The Patient Clinical Section

Entering MD and Interim Orders

Phone: (855) 400-4429 • Fax: (718) 679-9273

Contents

Phone: (855) 400-4429 • Fax: (718) 679-9273

Phone: (855) 400-4429 • Fax: (718) 679-9273

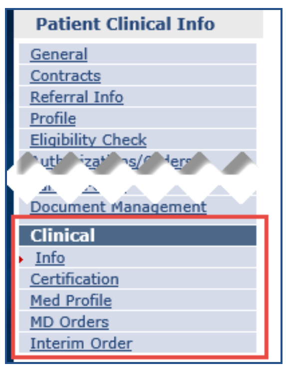
Clinical Section

Overview

The **Clinical** section of a Patient's Profile houses vital information regarding a Patient's clinical care from Physician information to diagnoses to MD Orders.

The **Clinical** pages are used to enter and manage a Patient's clinical details and associated information. This section provides a high-level review of the pages in the Clinical section, accessible using the Index (left navigation, pictured to the right).

This category provides instructions and guidance when using the **Clinical** pages and features on the HHAeXchange (HHAX) system.



Please direct any questions, comments, 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

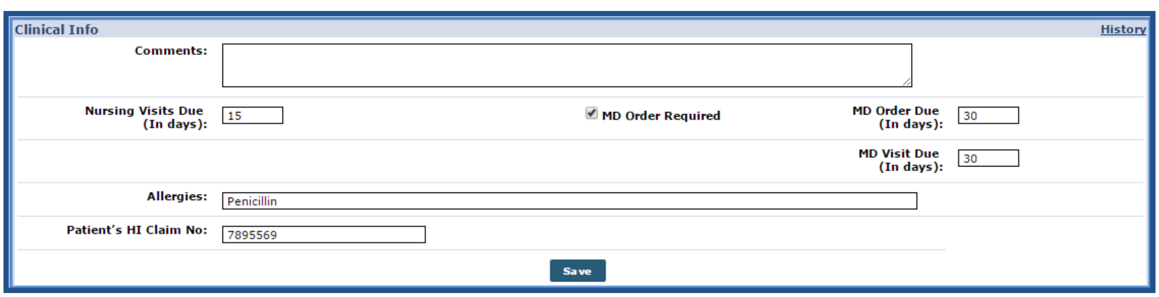
The Info Page

The Clinical **Info** page is used to track Patient medical information, comprised of seven sections described in the following table.

Section	Description (Contains/Used to…)
General	Miscellaneous Medical information such as Patient allergies, health insurance number, and Physician comments.
Advanced Dir-ectives	House documents stating a Patient's end-of-life decisions (such as DNRs and Living Wills).
Physicians	Indicates the Physician(s) in charge of the Patient's case. If the Patient's Phys-ician has not yet been added in the system, users can enter a record directly from this page.
MD Orders	Enter and track a Patient's **MD Orders**
Diagnosis	Record the Patient's conditions or illnesses using the International Clas-sification of Disease (**ICD**) codes.
Surgical Procedure	Record the Patient's surgical procedures. This section also uses **ICD** codes.
Pharmacies	Record the Patient's pharmacies in this section of the **Info** page.

General

The **General** section is used to capture miscellaneous medical information as described in the table below the image.



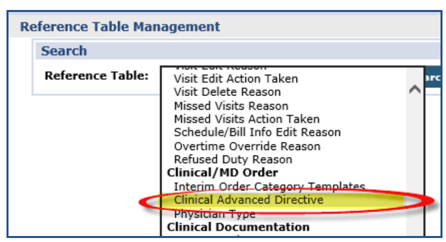
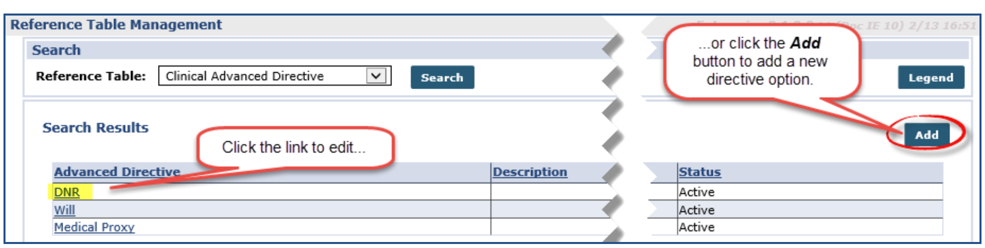
Info Page – General Section

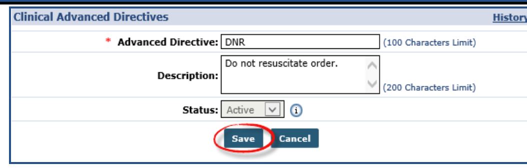
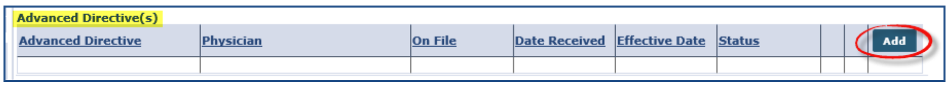
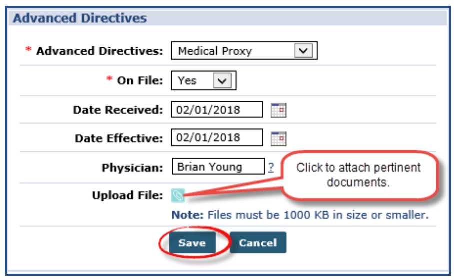
Field	Description (Contains/Used to…)
Comments	Free text field to note Referral or any miscellaneous clinical information

Nursing Visit Due	Indicate days corresponding to the *Nursing Visit Due* Reports (under Patient)
MD Order Required	Select checkbox if an MD Order is required for the Patient.
MD Order Due	If the MD Order required checkbox is selected, indicate (in number of days) when the *MD Order Due* Reports (Under Patient)
Allergies	Free text field to record any Patient allergies
Patient's HI Claim No	Text field to enter the Patient's health insurance claim number; this number appears on the MD Order.

Advanced Directives

The **Advanced Directives** section houses any instructions and documents provided by the Patient such as DNRs and Living Wills. The following table provides guidance on how to *add* or *edit* an **Advanced Directive**.

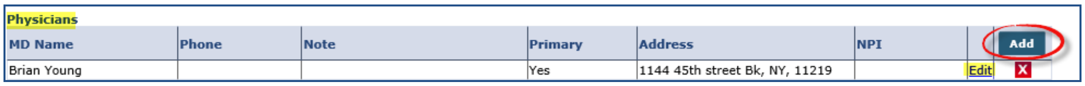
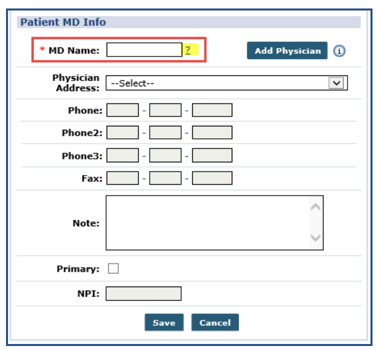
Step	Action
1	Navigate to **Admin > Reference Table Management**
2	Select *Clinical Advanced Directive* from the **Reference Table** dropdown and click the ***Search*** button. 
3	Click the ***Add*** button to create a new option or click the **Advanced Directive** hyperlink to edit an existing one (as illustrated). 
4	Complete the fields in the *Clinical Advanced Directives* window. The **Advanced Directive** field is required. Click the ***Save*** button.

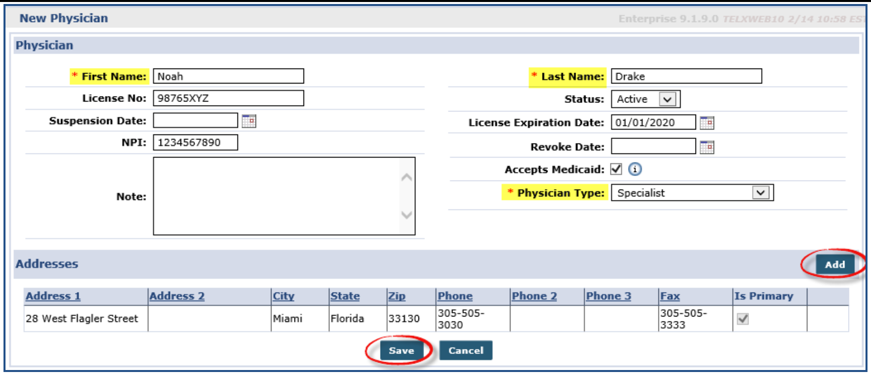
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>
</td></tr>
<tr><td>5</td><td>Navigate to Patient > Patient Search and select a Patient.</td></tr>
<tr><td>6</td><td>Select the <u>Info</u> link from the Index and go to the Advanced Directive(s) section.</td></tr>
<tr><td>7</td><td>Click the Add button to add an Advanced Directive.

</td></tr>
<tr><td>8</td><td>The Advanced Directives window opens. Complete the required fields (denoted with an asterisk).


<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td>*Advanced Dir-ective</td><td>(Required) Select the type of directive to add – DNR, Medical Proxy, Will, or any other added in the Reference Table.</td></tr>
<tr><td>On File</td><td>Is the directive on file? Select Yes or No.</td></tr>
<tr><td>Date Received</td><td>The date the directive was received.</td></tr>
<tr><td>Date Effective</td><td>The date the directive is effective.</td></tr>
<tr><td>Physician</td><td>The Patient’s Physician on record.</td></tr>
<tr><td>Upload File</td><td>(Icon) Attach applicable document(s).</td></tr>
</table></td></tr>
<tr><td>9</td><td>Click the Save button to complete.</td></tr>
</table>

Physicians

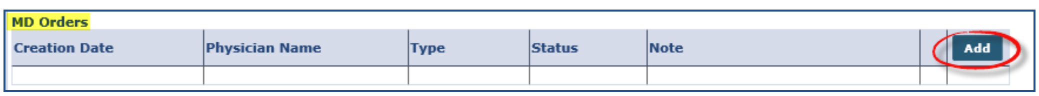
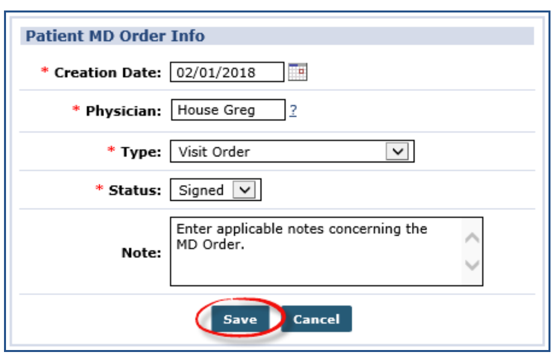
The *Physicians* section lists any Physician the Patient has on record in the system. Follow the instructions below to *add* a Physician to a Patient's Info page.

Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the Info link from the Index and go to the *Advanced Directive(s)* section.
3	Click the ***Add*** button to add a Physician or the ***Edit*** link to update Physician information.  ***Note:*** *The system designates the first Physician entered as the Primary; adjust accordingly.*
4	The *Patient MD Info* window opens. The **MD Name** field is required. To find a Physician in the system, click the "?" link to the right of the field. If the Physician is not found, go to ***Step 5***. Once the Physician is selected, the information (such as **Address**, **Phone**, **Phone2**, **Phone3**, **Fax** and **NPI** fields) populates in window, as entered in the Physician record. Click the ***Save*** button to apply to the Patient's profile. 
5	Physicians Profiles must be added to the system prior to adding to a Patient. If a Physician is not in the system, click the **Add Physician** button on the top-right and complete the *New Physician* window (required fields are denoted with an asterisk). Click the ***Add*** button to add the Physician's Address and Phone numbers. Click the ***Save*** button to save the Physician's record and apply to the Patient's profile.

Step	Action
	 ***Note:*** *Although not required, the **NPI** value is necessary for billing purposes. The Physician's **Fax Number** is required to fax MD and Interim Orders.*

MD Orders

Patient **MD Order** information, used for tracking purposes, is recorded in the *MD Orders* section of the **Info** section. Follow the instructions provided below to *add* an **MD Order** record.

Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the Info link from the Index and go to the *MD Orders* section.
3	Click the ***Add*** button to add an MD Order for a Patient. 
4	The *Patient MD Order Info* window opens. Complete the required fields, as described in the table underneath the image.  **Patient MD Order Info Window** **Field** / **Description** **Creation Date** / The date the Order was issued.

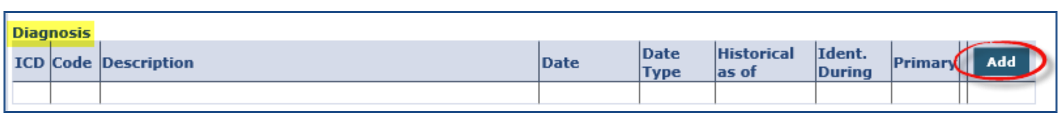
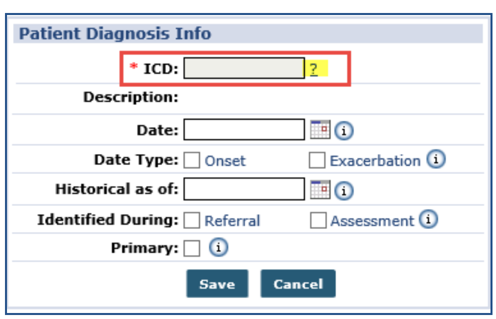
Step	Action
	Physician — The Physician issuing the Order. **Type** — Select the Order Type. **Status** — Order Status: Created, Sent, Signed. **Note** — (Optional) Enter notes as applicable.
5	Click the ***Save*** button to record the MD Order.

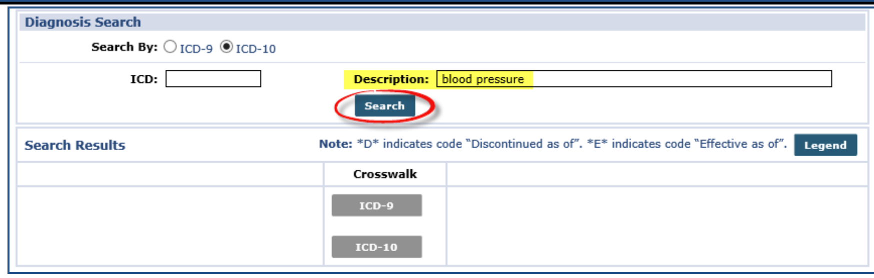
Diagnosis

The *Diagnosis* section of the **Info** page serves to capture a Patient's documented condition or illness. To apply this information, search for the **ICD Code** associated with the Patient's condition. Any **ICD Code** entered on this page is considered a "Clinical Code" and the system automatically applies it to **MD Orders**.

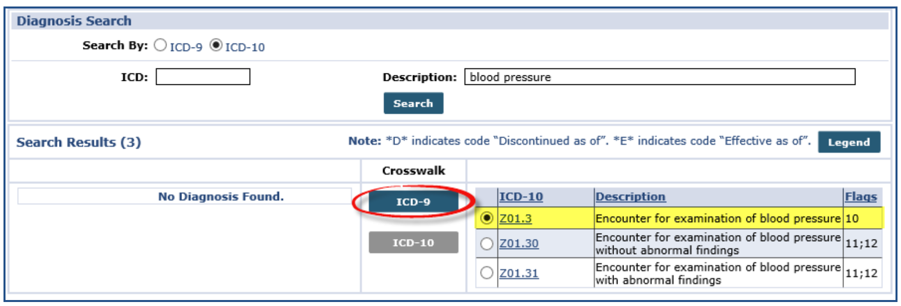
Note: In HHAX, the Diagnosis (Dx) Codes are "split" into Billing Dx Codes and Clinical Dx Codes. Refer to the Setting Billing Dx Codes Job Aid for further information.

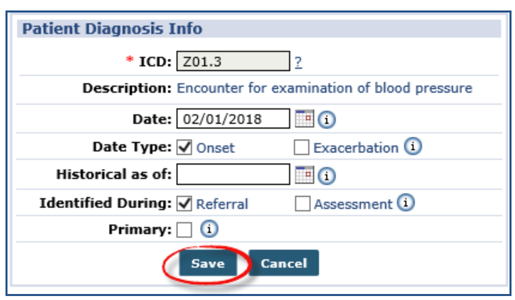
The following steps provide instructions to *add* a diagnosis to a Patient's profile.

Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the Info link from the Index and go to the *Diagnosis* section.
3	Click the ***Add*** button to add a diagnosis or the ***Edit*** link to update an existing diagnosis inform-ation for a Patient. 
4	The *Patient Diagnosis Info* window opens. Click the "?" to the right of the **ICD** field to search for the diagnosis code. 
5	In the *Diagnosis Search* window, enter the Patient's condition in the **Description** field and click the ***Search*** button.

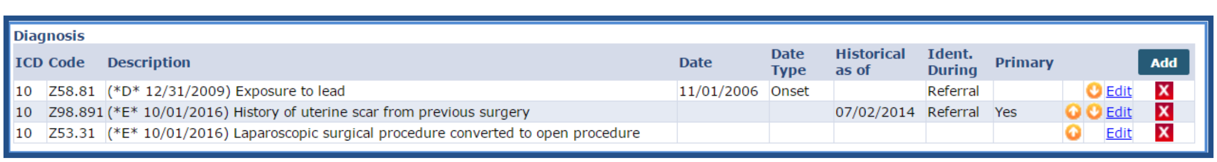
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>


Note: *The* ***ICD-10*** *radio button is selected for this example. Select the* ***ICD-9*** *radio button to search in the legacy database.*</td></tr>
<tr><td>6</td><td>From the results, select the applicable condition. To cross-reference, click the ICD-9 button (under the Crosswalk column) for more options. Click the ICD-10 code link to proceed.


</td></tr>
<tr><td>7</td><td>They system routes back to the Patient Diagnosis Info window. The selected ICD Code displays in the field with the description of the diagnosis. Complete the remaining (optional) fields.


</td></tr>
<tr><td>8</td><td>Click the Save button to record the diagnosis.</td></tr>
<tr><td>9</td><td>Repeat Steps 3-8 to apply additional conditions, as needed.</td></tr>
</table>

Once created, listed diagnoses can be edited, deleted, or re-ranked in The **Diagnosis** section of the Clinical **Info** page (as seen in the following image).



Diagnosis

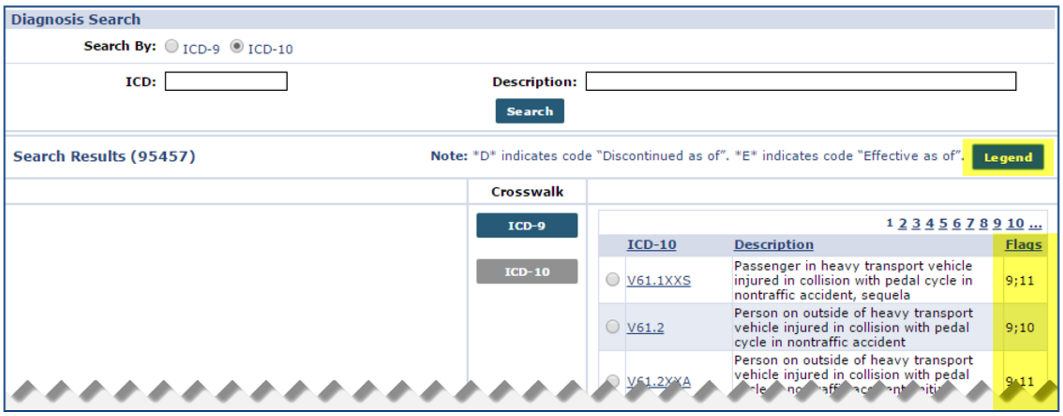
ICD	Code	Description	Date	Date Type	Historical as of	Ident. During	Primary	Add
10	Z58.81	(*D* 12/31/2009) Exposure to lead	11/01/2006	Onset		Referral		Edit
10	Z98.891	(*E* 10/01/2016) History of uterine scar from previous surgery			07/02/2014	Referral	Yes	Edit
10	Z53.31	(*E* 10/01/2016) Laparoscopic surgical procedure converted to open procedure						Edit

Updated *Diagnosis* Section

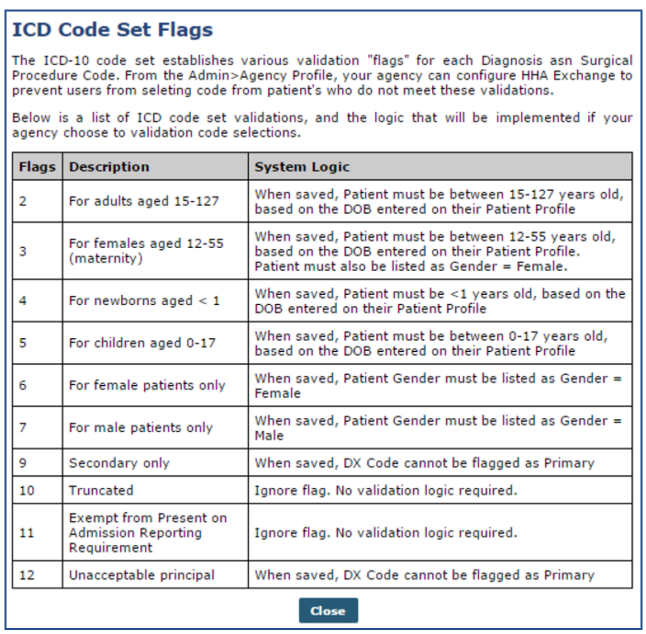
Validate ICD Code Selections

Agencies can set a validation requirement for ICD Codes on the **Agency Profile** page using the **Validate ICD Code Selections** field. This validation reviews ICD Code “flags”, or requirements associated with each code, to ensure that it can be applied to the selected Patient based on specific information (such as age or gender).

The **Diagnosis Search** window contains an ICD Code **Flags** column. A ***Legend*** (button) is available to review the meaning of each flag at any time.



ICD Code *Flag* Column / Legend Button



ICD Code Set Flags

The ICD-10 code set establishes various validation "flags" for each Diagnosis asn Surgical Procedure Code. From the Admin>Agency Profile, your agency can configure HHA Exchange to prevent users from seleting code from patient's who do not meet these validations.

Below is a list of ICD code set validations, and the logic that will be implemented if your agency choose to validation code selections.

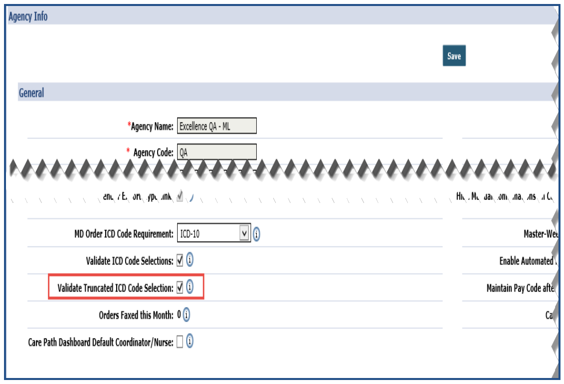
Flags	Description	System Logic
2	For adults aged 15-127	When saved, Patient must be between 15-127 years old, based on the DOB entered on their Patient Profile
3	For females aged 12-55 (maternity)	When saved, Patient must be between 12-55 years old, based on the DOB entered on their Patient Profile. Patient must also be listed as Gender = Female.
4	For newborns aged < 1	When saved, Patient must be <1 years old, based on the DOB entered on their Patient Profile
5	For children aged 0-17	When saved, Patient must be between 0-17 years old, based on the DOB entered on their Patient Profile
6	For female patients only	When saved, Patient Gender must be listed as Gender = Female
7	For male patients only	When saved, Patient Gender must be listed as Gender = Male
9	Secondary only	When saved, DX Code cannot be flagged as Primary
10	Truncated	Ignore flag. No validation logic required.
11	Exempt from Present on Admission Reporting Requirement	Ignore flag. No validation logic required.
12	Unacceptable principal	When saved, DX Code cannot be flagged as Primary

Close

ICD Code Flag Legend

Validate Diagnosis Entry for Flag 10-Truncated ICD DX Codes

Providers have the option to stop users from adding **Flag 10 ICD Codes** anywhere ICD Codes can be entered. To enable, navigate to ***Admin >Agency Profile*** and select the **Validate Truncated ICD Code Selection** checkbox.

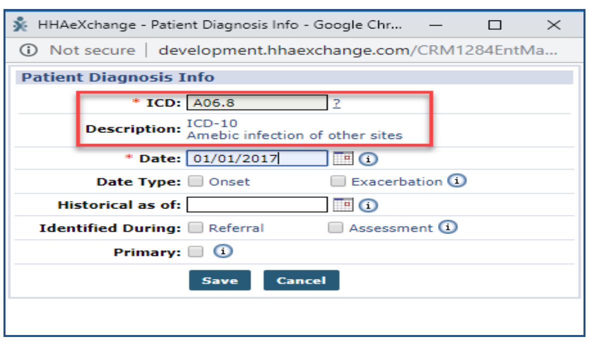


Agency Profile: Validate Truncated ICD Code Selection

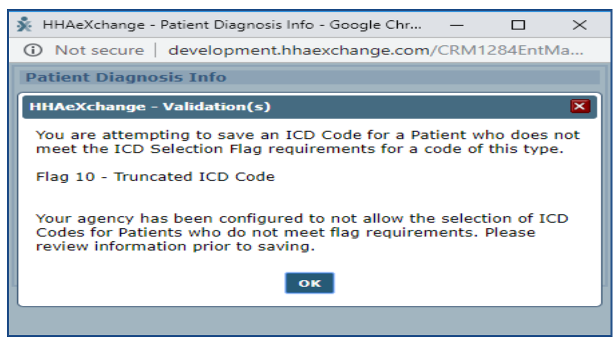
Notes:

- *Activating this validation does not remove existing Flag 10 diagnosis.*
- *This validation is extended to Billing Dx Codes.*

When the **Validate Truncated ICD code Selection** is selected, the validation for *Flag 10-Truncated ICD DX Codes* is applied anywhere an ICD Code can be entered. The following images illustrate an example and the validation generated.



Patient Diagnosis Info Window



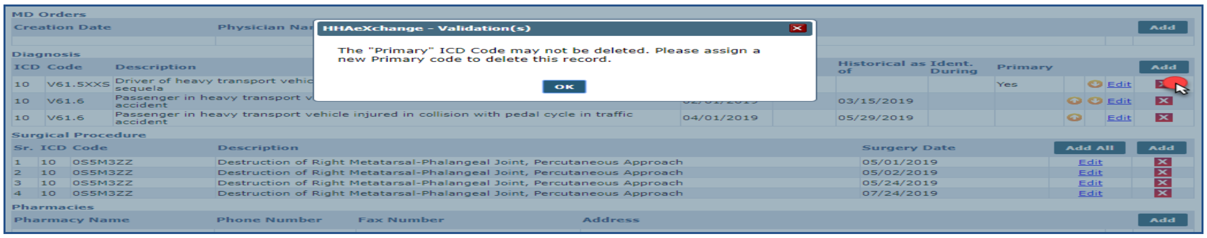
Truncated ICD Code Validation

Entering Matching ICD Code(s)

The *Diagnosis (ICD) Code* functionality in the Clinical module to allows Providers to enter duplicate ICD records, providing that there is no overlapping in date range. This is applicable for Patients with chronic conditions who periodically require follow-up treatments or surgeries for the same condition (same Diagnosis). The same logic applies wherever an ICD Code may be entered.

Replacement Primary Diagnosis Required when Deleting Existing Primary Code

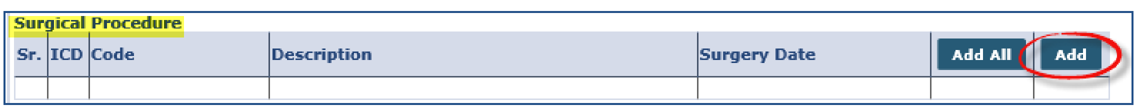
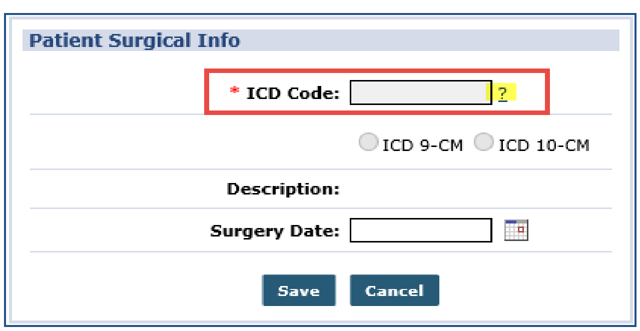
A "Primary" ICD Code must be assigned as required in the system. Users are restricted from deleting an ICD Code assigned as the Primary Code. When attempting to delete a Primary ICD record, the system issues a validation alert stating that another ICD Code must be assigned as a Primary before deleting the selected Primary Code.

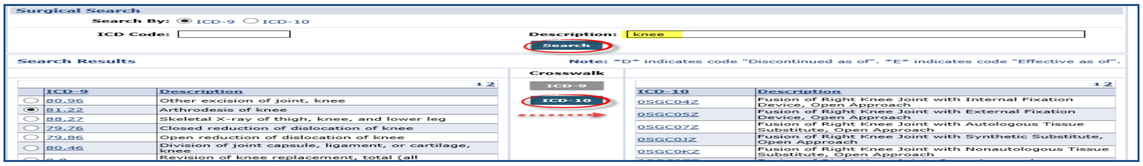
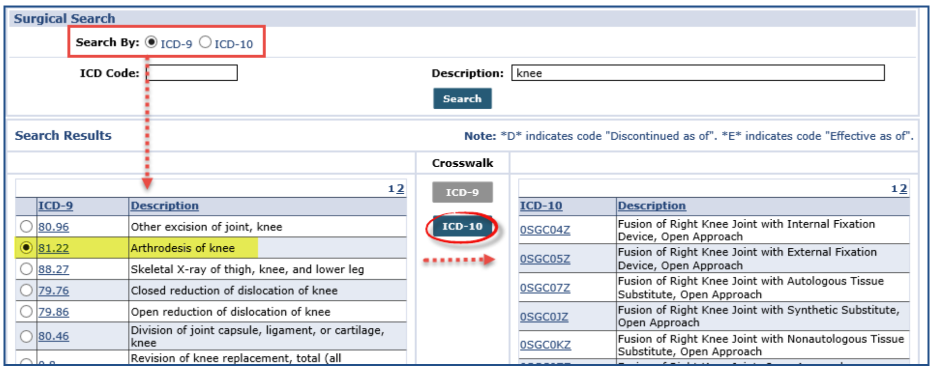
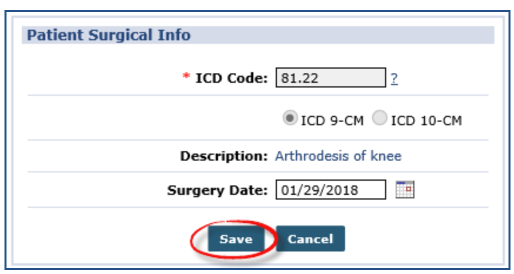


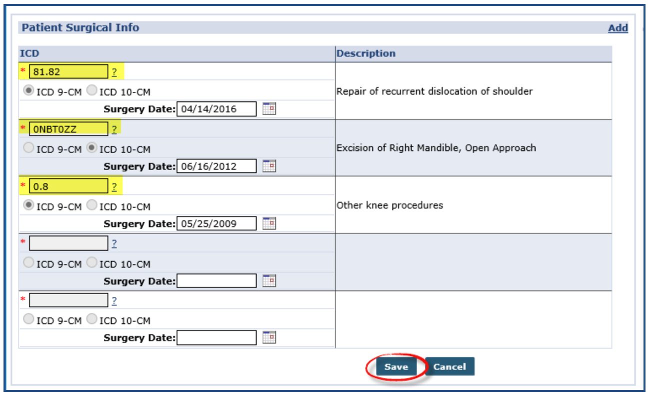
Furthermore, a Primary ICD Code cannot be assigned as a *Historical* record. In such a case, another record must be assigned as *Primary* before setting the current code as *Historical*.

Surgical Procedure

The *Surgical Procedures* section of the **Info** page serves to document the Patient's history of surgical procedures. Follow the instructions provided below to *add* surgical procedures to a Patient's profile.

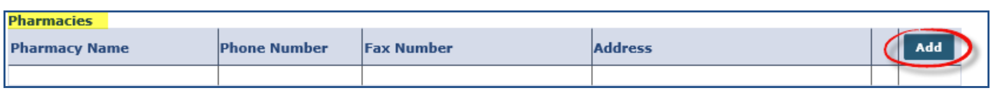
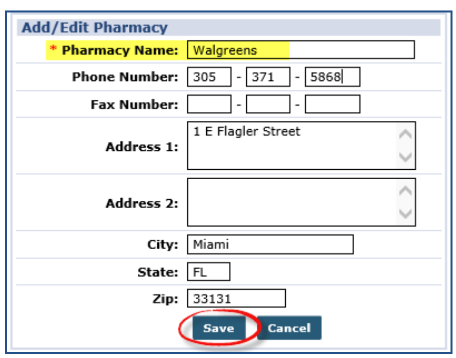
Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the Info link from the Index and go to the *Surgical Procedures* section.
3	Click the ***Add*** button to add a surgical procedure for a Patient.  ***Note:*** *The* ***Add All*** *button facilitates the entry of several procedures from one screen. See Step 8.*
4	The *Patient Surgical Info* window opens. Click the "?" to the right of the **ICD** field to search for the diagnosis code. 

Step	Action
5	In the *Surgical Search* window, enter the Patient's condition in the **Description** field, select the ICD code database to search, and click the ***Search*** button. 
6	From the results, select the applicable condition. To cross-reference, click the **ICD** (9 or 10) button (from the **Crosswalk** column) for more options. Click the applicable **ICD** code link to proceed. 
7	The system routes back to the *Patient Surgical Info* window. The selected ICD Code displays in the field with the description of the surgical procedure. Complete the remaining (optional) fields. Click the ***Save*** button to record. 
8	To add multi surgical procedures, click the ***Add All*** button (Step 3). Follow **Steps 4-6** to enter the various procedures with respective **Surgery Date**(s) for each. Click the ***Save*** button to record all entered surgeries.

Step	Action
	

Pharmacies

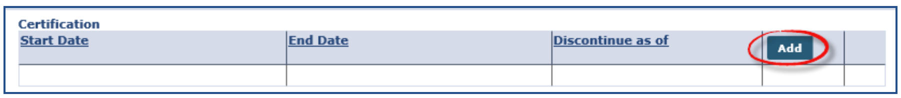
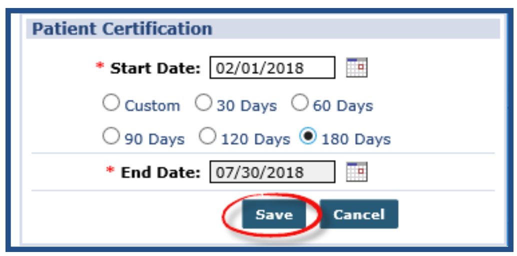
The *Pharmacies* section indicates the pharmacies where the Patient's is registered to pick up their medication. Follow the steps below to *add* a Patient's Pharmacy.

Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the Info link from the Index and go to the *Pharmacies* section.
3	Click the ***Add*** button to add a pharmacy for a Patient. 
4	The *Add/Edit Pharmacy* window opens. The **Pharmacy Name** field is required. Complete other applicable fields. Click the ***Save*** button to apply to the Patient's profile. 

The Certifications Page

A Patient must have a Physician's **Certification** (approval) to receive homecare services. Certifications are also required for **MD Orders** (one Certification per Order).

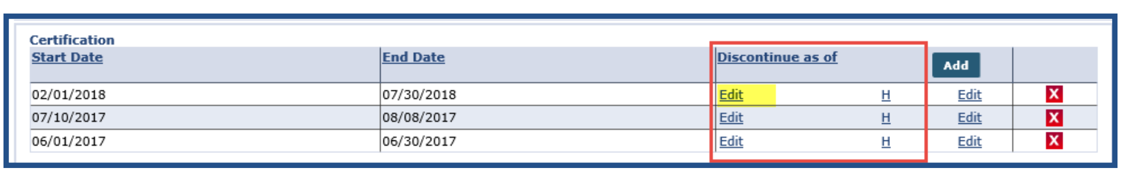
To enter a Certification, follow the steps provided below.

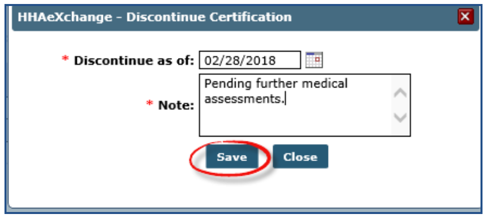
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Navigate to Patient > Patient Search and select a Patient.</td></tr>
<tr><td>2</td><td>Select the <u>Certifications</u> link from the Index.</td></tr>
<tr><td>3</td><td>Click the Add button to add a Certification for a Patient.

</td></tr>
<tr><td>4</td><td>The Patient Certification window opens. Select the Start Date and the duration (radio button) of the Certification. The End Date field populates according to the duration period selected. Click the Save button to apply.


Note: The first Certification Date defaults to the current date. Subsequent certifications default to the day after the last one expired.</td></tr>
</table>

Discontinue Certification

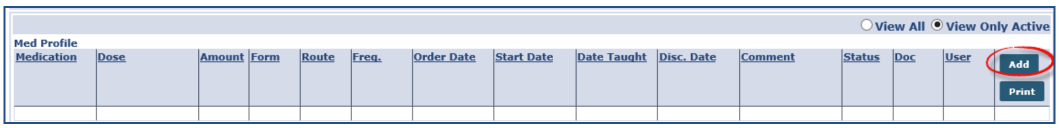
If a new MD Order needs to be issued before the current certification period is complete, a Certification must be discontinued. The following table provides the steps to discontinue an active Certification.

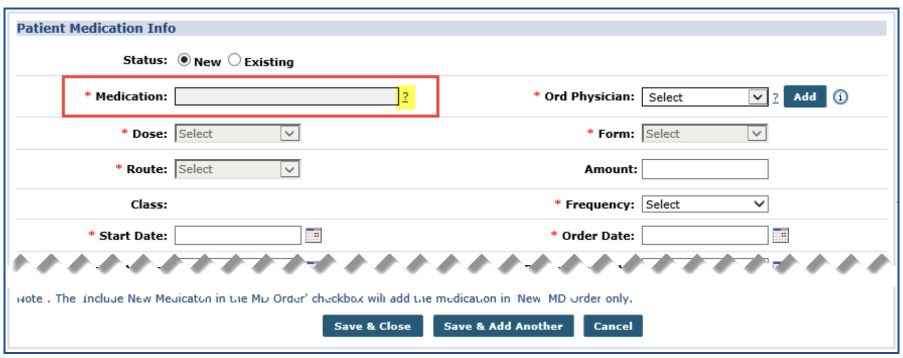
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>On the Patient's Certification page, click the Edit link of the applicable Certification from the Discontinue as of column.

</td></tr>
<tr><td>2</td><td>The Discontinue Certification window opens. Select the Discontinue as of Date and provide a reason in the required Notes field. Click the Save button to apply.</td></tr>
</table>

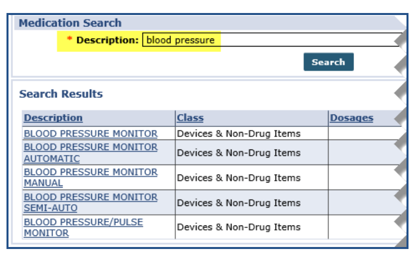
		HHAeXchange - Discontinue Certification * Discontinue as of: 02/28/2018 * Note: Pending further medical assessments. Save Close

The Med Profile Page

The **Med Profile** page is used to document a Patient's medications. To enter a Patient's medication record, follow the steps provided below.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Navigate to Patient > Patient Search and select a Patient.</td></tr>
<tr><td>2</td><td>Select the <u>Med Profile</u> link from the Index.</td></tr>
<tr><td>3</td><td>Click the Add button to add a medication for a Patient.


</td></tr>
<tr><td>4</td><td>The Patient Medication Info window opens. Complete the required fields (denoted with a red asterisk) using the descriptions on the table below the image.


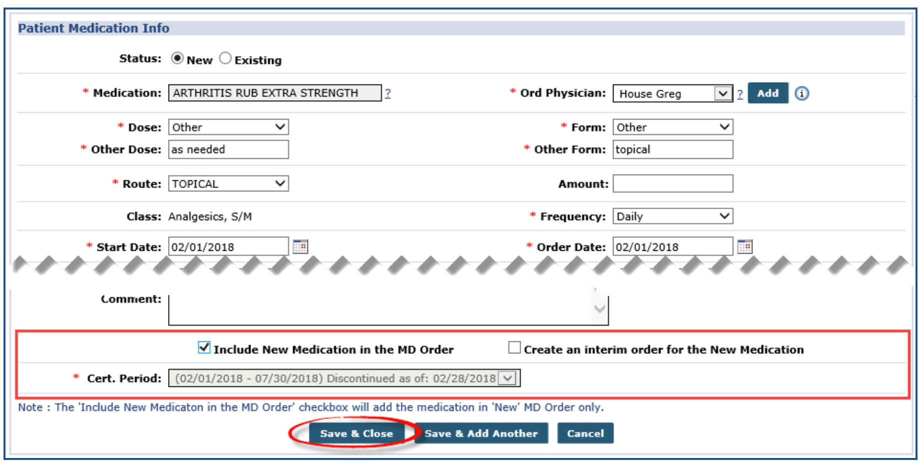
<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td>Status</td><td>Select if this is a New or Existing medication.</td></tr>
<tr><td>Medication</td><td>Click the "<u>?</u>" to search for the Medication. In the Medication Search window, enter the medication name in the Description field to search the database. In the results, click the applicable medication (link) to select and return to the Patient Medication Info page.


</td></tr>
<tr><td>Ord Physician</td><td>Select the Physician ordering the medication.</td></tr>
<tr><td>Dose</td><td>Select the prescribed dosage.</td></tr>
<tr><td>Form</td><td>Select the medication form (pills, liquid, etc.)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td></td><td>
<table>
<tr><td>Route</td><td>Select how the medication is administered (oral, injection, etc.)</td></tr>
<tr><td>Frequency</td><td>Select how often the medication is administered.</td></tr>
<tr><td>Start Date</td><td>Select the date when the Patient started/is to start the medication</td></tr>
<tr><td>Order Date</td><td>Select the date the Physician prescribed the medication.</td></tr>
</table>

Note: The values in these fields correspond to the selected medication.
</td></tr>
<tr><td>5</td><td>
Complete all other (optional) fields as needed.

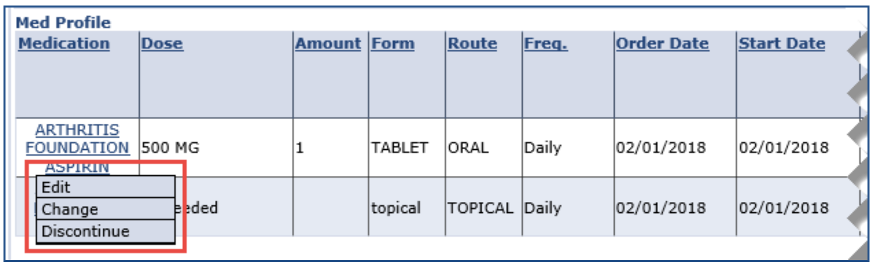
Select the Include New Medication in the MD Order checkbox if the medication is to be considered in the Patient’s MD Orders. When a MD Order is created for the selected Certification Period, the medication is automatically added.
If the medication was prescribed after the MD Order was issued, or the medication dosage was Changed, select the Create an interim order for the New Medication checkbox to generate an Interim Order for the medication change.



</td></tr>
<tr><td>6</td><td>Click the Save & Close button to complete. To record additional medications, click the Save & Add Another button and repeat the steps above.</td></tr>
</table>

Editing an Existing Medication

A Patient's medication record can be edited in one of three ways, depending on the reason for modification. To edit an existing medication record, click on the **Medication** (link) and select from the list of options (*Edit*, *Change*, or *Discontinue*), as illustrated in the following image and described in the table underneath.



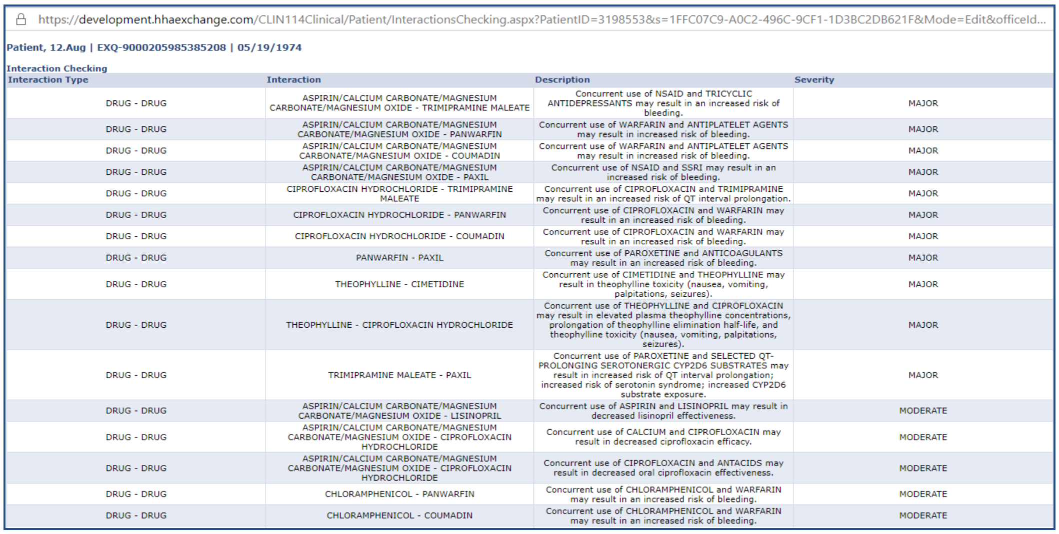
Select…	To/If…
Edit	Fix errors made when initially entering the medication.
Change	Apply any changes made to an existing prescription based on the Physician's order. For example, increased/decreased the *Amount* or *Frequency*.
Discontinue	The Physician has ordered the Patient to stop taking the medication. The **Discontinue Order Date** field is the date taken to create an Interim Order for the discontinuation. Select the **Create an Interim Order for the Medication Discontinuation** checkbox to open the required **Cert. Period** field. The *Certification Period* is automatically selected to reflect the date when the medication was ordered to discontinue.

Drug, Allergy, and Disease Interactions Checker

DISCLAIMER

This feature is activated by HHAX System Administration. Please contact HHAX Support Team for details, setup, and guidance.

The **Drug/Allergy/Disease Interactions Checker** allows Agencies to view and track a Patient's medication interactions (for example, allergic reactions and severity), as seen in the following image.


https://development.hhaexchange.com/CLIN114Clinical/Patient/InteractionsChecking.aspx?PatientID=3198553&s=1FFC07C9-A0C2-496C-9CF1-1D3BC2DB621F&Mode=Edit&officeId...

Patient, 12.Aug | EXQ-9000205985385208 | 05/19/1974

Interaction Checking

Interaction Type	Interaction	Description	Severity
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - TRIMIPRAMINE MALEATE	Concurrent use of NSAID and TRICYCLIC ANTIDEPRESSANTS may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - PANWARFIN	Concurrent use of WARFARIN and ANTIPLATELET AGENTS may result in increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - COUMADIN	Concurrent use of WARFARIN and ANTIPLATELET AGENTS may result in increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - PAXIL	Concurrent use of NSAID and SSRI may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - TRIMIPRAMINE MALEATE	Concurrent use of CIPROFLOXACIN and TRIMIPRAMINE may result in an increased risk of QT interval prolongation.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - PANWARFIN	Concurrent use of CIPROFLOXACIN and WARFARIN may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - COUMADIN	Concurrent use of CIPROFLOXACIN and WARFARIN may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	PANWARFIN - PAXIL	Concurrent use of PAROXETINE and ANTICOAGULANTS may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	THEOPHYLLINE - CIMETIDINE	Concurrent use of CIMETIDINE and THEOPHYLLINE may result in theophylline toxicity (nausea, vomiting, palpitations, seizures).	MAJOR
DRUG - DRUG	THEOPHYLLINE - CIPROFLOXACIN HYDROCHLORIDE	Concurrent use of THEOPHYLLINE and CIPROFLOXACIN may result in elevated plasma theophylline concentrations, prolongation of theophylline elimination half-life, and theophylline toxicity (nausea, vomiting, palpitations, seizures).	MAJOR
DRUG - DRUG	TRIMIPRAMINE MALEATE - PAXIL	Concurrent use of PAROXETINE and SELECTED QT-PROLONGING SEROTONERGIC CYP2D6 SUBSTRATES may result in increased risk of QT interval prolongation; increased risk of serotonin syndrome; increased CYP2D6 substrate exposure.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - LISINOPRIL	Concurrent use of ASPIRIN and LISINOPRIL may result in decreased lisinopril effectiveness.	MODERATE
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - CIPROFLOXACIN HYDROCHLORIDE	Concurrent use of CALCIUM and CIPROFLOXACIN may result in decreased ciprofloxacin efficacy.	MODERATE
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - CIPROFLOXACIN HYDROCHLORIDE	Concurrent use of CIPROFLOXACIN and ANTACIDS may result in decreased oral ciprofloxacin effectiveness.	MODERATE
DRUG - DRUG	CHLORAMPHENICOL - PANWARFIN	Concurrent use of CHLORAMPHENICOL and WARFARIN may result in an increased risk of bleeding.	MODERATE
DRUG - DRUG	CHLORAMPHENICOL - COUMADIN	Concurrent use of CHLORAMPHENICOL and WARFARIN may result in an increased risk of bleeding.	MODERATE

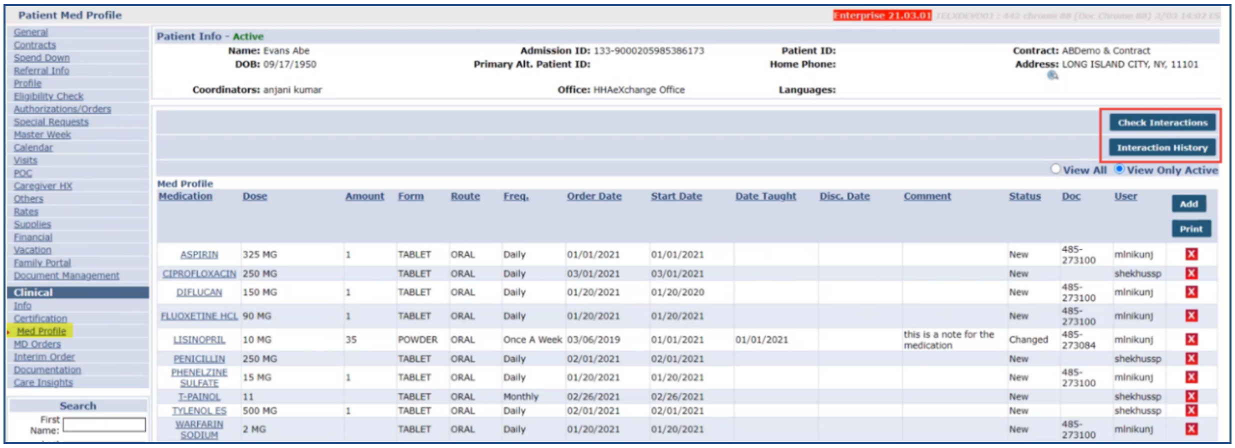
Interaction Checker

Note: *Allergies, medications, and diagnosis information must be entered in the Patient's Profile prior to using the feature. Allergies must be entered in the structured format for the* ***Interactions Checker*** *to function. Refer to the* *Structured Allergy Entry section* *for details.*

Check Interactions from the Patient Profile

On the Patient's *Med Profile* page (***Patient > Med Profile***), a ***Check Interactions*** button and an ***Interaction History*** button have been added to view a Patient's medication interactions (as described in the table and seen in the image underneath).

Select	To…
Check Interactions	to view and check all interactions entered for the Patient. Select the ***Check Interactions*** button, and then select *Check All medications* from the sub-menu.
Interaction History	view a historical view of all interactions for the Patient's medications. Refer to the Interaction History section below.



Patient Med Profile Page: Check Interactions Button and Interaction History Button

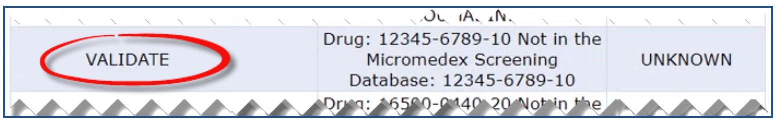
The *Interactions Checker* window opens to display the various interactions based on the Patient's pre-scribed medications, as seen in the following image. The window shows **Interaction Type** (for example: drug to drug, drug to disease, drug to allergy), **Interaction** (specific interaction between the two), **Description** (the risks), and the **Severity** (contraindicated, major, moderate, minor).

Evans, Abe | 133-9000205985386173 | 09/17/1950

Interaction Type	Interaction	Description	Severity
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - TRIMIPRAMINE MALEATE	Concurrent use of NSAID and TRICYCLIC ANTIDEPRESSANTS may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - PANWARFIN	Concurrent use of WARFARIN and ANTIPLATELET AGENTS may result in increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - COUMADIN	Concurrent use of WARFARIN and ANTIPLATELET AGENTS may result in increased risk of bleeding.	MAJOR
DRUG - DRUG	ASPIRIN/CALCIUM CARBONATE/MAGNESIUM CARBONATE/MAGNESIUM OXIDE - PAXIL	Concurrent use of NSAID and SSRI may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - TRIMIPRAMINE MALEATE	Concurrent use of CIPROFLOXACIN and TRIMIPRAMINE may result in an increased risk of QT interval prolongation.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - PANWARFIN	Concurrent use of CIPROFLOXACIN and WARFARIN may result in an increased risk of bleeding.	MAJOR
DRUG - DRUG	CIPROFLOXACIN HYDROCHLORIDE - COUMADIN	Concurrent use of CIPROFLOXACIN and WARFARIN may result in an increased risk of bleeding.	MAJOR

Patient Interaction Results

If there is an issue processing a data element, then a *Validate* label (as seen in the following image) under the **Interaction Type** column appears to indicate that interactions were not checked for that data element.



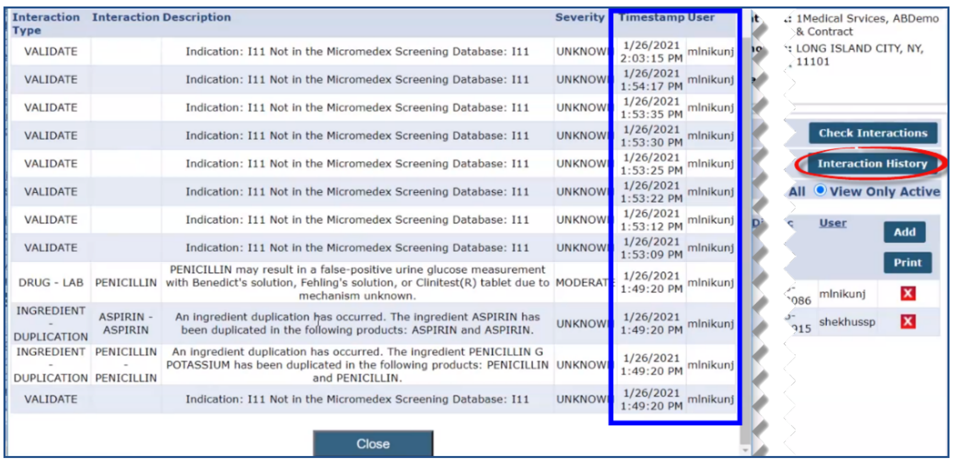
Interaction Type: Validate Label

Note: *The* ***Check Interactions*** *button is unavailable if the feature is not activated by HHAX System Administration. A pop-up message appears, as seen in the image to the right.*

Permission Disabled for Check Interactions

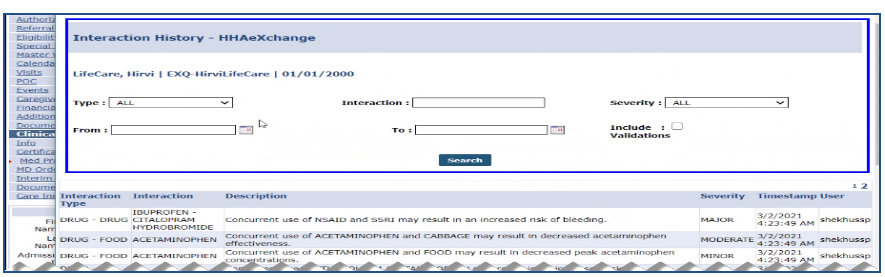
Interaction History

The ***Interaction History*** button, under the ***Check Interactions*** button, provides a historical view of all interactions for the Patient's medications to include a **Timestamp** column and **User** column to indicate the date, time, and the user who entered the information in the system.



Interactions History Window: Timestamp and User Columns

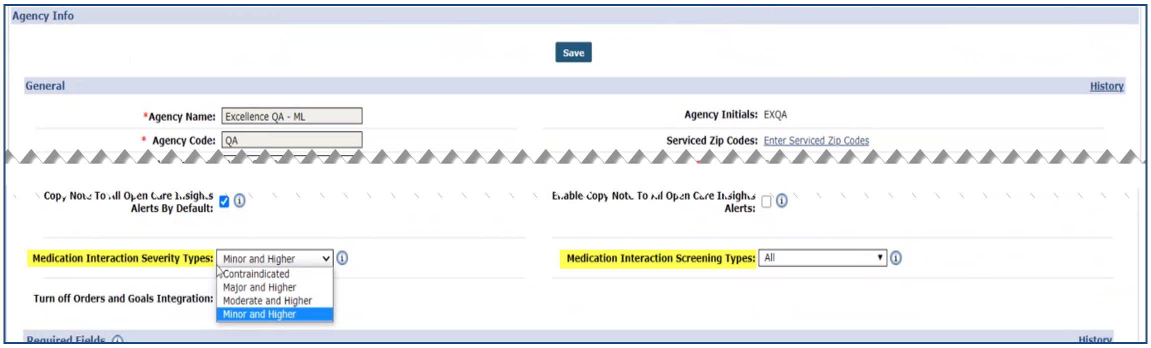
Use the *Interaction History* search filter fields (pictured below) to facilitate Interaction searches for the Patient.



Interaction History Search Fields

Configure Alerts and Details at Agency Level

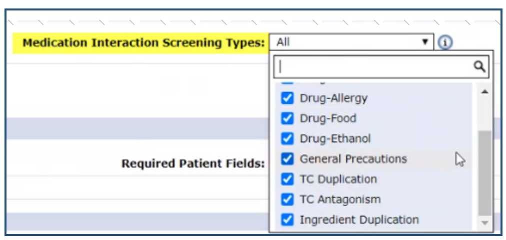
Providers can control which types of alerts to view and track by severity and type of interaction. In the *Agency Profile* page (***Admin-> Agency Profile***) under the *General* section, select the severity type (level) from the **Medication Interaction Severity Types** dropdown field and the screening types from the **Medication Interaction Screening Types** dropdown field, as seen in the following image.



Agency Profile: Medication Interactions Severity Types and Screening Types

While the **Medication Interaction Severity Types** field allows only one selection, the **Medication Interaction Screening Types** allows for multi-selections.

Note: *At least one option must be selected per field.*
The following screening types are not included: ***Drug-Pregnancy****,* ***Drug-Lactation****,* ***Drug-Tobacco****, and* ***Drug-Lab****.*

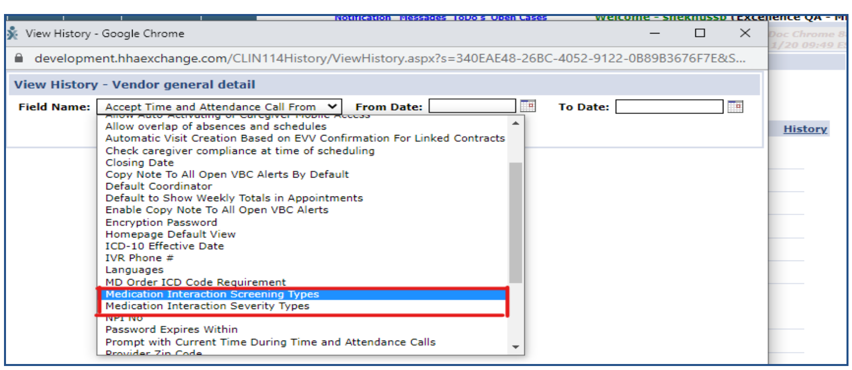


Screening Type Options

Once saved, the alerts appear on the Patients' Med Profile pages.

View History

Both fields have been added to the History log under the *General* section. To view history, click on the History link (at the top-right of the section header). In the *View History* window, select either *Medication Interaction Severity Types* or *Medication Interaction Screening Types* from the **Field Name**.



View History: Medication Interactions Severity Types and Screening Types

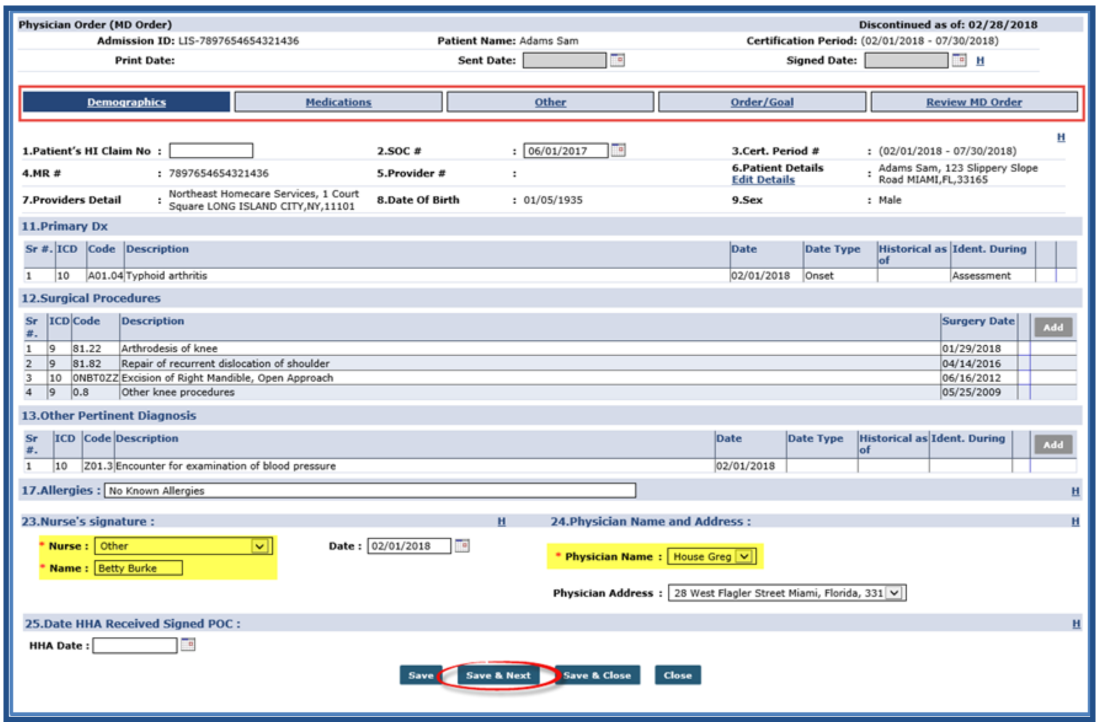
The MD Order Page

An **MD Order** is a comprehensive feature containing a Patient's clinical information such as medications, diagnosis, surgeries, prognosis, mental state and the homecare regiment prescribed by the Physician. Each MD Order must have a *Certification* and a *Med Profile* completed in the system.

An MD Order pulls information entered in the **Info**, **Med Profile**, and **Certification** pages.

Note: *Any changes to these pages after an MD Order is created is not reflected in the order. Likewise, information edited in the MD Order does not affect the corresponding data on the Clinical pages.*

The MD Order is comprised of 5 sections (**Demographics**, **Medications**, **Other**, **Order/Goal**, **Review MD Order**), as pictured in the following image and covered in the instructions underneath. To ensure all information is included, it is advised to review, add, and verify the information within.

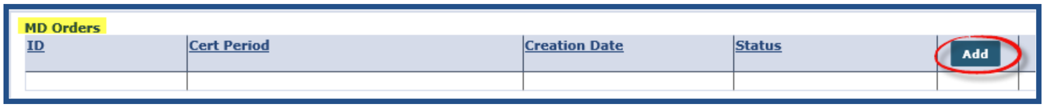
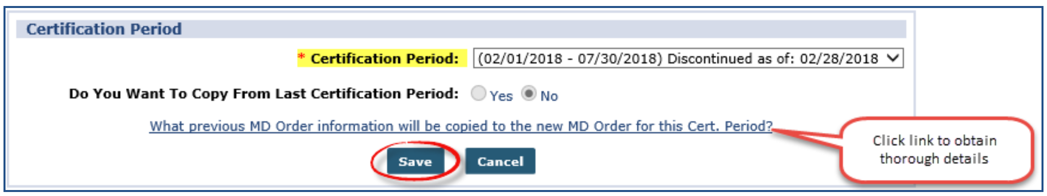


MD Order Section Tabs

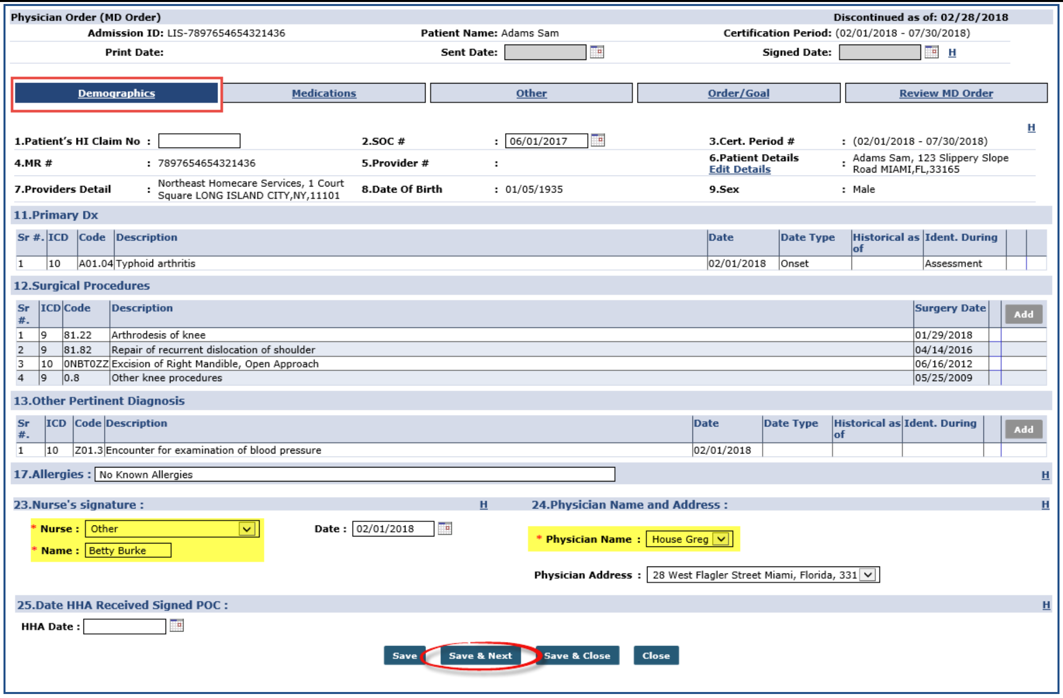
Note: *HHAX advises users to review and verify the information on each page and select the **Save & Next** button to navigate to the next section or toggle between tabs to access the various pages.*

To create an MD Order in the system, follow the steps provided below.

Step	Action
1	Navigate to **Patient > Patient Search** and select a Patient.
2	Select the MD Orders link from the Index.

Step	Action
3	Click the ***Add*** button to create the MD Order for a Patient. 
4	Select the applicable **Certification Period** for the MD Order when prompted by the system. Select the ***Yes*** radio button, if the same medication and care regiment (from a previous MD Order) applies to the new MD Order. Click the link provided to verify what was included in a previous order before copying the information. Click the ***Save*** button to proceed.  ***Note:*** *Only one Certification Period can be selected; not associated or linked to another MD Order.*
5	The *Physician Order (MD Order)* window opens to the *Demographics* section (as demonstrated in the image below). The *Demographics* page primarily consists of the information entered on the **Info** page, such as the **Primary DX** and **Surgical Procedures**. If required, users may edit this information, add or remove diagnosis. The **Nurse** field is required as well as the **Physician Name** associated with the Order. Click the **Save & Next** button to continue to the next page.

Step	Action

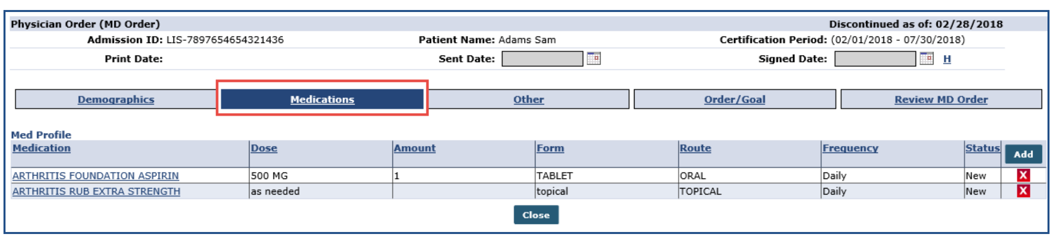


MD Order - *Demographics* section

6

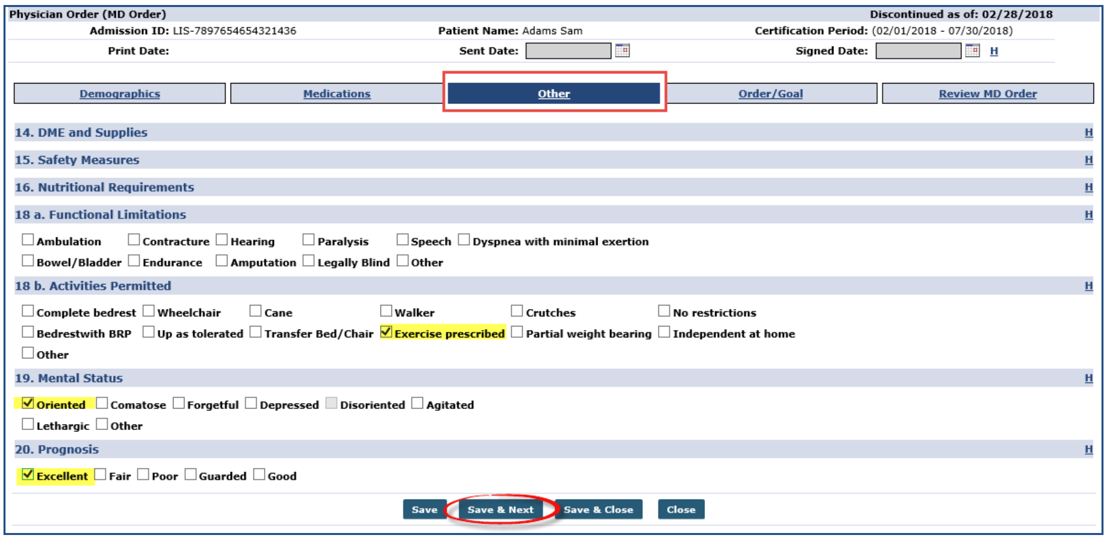
Medications entered on the **Med Profile** page automatically appear on the *Medications* section. Review the information. Remove or add medications as applicable to the Order.

Click the **Other** section (tab) to continue.



MD Order - *Medications* section

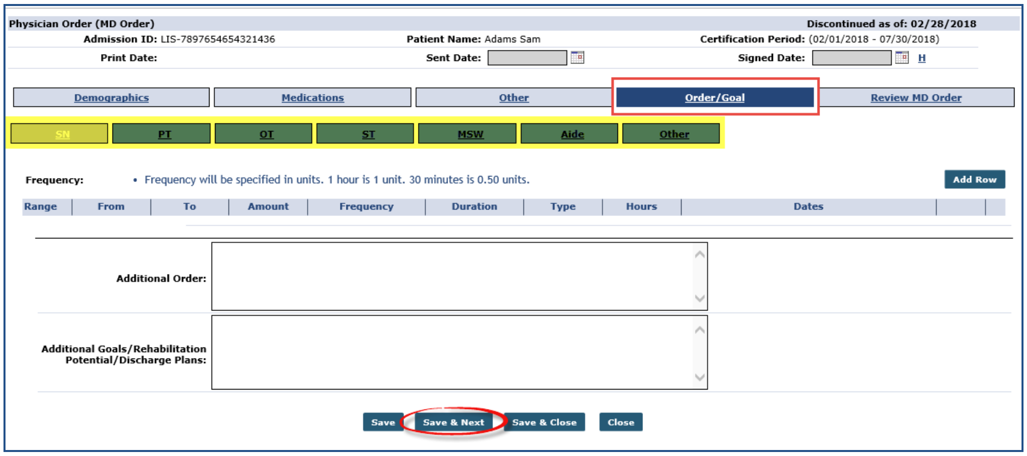
Step	Action



MD Order - *Other* section

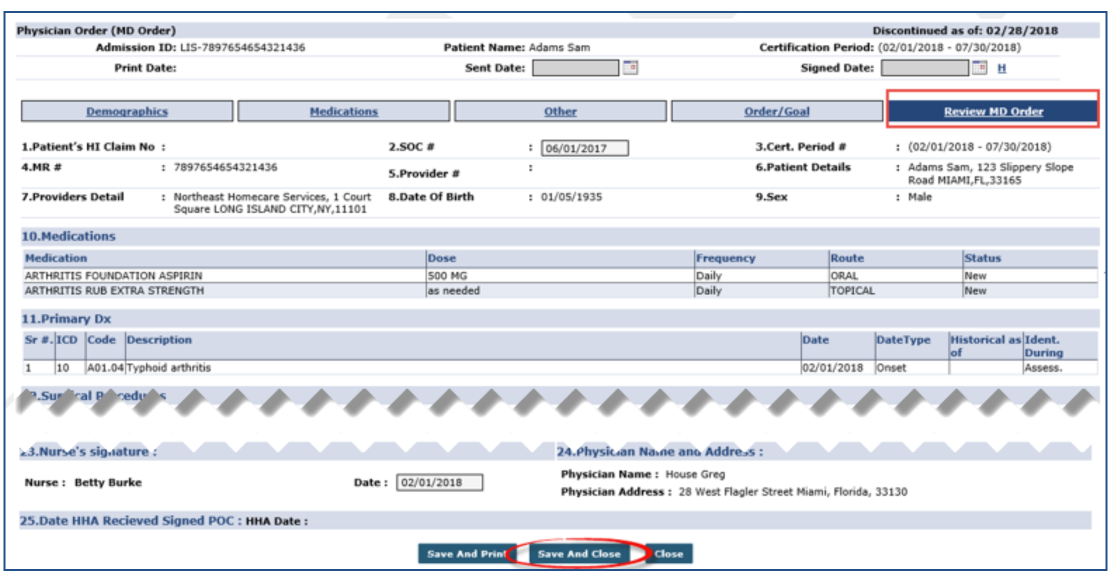
Section	Description
DME and Supplies	Durable Medical Equipment (**DME**) includes items such as canes, wheel-chairs, and bedpans. *Values/options are entered in the **Reference Table Management** functionality (**Admin > Reference Table Management**).*
Safety Measures	Precautionary orders in place to prevent a Patient's accident (such as 24-hour supervision, fall precaution, or Face Mask requirements). *Val-ues/options are entered in the Clinical Safety Measures Reference Table (**Admin > Office Setup > Search Office > Edit Office > Office Option Setup**).*
Nutritional Require-ments	Select the Patient's nutritional requirements (as prescribed by the Phys-ician). *Values/options are entered using the Clinical Nutritional Require-ments Reference Table in the Office Option Setup (as described above).*
Functional Limitations	Record the Patient's functional limitations such as hearing issues or speech problems.
Activities Permitted	Indicate activities the Patient is permitted to engage in
Mental Status	Indicate the Patient's mental status.
Prognosis	Indicate the Patient's prognosis

Step	Action
	and Goals are unique to each Skilled Caregiver discipline (as highlighted in the image). Select the applicable **discipline** and make notes. Click the ***Save & Next*** button to continue.

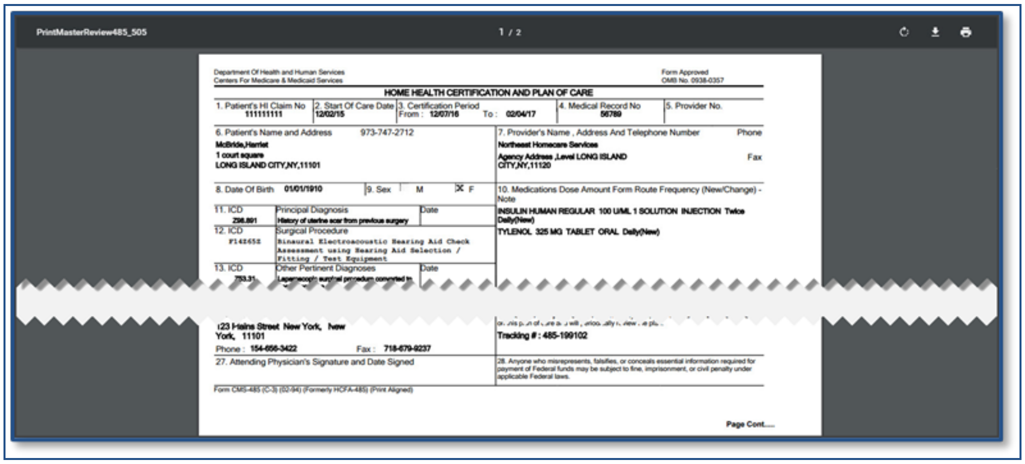
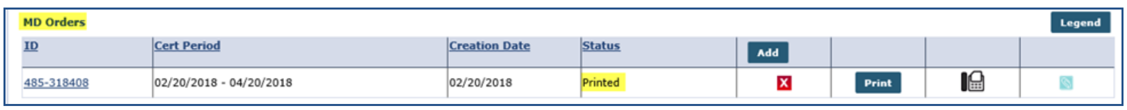
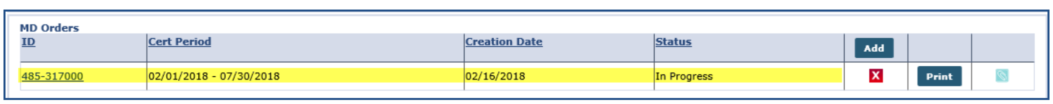


MD Order – *Order/Goal* section

Step	Action
9	The *Review MD Order* page provides an overview of the entire MD Order, allowing users to verify the information entered in the previous sections before saving the order. Click the ***Save and Print*** button or the ***Save and Close*** button to finalize.



MD Order – *Review MD Order* section

Step	Action
10	Selecting the ***Save and Print*** button initiates a download, creating a PDF copy of the MD Order on the user's workstation (as seen on the following image).  **Save and Print option - MD Order PDF** Once Printed, the Status changes to **Printed** (as seen in the following image).  **MD Order - Printed Status** Selecting the ***Save & Close*** button closes the MD Order window and routes back to the **Patient MD Order** page. The new MD Order record displays (as shown in the image below).  **Save and Close option - MD Order Entered**

MD Order Status

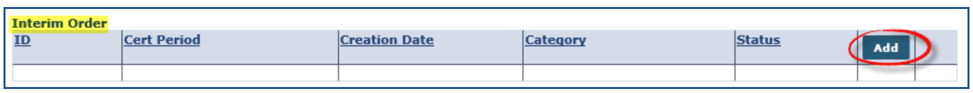
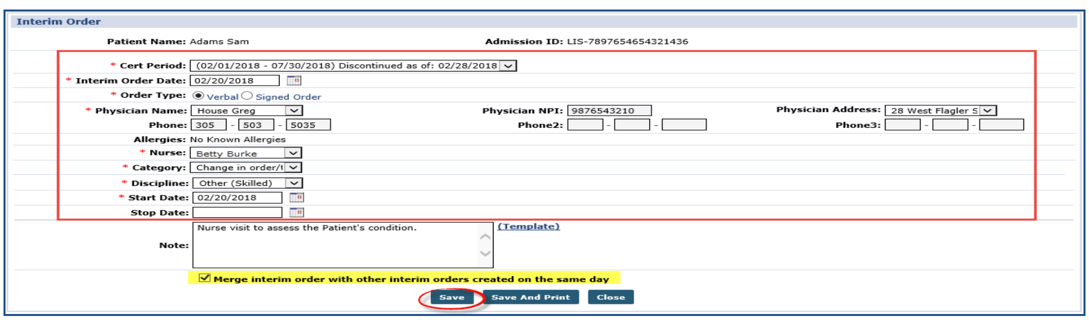
The following table provides the various **Status** types and descriptions for MD Orders.

Status	Description
In Progress	The MD Order has been created pending completion. but has not yet been completed or printed.
Complete	The MD Order is completed but not yet Printed.
Printed	The MD Order has been completed and downloaded to the user's workstation as a PDF.
Sent	The printed MD Order has been sent to the Physician for review and

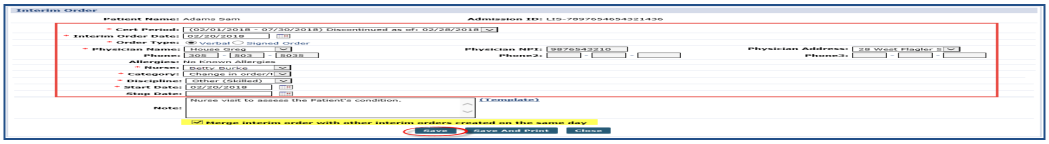
	approval.
Signed	The MD Order has been signed by the Physician.

Interim Order

An **Interim Order** is an addendum to an active MD Order. Interim Orders are issued for changes in medication, the type of service the Patient receives, or the frequency of service. Complete the following steps to enter an Interim Order.

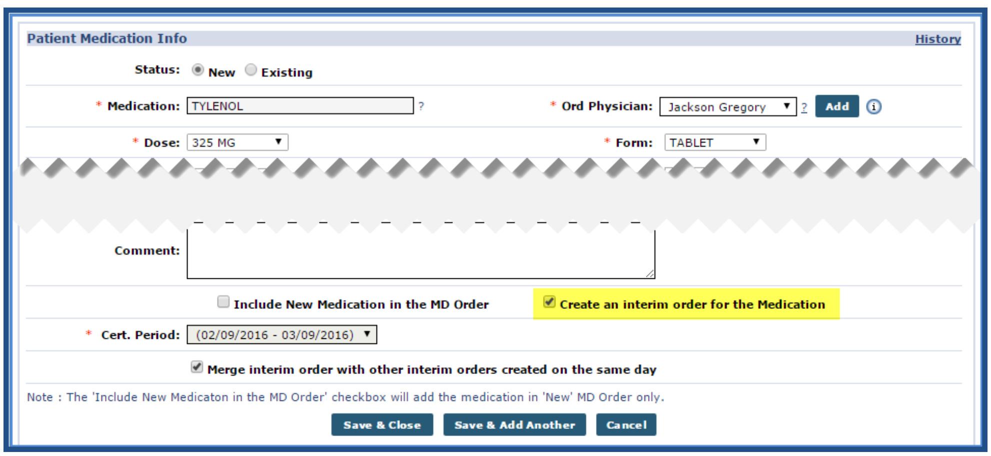
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Navigate to Patient > Patient Search and select a Patient.</td></tr>
<tr><td>2</td><td>Select the <u>Interim Orders</u> link from the Index.</td></tr>
<tr><td>3</td><td>Click the Add button to create an Interim for a Patient.

</td></tr>
<tr><td>4</td><td>The Interim Order window opens. Select the required fields (denoted by the red asterisk); described in the table below the image.


Interim Order window (top)
<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td>Cert Period</td><td>Select the applicable Certification Period.</td></tr>
<tr><td>Interim Order Dates</td><td>The date the Interim Order is issued.</td></tr>
<tr><td>Order Type</td><td>Select if a Verbal or Signed Order</td></tr>
<tr><td>Physician Name</td><td>Select the ordering Physician. Note: Upon selection, the Physician's address and phone numbers populate in said fields.</td></tr>
<tr><td>Nurse</td><td>Select the Patient's nurse.</td></tr>
<tr><td>Category</td><td>Select the reason for the order. The selected Category field determines the remaining fields to complete.</td></tr>
<tr><td>Start Date</td><td>The date in which the order is executed.</td></tr>
</table></td></tr>
<tr><td></td><td></td></tr>
<tr><td>5</td><td>If multiple Interim Orders are applied to a single Certification Period, select the Merge Interim</td></tr>
</table>

	Order… checkbox at the bottom of the page.  **Interim Order window (bottom)**
6	Click the ***Save*** button to complete.

Interim Orders – Medication Changes

Interim Orders for medication changes are generated by entering the new medication on the **Med Profile** and selecting the **Create an interim order for the Medication** checkbox.

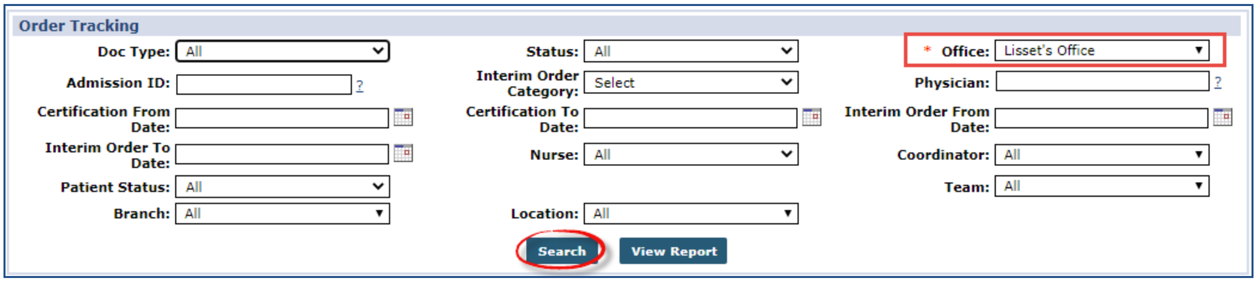


Create Interim Order for Medication

Order Tracking

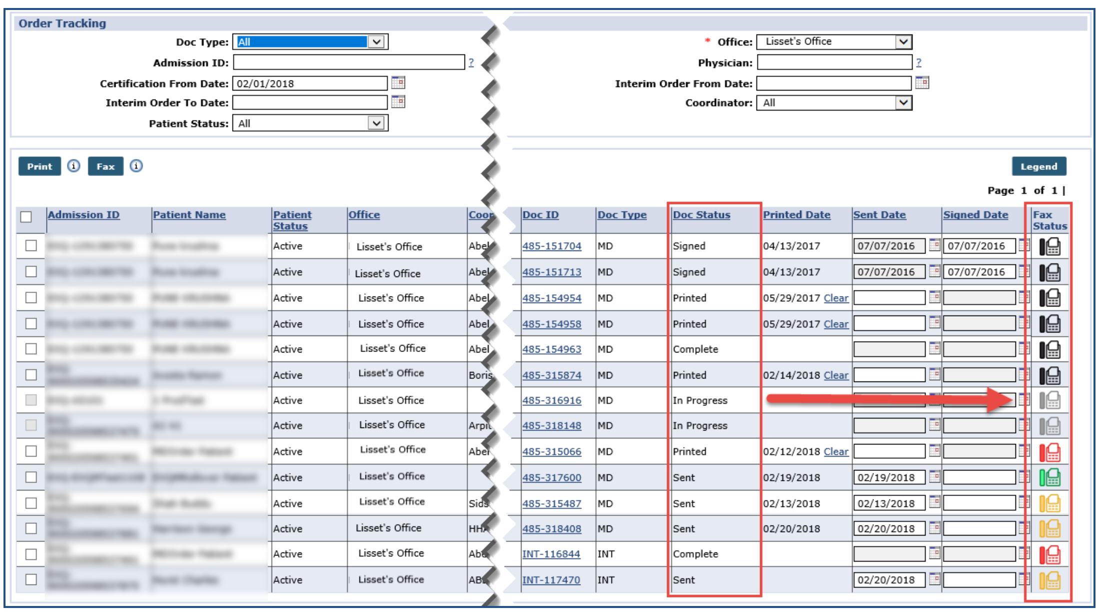
MD and Interim Orders can be managed from the **Order Tracking** page (**Action > Order Tracking**). Search filters are available to locate MD or Interim Orders by defining criteria such as the timeframe when the order was issued, the ordering Physician, or the Order Status.

To generate a search, select the required **Office** filter and click the ***Search*** button.



Order Tracking Search

On the results panel, a **Fax Status** column with a ***Fax*** icon facilitates faxing directly from the page (as pictured in the following image). Users can either fax or print individual Orders or in bulk from this page, providing that the Doc Status permits.



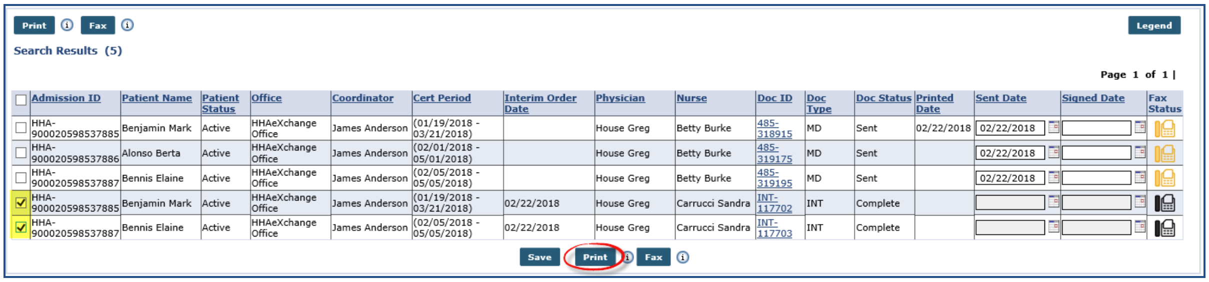
Order Tracking Page

DISCLAIMER

The faxing feature is activated by System Administration. Please contact HHAX Support Team for details, setup, and guidance. Refer to the Faxing MD and Interim Orders category for further details.

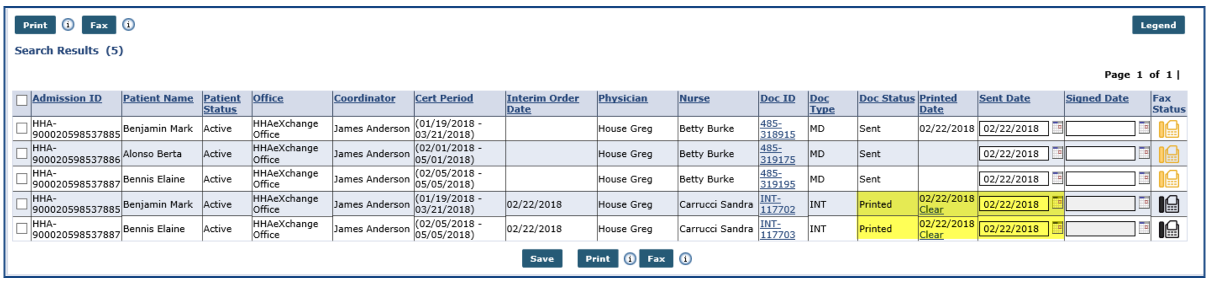
Printing from the Order Tracking Page

To print, select the *checkbox* (far-left) and click the ***Print*** button, as shown in the following image.



Printing from Order Tracking Page

Once printed, the Status changes to **Printed**. Users can select/enter the **Sent Date**.



Order Tracking Page – Printed Status

Note: *If printing multiple records, the Document Types must be the same. MD Orders and Interim Order cannot be printed simultaneously. HHAX does not allow users to enter a **Signed Date** for an MD Order (meaning Physician-verified), until it has gone through the Status cycle as follows: **In Progress > Printed > Sent > Signed**.*

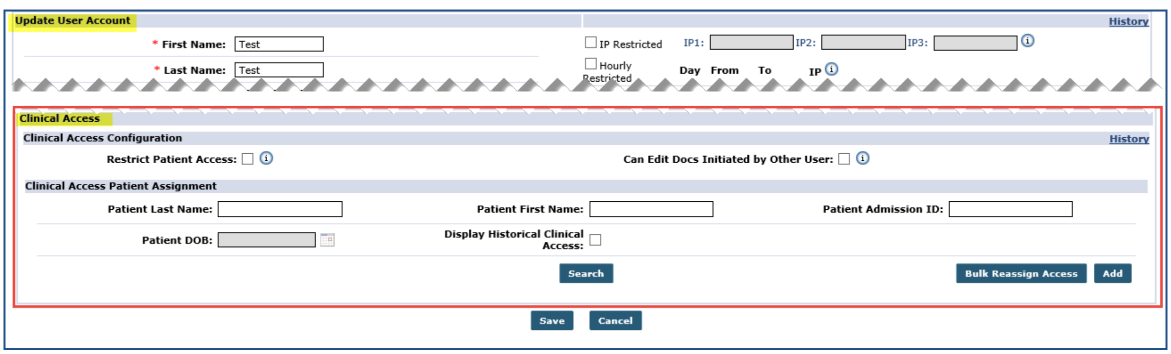
Control Access to Patient's Clinical Records

The **Clinical Access** feature enhances security by allowing Providers to limit a clinical user's access to only an assigned Patient's clinical records and documentation (such as a Nurse in charge of the Patient's care). For example, if a Nurse (user) works with only Patient A and Patient C, then this user does not need to view/access Patient B's Profile.

DISCLAIMER
The ability to control the access to individual Patient clinical information is set at the HHAX System User level. Access to other non-clinical Patient information is determined by Permissions set at the Role level. HHAeXchange strongly urges the Agency to review all roles to ensure users have only the access needed to Patient information.

Clinical Access

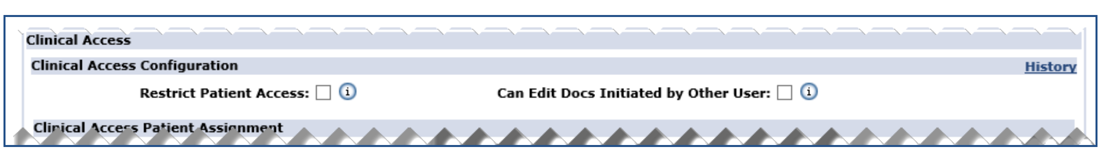
In the *Update User Account* page (***Admin > User Management > Search User***), the **Clinical Access** section is used to configure users with the proper permissions or to limit access accordingly. This section becomes available when editing an existing user (i.e., after the *User Profile* has been created). Refer to the Permissions section for permissions details.



User Profile: Clinical Access Section

Clinical Access Configuration

The *Clinical Access Configuration* section contains two options: **Restrict Patient Access** and **Can Edit Docs Initiated by Other User**.



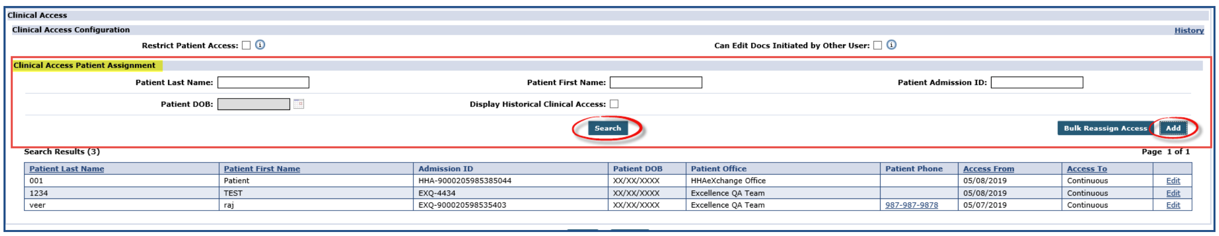
Clinical Access Configuration

Select the **Restrict Patient Access** checkbox to restrict the user's access to view the Patient Profiles (records and Visits), with the exception of the Patients listed in the *Clinical Access Patient Assignment* section (covered below). Selecting this option without defining Patients restricts the user from access to any Patient information.

Select the **Can Edit Docs Initiated by Other User** checkbox to allow the user to edit a Patient's clinical documents that were created by another user.

Clinical Access Patient Assignment

The *Clinical Access Patient Assignment* section is used to assign the access permission to specific Patient information. This section is also visible in Edit User details. Click ***Search*** to view previously assigned Patients (Search Results) or click the ***Add*** button to assign user access to a Patient, as illustrated in the following image.

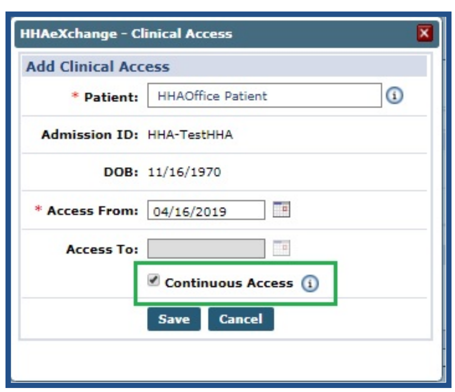


Clinical Access Patient Assignment

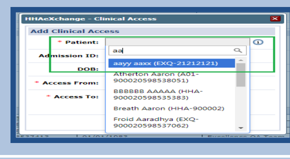
Note: *The user must be associated to at least one Office before adding Clinical access. Refer to the Office Setup section in the User Account page.*

Adding Clinical Access to a Patient

The *Clinical Access* window opens (when clicking the ***Add*** button) to assign a Patient to a User Account. Complete the required fields (denoted with red asterisk), as described in the table below. Click ***Save*** to add.

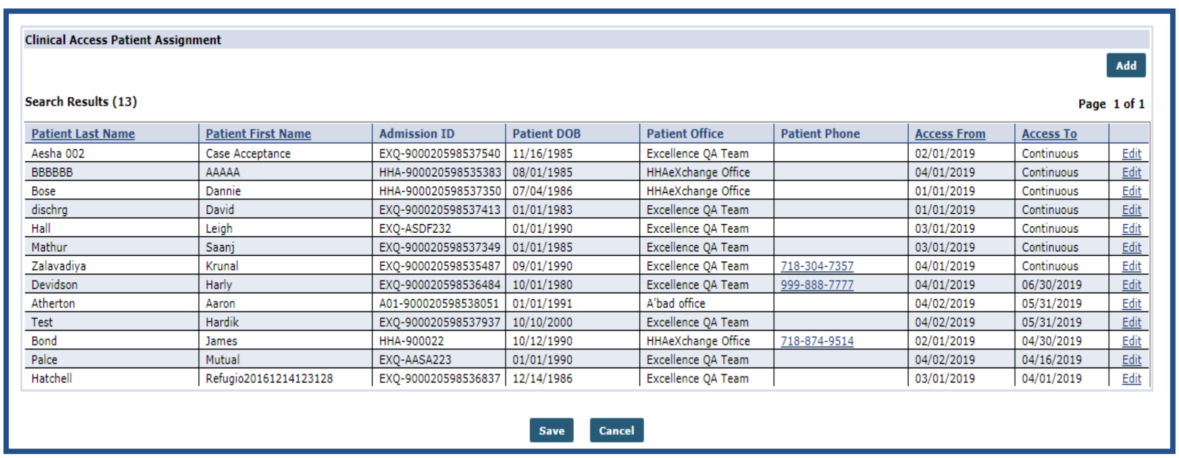


Add Clinical Access

Field	Description
***Patient**	Enter the Patient's name. This field auto-fills as characters are entered. 
Admission ID	Field auto-populates when the Patient is selected.
DOB	Field auto-populates once the Patient is selected.
***Access From**	Define the effective date as of when the user has access to the Patient inform-ation.
***Access To**	This date is only required if the **Continuous Access** checkbox is unselected.
Continuous Access	Select this checkbox to grant access to Patient information on an ongoing basis. When selected, the **Access To** field becomes unavailable.

Existing Patient Assignment (Search Results)

As seen above, clicking the ***Search*** button generates search results in the *Clinical Access Patient Assign-ment* section. Each line item contains the Patient's **Last Name**, **First Name**, **Admission ID**, **DOB**, **Office**, **Phone Number**, **Access From/To**, and an Edit link.


Clinical Access Patient Assignment

Add

Search Results (13)

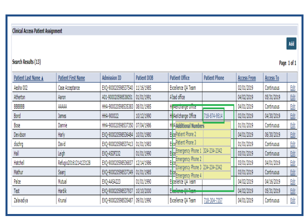
Page 1 of 1

Patient Last Name	Patient First Name	Admission ID	Patient DOB	Patient Office	Patient Phone	Access From	Access To	
Aesha 002	Case Acceptance	EXQ-900020598537540	11/16/1985	Excellence QA Team		02/01/2019	Continuous	Edit
BBBBBB	AAAAA	HHA-900020598535383	08/01/1985	HHAeXchange Office		04/01/2019	Continuous	Edit
Bose	Dannie	HHA-900020598537350	07/04/1986	HHAeXchange Office		01/01/2019	Continuous	Edit
dischrg	David	EXQ-900020598537413	01/01/1983	Excellence QA Team		01/01/2019	Continuous	Edit
Hall	Leigh	EXQ-ASDF232	01/01/1990	Excellence QA Team		03/01/2019	Continuous	Edit
Mathur	Saanj	EXQ-900020598537349	01/01/1985	Excellence QA Team		03/01/2019	Continuous	Edit
Zalavadiya	Krunal	EXQ-900020598535487	09/01/1990	Excellence QA Team	718-304-7357	04/01/2019	Continuous	Edit
Devidson	Harly	EXQ-900020598536484	10/01/1980	Excellence QA Team	999-888-7777	04/01/2019	06/30/2019	Edit
Atherton	Aaron	A01-900020598538051	01/01/1991	A'bad office		04/02/2019	05/31/2019	Edit
Test	Hardik	EXQ-900020598537937	10/10/2000	Excellence QA Team		04/02/2019	05/31/2019	Edit
Bond	James	HHA-900022	10/12/1990	HHAeXchange Office	718-874-9514	02/01/2019	04/30/2019	Edit
Palce	Mutual	EXQ-AASA223	01/01/1990	Excellence QA Team		04/02/2019	04/16/2019	Edit
Hatchell	Refugio20161214123128	EXQ-900020598536837	12/14/1986	Excellence QA Team		03/01/2019	04/01/2019	Edit

Save Cancel

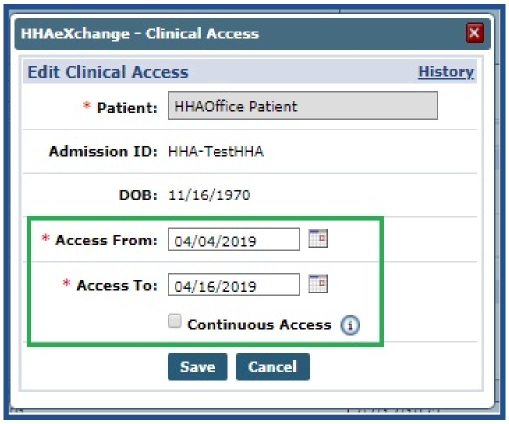
Clinical Access Patient Assignment Search Results

The **Name** and **Date** columns are sortable. Hovering over a **Patient Phone** number populates a pop-up window displaying other Phone Numbers listed for the Patient.



Edit Patient Details

Click the Edit link (from a record line) to edit a record. The *Clinical Access* window opens. Update the date range information or select/deselect the **Continuous Access** checkbox. The **Patient Name**, **Admission ID**, and **DOB** are unavailable to edit. Click ***Save*** to update.

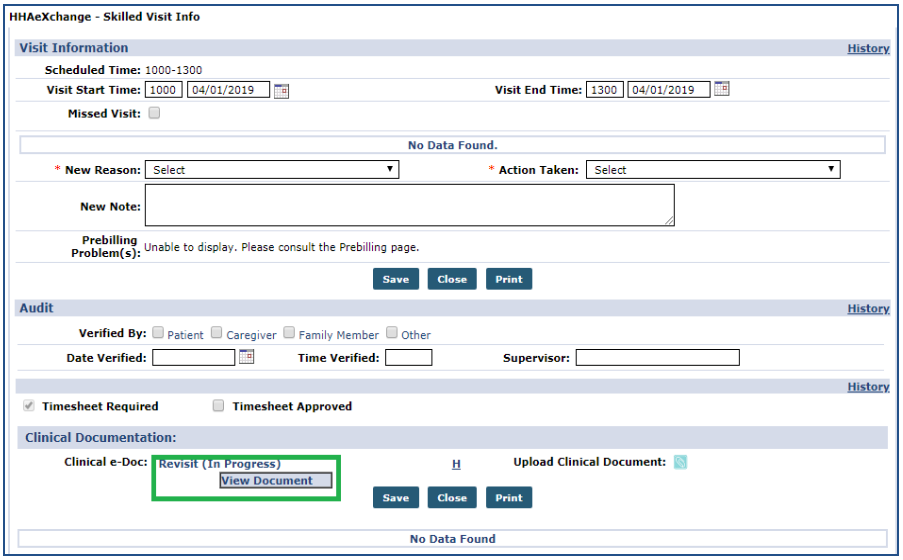


Edit Clinical Access

Note: *To view historical data on Clinical Access, click the History link on the top-right ow the Clinical Access window.*

Editing Clinical Documents

With the **Can Edit Docs Initiated by Other Users** checkbox selected, users can *edit* Patient Clinical Documents (in the Visit Info tab) created by another user. Users without edit access can still view the information provided that they do not have restricted access for said Patient (as seen in the following image).

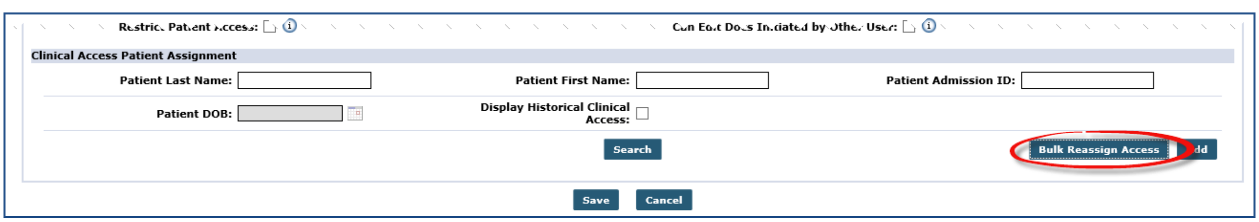


Visit Info Tab – Clinical Documentation

Note: *The Edit or Delete options are not visible for View Only access.*

Bulk Reassign Access Functionality

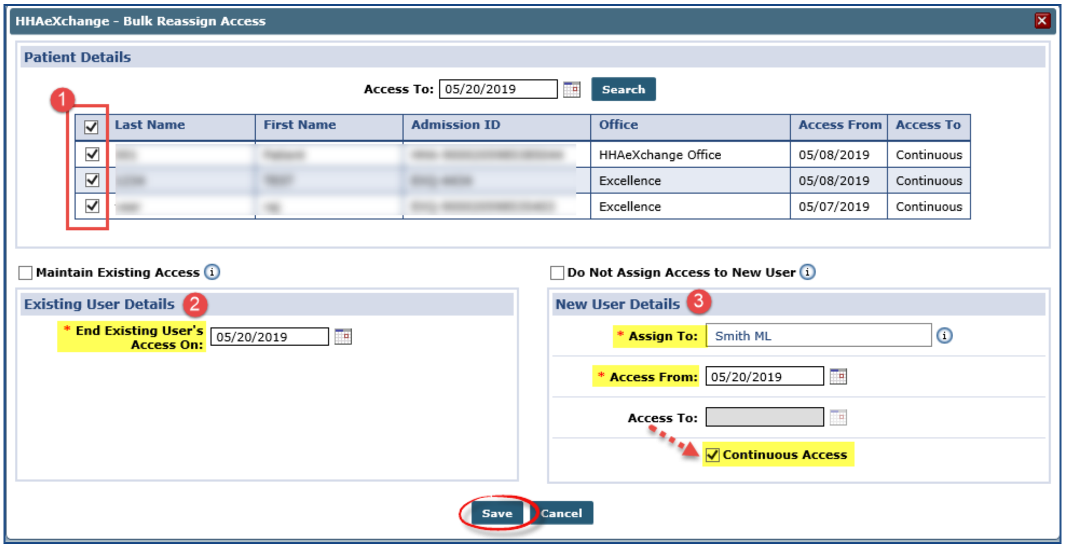
Use the *Bulk Reassign Access* functionality to update multiple access records/details in one transaction. This is typically useful when either a user (such as a Nurse) leaves the organization and the Patients must be reassigned; or, when workloads are redistributed. Click the ***Bulk Reassign Access*** button to reassign multiple Patient access records (as illustrated in the image below).



Bulk Reassign Access Button

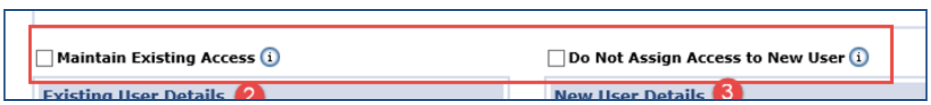
The *Bulk Reassign Access* window opens. The **Access To** date filter specifies the effective date for the change with a list of Patients for the defined date. Complete the following steps (as illustrated in the following image):

1. In the *Patient Details* section, select the Patients to reassign by choosing respective checkboxes.
2. In the *Existing User Details* section, define an end date in the required **End Existing User's Access On** field.
3. In the *New User Details* section, complete the required fields: **Assign To**, **Access From** and **Access To** (or select **Continuous Access**).



Bulk Reassign Access Window

The following two options are also available in the *Bulk Reassign Access* window:

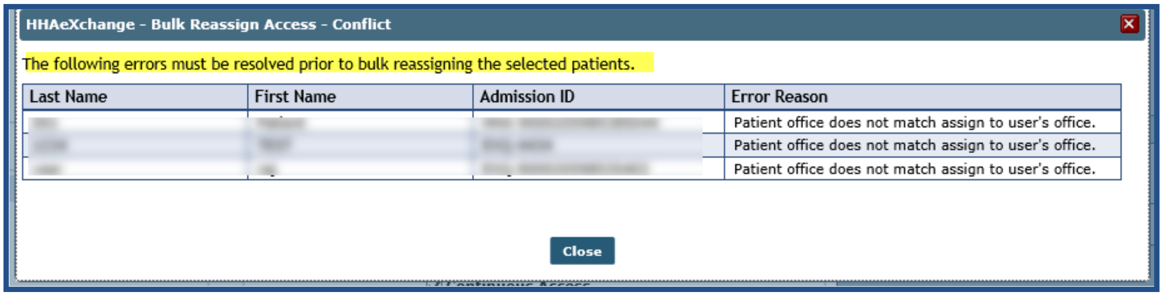


- Select the **Maintain Existing Access** checkbox to *disable* the **Access To** field and the **End Existing User's Access** checkbox, providing access to new users while retaining the existing user's access intact.

- Select the **Do Not Assign Access to New User** checkbox to end the existing user's access for the selected Patients. When selected, the fields in the *New User Details* section become unavailable and any included values are disregarded (i.e., not assigning access to a new user).

Conflict Screen

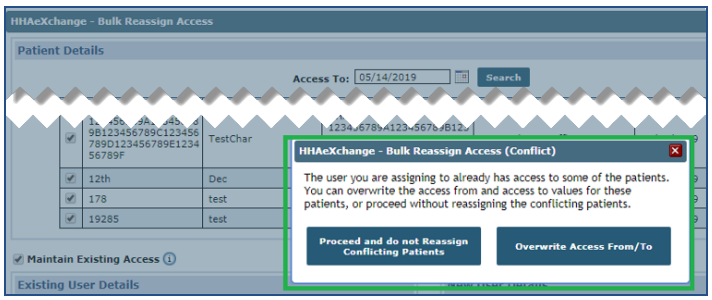
If any conflicts arise from the bulk reassignment, the *Bulk Reassign Access - Conflict* window opens alerting the user of errors found (as illustrated in the following image). These errors must be corrected (as per provided **Error Reason**) for the reassignment to be saved.



Bulk Reassign Access Conflict Window

Existing Patient Access Conflict

If a user already has Patient access upon a reassignment, then the popup (as illustrated in the following image) appears alerting the user of the conflict.

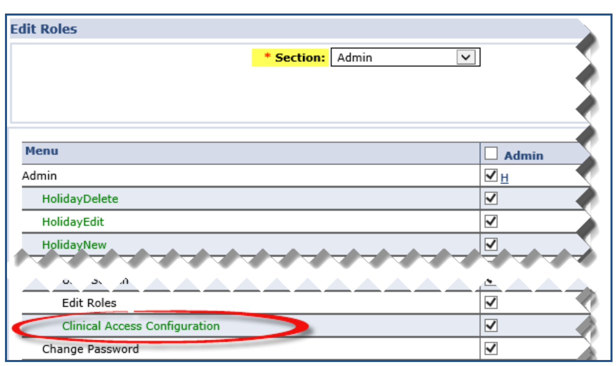


From here, users can either:

- Click the ***Proceed and do not Reassign Conflicting Patients*** button and any conflicting Patients are not reassigned to New Users; OR
- Click ***Overwrite Access From/To*** button to overwrite the reassignment.

Permissions: Clinical Access

Agency Admin Users must have the ***Clinical Access Configuration*** permission selected to restrict and/or assign Patient-specific access. To enable, navigate to ***Admin > User Management > Edit Roles***. Select *Admin* from the **Section** dropdown (as illustrated in the image below).



Admin Permissions

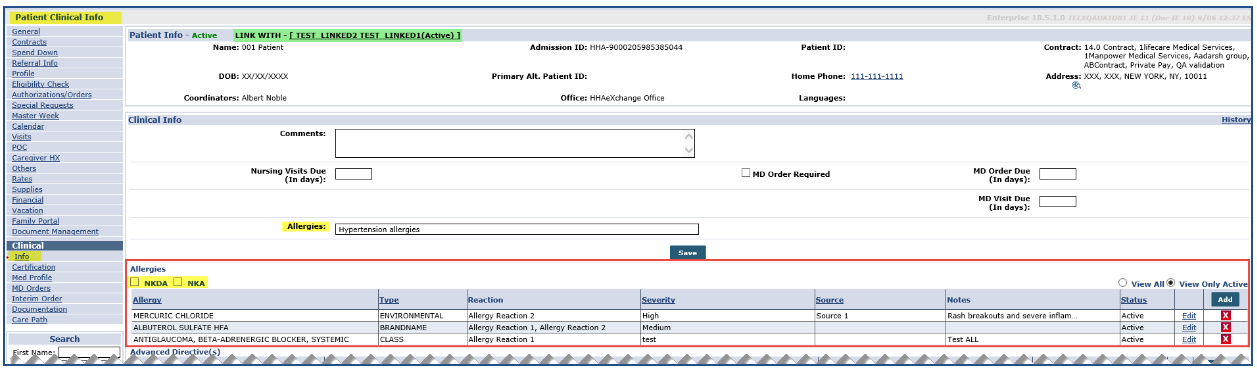
Note: *Restricting User Access to Patient Information and documentation **only** restricts access to the Patient Profile and Visit information. All other permissions are role-based and assigned to users according to their role.*

Structured Allergy Entry

The **Structured Allergy Entry** function has been created to improve data integrity. Providers can enter a Patient's allergy information (to include **Allergy Reaction**, **Allergy Severity**, and **Allergy Source**, created and managed via the Reference Table Management function) in the Patient's *Clinical Info* page (***Patient > Clinical Info***) where the allergy name can be selected from a system defined picklist.

The following image illustrates the *Allergies* section in the *Clinical Info* page. Although the free-text **Allergies** field (found throughout the system) remains available for current Providers, this function replaces the field, as a more reliable source. Refer to the ***Allergies Free-Text Field*** section for further details.

Furthermore, a **NKDA** (No Known Drug Allergies) and **NKA** (No Known Allergies) checkboxes are now available (above the *Allergies* grid) to indicate if the Patient has no allergies documented. Refer to the NKDA and NKA section for details.



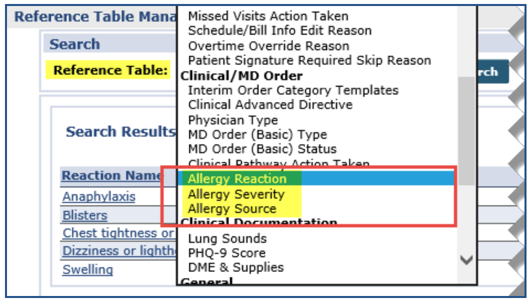
Patient Clinical Info Page: Allergies Section

This update applies to all pages where Patient Clinical Info and Medications are entered such as *New Patient*, *Patient Clinical Info*, *New Referral* and *Referral Clinical Info*. Allergy information is automatically transferred once a Referral is converted to a Patient.

Allergy information is also reflected in the *MD Orders* and *Interim Orders* pages as entered in the *Allergies* grid (in the above-mentioned pages). Note that only allergy names are displayed on these pages.

Reference Table Management

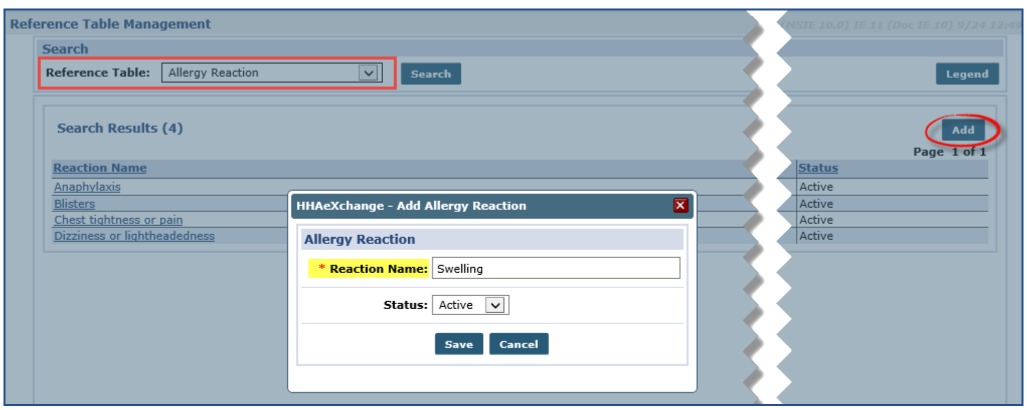
Values for **Allergy Reaction**, **Allergy Severity**, and **Allergy Source** are created and managed via the *Reference Table Management* functionality. To access, navigate to ***Admin > Reference Table Management*** and select the applicable Allergy reference table from the **Reference Table** field (as seen in the following image). Functionality for all three tables is the same and covered in the following sections.



Allergy Reference Tables

Allergy Reaction Reference Table

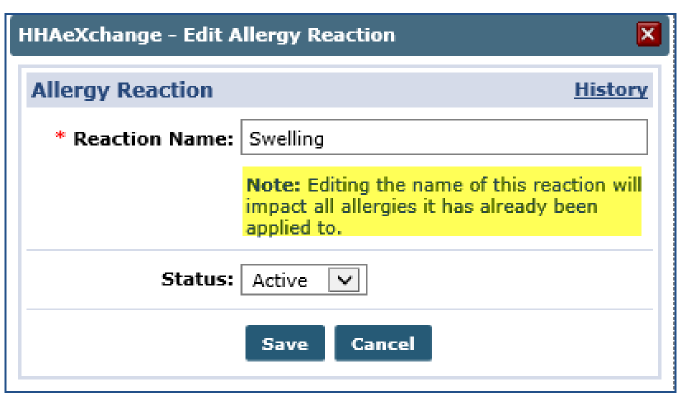
Use the **Allergy Reaction** Reference Table to add an allergy reaction. Click the ***Add*** button to access the *Add Allergy Reaction* window. Enter the **Reaction Name** (required) and ensure the **Status** is *Active*. Click ***Save***.



Reference Table: Allergy Reaction

Note: *Allergy Reactions can be added, edited, and inactivated but cannot be deleted.*

To edit an Allergy Reaction value, click on the Reaction Name (link) from the Results section. The *Edit Allergy Reaction* window opens. From here, the **Reaction Name** or **Status** can be changed. Click ***Save***.

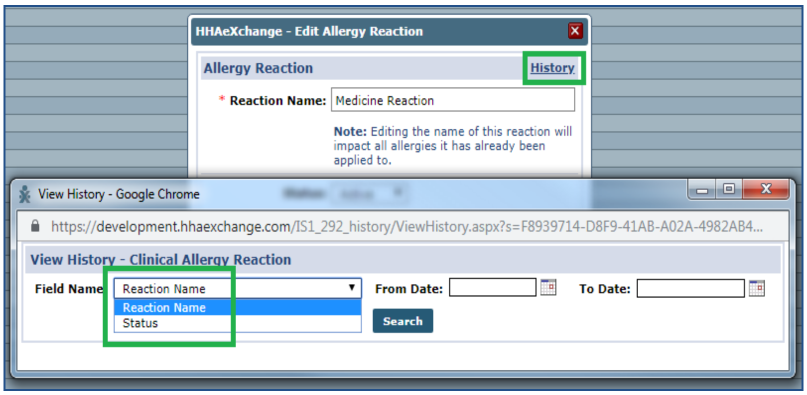


Editing Allergy Reaction

Note: *Editing the* ***Reaction Name*** *impacts any associated allergy.*

History for Allergy Reaction

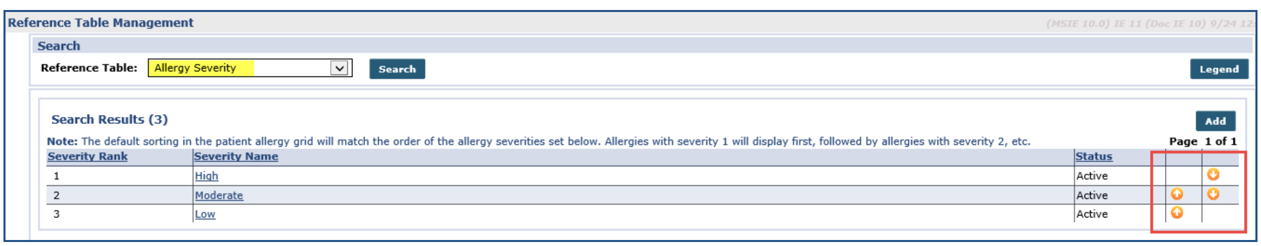
To view the history for edits made to Allergy Reactions, click on the History link to open the *View History - Clinical Allergy Reaction* pop up. From here, search the Reaction history by **Reaction Name** and/or **Status**.



Allergy Reaction Status

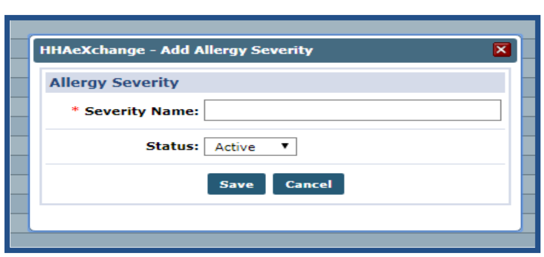
Allergy Severity Reference Table

Allergy Severity is added on the **Allergy Severity** Reference Table. As with the Allergy Reaction Table, items can be added and edited by not deleted. On this table, Allergy Severity can be ranked (by level of severity, from high to low) using the up and down arrows, as seen in the following image.



Allergy Severity Reference Table

Clicking the ***Add*** button opens the *Add Allergy Severity* window. Enter the required **Severity Name** field. Select *Active* for **Status** and click ***Save*** to finalize.

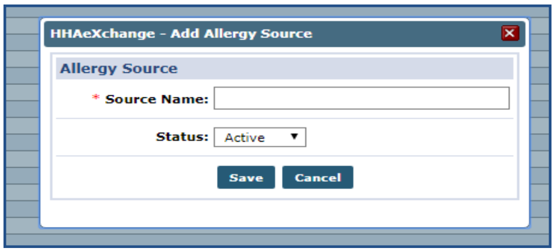


Add Allergy Severity

Note: *The same functionality (previously covered in the Allergy Reaction section) applies to this table when editing an Allergy Severity and when accessing the History (link in edit pop-up).*

Allergy Source Reference Table

As with the previous tables, an **Allergy Source** can be added and edited (but not deleted) in the Allergy Source Reference Table.

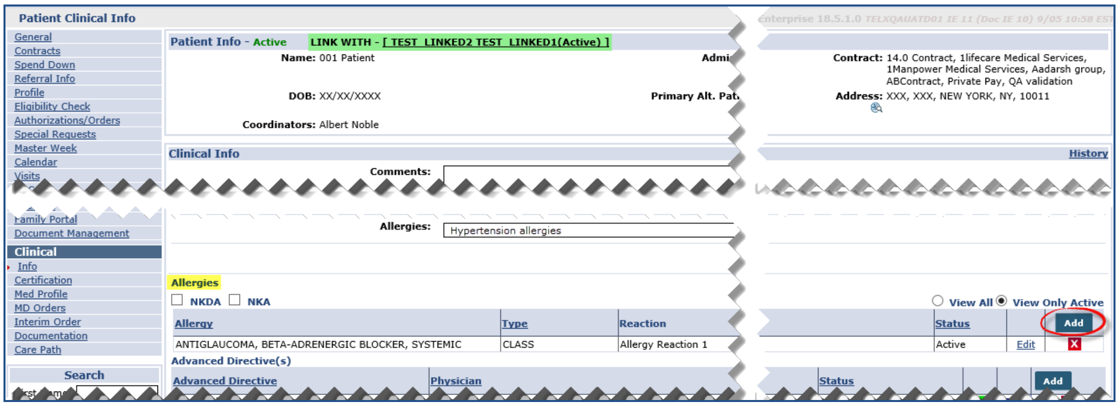


Add Allergy Source

Note: *The same functionality (previously covered in the Allergy Reaction section above) applies to this table when editing an Allergy Source and when accessing the History (link in edit pop-up).*

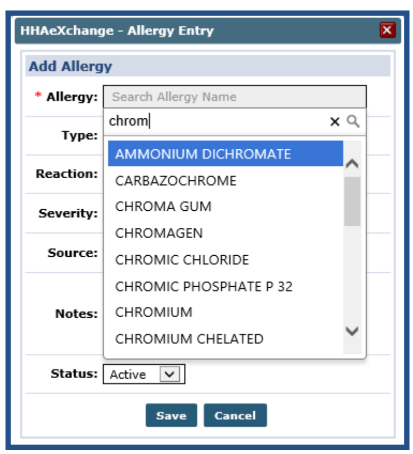
Applying Allergy Information to a Patient

Once values have been created in the Reference Tables, Allergy information can be added to a Patient's *Clinical Info* page (***Patient > Clinical Info***). Scroll to the *Allergies* section and click on the ***Add*** button (as seen in the following image.



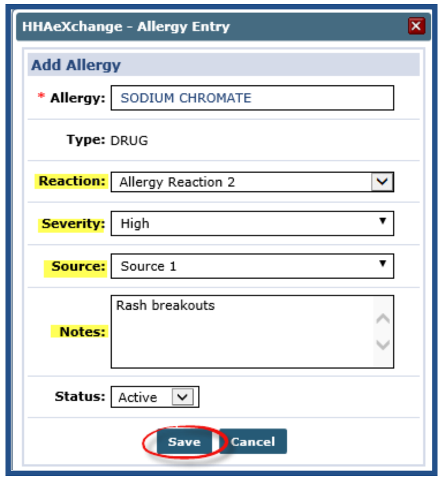
Patient Clinical Info: Allergies Section

The *Allergy Entry* window opens. Enter the allergen (e.g., medication) into the required **Allergy** field. Upon entering the first two characters, the system auto-generates an allergen picklist (as seen in the image below). Select the applicable allergen.



Health Allergen Pick List

The **Type** field auto-fills depending on the chosen Allergy field (e.g., *Drug*, *Environmental*, etc.). Complete the rest of the fields, as needed. In the following example, the **Reaction***, **Severity**, and **Source** have been selected according to the values created in the respective Reference Tables.

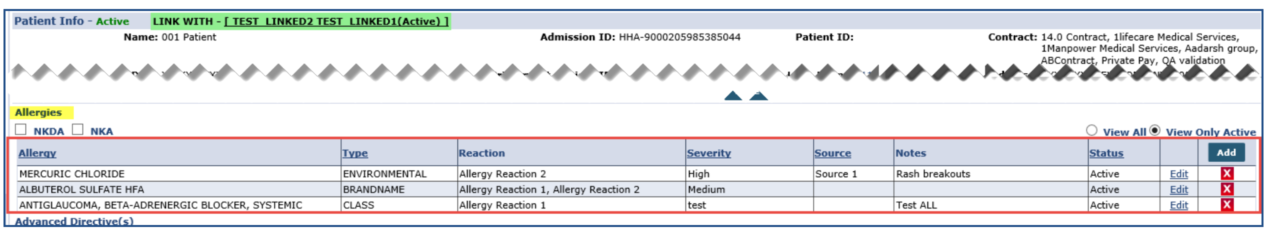


Adding an Allergy Entry

Enter **Notes** if applicable and click ***Save*** to finalize. Click ***OK*** when the system saves the Allergy information successfully.

****Note:** The **Reaction** field is multi-select; select all applicable reactions.*

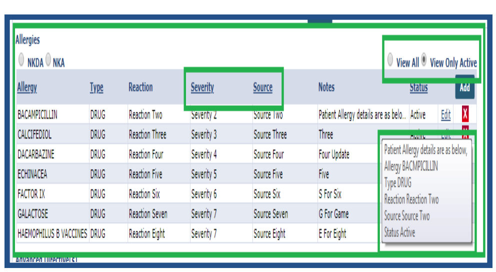
Once saved, the added Allergy appears under the *Allergies* section (as illustrated below). Each record displays the **Allergy**, **Type**, **Reaction**, **Severity**, **Source**, **Notes**, and **Status**. From here, records can be edited and deleted.



Added Allergies

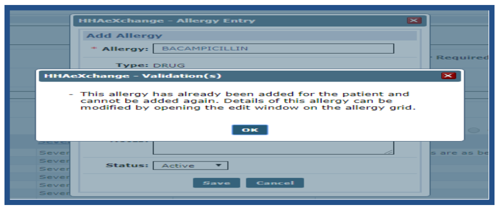
The **NKDA** (No Known Drug Allergies) and **NKA** (No Known Allergies) checkboxes are located above the grid. Once drug allergies are entered for a Patient, the system does not allow a user to select the **NKDA** checkbox. The same applies when selecting the **NKA** checkbox if the Patient has <u>*any*</u> allergy entered.

Hovering over the **Notes** provides a pop-up to display longer notes. Select the **View All** (*Active* and *Inactive* records) or **View Only Active** radio buttons to display desired information.



Duplicate Allergy Records

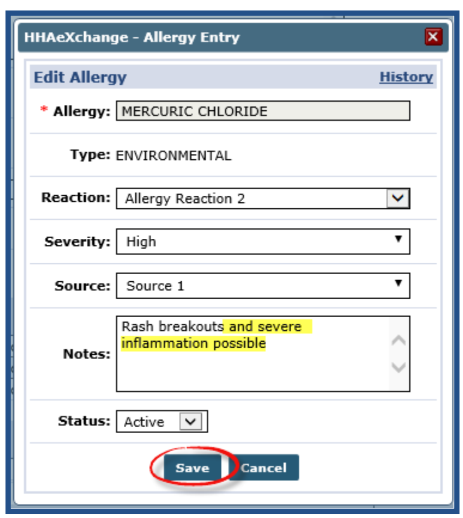
The system does not allow for duplicate Allergy information for the same Patient. When attempting to add an Allergy which has already been added, the system alerts with a Validation message (as illustrated in the image below). This validation applies to both *Active* and *Inactive* records. Inactive allergies can be activated, if needed.



Duplicate Error

Editing an Allergy Entry

To edit an Allergy Entry, click on the Edit link on the applicable Allergy record line. The *Allergy Entry* window opens. Note that the **Allergy** field cannot be changed; only the **Reaction**, **Severity**, **Source**, **Notes**, and **Status** fields are editable. Click ***Save*** once updated.

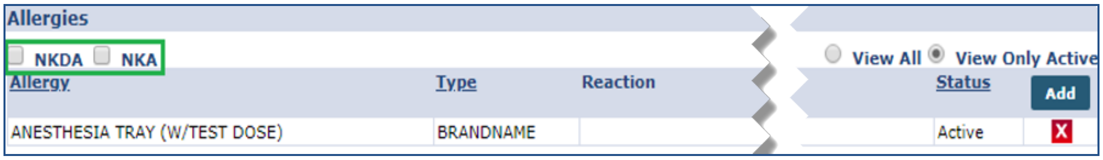


Editing an Allergy Entry

To view a history of changes to the Patient's Allergy record, click the History link (on the top-right).

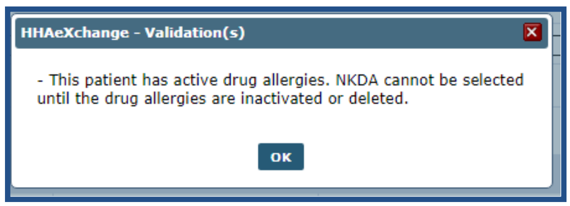
NKA and NKDA

As stated earlier, a **NKDA** (No Known Drug Allergies) and **NKA** (No Known Allergies) checkboxes are available (above the *Allergies* grid) to indicate if the Patient has no allergies documented. If the **NKDA** checkbox is selected, then no drug allergies can be entered for a Patient until deselected. If the **NKA** checkbox is selected, then *no* allergy can be entered until deselected.



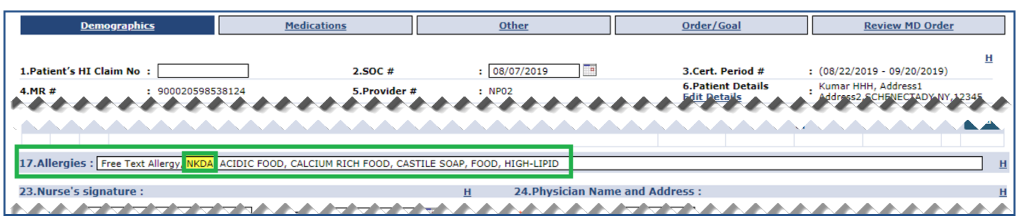
NKDA and NKA Checkboxes

Adding an Allergy when either of these checkboxes are selected, the system generates a validation error as seen in the image below.



NKDA Selected Validation

These selections also appear in Patients' MD Orders or Interim Orders in the Allergies free text field as illustrated below.

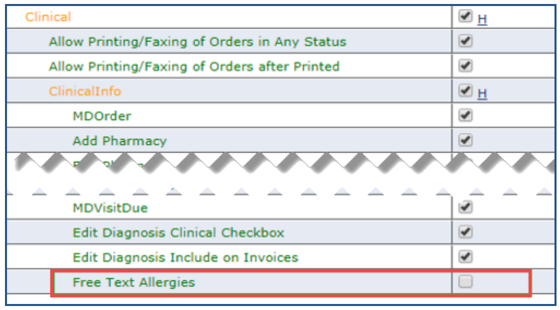


Patient MD Order: NKDA Selected for Patient

Permissions: Allergies Free-Text Field

The **Allergies** free-text field remains in the system for current Providers, as information has been captured in this field. If this field is enabled, users must have permissions to access the **Allergies** field throughout the applicable system pages. To grant role permission, navigate to ***Admin > User Management > Edit Roles***.

Select *Patient* from the **Section** field and applicable **Roles**. Scroll to locate and select **Free Text Allergies** checkbox (under the *Clinical Info* category), as illustrated in the image below. Click ***Save***.



Note: *The **Allergies** free-text field remains visible in the MD Orders and Interim Orders pages (regardless of permissions). This field is not available to new Providers.*

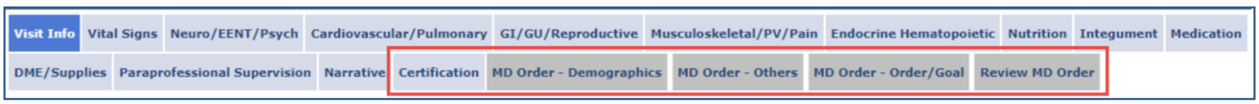
Integrated MD Orders

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).*

Additional MD Order Tabs via eDocs

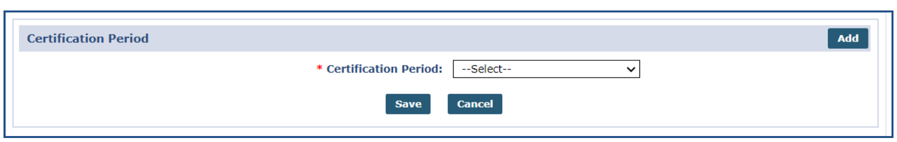
On the *eDoc* page (***Patient > Calendar > Visit Info***), the following five tabs are available to integrate newly entered information into an integrated MD Order: *Certification*, *MD Order-Demographics*, *MD Order-Others*, *MD Order-Order/Goal*, and *Review MD Order* (as seen in the image below).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



New eDoc MD Order Tabs

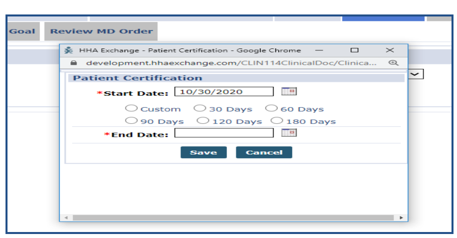
MD Order: Certification Period

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.



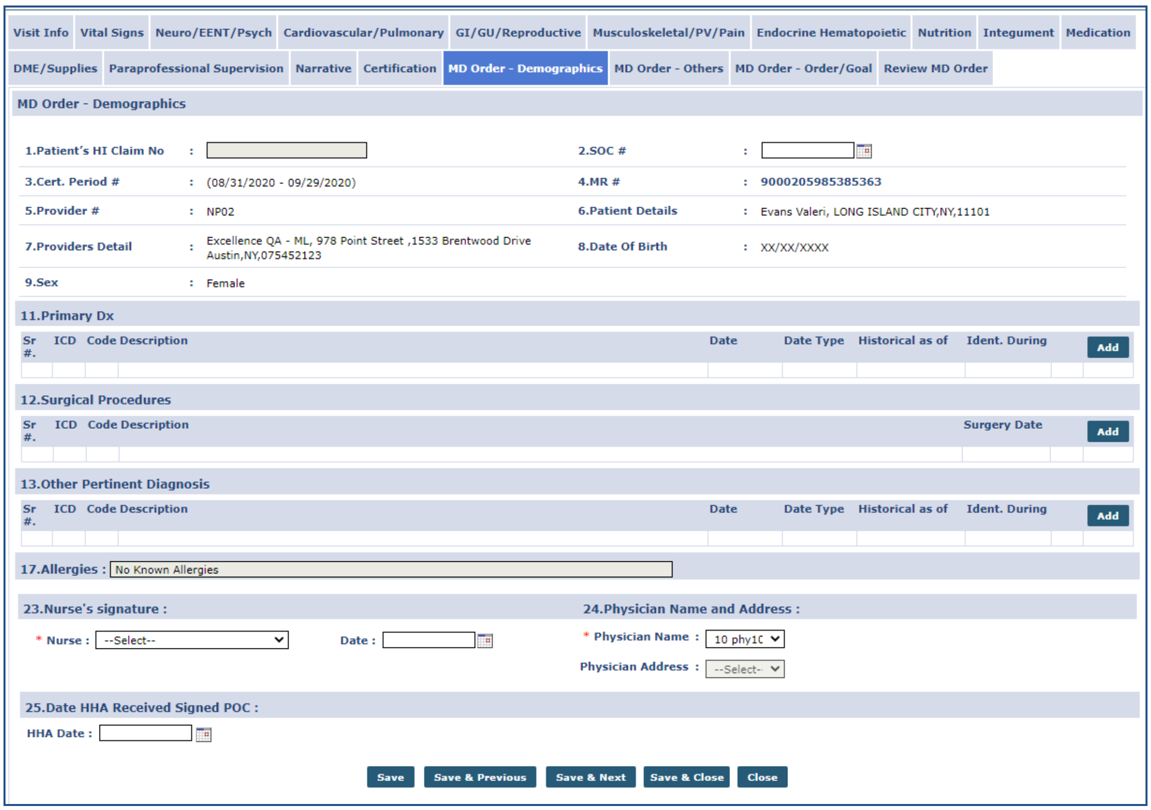
Entering a Patient Certification

Once saved, the **Certification Period** can be applied to an MD Order via the eDoc assessment. This Certification Period and the MD Order are then displayed in both the eDoc assessment as well as in the Patient Profile (***Patient > MD Orders***).

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

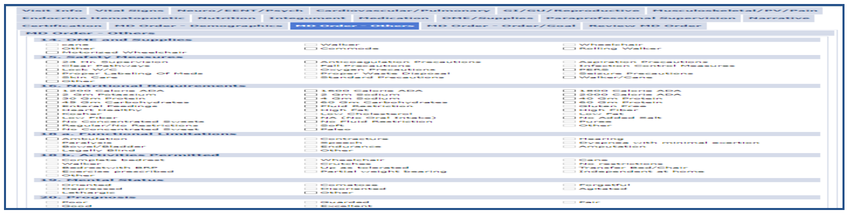
The *MD Order-Demographics* tab is available on the eDoc assessment (***Patient > Calendar > Visit Info***) as part of the Integrated MD Order feature. Nurses can enter information as needed via the eDoc assessment functionality. Details on this tab are pulled in from the Patient Profile when the integrated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



eDocs: MD Order-Demographics Tab

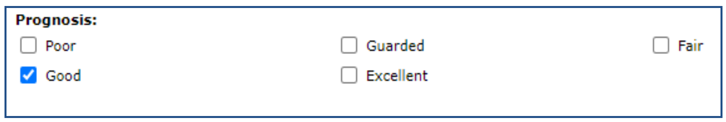
MD Order–Others Tab

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.



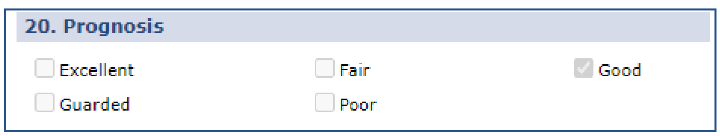
eDocs: MD Order- Others Tab

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

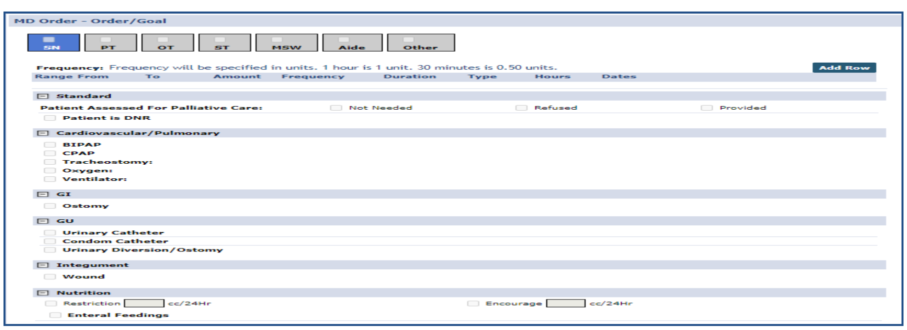
On the MD Order, the fields are all disabled because the *Prognosis* section is updated via the eDoc assessment.



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).

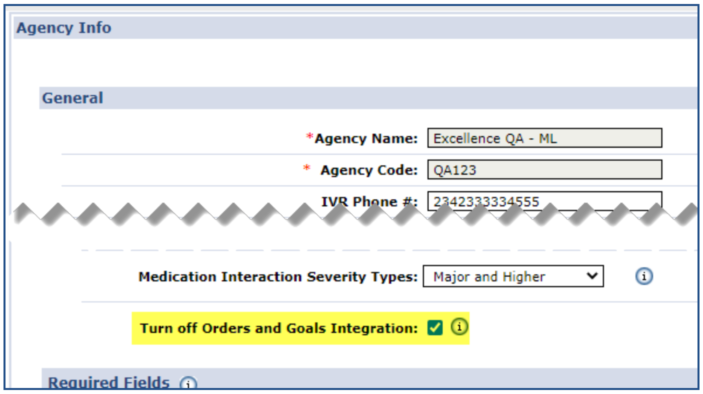


eDocs: MD Order-Order/Goal Tab

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.*

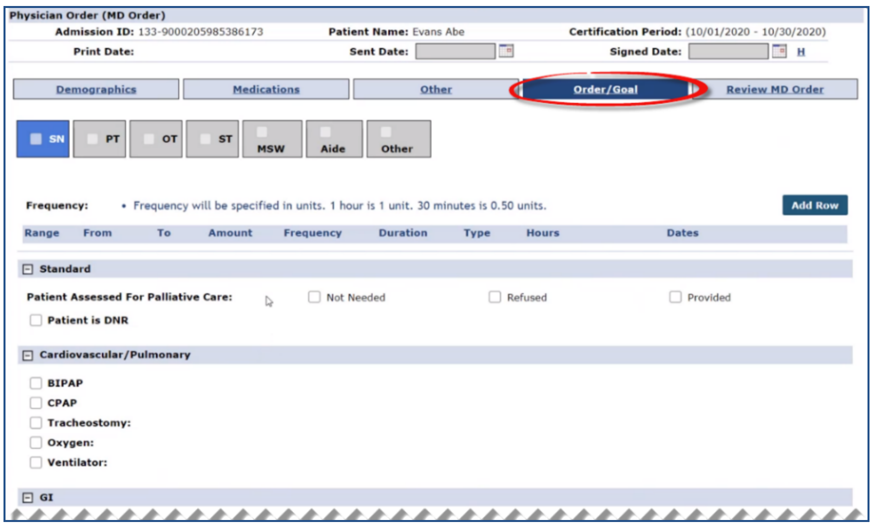
Integrated MD Orders and Goals Configuration

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

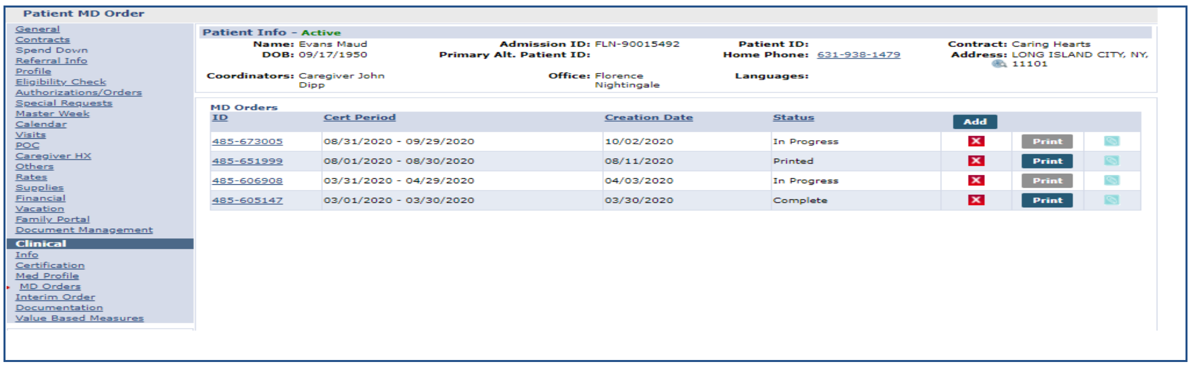
Integration of Medications on the MD Order

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.

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.



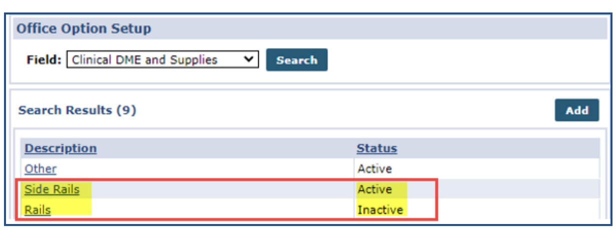
Patient MD Order Page

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 image below, "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