Clinical E-Docs Process Guide

Adding a Clinical E-Doc

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Clinical E-Docs

Overview

DISCLAIMER

The **Clinical E-Docs** feature is activated by System Administration. Please contact HHAX Support Team for details, setup, and guidance.

Clinical E-Docs are created based on Caregiver Discipline and by Service Code per Contract. The HHAeXchange (HHAX) Clinical Team works closely with Clients to customize forms (pages) which become available as the feature is activated.

The **Clinical E-Docs** function allows one to enter clinical information for a specific Skilled visit in the HHAX application. This category covers the **Clinical e-Docs** feature and provides a high-level overview of the function as well as requirements when manually completing e-docs that are unique to HHAX.

Please direct any questions, thoughts, or concerns regarding the content herein to HHAeXchange Customer Support.

HHAX System Key Terms and Definitions

The following provides basic definition of HHAX System key terms applicable throughout the document.

Term	Definition
Patient	Refers to the Member, Consumer, or Recipient. The Patient is the person receiving services.
Caregiver	Refers to the Aide, Homecare Aide, Homecare Worker, or Worker. The Caregiver is the person providing services.
Provider	Refers to the Agency or organization coordinating services.
Payer	Refers to the Managed Care Organization (MCO), Contract, or HHS. The Payer is the organization placing Patients with Providers.
HHAX	Acronym for HHAeXchange

Clinical E-Docs

The **Clinical E-Docs** function allows clinical information to be entered for a specific Skilled visit. Complete the following steps to enter an e-Doc in the HHAX system.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Navigate to the Patient’s Calendar page and select the appropriate visit.</td></tr>
<tr><td>2</td><td>On the Visit Info tab, scroll down to the Clinical Documentation section. There are two options (Add or Upload) as described in the table below the following image.

Clinical Documentation – Visit Info Tab

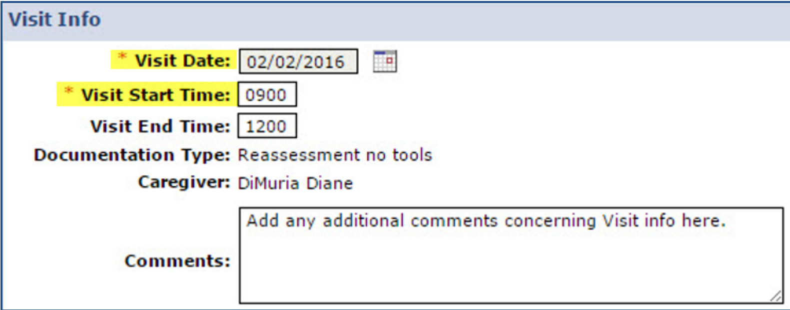
<table>
<tr><th>Select…</th><th>To…</th></tr>
<tr><td>Add (dropdown)</td><td>Select from the e-Doc forms dropdown to add a new form created by the Agency.</td></tr>
<tr><td>Upload (icon)</td><td>Upload a copy of the assessment if already file.</td></tr>
</table>
</td></tr>
<tr><td>3</td><td>Depending on the selected form, the applicable page opens to complete. In this example, the Clinical Document window opens. Use the tabs on the top to navigate to the various pages of the document. Enter the required information.

Clinical e-Docs Tabs

Alternatively, click the Save & Next button at the bottom of each page to move from one page to the next in order.</td></tr>
<tr><td>4</td><td>Click the Save & Close button if completing the assessment during the visit.</td></tr>
</table>

Visit Info

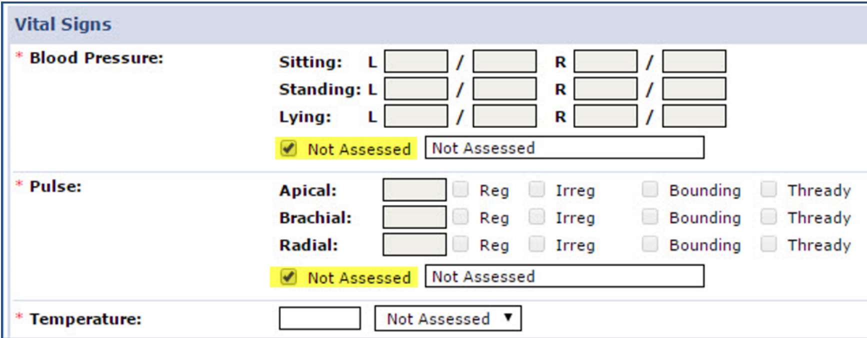
The *Visit Info* page is automatically opened when adding a **Clinical e-Doc**. The **Visit Start Time** and **Visit Date** must be entered prior to navigating to any other page.



Visit Info Page

Vital Signs

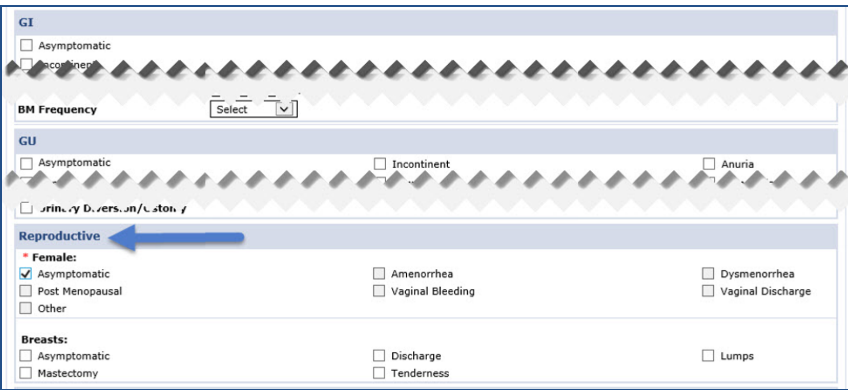
The *Vital Signs* page contains fields to record **Blood Pressure, Pulse, Temperature, Respiration, Lungs,** and **Weight**. If Patient's Blood Pressure, Pulse, or Temperature was not assessed, select the **Not Assessed** checkbox in the applicable sections (as illustrated in the image below).



Not Assessed Values

GI/GU/Reproductive

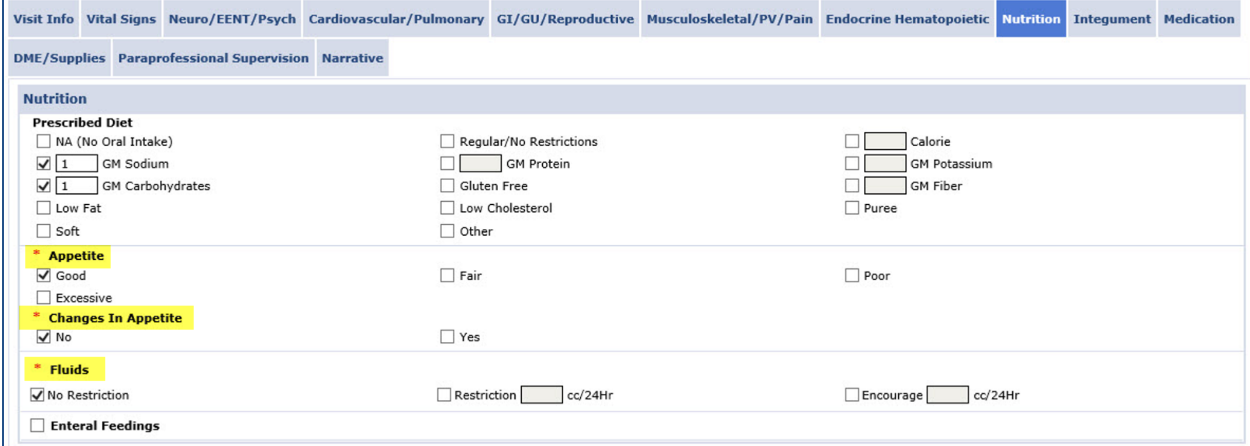
The *GI/GU/Reproductive* page contains fields to record information pertaining to the Patient's gastrointestinal and genitourinary assessment. The fields in the *Reproductive* section correspond to the Patient's gender.



GI/GU/Reproductive

Nutrition

The *Nutrition* page is used to record and keep notes on the Patient's diet. Some fields, such as **GM Sodium** and **GM Carbohydrates**, require an additional value if selected. The requirement for each of these fields varies.



Nutrition

Medication

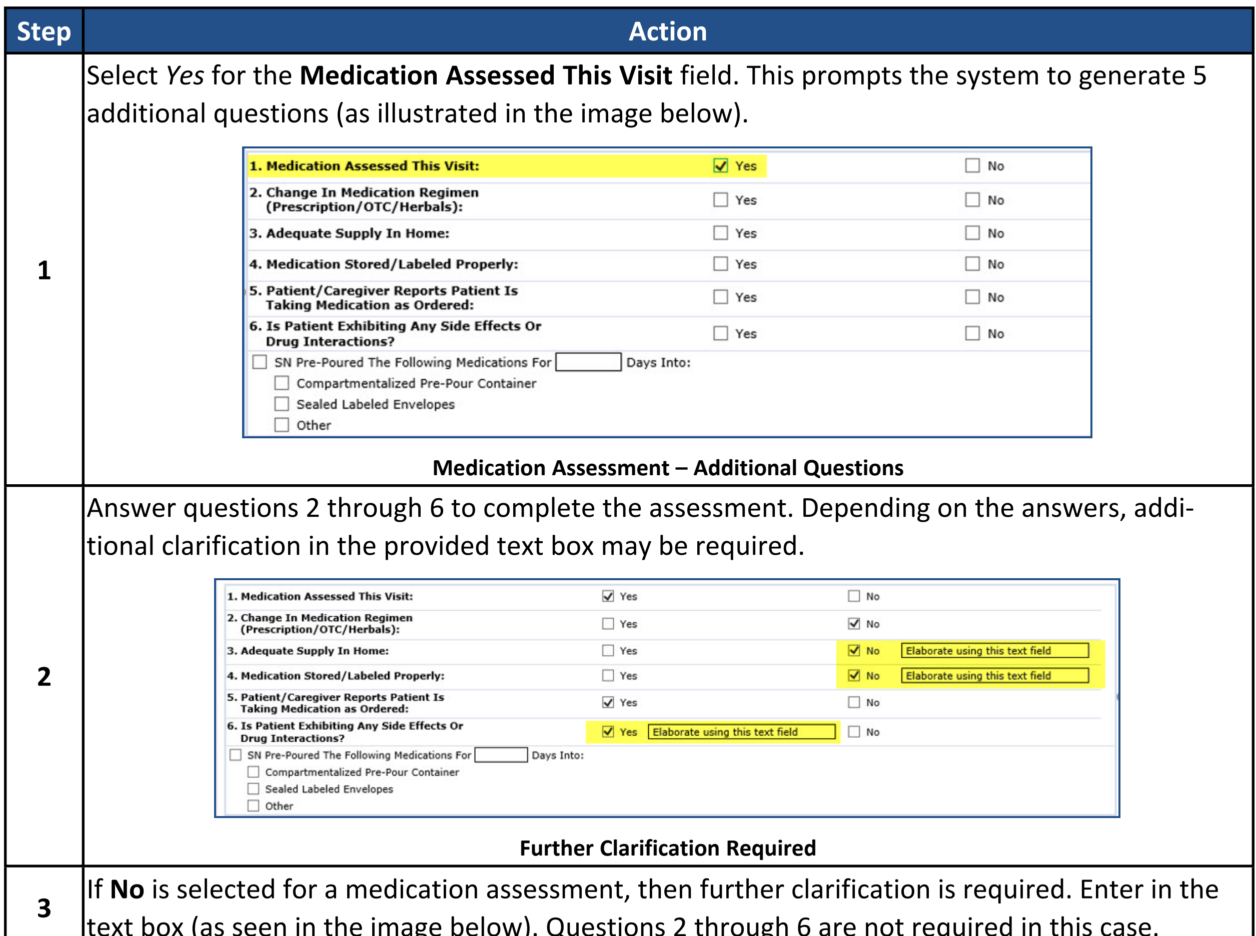
The *Medication* page is used to record medication assessments and maintain a history of the Patient's medication regimen. When a Patient's medication is added, edited, discontinued, or deleted in the eDoc or MD Order, the change syncs displaying in the Patient Med Profile page (***Patient > Med Profile***). When a medication is changed to a different one, then the new medication information replaces the older one. If deleted, then the medication is deleted from the Med Profile.

Note: *Information only syncs from the Patient's Med Profile to the eDoc/MD Order one time; when created. If information is added or changed on the Patient's Med Profile (after the eDoc or the MD Order is created), then it does not sync to either the eDoc or MD Order.*

This section covers entering medication assessments and updating the Med Profile.

Medication Assessment

Complete the following steps to enter a new medication assessment.

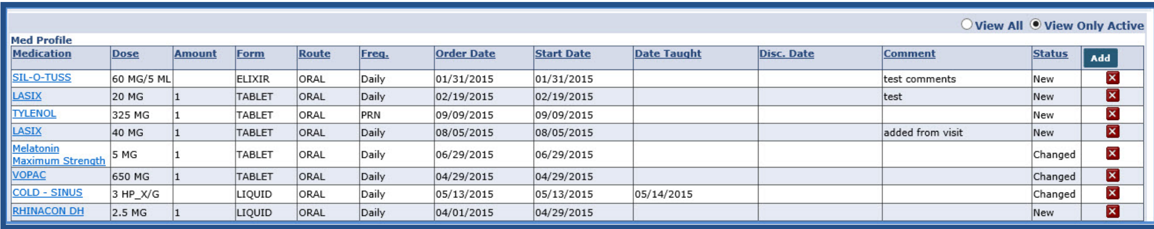


Step	Action
1	Select *Yes* for the **Medication Assessed This Visit** field. This prompts the system to generate 5 additional questions (as illustrated in the image below). **Medication Assessment – Additional Questions**
2	Answer questions 2 through 6 to complete the assessment. Depending on the answers, additional clarification in the provided text box may be required. **Further Clarification Required**
3	If **No** is selected for a medication assessment, then further clarification is required. Enter in the text box (as seen in the image below). Questions 2 through 6 are not required in this case.

Step	Action
	1. Medication Assessed This Visit: ☐ Yes ☑ No [Elaborate using this text field] ☐ SN Pre-Poured The Following Medications For [ ] Days Into: ☐ Compartmentalized Pre-Pour Container ☐ Sealed Labeled Envelopes ☐ Other **No Medication Assessment Completed**

Med Profile

The Med Profile is a record of every medication used by the Patient. From the Med File, one can add, edit existing records, add new medications, or delete entries that are no longer relevant.



View All View Only Active

Med Profile

Medication	Dose	Amount	Form	Route	Freq.	Order Date	Start Date	Date Taught	Disc. Date	Comment	Status	Add
SIL-O-TUSS	60 MG/5 ML		ELIXIR	ORAL	Daily	01/31/2015	01/31/2015			test comments	New	
LASIX	20 MG	1	TABLET	ORAL	Daily	02/19/2015	02/19/2015			test	New	
TYLENOL	325 MG	1	TABLET	ORAL	PRN	09/09/2015	09/09/2015				New	
LASIX	40 MG	1	TABLET	ORAL	Daily	08/05/2015	08/05/2015			added from visit	New	
Melatonin Maximum Strength	5 MG	1	TABLET	ORAL	Daily	06/29/2015	06/29/2015				Changed	
VOPAC	650 MG	1	TABLET	ORAL	Daily	04/29/2015	04/29/2015				Changed	
COLD - SINUS	3 HP_X/G		LIQUID	ORAL	Daily	05/13/2015	05/13/2015	05/14/2015			Changed	
RHINACON DH	2.5 MG	1	LIQUID	ORAL	Daily	04/01/2015	04/29/2015				New	

Med Profile

Complete the following steps to update an existing record on the Med Profile page.

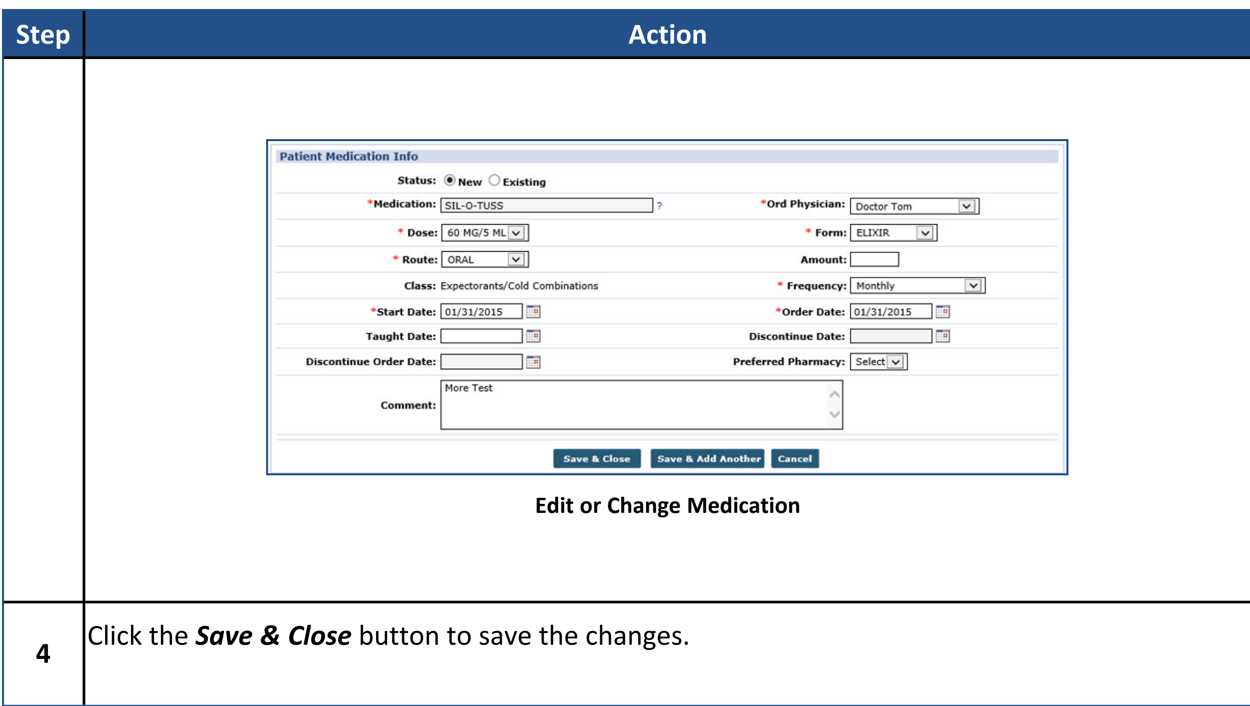
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Click on the medication name.</td></tr>
<tr><td>2</td><td>Select an option from the dropdown to either Edit, Change, or Discontinue.

Edit, Change, Discontinue Menu

<table>
<tr><th>Select…</th><th>To…</th></tr>
<tr><td>Edit</td><td>update the record to reflect the changes.
Note: This option should only be selected if a clerical mistake was made when the Medication was originally entered.</td></tr>
<tr><td>Change</td><td>create an entirely new active entry and Discontinue the previous record.</td></tr>
<tr><td>Discontinue</td><td>make it inactive and lock in the information.</td></tr>
</table></td></tr>
<tr><td>3</td><td>If Edit or Change is selected, the Patient Medication window opens. Make the necessary updates to the record.</td></tr>
</table>

Proprietary and Confidential

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>



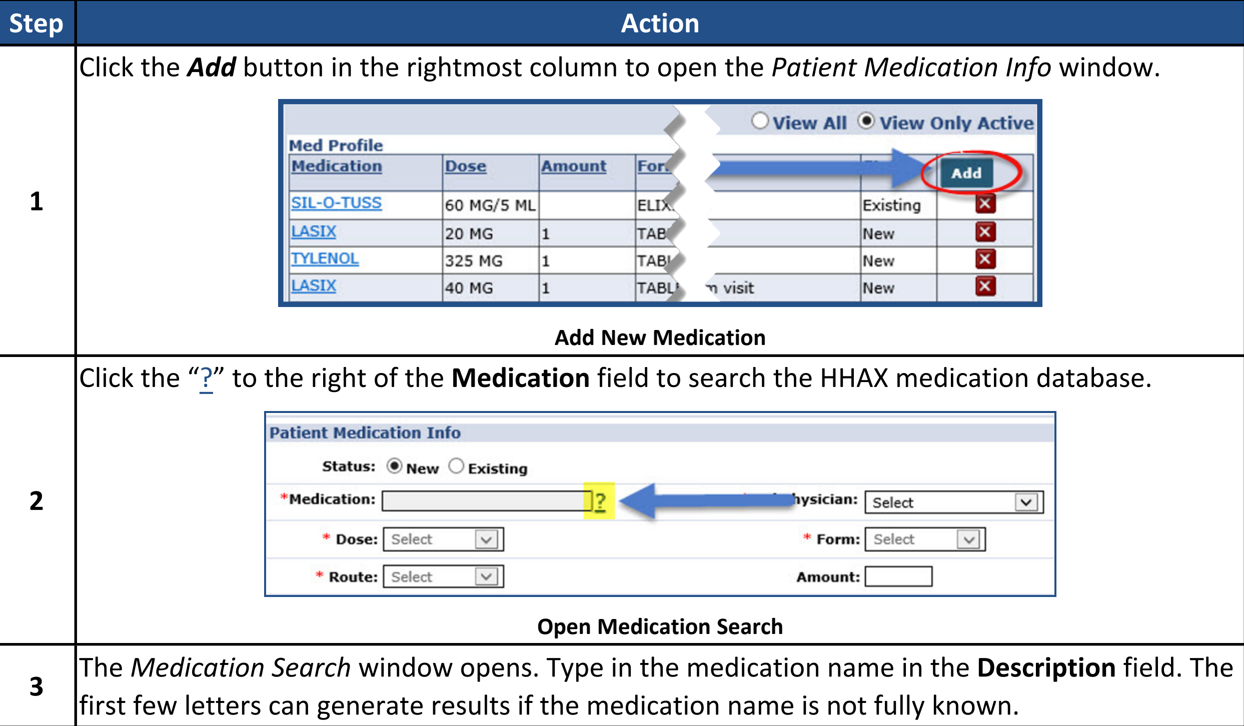
Edit or Change Medication

</td></tr>
<tr><td>4</td><td>Click the Save & Close button to save the changes.</td></tr>
</table>

Complete the following steps to add a new medication for the Patient on the Med Profile page.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>

Click the ***Add*** button in the rightmost column to open the *Patient Medication Info* window.



Add New Medication

</td></tr>
<tr><td>2</td><td>

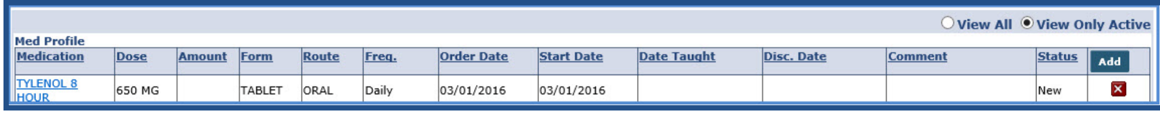
Click the "?" to the right of the **Medication** field to search the HHAX medication database.

Open Medication Search

</td></tr>
<tr><td>3</td><td>The Medication Search window opens. Type in the medication name in the Description field. The first few letters can generate results if the medication name is not fully known.</td></tr>
</table>

Step	Action
	Search Results
4	Click on the name of the medication to apply it to the **Medication** field. Enter the **Dose, Route,** and **Form**. The values in these dropdowns correspond to the specified Medication. **Medication Added**
5	Select the **Ord Physician, Frequency, Start Date,** and **Order Date** (required fields). Click **Save & Close** to save. **Required Fields Completed** ***Note:*** *The Patient Medication Info window also includes optional fields including* ***Amount***, ***Taught Date***, ***Discontinue Order Date***, ***Discontinue Date***, ***Preferred Pharmacy***, *and* ***Comment***.

Once saved, the Medication may be reviewed, edited, or deleted from the **Med Profile.** To edit a Medication, click the name of the medication. Click the red X icon to delete it.



Med Profile — View All / View Only Active

Medication	Dose	Amount	Form	Route	Freq.	Order Date	Start Date	Date Taught	Disc. Date	Comment	Status	Add
TYLENOL 8 HOUR	650 MG		TABLET	ORAL	Daily	03/01/2016	03/01/2016				New	

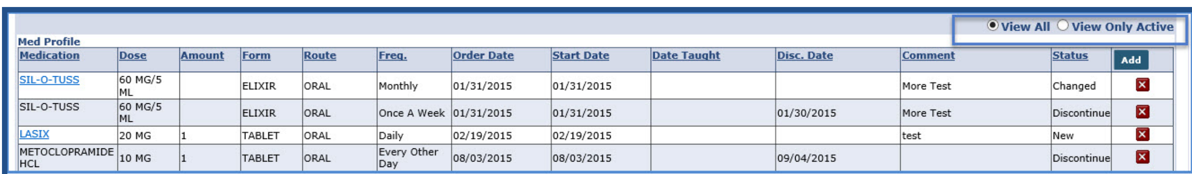
Medication Listed in Med Profile

Note: *If a medication name displays as a* [*Link*], *then it is still active. If not, then it has been Discontinued.*

Proprietary and Confidential

HHAeXchange maintains a comprehensive record of every medication entered for each Patient, as well as any edits or changes made to the prescription or use of the med. Users may opt to review only the most current medication (s) a Patient is using, or a history of every medication they used.

To see all medication records on the **Med Profile**, select the *View All* radio button:



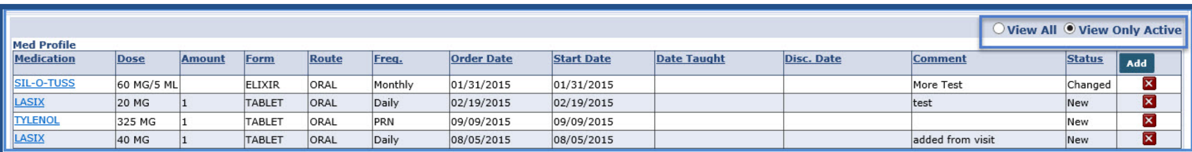
View All View Only Active

Med Profile

Medication	Dose	Amount	Form	Route	Freq.	Order Date	Start Date	Date Taught	Disc. Date	Comment	Status	Add
SIL-O-TUSS	60 MG/5 ML		ELIXIR	ORAL	Monthly	01/31/2015	01/31/2015			More Test	Changed	
SIL-O-TUSS	60 MG/5 ML		ELIXIR	ORAL	Once A Week	01/31/2015	01/31/2015		01/30/2015	More Test	Discontinue	
LASIX	20 MG	1	TABLET	ORAL	Daily	02/19/2015	02/19/2015			test	New	
METOCLOPRAMIDE HCL	10 MG	1	TABLET	ORAL	Every Other Day	08/03/2015	08/03/2015		09/04/2015		Discontinue	

View All Medication Records

To view only active medication records on the **Med Profile**, select the *View Only Active* radio button:



View All View Only Active

Med Profile

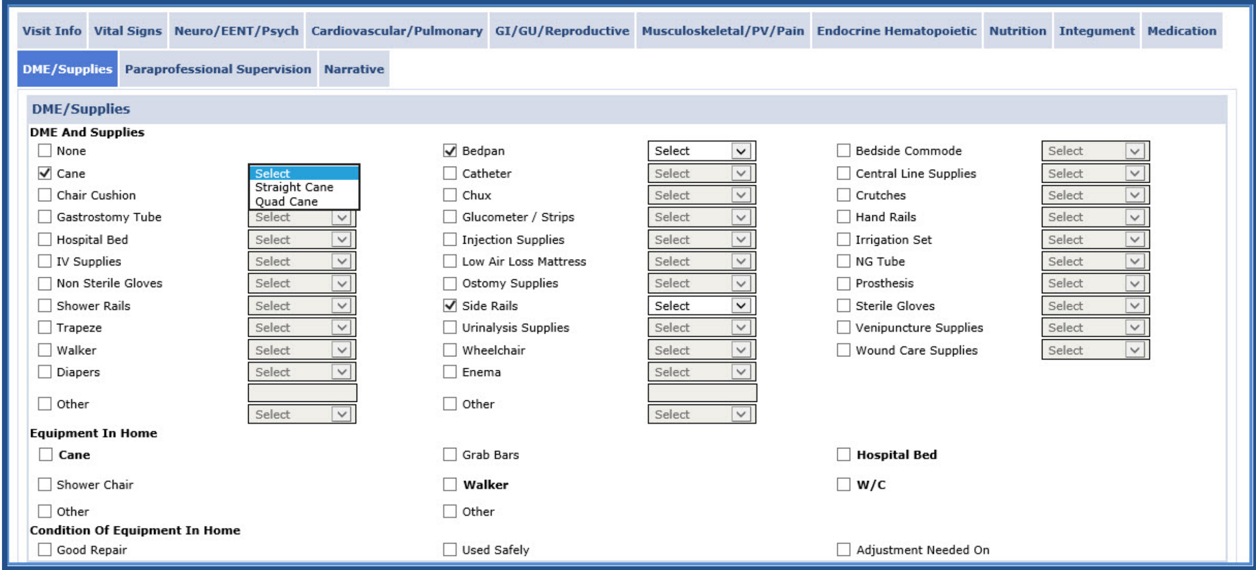
Medication	Dose	Amount	Form	Route	Freq.	Order Date	Start Date	Date Taught	Disc. Date	Comment	Status	Add
SIL-O-TUSS	60 MG/5 ML		ELIXIR	ORAL	Monthly	01/31/2015	01/31/2015			More Test	Changed	
LASIX	20 MG	1	TABLET	ORAL	Daily	02/19/2015	02/19/2015			test	New	
TYLENOL	325 MG	1	TABLET	ORAL	PRN	09/09/2015	09/09/2015				New	
LASIX	40 MG	1	TABLET	ORAL	Daily	08/05/2015	08/05/2015			added from visit	New	

View Only Active Records

Note that two of the records in the *View All* view are locked and have a **Status** of *Discontinue*, whereas all the records listed in the *View Only Active* view may be edited and have a **Status** of *New* or *Changed*.

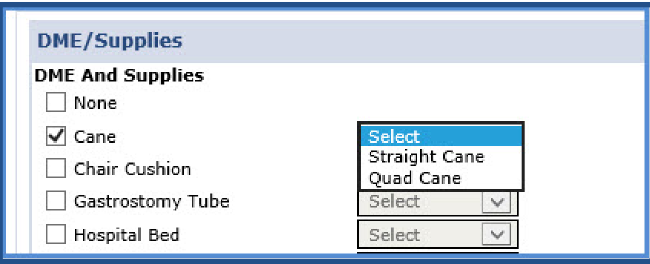
DME/Supplies

The *DME/Supplies* page is used to keep a record of equipment being used by the Patient as well as the condition of the equipment.



DME/Supplies Page

To add new supplies, select the desired checkbox and then use the dropdown to specify what type of supply it is.



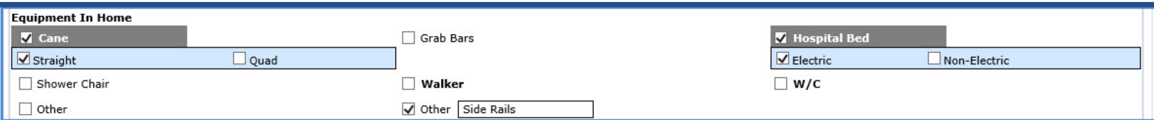
Add DME/Supplies

For example:

1. Click on the **Cane** checkbox to open the dropdown menu.
2. Select one of the available values (*Straight Cane* or *Quad Cane*).
3. Repeat this process until every DME and/or Supply item has been entered.
4. Click ***Save*** to finalize.

Note: *Values in these dropdowns are managed by the Agency (not HHAeXchange). Contact the Agency Representative if a value is not listed.*

If the Patient already has equipment in their home, use one of the checkboxes in the **Equipment In Home** section to specify what equipment they have:



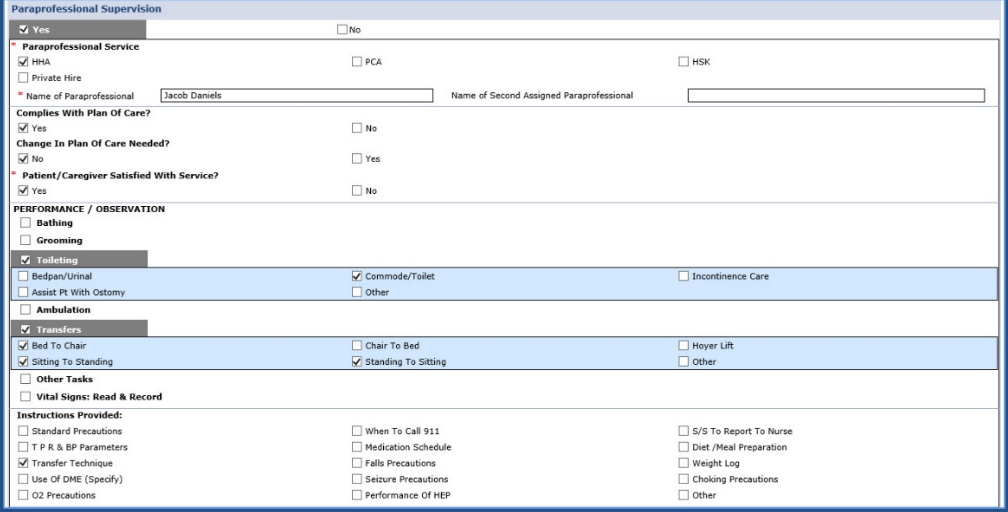
Equipment in Home

If the Patient has equipment that is not listed by one of the available checkboxes, use the **Other** fields to manually type in the DME/Supply item. Lastly, specify the condition of the Patient's equipment in the **Condition of Equipment In Home** section:

Condition of Equipment

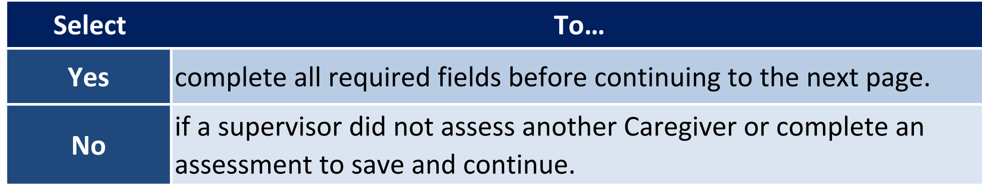
Paraprofessional Supervision

The *Paraprofessional Supervision* page is used to enter an assessment when a Non-Skilled Caregiver is assessed or supervised during a visit. Initially, the page consists of two checkboxes, *Yes* and *No*. Selecting *Yes* generates additional fields, as seen in the image below.



Paraprofessional Supervision

The fields provided are used to document the Non-Skilled Caregivers Name and designation, their competency performing POC tasks, any instructions provided to them, and their response to instructions. At the top of the page:



Select	To…
Yes	complete all required fields before continuing to the next page.
No	if a supervisor did not assess another Caregiver or complete an assessment to save and continue.

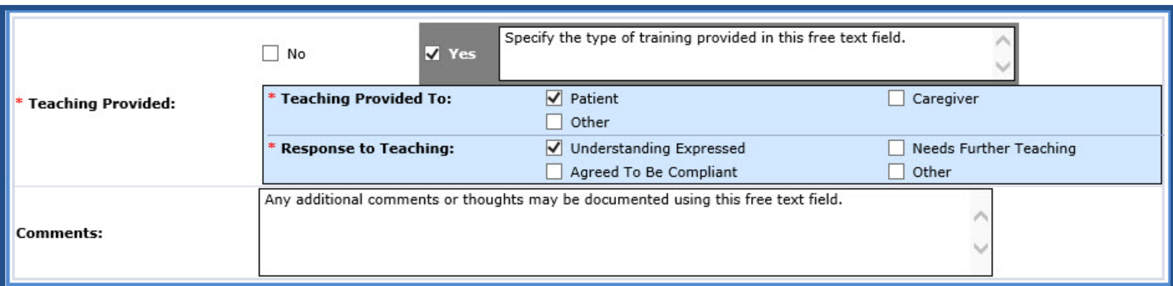
Additional Clinical E-Doc Information

Tip: You can press **Ctrl-F** on your keyboard to search this topic.

Teaching Provided Field

The **Teaching Provided** field reoccurs frequently throughout the clinical e-doc and is used to capture information pertaining to any training provided to the Patient, another Caregiver, or any other individual associated with the Patient's care.

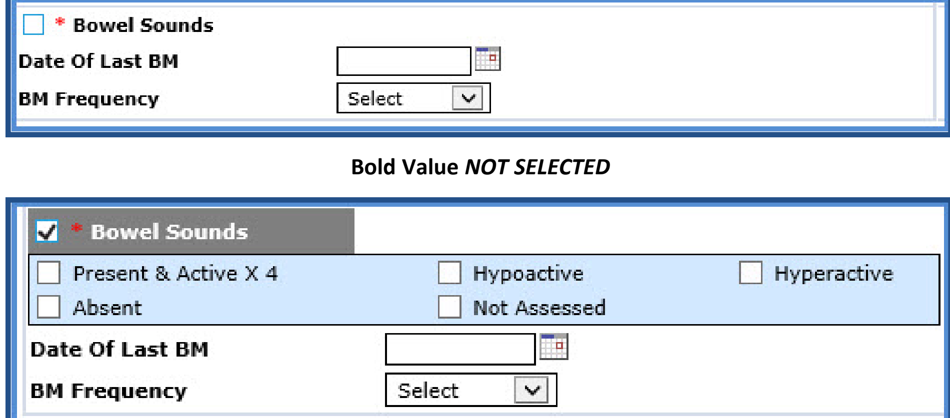
Select *Yes* in this field, which prompts one to specify to whom training was provided, as well as how the training was received. The free text field may be used to specify the actual training provided to the selected party(s). In the **Comments** free text field, record any additional notes or comments on the training session.



Teaching Provided Field

Bold Values

Many of the values throughout the clinical e-doc display in **Bold**. Anytime one of these values is selected, the system generates additional informational/assessment fields.



Bold Value *NOT SELECTED*

Bold Value *SELECTED*

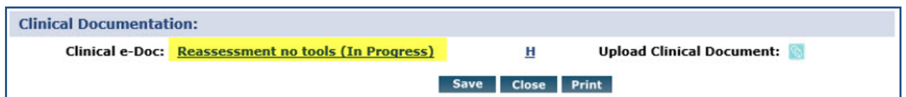
In most cases, an additional value must be selected to save the information and move to the next page of the clinical e-doc.

E-Doc Status

The following table provides Status levels for a **Clinical e-Doc**.

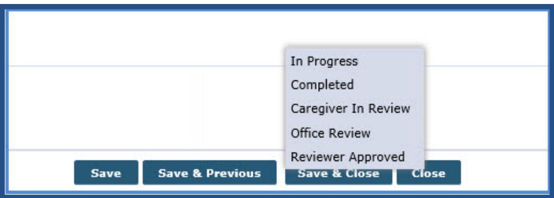
Status	Description
In Progress	Document has been started but not completed.
Completed	All required fields in the document have been completed.
Caregiver in Review	Document is completed by a Clinician and being reviewed by another Caregiver.
Office Review	(Optional) Document is completed and being reviewed by the managing Office.
Reviewer Approved	(Optional) Document has been approved by the managing Office or the other Caregiver.

An **In Progress** status is automatically assigned when beginning a new document.



Clinical e-Doc *In Progress*

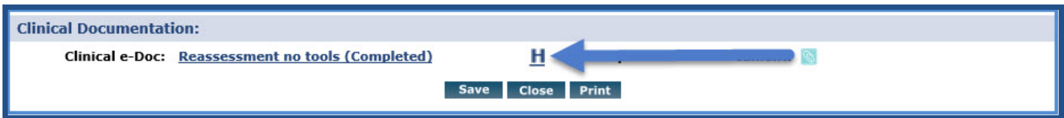
Upon completion, a new Status can be assigned to the document (as illustrated in the image).



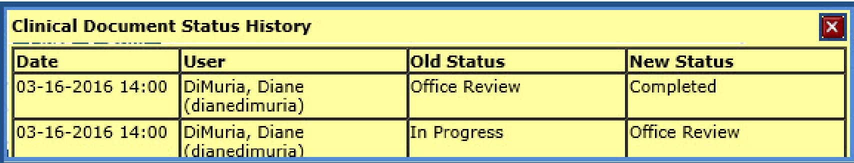
Select e-Doc Status

Access to Status levels depend on the Agency's permission setup. Furthermore, once the document is completed, one can access it again. Consult with your Agencies regarding their internal practices and the permissions granted to their field staff.

To review the status history of an e-Doc, as well as the user(s) who worked on it, click on the H found in the **Clinical Documentation** section of the *Visit Info* tab:



History Link


Clinical Document Status History

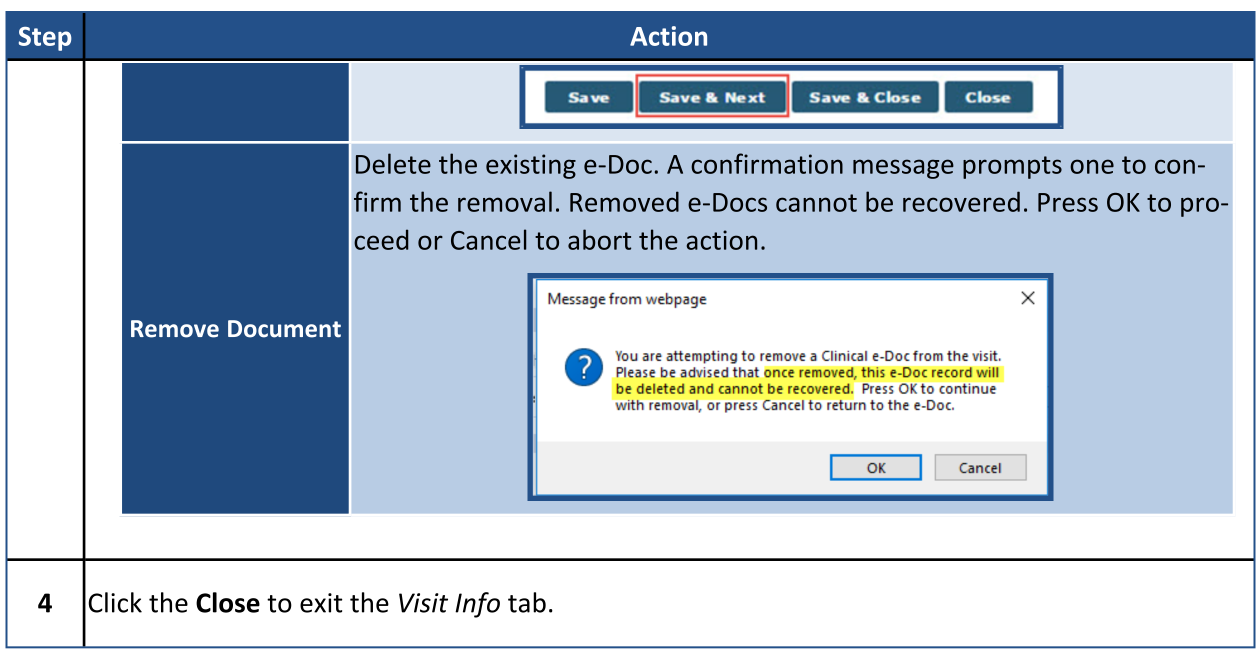
Date	User	Old Status	New Status
03-16-2016 14:00	DiMuria, Diane (dianedimuria)	Office Review	Completed
03-16-2016 14:00	DiMuria, Diane (dianedimuria)	In Progress	Office Review

Clinical e-Doc Status History

Accessing Existing E-Documentation

Complete the following steps to view, edit or remove an existing E-Document.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Navigate to the Patient's Calendar page and locate the appropriate visit. Visits with E-Documentation are displayed in orange labeled with an "RN" prefix (hyperlink) in the title (as illustrated in the image). Click the RN hyperlink to open the Visit Info tab.
Existing E-Documentation</td></tr>
<tr><td>2</td><td>On the Visit Info tab, scroll down to the Clinical Documentation section. Existing e-Docs appear as a link below the field. To edit an existing Clinical e-Doc, click on the link and select Edit Document (as seen in the image).
Editing an Existing Clinical e-Doc</td></tr>
<tr><td>3</td><td>Select the course of action: View, Edit, or Remove Document.
Accesing Existing e-Document
<table>
<tr><th>Select…</th><th>To…</th></tr>
<tr><td>View Document</td><td>View the existing e-Doc and navigate from section to section.</td></tr>
<tr><td>Edit Document</td><td>Update the existing e-Doc. The Save options become available with this option. Select Save & Close once all updates are applied.</td></tr>
</table></td></tr>
</table>



Step	Action
	Remove Document — Delete the existing e-Doc. A confirmation message prompts one to confirm the removal. Removed e-Docs cannot be recovered. Press OK to proceed or Cancel to abort the action.
4	Click the **Close** to exit the *Visit Info* tab.

Viewing a Patient’s Documentation History

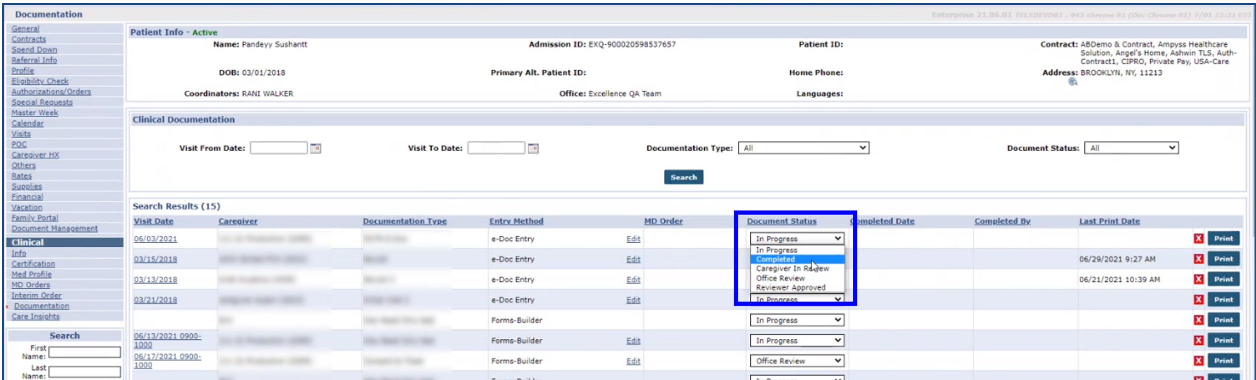
Complete the following steps to view or edit an existing E-Document from the Patient’s Documentation page.

Step	Action
1	Navigate to the **Patient > Documentation** page to view a history of e-Docs for a Patient (as illustrated in the image below). **Patient Documentation Page**
2	Locate the specific e-Doc for a visit and click the Edit (hyperlink) under the **Entry Method** column. Select *View Document* to view the document or *Edit Document* to edit. **View or Edit Patient E-Doc**

Select…	To…
View Document	View the existing e-Doc and navigate from section to section.
Edit Document	Update the existing e-Doc. The Save options become available with this option. Select ***Save & Close*** once all updates are applied.

Document Status Tracking

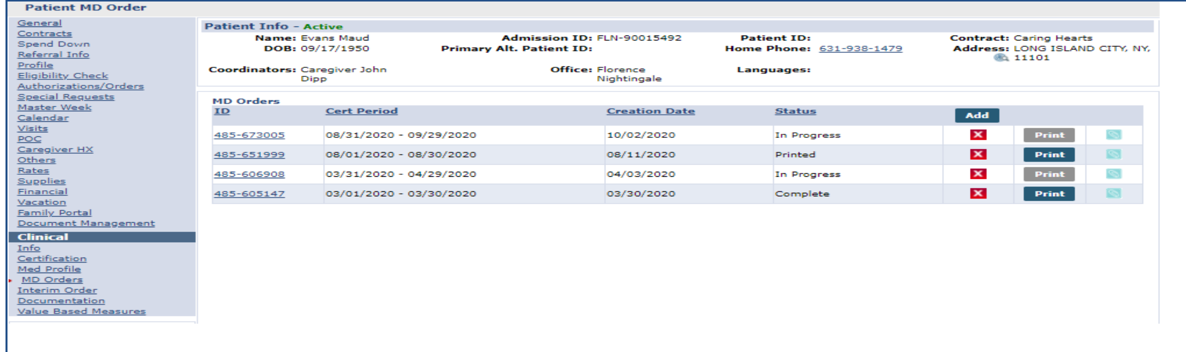
Providers can update the status of a document directly on the Patient Documentation page (***Patient > Documentation***) by selecting a status from the **Document Status** column, as seen in the following image.



Patient Documentation: Document Status

Accessing the Integrated MD Order from the Patient Profile

When an integrated MD Order is created from an eDoc, it also appears in the *Patient MD Orders* page (***Patient > MD Order***). Fields that were disabled on the integrated MD Order when accessed from the assessment are disabled when accessed from the Patient *MD Orders* page. Any modifications to these fields must be made from the assessment to ensure consistency between the documents.



Patient MD Order Page

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Integrated MD Orders

Tip: You can press **Ctrl-F** on your keyboard to search this topic.

Assessment and Reassessment eDocs can be integrated with an MD Order to reduce duplicate documentation. As nurses complete their Patient visit assessments, they have the option to create an MD Order directly from within the eDoc. The assessment entered in the eDoc then flows into the MD Order. After the integrated MD Order is created, information continues to flow as the assessment is edited.

Note: *HHAX does not support MD Order integration with revisits (such as post-hospitalization follow-ups).*

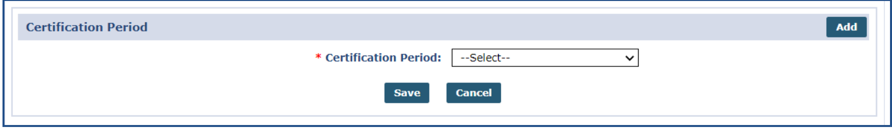
New MD Order Tabs via eDocs

On the *eDoc* page (***Patient > Calendar > Visit Info***), the following five new tabs are now available to integrate newly entered information into an integrated MD Order: *Certification*, *MD Order-Demographics*, *MD Order-Others*, *MD Order-Order/Goal*, and *Review MD Order* (as seen in the image below). Each of these tabs is covered in sections below.

New eDoc MD Order Tabs

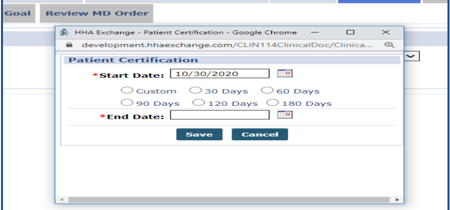
MD Order: Certification Period

As for all MD Orders, a **Certification Period** is required. When creating an MD Order via eDocs (*Certification* tab), a **Certification Period** can be created directly (click ***Add*** to apply a new one) or an existing **Certification Period** can be selected from this page.



Creating a Certification Period

To create a Certification Period, enter the **Start Date** and **End Date** fields (required, as denoted by the red asterisk) on the *Patient Certification* window.



Entering a Patient Certification

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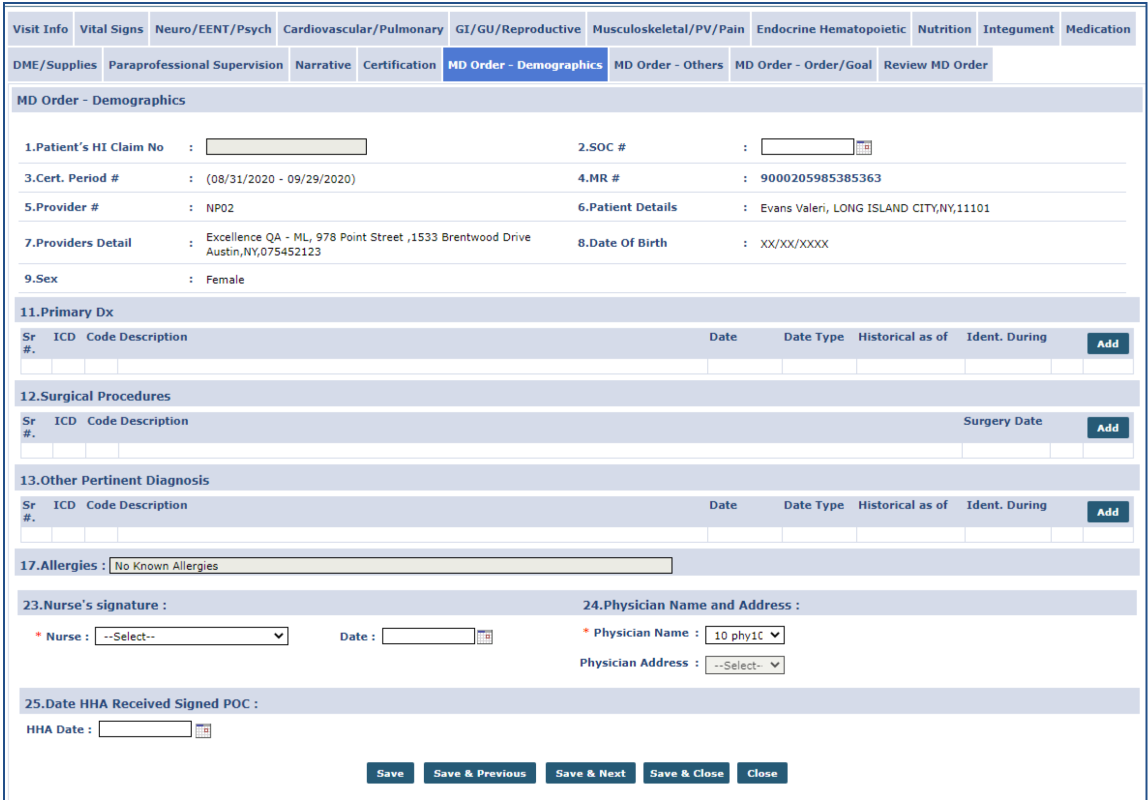
Consequently, the new MD Order tabs on the eDoc assessment are enabled and values from the assessment populate the MD Order.

MD Order–Demographics Tab

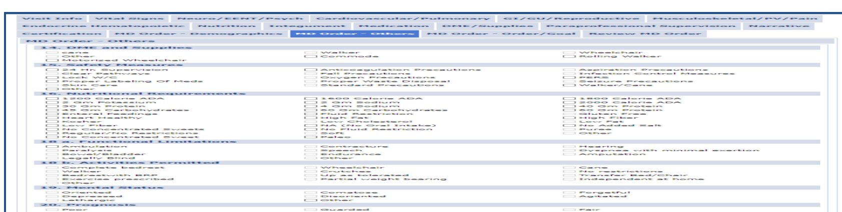
The *MD Order-Demographics* tab is available on the eDoc assessment (***Patient > Calendar > Visit Info***) as part of the Integrated MD Order feature. Nurses can enter information as needed via the eDoc assessment functionality. Details on this tab are pulled in from the Patient Profile when the integrated MD Order is created.



eDocs: MD Order-Demographics Tab

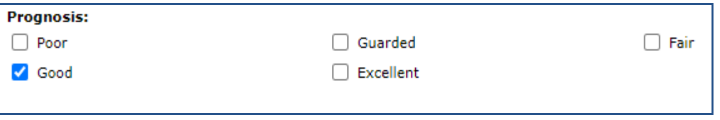
MD Order–Others Tab

Details on the integrated *MD Order–Others* tab are populated based on details entered via the eDoc assessment. To ensure the consistency of information between the two documents, any value that is present on the eDoc assessment is disabled on the integrated MD Order (even if not selected in the e-Doc assessment). The nurse must always go back to the eDoc assessment to modify any MD Order value that is disabled.



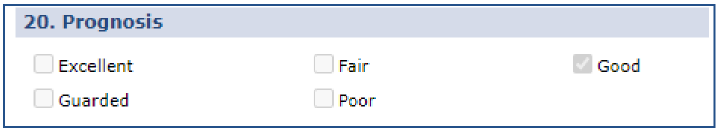
eDocs: MD Order- Others Tab

For example, documenting the *Prognosis* on the *Narrative* tab of the eDoc, the same value is added to the MD Order.



MD-Orders-Others Tab: ***Prognosis*** **Section**

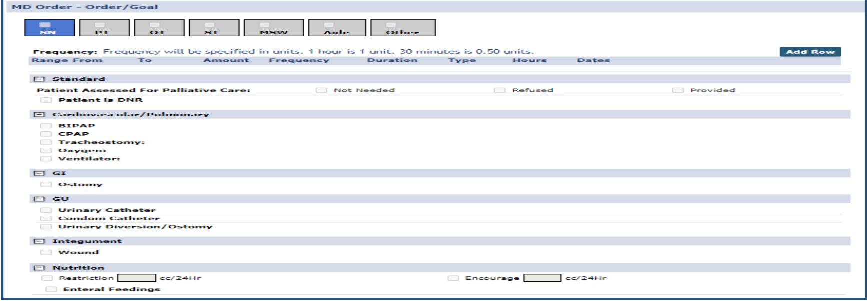
On the MD Order, the fields are all disabled because the *Prognosis* section is updated via the eDoc assessment.



MD-Orders Tab: ***Prognosis*** **Section**

MD Orders–Order/Goal Tab

As with the *MD Orders-Others* tab, details in the **MD Order-Order/Goal** tab are populated based on the information entered in the eDoc assessment. Any Order/Goal values that are present on the eDoc assessment are disabled on the integrated MD Order (even if not selected).

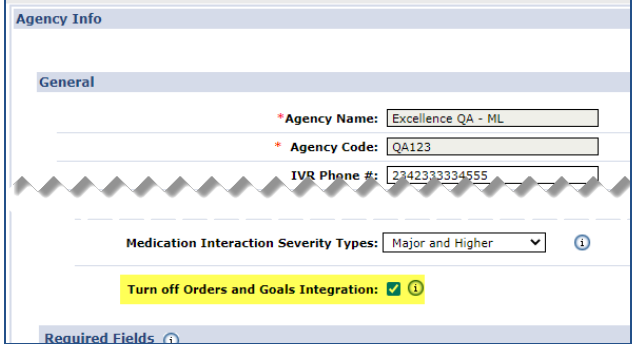


eDocs: MD Order-Order/Goal Tab

Note: *Any custom-created sections on the MD Order-Order/Goal tab are available on the integrated MD Order; however, information does not flow from the eDoc assessment.*

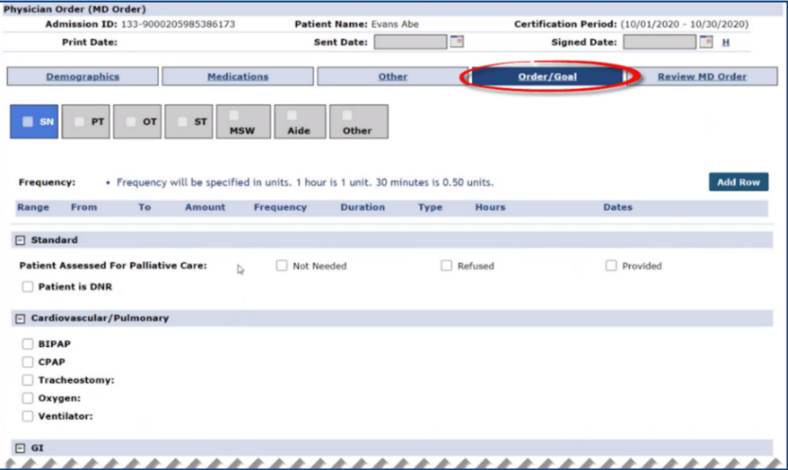
Integrated MD Orders and Goals Configuration

Providers can turn off the **Orders/Goals** mapping for Integrated MD Orders (primarily a configuration for LHCSAs) via the Agency Profile (***Admin > Agency Profile***). To disable the **Orders/Goals** integration with the eDoc, select the ***Turn off Orders and Goals Integration*** checkbox, as seen in the following image.



Agency Profile: Turn Off Orders and Goals Integration Checkbox

When this configuration is selected at the Agency level, the information from the eDoc does not sync to the **Order/Goal** tab of the MD Order, as seen in the following image.



MD Order: Order/Goal Tab

Integration of Medications on the MD Order

Because the *Medications* tab on the MD Order and the eDoc assessment are so closely matched, only one version exists in the integrated MD Order. The *Medications* tab on the eDoc assessment continues to be available and syncs to the Review tab on the integrated MD Order.

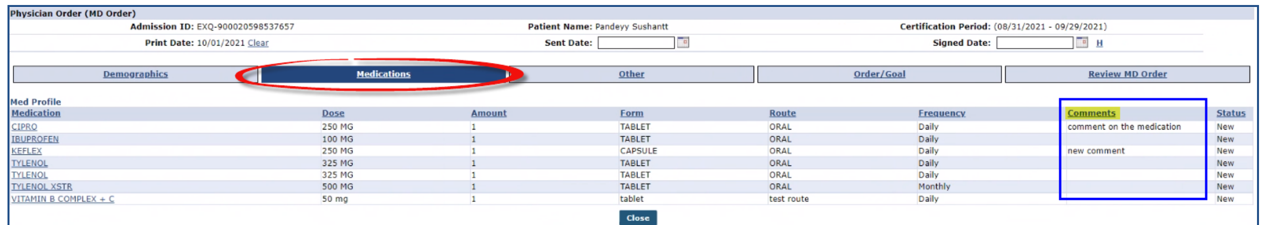
The *Medications* tab on the eDoc assessment syncs to the MD Order *Review* tab, even after the MD Order is created. This behavior differs from what happens when a medication is added or edited in the Patient Profile after creation of the MD Order, in which case the modifications do not sync.

As stated previously, when a Patient's medication is added, edited, discontinued, or deleted in the eDoc or MD Order, the change syncs displaying in the Patient Med Profile page (***Patient > Med Profile***). When a medication is changed to a different one, then the new medication information replaces the older one. If deleted, then the medication is deleted from the Med Profile.

Note: *Information only syncs from the Patient's Med Profile to the eDoc/MD Order one time; when created. If information is added or changed on the Patient's Med Profile (after the eDoc or the MD Order is created), then it does not sync to either the eDoc or MD Order.*

Standardize Med Profile in MD Orders

Several columns on the Patient MD Order (***Patient > MD Orders***) in the *Medication* and *Review MD Order* tabs provide better visibility for a physician or nurse to view to include a **Comments** column in the *Medication* tab as seen in the following image.



Medication	Dose	Amount	Form	Route	Frequency	Comments	Status
CIPRO	250 MG	1	TABLET	ORAL	Daily	comment on the medication	New
IBUPROFEN	100 MG	1	TABLET	ORAL	Daily		New
KEFLEX	250 MG	1	CAPSULE	ORAL	Daily	new comment	New
TYLENOL	325 MG	1	TABLET	ORAL	Daily		New
TYLENOL	325 MG	1	TABLET	ORAL	Daily		New
TYLENOL XSTR	500 MG	1	TABLET	ORAL	Monthly		New
VITAMIN B COMPLEX + C	50 mg	1	tablet	test route	Daily		New

Patient MD Order: Medication Tab, Comments Column

Amount, **Form**, and **Comments** columns have been added to the *Review MD Order* tab, as seen below.

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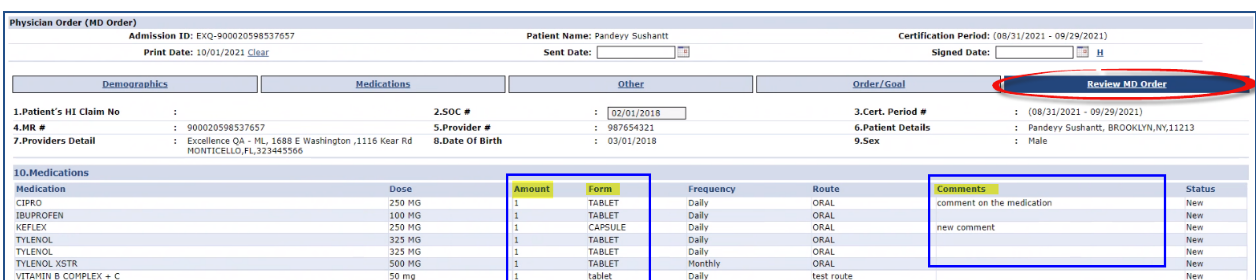


Physician Order (MD Order)

Admission ID: EXQ-900020598537657 | Patient Name: Pandeyy Sushantt | Certification Period: (08/31/2021 - 09/29/2021)

Print Date: 10/01/2021 Clear | Sent Date: | Signed Date: H

Demographics | Medications | Other | Order/Goal | Review MD Order

1.Patient's HI Claim No	:		2.SOC #	:	02/01/2018	3.Cert. Period #	: (08/31/2021 - 09/29/2021)
4.MR #	:	900020598537657	5.Provider #	:	987654321	6.Patient Details	: Pandeyy Sushantt, BROOKLYN,NY,11213
7.Providers Detail	:	Excellence QA - ML, 1688 E Washington ,1116 Kear Rd MONTICELLO,FL,323445566	8.Date Of Birth	:	03/01/2018	9.Sex	: Male

10.Medications

Medication	Dose	Amount	Form	Frequency	Route	Comments	Status
CIPRO	250 MG	1	TABLET	Daily	ORAL	comment on the medication	New
IBUPROFEN	100 MG	1	TABLET	Daily	ORAL		New
KEFLEX	250 MG	1	CAPSULE	Daily	ORAL	new comment	New
TYLENOL	325 MG	1	TABLET	Daily	ORAL		New
TYLENOL	325 MG	1	TABLET	Daily	ORAL		New
TYLENOL XSTR	500 MG	1	TABLET	Monthly	ORAL		New
VITAMIN B COMPLEX + C	50 mg	1	tablet	Daily	test route		New

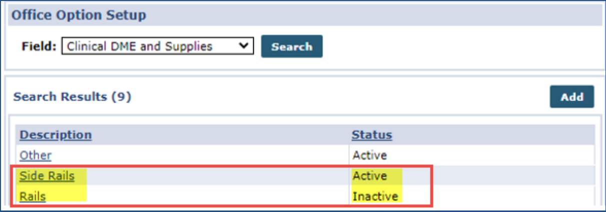
Patient MD Order: Review MD Order Tab, Amount, Form, and Comments Column

Modifications to the MD Order Configuration

Several sections of the MD Order are configurable such as **DME and Supplies**, **Nutritional Requirements**, and **Safety Measures**. The system uses exact (matching) text for the information to flow from the eDoc assessment to the MD Order in these sections.

Values that have been previously created, can now be *inactivated* in the *Office Option Setup* section of the *Edit Office* page (***Admin > Office Setup > Office Edit***). Therefore, a field that does not match a corresponding field in the assessment, can now be *inactivated* and replaced with a label that does match.

For example, in the following image, "Rails" is *inactivated* and replaced with "Side Rails". Once saved, the custom MD Order field matches the text on the eDoc assessment **DME and Supplies** tab.



Office Option Setup