



Allscripts Enterprise EHR™

Enhancement Supplement

Encounter Clinical Summary

Applies to versions 11.2.1 HF 6, 11.2.2 HF 3, and 11.2.3

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Table of Contents

Providing Encounter Clinical Summaries 5

Configuration considerations 7

Clinical Summary configuration overview 7

EnableCSOnScheduleDaily preference 8

EnableCSOnScheduleProvider preference 8

EncounterSummaryAlwaysProvide ClinicalSummary preference 9

Indicate whether to generate a Clinical Summary before the note is finalized 10

DefaultClinicalSummaryDocument preference 11

Visit Summary CED document type 11

Clinical Summary-RTF document type 16

CSDefaultReasonForVisitNoteSection preference 19

CSDefaultTreatmentPlanNoteSection preference 20

CSIncludeProblemSection preference 20

Set auto-print defaults for the Clinical Summary 21

Mark a document type as a Clinical Summary 21

Personalize Daily and Provider Schedules to display Clinical Summary (CS) icon 22

Document a patient's preferred method of communication for Clinical Summaries 24

Security considerations when providing the Clinical Summary 27

What the Clinical Summary (CS) icon indicates 29

**How a Clinical Summary is generated based on the patient's
Clinical Summary preference 33**

Provide a Clinical Summary from the Encounter Summary 37

Provide a Clinical Summary from the Daily or Provider Schedule 39

**Add a Chart Alert to indicate the Clinical Summary should not be
provided 41**

For more information 43

Contact us 45

Providing Encounter Clinical Summaries

The Meaningful Use criteria defined by the EHR Stimulus program require that Electronic Health Record applications be able to provide a Clinical Summary for at least 50% of all patients your organization sees. To meet this requirement, Allscripts Enterprise EHR™ enables you to provide patients with a Clinical Summary on request each time you see them.

The Meaningful Use Rules define a Clinical Summary as an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the following:

- > The patient name
- > The provider's office contact information
- > The date and location of visit
- > An updated medication list and summary of current medications
- > Updated vitals
- > The reason or reasons for visit
- > Procedures and other instructions based on clinical discussions that took place during the office visit
- > Any updates to a problem list
- > Immunizations or medications administered during visit
- > A summary of topics covered or considered during visit
- > The time and location of next appointment or testing if scheduled or a recommended appointment time if not scheduled
- > A list of other appointments and testing patient needs to schedule with contact information
- > Recommended patient decision aids
- > Laboratory and other diagnostic test orders
- > Test or laboratory results (if received before 24 hours after visit)
- > Symptoms

On the Daily and Provider Schedules, a new column, **CS**, appears. For each "arrived" appointment, an icon appears in the CS column indicating whether or not a Clinical Summary

has been or needs to be generated for the patient. Depending on your workflow, providers or clinical/office staff can generate the Clinical Summary as part of completing the patient visit—either as part of the clinical encounter or during the checkout process.

For reporting, the application reports on the percentage of all arrived appointments whose the Clinical Summary Icon has been set to provided.

Configuration considerations

Clinical Summary configuration overview

Before you can take advantage of the ability to provide Clinical Summaries to the patient at each encounter, there are a number of configuration steps that must be completed.

To be performed by an administrator

- > Set the **EnableCSOnScheduleDaily** and **EnableCSOnScheduleProvider** preferences to **Y** if you want to enable users to personalize their Daily and Provider Schedules to include the Clinical Summary (CS) column. You must also select the **User Can Override** option for each preference. See *EnableCSOnScheduleDaily preference* and *EnableCSOnScheduleProvider preference* for more information.
- > Set the **EncounterSummaryAlwaysProvideClinicalSummary** preference as required by your organization. See *EncounterSummaryAlwaysProvideClinicalSummary preference* for more information.
- > Set the **AllowClinicalSummaryWhenNoteUnFinal** preference appropriately. See *Indicate whether to generate a Clinical Summary before the note is finalized* for more information.
- > Set the **DefaultClinicalSummaryDocument** preference appropriately. See *DefaultClinicalSummaryDocument preference* for more information.
- > If the Clinical Summary-RTF or Visit Summary CED document type is being used for Clinical Summaries, ensure that the **CSDefaultReasonForVisitNoteSection** and **CSDefaultTreatmentPlanNoteSection** preferences are set as required by your organization. See *CSDefaultReasonForVisitNoteSection preference* and *CSDefaultTreatmentPlanNoteSection preference* for more information.

Note: The Clinical Summary-RTF document type can only be used for Clinical Summaries that are printed or saved to media. To send a Clinical Summary to the Allscripts Patient Portal, use the Visit Summary CED format or a v10 Note type designated as a Clinical Summary.

- > Set the auto-print defaults for the Clinical Summary. See *Set auto-print defaults for the Clinical Summary* for more information.
- > In the Document Type Dictionary, mark each appropriate document type as a Clinical Summary. See *Mark a document type as a Clinical Summary* for more information.

To be performed by each user

- > Use the **Personalize** option off of the clinical toolbar to include the Clinical Summary (CS) column on the Daily or Provider schedules. See *Personalize Daily and Provider Schedules to display Clinical Summary (CS) icon* for more information.
- > Ensure the patient's preference for receiving Clinical Summaries is set in the Patient Profile. See *Document a patient's preferred method of communication for Clinical Summaries* for more information.

Installation and upgrade considerations

If you are a v11 Note client, Allscripts will apply upgrade scripts for this functionality. If you already have a Note output to be used as a Clinical Summary, but this output is not a default Note output, Allscripts will provide a script to make it a default. A script will also be provided to add the output (as Clinical Summary) to as a default to any Note input.

EnableCSOnScheduleDaily preference

The EnableCSOnScheduleDaily preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level.

When the preference is set to **Y**, the Clinical Summary icon displays on the Daily Schedule, indicating whether or not a Clinical Summary has been provided or needs to be generated for the patient. If the preference is set to **N**, this icon does not display on the Daily Schedule.

By default this preference is set to **Y** and the **User Can Override** option is selected.

EnableCSOnScheduleProvider preference

The EnableCSOnScheduleProvider preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level.

When the preference is set to **Y**, the Clinical Summary icon displays on the Provider Schedule, indicating whether or not a Clinical Summary has been provided or needs to be generated for the patient. If the preference is set to **N**, this icon does not display on the Provider Schedule.

By default this preference is set to **Y** and the **User Can Override** option is selected.

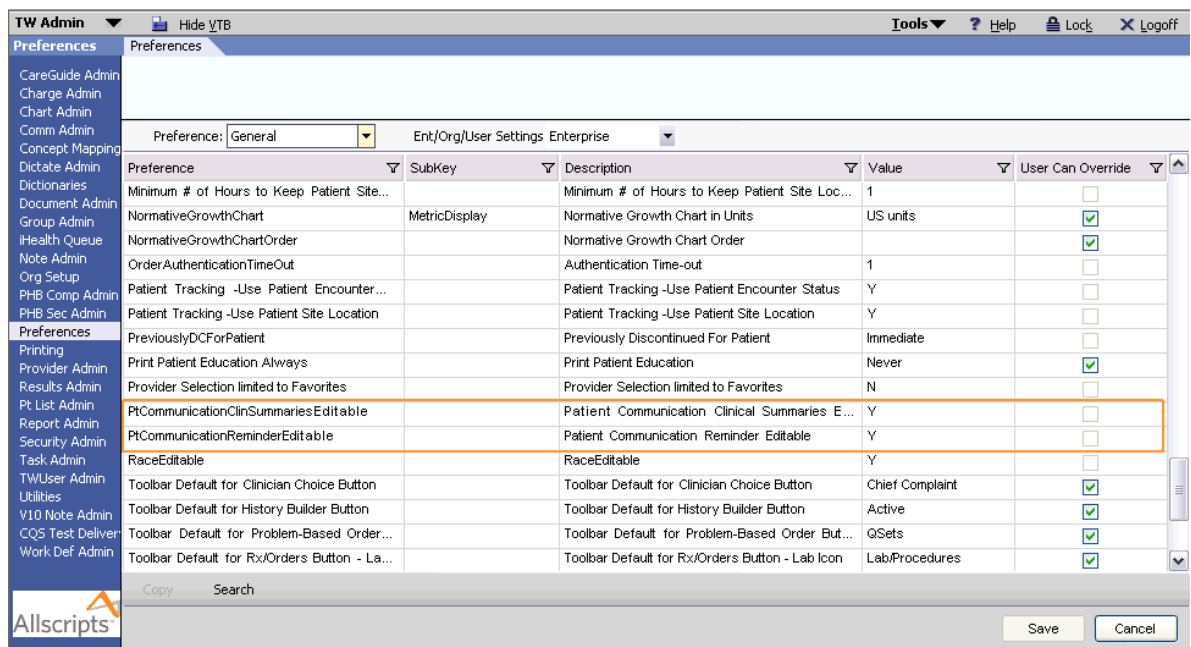
EncounterSummaryAlwaysProvide ClinicalSummary preference

The EncounterSummaryAlwaysProvideClinicalSummary preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level.

When the preference is set to **Y**, the **Provide Clinical Summary** check box on the Encounter Summary is selected by default. The provider can clear the check box if they do not want to provide a clinical summary for that encounter. If the preference is set to **N**, by default the **Provide Clinical Summary** check box is not selected. The provider can select the check box to provide a clinical summary for that encounter. If the preference is set to **Disable**, the **Provide Clinical Summary** check box is not selected and is disabled. Providers are unable to select the check box.

By default this preference is set to **Y**.

Important: If you want to ensure that this preference is set to Disable for all of your users, regardless of their current settings, submit a case in SupportForce.com.



The screenshot shows the TW Admin interface with the Preferences window open. The 'General' tab is selected, and the 'Ent/Org/User Settings Enterprise' dropdown is set to 'Enterprise'. The table below lists various preferences, with the 'PtCommunicationClinSummariesEditable' preference highlighted in orange. This preference is set to 'Y' and has the 'User Can Override' checkbox checked.

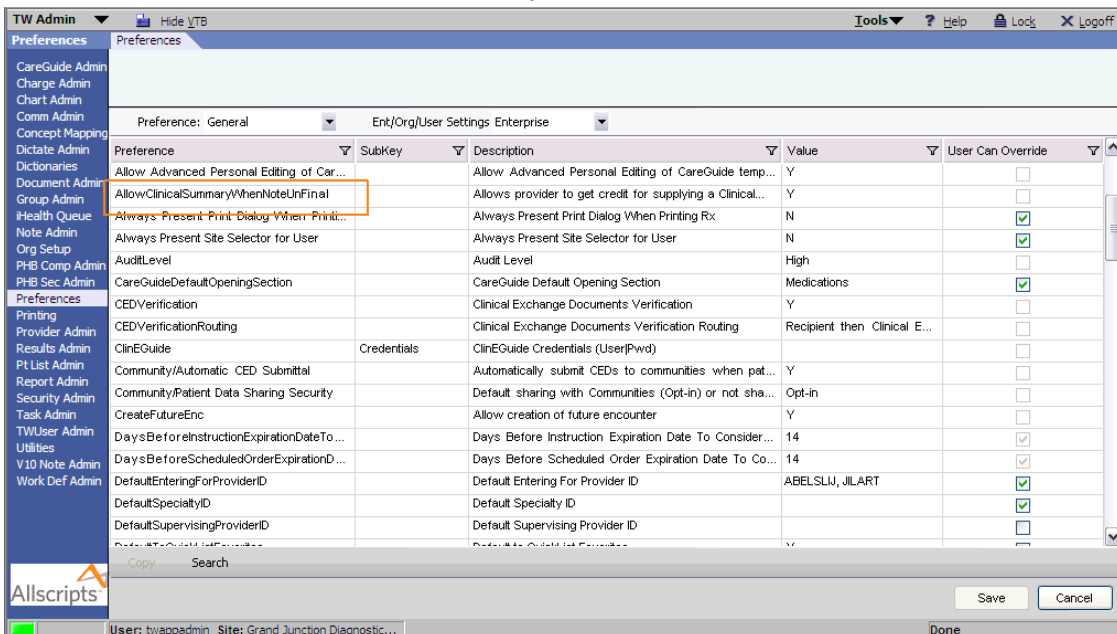
Preference	SubKey	Description	Value	User Can Override
Minimum # of Hours to Keep Patient Site...		Minimum # of Hours to Keep Patient Site Loc...	1	<input type="checkbox"/>
NormativeGrowthChart	MetricDisplay	Normative Growth Chart in Units	US units	<input checked="" type="checkbox"/>
NormativeGrowthChartOrder		Normative Growth Chart Order		<input checked="" type="checkbox"/>
OrderAuthenticationTimeOut		Authentication Time-out	1	<input type="checkbox"/>
Patient Tracking -Use Patient Encounter...		Patient Tracking -Use Patient Encounter Status	Y	<input type="checkbox"/>
Patient Tracking -Use Patient Site Location		Patient Tracking -Use Patient Site Location	Y	<input type="checkbox"/>
PreviouslyDCForPatient		Previously Discontinued For Patient	Immediate	<input type="checkbox"/>
Print Patient Education Always		Print Patient Education	Never	<input checked="" type="checkbox"/>
Provider Selection limited to Favorites		Provider Selection limited to Favorites	N	<input type="checkbox"/>
PtCommunicationClinSummariesEditable		Patient Communication Clinical Summaries E...	Y	<input type="checkbox"/>
PtCommunicationReminderEditable		Patient Communication Reminder Editable	Y	<input type="checkbox"/>
RaceEditable		RaceEditable	Y	<input type="checkbox"/>
Toolbar Default for Clinician Choice Button		Toolbar Default for Clinician Choice Button	Chief Complaint	<input checked="" type="checkbox"/>
Toolbar Default for History Builder Button		Toolbar Default for History Builder Button	Active	<input checked="" type="checkbox"/>
Toolbar Default for Problem-Based Order...		Toolbar Default for Problem-Based Order But...	QSets	<input checked="" type="checkbox"/>
Toolbar Default for Rx/Orders Button - La...		Toolbar Default for Rx/Orders Button - Lab Icon	Lab/Procedures	<input checked="" type="checkbox"/>

Indicate whether to generate a Clinical Summary before the note is finalized

This setting applies at the Enterprise/Organization level. Individual users cannot override this setting.

This task has 6 steps.

1. Log into Allscripts Enterprise EHR™ using the TWAdmin username and password.
2. Select **Preferences** from the vertical toolbar.
3. Select the **General** preference group.
4. Scroll to locate the AllowClinicalSummaryWhenNoteUnFinal preference.



Preference	Subkey	Description	Value	User Can Override
Allow Advanced Personal Editing of Car...		Allow Advanced Personal Editing of CareGuide temp...	Y	<input type="checkbox"/>
AllowClinicalSummaryWhenNoteUnFinal		Allows provider to get credit for supplying a Clinical...	Y	<input type="checkbox"/>
Always Present Print Dialog When Printi...		Always Present Print Dialog When Printing Rx	N	<input checked="" type="checkbox"/>
Always Present Site Selector for User		Always Present Site Selector for User	N	<input checked="" type="checkbox"/>
AuditLevel		Audit Level	High	<input type="checkbox"/>
CareGuideDefaultOpeningSection		CareGuide Default Opening Section	Medications	<input checked="" type="checkbox"/>
CEDVerification		Clinical Exchange Documents Verification	Y	<input type="checkbox"/>
CEDVerificationRouting		Clinical Exchange Documents Verification Routing	Recipient then Clinical E...	<input type="checkbox"/>
ClinEGuide	Credentials	ClinEGuide Credentials (UserPwrd)		<input type="checkbox"/>
Community/Automatic CED Submittal		Automatically submit CEDs to communities when pat...	Y	<input type="checkbox"/>
Community/Patient Data Sharing Security		Default sharing with Communities (Opt-in) or not sha...	Opt-in	<input type="checkbox"/>
CreateFutureEnc		Allow creation of future encounter	Y	<input type="checkbox"/>
DaysBeforeInstructionExpirationDateTo...		Days Before Instruction Expiration Date To Consider...	14	<input checked="" type="checkbox"/>
DaysBeforeScheduledOrderExpirationD...		Days Before Scheduled Order Expiration Date To Co...	14	<input checked="" type="checkbox"/>
DefaultEnteringForProviderID		Default Entering For Provider ID	ABELSLU, JILART	<input checked="" type="checkbox"/>
DefaultSpecialtyID		Default Specialty ID		<input checked="" type="checkbox"/>
DefaultSupervisingProviderID		Default Supervising Provider ID		<input type="checkbox"/>

5. Set the preference:
 - > Enter **Y** if you want providers to be able to generate the Clinical Summary before the note is finalized.
 - > Enter **N** if you do not want providers to be able to generate the Clinical Summary before the note is finalized.

6. Click **Save**.

DefaultClinicalSummaryDocument preference

The **DefaultClinicalSummaryDocument** preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level. This preference applies only if the **Patient Preferred Communication for Clinical Summary** is set to **Print** or **Patient Portal & Print** on the **Patient Profile**.

This preference enables you to determine the type of Clinical Summary that will be printed by the application if no structured note output is linked to the appointment in context and defined as a Clinical Summary in the Document Type dictionary. If this preference is set to **CED**, the default Clinical Summary document to use when a Clinical Summary is printed is the CED (Clinical Exchange Document). If this preference is set to **RTF**, the default Clinical Summary document to use when a Clinical Summary is printed is RTF (Rich Text Format).

By default this preference is set to **CED**.

Visit Summary CED document type

This document type is delivered to provide a Clinical Summary document that meets American Recovery and Reinvestment Act (ARRA) Meaningful Use requirements and also provides a clear, readable, and understandable encounter record for patients. Clinical Summaries sent to Allscripts Patient Portal must be Visit Summary CED or a v10 Note type designated as a Clinical Summary in the Document Type dictionary.

The Visit Summary CED document uses the Visit Summary template as supplied in IHE Services version 3.1. This summary is encounter-based.

The Visit Summary CED document is made up of the following sections:

Patient

The **Patient** section of the Visit Summary CED document contains the following information:

Patient Detail for

Displays the patient's name in FirstName LastName format.

Contact

Displays the patient's name in FirstName LastName format.

Address

Displays the patient's address in Street, City, State abbreviation, zip code format, and the patient's home phone number, including area code.

Gender

Displays the patient gender as Male or Female.

MRN

Displays the patient's medical record number (MRN).

Date of Birth

Displays the patient's birth date, in Month DD, YYYY format.

Language

Displays the language spoken by the patient.

Marital Status

Displays the marital status of the patient. For example, S for single, M for married, D for divorced.

If any of the demographic information is not documented, the field is displayed but is blank.

Problems

The Problems section is optional and whether or not to include the section is controlled by the **CSIncludeProblemSection** preference. By default, this preference is set to **No**, and this section is not included in the Clinical Summary. If the preference is set to **Yes**, this section is included.

When this section is included, it displays a list of the patient's active problems and the status of these problems. Problems that are Inactive, Unverified, Suppressed are not included. Problems that are EIE (entered in error), Suppressed, or Resolved during the current encounter are also not included. Associated ICD-9 codes are not displayed.

If this list includes active problems from other lists, the appropriate qualifier or prefix displays with the problem name. For example, if the patient has a family history of breast cancer, and this is documented as an active problem on the **Family History** list, it displays here as **Family History of Breast Cancer**.

If there is no data to import into this section, the following message displays: "No Active Problems."

Reason for Visit

Information displayed here depends on how the **CSDefaultReasonForVisitNoteSection** preference is set. The text from either the Reason for Visit or Chief Complaint section of the

note associated with the encounter displays in a bulleted list. This section also displays Chief Complaints selected from the **Add Clinical Item (ACI)** workspace during the encounter. If the preference is set to **None**, or if there is no data to import into this section, the section does not display.

Assessment

Displays a bulleted list of problems assessed during the current encounter. Problems that are Inactive, Unverified, Suppressed, or EIE (entered in error) are not included. The status of the problem and the associated ICD-9 codes do not display. If there is no data to import into this section, the section does not display.

Treatment Plan

The **Treatment Plan** section of the Visit Summary CED document contains the following information:

Medication Changes

Displays a bulleted list of any medications that were added, renewed, or discontinued during the current encounter. Existing medications that were unchanged during the encounter are not listed. In other words, medications updated to **Record D/C** are not listed.

Labs/Procedures/Imaging

Displays a bulleted list of any labs or procedures that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Instructions

Displays a bulleted list of all instructions ordered with the encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Follow-ups/Referrals

Displays a bulleted list of any follow-ups or referrals that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Supplies

Displays a bulleted list of any supplies that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Medications/Immunizations Administered

Displays a bulleted list of medications or immunizations that were administered during the current encounter or ordered to be administered later. If the administration was only ordered, the **Item Name** and the **To Be Done** date are displayed. If the item was ordered and administered during the encounter, the **Item Name** and **Administered on** date are displayed.

Information displayed here depends on how the **CSDefaultTreatmentPlanNoteSection** preference is set and whether the note associated with the encounter is a v10 Note or a v11 Note. If the note associated with the encounter is a v10 Note, text from either the Orders or Discussed section of the note displays. If the note associated with the encounter is a v11 Note, the text from either the Plan or Discussion/Summary section of the note is displayed. If the preference is set to **None**, nothing displays in this section. If there is no data to import into this section, the following message displays: "Treatment plan not documented. Please contact your provider."

If there are sections under Treatment Plan for which there is no data to import, the section headings do not display. If there is no data to import for the entire Treatment Plan section, the entire section does not display.

Vital Signs

Displays the date and time the vitals were recorded and a table listing all vitals recorded during the encounter. The table includes **Date**, **Description**, **Test**, and **Result** (includes units) columns. The date displays only once at the top row, even if multiple vitals are recorded. The order of the vitals listed in the CED matches the order in which they display in the application. For certain types of vitals, the units might not be supported by the Result column. In this case, the result value and units display in the Test column and the value also displays in the Result column (without the unit). If there is no data to import into this section, the section does not display.

Medications

Displays a bulleted list of all current active medications for the patient. If there is no data to import into this section, the following message displays: "No Active Medications." Includes active medications with the **Record w/o Ordering** flag selected.

Allergies and Adverse Reactions

Displays a bulleted list of the patient's active allergies. The list includes the allergy name and associated reactions (if any). If there is no data to import into this section, the following message displays: "No Known Allergies."

Results

This section displays results of orders entered by the provider linked to the current encounter in table format. Results entered in Allscripts Enterprise EHR, as well as received through an interface that are recorded within a certain number of days of the encounter are listed (based on the setting of the **Number of Days of Results to Include in Clinical Exchange Document** preference). If there is no data to import into this section, the section does not display.

Future Visits

Displays a bulleted list of pending and rescheduled appointment encounters. The list includes the provider, the date, and the time of the pending appointment.

Note: If the **Secure Schedule** check box is selected for the provider in **TW Admin > TWUserAdmin > User Admin**, this list does not include pending appointments for this provider. The check box is located in the **Provider Detail 1** section.

If there is no data to import into this section, the section does not display.

Healthcare Providers

The **Healthcare Providers** section includes the following information:

Provider

The provider's name, in LastName, FirstName, Credentials format.

Address

The site address, including street, city, state, and zip code.

Phone

The site phone number, including area code.

Document Details

The **Document Details** section includes the following information:

Encounter

The date and time of the encounter in context, in Month DD, YYYY HH:MM format.

Created

The date and time the Clinical Summary was created, in Month DD, YYYY HH:MM format.

From

Information about the release from which the Clinical Summary was created.

Site

The name and address of the site from which the encounter was documented.

Work Phone

The site phone number, including area code.

By

The name of the provider.

If not noted above, fields that do not contain data display the following message: "Not documented."

Clinical Summary-RTF document type

This document type is delivered to provide a Clinical Summary document that meets American Recovery and Reinvestment Act (ARRA) Meaningful Use requirements and also provides a clear, readable, and understandable encounter record for patients. It can only be used for Clinical Summaries that are printed or saved to media. Clinical Summaries sent to Allscripts Patient Portal must be Clinical Summary-CED or a v10 Note type designated as a Clinical Summary in the Document Type dictionary.

The Clinical Summary-RTF document is made up of the following sections:

Patient

The **Patient** section of the Clinical Summary-RTF document contains the following information:

Name

Displays the patient's name in FirstName LastName format.

Address

Displays the patient's address.

Phone

Displays the patient's home phone number, including area code.

MRN

Displays the patient's medical record number (MRN).

Date of Birth

Displays the patient's birth date, in MM/DD/YYYY format.

Language

Displays the language spoken by the patient. If no language information is included in the patient demographics, **Not Documented** displays.

Appointment Date and Time

Displays the date and time of the appointment with which this Clinical Summary associated in MM/DD/YYYY; HH:MM AM/PM format.

Reason for Visit

Information displayed here depends on how the **CSDefaultReasonForVisitNoteSection** preference is set. The text from either the Reason for Visit or Chief Complaint section of the note associated with the encounter displays. This section also displays Chief Complaints selected from the **Add Clinical Item** (ACI) workspace during the encounter. If the preference is set to **None**, nothing displays in this section. If there is no data to import into this section, the section is suppressed.

Assessed Problems

Displays a bulleted list of problems assessed during the current encounter. If there is no data to import into this section, the section is suppressed.

Treatment Plan

The **Treatment Plan** section of the Clinical Summary-RTF document contains the following information:

Medication Changes

Displays a bulleted list of any medications that were added, renewed, or discontinued during the current encounter. Existing medications that were unchanged during the encounter are not listed. In other words, medications updated to **Record D/C** are not listed.

Labs/Procedures/Imaging

Displays a bulleted list of any labs or procedures that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Instructions

Displays a bulleted list of all instructions ordered with the encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Follow-ups/Referrals

Displays a bulleted list of any follow-ups or referrals that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Supplies

Displays a bulleted list of any supplies that were ordered during the current encounter. If an order was created, but not completed, the **To Be Done** date displays with the item. If an order was completed in this encounter, the **Done** date displays.

Medications/Immunizations Administered

Displays a bulleted list of medications or immunizations that were administered during the current encounter or ordered to be administered later. If the administration was only ordered, the **Item Name** and the **To Be Done** date are displayed. If the item was ordered and administered during the encounter, the **Item Name** and **Administered on** date are displayed.

Information displayed here depends on how the **CSDefaultTreatmentPlanNoteSection** preference is set and whether the note associated with the encounter is a v10 Note or a v11 Note. If the note associated with the encounter is a v10 Note, text from either the Orders or Discussed section of the note displays. If the note associated with the encounter is a v11 Note, the text from either the Plan or Discussion/Summary section of the note is displayed. If the preference is set to **None**, nothing displays in this section. If there is no data to import into this section, the section is suppressed.

Vitals

Displays the date and time the vitals were recorded and lists all vitals recording during the encounter. If there is no data to import into this section, the section is suppressed.

Current Medications

Displays a bulleted list of all current active medications for the patient. If there is no data to import into this section, the following message displays: "No Active Medications."

Allergies

Displays a bulleted list of the patient's active allergies. The list includes the allergy name, and associated reactions (if any). If there is no data to import into this section, the following message displays: "No Known Allergies."

Results

This section displays results of orders entered by the provider linked to the current encounter. Results entered in Allscripts Enterprise EHR, as well as received through an interface that are recorded within a certain number of days of the encounter are listed. If there is no data to import into this section, the section should be omitted or suppressed from the Clinical Summary.

Future Appointments

Displays a bulleted list of pending appointment encounters. The list includes the provider, the date, and the time of the pending appointment. If there is no data to import into this section, the section is suppressed.

Document and Provider Details

This **Document and Provider Details** section includes the following information:

Document

Lists the document as a Clinical Summary.

Site

The site from which the encounter was documented.

Provider

The provider's name, in FirstName LastName, Credentials format.

Provider address

The site address. If not available, this section does not display in the Clinical Summary.

Provider Phone

The site phone number, including area code. If not available, this section does not display in the Clinical Summary.

If not noted above, fields that do not contain data display the following message: "Not documented."

CSDefaultReasonForVisitNoteSection preference

The **CSDefaultReasonForVisitNoteSection** preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level, but it can also be overridden by the user.

The **CSDefaultReasonForVisitNoteSection** preference enables you to define the information that should cite into the **Reason for Visit** section of the Clinical Summary-RTF or Visit Summary CED. If this preference is set to **Reason for Visit**, information from the **Reason for Visit** section of a V10 or V11 note is cited into the **Reason for Visit** section of the Clinical Summary. This includes any free text comments that are in that note section. If this preference is set to **Chief Complaint**, information from the **Chief Complaint** section of a V10 or V11 note is cited into the **Reason for Visit** section of the Clinical Summary. This includes any free text comments that are in that note section. If this preference is set to **None**, no text

comments from the structured note are cited into the **Reason for Visit** section of the Clinical Summary.

This preference is set to **Reason for Visit** by default.

CSDefaultTreatmentPlanNoteSection preference

The **CSDefaultTreatmentPlanNoteSection** preference is found on the **General** tab of Preferences in TWAdmin. You can set this preference at both the Enterprise and Organization level, but it can also be overridden by the user.

The **CSDefaultTreatmentPlanNoteSection** preference enables you to define the information that should cite into the **Treatment Plan** section of the Clinical Summary-RTF or Visit Summary CED. If this preference is set to **Order/Plan**, information from the **Orders** section of a V10 note or the **Plan** section of a V11 note is cited into the **Treatment Plan** section of the Clinical Summary. This includes any free text comments that are in that note section. If this preference is set to **Discussion/Summary**, information from the **Discussed** section of a V10 note or the **Discussion Summary** section of a V11 note is cited into the **Treatment Plan** section of the Clinical Summary. If this preference is set to **None**, no text comments from the structured note are cited into the **Treatment Plan** section of the Clinical Summary.

This preference is set to **Order/Plan** by default.

CSIncludeProblemSection preference

This preference controls whether the **Problems** section displays in a Clinical Summary that uses the Clinical Summary-CED document type. If included, the section includes a list of active problems for the patient. If this preference is set to **No** (default value), the **Problems** section is not included in the Clinical Summary. If this preference is set to **Yes**, the section is included in the Clinical Summary.

Valid values	Default value	Level	User
No Yes	No	Ent/Org	N/A

Set auto-print defaults for the Clinical Summary

You can set these defaults for Providers Only and All Users. Only the **Original** copy type is available for Clinical Summaries. You can only print a Clinical Summary; faxing is not supported.

If you are printing the Clinical Summary, the application uses the auto-print defaults set up in TWAdmin to determine which printer to use and other settings. No Print dialog appears at the time of printing. If no auto-print defaults are set, the application displays a Print dialog at the time of printing.

You can print Clinical Summaries for v10 and v11 Notes and for CEDs, if there is no v10/v11 Note linked to the encounter.

Note: These steps describe setting up the Auto-Print defaults for Clinical Summary-CED only. Auto-print defaults for v10 and v11 document types are set up separately. However, the current functionality does not differ when using these document types as Clinical Summary.

This task has 8 steps.

1. Log into Allscripts Enterprise EHR™ using the TWAdmin username and password.
2. Select **Printing** from the vertical toolbar.
3. Select the **AutoPrint Defaults** tab.
4. In the **Type** drop-down, select **Clinical Exchange Document**.
5. From the list on the left, select the document you want to configure.
6. Click **Add/Edit Settings**.
7. Make the appropriate changes.

For details on the available settings, refer to the *Application Design and Behavior Resource*.

8. Click **OK**.

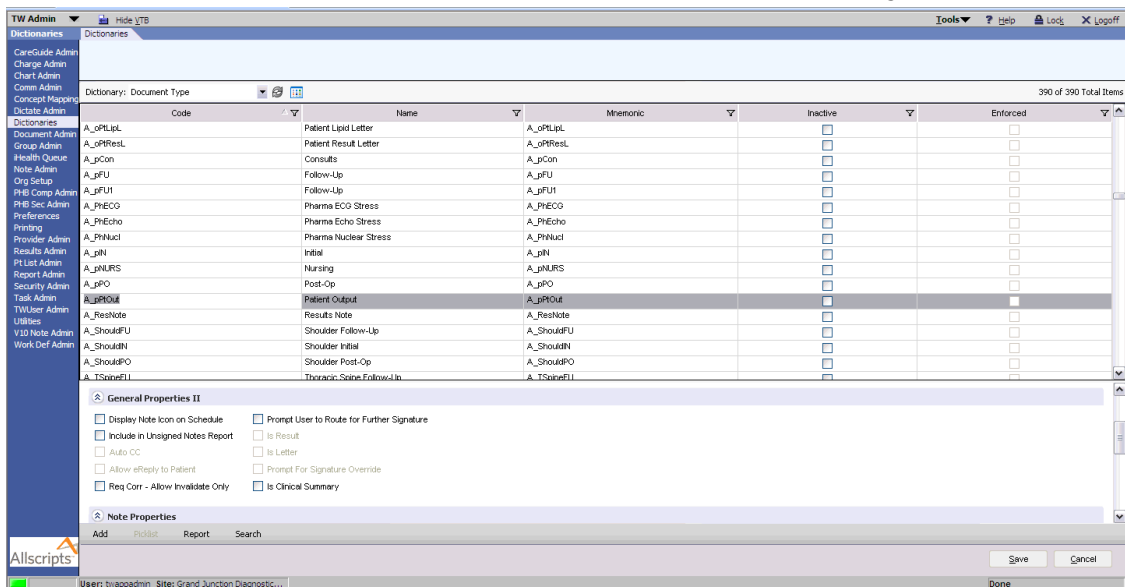
Mark a document type as a Clinical Summary

Allscripts delivers two document types to be used for Clinical Summaries: Clinical Summary-CED and Clinical Summary-RTF. To mark additional document types as Clinical

Summary documents, you use the **Is Clinical Summary** property in the Document Type dictionary. You can designate v10 and v11 Note types as Clinical Summaries. You cannot create new document types for CEDs.

This task has 6 steps.

1. Log into Allscripts Enterprise EHR™ using the TWAdmin username and password.
2. Select **Dictionaries** from the vertical toolbar.
3. Select **Document Type** from the **Dictionary** drop-down.
4. In the grid, select the document type you want to mark as a Clinical Summary.
5. In the **General Properties II** section, select the **Is Clinical Summary** check box.



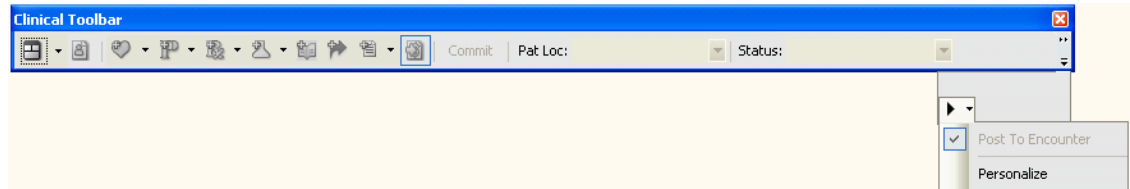
The screenshot shows the TWAdmin interface with the 'Document Type' dictionary selected. The grid lists various document types with columns for Code, Name, Mnemonic, Inactive, and Enforced. The 'Patient Output' document type (Code: A_pPO) is selected. Below the grid, the 'General Properties II' section is expanded, and the 'Is Clinical Summary' checkbox is checked. Other checkboxes include 'Display Note Icon on Schedule', 'Include in Unsigned Notes Report', 'Auto CC', 'Allow eReply to Patient', 'Req Corr - Allow Invalidate Only', 'Prompt User to Route for Further Signature', 'Is Result', 'Is Letter', and 'Prompt For Signature Override'. The 'Note Properties' section is also visible at the bottom.

6. Click **Save**.

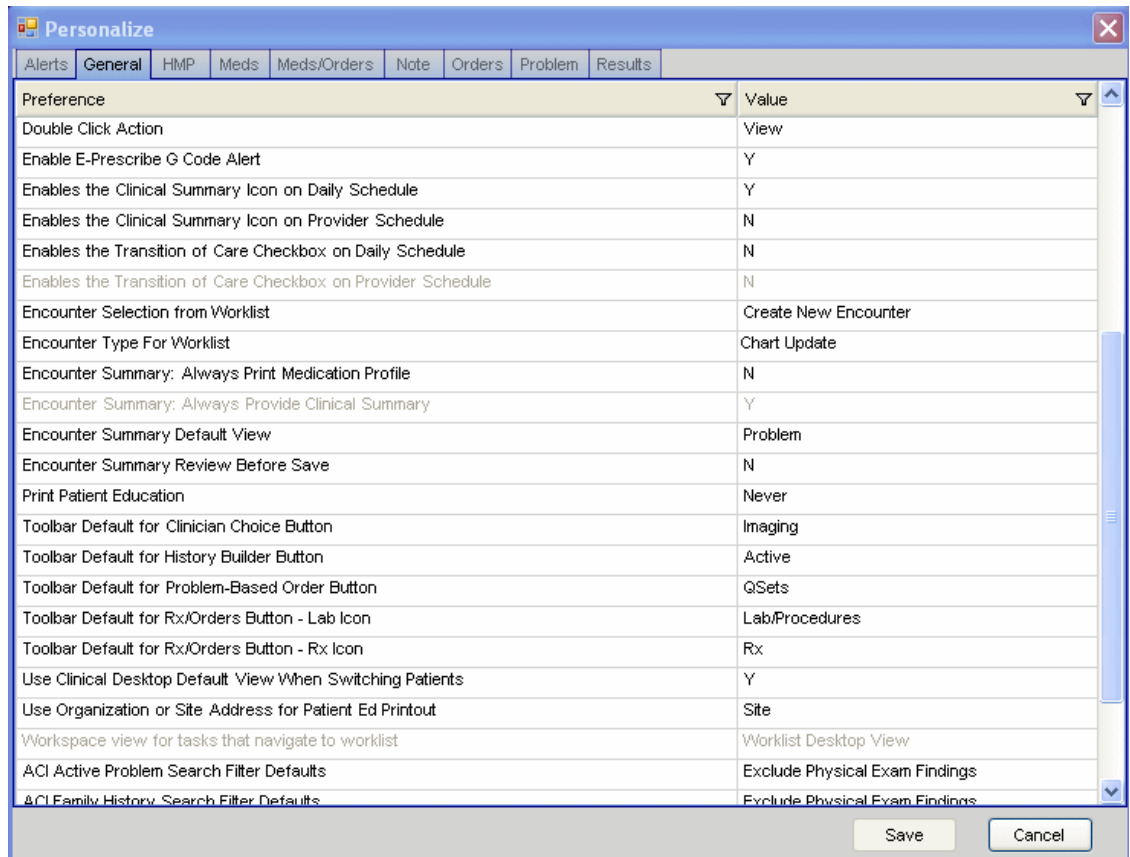
Personalize Daily and Provider Schedules to display Clinical Summary (CS) icon

This task has 5 steps.

1. Click the **Main Menu** arrow on the Clinical Toolbar.



2. Select **Personalize**.
3. Click **General**.



4. To display the Clinical Summary icon on the Daily Schedule, select **Enables the Clinical Summary Icon on Daily Schedule** and set the Value to **Y**.
5. To display the Clinical Summary icon on the Provider Schedule, select **Enables the Clinical Summary Icon on Provider Schedule** and set the Value to **Y**.

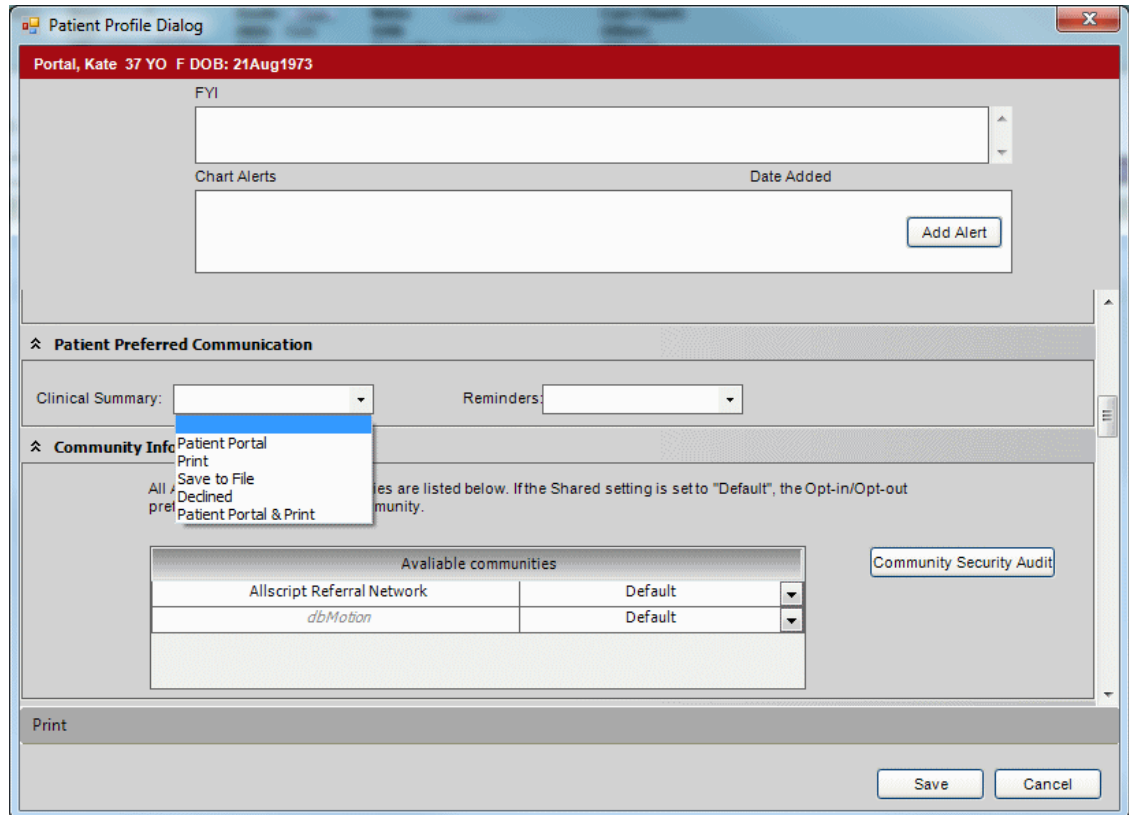
Note: If these preferences are grayed out, then the system administrator has not selected the **User Can Override** check box for them in **TWAdmin > Preferences**.

Document a patient's preferred method of communication for Clinical Summaries

Before you begin

You must have the Patient Profile Edit security class in TWAdmin to make changes to the Patient Profile. The PtCommunicationClinSummariesEditable preference (part of the General group) must be set to **Y**.

1. In Allscripts Enterprise EHR™, with a patient in context, click the **i** icon on the Patient Banner or highlight a patient on the schedule and click **Patient Profile**.



The screenshot shows the 'Patient Profile Dialog' window for a patient named Kate, 37 years old, female, born on 21 Aug 1973. The window is divided into several sections:

- FYI:** A text input field.
- Chart Alerts:** A table with columns for 'Chart Alerts' and 'Date Added', and an 'Add Alert' button.
- Patient Preferred Communication:** Contains two dropdown menus: 'Clinical Summary:' and 'Reminders:'. The 'Clinical Summary:' dropdown is currently open, showing options: 'Patient Portal', 'Print', 'Save to File', 'Declined', and 'Patient Portal & Print'. 'Patient Portal' is selected.
- Community Info:** Contains a table of 'Available communities' and a 'Community Security Audit' button.

Available communities	
Allscript Referral Network	Default
dbMotion	Default

At the bottom of the window are 'Print', 'Save', and 'Cancel' buttons.

2. In the **Patient Preferred Communication** section, select the appropriate communication method from the **Clinical Summary** drop-down.

The default is **Print** unless the patient is enrolled in Patient Portal. The choices in this field come from the Clinical Summary picklist in the Patient Communication dictionary.

For details on how the application sends or prints Clinical Summaries, refer to the Provide Clinical Summaries documentation.

Note: If the patient is enrolled in Patient Portal, the default is **Patient Portal**. This option and **Patient Portal & Print** are available only if the patient is enrolled in Patient Portal.

3. Click **Save**.

What to do next

Changes to the patient's preferred communication method are recorded in the Audit Log and appear on the Patient Profile printout.



Configuration considerations

If a patient is later enrolled in Patient Portal, and the default settings for Clinical Summary have never been changed (that is, it is still **Print**), the application automatically updates the settings to the Patient Portal defaults described above. If the settings have been changed, you must manually update them to the Patient Portal defaults (if appropriate).

|| **Note:** If the portal is MS HealthVault, the application leaves the default set to **Mail**.

Security considerations when providing the Clinical Summary

You must have Chart View and Chart Print security in order to provide the Clinical Summary to patients. If you do not have Chart View and Chart Print security, the application displays a message, `You do not have privileges to provide Clinical Summary.`

If you do have Chart View and Chart Print security, the application next checks to see if there are Clinical Summary documents linked to the Arrived Appointment encounter. If so, then based on the security of those documents, the application verifies if you have adequate security to view them. If not, the application displays a message, `You do not have privileges to view one or more Clinical Summary Notes and does not allow you to provide the Clinical Summary.`



Security considerations when providing the Clinical Summary

What the Clinical Summary (CS) icon indicates

The **CS** column on the Daily and Provider Schedule displays an icon indicating whether or not the Clinical Summary has been provided for the appointment. This icon appears only for arrived appointments. (If you change the status of the appointment to something other than arrived, the icon no longer appears.)

Note: The CS column appears only if the EnableCSOnScheduleDaily and EnableCSOnScheduleProvider preferences are set to **Y** at both the system and your individual user level, and you have added the CS column to your Daily or Provider Schedule. These preferences are set from **TWAdmin > Preferences** and are in the **General** preference set.

There are two appearances of this icon.



This icon indicates the Clinical Summary has **not** been provided and that action is required.



This icon indicates the Clinical Summary has been printed, sent to the patient portal, printed and sent to the portal, or saved to a file. (The tooltip indicates exactly which action was performed, based on the patient preference.) This icon can also indicate that no action is required.

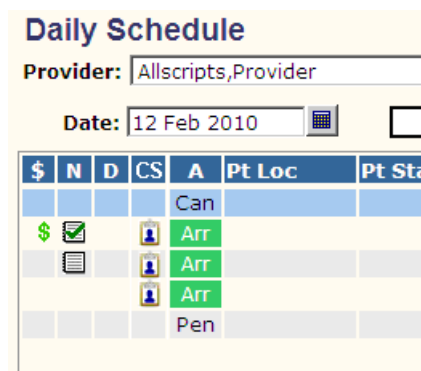
What the Clinical Summary (CS) icon indicates

The CS column can also indicate **N/A**, which means that the patient preference for Clinical Summaries is set to **Declined**.

When you click the icon in its “action required” state, Allscripts Enterprise EHR™ provides the Clinical Summary in whatever format the patient has indicated as his or her preference in the **Patient Profile** (Print, Patient Portal, Save to File and Patient Portal & Print).

The following examples show how the CS icon appears on the Daily Schedule.

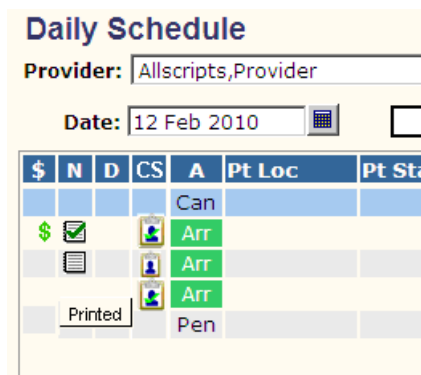
For Initial state - action required:



Daily Schedule
 Provider: Allscripts,Provider
 Date: 12 Feb 2010

\$	N	D	CS	A	Pt Loc	Pt Sta
				Can		
\$	✓		👤	Arr		
			👤	Arr		
			👤	Arr		
				Pen		

For Clinical Summary provided - tooltip indicates method:



Daily Schedule
 Provider: Allscripts,Provider
 Date: 12 Feb 2010

\$	N	D	CS	A	Pt Loc	Pt Sta
				Can		
\$	✓		👤	Arr		
			👤	Arr		
			👤	Arr		
				Pen		

Printed



For Clinical Summary declined by patient:

What the Clinical Summary (CS) icon indicates

Daily Schedule

Provider: Allscripts,Provider

Date: 12 Feb 2010

\$	N	D	CS	A	Pt Loc	Pt Sta
				Can		
\$	✓			Arr		
				Arr		
				Arr		
				Arr		
				Clinical Summary Declined		



What the Clinical Summary (CS) icon indicates

How a Clinical Summary is generated based on the patient's Clinical Summary preference

Based on the patient's Clinical Summary preference in his or her Patient Profile, Allscripts Enterprise EHR™ generates the Clinical Summary in different ways.

If the patient's Clinical Summary preference is...

- > **Print**, the application prints the Clinical Summary using the auto-print defaults set up in TWAdmin. Auto-print defaults are not required, but can be used to automate as with printing any document. If auto-print defaults are not defined, the application displays the **Print** dialog so you can choose the printer. The format in which the Clinical Summary is printed is determined by the value set for the **DefaultClinicalSummaryDocument** preference.
- > **Save to File**, the application saves the Clinical Summary to any drive that you specify (typically a Flash/USB drive that the patient has provided). You can save the Clinical Summary for a CED, RTF, or v10/v11 Note to file as a PDF.
- > **Patient Portal**, the application sends the Clinical Summary to the portal (only for v10 Notes and CEDs).
- > **Declined**, the application does not generate the Clinical Summary and the Provider or Daily Schedule displays N/A for the appointment. You receive credit for attempting to provide the Clinical Summary.
- > **Patient Portal & Print**, the application prints the Clinical Summary and also sends it to the portal.

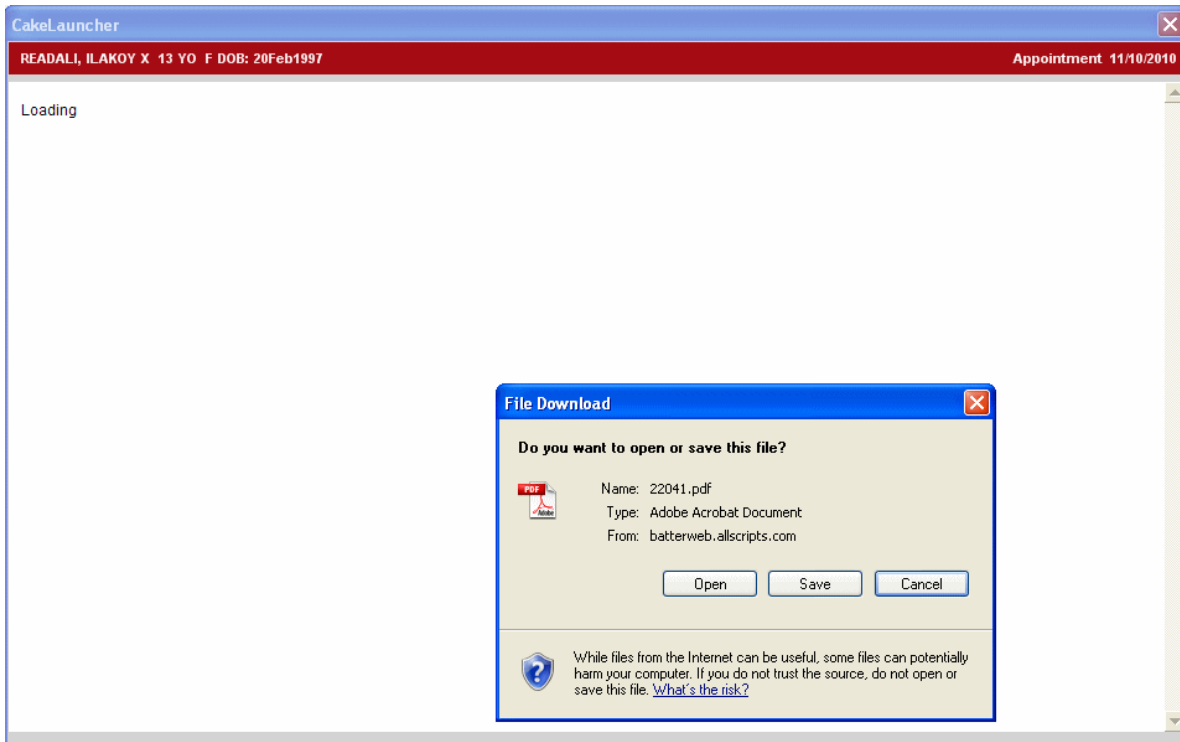
Note: If a v10 or v11 Note is linked to the encounter, that document is printed, but the CED is sent to Portal. The one exception is if the portal is Intuit Health and the Note is v10 Note. In that case the application can send the v10 Note to Portal, as well as print for the patient.

If the patient does not have a preference set, the application behaves as if the preference were **Print**.

How a Clinical Summary is generated based on the patient's Clinical Summary preference

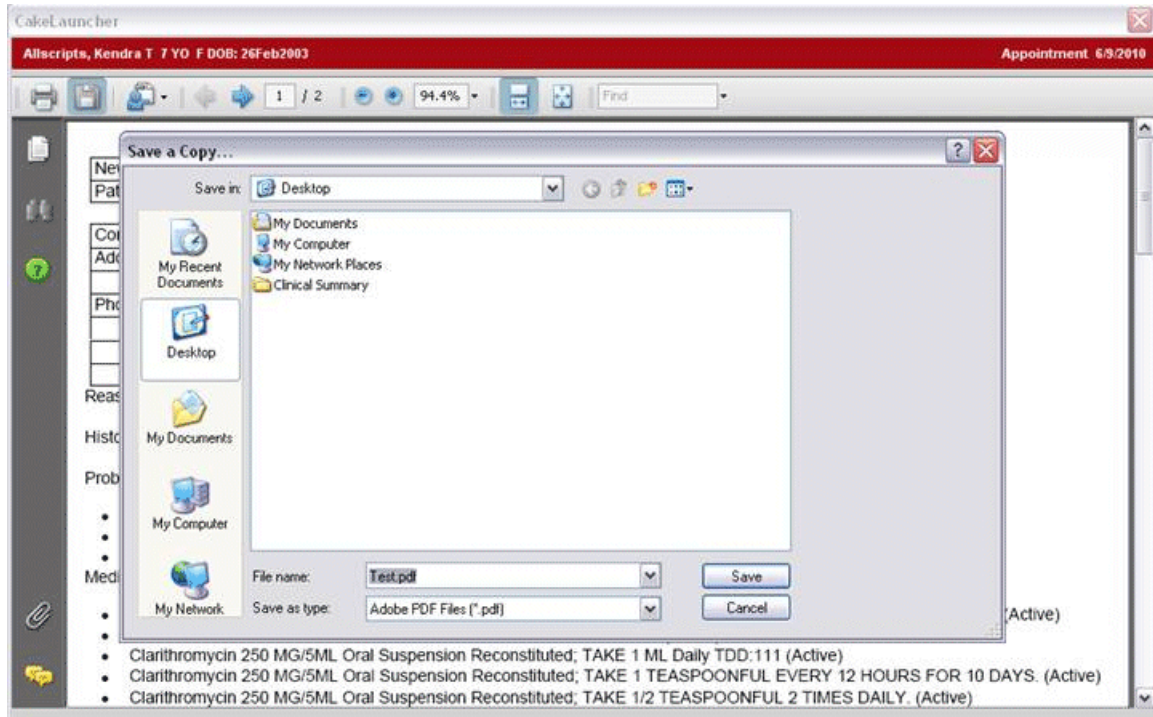
Saving a Clinical Summary to file

When the patient Clinical Summary preference is set to Save to File, when you generate the Clinical Summary, the CakeLauncher page displays, along with a prompt to Open or Save the file.



If you click **Open**, you can preview the PDF file. You can then save the file from the preview page. If you click **Save**, you are immediately prompted to select the location to which you want to save the file based on the electronic media (for example, a USB drive) presented by the patient.

How a Clinical Summary is generated based on the patient's Clinical Summary preference





How a Clinical Summary is generated based on the patient's Clinical Summary preference

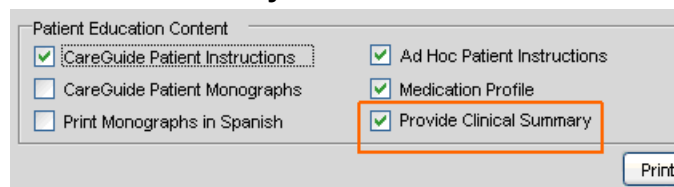
Provide a Clinical Summary from the Encounter Summary

Before you begin

These steps assume you have completed the chart note, committed the encounter and are viewing the **Encounter Summary**.

Note: You must have Chart-View security enabled to provide the Clinical Summary. If you do not, the application displays the standard Document Security warning and you cannot provide the Clinical Summary.

1. Review the **Encounter Summary** to verify you are ready to provide the Clinical Summary.
2. Select the **Provide Clinical Summary** check box.



Patient Education Content

<input checked="" type="checkbox"/> CareGuide Patient Instructions	<input checked="" type="checkbox"/> Ad Hoc Patient Instructions
<input type="checkbox"/> CareGuide Patient Monographs	<input checked="" type="checkbox"/> Medication Profile
<input type="checkbox"/> Print Monographs in Spanish	<input checked="" type="checkbox"/> Provide Clinical Summary

Print

3. Click **Save & Continue** or **Print Pt. Ed.**

One of the following happens.

- > If the note has been finalized, the application generates the Clinical Summary according to the patient's **Clinical Summary** preference in the **Patient Profile**.
- > If the note has not been finalized and the **AllowClinicalSummaryWhenNoteUnFinal** preference is set to **Y**, the application generates the Clinical Summary according to the patient's **Clinical Summary** preference in the **Patient Profile**.
- > If the note has not been finalized and the **AllowClinicalSummaryWhenNoteUnFinal** preference is set to **N**, a message appears: The document that you are trying to print as a Clinical Summary has not been finalized. This

Provide a Clinical Summary from the Encounter Summary

document must be final in order to provide as a Clinical Summary.

- > If there is no v10 or v11 document linked to the encounter, the application generates a Clinical Summary in either RTF or CED format, depending on how the **DefaultClinicalSummaryDocument** preference is set for the user and according to the patient's **Clinical Summary** preference in the **Patient Profile**.

For details on how the Clinical Summary is generated, refer to *How a Clinical Summary is generated based on the patient's Clinical Summary preference*.

After the Clinical Summary is generated, the application updates the icon in the **CS** column of the Provider or Daily Schedule to reflect that the Clinical Summary has either been provided or declined. The tooltip associated with the icon reflects exactly what action was performed. You can click it again and generate another Clinical Summary if further updates are made to the encounter. If a note was used as the Clinical Summary the first time, the most recent version of the note is retrieved when you click the icon again. If a CCD was used as the Clinical Summary the first time, the CCD is regenerated when you click the icon again.

Provide a Clinical Summary from the Daily or Provider Schedule

Before you begin

These steps assume the provider has completed the patient encounter.

These steps also assume that the chart note or other document linked to the encounter is set up to be a Clinical Summary document type.

Note: You must have Chart-View security enabled to provide the Clinical Summary. If you do not, the application displays the standard Document Security warning and you cannot provide the Clinical Summary.

On the Schedule, click the icon in the **CS** column beside the appointment.

One of the following happens.

- > If the note has been finalized, the application generates the Clinical Summary according to the patient's **Clinical Summary** preference in the **Patient Profile**.
- > If the note has not been finalized and the **AllowClinicalSummaryWhenNoteUnFinal** preference is set to **Y**, the application generates the Clinical Summary according to the patient's **Clinical Summary** preference in the **Patient Profile**.
- > If the note has not been finalized and the **AllowClinicalSummaryWhenNoteUnFinal** preference is set to **N**, a message appears: The document that you are trying to print as a Clinical Summary has not been finalized. This document must be final in order to provide as a Clinical Summary.
- > If there is no v10 or v11 document linked to the encounter, the application generates a Clinical Summary in either RTF or CED format, depending on how the **DefaultClinicalSummaryDocument** preference is set for the user and according to the patient's **Clinical Summary** preference in the **Patient Profile**.

Provide a Clinical Summary from the Daily or Provider Schedule

For details about how the Clinical Summary is generated, refer to *How a Clinical Summary is generated based on the patient's Clinical Summary preference*.

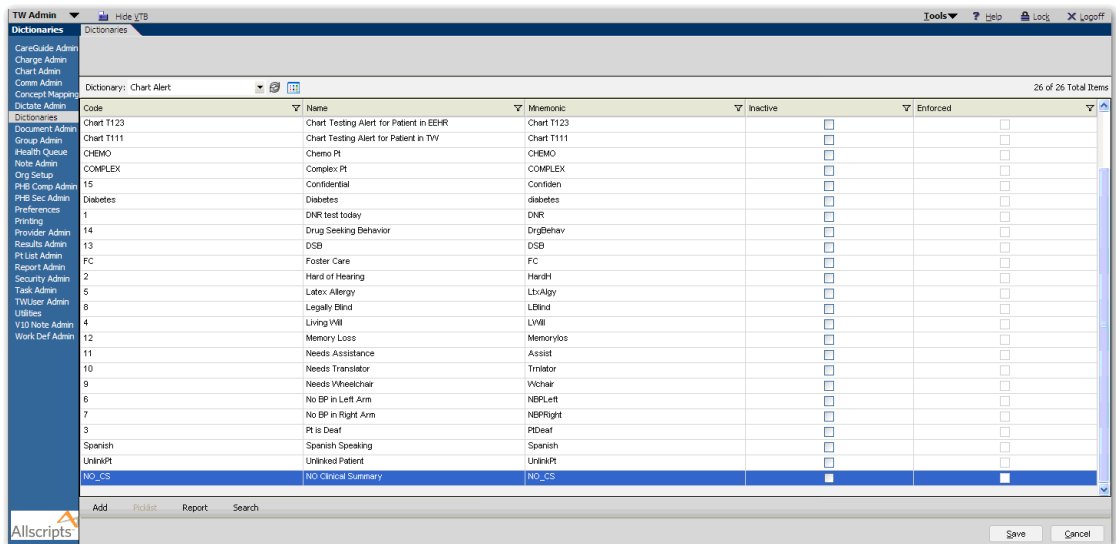
After the Clinical Summary is generated, the application updates the icon in the **CS** column of the Provider or Daily Schedule to reflect that the Clinical Summary has either been provided or declined. The tooltip associated with the icon reflects exactly what action was performed. You can click it again and generate another Clinical Summary if further updates are made to the encounter. If a note was used as the Clinical Summary the first time, the most recent version of the note is retrieved when you click the icon again. If a CCD was used as the Clinical Summary the first time, the CCD is regenerated when you click the icon again.

Add a Chart Alert to indicate the Clinical Summary should not be provided

Sometimes a provider might not want the Clinical Summary provided to the patient. The patient's chart or encounter may contain clinical items that should be withheld from such a summary, or that require direct provider follow-up with the patient.

1. In the **Chart Alerts Dictionary**, add a new chart alert to notify users that Clinical Summary should not be provided.

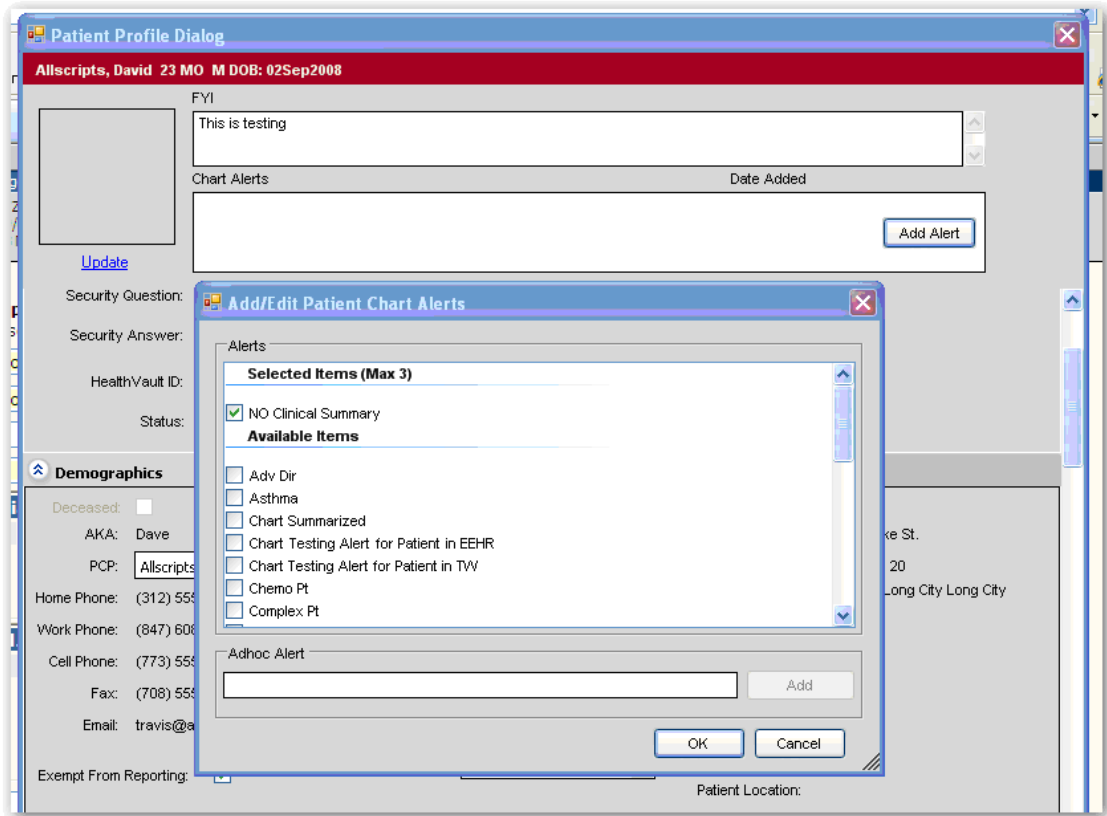
Refer to the ADBR for detailed instructions on using the Chart Alerts Dictionary.



Code	Name	Mnemonic	Inactive	Enforced
Chart T123	Chart Testing Alert for Patient in EHR	Chart T123	<input type="checkbox"/>	<input type="checkbox"/>
Chart T111	Chart Testing Alert for Patient in TW	Chart T111	<input type="checkbox"/>	<input type="checkbox"/>
CHEMO	Chemo Pt	CHEMO	<input type="checkbox"/>	<input type="checkbox"/>
COMPLEX	Complex Pt	COMPLEX	<input type="checkbox"/>	<input type="checkbox"/>
	Confidential	Confiden	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	Diabetes	diabetes	<input type="checkbox"/>	<input type="checkbox"/>
1	CNR test today	CNR	<input type="checkbox"/>	<input type="checkbox"/>
14	Drug Seeking Behavior	DrugBehav	<input type="checkbox"/>	<input type="checkbox"/>
13	DSB	DSB	<input type="checkbox"/>	<input type="checkbox"/>
FC	Foster Care	FC	<input type="checkbox"/>	<input type="checkbox"/>
2	Hard of Hearing	HardH	<input type="checkbox"/>	<input type="checkbox"/>
5	Ltfx: Allergy	LtfxAlrgy	<input type="checkbox"/>	<input type="checkbox"/>
8	Legally Blind	LBlind	<input type="checkbox"/>	<input type="checkbox"/>
4	Living Will	LWill	<input type="checkbox"/>	<input type="checkbox"/>
12	Memory Loss	Memorylos	<input type="checkbox"/>	<input type="checkbox"/>
11	Needs Assistance	Assist	<input type="checkbox"/>	<input type="checkbox"/>
10	Needs Translator	Translator	<input type="checkbox"/>	<input type="checkbox"/>
9	Needs Wheelchair	Wchair	<input type="checkbox"/>	<input type="checkbox"/>
6	No BP in Left Arm	NEPLleft	<input type="checkbox"/>	<input type="checkbox"/>
7	No BP in Right Arm	NEPRight	<input type="checkbox"/>	<input type="checkbox"/>
3	Pt is Deaf	PtDeaf	<input type="checkbox"/>	<input type="checkbox"/>
Spanish	Spanish Speaking	Spanish	<input type="checkbox"/>	<input type="checkbox"/>
UnlinkPt	Unlinked Patient	UnlinkPt	<input type="checkbox"/>	<input type="checkbox"/>
NO_CS	NO Clinical Summary	NO_CS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. In **Patient Demographics**, select the Chart Alert that indicates not to provide a Clinical Summary.

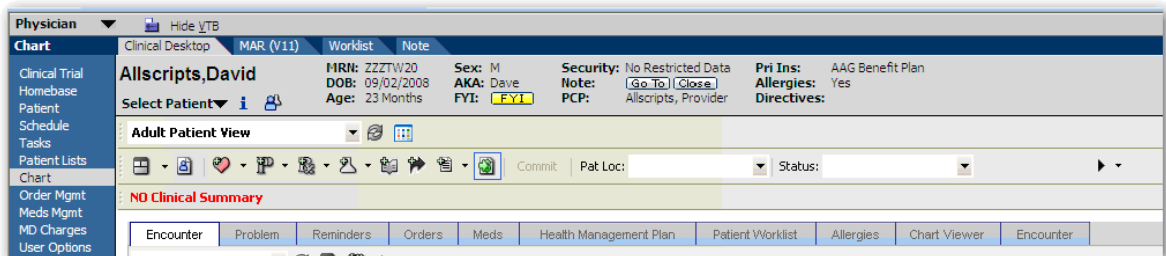
Add a Chart Alert to indicate the Clinical Summary should not be provided



3. Click **OK** to apply the Chart Alert.

Results of this task

When a provider or clinical staff views the patient's chart he or she now knows that the Clinical Summary should not be provided to the patient, and the action on the Schedule can be ignored.



For more information

For more information, go to the Allscripts™ Client Support page at www.allscripts.com/client-login.asp. You can access the product documentation library from that page.

This task has 8 steps.

1. Select your product.
For example, **Allscripts Professional EHR**.
2. Enter your login credentials in **User ID** and **Password**.

Note: If you do not have a User ID and Password for the Allscripts Client Support page, click the link on the right side of the page to register for an account.
3. Click **Log in**.
4. Click the **Product Documentation** tab.
5. For **Select Product**, select the product for which you want to view documentation.
For example, **Allscripts Professional EHR**.
6. For **Select Release Name**, select a release for your selected product.
For example, **9.0**.
7. For **Select Documentation Type**, select the type of documentation you want to view.
For example, **Release Notes**.
8. Click the document you want to view.



For more information

Contact us

We welcome your feedback. To submit a question, comment, or suggestion regarding product documentation, send an email to techpubsteam@allscripts.com.

Please include as much of the following information in your email as possible so that we are better able to address your comments.

- > The product name and release
- > The title of the document you are referring to (PDF only)
- > The title of the section you are referring to (PDF only)
- > The date that appears on the bottom of the page in the document (PDF only)
- > The version and build number of the help system you are referring to (online help only)
- > The title of the help topic you are referring to (online help only)



Contact us