Documentation - Setup

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Version : 21

Published : April 2024

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for the **Documentation Setup application** for release Version 21. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 21 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Release Identifier (Jira or Work Request number) and the description. If further information is needed, please contact **Client Services**.

NOTE: *There are no new enhancements for release Version 21.07.*

Chapter 2 Overview

The TruBridge EHR Documentation application provides a complete ambulatory charting system for management of patient care in the Emergency Department and TruBridge Provider-EHR software. It allows multiple users to access, view, and document on the same patient record while the TruBridge EHR maintains the integrity of the individual entry without interrupting work flow. The Documentation application uses both Provation® and TruBridge documents which, together, provide the most up-to-date clinical content. It also allows for customized Documentation Reports that may be built to bring together all pertinent information into one final note.

This user guide will explain in detail all the setup options for the Documentation application.

NOTE: *HIPAA regulations require that Psychotherapy Notes be kept separate from the rest of the medical record and that only the originator of the document have access to them. The TruBridge EHR is built to be a collaborative tool and therefore does not have the ability to control access specifically to Psychotherapy Notes. For this reason, all Psychotherapy Notes should be stored outside the TruBridge EHR.*

Chapter 3 Signature Statements

3.1 Overview

The Signature Statements table allows for the creation of pre-defined physician statements which will populate on the Document and Report signature screens. These statements, when selected, will display on documents and reports above the signature line.

- The statements contained within the drop-down menu will display in the order in which they are entered in the setup table.
- There is no default statement.The drop-down menu will be blank when the signature screen is opened.
- Users will have the ability to select "Other" from the drop-down menu, which allows a free text capability within a rich text box.
- Once selected, a statement may have characters added or deleted from the pre-defined statement. Any edits made from this area will not save to the original pre-defined statement. Any changes made will only reflect on the documents and reports users sign from this screen.
- If a document is amended, the statement that was previously used will be removed.
- The signature statement will show only in the PDF version of the document or report.

3.2 To Add a Signature Statement

Select **Tables** > **Clinical** > **Signature Statements**

The following buttons are available within the action bar:

- **New:** Allows the user to create a pre-defined statement on the Signature Statement Edit screen.
- **Edit:** Allows the user to make edits to an existing pre-defined signature statement. When selected, this will open the Signature Edit Screen.
- **Delete:** Once a signature statement is selected, this button will become available. When selected, the prompt, "Are you sure you want to delete?" will display. Users may then select **Yes** to remove the signature statement or **No** to return to the Signature Statements List.
- **Change Order:** Allows the user to change to order in which the signature statements display.

To add a Signature Statement:

1. Select **New**.

2. Type a description in the **Description** field.

3. Type a pre-defined statement.This statement is what will appear above the signature line on documentation documents and reports.

4. Select **Update** to save the information.

Chapter 4 Department Categories

4.1 Overview

The Department Category option allows the facility to assign categories to a department. Once categories have been assigned to the department, specific documents may be added to the category. The assigned categories and documents will be accessible from the New Documents option on the Document Tree in the designated department.

4.2 Category Setup

From within the Clinical are of Tables, select **Department Categories** to access the department setup.

- A list of departments that are currently set up to use the Point of Care Whiteboard will be listed in the Department Menu drop-down menu. Please see the Point of Care Setup user guide for additional information on setting up the Point Of Care Whiteboard.

- Once the department has been located in the drop-down menu, select the department to access the Category setup.

Several set up options are available from the action bar.

- **New** will launch the Category Maintenance screen where categories may be assigned to the department.

- **Copy** allows the current departments setup to be copied to another department.

- **Preview** will display the a preview of the categories and documents as they will appear when New is selected from the Documentation main page.

A Category must be added to a department before specific documents may be selected. Select **New** from the action bar to add a Category to the department. The Clinical Documentation Category Maintenance page will then display.

To create a new Category:

- Type the Category name into the Category text box. This may be up to 50 characters.

- Select Save.

To select a preexisting Category Title:

- Select the Binocular icon to launch the Category display menu.
- Select the Category and select the Back Arrow to return to the Clinical Documentation Category Maintenance page.
- Select **Save** to save the category.

4.3 Adding/Removing Documents to a Category

To add documents to a category, select **Add** to display the Document look-up page. From here, Documents may be added to the Category.

- Select a Document type to search for a specific type of document.
  - The available document types are Flowcharts, Forms and Multi-Clinician Documents.
- The Title Search field may be used to search for a Document by the Title.
- Once the document has been located within the table, double-click the document to add the Document to the Category or select the document and choose the select button from the action bar. Descriptions entered in the Description field of a document in Document Maintenance will display.
- Documents may be multi-selected using the Shift/Control keys on the keyboard.
- This process may be repeated as many times as needed.
- Once all Documents have been added to the Category, several options are available from the action bar and may be used to edit the Documents that are listed in the category.
  - The **Back Arrow** will return the user to the Department Category Listing.
  - **Save** will save any changes that have been made to the Category.
  - **New** is for TruBridge use only and will be inactive.
  - **Add** may be selected to add additional Documents to the Category.
  - **Change Order** may be selected to change the order that the Documents will display within the Category.
- When a Document is selected, Review and Edit will appear on the action bar.
  - Remove will remove the selected Document from the Category.
  - Edit will launch the Document Setup screen. Please see the Document Setup section for additional information.

Once all changes have been made to the Category, select Save and the Back Arrow to return to the Department Category Listing.

4.4 Copying a Category

The Copy option from the action bar will allow the setup of the current department to be copied to another department.

- To copy a department's categories, select the department that the categories are to be copied from and select **Copy**.
- The Department look-up table will then display.
- Double click the department from the look-up table to paste the setup.
- The selected departments setup will then display with the copied setup.

Chapter 5 Flowcharts/Pathways/Documents

5.1 Overview

Flowcharts/Pathways/Documents allows access to the list of Documents available within the Documentation application. Selecting a document from the list will allow the user to make specific setup to a document that may be applied at the section level, question level and answer level.

5.2 Document List

The Document List displays a list of all available documents in the Documentation Library. The screen will display a maximum of 250 documents at one time.

The following buttons are available within the action bar:

- **New**: This option is for TruBridge use only.
- **Edit**: This option allows access to the Document Maintenance Screen. A document must be selected to enable this button.
- **Add to Worklist**: This option creates a logname-based worklist of documents. A document must be selected to enable this button.
- **Save As**: This option is for TruBridge use only.
- **Print**: This option creates a PDF version of the document for the use of validation of conversion, support purposes, and for TruBridge EHR downtime procedures. A document must be selected to enable this button. See Print Document 9 for additional information.

Document Type: May be used to narrow down the document search results.

- Select the Document type from the drop-down menu to establish the document type filters. The available document types are Flowcharts, Forms and Multi-Clinician Documents. The default is **All**.
  - **All**: Allows all document types to display. This is the default option for the document type.
  - **Flowcharts**: A document with pre-defined questions and answers. It is intended for multiple entries and provides a Grid View for comparison of the entries.
  - **Multi-Clinician**: A template-based document with pre-defined questions and answers. It is intended for one-time documentation by multiple users.
  - **Forms:** A document that will be used to capture signatures for consent forms and doctors' notices.

Filter: Allows a user to search by document **Title** or by document **Description**. **Title** is the default.

Status: Allows a user to filter the search by **All**, **Active**, **Inactive**, **Worklist** or **Hidden Documents**.

Search: Allows the user to search documents by document title within the Document List. Search utilizes smart search capabilities, and the result list will automatically populate.

The Document List columns display as follows:

- **Title**: Displays the title of the document
- **Type**: Displays the document type. The following document types are currently available: Multi-Clinician, Flowcharts, and Forms.
- **Status**: Displays the document status. Only Active documents will be available within the Document List.
- **Gender**: Displays the document gender tag that is associated with the document.
- **Age**: Displays the document age tag that is associated with the document.
- **Setting**: Displays the document setting tag that is associated with the document.

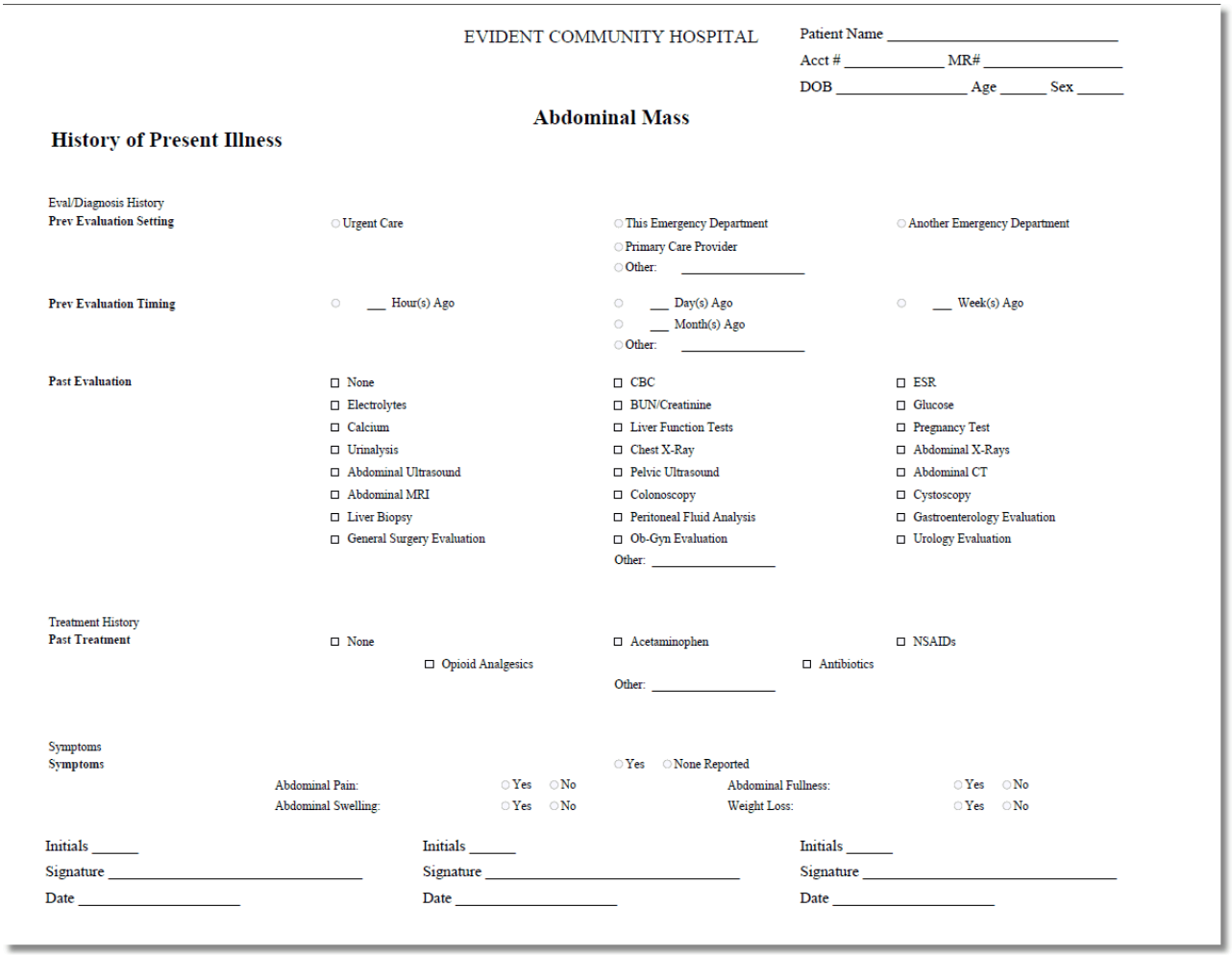
NOTE: *An asterisk in front of a document title indicates that the document is hidden from the end user search options.*

Print Document

Select the **Print** button from either the Document List or the Document Maintenance screen to display the document in PDF format.

Each page will include a header that will allow the user to write in Patient Name, Account Number, Medical Record Number, Date of Birth, Age and Sex. The title of the document will also be included in the header and will display the center of the PDF version of the document. A footer is also included on each page that will allow the following information to be documented in three places: Initials, Signature, and Date.

Select **Tables** > **Clinical** > **Flowcharts/Pathways/Document** > **Select a Document** > **Print**



EVIDENT COMMUNITY HOSPITAL

Patient Name _____
Acct # _____ MR# _____
DOB _____ Age _____ Sex _____

Abdominal Mass

History of Present Illness

Eval/Diagnosis History
Prev Evaluation Setting
○ Urgent Care ○ This Emergency Department ○ Another Emergency Department
○ Primary Care Provider
○ Other: _____

Prev Evaluation Timing
○ ___ Hour(s) Ago ○ ___ Day(s) Ago ○ ___ Week(s) Ago
○ ___ Month(s) Ago
○ Other: _____

Past Evaluation
☐ None ☐ CBC ☐ ESR
☐ Electrolytes ☐ BUN/Creatinine ☐ Glucose
☐ Calcium ☐ Liver Function Tests ☐ Pregnancy Test
☐ Urinalysis ☐ Chest X-Ray ☐ Abdominal X-Rays
☐ Abdominal Ultrasound ☐ Pelvic Ultrasound ☐ Abdominal CT
☐ Abdominal MRI ☐ Colonoscopy ☐ Cystoscopy
☐ Liver Biopsy ☐ Peritoneal Fluid Analysis ☐ Gastroenterology Evaluation
☐ General Surgery Evaluation ☐ Ob-Gyn Evaluation ☐ Urology Evaluation
Other: _____

Treatment History
Past Treatment
☐ None ☐ Acetaminophen ☐ NSAIDs
☐ Opioid Analgesics ☐ Antibiotics
Other: _____

Symptoms
Symptoms
○ Yes ○ None Reported
Abdominal Pain: ○ Yes ○ No Abdominal Fullness: ○ Yes ○ No
Abdominal Swelling: ○ Yes ○ No Weight Loss: ○ Yes ○ No

Initials _____ Initials _____ Initials _____
Signature _____ Signature _____ Signature _____
Date _____ Date _____ Date _____

PDF Format of a Document

Forms

A form is a type of document that will be used to capture signatures for consent forms and doctors' notices. Forms also pull to Clinical History and Print EMR. To Preview a form to see how it will display in Documentation:

1. Select **Form** from the Document Type dropdown menu.

2. Select the form

3. Select **Edit**

4. Select **Preview**

The following options are available within the action bar:

- **Save:** This option is for TruBridge use only.
- **Save As**: This option is for TruBridge use only.
- **Settings**: This option is for TruBridge use only.
- **Add Checkbox:** This option is for TruBridge use only.
- **Add Dropdown**: This option is for TruBridge use only.
- **Add Text Box**: This option is for TruBridge use only.
- **Add Label**: This option is for TruBridge use only.
- **Add Radio Button**: This option is for TruBridge use only.
- **Add Markup**: This option is for TruBridge use only.
- **Add e-Sign Location**: This option is for TruBridge use only.
- **Preview**: This option displays a preview of the selected form. The preview area also allows the user to select different controls and see how the form will display for the end user.

NOTE: *The preview display does not have patient information or saving capabilities so some functionality is not available.*

5.3 Document Maintenance

Documentation Maintenance allows for specific setup that will apply to the entire document.

The following buttons are available within the action bar:

- **Save As**: This option is for TruBridge use only.
- **New Version**: This option is for TruBridge use only.
- **Make Obsolete**: This option is for TruBridge use only.
- **Settings**: This option allows access to the Document Settings. See Settings 17 for additional information.
- **Preview**: This option displays a preview of the selected document, and any information placed in the Description field will display. See Preview 17 for additional information.
- **Print**: This option creates a PDF version of the document for the use of validation of conversion, support purposes, and for TruBridge EHR downtime procedures. See Print Document 9 for

additional information.

- **Display Status**: This option allows access to the Question Display Status screen. See Display Status 14 for additional information.

The **Title** field is the hard coded title assigned to the document by TruBridge.

The **Description** field allows a user to label documents in a way that would benefit personnel use. This description will then display when added to a Department Category. The Title will remain unchanged and is viewable in Document Maintenance.

The **Type** field indicates the document type. The following document types could display: Multi-Clinician, Flowchart and Form.

The **Status** will always display Active and is for TruBridge Use Only**.**

The **Version** displays what version number of the document that is currently displaying and is a TruBridge Use Only field.

The **RFV ID** displays the Reason for Visit Identification Number. This field is for TruBridge Use Only.

Settings

The document settings allows specific setup that will apply to the entire document.

Select **Settings**. The buttons available on the action bar are as follows:

- **Save:** Allows any changes made to the document settings to be saved.
- **Add Code:** TruBridge use only.
- **Remove:** TruBridge use only.
- **Roles:** Allows the Roles for Required Signature screen to launch where the user may assign the required signature option to a specific role(s). This button is enabled when the Requires Signature check box is selected. See Roles 13 for additional information

The following options are available within the Document Settings:

- Select the check box **Restrict Charting Options** to prevent any user from selecting the Charting Options button when documenting in the selected document. For additional information on Charting Options see the Documentation User Guide.
- Select the radio button **Send to Print EMR**:
  - **Never:** When selected, the documentation report never pulls to Print EMR.
  - **Always:** Allows for the documentation report to always pull to Print EMR. This is the default option.

- Select the radio button **Send to Clinical History**:
  - **Never:** Allows that the documentation report never pulls to Clinical History.
  - **Always:** Allows for the documentation report to always pulls to Clinical History. This is the default option. If this option is selected the last version of the report will pull to Clinical History with the report title, the creation date and completion date.

- Select the check box **Requires Signature** to require the document to be signed by the designated roles. Selecting this option will also pull the document to the "Documentation Signed" component on the Discharge Checklist, place an alert on the designated role(s) Homescreen and pull the document to the Required filter on the Multiple Signing Screen if the document is left unsigned. See the Discharge Checklist for additional setup and Signing Documentation within the Documentation User Guide for addition information on the Multiple Document Signing Selection screen. To assign a specific role(s) please see Roles 13 for addition information.

- Select the check box **Exclude Credentials Date/Time** to allow for information to display without any user credentials and corresponding date/time stamps.

- Select the check box **Distribute When Signed** to allow for the distribution of Reports and Documents via fax number or printer TTY specific to each physician on the account, as well as the signer of the note. Setup also includes options in the Physician Tables in Tables and this functionality is exclusive to providers. The system will default this option to unchecked but it can be changed.

- Select **Hide Document in Search Option** to allow for the ability to hide documents. When selected, the document will not display in the search options within the Documentation application.

NOTE: *Hidden documents will display with an asterisk in front of the title on the Document List screen.*

The dropdown menu titled **Content Source** is for TruBridge use only.

Roles

Selecting the Requires Signature check box enables the Roles button from the action bar. This allows the user to assign the required signature option to a specific role(s). This screen allows the user to select multiple roles at once.

- Select the check boxes to assign the required signature for a specific role. Once all roles are selected, choose **Update** from the action bar to save the selected roles.

NOTE: *Documents that require a signature creates an alert on the Home screen which reads "Unsigned Document," which will take the user to the Multiple Signing screen when selected. The Home screen alert is then removed once the document is signed. The user also has the option of acknowledging the alert without signing. See Home Screen for additional information.*

Preview

To Preview a document from Document Maintenance:

- Select the **Preview** button from the action bar. Information entered in the Description field of the Document Maintenance will display as the Document Title.
- The preview area allows the user to select on the different controls and see what the end user functionality will entail.

NOTE: *The preview display does not have patient information or saving capabilities so some functionality is not available.*

Display Status

Selecting **Display Status** on the action bar allows access to the Question Display Status screen. This screen allows multi-select hiding of Sections, Questions and Answers within the entire document.

Columns on the screen include:

- **Section Titles**: This column will display the Sections as they are listed on the entry screen.
- **Question Titles**: This column will display the Questions as they are listed on the entry screen by Section.
- **Answers**: This column will display as many answers that will fit in the column.
- **Display Status**: This column will display the action selected for display status, **Always**, **Show More** and **Never**. **Always** is the default.

The user will be able to multi-select rows. Upon selecting a row(s), the action buttons will be enabled. The action selected will apply to all highlighted rows.

Action buttons include the following:

- **Answer Display Status**: Displays all answers for the selected questions. This button is enabled when an item is selected.
- **Always**: Allows questions to always display. This button is enabled when an item is selected.
- **Show More**: Allows questions that are hidden to display when the **Show More** button is selected from within Documentation documents. This button is enabled when an item is selected.
- **Never**: Allows questions to not display within Documentation documents.This button is enabled when an item is selected.

Answer Display Status

The Answer Display Status screen displays answers to selected questions.

Columns on the screen include:

- **Question Title**: This column will display the questions as they are listed on the entry screen by Section.
- **Answers**: This column will display a single answer for the question per row.
- **Display Status**: This column will display the action selected for display status, Always, Show More and Never. Always is the default.

The user will be able to multi-select rows. Upon selecting a row(s), the action buttons will be enabled. The action selected will apply to all highlighted rows.

Action buttons include the following:

- **Always**: Allows questions to always display.
- **Show More**: Allows questions that are hidden to display when the Show More button is selected from within Documentation documents.
- **Never**: Allows questions to not display within Documentation documents.

5.4 Section Maintenance

Section Maintenance allows the set up of the section's display status, set up specific settings and view the section's associations.

The following buttons are available within the action bar:

- **New Version**: TruBridge use only.
- **Delete**: TruBridge use only.
- **Associations:** Displays each document that the current section is also associated with and gives access to the Display Status for the selected section. See Associations 16 for additional information.
- **Preview**: Displays a preview of the selected document. See Preview 17 for additional information.
- **Settings**: Allows access to the section settings. See Settings 17 for additional information.
- **Change Order**: TruBridge use only.

- **Display Status**: Allows control of the setup of when a question displays with a section within Documentation Documents. See Display Status 19 for additional information.

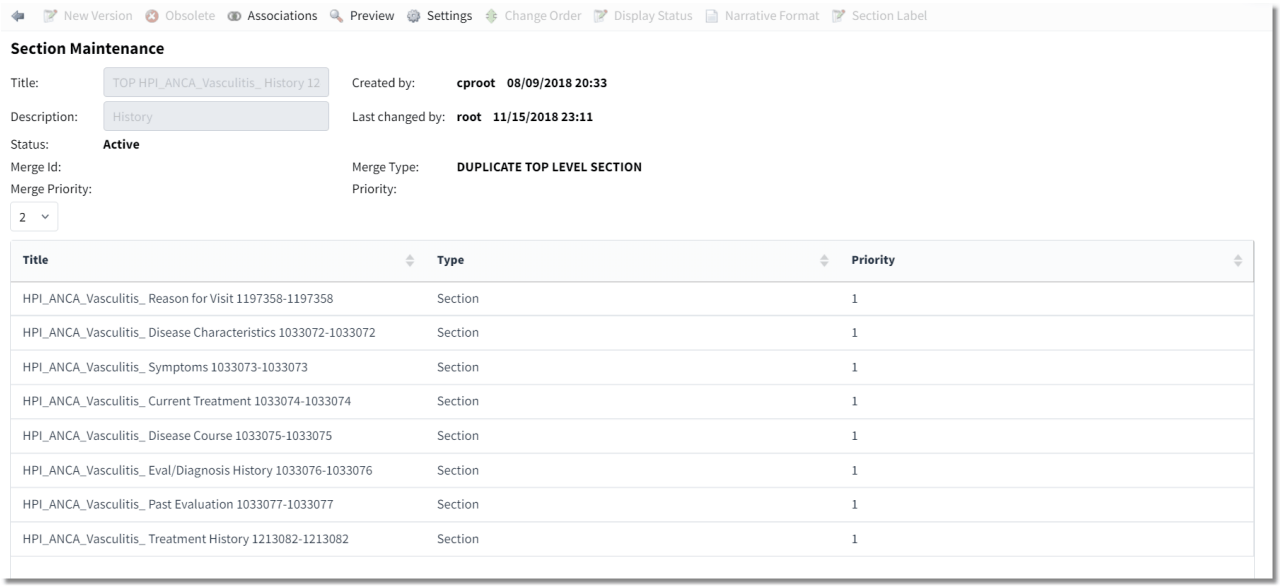
- **Narrative Format**: TruBridge use only.

The fields for **Title** and **Description** are for TruBridge use only.

The **Version** drop down-list allows the user to select and view previous versions of the selected section.

The Section Maintenance Table displays the **Title** of the sections/questions included within the section, **Type** displays whether the information listed is a section type or question type and **Priority** displays the priority setting on the individual section or question maintenance screen.

Select **Tables** > **Clinical** > **Flowcharts/Pathways/Document** > **Document Maintenance** > **Section Maintenance**



Section Maintenance

Associations

The Associations button will display each document that the current section is also associated with.

To view Associations of a section, select **Associations**. The associations screen will display each document that the current section is also associated with.

Columns on the screen include:

- **Title:** Displays the document title the section is associated with.

- **Description:** Displays the description of the document, including descriptions that are site-specific.
- **Type:** Displays the document type associated with the section.
- **Status**: Indicates the status of the section.

The **Remove** button on the action bar is for TruBridge use only.

For Display Status options, see Display Status 19.

Preview

There are two options to preview a section. The first option is to preview the section from the Section/Question List, and the second option is to preview the section from the section maintenance screen.

To Preview a section from Section/Questions List:

- Select the **Section** from the Section/Question List. Once the section is Selected it will display on the right in the preview area.

To Preview a section from the Section Maintenance Screen:

- Select the **Preview** button from the action bar.
- The preview area allows the user to select the different controls and see what the end-user functionality will entail.

NOTE: *The preview display does not have patient information or saving capabilities so some functionality is not available.*

Settings

The Section Settings allow the setup of Copy Forward and Special Coding.

NOTE: *Any changes made within the Section Settings will apply to all documents associated with the selected section. See Associations 16 for additional documents.*

To apply settings to a section:

- Select **Settings** from the action bar.
- **Section:** The title that displays in the maintenance search tables.
- **Description:** The title that displays on the document as the section description.
- **Merge Id:** A read-only field that is used to merge Provation documents when the documents

have the same question but different answers.

- **Merge Priority:** A read-only field that is used to merge Provation documents when the documents have the same question but different answers.

- **Copy Forward:** This provides the ability to pass along information from visit to visit. If the box is checked, all questions within the section will copy forward.

  NOTE: *If a section is a Top Level Section, the copy forward needs to be set on each section within that Top Level Section in order for copy forward to pull documentation from each subsection. Setting copy forward on a Top Level Section will not turn copy forward on for each subsection. See* *Question Settings* 22 *and Clinical Documentation Control Table* 74 *for further copy forward setup. If a section is associated with other documents and Copy Forward is turned on, this will set the section to copy forward on each associated document.*

- **Section Type:** This identifies each type of section for use in Report Applications and Section Preferences. The section type will determine the type of Report Application to be used when pulling the information to a Documentation Report, or to be used when setting up a UBL/ Department's Section Preferences. This field is hard coded and is maintained by TruBridge.

- **Content Source:** TruBridge use only.

- **Edit Effective Date:** TruBridge use only.

- **Version Effective Dates**: A read-only field that allows the edit date and version of the section to display.

Special coding may be attached to sections to pull documentation to other places in TruBridge EHR.

NOTE: *The CCDA Document Code is the only code that is currently functional for setup.*

To allow sections to pull to the Discharge Instruction section of the CCD:

1. Select **Add Code** from the action bar.

2. Select **CCDA Document Codes** from the Code Type drop-down.

3. Highlight the code, and select **Insert** or double-click the code to save. (To cancel and not save, use the back arrow instead.)

4. To remove the code, highlight the code and select **Remove**.

NOTE: *The CCDA Document code will only pull plan text into the instruction section of the CCD. Any markups or formatting used within that section will not pull to the CCD, as it does not support rich text documentation.*

Display Status

The Display Status controls when a question is to be hidden from within the section or within the Documentation Document.

NOTE: *If this a top level section, then the selected section will be hidden from the top level section of the document.*

To apply Display Settings to a question or a section within the Section:

1. Select the question or section where the Display Settings will be applied.

2. Select **Display Status**.

3. Select the appropriate display option from the **Display Status drop-down**. The drop-down options are:
   - **Always:** Allows the question or section to always display. This is default for all sections
   - **Show More:** Allows the question or section that are hidden to display when the show more button is selected from within Documentation.
   - **Never:** Allows the question or section to not display within Documentation.

4. Select **Save**. This question will display per the settings applied in step 3 within the current document.

The display status may also be set up through the **Associations** button on the action bar. The display status button within Associations allows the selected section to be hidden among several different documents.

1. Select **Associations**.

2. Select the document where the display settings should be applied.

3. Select **Display Status**. The Display Status Maintenance screen will display, and the item that is being edited will be listed along with the document where the display settings will be applied.

4. Select the appropriate display option from the **Display Status** drop-down.

5. Select **Save**.

6. Select the **Back Arrow** to return to the Associations screen. Once the Display Status has been assigned, it will display in the Display Status column.

NOTE: *If a section is set as a top level section and* ***Show More*** *is selected, the top level section title will continue to display on the navigation menu. If a section is a top level section and never is selected, the top level section title will not display on the navigation menu.*

5.5 Question Maintenance

Question Maintenance allows the set up of the question's display status, set specific question settings and view the question's associations.

The following buttons are available within the action bar:

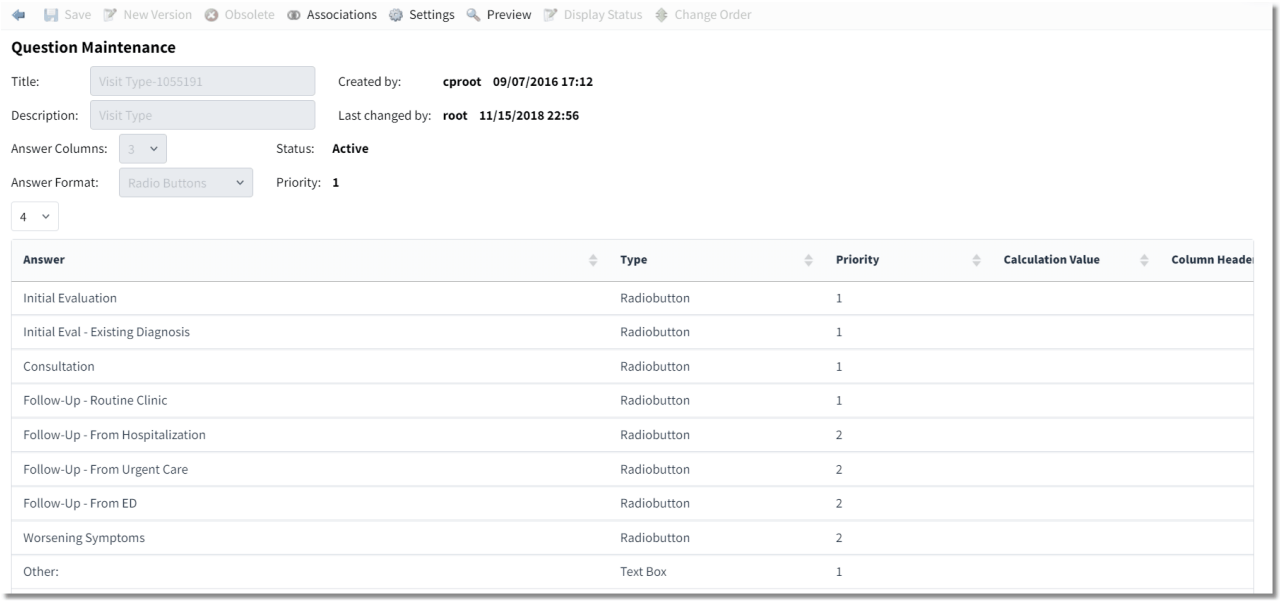
- **Save**: TruBridge use only.
- **New Version**: TruBridge use only.
- **Obsolete**: TruBridge use only.
- **Associations:** Displays each document that the current question is also associated with and gives access to the Display Status for the selected question. See Associations 21 for additional information.
- **Settings**: Allows access to the question settings. See Settings 22 for additional information.
- **Preview**: Displays a preview of the selected question. See Preview 23 for additional information.
- **Display Status**: Allows control of the setup of when an answer displays with the question in a Documentation Document. See Display Status 21 for additional information.
- **New Answer**: TruBridge use only.
- **Change Order**: TruBridge use only.

The fields for **Title** and **Description** are for TruBridge use only.

The **Version** drop down list allows the user to select and view previous versions of the selected question.

The Question Maintenance Table displays the **Answer**(s) of the question, **Type** displays the control type of the answer, **Priority** displays the priority setting on the individual answer maintenance screen, **Calculation Value** displays the value of the answer when it is included in a calculation and **Column Header** displays the header of the column that answer displays within.

Select **Tables** > **Clinical** > **Flowcharts/Pathways/Document** > **Document Maintenance** > **Section Maintenance** > **Question Maintenance**



Question Maintenance

Associations

The **Associations** button will display each document that the current question is also associated.

- Select **Associations**. The associations screen will display each document the current question is also associated.

The button on the action bar for **Remove** is for TruBridge use only.

For Display Status options see Display Status 21.

Display Status

The **Display Status** controls when an answer within the selected question displays within Documentation Documents.

The drop-down options are:
- **Always**: Allows questions to always display. This is default for all questions.
- **Show More**: Allows questions that are hidden to display when the show more button is selected from within Documentation Documents.
- **Never**: Allows questions to not display within Documentation Documents.

To apply Display Settings to an answer within the selected question:

1. Select the answer from the Question Maintenance Screen that the Display Settings will be applied.

2. Select **Display Status.** The Display Status Maintenance screen will display. The item that is

being edited will be listed along with the document title that the display settings will be applied.

3. Select the appropriate display option from the **Display Status drop-down**.

4. Select **Save**.

The display status may also be set up through the Associations button to hide the entire from the action bar. The display status button within Associations allows questions to be hidden among several different documents.

1. Select **Associations** from the Question Maintenance screen .

2. Select the document from the list

3. Select **Display Status**.

4. Select the appropriate display option from the **Display Status drop-down**.

5. Select **Save**.

6. Select the **Back Arrow** to return to the Associations screen. Once the Display Status has been assigned, it will display in the Display Status column.

Settings

The Question Settings allows specific setup to be made a question within a document.

NOTE: *Any changes made within the Question Settings will apply to all documents associated with the selected question. See* *Associations* 21 *for additional documents.*

Select **Settings** to display the different question setting options.

The **Add Code**, **Remove**, and **Edit Effective Date** options on the action bar are for TruBridge use only.

- **Question:** Displays the question title.

- **Autopopulate other flowcharts:** If selected, the answers documented will autopopulate other documents with the same question.

- **Pull most recent answer:** If selected, the previous answer will pull forward to the question when opened again on the same document or a different document with the same question.

  NOTE: *Both* ***Autopopulate other flowcharts*** *and* ***Pull most recent answer*** *must be selected for answers to share between documents.*

- **Copy Forward:** Allows the documentation from this question to copy forward from visit to visit. The drop down options are:

- **Follow section settings:** Allows the question to follow the copy forward status on the section. This is the default setting.
- **Yes:** Allows the question to copy forward information regardless of the section settings. If the question is set to "yes" and the section is not set to copy forward, the question setting will override the section and copy forward the documentation for this question.
- **No:** Allows copy forward to be turned off for the question . If a question is set to "no" and the section is set to copy forward, the question setting will override the section and will not copy forward the documentation for this question.

NOTE: *If a question is associated with other documents and* ***Copy Forward*** *is turned on, this will set the question to copy forward on each associated document. See* *Section Settings* 17 *and Clinical Documentation Control Table* 74 *for further copy forward setup.*

- **Requirement:** Allows the question to be set as a required question or warning question.
  - **None:** Allows no requirement for the question and is the default setting.
  - **Required:** Allows the question to be set as required. The user will not be able to leave the section until the required question has been addressed.
  - **Warning:** Allows a warning prompt that will alert the user the question is unaddressed. The user will be able to leave the section with out addressing the question

  NOTE: *When questions are set to be* ***Required*** *or* ***Warning****, they will appear red within the Documentation Document*.

- **Check Box Location:** Allows the set up of the check box location. This option is only available if the question uses a check box format.
  - **Before Label:** If selected the check box will be placed before the label of the question's answers. This is the default setting.
  - **After Label:** If selected the check box will be placed after the label of the question's answers.

- **Special Coding:** TruBridge use only.

- **Version Effective Dates:** A read-only field that allows the edit date and version of the section to display.

Preview

There are two options to preview a question. The first option is to preview the question from the Section/Question List, and the second option is to preview the question from the question maintenance screen.

To preview a question from the Section/Question List:

- Select the **Question radio button** from the Section/Question maintenance screen.

- Select the question from the Section/Question List. Once the question is selected it will display on the right in the preview area.

To preview a question from the Question Maintenance Screen:

- Double-click a question from the Question Maintenance Screen.
- Select the Preview button from the action bar.
- The preview area allows the user to select the different controls and see what the end-user functionality will entail.

NOTE: *The preview display does not have patient information or saving capabilities so some functionality is not available.*

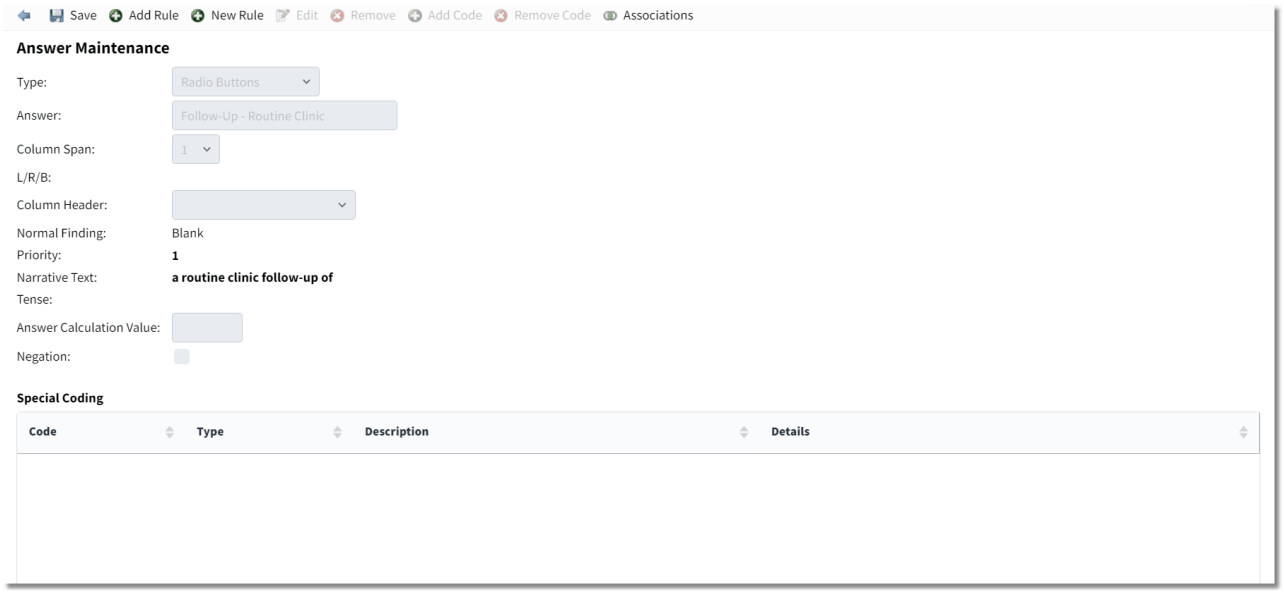
5.6 Answer Maintenance

Answer Maintenance allows the set up of reflex rules, set the answer's display settings and view the answer's associations.

- The Special Coding table displays any codes that may be attached to the answer. Reflex rules will display within the special coding table on the Answer Maintenance screen. If a reflex is created by TruBridge, a TruBridge ID for the reflex will display within the Code column. For site specific reflexes, the code column will remain blank.
- The following options are available within the action bar:
  - **Save:** TruBridge use only.
  - **Add Rule:** Adds existing reflex rules to the answer. See Reflex Rules 26 for additional information.
  - **New Rule:** Creates a new reflex rule to attach to the answer. See Reflex Rules 26 for additional information.
  - **Edit:** Allows an attached reflex rule to be modified. A reflex rule must be selected to enable this button.
  - **Remove:** Allows an attached rule to be removed. A reflex rule must be selected to enable this button.
  - **Add Code:** TruBridge use only
  - **Remove Code:** TruBridge use only.
  - **Associations:** Displays each document that the current answer is associated with and gives access to the Display Status for the selected answer. See Associations 25 for additional information.

The fields for **Type, Answer, Column Span, L/R/B, Column Header, Normal Findings, Priority, Narrative Text, Tense, Answer Calculation Value and Negation** are for TruBridge use only.

Select **Tables** > **Clinical** > **Flowcharts/Pathways/Document** > **Document Maintenance** > **Section Maintenance** > **Question Maintenance** > **Answer Maintenance**



Answer Maintenance

Associations

The **Associations** button will display each document the current answer is also associated.

1. Select **Associations**. The Association screen will then display a list of all documents that the answer is associated.

The button on the action bar for **Remove** is for TruBridge use only.

For Display Status options, see Display Status 25.

Display Status

The Display Status controls when an answer displays within Documentation Documents.

The drop-down options are:

- **Always**: Allows answers to always display. This is default for all questions.
- **Show More**: Allows answers that are hidden to display when the show more button is selected from within Documentation Documents.
- **Never**: Allows answers to not display within Documentation Documents.

To apply Display Settings to an answer:

1. Select **Associations**.

2. Select the Document the display setting should be applied.

3. Select **Display Status**.

4. Select the appropriate display option from the **Display Status drop-down**.

5. Select **Save**

Select the **Back Arrow** to return to the Associations screen. Once the Display Status has been assigned, it will display in the Display Status column.

Reflex Rules

Reflexing allows TruBridge EHR to automatically generate questions, sections, orders, instructions, markups, charges, create prescriptions, send preventatives and send messages based on the answer choices that are selected during documentation. Reflex set up will utilize the Rule Builder functionality.

NOTE: *Any reflexes added to an Answer will apply to all documents associated with the selected answer. See* *Associations* 25 *for additional documents.*

The ability to reflex is only available with the following answer types:

- Radio Buttons
- Check boxes
- Drop-Down

Adding a Reflex

To attach a reflex to an answer:

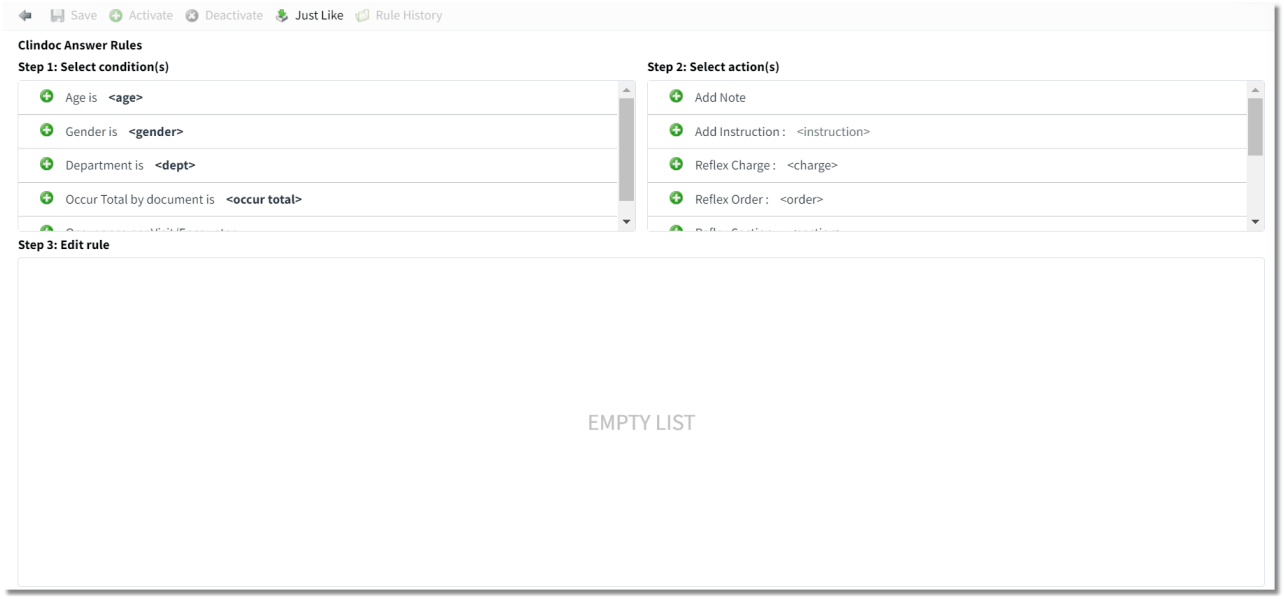
- Select **Add Rule** to add an existing reflex rule.
- Select **New Rule** to create a new reflex rule.

Create a New Rule

To create a new rule:

- Select **New Rule**.

Select **Tables** > **Clinical** > **Sections/Questions List** > **Question** > **Answer** > **New Rule**



New Reflex Rule

Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option.

- **Age** allows the set up of a specific age group that would generate the reflex when the designated answer is chosen. To set up a specific age group select **<age>** from Step 3 and address the units, age is greater than and age is less than.

- **Gender** allows the set up of a specific gender that would generate the reflex when the designated answer is chosen. To set up a specific gender group select **<gender>** from Step 3 and select one of the following options: Female, Male and Unknown.

- **Department** allows the set up of a specific department that would generate the reflex when the patient is located in the chosen department and the designate answer is chosen. To set up a specific department, select **<department>** from Step 3 and select the department that the patient must be located in to trigger the reflex.

- **Occur Total** allows the set up for a reflex to trigger for an occurrence of Once, Every Time, Hour(s), or Day(s). The occurrence type is as follows:
  - **Once**: Allows the reflex to trigger only one time per document.
  - **Every Time:** Allows the reflex to trigger every time the answer(s) is saved per document.
  - **Hour(s):** Determines the amount of time per document that must pass after a reflex has been triggered before it may be triggered again. If selected, the occurrence value should also be entered with the number of hours that should pass between reflex generation.
  - **Day(s):** Determines the number of 24-hour intervals per document that must pass after a reflex has been triggered before it may be triggered again. If selected, the occurrence value should also be entered with the number of 24-hour intervals that should pass between reflex generation.

- **Occur once per Visit/Encounter** allows the reflex to only be generated once per visit. For example, if a second document is opened on a patient's account and an answer is selected with

the same reflex code, the second document will not regenerate the reflex if Occur once per Visit/ Encounter is a selected condition.

NOTE:*This is not a required field and may be skipped if no conditions apply.*

Select the action by choosing the type of Reflex from step two. Multiple reflexes may be set up by selecting additional options from Step Two.

- **Add Note** allows the selected answer to insert a free text box into the template when it is selected. See Reflexing a Note 29 for additional set up.
- **Add Instruction** allows the selected answer to insert an existing instruction when it is selected. See Reflexing an Instruction 29 for additional set up.
- **Reflex Charge** allows the selected answer to drop a charge when it is selected. See Reflexing a Charge 30 for additional set up.
- **Reflex Order** allows the selected answer to create an order when it is selected. See Reflexing an Order 31 for additional set up.
- **Reflex Section** allows the selected answer to insert a new section of questions into the template when it is selected. See Reflexing a Section 32 for additional set up.
- **Reflex Question** allows the selected answer to insert a new question into the template when it is selected. See Reflexing a Question 33 for additional set up. Reflexing a question also allows the selected answer to insert a markup into the template. See Reflexing a Markup 33 for additional set up.
- **Reflex Rx** allows the selected answer to insert a Rx into the template when it is selected. See Reflexing a Prescription 34 for additional set up.
- **Reflex Message** allows the selected answer to insert a predefined message into the template when it is selected. See Reflexing Message 36 for additional set up.
- **Reflex Preventative** allows the selected answer to insert a preventative into the template when it is selected. See Reflexing a Preventative 36 for additional set up.

Select the rule description from step three. This will show the selected conditions and actions in the sequence that are selected.

Select **Save** to complete the reflex rule. The Input Prompt screen will display to allow a rule title to be entered. Add the reflex name in the **Enter rule title** field. The rule title will display above Step 1 within the Clindoc Answer Rules screen. If the rule is TruBridge created, it will also display the TruBridge ID along with the rule title and system generated Rule ID.

Add an Existing Rule

To add an existing rule:

1. Select **Add Rule**.

2. Highlight an existing rule to view additional options from the action bar.
   - **Select** attaches the chosen rule to the selected answer and displays it on the Answer Maintenance screen.
   - **Edit** allows maintenance to be performed for the rule.
   - **New** allows a new reflex rule to be created.
   - **Delete** removes the selected rule.
   - **PDF** displays the complete list of rules in PDF format.

NOTE: *If a new reflex is created from within the Clindoc Answer Rules screen it will need to be highlighted and* ***Select*** *chosen to add it to the answer. New reflex rules do not automatically add to the answer from within this screen.*

Reflexing a Note

Reflexing a note allows TruBridge EHR to automatically insert a free text section based on the answer choices that were selected during documentation. Reflex setup will utilize the Rule Builder functionality.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select **Add Note** from Step 2.

3. Select save to save the new Reflex Rule.

4. Assign a reflex title to the reflex by entering it in the Enter rule title field.

5. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing an Instruction

Instructions may be reflexed into documents based on the answer choice that is selected.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step 1 by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Add Instruction** from step 2. Multiple reflexes may be set up by selecting additional options from step 2.

4. Select **My Favorites** or **All** to select an instruction from the list. To build a new instruction to be inserted, see steps below.

5. Once the instruction has been located within the table, select the instruction to view a preview in the preview area.

6. Select the check box of the instructions needed and select **Insert** to the add instructions to the rule.

7. The instruction that was added will display in step 3 of the rule.

8. Select **Save** to save the instruction, or select the red "x" in step 3 to deleted the instruction.

9. Assign a reflex title to the reflex by entering it in the **Enter rule title** field.

10. Select **OK** to save the title or **Cancel** to return to the reflex setup without saving.

To create a new instruction:

1. To build a new instruction, select **Create New Instruction**.

2. Enter the Instruction Title in the title box and add the instruction that will display when it is reflexed into a document.

3. Select the scheduled check box if the instruction should be available for selection within the Scheduling 5 application.

4. Select **save** to save the instruction, or **Cancel** to return to the instruction rule screen without saving.

Reflexing a Charge

Reflexing a charge allows TruBridge EHR to automatically generate charges based on the answer choices that were selected during documentation. Reflex setup will utilize the Rule Builder functionality.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Charge** from Step Two. Multiple reflexes may be set up by selecting additional options from Step Two.

4. Select **<charge>** from step three to assign the charge that should be generated when the reflex is triggered.

5. Designate the list type that should be used to search for the chargeable item.
   - Select the radio button next to **Charge Sets** to view all available charge sets. Only the charge set description will display. The individual items will be selected by the user once the charge set is reflexed with in the documentation.
   - Select the radio button next to **Department** to search for the item by the issuing department. A department drop-down will display all issuing departments. When a department is selected from the drop-down, the list to the left will only display items from that department. If a department is not selected, the screen will display items from all issuing departments.
   - The search field may be used to search for an item by description.

6. Select the charge item or set that should be reflexed, then select **Move to Pending** or **double-click** the selected item.
   - If a charge set is moved to the Selected Orders column, only the charge set title will display.
   - Multiple items may be selected at one time by holding down the control key on the keyboard, then selecting all items that need to be added.
   - To remove an item from the Selected Orders column, select the order, then select **Remove** from the action bar. Or, select **Clear All Pending Orders** to remove all orders from the Selected Orders column.

7. Select **Insert** to add the selected charge to the reflex.
   - All charge items that were added to the reflex will be displayed in Step Three.

8. Select **Save** to save the reflex.

9. Assign a reflex title to the reflex by entering it in the **Enter rule title** field.

10. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing an Order

Reflexing orders allows TruBridge EHR to automatically generate orders based on the answer choices that were selected during documentation. Reflex setup will utilize the Rule Builder functionality.

1. Select **New Rule** to create a New Order Reflex Rule.

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select the green plus sign next to **Reflex Order** from Step Two. Multiple reflexes may be set up by selecting additional options from Step Two.

4. Select **<order>** from step three to assign the charge that should be generated when the reflex is triggered.

5. Designate the list type that should be used to search for the item.
   - Select the radio button next to **Order Sets** to view all available order sets. Double-click the order set to move to pending. Only the order set description will display. The individual items

will be selected by the user once the order set is reflexed with in the documentation.
- Select the radio button next to **Department** to search for the item by the issuing department. A department drop-down will display all issuing departments. When a department is selected from the drop down, the list to the left will only display items from that department. If a department is not selected, the screen will display items from all issuing departments.
- The search field may be used to search for an item by description.

6. Select the item or order set that should be reflexed, then select **Move to Pending** or **Double-click** the selected item.
   - Multiple items may be selected at one time by holding down the control key on the keyboard, then selecting all items that need to be added.
   - To remove an item from the Selected Orders column, select the order, then select **Remove** from the action bar. Or, select **Clear All Pending Orders** to remove all orders from the Selected Orders column.

7. Select **Insert** to add the selected order to the reflex.
   - All items that were added to the reflex will be displayed in Step Three.

8. Select **Save** to save the reflex.

9. Assign a reflex title to the reflex by entering it in the Enter rule title field.

10. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing a Section

Sections of questions may be reflexed into documents based on the answer choice that is selected.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select Reflex Question from step two. Multiple reflexes may be set up by selecting additional options from Step Two.

4. Select <question> from step three to view all available questions.

5. Type the beginning description of the section in the Title Search field.

6. The status may also be set to search for questions that are Active, Inactive, or questions that have been added to the users Worklist.

7. Once the section has been located within the table, select the section to view a preview in the preview area.

8. **Double click** the section to add it to the rule or select **Add** from the action bar and then select

the **back arrow**.

9. The section that was added will display in step three of the rule.

10. Select **Save** to save the reflex.

11. Assign a reflex title to the reflex by entering it in the Enter rule title field.

12. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing a Question

Questions may be reflexed into documents based on the answer choice that is selected.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Question** from step 2. Multiple reflexes may be set up by selecting additional options from step 2.

4. Select **<question>** from step 3 to view all available questions.

5. Type the beginning description of the question in the **Title Search** field.

6. The **Status** may also be set to search for questions that are Active, Inactive, or questions that have been added to the user's Worklist.

7. Once the question has been located within the table, select the question to view a preview in the preview area.

8. Double-click the question to add it to the rule, or select **Add** from the action bar and then select the **back arrow.**

9. The question that was added will display in step 3 of the rule.

10. Assign a reflex title to the reflex by entering it in the **Enter rule title** field.

11. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing a Markup

Markups may be reflexed into documents based on the answer choice that is selected. This functionality is available by reflexing a question.

To attach a reflex to an answer:

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Question** from step two. Multiple reflexes may be set up by selecting additional options from Step Two.

4. Select **<question>** from step three to view all available questions.

5. Type the beginning description of the question in the Title Search field. To insert a markup type **Markup** into the search field to find the list of markups available.

6. The Status may also be set to search for questions that are Active, Inactive, or questions that have been added to the user's Worklist.

7. Once the markup has been located within the table, select the markup to view a preview in the preview area.

8. Double click the markup to add it to the rule or select **Add** from the action bar and then select the **back arrow**.

9. The markup that was added will display in step three of the rule.

10. Select **Save** to save the reflex.

11. Assign a reflex title to the reflex by entering it in the Enter rule title field.

12. Select **OK** to save the title, or **Cancel** to return to the reflex setup without saving.

Reflexing a Prescription

Reflexing a prescription allows TruBridge EHR to attach a prescription to an answer. Once the reflex is generated, the user may select the prescription from pending and edit, if needed. Once processed, the reflex is saved in Rx Writer as a temporary prescription. Additional medications may be prescribed once Rx Writer is accessed.

To attach a Prescription to an answer:

1. Select **New Rule**

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Rx:** from step 2. Multiple reflexes may be set up by selecting additional options from step 2.

4. Select **<rx>** from step three to assign the prescription that should be generated when the reflex is triggered. The prescription reflex may also be left blank which allows the user's My Meds list to

display when reflex is generated. If the user does not have a My Meds list set up, then the Medication Search screen will display.

5. The Medication Search screen will display. In the **Name** field, search for the desired prescription using the Micromedex Drug Database. This field has smart search capability.

6. **Select** will attach the medication to step 3 and bring the user back to the Clindoc Answer Rules screen.

7. Select **Save**.

8. Enter a rule title, and then select **OK**.

9. Select the back arrow to return to the Clindoc Answer Rules screen. Choose the appropriate rule and then **Select**.

10. Select **Save**.

11. Assign a reflex title to the reflex by entering it in the **Enter rule title** field.

12. Select **OK** to save the title or **Cancel** to return to the reflex setup without saving.

Reflexing a Message

Reflexing a message allows TruBridge EHR to save a predefined message or trigger a blank message to be addressed based on the answer choice selected.

- Date/time will default to the date/time the reflex is triggered.
- The reflex will display as a Pending action.
- Messages may be edited before being processed.

To create a new reflex message:

1. Select **New Rule**

2. Select the conditions that should be applied to the rule in step one by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Message** from step two. Multiple reflexes may be set up by selecting additional options from Step Two.

4. Select **<message>** from step three to assign the message that should be generated when the reflex is triggered.

5. The Message Detail screen displays.
   - A default recipient can be set up or it may be left blank.
   - Selecting the lookup icon will enable the user to designate the recipient as either a Department

or a User.
- A default Subject can be setup or this field may be left blank.
- A default message may be setup or this field may be left blank.

6. Enter the desired information.

7. Select **OK**.

8. Select **Save**.

9. Assign a reflex title to the reflex by entering it in the Enter rule title field and then select **OK**.

10. Select the back arrow to return to the Clindoc Answer Rules screen. Choose the appropriate rule and then **Select**.

Reflexing a Preventative

Reflexing a preventative allows TruBridge EHR to save a predefined preventative or trigger a blank preventative to be addressed based on the answer choice selected.

- Date/time will default to the date/time the reflex is triggered.
- The reflex will display as a Pending action.
- A preventative may be edited before being processed.

NOTE: *The user will be prompted to enter a Due Date when processing a Preventative in the Documentation application.*

1. Select **New Rule**.

2. Select the conditions that should be applied to the rule in step 1 by selecting the green plus sign next to the appropriate option. This is not a required field.

3. Select **Reflex Preventative** from step 2. Multiple reflexes may be set up by selecting additional options from step 2.

4. Select **<preventative>** from step 3 to assign the preventative that should be generated when the reflex is triggered.

   The Preventative Reflex Setup screen displays.
   - **Type:** Preventative or Followup is available for selection.
   - **Title:** A default title can be set up or this field may be left blank.
   - **Details:** Default details can be set up or this field may be left blank.

5. Enter the desired information.

6. Select **OK**.

7. Select **Save**.

8. Assign a reflex title to the reflex by entering it in the Enter rule title field and then select **OK**.

9. Select the back arrow to return to the Clindoc Answer Rules screen. Choose the appropriate rule and then **Select**.

NOTE: *This functionality is exclusive to the TruBridge Provider EHR setting.*

Chapter 6 Section/Questions List

The Section Question List allows access to a list of all sections and questions available in the Documentation Documents where specific setup may be applied to the section level, question level and answer level of each document.

Select the **Section** or **Question radio button** from the Section/Question maintenance screen. Selecting the Section radio button will display a list of all sections available within every document in the Document List. Selecting the Question radio button will display a list of all questions available within every document in the Document List.

Once a section or question is selected it will display on the right in the preview area.

The following buttons are available within the action bar:

- **New Question:** TruBridge use only.
- **Save As**: TruBridge use only.
- **Edit**: Allows the user to access the Section or Question maintenance of the selected section or question. See Section Maintenance 15 or Question Maintenance 20 for additional information
- **Delete**: TruBridge use only.
- **Add to Worklist**: Saves the selected section or question to a UBL based favorites list.
- **Associations**: Displays each document that the current question is also associated with and gives access to the Display Status for the selected question. See Section Associations 16 for additional information when the Section radio button is selected and Question Associations 21 for additional information when the Question radio button is selected.
- **Add**: TruBridge use only.

Chapter 7 Report Department Categories

7.1 Overview

The Report Department Categories creates the ability to add Documentation Reports to department categories under the New Reports folder in the Document Tree.

7.2 Category Setup

Select Report Department Categories to access the report department categories setup.

- A list of departments that are currently set up to use the Point of Care Whiteboard will be listed in the Department Menu drop-down menu. See the Point of Care Setup user guide for additional information on setting up the Point Of Care Whiteboard.
- Once the department has been located in the drop-down menu, select the department to access the Category setup.

Select **Tables** > **Clinical** > **Report Department Categories** > **Department**

Several set up options are available from the action bar.

- **New** will launch the Category Maintenance screen where categories may be assigned to the department.
- **Copy** allows the current departments setup to be copied to another department.
- **Preview** will display the a preview of the categories and documents as they will appear when New Reports is selected from the Documentation main page.

A Category must be added to a department before specific documents may be selected. Select **New** from the action bar to add a Category to the department.

To create a new Category:

- Type the Category name into the Category text box. This may be up to 50 characters.
- Select Save.

To select a preexisting Category Title:

- Select the Binocular icon to launch the Category display menu.
- Select the Category then select the Back Arrow to return to the Clinical Documentation Category Maintenance page.

- Select **Save** to save the category.

7.3 Adding/Removing Reports to a Category

To add documentation reports to a category, select **Add** to display the Documentation reports look-up page. Reports may be added to the Category from here.

- The Title Search field may be used to search for a Documentation Report by the Title.
- Once the documentation report has been located within the table, double-click the report to add the report to the Category or select the report and choose the select button form the action bar.
- Reports may be multi-selected using the Shift/Control keys on the keyboard.
- This process may be repeated as many times as needed.
- Once all Documents have been added to the Category, several options are available from the action bar and may be used to edit the Documents that are listed in the category.
  - The **Back Arrow** will return the user to the Department Category Listing.
  - **Save** will save any changes that have been made to the Category.
  - **New** is for TruBridge use only and will be inactive.
  - **Add** may be selected to add additional Documents to the Category.
  - **Change Order** may be selected to change the order that the Documents will display within the Category.
- When a Report is selected, Review and Edit will appear on the action bar.
  - Remove will remove the selected Report from the Category.
  - Edit will launch the Report Maintenance screen. Please see the Editing Documentation 60 chapter for additional information.

Once all changes have been made to the Category, select Save and the Back Arrow to return to the Report Department Category Listing.

7.4 Copying Report Category

The Copy option from the action bar will allow the setup of the current department to be copied to another department.

- To copy a report department's categories, select the department that the categories are to be copied from and select copy.
- The Department look-up table will then display.
- Double-click the department from the look-up table to paste the setup.
- The selected departments setup will then display with the copied setup.

Chapter 8 Documentation Reports

8.1 Overview

Documentation Reports allow facilities to create custom reports that may be generated based on documentation. This chapter will go over the set up of creating a custom Documentation or Multi Visit report.

8.2 Documentation Report List

Documentation Report List will display all Active and Inactive Documentation and Multi Visit Reports. This screen will display a maximum of 250 reports at one time.

The following options are available from the action bar:

- **New**: Allows the creation of a new report. See Creating New Documentation Reports 43 or Multi Visit Reports 61 to build a new report.
- **Edit:** Allows existing reports to edited or modified. See Editing Documentation Reports 60 or Editing Multi Visit Reports 64 to edit an existing report. This button is only enabled when a report is selected.
- **Add to Worklist:** Adds the report title to the user's worklist. This button is only enabled when a report is selected.
- **Save As:** Allows a copy of the selected report to be created. This button is only enabled when a report is selected.

8.3 Settings

Documentation Report **Settings** allows the set up of specific report options when it is generated from within the Documentation application.

Select **Settings** to establish the report generation settings.

- **Date/Time Filter** may also be applied the documentation report:
  - **Entire Stay:** Will pull all documentation that has been recorded within Documentation Documents.
  - **Hours:** Will allow a specific hour range to be entered. Only data that was documented within this range will will pull to the report.
    - Select the radio button next to Hours, and type the number of hours in the Hour text-box to the right.
  - **Days:** Will allow a specific number of days to be entered. Only data that was documented within this range will pull to the report.
    - Select the radio button next to Days, and type the number of days in the Day text-box to the right.

- **Department Filter:** Allows a department number to be entered for the report so it will only pull documentation for when the patient was located within the selected department. Selecting the magnifying glass will display the Department List. To select a specific department number, double-click the needed department. This field uses the Patient Location Summary log to determine the time frame that the patient was within the selected department.

- **Include Stricken** will pull any amended documentation.

- **Sort By** sorts the report by Section then Date and Time. This drop-down is currently disabled.
  - **Reverse Chronological:** Will display the documentation in Reverse Chronological Order.

- **Requires Signature:** Requires the report to be signed by a provider. Selecting this option will also pull the document to the "Documentation Signed" component on the Discharge Checklist, place an alert on the designated role(s) Homescreen and pull the document to the Required filter on the Multiple Signing Screen if the document is left unsigned. See the Discharge Checklist for additional setup and Signing Documentation within the Documentation User Guide for addition information on the Multiple Document Signing Selection screen.
  - Selecting the Requires Signature check box enables the **Roles** button from the action bar. This allows the user to assign the required signature option to a specific role(s). This screen allows the user to select multiple roles at once.

  NOTE: *Reports that require a signature create an alert on the Home screen which reads "Unsigned Report," which will take the user to the Multiple Signing screen when selected. The Home screen alert is then removed once the report is signed. The user also has the option of acknowledging the alert without signing. See Home Screen for additional information.*

- **Send to Print EMR**:
  - **Never**: The documentation report will never pull to Print EMR.
  - **Always**: Allows for the documentation report to always pull to Print EMR. This is the default option.

- **Send to Clinical History**:
  - **Never**: The documentation report will never pull to Clinical History.
  - **Always**: Allows for the documentation report to always pulls to Clinical History. This is the default option. If this option is selected, the last version of the report will pull to Clinical History with the report title, the creation date and completion date.

- **Progress Note**: Allows individual reports to be marked as Progress Notes. When a Documentation Report is checked as a Progress Note and then signed, it will count towards the numerator of the Meaningful Use II Electronic Notes Statistic for an eligible provider.

  NOTE: *If the report is marked as a Progress Note after the report has been signed on a patient's account for an eligible provider, the MU Stats Report will retroactively be updated and that patient will then pull to the numerator of the Electronic Notes Statistic.*

- **Exclude Credentials Date/Time**: Allows for information to display without any user credentials and corresponding date/time stamps.

- **Exclude sections with no data**: Defaults to unchecked. When selected, any sections that do

not contain data and are set up to pull to a report will not display the section title or "No data for this section."

- **Distribute When Signed**: Allows for the distribution of Reports and Documents via a fax number or printer TTY specific to each physician on the account, as well as the signer of the note. Setup also includes options in the Physician Tables in Tables and this functionality is exclusive to providers. The system default for this option is unchecked but it can be changed.

8.4 Creating New Documentation Reports

Documentation reports generate documentation from the current visit of a patient's chart. Applications and sections/questions may be set up to pull information into a Documentation report.

To create a new Documentation Report:

1. Select **New** from the Documentation Report screen.

2. Type the name of the report in the Title field.

3. Select **Save**.

When a new report is created, the status will be set to inactive once the report is saved and will display the name of the employee that created the document along with the date and time that it was created.

In order for the document report to pull in information, sections will need to be added to the setup. Existing sections may be added to the document report, or a new section may be created. Sections may either be set up to pull specific items into the document report or entire applications.

Once the title is saved for the documentation report, the documentation reports maintenance screen opens. The buttons available on the action bar:

- **Back Arrow**: Exits to the previous screen without saving changes.

- **Save as**: Allows the user to save the document under a new name and creates a new copy of the report document.

- **Make Active**: Allows the document report to move from inactive status to an active status. This button is enabled when the documentation report is inactive.

- **Make Obsolete**: Makes the document report obsolete.

- **Settings**: Allows the set up of report document settings. See Report Document Settings 41 for additional information.

- **New Section**: Allows the creation of a new section within the documentation report.

- **Add Section**: Allows the selection of an existing section to be pulled into the report.

8.5 Adding Sections

To create a new section in a Documentation Report:

1. Select **New Section**.

2. Enter the name of the section into the title field and select **Enter**. The description field will automatically display but may be changed. The description field will be what displays on the report.

3. Once the title and description have been addressed, select **Save**.

To add a specific item to the Document Report, select **Add Item**. This will allow questions or sections to be pulled into the document report from Documentation documents.

1. Select the radio button next to **Question** or **Section**.

2. Type the beginning description of the question or section into the search field. The results will populate as it is typed.

3. When a section or question is selected, it will display in the preview area.

4. To add the question(s) or section(s) to the documentation report, select **Add**. Multi-select functionality can be utilized using the Shift/Control keys on the keyboard to add multiple Questions or Sections at one time.

5. To add the question or section to the worklist. Select the question or section and select **Add to Worklist**.
   - The question and section associations may also be viewed from this screen.
   - Once all questions and sections have been added to the section of the documentation report, select the back arrow to review the section.

6. Select **Save** once all items have been added to the section.

7. Select **Make Active** to set this section to Live.

Existing sections may also be pulled into the Document Report:

1. Select **Add Section** to add an existing section to the report. The existing sections will then display. Multi-select functionality can be utilized using the Shift/Control keys on the keyboard.

2. To view only active sections, select the **Active radio button**.
   - To preview the section before it is added, select the section title. Each application and item that is set up for that section will display in the preview area on the right side of the screen.

3. To add the section, select Add or double-click the title. Multi-select functionality can be utilized

using the Shift/Control keys on the keyboard.

Once all sections have been added to the report, the order of the sections may be rearranged:

1. Select **Change Order** and then the section that needs to be moved.

2. Select the action that needs to be performed. The available options are:
   - **To Top**
   - **Move Up**
   - **Move Down**
   - **To Bottom**

3. Select **Settings** to establish the report generation settings. See Report Settings 41 for further information.

4. Once all filters have been assigned, select **Save**.

5. Select **Make Active** once all set up has been completed for the report to make the form available in Documentation.

Applications

Applications may also be added to sections:

To add an existing Application to the Documentation Report:

- Select **Add Application**

- Select the application to be pulled to the documentation report and select **Add.** Multi-select functionality can be utilized using the Shift/Control keys on the keyboard to add multiple applications at one time.

- Select **Save**

To add a new application that is not listed in the Application List, select **New Application**.

- Select the application title and select insert or double-click the application title.

Report applications labeled **All** _____ **Data** pull documentation based on the designation populated from the Section Type drop down menu within the section settings of a document. To view the Section Type drop down, see Section Settings. 17 Other report applications pull information from other applications within TruBridge.

- Once the application title is selected from the list and inserted. The title and the description of the application may be edited. The title displays in the application list, and the description displays in the documentation report. For additional setup options, see the following applications:
  - All Admission Data 46
  - All Assessment Data 46
  - All Intraprocedure Data 50
  - All Physical Assessment
  - Medical History 53
  - Medications 54

- All Assessment: Function Data 47
- All Assessment: Nutrition Data 47
- All Assessment: Pain Data 47
- All Assessment: Psychiatric Data 47
- All Discharge Planning Data 47
- All Disposition (Non-Provider) Data 48
- All Disposition Data 48
- All Documents Data 48
- All ED Course Data 48
- All Education (Non-Provider) Data 48
- All Education Data 48
- All History (Non-Provider) Data 49
- All History Data 49
- All HPI Data 49
- All Interpretation Data 49
- All Intervention Data 49
- All Physical Exam Data 50
- All Plan Data 50
- All Plan of Care Data 50
- All Postprocedure Data 51
- All Preprocedure Data 51
- All Procedure Data 51
- All Review of Systems Data 51
- All Screenings Data 51
- Allergies 52
- Ancillary Orders 52
- Chief Complaint 52
- Family Health History 52
- Functional Status 53
- Future Schedule Tests 59
- Hospital Discharge Instructions 53
- Immunizations 53
- Medications Administered 54
- Nursing Orders 57
- Order Results 57
- Past Medical Procedures and Interventions 58
- Patient Decision Aids 58
- Plan of Care 58
- Preventative List 60
- Problems 58
- Procedures 59
- Referral/Transition of Care 59
- Social History 59
- Vital Signs 59

- Once all applications have been entered to the section, select **Save** and then select make active.

All Admission Data

The **All Admission Data** application allows all Admission Data sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Assessment Data

The **All Assessment Data** application allows all Assessment sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Assessment section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Assessment: Function Data

The **All Assessment: Function Data** application allows all Assessment: Function sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Assessment: Nutrition Data

The **All Assessment: Nutrition Data** application allows all Assessment: Nutrition sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Assessment: Pain Data

The **All Assessment: Pain Data** application allows all Assessment: Pain sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Assessment: Psychiatric Data

The **All Assessment: Psychiatric Data** application allows all Assessment: Psychiatric sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Discharge Planning Data

The **All Discharge Planning Data** application allows all Discharge Planning sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Disposition (Non-Provider) Data

The **All Disposition (Non-Provider) Data** application allows all Disposition (Non-Provider) sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Disposition Data

The **All Disposition Data** application allows all disposition sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Disposition section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Documents Data

The **All Documents Data** application allows all documentation that is recorded in Documentation to pull into the report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All ED Course Data

The **All ED Course Data** application allows all ED Course sections across multiple Emergency Department documents to pull together in the same section of the report. If sections are documented on multiple Emergency Department documents, each individual document's section will appear as a sub-section under the ED Course section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Education (Non-Provider) Data

The **All Education (Non-Provider) Data** application allows all Education (Non-Provider) sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Education Data

The **All Education Data** application allows all education sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each

individual document's section will appear as a sub-section under the Education section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All History (Non-Provider) Data

The **All History (Non-Provider) Data** application allows all History (Non-Provider) sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All History Data

The **All History Data** application allows all History sections within the Well Child and Prenatal documents to appear in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the History section of the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All HPI Data

The **All HPI Data** application allows all History of Present Illness sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the History of Presentation Illness section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Interpretation Data

The **All Interpretation Data** application allows all Interpretation sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Intervention Data

The **All Intervention Data** application allows all intervention sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Intervention section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Intraprocedure Data

The **All Intraprocedure Data** application allows all Intraprocedure sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Physical Assessment Data

The **All Physical Assessment Data** application allows all Physical Assessment sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Physical Exam Data

The **All Physical Exam Data** application allows all Physical Exam sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Physical Exam section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Plan Data

The **All Plan Data** application allows all Plan sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Plan section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Plan of Care Data

The **All Plan of Care Data** application allows all Plan of Care sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Postprocedure Data

The **All Postprocedure Data** application allows all Postprocedure sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Preprocedure Data

The **All Preprocedure Data** application allows all Preprocedure sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Procedure Data

The **All Procedure Data** application allows all procedure sections across multiple documents to pull together in the same section of the report. If sections are documented on multiple documents, each individual document's section will appear as a sub-section under the Procedure section on the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Review of Systems Data

The **All Review of Systems Data** application allows all Review of Systems sections across multiple documents to pull together in the same section to the Documentation Report.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

All Screenings Data

The **All Screenings Data** application allows all Screenings sections across multiple documents to pull together in the same section of the report. To determine the **Section Type** of a section within a Document, see Section Settings. 17 This report application will display documentation typically entered by a non-provider user.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Allergies

The **Allergies** application displays the patient's allergies sorted by allergy type (i.e. drug, environmental or food) along with the description, reaction, severity and status.

- Select the type of allergy to pulled to the report by selecting the check box to include:
  - **Active**: Pulls active allergies on the patient's account
  - **Inactive**: Pulls inactive allergies on the patient's account
  - **Removed**: Pulls removed allergies on the patient's account
  - **All**: Pulls active, inactive and removed allergies on the patient's account. When all is selected the other check boxes are disabled.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Ancillary Orders

The **Ancillary Orders** application displays the test name, frequency, scheduled date/time and the ordering physician.

- Select **Add Dept** to include ancillary orders from specific departments.

- Double-click the department description to add the department. The department list includes all AHIS and OE prefix departments.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Chief Complaint

The **Chief Complaint** application pulls from the CCDA Chief Complaint and Reason for Visit section. This will display the chief complaint and the onset date.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Family Health History

The **Family Health History** application displays all of the Family Health History problems that have been entered on the patient's account along with the associated family member(s).

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Functional Status

The **Functional Status** application displays all of the patient's functional/cognitive conditions along with the description, date, type and status.

- Select the type of functional/cognitive conditions to be pulled to the report by selecting the check box to include:
  - **Active**: Pulls active functional/cognitive conditions on the patient's account
  - **Inactive**: Pulls inactive functional/cognitive conditions on the patient's account
  - **Removed**: Pulls removed functional/cognitive conditions on the patient's account
  - **All**: Pulls active, inactive and removed functional/cognitive conditions on the patient's account. When all is selected the other check boxes are disabled.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Hosptial Discharge Instructions

Hospital Discharge Instructions will pull a hard-coded, prebuilt body of text that contains the name of the hospital facility, the patients' admit date (and discharge date if applicable), as well as a generic medical follow up statement "If you have questions, please follow up with your primary care", etc...

- Select **Save** and then select **Make Active**.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Immunizations

The **Immunizations** application will displays the patient's immunization description, date and time administered and whether the entry is referring to an administration or historical entry.

- Select the type of immunization to be pulled to the report by selecting the check box to include:
  - **All**: Pulls active and removed immunization on the patient's account. When all is selected the other check boxes are disabled.
  - **Active**: Pulls active immunizations on the patient's account
  - **Removed**: Pulls removed immunizations on the patient's account
  - **Excluded**: Pulls excluded immunizations on the patient's account

- Select the type of Visit to be pulled to the report:
  - **All**: Pulls all of the patient's accounts. This is the default selection.
  - **Current**: Pulls only the current account

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Medical History

The **Medical History** application displays all of the Medical History from the Health History application that has been entered on the patient's account.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Medications

The **Medications** application will display all medications that have been entered on the patient's account.

- Select the type of medications to be pulled to the report:
  - **Home Medications**: Pulls from Medication Reconciliation. This will display the medication description, dose, unit, route and frequency.
  - **Removed Home Medications**: Pulls from Medication Reconciliation. This will display the medication description, dose, unit, route and frequency.
  - **Discharge Medications**: Pulls from Medication Reconciliation and Prescription Writer. This will display the medication description, dose, unit, route, frequency, start date/time and discharge status if Prescription Writer has been activated. Discharge medications will also include prescriptions that have been renewed. The discontinued prescription, the renew was created from, however, will pull to the Discontinued Prescriptions filter.
  - **Discontinued Prescriptions:** Pulls any processed prescriptions that have been discontinued from the Prescription Writer application**.**
  - **New Prescriptions This Visit:** Pulls any processed prescriptions that were created on the current visit using the Prescription Writer application and the delivery method selected is one of the following options: View, Electronic, Print or Fax. If "No RX Needed" is selected and the medication is processed, it will not display within the "New Prescriptions this Visit" filter.
  - **Active:** Pulls from Order Chronology. This will display the medication description, dose, unit, route, frequency, start date/time and stop date/time if applicable.
  - **Discontinued Active Meds**: Pulls all medications that have been discontinued from the patient's Medication Profile and any active medications that have been discontinued upon admission reconciliation and discharge reconciliation.
  - **All:** Pulls all medications on the patient's account. When **All** is selected, the other check boxes are disabled.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Medications Administered

The **Medications Administered** application displays the patient's Medication Administration Record (MAR) with an option to display either the most recent administration or all administrations. Elements displayed include the item description, dose, units, frequency, route, instructions and the date/time for administration, omission or discontinued events.

- Select the type of Administration:
  - **All:** Selecting this button will list all medication administrations.
  - **Last:** Selecting this button will list the last administration for each medication.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Medications Administered components will display on the Report as follows.

Non-IV Medications

- **Information:** This information will display on one line in the order listed below.
  - Medication Name
  - Dose
  - Units
  - Frequency
  - Route

- **Administration and Action:** This information will display on one line in the order listed below.
  - Date and Time of Action
  - Action: This will display as Given, Omitted, Discontinued. If omitted, the omission reason will display after the word Omitted. Dose, units and site will not display. If discontinued, dose, units and site will not display.
  - Dose
  - Units
  - Site (if applicable)
  - Reason: If applicable, the PRN reason entered on the administration will display.
  - Comment: If applicable, the comment entered on the administration will display.
  - User Name
  - Witness: If applicable, the second witness user name will display here.

- **Additional Line Information**:This information will display on one line in the order below.
  - Assessment: This will display the date and time, Assessment: (bold), user name.

Non IV Medication Administered on a Documentation Report

IV Medications

- **Order Information:** This information will display on one line in the order below.
  - Medication Name
  - Flowrate
  - Frequency
  - Route

- **Administration and Action:** This information will display on one line in the order below.
  - Date and Time of Action
  - Action: This will display as Given, Omitted, Discontinued. If omitted, the omission reason will display after the word Omitted. Dose, units, and site will not display. If discontinued, dose, units and site will not display.
  - Dose
  - Units
  - Site (if applicable)
  - Reason: If applicable, the PRN reason entered on the administration will display.
  - Comment: If applicable, the comment entered on the administration will display.

- User Name
- Witness: If applicable, the second witness user name will display.

- **Additional Line Information**:This information will display on one line in the order below.
  - Infusion Complete: This will display chronologically in relation to the associated administration in the following order.
    o Date, Time, Action (Infusion Complete), Complete: followed by comment, User name
  - Titrate: This will display chronologically in relation to the administration it is associated with in the following order.
    o Date, Time, Action (Titrate), Complete: followed by comment, User name
  - Infusion Stop Time: This will display chronologically in relation to the associated administration in the following order.
    o Date, Time, Action (Infusion Stop), Complete: followed by comment, User name
  - Infusion Start: This will display chronologically in relation to the associated administration in the following order.
    o Date, Time, Action (Infusion Start), Complete: followed by comment, User name
  - Assessment: This will display the date and time, Assessment: (bold), user name.


Medications Administered

ROCEPHIN/D5W IVPB: 100 ml/hr CONTINUOUS IVPB
- 06/03/2015 08:00 Given 1 GM Right Arm (HUTSON M)
  - 06/03/2015 09:00 Titrate 160.00ml/hr Comment: Patient happy (HUTSON M)
  - 06/03/2015 14:02 Infusion Complete Comment: Patient happy (HUTSON M)
  - 06/03/2015 14:02 Assessment: Pain Relieved (HUTSON M)

IV Medication Administered on Documentation Report

Diabetic Record Medications

- **Order Information:** This information will display on one line in the order below:
  - Medication Name
  - Per Protocol
  - Protocol Frequency: This information will display the associated protocol frequency and route

- **Protocol Line**:This information will display on one line in the order below:
  - Protocol Title

- **Administration and Action:** This information will display on one line in the order below:
  - Date and Time of Action
  - BG/Carb Level
  - Action: This will display as Given, Omitted, Discontinued. If omitted, the omission reason will display after the word Omitted. Dose, units, and site will not display. If discontinued, dose, units and site will not display.
  - Dose
  - Units
  - Site (if applicable)
  - Protocol Name
  - Reason: If applicable, the PRN reason entered on the administration will display.
  - Intervention: This will display the intervention entered on the administration.

- User name
- Witness: If applicable, the user name of the second witness displays here.

- **Additional Line Information**: This will display on one line in the order below:
  - Assessment: This will display the date and time, Assessment: (bold), user name.

PCA Medications

- **Order Information:** This will display on one line in the order below:
  - Medication Name
  - Per Protocol

- **Administration and Action:** This will display on one line in the order below:
  - Date and Time of Action
  - Action: This will display as Start PCA, Effective, Ineffective, Bolus, New Syringe, New Protocol, Discontinued.
  - User Name
  - Witness: If applicable, the user name of the second witness will display.

- **Additional Line Information**: This will display on one line in the order below:
  - Assessment: This will display the date and time, Assessment: (bold), user name

Nursing Orders

The **Nursing Orders** application displays the order description, action and the action date/time. Specific orders may be selected to pull to the report or by not selecting any specific orders, all Nursing Orders will pull to the report.

- Select the type of nursing order to be pulled to the report:
  - **All:** Pulls all nursing orders
  - **First:** Pulls the first entry of each nursing order
  - **Last:** Pulls the last of each nursing order. When last is selected a numeric value field enables to define the number of hours, days or entries to be pulled to the report.

- Select Add Category to pull only the nursing orders from the selected category.

- Double-click the category to add to the category list.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Order Results

The **Order Results** application displays all results along with the Item description, result, test units, collect date/time and the reference range.

- Select **Add Dept** to include order results from specific departments.

- Double-click the department description to add the department. The department list includes all

AHIS and OE prefix departments.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Past Medical Procedures and Interventions

The **Past Medical Procedures and Interventions** application displays all of the past medical procedures and interventions that have been entered within the Surgical/Procedural History area of the Health History application on the patient's account along with the date that they were performed.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Patient Decision Aids

The **Patient Decision Aids** application displays the title of any Patient Education Document that have been added to the patient's account.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Plan of Care

The **Plan of Care** application displays all problems entered on the patient's account with associated goals and instructions.

- Select the type of problems to pulled to the report by selecting the check box to include:
  - **Active**: Pulls the active problems on the patient's account
  - **Inactive**: Pulls the inactive problems on the patient's account
  - **Removed**: Pulls the removed problems on the patient's account
  - **Resolved**: Pulls the resolved problems on the patient's account
  - **All**: Pulls active, inactive, resolved and removed problems on the patient's account. When all is selected the other check boxes are disabled.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Problems

The **Problems** application displays all problems that have been entered in the Physician's Problem list, along with the problem's status, the onset date, addressed date and resolved date.

- Select the type of problems to list in the report by selecting the appropriate check box.
  - **Active**: This option pulls the active problems on the patient's account**Inactive**: This option pulls the inactive problems on the patient's account
  - **All**: This option pulls active, inactive, resolved and removed problems on a patient's account. When All is selected, the other check boxes are disabled.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Procedures

The **Procedures** application pulls from the CCDA Procedures section. This will display the procedure description and procedure date.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Referral/Transition of Care

The **Referral/Transition of Care** application displays referrals and transitions of care separately in subsections along with the reason for referral, referred provider, address, area code and phone number and appointment date.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Social History

The **Social History** application will display all of the patient's social history. The Social History will include the following types: Exercise, Drug Use, Substance Use, Environmental, Travel and Sexual.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Undocumented Medication Orders

The **Undocumented Medication Orders** application will display information pertaining to medications that were ordered within Order Entry for this visit, but were never administered, omitted, or discontinued during the course of the patient visit.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Vital Signs

The **Vital Signs** application displays all vital signs that have been documented on the patient's account.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Thrive Provider EHR Specific Applications

The following applications are for TruBridge Provider EHR use only.

Future Scheduled Tests

The **Future Scheduled Tests** application pulls from Temporary Orders, also known as Hospital

Orders. It will display the item description, scheduled date and time, recurrence date/frequency, status, expiration date and ordering physician for the order.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Future Appointments

The **Future Appointments** application pulls from the Preventatives that are a Follow-up type. It will display the follow-up title, follow-up details and follow-up due date.

- Select **Save** and then select **Make Active** to make the application available to add to a report.

Preventative List

The **Preventative List** application displays preventative title, preventative type and the preventative due date.

- Select the type of preventatives to be pulled to the report by selecting the radio button to include:
  - **Outstanding**: Pulls any preventatives that are not marked as complete
  - **Added This Visit**: Pulls only preventatives added to the current visit

- Select **Save** and then select **Make Active** to make the application available to add to a report.

8.6 Editing Documentation Reports

To edit a Documentation Report that is active:

- Select the report from the Documentation Report List.

- Select Edit from the action bar.

- Select **New Version** to edit an active report. Once New Version is selected, the following buttons will become available on the action bar:
  - **New Section**
  - **Add Section**
  - **Change Order**

- Make any changes needed to the Documentation Report. See Adding Sections 44 and Report Settings 44 for additional information to edit the Documentation Report.

- Once all changes have been made select **Make Active** to make the Documentation Report live.

8.7 Multi Visit Reports

Multi Visit Reports allow sections and questions from Documentation to pull information from multiple visits into one report. This type of report was created for OB visits, Diabetic patients and Coumadin patients to follow their care from visit to visit. Completing a Multi Visit Report will allow a new Multi Visit report to be opened and not have it pull any previous documentation from the completed Multi Visit Report.

To create a New Multi Visit Report:

1. Select **New** from the Documentation Report screen.

2. Type the name of the report in the Title field.

3. Select the Type as **Multi Visit Report**.

4. Select **Save**.

When a new report is created, the status will be set to Inactive once the report is saved. It will display the name of the employee who created the document along with the date and time that it was created.

In order for the report to pull in information, sections will need to be added to the setup. Existing sections may be added to the Multi Visit Report, or a new section may be created. Sections may be set up to pull specific sections or questions that are available within Documentation Documents.

Once the title is saved for the Multi Visit Report, the Report Maintenance screen opens.

The buttons available on the action bar are:

- **Back Arrow**: This option returns the user to the previous screen without saving changes.
- **Save as**: This option allows the user to save the document under a new name and creates a new copy of the report document.
- **Make Active**: This option allows the document report to move from Inactive to Active status. This button is enabled when the documentation report is inactive.
- **Make Obsolete**: Selecting this option makes the document report obsolete.
- **Settings**: This option allows the setup of report document settings. See Report Document Settings 41 for additional information.
- **Preview**: Opens a preview of the report
- **New Section**: This option allows the creation of a new section within the Multi Visit Report.
- **Add Section**: This option allows the selection of an existing section to be pulled into the report.

Adding Sections

To create a new section:

1. Select **New Section**.

2. Enter the name of the section in the Title field and select **Enter**. The Description field will automatically display but is editable. The Description field is what will display on the report.

3. Once the Title and Description fields have been addressed, select **Save**.

To add an item to the Multi Visit Report, select **Add Item**. This will allow questions or sections to be pulled into the document report from Documentation documents.

1. Select the radio button next to **Question** or **Section**.

2. Type the beginning description of the question or section into the search field. Results will begin to display as typing continues.

3. When a section or question is selected, it will populate the preview area.

4. To add the question or section to the Multi Visit Report, items must be selected one at a time from the list. To do so, select **Add**. Repeat the steps above to add each question and section needed for the documentation report.

5. To add the question or section to the worklist, choose the desired question or section and select **Add to Worklist**.

The question and section associations may also be viewed from this screen.

1. Once all questions and sections have been added to the section of the Multi Visit Report, select the back arrow to review the section.

2. Select **Save** once all items have been added to the section.

3. Select **Make Active** to set this section to Live.

Existing sections may also be pulled into the Multi Visit Report:

1. Select **Add Section** to add an existing section to the report. The existing sections will then display.

2. To view only Active sections, select the **Active radio button**.
   - To preview the section before it is added, select the section title. Each application and item that is set up for that section will display in the preview area on the right side of the screen.

3. To add the section, select **Add** or double-click the title.

Once all sections have been added to the report, the order of the sections may be rearranged:

1. Select **Change Order** and then the section that needs to be moved.

2. Select the action that needs to be performed. The available options are:
   - **To Top**
   - **Move Up**
   - **Move Down**
   - **To Bottom**

3. Select **Settings** to establish the report generation settings. See Report Document Settings 41 for further information.

4. Once all filters have been assigned, select **Save**.

5. Select **Make Active** once all setup has been completed for the report. Doing so will make the form available in Documentation.

Adding Applications

Applications may also be added to sections in Multi Visit Reports:

To add an existing application to a Multi Visit Report:

- Select **Add Application**.

- Select the application from the Application List screen to be pulled to the Multi Visit Report and select **Add**.

- Select **Save**.

To add a new application that is not listed in the Application List, select **New Application**.

- Select the application title and select insert or double-click the application title.

- Once the application title is selected from the list and inserted, the title and the description of the application may be edited. The title displays in the application list, and the description displays in the documentation report.

- For additional setup options, see the following applications:
  - Medications Administration 64
  - Immunizations 64
  - Lab Results 64

- Once all applications have been entered to the section, select **Save** and then select make active.

Medications Administration

The Medications Administration application will pull information to the Multi Visit Report if the item has been ordered and administered on the patient. It will display the Item Description on the left column of the grid. Administration details will display to the right of the item name under the specific date columns the item was ordered.

1. For a medication(s) to pull to the Multi Visit Report, select the medication(s) from the list. Medications may be multi-selected using the Shift/Control keys on the keyboard.

2. Once the medication(s) has been selected, choose select to create the application. If multiple medications were selected then an application will be created for each individual medication. Each individual Medication Administration application must then be added to the section.

Lab Results

The Lab Results application will pull information to the Multi Visit Report if the item has been ordered and resulted on the patient. The Item Description will display on one line of the grid. All components of the test will display beneath the test name on separate lines of the grid.

1. For lab(s) to pull to the Multi Visit Report, select the lab(s) from the list. Labs may be multi-selected using the Shift/Control keys on the keyboard.

2. Once the lab(s) has been selected, choose select to create the application. If multiple labs were selected, then an application will be created for each individual lab. Each individual Lab Result application must then be added to the section.

Immunizations

The Immunizations application allows the user to select from a test list which will then allow the Immunization and Date Given to display within the Multi Visit Report. Information will pull if the Immunization has been ordered and given to the patient. Item Description will display on one line of the grid. All administration dates will display in the Date column.

1. For immunization(s) to pull to the Multi Visit Report, select the immunization(s) from the list. Immunizations may be multi-selected using the Shift/Control keys on the keyboard.

2. Once the immunization(s) has been selected, choose select to create the application. If multiple immunizations were selected, then an application will be created for each individual immunization. Each individual Immunization application must then be added to the section.

Editing Multi Visit Reports

To edit a Multi Visit Report that has a Status of Active:

- Select the report from the Documentation Report List.

- Select Edit from the action bar.

- Select New Version to edit an active report. Once New Version is selected, the following buttons will become available on the action bar:
  - **New Section**
  - **Add Section**
  - **Change Order**

- Make any changes needed to the Documentation Report. See Adding Sections 62 and Report Settings 44 for additional information regarding Multi Visit Reports.

- Once all changes have been made, select **Make Active** to activate the Documentation Report.

Chapter 9 Backup Reports by Department

Backup Reports by Department is used to set up the Documentation Reports that will be spooled to the PC Backup for any departments that use Documentation. Any Documentation Report set up in this table will pull in PDF format and include any documentation entered over the course of the last 24 hours. It will be sent to the PC Backup every hour on the half hour.

- To access the Backup Reports by Department from Tables, select **Clinical**.
- Then, select **Backup Reports by Department**.

The action bar displays as follows:

- **New:** This option allows the user to set up a new backup report for a department and launches the Backup Report Edit screen.
- **Edit:** This option will launch the Backup Report Edit screen and allow modifications to be made to the selected backup report. This option is only available when a report is selected for the list of backup reports.
- **Delete:** This option will stop the selected report from spooling to PC Backup. It will also remove it from the report list.

The backup reports will display on the screen under the **Report Title** column along with the assigned departments to that report.

To set up a new backup report:

1. Select **New** from the action bar.

   The action bar is as follows:

   - **Back Arrow**: Selecting this option will take the user to the Backup Report Edit screen without saving and reopen the Backup Reports by Department screen.
   - **Save**: Selecting this option will save any changes made within the screen.
   - **Documentation Report**: Selecting this option will launch the Documentation Report screen. When a report is selected, it will be added as the backup report. If an existing report already displays on the Backup Report Edit screen, the new report selected will replace the existing report and the associated departments will then become associated with the new report.
   - **Assign Depts**: This option will launch a list of departments that are not already associated to a backup report and allow the assignment of a department to the selected report. A department can only be assigned to one report. If the selected department is currently assigned to another report, a message will display which states "Selected department (number) is already assigned to a different documentation report."

- **Remove Depts**: This option allows the removal of the report's assigned department.

2. Select **Documentation Report** to add a new backup report.

   NOTE: *Only active Documentation Reports will be available on the Documentation Reports screen.*

3. Select the report that will be spooled to the Backup PC. Then, select **Update**. The selected report will display under Report Title.

To assign departments to the report:

1. Select **Assign Depts**.

2. Select the department that will be associated with the backup report and choose **Select**. Double-clicking the department will also associate it to the backup report.

3. Once all needed departments are assigned, select **Save**.

Chapter 10 Documentation Header/Footer

10.1 Overview

Documentation Headers/Footers allows facilities to set up specific headers/footers per department or per facility within Documentation.

10.2 Document Header/Footer

The Document Header/Footer List allows the addition of new headers/footers or editing existing headers/footers.

The action bar options are as follows:

- **New** will open the header/footer edit screen to create a new header/footer.
- **Edit** allows access to the Document Header/Footer Maintenance Screen after a header/footer is selected from the list and edit the selected header/footer. Double-clicking a header/footer will also allow the user to access the Document Header/Footer Maintenance Screen.
- **Delete** allows the user to delete a header/footer selected from the list. A prompt will notify the user asking, "Are you sure you want to delete this header or footer?" Selecting yes will delete the header/footer, and selecting no will not make any changes to the header/footer.

10.3 Header/Footer Maintenance

To create a new header or footer, select **New** from the Document Header/Footer List Screen.

The action bar options are as follows:

- **Back Arrow** exits without saving the header/footer.
- **Save** will save any changes made to the header/footer.
- **Save As** allows the user to copy the existing setup and save it under a new description.

NOTE: *If the existing header/footer is saved as a global default, do not save the new header/footer as the default header. Also do not include any department assignments with the new header.*

- **Edit** will allow access to the Cell Maintenance. Double-clicking the cell will also allow access to the cell Maintenance Screen.This button is disabled until a cell is selected.
- **Remove** will allow the removal of a an element from the gird. This button is disabled until a cell is selected.

- **Departments** will allow access to the Document Header/Footer Department List where departments may be viewed, assigned or removed. See Assigning Departments for additional setup.

- **Preview** will show a preview with the element title in the place of where the content would be placed within the header/footer.

Address the following fields:

- **Description** is the name of the header/footer. This is a free-text entry of 50 alphabetic or numeric characters.

- Select the **Type**: header or footer.

- Address the header/footer **Size**. The size should not exceed 180 mm. The size text box only accepts up to three numeric values. The default size is 60mm.

- Select the **Default** check box to designate the header/footer as the default for the selected Facility ID.

- The Representation Grid columns are as follows:
  - **Left** will align any setup in this area to the left.
  - **Center** will center any setup in this area.
  - **Right** will align any setup in this area to the right.

- The Representation Grid has a max of 10 rows. See Cell Maintenance 69 for additional Representation Grid Setup.

NOTE: *All Elements added to the grid that are not labels will display in blue.*

10.4 Cell Maintenance

To insert elements into the grid, select the cell the elements that will be placed, and select edit or double-click within the cell.

The action bar options are as follows:

- **Back Arrow** exits without saving the header/footer. If the back arrow is selected, the prompt "Changes are not saved. Are you sure you want proceed?" will display. Selecting yes will move to the header/footer maintenance screen without saving, and selecting no will open the cell maintenance screen to all the user to update the changes made to the header/footer cell.

- **Update** will save any changes made to the header/footer cell.

- **Edit** allows the user to edit the selected element and opens the appropriate screen to make any needed changes.This button is disabled until a row is selected.

- **Add Label** will open the Label Maintenance screen. See Label Maintenance 70 for additional information.
- **Add DB Code** will open the Database Code Maintenance screen. See Database Maintenance 71 below for additional Information.
- **Add Image** will open the Image Maintenance screen. See Image Maintenance 72 below for additional information.
- **Add Line Break** inserts a line between the elements in the cells.
- **Delete** will delete the information from the selected row. This button is disabled until a row is selected.

When elements are set up, they will display on the screen as follows:

- **Text** will display any text entered on the label maintenance screen, any database code that is selected and an image name if one is set up.
- **Font** will display the font option selected.
- **Sequence** will display the setup on the label, database and image screen.
- **Type** will display the type of element selected. The available types are:
  - **Label**
  - **DB Code**
  - **Image**

Label Maintenance

To add a Label, select Add Label.

- Position displays the cell location on the Representation Grid.
- Select **Text** to insert a text label that will display in the header/footer. The text field can hold up to 50 characters.
- Select **Font Size** to choose the appropriate font size.The default font size is 12 pts. This is a drop-down with the following font size options:
  - **8 pts**
  - **10 pts**
  - **12 pts**
  - **14 pts**
- Select the **Bold** check box if the text label is to display bold.
- Select the **Italics** check box if the if the text label is to display in italics.

- Select the **Underline** check box if the text label is to display underlined.
- The **Sequence** drop-down allows the ability to sequence the label if there are multiple items set up within the same cell. The drop-down box options are 1-10.

Database Maintenance

To add a Database Code, select Add DB Code.

- Position displays the cell location on the Representation Grid.
- Select **Database Code** magnifying glass to access the database lookup selection screen.
- Select the appropriate database code and choose the select button from the action bar to insert the database code or double-click the database code to add it to the cell. The following database codes are available for selection:

- Admit Date and Time
- Admitting Diagnosis
- Allergies
- Attending Physician
- BMI
- BSA
- Chief Complaint
- Completed By User Name and Credentials
- Completed Date and time (MM/DD/YYYY HH:MM)
- Consulting Physician (All)
- Copy to Physician*
- CrCl
- Date of Birth
- Discharge Date and Time
- Do Not Resuscitate Code
- Document/Report Description (also displays the PhysDoc Note Title)
- Entry Date*
- ER Physician
- Facility Address
- Facility Email
- Facility Fax Number
- Facility Name
- Facility Phone Number
- Fall Risk
- Height
- ID for Medicaid Insurance Policy
- Isolation
- Medical Record Number
- MRSA
- Page number (Page 1, Page 2, Page 3, etc.)
- Patient Age
- Patient First Name
- Patient Full Name
- Patient Gender
- Patient Last Name
- Patient Middle Name
- Primary Physician
- Print Date and Time (MM/DD/YYYY HH:MM)
- Room Number
- Secondary Physician
- Signed By Provider Name and Credentials
- Signed Date and time (MM/DD/YYYY HH:MM)
- Smoking Status
- Stay Type
- Time Last Amended*
- Violent Patient
- Visit Number
- VRE
- Weight

***NOTE**: Database codes that display an '*' are specific to documentation within PhysDoc. If used in a header or footer for Documentation Documents, or Reports, these database codes will not display any information.*

- Select **Font Size** to choose the appropriate font size.The default font size is 12 pts. This is a drop-down with the following font size options:
  - **8 pts**
  - **10 pts**
  - **12 pts**
  - **14 pts**

- Select the **Bold** check box if the text label is to display bold.

- Select the **Italics** check box if the if the text label is to display in italics.

- Select the **Underline** check box if the text label is to display underlined.

- The **Sequence** drop-down allows the ability to sequence the label if there are multiple items set up within the same cell. The drop-down box options are 1-10.

Image Maintenance

To add an image select Add Image.

- Position displays the cell location on the Representation Grid.

- Select the Image Name magnifying glass to access the image lookup selection screen.

- Select the appropriate image and choose the **Select** button from the action bar to insert the image into the cell. Double-clicking the image will also add it to the cell.

- The **Sequence** drop-down allows the ability to sequence the label if there are multiple items set up within the same cell. The drop-down box options are 1-10.

- Select **Update** to save the changes made to the cell.

10.5 Assigning Departments

After a header/footer is created, departments may be assigned to the header/footer so it pulls to documents or reports when selected in the assigned departments.

To assign departments to a Document Header/Footer:

- Select a header/footer from the Header/Footer List.
- Select **Edit** to assign departments to the header/footer.
- Select **Departments**.
- Select **Add** to assign departments to the header/footer.
- Select the appropriate department and choose the **Select** button from the action bar to assign the department to the header/footer. Double-clicking the department will also assign it to the header/footer.

  NOTE: *More then one department may be selected at time. This is a multi-select screen. Holding down the Shift key will allow the user to select a block of departments, and holding down the Control key will allow the user select multiple individual departments.*

- To delete a department, select the department and select the **Delete** button from the action bar.
- Once all departments have been added, select the **back arrow** to access the Cell Maintenance screen.
- The assigned departments now display in the departments field.

Chapter 11 Clinical Documentation Control Table

The Clinical Documentation Control Table is used to set different controls available for Documentation within TruBridge EHR.

The action bar options are as follows:

- **Save:** Allows any changes made to the Clinical Documentation Control to be saved.
- **Narrative:** Allows users to select the end user narrative output display for the specified department. See Narrative 75 for additional information.
- **Roles:** Allows the Roles for Required Signature screen to launch where the user may assign the required signature option to a specific role(s). This option is enabled when the Requires Signature check box is selected. See Roles 75 for additional information.
- **Retract Reasons:** Allows for a user defined table of retract reasons that may be selected after choosing to retract a document within the Documentation application. See Retract Reasons 76 for additional information.
- **Documentation Version**: Displays a view only database query of the sites content version and when the content was last updated for the Document Library for Documentation. See Documentation Version 77 for additional Information.
- **Copy Forward XXX maximum days:** Sets the number of days that TruBridge EHR looks back to pull documentation from visit to visit. The field will hold up to 3 characters with a default of 365 days and a maximum of 999 days. This setting will apply to ED and hospital departments.
- **Timeframe for updated information to pull to Charting Options:** Sets the number of hours TruBridge EHR will look back to pull data to the right side of the Charting Options screen. The time should be in hours, with a max of 3 characters. The starting point of time will be the patient's admit date and time. TruBridge EHR will look at the location of the patient to determine which setting to use:
  - If the patient is located in the Emergency Department, TruBridge EHR will look to the ED Control Table for the time frame. If the field is left blank in the ED Control Table, then charting options will look at the setting in the Clinical Documentation Control Table. Please see ED Control Table for additional setup information.
  - If the patient is located in the Clinic, TruBridge EHR will look to the Clinic Control Table. If the clinic is a department of the hospital and the field is blank, then charting options will look at the Clinical Documentation Control Table. If the clinic is a in a separate AR, then it will only look in the Clinic Control Table. Please see the Clinic Control Table for additional setup information.
- **Timeframe for late entry documentation:** Allows for documentation to be tagged as late entry based on a value placed in this field when Change Date/Time is used in documentation. "Late Entry: (actual date/time)" is added to the existing user/date/time stamp on the narrative. Up to three digits may be entered and will read in hours. If this field is left blank, the feature is turned "off."
- **Display/Hide documents per specialty:** TruBridge use only.

- **Requires Signature:** Allows the ability to make all documents required to be signed, disables the requirement to sign all documents, or allows the ability for individual documents to be required to be signed within the document settings. The following options are available for selection:
  - **Enable All**: When selected it will auto select Require Signature within the document settings of all Multi Clinician Documents and Flowcharts in the Documentation Library. This will require all Multi Clinician Documents and Flowcharts to be signed by the designated role(s). Selecting this option will also pull the document to the "Documentation Signed" component on the Discharge Checklist, place an alert on the designated role(s) Home Screen and pull the document to the Required filter on the Multiple Signing Screen if the document is left unsigned. See the Discharge Checklist for additional setup and Signing Documentation within the Documentation User Guide for additional information on the Multiple Document Signing Selection screen. To assign a specific role(s), please see Roles 75 for addition information.
  - **Disable All**: When selected it will remove the check mark for the check box Require Signature within the document settings and disable the field within the document setting so they may not be selected as required.
  - **Document Level**: When selected it will activate the Requires Signature check box within the document settings allowing the user to individually require a signature on each document. This is the default selection.

11.1 Narrative

The **Narrative** button from the action bar will launch the Clinical Documentation Narrative Settings screen.

A full list of departments within the facility will display**.** List Narrative is the default Narrative Setting. Selecting a department will enable the Paragraph Narrative and List Narrative options, which can then be selected in order to change the narrative output for documentation.

Paragraph Narrative: Allows for the narrative output for Documentation to display in a paragraph format.

List Narrative: Allows for the narrative output for Documentation to display in a list format.

11.2 Roles

Selecting the Requires Signature check box enables the Roles option from the action bar. This allows the user to assign the required signature option to a specific role(s). This screen allows the user to select multiple roles at once.

NOTE: *The role(s) assigned within the Document setting will supersede the role(s) assigned within the Clinical Documentation table.*

- Select the check boxes to assign the required signature for all Multi Clinician Documents and Flowcharts to a specific role. Once all roles are selected, select **Update** from the action bar to save the selected roles.

NOTE: *Documents that require a signature create an alert on the Home screen that reads "Unsigned Document," which will take the user to the Multiple Signing screen when selected. The Home screen alert is then removed once the document is signed. The user also has the option of acknowledging the alert without signing. See Home Screen for additional information.*

11.3 Retract Reasons

Selecting the **Retract Reasons** option will launch the Retract Reason List where retract reasons may be added to the table. This table is used to build a list of retract reasons that may be selected when the **Retract** option is selected on a document or report from the Documentation application.

The action bar options are as follows:

- **Add:** Allows the addition of new retract reasons to the table.
- **Edit:** Allows changes to be made to existing retract reasons. This option is enabled when a retract reason is selected.
- **Delete:** Allows existing retract reasons to be deleted from the table. This option is enabled when a retract reason is selected.

To add a new retract reason:

1. Select **Add**

2. Enter the retract reason in the field and select **OK** to save.

NOTE: *The retract reason table will automatically default an "Other" option as the last option in the list, that will allow the user to free text in a retract reason from within the Documentation application.*

To edit an existing retract reason:

1. Select the reason that needs to be edited and then select **Edit**.

2. Enter the needed changes and select **OK** to save.

To delete an existing retract reason:

1. Select the reason that needs to be deleted.

2. Select **Delete** to remove the reason from the list.

11.4 Display/Hide documents per Specialty Edit

TruBridge Use Only.

11.5 Documentation Version

Selecting the **Documentation Version** option will launch the Documentation Content Version screen. This view only screen allows the user to see the content version for both TruBridge Content and Provation Content, along with the date and time the content was last updated. This screen is facility specific.

***NOTE**: If content has never been installed, the display field will be blank.*

Chapter 12 Section Preferences

The **Section Preference** table allows the user to set up the order of sections which will automatically display in the Section List of Documentation when documents are accessed.

Selecting Section Preferences opens the **Section Preference List**.

The following options are available from the action bar:

- **Add UBL:** Displays a listing of UBLs.
  - List can be filtered using the radio buttons All, Enabled, and Disabled.
  - A search field is available for free text search.
  - A dropdown containing Name and UBL is available.

- **Add Department:** Displays the Department List table.

Upon adding a user Login or Department to the Section Preference List, double-click the selection or highlight and choose **Edit** to open the Section Preference Edit screen.

- The Section Preference Edit screen displays the application list currently in place in the navigation panel for the user or department. The following sections are hard-coded and cannot be removed:
  - **History of Present Illness:** Displays the HPI section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
  - **History:** Displays the History section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list within the navigation panel.
  - **Review of Systems:** Displays the Review of Systems section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
  - **Physical Exam:** Displays the all of Physical Exam sections from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
  - **ED Course:** Displays the ED Course section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
  - **Assessment:** Displays the Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
  - **Plan:** Displays the Plan section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.

NOTE: *If a section preference for a UBL or Department displays a document section that does not exists within the selected document it will not display on the section list. For example, the ED Course section is only available in Emergency Department Documents.*

To add additional section preferences select **Add Application**.

Application may be added one application at a time. Select the desired application and choose **Select**.

The following Applications may be added:

- **Interpretation:** Displays the Interpretation section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Procedures:** Displays the Procedure section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Pre-Procedures:** Displays the Pre-procedure section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Intra-Procedures:** Displays the Intra-Procedure section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Post-Procedures:** Displays the Post-procedure section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Admission Data:** Displays the Admission Data section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **History (Non-Provider):** Displays the History (Non-Provider) section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Vital Sign Entry:** Displays the Vital Sign Entry section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Assessment: Pain:** Displays the Pain Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Assessment: Psychiatric:** Displays the Psychiatric Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Assessment: Function:** Displays the Function Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Assessment: Nutrition:** Displays the Nutrition Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Screenings:** Displays the Screenings section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Physical Assessment:** Displays the Physical Assessment section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Plan of Care Document:** Displays the Plan of Care section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.

- **Discharge Planning:** Displays the Discharge Planning section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Interventions:** Displays the Interventions section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Education (Non-Provider):** Displays the Education (Non-Provider) section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Disposition (Non-Provider):** Displays the Disposition (Non-Provider) section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Education:** Displays the Education section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Disposition:** Displays the Disposition section from within a Document. This allows the user the ability to choose where this information will display in the document based on where this item displays in their section list in the navigation panel.
- **Vital Signs/Diabetic Monitoring:** Displays all vital signs and diabetic monitoring for the current visit of the patient's account.
- **Allergies:** Displays all allergies for the current visit of the patient's account.
- **Immunizations:** All immunizations for the current visit of the patient's account.
- **Lab Results:** Displays all labs resulted on the current visit of the patient's account.
- **Patient Education Documents:** Displays all Patient Education Document titles added to a patient's account.
- **Order Chronology:** Displays all items from within Order Chronology.
- **Medication List:** This will launch the patient's Medication List and allow the user to select which medications will be inserted into the document.
- **Problem List:** This will launch the Physician Problem List and allow the user to select which entries will be inserted into the document.
- **Plan of Care:** This will launch the Plan of Care application and allow the user to select which entries will be inserted into the document.
- **Health History:** This will launch the Health History application and allow the user to select which entries will be inserted into the document.
- **Group Note**: Displays the Group Note associated to the event the user used to access the Documentation application and will display in a text format.

NOTE: *If a section preference for a UBL or Department displays a document section that does not exists within the selected document, it will not display on the section list.*

NOTE: *To determine the section type of section in a document see* *Section Settings* 17.

Once all applications have been selected, the order of the section preferences will display it may be rearranged by selecting **Change Order**.

- Once the desired applications have been added to the UBL or department, select **Update** to return to Section Preference List.

Chapter 13 Synonym List

Synonym List enables a user to create a new synonym to associate with a document and edit existing synonyms to documents.

The Search field allows a user to search for existing synonyms. This is a smart search field. All options containing the sequence of letters and/or numbers entered in the search field will display. The synonym list also includes most commonly misspelled words.

The following action buttons are available:

- **New**: Allows a user to create a synonym and associate created synonyms to a document(s).
- **Edit**: Allows a user to associate documents or remove documents from an existing synonym.
- **Remove Associations**: Allows a user to remove documents associated with a synonym. This functionality does not apply to Provation synonyms that are predefined and associated to Provation documents. This feature applies only to documents associated by the user.

13.1 Adding New Synonyms

To create a new synonym to associate to a document:

1. Select **New** from the action bar.
2. Enter a synonym value in the search field and select Enter. If the synonym is already in use, a prompt that reads "Invalid synonym description. This synonym already exists" will display.
3. Select **Add Document** to associate a document(s) to the synonym. The Document List screen will display. This screen has multi-select functionality.
4. Select the desired document(s) and then select **Add** from the action bar.
5. Select **Save.**

The following action buttons are enabled:

- **Delete Synonym** allows the user to immediately delete the synonym and return to the Synonym List.
- **Add Document** enables the user to add additional documents to associate to the synonym.
- **Remove Document** is enabled once a document has been added and then highlighted. This will remove the designated document from the Synonym Edit screen.

NOTE: *This functionality does not apply to Provation synonyms that are predefined and associated to Provation documents.*

13.2 Editing Synonyms

Editing an existing synonym allows the user to associate user-designated documents to the synonym or remove existing document associations. Provation synonyms, however, are predefined and may not be removed.

To add a document(s) to a synonym:

1. Highlight the desired synonym and select **Edit** from the action bar. The Synonym Edit screen will display. This screen contains all documents associated with the synonym.

2. Select **Add Document** to associate a document(s) to the synonym. The Document List screen will display. This screen has multi-select functionality.

3. Select the desired document(s) and then select **Add** from the action bar.

4. Select **Save**.

The following action buttons are enabled:

- **Delete Synonym** allows the user to immediately delete the synonym and return to the Synonym List.

- **Add Document** enables the user to add additional documents to associate to the synonym.

- **Remove Document** is enabled once a document has been added and highlighted. This will remove the designated document from the Synonym Edit screen.

NOTE: *This functionality does not apply to Provation synonyms that are predefined and associated to Provation documents.*

5. Select the back arrow to return to the Synonym List screen.

Chapter 14 PDF Forms

For TruBridge Use only.