searching for a Single Patient

To search for a single patient:

1. To load demographic and DOQ-IT data for a single patient, click the check box next to the **Single Patient** field.
2. Click the **Search** button in the **Single Patient** field.
3. Search for the patient in the Find Chart Patient field.
4. Highlight the desired patient and click the Select icon on the toolbar.
5. The patient’s demographic data and exclusion/inclusion status appear near the center of the screen.
6. To see the patient’s DOQ-IT eligibility and compliance information click the Refresh button on the toolbar.

   Note: This only includes data added to the database prior to midnight of the current date.

To set exclusions:

1. To load demographic and DOQ-IT data for a single patient, click the check box next to the Single Patient field.
2. Click the Search icon in the Single Patient field.
3. Search for the patient in the Find Chart Patient field.
4. Highlight the desired patient and click the Select icon on the toolbar.
5. Click the Excluded check box in the patient demographics section.
6. Choose an exclusion reason or type one into the provided field and click OK.
7. This patient's data will now be excluded from the DOQ-IT program.

Searching for Multiple Patients

To filter by name:

1. Click the **Filter Patient Name** check box.
2. Enter the last name of patients to be searched for.
3. Set the DOQ-IT Inclusion/Exclusion Status.
4. Set the Eligibility/Compliance Status.
5. In the Topic Measures section, select either "Any" or "All." If the option, "Any" is selected, then the system will return patients who have any matches to the topic measures selected. If "All" is chosen then the patient's data has to match every selected topic measure.
6. Select desired topic measures to search by.
7. Click the Retrieve icon on the toolbar.

To filter all patients:

1. Set the DOQ-IT Inclusion/Exclusion Status.
2. Set the Eligibility/Compliance Status.
3. In the Topic Measures section select either "Any" or "All." If the option, "Any" is selected, then the system will return patients who have any matches to the topic measures selected. If "All" is chosen then the patient's data has to match every selected topic measure.
4. Select desired topic measures to search by.
5. Click the Retrieve icon on the toolbar.

Toolbar Functions

Click the **Single Patient** check box. Search for and select a patient. The toolbar functions are listed below.

Toolbar Items	
Edit	The patient's demographic file appears and allows for edits to the information.
Chart	Opens the patient's chart.
Schedule	Opens schedule so that an appointment can be scheduled.
Forms	Loads the Select Form/Letter window so that the user can print patient specific word forms.
Legend	Legend that shows what the icons used in the Status/Measures section correspond to on the Patient Browser.

Appendix A
Clinical Reference Libraries

Searching for Codes

Locations of the ICD-9 Search

The ICD-9 Search can be found in several locations:

In References:

Click **Reference** on the main e-MDs Chart toolbar, and select the **ICD Search** menu option.

In the Current Problems section of a patient's Health Summary:

Click **New** to launch the search.

In the HPI and Assessment sections of a Visit or Order Note:

Click **New** to launch the search in either area.

Searching for an ICD-9 Code

Find an ICD-9 Code by searching the ICD Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the ICD-9 Search toolbar to display the entire ICD-9 database in outline form. The first level of the outline lists general categories (for example, Infectious and Parasitic Diseases, ICD code range 001-139).
2. Click the plus sign next to any category to further expand the tree, displaying the subcategories (for example, Intestinal Infectious Diseases, ICD code range 001-009).
3. Continue clicking the plus signs to drill down to individual codes.
4. At the level of an individual ICD code, click the plus sign to expand the tree and reveal two additional nodes, labeled **Alternate Descriptions** and **Search Keywords**. Alternate Descriptions lists synonyms for the selected diagnosis. Search Keywords shows words that are linked to this diagnosis, which, when typed into the search field, will return this ICD code in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the Full toolbar button) or only the pre-defined list of favorite codes (by clicking Short).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*.

   OR

Choose to search by actual ICD number. Mark your preference by clicking one of the four buttons in the second horizontal toolbar, located after the words **Search By**.

3. Type your search criteria into the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official description of each code in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Many abbreviations have been added to the keyword list (i.e. "ARF" for Acute Renal Failure).
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word. If more than one word is entered, separate each with a space. For example, to search for "diabetes with renal complications", enter the search criteria "diab ren comp."
   - When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "ren comp diab" would return the same search results as "diab ren comp."
   - In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
   - To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from **And** to **Or**.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

Using the "Parent" Button

Highlight any item in an ICD-9 search result and click Parent to display the code that immediately precedes the selected code in the tree hierarchy. This is useful when a search returns an unspecified code (represented by a yellow icon), as this function will then display more specific, related codes that are more appropriate for billing purposes. For example, a search for "colon cancer" returns the four-digit, unspecified code 153.9: Malignant Neoplasm of the Colon" (among other items). Highlight this result and click Parent to display the three-digit parent ICD code, 153. Then click the plus sign next to this parent code to expand the tree and reveal all of the four-digit children codes, including the more specific, billable choices.

Eliminating Nonspecific and Unspecified Codes from Searches

Non-specified codes, represented by green icons, are used when the ICD database does not contain a specific code for the diagnosis in question. These codes are acceptable to most third-party payers, but medical documentation should accompany the claim. Unspecified codes, identified by yellow icons, should be avoided at all costs as many insurance companies automatically deny payment when the documentation is not more specific.

When ICD searches are performed, the results are returned along with the colored icons. To avoid reimbursement delays, avoid the use of codes with green or yellow icons whenever possible. To further ensure that these problematic codes are not used, click the green and yellow Exclude button on the toolbar. Then select either or both of the menu options, Other Specified Codes and Unspecified Codes. When selected, check marks will appear next to these options, and codes with those color icons will be excluded from the search results.

Searching Current or Previous Year's ICD Codes

Each ICD code is identified by the date that it was added to the database. Searches automatically default to searching the database for current codes. To view codes that were valid in a previous year, click the button labeled View, and then select the Previous Codes option. A check mark will appear next to the option once it has been selected. This is a valuable tool when resubmitting claims from a previous year, and for use during the first quarter of the year, when some carriers recognize new codes while other payers have not yet converted from the old ones.

Identifying Billing Status by Color Coded Icons

Whether searching by Outline or by Keyword, individual ICD codes are displayed with color-coded icons. To review the meaning of these colors, click the toolbar button labeled Legend.

Button Legend	
White	The white icon signifies billable codes.
Red	Red identifies non-billable, three or four-digit codes that must be further specified by a fourth or fifth digit, respectively. Payers uniformly reject these codes. Click the plus sign next to any red code to expand the tree and display the more specific four and five-digit code choices.
Green	Non-specified codes, represented by green icons, are used when the ICD database does not contain a specific code for the diagnosis in question. For example, expand the three-digit ICD code 250: Diabetes. Specific four-digit codes identify various diabetic complications (for example, 250.1: Diabetes with Ketoacidosis). However, some fairly specific diagnoses (for example, Cardiovascular Complications of Diabetes) do not have a corresponding code. In this case, the most appropriate code is the non-specified code 250.8: Diabetes with Other Specified Manifestation. These codes are acceptable to most third-party payers, but medical documentation should accompany the claim.
Yellow	Unspecified codes, identified by yellow icons, should be avoided at all costs because many insurance companies automatically deny payment of CPT codes linked to these unspecified diagnoses. Typically, more specific codes exist in the same code family and should be used instead. For example, avoid the yellow code 461.0: Acute Sinusitis, Unspecified. Instead, choose a more specific, billable diagnosis, such as 461.0: Acute Maxillary Sinusitis.
Blue	Blue icons represent manifestation codes, which identify conditions caused by another disease. The causative disease must be coded along with the manifestation code. For example, the manifestation code 366.41: Diabetic Cataract must be accompanied by a code from the 250: Diabetes code family.

Viewing the Billing Details of an ICD-9 Code

Click the **Details** toolbar button to review detailed billing notes for each ICD code. Click the button a second time to close the Details window, if desired. The individual fields in the Details window are explained below.

Billing Details Options	
Display Description	In e-MDs Chart, this description appears in the Assessment section of a Visit or Order Note and in the Current Problem list. This field is non-editable for e-MDs-entered codes. This is a calculated description whose appearance depends on which of the display-building buttons (labeled Self, Parent, and Parent, Self) is selected. If Self is chosen, the display description will be the same as the official description that is entered in the ICD outline tree (see ICD code 001 for an example). If Parent is selected, that particular item will display the description of its parent code, which is the code immediately preceding in the tree hierarchy (see ICD code 001.9 for an example.) If Parent, Self is chosen, the description will be that of the parent code, followed by a comma, and then the official description (see ICD code 001.0 for an example.)

Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. This field is unalterable for e-MDs-entered codes. For user-entered codes, free-text descriptions up to 255 characters in length may be typed.
Billing Status	The colored-coded billing status of each ICD code is set in this window (see the Legend for an explanation of the colors.) These selections are unalterable for e-MDs-entered codes, but the window is active for user-entered codes.
Code Valid	This field indicates the date range in which each code is active. For example, if a new code is adopted on January 1st, 2001, that date will appear in the "From" field. When codes are discontinued, the discontinuation date (typically December 31st) will appear in the "Through" field. **Note:** You may notice that the "Through" date field is running date- i.e. always shows the current date. If a code has been discontinued, the "Through" check box will be checked, and the actual discontinuation date displayed.) These dates cannot be edited for e-MDs-entered codes, but the field is active for user-entered codes.
Billing Rules	This window, accessed by clicking the Billing Rules tab, displays helpful billing rules and tips. Many codes have official billing rules entered by e-MDs, although this section is editable by the user.
Includes	This window, opened by clicking the Includes tab, lists related diseases that are encompassed by the selected ICD code. Many codes have Includes text entered by e-MDs, although this section is editable by the user.
Excludes	This window, opened by clicking the Excludes tab, lists diseases that are similar to the selected code, but which have their own ICD codes. These diseases should not be billed with the selected code. In most cases, the appropriate ICD code follows the disease description in parentheses. Many codes have Excludes text entered by e-MDs, although this section is editable by the user.
Notes	This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected ICD code may be entered.

Adding an ICD-9 Code to Your "Short List"

Get quicker results and greater precision by searching only your pre-defined list of favorite codes, rather than the full database. (Perform this type of search by clicking Short on the toolbar.)

- To add an individual ICD code to your favorites list, simply click the check box located to the left of that code description in the tree.
- To remove an ICD code from your favorites list, clear the same box.

Adding an Alternate Description to an ICD-9 Code

Many ICD codes already have alternate descriptions listed. Click the plus sign next to an individual ICD code to expand the tree and reveal a node labeled Alternate Descriptions. Click the plus sign next to this node to view all synonyms currently linked to this ICD code. You may want to add more synonyms, such as commonly used descriptions in your individual practice, to assist the billing staff in correct coding.

To add a synonym:

1. Highlight and right-click **Alternate Descriptions**.
2. Select **Add an Alternate Description**.
3. In the pop-up window that appears, enter the description.
4. Press either the **Enter** or **Tab** key to save the synonym.

   Note: Remember to add keywords from your new description to the Search Keyword list, so that a search for your alternate description returns the correct ICD code. (See the "Add and Delete Search Keywords" section.)

To edit an Alternate Description:

1. Right click to select the alternate description.
2. Select **Edit Description**.
3. Make your changes as desired in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save the updated description.

To delete an Alternate Description:

1. Right click to select the alternate description.
2. Select **Delete Description**.

Adding a Search Keyword to an ICD-9 Code

Although keywords have already been linked to each ICD code, additional words may be added, if needed, to improve search results. Click the plus sign next to any ICD code to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this code.

To add a search keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter your keywords. To add more than one word, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the search keyword(s).

When linking the same set of keywords to multiple codes, simplify the task by creating a Keyword Copy List.

To create a keyword copy list:

1. Right-click any keyword and go to Keyword Copylist Operations > Add Selected Keyword(s) to List.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. Once a group of keywords is highlighted, right-click and select the **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Select the **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items** menu options.

When a new ICD code is added to the database, its description will automatically be parsed into the keyword list. However, if that description is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the description and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Right-click the keyword.
2. Select **Remove Keyword Link**.

Adding New ICD Categories

The ICD table is divided into categories and subcategories, each representing a range of related diagnosis codes. The category ranges created by e-MDs cannot be altered, but new categories can be added. The main ICD outline contains 19 pre-defined parent-level categories. Any new category that is added must fall within one of these parent ranges.

To add new ICD categories:

1. Select and right-click an existing code range.
2. Select **Add Category**.
3. In the pop-up Category Entry window that appears, enter the ICD code range in the **From** and **To** fields and enter a description for that category range.
4. Press either the **Enter** or **Tab** key to save the new categories.

Editing and Deleting ICD Categories

ICD categories created by e-MDs cannot be edited.

To edit either the numerical range or the description of a category created by the user:

1. Select and right-click the category.
2. Select **Edit Category**. This will open the Category Entry window.
3. Make the desired changes and press either the **Enter** or **Tab** key to save your changes..

ICD categories created by e-MDs cannot be deleted.

To delete a category created by the user:

1. Select and right-click the category.
2. Select **Delete Category**.

Adding New ICD Codes

The ICD database is divided into categories, each representing a range of related ICD codes. Each individual ICD falls within one of these categories. For example, the ICD code 008 falls within the pre-defined 001-009 range.

To add new ICD codes:

1. Find the appropriate category (or subcategory) range for the new ICD code.

   Note: If the ICD does not fit within a pre-defined category range, first create a new category.
2. Select and right-click the category.
3. Select **Add ICD**.
4. In the pop-up Add ICD window that appears, enter the ICD code and its description (limited to 100 characters).
5. Press either the **Enter** or **Tab** key to save the new codes

Editing and Deleting ICD Codes

ICD codes created by e-MDs cannot be edited (although Alternate Descriptions and Keywords can be added to those codes).

To edit a code created by the user:

1. Select and right-click the code.
2. Select **Edit ICD**.
3. Make the desired changes in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save your changes.

ICD codes created by e-MDs cannot be deleted.

To delete a code created by the user:

1. Select and right-click the code.
2. Select **Delete ICD**.

Entering the Billing Details of a New ICD Code

Enter the billing details of the new code in the Billing Details window. If this window is not visible, click Details on the toolbar. The various data fields in the Details window are described below.

Billing Details Options	
Display Description	In e-MDs Chart, a separate application, this description appears in the Assessment section of a Visit or Order Note, as well as in the Current Problem list. This is a calculated description whose appearance depends upon which of the display-building buttons (labeled Self, Parent, and Parent, Self) is selected. • *If **Self** is selected,* the display description will be the same as the official description entered in the ICD outline tree (see ICD code 001 for an example). • *If **Parent** is selected,* that particular item will display the description of its parent code, which is the code immediately preceding in the tree hierarchy (see ICD code 001.9 for an example). • *If **Parent**, **Self** is chosen,* the description will be that of the parent code, followed by a comma, and then by the official description (see ICD code 001.0 for an example.) Again, the Display Description is irrelevant in the independent e-MDs Search module.
Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. Free-text descriptions up to 255 characters in length may be typed.
Billing Status	Set the colored-coded billing status of the ICD code in this window (See the Legend for an explanation of the colors.)
Code Valid	Enter the date that this code became valid in the From field. If any code is later discontinued, enter the discontinuation date in the Through field. **Note:** You may notice that the "Through" date field is running date - i.e. always shows the current date. If a code has been discontinued, the "Through" check box will be checked, and the actual discontinuation date displayed.

Billing Rules	Enter helpful billing rules and tips in this window. There is no character limit to this field. If a four or five-digit code is added whose billing rules are the same as those of the parent code (i.e. the corresponding three or four-digit code immediately preceding this code in the tree hierarchy), these may be easily copied. Highlight the new ICD code and right-click. Select the **Inherit** > **Billing Rules** menu options. Another option is to highlight the parent ICD code, right-click, and select the **Cascade** > **Billing Rules** menu options. Be careful, though, as this will cascade the parent information to *all* children codes, not just to the newly entered code.
Includes	In this window, list related diseases that are encompassed by the selected ICD code. There is no character limit to this field. If a four or five-digit code is added whose Includes text is the same as those of the parent code (i.e. the corresponding three or four-digit code immediately preceding this code in the tree hierarchy), this may be easily copied. Highlight the new ICD code and right click. Go to the **Inherit** > **Includes** menu options. Another option is to highlight the parent ICD code, right-click and select **Cascade**, and then **Includes** options. Be careful, though, as this will cascade the parent information to *all* children codes, not just to the newly entered code.
Excludes	In this window, list diseases that are similar to the selected code, but which have their own ICD codes. It is helpful to include the appropriate ICD code in parentheses. There is no character limit to this field. If a four or five-digit code is added whose Excludes text is the same as those of the parent code (i.e. the corresponding three or four-digit code immediately preceding this code in the tree hierarchy), this may be easily copied. Highlight the new ICD code and right click. Select the **Inherit** > **Excludes** menu options. Another option is to highlight the parent ICD code, right click, and select the **Cascade** > **Excludes** menu options. Be careful, though, as this will cascade the parent information to all children codes, not just to the newly entered code.
Notes	This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected ICD code may be entered.

Searching for CPT Codes

The CPT Search functionality can be found in several locations:

In References:

Click **Reference** on the main e-MDs Chart toolbar, and select the **CPT Search** menu option.

In the Plan section of a Visit or Order Note, linked to a diagnosis:

1. Under a diagnosis header in Plan, click **Orders** to see a list of CPT codes linked to that diagnosis.
2. Click **Add CPT** to launch the full CPT Search.
3. Note that any CPT codes selected from this Search will automatically be linked to the selected diagnosis.

In the Plan section of a Visit or Order Note, unlinked to any diagnoses:

1. To launch the CPT Search without linking a CPT to an ICD code, click the **Other Orders** section of Plan.
2. Click **New** (CPT Search).

Find a CPT Code by searching the CPT Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire CPT database in outline form. The first level of the outline lists general categories (for example, Anesthesia: CPT code range 00100-01999).
2. Click the plus sign (**+**) next to any category to further expand the tree, displaying the subcategories (for example, Head: CPT code range 00100-00222).
3. Continue clicking the plus signs to drill down to individual codes.
4. At the level of an individual CPT code, click the plus sign to expand the tree and reveal two additional nodes, labeled Alternate Descriptions and Search Keywords. Alternate Descriptions lists synonyms for the selected code. Search Keywords lists words that are linked to this code, which, when typed into the search field, will return this CPT code in the search results.

To search by keyword:

1. Decide whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite codes (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Define whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. You can also choose to search by actual ICD number.

   Mark your preference by clicking one of the four buttons in the second horizontal toolbar, located after the words Search By.

3. Type your search criteria into the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official description of each code in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Many abbreviations have been added to the keyword list (i.e. "MRI" for "Magnetic Resonance Imaging").
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word.
   - If more than one word is entered, separate each with a space. For example, to search for "magnetic resonance imaging of the knee", enter the search criteria "mri knee."
   - When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "knee mri" would return the same search result as "mri knee."
   - In multiple-word searches, the default search mode returns only those results that contain *all* of the words. To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from And to Or.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

Searching Current or Previous Year's CPT Codes

Each CPT code is identified by the date that it was added to the database. Searches automatically default to searching the database for current codes.

To view codes that were valid in a previous year, click the button labeled **View**, and then select the **Previous Codes** option. A black check mark will appear next to this menu item once it has been selected. This is a valuable tool when resubmitting claims from a previous year, and for use during the first quarter of the year, when some carriers recognize new codes while other payers have not yet converted from the old ones.

Viewing the Billing Details of a CPT Code

Click the **Details** toolbar button to review detailed billing notes for each CPT code. Click the button a second time to close the Details window, if desired. The individual fields in the Details window are explained below.

Billing Details Options	
Kind of Service	Allows the CPT table to be subdivided by Labs, Tests, and Procedures. Has some bearing on which modifiers are attached to individual CPT codes.
In House	Identify individual CPT tests that are typically performed in-house (and, therefore, billed) by checking the In House box.
Type of Service	Type of Service is required when billing a CPT code. A default Type of Service has been chosen for each CPT, though users may click the small down arrow to reveal other choices and change this.
Place of Service	Place of Service is required when billing a CPT code. A default Place of Service has been chosen for ach CPT, though users may click the small down arrow to reveal other choices and change this.
Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. This field is unalterable for e-MDs-entered codes. For user-entered codes, free-text descriptions up to 255 characters in length may be typed.
Code Valid	This field indicates the date range in which each code is active. For example, if a new code is adopted on January 1st, 2001, that date will appear in the "From" field. When codes are discontinued, the discontinuation date (typically December 31st) will appear in the "Through" field. These dates cannot be edited for e-MDs-entered codes, but the field is active for user-entered codes. **Note:** You may notice that the "Through" date field is running date - i.e. always shows the current date. If a code has been discontinued, the "Through" check box will be checked, and the actual discontinuation date displayed.
Lab Tracking	This section has 2 fields. One field designates whether or not the item is tracked through the Lab Tracking module. The other field is used to indicate the number of days that the Lab Tracking module uses to determine whether an item is considered overdue.
Private/Cost/ABU	If desired, the private fee schedule, internal cost, and anesthesia billing unit for each CPT procedure may be entered into the appropriate fields.
Relative Value Unit	If desired, the determining factors for the Relative Value Unit (RVU) assigned to each CPT may be entered into the appropriate fields. The fields represent the total RVU, the Work portion, Practice Expense, and Malpractice Cost.
Categorical Modifiers	Modifiers that apply to the entire category in which a particular CPT falls can be listed in this field. Some modifiers have already been assigned, but the user can add additional modifiers.
Notes	This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected CPT code may be entered.

You can get quicker results and greater precision by searching only your pre-defined list of favorite codes, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

To add a CPT code to your "Short List":

- To add an individual CPT code to your favorites list, simply click the check box located to the left of that code description in the tree.
- To remove a CPT code from your favorites list, clear the same box.

Many CPT codes already have alternate descriptions listed.

To add an alternate description for a CPT code:

- Click the plus sign next to an individual CPT code to expand the tree and reveal a node labeled Alternate Descriptions.
- Click the plus sign next to this node to view all synonyms currently linked to this CPT code.

You may want to add more synonyms, such as commonly used descriptions in your individual practice, to assist the billing staff in correct coding.

To add a synonym:

1. Highlight and right-click **Alternate Descriptions**.
2. Select **Add an Alternate Description**.
3. In the pop-up window that appears, enter the description.
4. Press either the **Enter** or **Tab** key to save the new synonym.

Note: Remember to add keywords from your new description to the Search Keyword list, so that a search for your alternate description returns the correct CPT code. (See the “Add and Delete Search Keywords” section.)

To edit an alternate description:

1. Select and right-click the alternate description.
2. Select **Edit Description**.
3. Make changes as desired in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save your changes.

To delete an alternate description:

1. Select and right-click the description.
2. Select Delete Description.

Adding a Search Keyword to a CPT Code

Although keywords have already been linked to each CPT code, additional words may be added, if needed, to improve search results.

- Click the plus sign (+) next to any CPT code to expand the tree and reveal a node labeled Search Keywords.
- Click the plus sign (+) next to this node to display all words currently linked to this code.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.

3. In the pop-up window that appears, enter the keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the new keyword(s).

When linking the same set of keywords to multiple codes, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and go to **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. After a group of keywords is highlighted, right-click and go to **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Go to **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items**.

When a new CPT is added to the database, its description will automatically be parsed into the keyword list. However, if that description is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right clicking the description and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding and Deleting CPT Codes

Adding New CPT Categories

The CPT table is divided into categories and subcategories, each representing a range of related procedure codes. The category ranges created by e-MDs cannot be altered, but new categories may be added. The main CPT outline contains six pre-defined parent-level categories. Any new category that is added must fall within one of these parent ranges.

To add new CPT categories:

1. Select and right-click an existing code range.
2. Select **Add Sub Category**.
3. In the pop-up Category Entry window that appears, enter the CPT code range in the **From** and **To** fields and enter a description for that category range.
4. Press either the **Enter** or **Tab** key to save the new category.

Editing and Deleting CPT Categories

CPT categories created by e-MDs cannot be edited or deleted, but user-created categories can be.

To edit either the numerical range or the description of a category created by the user:

1. Select and right-click the category.
2. Select **Edit Category**. This will open the Category Entry window.
3. Make the desired changes and press either the **Enter** or **Tab** key to save your changes.

To delete a category created by the user:

1. Select and right-click the category.
2. Select **Delete Category**.

Adding New CPT Codes

The CPT database is divided into categories, each representing a range of related CPT codes. Each individual CPT falls within one of these categories. For example, the CPT code 00100 falls within the pre-defined 00100-00222 range.

To add new CPT codes:

1. Find the appropriate category (or subcategory) range for the new CPT code.

   Note: If the CPT does not fit within a pre-defined category range, first create a new category. See the "Add a New ICD Category" section.

2. Select and right-click the category.
3. Select **Add CPT**.
4. In the pop-up Add CPT window, enter the CPT code and its description (limited to 100 characters).
5. Press either the **Enter** or **Tab** key to save the new code.

Editing and Deleting CPT Codes

CPT codes created by e-MDs cannot be edited (although Alternate Descriptions and Keywords can be added to those codes), but user-created codes can be edited.

To edit a code created by the user:

1. Select and right-click the code.
2. Select **Edit a CPT**.
3. Make desired changes in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save the updated code.

CPT codes created by e-MDs cannot be deleted, but user-created codes can be deleted.

To delete a code created by the user:

1. Select and right-click the code.
2. Select **Delete CPT**.

Entering the Billing Details of a New CPT Code

Enter the billing details of the new CPT code in the Billing Details window. If this window is not visible, click Details on the toolbar. The various data fields in the Details window are described below.

Billing Details Options	
Kind of Service	Allows the CPT table to be subdivided by Labs, Tests, and Procedures. Has some bearing on which modifiers are attached to individual CPT codes.
In House	Identify individual CPT tests that are typically performed in-house (and, therefore, billed) by checking the In House box.
Type of Service	Type of Service is required when billing a CPT code. A default Type of Service has been chosen for each CPT, though users may click the small down arrow to reveal other choices and change this.
Place of Service	Place of Service is required when billing a CPT code. A default Place of Service has been chosen for ach CPT, though users may click the small down arrow to reveal other choices and change this.
Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. Free-text descriptions up to 255 characters in length may be typed.
Code Valid	Enter the date that this code became valid in the **From** field. If any code is later discontinued, enter the discontinuation date in the **Through** field. **Note:** The current date will always show in the **Through** field until a code has been discontinued.
Private/Cost/ABU	If desired, the private fee schedule, internal cost, and anesthesia billing unit for the CPT procedure may be entered into the appropriate fields.
Relative Value Unit	If desired, the determining factors for the Relative Value Unit (RVU) assigned to the CPT may be entered into the appropriate fields. The fields represent the total RVU, the Work portion, Practice Expense, and Malpractice Cost.
Categorical Modifiers	Modifiers that apply to the entire category in which a particular CPT falls can be listed in this field. Right click within the Categorical Modifiers field and select the Insert Modifier menu option. This will open a window listing all possible modifiers. Click the desired modifier; this will close the window and add that modifier to the CPT. Remember, this modifier will be added to every CPT code within that category. To remove a modifier, select it, right click, and choose the Remove Modifier menu option. This will remove that modifier from every CPT code within that category. **Note:** This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected CPT code may be entered.

Searching for HCPCS Codes

The HCPCS Search can be found in several locations:

In References:

Click **Reference** on the main e-MDs Chart toolbar, and select the **HCPCS Search** menu option.

In the Plan section of a Visit or Order Note, linked to an order (i.e. linked to a CPT code):

1. Click any particular order in Plan, and then select the **HCPCS** menu option. This will open a window displaying all HCPCS codes linked to that particular CPT code.
2. Click **Add HCPCS** to launch the HCPCS Search.

   Note: Any HCPCS codes selected in this Search will automatically be linked to that CPT code.

Find a HCPCS Code by searching the HCPCS Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire HCPCS database in outline form. The first level of the outline lists general categories (for example, Medical and Surgical Supplies: HCPCS code range A4000-A8999).
2. Click the plus sign next to any category to further expand the tree, displaying the subcategories (for example, Miscellaneous Supplies: HCPCS code range A4206-A4290).
3. Continue clicking the plus signs to drill down to individual codes.
4. At the level of an individual HCPCS code, click the plus sign to expand the tree and reveal two additional nodes, labeled **Alternate Descriptions** and **Search Keywords**. Alternate Descriptions list synonyms for the selected code.
5. Search Keywords lists words that are linked to this code, which, when typed into the search field, will return this HCPCS code in the search results.

To search by keyword:

1. Choose whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite codes (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Determine if the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*.

   You may also choose to search by actual ICD number. Mark your preference by clicking one of the four buttons in the second horizontal toolbar, located after the words **Search By**.

3. Type your search criteria in the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official description of each code in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Many abbreviations have been added to the keyword list (i.e. "MDI" for "Metered Dose Inhaler").
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word.
   - If more than one word is entered, separate each with a space. For example, to search for "spacer for metered dose inhaler", enter the search criteria "spacer mdi."
   - When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "mdi spacer" would return the same search result as "spacer mdi."
   - In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
   - To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from And to Or.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

Searching Current or Previous Year's HCPCS Codes

Each HCPCS code is identified by the date that it was added to the database. Searches automatically default to searching the database for current codes. To view codes that were valid in a previous year, click the button labeled View, and then select the Previous Codes option. A check mark will be displayed next to this option once it is selected. This is a valuable tool when resubmitting claims from a previous year, and for use during the first quarter of the year, when some carriers recognize new codes while other payers have not yet

Viewing the Billing Details of a HCPCS Code

Click the **Details** toolbar button to review detailed billing notes for each HCPCS code. Click the button a second time to close the Details window, if desired. The individual fields in the Details window are explained below.

Billing Details Options	
Type of Service	This option is required when billing a HCPCS code. A default Type of Service has been chosen for each HCPCS, though the user can click the small down arrow to reveal other choices and change this.
Place of Service	This option is required when billing a HCPCS code. A default Place of Service has been chosen for each HCPCS, though the user can click the small down arrow to reveal other choices and change this.
Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. This field is unalterable for e-MDs-entered codes. For user-entered codes, free-text descriptions up to 255 characters in length may be typed.
Code Valid	This field indicates the date range in which each code is active. For example, if a new code is adopted on January 1st, 2001, that date will appear in the "From" field. When codes are discontinued, the discontinuation date (typically December 31st) will appear in the "Through" field. These dates cannot be edited for e-MDs-entered codes, but the field is active for user-entered codes. **Note:** You may notice that the "Through" date field is running date (that is, it always shows the current date). If a code has been discontinued, the "Through" check box will be checked, and the actual discontinuation date displayed.
Private/Cost	If desired, the private fee schedule and internal cost of each HCPCS procedure may be entered into the appropriate fields.
Relative Value Unit	When applicable, the determining factors for the Relative Value Unit (RVU) assigned to a HCPCS code may be entered into the appropriate fields. The fields represent the total RVU, the Work portion, Practice Expense, and Malpractice Cost.
Categorical Modifiers	Modifiers that apply to the entire category in which a particular HCPCS code falls can be listed in this field. Some modifiers have already been assigned, but the user can add additional modifiers (see the "Enter the Billing Details of a New HCPCS Code" section). **Note:** This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected HCPCS code may be entered.

Adding a HCPCS Code to Your "Short List"

Get quicker results and greater precision by searching only your pre-defined list of favorite codes, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.) To add an individual HCPCS code to your favorites list, simply click the check box located to the left of the code description in the tree. To remove a HCPCS code from your favorites list, clear the same box.

Adding an Alternate Description to a HCPCS Code

Many HCPCS codes already have alternate descriptions listed. Click the plus sign next to an individual HCPCS code to expand the tree and reveal a node labeled Alternate Descriptions. Click the plus sign next to this node to view all synonyms currently linked to this HCPCS code. You may want to add more synonyms, such as commonly used descriptions in your individual practice, to assist the billing staff in correct coding.

To add a synonym:

1. Highlight and right-click **Alternate Descriptions**.
2. Select **Add an Alternate Description**.
3. In the pop-up window that appears, enter the description.
4. Press either the **Enter** or **Tab** key to save the new synonym.

   Note: Remember to add keywords from your new description to the Search Keyword list, so that a search for your alternate description returns the correct HCPCS code. (See the "Add and Delete Search Keywords" section.)

To edit an Alternate Description:

1. Select and right-click the alternate description.
2. Select **Edit Description**.
3. Make changes as desired in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save your changes.

To delete and Alternate Description:

1. Select and right-click the alternate description.
2. Select **Delete Description**.

Adding a Search Keyword to a HCPCS Code

Although keywords have already been linked to each HCPCS code, additional words may be added, if needed, to improve search results. Click the plus sign next to any HCPCS code to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this code.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter the keyword(s). If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the keyword.

When linking the same set of keywords to multiple codes, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and choose the Keyword Copylist Operations > Add Selected Keyword(s) to List.

2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.

3. After a group of keywords is highlighted, right-click and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Select the **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items** menu options.

When a new HCPCS code is added to the database, its description will automatically be parsed into the keyword list. However, if that description is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the description and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding, Editing and Deleting HCPCS Codes

Adding New HCPCS Categories

The HCPCS table is divided into categories and subcategories, each representing a range of related procedure or supply codes. The category ranges created by e-MDs cannot be altered, but new categories may be added. The main HCPCS outline contains 21 pre-defined parent-level categories. Any new category that is added must fall within one of these parent ranges.

To add new HCPCS categories:

1. Select and right-click an existing code range.
2. Select **Add Sub Category**.
3. In the pop-up Category Entry window, enter the HCPCS code range in the **From** and **To** fields and enter a description for that category range.
4. Press either the **Enter** or **Tab** key to save the new category.

Editing and Deleting HCPCS Categories

HCPCS categories created by e-MDs cannot be edited or deleted but user-created categories can be.

To edit the numerical range or the description of a category created by the user:

1. Select and right-click the category.
2. Select **Edit Category**. This will open the Category Entry window.
3. Make desired changes and press either the **Enter** or **Tab** key to save your changes.

To delete a category created by the user:

1. Select and right-click the category.
2. Select **Delete Category**.

Adding New HCPCS Codes

The HCPCS table is divided into categories, each representing a range of related HCPCS codes. Each individual HCPCS falls within one of these categories. For example, the HCPCS code A0021 falls within the pre-defined A0000-A0999 range.

To add new HCPCS codes:

1. Find the appropriate category (or subcategory) range for the new CPT code.
2. If your HCPCS does not fit within a pre-defined category range, first create a new category. See the "Add a New HCPCS Category" section.
3. Select and right-click the category.
4. Select **Add HCPCS**.
5. In the pop-up Add HCPCS window that appears, enter the HCPCS code and its description (limited to 100 characters).
6. Press either the **Enter** or **Tab** key to save the new code.

Editing and Deleting HCPCS Codes

HCPCS codes created by e-MDs cannot be edited (although Alternate Descriptions and Keywords can be added to those codes) or deleted, but user-created codes can be.

To edit a code created by the user:

1. Select and right-click the code.
2. Select **Edit a HCPCS**.
3. Make the desired changes in the pop-up window that appears.
4. Press either the **Enter** or **Tab** key to save the updated code.

To delete a code created by the user:

1. Select and right-click the code.
2. Select **Delete HCPCS**.

Entering the Billing Details of a New HCPCS Code

Enter the billing details of the new code in the Billing Details window. If this window is not visible, click **Details** on the toolbar. The various data fields in the Details window are described below.

Billing Details Options	
Type of Service	This option is required when billing a HCPCS code. A default Type of Service has been chosen for each HCPCS, though the user can click the small down arrow to reveal other choices and change this.
Place of Service	This option is required when billing a HCPCS code. A default Place of Service has been chosen for each HCPCS, though the user can click the small down arrow to reveal other choices and change this.
Billing Description	In e-MDs Bill, this description appears in the billing invoice.
Detail Description	Official, full-text, detailed description of the individual code. This field is unalterable for e-MDs-entered codes. For user-entered codes, free-text descriptions up to 255 characters in length may be typed.

Code Valid	This field indicates the date range in which each code is active. For example, if a new code is adopted on January 1st, 2001, that date will appear in the "From" field. When codes are discontinued, the discontinuation date (typically December 31st) will appear in the "Through" field. These dates cannot be edited for e-MDs-entered codes, but the field is active for user-entered codes. **Note:** You may notice that the "Through" date field is running date (that is, it always shows the current date). If a code has been discontinued, the "Through" check box will be checked, and the actual discontinuation date displayed.
Lab Tracking	This section has 2 fields. One field designates whether or not the item is tracked through the Lab Tracking module. The other field is used to indicate the number of days that the Lab Tracking module uses to determine whether an item is considered overdue.
Private/Cost	If desired, the private fee schedule and internal cost of each HCPCS procedure may be entered into the appropriate fields.
Relative Value Unit	When applicable, the determining factors for the Relative Value Unit (RVU) assigned to a HCPCS code may be entered into the appropriate fields. The fields represent the total RVU, the Work portion, Practice Expense, and Malpractice Cost.
Categorical Modifiers	Modifiers that apply to the entire category in which a particular HCPCS falls can be listed in this field. Right click within the Categorical Modifiers field and select the Insert Modifier menu option. This will open a window listing all possible modifiers. Click the desired modifier; this will close the window and add that modifier to the HCPCS. Remember, this modifier will be added to every HCPCS code within that category. To remove a modifier, select it, right click, and choose the Remove Modifier menu option. This will remove that modifier from every HCPCS code within that category. **Note:** This is a free-text memo field with a 255-character length. Billing memos of any type related to the selected HCPCS code may be entered.

Locating Medical Art

Medical Art can be found in several locations:

In References:

1. Click **Reference** on the main e-MDs Chart toolbar.
2. Select **Medical Art**.

On the Visit Note Navigation bar:

(buttons that run vertically down the left side of an OPEN note):

1. Click the **Art** button to open the Medical Art Quick Selector.
2. In the Medical Art Quick Selector window, click the **Search** button on the toolbar  .

In the HPI, Exam, Procedure, and Plan sections of a Visit or Order Note:

1. In any of these sections, click any free text icon (the gray circles that turn into yellow squares when hovered over).
2. Click the **Other Options** button located at the bottom of the Free Text window.
3. Select **Medical Art**.

Searching for Medical Art

Find a Medical Art document by searching the document Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire Medical Art database in outline form. Documents are arranged alphabetically.
2. Click the plus sign next to any document title to expand the tree and reveal a node labeled Search Keywords.
3. Search Keywords lists words that are linked to this document, which, when typed into the **Search** field, will return this document in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite documents (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. Mark your preference by clicking one of the three buttons in the second horizontal toolbar, located after the words **Search By**.
3. Type your search criteria into the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official title of each document in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word.
   - If more than one word is entered, separate each with a space.
   - When listing more than one word (or group of letters), the order of the words does not matter.
   - In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
   - To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from **And** to **Or**.

7. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

To view documents:

1. Find the desired document by performing an Outline or Keyword Search.
2. Right-click the title of the document.
3. Select **Display Selected Medical Art**.

Adding Medical Art to Your "Short List"

Get quicker results and greater precision by searching only your pre-defined list of favorite Medical Art images, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

- To add an individual document to your favorites list, click the check box located to the left of the document title in the tree.
- To remove a document from your favorites list, clear the same box.

Editing Medical Art

e-MDs provides Medical Art images as part of the clinical content. These images cannot be altered, although copies can be made and those can be edited.

To copy and edit an image:

1. Right-click the title of the original image.
2. Select **Copy Selected Medical Art**.
3. When a pop-up window prompts for a description; enter an image title and press **Enter**. This copies the Medical Art, applies the new title, and enters the copied image into the Medical Art Outline.

   Note: The title cannot be identical to the description of the original artwork.
4. Right-click the description of the copied image and select the **Display Selected Medical Art**.
5. Edit the art by drawing or adding text, and click **Save** (the button with the floppy disk icon.)

Adding a Search Keyword to Medical Art

Although some keywords have already been linked to each Medical Art image, additional words may be added, if needed, to improve search results. Click the plus sign next to an image title to expand the tree and reveal a node labeled **Search Keywords**. Click the plus sign next to this node to display all words currently linked to this image.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter your keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save your keywords.

When linking the same set of keywords to multiple images, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and select Keyword Copylist Operations > Add Selected Keyword(s) to List.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.

3. Once a group of keywords is highlighted, right-click and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another image.
5. Select **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items**.

When a new Medical Art image is added to the database, its title will automatically be parsed into the keyword list. However, if that title is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the title and selecting the menu option labeled Parse Title into Keyword List.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding New Medical Art

Adding New Medical Art Categories

The Medical Art database is divided into categories and subcategories, each representing a group of related images. The main outline contains categories labeled by organ system. Subcategories divide the images into three types: Exam, Medical Reference, and Patient Ed.

To add new medical art categories:

1. Select and right-click an existing category or subcategory (or the main Medical Art Outline node at the top of the outline).
2. Select and right-click **Add Category**.
3. In the pop-up Category Entry window that appears, enter a description for the category.
4. Press either the **Enter** or **Tab** key to save the new category.

Adding New Medical Art Images

Images stored in an electronic format can be imported into the Medical Art database.

To add new medical art images:

1. Find the appropriate category (or subcategory) for the new image.
2. Right-click the category and select **Add Medical Art**.
3. When the Medical Art Loader window opens, browse files on your computer (or network).
4. Select the desired file and click **Open**. The Medical Art Description window opens, with a default description automatically entered (based on the title of the file).
5. Type the image description, if desired.
6. When the description is correct, press either the **Enter** or **Tab** key to save the new image.

Locating Patient Education Documentation

Patient Education documents can be found in several locations:

In References:

1. Click **Reference** on the main e-MDs Chart toolbar.
2. Select the **Patient Education** menu option.

In the Plan section of a Visit or Order Note, linked to a diagnosis:

1. Under a diagnosis header in Plan, click **Patient Education Handouts**.
2. Select **Patient Education** to see a list of documents linked to that diagnosis.
3. Click **Add Patient Ed** to launch the full Patient Education Search.

   Note that any Patient Education document selected from this search will automatically be linked to the selected diagnosis.

In the Plan section of a Visit or Order Note, unlinked to any diagnoses:

1. To launch the Patient Education Search without linking a document to an ICD code, click the **Other Patient Education Handouts** section of Plan.
2. Click **Patient Education**.

Accessing Krames Patient Education Documents

In addition to the e-MDs created Patient Education documents, you can also access Krames patient education documents. e-MDs provides access to Krames as part of the Solution Series offering. Krames is an industry leader in providing evidence-based, peer-reviewed patient education content that supports health literacy, increases compliance and motivates behavior change.

To access Krames from a Visit or Order Note:

1. In the Plan section of a Visit or Order Note, under a diagnosis header in Plan, click the header labeled **Patient Education Handouts**.
2. Select **Patient Education** from the pop-up menu.
3. In the Linked Patient Education window, click the button at the top right labeled **Krames**.
4. A Web page will open displaying a list of patient education documents that match the diagnoses (ICD codes) and or procedures (CPT codes) that are in the note.

   Note: In addition to the linked documents, a search tab is available to allow searching on keywords and a browse tab is available to search by alphabetical listing.
5. Type a search keyword in the **Search** field (for example. **Diabetes**) and press **Enter** to see a list of available patient education documents related to the keyword.

   In the **Browse** tab, a list from A to Z is displayed.
6. Click a letter to see documents whose keyword start with the letter.

To access Krames from outside a patient chart:

1. On the main Chart menu, click **References,** then select **Krames Patient Education**.
2. A Web page will open to a search tab to allow searching on keywords and a **Browse** tab is available to search by alphabetical listing.
3. Type a search keyword in the **Search** field (for example, **Diabetes**) and press **Enter** to see a list of available patient education documents related to the keyword.

Searching for a Patient Education Document

Find a Patient Education document by searching the document Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire Patient Education database in outline form. Documents are arranged alphabetically.
2. Click the plus sign next to any document title to expand the tree and reveal two nodes labeled **Translations** and **Search Keywords**.
3. Click **Translations** to view the document's Spanish equivalent. Search Keywords lists words that are linked to this document, which, when typed into the search field, will return this document in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite documents (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. Mark your preference by clicking one of the three buttons in the second horizontal toolbar, located after the words **Search By**.
3. Type your search criteria in the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official title of each document in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word.
   - If more than one word is entered, separate each with a space. For example, to search for "acute bronchitis", enter the search criteria "acu bronc."
   - When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "acu bronc" would return the same search result as "bronc acu." In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
   - To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from And to Or.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

Viewing Documents

Find the desired document by performing an Outline or Keyword Search.

To view documents:

1. Highlight the title of the document and then click **View** on the toolbar.

   OR

   Right-click the title and select **View Document**.

   Note: Although the View window allows editing and printing of documents, edits are not saved.

2. Close the View window by clicking either the **X** in the upper right corner or the **Exit** button (with the open door icon).

Finding Spanish Translations of Documents

Most documents in the Patient Education module include a Spanish translation. Spanish handouts are linked to their English counterparts. The keyword search, however, does not include any Spanish terms.

To find Spanish translations of documents:

1. Find the desired document in English (see the “Search for a Patient Education Document” section).
2. Click the plus sign next to the English-titled document to expand the tree and reveal the Translations node.
3. Click the plus sign next to the **Translations** node to display the Spanish document title.

   The content of the Spanish documents is essentially identical to their English equivalents. If desired, Spanish keywords can be linked to any document if you plan to perform document searches in Spanish (see the “Add Keywords” section).

Adding a Patient Education Document to Your "Short List"

Get quicker results and greater precision by searching only your predefined list of favorite documents, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

- To add an individual document to your favorites list, simply click the check box located to the left of the document title in the tree.
- To remove a document from your favorites list, clear the same box.

Note: Because Spanish educational handouts are linked to their corresponding English documents in the tree, individual Spanish documents cannot be added to the short list. Instead, add the English document to the favorites list, which will, in effect, also add the associated Spanish translation.

Editing a Patient Education Document

To make minor changes to an e-MDs’ source document, the easiest solution is to edit a source document rather than to add a custom document (which involves creation of a new document from scratch).

Note: Source documents are not actually alterable. Instead, an editable copy of a document is spawned. The original source document will remain in the database, along with the edited copy. The edited version appears as a new document in the tree, flagged with a yellow book icon, distinguishing it from e-MDs’ source documents, which are noted by blue books.

The new title of the edited document will automatically be parsed into the keyword list. To add additional search keywords, see the “Add a Search Keyword” section. The edited version of the source document is now considered to be a Custom Document.

To edit a source document:

1. Highlight the source document and either click **Copy** on the toolbar, or right-click and select **Create Copy of Document**. The copied document will automatically be titled the same as the original followed by the addition of ".1".
2. If desired, change the title in the pop-up window and press either the **Tab** or **Enter** key. The new title cannot be exactly the same as that of the source document.

   Note: "Title" refers to the document's database title, as it appears in the outline. The "title" or header that appears on the printed Patient Education handout is unaffected by changing the database title.

   Selecting a title opens a word processor window containing the original document. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.
3. Make changes as desired. When finished, save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

   OR

   To delete the new document before it has been entered into the database, click the **Delete** button (with the red **X**) within the word processor window.

Adding a Search Keyword to a Patient Education Document

Although some keywords have already been linked to each document, additional words may be added, if needed, to improve search results. Click the plus sign next to a document title to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this document.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter your keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the new keywords.

When linking the same set of keywords to multiple documents, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. After a group of keywords is highlighted, right-click and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Select the **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items** menu options.

When a new document is added to the database, its title will automatically be parsed into the keyword list. However, if that title is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the title and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding, Editing and Deleting Custom Patient Education Documents

To add a custom document:

1. Add a custom Patient Education document by clicking the **Add** button on the toolbar. (Documents cannot be added from the Search screen. If the **Add** button is disabled, first click **Outline**.)

   OR

   Right-click any document title in the outline and select **Add Document**.

2. Enter the new document's title in the pop-up window that appears (limited to 100 characters), and press either the **Tab** or **Enter** key.

   Note: The title cannot match that of any existing titles in the database.

   Selecting a title will open the word processor window. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.

3. Create the document by typing into the word processor, pasting text from another source, or loading an electronic document from another location (that is, click **File** > **Load**, browse for the desired text (.txt) or rich text (.rtf) document, and click **Open**).
4. When finished, save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

Custom documents will appear in the tree with a yellow book icon, distinguishing them from e-MDs' source documents, which are noted by blue books. The title of the document will automatically be parsed into the keyword list. To add additional search keywords, see the "Add and Delete Search Keywords" section.

To edit the title of a custom document:

Right-click the custom document title and select **Edit Title**. Titles have a 100-character limit in length.

Note: This changes only the database title of the document, and does not affect the title that appears on the printed Patient Education handout.

Titles of e-MDs' source documents, which are identified by blue book icons, cannot be edited.

To edit the content of a custom document:

1. Highlight the document title and either click **Edit** on the toolbar, or right-click and select **Edit Document**.
2. Make your changes in the word processor window.
3. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

To delete a custom document:

Highlight the document title and either click **Delete** on the toolbar.

OR

Right-click and select **Delete Document**. e-MDs' source documents, which are identified by blue book icons, cannot be deleted.

Note: Any edits made in the View window will not be saved. Use the word processor via the steps outlined above, rather than the View window, for editing.

Locating Curbside Consults Documentation

Curbside Consults can be found in several locations:

In References:

1. Click **Reference** on the main e-MDs Chart toolbar.
2. Select the **Curbside Consults** menu option.

In the HPI, Assessment, and Plan sections of a Visit or Order Note:

1. Click the bold black diagnosis description in any of these sections and select the **Curbside Consults** menu option. This will display a window listing Curbside documents linked to that diagnosis.
2. Click **Add Consult** to launch the full Curbside Consult Search. Note that any Consult document selected from this search will automatically be linked to the selected diagnosis.

Searching for a Curbside Consult

Find a Curbside Consult document by searching the document Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire Curbside Consult database in outline form. Documents are arranged alphabetically.
2. Click the plus sign next to any document title to expand the tree and reveal a node labeled **Search Keywords**.

   Search Keywords lists words that are linked to this document, which, when typed into the **Search** field, will return this document in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite documents (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.
2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. Mark your preference by clicking one of the three buttons in the second horizontal toolbar, located after the words **Search By**.
3. Type your search criteria in the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official title of each document in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.

- Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
- The search is case-insensitive, meaning there is no need to capitalize any word.
- If more than one word is entered, separate each with a space. For example, to search for "acute bronchitis", enter the search criteria "acu bronc."
- When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "acu bronc" would return the same search result as "bronc acu."
- In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
- To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from **And** to **Or**.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

To view documents:

1. Find the desired document by performing an Outline or Keyword Search.
2. Highlight the title of the document and then click **View** on the toolbar.

   OR

   Right-click the title and select **View Document**. Although the View window allows editing and printing of documents, edits are not saved.
3. Close the View window by clicking either the **X** in the upper right corner, or the **Exit** button (with the open door icon).

Add a Curbside Consult to Your "Short List"

Get quicker results and greater precision by searching only your pre-defined list of favorite documents, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

- To add an individual document to your favorites list, simply click the check box located to the left of the document title in the tree.
- To remove a document from your favorites list, clear the same box.

Edit a Curbside Consult

To make minor changes to an e-MDs' source document, the easiest solution is to edit a source document rather than to add a custom document (which involves creation of a new document from scratch).

Note: Source documents are not actually alterable. Instead, an editable copy of a document is spawned. The original source document will remain in the database, along with the edited copy. The edited version appears as a new document in the tree, flagged with a yellow book icon, distinguishing it from e-MDs' source documents, which are noted by blue books.

To edit a source document:

1. Highlight the source document and either click **Copy** on the toolbar, or right-click and select **Create Copy of Document**. The copied document will automatically be titled the same as the original followed by the addition of ".1".
2. If desired, change the document title in the pop-up window and press either the **Tab** or **Enter** key. The new title cannot be exactly the same as that of the source document.

Note: "Title" refers to the document's database title, as it appears in the outline. The "title" or header that appears on the Curbside Consult itself is unaffected by changing the database title.

Selecting a title opens a word processor window containing the original document. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.

3. Make document changes as desired.
4. When finished, save the document by clicking the **Save** button (with the floppy disk icon) or by going to **File** > **Save** and **Exit**.
5. To delete the new document before it has been entered into the database, click the **Delete** button (with the red **X**) within the word processor window.

The new title of the edited document will automatically be parsed into the keyword list. To add additional search keywords, see the "Add and Delete Search Keywords" section. The edited version of the source document is now considered to be a Custom Document.

Add a Search Keyword to a Curbside Consult

Although some keywords have already been linked to each document, additional words may be added, if needed, to improve search results. Click the plus sign next to a document title to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this document.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter your new keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the new keyword(s).

When linking the same set of keywords to multiple documents, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and choose the **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. After a group of keywords is highlighted, right-click and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document and selecting **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items**.

When a new document is added to the database, its title will automatically be parsed into the keyword list. However, if that title is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the title and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Add, Edit and Delete Curbside Consult Documents

Custom documents will appear in the tree with a yellow book icon, distinguishing them from e-MDs' source documents, which are noted by blue books. The title of the document will automatically be parsed into the keyword list when the custom document is created. To add additional search keywords, see the "Add and Delete Search Keywords" section.

To add a custom Curbside Consult document:

1. Click the **Add** button on the toolbar.

   Note: Documents cannot be added from the Search screen. If the **Add** button is disabled, first click **Outline**.

   OR

   Right-click any document title in the outline and select **Add Document**.

2. Enter the new document's title in the pop-up window that appears (limited to 100 characters), and press either the **Tab** or **Enter** key.

   Note: The title cannot match that of any existing titles in the database.

   Selecting a title will open the word processor window. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.

3. Create the document by typing into the word processor, pasting text from another source, or loading an electronic document from another location (that is, click **File** > **Load**, browse for the desired text (.txt) or rich text (.rtf) document, and click **Open**).
4. When finished, save the document by clicking the **Save** button (with the floppy disk icon) or by going to **File** > **Save** and **Exit**.

To edit the title of a custom Curbside Consult document:

1. Right-click the document title and select **Edit Title**. Titles have a 100-character limit in length.

   Note: This changes only the database title of the document, and does not affect the title that appears on the printed Patient Education handout. Titles of e-MDs' source documents, which are identified by blue book icons, cannot be edited.

2. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

To edit the content of a custom Curbside Consult document:

1. Highlight the document title and either click **Edit** on the toolbar, or right-click and select **Edit Document**.
2. Make your changes in the word processor window.
3. When finished, save the document by clicking the **Save** button (with the floppy disk icon) or by going to **File** > **Save** and **Exit**.

To delete a custom Curbside Consult document:

Highlight the document title and either click **Delete** on the toolbar, or right-click and select **Delete Document**.

e-MDs' source documents, that are identified by blue book icons, cannot be deleted.

Note: Any edits made in the View window will not be saved. Use the word processor via the steps outlined above, rather than the View window, for editing.

Locating Drug Education Documentation

Drug Education documents can be found in several locations:

In References:

Click **Reference** on the main e-MDs Chart toolbar, and select the **Drug Education** menu option.

In the Plan section of a Visit or Order Note, linked to a diagnosis:

1. Under a diagnosis header in Plan, click **Patient Education Handouts** and then select **Drug Education** to see a list of documents linked to that diagnosis.
2. Click **Add Drug Ed** to launch the full Drug Education Search.

   Note that any Drug Education document selected from this search will automatically be linked to the selected diagnosis.

In the Plan section of a Visit or Order Note, unlinked to any diagnoses:

To launch the Drug Education Search without linking a document to an ICD code, click the **Other Patient Education Handouts** section of Plan and then click **Drug Education**.

Searching for a Drug Education Document

Find a Drug Education document by searching the document Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire Drug Education database in outline form. Documents are arranged alphabetically.
2. Click the plus sign next to any document title to expand the tree and reveal two nodes, labeled **Translations** and **Search Keywords**.
3. Click **Translations** to view the document's Spanish equivalent. Click **Search Keywords** to list words that are linked to this document, which, when typed into the **Search** field, will return this document in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite documents (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.
2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. Mark your preference by clicking one of the three buttons in the second horizontal toolbar, located after the words **Search By**.
3. Type your search criteria in the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official title of each document in addition to the linked keywords.

- Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
- Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
- The search is case-insensitive, meaning there is no need to capitalize any word.
- If more than one word is entered, separate each with a space. For example, to search for "acute bronchitis", enter the search criteria "acu bronc."
- When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "acu bronc" would return the same search result as "bronc acu."
- In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
- To search for entries that match *any* (rather than all) of the keywords, change the Search Criteria (in the second horizontal toolbar) from **And** to **Or**.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

To view documents:

1. Find the desired document by performing an Outline or Keyword Search.
2. Highlight the title of the document and then click **View** on the toolbar.

   OR

   Right-click the title and select **View Document**.

   Although the View window allows editing and printing of documents, edits are not saved.
3. Close the View window by clicking either the **X** in the upper right corner or the **Exit** button (with the open door icon).

Finding Spanish Translations of Drug Education Documents

Most documents in the Drug Education module include a Spanish translation. Spanish handouts are linked to their English counterparts. The keyword search, however, does not include any Spanish terms.

To find Spanish translations of Drug Education documents:

1. Locate the desired document in English (see the “Search for a Drug Education Document” section).
2. Click the plus sign next to the English-titled document to expand the tree and reveal the Translations node.
3. Click the plus sign next to this node to display the Spanish document title.

The content of the Spanish documents is essentially identical to their English equivalents. If desired, Spanish keywords can be linked to any document if you plan to perform document searches in Spanish (see the “Add Keywords” section).

Adding a Drug Education Document to Your "Short List"

Get quicker results and greater precision by searching only your predefined list of favorite documents, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

- To add an individual document to your favorites list, simply click the check box located to the left of the document title in the tree.
- To remove a document from your favorites list, clear the same box.

Note: Because Spanish educational handouts are linked to their corresponding English documents in the tree, individual Spanish documents cannot be added to the short list. Instead, add the English document to the favorites list, which will, in effect, also add the associated Spanish translation.

Editing a Drug Education Document

To make minor changes to an e-MDs' source document, the easiest solution is to edit a source document rather than to add a custom document (which involves creation of a new document from scratch).

Note: Source documents are not actually alterable. Instead, an editable copy of a document is spawned. The original source document will remain in the database, along with the edited copy. The edited version appears as a new document in the tree, flagged with a yellow book icon, distinguishing it from e-MDs' source documents, which are noted by blue books.

The new title of the edited document will automatically be parsed into the keyword list. To add additional search keywords, see the "Add a Search Keyword?" section. The edited version of the source document is now considered to be a Custom Document.

To edit a source document:

1. Highlight the source document and either click **Copy** on the toolbar or right-click and select **Create Copy of Document**.

   The copied document will automatically be titled the same as the original followed by the addition of ".1".

2. If desired, change the document title in the pop-up window and press either the **Tab** or **Enter** key. The new title cannot be exactly the same as that of the source document.

   Note: "Title" refers to the document's database title, as it appears in the outline. The "title" or header that appears on the printed Drug Education handout is unaffected by changing the database title.

   Selecting a title opens a word processor window containing the original document. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.

3. Make changes as desired.
4. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.
5. To delete the new document before it has been entered into the database, click the **Delete** button (with the red **X**) within the word processor window.

Adding a Search Keyword to a Drug Education Document

Although some keywords have already been linked to each document, additional words may be added, if needed, to improve search results. Click the plus sign next to a document title to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this document.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, enter your keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the new keyword(s).

When linking the same set of keywords to multiple documents, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. After a group of keywords is highlighted, right-click and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Select the **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items** menu options.

When a new document is added to the database, its title will automatically be parsed into the keyword list. However, if that title is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the title and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding New Drug Education Documents

To add a custom Drug Education document:

1. Click the **Add** button on the toolbar.

   Note: Documents cannot be added from the Search screen. If the **Add** button is disabled, first click **Outline**.

   OR

   Right-click any document title in the outline and select **Add Document**.
2. Enter the new document's title in the pop-up window (limited to 100 characters), and press either the **Tab** or **Enter** key.

   Note: The title cannot match that of any existing titles in the database.

   Selecting a title will open the word processor window. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.
3. Create the document by typing into the word processor, pasting text from another source, or loading an electronic document from another location (that is, click **File** > **Load**, browse for the desired text (.txt) or rich text (.rtf) document, and click **Open**).
4. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

Custom documents will appear in the tree with a yellow book icon, distinguishing them from e-MDs' source documents, which are noted by blue books. The title of the document will automatically be

parsed into the keyword list. To add additional search keywords, see the “Add a Search Keyword” section.

To edit the title of a custom document:

1. Right-click the document title and select **Edit Title**. Titles have a 100-character limit in length.

   Note: This changes only the database title of the document, and does not affect the title that appears on the printed Drug Education handout.

   Titles of e-MDs’ source documents, which are identified by blue book icons, cannot be edited.

2. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

To edit the content of a custom document:

1. Highlight the document title and either click **Edit** on the toolbar, or right-click and select **Edit Document**.
2. Make your changes in the word processor window.
3. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

To delete a custom document:

Highlight the document title and either click **Delete** on the toolbar, or right-click and select **Delete Document**.

e-MDs’ source documents, which are identified by blue book icons, cannot be deleted.

Note: Any edits made in the View window will not be saved. Use the word processor via the steps outlined above, rather than the View window, for editing.

Locating Patient Instructions

Patient Instructions are used in e-MDs schedule to inform patients about preparing for appointments. A default patient instruction is provided with the system but users can add their own or edit the provided one. See “Add New Patient Instructions Documents” for details.

Currently the Patient Instructions Document Editor can only be accessed from within the Code Linker module.

To access the patient instructions document editor:

1. Open the Code Linker by clicking **Tools** on the main Chart toolbar and selecting **Code Linker**.
2. Log in to Code Linker using the same login name and password as Chart.
3. In the Code Linker window, click the text along the left side of the window labeled **Patient Ins**.
4. The Document Maintenance - Patient Instructions window will open.

Searching for a Patient Instructions Document

Find a Patient Instructions document by searching the document Outline or by entering keywords into the Full Search or a user-defined Short Search.

To search by outline:

1. Click the **Outline** button on the toolbar to display the entire Patient Instructions database in outline form. Documents are arranged alphabetically.

2. Click the plus sign next to any document title to expand the tree and reveal two nodes, labeled **Translations** and **Search Keywords**.
3. Click **Translations** to view the document's Spanish equivalent. Click **Search Keywords** to list words that are linked to this document, which, when typed into the search field, will return this document in the search results.

To search by keyword:

1. Determine whether to search the full database (by clicking the **Full** toolbar button) or only your pre-defined list of favorite documents (by clicking **Short**).

   Note: If a Short List search is initiated and no matches are found, the search automatically converts to a full database search.

2. Determine whether the search will look for items that *Begin With* the letters typed into the search field, that *Contain* those letters, or that are an *Exact Match*. Mark your preference by clicking one of the three buttons in the second horizontal toolbar, located after the words **Search By**.
3. Type your search criteria in the **Keywords** field.

   Search Hints:

   - The search utilizes the words in the official title of each document in addition to the linked keywords.
   - Do not include non-descriptive words (i.e. "the") and conjunctions (i.e. "and") in the search.
   - Full words are not necessary; typing the first few letters of a word is adequate and lessens the chances of spelling errors.
   - The search is case-insensitive, meaning there is no need to capitalize any word.
   - If more than one word is entered, separate each with a space. For example, to search for "acute bronchitis", enter the search criteria "acu bronc."
   - When listing more than one word (or group of letters), the order of the words does not matter. For example, in the search just described, "acu bronc" would return the same search result as "bronc acu."
   - In multiple-word searches, the default search mode returns only those results that contain *all* of the words.
   - To search for entries that match *any* (rather than all) of the keywords, change the **Search Criteria** (in the second horizontal toolbar) from **And** to **Or**.

4. To perform the search, press **Enter** or click **Search**. Previous search criteria are saved in the keyword drop-down list and can be cleared by clicking **Clear Dropdown**.

To view documents:

1. Locate the desired document by performing an Outline or Keyword Search.
2. Highlight the title of the document and then click **View** on the toolbar.

   OR

   Right-click the title and select **View Document**.

   Although the View window allows editing and printing of documents, edits are not saved.

3. Close the View window by clicking either the X in the upper right corner or the **Exit** button (with the open door icon).

Finding Spanish Translations of Patient Instructions Documents

Documents in the Patient Instructions module can include a Spanish translation. Spanish instructions can be linked to their English counterparts.

To find Spanish translations of patient instructions documents:

1. Locate the desired document in English (see the "Search for a Patient Instructions Document" section).
2. Click the plus sign next to the English-titled document to expand the tree and reveal the **Translations** node.
3. Click the plus sign next to this node to display the Spanish document title.

   If desired, Spanish keywords can be linked to any document if you plan to perform document searches in Spanish (see the "Add a Search Keyword to a Patient Instructions Document" section).

Adding a Patient Instructions Document to Your Short List

Get quicker results and greater precision by searching only your predefined list of favorite documents, rather than the full database. (Perform this type of search by clicking **Short** on the toolbar.)

- To add an individual document to your favorites list, click the check box located to the left of the document title in the tree.
- To remove a document from your favorites list, clear the same box.

Note: Because Spanish patient instructions are linked to their corresponding English documents in the tree, individual Spanish documents cannot be added to the short list. Instead, add the English document to the favorites list, which will, in effect, also add the associated Spanish translation.

Editing a Patient Instructions Document

To make minor changes to an e-MDs' source document, the easiest solution is to edit a source document rather than to add a custom document (which involves creation of a new document from scratch).

Note: Source documents are not actually alterable. Instead, an editable copy of a document is spawned. The original source document will remain in the database, along with the edited copy. The edited version appears as a new document in the tree, flagged with a yellow book icon, distinguishing it from e-MDs' source documents, which are noted by blue books.

The new title of the edited document will automatically be parsed into the keyword list. To add additional search keywords, see the "Add a Search Keyword to a Patient Instructions Document" section. The edited version of the source document is now considered to be a Custom Document.

To edit a Patient Instructions source document:

1. Highlight the source document and either click **Copy** on the toolbar or right-click and select **Create Copy** of **Document**.

   The copied document will automatically be titled the same as the original followed by the addition of ".1".

2. If desired, change the title in the pop-up window and press either the **Tab** or **Enter** key.

   The new title cannot be exactly the same as that of the source document.

   Note: "Title" refers to the document's database title, as it appears in the outline. The "title" or header that appears on the printed Patient Instructions Document is unaffected by changing the database title.

3. Selecting a title opens a word processor window containing the original document. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available. Make changes as desired.
4. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.
5. To delete the new document before it has been entered into the database, click the **Delete** button (with the red **X**) within the word processor window.

Adding a Search Keyword to a Patient Instructions Document

Although some keywords may have already been linked to each document, additional words may be added, if needed, to improve search results. Click the plus sign next to a document title to expand the tree and reveal a node labeled Search Keywords. Click the plus sign next to this node to display all words currently linked to this document.

To add a keyword:

1. Highlight and right-click **Search Keywords**.
2. Select **Add Linked Keywords**.
3. In the pop-up window that appears, type your keywords. If more than one word is added, separate words with a space.
4. Press either the **Enter** or **Tab** key to save the new keyword(s).

When linking the same set of keywords to multiple documents, simplify the task by creating a Keyword Copy List.

To create a Keyword Copy List:

1. Right-click any keyword and select **Keyword Copylist Operations** > **Add Selected Keyword(s) to List**.
2. Add multiple keywords to the list by holding down the **Control** key and then clicking any two keywords, which will highlight the entire group of keywords residing in the tree between the two selected words.

   OR

   Hold down the **Shift** key and click multiple, noncontiguous keywords.
3. After a group of keywords is highlighted, right-click and select **Keyword Copylist Operations > Add Selected Keyword(s) to List**.
4. Insert this copy list elsewhere by right-clicking the **Search Keywords** node of another document.
5. Select the **Keyword Copylist Operations** > **Insert Copylist** > **Insert All Items** menu options.

When a new document is added to the database, its title will automatically be parsed into the keyword list. However, if that title is edited at any point, the new words will not automatically be added. At that point, simplify the task of adding the new keywords by right-clicking the title and selecting the menu option labeled **Parse Title into Keyword List**.

To remove an individual keyword:

1. Select and right-click the keyword.
2. Select **Remove Keyword Link**.

Adding a New Patient Instructions Document

To add a new patient Instructions custom document:

1. Click the **Add** button on the toolbar.

   Note: Documents cannot be added from the Search screen. If the Add button is disabled, first click Outline.

   OR

   Right-click any document title in the outline and select **Add Document**.

2. Enter the new document's title in the pop-up window (limited to 100 characters), and press either the **Tab** or **Enter** key.

   Note: The title cannot match that of any existing titles in the database.

   Selecting a title will open the word processor window. Typical word processor functionality, such as various fonts, styles, colors, formatting, and highlighting is available.

3. Create the document by typing into the word processor, pasting text from another source, or loading an electronic document from another location (that is click **File** > **Load**, browse for the desired text (.txt) or rich text (.rtf) document, and click **Open**).

4. Save the document by clicking the **Save** button (with the floppy disk icon) or by clicking **File** > **Save** and **Exit**.

Custom documents will appear in the tree with a yellow book icon, distinguishing them from e-MDs' source documents, which are noted by blue books. The title of the document will automatically be parsed into the keyword list. To add additional search keywords, see the Add a Search Keyword section.

To edit the title of a custom document:

1. Right-click the document title and select **Edit Title**. Titles have a 100-character limit in length.

   Note: This changes only the database title of the document, and does not affect the title that appears on the printed Drug Education handout.) Titles of e-MDs' source documents, which are identified by blue book icons, cannot be edited.

2. Save the document by clicking the **Save** button (with the floppy disc icon) or by clicking **File** > **Save** and **Exit**.

To edit the content of a custom document:

1. Highlight the document title and either click **Edit** on the toolbar, or right-click and select **Edit Document**.

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Index