

# Clinical 2011 User Manual



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# **Welcome to SOAPware**

## Welcome to SOAPware

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Thank you for choosing SOAPware as your EMR.

SOAPware can streamline nearly every facet in a clinical practice. As with any new piece of equipment, there is a learning curve; we strive to make the users' learning experience as simple and straightforward as possible.

Before entering actual patient information into SOAPware and using the software “live” in a clinical setting, implementation and setup processes need to be planned and completed. SOAPware's EMR Coaches are available to assist clinicians and other implementation leaders in the clinic environment to successfully complete this critically important process.

### Meaningful Use Certified

SOAPware 2011+ is Meaningful Use Certified (Certification Number: CC-1112-565910-1). In addition, SOAPware users are able to qualify for up to \$44,000-\$64,000 in Medicare/Medicaid bonuses between 2011 and 2015.

[Please click here for the ONC-ATCB Certification Details.](#)

## SOAPware Resources

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At SOAPware, we believe that empowering our users is the key to success. We've created three categories to provide comprehensive information and support in a variety of contexts designed to fit the users' learning styles and busy schedules.

### Training

We offer a number of training options, including our SOAPware Learning Center (SLC). The SOAPware SLC contains a comprehensive series of self-teach and guided learning modules, instructional and interactive videos, and pre-recorded webinar sessions. To contact the SOAPware Training Department, [please click here to complete the online contact form](#).

### Support

SOAPware Support Team services offer a wide range of experience ranging from providing advice on new hardware to troubleshooting software issues.

A user can submit a ticket to our Technical Support Team [here](#).

A user can also schedule an appointment with our Technical Support department by [clicking here](#).

### Online Communities

Join a SOAPware-hosted User Forum, collaborate with peers; get the latest industry news and updates from SOAPware; share tips; and give us feedback and suggestions to help improve our product and services. For more information, visit: <http://forums.mysoapware.com/index.php>

### SOAPware Meaningful Use Resources

- \* [Meaningful Use Road Map](#)
- \* Step 1: Register for Meaningful Use
  - \* [Registration Walkthrough Video](#)
  - \* [Registration Walkthrough PDF](#)
- \* Meaningful Use Videos
  - \* [SOAPware 2011 New Features](#)
- \* [ONC-ATCB Certification Details](#)
- \* [Standards and Certification Info from HIT](#)

- \* [Randall Oates, MD, Blog](#)
- \* [SOAPware Community Forums](#)



## Backing Up SOAPware Data

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The SOAPware DataManager is a database utility designed for the Postgres database. It uses existing, tried-and-true utilities provided by Postgres and Windows, but is wrapped up in a simple, easy-to-use interface.

The DataManager allows the user to create and schedule backups, schedule maintenance tasks and perform database restores. Before going live using SOAPware in a production environment, it is important to do a restore test on a different PC/server. Establish a schedule to perform regular test restores in the future and do them anytime there are changes in the system configurations.

**SOAPware HIGHLY recommends that all users use Data Manager to create regular backups.**

### Installing Data Manager

To install Data Manager, see the link here: [Installing Data Manager](#).

### Data Manager Changes

The SOAPware Database Service is shut down during a backup - all users must be out of SOAPware before making a backup.

If a user previously scheduled a backup with any version **before** 2010, this scheduled backup will NO LONGER WORK with 2011 Data Manager. A user needs to create a new scheduled backup.

### Start the SOAPware Data Manager



To Start the SOAPware DataManager, Click Start, All Programs, SOAPware, SOAPware DataManager.

If users are running on Windows Vista or 7, users will need to Right-Click and "Run as administrator."

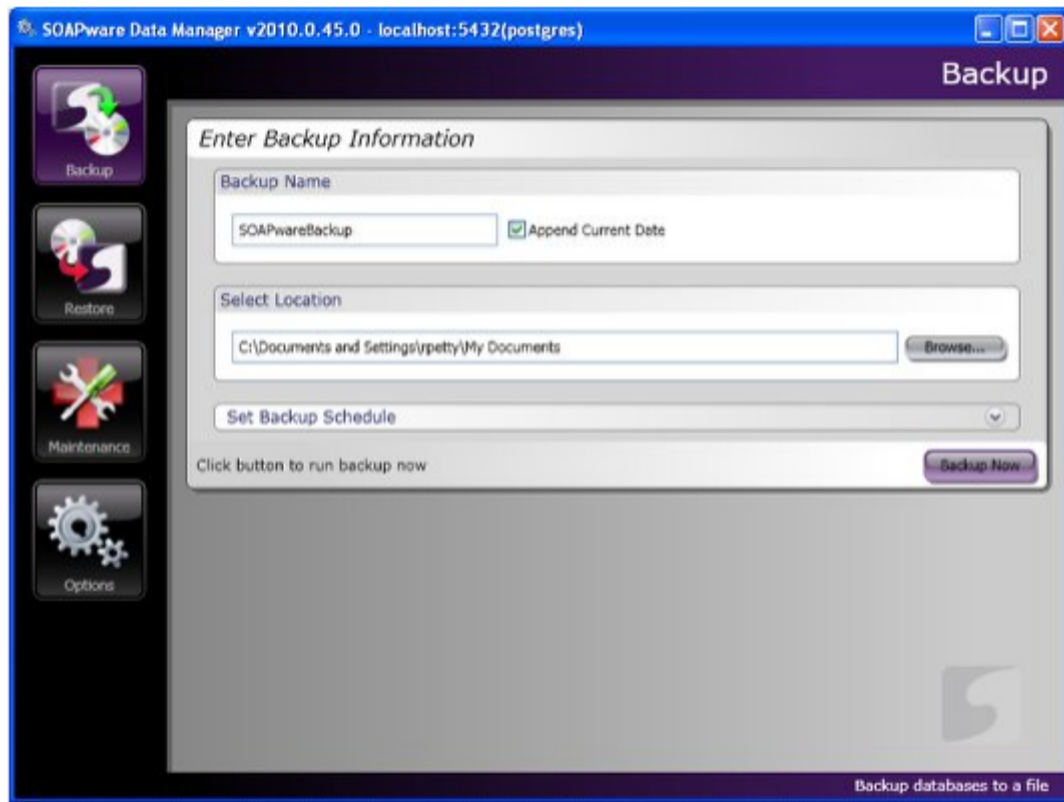


When a user starts DataManager, the user must login with the database administrator password. This defaults to the postgres user account on the database. (This is the second set of passwords created during the SOAPware Data Server install).

NOTE: The database administration password is NOT the same as the SOAPware Administration password. The database administration account only accesses the Postgres database.

Only use the Advanced section if the server, port, or database administration user name, is different than the default install.

- \* Server: Host name or IP address where database is running. Defaults to localhost.
- \* Port: Port number where database is listening. Defaults to port 5432.
- \* User Name: The administration user on the database. User must have administration privileges. Defaults to postgres.



The backup routine creates a copy of the user's data folder. It contains all the user, tablespace, table and data information needed to restore the user's database completely.

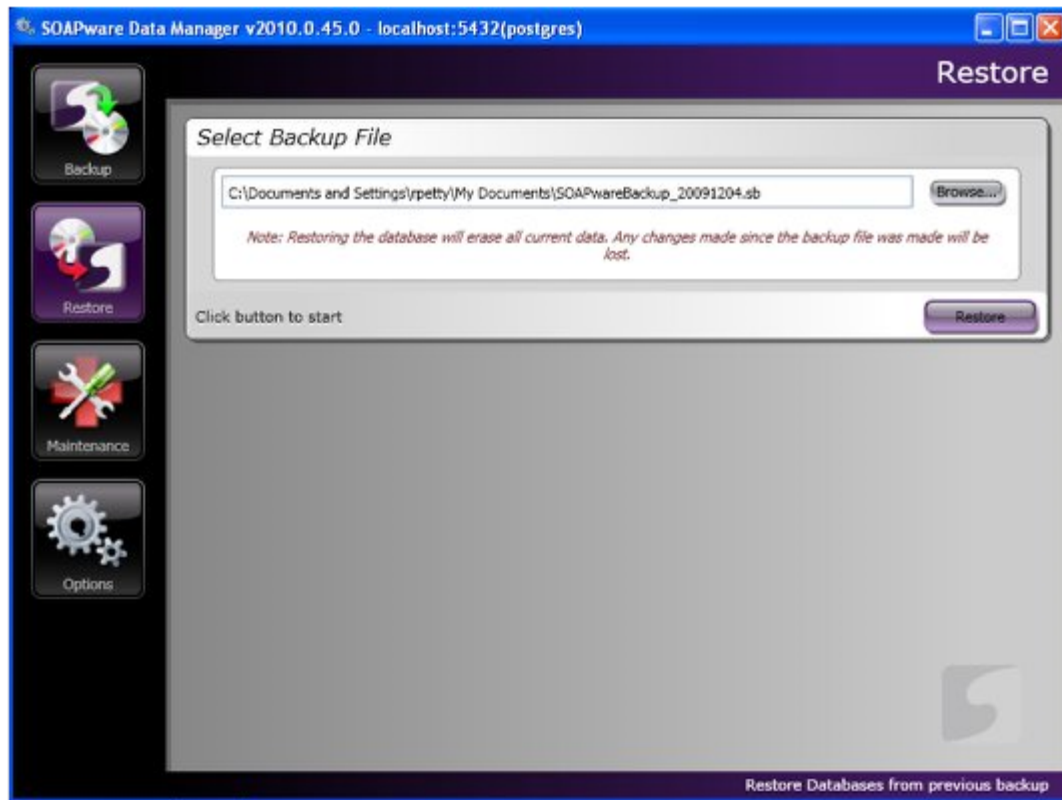
Backup file sizes can range from about 50MB to many Gigabytes, depending on database size and compression options.

It can take from 20 minutes to several hours for a backup to complete. SOAPware cannot be used while the backup is running. Please plan to schedule backups to run nightly for the best results.

- \* **Backup Name:** Users should use any name which is meaningful, for a backup name.
- \* **Append Current Date:** Will attach a date stamp of when the backup was run. If checked, new backup files will be created each day creating multiple backups. This helps ensure the user's data, but a user must also delete old backup files every so often to prevent the backups from taking all the space on the drive. If this is not checked, the backup will overwrite the last backup each time.
- \* **Select Location:** Users should choose the folder where the backup file to be placed.
- \* **Set Backup Schedule:** This header is collapsible. Click it to view or hide scheduling options. See the Scheduling section below for more details on setting a backup schedule.
- \* **Backup Now Button:** Click this button to run a backup using the settings on this tab.

Note: A backup can be canceled. It will delete the current backup file and a user's database is not affected. If a backup is canceled, go to Start > Programs > PostgreSQL 8.x, and Click Start Service.

## Restore



The DataManager can take a previously made backup file and restore the database to the exact state as when the backup is made.

Note: After the restore is completed, any user passwords or preferences changed since the backup will be reset to previous state.

- \* Select Backup File: Choose the backup file created by the DataManager to run a restore.
- \* Restore Button: Click this button to start the restore.

If restoring a compressed backup file, the DataManager needs to decompress the backup to the PostgreSQL data directory. The data folder can take as much as seven times the compressed file size needed in hard drive space. For example, a 3GB compressed backup may need an extra 20GB of hard drive space to run the recovery.

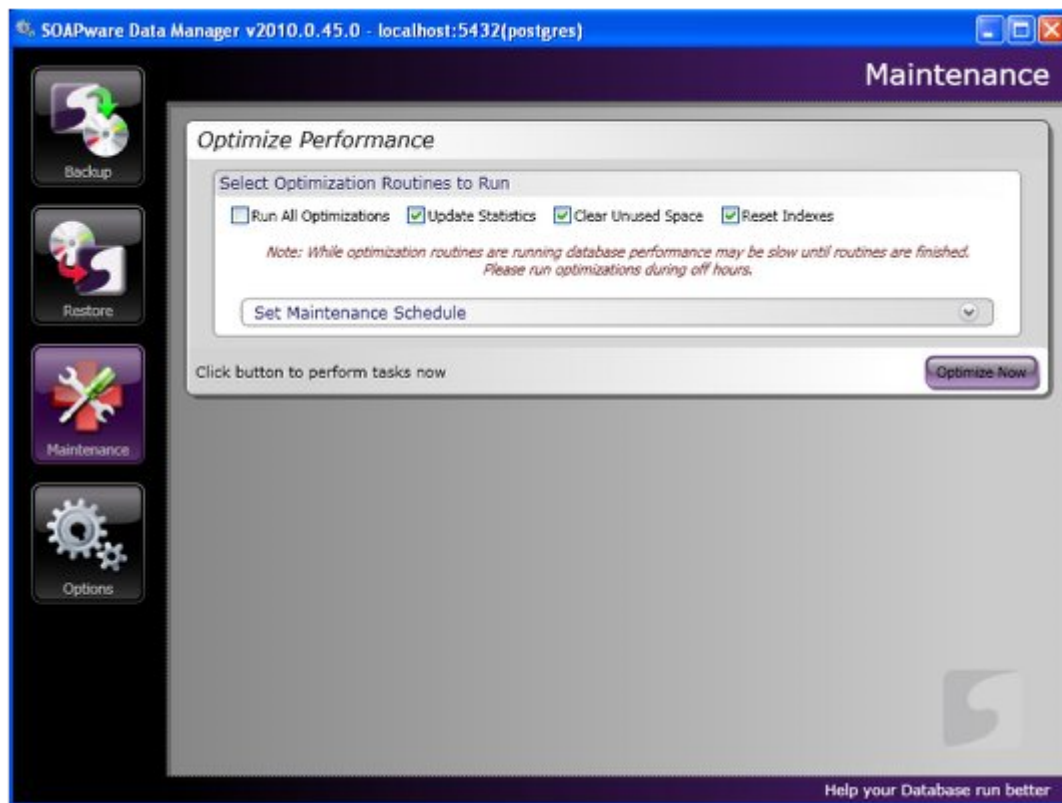
If a restore is tried and there is not enough room to decompresses the file, the recovery will fail and must be restarted. Simply make more room, or re-install the SOAPware PostgreSQL Data Server to another drive with more space and restore to it.

Note: Users must wait 10 minutes between creating a backup and running a restore in order to clear out the connections.

Warning: Running a restore will replace all the data and table structures of a user's database. The old database will be deleted.

The process cannot be canceled.

## Maintenance



Databases need to be optimized and cleaned up routinely for maximum performance. Higher traffic databases should be optimized more often, sometimes daily. Lower traffic databases may only need to be optimized once a week or month.

Optimizations may take from 30 minutes to several hours to complete.

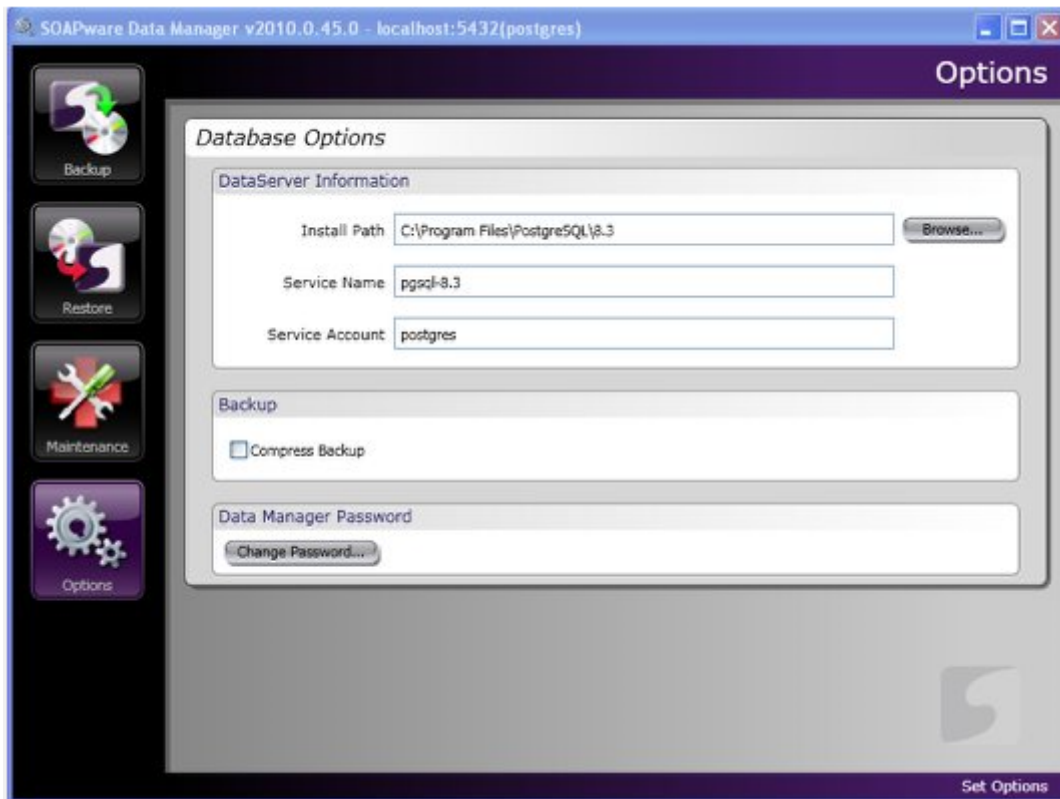
- \* Run All Optimizations: Perform each optimization. (Recommended)
- \* Update Statistics: Resets all table statistics, row counts, etc.
- \* Clear Unused Space: Useful after many deletes to reclaim space left behind.
- \* Reset Indexes: Refreshes table indexes to help data retrieval.
- \* Set Maintenance Schedule: This header is collapsible. Click it to view or hide scheduling

options. See the Scheduling section for more details on setting a maintenance schedule.

\* Optimize Now Button: Click button to perform selected optimizations.

Note: Running optimizations may degrade database performance. We recommend setting a Maintenance schedule to run at night or weekends when database traffic is low.

## Options



\* Database Install Path: The DataManager uses Postgres utilities for backup and restore. This path should not be changed unless the Postgres install path is different than listed.

\* Service Name: The service name is the name of the SOAPware PostgreSQL Data Server service. Typically, this will be pgsql-8.3

Go to Start > Programs > PostgreSQL 8.x, a user will see either PostgreSQL 8.3 or PostgreSQL 8.2. The service name will either be pgsql-8.3 or pgsql-8.2 depending on which version a user has.

\* Service Account: This is the windows user that starts the SOAPware PostgreSQL Data Server after the backup is complete. This should always be postgres.

\* Compress Backup: This option compresses the backup file as it is being written. Use this option to keep file sizes at a minimum.

\* Data Manager Password: Use this to change the database administration password.

Note: The database administration password is NOT the same as the SOAPware Administration password. The database administration account only accesses the Postgres database.

## Scheduling Backups and Maintenance

The DataManager provides an easy-to-use interface to create a Windows Task scheduled event to run a user's backup and maintenance routines. Simply setup a backup or maintenance task as outlined above, then choose the schedule frequency. When a user saves the schedule, a user's task will run at that time.

For advanced users, maintain existing tasks using the Windows Task scheduler. For more information, start here at the [Microsoft Task Knowledge Base](#).

### Create a New Scheduled Task

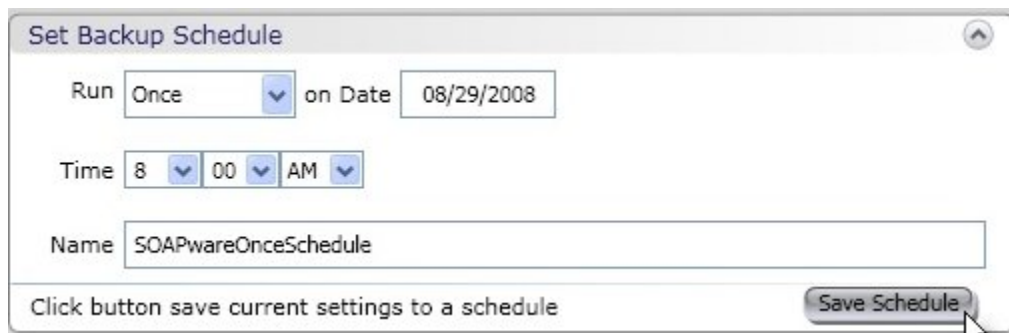
After a user sets the backup or maintenance information, expand the schedule tab by Clicking on the down arrow icon.

Under the Run dropdown, a user can choose the schedule type from Once, Daily, Weekly or Monthly. Different options will appear depending on what type of schedule is selected.

Set the time for the task to run. Set the task to run at a time when there is no database activity.

Name the schedule so it will be unique in the Windows Task Manager. If there is already a task with the same name, it will ask if a user would like to overwrite the existing task.

### Run Once



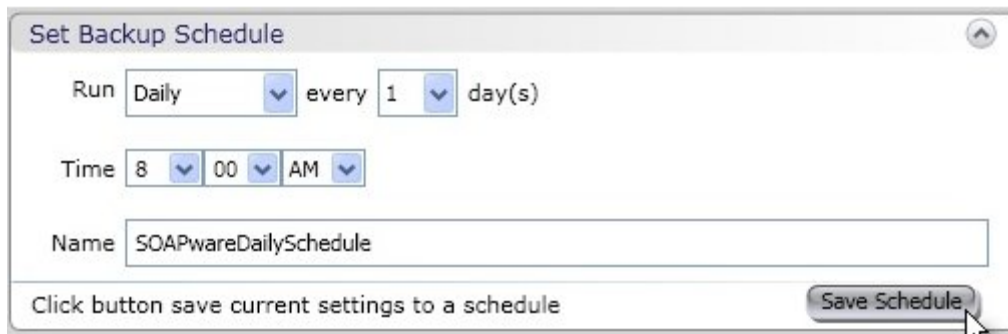
The screenshot shows a dialog box titled "Set Backup Schedule". It contains the following fields and controls:

- Run:** A dropdown menu set to "Once".
- on Date:** A text box containing "08/29/2008".
- Time:** Three dropdown menus set to "8", "00", and "AM".
- Name:** A text box containing "SOAPwareOnceSchedule".
- Footer:** A message "Click button save current settings to a schedule" and a "Save Schedule" button.

This option will run the task only once on the specified day and time.



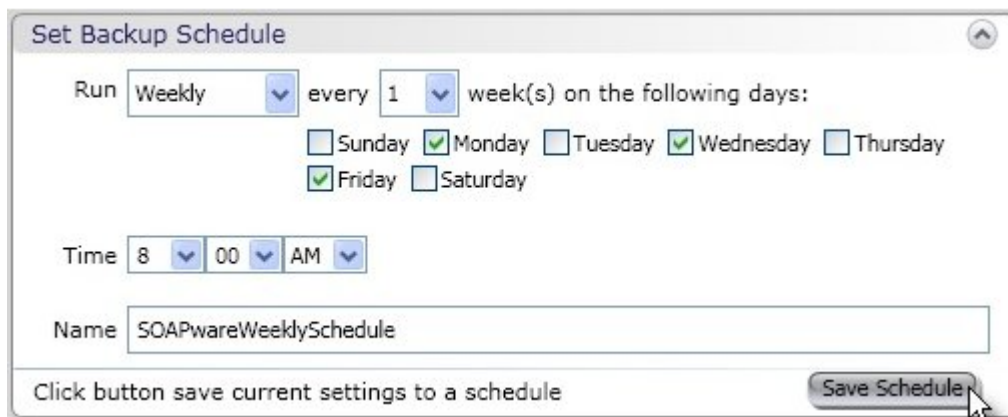
## Run Daily



The 'Set Backup Schedule' dialog box is shown with the 'Run' dropdown set to 'Daily'. The frequency is set to 'every 1 day(s)'. The time is set to '8:00 AM'. The name field contains 'SOAPwareDailySchedule'. At the bottom, there is a 'Save Schedule' button and a note: 'Click button save current settings to a schedule'.

This option will run the task daily. Auser can choose to skip a number of days.

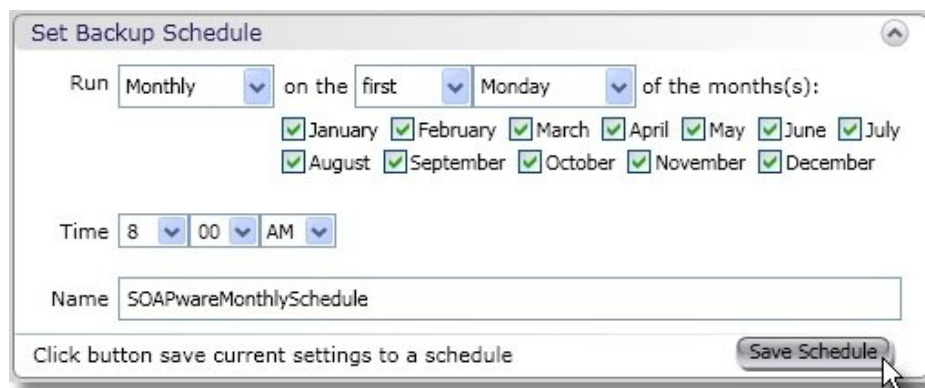
## Run Weekly



The 'Set Backup Schedule' dialog box is shown with the 'Run' dropdown set to 'Weekly'. The frequency is set to 'every 1 week(s) on the following days:'. The days of the week are listed with checkboxes: Sunday (unchecked), Monday (checked), Tuesday (unchecked), Wednesday (checked), Thursday (unchecked), Friday (checked), and Saturday (unchecked). The time is set to '8:00 AM'. The name field contains 'SOAPwareWeeklySchedule'. At the bottom, there is a 'Save Schedule' button and a note: 'Click button save current settings to a schedule'.

Running a task weekly allows a user to choose which days of the week to run. Auser may also skip weeks.

## Run Monthly



The 'Set Backup Schedule' dialog box is shown with the 'Run' dropdown set to 'Monthly'. The frequency is set to 'on the first Monday of the months(s):'. The months of the year are listed with checkboxes: January (checked), February (checked), March (checked), April (checked), May (checked), June (checked), July (checked), August (checked), September (checked), October (checked), November (checked), and December (checked). The time is set to '8:00 AM'. The name field contains 'SOAPwareMonthlySchedule'. At the bottom, there is a 'Save Schedule' button and a note: 'Click button save current settings to a schedule'.

AMonthly task allows a user to set the task to run once a month on a certain day. Auser may check the months to run the task.



## Change Existing Schedule

To change an existing schedule, a user would simply setup a new schedule with any new backup or maintenance or schedule data, and give the same schedule name as an existing task. This will overwrite the existing task with the new information.

To find a list of a user's existing schedules, look in the Windows Task Scheduler for the tasks. Go to the Windows Start menu, then open the Control Panel. Open Scheduled Tasks and it will list all the current tasks. A user may edit these directly to change the schedule, but to change the backup or maintenance parameters, a user must use the DataManager and overwrite one of the tasks.

## Delete Existing Schedule

To delete an existing schedule, open the Scheduled Tasks control panel as mentioned above. Right click on the task and choose Delete.

## Data Manager Log Files

Log files can give the user details on how tasks are running. They provide information about what tables were used and any warnings or errors which may have occurred. Each time the DataManager is used, either in the GUI or in a scheduled task, it will create a log file of the events.

Find the logs where DataManager is installed at: %DataManager Install Path%\Logs

The Logs directory will only keep the last 10 log files so there is no need to clean out this directory or to worry about it filling up. If a user plans to keep a log file for support or other needs, be sure to move it out of this directory, or it could be deleted as more log files are created.

## SOAPwareXchangeHL7 and SOAPwareXchange

Users who are running either the SOAPwareXchangeHL7 or SOAPwareXchange, must NOT be running when a backup via Data Manager is running. If a user has a scheduled backup set, then both Xchange and XchangeHL7 must be not be running. This can be accomplished by using the [SOAPwareXchangeHL7 & SOAPwareXchange Command Line](#) article to both stop and start around a Data Manager scheduled backup.

# 2011 Terminology

### Glossary Terms (A-C)

**About SOAPware** - A menu command under the Help menu that displays information regarding the version of SOAPware that is running.

**Active Background** - Highlighted area showing the cursor is placed in a field that is active and data can now be inserted.

**Active Problems field** - Located in the Summary chart section this field is for documenting all medical problems for which the patient is currently being treated.

**Active Provider** - Located under the SOAPware menu and displays a dialog box of all providers that have a SOAPware license within the practice. The name of the Active also displays at the top of the SOAPware screen.

**Addendum** - Text that is added to a document after it has been finalized.

**Alerts** - Pop-ups or reminders. An automated warning system such as clinical alerts, preventive health maintenance, medication interactions etc.

**Ambulatory Care** - Medical care provided on an outpatient basis.

**AMP** - An acronym for "Amping up your documentation" suggesting that users begin entering structured data within the Assessment, Medications, and Plan fields.

**Allergies field** - Located in the Summary chart section this field is for documenting the patient's allergies.

**All Refill Requests** - A queue under the View menu that houses all pending electronic refill requests for the Active Provider.

**ARRA** - American Recovery and Reinvestment Act of 2009

**Archiver** - Located under the Chart menu and is a utility that allows the user to remove inactive patient charts from the Chart Rack.

**Assessment field** - Located in the SOAPnote chart section this field is to document the patient's diagnosis related to that day's visit.

**Available Document Designs** - An area that lists all available print reports. This area can either be docked, accessed from the Docuainers menu by clicking on Print, or by clicking on the Print button on the common tool bar.

**Billing Statement chart section** - An area where all Billing Statements are created and stored for the patient.

**Bubble Bar** - An optional toolbar located at the bottom of the SOAPware screen that allows the user to access other workspaces within SOAPware. The Bubble Bar can be displayed by selecting it from the View menu.

**CCD** - Continuity of Care Document

**CCR (Continuity of Care Records)** - A standardized electronic snapshot of a patient's medical record, demographic and insurance. Data is transmitted in XML enabling a patient's CCR to be shared among any number of providers.

**CCR chart section** - the area in which CCR records will be stored.

**Change Password** - Located under the Tools menu this allows the user to change their SOAPware password.

**Chart Layouts** - Located under the View menu this allows users to create individual chart layouts consisting of tabbed chart sections.

**Chart Navigator** - Located under the Chart menu (or as a Docked Tab) this area houses and allows the user to access all the patients chart sections.

**Chart Rack** - Located under the Chart menu this area houses all patient charts and allows the user to create new charts.

**Chart Section** - Specific areas in the chart to document the patient's medical information. For example: Radiology, SOAPnotes, Demographics etc.

**Chart Section Editor** - An area located under the Tools menu that allows for the creation of new Chart Sections and setting Default Docuplates.

**Clinical Decision Support** - CMS provides the following definition: HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

**Clinical Decision Support Rule**- An automated, electronic rule based on data elements included in the problem list, medication list, demographics and lab test results.

**Clinical Summaries**- A summary of each office visit to be given to the patient within 3 business days of visit. CMS provides the following definition for Meaningful Use Clinical Summaries: An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit, and symptoms.

**CMS** - Centers for Medicare& Medicaid Services.

**CMS Quality Reporting Dashboard**- A tool within SOAPware used to export Quality Measures.

**Clinical Alerts Manager** - Located under the Tools menu, this is an area that allows the user to set prompts or reminders when a defined value is found in a specific location. For example, a Diabetes diagnosis in the Active Problems field or a certain CPT.

**Contacts** - located under the Tools menu, allows users to keep a master list of all referring providers.

**Correspondence In chart section** - An area where correspondence received from outside the clinic can be stored.

**Correspondence Out chart section** - An area where correspondence sent out of the clinic, such as consult letters or work excuses, can be stored.

**CPOE Computerized Provider Order Entry** - CPOE refers to the act of a clinician entering an order for patient services into an information system.

**CPT Current Procedural Terminology** - The purpose of CPT codes is to provide a uniform language that accurately describes medical, surgical, and diagnostic services.

**Custom Demographic Titles** - An area that allows the user to define custom patient information such as, emergency contact or guardian information.

## Glossary Terms (D-H)

**Data conversion** - The conversion of data from one software to another.

**Data Explorer** - Located under the SOAPware menu and is a workspace that allows for specific database searches to be created and performed. For example, all patients with the diagnosis of diabetes.

**Demographics** - A chart section that contains all basic patient demographic information.

**Denominator** - The number below the line in a common fraction; a divisor. A figure representing the total population in terms of which statistical values are expressed.

**Docked Tabs** - Commonly used tools that can be docked to any of the four edges of the SOAPware screen, float or remain locked open.

**Document Demographics** - Information about the document including a date and time stamp.

**Document Importer** - A workspace that allows the user to drag and drop documents into a patient's chart section without the need to open each individual chart.

**Document Management** - Allows the clinic to store the patient's X-rays, paper reports, Lab reports etc. Document Management includes scanning, dragging and dropping directly into the patient's chart and Document Importer.

**Docutainers** - A hybrid word for Documentation Containers. Most chart sections within SOAPware are docutainers due to the fact that they can contain not only documents but PDFs, video files, images, etc.

**Docuplates** - A hybrid word for Documentation Templates. Docuplates can be created for almost any chart section and consist of pre-built data entry to allow for speedier documentation.

**Document Designer** - An area that allows for documents to be created for printing, faxing or storing in the patient's chart.

**Document History** - A history of when a document was created and updated. Also shows by which user and on what computer the document was updated.

**Drug Interactions** - A feature of the Rx manager that can run an interaction check between the contents of the Active Problems, Medication and Allergy fields in the Summary against the medications that are being prescribed within the SOAPnote.

**EHR** - Electronic Health Record

**Eligibility** - Patient insurance eligibility data which can be checked either individually or in batches.

**EM Coder** - Located under the Tools menu, the EM Coder is the utility that helps the provider determine the level of service to be charged based on documentation.

**Emergency Access Role** - A role that is set up in Security that allows a user access to all areas within SOAPware in an emergency situation.

**Encryption** - Process of converting messages or data into a form that cannot be read without decrypting or deciphering it.

**EP** - Eligible Provider or Eligible Professional.

**e-Prescribing** - Prescribing medication through an automated data-entry process and

transmitting the information to participating pharmacies.

**Ethnicity**- Refers to selected cultural characteristics used to classify people into groups or categories considered to be significantly different from others such as American Indian, Latinos, Chinese etc.

**Exclusion**- In terms of Meaningful Use an exclusion refers to an EP excluding a particular Meaningful Use objective because it is not applicable to the EP.

**Export** - Located under the Chart menu and is a tool used to export a SOAPware patient chart in a format that will allow the chart to be imported into another SOAPware database.

**Exit SOAPware** - Located under the SOAPware menu this will allow the user to exit the SOAPware program.

**Face to Face encounter**- An encounter type that designates the patient had a face to face encounter (office visit) with the provider.

**Facilities** - All clinics that are set up under the Scheduler workspace.

**Family History field** - Located in the Summary chart section this field is for documenting the patient's medical family history.

**Field Header** - The beginning of a SMARTText data block in a Chart Section.

**Financial chart section** - An area that houses all financial related documents that do not need a provider's signature. For example, letters from insurance companies.

**Flow Sheets** - An area to create, store and monitor patient flow sheets.

**Flow Sheet items** - Located under the Tools menu this allows the user to create and edit flow sheet items.

**Follow up field** - Located in the SOAPnote chart section this field is for the patients follow up instructions.

**Groups** - Located under the Tools menu as “Manage Groups” this allows the user to designate a billing provider. Insurance companies identify the providers by which group they are assigned.

**Growth Charts chart section** - An area that allows users to automatically track growth rates and percentile comparisons for patients over time. The measurements are automatically plotted on a standard, growth chart graph, which can be viewed onscreen or printed out for off line use.

**Handouts** - Located under the Docutainers menu this allows the user to create, edit and delete patient handouts.

**Header (or SMARTText Header)** - The first word or description of a SMARTText item, usually in large dark blue font. For example the name of a medication or diagnosis.

**Health Maintenance chart section** - The area to track preventative and chronic disease health care.

**Health Maintenance Rules and Sets** - Located under the Tools menu this area is for creating, editing and deleting Health Maintenance Rules and Sets.

**Health Maintenance Rules** - Individual items that Health Maintenance can track. An example of this would be an Influenza vaccine or a mammogram.

**Health Maintenance Sets** - A collection/set of rules. It's a way to group a set of related items together, such as sets of vaccines for age groups or sets of items related to preventative health care for diabetes.

**Help** - Located on the menu toolbar this contains company contact information as well as access to documentation material and product version information.

**HHS-** U.S. Department of Health & Human Services

**HIE-** Health Information Exchange.

**HIMSS-** Healthcare Information and Management Systems Society

**HIPAA Health Insurance Portability and Accountability Act** - HIPAA seeks to establish standardized mechanisms for electronic data interchange (EDI), security, and confidentiality of all health care-related data.

**HIPAA Disclosures chart section** - An area for storing HIPAA documents.

**History and Physicals chart section** - An area to store the patient's History and Physicals.

**HITECH Act (The Health Information Technology for Economic and Clinical Health Act)** -

Legislation created to stimulate the adoption of electronic health records (EHR) and supporting technology in the United States. President Obama signed HITECH into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA), an economic stimulus bill.

## Glossary Terms (I-Q)

**ICD-9 or ICD-10 International Classification of Diseases** - ICD is the classification and coding of diseases and injuries.

**Import** - Located under the Chart menu, and is a tool to import a previously exported SOAPware chart into a SOAPware database.

**Inactive Problems field** - Located in the Summary chart section this field is for documenting the patients past medical history.

**Insurance Companies** - Located under the Tools menu this is a master list of all insurance companies and related information.

**Item Bundles** - A SMARText item in which several separate SMARText items can be “bundled” together to be displayed when the Bundle is selected.

**Item Clusters** - A SMARText item in which several separate SMARText items can be “clustered” together. A cluster is different than a bundle in that clusters have no header to be selected.

**Item Groupers** - A SMARText item in which several different items can be combined and inserted at the same time with one shortcut code.

**Intervention field** - Located in the Summary chart section, this field is to record miscellaneous information.

**In Use** - Located under the Docutainers menu this will show what user is in a locked section of a chart, what computer they are on and the date and time they were in the chart.

**Keywords** - Provide a method for searching in areas of SOAPware such as Docuplates and SMARText. Keywords are assigned when creating an item or can be added or edited later.

**Labs chart section** - An area to store in-house labs results or labs done at other facilities.

**Lab Tests** - Located under the Tools menu and allows for the creation, editing and deletion of specific lab tests and their parameters.

**List Options** - A section of SOAPware located under the Tools menu that controls what options are available for selection in various drop down locations in SOAPware. Here, a user can modify existing lists or remove unused lists or list items.

**Lock Layout** - Located under the View menu, this removes the ability to X out of a chart section.

**Log Out** - Located under the SOAPware menu, this will log the user out of SOAPware.

**MAC**-Medicare Administrative Contractor.

**Macro** - A SMARTText shortcut code that enters a SMARTText item or block of text quickly when typed in field and the spacebar is pressed.

**Meaningful Use** - A set of standards enforced by the American Recovery and Reinvestment Act in addition to HIPAA standards and regulations.

**Medication Reconciliation**- The process of reconciling medications when the EP receives a patient from another setting or provider of care. CMS provides the following definition: The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

**Memo chart section** - An area that can hold sensitive patient information for which access can be limited through security settings.

**Merger** - A utility that allows users to merge duplicate charts.

**Messages chart section** - An area in which messages such as phone calls, can be documented.

**Misc chart section** - An area to store miscellaneous documents.

**MU**- Meaningful Use.

**MU Dashboard** - A tool within SOAPware that allows the provider to view a snapshot of their compliance percentage with various MU requirements.

**MU (Meaningful Use) Patient Dashboard** - A tool within SOAPware used to track the compliance of an individual patient with Meaningful Use requirements.

**NDC (National Drug Code)** - A medical code set maintained by the FDA that contains codes for drugs that are FDA approved. A medication must have an NDC number to be sent via Rx Manager.

**No Know SMARTText Items** - Structured SMARTText item that can be entered when a patient has no current diagnosis, medications or allergies.

**NPRM**- Notice of Proposed Rule Making.

**Numerator**- The number above the line in a common fraction showing how many of the parts indicated by the denominator are met.

**Objective Field** - Located in the SOAPnote, the Objective field is for documenting the patient's physical exam.

**OCR** - Optical Character Recognition is the translation of documents into text. OCR works better with simple documents that do not contain images or special characters.

**Office Visit** - CMS offers the following definition: Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

**ONC or ONCHIT**-Office for the National Coordinator of Health IT (an agency of the Dept. of Health & Human Services).

**Options** - Located under the Tools menu the Options area is where user specific settings are designated.

**Order Entry** - A utility in which the user can order labs/tests and fax to outside facilities.



**Order Manager** - Another component of Order Entry in which the user can define specific sub-items before ordering the labs/tests.

**Patient Portal**- The means in which SOAPware provides patient's access to view their medical records through online access.

**Patient Specific Education Resources**- Patient education, information or handouts related to the patient's condition. CMS provides the following definition: Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

**Pathology chart section** - An area in which to store pathology reports.

**Pharmacies** - Located under the Tools menu this area is used to search for and download pharmacies that will except electronic prescriptions and manually add pharmacies that accept faxed prescriptions.

**Pick List** - A type of SMARTText item in which a macro or shortcut code has a list of SMARTText items associated with it. For example a medication pick list could display a list of commonly prescribed medications for the provider to choose from.

**Preferred Language** - The language by which the patient prefers to communicate.

**Print** - Located under the Docutainers menu this selection will bring up a list of Available Document Designs.

**Printed Encounter chart section** - An area in which printed patient encounter notes can be stored.

**Plan field** - Located in the SOAPnote this field is for documenting any CPT's and care plans associated with the patients visit.

**PMS** - Practice Management System.

**Problem List** - CMS offers the following definition: A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

**Provider Manager** - Located under the Tools menu this area houses provider demographic information such as DEA, NPI numbers, and can also store the provider's electronic signature to be imported onto document designs.

**Physical field** - Located in the Summary section this is a legacy field from earlier versions of SOAPware in which the most recent patient objective exam can be stored.

**Public Health Agency** - CMS provides the following definition: An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

**Quality Measures**- Tools that help measure or quantify healthcare processes and outcomes that are associated with the ability to provide high-quality health care that relate to one or more quality goals for health care.

## Glossary Terms (R-Z)

**Race**- Refers to the categorization of humans into populations or groups on the basis of various sets of heritable characteristics.

**Radiology chart section** - An area in which radiology reports can be stored.

**Record of Disclosures** - Used to record disclosures made for treatment, payment and health

care operations.

**Reference Library** - Located under the SOAPware menu, this is an area that providers can store reference material.

**Re-file**- This button, located on the Common Toolbar and under the Chart menu, re-files the chart back into the Chart Rack. **CAUTION:** Due to CCHIT certification criteria it is possible to re-file a chart that contains unsigned documents. The ability to do this can be restricted through Security settings.

**Remove Unused Items** - Located under the Edit menu and available by right-clicking over any field header, this command allows the user to remove any unused SMARTText item.

**ROS (Review of Systems) field** - Located in the Summary section this is another legacy field from an earlier version of SOAPware in which the patients most recent Review of Systems can be stored.

**Rx Hub** - The ability (in SOAPware 2010.1 and later versions) to check the patient's prescription insurance eligibility.

**Rx Manager** - The tool used by which prescriptions can be sent electronically, faxed, or printed. A history of medications prescribed and discontinued is kept here as well.

**Scheduler** - A workspace that manages patient appointments, holiday closings, provider and clinic schedules.

**Security** - The security system in SOAPware has been set up to help ensure only authorized users are able to access patients' information. Once a user has logged into the system, the security system will track everything the user views and it logs all changes the user makes.

**Security Manager** - A workspace which allows the user to track users actions within SOAPware. The user must have their own login ID and password to be tracked.

**Share Charts** - A workspace which allows the user to export all or portions of a medical record to a PDF file.

**Signature Password** - Signature Password, when enabled, will require passwords to sign off documents and to have multiple providers co-sign on the same documents.

**SMARTText** - A tool to create, edit and use structured documentation that is both searchable and reportable. There are several different types of SMARTText items such as diagnosis, CPTs, Medications and pick lists.

**SMARTText Builder** - An advanced workspace which will allow the user to create SMARTText Item Clusters and SMARTText Item Groupers.

**SMARTText Color Coding** - A setting located under the Tools menu which allows the user to color code specific SMARTText items such as pick lists, field headers, and the active background.

**SMARTText Designer** - The area in which a SMARTText item is created or the original SMARTText item is edited.

**SMARTText Location Pick List** - A user-specific pick list that will display previously used SMARTText items in the SMARTText Quick Access depending on what field the cursor is active in.

**SMARTText Manager** - Located under the Docutainers menu, this area is for searching for SMARTText items and opening the SMARTText Designer to create or edit a SMARTText item.

**SMARTText Quick Access** - Located under the Tools menu, this dialog box is used in conjunction with pick lists, SMARTText location pick lists, and SMARTText sub-items. It can be docked for easier access.

**SNOMED CT® - Systematized Nomenclature of Medicine – Clinical Terms** - SNOMED CT® is a clinical, health care terminology and infrastructure. SNOMED CT® contains over 366,170 health care concepts with unique meanings and formal logic-based definitions organized into hierarchies.

**SOAPnote** - A documentation or progress note format that consists of Subjective, Objective, Assessment and Plan fields. In SOAPware, the Plan field has been further divided to include the Medication Field and the Follow up Field.

**SOAPnote chart section** - An area in which to document all patient visits and communication.

**SOAPnote Medication field** - Located in the SOAPnote chart section, the Medication field is used to document and prescribe all the patients medications.

**Social History field** - Located in the Summary chart section the Social History field is for documenting social issues such as living situation, support systems etc.

**Splitter Bar** - Located in almost all chart sections, the splitter bars (located above or below a section) can open or close to reveal the document date and stamp as well as other action buttons used to manage the document.

**Subjective field** - Located in the SOAPnote chart section, this field is for documenting the patient's Chief Complaint, History of Present Illness and Review of Systems. This area is also used to document patient phone calls.

**Structured Data** - Structured data is managed by technology that allows for querying and reporting against predetermined data types and understood relationships.

**Structured CPT**- A SMARText item used to document level of service or procedures in the Plan field.

**Structured Dx** - A SMARText item used to document the patient's diagnosis.

**Structured Order Entry** - A SMARText item that is used in the Order Manager or with Order Entry.

**Structured Rx** - A SMARText medication item that can be e-Prescribed.

**Summary at Transition of Care**- A summary of care record for patient's whom are being referred to or transferred to another providers care.

**Summary chart section** - An area to record the patients past medical, family and social history.

**Summary to SOAP** - An option that can be set under the Tools-Options menu that will copy specified areas of the Summary chart section into the SOAPnote chart section.

**Summary Medication field** - This medication field located in the summary chart section is for documenting *all* medications the patient is currently taking.

**Surgeries field** - Located in the summary chart section, this field is for documenting the patients past surgeries and procedures.

**Syndromic Health Surveillance**- The capability to submit electronic syndromic data to public health agencies.

**Tasks**- A reminder located on the user's task list that needs to be completed.

**Task Manager**- An area in which each user can manage and complete patient related tasks such as refill requests, lab results etc.

**Tobacco Field** - Located in the summary chart section, this field is for documenting the patient's tobacco use history.

**Threshold**- The resulting percentage of the denominator divided by the numerator.

**Transition of Care (TOC)**- When a patient is referred to or transferred to care of another provider.

CMS provides the following definition: The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

**Unfiled chart section** - An area in which documents that do not belong in other chart section can be kept. For example, scanned documents from paper charts.

**Unique Patient-** CMS offers the following definition: If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Up-to-date-** CMS offers the following definition when related to Meaningful Use: The term “up-to-date” means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

**View Previous Encounters** - Located under the Tools menu, this utility allows the user to view the patients previous encounters while also viewing the current one. A previous encounter, or part of it, can also be added to the new encounter if desired.

**View Signatures** - A right-click menu option that displays when a document was signed off, by whom and at what computer.

**Vital Signs chart section** - An area for documenting and graphing the patient's vital signs.

**Workspaces** - Areas within SOAPware to manage and record patient care.

# SOAPware Education Journey

## SOAPware Education Journey's

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SOAPware has created two Education Journey's that have been designed for users who are updating or converting from an older version of SOAPware. Please select the Educational Journey that you wish to view from the list of options below:

### **Educational Journey for Users Upgrading from SOAPware 2010**

The 2010 to 2011 Education Journey is an educational path for users who are upgrading from SOAPware 2010 to SOAPware 2011. The Journey will guide users through a step-by-step introduction to the new features and Meaningful Use in SOAPware 2011.

#### [\*\*2010 to 2011 Education Journey\*\*](#)

### **Educational Journey for Users Converting from Version 4**

The Version 4 to 2011 Education Journey is an educational path for users who are converting from SOAPware Version 4 to SOAPware 2011. The Journey will guide users through a step-by-step learning process while preparing for the conversion.

#### [\*\*Version 4 to 2011 Education Journey\*\*](#)

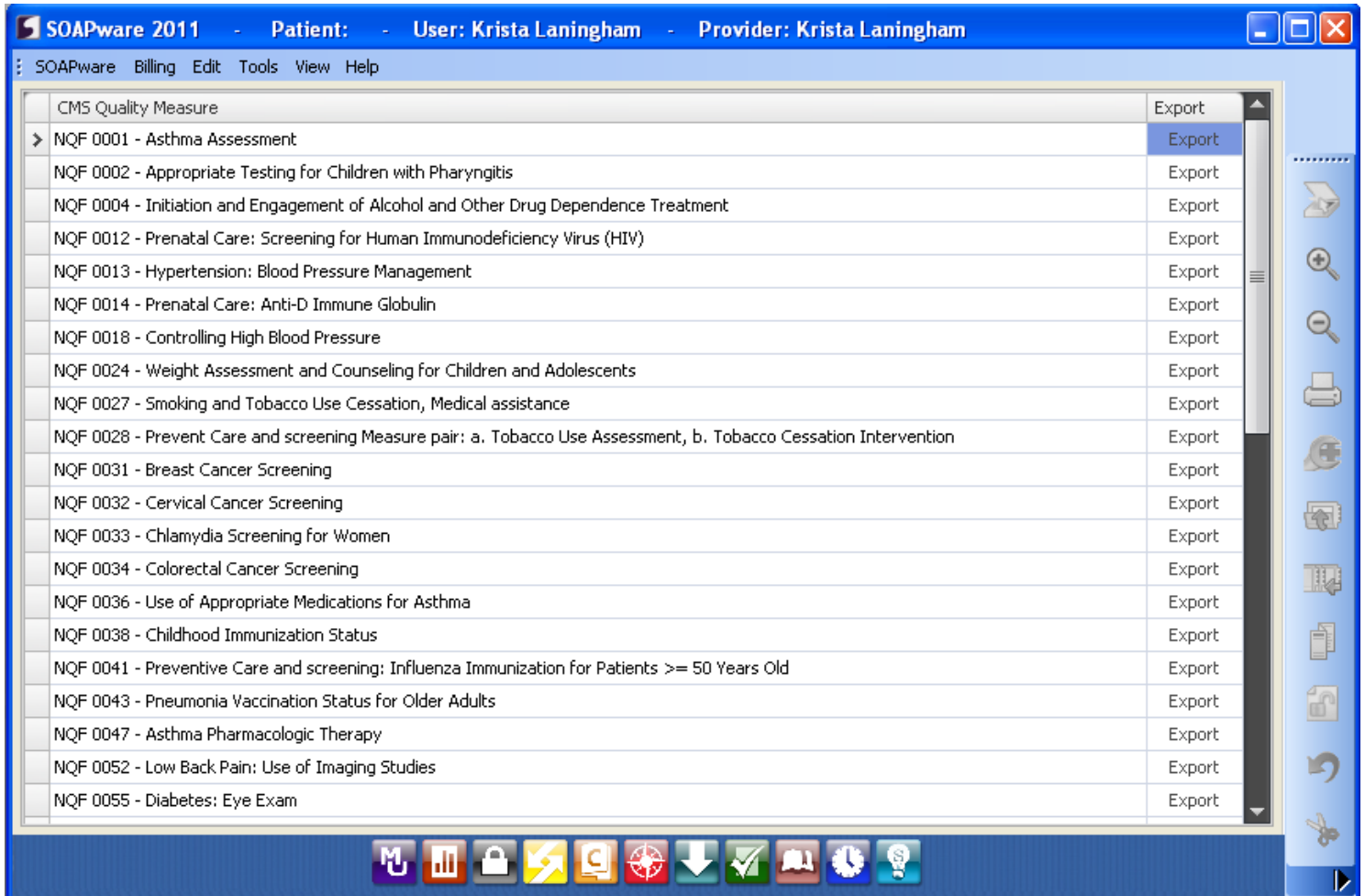
# **SOAPware 2011 New Features**

## New Features of SOAPware 2011

### Certified for Meaningful Use

SOAPware provides all of the features needed for qualifying practices to achieve Meaningful Use status in order to receive Federal EHR stimulus incentives.

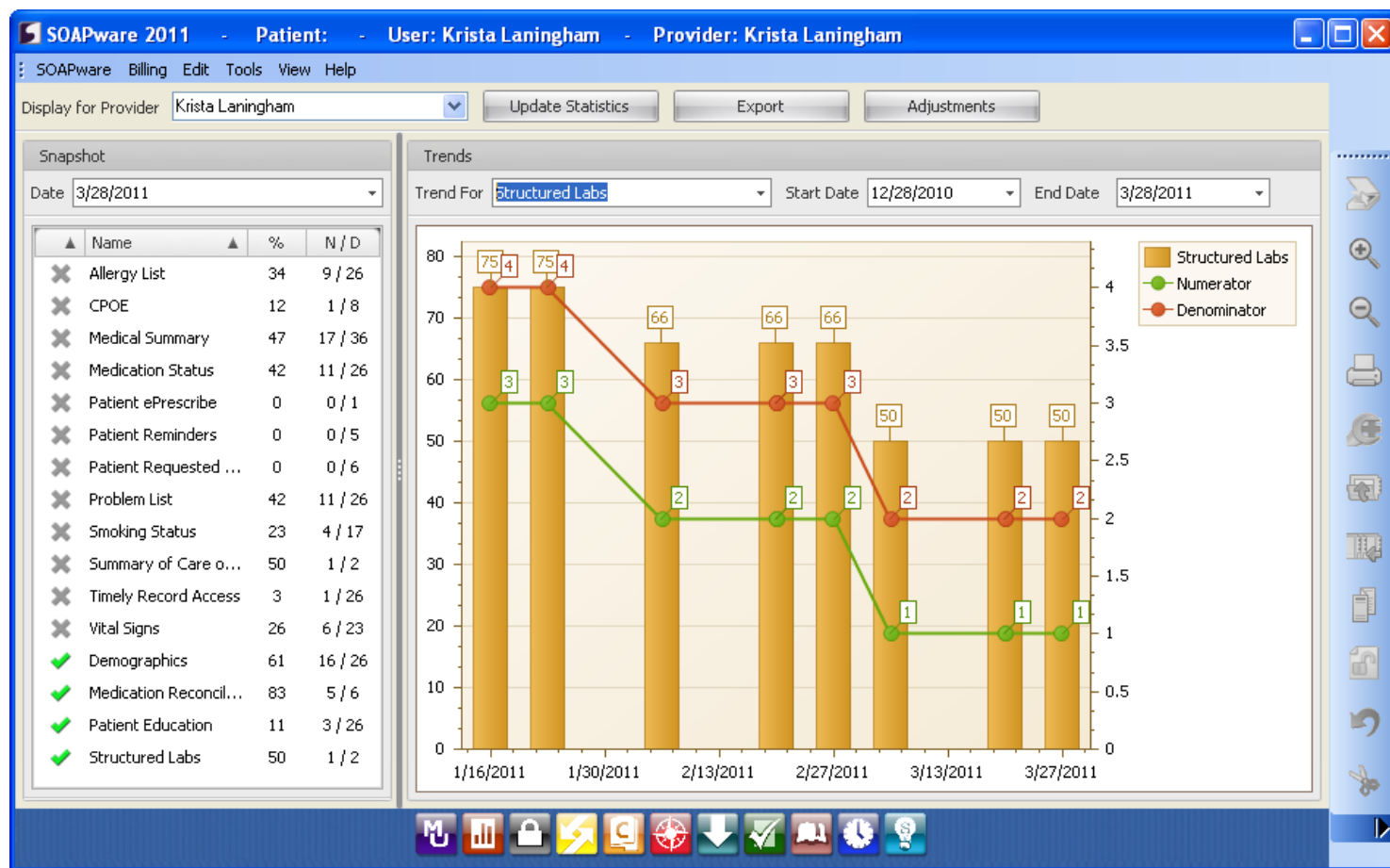
### Support Full Spectrum of Meaningful Use Clinical Quality Measures



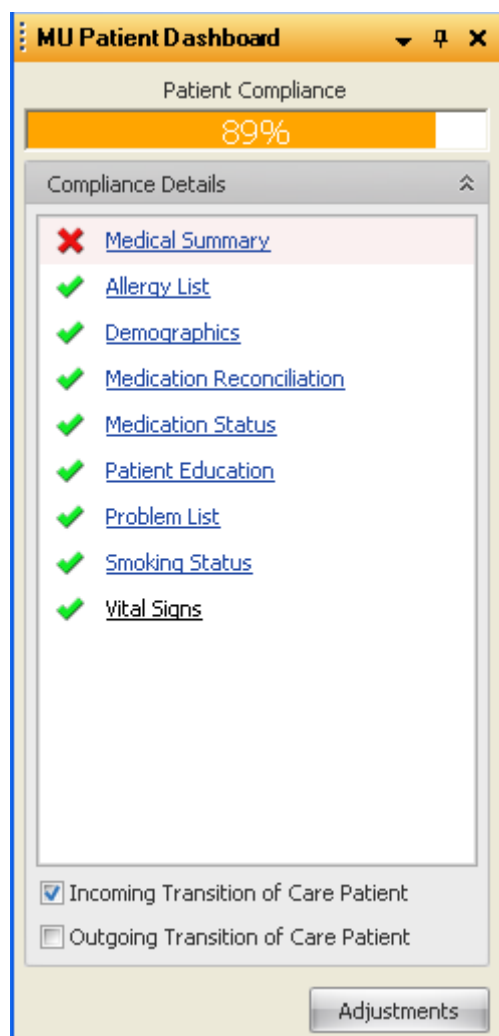
SOAPware 2011 is certified for 44 [clinical quality measures](#), as specified by Stage I meaningful use measures as issued by the Secretary of Health and Human Services.



## Auto-tracking of Provider Meaningful Use Statistics



Newly developed [Meaningful Use Dashboard](#) automatically keeps track of key provider statistics.



In the [Patient Meaningful Use Dashboard](#), live-time, easy-to-use visual prompts mark the path to achieving Meaningful Use requirements as a user documents.



### Documents for Shawn Test

File Date	Patient Name	Provider Name
3/28/2011	Test, Shawn	Fogg, Phineas

### File Information

Date Created	From	To	Purpose
Mon Mar 28, 2011 at 07:19 PM UTC	Phineas M.L. Fogg		

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Shawn R. Test	May 04, 1988	Male	MRN ST6789 SSN 123456789	Home Address 123 Test Rd. Fayetteville, AR72701-1234	Home Phone 5551234567 Work Phone 5552345678

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy			CODEINE: rash		SOAPware 2011.0.193.0 (EHR)

### Problems

Type	Date	Code	Description	Status	Source
Diagnosis	Onset: Jul 14, 2001	250.01 (ICD9-CM)	Diabetes - Type 1	Active	SOAPware 2011.0.193.0 (EHR)

### Medications

Medication	Date	Status	Form	Strength	Quantity	SIG	Indications	Instruction	Refills	Source
Metformin (Glucophage): (Metformin (Glucophage): )	Start: Jul 14, 2001	Active	tablet	500 mg (tablet)		1 tab(s) once a day (in the morning)				SOAPware 2011.0.193.0 (EHR)

### Vital Signs

Vital Sign	Date	Result	Source
Height	Assessment Time: Mar 28, 2011 : 07:16 PM UTC	72 in	SOAPware 2011.0.193.0 (EHR)
Weight	Assessment Time: Mar 28, 2011 : 07:16 PM UTC	205lbs 0oz	SOAPware 2011.0.193.0 (EHR)
Blood Pressure	Assessment Time: Mar 28, 2011 : 07:16 PM UTC	120 80	SOAPware 2011.0.193.0 (EHR)
Temperature	Assessment Time: Mar 28, 2011 : 07:16 PM UTC	98.6 F	SOAPware 2011.0.193.0 (EHR)

Online access through the [Patient Portal](#) permits patients to communicate with doctor and practice & access important health information via the Internet.

## Additional Features

Click on the links below to view more information on each feature:

[Patient Reminders](#)

[Clinical Decision Support Rules](#)

CCR Generation, Transmission, and Receiving

SOAPnote Types

Office Visit Clinical Summaries

Demographics - Race, Ethnicity, Language

Immunization Export

Drug Interaction Filtering

Summary at Transition of Care

Medication Reconciliation

Record of Disclosures

Syndromic Health Surveillance

Patient Copies of Medical Records

EmergencyAccess Security Role

## Overview of Security Changes in SOAPware 2011.0

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This lesson is an overview of the security changes from SOAPware 2010 to SOAPware 2011.

### Legend

The following items are a list of new security settings within SOAPware 2011 and their default access for a variety of Roles.

*\*Note: The default access can be changed for any of the roles, if desired by the Security Administrator.*

**Allowed** = Access is granted

**Neutral** = Access is denied until turned on

### MU Patient Dashboard

- A. Accessible (*View > MU Patient Dashboard* menu item)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Allowed**
  - iii. Nurse Role - **Allowed**
  - iv. Office Manager Role - **Allowed**
  - v. Receptionist Role - **Allowed**
  
- B. Measure Adjustments (Adjustments button on MU Patient Dashboard)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Neutral**
  - iii. Nurse Role - **Neutral**
  - iv. Office Manager Role - **Neutral**
  - v. Receptionist Role - **Neutral**
  
- C. Provide Patient Visit Summary (Controls ability to print visit summary from MU Patient Dashboard)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Neutral**
  - iii. Nurse Role - **Neutral**
  - iv. Office Manager Role - **Neutral**
  - v. Receptionist Role - **Neutral**

## CCR (Continuity of Care Record) Related Items

- A. Accessible (*Chart > Export > CCR* menu item)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Neutral**
  - iii. Nurse Role - **Neutral**
  - iv. Office Manager Role - **Neutral**
  - v. Receptionist Role - **Neutral**

## Encounter Type (Charts Feature)

- A. Type (Controls ability to change encounter type)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Allowed**
  - iii. Nurse Role - **Allowed**
  - iv. Office Manager Role - **Allowed**
  - v. Receptionist Role - **Allowed**

## Immunization Reporting

- A. Accessible (*Chart > Export > Immunization Records* menu item)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Neutral**
  - iii. Nurse Role - **Neutral**
  - iv. Office Manager Role - **Neutral**
  - v. Receptionist Role - **Neutral**

## Patient Requested Copies

- A. Accessible (*Chart > Export > Patient Records in PDF* menu item)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Neutral**
  - iii. Nurse Role - **Neutral**
  - iv. Office Manager Role - **Neutral**
  - v. Receptionist Role - **Neutral**

## SMARTflow Related Items

- A. Accessible (*View > SMARTflow Results* menu item)
  - i. Clinician Role - **Allowed**
  - ii. Medical Assistant Role - **Allowed**
  - iii. Nurse Role - **Allowed**
  - iv. Office Manager Role - **Allowed**

v. Receptionist Role - **Allowed**

B. SMARTflow Designer (*Tools > SMARTflow Designer* menu item)

- i. Clinician Role - **Neutral**
- ii. Medical Assistant Role - **Neutral**
- iii. Nurse Role - **Neutral**
- iv. Office Manager Role - **Neutral**
- v. Receptionist Role - **Neutral**

### Meaningful Use Dashboard (Workspace)

A. Accessible (*SOAPware > Meaningful Use Dashboard* menu item)

- i. Clinician Role - **Allowed**
- ii. Medical Assistant Role - **Neutral**
- iii. Nurse Role - **Neutral**
- iv. Office Manager Role - **Neutral**
- v. Receptionist Role - **Neutral**

### CMS Quality Reporting Dashboard (Workspace)

A. Accessible (*SOAPware > CMS Quality Reporting Dashboard* menu item)

- i. Clinician Role - **Allowed**
- ii. Medical Assistant Role - **Neutral**
- iii. Nurse Role - **Neutral**
- iv. Office Manager Role - **Neutral**
- v. Receptionist Role - **Neutral**

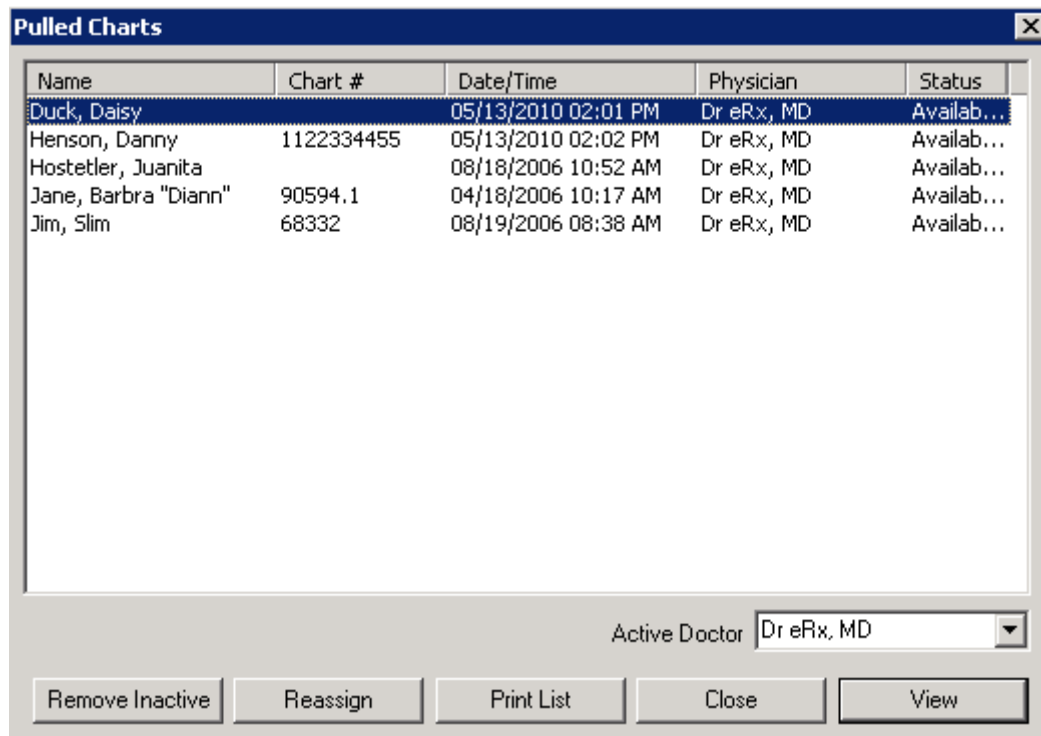
# **For Users Converting from SOAPware Version 4 to SOAPware 2011**



## Areas That Do Not Convert from Version 4

When converting from SOAPware version 4.x to 2011, all patient documents and information are carried over into the new version. However, the following areas DO NOT carry over...

### Pulled Chart Information does not convert



We now encourage our v4 users NOT TO USE Pulled Charts to manage tasks, or to track what needs to be signed/completed.

When the SOAPware is installed, Pulled Charts will not be displayed.

Instead, use the Tasks Manager (formally the ToDo List) to keep track of and manage what needs to be signed/completed: [Tasks Manager](#).

## ToDo List information does not convert

**SOAPware To Do List**

View List for - All Users ☐ Display Inactive Items

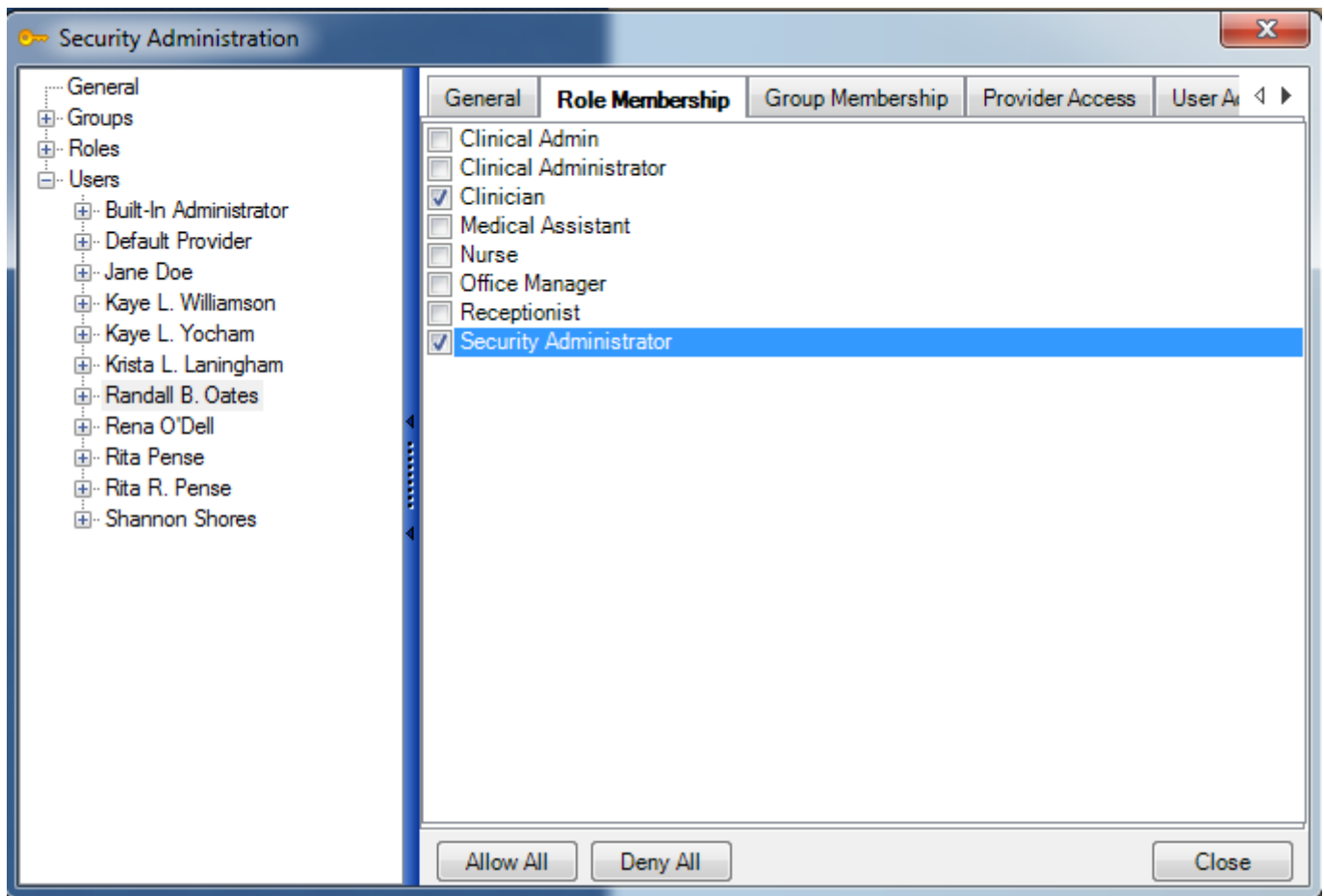
Description	Priority	Due	Status	Patient	Last Upd
Needs cxr follow up	2 - High	08/25/200...	Review/Sign	Jim, Slim	08/18/20...
Drawings - Brain, External, L...	4 - Low	08/19/200...	Review/Sign	Jim, Slim	08/19/20...
Encounter Created	4 - Low	08/19/200...	Review/Sign	Jim, Slim	08/19/20...
MRI - Imported	4 - Low	08/19/200...	Review/Sign	Jim, Slim	08/19/20...
Encounter Created	4 - Low	08/18/200...	Review/Sign	Hostetter, ...	08/18/20...
Encounter Created	4 - Low	08/18/200...	Review/Sign	Mohamedy...	08/18/20...
Encounter Created	4 - Low	08/18/200...	Review/Sign	MOHAME...	08/18/20...
Encounter Created	4 - Low	08/18/200...	Review/Sign	Hostetter, ...	08/18/20...
Encounter Created	4 - Low	08/18/200...	Review/Sign	Duck, Daisy	08/18/20...
Test - Imported	4 - Low	04/20/200...	Review/Sign	Laningham...	04/20/20...
- Imported	4 - Low	04/20/200...	Review/Sign	Jill, Jackin ...	04/20/20...
- Imported	4 - Low	04/20/200...	Review/Sign	Jim, Slim	04/20/20...
Lab - Hgb A1c	4 - Low	04/20/200...	Review/Sign	Joe, Sally S.	04/20/20...
Encounter Created	4 - Low	04/20/200...	Review/Sign	Pyle, Karke...	04/20/20...
Encounter Created	4 - Low	04/20/200...	Review/Sign	Laningham...	04/20/20...
Misc. - Clinic Visit Note	4 - Low	04/20/200...	Review/Sign	Jim, Slim	04/20/20...
- Created	4 - Low	04/18/200...	Review/Sign	Jim, Slim	04/18/20...
- Imported	4 - Low	04/18/200...	Review/Sign	Jane, Barbr...	04/18/20...

☒ Auto refile charts.

Buttons: Close, Add, Edit, Reassign, Remove, Set Status, Sign Off, Print Report, Print List, Delete

Be advised to clean up all ToDo Lists BEFORE converting to the new version of SOAPware.

## Security settings do not convert



This will be one of the first things that will need to be set up after conversion.

Enabling Security was an option in version 4, but it is required in the new SOAPware. Security in the new SOAPware has been completely re-written to meet specific HIPAA and federal guidelines.

SOAPware will automatically add Providers who have an active SOAPware license and their Role will be set as Clinician. All other Users will need to be manually added.

For more information, see: [Security](#).

## Superbills and its functionality has been completely re-written

The screenshot shows the SOAPware Superbill window. It has a title bar 'SOAPware Superbill' with a close button. The window is divided into several sections:

- Available Codes:** A list of medical codes and descriptions. The visible codes are:

Code	Description
611 90782	Allergy Shot
204 46600	Anoscopy
544 80072	Arthritis Panel
200 92552	Audiogram
509 87082	BID
504 84520	Bun
501 85031	CBC
702 71010	Chest - 1 View
703 71020	Chest X-Ray
528 82465	Cholesterol
605 90701	DPT
557	Drug Abuse Screen
583	Drug Screen Collection
644 90718	D-Tetanus
201 69210	Ear Irrigation
700 93000	EKG
701 93040	EKG Rhythm Strip
108 00000	Emply/DOE
104 99212	Estab. Pt Eval/Management
105 99213	Estab. Pt Eval/Management
106 99214	Estab. Pt Eval/Management
100 00015	Estab. Pt Eval/Management
- Currently Selected:** A large empty text area for selecting a code.
- Remarks:** A text area containing the code '29085'.
- Assessment:** A text area containing the following text:

Congestive Heart Failure (enlarged and weakened heart) #428.0.  
GERD - Esophagitis - reflux (irritated swallowing tube) #530.10.  
Pharyngitis (sore throat) #462.

At the bottom of the window are three buttons: 'Close', 'Print', and 'Post'.

Superbill Codes in version 4, as seen in the above screen shot, **will not convert** to the new SOAPware

## The new Billing Statements in SOAPware are designed to populate with structured data only

The screenshot shows the SOAPware interface with the 'Billing Statements' tab selected. The window displays patient information, a table of services, and a detailed SOAP note on the right.

**SOAPware Billing Statements Window:**

- Menu Bar:** SOAPware, Chart, Docutainers, Edit, SOAP Notes, Tools, View, Help
- Sub-Menu Bar:** Vital Signs, Demographics, Billing Statements (selected), SOAP Notes, Labs, Radiology
- Date/Time:** 05/07/2010 1:52 PM
- Fields:** Posted On: N/A, Owner: Kaye L. Yocham, Facility: DOCS INSTIT...
- Table:**

Description	CPT	Diagnoses
OFFICE/OUTPATIENT VISIT, EST	992...	Peptic ulcer disease, acute ,
COMPLETE CBC W/AUTO DIFF WBC.	850...	Fatigue and Malaise
- Assessment:**
  - Fatigue and Malaise ICD#780.79
  - Peptic ulcer disease, acute ICD#533.30
- Plan:**
  - OFFICE/OUTPATIENT VISIT, EST #99213 [Related Dxs-](#) Peptic ulcer disease, acute , Fatigue and Malaise [Modifiers-](#)
  - COMPLETE CBC W/AUTO DIFF WBC. #85025 [Related Dxs-](#) Fatigue and Malaise [Modifiers-](#)
  - discussed importance of regular and adequate sleep, nutrition, and hydration, and regular exercise. Advised to call if symptoms worsen or persist.
  - [Actions:](#) [Lab/Tests:](#) ordered
- Medications:**
- Follow Up:**
  - Return if problems develop or worsens.
  - [Schedule:](#)
  - Electronically Signed By Kaye L. Yocham

In the new SOAPware, the Billing Statements will only populate with structured ICD and CPT codes (See example in screen shot above). Note that Structured data will have bold, blue headers.

In the new SOAPware this type of structured data is called SMARText.

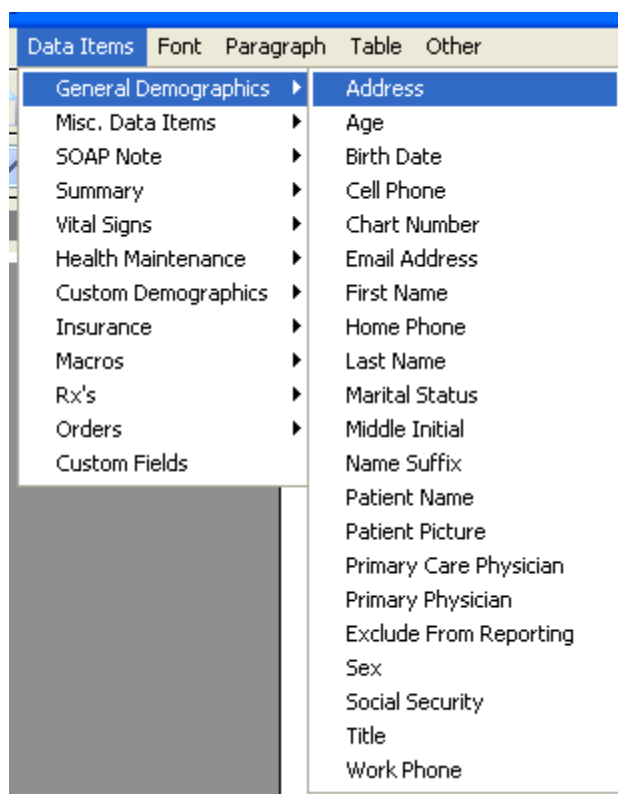
## Certain Report Writer/Document Designer Codes Do Not Convert

There are certain V4 Report Writer commands that will not convert correctly into the new Document Designer.

Below is a list of the converted macros that DO NOT convert correctly from V4 to SOAPware 2011. Please note that this only refers to Report Writer/Document Designer commands and it does not refer to shortcut codes/macros or anything else.

To correct these macros, the easiest workflow is to open Document Designer in SOAPware 2011 after conversion and reinsert the commands listed below onto each document design that uses them. This is a one-time fix after conversion from V4 to 2011.

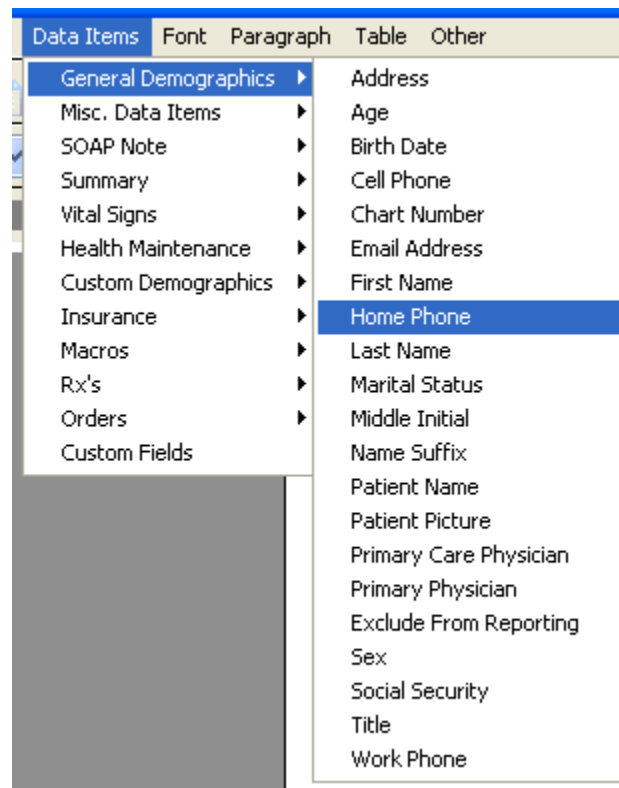
## Document Designer Commands: Patient Address



Report Writer Menu Item in V4  
General Demographics Address

New Data Item in SOAPware 2011  
Data Items > General Demographics > Address

## Document Designer Commands: Patient Home Phone



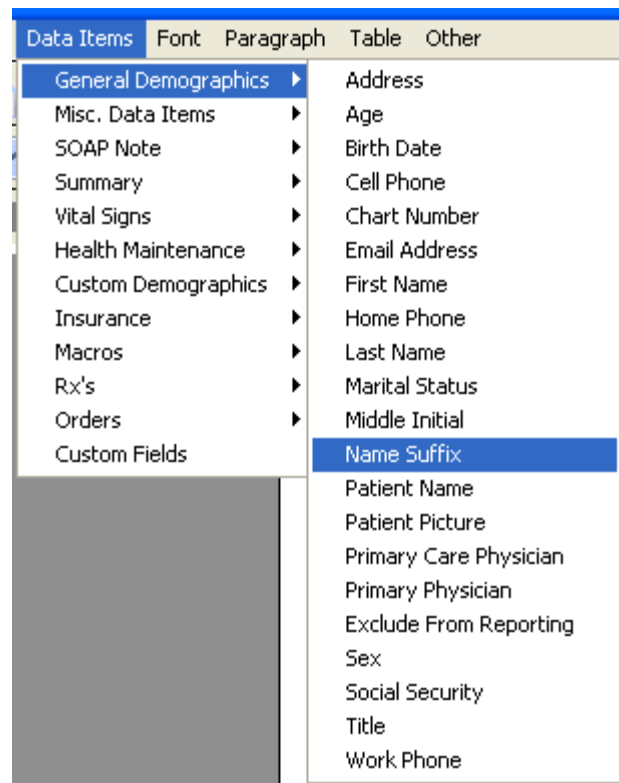
### Report Writer Menu Item in V4

General Demographics Home Phone

### New Data Item in SOAPware 2011

Data Items > General Demographics > Home Phone

## Document Designer Commands: Patient Name Suffix

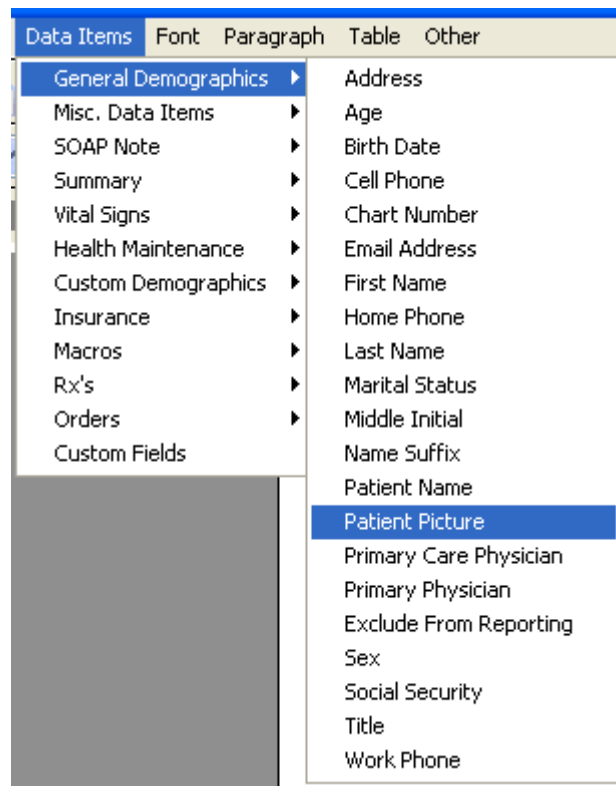


Report Writer Menu Item in V4  
General Demographics Name Suffix

New Data Item in SOAPware 2011  
Data Items > General Demographics > Name Suffix



## Document Designer Commands: Patient Picture



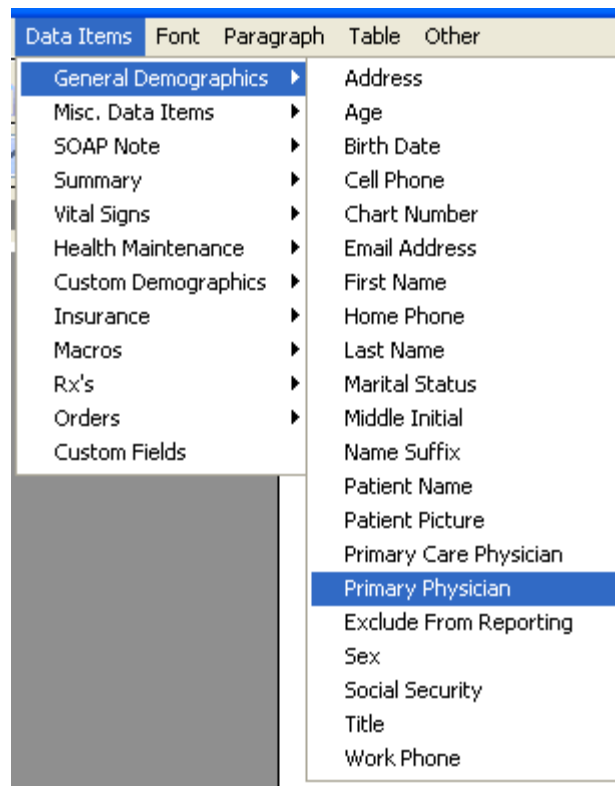
### Report Writer Menu Item in V4

General Demographics Patient Picture

### New Data Item in SOAPware 2011

Data Items > General Demographics > Patient Picture

## Document Designer Commands: Patient Primary Physician



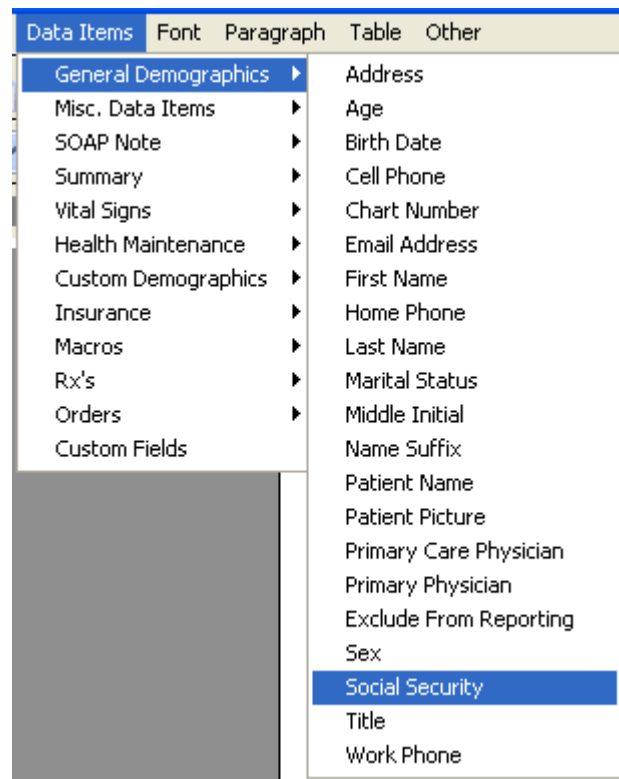
### Report Writer Menu Item in V4

General Demographics > Primary Physician

### New Data Item in SOAPware 2011

Data Items > General Demographics > Primary Physician

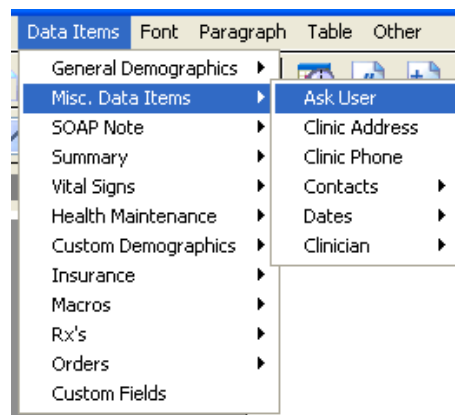
## Document Designer Commands: Patient Social Security Number



Report Writer Menu Item in V4  
General Demographics Social Security

New Data Item in SOAPware 2011  
Data Items > General Demographics > Social Security

## Document Designer Commands: Ask User Question

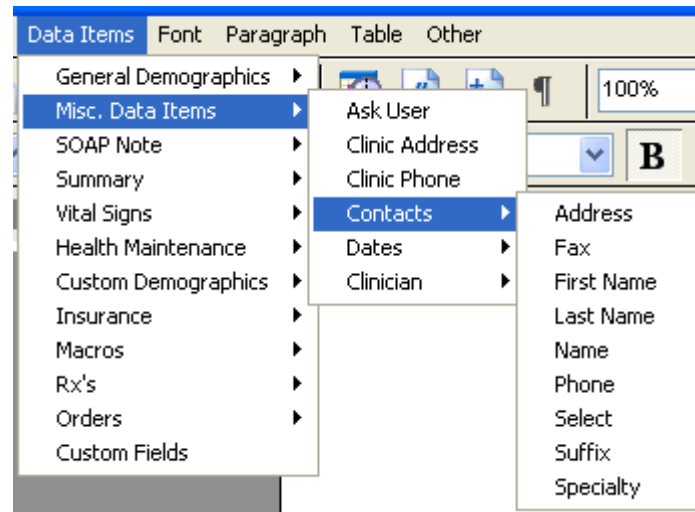


Report Writer Menu Item in V4  
Misc. Data Items Ask User

## New Data Item in SOAPware 2011

Data Items > Misc. Data Items > Ask User

### Document Designer Commands: Contacts



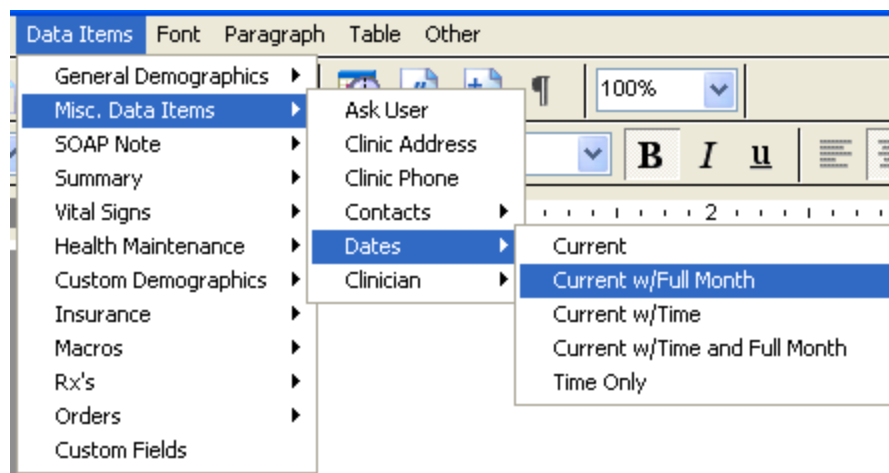
## Report Writer Menu Item in V4

Misc. Data Items everything in the Consultants menu from V4

## New Data Item in SOAPware 2011

Data Items > Misc. Data Items > Contacts (all items)

### Document Designer Commands: Current Date with Full Month



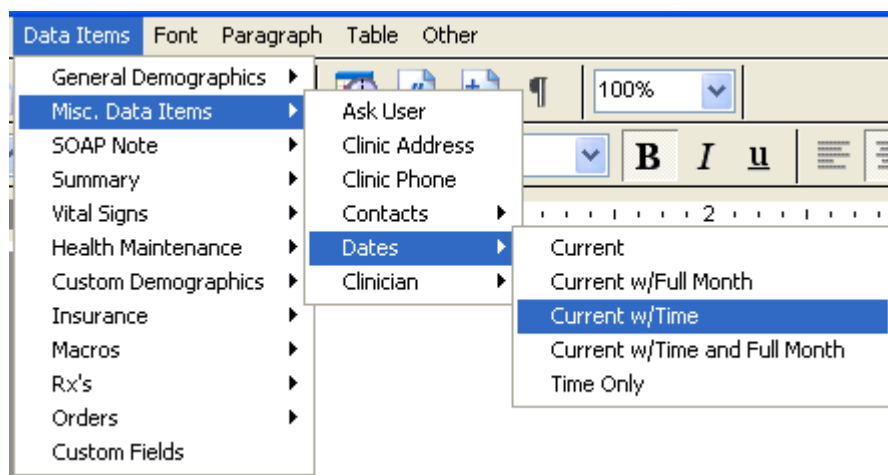
## Report Writer Menu Item in V4

Misc. Data Items Current Date w/Full Month

## New Data Item in SOAPware 2011

**Data Items > Misc. Data Items > Dates > Current w/Full Month**

### Document Designer Commands: Current Date/Time



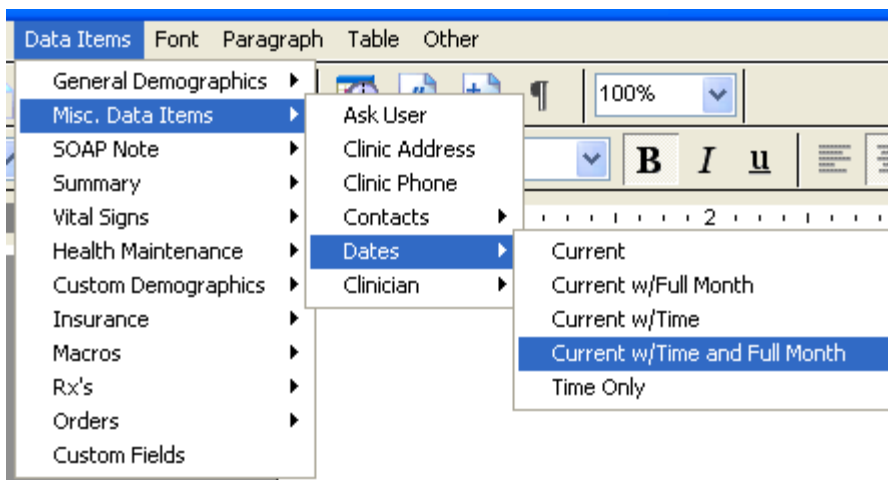
Report Writer Menu Item in V4

Misc. Data Items Current Date/Time

New Data Item in SOAPware 2011

**Data Items > Misc. Data Items > Dates > Current w/Time**

### Document Designer Commands: Current Date/Time with Full Month



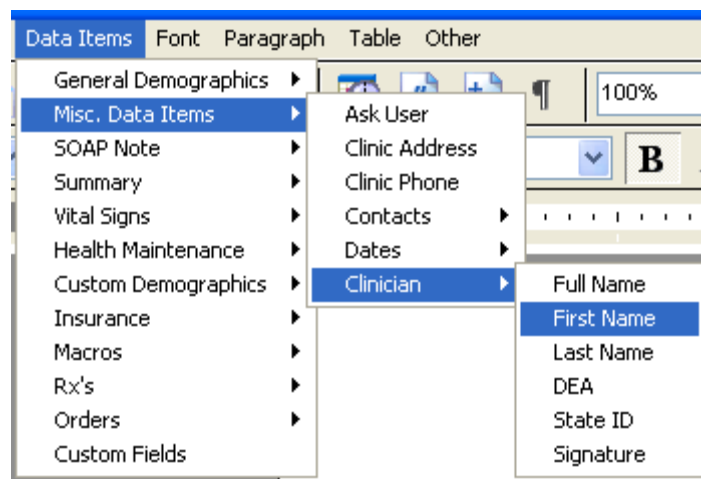
Report Writer Menu Item in V4

Misc. Data Items Current Date/Time w/FullMonth

New Data Item in SOAPware 2011

**Data Items > Misc. Data Items > Dates > Current w/Time and Full Month**

## Document Designer Commands: Clinician First Name



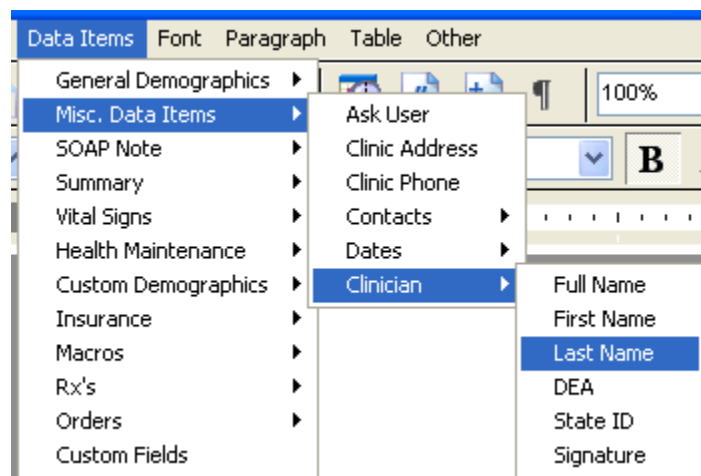
Report Writer Menu Item in V4

Misc. Data Items Current Doctor First Name

New Data Item in SOAPware 2011

Data Items > Misc. Data Items > Clinician > First Name

## Document Designer Commands: Clinician Last Name



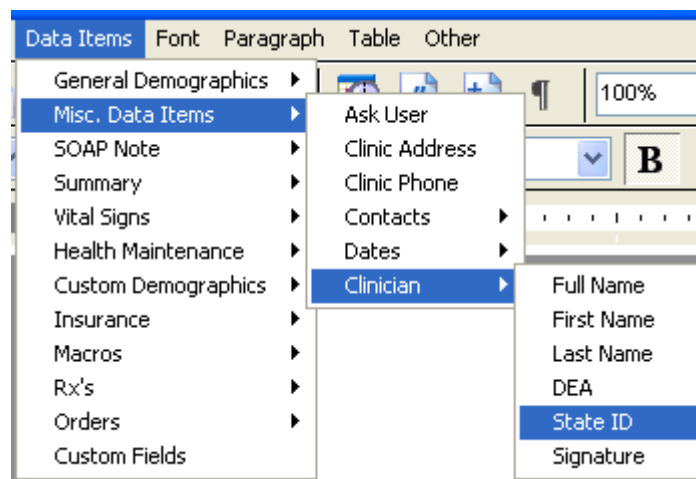
Report Writer Menu Item in V4

Misc. Data Items Current Doctor Last Name

New Data Item in SOAPware 2011

Data Items > Misc. Data Items > Clinician > Last Name

## Document Designer Commands: Clinician State ID



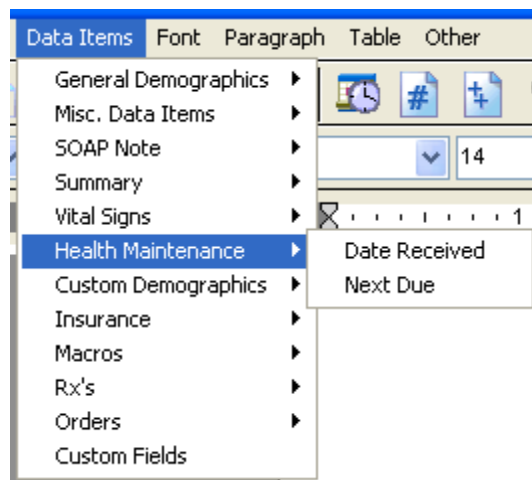
### Report Writer Menu Item in V4

Misc. Data Items Doctor State ID

### New Data Item in SOAPware 2011

Data Items > Misc. Data Items > Clinician > State ID

## Document Designer Commands: Health Maintenance



### Report Writer Menu Item in V4

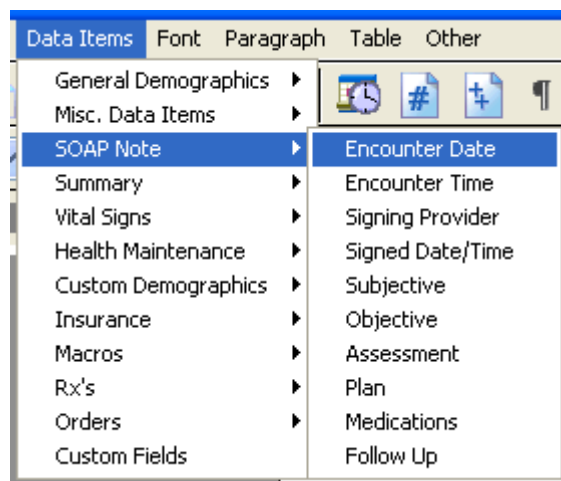
Misc. Data Items Health Maintenance Items\*

*\*This has been replaced by 2 HM items in 2011*

### New Data Item in SOAPware 2011

Data Items > Health Maintenance > Date Received & Next Due

## Document Designer Commands: Encounter Date/Time



### Report Writer Menu Item in V4

SOAP Note Encounter Date

SOAP Note Encounter Time

SOAP Note Encounter Date/Time

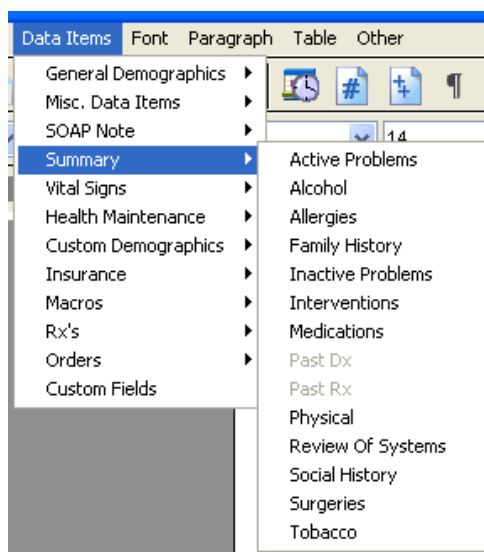
### New Data Item in SOAPware 2011

Data Items > SOAP Note > Encounter Date

Data Items > SOAP Note > Encounter Time

Select both Data Items for Date and Time as indicated above

## Document Designer Commands: Past Rx/Dx



### Report Writer Menu Item in V4

Summary Past DX

Summary Past RX

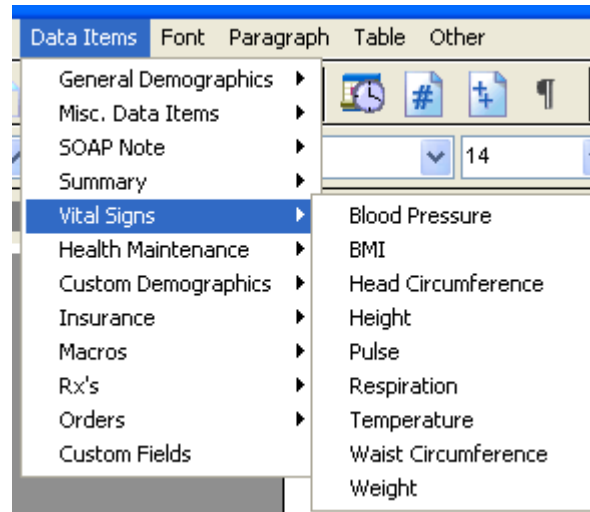


## **New Data Item in SOAPware 2011**

**Not available**

**Not available**

### **Document Designer Commands: Vital Signs**



## **Report Writer Menu Item in V4**

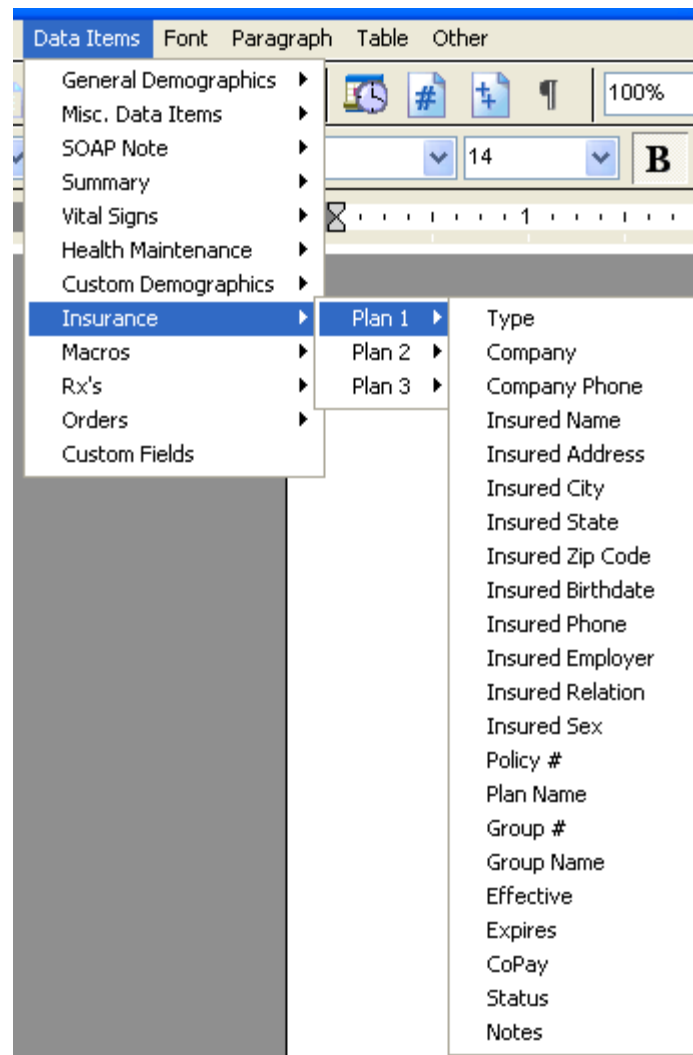
Vital Signs - BMI

Vital Signs - Head Circumference

## **New Data Item in SOAPware 2011**

**Data Items > Vital Signs > BMI**

**Data Items > Vital Signs > Head Circumference**



### Report Writer Menu Item in V4

Insurance - Plan 1 & 2 Contact Name

Insurance Plan 1 & 2 Expiration Date

Insurance Plan 1 & 2 Note

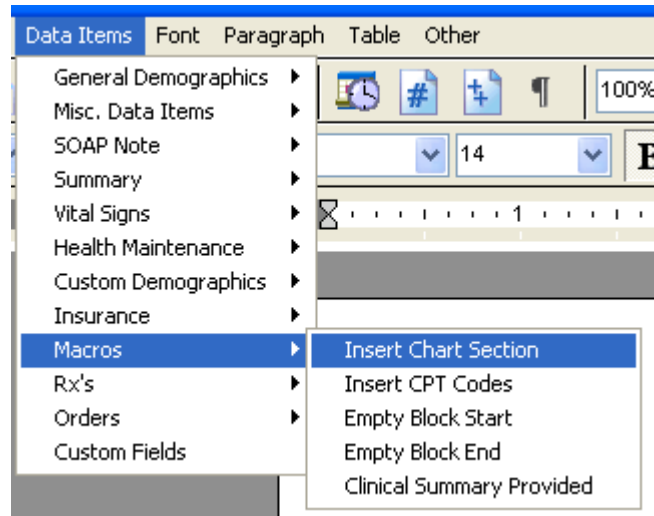
### New Data Item in SOAPware 2011

No longer available

**Data Items > Insurance > Select Plan > Expires**

**Data Items > Insurance > Select Plan > Notes**

## Document Designer Commands: Insert Chart Section



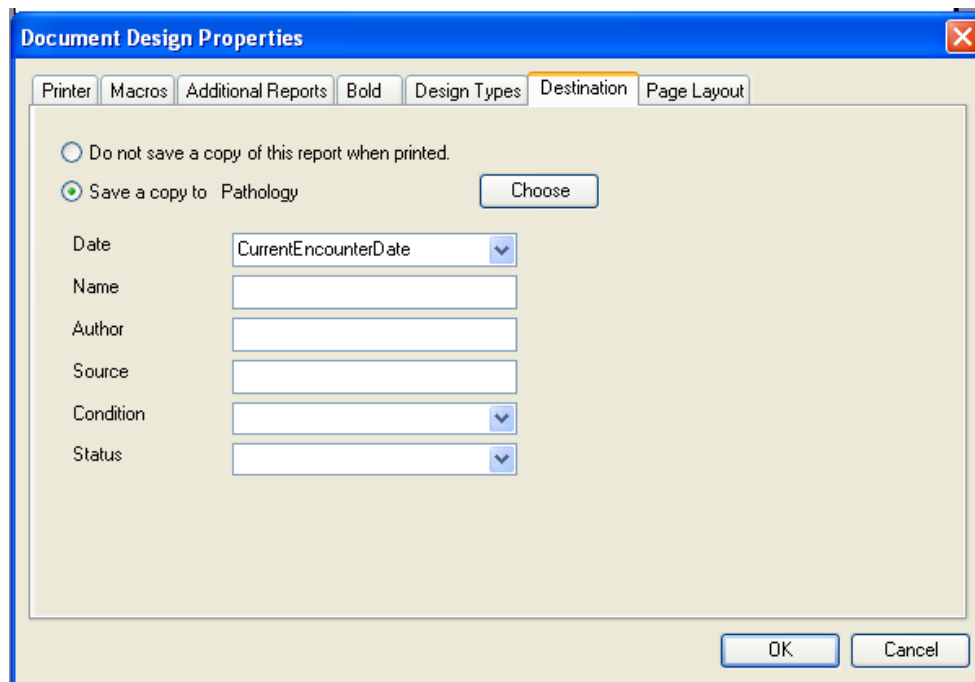
### Report Writer Menu Item in V4

Macros Every Insert Chart Section

### New Data Item in SOAPware 2011

Data Items > Macros > Insert Chart Section

## Document Designer Commands: Save to a Chart Section



### Report Writer Menu Item in V4

Macros Save to Misc. Reports

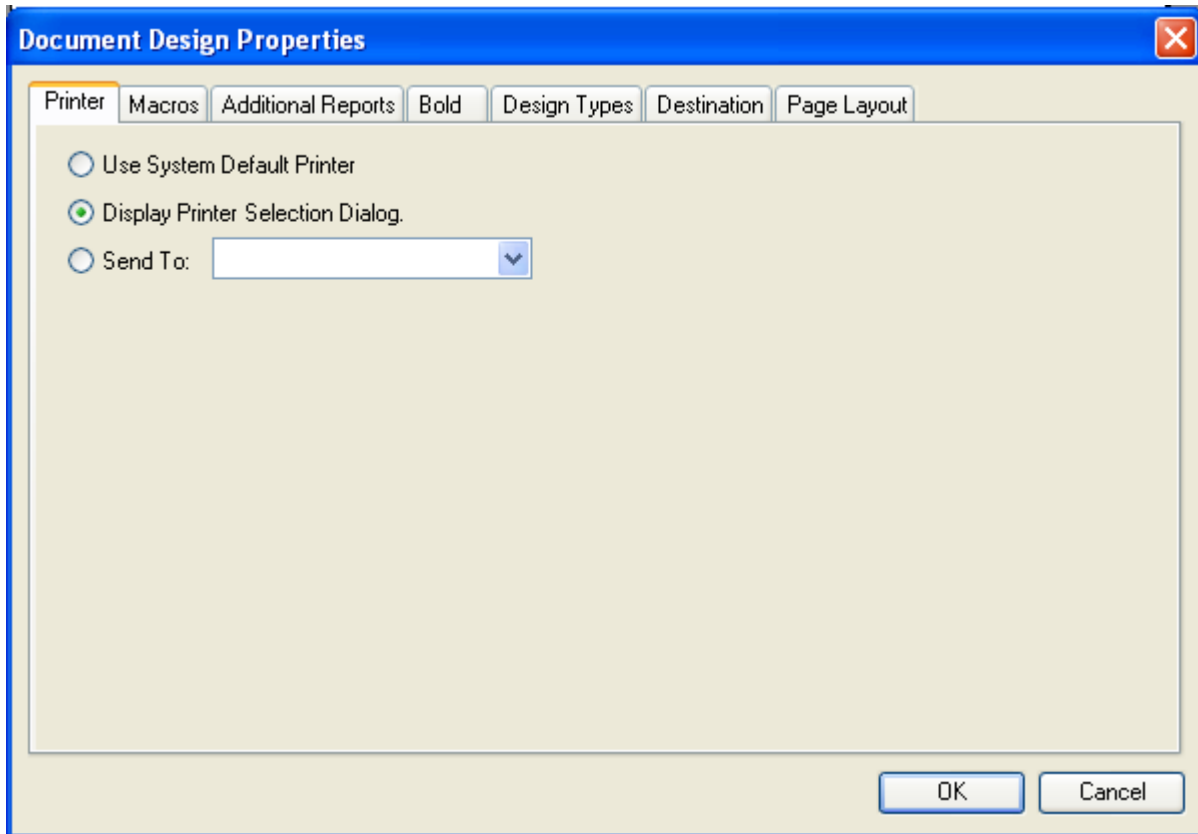
Macros Save to Pathology

Macros Save to Radiology

### New Menu Item in SOAPware 2011

These are now all located under **Edit > Design Properties > Destination > "Save Copy to"**

### Document Designer Commands: Printer Dialog Options

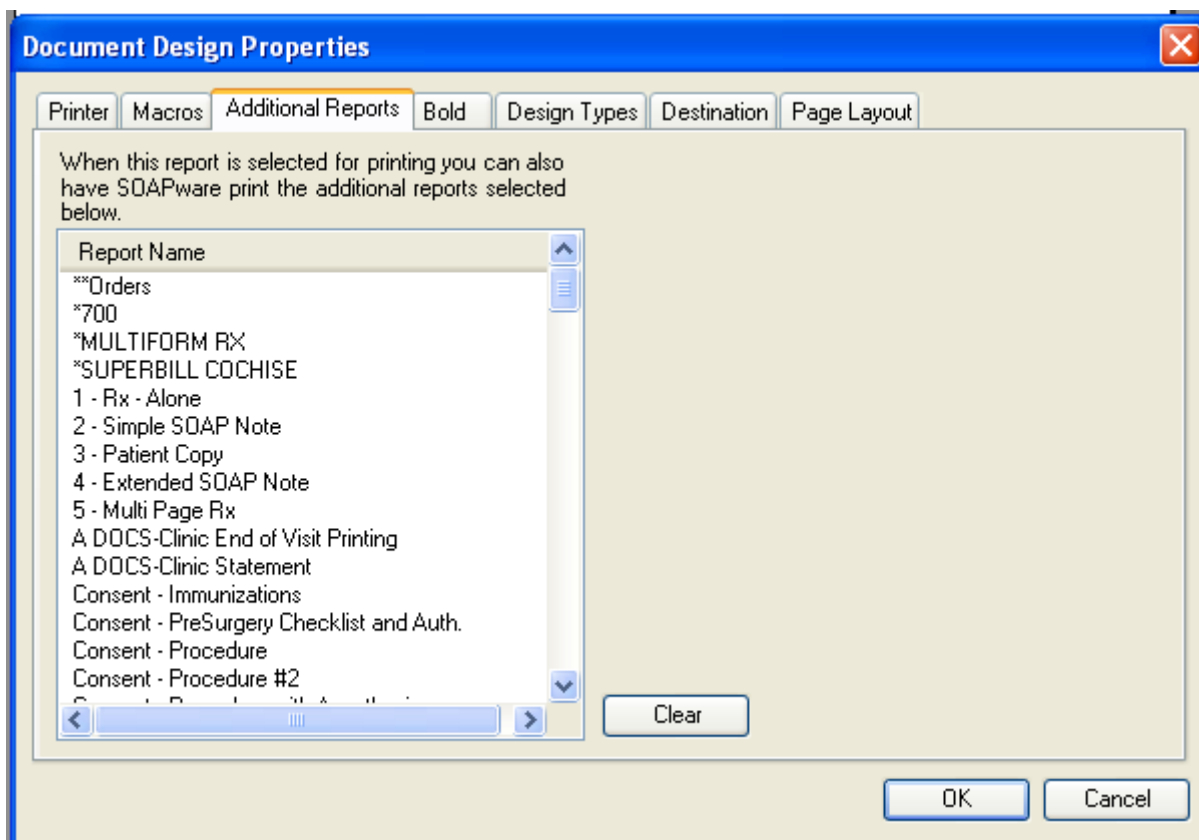


### Report Writer Menu Item in V4

Format Display Printer Dialog

### New Menu Item in SOAPware 2011

**Edit > Design Properties > Printer**



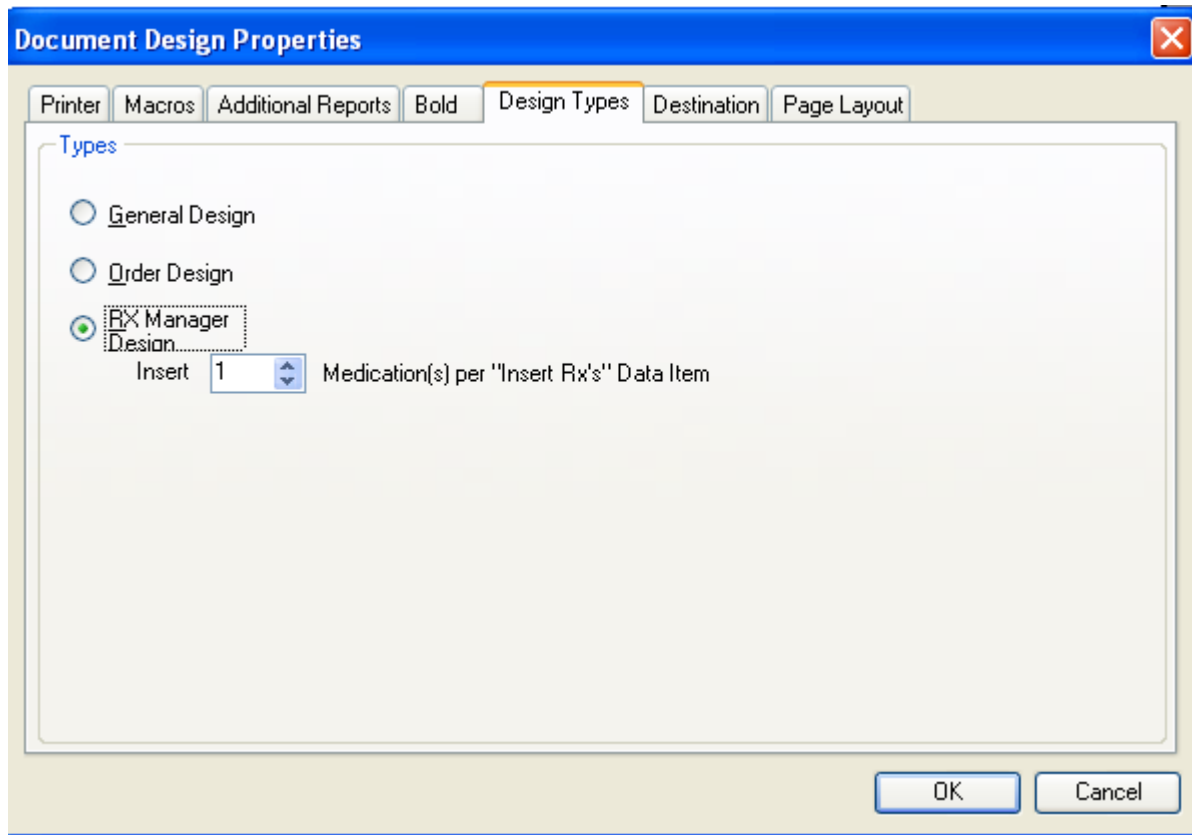
### Report Writer Menu Item in V4

#### Macros Print Report

(this prints an additional report when this report is printed)

### New Menu Item in SOAPware 2011

#### Edit > Design Properties > Additional Reports



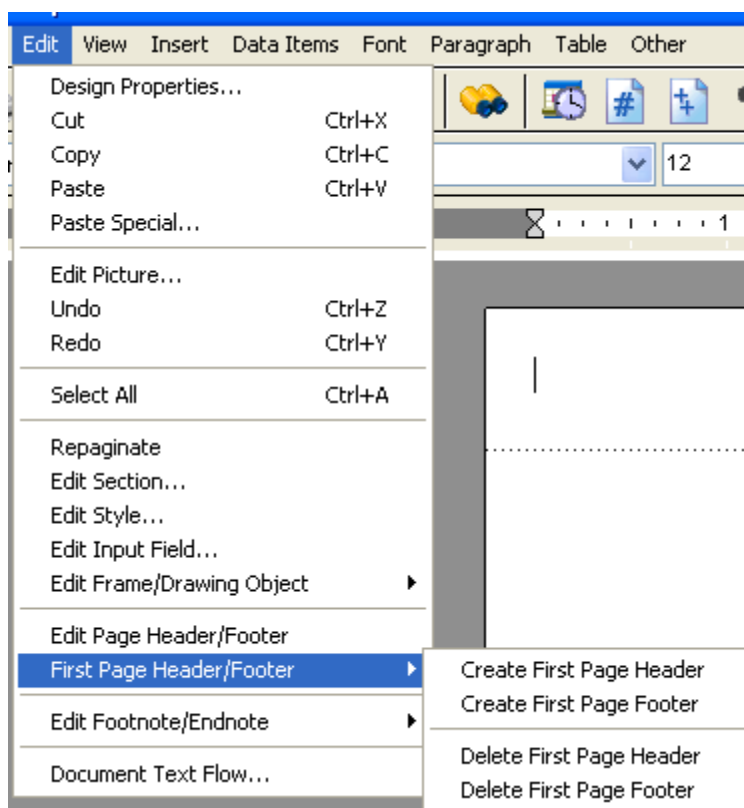
### Report Writer Menu Item in V4

Multi page RX reports need to be redone

### New Menu Item in SOAPware 2011

**Edit > Design Properties > Design Types > Select Rx Manager Design & Select Desired Number of Medications per Data Item**

## Document Designer Commands: Page Header/Footers



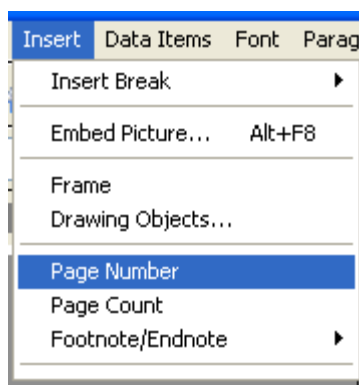
Report Writer Menu Item in V4

All Headers & Footers

New Menu Item in SOAPware 2011

**Edit > Edit Page Header/Footer or First Page Header/Footer**

## Document Designer Commands: Insert Page Numbers



Report Writer Menu Item in V4

Insert, Total Pages Count

## **New Menu Item in SOAPware 2011**

**Insert > Page Number or Page Count**



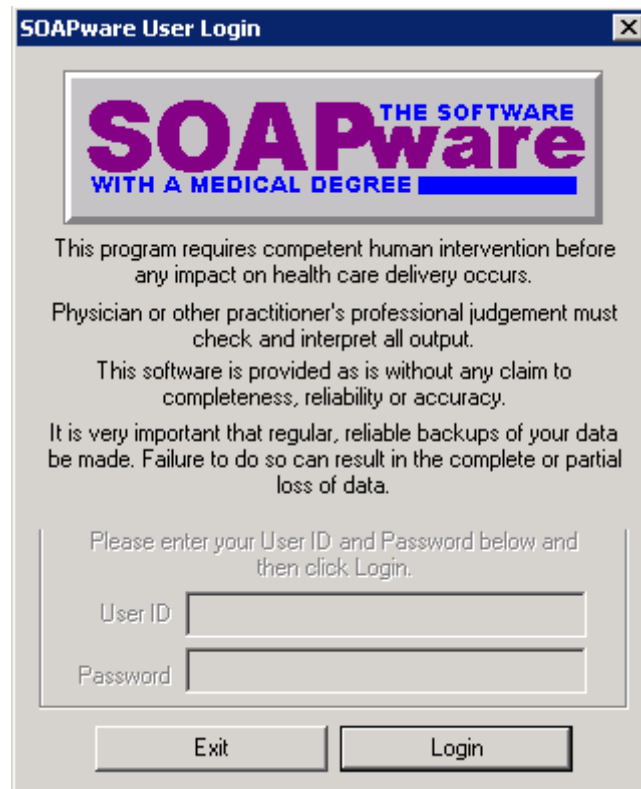
## Differences in SOAPware Version 4 and SOAPware 2011+

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This lesson will outline some of the main differences between SOAPware Version 4 and SOAPware 2011.

**\*Note:** The following steps are applicable to SOAPware 2011, despite the difference of versions shown in the following screenshots.

### Version 4 User Log In



The image shows a screenshot of the 'SOAPware User Login' dialog box. The title bar is blue with the text 'SOAPware User Login' and a close button. The main area has a light gray background. At the top, there is a logo for 'SOAPware' in large purple letters, with 'THE SOFTWARE' in smaller blue letters above it and 'WITH A MEDICAL DEGREE' in blue letters below it. Below the logo, there is a disclaimer in black text: 'This program requires competent human intervention before any impact on health care delivery occurs. Physician or other practitioner's professional judgement must check and interpret all output. This software is provided as is without any claim to completeness, reliability or accuracy. It is very important that regular, reliable backups of your data be made. Failure to do so can result in the complete or partial loss of data.' Below the disclaimer, there is a prompt: 'Please enter your User ID and Password below and then click Login.' There are two input fields: 'User ID' and 'Password'. At the bottom, there are two buttons: 'Exit' and 'Login'.

SOAPware User Login

**SOAPware**  
THE SOFTWARE  
WITH A MEDICAL DEGREE

This program requires competent human intervention before any impact on health care delivery occurs.

Physician or other practitioner's professional judgement must check and interpret all output.

This software is provided as is without any claim to completeness, reliability or accuracy.

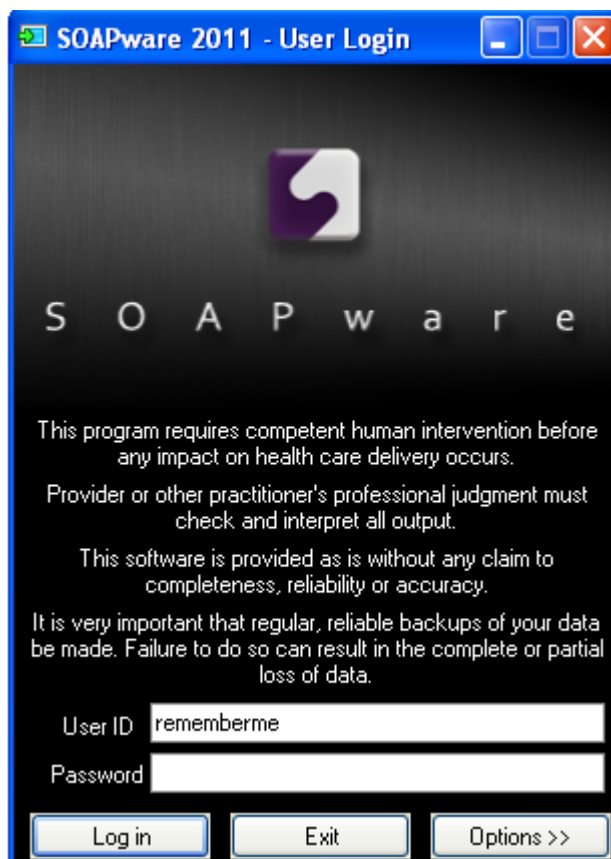
It is very important that regular, reliable backups of your data be made. Failure to do so can result in the complete or partial loss of data.

Please enter your User ID and Password below and then click Login.

User ID

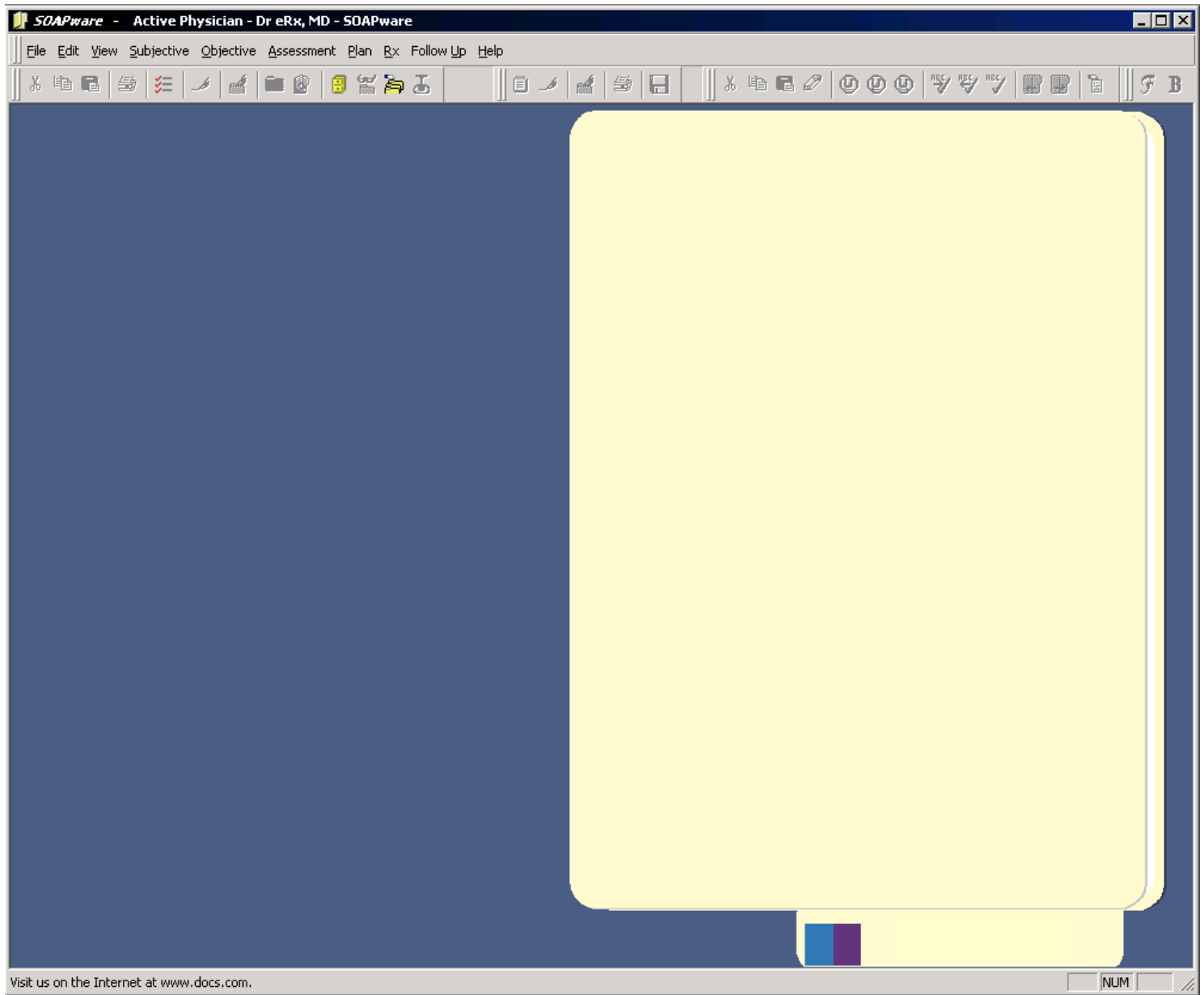
Password

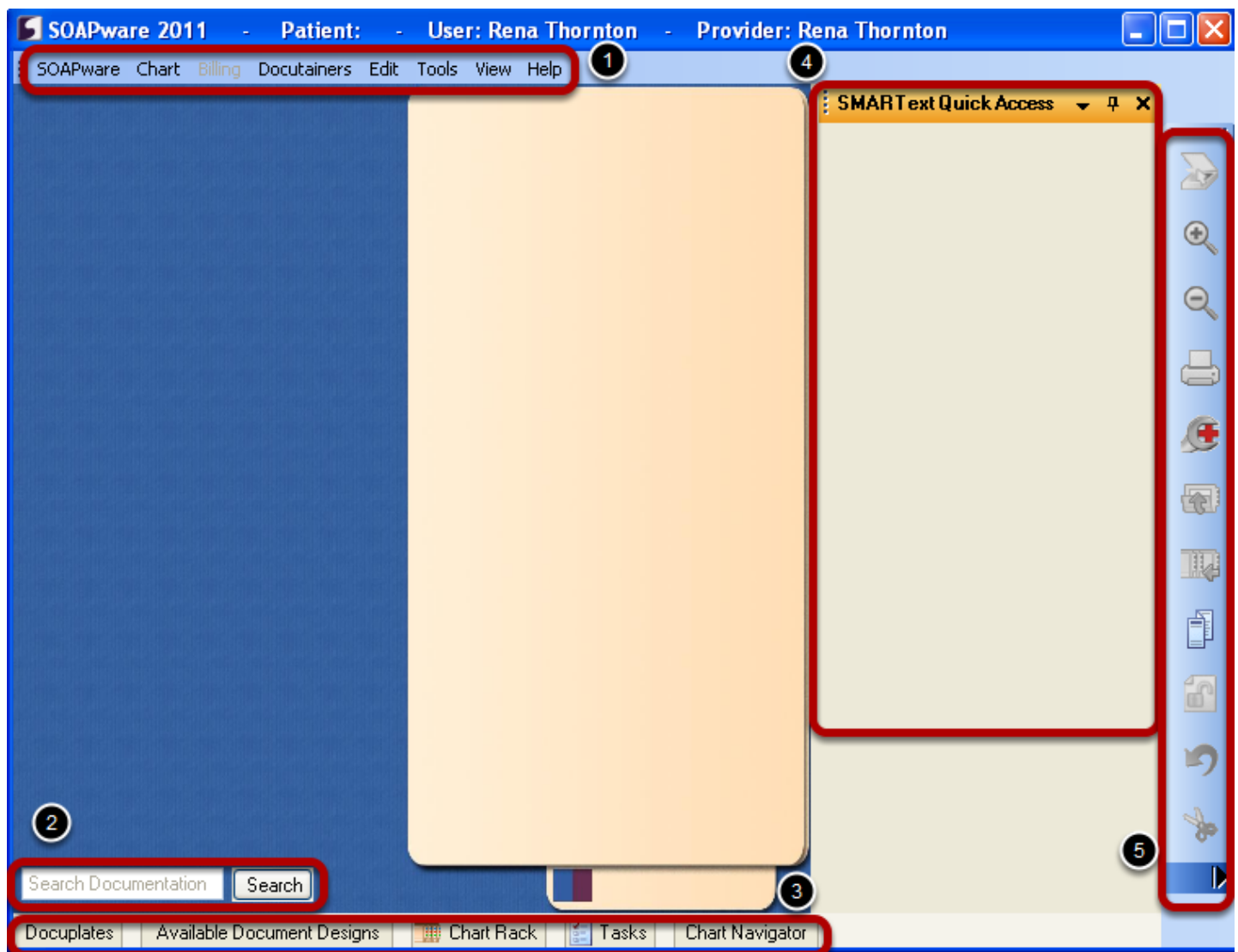
Exit Login



SOAPware 2011 has the capability to remember the last user that was logged in on a specific computer. This setting is managed as a security setting.

## Version 4 Interface

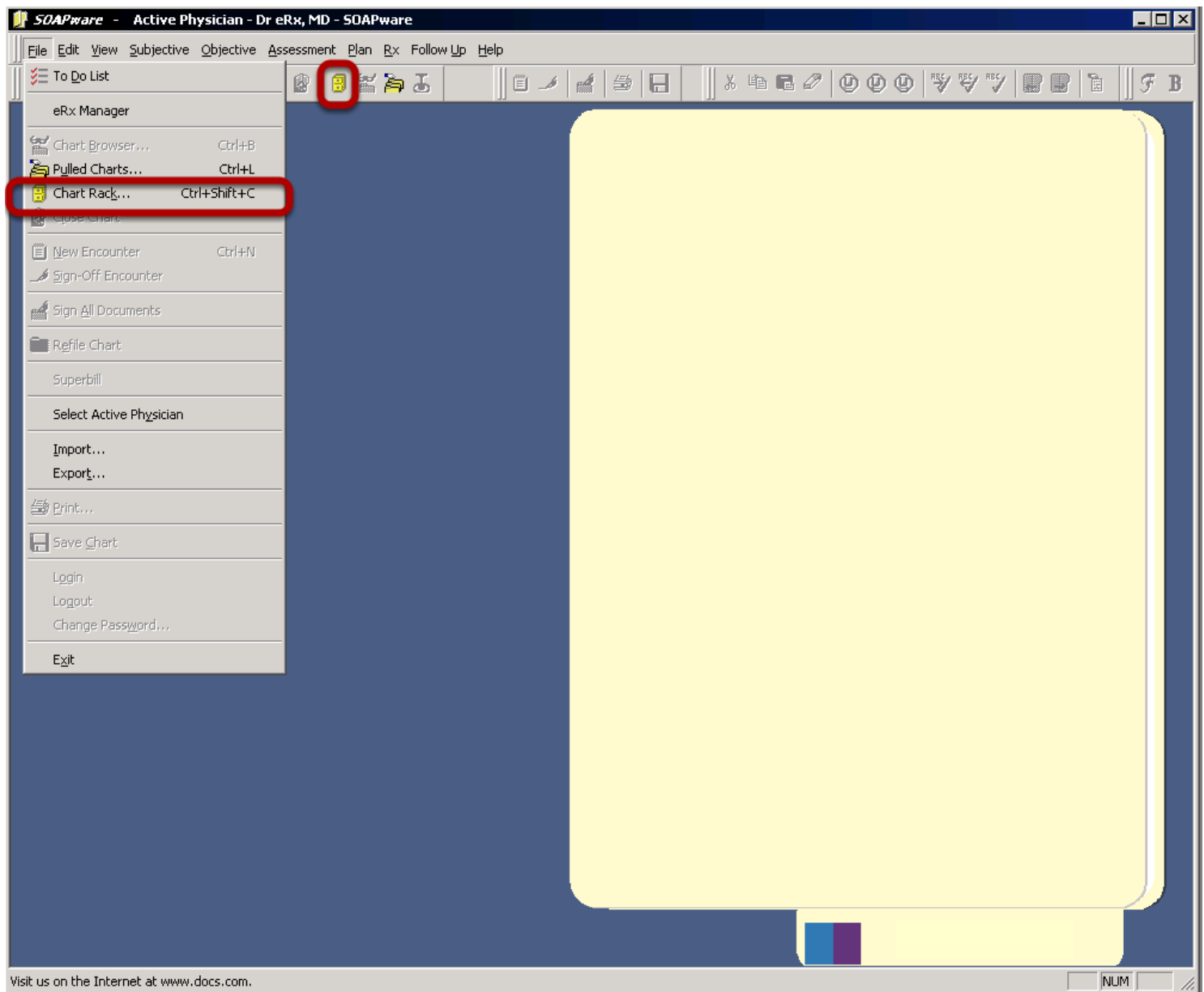


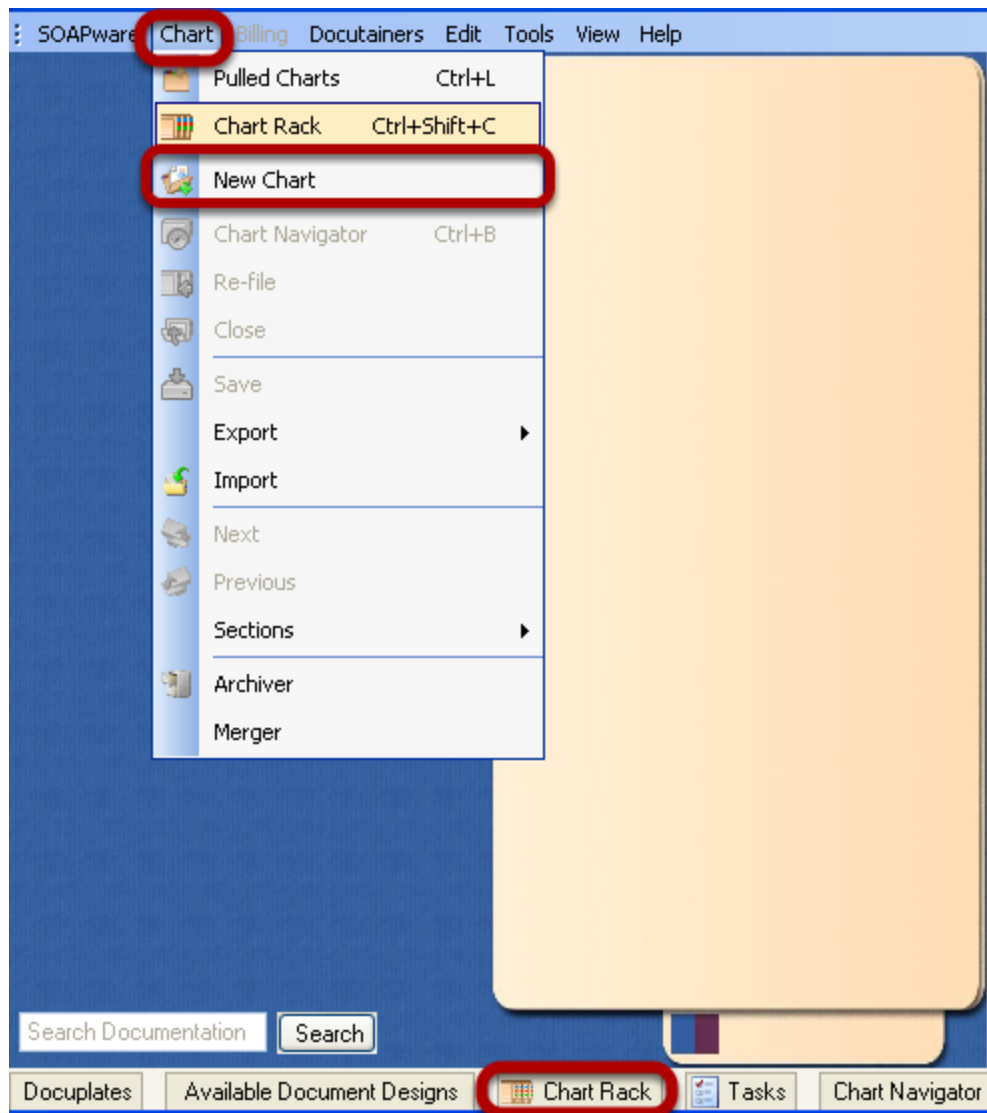


The interface background of SOAPware 2011 is similar to SOAPware Version 4 with several new features

1. New Menu Item Bar
2. SOAPedia Search box
3. Docked Tabs
4. SMARText Quick Access Window
5. Common Toolbars

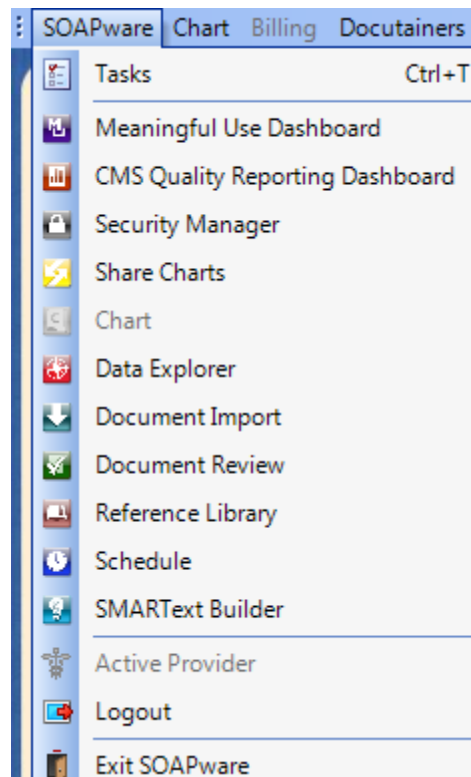
## Accessing Charts in Version 4





It is possible to access the Chart Rack by:

1. Clicking on the Chart Rack Docked Tab
2. Clicking on Chart From the Menu Item Bar and selecting Chart Rack
3. Using the keyboard command Ctrl+Shift+C



SOAPware now contains different workspaces, Version 4 only included the Chart workspace.

1. Meaningful Use Dashboard
2. CMS Quality Reporting Dashboard
3. Security Manager
4. Share Charts
5. Chart
6. Data Explorer
7. Document Import
8. Document Review
9. Reference Library
10. Schedule
11. SMARText Builder

**SOAPware To Do List** [X]

View List for -  ☐ Display Inactive Items

Description	Priority	Due	Status	Patient	Last Update
Encounter Created	4 - Low	09/15/201...	Review/Sign	Jane, Barbr...	09/15/2010
Encounter Created	4 - Low	09/15/201...	Review/Sign	Jane, Barbr...	09/15/2010
Encounter Created	4 - Low	08/23/201...	Review/Sign	Joe, Sally S.	08/23/2010
Encounter Created	4 - Low	08/19/201...	Review/Sign	Henson, D...	08/19/2010
Encounter Created	4 - Low	08/19/201...	Review/Sign	Jim, Slim	08/19/2010
Encounter Created	4 - Low	07/08/201...	Review/Sign	Jim, Slim	07/08/2010
Encounter Created	4 - Low	06/29/201...	Review/Sign	Caselman, ...	06/29/2010
Encounter Created	4 - Low	05/13/201...	Review/Sign	Henson, D...	05/13/2010
Drawings - Brain, External, L...	4 - Low	08/19/200...	Review/Sign	Jim, Slim	08/19/2006
Encounter Created	4 - Low	08/19/200...	Review/Sign	Jim, Slim	08/19/2006
Encounter Created	4 - Low	08/18/200...	Review/Sign	Hostetler, ...	08/18/2006
Encounter Created	4 - Low	08/18/200...	Review/Sign	Hostetler, ...	08/18/2006
- Created	4 - Low	04/18/200...	Review/Sign	Jim, Slim	04/18/2006
- Imported	4 - Low	04/18/200...	Review/Sign	Jane, Barbr...	04/18/2006

☒ Auto refile charts.

Buttons: Close, Add, Edit, Reassign, Remove, Set Status, Sign Off, Print Report, Print List, Delete



**Tasks**

User: Sample Nurse, R.N.

Show Tasks: Assigned Tasks Show Tasks due in: --Show All--

Layout: [ ]

Drag a column header here to group by that column.

Patient	Description	Notes	Priority	Action/Status	Due Date	Assigned To	Last Modified	Completed
Mouse, Mickey A.	SOAPNote		Normal	Needs Review	10/02/2010	Sample Nurse, R.N.	09/30/2010 15:04	<input type="checkbox"/>
Mouse, Mickey A.	HEPB VACC PE		Urgent	LMTC	10/02/2010	Sample Nurse, R.N.	09/30/2010 15:04	<input type="checkbox"/>
Mouse, Mickey A.	RichText		Normal	Needs Review	09/15/2010	Sample Nurse, R.N.	09/30/2010 15:04	<input type="checkbox"/>

The To Do List from Version 4 is now known as the Task Manager. To Do Lists from Version 4 do not transfer to SOAPware 2011. Every user with a log in ID will now automatically have a Task List. To ensure seamless transition, all To Do Lists must be completed prior to the conversion. Tasks have more functionality and contain more information than To Do Lists.

1. Control Buttons have been replaced and Quick Access Buttons have been added.
2. Tasks can show all tasks assigned, owned, created or pertinent to a specific patient.
3. Tasks can be sorted by columns.
4. Notes can be displayed and viewed with mouse over.
5. Reminders can be associated with Task Items.

## Version 4 Chart Layout

SOAPware - Active Physician - Dr eRx, MD - SOAPware

File Edit View Subjective Objective Assessment Plan Rx Follow Up Help

Messages Reports Summary Vital Signs  
Demographics Encounters Flow Sheets

**Active Problems**  
Congestive Heart Failure (enlarged and weakened heart) #428.0.  
GERD - Esophagitis - reflux (irritated swallowing tube) #530.10.  
Pharyngitis (sore throat) #462.

**Inactive Problems**  
Pneumonia #486.  
Otitis media (middle ear infection) #382.9.

**Surgeries**  
Has had an Appendectomy. - 2005

**Medications**  
updated 08/18/2006 0935 Cindy Savage, R.N.  
Lasix 40 mg (Disp- #100) Take one each morning (Refill - 1 year). Note - Check potassium every 6 to 12 months.(ID-d00070) - not taking  
Prilosec 20 mg Caps (Disp - #100) Take one daily (Refills- 1 year).(ID-d00325)  
Discounted Meds.  
Lasix 40 mg (Disp- #100) Take one each morning (Refill - 1 year). Note - Check potassium every 6 to 12 months.(ID-d00070) - not taking  
Keflex tablets 250 mg (Disp - #20) Take one twice daily (Refill - 0)

**Allergies**  
The patient reports no known drug allergies.

**Family History**  
**FATHER:** Good Health(+).  
**MOTHER:** Diabetes-Type 2 (+)takes medication. Good Health(-).  
**SIBLINGS:** Good Health(+).

Visit Date 05/15/2010 08:54  
Subjective  
Objective  
Assessment  
Congestive Heart Failure (enlarged and weakened heart) #428.0.  
GERD - Esophagitis - reflux (irritated swallowing tube) #530.10.  
Pharyngitis (sore throat) #462.  
Plan  
Hand cast CPT#29085.  
Medications  
asacol  
Follow Up

68332 Age- 78  
Jim, Slim

Visit us on the Internet at [www.docx.com](http://www.docx.com). NUM

## 2011 Default Chart Layout

**Summary** | Vital Signs | Demographics | Health Ma | SOAP Notes | Labs | Radiology | Billing Statements | Correspond

**Active Problems**  
Yodaism  
**Asthma** ICD#493.9 Onset: Status:  
**Anemia** ICD#285.9 Onset: Status:

**Inactive Problems**  
Fear of Darth Vader  
Cancer of Colon

**Surgeries**  
Upper Extremity Amputation  
Parathyroidectomy

**Medications**  
Current Meds: None.  
**Avandia:** Strength- 4 mg (tablet)  
SIG- 1 tab(s) orally 2 times a day for 30 days Comment-  
**Lipitor:** Strength- 20 mg (tablet)  
SIG- 1 each once a day  
**Diovan:** Strength- 160 mg (tablet)  
SIG- 1 each once a day

**Allergies**  
Pick List - Allergies:

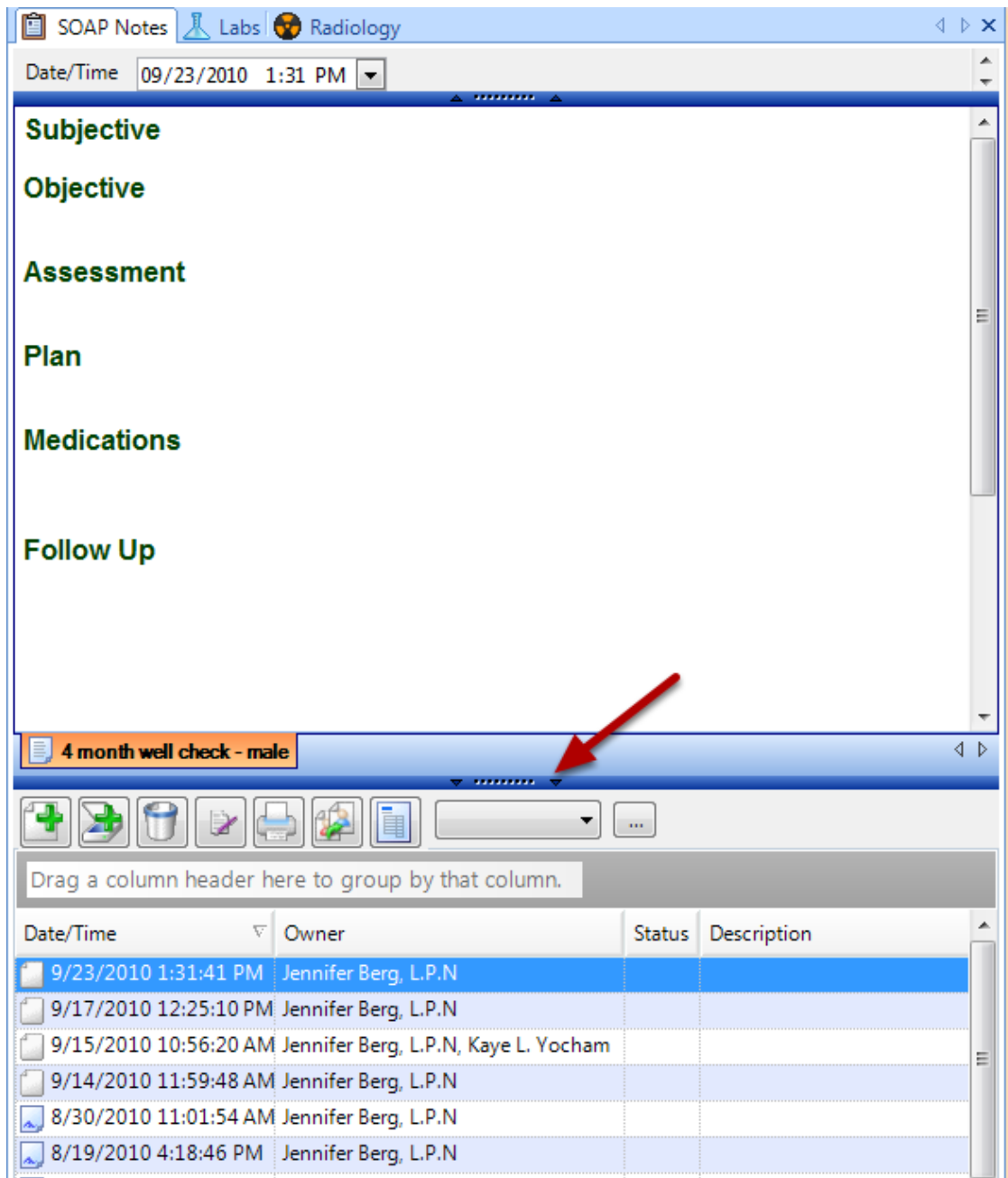
**SOAP Notes**  
Date/Time 02/22/2011 3:07 PM  
**Subjective**  
CHIEF COMPLAINT(S): Rash-localized, Earache or otalgia, Fever.  
[ HPI:  
SYMPTOMS/RELATED: Symptoms include fatigue (malaise or lethargy), weakness or tiredness, fever, night sweats.  
LOCATION: Area of involvement described as mouth, ear, face, sinus.  
QUALITY/COURSE: Symptoms reported to be unchanged.  
INTENSITY/SEVERITY: unremarkable  
DURATION: The general length of symptoms is reported to be days.  
ONSET/TIMING: Occurrence reported as 1 week ago.  
CONTEXT/WHEN: Usually associated with activity, hot weather, inactivity.  
MODIFIERS/TREATMENTS: Improved by analgesic, antihistamine, Chloraseptic, decongestant.  
ROS:  
**Objective**  
Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.  
**Assessment**  
SOAPNote  
Date/Time Owner Status Description Related  
02/22/2011 3:07 PM [Redacted] [Redacted] [Redacted] [Redacted]

Search Documentation Search

Docuplates Available Document Designs Chart Rack Tasks Chart Navigator

Skywalker, Luke Age-13 12/18/1997

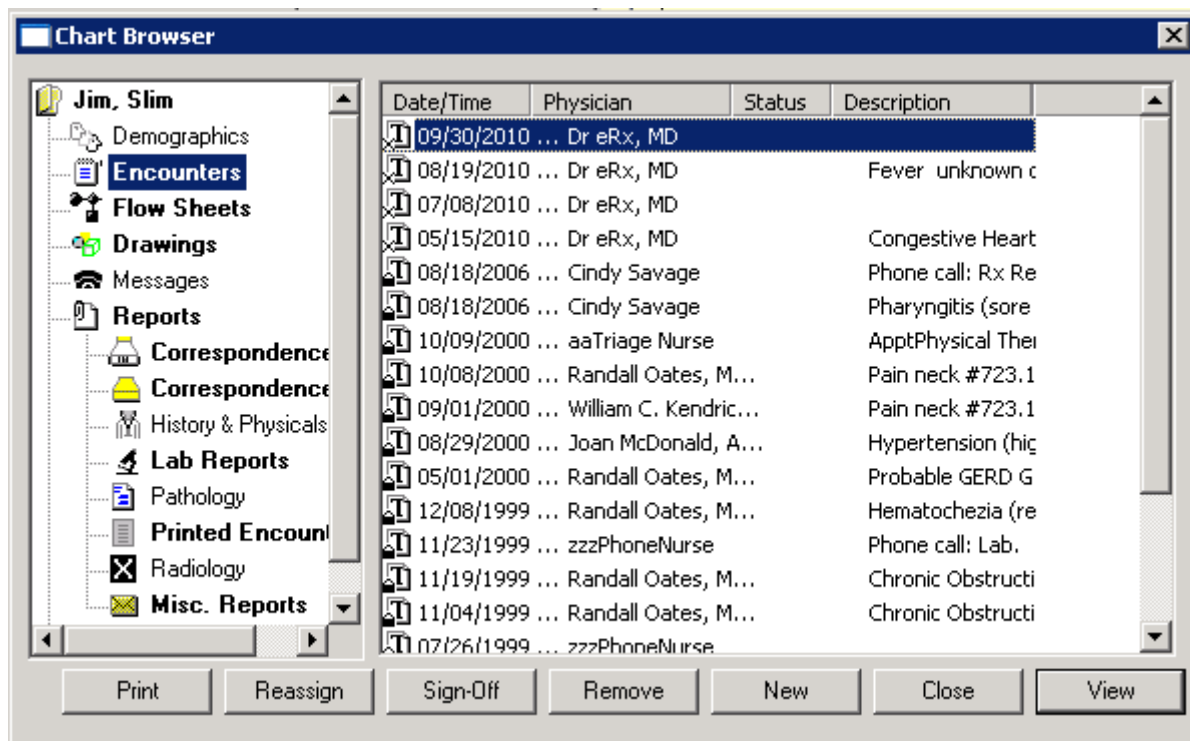
Charts Layouts can now be customized per user. Chart sections can be added or removed from the Chart Workspace. Version 4 Chart Layout could not be customized, and only displayed the Summary and SOAPnote.



Splitter bars are a function that will open or close, to give the user more or less information within a chart section.

Splitter bars will collapse or expand to display more information including a mini toolbar, as well as a document list within a chart section.

Actions such as creating a new docutainer, scanning, removing, and signing off a docutainer can be performed within the splitter bar.



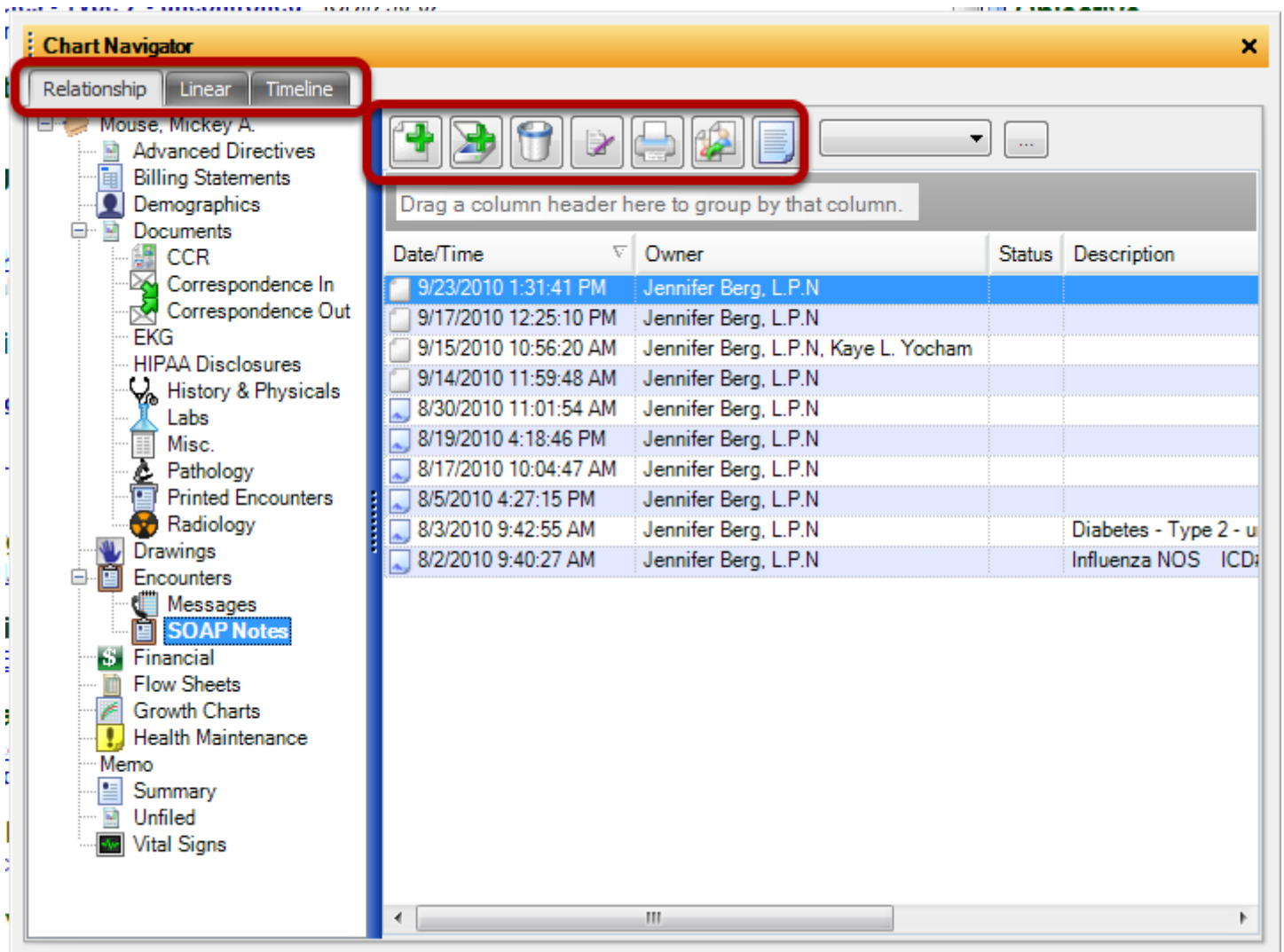
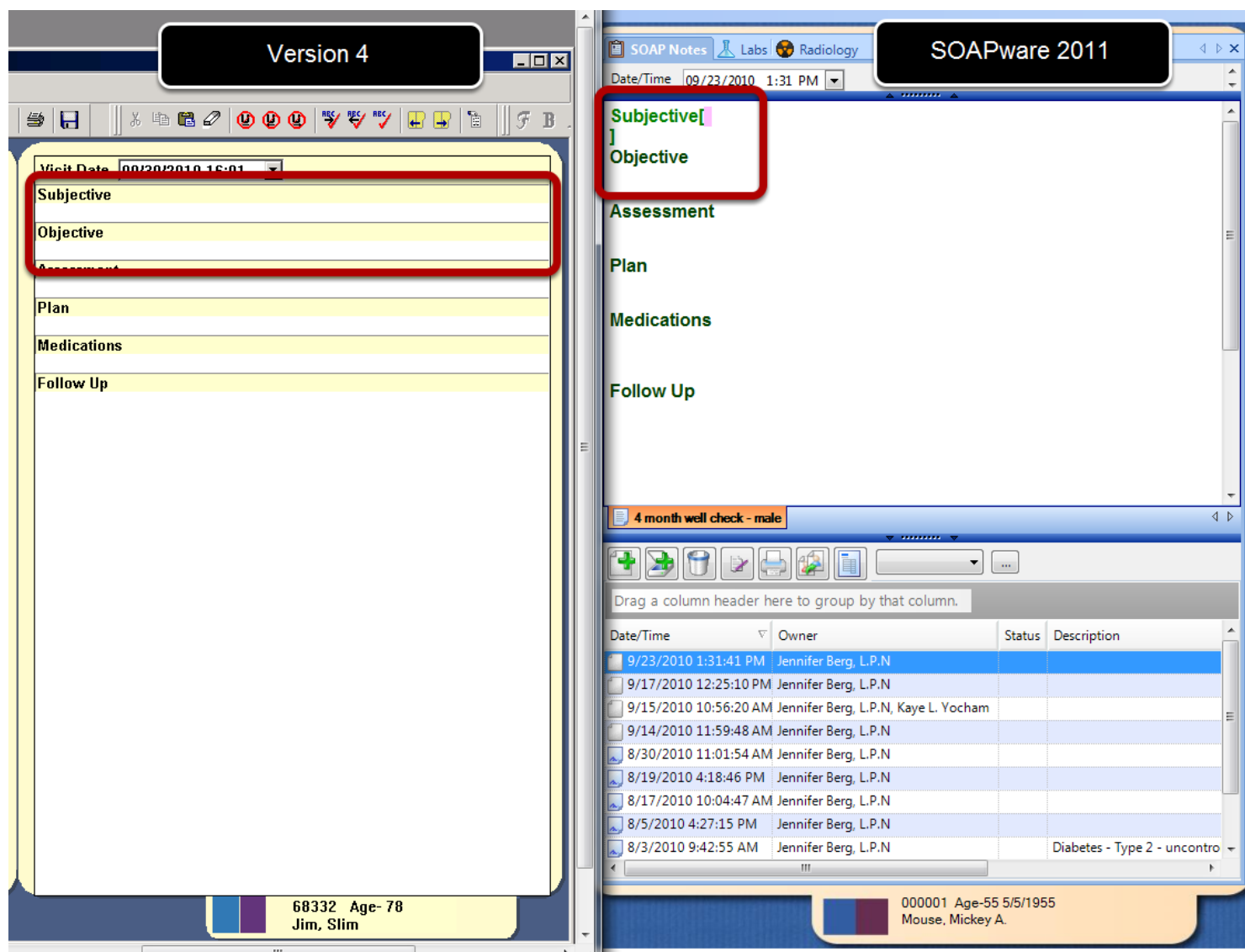


Chart Navigator can be viewed by Relationship, Linear or by Timeline for the patient. Control buttons have been replaced with quick access buttons. Docutainers can be moved from one chart section to another by the drag and drop method. Chart sections in the Chart Navigator can be added to the Chart Layout. The Chart Navigator can be accessed by clicking on the Docked tab or selecting Chart > Chart Navigator from the Menu Item Bar.



Encounters are now called SOAPnotes. Each field in version 4 was separated by lines, now in 2011 each field is separated by brackets.

Demographics	Encounters	Flow Sheets
Messages	Reports	Summary
Vital Signs		

**Active Problems**

Congestive Heart Failure (enlarged and weakened heart) #428.0.

GERD - Esophagitis - reflux (irritated swallowing tube) #530.10.

Pharyngitis (sore throat) #462.

**Inactive Problems**

Pneumonia #486.

Otitis media (middle ear infection) #382.9.

**Surgeries**

Has had an Appendectomy. - 2005

**Medications**

updated 08/18/2006 0935 Cindy Savage, R.N.

Lasix 40 mg (Disp- #100) Take one each morning (Refill - 1 year). Note - Check potassium every 6 to 12 months.(ID-d00070) - not taking

Prilosec 20 mg Caps (Disp - #100) Take one daily (Refills- 1 year).(ID-d00325)

Discounted Meds.

Lasix 40 mg (Disp- #100) Take one each morning (Refill - 1 year). Note - Check potassium every 6 to 12 months.(ID-d00070) - not taking

Keflex tablets 250 mg (Disp - #20) Take one twice daily (Refill - 0)

**Allergies**

The patient reports no known drug allergies.

**Family History**

**FATHER:** Good Health(+).

**MOTHER:** Diabetes-Type 2(+)takes medication. Good Health(-).

**SIBLINGS:** Good Health(+).

Version 4 documentation consisted of information free text typed into each field.



Summary Vital Signs Demographics

Active Problems

Alcohol problems ICD#303.90  
Benign hypertension ICD#401.1  
Atrial fibrillation ICD#427.31 controlled  
Heart Valve Disease ICD#429.9

Inactive Problems

Breast cancer ICD#174.9 right breast, in remission for 10 years.

Surgeries

Mastectomy: right. 1998.  
Cholecystectomy. 2 years ago, no compl.

Medications

Cromolyn Ophthalmic Solution 4% (solution) SIG- 1 drop(s) 4 times a day Lipitor: 20 mg (tablet) SIG- 1 each once a day Diovan HCT(Valsartan/HCTZ): 12.5 mg-80 mg (tablet) SIG- 1 each once a day  
Plavix (Clopidogrel): 75 mg (tablet) SIG- 1 each once a day  
Lipitor: 20 mg (tablet) SIG- 1 each once a day

Allergies

PENICILLIN: rash  
Drug Allergies: No known. (ID-Ignore)

Family History

PARENTS: Cancer of Breast: mother  
Positive family history for - Strokes -Cerebrovascular Disease;; Coronary artery disease: on both sides

Tobacco

No exposure to tobacco.

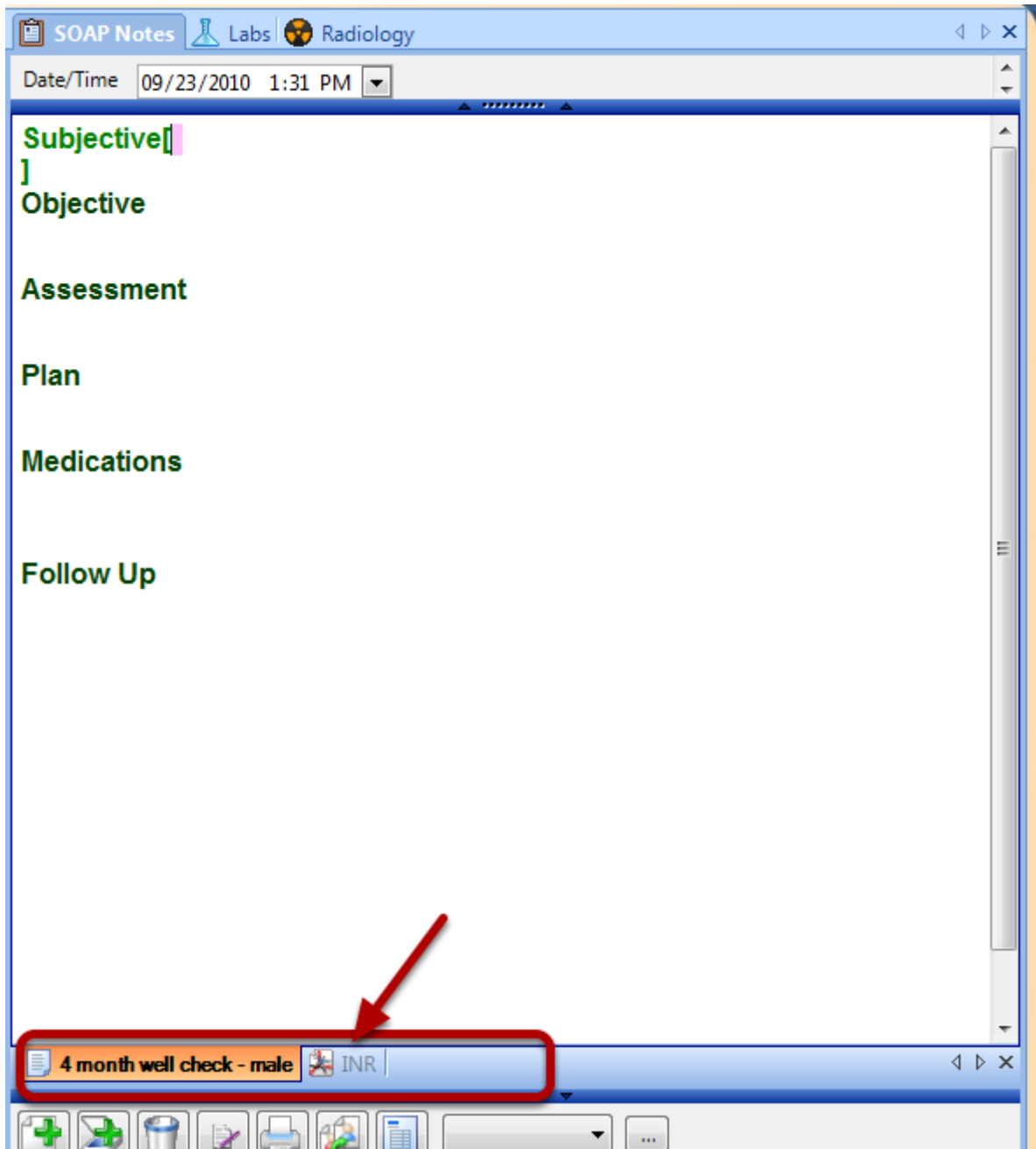
Alcohol

No alcohol consumed.

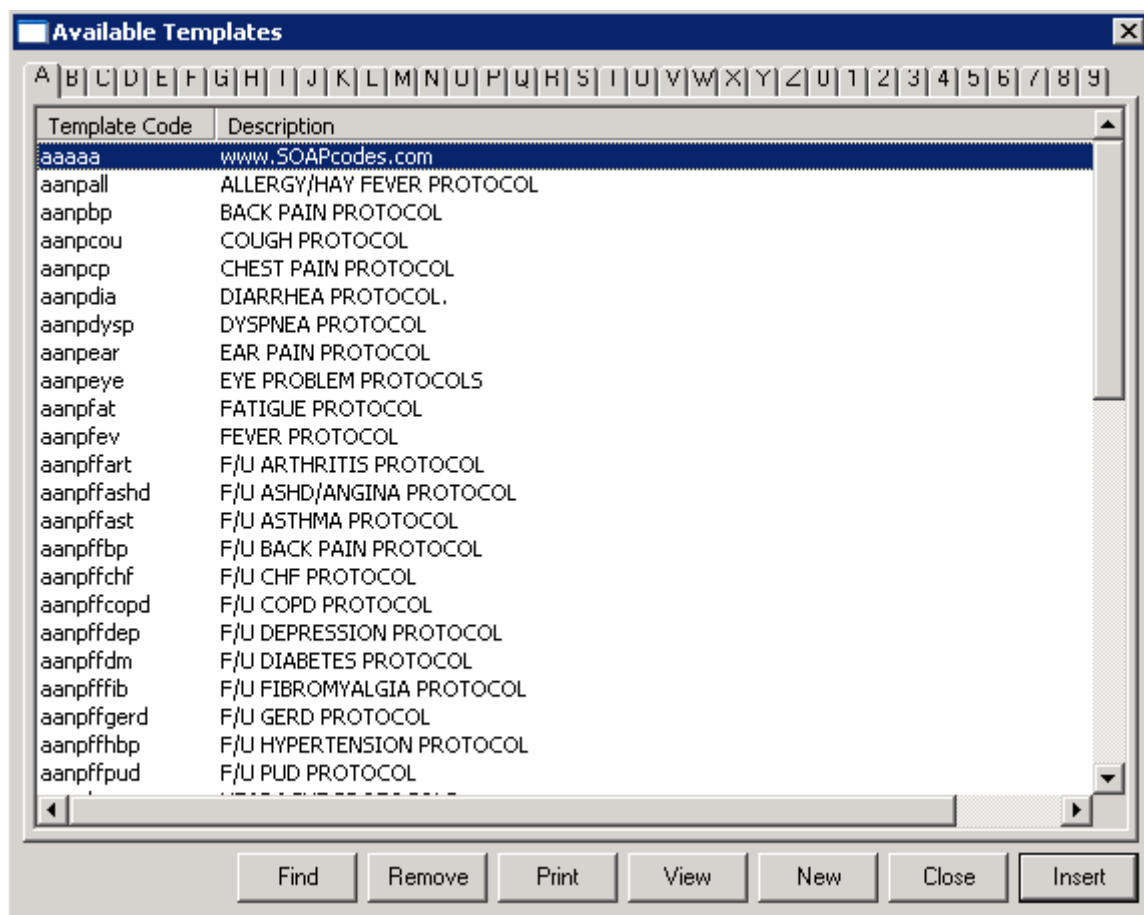
Interventions

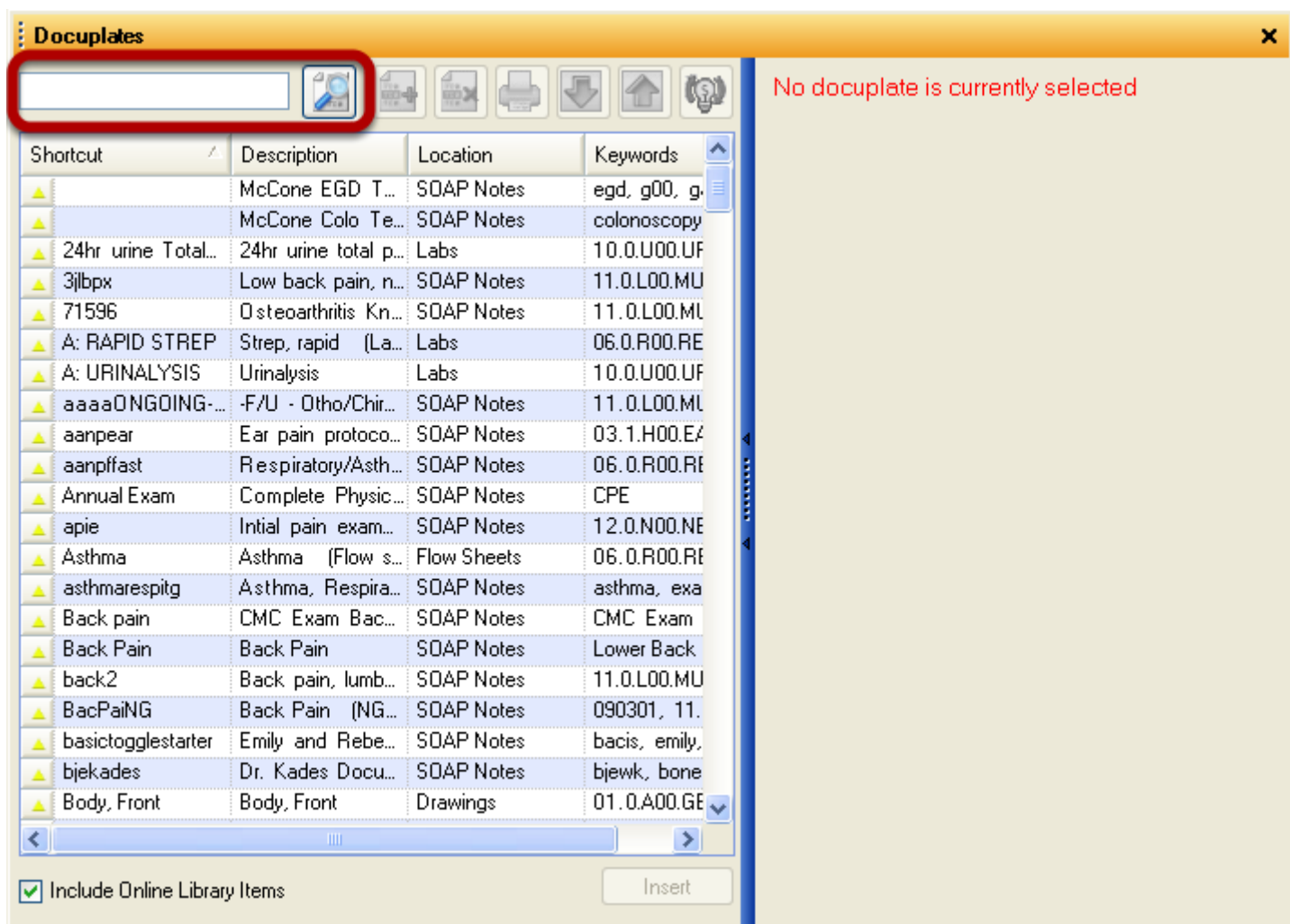
Summary

2011 documentation may consist of unstructured free text data, pick lists, and structured data called SMARText, that is searchable and reportable. Pick lists give users SMARText Items to choose and select from, in the SMARText Quick Access Window.

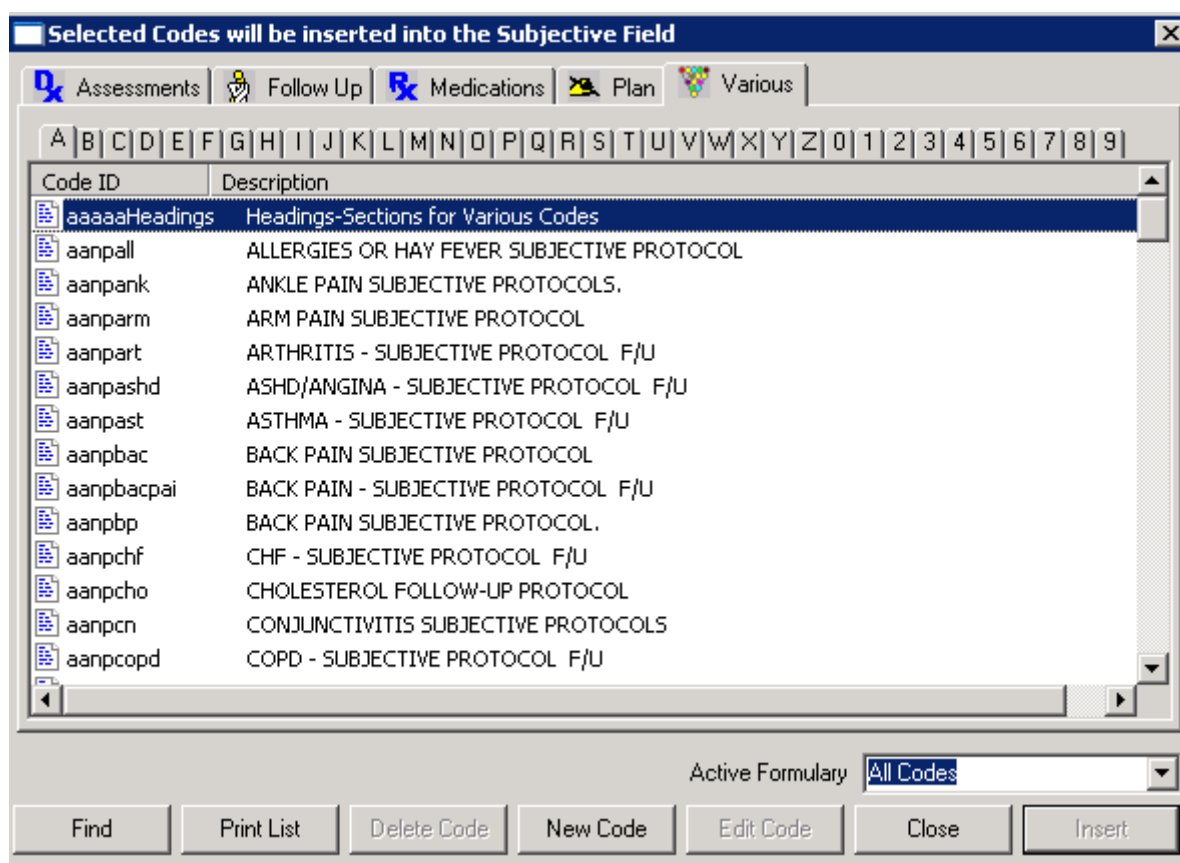


In Version 4, documents were individual pieces of information. SOAPware 2011 has the ability to attach multiple documents to a single Docutainer in all chart sections. Multiple documents can include Lab, Radiology reports, videos and Growth Charts.

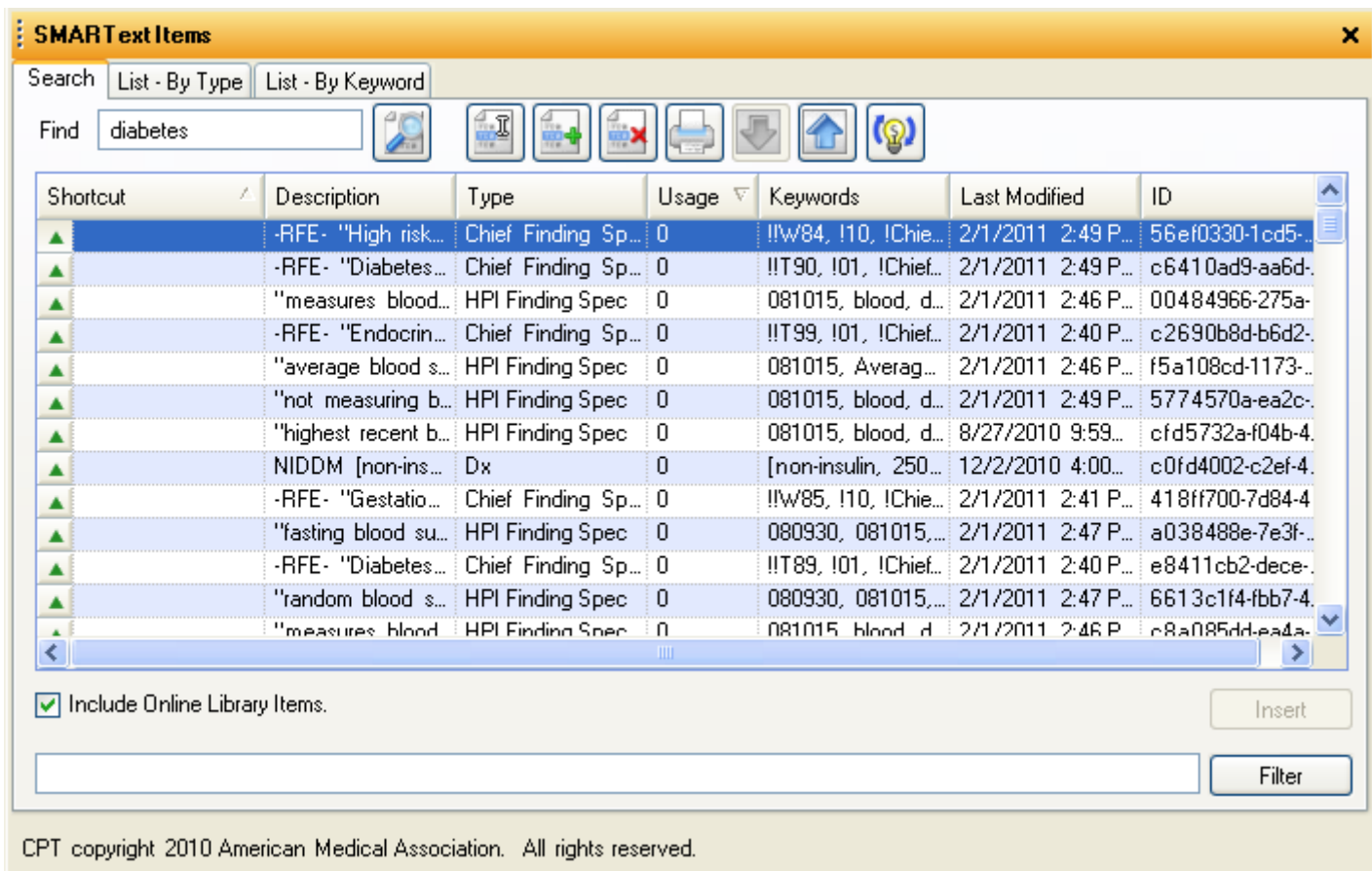




Version 4 Templates have now been replaced with 2011 Docuplates. Templates created in Version 4 will convert to 2011, but their function is now considered obsolete. Docuplates can be found in the user's local database, as well as the SOAPware Online Library. Docuplates can be created for every chart section. To access Docuplates, either Click on the docked tab or Select Docutainers from the Menu Item Bar.



Shortcut Codes created in Version 4 were either field specific or various.



SMARText Items

Search List - By Type List - By Keyword

Find diabetes

Shortcut	Description	Type	Usage	Keywords	Last Modified	ID
▲	-RFE- "High risk...	Chief Finding Sp...	0	!!W84, !I10, !Chie...	2/1/2011 2:49 P...	56ef0330-1cd5...
▲	-RFE- "Diabetes...	Chief Finding Sp...	0	!!T90, !I01, !Chie...	2/1/2011 2:49 P...	c6410ad9-aa6d...
▲	"measures blood...	HPI Finding Spec	0	081015, blood, d...	2/1/2011 2:46 P...	00484966-275a...
▲	-RFE- "Endocrin...	Chief Finding Sp...	0	!!T99, !I01, !Chie...	2/1/2011 2:40 P...	c2690b8d-b6d2...
▲	"average blood s...	HPI Finding Spec	0	081015, Averag...	2/1/2011 2:46 P...	f5a108cd-1173...
▲	"not measuring b...	HPI Finding Spec	0	081015, blood, d...	2/1/2011 2:49 P...	5774570a-ea2c...
▲	"highest recent b...	HPI Finding Spec	0	081015, blood, d...	8/27/2010 9:59...	cfd5732a-f04b-4...
▲	NIDDM [non-ins...	Dx	0	[non-insulin, 250...	12/2/2010 4:00...	c0fd4002-c2ef-4...
▲	-RFE- "Gestatio...	Chief Finding Sp...	0	!!W85, !I10, !Chie...	2/1/2011 2:41 P...	418ff700-7d84-4...
▲	"fasting blood su...	HPI Finding Spec	0	080930, 081015,...	2/1/2011 2:47 P...	a038488e-7e3f...
▲	-RFE- "Diabetes...	Chief Finding Sp...	0	!!T89, !I01, !Chie...	2/1/2011 2:40 P...	e8411cb2-dece...
▲	"random blood s...	HPI Finding Spec	0	080930, 081015,...	2/1/2011 2:47 P...	6613c1f4-fbb7-4...
▲	"measures blood	HPI Finding Spec	0	081015, blood, d...	2/1/2011 2:46 P...	c8a085dd-ea4a...

☒ Include Online Library Items.

Insert

Filter

CPT copyright 2010 American Medical Association. All rights reserved.

SOAPware 2011 SMARText Items have many different item types and functionalities. SMARText items are the backbone for documentation within SOAPware. These items may be used in any field or Chart Section. Structured SMARText items are searchable and reportable and are necessary to participate in the Meaningful Use Initiatives. Items in the SMARText Items manager can be searched in the user's local database, or on the SOAPware Online Library. To access the SMARText Items Manager select Docutainers from the Menu Item Bar or use the keyboard command F10.

**SOAPware Superbill** [X]

Available Codes		Currently Selected
Allergy Shot	611 90782	
Anoscopy	204 46600	
Arthritis Panel	544 80072	
Audiogram	200 92552	
BID	509 87082	
Bun	504 84520	
CBC	501 85031	
Chest - 1 View	702 71010	
Chest X-Ray	703 71020	
Cholesterol	528 82465	
DPT	605 90701	
Drug Abuse Screen	557	
Drug Screen Collection	583	
D-Tetanus	644 90718	
Ear Irrigation	201 69210	
EKG	700 93000	
EKG Rhythm Strip	701 93040	
Emply/DOT	108 00000	
Estab. Pt Eval/Management	104 99212	
Estab. Pt Eval/Management	105 99213	
Estab. Pt Eval/Management	106 99214	
Estab. Pt Eval/Management	100 00015	
Assessment		Remarks

Close Print Post

SOAP Notes Labs Radiology **Billing Statements**

Posted On N/A Owner Jennifer Berg, L.P.N. Facility Jennifer's Clinic

Description	CPT	Diagnosis	Modifiers
X Diabetic management program.	S9465		
X SPRING-POWERED LANCET DEVICE.	A4258		
X Urine reagent strips/tablets.	A4250		
X Replace lensshield cartridge.	A4257		
X ASSAY, GLUCOSE, BLOOD QUANT.	82947		
X GENERAL HEALTH PANEL.	80050		

Assessment Misc. Info

Diabetes - Type 2 - uncontrolled #250.82

Notes

Drag a column header here to group by that column.

Date	Name	Status	Owner
10/1/2010 2:29:31 PM	Superbill		

2011 Billing Statements are contained within the patient's chart as a chart section named "Billing Statements". Billing Statements pull structured information from the Assessment and Plan fields of the SOAPnote. New functionality has been added to this section with the addition of the CMS 1500 Form.



**New Rx Submission**

Pharmacy

Name SOAPware: Test Fax

Address Test Fax

Phone

Fax 866-237-9073

Find

Script

Medication	Dose/Unit	Amount	Units	Refills
------------	-----------	--------	-------	---------

Add Rx

Update SW

Submit

Cancel

Rx Manager

Rx Pad

Medications

History

Patient - Refill Requests

Pharmacy CITY PHARMACY (Ph#- 479-751-2072 Fax#- 479-751-2341) 701A SOUTH THOMPSON SPRINGDALE, AR 72764

Patient Information

Allergies

CEPHALOSPORIN - (e.g. KEFLEX):

Notes

Add Rx

Update Summary

Interactions

Show Header

Actions	Rx	Misc	
<input checked="" type="checkbox"/> 	<b>Metformin (Glucophage):</b> 500 mg (tablet) 1 each 2 times a day orally #60 Substitutions Allowed 12	Pending CITY PHARMACY Jennifer Berg, L.P.N. Valid Script Coverage Details	10/1/2010 Remove Rx
<input checked="" type="checkbox"/> 	<b>Actos (Pioglitazone):</b> 30 mg (tablet) 1 each once a day orally #30 Substitutions Allowed 12	Pending CITY PHARMACY Jennifer Berg, L.P.N. Valid Script Coverage Details	10/1/2010 Remove Rx

Retrieve Eligibility Info

Submit

2011 Rx Manager has many new functionalities. Information is pulled from various sections of the chart and displayed in the Rx Manager. Allergy information as well as drug interaction information will display in the Rx Pad. When adding a new prescription, the Rx Manager will automatically update the SOAPnote Medication Field as well as prompting the user to update the Summary Medication Field. Rx Manager can retrieve patient eligibility and drug formulary information. Rx Manager meets the Meaningful Use Stage 1 Criteria for e-Prescribing. This can be accessed from the Docutainer Menu Item and selecting Rx Manager, or by using keyboard command F8.

## Version 4 Pulled Charts

**Pulled Charts** [X]

Name	Chart #	Date/Time	Physician	Status
Caselman, Keith W		07/20/2010 02:40 PM	Dr eRx, MD	Availab...
Duck, Daisy		08/30/2010 11:32 AM	Dr eRx, MD	Availab...
Henson, Danny	1122334455	05/13/2010 02:02 PM	Dr eRx, MD	Availab...
Hostetler, Juanita		08/18/2006 10:52 AM	Dr eRx, MD	Availab...
Jane, Barbra "Diann"	90594.1	04/18/2006 10:17 AM	Dr eRx, MD	Availab...
Jim, Slim	68332	08/19/2006 08:38 AM	Dr eRx, MD	Availab...
Joe, Sally S.	98732.0	08/23/2010 10:30 AM	Dr eRx, MD	Availab...

Active Doctor: Dr eRx, MD [v]

Remove Inactive Reassign Print List Close View

## 2011 Pulled Charts

**Pulled Charts** [X]

All Providers [v] [Icons]

Name /	Chart Number	Status	Location	Visit Date
Catipillar, Hermie	001			09/13/2010 11:35
Clyde, Annie				09/30/2010 16:23
Duck, Donald				08/26/2010 15:31
Mouse, Minnie				09/23/2010 10:11

Pulled Charts in SOAPware 2011 is still available, but it's functionality is considered obsolete. SOAPware recommends users to manage items from the Task Manager.

Previous Encounters

Subjective

Objective

Assessment

Plan

Medications

Follow Up

Date/Time	Physician	Status	Description
09/30/2010 16:01	Dr eRx, MD		
08/19/2010 13:50	Dr eRx, MD		Fever unknown or..
07/08/2010 14:27	Dr eRx, MD		
05/15/2010 08:54	Dr eRx, MD		Connective Heart...

Print

Close

**Encounter Viewer** [X]

By Date | By Rx | By Dx

**Subjective**

CHIEF COMPLAINT: Diabetes - Non-insulin dependent.

HPI: SYMPTOMS/RELATED: Reports symptoms of  
Denies symptoms of anorexia or loss of appetite, dehydration, foot/toe pain or problems, polydipsia or excessive thirst, polyuria, weight gain, weight loss, weakness or tiredness.  
 +++++ uncertain | unremarkable | N/A | no complaints |

QUALITY/COURSE: Reports condition is  
Denies, in general,  
 +++++ improving | unchanged | worsening | resolved | uncertain | unremarkable | N/A |

INTENSITY/SEVERITY: Reports measurement ( or degree) as  
Declines to define as  
 +++++ mild | moderate | severe | highest recent blood sugar was- | lowest recent blood sugar was- |  
 measures blood sugar at least daily | measures blood sugar at least monthly | not measuring blood sugar |  
 readings are good | readings are poor | readings are within goals | highest recent blood sugar was- | highest recent blood sugar was- | uncertain | unremarkable | N/A |

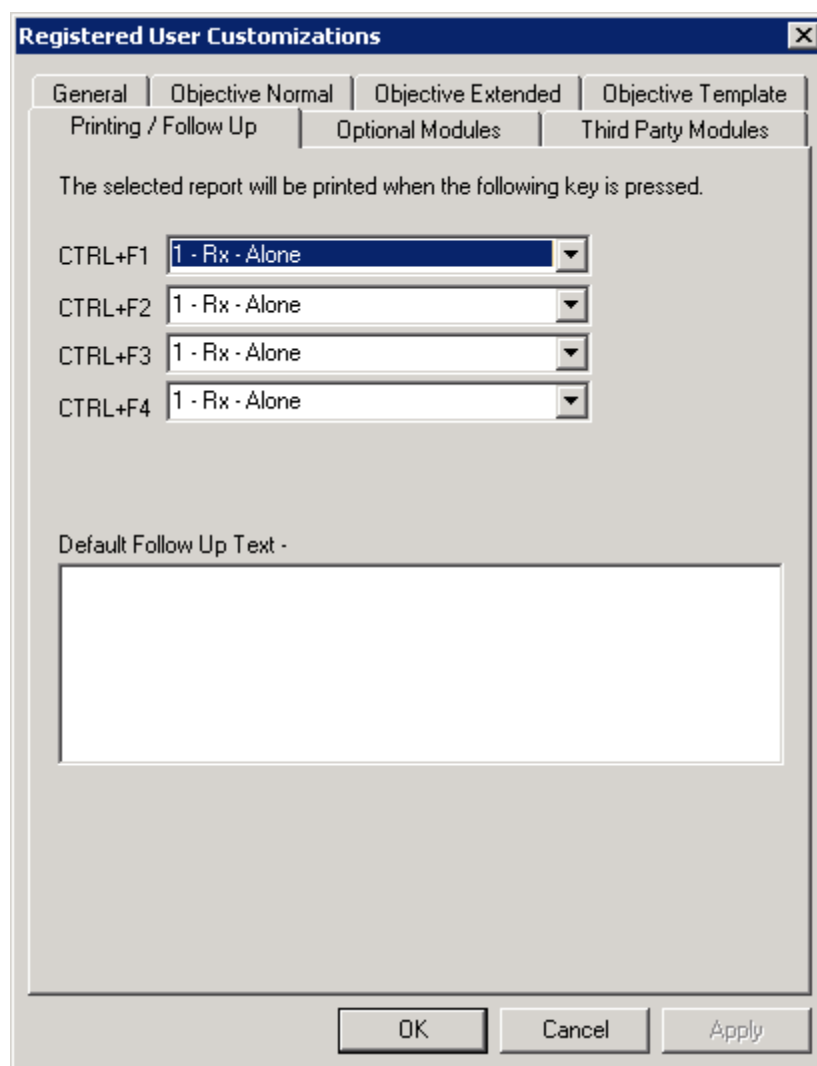
ONSET/TIMING: Reports occurrence as chronic.

**SOAPNote**

Date	Description	Provider
10/1/2010 2:27 PM	Diabetes - Type 2 - uncontrolled ICD#250.82	Jennifer Berg, L.P.N
9/23/2010 1:31 PM		Jennifer Berg, L.P.N
9/17/2010 12:25 PM		Jennifer Berg, L.P.N
9/15/2010 10:56 AM		Jennifer Berg, L.P.N, Kaye L. Yocham

Add Active Field to Current Encounter    Add Active Document to Current Encounter

2011 Encounter Viewer offers the ability to search documentation by Date, Prescription or Diagnosis. Added functionality includes the ability to copy a field or an entire document to a current SOAPnote. This is accessed through the Tools Menu Item.



The dialog box is titled "Registered User Customizations" and has a close button (X) in the top right corner. It contains several tabs: "General", "Objective Normal", "Objective Extended", "Objective Template", "Printing / Follow Up", "Optional Modules", and "Third Party Modules". The "Printing / Follow Up" tab is currently selected. Below the tabs, there is a text label: "The selected report will be printed when the following key is pressed." Below this label, there are four rows of key command settings, each with a label and a dropdown menu:

Key Command	Selected Value
CTRL+F1	1 - Rx - Alone
CTRL+F2	1 - Rx - Alone
CTRL+F3	1 - Rx - Alone
CTRL+F4	1 - Rx - Alone

Below the key command settings, there is a text label: "Default Follow Up Text -". Below this label is a large, empty text box for entering the default follow-up text. At the bottom of the dialog box, there are three buttons: "OK", "Cancel", and "Apply".

Version 4 Print commands were provider-specific. Security access was required to edit these settings.

**Options**

- Chart Layouts
- Chart Rack
- Document Designer**
- Docuplates
- OCR
- Pharmacy Manager
- Pulled Charts
- Scanning
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Immunization Entry
- Structured Order Entry
- Structured Rx
- Summary To SOAP
- Toolbars
- Vital Signs
- Workflow

Ctrl + F1 - Print	1 - Rx - Alone
Ctrl + F2 - Print	4 - Extended SOAP Note
Ctrl + F3 - Print	2 - Simple SOAP Note
Ctrl + F4 - Print	3 - Patient Copy

2011 Print Commands are user-specific, and are managed by individual users. User-specific settings are customized through the Tools Menu Item and selecting Options.

**Report Writer - 1 - Rx - Alone**

Reports Edit Insert Format Table Data Items Macros

**B** *I* U [List Icons] [Align Icons]

0 1 2 3 4 5 6 7 8

##\$DisplayPrinterDialog\$##\$RxAlone\$## **PRESCRIPTION:** (Give to the pharmacist)

---

##\$CurrDoctor\$##

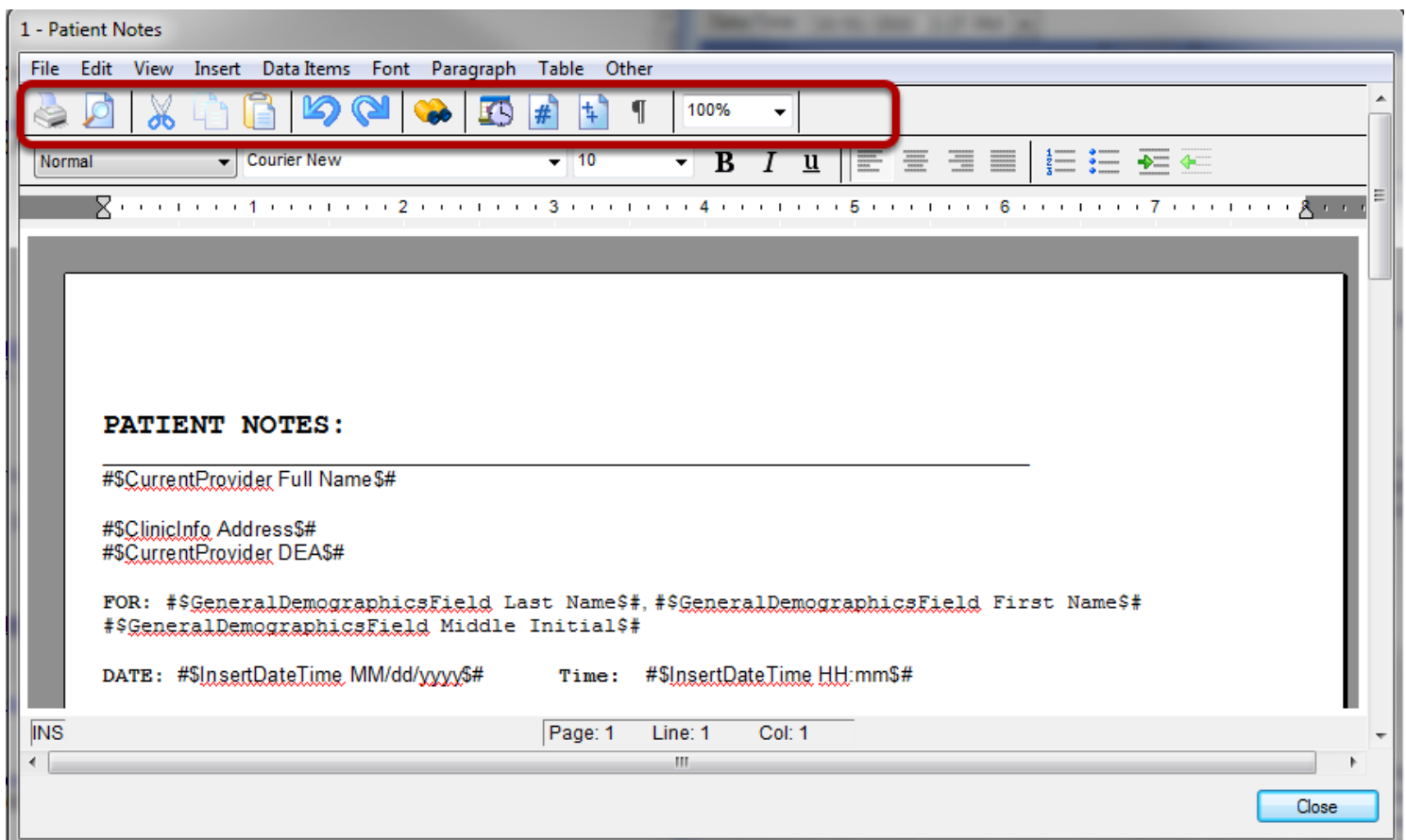
##\$ClinicAddress\$##  
##\$DoctorDEA\$##  
##\$CurrDoctorStateID\$##

**FOR:** ##\$DBRecord Name\$## **Age:** ##\$DBRecord PatientAge\$##

**DATE:** ##\$CurrDate\$## **TIME:** ##\$InsertTime\$##

TextControl StatusBar





Report writer has been changed to Document Designer. Edit buttons have been added for easy access . Some Data Commands used in Version 4 will not convert to SOAPware 2011. Document Designer is located in the Tools Menu Item.

**Security Administration** [X]

☐ Security Enabled

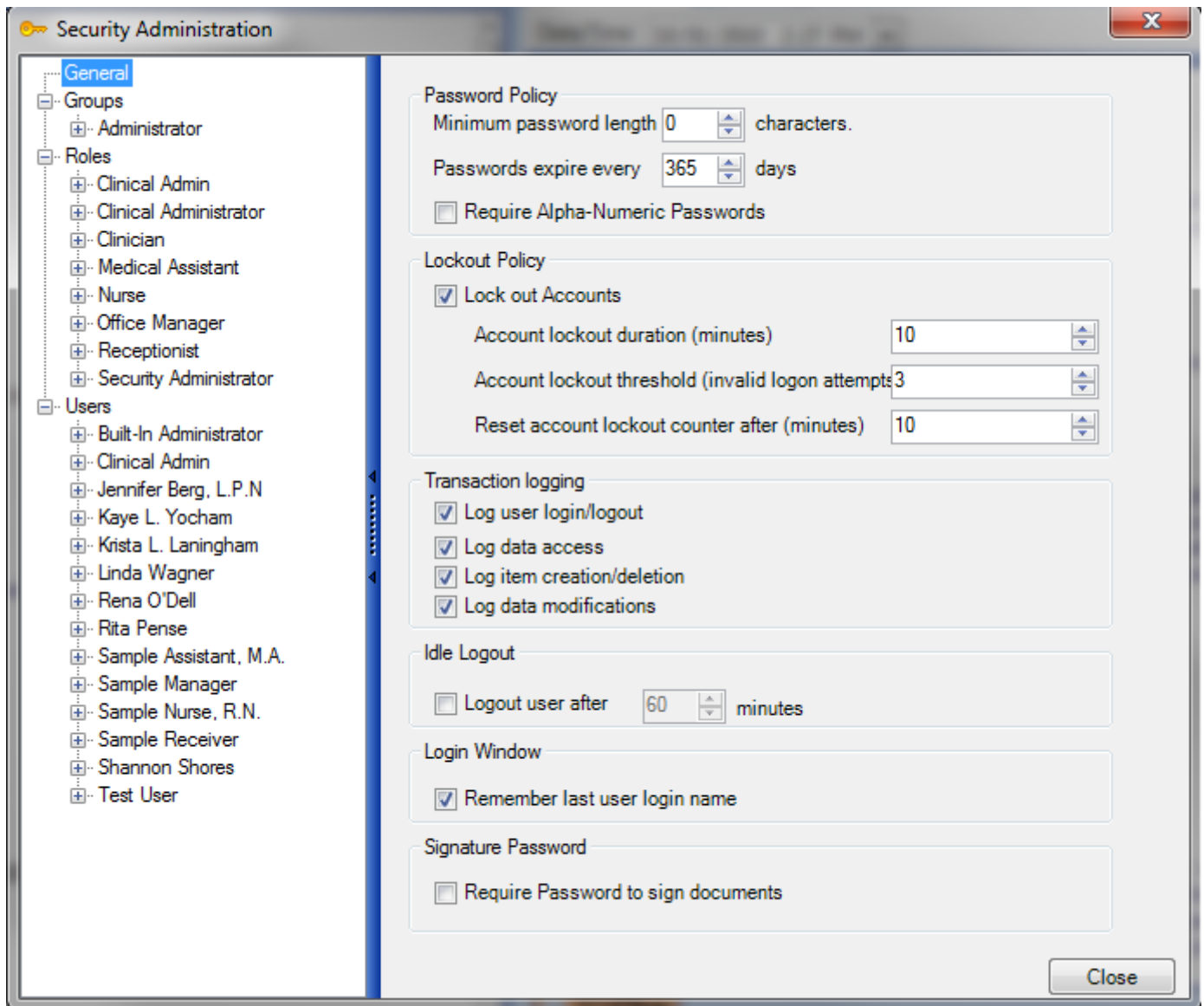
admin  
Cindy Savage  
Kaye Yocham  
SW1  
SW10  
SW11  
SW12  
SW13  
SW14  
SW15  
SW16  
SW17  
SW18  
SW19  
SW2  
SW20  
SW3  
SW4  
SW5  
SW6  
SW7  
SW8  
SW9

Add  
Edit  
Delete  
Close

☐ Load last accessed patient on Log In.

☐ Enable Transaction Checking

☐ Auto Logout after  minutes of inactivity.



Security settings from Version 4 will not transfer to SOAPware 2011. Security is required in SOAPware 2011 for all users. Groups and Roles have been added to allow or deny access to various functions and chart sections within SOAPware. All current and inactive user actions are now logged automatically and can be tracked with audit logs. Audit logs can also be performed on a specific patient's chart. Security is accessed by clicking on the Tools Menu Item or through the Security Manager Workspace.

## V4 Conversion FAQ's

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1. Q: How do I convert my old V4 shortcut codes into structured SMARText items?
2. Q: When reassigning V4 shortcut codes to a structured SMARText Item, how can then change be permanent?
3. Q: Why are my print reports from V4 not printing out the patient's name/dob/address in the new version?
4. Q: Where are my templates from V4?

# Setup

## SOAPware Set-up

---

Many of the SOAPware setup tasks involve simple data entry, however, there are several areas that require clinician input and direction. The many customizable settings and options available in SOAPware mean virtually any Individual preferences and needs related to workflow can be accommodated.

### First Things First - Planning Clinical and Office Work Environments

Establishing productive workflows is dependent upon many factors, including the physical layout of computer workstations, printers, scanners and faxing equipment in clinical and office spaces.

#### 1. Printers

Printers should be placed in a location that is convenient to providers and staff members needing to retrieve letters, forms and prescriptions printed out for patients.

Example: Printers placed at the nursing desk, in each exam room and/or at the front desk. A combination of any of these locations may be required, including a centrally-located printing station connected to the clinic network.

#### 2. Scanners

Scanner(s) should be placed in a location that is convenient for use by staff members authorized to scan documents, images, etc. into patient charts.

#### 3. Fax Machines

Like printers, fax machines should be placed in areas accessible to all who will be using this equipment during the normal clinic workflow. Multi-function machines such as a printer/fax/copier are sometimes beneficial to improving workflow.

#### 4. Fax Software

Fax software can be used to fax prescriptions and/or notes and information directly from SOAPware to outside providers. The fax software is displayed as a print option from within SOAPware. When selecting fax software, care should be taken to acquire software that meets HIPAA encryption requirements for protecting patient confidentiality.

## Beginning the Set-up Process

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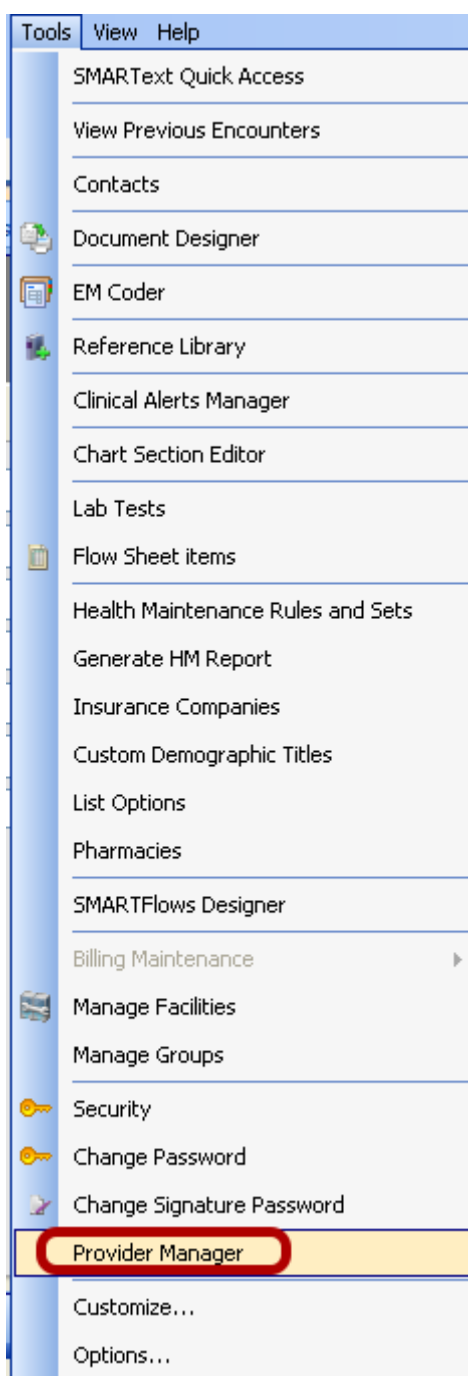
### Activate Licenses

Clinic provider licenses are normally activated during the installation process. If this is not the case, please consult the SOAPware Installation Guide for instructions.

### ePrescribing

e-Prescribing requires entry of a DEA number and a fax number for each provider. This is done in Provider Manager.

**NOTE: A Nurse Practitioner without a DEA number must enter their NPI number.**



To enter this information, first open Provider Manager. Click Tools in the menu bar and Click the Provider Manager menu item.



## Update Provider Information

**Providers**

Providers

- Kaye L. Yocham
- Krista L. Laningha
- Rena Thornton
- Rita Pense
- Shannon Shores

**General** Misc Codes Signature

**Name**

Title First M Last Suffix

First: Kaye M: L Last: Yocham

**Address**

Clinic: SOAPware 2008 - Traini

Street: 4220 N. Crossover Rd.

City: Fayetteville State: AR Zip Code: 72703-

**Contact Information**

Phone #: 8004557627500

Fax #: ( ) -

Email: kaye.yocham@soapware.com

**Physician Numbers**

DEA #: BB0000 State ID:

NPI#: 111111111| UPIN#:

☒ Is Supervisor

**Update**

1. Enter in the provider(s) information (including DEA and NPI numbers)
2. Click Update.

## Update Provider Information - Register Provider

Once this information is entered, SOAPware Support will register the provider(s) with the SureScripts network and the user will receive an email confirmation with registration information within 1-2 business days.

## SOAPwareXchange (additional enhancement)

SOAPwareXchange is an enhancement that integrates SOAPware with other systems. Most often, this is a billing or PMS system. SOAPwareXchange only needs to run on one computer in the office.

If users have X-Link or Link Runner, SOAPwareXchange needs to run on the same computer as these. This also needs to be running at all times in order for data to transfer across SOAPware and another system. Someone in the office should be designated to ensure this is open and running each day.

## SOAPwareXchange Setup

If desired, SOAPwareXchange can be added to the Startup folder in Windows. This will open SOAPwareXchange when the computer starts, but someone will still need to log in to start the interface. SOAPwareXchange continually scans the In folder which is inside a specified directory.

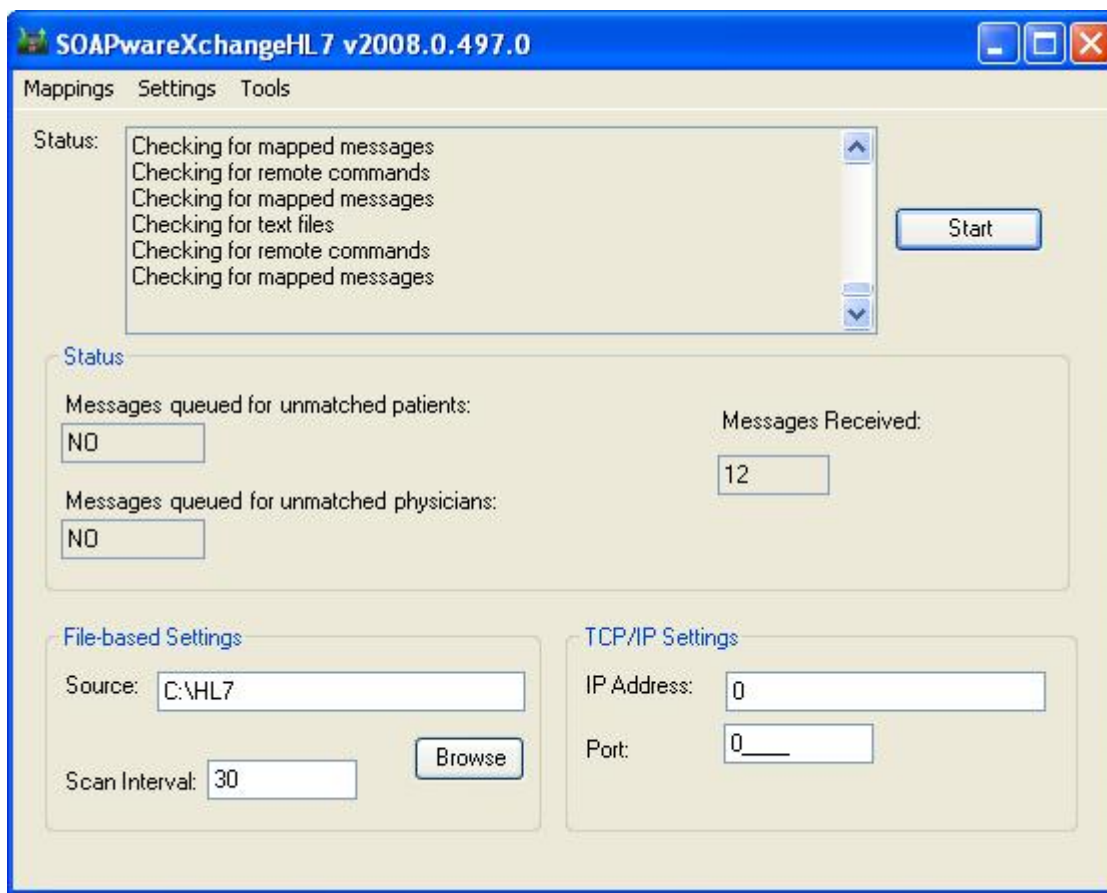
Typically, this is C:\Program Files\SOAPware\SOAPwareXchange\In\, but can be changed during the installation of SOAPwareXchange. Direct the billing system output to this folder. If the user wants SOAPware to transmit data TO a billing or PMS system, then SOAPwareXchange will send this data to the Out folder which is in the same directory as the In folder. Set the billing system to accept input from this folder.

## SOAPwareXchange Options

Once SOAPwareXchange is installed, there are a few configuration options that should always be considered:

1. With SOAPwareXchange open, Click Outbox Settings. If a user is going to be posting Superbills from SOAPware to a billing system, Click the Post Superbill checkbox.
2. If a user wants to send demographics from SOAPware to a billing or PMS system, then Click the Send General Demographic Changes checkbox.
3. Under the Settings menu, there is an option to Auto Create Charts. When a user's billing or PMS system sends demographics over to SOAPwareXchange, if it does not find a match of the chart based on name, birthdate and either social security, chart number or gender, then it will think this is a new chart. If a user checks the Auto Create Charts button, it will automatically create a new chart. If the user leaves it unchecked, then it will place these charts it can't find a match for in the Queue Manager. Go to Start > Programs > SOAPware > Queue Manager. From here, the user can set whether the user wants a chart to be a new chart or can map it to a chart in SOAPware if it already exists.

## SOAPwareXchange HL7 (additional enhancement)



SOAPwareXchangeHL7 is an HL7 interface between SOAPware and most commonly a lab company. It allows for downloading of lab results directly into SOAPware for review & comparison. Some of the most popular labs are as follows: Labcorp, Quest, Spectrum, Bio-reference, 4medica, etc...

This program also needs to be installed on one computer, and can be any computer in the office. Lab companies typically designate one of the user's computers to receive the files. SOAPwareXchangeHL7 is usually installed on the same computer. This program also needs to be open constantly in order for it to import labs into SOAPware. Someone at the office should be assigned to ensure the program is open each day and to take care of Unmatched Patients which is explained below. Take note of several things in the SOAPwareXchangeHL7 window.

### Running SOAPwareXchange HL7

The Start button must always be clicked when SOAPwareXchangeHL7 is opened. Lab importing will not start until it is clicked.

There is a Browse button near the bottom. This lets the user select the folder to receive the HL7 labs results. The lab company should let the user know where the labs will be going. Then we

just point the SOAPwareXchangeHL7 to this folder. If a user is not sure what folder this is, ask the lab company representative.

There are two areas that contain the word NO. These fields indicate whether or not there are any unmatched patients or physicians. When a user first starts using SOAPwareXchangeHL7, the user will get Unmatched Physicians. It will say YES under Messages queued for unmatched physicians. Go to Mappings > Edit/View > Unmatched Physicians. Then, Click a provider's name, and Click Map. Click the provider's name that matches, and Click OK. Do this for each physician listed in Unmatched Physicians. When labs come in, SOAPware tries to match the lab's patient demographics to patient demographics in SOAPware. If a match is found, the lab will automatically go to the chart. If it doesn't find a match, it puts it into a queue known as Unmatched Patients. Whenever a user see a YES under Unmatched Patients, then the user needs to map a lab(s) to patient(s) in SOAPware. Go to Mappings > Edit/View > Unmatched Patients. Click a patient, and Click Map. The Chart Rack viewer will pop-up. Match the chart in the list to the chart in the Chart Rack by double-clicking the chart. Do this until all labs are mapped. From then on, labs for these patients that have been mapped will automatically go to the chart matched. Someone should check SOAPwareXchangeHL7 once a day or so to see if there is any more Unmatched Patients.

### **Scanning and Document Management (Standard & Professional Versions)**

SOAPware allows the user to scan directly into patient charts. Any scanner a user purchases, MUST have TWAIN drivers to be able to work with SOAPware. If the user already owns a scanner, contact the scanner manufacturer to be sure the model has TWAIN drivers. Brother scanners should not be purchased for use with SOAPware because of the problems that these scanners often have with SOAPware. HP's, Fujitsu's and Canon's all usually work well with SOAPware.

Keep in mind that user scanner preferences when scanning, will determine the size of the image stored in the SOAPware database. It will give a user options for Black and White, Grayscale or Color. Color takes the most memory, then grayscale, then black and white using the least amount of memory. Unless the user needs color, use black and white to refrain from using unnecessary amounts of space in the database. DPI or Resolution is another component of scanning that will affect the image size in the database. 150 or 200 DPI is normally recommended. The higher the DPI or resolution, the higher quality image it will be, but it will also take up more space in the database. Testing should be done to find a happy medium to find a low DPI, but one that still creates an acceptable quality of the image/document.

### **Welch-Allyn Vital Integration (Professional Version Only)**

This integration only works with the Welch-Allyn Vitals device. Make sure the Welch-Allyn device is attached to the computer, then open a chart and go to Vital Signs (Chart > Sections > Vital Signs). When the user has taken the reading on the device, in the Vital Signs section of SOAPware, Click

the Take Vitals button on the far right of the Vitals toolbar. This should be active when the user has the Welch-Allyn device connected. If the button is grayed-out, then it does not detect the Welch-Allyn device.

### Instant Medical History Integration (Professional Version Only)

Instant Medical History must be installed on any computer the user wishes to use SOAPware with Instant Medical History. SOAPware, Inc. does not sell Instant Medical History, but does provide an integration that is included in the SOAPware Professional version.

To setup the integration, once Instant Medical History is installed on a computer, open SOAPware.

1. Open an unsigned SOAPnote in a chart.
2. Right-click on the Subjective header.
3. Go to History Present Illness > Settings.
4. Auser can make sure that the install location for Instant Medical History is set to the correct install location for Instant Medical History. Auser can also change the display format for results to Rich Text Format or E/M Coding Compatible format.

Auser can test the interface by:

1. Right-clicking on the Subjective header again.
2. Go to History Present Illness > Import Medical History and/or Take Medical History.

Import Medical History will let the user import Instant Medical History results that have already been saved from that program. Take Medical History will open the program Instant Medical History and will allow for patient history to be taken at this point. When done, there is a Transfer to SOAPware button that will send it back into the SOAPnote. Make sure the interface is working and the workflow is understood.

### SOAPware Faxing Service (additional enhancement)

After a user has downloaded the SOAPware license(s) in Provider Manager, it is time to set up all of the contacts to which faxes will be sent. This is located under the Tools menu. When a user needs to fax a document in a chart, Click Docutainers in the menu bar, and Click Print. Click the document design to use, and Click the Fax button. Then, Click the contact who will be receiving the fax. Click the Fax button again to send the document.

**NOTE: SOAPware Faxing Service only lets the user send electronic faxes out of SOAPware. The user cannot currently receive incoming faxes electronically into SOAPware. If users are interested in being completely paperless and storing even incoming faxes and distributing them to the appropriate patient's chart, users will need to make sure to have a faxing software, i.e. Snappy Fax, WinFax, etc, installed on the computer attached to the fax machine. The fax will be stored on one of the local drives and could then be dragged and dropped into any patient's chart from there.**

### **SOAPware Offsite Backup Service (additional enhancement)**

A user will be contacted shortly after this purchase, in order to get the Offsite Backup Service running. If a user has not purchased this and is interested, contact [Sales@soapware.com](mailto:Sales@soapware.com) or call 800-455-7627 ext. 200.

### **Dragon Naturally Speaking (additional product)**

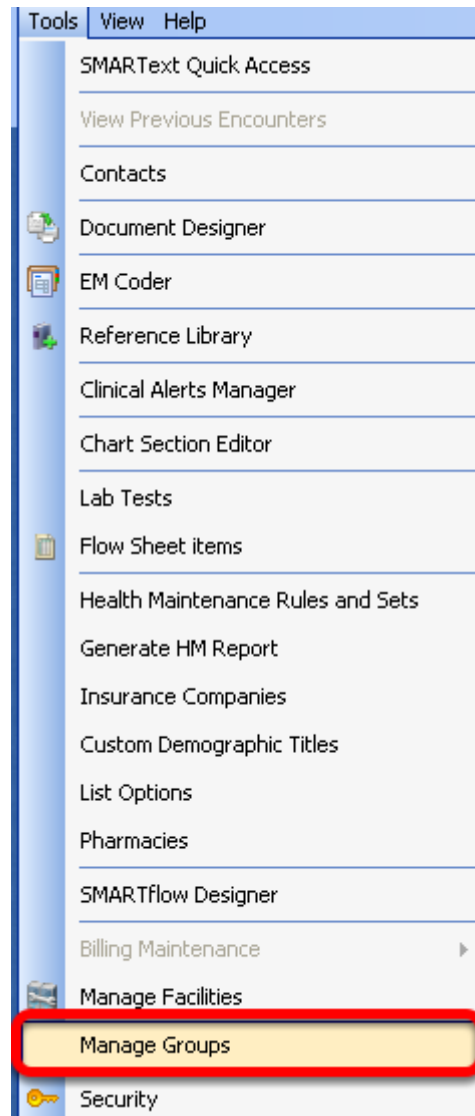
Dragon Naturally Speaking must be installed in order to use it with SOAPware. SOAPware, Inc. does not provide Dragon Naturally Speaking, but it does allow the user to use Dragon Naturally Speaking with SOAPware. To use it, open the Dragon Naturally Speaking first, then open SOAPware. Open up SOAPware, go to a desired chart section to speak to type, and enable the mic/recording on the Dragon toolbar. Start speaking, and it will start typing text at the cursor.

## Manage Groups

---

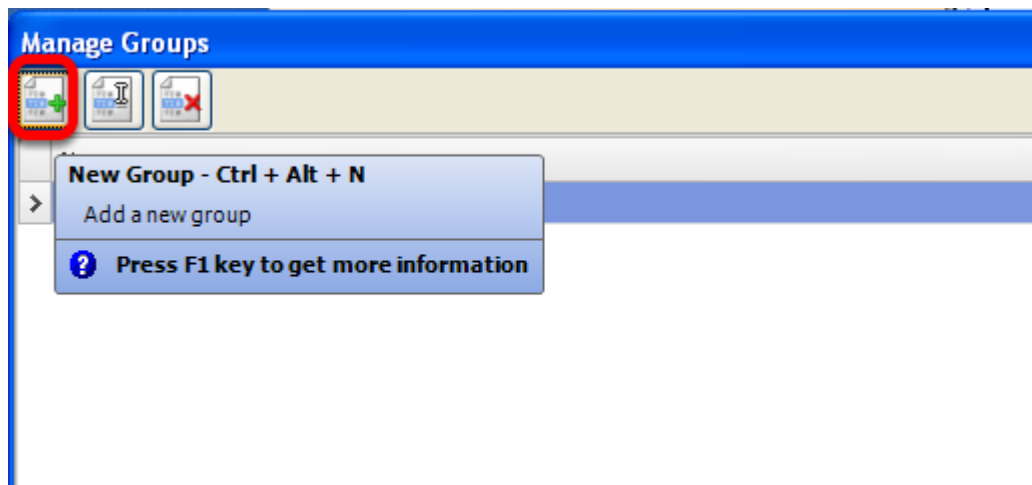
A Group is used to define a business entity or individual within a clinic. This information will be useful for populating information to the CMS 1500 form. Newly added Groups may contain more than one provider, but a provider may only be associated with one group.

### Access Manage Groups



Click on the Tools menu item > Manage Groups.

## Create New Group



Click on the button with the green plus to create a New Group.

## Add Group

A screenshot of the 'Add Group' window. The window has a blue header bar with the title 'Add Group' and a close button (X) in the top right corner. The main area is divided into three sections, each with a numbered circle in the top left corner: 1. Contact Information: Contains fields for Name (filled with 'SOAPware'), Address, City, Zip, Phone, and Entity Type (radio buttons for 'Person' and 'Non Person', with 'Non Person' selected). 2. Id Numbers: Contains fields for Tax ID (radio buttons for 'EIN' and 'SSN', with 'SSN' selected and a dashed line for input), Submitter ID, Legacy ID, and NPI. 3. Insurance Information: Contains a 'Company' dropdown menu. At the bottom right, there are 'Save' and 'Cancel' buttons.

Creating a Group and associating a provider with a Group will cause the group information to default as the provider's Pay To/Billing Provider information, with each insurance company.

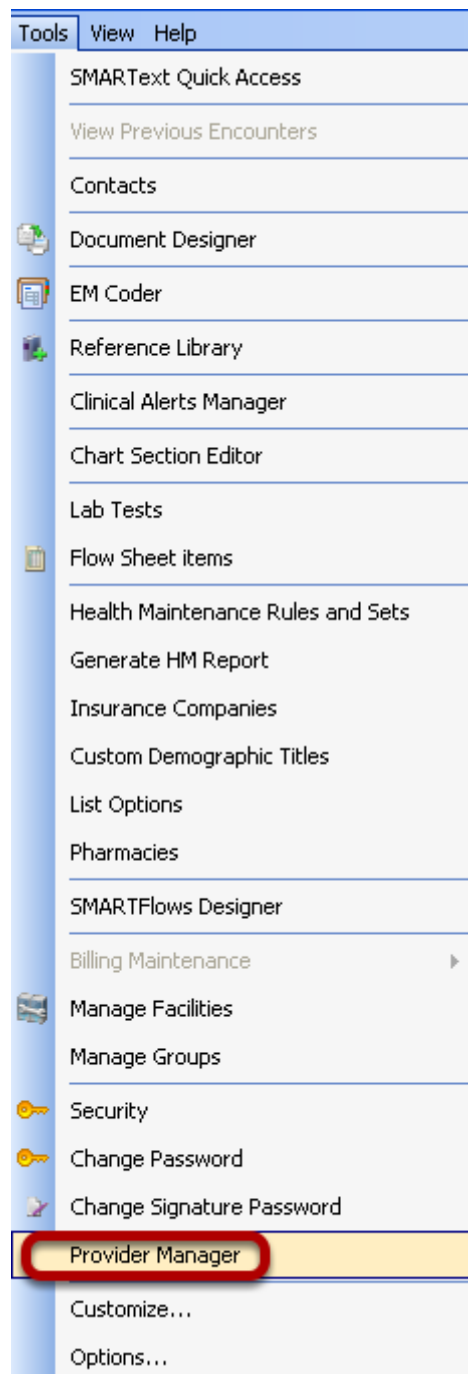
1. **Contact Information**- Enter the basic demographic information for the group.
2. **ID Numbers**- Enter the appropriate ID numbers for each field.
3. **Insurance Information**- Insurance Companies need to be set up first before taking advantage of this area.



[Click here](#) for more information from the Practice Management User Manual for detailed information for set up.

Click the Save button to save changes.

### Accessing Provider Manager



To open Provider Manager, Click Tools in the menu bar and select Provider Manager.

**Providers**

Providers

- Kaye L. Yocham
- Krista L. Laningham
- Rena Thornton
- Rita Pense
- Shannon Shores

**General** Misc Codes Signature

**Name**

Title First M Last Suffix

[ ] Kaye L Yocham [ ]

**Address**

Clinic SOAPware Training

Street 4220 N. Crossover Rd.

City Fayetteville State AR Zip Code 72703-

**Contact Information**

Phone # 8004557627500

Fax # (866) 237-9073

Email kaye.yocham@soapware.com

**Physician Numbers**

DEA # SW000000 State ID [ ]

NPI# [ ] ! UPIN# [ ]

Taxonomy [ ]

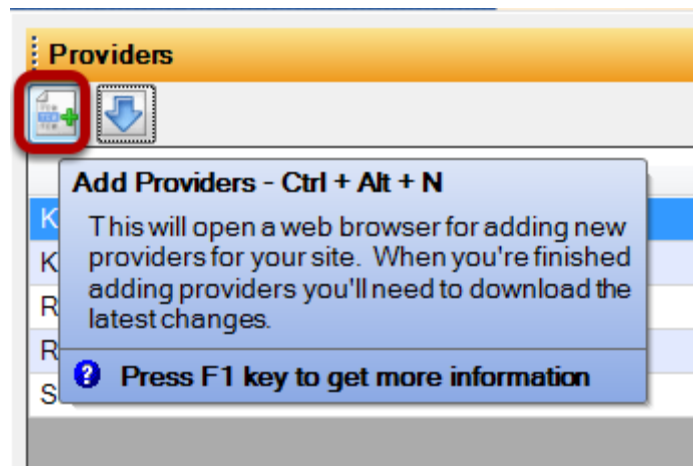
☒ Is Supervisor

**Update**

The General tab will display the providers demographic information including Name, Address, Contact information (phone, fax and email address) and Physician numbers (DEA, NPI, State ID, UPIN)

If the provider displayed is a supervising clinician in the practice, a check needs to be placed in the box next to Is Supervisor. For more information on Is Supervisor, see: [Co-Signatures](#).

Fields that are marked red in the screen shot are required fields for ePrescribing. Add all required provider demographics and Click the Update button at the bottom of the window. If a required field is missing, it will be indicated with a warning icon.



The Provider Manager can also be used to add new providers and edit existing providers. When users first purchase SOAPware, the licenses purchased will be entered as a part of the setup. However, if users add additional providers at a later date, users will need to use provider manager to add these providers.

Click the Add Provider button.

# Provider Administration

Save/Add New
 Save & Close
 Cancel

## Add Provider

\* Items in red are required.

### Step 1: Provider Demographics

Title:			
First:	First Name	MI	Last Name
Suffix:			
DEA Number:			
NPI Number:			
<input type="checkbox"/> I would like to add this provider without a DEA number. This will disable E-Prescribing.			
SPI Number			
Email:			
Clinic Name:	SOAPware 2008 - Training		
Phone Number:	800	- 455	- 7627 ext: 500
Fax Number:		-	
Address:	4220 N. Crossover Rd.		
City:	Fayetteville	State:	AR Zip: 72703

### Custom Fields

Custom 1:	
Custom 2:	
Custom 3:	
Custom 4:	
Custom 5:	
Custom 6:	

#### Current Registered Providers

- Katie Rogers
- Linda Wagner
- Jennifer Berg
- Kaye L. Yocham
- Krista L. Laningham
- Shannon Shores
- Rena O'Dell
- Rita Pense
- Shannon Shores [Inactive]

Fill in the required information for that provider (a license must be available for the provider to be added).

## Assign Licenses

### Step 2: Assign Licenses

**Choose Licenses**

<input type="checkbox"/> ALL	
<input type="checkbox"/> IQmark ECG	<input type="checkbox"/> FlowSheets
<input type="checkbox"/> IQmark Holter	<input type="checkbox"/> Spell Checking
<input type="checkbox"/> IQmark Spirometry	<input type="checkbox"/> Health Maintenance
<input type="checkbox"/> Welch Allyn® Vitals Device Integration	<input type="checkbox"/> Document Management
<input type="checkbox"/> Instant Medical History Integration	<input type="checkbox"/> OCR
<input type="checkbox"/> Dragon Naturally Speaking Integration	<input type="checkbox"/> SOAPwareXchange
<input type="checkbox"/> Tablet PC Enhancements	<input type="checkbox"/> E&M coder
<input type="checkbox"/> Clinical Knowledge Module	<input type="checkbox"/> Chart Searcher
<input type="checkbox"/> SOAPwareXchange HL7 Integration	<input type="checkbox"/> Lab Forms
<input type="checkbox"/> SOAPware Faxing Services	<input type="checkbox"/> ePrescribing
<input type="checkbox"/> Flash Code	<input type="checkbox"/> ChartPortal
<input type="checkbox"/> Scheduling	<input type="checkbox"/> SOAPware Billing

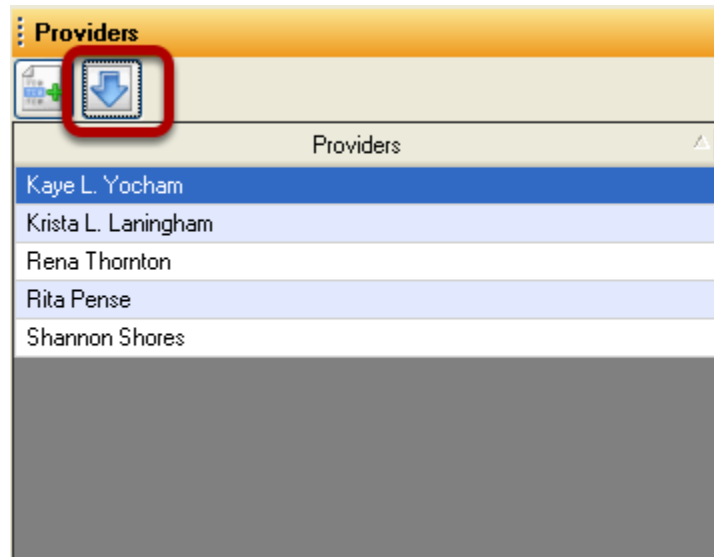
Assign the licenses.

## Save and Close



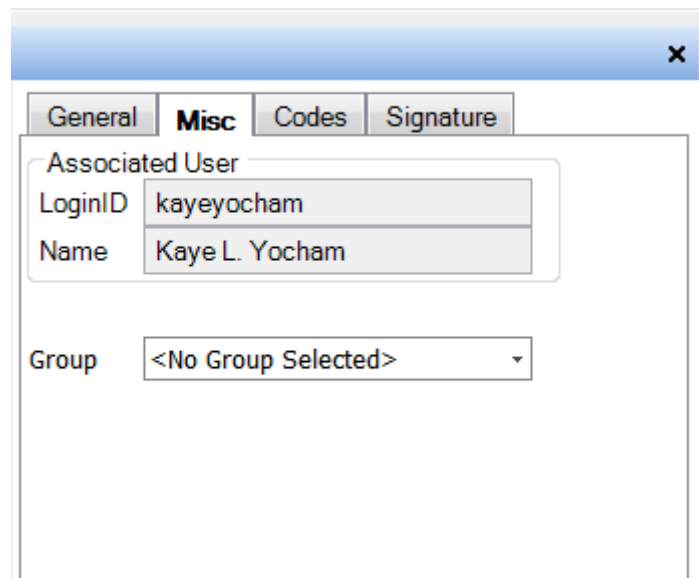
Click Save & Close.

## Download New Provider



Click the Download Providers button to add the new provider information from Site Administration to the local network.

## Misc Tab



The Misc tab will display the Associated User which includes the LoginID and Providers name.

The Group option is for Insurance billing purposes. Prior to assigning this Provider to a group, the Add Groups/Billing Information must be completed.

1. When a provider is associated with a Group and the Group is contracted with Insurance Carriers/Payers as the Billing/Pay To source:

Using the drop down arrow, Click the Group with which the Provider is associated. The group name will populate the field and link the active provider to that group.

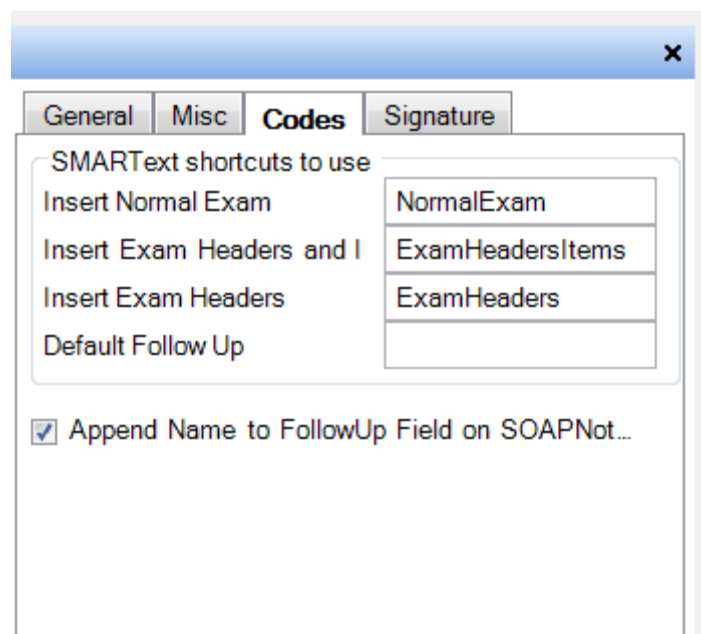
2. If a provider is not associated with a Group:

Using the drop down arrow, Click the Provider's name in the drop down list. For more information on setting up groups, see: [Set Up Groups](#).

After making any changes, click Update at the bottom of the window.

**NOTE: All services rendered by this clinician will be paid to the individual or group selected here by all Payers.**

## Codes Tab



The screenshot shows a window titled "Provider Manager" with a close button (X) in the top right corner. The window has four tabs: "General", "Misc", "Codes" (which is selected and highlighted), and "Signature". Inside the "Codes" tab, there is a section titled "SMARText shortcuts to use" which contains a table with two columns. The first column lists SMARText codes, and the second column lists the corresponding menu items. Below this table is a checkbox labeled "Append Name to FollowUp Field on SOAPNot...".

SMARText shortcuts to use	
Insert Normal Exam	NormalExam
Insert Exam Headers and I	ExamHeadersItems
Insert Exam Headers	ExamHeaders
Default Follow Up	

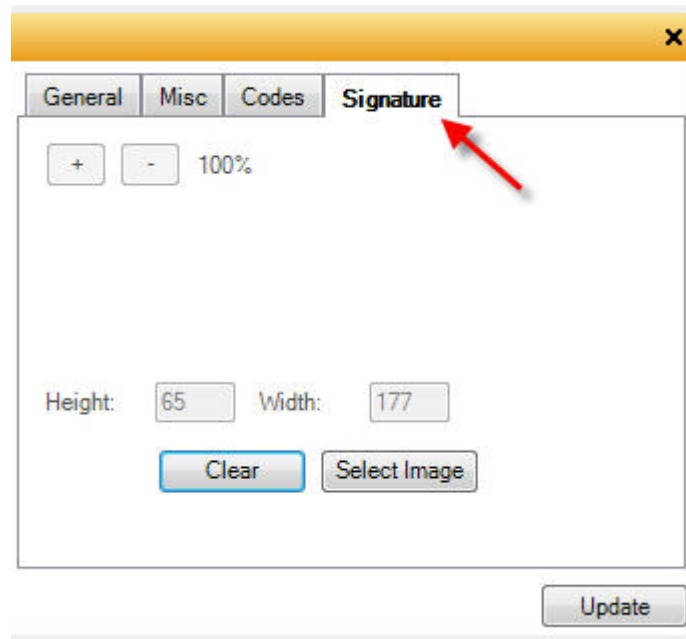
☒ Append Name to FollowUp Field on SOAPNot...

The Codes Tab in Provider Manager allows users to set default menu items for the Objective field menu, a default follow up statement for an encounter note, as well as giving users the option to have the provider's name appear in every new encounter that is created.

By typing in the SMARText code for the common exams that are used, they will appear as selections in the Objective field menu.

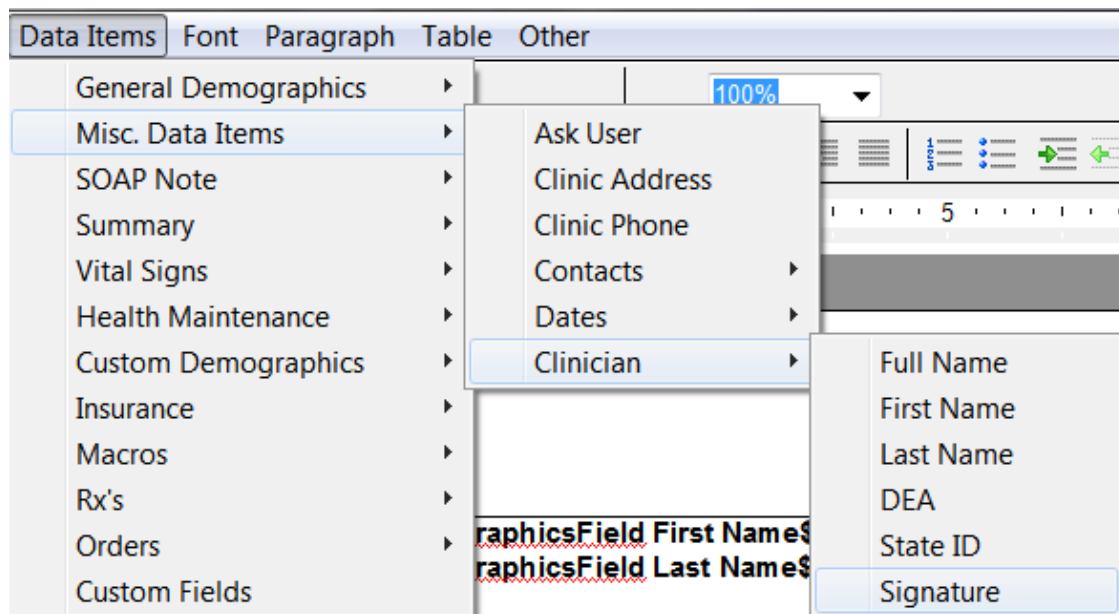
After making any changes, click Update at the bottom of the window.





1. Click on the Select Image button.
2. Once the image has been located, double click to insert.
3. The image will not immediately be in view. Click on the button with the "-" sign repeated to re size the image and bring it into view. Note that the size percentage changes as the image is re sized.
4. To save, Click the Update Button in the lower right hand corner.

To remove the image, simply Click on the Clear button.



To insert a physician's signature on a document design, click Data Items > Misc. Data Items > Clinician > Signature

For more information on using Document Designer, see: [About Document Designer](#).

## Set Up Clinician(s)

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### 1. Preferred Chart Layout

There are hundreds of different options when it comes to possible chart layouts. Primarily, the chart layouts deal with the arrangement of tabbed chart sections. Layout preferences are saved per user. This means that anywhere a user logs in on a network, the user's default layout preference will follow. Please look at a couple of the layouts that are available in SOAPware. Eventually, it is likely that each user will customize their own layouts to best meet their preferences. Different layouts are often used for different types of patient encounters.

#### **The Default Layout:**

Notice that for this layout, the Summary, Vital Signs, and Demographics tabs are on the top left. On the top right are tabs for the SOAPnotes, Labs and Radiology tabbed chart sections.

#### **The 4.X Layout:**

This layout is one of the simplest options for a chart layout. The Summary section tab is the only one on the left and the SOAPnotes section tab is the single one on the right.

#### **The DOCS Clinic Layout:**

This layout is the one preferred in the DOCS-clinic. For this layout, the Summary, Vital Signs, Demographics, Printed Encounters and Health Maintenance tabbed chart sections are on the top left. On the right are SOAPnotes, Labs, Radiology, Correspondence In and Flow Sheets tabbed chart sections.

#### **The Multi Layout:**

This layout splits the chart workspace into 3 panes. On the left side, are both Summary and Demographics in view, consecutively. Summary is above Demographics. On the right is a single viewer for the SOAPnote chart section.

For instructions on how to customize Layouts, see: [Chart Layouts](#)

### 2. Select Data Entry Methods

The way in which a user will actually enter data and document patient's visits, will be one of the most important issues a user will address. Users not want to just jump in and make a decision on this without first doing an analysis.

Questions for a user to ask him/herself include:

What is the user doing now?

What are the resources?

What is reasonable and feasible?

Below is a set of questions that are designed to help the user narrow down the options. Based on the answers, we offer some suggestions.

Does the user desire to participate in "Meaningful Use" and "Pay for Performance" Initiatives, and to engage in practice quality improvements, and/or electronic prescribing?

If No, then it is an option to use free text.

It is not mandatory that a user enters structured documentation for patients. However, while using free text may be familiar and seem easier, it would greatly be to a user's advantage to investigate how he or she can start structuring more of the documentation. It will not only make the user more efficient, but it will also be more likely to allow the user to receive greater reimbursement in the near future. In fact, it appears those not participating in meaningful use and P4P initiatives will likely be penalized.

If Yes, the key to being able to participate with the new initiatives is to ensure that the Assessment, Plan and Medications sections within encountered notes are structured. Other sections of encounter documentation (i.e. Subjective, Objective) have less need for structured data entry at this point in time.

There are a number of different charting methods available in SOAPware offering great flexibility in how information can be entered. Most use a combination of data entry methods. Users have a choice with each section of the encounter and with each patient. More than likely, one solution will not be sufficient for all chart sections. Just as one shoe does not fit all, one charting method does not fit every type of visit or patient.

Choices of methods for data entry include:

- \* Free Text (Typing or dictation)
- \* SMARTText Pick Lists and Docuplates/Templates
- \* Speech Recognition (Dragon Naturally Speaking)
- \* Scan in paper encounter forms
- \* Dictate and have transcriptionist type into electronic notes
- \* Scan in handwritten documentation
- \* Use a Tablet-PC and record the "digital ink"

### 3. Define "Top 20" Usage Lists

- a. Diagnosis Codes
- b. CPT Codes
- c. Medications
- d. Orders
- e. Patient Handouts
- f. Reason for Encounters or Chief Complaints

Defining the above usage lists, a user will have a great head start to downloading or creating customized templates or "docuplates" to use for encounters. As well as the user's Top 20, consider looking at the clinic superbill for more items frequently used.

#### 4. CPT-Coded Item Setup

During initial set up, it is important to take all the procedure codes on the clinic's Superbill and confirm they are downloaded locally. These are SMARText items of the Plan item type.

Have each clinician that will be entering procedure codes, look at each downloaded term from the Superbill list, and indicate how they would do a search for that term. If the clinician's choice of search words is not in the description, check to see if it is included as a keyword. If not, then we suggest contacting SOAPware, so that we can add it for all SOAPware users. Send an email message of suggestions to [fsanford@SOAPware.com](mailto:fsanford@SOAPware.com).

Over time, create docuplates that include pick lists having procedure items that only include those preferred and with verbiage the clinicians prefer.

SMARText is a toolkit containing all the tools (i.e. all the CPT codes). But, it is important for clinicians to realize that the descriptions that accompany the codes are often not the ones that are familiar.

For example, searching for x-ray only retrieves those items that SOAPware has added x-ray as a keyword. This is because the CPT descriptions use the terms radiological exam instead of x-ray.

Sometime after initially going live with SOAPware, start introducing order entry items in addition to the plan items that contain CPT codes.

#### 5. Diagnosis Item Setup

It usually comes as a shock to most physicians how much inconsistency is present as to the selection of diagnoses among different physicians in different specialties and localities. It also typically comes as a shock to learn how varied are the terms that individual physicians prefer to utilize to describe the same diagnosis.

The library includes the ICD-9 codes within SMARText items of the Structured Dx type. But, it is important for clinicians to realize that the descriptions that accompany ICD-9 codes are often not the ones that are familiar.

No EMR, out of the box, is going to be able to generate a simple list such as this that is going to reflect what any individual clinician expects and using the wording any individual clinician prefers.

The ICD-9 terms/descriptions, in original form are very limited. Each word in the description is a keyword that can be searched. And, SOAPware is in the process of adding thousands of keywords on a monthly basis. Again, when SOAPware users need a keyword added, we invite them to send an email message of suggestions to [fsanford@SOAPware.com](mailto:fsanford@SOAPware.com).

### **Shortcuts:**

A few clinicians strongly prefer to enter common diagnoses using the shortcut entry method. Notice that the diagnosis items that have been edited (i.e. descriptions enclosed in double-quotes), often have tentative shortcuts added as well. The shortcuts can also be changed to meet user preferences. Several considerations have led to the shortcuts that are included within edited diagnosis items in the library. These are simply included for convenience, and clinicians are encouraged to edit them to create ones they prefer and can remember.

## **6. Default Docuplate Setup**

**NOTE: The default SOAPnote docuplate when SOAPware is installed is for getting started/introduction purposes only. It needs replacement once users have completed the initial Introduction to SOAPware.**

Docuplates allow common sets of document items for various chart sections to be saved and reused later. This capability is particularly useful for documenting common conditions seen repeatedly. They are also great tools for implementing Best Practice Guidelines and more consistency in documentation.

A user will want to have a docuplate set up as the default, as well as docuplates for specific visit types.

For information on downloading, using, and creating docuplates, see [Docuplates](#).

## **7. Order Entry Setup**

Searches within the Order Manager will not search the online library, but are limited to order entry items that are local. It is necessary to first go to the SMARText items Manager and download the order entry items.

In order to download the Order Entry items needed in the practice:

1. Make a list of the most frequent orders in the practice.
2. Search the SOAPware online library for these Order Entry items and download the appropriate ones.
3. Customize the downloaded orders. Rarely should the user need to create new ones.

If users are not ready to identify and download the items his or her will need, but want to explore the use of Order Entry, here is an alternative means to get started. In order to obtain a set of the generally most common starting order entry items, search and download the order entry items containing the keywords---- (i.e. s and 4 dashes).

Understand that the need to first download order entry items is a unique characteristic of the Order Entry SMARTText item type. Again, this is because the Order Manager does not search in the online library. SOAPware allows for searching in the online library in almost every other setting where SMARTText is searched.

To download these items, Click Docutainers in the menu bar, and Click the SMARTText Items menu item (or Press F10 key). In the Type column, the Order Entry can be identified. (Clicking on the Type column header will group together the items). Select/Highlight the items to download and Click the Download button. Users can download them one by one, or select multiple items at once by holding the control or shift button.

For orders that are not available on the online library, users can create custom order entry items. Users can also modify existing order entry items to include the sub items her or she wants to include with the order.

For instructions on downloading and creating orders, see: [Order Entry Set Up](#).

## 8. Patient Handouts

Paper-based patient education handouts can be used in SOAPware and printed automatically from the patient's chart. Now is the time to decide what handouts the user would like to include. There are many available on the online library and the user can edit these to customize them as well as create brand new handouts. To learn how to download, edit, and create handouts, see: [Handouts](#).

## 9. Structured Text Data Entry

SMARTText is a type of data entry that is unique to SOAPware. It was created by associating hidden information to the words and phrases used in documentation. This results in the documentation being able to be identified electronically and read by computers. Simply put, SMARTText is a Lego set for medical information. Just like the Lego's of a user's youth, SMARTText has many different pieces that can be put together in almost limitless ways. The "pieces" in SMARTText are called items and they are of many differing types. The Type defines what the SMARTText item may contain, represent, and do.

For example, within SOAPware, all the CPT/HCPCS items, ICD-9 items, and medications have each been associated with specific SMARTText items for immediate use when creating documentation.

Users will see that with SMARTText, users will be able to:

- \* quickly and easily associate information that needs to be grouped together (i.e. a SMARTText item of the appropriate type)
- \* do it all in one location (i.e. a SMARTText item of the appropriate type)
- \* save it for reuse in the future (save it in the SMARTText library)

## 10. More Data Entry Options

### Pick Lists

SMARTText items (except for Order Entry) can be arranged into pick lists, and be selected by simple clicking. So, they function much like a paper superbill, where the individual would either circle or check boxes. Customized pick lists are one of the most efficient data entry methods. Create custom pick lists containing the items that the user commonly-repeatedly utilize. Pick lists allow the user to perform data entry via a click for an item the user would desire to insert into documentation.

### Docuplates

Docuplates are simply stored templates for encounter notes, procedure notes or just about any section of the chart. A user can have docuplates for not only SOAPnotes (encounters), but also for Flow Sheets, Labs, Patient Summary, Drawings, etc. In regards to documenting a SOAPnote, a user can have a docuplate that has some free text in one section, some SMARTText items defaulted in another, and several different pick lists inserted.

In general, there are 2 main approaches to use docuplates.

1. Set up a docuplate for each of the most common appointment types or chief complaints.
2. Set up a generic or "general" docuplate that is used for all types of visits. Typically, these generic docuplates/templates require a little more data entry at the time of the encounter than those designed for particular types of encounters.

### Customize Wording, Appearance, Order, and Spacing of SMARTText

It is not usually apparent, when starting, that almost any clinician can use SMARTText items and have the final appearance of the documentation appear exactly as they prefer. For example, the Chief Complaint SMARTText item could be changed to CC if preferred.

### Free or Unstructured Text

Free-text or unstructured data entry involves nothing more than clicking into a field and typing away. So, free-text is the same as simple typing into Microsoft Word or other word-processing document. Obviously, free text typing can be by the clinicians, assistants or transcriptionists, and should be minimal by the clinicians. There are some considerations when working with free-text



in SOAPware.

### **Dictate and Use Transcriptionist**

Some doctors choose to dictate, and have their transcriptionist document directly into the electronic SOAPnote. This is not very efficient for the long term, but can be a transitional workflow when trying to migrate towards more modern-efficient documentation.

### **Dragon Naturally Speaking**

Dragon Naturally Speaking is a speech recognition software that allows the user to dictate into a microphone at the computer, and the software translates spoken words to text in real time. Users are able to dictate directly into SOAPware in order to make data entry easier and more efficient. Dragon Naturally Speaking is a separate program that works in conjunction with SOAPware. Contact the SOAPware Sales dept at 800.455.7627 for pricing and details. See the links below for illustrations of Dragon and SOAPware:

<http://www.nuance.com/naturallyspeaking/>

<http://www.youtube.com/watch?v=q8qIt5YMMh0>

### **Getting Started with Creating Documentation**

Consider creating a docuplate for each of the 10 most common encounter types or reason for encounters in the practice. When creating these docuplates, a user will need to go through each section and determine if the user wants to just have defaulted text for that section or would like to pick from a list, etc. Again, the Assessment, Plan and Medications fields are most benefited by structured information. Particularly, in the beginning, the user may want to mostly use free-text into the Subjective and Objective fields. This is especially the case for those converting from other free-text based EMR's. When the user gets to the Assessment field, plan to start transitioning to structured entry. For example, a user might want to default a pick list of SMARText items Structured Dx/Assessment items containing the ICD codes needed for billing. Similarly, consider the same for the Plan field, and for the Medications field. Electronic prescribing results in the use of Structured Rx/Medications, by default.

Another tool most use, to some degree, is to have particular SMARText items that are almost always used, and rarely change, already entered into starting docuplate/templates.

Once a user has created these docuplates/templates for a user's 10 most common types of visits, just insert them into future encounter notes and edit as needed. Auser can create as many or as few docuplates as needed. It is all up to the user. Auser could start with 5 or with 20.

## 11. Schedule Set-Up

This section is designed to help the user set up the schedule, and plan for the days to block off for various reasons (ie. vacation, conferences, catch up days, etc.) If the user has numerous clinics amongst which he or she travels, the user will want to make sure the clinic rotation is accurately reflected on all various facility schedules.

There are three main sections here: Provider/Resource Management, Business Hours Management, and Facility Closings.

### **Provider/Resource Management**

In this area, should be a list of licensed providers for the site. If the provider is not already in this list, the provider likely does not have a license to the Scheduler. This area is the location to actually activate the providers/resources that will be using the Facility.

### **Working Hours Management**

This section allows the working hours for the Provider/Resource to be set for the facility. If the user has multiple facilities, among which a Providers/Resource travel, set the days and hours that each will be working at each facility each week. These times that are set up will then be available for scheduling for each Provider/Resource.

### **Recurrence Management**

This allows the set up of regular blocks for a provider at the facility. For instance, if the provider regularly takes lunch from 1pm-2pm on the days she/he is at the facility, set that time from this section.

### **Business Hours Management**

Set the overall operating business hours for the facility in this section, regardless of the provider that is there. Changing this section will be identical to setting the hours for a provider in the Working Hours Management section. This should be relatively simple to update and edit.

### **Facility Closings**

Block off the days the clinic will not be open to see patients, or is closed entirely for holidays, etc. Notice this section applies to the overall facility regardless of the provider.

## 12. Tools - Options

When SOAPware is installed, it includes certain defaults and settings that can be changed whenever needed. The Options dialog contains numerous, miscellaneous options to allow SOAPware to best match the user's preferred needs and work-flows.

To see all of the options settings, see: [Tools - Options](#)

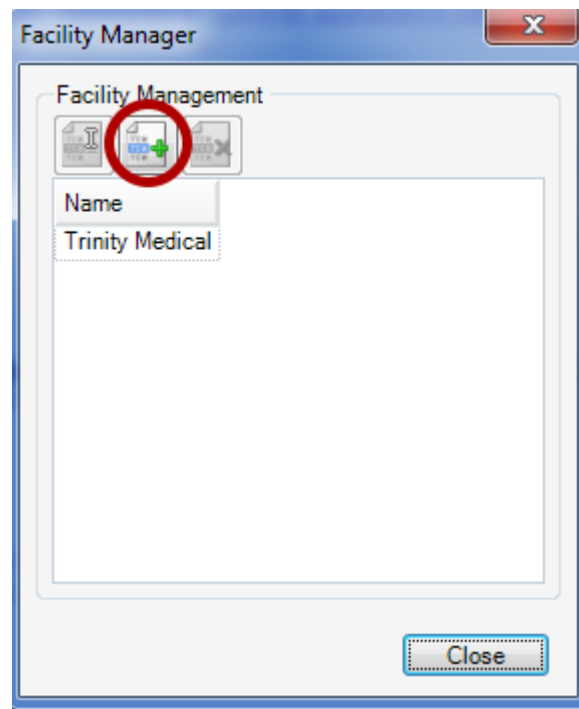
## Manage Facilities

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This section is designed to inform the user about all that is available in regards to setting up facilities. The user may not want to set up all of the sections related to the facilities ( that are discussed here), at this time. However, it is very important, to address these 3 areas: (1) Facility Name, (2) Provider/Resource Management section on Scheduler Tab, and (3) Business Hours Management section on Scheduler Tab.

**NOTE: Facilities represent the places in which providers provide services including all Hospitals or Clinics at which the provider will be performing services. Facilities will be used in several areas of SOAPware including the POS (Place Of Service) section of health claims to be filed with insurance, and in the Scheduler (available in both SOAPware Standard and SOAPware Professional).**

### Facility



The Facility Manager provides the backbone to the overall set-up and workflow of the clinic(s) and provider(s). This will be the general name for the facility that will need to be easily recognizable by staff. The name entered here will also be the one that is displayed on Scheduler.

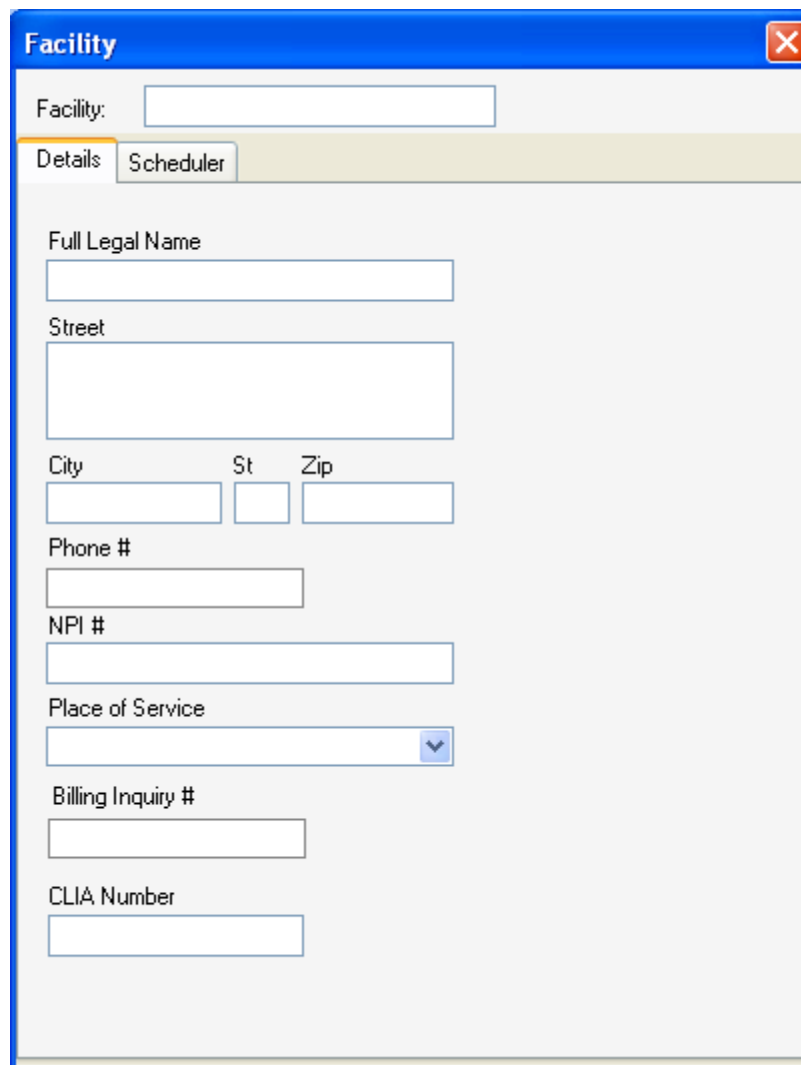
To begin, Click Tools on the menu bar, and Click the Manage Facilities menu item.

In the Facility Manager dialog, to add a facility, Click the Create New Facility button (with the green

plus sign).

The Facility dialog presents containing the Details and Scheduler tabs.

## 1. Details Tab



The screenshot shows a software dialog box titled "Facility" with a standard Windows-style title bar (blue background, white text, and a red close button). Below the title bar, there is a "Facility:" label followed by a text input field. Underneath this, there are two tabs: "Details" (which is selected and highlighted with a yellow background) and "Scheduler". The "Details" tab contains several form fields arranged vertically: "Full Legal Name" (a single-line text box), "Street" (a single-line text box), "City" (a single-line text box), "St" (a single-line text box), "Zip" (a single-line text box), "Phone #" (a single-line text box), "NPI #" (a single-line text box), "Place of Service" (a dropdown menu with a blue arrow icon), "Billing Inquiry #" (a single-line text box), and "CLIA Number" (a single-line text box).

This is the location of basic demographic information for the facility.

### a. Full Legal Name

The name entered here will be the official legal name for the Facility, if different than the general name in the field above.

### b. Street Address

This is the address for the Facility.

#### **c. City, State, Zip**

This is the address for the Facility.

#### **d. NPI Number**

This will be the National Provider Identifier number that has been designated by CMS (Centers for Medicare and Medicaid Services) for the Facility (NOT for the provider). This will be particularly useful once the SOAPware Billing system is available.

#### **e. Place of Service**

This is the general code that is assigned to describe the type of Facility. This will also be particularly important for billing purposes.

#### **f. Billing Inquiry #**

This will be the contact number for the facility billing department or billing company that will be listed on billing statements. This will be useful if a patient needs to contact the facility with questions regarding their balance or charges listed on their billing statement.

#### **g. CLIA Number**

This number is used to reference the lab for the facility and will be placed on the billing claim form.

## 2. Scheduler Tab

The screenshot shows a window titled "Facility" with a close button (X) in the top right corner. Below the title bar is a "Facility:" text box. There are two tabs: "Details" and "Scheduler", with "Scheduler" being the active tab. The window is divided into three main sections:

- Provider/Resource Management:** Contains sub-tabs "Providers" and "Resources". The "Resources" sub-tab is active, showing a table with two columns: "Name" and "Visible".

Name	Visible
Kaye L. Yocham	No
Krista L. Laningham	No
- Business Hours Management:** Contains a table with four columns: "Day", "Open Time", "Close Time", and "Open".

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	8:00 AM	5:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes
Friday	8:00 AM	5:00 PM	Yes
Saturday	8:00 AM	5:00 PM	No
Sunday	8:00 AM	5:00 PM	No
- Facility Closings:** Contains a table with three columns: "Closings", "Start Time", and "End Time".

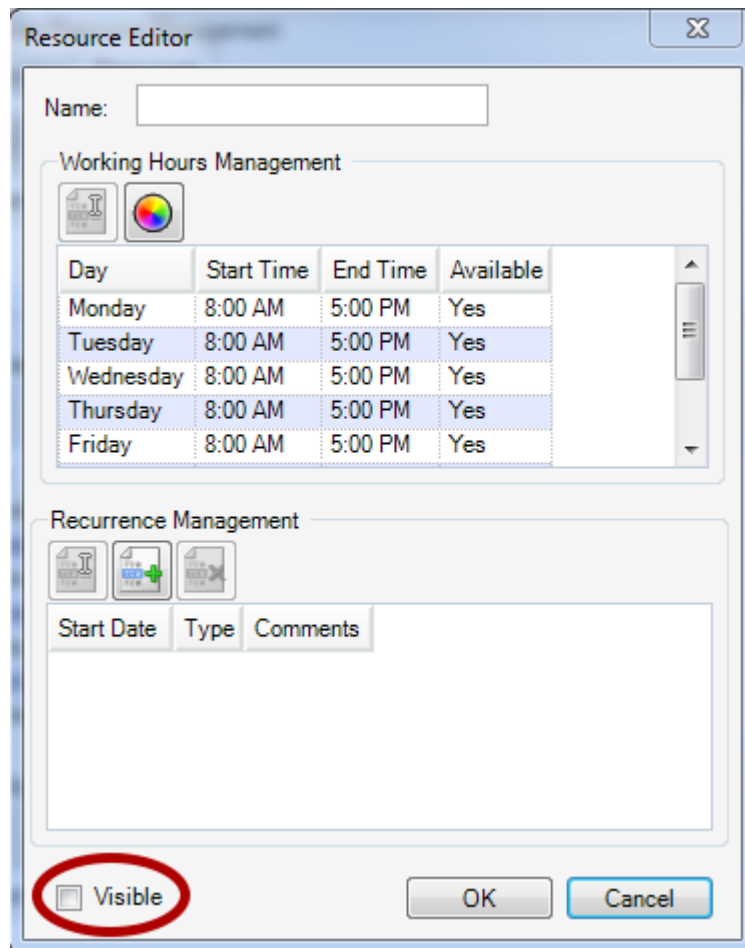
At the bottom of the window are "Save" and "Cancel" buttons.

This is the location for the functional details of facilities in the Scheduler. Three main sections here: Provider/Resource Management, Business Hours Management, and Facility Closings.

### a. Provider/Resource Management

In this area, should be a list of licensed providers for the site. If a provider is not already in this list, the provider likely does not have a license to the Scheduler. This area is the location to actually activate the providers/resources that will be using the Facility.

## b. Adding a Resource



The Resource Editor dialog box is shown. It has a title bar with a close button. Below the title bar is a text field for 'Name:'. Below that is a section titled 'Working Hours Management' which contains two icons (a calendar and a color wheel) and a table. The table has four columns: 'Day', 'Start Time', 'End Time', and 'Available'. The rows are for Monday through Friday, all showing '8:00 AM' for start time, '5:00 PM' for end time, and 'Yes' for available. Below the table is a section titled 'Recurrence Management' which contains three icons (a calendar, a plus sign, and a minus sign) and a table with three columns: 'Start Date', 'Type', and 'Comments'. At the bottom left, there is a checkbox labeled 'Visible' which is circled in red. At the bottom right, there are 'OK' and 'Cancel' buttons.

Day	Start Time	End Time	Available
Monday	8:00 AM	5:00 PM	Yes
Tuesday	8:00 AM	5:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes
Friday	8:00 AM	5:00 PM	Yes

Start Date	Type	Comments
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☒ Visible

OK Cancel

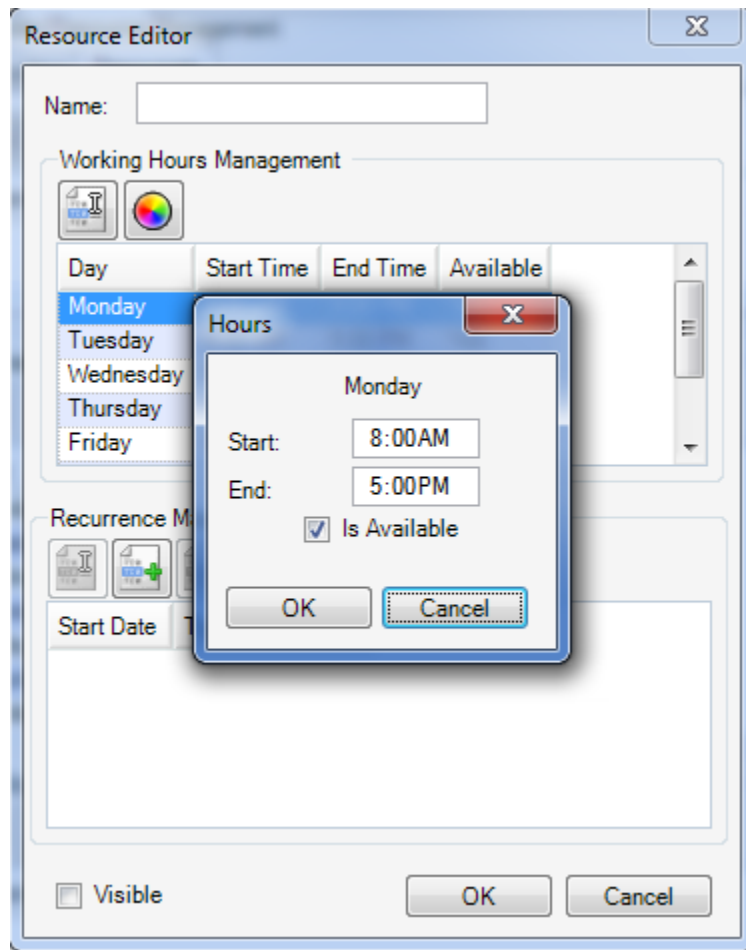
**Note: This is available only in SOAPware Professional.**

Add Resources to be scheduled, in addition to Providers. Resources are anything for which patient times are scheduled. For instance, this could be an R.N., an exam room or even a device, such as x-ray. These are completely determined by the user, and are designed to more efficiently schedule and manage resources for patient visits.

To add a new Resource, Click the Resources tab. Click the Add Resource button (with the green plus sign). The Resource Editor dialog is displayed. Type a Name for the Resource. This dialog manages the time for both Providers and Resources.

To activate the Provider or Resource selected, Click the Visible checkbox. Every Facility has to have at least 1 Provider visible to be able to schedule appointments for that facility.

## c. Working Hours Management



This section allows the working hours for the Provider/Resource to be set for the facility. If the user has multiple facilities, among which a Providers/Resource travel, set the days and hours that each will be working at each facility each week. These times that are set up will then be available for scheduling for each Provider/Resource.

To edit each day's working hours, Double-click a time, or Select a line, and Click the Edit button.

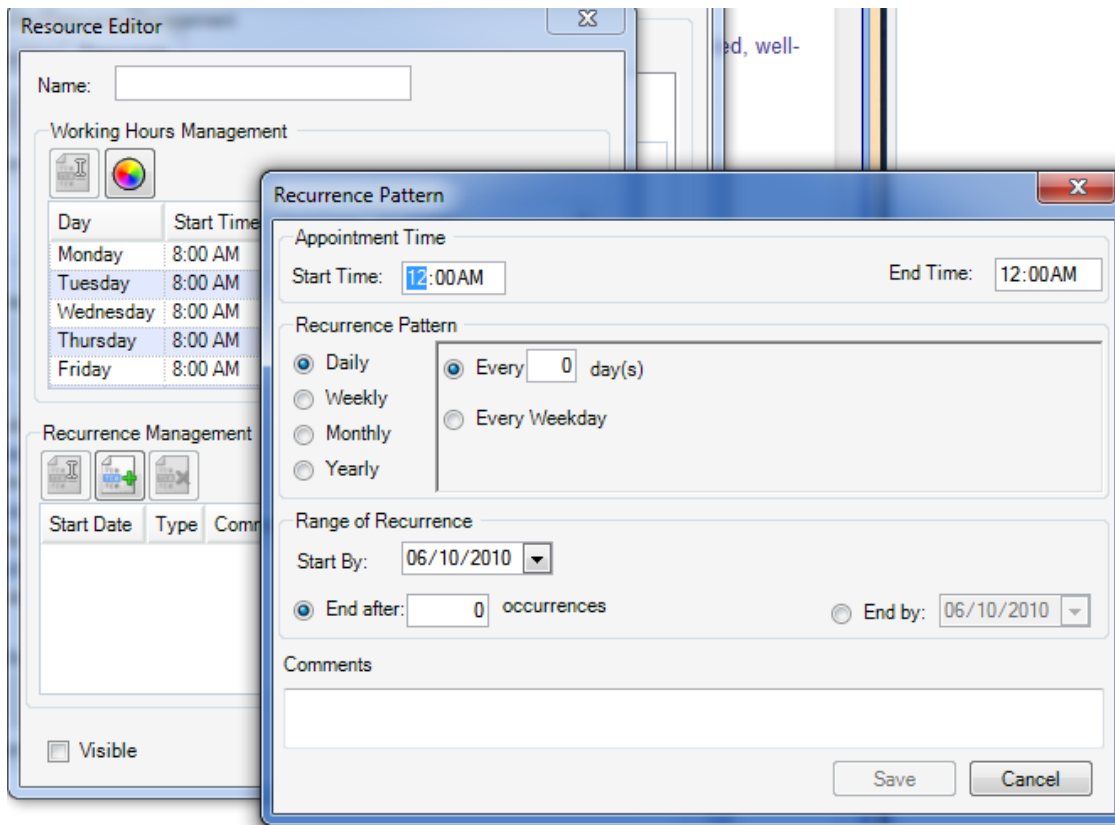
Click OK when done, and repeat with following days.

To set the Provider/Resource's coloring for their open scheduling time, Click the Color Wheel button and Click the color to change as preferred.

Click Save.



## d. Recurrence Management



This allows the set up of regular blocks for a provider at the facility. For instance, if the provider regularly takes lunch from 1pm-2pm on the days she/he is at the facility, set that time from this section.

Go to the Tools menu > Manage Facilities. Click on the facility, Click on the Edit button, then Click on the Schedule tab.

Click to highlight the provider's name and then Click on the Edit button.

Click on the Button with the green plus under Recurrence Management

## e. Appointment Time

Type Start Time and End Time for the blocked time.

## f. Recurrence Pattern

Click the Recurrence Pattern radio button to designate whether the time block will be Daily (or every weekday), Weekly, Monthly or Yearly.

## g. Range of Recurrence

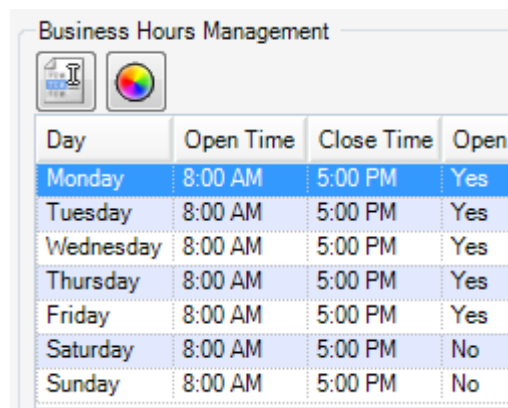
This allows the blocks to start on a set date, and have them reoccur a certain number of occurrences, or end by a certain date. If this is set to end after 0 occurrences, the block will not have an end date.

## h. Comments

For example, Type the name of the blocked time, and it will show up for the facility on the scheduler.

Click Save when finished setting the block, and the display returns to the Facility dialog's Scheduler tab.

## i. Business Hours Management

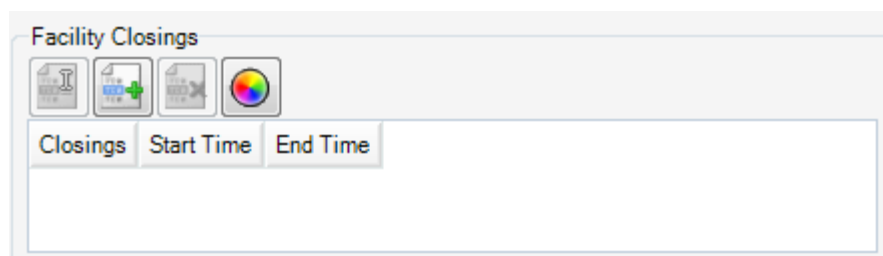


The Business Hours Management dialog box features a title bar with the text "Business Hours Management". Below the title bar are two icons: a document with a pencil and a color wheel. The main area contains a table with four columns: "Day", "Open Time", "Close Time", and "Open". The table lists the days of the week from Monday to Sunday. Monday through Friday show "8:00 AM" for Open Time, "5:00 PM" for Close Time, and "Yes" for Open. Saturday and Sunday show "8:00 AM" for Open Time, "5:00 PM" for Close Time, and "No" for Open.

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	8:00 AM	5:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes
Friday	8:00 AM	5:00 PM	Yes
Saturday	8:00 AM	5:00 PM	No
Sunday	8:00 AM	5:00 PM	No

Set the overall operating business hours for the facility in this section, regardless of the provider that is there. Changing this section will be identical to setting the hours for a provider in the Working Hours Management section. This should be relatively simple to update and edit.

## j. Facility Closings



The Facility Closings dialog box has a title bar with the text "Facility Closings". Below the title bar are four icons: a document with a pencil, a document with a green plus sign, a document with a red X, and a color wheel. Below the icons are three tabs: "Closings", "Start Time", and "End Time". The "Closings" tab is currently selected, and it contains a large empty text area for listing closings.

Block off the days the clinic will not be open to see patients, or is closed entirely for holidays, etc. Notice this section applies to the overall facility regardless of the provider. To set up a new closing, Click the Add Closing button (with the green plus sign).

Type the Name for the closing as well as the Start Date and End Date. Click OK when finished.

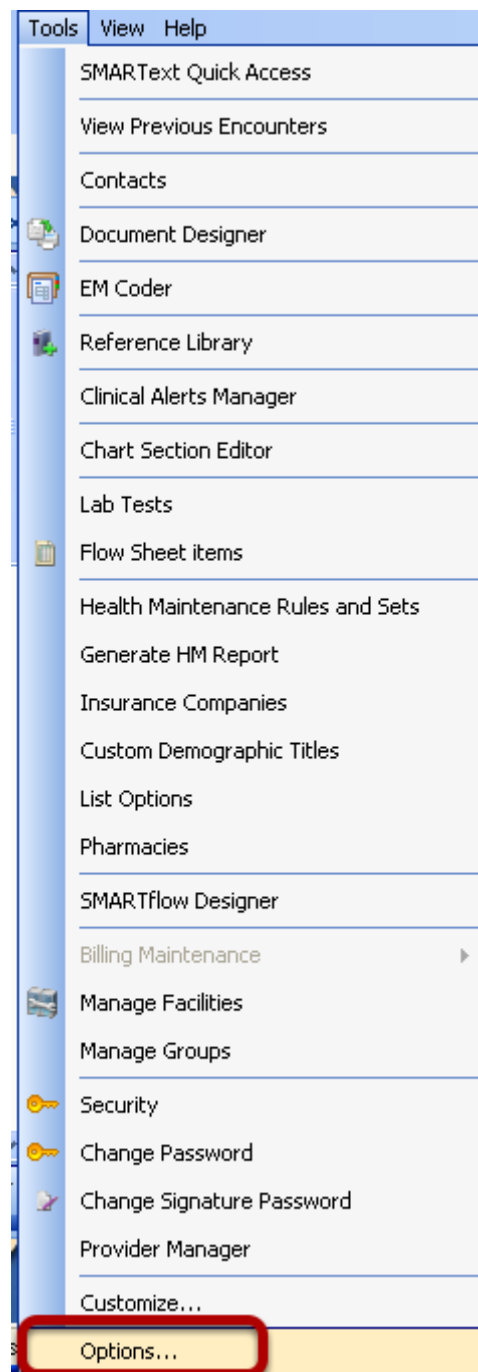
## Tools - Options

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When SOAPware is installed, it includes certain defaults and settings that can be changed whenever needed. The Options dialog contains numerous, miscellaneous options to allow SOAPware to best match the user's preferred needs and work-flows.

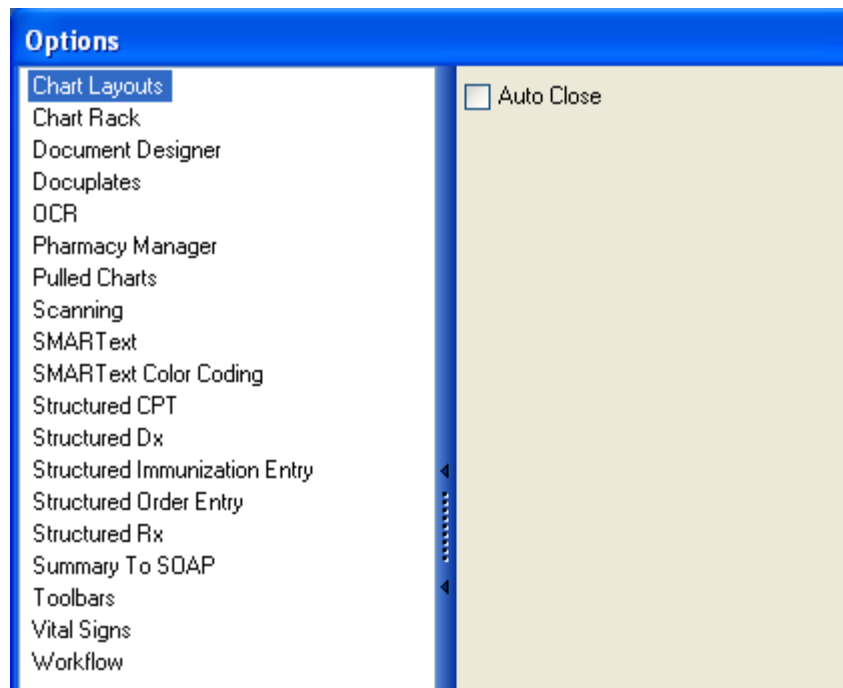
To access and go through this list of options, Click Tools in the menu bar, and Click the Options menu item. Below are brief descriptions of each item in this dialog.

**\*\*Note:** any menu options which are grayed out are options currently turned off or unavailable.



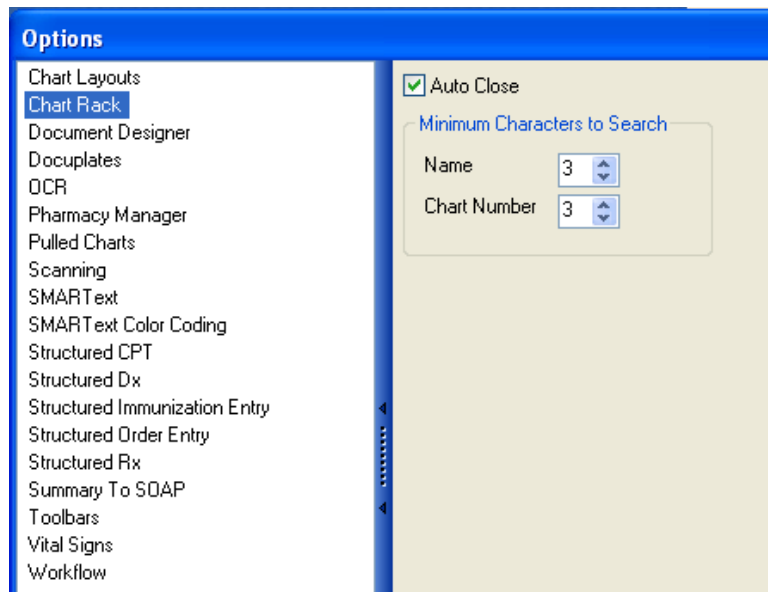
To open Tools - Options, go to the Tools Menu and choose Options from the bottom of the list.

## Chart Layouts



**Auto Close:** If checked, the Chart Layouts display will close as soon as an option is selected. If it is not checked, the window will stay open even after a selection is made. To close, the user will have to manually close it.

## Chart Rack

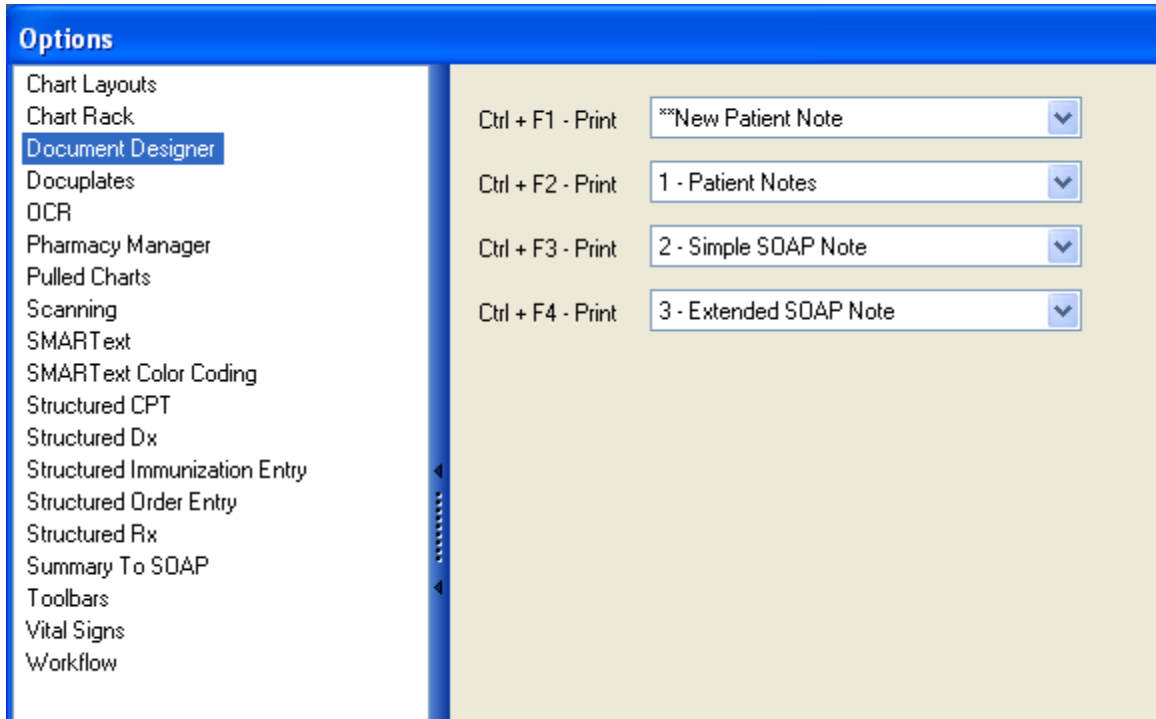


**Auto Close:** If checked, this option closes the Chart Rack after a patient has been selected.

**Minimum Characters to Search:** These settings determine how many characters a user will have

to type in for matching patients to show up. These settings are applied when searching by Name or Chart Number.

## Document Designer

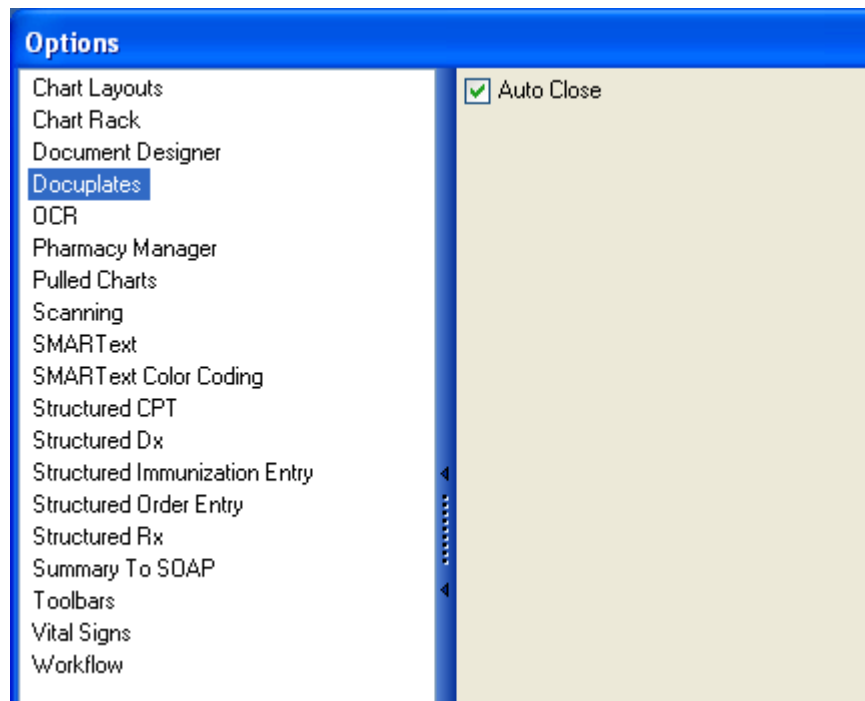


When in a chart, the user can default particular documents to be created off of the active SOAP Note, by using one of the keyboard shortcuts listed. To select a report to be printed when the shortcut key is pressed, use the drop-down box next to the appropriate key. The user will be able to set these shortcuts for any document that is setup in Document Designer.

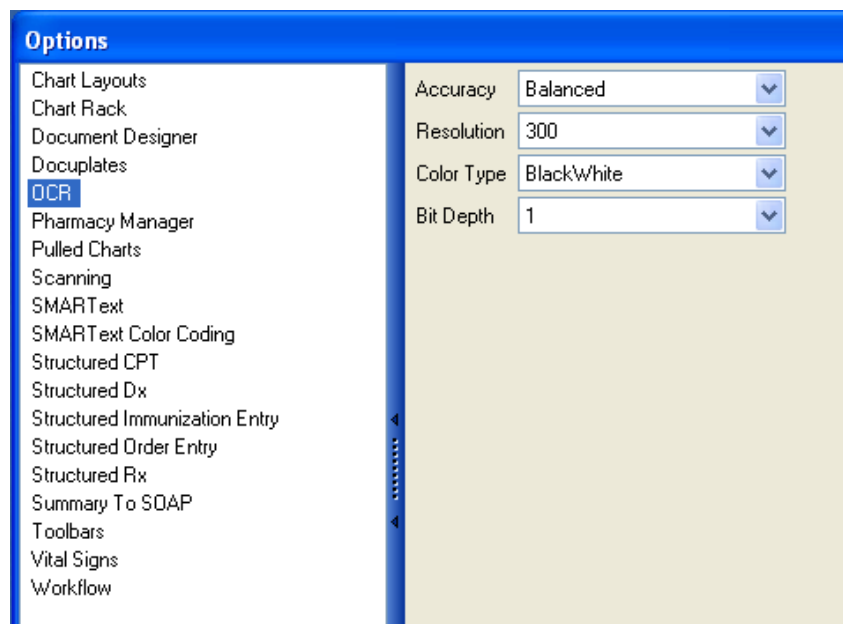
To save time when printing the most commonly used document designs in a practice, it is wise to set up some key-command for quick printing of the 4 most commonly printed documents. The following key-commands can be designated to directly print a document type (i.e. document design) without having to scroll through the print menus.

- \* CTRL + F1
- \* CTRL + F2
- \* CTRL + F3
- \* CTRL + F4

**\*\*IMPORTANT: Do not set up printing of a prescription as a Quick Print Key Command. Print prescriptions from Rx Manager. This is because printing prescriptions otherwise through the Print option does not store the prescription under the Rx History tab in Rx Manager. By always printing prescriptions from Rx Manager, all of the printed prescriptions are together in one place.**



**Auto Close:** Once a Docuplate is selected, the Docuplates window will close. If not checked, the Docuplates window will remain open, even after a selection.



OCR stands for Optical Character Recognition. This feature will convert a scanned image into an editable document. The following settings will affect the manner in which it "reads" the user's scanned image.



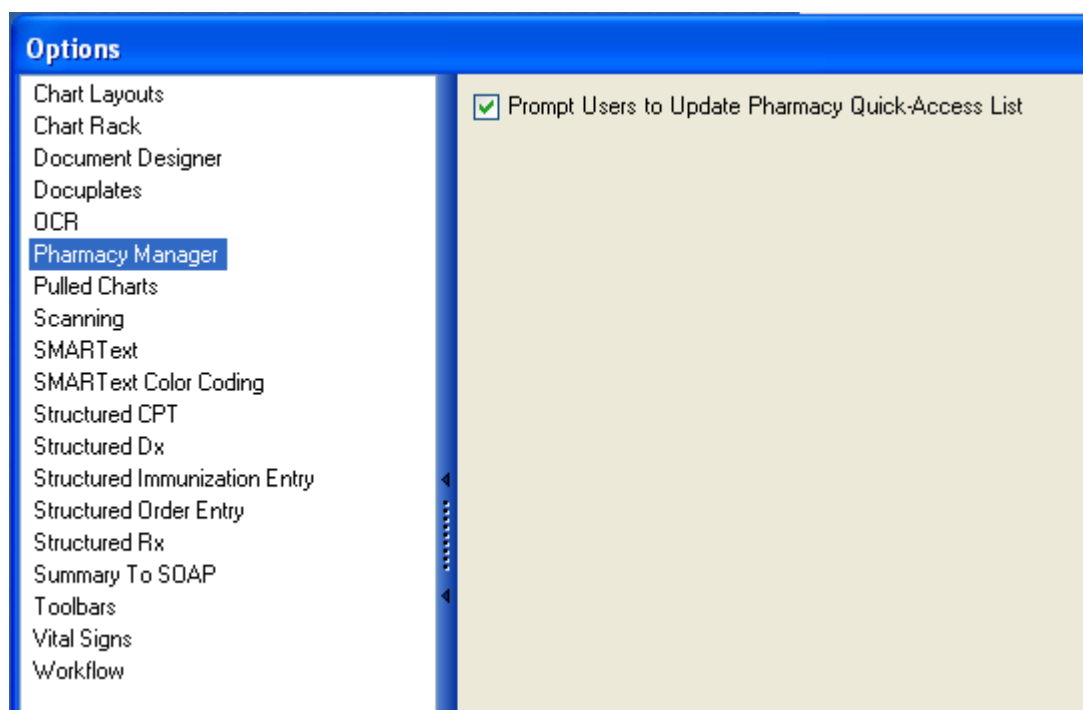
**Accuracy:** The user's options are Accurate, Balanced and Fast. If the user selects Accurate, it will take a longer amount of time to convert a document, but it will be most accurate in its conversion. Balanced will give a decent amount of accuracy and still convert in reasonable amount of time. Fast will lower the accuracy and will do the conversion quickly.

**Resolution:** This controls the dots per inch. The higher the resolution is set, the larger a user's database will get.

**Color Type:** Auser will be able to select Black and White, Gray or Color. Black and White will be the most accurate and fastest option. If the user wants to convert color documents, the user certainly can. Both Gray and Color will affect the Bit Depth of the conversion as well.

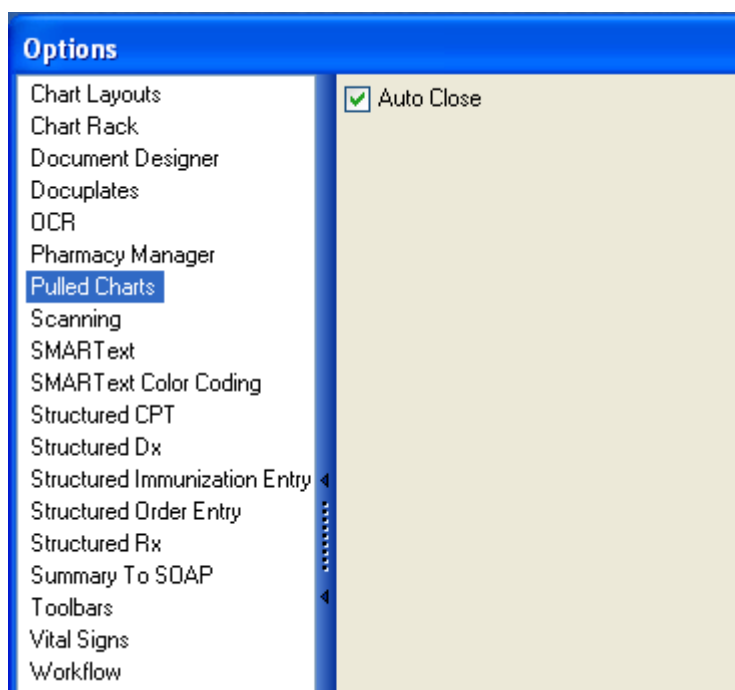
**Bit Depth:** Affects the granularity of the conversion. If the user has a Gray or Color type set, the higher the bit depth the user selects, the clearer the picture will be.

## Pharmacy Manager



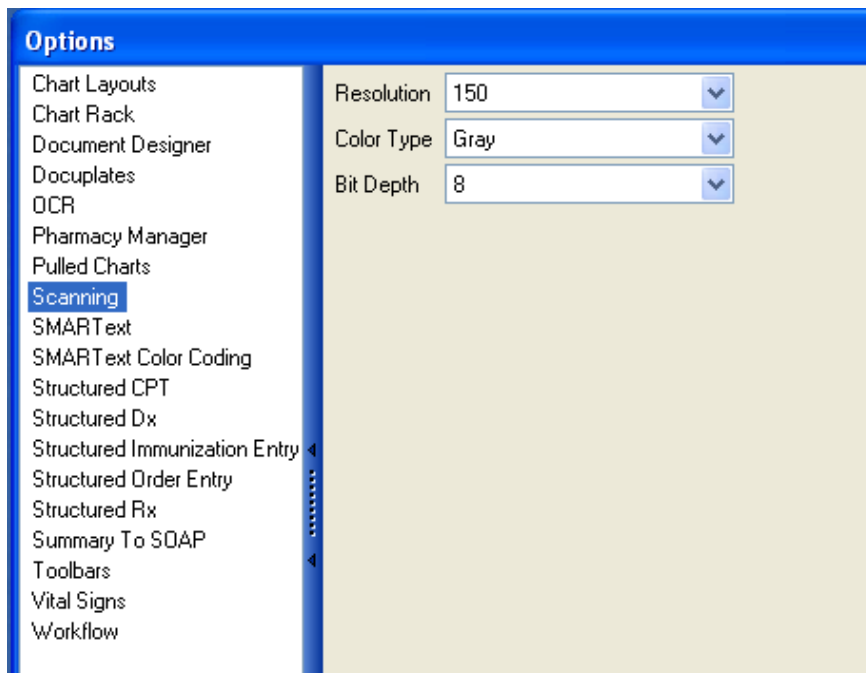
**Prompt Users to Update Pharmacy Quick-Access List:** Check this option and SOAPware will prompt users to update the Pharmacy Quick-Access list each time the Pharmacy Manager is launched.

## Pulled Charts



**Auto Close:** If checked, the Pulled Charts dialog will close once a patient is selected from the list.

## Scanning



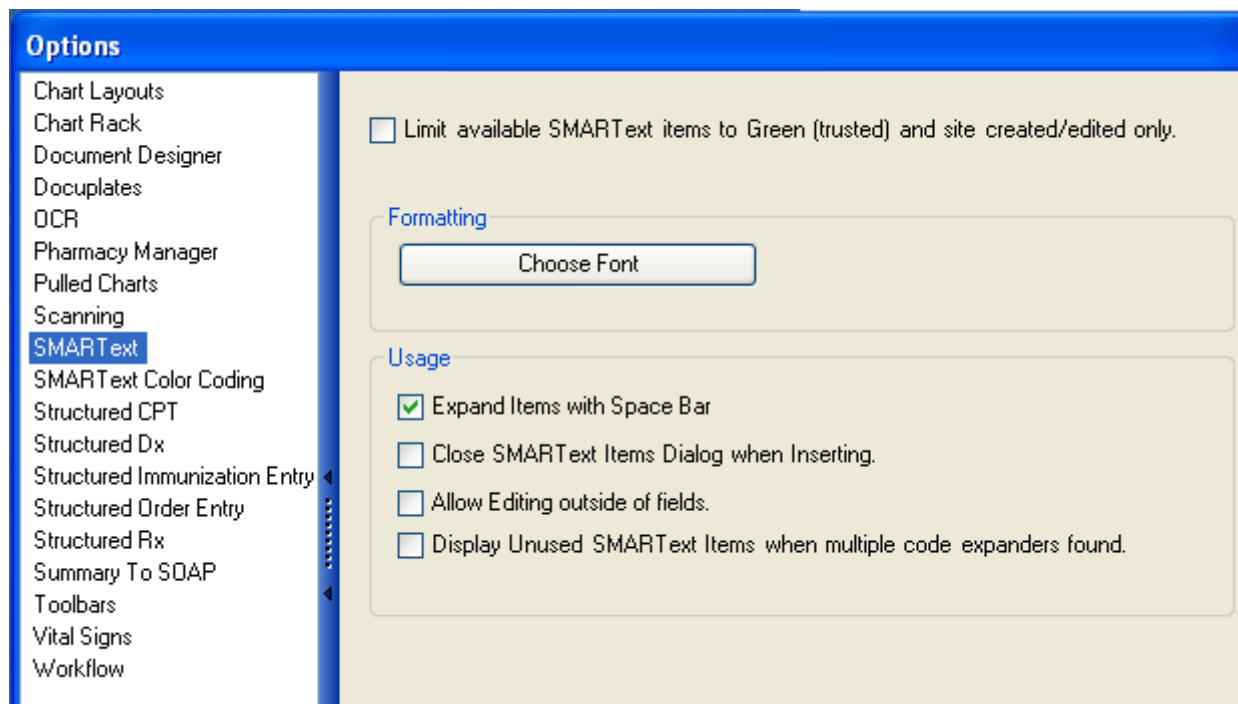
These settings determine the quality of the user's scanned images. Remember that the higher resolution that is set, the clearer the picture, but the slower the scanning time will be.

**Resolution:** This controls the dots per inch. The higher the resolution is set, the larger the user's database will get.

**Color Type:** The user will be able to select Black and White, Gray or Color. Black and White will be the most accurate and fastest option. If the user wants to convert color documents, the user certainly can. Both Gray and Color will affect the Bit Depth of the conversion as well.

**Bit Depth:** Affects the granularity of the conversion. If the user has a Gray or Color type set, the higher the bit depth selected, the clearer the picture will be.

## SMARText



This area will allow the user to set some specific preferences in regards to how the user will use SMARText, in addition to setting the size and look of the user's SMARText font.

**Limit available SMARText items to Green (trusted) and site created/edited only:** Allows the user to view only the green triangle SMARText items in the SMARText Items Manager, which have been created by SOAPware, or has been created/edited by those on site.

**Choose Font:** Allows the user to select the default font for SMARText. After clicking the button, the user will be presented with a standard font selection dialog where the user can change the font, style and size of the default SMARText font used in SOAPware.

**\*\*Note:** The changes will not take effect until after the user closes and reopens SOAPware and the font changes are not retroactive for previously created document items, it will only change

items that are created after the font change.

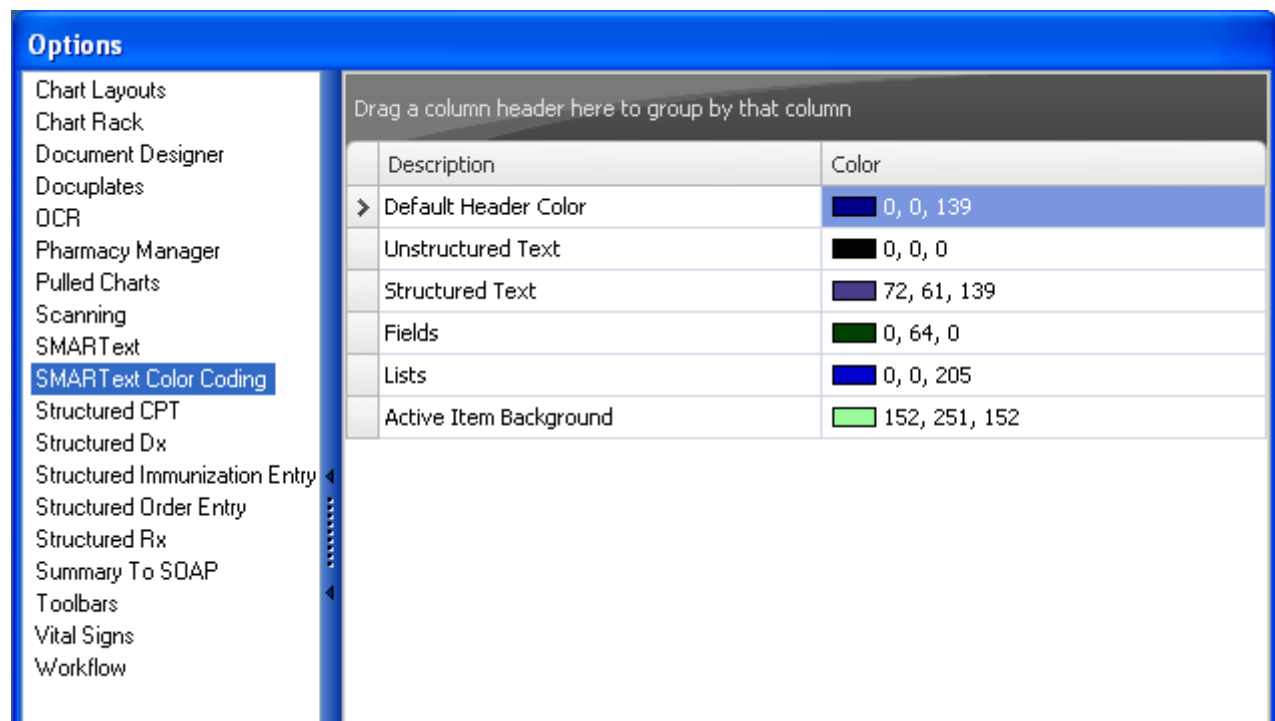
**Expand Items with Space Bar:** Allows the user to set whether a SMARText Item expands to full length when the user presses the space bar. To enable this feature, check the box. To disable this feature, uncheck the box.

**Close SMARText Items Dialog when Inserting:** Allows the user to set whether the SMARText Dialog closes after the user has placed a SMARText Item into a document. To enable this feature, check the box. To disable this feature, uncheck the box.

**Allow Editing Outside of Fields:** Allows the user to set whether text entry is allowed outside the green SMARText brackets in an Encounter Field. To enable text entry outside of these brackets, check the box. To disable text entry outside these brackets, uncheck the box.

**Display Unused SMARText Items:** Display Unused SMARText Items when multiple code expander's found - allows the user to set to show SMARText item sections that are not used. When this setting is off, sections that the user never use will be hidden from view.

## SMARText Color Coding



This setting gives the user the option to color code different types of SMARText for easy recognition.

The screenshot shows a software window titled "Options" with a blue header. On the left is a list of menu items, with "Structured CPT" highlighted in blue. On the right, under the heading "Include the following items:", there is a list of checkboxes. The first two, "Related Dx" and "Modifiers", are checked with green checkmarks. The remaining checkboxes are unchecked.

Option	Selected
Chart Layouts	
Chart Rack	
Document Designer	
Docuplates	
OCR	
Pharmacy Manager	
Pulled Charts	
Scanning	
SMARText	
SMARText Color Coding	
<b>Structured CPT</b>	
Structured Dx	
Structured Immunization Entry	
Structured Order Entry	
Structured Rx	
Summary To SOAP	
Toolbars	
Vital Signs	
Workflow	

Include the following items:	
<input checked="" type="checkbox"/> Related Dx	
<input checked="" type="checkbox"/> Modifiers	
<input type="checkbox"/> Date of Service From	
<input type="checkbox"/> Date of Service To	
<input type="checkbox"/> Place of Service	
<input type="checkbox"/> EPSDT	
<input type="checkbox"/> Family Plan	
<input type="checkbox"/> Supplemental	
<input type="checkbox"/> Days or Units	
<input type="checkbox"/> Emergency	

Select sub-items for the structured CPT items which will be inserted in the Plan section of the SOAP Note.

Options																											
Chart Layouts	<p>Include the following items:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> Description</td> <td><input checked="" type="checkbox"/> Status</td> </tr> <tr> <td><input type="checkbox"/> Lay Term</td> <td><input type="checkbox"/> EncounterDates</td> </tr> <tr> <td><input checked="" type="checkbox"/> ICD#</td> <td><input type="checkbox"/> Cause</td> </tr> <tr> <td><input type="checkbox"/> Responsible MD</td> <td><input type="checkbox"/> Subjective</td> </tr> <tr> <td><input checked="" type="checkbox"/> Onset</td> <td><input type="checkbox"/> Objective</td> </tr> <tr> <td><input type="checkbox"/> Resolved</td> <td><input type="checkbox"/> System</td> </tr> <tr> <td><input type="checkbox"/> Orders</td> <td><input type="checkbox"/> Variable</td> </tr> <tr> <td><input type="checkbox"/> Plan</td> <td><input type="checkbox"/> Value</td> </tr> <tr> <td><input type="checkbox"/> Problem Number</td> <td><input type="checkbox"/> Location</td> </tr> <tr> <td><input type="checkbox"/> Course</td> <td><input type="checkbox"/> Extent</td> </tr> <tr> <td><input type="checkbox"/> Recorded</td> <td><input type="checkbox"/> Duration</td> </tr> <tr> <td><input type="checkbox"/> Diagnosing MD</td> <td><input checked="" type="checkbox"/> Comments</td> </tr> <tr> <td><input type="checkbox"/> Initial Date</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Description	<input checked="" type="checkbox"/> Status	<input type="checkbox"/> Lay Term	<input type="checkbox"/> EncounterDates	<input checked="" type="checkbox"/> ICD#	<input type="checkbox"/> Cause	<input type="checkbox"/> Responsible MD	<input type="checkbox"/> Subjective	<input checked="" type="checkbox"/> Onset	<input type="checkbox"/> Objective	<input type="checkbox"/> Resolved	<input type="checkbox"/> System	<input type="checkbox"/> Orders	<input type="checkbox"/> Variable	<input type="checkbox"/> Plan	<input type="checkbox"/> Value	<input type="checkbox"/> Problem Number	<input type="checkbox"/> Location	<input type="checkbox"/> Course	<input type="checkbox"/> Extent	<input type="checkbox"/> Recorded	<input type="checkbox"/> Duration	<input type="checkbox"/> Diagnosing MD	<input checked="" type="checkbox"/> Comments	<input type="checkbox"/> Initial Date	
<input checked="" type="checkbox"/> Description		<input checked="" type="checkbox"/> Status																									
<input type="checkbox"/> Lay Term		<input type="checkbox"/> EncounterDates																									
<input checked="" type="checkbox"/> ICD#		<input type="checkbox"/> Cause																									
<input type="checkbox"/> Responsible MD		<input type="checkbox"/> Subjective																									
<input checked="" type="checkbox"/> Onset		<input type="checkbox"/> Objective																									
<input type="checkbox"/> Resolved		<input type="checkbox"/> System																									
<input type="checkbox"/> Orders		<input type="checkbox"/> Variable																									
<input type="checkbox"/> Plan		<input type="checkbox"/> Value																									
<input type="checkbox"/> Problem Number		<input type="checkbox"/> Location																									
<input type="checkbox"/> Course		<input type="checkbox"/> Extent																									
<input type="checkbox"/> Recorded		<input type="checkbox"/> Duration																									
<input type="checkbox"/> Diagnosing MD		<input checked="" type="checkbox"/> Comments																									
<input type="checkbox"/> Initial Date																											
Structured Immunization Entry																											
Structured Order Entry																											
Structured Rx																											
Summary To SOAP																											
Toolbars																											
Vital Signs																											
Workflow																											

This section determines what items are auto inserted when a structured diagnosis is entered into the chart. Check only the options that a Provider, would likely use and fill out when entering diagnosis codes for visits.

**Description:** Technical description for the ICD code

**Lay Term:** An easy-to-understand, non-technical description

**ICD#:** Numeric diagnosis code

**Responsible MD:** The provider responsible for the diagnosis

**Onset:** Provides further detail as to when the particular diagnosis began

**Orders:** Links any associated orders needed for the particular diagnosis code used

**Plan:** Allows a plan to be indicated for the particular diagnosis code

**Problem Number:** Related to E&M Coder calculation

**Course:** Related to E&M Coder calculation

**Initial Date:** Related to E&M coder calculation

**Status:** Allows a diagnosis status to be set as one of the following: Active, Inactive, Resolved, Undetermined, Chronic.

**Comments:** Allows any further details concerning the diagnosis to be entered.

## Structured Immunization Entry

**Options**

- Chart Layouts
- Chart Rack
- Document Designer
- Docuplates
- OCR
- Pharmacy Manager
- Pulled Charts
- Scanning
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Immunization Entry**
- Structured Order Entry
- Structured Rx
- Summary To SOAP
- Toolbars
- Vital Signs
- Workflow

**Immunizations**

**Immunization Specific**

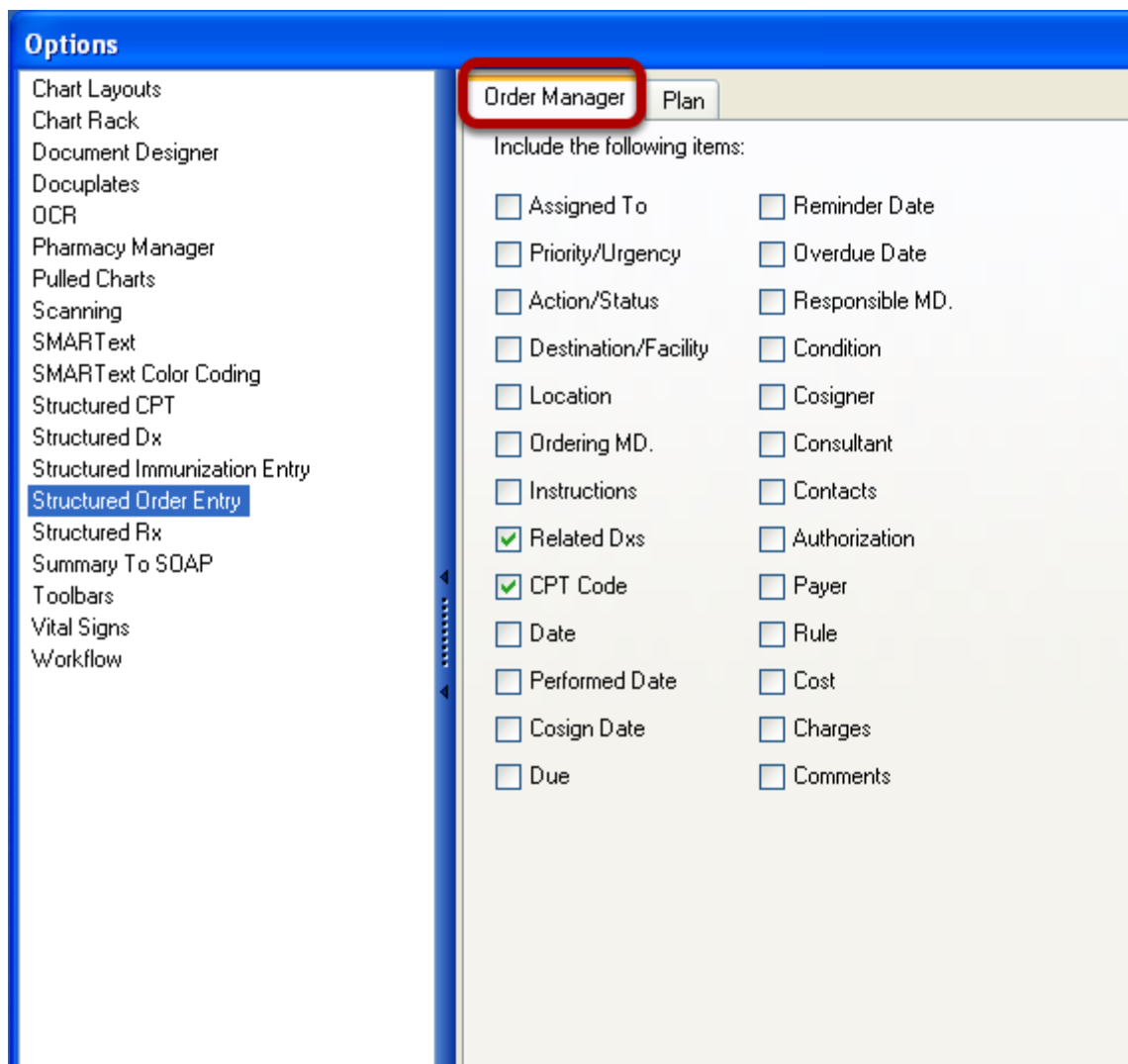
<input checked="" type="checkbox"/> Dose	<input checked="" type="checkbox"/> Site
<input checked="" type="checkbox"/> Manufacturer	<input checked="" type="checkbox"/> Lot #

**Generic Order Entry**

Include the following items:

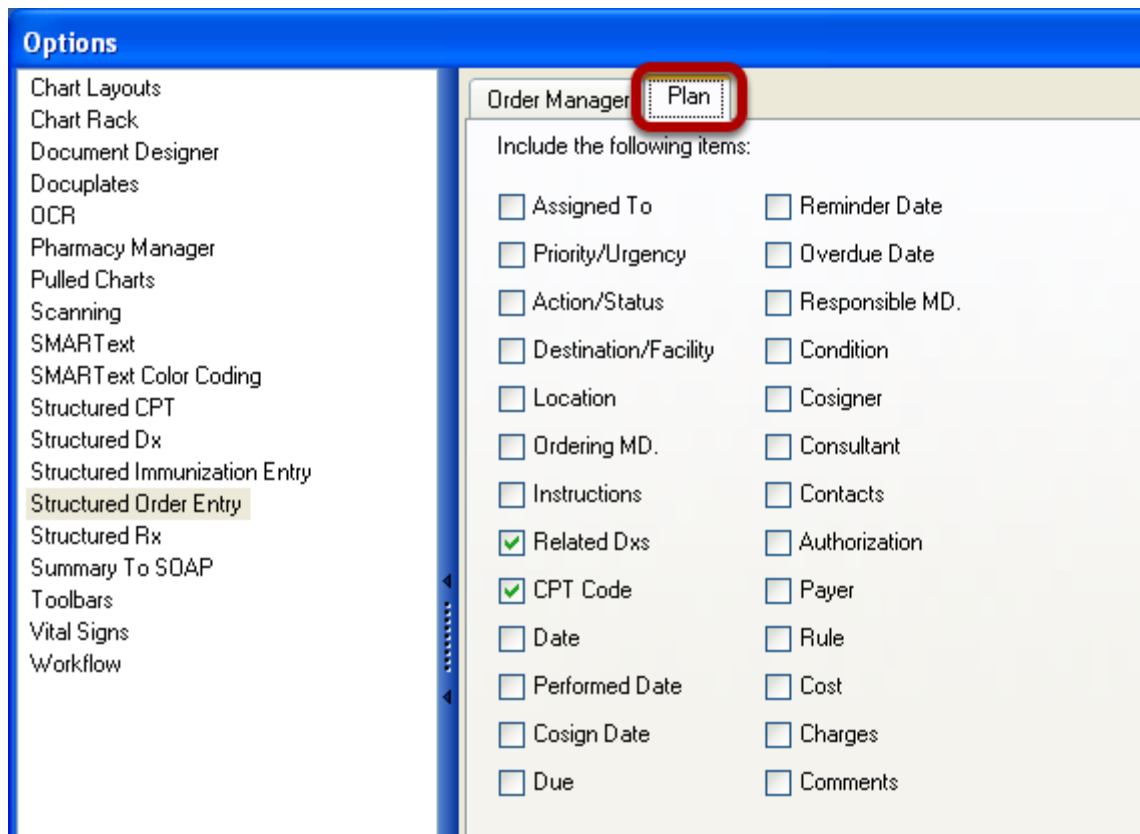
<input checked="" type="checkbox"/> Assigned To	<input type="checkbox"/> Reminder Date
<input type="checkbox"/> Priority/Urgency	<input type="checkbox"/> Overdue Date
<input type="checkbox"/> Action/Status	<input type="checkbox"/> Responsible MD.
<input type="checkbox"/> Destination/Facility	<input type="checkbox"/> Condition
<input type="checkbox"/> Location	<input type="checkbox"/> Cosigner
<input type="checkbox"/> Ordering MD.	<input type="checkbox"/> Consultant
<input type="checkbox"/> Instructions	<input type="checkbox"/> Contacts
<input checked="" type="checkbox"/> Related Dxs	<input type="checkbox"/> Authorization
<input checked="" type="checkbox"/> CPT Code	<input type="checkbox"/> Payer
<input type="checkbox"/> Date	<input type="checkbox"/> Rule
<input type="checkbox"/> Performed Date	<input type="checkbox"/> Cost
<input type="checkbox"/> Cosign Date	<input type="checkbox"/> Charges
<input type="checkbox"/> Due	<input type="checkbox"/> Comments

Select the sub-items to be entered when using Immunization Order Entry items. When immunization orders are transferred to the Plan field via either Order Manager or with the Quick Entry (i.e. F4 method), the sub-items that are checked (see screen shot above), will be displayed.



When orders are displayed in the Order Manager, the sub-items that are checked (see screen shot above) will be displayed in the lower pane of the Order Manager when the order is clicked.





When orders are transferred to the Plan field via either Order Manager or with the Quick Entry (i.e. F4 method), the sub-items that are checked (see screen shot above), will be displayed.

### List and Explanations of Order Entry Sub-Items

**Assigned To:** Allows for the selection of the SOAPware user to whom the order is assigned. Note that the value selected at this step will be indicated in the Task item associated with the order.

**Priority/Urgency:** Allows for the setting of the priority of the order (e.g. High, Low, Urgent, Normal, etc.). The value selected at this step will be indicated in the Task item associated with the order.

**Action/Status:** Allows for the definition of a particular default status or action for the order (e.g. Signature Needed, Review, Waiting on call-back, etc.). This will be displayed-associated with its Task Item.

**Destination/Facility:** Specifies the facility where the order will be performed. The options provided here are pulled from the Destinations entered from the Docutainers menu, under Order Entry. Defining the Destinations should be a part of initial implementation set-ups.

**Location:** Defines where the patient is located (e.g. exam room, lab, etc.) Define destinations via

the [Tools > List Options](#). Alternatively, it define where an order is to be performed.

**Ordering MD:** This is an [Order Manager](#) item - By default, the [Owner](#) of an order is the [Active Provider](#).

**Instructions:** Provides specific directions or further details pertaining to the order.

**Condition:** Or interpretation (Normal, Abnormal, etc.) Type the condition here (in [Order Manager](#)) and an icon is placed in this column in its [Task Item](#). Clicking on the icon will bring up the order in [Order Manager](#).

**Co-signer:** Specifies who will need to co-sign on the order to approve it.

**Consultant:** References consulting clinicians who are associated with the order in some fashion. This links to the [Contact Manager](#).

**Contacts:** References any person, other than consultants, who are associated with the order in some fashion. This links to the [Contact Manager](#).

**Authorization:** This indicates that a particular payer requires prior authorization for the order and procedure(s).

**Payer:** Will be implemented in a later version.

**Rule:** Will be implemented in a later version.

**Cost:** Will be implemented in a later version.

**Charges:** Will be implemented in a later version.

**Comments:** Allows additional information or details to be entered.

Note that there are some Order Entry sub-items that are not typically included as sub-items in the [Order Entry](#) items themselves. These items are accessed in the [Order Manager](#), except for the CPT code.

**Related Dxs** - Allows the order to be associated with a diagnosis in the [Assessment](#) field.

**CPT Code** - This is defined in the Codes/Notes area of the [Order Entry](#) item.

**Date** - Defines when the order was placed-executed or entered into chart.

**Performed Date** - Defines when order was actually performed.

**Co-sign Date** - Defines when the order was co-signed by another clinician.

**Due** - Defines when an order is considered as due, or when it should have been completed.

**Reminder Date** - The Reminder Date is just that. It is an alert sent to the physician responsible for the order.

**Overdue Date** - The Overdue Date will eventually be able to trigger a message to be sent to an administrator or medical director. This function is not currently available, but will be added in a future release.

**Responsible MD** - This is the clinician who is ultimately responsible and who oversees the order.

## Structured Rx - Default Layout

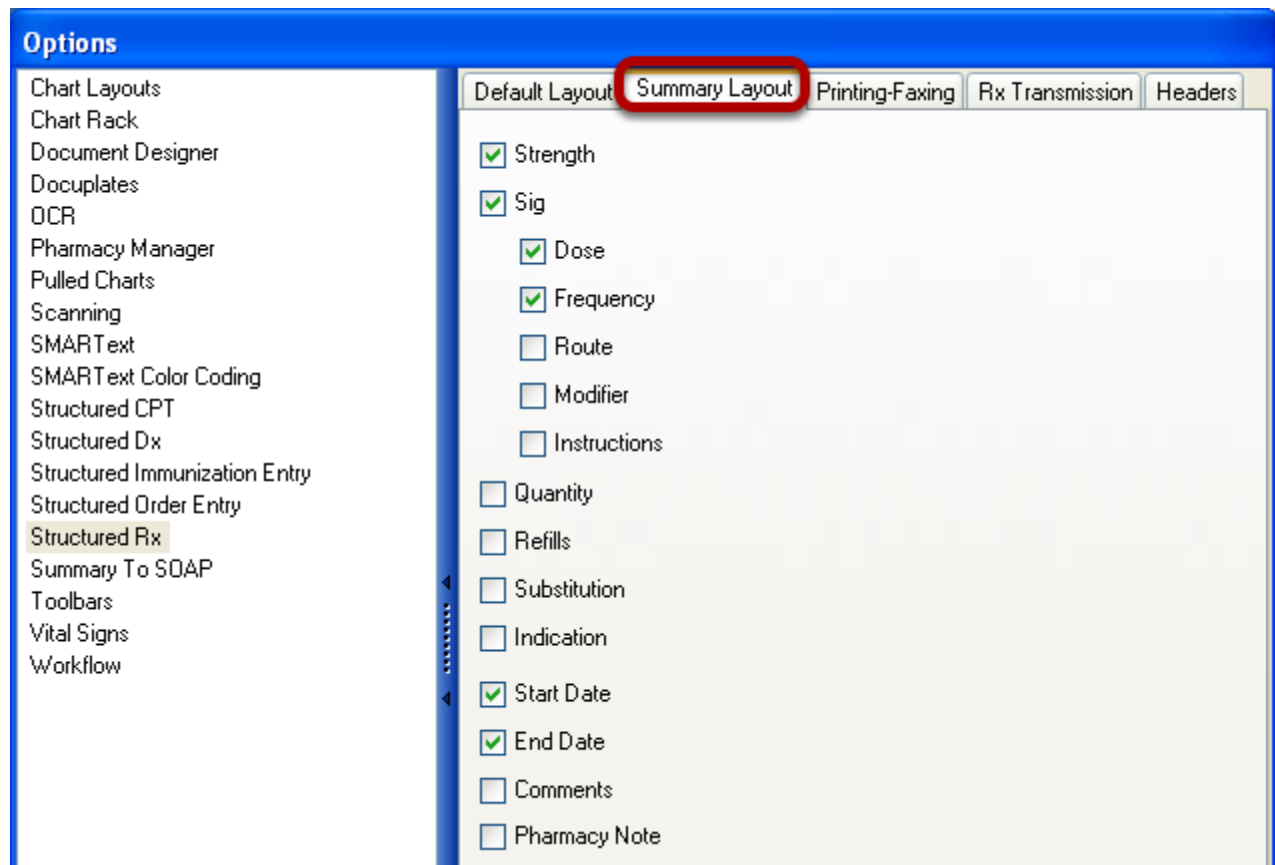
The screenshot shows the 'Options' dialog box with the 'Default Layout' tab selected. The left sidebar lists various options, with 'Structured Rx' highlighted. The right pane displays a list of fields for a structured prescription, each with a checkbox. The checked fields are: Strength, Sig, Dose, Frequency, Route, Quantity, Refills, Substitution, Start Date, End Date, and Pharmacy Note. The unchecked fields are: Modifier and Instructions.

Field	Checked
Strength	Yes
Sig	Yes
Dose	Yes
Frequency	Yes
Route	Yes
Modifier	No
Instructions	No
Quantity	Yes
Refills	Yes
Substitution	Yes
Indication	No
Start Date	Yes
End Date	Yes
Comments	No
Pharmacy Note	Yes

**Default Layout:** This section of Options allows the user to select what fields are included when entering a Structured Prescription.

The Default choices affect the Structured Prescription as it appears in the SOAPnote. Select the boxes of the items that would be filled out when prescribing a medication.

## Structured Rx - Summary Layout



The Summary Medications Field choices affect the Structured Prescription as it appears in the summary or when transferred to the Summary via SOAP to Summary, Drag and Drop, etc.

## Structured Rx - Printing-Faxing

**Options**

- Chart Layouts
- Chart Rack
- Document Designer
- Docuplates
- OCR
- Pharmacy Manager
- Pulled Charts
- Scanning
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Immunization Entry
- Structured Order Entry
- Structured Rx
- Summary To SOAP
- Toolbars
- Vital Signs
- Workflow

Default Layout Summary Layout **Printing-Faxing** Rx Transmission Headers

Printing Rx/Fax - Alone\*

Faxing Rx/Fax - Alone\*

Printing-Faxing settings determine what document design is printed when a user prints or faxes a prescription. To set up these reports, see: [Document Designer](#)

## Structured Rx - Rx Transmission

**Options**

- Chart Layouts
- Chart Rack
- Document Designer
- Docuplates
- OCR
- Pharmacy Manager
- Pulled Charts
- Scanning
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Immunization Entry
- Structured Order Entry
- Structured Rx
- Summary To SOAP
- Toolbars
- Vital Signs
- Workflow

Default Layout Summary Layout Printing-Faxing **Rx Transmission** Headers

Transmit Via

Default eRx

Schedule II Fax and Print

Schedule III Print

Schedule IV Print

Schedule V Print

Rx Transmission is the default settings for how prescriptions submit from Rx Manager.

**\*REQUIRED FOR MEANINGFUL USE (MU) CORE REQUIREMENT - PRESCRIBING FOR 40% OF**

## PERMISSIBLE SCRIPTS

[Click here to view Meaningful Use Criteria](#)

### Structured Rx - Headers

**Options**

Chart Layouts  
Chart Rack  
Document Designer  
Docuplates  
OCR  
Pharmacy Manager  
Pulled Charts  
Scanning  
SMARText  
SMARText Color Coding  
Structured CPT  
Structured Dx  
Structured Immunization Entry  
Structured Order Entry  
**Structured Rx**  
Summary To SOAP  
Toolbars  
Vital Signs  
Workflow

Default Layout Summary Layout Printing-Faxing Rx Transmission **Headers**

**Item Headers**

<input checked="" type="checkbox"/> Visible only when empty.	Strength Header	Strength-
	Sig Header	SIG-
<input checked="" type="checkbox"/> Visible only when empty.	Dose Header	Dose-
<input checked="" type="checkbox"/> Visible only when empty.	Frequency Header	Freq-
<input checked="" type="checkbox"/> Visible only when empty.	Route Header	Route-
<input type="checkbox"/> Visible only when empty.	Modifier Header	Modifier-
<input type="checkbox"/> Visible only when empty.	Instructions Header	Instructions-
<input checked="" type="checkbox"/> Visible only when empty.	Dispense Header	Dispense-
	Refills Header	Refills-
<input checked="" type="checkbox"/> Visible only when empty.	Substitutions Header	Substitutions-
<input type="checkbox"/> Visible only when empty.	Indication Header	Related Dxs-
<input type="checkbox"/> Visible only when empty.	Start Date Header	Start Date-
<input type="checkbox"/> Visible only when empty.	End Date Header	End Date-
<input checked="" type="checkbox"/> Visible only when empty.	Note Header	Notes-

**Rx Layout**

☒ Single Line  
☐ 4 - Lines

☒ Separate with blank lines

**Substitutions Denied Wording**

Substitutions Not Allowed

Close

**Item Headers:** Allows the user to choose which headers are visible and which headers are only visible when they are empty.

#### Rx Layout:

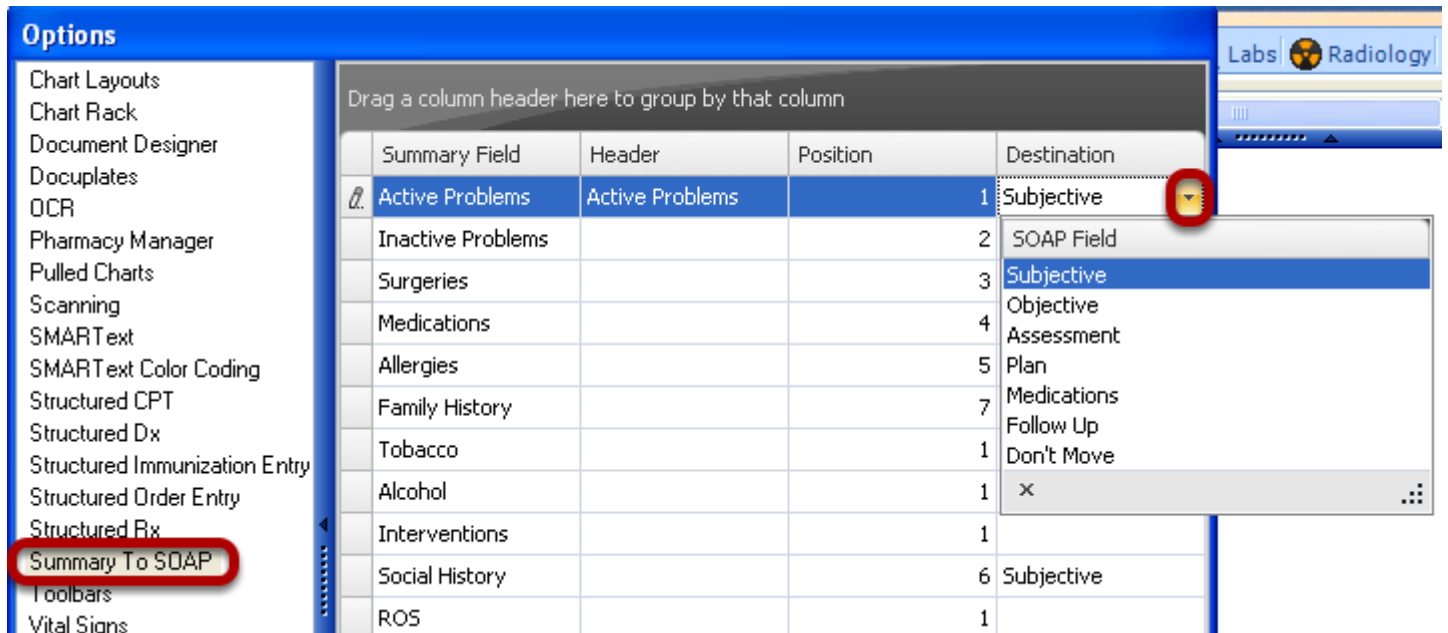
**Single Line:** This setting displays medications on a single line but medications may wrap to the screen due to space limitations.

**4 - Lines:** This setting splits up medications into three lines and makes them easier to read.

**Separate with blank Lines:** This setting separates medications with blank lines.

**Substitutions Denied Wording:** This box allows the user to enter custom text that will be used when the user chooses to deny substitutions in a prescription. To change the text, replace the default wording by typing it into the box.

## Summary to SOAP



Options

Chart Layouts  
Chart Rack  
Document Designer  
Docuplates  
OCR  
Pharmacy Manager  
Pulled Charts  
Scanning  
SMARText  
SMARText Color Coding  
Structured CPT  
Structured Dx  
Structured Immunization Entry  
Structured Order Entry  
Structured Rx  
**Summary To SOAP**  
Toolbars  
Vital Signs

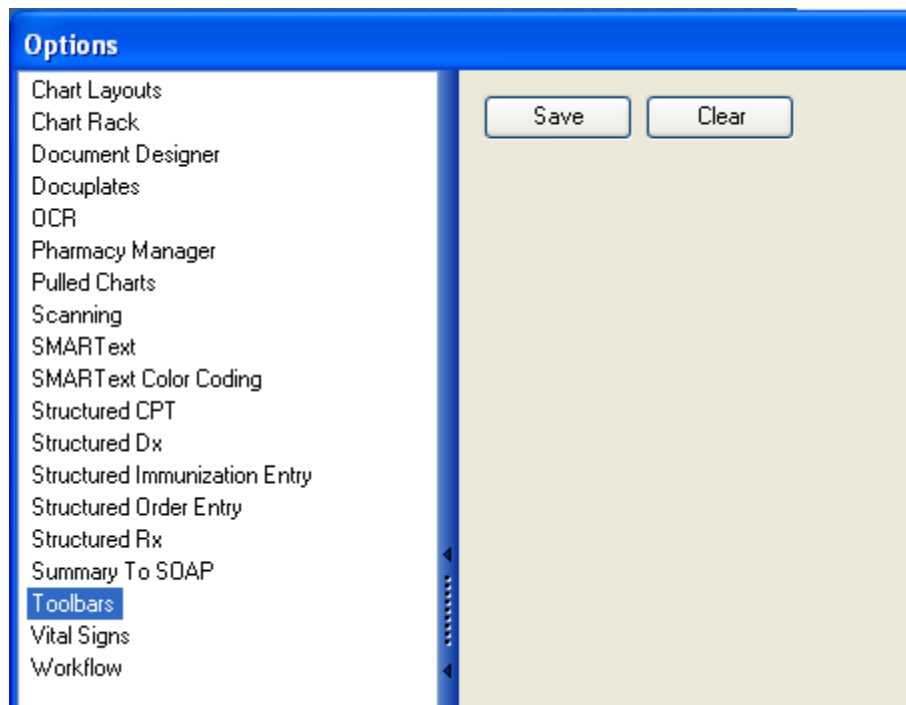
Drag a column header here to group by that column

Summary Field	Header	Position	Destination
Active Problems	Active Problems	1	Subjective
Inactive Problems		2	SOAP Field
Surgeries		3	Subjective
Medications		4	Objective
Allergies		5	Assessment
Family History		7	Plan
Tobacco		1	Medications
Alcohol		1	Follow Up
Interventions		1	Don't Move
Social History		6	X
ROS		1	X

Labs Radiology

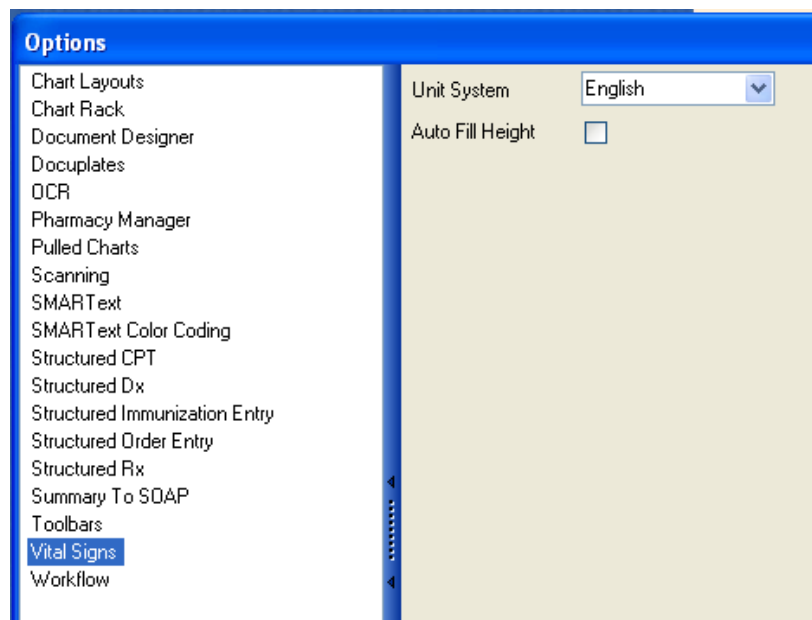
Allows for pulling over information under any field header in the Summary section to any area in the SOAP Note.

## Toolbars



This box will save customizations made to toolbars. The option is also made available if the user would like to clear out toolbars and revert to what was defaulted with the system originally.

## Vital Signs

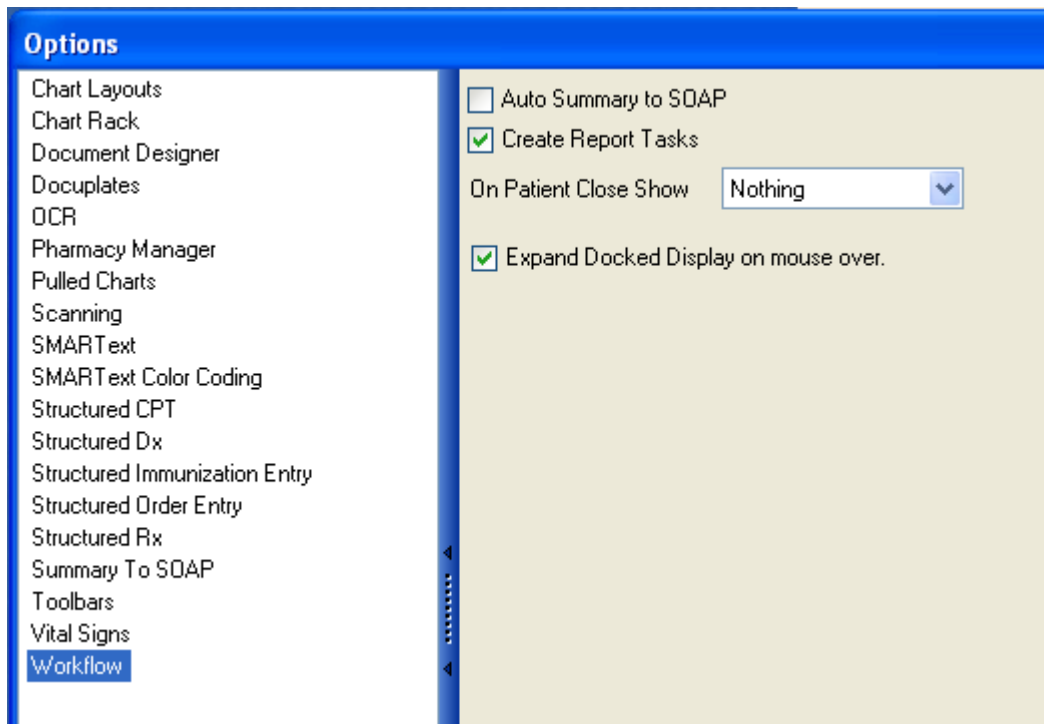


**Unit System:** Allows the user to determine whether the user's units for Vital Signs are English or Metric.



**Auto Fill Height:** Allows the patient's height to be auto filled from the previous vital reading. Useful in clinics where patients' heights don't frequently change.

## Workflow



**Options**

- Chart Layouts
- Chart Rack
- Document Designer
- Docuplates
- OCR
- Pharmacy Manager
- Pulled Charts
- Scanning
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Immunization Entry
- Structured Order Entry
- Structured Rx
- Summary To SOAP
- Toolbars
- Vital Signs
- Workflow**

☐ Auto Summary to SOAP

☒ Create Report Tasks

On Patient Close Show:

☒ Expand Docked Display on mouse over.

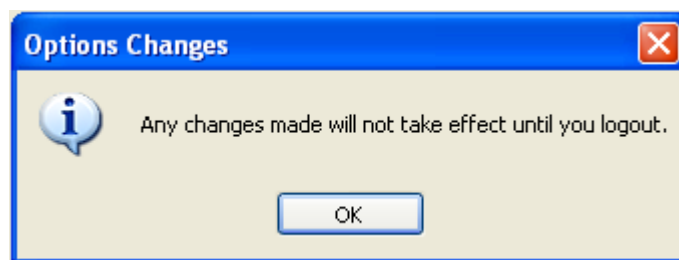
**Auto Summary to SOAP:** Checking this box will automatically pull the user's Summary findings into every new SOAPnote created.

It moves the Summary Physical section to the Encounter/SOAPnote Objective section, the SummaryActive Problems section to the SOAPnote Assessment section, and the Summary Medications section to the SOAPnote Medications Section.

**Create Report Tasks:** If this box is checked, anytime a SOAPnote is created, the user will be able to report an associated task.

**On Patient Close Show:** Anytime a patient's chart is closed, the user can select what the user would like to happen at that time. The user can opt to have the Pulled Charts window, Chart Rack window or the Tasks window to pop up upon the close. The user can also choose for the system to do nothing upon a chart close.

**Expand Docked Display on mouse over:** Docked displays can be set to either auto expand when the user's mouse hovers over the tab, or it can be set to require a Click before expanding. By default, the tabs are set to require a Click. That is, the user will have to Click on the tab before the panel will slide out.



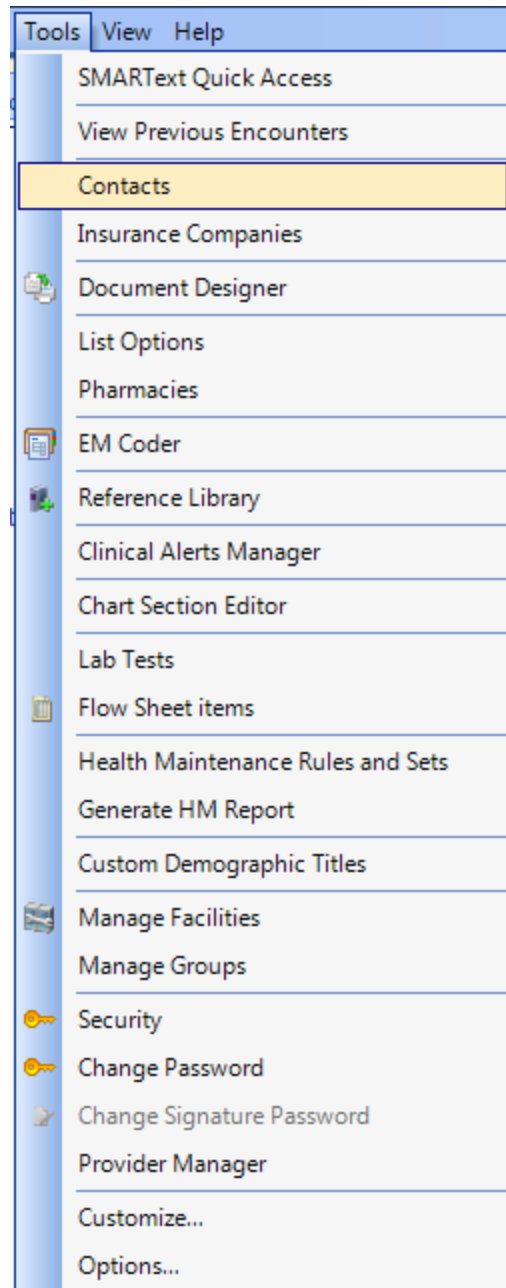
Any time a user makes a change under the Tools > Options menu, SOAPware requires the user to logout and log back in before the change will take effect.

## Contacts

---

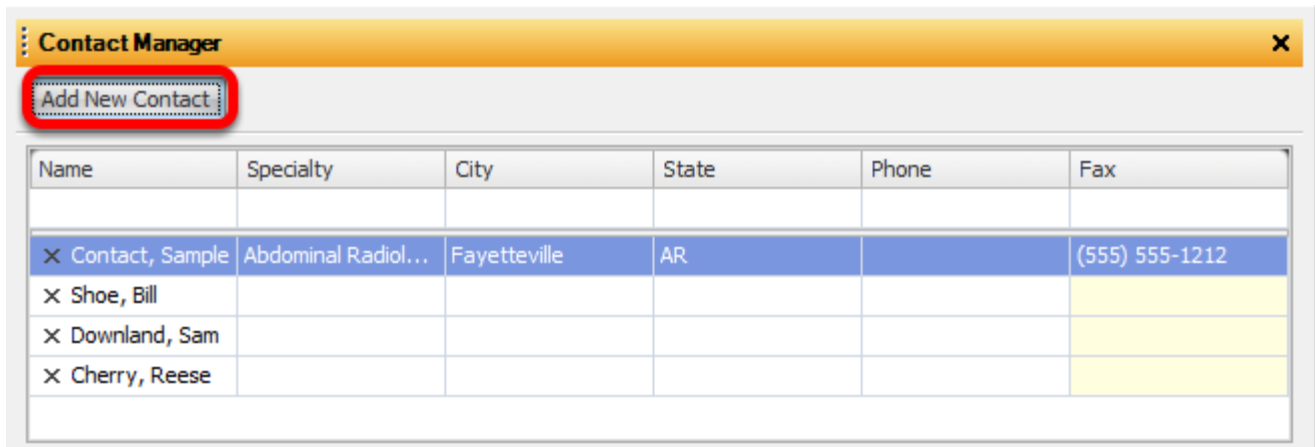
SOAPware can maintain a list of frequently used contacts along with their basic demographic information. SOAPware's document designs can then pull this information to create personalized documents such as referral letters. The contact list is also used to maintain frequently used names and addresses. In this fashion it functions much as a Rolodex.

### Opening Contact Manager



Click Tools in the menu bar, and Click the Contact Manager menu item.

## Adding Contacts



Name	Specialty	City	State	Phone	Fax
× Contact, Sample	Abdominal Radiol...	Fayetteville	AR		(555) 555-1212
× Shoe, Bill					
× Downland, Sam					
× Cherry, Reese					

The SOAPware Contact Manager dialog has an added Insurance Information section, allowing Insurance-assigned legacy number entry in addition to the NPI number. The contact name will print in box 17 on the CMS 1500 claim form when listed as the Referring Provider in the general Demographics section of a patient chart. The NPI number typed here will print in box 17b on the CMS 1500 form and the legacy number will print in box 17a.

To add a contact, Click the Add New Contact button in the Contact Manager viewer.

**New Contact**

Title First Name Middle Last Name Suffix

Address

City St Zip Code

Office Phone Home Phone Cell Phone

Fax Pager

Email

Website

Notes

**Provider Information**

NPI UPIN Specialty Taxonomy

**Insurance Information**

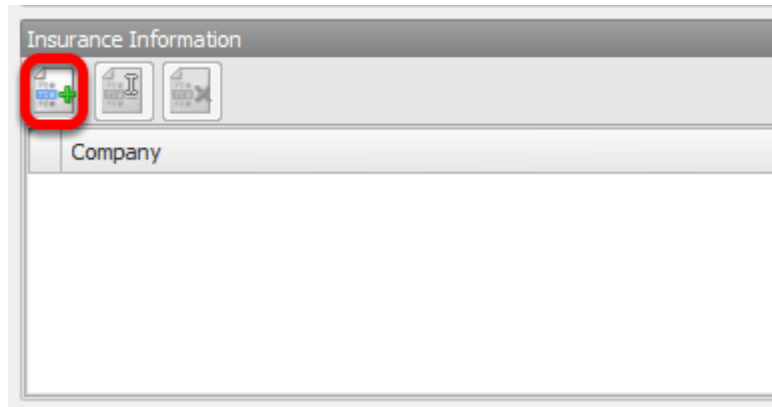
Company

Okay Cancel

This displays the New Contact dialog as seen in the above screen shot. Complete the New Contact information and the Provider Information section for Insurance filing purposes. The UPIN field next to the NPI entry is being phased out and in current versions of SOAPware the field will be grayed out. If the UPIN is still required by certain Insurance companies, the number can be typed in the Legacy number field as instructed in the ID Number step below.

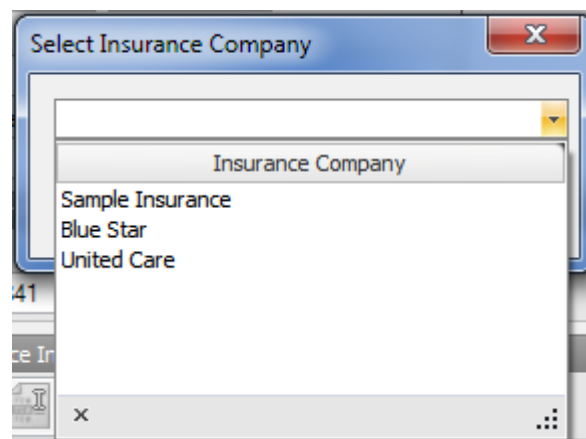
If data is entered in the highlighted fields, it must be a valid phone number. A warning icon will prompt the user if the number is invalid.

## Insurance Mapping



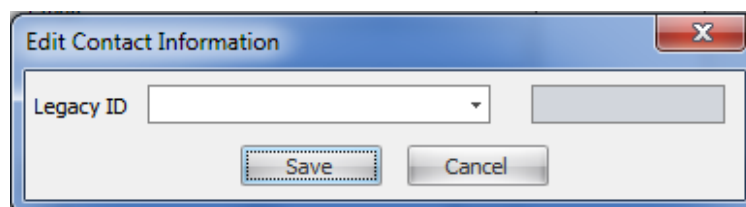
Click the New Insurance Mapping button in the Insurance Information section. The Select Insurance Company dialog displays.

## Insurance Company Manager



Click the Drop-down menu to display a list of insurance companies from the Insurance Company Manager.

## ID Number



Click the Drop-down button to display the list of different types of legacy numbers, followed by the legacy number ID Qualifier. Type the contact/Referring Provider Medicare legacy number and Click Save.

## Updating/Editing Contacts

**Contact Manager**

Add New Contact

Name	Specialty	City
× Contact, Sample	Abdominal Radiol...	Fayetteville
× Shoe, Bill		
× Downland, Sam		
× Cherry, Reese		

**Plan**  
FLU VACCINE, 3 YRS & >, IM. CPT 90658  
FLU VACCINE, 3 YRS & >, IM. CPT 90658  
999288-3 [Related Dx's](#) [Site](#):

**Medications**

**Follow Up**  
Return if problems develop or worsens.  
[Schedule](#): Shannon Shores

**SOAPNote**

Drag a column header here to group by the

Date/Time Owner

**Edit Contact Information**

Title First Name Middle Last Name Suffix  
| Sample | Contact |

Address  
172

City St Zip Code  
Fayetteville AR 72703-

Office Phone Home Phone Cell Phone  
( ) - ( ) - ( ) -

Fax Pager  
(555) 555-1212 ( ) -

Email  
Website

Notes

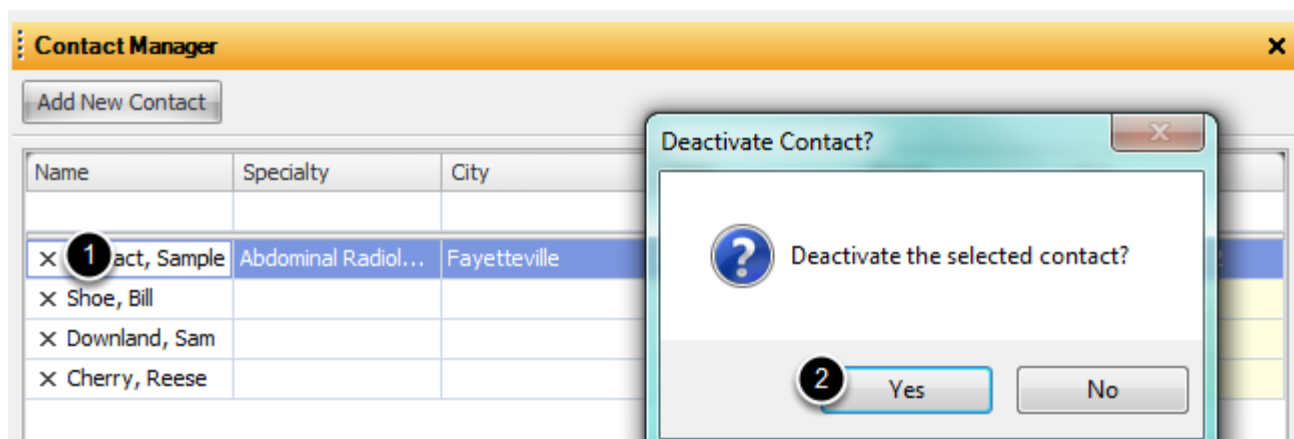
**Provider Information**  
NPI UPIN Specialty Taxonomy  
Abdominal Radi

**Insurance Information**  
Company

Okay Cancel

1. Double click a Contact list item.
2. Perform edits.
3. Click the Okay button to save, or Click the Cancel button and return to the Contact Manager viewer.

## Removing Contact



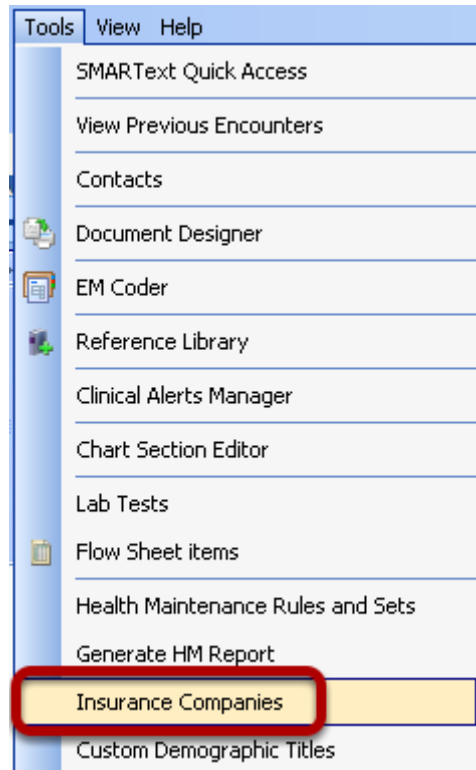
1. Do delete.remove a contact, Click on the **X** next to the contact name.
2. Click the Yes button when asked to verify the deactivation. Click Cancel to return to the Contact Manager viewer.



## Insurance Company Manager

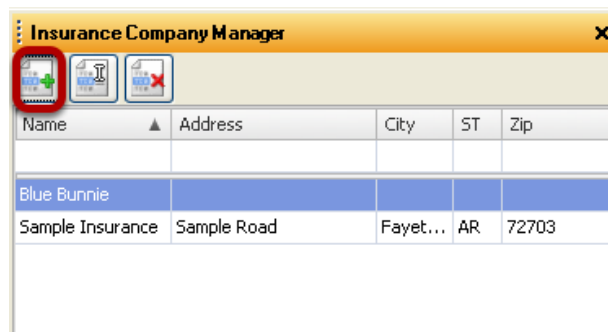
Adding Insurance Companies for the Drop list will be created with this tool. The user will fill in the appropriate information for the Insurance Company.

### Insurance Company Manager



Insurance Company Manager to build Insurance Company demographics is accessible by going to Tools and clicking on Insurance Companies.

### Creating/Editing/Removing Insurance Companies in Insurance Company Manger



To Create or Add an Insurance Company the user will Click on the button with the **Green +** . To Edit click on button with the white cursor. To Remove an Insurance Company, click on the button with the **Red X**.

## Adding/Editing Insurance Company Demographics

The screenshot shows a web form titled "Edit Insurance Company" with a blue header. The form contains the following fields: "Company Name" (text input with "Blue Bunnie" entered), "Address" (two stacked text inputs), "City" (text input), "State" (dropdown menu), "Zip" (text input with a hyphen), "Phone" (text input with area code and hyphen), "ext" (text input), "Fax" (text input with area code and hyphen), "Type (CMS 1500)" (dropdown menu), "Group Provider (Legacy)" (grayed-out text input), "Fee Schedule (Legacy)" (grayed-out text input), and "Fee Schedule" (dropdown menu with "Default" selected).

Enter in the information for the Insurance Company in available fields. The user will notice that Group Provider Legacy and Fee Schedule fields are grayed out. These legacy fields will only be used by customers that converted from SOAPware version 4 if they used these areas previously in that version.

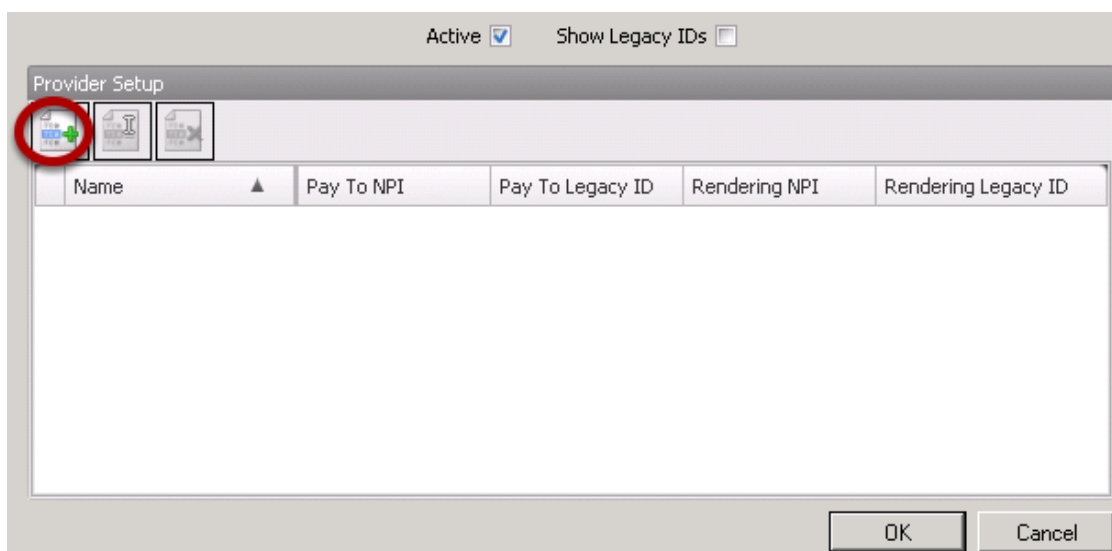
The same window will display when Editing Insurance Company information.

## Insurance Electronic Submission Info

The screenshot shows a web form titled "Electronic Submission Info" with a gray header. The form contains the following fields: "Payer Qualifier" (dropdown menu), "Payer ID" (text input), "Clearinghouse Name" (text input with "Gateway EDI" entered), "Clearinghouse ID" (text input), "Type (If Primary)" (dropdown menu), "Type (If Secondary)" (dropdown menu), "Receiver Qualifier" (dropdown menu), and "Receiver ID" (text input).

This area will be for entering and choosing information from Drop Down menus needed for Electronic Submission of CMS 1500 forms.

## Insurance Provider Setup

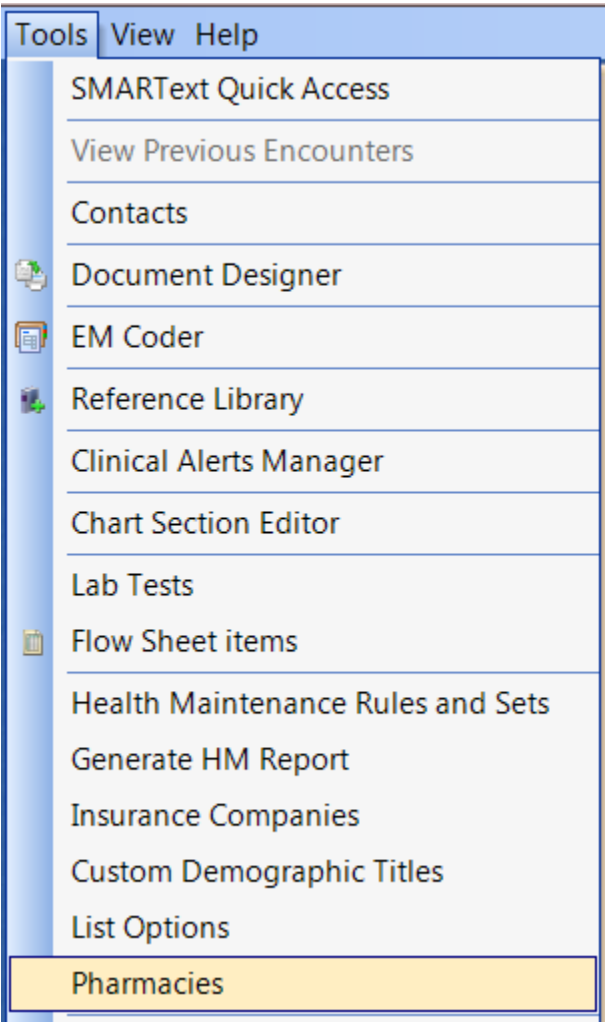


The Provider Setup window will be an area to select Provider(s) within a user's network that are under contract with that Insurance Company. Clicking on the **Green +** will display a window with a user's network Providers to choose from. Click OK after completion.

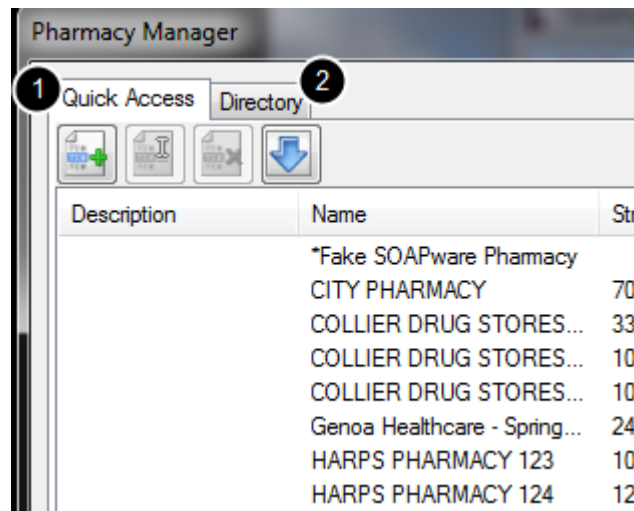
# Pharmacy Setup

Prior to sending prescriptions electronically or faxing to a participating pharmacy, Pharmacies must be set up in the Pharmacy Manager.

## Pharmacy Manager



To access Pharmacy Manager, Click Tools in the menu bar, and Click the Pharmacies menu item. Click the Directory tab in order to search for pharmacies to include in the Quick Access list.



There are two tabs in the Pharmacy Manager:

1. Quick Access: Includes the list of pharmacies on the local database (this list will be used to populate the drop-down pharmacy selection in Rx Manager. There are two ways to add pharmacies to quick access. One is to add them manually, using the buttons in the toolbar. Pharmacies added manually in this way can only be used for faxing prescriptions. The second way to add pharmacies is to use the directory.

2. Directory: Use the directory to add pharmacies from the Sure Scripts network. The pharmacies added from the Directory tab are the ones used to send ePrescriptions.

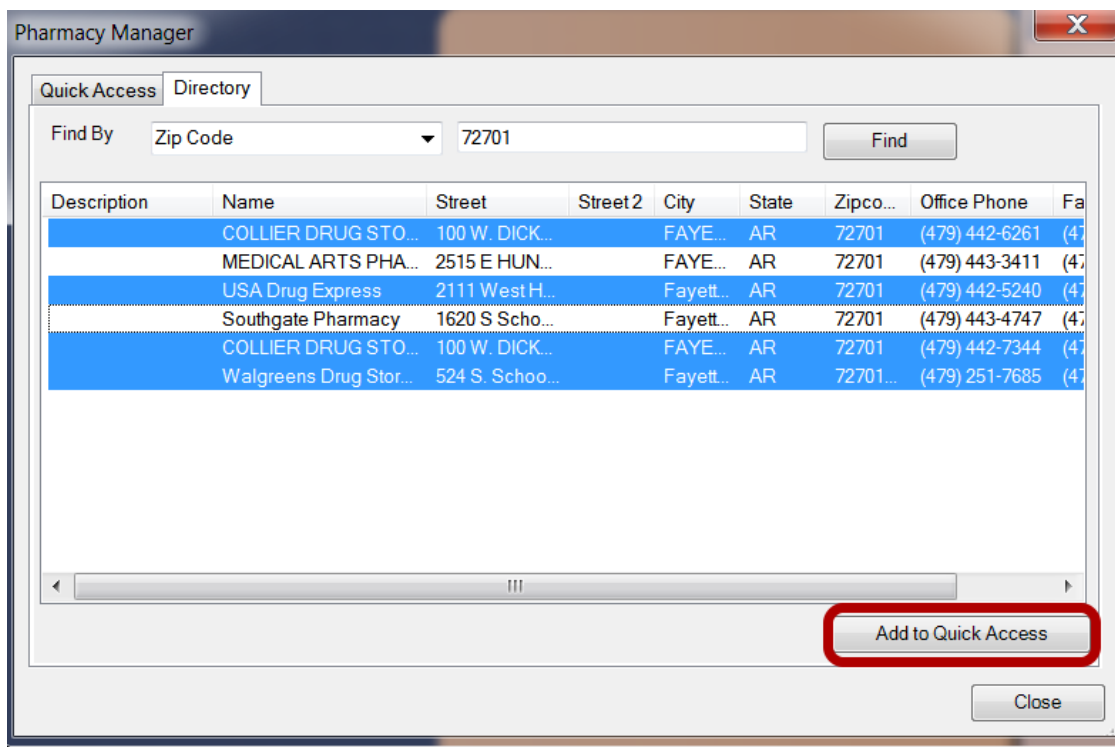
## Adding Pharmacies using the Directory - ePRESCRIBING PHARMACIES

The screenshot shows the 'Pharmacy Manager' application window with the 'Directory' tab selected. The 'Find By' dropdown menu is set to 'Zip Code'. The text input field next to it contains '72701'. The 'Find' button is highlighted. Below these fields is a table of search results. The table has columns: Description, Name, Street, Street 2, City, State, Zipcode, and Office Phone. The results list several pharmacies in Fayetteville, AR, with zip codes 72701 and 727015. At the bottom right of the window, there is an 'Add to Quick Access' button and a 'Close' button.

Description	Name	Street	Street 2	City	State	Zipcode	Office Phone
	COLLIER DRUG STORES...	100 W. DICKSON		FAYET...	AR	72701	(479) 442-6261
	MEDICAL ARTS PHARMA...	2515 E HUNTS...		FAYET...	AR	72701	(479) 443-3411
	USA Drug Express	2111 West Hwy ...		Fayette...	AR	72701	(479) 442-5240
	Southgate Pharmacy	1620 S School ...		Fayette...	AR	72701	(479) 443-4747
	COLLIER DRUG STORES...	100 W. DICKSO...		FAYET...	AR	72701	(479) 442-6262
	Walgreens Drug Store 07847	524 S. School A...		Fayette...	AR	727015...	(479) 251-7685

ePrescribing pharmacies are found via searching options in the Directory tab allows.

1. Click the "Find by" drop down menu to obtain a menu list containing Pharmacy Name, Zip Code, Phone Number or State.
2. *In our example we will search by zip code.* Type the zip code into the field to the right of the Find By field.
3. Press the Find button. The results of the search will display in the list area below.



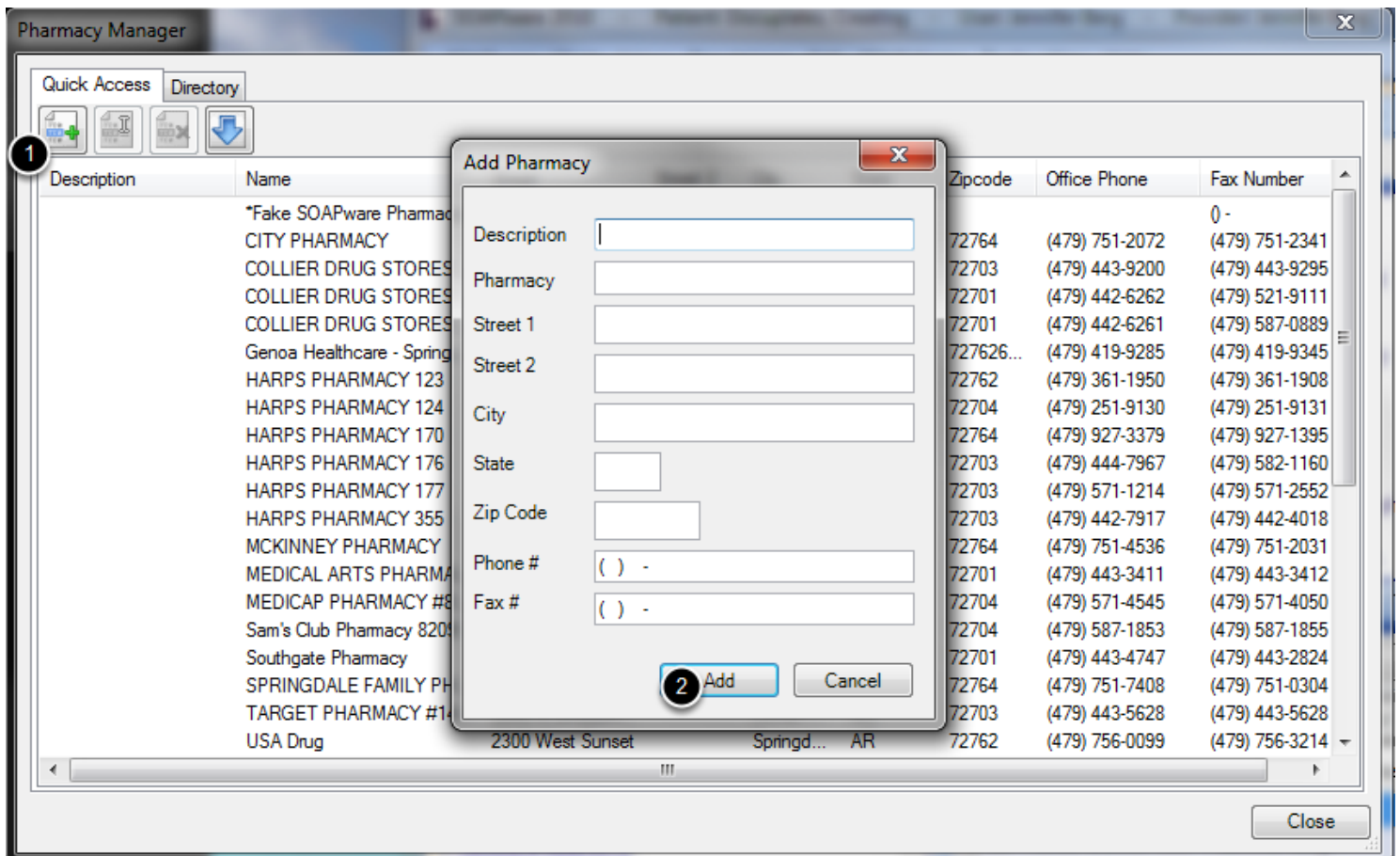
Selection of pharmacies to add to Quick Access can be accomplished using the following methods:

1. To select an individual pharmacy, Click the Name of the pharmacy.
2. To select a group of pharmacies, all of which are contiguous, Click on the first pharmacy in the list. Then, Press and hold-down the shift key while Clicking on the last pharmacy. This select-highlights all pharmacies between the first and the last.
3. Holding-down the control key, Click on noncontinuous pharmacy items in a random fashion.

After pharmacy selections are made, Press the Add to Quick Access button.

Click the Quick Access tab to view the pharmacies added.

## Manually Add Pharmacies - PRINT/FAX ONLY

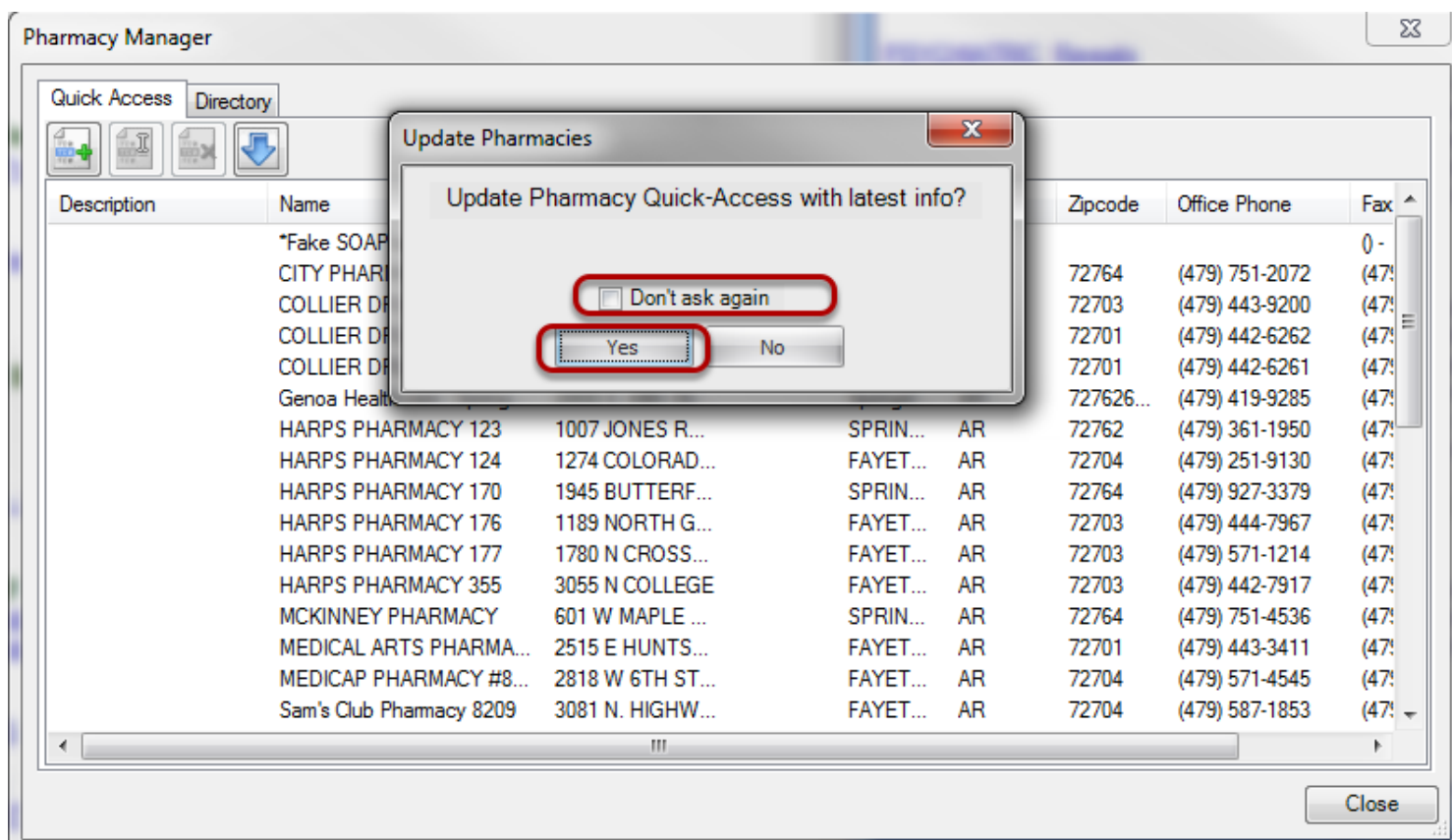


Pharmacies not found searching in the Directory tab can be manually added in the Quick Access tab. **A user will only be able to print or fax the prescription when a pharmacy is added using the Quick Access tab.** (Please refer to the directions above to add an ePrescribing pharmacy.)

1. Click the Create button at the top left.
2. Type the pharmacy information into the Add Pharmacy dialog as in screen shot, and Click the Add button. When adding or editing a pharmacy, a user must input a valid 10 digit fax number. A warning symbol will display, once they Add button has been clicked, if this entry is invalid.

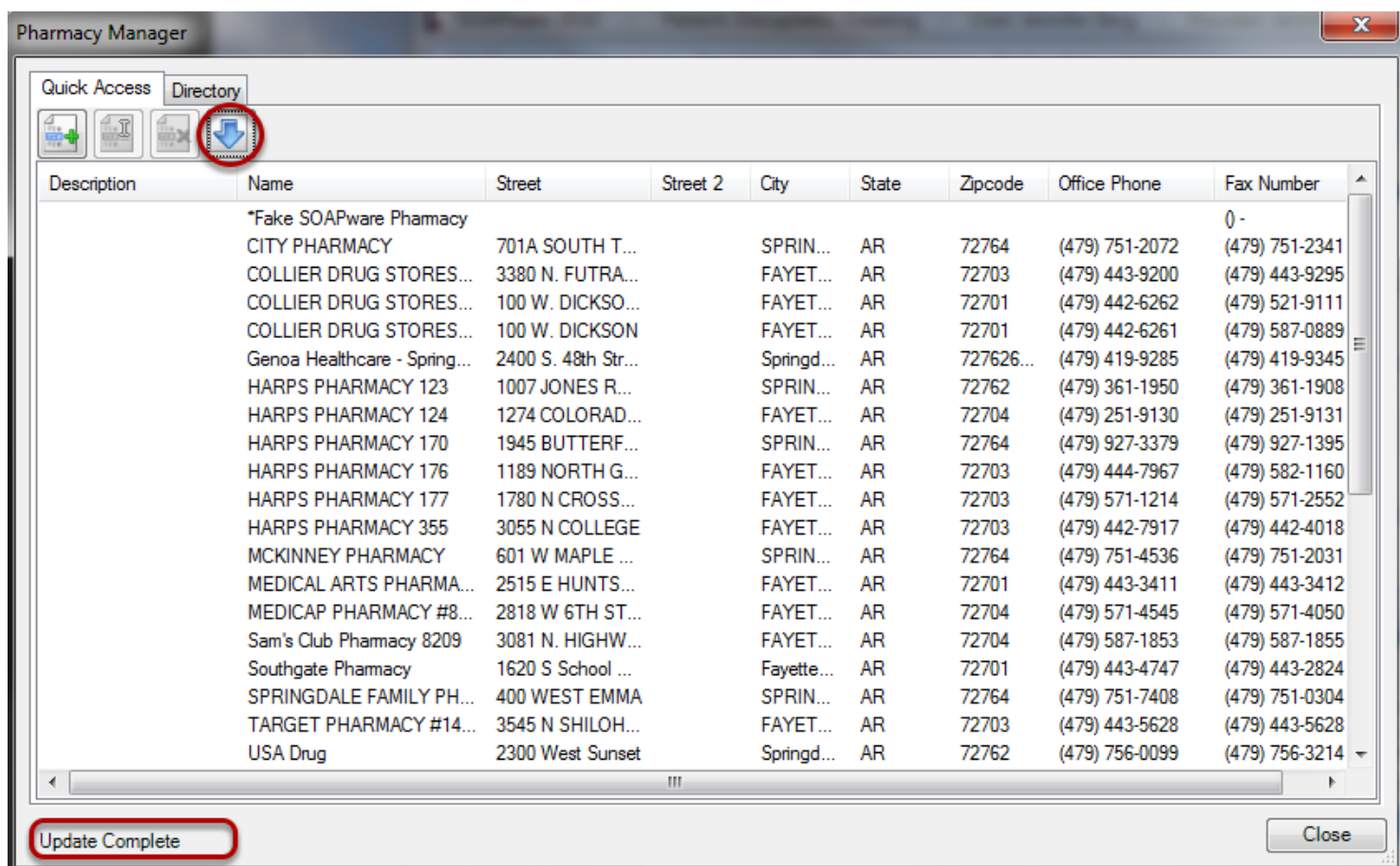


## Automatically Update Pharmacies



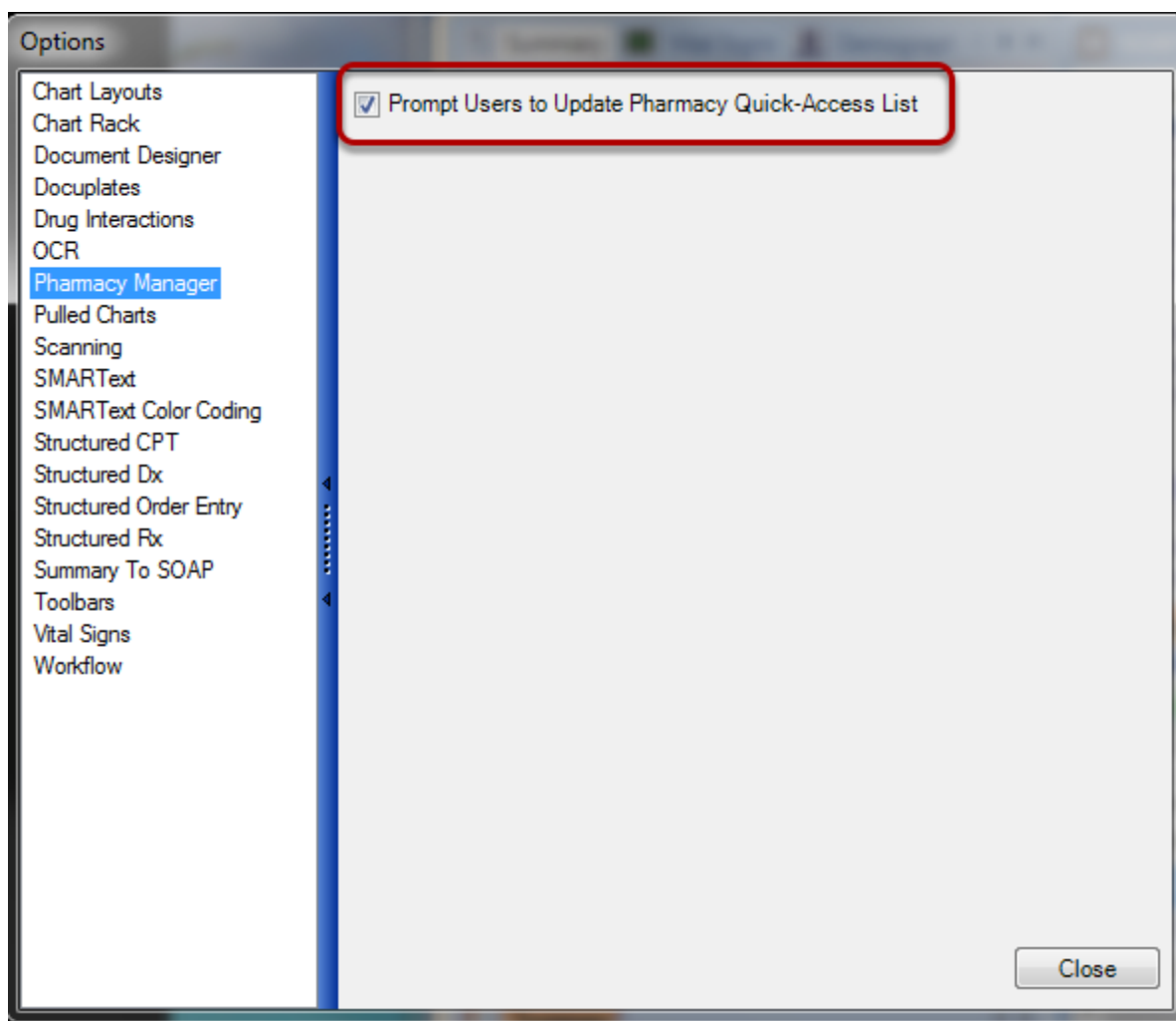
By Default each time the Pharmacy Manager is opened an Update Pharmacies dialog box appears. This feature allows SOAPware to automatically download the latest pharmacy data. If the "Don't ask again" check box is checked. SOAPware will no longer prompt any user in the system to update the pharmacy list.

## Updating Pharmacy Information



Manually updating pharmacy information in the local database can be performed.

1. Click on the blue downward facing arrow. When the search is complete the status text at the bottom of the window will display "Update Completed".



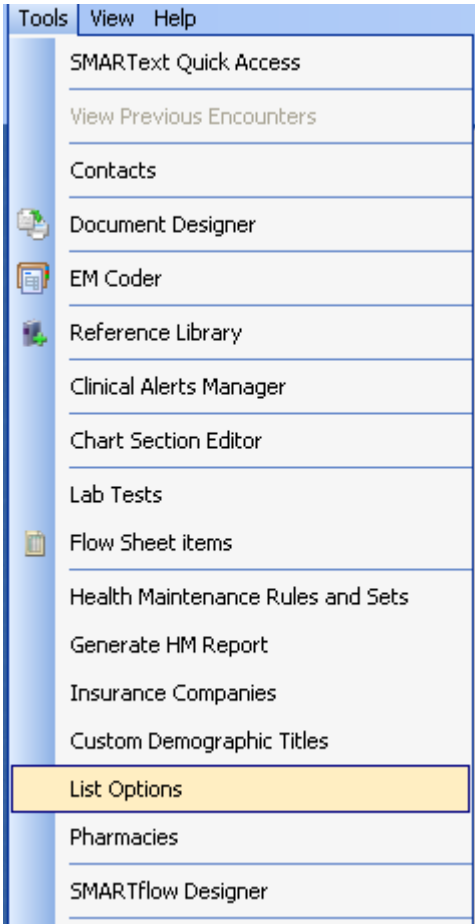
The Update Pharmacy dialog pop up box is a customizable feature that is set under Tools > Options.

Check this option and SOAPware will again prompt users to update the Pharmacy Quick-Access list when Pharmacy Manager is launched.

# List Options

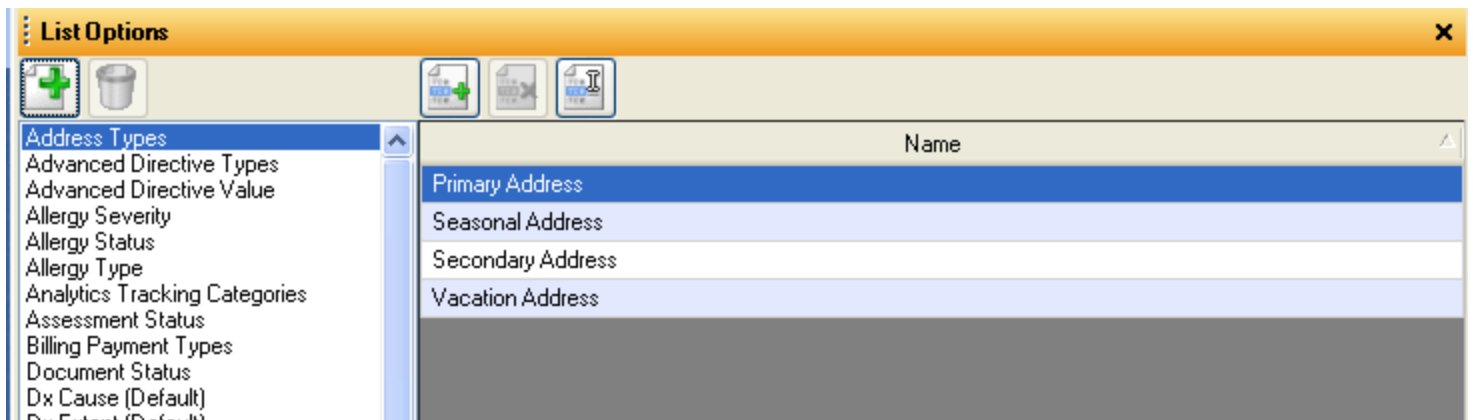
In many areas, there are Drop-Down Menu Lists from which items can be selected. Therefore, these are usually referred to as menu lists rather than pick lists. These are not related to SMARText Items, but are set up for all users to have in common. These are defaulted with SOAPware, but can be customized in List Options.

## List - Options



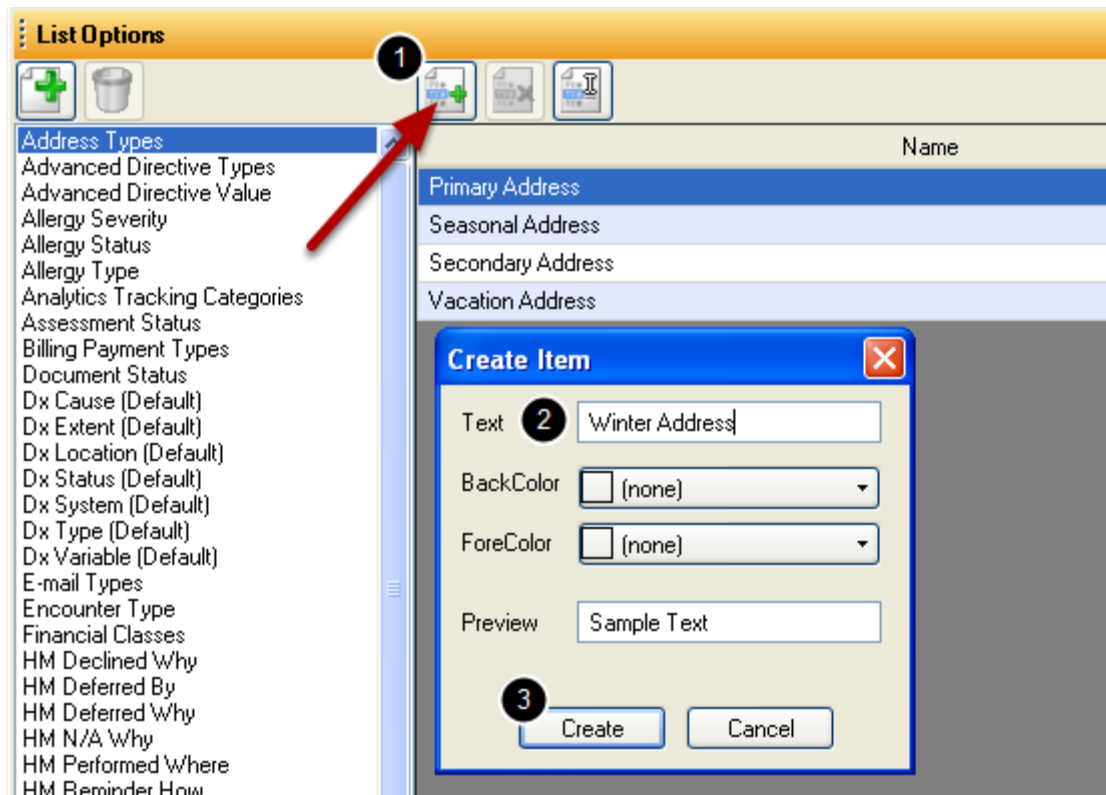
To change these lists, Click Tools > List Options. This will provide the user with all of the drop-down lists that a user is able to customize.

## List Types



There are many areas in SOAPware that allow a user to add to the list options.

## Add a List Option



To add a list option:

1. Click on the Add button.
2. Insert the text to appear for the list option item. The user can also choose both background and foreground colors for this list item.
3. Click Create.

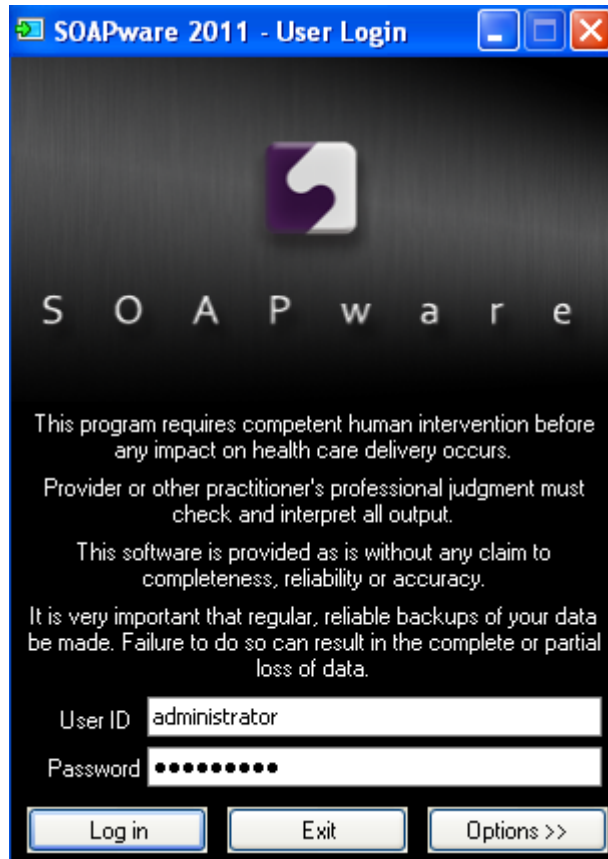
# Security Settings

## Intro to Security

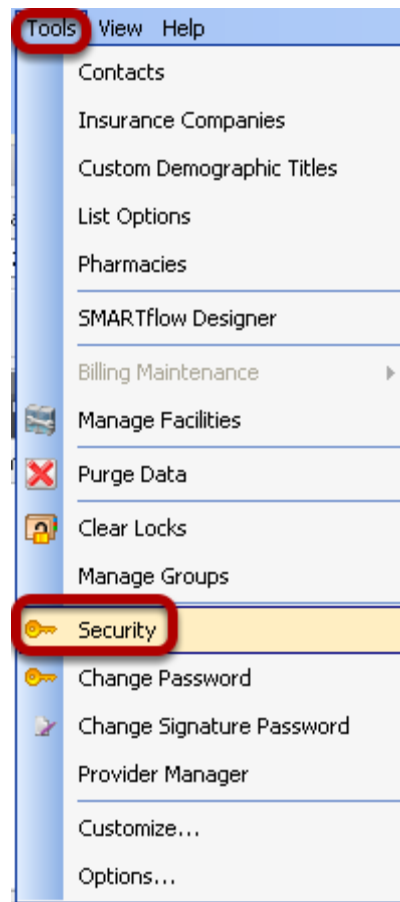
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This lesson teaches how to setup Security for a clinic staff that will include settings for Groups, Roles, and individual users according to HIPAA guidelines and regulations for electronic health records.

### Logging into Security as Administrator



Log in as administrator using the User ID and Password given at time of install. The Administrator account is used to set-up all user accounts but does not allow access to patient information.



1. Click on the Tools menu
2. Click on Security



## Security Settings

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**\*THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT - PROTECT ELECTRONIC HEALTH INFORMATION**

To gain access to Security, a user must be granted the access rights of a System Administrator. Before beginning to assign security settings, the System Administrator should become familiar with the functions related to Groups, Roles and Users.

### 1. Intro to Security Manager

Start SOAPware, and Log in as an administrator using the User ID and Password given at time of install. The Administrator account is used to set-up all user accounts but does not allow access to patient information.

After logging in to SOAPware using the System Administrator account, Click on Tools in the main menu bar, then Click the Security menu item to access the SecurityAdministration dialog window.

The security system in SOAPware has been set up to help ensure only authorized users are able to access patients' information. Once a user has logged into the system, the security system will track everything the user views, and it logs all changes the user makes. Since this tracking is available, it is **very important that each staff member have a unique log-in ID**. For example, if a shared log-in is being used, there is no way to know what person in the office actually changed a patient's demographics or removed a medication from the chart.

## 2. Logging On and Logging Off

The screenshot shows the 'Security Administration' window with a tree view on the left containing 'General', 'Groups', 'Roles', and 'Users'. The 'General' tab is selected. The main area contains several sections: 'Password Policy' with fields for 'Minimum password length' (0) and 'Passwords expire every' (365) days, and a checkbox for 'Require Alpha-Numeric Passwords'; 'Lockout Policy' with a checked 'Lock out Accounts' checkbox and fields for 'Account lockout duration (minutes)' (10), 'Account lockout threshold (invalid logon attempts)' (3), and 'Reset account lockout counter after (minutes)' (10); 'Transaction logging' with four checked checkboxes: 'Log user login/logout', 'Log data access', 'Log item creation/deletion', and 'Log data modifications'; 'Idle Logout' with a checkbox for 'Logout user after' (60) minutes; 'Login Window' with a checked 'Remember last user login name' checkbox; and 'Signature Password' with a checkbox for 'Require Password to sign documents'. A 'Close' button is at the bottom right.

### a. Password Policies

This setting is to ensure passwords are secure and cannot be easily guessed. Unfortunately, it's a common practice to write passwords on post-it notes attached on or near computers. We definitely advise against this.

### b. Account Lockout Policies

This can be setup to ensure that if somebody is trying to guess another user's password, it will disable the account for a period of time.

### c. Auto Log-Out

This determines when to log out a user after a certain amount of idle time has occurred. This is done to make sure that patient information is not visible.

#### d. Log Options

Allows the administrator to disable logging of certain events in the system.

### 3. Search Audit Log

Audit Log

Start Date: 2/21/2011 12:00 AM | End Date: 2/21/2011 11:59 PM | User Name: | Location: | IP Address: | Section: All | Patient: +

☐ Include Inactive Users

Drag a column header here to group by that column

Date Time	User Name	Location	IP Address	Action/Section	Patient	Description
-----------	-----------	----------	------------	----------------	---------	-------------

Audit Details

Value	Before	After
-------	--------	-------

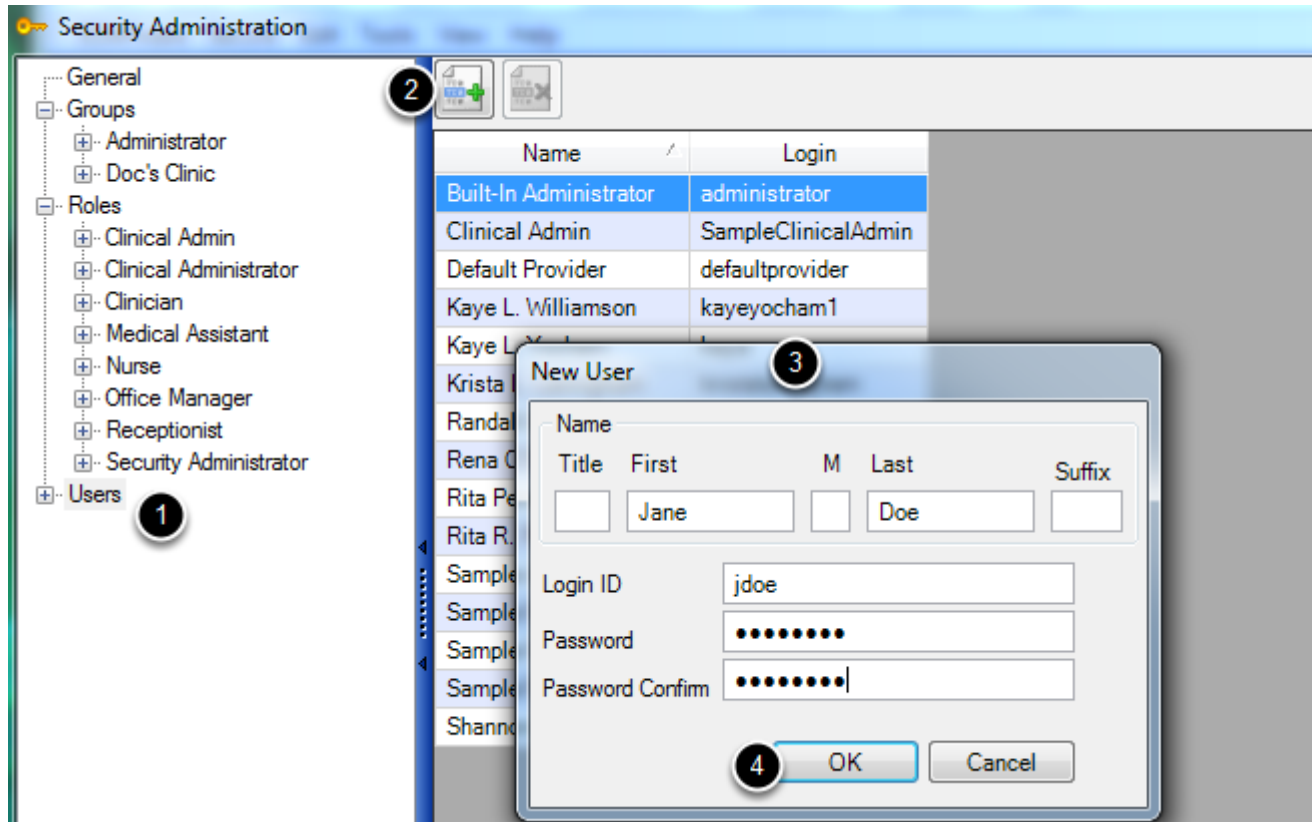
Audit Logs are the way SOAPware tracks changes and events in the system such as users logging in and patient information being modified. When a user logs in as the administrator, he/she will see the Search Audit Log window. Notice the main display has some fields at the top. To demo, use these fields to perform a search for log-ins to the system. Click on the Transaction Type drop-down menu; Click on the Log-in menu item; and Click the Search button. Now the user should see some records displayed showing all the log-ins to the system including when he/she logged in. To be able to search the Audit Logs, a SOAPware Standard or SOAPware Professional license is required.

For Detailed Instructions, see: [Security Auditing in SOAPware](#).

## Users in Security

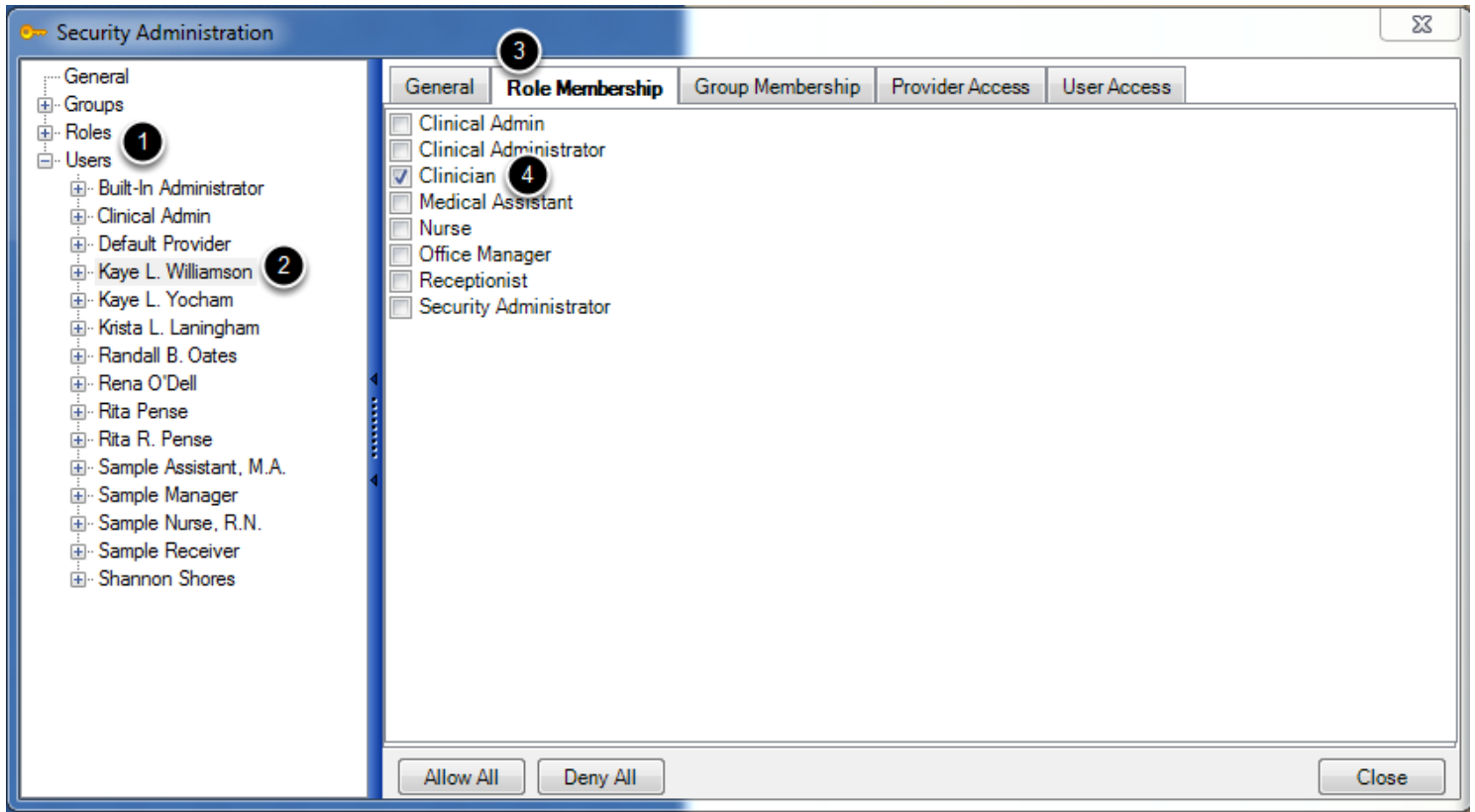
Users are the individuals accessing SOAPware. So, everyone needing access to SOAPware will need to be set up as a specific, individual User.

### Creating a new User



1. Click to highlight "Users"
2. Click the New User button
3. Fill in the First name, Last name, assign a Login ID, assign a Password, Confirm the password (***the user will be told that their Password has expired when they log in for the first time allowing them to change the password to one that only they will know***)
4. Click on OK

## Setting Up a New User and Assign a Role

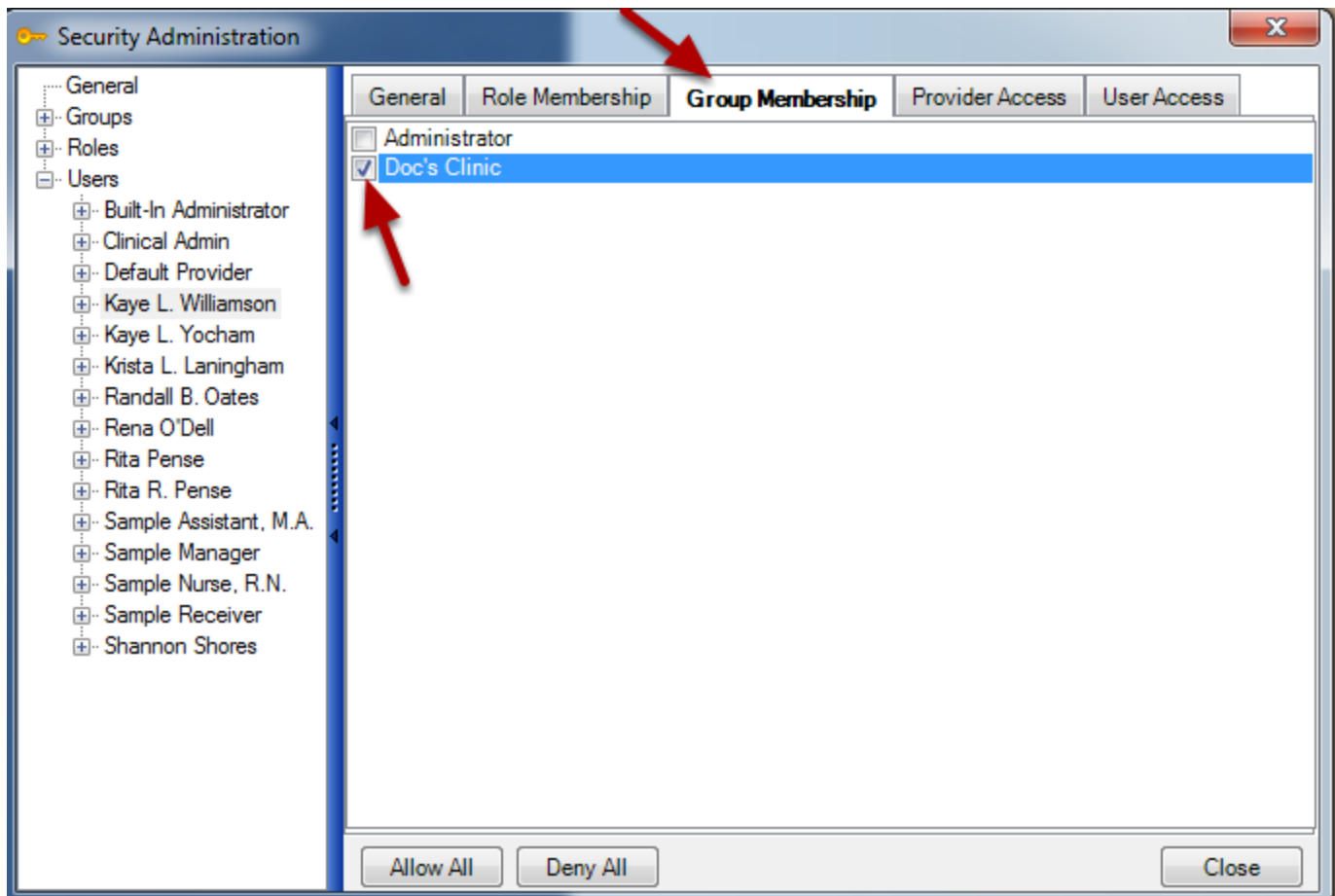


**Important to note:** Any clinician that owns a SOAPware license will be set up in Security in the Role of Clinician automatically once the license is activated

**Another important note:** A User will not be able to log into SOAPware unless they are assigned a Role

1. Click on the + next to User to drop down user names
2. Click to highlight the User's name
3. Click on the Role Membership tab
4. Place a check next to the User's assigned Role (more than one Role may be selected)

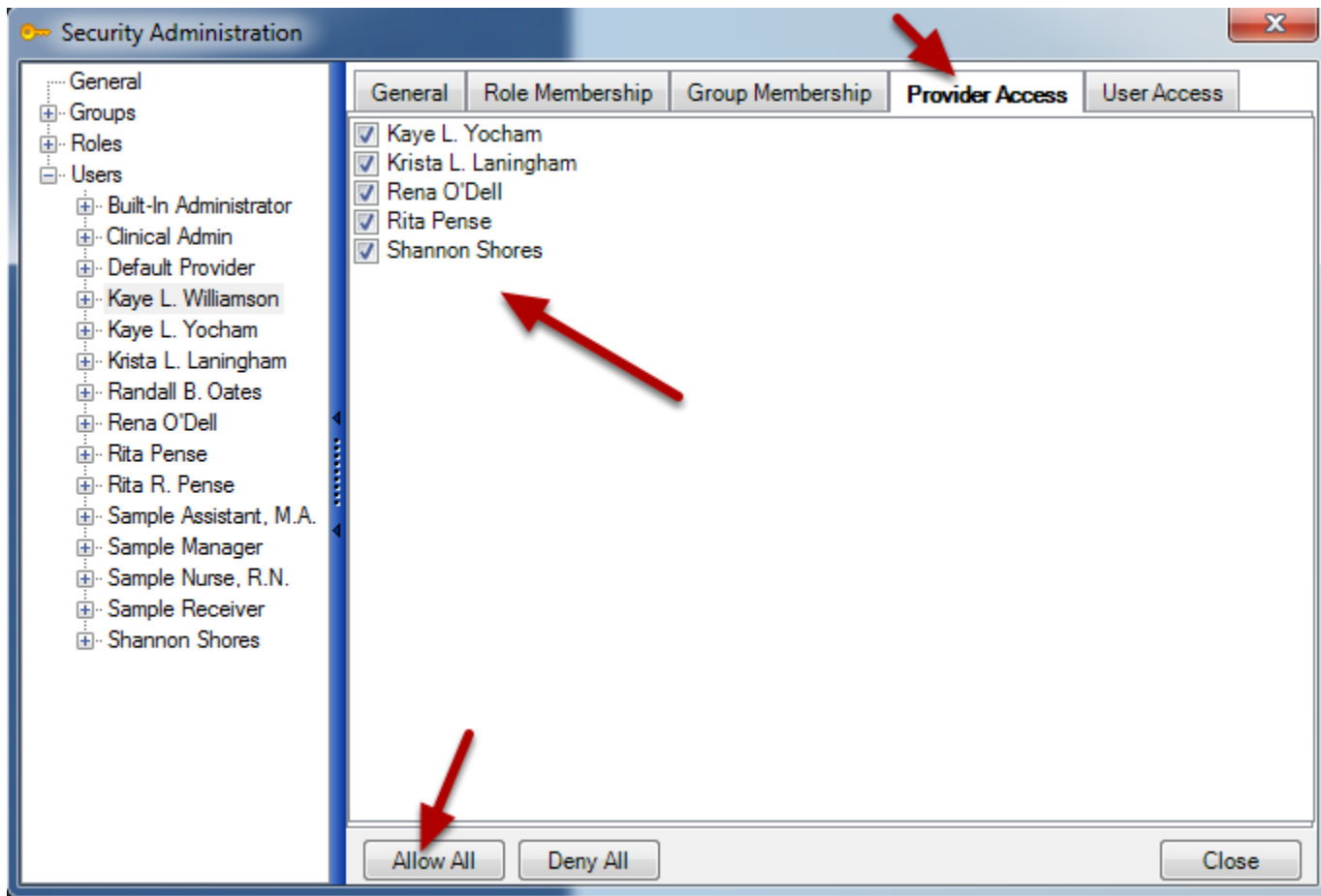
## Assign a New User to a Group



Click on the Group Membership tab.

Place a check next to the Group that the User will be a member of (**Administrator Group is a default and does not need to be selected unless the user is an Administrator in the facility**)

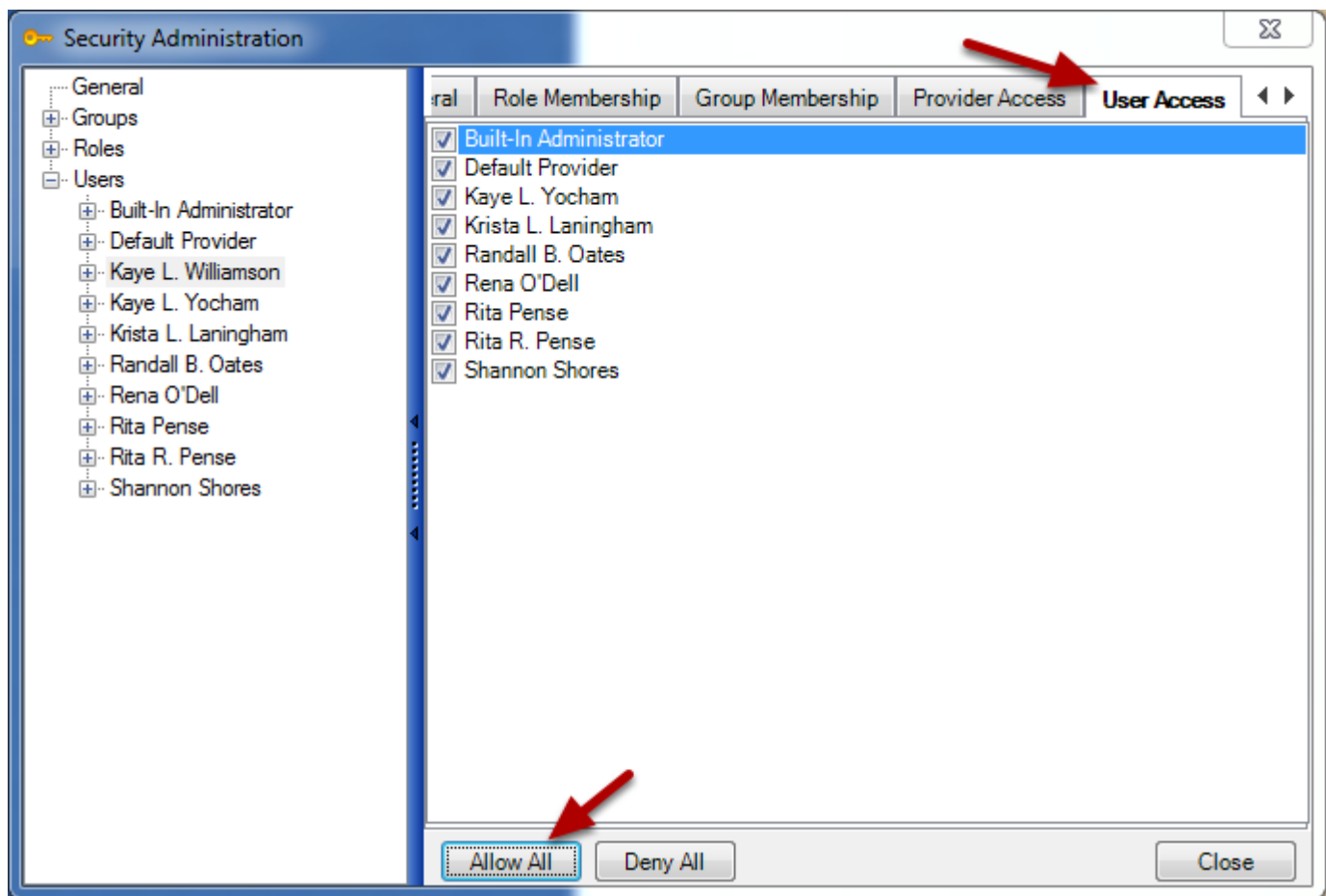
## Assigning Provider Access for a New User



Click on the Provider Access tab (***A User will not have access to patient charts in the Chart Rack unless Provider Access is given***)

Place a check next to the Providers name whose charts the User will be accessing (most clinics Click Allow All)

## Assigning User Access for a New User

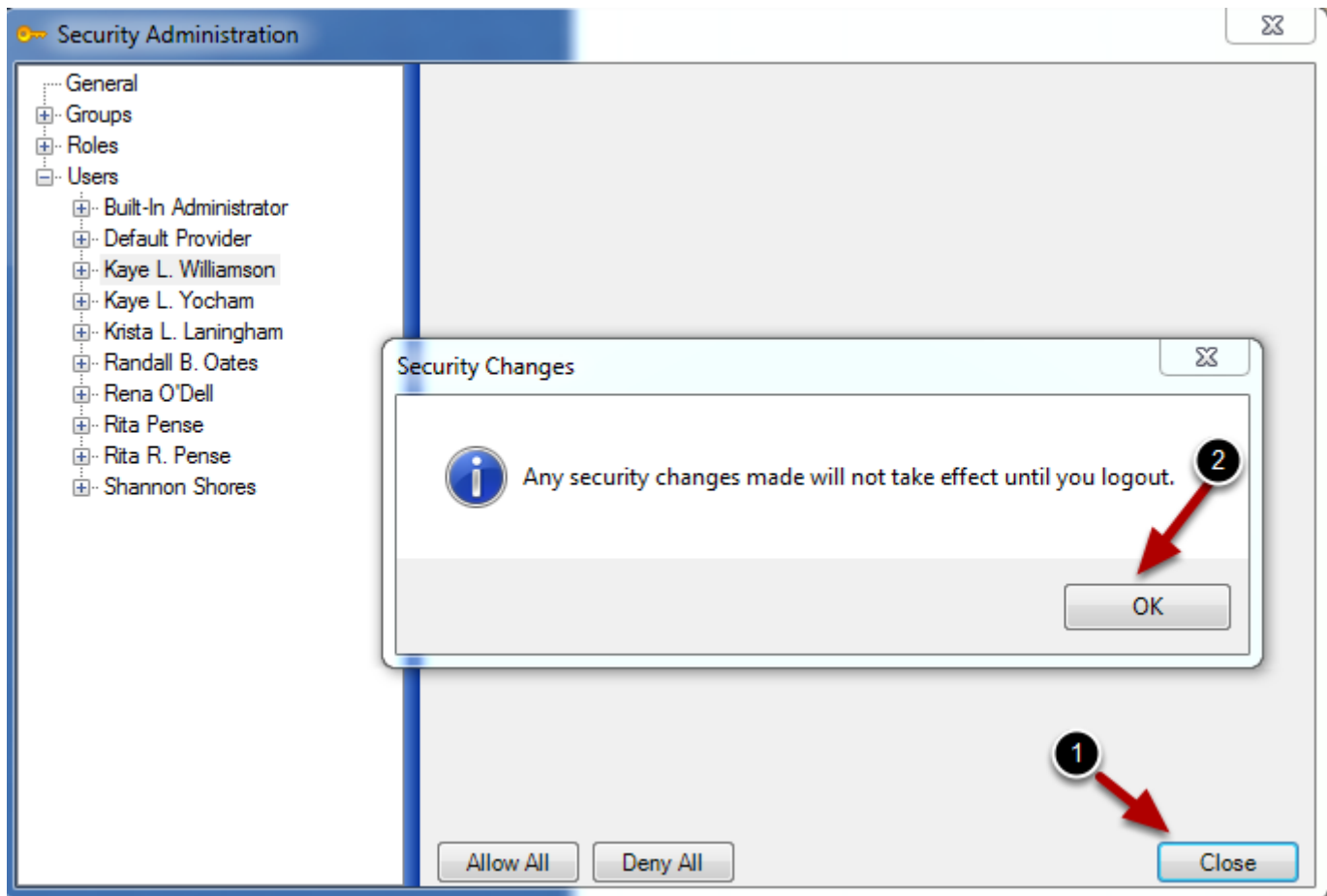


Click on the User Access tab (***A User will not have access to other Task lists (formally known as the ToDo List) unless User Access is given***)

Place a check next to the User names that the new User will need to send Tasks (***most clinics Click on Allow All***)



## Saving Changes in Security



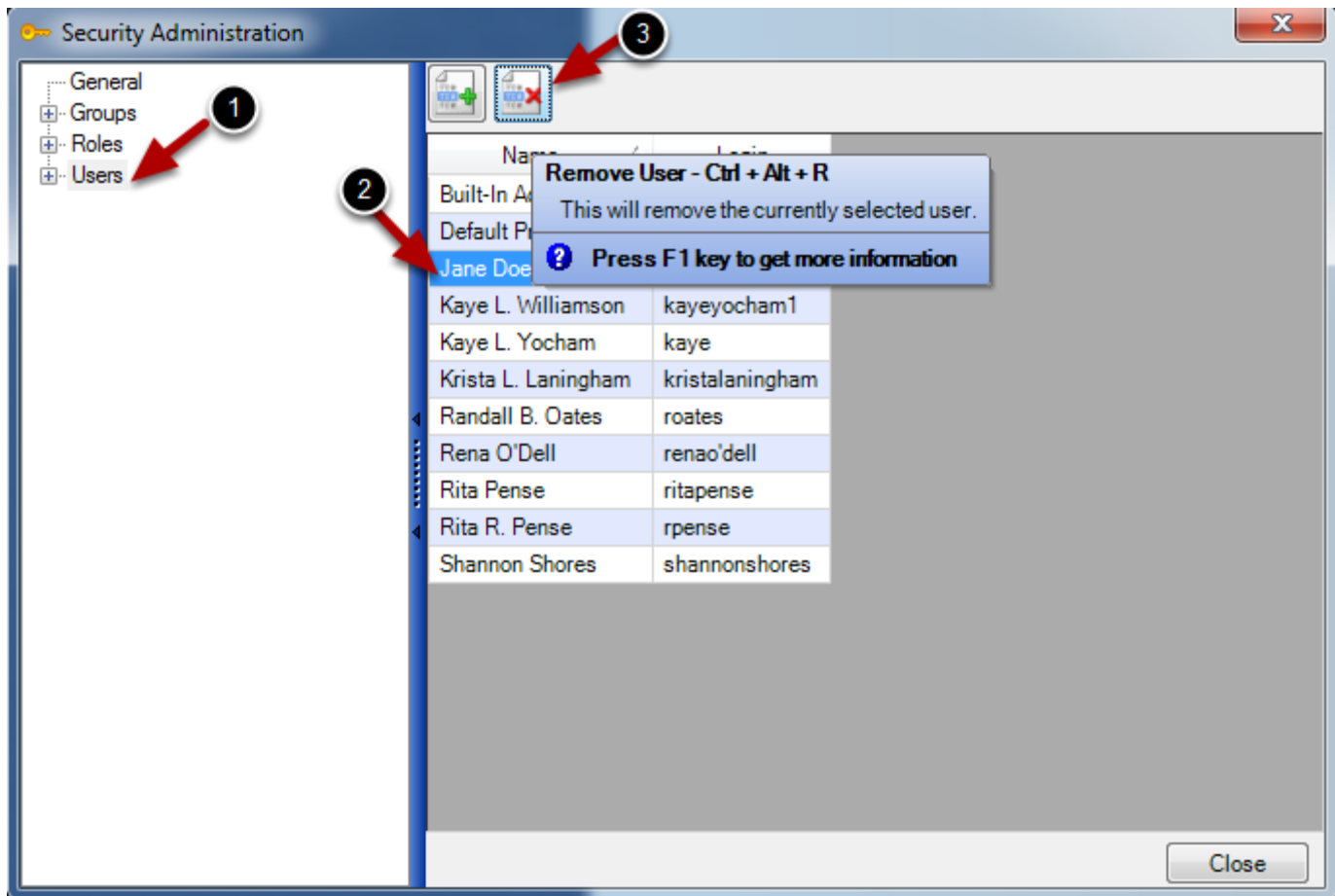
1. When all changes are completed, Click on the Close button

***Note that any Security changes will not take effect until the user logs out***

2. Click on OK

Log out of SOAPware by going the SOAPware menu and then Click on Log Out

## How to Delete/Remove a User from Security



**Important: A clinician with a SOAPware license cannot be deleted/removed from SOAPware Security. The license must be made Inactive in Site Administration. Removing all permissions in Security and un-checking their name in the Group, Provider Access, and Users tabs will make them invisible.**

1. Click to highlight Users
  2. Click to highlight the name of the User to be Deleted/Removed
  3. Click on the Remove User button
- Click on Yes to remove selected User

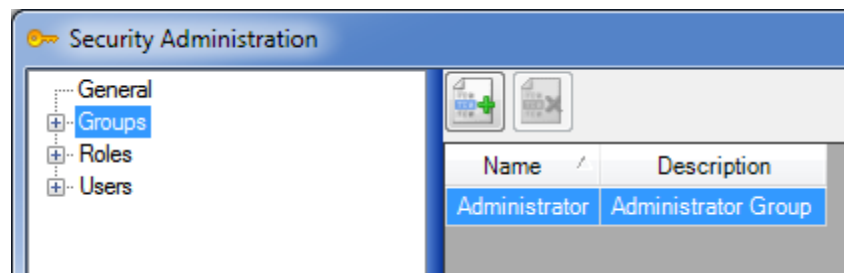
## Groups and Roles in Security

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SOAPware Groups describe a set of privileges that can be applied to a selection individual users. Groups can be thought of as departments within an office, and a listing the responsibilities and limitations of members of that group. Users can belong to any number of groups simultaneously, and entire groups can be assigned to Group.

A Role is intended to represent a particular job function within the clinic, such as Nurse, Office Manager, Clinician, etc. Each one of these roles will need restricted access to particular actions.

### Groups in Security

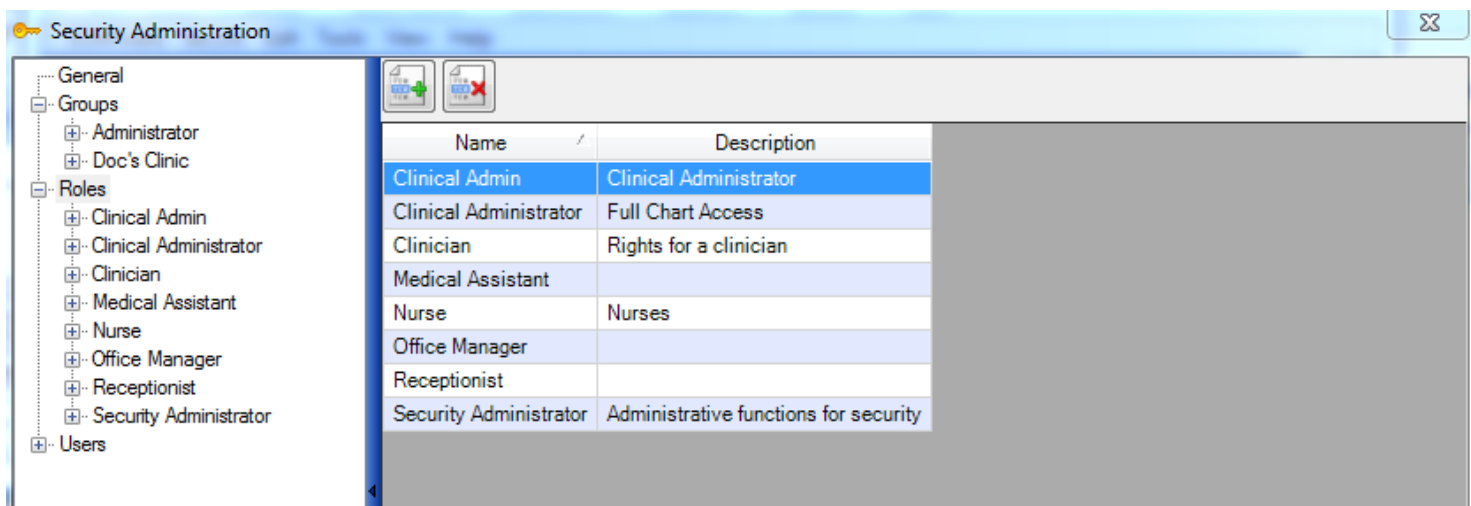


Think of a Group as being very similar to a department within the clinic. For example, there is commonly a clinical user group and a front office user group. Within each of these groups, there are, typically, different Roles. For instance, in a clinical group, there may be an R.N. and a clinical assistant. In a front office group, there may be a main scheduler and a check-In person. So, the individuals in a Group can serve different Roles.

A Group could also refer to different clinics in a multi-clinic installation. SOAPware has a default Administrator Group that cannot be edited.

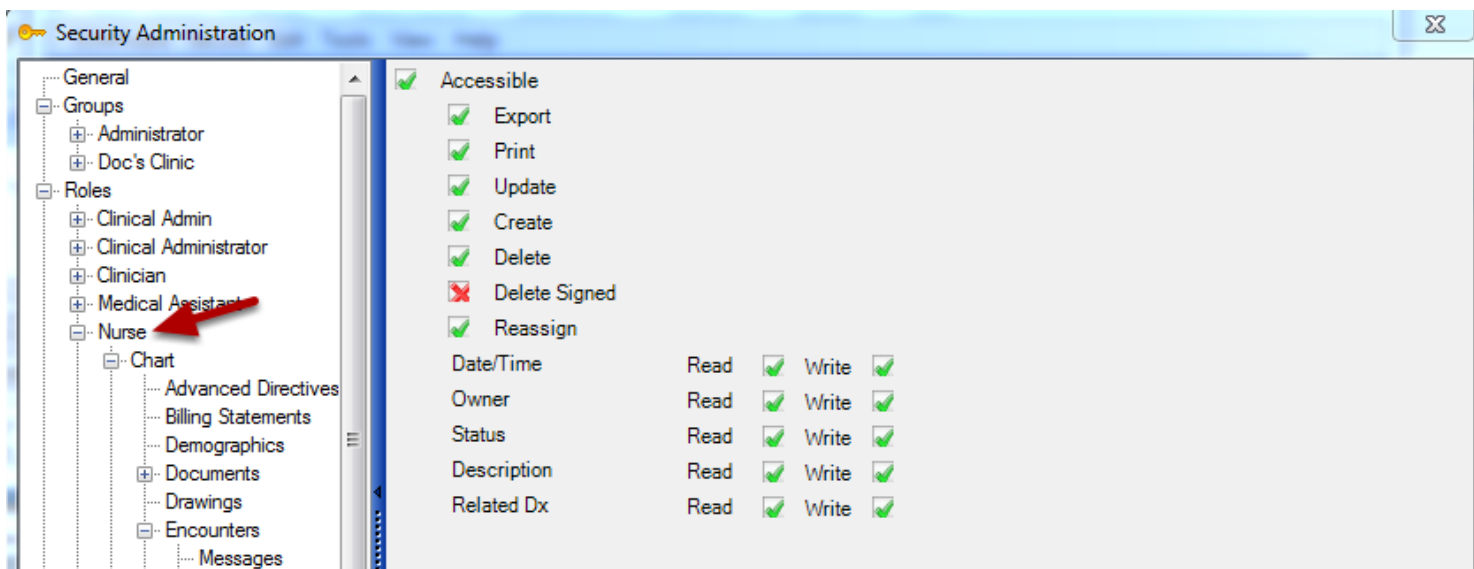
Make a list of the members of clinic staff and sort into the relevant groups. Then sort further by defining the roles. Use this sorted list of Groups and Roles to define access rights for each individual that is based upon what they have in common to each Group and Role. It is easy to add users to groups/roles, and they will immediately inherit the security rights that have been set for the group or role.

## Default Roles in Security



SOAPware, at installation, includes some users roles with pre-set security rights common to most clinics. These are completely customizable, and can be edited and changed in any fashion or even deleted. **Note: Users must be created first and then assigned a Role**

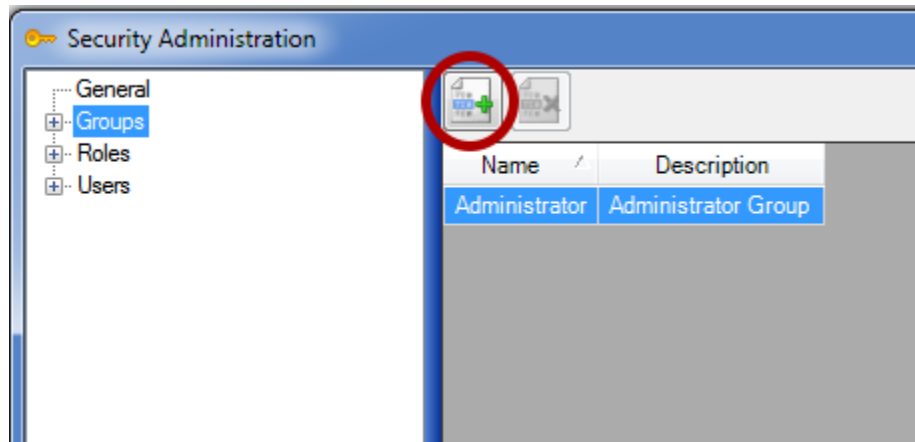
## Example of pre-set security Role (Nurse)



Clicking on the plus sign next to the Role will begin to expand the areas in SOAPware that Security needs to be enabled.

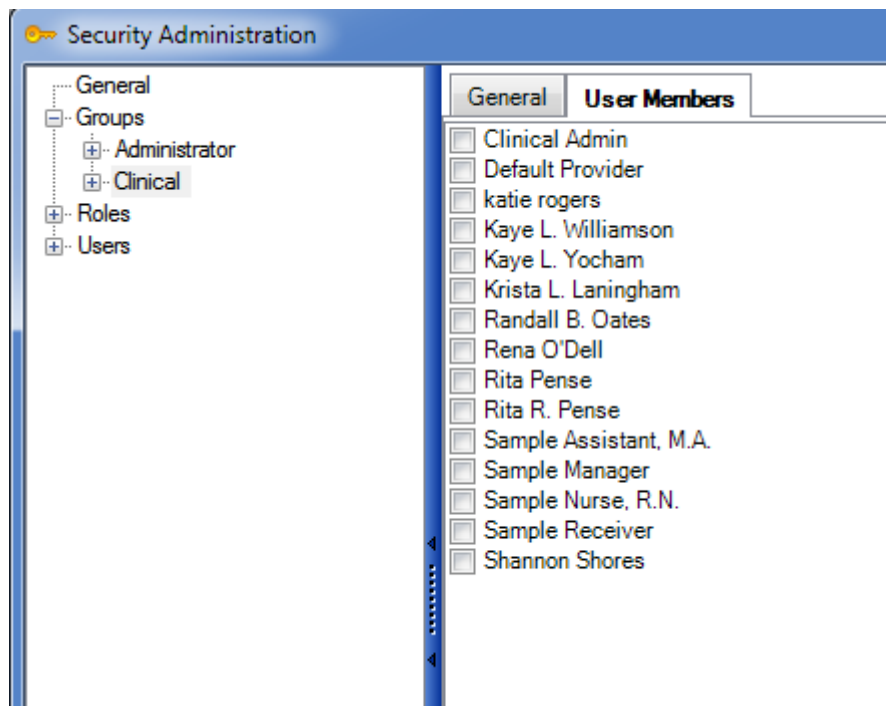
Clicking on specific area will display what can be designated as permission given (green check) or permission denied (red X).

## Setting up a Group/Role



Adding a Group or a Role is basically the same. Click on the Groups List item. Click the Create Group button (green +), and Type a Group Name (i.e. Clinical) and Description. (ie: Clinical Staff). Click OK.

## Editing Groups/Roles

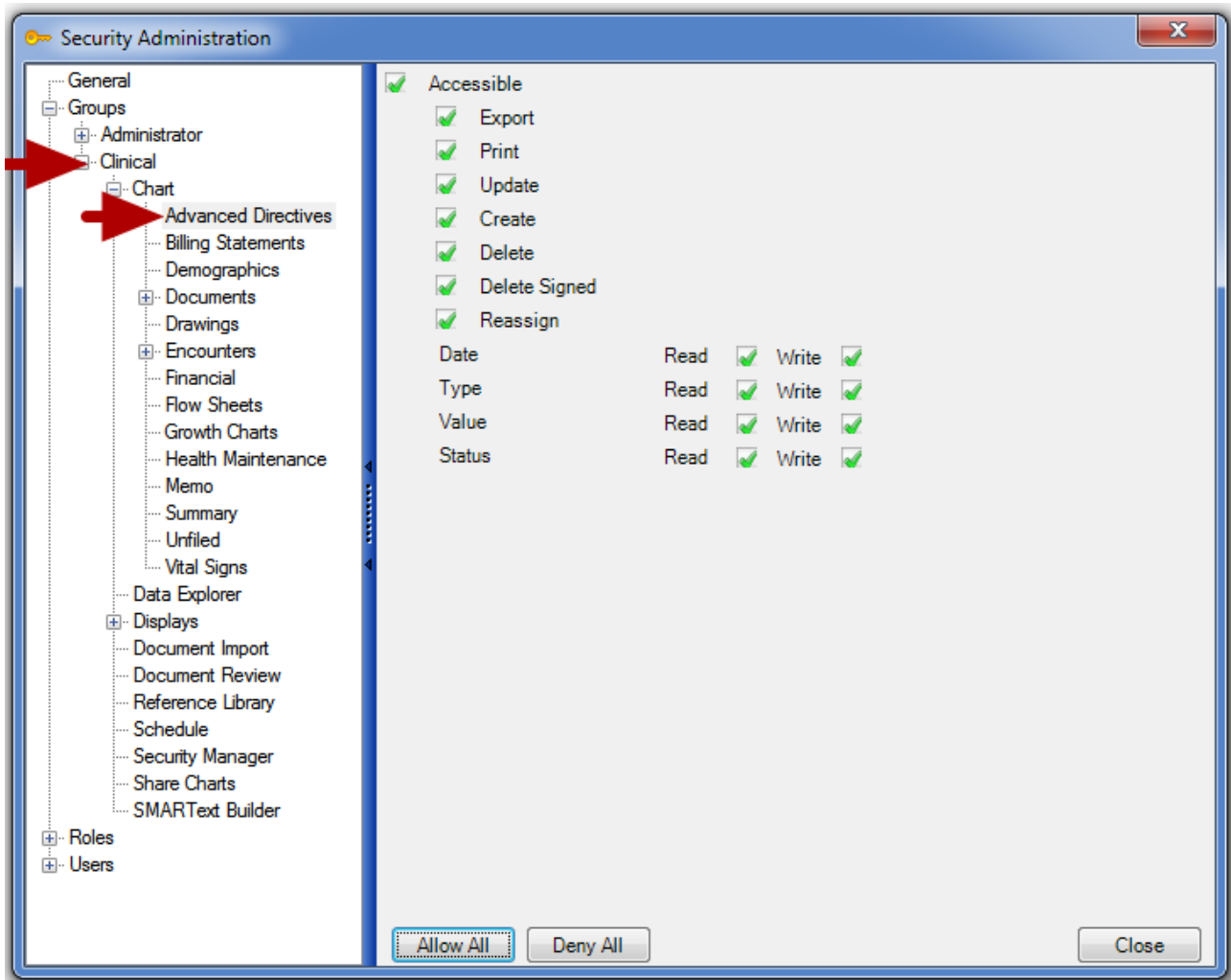


The new Group name should appear in the item list on the left (i.e. under the Administrator list item). Name of the new group to see the group settings. There will be two tabs displayed in the window to the right. The first tab, General, will show the Name and Description set up for the group. The second tab, User Members, is where someone will assign users to this group.

To add users to the group, Click the User Members tab, and Click the Name check boxes for the

users to include. To set the group's shared security settings, navigate down the list of categories, and Click the + signs to expand the security items needing action. Follow the same instructions (above) to add a Role. Click the Roles list item to get started.

## Changing Security Privileges



To change security privileges for groups and roles, Click the plus sign to the left of the group. This will expand all of the security areas for this group. From here, the user can Click on the areas he/she wishes to edit and use the window on the right to customize the security settings. A green check mark indicates the user will have access, a red X indicates the user will not have access and an empty box indicates that the setting will default to the user's individual rights.

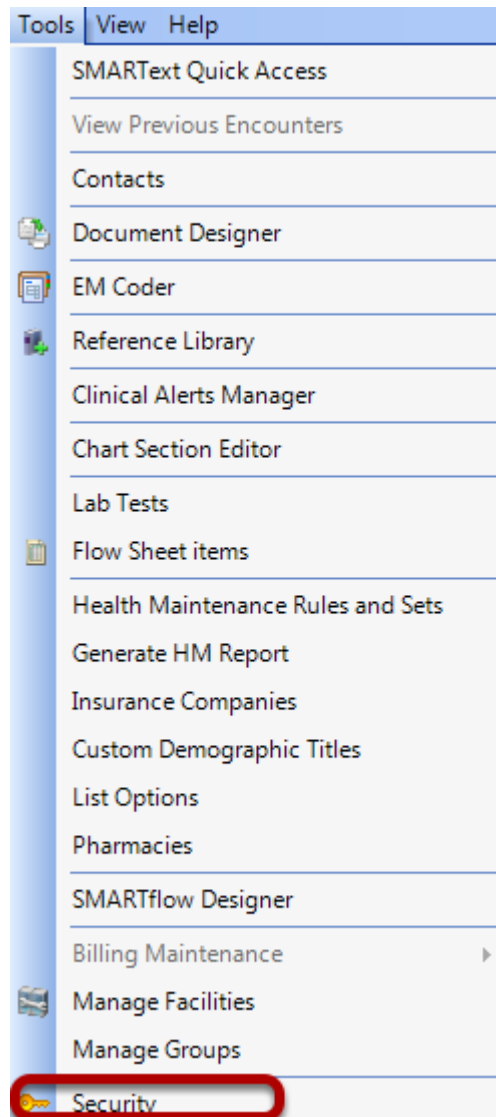
## Emergency Access Role

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This lesson will demonstrate the steps necessary to permit an authorized user ( who is authorized for emergency situations) to access electronic health information during an emergency.

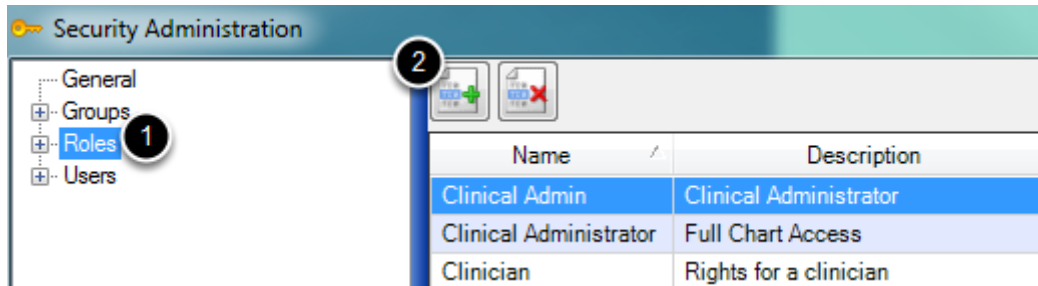
**\*THIS LESSON CONTAINS THE FOLLOWING MEANINGFUL USE (MU) CORE REQUIREMENTS:**  
**PROTECT ELECTRONIC HEALTH INFORMATION :** [Click here to view Meaningful Use Criteria.](#)

### Access Security



As the system administrator, access the SecurityAdministration dialog by Selecting Tools > Security.

## Create an Emergency Role

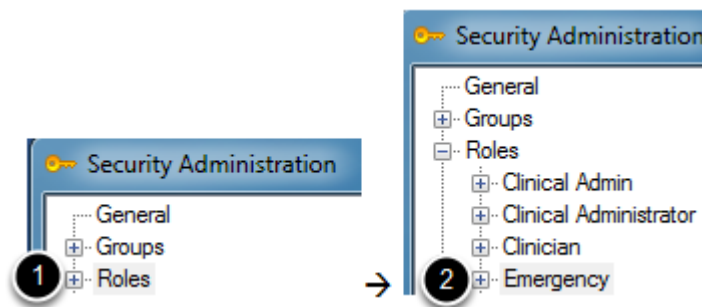


1. Click to highlight the word, "Roles."
2. Click on the new role button.

The 'New Role' dialog box is shown. It has two text input fields: 'Role Name:' containing 'Emergency' and 'Description:' containing 'Emergency'. A red circle with the letters 'MU' is overlaid on the top right of the dialog. At the bottom are 'OK' and 'Cancel' buttons.

Fill in the Role Name and a Description for the new role. Then Click OK.

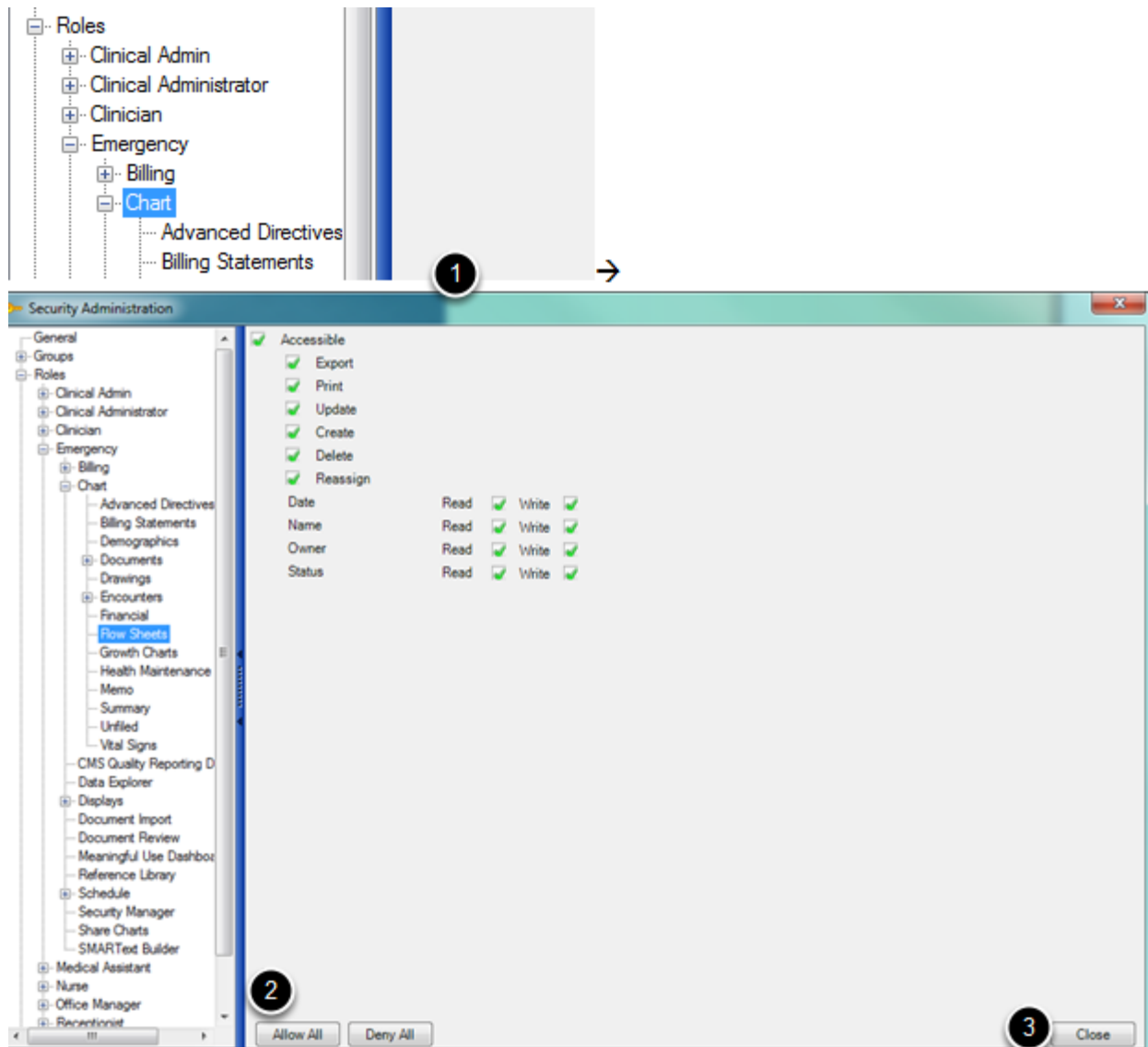
## Find the Emergency Role



1. Click on the plus sign next to "Roles" to expand.
2. Click on the plus sign next to "Emergency" to expand.

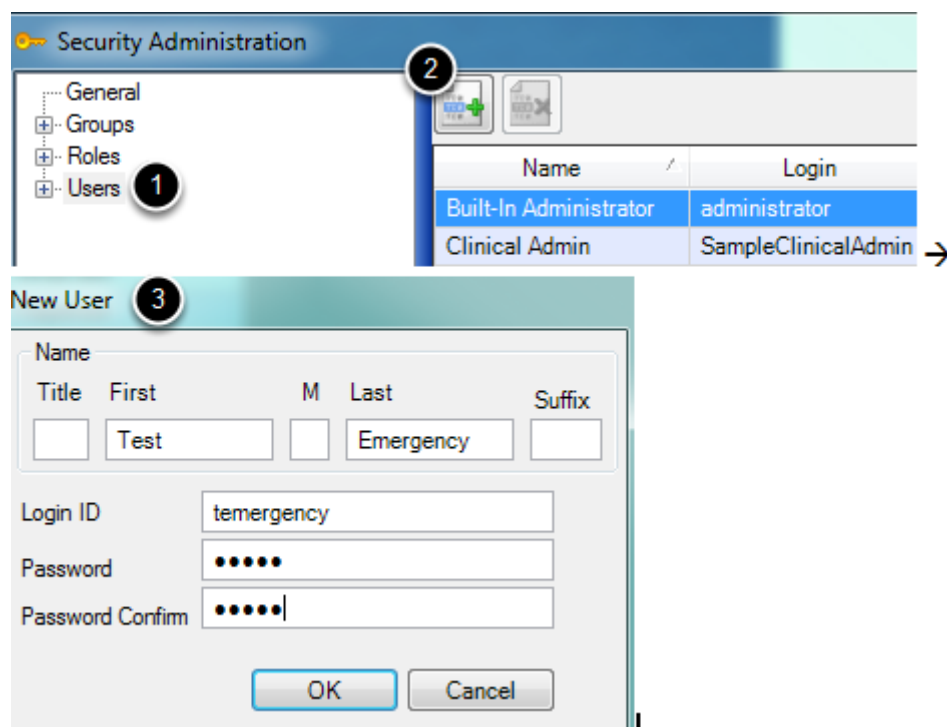


## Define Emergency Role Access



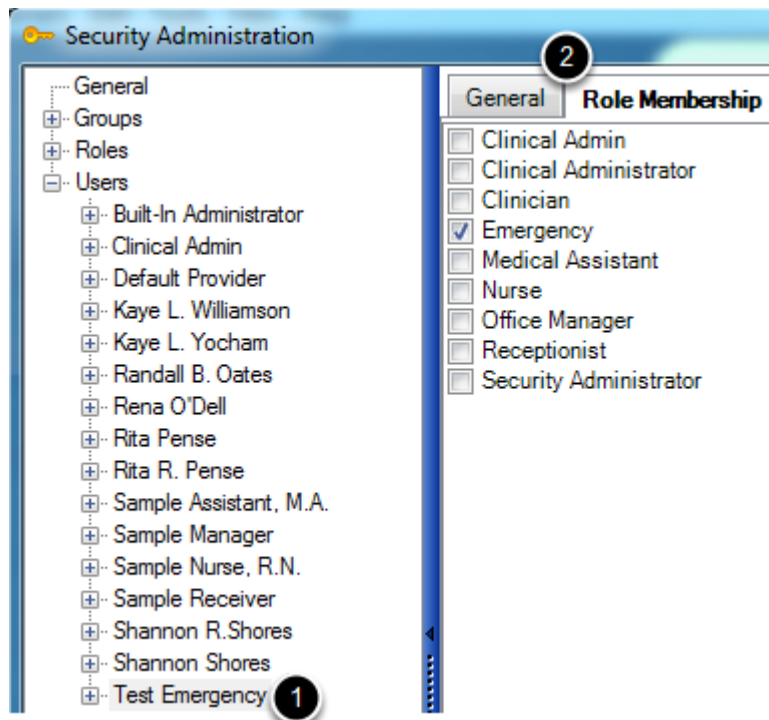
1. Drill down each area in SOAPware that a user can be given access, to define what is deemed necessary in an emergency situation. This will vary based on the clinic's needs.
2. As a time saver, remember, one can click on the "Allow All" or "Deny All" buttons.
3. Select "Close."

## Create an Emergency User



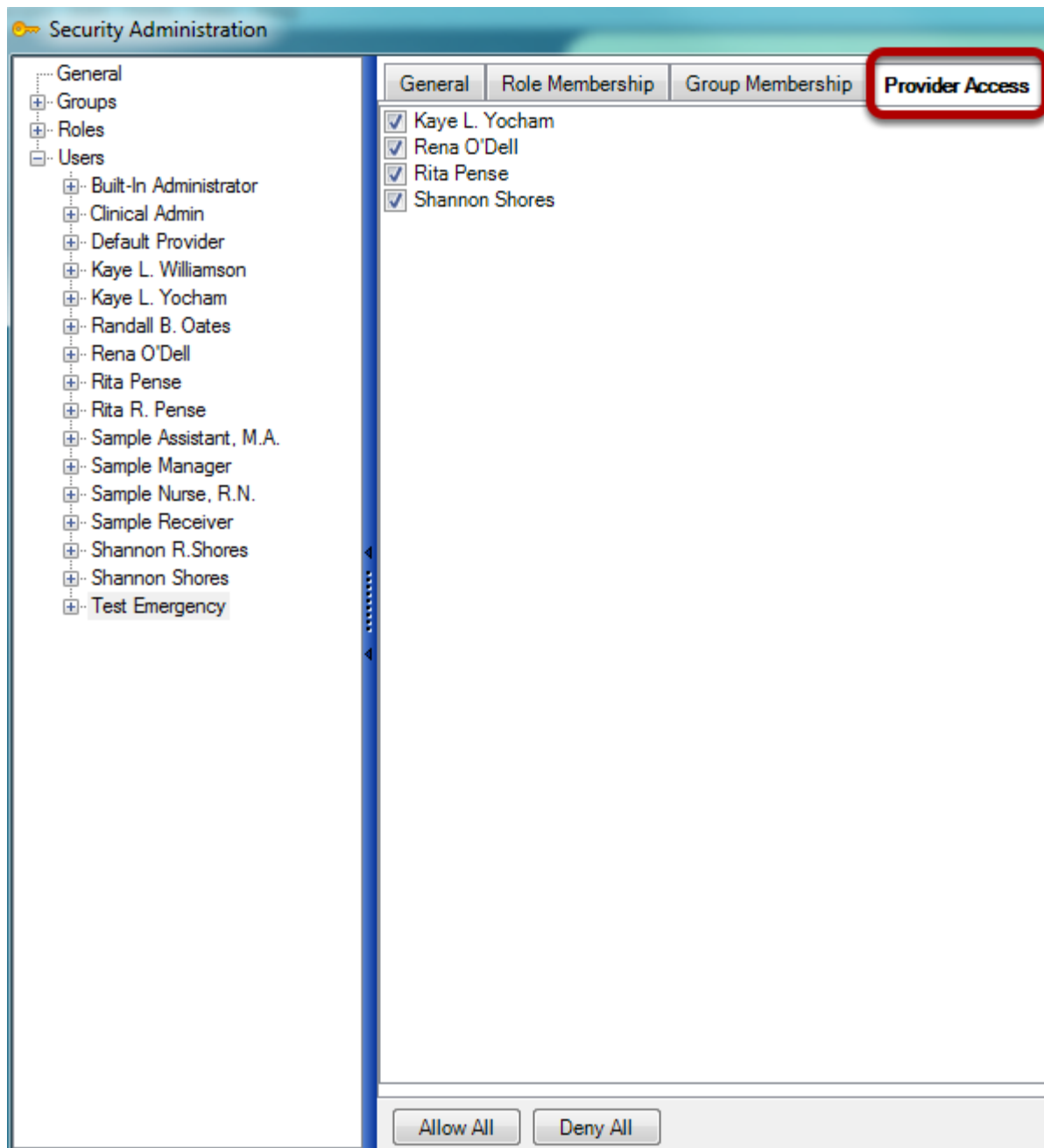
1. Click to highlight the word, "Users."
2. Click on the new user button.
3. Fill out the boxes shown and Click OK.

## Assign the Emergency User Emergency Access - Role Membership Tab



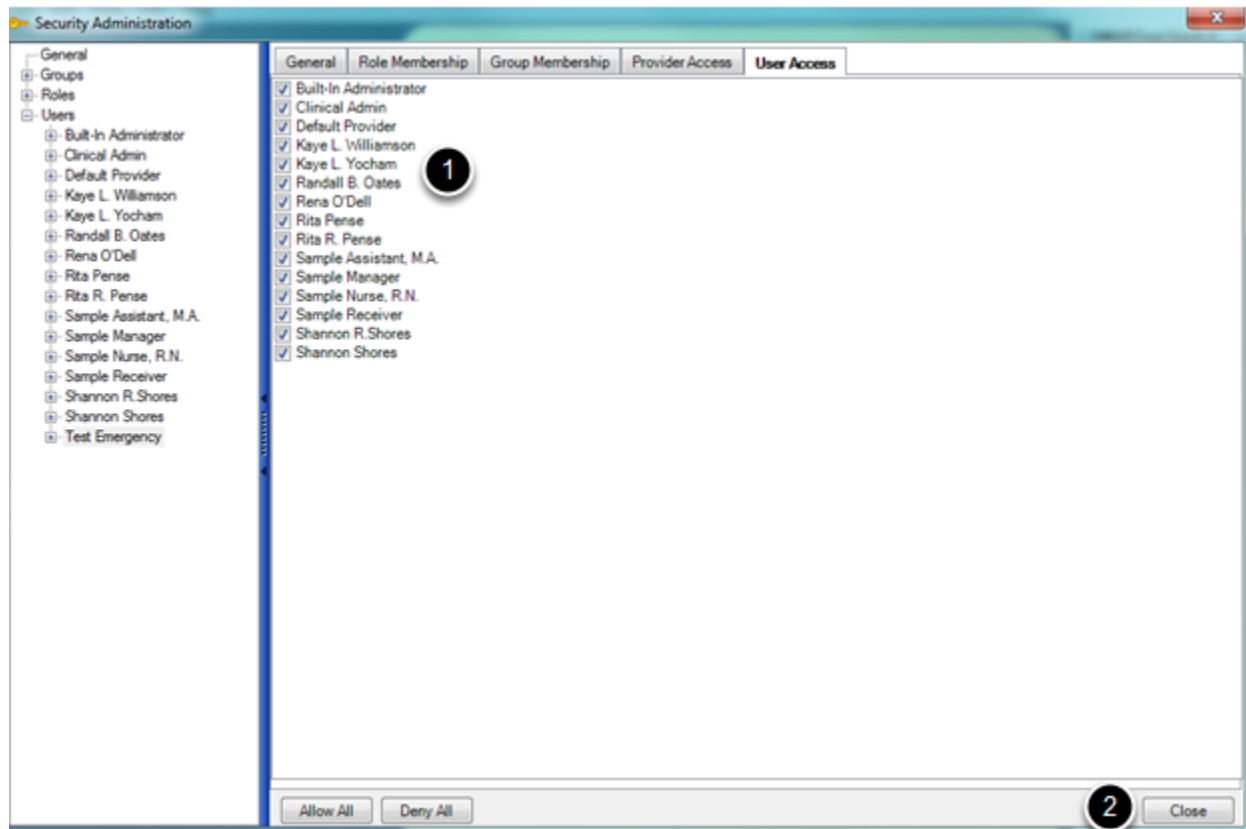
1. Click to highlight the user.
2. Click on the "Role Membership" tab and place a check mark next to the Emergency role previously created.

## Assign the Emergency User Emergency Access - Provider Access Tab



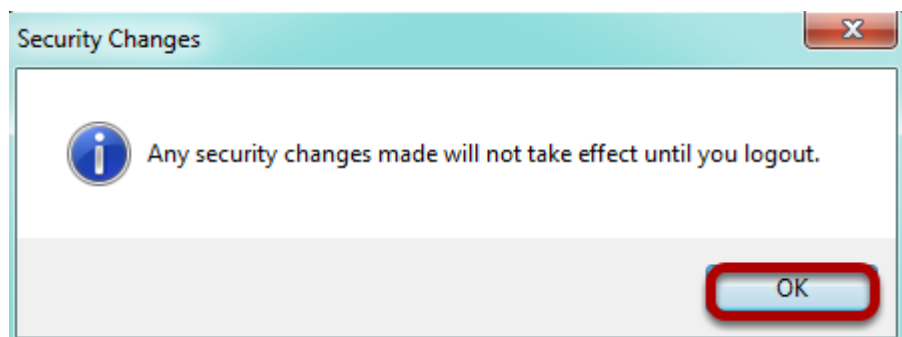
Click on the "Provider Access" tab and select which provider(s) this user will have access to, to view their patients charts.

## Assign the Emergency User Emergency Access - User Access Tab



1. Click on the "User Access" tab and select which other users' task lists this emergency user will be able to view.
2. Click Close.

## Security Changes Prompt



Click OK when prompted, and logout of SOAPware, then log back in.

## Give the Designated Security User the Log in and Password

The clinic will designate their own policy for this security user--as for whether this user will know the emergency log in and password ahead of time, or will contact the administrator to get the log in information, during an emergency.

**Note:** SOAPware will require the user to change their password the first time they log in.

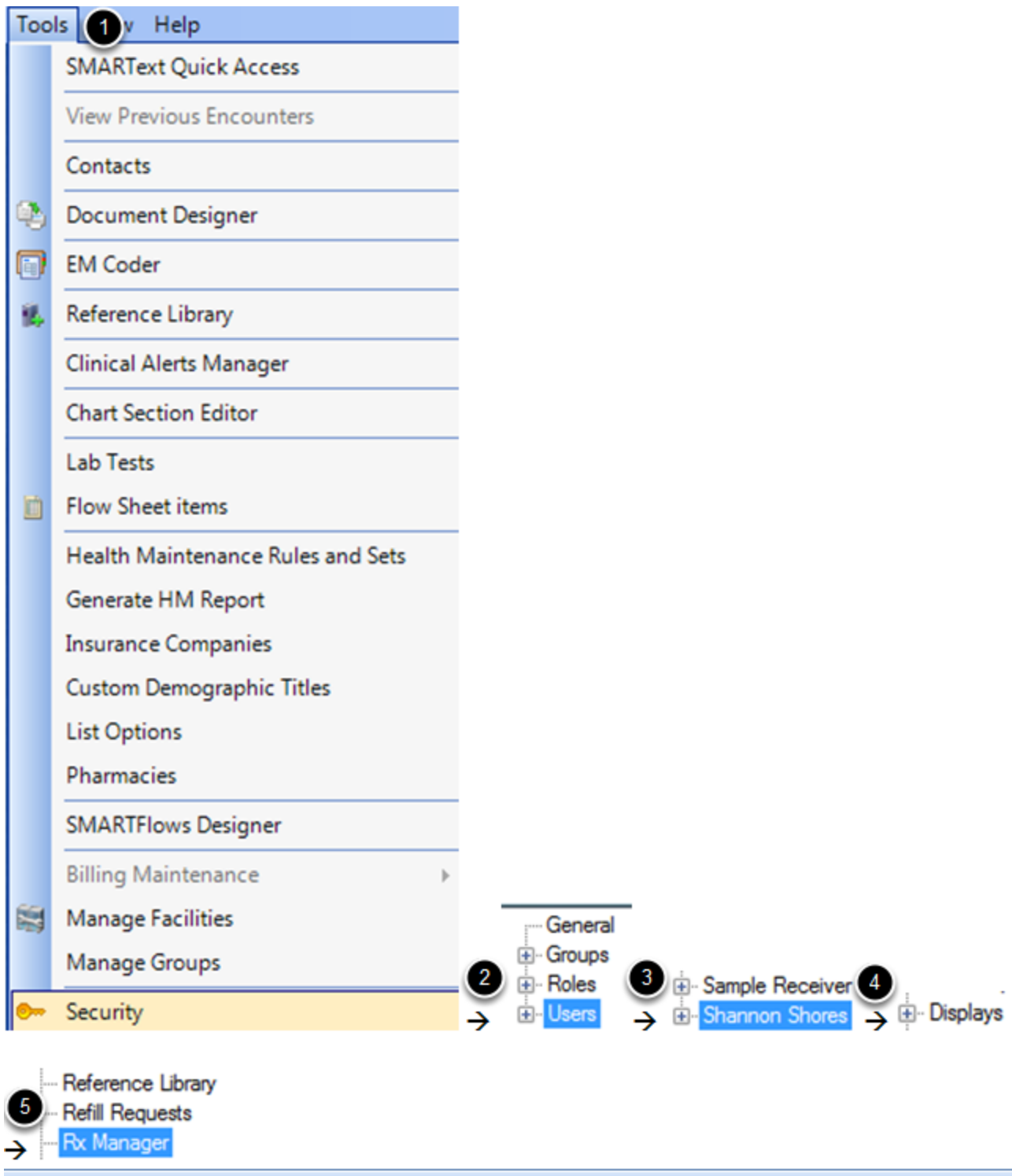
## Security - Drug Interaction Filtering

---

This lesson will show how to enable/disable drug/allergy interaction alerts at the user level. Drug/Allergy interaction alerts can also be enabled/disabled at the group or role level. Remember, changing a user at the user level, will override what is indicated at the group or role level.

**\*REQUIRED FOR MEANINGFUL USE (MU) CORE REQUIREMENT - DRUG INTERACTION CHECKS**

[Click here to view Meaningful Use Criteria](#)

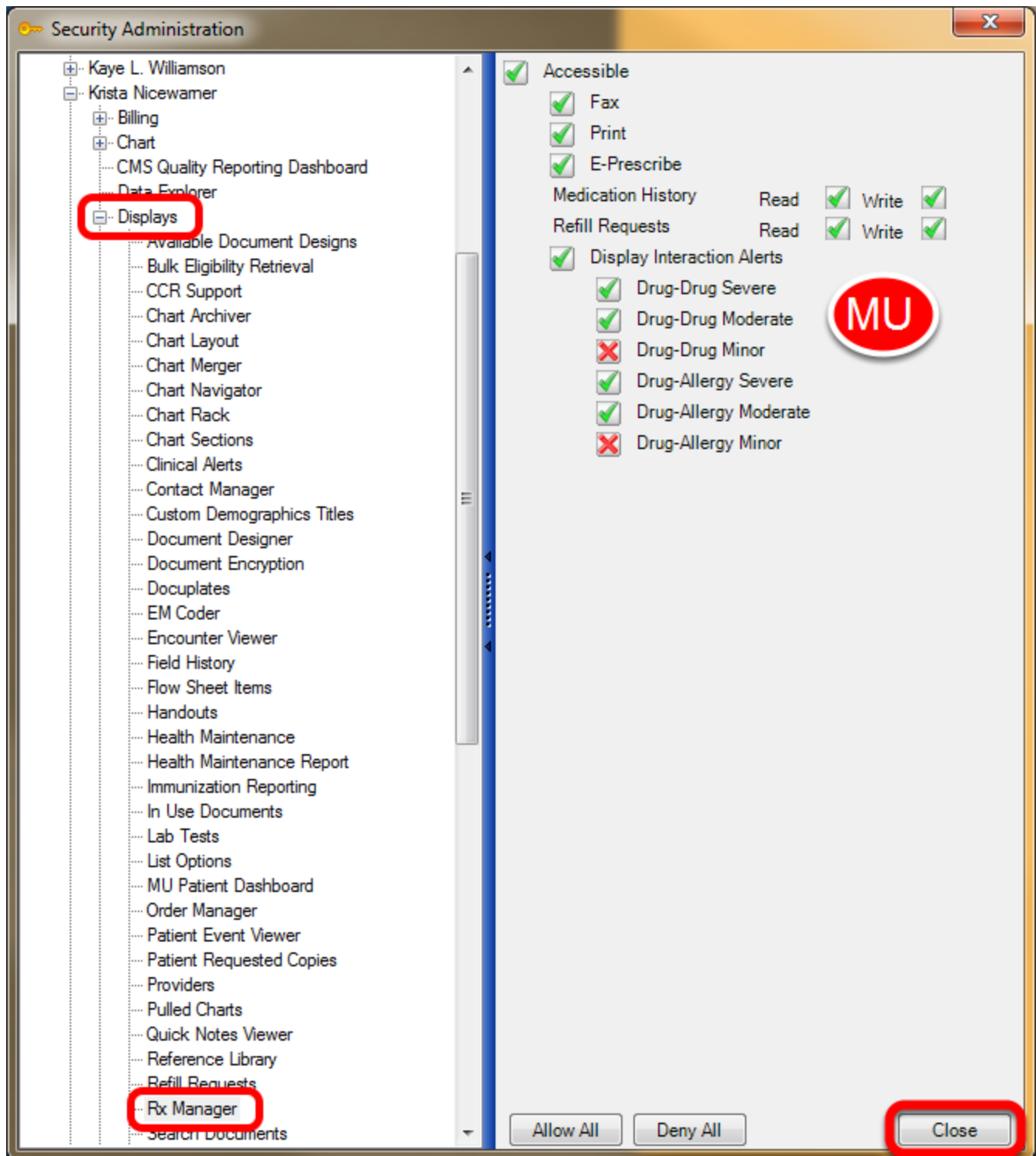


To change security privileges for an individual user...

1. Click on Tools > Security.
2. Click on the plus sign to the left of "Users."



3. Click the plus sign to the left of the user. This will expand all of the security areas for this user.
4. Click on the plus sign next to the word, "Displays."
5. Select "Rx Manager."



In SOAPware, there are many ways to customize what alerts are presented to a user, based on severity level.

- A green check mark indicates the user will receive drug/allergy interaction alert pop-ups.
- A red X indicates the user will not receive drug/allergy interaction alert pop-ups.
- Click the "Close" button when finished.

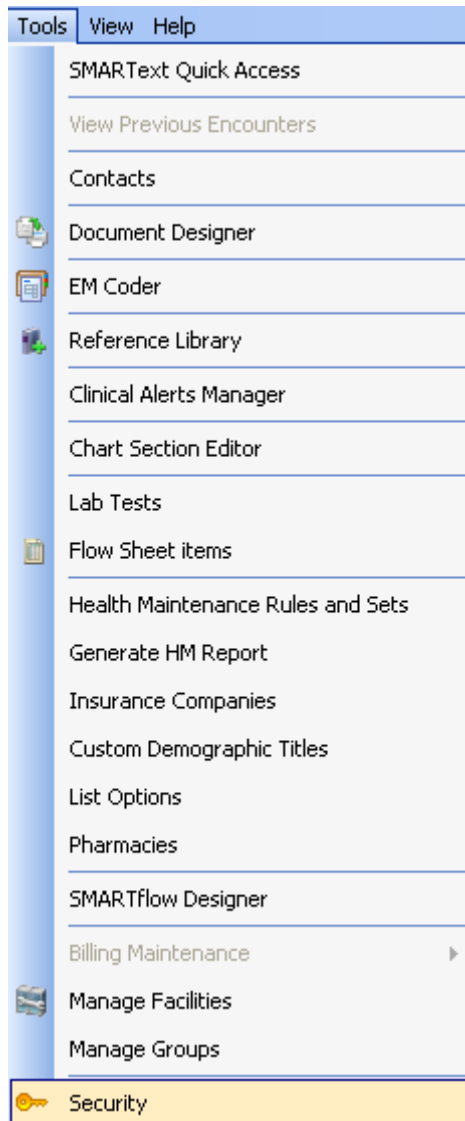
\*Remember, security settings will not take effect until a user logs out of SOAPware, and logs back into SOAPware.

## Security- Encounter Type

---

This lesson will discuss security settings for the encounter type. This security privilege will allow a user to select whether the encounter is a Face to Face or Non Face to Face Encounter for the SOAPnote documentation to be applied. By default, the encounters will be flagged "Face to Face". This setting may be Role or User specific. This is a Meaningful Use Requirement.

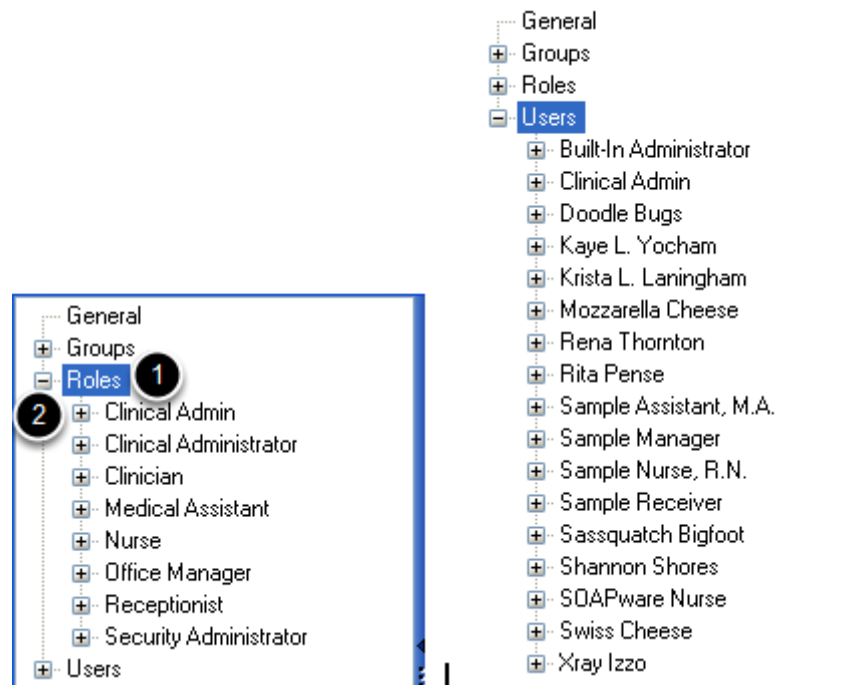
### Access Security



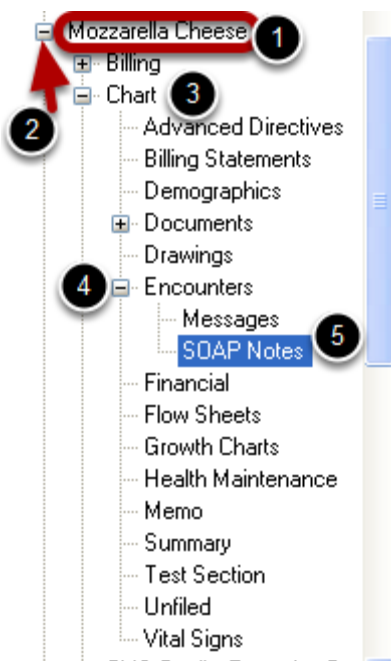
To access Security, Click on Tools>Security

Note: Only users with Administrative Rights may access Security.

## Selecting Roles or Users

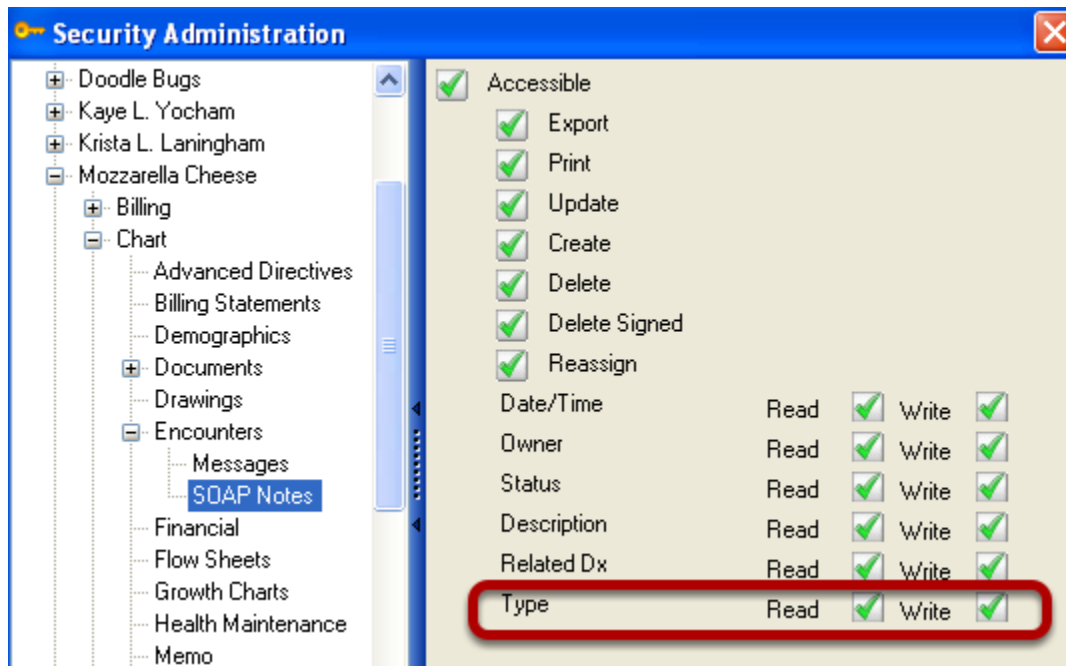


1. Click to highlight Roles or Users to set security privileges.
2. Click the "+" or node next to Roles or Users.



1. Click to highlight the Users name.
2. Click the "+" or node next to the User's name
3. Click the "+" or node next to Chart. This will expand different Chart Sections in SOAPware.
4. Click the "+" or node next to Encounters.

5. Click to select SOAPnotes.



Select the Encounter Type privilege for the user in the box. Placing a green check mark for Read and Write will allow the user to select Face to Face or Non Face to Face for the encounter that has been created in the Task Item window.

## Encounter Type Selection

**Add Document Task**

**Task Info**

Description: SOAPNote

Owner: Rena Thornton

Assigned To: Rena Thornton

Due: 3/14/2011

Reminder: / / : :

Priority: Normal

Action/Status: Needs Review

Type: SOAP Note

Notes:

**Docutainer Info**

Date/Time: 03/14/2011 10:59 AM

Type: Face to Face

Owner: Rena Thornton

Status:

Description:

Related Dx:

☐ Apply To All

Add Cancel

Once a user creates a new encounter, the Add Document Task window will appear. The encounter type may be selected at this time by Clicking on the drop down arrow. By default, encounters will be flagged as a Face to Face encounter.

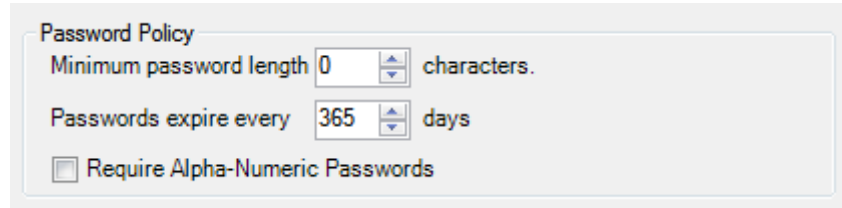
For more information on Encounter Type, [Click here](#).

**RECORDING THE APPROPRIATE ENCOUNTER TYPE IS REQUIRED FOR MEANINGFUL USE.**

## Setting Practice Security Defaults

---

### Password Policy



The screenshot shows a 'Password Policy' configuration window. It contains three settings: 'Minimum password length' set to 0 characters, 'Passwords expire every' set to 365 days, and a checkbox for 'Require Alpha-Numeric Passwords' which is currently unchecked.

#### Minimum Password Length

Sets a minimum requirement for password length.

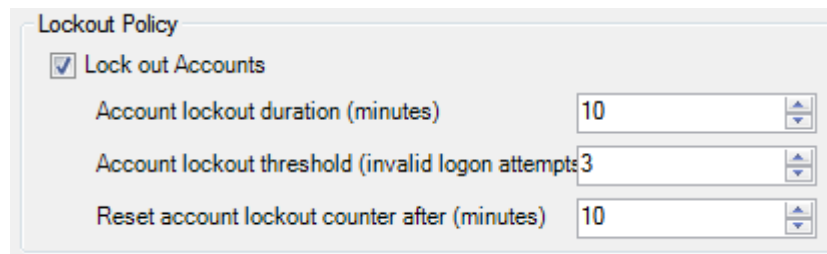
#### Passwords expire Every \_\_ Days

This number determines how frequently users must reset passwords.

#### Require Alpha-Numeric Passwords

Clicking this checkbox mandates that all users passwords will contain at least one number and one letter.

### Lockout Policy



The screenshot shows a 'Lockout Policy' configuration window. It contains four settings: a checked checkbox for 'Lock out Accounts', 'Account lockout duration (minutes)' set to 10, 'Account lockout threshold (invalid logon attempts)' set to 3, and 'Reset account lockout counter after (minutes)' set to 10.

#### Lock Out Accounts

The default is to have a check in the checkbox for Lock out Accounts. Click the Lock out Accounts checkbox to un check if the preference is for users to never to be locked out. The lock out policy only applies if the wrong password has been entered too many times.

#### Account Lockout Duration

Sets the amount of time, in minutes, that the user account will be locked out.

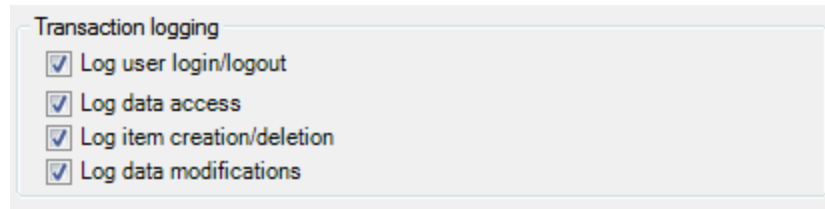
#### Account Lockout Threshold

The number of incorrect attempts allowed before the lockout

## Reset Account Lockout Counter

This setting determines the amount of time, in minutes, that the user has to wait before they can attempt to log in again.

## Transaction Logging

A screenshot of a 'Transaction logging' settings window. It contains four checkboxes, all of which are checked. The checkboxes are labeled: 'Log user login/logout', 'Log data access', 'Log item creation/deletion', and 'Log data modifications'.

This section defines the kind of user activity that will be tracked/logged within the system. Check all that apply.

### Log User Log in/Logout

This setting will track the time that users log in and logout.

### Log Data Access

Tracks the data that each user views and opens.

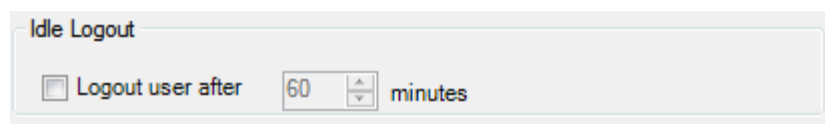
### Log Item Creation/Deletion

Tracks when anything new is created or deleted by a user within the system.

### Log Data Modifications

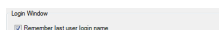
Any time information is changed or edited, it will be tracked and the time shown for the time of the change.

## Idle Logout

A screenshot of an 'Idle Logout' settings window. It features a checkbox labeled 'Logout user after' which is currently unchecked. To the right of the checkbox is a numeric input field containing the value '60', followed by a 'minutes' label.

This setting determines how long a computer can be idle, until a user is logged-out. This is a security setting that helps prevent non-staff/non-employees from accessing patient records illegally.

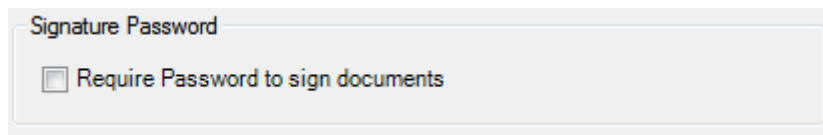
## Login Window

A small screenshot of a 'Login Window' checkbox. The checkbox is checked, and the text next to it reads 'Remember last user login name'.

Check this box to enable SOAPware to save the last user log-in ID in the Log-in field when the next attempt is made.



## Signature Password



Signature Password

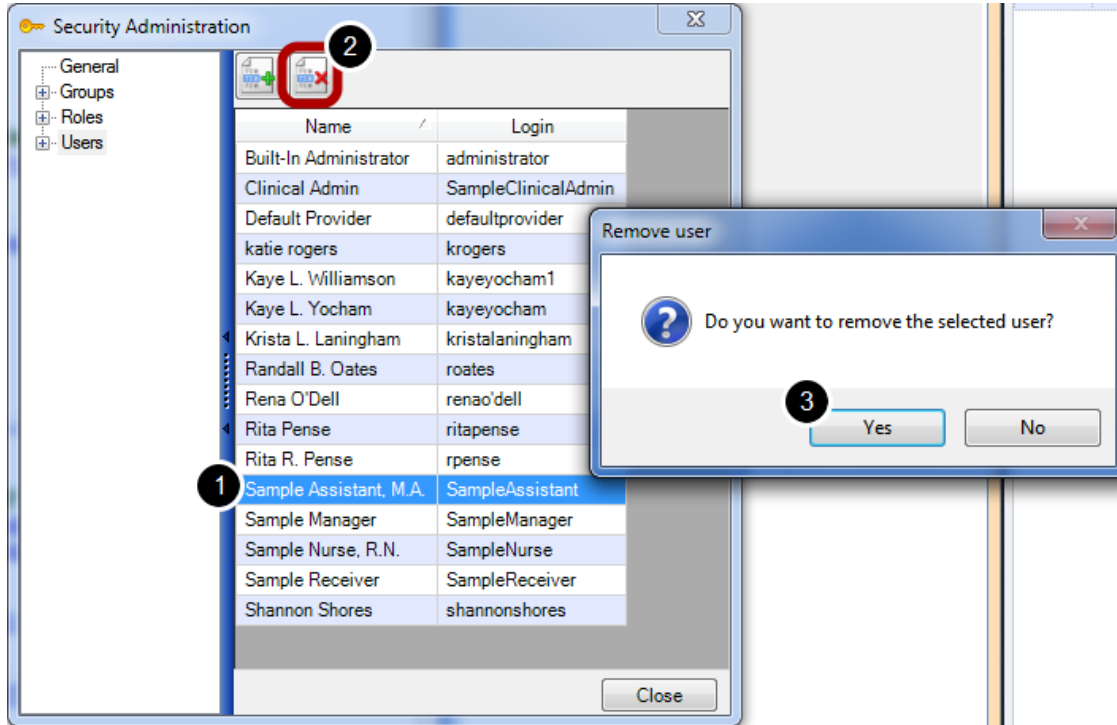
☐ Require Password to sign documents

The image shows a software dialog box titled "Signature Password". It contains a single checkbox labeled "Require Password to sign documents". The checkbox is currently unchecked.

Specifies whether a password is necessary to sign-off documents.

## Deleting Users & Reassign Tasks

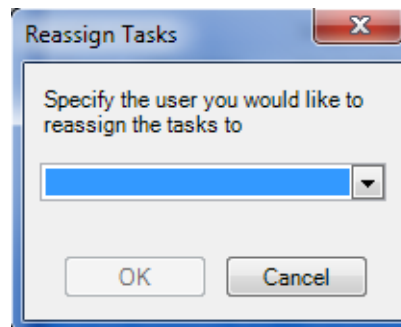
### Delete User



A user can delete Users in Security by going to Tools, Security. This will bring up the Security Administration window.

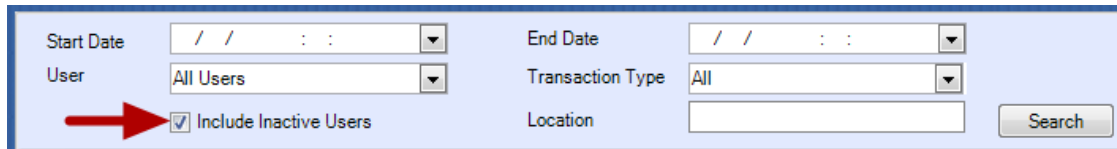
1. Highlight the name of the user to delete
2. Click the delete button
3. A prompt window will display to verify this action. Select "Yes" or "No".

### Reassign Tasks



A "Reassign Tasks" window will appear to prompt the action to reassign the deleted user's tasks to another user. Select the user to reassign the tasks to from the drop-down menu. After this, the Security Changes window will display a prompt to log out before these changes will take place.

## Searching the Audit Log of Deleted Users



The screenshot shows a search interface for the SOAPware Audit Log. It includes fields for Start Date, End Date, User (set to 'All Users'), Transaction Type (set to 'All'), and Location. A red arrow points to the 'Include Inactive Users' checkbox, which is checked. A 'Search' button is located on the right.

After deleting a User, their SOAPware activity may still be viewed in the audit log located in the Security Manager workspace. To do so, log in as the administrator and Click on the SOAPware menu item, then Click on Security Manager. A user will check the "Include Inactive Users" box.

## New Security Settings in SOAPware 2011

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SOAPware 2011 includes many new features that have security settings that must be established for users, roles and groups.

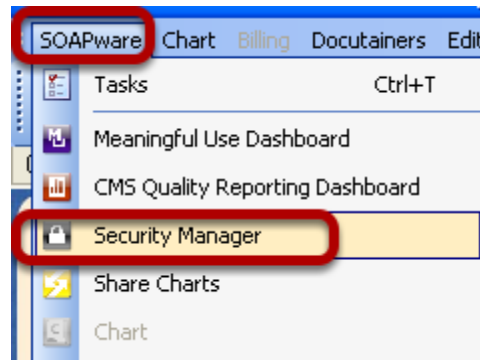
### Overview of Security Changes in SOAPware 2011

To view an overview of all new security administration items within SOAPware 2011, please see: [Overview of Security Changes in SOAPware 2011](#).

## Security Auditing in SOAPware

Once Security has been set up and all staff members have a unique login and password, it is possible to track changes and events in SOAPware connecting modifications made to patient information to a specific user. *To be able to search the Audit Logs, a SOAPware Standard or SOAPware Professional license is required.*

### How to access Security Manager



**Note:** Only the person with Security Administration rights should access Security Manager. The Security Login ID and Password are assigned specifically for Setting up Security and to perform a Search Audit log.

Click on the SOAPware Menu Item  
Click on Security Manager

### How to perform a Search Audit Log

A screenshot of the SOAPware application's 'Audit Log' search interface. The interface includes a search bar with various filters and a table of results. Numbered callouts (1-8) point to specific elements: 1. Start Date dropdown, 2. User Name dropdown, 3. Location dropdown, 4. IP Address dropdown, 5. Section dropdown, 6. Patient dropdown, 7. Include Inactive Users checkbox, and 8. Search button. The table below shows a list of audit events with columns for Date Time, User Name, Location, IP Address, Action/Section, Patient, and Description.

Date Time	User Name	Location	IP Address	Action/Section	Patient	Description
2/8/2011 1:47 PM	Rena Thornton ...	RENADELL760 (...)		Field_Updated	Luke Skywalker	Updated
2/8/2011 1:47 PM	Rena Thornton ...	RENADELL760 (...)		DocutainerDisplayed	Luke Skywalker	Ortho Assessment Pick List displayed in s...
2/8/2011 1:47 PM	Rena Thornton ...	RENADELL760 (...)		DocutainerDisplayed	Luke Skywalker	Summary displayed in section Summary
2/8/2011 1:46 PM	Rena Thornton ...	RENADELL760 (...)		ChartRackQuery		Search for patients last name that begins...
2/8/2011 8:14 AM	Rena Thornton ...	RENADELL760 (...)		Login		rena1 Logged In

1. Select a Start Date and an End Date for the Audit search
2. Select the User
3. Select a Location. Note: Location to the name of the computer

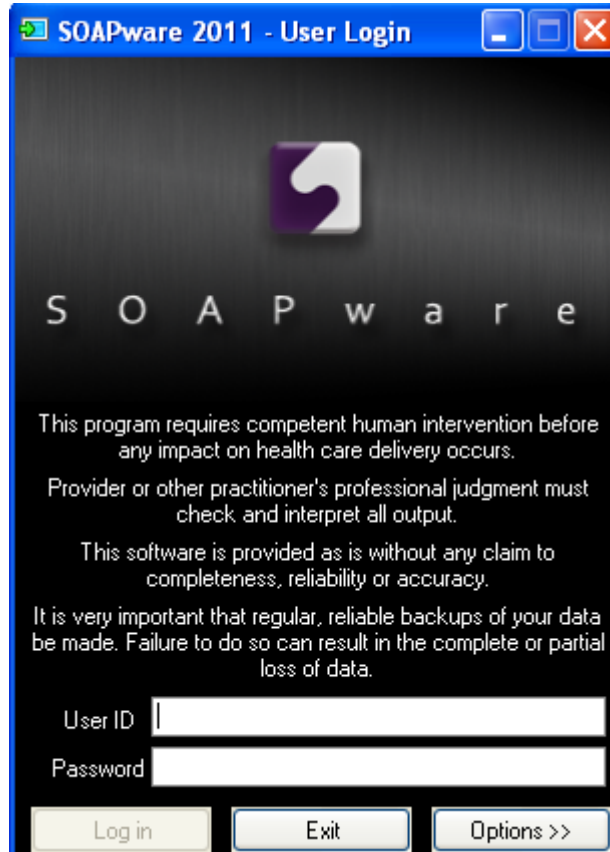
4. Enter the computer IP Address
  5. Select the Section of SOAPware to perform the search
  6. Select the Patient
  7. Inactive Users refers to users who were deleted from the system or whose SOAPware license was inactivated
  8. Click on the Search Button
- A list of activities will display

# Exploring SOAPware

## Open and Log In to SOAPware

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### Open SOAPware

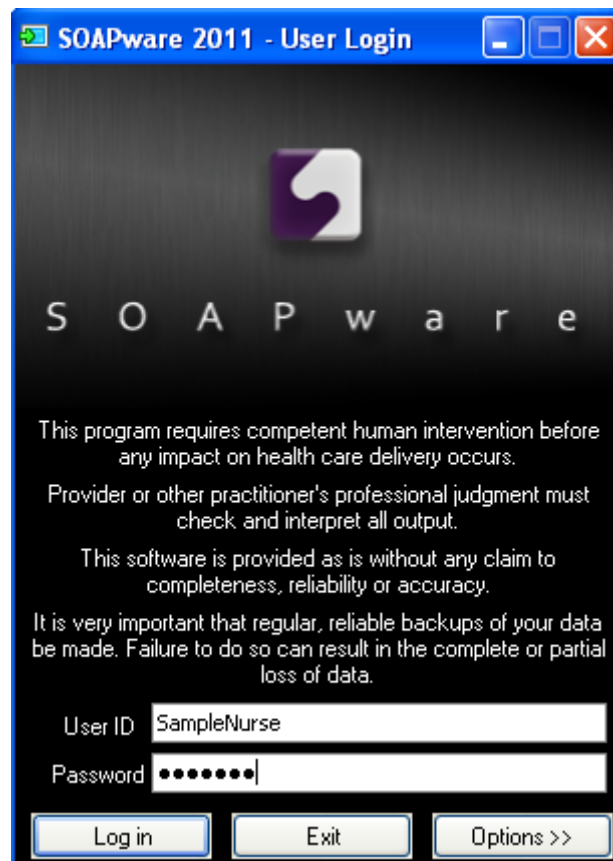


Start by opening SOAPware.

1. Click Start
2. Click the Programs (or All Programs) menu item
3. Click the SOAPware folder
4. Click the SOAPware menu item

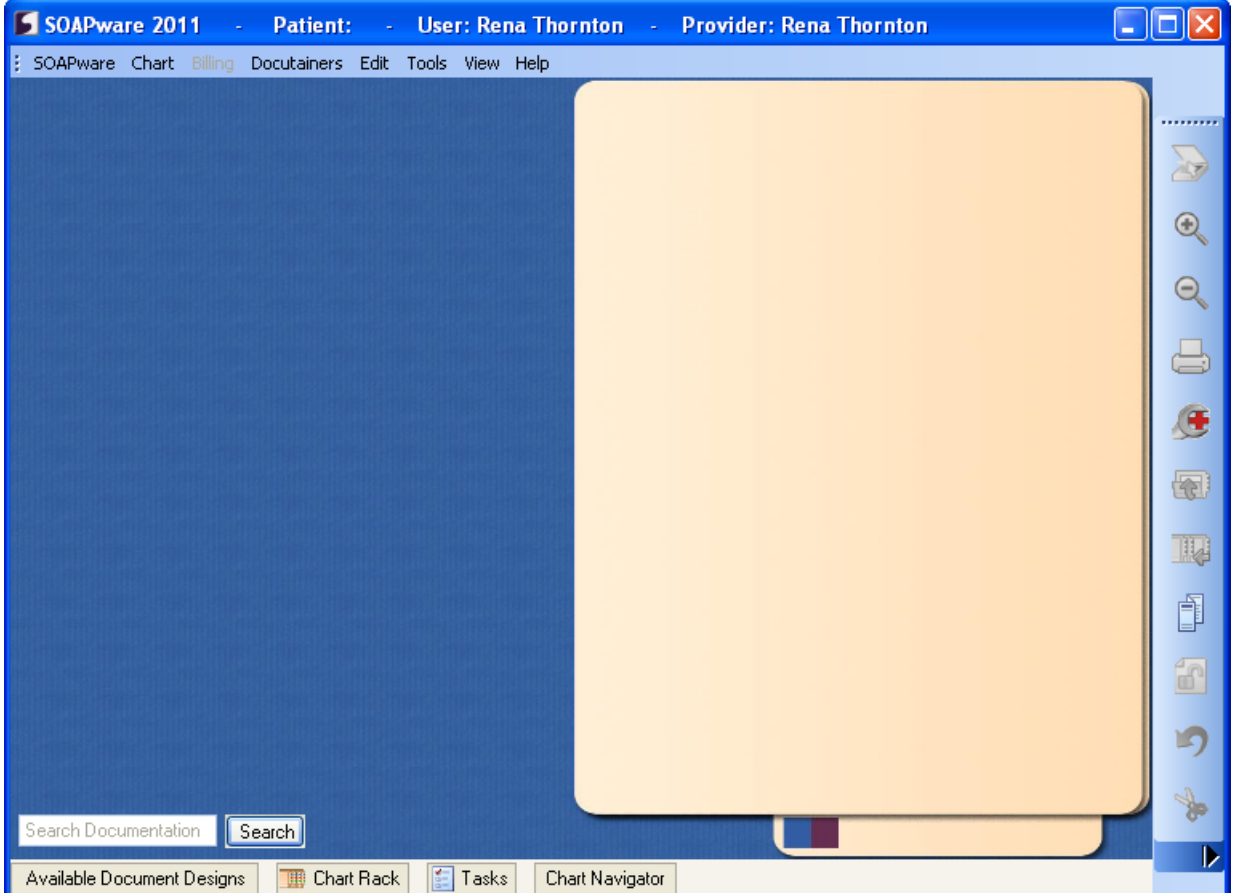
SOAPware opens with the User Log-In dialog.





At the start of every SOAPware session, log in to the system with both a user ID and password. For now, sign in will be with a default user. Type SampleNurse in the User ID and samplenurse for the Password, and Click LogIn.

If a user is not able to log in with SampleNurse, the final step of installation was not performed. Obtain an alternative ID and Password from the clinic administrator.



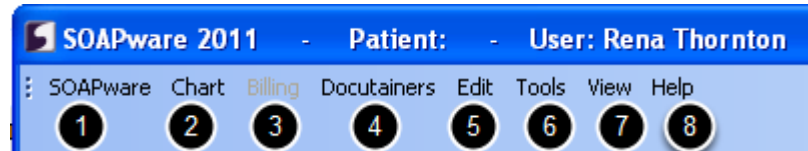
Once SOAPware fully loads, the Chart workspace is displayed. If this is the first time to log in as SampleNurse, there may be an additional dialog presented where the Active Provider for SampleNurse is selected.

## Exploring the SOAPware Interface - Toolbars

---

Many commands in SOAPware are used repeatedly, and it is common to place frequently used commands on toolbars. By default, a common toolbar is placed on the right side of the screen. Multiple toolbars are an option, and they can be placed/docked to any edge of the screen. Also, they can float anywhere desired.

### Primary Toolbar - Menu



#### 1. SOAPware Workspaces

SOAPware contains many different workspaces. Each has a different function. If users want to change workspaces, just Click on SOAPware, and select another workspace.

#### 2. Chart

The Chart menu provides many of the tools needed for the chart workspace.

#### 3. Billing

The Billing menu will be grayed out unless the user has the SOAPware Billing Suite. This area allows the user to maintain their billing workspace.

#### 4. Docutainers

This menu area includes many tools needed to create and build users' documentation, including Rx Manager, Docuplates, and SMARText, as well as many other tools.

#### 5. Edit

The Edit menu provides tools needed for editing documentation.

#### 6. Tools

The Tools menu is an area where users will do a lot of set up for their SOAPware workflow. For example, a user would want to come to this menu option to set up insurance companies, pharmacies, and contacts.

#### 7. View

The View menu includes refill requests, layouts, and several view-related settings.

#### 8. Help Menu

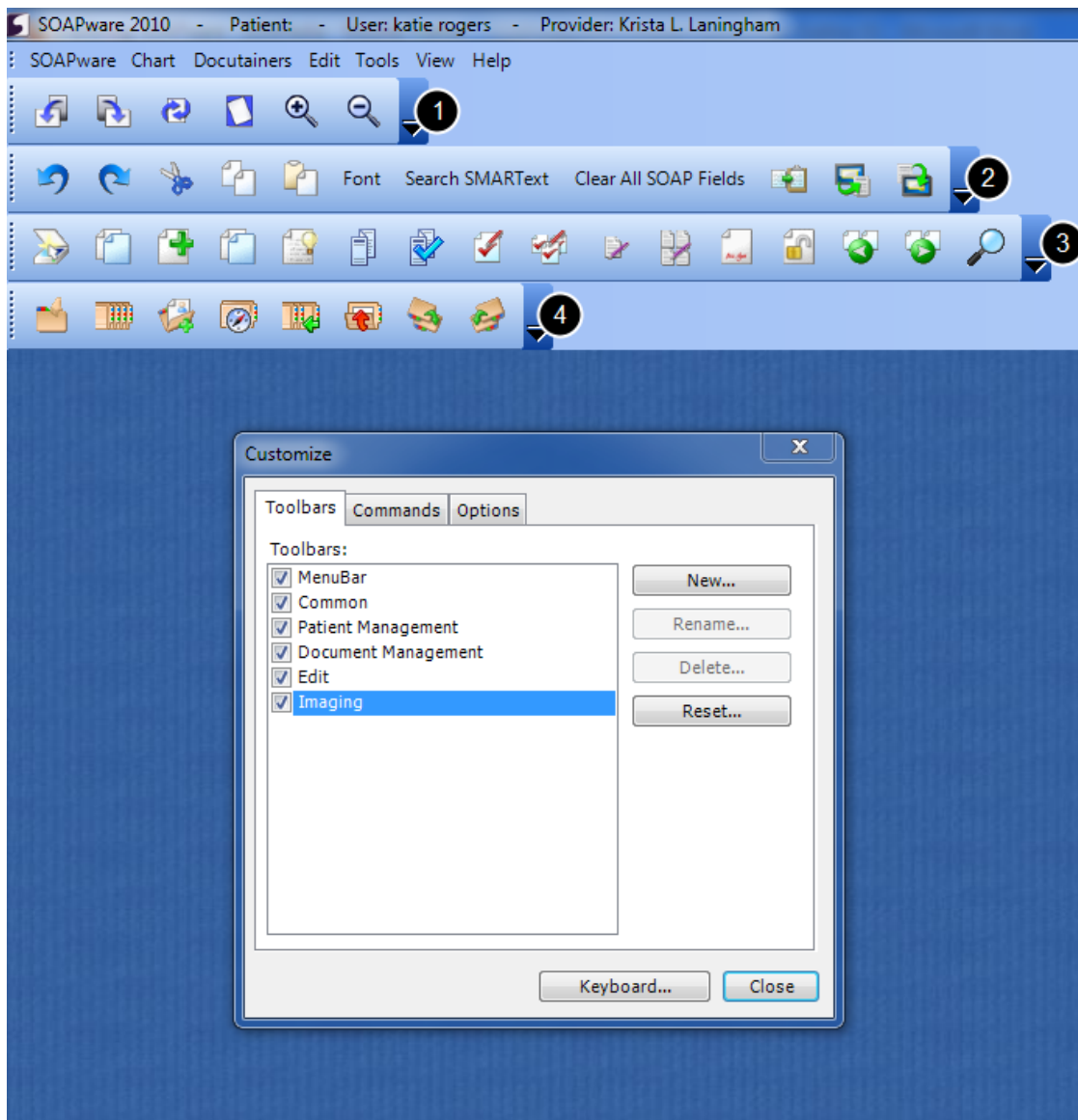
One of the many options within the Help Menu is to view what version of SOAPware is running on the database. Click Help > About SOAPware.



The Common Toolbar provides quick access to many frequently used tools in SOAPware. Instead of having to search using the primary tool, Click on the buttons on the toolbar to perform the following actions:

1. Scan an image
2. Zoom in
3. Zoom out
4. Print a document from Available Document Designs
5. Manage an order
6. Close the chart
7. Refile a chart
8. Handout Manager
9. Unlock chart sections
10. Undo
11. Cut

## Multiple Toolbar Options

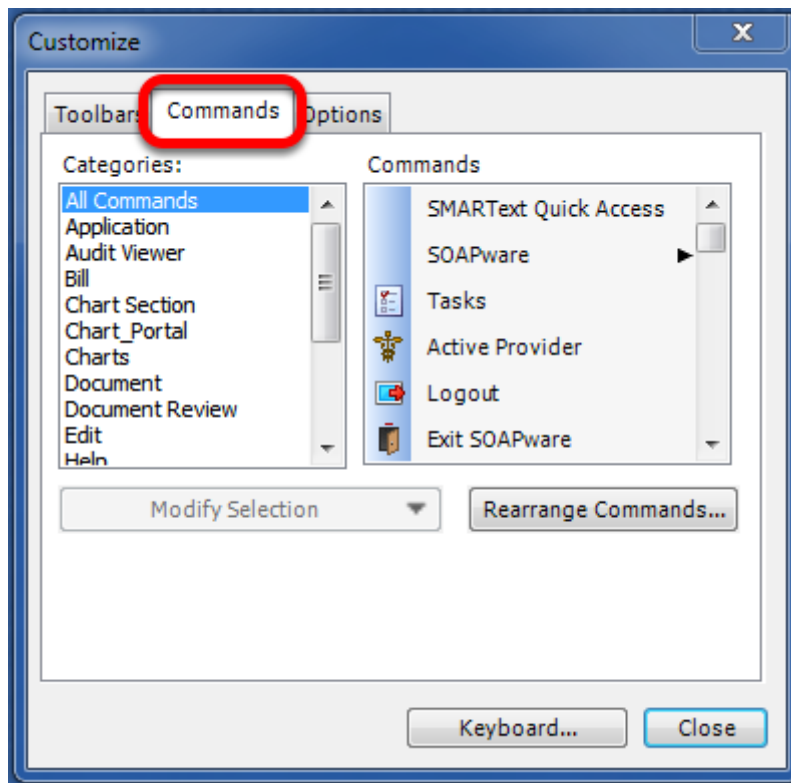


In addition to the Common Toolbar, there are several additional toolbars available. To view these, Click on the Tools Menu and select "Customize". This will bring up the Customize window above. Click each individual toolbar wished to be displayed.

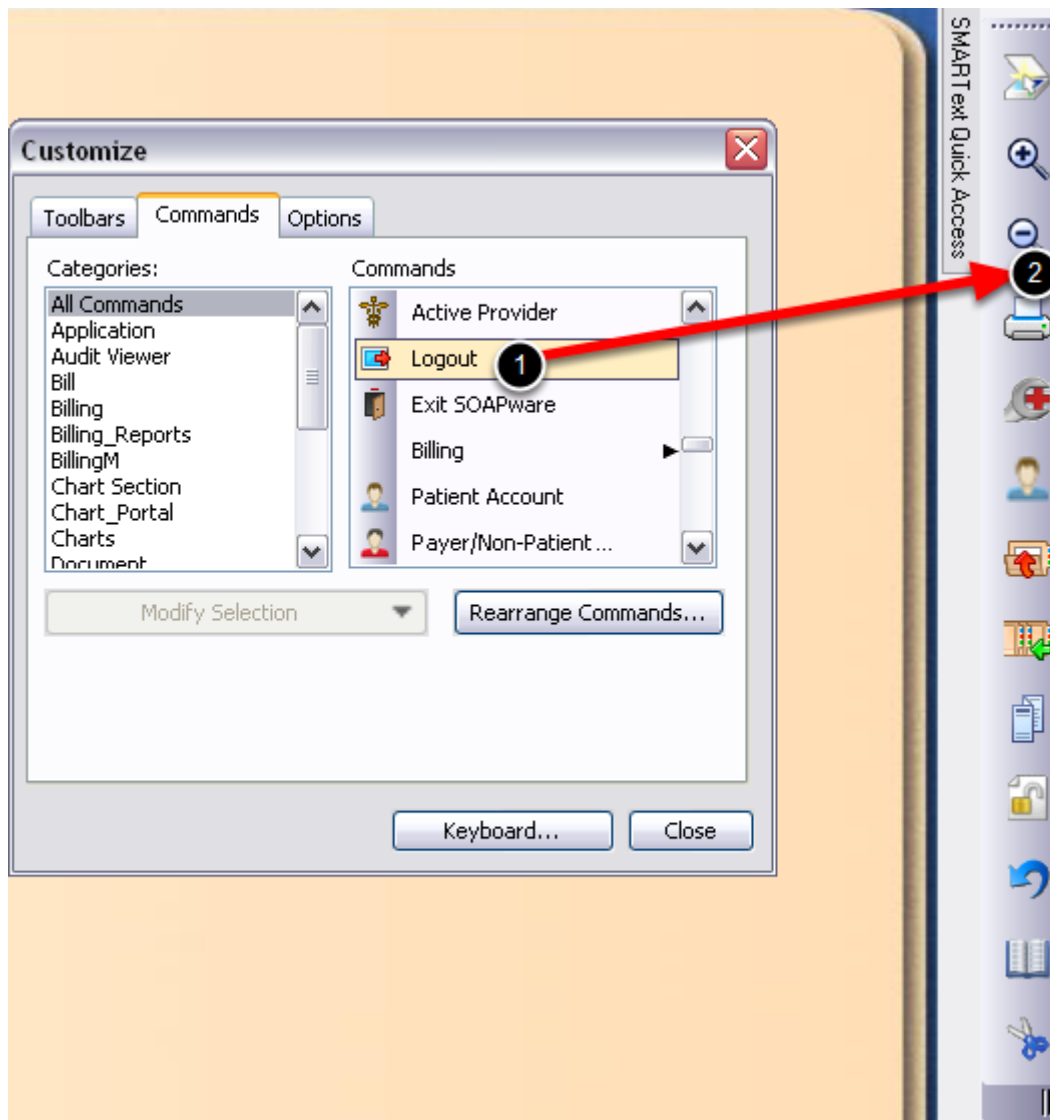
The additional toolbars are:

1. Imaging
2. Edit
3. Document Management
4. Patient Management

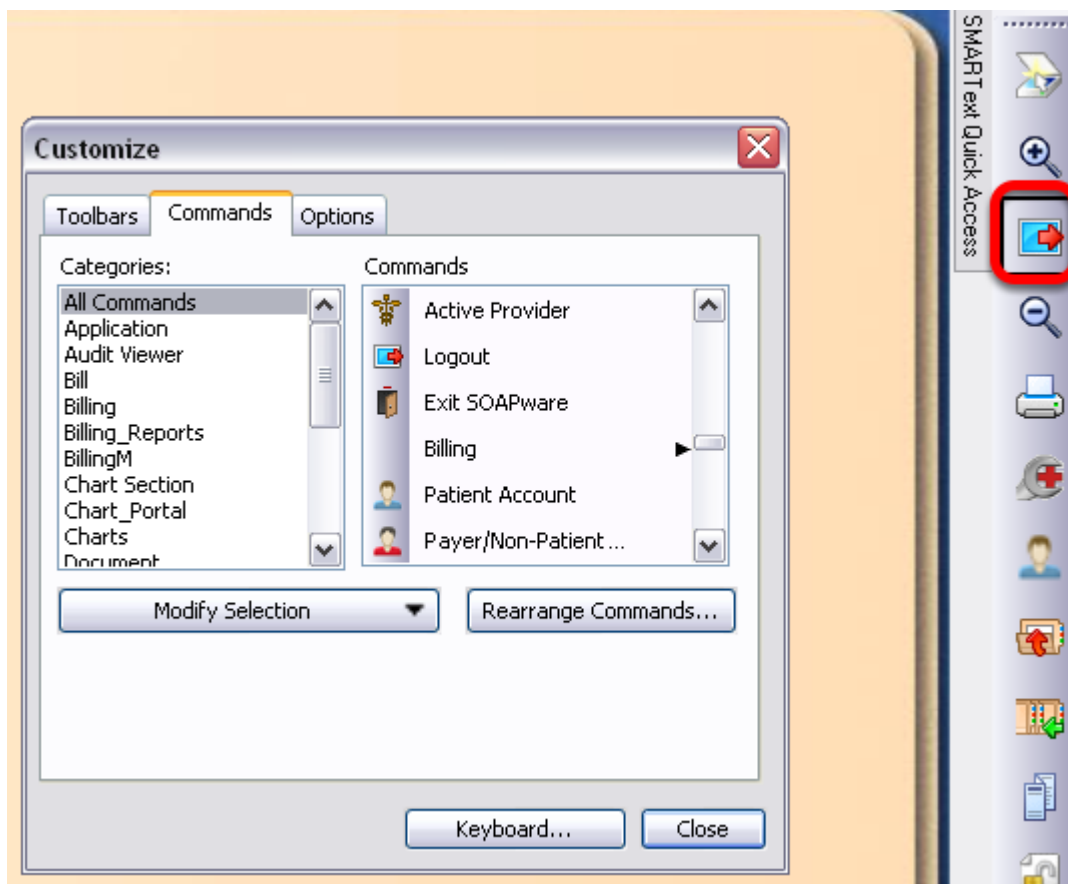
Users may also Click "New" to create their own customized toolbar, and may Click Reset to reset the toolbars to the default settings.



Users may customize the existing toolbars by adding and deleting buttons from the existing toolbar. To do this, Click the Commands tab in the Customize window shown above.



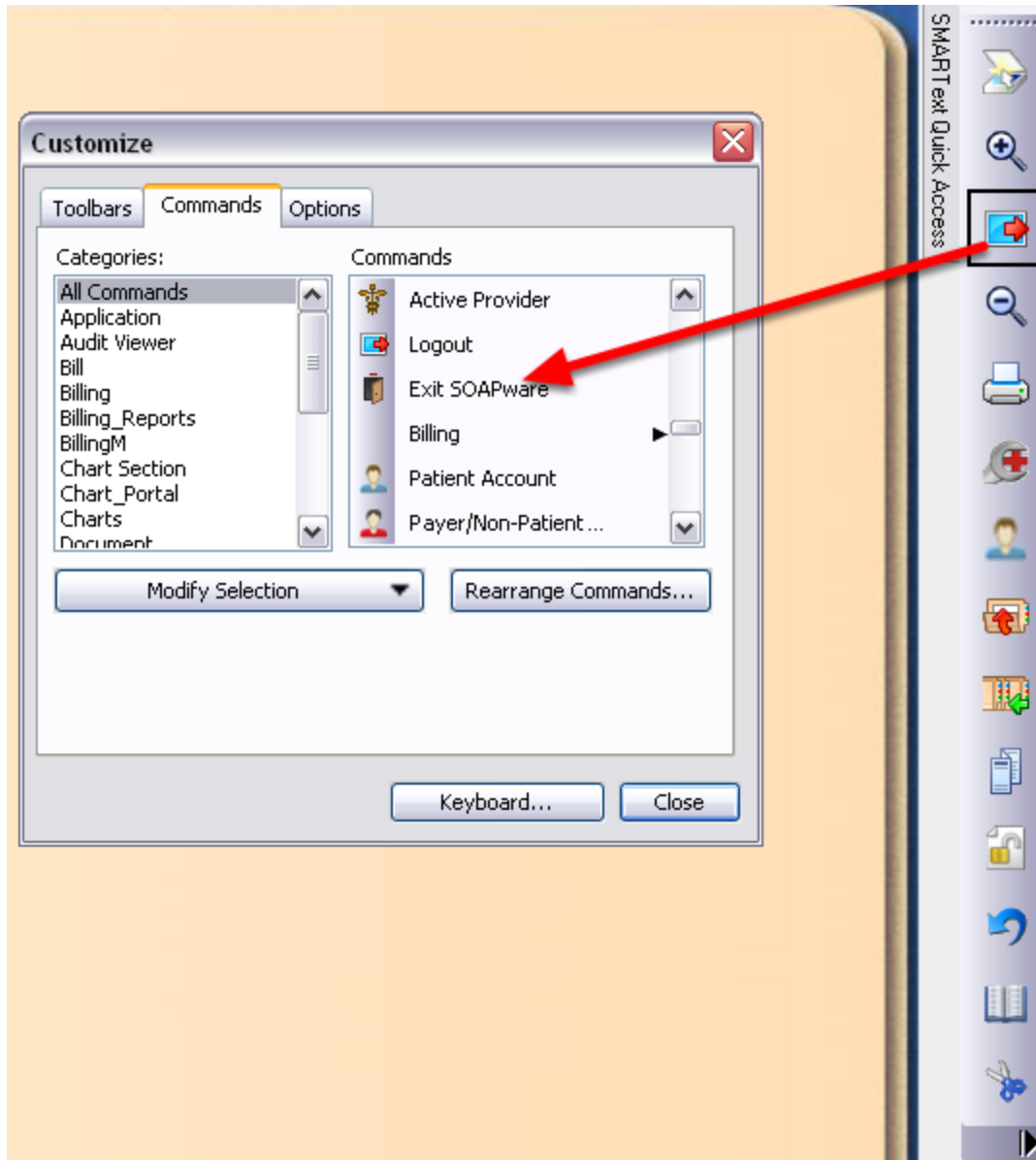
1. To add commands to a toolbar, locate the command to add. To locate the commands a user would like to include, Click on "All Commands", or browse by category, such as "Chart Section" or "Edit".
2. Next, Click and hold on the command in the "Command" section of the window and drag it to the toolbar and drop it in the desired location. When the command is ready to drop, a black bar will be visible in the toolbar, indicating where the new command will be located.



Once the command is dropped, a new button will be placed on the users toolbar.

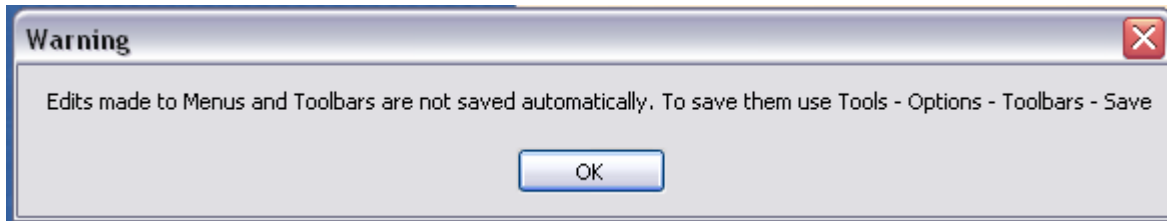


## Removing a Command from the Toolbar

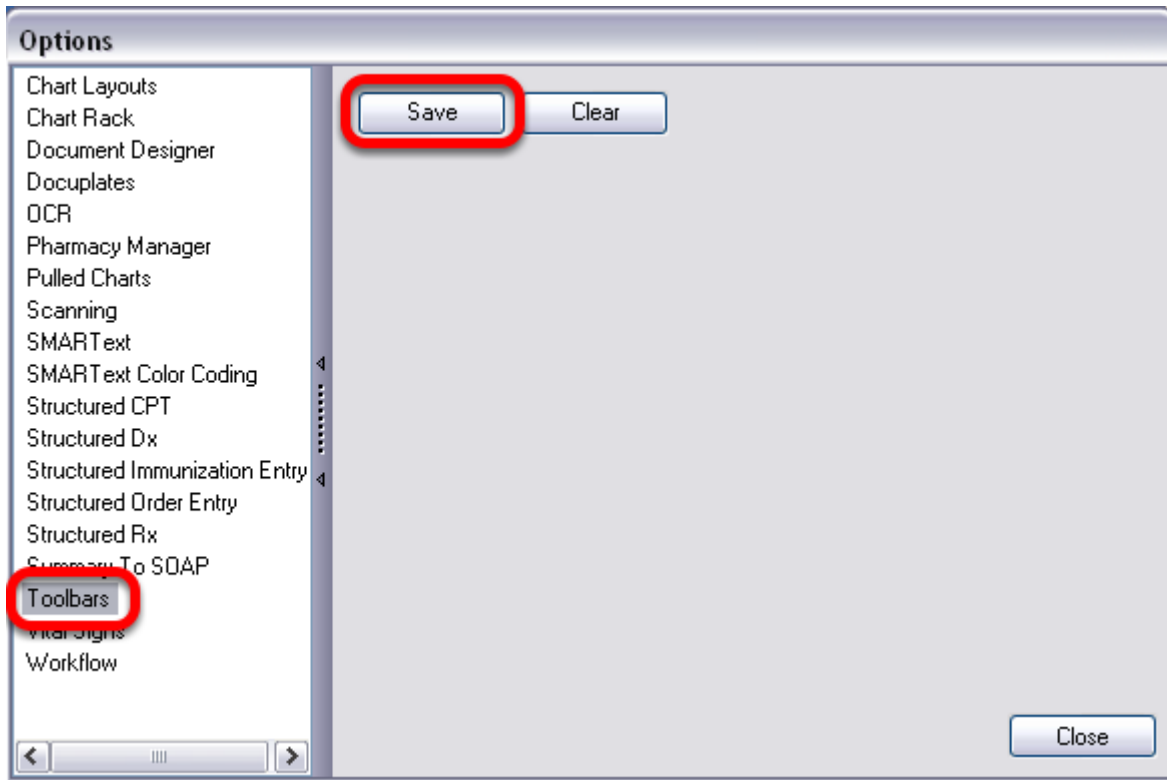


To remove a command from a toolbar, with the command window above still open, Click and hold the button on the toolbar and drag it to the command window and drop it. This will remove it from the toolbar. Users may also use this method to rearrange the commands on the toolbars by dragging them to another position.

## Saving Toolbar Customizations



To save the changes that were made to the toolbar, we will first Close the Customizations window. Users will then be presented with the warning shown above.



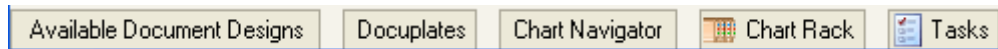
Anytime a user makes changes to their toolbar, they must save their changes by going to Tools > Options > Toolbars > Save.

## Exploring the SOAPware Interface - Docked Tabs

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At the bottom edge of the SOAPware Interface, docked tabs are displayed. These docked tabs can be moved to any corner of the screen, can be free floating, removed entirely, and are user-specific.

### Docked Tabs

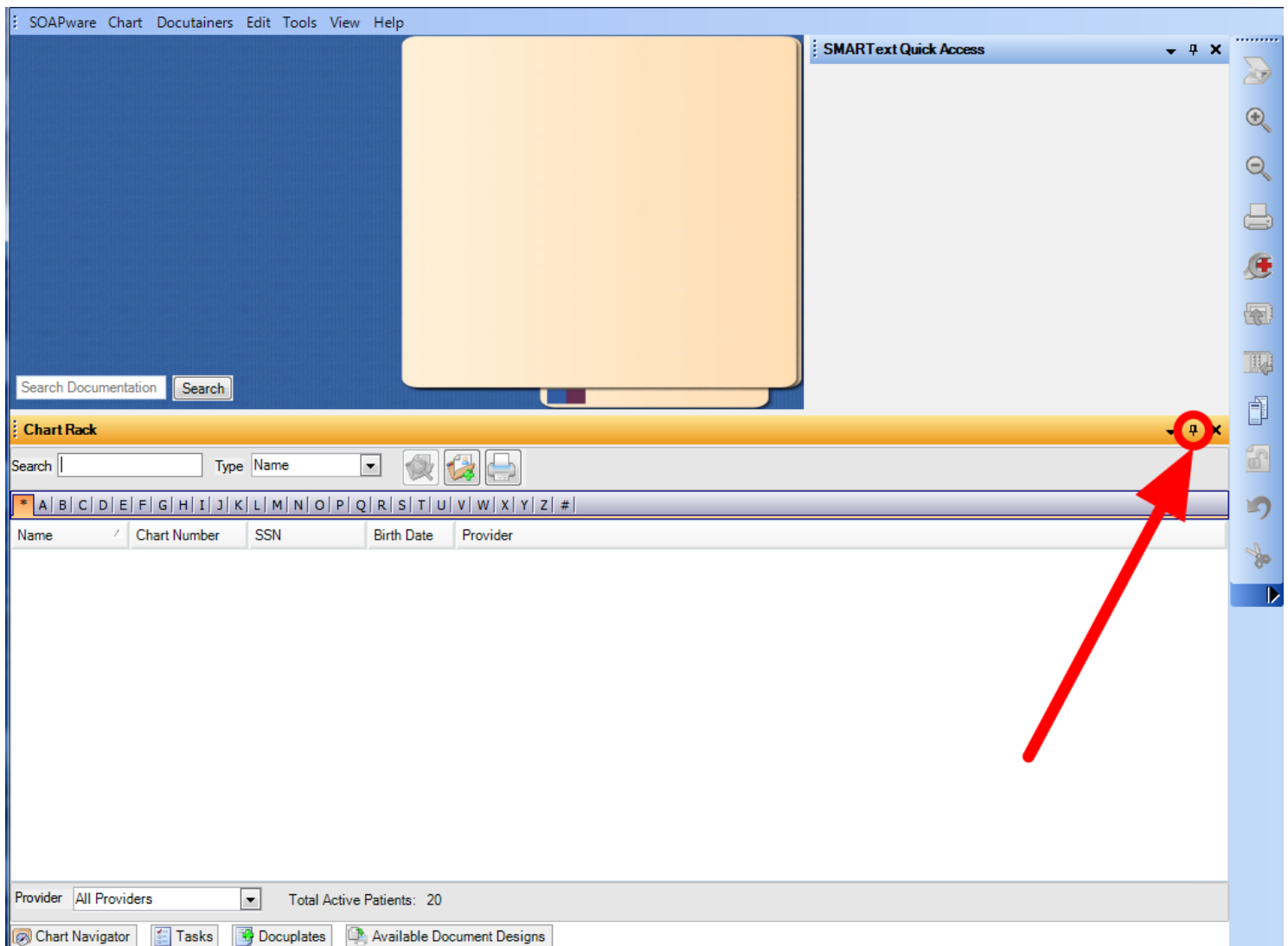


These five docked tabs come defaulted with SOAPware. A user may click on each of the tabs to expand them, or have them expand automatically when moused over or hovered over.

Simply pointing to/on (or hovering over) these tabs causes their viewers to pop-out, or expand, to a full view. Once a viewer is expanded, click somewhere outside of the viewer, and the window will collapse back into the tab. *Note: The Chart Rack viewer will remain open until a chart is selected.*

Many of the viewers in SOAPware can be docked to any of the four edges of the Chart workspace. Viewers that are docked can be undocked, so that they can float anywhere.

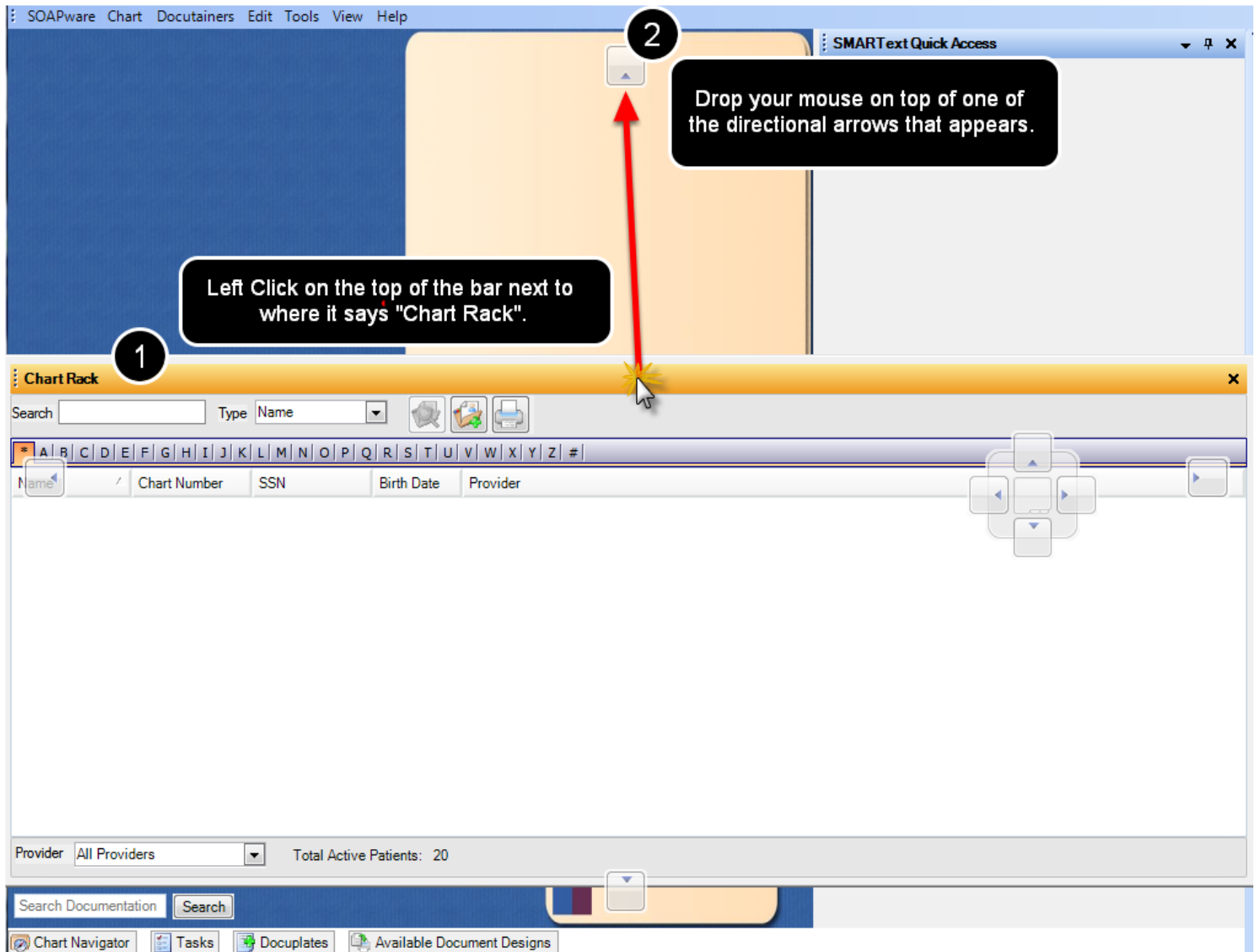
## Pin-Open Docked Tabs



Sometimes, it is preferred that the viewer remain in full view even if the mouse is moved outside of the window. To pin the viewer open, open a docked tab (such as the Chart Rack), and Click on the small pin icon in the upper right corner of an expanded viewer (see screenshot above, noticing the downward pointing pin). Clicking the push pin icon once will "pin open" the window so it will not collapse (notice that it also removes the docked tab from the bottom of the screen).

Re-Clicking the push pin icon will "un-pin" the window and thus reactivate the viewer's ability to collapse back into the tab.

## Move a Docked Tab

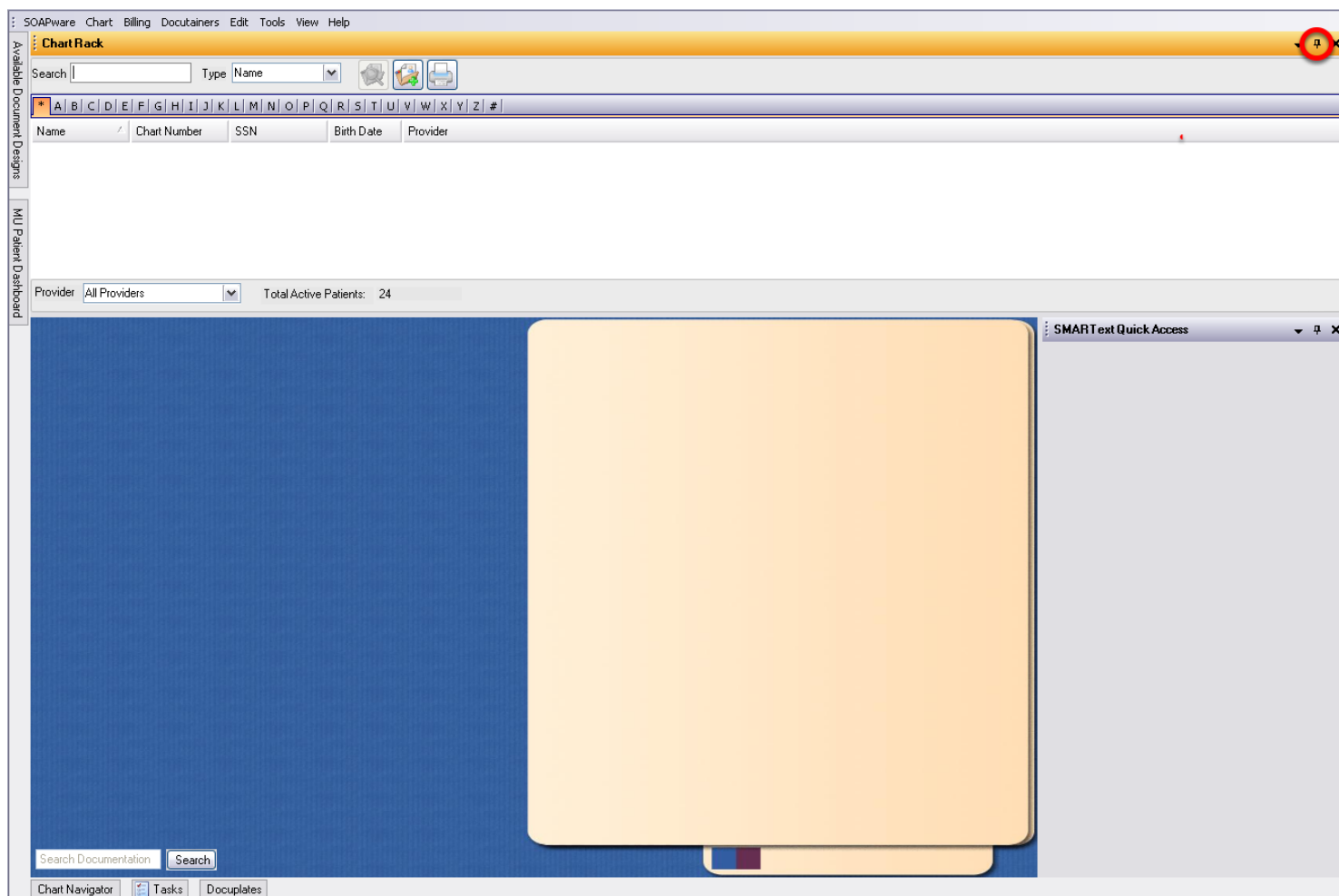


To move a docked tab the users first action will be to pin it open using the instructions above for pinning open a docked tab.

1. Next, Left-Click and hold on the docked tab title bar (orange bar at the top of the window), and continue to hold down the left-click to start to move the docked tab. Auser will notice some directional arrows which have now appeared on the screen while the user was holding down a left-click.

2. To dock a tab at the top of the screen next to the Menu Toolbar, drag and drop the tab to the arrow that appears at the top of the screen. There are arrows which correspond with each of the four sides of the screen, as well as arrows in the middle which also correspond to the four sides of the screen. Make sure to drag the top bar of the docked tab to the directional arrow. Auser can let go of a left-click when he/she sees the blue shading appear.

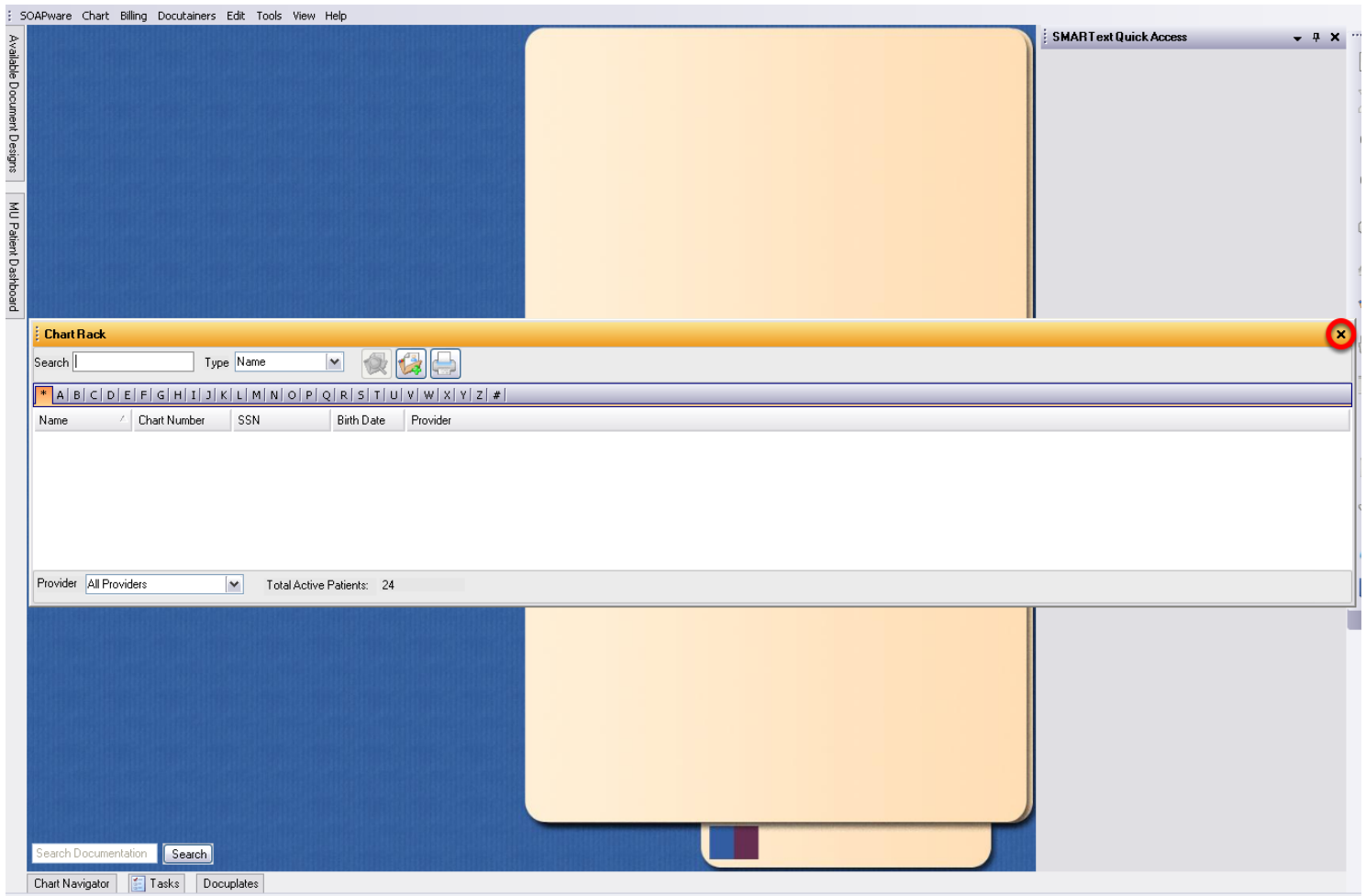
## Un-Pin the Docked Tab



Notice that the chart rack docked tab is now placed to the top of the screen.

Un-pin the window by Clicking on the push-pin icon. The pin should be facing to the side now. Click on the "X" to close the docked tab.

## Remove a Docked Tab

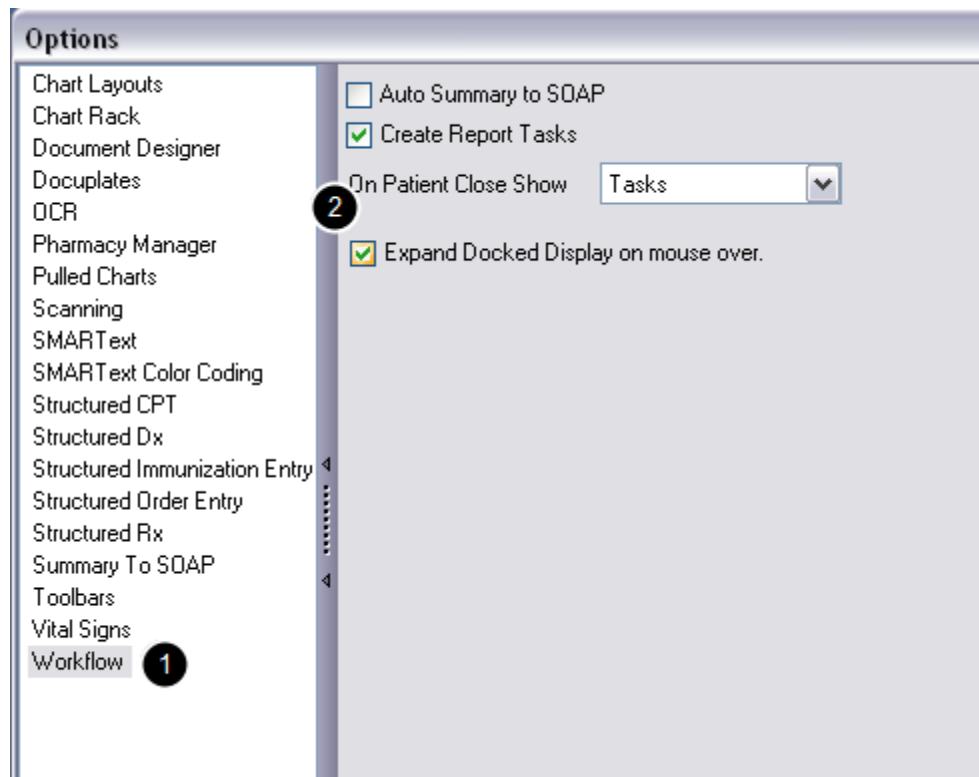


To leave a tab free-floating so that it is no longer docked, Click on a docked tab to expand the tab, and pin the window open as shown above.

Left-click on the docked tab title bar, and continue to hold down a left-click in order to move the docked tab.

Instead of dropping the tab on one of the arrows provided, instead drop the tab out in the middle section of the screen. This will leave it free-floating and the user can now Click on the "X" to remove the docked tab from a user's view.

## Expand Docked Tabs Automatically



A user can set up docked tabs to expand automatically, so that when the user hovers the mouse over the docked tab to expand, it will happen automatically instead of clicking to expand.

To set this as a preference, Click on Tools > Options

1. Click on Workflow.
2. Check the box next to "Expand Docked Display on mouse over." Click Close.
3. Close the window and log out and back in to SOAPware to save changes.

### **Log Out**

Click on SOAPware > Log Out. Then log back in for this change to take effect. This change is user-specific.

## User Tip

While Pulled Charts is a docked tab option, using Pulled Charts is not recommended in SOAPware. It is only available as a legacy item for customers converting from Version 4. SOAPware recommends using the Task List to manage all task items/unsigned charts.



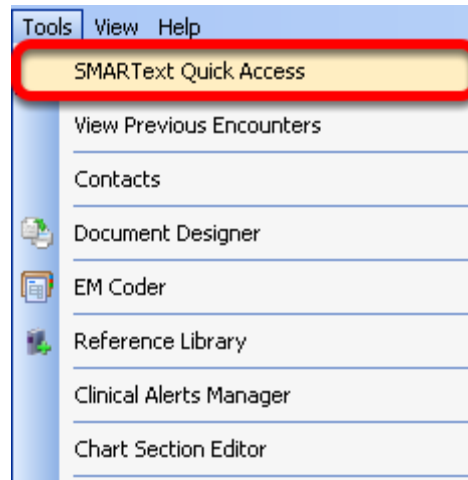
## TIP - Docking SMARText Quick Access

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In this lesson we will describe how to dock the SMARText Quick Access window.

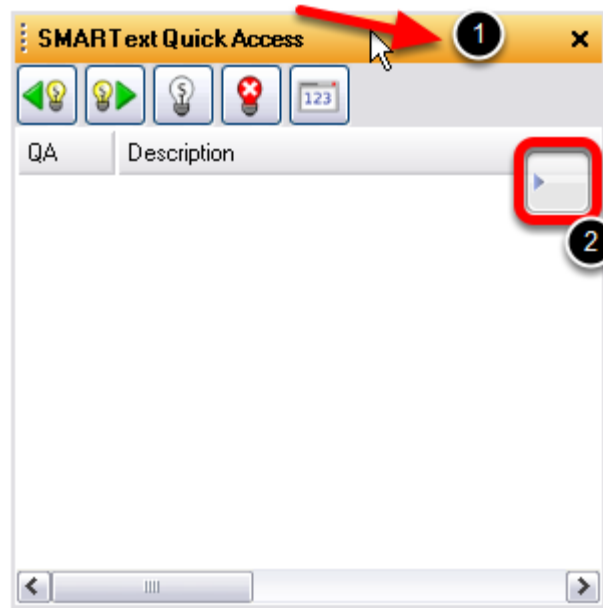
The SMARText Quick Access window is used when working with SMARText and Location Pick Lists. A user can dock the SMARText Quick Access window on any side of a computer screen, however we suggest that the SMARText Quick Access be docked on the right hand side of the screen for easy retrieval of the Pick List items.

### Retrieving the SMARText Quick Access Window



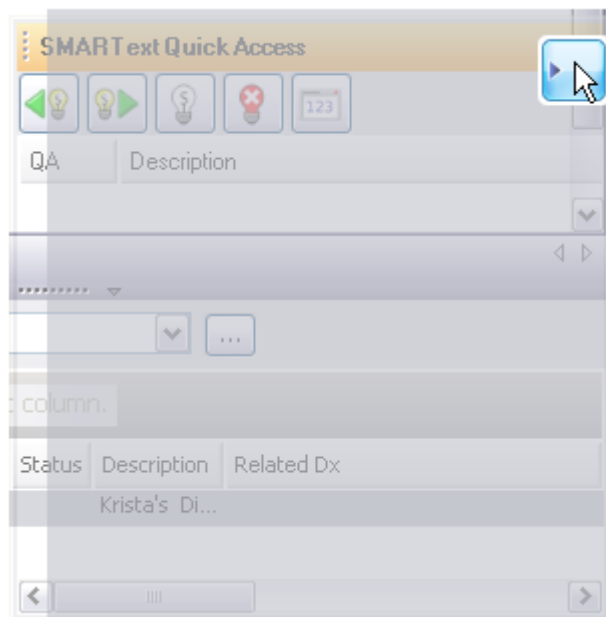
1. Click on Tools in the Menu bar.
2. Select SMARText Quick Access

## Dragging the SMARText Quick Access Window



1. Left-Click on the SMARText Quick Access title bar (orange bar at the top of the window).
2. While holding the left-click, begin dragging the SMARText Quick Access window towards the blue arrow box on the right side of the screen (see above).

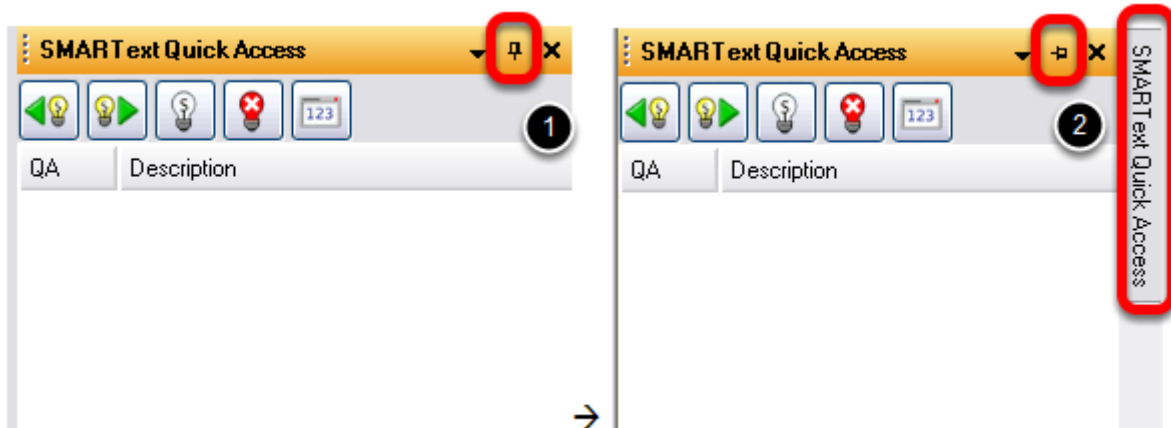
## Positioning the Cursor to Dock the SMARText Quick Access Window



1. When the cursor is directly on top of the blue arrow, the arrow box will turn darker blue with light blue shading. This indicates that it is ok to release your left-click.
2. Release the left-click to place the SMARText Quick Access window on the right side of the

screen.

## Docking the SMARText Quick Access Window



1. When the SMART Quick Access window is released, the push pin button will be pointing down indicating that the window is pinned open. To dock the window, Click once on the push pin button (see above).
2. The push pin button will now be pointing to the side and the SMARText Quick Access docked tab will appear.

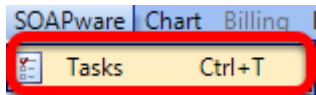
## What Can Be a Docked Tab?

---

This lesson will demonstrate what items in SOAPware, can be a docked tab. To review how to dock a tab, see: [Docked Tabs](#).

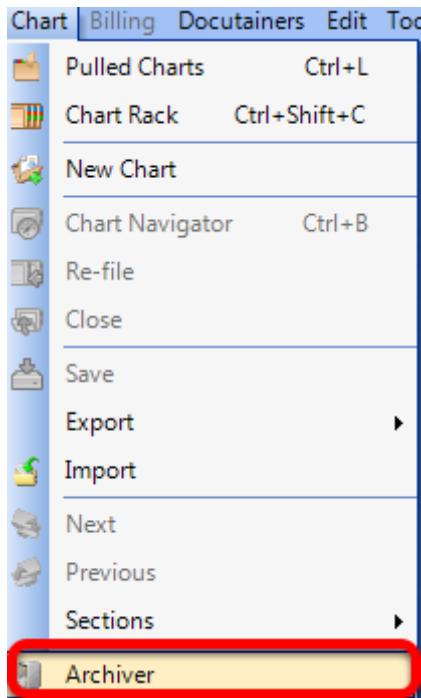
**Note:** A user can dock an item to the top, bottom, right, or left side of the SOAPware Interface. A user is also able to leave the item free floating .

### SOAPware- Tasks



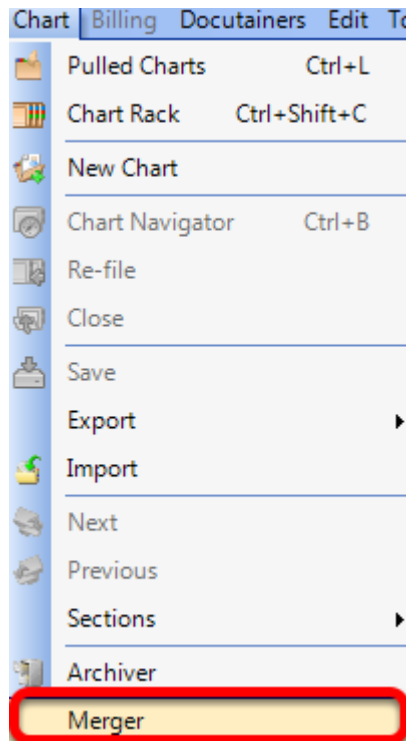
To dock Tasks, Click SOAPware > Tasks.

### Chart - Archiver



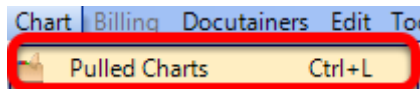
To dock Chart Archiver, Click Chart > Archiver.

## Chart - Merger



To dock Chart Merger, Click Chart > Merger.

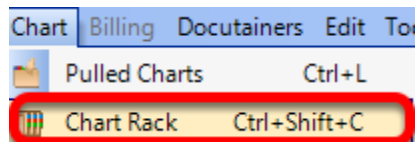
## Chart - Pulled Charts



To dock Pulled Charts, Click Chart > Pulled Charts.

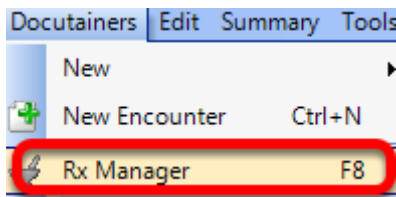
**Note:** While Pulled Charts is a docked tab option, using Pulled Charts is not recommended in SOAPware. It is only available as a legacy item for customers converting from Version 4. SOAPware recommends using the Task List to manage all task items/unsigned charts.

## Chart - Chart Rack



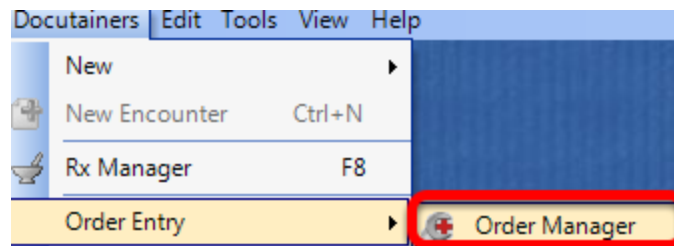
To dock the Chart Rack, Click Chart > Chart Rack.

## Docutainers - Rx Manager



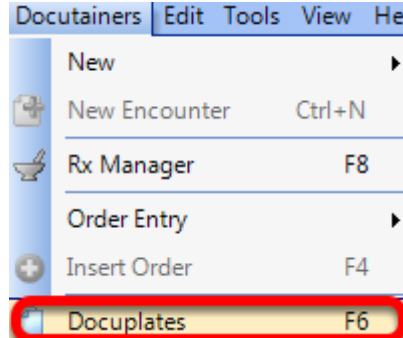
To dock Rx Manager, Click Docutainers > Rx Manager.

## Docutainers - Order Manager



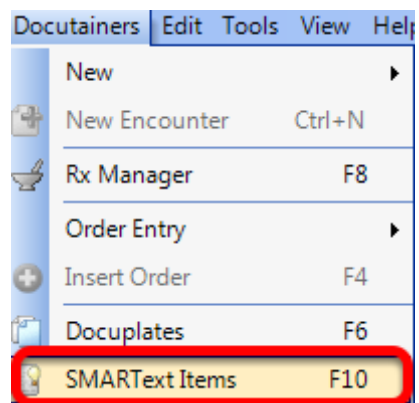
To dock Order Manager, Click Docutainers > Order Entry > Order Manager.

## Docutainers - Docuplates



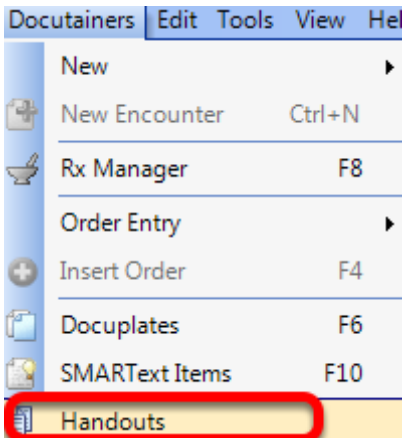
To dock Docuplates, Click Docutainers > Docuplates.

## Docutainers - SMARTText Items



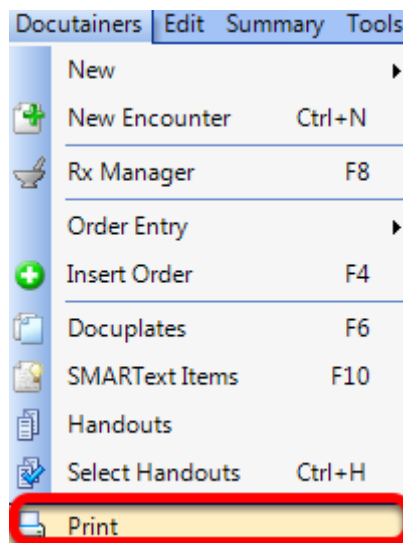
To dock SMARTText Items, Click Docutainers > SMARTText Items.

## Docutainers - Handouts



To dock Handouts, Click Docutainers > Handouts.

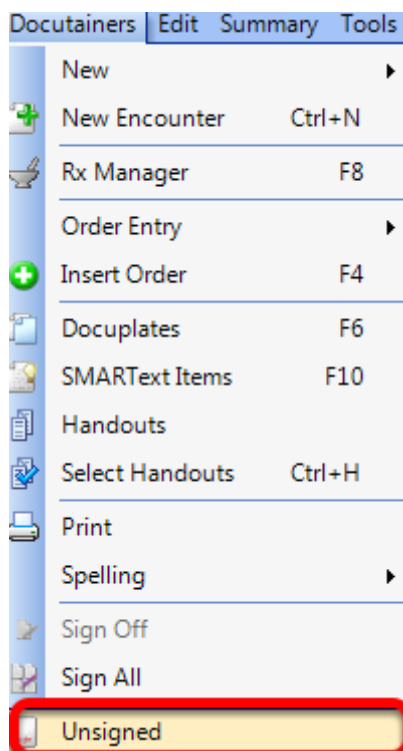
## Docutainers - Print Available Document Designs



To dock Print, Click Docutainers > Print.

**Note:** The Print item is a list of a user's Available Document Designs.

## Docutainers - Unsigned

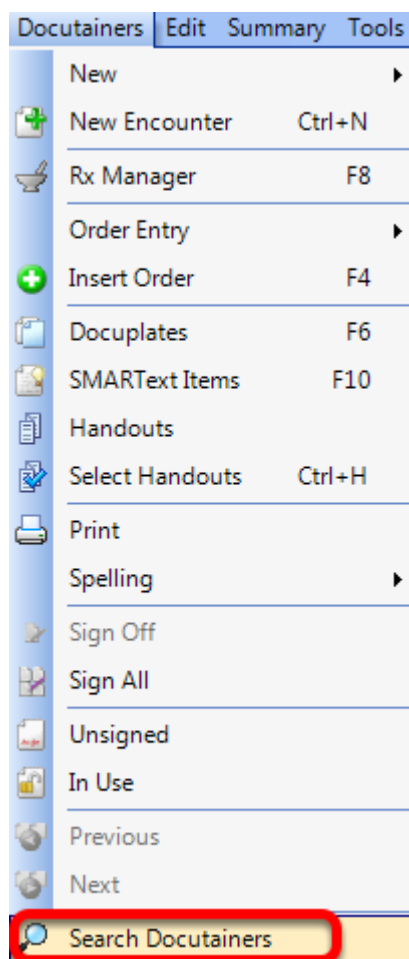


To dock Unsigned, Click Docutainers > Unsigned.

**Note:** This item brings up the "Unsigned Documents" dialog.

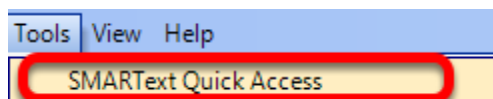


## Docutainers - Search Docutainers



To dock Search Docutainers, Click Docutainers > Search Docutainers.

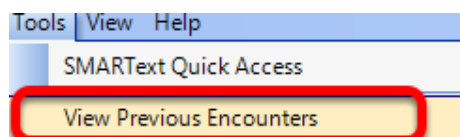
## Tools - SMARText Quick Access



To dock SMARText Quick Access, Click Tools > SMARText Quick Access.

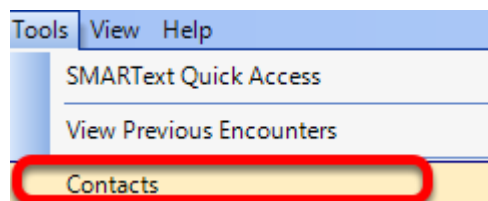
To view more information on docking SMARText Quick Access, Click [here](#).

## Tools - View Previous Encounters



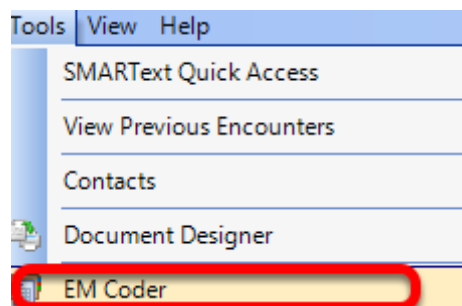
To dock View Previous Encounters, Click Tools > View Previous Encounters.

## Tools - Contacts



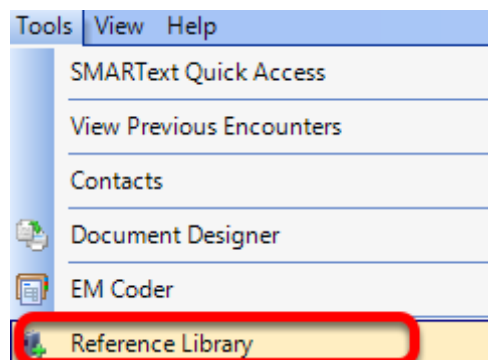
To dock Contacts, Click Tools > Contacts.

## Tools - EM Coder



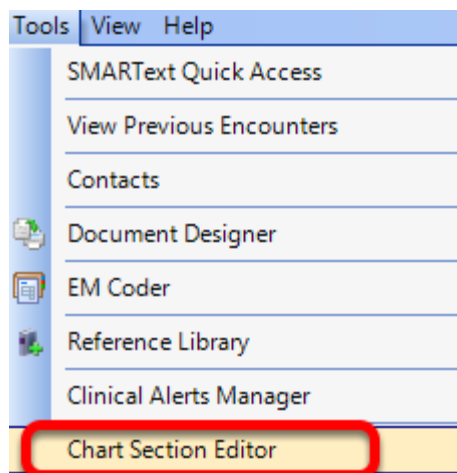
To dock EM Coder, Click Tools > EM Coder.

## Tools - Reference Library



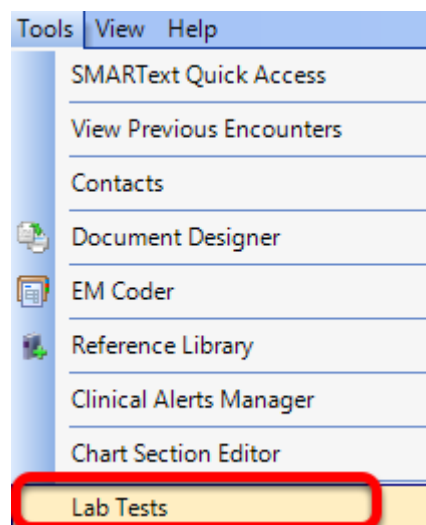
To dock the Reference Library, Click Tools > Reference Library.

## Tools - Chart Section Editor



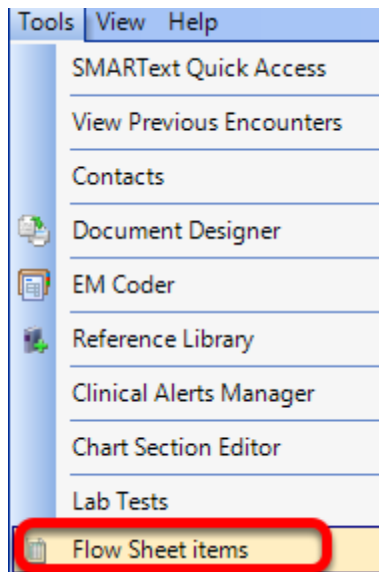
To dock Chart Section Editor, Click Tools > Chart Section Editor.

## Tools - Lab Tests



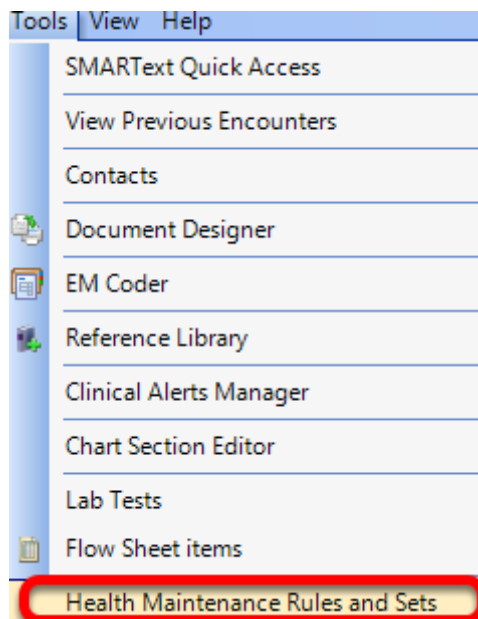
To dock Lab Tests, Click Tools > Lab Tests.

## Tools - Flow Sheet Items



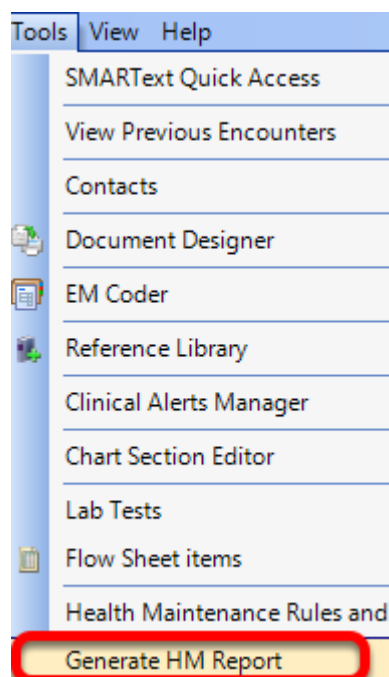
To dock Flow Sheet items, Click Tools > Flow Sheet items.

## Tools - Health Maintenance Rules and Sets



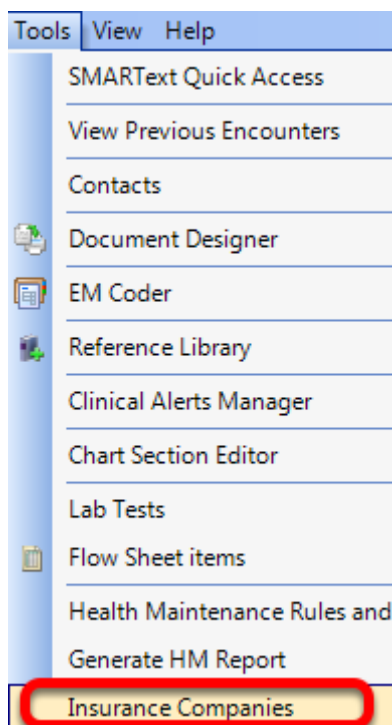
To dock Health Maintenance Rules and Sets, Click Tools > Health Maintenance Rules and Sets.

## Tools - Generate HM Report

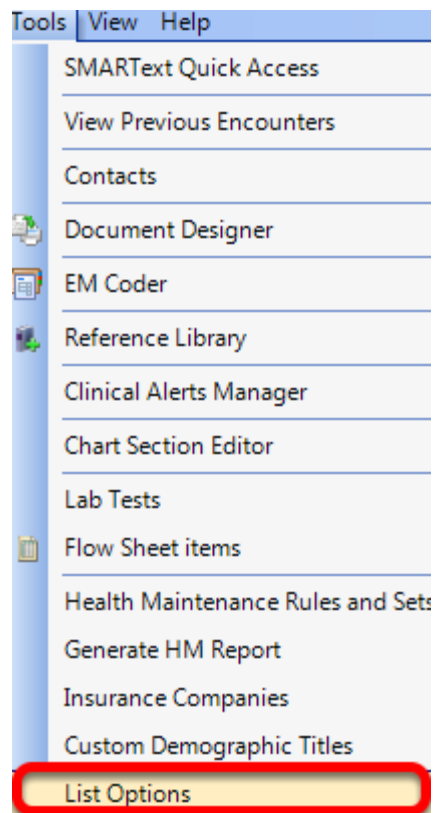


To dock the Generate Health Maintenance Report dialog, Click Tools > Generate HM Report.

## Tools - Insurance Companies

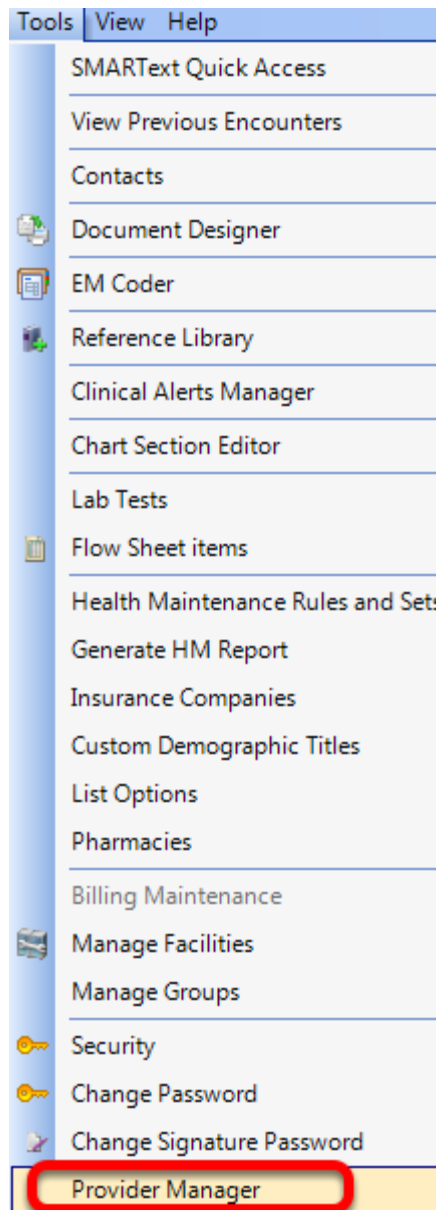


To dock Insurance Companies, Click Tools > Insurance Companies.



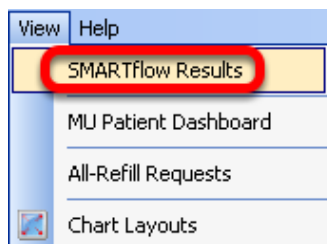
To dock List Options, Click Tools > List Options.

## Tools - Provider Manager



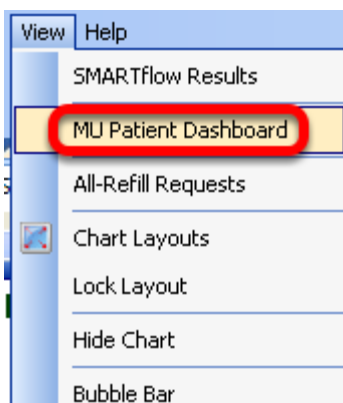
To dock Provider Manager, Click Tools > Provider Manager.

## View- SMARTflow Results



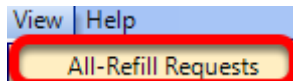
To dock SMARTflow Results, Click View> SMARTflow Results.

## View- MU Patient Dashboard



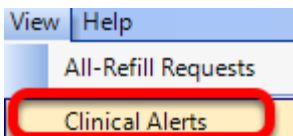
To dock MU Patient Dashboard, Click View> MU Patient Dashboard.

## View - All Refill Requests



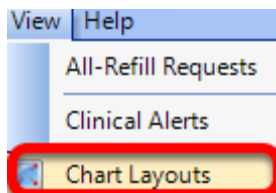
To dock All Refill Requests, Click View > All Refill Requests.

## View - Clinical Alerts



To dock Clinical Alerts, Click View > Clinical Alerts.

## View - Chart Layouts



To dock Chart Layouts, Click View > Chart Layouts.

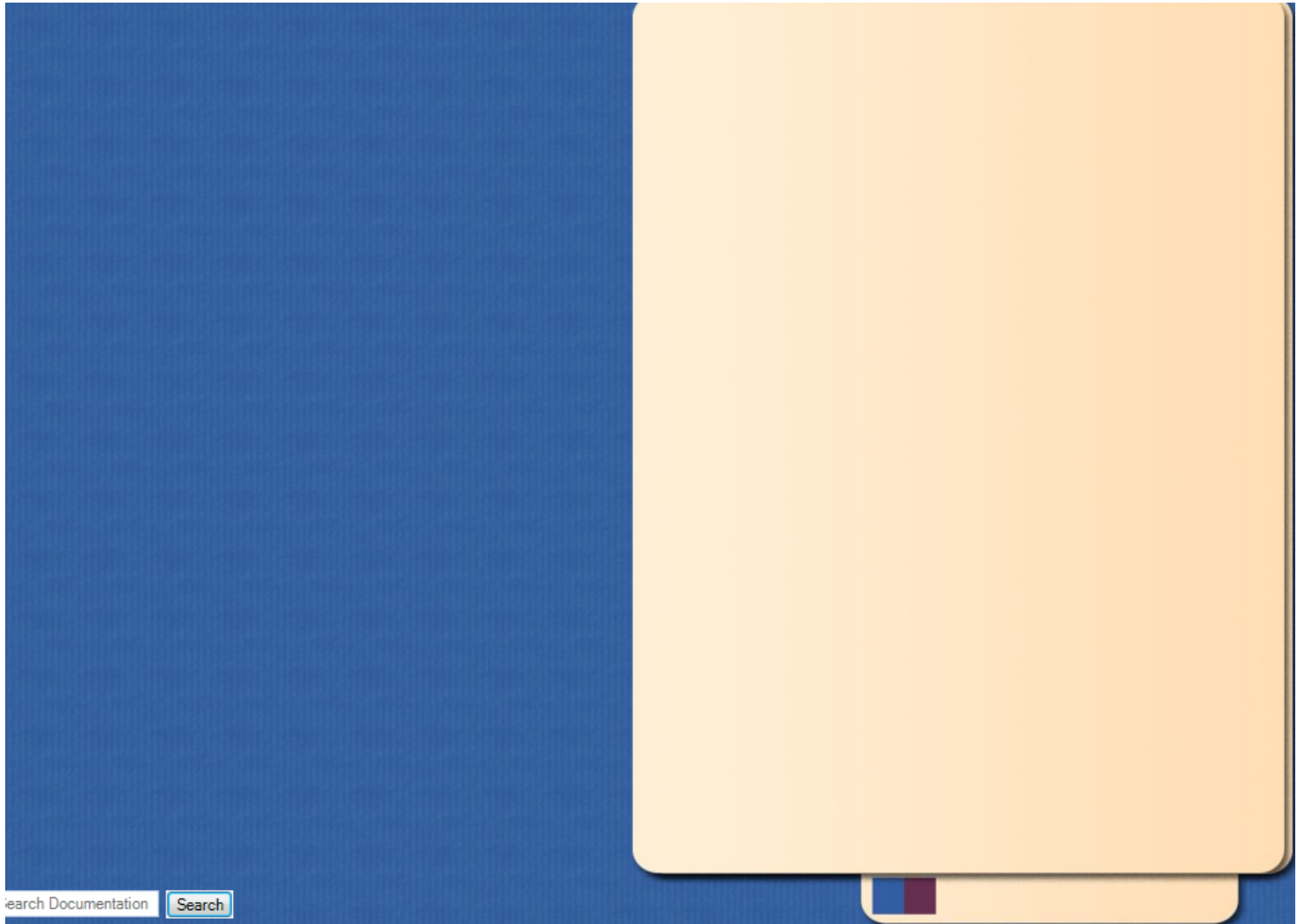


## SOAPware Workspaces

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This introductory lesson is designed to teach the user how to change workspaces when working in SOAPware.

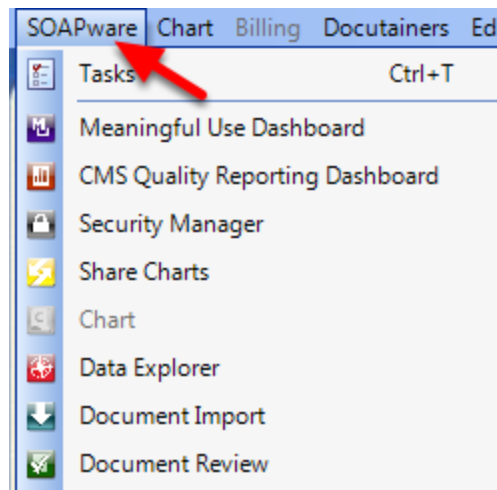
### Charts Workspace



When users first log in to SOAPware, users are in the Charts workspace.

A user knows he/she is in the chart workspace because the user will see a manila file folder.

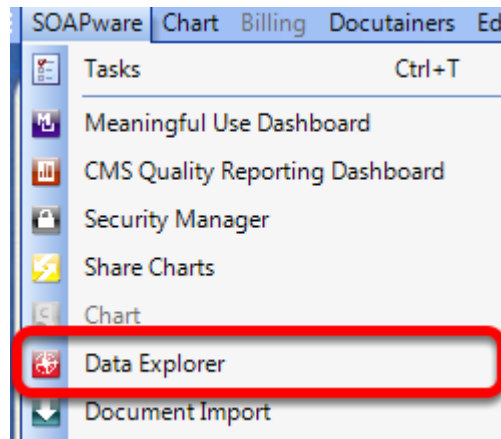
## SOAPware Menu



The SOAPware menu lists all of the available workspaces. Notice that the Chart workspace is grayed out because we are currently viewing the Chart workspace.

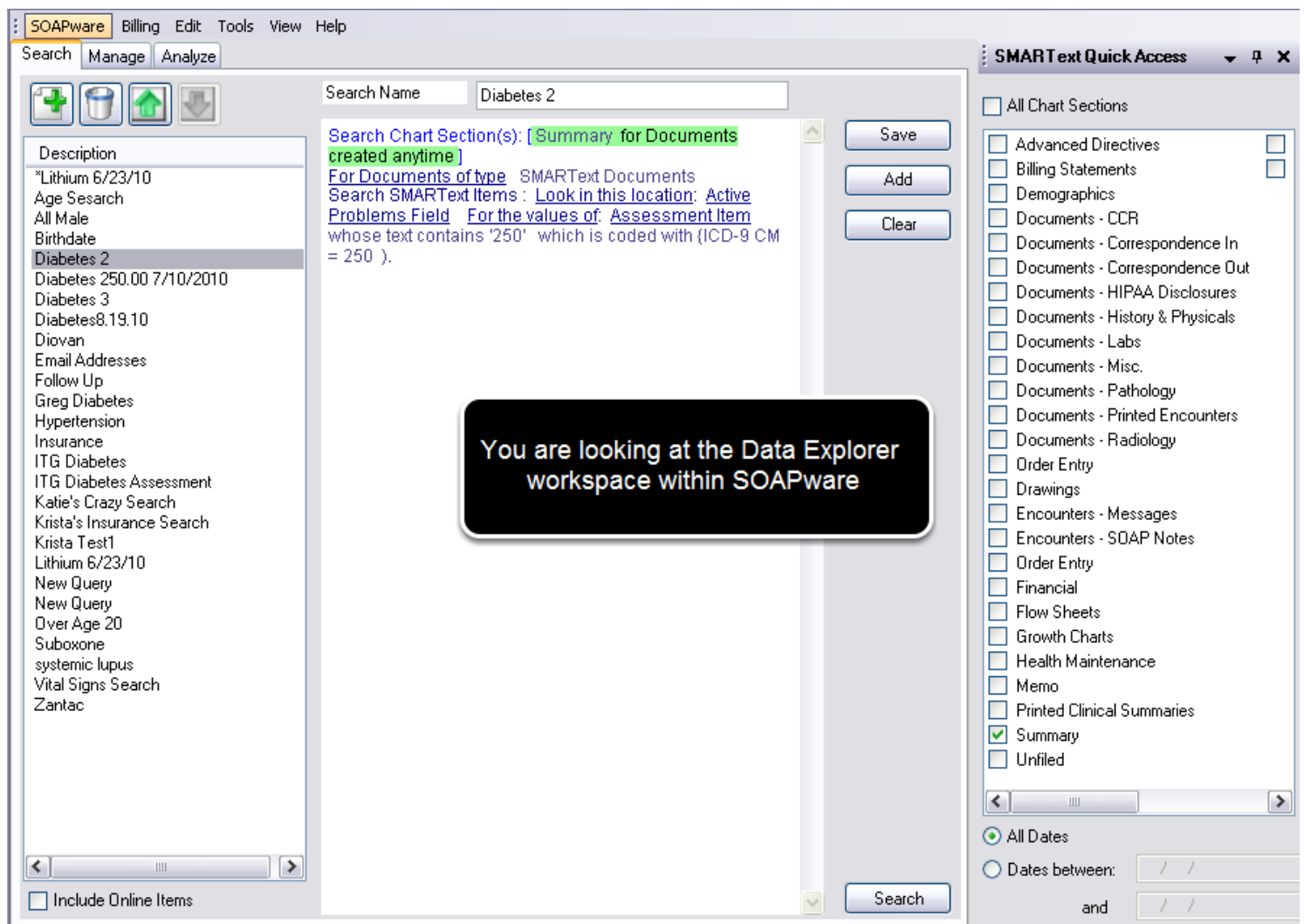
To change the workspace that the user is viewing, Click on the SOAPware menu.

## Changing Workspaces

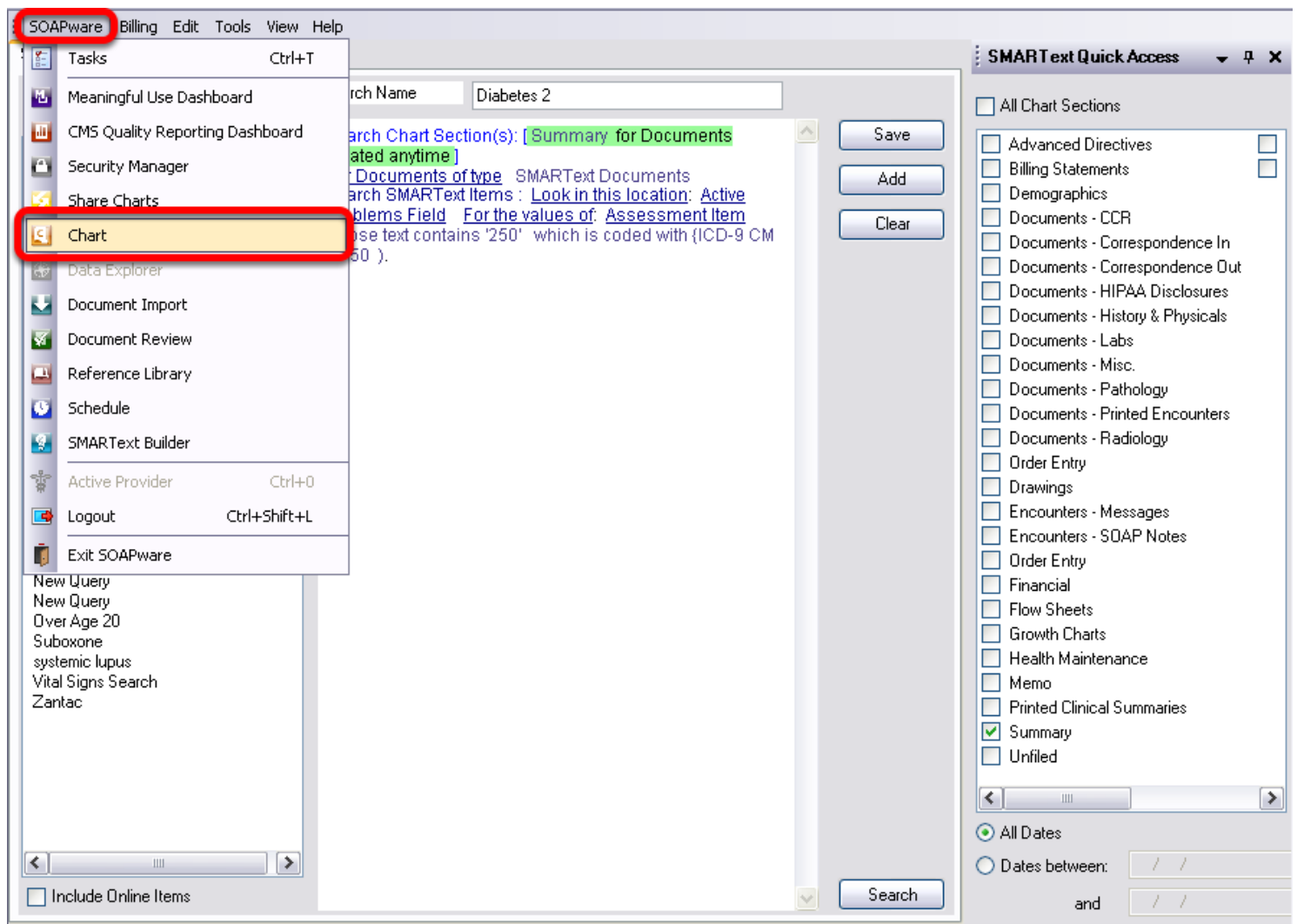


To view a different workspace, simply select the desired workspace from the SOAPware menu.

In this example, we selected Data Explorer.



The selected workspace will open.



To return to the Chart workspace, Click the SOAPware menu and select Chart.

## Understanding SOAPware Commands

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Most SOAPware commands are available via several actions:

1. Clicking a menu item
2. Clicking a button
3. Pressing combinations of keyboard keys

### Menu Buttons vs. Key Commands

Buttons exist in the toolbar and within most of the viewers. Beginners tend to prefer to click on menu items or buttons, and later tend to use more key-commands. Key-commands are often, but not always, listed to the right of menu items.

For example, Click Help in the menu bar (as in screenshot below), notice F1 is the key-command for SOAPware Help). As an example of a key-command using a combination of keys, the Chart Rack menu item is located under the Chart menu, and has a key-command of Control + Shift + C. This means that while holding-down the Control and Shift keys, pressing the C key will open the Chart Rack viewer.

### Exception Set-ups that Prevent Key-Command Actions

Note, in some set-ups where SOAPware is operating in a remote desktop, vps, Citrix meta frame, Terminal Services or thin-client situation, some of the key-commands may not function.

### The Alt Key

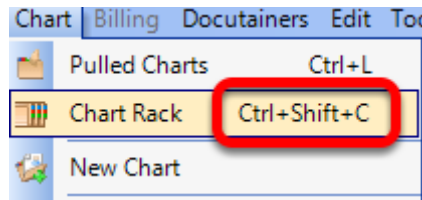
The Alt key is often used in key-commands. Most menus and menu items include an underlined letter. Pressing the Alt key and the corresponding underlined letter at the same time either opens the menu or activates a menu item. For example, in the Chart workspace, Press Alt + C. This opens the Chart menu, so that pressing k will open the Chart Rack.

## Key Commands

---

This lesson will demonstrate the steps necessary to use the Chart Rack key command.

### Access the Chart Rack



If SOAPware has a key command assigned to an item or a function within SOAPware, it will often display to the right of the menu item.

### Use the Key Command

In the screen shot above, the key command to display the Chart Rack is Ctrl + Shift + C. To use this command, press and hold down the "Ctrl" key, then press and hold down the "Shift" key, and finally press and hold the "C" key. Once the Chart Rack is open, release the keys.

**Note: Ctrl = Control Key**

## Key Commands - Reference Guide

---

This lesson will demonstrate a list of key commands within SOAPware, divided into various sections.

### General Windows Shortcuts

The General Windows Shortcut list includes:

- \* **Alt + Tab** Quickly switch between open programs.
- \* **Alt + F4** Closes the currently active program or window.
- \* **Ctrl + X** Cuts selected text.
- \* **Ctrl + C** Copies selected text.
- \* **Ctrl + V** Pastes text.
- \* **Ctrl + Z** Undo the last action performed.
- \* **Ctrl + Y** Redo is performed once the undo command has been used.

### Navigation

The Navigation list includes:

- \* **Alt + Underlined Menu letter** Drops down the selected menu from the top of the screen.  
Example: Alt + S drops down the SOAPware menu.

[ In a case where two or more menu items share the same access letter, press Alt + the letter and then enter, to access the items in the first menu, and Alt + the letter again, to access the items in the additional menu (s). ]

- \* **Ctrl + B** Open Chart Navigator.
- \* **Ctrl + Shift + C** Open Chart Rack.
- \* **Ctrl + Alt + P** Initiate the print list function within Chart Rack dialog.
- \* **Ctrl + T** Open Task List.
- \* **Ctrl + N** Create a new SOAPnote encounter in the currently opened chart.
- \* **Ctrl + Shift + L** Display/Hide the document/docutainer list under a lower splitter bar.
- \* **Ctrl + Alt + T** Transfer vital signs to the Objective field in the active SOAPnote.

### Navigation between SMARText Items

The Navigation between SMARText Items list includes:

- \* **Tab** Move to the next SMARText item.

- \* **Shift + Tab** Move to the previous SMARTText item.
- \* **Ctrl + Tab/Shift Tab** Move to the previous and next fields ( Within the Summary or the SOAPnote.)

## Date/Time

The Date/Time list includes:

- \* **Ctrl + D** Insert the current date and time in text field in the format of MM/DD/YYYY HH:MM.
- \* **Ctrl + Shift + Y** Insert current time in 24 hour military format of HH:MM.

## Task List

The Task list includes:

- \* **Ctrl + Left Arrow** Move to the next field to the left in the Task List.
- \* **Ctrl + Right Arrow** Move to the next field to the right in the Task List.
- \* **Ctrl + Alt + E** Edit the selected task.
- \* **Ctrl + Alt + N** Add a new task.
- \* **Ctrl + Alt + P** Initiate the print list function.
- \* **Ctrl + Alt + R** Delete task permanently and remove from the Task List.
- \* **Ctrl + Alt + S** Sign off the selected task and associated document in the patient's chart.
- \* **Ctrl + Alt + V** View the document associated with the currently selected task.

## Document Designer

The Document Designer list includes:

- \* **Ctrl + X** Cuts selected text.
- \* **Ctrl + C** Copies selected text.
- \* **Ctrl + V** Pastes text.

## Quick Print Key Commands

The Quick Print list includes:

- \* **Ctrl + F1**
- \* **Ctrl + F2**
- \* **Ctrl + F3**
- \* **Ctrl + F4**



These key commands can be designated to directly print a document design without having to go through the print menus. For more information, see: [Quick Print Key Commands](#)

## SMARText

The SMARText list includes:

- \* **Ctrl + Del** Clear out the contents of the active SMARText item.
- \* **F10** Display the SMARText Items Manager.

## Encounter Specific

The Encounter list includes:

- \* **Ctrl + Shift + Del** Clear out the content of the current field. (Subjective, Objective...)
- \* **Ctrl + H** When used in the Plan field, this command will insert handouts based on the diagnosis and medication prescribed. For more information, see: [Handouts](#)
- \* **Ctrl + R** Delete everything to the right of the cursor to the next period.
- \* **Ctrl + W** Inserts the word, "normal".
- \* **Ctrl + >** Open a search list for code expanders and shortcuts.
- \* **Ctrl + /** Display the field history.
- \* **Ctrl + Up Arrow** Move the cursor to the beginning of the previous section.
- \* **Ctrl + Down Arrow** Move the cursor to the beginning of the next section.
- \* **F9** Remove unused items in all docutainers actively open. (Usually used for cleaning up the Summary and SOAPnote simultaneously)
- \* **Ctrl + F9** Remove unused items in the active docutainer.
- \* **Spacebar** Used after a code expander or shortcut, to expand it. For example: typing "tyl3" and pressing the spacebar, expands to the Tylenol #3 Medication.
- \* **Ctrl + F7** Initiate Spellcheck for all documents.
- \* **F7** Initiate Spellcheck for the current document.

## Docuplate Specific

The Docuplate list includes:

- \* **Ctrl + Shift + T** Save the current docuplate information as a new docuplate.
- \* **F5** Initiate Quick Entry dialog box for easy insertion of a docuplate.
- \* **F6** Open Docuplates.
- \* **F11** Expand a code or shortcut. This command is useful if the spacebar expand command is turned off.

### Objective

The Objective list includes:

- \* **Ctrl + Shift + J** Store exam/ Copy Objective to Summary Physical - will prompt to append or replace Summary Physical with SOAPnote Objective field.
- \* **Ctrl + J** Get stored exam/ Copy Summary Physical to Objective - will prompt to replace or append SOAPnote Objective field with Summary Physical.
- \* **Ctrl + O** Enter Objective field/ Position cursor in the Objective field.
- \* **Ctrl + Shift + O** Empty Objective field/ Position cursor in the Objective field and will remove all text in the field.

### Assessment

The Assessment list includes:

- \* **Ctrl + Shift + F6** Store Assessment field -will prompt to append or replace Summary Active Problems with Assessment field.
- \* **Ctrl + F6** Get stored Assessment field - will prompt to replace or append Assessment field with Active Problems.
- \* **Ctrl + A** Enter Assessment field / Position cursor in the Assessment field.
- \* **Ctrl + Shift + A** Empty Assessment field/ Position cursor in the Assessment field and remove all text in the field.

### Medications

The Medications list includes:

- \* **Ctrl + F8** Store Rx field - will prompt to append or replace Summary Medications with SOAPnote Medications field.
- \* **Ctrl + Shift + F8** Get stored Rx field - will prompt to replace or append SOAPnote Medications field with Summary Medications field.
- \* **Ctrl + M** Enter Medications field / Position cursor in the Medications field.
- \* **Ctrl + Shift + M** Empty Medications field / Position cursor in the Medications field and removes all text in the field.

## Rx Pad Key Commands

The RxPad list includes:

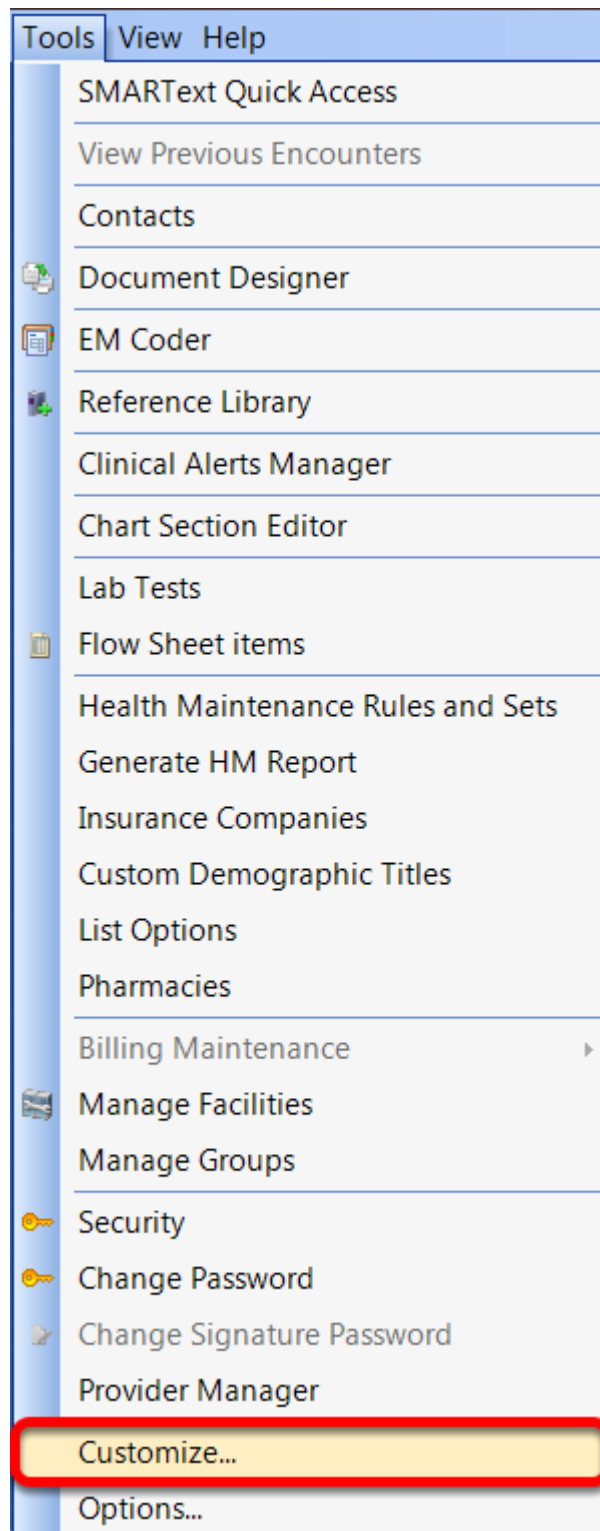
- \* **Ctrl + Alt + R**      Open "Add Rx" dialog.
- \* **Ctrl + Alt + I**      Display the "Interaction Summary" dialog.
- \* **Ctrl + Alt + P**      Activate the print command.
- \* **Ctrl + Alt + U**      Display the "Update Summary" dialog.
- \* **Ctrl + Alt + S**      Activate the "Submit" button.
- \* **Ctrl + Alt + F**      Activate the fax command.
- \* **Ctrl + Alt + E**      Place the cursor in the Eligibility field.
- \* **Ctrl + Alt + H**      Activate the Pharmacy list.

## Key-Command Customization

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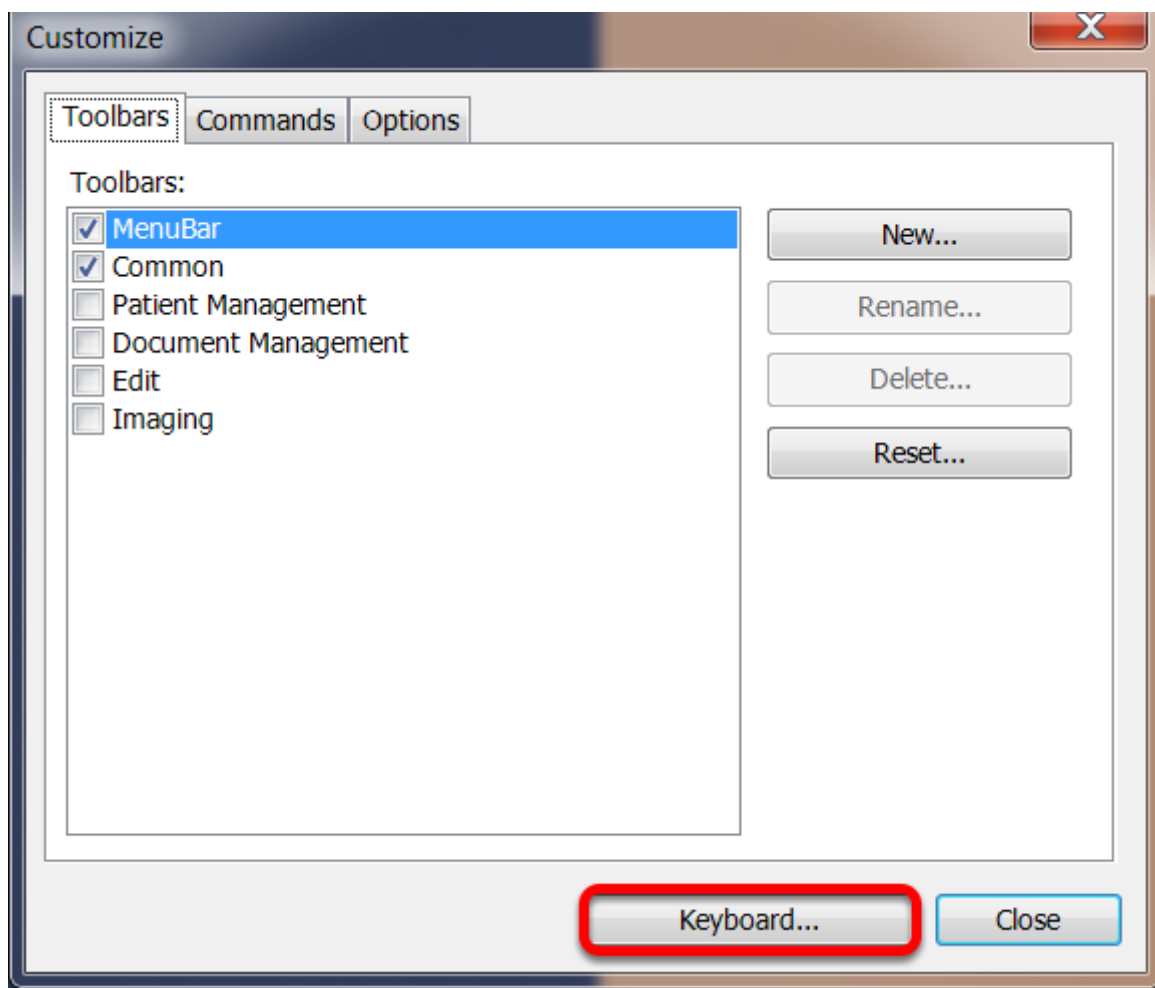
The Customize Keyboard tool allows shortcut key-command to be assigned for use within SOAPware. This can greatly increase productivity by making it faster and easier to access the SOAPware functions. Keyboard commands are user-specific in SOAPware.

## Open the Customize Window.

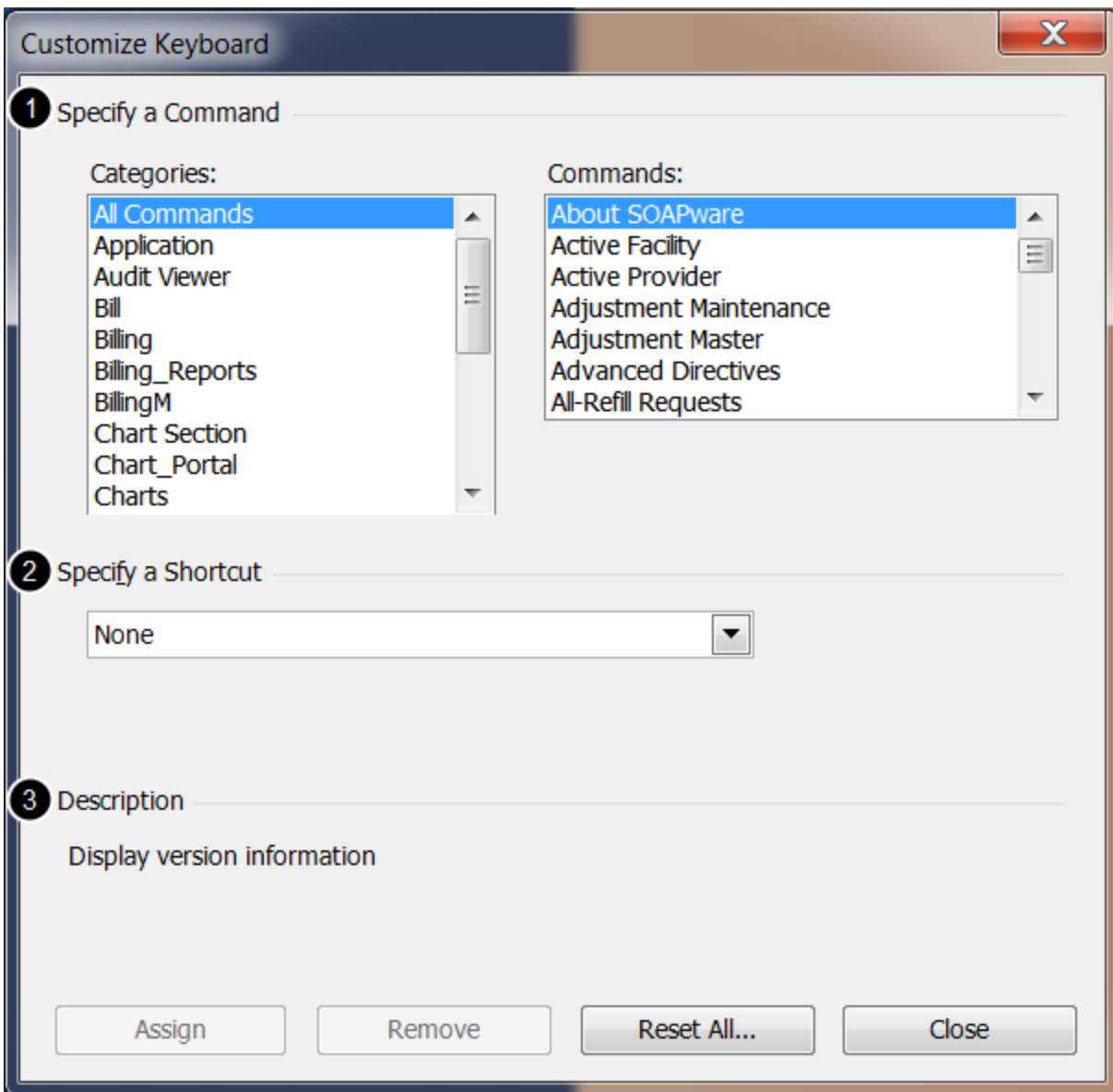


Open the Key Command Customization tool by selecting Tools > Customize.

## Select the Commands Window



Next, select the Keyboard button.



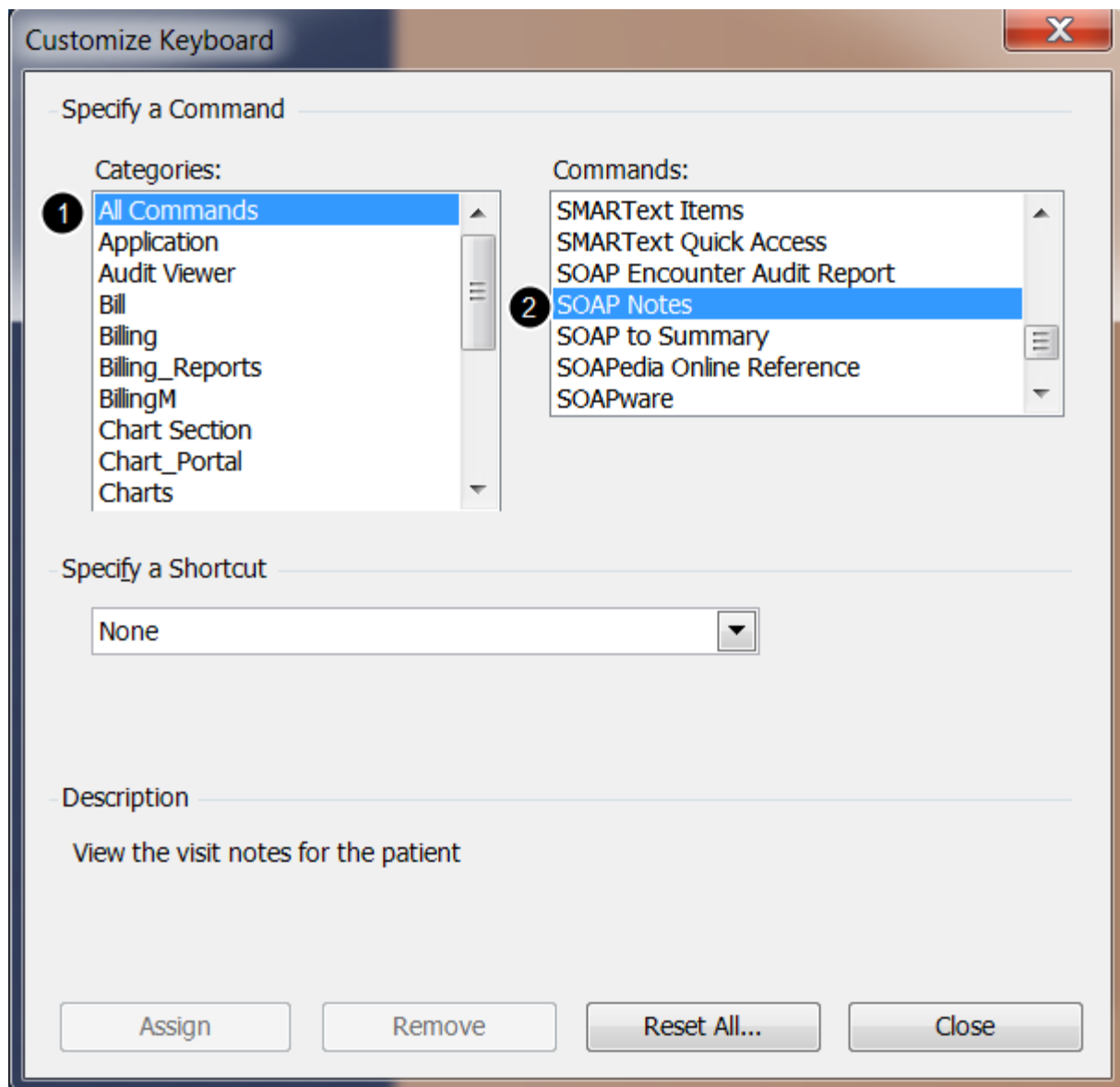
The Customize Keyboard dialog has three main areas which work together in setting-up keyboard commands.

1. The top section, Specify a Command, allows for the selection of a command to assign to a key-command shortcut.

2. The center section, Specify a Shortcut, presents a list of possible keys and key combinations to allow for selection.

3. The bottom section, Description, displays a short explanation of what the selected command does within SOAPware.

## Assigning a Keyboard Shortcut to a Command



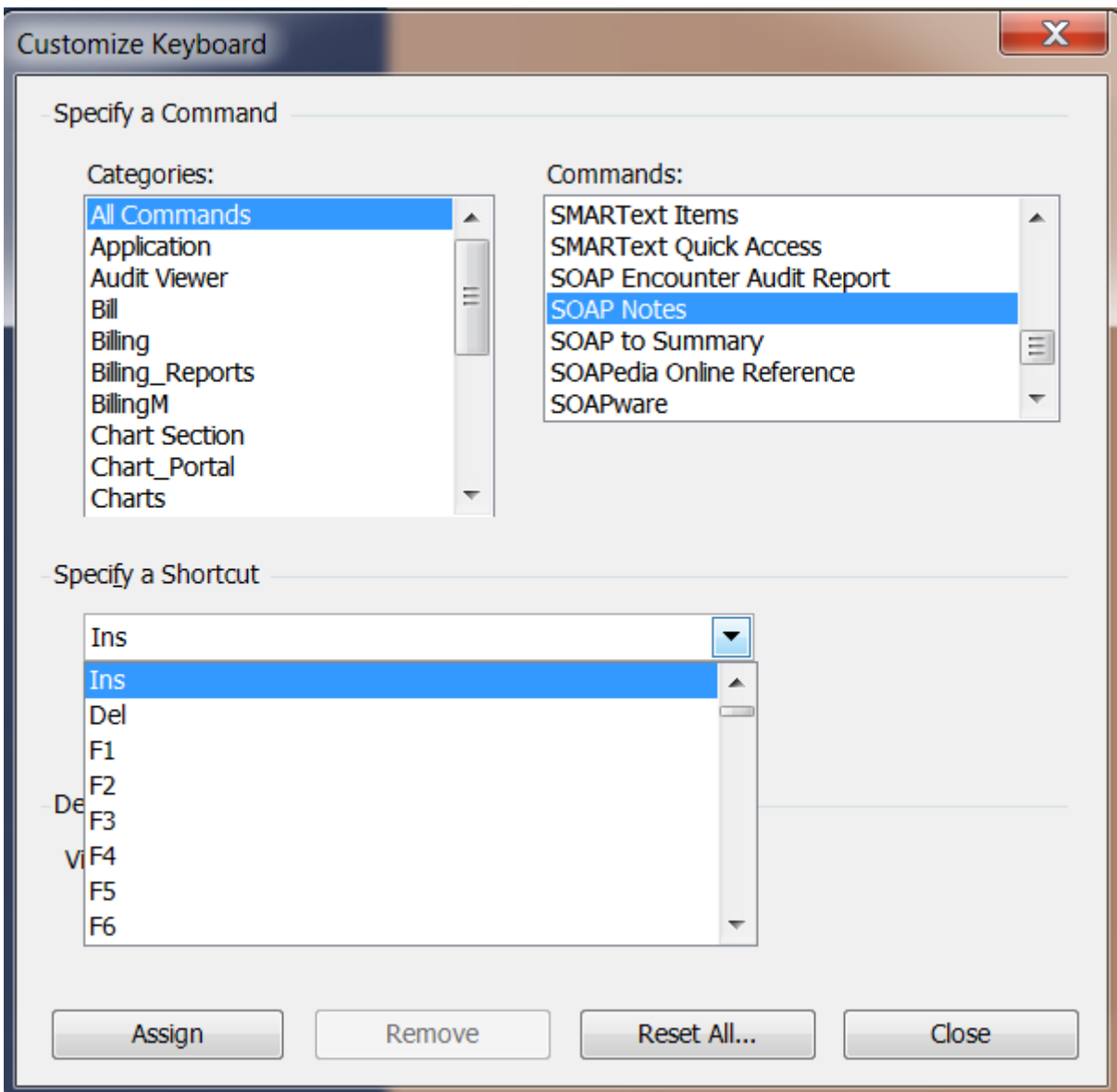
To assign a key-command shortcut to a SOAPware command:

1. Click a Categories list item,
2. Click a Commands list item.

**NOTE:** When browsing commands in the All Commands category, some commands appear to have the same name. If the Description doesn't help identify the difference between commands, try to find the command in a more specific category.



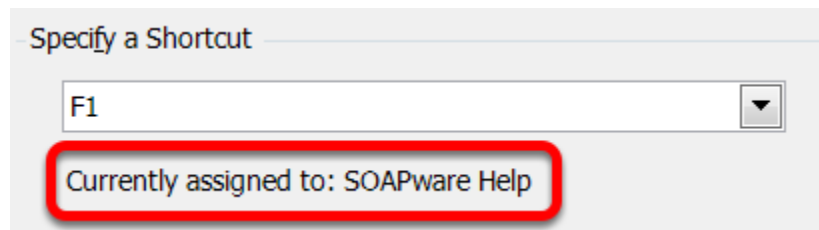
## Specify a Shortcut



Once a command is selected, click the specify a Shortcut drop down list to choose a key-command shortcut.

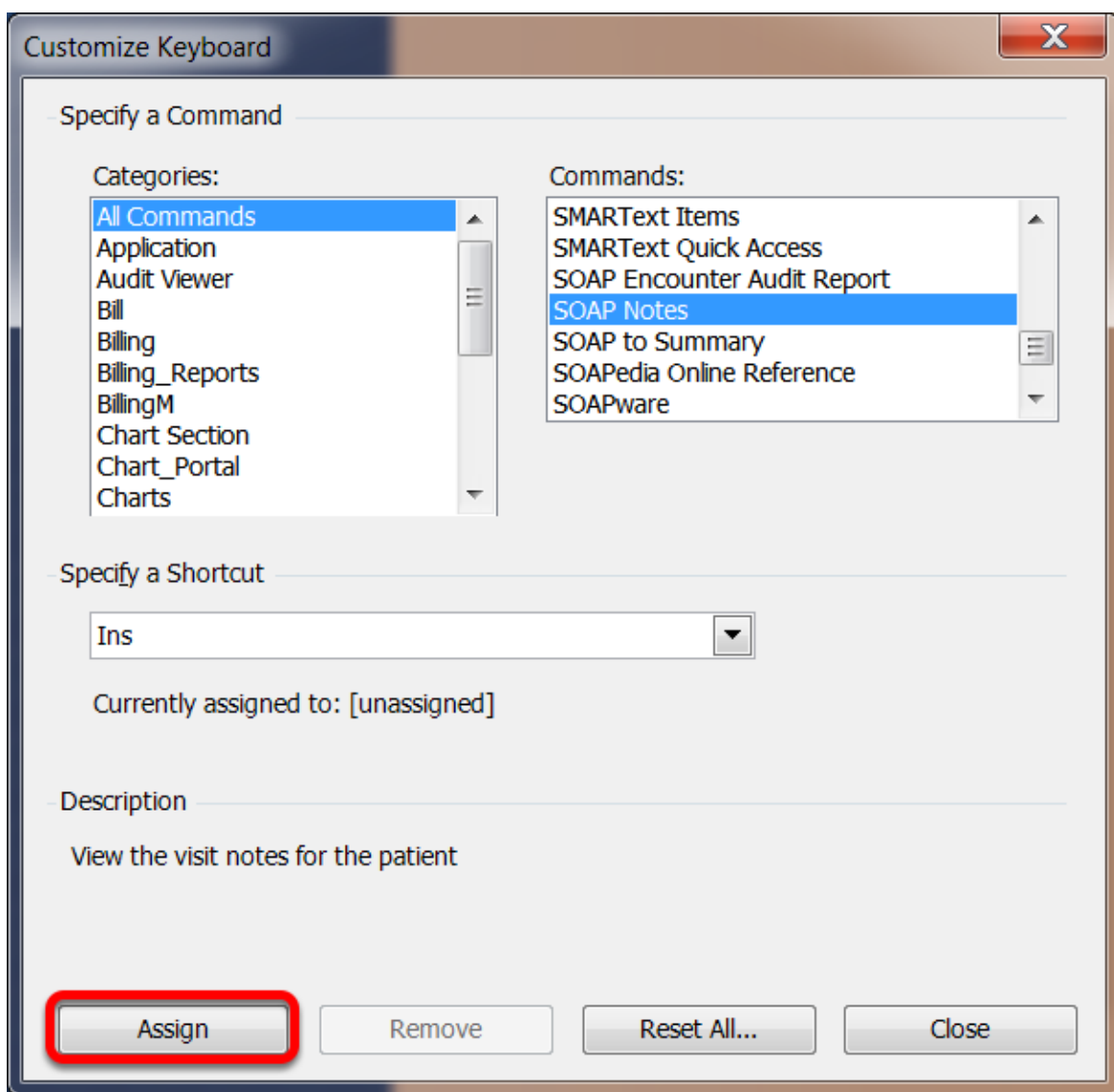
In the example above, it specifies that Pressing the Insert key causes the SOAP Notes chart section to open.

## When Shortcuts are Already Assigned



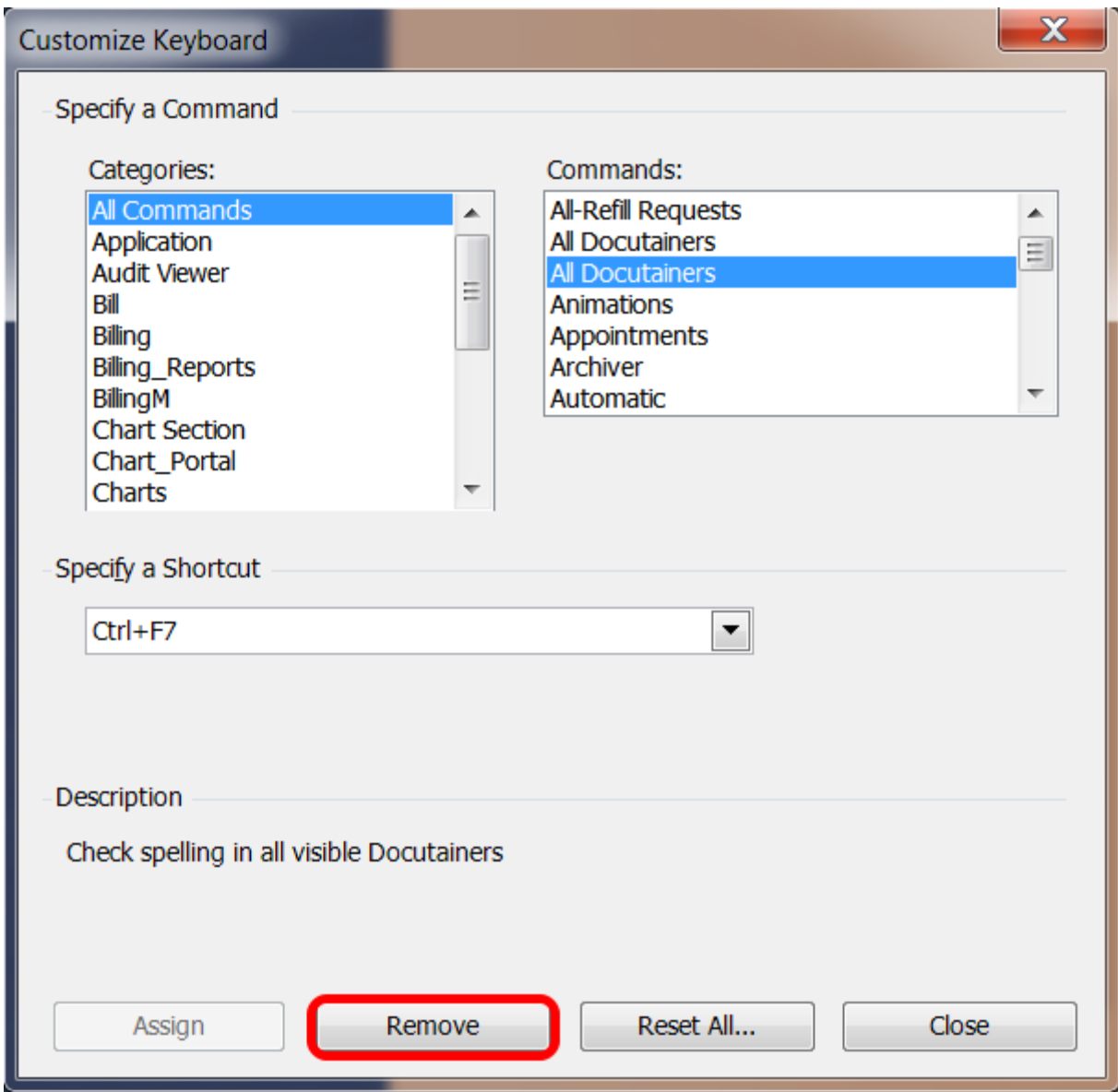
**NOTE:** If the selected keyboard shortcut is already assigned to another command, SOAPware warns by displaying a message in the Specify a Shortcut field.

## Assign



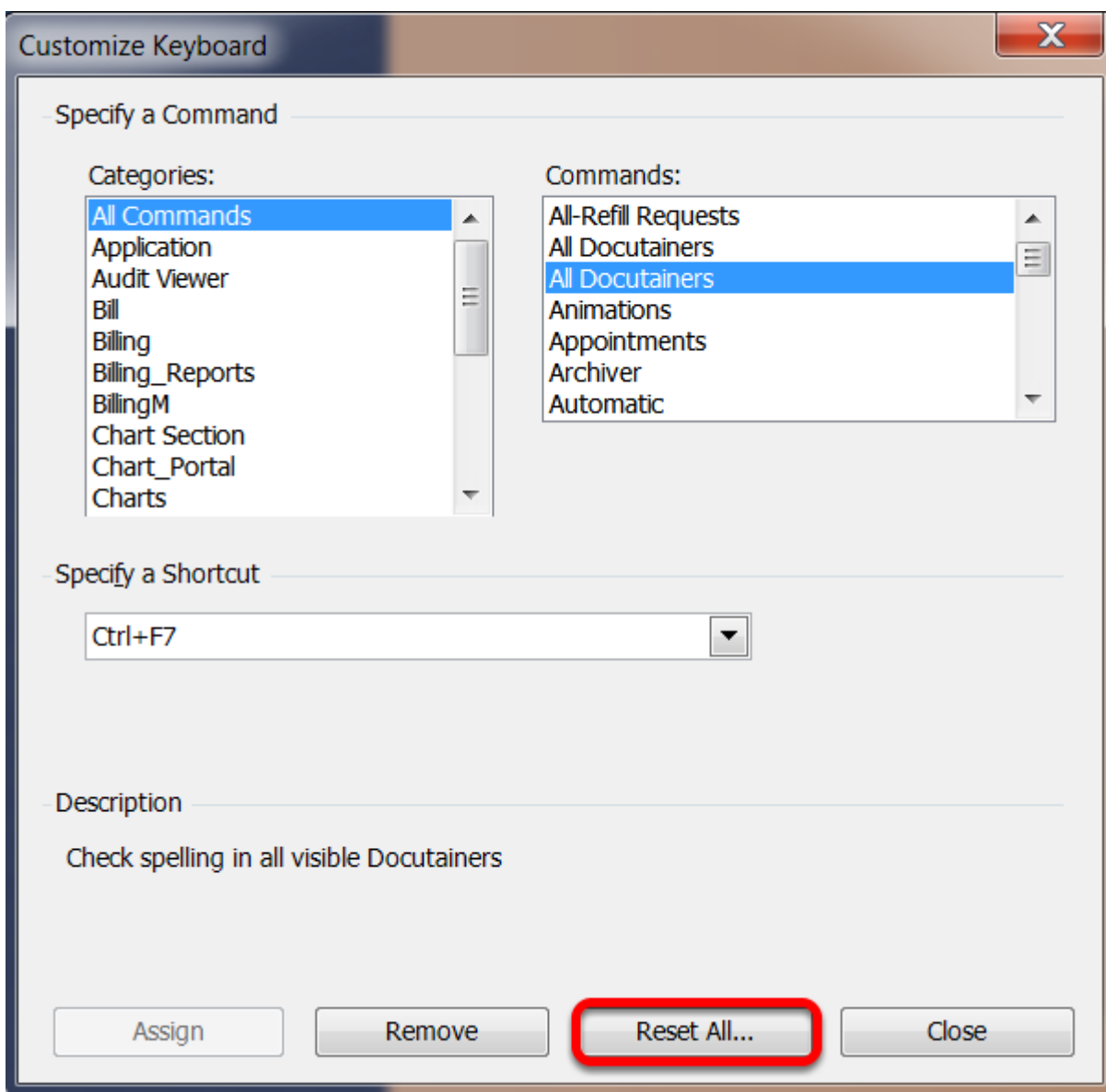
Finally, click the Assign button located at the bottom to assign the selected key-command shortcut to the specified SOAPware command.

## Removing a Keyboard Shortcut from a Command

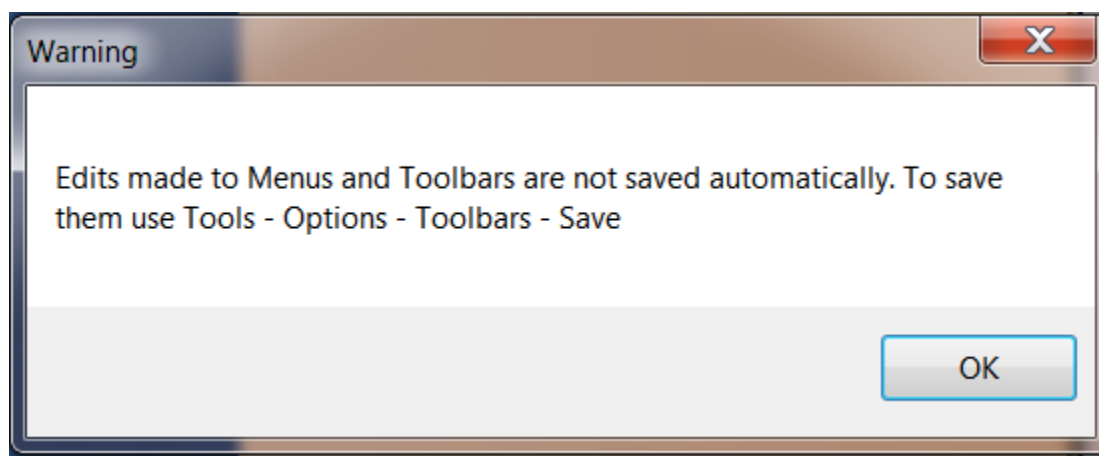


To remove a previously assigned key-command shortcut from a SOAPware command, click the Category list item, then click the command list item, and click the specified Shortcut list item to modify. Once the command is selected, click the Remove button located at the bottom. The shortcut will be removed from the selected command.

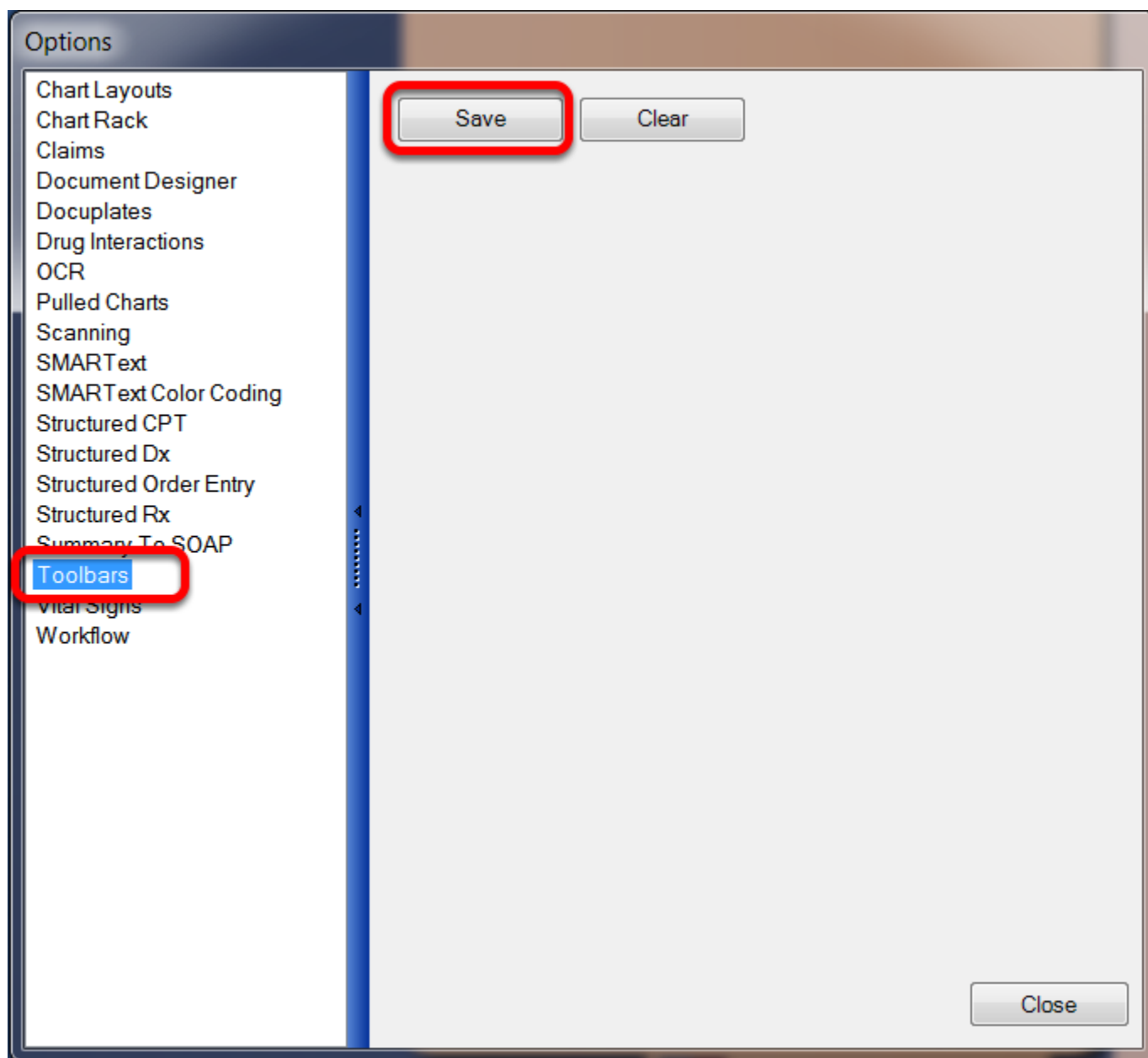
## Resetting all Keyboard Shortcuts



To reset all keyboard shortcuts to their default commands, Click the Reset All... button located at the bottom. SOAPware asks for confirmation. Click Ok to do so, and all key-command shortcuts will be reset to their defaults.



Once finished customizing Key Commands, it is necessary to save the changes manually.



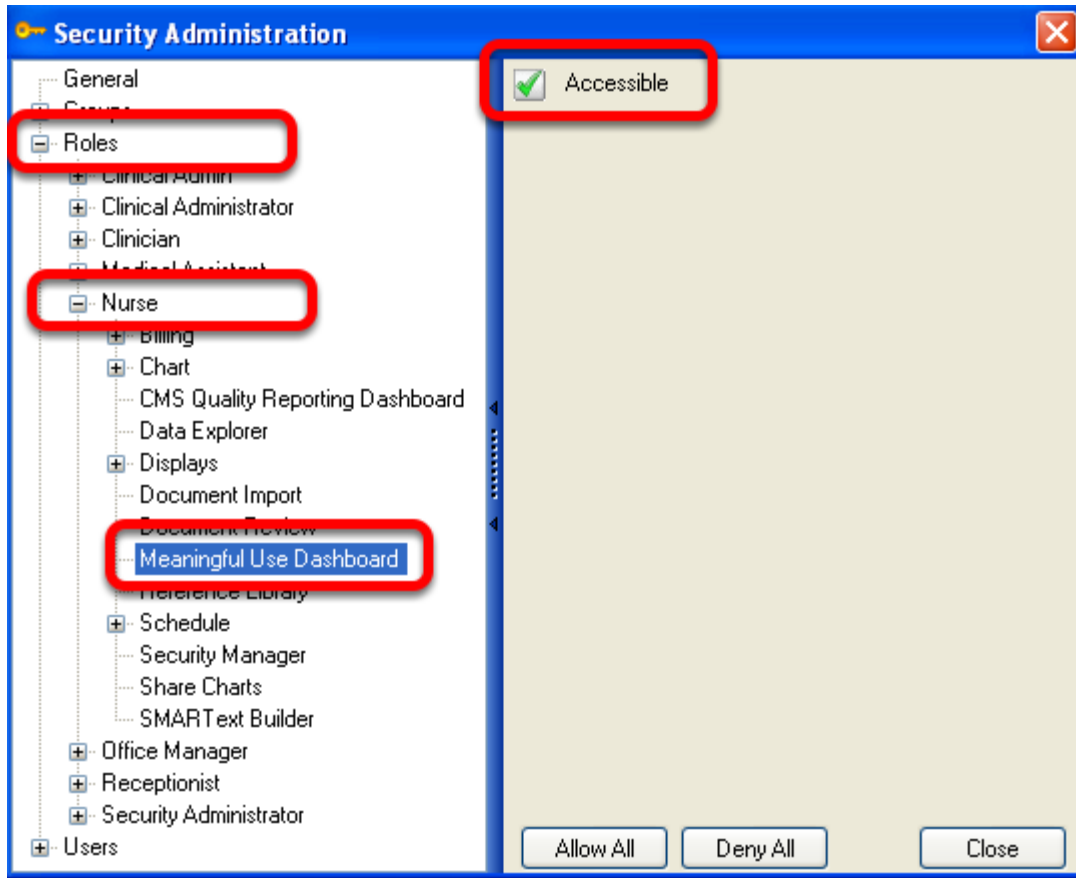
To do this, go to Tools > Options > Toolbars, and click Save. The user must log out and log back into SOAPware to save the changes.

# Meaningful Use Dashboard

## Meaningful Use Dashboard

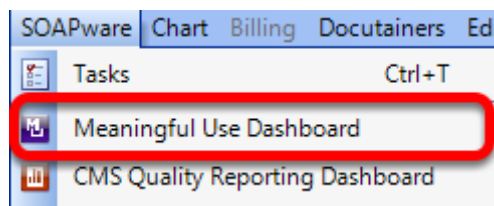
In 2011+ versions of SOAPware, providers can now view, export and trend Meaningful Use usage statistics.

### Granting Security Access for Meaningful Use Dashboard



Only a user that has administrator rights will have the ability to set up security access for users to the Meaningful Use Dashboard. [Click here](#) for instructions to Changing Security Privileges for Roles/Groups.

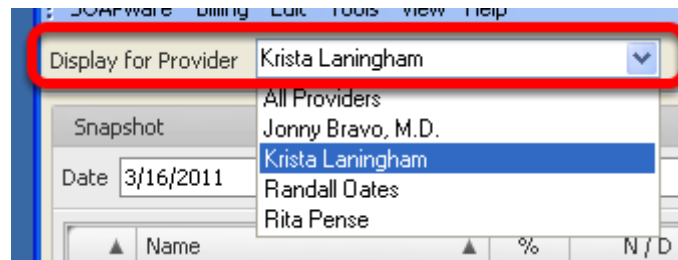
### Access the Meaningful Use Dashboard



Click on Soapware > Meaningful Use Dashboard.

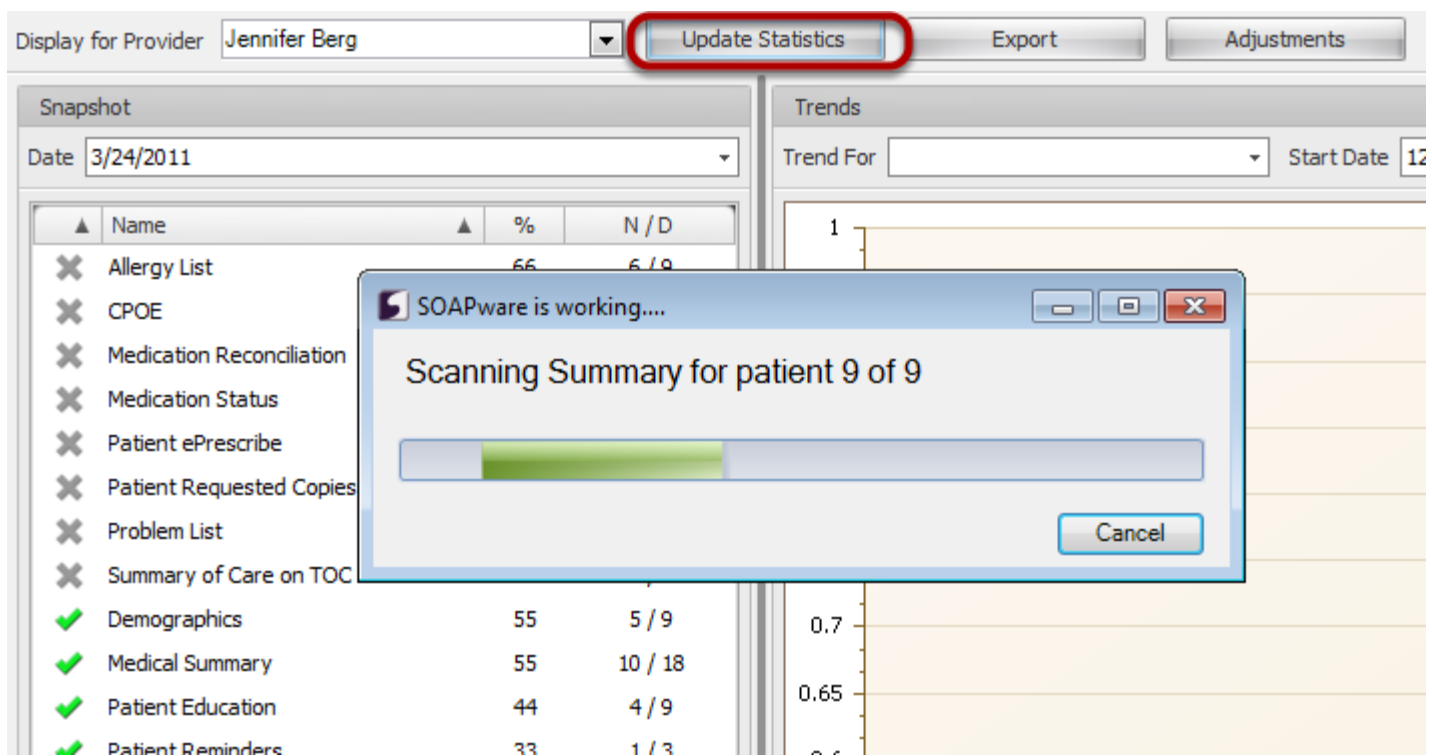


## Select a Provider



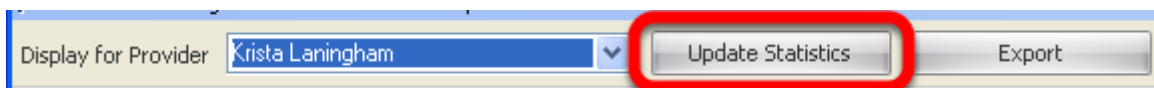
To view the Meaningful Use statistics for a provider, Click the "Display for Provider" drop-down menu and select the desired provider (or All Providers).

## Update Statistics



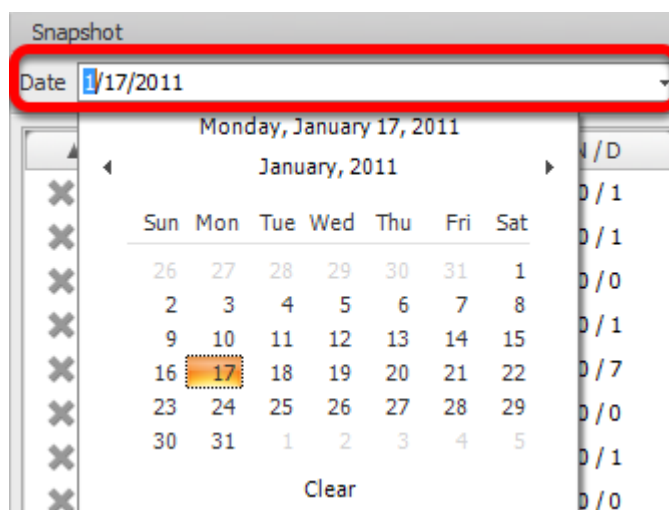
After selecting the provider, Click the "Update Statistics" button. SOAPware will scan the users encounters to report the appropriate statistics.

## Switching Providers



If a user would like to view the Meaningful Use statistics for another provider, repeat the previous step and Click the "Update Statistics" button.

## Snapshot Date



A user is able to select a snapshot date, using the drop-down menu.

**Note:** The statistics displayed, will be for the 90 days *previous* to the date selected.

## Meaningful Use Items List

Snapshot

Date 3/16/2011

MU

Name	%	N / D
✕ Allergy List	38	8 / 21
✕ CPOE	0	0 / 6
✕ Medication Status	42	9 / 21
✕ Patient Education	8	2 / 25
✕ Patient ePrescribe	0	0 / 0
✕ Patient Reminders	0	0 / 3
✕ Patient Requested Copies	0	0 / 1
✕ Problem List	47	10 / 21
✕ Smoking Status	18	3 / 16
✕ Structured Labs	0	0 / 0
✕ Timely Record Access	4	1 / 21
✕ Vital Signs	26	5 / 19
✓ Demographics	71	15 / 21
✓ Medical Summary	60	15 / 25
✓ Medication Reconciliation	100	5 / 5
✓ Summary of Care on TOC	100	1 / 1

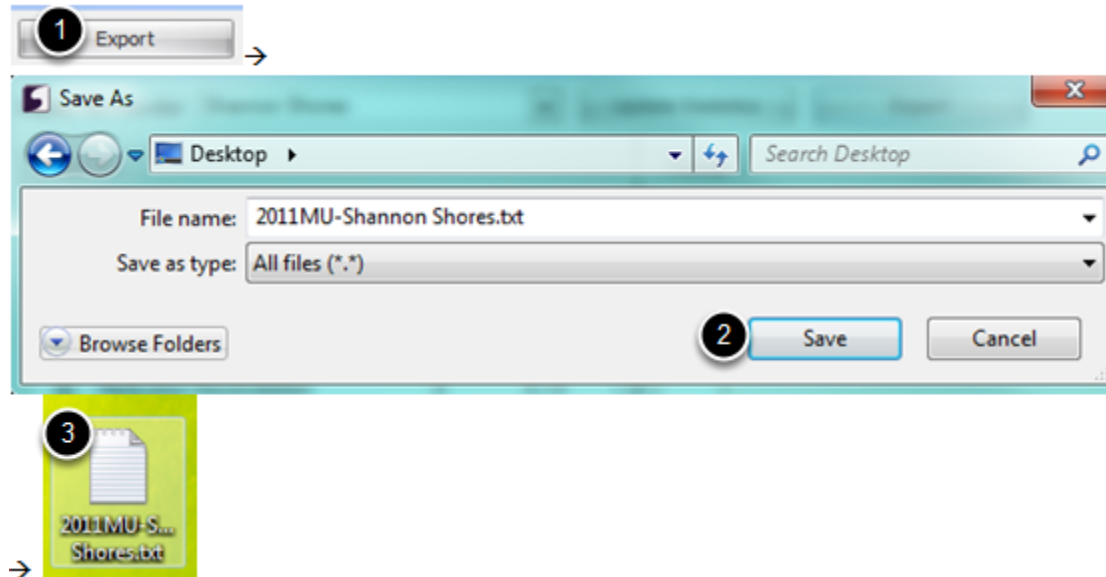
Under the snapshot date, meaningful use items will be listed.

\*A green check mark indicates that the item has met the Meaningful Use requirements.

\*Agrey 'X' indicates that the item has not met the Meaningful Use Criteria.

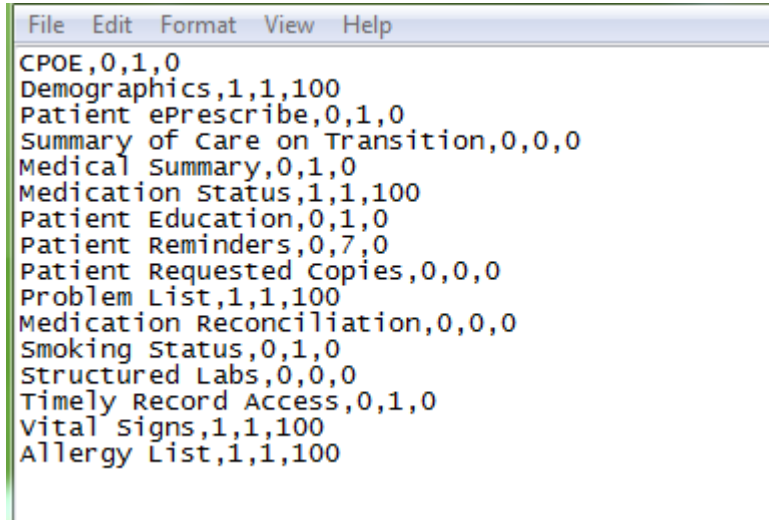
Auser is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.

## Export this Report



To export the information displayed, including the numerator, denominator, and percentage for the meaningful use items listed:

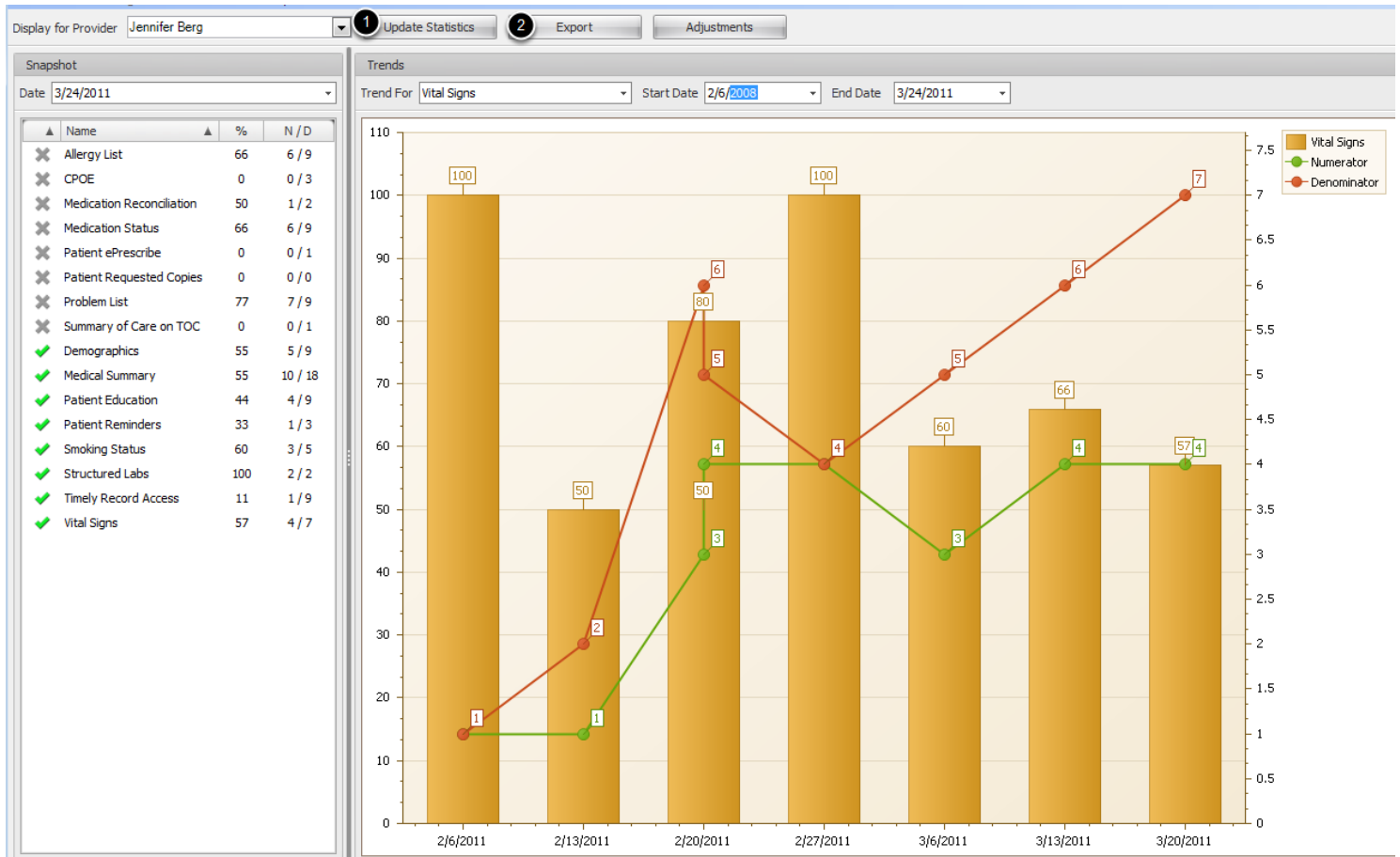
1. Click on the "Export" button, in the Meaningful Use Dashboard.
2. Select the location for the file to be exported, and Click "Save."
3. Find the file, and Double-Click to open and view the report.



```
File Edit Format View Help
CPOE,0,1,0
Demographics,1,1,100
Patient ePrescribe,0,1,0
Summary of Care on Transition,0,0,0
Medical Summary,0,1,0
Medication Status,1,1,100
Patient Education,0,1,0
Patient Reminders,0,7,0
Patient Requested Copies,0,0,0
Problem List,1,1,100
Medication Reconciliation,0,0,0
Smoking Status,0,1,0
Structured Labs,0,0,0
Timely Record Access,0,1,0
Vital signs,1,1,100
Allergy List,1,1,100
```

Each Meaningful Use requirement is listed in the exported text file, followed by the numerator, denominator, and percentage met.

## Trend Graph



The Meaningful Use Dashboard allows users to view a graph of the trend for each meaningful use requirement that is listed on the dashboard. To view the graph:

1. Click the "Trend For" drop down menu and select the desired meaningful use measure.
2. Select a Start Date and End Date for the trend.
3. The trend graph will display based upon the above selections.

### Legend:

- \* The red line represents the denominator for the measure.
- \* The green line represents the numerator for the measure.
- \* The orange bar represents the percentage met for the measure.

## Viewing Adjustments

The screenshot shows the MU dashboard for Jennifer Berg. The 'Display for Provider' dropdown is set to 'Jennifer Berg'. The 'Adjustments' button is highlighted with a red box. The 'Snapshot' section shows a table of measures with their percentages and N/D values. The 'Trends' section shows a 'Trend For' dropdown and a 'Start Date' of 2/6/2008.

Name	%	N / D
Allergy List	66	6 / 9
CPOE	0	0 / 3
Medication Reconciliation	50	1 / 2
Medication Status	66	6 / 9
Patient ePrescribe	0	0 / 1

MU dashboard will automatically calculate each MU criteria as interpreted by SOAPware Inc. In some instances providers might interpret a measure differently. Adjustments are made on the Patient MU dashboard within the Chart workspace at the point of care. The Adjustments feature gives the provider the opportunity to manually track Meaningful Use items that they feel did not calculate according to their individual interpretation at the point of care. **Adjustments made will not change the automatic calculation by SOAPware but does track adjustments and allows users to print at the time of self attestation.** Reporting Provider will be responsible for adjustments at the time of self attestation.

To View and export adjustments made at the point of care click on the Adjustments Button here. The Adjustments tab will only illuminate after a Display Provider has been selected.

## Printing Adjustments

The screenshot shows the 'Measure Adjustments: Jennifer Berg' window. It contains a table with columns: Date Time, User Name, Patient Name, Measure, Numerator, Denominator, and Notes. The 'Print' button is highlighted with a red box.

Date Time	User Name	Patient Name	Measure	Numerator	Denominator	Notes
3/24/2011	Jennifer Berg	Catipillar, Wor...	Medical Summary	50	50	Changed to 50...
3/24/2011	Jennifer Berg	Catipillar, Wor...	Patient Remin...	98	100	Printed HM re...

Adjustments will display the Date/time that the Adjustments are entered and the user that entered the adjustments. Adjustments cannot be added or deleted in the MU Dashboard Workspace. Any changes must be done in the Patient MU Dashboard at the Point of care.

To print the report Click on the Print button.

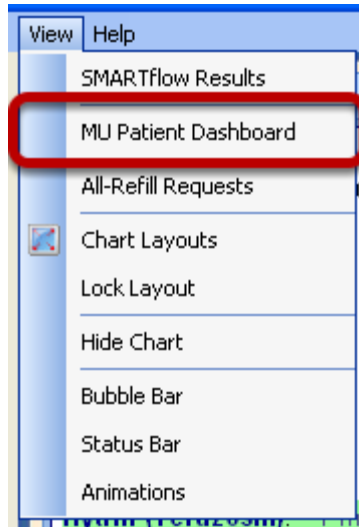
# Meaningful Use Patient Dashboard



## Patient Meaningful Use Dashboard

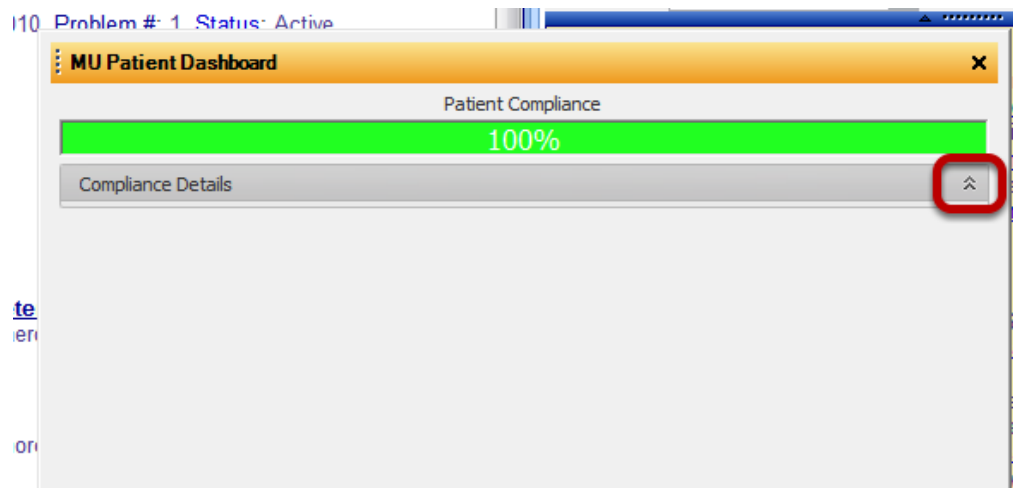
The MU Patient Dashboard is a tool used to track the compliance of an individual patient with Meaningful Use requirements as well as a location to trigger the Meaningful Use work flows. This lesson focuses on highlighting how to use the dashboard and what information is being represented for this patient.

### Opening the Dashboard



To access the MU Patient Dashboard, begin by opening the patient's chart. Then, Click on View > MU Patient Dashboard.

### Dashboard



When the dashboard first opens, the patient compliance displays, represented by a percentage. To view the individual areas of compliance, the user may need to Click on the small arrows to the right of the compliance details to drop-down the additional information.

The screenshot displays the 'MU Patient Dashboard' window. At the top, a green bar indicates 'Patient Compliance' at '100%'. Below this, a section titled 'Compliance Details' contains a list of eight items, each preceded by a green checkmark and underlined text: 'Allergy List', 'Demographics', 'Medical Summary', 'Medication Status', 'Patient Education', 'Problem List', 'Smoking Status', and 'Vital Signs'. A red circular badge with the text 'MU' is positioned over the list. At the bottom of the list, there are two unchecked checkboxes: 'Incoming Transition of Care Patient' and 'Outgoing Transition of Care Patient'. An 'Adjustments' button is located at the bottom right of the window.

Compliance Item	Status
Allergy List	✓
Demographics	✓
Medical Summary	✓
Medication Status	✓
Patient Education	✓
Problem List	✓
Smoking Status	✓
Vital Signs	✓
Incoming Transition of Care Patient	<input type="checkbox"/>
Outgoing Transition of Care Patient	<input type="checkbox"/>

The detailed list displays the areas of Meaningful Use for this patient. To record any of the necessary information, simply click on the underlined item. The above example shows a patient whom is currently meeting all of the MU Requirements.

The screenshot shows a software window titled "MU Patient Dashboard" with a close button (X) in the top right corner. Below the title bar, there is a section labeled "Patient Compliance" which contains a progress bar and the text "50%". Underneath this is a "Compliance Details" section with a dropdown arrow. This section contains a list of items, each with a status icon and a link:

- ✗ [Demographics](#)
- ✗ [Medical Summary](#)
- ✗ [Medication Status](#)
- ✗ [Patient Education](#)
- ✓ [Allergy List](#)
- ✓ [Problem List](#)
- ✓ [Smoking Status](#)
- ✓ [Vital Signs](#)

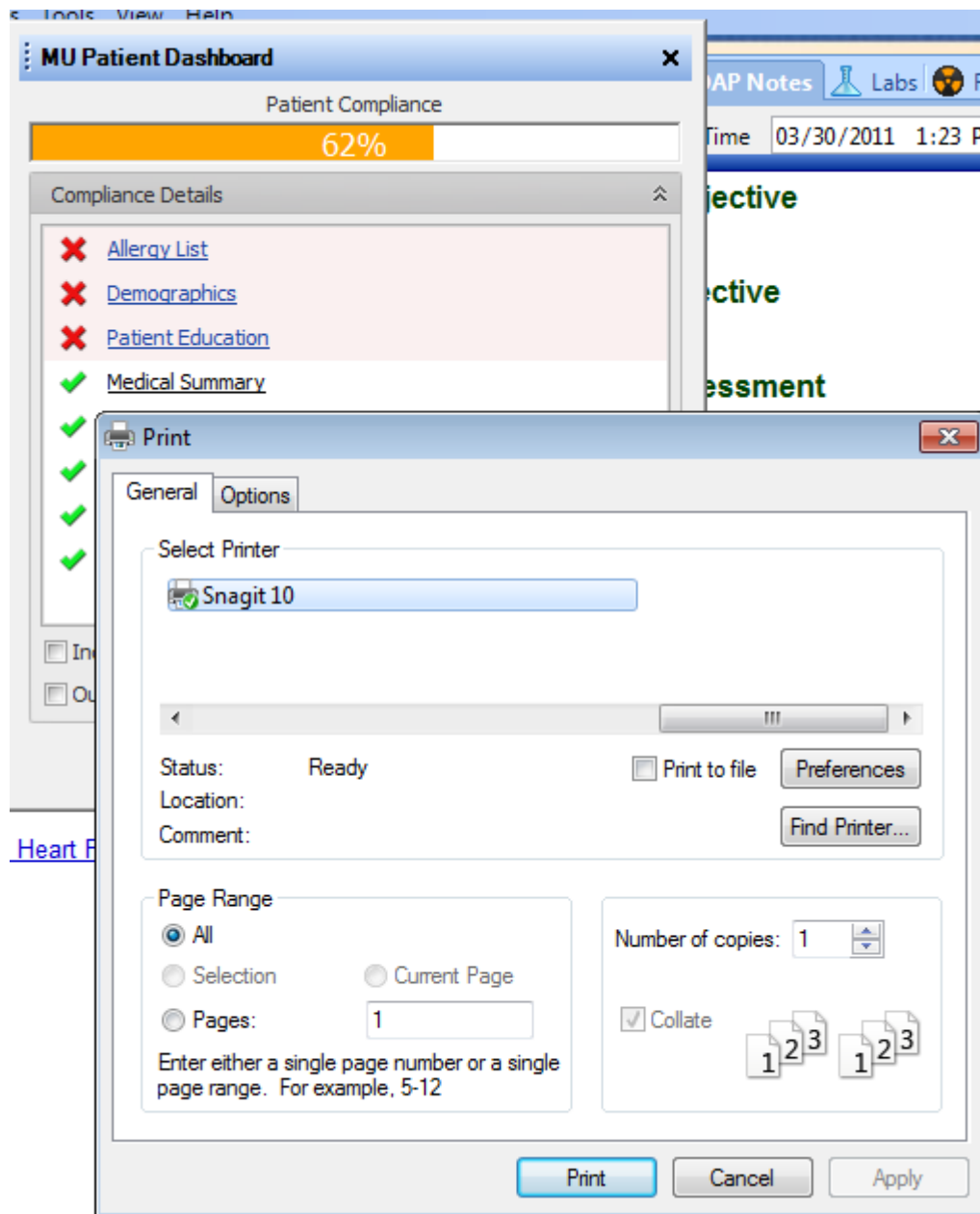
Below the list, there are two checkboxes:

- ☐ Incoming Transition of Care Patient
- ☐ Outgoing Transition of Care Patient

In the bottom right corner of the window, there is a button labeled "Adjustments".

If an area of Meaningful Use is not met for this patient, the item will be represented with a red X next to the underlined item, with a red highlight behind it. The Patient Compliance percentage will also reflect that the patient is not meeting 100% of the patient-specific Meaningful Use requirements.

## Example: Provide Medical Summary



For example, Clicking on Medical Summary opens Print Menu box to print the patient's summary information. After this information is printed, the red X next to Medical Summary will change to a green check mark .

## Incoming and Outgoing Transition of Care

**MU Patient Dashboard** [X]

Patient Compliance

40%

Compliance Details [^]

- ✗ [Demographics](#)
- ✗ [Medical Summary](#)
- ✗ [Medication Reconciliation](#)
- ✗ [Medication Status](#)
- ✗ [Patient Education](#)
- ✗ [Summary of Care on TOC](#)
- ✓ [Allergy List](#)
- ✓ [Problem List](#)
- ✓ [Smoking Status](#)
- ✓ [Vital Signs](#)

☒ Incoming Transition of Care Patient

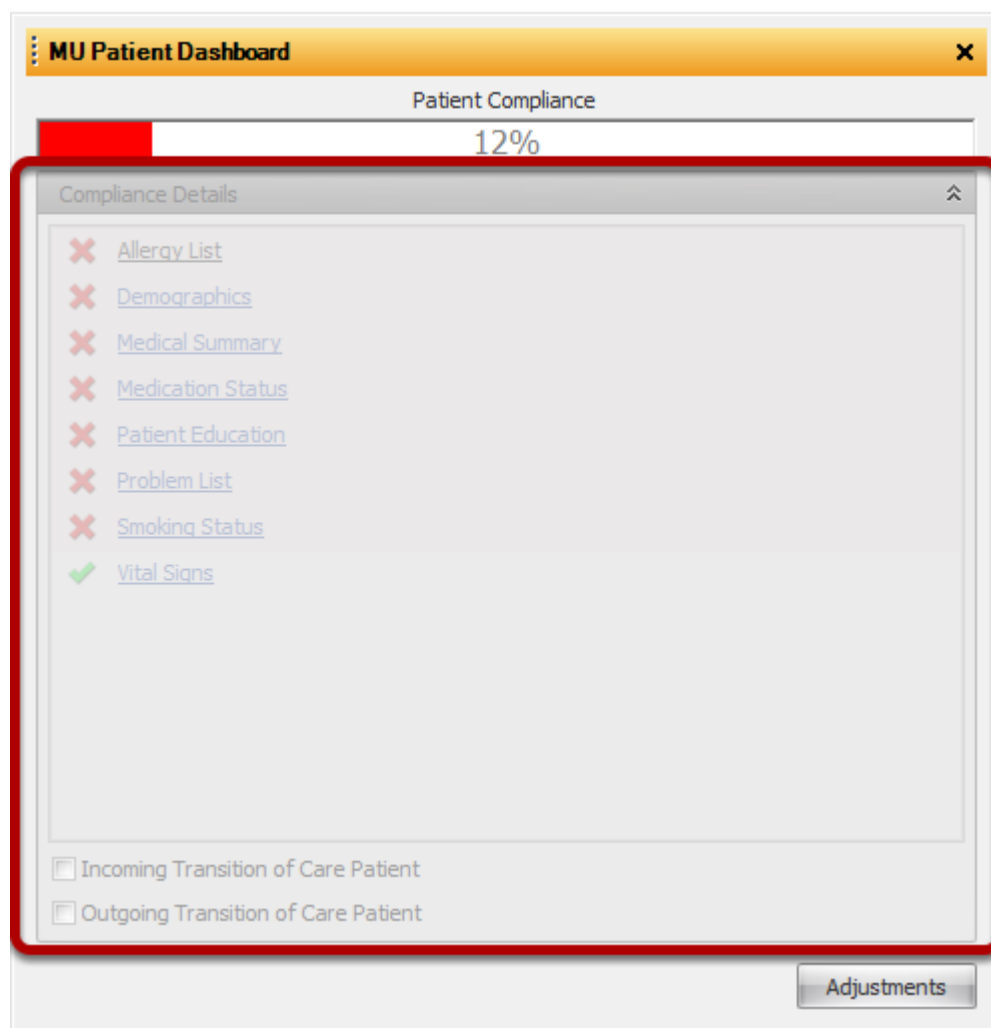
☒ Outgoing Transition of Care Patient

Adjustments

In addition, notice the Incoming and Outgoing "Transition of Care Patient" boxes at the bottom. These will both default to be unchecked, but checking each box will add additional items for "Summary of Care on TOC" and for "Medication Reconciliation" to the above list.

## Importance of the Patient MU Dashboard

The MU Patient Dashboard is important not only for tracking a patient's individual compliance with Meaningful Use, but it is also a key place to trigger some of the Meaningful Use work flows. The Incoming and/or Outgoing Transition of Care items, for instance, need to be triggered if they apply to the patient. This will ensure that the overall physician's Meaningful Use Dashboard is keeping track of the numbers and percentages correctly. SOAPware recommends using the MU Patient Dashboard for patients on a regular basis to assist the user with utilizing the software to its potential in meeting the practice's meaningful use requirements.



The MU Patient Dashboard will be grayed out if there are no SOAPnote encounters. It will also remain grayed out if the active SOAPnote encounter is signed off or if the SOAPnote encounter is a Non Face-to-Face encounter.

Adjustments may still be made even if no face to face encounter was created.

The screenshot shows the 'MU Patient Dashboard' window. At the top, it displays 'Patient Compliance' with a progress bar at 50%. Below this is a 'Compliance Details' section with a list of items: Demographics, Medical Summary, Medication Status, and Patient Education are marked with red 'X' icons, indicating they are not compliant. Allergy List, Problem List, Smoking Status, and Vital Signs are marked with green checkmarks, indicating they are compliant. At the bottom of the dashboard, there are two checkboxes: 'Incoming Transition of Care Patient' and 'Outgoing Transition of Care Patient'. A red box highlights the 'Adjustments' button in the bottom right corner.

The Patient MU dashboard will automatically calculate each MU criteria as interpreted by SOAPware Inc. In some instances providers might interpret a measure differently. The Adjustments button gives the provider the opportunity to manually track Meaningful Use items that they feel did not calculate according to their individual interpretation at the point of care. Adjustments made will not change the automatic calculation by SOAPware but does track adjustments and allows users to export at the time of self attestation. Reporting Provider will be responsible for adjustments at the time of self attestation.

User Access to this function will only be given by default to Clinical Administrators and Clinicians. User access for other roles may be granted in security.

## Entering Adjustments

Measure Adjustments: Mouse, Minnie

Date	User Name	Measure	Numerator	Denominator	Notes
03/21/2011	Jennifer Berg	Medical Summary	0	0	

Measure dropdown menu:

- Allergy List
- CPOE
- Demographics
- Medical Summary
- Medication Reconciliation
- Medication Status
- Patient Education
- x

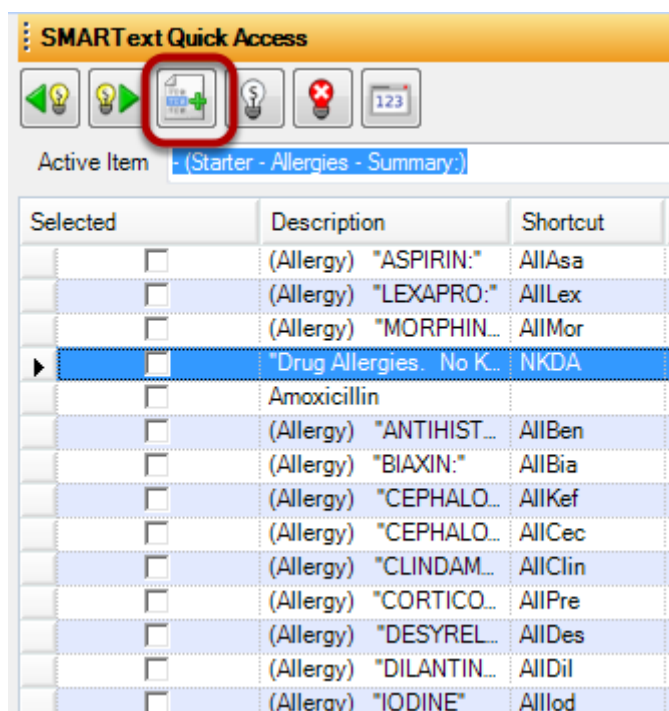
Okay

When entering an adjustment SOAPware will automatically track the date an adjustment was made and the user that entered it. Users must select which measure to adjust, then enter the Numerator and denominator.

The Notes section is to document why this adjustment is being made.

Adjustment Information entered at the point of care can be exported using the MU Dashboard workspace at the time of attestation.





Items entered using the pick list all- or via the F11/ Shift F11 Method will calculate on the Patient MU Dashboard.

**If Allergies have been added to the All- pick list using the Quick Entry Method in the SMARText Quick Access, these items when selected WILL NOT Trigger the Patient MU Dashboard.** To add allergy items to the All- Pick list this will need to be edited in the SMARText Items Manager. Allergy Items must be dragged and Dropped into this list. For instructions on Editing a SMARText Pick List [Click Here](#).

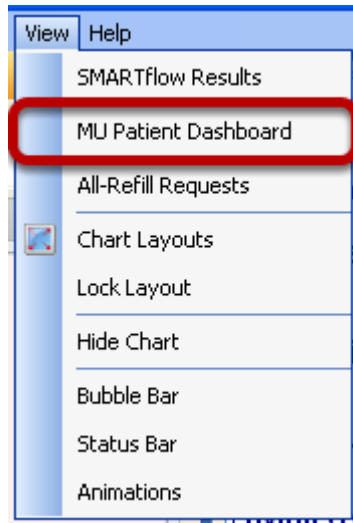
## Outgoing Transition of Care Patient - Summary of Care

---

Providers whom transition or refer their patients to another setting of care or provider of care can now provide a summary care record for each transition of care or referral.

**\*REQUIRED FOR MEANINGFUL USE (MU) OPTIONAL MENU SET (CHOOSE 5 OF 10)**  
**TRANSITION OF CARE SUMMARY-** [Click here](#) to view [Meaningful Use Criteria](#)

### Opening the MU Patient Dashboard



Click on View > MU Patient Dashboard.

**\*Note:** Make sure that a patient's chart is open and that the patient has an active encounter during the time period the analytics are being gathered.

## MU Patient Dashboard - Outgoing Transition of Care Patient

The screenshot displays the 'MU Patient Dashboard' window. At the top, the title bar reads 'MU Patient Dashboard' with a close button. Below the title bar, the 'Patient Compliance' section shows a progress bar at 44%. Underneath, the 'Compliance Details' section lists various patient data points with status indicators: 'Allergy List', 'Patient Education', 'Smoking Status', 'Summary of Care on TOC', and 'Vital Signs' are marked with red 'X' icons, while 'Demographics', 'Medical Summary', 'Medication Status', and 'Problem List' are marked with green checkmarks. At the bottom of the dashboard, there are two checkboxes: 'Incoming Transition of Care Patient' (unchecked) and 'Outgoing Transition of Care Patient' (checked). The 'Outgoing Transition of Care Patient' checkbox is highlighted with a red rectangular border.

At the bottom of the MU Patient Dashboard, Click in the box next to "Outgoing Transition of Care Patient" to indicate that this patient is being transitioned or referred to another setting of care or provider of care.

## Printing a Transition of Care (TOC) Summary

The screenshot shows the 'MU Patient Dashboard' window. At the top, there's a 'Patient Compliance' section with a progress bar and the value '44%'. Below this is a 'Compliance Details' section with a list of items. The first five items are marked with a red 'X' and are underlined: 'Allergy List', 'Patient Education', 'Smoking Status', 'Summary of Care on TOC', and 'Vital Signs'. The last four items are marked with a green checkmark and are underlined: 'Demographics', 'Medical Summary', 'Medication Status', and 'Problem List'. At the bottom of the dashboard, there are two checkboxes: 'Incoming Transition of Care Patient' (unchecked) and 'Outgoing Transition of Care Patient' (checked). The 'Summary of Care on TOC' item is highlighted with a red rectangular box.

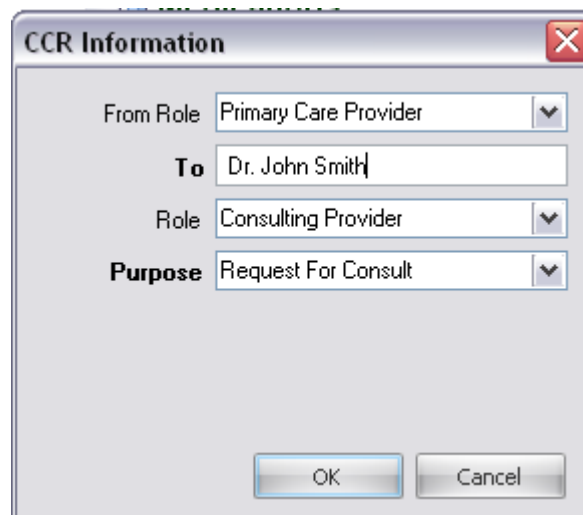
After checking the "Outgoing Transition of Care Patient" box, a new item will appear in the MU Patient Dashboard. Click on the words "Summary of Care on TOC."

## Printing a TOC Summary: Verification Prompt

The screenshot shows a 'SOAPware' dialog box with a question mark icon. The text inside the dialog box asks: 'Will a Summary of Care be provided to the receiving facility?'. At the bottom of the dialog box, there are two buttons: 'Yes' and 'No'. The 'Yes' button is highlighted with a red rectangular box.

Click "Yes" to indicate that a Transition of Care Summary is being provided to the receiving facility.

## Printing a TOC Summary: CCR Information



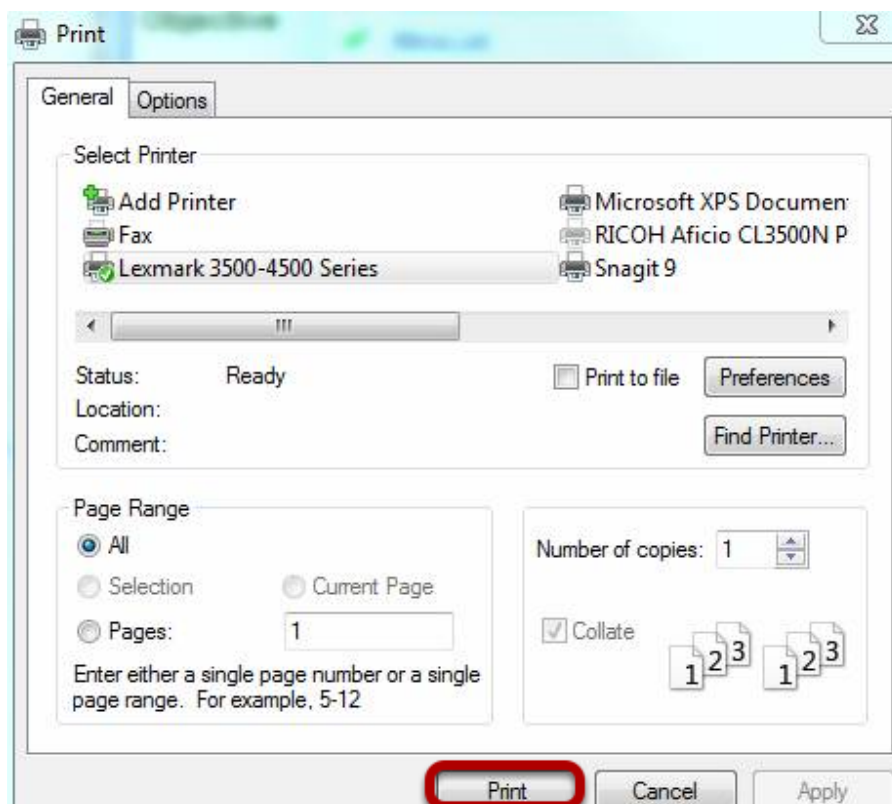
The CCR Information dialog box contains the following fields:

- From Role:** Primary Care Provider (dropdown menu)
- To:** Dr. John Smith (text field)
- Role:** Consulting Provider (dropdown menu)
- Purpose:** Request For Consult (dropdown menu)
- Buttons:** OK, Cancel

Using the drop-down menu options, fill out the appropriate information.

Click OK when finished.

## Printing a TOC Summary: Print Dialog



The Print dialog box shows the following settings:

- General tab:** Selected printer is Lexmark 3500-4500 Series.
- Status:** Ready
- Location:**
- Comment:**
- Page Range:** All (radio button selected), Selection, Current Page, Pages: 1
- Number of copies:** 1
- Collate:** Checked (checkbox)
- Buttons:** Print (highlighted with a red circle), Cancel, Apply

Select the desired printer and Click the "Print" button to print the patient's TOC summary in CCR format.

## Providing the Summary Care Record to the Next Provider

For more information and requirements on providing the summary care record to the next provider, please refer to the CMS guidelines in the following reference document: see, [CMS Transition of Care Summary](#). Please review this document, as well as the Additional Information section of the document for further explanation.

## TOC Summary: CCR Format

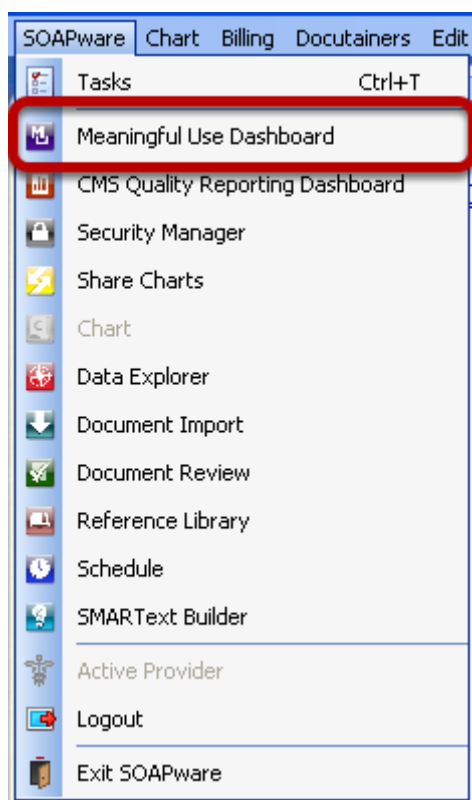
### File Information

Date Created	From	To	Purpose
Wed Jul 13, 2011 at 07:54 PM UTC	Krista Laningham (Primary Care Provider)	Dr. John Smith (Consulting Provider)	Request For Consult

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Slim A. Jim	Mar 21, 2006	Male	MRN 68332	Home Address	Home Phone
			SSN 999999999	1539 COUNTY LINE RD Home Town, AR72711	Work Phone
					5015557110
					5015559000

Above is an example of the beginning of the printed TOC Summary in CCR format.



To review a provider's statistics for Outgoing Transition of Care Summary, Click on the SOAPware menu > Meaningful Use Dashboard.

## Meaningful Use Dashboard - Outgoing Transition of Care Summary

Display for Provider Shannon Shores 1

Snapshot

Date 1/27/2011 2

	Name	%	N / D
✕	Allergy List	0	0 / 0
✕	CPOE	0	0 / 0
✕	Demographics	0	0 / 0
✕	Medical Summary	0	0 / 0
✕	Medication Status	0	0 / 0
✕	Patient Education	0	0 / 0
✕	Patient ePrescribe	0	0 / 1
✕	Patient Reminders	0	0 / 7
✕	Patient Requested Copies	0	0 / 0
✕	Problem List	0	0 / 0
✕	Smoking Status	0	0 / 0
✕	Structured Labs	0	0 / 0
✕	Timely Record Access	0	0 / 0
✕	Vital Signs	0	0 / 0
✓	Medication Reconciliation	75	3 / 4
✓	Summary of Care on TOC	100	5 / 5

1. Select a provider.

2. Select a "snapshot" date. (**Note:** the statistics displayed will be for the 90 days *previous* to the date selected.)

A green check mark indicates that the item has met the Meaningful Use requirements. A gray X means that the meaningful use requirement has not yet been met.

A user is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.



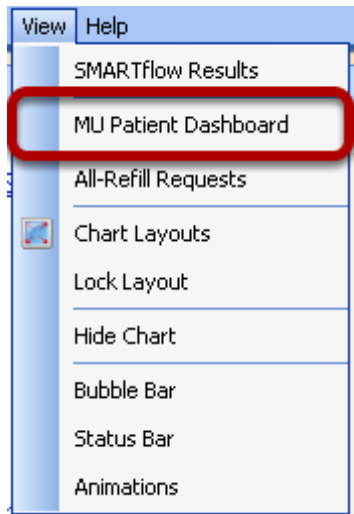
## Incoming Transition of Care Patient - Medication Reconciliation

---

This lesson will demonstrate the steps necessary to meet the Meaningful Use requirement for Medication Reconciliation. When the eligible provider receives a patient from another setting or provider of care, they should reconcile the patient's medications list.

**\*REQUIRED FOR MEANINGFUL USE (MU) OPTIONAL MENU SET (CHOOSE 5 OF 10)**  
**MEDICATION RECONCILIATION** - [Click here to view Meaningful Use Criteria.](#)

### Opening the MU Patient Dashboard



Click View > MU Patient Dashboard.

**\*Note:** Make sure that a patient's chart is open and that the patient has an active encounter during the time period the analytics are being gathered.

## MU Patient Dashboard - Incoming Transition of Care Patient

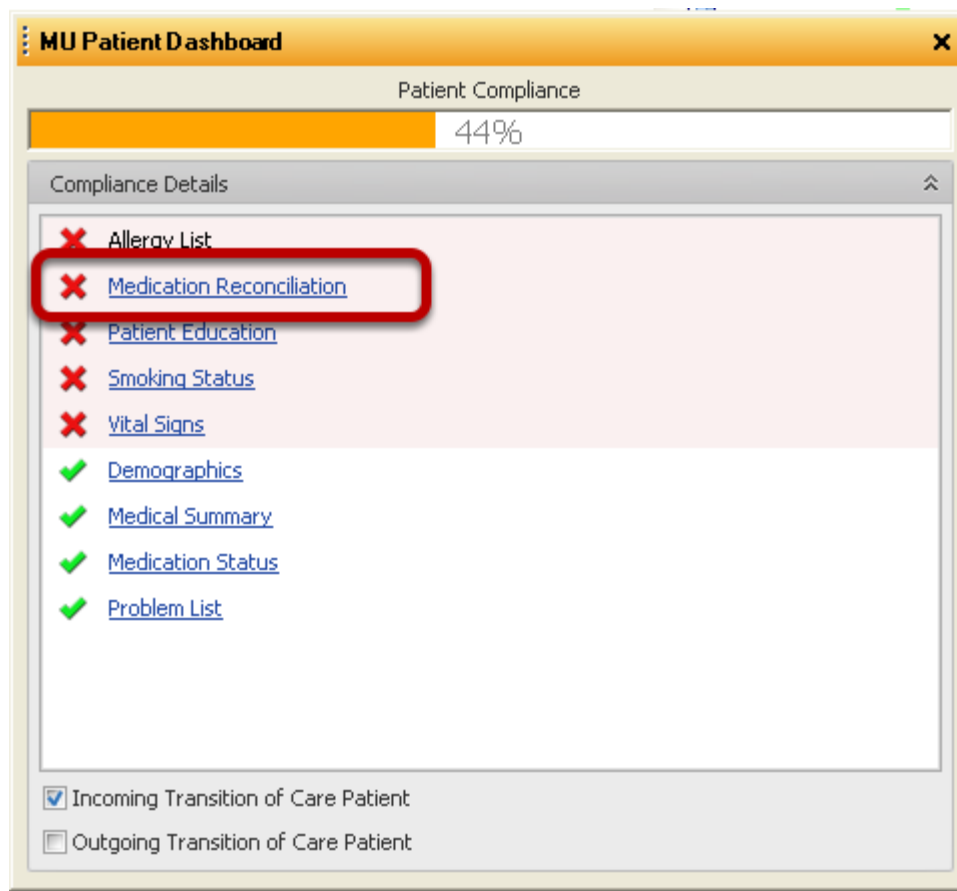
The screenshot shows the 'MU Patient Dashboard' window. At the top, there's a title bar with 'MU Patient Dashboard' and a close button. Below it, a 'Patient Compliance' section shows a progress bar at 44%. Underneath is a 'Compliance Details' section with a list of items, each preceded by a red 'X' or a green checkmark. The items are: Allergy List, Medication Reconciliation, Patient Education, Smoking Status, Vital Signs, Demographics, Medical Summary, Medication Status, and Problem List. At the bottom of the dashboard, there are two checkboxes: 'Incoming Transition of Care Patient' (which is checked and highlighted with a red box) and 'Outgoing Transition of Care Patient' (which is unchecked).

Item	Status
Allergy List	Not Completed (X)
Medication Reconciliation	Not Completed (X)
Patient Education	Not Completed (X)
Smoking Status	Not Completed (X)
Vital Signs	Not Completed (X)
Demographics	Completed (Checkmark)
Medical Summary	Completed (Checkmark)
Medication Status	Completed (Checkmark)
Problem List	Completed (Checkmark)

☒ Incoming Transition of Care Patient  
☐ Outgoing Transition of Care Patient

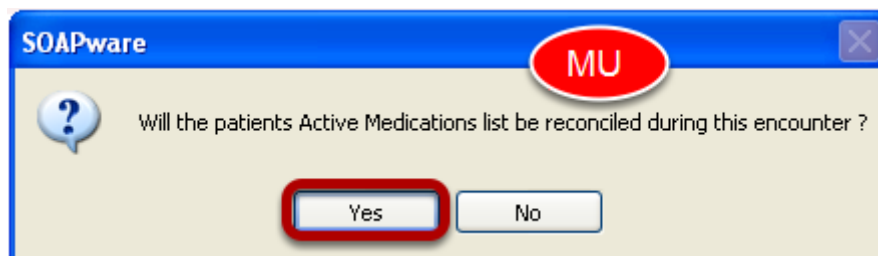
At the bottom of the MU Patient Dashboard, Click in the box next to "Incoming Transition of Care Patient" to indicate that this patient is being received from another setting or provider of care.

## Indication that Medication Reconciliation has Been Performed



After checking the "Incoming Transition of Care Patient" box, a new item will appear in the MU Patient Dashboard. Click on the words "Medication Reconciliation".

## Medication Reconciliation Prompts



Click "Yes" to indicate that the active medications list will be reconciled during the encounter.

## Confirmation within the MU Patient Dashboard

**MU Patient Dashboard** [X]

Patient Compliance

56%

Compliance Details [^]

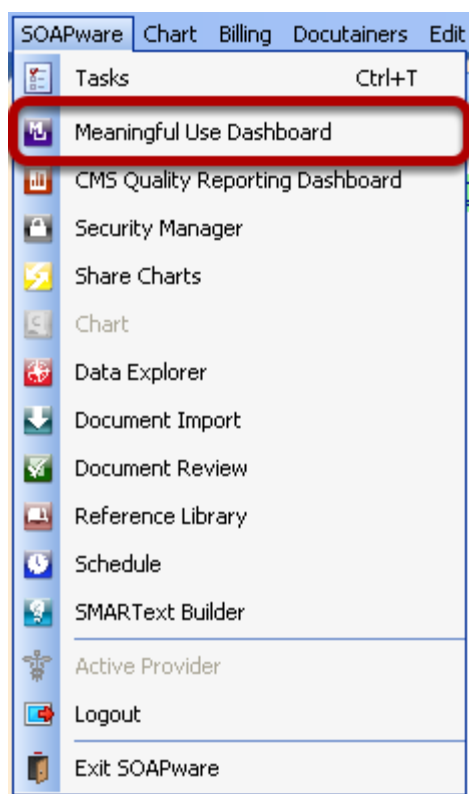
- ✗ [Allergy List](#)
- ✗ [Patient Education](#)
- ✗ [Smoking Status](#)
- ✗ [Vital Signs](#)
- ✓ [Demographics](#)
- ✓ [Medical Summary](#)
- ✓ [Medication Reconciliation](#)
- ✓ [Medication Status](#)
- ✓ [Problem List](#)

☒ Incoming Transition of Care Patient

☐ Outgoing Transition of Care Patient

A green check mark will replace the red X, to the left of Medication Reconciliation, once the user has acknowledged that the patient's Active Medications list will be reconciled during the encounter.

## Meaningful Use Dashboard - Medication Reconciliation



To review a provider's statistics for Medication Reconciliation, Click on the SOAPware menu > Meaningful Use Dashboard.

## Meaningful Use Dashboard - Medication Reconciliation

Display for Provider Shannon Shores **1**

Snapshot

Date 1/27/2011 **2**

	Name	%	N / D
✕	Allergy List	0	0 / 0
✕	CPOE	0	0 / 0
✕	Demographics	0	0 / 0
✕	Medical Summary	0	0 / 0
✕	Medication Status	0	0 / 0
✕	Patient Education	0	0 / 0
✕	Patient ePrescribe	0	0 / 1
✕	Patient Reminders	0	0 / 7
✕	Patient Requested Copies	0	0 / 0
✕	Problem List	0	0 / 0
✕	Smoking Status	0	0 / 0
✕	Structured Labs	0	0 / 0
✕	Timely Record Access	0	0 / 0
✕	Vital Signs	0	0 / 0
✓	Medication Reconciliation	75	3 / 4
✓	Summary of Care on TOC	100	5 / 5

1. Select a provider.

2. Select a "snapshot" date. (**Note:** the statistics displayed will be for the 90 days *previous* to the date selected.)

A green check mark indicates that the item has met the Meaningful Use requirements.

A user is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.

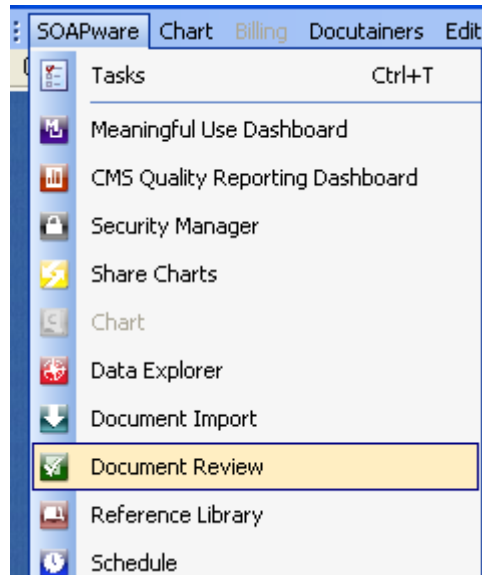
# Document Review

## Document Review Workspace

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Document Review is a workspace in SOAPware where users can review tasks and documents associated those tasks without opening each patient chart.

### Document Review Workspace:

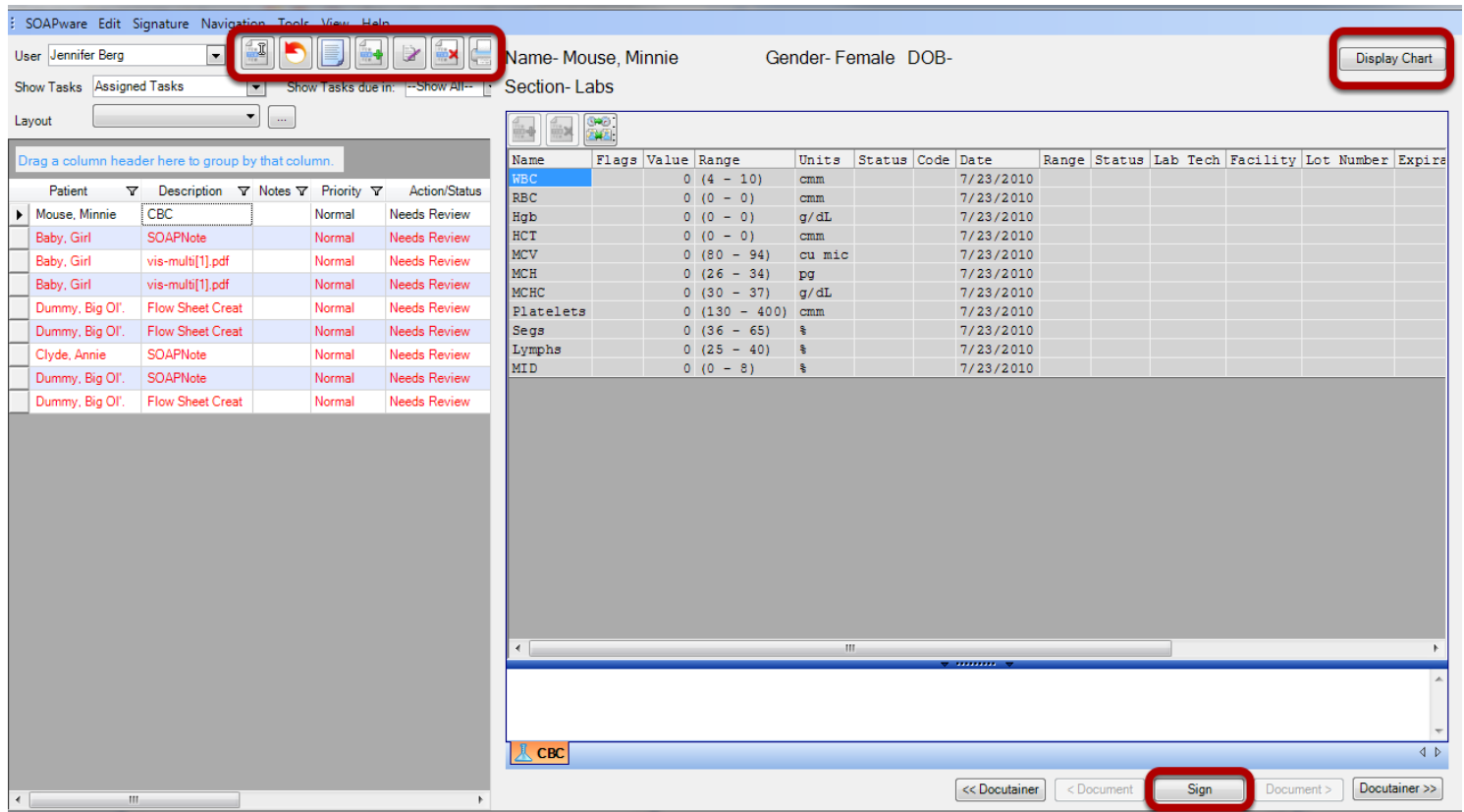


To open the Document Review Workspace, Click SOAPware and select Document Review.

This will close the Chart workspace and open Document Review.



## Interface



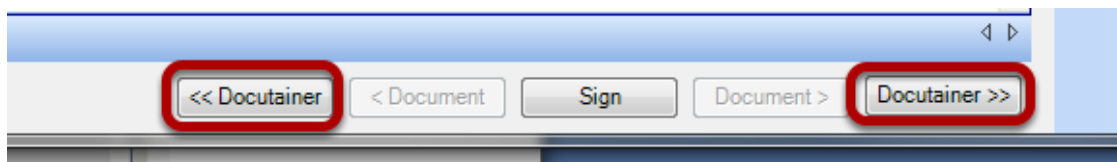
The left side of the screen displays the users Task List.

Task items in this section can be manually created, assigned, reassigned, edited, removed and signed off.

On the right side of the screen, the document associated to the task selected displays. Items can be signed off from this section by clicking on the Sign button at the bottom of the screen.

Documents associated with tasks can be displayed for review but cannot be edited from this workspace. To edit the document click on the Display Chart button at the top of the screen. This will close the Document Review workspace, open the Chart workspace and automatically open the chart and document that was displayed in Document Review.

## Change Docutainers



To move to the next or previous docutainer on a task list, click on one of the Docutainer buttons located at the bottom of the screen.

## Display

SOAPware Edit Signature Navigation Tools View Help

User: Jennifer Berg

Name: Baby, Girl Gender: Female DOB: 1/5/2010

Section: SOAP Notes

Display Chart

Layout: [Dropdown]

Drag a column header here to group by that column.

Patient	Description	Notes	Priority	Action/Status
Mouse, Minnie	CBC		Normal	Needs Review
Baby, Girl	SOAPNote		Normal	Needs Review
Baby, Girl	vis-multi[1].pdf		Normal	Needs Review
Baby, Girl	vis-multi[1].pdf		Normal	Needs Review
Dummy, Big Ol'	Flow Sheet Creat		Normal	Needs Review
Dummy, Big Ol'	Flow Sheet Creat		Normal	Needs Review
Clyde, Annie	SOAPNote		Normal	Needs Review
Dummy, Big Ol'	SOAPNote		Normal	Needs Review
Dummy, Big Ol'	Flow Sheet Creat		Normal	Needs Review

**Subjective**

CHIEF COMPLAINT: Well child. 4 month checkup.

CONCERNS: None.

DEVELOPMENT:

Holds head erect.

Bearing weight on legs.

Pushing up when prone. May be rolling over.

Reaching/grabbing/playing with hands.

Eyes tracking moving objects to 180 degrees.

Social smile, may laugh or squeal.

Blows bubbles, makes "raspberries."

DIET:

Breast \_\_. Bottle(+).

Type Formula: Taking \_\_oz every \_\_ hours.

Teaching: May begin solids (cereals), no bottle propping.

OUTPUT:

Normal stools and urination.

SAFETY ISSUES:

Sleeping on back or side. Car seat use (backward facing until 20 lbs and 1 year of age, in back seat). Guns locked up. No smoking in house.

Hot water heaters to 120 degrees. Use sunscreen. Watch for baby rolling over.

**Objective**

Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress, in no acute distress, dysmorphic.

HEAD/EARS/NOSE/THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.

Head and face exam reveals normocephalic findings, fontanelle anterior soft and flat, scalp normal.

Otoscopic Exam: External auditory canals and tympanic membranes are normal.

Nose exam, internally, reveals nasal mucosa, septum and turbinates are unremarkable.

Oropharynx demonstrates oral mucosa, salivary glands, tongue, tonsils, posterior pharynx, hard-soft palates are normal.

4 month well check - male vis-multi[1].pdf

<< Docutainer < Document Sign Document > Docutainer >>

The Next or Previous Docutainer on the task last will display.

If documents are attached to a docutainer, the two "Document" icons will appear. This allows navigation between documents in the docutainer.

## Return to Chart Workspace

SOAPware Billing Edit Signature Navigation

- Tasks Ctrl+T
- Meaningful Use Dashboard
- CMS Quality Reporting Dashboard
- Security Manager
- Share Charts
- Chart
- Data Explorer
- Document Import

Click on SOAPware and Select Chart.

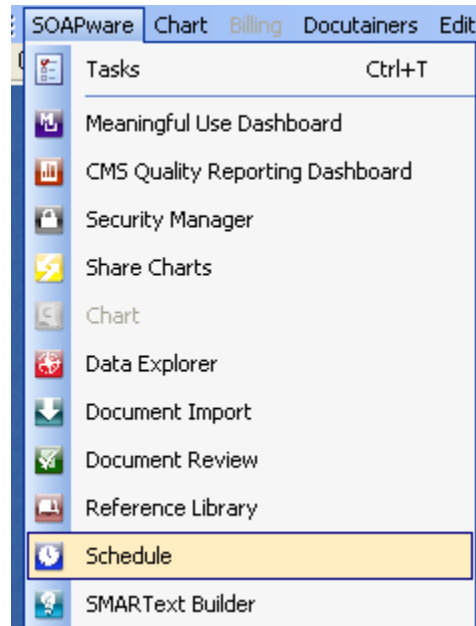
# Schedule

## Intro to Schedule

---

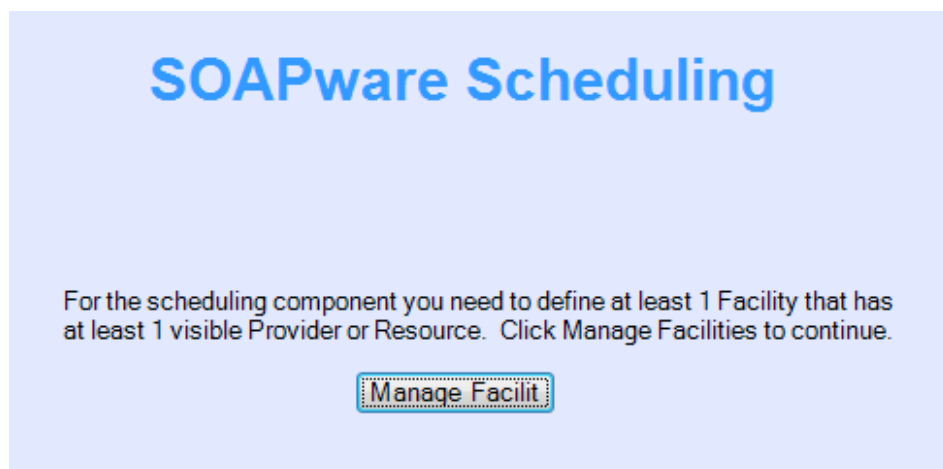
SOAPware Schedule is an integrated scheduling application that shares information with SOAPware as needed. Therefore, the SOAPware Schedule workspace runs inside of SOAPware.

### Open Schedule



To open the Schedule workspace, Click on SOAPware in the menu bar at the top left. Then Select the Schedule menu item.

### Set up Schedule

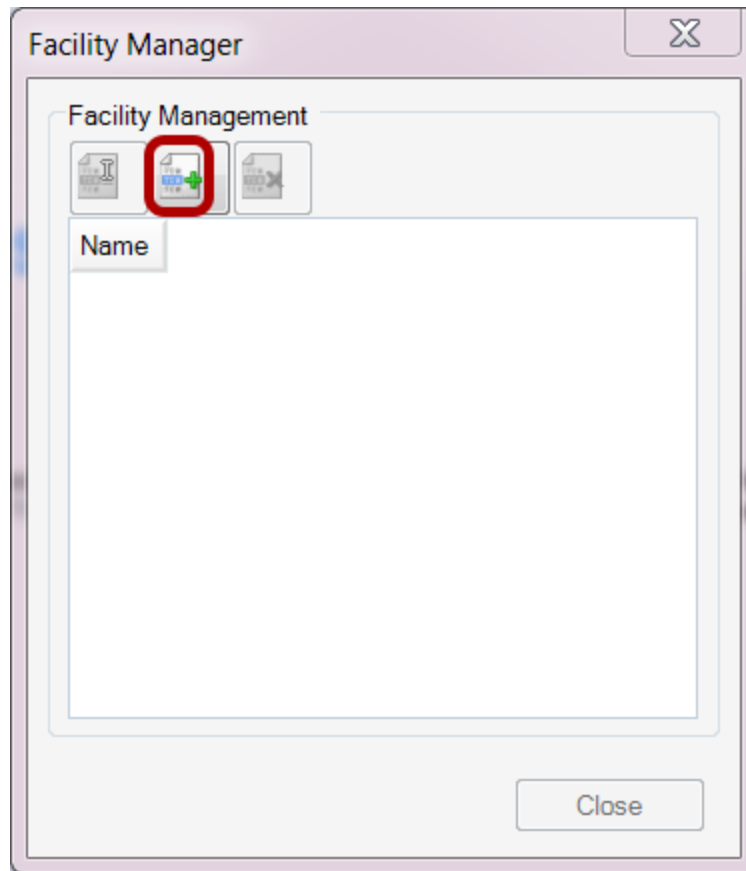


The first time that the user enters SOAPware Schedule, the user will be prompted to create a facility. If so, Click on the "Manage Facilities" button.

NOTE: If the user does not get the above message, Click Tools in the menu bar, and Select Manage Facilities to initiate the Schedule setup process.

Facilities represent the office. SOAPware Schedule is able to handle any number of facilities or offices that the user wants to define. Some users may want to define a single facility for all their offices, but this is not advised. A user will later find that having a facility defined for each of the locations is important for billing purposes.

## Facility Manager



The user should now see the Facility Manager. The Facility Manager allows for the set-up of any number of facilities, and allows for the customizations of the facilities to the practice. Click the Create New Facility button.

The screenshot shows a 'Facility' window with a 'Details' tab selected. The window contains several input fields, each with a numbered callout (1-9) indicating a step in the process. The fields are: Facility (1), Full Legal Name (2), Street (3), City (4), St (4), Zip (4), Phone # (5), NPI # (6), Place of Service (7), Billing Inquiry # (8), and CLIA Number (9). The 'Save' button is highlighted with a red box.

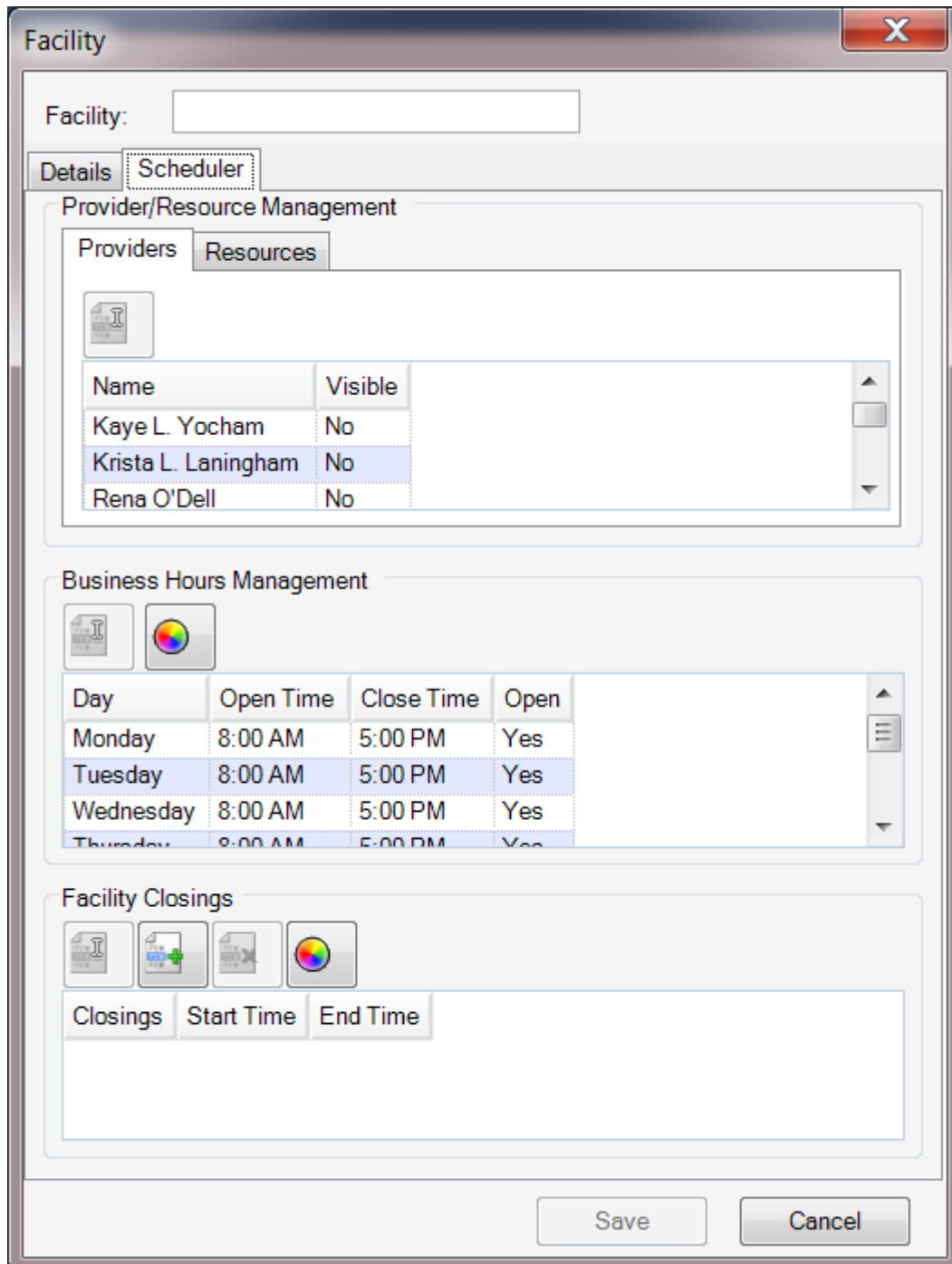
Steps 1-5 identifies the Place of Service-Block 32

1. The commonly known Facility Name.
2. Legal Name of the facility. (block 32)
3. Physical address of the facility. (block 32)
4. City, State and Zip of the facility. (Block 32)
5. Clinic Phone number.
6. NPI number assigned to the facility. (Block 32a)
7. Place of Service this selection specifies the code that is placed on claims (Block 24B) identifying the type of facility.
8. Phone number for Billing Inquiries. This number will appear on Patient Statements, Receipts, etc. for billing questions

9. CLIA Number (Optional).

Click on the Save button to save changes.

## Facility - Scheduler Tab



The screenshot shows the 'Facility' window with the 'Scheduler' tab selected. The 'Facility' field is empty. The 'Provider/Resource Management' section has the 'Providers' tab active, showing a list of providers with their names and visibility status. The 'Business Hours Management' section shows a table of business hours for Monday through Thursday. The 'Facility Closings' section has icons for adding, deleting, and editing closings, and a table with columns for Closings, Start Time, and End Time.

Facility:

Details Scheduler

Provider/Resource Management

Providers Resources

Name	Visible
Kaye L. Yocham	No
Krista L. Laningham	No
Rena O'Dell	No

Business Hours Management

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	8:00 AM	5:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes

Facility Closings

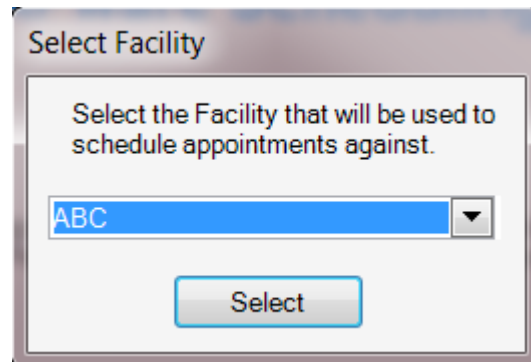
Closings	Start Time	End Time
----------	------------	----------

Save Cancel

The Provider/Resource Management section under the Providers tab will be a list of the Providers who have a SOAPware license. The Resources tab will represent other types of appointments, such as Labs, Nurse visits, procedures, etc. The Resource tab can also be used for the providers

satellite clinic. The Business Hours Management Section is where the business hours are set for the practice NOT for the individual Providers. The Facility Closings section is for designating days that the practice will be closed, such as major holidays.

## Select Facility



After setting up the Facility, SOAPware Schedule will prompt the user to select the active facility. The user should choose the facility he/she would like to use and Click Select.



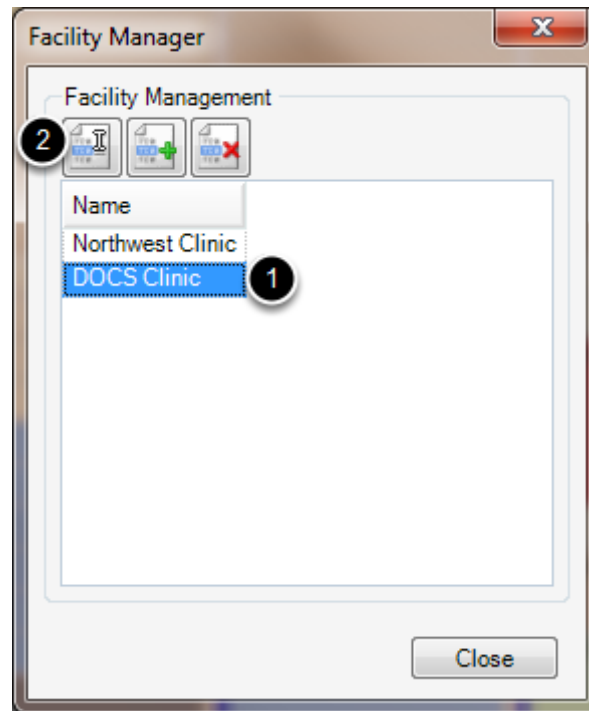
## Entering Facility Business Hours

---

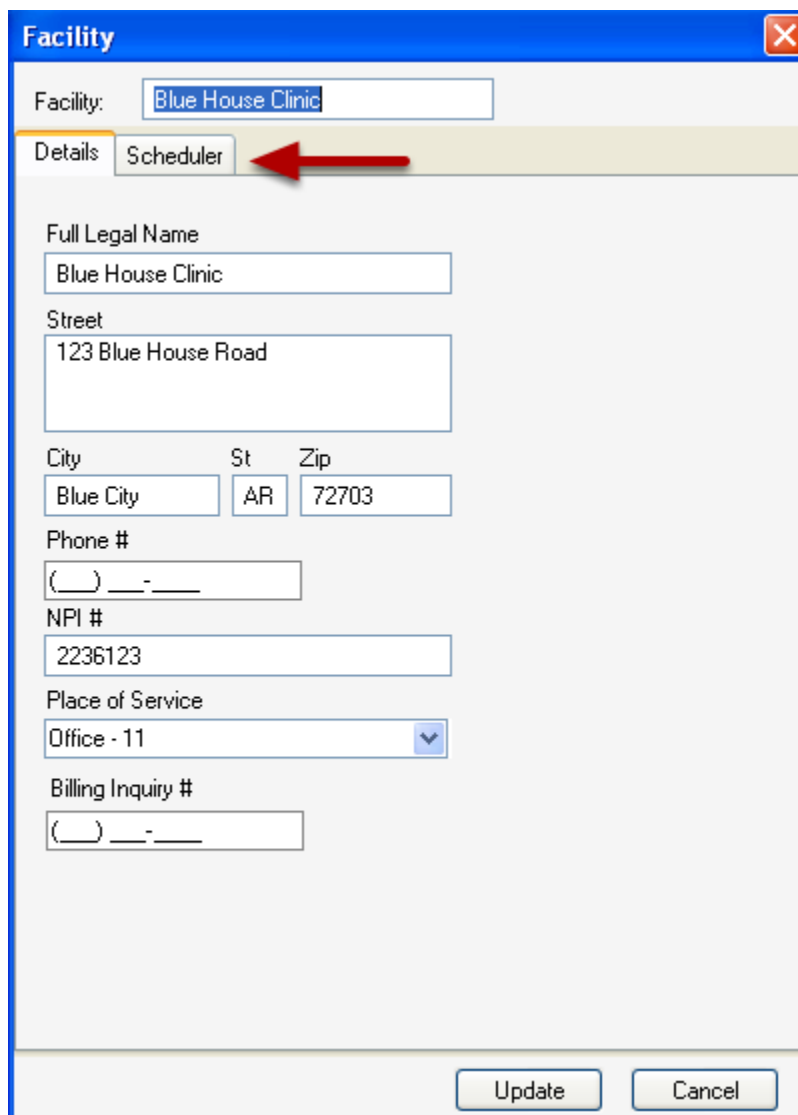
This lesson will demonstrate the steps needed to set up the hours of operation for a facility.

First Click Tools > Manage Facilities, to open the "Facility Manager" dialog.

### Open the Facility



1. Select the Facility.
2. Click Edit.

A screenshot of a software window titled "Facility" with a close button in the top right corner. Below the title bar, there is a "Facility:" label followed by a text box containing "Blue House Clinic". Below this, there are two tabs: "Details" and "Scheduler". A red arrow points to the "Scheduler" tab. The "Scheduler" tab is active and contains several form fields: "Full Legal Name" with a text box containing "Blue House Clinic"; "Street" with a text box containing "123 Blue House Road"; "City" with a text box containing "Blue City", "St" with a text box containing "AR", and "Zip" with a text box containing "72703"; "Phone #" with a text box containing "( ) - "; "NPI #" with a text box containing "2236123"; "Place of Service" with a dropdown menu showing "Office - 11"; and "Billing Inquiry #" with a text box containing "( ) - ". At the bottom right of the window, there are two buttons: "Update" and "Cancel".

Facility: Blue House Clinic

Details Scheduler

Full Legal Name  
Blue House Clinic

Street  
123 Blue House Road

City St Zip  
Blue City AR 72703

Phone #  
( ) -

NPI #  
2236123

Place of Service  
Office - 11

Billing Inquiry #  
( ) -

Update Cancel

Click the Scheduler Tab.

## Edit Business Hours

Facility: DOCS Clinic

Details Scheduler

Provider/Resource Management

Providers Resources

Name	Visible
Mark Smith	Yes
Sample Doc	No

Business Hours Management

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	6:00 AM	6:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes

Facility Closings

Closings	Start Time	End Time
WINTER STORM	01/29/2010	01/29/2010

Update Cancel

1. Click on a day of the week.

## Edit the day

Hours

Tuesday

Open Time: 6:00AM

Close Time: 6:00PM

☒ Is Open

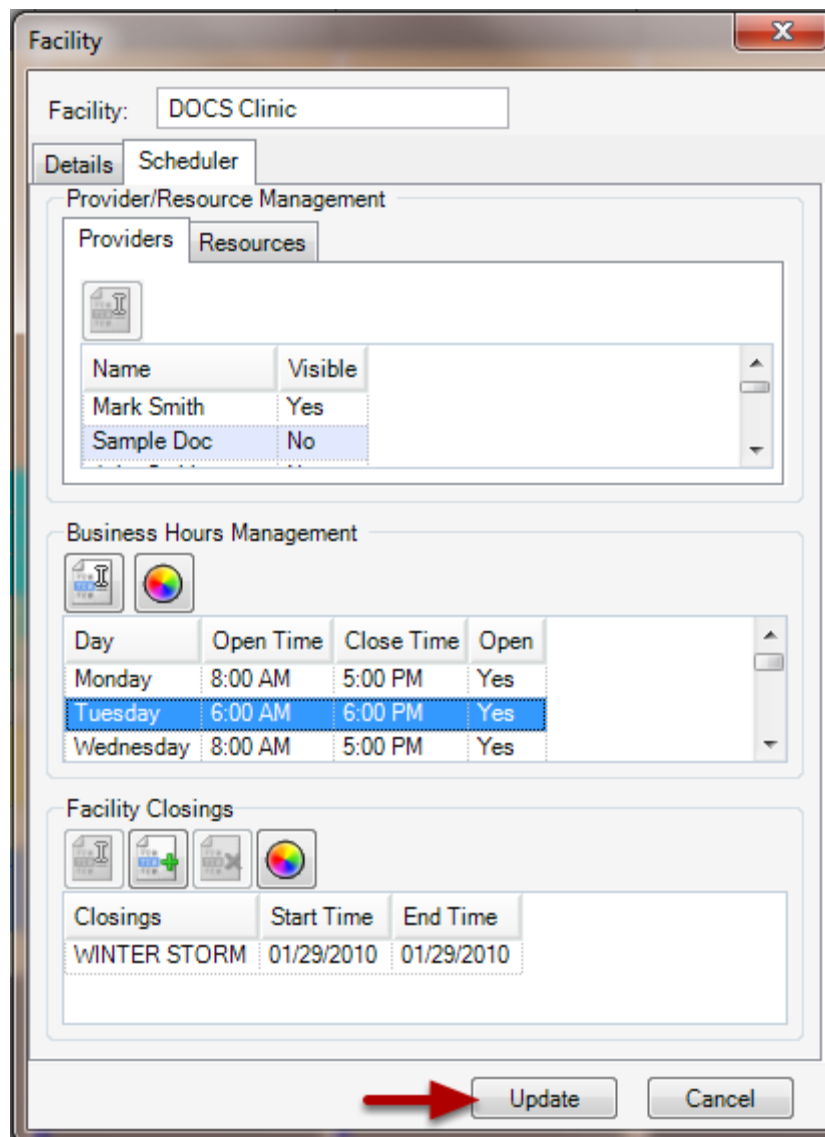
OK Cancel

1. Enter the Open Time of the clinic for the specific day.
2. Enter the Close Time of the clinic for the specific day.
3. Check the box next to "Is Open" if the facility will be open for business on the specified day of

the week.

4. Click OK to save.

## Update the Schedule



The screenshot shows a 'Facility' window with a title bar containing a close button. The 'Facility' field is set to 'DOCS Clinic'. The 'Scheduler' tab is active, showing 'Provider/Resource Management' and 'Business Hours Management' sections. The 'Providers' sub-tab is selected, displaying a table of providers. The 'Resources' sub-tab is also visible. The 'Business Hours Management' section shows a table of business hours for Monday, Tuesday, and Wednesday. The 'Facility Closings' section shows a table with one closing event: 'WINTER STORM' on 01/29/2010. At the bottom, there are 'Update' and 'Cancel' buttons, with a red arrow pointing to the 'Update' button.

Facility: DOCS Clinic

Details Scheduler

Provider/Resource Management

Providers Resources

Name	Visible
Mark Smith	Yes
Sample Doc	No

Business Hours Management

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	6:00 AM	6:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes

Facility Closings

Closings	Start Time	End Time
WINTER STORM	01/29/2010	01/29/2010

Update Cancel

Click the Update button to update the Schedule.

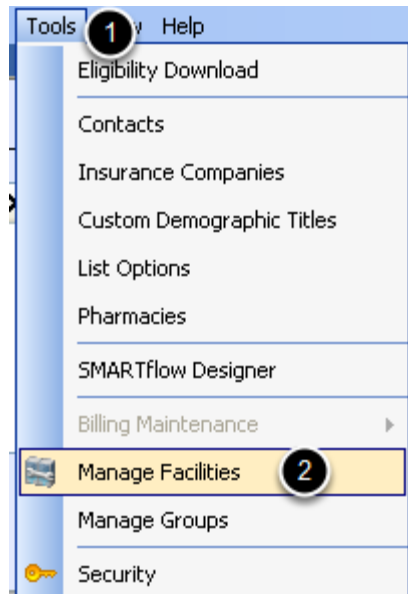
## Activate Providers/Resources for a Facility

---

This lesson will demonstrate the steps required to set scheduling defaults.

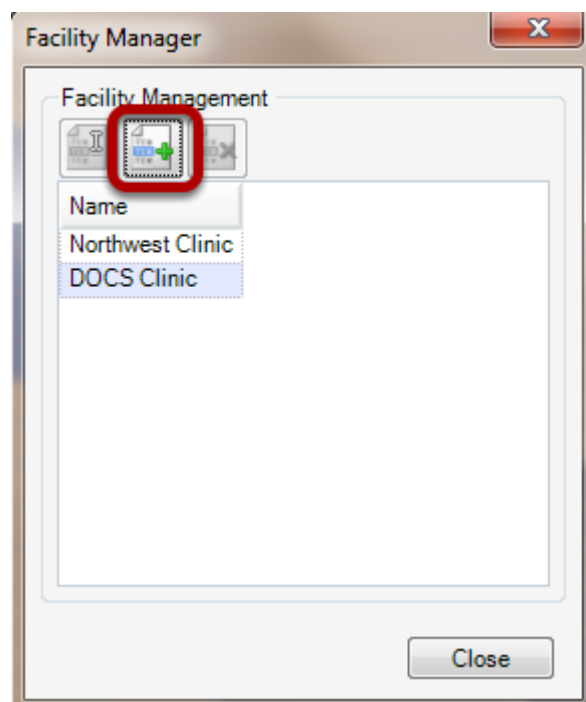
To access the Scheduler workspace, go to the SOAPware menu and Click Schedule.

### Add a Facility

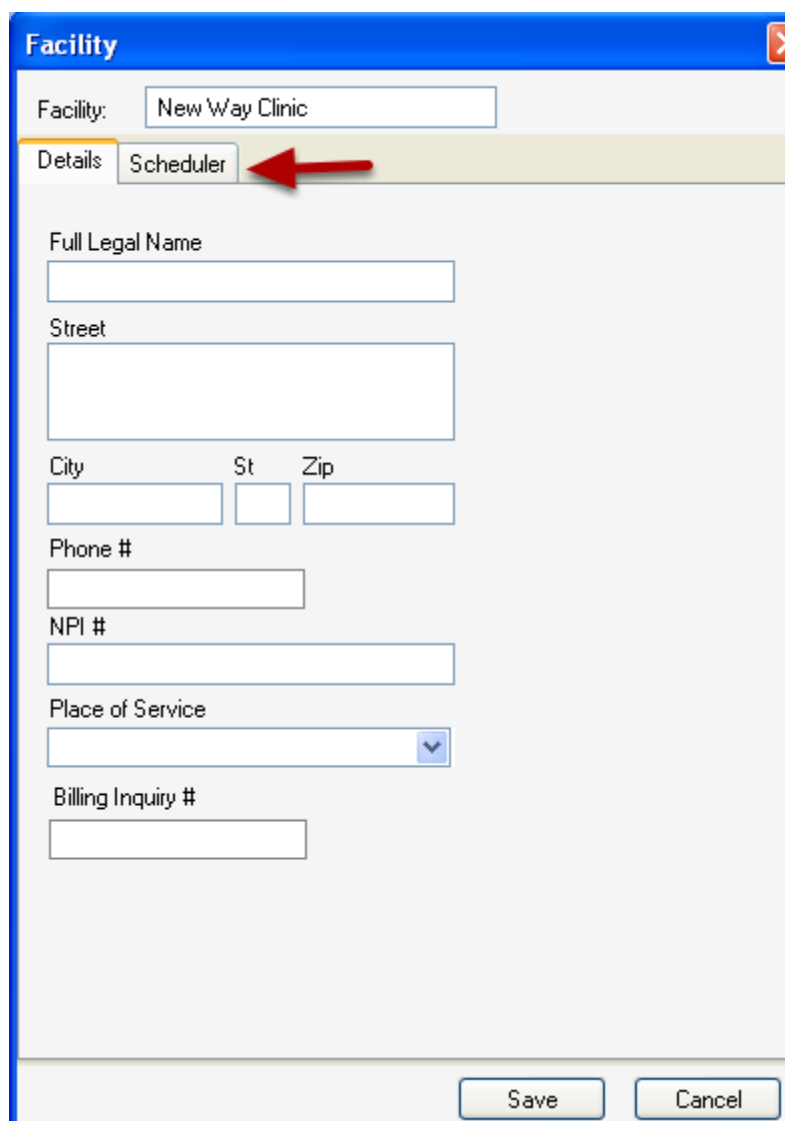


1. Click on the Tools menu.
2. Select Manage Facilities.

## Create a New Facility



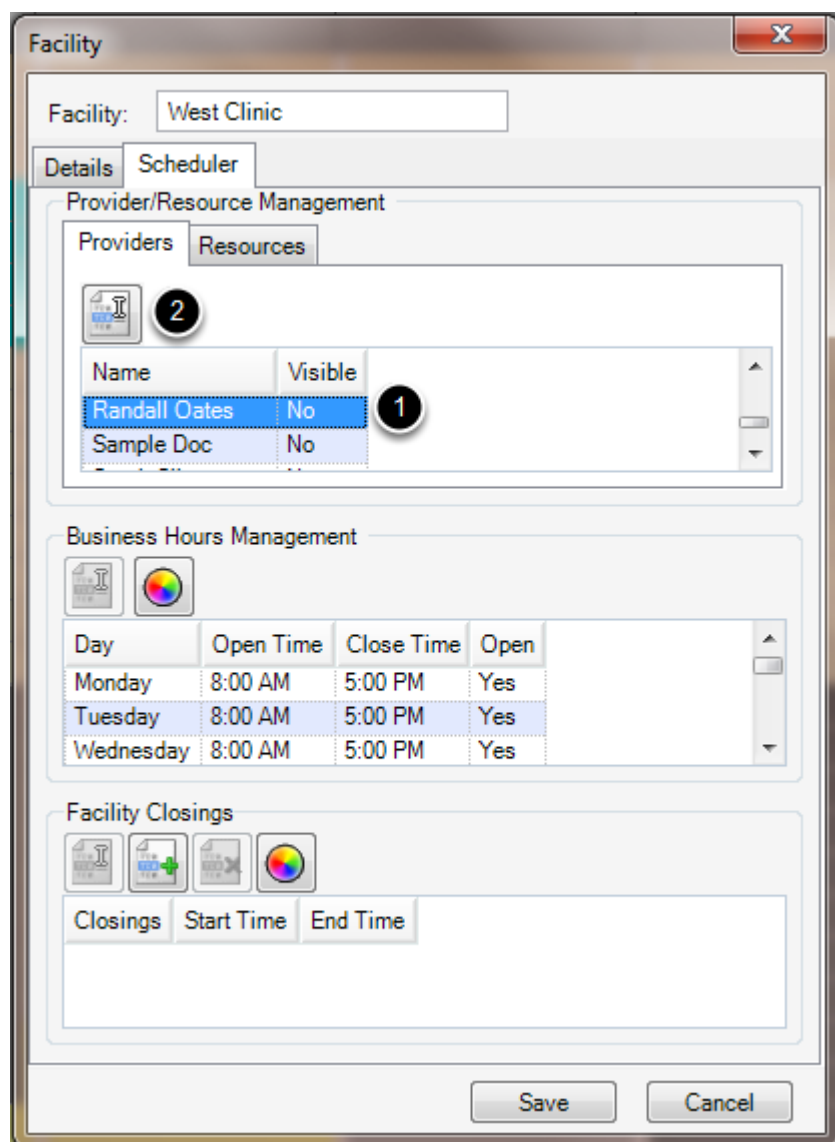
Click the Create New Facility button, to setup a new facility. If a user already has a facility setup, skip this lesson.



The image shows a software window titled "Facility" with a blue header bar. Below the header, there is a "Facility:" label and a text box containing "New Way Clinic". Below this, there are two tabs: "Details" and "Scheduler". A red arrow points to the "Scheduler" tab. The "Scheduler" tab is active, showing several input fields: "Full Legal Name" (a single-line text box), "Street" (a multi-line text box), "City" (a single-line text box), "St" (a single-line text box), "Zip" (a single-line text box), "Phone #" (a single-line text box), "NPI #" (a single-line text box), "Place of Service" (a dropdown menu with a blue arrow icon), and "Billing Inquiry #" (a single-line text box). At the bottom right of the window, there are two buttons: "Save" and "Cancel".

Click the Scheduler tab to setup the clinic's defaults.

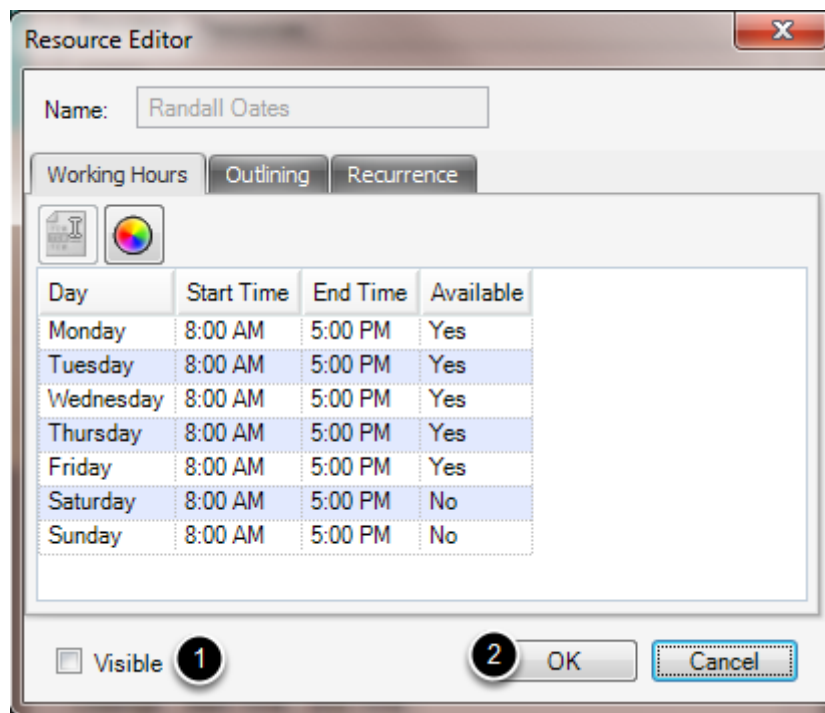
## Opening the Provider's Schedule Defaults



1. Click on a provider name.
2. Click Edit.

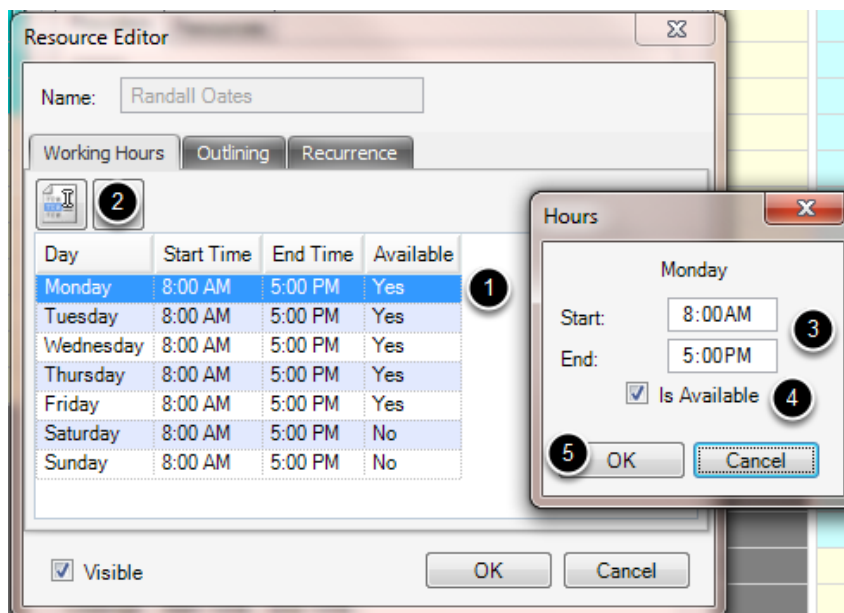


## Making a Provider visible for the Clinic



1. Check the box next to Visible to activate the provider for the clinic.
2. Click OK.

## Set Working Hours for the Provider



1. Click on a day.
2. Click Edit.
3. Enter the Start and End Times.

4. Check the "Is Available" box, to make the provider available for appointments.
5. Click OK.

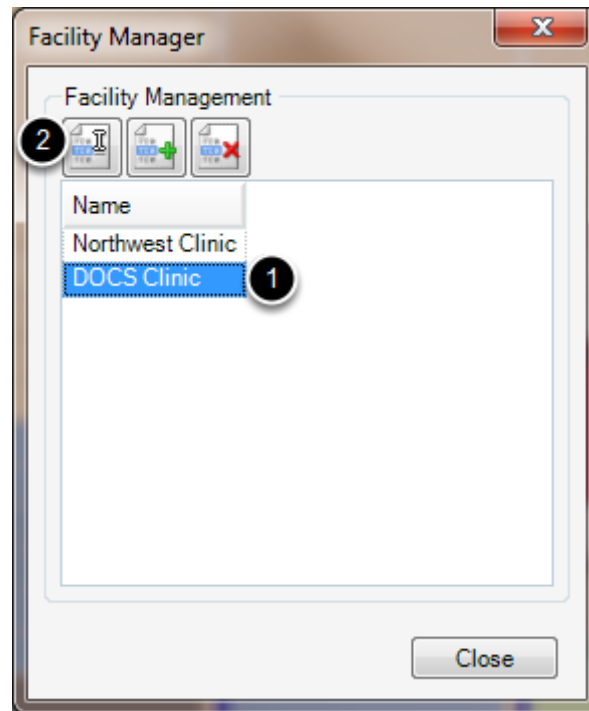
## Creating Holidays/Closings

---

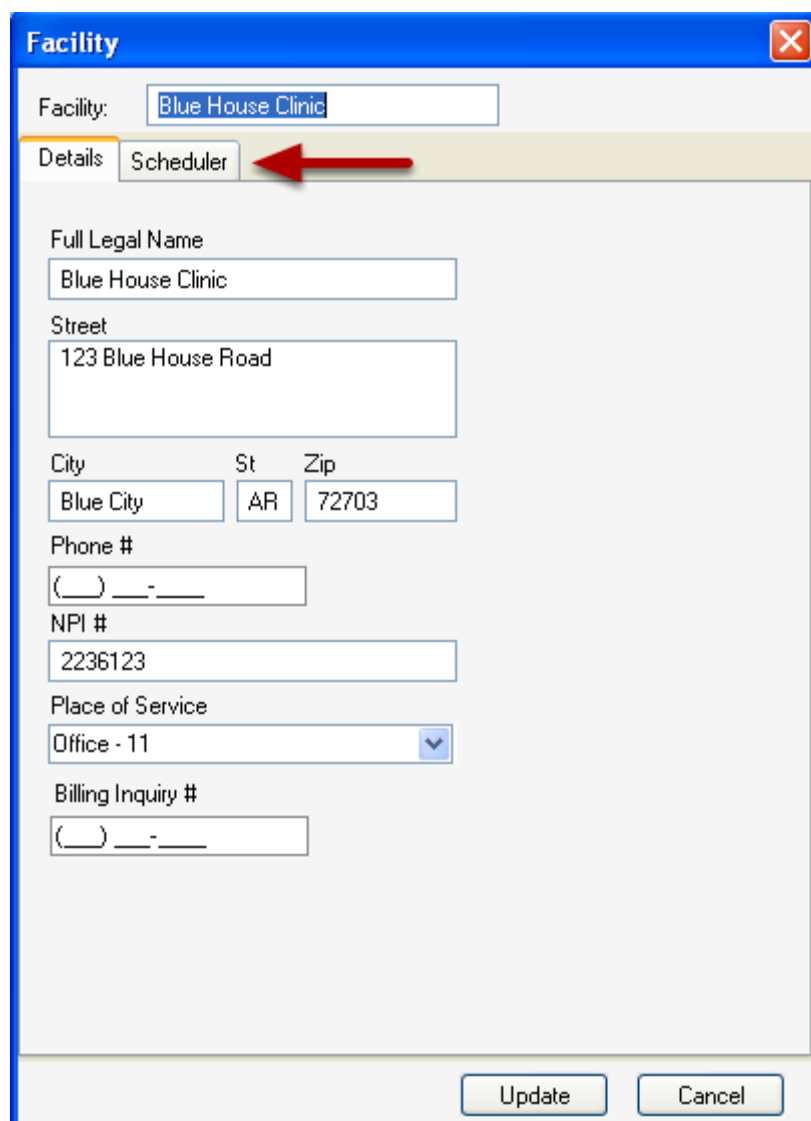
This lesson will demonstrate the steps required to set up the days the facility will be closed.

First Click Tools > Manage Facilities, to access the "Facility Manager" dialog.

### Open the facility



1. Select the Facility.
2. Click Edit.

A screenshot of a software window titled "Facility" with a close button in the top right corner. The window contains a tabbed interface with two tabs: "Details" and "Scheduler". A red arrow points to the "Scheduler" tab. The "Details" tab is currently active, showing various input fields for facility information. At the bottom of the window are "Update" and "Cancel" buttons.

Facility:

Details Scheduler

Full Legal Name

Street

City St Zip

Phone #

NPI #

Place of Service

Billing Inquiry #

Update Cancel

Click the Scheduler Tab.

## Create Facility Closings

The screenshot shows the 'Facility' window with the 'Scheduler' tab selected. The 'Facility' dropdown is set to 'DOCS Clinic'. The 'Provider/Resource Management' section has the 'Resources' sub-tab selected, showing a table with two resources: 'Mark Smith' (Visible: Yes) and 'Sample Doc' (Visible: No). The 'Business Hours Management' section shows a table with columns 'Day', 'Open Time', 'Close Time', and 'Open'. The table lists hours for Monday through Thursday. The 'Facility Closings' section has a red box around the 'Add Closing' button (a document icon with a green plus sign). Below this button is a table with columns 'Closings', 'Start Time', and 'End Time', containing one entry: 'WINTER STORM' with start and end times of '01/29/2010'. At the bottom are 'Update' and 'Cancel' buttons.

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	6:00 AM	6:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes

Closings	Start Time	End Time
WINTER STORM	01/29/2010	01/29/2010

1. Click the Add Closing button.

## Edit the Day

The screenshot shows the 'Closing' dialog box. It has three numbered steps: 1. 'Name' field with 'Christmas Day' entered. 2. 'Start Date' and 'End Date' dropdowns, both set to '12/25/2010'. 3. 'OK' button. There is also a 'Cancel' button.

Name	Start Date	End Date
Christmas Day	12/25/2010	12/25/2010

1. Enter the Name of the closing.
2. Enter the Start and End Dates of the closing.
3. Click OK to save.

## Update the Schedule

Facility

Facility: DOCS Clinic

Details Scheduler

Provider/Resource Management

Providers Resources

Name	Visible
Mark Smith	Yes
Sample Doc	No

Business Hours Management

Day	Open Time	Close Time	Open
Monday	8:00 AM	5:00 PM	Yes
Tuesday	6:00 AM	6:00 PM	Yes
Wednesday	8:00 AM	5:00 PM	Yes
Thursday	8:00 AM	5:00 PM	Yes

Facility Closings

Closings	Start Time	End Time
WINTER STORM	01/29/2010	01/29/2010
Christmas Day	12/25/2010	12/25/2010

Update Cancel

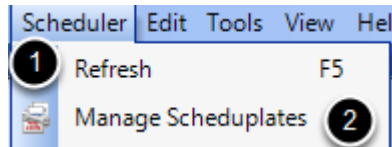
Click the Update button to update the Schedule.

## Creating Scheduplates

---

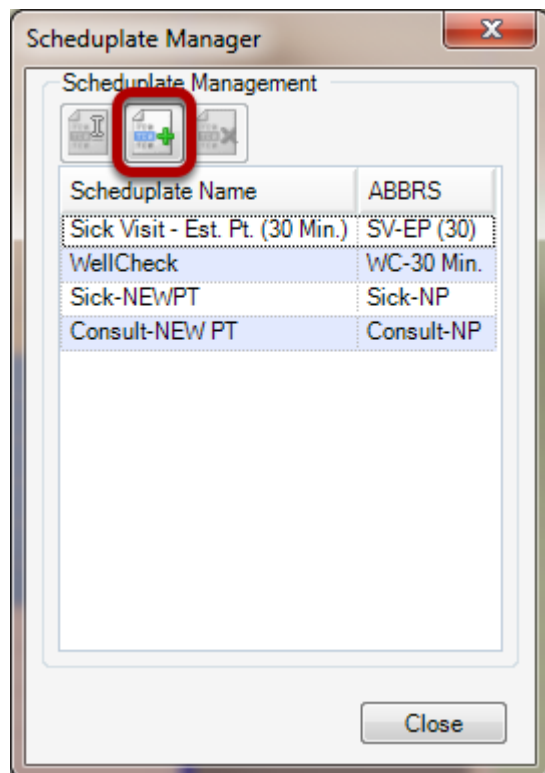
This lesson will demonstrate the steps needed to set up various facility appointment types.

### Open the Scheduplate Manager



1. Click on the Scheduler menu.
2. Select Manage Scheduplates.

### Add a Scheduplate



Click the Create New Template button.

## Enter Scheduplate information

Scheduplate Editor

Scheduplate Name: Sick Visit - Est. Pt. (30 Min.) ABBRS: SV-E

BackGround ForeGround Sample Text

Resources

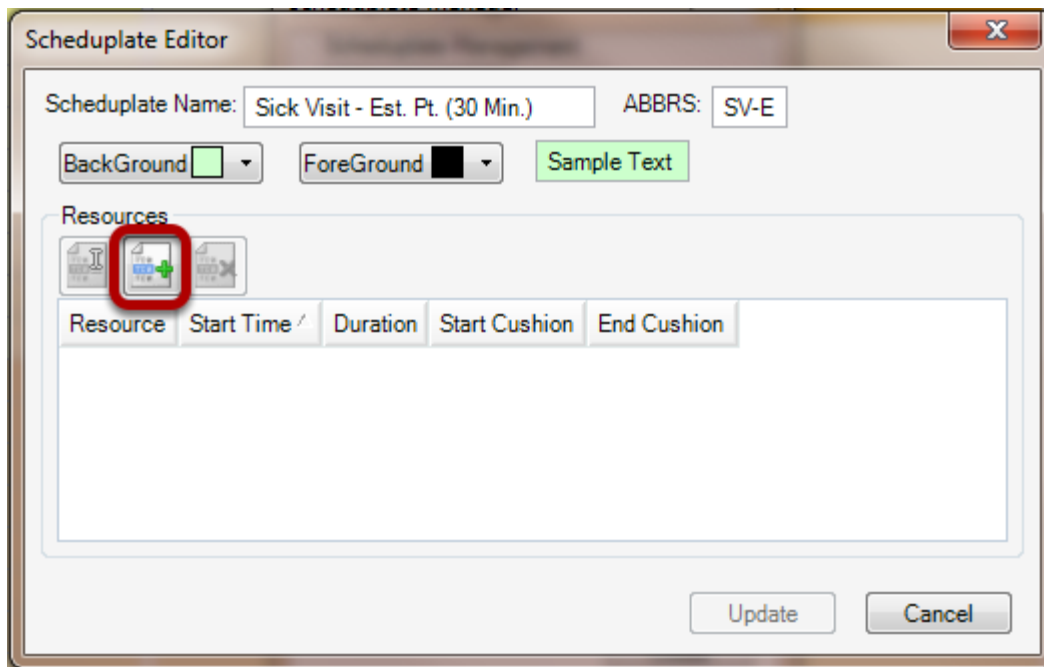
Resource	Start Time	Duration	Start Cushion	End Cushion
----------	------------	----------	---------------	-------------

Update Cancel

1. Type in a Scheduplate Name and Abbreviation. The abbreviation will be shown on the appointment at a glance, and the full scheduplate name will be helpful in selecting the correct appointment type.
2. Select a Background color to show on the appointment.
3. Select a Foreground color for the text displayed. (After selecting the background and foreground colors, the sample text will display what the appointment will look like on the Schedule.)

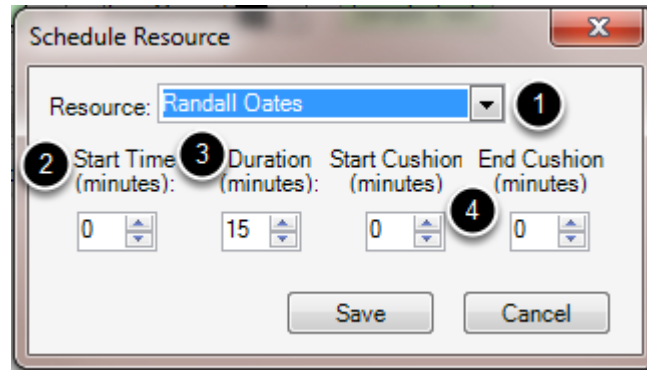


## Adding a Resource



Click the Add Resource button.

## Entering Resource time



1. Select the Resource to whom the scheduplate will apply.

-Note: Selecting Pick Resource from the drop down list will allow users to select the Resource for the Scheduplate at the time the appointment is scheduled.

2. Enter the number of minutes needed, prior to the patient being seen by the Provider/Resource.

3. Enter the Duration of the appointment with the resource selected. This indicates the length of time needed with the Resource.

4. The Start Cushion indicates the amount of time needed to prepare the patient for the Provider/Resource's time. Enter the number of minutes by typing the number or clicking the arrows.\*

5. The End Cushion allows for any follow up work related to the appointment to be indicated and

accounted. Enter the number of minutes by typing the number or clicking the arrows.\*  
6. Click Save.

\*Both the Start and the End Cushion are designed to help prepare for the full length of the appointment. These fields are not necessary to create a scheduplate.

## Update Scheduplates

Scheduplate Editor

Scheduplate Name: Sick Visit - Est. Pt. (30 Min.) ABBRS: SV-E

BackGround ForeGround Sample Text

Resources

Resource	Start Time	Duration	Start Cushion	End Cushion
Randall Oates	00:00:00	00:15:00	00	00

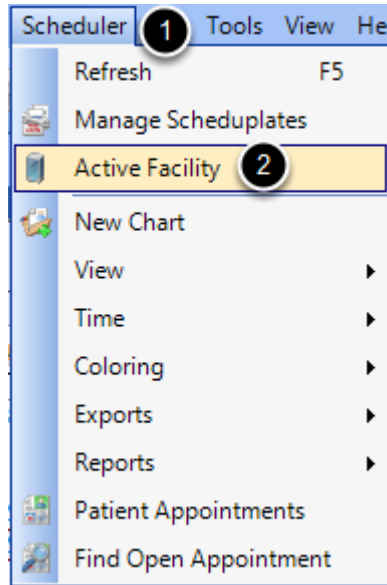
Update Cancel

Click Update to save the Scheduplate.

## Change the Active Facility

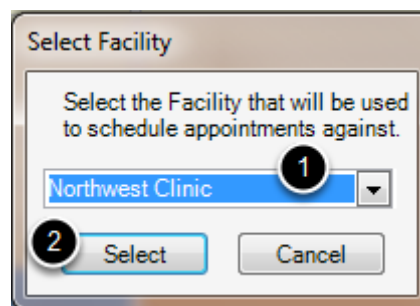
This lesson will demonstrate the steps to change the active facility, if a clinic is part of a multiple site practice.

### Open Active Facility



1. Click on Scheduler.
2. Select Active Facility.

### Select the new Active Facility



1. Click the drop down menu to find the desired facility.
2. Click Select.

## Navigation

This lesson will show the various ways to navigate in the Schedule workspace.

### Move Quickly between Days, Weeks, and Months

The screenshot displays the SOAPware 2011 Scheduler interface. At the top, the title bar shows "SOAPware 2011 - Patient: - User: Rena Thornton - Provider: Rena Thornton". Below the title bar is a menu bar with "SOAPware", "Billing", "Scheduler", "Edit", "Tools", "View", and "Help".

The main interface features a navigation bar with six numbered buttons (1-6) and three icons. Below the navigation bar is a header for "Blue House Clinic" with three icons. The main area shows a calendar for February 2011 on the left, with the date "Monday, February 21, 2011" selected. The calendar shows the days of the week (S M T W T F S) and the dates (30 31 1 2 3 4 5, 6 7 8 9 10 11 12, 13 14 15 16 17 18 19, 20 21 22 23 24 25 26, 27 28 1 2 3 4 5, 6 7 8 9 10 11 12). The "Today" button is highlighted.

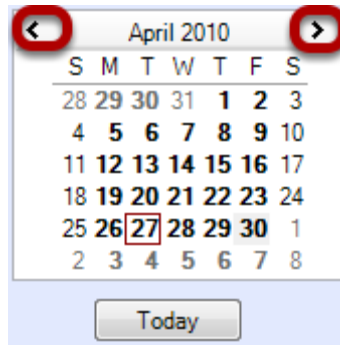
Below the calendar is a list of providers and resources. The "Providers" tab is selected, showing a list of providers: Kaye L. Yocham, Rita Pense, Shannon Shores, and Krista L. Laningham. The "Resources" tab is also visible.

The main schedule area shows a grid for Monday, February 21, 2011. The grid has three columns for providers: Kaye L. Yocham, Rita Pense, and Shannon Shores. The rows represent time slots from 1 pm to 5 pm. The schedule is filled with pink blocks, indicating appointments. The following appointments are listed:

- 1 pm: Imm - Kenobi, Obi-Wan -
- 2 pm: Kitty, Calico -
- 3 pm: NP - Skywalker, Luke -

1. Move back 1 day.
2. Move back 1 week.
3. Move back 1 month.
4. Move ahead 1 day.
5. Move ahead 1 week.
6. Move ahead 1 month.

## Monthly Calendar



Click the arrows to move quickly to the month desired.

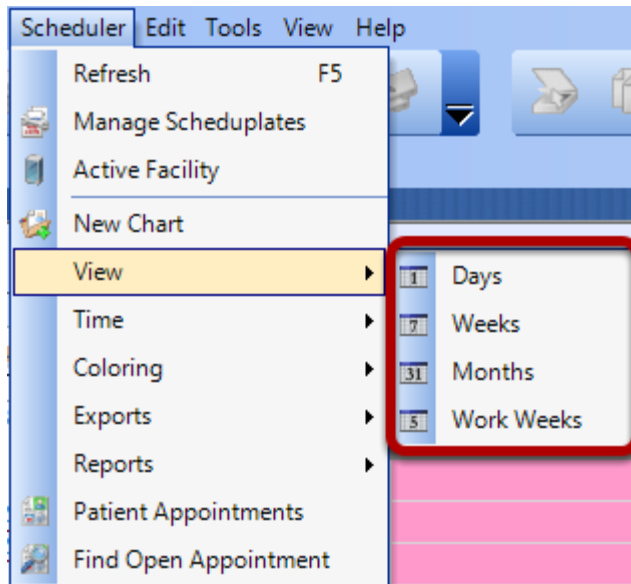
## Views

---

View the Schedule as Days, Weeks, Months, or Work Weeks.

First Select Scheduler > View.

### Select the Schedule View



Select the preferred view.

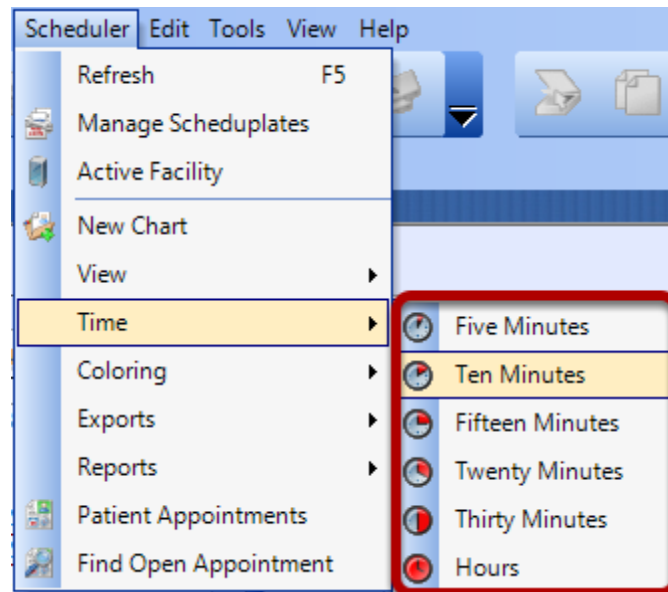
## Time Increments

---

This lesson will show how to set the time increments shown on the Schedule.

First Select Scheduler > Time.

### Select the Time Increment



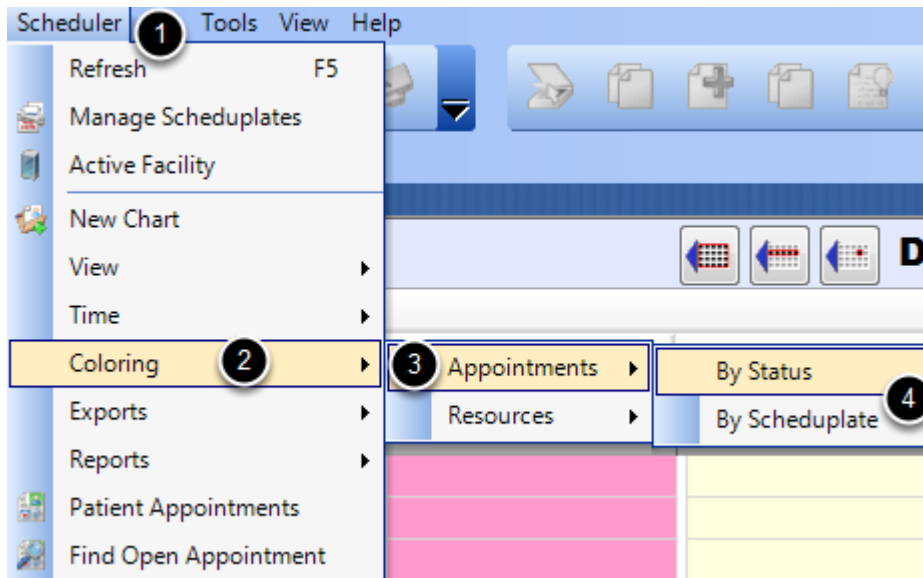
Choose the option that best fits the practice's scheduling needs. The time increment selected here will be displayed to the left of the schedule.

## Coloring

---

This lesson will show how to set the coloring for Appointments and Resources.

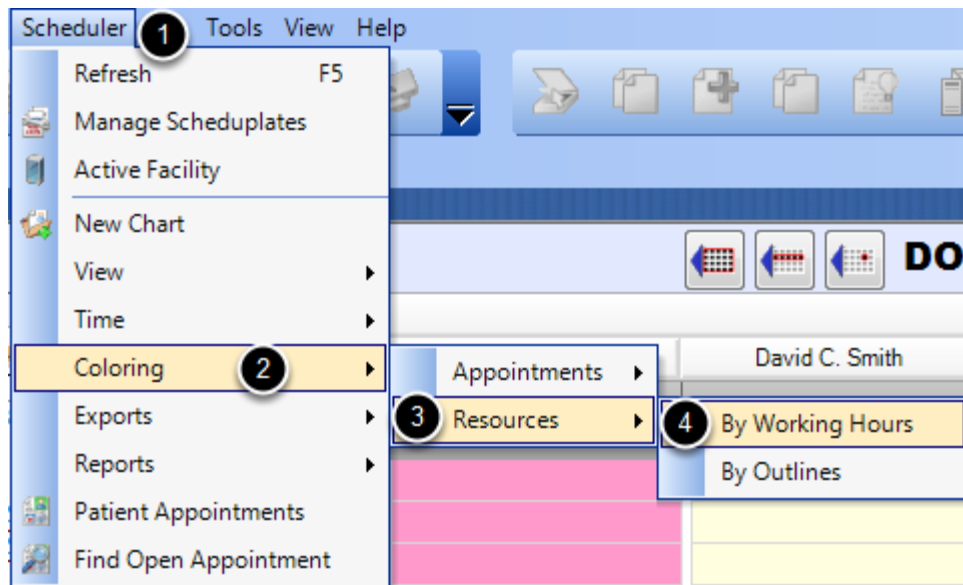
### Coloring for Appointments



1. Click on Scheduler.
2. Select Coloring.
3. Select Appointments.
4. Select either **By Status** or **By Scheduplate**. By Status, will show the shading of the status as it changes, and not show the Scheduplate coloring. By Scheduplate, will show the shading associated with the Scheduplate, and not show the status color changes.



## Coloring for Resources



1. Click on Scheduler.
2. Select Coloring.
3. Select Resources.
4. Select either **By Working Hours** or **By Outlines**. By Working Hours, will only show the hours the provider is available to see patients in the clinic. By Outlines, will show the outline shading associated with how the providers have indicated they want their days scheduled.

## Scheduling an Appointment

---

This lesson will demonstrate how to schedule a patient appointment.

### Double Click on a Needed Time Slot

Chart Rack 1

Search 2 Type Name

\* A B C D E F G H I J K L M N O P Q R S T U V W

Name	Chart Number	SSN	Birth Date	Provider
------	--------------	-----	------------	----------


Provider All Providers Total Active Patients: 57

3 Select Cancel

1. The Chart Rack will be pulled up.
2. Type in the patient's name.
3. When the correct patient is pulled up, Click Select or double click the patient.

## Schedule Tab - Patient Appointments

Jim, Slim T.



**Jim, Slim T.**

Account 34  
Chart 68332

Date of Birth 3/21/1970 Age 40 Sex Male Status Unknown

Address 1539 COUNTY LINE RD Home Town, AR 72711

Home (501) 111-1111 Work (501) 555-9000 Cell (479) 987-6543

Email jslim@email.com

**Balances**

Family \$25.00  
Personal \$454.00  
**Total \$479.00**

☐ Self Pay Co-Pay \$20.00

Schedule Demographics Insurance Custom Ledger Family Claims Statements **New Charges**

**Visit Detail for 4/27/2010 7:45 AM - 8:00 AM (0:15)**

Scheduplate 2 Referral 3 Facility 4 Status 5 Recurrence 6

SV-EP (30) - Sick Visit - Est. Pt. ... + Joe Schmo ... DOCS Clinic Confirmed

Resources 7

Date	Start	End	Name
4/27/2010	7:45 AM	8:00 AM	Randall Oates

+ Add Resource

Visit Comments 8

Patient has fever and chills. Bringing updated insurance cards. LO

Verification 9

☒ Insurance Verified

Date 4/27/2010

User randalloates

Check In 10

Check In

Take Co-Pay 11

Visit List 12

Date	Start	End	Facility	Resource Name	Scheduplate
4/30/2010	11:30 AM	12:15 PM	DOCS Clinic	David C. Smith	
4/27/2010	7:45 AM	8:00 AM	DOCS Clinic	Randall Oates	Sick Visit - Est. ...
4/23/2010	8:45 AM	9:15 AM	DOCS Clinic	Randall Oates	Sick Visit - Est. ...
4/22/2010	2:00 PM	2:15 PM	DOCS Clinic	David C. Smith	
4/22/2010	8:45 AM	9:00 AM	DOCS Clinic	Sarah Slim	
4/21/2010	1:45 AM	12:00 PM	DOCS Clinic		Sick Visit - Est. ...
4/20/2010	10:15 AM	10:30 AM	DOCS Clinic	Ben Jim	

Today 13

Print Visit 14 New Visit 15

Enter the Appointment information, as needed:

- Visit Detail:** Summary of the overall length of the appointment
- Scheduplate:** The appointment type
- Referral:** Referring Provider
- Facility:** Place of Service
- Status:** The status of the patient visit within the clinic's work flow. (This list is completely customizable by clinic.)

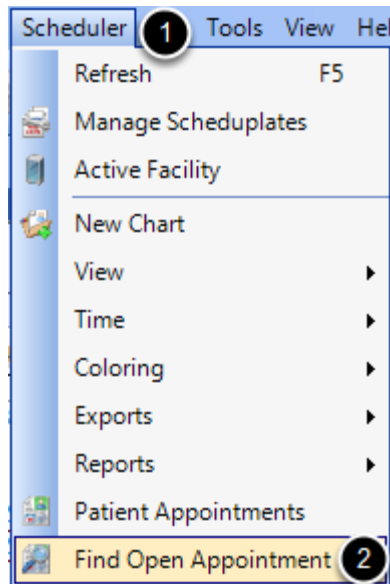
6. **Recurrence:** Sets recurrences of the visit, if needed.
7. **Resources:** Allows the scheduling of one to multiple resources for one visit
8. **Visit Comments:** Allows miscellaneous information and visit details to be entered and stored for the visit.
9. **Verification:** Indicates the date and user who verified the patient's insurance benefits and eligibility.
10. **Check-In:** Allows a patient to be checked in with the click of a button.
11. **Take Co-Pay:** Allows a patient's co-pay to be taken at the beginning of the visit.
12. **Visit List:** Displays all of the patient's past, current and future appointments to be displayed in one place, to help prevent double booking an appointment.
13. **Today:** Immediately selects the current day's visit.
14. **Print Visit:** Prints out the selected visit.
15. **New Visit:** Creates a new appointment for the patient.

## Searching for Available Appointments

---

This lesson will show how to search for open appointments.

### Find an Open Appointment



1. Click on Scheduler.
2. Select Find Open Appointment.

Find Open Appointment

**Facility: DOCS Clinic**

Search Criteria

Resource: Randall Oates 1

Start Time: 04/27/2010 12:00AM 2

End Time: 05/11/2010 11:59PM

Start Cushion: 0 3 Duration: 15 4 End Cushion: 0

Advanced Search 5

Open Appointments

Date	Time	Resource Name	Facility
4/27/2010	8:30 AM	Randall Oates	DOCS Clinic
4/27/2010	8:45 AM	Randall Oates	DOCS Clinic
4/27/2010	9:00 AM	Randall Oates	DOCS Clinic
4/27/2010	9:15 AM	Randall Oates	DOCS Clinic
4/27/2010	9:30 AM	Randall Oates	DOCS Clinic
4/27/2010	9:45 AM	Randall Oates	DOCS Clinic
4/27/2010	10:00 AM	Randall Oates	DOCS Clinic
4/27/2010	10:15 AM	Randall Oates	DOCS Clinic
4/27/2010	10:30 AM	Randall Oates	DOCS Clinic
4/27/2010	10:45 AM	Randall Oates	DOCS Clinic
4/27/2010	1:30 PM	Randall Oates	DOCS Clinic
4/27/2010	1:45 PM	Randall Oates	DOCS Clinic
4/27/2010	2:00 PM	Randall Oates	DOCS Clinic
4/27/2010	2:15 PM	Randall Oates	DOCS Clinic
4/27/2010	2:30 PM	Randall Oates	DOCS Clinic

Select 7 Cancel

1. Select the **Resource** needed from the drop down menu.
2. Enter the **date ranges** for the possible appointment.
3. Enter the **Start and End Cushions** that the appointment will need to have.
4. Enter the **Duration** for the appointment needed.
5. Click **Search**.
6. If a suitable appointment has been found, **select the appointment time**.
7. Click **Select**.

## Enter Advanced Search Criteria

The image shows a 'Find Open Appointment' dialog box with the following elements and numbered callouts:

- 1**: Facilities list with checkboxes for 'Northwest Clinic' and 'DOCS Clinic'.
- 2**: Start Time dropdown menu showing '04/27/2010 12:00AM'.
- 3**: End Time dropdown menu showing '05/11/2010 11:59PM' and a 'Scheduplate' dropdown menu.
- 4**: Resource selection area with icons for adding and removing resources.
- 5**: Search button.
- 6**: Open Appointments table with columns 'Date', 'Time', and 'Facility'.
- 7**: Select button.

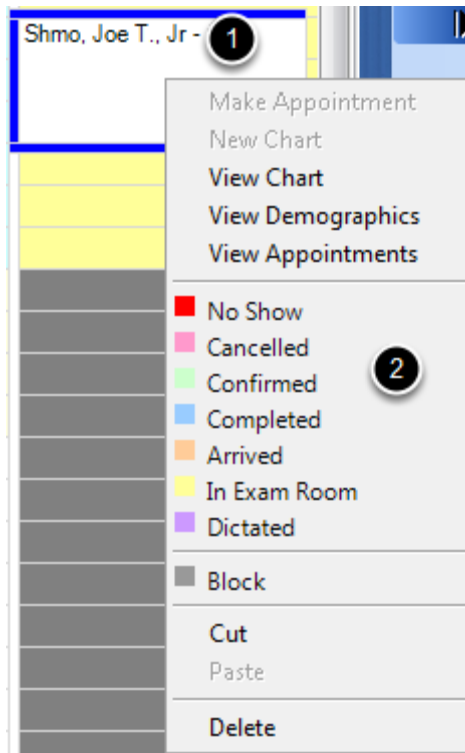
Buttons at the bottom include 'Basic', 'Search', 'Select', and 'Cancel'.

1. Check the **Facility** needed for the appointment.
2. Enter the **date ranges** for the possible appointment.
3. Select a preferred **Scheduplate**.
4. Add a **Provider/Resource** to help narrow down the search.
5. Click **Search**.
6. If a suitable appointment has been found, **Select the appointment time**.
7. Click **Select**.

## Change the Appointment Status

---

This lesson will demonstrate how to change an appointment status.



1. Right click on the desired appointment.
2. Select the needed status for the appointment. (The status should be updated automatically on the Schedule, and in the patient's visit list.)



## Scheduling Repeat Appointments

This lesson will show how to set up repeat appointments for patients.

### Open the Patient Account

**Jim, Slim T.** 1

**Account** 34  
**Chart** 68332

**Date of Birth** 3/21/1970 **Age** 40 **Sex** Male **Status** Unknown

**Address** 1539 COUNTY LINE RD Home Town, AR 72711

**Home** (501) 111-1111 **Work** (501) 555-9000 **Cell** (479) 987-6543

**Email** jslim@email.com

**Balances**  
Family \$25.00  
Personal \$454.00  
**Total** \$479.00

☐ Self Pay ☐ Co-Pay \$20.00

**Schedule** **Demographics** **Insurance** **Custom** **Ledger** **Family** **Claims** **Statements** **New Charges**

**Visit Detail for 4/27/2010 7:45 AM - 8:00 AM (0:15)**

**Scheduplate** SV-EP (30) - Sick Visit - Est... **Referral** Joe Schmo **Facility** DOCS Clinic **Status** Confirmed 2 **Recurrence**

**Resources** 3 **Add Resource**

Date	Start	End	Name
4/27/2010	7:45 AM	8:00 AM	Randall Oates

**Visit Comments**  
Patient has fever and chills. Bringing updated insurance cards. LO

**Verification**  
☒ Insurance Verified  
Date 4/27/2010  
User randalloates

**Check In**

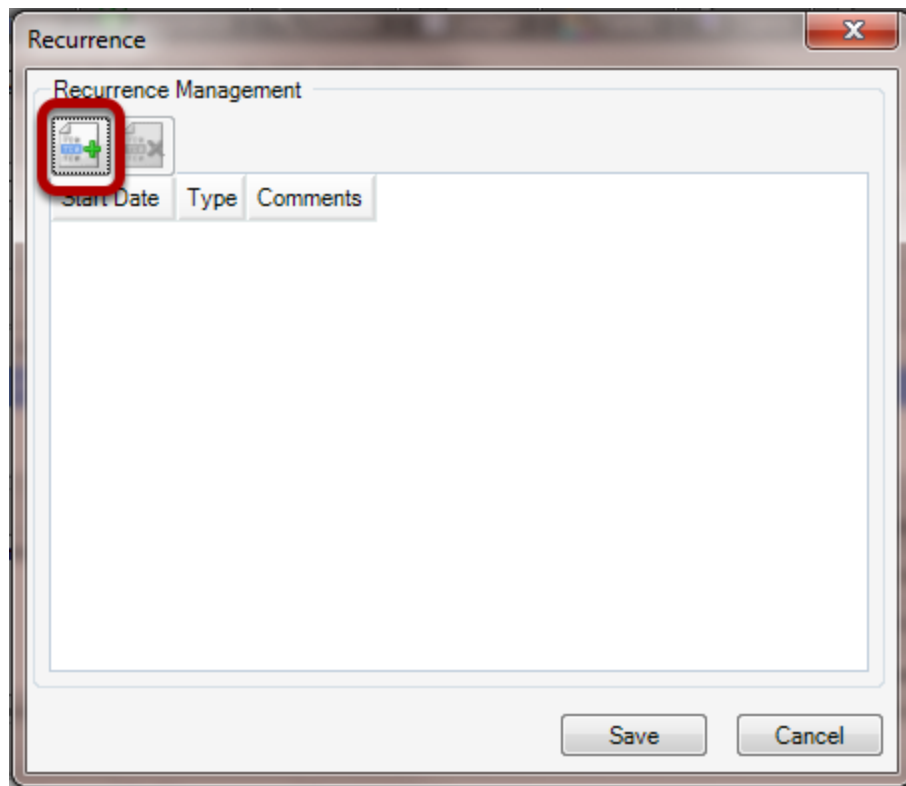
**Visit List**

Date	Start	End	Facility	Resource Name	Scheduplate
4/30/2010	11:30 AM	12:15 PM	DOCS Clinic	David C. Smith	
4/27/2010	7:45 AM	8:00 AM	DOCS Clinic	Randall Oates	Sick Visit - Est. ...
4/23/2010	8:45 AM	9:15 AM	DOCS Clinic	Randall Oates	Sick Visit - Est. ...
4/22/2010	2:00 PM	2:15 PM	DOCS Clinic	David C. Smith	
4/22/2010	8:45 AM	9:00 AM	DOCS Clinic	Sarah Slim	
4/21/2010	1:45 AM	12:00 PM	DOCS Clinic		Sick Visit - Est. ...

**Today** **Print Visit** **New Visit**

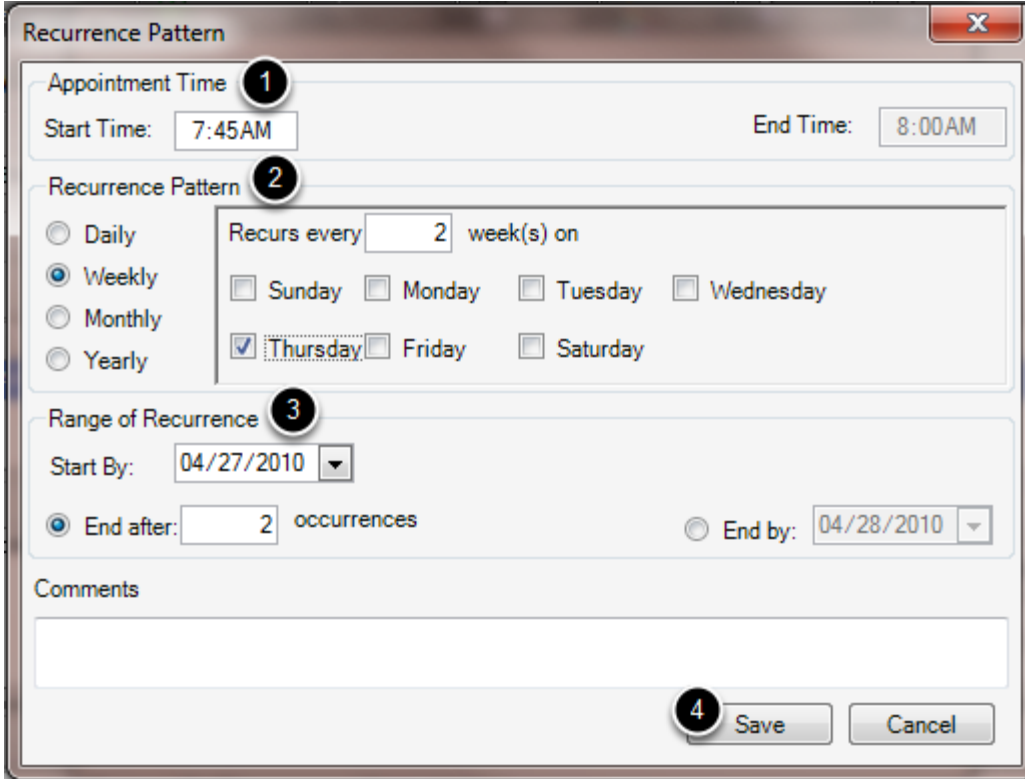
1. Double Click the appointment, needing to be repeated. This will open the patient's account dialog window.

2. On the Schedule tab, Click Recurrence.



Click the Create Recurrence button.

## Set the Recurrence Pattern



The image shows a 'Recurrence Pattern' dialog box with four numbered callouts. Callout 1 points to the 'Appointment Time' section, which includes 'Start Time' (7:45AM) and 'End Time' (8:00AM). Callout 2 points to the 'Recurrence Pattern' section, which has radio buttons for 'Daily', 'Weekly' (selected), 'Monthly', and 'Yearly'. Below these, it says 'Recurs every 2 week(s) on' followed by checkboxes for 'Sunday', 'Monday', 'Tuesday', 'Wednesday', 'Thursday' (checked), 'Friday', and 'Saturday'. Callout 3 points to the 'Range of Recurrence' section, which has a 'Start By' date of 04/27/2010 and two options: 'End after: 2 occurrences' (selected) and 'End by: 04/28/2010'. Callout 4 points to the 'Save' button at the bottom right, next to a 'Cancel' button. A 'Comments' text area is located above the buttons.

1. Enter the appointment time.
2. Select whether the appointment will be on a **Daily, Weekly, Monthly or Yearly** basis.
3. Indicate how long the recurrence will take place. **Select the Start Date**, as well as either the **number of occurrences** for the appointment or an **End Date** for the recurrence.
4. Click Save.

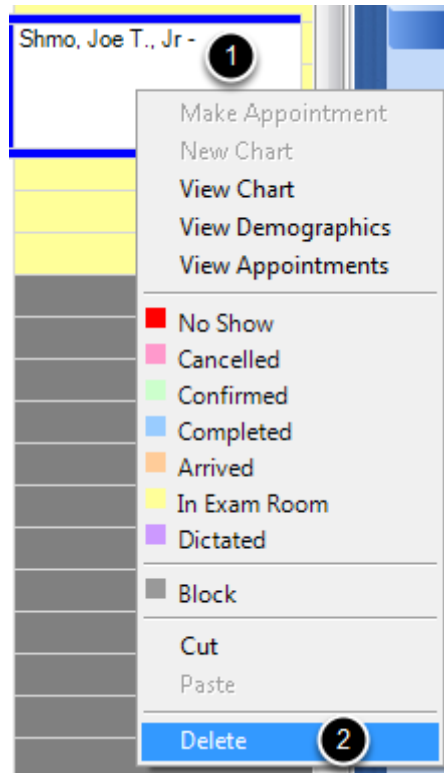
The recurring appointments should be scheduled, and the patient's account updated automatically.

## Deleting an Appointment

---

This lesson will show how to delete a patient appointment.

### Delete an Appointment



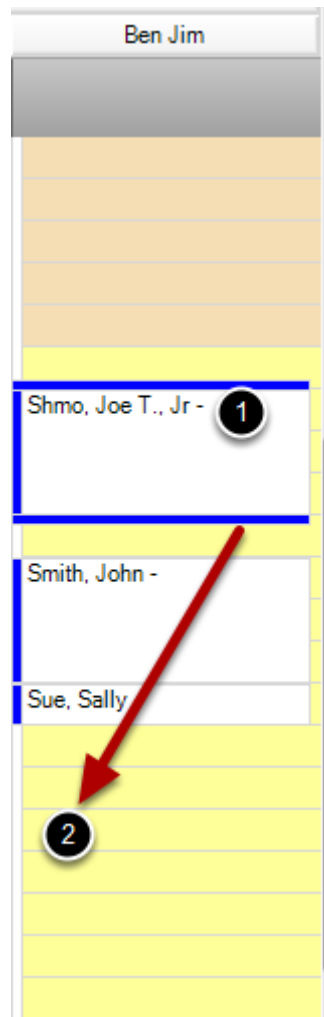
1. Click to select the appointment.
2. Right click on the appointment and select Delete, or Click Delete on the keyboard. (A warning will pop up to make sure the appointment is to be deleted. Click Yes to continue, or No to cancel.)

## Moving an Appointment

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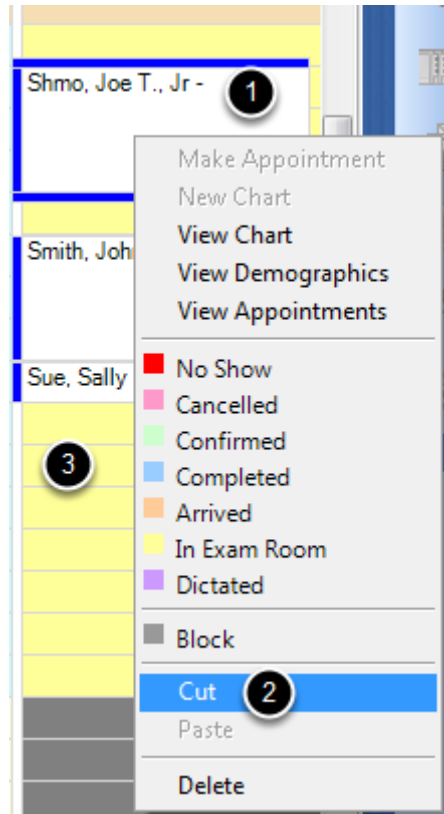
This lesson will demonstrate how to move an appointment to a different time slot.

### Dragging and Dropping



1. Click to select the appointment.
  2. With the left mouse button held down, drag the appointment to the desired time slot and release the mouse.
- The appointment should then be placed at a new time, and the patient's appointment details updated automatically.

## Cutting and Pasting



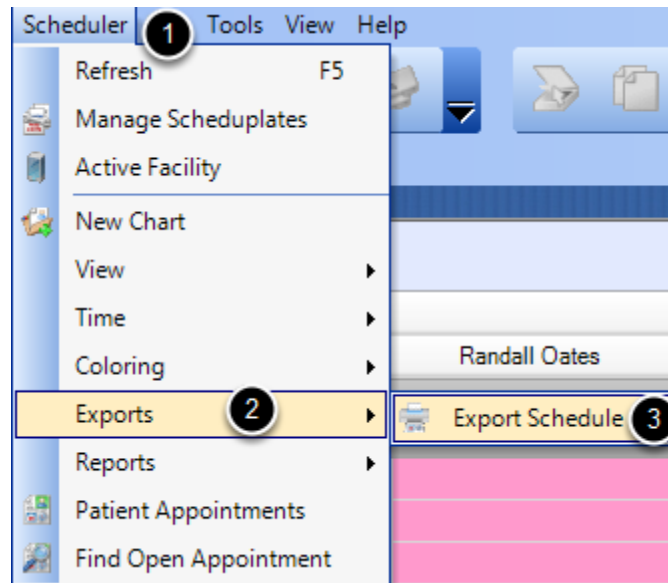
1. Click to select the appointment.
2. Right click on the desired appointment, and Select cut.
3. Click the desired time slot. Right click on the mouse and select Paste. The appointment should then be placed at a new time, and the patient's appointment details updated automatically.

## Export the Schedule

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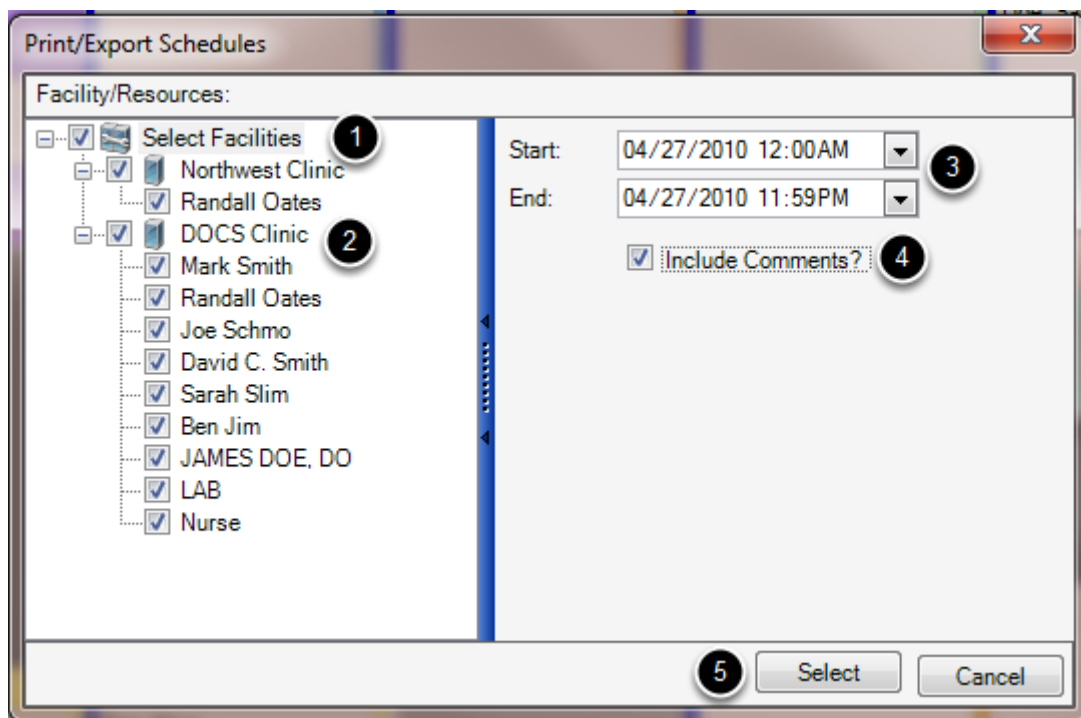
This lesson will demonstrate how to export the clinic's schedule.

### Export the Schedule



1. Select Scheduler.
2. Click on Exports.
3. Select Export Schedule.

## Select the Facilities/Resources to Export



1. Check the boxes of the Facilities to be shown.
2. Select the Resources whose schedules need to be exported.
3. Enter the range of dates to be exported.
4. Check to include the visit comments on the report as reference, if needed.
5. Click Select. The file will be exported as a CSV file.

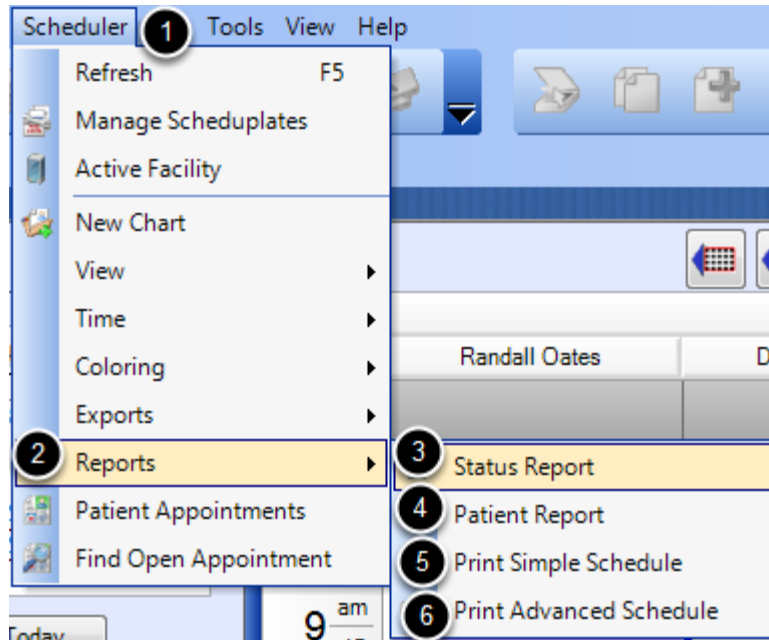


## Schedule Reports

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This lesson will demonstrate how to access reports on the Schedule data.

### Print various Schedule Reports



1. Click on Scheduler.
2. Click on Reports.
3. Status Report: View a summary of patients based on their appointment status.
4. Patient Report: Provides both a summary of the specified patient's appointments, but also provides a breakdown of the time spent at each status of each appointment.
5. Print Simple Schedule: Provides a summary of the appointments scheduled by Provider. Indicates the Time, Patient Name, Phone Number, Scheduplate, Status and visit Comments.
6. Print Advanced Schedule: Provides a summary of appointments scheduled across Facilities and Resources. Time, Patient Name, Phone Number, Scheduplate, Status and visit Comments.

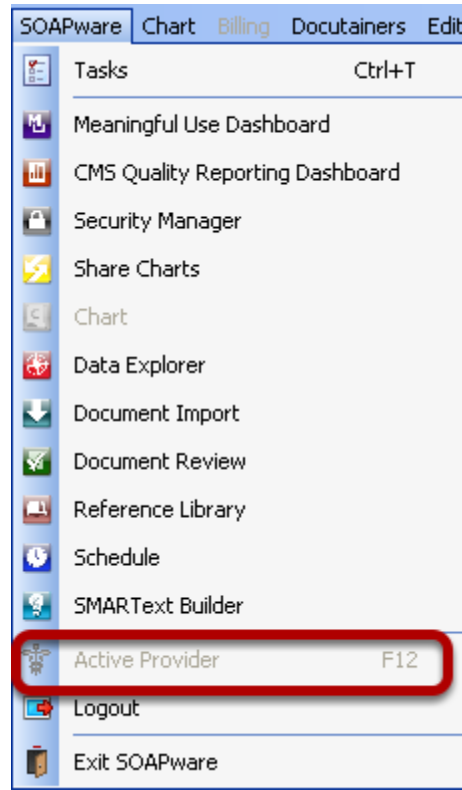
# Workflow Considerations

## Active Provider

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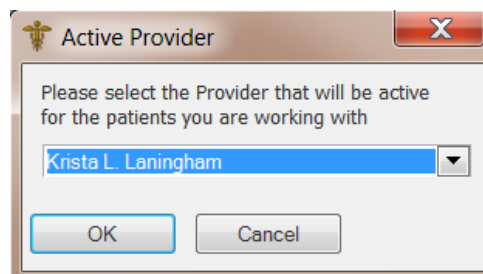
The Active Provider dialog allows the user to switch the currently selected Active Provider in SOAPware. Switching the Active Provider in SOAPware allows the user to access the selected Provider's Chart Rack, and the create, edit and sign off items in SOAPware created under the selected Provider's name.

### Open Active Provider



To access the Active Provider dialog, simply click SOAPware, Active Provider in the main menu bar

### Select Active Provider



The user would Click the drop-down list box arrow and select the new Provider that he/she would like to use in SOAPware. Once the proper Provider has been selected, simply Click OK.

After the user has selected the new Active Provider in SOAPware, the user will notice that the new Active Provider is displayed in the SOAPware title bar. In addition, any charts that the user creates, or items within charts, will be associated with the newly selected Provider.

## Docu-Portal

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Docu-Portal is a new module for SOAPware users which provides two major feature additions to the EMR: (1) inbound and outbound faxing which is integrated with the chart, and (2) a secure patient portal for providing records to patients. In addition, there are a host of additional communication, document editing, and document capturing features included in the Docu-Portal, such as secure messaging to non-patient contacts, screen capture, PDF editing and generation, and scanned document uploads. Docu-Portal provides tracking of fax and e-mail communications and provides configurable individual and shared views to inboxes and sent items. Docu-Portal has been developed for SOAPware by [Updox](#).

### Interface

Docu-Portal is viewed through popular browsers, such as Internet Explorer, Google Chrome, Firefox and Safari. Depending on a user's configuration, Docu-Portal is accessible anywhere on the Internet or only within the user's SOAPware VPN. An icon saved to the desktop will bring the user to the sign-in screen after set-up. The user can also keep Docu-Portal running in the system tray, so that the screen can be hidden, except when being used. Small messages appear in the system tray to let the user know that Docu-Portal has a new item for the user to work. The user can also choose to receive notifications on the user's desk or phone e-mail to alert the user to certain items.

**\*SHS Customers:** If users are using the SOAPware Hosting Service, users will follow the same instructions below on the VPS and not on the local PC.

### Requirements

Requirements = [Java version 6](#), SOAPwareXchange 2010.1.X or above  
[Click Here](#), verify that all the aspects of the interface are installed & configured.

### Docu-Portal Connector



When creating a Docu-Portal account, the user will be prompted to select an EMR, in our case SOAPware & a custom connector will be created for this interfacing between SOAPware & Docu-Portal, called the Docu-Portal Connector. The connector is a file (soapware\_hosted.jnlp) that is ran by Java, installed to Start > Programs > Docu-Portal Connector and has several settings that can be adjusted to assist the user with personal & EMR interaction with Docu-Portal.

**Docu-Portal Connector Settings**

**Connection Information**

1 User Name/Email Address: doctor@gmail.com

Password: \*\*\*\*\*

Confirm Password: \*\*\*\*\*

Server Location: https://www.myupdox.com/udb

**Save to Disk Options**

2 Patient Home Folder: ... PatientData

Patient Folder Pattern: @LI@/@LN@, @FN@

**Import Directory Options**

3 SOAPwareXchange 'In' Directory: ... IN

Report Download Directory: ... ImageFolder

**Other Options**

Run on Startup: ☒

OK Cancel Stop Help

The Connector creates the link between the Updox Service Database & SOAPwareXchange. The application logs into the account on Docu-Portal so that the user can send & receive requested documents/information from the local computer or SOAPware.

**1. Connection Information:** The connection information contains the user's personal login information so that the connector can interface with Docu-Portal. The Server Location setting (<https://www.myupdox.com/udb>) is generally never modified unless directed differently by SOAPware Technical Support.

**2. Save to Disk Options:** The Patient Home Folder is the location on the local computer where the Patient Chart Directory File will be created. The option "Send to Disk" in patient associated actions will automatically create a series of sub-folders within this folder, as configured by the "Patient Folder Pattern". The Patient Folder Pattern directs the filing order and file naming of patient-specific folders which are saved directly to a user's computer (in addition to saving them in SOAPware). When users select a category at the time of filing the record, that category will become (or populate an existing) sub directory under the patient folder. For example, assuming the home folder is C:\PatientData and the record is titled "Test File", and it is associated with patient "Joe Smith" and categorized as "Radiology", the default file pathway of (@LI@/@LN@, @FN@) will create the following file location:

C:\PatientData\S\Smith, Joe\Radiology\Test File.pdf

The following abbreviations are used to construct the actual folder path based on patient and action attributes:

- @LI@ – Labeled with the patient's last initial
- @FI@ – Labeled with the patient's first initial
- @LN@ – Labeled with the patient's last name
- @FN@ – Labeled with the patient's first name
- @ID@ – Labeled with the patient's account number
- @BD@ – Labeled with the patient's birth date

**3. Import Directory Options:** Ordinarily, users do not change the SOAPwareXchange "In" Directory from the default setting. This must match the "In" folder location of SOAPwareXchange, specified in the SOAPwareXchange "Set Locations" settings. In addition, the Report Download Directory is ordinarily not changed from the default setting. This must match the location SOAPwareXchange expects to find the files to be imported, as specified in the file sent by the Docu-Portal Connector to SOAPwareXchange for processing.

## Docu-Portal for SOAPware



After the user's Docu-Portal Account is created, when the user goes to login at <http://www.Updox.com> the user will be prompted to select the EMR, SOAPware in our case, then a file will begin to download (soapware\_hosted.jnlp). This file will be ran by Java & start the "Updox for SOAPware" Helper which includes all the same tools mentioned below in "Main Menu Explained" & a few others.

1. Open Docu-Portal Browser will take users to the login page of the practice Docu-Portal website or the main page if he/she is already logged in.
2. Open Auto Upload Folder will open, on the user's local computer, the folder associated with the "auto upload to Docu-Portal" function (default = C:\Documents and Settings\USER\SendToDocu-Portal).

## Main Menu

Actions Tools Admin Help What's new?

Wednesday 3:04 PM

### Actions

Compose will allow users to create a document (w/ attachment) to send to a patient's chart in

SOAPware, to fax to a contact in SOAPware, or send to another Docu-Portal enabled Practice.

Add File allows users to upload any file to the Docu-Portal so that it can be passed securely from patient, contact or SOAPware.

Capture Screenshot allows users to store a pre-selected area of what's displayed on a user's monitor in an image file; so that the user may edit it or send securely through Docu-Portal.

Open Image Editor opens a window allowing users to create an image similar to Microsoft Paint; when a image is being viewed a menu will appear above the image allowing users to edit the image using the same tools found in Image Editor.

Sign Out will log out the current user that is logged into the Updox Docu-Portal.

## **Tools**

Change Password allows users to create a new password for the users' Docu-Portal User ID.

My Profile allows users to edit the Name, Address, Time Zone, Email, & Signature Image of the users' Docu-Portal User ID.

Usage Information allows users to view the usage & limits associated with the users' Docu-Portal Monthly Plan; Chart Imports, Email, Fax Pages, Portal Messages, Saves, Secure Messages, User Accounts.

Clear Cache

## **Admin**

Manage Users allows users to manage users (view, edit or add) in the Docu-Portal Practice.

Practice Profile allows users to view or edit the practice information associated with Docu-Portal; Name, Address, Phone, Fax, & Settings.

Practice Portal allows users to enable or disable the Practice Portal; as well as view/edit the name displayed & the web address (for example: [http://soapware\\_clinic.myupdox.com](http://soapware_clinic.myupdox.com)) used to access it from anywhere with web access.

Manage Templates

Edit Fax Coversheet allows users to view/edit the default coversheet used by all faxes being sent by Docu-Portal. Certain Text, referred to as Marcos, are required for the coversheet to function correctly; {fromName}, {fromFax}, {toName}, {toFax}, {subject}, {instructions} are used by the faxing



function so that it knows what fields to pull & where to place it in a user's coversheet.

Billing Information allows users to view the usage & limits associated with the users' Docu-Portal Monthly Plan, Bill Dates & amounts as well as edit Credit Card Information.

Connect to EMR

## **Help**

General Overview links to the following PDF ([http://myupdox.com/udb/files/help/ov...w\\_soapware.pdf](http://myupdox.com/udb/files/help/ov...w_soapware.pdf)) for a document describing the Docu-Portals usage.

Setup References links to the following PDF ([http://myupdox.com/udb/files/help/setup\\_soapware.pdf](http://myupdox.com/udb/files/help/setup_soapware.pdf)) for a document describing how to link Outlook Mail, Gmail, Faxing Service, or MAC to you your Docu-Portal.

FAQ links to the following PDF ([http://myupdox.com/udb/files/help/faq\\_soapware.pdf](http://myupdox.com/udb/files/help/faq_soapware.pdf)) describing many functions of the Docu-Portal.

Have an Idea for Us? allows you to send question or comments directly to Updox for review; pertaining to an idea, question, problem or praise.

Contact Us gives you contact information for SOAPware Support (1-800-455-7627x3)

## **What's New?**

Takes the user to the following address ([https://myupdox.com/udb/whats\\_new.html](https://myupdox.com/udb/whats_new.html)) where the user can find new features & bug fixes being added to Updox.

## Changing Settings: User Specific, Computer Specific, and Global Settings

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### Tools - Options: User Specific Customizations

- Chart Rack
- Document Designer
- Docuplates
- Drug Interactions
- Pulled Charts
- SMARText
- SMARText Color Coding
- Structured CPT
- Structured Dx
- Structured Order Entry
- Structured Rx
- Summary to SOAP

### Tools - Options: Network Specific Customizations

- Billing Statement
- OCR Settings
- Scanning Settings
- Structured Billing
- Vital Signs

### Other Customization Areas: User Specific Customizations

- Customize Options
- Task Manager Columns View
- Chart Section Editor-Default Chart Section Docuplates may be customized per user or by network

### Other Customization Areas: Network Specific Customizations

- Creating/Editing SMARText and Docuplates
- List Options
- Custom Demographic Titles
- Flow Sheet Items
- Health Maintenance Rules and Sets
- Chart Section Editor-Default Chart Section Docuplates may be customized per user or by network

## Computer & User Specific Customizations

Toolbars

Docked Tabs

Chart Layout

# Introduction to Charts

## Understanding the Chart Workspace

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The Chart Workspace is the main chart interface for SOAPware. It is the interface for all of the data in a patient's chart.

### Functionality

The chart view appears as an open file folder in the SOAPware window. In the lower right corner is the patient's name and other identifying information. The data areas consist of document managers that the user can add, remove, or rearrange to meet a user's particular needs.

The Document Managers currently available in the chart are listed as tabs across the top of the chart area. Examples are Demographics, Summary, SOAPnote, etc.

To add new document managers to the user's view, open Chart Navigator (Chart-Chart Navigator), select a manager from the list, then drag and drop that manager onto the manager tab list at the top of the chart. To remove a manager, click to select it, then click the X at the right end of its tab list. A user can rearrange the managers by clicking on the title tab and dragging it to another location. Managers can be dragged to another tab list, or to a new area in the chart view, thus creating a new tab group.

For information on the use of specific document managers, see the document manager section.

### Lock/Unlock View

If users have created a view that he/she would like to lock, Click View > Lock Layout. This will prevent document sections and a user's layout from being rearranged.

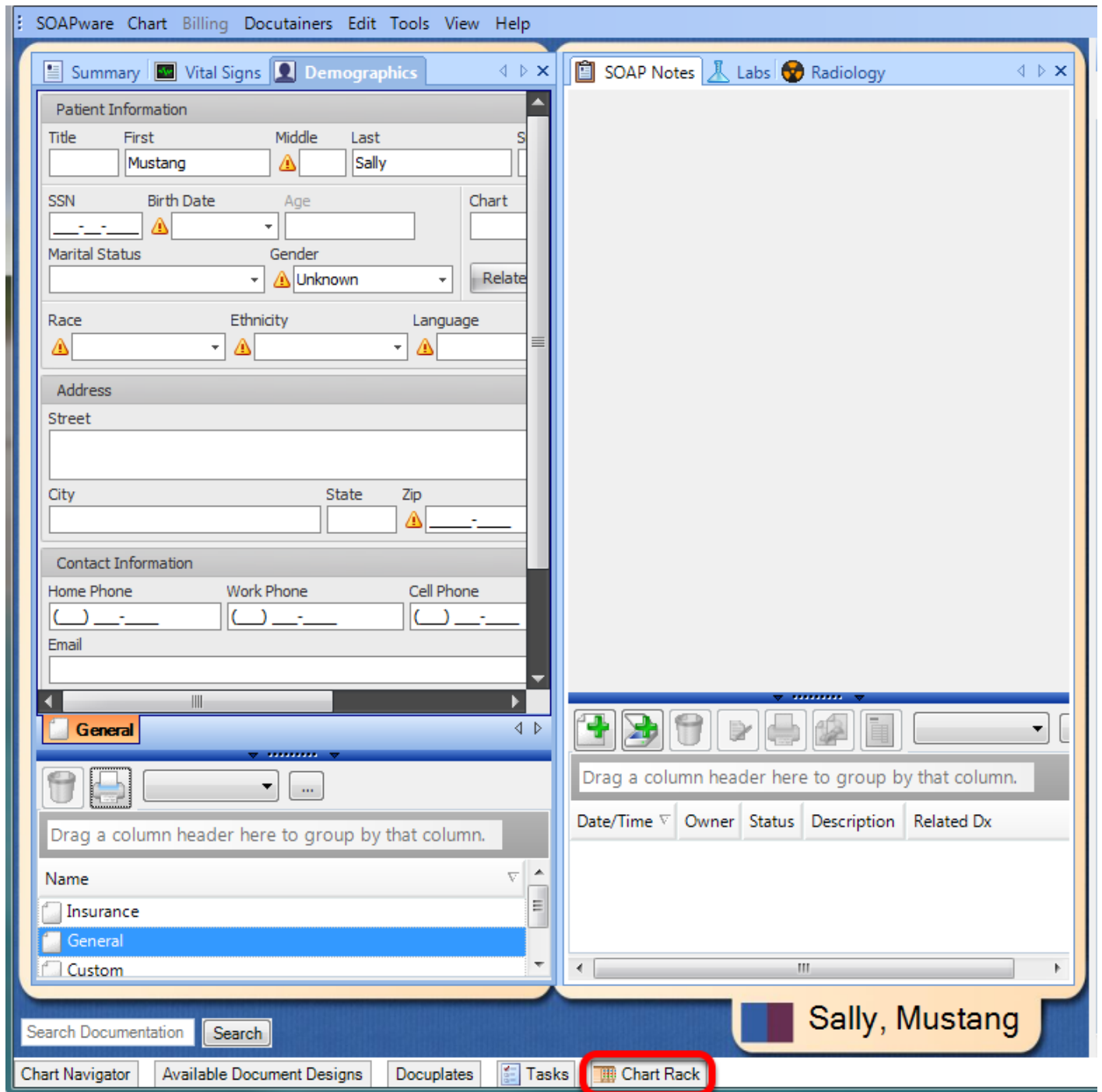
### More on Layouts

Once the user has created and saved several layouts, the user can easily switch between them by Clicking View > Chart Layouts and selecting the saved layout from the list.

## Chart Rack

The Chart Rack is used to search for a patient chart.

### Accessing the Chart Rack

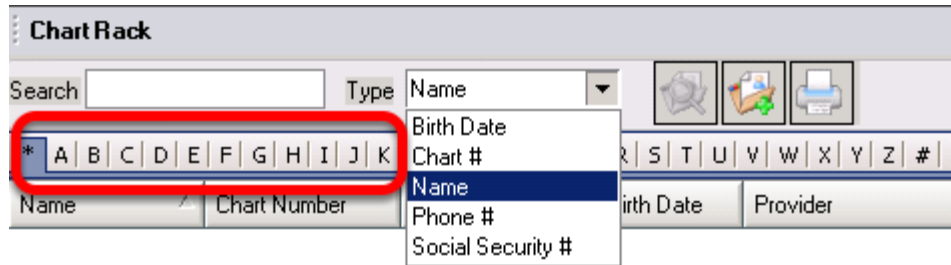


To open the Chart Rack, use one of the following methods:

1. Click the Chart Rack Docked Tab

2. Press Control + Shift + C keys
3. Click Chart in the Menu bar, and Click the Chart Rack Menu item

## Chart Retrieval



A chart can be retrieved and opened by searching for a patient by any one of the following:




- \* Last Name
- \* Birth Date
- \* Chart #
- \* Social Security #
- \* Phone #

Also, a chart may be retrieved by using the Alphabet bar by clicking on the corresponding letter of the patient last name.

## Open Chart

**Chart Rack**

Search  Type

**Open chart - Ctrl + Alt + V**  
This will open the currently selected patient chart. You can then add visit notes and enter other information related to the patient.

**Press F1 key to get more information**

Name	Chart Number	SSN	Birth Date	Provider
Test, Jane T.	JT0000	000-00-0000	01/01/1958	Krista Lan
Test, Jessa			12/14/1989	Krista Lan
Test, Lisa			12/18/2006	Krista Laningham
Test, Reece			11/17/1982	Krista Laningham
Test, Tesa T.	TT6789	123-45-6789	05/12/1994	Krista Laningham

Provider  Total Active Patients: 87

A chart can be opened by taking one of the following actions:

1. Double click on the highlighted patient name
2. Press the enter key
3. Click the Open Chart button

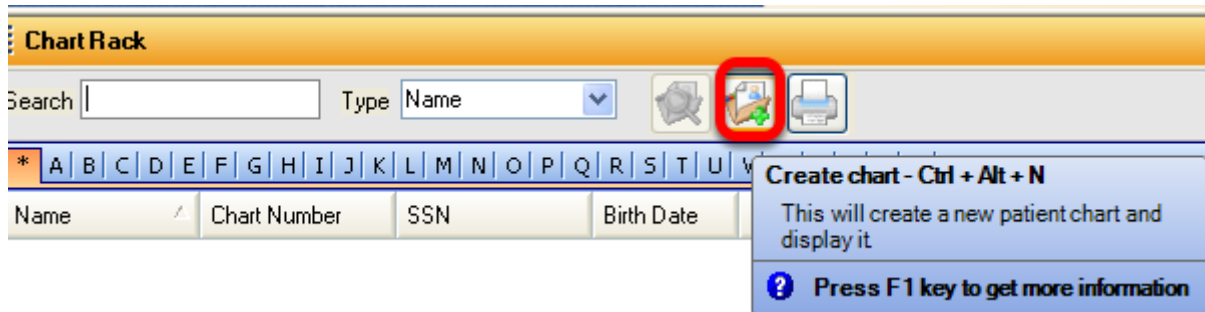


## Creating A New Chart

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A new chart can be created from within the Chart Rack.

### How to Create a New Chart



To create a new chart, the user will click on the Create chart button.

### Creating a New Chart

The image shows a "Create Chart" dialog box. It has two text input fields: "First" with the text "Mustang" and "Last" with the text "Sally". At the bottom, there are two buttons: "OK" and "Cancel". The "OK" button is highlighted with a red circle.

Enter the first and last name of the patient, then Click OK.

## New Chart has been Created

The screenshot displays the SOAPware software interface. The main window is titled "SOAPware Chart Billing Docutainers Edit Tools View Help". The "Demographics" tab is active, showing a form for patient information. The form includes fields for Title, First, Middle, Last, and Suffix. The "First" field contains "Mustang". The "SSN" field has a warning icon. The "Birth Date" field has a warning icon. The "Age" field is empty. The "Chart" field is empty. The "Marital Status" field is empty. The "Gender" field is set to "Unknown". The "Race" field has a warning icon. The "Ethnicity" field has a warning icon. The "Language" field has a warning icon. The "Address" section includes fields for Street, City, State, and Zip. The "Contact Information" section includes fields for Home Phone, Work Phone, Cell Phone, and Email. The "General" tab is selected, showing a list of categories: Insurance, General, and Custom. The "SOAP Notes" window is open, showing a table with columns: Date/Time, Owner, Status, Description, and Related Dx. The patient name tag at the bottom right reads "Sally, Mustang".

SOAPware Chart Billing Docutainers Edit Tools View Help

Summary Vital Signs Demographics SOAP Notes Labs Radiology

Patient Information

Title First Middle Last Suffix

SSN Birth Date Age Chart

Marital Status Gender

Race Ethnicity Language

Address

Street

City State Zip

Contact Information

Home Phone Work Phone Cell Phone

Email

General

Insurance General Custom

SOAP Notes

Drag a column header here to group by that column.

Date/Time Owner Status Description Related Dx

Sally, Mustang

A new chart will open immediately to the Demographics section of the chart. This feature allows the creator to enter the demographic information now or to defer the demographic information entry if needed due to limited time.

## Entering Demographics

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Demographics can be entered and edited within the Demographics chart section.

**\*THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT - SEE RECORD DEMOGRAPHICS**

### **Patient Meaningful Use Dashboard:**

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#).

## Entering General Demographic Information

The screenshot shows the 'Demographics' tab in a medical software interface. The form is divided into several sections:

- Patient Information:** Fields for Title, First (Mustang), Middle (with a yellow warning icon), Last (Sally), and Suffix. Below these are SSN, Birth Date (with a yellow warning icon), Age, and Chart.
- Marital Status and Gender:** Marital Status is a dropdown menu. Gender is a dropdown menu set to 'Unknown' (with a yellow warning icon). A 'Related To...' button is next to it.
- Race, Ethnicity, and Language:** Each of these fields has a dropdown menu and a yellow warning icon.
- Address:** Fields for Street, City, State, and Zip (with a yellow warning icon).
- Contact Information:** Fields for Home Phone, Work Phone, and Cell Phone, each with a format guide ( ) - - . An Email field is also present.
- Bottom Section:** A tabbed interface with three tabs: 'General' (selected), 'Insurance', and 'Custom'. The 'General' tab is highlighted with a red circle. Above the tabs is a message: 'Drag a column header here to group by that column.'

Yellow warning icons indicate that these items are required in order to successfully retrieve eligibility for the patient and report meaningful use data. When valid data is entered, the icon will disappear.

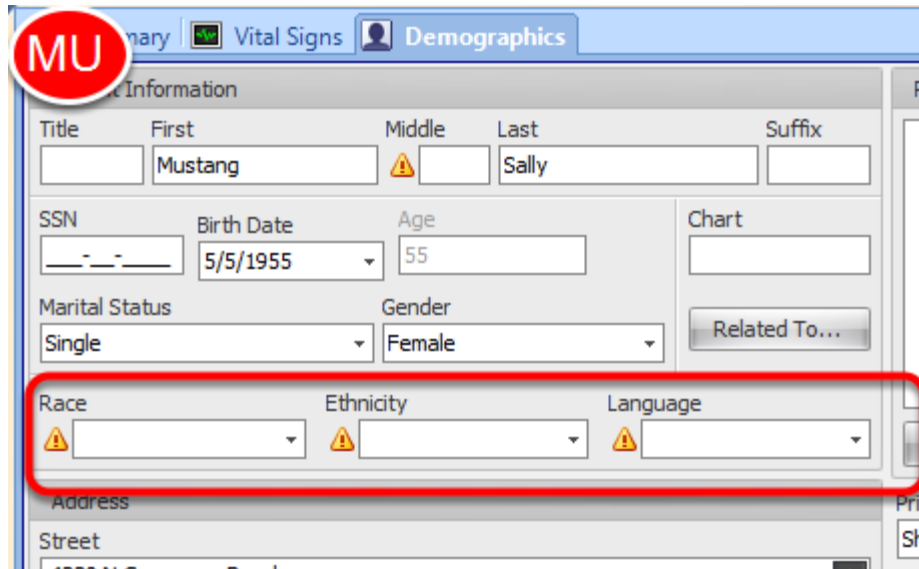
Yellow Warning icons indicate that these items are required in order to successfully retrieve eligibility for the patient and report meaningful use data. When valid data is entered, the icon will disappear.

A user will notice three tabs under the Demographics chart section: (1) Insurance, (2) General, and (3) Custom.

The General demographics section of the chart contains all of the basic identifying information

about a patient. The patients' name, provider, and contact information can all be found in this section. Auser will also see several fields that are highlighted in yellow. These are required fields for ePrescribing. If users do not have all the necessary information entered for the patient, users will not be able to ePrescribe.

## Race, Ethnicity and Language

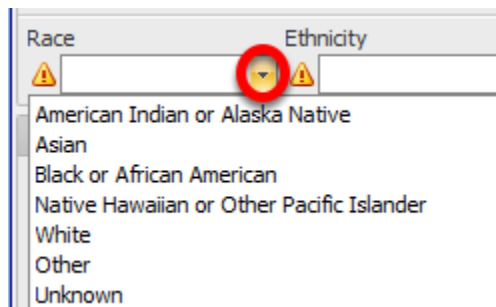


The screenshot shows a patient information form with tabs for 'Primary', 'Vital Signs', and 'Demographics'. The 'Demographics' tab is active. The form includes fields for Title, First, Middle, Last, and Suffix. The First name is 'Mustang'. There are yellow warning icons next to the Middle and Last name fields. Below these are fields for SSN, Birth Date (5/5/1955), Age (55), and Chart. Marital Status is 'Single' and Gender is 'Female'. At the bottom, the 'Race', 'Ethnicity', and 'Language' fields are highlighted with a red rectangle. Each of these fields has a yellow warning icon. A red circle with the letters 'MU' is in the top left corner of the form.

Race, Ethnicity and Language are required to meet the Meaningful Use Criteria.

The choices in these lists are determined by the U.S. Centers for Disease Control and Prevention (CDC). They have prepared a code set for use in coding race and ethnicity data. This code is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the OMB (for Meaningful Use Reporting) and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census.

## Race and Ethnicity



The screenshot shows a dropdown menu for 'Race' and 'Ethnicity'. The 'Race' dropdown is open, displaying a list of options: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Other, and Unknown. A red circle highlights the downward arrow on the 'Race' dropdown. The 'Ethnicity' dropdown is also visible with a yellow warning icon.

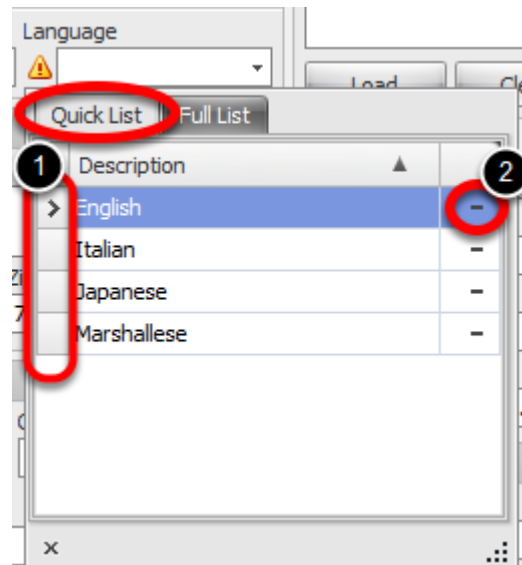
To enter Race and Ethnicity:

1. Click on the Downward facing Arrow.

2. Then select desired choice.

**Note:** The Race and Ethnicity lists have been simplified from previous versions of SOAPware and now contain a shorter list of options. If a user had previously selected a value that has now been eliminated from the list of options the value will be set to "Unknown". The "Unknown" value will count as an accurate value for Meaningful Use statistics; however it is recommended that these be updated as necessary.

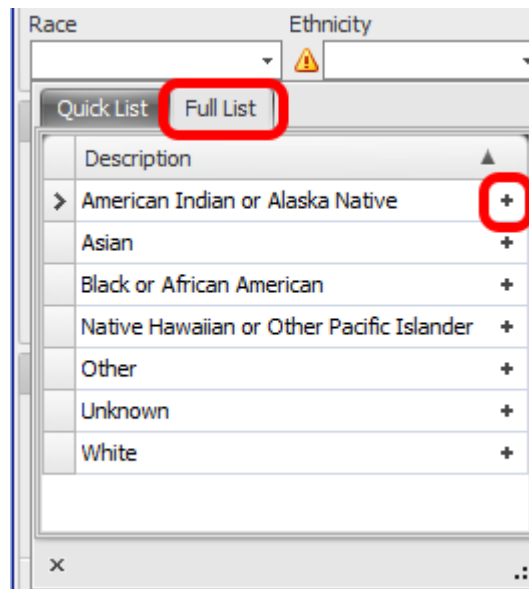
## Language Quick List



This list is compiled of user-defined items that are chosen from the full list. Once this list is setup, it is the same for all users.

1. To select an item for the patient, click on the row indicator area and save the chart.
2. Users can remove items from this list by clicking the [ - ] of the selected row. To select the row in order to remove, click the actual item description and it will highlight the row and expose the [ - ] button.

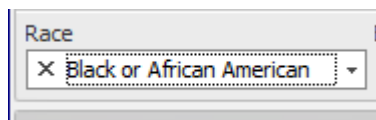
## Language- Full List



To access the Full List Click on the Full List tab to see a list of all languages . From this list the user can build a smaller quick access list. Items can be added to the Quick Access by clicking the [+] symbol of the selected row.

**Note:** The Language list has been simplified from previous versions of SOAPware and now contains a shorter list of options. If a user had previously selected a value that has now been eliminated from the list of options the value will be set to "Unknown". The "Unknown" value will count as an accurate value for Meaningful Use statistics; however it is recommended that these be updated as necessary.

## Clearing Patient Language/Ethnicity/Race



There are two options to clear the selected item.

Selection may be deleted by either Clicking the [X] button on the drop down box or pressing the DELETE or BACKSPACE keys on the keyboard.

The screenshot shows the 'Demographics' tab in the SOAPware interface. The form contains various fields for patient information, including name (Middle, Last, Suffix), age, gender, ethnicity, language, state, zip, work phone, and cell phone. On the right side, there is a 'Patient Picture' section with a 'Load' and 'Clear' button. Below this, there are sections for 'Primary Provider' (Shannon Shores), 'Referring Provider' (with a red circle around the '...' button), 'PCP' (with a red circle around the '...' button), 'Preferred Pharmacy', and 'Billing Information' (Guarantor, Financial Class, Student Status). A black callout box with white text says 'Click on the "..." to add to each list.' with a red arrow pointing to the '...' button in the Referring Provider field.

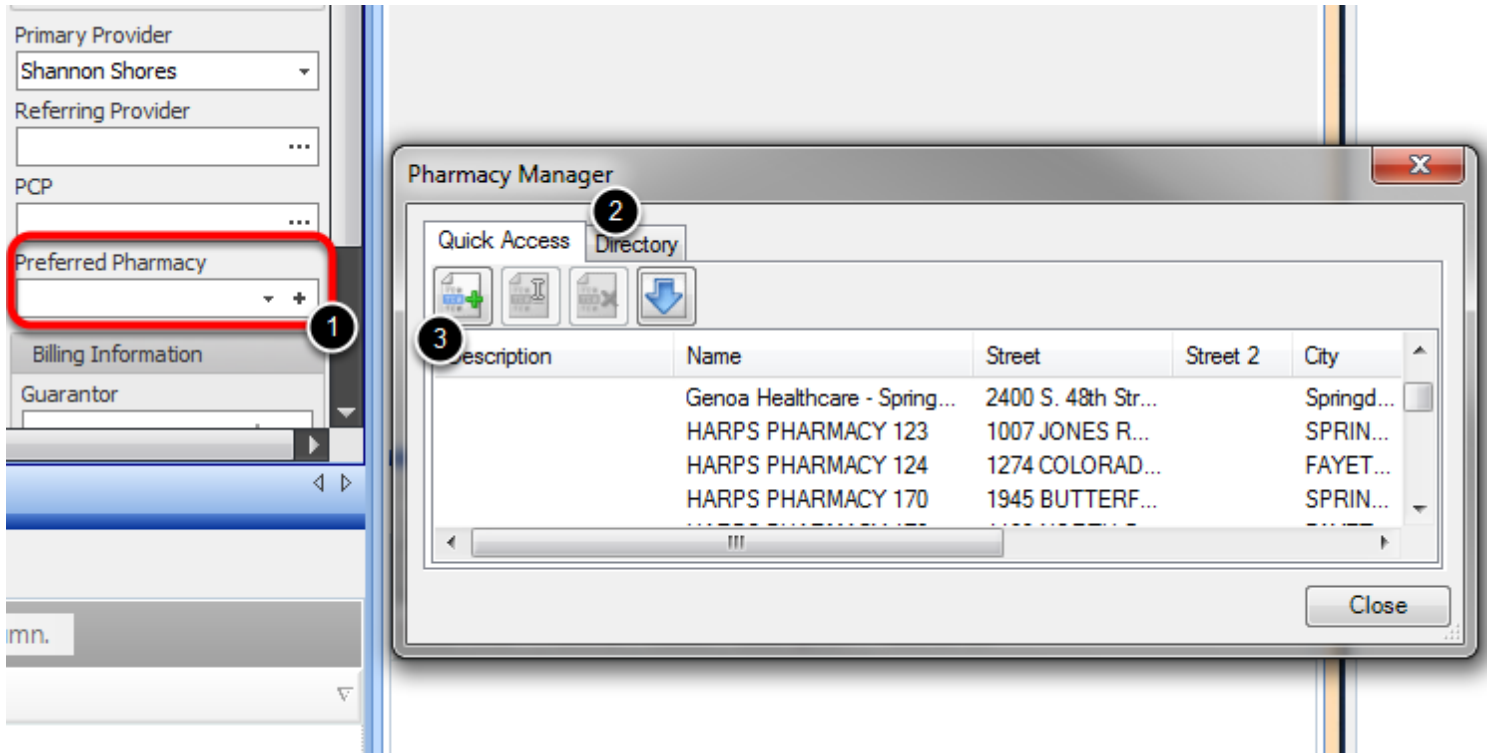
These two drop-down menus are used to select the patient's Primary Care Physician, and/or a Referring Physician.

SOAPware can maintain a list of frequently used contacts along with basic demographic information for each of them. SOAPware's document designs can then use this information to create personalized documents such as referral letters. The contact list is also used to maintain frequently used names and addresses. In this fashion it functions much as a Rolodex. This contacts list is used in the patient's demographics area to choose their PCP/Referring Provider.

If a user would like to add a referring provider to the list on the fly (who is not listed in the drop-down menu), Click the + button and Contact Manager will open. Simply add the provider to the list and it will appear in the Referring Provider drop down list.



## Preferred Pharmacy



This drop-down list box is used to select the patient's preferred pharmacy. This will automatically populate on this patient's Rx Manager when the user chooses to ePrescribe medications. By setting a default preferred pharmacy in demographics, the Rx Manager will also have a default pharmacy. The drop-down list is populated from what is set up in the Pharmacy Manager.

If users would like to add to the list of pharmacies on the fly:

1. Click the + button and the Pharmacy Manager dialog window will open.
2. Choose the Directory tab to search for the pharmacy if they accept ePrescribing
3. Or Click the plus button to manually add to the list.

The new pharmacy will appear in the Preferred Pharmacy list as a new selection.

## Email

Contact Information		
Home Phone	Work Phone	Cell Phone
( ) - -	( ) - -	( ) - -
Email		

This text box is used to enter the patient's email address. At this time, there is not a way to email patients from SOAPware, but demographics acts as a central place to store all information about this patient.

An accurate email address will be required in order to register a patient for the [SOAPware Patient Portal](#).

## Insurance Demographics

The screenshot shows the 'Insurance Policy' window in the SOAPware Patient Portal. The window is titled 'Insurance Policy' and contains several sections: 'Insured Information' with fields for Relation (Self), Name (FML) (Mustang), Middle (Sally), Address (4220 N Crossover Road), City (Fayetteville), State (AR), Zip (72703-), Birthday (5/5/1955), Gender (Female), and Phone; 'Policy Information' with fields for Policy # (Policy Number), Plan Name, Group #, Group Name, Effective, and Expires; 'Payment Options' with radio buttons for Co-Pay (\$0.00) and Co-Ins (0%), and a Status dropdown (Primary); and a 'Notes' section. A 'Save' button is at the bottom right. Numbered callouts 1 through 4 indicate key steps: 1 points to the 'Insurance' tab in the left sidebar, 2 points to the 'New Insurance' button, 3 points to the 'Insurance Policy' window title, and 4 points to the 'Save' button.

To add and edit patient's insurance information:

1. Click on the "Insurance" tab at the bottom of the demographics section.
2. Click the button with the green plus.
3. This will bring up a window where a user will type in the insurance information.
4. Click Save and a user will see the patient's insurance information listed at the top of the demographics window. Items with a red X must be completed before insurance policy is saved.

The screenshot shows a software window titled "Demographics" with a "Summary" tab. The main area contains a list of fields on the left and a large text input area on the right. The fields are: Emergency #, Spouses Name, Caregiver's Name, Custom 4, Custom 5, Custom 6, Custom 7, Custom 8, Custom 9, Custom 10, Custom 11, Custom 12, and Custom 13. Below this list is a "Custom" tab. Under the "Custom" tab, there is a toolbar with a trash icon, a printer icon, a dropdown menu, and a button with three dots. Below the toolbar is a text box with the instruction "Drag a column header here to group by that column." Below this is a "Name" section with a list of items: "General" and "Custom". The "Custom" item is selected and highlighted in blue.

Emergency #:	
Spouses Name:	
Caregiver's Name:	
Custom 4	
Custom 5	
Custom 6	
Custom 7	
Custom 8	
Custom 9	
Custom 10	
Custom 11	
Custom 12	
Custom 13	

**Custom**

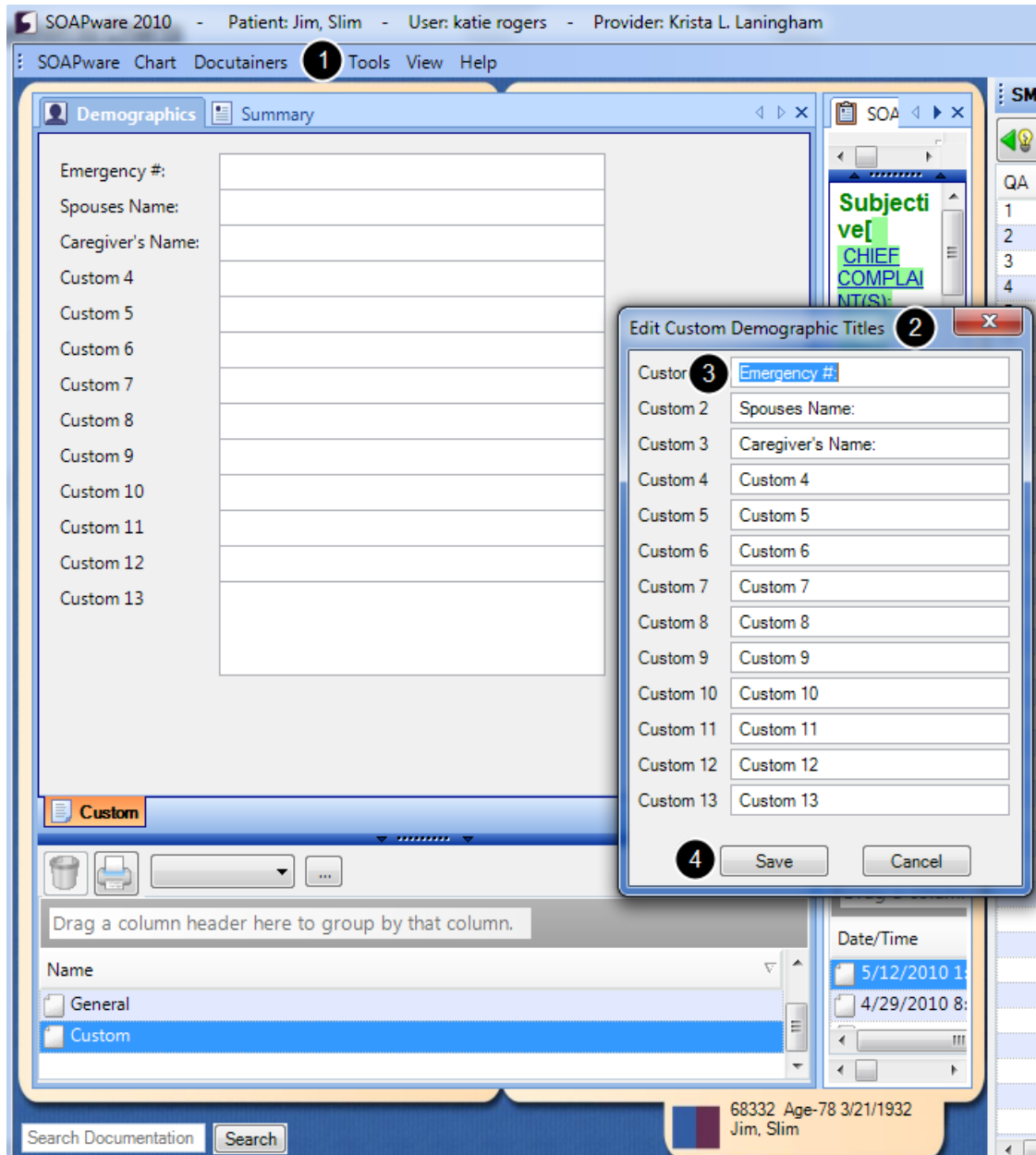
Drag a column header here to group by that column.

Name

- General
- Custom**

The Custom Demographics section of the chart contains the information not otherwise contained elsewhere in the demographics area, but which may be needed in most patients' charts. Custom field 13 is a note or memo text box; it is used to store more information than the other fields.

## Setting Custom Demographics Titles



By editing custom demographics titles, a user can add additional demographic fields to SOAPware, with names that the user assigns to them. To modify the custom demographics headings:

1. Click Tools > Custom Demographic Titles.
2. A user will see a list of custom demographics text boxes. The current name of each field is shown in an edit box where the user can enter the new name.
3. Fill in as many of these fields as the user wishes, then click Save to save changes.
4. Click Save, then close SOAPware and restart to see the new titles displayed.

**Note:** This setting will change the titles of all custom demographic fields on all patients in the database.

## Closing A Chart

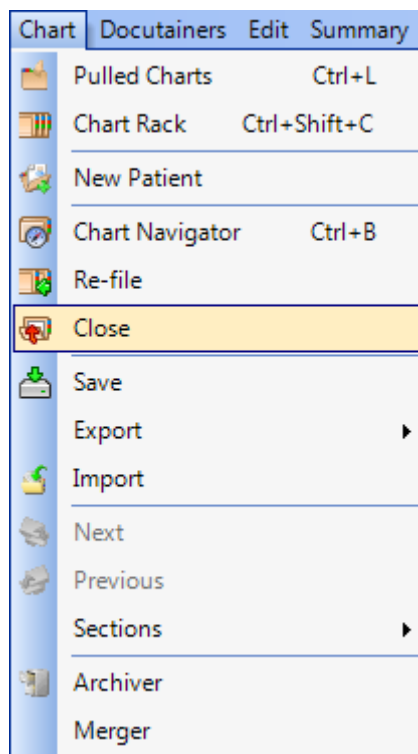
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### Closing Charts - Using the Toolbar



To close a chart, Click on the Close button in the Common Toolbar.

## Closing Charts - Using the Menu Bar



Auser can also close the chart using the Menu Bar by selecting Chart > Close.

## Workflow Options

When closing a chart, workflow options are available that give the user several options including Open Chart Rack, Open Pulled Charts, Open Task List. To set these options, see the section on Tools - Options.

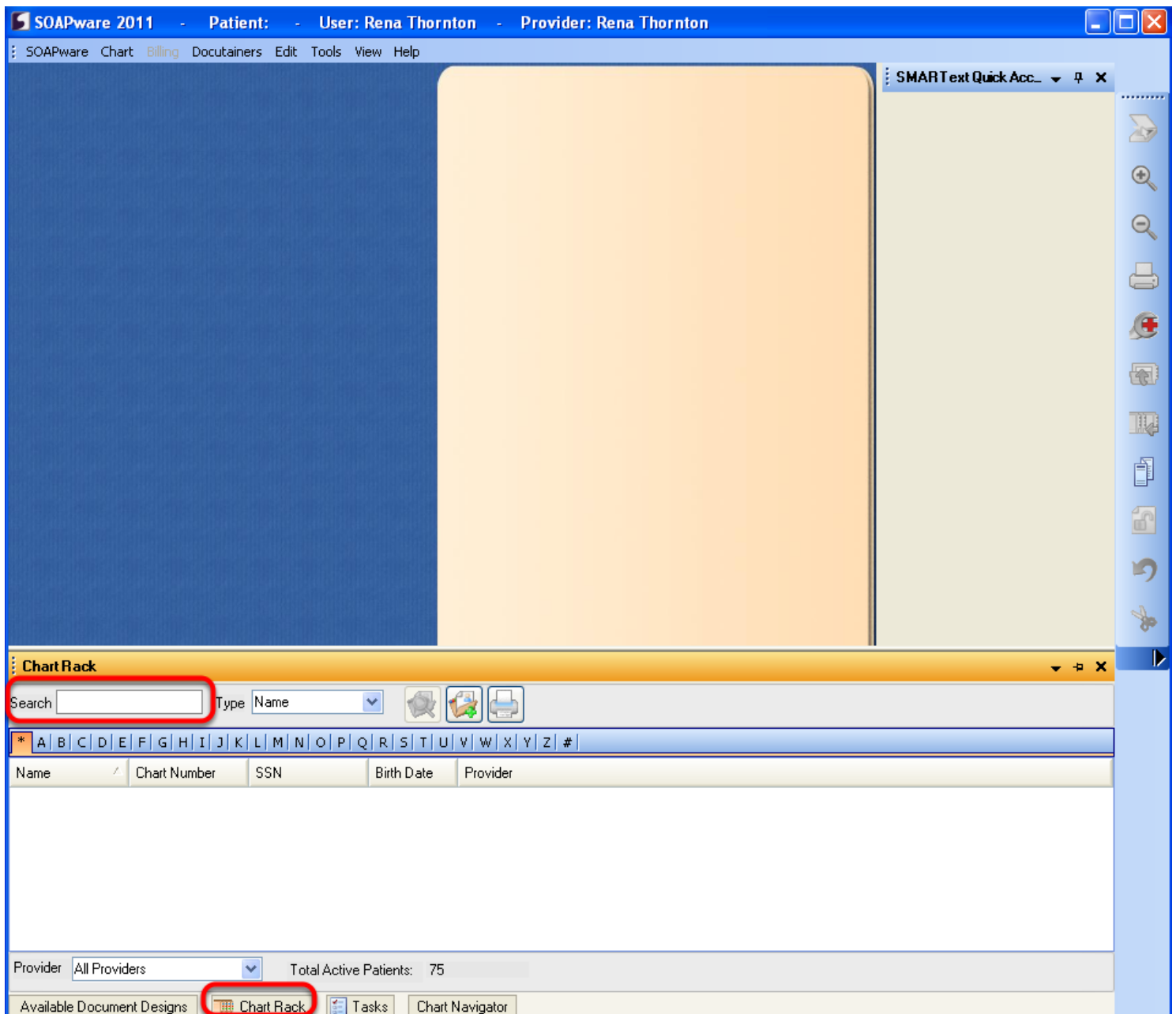
## Accessing Patient Charts

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Chart Rack is very similar to a user's chart room.



## Open the Chart Rack



To reopen a chart, select the Chart Rack docked tab located at the bottom of the Chart workspace. At the top of the Chart Rack viewer is a field, or box, labeled Search, and the cursor should be blinking in it.

## Search for the Chart

**Chart Rack**

Search  Type

\* A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Name /	Chart Number	SSN	Birth Date	Provider
Jim, Slim	68332	999-99-9999	03/21/1932	**None**

A specific chart can be retrieved via 5 methods:

1. Birth Date
2. Chart Number
3. Name
4. Phone Number
5. Social Security Number

To retrieve the chart by Name, begin typing the name. As the letters in the last name are entered, notice the corresponding chart name is highlighted-selected in the list after entering the third letter.

To search using another method, use the Type drop-down menu to change the search Type to one of the others listed above.

## Open the Chart

**Chart Rack**

Search  Type

\* A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

Name /	Chart Number	SSN	Birth Date	Provider
Jim, Slim	68332	999-99-9999	03/21/1932	**None**

Once the name is highlighted-selected, in order to actually retrieve the chart, there are 3 options:

1. Press the Enter key
2. Click the Open Chart button

3. Double-Click on the name

## Chart Navigator

Chart Navigator functions as the table of contents for charts. Chart Navigator allows a user to insert chart sections, as well as view documents in a patient's chart, in various chart sections.

### Access Chart Navigator

1. Click on the Chart Navigator tab docked at the bottom of the screen.
2. If Chart Navigator is not docked at the bottom, Click on Chart in the main menu toolbar, and Click on Chart Navigator.
3. Press Control + B on the keyboard.

### Two main regions

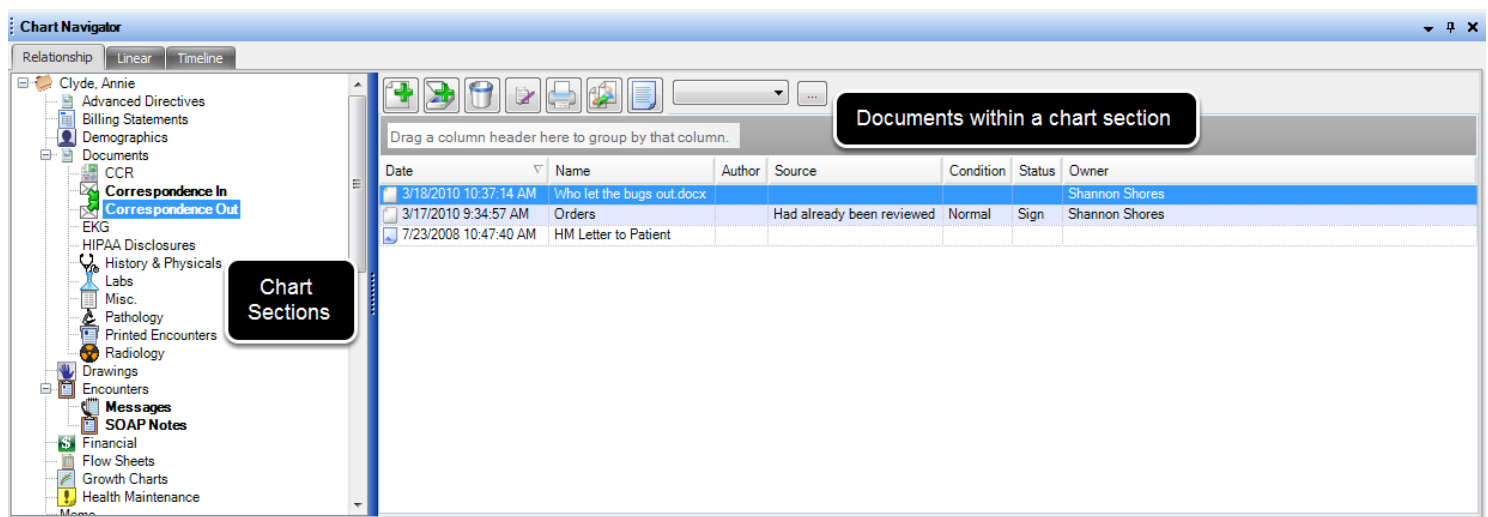
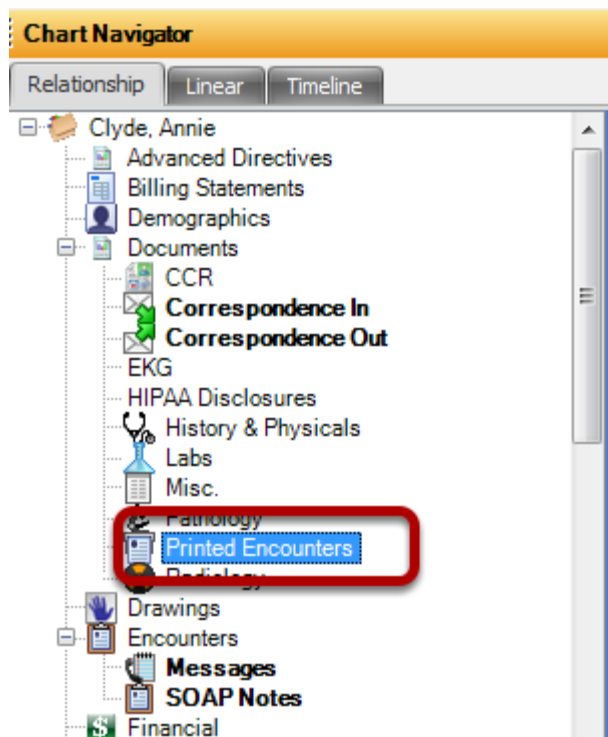


Chart Navigator is divided into two main regions: the left side is a list of all the chart sections, and the right side will display what documents are within a particular chart section.

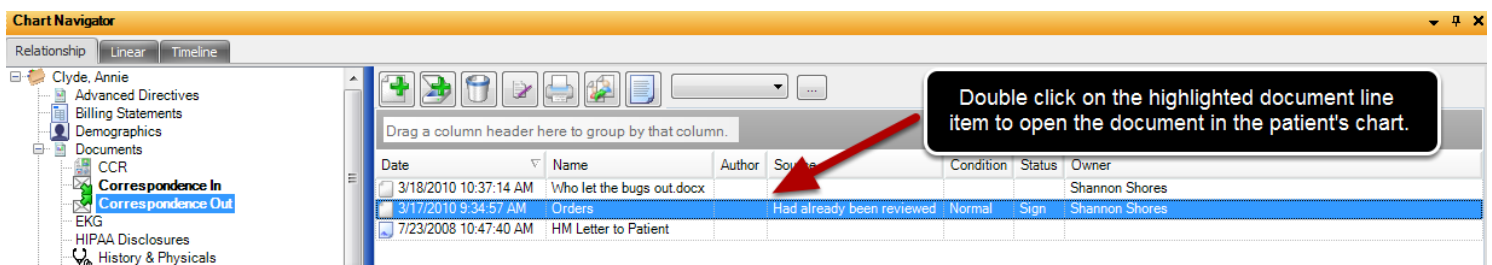
**Helpful hint to the user:** a chart section will be bold black if there are unsigned documents within the chart section.

## Open Chart Sections not currently displayed in Chart Layout



Double-click on any chart section within Chart Navigator, and a new tab will be created in a user's chart layout. Remember, the chart section will appear on whichever side of the chart the user last used-or which side of the chart the user's cursor was last placed on.

## Document List



To view a particular document within a chart section, double click on the line item.

## Action buttons on mini toolbar within Chart Navigator



1. Create a new document in the chart section that is highlighted on the left side of Chart Navigator.
2. Scan in a new document in a chart section.

3. Remove a document from a chart section.
4. Sign off a document if the user is a clinician.
5. Print off a document in a chart section.
6. Reassign a document to another clinician if the document is not already signed off.
7. View the selected document.

## Chart Navigator Views

In this lesson, the user will learn about the 3 different chart navigator view options.

### Access Chart Navigator

1. Click on the Chart Navigator tab docked at the bottom of the screen.
2. If Chart Navigator is not docked at the bottom, Click on Chart in the main menu toolbar, and Click on Chart Navigator.
3. Press Control + B on the keyboard.

### Chart Navigator Views: Relationship

The screenshot shows the 'Chart Navigator' window with the 'Relationship' tab selected. On the left is a tree view of chart sections for 'Clyde, Annie', including 'Advanced Directives', 'Billing Statements', 'Demographics', 'Documents', 'EKG', 'HIPAA Disclosures', 'History & Physicals', 'Labs', 'Misc.', 'Pathology', 'Printed Encounters', 'Radiology', 'Drawings', 'Encounters', 'Messages', 'SOAP Notes', and 'Financial'. The main area displays a table of documents. A red arrow points to the 'Date/Time' column header, and a callout box says 'Click on a column header to sort through the list of documents.'

Date/Time	Owner	Status	Description	Related Dx
4/28/2010 10:46:39 AM	Shannon Shores		Diabetes - Type 2 - with complications ICD#250.	Diabetes - Type 2 - with complications
3/29/2010 10:05:56 AM	Shannon Shores		Acute venous embolism & thrombosis of superficial	Cardiac arrest
3/17/2010 9:34:57 AM	Shannon Shores		Hypertension with complications ICD#997.91	Hypertension with complications
3/5/2010 4:43:40 PM			Viral Gastroenteritis ICD#008.8	Viral Gastroenteritis
12/1/2009 1:03:58 PM			Influenza NOS ICD#487.1	Influenza NOS
10/29/2009 2:36:10 PM			Viral Gastroenteritis ICD#008.8	Viral Gastroenteritis
10/29/2009 1:33:54 PM				
10/28/2009 10:16:41 AM				
7/1/2009 11:24:03 AM	Shannon Shores		Chronic obstructive pulmonary disease ICD#496	Chronic obstructive pulmonary disease
4/29/2009 3:17:49 PM			Benign hypertension ICD#401.1	Benign hypertension
4/29/2009 10:10:46 AM			Anticoagulant Use ICD#V58.61 Comment-	Anticoagulant Use
3/22/2009 3:10:56 PM			Anticoagulant Use ICD#V58.61 Comment-	Anticoagulant Use
2/26/2009 3:00:05 PM			Anticoagulant Use ICD#V58.61 Comment-	Anticoagulant Use

The Relationship view is the traditional, table of contents view. The patient's name will be displayed to the left, with a list of chart sections. The patient's list of documents within a chart section will be displayed to the right. See image above.

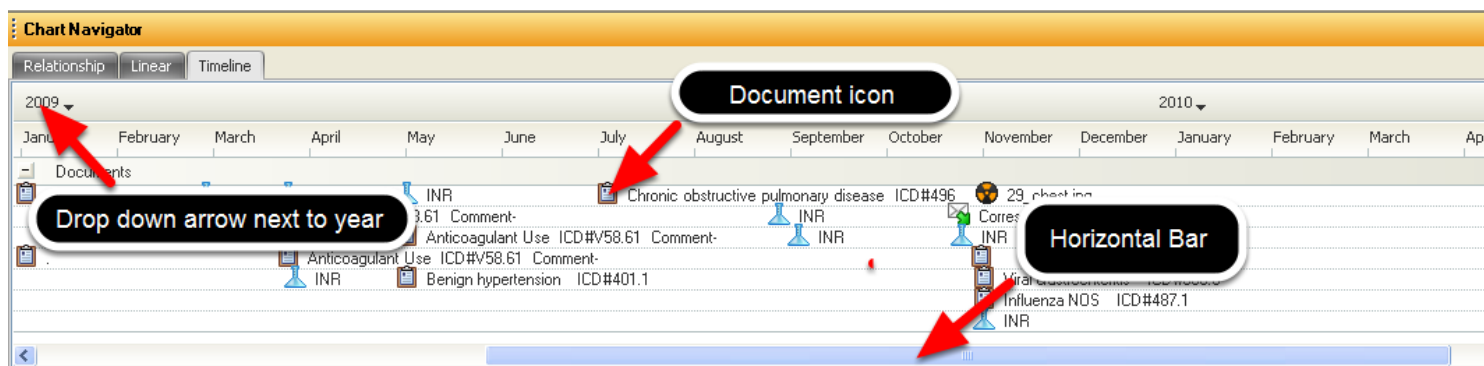
Helpful hints: 1. This view is most similar to Chart Browser, for those on a previous version of SOAPware. 2. Auser can Click on a column header to help them sort through the document list.

## Chart Navigator Views: Linear

Chart Navigator				
Relationship Linear Timeline				
Date/Time	Section	Docutainer	Owner	Status
4/28/2010 10:46:39 AM	SOAP Notes		Shannon Shores	
3/29/2010 10:05:56 AM	SOAP Notes	Diabetes - Type 2 - with complications ICD#250.	Shannon Shores	
3/26/2010 3:19:19 PM	Correspondence In	Shannon Feb Outline.docx	Shannon Shores	
3/18/2010 10:43:21 AM	Messages	Message	Shannon Shores	
3/18/2010 10:37:14 AM	Correspondence Out	Who let the bugs out.docx	Shannon Shores	
3/17/2010 9:34:57 AM	Correspondence Out	Orders	Shannon Shores	Sign
3/17/2010 9:34:57 AM	SOAP Notes	Acute venous embolism & thrombosis of superficial	Shannon Shores	
3/5/2010 4:43:40 PM	SOAP Notes	Hypertension with complications ICD#997.91	Shannon Shores	

The Linear view is one consolidated list of all the documents in a patient's chart. This list is initially sorted by Date/Time, but remember, the user can Click on another column header, like "section", to sort the document list. Double-click on a line item to open a document in a patient's chart.

## Chart Navigator Views: Timeline

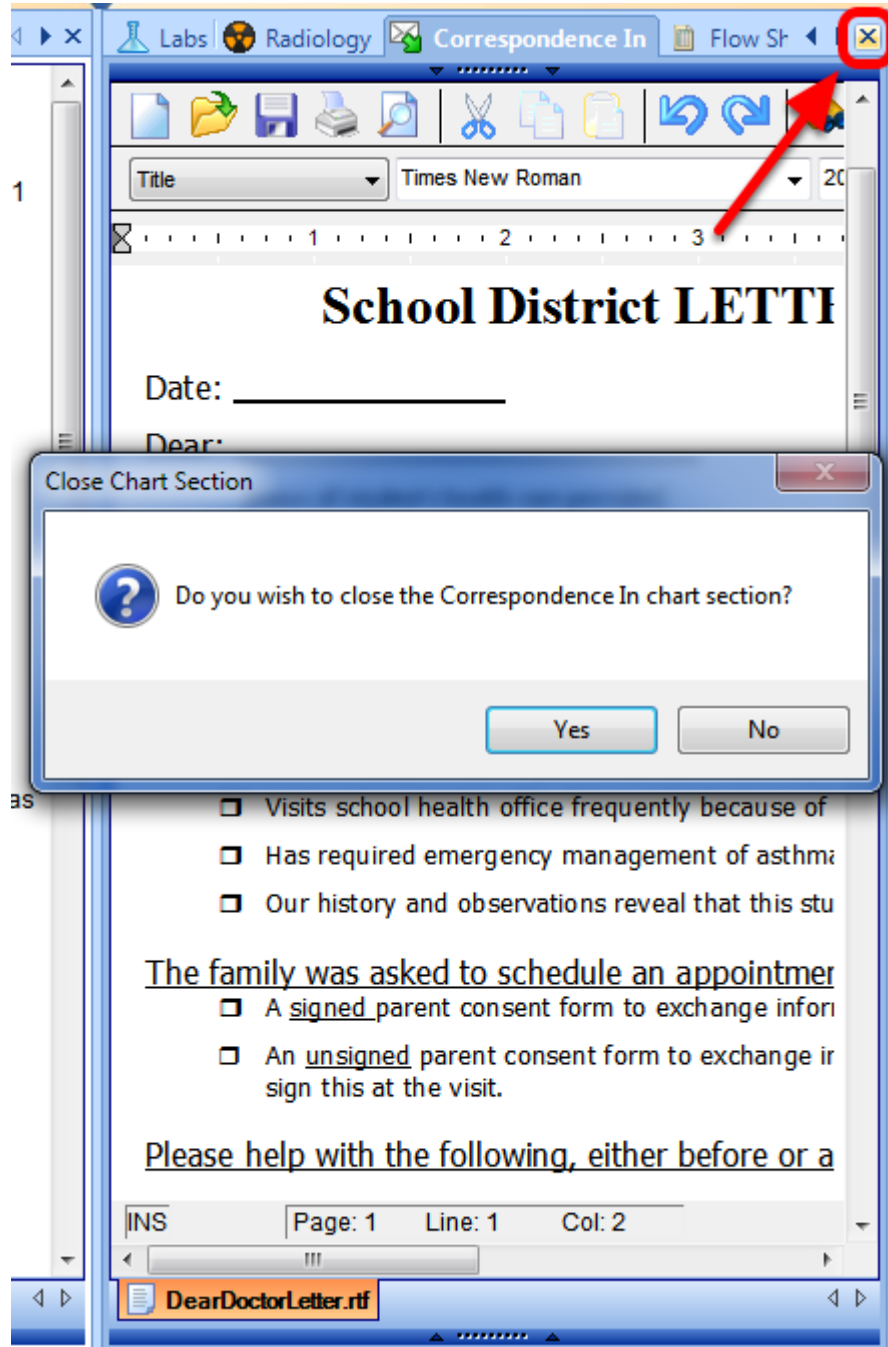


The Timeline view is mainly for viewing the relationship between documents over time. Click on the horizontal bar at the bottom to move forward/backward in time, or Click on the drop-down arrow next to the year. This will then bring up a calendar, where the user can select a month, date, and year. To view a document from this view, double-click on a document icon.



## Closing A Chart Section

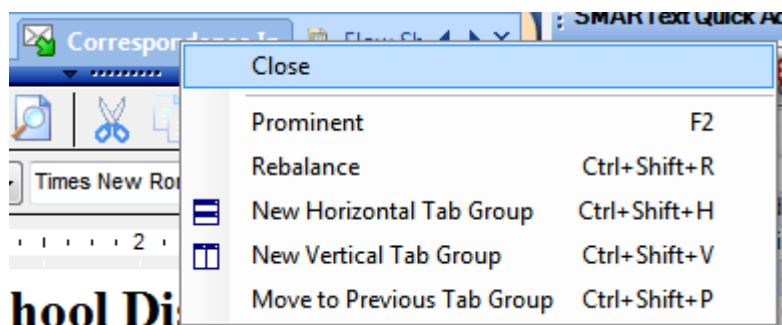
### Closing Chart Sections - Click on the X



In order to close out or remove a chart section viewer from a chart layout, Click on the X at the top right corner.

A window will appear asking for confirmation from the user that he/she wishes to close this section.

## Closing Chart Sections - Section Menu

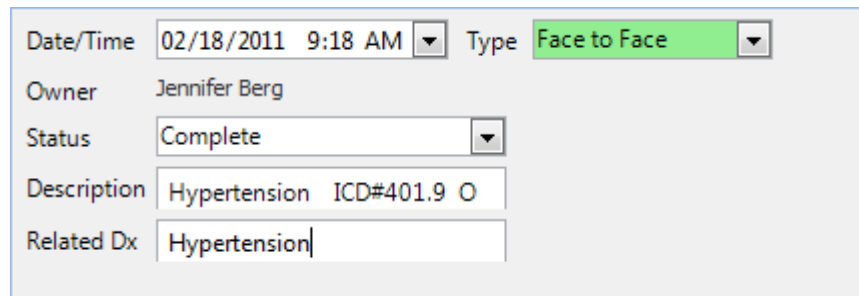


Alternatively, Right-click the Section tab, and Select Close.

## Splitter Bars

Splitter Bars are blue bars with arrows and dots in the center of them. When clicked on, they will collapse or expand to display more information, buttons, document lists, etc. They are also designed where the user can click on them to resize them.

### Upper Splitter Bar

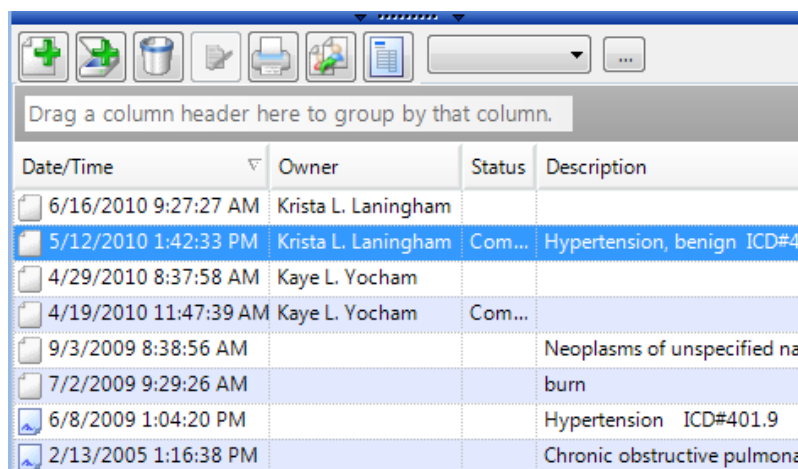


A screenshot of the Upper Splitter Bar in a software application. It contains several input fields and dropdown menus. The 'Date/Time' field shows '02/18/2011 9:18 AM' with a dropdown arrow. The 'Type' dropdown is set to 'Face to Face'. The 'Owner' field shows 'Jennifer Berg'. The 'Status' dropdown is set to 'Complete'. The 'Description' field shows 'Hypertension ICD#401.9 O'. The 'Related Dx' field shows 'Hypertension'.

Near the top of most chart section viewers (e.g. SOAPnote) is a very narrow, horizontal, blue bar with a couple of black triangles near the center. This is the Upper Splitter Bar. Click-Hold down on the left mouse button on the Upper Splitter Bar, and drag the bar down to display the area above it. Click on it again to hide the area. Practice expanding, collapsing, and resizing the Upper Splitter Bar area. Of note is that the default state for its area is for it to not be completely closed in that it leaves the Date/Time within view.

The Upper Splitter Bar hides and displays the docutainer's demographic information such as Owner, Status, Description, and Related Dx.

### Lower Splitter Bar



A screenshot of the Lower Splitter Bar in a software application. It shows a table with patient records. The table has columns for Date/Time, Owner, Status, and Description. The first row is highlighted in blue. The table is titled 'Drag a column header here to group by that column.'

Date/Time	Owner	Status	Description
6/16/2010 9:27:27 AM	Krista L. Laningham		
5/12/2010 1:42:33 PM	Krista L. Laningham	Com...	Hypertension, benign ICD#4
4/29/2010 8:37:58 AM	Kaye L. Yocham		
4/19/2010 11:47:39 AM	Kaye L. Yocham	Com...	
9/3/2009 8:38:56 AM			Neoplasms of unspecified na
7/2/2009 9:29:26 AM			burn
6/8/2009 1:04:20 PM			Hypertension ICD#401.9
2/13/2005 1:16:38 PM			Chronic obstructive pulmona

As noted earlier, near the bottom of most chart section docutainer viewers (e.g. SOAPnote) is a very narrow, horizontal, blue bar with a couple of black triangles near the center called the Lower Splitter Bar. Left Click on the Lower Splitter Bar to hide the area beneath it. Click on it again to

reopen the area. Practice expanding and collapsing the Lower Splitter Bar area with consecutive clicks. Just as with the Upper Splitter Bar, it can also be resized by clicking-dragging.

At the bottom of the viewer is the Docutainer/document List. It displays all the docutainers (i.e. documents) within a particular chart section's docutainer viewer. It should now list the single SOAPnote just created.

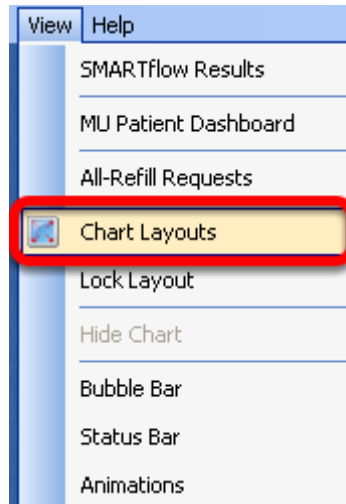
## Using Splitter Bars

For more information on how to use splitter bars, see: [Splitter Bars](#).

## Default Chart Layouts

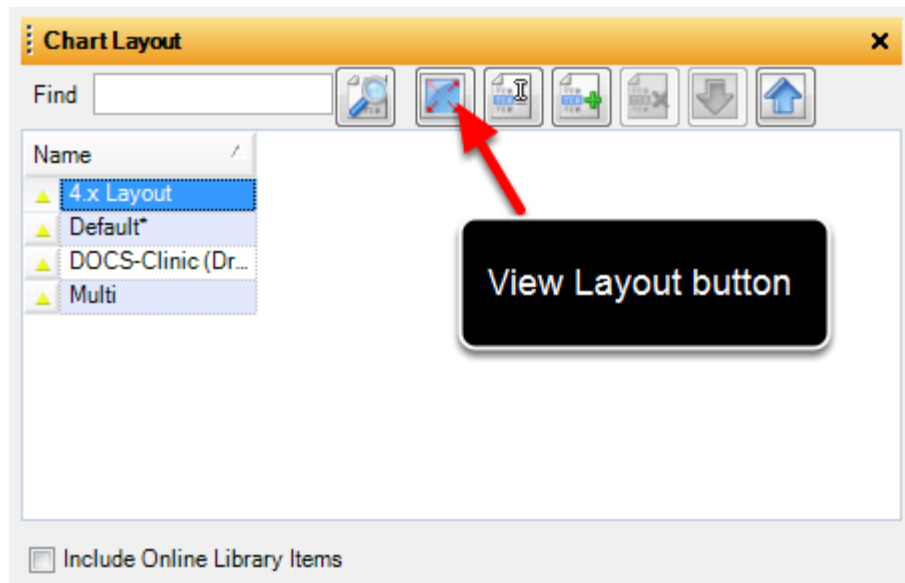
There are several different possible layouts a user can pick from for their chart layout. A user can even modify a chart layout and save it as their own.

### Pre-defined Chart Layouts



To find these chart layouts, Click on View in the main menu bar at the top of the screen, and Click on Chart Layouts.

### View Layout



In the image above, the user will see four chart layout choices that come defaulted with SOAPware. To preview each chart layout, the user will need to be sure to have a patient's chart open. If the user wants to preview the 4.x Layout--the user will highlight that title from our list and

Click on the "View Layout button."

## V4 Classic Layout

The screenshot displays the V4 Classic Layout interface, which is divided into two main panes. The left pane, titled "Summary", contains a list of medical categories with links to their respective sections: Active Problems, Inactive Problems, Surgeries, Medications, Allergies, Family History, Tobacco, and Alcohol. The right pane, titled "SOAP Notes", shows a form for entering patient information, including Date/Time, Subjective, Objective, and Assessment sections. Below the SOAP Notes form is a table with columns for Date/Time, Owner, Status, Description, and Related Dx. The bottom of the interface features a search bar and a navigation bar with icons for Chart Navigator, Tasks, Docuplates, and Chart Rack.

**Summary**

**Active Problems**  
[Starter - Active Problems:](#)

**Inactive Problems**  
[Starter - Inactive Problems:](#)

**Surgeries**  
[Pick List - Surgeries](#)

**Medications**

**Allergies**  
[Starter - Allergies - Summary:](#)

**Family History**  
[Positive family history for](#) -  
[Negative family history for](#) -  
[PARENTS:](#)  
[CHILDREN:](#)  
[GRANDPARENTS:](#)  
[SIBLINGS:](#)  
[UNCLES/AUNTS:](#)  
[OTHERS/DISTANT:](#)

**Tobacco**  
[Pick List - Tobacco - Summary](#)

**Alcohol**

**SOAP Notes**

Date/Time: 05/07/2010 9:04 AM

**Subjective**  
CHIEF COMPLAINT(S):

HPI: SYMPTOMS/RELATED: Reports symptoms of  
LOCATION: Reports area of involvement as  
QUALITY/COURSE: Reports condition is  
INTENSITY/SEVERITY: Reports measurement ( or degree) as  
DURATION: Reports the general length of symptoms to be  
ONSET/TIMING: Reports occurrence as  
CONTEXT/WHEN: Reports usually associated with  
MODIFIERS/TREATMENTS: Improved by

**ROS:**  
1

**Objective**  
Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.

**Assessment**

**SOAPNote**

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx
5/7/2010 9:04:27 AM	Shannon Shores			

Search Documentation Search

Chart Navigator Tasks Docuplates Chart Rack

Shores, Olive

This layout is one of the simplest options for users....as it only displays the Summary Chart Section to the left, and the SOAPnote Chart Section to the right.

## Default Layout

**Summary** | Vital Signs | Demographics

**Active Problems**  
[Starter - Active Problems:](#)

**Inactive Problems**  
[Starter - Inactive Problems:](#)

**Surgeries**  
[Pick List - Surgeries](#)

**Medications**

**Allergies**  
[Starter - Allergies - Summary:](#)

**Family History**  
[Positive family history for -](#)  
[Negative family history for -](#)  
[PARENTS:](#)  
[CHILDREN:](#)  
[GRANDPARENTS:](#)  
[SIBLINGS:](#)  
[UNCLES/AUNTS:](#)  
[OTHERS/DISTANT:](#)

**Tobacco**  
[Pick List - Tobacco - Summary](#)

**Alcohol**

**SOAP Notes** | Labs | Radiology

Date/Time: 05/07/2010 9:04 AM

**Subjective**  
**CHIEF COMPLAINT(S):**

HPI: SYMPTOMS/RELATED: [Reports symptoms of](#)  
LOCATION: [Reports area of involvement as](#)  
QUALITY/COURSE: [Reports condition is](#)  
INTENSITY/SEVERITY: [Reports measurement \( or degree\) as](#)  
DURATION: [Reports the general length of symptoms to be](#)  
ONSET/TIMING: [Reports occurrence as](#)  
CONTEXT/WHEN: [Reports usually associated with](#)  
MODIFIERS/TREATMENTS: [Improved by](#)

**ROS:**

**Objective**  
Exam: [GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.](#)

**Assessment**

**Plan**

**SOAPNote**

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx
5/7/2010 9:04:27 AM	Shannon Shores			

Search Documentation | Search

Shores, Olive

The Default Layout shows that a user can have multiple chart sections on the left and right of their chart layout.

## Multi-Layout

The screenshot displays the SOAPware Multi-Layout interface, which is divided into three main panes. A callout box with the text "Notice the three panes" points to the layout.

- Summary Pane (1):** Contains sections for **Active Problems**, **Inactive Problems**, **Surgeries**, and **Medications**. Each section has a "Starter" link and a "Pick List" link.
- SOAP Notes Pane (3):** Displays a SOAP note for a patient. It includes a date/time field (05/07/2010 9:04 AM) and sections for **Subjective**, **Assessment**, and **Plan**. The **Subjective** section contains a "CHIEF COMPLAINT(S)" and a list of HPI (History of Present Illness) symptoms/related conditions. The **Assessment** section contains a "General appearance" description. The **Plan** section contains a "SOAPNote" table.
- Demographics Pane (2):** Contains a "Demographics" section with fields for Title, First, Middle, Last, and Suffix. Below this is a "General" section with a "Patient Picture" field and a "Drag a column header here to group by that column." instruction. At the bottom is a "Search Documentation" field.

The patient's name, **Shores, Olive**, is displayed in the bottom right corner of the interface.

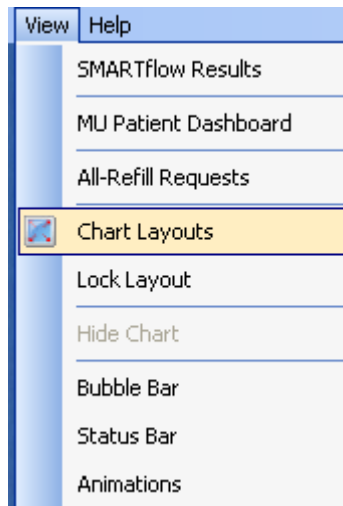
The Multi-Layout splits the chart workspace into 3 panes.



## View Chart Layouts from Online Library

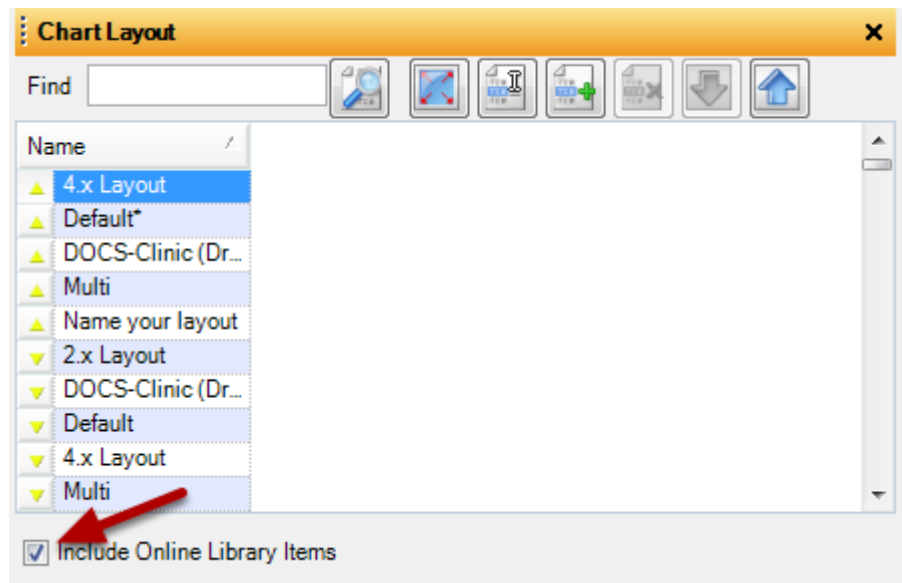
In this lesson, the user will learn how to view chart layouts from the online library.

### View Chart Layouts from online library



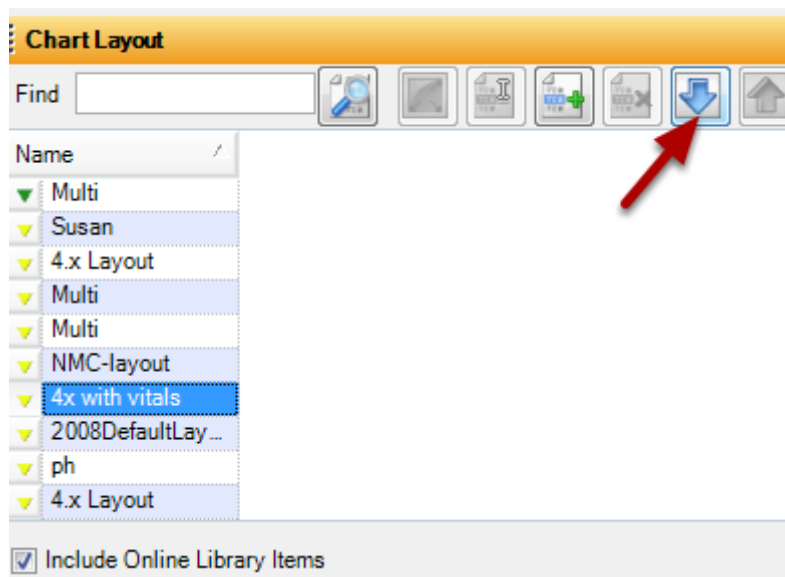
Click on View > Chart Layouts.

### Chart Layouts



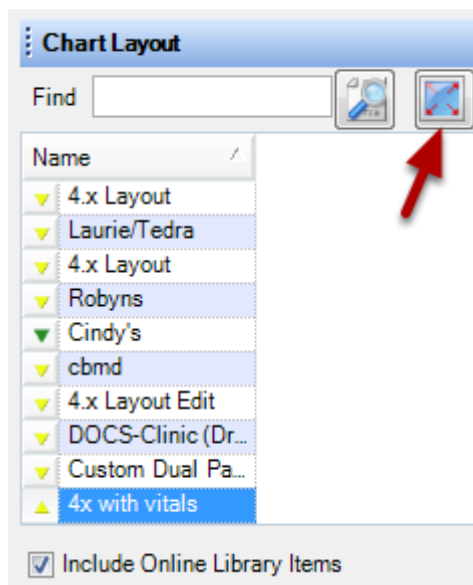
Check the "include online library items box." The user will now be able to view all the layouts created and uploaded to the online library.

## Download Layouts



Should the user want to view one of the layouts from the online library, highlight the name of the layout and Click on the blue download button.

## View Layout

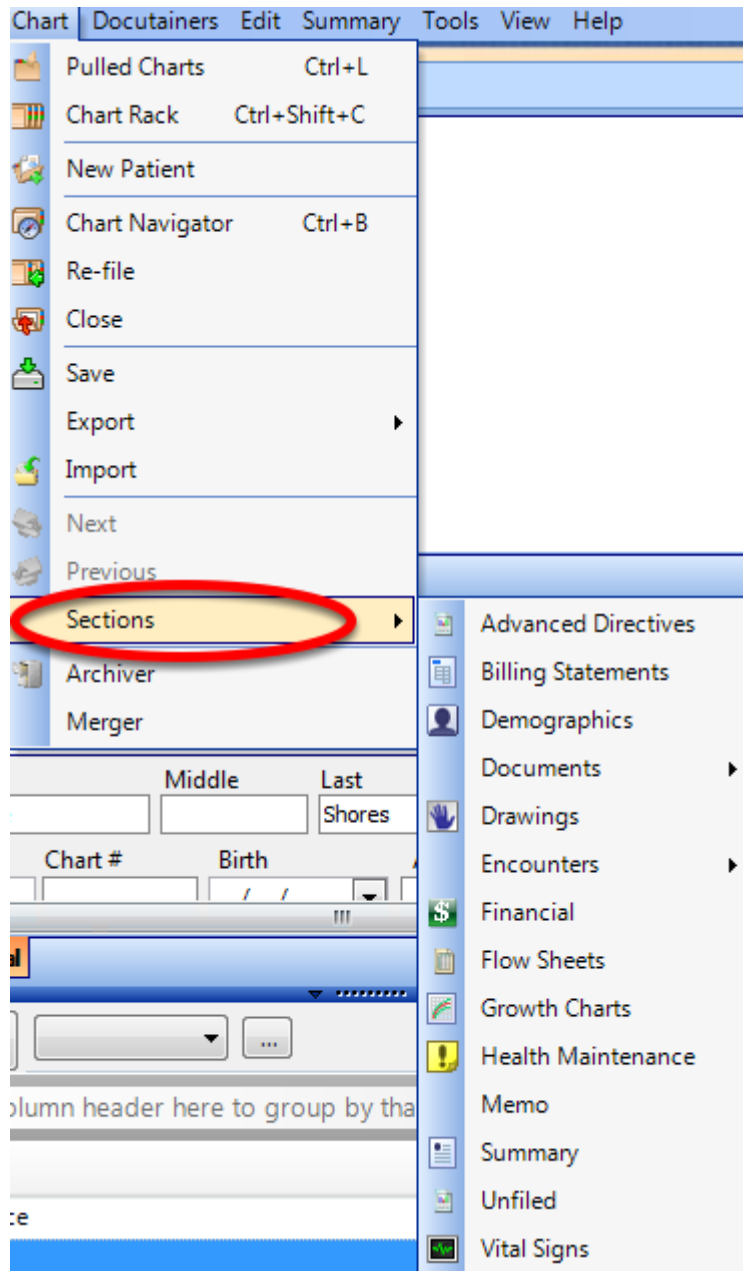


Lastly, Click on the view layout button.

## Add Chart Sections to a Layout

In this lesson, the user will learn how to add chart sections to a layout.

### Add Chart Sections to a layout



Click on Chart > Sections, and then choose from a variety of chart sections.

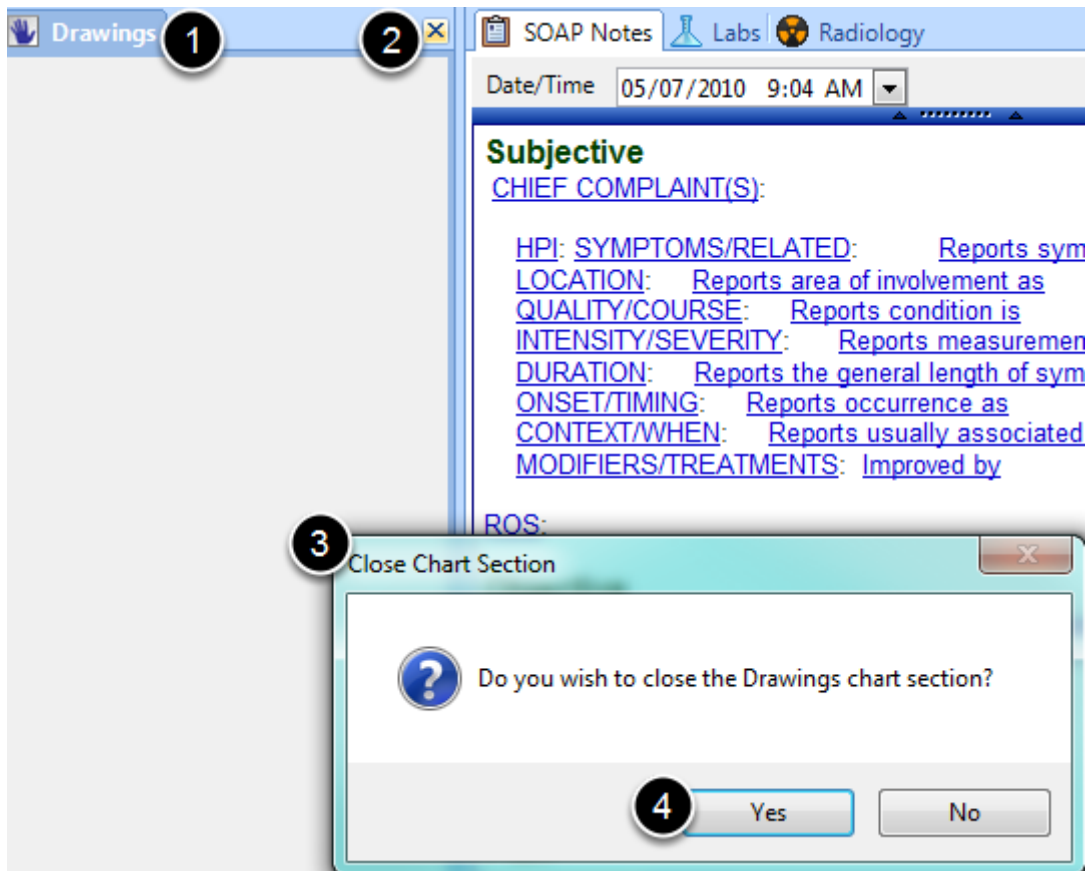
As a helpful hint for the user: the chart section will insert into the user's chart layout on the side where the cursor was last placed.

## Remove a Chart Section

---

In this lesson, the user will learn how to remove a chart section.

### Remove a Chart Section

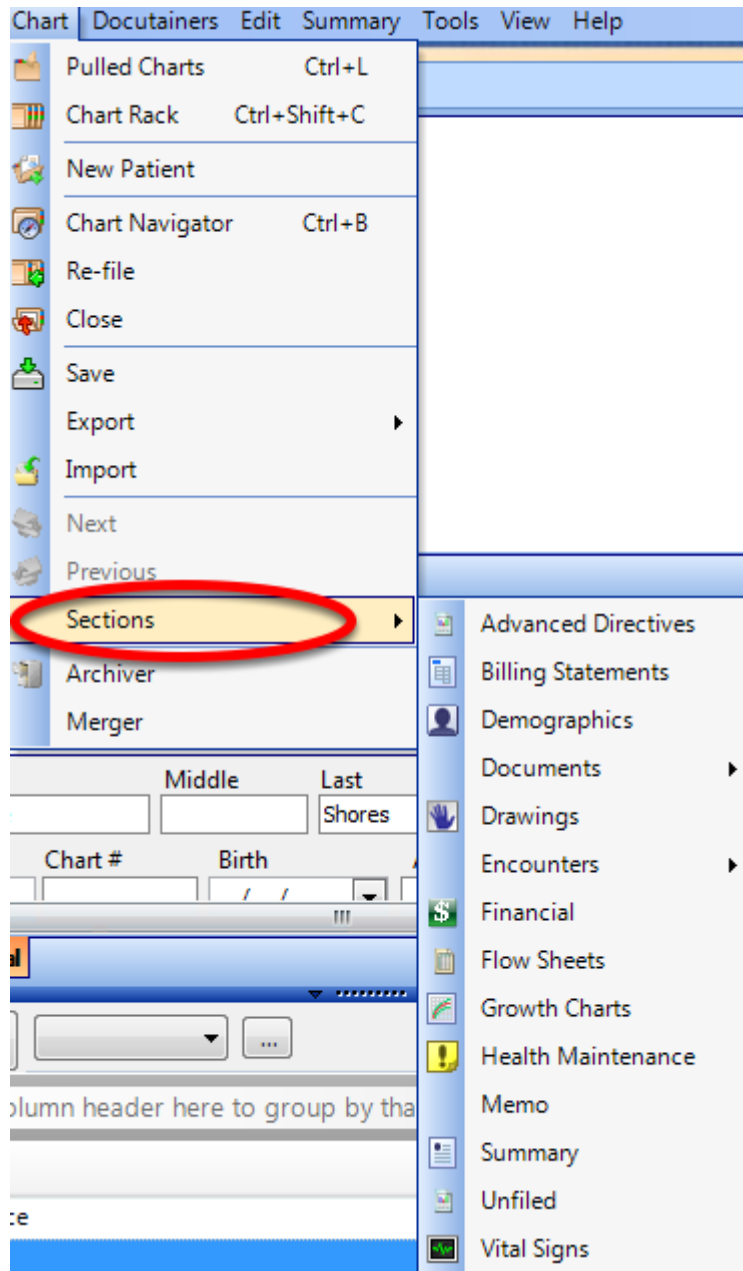


1. Click on the tab to be removed-notice the chart section tab will be blue when selected.
2. Click on the X.
3. The user will be prompted, "Do you wish to close the chart section?"
4. Click Yes.

## Move a Chart Section

In this lesson, the user will learn how to move a chart section.

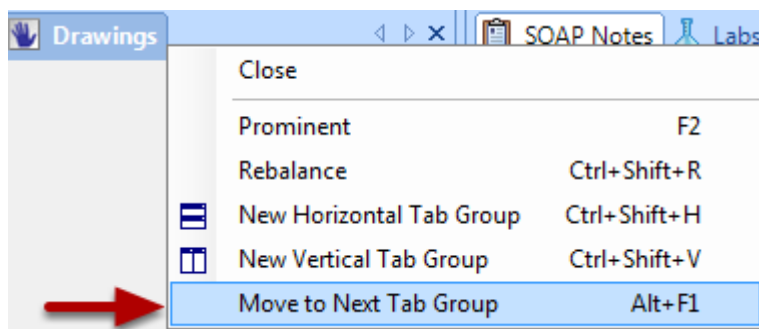
### Add Chart Sections to a layout



Click on Chart > Sections, and then choose from a variety of chart sections.

As a helpful hint for the user: the chart section will insert into the user's chart layout on the side where the cursor was last placed.

## Move a Chart Section

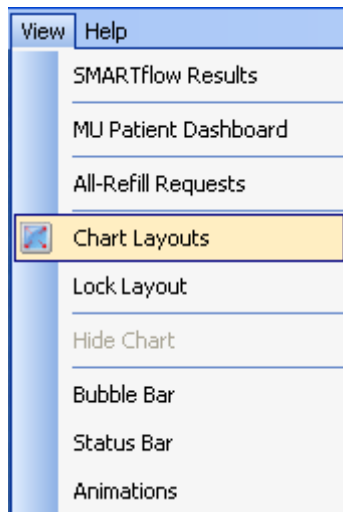


Once a chart section has been inserted, a user can right-click on the top chart section tab, and Click "Move to Next Tab Group." This action would take the chart section from the left side of the user's layout, to the right side of the user's layout. If a user wanted to make the chart section a new horizontal tab group, the user would right-click on the chart section tab and Choose "New Horizontal Tab Group."

## Saving Chart Layouts

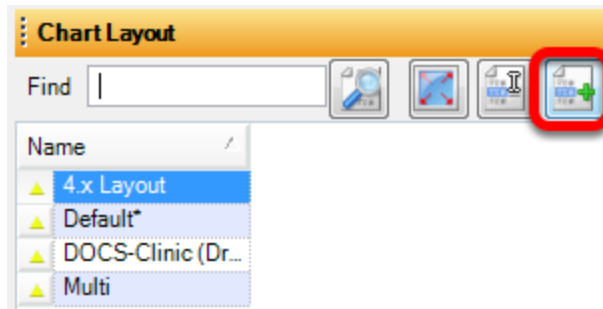
In this lesson, a user will learn how to save a chart layout.

### Save a Chart Layout



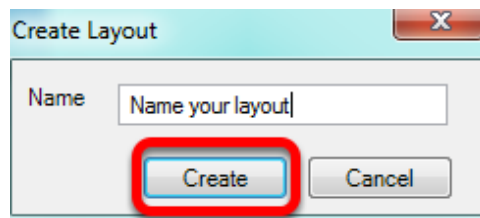
Once the preferred chart layout has been selected, Click View > Chart Layouts.

### Add the Layout



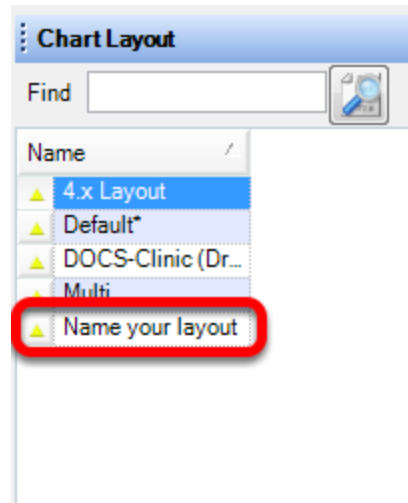
Click on the green plus.

### Name the Layout



Type in the name of the layout and Click CREATE.

## Select the Layout



A user's layout will now be listed with the four default layouts.

Helpful hint for the user: do not X out of SOAPware (meaning do not hit the red X at the top right of the screen as a means to log off or exit SOAPware), as this could cause a user's specific layout to not automatically display when he/she logged in each day.

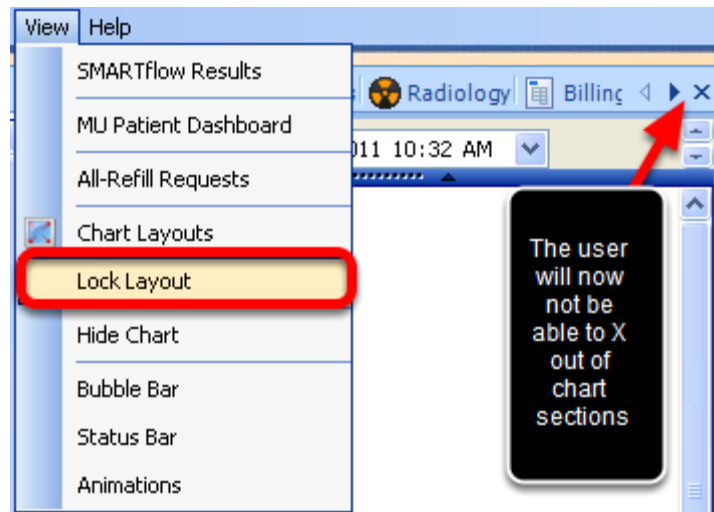


## Locking Chart Layouts

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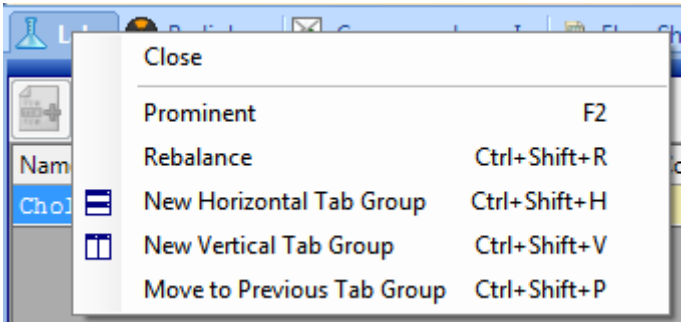
In this lesson, the user will learn how to lock a chart layout.

### Lock Chart Layout



Click on View > Lock Layout. The X-as shown above-will be removed, and the user will not be able to remove chart sections from their layout.

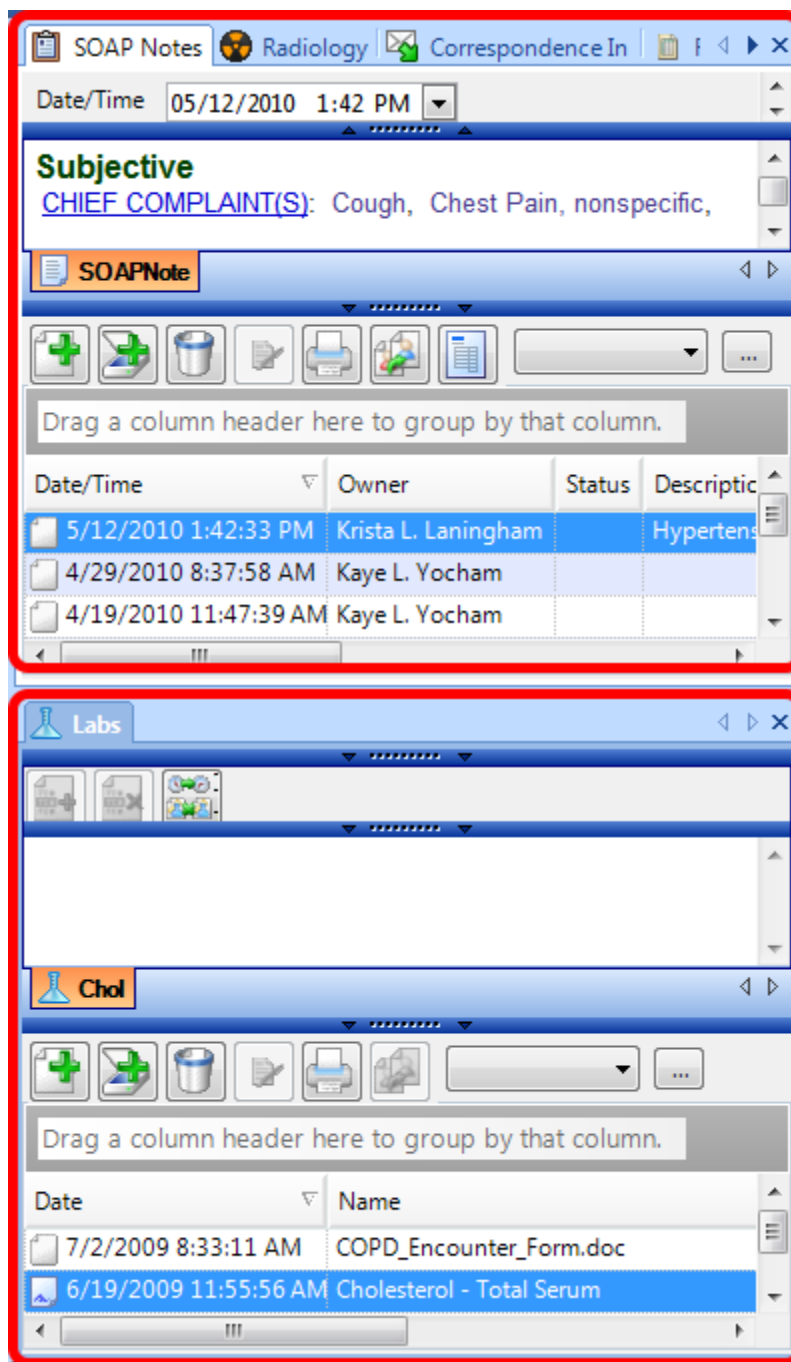
Prominent and Rebalance



There are some options for customizing the chart layout of tabs that are in addition to those previously discussed in the introduction. The individual, tabbed chart sections can be changed in a number of ways.

Prominent is used to make a chart section temporarily take up most of the screen. Choosing Rebalance will return it to the original setting.

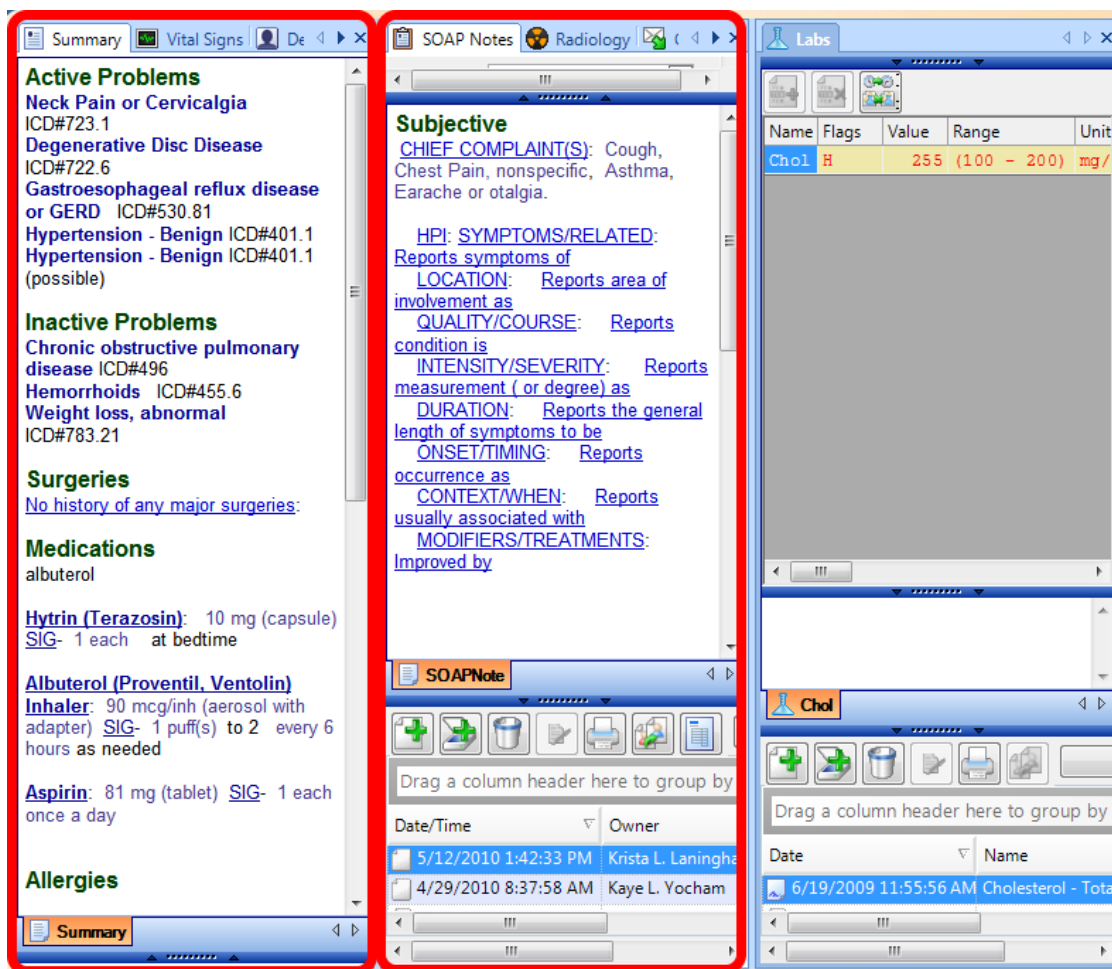
## Add a Horizontal Separator to a Chart Layout



New Horizontal Tab Group splits the layout, horizontally. In the example above, Labs was selected as a New Horizontal Tab Group and it is displayed below in its original position.

To revert back to the original tab arrangement, Right-Click on the Demographics chart tab, and Click the Move to Previous Tab Group menu item.

## Add a Vertical Separator to a Chart Layout



New Vertical Tab Group will split the layout vertically. In the example above, Labs was selected as a new Vertical Tab Group so that now there are three vertical tab groups instead of two.

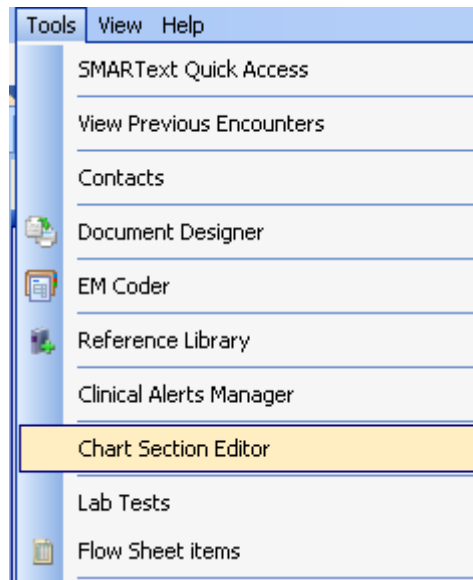
Once again, to revert back to the original tab arrangement, simply right-Click on the Labs chart section tab and Click Move to Previous Tab Group.

## Creating a New Chart Section

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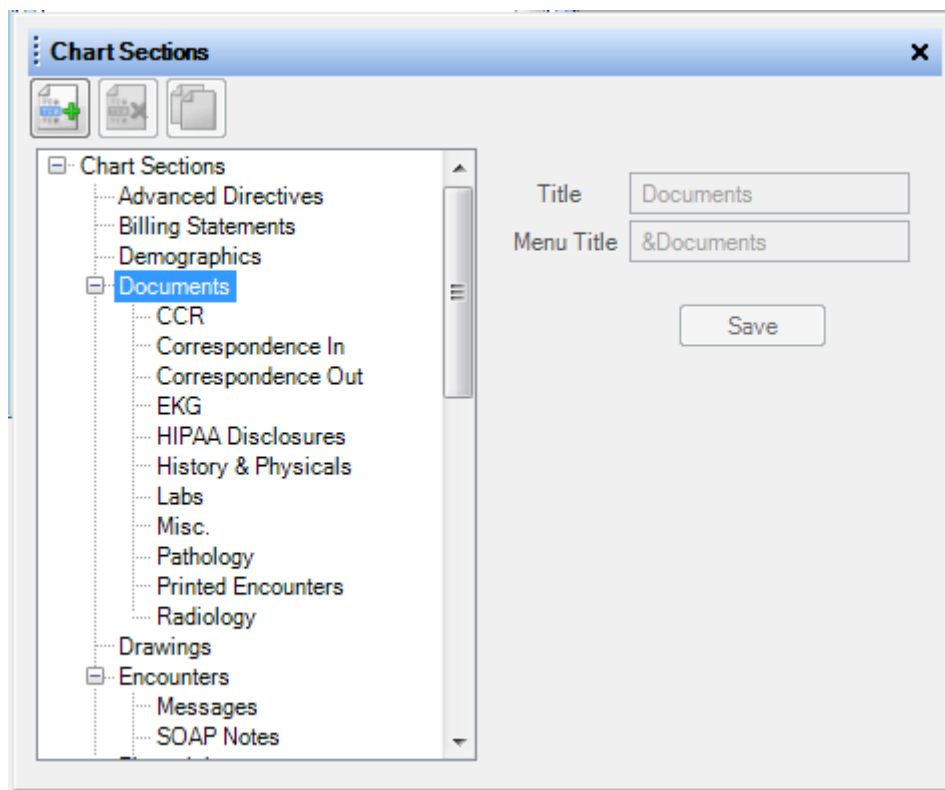
These instructions will show how to create new chart sections within Chart Navigator.

### Open the Chart Section Editor



Click Tools, and Click Chart Section Editor.

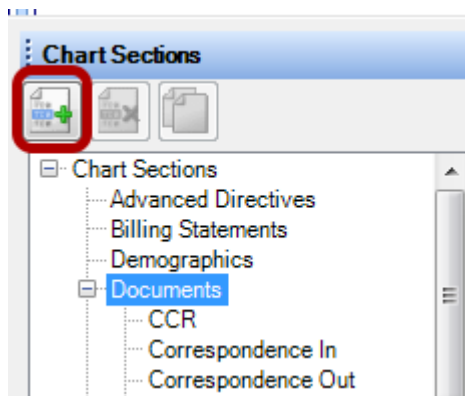
## Locate the Parent Section



Click on the area that you wish to add a Chart Section.

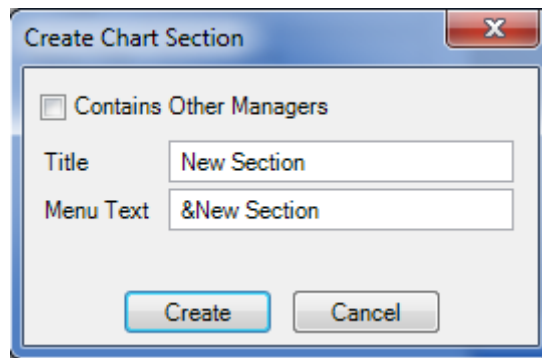
In this example we are adding to the Documents section.

## Click the Add Button



Click the Add button (i.e. the green +).

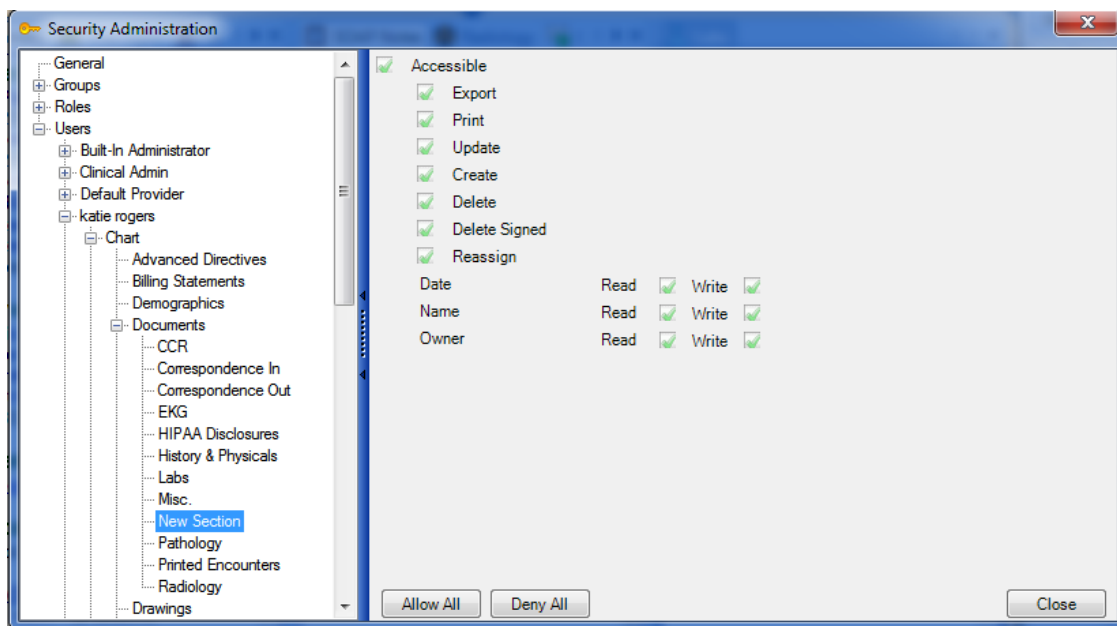
## Type the Name



Type the name of the new chart section to add in both the Title and the Menu field/boxes and Click Create.

A window will appear letting you know that you need to restart SOAPware.

## User Privileges



Now, using your Administrator login, Click Tools -> Security. Click the + sign next to a user's name. Click the + sign next to Charts. Click the + sign next to Documents. Click the new Chart Section name, and Click the Allow All button. Click the check boxes that you do not wish the user to have access to and a red X will display. DO THIS FOR EACH USER THAT WILL NEED ACCESS TO THIS SECTION.

Click Close, and you are presented a prompt to logout of SOAPware for the new settings to take place.

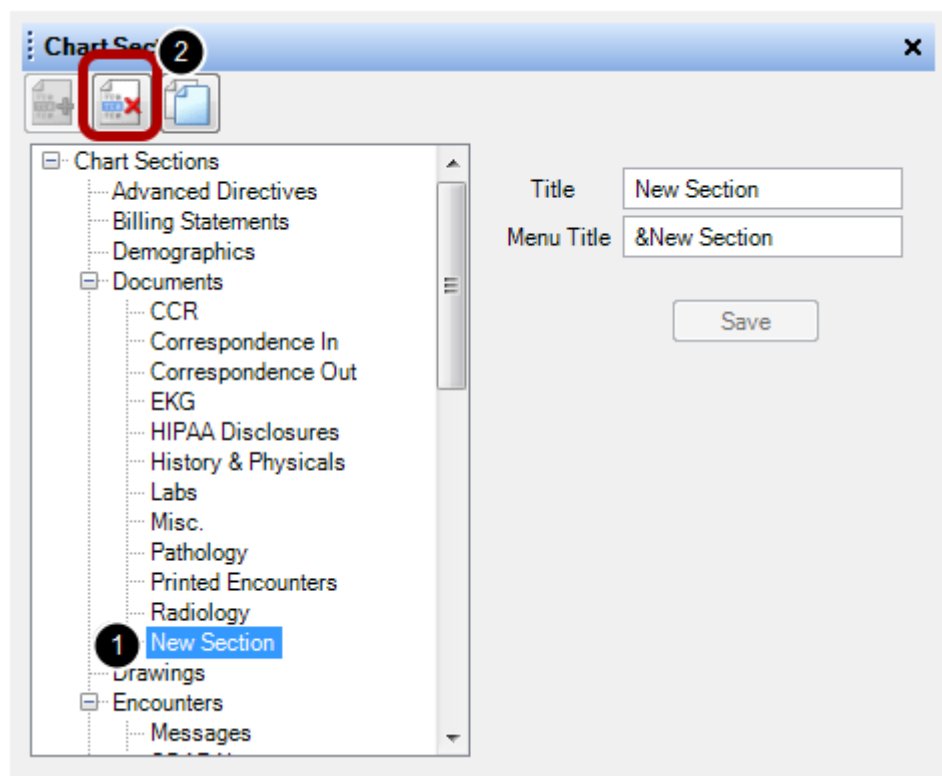
In order to be able to perform the above tasks the user must have proper access in the Security Section.

## Removing a Chart Section

Note: You cannot remove SOAPware's default Chart Sections. This action can only be performed on chart sections that you have created.

**WARNING: This operation should only be performed after you have assured that there are no other users currently working with patient charts. This will help to prevent the loss of patient data.**

## Removal Process

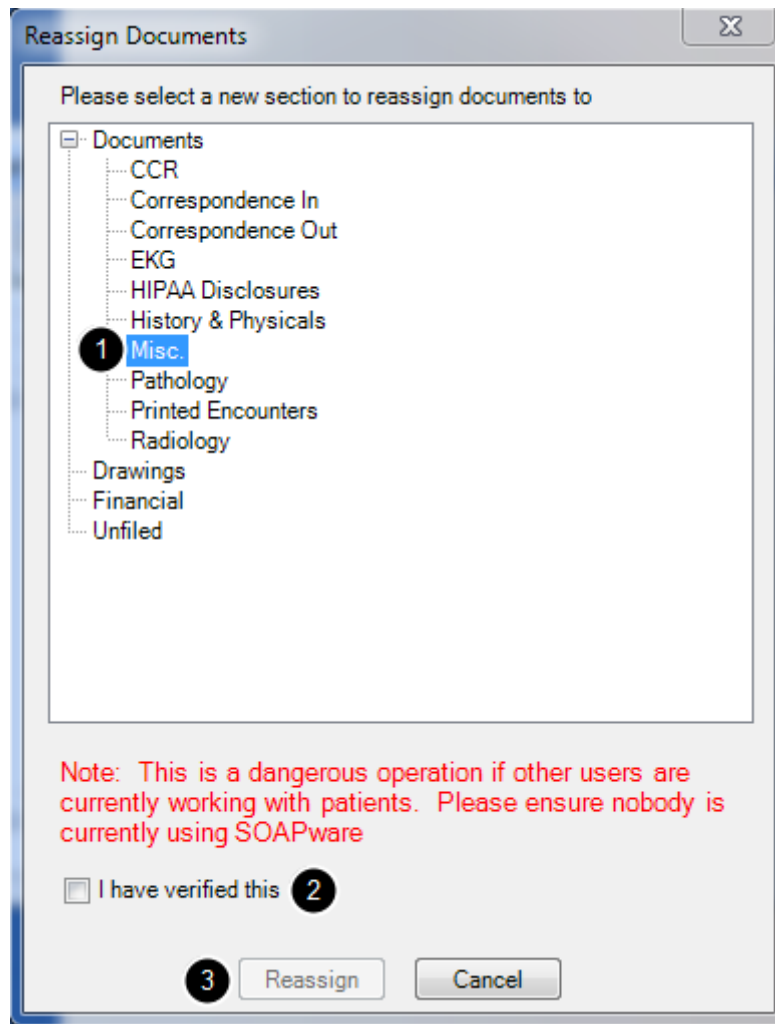


To remove a Chart Section:

1. Click to highlight it in the list.
2. Click the Remove Section Button (or Press Ctrl + Alt + R).

SOAPware will display a prompt to confirm this action. Click Yes or Click Cancel, and SOAPware will return to the Chart Sections Editor.





When a user wishes to remove a Chart Section, SOAPware will display a prompt for the location to place the Document(s) contained within that section. The Reassign Documents dialog box will open.

1. Choose the Section in which to place the documents by Clicking to highlight it in the list.
2. Because of the sensitive nature of performing this action, verification is requested that the user has read the warning, and has ensured that no other users are working with patient charts. To perform this action, Click to check the box "I have verified this."
3. Then, Click the Reassign Button.

The documents contained within the section to be deleted will be moved, and the section will also be removed.

Click Cancel if this action needs to be stopped, and SOAPware will return to the Chart Sections editor.

# Data Entry in SOAPware

## SMARTText Introduction

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**\*THE USE OF SMARTTEXT IS REQUIRED FOR MEANINGFUL USE:** [Click here to view Meaningful Use Roadmap.](#)

For instructions to update SMARTText Items, [Click here.](#)

### Importance of SMARTText

Exclusive to SOAPware, SMARTText is the backbone for medical documentation using our EMR. SMARTText entries replaces and extends macros to auto-enter blocks of text data that are specially designed to be searchable by computer.

Because SMARTText items contain much more data than plain (free) text, these entries make it possible for items used in documentation to have underlying relationships to other items in the medical record. Using SMARTText structured items will prepare clinics for important quality measure reporting linked to Meaningful Use data, as well as to the requirements related to the Patient Centered Medical Home.

SOAPware now includes new No Known SMARTText Item Types that may be used in the Summary to document a negative history for the Active Problems field, Surgeries field, Medications field, and Allergies field. Previously used (SOAPware 2010) No Known SMARTText Item Types in these fields will not calculate properly for Meaningful Use. **A user must update all SMARTText Items** within SMARTText Items Manager to capture newly created or changed SMARTText Items to meet Meaningful Use Requirements when documenting. This requirement will need to be recorded by using structured data.

The shortcut for the following Summary fields for No Know SMARTText Item Types. If these items were used in version prior to SOAPware 2011, they will need to be re-downloaded. For more information, see: [Using No Known SMARTText Items Types in the Summary.](#)

**Active Problems-** "NoPro"

**Surgeries-** "SurNo"

**Medications-** "NoMeds"

**Allergies-** "NKDA"

### What is SMARTText

Pieces of information or objects, including text; CPT codes; medication items; images; photos; videos and audio files; can be combined to form SMARTText items. Entered using a combination of shortcuts and keystrokes, multiple SMARTText items can be placed together to form new and useful structures.

## Unstructured Text

Assessment[  
hypertension  
]

Shortcuts that, when expanded, display a single word or statement. These items are displayed in Black text.

Examples:

htn = hypertension

ver = verbalizes understanding at this time

## Structured Text

Assessment[  
Hypertension, benign ICD#401.1  
]

"Bar-Coded" text (data that is computer-readable), specially formatted to allow communication between computers. These items are displayed in **Blue** text.

## Pick List

Medications[  
medications]

Pick Lists may contain both Structured and Unstructured SMARText. When clicked-on, these items will display a list of choices in the SMARText Quick Access Guide located on the right side of the monitor screen. These items are displayed in underlined **Blue** text.

## Examples of Free Text vs. Structured Text

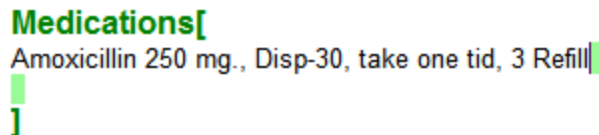
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With free-text, each letter is actually an independent object. As far as the computer is concerned, no individual letter or number has any relationship to any other letter or number.

### Meaning Behind the Words

When typed using free-text, Amoxicillin and moAcXllicin appear the same to the computer -- both letter groupings are equally meaningless. In contrast, objects in SOAPware can include multiple letters and/or numbers that as a group have been identified and are recognizable to the computer. SOAPware displays the start and end points of a SMARTText item (i.e. object) with an open bracket followed by a close bracket. Everything inside those brackets is considered to be part of the item.

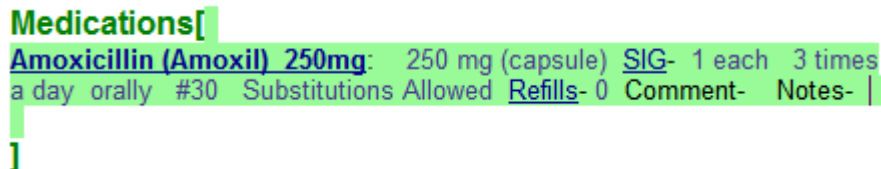
### Free Text



The image shows a free-text medication entry. It consists of the word "Medications" in green, followed by an opening square bracket "[", then the text "Amoxicillin 250 mg., Disp-30, take one tid, 3 Refill" in black, and finally a closing square bracket "]" in green. The entire entry is highlighted with a light green background.

The image above is a free-text medication. While this entry is functional, it is not considered "meaningful data."

### Structured Text



The image shows a structured medication entry. It starts with "Medications" in green, followed by an opening square bracket "[", then the text "Amoxicillin (Amoxil) 250mg: 250 mg (capsule) SIG- 1 each 3 times a day orally #30 Substitutions Allowed Refills- 0 Comment- Notes- |" in black, and finally a closing square bracket "]" in green. The entire entry is highlighted with a light green background.

The image above shows the same information, but in a SMARTText format that allows the information to easily be inserted into the chart, ePrescribed, and read by a computer.

### Added Value

With SMARTText, a user will be able to:

Quickly and easily associate information that needs to be grouped together (i.e. a SMARTText item of the appropriate type)

Do it all in one location (i.e. a SMARTText item of the appropriate type)

Save the item for reuse in the future (save it in the SMARTText library)

## Free Text or Structured Data?

---

### Text Entry Choices

SOAPware offers a variety of different charting methods, permitting great flexibility for information entry. Most use a combination of data entry methods for each section of the encounter and with each patient. One solution will not be sufficient for all chart sections -- just as one shoe does not fit all, one charting method does not fit every type of visit or patient.

Choices of data entry methods include:

- Free Text (Typing or dictation)
- SMARTText Pick Lists and Docuplates/Templates
- Speech Recognition (Dragon Naturally Speaking)
- Scan in paper encounter forms
- Dictate and have transcriptionist type into electronic notes
- Scan in handwritten documentation
- Use a Tablet-PC and record the "digital ink"

### Free Text or Structured Data?

The way in which a user actually enters data and documents his/her patient's visits, will be one of the most important issues the user will address...

- Where does the user start?
- What are the user's options?

SOAPware recommends taking time for a short 3-question analysis before making this important decision:

- What charting method does the user currently use?
- What are the user's resources?
- What is reasonable and feasible for the user and in the best interest of the user's practice?

### Reasons to Use Structured Data

If the user desires to participate in "Meaningful Use" and "Pay for Performance" (P4P) initiatives, to engage in practice quality improvements, and/or electronic prescribing, then the user will need to use structured data.

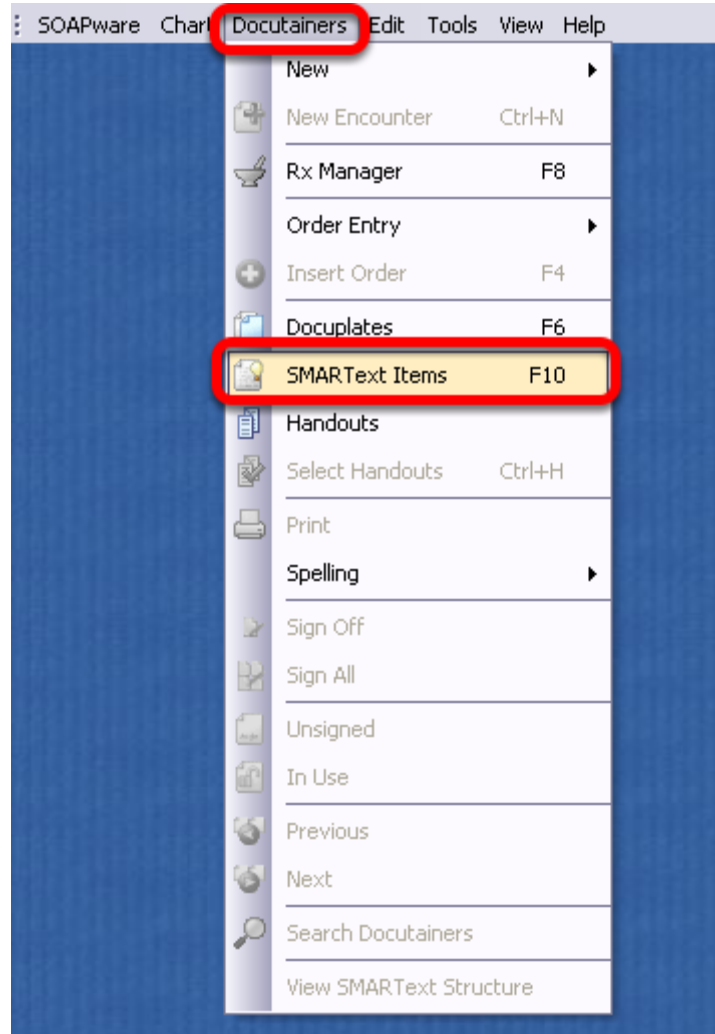
Note: It is not mandatory that the user use structured documentation in his/her patient charting

procedures. However, while using free text may be familiar and seem easier, taking the time to learn more about the benefits associated with using structured data entry could greatly benefit the user's practice on many levels. Structured data entry not only makes the user more efficient, it will also be more likely to allow the user to receive greater reimbursement in the near future. In fact, it appears those physicians who choose not to participate in Meaningful Use and P4P initiatives will likely be penalized.



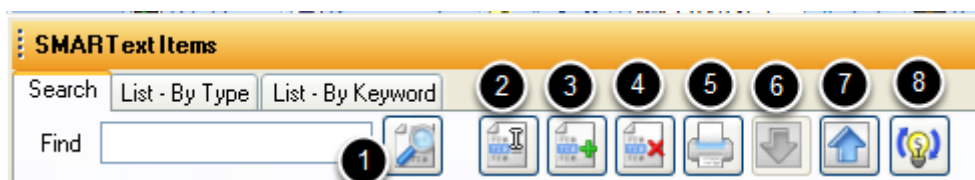
## Find SMARText Items

### Accessing SMARText Items Manager



To access the SMARText Items Manager, Click on the Docutainers menu and Select "SMARText Items" or press F10 on the keyboard.

### SMARText Items Manager Interface- Action Buttons



#### Action Buttons

**1. Search button-** Allows the user to search SMARText Items after typing a single word into the

Find field. If the Find field is left blank when searching, this will display a list of ALL SMARText Items. If the box for Include On line Library Items is checked, the search results will include SMARText Items created by SOAPware (green triangle items) and by other SOAPware users (yellow triangle items). If the box is not checked for Include On line Library Items, the results will include only SMARText Items from the users local database (local library).

**2. Edit button-** Using the Edit button will allow users to edit a SMARText Item. It is not recommended to edit anything other than the shortcut code for a SOAPware created item (green triangle item). If a user edits any other field of that item, this will prevent any updates for that item to be made. This includes any CPT Code, ICD code, or Description changes when applicable that SOAPware is required to make. For more information on Editing a SMARText Item, see: [Creating and Editing SMARText Items in the SMARText Items Manager](#).

**3. Create New SMARText Item button-** Allows the user to create a new SMARText Item. Click on each of the links below for additional information:

- \* [Creating SMARText Items](#)
- \* [Creating Pick Lists](#)
- \* [Creating Medications](#)

**4. Remove button-** Allows the user to remove a SMARText Item.

**5. Print button-** Allows the user to print a list of the SMARText Items that are currently displayed.

**6. Download button-** SMARText Items with a down-facing triangle will need to be downloaded before they can be used in the local database. Clicking on this button will download the highlighted SMARText Item to the user's local database (local library).

**7. Upload button-** Allows the user to upload a SMARText Item that they have created to "share" with other SOAPware users. Uploading the item will place it on the Online Library to be downloaded and used by other users.

**8. Update button-** This button should **ONLY** be Clicked during **Non-Clinic** hours. This action will update ALL SMARText Items with a green triangle and will add any new SOAPware created (green triangle) SMARText Items to the On line Library for use. This process may take anywhere from 45 minutes up to 2 hours to complete. It is **recommended** that this action be performed at least on a monthly basis to keep SMARText Items up to date. **Note:** If a user edits or changes a field other than the shortcut of a green triangle SMARText Item, it will not be updated. For information on Editing SMARText Items, [Click here](#).

## SMARText Items Manager Interface- Columns

Shortcut	Description	Type	Usage	Keywords	Last Modified	ID
▼ AmoS115	"Amoxicillin (Amoxil) 125/5...	Rx	0	01.O.A.GEN, 081022,...		3be8eda0-ac27-
▲ AmoS11	"Amoxicillin (Amoxil) 125/5...	Rx	0	01.O.A.GEN, 081022,...	4/23/2010 10:22...	c5f84f74-c61f-41
▲ AmoS11	"Amoxicillin (Amoxil) 125/5...	Rx	0	01.O.A.GEN, 081022,...		c5f84f74-c61f-41
▲ AmoS4	"Amoxicillin (Amoxil) 400/...	Rx	0	01.O.A.GEN, 080812,...	5/3/2010 2:12 PM	d1817095-0208-

### Column #1: Triangles

- \* **Upward facing triangle:** Indicates the SMARText item is located on a user's local database.
- \* **Downward facing triangle:** Indicates the SMARText item is located on the SOAPware Online Library.
- \* **Green triangle:** Indicates that the SMARText item was created by SOAPware.
- \* **Yellow triangle:** Indicates that the SMARText item has been edited or created by a SOAPware user.
- \* **Red triangle:** Indicates that the SMARText item is not available for use.

**A feature to remember:** SOAPware now has the ability for users to limit the display of SMARText items in the SMARText Items Manager, to those with green arrows only. (Meaning, a user will only see SMARText items created by SOAPware, or those created/edited by the site itself.) This user-specific setting can be found in Tools > Options > SMARText.

### Column #2: Shortcut

- \* This is the Shortcut code that is assigned to the SMARText item. The Shortcut code can be used to enter the item into the documentation (see "Shortcut Code Entry Method" below).

### Column #3: Description

- \* This column gives a description of the SMARText item. In a description that includes text with quotes, the text within quotes **will be** inserted into the documentation. In a description that includes text with parenthesis, the text within parenthesis **will not be** inserted into the documentation.

### Column #4: Type

- \* There are several different types of SMARText items. This column will indicate the item type (ie:

Dx, Rx, Multi-Sel List, Chief Finding, etc.).

### **Column #5: Usage**

\* This column indicates the number of times the SMARText item has been inserted by the User.

### **Column #6: Keywords**

\* This column will list all of the keywords that are associated with the SMARText item. When the user searches for a SMARText item, it will search for all SMARText items containing the keyword the user entered.

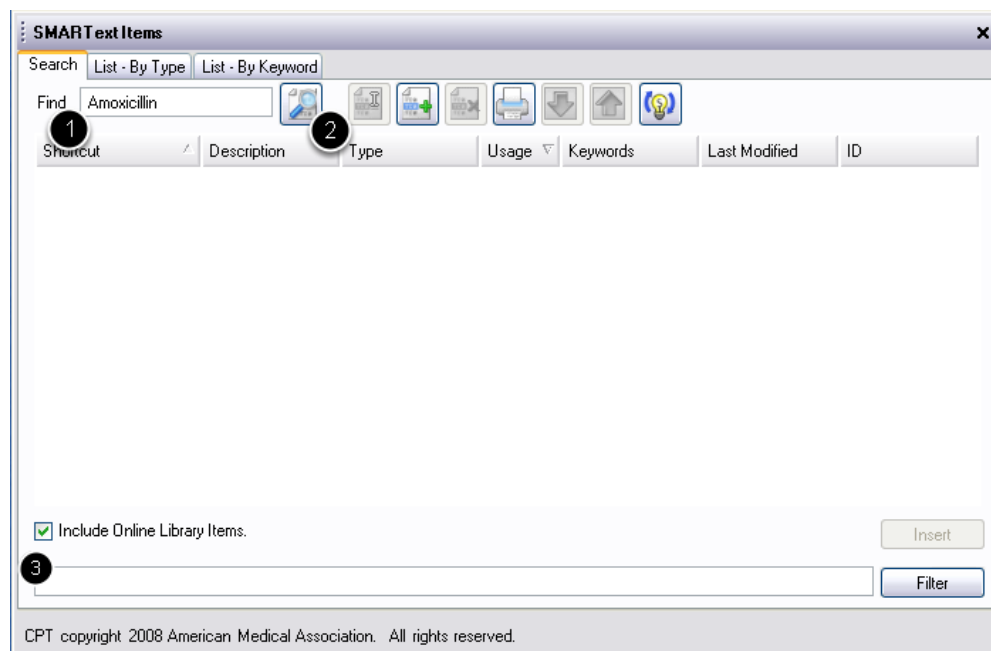
### **Column #7: Last Modified**

\* This column indicates the date that the SMARText item was last modified or updated.

### **Column #8: ID**

\* The column contains an identifier for the location where the SMARText item was created or modified.

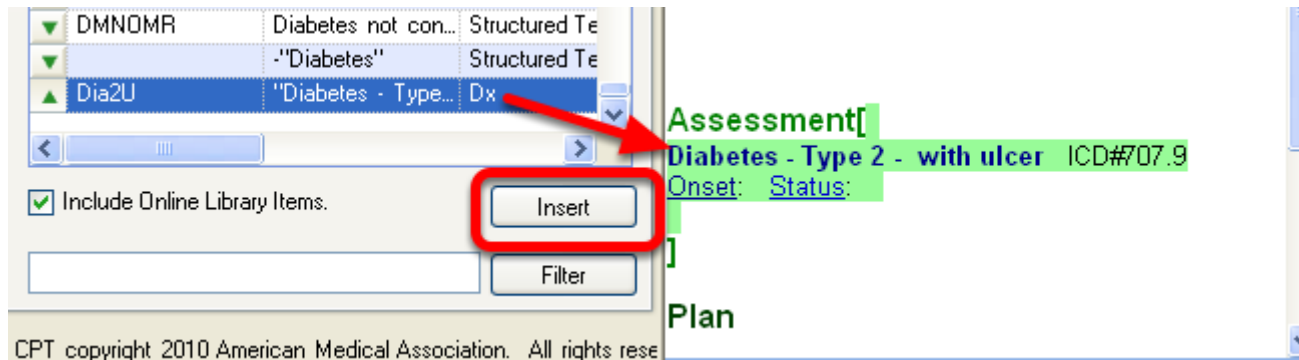
## **Searching within SMARText Items Manager**



SMARText items can have a single shortcut and multiple keywords associated with them. To search for a SMARText Item, complete the following steps:

1. Type in a keyword (single word or medical abbreviation).
2. Click on the Find button as shown above.
3. The user can also filter a search using this box to narrow down the results.

## Inserting Items with SMARText Items Manager



To insert a SMARText Item into an active field using SMARText Items Manager:

1. With a chart open, place the cursor into the desired field (ie: Active Problems, Medications, etc.).
2. Left-Click on the SMARText Item to highlight.
3. Double-Click on the item to insert it into the field, or Press "Insert".

## SMARTText Data Entry Methods

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This lesson will demonstrate the various ways to search for and use SMARTText in the patient's documentation.

### Various SMARTText Data Entry Methods

The various data entry methods include:

- \* SMARTText Items Manager
- \* Shift + F11
- \* F11
- \* Shortcut Code
- \* Quick Access Location Pick List
- \* Quick Access SMARTText Pick List

*Note: For purposes of demonstration we will be using a limited number of fields within SOAPware. The data entry methods discussed can be used in all fields within the Summary and SOAPnote.*

### Using SMARTText to Document for Meaningful Use

Using SMARTText structured items for documentation in the fields listed below will assist clinics with documenting to meet meaningful use requirements:

Demographics  
Active Problems  
Summary Medications  
Allergies  
Tobacco  
Assessment  
SOAPnote Medications  
Plan  
Vital Signs  
Labs

SMARTText is a type of data entry that was created by associating hidden information to the words and phrases used in documentation. As a result, the documentation is able to be identified electronically and read by the computer thus making the user's documentation more searchable.

For More information on Meaningful Use requirements, [Click Here](#).

## Inserting Items with SMARText Items Manager

**Double Click on the SMARText item**

**The item will be inserted into the field**

Medications[  
Amoxicillin (Amoxil) 125/5 Susp 125 mg/5 mL (powder for reconstitution)  
SIG- 5 3 times a day ]

CPT copyright 2008 American Medical Association. All rights reserved.

To insert a SMARText Item into an active field using SMARText Items Manager:

1. With a chart open, place the cursor into the desired field (ie: Active Problems, Medications, etc.).
2. Left-Click on the SMARText Item to highlight.
3. Double-Click on the item to insert it into the field or Click the "Insert" button.

## Shift + F11 Entry Method

**Press Shift + F11 to view search results**

Active Problems[  
copd ]

QA	Description	Shortcut	T.	Usage
1	"Restrictive lung disease #516.8"	ResL	Dx	1
2	"COPD, Bronchitic" (without exacerbatio...	ChrObsDB	Dx	1
3	"Centriacinar Emphysema" (ICD#492.8)	CenE	Dx	1
4	"Chronic obstructive pulmonary disease" ...	ChrO	Dx	1
5	"COPD, Bronchitic" (with acute exacerba...	ChrObsBa	Dx	1
	"COPD, Bronchitic" (without exacerbatio...	ChrObsDB	Dx	1
	"COPD, Bronchitic" (with acute exacerba...	ChrObsBa	Dx	1
	"Chronic obstructive pulmonary disease wit...	ChrObsDALRI	Dx	1
	"COPD, Bronchitic" (without exacerbatio...	COPDBRC	Dx	1
	COPD [Chronic obstructive pulmonary disea...		Dx	1
	"Moderate chronic obstructive pulmonary di...	ModChrOPD	Dx	1
	"Restrictive lung disease" (ICD#516.8)	ResLun	Dx	1

Find [ ]

Show Unused

SMARText items may be searched within each field. A "Shift + F11" search will display a list of SMARText items that are located on the SOAPware Online Library and the users local database. To conduct a "Shift + F11" search:

1. With a chart open, place the cursor into the desired field.
2. Type in a single keyword or medical abbreviation.
3. Press the Shift "+" (plus) the F11 key to conduct a search.

Notice the items in the pop-up dialog box include triangles that point both up and down and also includes many of the headers discussed above.

## Inserting an Item From a Shift + F11 Search

**Active Problems[**  
copd

**Double click the SMARTText Item**

QA	Description	T.	Usage
▲ 1	"Restrictive lung disease #516.8"	ResL	Dx 1
▲ 2	"COPD, Bronchitic" (without exacerbatio...	ChrObsDB	Dx 1
▲ 3	"Centriacinar Emphysema" (ICD#492.8)	CenE	Dx 1
▲ 4	"Chronic obstructive pulmonary disease" ...	ChrO	Dx 1
▲ 5	"COPD, Bronchitic" (with acute exacerba...	ChrObsBa	Dx 1
▼ 6	"COPD, Bronchitic" (without exacerba...	ChrObsDB	Dx 1

**The item will be inserted into the field**

**Active Problems[**  
COPD, Bronchitic ICD#491.20  
→ ]

To insert a SMARTText Item into an active field using a Shift + F11 search:

1. Left Click on the desired SMARTText Item to highlight it.
2. Double Click on the item to insert it into the field.

## F11 Entry Method

**Inactive Problems[**  
bronchitis

**Press F11 to view search results**

QA	Description	Shortcut	T.	Usage
▲ 1	"Croup" (ICD#464.4)	Cro	Dx	1
▲ 2	"Asthma" (nonspecific - 493.10)	Ast	Dx	1
▲ 3	"Chemical Bronchitis" (acute - ICD#506.0)	CheB	Dx	1
▲ 4	"Bronchitis, acute" (viral - ICD#466.0)	BroA	Dx	1
▲ 5	"COPD, Bronchitic" (without exacerba...	ChrObsDB	Dx	1
▲ 6	"Chronic bronchitis" (nonspecific - ICD#4...	ChrB	Dx	1
▲ 7	"COPD, Bronchitic" (with acute exacerba...	ChrObsBa	Dx	1

☐ Show Unused

Find

**Inactive Problems[**  
Bronchitis, acute ICD#466.0  
→ ]

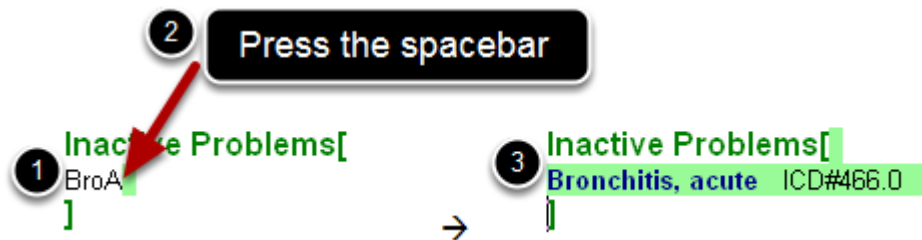
An "F11" search will display a list of SMARTText items that are located on the users local database. To conduct an "F11" search:



1. With a chart open, place the cursor into the desired field.
2. Type in a single keyword or medical abbreviation.
3. Press the F11 key to conduct a search.
4. Insert the SMARTText item into the desired field by double Clicking on the item.

Notice the items in the pop-up dialog box include triangles that point only up denoting the items are located on the users local database.

### Shortcut Code Entry Method

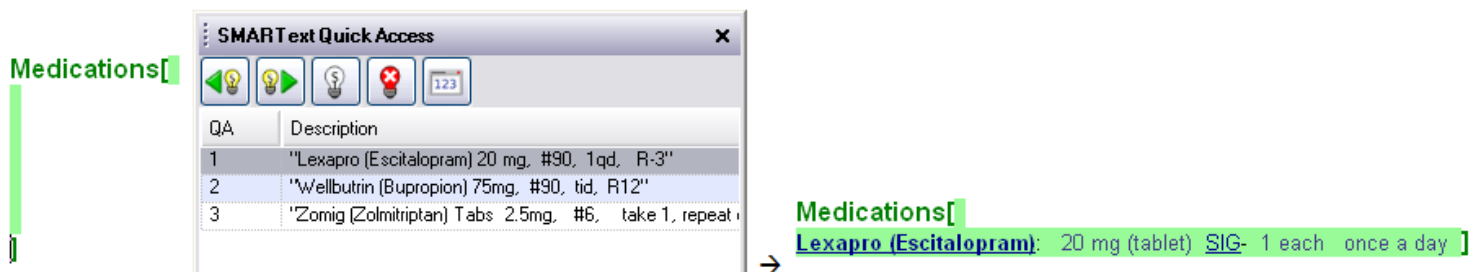


If the shortcut code to a SMARTText item is known, it can be inserted by following the steps below:

With a chart open, place the cursor into the desired field.

1. Type in the shortcut code for the SMARTText item to insert.
2. Press the spacebar on the keyboard.
3. The SMARTText item will expand.

### Quick Access Location Pick List Entry Method



Clicking in most fields causes a list of SMARTText items that were previously used in that field (in any patients chart) to be presented in the SMARTText Quick Access dialog box. The Quick Access Location pick list is User specific and allows for inserting a previously used item without conducting a search.

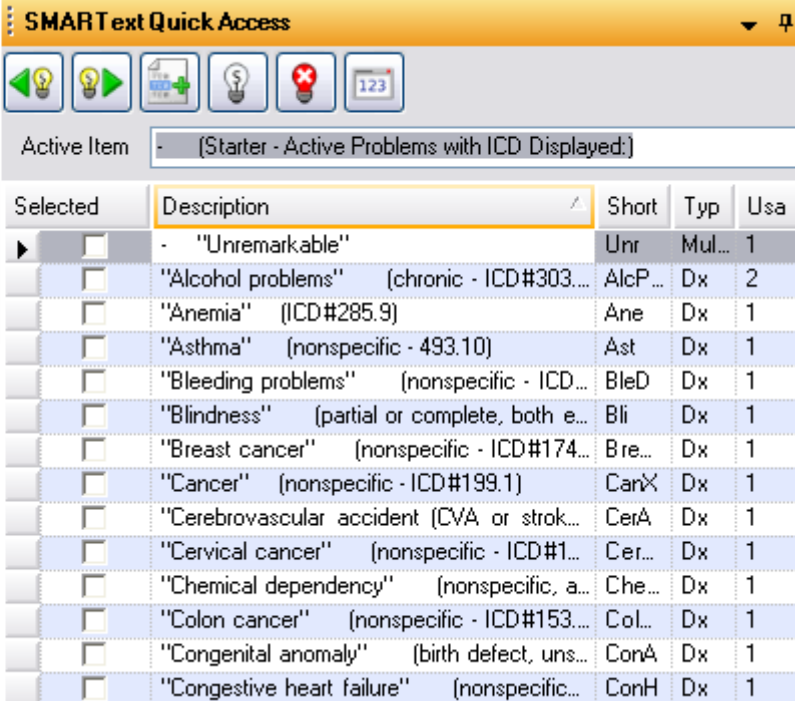
To insert a item from the Quick Access Location Pick List, simply double Click on the item in the SMARTText Quick Access dialog box.

**NOTE:** If a user does not see the SMARText Quick Access window, please see: [Docking SMARText Quick Access](#).

## Quick Access SMARText Pick List Entry Method

The list displayed to the right is attached to the pick list below.

Active Problems[  
[Starter - Active Problems:](#)  
]



The screenshot shows the SMARText Quick Access window. It has a toolbar with icons for undo, redo, insert, delete, and a numeric keypad. Below the toolbar is a dropdown menu for 'Active Item' showing '(Starter - Active Problems with ICD Displayed:)'. The main area is a table with columns: Selected, Description, Short, Typ, and Usa. The table lists various medical conditions with checkboxes in the 'Selected' column.

Selected	Description	Short	Typ	Usa
<input type="checkbox"/>	- "Unremarkable"	Unr	Mul...	1
<input type="checkbox"/>	"Alcohol problems" (chronic - ICD#303...	AlcP...	Dx	2
<input type="checkbox"/>	"Anemia" (ICD#285.9)	Ane	Dx	1
<input type="checkbox"/>	"Asthma" (nonspecific - 493.10)	Ast	Dx	1
<input type="checkbox"/>	"Bleeding problems" (nonspecific - ICD...	BleD	Dx	1
<input type="checkbox"/>	"Blindness" (partial or complete, both e...	Bli	Dx	1
<input type="checkbox"/>	"Breast cancer" (nonspecific - ICD#174...	Bre...	Dx	1
<input type="checkbox"/>	"Cancer" (nonspecific - ICD#199.1)	CanX	Dx	1
<input type="checkbox"/>	"Cerebrovascular accident (CVA or strok...	CerA	Dx	1
<input type="checkbox"/>	"Cervical cancer" (nonspecific - ICD#1...	Cer...	Dx	1
<input type="checkbox"/>	"Chemical dependency" (nonspecific, a...	Che...	Dx	1
<input type="checkbox"/>	"Colon cancer" (nonspecific - ICD#153...	Col...	Dx	1
<input type="checkbox"/>	"Congenital anomaly" (birth defect, uns...	ConA	Dx	1
<input type="checkbox"/>	"Congestive heart failure" (nonspecific...	ConH	Dx	1

Many SMARText items have lists associated with them which allow a desired item (ie: list of common diagnosis or surgeries) to be inserted. SOAPware refers to these items as "Pick Lists". In SOAPware, text that appears [Blue](#) and [Underlined](#) indicates that a Pick List is attached to the SMARText Item (as shown above).

SOAPware has created numerous Starter Pick Lists, such as the one shown above. To learn how to insert and use the Starter Pick Lists, please follow the links below:

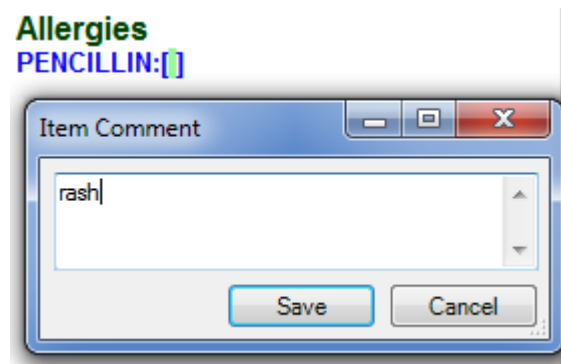
- \* [Active Problems](#)
- \* [Inactive Problems](#)
- \* [Surgeries](#)
- \* [Medications](#)
- \* [Allergies](#)
- \* [Family History](#)

- \* Tobacco
- \* Alcohol
- \* Interventions
- \* Social History
- \* ROS & Physical

## Editing SMARText Items

For information on how to copy, move, and delete SMARText, see: [Editing Text in SOAPware](#).

## Click and Type



All SMARText items can have free-text comments attached to them. To edit/add a comment, Click on a SMARText item, and begin typing. The Item Comment box will display, showing the text with the note field.

It is not wise to simply Click after a SMARText item, and just start typing. Anything typed in this fashion is not associated with the chief complaint, but is freely floating somewhere in Subjective. This lowers the value of the information, and can causes some formatting problems when issuing the Remove Unused command.

## Editing Text in SOAPware

---

In this lesson we will describe how to edit SMARTText items within a user's documentation.

Even though SMARTText appears similar to free-text, SMARTText has hidden information associated with the words and phrases used in documentation. As a result, the documentation is able to be identified electronically and read by the computer thus making a user's documentation more searchable. Therefore, when editing SMARTText items a user should follow the rules described in this lesson.

### Highlighting & Selecting SMARTText Items

At times a user may find it necessary to highlight a SMARTText item so a user can drag & drop it into another field. When highlighting and selecting a SMARTText item it is important that the cursor be at the beginning or end of the SMARTText item, rather than on or in the middle of the item.

**NOTE: Many users find it easier to use the double-click method to highlight a SMARTText item. We will discuss this method below.**

### Double-Click Method for Selecting SMARTText Items

After double-clicking on the "Lexapro" header, note that the entire SMARTText item has been highlighted.

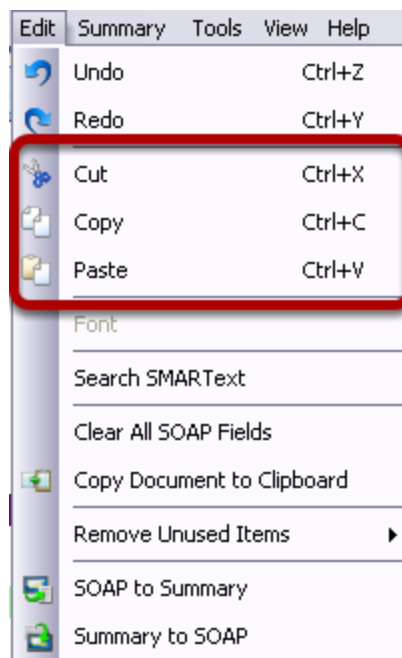
Medications[ Lexapro (Escitalopram): 20 mg (tablet) SIG- 1 each once a day ] → Medications[ Lexapro (Escitalopram): 20 mg (tablet) SIG- 1 each once a day ]

To select the SMARTText item, double-click on the item header (ie: the name of the medication, name of the diagnosis, etc.).

This will highlight the all of the items associated with the SMARTText header (ie: the strength and dose of a medication or the ICD9 code of a diagnosis, etc.).

\*This is the recommended method to select a SMARTText item.

## Cut/Copy/Paste SMARText Items



SOAPware will only cut/copy/paste items that are fully contained in the highlighted selection. Before attempting to cut/copy/paste a SMARText item, select the entire item using the double-click method as described above.

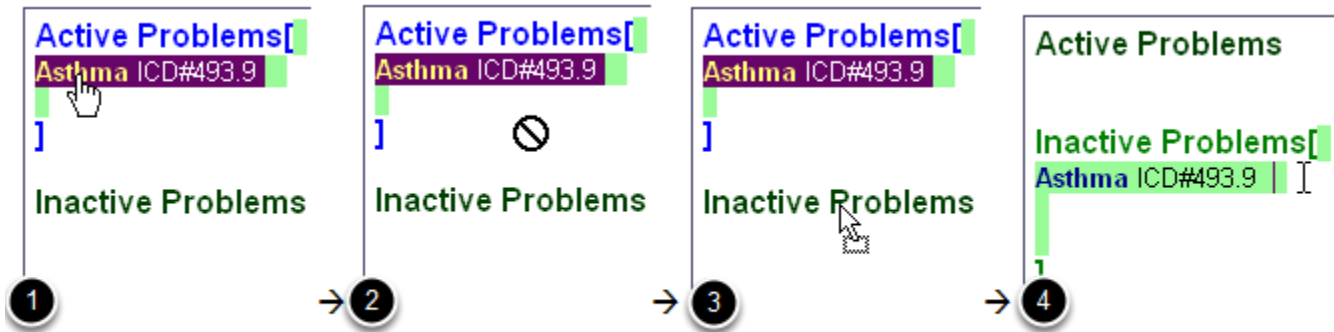
- \* To cut a SMARText item, select Edit then Cut from the Menu bar or press Ctrl + X on the keyboard.
- \* To copy a SMARText item, select Edit then Copy from the Menu bar or press Ctrl + C on the keyboard.
- \* After cutting or copying an item the user can then paste the item into a field. To paste a SMARText item, select Edit then Paste from the Menu bar or press Ctrl + V on the keyboard.

## Deleting SMARText Items

SOAPware will only delete items that are fully contained in the highlighted selection. When a SMARText item is selected using the double-click method, simply press Backspace or Delete on the keyboard to delete the SMARText item.

If the SMARText item is not previously selected, to delete the item the user can also click on the item header once and press the delete key. The first press of the delete key will select the entire SMARText item. Press the delete key a 2nd time to delete the entire SMARText item.

## Move or Drag & Drop SMARText Items



SOAPware will only drag & drop items that are fully contained in the highlighted selection. The user can only drag & drop items into a different field (ie: from Active Problems to Inactive Problems). The user cannot drag & drop an item within the same field. To drag & drop, follow the steps below:

1. Highlight and select the item by using one of the methods that was previously described.
2. While holding a left-click, begin dragging the item to another field. The user will see a circle with a line through it indicating that he/she can not yet drop the item.
3. Place the cursor directly over the field header in which the user wishes to drop the item (ie: Inactive Problems, as shown above). The cursor will have a gray rectangle indicating that the user can drop the item into that field.
4. With the cursor still **directly over the field header** let go of the left-click. The item will be placed into that field.

## SMARText Items in Pick Lists

SMARText Items (except for Order Entry) can be arranged into pick lists, and can be selected by simple clicking. These function much like a paper superbill, where the user will either circle or check boxes.

Customized pick lists are one of the most efficient data entry methods. Creating custom pick lists that contain the items that the user commonly and repeatedly utilize, allows data entry to be performed quickly and efficiently via a click for insertion into documentation.

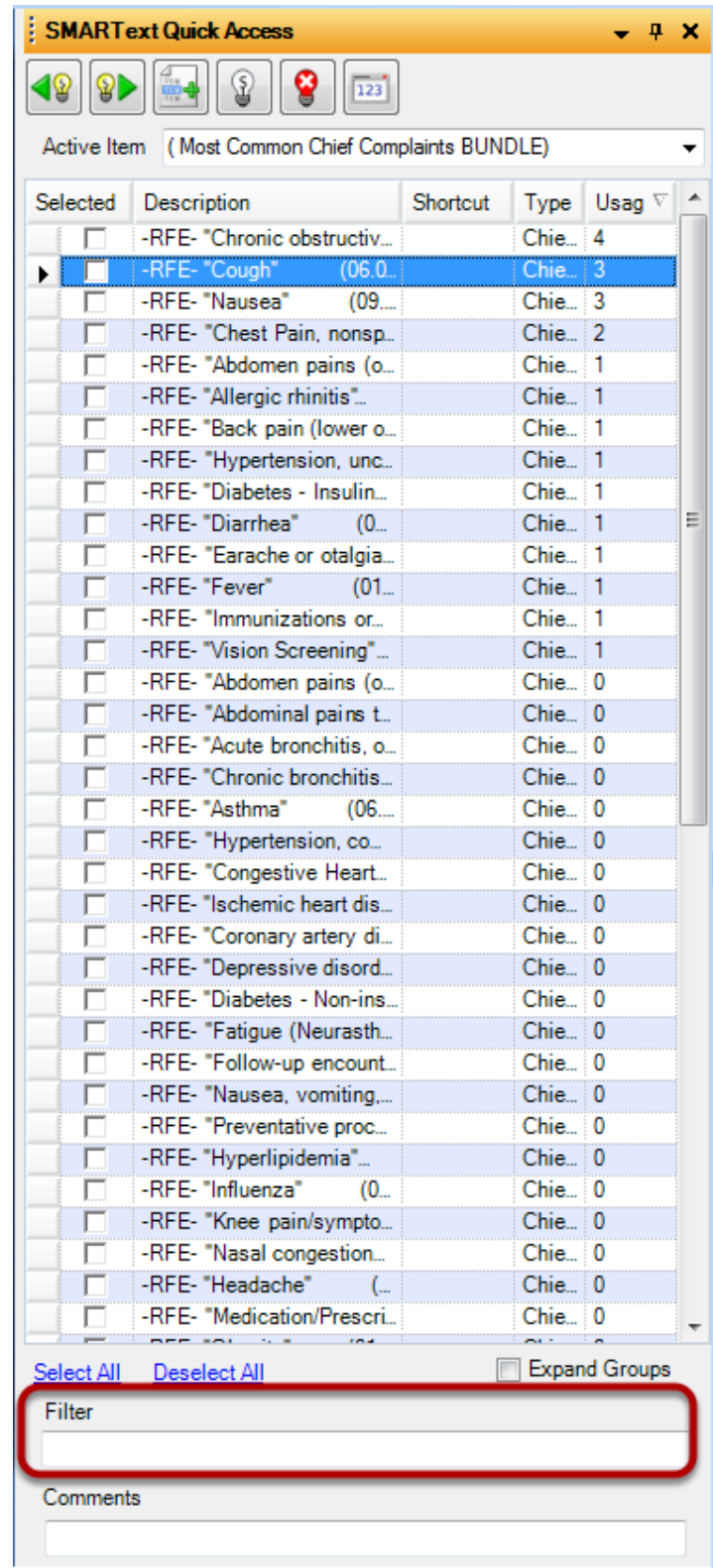
### Pick Lists

The screenshot shows the SOAP Notes application interface. On the left, there's a sidebar with sections: Subjective, Objective, Assessment, Plan, Medications, and Follow Up. The 'Subjective' section is active, showing 'CHIEF COMPLAINT(S)/REASON FOR VISIT:[]'. On the right, the 'SMARText Quick Access' window is open, displaying a pick list for 'CHIEF COMPLAINT(S):'. The pick list has a table with columns 'Select', 'Description', and 'S'. The first item, '( A - GENERAL and Unspecified )', is selected. Other items include '( B - BLOOD and IMMUNE )', '( D - DIGESTIVE )', '( F - EYE )', '( H - EAR )', '( K - CARDIOVASCULAR )', '( N - NEUROLOGICAL )', '( P - PSYCHOLOGICAL )', '( R - RESPIRATORY )', '( S - SKIN )', '( T - ENDOCRINE/METABOLIC/...', '( U - UROLOGICAL )', '( W - PREGNANCY/CHILDBIRT...', '( X - FEMALE GENITAL )', '( Y - MALE GENITAL )', '( Z - SOCIAL PROBLEMS )', '( L - MUSCULOSKELETAL )', and '( Most Common Chief Complaint...'. The 'S' column contains a small 'S' icon.

Select	Description	S
<input checked="" type="checkbox"/>	( A - GENERAL and Unspecified )	S
<input type="checkbox"/>	( B - BLOOD and IMMUNE )	
<input type="checkbox"/>	( D - DIGESTIVE )	
<input type="checkbox"/>	( F - EYE )	
<input type="checkbox"/>	( H - EAR )	
<input type="checkbox"/>	( K - CARDIOVASCULAR )	
<input type="checkbox"/>	( N - NEUROLOGICAL )	
<input type="checkbox"/>	( P - PSYCHOLOGICAL )	
<input type="checkbox"/>	( R - RESPIRATORY )	
<input type="checkbox"/>	( S - SKIN )	
<input type="checkbox"/>	( T - ENDOCRINE/METABOLIC/...	
<input type="checkbox"/>	( U - UROLOGICAL )	
<input type="checkbox"/>	( W - PREGNANCY/CHILDBIRT...	
<input type="checkbox"/>	( X - FEMALE GENITAL )	
<input type="checkbox"/>	( Y - MALE GENITAL )	
<input type="checkbox"/>	( Z - SOCIAL PROBLEMS )	
<input type="checkbox"/>	( L - MUSCULOSKELETAL )	
<input type="checkbox"/>	( Most Common Chief Complaint...	

In the example above, the user will see that when the user clicks in the picklist, a list of choices comes into view within the SMARText Quick Access window. Frequently used items can be grouped into Pick Lists to make them easy and efficient to find and use.

## Searching for items in the SMARText Quick Access



The SMARText Quick Access display for Multi Select and Toggle items now has a "Filter" option available located at the bottom of the display. When text is entered here ONLY items that have a keyword that starts with the entered filter will be displayed.

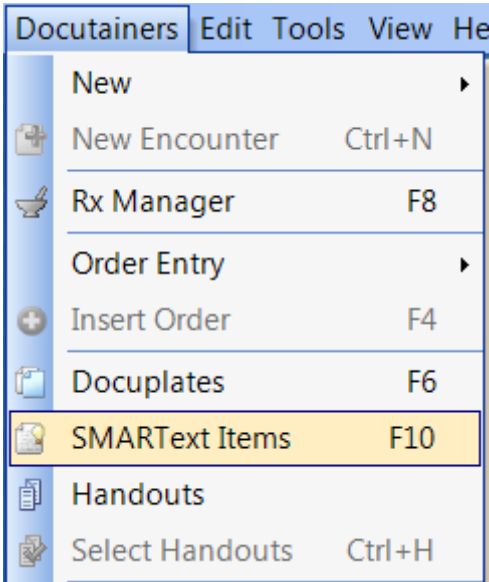


# Creating SMARText Items

# Code Expander/Macro

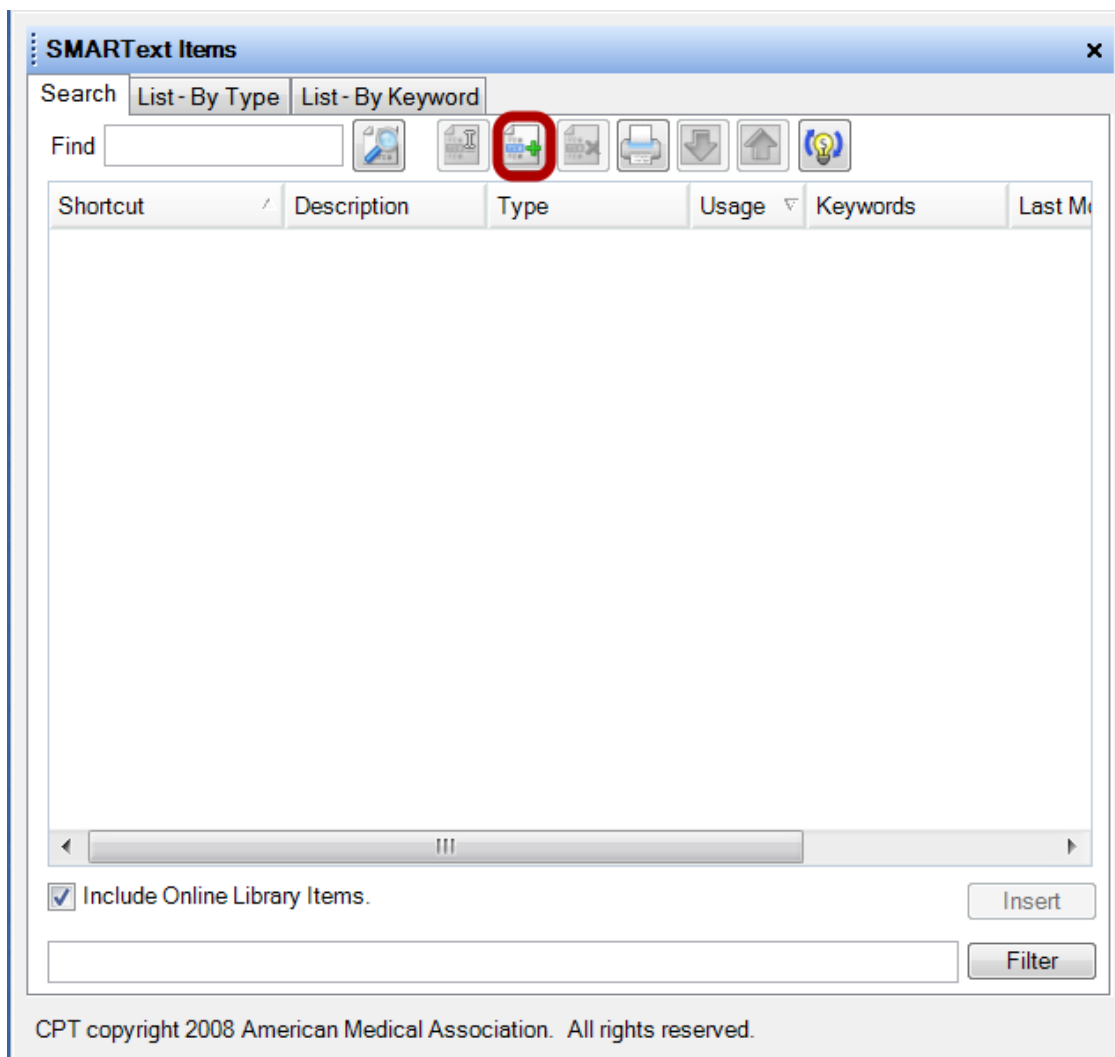
A macro can be very helpful when inserting strings of unstructured text that a user types on a regular basis. By creating an expander code, the user can quickly insert this text without having to type the entire string of text.

## Open SMARText Items



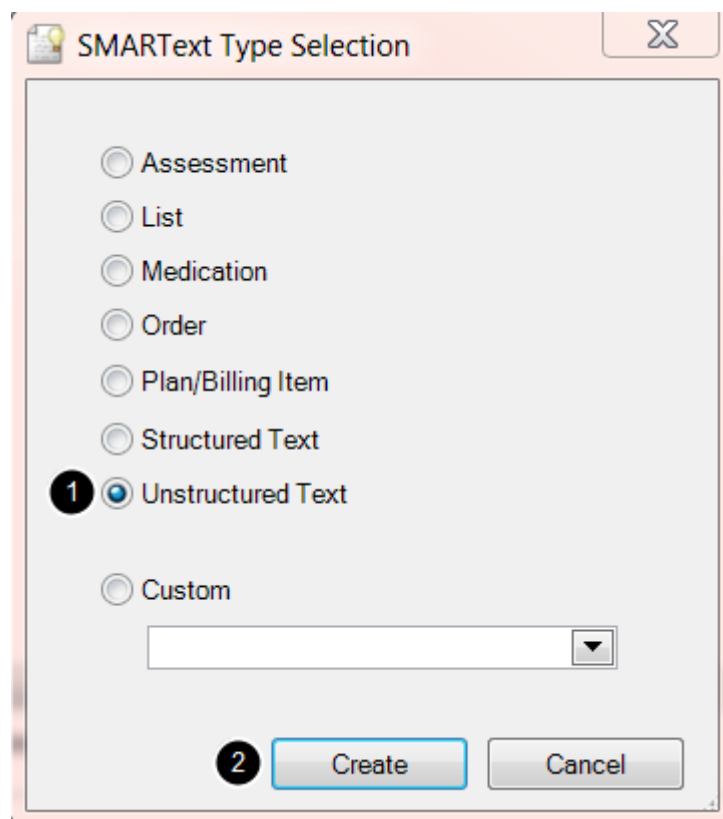
Go to Docutainers > SMARText Items.

## Add an Item



Click on the Create button.

## Choose Item Type



1. Choose Unstructured Text
2. Click Create

## Create the Item

The screenshot shows the SMARTText Designer dialog box with the following fields and settings:

- Shortcut:** KTR (labeled 1)
- Description:** Katie Signature (labeled 2)
- Keywords:** katie, signature, macro (labeled 3)
- Display Header:** ☐ (labeled 4)
- only when item is empty:** ☐
- Advanced:** General (labeled 5)
- Item Type:** Free/Unstructured Text
- Text Box:** [Katie Rogers, L.P.N.] (labeled 6)
- Item Properties:** As Is (selected), English List (and), English List (or), End with (labeled 7)
- Buttons:** Save, Cancel (labeled 8)

1. Type in a Shortcut (this will be what the user wants to type in for the text to expand)
2. Type in a Description (how the user will identify his/her code).
3. Type in Keywords - single words separated by comma's and a space (these are used to search for the item)
4. Click in the large white text box until the user sees green brackets.
5. Type the text that the user wants to display within the green brackets.
6. Click Save.

INTENSITY/SEVERITY: Reports measurement (  
or degree) as moderate.  
ONSET/TIMING: Reports occurrence as sudden.  
ROS: LUNGS/Respiratory: Denies symptoms  
such as sputum/phlegm production that is  
purulent.  
Katie Rogers, L.P.N.

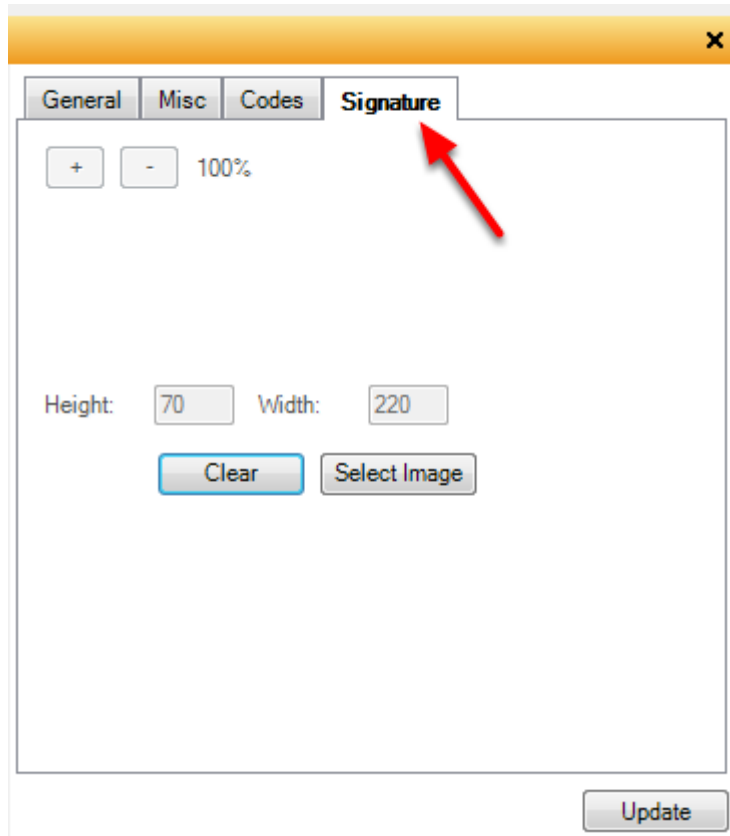
Now, the user can type his/her shortcut into a SOAPnote or Summary and hit the space bar, the code will expand to display the user's text. This is often quite useful for creating a signature to enter at the bottom of documentation; denoting who created the documentation and for paragraphs of patient teaching.

## Creating a SMARText item for a Provider's Cursive Signature

---

This lesson will demonstrate how to create a SMARText item that contains a physician's cursive signature. In the lesson on [Provider Manager](#), it was demonstrated how to save the provider's signature into Provider Manager. This lesson will show how to take that signature, and create a SMARText item that can be placed into a docutainer.

### Entering the Signature in Provider Manager

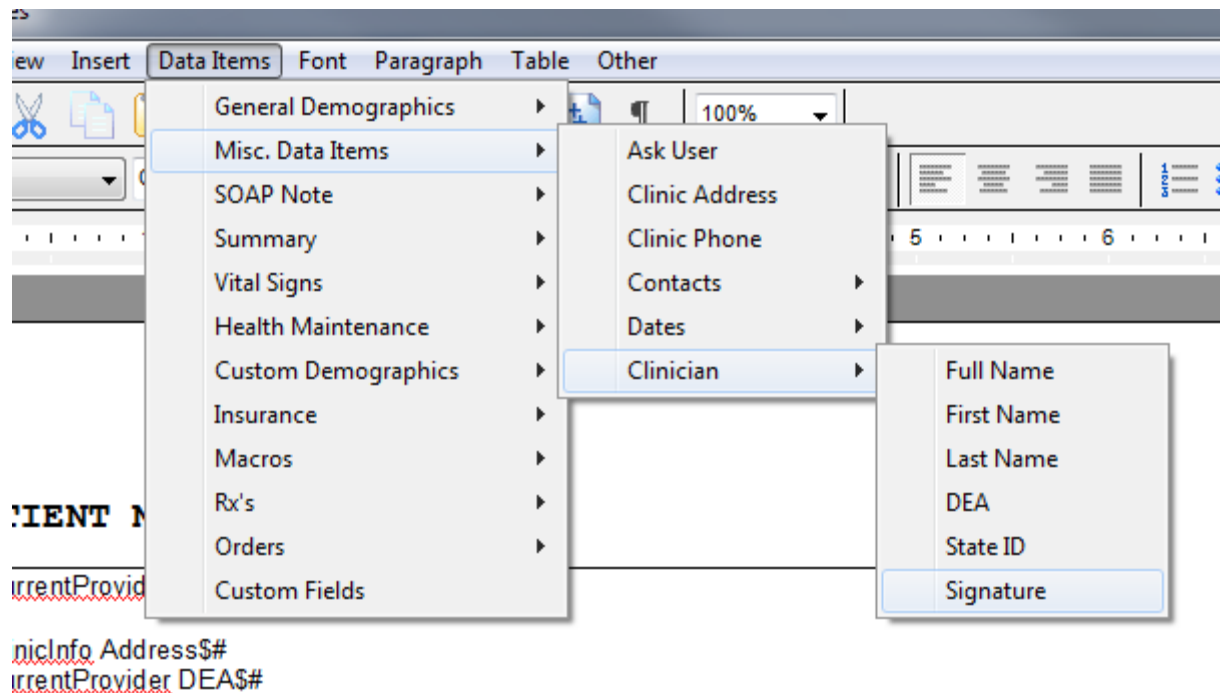


First scan the Providers signature using the scanners software, and save on the computer.

1. Click on the Select Image button.
2. Once the image has been located, double click to insert.
3. The image will not immediately be in view. Click on the button with the "-" sign repeated to re-size the image and bring it into view. Note that the size percentage changes as the image is re-sized.
4. To save, Click the Update Button in the lower right hand corner.

To remove the image, simply Click on the Clear button.

## Placing Signatures in a Document Design



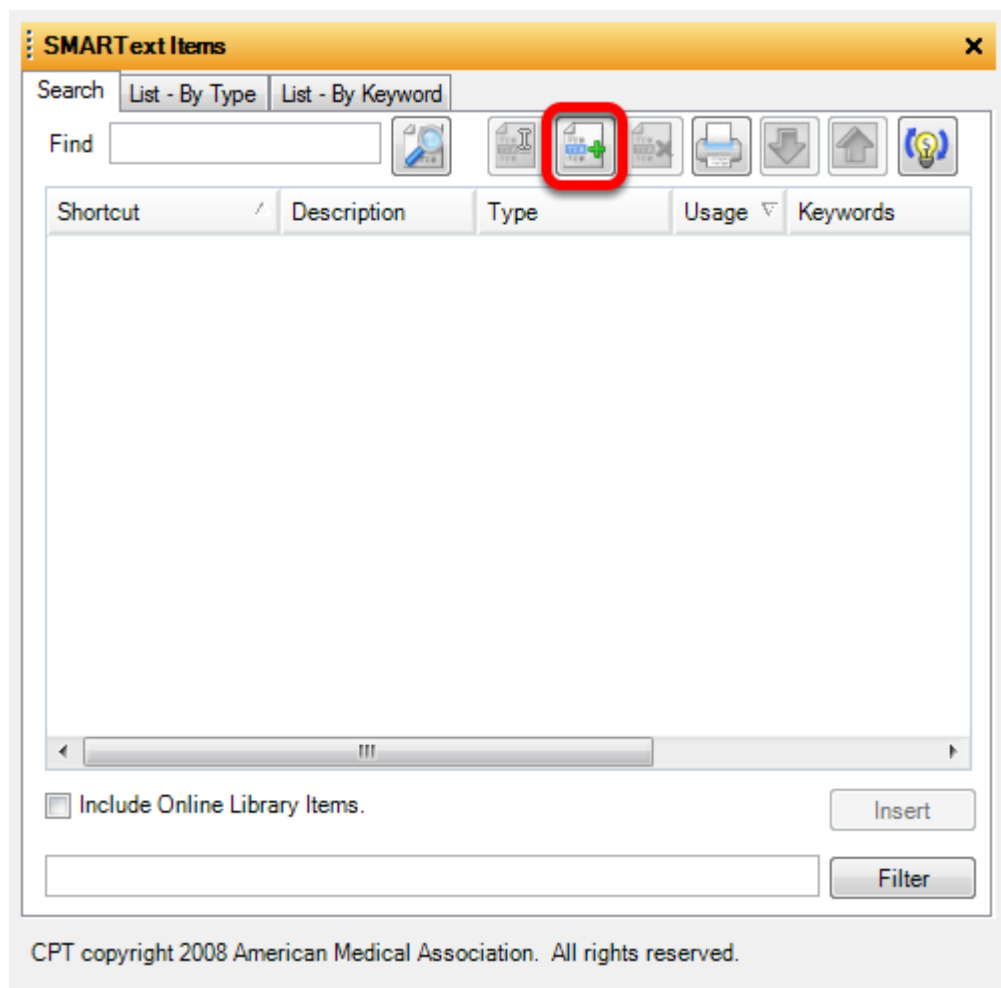
This signature can be placed in a document design for printing for faxing.

To insert a physician's signature on a document design, click Data Items > Misc. Data Items > Clinician > Signature

It is now possible to create a SMARTText Signature Item to insert the signature into any docutainer using a shortcut.

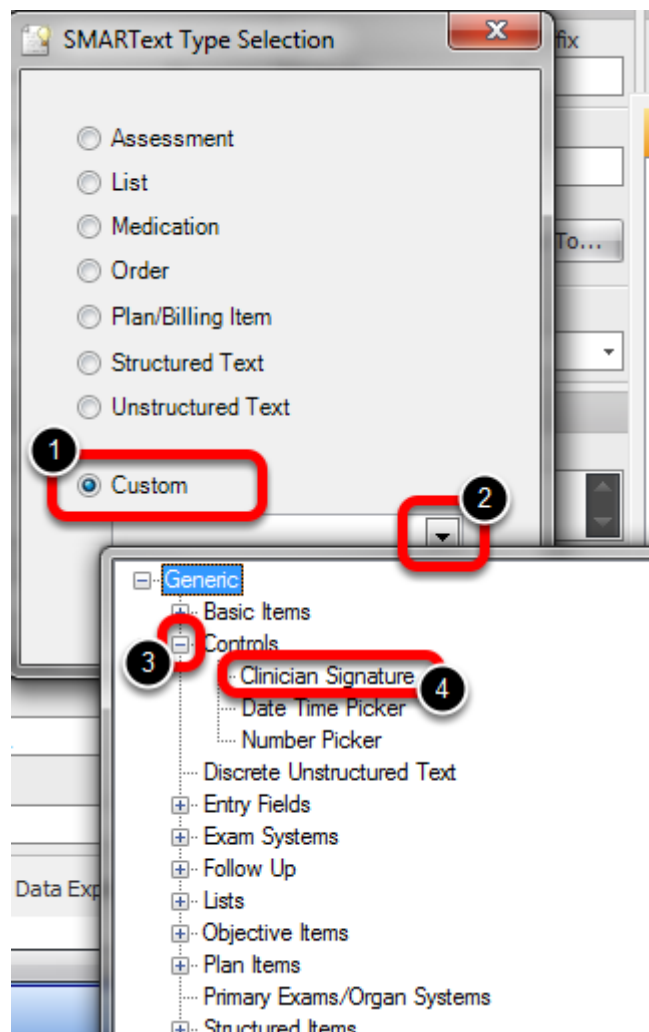


## Creating a SMARText Signature Item



Open the SMARText Items Manager by choosing Docutainer > SMARText Items Manager, or Press F10 on the keyboard.

Click on the Green + to create a new SMARText Item.



To create a Signature item:

1. Click Custom
2. Click on the downward facing arrow to display list
3. Click on the node next to Controls
4. Select Clinician Signature

Click Create.

SMARTText Designer

Shortcut

Description

Keywords

☒ Display Header  ☐ only when item is empty.

Advanced

General

Item Type

*Test Signature*

Item Settings

Item Properties

Item Separators

☐ As Is ☐ English List (and)

☒ Separate with  ☐ English List (or) ☐ End with

☐ Separate Lines

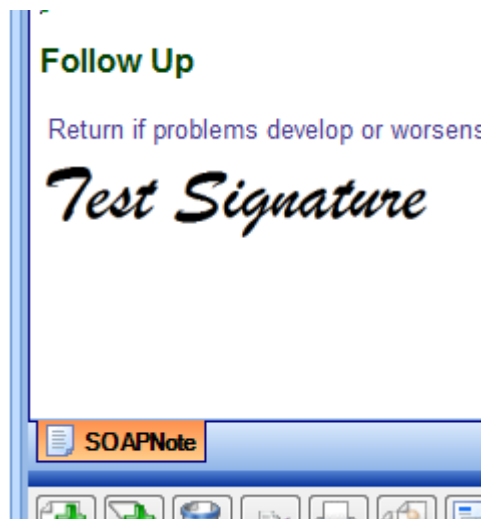
☒ Include in EM Coder point calculations.

Remove this item via Remove Unused -

Save Cancel

Enter the Shortcut, Description and Keywords. Do not fill out Display Header.

Click Save.

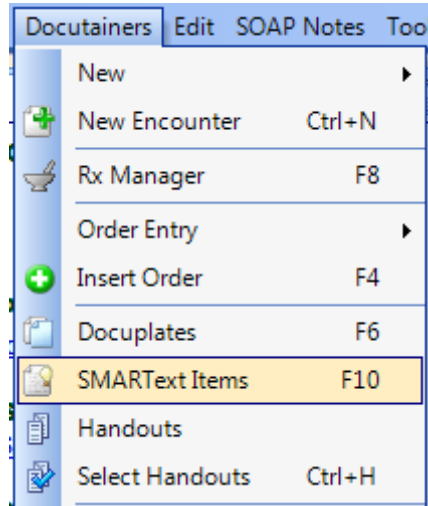


To insert the SMARTText item into the SOAPnote, type in the shortcut in one of the SOAPnote fields, and press the space bar.

The SMARTText Item will then be displayed in field.

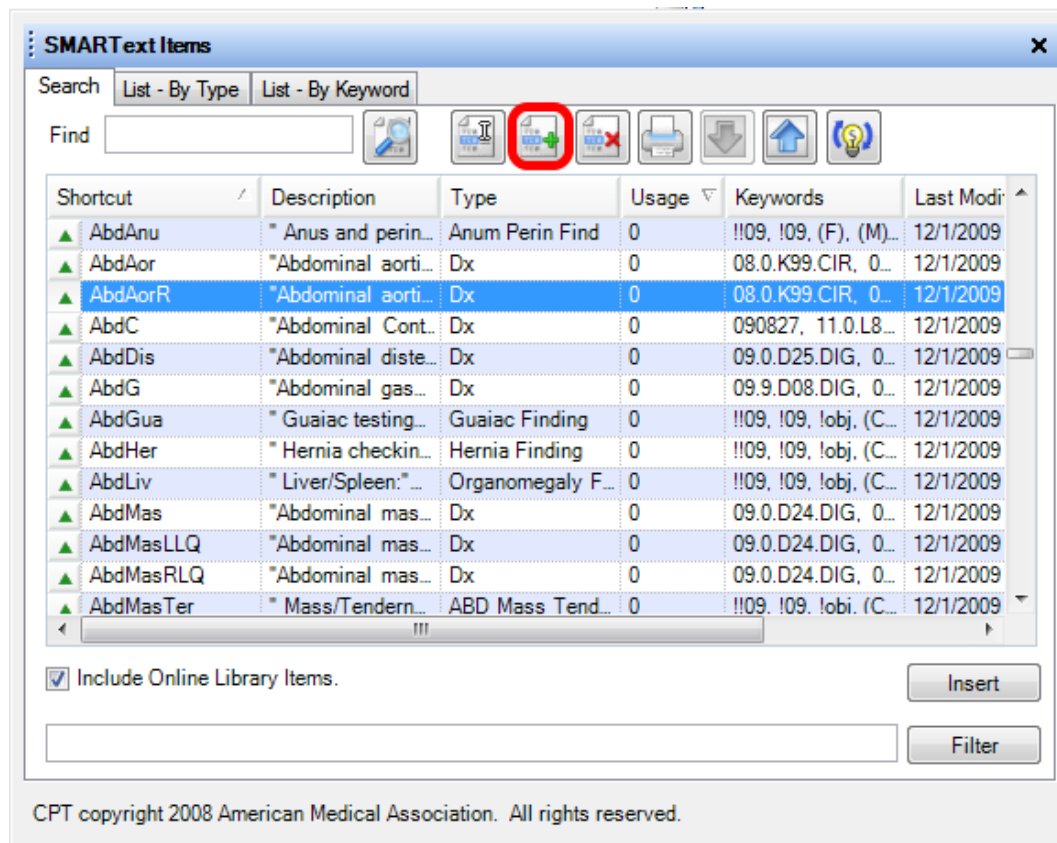
## Creating and Editing SMARText Items in the SMARText Items Manager

### SMARText Manager

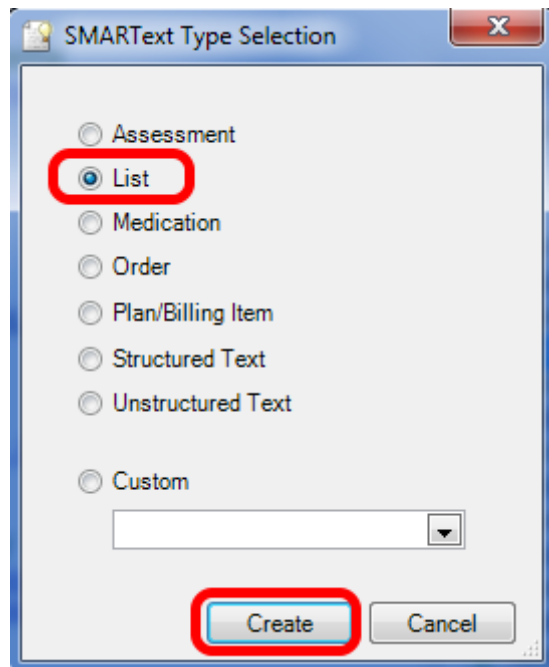


Open the SMARText Manager by going to Docutainers - SMARText Items

### Create New



Click the create new button.



Choose the item type and Click create.

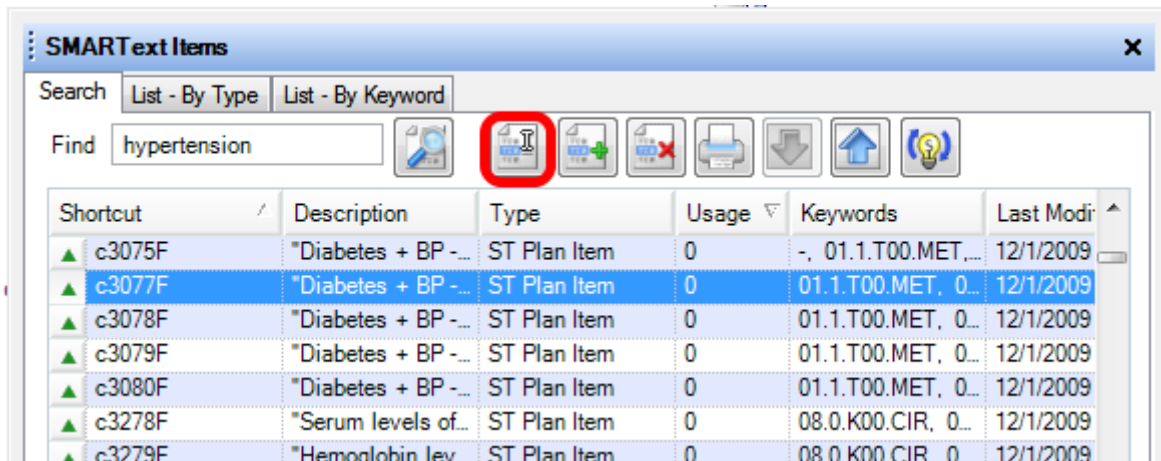
The image shows the SMARText Designer application window. It has a title bar "SMARText Designer" and a "Help" button. The main area is divided into sections:

- Shortcut:** A text box containing "medlist".
- Description:** A text box containing "Medications List".
- Keywords:** A text box containing "medicaitons, list".
- Display Header:** A checked checkbox labeled "Display Header" followed by a text box containing "Medications|". To the right is an unchecked checkbox labeled "only when item is empty".
- Advanced:** A tabbed interface with two sub-sections:
  - General:** Contains an "Item Type" dropdown menu set to "Multi-Sel List". Below it is a large empty text area.
  - Item Properties:** Contains an "Item Settings" text box and an "Item Separators" section. The "Item Separators" section has four radio buttons: "As Is", "Separate with" (selected), "Separate Lines", "English List (and)", and "English List (or)". There is also an "End with" checkbox and a text box.

At the bottom right are "Save" and "Cancel" buttons.

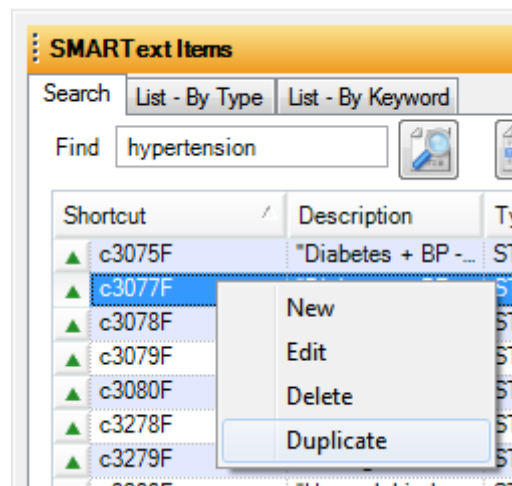
Use the SMARText Designer to assign a shortcut, description, keywords, and a Display Header. Click Save.

## Edit a SMARText Item



To edit a SMARText item select the item in the SMARText Items Manager, then click the Edit button. This will bring up the SMARText Designer.

## Duplicating a SMARText Item



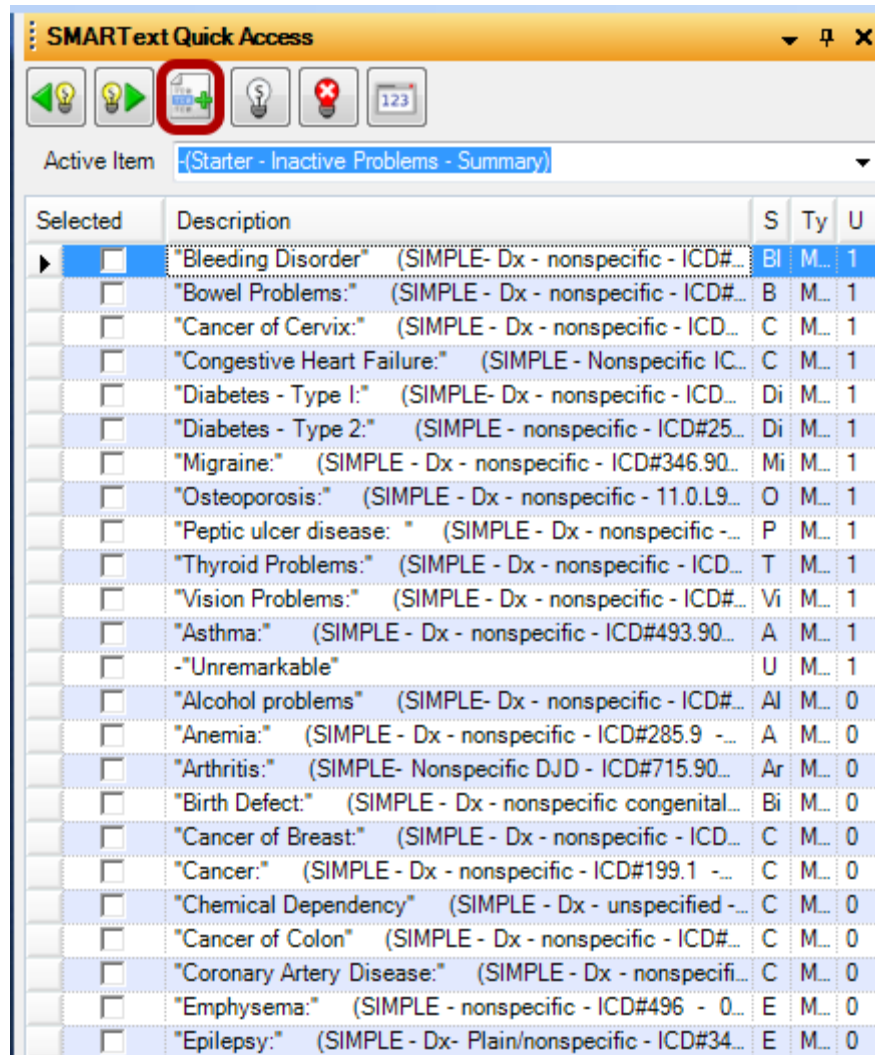
A user can also duplicate SMARText items to edit them without modifying the original item. To do this, right-click an existing SMARText item in the manager and click Duplicate. This item will have a green triangle and a yellow triangle SMARText item. The yellow item is now user created and may be edited, allowing the originally SOAPware created item to remain the same and have the ability to be updated when needed.



## Creating SMARText Items from Quick Access

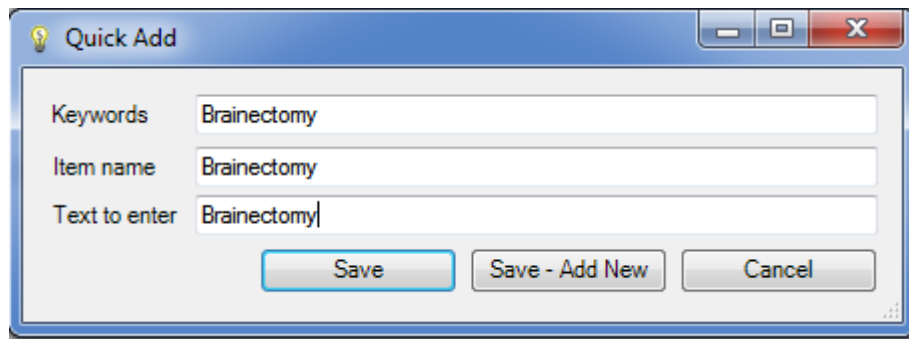
Most users will want to add and remove items from pick lists. This demo will show an easy means to add items to any pick list, anywhere.

### Quick Add



In Quick Access, Click the Add button on the mini toolbar at the top to present the Quick Add dialog as shown below.

## Assign Keywords, Description, and Value



The image shows a 'Quick Add' dialog box with a light blue title bar and standard Windows window controls. It contains three text input fields: 'Keywords', 'Item name', and 'Text to enter'. Each field has the word 'Brainectomy' entered. Below the fields are three buttons: 'Save', 'Save - Add New', and 'Cancel'. The 'Save' button is highlighted with a blue border.

Keywords	Brainectomy
Item name	Brainectomy
Text to enter	Brainectomy

Buttons: Save, Save - Add New, Cancel

Type the Keyword, Description and Text to enter. Click Save.

## Using the Newly Added Item

SMARText Quick Access					
<div> </div>					
Active Item: (Starter - Inactive Problems - Summary)					
Selected	Description	S	Ty	U	
<input type="checkbox"/>	"Bleeding Disorder" (SIMPLE- Dx - nonspecific - ICD#...	BI	M...	1	
<input type="checkbox"/>	"Bowel Problems:" (SIMPLE - Dx - nonspecific - ICD#...	B	M...	1	
<input type="checkbox"/>	"Cancer of Cervix:" (SIMPLE - Dx - nonspecific - ICD...	C	M...	1	
<input type="checkbox"/>	"Congestive Heart Failure:" (SIMPLE - Nonspecific IC...	C	M...	1	
<input type="checkbox"/>	"Diabetes - Type I:" (SIMPLE- Dx - nonspecific - ICD...	Di	M...	1	
<input type="checkbox"/>	"Diabetes - Type 2:" (SIMPLE - nonspecific - ICD#25...	Di	M...	1	
<input type="checkbox"/>	"Migraine:" (SIMPLE - Dx - nonspecific - ICD#346.90...	Mi	M...	1	
<input type="checkbox"/>	"Osteoporosis:" (SIMPLE - Dx - nonspecific - 11.0.L9...	O	M...	1	
<input type="checkbox"/>	"Peptic ulcer disease: " (SIMPLE - Dx - nonspecific - ...	P	M...	1	
<input type="checkbox"/>	"Thyroid Problems:" (SIMPLE - Dx - nonspecific - ICD...	T	M...	1	
<input type="checkbox"/>	"Vision Problems:" (SIMPLE - Dx - nonspecific - ICD#...	Vi	M...	1	
<input type="checkbox"/>	"Asthma:" (SIMPLE - Dx - nonspecific - ICD#493.90...	A	M...	1	
<input type="checkbox"/>	"Unremarkable"	U	M...	1	
<input type="checkbox"/>	"Alcohol problems" (SIMPLE- Dx - nonspecific - ICD#...	Al	M...	0	
<input type="checkbox"/>	"Anemia:" (SIMPLE - Dx - nonspecific - ICD#285.9 - ...	A	M...	0	
<input type="checkbox"/>	"Arthritis:" (SIMPLE- Nonspecific DJD - ICD#715.90...	Ar	M...	0	
<input type="checkbox"/>	"Birth Defect:" (SIMPLE - Dx - nonspecific congenital...	Bi	M...	0	
<input type="checkbox"/>	"Cancer of Breast:" (SIMPLE - Dx - nonspecific - ICD...	C	M...	0	
<input type="checkbox"/>	"Cancer:" (SIMPLE - Dx - nonspecific - ICD#199.1 - ...	C	M...	0	
<input type="checkbox"/>	"Chemical Dependency" (SIMPLE - Dx - unspecified - ...	C	M...	0	
<input type="checkbox"/>	"Cancer of Colon" (SIMPLE - Dx - nonspecific - ICD#...	C	M...	0	
<input type="checkbox"/>	"Coronary Artery Disease:" (SIMPLE - Dx - nonspecifi...	C	M...	0	
<input type="checkbox"/>	"Emphysema:" (SIMPLE - nonspecific - ICD#496 - 0...	E	M...	0	
<input type="checkbox"/>	"Epilepsy:" (SIMPLE - Dx- Plain/nonspecific - ICD#34...	E	M...	0	
<input type="checkbox"/>	"Glaucoma:" (SIMPLE - nonspecific - 04.0.F93.EYE)	GI	M...	0	
<input type="checkbox"/>	"Hypertension" (SIMPLE - - Dx - nonspecific - ICD#4...	H	M...	0	
<input type="checkbox"/>	"Kidney disease:" SIMPLE - Dx - nonspecific - 10.0.U...	Ki	M...	0	
<input type="checkbox"/>	"Mental Illness:" (SIMPLE - Dx - nonspecific - ICD#v4...	M	M...	0	
<input type="checkbox"/>	"Obesity:" (SIMPLE - Dx - nonspecific - ICD#278.00...	O	M...	0	
<input type="checkbox"/>	"Strokes -Cerebrovascular Disease:" (SIMPLE - Dx - ...	C	M...	0	
<input type="checkbox"/>	"Tuberculosis:" (SIMPLE - Dx - nonspecific - 01.0.A7...	T	M...	0	
<input type="checkbox"/>	"Healthy, no disease:" (SIMPLE - nonspecific - ICD#6...	H	M...	0	
<input type="checkbox"/>	"High Cholesterol/Lipids:" (SIMPLE - Dx - nonspecific...	C	M...	0	
<input type="checkbox"/>	"Cancer of Prostate:" (SIMPLE - Nonspecific - ICD#1...	C	M...	0	
<input type="checkbox"/>	"Depression:" (SIMPLE - Nonspecific Dx - ICD#311)	D	M...	0	
<input type="checkbox"/>	"Cancer, Ovarian:" (SIMPLE- Nonspecific -Dx - ICD#...	C	M...	0	
<input type="checkbox"/>	"Hearing Problems:" (SIMPLE - Dx - nonspecific - 03...	H	M...	0	
<input type="checkbox"/>	"Miscarriage/Stillbirths:" (SIMPLE - Dx - nonspecific - ...	Mi	M...	0	
<input checked="" type="checkbox"/>	Brainectomy	S...		0	

The newly created item will appear at the bottom of the list.

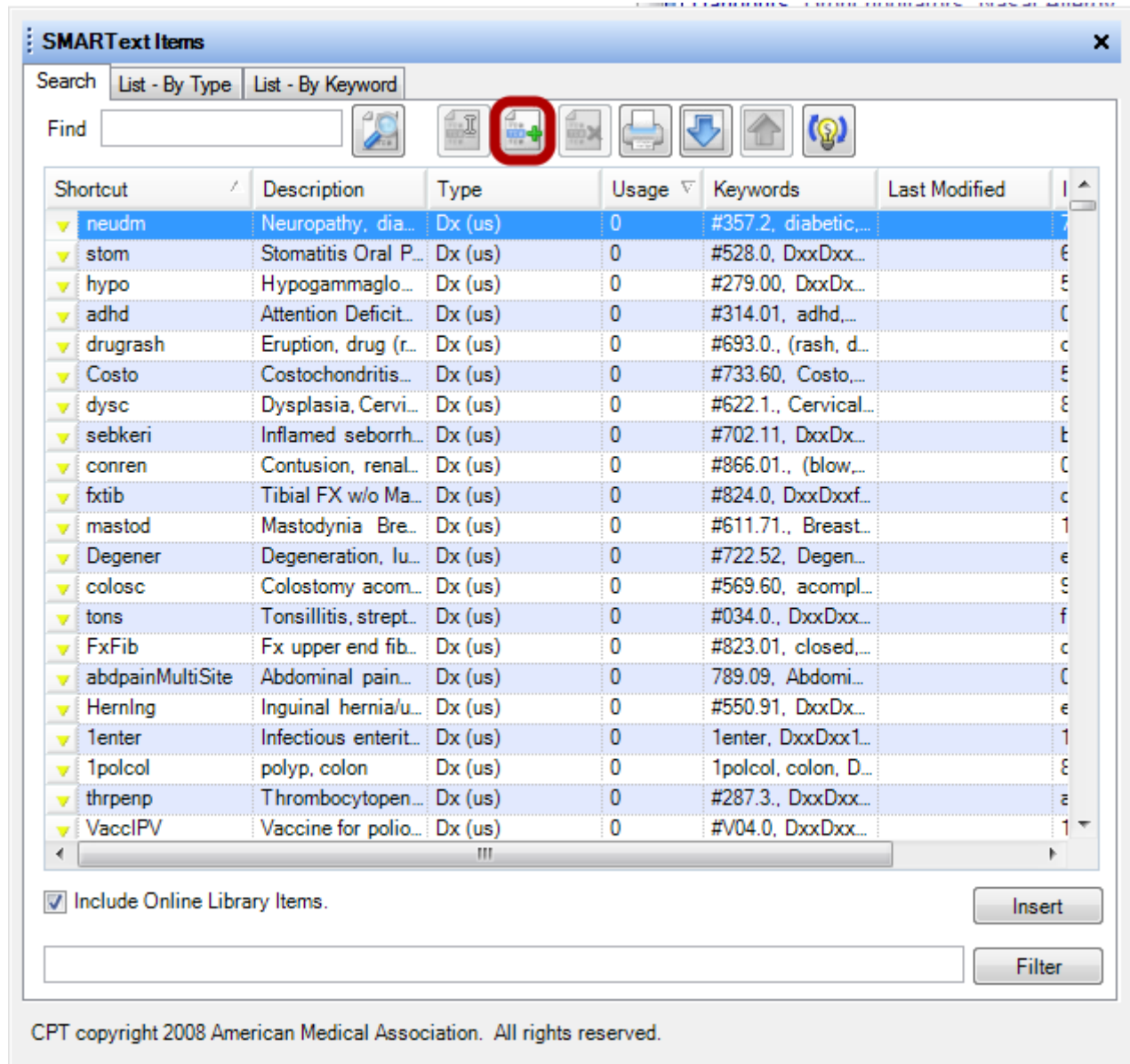
### Surgeries

[Brainectomy]

Notice that when the newly added item is selected in this fashion, it appears in the summary as black text rather than the blue, underlined text as the other items appear. When printed or stored permanently, by default, all the text is generally converted to just plain black. Quick-Add creates an item as an structured SMARText item.

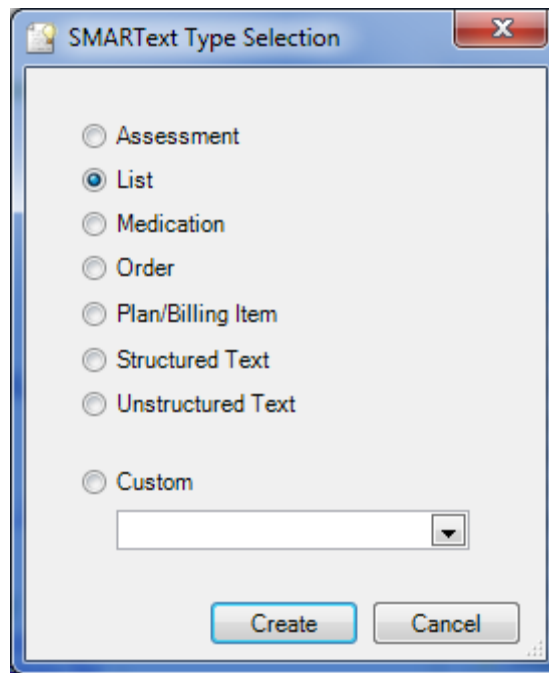
## Creating SMARText Pick Lists

### SMARText Items



In this example, we will be creating a pick list of diagnoses. Diagnosis items that are Structured Dx items are the type we suggest be entered into the Assessment field of SOAPnotes and in the Active/Inactive Problems in the Summary.

1. Click Docutainers in the menu bar menu (or Press F10), and Click the SMARText Items menu item to display the SMARText Items dialog.
2. Click the New Item button as shown in the screen shot below.



Click the List radio button in the SMARTText Type Selection dialog, and Click the Create button.

SMARText Designer

Shortcut

Description

Keywords

☒ Display Header  ☐ only when item is empty.

Advanced

General

Item Type Multi-Sel List

Item Properties

Item Settings

Item Separators

☐ As Is ☐ English List (and)

☒ Separate with  ☐ English List (or) ☐ End with

☐ Separate Lines

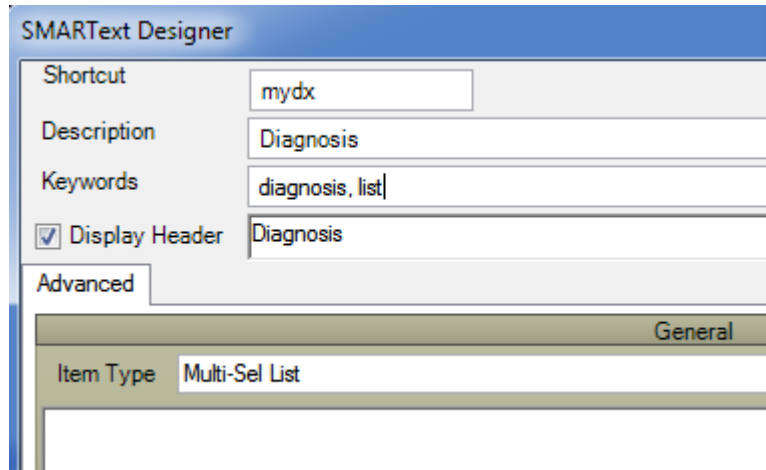
Save Cancel

This will open the newly created item's SMARText Designer dialog.

### Enter Shortcut

Type a Shortcut for this new Multi-Select List item. When creating documentation, use this shortcut, followed by pressing the space bar in order to insert the item. This action will insert a header into the chart documentation, that when clicked, presents a pick list in the Quick Access dialog. For this demo, we want to create a pick list for diagnosis items, so let's use the shortcut mydx. (Use any shortcut that will be easy to remember.)

## Enter Information



The image shows a screenshot of the 'SMARTText Designer' dialog box. The 'General' tab is active. The fields are as follows:

Field	Value
Shortcut	mydx
Description	Diagnosis
Keywords	diagnosis, list
Display Header	<input checked="" type="checkbox"/> Diagnosis
Item Type	Multi-Sel List

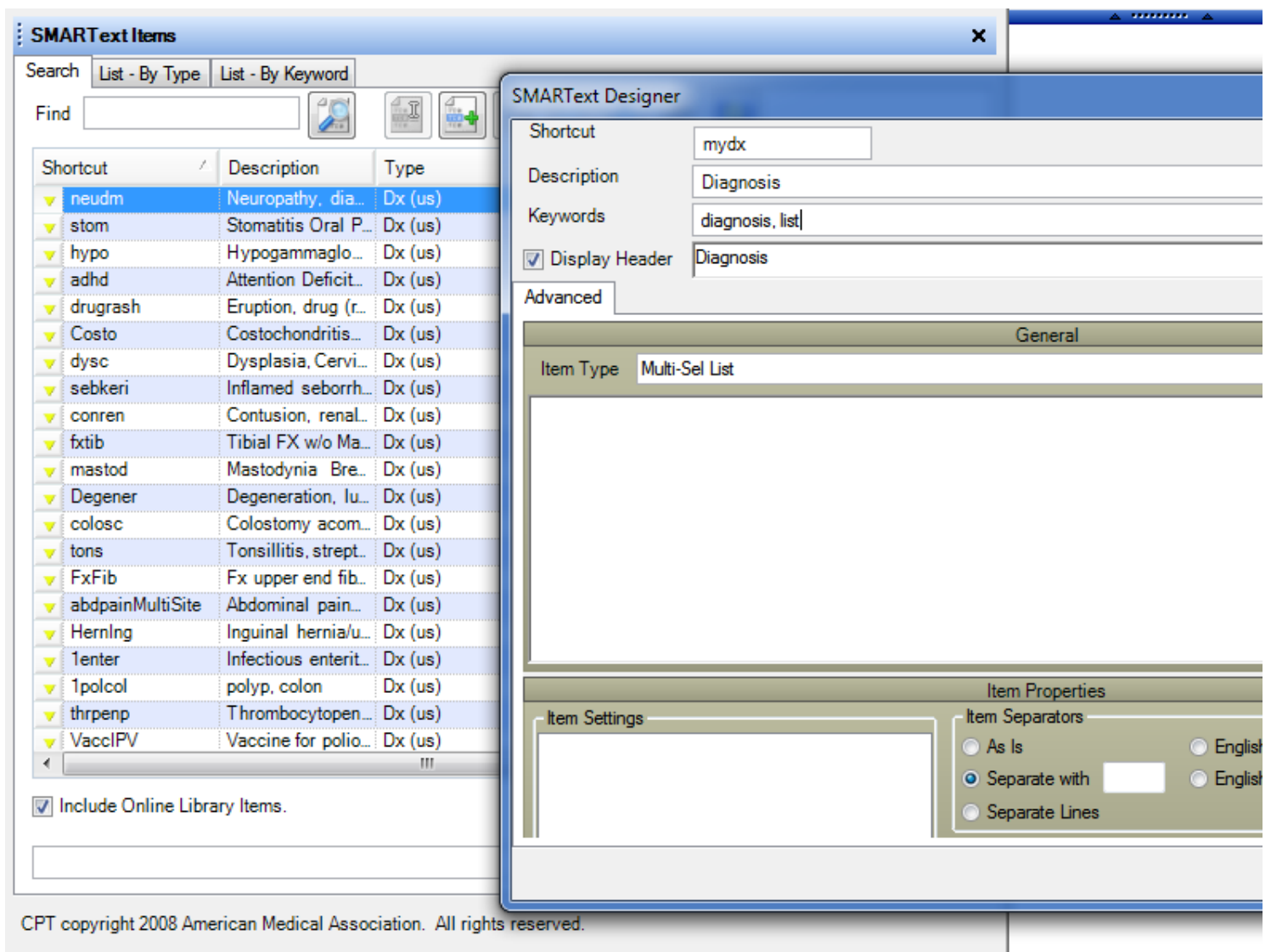
1. Type a Description to help identify this item. Let's use diagnosis.
2. Type Keywords to aid in looking up this SMARTText item when later doing searches (e.g. in the SMARTText Items Manager).
3. For the Display Header, Type diagnosis. This is what will display, as the header, when this item is inserted into documentation. The check in the Display Header check box designates that the header will be displayed when this item is used when creating documentation.
4. Click the only when item is empty check box. This will display the header only until an item is chosen from the list in Quick Access.

## Add List Items

We are now ready to add SMARTText items of the Structured Dx type to the SMARTText pick list of the Multi-Sel List type as demonstrated below. In order to explain the terminology, the Structured Dx SMARTText items that we add, below, will be sub-items in/of the Multi-Sel List SMARTText item we just created.

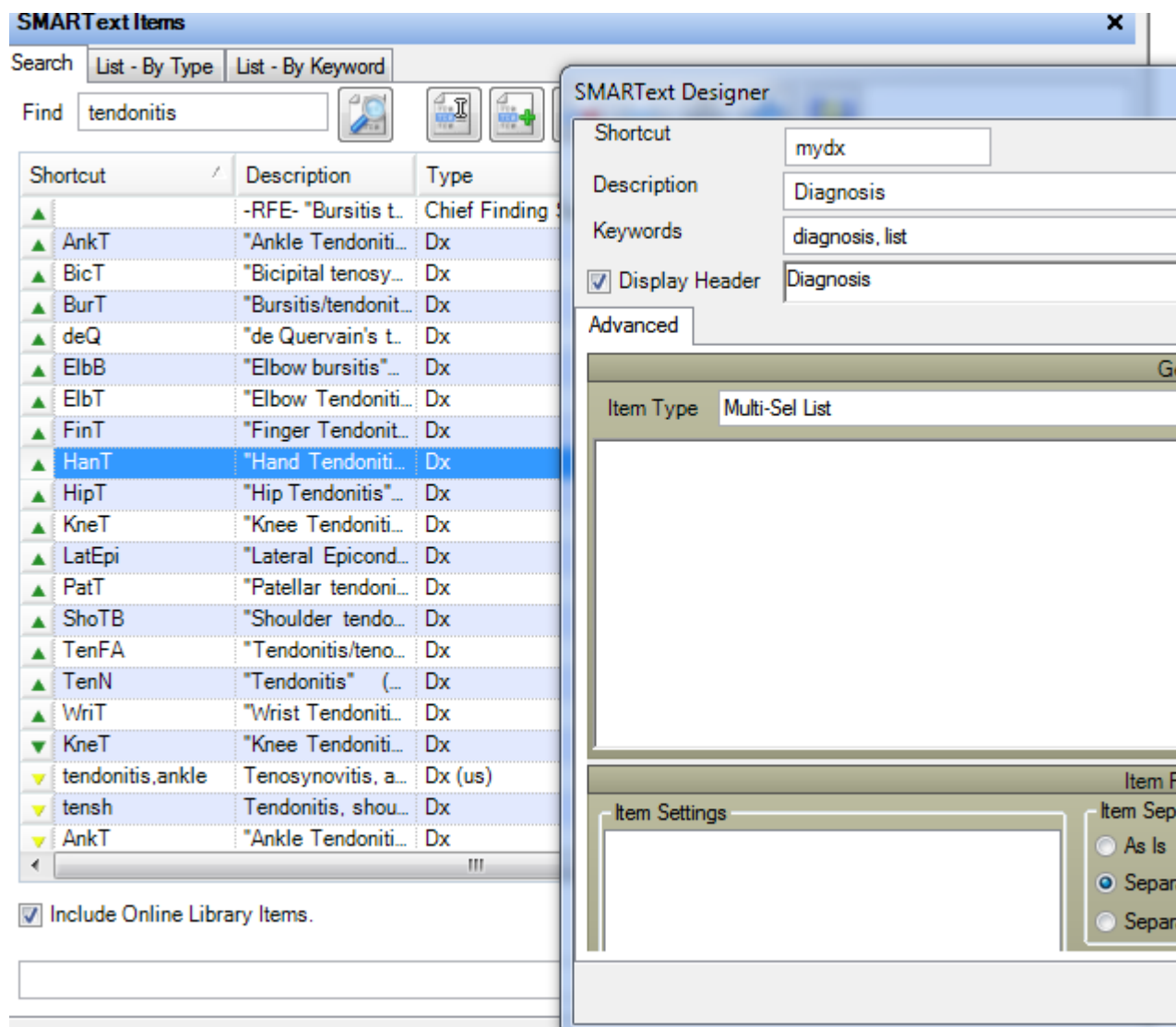


## Add Items to a Pick List Using SMARText Items in the Local Library



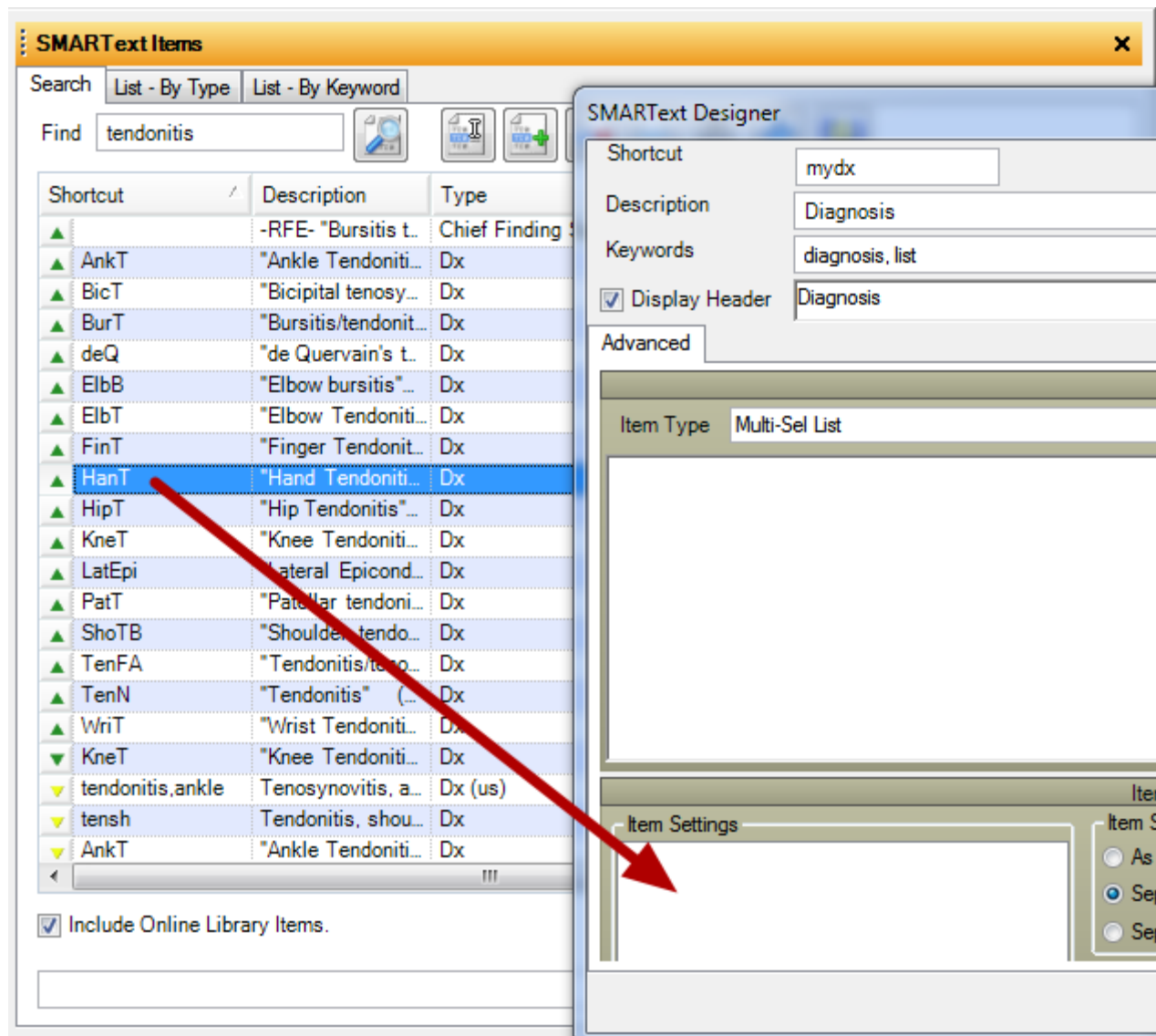
Items can be added to pick lists by dragging and dropping from the SMARText Items Manager into the pick list's SMARText Designer dialog. One fashion to accomplish this is to place the SMARText Items Manager display next to the our new pick list's SMARText Designer dialog so that both are visible (as shown above).

## Search for List Items



In the SMARTText Items dialog, shown on the left side of the screen shot, search for the items to add to the pick list by typing in a keyword or word that would be associated with that item. For example, if we wanted to find a Structured Dx SMARTText item for Hand Tendinitis, we could search on either hand or tendinitis. Now, either Press the Enter key or Click the Search button to locate items that contain the keyword entered.

## Move List Items

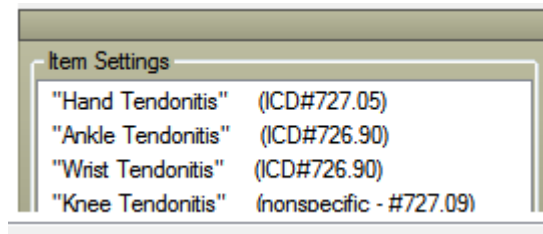


Scroll through the list to find the item to add to the pick list. Click the desired list item to add while holding-down the left mouse button. Continue to hold-down the left mouse button and drag the item until the cursor/pointer is within the Item Settings area as outlined in red in the above screen shot.

As the user drags the item toward the SMARTText Designer dialog, the cursor/pointer will change to a black circle with a slash. When the cursor is in the correct location (i.e. Items Settings), it will have a box with a small plus. Drop the item into Item Settings by releasing the mouse button.

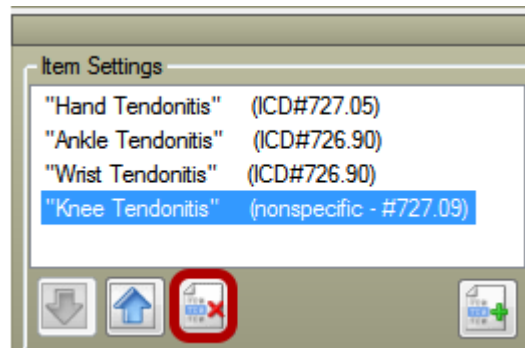
Repeat this for each item the user wants to add to the pick list.  
Click the Save button.

## Item Settings Box



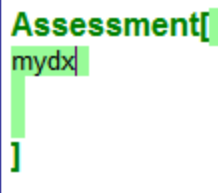
The items will be listed in the Item Settings box after dragging and dropping the items there.

## Remove Items from a Pick List



To remove any items, select the item the user wishes to remove, and Click the Remove Item button located below Item Settings.

## Add a Pick List Header to Documentation



This new pick list item is now ready for actual use. Type mydx into an encounter note, and Press the space bar. This inserts the header (i.e. diag.) into the document. Click diag. in the document to display the items added to the newly created pick list in the SMARTText Quick Access dialog (usually docked on the right side). For example, in the SOAP encounter note screen shot above, "mydx" was typed (the shortcut) in the Assessment field.

## Press the Spacebar

Assessment[  
Diagnosis  
]

Next, the space bar is pressed. This causes the header for the newly created pick list to be inserted. In other words, pressing the space bar after typing the shortcut "mydx" causes this pick list item's header, Diagnosis., to be inserted into the documentation.

## Display the Pick List

Selected	Description
<input type="checkbox"/>	"Hand Tendonitis" (ICD#727.05)
<input type="checkbox"/>	"Ankle Tendonitis" (ICD#726.90)
<input type="checkbox"/>	"Wrist Tendonitis" (ICD#726.90)
<input type="checkbox"/>	"Knee Tendonitis" (nonspecific - #727.09)

Click on the diagnosis header to display the pick list in the SMARTText Quick Access.

## Choose Pick List Items

Assessment

Diagnosis[Hand Tendonitis ICD#726.90 Hand]

Selected	Description
<input checked="" type="checkbox"/>	"Hand Tendonitis" (ICD#727.05)
<input type="checkbox"/>	"Ankle Tendonitis" (ICD#726.90)
<input type="checkbox"/>	"Wrist Tendonitis" (ICD#726.90)

After the Quick Access dialog displays a list of items, select an item by clicking in the check boxes next to them. This action places a check in the box, and the checked item will be inserted into the Assessment field. The header (i.e diag.) disappears once a pick list item is selected because we earlier selected "Display only when empty" when creating the pick list in SMARTText Designer.

## Editing Pick Lists

Any SOAPware user with appropriate security access can edit any SMARText item created by SOAPware or by a SOAPware user. When an item is edited by a SOAPware user the item will then display with a yellow arrow rather than a green arrow. This lesson will demonstrate how to Edit a pick list available the local database.

### Searching for a Pick list

The screenshot shows the 'SMARText Items' window. At the top, there are tabs for 'Search', 'List - By Type', and 'List - By Keyword'. The 'Search' tab is active. Below the tabs, there is a 'Find' text box containing 'all-' and a magnifying glass icon. To the right of the 'Find' box are several icons: a document with a pin, a document with a plus sign, a document with a minus sign, a printer, a download arrow, an upload arrow, and a lightbulb. Below these icons is a table with the following columns: Shortcut, Description, Type, Usage, Keywords, Last Modified, and ID. The table contains several rows of data, with the first row highlighted in blue. Below the table, there is a checkbox labeled 'Include Online Library Items.' and an 'Insert' button. At the bottom right, there is a 'Filter' button. The footer of the window reads 'CPT copyright 2010 American Medical Association. All rights reserved.'

Shortcut	Description	Type	Usage	Keywords	Last Modified	ID
All-	-( Starter - Allerg...	Multi-Sel List	11	081117, 100525,...	5/2/2011 11:46...	bc65ed7f-6e38-4c1b-9a62-472182b7...
	All-Nite Cold	Rx	0	All-Nite, Cold		fdb5a335-e348-461d-9df7-8c228694b...
All-rp	-( Starter - Allerg...	Multi-Sel List	0	081117, 100525,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-( Starter - Allerg...	Multi-Sel List	0	081117, 081220,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-( Starter - Allerg...	Multi-Sel List	0	081117, 100525,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-( Starter - Allern...	Multi-Sel List	0	081117, 081220...		bc65ed7f-6e38-4c1b-9a62-472182b7...

To search for a pick list type the shortcut or keyword in the find box and click on the Find button.

## Edit the Item

The screenshot shows the 'SMART Text Items' window. At the top, there are tabs for 'List - By Type' and 'List - By Keyword'. Below these is a 'Find' search bar and a toolbar with icons for search, edit, add, delete, print, download, and help. The main area is a table with columns: Shortcut, Description, Type, Usage, Keywords, Last Modified, and ID. The first row is highlighted in blue. A red circle labeled '1' is around the first row, and a red circle labeled '2' is around the Edit button in the toolbar.

Shortcut	Description	Type	Usage	Keywords	Last Modified	ID
All-	-(Starter - Allerg...	Multi-Sel List	11	081117, 100525,...	5/2/2011 11:46...	bc65ed7f-6e38-4c1b-9a62-472182b7...
All-Nite Cold	Rx	0	All-Nite, Cold			1db5a335-e348-4b1d-9d17-8c228694b...
All-rp	-(Starter - Allerg...	Multi-Sel List	0	081117, 100525,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-(Starter - Allerg...	Multi-Sel List	0	081117, 081220,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-(Starter - Allerg...	Multi-Sel List	0	081117, 100525,...		bc65ed7f-6e38-4c1b-9a62-472182b7...
All-	-(Starter - Allerg...	Multi-Sel List	0	081117, 081220		bc65ed7f-6e38-4c1b-9a62-472182b7...

☒ Include Online Library Items.

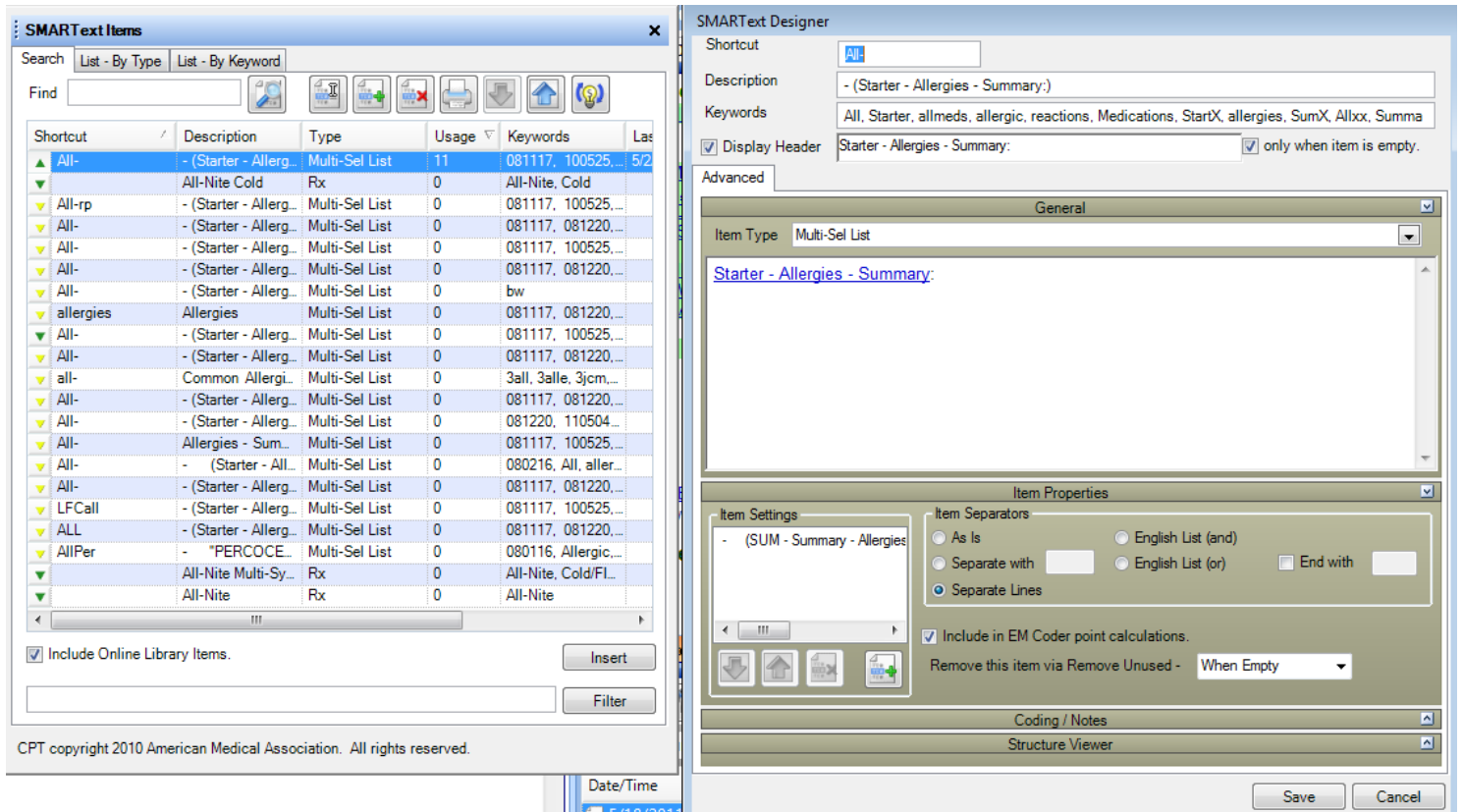
Insert

Filter

CPT copyright 2010 American Medical Association. All rights reserved.

- 1) Highlight the item to be edited.
- 2) Click on the Edit button

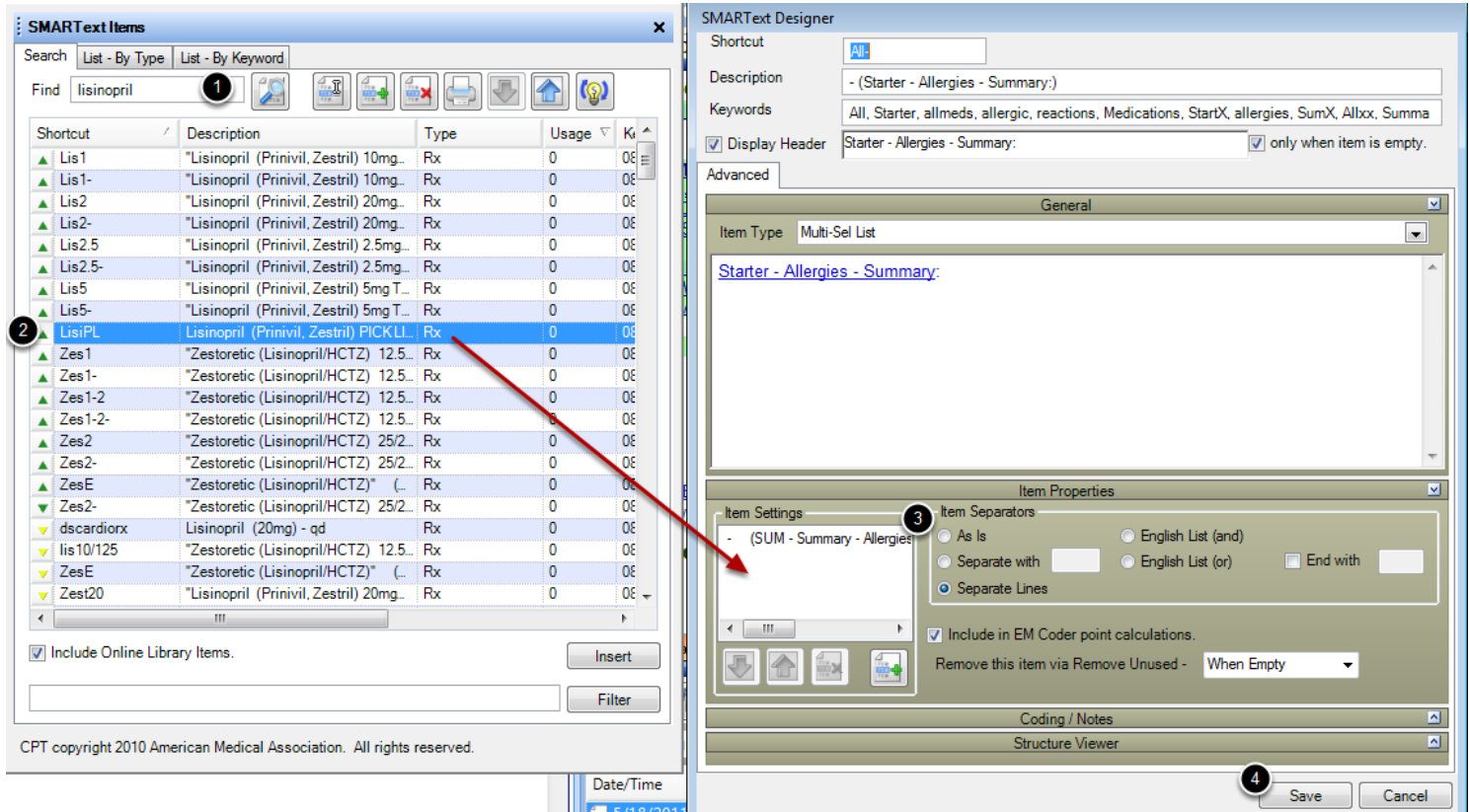
## Arrange the boxes



Place the SMARTText Items Manager box and the SMARTText Designer box side by side.



## Adding items to a pick list



To add items to the pick list:

- 1) Search for the item in the SMARTText Items Manager.
- 2) Click on the Item
- 3) Drag and Drop the item into the Items Settings box of the SMARTText Designer Box. Repeat for additional items.
- 5) Click Save.

**\*NOTE\*** For this example the all- pick list was used. If editing this pick list the user must add items with the item type of either **"Rx"** or **"Allergy"** for this to calculate properly for Meaningful Use.

## Creating SMARText Medications

---

This lesson will explain how SMARText medications must be created so they are able to be ePrescribed.

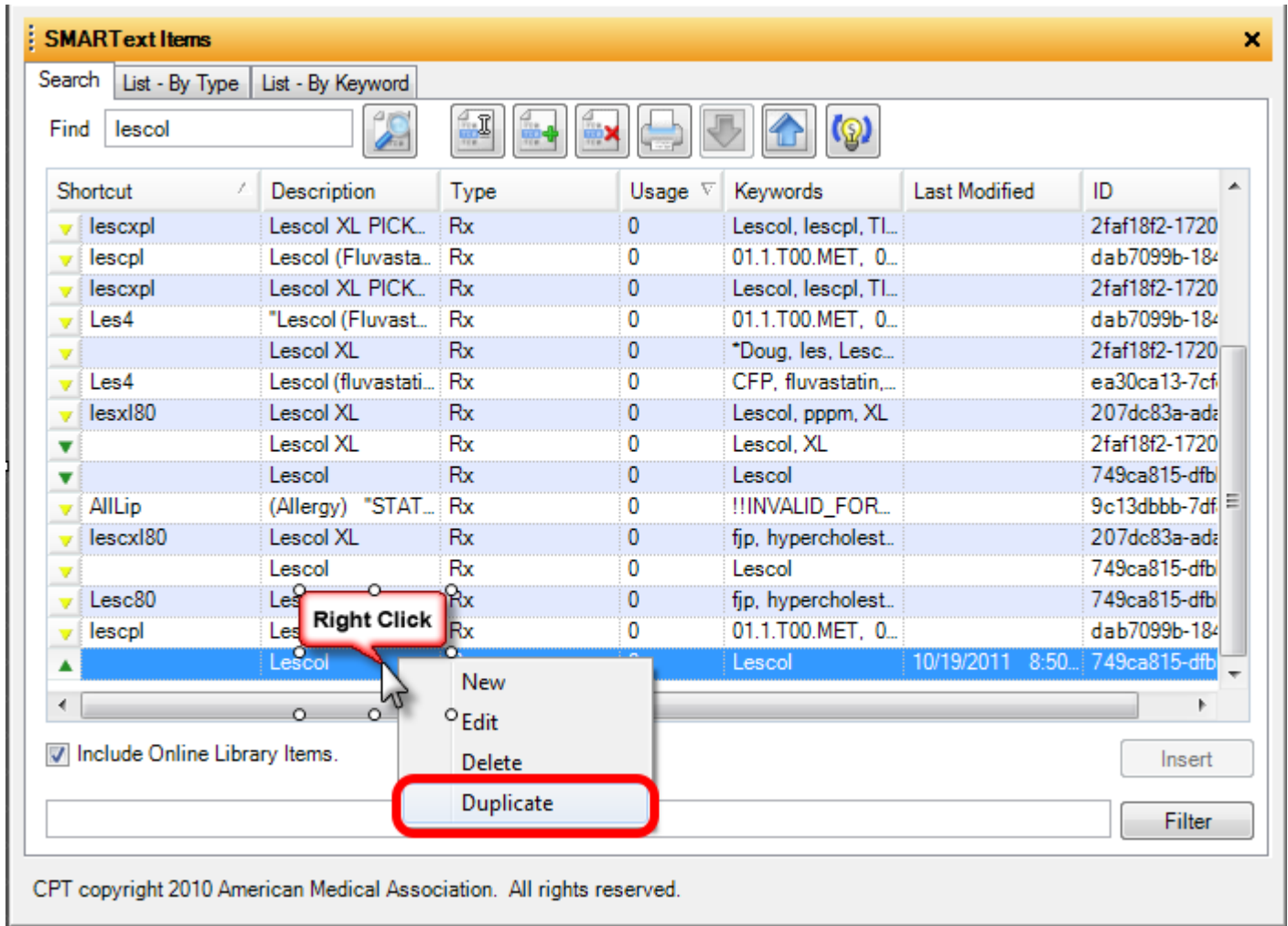
### SMARText Medications

Medications items to be ePrescribed cannot be created by end users. These items contain coding in the background necessary for ePrescribing, drug interactions, and database searching. Medications for ePrescribing are created and maintained by SOAPware and Multum, the national drug database. Medication items can, however be duplicated and customized in the users local database.

### Finding the item

Items can be searched on the online library using the SMARText Items Manager or a Shift F11 search.

## Duplicating the Item in the SMARText items Manager











Right-click over a green item and Select Duplicate.

This will create a yellow item in the local database that is exactly the same as the green item. The user may then edit the SMARText item.

## Editing the item

**SMARText Items**

Search  List - By Type List - By Keyword

Find         

Shortcut	Description	Type	Usage	Keywords	Last Modified
	Lescol	Rx	0	Lescol	2/17/2011 12:58...
▲ AllLes	(Allergy) Lescol (Fluvastatin)	Rx	0	!!INVALID_Stren...	12/21/2008 2:21...
▲ AllLip	(Allergy) "STATIN - (e.g. LIPITOR)"	Rx	0	!!INVALID_FOR...	9/24/2010 1:32...
▲ Les4	"Lescol (Fluvastatin) 40mg, #90, 1qd, R...	Rx	0	01.1.T00.MET, 0...	9/24/2010 1:10...
▼	Lescol XL	Rx	0	Lescol, XL	
▼ Les4	"Lescol (Fluvastatin) 40mg, #90, 1qd, R...	Rx	0	01.1.T00.MET, 0...	
▼ lescxpl	Lescol XL PICK LIST	Rx	0	Lescol, lescpl, TI...	
▼ lescpl	Lescol (Fluvastatin) PICK LIST	Rx	0	01.1.T00.MET, 0...	
▼ lescxpl	Lescol XL PICK LIST	Rx	0	Lescol, lescpl, TI...	
▼ Les4	"Lescol (Fluvastatin) 40mg, #90, 1qd, R...	Rx	0	01.1.T00.MET, 0...	
▼ Les4	Lescol (fluvastatin)	Rx	0	CFP, fluvastatin,...	
▼ lesxl80	Lescol XL	Rx	0	Lescol, ppm, XL	
▼	Lescol	Rx	0	Lescol	
▼ lescpl	Lescol (Fluvastatin) PICK LIST	Rx	0	01.1.T00.MET, 0...	

☒ Include Online Library Items. Insert Filter

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Highlight the newly created medication and Click the Edit button.

SMARText Designer

Shortcut

Description

Keywords

☒ Display Header  ☐ only when item is empty.

Advanced

General

Item Type

Lescol: Strength- SIG- Dose- Freq- Route- Modifier- Instructions- Dispense-  
Substitutions- Refills- 0 Related Dxs- Start Date- End Date- Comment- Notes-

Item Properties

Item Settings

Item Separators

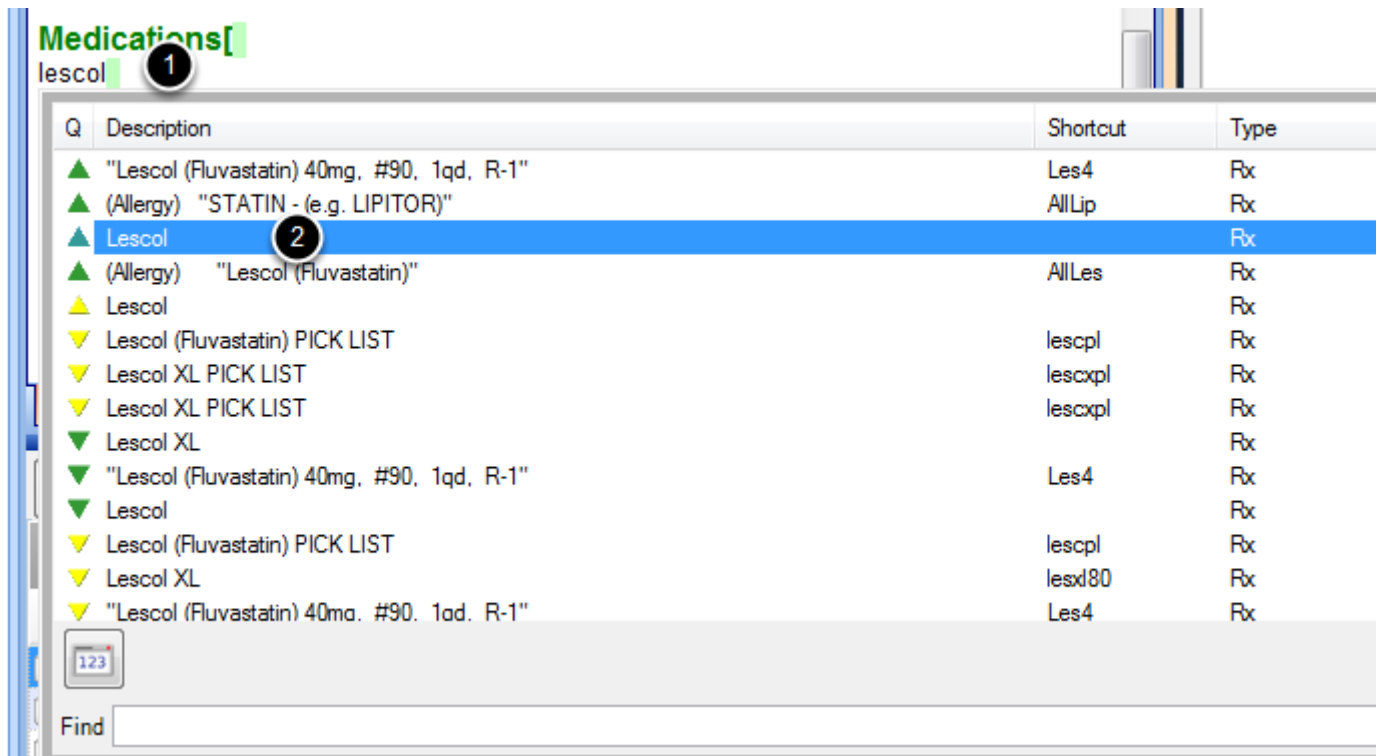
☐ As Is ☐ English List (and)  
☒ Separate with  ☐ English List (or) ☐ End with   
☐ Separate Lines

☒ Include in EM Coder point calculations.

Save Cancel

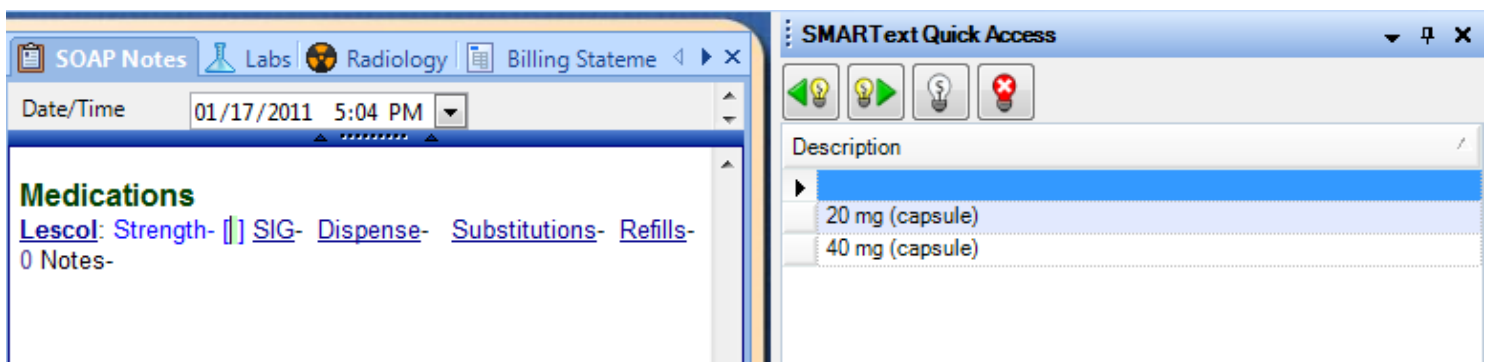
Customized shortcuts and keywords can now be added. The description and header should not be changed. Click the Save button.

## Duplicating the item within the Chart



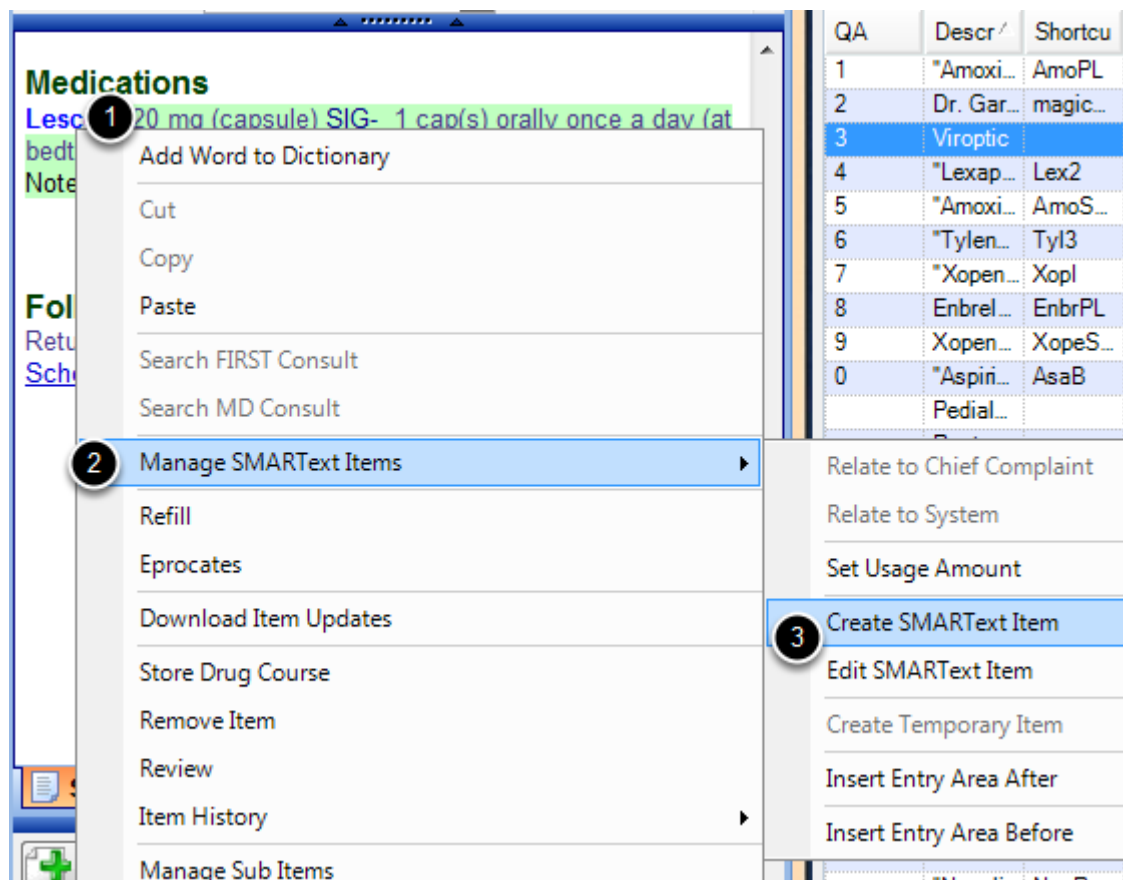
Medication items can also be edited and created in the patient's chart using a Shift F11 search.

1. Enter a keyword and press Shift F11 on the keyboard.
2. Highlight desired item that has a green arrow. Items with green arrows are created by SOAPware and contain necessary background coding for ePrescribing.



Perform desired edits to item. Edits made will display when the item is inserted into the patients chart. It is advised that the user enter the most common way of prescribing the medication at this time.

## Creating the SMARText Item



To create the item:

1. Right-click over the header (or name) of the medication.
2. Select Manage SMARText Items.
3. Select Create SMARText Item.

SMART-ED Designer

Shortcut

Description

Keywords

☒ Display Header Lescol:  ☐ only when item is empty.

Advanced

General

Item Type

Lescol: 20 mg (capsule) SIG- 1 cap(s) orally once a day (at bedtime) for 30 days #30  
Substitutions Allowed Refills- 0 Notes-

Item Properties

Item Settings

Item Separators

☐ As Is ☐ English List (and)

☒ Separate with  ☐ English List (or) ☐ End with

☐ Separate Lines

☒ Include in EM Coder point calculations.

2 Save Cancel

The item is now created exactly the way it is displayed within the chart.

1. Shortcut, Description, and keywords will need to be added.
2. Click the Save button.

## Adding Drug Courses and Custom Sigs

Now that the custom item is created, drug courses and custom sigs may be entered.  
Select link for more information on [Drug Courses](#) and [Creating Custom Sigs](#).



# Pick Lists

## Pick Lists - Overview

---

Pick lists provide an extremely powerful and flexible way to quickly enter data. They are predefined lists of data items. The items can be inserted into documentation from the pick list. What may not be obvious, in the beginning, is the different types of pick lists. Some are presented in the SMARText Quick Access dialog, and others pop-up within documents while in the process of creating documentation. Once the different types of lists and their different functions are understood, their use becomes more intuitive. In the beginning, without a knowledge of the different lists and how they function, they may seem a bit inconsistent and illogical.

### Two Classes of Pick Lists

1. Pop-Up Pick Lists
2. Quick Access Pick Lists

### Five Types of Pick Lists

**F11 Pop-Up:** Enter a keyword (or a few letters); CPT code; or ICD code, and press F11 to get a pop-up list of local items.

**Shift + F11 Pop-Up:** Enter a keyword (or a few letters); CPT code; or ICD code, and press Shift + F11 to get a pop-up list of local and online items.

**Spacebar Pop-Up:** Enter a shortcut code and press space bar; if more than one ST item has a Shortcut matching the group of letters, then a list of those items is presented. If only one ST item has an exact Shortcut match, it is automatically inserted.



**Location - Quick Access:** Click in a field, and a list of items, ranked on past usage, presents in the Quick Access dialog.

**SMARText - Quick Access:** Click on a ST item header and various types of pick lists are presented in the Quick Access dialog.

**Active Problems[**

headache

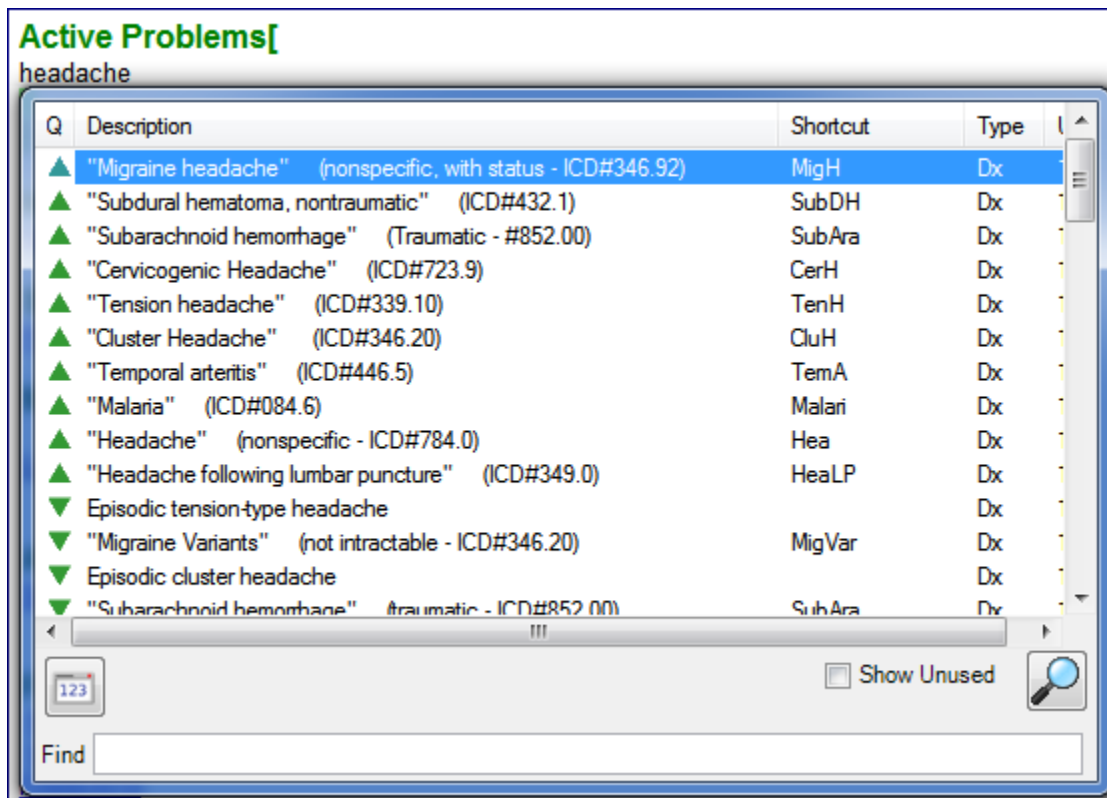
Q	Description	Shortcut	Type	U
▲	"Migraine headache" (nonspecific, with status - ICD#346.92)	MigH	Dx	1
▲	"Subdural hematoma, nontraumatic" (ICD#432.1)	SubDH	Dx	1
▲	"Subarachnoid hemorrhage" (Traumatic - #852.00)	SubAra	Dx	1
▲	"Cervicogenic Headache" (ICD#723.9)	CerH	Dx	1
▲	"Tension headache" (ICD#339.10)	TenH	Dx	1
▲	"Cluster Headache" (ICD#346.20)	CluH	Dx	1
▲	"Temporal arteritis" (ICD#446.5)	TemA	Dx	1
▲	"Malaria" (ICD#084.6)	Malari	Dx	1
▲	"Headache" (nonspecific - ICD#784.0)	Hea	Dx	1
▲	"Headache following lumbar puncture" (ICD#349.0)	HeaLP	Dx	1


☐ Show Unused


Find

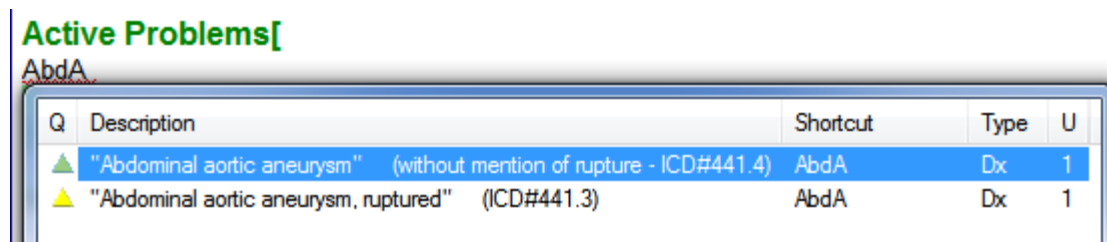
Enter a keyword (or a few letters); CPT code; or ICD code, and press F11 to get a pop-up list of local items.

## Shift + F11 Pop-Up



Enter a keyword (or a few letters); CPT code; or ICD code, and press Shift + F11 to get a pop-up list of local and online items.

## Spacebar Pop-Up

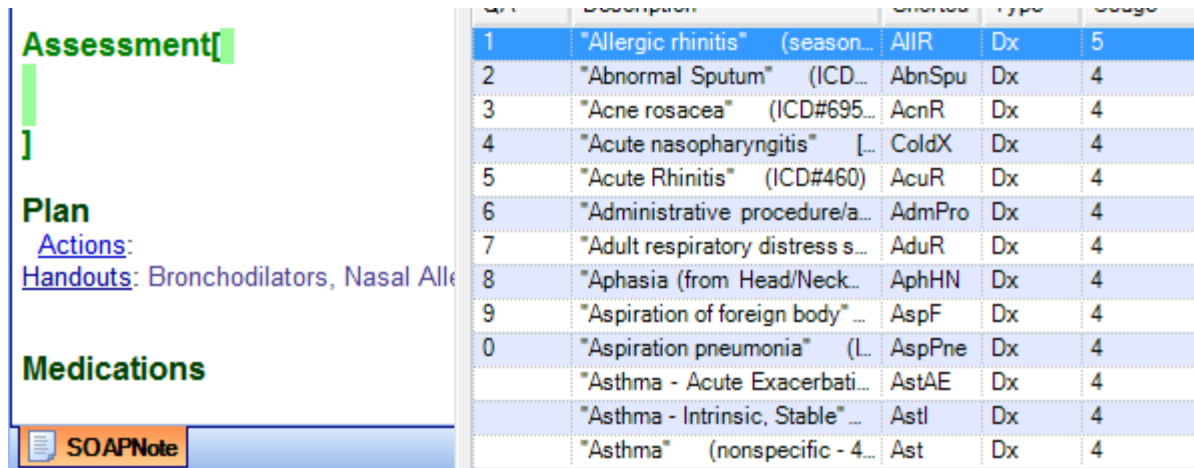


Enter a shortcut and press space bar; if more than one SMARText item has a shortcut matching the group of letters, then a list of those items is presented. If only one ST item has an exact Shortcut match, it is automatically inserted.

## Quick Access Pick Lists

Many SMARText items that offer pick lists will have a header displayed in blue, underlined text to signify that clicking on them will display pick list items for selection. The items are displayed in the SMARText Quick Access dialog, which by default, is docked to the right side of SOAPware.

### Pick Lists in Quick Access Based on Location



The screenshot shows the SOAPware interface. On the left is a SMARText form with sections: **Assessment** (with a green header and a green bar), **Plan** (with a blue header and links for [Actions:](#) and [Handouts:](#) Bronchodilators, Nasal All...), and **Medications** (with a green header). At the bottom of the form is a button labeled **SOAPNote**. On the right is a Quick Access pick list dialog showing a table of medical conditions.

ID	Description	Codes	Type	Usage
1	"Allergic rhinitis" (season...	AllR	Dx	5
2	"Abnormal Sputum" (ICD...	AbnSpu	Dx	4
3	"Acne rosacea" (ICD#695...	AcnR	Dx	4
4	"Acute nasopharyngitis" [...	ColdX	Dx	4
5	"Acute Rhinitis" (ICD#460)	AcuR	Dx	4
6	"Administrative procedure/a...	AdmPro	Dx	4
7	"Adult respiratory distress s...	AduR	Dx	4
8	"Aphasia (from Head/Neck...	AphHN	Dx	4
9	"Aspiration of foreign body" ...	AspF	Dx	4
0	"Aspiration pneumonia" (L...	AspPne	Dx	4
	"Asthma - Acute Exacerbat...	AstAE	Dx	4
	"Asthma - Intrinsic, Stable" ...	AstI	Dx	4
	"Asthma" (nonspecific - 4...	Ast	Dx	4

Whenever entering a field, the SOAPware Quick Access pick list will present the most likely data items the user is going to need without the user having to do anything. The items in the list are SMARText items that have been previously used in that field.

## Pick Lists in Quick Access from Clicking a SMARTText Header

### Subjective

CHIEF COMPLAINT(S): [ ]

HPI: SYMPTOMS/RELATED: Reports symptoms of  
LOCATION: Reports area of involvement as  
QUALITY/COURSE: Reports condition is  
INTENSITY/SEVERITY: Reports measurement ( or degree) as  
DURATION: Reports the general length of symptoms to be  
ONSET/TIMING: Reports occurrence as  
CONTEXT/WHEN: Reports usually associated with  
MODIFIERS/TREATMENTS: Improved by

ROS:

### Objective

Exam: GENERAL: Appearance: General appearance can be descri

### Assessment

SOAPNote

Drag a column header here to group by that column.

Active Item "CHIEF COMPLAINT(S):"

Selected	Description
<input checked="" type="checkbox"/>	( A - GENERAL and Unspecified )
<input type="checkbox"/>	( B - BLOOD and IMMUNE )
<input type="checkbox"/>	( D - DIGESTIVE )
<input type="checkbox"/>	( F - EYE )
<input type="checkbox"/>	( H - EAR )
<input type="checkbox"/>	( K - CARDIOVASCULAR )
<input type="checkbox"/>	( N - NEUROLOGICAL )
<input type="checkbox"/>	( P - PSYCHOLOGICAL )
<input type="checkbox"/>	( R - RESPIRATORY )
<input type="checkbox"/>	( S - SKIN )
<input type="checkbox"/>	( T - ENDOCRINE/METABOLIC/NUTRITIONAL )
<input type="checkbox"/>	( U - UROLOGICAL )
<input type="checkbox"/>	( W - PREGNANCY/CHILDBIRTH/FAMILY PLANNING...
<input type="checkbox"/>	( X - FEMALE GENITAL )
<input type="checkbox"/>	( Y - MALE GENITAL )
<input type="checkbox"/>	( Z - SOCIAL PROBLEMS )
<input type="checkbox"/>	( L - MUSCULOSKELETAL )
<input type="checkbox"/>	( Most Common Chief Complaints BUNDLE)

Many SMARTText Item offer pick lists (e.g. Chief Complaint, and HPI Item types.) These generally have the same function/action as Multi-Sel List types (to be discussed later). Another area using the same functionality as Multi-Sel Lists are the Structured Dx and Structured Rx Item types.

# Docuplates

### What are Docuplates?

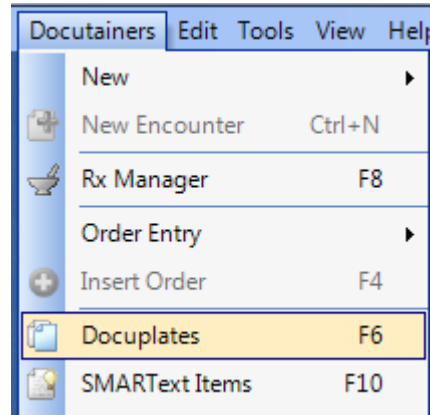
Docuplates are Documentation-Templates. They allow common sets of document items to be saved as a group so that they can be reused later. Similar in nature to templates, Docuplates can contain a pre-formatted SOAPnote for aiding in documenting an encounter. This capability is useful for documenting common conditions or frequently repeated encounters, eliminating the need to recreate the same collection of document items each time.

**User Tip:** Docuplates can be created from almost any document in SOAPware, including SOAPnotes; Flow Sheets; Labs; Drawings; Summary, etc.



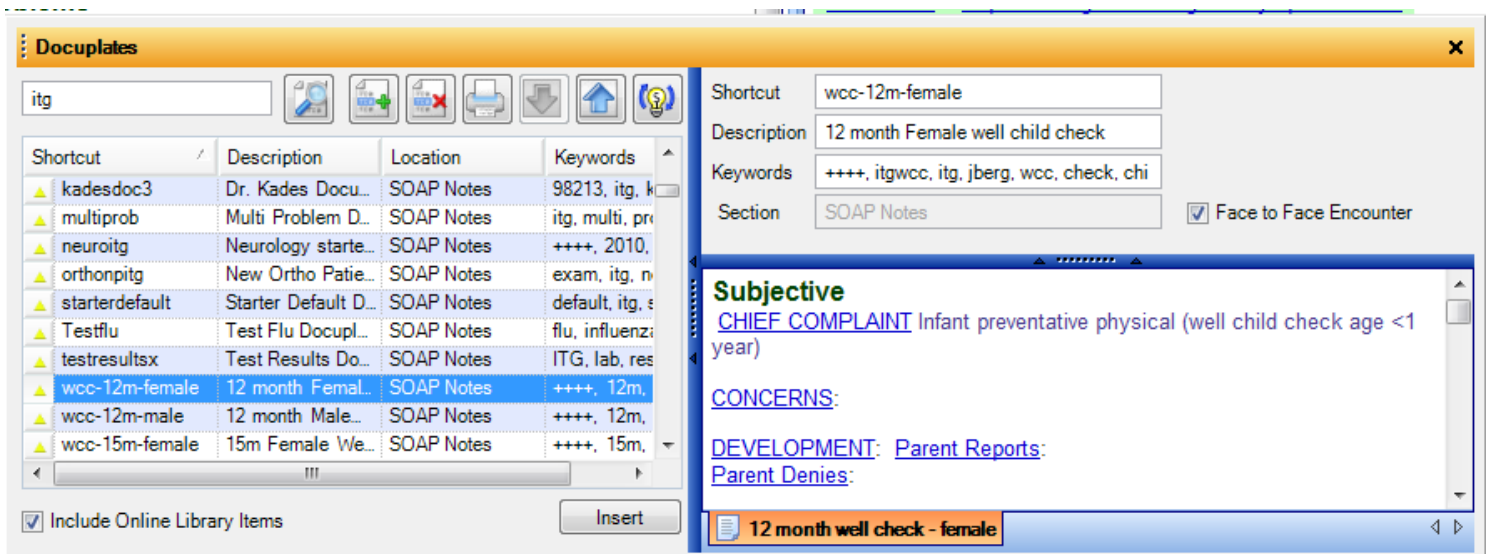
## Accessing Docuplates

### Finding Docuplates



1. Go to the Docutainers menu
2. Click on Docuplates (or press F6 on the keyboard)

### The Docuplates Interface

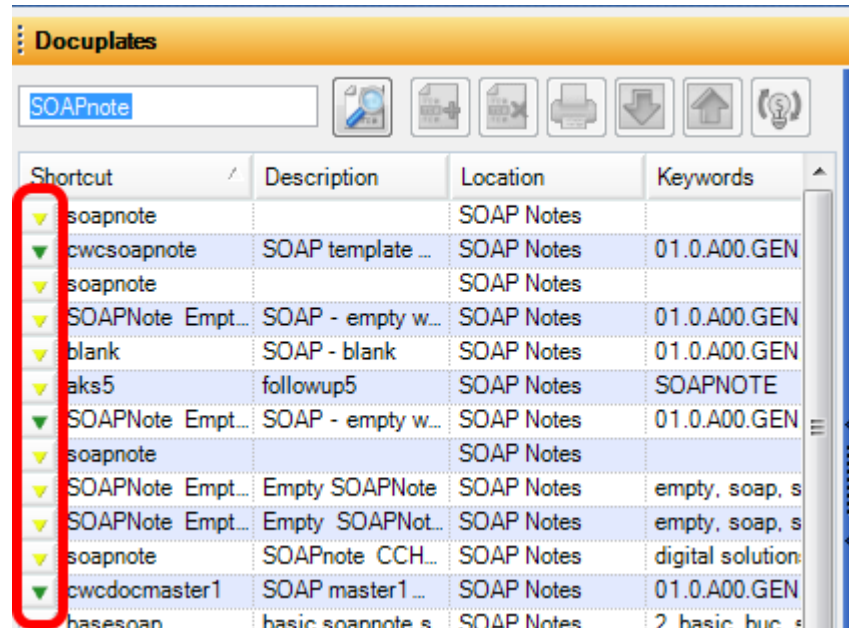


The interface has the ability to search for existing docuplates, including those online (by checking the Include Online Library Items box). Once docuplates have been downloaded on your a user's library, they may be previewed in the window to the right.

## Docuplate Controls

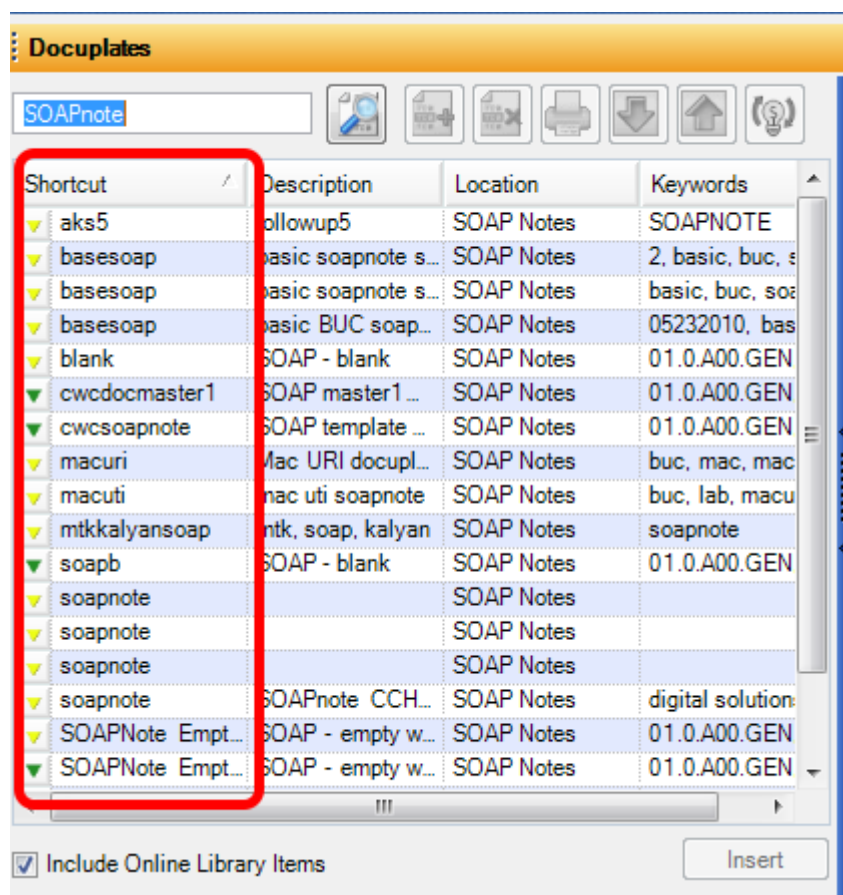
The docuplate library now contains thousands of docuplates, containing tens of thousands of keywords to assist with searching-finding. When reviewing docuplates, consider the following.

### Green and Yellow Triangles

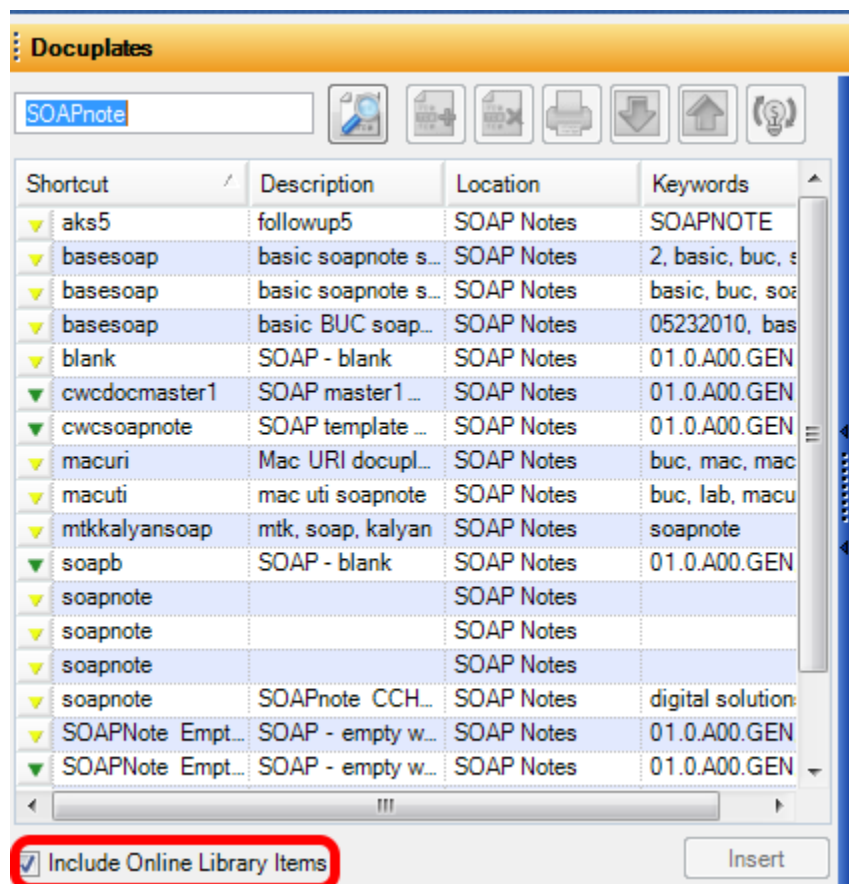


Shortcut	Description	Location	Keywords
▼ soapnote		SOAP Notes	
▼ cwsoapnote	SOAP template ...	SOAP Notes	01.0.A00.GEN
▼ soapnote		SOAP Notes	
▼ SOAPNote Empt...	SOAP - empty w...	SOAP Notes	01.0.A00.GEN
▼ blank	SOAP - blank	SOAP Notes	01.0.A00.GEN
▼ aks5	followup5	SOAP Notes	SOAPNOTE
▼ SOAPNote Empt...	SOAP - empty w...	SOAP Notes	01.0.A00.GEN
▼ soapnote		SOAP Notes	
▼ SOAPNote Empt...	Empty SOAPNote	SOAP Notes	empty, soap, s
▼ SOAPNote Empt...	Empty SOAPNot...	SOAP Notes	empty, soap, s
▼ soapnote	SOAPnote CCH...	SOAP Notes	digital solution
▼ cwcdocmaster1	SOAP master1 ...	SOAP Notes	01.0.A00.GEN
basessoan	basic soannote s	SOAP Notes	2 basic buc s

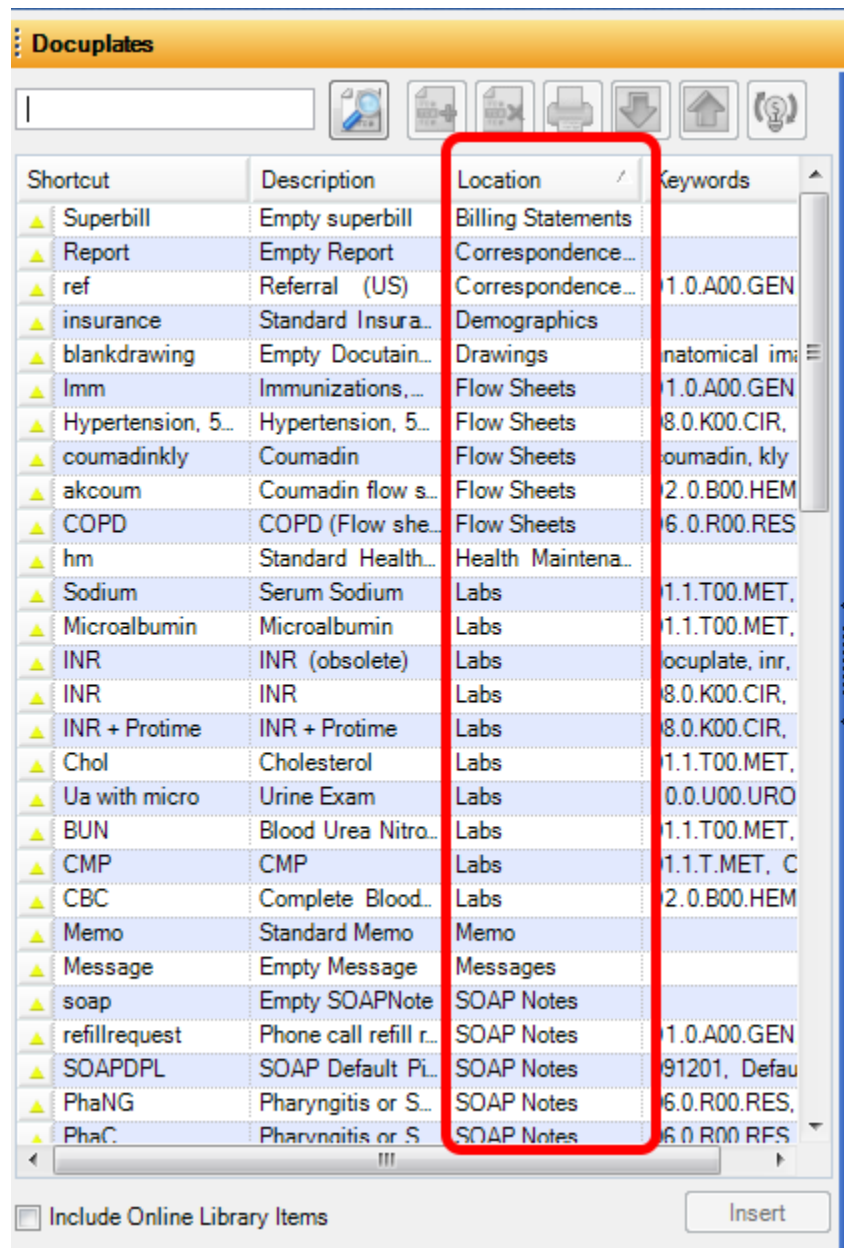
Docuplates with green triangles have been created by SOAPware, Inc. as appropriate for others to download. Docuplates with yellow triangles have been created or edited by a SOAPware user.



As users upload docuplates, SOAPware, Inc. avoids changing the shortcut's users have defined, but take liberty to modify descriptions, and to add keywords. For example, the words template and docuplate are usually removed from the descriptions and keywords because every item in the list is a template/docuplate.



By selecting the "Include Online Library" box at the bottom of the window, users will get results not only from their local database, but also from SOAPware and other SOAPware users.



The screenshot shows the 'Docuplates' application window. At the top is a search bar and a toolbar with icons for search, add, delete, print, download, and help. Below is a table with four columns: Shortcut, Description, Location, and Keywords. The 'Location' column header is highlighted with a red box. The table is sorted by Location, with entries grouped under 'Billing Statements', 'Correspondence...', 'Demographics', 'Drawings', 'Flow Sheets', 'Health Maintena...', 'Labs', 'Memo', 'Messages', and 'SOAP Notes'. The 'Labs' and 'SOAP Notes' categories contain the majority of the entries.

Shortcut	Description	Location	Keywords
Superbill	Empty superbill	Billing Statements	
Report	Empty Report	Correspondence...	
ref	Referral (US)	Correspondence...	1.0.A00.GEN
insurance	Standard Insura...	Demographics	
blankdrawing	Empty Docutain...	Drawings	anatomical im...
Imm	Immunizations,...	Flow Sheets	1.0.A00.GEN
Hypertension, 5...	Hypertension, 5...	Flow Sheets	8.0.K00.CIR,
coumadinkly	Coumadin	Flow Sheets	coumadin, kly
akcoum	Coumadin flow s...	Flow Sheets	2.0.B00.HEM
COPD	COPD (Flow she...	Flow Sheets	6.0.R00.RES
hm	Standard Health...	Health Maintena...	
Sodium	Serum Sodium	Labs	1.1.T00.MET,
Microalbumin	Microalbumin	Labs	1.1.T00.MET,
INR	INR (obsolete)	Labs	ocuplate, inr,
INR	INR	Labs	8.0.K00.CIR,
INR + Protime	INR + Protime	Labs	8.0.K00.CIR,
Chol	Cholesterol	Labs	1.1.T00.MET,
Ua with micro	Urine Exam	Labs	0.0.U00.URO
BUN	Blood Urea Nitro...	Labs	1.1.T00.MET,
CMP	CMP	Labs	1.1.T.MET, C
CBC	Complete Blood...	Labs	2.0.B00.HEM
Memo	Standard Memo	Memo	
Message	Empty Message	Messages	
soap	Empty SOAPNote	SOAP Notes	
refillrequest	Phone call refill r...	SOAP Notes	1.0.A00.GEN
SOAPDPL	SOAP Default Pl...	SOAP Notes	91201, Defau
PhaNG	Pharyngitis or S...	SOAP Notes	6.0.R00.RES,
PhaC	Pharyngitis or S...	SOAP Notes	6.0.R00.RFS

At the bottom of the window, there is a checkbox labeled 'Include Online Library Items' and an 'Insert' button.

In the screen shot above, the Location column header has been clicked. In this case, it sorted the list of docuplates into Labs and SOAPnotes. Presently, over 95% of docuplates are one of the following types, with over 90% being of the type SOAPnotes.

1. Drawings
2. Flow Sheets
3. Labs
4. SOAPnotes

## Docuplate Actions

At the top of the List view, above the list, are the control buttons for Docuplates. They are Edit, Add, and Remove the currently selected Docuplate.

### Edit

The screenshot displays the 'Docuplates' application interface. On the left, a list of docuplates is shown with columns for Shortcut, Description, Location, and Keywords. The 'neuroitg' docuplate is selected. On the right, a detailed view of the 'neuroitg' docuplate is shown, including fields for Shortcut, Description, Keywords, and Section. Below these fields, a 'Subjective' section is visible, containing a 'CHIEF COMPLAINT(S)' and a 'HPI' (History of Present Illness) section. The HPI section includes a 'SYMPTOMS/RELATED' section with a list of symptoms and a 'LOCATION' section with a list of body parts. The 'QUALITY/COURSE' section includes a list of quality/course options. The 'INTENSITY/SEVERITY' section includes a list of intensity/severity options. The 'ONSET/TIMING' section includes a list of onset/timing options. The 'CONTEXT/WHEN' section includes a list of context/when options. The 'MODIFIERS/TREATMENTS' section includes a list of modifiers/treatments. The 'Improved by' section includes a list of improved by options.

Shortcut	Description	Location	Keywords
jbsumtest	Jennifer's Summ...	Summary	docuplate, it
Jbtest	Jennifer's Test w...	SOAP Notes	addendum,
jbvitals	Jennifer's Vitals S...	Vital Signs	itg, Jberg, si
jhskinrash	Derm/skin compl...	SOAP Notes	14.0.S00.SK
kadesdoc3	Dr. Kades Docu...	SOAP Notes	98213, itg, k
llc-summary	LLC-Summary w...	Summary	d/c, jberg, ll
mcntcmpt2	Complete SOAP...	SOAP Notes	complete, g
Memo	Standard Memo	Memo	
Message	Empty Message	Messages	
Microalbumin	Microalbumin	Labs	01.1.T00.ME
mtkclinicfu	Kalyan Generic...	SOAP Notes	generic, kal
mtkconsult	Kalyan Clinic Co...	SOAP Notes	Clinic, consi
mtksleep	kalyan sleep con...	SOAP Notes	consult, kaly
multiprob	Multi Problem D...	SOAP Notes	itg, multi, pri
neuroitg	Neurology starte...	SOAP Notes	++++, 2010,
nixeye	Opt Exam Gener...	SOAP Notes	ehrcs, exam
nixeye8-15	nixeye8-15	SOAP Notes	nixeye8-15
npdjd	NP - Degenerati...	SOAP Notes	11.0.L00.MI
ObjjHA	Objective Heade...	SOAP Notes	01.0.A00.Gi
ObjX1c	Objective Toggle...	SOAP Notes	01.0.A00.Gi
orthoback	Back Pain (NG)	SOAP Notes	11.0.L00.ML
orthonpitg	New Ortho Patie...	SOAP Notes	exam, itg, n
papsw	Well adult, femal...	SOAP Notes	01.0.A00.Gi
pcxx	Phone call (Me...	SOAP Notes	01.0.A00.Gi
PFTped	Pulmonary Func...	SOAP Notes	06.0.R00.RI
PhaC	Pharyngitis or S...	SOAP Notes	06.0.R00.RE
PhaNG	Pharyngitis or S...	SOAP Notes	06.0.R00.RE
pjBacPaiNG	Back Pain (NG)	SOAP Notes	090301, 11.

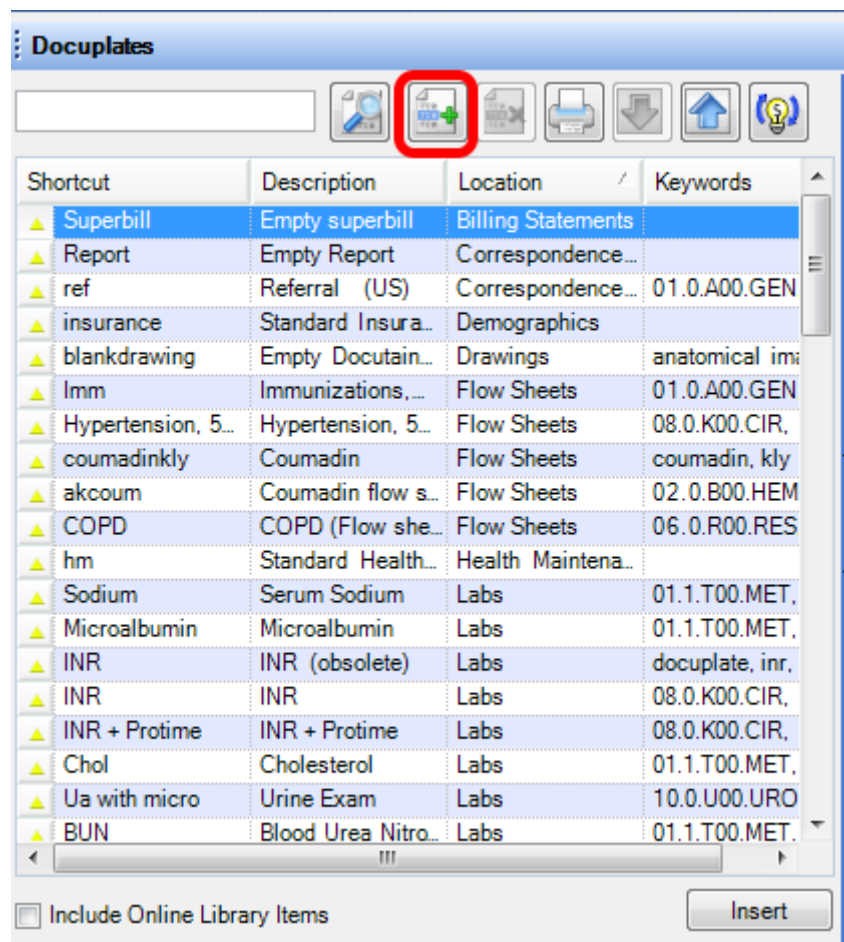
Shortcut: neuroitg  
Description: Neurology starter docuplate  
Keywords: 2010, +++, neurology, neuro, itg, jber  
Section: SOAP Notes ☒ Face to Face Encounter

**Subjective**  
CHIEF COMPLAINT(S)

HPI:  
SYMPTOMS/RELATED: Reports symptoms of  
Denies symptoms of  
+++++ pain | weakness | swelling | numbness | tingling | loss of mobility | fever | insomnia |  
LOCATION: Reports area of involvement as  
Denies regionality as  
+++++ face | jaw | left upper extremity | right upper extremity | left lower extremity | right lower extremity  
| shoulder | arm | forearm | wrist | hand | finger | hip | thigh | shin | knee | ankle | foot | toe | right |  
left |  
QUALITY/COURSE: Reports condition is  
+++++ improving | unchanged | worsening |  
INTENSITY/SEVERITY: Reports measurement ( or degree) as  
+++++ mild | moderate | severe | unremarkable |  
ONSET/TIMING: Reports occurrence as  
+++++ < 1 week ago | > 1 week ago | < 1 month ago | > 1 month ago | < 1 year ago | > 1 year ago | 1  
day ago | 2 days ago | 3 days ago | 4 days ago | 5 days ago | 6 days ago | 1 week ago | 2 weeks ago | 3  
weeks ago | 4 weeks ago | 1 month ago | 2 months ago | 3 months ago | 4 months ago | 5 months ago | 6  
months ago | suddenly after injury | acute | chronic |  
CONTEXT/WHEN: Reports usually associated with  
+++++ inactivity | activity | exertion | sitting | standing | lying | nocturnal |  
MODIFIERS/TREATMENTS: Has tried  
Improved by  
+++++ medication | analgesic | ice | hypertension | none/nothing |

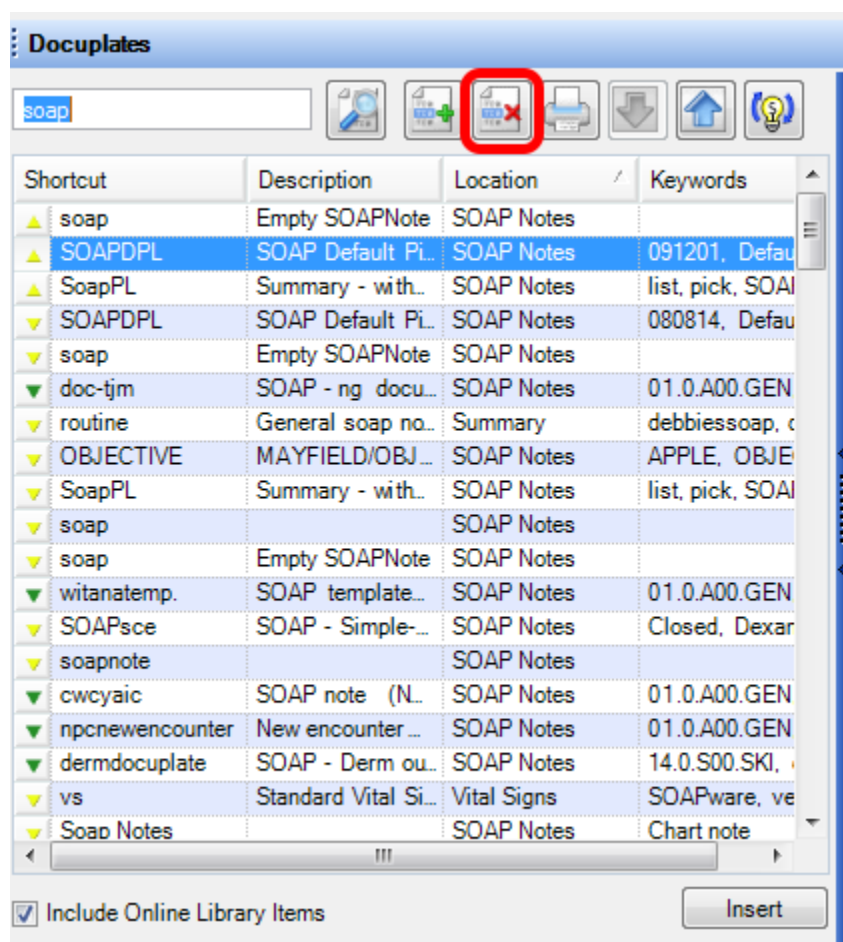
Selecting a docuplate on the user's local library opens the Docuplate for editing. The window to the right provides a preview of any docuplate selected once the docuplate has been downloaded. In this window, the user can edit the docuplate and the changes will be auto-saved.

## Add Button



The button with the green plus allows users to create a docuplate from what has been created in a patient's chart.

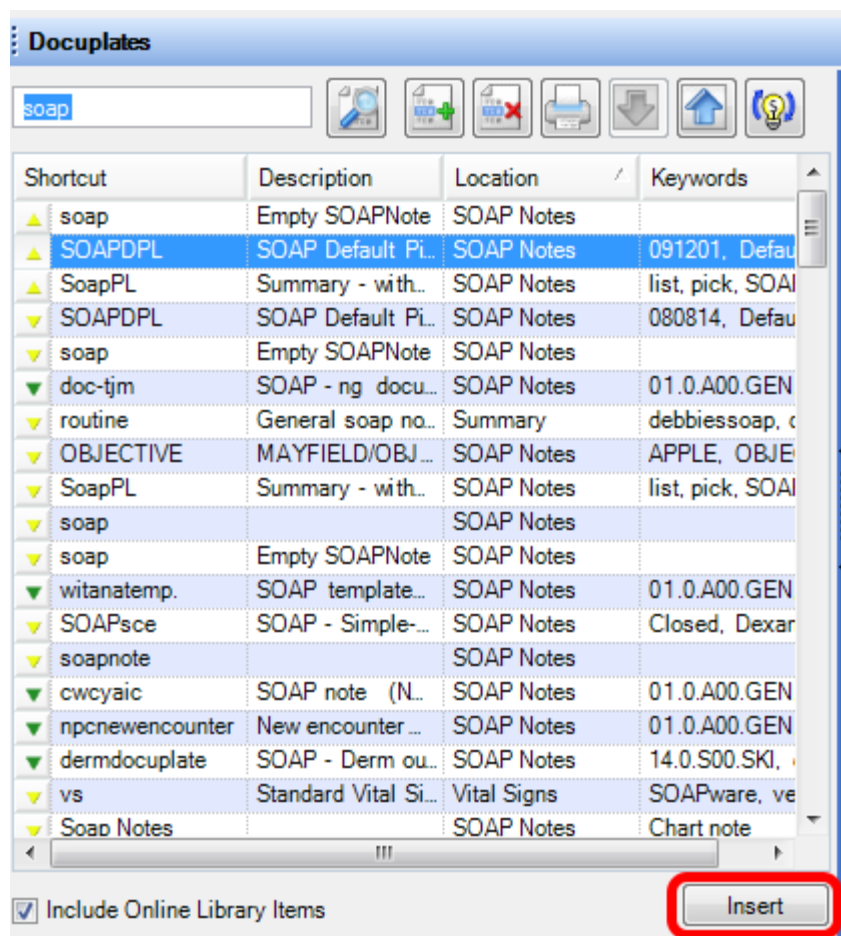
## Remove Button



To remove a docuplate from a user's local library, the user can use the Remove Docuplate button.



## Insert Button



When selecting a docuplate and then Clicking Insert, the selected docuplate will be inserted in the active chart section of an open patient's chart.

## Docuplate Information

### Shortcut

Shortcut	SOAPDPL
Description	SOAP Default Pick List - 091201
Keywords	SOAP, Default, Pick, List, 091201
Section	SOAP Notes
<input checked="" type="checkbox"/> Face to Face Encounter	

The Shortcut is a short code that can be typed to immediately add a Docuplate to a Document.

### Description

Shortcut	SOAPDPL
Description	SOAP Default Pick List - 091201
Keywords	SOAP, Default, Pick, List, 091201
Section	SOAP Notes
<input checked="" type="checkbox"/> Face to Face Encounter	

The Description provides a brief explanation of the intended use of the Docuplate.

### Keywords List

Shortcut	SOAPDPL
Description	SOAP Default Pick List - 091201
Keywords	SOAP, Default, Pick, List, 091201
Section	SOAP Notes
<input checked="" type="checkbox"/> Face to Face Encounter	

The Keywords list is a list of comma and space-separated keywords associated with that Docuplate. They can be used to provide additional searchable information about a Docuplate. Short phrases can also be used, provided they do not include commas or other punctuation. Spaces are allowed.

## Face to Face Encounter

Shortcut	SOAPDPL
Description	SOAP Default Pick List - 091201
Keywords	SOAP, Default, Pick, List, 091201
Section	SOAP Notes

☒ Face to Face Encounter

This check box indicates whether the selected docuplate is used for a Face to Face encounter or a Non Face to Face encounter. When the selected docuplate is inserted by the user, the active SOAPnote will default to a Face to Face encounter if the box is checked. If the box is not checked, the active SOAPnote will default to a Non Face to Face encounter.

If an encounter is a Face to Face office visit it must be specified in the SOAPnote Types. Meaningful Use dashboard will only calculate statistics for meaningful use office visits if the SOAPnote Type is set to Face to Face. See: [Creating a SOAPnote](#) for more information.

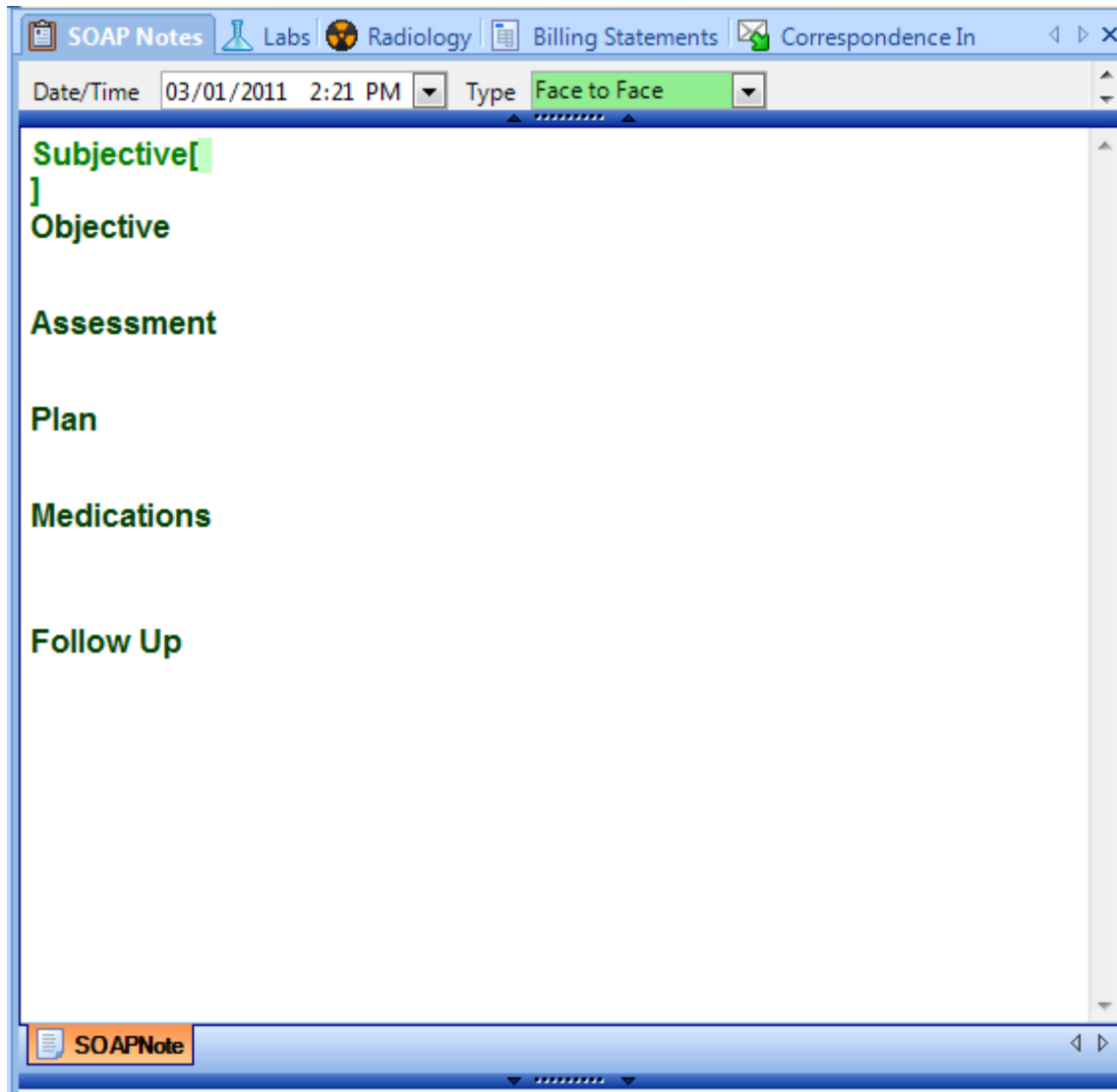
## Creating a Docuplate

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Docuplates may be created either from scratch, or by using an existing docuplate and then edited or modified.

This lesson will explain how to create a docuplate using an existing docuplate, how to delete a docuplate, and how to build a docuplate from scratch.

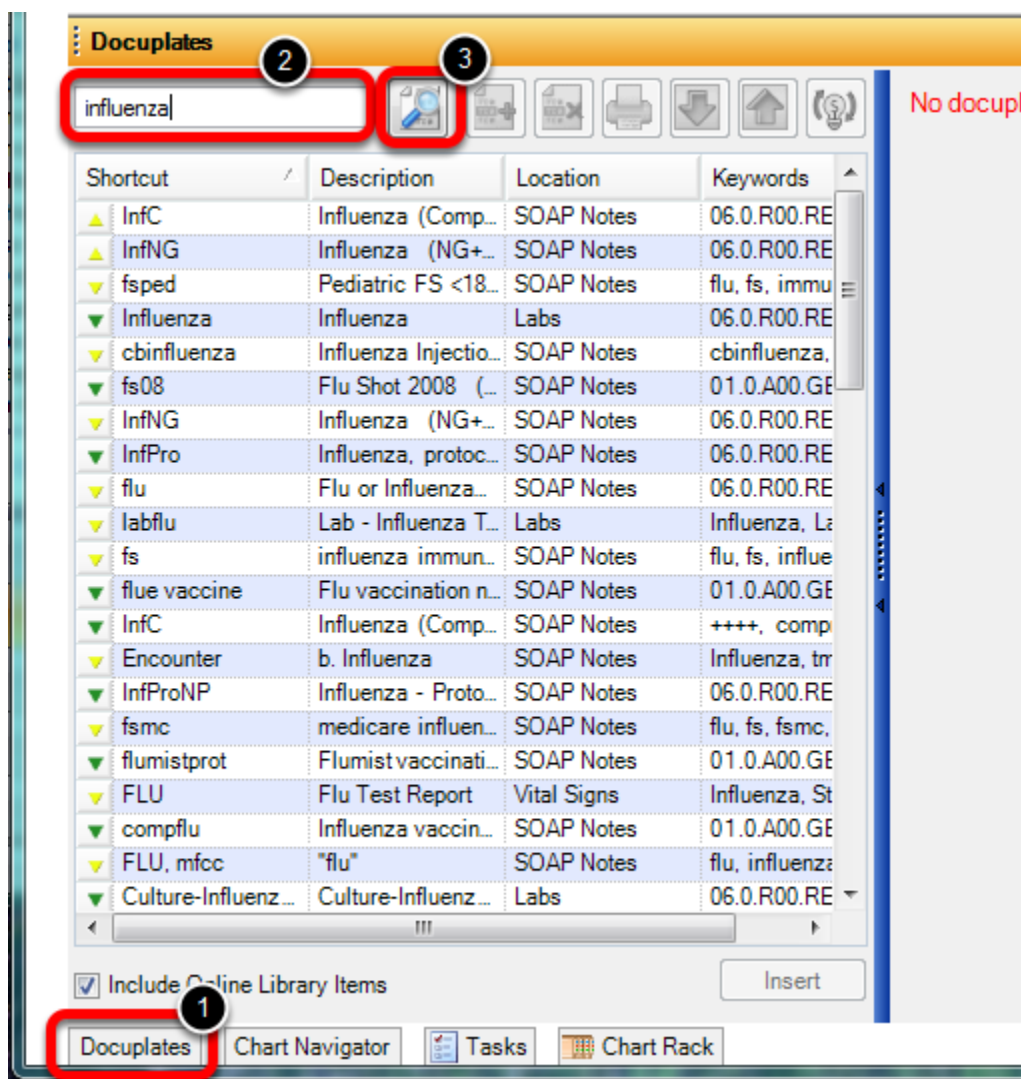
### Create a Docuplate from an Existing Docuplate



The screenshot displays the SOAPware application window. The top menu bar includes 'SOAP Notes', 'Labs', 'Radiology', 'Billing Statements', and 'Correspondence In'. Below the menu bar, there is a header section with 'Date/Time' set to '03/01/2011 2:21 PM' and 'Type' set to 'Face to Face'. The main content area is a large text box containing the following fields: 'Subjective[ ]', 'Objective', 'Assessment', 'Plan', 'Medications', and 'Follow Up'. The 'SOAPNote' tab is selected at the bottom of the window.

Begin with an empty document in a test patient chart. To clear out the contents of a SOAPnote, Select Edit > Clear All SOAP Fields.

## Inserting a Docuplate



To insert an existing docuplate:

1. Open the Docuplates dialog. Click on the Docuplates docked tab at the bottom of the screen, Select Docutainers > Docuplates from the Menu Bar, or Press F6 on the keyboard.
2. Insert a keyword to find a desired docuplate.
3. Click Search.

**Docuplates**

Search:

Shortcut:  Description:  Keywords:  Section:  ☒ Face to Face Encounter

Shortcut	Description	Location	Keywords
InfC	Influenza (Comp...	SOAP Notes	06.0.R00.RE
<b>InfNG</b>	<b>Influenza (NG+...</b>	<b>SOAP Notes</b>	<b>06.0.R00.RE</b>
Testflu	Test Flu Docupi...	SOAP Notes	flu, immuena
fsped	Pediatric FS <18...	SOAP Notes	flu, fs, immu
Influenza	Influenza	Labs	06.0.R00.RE
cbinfluenza	Influenza Injectio...	SOAP Notes	cbinfluenza,
fs08	Flu Shot 2008 (...)	SOAP Notes	01.0.A00.GE
InfPro	Influenza, protoc...	SOAP Notes	06.0.R00.RE
flu	Flu or Influenza...	SOAP Notes	06.0.R00.RE
labflu	Lab - Influenza T...	Labs	Influenza, La
fs	influenza immun...	SOAP Notes	flu, fs, influe
flue vaccine	Flu vaccination n...	SOAP Notes	01.0.A
InfProNP	Influenza - Proto...	SOAP Notes	06.0.F
fsmc	medicare influen...	SOAP Notes	flu, fs,
flumistprot	Flumist vaccinati...	SOAP Notes	01.0.A
<hold SHIFT>FL	Flu Test Report	Labs	Influen

**Subjective**  
COMPLAINT or ISSUE - Influenza.  
 HPI: SYMPTOMS/RELATED: Reports symptoms of fever, headache, fatigue (lethargy), muscle pain.  
Denies symptoms of  
 +++++ cough | diarrhea | rhinorrhea | sore throat |  
 condition is continuous, persisting.  
 its measurement ( or degree) as moderate.

**Insert docuplate**  
 Inserts the selected docuplates to their default area.  
 You can drag/drop an item if you want it to be inserted in a different area.  
 ? Press F1 key to get more information

☒ Include Online Library Items

SOAPNote

Click to highlight the desired docuplate, and Click the "Insert" button .

## Editing the Docuplate

Date/Time 03/01/2011 2:21 PM Type Face to Face

**Subjective[**  
COMPLAINT or ISSUE - Influenza.

HPI: SYMPTOMS/RELATED: Reports symptoms of fever, headache, fatigue (malaise or lethargy), muscle pain.  
Denies symptoms of  
+++++ cough | diarrhea | rhinorrhea | sore throat |

QUALITY/COURSE: Reports condition is continuous, persisting.  
Denies, in general,  
+++++

INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.  
Declines to define as  
+++++

ONSET/TIMING: Reports occurrence as sudden.  
Denies onset as  
+++++ gradual | < 48 hours ago | > 48 hours ago | < 1 week ago | > 1 week ago |

CONTEXT/WHEN: Reports usually associated with  
Denies association with  
+++++ activity | smokers in home | irritant exposure (smoke/dust/fumes) |

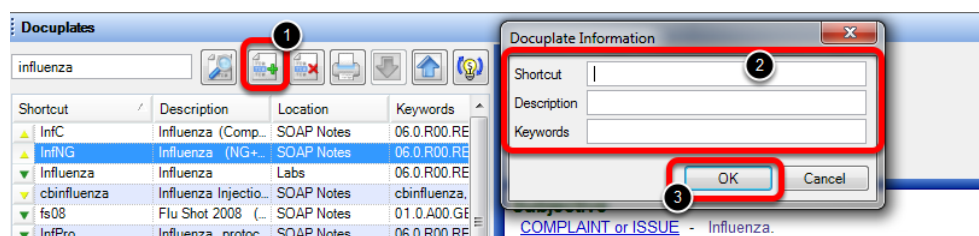
MODIFIERS/TREATMENTS: Improved by  
Has tried  
History of  
Past evaluation and/or work-up includes

SOAPNote

The selected docuplate will now be displayed in the desired chart section.

Edit the docuplate by entering or removing information as needed.

## Saving the New Docuplate



To save this as a new docuplate , be sure the cursor is active in the preferred chart section, and Open the Docuplates dialog. ( Use F6 or Click the Docuplates docked tab).

1. Click on the Green + to create the new docuplate.
2. Enter a Shortcut, Description and Keywords in the Docuplate Information dialog.
3. Select OK.

## Setting a Docuplate Type

The screenshot shows the 'Docuplates' dialog box. On the left is a table with columns: Shortcut, Description, Location, and Keywords. The table contains three entries: 'InfNG' (Influenza (NG+...), SOAP Notes, 06.0.R00.RES.), 'flu' (Flu or Influenza..., SOAP Notes, 06.0.R00.RES.), and 'InfNG' (Influenza (NG+..., SOAP Notes, 06.0.R00.RES.).

On the right, the 'Docuplate Information' section is visible. It includes fields for:
 

- Shortcut: InfNG
- Description: Influenza (NG++++)
- Keywords: R00, 06.0.R00.RES, 090128, generatio
- Section: SOAP Notes
- A checkbox labeled 'Face to Face Encounter' which is checked and highlighted with a red rectangle.

Below the information section, the 'Subjective' field is populated with the following text:
   
COMPLAINT or ISSUE - Influenza.
   
HPI: SYMPTOMS/RELATED: Reports symptoms of fever, headache, fatigue (ma
   
Denies symptoms of
  
+++++ cough | diarrhea | rhinorrhea | sore throat |
   
QUALITY/COURSE: Reports condition is continuous, persisting.
   
Denies, in general,
  
+++++

The Face to Face Encounter check box indicates whether the selected docuplate is used for a Face to Face encounter or a Non Face to Face encounter. When the selected docuplate is inserted by the user, the active SOAPnote will default to a Face to Face encounter if the box is checked. If the box is not checked, the active SOAPnote will default to a Non Face to Face encounter.

If an encounter is a Face to Face office visit it must be specified in the SOAPnote Type. The Meaningful Use dashboard will only calculate statistics for meaningful use office visits if the SOAPnote Type is set to Face to Face.

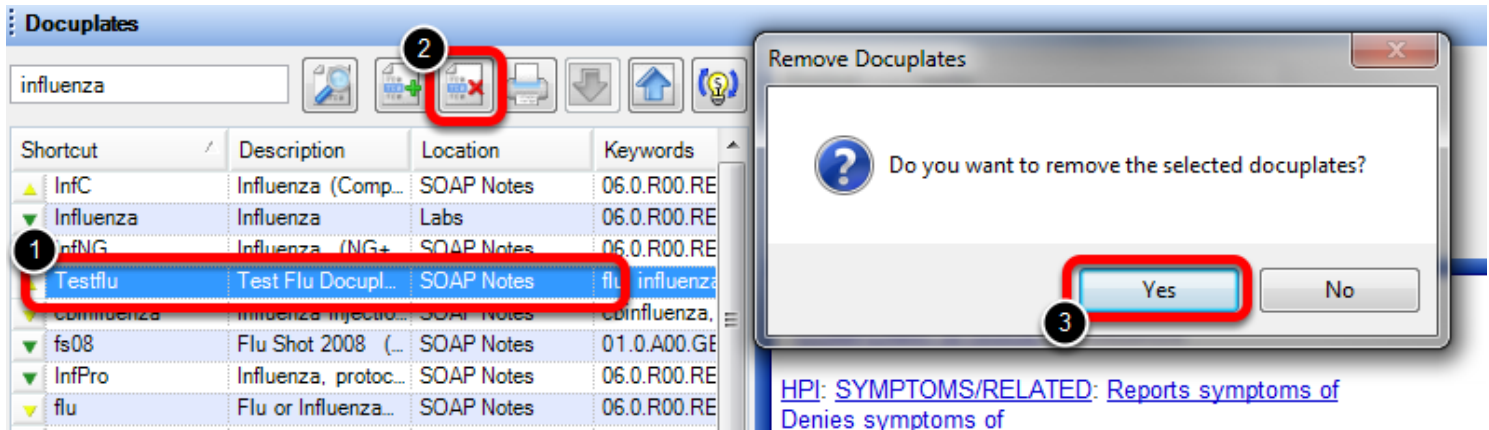
The screenshot shows the 'Docuplates' dialog box with the search term 'influenza' in the search bar. The table below lists the results:

Shortcut	Description	Location	Keywords
InfC	Influenza (Comp...	SOAP Notes	06.0.R00.RE
InfNG	Influenza (NG+...	SOAP Notes	06.0.R00.RE
Testflu	Test Flu Docupl...	SOAP Notes	flu, influenza
Influenza	Influenza	Labs	06.0.R00.RE
cbinfluenza	Influenza Injectio...	SOAP Notes	cbinfluenza,
fs08	Flu Shot 2008 (...)	SOAP Notes	01.0.A00.GE
InfPro	Influenza, protoc...	SOAP Notes	06.0.R00.RE
flu	Flu or Influenza...	SOAP Notes	06.0.R00.RE
labflu	Lab - Influenza T...	Labs	Influenza, La

The new docuplate will display, as well as the original docuplate, within the Docuplates dialog.



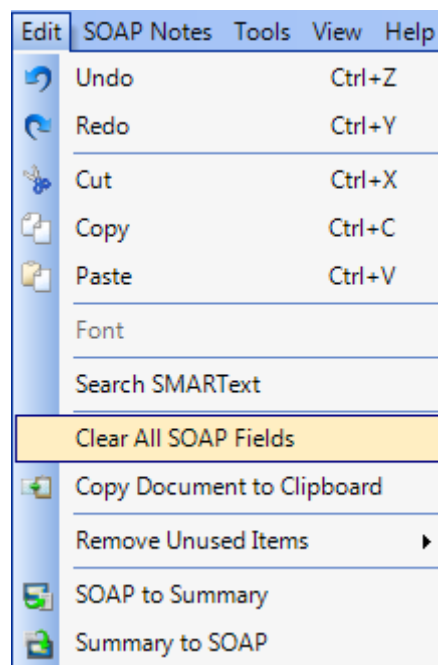
## Delete a Docuplate



To delete a docuplate:

1. Highlight the desired docuplate.
2. Click the delete button.
3. Confirm the action of removing the selected docuplate by Clicking the "Yes" button.

## Create a Docuplate from Scratch



To create a docuplate without using an existing docuplate, begin with an empty document in a test patient chart. Select Edit > Clear All SOAP Fields, from the Menu Bar.

Date/Time 03/01/2011 2:21 PM Type Non Face to Face

**Subjective**  
 Phone message:

Follow up for phone call: F verbalizes understanding.

**Objective**

**Assessment**  
 Phone Message.

**Plan**

**Medications[**  
**Ibuprofen (Advil, Motrin):** 200 mg (tablet) SIG- 1-2 tab(s) 4 times a day orally #1 Bottle(s) Substitutions Allowed Refills- 0 Notes-

**]**

**Follow Up**

SOAPNote

Enter desired information in the SOAPnote. Docuplates may contain Free Text, SMARText, and Pick Lists.

Add the desired document items to be displayed in the docuplate. Docuplates may contain Free Text, SMARText, and Pick Lists.

**Docuplates** 1

Shortcut	Description	Location	Keywords
aaaaDailySoap	SOAP starter (U...	SOAP Notes	01.0.A00.GE
aaaaONGOING...	-F/U - Otho/Chir...	SOAP Notes	11.0.L00.MU
akcoun	Coumadin flow s...	Flow Sheets	02.0.B00.HE
blankdrawing	Empty Docutain...	Drawings	anatomical i
BUN	Blood Urea Nitro...	Labs	01.1.T00.ME
CBC	Complete Blood...	Labs	02.0.B00.HE
Chol	Cholesterol	Labs	01.1.T00.ME

**Docuplate Information**

Shortcut

Description

Keywords

OK Cancel

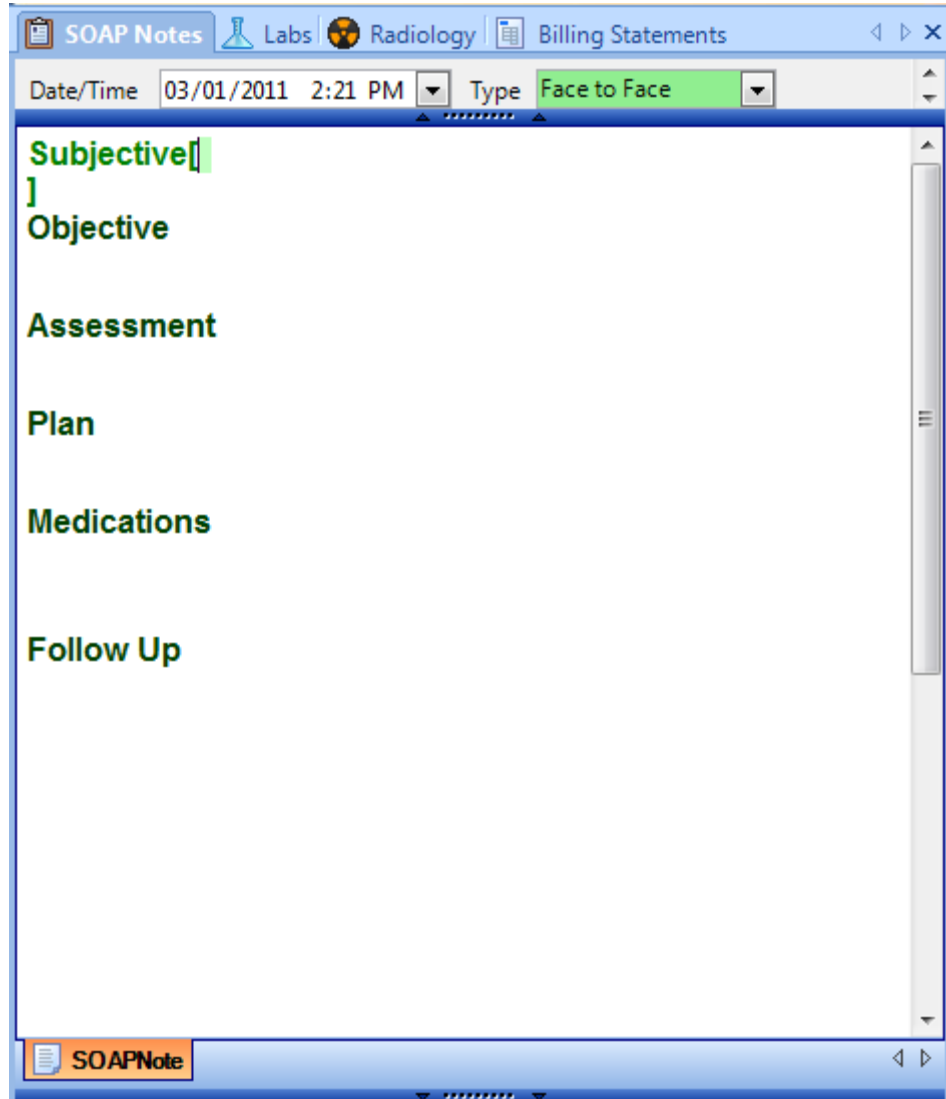
To save the docuplate:

1. Open the Docuplates dialog. ( Use F6 or Click the Docuplates docked tab).
2. Click on the green + to create a new docuplate.
3. Enter a Shortcut, Description and Keywords in the Docuplate Information dialog.

4. Click OK .

## Inserting a Docuplate

### Open Document



The screenshot displays the SOAPware Clinical application window. The title bar includes tabs for 'SOAP Notes', 'Labs', 'Radiology', and 'Billing Statements'. Below the title bar, there is a 'Date/Time' field showing '03/01/2011 2:21 PM' and a 'Type' dropdown menu set to 'Face to Face'. The main content area is a large text field with a vertical scrollbar on the right. The text field contains the following default SOAP Note structure:

- Subjective**
- Objective**
- Assessment**
- Plan**
- Medications**
- Follow Up**

At the bottom of the window, there is a 'SOAPNote' tab and a status bar.

To insert a Docuplate, open the Document to insert the Docuplate. In a SOAPnote, clear out the default docuplate to insert an all-new docuplate. To do this, go to Edit > Clear All SOAP Fields.

If a blank document is not available, a prompt will display with several options on how to insert the docuplate.

## Search and Insert

**Active Problems**

Glaucoma ICD#365.9 Onset: Status:

Alcohol dependence, in remission ICD#303.90 #303.93 Onset: Status: Active

Hypertension, benign ICD#401.1 Onset: Status: Chronic

Diabetes - Type 2 - uncontrolled ICD#250.02 Onset: Status:

**Inactive Problems**

COPD, Bronchitic with acute exacerbation ICD#491.21 Onset:

**Docuplates**

Shortcut	Description	Location	Keywords
StaE	Starter - Extend...	SOAP Notes	090210, 200
StaO	StaO - Starter O...	SOAP Notes	090222, 200
starterdefault	Starter Default D...	SOAP Notes	default, itg, s
pijcwcmaster1	SOAP master (...)	SOAP Notes	01.0.A00.GE
basictogglestarter	Emily and Rebe...	SOAP Notes	basis, emily
gyns	Gynecology, Sta...	SOAP Notes	Gynecology
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
gyns	Gynecology, Sta...	SOAP Notes	Gynecology
msoap	StaO - Starter O...	SOAP Notes	090222, 200
cwcyaic	SOAP note (N...	SOAP Notes	01.0.A00.GE
dermdocuplate	SOAP - Derm ou...	SOAP Notes	14.0.S00.SK
cwcsoapnote	SOAP template ...	SOAP Notes	01.0.A00.GE
pijGen Allergy - c...	Allergy, new (N...	SOAP Notes	090702, ext
GEN SOAP	HARMON SOAP	SOAP Notes	default, harr
starterdefault2	Starter Default D...	SOAP Notes	default, itg, s
basesoap	Basic Soapnote	SOAP Notes	05042010, t
jcr basic	SOAP starter, g...	SOAP Notes	01.0.A00.GE
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
EMCo	Starter Outline (...)	SOAP Notes	2008+, Codi
starterdefault2	Starter Default D...	SOAP Notes	default, itg, s
starterdefault	Starter Default D...	SOAP Notes	default, itg, s
blank2	Soap-blank with...	SOAP Notes	blank, eab, s
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
neuroita	Neurology starte...	SOAP Notes	2010

**SOAP Notes**

Date/Time: 03/01/2011 2:21 PM Type: Face to Face

**Subjective**

**Objective**

**Assessment**

**Plan**

**Subjective**

CHIEF COMPLAINT(S)/REASON FOR VISIT:

HPI: SYMPTOMS/RELATED: Reports symptoms of

ONSET/TIMING:

QUALITY/COURSE:

MODIFIERS/TREATMENTS: Has tried

**PROBLEM #2:**

COMPLAINT or ISSUE:

HPI: SYMPTOMS/RELATED: Reports symptoms of

ONSET/TIMING:

QUALITY/COURSE:

MODIFIERS/TREATMENTS: Has tried

ROS: GEN- Constitutional:

HENT:

EYES:

LUNGS/Respiratory:

HEART/Cardiovascular:

ABD/Gastrointestinal:

GENT/Genitourinary:

**SOAPNote**

**Insert**

1. Open the Docuplates panel using the Docked Tab, or press F6.
2. Then, select the Docuplate(s) to insert from the list.
3. Click the Insert button.

## If the Document is Not Empty

The screenshot displays the SOAPware clinical interface. At the top, navigation tabs include Summary, Vital Signs, Demographics, Growth Charts, SOAP Notes, Labs, Radiology, and Billing Statements. The 'SOAP Notes' tab is active, showing a patient record for 03/01/2011 at 2:21 PM, Type: Face to Face. The 'Active Problems' section lists: Glaucoma (ICD#365.9), Alcohol dependence, in remission (ICD#303.90), Hypertension, benign (ICD#401.1), and Diabetes - Type 2 - uncontrolled (ICD#250.02). The 'Subjective' section contains fields for CHIEF COMPLAINT(S)/REASON FOR VISIT, HPI: SYMPTOMS/RELATED, ONSET/TIMING, QUALITY/COURSE, and MODIFIERS/TREATMENTS. The 'Docuplates' section at the bottom shows a list of templates with columns for Shortcut, Description, and a table of associated SOAP Notes. A 'Data Exchange' dialog box is open, prompting the user to select 'Ignore', 'Append', 'New', or 'Cancel' when adding a docuplate to an existing item.

If the document is not empty when inserting the docuplate, a prompt will display with several options on how to insert the docuplate..

**Ignore** to not insert any docuplate information into any SOAPnote fields that already have content.

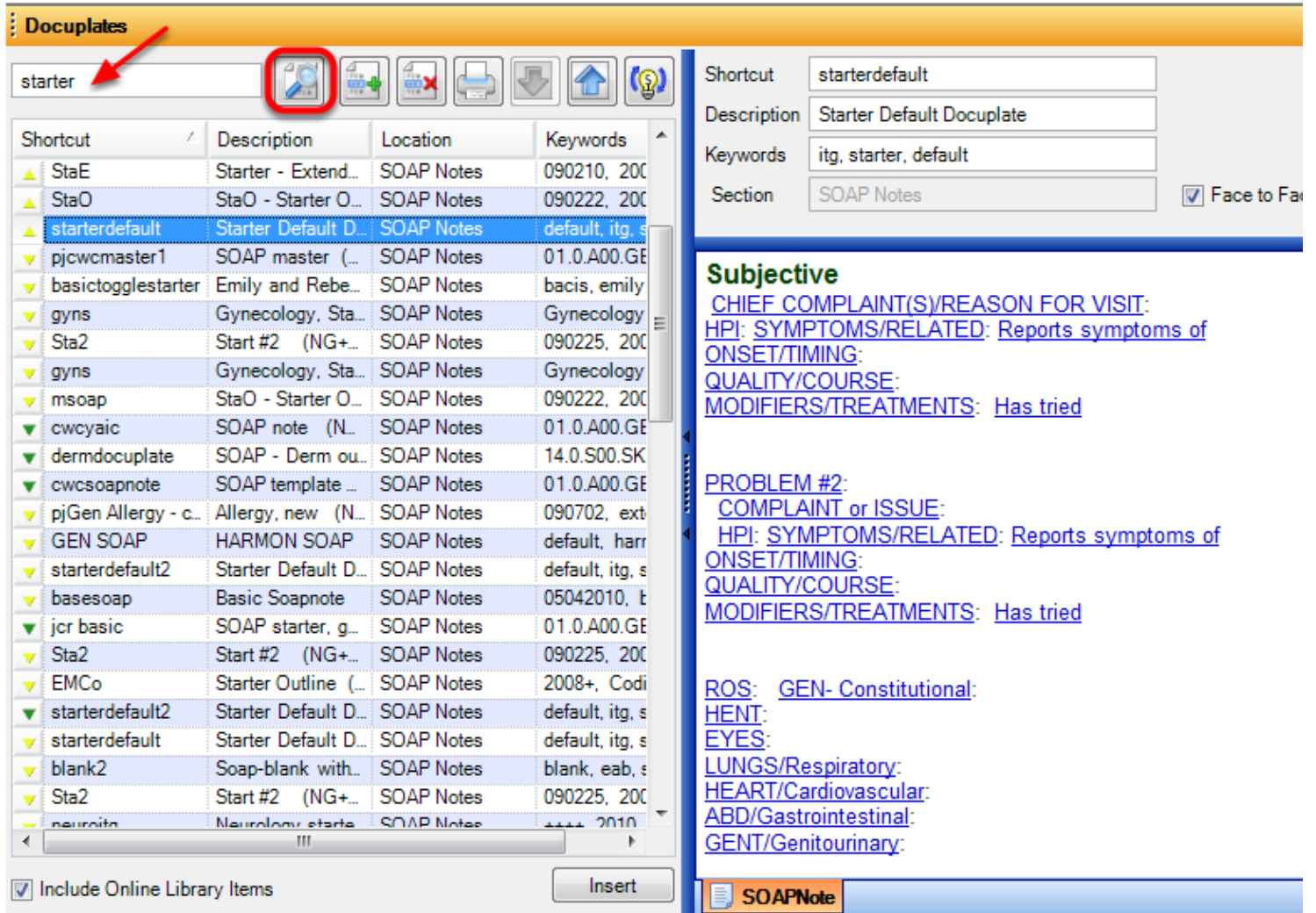
**Append** to add the docuplate information after any existing content in SOAPnote fields.

**New** to create a new, empty/blank SOAPnote next to the existing one. This could be useful if seeing the patient for a sore throat and a workman's comp. appointment at the same visit.

**Cancel** to exit the dialog and not perform any information insertion into the SOAPnote.

## Editing a Docuplate

### Search



The screenshot shows the Docuplates interface. At the top, there is a search bar with the text 'starter' and a magnifying glass icon. Below the search bar is a table of docuplates. The 'starterdefault' docuplate is selected, and its details are shown on the right.

Shortcut	Description	Location	Keywords
StaE	Starter - Extend...	SOAP Notes	090210, 200
StaO	StaO - Starter O...	SOAP Notes	090222, 200
starterdefault	Starter Default D...	SOAP Notes	default, itg, s
pjcwcmaster1	SOAP master (...)	SOAP Notes	01.0.A00.GE
basictogglestarter	Emily and Rebe...	SOAP Notes	basis, emily
gyns	Gynecology, Sta...	SOAP Notes	Gynecology
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
gyns	Gynecology, Sta...	SOAP Notes	Gynecology
msoap	StaO - Starter O...	SOAP Notes	090222, 200
cwcyaic	SOAP note (N...	SOAP Notes	01.0.A00.GE
dermdocuplate	SOAP - Derm ou...	SOAP Notes	14.0.S00.SK
cwcsoapnote	SOAP template ...	SOAP Notes	01.0.A00.GE
pjGen Allergy - c...	Allergy, new (N...	SOAP Notes	090702, ext
GEN SOAP	HARMON SOAP	SOAP Notes	default, harr
starterdefault2	Starter Default D...	SOAP Notes	default, itg, s
basesoap	Basic Soapnote	SOAP Notes	05042010, b
jcr basic	SOAP starter, g...	SOAP Notes	01.0.A00.GE
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
EMCo	Starter Outline (...)	SOAP Notes	2008+, Codi
starterdefault2	Starter Default D...	SOAP Notes	default, itg, s
starterdefault	Starter Default D...	SOAP Notes	default, itg, s
blank2	Soap-blank with...	SOAP Notes	blank, eab, s
Sta2	Start #2 (NG+...	SOAP Notes	090225, 200
neuroita	Neurology starte...	SOAP Notes	2010

On the right side, the details for the 'starterdefault' docuplate are shown:

Shortcut: starterdefault  
Description: Starter Default Docuplate  
Keywords: itg, starter, default  
Section: SOAP Notes ☒ Face to Face

**Subjective**  
CHIEF COMPLAINT(S)/REASON FOR VISIT:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried

**PROBLEM #2:**  
COMPLAINT or ISSUE:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried

ROS: GEN- Constitutional:  
HENT:  
EYES:  
LUNGS/Respiratory:  
HEART/Cardiovascular:  
ABD/Gastrointestinal:  
GENT/Genitourinary:

At the bottom, there is a checkbox for 'Include Online Library Items' and an 'Insert' button.

Click Docutainers in the menu bar, and Click Docuplates (or Press the F6 key).

When the Docuplates viewer appears, Type a shortcut or keyword in the Search field/box that is associated with the desired docuplate. Only single words can be entered into the Search field/box. Then, Click the search button.

## Search Results

Shortcut	Description	Location	Keywords
▲ EMCs	Starter (E&M Coding) 02-25-2...	SOAP Notes	2008+, coding, E&M, emcs, starter
▲ StaD	Starter For Docuplates (NG++...	SOAP Notes	090227, 2008+, Docuplates, NG++++, StaD
▲ StaE	Starter - Extended (NG) 02-10...	SOAP Notes	090210, 2008+, extended, ng, StaE, starter
▲ starterdefault	Starter Default Docuplate	SOAP Notes	default, itg, starter
▲ Sta	Start - Routine or Default (NG...	SOAP Notes	090226, 2008+, Default, emc, NG++++, Routine...
▲ Sta2	Start #2 (NG++++)	SOAP Notes	090225, 2008+, emc, NG++++, Sta2, Starter
▲ StaO	StaO - Starter Outline (2-22-...	SOAP Notes	090222, 2008+, Outline, StaO, Starter
▼ gyms	Gynecology, Starter	SOAP Notes	Gynecology, Starter, Txxg
▼ Sta2	Start #2 (NG++++)	SOAP Notes	090225, 2008+, emc, NG++++, Sta2, Starter
▼ gyms	Gynecology, Starter	SOAP Notes	Gynecology, Starter, Txxg
▼ msoap	StaO - Starter Outline (2-22-...	SOAP Notes	090222, 2008+, Outline, StaO, Starter
▼ cwcyaic	SOAP note (NG++) YAIC	SOAP Notes	01.0.A00.GEN, A00, cwc.note, NG+++ , soap, st...
▼ dermdocuplate	SOAP - Derm outline (NG+++)	SOAP Notes	14.0.S00.SKI, dcox, derm, NG+++ , S00, soap, s...
▼ cwcsoapnote	SOAP template (NG - Starter)	SOAP Notes	01.0.A00.GEN, A00, cwc, NG, soapnote, starter...
▼ starterdefault2	Starter Default Docuplate	SOAP Notes	default, itg, starter

Docuplates having matching keywords will be list items in the area below the Search field/box on the left side of the Docuplates viewer.



## Edit Using the Preview Window

Shortcut	starterdefault
Description	Starter Default Docuplate
Keywords	itg, starter, default
Section	SOAP Notes <input checked="" type="checkbox"/> Face to Face Encounter

**Subjective**  
CHIEF COMPLAINT(S)/REASON FOR VISIT:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried  
  
PROBLEM #2:  
COMPLAINT or ISSUE:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried  
  
ROS: GEN- Constitutional:  
HENT:  
EYES:  
LUNGS/Respiratory:  
HEART/Cardiovascular:  
ABD/Gastrointestinal:  
GENT/Genitourinary:

SOAPNote

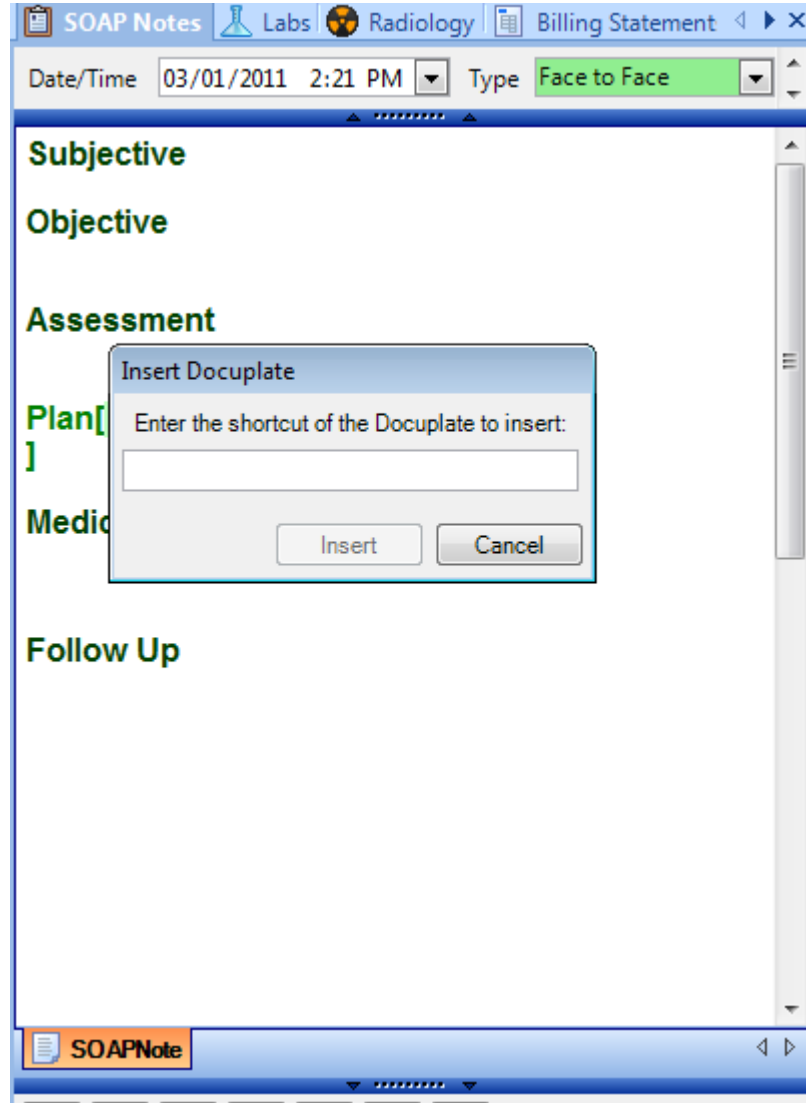
Click the docuplate list item for the desired docuplate, and the docuplate is displayed on the right side of the Docuplates viewer. Edit the docuplate's data elements as needed.

## Autosave

The information within the docuplate is always, automatically saved without having to issue a save command. There is no save button. Simply Clicking anywhere outside of the Docuplates viewer or viewing another docuplate causes any edits to be saved automatically.

## F5 Quick Entry of a Docuplate

### Quick Entry



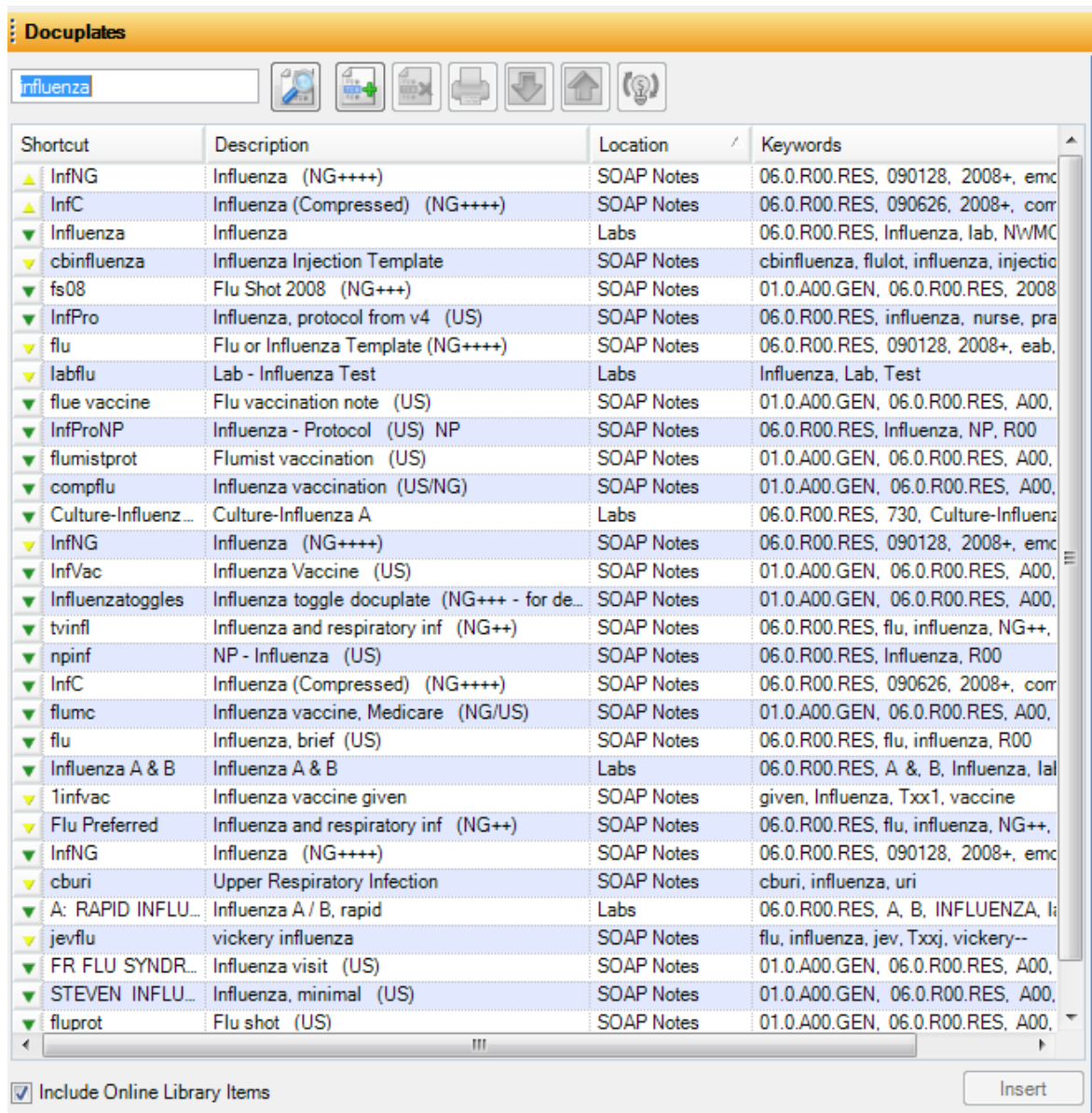
For those docuplates used on a regular basis, any SOAPware users find it convenient to use a keyboard shortcut to enter those most commonly-used - Press the F5 key, and type the Shortcut for the docuplate.

Then, Click the Insert button, or Press the Enter key to insert the docuplate. If a user knows the shortcut to a docuplate, this is the fastest method to enter the docuplate in a document.

## Search for Docuplates

The Docuplate Library now contains thousands of docuplates, containing tens of thousands of keywords to assist with searching-finding. SOAPnote docuplates reviewed by SOAPware, Inc. have often had some qualifiers added to their descriptions. SOAPware docuplates vary in sophistication from those containing only unstructured, free-text to those that contain mostly structured items. To reflect this, a convention is being followed to assist with ranking, sorting, and retrieving.

### Continuum of Unstructured (US) to New Generation (NG)



The screenshot shows a software window titled "Docuplates" with a search bar containing the word "influenza". Below the search bar are several icons for document operations. The main area is a table with four columns: "Shortcut", "Description", "Location", and "Keywords". The table lists various influenza-related docuplates, each with a small triangle icon in the shortcut column indicating its category (US, US/NG, or NG/US). The "Keywords" column contains alphanumeric codes and descriptive terms.

Shortcut	Description	Location	Keywords
InfNG	Influenza (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, emc
InfC	Influenza (Compressed) (NG++++)	SOAP Notes	06.0.R00.RES, 090626, 2008+, cor
Influenza	Influenza	Labs	06.0.R00.RES, Influenza, lab, NWMC
cbinfluenza	Influenza Injection Template	SOAP Notes	cbinfluenza, flulot, influenza, injectio
fs08	Flu Shot 2008 (NG+++)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, 2008
InfPro	Influenza, protocol from v4 (US)	SOAP Notes	06.0.R00.RES, influenza, nurse, pra
flu	Flu or Influenza Template (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, eab,
labflu	Lab - Influenza Test	Labs	Influenza, Lab, Test
flue vaccine	Flu vaccination note (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
InfProNP	Influenza - Protocol (US) NP	SOAP Notes	06.0.R00.RES, Influenza, NP, R00
flumistprot	Flumist vaccination (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
compflu	Influenza vaccination (US/NG)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
Culture-Influenz...	Culture-Influenza A	Labs	06.0.R00.RES, 730, Culture-Influenz
InfNG	Influenza (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, emc
InfVac	Influenza Vaccine (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
Influenzatoggles	Influenza toggle docuplate (NG+++ - for de...	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
tvinfl	Influenza and respiratory inf (NG++)	SOAP Notes	06.0.R00.RES, flu, influenza, NG++,
npinf	NP - Influenza (US)	SOAP Notes	06.0.R00.RES, Influenza, R00
InfC	Influenza (Compressed) (NG++++)	SOAP Notes	06.0.R00.RES, 090626, 2008+, cor
flumc	Influenza vaccine, Medicare (NG/US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
flu	Influenza, brief (US)	SOAP Notes	06.0.R00.RES, flu, influenza, R00
Influenza A & B	Influenza A & B	Labs	06.0.R00.RES, A & B, Influenza, lab
1invac	Influenza vaccine given	SOAP Notes	given, Influenza, Txx1, vaccine
Flu Preferred	Influenza and respiratory inf (NG++)	SOAP Notes	06.0.R00.RES, flu, influenza, NG++,
InfNG	Influenza (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, emc
cburi	Upper Respiratory Infection	SOAP Notes	cburi, influenza, uri
A: RAPID INFLU...	Influenza A / B, rapid	Labs	06.0.R00.RES, A, B, INFLUENZA, la
jevflu	vickery influenza	SOAP Notes	flu, influenza, jev, Txxj, vickery--
FR FLU SYNDR...	Influenza visit (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
STEVEN INFLU...	Influenza, minimal (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,
fluprot	Flu shot (US)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, A00,

☒ Include Online Library Items Insert

(US) – Unstructured, free-text.

(US/NG) – Mostly unstructured, but some New Generation structured items are included.

(NG/US) – Mostly New Generation, structured content, but much unstructured, free-text is present.

(NG) – Mostly New Generation, but often highly customized to a specific user or user type.

(NG+) - Mostly New Generation, but some free-text is present.

(NG++) - Less free-text.

(NG+++)- Little remaining, free-text.

(NG++++)- Majority of content is New Generation.








**Note:** Most official SOAP encounter docuplates are those with green triangles retrieved by searching on NG++++. Also, notice that searching on NG+++ will retrieve docuplates having keywords containing NG++++ as well as NG+++.

## Retrieve Docuplates Based on Organ System

Codes	17 Systems Categories
<b>A00</b>	General
<b>T00</b>	Metabolic, Endocrine
<b>B00</b>	Blood, Blood Forming
<b>H00</b>	Ear
<b>F00</b>	Eye
<b>R00</b>	Respiratory
<b>K00</b>	Circulatory
<b>D00</b>	Digestive
<b>U00</b>	Urinary
<b>W00</b>	Pregnancy, Family Planning
<b>X00</b>	Female genital
<b>Y00</b>	Male genital
<b>L00</b>	Musculoskeletal
<b>N00</b>	Neurological
<b>P00</b>	Psychological
<b>Z00</b>	Social
<b>S00</b>	Skin

Use one of these codes to review docuplates by one of 17 systems.

## Searching by System

Docuplates			
<div> <input type="text" value="R00"/>        </div>			
Shortcut	Description	Location	Keywords
▲ InfNG	Influenza (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, emc
▲ PhaNG	Pharyngitis or Sore Throat (NG++++)	SOAP Notes	06.0.R00.RES, 090128, 2008+, emc
▲ PhaC	Pharyngitis or Sore Throat (Compressed) ...	SOAP Notes	06.0.R00.RES, 090128, 2008+, cor
▼ hentj	ENT Problems (NG+++)	SOAP Notes	03.1.H00.EAR, 06.0.R00.RES, ear, i
▼ 5 uri - sinus	Sinus problems (US)	SOAP Notes	06.0.R00.RES, 5, R00, sinus, uri
▼ zast	Asthma protocol (US/NG)	SOAP Notes	06.0.R00.RES, asthma, protocol, R00
▼ Bro	Bronchitis (US/NG)	SOAP Notes	06.0.R00.RES, bronchitis, CFP, R00
▼ npresp	NP - Resp Protocol (US)	SOAP Notes	06.0.R00.RES, NP, Protocol, R00, R
▼ 2wKoatemplate	Snoring-Seep Apnea (US)	SOAP Notes	06.0.R00.RES, 2wKoatemplate, ap
▼ npltb	NP - Laryngotracheobronchitis (croup) (US)	SOAP Notes	06.0.R00.RES, croup, Laryngotrach
▼ jhasthm	Asthma- Peds Initial Evaluation (US)	SOAP Notes	06.0.R00.RES, asthma, pediatric, R0
▼ fs08	Flu Shot 2008 (NG+++)	SOAP Notes	01.0.A00.GEN, 06.0.R00.RES, 2008
▼ aanpffast	Respiratory/Asthma (US)	SOAP Notes	06.0.R00.RES, ASTHMA, COOK, P
▼ FCFP	Cough (US)	SOAP Notes	06.0.R00.RES, COUGH, R00
▼ zsin	Sinusitis (US/NG)	SOAP Notes	06.0.R00.RES, protocol, R00, sinusit
▼ npbro	NP - Bronchitis (US)	SOAP Notes	06.0.R00.RES, Bronchitis, NP, R00
▼ BronchitisN	Bronchitis ST (NG+++)	SOAP Notes	06.0.R00.RES, Bronchitis, NG+++
▼ cwcnotesob	Dyspnea (NG) cwc	SOAP Notes	06.0.R00.RES, copd, cough, cwc, d
▼ hmeval2	Initial Eval Pulmonology (US)	SOAP Notes	06.0.R00.RES, hmeval2, pulmonary
▼ ConStrep-1	Strep Throat (US)	SOAP Notes	06.0.R00.RES, GABHS, R00, strep
▼ nptons	NP - Tonsillitis, strep (exudative) (US)	SOAP Notes	06.0.R00.RES, exudative, R00, strep
▼ chestpainx	Chest pain, brief (US/NG)	SOAP Notes	06.0.R00.RES, 08.0.K00.CIR, 11.0.1
▼ zc	Cough protocol (US/NG)	SOAP Notes	06.0.R00.RES, bronchitis, cough, R0
▼ URlcrosby	URI (US) TC's	SOAP Notes	06.0.R00.RES, crosby, infection, R0
▼ npast	NP - Asthma (US)	SOAP Notes	06.0.R00.RES, Asthma, NP, R00
▼ jbepistaxis	Epistaxis, nosebleed (NG+++)	SOAP Notes	06.0.R00.RES, epistaxis, jbepistaxis
▼ tvsinNG	Sinusitis (NG++) tv's	SOAP Notes	06.0.R00.RES, NG++, R00, sin, sinu
▼ FR LARYNGOM...	Laryngomalacia (US) KR's	SOAP Notes	06.0.R00.RES, LARYNGOMALACIA,
▼ zcopd	COPD (US/NG)	SOAP Notes	06.0.R00.RES, copd, protocol, R00
▼ .uri2	Upper resp infection (US)	SOAP Notes	.uri2.scw.witana, 06.0.R00.RES, 07
▼ npbroc	NP - Bronchitis, chronic (US)	SOAP Notes	06.0.R00.RES, Bronchitis, chronic, N

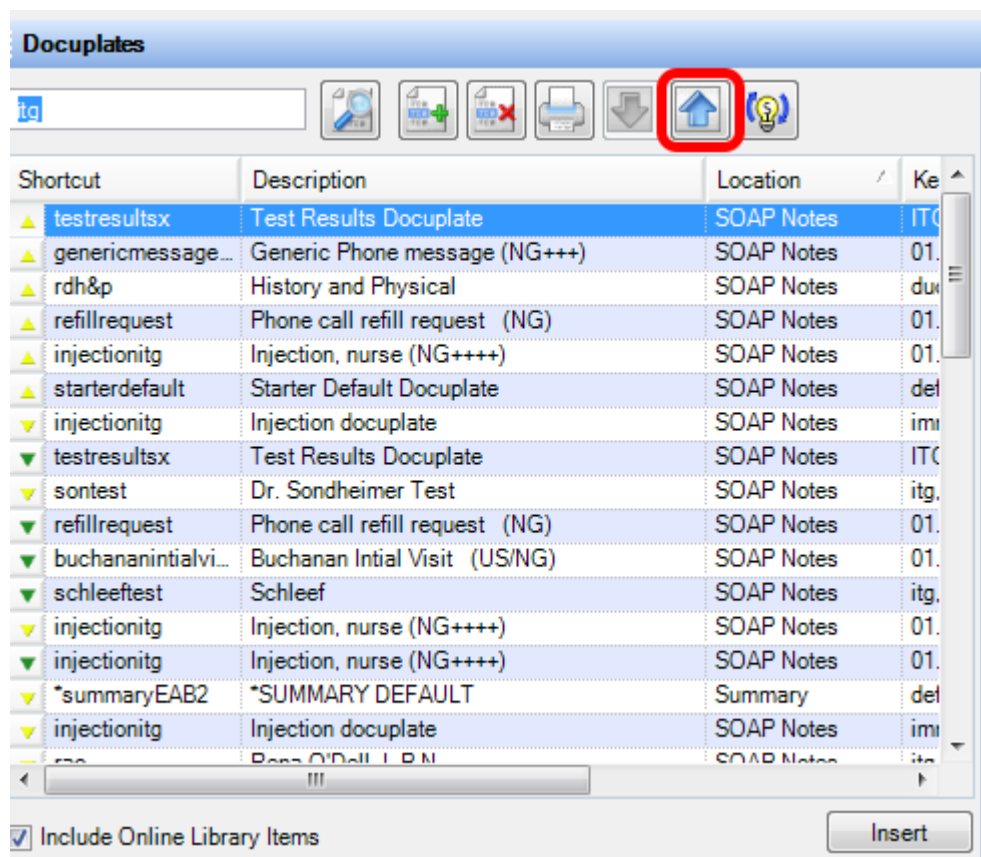
For example, a Pulmonologist or Allergist would like to only retrieve respiratory docuplates, search with R00 (R + zero + zero).

## Sharing and Downloading Docuplates

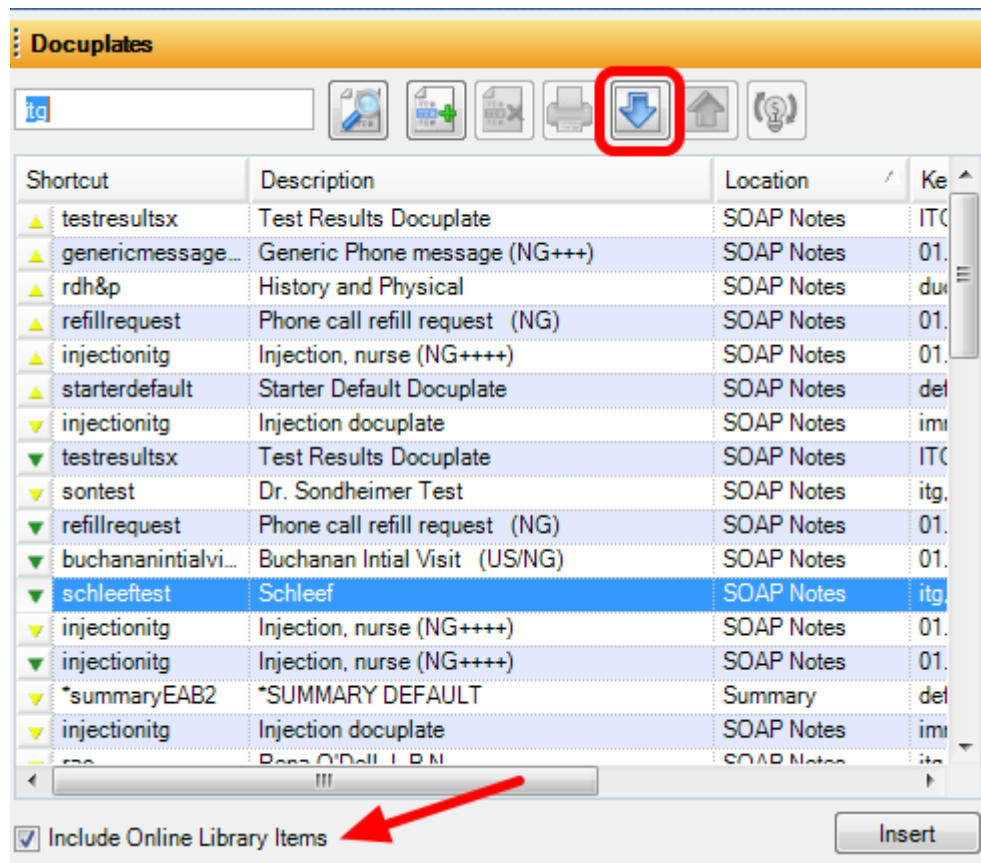
Checking the box to Include Online Library Items at the top of the Docuplates panel will expand a user's Docuplates list to include additional items available in the SOAPware Online Customizations Library.

**Time saver tip:** Before creating a docuplate from scratch, it can be beneficial to review existing Library Items to see if another user has shared a docuplate that meets another user's needs, or can serve as a template from which to base a customized docuplate. To help expand the Online Library content, please consider sharing docuplate designs with the rest of the SOAPware community.

### Upload



To share a docuplate, select the docuplate and Click the Upload button. It will be uploaded to the Online Library. Before sharing a docuplate, please make sure that no patient data is present in the docuplate.



To download a docuplate, Click the Download button in the library column of the desired docuplate. Include Online Library Items must be checked in order to view and download online docuplates.



## Docuplate Toolkit - Getting Started with Documentation

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The following segments introduce some more realistic items that may be used when creating documentation. Take time to play/practice, as this can help provide context, making further learning faster and easier.

### Starter Shortcuts



**Subjective**

CHIEF COMPLAINT:

HPI:

SYMPTOMS/RELATED: Reports symptoms of

LOCATION: Reports area of involvement as

QUALITY/COURSE: Reports condition is

INTENSITY/SEVERITY: Reports measurement ( or degree) as

DURATION: Reports the general length of symptoms to be

ONSET/TIMING: Reports occurrence as

CONTEXT/WHEN: Reports usually associated with

MODIFIERS/TREATMENTS: Improved by  
Has tried  
History of  
Past evaluation and/or work-up includes

ROS:

GEN- Constitutional: Reports symptoms of

SOAPNote

### SOAPnote

**Subjective:** Sub-

**Objective:** Obj-

**Plan:** Pla-

**Follow Up:** Fol-

### Summary

**Active Problems:** Act+

**Inactive Problems:** Ina-

**Surgeries:** Sur-

**Allergies:** All-



**Family History:** Fam-

**Tobacco:** Tobmu

**Alcohol:** Alc-

**Social History:** Soc-

## Using Starters

To use these shortcuts, simply type the shortcut into the corresponding field, then press the spacebar. This will expand the shortcut.

**Note:** This guide is about getting started; the focus is on simple demonstration, not full support of comprehensive charting. These abbreviated terms are provided only to assist in getting started.

*They are not comprehensive, and are not intended to contain all the items a user will use.*

## Additional Starter Shortcuts








**Subjective:** Sub-, Sub--, Sub=, Subt, ROSX, ChiX, nexc, nextd and nexs

**Objective:** Obj-, Objs, Objn, ObjX, ObjX1c, ObjX1n and ObjHA

**Plan:** Pla-

**Follow Up:** Fol-

## Starter Docuplates

Docuplates			
2008+		      	
Shortcut	Description	Location	Key
▼ InfC	Influenza (Compressed) (NG++++)	SOAP Notes	06.
▼ DM2	Diabetes - Type 2 (NG++++)	SOAP Notes	01.
▼ Sta2	Start #2 (NG++++)	SOAP Notes	09I
▼ Sta	Start - Routine or Default (NG++++)	SOAP Notes	09I
▼ IngToe	Ingrown Toenail (NG++++)	SOAP Notes	09I
▼ BacPaiNG	Back Pain (NG++++)	SOAP Notes	09I
▼ GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
▼ UriC	Upper Respiratory Infection (Compressed)...	SOAP Notes	09I
▼ PhaNG	Pharyngitis or Sore Throat (NG++++)	SOAP Notes	06.
▼ dmeab3	Diabetic Visit Template (NG+++)	SOAP Notes	01.
▼ DysNG	Dysuria (NG) 02-19-2009	SOAP Notes	09I
▼ Uritsp	Upper Respiratory Infection (Compressed)...	SOAP Notes	09I
▼ InfNG	Influenza (NG++++)	SOAP Notes	06.
▼ DM2	Diabetes - Type 2 (6-9-2009)	SOAP Notes	2. :
▼ Sta2	Start #2 (NG++++)	SOAP Notes	09I
▼ DM2	Diabetes - Type 2 (6-9-2009)	SOAP Notes	2. :
▼ BacPaiC	Back pain (Compressed) (NG++++)	SOAP Notes	09I
▼ IngToe	Ingrown Toenail, custom (NG++++)	SOAP Notes	09I
▼ URICustomA	URICustomA - URI encounter form demo	SOAP Notes	09I
▼ uri	URI Template (NG++++)	SOAP Notes	09I
▼ GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
▼ sthroat	Sore Throat Template (NG++++)	SOAP Notes	06.
▼ UriC	Upper Respiratory Infection (Compressed)...	SOAP Notes	09I
▼ Hea	Headache (NG++++)	SOAP Notes	09I
▼ GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
▼ EMCs	Starter (E&M Coding) (NG++++)	SOAP Notes	09I

Click Docutainers in the menu bar, then Click Docuplates (or Press F6). In the Docuplates Viewer, Type 2008+ in the Search field/box, and Click the Search button. This search will display Docuplates that contain SMARText Items. These are also known as New Generation Docuplates.

### Additional Starters - Comparing New Generation Docuplates

- PhaC** - Pharyngitis or Sore Throat (Compressed)
- GasC** - Gastroenteritis (Compressed)
- InfC** - Influenza (Compressed)
- URIC** - URI - Upper Respiratory Infection (Compressed)
- DysC** - Dysuria (Compressed) Female Cystitis
- IngToe** - Ingrown Toenail (Compressed)

Click on the docuplate description to select-highlight, then Click the Download button. Even though many of these docuplates may be associated with disorders rarely/never treated in the

practice, they may be useful in helping provide insight into complementary/alternative work flows.

- PhaNG** - Pharyngitis or Sore Throat (NG)
- GasNG** - Gastroenteritis (NG)
- InfNG** - Influenza (NG)
- URIC** - URI - Upper Respiratory Infection (NG)
- DysC** - Dysuria (NG) Female Cystitis
- IngToe** - Ingrown Toenail (NG)

It may be helpful to reduce the complexity of a downloaded docuplate item. After inserting the NG docuplate/template, Press Control + F9 to perform a Remove Unused Items command. This will immediately simplify the docuplate/template encounter format, revealing the basic organization/framework suggested for the documentation process. New Generation Docuplates that display many "+" in the generation, contain more SMARTText Items.

## General Purpose Starters

Docuplates				
<div>sta</div> <div> </div>				
Shortcut	Description	Location	Key	
▼ MMST	Mini Mental Status Test (US)	SOAP Notes	12.	
▼ msoap	StaO - Starter Outline (2-22-2009)	SOAP Notes	091	
▼ Ovw	Obesity (NG++)	SOAP Notes	01.	
▲ Sta	Start - Routine or Default (NG++++)	SOAP Notes	091	
▼ Sta	Start - Routine or Default (NG++++)	SOAP Notes	091	
▲ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▼ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▼ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▼ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▼ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▼ Sta2	Start #2 (NG++++)	SOAP Notes	091	
▲ StaD	Starter For Docuplates (NG++++) 02-27-2...	SOAP Notes	091	
▼ StaD	Starter For Docuplates (NG++++) 02-27-2...	SOAP Notes	091	
▲ StaE	Starter - Extended (NG) 02-10-2009	SOAP Notes	091	
▲ StaO	StaO - Starter Outline (2-22-2009)	SOAP Notes	091	
▲ starterdefault	Starter Default Docuplate	SOAP Notes	del	
▼ starterdefault	Starter Default	SOAP Notes	del	
▼ starterdefault	Starter Default Docuplate (7/13/2009)	SOAP Notes	itg.	
▼ starterdefault2	Starter Default Docuplate	SOAP Notes	del	
▼ starterdefault2	Starter Default Docuplate	SOAP Notes	del	
▼ starterdefault2	Starter Default Docuplate	SOAP Notes	del	
▼ STATEMENT P...	STATEMENT PROCEDURE	SOAP Notes	PA	
▼ Sutures	Sutures/staples (US)	SOAP Notes	14.	
▼ suzigahlpt	Physical Therapy (NG)	SOAP Notes	NG	
▼ suzigahlpt	Physical Therapy (NG)	SOAP Notes	NG	
▼ URI-1	URI docuplate created from URICustom	SOAP Notes	del	

Also download the docuplate/template that has "Sta" as a Shortcut and Start-Routine or Default as the Description. This can serve as a plain or generic starter for any type of encounter.

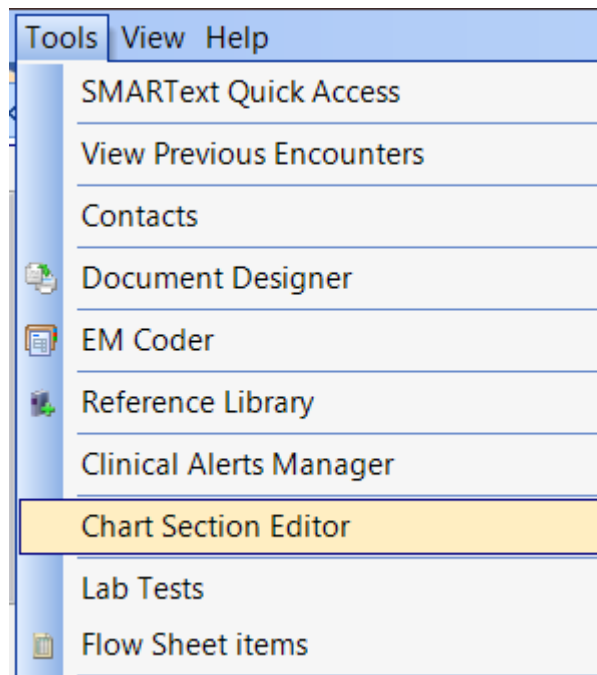
## Setting the Default Docuplate

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Docuplates allow common sets of document items for various chart sections to be saved and reused later. This capability is particularly useful for documenting common conditions seen repeatedly. They are also great tools for implementing Best Practice Guidelines and more consistency in documentation.

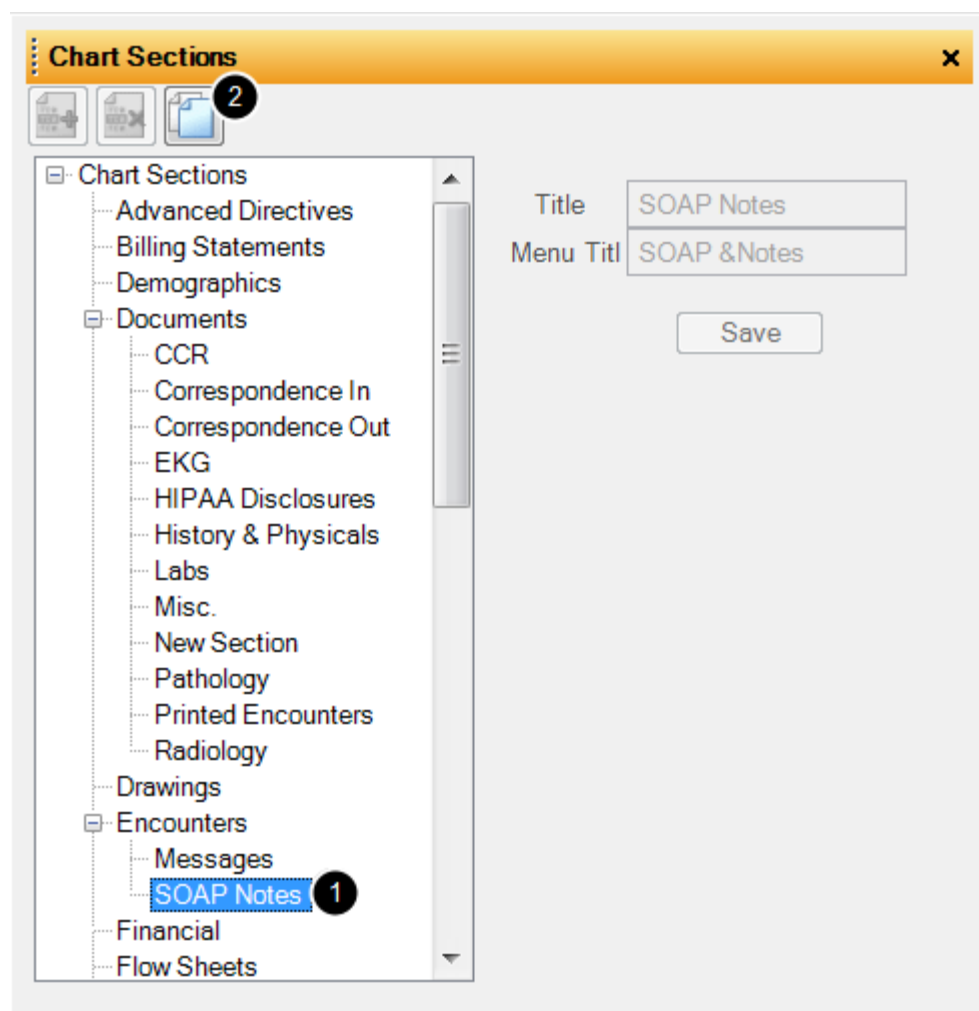
**NOTE: The default SOAPnote docuplate when SOAPware is installed is for Getting Started or Introduction purposes only. It needs replacement once users have completed the initial Introduction to SOAPware.**

### Open the Chart Section Editor



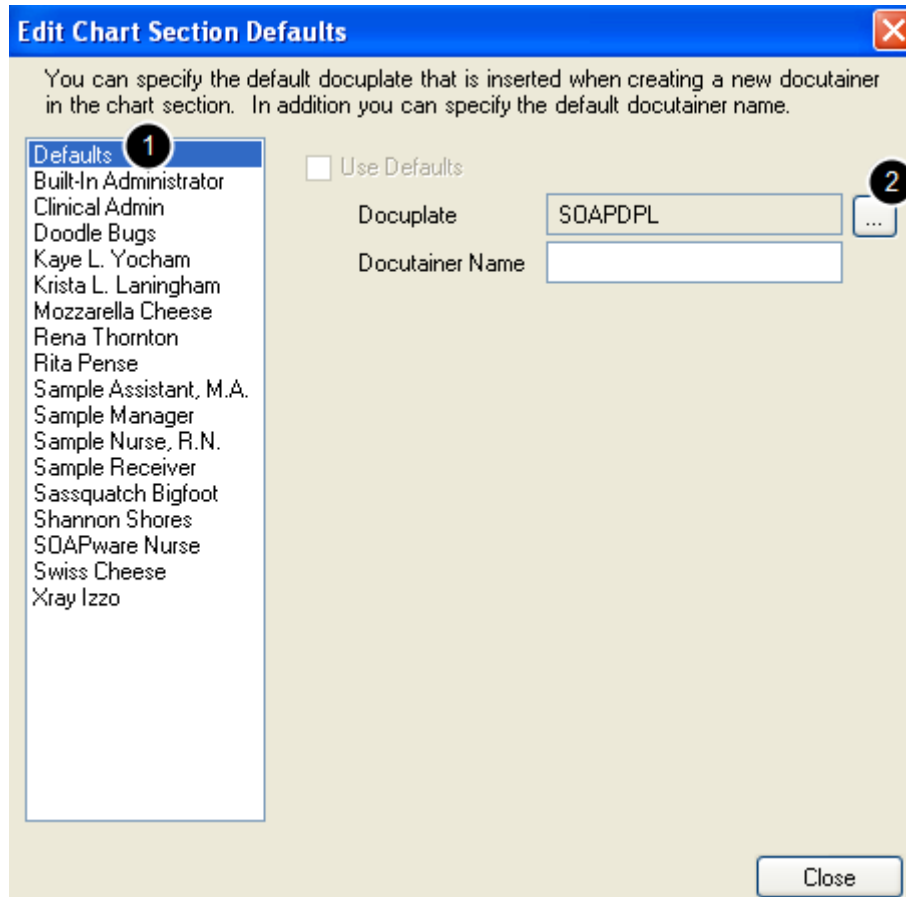
Click Tools > Chart Section Editor

## Select the Chart Section



In order to select a chart section for editing

1. Click the chart section list item of choice.
2. Then, Click Edit Section Defaults.

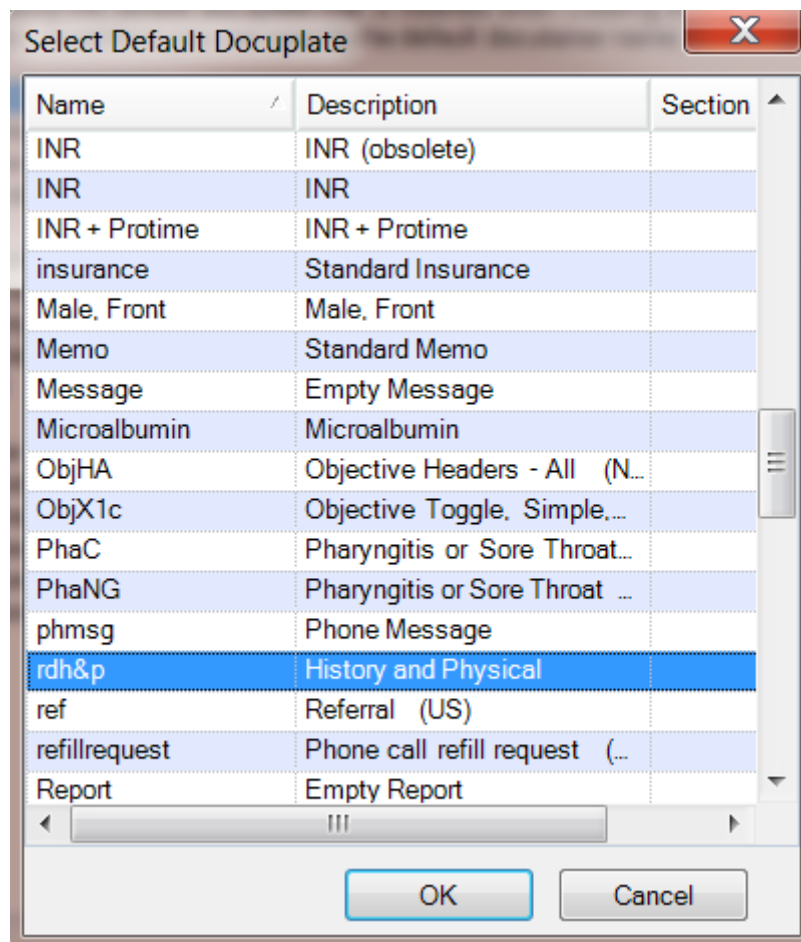


1. Click on the Defaults list item on the left to establish the default docuplates for the entire network (all users).

2. Click the Browse button to the right as shown in the screen shot above, to open Select Default Docuplates dialog.

**NOTE:** Clicking a User list item from the list, is the route to establish the default docuplates for that user only.

## Select Docuplate



1. Click the docuplate name list item to select as a default, and then Click OK.
2. In the subsequent dialog, Click Close.
3. Exit and restart SOAPware to activate the changes.

# Docutainers



## Intro to Docutainers

---

Docutainers are document managers used to control the display and editing of groups of similar Documents, e.g. Encounters or Reports. Docutainers correspond to sections of a paper chart that contain different kinds of patient information, similar to having separate folders inside a chart for encounter notes, x-rays, lab results, and other information.

The Docutainer List section exists in each Chart Section. It is located below the main docutainer viewer and is separated from the docutainer by a horizontal Splitter Bar.

**1** /Time 03/01/2011 2:21 PM Type Face to Face

Owner Jennifer Berg

Status

Description

Related Dx Influenza NOS

**2** **Objective**

COMPLAINT or ISSUE - Influenza.

HPI: SYMPTOMS/RELATED: Reports symptoms of fever, headache, muscle pain, diarrhea.

Denies symptoms of fatigue (malaise or lethargy).

QUALITY/COURSE: Reports condition is continuous, persisting.

INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.

ONSET/TIMING: Reports occurrence as sudden.

CONTEXT/WHEN: Reports usually associated with irritant exposure (smoke/dust/fumes).

MODIFIERS/TREATMENTS: Improved by exposure to others with similar symptoms, influenza vaccination NOT RECEIVED this season, OTC cough/decongestant.

ROS: LUNGS/Respiratory: Denies symptoms such as sputum/phlegm production that is purulent.

**Objective**

**3**

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description
3/1/2011 2:21:12 PM	Jennifer Berg		
2/18/2011 9:18:51 AM	Jennifer Berg	Complete	Hypertension
2/11/2011 7:52:11 AM	Jennifer Berg		Test lists
2/10/2011 9:44:17 AM	Jennifer Berg		Tuberculosis

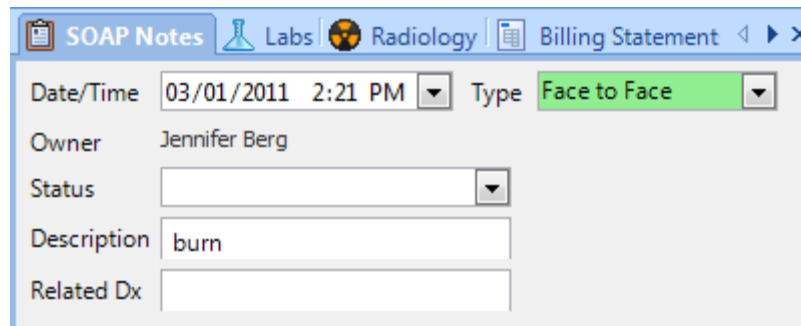
Although the exact functionality of a docutainer varies depending on the specific type and purpose, the one thing all docutainers have in common is that they act as containers and managers for documents.

Most Docutainers consist of three parts:

1. A document info sliding panel at the top
2. A document list sliding panel at the bottom
3. A document viewer area in the middle.

Depending on the type of document, one or more of the parts listed above may not be available, or their appearance may differ slightly.

## Document Info Panel

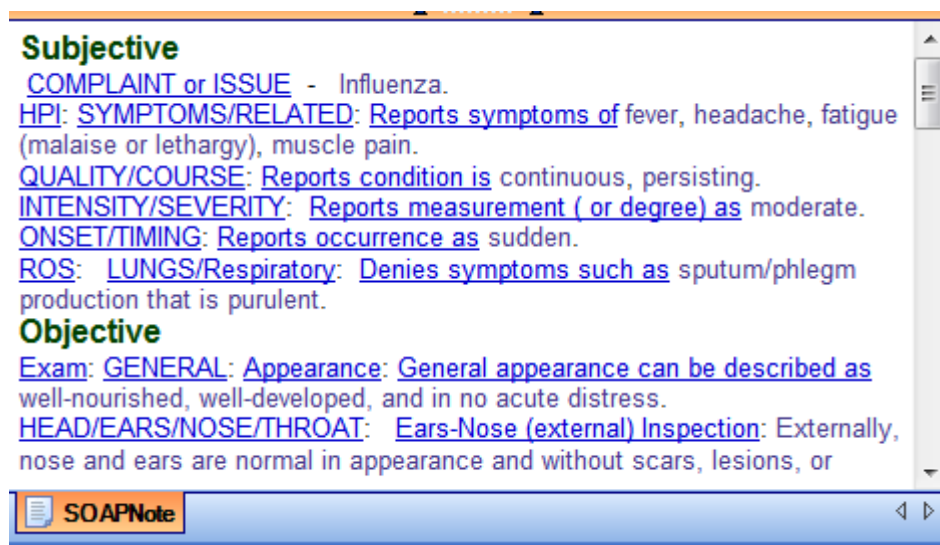


The screenshot shows a software interface with a tabbed menu at the top containing 'SOAP Notes', 'Labs', 'Radiology', and 'Billing Statement'. The 'SOAP Notes' tab is active. Below the tabs, there are several input fields: 'Date/Time' is set to '03/01/2011 2:21 PM' with a dropdown arrow; 'Type' is set to 'Face to Face' with a dropdown arrow; 'Owner' is 'Jennifer Berg'; 'Status' is an empty dropdown menu; 'Description' contains the text 'burn'; and 'Related Dx' is an empty text box.

The document demographic panel displays information about the specific document that is currently open. It appears as a bar at the top of the Docutainer.

Pointing the cursor at the bar will cause it to expand, and Clicking the pin will lock it in the open position. The information displayed depends upon the specific document type. (For details, refer to the documentation for the specific type of document.)

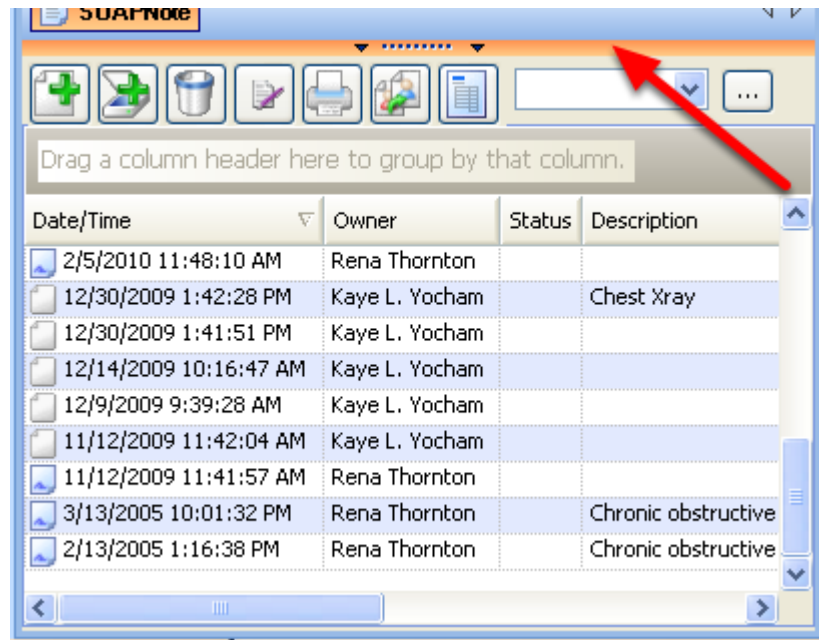
## Document Viewer



The screenshot shows a document viewer window with a blue header bar. The main content area displays a SOAP Note. The 'Subjective' section is highlighted in green and includes the following text: 'COMPLAINT or ISSUE - Influenza.', 'HPI: SYMPTOMS/RELATED: Reports symptoms of fever, headache, fatigue (malaise or lethargy), muscle pain.', 'QUALITY/COURSE: Reports condition is continuous, persisting.', 'INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.', 'ONSET/TIMING: Reports occurrence as sudden.', and 'ROS: LUNGS/Respiratory: Denies symptoms such as sputum/phlegm production that is purulent.' The 'Objective' section is also highlighted in green and includes: 'Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.', 'HEAD/EARS/NOSE/THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or'. At the bottom of the window, there is a blue bar with a 'SOAPNote' tab and navigation arrows.

The document viewer area displays the document content, in the appropriate format for that particular document type. (Refer to the Document instructions for full details.)

## Document List



The document list panel displays a list of documents along with some basic document details. This list is used to select and display document details, the document list panel appears as a bar at the bottom of the Docutainers, with the name of the document type.

Pointing the cursor at the splitting bar will cause it to expand. The column headings in the list depend on the type of document being displayed, but they typically include information such as document names, dates, and authors. Clicking on a document in the list will display that document in the viewer. (For details, refer to the documentation for specific documents.)

## Document Control



Above the docutainer list is a set of action buttons in a mini-toolbar.

## Create Document



The button highlighted above is used to add a new docutainer of the current type (chart section).

## Remove Documents



Used to remove one or more selected docutainers from the list or current docutainer. The user can select multiple docutainers by holding down the control or shift key while Clicking on docutainers in the list.

**Note:** Only unsigned docutainers may be removed.

## Sign Documents



Used to sign one or more selected docutainers from the list. The user can select multiple docutainers by holding down the control or shift key while Clicking on docutainers in the list.

## Print Documents



Prints the currently selected docutainer item.

## Reassign Documents

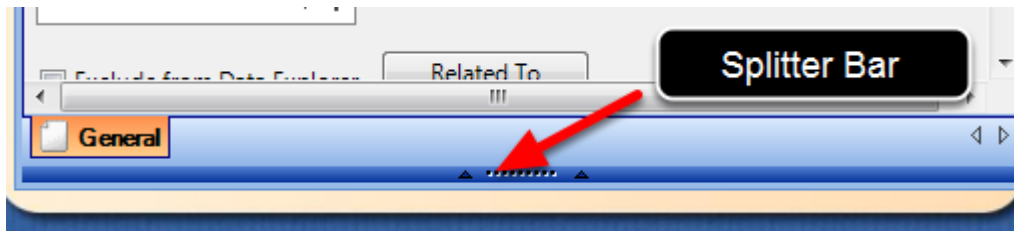


Used to assign one or more selected docutainers from the list to another provider. The user may select multiple docutainers by holding down the control or shift key while Clicking on docutainers in the list.

## Splitter Bars

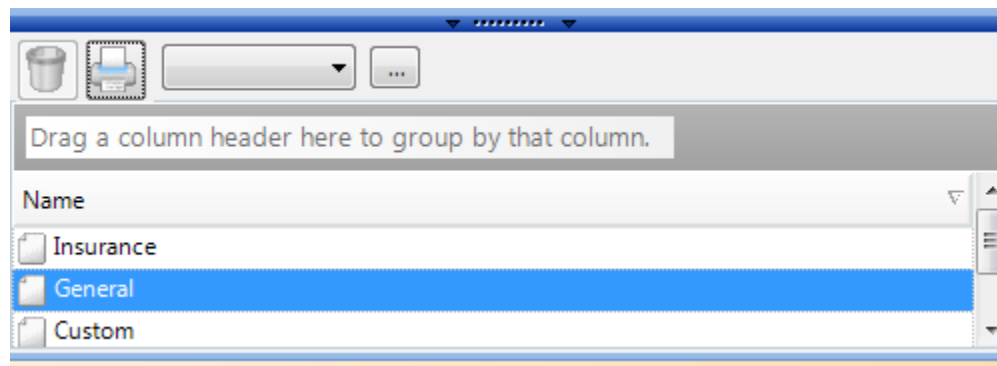
Splitter Bars are blue bars with arrows and dots in the center of them. When clicked on, they will collapse or expand to display more information, buttons, document lists, etc. They are also designed where the user can click on them to resize them.

### Lower Splitter Bar



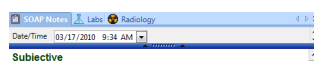
In the image above, we are looking at the lower splitter bar at the bottom of the Demographics chart section. Notice that the arrows in the center of the splitter bar are pointed upwards. This is a visual indicator that when we left click on the splitter bar, the bar will move upwards, and will display hidden features. See image below.

### Change Docutainer View



We are now able to change the Demographics view from "General" to "Insurance" or "Custom", and can even print out Demographics. Notice that the arrows on the lower splitter bar are now pointed down. This is a visual indicator that when we left click on the splitter bar, the bar will collapse back down.

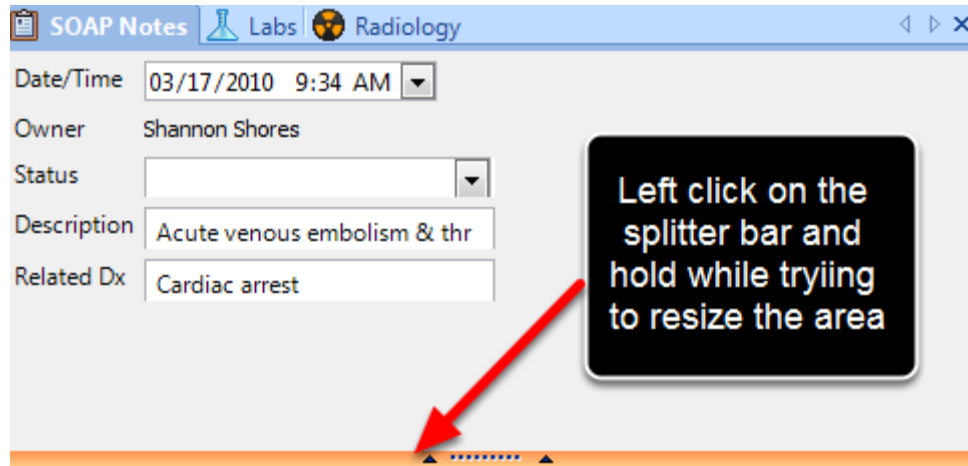
### Upper Splitter Bar



The above image displays an upper splitter bar in the SOAPnotes chart section. Currently, we are able to view the date and time this encounter note was created. If we left click once on the splitter bar, the splitter bar will move upwards and hide this information. If we left click on the splitter bar

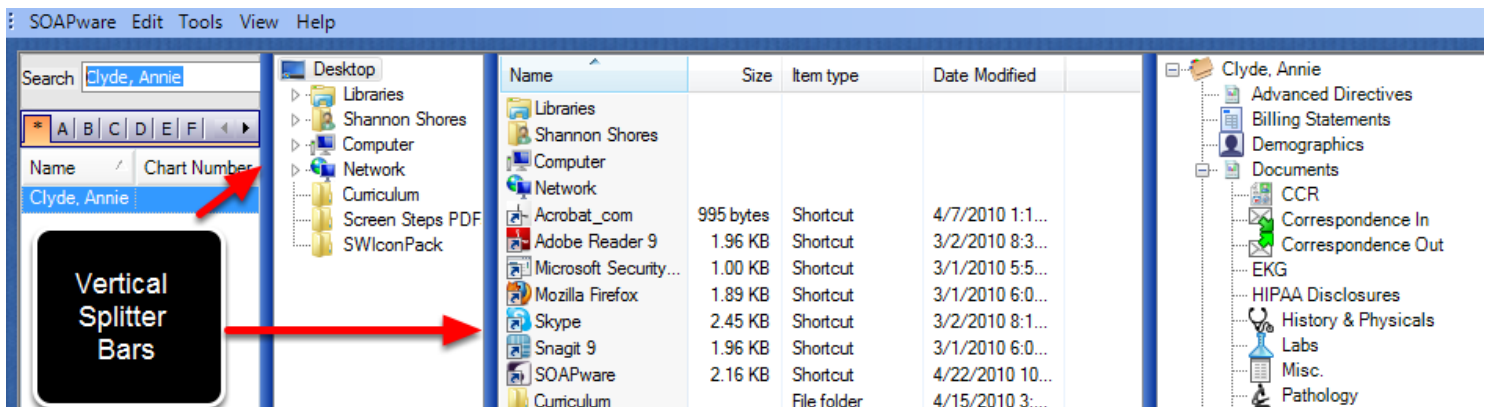
and drag our mouse down, we will resize the area and be able to view more document/docutainer information on the encounter note. View image below.

## View/Hide Document Information



This image displays more document/docutainer information after the splitter bar was drug downwards and resized. Notice that when a splitter bar is being resized, the bar will change from the color blue, to the color orange.

## Vertical Splitter Bar



There are also vertical splitter bars. These bars mainly respond to resizing.

## Finding Docutainer Documents via Chart Navigator

---

There will be times when documents need to be viewed that are contained within chart sections other than the ones currently visible in the Chart Layout. Chart Navigator provides a complete table of contents for the entire chart and all chart sections.

### Chart Navigator

The Chart Navigator is divided into two main areas. The left side lists the Chart Sections, and the right displays Docutainer-Document Lists. Click a Chart Section (on the left) in order to display (on the right) a list of docutainers/documents for that section.

To learn about Chart Navigator, see: [Chart Navigator](#).

### Chart Navigator Views

To learn more about Chart Navigator Views, see: [Chart Navigator Views](#)



# Summary Documentation

## Intro to Summary

---

**\*REQUIRED FOR SEVERAL MEANINGFUL USE CORE REQUIREMENTS:** [Click here to view the Meaningful Use Roadmap.](#)

This lesson will cover how to access the Summary chart section and a description of each of the fields contained within the Summary.

The Summary chart section is used for documenting the patients medical history.

### Accessing the Summary Chart Section



1. Within the Chart Workspace, open a patients chart.
2. Click on the Summary chart tab to display the Summary chart section (as shown above).

### Summary Fields

By default the Summary chart section contains the following fields:

- \* **Active Problems:** Current or active medical problems.
  - \* **Inactive Problems:** Previous or inactive medical problems.
  - \* **Surgeries:** List of surgeries and/or procedures.
  - \* **Medications:** Current or active medications.
  - \* **Allergies:** List of drug and non-drug allergies.
  - \* **Family History:** Family medical history.
  - \* **Tobacco:** Past and present tobacco use history.
  - \* **Alcohol:** Past and present alcohol use history.
  - \* **Intervention:** Miscellaneous field that may include things such as last significant medial testing and/or lab work.
  - \* **Social History:** List of social issues such as living situation, support systems, etc.
- \* **Note:** When a patient has a negative history for Active Problems, Medications, or Allergies,

documentation must be entered by using the shortcut to enter the SMARTText Item appropriate for each field. Meaningful Use requires that the involved fields have structured data recorded. Please see: [Using No Known SMARTText Items Types in the Summary](#) for more information.

The following fields are from previous versions of SOAPware and are rarely used in more current versions of SOAPware:

- \* **ROS:** Stores a review of systems related to the various organ systems.
- \* **Physical:** Stores a physical examination for easy retrieval.

The screenshot shows a window titled "Summary" with tabs for "Vital Signs" and "Demographics". The main content area displays a template for a medical summary with the following sections and links:

- Active Problems**  
[Starter - Active Problems:](#)
- Inactive Problems**  
[Starter - Inactive Problems:](#)
- Surgeries**  
[Pick List - Surgeries](#)
- Medications**
- Allergies**  
[Starter - Allergies - Summary:](#)
- Family History**  
[Positive family history for -](#)  
[Negative family history for -](#)  
[PARENTS:](#)  
[CHILDREN:](#)  
[GRANDPARENTS:](#)  
[SIBLINGS:](#)  
[UNCLES/AUNTS:](#)  
[OTHERS/DISTANT:](#)
- Tobacco**  
[Smoker Status:](#)  
[Tobacco use:](#)  
[Tobacco cessation:](#)
- Alcohol**  
[Starter - Alcohol - Summary](#)
- Interventions**
- Social History**  
[Starter Pick List - Social History](#)
- ROS**
- Physical**

The window has a "Summary" tab selected at the bottom.

When SOAPware is installed, the default Summary docuplate will be set to "Summary-DPL" which is seen above. This is a good starter docuplate to use that also allows for an introduction to using SMARText Items and Pick Lists in a user's Summary documentation. A user can modify or

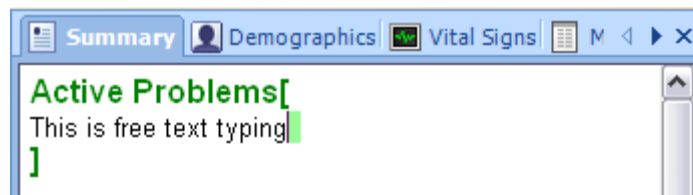
set the default to another docuplate if desired.

## Summary Documentation

There are many different methods and styles for creating documentation within SOAPware. In this introduction to Summary documentation, we will demonstrate the two most common methods of documenting in the Summary chart section.

1. Free Text or Unstructured Data
2. SMARText or Structured Data

## Free Text or Unstructured Data



It is not mandatory that the user uses structured documentation for his/her patients. A user can always document in the Summary chart section as though it was a word processor by just typing the documentation manually. To do this, simply click within one of the Summary fields and type between the bold green brackets as shown above. A user can highlight, delete, backspace, and insert text easily using this method of data entry.

Free text data entry is not searchable nor is it reportable for meaningful use. It would be to a user's advantage to start structuring more of the documentation because it will make the user more efficient and give the user data that is both searchable and reportable.

## Using No Known SMARText Item Types in the Summary

SOAPware now includes new No Known SMARText Item Types that may be used in the Summary to document a negative history for the Active Problems field, Surgeries field, Medications field, and Allergies field.

**\*THIS LESSON CONTAINS MEANINGFUL USE REQUIREMENTS**

### Updating or Re downloading the No Known SMARText Items

The screenshot shows the SOAPware Summary window with three sections, each containing a SMARText item table:

- 1 Active Problems[**  
Shortcut: nopro  
Table:

QA	Description	Shortcut	Type	Usage
▼	"No problems" (no disease - V65.9)	NoPro	No Known Items	0
- 2 Medications[**  
Shortcut: nomeds  
Table:

QA	Description	Shortcut	Type	Usage
▼	"Current Meds: None." (ID-Ignore)	NoMeds	No Known Items	0
- 3 Allergies[**  
Shortcut: nkda  
Table:

QA	Description	Shortcut	Type	Usage
▲ 1	"Drug Allergies. No Known."	NKDA	Structured Text	0
▼	"Drug Allergies. No Known."	NKDA	No Known Items	0

Previously used (SOAPware 2010 and earlier) Structured Text items for "No Problems", "No Medications" and "No Known Allergies" will not calculate properly for Meaningful Use. **A user must update or re-download these SMARText Items** to capture the newly created "No Known Items" that are required for Meaningful Use when documenting.

To re-download the new "No Known Items", enter the shortcut code (shown below) and Press Shift F11 to search the SOAPware online library. Double-click on the SMARText Item with the type of "No Known Items" to download it to your library. If SOAPware prompts to overwrite the current item on the system, select "Yes" to replace the old "Structured Text" item.

#### **Shortcut code**

nopro = No Problems

nomeds = Current Meds: None

nkda = Drug Allergies: No Known

Active Problems[

nopro

]

Inactive Problems

Surgeries

surno

Medications

nomeds

Allergies

nkda



The Active Problems, Surgeries, Medications, and Allergies field of the Summary may not be left blank. Even if a patient has a negative history for these specific fields, it must be documented that No Known history has been determined.

Type the shortcut into the appropriate Summary field to extend the No Known SMARText Item Type for the field. If the item has never been used and not in the local database for the user, a Shift + F11 search will need to be performed for the first time it is used. After the item has been downloaded to the database, the user will only need to Press the spacebar on the keyboard to extend the SMARText Item Type.

The shortcut for the following Summary fields for No Known SMARText Item Types:

**Active Problems-** "NoPro"

**Surgeries-** "SurNo"

**Medications-** "NoMeds"

**Allergies-** "NKDA"

### **\*REQUIRED FOR MEANINGFUL USE CORE REQUIREMENTS:**

- Maintain Problem List
- Active Medication List
- Medication Allergy List

### Active Problems[

No problems

]

### Inactive Problems

### Surgeries

[No history of any major surgeries:](#)

### Medications

Current Meds: None.

### Allergies

Drug Allergies. No Known.

Using No Known SMARText Item Types will record documentation as structured data.



## **TIP: Docking SMARText Quick Access**

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It is recommended that the user keeps SMARText Quick Access docked and pinned open on the right side of the the SOAPware screen to view Pick Lists. See this link for instructions - [Docking SMARText Quick Access](#).

## Active Problems

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This lesson will demonstrate how to insert the Active Problems Starter Pick List if the user's Summary docuplate does **not** already contain the Starter Pick List. This lesson will also describe how to use the Active Problems Starter Pick List.

### **\*REQUIRED FOR MEANINGFUL:**

- [Maintain Problem List](#)
- [Patient Lists](#)

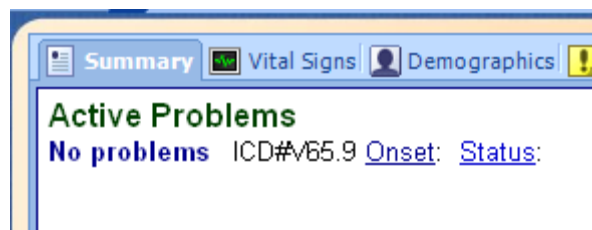
### **Patient Meaningful Use Dashboard:**

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#).

### Summary Active Problems Field

The Active Problems field in the Summary is for recording all medical problems the patient is currently being treated for.

### Recording "No Problems"

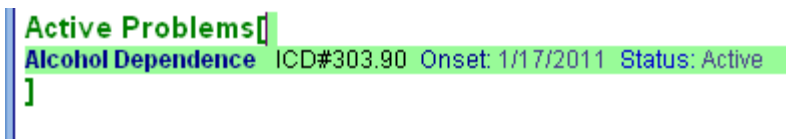


When a patient has a negative history for Active Problems, documentation must be entered as structured data by using the SMARText Item for "No Problems".

Type "NoPro" into the Active Problems field and Press the space bar. This will expand into the structured data required for this field if there are no active problems history for the patient.

\*Note: Users will need to re-download the "NoPro" SMARText Item for use within SOAPware. For instructions on re-downloading this item, please see: [Using No Known SMARText Item Types in the Summary](#).

## Entering a Problem Using Shortcut Codes



Click somewhere just below the Active Problems field header in the Summary. Type the diagnosis shortcut code and then press the space bar (example: type "AlcDep" (a shortcut code for a Structured Dx SMARTText item that indicates alcohol dependence)).

Regarding Shortcut Codes:

1. A SMARTText item can only have one Shortcut.
2. Not all SMARTText items have Shortcuts.
3. Users can add and change Shortcuts to meet their preferences.

## Entering a Diagnosis Using Keywords

**Active Problems[**  
depression

Enter the "Keyword" then press Shift + F11.

QA	Description	Shortcut	Type	Usage
▲	"Severe recurrent major depression without psychotic behavior" (ICD-296.33)	SevRecMD	Dx	1
▲	"Depression with anxiety" (ICD-300.4)	DepAnx	Dx	1
▲	"Depression" (ICD-311.00)	Depres	Dx	1
▲	"Major depression, single episode" (ICD-296.22) **	MajDepS	Dx	1
▲	"Affective psychosis" (ICD-296.90)	AffPsy	Dx	1
▼	Endogenous depression, recurrent episode		Dx	1
▼	Reactive depression		Dx	1
▼	Cerebral depression in newborn		Dx	1
▼	"Major Depressive Disorder, Single Episode, In Full Remission" (296.26)	MajDepDS...	Dx	1
▼	"Bipolar I Disorder, Most Recent Episode Manic, Mild" (296.41)	BipDisMRE...	Dx	1
▼	"Cyclothymic Disorder" (301.13)	CycDis	Dx	1
▼	"Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission" (296.45)	BipDisMRE...	Dx	1
▼	"Recurrent major depression" (NOS - ICD#296.30)	c296.30	Dx	1
▼	"Bipolar I Disorder, Most Recent Episode Depressed, Moderate" (296.52)	BipDisMRE...	Dx	1
▼	"Depression with psychosis" (ICD-296.20) **	DepPsy	Dx	1
▼	"Family tension" (ICD#V61.9)	FamTen	Dx	1
▼	Major Depression, Recurrent, NOS	29630	Dx	1
▼	Severe recurrent major depression without psychotic behavior		Dx	1
▼	Multi-infarct dementia with depression		Dx	1
▼	"Bipolar I Disorder, Most Recent Episode Mixed, Severe 'With Psychotic Features'" (296.64)	BipDisMRE...	Dx	1
▼	"Dysthymia" (nonspecific - ICD#311)	Dys	Dx	1
▼	"Cyclothymic disorder" (301.13)	CycDis	Dx	1
▼	Major depression, single episode NOS	29620	Dx	1
▼	"Adjustment Disorder 'With Depressed Mood'" (309.00)	AdjDisDM	Dx	1

Find

☐ Show Unused

To search for a SMARText diagnosis item by using a keyword, Type the keyword into the Active Problems field (ex: "depression") and then press Shift + F11 on the keyboard to view the search results. The Shift + F11 search will allow the user to view list of diagnosis items that are located on the local library AND on the SOAPware Online Library. An F11 search may also be used to view only a list of SMARText items that are on the local library.

Double-click on the desired SMARText Item to enter it into the patient's Active Problems field.

Regarding Keywords:


1. A SMARText item can have an unlimited number of Keywords.
2. No SMARText item has every possible Keyword that users prefer.
3. Users can add Keywords to meet their preferences.
4. The longer the Keyword (i.e. typed entry to search), the faster the search.

## Selecting a Diagnosis from a Shift+F11 Search

When items in the online library are selected from the pop-up list and inserted (as shown above with depression), SOAPware automatically:

1. Downloads the item.
2. Adds the item to the local library.
3. Inserts the item into the field at the insertion point.

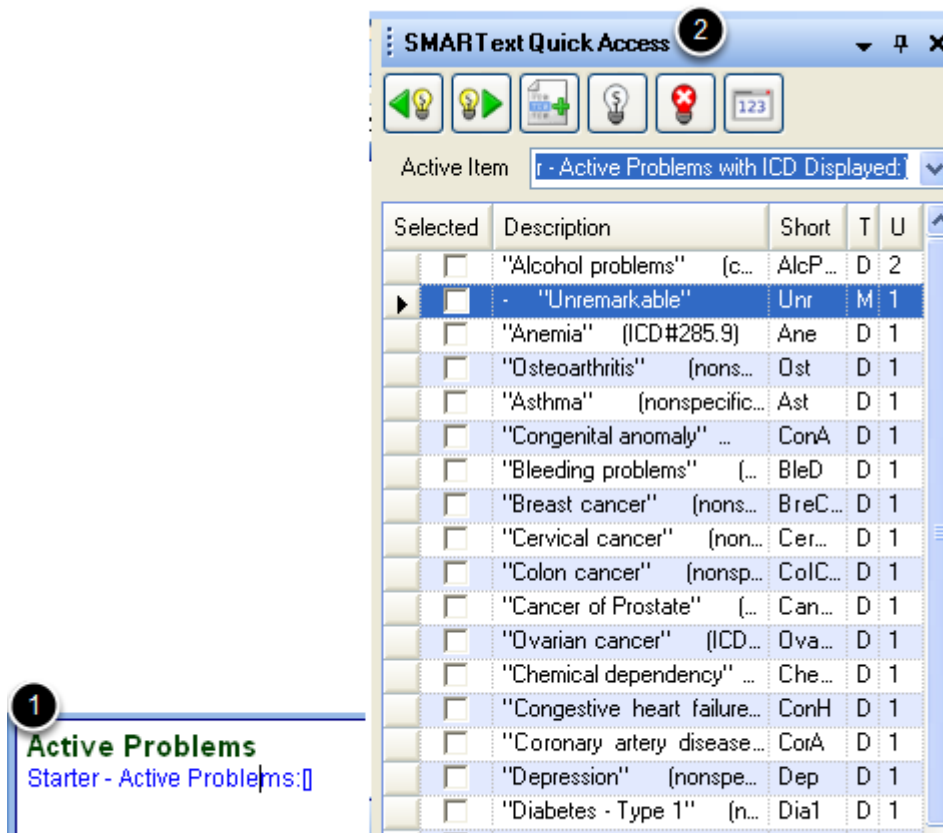
## Entering a Diagnosis using a Starter Pick List

A screenshot of a software interface showing a text field labeled "Active Problems[" with a green highlight. Below the field, a blue line indicates a starter pick list: "Starter - Active Problems: |". A green bracket is positioned to the right of the pick list text.

The Active Problems starter pick list contains a list of some of the most common diagnosis items.

To enter the Starter Pick List for Active Problems, Type the shortcut code "act+" into the Active Problems field then Press the spacebar.

**Note:** The first time this Pick List is used, it must be downloaded from the SOAPware Online Library. To download the pick list, Type "act+" into the Active Problems field and Press Shift + F11 on the keyboard. Double-click on the appropriate item in the search results window to download the Pick List to the database.



In SOAPware, text that appears Blue and Underlined indicates that a Pick List is attached to the SMARTText Item.

1. Left click on the Pick List header (ie: Starter - Active Problems)
2. A list of diagnosis items will appear in the SMARTText Quick Access window.

## Choosing Items from the Active Problems Pick List

The screenshot shows the SOAPware interface. At the top, there's a toolbar with icons for undo, redo, save, delete, and a numeric keypad. Below the toolbar is a dropdown menu labeled "Active Item" with the text "rter - Active Problems with ICD Displayed - Short List". Below this is a table with columns: Selected, Description, Short, Type, and Usage. The table lists various medical conditions. Two items, "Anemia" and "Coronary artery disease", are selected, indicated by checkmarks in the "Selected" column. To the right of the table is a box labeled "Active Problems[" with a closing bracket "]". Inside this box, the selected items are listed: "Anemia [ICD#285.9 Onset: 2/21/1999 Status: Active]" and "Coronary artery disease ICD#414.01 Onset: 12/30/2008 Status: Active". A green arrow points from the "Selected" column of the table to the "Active Problems" box. A red circle with the number 1 is around the "Selected" column header, and a red circle with the number 2 is around the "Active Problems" box.

Selected	Description	Short	Type	Usage
<input type="checkbox"/>	"Breast cancer" (nonspecific...	Bre...	Dx	2
<input type="checkbox"/>	"Unremarkable"	Unr	Multi...	1
<input type="checkbox"/>	"Alcohol dependance, in remis...	AlcD...	Dx	1
<input checked="" type="checkbox"/>	"Anemia" (ICD-285.9)	Ane...	Dx	1
<input checked="" type="checkbox"/>	"Asthma" (nonspecific - 493...	Asth...	Dx	1
<input checked="" type="checkbox"/>	"Coronary artery disease" (n...	Cor...	Dx	1
<input type="checkbox"/>	"Diabetes - Type 1 " (nonspe...	Dia1	Dx	1
<input type="checkbox"/>	"Diabetes - Type 2 " (nonsp...	Dia2	Dx	1
<input type="checkbox"/>	"Glaucoma" (nonspecific - IC...	Glau...	Dx	1
<input type="checkbox"/>	"Hearing loss" (nonspecific - ...	Hea...	Dx	1
<input type="checkbox"/>	"Benign hypertension" (ICD#...	Ben...	Dx	1
<input type="checkbox"/>	"Migraine" (nonspecific - ICD...	Migrai	Dx	1

With the Active Problems Pick List displayed in the SMARText Quick Access window:

1. Users should Click in the box in the "Selected" column next to each of the items that he/she wants to insert into the Active Problems field.
2. When the items are inserted, the Starter Active Problems header will disappear.

## Optional Sub Items

The screenshot shows the "Active Problems[" field in the SOAPware interface. It contains two entries: "Alcohol Dependence ICD#303.9 Onset: 1/17/2000 Status: Active" and "Anemia ICD#285.9 Onset: 1/17/2011 Status: Active". Red boxes highlight the "Onset" and "Status" sub-items for each entry. A red circle with the number 1 is around the "Active Problems[" header, and a red circle with the number 2 is around the "Onset" and "Status" sub-items.

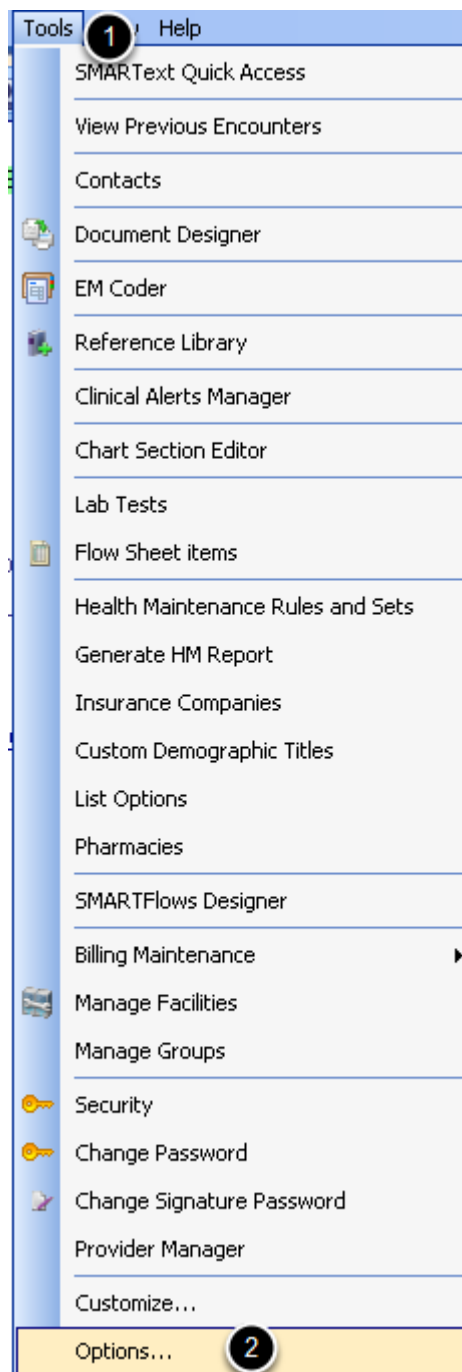
In SOAPware 2011+, the user can now use some new sub-items to assist with maintaining the Problem list. The Onset and Status sub-items are optional for the user.



Users can now utilize a sub-items to indicate Onset date and Status. The Status sub-item provides the following options:

- \* Active
- \* Inactive
- \* Resolved
- \* Undetermined
- \* Chronic



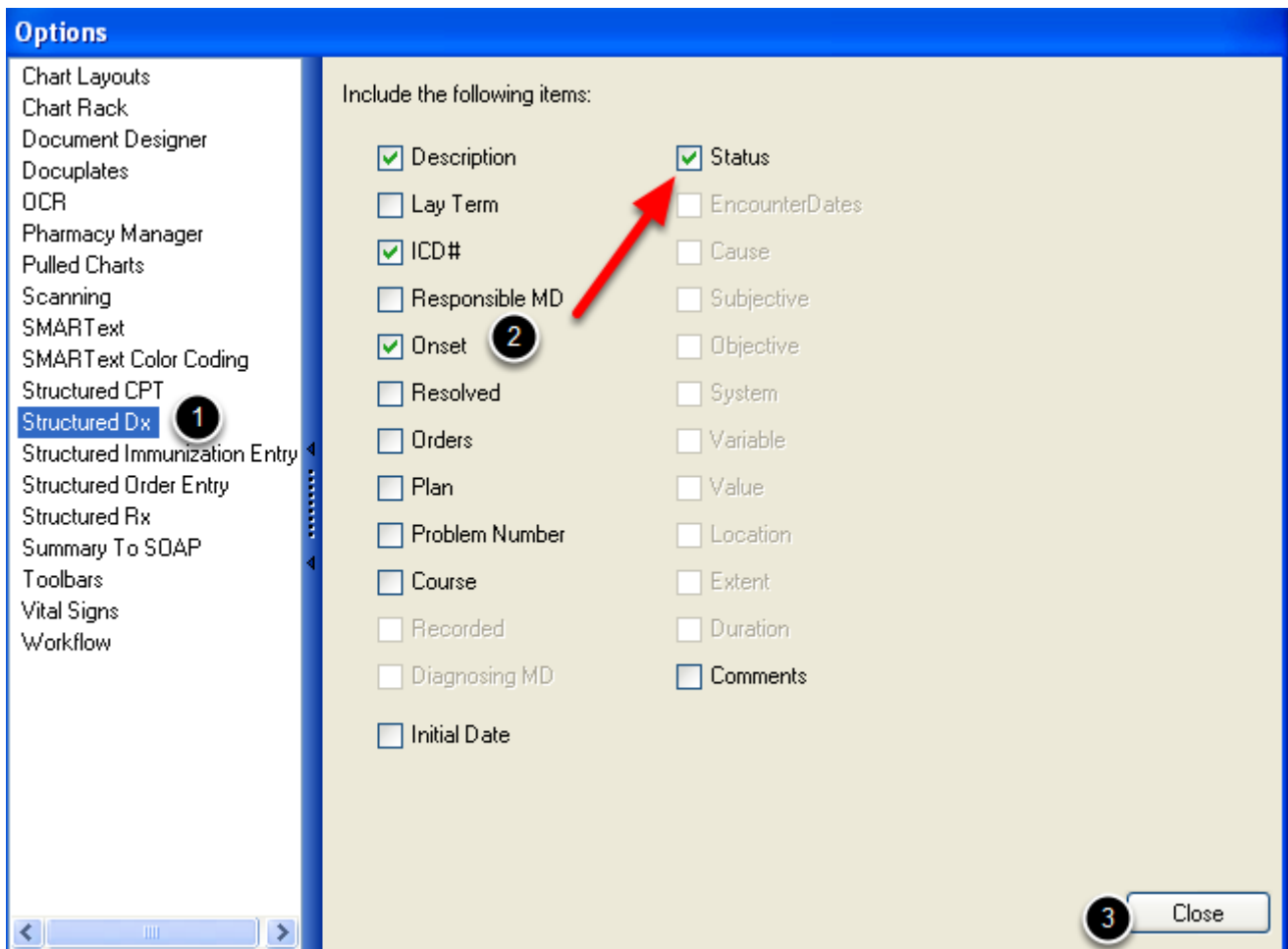


If a user wishes to utilize any of the optional sub-items within the Active Problems list, the desired sub-items must be defined in the users Options.

To define these options:

1. Click on Tools.
2. Select Options.

## Setting Default Sub Items: Structured Dx



1. Select "Structured Dx." from the options menu.
2. Click to place a check in the boxes next to the desired sub-items (ie: Onset and Status).
3. Click on Close.

SOAPware will then require the user to log out and log back in to save the changes. Once the user has logged back in, the newly selected sub-items will now appear by default each time a SMARText diagnosis item is entered.

This is a user-specific setting.

## SOAPware Learns Users' Preferences

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After some time, and the insertion of several SMARTText items into some of the Summary fields, go back and see how SOAPware has learned a user's preferences. In order to see choices a user has made in the past, simply click in a field and SOAPware Quick Access displays the items a user has previously used. SOAPware actually counts the usage, automatically ranking the items in the list accordingly.

### Train and Practice the Summary Fields

Users should consider taking some time to teach SOAPware a little bit about his/her preferred items. The simplest way to do this is to create a practice chart, then find/insert the most commonly used items into the appropriate fields.

**NOTE:** SOAPware stores each user's usage patterns separately so that the list in Quick Access is unique to each user.

## Inactive Problems

---

This lesson will demonstrate how to insert the Inactive Problems Starter Pick List if the Summary docuplate does not already contain the Starter Pick List.

The Inactive Problems field in the Summary is for recording all the medical problems the patient has had in the past but is not currently being treated for at this time.

### Placing of the Insertion Point

A screenshot of a software interface showing the text "Inactive Problems[" in green. A small green cursor is positioned at the end of the opening bracket, indicating the insertion point.

With a patient's chart open and the Summary chart section visible:

1. Place the insertion point to the right of the field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), the the field is active and ready for data.

### Inserting the Starter Pick List for Inactive Problems

A screenshot of the software interface showing "Inactive Problems[" in green. Below the opening bracket, the text "ina-" is entered in green, and a small green cursor is at the end of it.

To insert the Starter Pick List for the Inactive Problems:

1. Type ina- into the Inactive Problems field (as shown above)
2. Press the Spacebar to expand the Pick List.

**Note:** If the Pick List does not expand when the Spacebar is pressed, the user may need to do a *Shift + F11* search to download the item to the local database. After the user has used the Pick List once, the user will be able to expand it using the Spacebar method.

See this link for searching instructions: [SMARText Data Entry Methods](#).

### Inactive Problems Starter Pick List

A screenshot showing the text "Inactive Problems[" in green. Below it, a dropdown menu is open, displaying "Starter - Inactive Problems:" in blue text.

The Inactive Problems Starter Pick List contains a list of some of the most common diagnosis. It may not contain all items a user will use in while charting.

## Accessing the Inactive Problems Pick List

Left-click on Starter - Inactive Problems

1

Inactive Problems  
Starter - Inactive Problems:[]

2

SMARText Quick Access

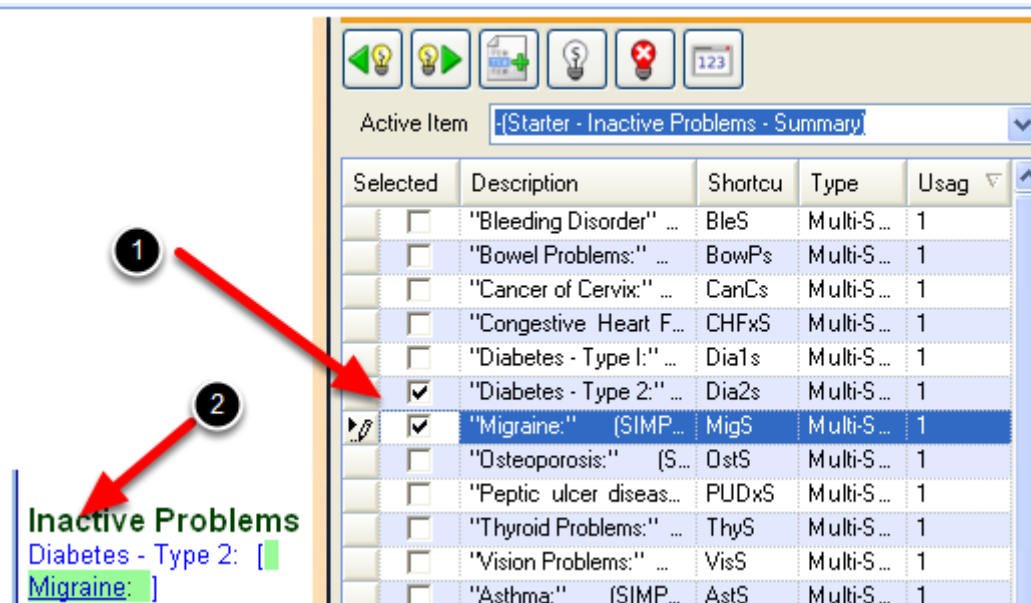
Active Item: [Starter - Inactive Problems - Summary]

Selected	Description	Shortcut	Type	Usage
<input type="checkbox"/>	"Bleeding...	BleS	Multi-Sel...	1
<input type="checkbox"/>	"Bowel P...	BowPs	Multi-Sel...	1
<input type="checkbox"/>	"Cancer...	CanCs	Multi-Sel...	1
<input type="checkbox"/>	"Congesti...	CHFxS	Multi-Sel...	1
<input type="checkbox"/>	"Diabetes...	Dia1s	Multi-Sel...	1
<input type="checkbox"/>	"Diabetes...	Dia2s	Multi-Sel...	1
<input type="checkbox"/>	"Migraine...	MigS	Multi-Sel...	1
<input type="checkbox"/>	"Osteopo...	OstS	Multi-Sel...	1
<input type="checkbox"/>	"Peptic ul...	PUDxS	Multi-Sel...	1
<input type="checkbox"/>	"Thyroid...	ThyS	Multi-Sel...	1
<input type="checkbox"/>	"Vision P...	VisS	Multi-Sel...	1
<input type="checkbox"/>	"Asthma...	AstS	Multi-Sel...	1
<input type="checkbox"/>	"Unrema...	Unr	Multi-Sel...	1
<input type="checkbox"/>	"Alcohol...	AlcS	Multi-Sel...	0
<input type="checkbox"/>	"Anemia...	AneS	Multi-Sel...	0
<input type="checkbox"/>	"Arthritis...	ArtSs	Multi-Sel...	0
<input type="checkbox"/>	"Birth Def...	BirDefs	Multi-Sel...	0

In SOAPware, text that appears, Blue and Underlined indicates that a Pick List is attached to the SMARText Item.

1. Left-click on the Pick List header (ie: Starter Inactive Problems)
2. A list of item will appear in the SMARText Quick Access

## Choosing Items from the Inactive Problems Pick List



With the Inactive Problems Pick List displayed in the SMARTText Quick Access Dialog, users will Click in the box in the "Selected" column next to each of the items that he/she wishes to insert into the Inactive Problems field.

When the items are inserted, the Starter Inactive Problems header will disappear.

## Surgeries

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This lesson will demonstrate how to insert the Surgeries Starter Pick List if the Summary docuplate does not already contain the Starter Pick List. This lesson will also described how to use the Surgeries Starter Pick List.

The Surgeries field in the Summary is for recording the patients past Surgical and procedural history.

### Placing of the Insertion Point

Surgeries[  
]

With a patient's chart open and the Summary chart section visible:

1. Place the insertion point to the right of the field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), then the field is active and ready for data.

### Using No Known SMARTText Item Types

Surgeries[  
No history of any major surgeries:  
]

Entering the shortcut "SurNo" into the Surgeries field and Pressing the space bar will expand the structured data need to record documentation if the patient has a negative surgery history.

### Using No Known SMARTText Item Types in the Summary

### Inserting the Starter Pick List for Surgeries

Surgeries[  
sur-  
1

To insert the Starter Pick List for the Surgeries field:

1. Type sur- into the Surgeries Field (as shown above)

2. Press the Spacebar to expand the Pick List.

\*If a patient has a negative history for any major surgeries, the shortcut "SurNo" may be used.

**Note:** If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. After the user has used the Pick List once, the user will be able to expand it using the Spacebar method.

## Surgeries Starter Pick List

```
Surgeries[  
  Starter - Surgeries:  
]
```

The Surgeries Starter Pick List contains a list of some of the most common surgeries. It **may not** contain all the items that a user will use when documenting.

## Accessing the Surgery Pick List

Click on Starter - Surgeries

Click on Starter - Surgeries

SMARTText Quick Access

Active Item: [Starter - Surgeries - Summary]

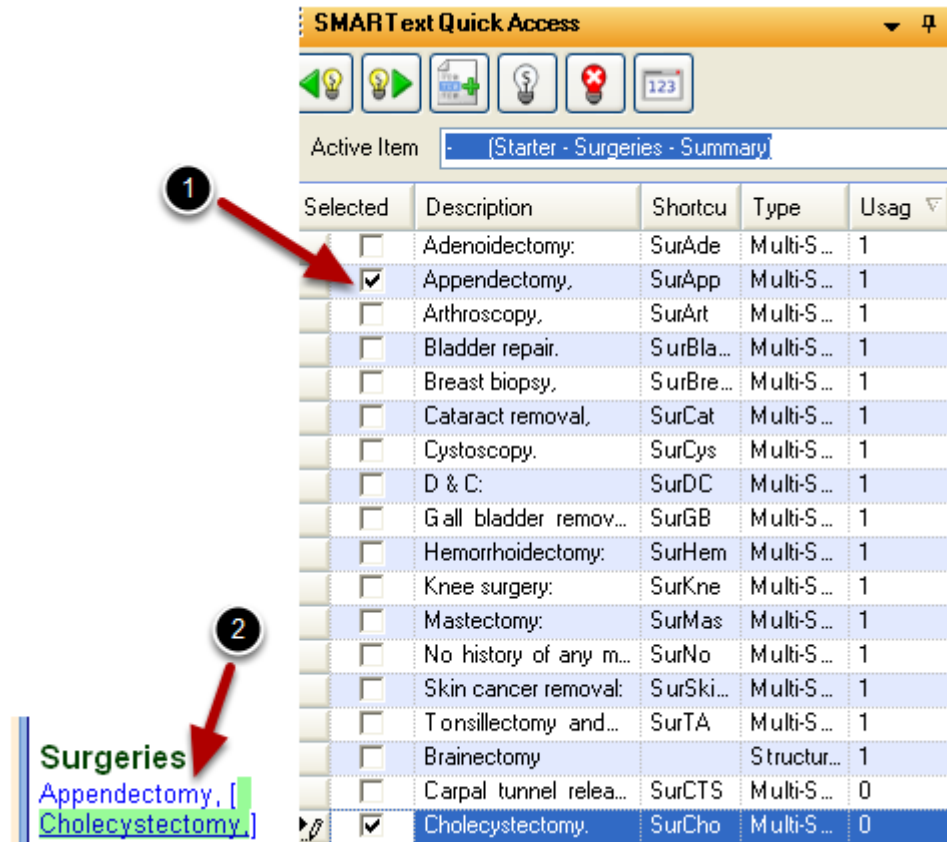
Selected	Description	Shortcu	Type	Usag
<input checked="" type="checkbox"/>	Adenoidectomy:	SurAde	Multi-S...	1
<input type="checkbox"/>	Appendectomy,	SurApp	Multi-S...	1
<input type="checkbox"/>	Arthroscopy,	SurArt	Multi-S...	1
<input type="checkbox"/>	Bladder repair.	SurBla...	Multi-S...	1
<input type="checkbox"/>	Breast biopsy,	SurBre...	Multi-S...	1
<input type="checkbox"/>	Cataract removal,	SurCat	Multi-S...	1
<input type="checkbox"/>	Cystoscopy,	SurCys	Multi-S...	1
<input type="checkbox"/>	D & C:	SurDC	Multi-S...	1
<input type="checkbox"/>	Gall bladder remov...	SurGB	Multi-S...	1
<input type="checkbox"/>	Hemorrhoidectomy:	SurHem	Multi-S...	1
<input type="checkbox"/>	Knee surgery:	SurKne	Multi-S...	1
<input type="checkbox"/>	Mastectomy:	SurMas	Multi-S...	1
<input type="checkbox"/>	No history of any m...	SurNo	Multi-S...	1
<input type="checkbox"/>	Skin cancer removal:	SurSki...	Multi-S...	1
<input type="checkbox"/>	Tonsillectomy and...	SurTA	Multi-S...	1

In SOAPware, text that appears Blue and Underlined indicates that a Pick List is attached to the SMARTText Item.



1. Left-click on the Pick List header (ie Starter - Surgeries)
2. A list of items will appear in the SMARText Quick Access Dialog.

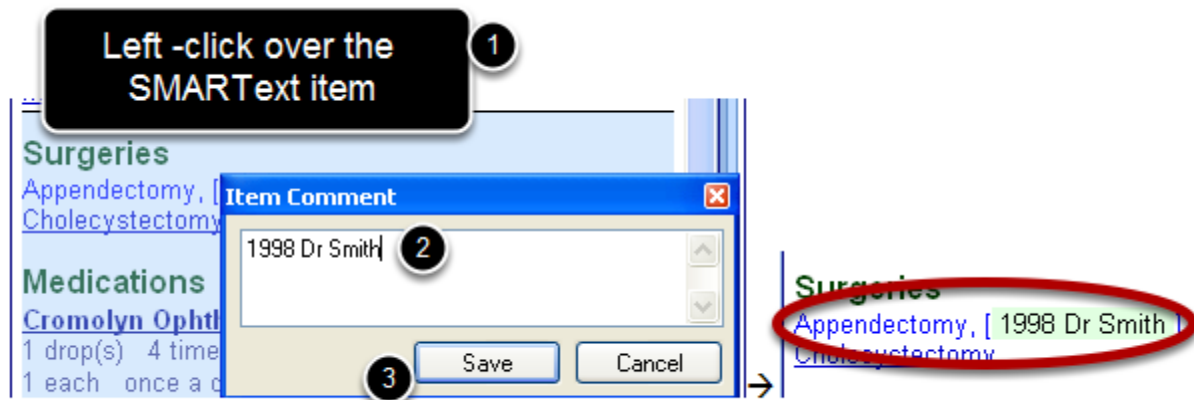
## Choosing Items from the Starter Surgeries Pick List



With the Surgery Pick List displayed in the SMARText Quick Access Dialog, Click in the box in the "Selected" column next to each of the items to insert in the Surgeries field.

When the items are inserted, the Starter Surgeries header will disappear.

## Attach Comments to a Pick List Item



To attach a free text comment to the SMARTText item:

1. Left-click on top of the SMARTText item (ie: Appendectomy - see above)
2. Begin typing the desired comments (ie: 1998 by Dr. Smith, as shown above). The Item Comment box will only appear **after** typing has begun. Some users find this process easier by pressing the spacebar after Clicking on the item to display the Item Comment box before typing.
3. Click Save to insert the comments or press the Enter key.

## Medications

---

This lesson will demonstrate how to insert the patients current medications in the Medications field on the Summary side using the Shift + F11 searching method.

The Summary Medications field is used to record the patients active medications list.

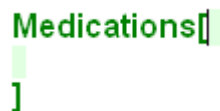
### **\*REQUIRED FOR MEANINGFUL USE:**

- Active Medication List
- CPOE for Medication Orders
- Medication Reconciliation

### **Meaningful Use Dashboard**

This measure is tracked within the [Patient Meaningful Use Dashboard](#) and the [Meaningful Use Dashboard](#) workspace.

### Placing of the Insertion Point



Medications[  
]

With the patients chart open and the Summary chart section visible:

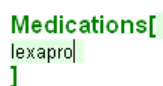
1. Place the insertion point to the right of the Medications field header.
2. Left-click the mouse to insert the cursor.

OR

The Meaningful Use Patient Dashboard can also be used to activate the field. Click on the Medication Status item within the Meaningful Use Patient Dashboard to activate the corresponding field.

If the bold green brackets appear (as shown above), the field is active and the user can begin documenting.

### Entering the Medication Keyword



Medications[  
lexapro]

To enter a medication into the Summary Medications field, type the name of the medication into the field, leaving the cursor at the end of word (as shown above).

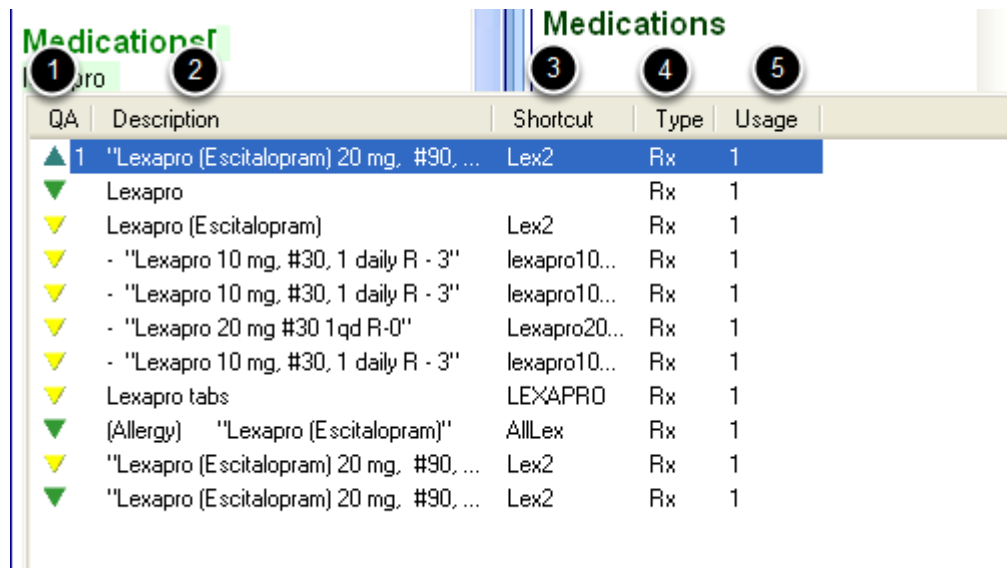
## Conducting a Shift + F11 Search to Enter a Medication



With the cursor at the end of the medication name, insert the medication using a Shift F11 search:

- 1) Press the Shift + F11 key on the keyboard to conduct the search.
- 2) A search results dialog box will be displayed (as shown above).

## Search Results Dialog Box Interface



### Column #1: Triangles

- \* **Upward facing triangle:** Indicates the SMARText item is located on the local database.
- \* **Downward facing triangle:** Indicates the SMARText item is located on the SOAPware Online Library.
- \* **Green triangle:** Indicates that the SMARText item was created by SOAPware.

\* **Yellow triangle:** Indicates that the SMARTText item has been edited or created by a SOAPware user.

\* **Red triangle:** Indicates that the SMARTText item is not available for use.

## Column #2: Description

\* This column gives a description of the SMARTText item. In a description that includes text with quotes, the text within quotes **will be** inserted into the documentation. In a description that includes text with parenthesis, the text within parenthesis **will not be** inserted into the documentation.

## Column #3: Shortcut

\* This is the Shortcut code that is assigned to the SMARTText item. The Shortcut code can be used to enter the item into the documentation.

## Column #4: Type

\* There are several different types of SMARTText items. This column will indicate the item type (ie: Rx)

## Column #5: Usage

\* This column indicates the number of times the SMARTText item has been inserted by the User.

## Inserting the Medication

The diagram shows a workflow for inserting a medication. On the left, a table lists medication items. A callout box labeled '1' points to the first row, with the instruction 'Double click on the medication item'. On the right, a text field labeled 'Medications[' shows the result of the action. A callout box labeled '2' points to the inserted text, with the instruction 'The medication will be inserted into the field'.

QA	Description	Shortcut	Type	Usage
1	"Lexapro (Escitalopram) 20 mg, #90, ...	Lex2	Rx	1
	Lexapro		Rx	1
	Lexapro (Escitalopram)	Lex2	Rx	1
	- "Lexapro 10 mg, #30, 1 daily R - 3"	lexapro10...	Rx	1

Medications[ Lexapro (Escitalopram): 20 mg (tablet) 1 each once a day ]

To insert the desired medication, simply double-click on the desired medication.

## Using other Methods to insert SMARText Medications

The above instructions demonstrated the Shift F11 search method that can be used to enter SMARText Medication. In addition to using Shift F11, the following SMARText entry methods could also be used:

1. F11 search
2. Custom Pick List
3. Quick Access Pick List
4. SMARText Items Manager
5. Shortcut Codes

For more information on the above entry methods, please see: [SMARText Data Entry Methods](#).

## Medication Sub-Items

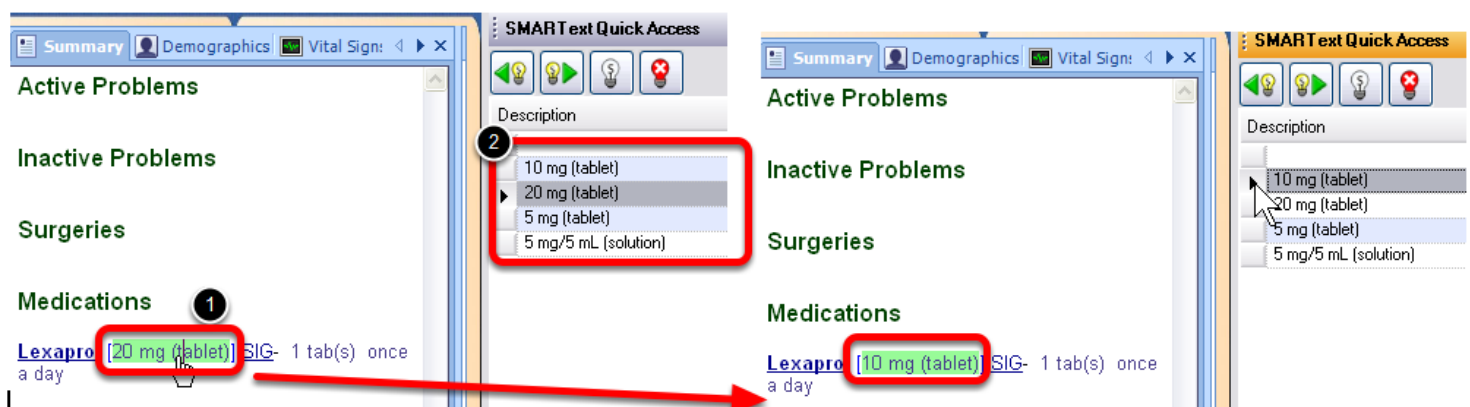
### Medications

Lexapro 20 mg (tablet) SIG- 1 tab(s) once a day

All SMARText Items, including Medication SMARText Items, have sub-items that can be changed.

The above medication Lexapro has three sub-items that are currently displayed in the Summary Medications field. It includes the Strength (*20 mg tablet*), the Dose (*1 tab*), and the Frequency (*once a day*).

## Changing Medication Sub-Items



To change or edit a sub-item of a medication:

1. Click on top of the sub-item (ie: *20mg tablet* OR *1 tabs* OR *once a day*)

2. Select the desired option from the SMARText Quick Access window

## Using No Known SMARText Item Types

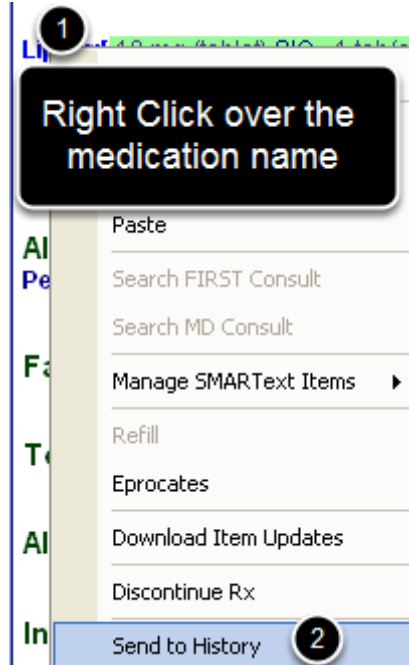


When a patient has no current medications, documentation must be entered as structured data by using the SMARText Item for "Current Meds: None".

Type "NoMeds" into the Summary Medications field and Press the space bar. This will expand into the structured data required for this field.

**\*Note:** Users will need to re-download the "NoMeds" SMARText Item for use within SOAPware. For instructions on re-downloading this item, please see: [Using No Known SMARText Item Types in the Summary](#).

## Storing an Active Medication List



Medications that are added to the active Summary Medications list can be stored in the Medication History within Rx Manager if desired. To do this:

1. Right Click on the medication name
2. Choose Send to History

## Sending to History with Notes

1. Today's date will be defaulted for "Stored On"
2. Type "Active" in the notes area
3. Click Store

## Viewing the Stored Active Medications List

Rx Manager					
<div> <span>Rx Pad</span> <span>Medications</span> <span style="border: 2px solid red; padding: 2px;">History</span> <span>Patient - Refill Requests</span> </div>					
Drag a column header here to group by that column					
Action	Drug	Status	Details	Notes	Pharmacy
Type	Sent	Response			
	Fill Date	Provider			
Refill Rx Added	<b>Lexapro (Escital...</b> 1/17/2011 1/1/0001	Rx Added ▼ Added ▼ 8f78ce5e-fa41-4...	20 mg (tablet) SIG- 1 tab(s) once a day	Added on 1/17/2011 Active	Ph# - Fax# -
Refill Rx Added	<b>Diovan</b> 1/17/2011 1/1/0001	Rx Added ▼ Added ▼ 8f78ce5e-fa41-4...	320 mg (tablet) SIG- 1 tab(s) once a day	Added on 1/17/2011 Active	Ph# - Fax# -
Refill Rx Added	<b>Metformin (Gluc...</b> 1/17/2011 1/1/0001	Rx Added ▼ Added ▼ 8f78ce5e-fa41-4...	1000 mg (tablet) SIG- 1 each 2 times a day	Added on 1/17/2011 Active	Ph# - Fax# -

Within the Rx Manager, on the History tab, the stored medications will be displayed with the date stored.



## Allergies

---

This lesson will demonstrate how to insert the Allergy Starter Pick List if the Summary docuplate does not already contain the Starter Pick List. This lesson will also describe how to use the Allergy Starter Pick List and how to insert Allergies that are not drug related allergies.

The Allergy field in the Summary chart section is used to record a list of the patients allergies and intolerance. This list is used when ePrescribing to alert the physician of any possible allergy to drug interactions.

### **\*REQUIRED FOR MEANINGFUL USE**

- Medication Allergy List
- Drug Interaction Checks

### **Patient Meaningful Use Dashboard:**

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

### Placing of the Insertion Point

Allergies[  
]

With a patient chart open and the Summary chart section visible:

1. Place the insertion point to the right of the field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

### Using No Known SMARText Item Types



When a patient has no known allergies, documentation must be entered as structured data by using the SMARText Item for "Drug Allergies: No Known".

Type "nkda" into the Allergies field and Press the space bar. This will expand into the structured data required for this field.

**\*Note:** Users will need to re-download the "nkda" SMARTText Item for use within SOAPware 2011. For instructions on re-downloading this item, please see: [Using No Known SMARTText Item Types in the Summary](#).

## Inserting the Starter Pick List for Allergies

```
Allergies[
all-
]
```

To insert the Starter Pick List for Allergies:

1. Type all- into the Allergies field (as shown above).
2. Press the spacebar to expand the Pick List.

**Note:** *If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. Once the user has used the Pick List once, the user will be able to expand it using the Spacebar method.*

## Allergies Starter Pick List

```
Allergies[
Starter - Allergies - Summary:
]
```

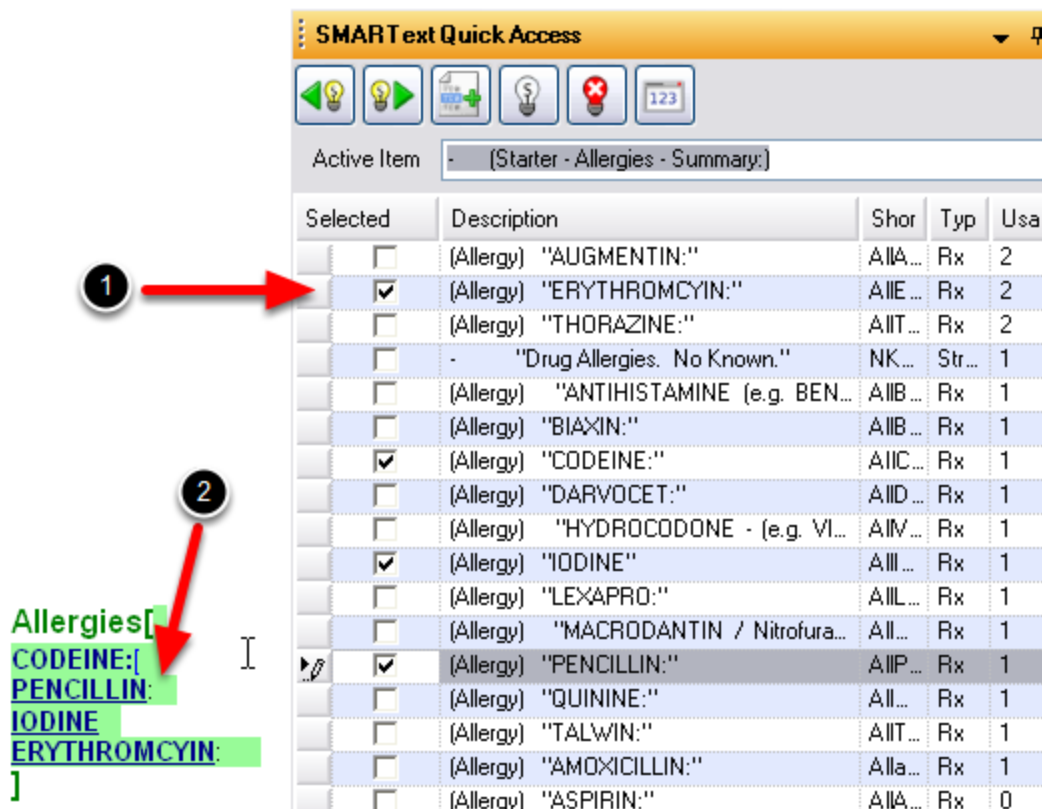
The allergies Starter Pick List is used to record a list of the patients allergies and intolerances. This list is used when ePrescribing to alert the physician of any possible allergy to drug interactions.

## Accessing the Allergy Starter Pick List

In SOAPware, text that appears [Blue](#) and [Underlined](#) indicates that a Pick List is attached to the SMARTText item.

Left click on the Pick List header (ie: Starter - Allergies - Summary) and a list of items will appear in the SMARTText Quick Access Dialog.

## Choosing Items from the Allergy Pick List



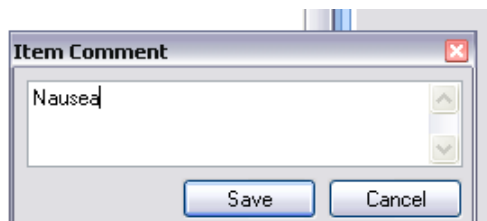
With the Allergy Pick List displayed in the SMARText Quick Access dialog, Click to place a check in the box in the "Select" field next to each of the items desired, to insert into the Allergy field.

When the items are inserted, the Allergy Pick List header will disappear.

The Allergy Pick List only contains drug related allergies. To enter non-drug related allergies, such as food intolerance, see the step titled Entering Non-Drug Related Allergies below.

## Attaching Item Comments to Allergies

Allergies  
CODEINE: Rash  
PENCILLIN:  
IODINE  
ERYTHROMCYIN:[]



To attach a free text comment to the SMARText item:

1. Left-click on top of the SMARText item (ie: Codeine - see above).

2. Begin typing desired comments (ie: Nausea - as shown above). An "Item Comment" box will appear for the user to type in.

Click Save.

The item comment will be inserted next to the SMARTText item (see Codeine example above).

## Entering Non-Drug Related Allergies

```
Allergies[
Peanuts
]
```

The Allergy Pick List only contains SMARTText items for drug related allergies. As a result, there will be a need to add non-drug related allergies such as food intolerance, in a free text fashion. To enter free text non-drug related allergies, simply free-text type the intolerance into the allergy field (as shown above).

## Adding SMARTText Code to Non-Drug Related Allergies

```
1 Allergies[
Peanuts id-
]

2 Allergies[
Peanuts (ID-Ignore)
]
→
```

After adding the free-text non-drug related allergy, we suggest that a user add a SMARTText code so the system won't recognize it as a drug interaction when performing the ePrescribing function.

The SMARTText item that the user will want to attach enters the text **(ID-Ignore)** next to the free-text allergy. This will allow the sentence or line of text to be ignored in the drug interaction check. If the user do not enter this SMARTText item next to a free-text allergy the system will see the item as uncoded and will alert the user that there is an item it doesn't recognize, when the user is ePrescribing.

To insert the (ID-Ignore) SMARTText item:

1. Type the shortcut code id- next to the free-text allergy.
2. Press the spacebar key on the keyboard to expand the SMARTText item to read (ID-Ignore).

## Family History

---

This lesson will demonstrate how to insert the Family History Starter Pick List if the Summary docuplate does not already contain the Starter Pick List. This lesson will also describe how to use the Family History Starter Pick List and how to insert an Item Comment.

The Family History field in the Summary chart section is used to record the patients family medical history.

### Placing of the Insertion Point



Family History[ ]

With a patient chart open and the Summary chart section visible:

1. Place the insertion point to the right of the field header.
2. Left-click the mouse to insert your cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

### Inserting the Starter Pick List for Family History



Family History[ ]  
fam-

To insert the Starter Pick List for Family History:

1. Type fam- into the Family History field (as shown above).
2. Press the Spacebar to expand the Pick List.

**Note:** *If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. Once the user has used the Pick List once, the user will be able to expand it using the Spacebar method.*

## Family History Starter Pick List

### Family History[

PARENTS:

CHILDREN:

GRANDPARENTS:

SIBLINGS:

UNCLES/AUNTS:

OTHERS/DISTANT:

Positive family history for -

Negative family history for -

]

The Family History Starter Pick List will expand to include the information shown above.

The Family History Starter Pick List should be used as a guide. It may not contain all the items used while charting.

## Choosing Items from the Family History Pick List

### Family History

PARENTS:

CHILDREN:

GRANDPARENTS:

SIBLINGS:

UNCLES/AUNTS:

OTHERS/DISTANT:

Positive family history for - [ Cancer of Colon ; Diabetes - Type 2 ; Asthma ; ]

Negative family history for -

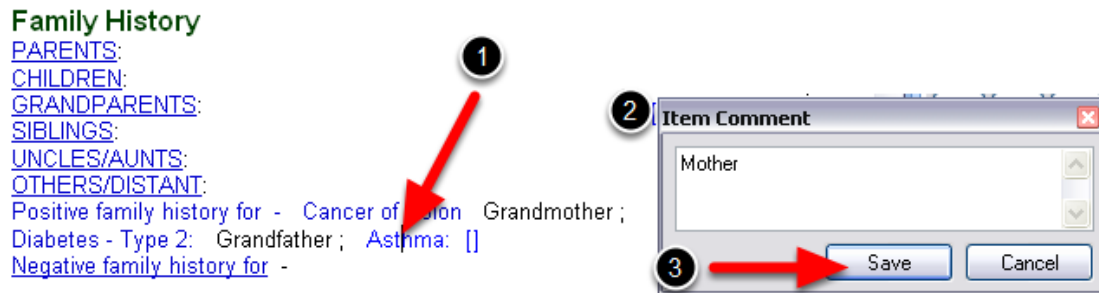
Selected	Description	Sho	Type	Usa
<input type="checkbox"/>	- "Unremarkable"	Unr	Mult...	1
<input type="checkbox"/>	"Alcohol problems" (SIMPL...	AlcS	Mult...	1
<input type="checkbox"/>	"Anemia:" (SIMPLE - Dx ...	An...	Mult...	1
<input type="checkbox"/>	"Arthritis:" (SIMPLE - Nons...	Art...	Mult...	0
<input checked="" type="checkbox"/>	"Asthma:" (SIMPLE - Dx ...	AstS	Mult...	2
<input type="checkbox"/>	"Birth Defect:" (SIMPLE - ...	Bir...	Mult...	1
<input type="checkbox"/>	"Bleeding Disorder" (SIMPL...	BleS	Mult...	1
<input type="checkbox"/>	"Bowel Problems:" (SIMPL...	Bo...	Mult...	1
<input type="checkbox"/>	"Cancer of Breast:" (SIMP...	Ca...	Mult...	1
<input type="checkbox"/>	"Cancer of Cervix:" (SIMP...	Ca...	Mult...	1
<input checked="" type="checkbox"/>	"Cancer of Colon" (SIMPL...	Ca...	Mult...	2
<input type="checkbox"/>	"Cancer of Prostate:" (SIM...	Ca...	Mult...	1
<input type="checkbox"/>	"Cancer, Ovarian:" (SIMPL...	Ca...	Mult...	0
<input type="checkbox"/>	"Cancer:" (SIMPLE - Dx - n...	Ca...	Mult...	1
<input type="checkbox"/>	"Chemical Dependency" (...	Ch...	Mult...	1
<input type="checkbox"/>	"Congestive Heart Failure:" ...	CH...	Mult...	1
<input type="checkbox"/>	"Coronary artery disease:" ...	CA...	Mult...	0
<input type="checkbox"/>	"Depression:" (SIMPLE - N...	De...	Mult...	1
<input checked="" type="checkbox"/>	"Diabetes - Type 2:" (SIM...	Dia...	Mult...	2
<input type="checkbox"/>	"Diabetes - Type I:" (SIMP...	Dia...	Mult...	2

In SOAPware, text that appears Blue and Underlined indicates that a Pick List is attached to the SMARText Item.

To select items from a Pick List:

1. Left-click on top of the item (ie: "Positive family history for").
2. A list of items will appear in the SMARTText Quick Access dialog.
3. Users should place a check box in the "Selected" field next to each of the items that he/she wishes to insert into the Family History field.

## Attaching Item Comment to Family History



To attach a free text comment to the SMARTText item:

1. Left-click on top of the SMARTText item (ie: Asthma - see above).
2. Begin typing desired comments (ie: Mother, as shown above). An "Item Comment" box will appear for the user to type in.
3. Save the comments.

The item comment will be inserted next to the SMARTText item (see Diabetes - Type 2 example above).

## Tobacco

---

This lesson will demonstrate how to insert the Tobacco Starter Pick List if the Summary docuplate does not already contain the Starter Pick List. This lesson will also describe how to use the Tobacco Starter Pick List.

The Tobacco field in the Summary chart section is used to record the past and present tobacco use history.

**\*THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT**

- Record Smoking Status

### Patient Meaningful Use Dashboard:

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

#### Placing of the Insertion Point

Tobacco[  
]

1. Place the insertion point to the right of the Tobacco field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

#### Inserting the Starter Pick List for Tobacco

Tobacco[  
tobmu  
]

To insert the Starter Pick List for Tobacco:


1. Type tobmu into the Tobacco field (as shown above).
2. Press the Spacebar to expand the Pick List.

**Note:** *If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. After the user has used the Pick List once, the user will be able to expand it using the shortcut code method.*



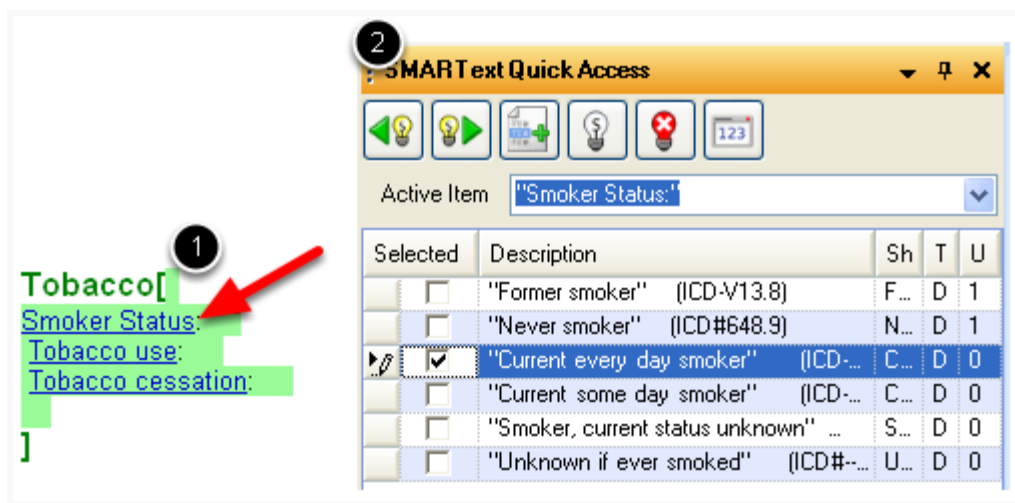
## Tobacco Starter Pick List

```
Tobacco[  
  Smoker Status:  
  Tobacco use:  
  Tobacco cessation:  
]
```



The Tobacco Starter Pick List is used to record past and present tobacco use. This list is prepared by SOAPware to record the meaningful use requirements for [Smoking Status](#) and also records the appropriate information for one of the [Clinical Quality Measures](#).

## Accessing the Tobacco Pick List

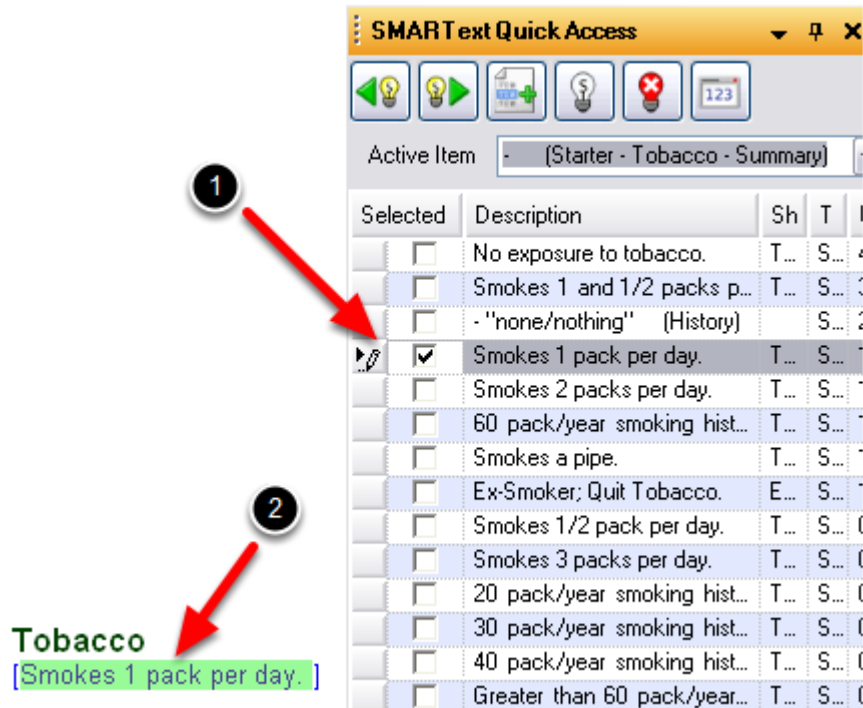


In SOAPware, text that appears [Blue](#) and [Underlined](#) indicates that a Pick List is attached to the SMARTText item.

1. Left click on the Pick List header (ie: Smoker Status)
2. A list of items will appear in the SMARTText Quick Access Dialog.

Left clicking on each Pick List header seen above, will display a list of items in the SMARTText Quick Access Dialog.

## Choosing Items from the Tobacco Pick List



With the Tobacco Pick List displayed in the SMARTText Quick Access dialog, a user should Click to place a check in the box in the "Selected" field next to each of the items that he/she wishes to insert into the Tobacco field.

After the items are inserted, the starter Tobacco Pick List header will disappear.

## Alcohol

---

This lesson will demonstrate how to insert the Alcohol Starter Pick List if the Summary docuplate does not already contain the Starter Pick List. This lesson will also describe how to use the Alcohol Starter Pick List.

The Alcohol field in the Summary chart section is used to record the past and present alcohol use history.

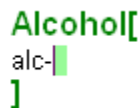
### Placing of the Insertion Point

A screenshot showing the text "Alcohol[" in a green font. A green bracket is positioned to the right of the opening square bracket, indicating the insertion point.

1. Place the insertion point to the right of the Alcohol field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

### Inserting the Starter Pick List for Alcohol

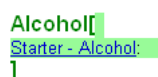
A screenshot showing the text "Alcohol[" in a green font. Below it, the text "alc-" is entered in a smaller green font. A green bracket is positioned to the right of the opening square bracket, indicating the insertion point.

To insert the Starter Pick List for Alcohol:

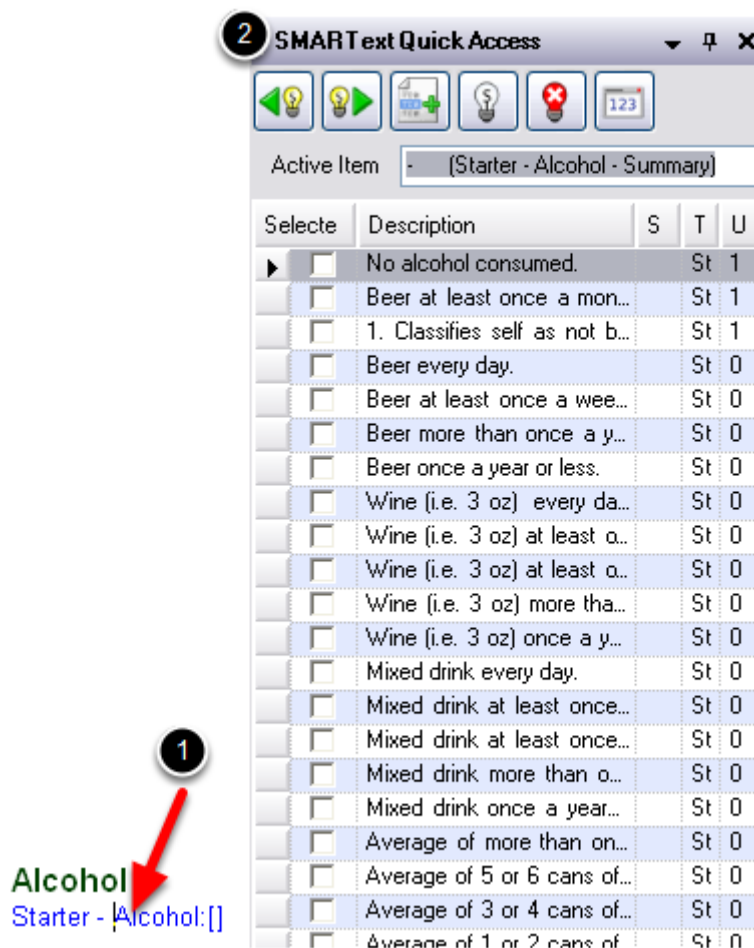
1. Type alc- into the Alcohol field (as shown above).
2. Press the Spacebar to expand the Pick List.

**Note:** *If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. After the user has used the Pick List once, the user will be able to expand it using the Spacebar method.*

### Alcohol Starter Pick List

A screenshot showing the text "Alcohol[" in a green font. Below it, the text "Starter - Alcohol:" is entered in a smaller green font. A green bracket is positioned to the right of the opening square bracket, indicating the insertion point.

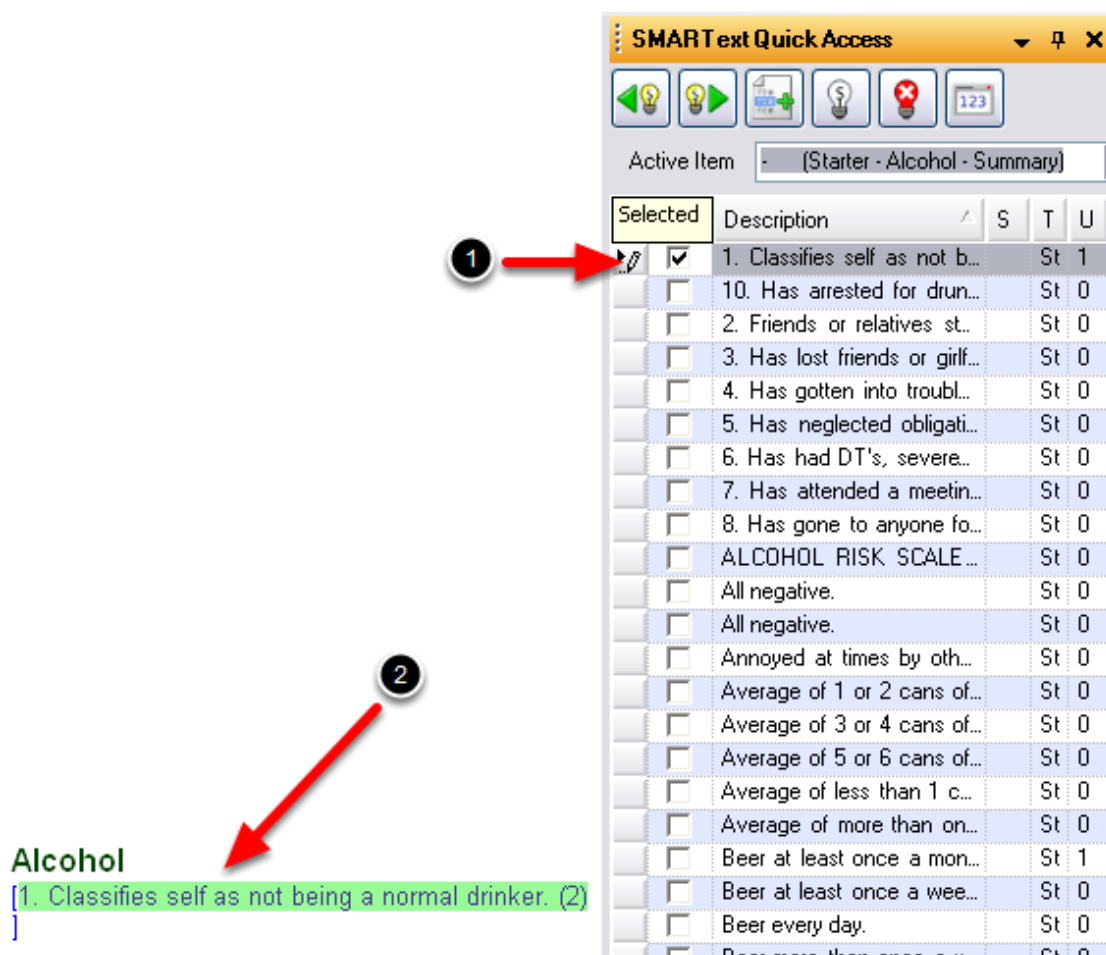
The Alcohol Starter Pick List is used to record past and present alcohol use. It may not contain all the items used while charting.



In SOAPware, text that appears Blue and Underlined indicates that a pick list is attached to the SMARTText item.

Left-click on the pick list header (ie: Starter - Alcohol:) and a list of items will appear in the SMARTText Quick Access Dialog.

## Choosing Items from the Alcohol Pick List



With the Alcohol pick list displayed in the SMARTText Quick Access dialog, the user should Click to place a check in the box in the "Selected" field next to each of the items that he/she wishes to insert into the Alcohol field.

When the items are inserted, the Alcohol Pick List header will disappear.

## Interventions

---

This lesson will demonstrate how to enter information into the Interventions field using free text data entry.

The Interventions field in the Summary chart section can be used as a miscellaneous field that may include things such as last significant medical testing and/or lab work.

### Placing the Insertion Point

**Interventions[**  
**]**

1. Place the insertion point to the right of the Interventions field header.
2. Left-click your mouse to insert your cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

### Entering Free Text Data into the Interventions field

**Interventions[**  
Interventions field can be used to enter  
miscellaneous data.**]**

The Interventions field is a miscellaneous field that can be used to document many items such as, last significant medical testing and/or lab work.

At this time there is not a Pick List available for the Interventions field, however a user can enter data into this field by free text typing. To free text type into the field, simply place the insertion point and begin typing information.

## Social History

---

This lesson will demonstrate how to insert the Social History Starter Pick List if the Summary docuplate does not already contain the starter pick list. This lesson will also describe how to use the Social History Starter Pick List.

The Social History field in the Summary chart section is used to record a list of social issues including such things as living situation, support systems, etc..

### Placing of the Insertion Point

A screenshot showing the text "Social History" in green. To the right of the text, there is a small green bracket-like cursor indicating the insertion point.

1. Place the insertion point to the right of the Social History field header.
2. Left-click the mouse to insert the cursor.

If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

### Inserting the Starter Pick List for Social History

A screenshot showing the text "Social History" in green. Below it, the text "soc-" is typed in a smaller font. To the right of "soc-", there is a small green bracket-like cursor indicating the insertion point.

To insert the Starter Pick List for Social History:

1. Type soc- into the Social History field (as shown above).
2. Press the Spacebar to expand the Pick List.

**Note:** *If the Pick List does not expand when the Spacebar is pressed, the user may need to do a Shift + F11 search to download the item to the local database. After the user has used the Pick List once, the user will be able to expand it using the Spacebar method.*

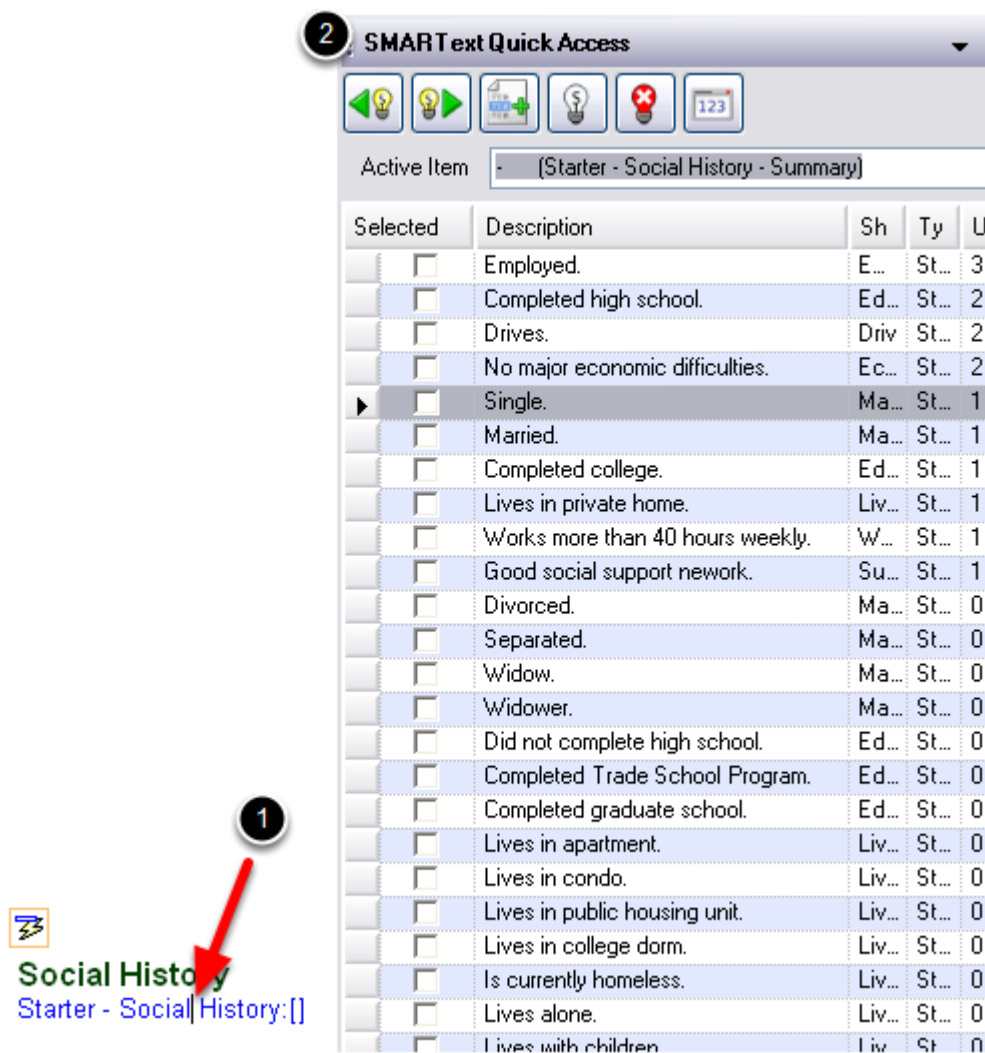
See this link for searching instructions: [SMARText Data Entry Methods](#).

## Social History Starter Pick List

Social History[  
Starter - Social History:  
]

The Social History Starter Pick List can be used to record a list of social issues including things such as living situation, support systems, etc. It may not contain all the items used while charting.

## Accessing the Social History Pick List



In SOAPware, text that appears Blue and Underlined indicates that a Pick List is attached to the SMARText item.

Left-click on the Pick List header (ie: Starter - Social History:) and a list of items will appear in the SMARText Quick Access Dialog.



## Choosing Items from the Social History Pick List

**SMARText Quick Access**

Active Item: (Starter - Social History - Summary)

Selected	Description	Sh	Ty	Us
<input checked="" type="checkbox"/>	Employed.	E...	St...	3
<input type="checkbox"/>	Completed high school.	Ed...	St...	2
<input type="checkbox"/>	Drives.	Driv	St...	2
<input checked="" type="checkbox"/>	No major economic difficulties.	Ec...	St...	2
<input type="checkbox"/>	Single.	Ma...	St...	1
<input checked="" type="checkbox"/>	Married.	Ma...	St...	1
<input type="checkbox"/>	Completed college.	Ed...	St...	1
<input checked="" type="checkbox"/>	Lives in private home.	Liv...	St...	1
<input type="checkbox"/>	Works more than 40 hours weekly.	W...	St...	1
<input checked="" type="checkbox"/>	Good social support network.	Su...	St...	1
<input type="checkbox"/>	Divorced.	Ma...	St...	0
<input type="checkbox"/>	Separated.	Ma...	St...	0
<input type="checkbox"/>	Widow.	Ma...	St...	0
<input type="checkbox"/>	Widower.	Ma...	St...	0
<input type="checkbox"/>	Did not complete high school.	Ed...	St...	0
<input type="checkbox"/>	Completed Trade School Program.	Ed...	St...	0
<input type="checkbox"/>	Completed graduate school.	Ed...	St...	0
<input type="checkbox"/>	Lives in apartment.	Liv...	St...	0
<input type="checkbox"/>	Lives in condo.	Liv...	St...	0
<input type="checkbox"/>	Lives in public housing unit.	Liv	St	0

**Social History**  
 [Employed. No major economic difficulties.  
 Married. Lives in private home. Strong  
 social support network. ]

With the Social History Pick List displayed in the SMARText Quick Access dialog, a user should Click to place a check in the box in the "Selected" field next to each of the items that he/she wishes to insert into the Social History field.

When the items are inserted, the Starter Social History Pick List header will disappear.

### Getting Started with Documentation - SUMMARY - ROS & Physical Documentation

The ROS field in the Summary chart section can be used to store a review of systems related to the various organ systems.

The Physical field in the Summary chart section can be used to store a physical examination for easy retrieval.

The ROS & Physical fields are from previous versions of SOAPware and are rarely used in more current versions of SOAPware.

#### Placing of the Insertion Point



If a user wishes to enter data in the ROS and/or Physical field, follow the steps below:

1. Place the insertion point to the right of the ROS or Physical field header.
2. Left-click the mouse to insert the cursor.
3. Begin entering desired data.

If the bold green brackets appear (as shown above), then the field is active and ok for data to be entered.

# Customized Field Headers

## Remove or Hide Field Headers

It is possible to hide field/headers in the SOAP or Summary chart sections (i.e. such as hiding the Subjective field in SOAP encounter notes)

### Manage Sub-Items

The screenshot shows the 'Docuplates' window with a list of docuplates on the left and a detailed view of the selected 'Summary-DPL' docuplate on the right. The list has columns for Shortcut, Description, Location, and Keywords. The right pane shows fields for Shortcut, Description, Keywords, and Section. Below these fields are sections for 'UNCLES/AUNTS: OTHERS/DISTANT:', 'Tobacco', 'Alcohol', 'Interventions', 'Social History', and 'Physical'. A right-click context menu is open over the 'Social History' section, with a red arrow pointing to the 'Manage Sub Items' option at the bottom. A black callout box with white text says 'Right-click at the very bottom of the docuplate window' with an arrow pointing to the right-click location.

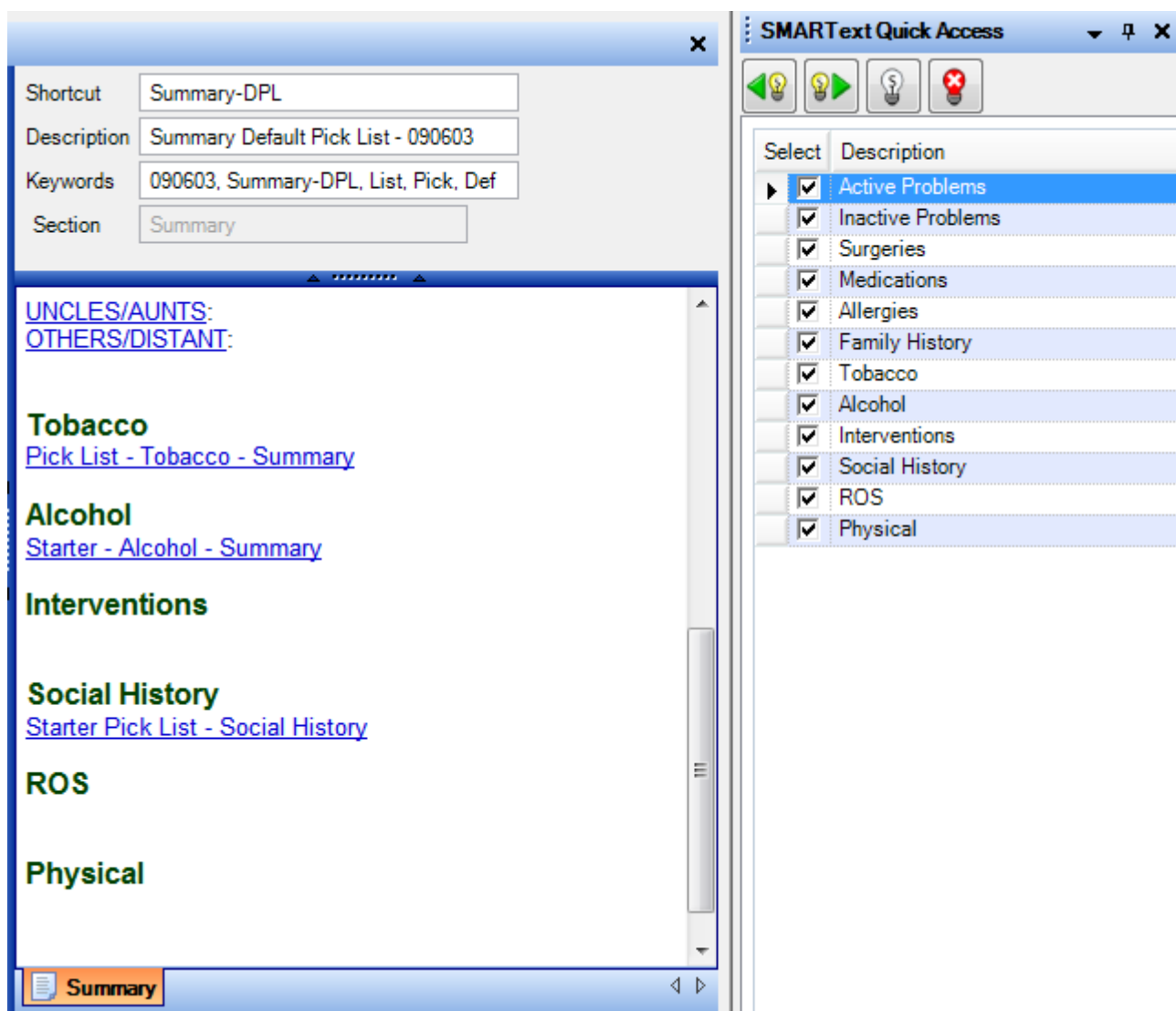
Shortcut	Description	Location	Keywords
SoapPL	Summary - with...	SOAP Notes	list, pick, SC
summary	Empty Summary	Summary	
Summary-DPL	Summary Default...	Summary	090603, Def
SumPL	Summary - with...	Summary	lists, pick, S
SumPL	Summary - with...	Summary	lists, pick, S
DrugFailSum	Summary Pick-L...	Summary	Allergy, Drug
evertsonsum	Geriatric summa...	Summary	01.0.A00.GE
summaryOURS	Custom Summar...	Summary	summary he
	Summary 2/16/2...	Summary	famdoc, sum
summary	DR.J #1	Summary	FEMALE
summary	summary - 9/09	Summary	summary
arp summary	arp summary	Summary	arp, summar
*summaryEAB2	*SUMMARY DE...	Summary	default, eab,
summary2	summary	Summary	summary
tfmpedsum	Pediatric summa...	Summary	01.0.A00.GE
Summary-DPL	Summary Default...	Summary	090603, Def
famdocsum	Default Summar...	Summary	
*summaryEAB	*SUMMARY DE...	Summary	
SumPL	Summary - with...	Summary	
jbsummary	Summary	Summary	
summaryEAB	Summary Default...	Summary	
summary	Empty Summary	Summary	
summary	summary - 9/09	Summary	CFP, summe

Right-click at the very bottom of the docuplate window

Press F6 to open the Docuplate manager, and Click the docuplate to modify (i.e. usually the choice is the default docuplate for that chart section).

With the docuplate to be edited in view, Right-click just underneath the last field in the docuplate (see screen-shot below). Positioning the cursor can be a little tricky because the right-click has to be in a location just after the last close bracket.

In the right-click menu, Click Manage Sub Items as seen below. (If the user sees a different menu when he/she right-clicks, move the mouse down just a little bit and try again.)



In the SMARTText Quick Access, all the fields in the docuplate should be displayed. To hide one, Click its Check-box to UN-check it. This doesn't actually remove the field, but has the same functional purpose.

**NOTE:** To reactivate the hidden field, simply re-check the field's check-box.

## The Result

The screenshot displays the SMARText Quick Access interface. On the left, a form contains the following fields:

- Shortcut: Summary-DPL
- Description: Summary Default Pick List - 090603
- Keywords: 090603, Summary-DPL, List, Pick, Def
- Section: Summary

The main content area shows a list of medical categories with checkboxes:

Select	Description
<input checked="" type="checkbox"/>	Active Problems
<input checked="" type="checkbox"/>	Inactive Problems
<input checked="" type="checkbox"/>	Surgeries
<input checked="" type="checkbox"/>	Medications
<input checked="" type="checkbox"/>	Allergies
<input checked="" type="checkbox"/>	Family History
<input checked="" type="checkbox"/>	Tobacco
<input checked="" type="checkbox"/>	Alcohol
<input checked="" type="checkbox"/>	Interventions
<input checked="" type="checkbox"/>	Social History
<input type="checkbox"/>	ROS
<input type="checkbox"/>	Physical

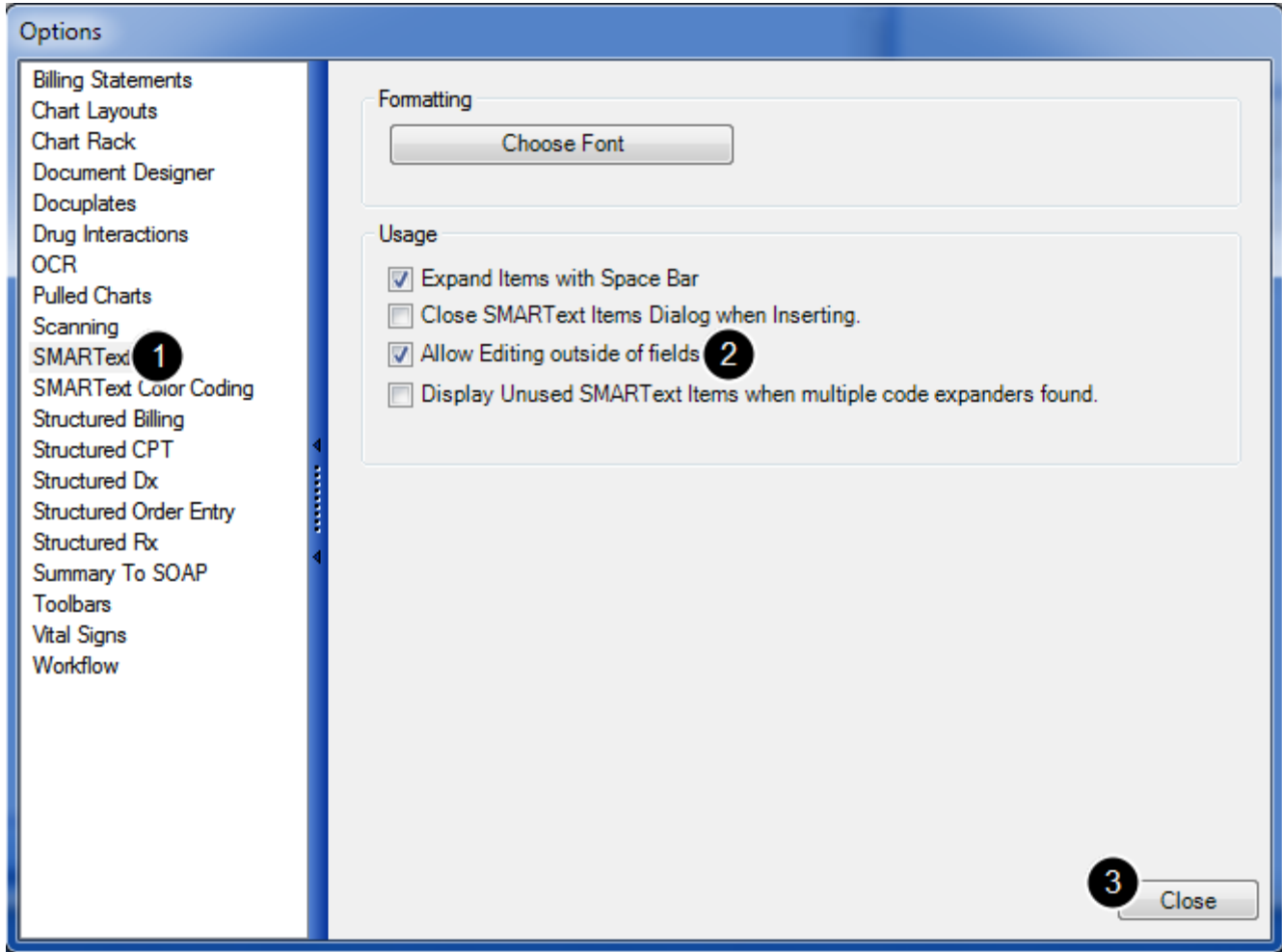
The 'Summary' tab is selected at the bottom. The main content area also displays a list of medical categories with checkboxes:

- UNCLES/AUNTS:**
- OTHERS/DISTANT:**
- Tobacco**  
[Pick List - Tobacco - Summary](#)
- Alcohol**  
[Starter - Alcohol - Summary](#)
- Interventions**
- Social History**  
[Starter Pick List - Social History](#)

With ROS and Physical Un-Checked, they are no longer visible in the docuplate.

## Create Custom Field Headers

### Enable Editing of SMARText Outside of the Fields



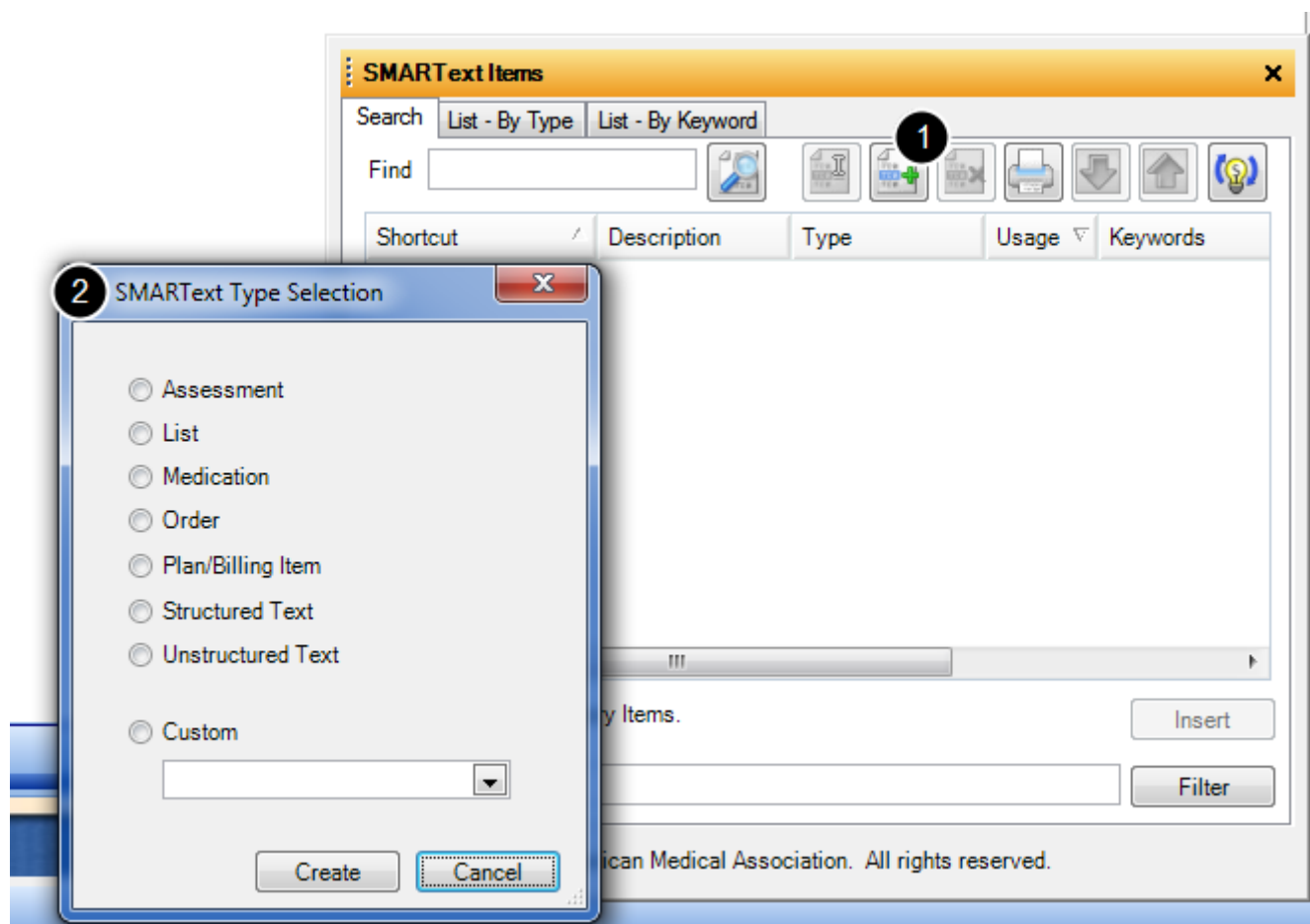
Click Tools in the menu bar, and Click the Options menu item.

1. Click the SMARText list item
2. Click the Allow Editing outside of fields check box
3. Click Close.

Then, log out of SOAPware and log back in.

**NOTE:** Changes will not take place until the user has completed the log out/log in process.

## Create the New Field Item

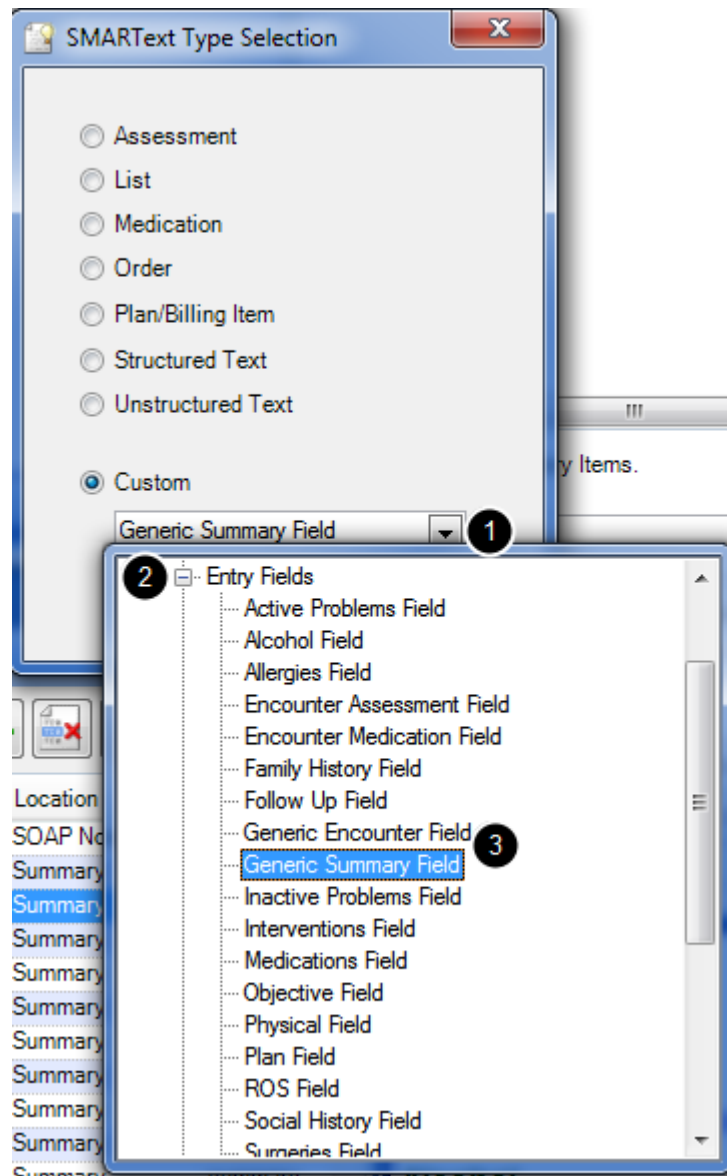


Click Docutainers in the menu bar, and Click the SMARTText Items menu item

1. When the SMARTText Items dialog opens, Click the Create button.
2. This will bring up the SMARTText Type Selection window.



## Select the Item Type



1. Click the Item Type drop-down menu near the bottom of the SMARTText Type Selection dialog.
2. Click the Entry Fields plus-box.
3. Double-click the appropriate type of field name (i.e. Generic Summary Field or Generic Encounter Field).

Click Create.

The screenshot shows the SMARText Designer window with the following configuration:

- Shortcut:** dismeds
- Description:** Discontinued Medications Field
- Keywords:** discontinued, meds, field
- Display Header:** ☒ Display Header: Discontinued Medications ☐ only when item is empty.
- Advanced:**
  - General:**
    - Item Type:** Generic Summary Field
  - Item Properties:**
    - Item Settings:** (Empty text area)
    - Item Separators:**
      - ☒ As Is
      - ☐ Separate with [ ]
      - ☐ Separate Lines
      - ☐ English List (and)
      - ☐ English List (or)
      - ☐ End with [ ]

At the bottom right, there are **Save** and **Cancel** buttons.

1. At the top of the SMARText Designer window, Type a Shortcut, Description and Keywords.
2. Type the Name of the Field Header in the Display Header box.
3. Click the Display Header check box. Click Save.

## Insert the New Field

### Medications

[  
dismeds

### ]Allergies

[Starter - Allergies - Summary:](#)

1. Open the docuplate to change.
2. The user should Click at the location where he/she wants to insert the new field name/header. A set of small green brackets will appear, indicating that the user is working outside of the fields within the docuplate. Hit enter three or four times to create some space for the new field.
3. Type the Shortcut for the new field.

## Insert the Field Header

### Medications

### Discontinued Medications

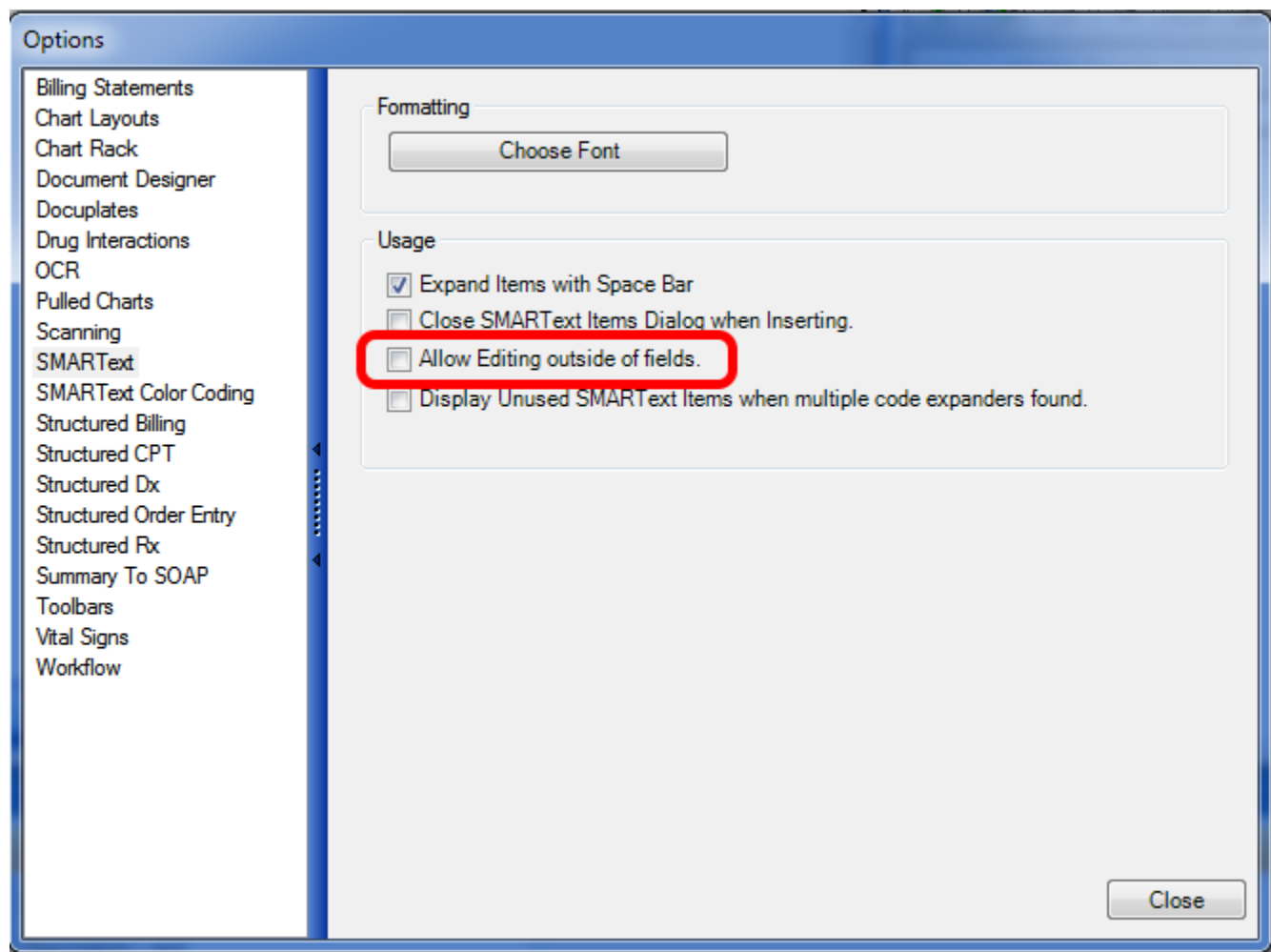
[ ]

### ]Allergies

[Starter - Allergies - Summary:](#)

Then press the space bar, and the field/header is inserted.

## Disable Editing Outside of Fields



Click Tools in the menu bar > Click the Options menu item > Click the SMARTText Items menu item > Click the Allow Editing outside of fields check box to toggle it back to unchecked > Click Close, and Log out/Log in.

# Vital Signs Section

## Introduction to Vital Signs

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The Vital Signs section of a patient chart allows the provider to enter vital sign readings by date and time, and to graph those readings to provide a fast, easily viewed means of tracking changes.

### \* REQUIRED FOR MEANINGFUL USE

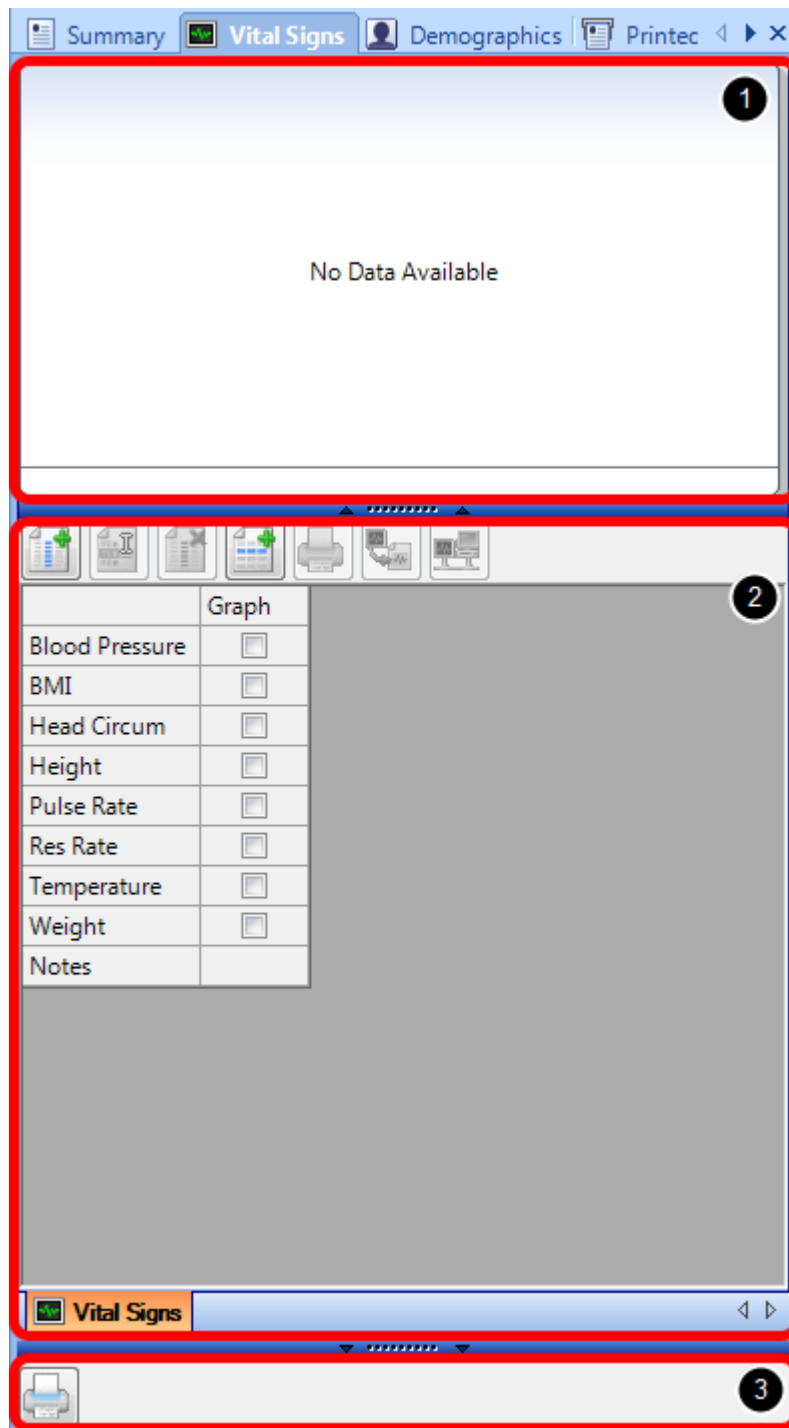
#### - Record Vital Signs

### Paper Connection

In a paper office, vital signs readings are often recorded directly into an encounter note. While this serves for the individual encounter, it does not provide an easy means of tracking possible changes in a patient's vital signs.

Since any changes might be indicative of an undiscovered problem, the ability to track changes can greatly enhance and improve the overall level of patient care.

In SOAPware, not only are vital signs easily entered and recorded in the Vital Signs section, they can easily be moved to the current SOAPnote via a few clicks of the mouse or a keyboard shortcut.



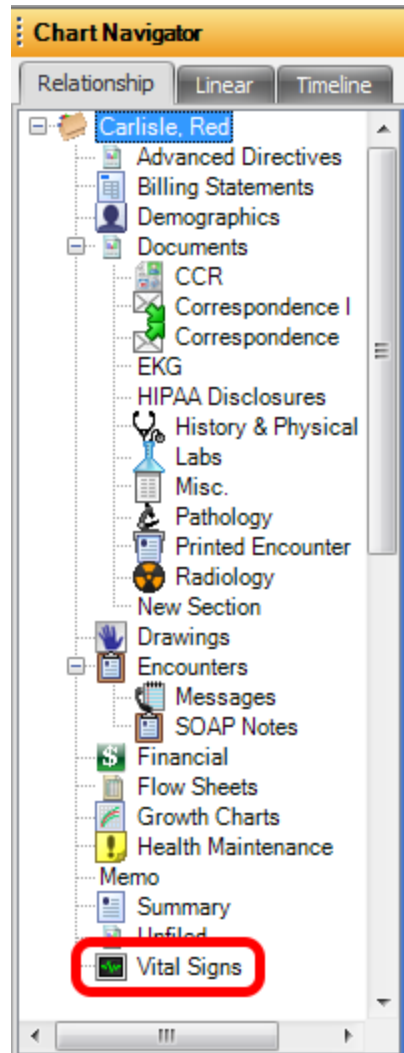
The Vital Signs section consists of three areas.

1. The top section is where a graph is displayed when data is selected for graphing.
2. The middle section contains the Vital Signs editor, which allows entry and modification of vital signs readings, and choices of vital signs to be graphed in the graph section.

3. The bottom section has a printer button.

User can resize these sections by using the splitter bar that separates them.

## Basics



To access the Vital Signs section: choose Sections > Vital Signs from the Chart menu located on the main SOAPware menu bar.

**NOTE:** A patient chart must be open in order to access the Vital Signs section.



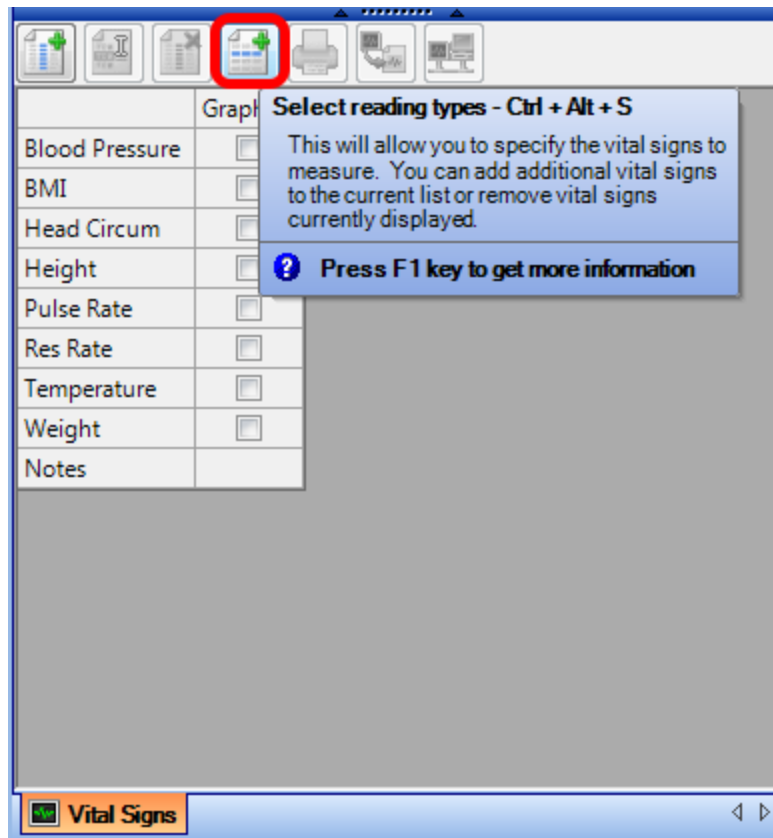
## Customizing Vital Signs View and Unit System

A user can customize what vital signs are included in the reading types. To customize the vital signs chart section to include the readings needed, follow the instructions below.

**\* REQUIRED FOR MEANINGFUL USE**

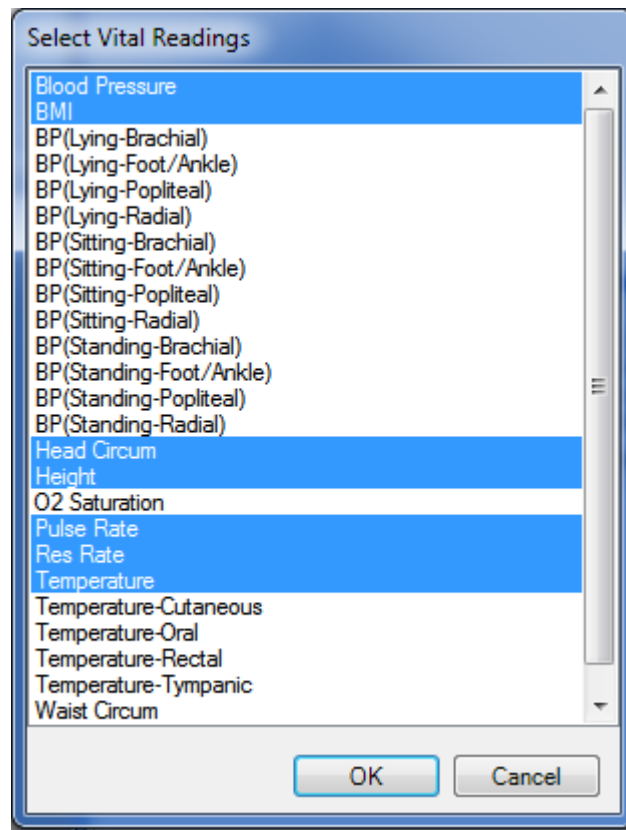
- Record Vital Signs

### Select Reading Types



Click on "Select Reading Types" icon.

## Choose the Vitals Readings



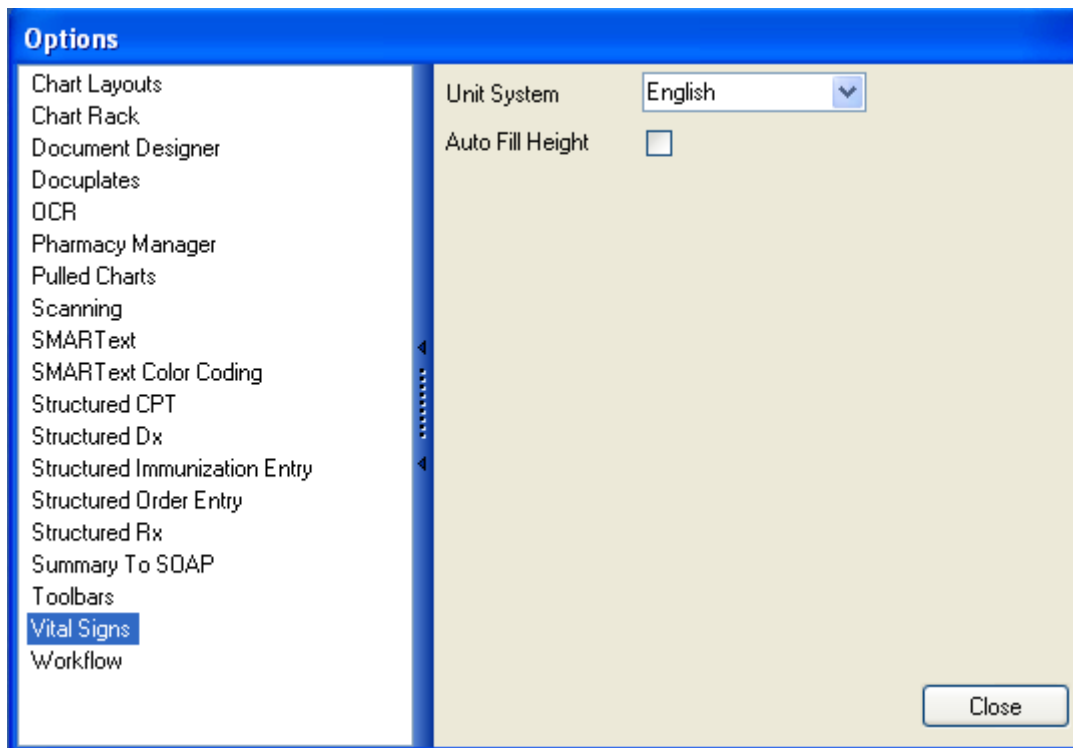
Click to highlight the vital signs to be included. There is no need to hold control or shift while doing this, simply left-clicking on a new selection will add it to the reading types to be included.

If a user wishes to remove vital signs, Click to un-highlight the vital signs to be excluded.

Click OK to save the settings.

**NOTE: These changes are not global; they will be per patient.**

## Customizing the Vital Signs Unit System (English vs Metric)



The Vital Signs chart section can be set to use either the English or Metric Unit System.

To access this options, Click the Tools menu, then select Options. Next, highlight the Vital Signs options from the menu on the left hand side of the window.

This option allows the user to choose English or Metric for the Unit System. In addition the Auto Fill Height options can be activated.

## Add / Edit Vital Reading Date

**\* REQUIRED FOR MEANINGFUL USE**

- Record Vital Signs

### Patient Meaningful Use Dashboard:

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

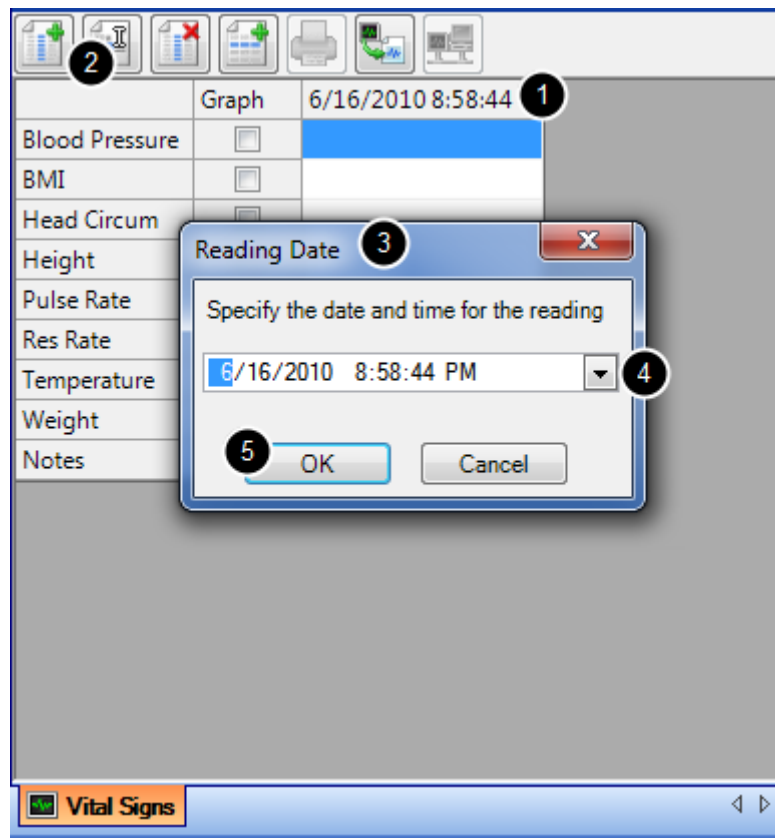
### Add a Reading Date

The screenshot shows a software interface for recording vital signs. At the top, there is a toolbar with icons for adding, editing, deleting, and printing. Below the toolbar is a table with the following rows: Blood Pressure, BMI, Head Circum, Height, Pulse Rate, Res Rate, Temperature, Weight, and Notes. Each row has a checkbox. A new column is added to the right of the table, with the date and time '6/16/2010 8:58:44' displayed at the top. The interface is titled 'Vital Signs' at the bottom.

To add a reading date:

1. Click the Add Reading Date Button (or press Control + Alt + N).
2. A new column will be created with the current date and time displayed at the top.

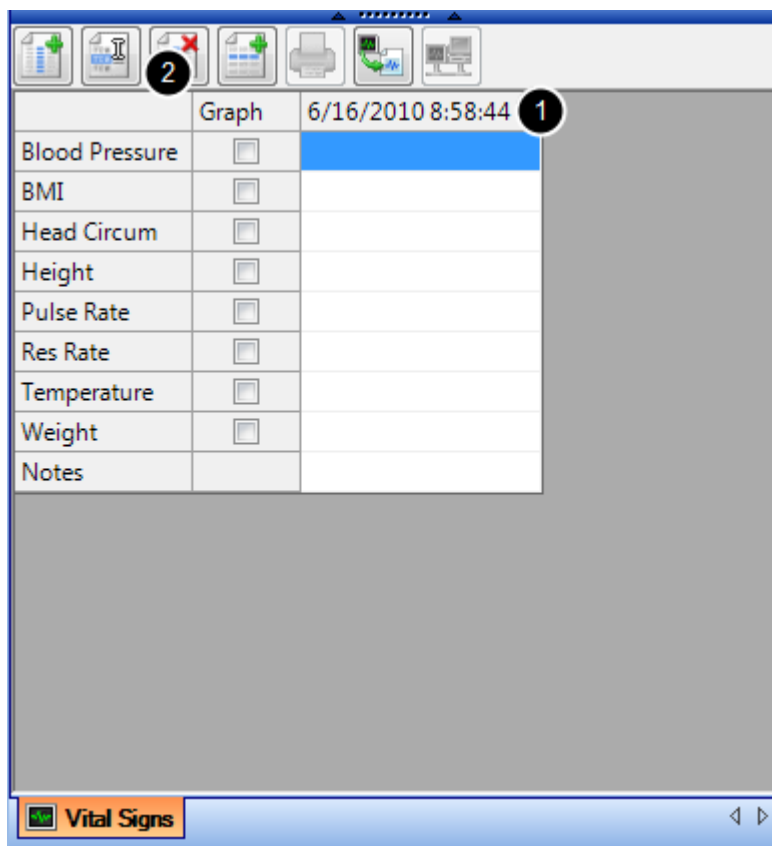
## Edit a Reading Date



To edit a reading date:

1. Select it by Clicking the top of the column.
2. Then, Click the Edit Reading Date Button (or press Control + Alt + E).
3. The Reading Date dialog box will open, asking the user to specify the date and time for the reading.
4. New information may be typed in, or entered using the drop-down arrow to select a date and then change the time manually.
5. When the user is satisfied with the changes, Click OK (or press Enter); the date and time will be changed at the top of the reading column.

## Remove a Reading Date



To remove a reading date:

1. Select it by Clicking the top of the column.
2. Then, Click the Remove Reading Date Button (or press Control + Alt + R).

**NOTE:** Removal of the selected selected reading date will result in the loss of all contained readings.

## Inserting Vital Signs

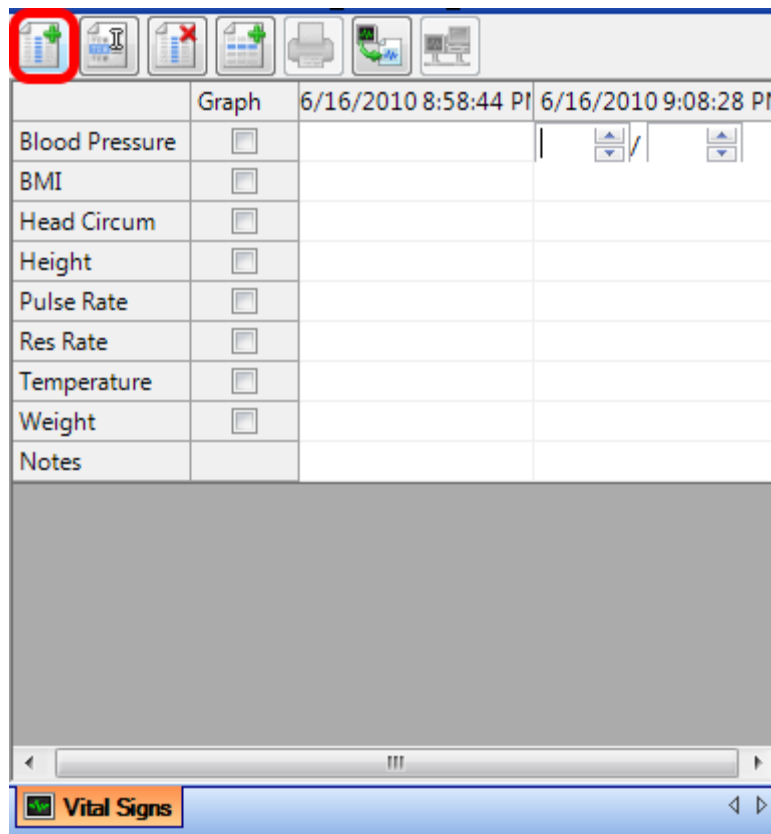
**\* REQUIRED FOR MEANINGFUL USE**

- Record Vital Signs

### Open Vital Signs

Click on the Vital Signs tab in the patient's chart (OR) Click on Chart in the SOAPware menu bar > Chart Navigator > Vital Signs.

### Add a Reading Date









	Graph	6/16/2010 8:58:44 PM	6/16/2010 9:08:28 PM
Blood Pressure	<input type="checkbox"/>		
BMI	<input type="checkbox"/>		
Head Circum	<input type="checkbox"/>		
Height	<input type="checkbox"/>		
Pulse Rate	<input type="checkbox"/>		
Res Rate	<input type="checkbox"/>		
Temperature	<input type="checkbox"/>		
Weight	<input type="checkbox"/>		
Notes			

Click on the "Add Reading Date" icon.

To change the reading date/time, see: [Add / Edit Vital Reading Date](#)

## Insert Vital Signs

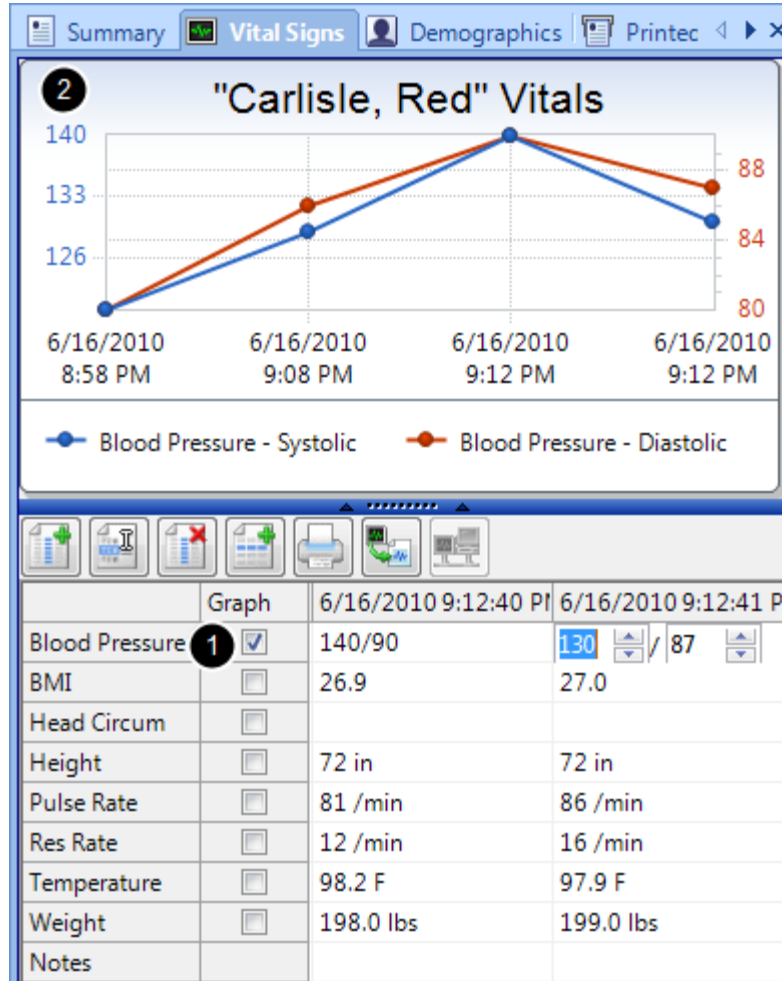
     		
	Graph	6/16/2010 8:58:44 PM
Blood Pressure	<input type="checkbox"/>	120 / 80
BMI	<input type="checkbox"/>	26.7
Head Circum	<input type="checkbox"/>	
Height	<input type="checkbox"/>	72 in
Pulse Rate	<input type="checkbox"/>	80 /min
Res Rate	<input type="checkbox"/>	16 /min
Temperature	<input type="checkbox"/>	98.6 F
Weight	<input type="checkbox"/>	197.0 lbs
Notes		

Meaningful Use Required fields for Vital Signs are blood pressure, height, weight, and BMI (which is auto calculated when height and weight measurements are entered for the patient).



## Graphing Vital Signs

### Select Vitals to Graph



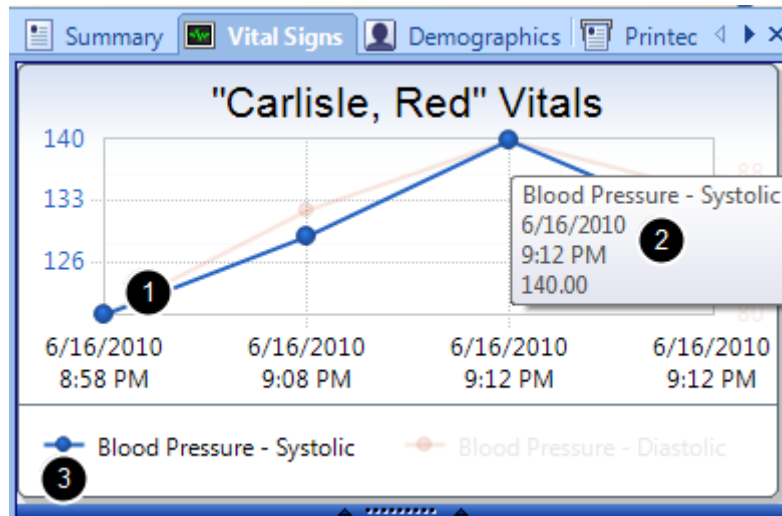
To graph vital signs:

1. Users simply place a check in the box next to the readings that he/she wishes to see displayed as a graph.
2. SOAPware will automatically display a graphical representation of the selected vital signs in the top area of the Vital Signs section of the patient chart.

**NOTE: Users must select a reading with multiple reading dates in order to view a graph of the selected vital sign(s).**

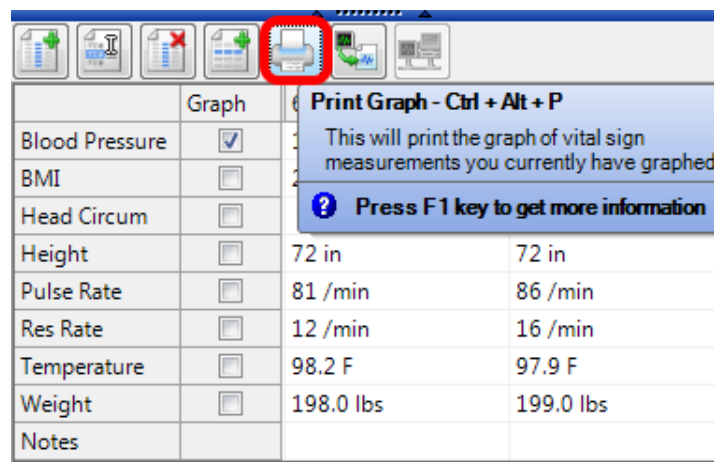
If several vital signs are selected, the graph may become difficult to read. If this occurs, expand SOAPware to a larger display size by clicking the "maximize" button in the top right of the SOAPware window.

## Reading the Graph



1. Hovering over any part of a particular line on the graph will bring the entire line forward and fade the others into the background. This allows the user to easily view the graph for a particular vital sign, without having to de-select the other graphed readings.
2. To display the values of a single point on the graph, the user needs to hover the mouse cursor over the point to view. The item, date, time, and value will be displayed.
3. Another method of viewing a single line at a time is to hover the mouse cursor over the legend entry for that particular reading. The legend appears directly below the graph in the graph area of the vital signs section.

## Printing a Graph



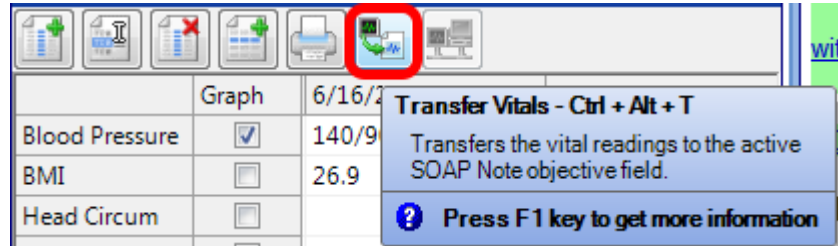
To print the currently graphed vital signs, click the Print Graph Button (or press Control + Alt + P).

A print dialog box will be displayed, allowing the user to select the printer and printing properties

for the graph. Once the user has chosen these, Click OK. The graph will be printed to the printer the user has chosen.

## Transferring Vital Signs to the Active SOAPnote

### Transfer Vitals



To transfer vital signs to the Objective field of the active SOAPnote:

1. Select a reading date to transfer by clicking on the head of the column.
2. Click the Transfer Vitals Button (or press Control + Alt + T). The readings for the selected reading date will be transferred to the active SOAPnote.

### The SOAPnote with Vitals

**Objective[**  
VS: BMI: 27.0. BP: 130/87. H: 72 in. P: 86 /min.  
RR: 16 /min. T: 97.9 F. W: 199.0 lbs. |  
Exam: GENERAL: Appearance: General  
appearance can be described as well-nourished,  
well-developed, and in no acute distress. ]

Vital Sign readings are now located in the SOAPnote, field header "Objective."

## Vital Signs Reading Types

---

The Vital Signs Reading (VSR) Types are the core of the Vital Signs section of the patient chart. Using VSR types, the user can input, modify, and track a patient's vital sign readings.

Each VSR type has pre-set upper and lower limits ("smart" values). These smart values assist in assuring accurate data entry by reducing the amount of erroneous data that can be entered into a given type.

**NOTE: These values should be sufficient for most practices. If the user finds that he/she regularly needs to enter a value outside these ranges, please contact SOAPware technical support.**

### Blood Pressure

The lower and upper limits of the systolic and diastolic ranges are 0-250 and 0-200, respectively.

### Head Circumference

The lower and upper limits of this range are 11.7 to 23.4 inches.

### Height

The lower and upper limits of this range are 15 to 95 inches.

### O2 Saturation

The lower and upper limits of this range are 50 to 100%.

### Pulse

The lower and upper limits of this range are 30 to 220/min.

### Respiratory Rate

The lower and upper limits of this range are 4 to 60/min.

### Temp

The lower and upper limits for this value are 90 to 110 (F).

## Weight

The lower and upper limits of this range are 3 to 550 pounds.

# Growth Charts Section

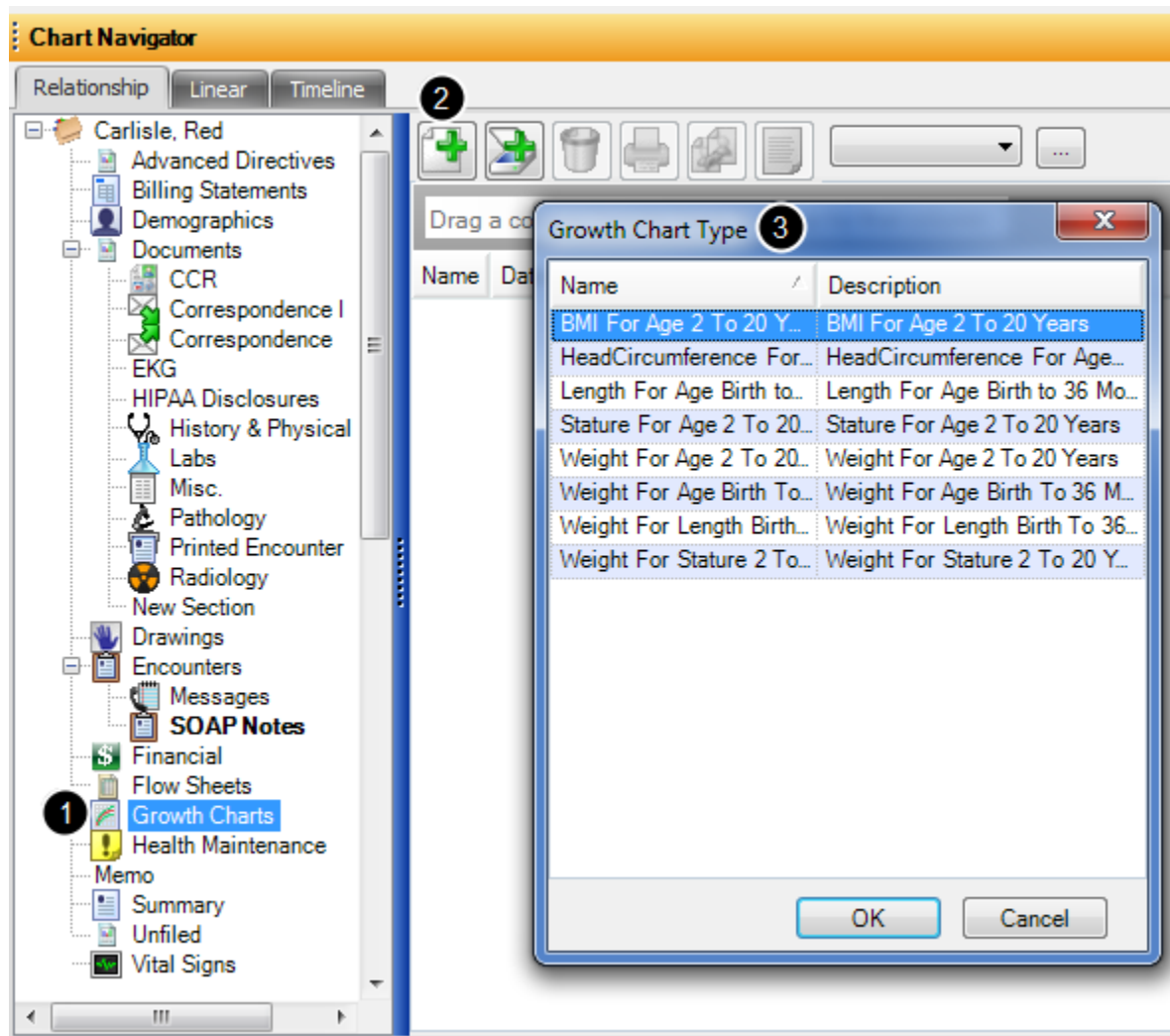
## Growth Charts Interface

SOAPware's Growth Charts can be used to automatically track growth rates and percentile comparisons for patients over time for both girl and boy genders. The patient's gender and birth date must be entered in the General Demographics chart section for this to take effect. Based on the CDC standard growth charts, measurement data points are pulled from patients' Vital Signs and automatically plotted. Growth charts may be printed for off line use.

**\* REQUIRED FOR MEANINGFUL USE**

- Record Vital Signs/Growth Charts

### Accessing Growth Charts from Chart Navigator



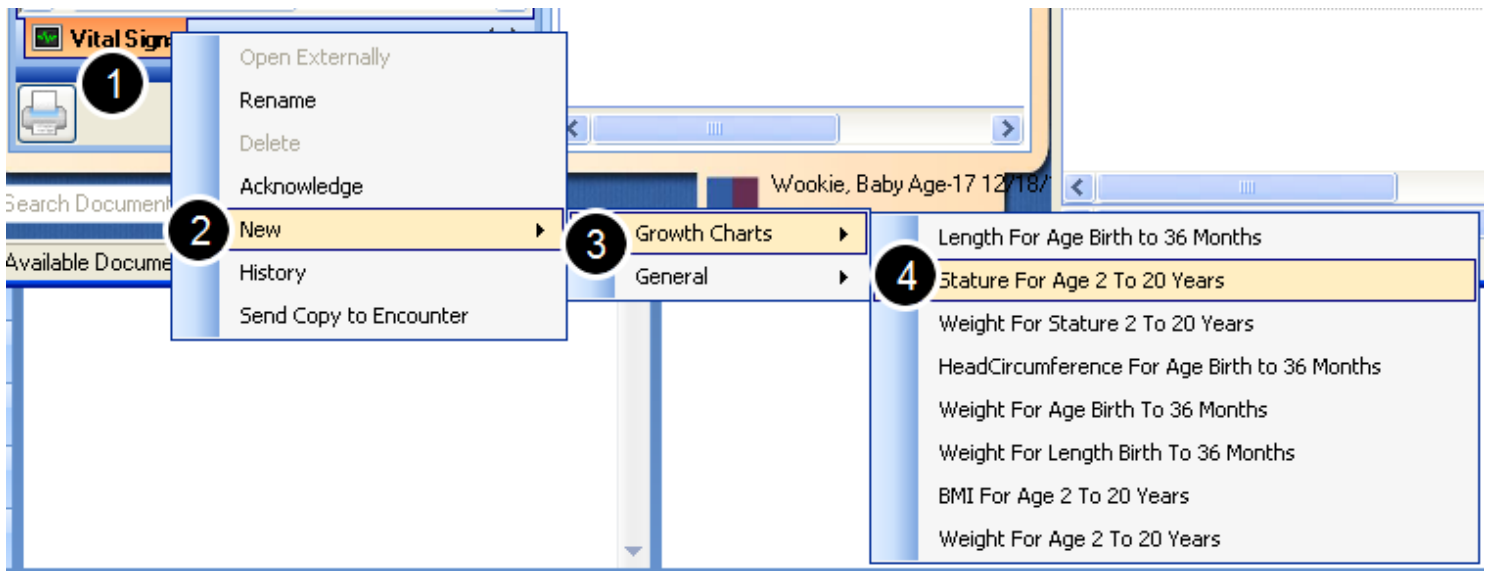
Go the Chart Menu > Chart Navigator

1. Choose Growth Charts
2. Click the Create Docutainer button in the window to the right.

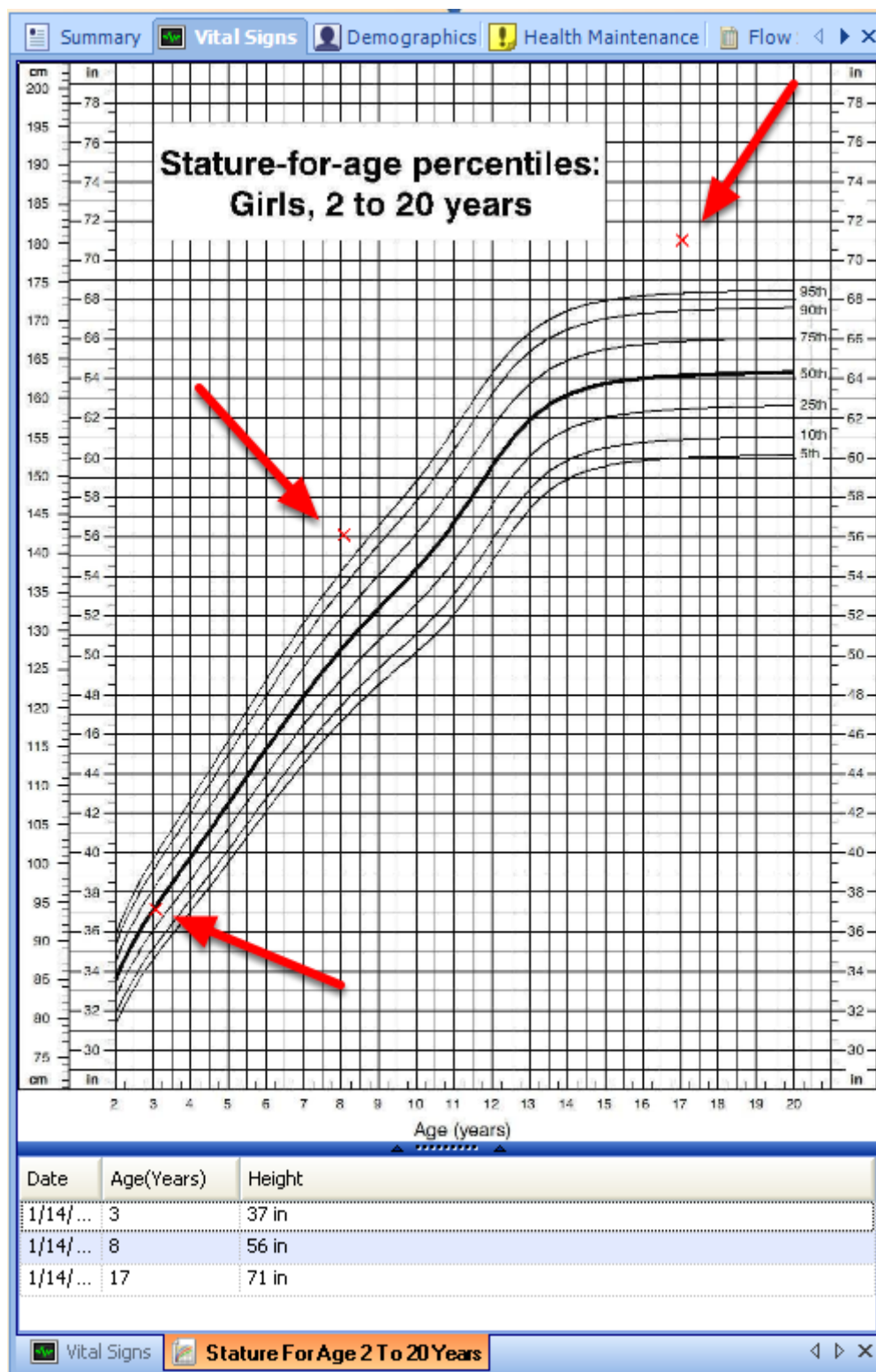


3. Select the desired Growth Chart Type.

## Accessing Growth Charts from Vital Signs



1. Right Click over the Vital Signs tab at the bottom of the section.
2. Select New
3. Select Growth Charts
4. Select desired Growth Chart



SOAPware will automatically plot the values on the chart using red X's and will continue to plot the Vital Signs by sequential dates.

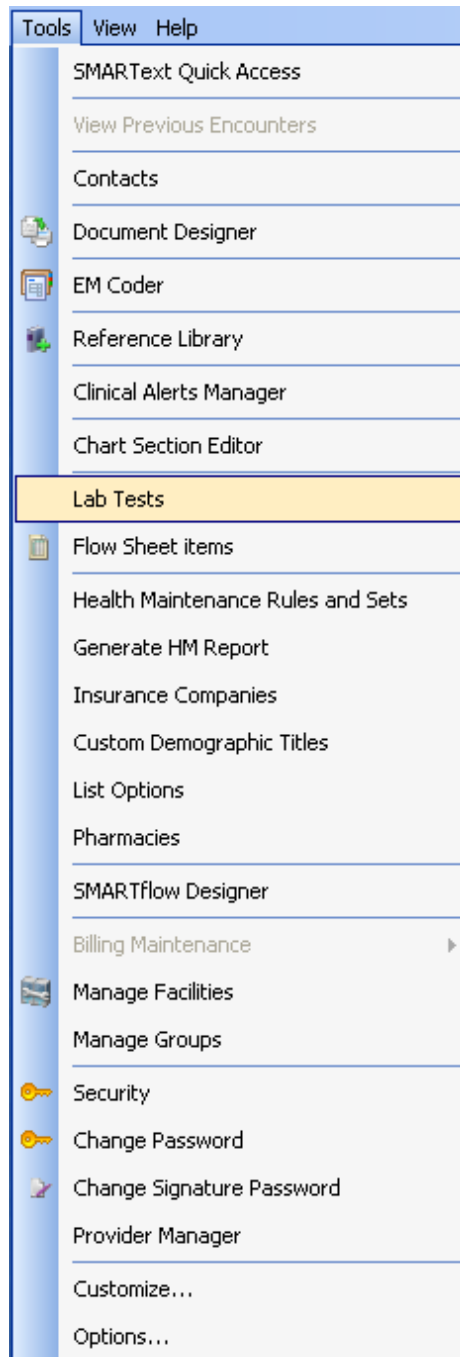
# Labs

## Creating and Editing Lab Tests

---

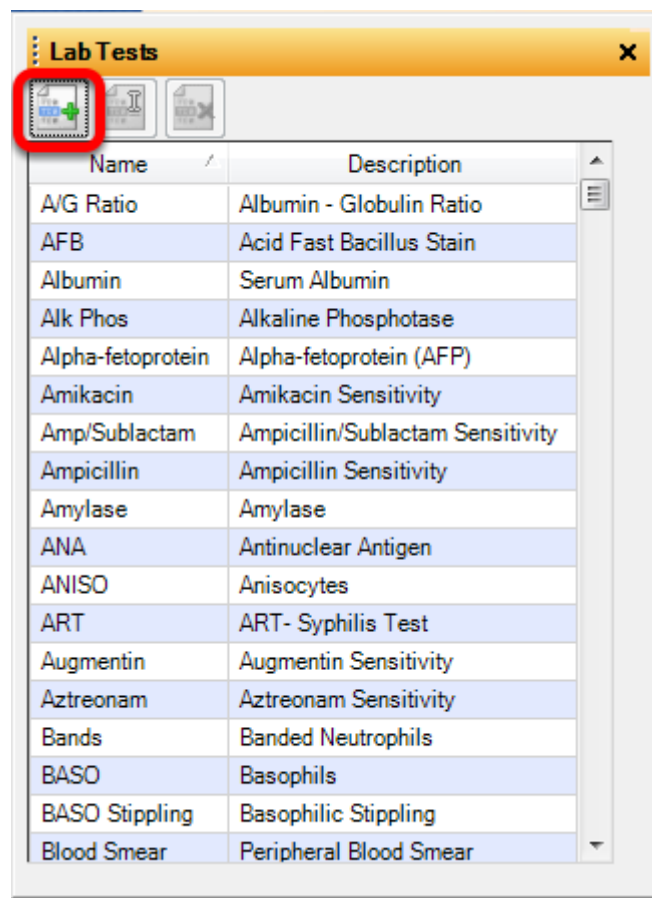
This lesson will explain how to create individual lab tests with reference ranges. These lab tests can be pulled into lab docuplates for documentation of lab results in the clinic. Lab docuplates will be discussed in the next lesson.

### Lab Tests



1. Go to the Tools Menu.
2. Click on Lab Tests.

## Add a Lab Test



To create a specific lab test the user will click on the green (+). This will bring up the Lab Test editor.

## Create Labs with Numeric Ranges

The image shows a 'Lab Test Editor' dialog box with the 'Test Type' set to 'Numeric Range'. The dialog includes fields for 'Test Name', 'Test Description', and 'Test Units'. Below these is a 'Reference Ranges' section with two columns, 'Low' and 'High', and four rows for 'Adult male', 'Adult female', 'Child', and 'General'. Each row has a numeric input field with up and down arrows. The 'OK' and 'Cancel' buttons are at the bottom right. Numbered callouts 1 through 6 point to the following elements: 1. Test Type dropdown, 2. Test Name field, 3. Test Description field, 4. Test Units dropdown, 5. Reference Ranges section, and 6. OK button.

1. Select Test Type.
2. Enter Test Name.
3. Enter Test Description.
4. Select Test Units.
5. Enter Reference Ranges for Adult Male, Adult Female, Child and General.
6. Click OK.

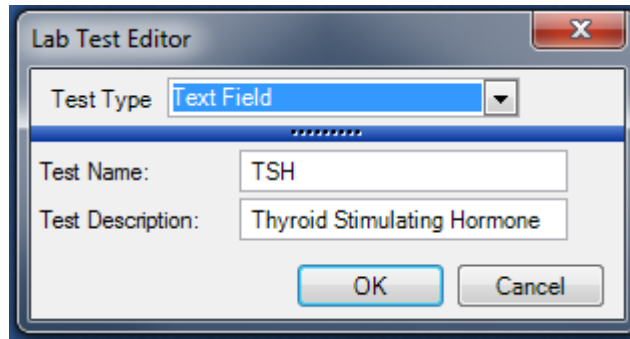
## Create Labs with Pick List Values

The image shows a 'Lab Test Editor' dialog box with the 'Test Type' set to 'Pick List'. The dialog includes fields for 'Test Name' and 'Test Description'. Below these is a 'Pick-list values (each entry on a single line):' section with a text area containing a list of values: 'Straw', 'Yellow', 'Dk. Yellow', 'Amber', 'Lite Amber', 'Dk. Amber', and 'Red'. The 'OK' and 'Cancel' buttons are at the bottom right.

1. Select Test Type.
2. Enter Test Name.
3. Enter Test Description.

4. Enter Pick list value press the "Enter key" and enter second Value. Press the "Enter Key" and enter third value. Continue until all values are entered in this box.
5. Press OK to save this lab test.

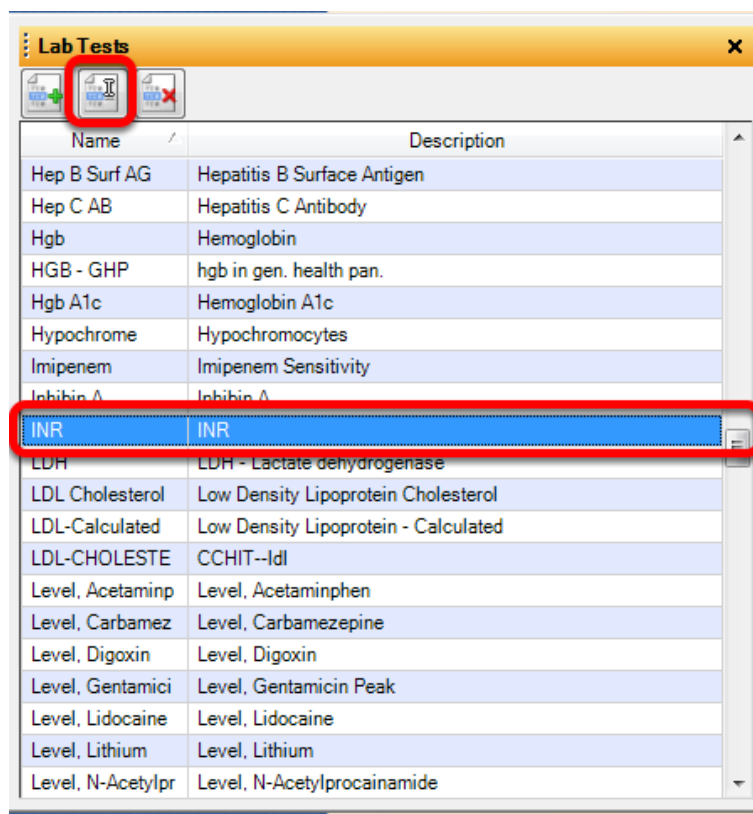
## Create Labs with Text Fields



The Lab Test Editor dialog box is shown. It has a title bar with a close button (X). Inside, there is a 'Test Type' dropdown menu set to 'Text Field'. Below this, there are two text input fields: 'Test Name' containing 'TSH' and 'Test Description' containing 'Thyroid Stimulating Hormone'. At the bottom right are 'OK' and 'Cancel' buttons.

Text Field labs allow the user to free text lab findings into the lab docuplate. These are not graph-able.

## Edit



The Lab Tests window is shown. It has a title bar with a close button (X). Below the title bar are three icons: a green plus, a red minus, and a red X. The main area is a table with two columns: 'Name' and 'Description'. The 'INR' row is highlighted with a red box. The 'LDH' row is also highlighted with a red box.

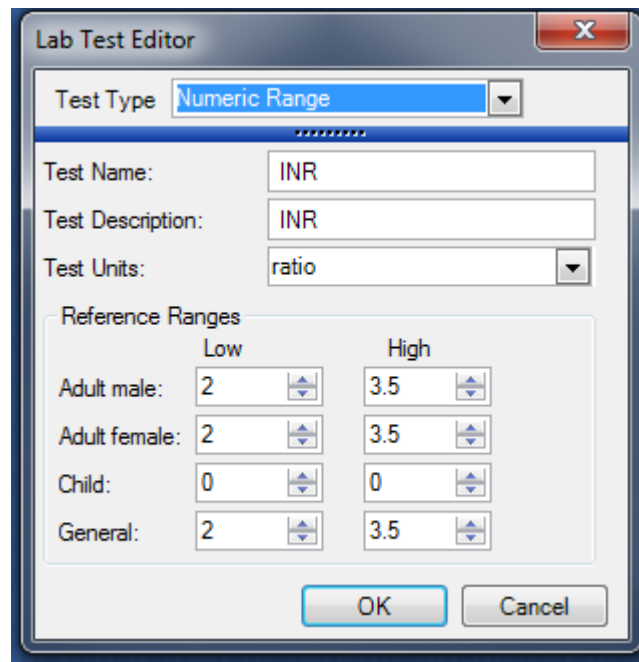
Name	Description
Hep B Surf AG	Hepatitis B Surface Antigen
Hep C AB	Hepatitis C Antibody
Hgb	Hemoglobin
HGB - GHP	hgb in gen. health pan.
Hgb A1c	Hemoglobin A1c
Hypochrome	Hypochromocytes
Imipenem	Imipenem Sensitivity
Inhibin A	Inhibin A
INR	INR
LDH	LDH - Lactate dehydrogenase
LDL Cholesterol	Low Density Lipoprotein Cholesterol
LDL-Calculated	Low Density Lipoprotein - Calculated
LDL-CHOLESTE	CCHIT--Idl
Level, Acetaminp	Level, Acetaminphen
Level, Carbamez	Level, Carbamezepine
Level, Digoxin	Level, Digoxin
Level, Gentamici	Level, Gentamicin Peak
Level, Lidocaine	Level, Lidocaine
Level, Lithium	Level, Lithium
Level, N-Acetylpr	Level, N-Acetylprocainamide

To Edit an Existing Lab:

1. Highlight lab to edit.

2. Click on the Edit Icon.

## Numeric Range



The Lab Test Editor dialog box is shown with the following fields and values:

- Test Type:** Numeric Range (dropdown menu)
- Test Name:** INR
- Test Description:** INR
- Test Units:** ratio (dropdown menu)
- Reference Ranges:**

	Low	High
Adult male:	2	3.5
Adult female:	2	3.5
Child:	0	0
General:	2	3.5

Buttons: OK, Cancel

Make necessary changes to Lab Test and press OK to save.



## Lab Docuplates

---

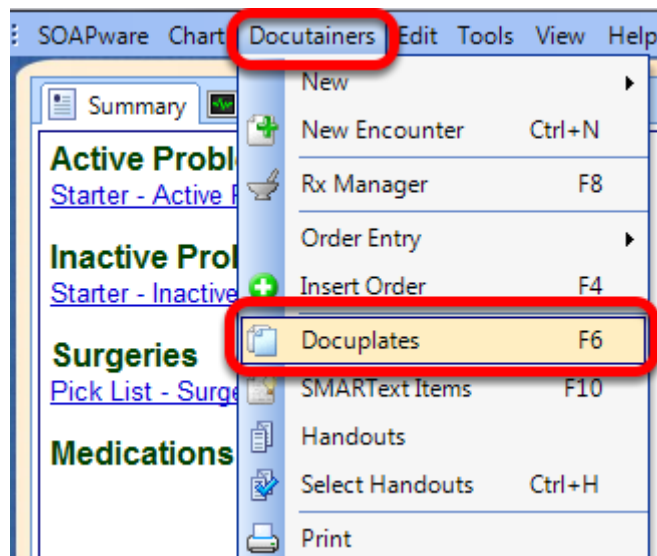
This lesson will cover how to search and create lab docuplates.

Lab docuplates are used for documenting groups of lab tests. For example a CBC is composed of many lab tests: WBC, RBC, Hbg, Hct, etc. A lab docuplate for a CBC would contain all of the individual tests that make up that CBC.

**\* REQUIRED FOR MEANINGFUL USE**

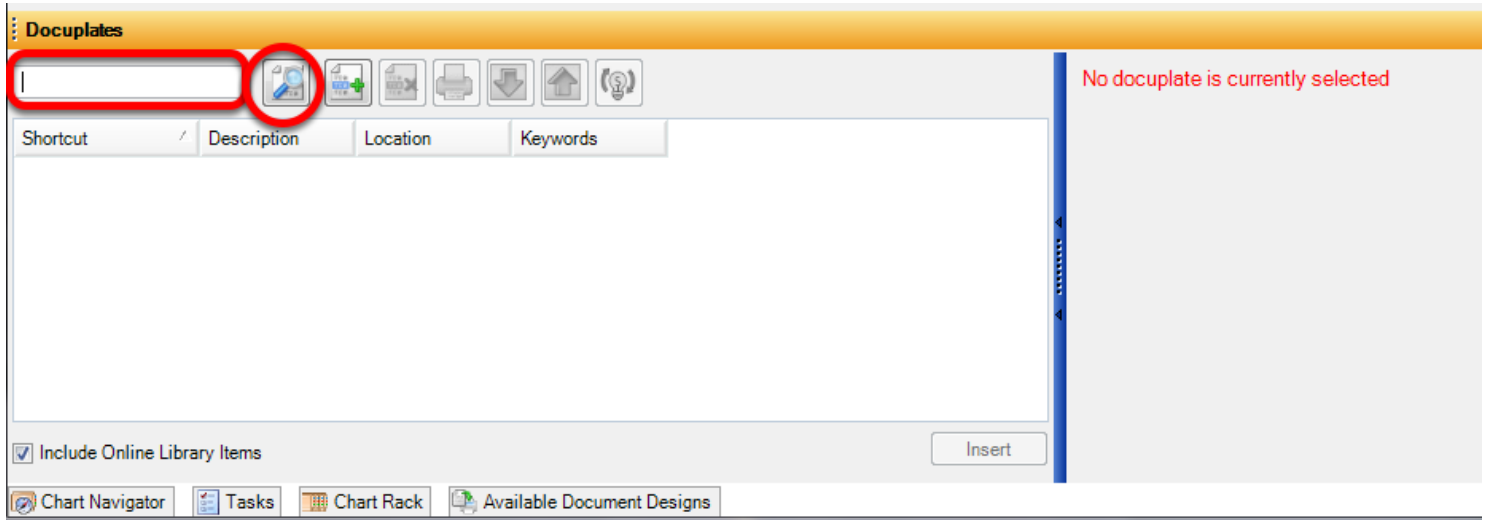
- Clinical Lab Test Results

### Searching for Lab Docuplates



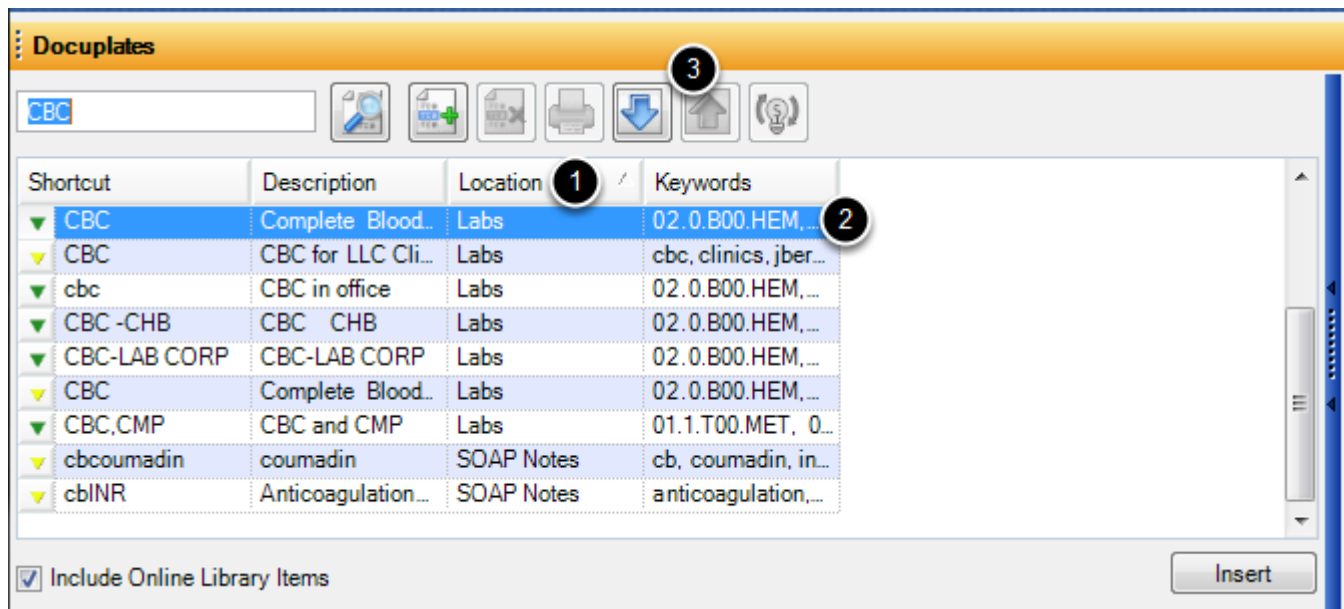
Many lab docuplates are pre-built by SOAPware. To search for available lab docuplates, click on the Docuplates tab docked at the bottom of the screen or click in the menu bar Docutainers > Docuplates

## Search



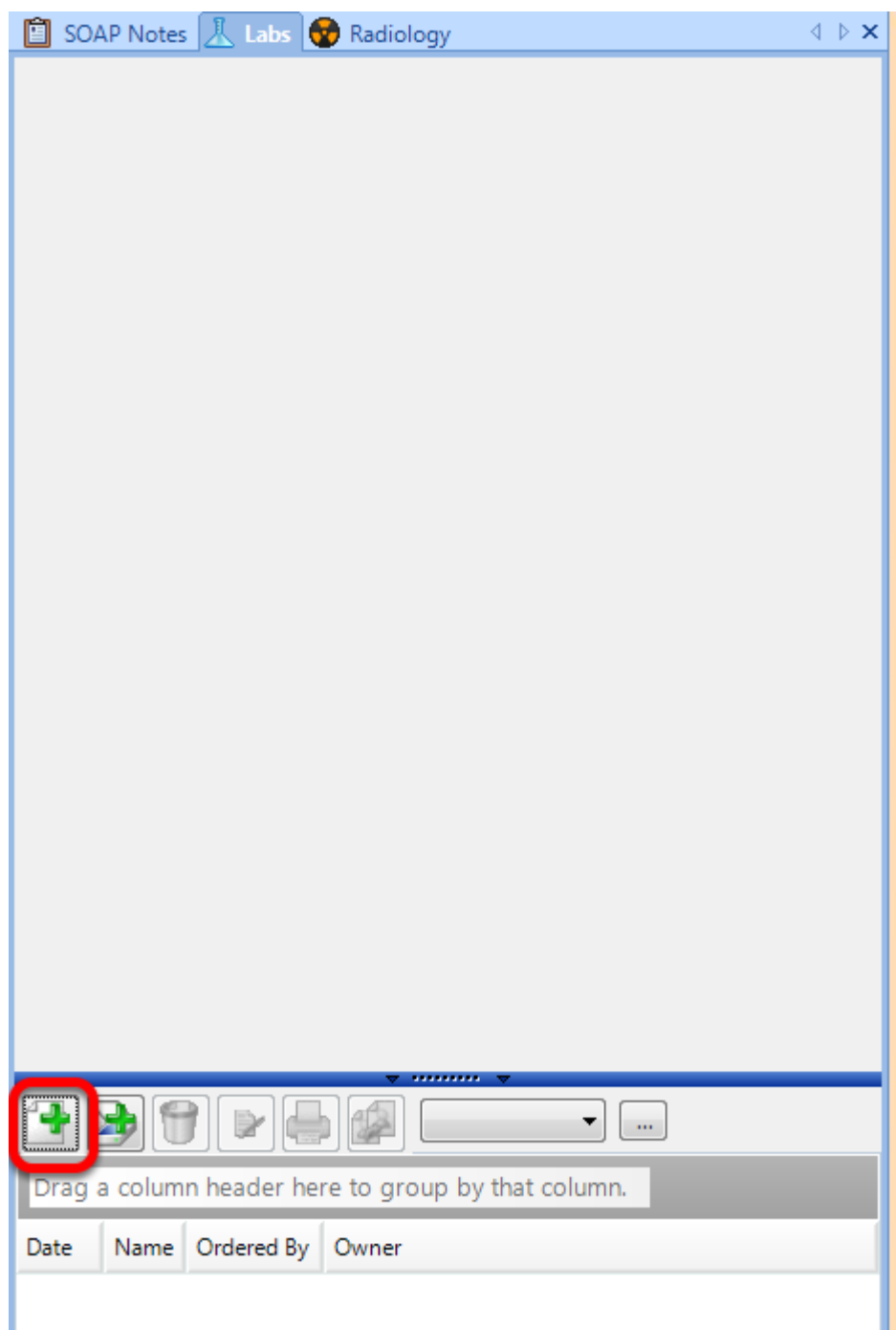
To search for a docuplate, enter a keyword and Click on the Search button.

## Download Docuplate



1. Click on Location to sort the docuplates.
2. Find docuplates in the Labs location.
3. Download the docuplate to the local library.

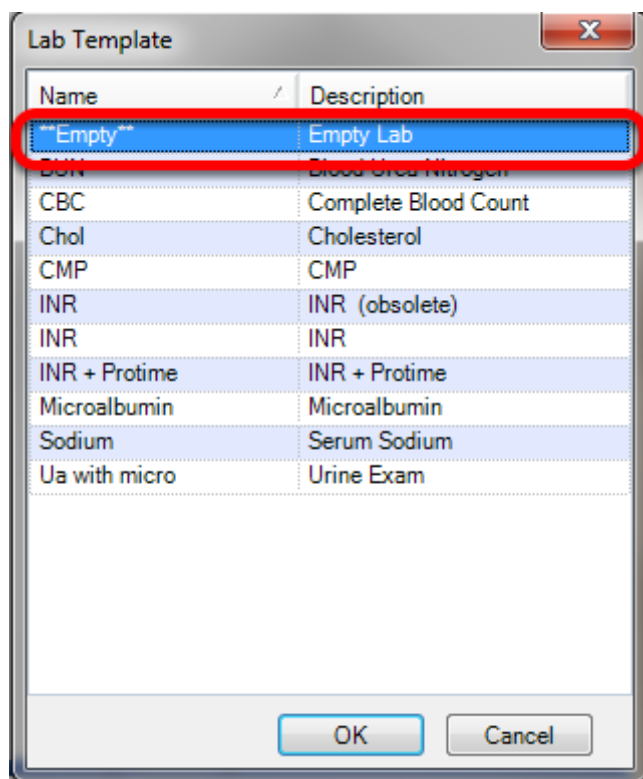
The docuplate is now ready to use within the network.



To Create a lab docuplate:

1. Open a "test" chart.
2. Open the Lab Chart section.
3. Click on the green + to create a new lab docutainer.

## Select Empty



Select the Empty Lab template and click OK.

## To Add a Lab Test

The screenshot shows the 'Radiology' application window. At the top, there are tabs for 'SOAP Notes', 'Labs', and 'Radiology'. Below the tabs is a form with the following fields:

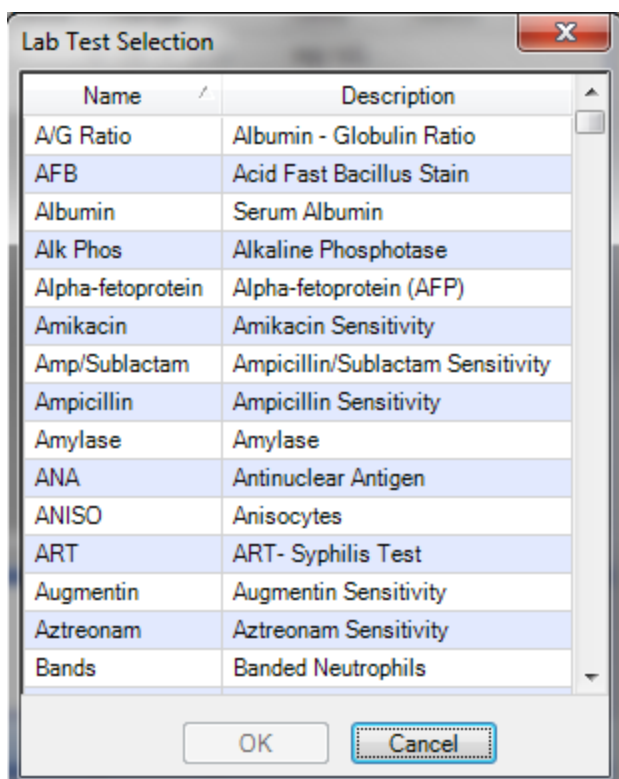
- Date: 07/22/2010 10:26 AM (dropdown)
- Name: Empty Lab (text input)
- Ordered By: (dropdown)
- Owner: Jennifer Berg (text input)

Below the form is a toolbar with icons for adding, deleting, and saving. The main area is a table with the following columns: Name, Flags, Value, Range, Units, Status, Code, Date, Range, Status. The table is currently empty. Below the table is a toolbar with icons for adding, deleting, and saving. The bottom of the window shows a status bar with the text 'Drag a column header here to group by that column.' and a table with the following data:

Date	Name	Ordered By	Owner
7/22/2010 10:26:20 AM	Empty Lab		Jennifer Berg

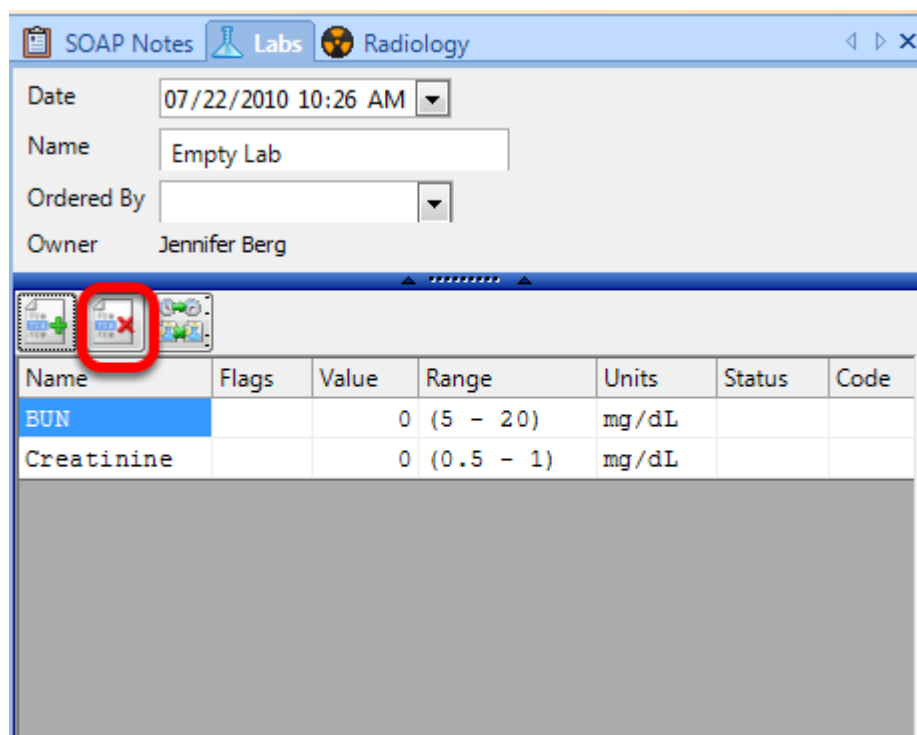
Click on the green + at the top of the Lab Encounter to enter lab tests.

## Select Lab Tests



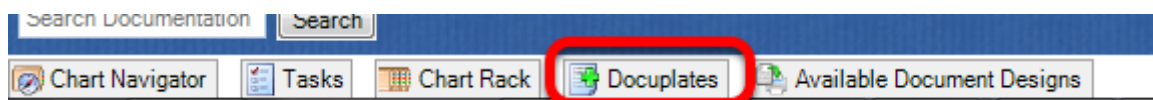
Auseris to highlight the lab tests he/she wants to include and Click OK. To highlight multiple lab tests, Click and hold down the Control key on the keyboard and select the lab tests to add. The lab tests will display in the order they are selected. These cannot be moved up or down.

## To Remove a Lab Test



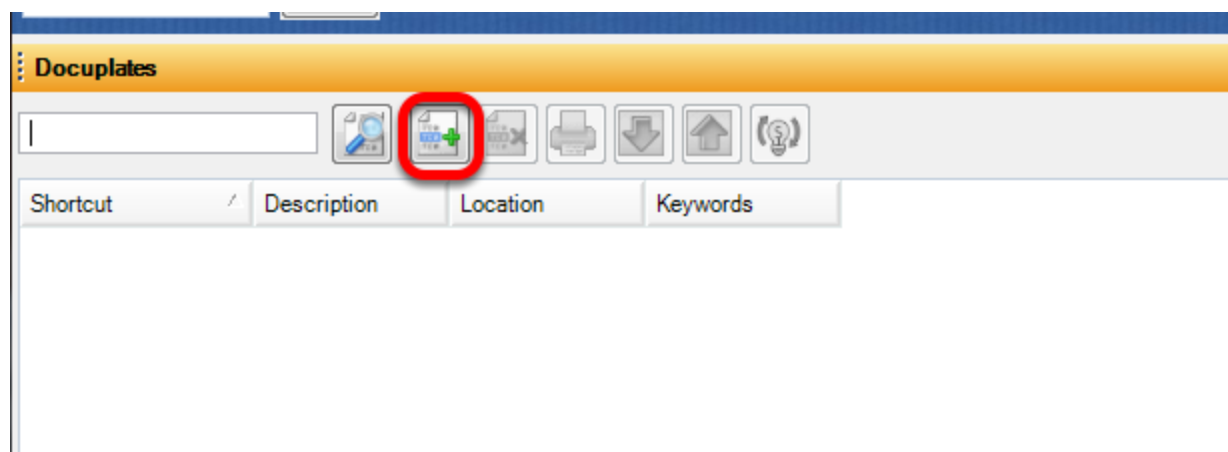
If a test needs to be removed, Click on the red X button.

## Creating the Docuplate



Click on the Docuplates tab docked at the bottom of the screen or select Docutainers > Docuplates from the menu bar.

## Create a New Docuplate



To create the new docuplate, Click on the green + in the Docuplates Menu.

## Enter Docuplate Information

A screenshot of a dialog box titled 'Docuplate Information'. It contains three text input fields labeled 'Shortcut', 'Description', and 'Keywords'. At the bottom, there are 'OK' and 'Cancel' buttons.

1. Give the docuplate a shortcut.
2. Enter a description for the docuplate.
3. Enter key words for the docuplate.



## Introduction to HL7 Labs

HL7 Labs are lab reports received electronically from outside lab facilities. To receive lab results electronically, a "SOAPwareXchangeHL7" license must be purchased.

### \* REQUIRED FOR MEANINGFUL USE

#### - Clinical Lab Test Results

For more information on Setup for SOAPwareXchangeHL7 please [click here](#).

## HL7 Labs in Patient Charts

Name	Flags	Value	Range	Units
REPORT GENERATED: 09/03/2009 10:42 AM				
Patient Name: Slim Jim				
Birthdate: 12/13/1950 12:00 AM				
Social Security: 263720372				
Accession Number: AT368302U				
Order Status: F				
Collection Date: 01/22/2007 12:00 AM				
<b>URIC ACID</b>				
Status: F				
URIC ACID	N	5.7	(1.7 - 7.5)	mg/dL
<b>COMPREHENSIVE METABOLIC PANEL W/EGFR</b>				
Status: F				
GLUCOSE	H	109	(65 - 99)	mg/dL
FASTING REFERENCE INTERVAL				
UREA NITROGEN (BUN)	N	20	(7 - 30)	mg/dL
CREATININE	N	0.8	(0.5 - 1.2)	mg/dL
GFR ESTIMATED	N	>60	> OR = 60	mL/min/1.73m2
IF THE PATIENT IS AFRICAN-AMERICAN				

Labs sent from outside facilities to SOAPware will display in a patient's Chart.

In addition to the lab values and reference ranges, HL7 labs will contain other information within

the report:

- \*Patient demographics
- \*Collection Date
- \*Specimen Source
- \*Report Generated Date
- \*Performing Facility Information

Information contained within this report cannot be edited or deleted.

## HL7 Lab Tasks

Drag a column header here to group by that column.

Patient	Description	Notes	Priority	Action/Status
▶ Jim, Slim	ABN: URIC ACID		Urgent	Needs Review

HL7 lab reports placed in the patient chart will automatically create a task and place item on the ordering provider's task list. This can be signed off or reassigned just as any other task . Note attached to task will say "HL7-facility name".

## Documenting Labs

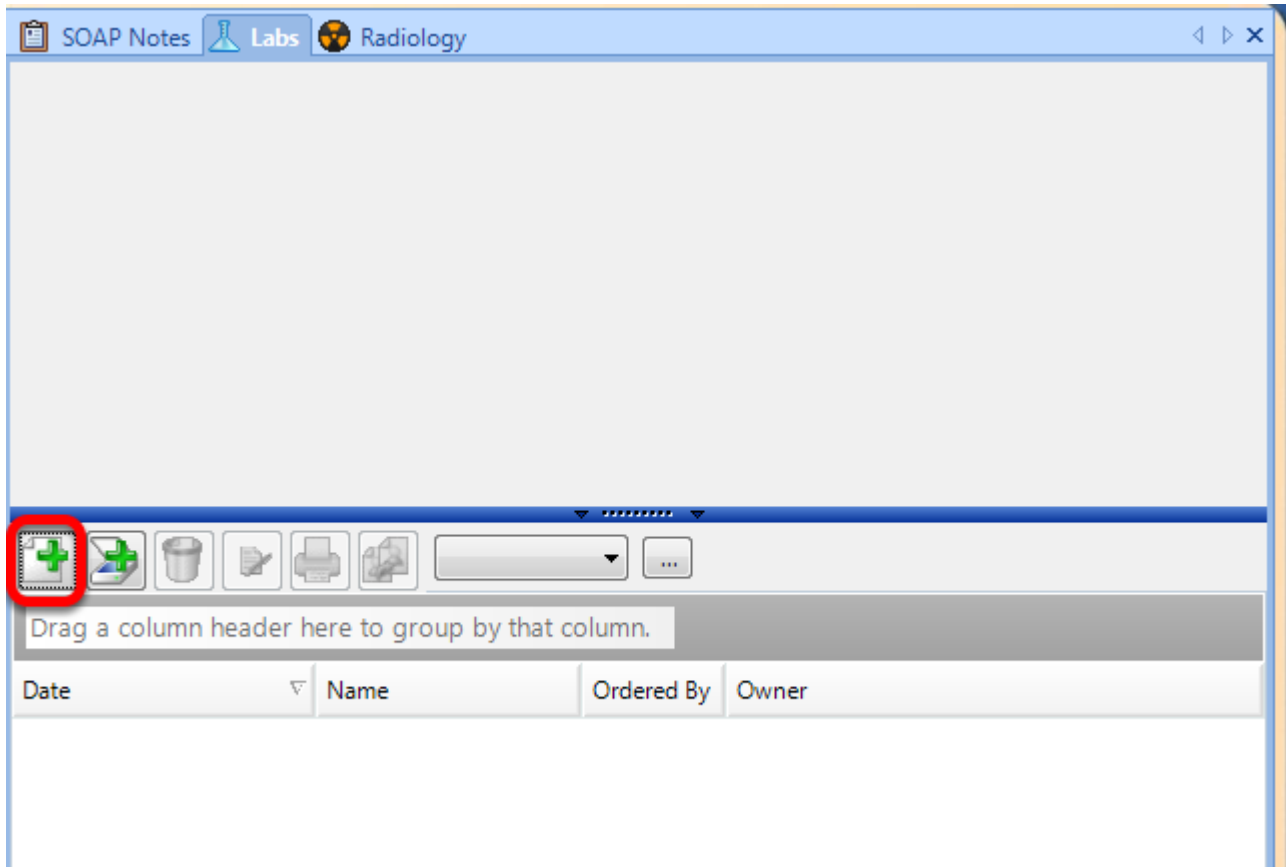
---

This lesson will walk through the workflow of entering Lab results.

**\* REQUIRED FOR MEANINGFUL USE**

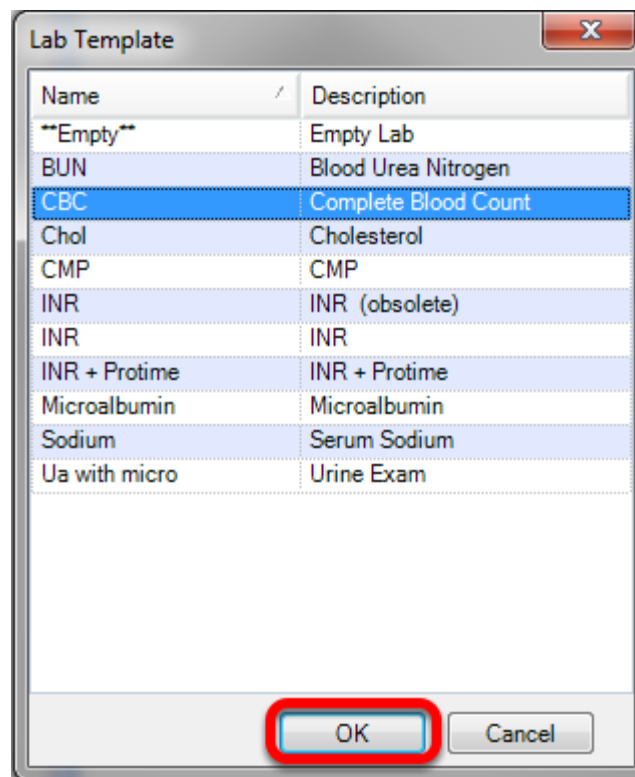
- Clinical Lab Test Results

### Creating a New Lab Result.



Click on the green + in the Labs Chart Section.

## Select Template



To alphabetically sort list click on the header Name or Description. The name of the lab is the information that was entered into the shortcut box when lab docuplate was created. The description of the lab is information that was entered into the description box when the lab docuplate was created. Highlight the desired lab template and select OK.

Add Document Task

Task Info

Description

Owner  Assigned To

Due  Reminder

Priority  Action/Status

Type

Notes

Docutainer Info

Date

Name

Ordered By

Owner Jennifer Berg

☐ Apply To All

This will automatically create a Document Task item. Click Add.

## Enter Results

SOAP Notes Labs Radiology

Date: 07/23/2010 3:35 PM

Name: Complete Blood Count

Name	Flags	Value	Range	Units	Status	Code	Date	Range	Status	Lab Tech
WBC		10	(4 - 10)	cmm			7/23/2010			2
RBC		0	(0 - 0)	cmm			7/23/2010			
Hgb		0	(0 - 0)	g/dL			7/23/2010			
HCT		0	(0 - 0)	cmm			7/23/2010			
MCV		0	(80 - 94)	cu mic			7/23/2010			
MCH		0	(26 - 34)	pg			7/23/2010			
MCHC		0	(30 - 37)	g/dL			7/23/2010			
Platelets		0	(130 - 400)	cmm			7/23/2010			
Segs		0	(36 - 65)	%			7/23/2010			
Lymphs		0	(25 - 40)	%			7/23/2010			
MID		0	(0 - 8)	%			7/23/2010			

MU

3

CBC

Drag a column header here to group by that column.

Date	Name	Ordered By	Owner
7/23/2010 3:35:57 PM	Complete Blood Count		Jennifer Berg

1. Enter lab values.
2. Enter lab tech initials.
3. This area is a free text area used specifically for CLIA documentation. In this section please include where the lab was performed, the address of the facility, and who enter the result. This is very important documentation. All lab results must have this information to be CLIA compliant.

# **Patient Visit Documentation - SOAPnotes Encounter Notes**

## SOAP Charting

---

SOAPware derives its name from the SOAP format used for encounter documentation (i.e. **Subjective**, **Objective**, **Assessment** and **Plan**).

In SOAPware, the legacy format for encounters is for the Plan to be further divided into two (2) fields:

1. Medications
2. Follow-up

### Subjective

#### Subjective[]

COMPLAINT or ISSUE - Respiratory symptom or complaint (other/misc) Cough Dyspnea or shortness of breath.

HPI: SYMPTOMS/RELATED: Reports symptoms of sore throat, rhinorrhea, fatigue (malaise or lethargy).

Denies symptoms of fever, muscle pain.

QUALITY/COURSE: Reports condition is continuous, persisting.

INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.

ONSET/TIMING: Reports occurrence as sudden, < 48 hours ago.

MODIFIERS/TREATMENTS: Has tried fluid intake increased, OTC cough/decongestant.

History of exposure to others with similar symptoms.

Past evaluation and/or work-up includes influenza vaccination not received this season.

ROS: GEN- Constitutional: Denies symptoms such as fatigue (malaise or lethargy), chills, fever (documented >100.5), fever (subjective, not confirmed).

HENT: Denies symptoms such as pain in face, hoarseness, dry mouth and/or lips, coryza, earache or otalgia, hearing problems, rhinorrhea that is purulent, post-nasal drainage/drip, rhinorrhea.

EYES: Denies symptoms such as red eyes, eye discharge, eye discharge that is purulent.

LUNGS/Respiratory: Denies symptoms such as sputum/phlegm production that is purulent, wheezing, hemoptysis, dyspnea. ]

The history or information offered by the patient.



## Objective

### Objective[]

Exam: GENERAL: Appearance: General appearance can be described as mildly ill.

LYMPHATIC: Neck node findings include diffuse tenderness.

Axillary node exam reveals no swollen or tender nodes under either arm.

HEAD, EARS, NOSE AND THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.

Otoscopic Exam: External auditory canals and tympanic membranes are normal.

Hearing assessment shows no problems with normal conversation.

Nose exam, internally, reveals coryza.

Teeth, Gingiva, and Lip Exams: No lesions or evidence of infection.

Oropharynx demonstrates mild pharyngeal swelling and mucosal erythema.

NECK: Neck tissue exam demonstrates no meningeal signs.

Thyroid exam reveals no masses, enlargements or tenderness.

LUNGS and RESPIRATORY: Lung auscultation elicits no wheezing, rhonchi, rales or rubs and with equal breath sounds.

Respiratory effort described as breathing is unlabored and chest movement is symmetrical.

HEART (Cardiovascular): Heart auscultation discovers regular rate and rhythm; no murmur, gallop or rub. Normal heart sounds.

Edema-Varicosity Exam: No significant peripheral edema or venous varicosities.

ABDOMEN (Gastrointestinal): Mass/Tenderness Exam: Neither are present.

Liver/Spleen: No hepatomegaly or splenomegaly.

MUSCULOSKELETAL (BJE): Gait and station demonstrate standing and walking are stable and functional.

Inspection-Palpation: Muscle inspection-palpation reveals diffuse tenderness.

SKIN: Skin Inspection: No rashes or lesions.

Skin Palpation: Normal turgor and without induration or nodules.]

The findings discovered by clinical examination.

## Assessment

### Assessment[]

Upper respiratory infection ICD#465.9

The diagnoses addressed during the encounter.

## Plan

### Plan[]

OFFICE/OUTPATIENT VISIT, EST #99213 Related Dx- Upper respiratory infection Date of Service From: 6/11/2011 Date of Service To: 6/11/2011 Place of Service: SOAPware Clinic, Inc. Days/Units: 1

Actions: Plans for New Diagnosis: INSTRUCTIONS - URI: This is likely to be a viral infection which should run its course in the next few days. Antibiotics will not help this type of infection, but getting plenty of rest, drinking plenty of fluids and eating nutritious meals should help your body to get well sooner. Treating symptoms such as nasal congestion, cough or fever and body aches with over the counter cold medications may make you more comfortable while your body is healing.

Occasionally after a viral respiratory infection, a person can develop a bacterial infection of the respiratory tract which would benefit from antibiotic treatment. If your symptoms persists for more than 1 week, or if you develop high fevers, chills, purulent sinus drainage, or tenderness in the sinus area please call. We may be able to call something in for you, or you may need to come back to the office for another examination.

Summary updated: The summary record was updated with pertinent information from previous records (5-10 minutes).

Handouts: Cold.]

The plans for the patient's care going forward.

## Medications

### Medications[]

**Robitussin DM (guaifenesin + dextromethorphan):** 10 mg-100 mg/5 mL (liquid) SIG- 5 milliliter(s) to 10 ml every 4 hours orally #30 Milliliter(s) Substitutions Allowed Refills- 0 Notes- ]

The medications prescribed.

## Follow-up

### Follow Up[]

Return in 3 to 5 days if not improved and sooner if worsening symptoms or signs indicative of secondary bacterial infection (Temp>100.5 continuous discolored sputum/nasal drainage, worsening facial pain, etc. If your symptoms are not beginning to improve in 4-5 days, let your doctor know. If you develop worsening breathing difficulty or shortness of breath, please return to clinic.

Electronically Signed By: Randall Oates, M.D.

]

The follow-up instructions.

SOAP Notes

Labs

Radiology

Billing Statements

Date/Time

06/11/2011 10:44 AM

Type

Face to Face

### Subjective

COMPLAINT or ISSUE - Respiratory symptom or complaint (other/misc) Cough Dyspnea or shortness of breath.  
HPI: SYMPTOMS/RELATED: Reports symptoms of sore throat, rhinorrhea, fatigue (malaise or lethargy).  
Denies symptoms of fever, muscle pain.  
QUALITY/COURSE: Reports condition is continuous, persisting.  
INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.  
ONSET/TIMING: Reports occurrence as sudden, < 48 hours ago.  
MODIFIERS/TREATMENTS: Has tried fluid intake increased, OTC cough/decongestant.  
History of exposure to others with similar symptoms.  
Past evaluation and/or work-up includes influenza vaccination not received this season.  
ROS: GEN- Constitutional: Denies symptoms such as fatigue (malaise or lethargy), chills, fever (documented >100.5), fever (subjective, not confirmed).  
HENT: Denies symptoms such as pain in face, hoarseness, dry mouth and/or lips, coryza, earache or otalgia, hearing problems, rhinorrhea that is purulent, post-nasal drainage/drip, rhinorrhea.  
EYES: Denies symptoms such as red eyes, eye discharge, eye discharge that is purulent.  
LUNGS/Respiratory: Denies symptoms such as sputum/phlegm production that is purulent, wheezing, hemoptysis, dyspnea.

### Objective

Exam: GENERAL: Appearance: General appearance can be described as mildly ill.  
LYMPHATIC: Neck node findings include diffuse tenderness.  
Axillary node exam reveals no swollen or tender nodes under either arm.  
HEAD, EARS, NOSE AND THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.  
Otoscopic Exam: External auditory canals and tympanic membranes are normal.  
Hearing assessment shows no problems with normal conversation.  
Nose exam, internally, reveals coryza.  
Teeth, Gingiva, and Lip Exams: No lesions or evidence of infection.  
Oropharynx demonstrates mild pharyngeal swelling and mucosal erythema.  
NECK: Neck tissue exam demonstrates no meningeal signs.  
Thyroid exam reveals no masses, enlargements or tenderness.  
LUNGS and RESPIRATORY: Lung auscultation elicits no wheezing, rhonchi, rales or rubs and with equal breath sounds.  
Respiratory effort described as breathing is unlabored and chest movement is symmetrical.  
HEART (Cardiovascular): Heart auscultation discovers regular rate and rhythm; no murmur, gallop or rub. Normal heart sounds.  
Edema-Varicosity Exam: No significant peripheral edema or venous varicosities.  
ABDOMEN (Gastrointestinal): Mass/Tenderness Exam: Neither are present.  
Liver/Spleen: No hepatomegaly or splenomegaly.  
MUSCULOSKELETAL (BJE): Gait and station demonstrate standing and walking are stable and functional.  
Inspection-Palpation: Muscle inspection-palpation reveals diffuse tenderness.  
SKIN: Skin Inspection: No rashes or lesions.  
Skin Palpation: Normal turgor and without induration or nodules.

SOAPNote

Depending upon the size of the monitor used for the display and/or the amount of information contained within the SOAPnote fields, all the information within the six SOAP fields may not be visible in a single view. In order to view additional SOAP field information, click the **Up or Down Arrows** in the vertical scroll bar located on the right side of the SOAPnote workspace.

## Creating a SOAPnote

---

This lesson discusses creating a SOAPnote.

## Open the SOAPnote Chart Section

SOAP Notes

Labs

Radiology

Billing Statements

Date/Time

06/11/2011 10:44 AM

Type

Face to Face

### Subjective

COMPLAINT or ISSUE - Respiratory symptom or complaint (other/misc) Cough Dyspnea or shortness of breath.

HPI: SYMPTOMS/RELATED: Reports symptoms of sore throat, rhinorrhea, fatigue (malaise or lethargy).  
Denies symptoms of fever, muscle pain.

QUALITY/COURSE: Reports condition is continuous, persisting.

INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.

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EYES: Denies symptoms such as red eyes, eye discharge, eye discharge that is purulent.

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Skin Palpation: Normal turgor and without induration or nodules.

SOAPNote

+

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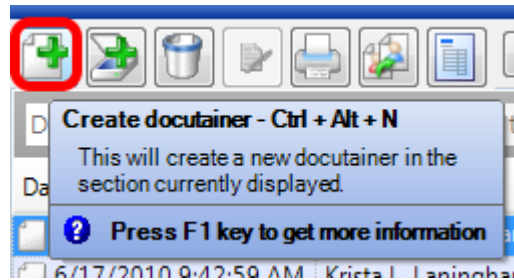
...

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx	Type
6/11/2011 10:44:14 AM	Kaye L. Williamson	Com...	Upper respiratory infection	ICD#465.9	Face to Face
6/15/2010 10:01:01 AM	Kaye L. Williamson		Cystitis, acute	ICD#595.0	Cystitis, acute
					Face to Face

To create a new SOAPnote, open the SOAPnote chart section. Here, the user will be able to view previous visits as well as create, sign off, print, and reassign encounters.

## Create Docutainer



Using the toolbar below the lower splitter bar, Click the Create docutainer button.

## Add Document Task

**Add Document Task**

**Task Info**

Description: SOAPNote

Owner: Jennifer Berg

Due: 3/ 1/2011

Priority: Normal

Type: SOAP Note

Assigned To: Jennifer Berg

Reminder: / / : :

Action/Status: Needs Review

Notes:

**Docutainer Info**

Date/Time: 03/01/2011 3:42 PM

Type: Face to Face

Owner: Jennifer Berg

Status:

Description:

Related Dx:

☐ Apply To All

Add Cancel

When the user creates new patient documents, the Add Document Task window will appear. Tasks helps to manage reminders to keep tasks on track and improve productivity and quality of care.

This document task for a SOAPnote will be associated with the encounter we are creating and can be set to have a particular action/status, indicating what needs to be addressed before the task is completed. The task can also have a reminder set, and can be assigned to anyone in the

clinic.

The primary reason that we need to make sure to always track SOAPnotes with a task associated is to make sure that the SOAPnote encounter is signed off. If the action/status is set as Needs Review or Sign, the task will automatically be marked as completed and will be removed from the user's task list when the document is signed off.

For more on Tasks, see: [Tasks List](#).

Using this window, the user can enter the information the user would like to include with the task, assign it to a user, set a due date and reminder, and choose an action/status. If the user clicks "Add", the task item will be added to the 'assigned to' person's task list. If the user clicks cancel, this will prevent SOAPware from creating a task item associated with this patient encounter.

## Encounter Type for Meaningful Use

The screenshot shows the SOAPware interface with the 'Add Document Task' window open. The 'Type' dropdown is set to 'Face to Face' in both the top bar and the window, highlighted with red boxes. The window includes fields for Description, Owner, Due, Priority, Type, Notes, Assigned To, Reminder, Action/Status, Date/Time, Status, Description, and Related Dx. The 'Add' button is highlighted.

Task Info	
Description	SOAPNote
Owner	Kaye L. Williamson
Assigned To	Kaye L. Williamson
Due	7/20/2011
Reminder	/ / : :
Priority	Normal
Action/Status	Needs Review
Type	SOAP Note
Notes	

Docutainer Info	
Date/Time	07/20/2011 10:07 AM
Type	Face to Face
Owner	Kaye L. Williamson
Status	
Description	
Related Dx	

☐ Apply To All Add Cancel

SOAPware now has an added field for the encounter "Type" that is used for Meaningful Use purposes. Auser can designate if this was a "face to face" encounter, or a "non face to face encounter" when the "Add Document Task" window appears, or from the docutainer

demographics area-found above the upper splitter bar.

By default, encounters will be flagged as "face to face" when they are created. If a docuplate is being used, the user can set a default encounter Type within the docuplate. See: [Creating a Docuplate](#) for more information.

**\*Only encounters flagged as "Face to Face" will trigger the inclusion of a patient in the Meaningful Use statistics for the reporting period selected by the provider.**

The Meaningful Use Dashboard will also only be valid for patient encounters that are recorded AFTER a clinic site has begun to use SOAPware version 2011+. Encounters for patients before the use of SOAPware 2011 will not be included in the providers Meaningful Use statistics.

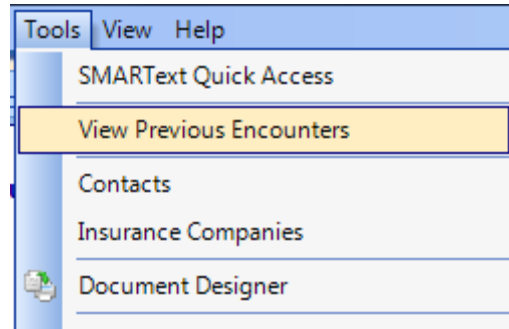


## View Previous Encounters

---

The View Previous Encounters window allows users to view all past patient encounters/SOAPnotes while viewing a current SOAPnote. This provides easy reference to past encounters and the ability to add past SOAPnote information to the current SOAPnote visit documentation.

### Open the View Previous Encounters Viewer



Click Tools and choose View Previous Encounters.

**Encounter Viewer**

By Date By Rx By Dx

**Subjective[**  
 Chief complaint: Patient returns for follow up on Hypertension..  
 HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.  
 QUALITY/COURSE: Reports condition is controlled with medicine.  
 INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.  
 MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.  
 History of No significant side effects from the medicine.  
 ROS: GEN- Constitutional: Denies symptoms such as fever.  
 LUNGS/Respiratory: Denies symptoms such as dyspnea.  
 HEART/Cardiovascular: Denies symptoms such as chest pain, palpitations, edema (swollen ankles/feet).  
 ABD/Gastrointestinal: Denies symptoms such as nausea, vomiting.  
 GENT/Genitourinary: Denies symptoms such as dysuria.  
 Musculoskeletal (BJE): Denies symptoms such as leg cramps.  
 NEURO/Neurological: Denies symptoms such as vertigo or dizziness.  
**]**

**Objective**  
 VS: BMI: 25.7. BP: 130/82. H: 68 in. P: 89 /min. RR: 16 /min. T: 98.8 F. W: 169lbs Ooz.  
 Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.  
 HEAD, EARS, NOSE AND THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.  
 Hearing assessment shows no problems with normal conversation.  
 EYES: Conjunctivae and Lids: No lesions, eye discharge or other abnormalities.  
 NECK: Neck tissue exam demonstrates no masses, symmetrical, and trachea is midline.  
 LUNGS and RESPIRATORY: Lung auscultation elicits no wheezing, rhonci, rales or rubs and

**SOAPnote**

Date	Description	Provider
2/11/2011 1:43 PM	Upper respiratory infection ICD#465.9	Kaye L. Yocham
1/3/2011 1:33 PM	Benign hypertension ICD#401.1	Kaye L. Yocham
12/1/2009 1:03 PM	Viral Gastroenteritis ICD#008.8	Kaye L. Yocham
10/29/2009 2:36 PM	Influenza NOS ICD#487.1	Kaye L. Williamson
10/29/2009 1:33 PM	Viral Gastroenteritis ICD#008.8	Kaye L. Williamson
10/29/2009 10:10 AM		

Add Active Field to Current Encounter Add Active Document to Current Encounter

The Encounter Viewer shows the SOAPnote preview at the top of the window and the list of SOAPnotes at the bottom. Users are to use the scroll bar to locate the visit he/she would like to view.

## Copy the Previous Encounter to the Current SOAPnote

**Encounter Viewer**

By Date By Rx By Dx

**Subjective**  
 Chief complaint: Patient returns for follow up on Hypertension..  
 HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.  
 QUALITY/COURSE: Reports condition is controlled with medicine.  
 INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.  
 MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.  
 History of No significant side effects from the medicine.  
 ROS: GEN- Constitutional: Denies symptoms such as fever.  
 LUNGS/Respiratory: Denies symptoms such as dyspnea.  
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12/1/2009 1:03 PM	Viral Gastroenteritis ICD#008.8	Kaye L. Yocham
10/29/2009 2:36 PM	Influenza NOS ICD#487.1	Kaye L. Williamson
10/29/2009 1:33 PM	Viral Gastroenteritis ICD#008.8	Kaye L. Williamson

Add Active Field to Current Encounter Add Active Document to Current Encounter

Click the "Add Active Document to Current Encounter" to add the entire previous visit to the current SOAPnote.

**NOTE:** To copy to a current encounter, the user needs to have an open, unsigned SOAPnote in this patient's chart.

**Encounter Viewer**

By Date By Rx By Dx

**Subjective** 1

Chief complaint: 1 Patient returns for follow up on Hypertension..

HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.  
QUALITY/COURSE: Reports condition is controlled with medicine.  
INTENSITY/SEVERITY: Reports measurement ( or degree) as moderate.  
MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.  
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**Objective**

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Hearing assessment shows no problems with normal conversation.  
EYES: Conjunctivae and Lids: No lesions, eye discharge or other abnormalities.  
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**SOAPnote**

Date	Description	Provider
2/11/2011 1:43 PM	Upper respiratory infection ICD#465.9	Kaye L. Yocham
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10/29/2009 2:36 PM	Influenza NOS ICD#487.1	Kaye L. Williamson
10/29/2009 1:33 PM	Viral Gastroenteritis ICD#008.8	Kaye L. Williamson

2

Add Active Field to Current Encounter Add Active Document to Current Encounter

To add just a field of the previous encounter to a SOAPnote:

1. Click into the field.
2. Click "Add Active Field to Current Encounter."

**NOTE:** To copy to a current encounter, the user needs to have an open, unsigned SOAPnote in this patient's chart.

## The Default Docuplate

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The default docuplate is a docuplate that is automatically entered when a SOAPnote is created. When SOAPware is installed, the default docuplate will be set to "SOAPDPL".

### SOAPDPL

#### Subjective[

CHIEF COMPLAINT(S):

HPI: SYMPTOMS/RELATED: Reports symptoms of  
LOCATION: Reports area of involvement as  
QUALITY/COURSE: Reports condition is  
INTENSITY/SEVERITY: Reports measurement ( or degree) as  
DURATION: Reports the general length of symptoms to be  
ONSET/TIMING: Reports occurrence as  
CONTEXT/WHEN: Reports usually associated with  
MODIFIERS/TREATMENTS: Improved by

ROS:

]

#### Objective

Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.

#### Assessment

#### Plan

Actions:

#### Medications

#### Follow Up

Return if problems develop or worsens.

Schedule: Krista L. Laningham

SOAPDPL is a good starter docuplate that allows for an introduction to using SMARTText Items in encounter documentation. We do not recommend using this docuplate for documenting live patient encounters. However, this docuplate can be used as a starter docuplate for the user to utilize when creating custom docuplates that will be used for documenting patient encounters.

Users can modify this docuplate and/or change their default docuplate to another available template.

## Subjective Entry

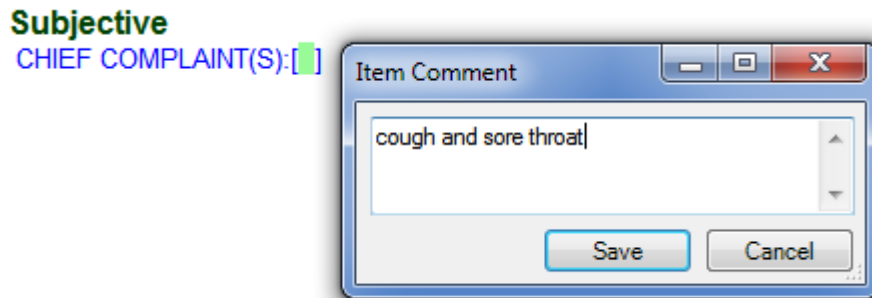
---

### Free Text

Subjective[  
Cough and sore throat]

The user can always use the SOAPnote fields as though this was a word processor and type the documentation manually. To do this, the user will need to click within one of the SOAPnote fields and type. The user can highlight, delete, backspace, and insert text easily using this method of data entry.

### Comment Box



Using the Item Comment will attach a free-text comment to a SMARTText item. In the SOAPnotes docutainer, Click CHIEF COMPLAINT(S) under Subjective. Notice that an open and a close bracket appears immediately following CHIEF COMPLAINT(S). These brackets indicate that CHIEF COMPLAINT(S) is a SMARTText item and that if the user starts typing in these brackets, the user's comment will be associated with the SMARTText item, making it more meaningful data.

When the user begins typing inside these brackets, the Item Comment box will appear. After the user types and Clicks Save, the comment will be associated with the Chief Complaint.

The screenshot displays the SOAPware interface. On the left, a SOAP Note is open for a patient named Catipillar, Wormie, dated 12/20/2010 at 2:15 PM. The note includes sections for Subjective, Objective, and Assessment. The Subjective section contains a Chief Complaint(S) field with a pick list icon. The SMARText Quick Access dialog is open on the right, showing a list of medical terms for selection. The dialog has a table with columns: Selected, Description, Shortcut, Type, and Usag. The first item is ( A - GENERAL and Unspe... with a Type of List It... and Usag of 0. Below the table are buttons for Select All, Deselect All, and Expand Groups, along with a Filter and Comments section.

**SOAP Note**

Date/Time: 12/20/2010 2:15 PM

**Subjective**

CHIEF COMPLAINT(S): [ ]

HPI: SYMPTOMS/RELATED: Reports symptoms of  
 LOCATION: Reports area of involvement as  
 QUALITY/COURSE: Reports condition is  
 INTENSITY/SEVERITY: Reports measurement ( or degree)  
 as  
 DURATION: Reports the general length of symptoms to be  
 ONSET/TIMING: Reports occurrence as  
 CONTEXT/WHEN: Reports usually associated with  
 MODIFIERS/TREATMENTS: Improved by

**ROS:**

**Objective**

Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.

**Assessment**

**SMARText Quick Access**

Active Item: "CHIEF COMPLAINT(S):"

Selected	Description	Shortcut	Type	Usag
<input checked="" type="checkbox"/>	( A - GENERAL and Unspe...		List It...	0
<input type="checkbox"/>	( B - BLOOD and IMMUNE...		List It...	0
<input type="checkbox"/>	( D - DIGESTIVE )		List It...	0
<input type="checkbox"/>	( F - EYE )		List It...	0
<input type="checkbox"/>	( H - EAR )		List It...	0
<input type="checkbox"/>	( K - CARDIOVASCULAR )		List It...	0
<input type="checkbox"/>	( N - NEUROLOGICAL )		List It...	0
<input type="checkbox"/>	( P - PSYCHOLOGICAL )		List It...	0
<input type="checkbox"/>	( R - RESPIRATORY )		List It...	0
<input type="checkbox"/>	( S - SKIN )		List It...	0
<input type="checkbox"/>	( T - ENDOCRINE/METAB...		List It...	0
<input type="checkbox"/>	( U - UROLOGICAL )		List It...	0
<input type="checkbox"/>	( W - PREGNANCY/CHILD...		List It...	0
<input type="checkbox"/>	( X - FEMALE GENITAL )		List It...	0
<input type="checkbox"/>	( Y - MALE GENITAL )		List It...	0
<input type="checkbox"/>	( Z - SOCIAL PROBLEMS )		List It...	0
<input type="checkbox"/>	( L - MUSCULOSKELETAL...		List It...	0
<input type="checkbox"/>	( Most Common Chief Com...		List It...	0

Select All Deselect All Expand Groups

Filter

Comments

Click on the CHIEF COMPLAINT(S), again, and notice the pick list displayed in the SMARText Quick Access dialog. The second column in the pick list is the Description. If the Description column is not wide enough, it can be expanded, or the user can point the cursor at the items and the user will see the complete description in a pop-up window. SOAPware recommends using SMARText items like these found in Pick Lists as much as possible. It can make documentation faster as well as make the documentation more meaningful and searchable. Most of this lesson will cover using SMARText Data Entry methods, but at any time the user can use free-text entry if that fits the user's needs best.



## Using Quick Access

Selected	Description	S	T	U
<input checked="" type="checkbox"/>	( A - GENERAL and Unspecified )		L	0
<input type="checkbox"/>	( B - BLOOD and IMMUNE )		L	0
<input type="checkbox"/>	( D - DIGESTIVE )		L	0
<input type="checkbox"/>	( F - EYE )		L	0
<input type="checkbox"/>	( H - EAR )		L	0
<input type="checkbox"/>	( K - CARDIOVASCULAR )		L	0
<input type="checkbox"/>	( N - NEUROLOGICAL )		L	0
<input type="checkbox"/>	( P - PSYCHOLOGICAL )		L	0
<input type="checkbox"/>	( R - RESPIRATORY )		L	0
<input type="checkbox"/>	( S - SKIN )		L	0
<input type="checkbox"/>	( T - ENDOCRINE/METABOLIC/NUTRITIONAL )		L	0
<input type="checkbox"/>	( U - UROLOGICAL )		L	0
<input type="checkbox"/>	( W - PREGNANCY/CHILDBIRTH/FAMILY PLAN..		L	0
<input type="checkbox"/>	( X - FEMALE GENITAL )		L	0
<input type="checkbox"/>	( Y - MALE GENITAL )		L	0
<input type="checkbox"/>	( Z - SOCIAL PROBLEMS )		L	0
<input type="checkbox"/>	( L - MUSCULOSKELETAL )		L	0
<input type="checkbox"/>	( Most Common Chief Complaints BUNDLE)		L	0

The user will see in SMARText Quick Access "Pick List" that the Chief Complaint items are listed by system, and that there is an additional item for Most Common Chief Complaints. When the user clicks on any of these lists using the "Select" box, this will display another list of items in the SMARText Quick Access dialog.

## Using Pick List Items

**SMARText Quick Access**

Active Item: (Most Common Chief Complaints BUNDLE)

Selected	Description	Shortcut	Type	Usag
<input type="checkbox"/>	-RFE- "Chronic obstructiv...		Chie...	4
<input checked="" type="checkbox"/>	-RFE- "Cough" (06.0...		Chie...	3
<input type="checkbox"/>	-RFE- "Nausea" (09...		Chie...	3
<input type="checkbox"/>	-RFE- "Chest Pain, nonsp...		Chie...	2
<input type="checkbox"/>	-RFE- "Abdomen pains (o...		Chie...	1
<input type="checkbox"/>	-RFE- "Allergic rhinitis"		Chie...	1
<input type="checkbox"/>	-RFE- "Back pain (lower o...		Chie...	1
<input type="checkbox"/>	-RFE- "Hypertension, unc...		Chie...	1
<input type="checkbox"/>	-RFE- "Diabetes - Insulin...		Chie...	1
<input type="checkbox"/>	-RFE- "Diarrhea" (0...		Chie...	1
<input type="checkbox"/>	-RFE- "Earache or otalgia...		Chie...	1
<input type="checkbox"/>	-RFE- "Fever" (01...		Chie...	1
<input type="checkbox"/>	-RFE- "Immunizations or...		Chie...	1
<input type="checkbox"/>	-RFE- "Vision Screening"...		Chie...	1
<input type="checkbox"/>	-RFE- "Abdomen pains (o...		Chie...	0
<input type="checkbox"/>	-RFE- "Abdominal pains t...		Chie...	0
<input type="checkbox"/>	-RFE- "Acute bronchitis, o...		Chie...	0
<input type="checkbox"/>	-RFE- "Chronic bronchitis...		Chie...	0
<input type="checkbox"/>	-RFE- "Asthma" (06...		Chie...	0
<input type="checkbox"/>	-RFE- "Hypertension, co...		Chie...	0
<input type="checkbox"/>	-RFE- "Congestive Heart...		Chie...	0
<input type="checkbox"/>	-RFE- "Ischemic heart dis...		Chie...	0
<input type="checkbox"/>	-RFE- "Coronary artery di...		Chie...	0
<input type="checkbox"/>	-RFE- "Depressive disord...		Chie...	0
<input type="checkbox"/>	-RFE- "Diabetes - Non-ins...		Chie...	0
<input type="checkbox"/>	-RFE- "Fatigue (Neurasth...		Chie...	0
<input type="checkbox"/>	-RFE- "Follow-up encount...		Chie...	0
<input type="checkbox"/>	-RFE- "Nausea, vomiting,...		Chie...	0
<input type="checkbox"/>	-RFE- "Preventative proc...		Chie...	0
<input type="checkbox"/>	-RFE- "Hyperlipidemia"...		Chie...	0
<input type="checkbox"/>	-RFE- "Influenza" (0...		Chie...	0
<input type="checkbox"/>	-RFE- "Knee pain/sympto...		Chie...	0
<input type="checkbox"/>	-RFE- "Nasal congestion...		Chie...	0
<input type="checkbox"/>	-RFE- "Headache" (...)		Chie...	0
<input type="checkbox"/>	-RFE- "Medication/Prescri...		Chie...	0

[Select All](#) [Deselect All](#) ☐ Expand Groups

Filter

Comments

In this second list (Most Common Chief Complaints), Click the Description column header to sort alphabetically. The user can click any column header to sort by that column to easily find the item needed.

## Selecting a Pick List Item

**SOAP Notes** | Radiology | Correspondence In | Flow Sheet

Date/Time: 06/17/2010 11:40 AM

**Subjective**

**CHIEF COMPLAINT(S):** [ Cough, Sore throat (Pharyngitis). ]

HPI: SYMPTOMS/RELATED: Reports symptoms of  
 LOCATION: Reports area of involvement as  
 QUALITY/COURSE: Reports condition is  
 INTENSITY/SEVERITY: Reports measurement ( or degree) a  
 DURATION: Reports the general length of symptoms to be  
 ONSET/TIMING: Reports occurrence as  
 CONTEXT/WHEN: Reports usually associated with  
 MODIFIERS/TREATMENTS: Improved by

ROS:

**SMARText Quick Access**

Active Item: ( Most Common Chief Complaints BUNDLE)

Selected	Description
<input checked="" type="checkbox"/>	-RFE- "Cough" (06.0.R05.RES)
<input checked="" type="checkbox"/>	-REF- "Sore throat (Pharyngitis)" (03.0.R21.RES   0...
<input type="checkbox"/>	-RFE- "Abdomen pains (or cramps) that are generalized" ...
<input type="checkbox"/>	-RFE- "Abdominal pains that are epigastric" (09.0.D...
<input type="checkbox"/>	-RFE- "Abdomen pains (or cramps) that are localized" ...
<input type="checkbox"/>	-RFE- "Allergic rhinitis" (06.0.R97.Res   03)
<input type="checkbox"/>	-RFE- "Back pain (lower or lumbar-sacral)" (11.0.L0...
<input type="checkbox"/>	-RFE- "Acute bronchitis, or bronchiolitis" (06.0.R78...
<input type="checkbox"/>	-RFE- "Chronic bronchitis" (06.0.R79.RES)

When the user (1) selects an item, the user will notice that it (2) inserts between the brackets of the CHIEF COMPLAINT(S) data entry area. All of these lists are completely customizable. Each clinician can create their preferred lists of commonly used Chief Complaints.

## RFE: Reason for Encounter

<input type="checkbox"/>	-RFE- "Follow-up encounter" (13.1.Z63.SOC)
<input type="checkbox"/>	-RFE- "Headache" (12.0.N01.NEU)
<input type="checkbox"/>	-RFE- "Hyperlipidemia" (01.1.T93.GEN)
<input type="checkbox"/>	-RFE- "Hypertension, complicated" (08.0.K87.CIR)
<input type="checkbox"/>	-RFE- "Hypertension, uncomplicated" (08.0.K86.CL...
<input type="checkbox"/>	-RFE- "Immunizations or boosters" (01.0.A44.GEN)
<input type="checkbox"/>	-RFE- "Influenza" (06.0.R80.RES)
<input type="checkbox"/>	-RFE- "Ischemic heart disease with angina" (08.0...
<input type="checkbox"/>	-RFE- "Knee pain/symptom/complaint" (11.0.L15...
<input type="checkbox"/>	-RFE- "Medication/Prescription renewal or injection" (GE...
<input type="checkbox"/>	-RFE- "Nasal congestion or sneezing" (06.0.R07.R...
<input type="checkbox"/>	-RFE- "Nausea" (09.0.D09.DIG)

Many visits don't really involve a complaint, but there is always a Reason For the Encounter, and this may or may not be a true complaint. The user will notice that in the description column of Quick Access, many of the items are also RFE items.

### Subjective[

CHIEF COMPLAINT(S): Cough, Sore throat (Pharyngitis).

HPI: SYMPTOMS/RELATED: Reports symptoms of  
LOCATION: Reports area of involvement as  
QUALITY/COURSE: Reports condition is  
INTENSITY/SEVERITY: Reports measurement ( or degree) a  
DURATION: Reports the general length of symptoms to be  
ONSET/TIMING: Reports occurrence as  
CONTEXT/WHEN: Reports usually associated with  
MODIFIERS/TREATMENTS: Improved by

ROS:

]

Active Item		" HPI" (Header)
Selected	Description	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" SYMPTOMS/RELATED:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" QUALITY/COURSE: "
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" ONSET/TIMING:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" CONTEXT/WHEN:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" MODIFIERS/TREATMENTS:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" INTENSITY/SEVERITY:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" LOCATION:"
<input checked="" type="checkbox"/>	<input type="checkbox"/>	" DURATION:"

The Subjective field also contains a number of History of Present Illness SMARText items. These HPI items present pick lists and function in the same manner as the CHIEF COMPLAINT(S) SMARText items. At this time, consider spending a few minutes clicking around on the HPI SMARText items and their associated pick lists. The user can also look over the ROS (Review of Systems) as well. These pick lists can greatly reduce the amount of time needed to document in the Subjective field, but the user will need to be familiar with them to locate the items needed.

### Subjective[

CHIEF COMPLAINT(S): Cough, Sore throat (Pharyngitis).

HPI: SYMPTOMS/RELATED: Reports symptoms of  
 LOCATION: Reports area of involvement as  
 QUALITY/COURSE: Reports condition is  
 INTENSITY/SEVERITY: Reports measurement ( or degree) as  
 DURATION: Reports the general length of symptoms to be  
 ONSET/TIMING: Reports occurrence as  
 CONTEXT/WHEN: Reports usually associated with  
 MODIFIERS/TREATMENTS: Improved by

ROS:

COMPLAINT or ISSUE -  
 HPI: SYMPTOMS/RELATED: Reports symptoms of  
 Denies symptoms of  
 LOCATION: Reports area of involvement as  
 Denies regionality as  
 QUALITY/COURSE: Reports condition is  
 Denies, in general  
 INTENSITY/SEVERITY: Reports measurement ( or degree) as  
 Declines to define as  
 DURATION: Reports the general length of symptoms to be  
 Declines to define duration as  
 ONSET/TIMING: Reports occurrence as  
 Denies onset as  
 CONTEXT/WHEN: Reports usually associated with  
 Denies association with  
 MODIFIERS/TREATMENTS: Improved by  
 Has tried  
 History of  
 Past evaluation and/or work-up includes

]

To add a third or fourth problem, an option would be to utilize the SMARText shortcut codes *nexc*, *nexs* or *nexd*. These codes will insert another, blank Subjective outline. In the screen shot above, the user can see the *nexd* item.

**Subjective**  
CHIEF COMPLAINT(S)/REASON FOR VISIT:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried  
PROBLEM #2:  
COMPLAINT or ISSUE:  
HPI: SYMPTOMS/RELATED: Reports symptoms of  
ONSET/TIMING:  
QUALITY/COURSE:  
MODIFIERS/TREATMENTS: Has tried  
ROS: GEN- Constitutional:  
HEENT:  
EYES:  
LUNGS/Respiratory:  
HEART/Cardiovascular:  
ABD/Gastrointestinal:  
GENT/Genitourinary:  
Musculoskeletal (BJE):  
NEURO/Neurological:  
PSYCH/Psychiatric:

There is a docuplate in the online library that will allow the user to document more than one complaint.

Start with an empty SOAPnote and hit F5 to use the [Quick Entry](#) insertion method.

In the Search field/box, Type *starterdefault*. This particular docuplate is designed to be used for two problems.

## Objective Entry

---

Just as in Subjective, this default template/docuplate, has a number of specific SMARTText items placed into the Objective field. Clicking on their headers causes Quick Access to display pick list items. In the objective exam, when the exam headers are selected, normal findings are pre-populated in the objective field from SMARTText Quick Access.

### Vital Signs

Vital Signs are recorded in a dedicated chart section and can be transferred to the objective field in the SOAPnote. To learn more about how to use the Vital Signs section, see: [Inserting Vital Signs](#), and [Transferring Vitals to the Active SOAPnote](#).

### Growth Charts

Growth Charts can be used to plot vital sign readings to track growth. To learn how to use these, see: [Growth Charts Interface](#).

### Exam Systems

Click the Exam pick list header in the Objective field. A list of exam systems will appear in the Quick Access dialog. The default for this demonstration only displays 1 of the 14 exam systems, the GENERAL system.

## Exam Systems Data Entry

### Objective

Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.

HEAD/EARS/NOSE/THROAT: Ears-Nose (external) Inspection:

Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.

Otoscopic Exam: External auditory canals and tympanic membranes are normal.

Oropharynx demonstrates oral mucosa, salivary glands, tongue, tonsils, posterior pharynx, hard-soft palates are normal.

EYES: Conjunctivae and Lids: No lesions, eye discharge or other abnormalities.

Pupils and irises: Pupils are equal, round, and reactive to direct light and are consensual to light bilaterally. Irises are symmetrical and without lesions.

LUNGS and RESPIRATORY: Lung auscultation elicits no wheezing, rhonchi, rales or rubs and with equal breath sounds.

HEART (Cardiovascular): Heart auscultation discovers regular rate and rhythm; no murmur, gallop or rub. Normal heart sounds.

ABDOMEN (Gastrointestinal): Mass/Tenderness Exam: Neither are present.

Liver/Spleen: No hepatomegaly or splenomegaly. ]

### Assessment

Selected	Description
<input type="checkbox"/>	" LYMPHATIC:" (Exam)
<input type="checkbox"/>	" NECK:" (Normal)
<input type="checkbox"/>	- "FEMALE-GENITOURINARY:" (Normal)
<input type="checkbox"/>	" MALE-GENITOURINARY:" ...
<input type="checkbox"/>	" BREASTS:" ...
<input checked="" type="checkbox"/>	" GENERAL:" ...
<input checked="" type="checkbox"/>	" HEAD/EARS/NOSE/THROAT:" (Normal)
<input checked="" type="checkbox"/>	" LUNGS and RESPIRATORY:" (Normal)
<input checked="" type="checkbox"/>	" HEART (Cardiovascular):" (Normal)
<input checked="" type="checkbox"/>	" ABDOMEN (Gastrointestinal):" (Normal)*
<input type="checkbox"/>	" MUSCULOSKELETAL (BJE):" ...
<input type="checkbox"/>	" NEUROLOGICAL:" ...
<input type="checkbox"/>	" PSYCHIATRIC:" ...
<input type="checkbox"/>	" SKIN:" ...
<input type="checkbox"/>	"+++++ (SMARTips) ...
<input checked="" type="checkbox"/>	" EYES:" (Normal)

The user can include any of these exam systems in documentation by checking the box next to the exam system. This will insert the exam as normal in the SOAPDPL docuplate.

## Modifying Normal Exams

LUNGS/Respiratory:

HEART/Cardiovascular:

ABD/Gastrointestinal:

GENT/Genitourinary:

Musculoskeletal (BJE):

NEURO/Neurological:

PSYCH/Psychiatric:

### Objective

Exam: GENERAL: Appearance: General appearance can be described as in mild distress. ]

HEAD/EARS/NOSE/THROAT: Ears-Nose (external) Inspection:

Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.

Otoscopic Exam: External auditory canals and tympanic membranes are normal.

Oropharynx demonstrates oral mucosa, salivary glands, tongue, tonsils, posterior pharynx, hard-soft palates are normal.

EYES: Conjunctivae and Lids: No lesions, eye discharge or other

Selected	Description
<input checked="" type="checkbox"/>	"in mild distress"
<input type="checkbox"/>	@well-nourished, well-developed, and in no acute dis...
<input type="checkbox"/>	"in acute distress"
<input type="checkbox"/>	"agitation"
<input type="checkbox"/>	"alcoholic"
<input type="checkbox"/>	"alert"
<input type="checkbox"/>	"allergic"
<input type="checkbox"/>	"anasarca"
<input type="checkbox"/>	"anxious"
<input type="checkbox"/>	"acutely ill"
<input type="checkbox"/>	"stated app"

To modify a normal exam:

1. Click on the pick list before the item to modify.



2. Deselect the current pick list item .
3. Select the exam finding to include.

## Customizing Exams

By building a customized docuplate, the user can create custom exams for all of the most common visits. This will help to speed up the user's documentation process, while also ensuring that the user is documenting encounters in a meaningful way.

## Assessment Entry

### \*MEANINGFUL USE: VIEW THE MEANINGFUL USE ROADMAP

- Maintain Problem List
- Syndromic Surveillance Data Submission

### Location Pick List

The screenshot displays the SOAPware interface. On the left, the 'Printed Encounters' tab is active, showing a patient encounter for 06/17/2010 at 11:40 AM. The 'Subjective' section is highlighted with a circled '1'. It contains the following text:   
**CHIEF COMPLAINT(S)/REASON FOR VISIT:** Hypertension, complicated.   
**HPI: SYMPTOMS/RELATED:** Reports symptoms of   
**ONSET/TIMING:**   
**QUALITY/COURSE:**   
**MODIFIERS/TREATMENTS:** Has tried   
  
**Objective**   
**Exam: GENERAL:** Appearance: General appearance can be described as in mild distress.   
**HEAD/EARS/NOSE/THROAT:** Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.   
**Otoscopy Exam:** External auditory canals and tympanic membranes are normal.   
**Oropharynx demonstrates** oral mucosa, salivary glands, tongue, tonsils, posterior pharynx, hard-soft palates are normal.   
**EYES: Conjunctivae and Lids:** No lesions, eye discharge or other abnormalities.   
**Pupils and irises:** Pupils are equal, round, and reactive to direct light and are consensual to light bilaterally. Irises are symmetrical and without lesions.   
**LUNGS and RESPIRATORY:** Lung auscultation elicits no wheezing, rhonchi, rales or rubs and with equal breath sounds.   
**HEART (Cardiovascular):** Heart auscultation discovers regular rate and rhythm; no murmur, gallop or rub. Normal heart sounds.   
**ABDOMEN (Gastrointestinal):** Mass/Tenderness Exam: Neither are present.   
**Liver/Spleen:** No hepatomegaly or splenomegaly.   
  
**Assessment[**   
**Plan**   
**Actions:** Lab/Tests:   
  
At the bottom of the encounter window is a 'SOAPNote' button. On the right, the 'SMARTText Quick Access' window is open, showing a list of medical conditions with a circled '2' over the search icon. The list has columns for QA, Description, Shortcut, Type, and Usage. The following table represents the data in this list:

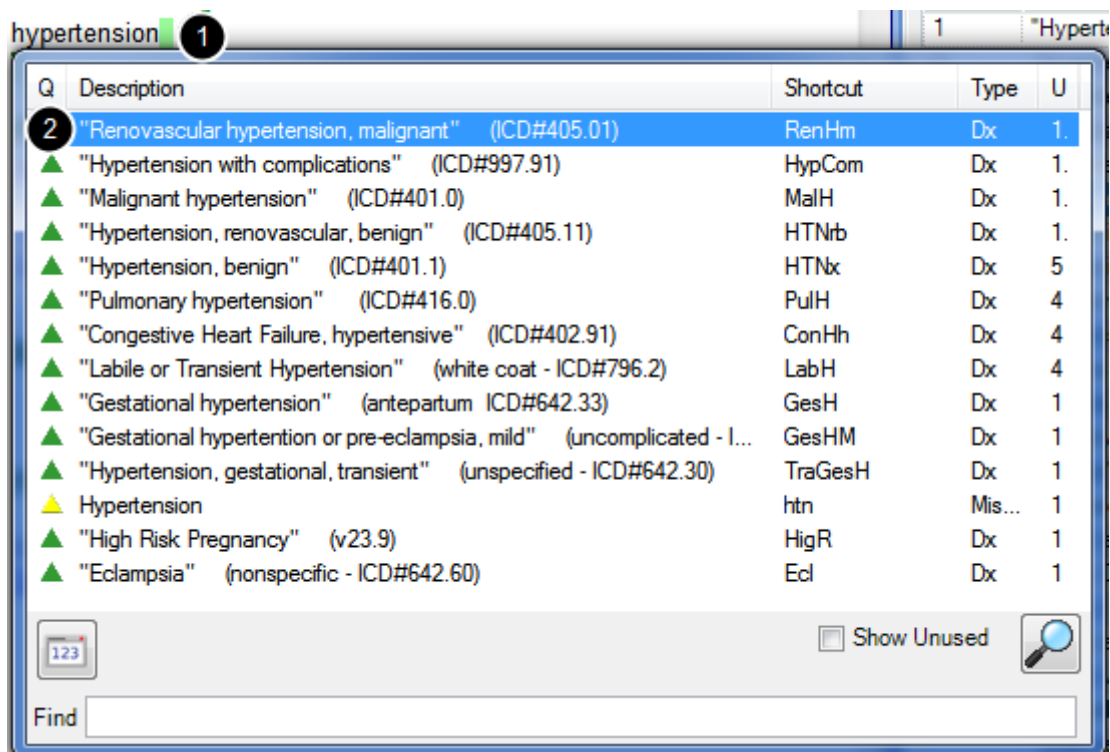
QA	Description	Shortcut	Type	Usage
1	"Hypertension with complica...	HypCo...	Dx	1000
2	"Hypertension, renovascular...	HTNr...	Dx	1000
3	"Hypertensive retinopathy L...	HypRet	Dx	1000
4	"Malignant hypertension"...	MalH	Dx	1000
5	"Renovascular hypertension...	RenHm	Dx	1000
6	"Hypertension, benign" (L...	HTNx	Dx	6
7	"Abdominal aortic aneurysm...	AbdAor	Dx	4
8	"Abdominal aortic aneurysm...	AbdAo...	Dx	4
9	"Abnormal electrocardiogra...	AbnE	Dx	4
0	"Administrative procedure/a...	AdmPro	Dx	4
	"Adverse effect of medicinal...		Dx	4
	"Adverse effects of anticoag...		Dx	4
	"Anaphylaxis" (ICD#995...	Anaphy	Dx	4
	"Angina" (nonspecific - IC...	Ang	Dx	4
	"Angioedema" (ICD#995...	Angl	Dx	4
	"Aortic aneurysm" (nonsp...	AorAne	Dx	4
	"Aortic Dissection" (ICD#...	AorD	Dx	4
	"Aortic insufficiency" (ICD...	AorI	Dx	4
	"Aortic stenosis" (ICD#42...	AorS	Dx	4
	"Aortic valve disorder" (no...	AorVD	Dx	4
	"Arterial occlusive disease...	ArtO	Dx	4
	"Arteriosclerotic cardiovasc...	ArtC	Dx	4
	"Asthma - Acute Exacerbati...	AstAE	Dx	4
	"Atherosclerosis, generaliz...	AthG	Dx	4
	"Atrial fibrillation" (ICD#4...	AtrF	Dx	4
	"Atrial Flutter" (ICD#427...	AtrFlu	Dx	4
	"Atrial Septal Defect" (IC...	AtrS	Dx	4
	"Bleeding esophageal varic...	BleEso	Dx	4
	"Bleeding Internal Hemorrh...	BleIH	Dx	4
	"Blood test" (SHARED) (V...	BloTes	Dx	4
	"Bradycardia" (ICD#427.8...	BraC	Dx	4
	"Bruit" (ICD#785.9)	Bru	Dx	4
	"Cardiac arrest" (ICD#42...	CarA	Dx	4
	"Cardiac arrhythmia" (ICD...	CarArr	Dx	4
	"Cardiac Contusion" (ICD...	CarC	Dx	4
	"Cardiomegaly" (ICD#429...	CarMeg	Dx	4
	"Cardiomyopathy" (nonsp...	CarM	Dx	4
	"Cardiovascular System Prob...	CarSys	Dx	4

Instead of selecting an item from a pre-built pick list, the Assessment field presents an opportunity to utilize a "location pick list". This list works by giving the user choices in Quick Access when the user clicks inside the Assessment field. The choices shown in Quick Access will be dependent on the Chief Complaint entered, as well as the items the user has used previously in the Assessment field and items in this patient's Active Problems list from the

## Summary.

In this example, with (1) hypertension entered as a Chief Complaint, (2) many hypertension-related diagnoses will appear in our assessment field location pick list. To choose one of these options, simply Double-click on the assessment in SMARTText Quick Access and it will insert into the assessment field of the active SOAPnote.

### F11 Pick List



To use the F11 Pick List:

1. Click in the Assessment field, type a keyword and press F11 to search local items (or Shift+F11, which searches online as well as local items to return more choices).
2. This presents a pop-up pick list below the keyword.

The user can scroll up and down on the list and double-click any item to select it and insert it into the field.

It is also possible to search by ICD-9 code if it is known. To narrow search results, type a word in the "Find" box at the bottom and hit enter or Click the magnifying glass. This will filter the search by the word the user typed, returning fewer choices.

Assessment[  
Hypertension with complications ICD#997.91 |  
]

When selecting a SMARTTextAssessment item, SOAPware will also insert the ICD code as well as several behind the scenes codes, making reporting and searching data much easier.

## Plan Entry

### \*MEANINGFUL USE: VISIT THE MEANINGFUL USE ROADMAP

#### - Patient Specific Educational Resources

#### Plan

Actions: [ [Lab/Tests:](#)  
[X-rays/Imaging:](#)  
[Studies \(other than lab or x-ray\):](#)  
[Summary updated:](#) ]

#### Medications

Selected	Description
<input type="checkbox"/>	"Plans (Other):"
<input checked="" type="checkbox"/>	"Lab/Tests:"
<input checked="" type="checkbox"/>	"X-rays/Imaging:"
<input checked="" type="checkbox"/>	"-Studies (other than lab or x-ray):"
<input type="checkbox"/>	"Old Records Requested:"
<input type="checkbox"/>	"Discuss with physician:"
<input checked="" type="checkbox"/>	"Summary updated:" (2P)
<input type="checkbox"/>	"Second Interpretation:" (2P)
<input type="checkbox"/>	"Plans for New Dx:"

The Actions pick list will display in the Plan field for assisting in documentation data entry. Or, the user can Click the sub-item to choose the specific action item. In this example, the user sees Lab/Tests, X-Rays/Imaging, Studies, and Summary updated have all been included as a part of the Plan field.

## Lab Tests

#### Plan

Actions: Lab/Tests: [ [COMPLETE CBC, AUTOMATED. #85027](#)  
[Related Dx-](#) [Modifiers-](#) ]  
[X-rays/Imaging:](#)  
[Studies \(other than lab or x-ray\):](#)  
[Summary updated:](#)

<input type="checkbox"/>	"ANTINUCLEAR ANTIBODIES" (LAB - ANA - 86038)
<input type="checkbox"/>	"THYROGLOBULIN ANTIBODY" (LAB - Anti-Thyroi...
<input type="checkbox"/>	"MICROSOMAL ANTIBODY" (LAB - TPO/Thyroid P...
<input type="checkbox"/>	"GLYCOSYLATED HEMOGLOBIN TEST" (LAB - H...
<input checked="" type="checkbox"/>	"COMPLETE CBC, AUTOMATED" (LAB - Auto He...
<input type="checkbox"/>	"TEST FOR ACETONE/KETONES" (LAB - Acetone...
<input type="checkbox"/>	"ASSAY OF AMYLASE" (LAB - Amylase, Serum - 8...

Click on Labs/Tests to see the pick list items, then Click a check box in front of a list item such as the CBC. This action inserts the selected pick list item into the Plan field.

## Related Dx

### Plan

Actions: Lab/Tests: **COMPLETE CBC, AUTOMATED.** #85027

[Related Dxs-](#) [Modifiers-](#)

[X-rays/Imaging:](#)

[Studies \(other than lab or x-ray\):](#)

[Summary updated:](#)

### Medications

S	C	ICD	Description
<input type="checkbox"/>	0	496	Chronic obstructive pulmonary disease
<input type="checkbox"/>	0	722.6	Degenerative Disc Disease
<input type="checkbox"/>	0	530.81	Gastroesophageal reflux disease or GERD
<input type="checkbox"/>	0	455.6	Hemorrhoids
<input type="checkbox"/>	0	401.1	Hypertension - Benign
<input type="checkbox"/>	0	401.1	Hypertension - Benign
<input type="checkbox"/>	0	997.91	Hypertension with complications
<input type="checkbox"/>	0	723.1	Neck Pain or Cervicalgia
<input type="checkbox"/>	0	783.21	Weight loss, abnormal

For billing purposes, it is often necessary to associate a diagnosis with a lab test. In order to be able to relate the Structured Dx SMARTText item types used in the Assessment field to this lab item (i.e. CBC), Click on the Related Dxs- sub-item for the lab test. This results in all diagnoses in the Assessment and Active Problems (i.e. Hypertension) to be displayed for selection in the SMARTText Quick Access dialog. Select the appropriate Assessment/diagnosis item to associate it to the Plan item.

## Handouts

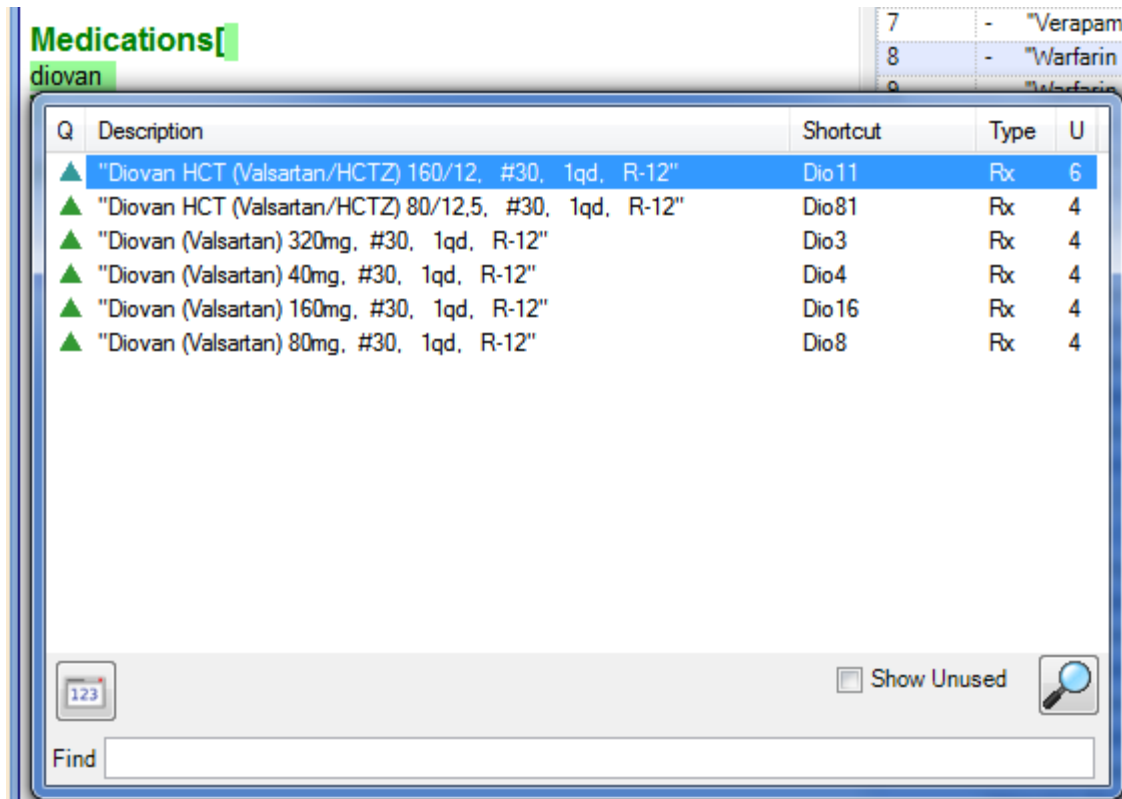
The Plan field is also where the user may choose to include patient handouts. To learn more about creating and using handouts, see - [Selecting Handouts Automatically.](#)

## Medication Entry

### \*MEANINGFUL USE: VISIT THE MEANINGFUL USE ROADMAP

- Active Medication List
- e-Prescribing (eRx)
- CPOE for Medication Orders
- Drug Interaction Checks

## Search for Medications



To enter a medication into the SOAPnote Medications field, Click in the Medication field and type a keyword (*ie: Diovan*) then press either F11 or Shift+F11 to search for the medication.

To select one of the medication items, simply Double-click on the medication to insert.

## Medication Sub-Items

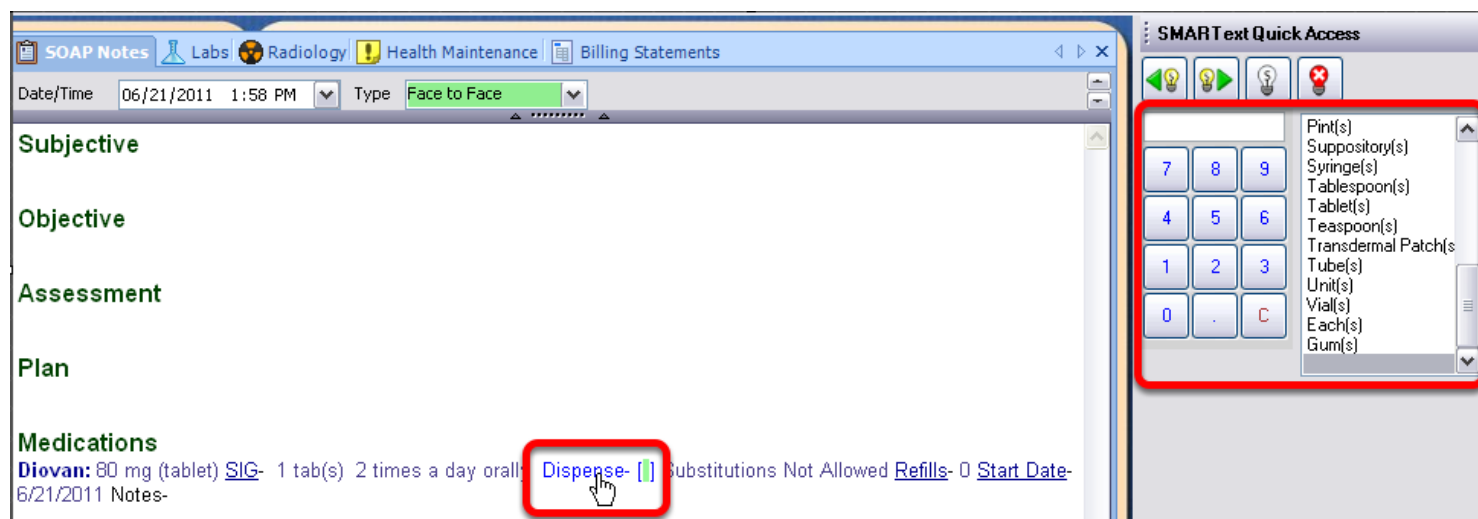
Medication	Strength	SIG	Dose	Freq	Route	Dispense	Substitutions	Refills	Start Date	End Date	Notes
Diovan											

All SMARTText Items, including Medication SMARTText Items, have sub-items that can be changed.

The above medication has numerous sub-items that are currently displayed in the SOAPnote

Medications field.

## Editing Sub-Items



Each of the sub-items can be clicked on. When clicked, additional options will be presented within the SMARText Quick Access window.

In the example display above, to select a Dispense:

1. Click on the Dispense sub-item.
2. Select a numerical dispense number using the number picker (*ie: 60*).
3. Choose a form (*ie: tablets*).

The dose, frequency and route sub-items are grouped together in a header called SIG. Custom SIGs can be created if the desired structured dose, frequency and route items do not exist. For more information on how to create custom SIGs, see: [Custom Sigs](#).

## ePrescribing

Once a medication has been inserted into the SOAPnote Medications field, it can then be ePrescribed, faxed or printed through Rx Manager. To learn more about the Rx Manager, see: [Intro to Rx Manager](#) and [Refills](#).

## Drug Courses

The user can also save courses of drugs that he/she prescribe often. This will speed things up when the user wants to prescribe one of these courses so that the strength, dose, frequency, etc. is already set up the way the user would need it to be. To learn about how to set these up, see: [Drug Course Creation](#).



## Follow Up

---

### Follow-up

#### Follow Up

Return if problems develop or worsens.

[Schedule:](#)

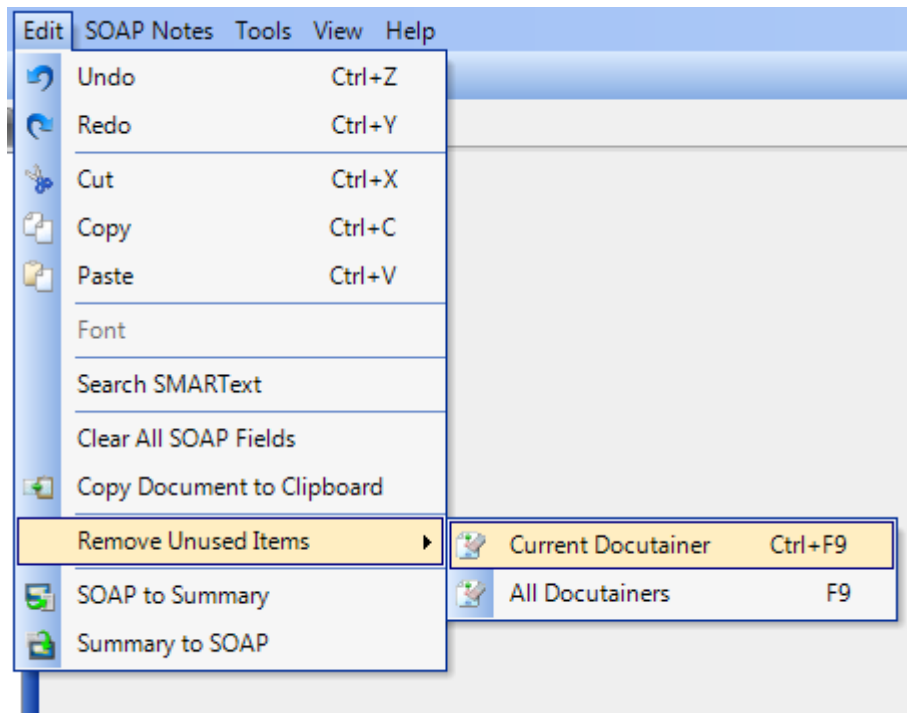
Notice that "Return if problems develop or worsens" has been entered into the Follow up by default. However, this default can be changed and/or additional information could be typed in a free text fashion. The user can also click on the link for "Schedule" to choose to have the patient return at a specific interval.

## Remove Unused Items

---

SOAPware has a convenient command to clean up documentation called Remove Unused Items. This command removes any SMARTText items that have not been used, and also removes extra spaces.

### Remove Unused Items



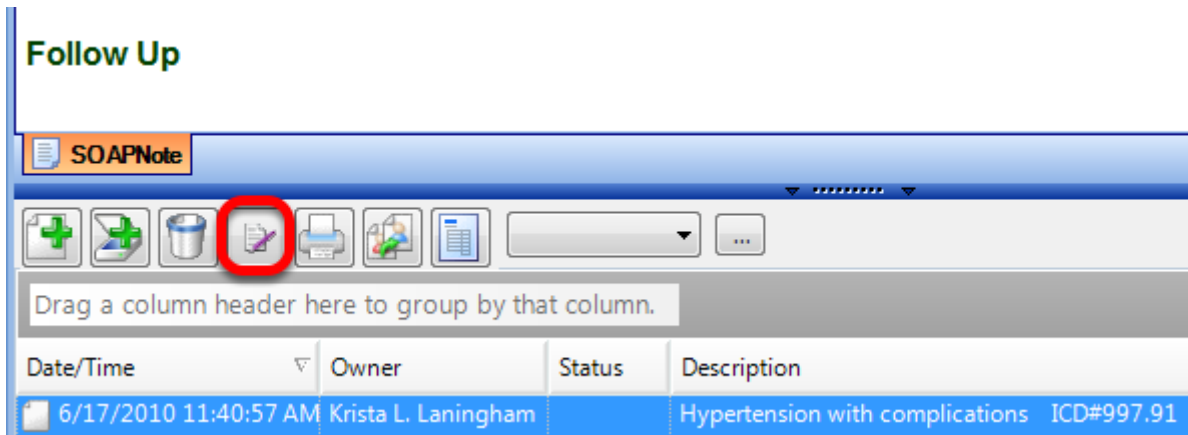
1. Click Edit in the menu bar.
2. Click the Remove Unused menu item
3. Click the Current Docutainer menu item.

**NOTE: Remove Unused Items of the Current Docutainer clears out the unused items in the active document. When the SOAPnote is active, this will only clear out unused SMARTText Pick Lists in the SOAPnote that we have open. If the user was to choose All Docutainers instead, this would apply to all of the patient's encounters as well as the summary.**

## Signing Off

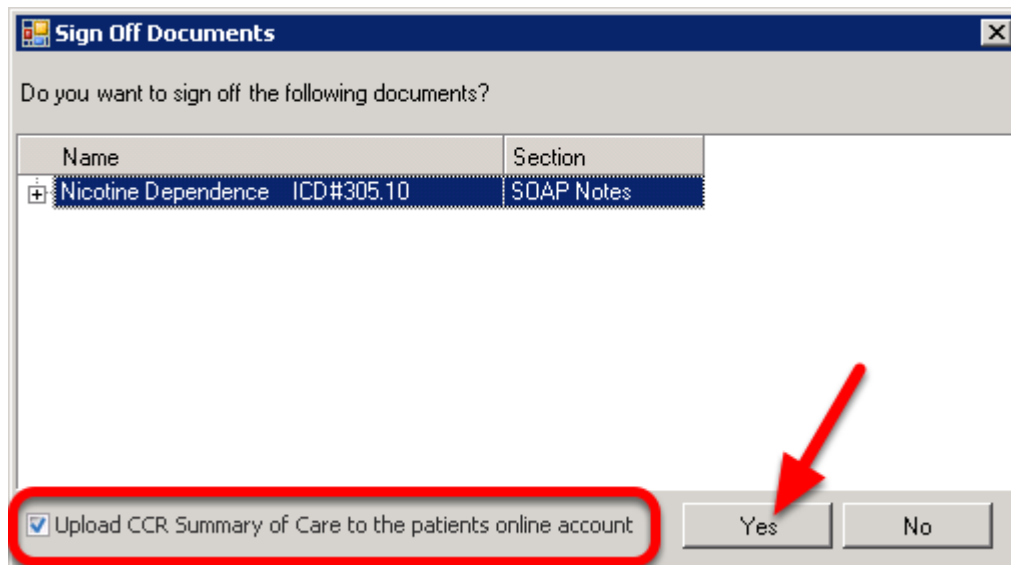
**NOTE:** Only providers have the security rights to sign off a document.

### Sign Off Documents Button



Click the Sign Off Documents button.

### Confirm Signing



A dialog box will display asking "Do you want to sign off the following documents?" Click Yes.

**\*Important:** Once the user has signed off the document, it is locked and unalterable.

In this window, users will now be able to check the "Upload CCR Summary of Care to the patients online account". If this box is checked, a new summary of care document will be uploaded to the

[SOAPware Patient Portal](#) after the new encounter is signed off (if unchecked, the new summary of care will not be uploaded). This box will be grayed out if the patient is not registered for the [SOAPware Patient Portal](#).

## Signed Off Documents

### Subjective

CHIEF COMPLAINT(S)/REASON FOR VISIT: Hypertension, complicated.

HPI: SYMPTOMS/RELATED: Reports symptoms of

ONSET/TIMING:

QUALITY/COURSE:

MODIFIERS/TREATMENTS: Has tried

### Objective

Exam: GENERAL: Appearance: General appearance can be described as in mild distress.

HEAD/EARS/NOSE/THROAT: Ears-Nose (external) Inspection: Externally, nose and ears are normal in appearance and without scars, lesions, or nodules.

Otoscopic Exam: External auditory canals and tympanic membranes are normal.

Oropharynx demonstrates oral mucosa, salivary glands, tongue, tonsils, posterior pharynx, hard-soft palates are normal.

EYES: Conjunctivae and Lids: No lesions, eye discharge or other abnormalities.

Pupils and irises: Pupils are equal, round, and reactive to direct light and are consensual to light bilaterally. Irises are symmetrical and without lesions.

LUNGS and RESPIRATORY: Lung auscultation elicits no wheezing, rhonchi, rales or rubs and with equal breath sounds.

HEART (Cardiovascular): Heart auscultation discovers regular rate and rhythm; no murmur, gallop or rub. Normal heart sounds.

ABDOMEN (Gastrointestinal): Mass/Tenderness Exam: Neither are present.

Liver/Spleen: No hepatomegaly or splenomegaly.

### Assessment

Hypertension with complications ICD#997.91

### Plan

Actions: Lab/Tests: COMPLETE CBC, AUTOMATED. #85027 Related Dx's: Modifiers-

X-rays/Imaging:

Studies (other than lab or x-ray):

Summary updated:

### Medications

Diovan HCT (Valsartan/HCTZ): 12.5 mg-160 mg (tablet) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 12

Comment- Notes-

### Follow Up[

SOAPNote

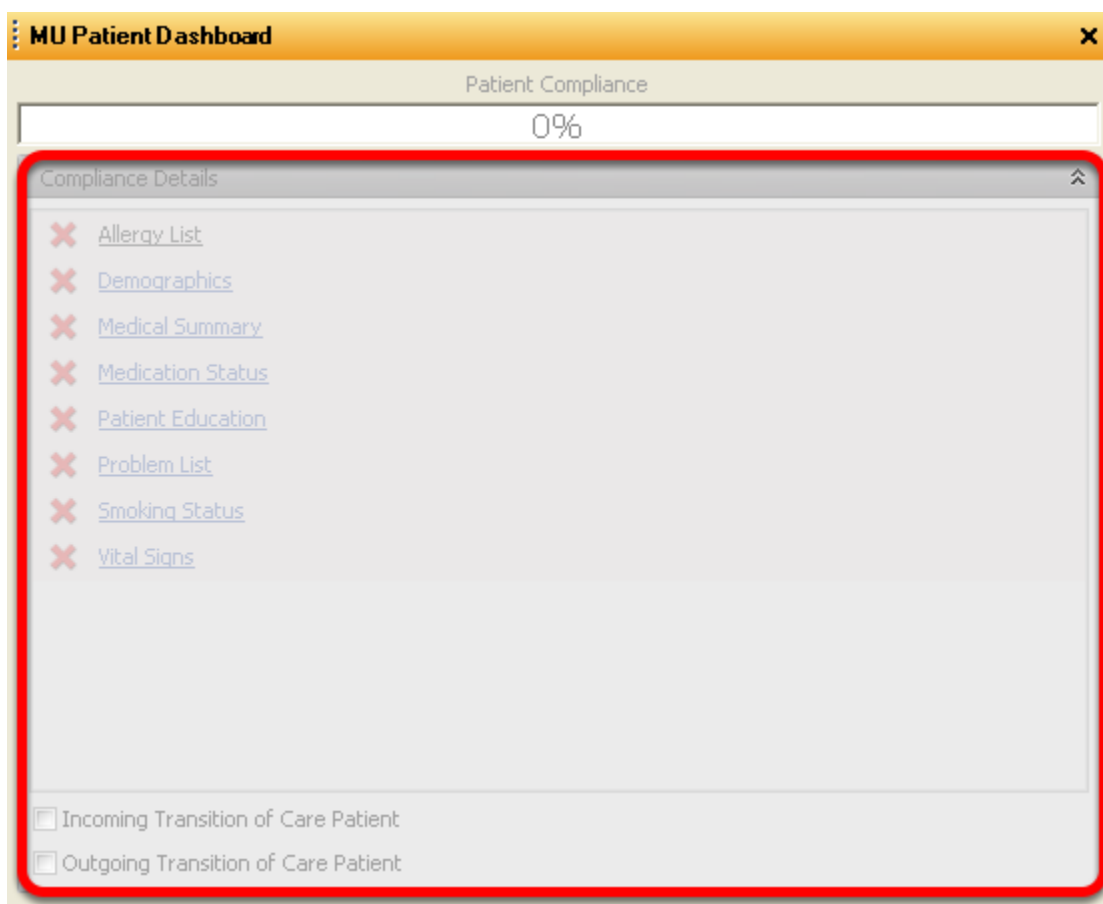


Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx
6/17/2010 11:40:57 AM	Krista L. Laningham		Hypertension with complications ICD#997.91	Hypertension with complications

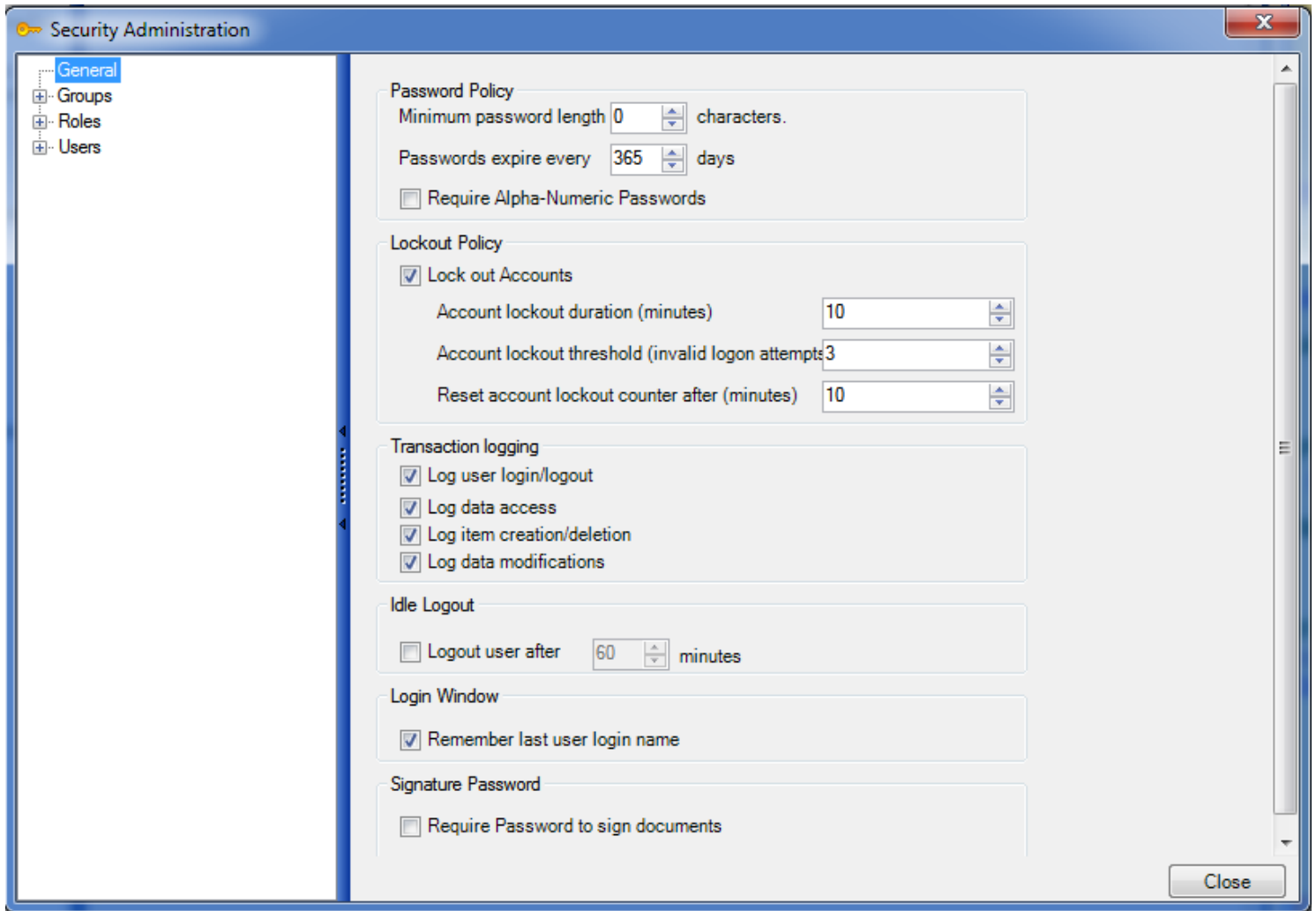
Now, the document will turn yellow indicating that it has been signed off and is unalterable. Note that the icon in the encounter list has changed to denote a signed off document.

## Patient MU Dashboard Grayed Out



The Patient MU Dashboard will be grayed out when the SOAPnote encounters are signed off or if a SOAPnote is not a Face to Face encounter.

## Signature Password



Signature Password, when enabled, will require passwords to sign off documents. This will store digital signatures from multiple providers on one document. To set up a signature password:

1. Click on Tools > Security in the menu bar.
2. At the bottom of the dialog window, check the box to Require Password to sign documents.

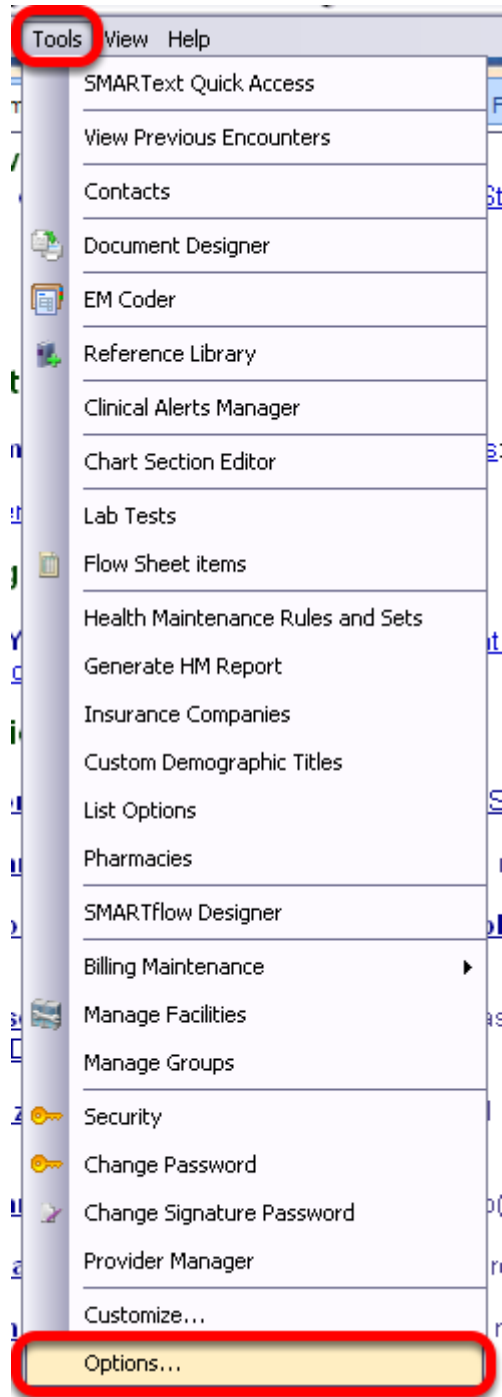
When using a signature password, inbetween clicking the sign-off button and confirming the sign-off documents, the user will be asked for a password.

## Summary To SOAP

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This lesson will describe how to set up the Summary to SOAP option, which will allow users to set Summary fields to transfer documentation to a new SOAPnote that has been created.

### Tools - Options



To set up the Summary to SOAP options, go to Tools > Options.



## Summary to SOAP

**Options**

Chart Layouts  
Chart Rack  
Document Designer  
Docuplates  
OCR  
Pharmacy Manager  
Pulled Charts  
Scanning  
SMARText  
SMARText Color Coding  
Structured CPT  
Structured Dx  
Structured Immunization Entry  
Structured Order Entry  
Structured Rx  
**Summary To SOAP**  
Toolbars  
Vital Signs  
Workflow

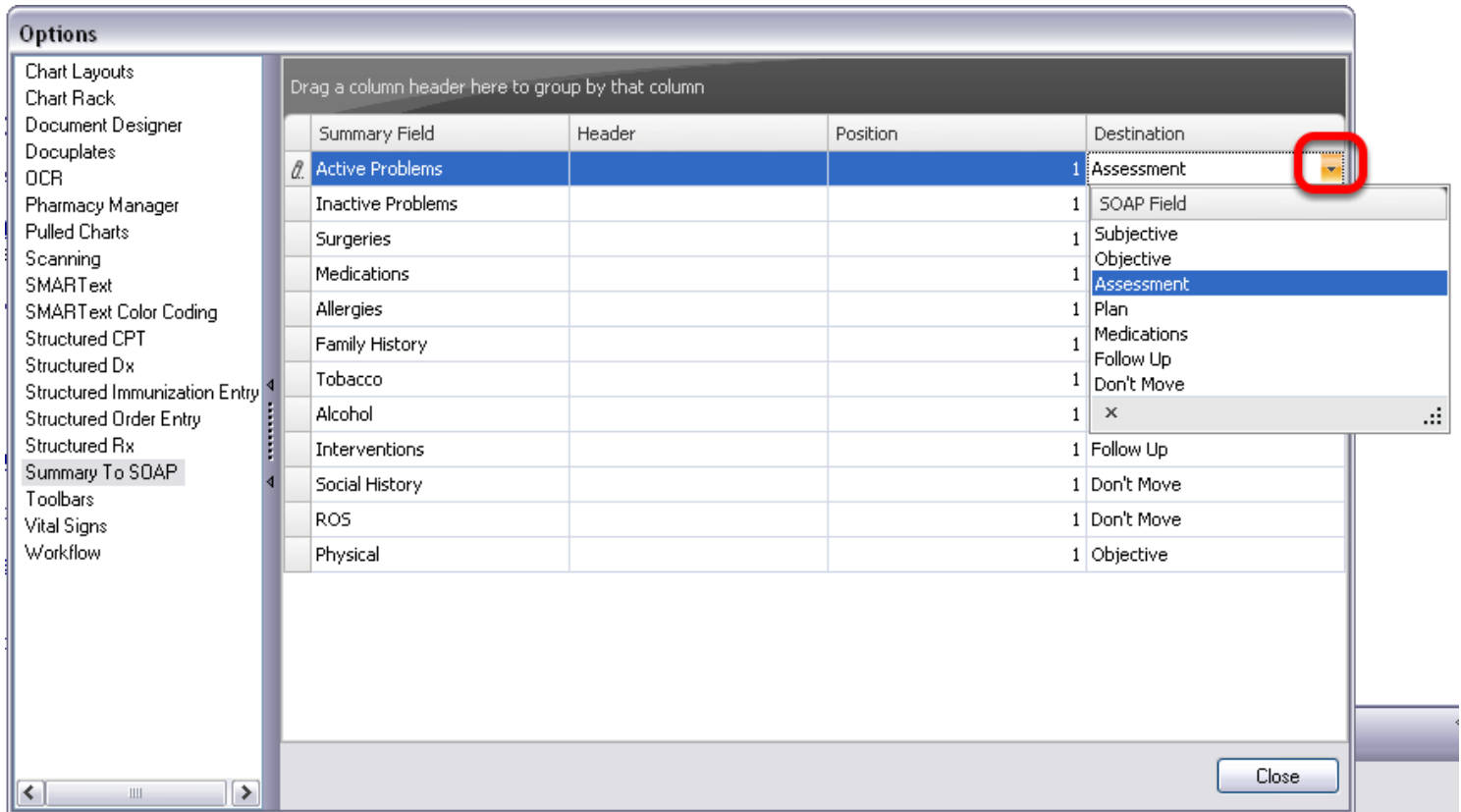
Drag a column header here to group by that column

Summary Field	Header	Position	Destination
> Active Problems		1	Assessment
Inactive Problems		1	Don't Move
Surgeries		1	Don't Move
Medications		1	Medications
Allergies		1	Don't Move
Family History		1	Don't Move
Tobacco		1	Don't Move
Alcohol		1	Don't Move
Interventions		1	Follow Up
Social History		1	Don't Move
ROS		1	Don't Move
Physical		1	Objective

Close

Select the Summary To SOAP item within the left side menu.

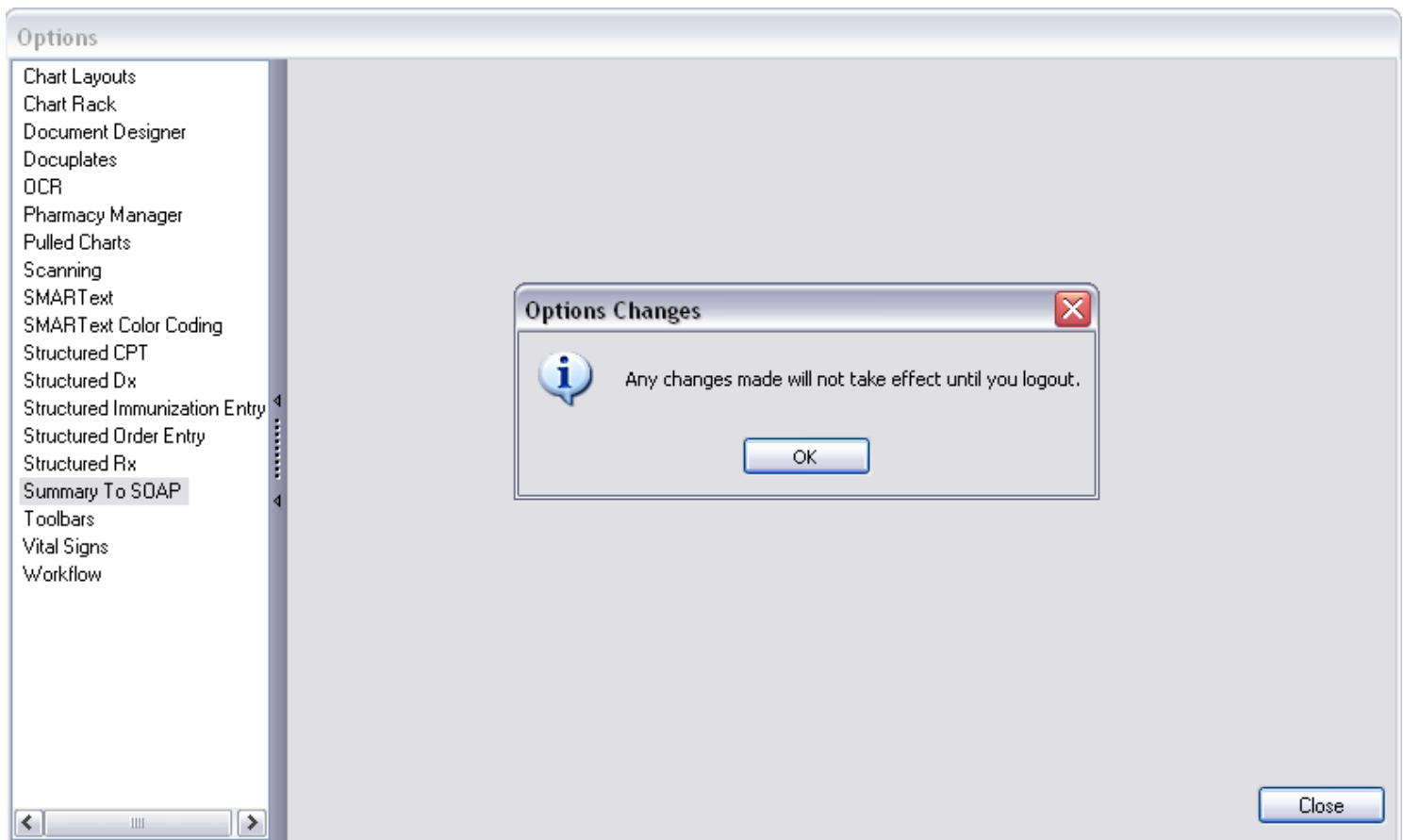
## Selecting the Destination



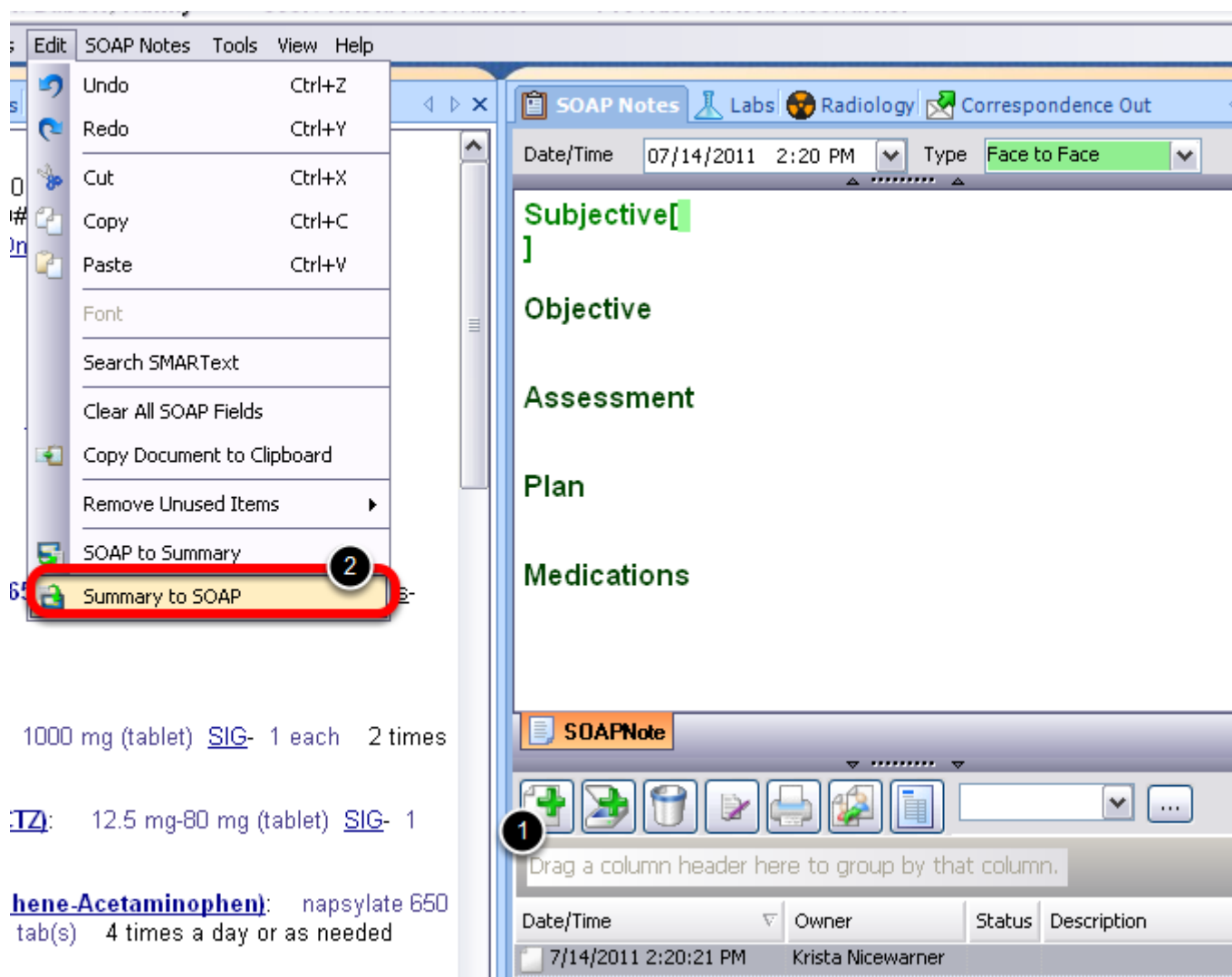
Click the drop down menu under the Destination column to specify the location that the documentation will be copied to. (Example: For Active Problems, we have selected Assessment - this will copy all of our Active Problems to the new SOAPnote Assessment field when a new encounter is created).

If the user does not wish for a field to be copied into a new SOAPnote, select "Don't Move".

## Saving the Changes



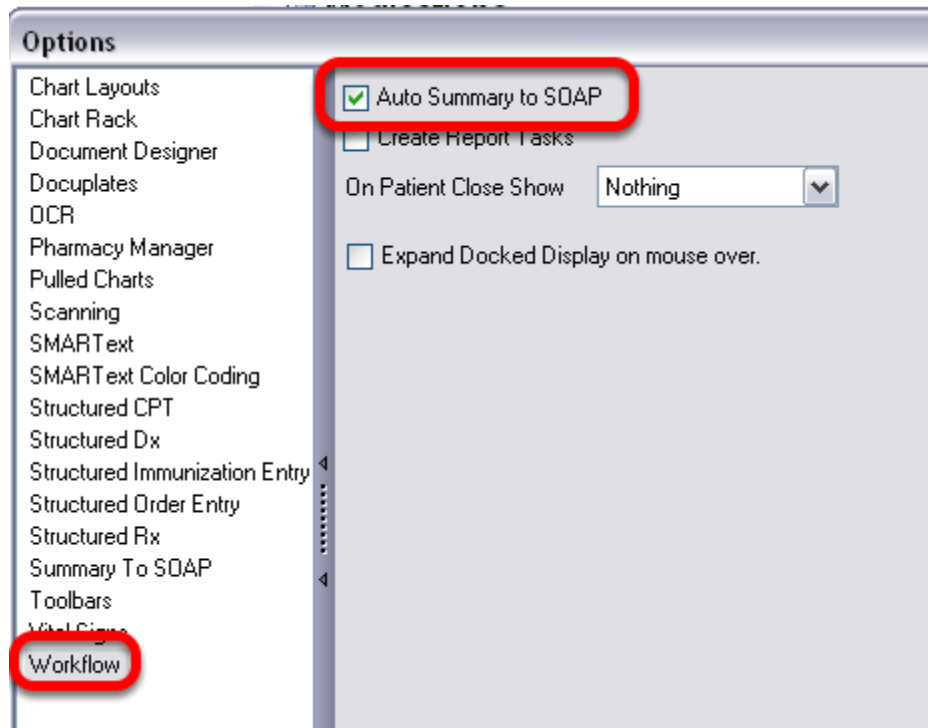
To save the changes, Click the Close button. The user must then log out and back in to SOAPware before the changes will take effect.



To manually transfer our Summary to SOAP documentation:

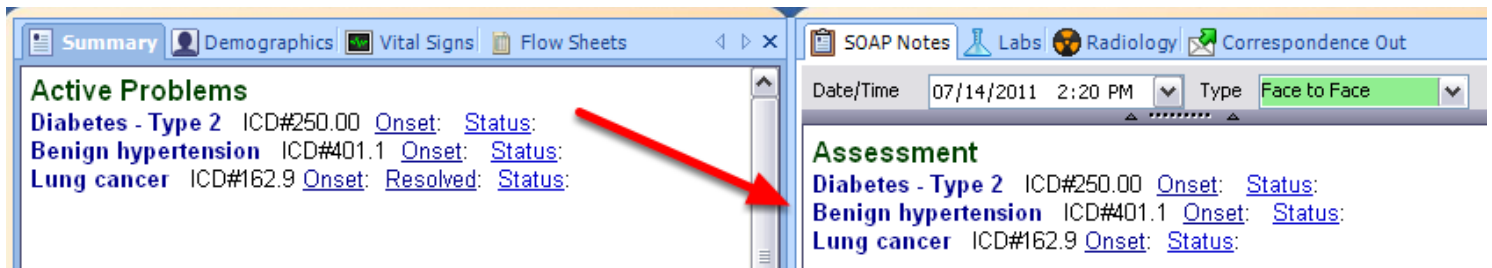
1. Create a new SOAPnote.
2. Click Edit > Summary to SOAP.

## Auto Summary to SOAP



Users can set their SOAPware options to automatically transfer documentation from the Summary to the SOAPnote upon SOAPnote creation. To do this:

1. Click Tools > Options.
2. Select Workflow.
3. Check "Auto Summary to SOAP."



With the Auto Summary to SOAP option activated, the Summary fields will automatically copy to the SOAPnote when a new encounter is created.

## User-Specific

The Summary to SOAP option is user-specific.

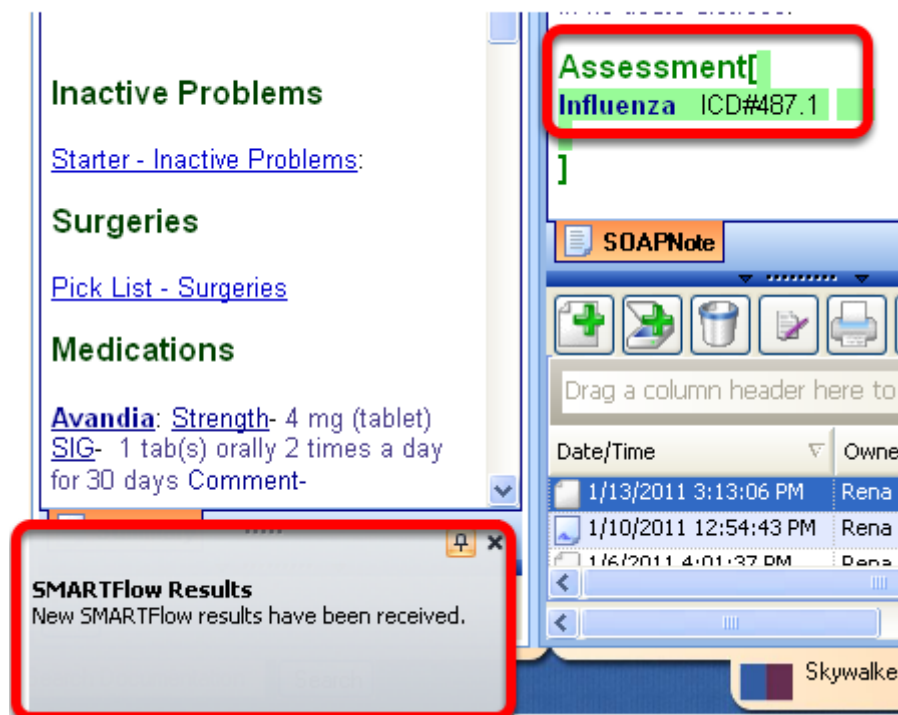
## Syndromic Health Surveillance

This lesson will demonstrate how SOAPware will detect a reportable diagnosis. An already created folder on the user's computer will need to be accessible to save the SMARTFlow Results to the computer.

### \*MEANINGFUL USE (MENU SET PUBLIC HEALTH MEASURE): VIEW THE MEANINGFUL USE ROADMAP

- Syndromic Surveillance Data Submission

#### SOAPnote Documentation

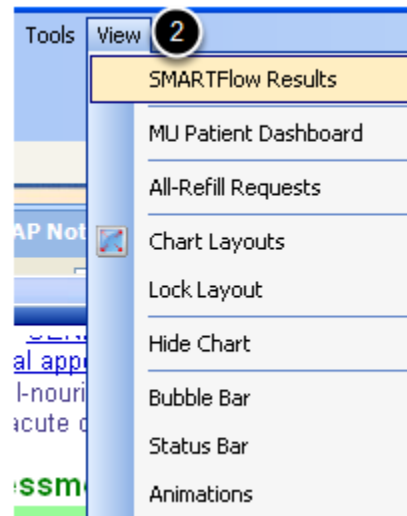
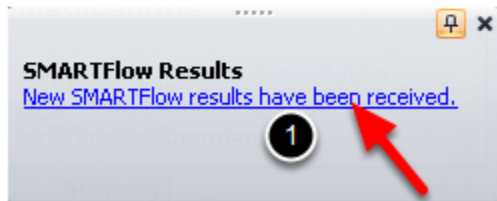


When entering a reportable diagnosis SMARTText item into the Assessment field of the SOAPnote, the SMARTFlow Results window will display. This window will prompt the user to review and save this information to their computer for future use if needed.

For instance, if Influenza (SMARTText diagnosis item) is used in the Assessment field the SMARTFlow Results window will appear in the far left bottom of SOAPware.







This window may be pinned open and may be moved by dragging to a desired location to view the SMARTFlow Results. If the pop-up window was missed, Click View > SMARTFlow Results.

## Viewing the SMARTFlow Results



To view the SMARTFlow Results:

1. Click the underlined text-*New SMARTFlow results have been received.*
2. Click View > SMARTFlow Results if the pop-up window was missed.

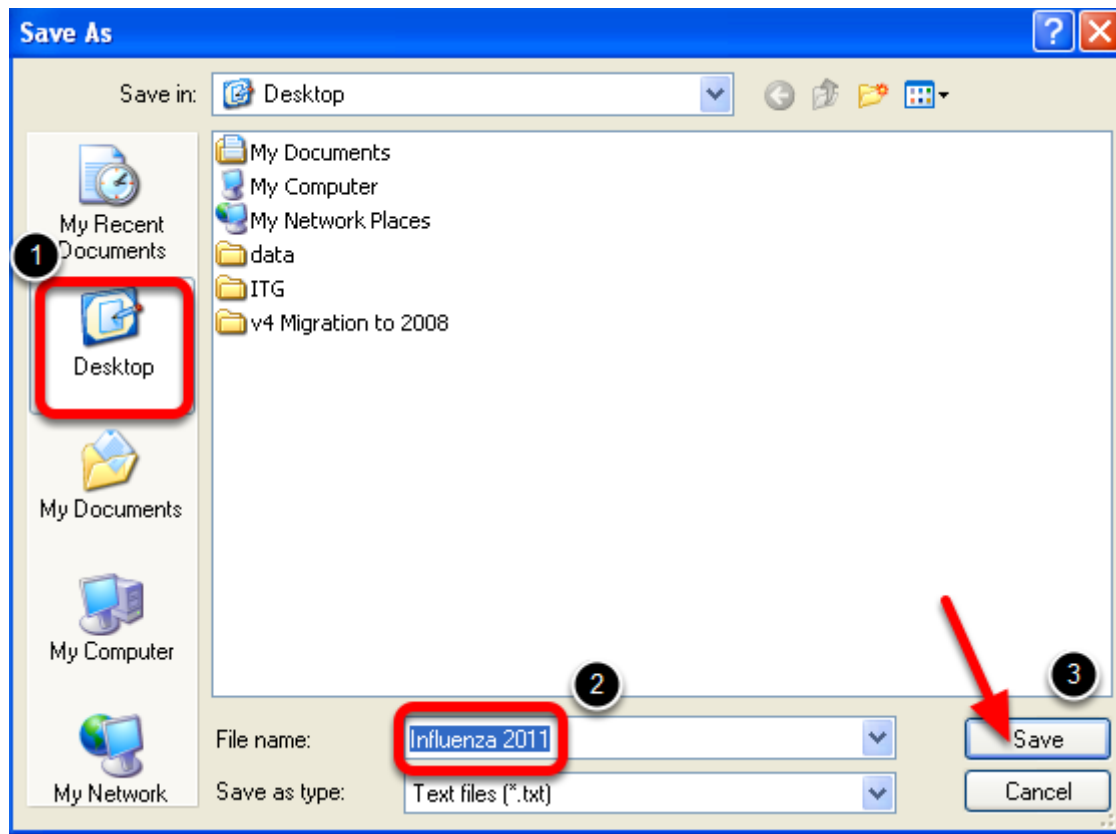
SMARTflow Results		
Workflow		Action
Result		Details
Category	Reference Link	
<b>Reportable Diagnosis Detected</b>		Do It
Influenza Diagnosis Detected--Reportable to health registries		
Check - Meaningful Use		
<b>Reportable Diagnosis Detected</b>		Do It
Influenza Diagnosis Detected--Reportable to health registries		
Check - Meaningful Use		
<b>Demographics</b>		Do It
		
Check - Meaningful Use		<a href="http://soapedia.mysoapware.com/020_Implementation...">http://soapedia.mysoapware.com/020_Implementation...</a>
<b>Medication Status</b>		Do It
Structured Rx Missing in Medications list		
Check - Meaningful Use		<a href="http://soapedia.mysoapware.com/020_Implementation...">http://soapedia.mysoapware.com/020_Implementation...</a>
<b>Allergy List</b>		Do It
Structured Item Missing in Allergies list		
Check - Meaningful Use		<a href="http://soapedia.mysoapware.com/020_Implementation...">http://soapedia.mysoapware.com/020_Implementation...</a>
<b>Problem List</b>		Do It
		

The SMART Flow result window displays the items for the patient whose chart is currently open.

1. Use the scroll bar to locate the Reportable Diagnosis Detected.
2. Click the "Do It" button.



## Saving the Reportable Diagnosis Detected



After Clicking the "Do It" button, the Save As window will be displayed for the user's computer.

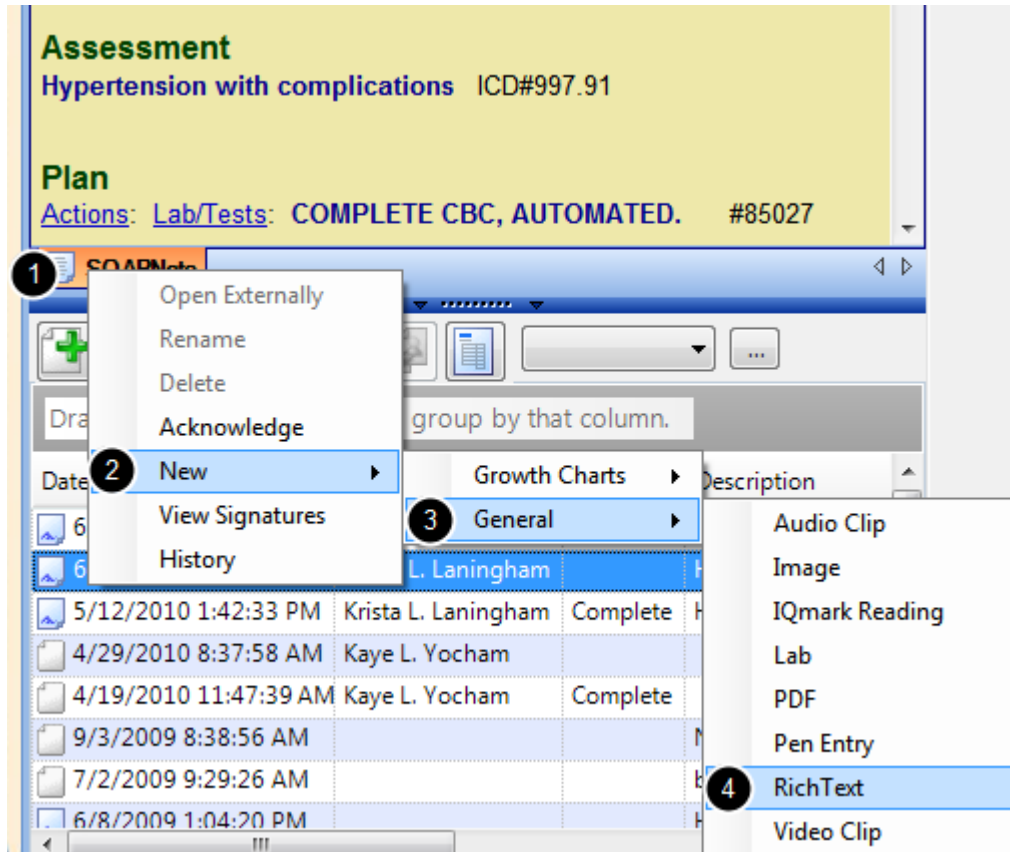
1. Select the location to create a file to save the Reportable Diagnosis Detected.
2. Give the file a name-i.e. the name of the Reportable Diagnosis.
3. Click Save.

# **Adding a SOAPnote Addendum**

## Creating an Addendum

The user can add an addendum to a SOAPnote if information needs to be added after the SOAPnote has been signed off.

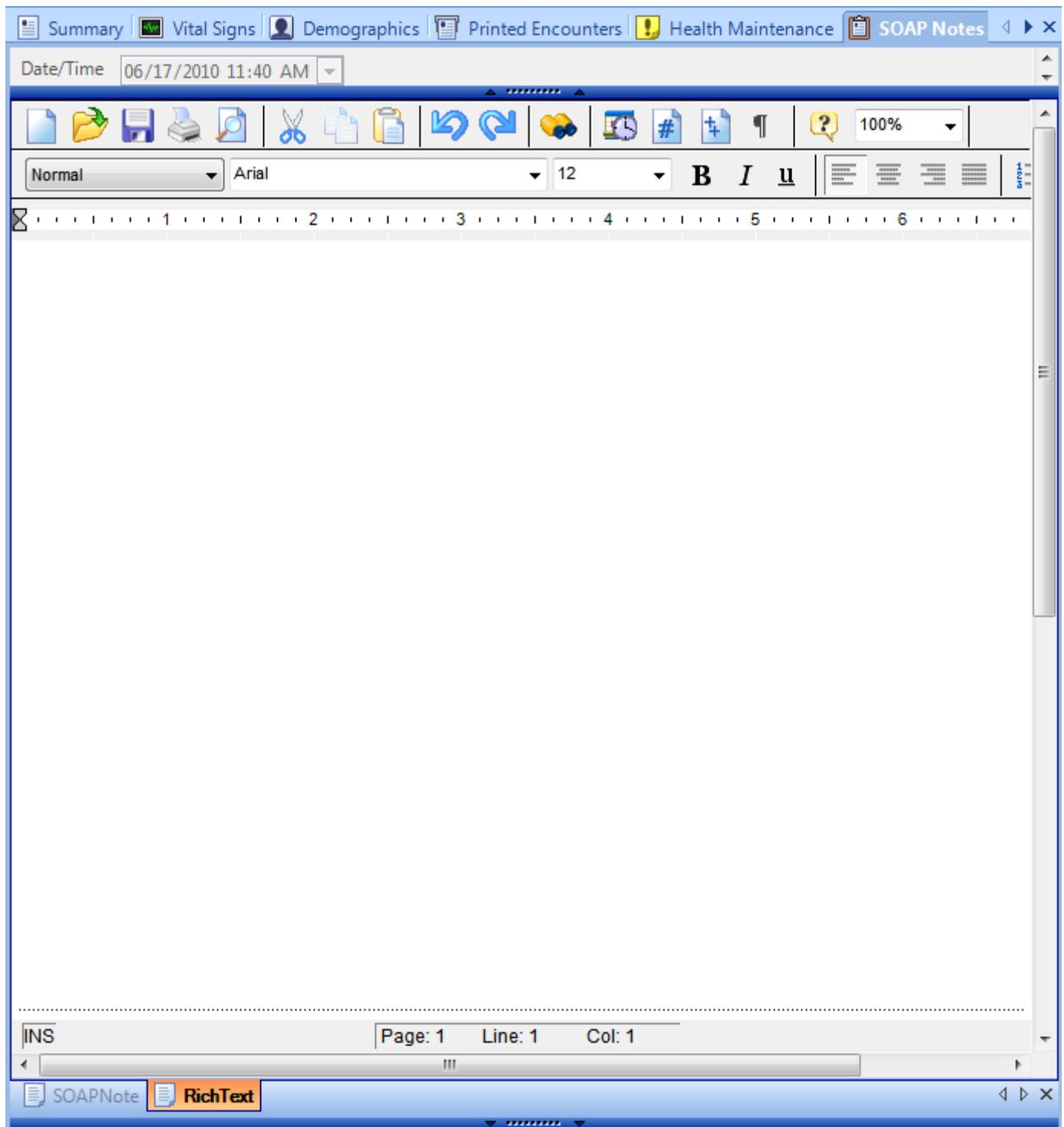
### Create a Rich-Text Addendum



To do this:

1. Right-click on the lower SOAPnote tab (just above the lower splitter bar).
2. A menu will appear and the user will choose New, (3) General, (4) Rich Text.

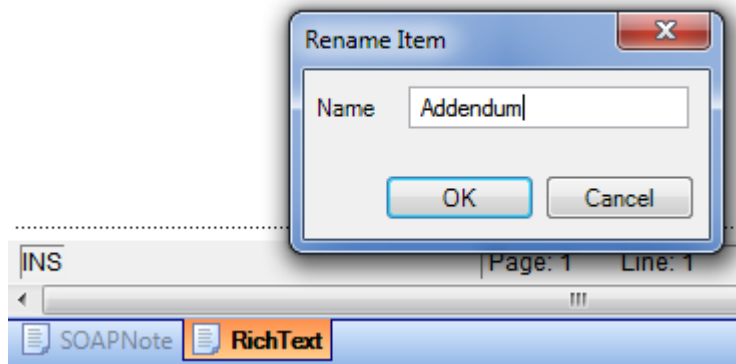
## Addendum is attached to the SOAPnote



The Addendum the user just created will appear and the user can type to add information, which will be 'attached' to the SOAPnote in the same docutainer.

**NOTE: The user will not be able to insert SMARText items in the addendum. The addendum is used for free-text only.**

## Rename the Addendum



The user can rename the addendum from "Rich Text". Right-click on the tab and choose "Rename".

# Billing Statements

## Creating a Billing Statement

The Billing Statements section displays previous superbills and allows for the creation of new billing statements.

Billing statements can often facilitate direct posting into the practice management system (this requires the SOAPwareXchange enhancement).

### Structured Data Entry

#### Assessment

Diabetes - Type 2 - with complications ICD#250.90  
Gastroesophageal reflux disease or GERD ICD#530.81

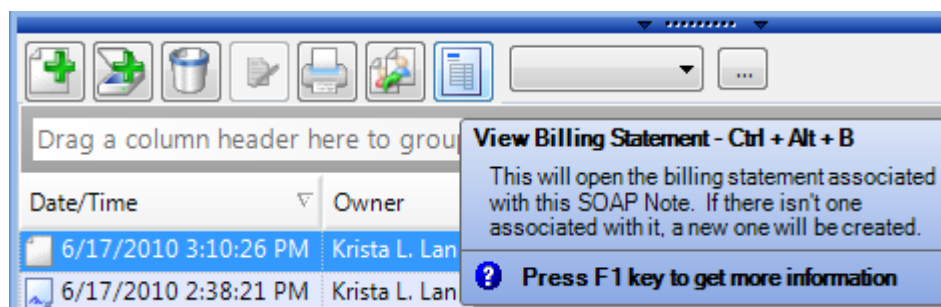
#### Plan

OFFICE/OUTPATIENT VISIT, EST. CPT 99214 [Related Dxs-](#) Gastroesophageal reflux disease or GERD ,  
Diabetes - Type 2 - with complications  
[Actions:](#) [Summary updated:](#) The summary record was updated with pertinent information from previous records (5-10 minutes).  
[Lab/Tests:](#) [Diabetes Lab:](#) GLYCOSYLATED HEMOGLOBIN TEST. #83036 [Relates Dxs-](#) [Modifiers-](#)  
GLUCOSE TOLERANCE TEST (GTT): #82951 [Relates Dxs-](#) [Modifiers-](#)

Specific types of SMARText items must be used in order to directly populate the Billing Statement. These specific items are Structured Dx and Structured Plan Item types.

Also, the Plan field needs to contain a Structured Plan Item type of SMARText item that is associated to a related diagnosis.

### Create Billing Statement



Click the View Billing Statement button. It is located beneath the Lower Splitter Bar of the current SOAP encounter note, and is above the area of the Document List.

## View Billing Statement

Demographics Printed Encounters Health Maintenance SOAP Notes **Billing Statements**

Posted On: N/A Owner: Krista L. Lanin... Facility: Trinity Medical

Description	CPT	Diagnoses
GLYCOSYLATED HEMOGLOBIN TEST.	83036	
GLUCOSE TOLERANCE TEST (GTT):	82951	
OFFICE/OUTPATIENT VISIT, EST.	99214	Gastroesophageal reflux disease or GERD , Diabetes - Type 2 - with complications

Assessment Misc. Info

Diabetes - Type 2 - with complications #250.90  
Gastroesophageal reflux disease or GERD #530.81

Notes

Drag a column header here to group by that column.

Date	Name	Status	Owner
6/17/2010 3:16:54 PM	Superbill		
10/23/2009 11:25:59 AM	Superbill		

An Add Document Task dialog box will display.

At this time Click on the Add button.



The Billing Statements viewer is displayed, and a new Superbill is populated with the information contained within the current SOAP encounter note.

## Associate and Post the Superbill

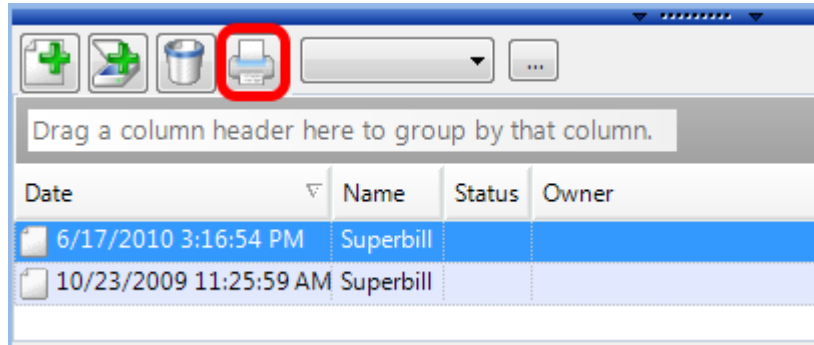
Description	CPT	Diagnoses
GLYCOSYLATED HEMOGLOBIN TEST.	83036	
GLUCOSE TOLERANCE TEST (GTT):	82951	
OFFICE/OUTPATIENT VISIT, EST.	99214	Gastroesophageal reflux disease or GERD , Diabetes - Type 2 - with complicatio

1. Click the Associate button
2. Then Click on the Post Superbill button

SOAPware sends the billing statement to the practice management system.

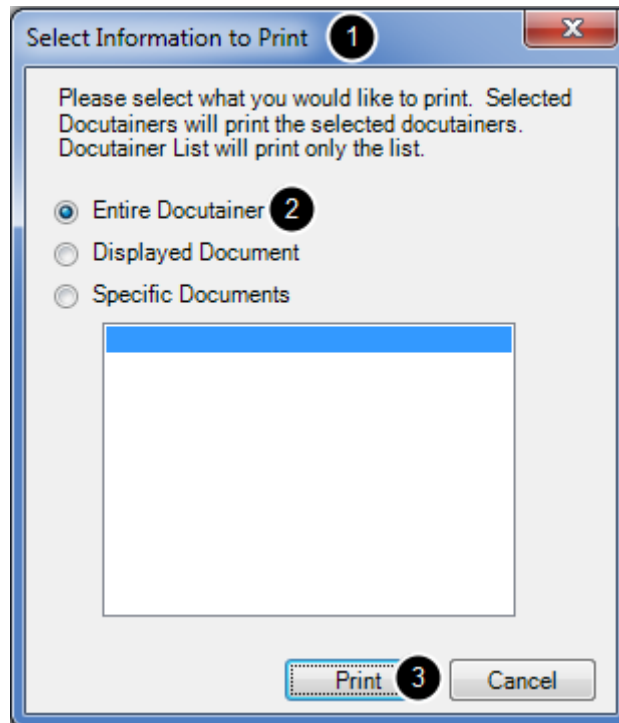
## Printing a Billing Statement

### Print Button



After creating the billing statement, Click the Print button beneath the Lower Splitter Bar.

### Select Printing Information



1. The Select Information to Print dialog will display.
2. Click the Entire Docutainer radio button (if not already selected by default).
3. Click the Print button.

# Introduction to Task Manager

## Task Lists

---

### Functions of Task Manager

In paper-based offices, there are common activities that generally result in sticky notes being placed on patient charts that are scattered around in multiple locations. These activities includes things such as:

- \* Refill requests
- \* Patient phone calls
- \* Recalls or follow ups
- \* Internal messaging

It is very inefficient, and it is easy to misplace these types of reminders. It potentially reduces productivity and quality of care.

With the Task Manager, all of these tasks and more are managed from a single, central location. Each and all users go to the same location to address tasks (i.e. view, act-on, sign-off, etc.). This tends to keep tasks on track and improves productivity and quality of care.

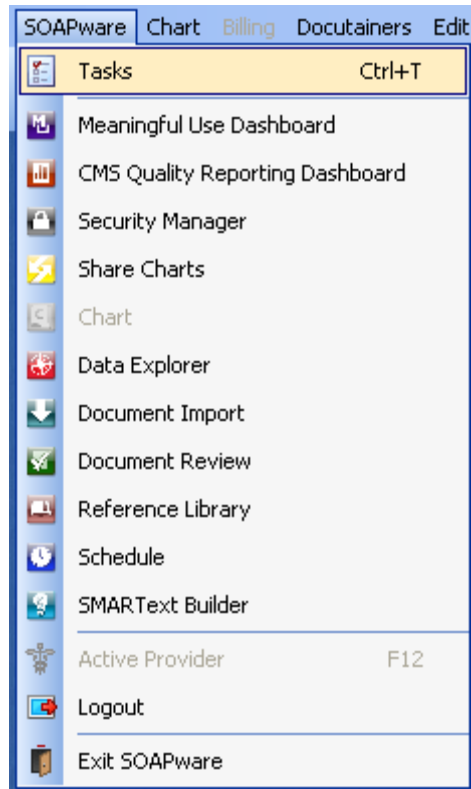
#### **The Task Manager has two key functions:**

1. Track the status of all tasks.
2. Send messages or reminders to various users.

### Interface

**IMPORTANT:** The Task lists section is not to be used for documentation purposes. Tasks are not a permanent part of the patient record. It is to keep track of tasks for the patient and to send messages or reminders to other users in the workplace.

## Access the Task Manager



To access the Task Manager, Click SOAPware in the menu bar, and Click the Tasks menu item (or Press Control+ T).

## Task Manager

The screenshot shows the Task Manager interface with the following components and callouts:

- 1**: User dropdown menu (currently set to 'All Users').
- 2**: Toolbar with various action icons (add, refresh, print, etc.).
- 3**: Instruction text: 'Drag a column header here to group by that column.'
- 4**: 'Show Tasks due in:' dropdown menu (currently set to '--Show All--').
- 5**: Layout dropdown menu.
- 6**: Task list table.

Patient	Description	Notes	Priority	Action/Status	Due Date	Assigned To	Last Modified	Completed
Odenkirk, Bob G.	EScript Error		Urgent	Needs Review	06/17/2010	Krista L. Laningham	05/03/2010 15:42	<input type="checkbox"/>
Jim, Slim	SOAPNote		Normal		06/17/2010	Krista L. Laningham	06/17/2010 14:38	<input type="checkbox"/>
Glenda, Tabitha	SOAPNote		Normal		05/10/2010	Krista L. Laningham	05/10/2010 14:57	<input type="checkbox"/>
Schnur, Dorothy	SOAPNote		Normal		05/03/2010	Krista L. Laningham	05/03/2010 10:59	<input type="checkbox"/>
Schnur, Dorothy	SOAPNote		Normal		05/02/2010	Kaye L. Yocham	05/02/2010 15:13	<input type="checkbox"/>
Odenkirk, Bob G.	SOAPNote		Normal	Sign	05/02/2010	Kaye L. Yocham	05/02/2010 15:20	<input type="checkbox"/>
Odenkirk, Bob G.	SOAPNote		Normal	Needs Review	05/02/2010	Kaye L. Yocham	05/02/2010 15:20	<input type="checkbox"/>
Odenkirk, Bob G.	SOAPNote		Normal		04/29/2010	Kaye L. Yocham	04/29/2010 16:46	<input type="checkbox"/>
Jim, Slim	SOAPNote		Normal	Acknowledged by M.D	04/19/2010	Kaye L. Yocham	04/19/2010 11:47	<input type="checkbox"/>

The Task Manager Overview:

1. Switch User Task lists
2. Perform a number of actions with the toolbar
3. Sort Tasks by type
4. Sort Tasks by due date
5. Create a Task layout
6. View the Task list

## Task Notes

The screenshot shows a task note popup for a task with priority 'Urgent'. The note contains the following information:

- Prescriber: Krista L. Laningham
- Patient: Odenkirk, Bob
- Medication: Diovan HCT (Valsartan/HCTZ): 12.5 mg-160 mg (tablet)
- Pharmacy: CVS/pharmacy #7284
- Sent: Monday, May 03, 2010
- Message: 601 - Receiver unable to process - DO NOT RETRY

Tasks can have notes associated with them. These are not notes that can be saved as a part of a patient's chart and will be deleted when the task is completed. To view the note, the user can hover the mouse over the note icon to view the message.

## Task Item/Information Area

The Tasks information area at the bottom of the Task Manager displays one task item per line/row, and various task characteristics organized/displayed in columns. The tasks characteristics that are displayed can be customized.

- \* Patient ( patient the task is associated with)
- \* Description (type of task, i.e. phone call, lab, office visit etc)
- \* Notes (pertinent information related to specific task)
- \* Priority (rank of urgency)
- \* Action/Status (what needs to be/has been done on task)
- \* Due Date (will default to date created, can be edited)
- \* Assigned To (person responsible for next action on the task)
- \* Completed ( when task is completed, checking this box will remove it from the Task List)

## Viewing Task Notes

If notes have been added to a task, view those notes by Pointing at the Notes icon in the Notes column of the task item.

### Viewing an Associated Document

Tasks

User: All Users

Show Tasks: Assigned Tasks

Layout: [Dropdown]

Drag a column header here to group by that column.

Patient	Description	Notes	Priority	Action/Status
Glenda, Tabitha	SOAPNote		Normal	
Jim, Slim	SOAPNote		Normal	Acknowledged by M
Jim, Slim	SOAPNote		Normal	
Odenkirk, Bob G.	SOAPNote		Normal	
Odenkirk, Bob G.	SOAPNote		Normal	Sign

If a task is related to a document, that document can be opened by Clicking the task item and Clicking the View Docutainer Button (or by Pressing CTRL + Alt + V). Alternatively, Double-click the task item.

ASOAPnote has been selected in this example, so the SOAPnote docutainer in the patient's chart opens for viewing.

### Using Task Manager to Retrieve Charts

Jim, Slim	SOAPNote		Normal
Jim, Slim	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal

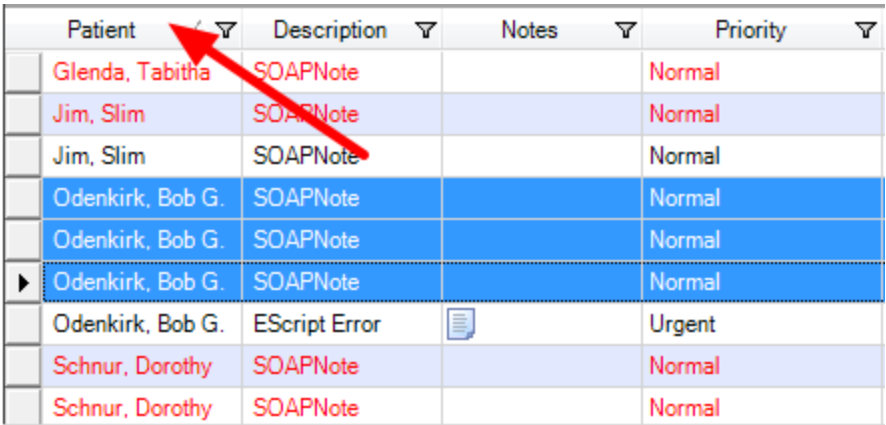
The Task Manager is the best means to retrieved charts needing some type of action. Thus the Task Manager can serve a role similar to that of a stack of pulled charts sitting on a desk. The stacks on a user's desk are now replaced with a list in Task Manager. Legacy SOAPware versions promoted the use of a Pulled Charts section for this purpose. The Pulled Charts functionality was very useful and intuitive in the old days before the need for electronic signatures



and legal electronic records. Even though current SOAPware versions still have this section, use of it is strongly discouraged. **Do not use the Pulled Charts List to manage ANY tasks, such as charts needing completion.**

To retrieve a chart from Tasks, Double-click on the gray box to the left of the Task line item.

## Grouping Task Items



Patient	Description	Notes	Priority
Glenda, Tabitha	SOAPNote		Normal
Jim, Slim	SOAPNote		Normal
Jim, Slim	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal
Odenkirk, Bob G.	SOAPNote		Normal
Odenkirk, Bob G.	EScript Error		Urgent
Schnur, Dorothy	SOAPNote		Normal
Schnur, Dorothy	SOAPNote		Normal

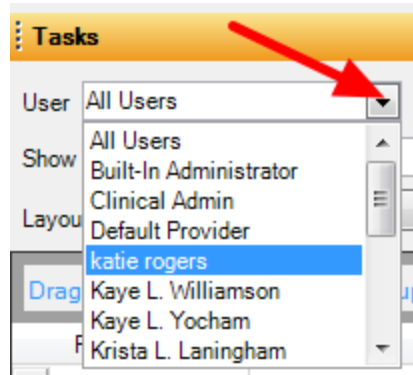
To group task items together, the user can sort by column header. For instance, the user can click on the patient column header to sort by patient and group all tasks related to a particular patient together.

## Managing the Tasks Area

The task manager area at the top contains the buttons and drop-down menus for viewing, editing, adding, deleting, signing and printing tasks, as well as options for customizing the layout of Task Manager.

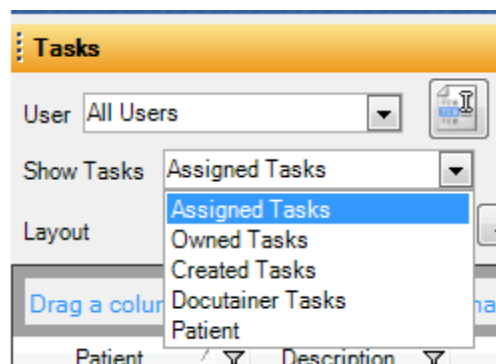
## Task List Functions

### Choosing Task User



To view a specific user's tasks, Click the User drop-down menu, and Click a User name. All tasks assigned to the selected user will be displayed. Click the All Users menu item in order to see all tasks in the entire system.

### Choosing Task Type



Click the Show drop-down menu, and Click on a Task type. This provides access to:

**Assigned Tasks** (all tasks assigned to the selected user)

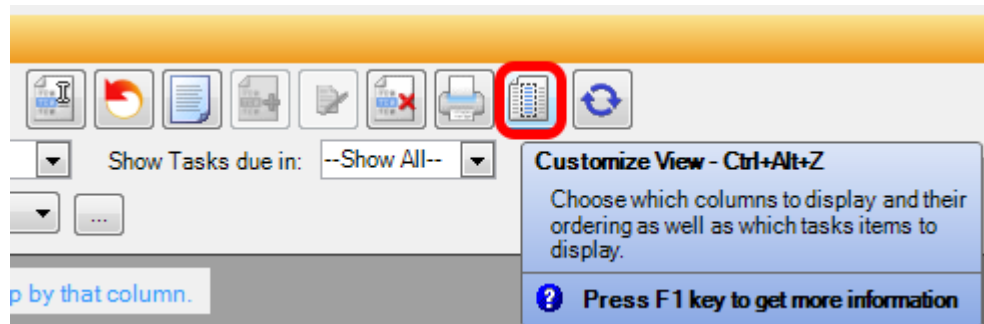
**Owned Tasks** (for the selected user, the owner will always be the Provider displayed at the top of SOAPware when the task was created)

**Created Tasks** (all tasks created by the selected user)

**Docutainer Tasks** (displays only tasks associated with a Document for the selected user ,not tasks that were manually created from the Task Manager)

**Tasks within the current Patient chart** (and NOT based on a selected user)

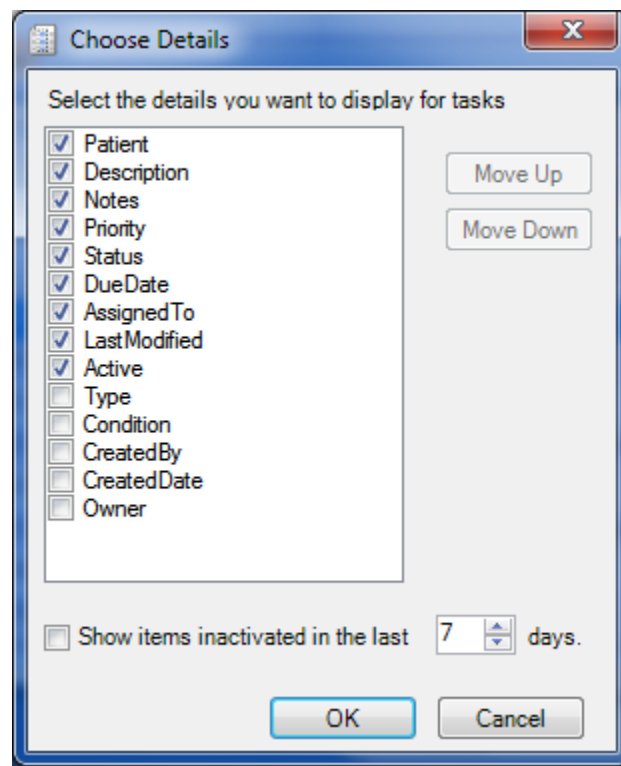
## Customize Task View



It is possible to customize the view of the Task Information area **per user** preference.

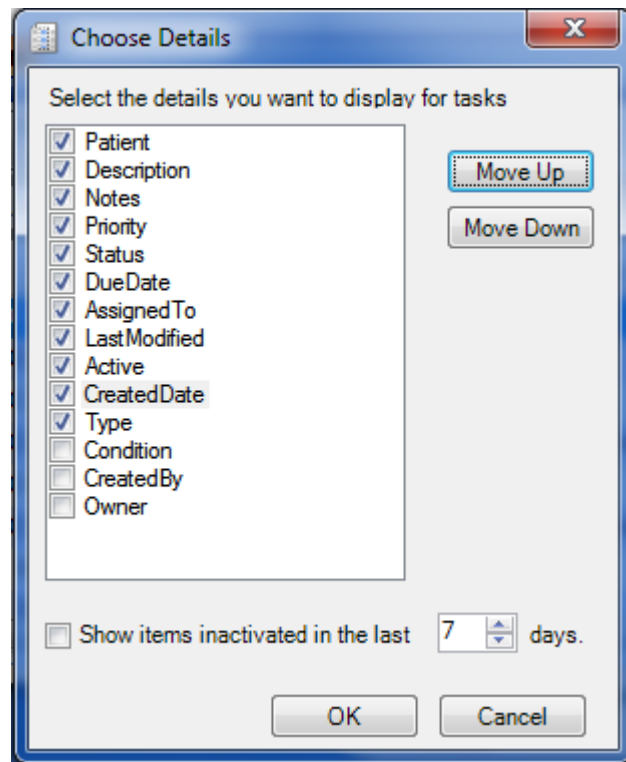
1. Click the Customize View button (or Press Control + Alt + Z) to display the Choose Details dialog.

## Customize Task View - Choose Details



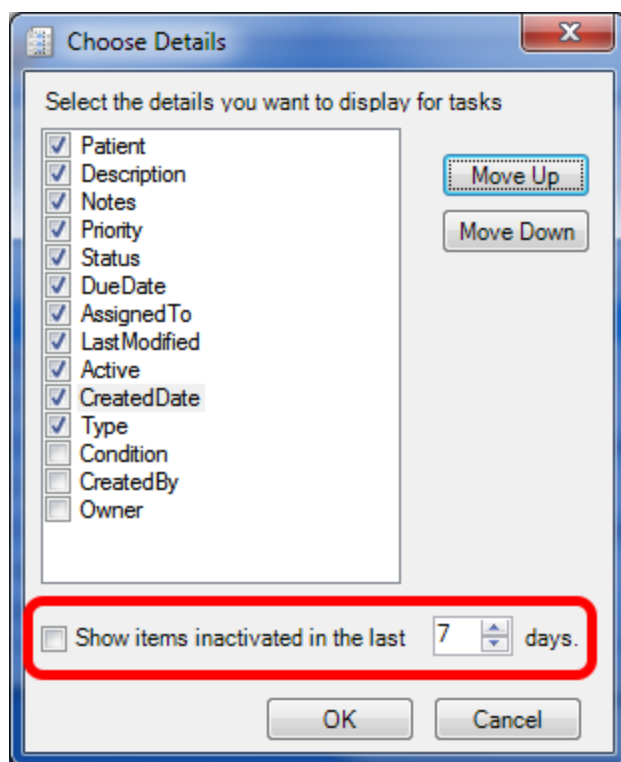
Click the check boxes to the left of the various columns available. This is the mechanism to select the columns displayed in the task list area of the Tasks Manager. Click to uncheck any items that are not to be displayed in the task list area.

## Rearrange Task Item Details



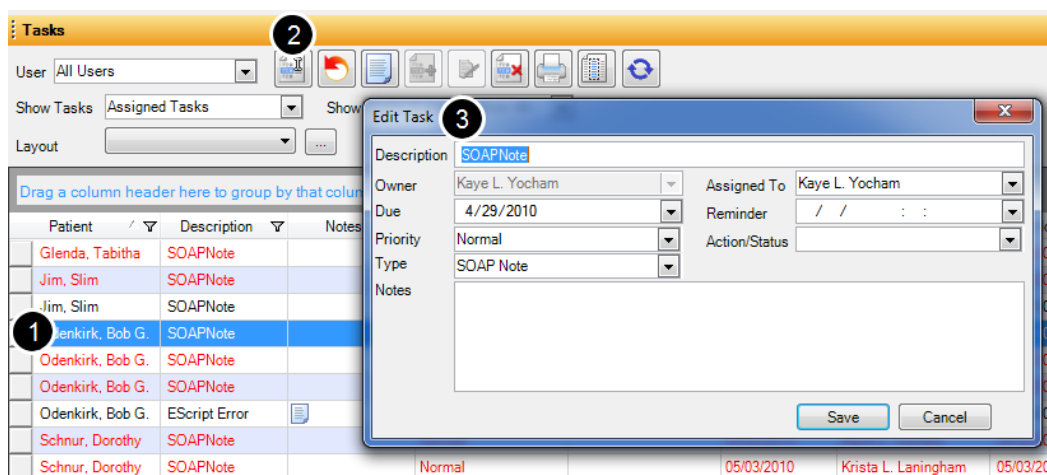
Click a Choose Details item, and Click the Move Up or Move Down buttons to rearrange the columns in the Task Manager. Click OK to save changes.

## Show Inactive and Deleted Task Items



In the Choose Details dialog, Click the "Show items inactivated in the last" check box, and Click the number of days down-arrow to retrieve and display tasks that have been removed (up to 100 days). Click OK to save. The Task Manager viewer will then show both active task items and inactivated task items in the same list. Inactivated tasks are displayed marked-through.

## Editing a Task

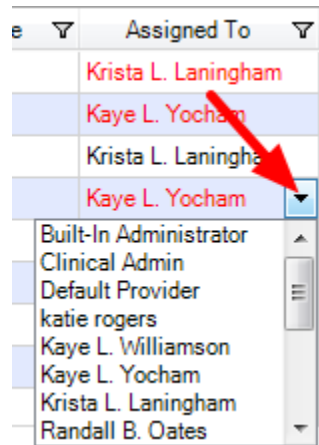


In order to edit a task from the Task Manager:

1. Click the selection box containing the black triangle to the left of the task item.

2. Click the Edit button.
3. The Edit Task window will open, allowing the user to edit the task information.

## Editing a Task - Option 2



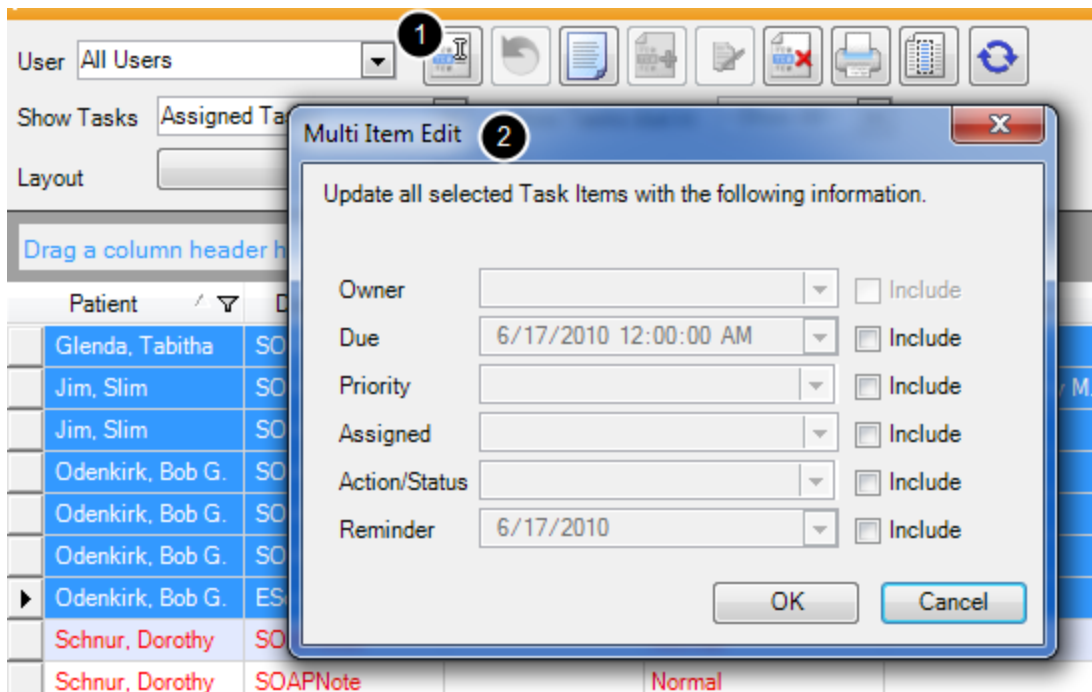
The user can also edit a Task one section at a time. To do this, Click the drop-down menu next to the item and select another option for the task item.

## Editing Multiple Items

	Patient	Description	Notes	Priority	Action/Status
	Glenda, Tabitha	SOAPNote		Normal	
	Jim, Slim	SOAPNote		Normal	Acknowledged by M.D
	Jim, Slim	SOAPNote		Normal	
	Odenkirk, Bob G.	SOAPNote		Normal	
	Odenkirk, Bob G.	SOAPNote		Normal	Sign
	Odenkirk, Bob G.	SOAPNote		Normal	Needs Review
▶	Odenkirk, Bob G.	EScript Error		Urgent	Needs Review

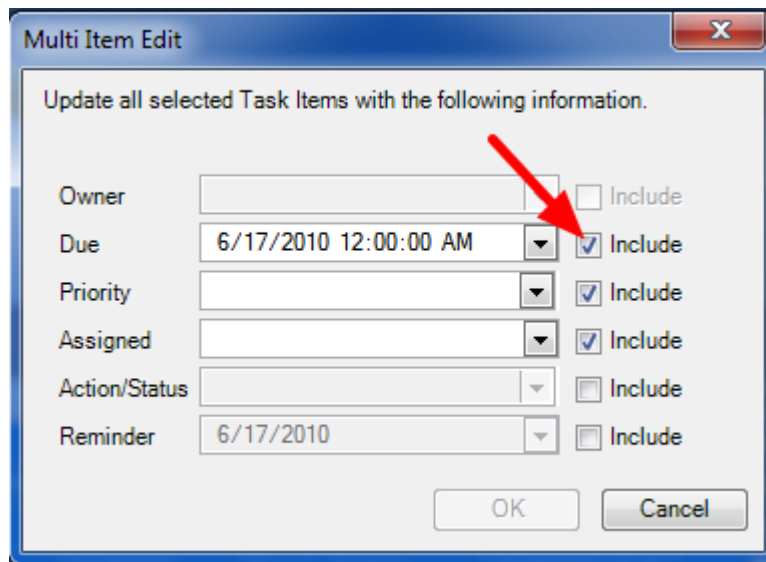
To make edits to multiple tasks all at once, first select the group of tasks to edit. Always Click the selection box containing the black triangle to the left of the task item whenever selecting tasks.

## Performing Edits

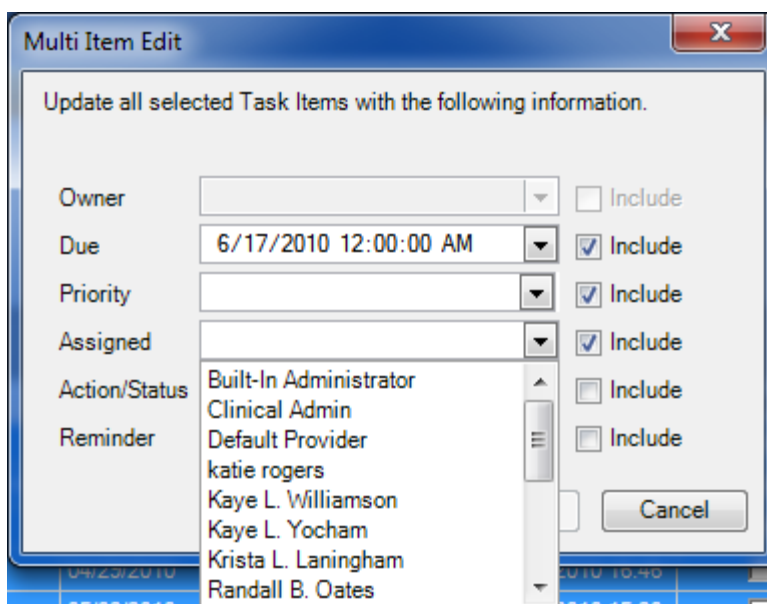


1. Once the tasks to edit are selected-highlighted, Click the Edit Task button.
2. This displays the Multi-Item Edit dialog.

## Include



Click the Include check boxes corresponding to the edits desired.



Once "Include" is checked, its drop-down menu becomes available to make changes. Click the drop-down menu of any item to change the assigned option. Click OK to save changes. In this example, we can bulk reassign all of these tasks at once, instead of having to do so individually.



## Auto Created Tasks

This lesson will discuss the creation and management of auto created Tasks.

### Task List

Each SOAPware User will have a Task List. This is the central location for all of the users "todo" items and communication with other staff regarding patients. In this area the user can track what refill requests have come in as well as what lab results need to be addressed and patient phone calls that need to be returned.

By default, new Task items are automatically created anytime a new docutainer-document is added to a chart. (There is a security setting where this can be turned off, but we strongly discourage turning off the auto-creation of task items).

### Add Task - Task Info Interface

**Add Document Task**

**Task Info**

1 Description SOAPNote

2 Owner Rita Pense

4 Due 3/12/2011

6 Priority Normal

8 Type SOAP Note

9 Notes

3 Assigned To Rita Pense

5 Reminder / / : :

7 Action/Status Needs Review

**Docutainer Info**

Date/Time 03/12/2011 11:41 AM

Type Face to Face

Owner Rita Pense

Status

Description soapnote

Related Dx

☐ Apply To All

Add Cancel

When a new docutainer or document is created or imported in SOAPware the Add Document Task window will display.

1. **Description** - Defaults to the area the docutainer or document was created. For example SOAPnote or Lab. The description of the Task Item can be typed here. For example, "refill request" or "test results".
2. **Owner** - The owner of the documentation, not necessarily whom the task is being assigned to. This will default to the Active Provider displayed at the top of the SOAPware screen and cannot be changed in this area.
3. **Assigned to** - Will also default to the Active Provider but can be changed by using the drop-down menu in order to assign the task to the proper user.
4. **Due Date** - Will default to the date the task was created and can be edited by using the drop-down calendar.
5. **Reminder** - By using the drop-down arrow and placing the desired date and time here, a pop-up will display when the user that the task is assigned to logs in. This feature should only be used for stat situations such as critical labs.
6. **Priority** - Defaults to Normal. The user has the ability to assign the task a priority of high, low, normal or urgent by using the drop-down menu.
7. **Action/Status** - Defaults to Needs Review. This section allow the user to indicate to the assigned user what needs to be done and also allows the assigned user to designate on their task list the actions done or needed in order to manage their list. This list can be customized by the clinic under the Tools > List Options menu.
8. **Type** - The type of docutainer or document created. For example SOAPnote or lab.
9. **Notes** - This area is optional. **This is not where the reason for the task is documented as this area is not a part of the patient's record and will not be saved.**

**Add Document Task**

**Task Info**

Description: SOAPNote

Owner: Rita Pense

Due: 3/12/2011

Priority: Normal

Type: SOAP Note

Assigned To: Rita Pense

Reminder: / / : :

Action/Status: Needs Review

Notes:

**Docutainer Info**

1 Date/Time: 03/12/2011 11:41 AM

2 Type: Face to Face

3 Owner: Rita Pense

4 Status:

5 Description: soapnote

6 Related Dx:

7 ☐ Apply To All

Add Cancel

**This information is optional and will appear under the top splitter in the docutainer.**

1. **Date/Time** - will default to the date the task was created and can be edited by using the drop-down calendar.
2. **Encounter Type** - This area designates whether the encounter is a Face to Face or non-Face to Face. This delineation in the type of encounter is required to calculate certain Meaningful Use guidelines and will default to Face to Face.
3. **Owner** - The owner of the documentation, not necessarily whom the task is being assigned to. This will default to the Active Provider displayed at the top of the SOAPware screen and cannot be changed in this area.
4. **Status** - A drop-down menu with options to indicate why this docutainer is not signed off.
5. **Description** - Defaults to the area the docutainer or document was created. For example SOAPnote or Lab. The description of the Task Item can be typed here. For example, "refill request" or "test results". Will also pull the first SMARTtext diagnosis from the SOAPnote Assessment Field.
6. **Related Dx** - The SMARTtext diagnosis in the Assessment field and primary diagnosis for the visit if the docutainer being created is a SOAPnote.
7. **Apply to All** - If a multi-page document is scanned into a patient's chart a Task Item will be created for each page. To avoid filling out the Add Document Task on all pages, simply fill out the

first one and select "Apply to All" by clicking to place a check mark in the box.

When the Task info section and the Docutainer info section (if needed) are filled out click Add to place this item on the users Task List in the "Assigned To" box. If a Task is not needed Cancel can be pressed but we highly recommend all items created or scanned in are put onto a Task List.

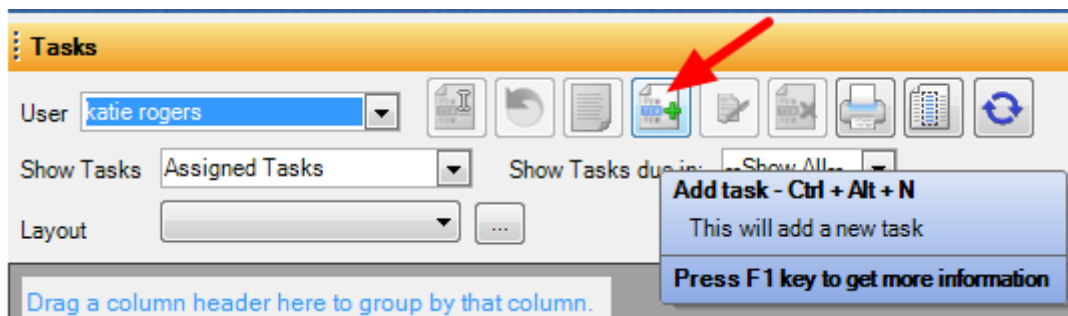
## Manually Created Tasks

---

When adding a task manually from the Tasks Manager, the Owner will default to the current User (person that is currently logged into SOAPware).

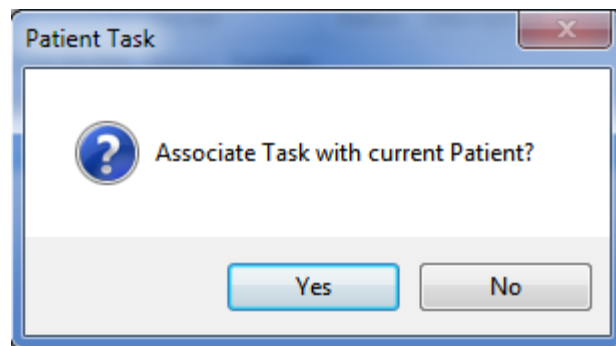
**NOTE: Manually added tasks cannot be signed off due to not being attached or associated with a docutainer. Therefore, manually created tasks will need to be "completed" within the Tasks Manager, not "signed off" .**

### Add Task



Manually add a new task directly to the Tasks Manager by Clicking the Add Task button.

### Associate the Task with a patient's chart



At this point a dialog will appear with the option to associate the new task with a patient chart. Choose Yes or No.

## Create Task Dialog

The screenshot shows a 'Create Task' dialog box with the following fields and callouts:

- 1: Description text field
- 2: Owner dropdown menu (selected: katie rogers)
- 3: Due date dropdown menu (selected: 6/17/2010)
- 4: Priority dropdown menu
- 5: Type dropdown menu
- 6: Assigned To dropdown menu (selected: katie rogers)
- 7: Reminder time dropdown menu (selected: / / : :)
- 8: Action/Status dropdown menu
- 9: Notes text area

At the bottom right are 'Create' and 'Cancel' buttons.

The Create Task dialog opens. Add appropriate information to the new task, and Click the Create button.

The information the user can include is:

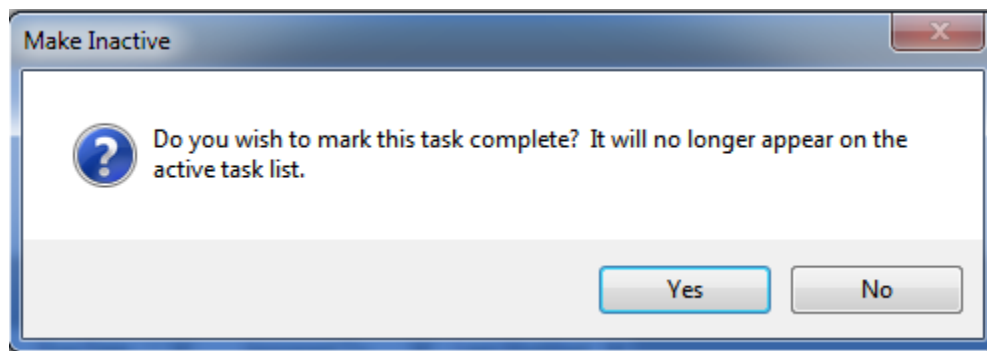
1. **Description** - this will be the description that shows up in the task list and will help the user identify what this document is.
2. **Owner** - this will always be the active provider for an automatic task, but will be the user when creating a manual task that is not associated with a patient's chart.
3. **Due** - this is when the task is set to be due. After this date, the task will turn red, indicating that it is past due.
4. **Priority** - this allows the user to rank tasks using a priority system so that the user can make sure to complete the most urgent tasks first.
5. **Type** - this indicates what kind of document this task is (i.e. SOAPnote, Radiology, etc.)
6. **Assigned To** - this is the user to whom this task is assigned. The task will appear on his/her task list.
7. **Reminder** - this allows us to set a reminder to pop up (similar to an outlook calendar reminder) when this item is due.
8. **Action/Status** - this indicates what action needs to be taken for this task to be complete.
9. **Notes** - this is a section where the user can attach temporary notes to a task as a reminder or to contain additional information. It is important to understand that this area will not be a permanent part of a patient's chart because it will be deleted after task completion.

## Completing a Manually Created Task

Patient	Description	Completed
▶ Odenkirk, Bob G.	EScript Error	<input checked="" type="checkbox"/>
Jim, Slim	SOAPNote	<input type="checkbox"/>
Schnur, Dorothy	SOAPNote	<input type="checkbox"/>

If a manually created task has been completed, to remove it from the list of tasks, Click the check box in the Completed column.

## Confirm

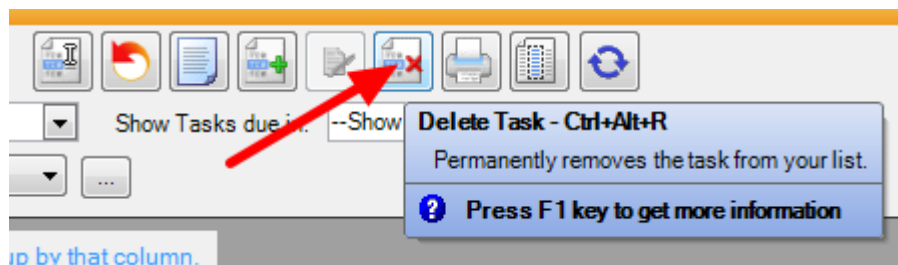


The user will be prompted to confirm. Click Yes.

## Task Removed

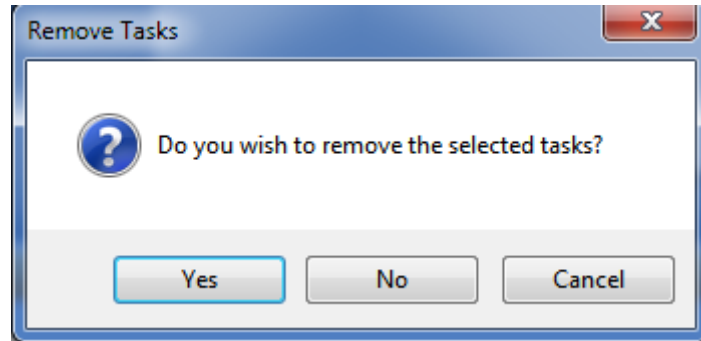
The task will then be removed from the list. If the user clicks No, the user will be returned to Task Manager.

## Deleting a Task



Tasks should generally be Signed Off or Completed to have a record of the Task (for 100 days). Use caution when deleting a Task.

To remove a task from the Tasks Manager, Click on the task item to delete, and Click the Delete Task button (or Press CTRL + Alt + R).



A dialog is presented that asks the user to confirm that they wish to review the selected task (as shown in the screen shot above). Click 'Yes' to remove the selected task or Click 'No' to return to the Task Manager.

Removing a task item from Task Manager does not remove the related document from a patient chart.



## Sign and Needs Review Task Items

This lesson will discuss the Action/Status settings needed for the Task to be **auto removed** from the Task list when the associated docutainer or document is signed off.

### Add Task as Sign/Needs Review

**Add Document Task**

**Task Info**

Description: SOAPNote

Owner: Jennifer Berg

Assigned To: Jennifer Berg

Due: 3/ 1/2011

Priority: Normal

Type: SOAP Note

Notes:

**Action/Status:** Needs Review (highlighted), Lab Pending, IMTC, PA Pending, Phone busy, Referral needed, Referral Pending, Sign (highlighted)

**Docutainer Info**

Date/Time: 03/01/2011 3:54 PM

Type: Face to Face

Owner: Jennifer Berg

Status:

Description:

Related Dx:

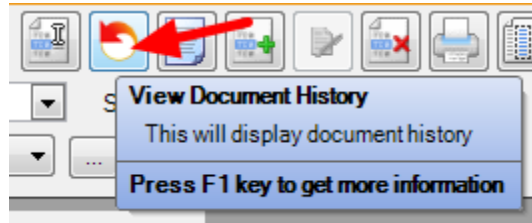
☐ Apply To All

Add Cancel

When adding a task, if the user selects the Action/Status item "Sign" or "Needs Review," the Task list item will be automatically removed when its related document is signed off. Otherwise, the Task List Item will remain on the task list until manually completed.

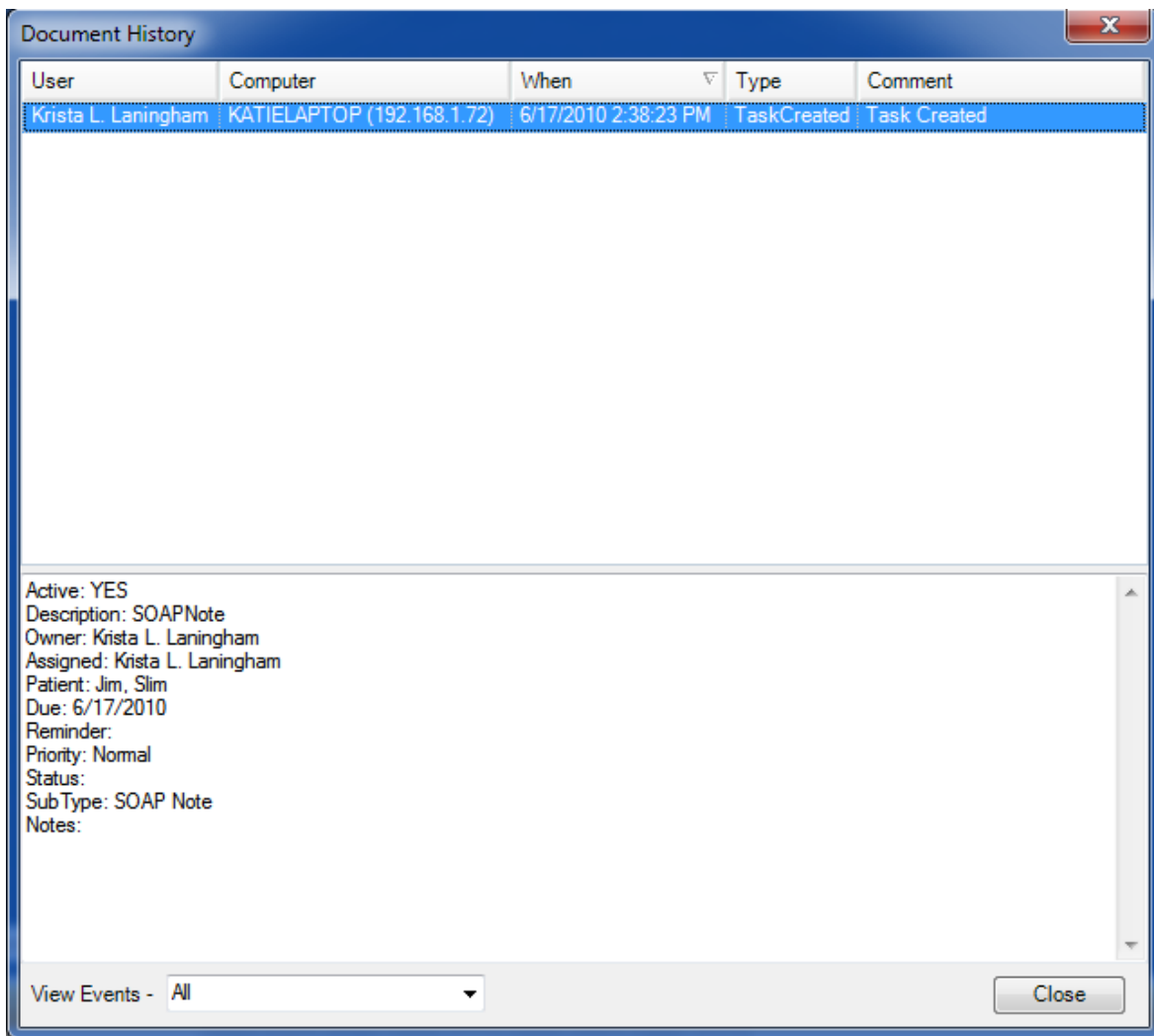
## Task Item History

### View Document History



Click the View Document History button to view the history of a document in Task Manager.

### Document History Window



Included in this History are the Users that have accessed the task, the Computers from which the task has been accessed, the When (i.e. Date/Time) of accesses, the Type of accesses, and a Comment.

## Sign Off Multiple Documents, Multiple Patients

### Signing Off on Multiple Documents

There is often a need for SOAPware providers who are the owners of documents to need to be able to sign off large groups of documents in one action. For example, in most clinics, paper documents come to the clinician's attention prior to having been scanned. The Clinician signs off the paper document and then the paper document (with the signature) is scanned into the electronic chart. Unfortunately, the emerging rules for electronic signature and the standard for the "Legal Electronic Health Record" are potentially in conflict with this workflow because there are requirements to have an electronic log of the date/times associated with signatures. The solution is to implement use of the Tasks Manager in a fashion so that the documents can be signed-off in a group, all at once, with a single action.

### Establish Efficient Workflows

	Patient ▼	Description ▼	Notes ▼	Priority ▼	Action/Status ▼ ▼
<input type="checkbox"/>	Odenkirk, Bob G.	SOAPNote		Normal	Sign
<input type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign
<input type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign
<input type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign
<input type="checkbox"/>	Cross, David M.	Lab Created		Normal	Sign
<input type="checkbox"/>	Cross, David M.	SOAPNote		Normal	Sign
<input type="checkbox"/>	Jim, Slim	SOAPNote		Normal	Sign
<input type="checkbox"/>	Glenda, Tabitha	SOAPNote		Normal	Sign

Establish work flows so that any documents that need to be signed in bulk have a common characteristic in one of the Tasks Manager columns. For example, it could simply be to select Sign as the option in the Action/Status column. Then, Clicking on the Action/Status header will group all the documents that need to be signed.

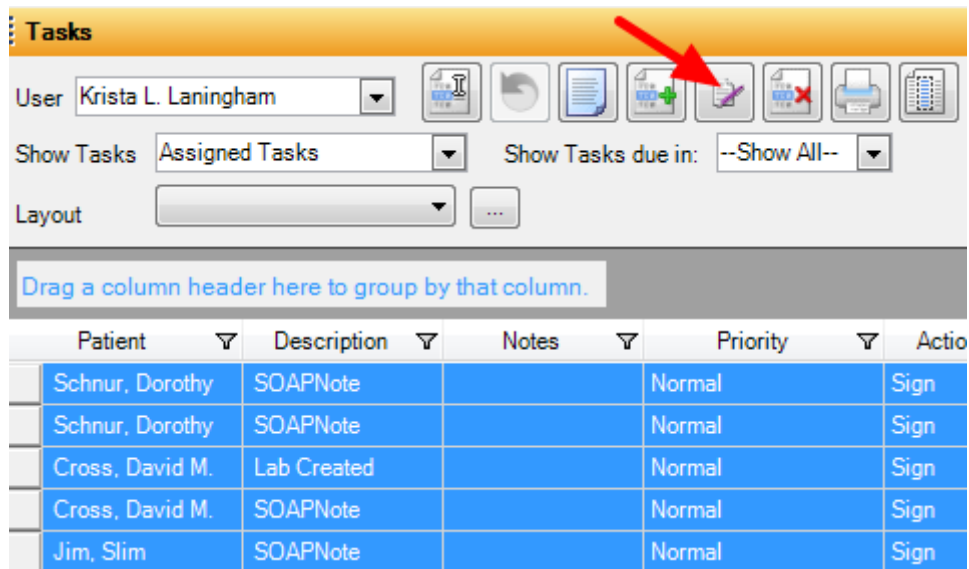
### Group Items

	Patient ▼	Description ▼	Notes ▼	Priority ▼	Action/Status ▼ ▼
<input type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign
<input type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign
<input type="checkbox"/>	Cross, David M.	Lab Created		Normal	Sign
<input type="checkbox"/>	Cross, David M.	SOAPNote		Normal	Sign
<input type="checkbox"/>	Jim, Slim	SOAPNote		Normal	Sign
<input type="checkbox"/>	Glenda, Tabitha	SOAPNote		Normal	Sign
<input type="checkbox"/>	Odenkirk, Bob G.	SOAPNote		Normal	Sign
<input checked="" type="checkbox"/>	Schnur, Dorothy	SOAPNote		Normal	Sign

Once the items that need to be signed-off as a group are clustered together, the next step is to select all of them. To do this, Click in the gray box at the far left of the first row. Next, hold down the shift key and Click in the gray box at the far left on the last item in the group. Doing this selects all

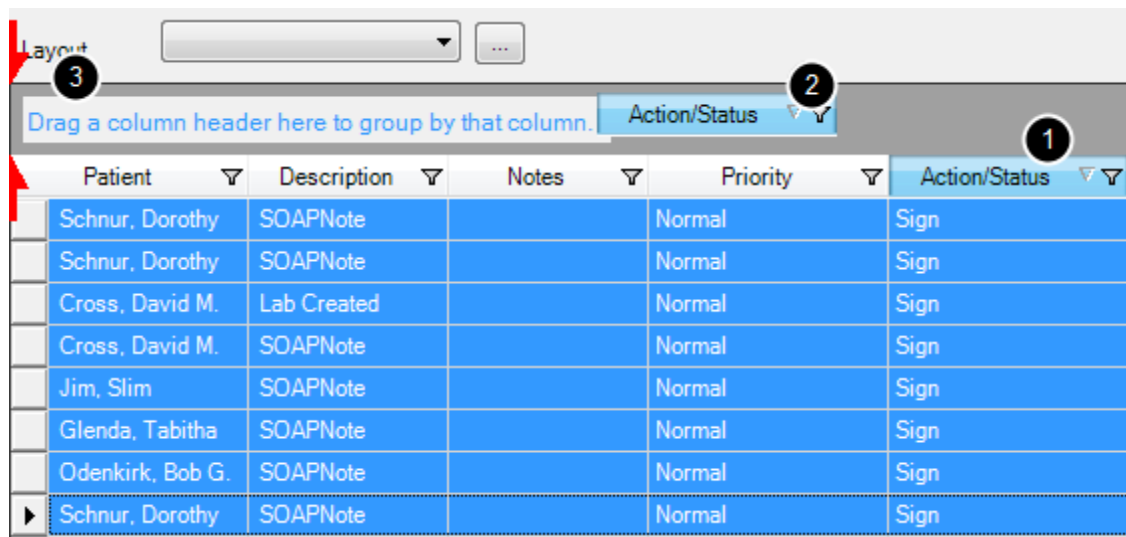
the items between the two clicks (while holding down the shift key).

## Sign



Once all the items to sign-off are selected, then Click on the Sign-off button. This results in all of the selected documents being signed off in one action.

## Group by Column



Simply drag the Action/Status Column up to the location of "Drag a column header here to group that by column" and the items are instantly grouped for selection and sign-off.

## Task Sorted by Type

The screenshot shows a 'Tasks' window with the following controls:

- User: Krista L. Laningham
- Show Tasks: Assigned Tasks
- Layout: (empty dropdown)
- Action/Status: (dropdown menu)

The 'Action/Status' dropdown is expanded, showing two options:

- Action/Status : Sign (9 items)
- Action/Status : Needs Review (1 item)

The tasks are all grouped by Action/Status type, allowing the user to view only one type at a time, or all types.

## Expand Type

The screenshot shows the 'Tasks' window with the 'Action/Status' dropdown set to 'Sign (9 items)'. The list of tasks is displayed with the following columns: Patient, Description, and Notes.

Patient	Description	Notes
Schnur, Dorothy	SOAPNote	
Schnur, Dorothy	SOAPNote	
Cross, David M.	Lab Created	
Cross, David M.	SOAPNote	
Jim, Slim	SOAPNote	
Glenda, Tabitha	SOAPNote	
Odenkirk, Bob G.	SOAPNote	
Schnur, Dorothy	SOAPNote	
Schnur, Dorothy	Report	

Below the list, there is a link to 'Action/Status : Needs Review (1 item)'.

To see all of the items of one type (i.e. Sign), Click the expander node next to the Type and a list of the items of that group will drop down into view.

## Tip

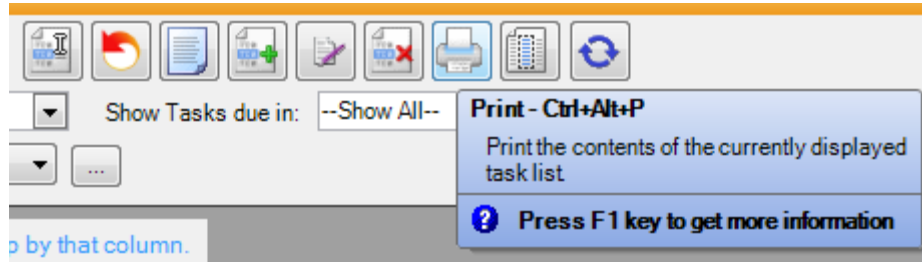
**NOTE:** Before the scanning person or nurse sends the documents to the clinician's list for final sign-off, establish a workflow where that person changes the status in item of a task item so that the clinician can sort all the documents needing signing to all be in one place. This makes it

possible to sign all of them in bulk without having to search around.

## Printing Task Manager Lists

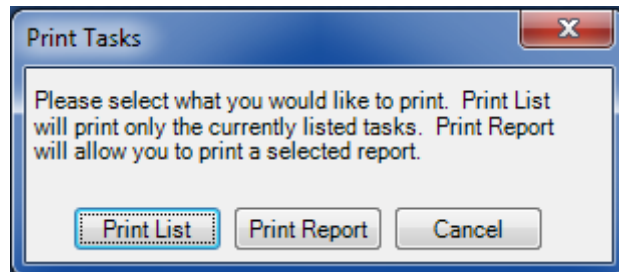
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### Click the Print Button

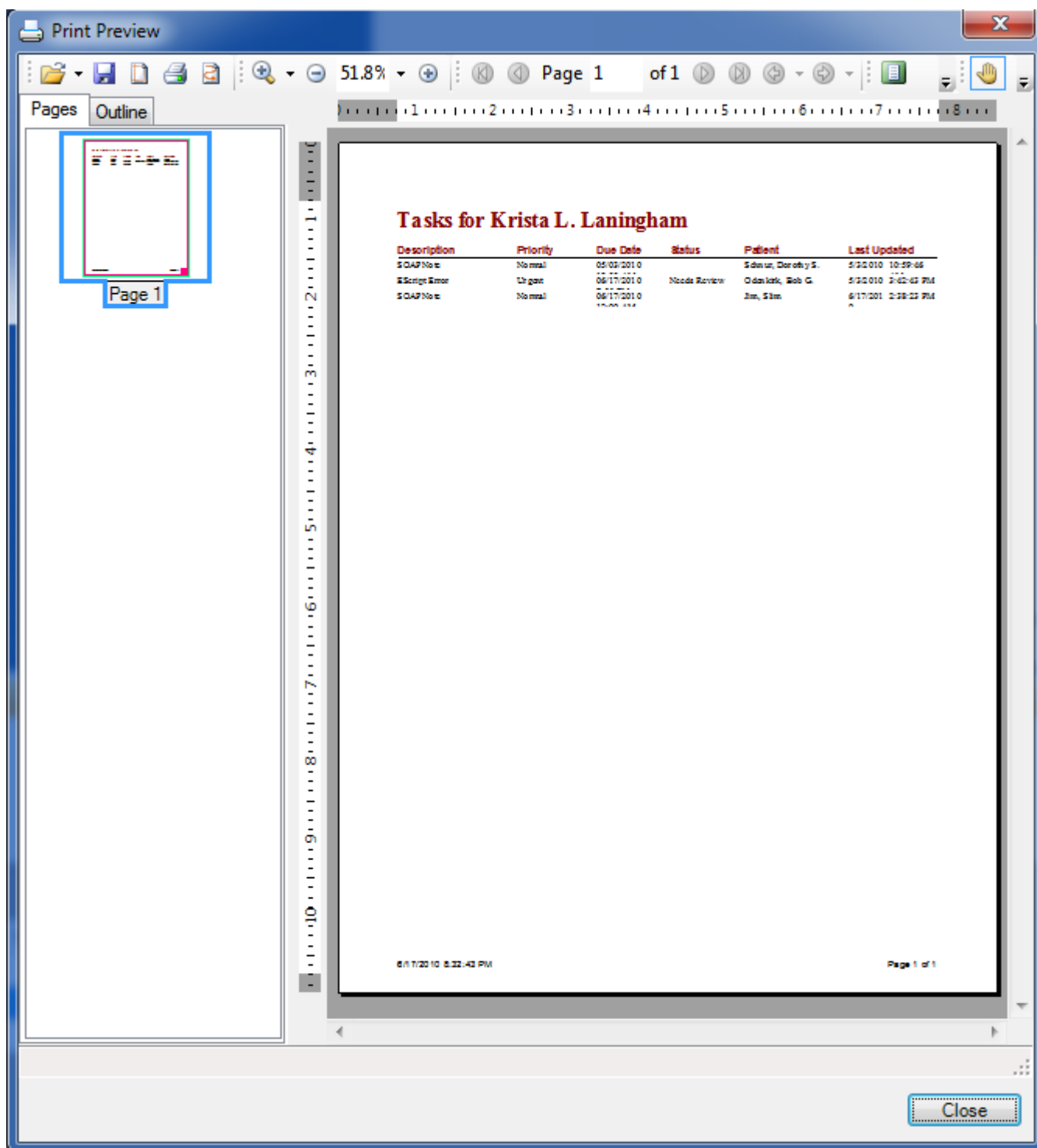


At any time, Click the Print button (or Press CTRL + Alt + P) to print a task manager list that is displayed.

### Choose List or Report

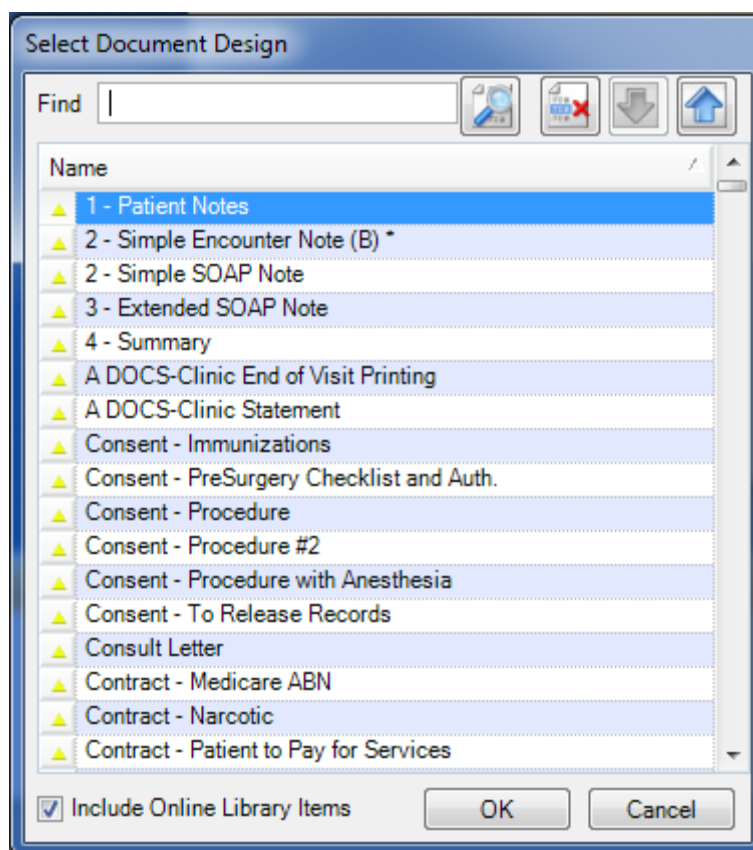


Click either the Print List or the Print Report buttons in the Print Tasks dialog.



A Print Preview of the currently displayed task manager will be displayed. To Print the task manager list, Click the Print button in the upper left of the Print Preview dialog.



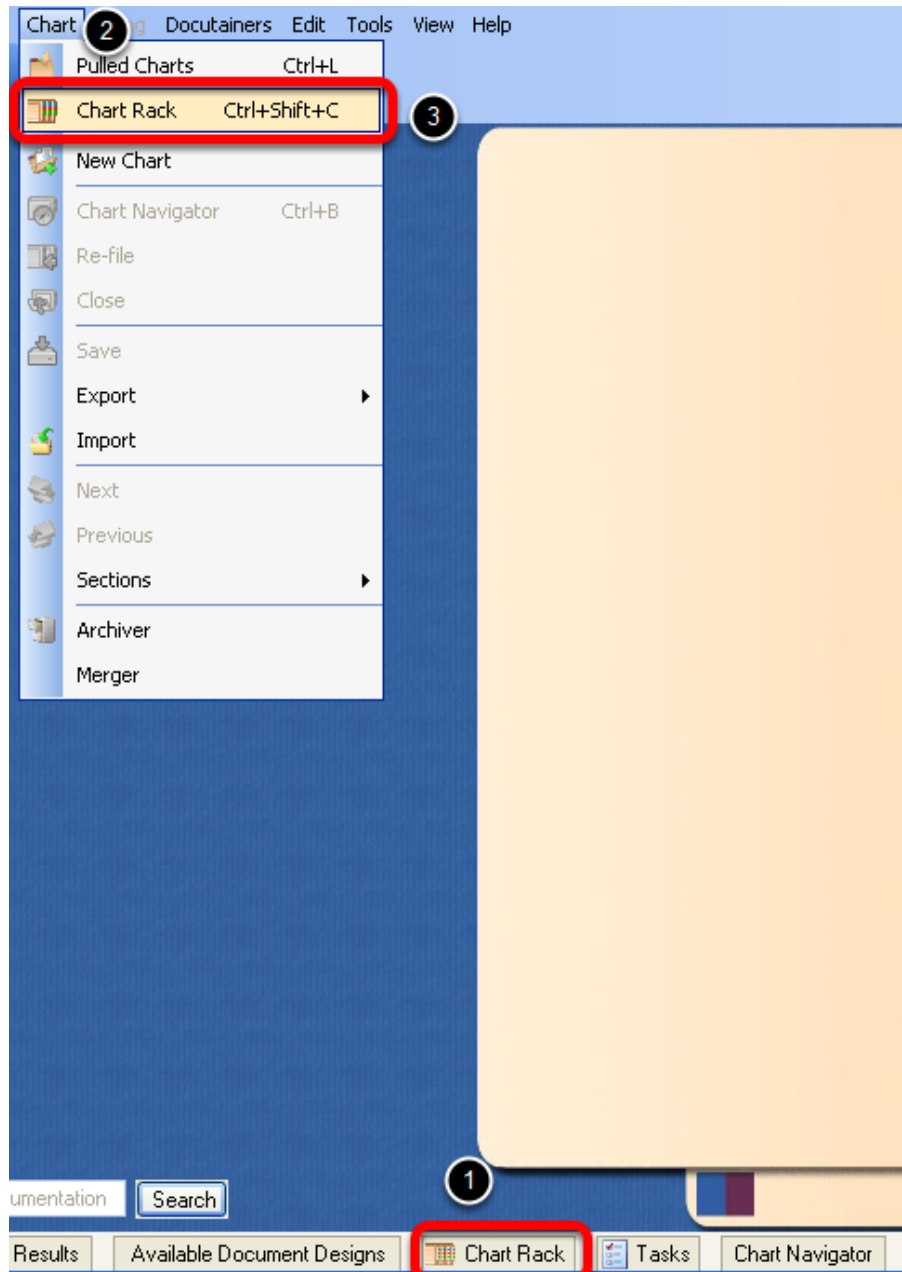


Print Report will prompt the user to choose a design to print with the task list information.

## Task Manager Workflow

This lesson will demonstrate a sample workflow in Task Manager for a phone call from the patient that is requesting a medication refill request.

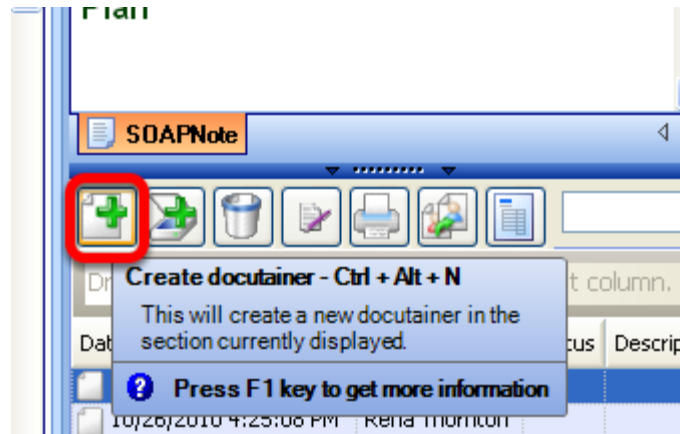
### Phone Call Received from Patient



The nurse or other user receives the refill request by phone from the patient. The patient's chart will be retrieved to begin documentation. To access the patient chart:

1. Click on the Chart Rack docked tab.
2. Or, Chart menu item > Chart Rack.
3. Or, Use the keyboard command Control + Shift + C.

## Create a New SOAPnote Docutainer



Creating a new docutainer will allow the user to document the phone call to make this patient interaction part of the permanent medical record.

## Add Document Task

The screenshot shows the 'Add Document Task' dialog box. The 'Docutainer Info' section is highlighted with a red box. The 'Type' dropdown is set to 'Face to Face'. A red arrow points to the 'Add' button.

**Document Task**

**Info**

Description: SOAPNote

Owner: Krista Laningham

Due: 3/30/2011

Priority: Normal

Type: SOAP Note

Notes:

Assigned To: Krista Laningham

Reminder: / / : :

Action/Status: Needs Review

**Docutainer Info**

Date/Time: 03/30/2011 12:58 PM

Type: Face to Face

Owner: Krista Laningham

Status:

Description: soapnote

Related Dx:

☐ Apply To All

**Add** **Cancel**

A Task Item will be automatically created to enter the Task information when a new docutainer has been created. This allows the user to enter a Description and Assign the Task (to name a few of the available fields) to a user to be further addressed when necessary. Click the Add button to send this Task Item to the selected user in the "Assigned To" field. By default, the "Assigned To" user will be the selected Active Provider in SOAPware and the "Action/Status" will default with "Needs Review".

## Encounter Types

The screenshot shows two examples of Encounter Type dropdown menus. The first is set to 'Face to Face' (green background) and the second is set to 'Non Face to Face' (orange background).

Encounter Type: Face to Face

Encounter Type: Non Face to Face

It is important to flag the Encounter Type for the created Task Item. This is a Meaningful Use Requirement. A **Face to Face** encounter (green background) relates to a patient being seen in a clinic setting. A **Non Face to Face** (orange background) encounter relates to a phone call or

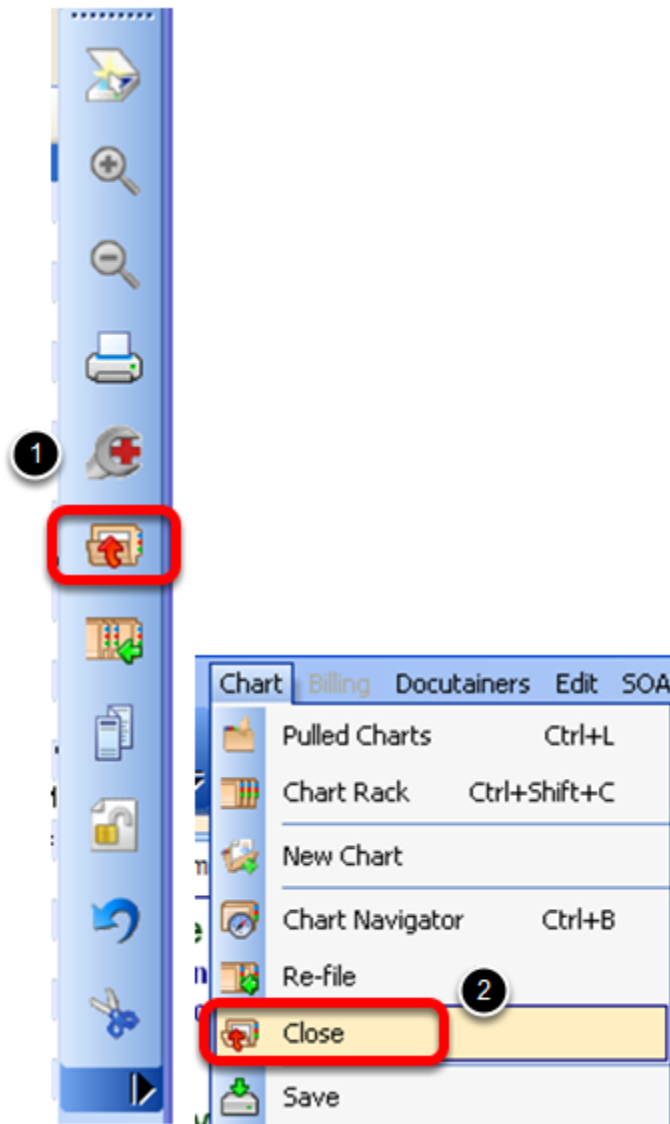
sending a letter with instructions, to name a few Non Face to Face Encounter Types. By default, Encounter Type will be set as Face To Face. Only encounters flagged as Face to Face will trigger the inclusion of a patient in the measured period from the Meaningful Use Dashboard.

[Click here](#) for more information regarding Encounter Types.

## Document Phone Call in SOAPnote

The screenshot shows a web-based SOAPnote interface. At the top, there are tabs for 'SOAP Notes', 'Labs', 'Radiology', and 'Billing'. The 'SOAP Notes' tab is active. Below the tabs is a search bar and a list of notes. The main content area is titled 'Subjective[' and contains the following text: 'Phone message for refill request: Patient calls requesting refill for - Ambien 5mg for sleep. Currently states she is taking one at bedtime as needed. Date of last office visit - 8/18/2010. Last refill date - 8/18/2010. Callers contact number - 800.455.7627 Preferred pharmacy - Tom Cat Express Follow up for phone call: Rena Thornton, LPN 03/01/2011 11:14]'. Below the 'Subjective' section are sections for 'Objective' and 'Assessment'. The 'Assessment' section contains the text 'Phone message'.

The phone call has been documented into the current SOAPnote which will be part of the patient's permanent record.



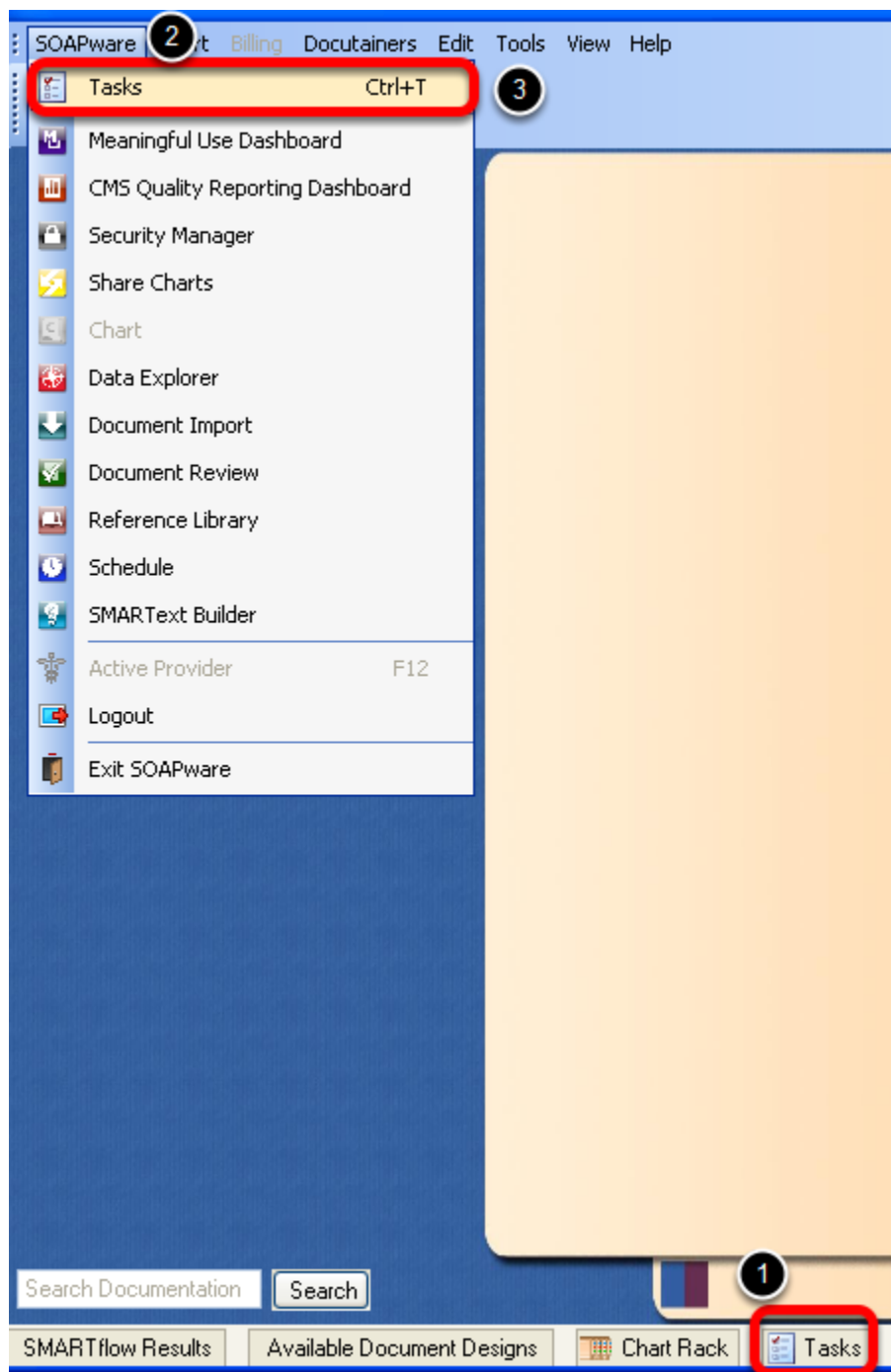
The user should close the patient chart once documentation has been completed with the patient's refill request information. Closing the electronic patient chart has the same benefits as closing the paper chart of a patient. A patient's paper chart should not be left open on a desk and it should not be left opened on a computer screen to be wrongfully available.

There are several available methods to Close a Chart:

1. Click on the Close Chart icon located on the Common Toolbar.
2. Chart menu item > Close.

Or, a keyboard command may be customized to Close a Chart. See [Key-Command Customization](#).

## Provider Accesses Their Tasks List



The provider will access their Task List to review any pending Task Items.

To access Task Manager:

1. Click on the Tasks docked tab.
2. SOAPware menu item > Tasks.
3. Use the keyboard command Control + T.

## Review Task Items

**Tasks**

User: Rena Thornton

Show Tasks: Assigned Tasks

Layout: [Dropdown]

**View docutainer - Ctrl+Alt+V**  
View the docutainer currently associated with this task. If none exists, the patient's chart will open.  
Press F1 key to get more information

Patient	Description	Notes	Priority	Action/Status	Due Date	Assigned To
Kitty, Calico	Medication Refill		Normal	Needs Review	03/01/2011	Rena Thornton
Skunkwalker, Luke	SOAPNote		Normal	Needs Review	02/23/2011	Rena Thornton

The provider will review displayed Task Items. To address an item, simply Click to the far left of the item to highlight the row with item information. Double Click on the highlighted item or Click on the View Docutainer button to open the patient's chart and view the docutainer associated with the Task Item to address.



## Review Documentation on SOAPnote

The screenshot shows a software window titled 'SOAP Notes' with tabs for 'Radiology', 'Memo', and 'Message'. The 'Subjective' section contains the following text: 'Phone message for refill request: Patient calls requesting refill for - Ambien 5mg for sleep. Currently states she is taking one at bedtime as needed. Date of last office visit - 8/18/2010. Last refill date - 8/18/2010. Callers contact number - 800.455.7627 Preferred pharmacy - Tom Cat Express Follow up for phone call:'. Below this is a signature line for 'Rena Thornton, LPN' dated '03/01/2011 11:14'. The 'Objective' section is empty. The 'Assessment' section contains the text 'Phone message'. The 'Plan' section contains the text 'Answer for refill request:'. The window has a standard Windows-style interface with a title bar, menu bar, and toolbar.

The provider will review the documentation on the current SOAPnote that is associated with the Task Item and enter the instructions, approval for the refill request, place the medication into the Medication field of the SOAPnote, need for office visit, etc. into the SOAPnote and reassign Task Item back to the user who will be completing the refill request.

## Nurse or Other User Accesses Tasks Manager

The nurse or other user will review the new orders or instructions that the provider has placed into the SOAPnote for the refill request from patient by accessing Tasks Manager. The docutainer with the refill request documentation will be viewed and understood. The patient will be notified by phone that their request has been approved or informed that they will need an office visit per the provider's instructions before their refill request can be granted.

## ePrescribe Patient Refill Request

The screenshot shows the Rx Manager interface with the following details:

- Buttons:** Add Rx, Update Summary, Interactions, Show Header (checkbox).
- Actions:** A dropdown menu is open, showing "Unknown" (highlighted in yellow) and a blue 'e' icon.
- Rx Details:**
  - Medication:** Ambien (Zolpidem): 5 mg (tablet)
  - Dosage:** 1 tab(s) once a day (at bedtime) orally
  - Refill:** #90
  - Substitutions Allowed:** 5
- Misc:** Pending, Valid Script, Coverage Details.

The nurse or other user will use Rx Manager to transmit the refill request medication for the patient. This will allow the user to ePrescribe, print, fax, or note that samples have been given to the patient.

## SOAPnote Documentation

The nurse or other user will complete their documentation in the current SOAPnote. The user will reassign the Task Item and select "Sign" in the Action Status drop down. This will alert the provider that this Task Item has been completed and is ready to be signed off.

## Provider Signs Off Task Item

The screenshot shows the Tasks Manager interface with the following details:

- Tasks Header:** Tasks
- User:** Rena Thornton
- Show Tasks:** Assigned Tasks
- Show Tasks due in:** (empty)
- Layout:** (empty)
- Task Item:** A task item is highlighted in blue, and a red circle is drawn around the "Sign" button in the toolbar.
- Tooltip:** A tooltip is displayed over the "Sign" button, stating: "Sign off - Ctrl+Alt+S. This will sign off the selected tasks. If the tasks have any associated doccontainers, those documents will be signed off also. Press F1 key to get more information."
- Task List Table:**

Patient	Description	Notes	Priority	Action/Status	Due Date
Kitty, Calico	Medication Refill		Normal	Sign	03/21/2011
Gump, Bubba	Flow Sheet Creat		Normal	Needs Review	12/10/2010

The provider will sign off the Task Item which will remove it from the Tasks List. A provider has the ability to sign off multiple items at once in Tasks Manager. See [Sign Off Multiple Documents, Multiple Patients](#)

**Note:** Manually created Task Items cannot be signed off. They can only be marked as "Completed". See [Manually Created Tasks](#)

# E-Prescribing

## Intro to Rx Manager

---

The Rx Manager is the user's ePrescribing station. It is here that the user will finalize medications, view prescription history, check eligibility status, and send prescriptions to pharmacies.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- ePrescribing (eRx)
- CPOE for Medication Orders
- Drug Interaction Checks
- Drug Formulary Checks

### Rx Manager Tabs

The screenshot shows the Rx Manager interface with the following components:

- Tabbed Sections:** Rx Pad (active), Medications, History, Patient - Refill Requests.
- Search Bar:** Ph. 1 cy type 2 custom 3 : here / KROG 4 ,OUTHWEST 327 (Ph#-).
- Patient Information:** Allergies section with a red text "Starter - Allergies - Summary:".
- Buttons:** Add Rx, Update Summary, Interactions.
- Table:** A table with two columns: Actions and Rx. The Actions column contains a checkbox and a blue circular icon. The Rx column contains the medication name "Flomax (Tamsulosin):", the dosage "1 each once a day orally", and the quantity "#30".

The Rx Manager has 4 tabbed sections:

1. **Rx Pad** - Used to write new prescriptions
2. **Medications** - Displays a list of previous prescriptions for the current patient.
3. **History** - A sequential, transactional list of all prescribing actions previously performed within

Rx Manager.

4. **Refill Requests** - List of any pending electronic refill requests for the current patient.

## Rx Manager Layout

The actual drug information appears in more of a spreadsheet format (i.e. straight rows and columns). This row/column view was created to make the task of reviewing lists of medications easier.

In all earlier versions of SOAPware each prescription had a trail of sub-items of varied length. Most/all the prescription sub-items in the Rx Pad are actually within pick lists.

## A Note for Ohio Users

### Updated 8.2.2011

The SOAPware team has recently reengaged the Ohio Pharmacy Board regarding certification for electronic prescribing in their state. Ohio has some requirements that are above and beyond the other 49 states. However, the key Ohio requirement involves the ability to have two factor user authentication. Two factor authentication is also a requirement for electronic prescribing of scheduled medications that will soon be a possibility in all 50 states. The deployment of two factor authentication methodologies that will meet both Ohio's requirements and those for scheduled medications are in SOAPware's development queue for 2012. In addition to the two factor authentication requirements, Ohio also specifies that practices have available audit logs of electronically prescribed medications. It is anticipated that the development of these will accompany, or shortly follow, the release of the dual authentication options.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- ePrescribing (eRx)
- CPOE for Medication Orders
- Drug Interaction Checks
- Drug Formulary Checks

**Medications must be prescribed through Rx Manager to have those items counted for Meaningful Use requirements. Medications solely printed out on document designs, will not be counted.**

### Rx Manager

Some workflow choices are now available in SOAPware that do not exist in some previous versions:

Changes to prescriptions within Rx Manager are now automatically reflected in the currently active SOAPnote as long as an encounter note is displayed and unlocked (i.e. not signed off or in use elsewhere). For example, removing a prescription within the Rx Pad in Rx Manager removes it from the SOAPnote Medications field.

Rx Manager now allows new prescriptions to be created from within the manager itself. In other words, any/all prescriptions can be created just within the Rx manager which subsequently updates the encounter note.

## Rx Pad Overview

The screenshot shows the Rx Manager application window. At the top, there are tabs for 'Rx Pad', 'Medications', 'History', and 'Patient - Refill Requests'. The 'Rx Pad' tab is active. Below the tabs, there is a 'Pharmacy' dropdown menu (1) showing 'CVS/pharmacy #7284'. Below this is the 'Patient Information' section (2), which includes an 'Allergies' field (3) with a 'PBMB' button and a 'Notes' button. Below the allergies is a 'Starter - Allergies - Summary:' field (4). Below this are three buttons: 'Add Rx' (5), 'Update Summary' (6), and 'Interactions'. Below these buttons is a table with columns: 'Actions', 'Rx', 'Misc', 'Date', 'Alternatives', and 'Warnings'. The table contains one row for 'Flomax (Tamsulosin): 0.4 mg (capsule)' (7). Below the table is a 'Retrieve Eligibility Info' button (8). At the bottom right is a 'Submit' button (9).

1. Pharmacy Selection
2. Allergies
3. Eligibility Information
4. Add Rx
5. Update Summary
6. Interactions Summary
7. Prescription(s)
8. Retrieve Eligibility Information
9. Submit Rx

## Preferred Pharmacy Selection

The screenshot shows the Rx Manager application window. The 'Pharmacy' dropdown menu is highlighted with a red rectangle, showing 'CVS/pharmacy #7284 (Ph#- 281-890-2479 Fax#- 281-807-7572) 13757 CYPRESS NORTH HOUSTON RD CYPRESS, TX 77429'.

A patient's preferred (or default) pharmacy can be designated as the pharmacy which is initially selected in the Rx Pad.

The Preferred Pharmacy drop-down menu in the Demographics chart section displays the pharmacy that will be used, by default, when prescribing. The reason for this is so that the default pharmacy can be defined (e.g. by front desk staff) in the patients General Demographics chart section as the patient's chart is initially created.

Change Pharmacy Selection

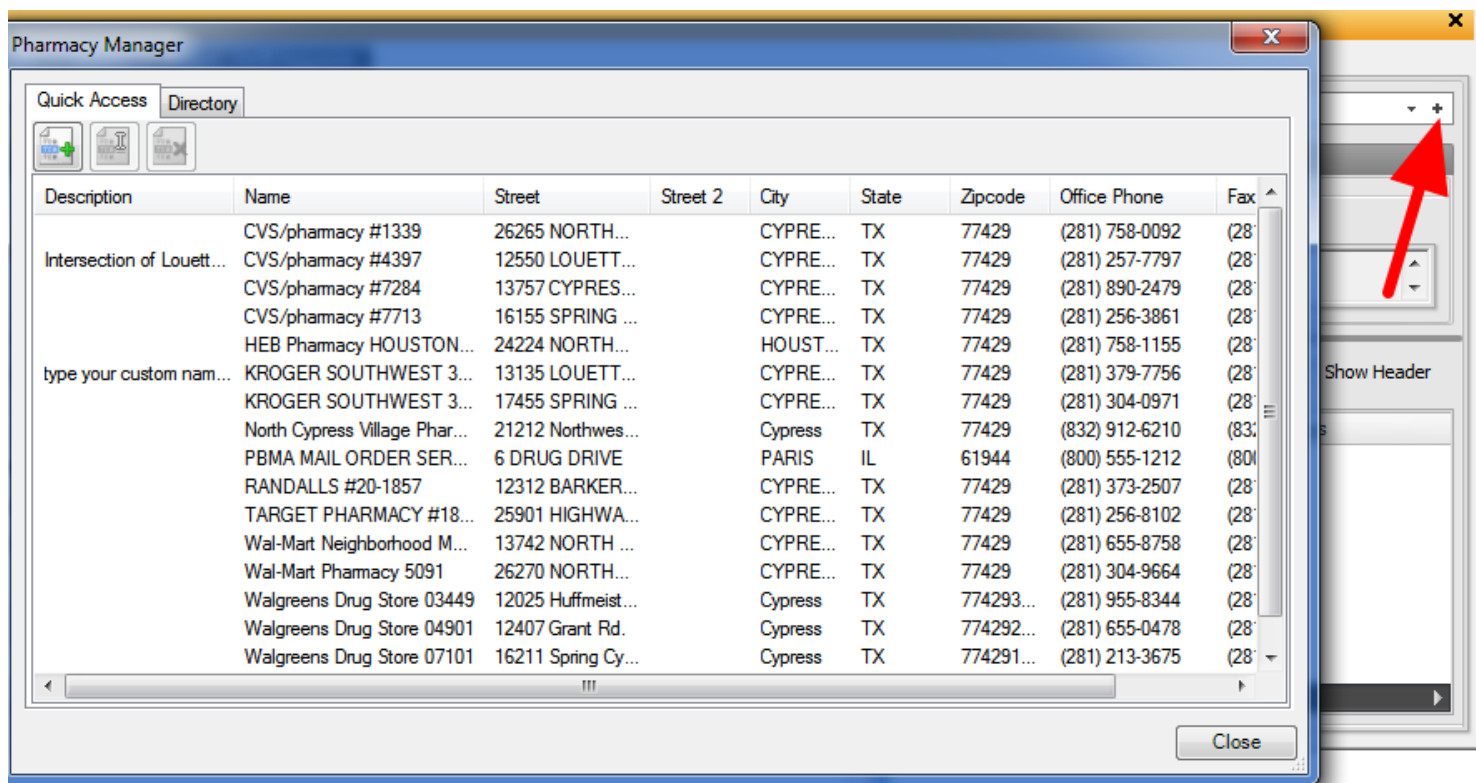
The screenshot shows the Rx Manager application window. The 'Pharmacy' field is set to 'CVS/pharmacy #7284 (Ph#- 281-890-2479 Fax#- 281-807-7572) 13757 CYPRESS NORTH HOUSTON RD CYPRESS, TX 77429'. A red arrow points to the dropdown arrow in the Pharmacy field. Below the Pharmacy field is a list of pharmacies with columns: Desc..., Name, Street, Stre..., City, State, Zipcode, Offic..., and Fax ...

Desc...	Name	Street	Stre...	City	State	Zipcode	Offic...	Fax ...
Inters...	CVS/pharmacy #1339	26265 NORTHWEST FREEWAY		CYPR...	TX	77429	281-7...	281-7...
	CVS/pharmacy #4397	12550 LOUETTA RD.		CYPR...	TX	77429	281-2...	281-2...
	CVS/pharmacy #7284	13757 CYPRESS NORTH HOUSTON RD		CYPR...	TX	77429	281-8...	281-8...
	CVS/pharmacy #7713	16155 SPRING CYPRESS RD		CYPR...	TX	77429	281-2...	281-2...
	HEB Pharmacy HOUSTON #53	24224 NORTHWEST FREEWAY		HOUS...	TX	77429	281-7...	281-7...
type y...	KROGER SOUTHWEST 327	13135 LOUETTA ROAD		CYPR...	TX	77429	281-3...	281-3...
	KROGER SOUTHWEST 362	17455 SPRING CYPRESS		CYPR...	TX	77429	281-3...	281-3...
	North Cypress Village Pharmacy	21212 Northwest Freeway Suite 101		Cypress	TX	77429	832-9...	832-9...
	PBMA MAIL ORDER SERVICE	6 DRUG DRIVE		PARIS	IL	61944	800-5...	800-5...
	RANDALLS #20-1857	12312 BARKER CYPRESS ROAD		CYPR...	TX	77429	281-3...	281-3...
	TARGET PHARMACY #1894	25901 HIGHWAY 290		CYPR...	TX	77429	281-2...	281-2...
	Wal-Mart Neighborhood Market 3506	13742 NORTH ELDRIDGE PKWY		CYPR...	TX	77429	281-6...	281-6...
	Wal-Mart Pharmacy 5091	26270 NORTHWEST FREEWAY		CYPR...	TX	77429	281-3...	281-3...
	Walgreens Drug Store 03449	12025 Huffmeister Rd.		Cypress	TX	77429...	281-9...	281-9...
	Walgreens Drug Store 04901	12407 Grant Rd.		Cypress	TX	77429...	281-6...	281-6...

To change the preferred pharmacy while within Rx Pad, Click the down-pointing triangle (i.e. at the right in the Pharmacy field), and Click a pharmacy in the list of local, Quick Access pharmacies.



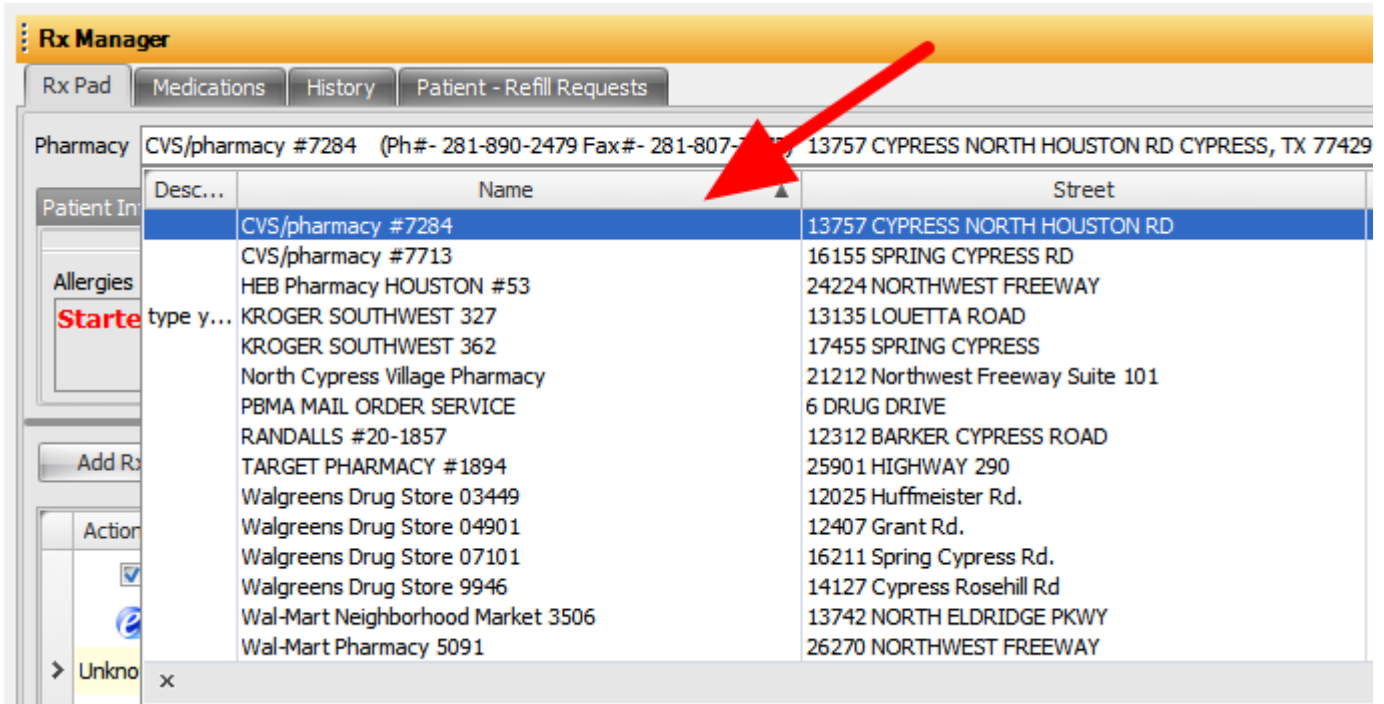
## Add Pharmacy Selection



To add a new pharmacy to the local, Quick Access pharmacy list, Click the Add button (i.e. plus sign at the far right).

Once a preferred/default pharmacy is selected, prescriptions will be automatically sent to that pharmacy when the Send button is clicked as long as there is a check in their checkbox in the Actions column.

## Sort Pharmacies



**Rx Manager**

Rx Pad   Medications   History   Patient - Refill Requests

Pharmacy: CVS/pharmacy #7284 (Ph#- 281-890-2479 Fax#- 281-807-7284) 13757 CYPRESS NORTH HOUSTON RD CYPRESS, TX 77429

Patient Information

Allergies: **Start** type y...

Add Rx

Action

Desc...	Name	Street
CVS/pharmacy #7284	CVS/pharmacy #7284	13757 CYPRESS NORTH HOUSTON RD
CVS/pharmacy #7713	CVS/pharmacy #7713	16155 SPRING CYPRESS RD
HEB Pharmacy HOUSTON #53	HEB Pharmacy HOUSTON #53	24224 NORTHWEST FREEWAY
KROGER SOUTHWEST 327	KROGER SOUTHWEST 327	13135 LOUETTA ROAD
KROGER SOUTHWEST 362	KROGER SOUTHWEST 362	17455 SPRING CYPRESS
North Cypress Village Pharmacy	North Cypress Village Pharmacy	21212 Northwest Freeway Suite 101
PBMA MAIL ORDER SERVICE	PBMA MAIL ORDER SERVICE	6 DRUG DRIVE
RANDALLS #20-1857	RANDALLS #20-1857	12312 BARKER CYPRESS ROAD
TARGET PHARMACY #1894	TARGET PHARMACY #1894	25901 HIGHWAY 290
Walgreens Drug Store 03449	Walgreens Drug Store 03449	12025 Huffmeister Rd.
Walgreens Drug Store 04901	Walgreens Drug Store 04901	12407 Grant Rd.
Walgreens Drug Store 07101	Walgreens Drug Store 07101	16211 Spring Cypress Rd.
Walgreens Drug Store 9946	Walgreens Drug Store 9946	14127 Cypress Rosehill Rd
Wal-Mart Neighborhood Market 3506	Wal-Mart Neighborhood Market 3506	13742 NORTH ELDRIDGE PKWY
Wal-Mart Pharmacy 5091	Wal-Mart Pharmacy 5091	26270 NORTHWEST FREEWAY

> Unknown x

The Pharmacy viewer displays full pharmacy information on a single line/row. When beginning to type a pharmacy name in the field, a drop-down appears listing all pharmacies that match the typed letters (much like with Chart Rack). The list of pharmacies would actually be in columns/rows, so they can be sorted by column (i.e. Pharmacy name, city, street, Zip, phone, fax etc.).

## Allergies / Eligibility

Allergies[

Drug Allergies: [ No known. (ID-Ignore)

MU

The Allergies field in RxPad displays a copy of the contents from the SummaryAllergies field. If the patient has no allergies the SMARText Item "Drug Allergies: No Known") must be displayed to meet Meaningful Use criteria.

The screenshot shows a software window with two tabs: 'PBMB' and 'Notes'. The 'Notes' tab is active and displays the following text:

Active Benefits:  
Retail:  
Mail Order:

Service Date: 08/01/2002  
Additional ID: BIN123

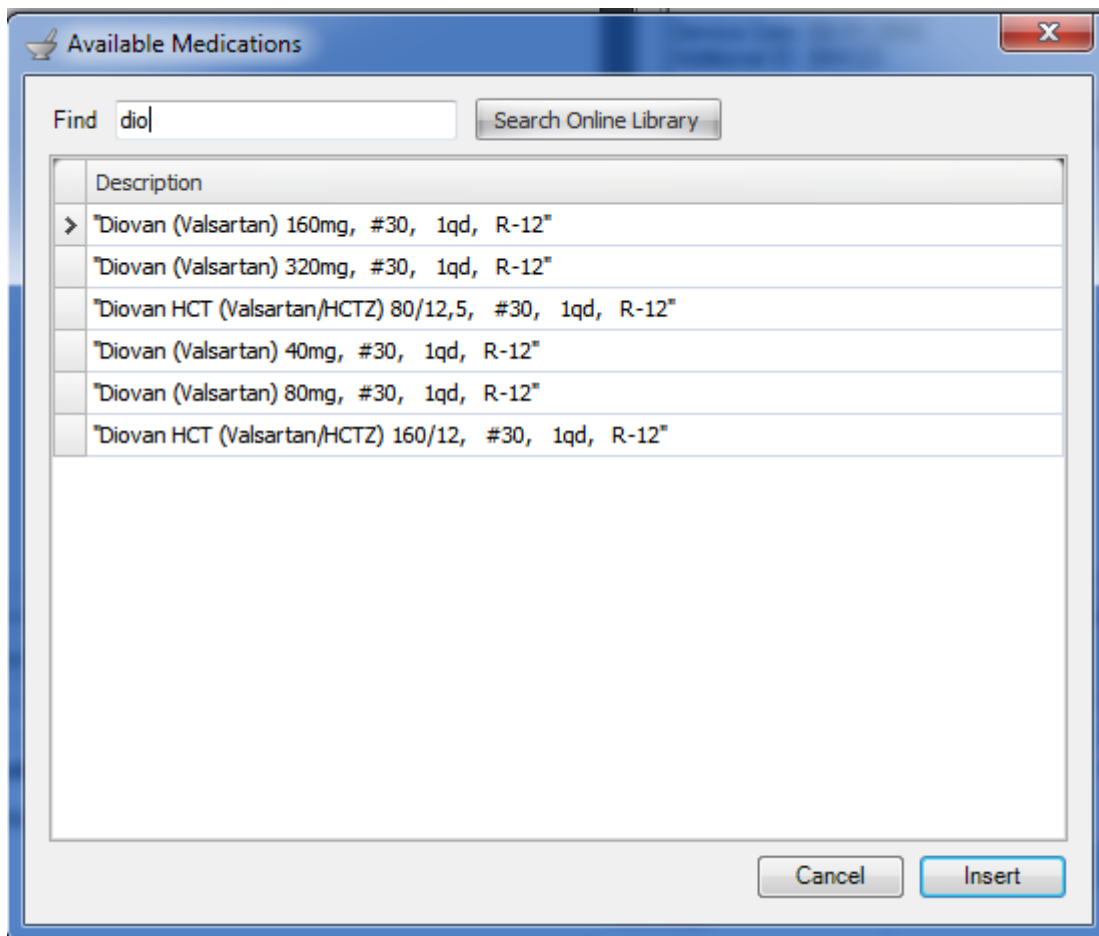
Plan Name/#: CARRGRPNAME / PLAN123 Group Name/#:  
CARRGRPNAME/CG111111111/CGID3333333  
Employee ID :

Covered Person(s):  
BOB G ODENKIRK  
100 MR SHOW LANE  
LOS ANGELES CA, 90001  
DOB: 12/25/1959 Gender: M

Card Holder:  
BOB G ODENKIRK  
100 MR SHOW LANE  
LOS ANGELES CA, 90001  
DOB: 12/25/1959 Gender: M

After Checking for Eligibility (either beforehand or when opening Rx Manager), several new tabs will appear within the "Notes" section of the Rx Manager. Each tab represents different coverage plans for this patient. Depending on the particular pharmacy benefit manager, the exact data and format returned for any given coverage will vary. At a minimum, the type of benefits will be displayed, e.g. retail, PBM (i.e. mail order or both). For example, in the above screen shot, the PBMA coverage supports only mail order.

## Add Rx Button

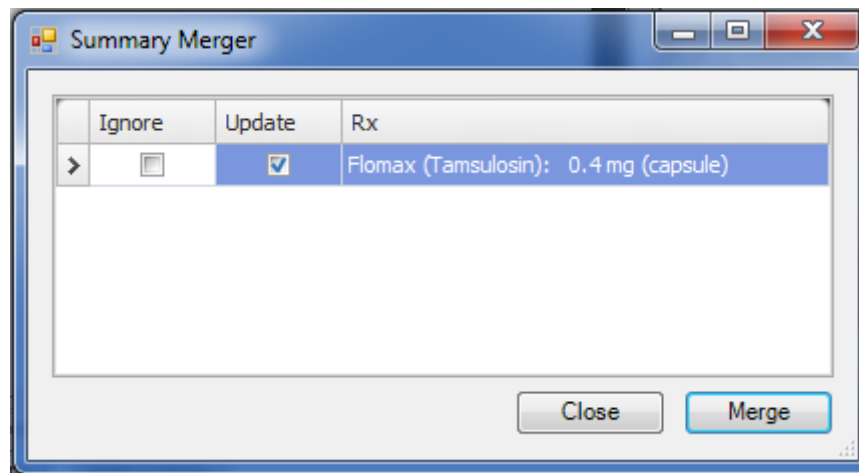


The Add Rx button displays an Available Medications dialog. Type in a drug name, and a list of matching prescriptions is automatically displayed. Double-clicking a prescription in the list adds it to the Medication list in Rx Pad.

1. Click the Find Rx button.
2. Begin typing a drug name in the Find field/box. After three characters have been typed, a list will appear. Further typing will result in a more refined list of results.

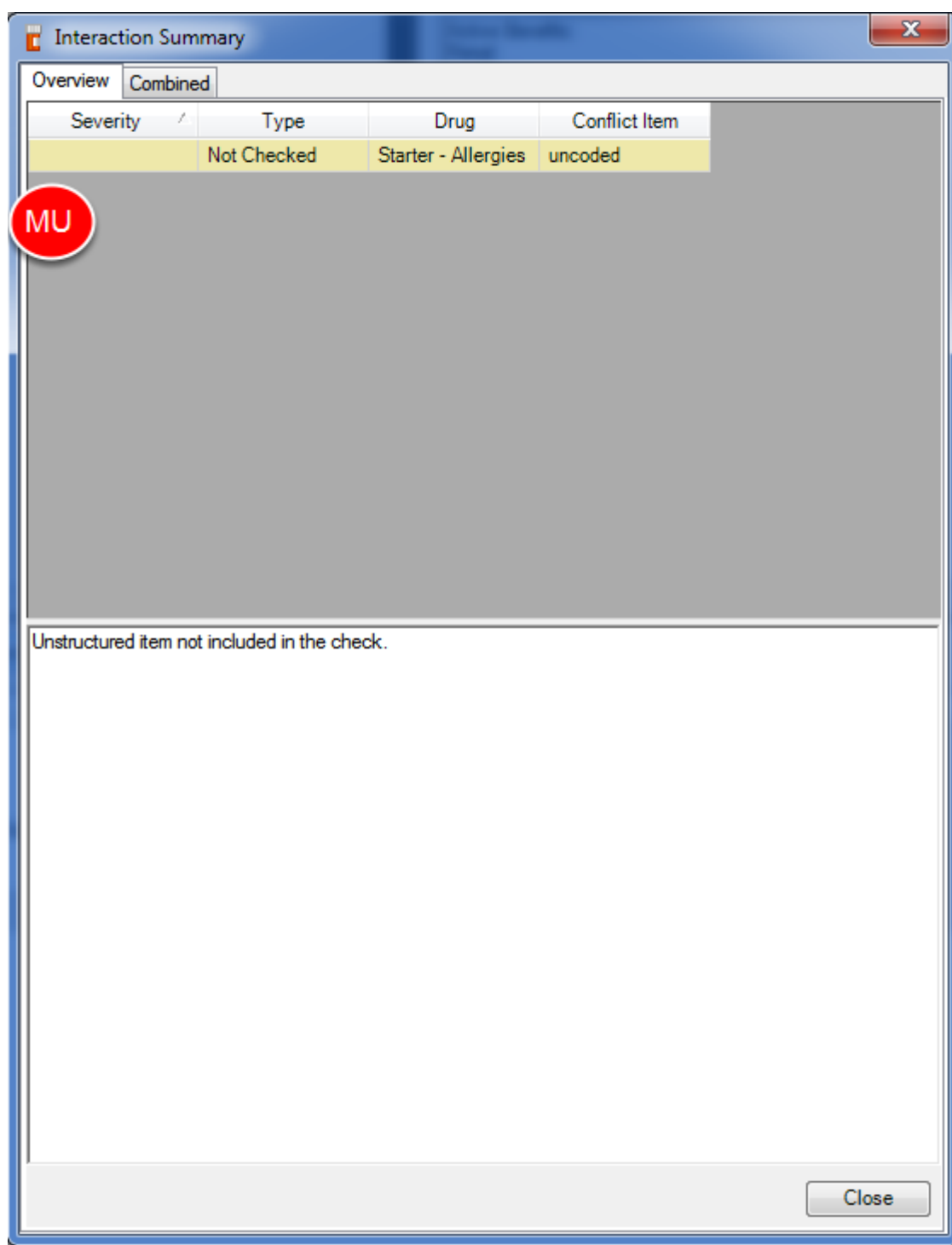
Alternatively, Click the prescription in the list once, then Click Insert. Only Structured Rx SMARText items that exist in the local library system will be displayed in this viewer. This list can contain a user's pre-defined, most commonly prescribed medications and his/her default values. Each user has their own list.

## Update Summary Button



The Update Summary button displays a Summary Merger dialog. This dialog allows for the merging of prescriptions in the Medication List in RxPad to the Summary Medications field. That is, it allows the user to specify whether or not to update/add a particular prescription to the Summary Medications list of on-going or chronic medications.

## Interactions Button



The Interactions button is grayed-out unless interactions are found. Clicking it displays the Interactions.

## Show Header Checkbox

The screenshot shows the Rx Pad interface with the 'Show Header' checkbox checked. A red arrow points to the checkbox. A red box highlights the table headers. The table has columns: Actions, Rx, Misc, Written Date, Alternatives, and Warnings. The Rx column is expanded, showing details for Flomax (Tamsulosin): 0.4 mg (capsule). The Misc column shows Pending, CVS/pharmacy #7284, Krista L. Laningham, Valid Script, and Coverage Details. The Written Date column shows 6/17/2010. The Alternatives column is empty. The Warnings column is empty.

Actions	Rx	Misc	Written Date	Alternatives	Warnings
<input checked="" type="checkbox"/>	<b>Flomax (Tamsulosin):</b> 0.4 mg (capsule) 1 each once a day orally	Pending CVS/pharmacy #7284 Krista L. Laningham Valid Script Coverage Details	6/17/2010 Remove Rx		

The Show Header checkbox toggles the display of the Rx field-headers names on and off. Above is a screen shot with a check in the checkbox and the headers displayed.

## Medication List

The screenshot shows the Medication List area with a table of prescriptions. The table has columns: Actions, Rx, Misc, Written Date, Alternatives, and Warnings. The Rx column is expanded, showing details for Flomax (Tamsulosin): 0.4 mg (capsule). The Misc column shows Pending, CVS/pharmacy #7284, Krista L. Laningham, Valid Script, and Coverage Details. The Written Date column shows 6/17/2010. The Alternatives column is empty. The Warnings column is empty.

Actions	Rx	Misc	Written Date	Alternatives	Warnings
<input checked="" type="checkbox"/>	<b>Flomax (Tamsulosin):</b> 0.4 mg (capsule) 1 each once a day orally	Pending CVS/pharmacy #7284 Krista L. Laningham Valid Script Coverage Details	6/17/2010 Remove Rx		

The Medication List area of Rx Pad displays all the individual prescriptions to be sent electronically, faxed, printed, or given as samples. Each medication listed in the patients Rx Pad view can be directly edited (much like using a spreadsheet).

Clicking on the drug name drops-down a list of predefined Drug Courses for automatic Sig/data entry.

## Actions Column

The screenshot shows the Actions column with a checkbox and a dropdown menu. The checkbox is checked. The dropdown menu shows 'Unknown'.

The Actions column allows individual prescriptions to either be included or excluded from a particular action. For example, there could be multiple prescriptions listed with all but one to be sent electronically. Simply uncheck the one not to be sent electronically. Note that faxing is not

considered the same as sending electronically (This is an industry-government differentiation and not the opinion of SOAPware, Inc.).

## Rx Column

Rx	
Flomax (Tamsulosin):	0.4 mg (capsule)
1 each once a day orally	
#30	Substitutions Allowed 0

The Rx column displays multiple fields offering detailed information about the prescription.

- \* Drug Name - e.g. Amoxicillin
- \* Strength - and form such as 250 mg. capsules
- \* Sig - (dose, frequency, route)
- \* Dispense - amount or quantity of medication
- \* Substitution - whether or not to allow generics
- \* Refills - the number entered here indicates how many refills are allowed
- \* Comment - location for typing in free-text message to be sent to the pharmacy

Clicking the down-arrows in each field displays the same pick list selections as when working with prescriptions in the Medications field in SOAP encounter notes.

## Misc Column

Misc
Pending
CVS/pharmacy #7284
Krista L. Laningham
Valid Script
Coverage Details

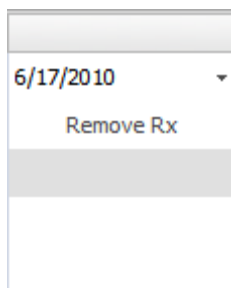
The Misc column displays status information such as:

- \* Submitted Via - This will say pending until sent, then it will be replaced by e-Rx, faxed, written (printed), or samples.
- \* Pharmacy - the destination pharmacy name.



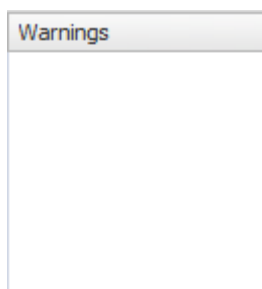
- \* Provider - the clinician responsible for the prescription.
- \* Valid Status - indicates whether the prescription can be sent electronically (this has nothing to do with faxing).

## Remove Column



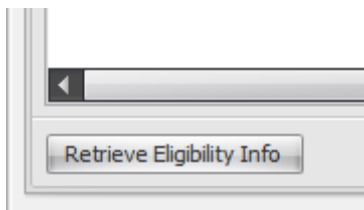
The last column on the right is the Remove column. It allows prescriptions to be removed from the Medications List. (and it subsequently removes it from the active SOAP encounter note if present there).

## Warnings Column



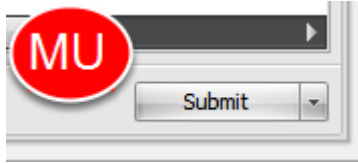
This column displays an alert when scheduled drugs are found.

## Retrieve Eligibility Information



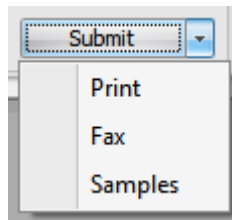
This button retrieves/updates the eligibility information for this patient. If no eligibility is displayed upon opening Rx Manager, use this button to update the eligibility information.

## Submit Rx



This button will send the prescriptions that are selected. It will send the prescriptions via the default method set under Tools - Options. For more information on these settings, see: [Tools - Options](#).

## Submission Options

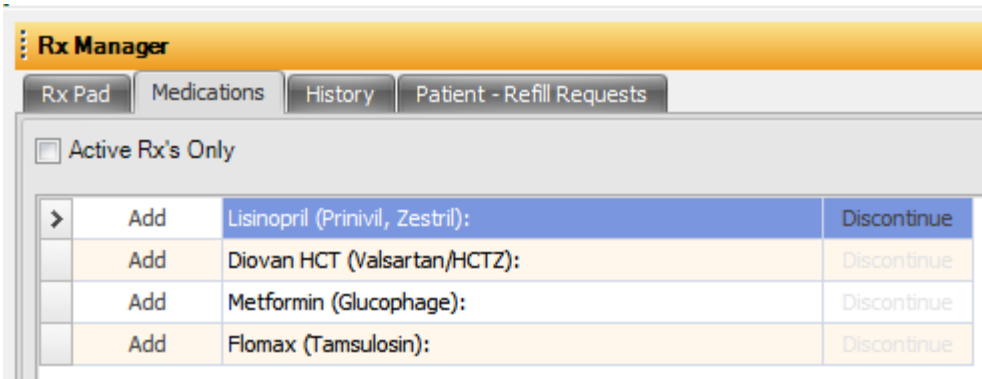


The user can also use the drop-down menu to the right of the Submit button to choose to send the prescription by printing, faxing, or by marking that the user gave samples.

# Rx Manager - Medications Tab

The Medications Tab area displays each structured prescription found in either the patient's Rx History or Summary Medications fields. It provides a quick way to view all medications the patient has ever been prescribed via SOAPware.

## Medications List



Auser can also choose to view Active Rx's Only, as well as to discontinue a medication or add it to the Rx Pad.

## Rx Manager - History Tab

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The area under the History tab displays a complete list of all prescribing actions-transactions (refills, add/remove, start/stop, print, fax edits etc.) performed in Rx Manager. It distinguishes refills from new prescriptions. It also lists whether prescriptions were sent electronically (i.e. eRx), printed, faxed, samples, etc. The columns can be sorted by clicking on the headers. The Add button allows for prescriptions to be added to the Medication List in RxPad. There are additional columns to the right of the display that are accessible via the horizontal scroll bar (i.e. destination pharmacy, prescribed by etc.)

## Medication History

**Rx Manager**

Rx Pad Medications History Patient - Refill Requests

Drag a column header here to group by that column

Action	Drug	Status	Details	Notes	Pharmacy	Remove
Type	Sent	Response				
	Fill Date	Provider				
Refill	<b>PHENYL CHLOR...</b> 1/1/0001		PHENYL CHLOR-TAN SUSPENSION Dispense: 120.0		CVS PHARMACY #0000	X
	1/17/2010					
Refill	<b>ZITHROMAX 100...</b> 1/1/0001		ZITHROMAX 100 MG/5 ML SUSP Dispense: 30.0		CVS PHARMACY #0000	X
	6/16/2010					
Refill	<b>POLYVIT/FLUORI...</b> 1/1/0001		POLYVIT/FLUORIDE 0.25 MG DRP Dispense: 50.0		CVS PHARMACY #0000	X
	5/1/2010					
Refill	<b>Diovan HCT (Val...</b> 5/3/2010	Error: 601 - Rec...	12.5 mg-160 mg (tablet) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 12 Comment- Notes-		CVS/pharmacy #7284 Ph# - 2818902479 Fax# - 2818077572 13757 CYPRESS NORTH	X
e-Rx Sent	1/1/0001	Unknown c540f39c-bcb9-4...				
Refill	<b>Metformin (Gluc...</b> 5/4/2010	Discontinued	850 mg (tablet) SIG- 1 each 2 times a day	Discontinued on 5/4/2010	Ph# - Fax# -	X
Discontinued	1/1/0001	Discontinued c540f39c-bcb9-4...				
Refill	<b>Flomax (Tamsulo...</b> 6/17/2010	Sent	0.4 mg (capsule) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 0 Comment- Notes-		CVS/pharmacy #7284 Ph# - 2818902479 Fax# - 2818077572 13757 CYPRESS NORTH	X
Sample Given	1/1/0001	Unknown c540f39c-bcb9-4...				
Refill	<b>Flomax (Tamsulo...</b> 6/17/2010	Sent	0.4 mg (capsule) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 0 Comment- Notes-		CVS/pharmacy #7284 Ph# - 2818902479 Fax# - 2818077572	X
Sample Given		Unknown				

Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

In order to renew a previous prescription in the list, Click the Refill button to the left of the medication. This action inserts that prescription into the patient's Rx Pad.

Refill
Refill
e-Rx Sent
Refill
Discontinued
Refill
Sample Given
Refill
Sample Given

The patient's History list shows all medications that have been prescribed via the Rx Manager as well as other prescriptions from the patient's Rx Hub.

### Important Tip

Also keep in mind that certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

## Rx Manager - Refill Requests

The Refill Requests tab provides a location to view this patient's matched refill requests. The user can approve or deny them here or the user can use the Refill Requests Manager to address all patient refills from one central place. To learn more about refill requests manager, see: [Refills](#).

### Refill Requests Tab

The screenshot shows a window titled "Refill Requests" with a close button (X) in the top right corner. The window contains a table with the following columns: Date Requested, Last Fill Date, Patient, Description, Refills (Total number of dispensings...), Comments, and Schedule Status. A button labeled "View pending refill requests" is located above the Description column. The table has one data row with the following information:

Date Requested	Last Fill Date	Patient	Description	Refills (Total number of dispensings...)	Comments	Schedule Status
5/19/2009 7:25 AM		Patient, Test SS# - 9/10/2008	Amoxil 500 mg Oral Tab Take 2 Tablet(s) By Oral Route BID Qty: Refills Requested: 2 Notes:	2	Note to pharmacy	Druglox Ph# - 4015633390 Fax# - 4016668888 333 SR 566

Below the table, there is a "Refresh" button on the left and "Delete Request" and "Send" buttons on the right.

To handle a request from the patient's Rx Manager, select an action, choose a number of refills (refills have to be set to at least one (1) or else the refill is marked as denied).

Once the user has approved or denied the refill request, hit the Send button at the lower right.

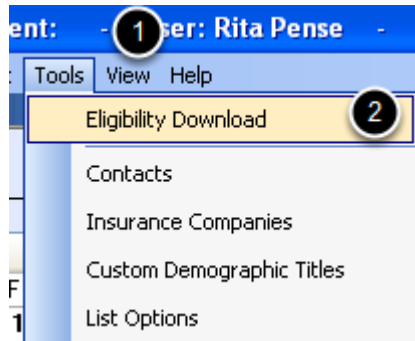
## Checking Patient Eligibility

---

This lesson will discuss checking the patient's prescription eligibility/forulary both individually and in bulk.

**Note:** The information received when a patient's eligibility is checked is determined by the information released by the insurance company.

### Bulk Download of Eligibility Information



This is initiated through the Scheduler workspace. The suggested workflow is to retrieve benefit information the night before for all patients scheduled for the next day. This allows front office staff to manage any verification issues.

1. From within the Scheduler workspace Click on Tools.
2. Click on Eligibility Download.



## Bulk Eligibility Retrieval Window

**Bulk Eligibility Retrieval** [X]

	SW First Name	SW MI	SW Last Name	SW Gender	SW DOB	SW Zipcode	Save Demographic Changes
	Ins. First Name	Ins. MI	Ins. Last Name	Ins. Gender	Ins. DOB	Ins. Zip Code	Accept Insurance Demographics
Retrieve	Olive	T	Garden	F	02/28/1952	72701	Save Changes
Discard							Accept Ins. Demographics
Retrieve	Tasty	T	Potatoes	M	01/02/1972	72764	Save Changes
Discard							Accept Ins. Demographics
Retrieve	Bunny	R	Ears	F	08/24/1981	72701-1234	Save Changes
Discard							Accept Ins. Demographics
Retrieve	Sweet		Baby Boy	M	10/11/2010	72700-1__	Save Changes
Discard							Accept Ins. Demographics

Refresh [Retrieve All]

After choosing to download eligibility information, the above window will appear. It displays patients on the schedule for the following day. Patients displayed are color-coded as to exact match, partial match, confirmation required OR no match.

## Confirmation Displayed

**Confirm Changes** [X]

SOAPware has recieved a benefits match. However, the information received differs from the information sent for Tad A Dockendorf.

Would you like to keep the current SOAPware Demographics, Update Tad A Dockendorf demographics with Rx hubs information or cancel the match?

SOAPware Data	RxHub
<input checked="" type="checkbox"/> Tad	<input type="checkbox"/> TAD
<input checked="" type="checkbox"/> A	<input type="checkbox"/> ALAN
<input checked="" type="checkbox"/> Dockendorf	<input type="checkbox"/> DOCKENDORF
<input checked="" type="checkbox"/> M	<input type="checkbox"/> M
<input checked="" type="checkbox"/> 19750705	<input type="checkbox"/> 19750704
<input checked="" type="checkbox"/> 82001	<input type="checkbox"/> 82001

Use All SOAPware [Use All RxHub]

Confirm [Cancel]

When a bulk match is performed for eligibility, SOAPware checks to see if current prescription eligibility information exists for the active patient. If this information is not found, SOAPware will request the most up-to-date information from Sure Scripts automatically.

In some cases, the patient demographics sent to Sure Scripts will result in a less-than-perfect match that will require human confirmation. There are three possible results:

**\*Perfect Match-** eligibility is displayed

**\*Partial Match** - confirmation dialog is displayed (see image above)

In the event an exact match is not found, a dialog is displayed asking for additional demographic information (any entered/edited is pushed to the patient's general demographics in SOAPware). At this point the user can cancel, enter/edit or resubmit. In some cases, Rx Hub will have a match, but the demographic information is slightly different than what is in SOAPware.

For example, in the above image display note the birth date is off by one day. In this case, both the SOAPware demographics and the Rx Hub demographics are displayed for a user's confirmation. It is suggested that the user accept the demographics presented by Rx Hub so that future matches do not result in this confirmation step. Once the user has verified the information displayed, and agreed that the patient listed on the right under Rx Hub is the same as the patient on the left, click Confirm. If the patients are not the same or not believed to be the same, Click Cancel.

**\*No Match-** error listed in the Eligibility dialog in Rx Manager.

## Manual Download - Single Patient Matching

**Rx Manager**

Rx Pad | Medications | History | Patient - Refill Requests

Pharmacy: SAFEWAY #25-0971 (Ph#- 510-582-5706 Fax#- 510-582-3527) 22280 FOOTHILL BLVD HAYWARD, CA 94541

Patient Information

Allergies

Notes

Add Rx | Update Summary | Interactions | Show Header

Actions	Rx	Misc
<input checked="" type="checkbox"/>	<b>Diovan (Valsartan):</b> 80 mg (tablet)	Pending
	1 tab(s) once a day orally	SAFEWAY #25-0971
> Unknown	#30 Substitutions Not Allowed 12	Rita Pense
	HCT 25 mg	Valid Script
		Coverage Details

Retrieve Eligibility Info | Submit

Eligibility can also be checked from the Rx manager from within a patient chart. To do this, Click on the "Retrieve Eligibility Info" button.

**Note:** While eligibility information can be checked for an individual patient at the point of care, we advise using the Bulk Eligibility functionality so that the patient's eligibility can be retrieved prior to the clinical seeing the patient.

## The Eligibility Tabs

PBMB PBMA PBMC Notes

Active Benefits:  
Mail Order: Medicaid - CSP - PBMA Pharmacy Primary Payer: PBMA OOP: \$30

Service Date: 08/01/2002  
Additional ID: A5 003858

Plan #: AAE Group Name: /A/ /AAE/

After checking for eligibility (through either bulk retrieval or individually), several new tabs will appear within the "Notes" section of the Rx Manager.

Each tab represents different coverage plans for this patient. Depending on the particular pharmacy benefit manager, the exact date and format returned for any given coverage will vary. At minimum, the type of benefits will be displayed, e.g. retail, PBM (i.e. mail order or both). For example, in the above screen shot, the PBMA coverage supports only mail order.

**Note:** The drug prescribed will be checked against the formulary of the tab that is selected at the time of prescribing.

## Formulary Information

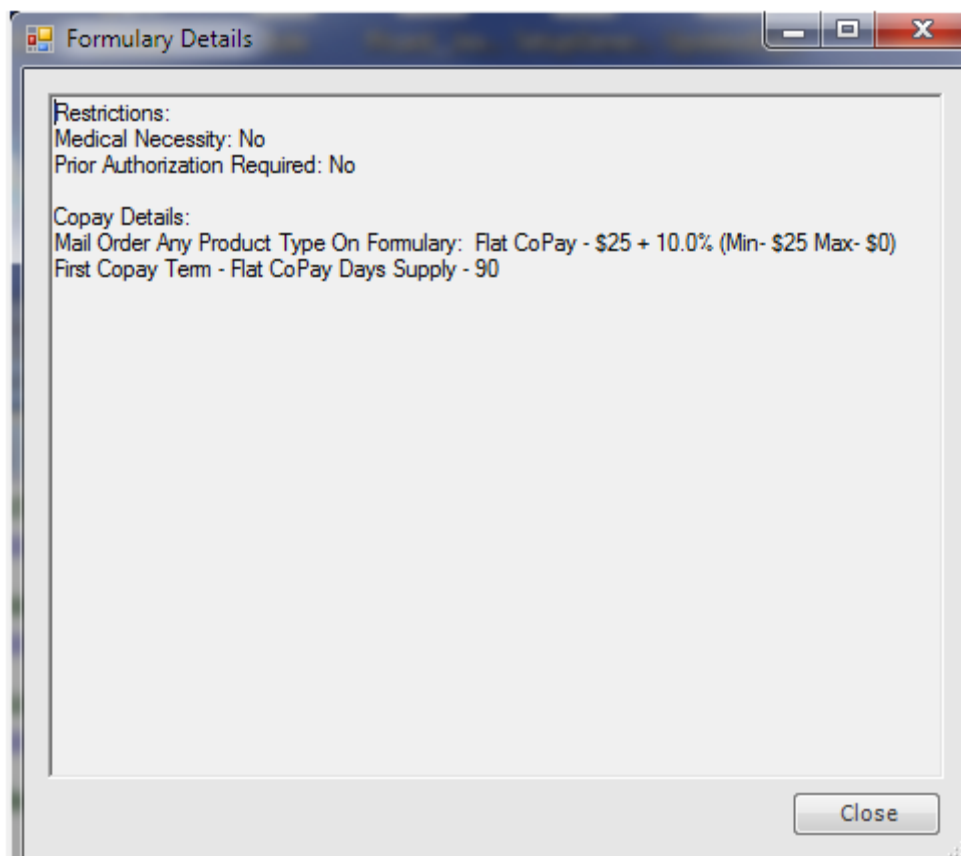
<input checked="" type="checkbox"/>	Wellbutrin SR:	100 mg (tablet, extended release)	Pending	4/11/2011	Therapeutic Alternatives
On Formulary (1)	60 each 2 times a day orally			Remove Rx	Pref Lvl-1 - Fluoxetine Hydrochloride 20 mg/5 mL solution
	#60 Tablet(s)	Substitutions Allowed	0	Brand Prescription (3)	Off Formulary - Anafranil 25 mg capsule
			Valid Script		Off Formulary - Anafranil 50 mg capsule
			Coverage Details (5)		

1. Displays the Formulary status for the prescription. In this case, it is On Formulary.
2. A summary of the cost for the medication is sometimes displayed in this section.
3. Info as to OTC/brand and generic/prescription status.
4. Alternative drugs supported by the selected coverage.
5. Displays an additional window with detailed Formulary Information.

**\*REQUIRED FOR MEANINGFUL USE OPTIONAL MENU SET- FORMULARY CHECKS**

[Click here for Meaningful Use Criteria](#)

## Additional Formulary Details



A screenshot of a 'Formulary Details' dialog box. The dialog has a title bar with standard window controls. The main content area is divided into two sections: 'Restrictions:' and 'Copay Details:'. Under 'Restrictions:', it lists 'Medical Necessity: No' and 'Prior Authorization Required: No'. Under 'Copay Details:', it lists 'Mail Order Any Product Type On Formulary: Flat CoPay - \$25 + 10.0% (Min- \$25 Max- \$0)' and 'First Copay Term - Flat CoPay Days Supply - 90'. A 'Close' button is located at the bottom right of the dialog.

Formulary Details

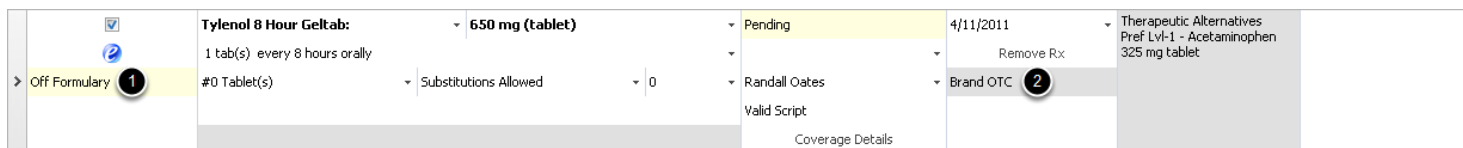
Restrictions:  
Medical Necessity: No  
Prior Authorization Required: No

Copay Details:  
Mail Order Any Product Type On Formulary: Flat CoPay - \$25 + 10.0% (Min- \$25 Max- \$0)  
First Copay Term - Flat CoPay Days Supply - 90

Close

To view detailed formulary information, Click on the "Coverage Details" button (#5 above)

## When a Drug is Not covered Under the Selected Coverage Tab



A screenshot of a software interface showing drug coverage details for 'Tylenol 8 Hour Geltab'. The interface includes a search bar with a checkmark icon, a dropdown menu for '650 mg (tablet)', a 'Pending' status indicator, a date '4/11/2011', and a 'Remove Rx' button. Below these, there are tabs for 'Off Formulary' (marked with a circled '1') and 'Brand OTC' (marked with a circled '2'). The 'Off Formulary' tab is active, showing '1 tab(s) every 8 hours orally' and '#0 Tablet(s)'. The 'Brand OTC' tab shows 'Therapeutic Alternatives: Pref Lvl-1 - Acetaminophen 325 mg tablet'. A 'Coverage Details' button is located at the bottom right of the interface.

Tylenol 8 Hour Geltab: 650 mg (tablet) Pending 4/11/2011 Remove Rx

1 tab(s) every 8 hours orally

Off Formulary 1

#0 Tablet(s) Substitutions Allowed 0

Randall Oates Valid Script

Brand OTC 2

Therapeutic Alternatives  
Pref Lvl-1 - Acetaminophen  
325 mg tablet

Coverage Details

1. This drug is not covered under the selected coverage.

2. It is available as an OTC Brand Name.

Note that, in this example, no alternatives are displayed.

## Electronic Refill Requests

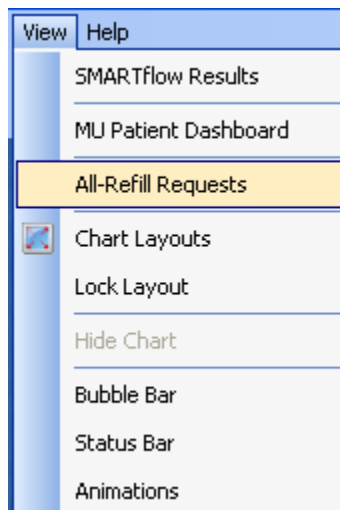
---

This lesson will demonstrate the steps necessary to receive and respond to electronic refill requests in SOAPware.

### eRx Monitor

In order to receive electronic refill requests in SOAPware, the user will need to run the eRx Monitor. For instructions on running the eRx Monitor see: [eRx Monitor](#).

### View - All Refill Requests



To access the Refill Requests dialog, Click View in the menu bar and Click the All-Refill Requests menu item. This will display the refill requests for All patients for the Active Provider.

## Refill Requests

Refill Requests					
Date Requested	Patient	Description	Pharmacy		
Last Fill Date	1	2	3	4	
Provider					
Action Required		Response	Fills (# of dispensings approved)	Comments	Schedule Status
11/20/2009 12:35 PM	Liger, Greg SS# - 19680919	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st		
Edward H. Jekyll					
Unmatched Patient	Match Patient	Approved	2		
11/20/2009 12:35 PM	Liger, Greg SS# - 19680919	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st		
Edward H. Jekyll					
Unmatched Patient	Match Patient	Approved	2		
11/20/2009 12:34 PM	Liger, Greg SS# - 19680919	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st		
Edward H. Jekyll					
Unmatched Patient	Match Patient	Approved	2		

Refresh Provider: All Providers Delete Request Send

The display is horizontally divided into 4 general areas (from left to right).

1. Refill Notice
2. Patient Information
3. Description
4. Pharmacy Information

**Note:** A similar display is also available in Rx Manager. However, that display only shows pending refill requests for the active patient chart at the time the Rx Manager is open, see: [Rx Manager: Refill Requests](#).

## Refill Notice

Refill Requests	
Date Requested	
Last Fill Date	
Provider	
Action Required	
11/20/2009 12:35 PM	
Edward H. Jekyll	
Unmatched Patient	

The first, or left-most, area of each refill request is the Refill Notice region and can contain Date Requested, Last Fill Date, Provider, and Action-Status rows (i.e. Ready, Scheduled Drug, Unmatched Patient etc.) When the refill request is complete and valid the Status will turn Green.

The Last Fill Date item is optionally sent by the pharmacies. An empty value does not imply the script has not been previously filled by the pharmacy.

**Note: If a provider elects to no longer receive refill requests electronically, they will need to send an email to [support@soapware.com](mailto:support@soapware.com) request that it be disabled.**

## Patient Information

Patient
Liger, Greg SS# - 19680919
Match Patient

The second area, horizontally, is the Patient Information passed to SOAPware from the pharmacy. When there is a match to a SOAPware chart (automatic or manual) the background is white. Red indicates the patient information from the pharmacy has not yet been matched to a specific SOAPware chart.

## Description

Description		
Response	Fills (# of dispensings approved)	Comments
Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:		
Approved	2	

The third area is the Description, and is largely made up of the actual medication-prescription details sent from the pharmacy. The bottom row provides the ability to Approve/Deny, define # of refills and provides an option to send a typed, free-text comment back to the pharmacy.



## Pharmacy Information

Pharmacy
Schedule Status
QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st

The fourth area is for the Pharmacy Information.

## Refill Requests Buttons - Actions

<input type="button" value="Refresh"/>	Provider: <input type="text" value="All Providers"/>	<input type="button" value="Delete Request"/>	<input type="button" value="Send"/>
--	--	---	-------------------------------------

### Refresh

The Refresh button checks for any new refill requests.

### Provider

This drop down menu will allow the user to choose to view refill requests for All Providers or for only an individual provider.

### Delete Request

The Delete Request button presents a dialog explaining that it is preferable to respond to the pharmacy with a Denied reason rather than deleting the request. It is best to then proceed to select one of the valid reasons for denial and add any necessary comments in the available comment box. Again, it is best to submit a Denied response, and this does remove the refill request from the list.

### Send

The Send button sends a response for the currently selected refill request.

## Matching a Patient

Date Requested	Patient	Description	Pharmacy
11/20/2009 12:35 PM	Liger, Greg SS# - 19680919	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st
Edward H. Jekyll	Unmatched Patient	Match Patient	Approved
		Fills (# of dispensings approved)	2
		Comments	
		Schedule Status	

Refresh Provider: All Providers Delete Request Send

When an electronic refill request is sent for a patient for the first time, the SOAPware user will need to match the patient with a SOAPware chart. If a clinic received a faxed refill request from the pharmacy on a patient, the clinic staff would verify that the patient's name, date of birth and SSN matched the patient's information on record with the clinic to ensure it was the same person. This is the same workflow that should be used electronically to match the patient.

When a refill request needs to be matched to a patient, the refill request will display in red and the Action Required will say "Unmatched Patient".

Date Requested	Patient	Description	Pharmacy
11/20/2009 12:35 PM	Liger, Greg SS# - 19680919	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 7035556678 123 Main st
Edward H. Jekyll	Unmatched Patient	Match Patient	Approved
		Fills (# of dispensings approved)	2
		Comments	
		Schedule Status	

Refresh Provider: All Providers Match Patient Delete Request Send

To match the electronic refill request with a patient's chart:

1. Click the Match Patient button

The screenshot shows a 'Patient Match' window. At the top, a box contains patient information: Name: Liger, Greg; Birth Date: 19680919; Sex: M. This box is circled in red with a '2' in a circle. Below this is a text field for 'Last Name' containing 'Liger'. A table below the text field has columns: T, First, MI, Last, Sex, Birth Date. The first row of data is circled in red with a '3' in a circle and contains: Greg, M, Liger, F, 9/19/1968. At the bottom right, there are three buttons: 'Cancel', 'New', and 'Match'. The 'Match' button is circled in red with a '4' in a circle.

T	First	MI	Last	Sex	Birth Date
	Greg	M	Liger	F	9/19/1968

2. The patient's Name, Birth Date and Sex as submitted by the pharmacy will display at the top of the Patient Match window
3. SOAPware will search for a patient that has a matching last name in SOAPware and the results will be displayed. Click on the correct patient after verifying the patient's information.
4. Click the Match button to indicate that this refill request matches the selected patient.

Date Requested	Patient	Description	Pharmacy
11/20/2009 12:35 PM	Liger, Greg SS# - 9/19/1968	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 703555668 Fax# - 7035556678 123 Main st
Edward H. Jekyll	Match Patient	Approved	2

Refresh Provider: All Providers Delete Request Send

When the refill request has been matched to a patient in the chart rack, the Action Required will be changed to "Ready" and the refill request will no longer be red. When a matched refill request is selected, the corresponding patient's chart will be opened.

## Approving a Refill Request

Date Requested	Patient	Description	Pharmacy
11/20/2009 12:35 PM	Liger, Greg SS# - 9/19/1968	Amoxil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 703555668 Fax# - 7035556678 123 Main st
Edward H. Jekyll	Match Patient	Approved	1

Refresh Provider: All Providers Delete Request Send

# Refills Approved

PRN

0

1

2

3

4

x

To approve a refill request:

1. Select a response of Approved.
2. Select the desired # of dispensings approved. In order to approve the refill request, the user must select a minimum of 1 # of Refills Approved. If a user selected 0 # of Refills Approved, they would essentially be denying the initial refill that was requested. By selecting 1 # Refills Approved, the clinic is approving the 1 refill that was requested today and no additional refills. By selecting 2 # Refills Approved, the clinic is approved 1 refill that was requested today and 1 additional refill.
3. Click the Send button to submit the approved refill request to the pharmacy.

**\*Note:** When an approved refill request is sent to the pharmacy, SOAPware will create documentation to indicate the user's response. If the patient has an unsigned SOAPnote that is selected in their chart, the documentation for the refill request will be placed in the Medications field of the unsigned SOAPnote. If the patient does not have an unsigned SOAPnote in the chart, a new SOAPnote will be created and the refill request documentation will be inserted into the new

SOAPnote.

**\*It is very important to make sure all notes are signed off on time so that a documentation for a refill request is not accidentally placed in an unsigned SOAPnote.**

## Denying a Refill Request

The screenshot shows the 'Refill Requests' window. A table lists a request for Amoxicillin 500 mg Oral Tab. The 'Response' column has a dropdown menu open, showing various denial reasons. The 'Fills' column is set to 0. The 'Send' button is highlighted with a red box and a circled number 3.

Date Requested	Patient	Description	Pharmacy
11/20/2009 12:35 PM	Liger, Greg SS# - 9/19/1968	Amoxicil 500 mg Oral Tab SIG- Take 2 Tablet(s) By Oral Route BID Qty: 40 Tablet(s) Refills Requested: 2 Notes:	QA Surescripts Pharmacy Ph# - 7035555668 Fax# - 70355556678 123 Main st

Response dropdown menu options:

- description
- Approved
- Denied Patient Already Picked Up
- Denied Patient Change Not Appropriate
- Denied Patient Contact Provider
- Denied Patient Never Prescribed
- Denied Patient Never Under Care
- Denied Patient No Longer Under Care
- Denied Patient Refill Not Appropriate
- Denied Patient Not Picked Up
- Denied Patient Partial Pickup
- Denied Patient Requested Too Soon
- Denied Patient Unknown
- Denied Refill NewRx To Follow
- Denied Patient Needs Appointment
- Denied Prescriber not Associated with Practice

To deny a refill request:

1. Click the drop down menu next to Approved and then select the appropriate Denied response.
2. Set the # of dispensings approved to 0.
3. Click the Send button to submit the response to the pharmacy.

***\*Note: Pharmacies will send refill requests for controlled medications. Since controlled medications cannot be ePrescribed at this time, the clinic should deny the electronic refill request for a controlled medication using an appropriate response. If the refill request needs to be approved, the clinic can then open a new SOAPnote for the patient to fill the refill request by printing/faxing the medication as needed.***

## Storing Prescription Information

All the information listed above is stored in the related patient's History section of Rx Manager after being submitted to the pharmacy (or removed).

If there is an active, unsigned SOAP encounter note, the prescriptions will also be transferred to the Medications field.

## Drug and Allergy Interaction Checking

Drug to Drug and Drug to Allergy interactions are checked each time a prescription is processed through the Rx Manager whether it is to be sent electronically, faxed or printed.

The severity of the interactions the user wants to be alerted to is a setting under Tools > Security which will also be covered in this lesson.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
- [Drug Interaction Checks](#)

### SMARText Medications and Allergies

#### Medications

Diovan HCT (Valsartan/HCTZ): 12.5 mg-80 mg (tablet) SIG- 1 tab(s)  
once a day

Darvocet-N 100 (Propoxyphene-Acetaminophen): napsylate 650 mg-100  
mg (tablet) SIG- 1 tab(s) 4 times a day or as needed

Prilosec (Omeprazole): 20 mg (delayed release capsule) SIG- 1 each  
once a day Start Date- End Date-

Alprazolam (Xanax): 0.5 mg (tablet) SIG- 1 each 3 times a day Start  
Date- End Date-

Diovan (Valsartan): 80 mg (tablet) SIG- 1 tab(s) once a day Start Date-  
End Date-

Dexilant (dexlansoprazole): 60 mg (delayed release capsule) SIG- 1  
cap(s) once a day

Augmentin (Amoxicillin/Clavulanate): 500 mg-125 mg (tablet) SIG- 1  
each every 8 hours

Dexilant (dexlansoprazole): 60 mg (delayed release capsule) SIG- 1  
cap(s) once a day

#### Allergies[

AMOXICILLIN: Comment- causes rash

In order for the drug interaction check to work, the patient's Summary medications and allergies must be documented in the SMARText format.

If the patient has no allergies the SMARText Item "Drug Allergies: No Known" must be displayed to meet Meaningful Use criteria.

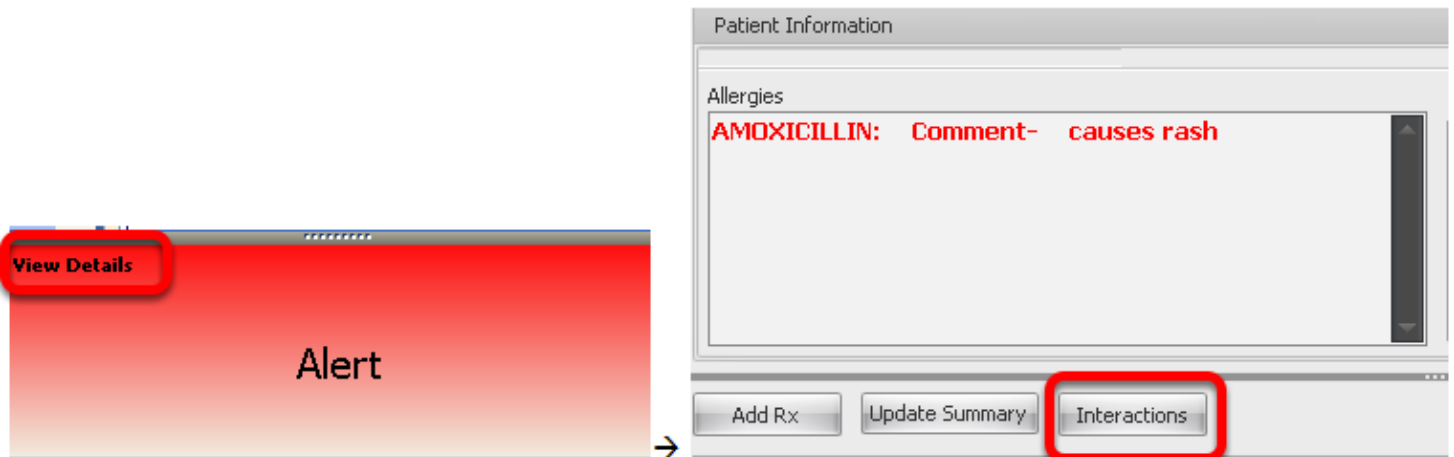
## Interaction Alert



When the Rx manager is accessed, if an interaction is found a pop up a color coded alert will display in the lower left hand corner of the screen.

- \*Red - Major Interaction
- \*Yellow - Moderate interaction
- \*Green - Minor Interaction

## Viewing the Interactions



The interactions can be viewed by either clicking on the View Details in the alert pop up or by clicking on the interaction button on the Rx Pad

## Interaction Information - Overview Tab

**Interaction Summary**

Overview Combined

Severity	Type	Drug	Conflict Item
Moderate	Rx/Rx	Alprazolam (Xanax):	Diovan HCT (Valsartan/HCT
Moderate	Rx/Rx	Darvocet-N 100 (Propoxyph	Diovan HCT (Valsartan/HCT
Major	Rx/Rx	Alprazolam (Xanax):	Darvocet-N 100 (Propoxyph
Moderate	Rx/Rx	Diovan HCT (Valsartan/HCTZ	Darvocet-N 100 (Propoxyph
Moderate	Rx/Rx	Alprazolam (Xanax):	Prilosec (Omeprazole):
Moderate	Rx/Rx	Darvocet-N 100 (Propoxyph	Diovan (Valsartan):
Major	Rx Allergy	Amoxicillin (Amoxil) 400/5 Su	AMOXICILLIN:
Major	Rx Allergy	Augmentin (Amoxicillin/Clavul	AMOXICILLIN:

**MONITOR** Many psychotherapeutic and CNS-active agents (e.g., anxiolytics, sedatives, hypnotics, antidepressants, antipsychotics, opioids, alcohol, muscle relaxants) exhibit hypotensive effects, especially during initiation of therapy and dose escalation. Coadministration with antihypertensive agents, in particular vasodilators and alpha-blockers, may result in additive effects on blood pressure and orthostasis.

**MANAGEMENT** Caution is advised during coadministration of these agents. Close monitoring for development of hypotension is recommended. Patients should be advised to avoid rising abruptly from a sitting or recumbent position and to notify their physician if they experience dizziness, lightheadedness, syncope, orthostasis, or tachycardia.

The Overview tab will display

- \*The severity of the interaction
- \*The type of interaction (e.g. drug/drug or drug/allergy)
- \*The drug and conflict item
- \*An overview on monitoring and management



## Interaction Information - Combined Tab

The screenshot shows a software window with two tabs: 'Overview' and 'Combined'. A red arrow points to the 'Combined' tab. Below the tabs, there are two red-bordered boxes highlighting specific interaction entries. Each entry includes a severity level ('Moderate'), the names of the interacting drugs, and detailed monitoring and management instructions.

**Overview** **Combined**

**Moderate**  
Alprazolam (Xanax):  
Diovan HCT (Valsartan/HCTZ):  
Rx/Rx

**MONITOR:** Many psychotherapeutic and CNS-active agents (e.g., anxiolytics, sedatives, hypnotics, antidepressants, antipsychotics, opioids, alcohol, muscle relaxants) exhibit hypotensive effects, especially during initiation of therapy and dose escalation. Coadministration with antihypertensive agents, in particular vasodilators and alpha-blockers, may result in additive effects on blood pressure and orthostasis.

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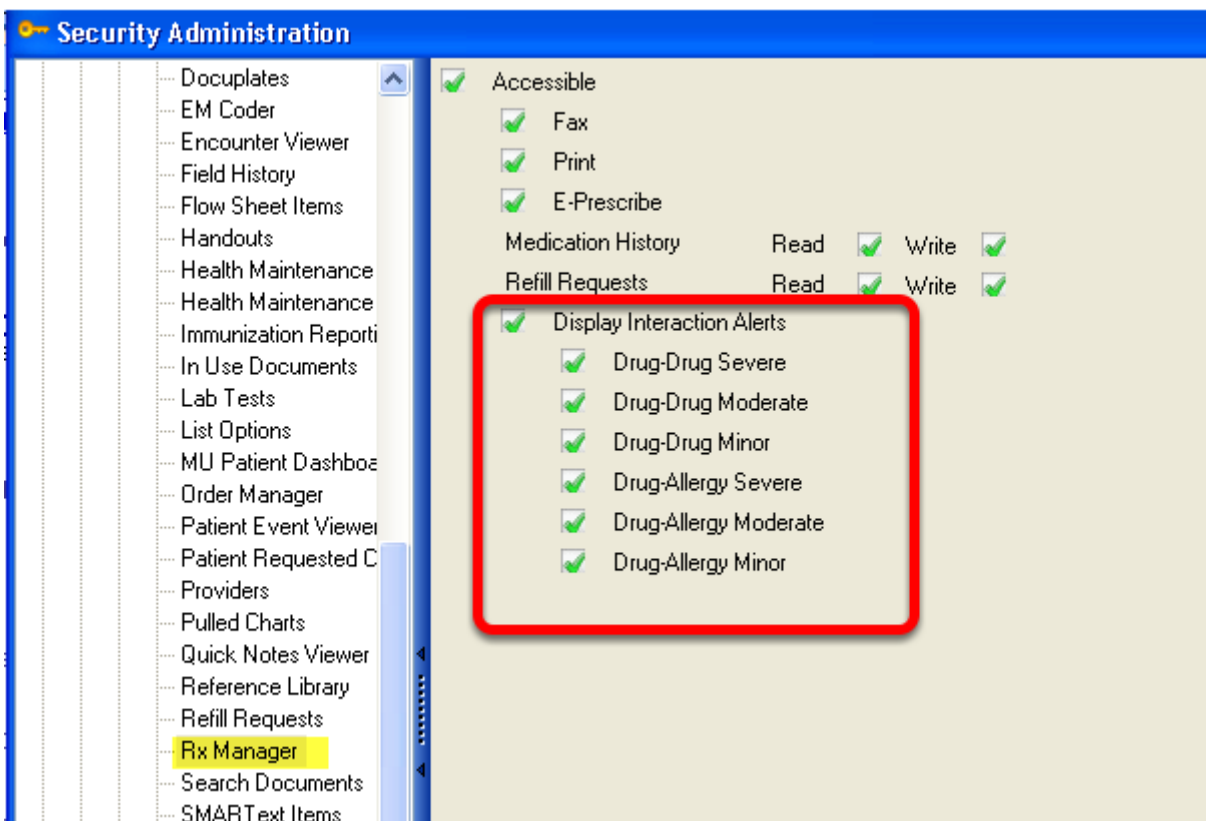
**Moderate**  
Darvocet-N 100 (Propoxyphene-Acetaminophen):  
Diovan HCT (Valsartan/HCTZ):  
Rx/Rx

**MONITOR:** Many psychotherapeutic and CNS-active agents (e.g., anxiolytics, sedatives, hypnotics, antidepressants, antipsychotics, opioids, alcohol, muscle relaxants) exhibit hypotensive effects, especially during initiation of therapy and dose escalation. Coadministration with antihypertensive agents, in particular vasodilators and alpha-blockers, may result in additive effects on blood pressure and orthostasis.

**MANAGEMENT:** Caution is advised during coadministration of these agents. Close monitoring for development of hypotension is recommended. Patients should be advised to avoid rising abruptly from a sitting or recumbent position and to notify their physician if they experience dizziness, lightheadedness, syncope, orthostasis, or tachycardia.

The combined tab will breakdown each interaction with monitoring and management information.

## Interaction Severity Settings



Within Security Setting is an area to designate what level of interaction a user wishes to be alerted about.

For more information see: [Security - Drug Interaction Filtering](#).

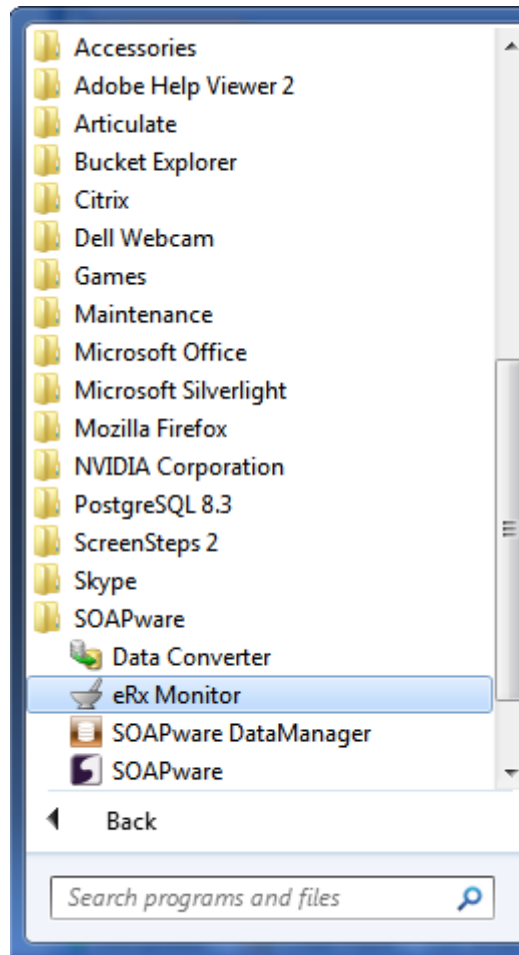
## eRx Monitor

---

This application is used to download a user's refills from Surescripts. If the application is running every 15 minutes, it will look at the Surescripts Server to see if the user has any refills to download. eRx Monitor needs to run only on one computer for the day.

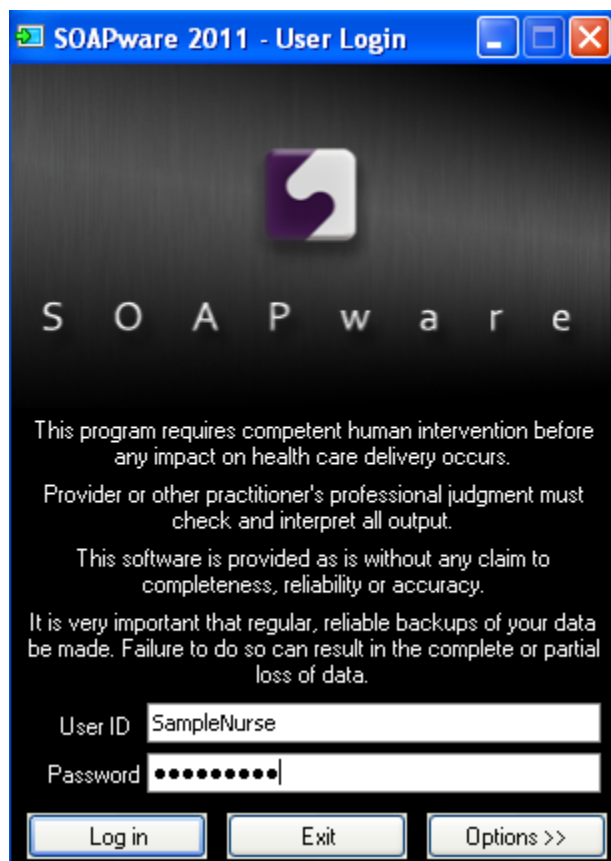
**Important:** The user will automatically be signed up for refill requests with SOAPware. The user must sign in to the eRx Monitor daily to receive those refill requests from the pharmacy.

### Starting eRx Monitor



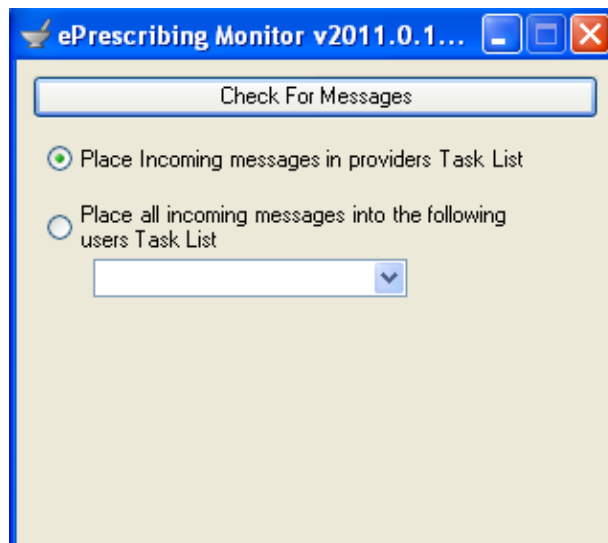
1. Click the Windows Start button.
2. Click the All Programs menu item.
3. Click the SOAPware menu item.
4. Click the ERx Monitor menu item.

## Signing In



Sign in as usual with a SOAPware log-in.

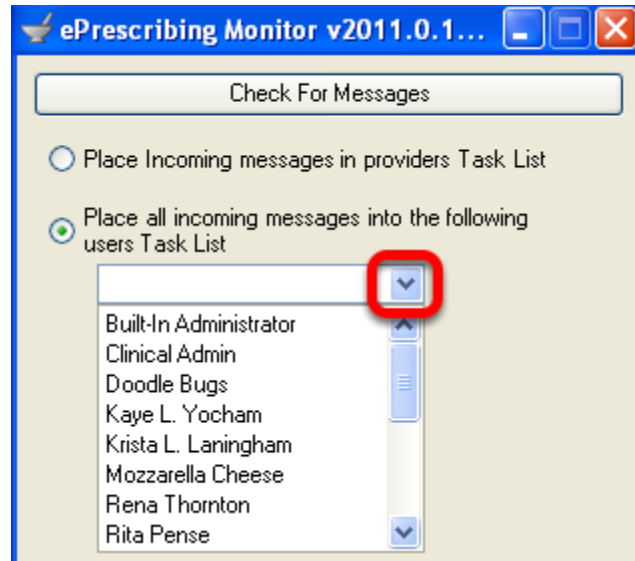
## Check for Messages



Click the Check for Messages button as needed.

Minimize the ePrescribing Monitor dialog and leave it running while the clinic is open.

## Select User Task List



The user can have it direct Refill Requests to the provider's task list or a certain task list the user chooses. The user can find any new refill requests in the Task List the user set to send the refills to.

In SOAPware, the user can also find all open Refill Requests by going to View > All-Refill Requests.

## Anti Tampering Features

---

Regarding Medicaid printed prescriptions, CMS has recently clarified their definition of secure printing to enable EMRs to directly print a secure prescription without the need for expensive security paper. Of course, the easiest route to preventing prescription fraud and errors is to directly submit prescriptions via electronic prescribing. The details of the CMS Guidelines can be found [here](#).

**Important:** It is not legal in any state to send scheduled medications electronically. Scheduled medications must be printed out and signed.

Check the state pharmacy boards for regulations about faxing scheduled drugs.

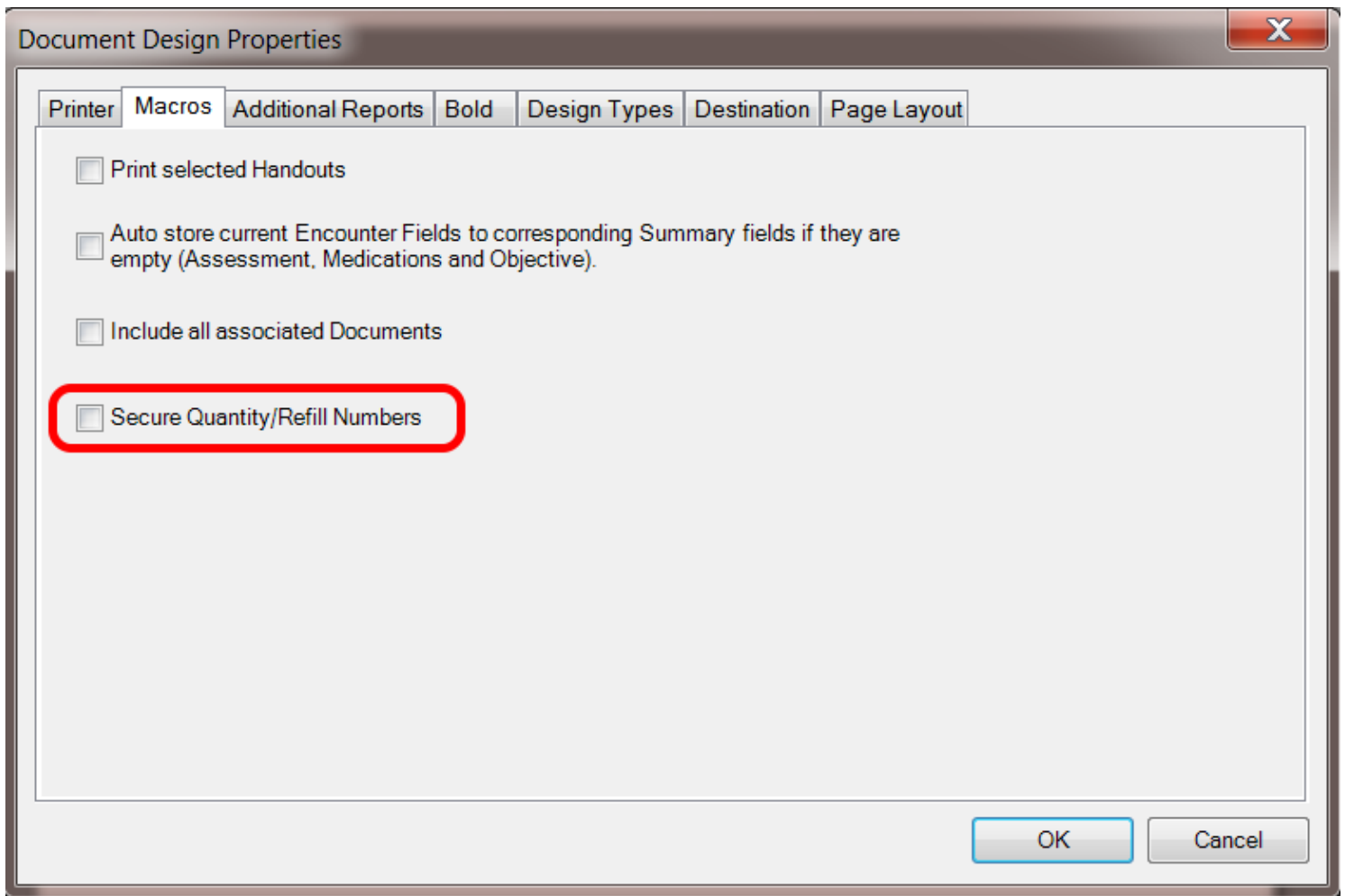
### Printing a Secure Rx from SOAPware

All 3 items are required in order for SOAPware to print secure prescriptions according to the rules.

1. Micro-printed Signature Line
2. Borders around the Quantity and Refill elements
3. Security features and descriptions listed on the prescription

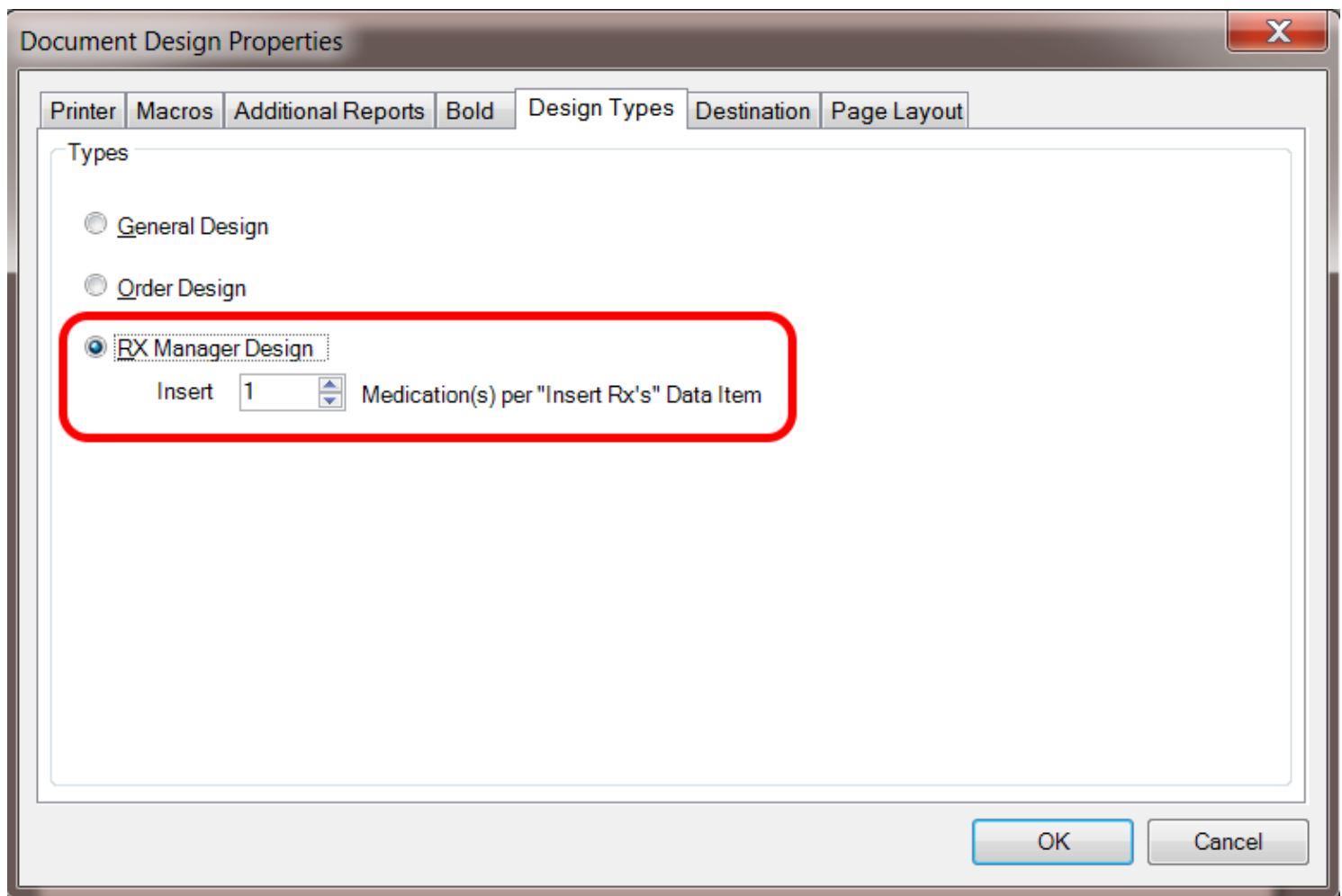
Micro-printing simply means the printing of a defined text string in a font too small to be copied (when it's copied it's either unreadable or appears as a line). Technically, it's defined as a font that is .5 points in size or smaller and requires 5x magnification or greater to read. The potential gotcha with printing these is that a user's printer may not be able to accurately reproduce fonts that small. It's suggested that the user print an Rx and view it under magnification to ensure the micro-printing is visible.

## Creating a "Secure" Rx Document Design



1. Open existing Document Design (Tools > Document Designer; Then choose File > Available Designs)
2. Display Document Design Properties (Edit > Design Properties)
3. Click on the 'Macros' Tab and check the box labeled - Secure Quantity/Refill Numbers

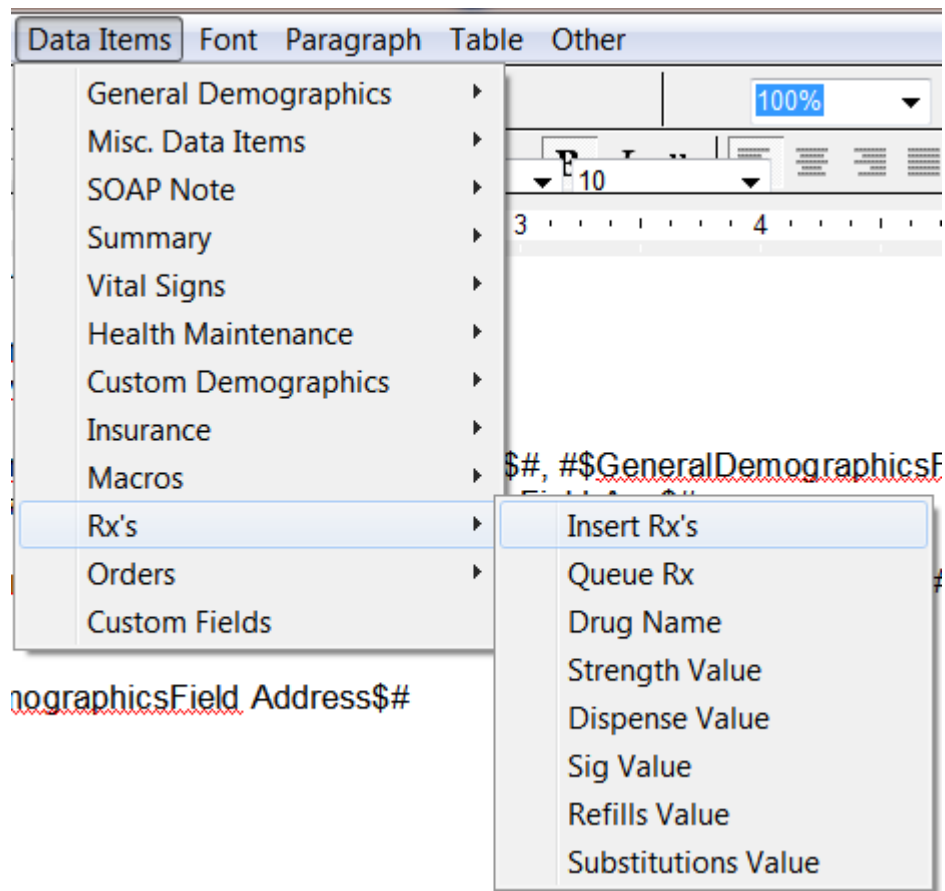
## Design Types



Select the Design Types tab and make sure Rx Manager Design is selected. The user can also select the number of Rx's per page to print.



## Insert Rx's



In the body of the Rx place the Command Data Items - Rx's - Insert Rx's at the location for the Rx(s) to be inserted.

## Signature Line

Rx:

**#\$RxPlaceHolder\$#**

Dr: \_\_\_\_\_ **#\$ClinicianSignature\$#** \_\_\_\_\_ **#\$CurrentProvider Full Name\$#** \_\_\_\_\_ **#\$CurrentProvider Full Name\$#**

Substitution permitted Dispense as written

Created with SOAPware Medical Software

**Regarding Refills:** After 12 months a medical history update and exam is necessary for any refills. Antibiot all addictive medications can not be refilled without a recheck in the clinic. Please call at least one day in adv refills of medications. Bring in all your prescription bottles for us to double check when you return for office vi

Current Medications: Please notify us if you are to be discontinued

Create a signature line that repeats "THIS IS AN ORIGINAL PRESCRIPTION" many times. We recommend using all caps to improve readability.

Set the font size of this line to ".5" by selecting the entire text, placing .5 in the Font Size drop down box in the tools bar and then pressing ENTER.

## Add Footer

---

Security Features: **\*\*surrounds both the Quantity and Refill numbers, the signature line is micro-printed with "THIS IS AN ORIGINAL PRESCRIPTION" and is viewable under 5x or > magnification.**

Click Edit > PageHeader/Footer and then Click into the Footer area of the document.

Enter the following text ***"Security Features: \*\* surrounds both the Quantity and Refill numbers, the signature line is micro-printed with 'THIS IS AN ORIGINAL PRESCRIPTION' and is viewable under 5x or > magnification."***

Then, save the document design by clicking File > Save.

## Default Rx Print Designs

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Options in the Printing-Faxing tab are used to define the default reports to use when Rx Manager is used to print and fax prescriptions. In previous versions, the layout of faxed prescription was hard-coded into the program. This has been changed to allow faxed prescriptions to now have the flexibility and formatting as is found in the Document Designer.

### Tools - Options

To learn more about how to set up the default Rx print and fax designs, see: [Tools - Options](#).

## Scheduled Drug Routing

The Rx Manager is a user's ePrescribing station. It is here that the user will finalize medications, view prescription history, check eligibility status, and send prescriptions to pharmacies.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- ePrescribing (eRx)
- CPOE for Medication Orders

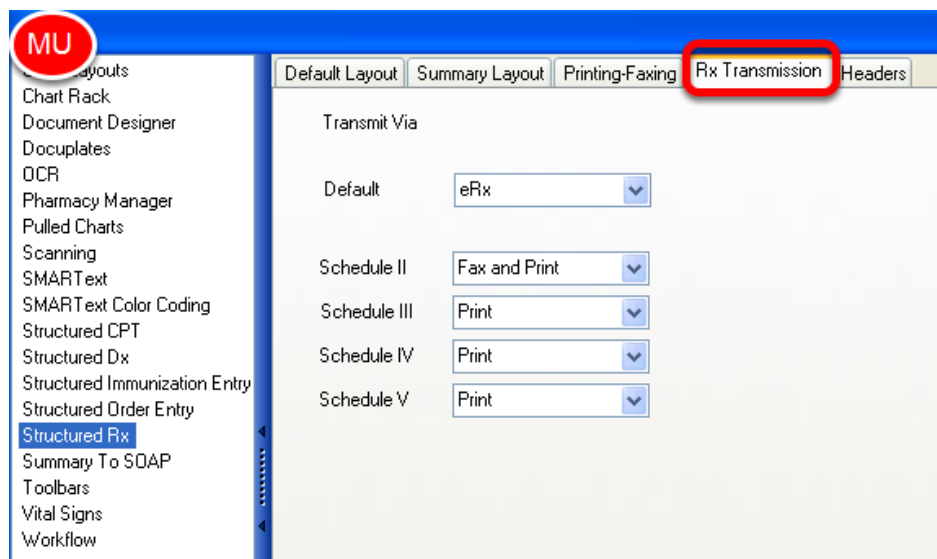
### Tools > Options

Scheduled drug routing is designated via: Tools > Options > Structured Rx > Rx Transmission.

The options on the Rx Transmission tab allows users to individually define how various, prescribed meds of differing schedules will be handled. There is much confusion here. At a national level, electronic transfer of any scheduled medications is illegal in all states. However, many state pharmacy boards allow for direct, manual faxing of some scheduled meds.

**\*NOTE: Users in almost every state have asked that we allow for initial faxing of scheduled meds (containing an image of their signature) from SOAPware. If the user chooses to do this, the user should implement workflows to subsequently provide pharmacies with a signed, hard-copy, paper prescription as a follow-up. The DEA is likely to announce rules that will allow electronic transmission of scheduled meds in the future.**

### Structured Rx-Rx Transmission



Rx Transmission is the default settings for how prescriptions are submitted from Rx Manager.

Controlled medications or narcotics cannot be ePrescribed at this time. These type of

prescriptions will need to be printed, faxed, or hand-written. If the Submit is set by default for ePrescribing, a narcotic or controlled medication will automatically be faxed.

Faxing of a scheduled medication or narcotic in all 50 states, requires a hand-written, fresh signature. However, some pharmacies, in some states will often accept a faxed prescription of a scheduled med that contains an image of a signature.

ePrescribed medications do not require an electronic or wet/fresh signature. When ePrescribing, there are coded identifiers in the background for that provider.

## Custom Sigs

In SOAPware, most medications have pre-built Sigs that cover the most common prescribing scenarios. If the user was a previous SOAPware user, the user will need to update the existing Rx's so that they contain the latest settings. This is easily accomplished via the Update SMARText command in the SMARText Items Manager

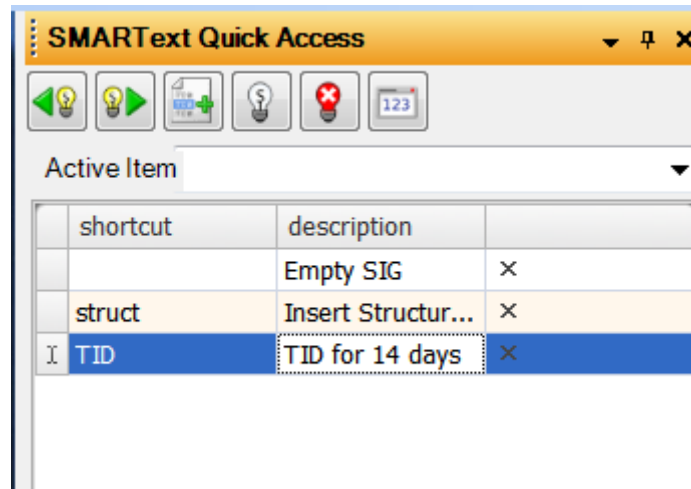
### Accessing Sigs

The screenshot shows the SOAPware interface. On the left, a window titled 'Radiology' contains a prescription note. The note includes instructions for a patient to take medication and lists several medications: acetaminophen (Tylenol), ibuprofen (Advil, Motrin), aspirin, cough syrup (Robitussin DM), and decongestants (such as Sudafed). Below the instructions, the word 'Medications' is highlighted in green. Under 'Medications', the text 'Tamiflu: SIG- [ 1 each 2 times a day orally ]' is highlighted in green. Below this, there are links for '#10 Substitutions Allowed', 'Refills- 0', 'Strength- Related Dxs-', 'Start Date-', and 'End Date-'. At the bottom of the window, there is a 'SOAPNote' button. On the right, the 'SMARText Quick Access' panel is open. It has a toolbar with icons for undo, redo, insert, delete, and a calendar. Below the toolbar, there is a dropdown menu labeled 'Active Item'. Below the dropdown, there is a table with three columns: 'shortcut', 'description', and a column with 'x' icons. The table contains three rows: the first row has a right arrow icon in the 'shortcut' column and 'Empty SIG' in the 'description' column; the second row has 'struct' in the 'shortcut' column and 'Insert Stru...' in the 'description' column; the third row has an asterisk icon in the 'shortcut' column and an empty 'description' column.

shortcut	description	
>	Empty SIG	x
struct	Insert Stru...	x
*		x

Available Sigs are accessed via the Quick Access display. Click on the SIG- header to activate. Clicking on the Sig list item in the Quick Access list inserts it into the prescription item.

## Adding Sigs



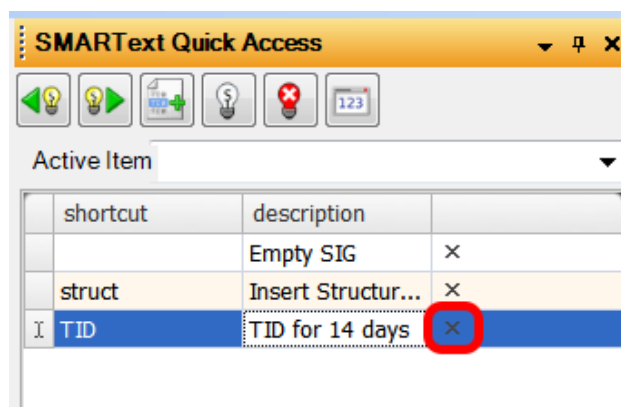
SOAPware allows users to modify the existing Sigs or add new ones at anytime.

To add a new Sig:

- 1: Select the empty sig line with the asterisk to the left.
2. The user must type a shortcut in the first column. This will not be entered into the SOAPnote medication, but is required to save the sig.
3. Type in the desired information directly into the Sig display. For example, we could add... tid for 14 days.
4. Click back to one of the previous sigs. This step will save the sig just created.
5. Click on the custom sig to insert it into the SOAPnote.

**NOTE: The Dispense/Quantity element does not automatically update based on the Sig.**

## Removing Sigs



Each Sig line has an X on the far right. Clicking on this will remove that Sig from the system.

**NOTE: The Empty Sig and Structured Sig items are always present. if removed, they will simply**

**be added the next time the Rx is activated.**



## Drug Course Creation

---

A new concept for SOAPware 2010 and later versions is the ability to have pick lists of customized Drug Courses for each individual medication. Meaning, each Drug Course can be displayed using customized text in the format the user prefers.

### What is a Drug Course?

What is a Drug Course? Drug Courses are the directions given (written) when prescribing a medication including, dose, route, frequency, substitutions, refills, etc.

Now, prescription details can match a format the prescribing clinician prefers.

For example, a Drug Course pick list item for Amoxicillin might include:

500mg tab, 1 tid, #30, Substitution-Allowed, R-0 or

250mg chewables 1 po tid for 10 days. Substitution-Not Allowed, 0 Refills

instead of:

500 mg (tablets) Dose- 1 each Freq- 3 times a day Route - orally Quantity-#30  
Substitution-Allowed Refills- 0

### Drug Courses

The user can create a prescription in whatever format is preferred, and have SOAPware store the values for future use. Even for the same drug, this process can be infinitely repeated to have as many different courses for that drug as desired. Subsequently, when the drug is prescribed, the user simply picks from the list of pre-defined Drug Courses in order to fill in all the prescription sub-items in one step.

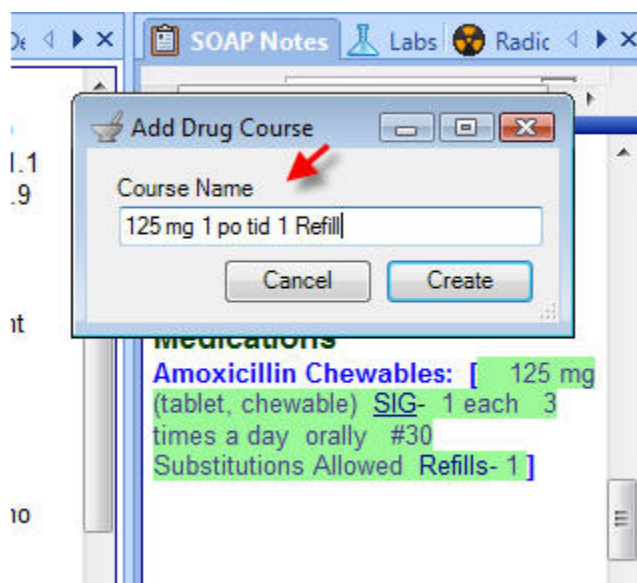
In earlier versions of SOAPware, the user had to first select the drug form, and then select a series of multiple sub-items for each Sig (i.e. Dose, Frequency, Route, etc.), dispense amounts, substitution status and refills. This created the need to have multiple, completed prescriptions for each medication, because a new one had to be created for each set of Form/Sig values.

Other considerations regarding Drug Courses include:

- \* Many different medications can have the same Drug Course.
- \* Drug Courses can be pre-defined, stored and selected via pick lists.
- \* Selecting a particular Drug Course will automatically place that course's values into the prescription.

\* Each Drug Course can be displayed using a user's own custom text (500 mg. tablet BID or 500 mg tab bid etc.).

## Creating Drug Courses



**IMPORTANT:** to use this feature optimally, go to the Tools menu > Options > Structured Rx > Click on the Headers tab and then make sure that there is NOT a check next to "Visible only when empty. Sig Header". Log out of SOAPware and log back in for this to take effect.

Insert SMARText medication into the medication field of the SOAPnote. To do this, type in the medication name and then press Shift F11 on the keyboard to search SMARText. Double click on the medication to insert it into the field.

Select the strength, SIG, Quantity, Substitutions and Refills.

Now, to create a new Drug Course, Right-click the drug name, and Click the Store Drug Course menu item. In the Store Drug Course dialog, Type the the Drug Course Description, for example, 125 mg 1 po tid. Click Create.

## Create as Many Courses as Needed for the Medication

**SMARTText Quick Access**

Active Item: n Chewables 250mg #30 1 tid

Description	
>	X
one po bid for 10 days	X
125 mg 1 po tid 1 Refill	X
400mg 1 po tid, no R...	X

**SOAP Notes** | **Labs** | **Radic**

**Plan**

**Medications**

**Amoxicillin Chewables:** [ 400 mg (tablet, chewable) SIG- 1 each 3 times a day orally #30 Substitutions Allowed Refills- 0 ]

Repeat the above steps for as many Drug Courses as needed for the medication.

## Removing a Course

To remove a course, Click the X that is located in Quick Access next to the Description of the one to remove.

## eRx Workflow

To access Rx Manager use the F8 key, right click over Medications in the SOAPnote or select Docutainers > Rx Manager from the menu.

**\*NOTE:** SMARText medications must be entered in the Summary medications field and the SOAPnote medications field to be ePrescribed. The patient's General Demographics section must contain the full patient name, birth date, and address.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

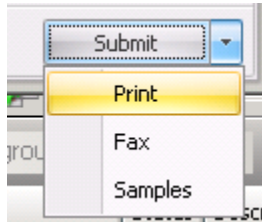
- [ePrescribing \(eRx\)](#)
- [CPOE for Medication Orders](#)

### ePrescribing a Prescription

The screenshot shows the Rx Manager application window. At the top, there are tabs for 'Rx Pad', 'Medications', 'History', and 'Patient - Refill Requests'. Below these is a pharmacy selection dropdown menu, which is highlighted with a red box and contains the text: 'Pharmacy COLIER DRUG STORES-NORTH HILLS (Ph#- 479-443-9200 Fax#- 479-443-9295) 3380 N. FUTRALL DRIVE ...'. Below the pharmacy selection is a section for 'Patient Information' containing 'Allergies' and 'Notes' fields. Below this are buttons for 'Add Rx', 'Update Summary', and 'Interactions', along with a 'Show Header' checkbox. The main area is a table with columns for 'Actions', 'Rx', and 'Mi'. The first row shows a checked checkbox in the 'Actions' column, a red circle icon, and the text 'Atenolol (Tenormin): 100 mg (tablet)' in the 'Rx' column. Below this, it says '1 each once a day orally'. The second row shows 'Unknown' in the 'Actions' column, '#90' in the 'Rx' column, and 'Substitutions Allowed' and '3' in the 'Mi' column. At the bottom left is a 'Retrieve Eligibility Info' button, and at the bottom right is a 'Submit' button, which is highlighted with a red box.

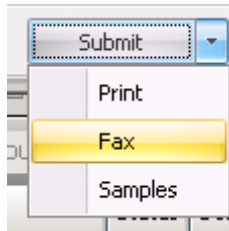
Clicking the submit button will transmit the prescription by ePrescribing. A participating pharmacy must be selected for ePrescribing. The submit button default setting is for ePrescribing. This action can be edited in Tools. See [Tools - Options](#).

## Printing a Prescription from Rx Manager



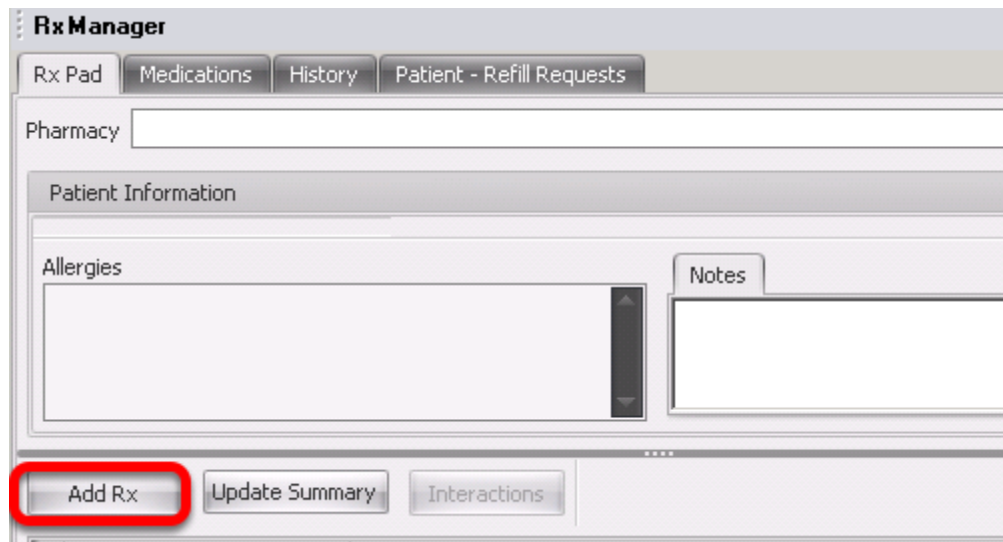
Click the drop-down arrow and highlight Print.

## Faxing a Prescription from Rx Manager



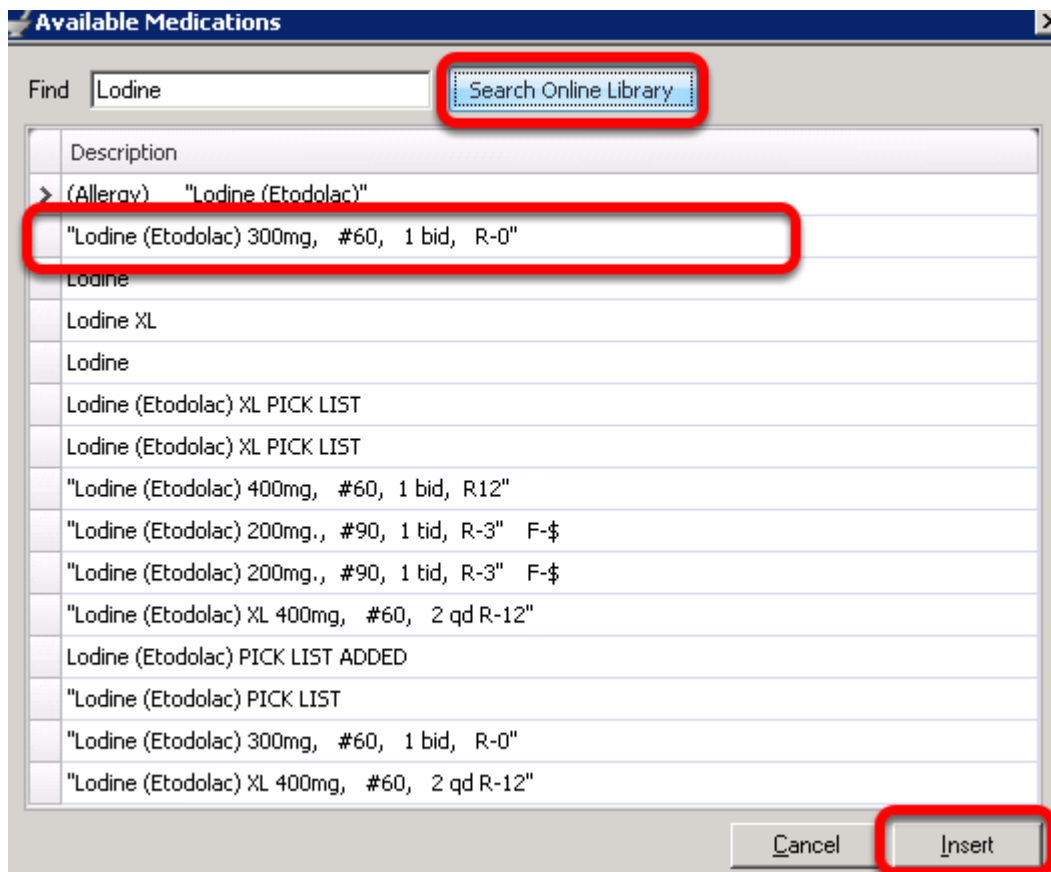
Click the drop-down arrow and highlight Fax. To note samples given for a patient, Click Samples.

## Adding a Prescription in Rx Manager



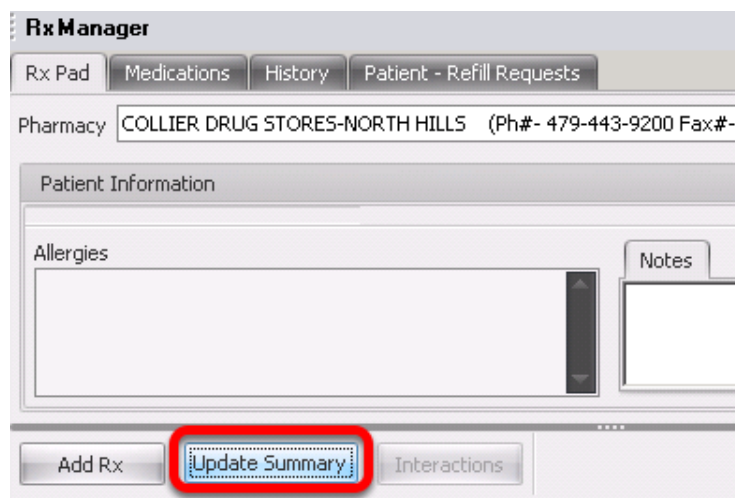
Click the Add Rx button.

## Checking Available Medications



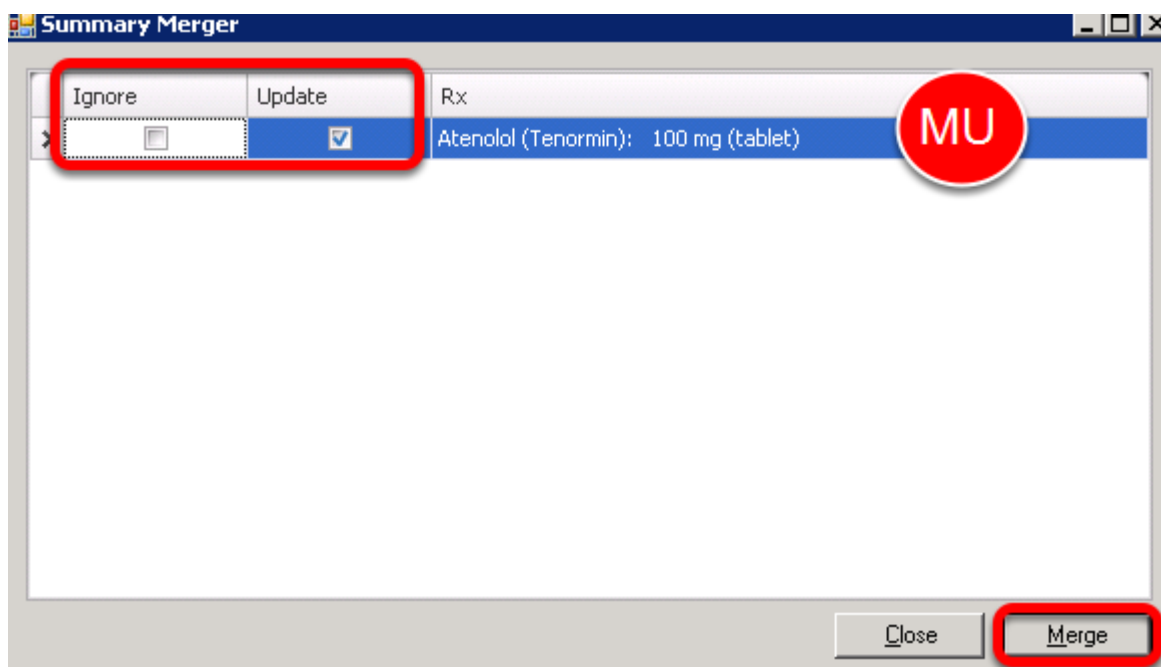
Enter name of medication for the search. Click the Search Online Library button. A list will populate related to the entered medication. Click to highlight medication, then Click Insert to place on Rx Pad.

## Updating Summary Medications



Clicking on Update Summary will take the user to the Summary Merger Display.

## Summary Merger



Medications can be updated/merged to the Summary Medications.

## G-Codes for Medicare Electronic Prescribing Bonus

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It is necessary to use SOAPware 2010.1 (or later) in order to qualify for the ePrescribing bonus.

For additional information regarding this initiative, visit the [CMS ePrescribing site](#).

### Using the G-Code

Practices that meet the ePrescribing criteria will be eligible for a 2 percent bonus in 2009 and 2010, a 1 percent bonus in 2011 and 2012 and a 0.5 percent bonus in 2013. Practices not ePrescribing will face a 1 percent cut in 2012 and 2013. That cut will grow to 2 percent in 2014 and beyond.

In order to participate, physicians simply add the following G-code to their Medicare claims for patient encounters:

Shortcut code: **eRx**

G-code: **G8553**

Description: At least 1 Rx via qualified eRx system

Explanation: All prescriptions created during the encounter were generated using a qualified ePrescribing system

### Notes

E&M services must be at least 10% of total allowed Medicare charges.

In addition, the physician must report the G-code, above, for at least 50% of the cases in which they apply (i.e..encounters with E&M codes).

The bonus is based on total Part B payments and not just E&M

The Average bonus is around \$1600/physician/year (ePrescribing is only \$500/physician/year)

This eRx bonus is in addition to other bonus programs such as the PQRI.



## Additional Codes Needed

The G-code must be listed as an additional procedure code on the standard claim form. However, it appears the electronic prescribing G-code has to be listed with one of the below codes in order for the G-code to be valid.

- \* (New Patient) 99201, 99202, 99203, 99204, 99205
- \* (Established Patient) 99211, 99212, 99213, 99214, 99215
- \* (Consultations) 99241, 99242, 99243, 99244, 99245
- \* (Psych Services) 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809
- \* (Behavioral Assessment) 96150, 96151, 96152
- \* (Screening & Diabetic Training) G0101, G0108, G0109.
- \* (Eye Codes) 92002, 92004, 92012, 92014

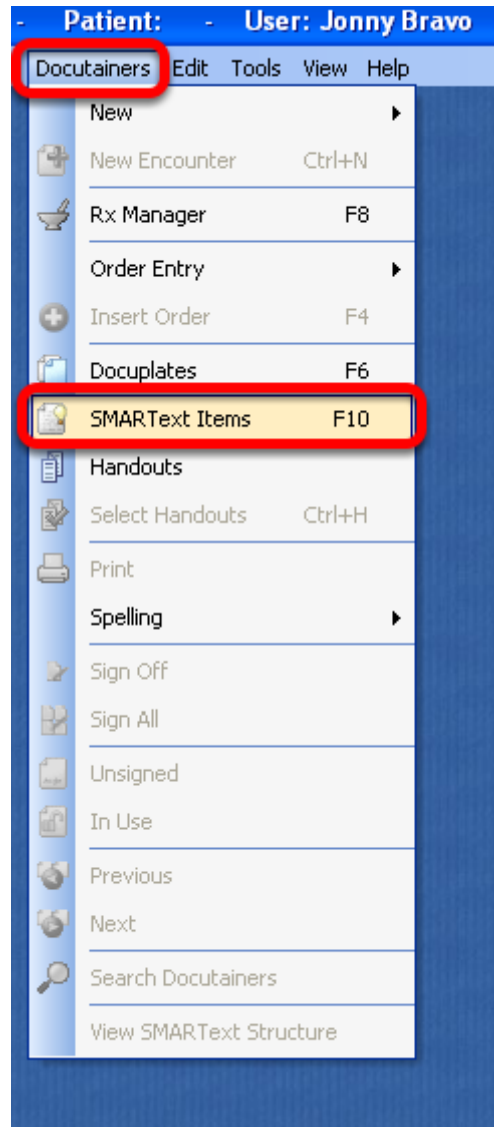
## Creating SMARText Prescriptions for Durable Medical Supplies

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Durable Medical Supplies can now be created as SMARText Items and **printed** or **faxed** from the Rx Manager.

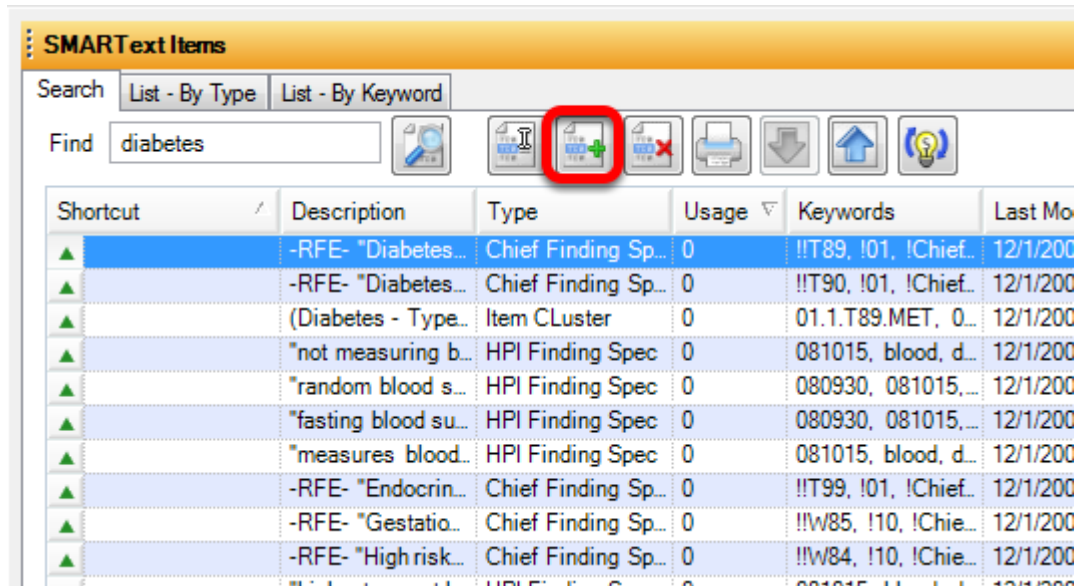
In this lesson we are going to create a prescription for Lancets.

### Accessing the SMARText Items Manager



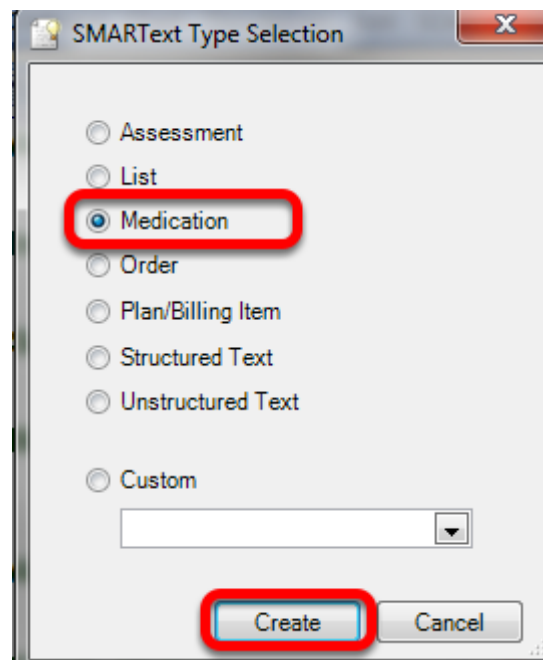
- 1) Click on Docutainers on the Menu Bar
- 2) Click on SMARText Items

## Creating a New Item



1) Click on the Green + to create a Medication Item.

**\*Note:** this should only be done when creating DME Items. Prescription medications should be duplicated and then edited. See [Creating SMARTText Items in the SMARTText Items Manager](#).



1) Click the radio button next to Medication.

2) Click Create.

SMARText Designer

Shortcut:  1

Description:  2

Keywords:  3

☒ Display Header  4 ☐ only when item is empty.

Advanced

General

Item Type:

Strength- [ ] Sig- Quantity- Substitution- Refills- Related Dxs- Start Date- End Date- Comment- Notes-

Item Properties

Item Settings

Item Separators

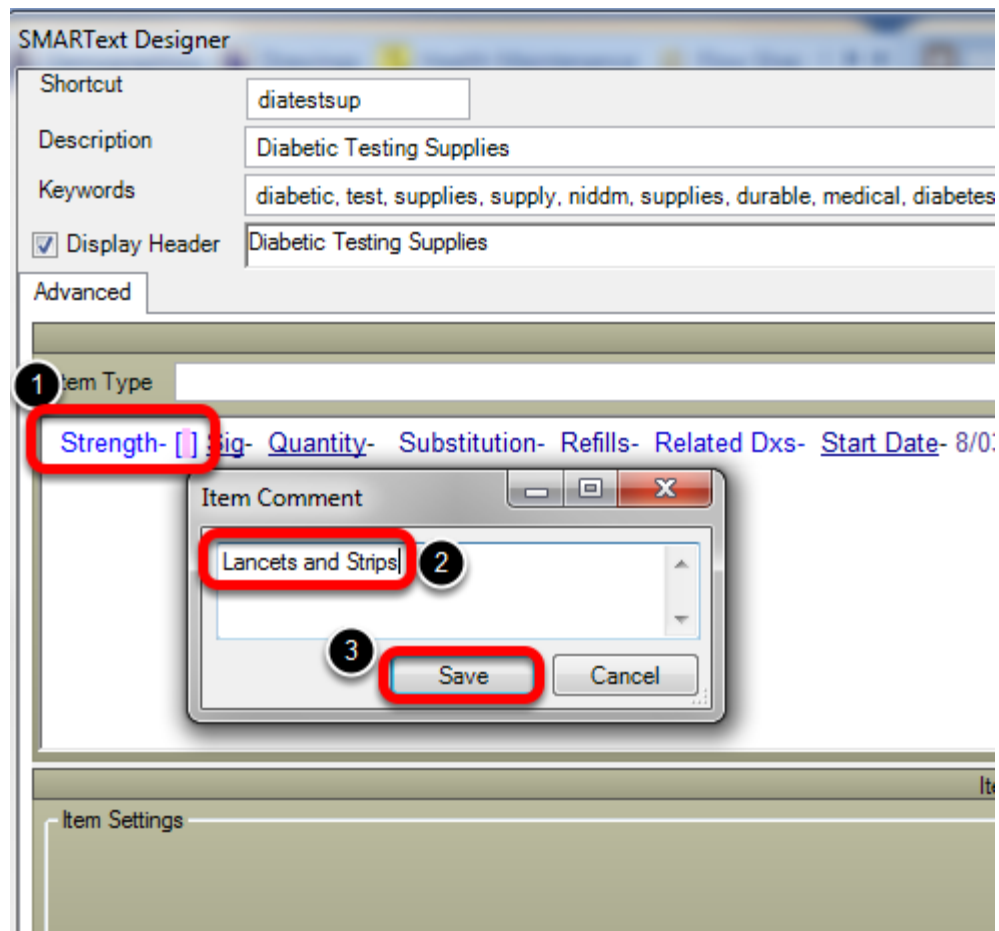
☐ As Is ☐ English List (and)

☒ Separate with  ☐ English List (or) ☐ End with

☐ Separate Lines

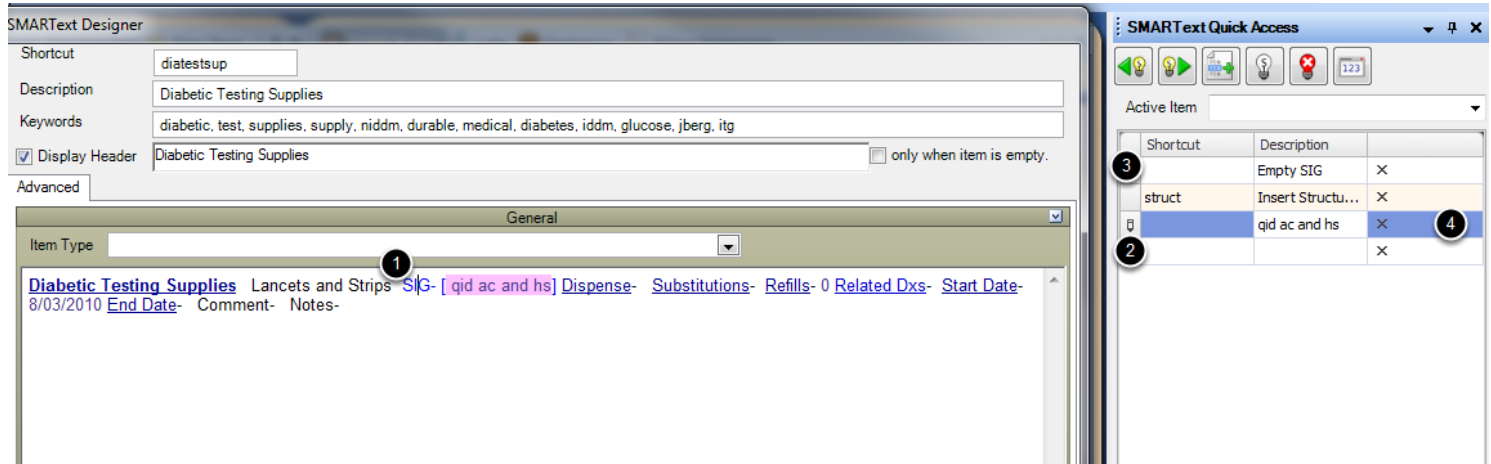
- 1) Enter Shortcut
- 2) Enter Description.
- 3) Enter Keywords
- 4) Check Box next to Display Header and Enter "Diabetic Testing Supplies."

## Entering the Strength



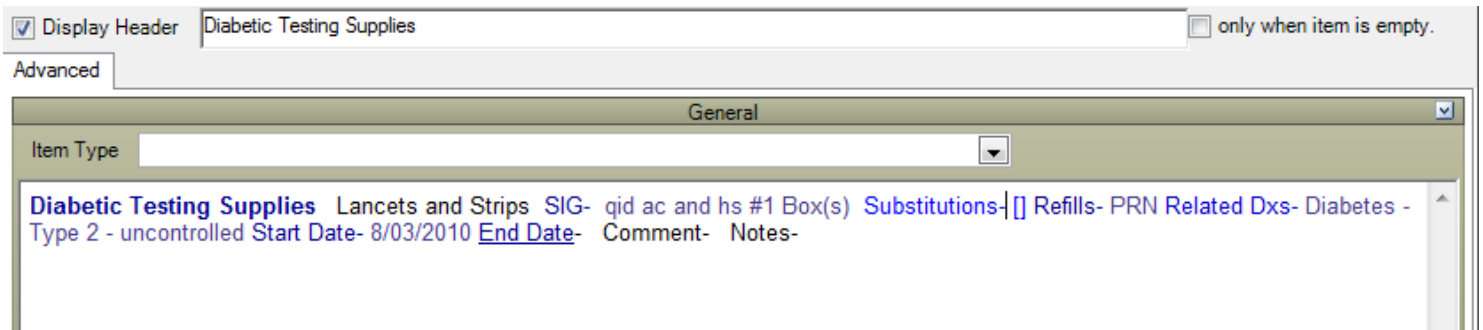
- 1) Left-click on Strength to bring up the Item Comment box.
- 2) Type in the Item Comment box "Lancets and Strips."
- 3) Click Save.

## Entering the Sig



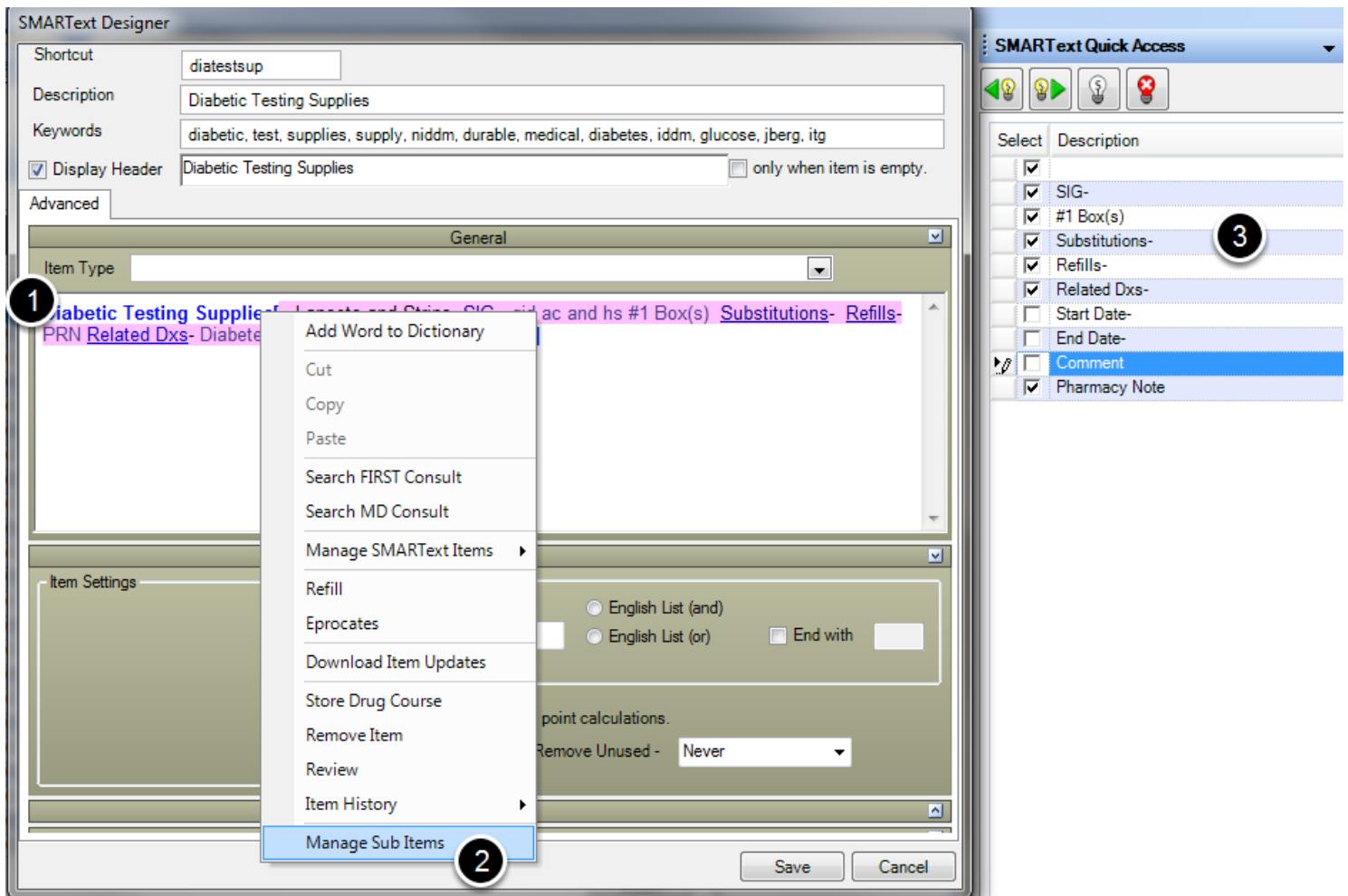
- 1) Left-click over Sig.
- 2) Create a new Sig by clicking in the blank sig line in the SMART Quick Access and enter personal Sig.
- 3) Click on the Empty SIG to save the newly created sig.
- 4) Click on the sig created to Insert this into the SMARText item.

## Fill out Remaining Items



Fill in Dispense number, Substitutions, and Refills.

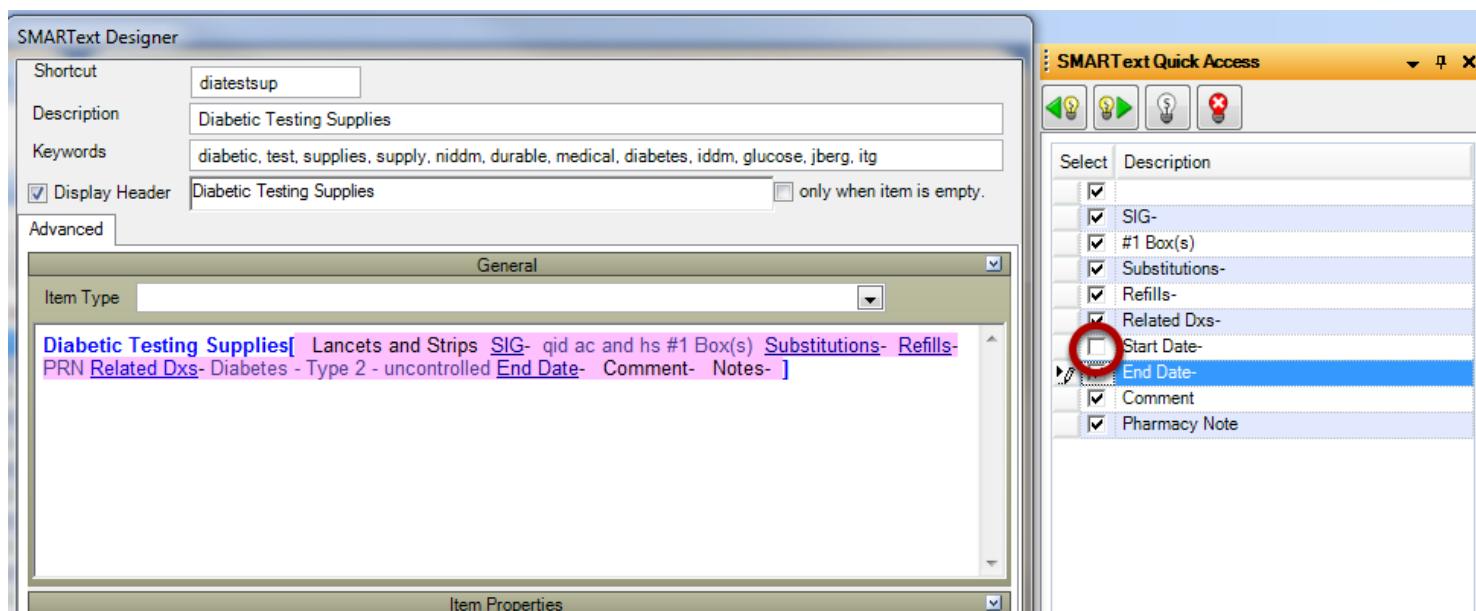
## Removing Sub Items



The SMARTText item will have sub items associated with a medication.  
To remove the sub items not needed:

- 1) Right-click over the SMARTText header.
- 2) Choose "Manage Sub items."
- 3) In the SMARTText Quick Access, un-check the sub items not needed, leaving only the sub Items Strength, Sig, Quantity, Substitutions Refills, and Related Dx.

**DO NOT CLICK SAVE AT THIS POINT**



Users are to un-check items he/she does not wish to display on the prescription such as: Start Date and End Date, Comments.



## Saving the Item

SMARTText Designer

Shortcut: diatestsup

Description: Diabetic Testing Supplies

Keywords: diabetic, test, supplies, supply, niddm, durable, medical, diabetes, iddm, glucose, jberg, itg

☒ Display Header: Diabetic Testing Supplies ☐ only when item is empty.

Advanced

General

Item Type: **Diabetic Testing Supplies** Lancets and Strips SIG- qid ac and hs #1 Box(s) Refills- PRN Related Dx- Diabetes - Type 2 - uncontrolled Notes- ]

Item Properties

Item Settings:

Item Separators:

- ☐ As Is
- ☒ Separate with
- ☐ Separate Lines
- ☐ English List (and)
- ☐ English List (or)
- ☐ End with

☒ Include in EM Coder point calculations.

Remove this item via Remove Unused -

Coding / Notes

Structure Viewer

Save Cancel

Complete the item and ensure that the item looks as it should be prescribed.  
Hit Save.

## Inserting the Prescription into the Chart

Medications[  
diatestsup  
]



Medications  
Diabetic Testing Supplies Lancets and Strips SIG- qid ac and  
hs #1 Box(s) Substitutions- Refills- PRN Comment- Notes-

In the Medication field of the SOAPnote, enter the shortcut, followed by the space bar.

## Related Diagnosis

Date/Time 08/03/2010 9:42 AM

**Subjective**

**Objective**  
Exam: GENERAL: Appearance: General appearance can be described as well-nourished, well-developed, and in no acute distress.

**Assessment**  
Diabetes - Type 2 - uncontrolled ICD#250.02

**Plan**

**Medications**  
Diabetic Testing Supplies Lancets and Strips SIG: aid as and  
hs #1 Box(s) Subs

**Follow Up**  
Return if problems c

**SOAPNote**

Drag a column head

Date/Time  
8/3/2010 9:42:55  
8/2/2010 9:40:27

Rx Manager

Context Menu:  
Add Word to Dictionary  
Cut  
Copy  
Paste  
Search FIRST Consult  
Search MD Consult  
Manage SMARText Items  
Refill  
Eprocates  
Download Item Updates  
Store Drug Course  
Remove Item  
Review  
Item History  
Manage Sub Items

SMARText Quick Access:

Select	Description
<input checked="" type="checkbox"/>	SIG-
<input checked="" type="checkbox"/>	#1 Box(s)
<input checked="" type="checkbox"/>	Substitutions-
<input checked="" type="checkbox"/>	Refills-
<input checked="" type="checkbox"/>	Related Dxs-
<input type="checkbox"/>	Start Date-
<input type="checkbox"/>	End Date-
<input checked="" type="checkbox"/>	Comment
<input checked="" type="checkbox"/>	Pharmacy Note

If the patient, insurance or pharmacy require a Related diagnosis:

- 1) Right-click on the Item Header.
- 2) Select "Manage Sub Items."
- 3) Check "Related Dxs" in the SMARText Quick Access.

\*\* In the Default Layout (Tools > Options > Structured Rx) if the user has Related Diagnosis checked, this will automatically display Related Diagnosis and the user will not need this step\*\*

## Printing or Faxing the Prescription

**Rx Manager**

Rx Pad | Medications | History | Patient - Refill Requests

Pharmacy: \*Fake SOAPware Pharmacy (Ph#- Fax#- 866-237-9073)

Patient Information

Allergies

Notes

Add Rx | Update Summary | Interactions | Show Header

Actions	Rx	Misc	
<input checked="" type="checkbox"/>	<b>Diabetic Testing Supplies</b>	<b>Lancets and Strips</b>	Pending 8/3/20
	qid ac and hs	*Fake SOAPware Pharmacy	
> Unknown	#1 Box(s)	Jennifer Berg	
		Strength Comment Not Allowed	
		Coverage Details	

Retrieve Eligibility Info

Submit

Print

Fax

Samples

- 1) Press the F8 key on the keyboard ( or right-click over the Medication field header and choose Rx Manager) to bring up the Rx Manager. The dose will say "Strength Comment Not Allowed". This warning will not affect printing or faxing the prescription.
- 2) Click on the drop-down arrow next to the Submit Button.
- 3) Choose Print or Fax.

## Item Sent

Rx Manager

Rx PadMedicationsHistoryPatient - Refill Requests

Drag a column header here to group by that column

Action	Drug	Status	Details	Notes	Pharmacy	Ren
Type	Sent	Response				
	Fill Date	Provider				
Refill	<b>Diabetic Testing ...</b>	Sent	Strips and Lancets SIG- bid ac and hs #1 Box(s) Substitutions Allowed Refills- PRN Related Dxs- Diabetes - Type 2 - uncontrolled Notes-		*Fake SOAPware Pharmacy Ph# - Fax# - 8662370973	
Printed	8/3/2010	Unknown				
	1/1/0001	98597f08-4f1e-4...				
Refill	<b>Diabetic Testing ...</b>	Sent	Strips and Lancets SIG- bid ac and hs #1 Box(s) Substitutions Allowed Refills- PRN Related Dxs- Diabetes - Type 2 - uncontrolled Notes-		*Fake SOAPware Pharmacy Ph# - Fax# - 8662379073	
Faxed	8/3/2010	Unknown				
	1/1/0001	98597f08-4f1e-4...				

Certain information may not be available or accurate in this report, including items that the patient asked not be disclosed due to patient privacy concerns, over-the-counter medication, and other information that may be subject to change.

The item has now been either faxed to the pharmacy or printed. The prescription will now display in the History tab of the Rx Manager.

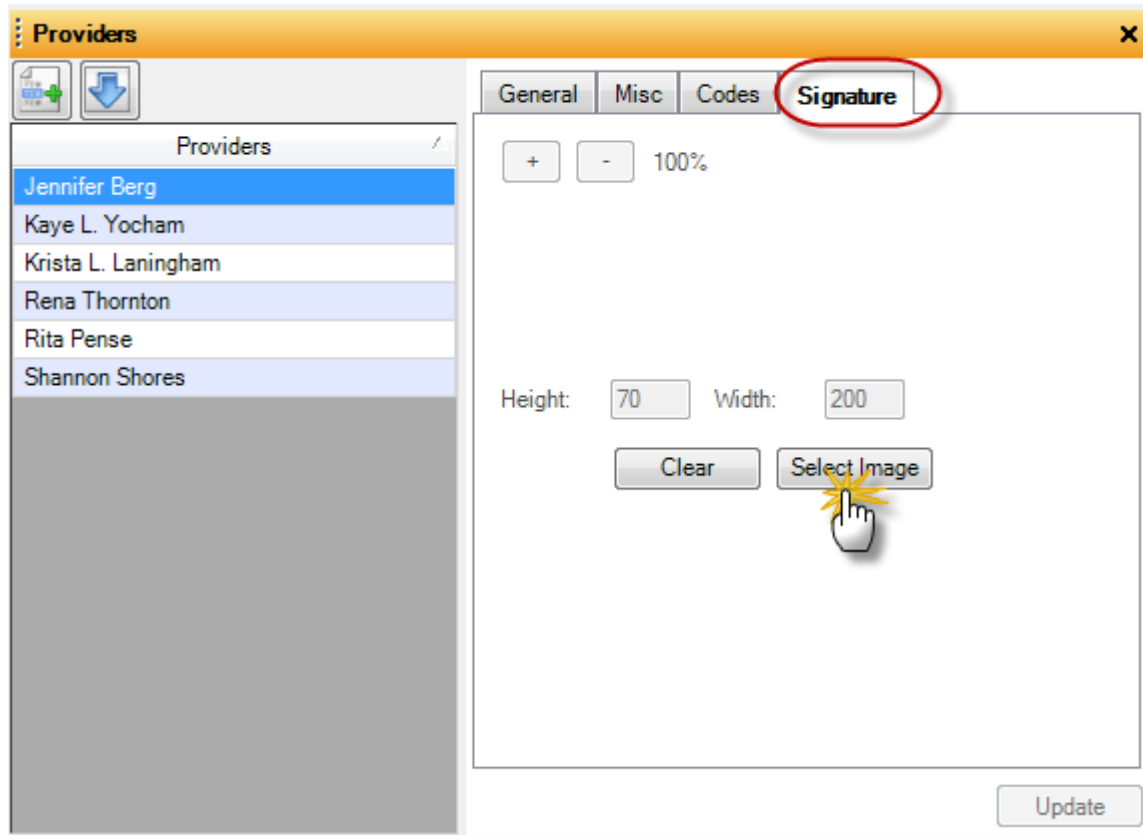
## Faxing and Printing from Rx Manager

This lesson will explain the steps required for setup prior to Printing or Faxing from the Rx Manager.

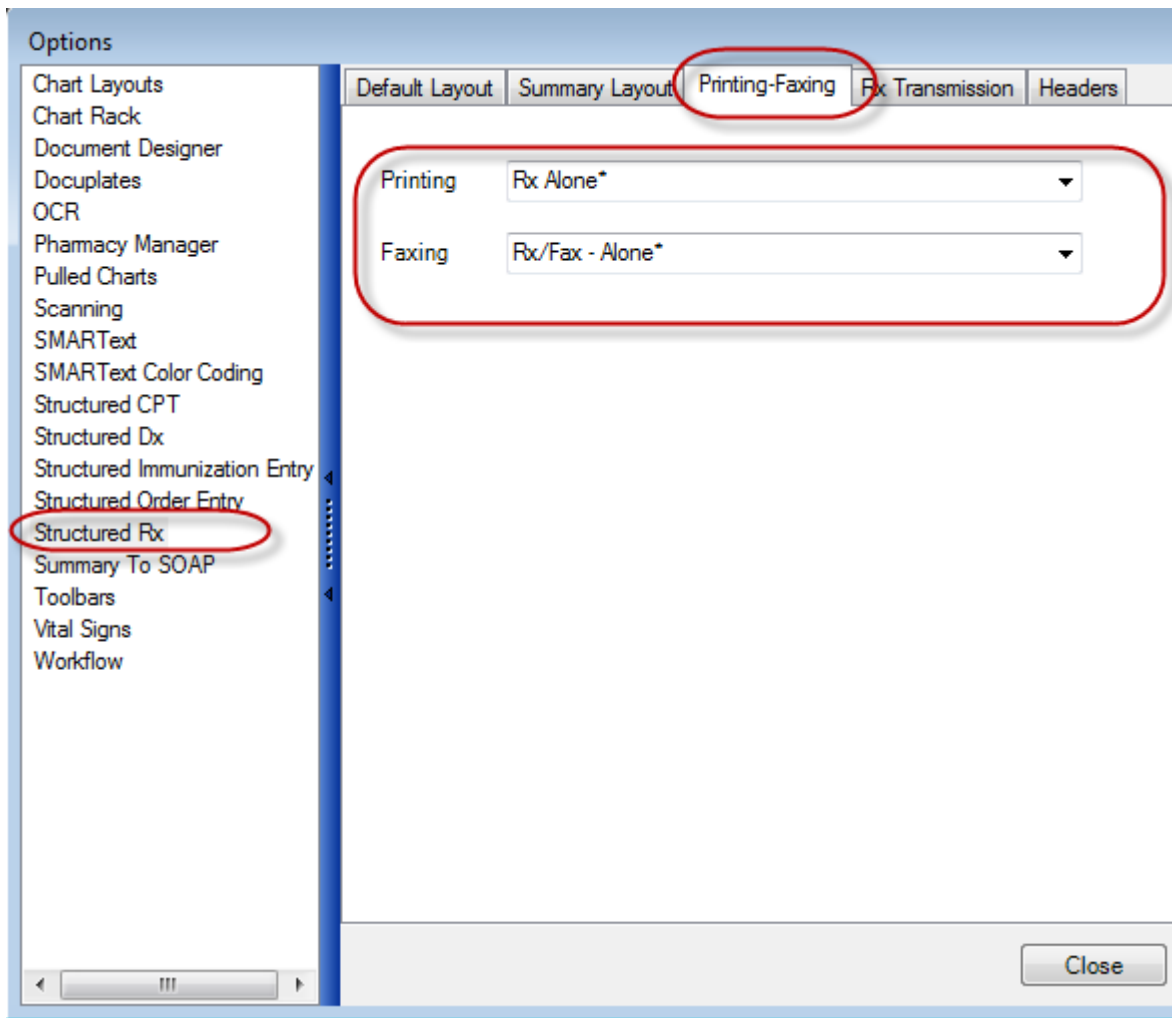
**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- ePrescribing (eRx)
- CPOE for Medication Orders

**Store the provider's signature in SOAPware.**

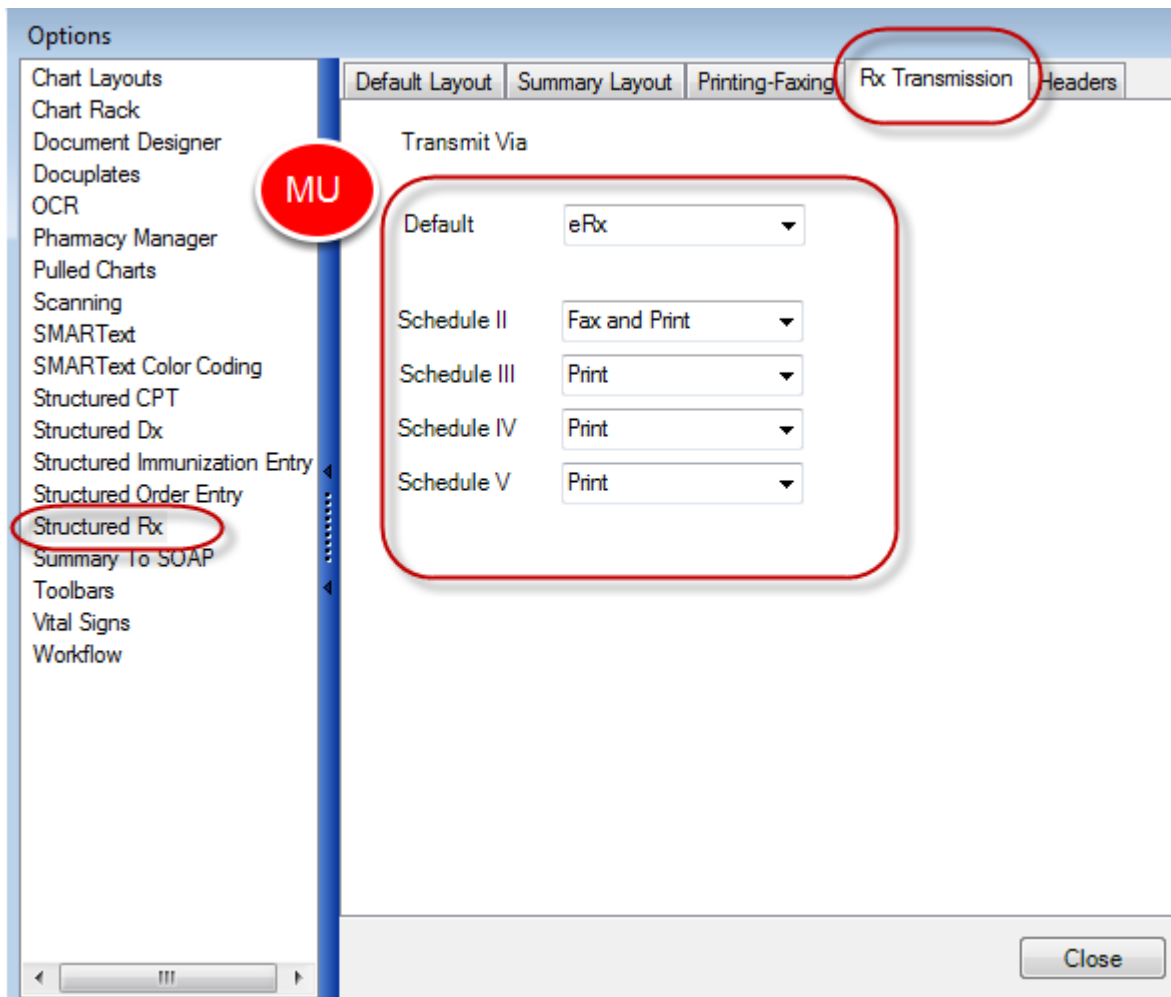


Prescriptions that will be faxed from SOAPware will need to have the provider's signature on the document design. The first step is to store the provider's signature in the Provider Manager. For more information, see: [Provider Manager](#).



After the provider's signature has been saved, the default Rx designs will need to be set. This is done under Tools > Options. Document designs for both printing and faxing have been created by SOAPware. If a different design is currently used in the network for printing, then a new design will need to be created with the data command for the provider's signature placed on the document for faxing. For more information about creating a document design [Click here](#). For more information on Entering Data commands [Click here](#).

## Setting Default Action



Within the Rx Manager, SOAPware has the ability to perform multiple actions when the submit button is clicked based on each user's personalized preferences. This is set under Tools > Options. With this example all non-scheduled medications will be ePrescribed to the pharmacy, scheduled II medications will be faxed to the pharmacy and printed in to the default printer, and all scheduled III-V medications will be printed to the default pharmacy.

# **Introduction to Document Designer**



## About Document Designer

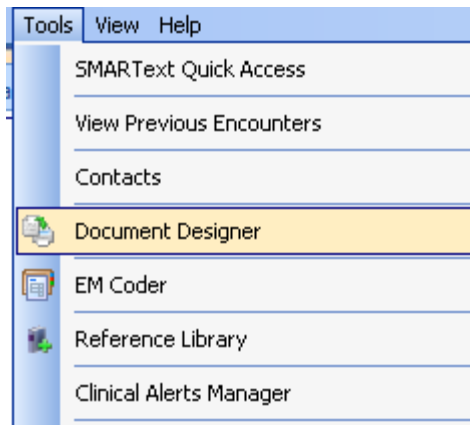
---

Document Designer (DD) can be used to design and edit documents which can be printed or faxed (when a user has the SOAPware Faxing Module) from SOAPware, i.e. referral letter, reports, etc. Documents can be created using free text or free text combined with commands and macros that automatically transfer data from a patient chart, e.g. patients name, demographics, vital signs, EKG/ECG reports, etc.

### Importance of Demographics, Provider Manager, and Contacts

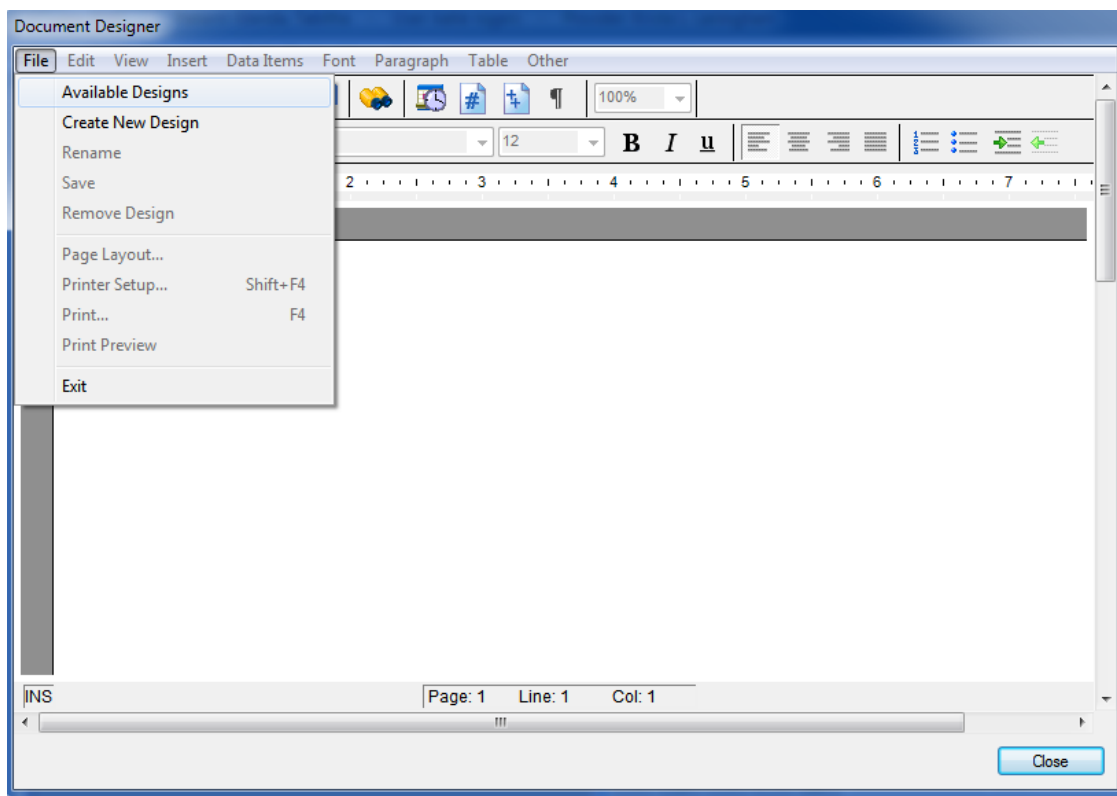
The Demographics, Provider Manager, and Contacts section of the patient chart needs to be filled out completely in order for information from these areas to be pulled onto a final document design.

### Using Document Designer



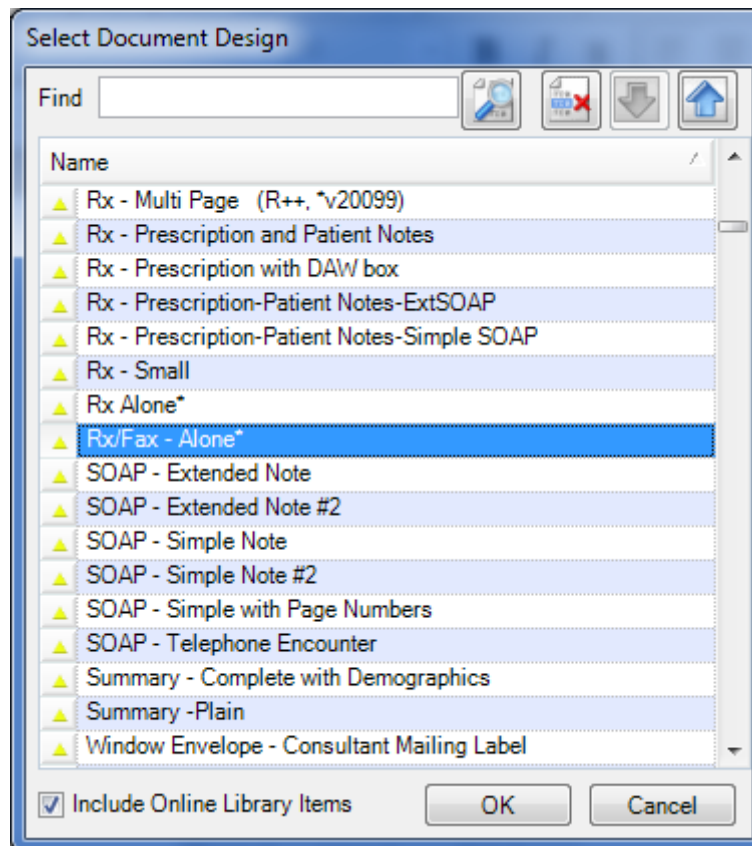
To access Document Designer, Click Tools in the menu bar, and then Click the Document Designer menu item.

## Available Designs



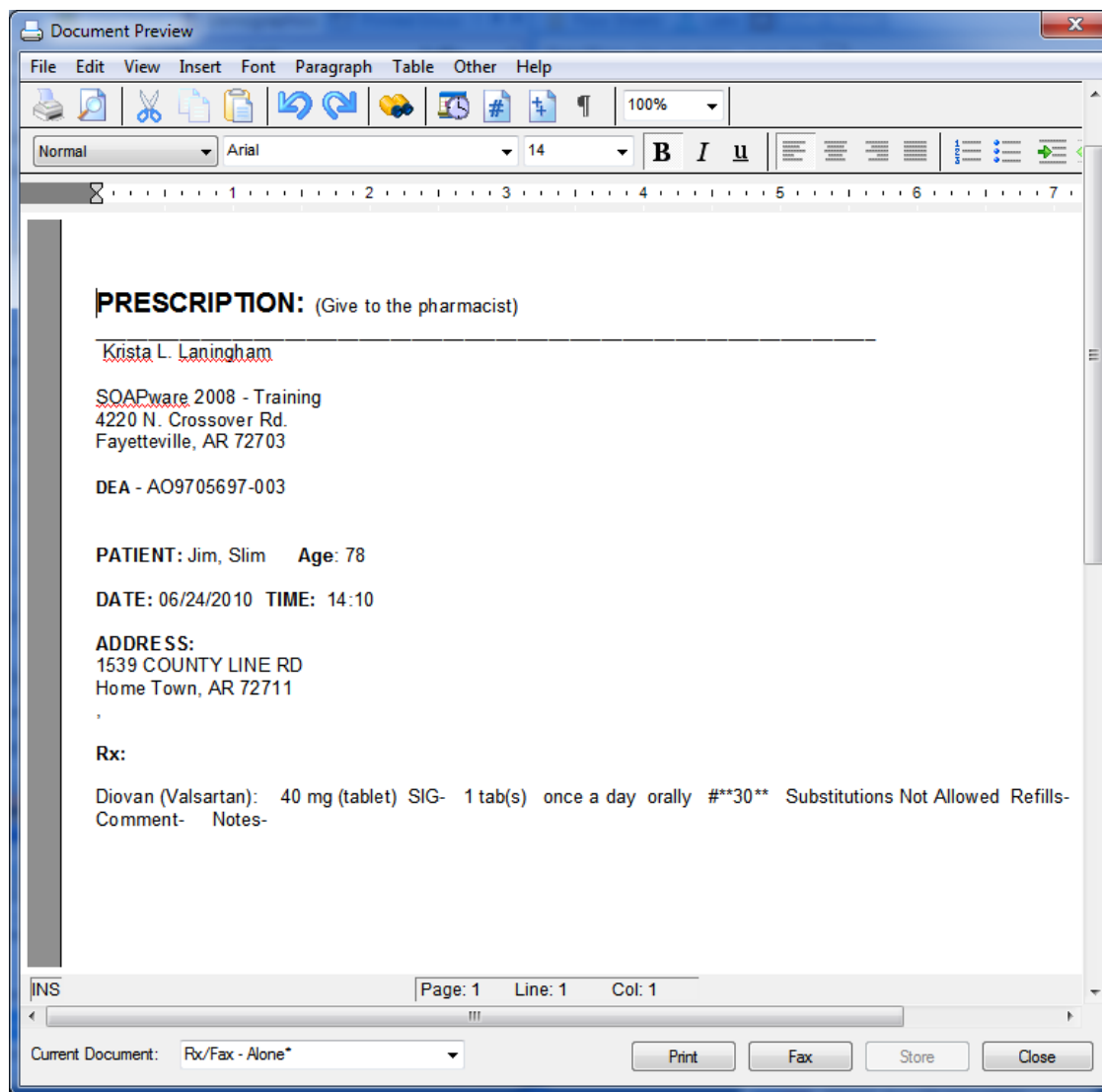
Click File, and then Click the Available Designs menu item. The available document designs will be displayed.

## Select Design



To view a particular design, Click a document design in the list (i.e. select/highlight), and Click the OK button. For example, Rx/Fax - Alone\* is one of items in the list of document designs.

## Examples of a Document Design



Here is an example of a prescription to be printed.

The screenshot shows a software window titled "Rx/Fax - Alone\*" with a menu bar (File, Edit, View, Insert, Data Items, Font, Paragraph, Table, Other) and a toolbar. The main area displays a prescription form design with the following text:

**PRESCRIPTION:** (Give to the pharmacist)

\_\_\_\_\_  
#CurrentProvider Full Name\$#

\_\_\_\_\_  
#ClinicInfo Address\$#

DEA - #CurrentProvider DEA\$#  
#CurrentProvider StateID\$#

PATIENT: #GeneralDemographicsField Last Name\$#, #GeneralDemographicsField First Name\$#  
#GeneralDemographicsField Middle Initial\$#    Age: #GeneralDemographicsField Age\$#

DATE: #InsertDateTime MM/dd/yyyy\$#    TIME: #InsertDateTime HH:mm\$#

ADDRESS:  
#GeneralDemographicsField Address\$#

Rx:  
#SRxPlaceholder\$#

\_\_\_\_\_  
#ClinicianSignature\$#

Dr. \_\_\_\_\_    #CurrentProvider Full Name\$#    #CurrentProvider Full Name\$#

Substitution permitted                      Dispense as written

\_\_\_\_\_  
Regarding Refills: After 12 months a medical history update and exam is necessary for any refills. Bring in all your prescription bottles for us to double check when you return for office visits.

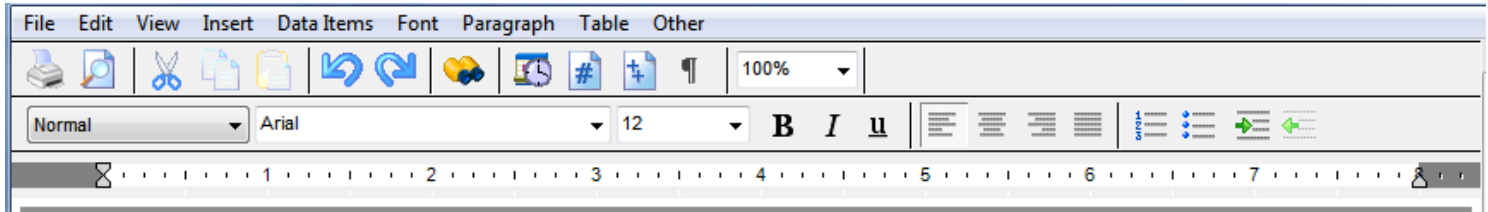
INS                      Page: 1    Line: 1    Col: 2

Close

This is an example of a prescription document design viewed within Document Designer. Free-text has been typed to customize the look of the design, and several command phrases (items that have ## \$#) are included. These pull information from either the patient's chart or from other areas in SOAPware to the document design.

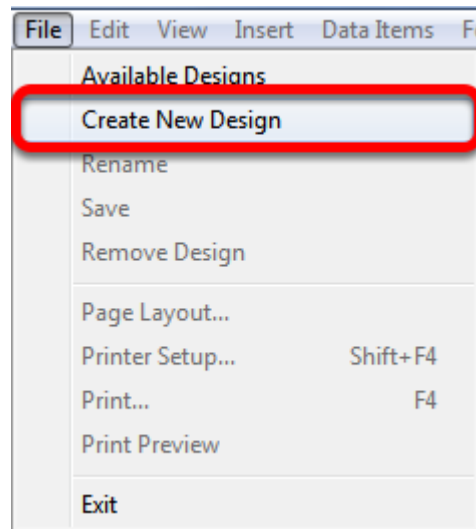
## Creating a Basic Document Design

### User Interface



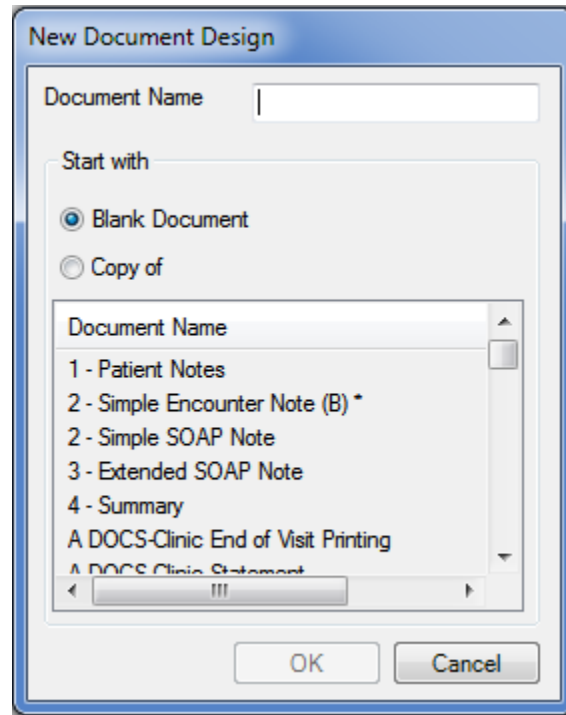
The menus and action buttons available allow the user to create or edit a design. Note that many of the functions within Document Designer resemble Microsoft Word, and allow easy customization to any design. To see what each action button represents, point to it with the mouse. A text balloon will appear explaining its function.

### Creating a New Design



To create a new document design, Click File, and Click the Create New Design menu item.

## New Document Design



Type the new Document Name. Click either the Blank Document or Copy of (i.e. an existing document) radio button. Click OK.

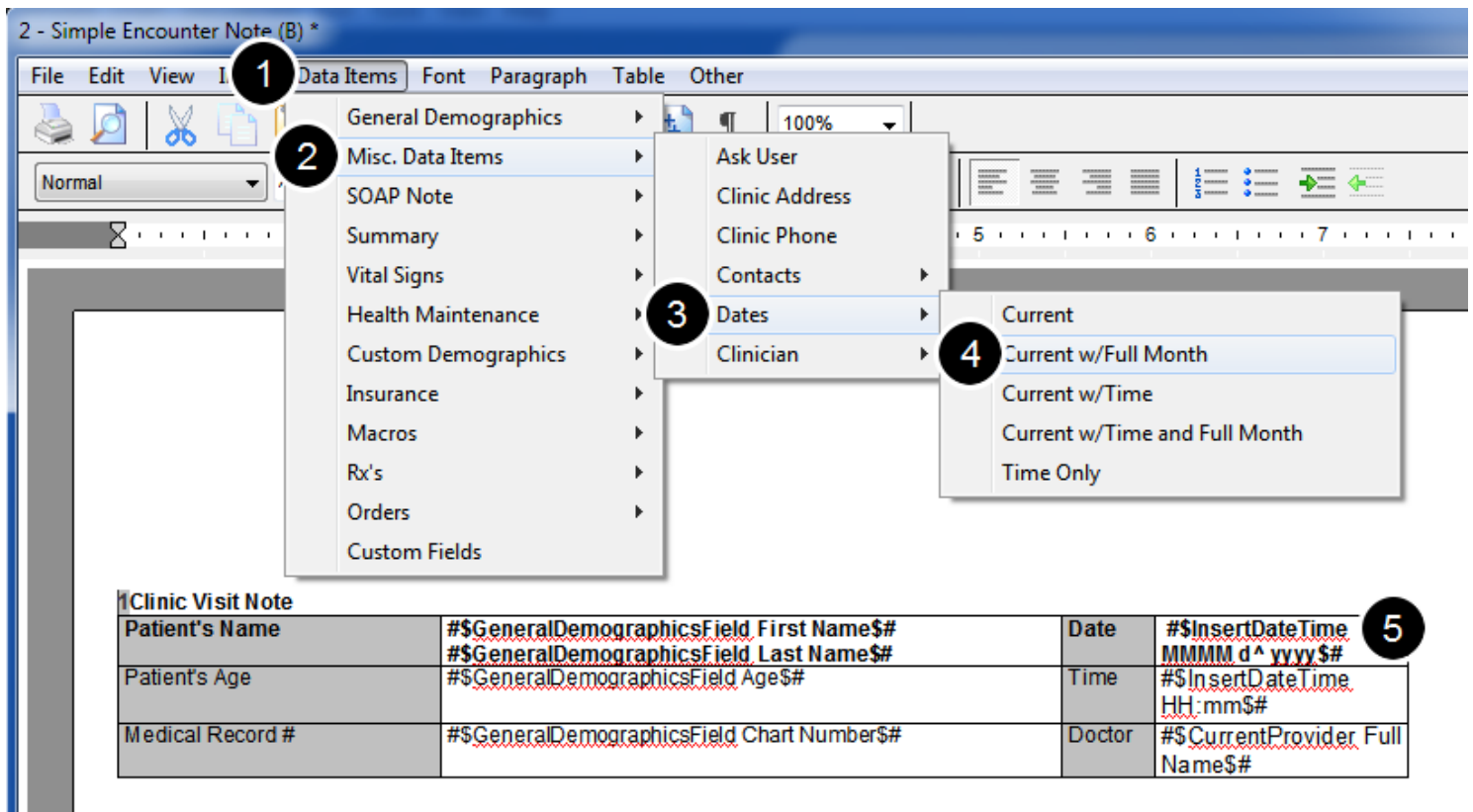
## New Design Recommendations

Making a decision, beforehand, on the content and layout of the design will expedite creation and minimize guesswork. As a suggestion, when creating new designs, create them as a copy of an existing design, or copy and paste content from an existing Word document. Then modify the design by using the commands in the Data Items menu to pull information from the patient chart to the design.

## Entering and Editing Text

A user may use document designer much like a word processor, but a user may also have the added ability to use data items to pull information automatically onto the report.

## Using Data Items and Macros



The Data Items menu houses all the commands that pull information from either the patient's Demographics (including the Insurance and Custom Demographics), the Provider Manager, the SOAPnote, Summary, or Contacts.

For example:

1. Click Data Items in the menu bar
2. Click the Misc. Data Items menu item
3. Click the Dates menu item
4. Click Current w/Full Month.
5. This will insert the command to pull the current date with the full month on to the Document Design



## Using a Document Design to Print a Clinical Summary

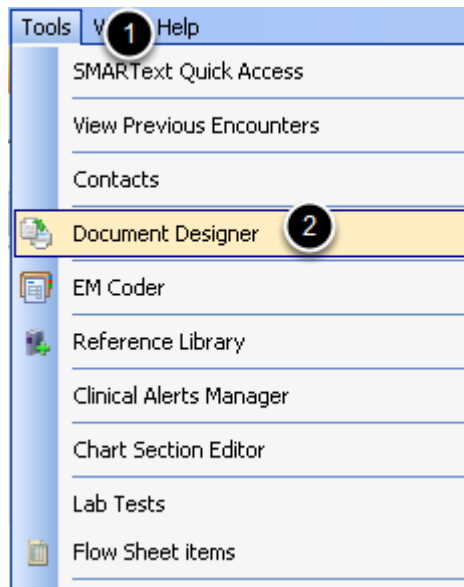
---

This lesson will describe how to use a document design to print a clinical summary as required by meaningful use.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- [Clinical Summaries](#)

### Using a Document Design to Provide a Clinical Summary

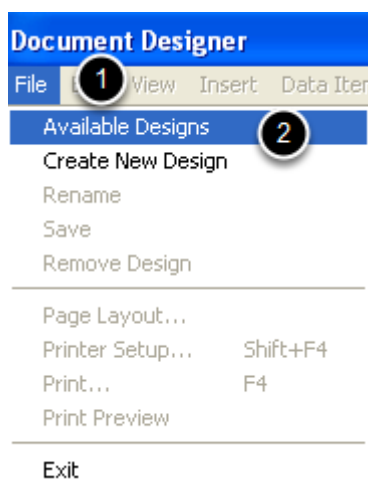


The command to indicate the a Clinical Summary was provided to the patient, must be placed on the proper Document Design.

To do this:

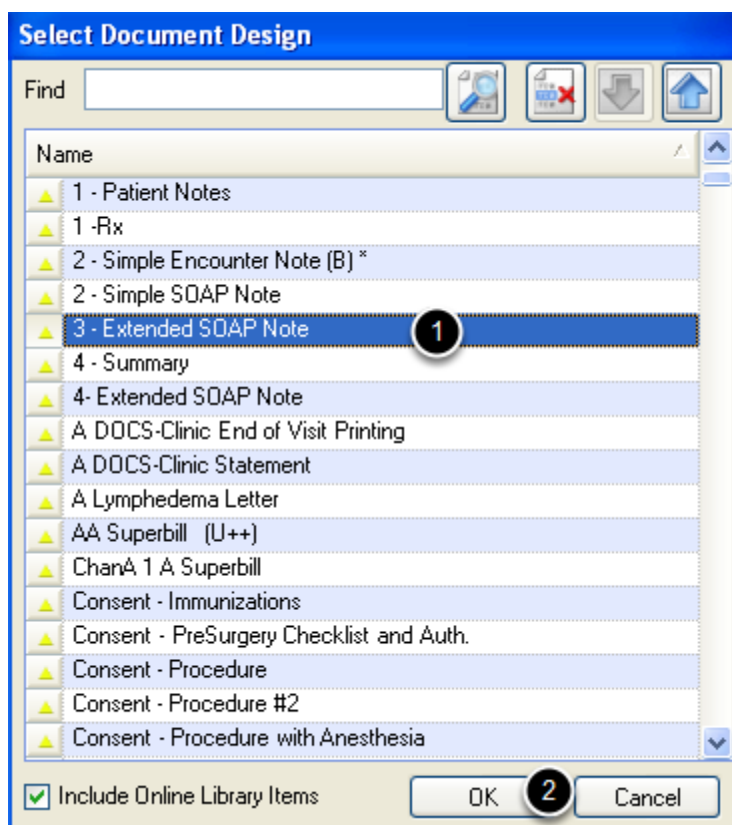
1. Click on Tools
2. Click on Document Designer

## File > Available Designs



1. Click on File
2. Click on Available Designs

## Selecting the Desired Design



1. Click to highlight the design that includes the Summary **and** SOAPnote information
2. Click Ok

## Inserting the Command

**3 - Extended SOAP Note**

File Edit View Insert **Data Items** Paragraph Table Other

General Demographics  
Misc. Data Items  
SOAP Note  
Summary  
Vital Signs  
Health Maintenance  
Custom Demographics  
Insurance  
**Macros**  
Rx's  
Orders  
Custom Fields

Insert Chart Section  
Insert CPT Codes  
Empty Block Start  
Empty Block End  
**Clinical Summary Provided**

Place cursor on design

Patient's Name	#\$GeneralDemographicsField First Name\$# #\$GeneralDemographicsField Last Name\$#	Date	#\$EncounterField DocumentDateTime, MM/dd/yyyy\$#
Patient's Age	#\$GeneralDemographicsField Age\$#	Time	#\$InsertDateTime HH:mm\$#
Medical Record #	#\$GeneralDemographicsField Chart Number\$#	Doctor	#\$CurrentProvider Full Name\$#

**1**

**SUBJECTIVE:**  
#\$EncounterField Subjective ,reported,denied\$#  
#\$RemoveIfEmptyEnd\$##\$RemoveIfEmptyStart\$#

**ACTIVE PROBLEMS:**  
#\$SummaryField Active Problems ,,\$#  
#\$RemoveIfEmptyEnd\$##\$RemoveIfEmptyStart\$#

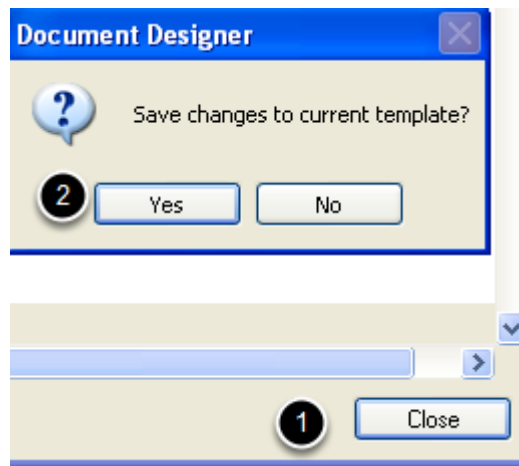
1. Place the cursor on the design. The location of the cursor and subsequent command is not important as the command runs in the background and is not visible when the design is printed.
2. Click on Data Items
3. Click on Macros
4. Click on Clinical Summary Provided

## The Command

<b>Clinic Visit Note</b>			
Patient's Name	#\$GeneralDemographicsField First Name\$# #\$GeneralDemographicsField Last Name\$#	Date	#\$EncounterField DocumentDateTime, MM/dd/yyyy\$#
Patient's Age	#\$GeneralDemographicsField Age\$#	Time	#\$InsertDateTime HH:mm\$#
Medical Record #	#\$GeneralDemographicsField Chart Number\$#	Doctor	#\$CurrentProvider Full Name\$#
#\$ClinicalSummaryProvided\$#			
<b>SUBJECTIVE:</b> #\$EncounterField Subjective ,reported,denied\$# #\$RemoveIfEmptyEnd\$##\$RemoveIfEmptyStart\$#			

The command will not appear on the design.

## Saving the edit



1. Click on Close
2. Click Yes

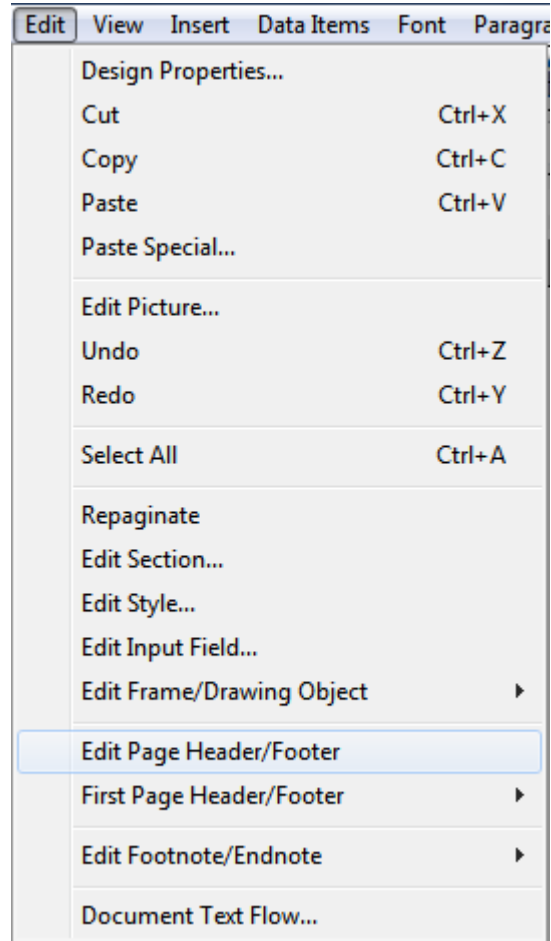
## Clinical Summary

There are two ways to provide a Clinical Summary for a patient; CCR document and using a Document Design.

Both methods will be reflected in the MU Patient Dashboard and Meaningful Use Dashboard.

To view the CCR method, please see: [Clinical Summaries for Each Office Visit](#).

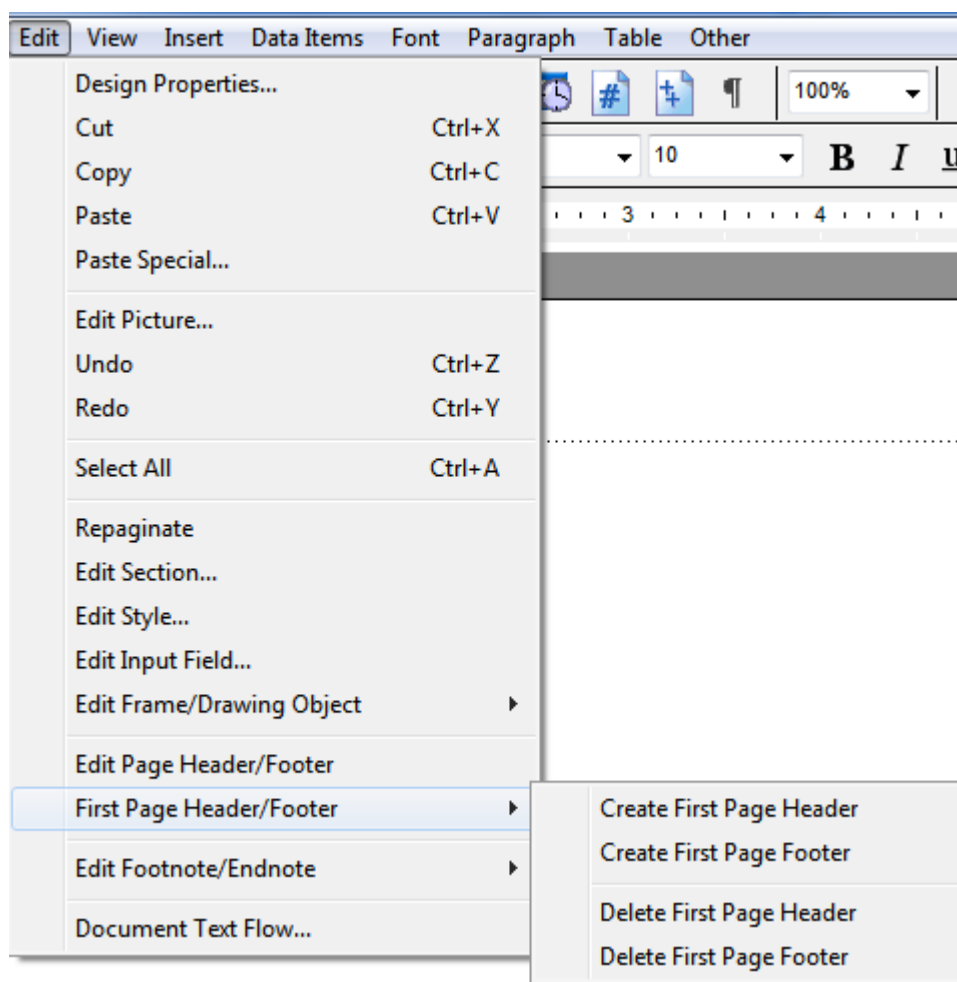
### Headers and Footers



Create headers and footers that include text and/or graphics. Examples of content include page numbers, dates, a clinic's logo, letterheads, etc.

To create/designate First Page Header/Footer Click on the Edit menu and Click on Edit Page Header/Footer.

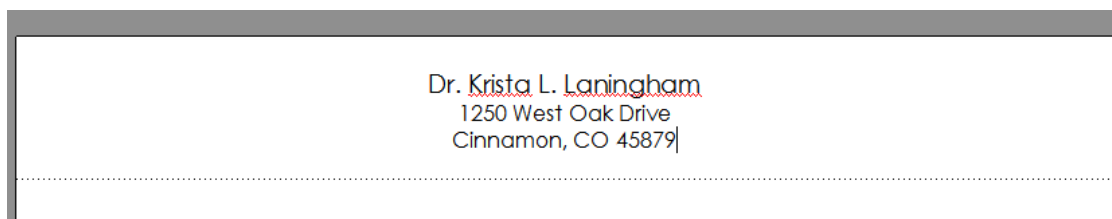
## Adding the Header



A dotted line will appear across the top and the bottom of the document design delineating the area to place the header or footer.

Now, Click Edit in the menu bar again. Click First Page Header/Footer>Create First Page Header (or Footer).

## Editing the Header



Insert the information for the header or footer, and then make the changes to the font, justification, font size, etc.

## Creating a Second Page Header/Footer

ALCOHOL: ##SummaryField Alcohol ,,\$#  
INTERVENTIONS/STUDIES:  
##SummaryField Interventions ,,\$#

---

SOCIAL HISTORY: ##SummaryField Social History ,,\$#

LAST PRINTED: ##InsertDateTime MM/dd/yyyy\$#

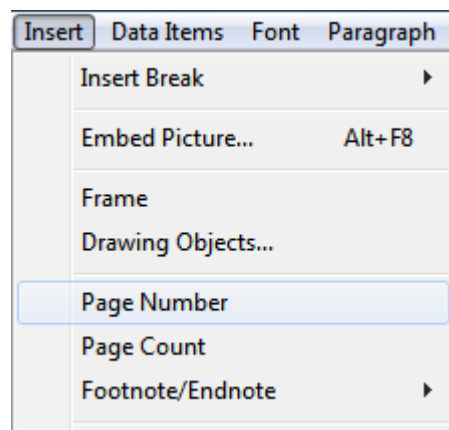
---

Dr. Krista L. Laningham  
1250 West Oak Drive  
Cinnamon, CO 45879

NS Page: 2 Line: 5 Col: 1

**IMPORTANT:** While still in the Edit phase, place the cursor at the bottom of the first page and then Press the Enter Key until a second page is created. Once the second page is created, the dotted-delination will appear allowing the user to create the second page information.

## Inserting Page Numbers



To insert page numbers and total page counts, Click the Insert menu, and then Click either Page Number or Page Count.

## Emptying a Block

The Empty Block Start and Empty Block End commands, available from the Insert menu, allow the user to have SOAPware leave out a section of the report when printing if that section doesn't contain any information. To use this command, "wrap" the commands around the section to ignore when empty.

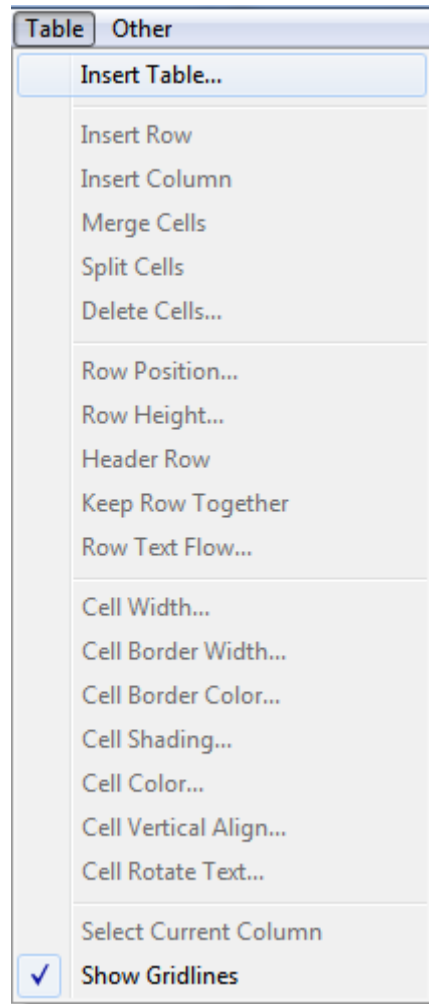
Example: To do this in the Document Designer, the user would select Empty Block Start from the Insert menu. Then, press Enter to go to the next line. Type "MEDICATION", followed by a colon. Bold the word "medication". Press enter, and select Data Items, SOAPnote, and Medications. Then, press Enter, and select Empty Block End from the Insert menu.

The end result will look like this:

```
#$RemovelfEmptyStart$#  
MEDICATION:  
#$EncounterField Medications ,,$#  
#$RemovelfEmptyEnd$#
```



## Creating Tables

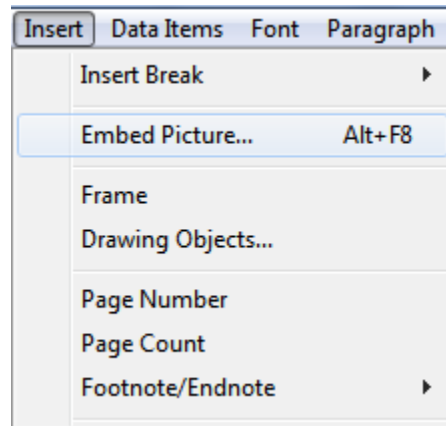


Using tables are ideal for formatting text that needs to be in columns/rows. To insert a table, Click Table in the menu bar, and then Click the Insert Table menu item . Indicate the number or rows and columns.

## Editing the Table


The table will display with the cell borders as faint lines. Fill in the cells with text as needed. Use the Table menu to modify and elegantly customize the table.

## Using Images

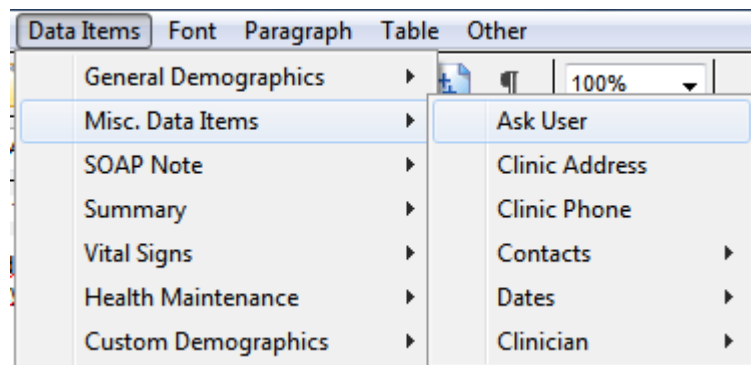


To insert an image, such as a logo, Click Insert, and then Click Embed Picture. Select the Image, and then Click Open. Once the image has been embedded, click on the image and then resize as needed.

## Inserting a Signature

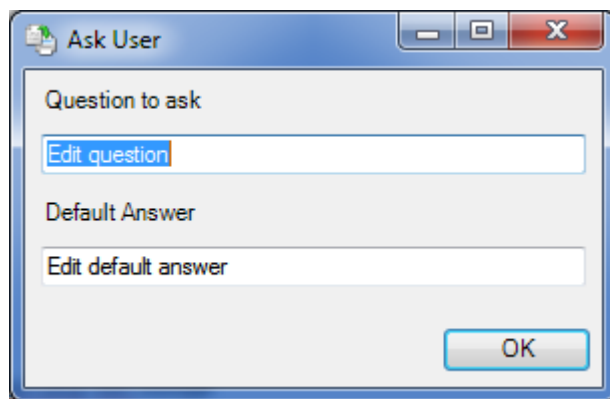
To embed a signature, scan the signature to a file on the computer and then follow the same instructions as for inserting an image (above).

## Ask User



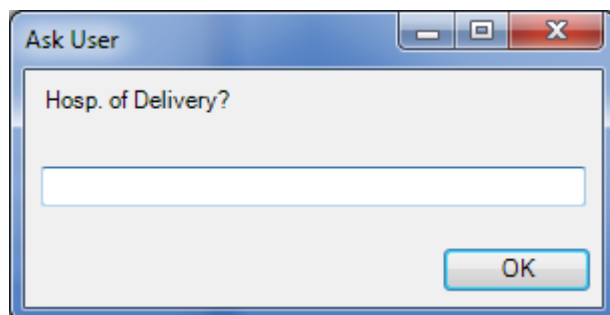
The Ask User commands allows the user to add unique, auto-populating commands, that are not available in the Data Items menu. This command inserts a custom question that can be used to insert additional information before printing the design. Click Data Items in the menu bar; Click Misc. Data Items, and then Click the Ask User menu item.

## Ask User Question



Type the question to be asked. (It is not necessary to remove Edit default answer.)

## Printing with an Ask User Question



When a document has been selected from a SOAPware Chart to print and the Ask User command was used, this is what will display.

## Quick Print Key Commands

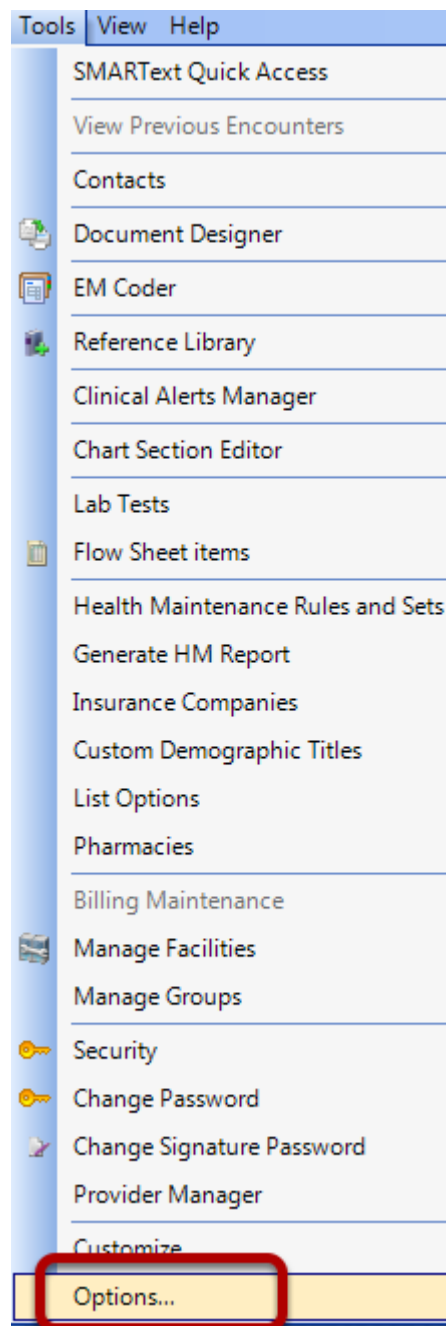
---

To save time when printing the four most commonly used document designs, it is recommended to set up Quick Print key commands. The following key commands can be designated to directly print a document design, without having to scroll through the print menus.

### Quick Print Key Commands

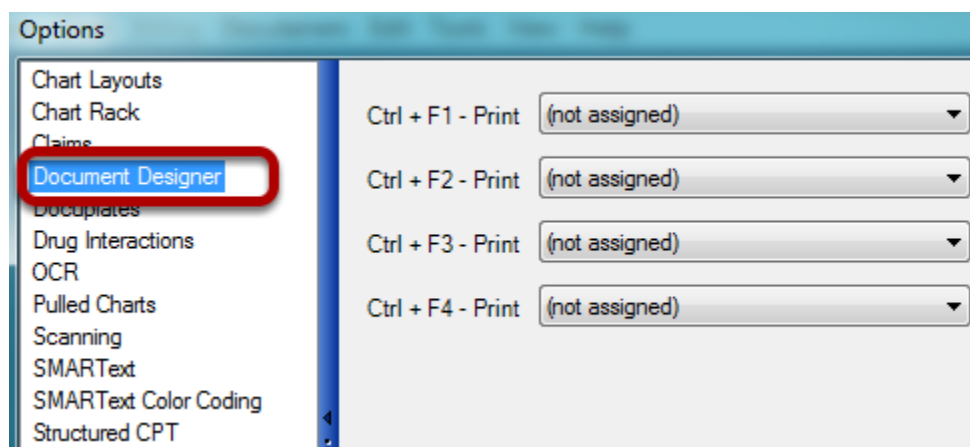
The Quick Print list includes:

- \* **Ctrl + F1**
- \* **Ctrl + F2**
- \* **Ctrl + F3**
- \* **Ctrl + F4**



Click on Tools > Options.

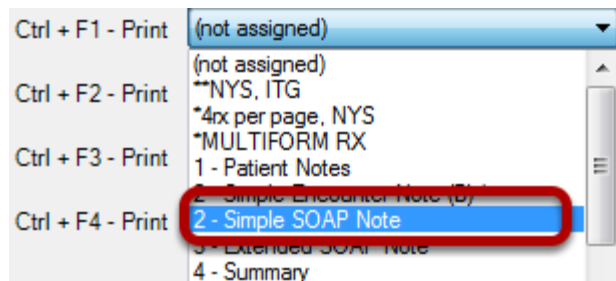
## Options Dialog



Click the Document Designer list item.

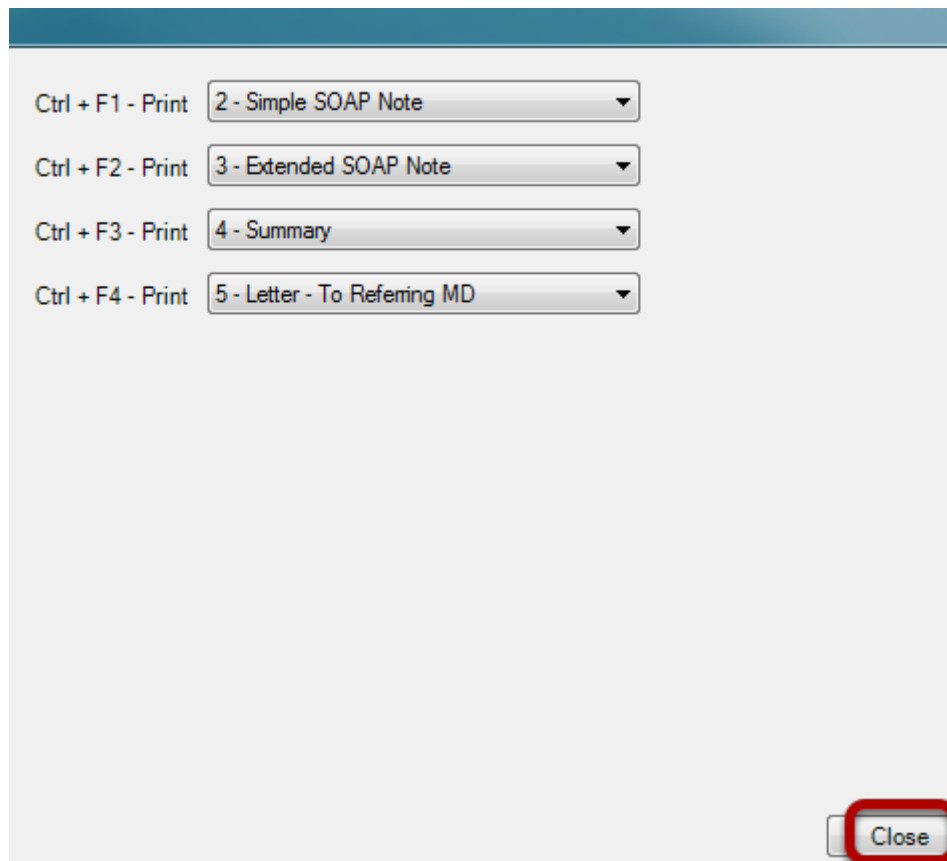
On the right side of the Options dialog, all four Quick Print commands are listed. Each is associated with a drop-down list of available document designs.

## Designate Document Designs



Select document designs to print for each Quick Print key command.

## Save Changes made within the Options dialog



The screenshot shows a dialog box with a light gray background and a blue header bar. It contains four rows, each with a keyboard shortcut and a dropdown menu:

- Ctrl + F1 - Print: 2 - Simple SOAP Note
- Ctrl + F2 - Print: 3 - Extended SOAP Note
- Ctrl + F3 - Print: 4 - Summary
- Ctrl + F4 - Print: 5 - Letter - To Referring MD

In the bottom right corner, there is a "Close" button, which is highlighted with a red rectangular box.

Once finished selecting a document design for each Quick Print key command, Click the "Close" button.

Changes will not be saved until the user logs out of SOAPware.

**Note:** Do not set up printing of a prescription as a Quick Print key command. We recommend printing prescriptions from Rx Manager to ensure that an account of each prescription printed is stored under the Rx history tab in the Rx Manager. For more information, see: [Default Rx Print Designs](#).

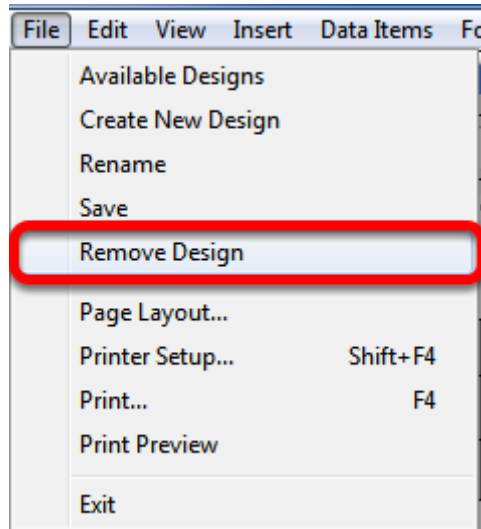
## Saving and Printing a Document Design

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### Saving a Document Design

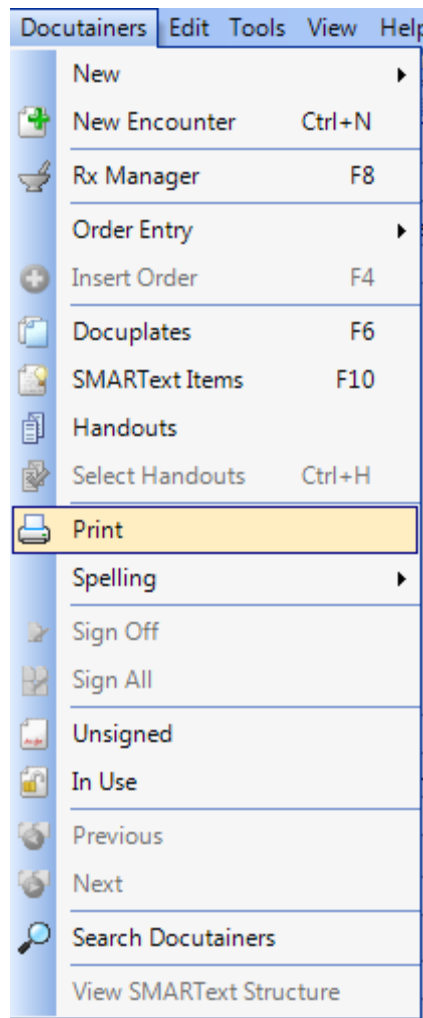
To save an edited document design, Click File in the menu bar, and then Click Save. It is always a good idea to close Document Designer, and then test by printing the document.

### Deleting a Document Design

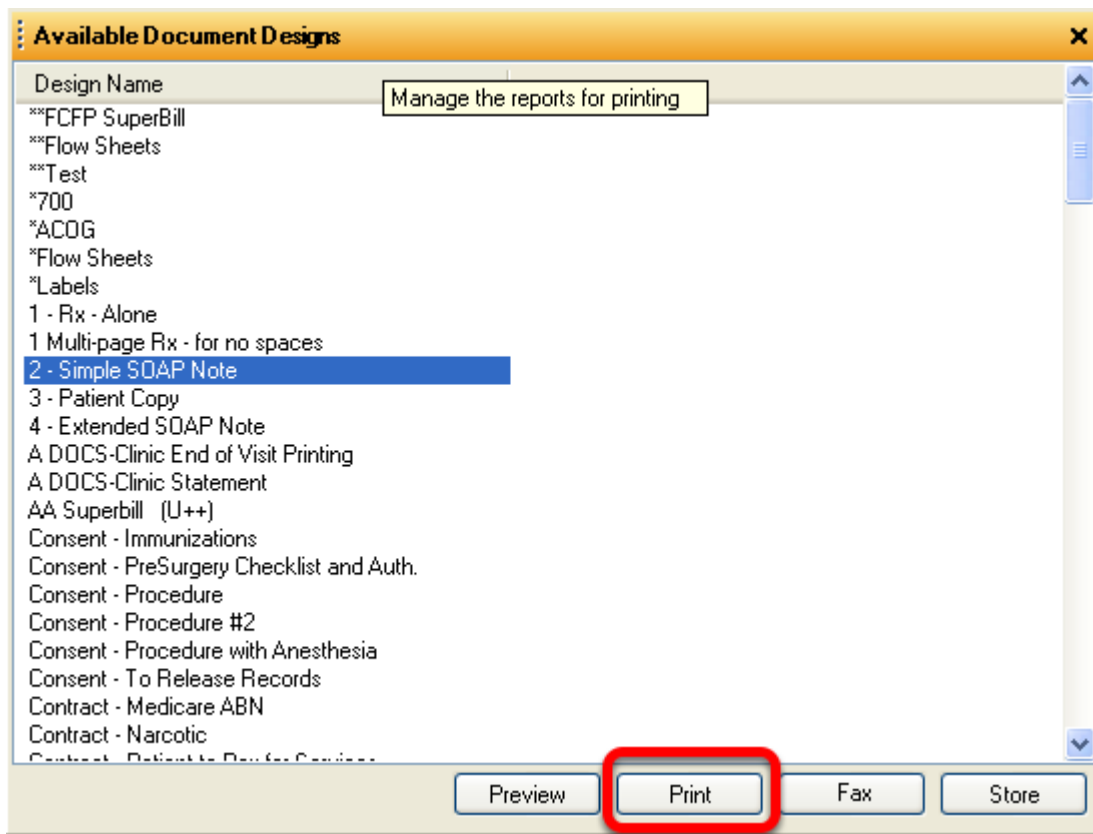


To delete a document design, Click File and choose Remove Design.



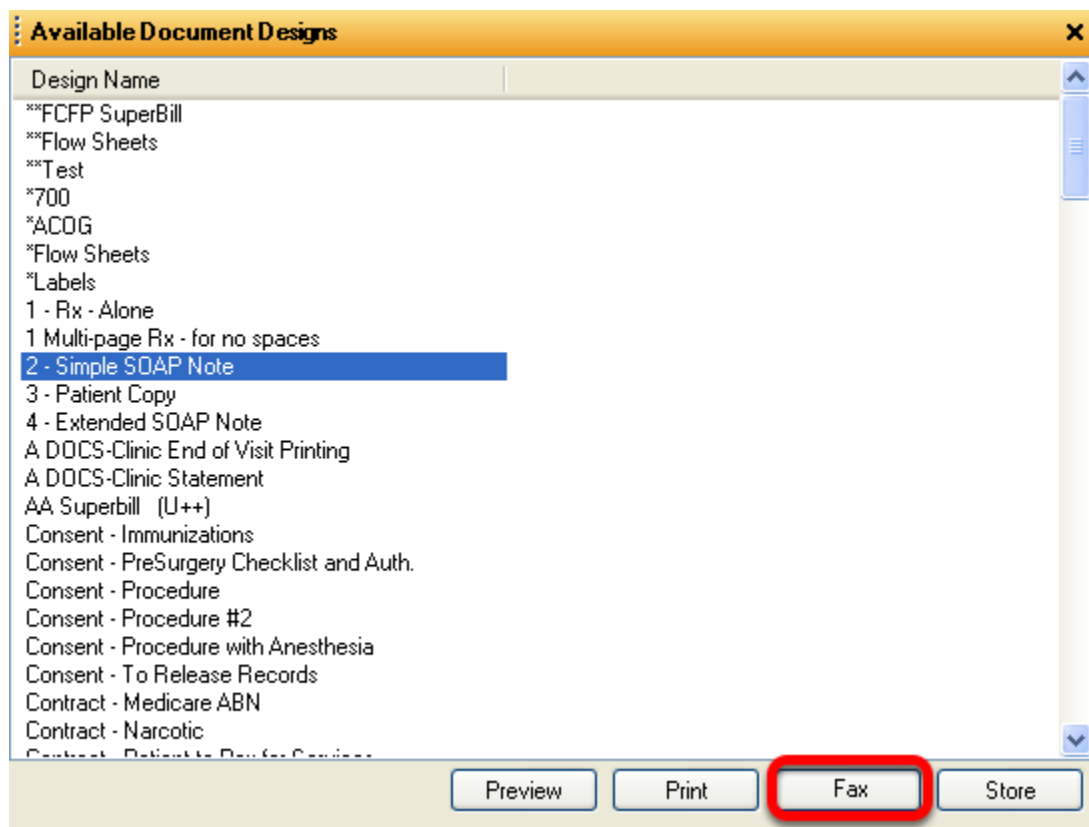


To print a document design, go to Docutainers - Print. This will pull up the available document designs, where the user can choose which design he/she would like to print.



Click to highlight the Document Design to Print. Click the Print button.

## Faxing a Document Design



A user must have the SOAPware Faxing Module or using a supported interfacing faxing module to fax a Document Design from SOAPware.

Click to highlight the Document Design. Click the Fax button.

**Fax Contact**

From: Rena Thornton

Re:

Name	Spe...	City	State	Phone	Fax
Contact, Sample	Abd...	Faye...	AR		(555)...
Willy, Chilly		Chilly	AL	(123...	
Birds, Flying					(555)...

Fax Cancel

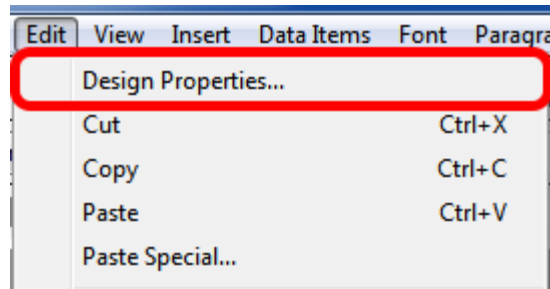
The Fax Contact window will display to select the Contact from Contacts Manager. Click the Contact of choice and then Click the Fax button.

## Document Designer Properties

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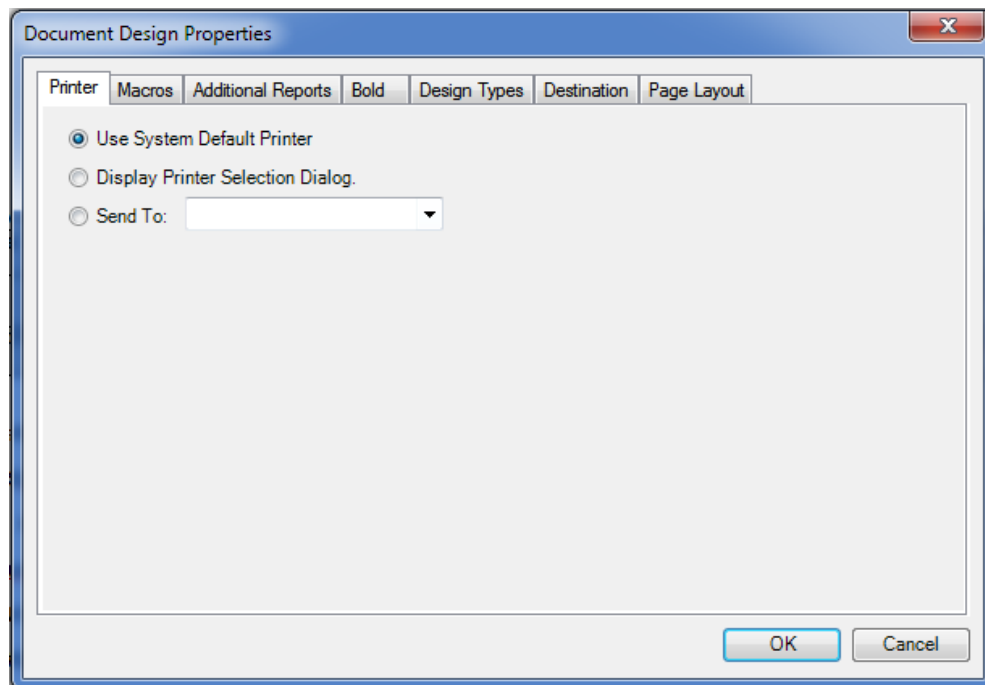
Once the document has been completed, there will be other, very important commands that the user will need to consider adding to a document. These commands are hidden in the background, but are embedded within the design. The Design Properties dialog offers the user a variety of options for controlling how a document design functions. These options are specific to the design so each can be controlled to an even greater extent.

### Document Design Properties



To access the Design Properties dialog, Click Edit in the menu bar, and then Click the Design Properties menu item.

### Printer

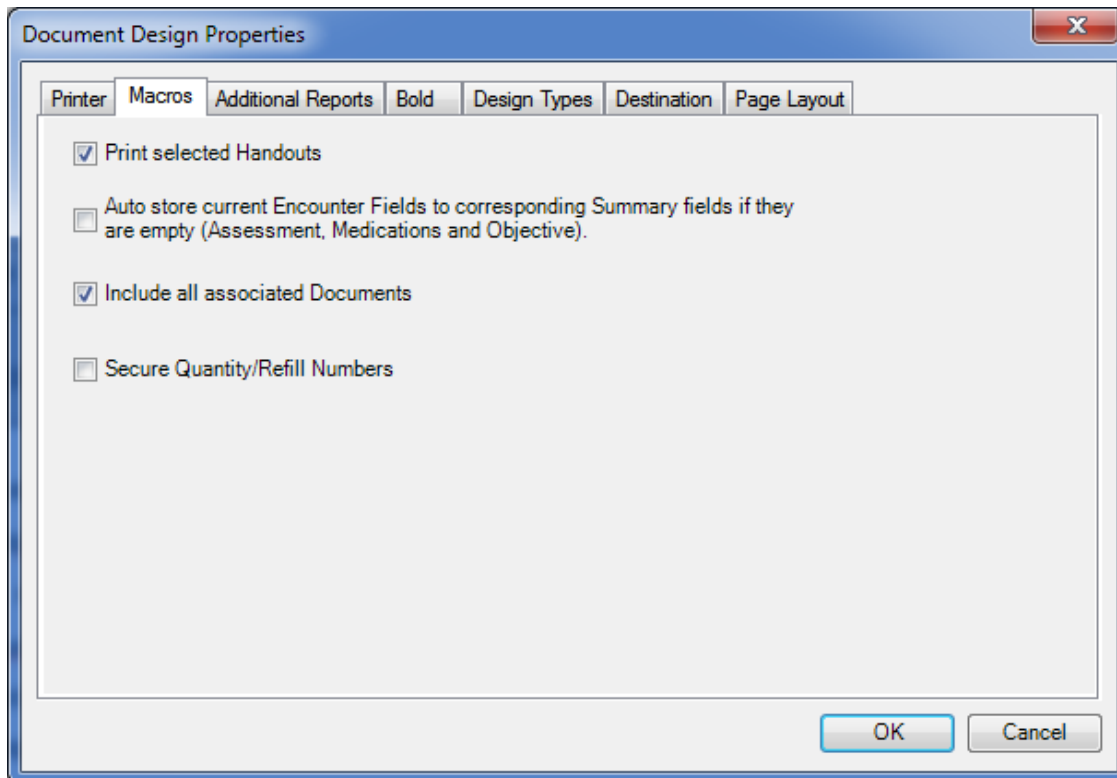


**User System Default Printer:** tells SOAPware to send the document design to the default printer.

**Display Printer Selection Dialog:** allows the user to choose a local printer to send document.

**Send to:** sends the document to the selected designated printer or fax.

## Macro

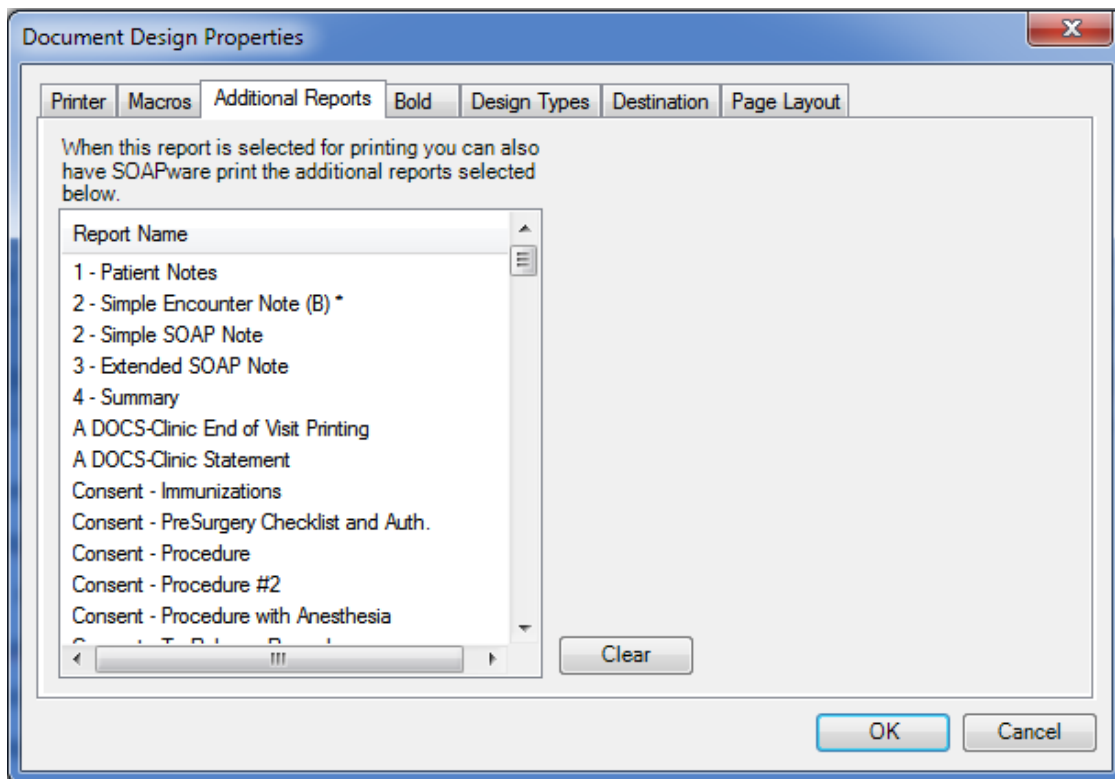


**Print Selected Handouts:** when a user prints the report, any handouts selected in the Plan field of the SOAPnote will also print.

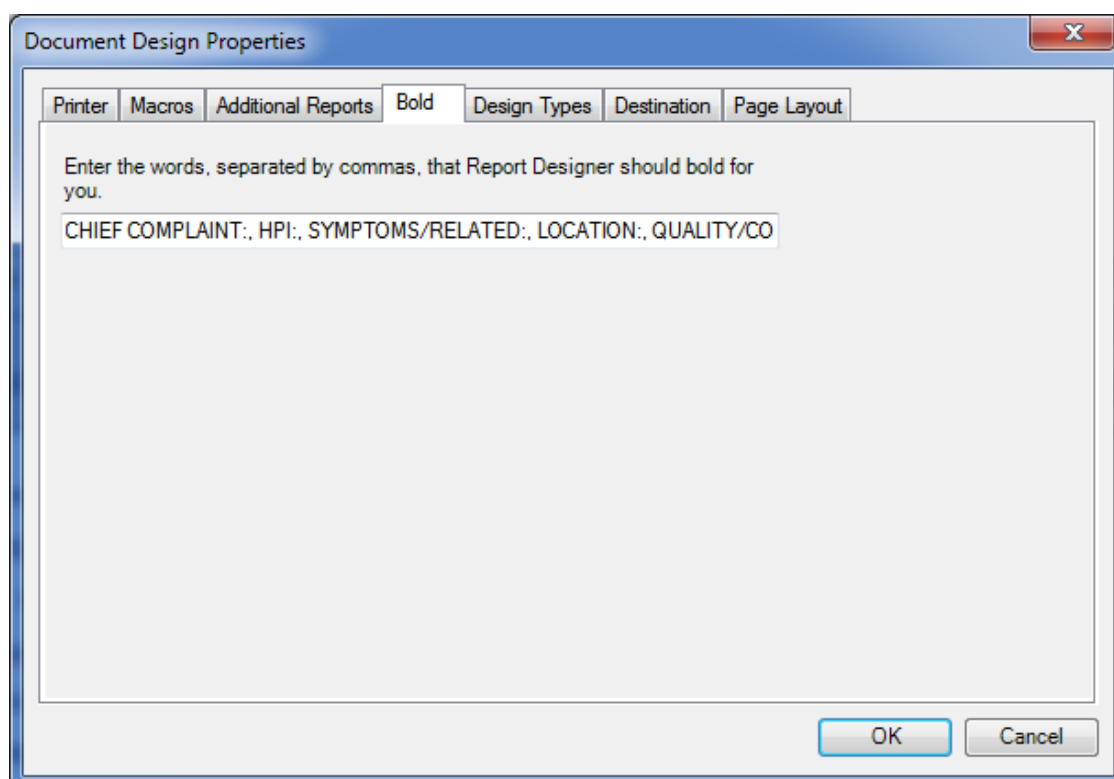
**Auto Store Current Encounter Fields to corresponding Summary fields if they are empty** (Assessment, Medications and Objective): sets SOAPware to transfer information from the currently active SOAPnote to the Summary side of the patient chart when printing, if it corresponds to an empty Summary field.

**Include all associated Document Items:** allows a design that prints to include any other documents that have been attached to that docutainer to print as well. For example, it would print all documents that are attached to a SOAPnote docutainer.

**Secure Quantity/Refill Numbers:** this command places double asterisks (\*\*) before and after the refill number making it difficult to add a numeric value to increase refills on a printed prescription.

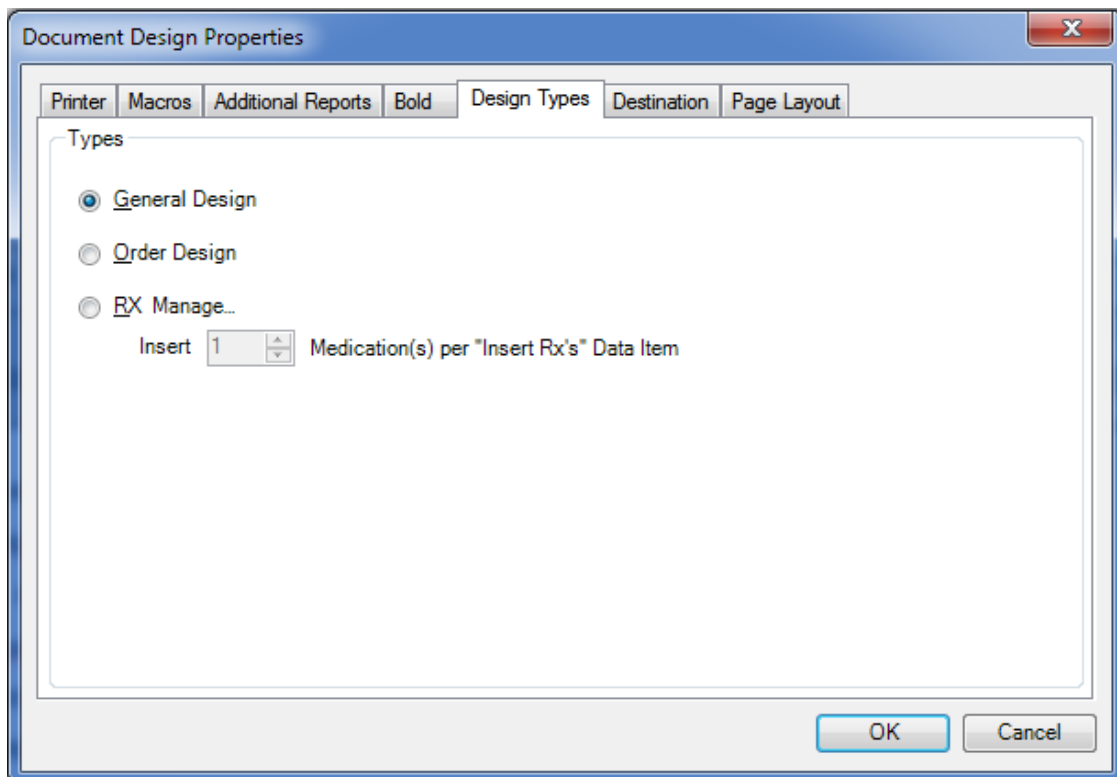


The selected additional document designs will print when this design is printed. For example, when a referral letter is printed a soap encounter note could be printed simultaneously.



This setting allows the user to automatically apply bold formatting to specific words. To specify the words to be made bold, enter them in the text box separated by commas.



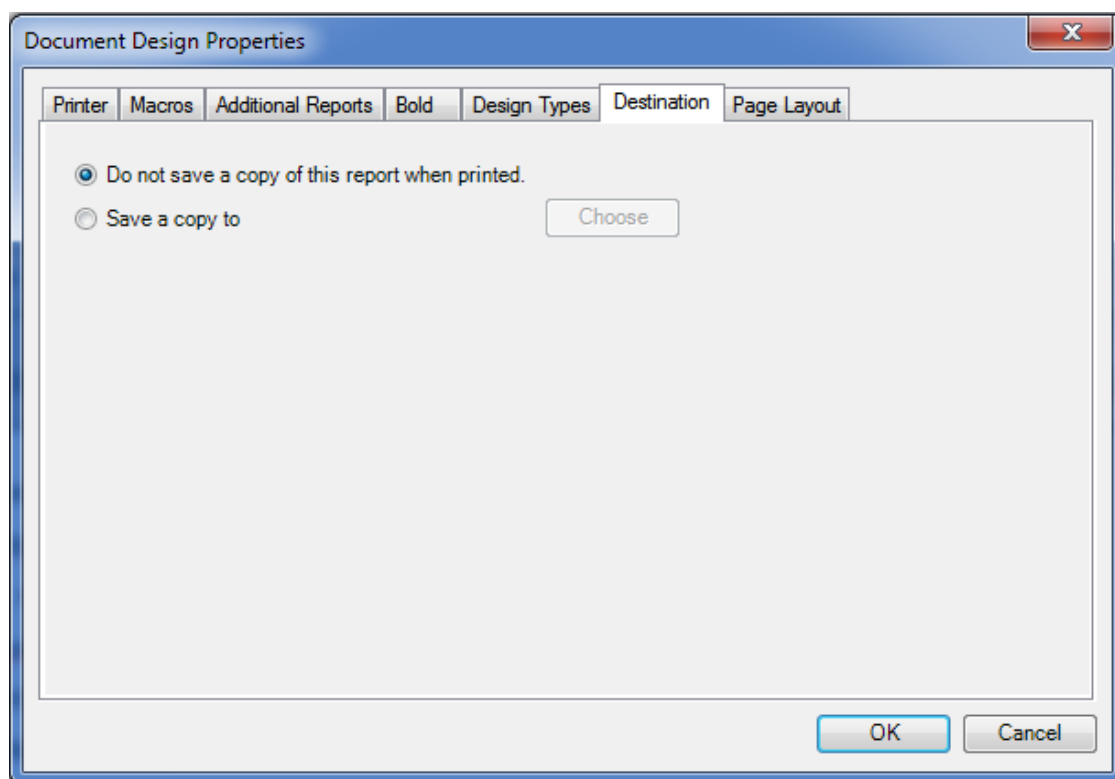


**General Design:** applies to all print designs other than Order or Rx Manager.

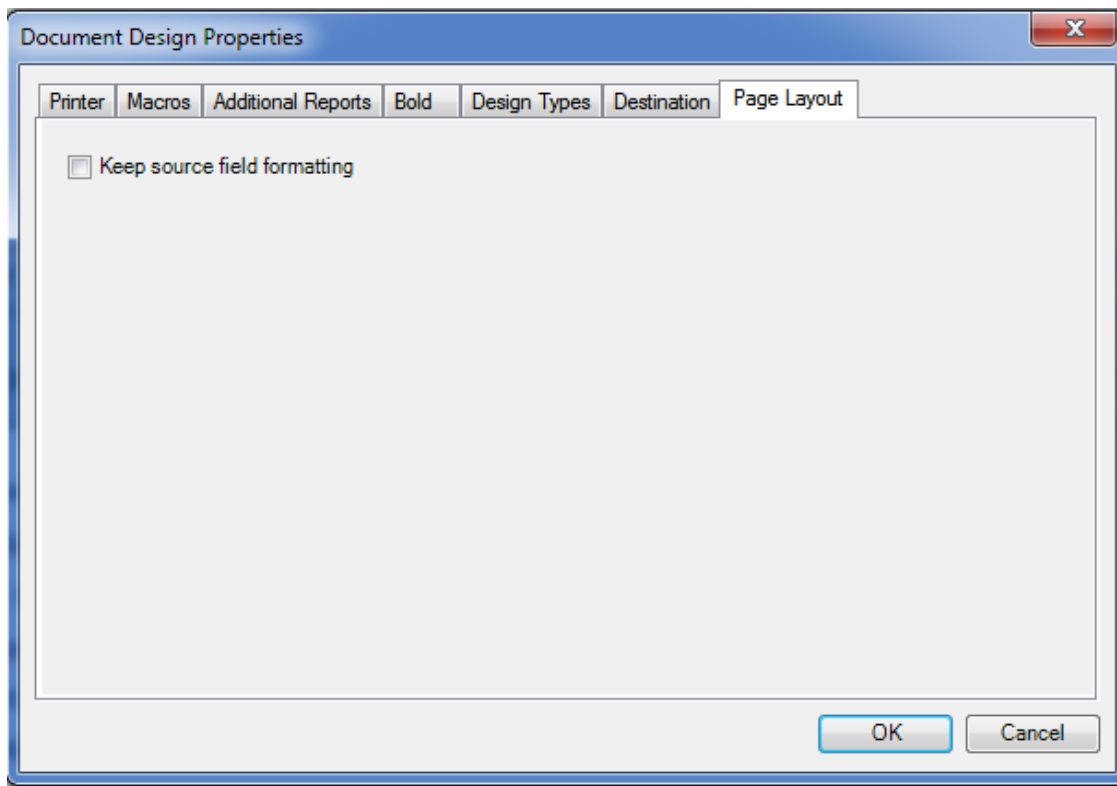
**Order Design:** applies to any design that is created to be used within Order Manager.

**Rx Manger:** applies to an prescription design that needs to specify how many prescriptions will print per page.

## Destination

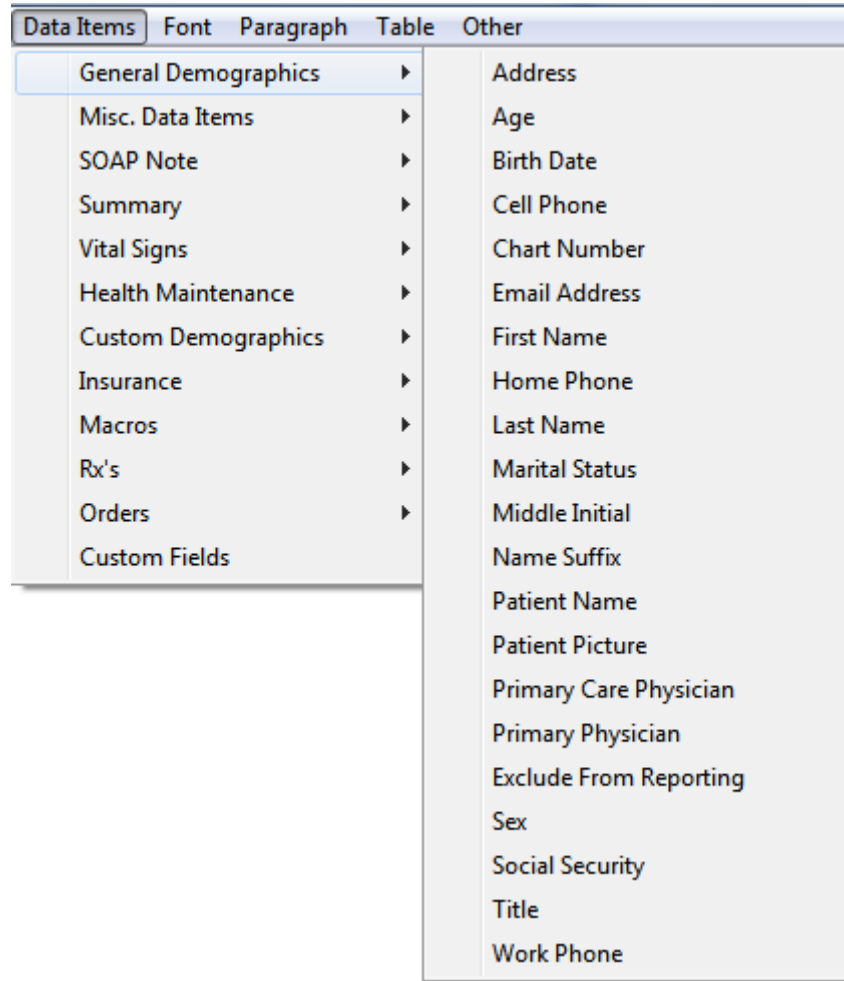


The Destination tabs allows the option of saving a copy of the printed document to a specific chart section in Chart Navigator. Or, Click "Do not save a copy of this report when printed."



Keep source field formatting: source field formatting will be preserved that exists in the original docutainer.

### Data Items - General Demographics

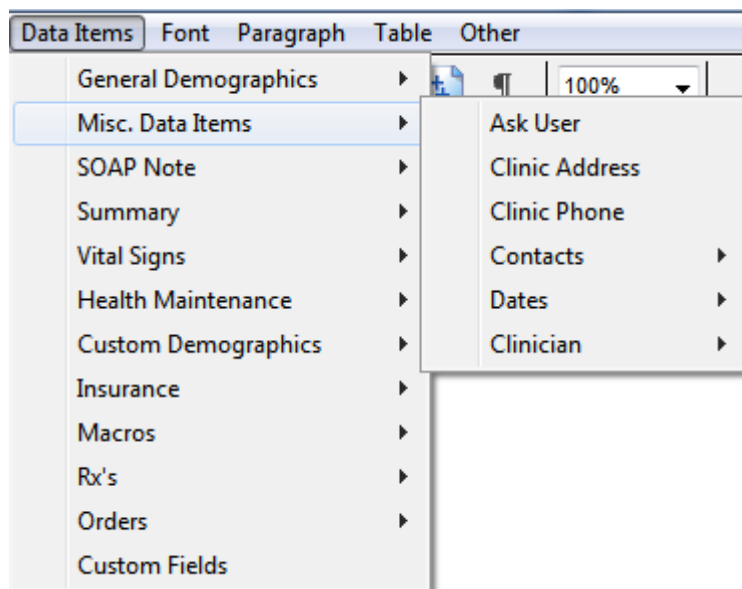


The General Demographics data item list includes:

Address  
Age  
Birth date  
Chart Number  
E-Mail Address  
First Name  
Home Phone  
Last Name  
Marital Status  
Middle Initial  
Name Suffix  
Patient Name

Primary Physician  
Sex  
Social Security  
Title  
Work Phone

## Miscellaneous Data Items



The Misc. Data Items list includes:

Ask User  
Clinic Address  
Clinic Phone

### **Contacts:**

Address  
Fax  
First Name  
Last Name  
Name  
Phone  
Select  
Suffix  
Specialty

### **Dates:**

Current Date  
Current Date with Full Month

Current w/Time

Current w/Time and Full Month

**Clinician:**

Full Name

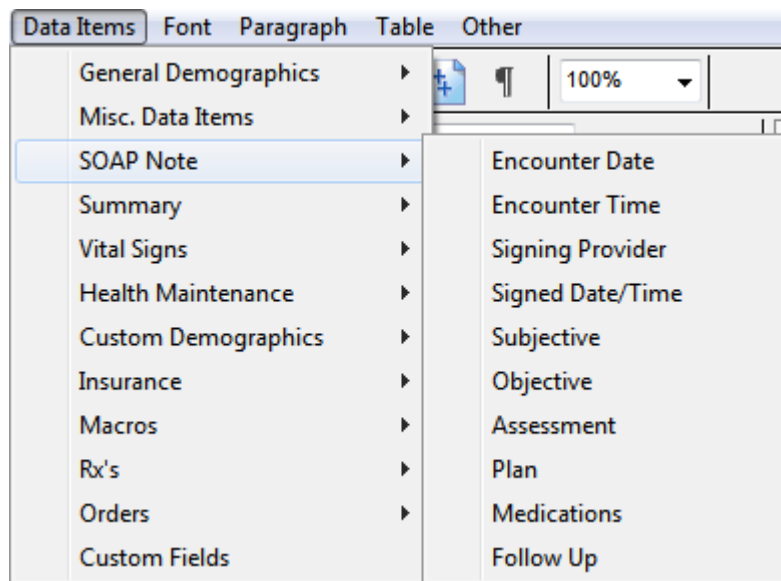
First Name

Last Name

DEA

05 State ID

## SOAPnote



The SOAPnote data item list includes:

Encounter Date

Encounter Time

Subjective

Objective

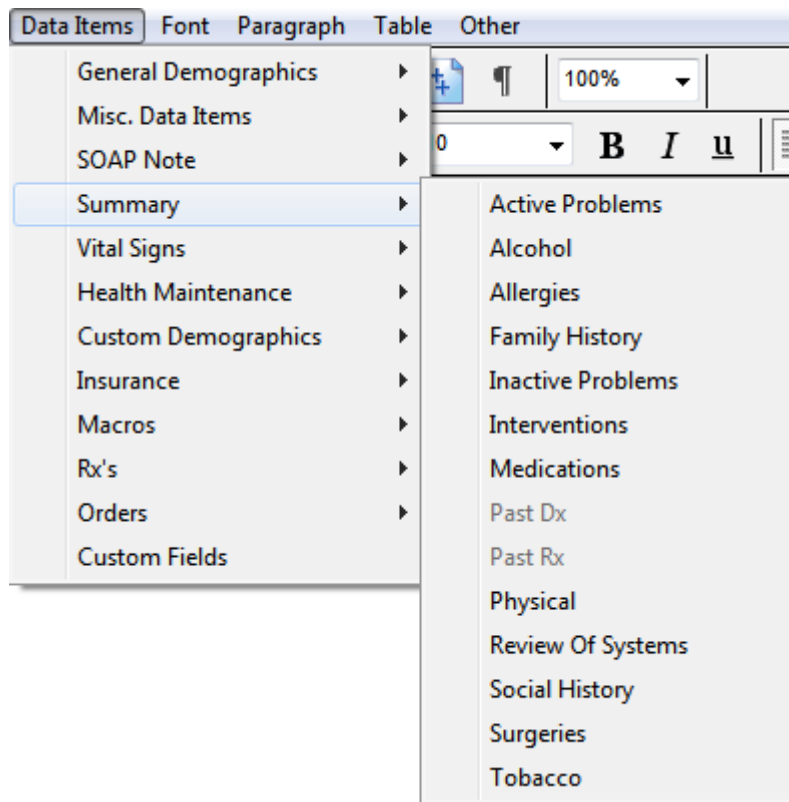
Assessment

Plan

Medications

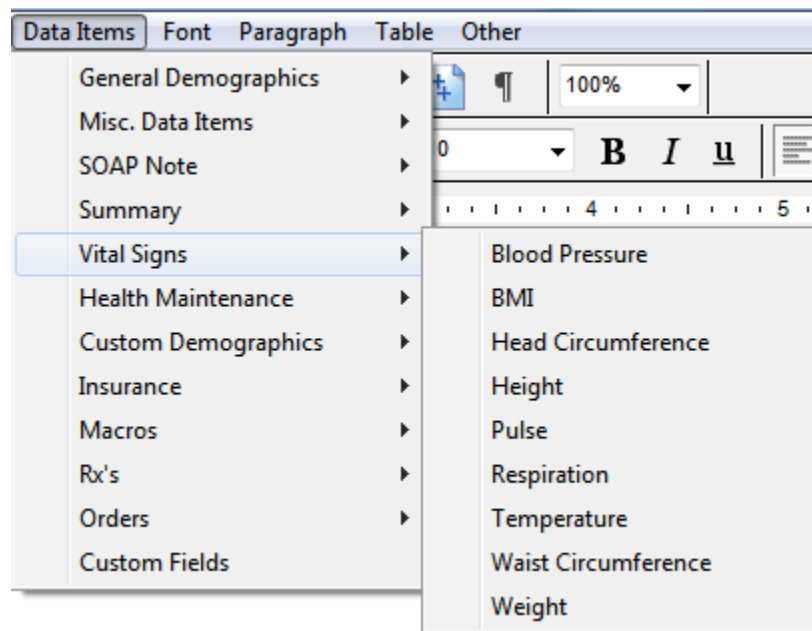
Follow Up

## Summary



The Summary data item list includes:

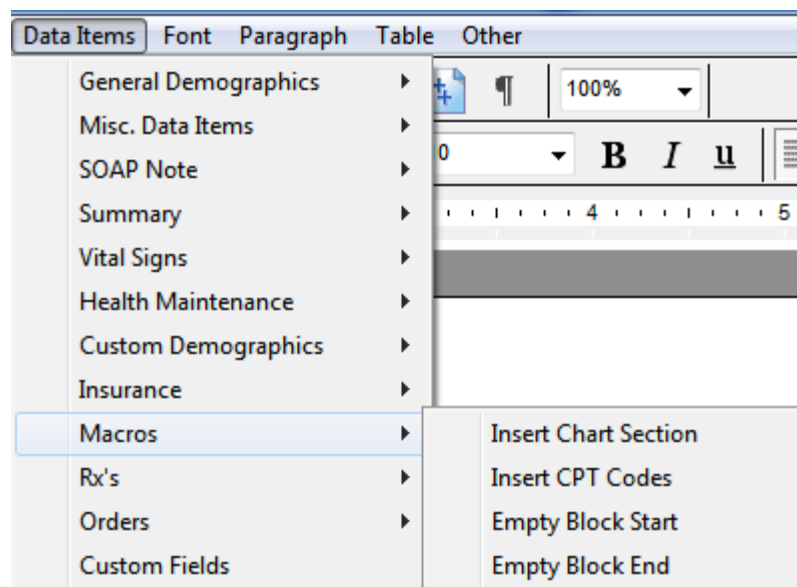
- Active Problems
- Alcohol
- Allergies
- Family History
- Inactive Problems
- Interventions
- Medications
- Past Dx
- Past Rx
- Physical
- Review of Systems
- Social History
- Surgeries
- Tobacco



The General Demographics data item list includes:

Blood Pressure  
BMI  
Head Circumference  
Height  
Pulse  
Respiration  
Temperature  
Weight





The Macros list includes:

- Insert Chart Section
- Insert CPT Codes
- Empty Block Start
- Empty Block End

# **Creating Patient Education Handouts**

## Handouts Manager

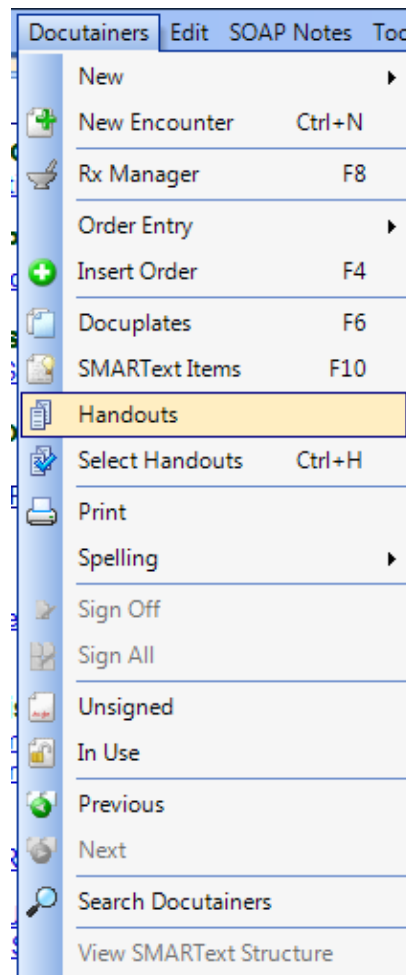
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In SOAPware, handouts are selectable by keywords and can still be organized by categories, but now they can also be found easily through a search window. Because of this, it is no longer necessary to search through categories to find a handout. Handouts are also much more than mere text documents. It is possible to create handouts as collections of related document items, rather than just single documents.

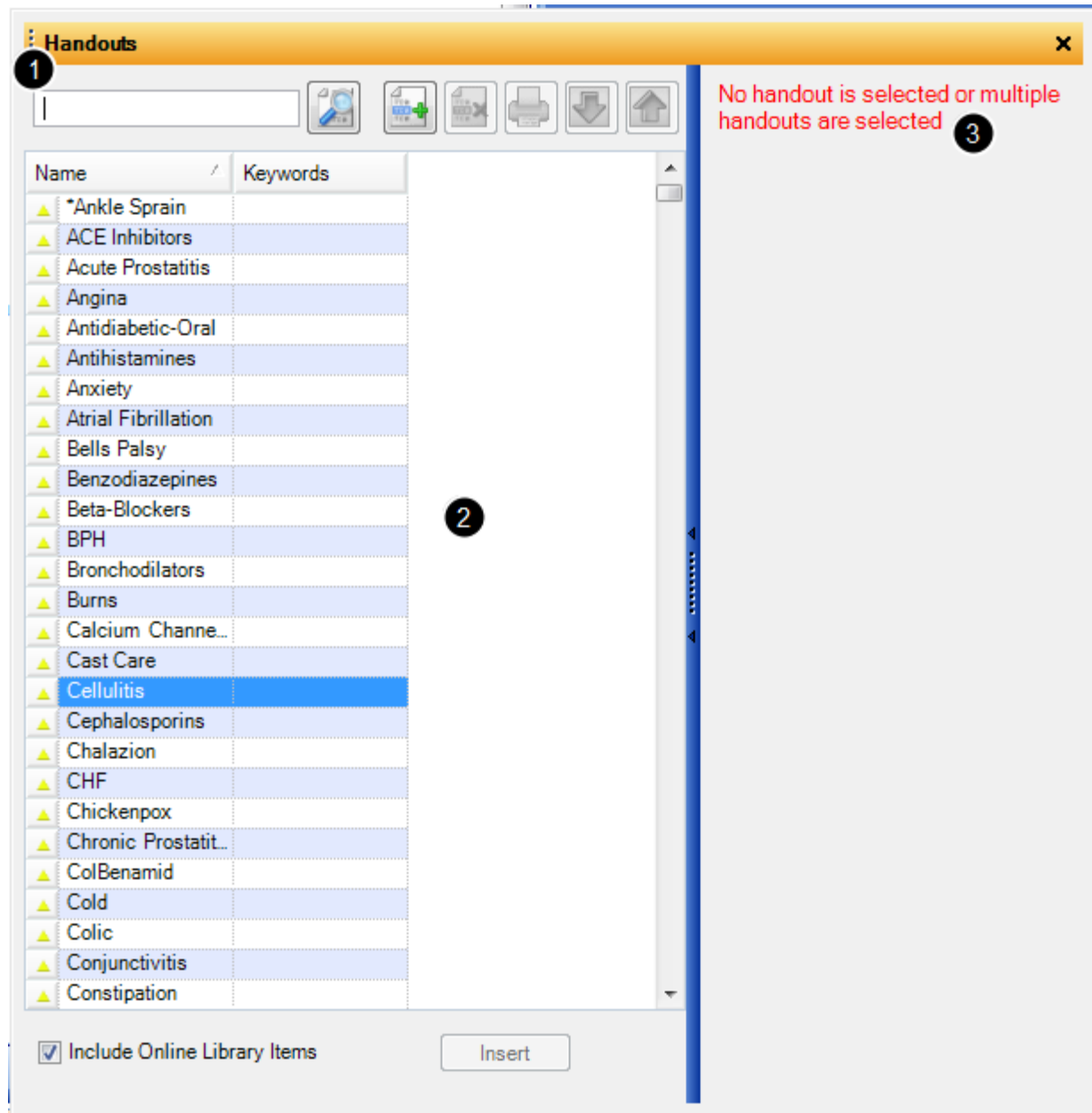
Paper-based patient education handouts can be used in SOAPware and printed from the patient's chart. Auser can select and print handouts manually, or have SOAPware automatically print them, and insert a notice of printing into the current encounter note.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Patient Specific Educational Resources](#)**

### Open the Handouts Manager



To open the Handouts Manager, Click Docutainers on the menu bar, and select the Handouts menu item.



The Handouts Manager has 3 main areas.

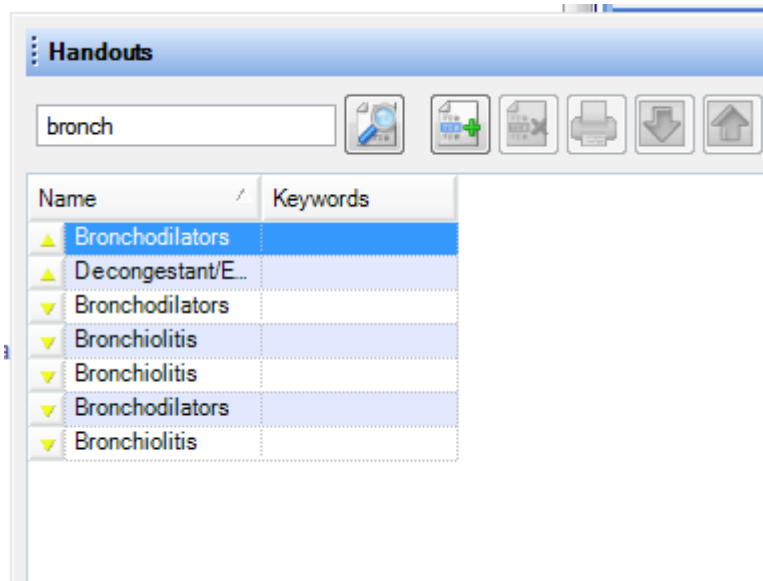
1. The left side of the Handouts Manager has a search field/box used for searching by keywords. This area also contains the mini-toolbar buttons (e.g. New Handout, Remove Handout, Print Handout, Download, and Upload).

2. Below the search field/box is the list of available handouts, which can be sorted by clicking the head of the column. These columns are Name, which displays the name of the handout, and Keywords. In order to see handouts available for download, Click the "Include Online Library Items" check box.

The top right area of the Handouts Manager contains the document demographics for handouts. These include Name, Description, Author, Email, and Keywords. If the user cannot see this section, it is hidden from view, Click the vertical splitter bar to expand it.

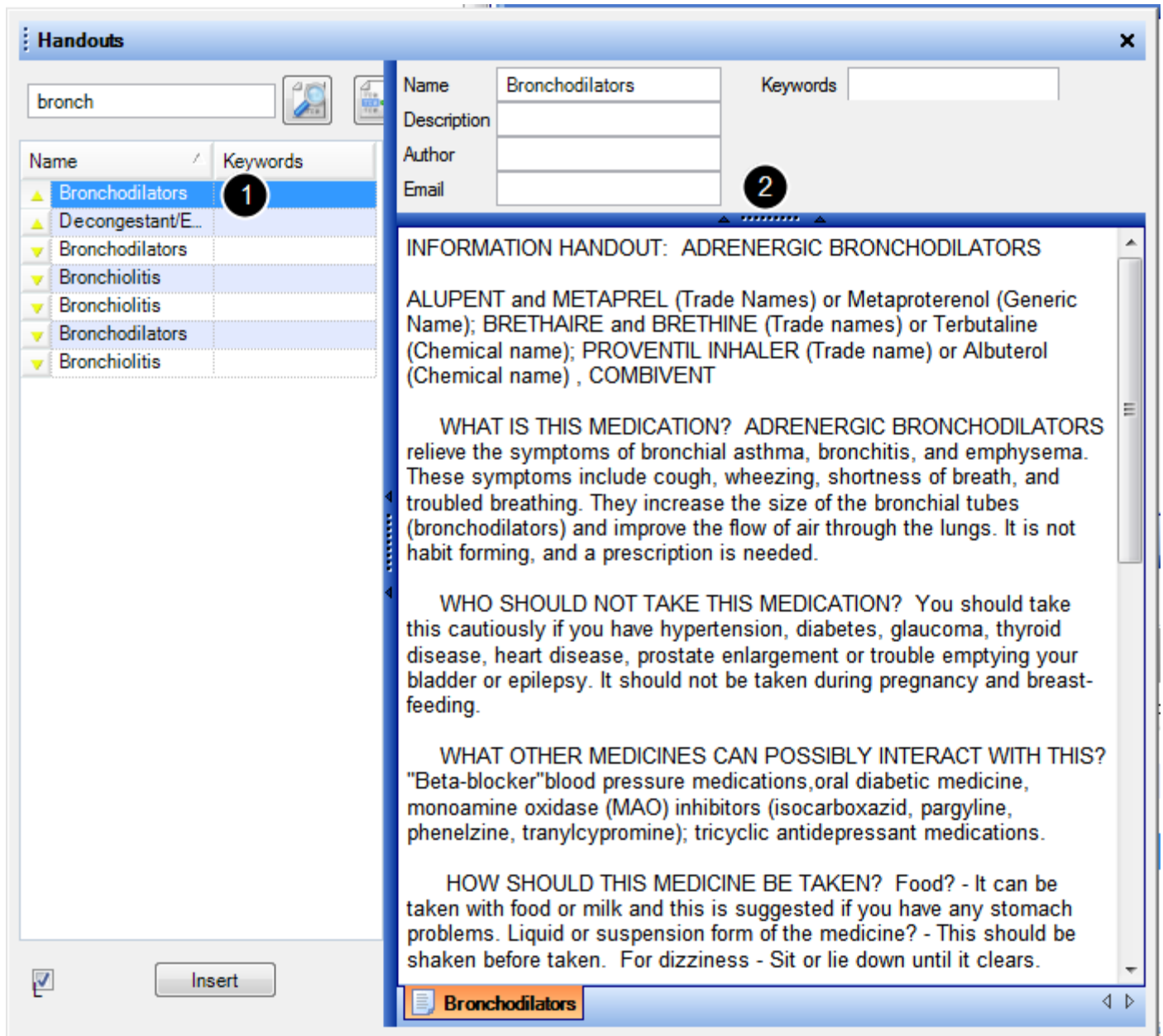
3. Finally, the lower right area of the Handouts Manager contains a preview window that displays the content of the handout currently selected in the handout list. Not only can the Handouts Manager itself be resized, but the individual sections within the Handouts Manager can be resized using the splitter bars between the sections.

## Search



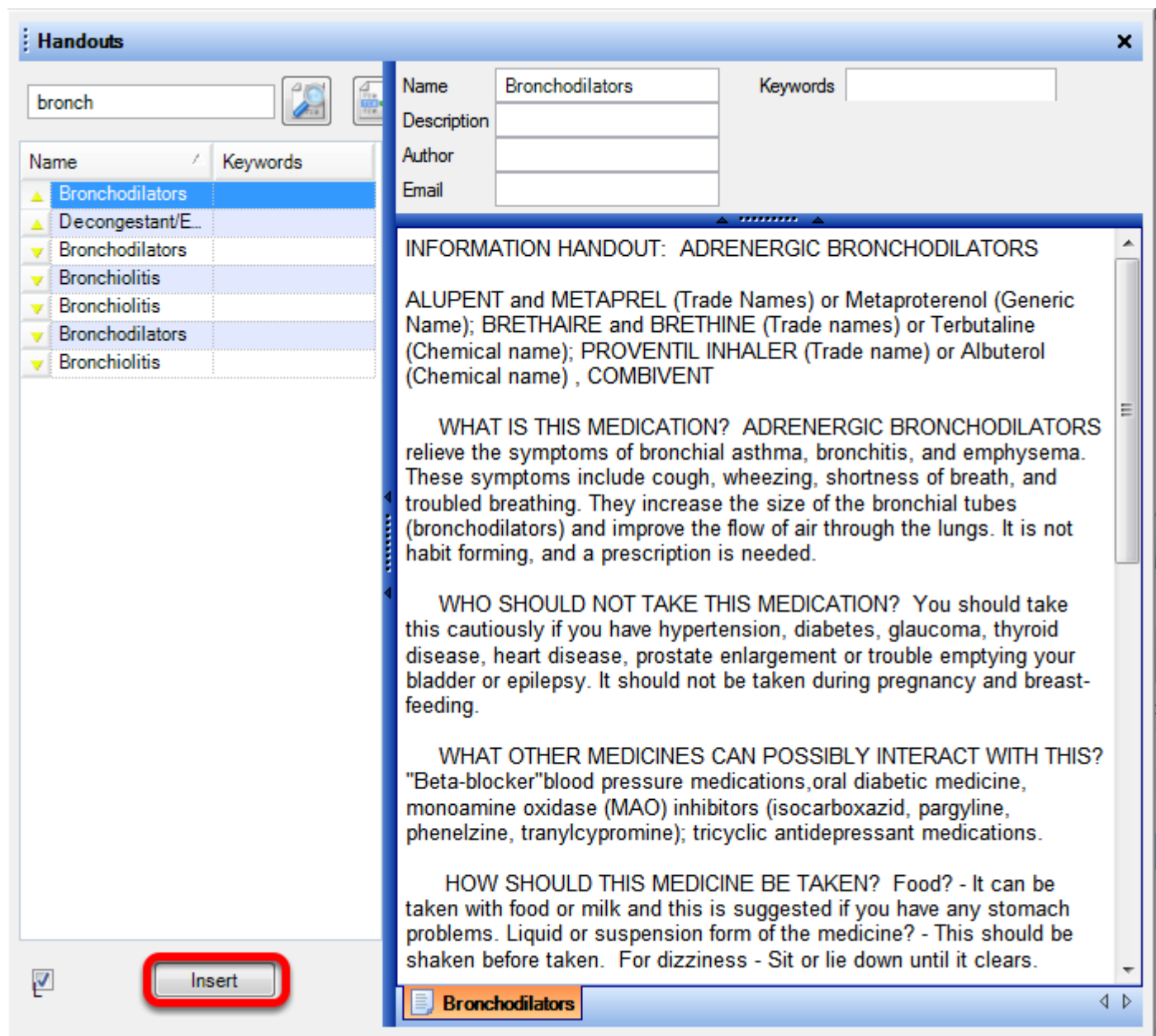
To select a handout, Click in the Search field/box, and type a keyword associated with the handout desired. For example, in order to select a handout on Bronchodilators, type branch. Once the keyword is entered into the search field, either Press the Enter key, or Click the Search button.

## Select a Handout



If there are handouts associated with the keyword, they will appear in the handouts list.

1. Click the handout name in the item list.
2. A preview of the handout will appear in the right side of the Handouts Manager.



Once a handout is selected, it can be inserted into the currently active document. To do this, Click the Insert button located under the handouts list.

## Selecting Handouts Automatically

---

SOAPware can look at the current SOAPnote and automatically select and print the appropriate handouts, based on keywords, in the Assessment, Plan and Medications fields.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- [Patient Specific Educational Resources](#)

### Patient Meaningful Use Dashboard:

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

#### Assessment and Medication

##### Assessment

Allergic rhinitis ICD#477.9

##### Plan

[Actions:](#)

##### Medications[

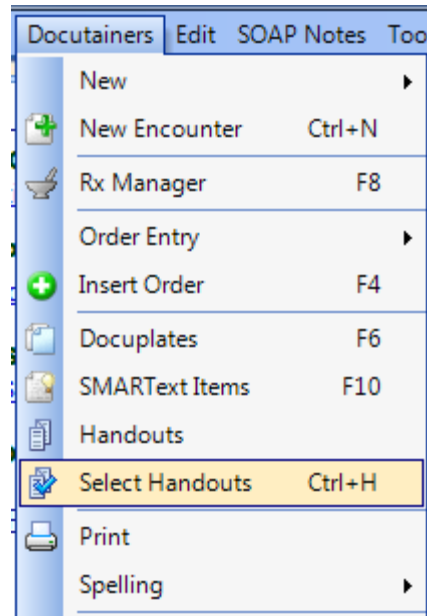
Albuterol (Proventil, Ventolin) Solution: 0.5% (solution) SIG- as directed via nebulizer every 6 hours  
asneeded inhaled #60 ml Substitutions Allowed Refills- 12 Comment- Notes- |

]

In this example, notice Allergic rhinitis is in the Assessment field and Albuterol is in the Medications field.

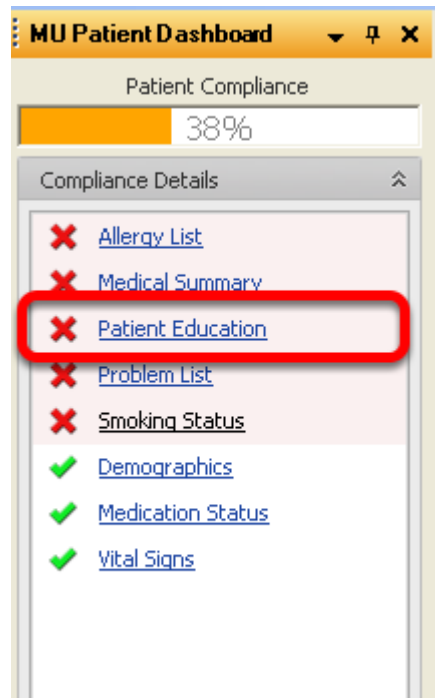


## Select Handouts



Once the SOAPnote's Assessment, Medications, and Plan fields are at or near completion, Click Docutainers in the menu bar, and Click Select Handouts (or Press Control + H).

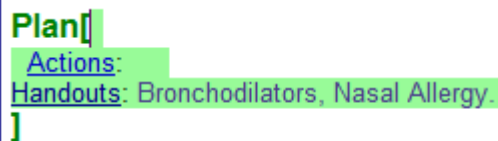
## Select Handouts using the MU Patient Dashboard



In addition to the method described above, a user can also insert handouts by Clicking on the "Patient Education" item within the MU Patient Dashboard.

Once handouts have been entered into the Plan field, the Red X in the MU Patient Dashboard will change to a Green Plus to indicate that the active SOAPnote contains Patient Education. See: [MU Patient Dashboard](#) for more information.

### Handouts Added to Plan



Plan[  
Actions:  
Handouts: Bronchodilators, Nasal Allergy.  
]

SOAPware checks to see if there are any handouts linked to keywords appearing in the current SOAPnote. If there are handouts available, the handouts will automatically be inserted into the Plan field.

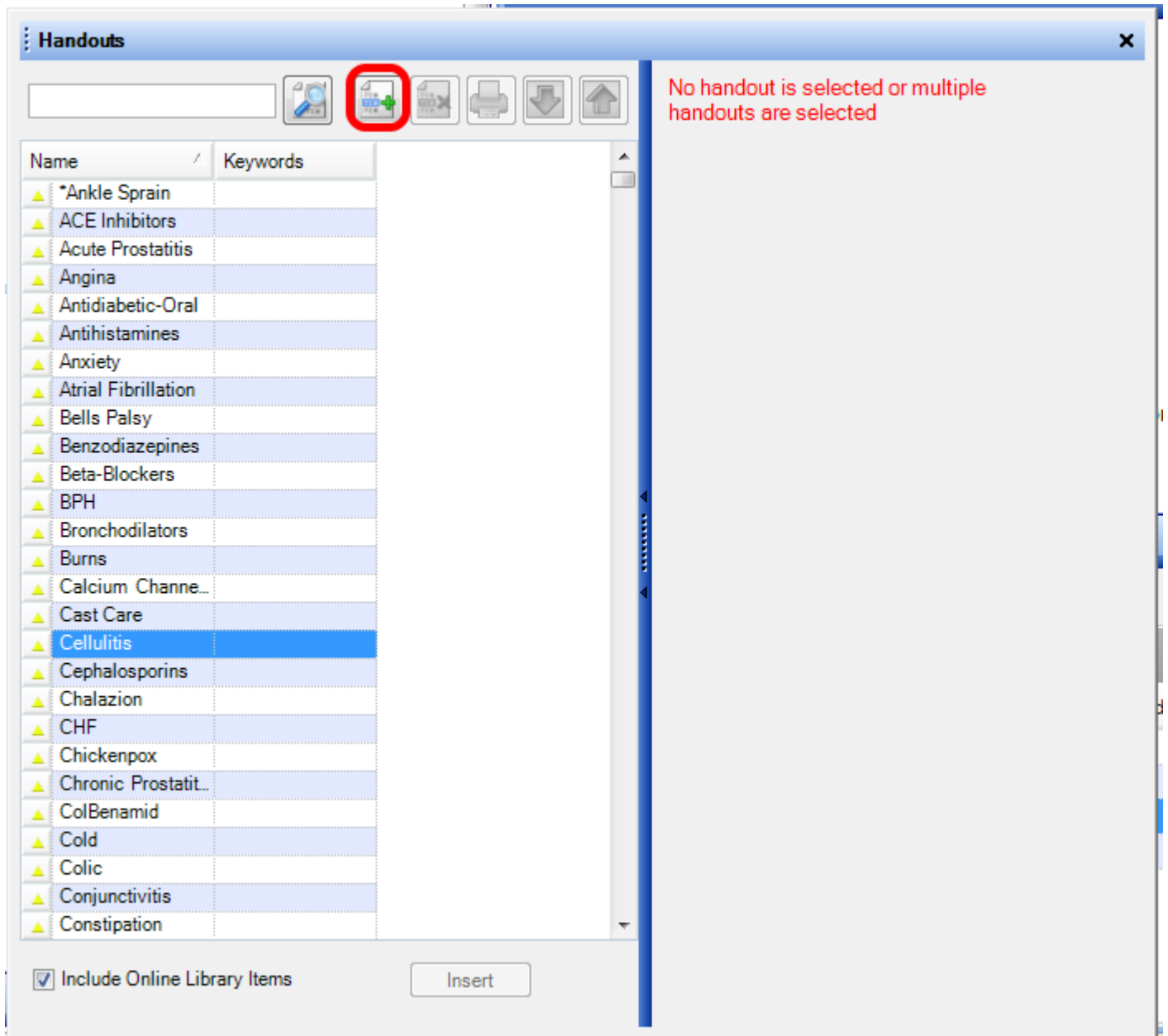
### Tips

Notice this function will only choose and insert handouts names if there are handouts in SOAPware that match an appropriate keyword from the current SOAPnote. If a user attempts to use this function and nothing happens, there are no handouts in SOAPware that match the user's current SOAPnote.

## Adding a New Handout

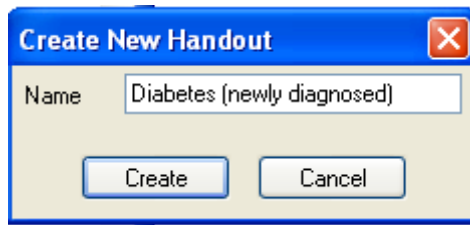
If the user needs to create a custom handout, or a handout on a topic not covered by an existing handout, the user can create his/her own.

### New Handout



New handouts can be created in the Handouts Manager by Clicking the New Handout button (or by Pressing Control + Alt + N).

## Create New Handout



Clicking the New Handout button will open the Create New Handout dialog. Enter the desired handout name then Click the Create button.

## Handout Demographic Information

The screenshot shows the 'Handouts' window in SOAPware. On the left is a list of existing handouts with columns for 'Name' and 'Keywords'. The 'Diabetes (newly diagnosed)' handout is selected. On the right is a form for adding a new handout, which is highlighted with a red box. The form has fields for Name, Description, Author, and Email, and a Keywords field. The 'Name' field is filled with 'Diabetes (newly diagnos' and the 'Keywords' field is filled with 'diabetes'. Below the list is a checkbox for 'Include Online Library Items' and an 'Insert' button.

Name	Keywords
Control de peso: lo que to...	
COPD	
Corneal Ulcer	corneal ulcer
Cortisone	celestone, cortef...
Cortisporin	cortisporin
Cough suppress/expectora...	benylin expector...
Cough suppress/expectora...	
Cough suppress/expectora...	
Coumadin	coumadin, warfa...
Coumadin	
Coumadin	
Coumadin	
Creating Handout with Ima...	
Croup	croup, ltb
CT Instruct	
Cyclobenzaprine	cyclobenzaprine...
Dash diet	
Decongestant/Expectorant	AMI-TEX LA, BA...
Decubitus Ulcers	bed sore, decubi...
depakote	
Depresion en la mujer	
Depresion en personas de...	
Depression	
Derrame cerebral: rehabilit...	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes (newly diagnosed)	diabetes
Diabetes Annual Checklist	

☒ Include Online Library Items

**Handout Demographic Information Form:**

Name	Diabetes (newly diagnos	Keywords	diabetes
Description	Diabetes Handout for N		
Author			
Email			

A new, empty handout will appear in the handout preview window. Complete the document demographic information. The new handout's name will be filled in automatically. Enter a short Description and at least one Keyword for the new handout. Other options are to type the name of the author and the author's email.

**\*Note:** The Keywords are what SOAPware uses to find handouts, so be sure to include any keywords that are related to the handout. Also note that the keywords need to be either a medication name or a diagnosis.

## Creating a Text Handout

The screenshot shows the 'Handouts' window in SOAPware. On the left is a list of medical conditions with expandable arrows. The 'Diabetes (newly diagnosed)' entry is selected, and its keywords 'diabetes' are visible. On the right, the details for this handout are shown, including its name, description, author, and email. Below this, the text of the handout is displayed, which is highlighted with a red border in the image. The text includes a definition of diabetes, its types, and potential complications like blindness, heart disease, and nerve damage.

Name	Keywords
Control de peso: lo que to...	
COPD	
Corneal Ulcer	corneal ulcer
Cortisone	celestone, cortef...
Cortisporin	cortisporin
Cough suppress/expectora...	benlyn expector...
Cough suppress/expectora...	
Cough suppress/expectora...	
Coumadin	coumadin, warfa...
Coumadin	
Coumadin	
Coumadin	
Creating Handout with Ima...	
Croup	croup, ltb
CT Instruct	
Cyclobenzaprine	cyclobenzaprine...
Dash diet	
Decongestant/Expectorant	AMI-TEX LA, BA...
Decubitus Ulcers	bed sore, decubi...
depakote	
Depresion en la mujer	
Depresion en personas de...	
Depression	
Derrame cerebral: rehabilit...	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes (newly diagnosed)	diabetes
Diabetes Annual Checklist	

**Diabetes (newly diagnosed)** Keywords: diabetes

**Description:** Diabetes Handout for N

**Author:**

**Email:**

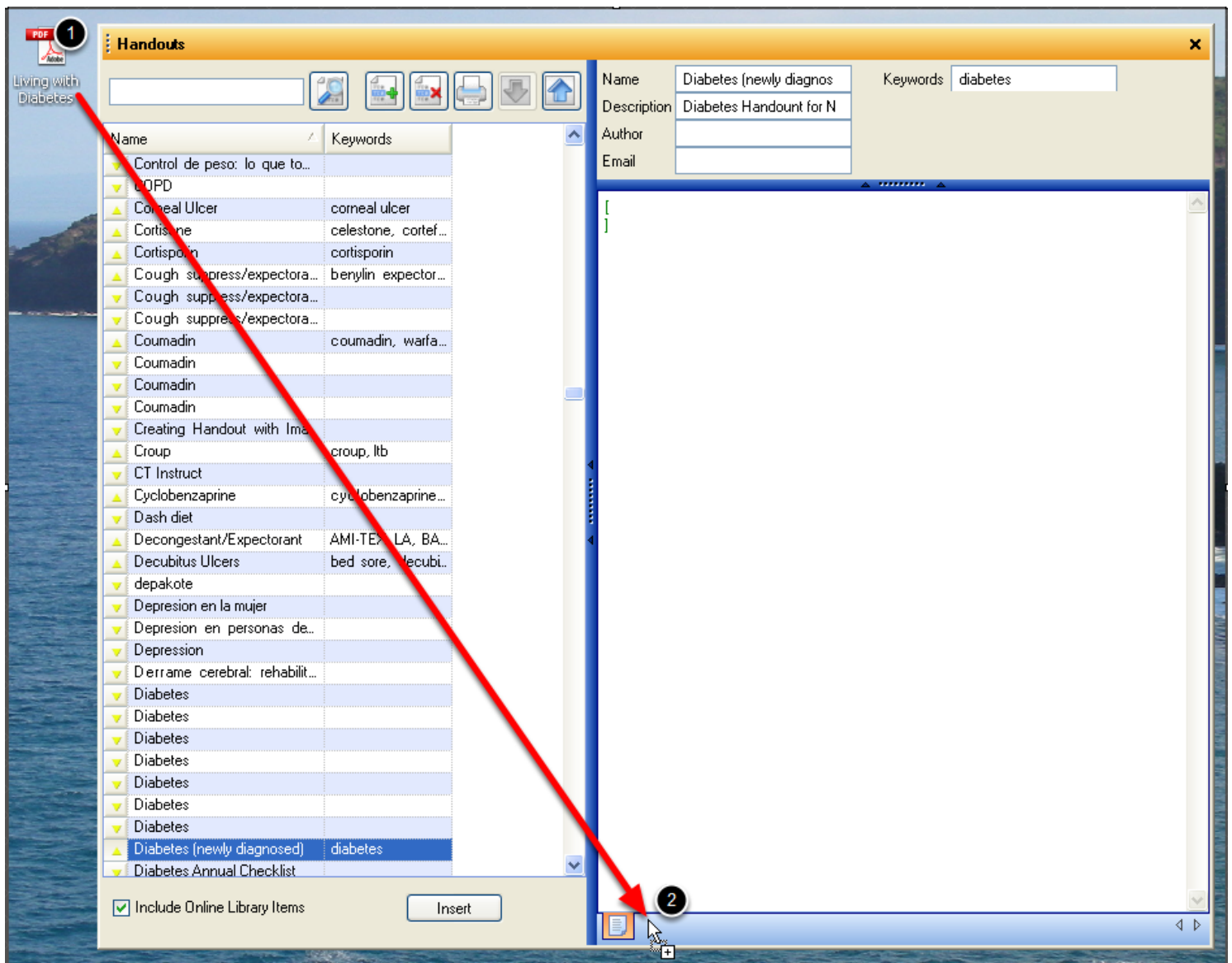
**[What is diabetes?]**  
 Diabetes is a disease that occurs when a person's body doesn't make enough of the hormone insulin or can't use insulin properly. There are 2 types of diabetes. Type 1 diabetes occurs when your body's pancreas doesn't produce any insulin. Type 2 diabetes occurs when the pancreas either doesn't produce enough insulin or your body's cells ignore the insulin. Between 90% and 95% of people who are diagnosed with diabetes have type 2 diabetes. When you digest food, your body changes most of the food you eat into glucose (a form of sugar). Insulin allows this glucose to enter all the cells of your body and be used as energy. When you have diabetes, your body doesn't make enough insulin or can't use it properly, so the glucose builds up in your blood instead of moving into the cells. Too much glucose in the blood can lead to serious health problems.

**What health problems can diabetes cause?**  
 Diabetes can be a dangerous and life-threatening disease if you don't control your blood sugar level. Over time, high blood sugar levels can damage your eyes, blood vessels, nerves and kidneys. Here are some of the problems (also called complications) diabetes can cause: **Blindness and vision loss (called diabetic retinopathy):** Diabetes can damage the small blood vessels in the retina, which can cause vision loss and even blindness. For more information, read our Diabetes: Eye Care handout.

**Heart disease:** People who have diabetes are twice as likely to have heart disease and damage to the blood vessels in the heart. This increases their risk of heart attack and stroke. For more information, read our Diabetes and Heart Disease handout. **Nerve and blood vessel damage (called diabetic neuropathy):** Damage to blood vessels in the legs can limit the supply of blood to the nerves in the legs and feet.

To create the content for the new handout, type information, or copy and paste information from another text document in between the green brackets. The new handout is automatically saved when exiting.

## Step 1: Creating a PDF Handout



To create a PDF handout, follow the steps below:

1. Locate the PDF document that the user wishes to import into SOAPware.
2. Left-click on the PDF document and begin dragging it into the Handouts window. Place the mouse cursor to the right of the active tab within the newly created handout, then release the Left Click. This will import the PDF document into SOAPware Handouts.

## Step 2: Creating a PDF Handout

The screenshot shows the 'Handouts' application window. On the left is a list of handouts with columns for 'Name' and 'Keywords'. The 'Diabetes (newly diagnosed)' handout is selected. To the right is a form for creating a new handout with fields for Name, Description, Author, and Email. Below the form is a toolbar with icons for printing, saving, and other actions. On the right side of the window is a PDF viewer displaying a document titled 'Living with Diabetes.pdf'. A red arrow points to the 'Delete' option in a right-click context menu over an empty tab in the PDF viewer.

**Handouts List:**

Name	Keywords
Control de peso: lo que to...	
COPD	
Corneal Ulcer	corneal ulcer
Cortisone	celestone, cortef...
Cortisporin	cortisporin
Cough suppress/expectora...	benylin expector...
Cough suppress/expectora...	
Cough suppress/expectora...	
Coumadin	coumadin, warfa...
Coumadin	
Coumadin	
Coumadin	
Creating Handout with Ima...	
Croup	croup, ltb
CT Instruct	
Cyclobenzaprine	cyclobenzaprine...
Dash diet	
Decongestant/Expectorant	AMI-TEX LA, BA...
Decubitus Ulcers	bed sore, decubi...
depakote	
Depresion en la mujer	
Depresion en personas de...	
Depression	
Derrame cerebral: rehabilit...	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes	
Diabetes (newly diagnosed)	diabetes
Diabetes Annual Checklist	

**Handout Form:**

Name: Diabetes (newly diagnos  
Description: Diabetes Handout for N  
Author:  
Email:

**PDF Viewer:**

Diabetes is a disease that occurs when a person's body doesn't make enough or use the insulin properly. There are 2 types of diabetes. Type 1 diabetes occurs when your body's pancreas doesn't produce any insulin. Type 2 diabetes occurs when the pancreas either doesn't produce enough insulin or your body's cells ignore the insulin. Between 90% and 95% of people who are diagnosed with diabetes have type 2 diabetes.

When you digest food, your body changes most of the food you eat into glucose (a form of sugar). Insulin allows this glucose to enter all the cells of your body and be used as energy. When you have diabetes, your body doesn't make enough insulin or can't use it properly, so the glucose builds up in your blood instead of moving into the cells. Too much glucose in the blood can lead to serious health problems.

**What health problems can diabetes cause?**

Diabetes can be a dangerous and life-threatening disease if you don't control your blood sugar level. Over time, high blood sugar levels can damage your eyes, blood vessels, nerves and kidneys. Here are some of the problems (also called complications) diabetes can cause:

**Blindness and vision loss (called diabetic retinopathy):** Diabetes can damage the small blood vessels in the retina, which can cause vision loss and even blindness. For more information, read our [Diabetes: Eye Care](#) handout.

**Heart disease:** People who have diabetes are twice as likely to have heart disease and damage to the blood vessels in the heart. This increases their risk of heart attack and stroke. For more information, read our [Diabetes and Heart Disease](#) handout.

**Nerve and blood vessel damage (called diabetic neuropathy):** Damage to blood vessels in the legs can limit the supply of blood to the nerves in the legs and feet. This can cause burning, tingling and numbness in the affected areas (usually starting in the toes and spreading to the whole foot). It also makes it difficult to feel injuries (such as foot sores). Damage to the blood vessels can also put you at risk for infections and sores that don't heal. In severe cases, parts of the foot or lower leg may have to be amputated (removed). For more information, read our [Diabetic Neuropathy](#) handout.

**Kidney disease (called diabetic nephropathy):** Diabetes can damage the small blood vessels in the kidneys, which then can't filter out the body's waste. In some people, the kidneys stop working completely. These people require dialysis or a kidney transplant. Dialysis is a treatment that eliminates wastes in the blood. For more information, please read our [Diabetic Nephropathy](#) handout.

The good news is that diabetic complications can often be prevented by taking care of yourself, following your doctor's orders and controlling your blood sugar level. For more information on how to prevent these problems, please read our [Preventing Diabetic Complications](#) handout.

**How is diabetes treated?**

The goal of diabetes treatment is to keep your blood sugar level as close to normal as possible—not too high (called hyperglycemia) and not too low (called hypoglycemia).

The first step is to eat a [healthy diet](#) and to [exercise](#). This may mean you'll need to change your current diet and exercise habits. You'll also have to watch your weight (or even lose weight if you are overweight). Your doctor will talk to you about the kinds of food you should eat and how much exercise you'll need every week.

Regularly checking your blood sugar is a key to helping you control it. Blood sugar checks can help you see how food

**Context Menu:**

- Open Externally
- Rename
- Delete
- New
- History
- Send Copy to Encounter

After the user has imported the PDF handout, the blank text handout tab will need to be deleted. To do this, Right-click on top of the empty tab and Select Delete.



## Editing Existing Handouts

It is easy to modify existing handouts to keep them up to date and comprehensive.

### Editing Handouts

The screenshot shows the 'Handouts' window with a search bar containing 'asthma'. Below the search bar is a list of handouts with columns for 'Name' and 'Keywords'. The first item, 'Asthma', is selected. To the right of the list is a form for editing the selected handout. The form includes fields for 'Name' (Asthma), 'Description' (New Handout), 'Author', and 'Email'. Below these fields is a large text area containing the text of the handout. The text is titled 'Management of Asthma: Information for Patients Community Practice Guideline' and includes a URL 'http://www.asthma.com/'. The text is highlighted in green. At the bottom of the window, there is a checkbox labeled 'Include Online Library Items' and an 'Insert' button.

Name	Keywords
Asthma	
Asthma - patient...	
Asthma - patient...	
Asthma - patient...	

Name: Asthma  
Description: New Handout  
Author:   
Email:   
Keywords:   
  
Management of Asthma: Information for Patients  
Community Practice Guideline  
  
<http://www.asthma.com/>  
  
You know, of course, that breathing is essential to life. So is good medical care - which is where today's highly effective treatments for asthma come in. A diagnosis of asthma may threaten to throw your life off balance. But your doctor has a wider variety of proven ways to manage your asthma than ever before. Once you know the asthma "triggers" to avoid and the correct way to use your medications, you'll be in good shape to control your symptoms - and keep asthma from controlling your life.  
What is asthma and what causes an asthma attack?  
Asthma is a chronic disease of "over-sensitivity" of the airways (breathing passages). When you have an asthma attack, your airways narrow in response to some form of irritation, or "trigger," making breathing difficult. Asthma "attacks" range from mild to life-threatening; in most cases, treating your asthma on a daily basis can greatly limit your chances of having an attack. People of all ages and backgrounds can have asthma. There are over 15 million Americans with asthma - including almost 5 million children - and their numbers are increasing. Common asthma triggers include pollen, molds, animal dander, dust mites.

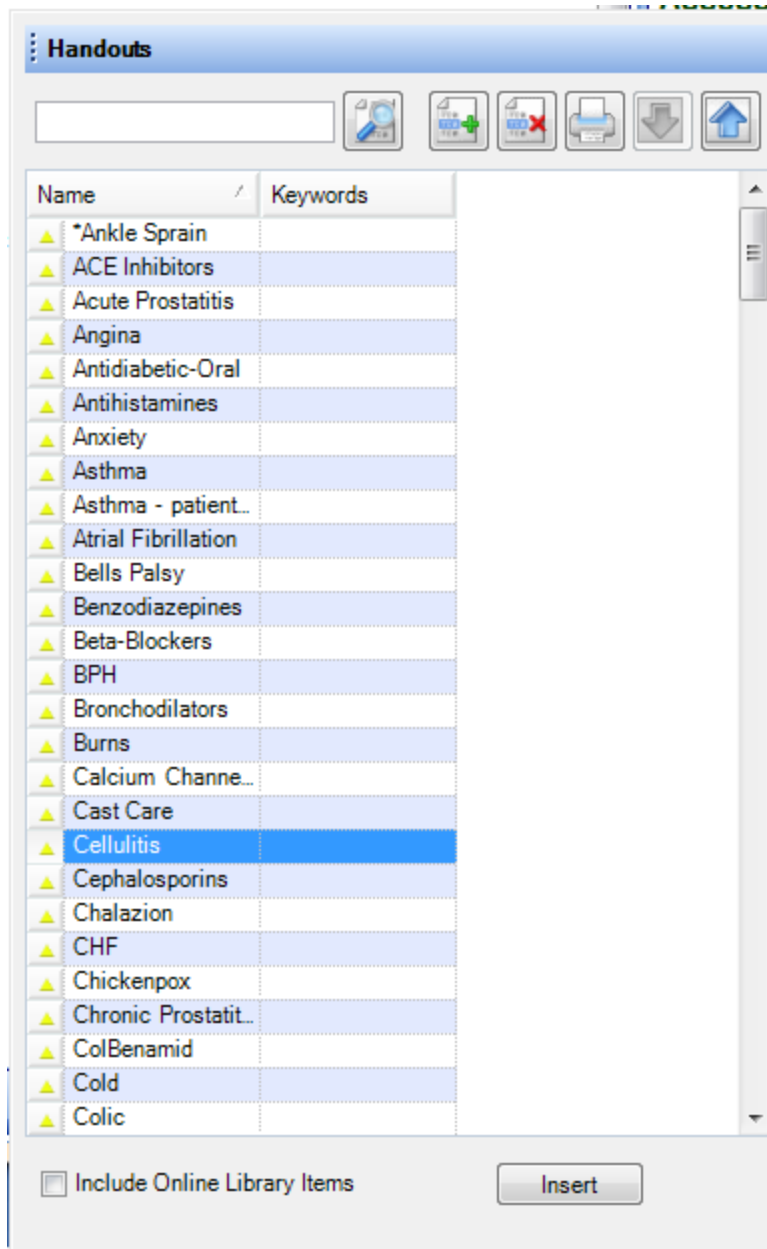
☒ Include Online Library Items

To modify or customize an existing handout, first select that handout to make it appear in the preview window on the right. The user is to make any changes to the handout in the same way that he/she would if creating a new handout, and close the Handouts Manager. The handout will now appear with any edits or modifications made.

## Deleting Existing Handouts

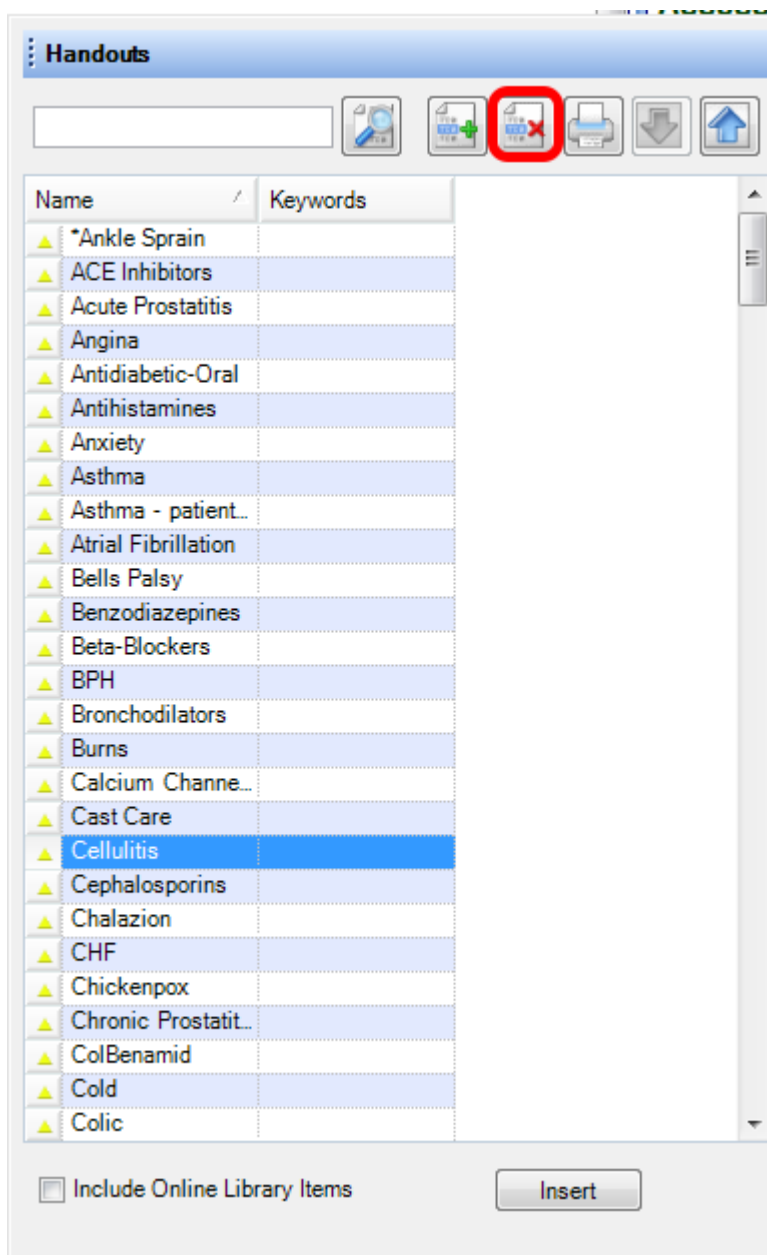
Deleting Handouts from the local library is a good way to keep them easy to use so that only the most current handouts are included with the Select Handouts Automatically option.

### Search and Select



To delete an existing handout, click the Name in the list (of the handout to be deleted). Do this by searching for the handout by keyword, and selecting it from the handouts list.

## Delete Handout

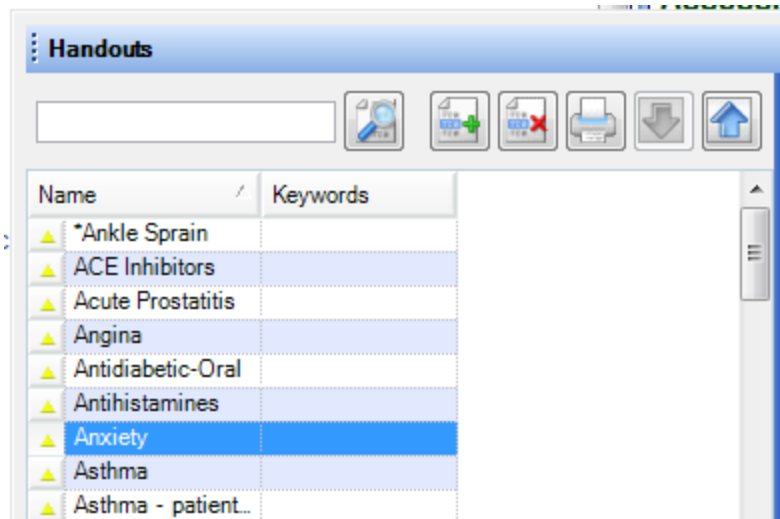


After selecting the handout to be deleted, Click the Remove Handout button (or Press Ctrl+Alt+R). SOAPware will ask for confirmation to delete the handout. Click Yes, and the handout will be removed from the list. Otherwise, Click No.

## Printing Individual Handouts

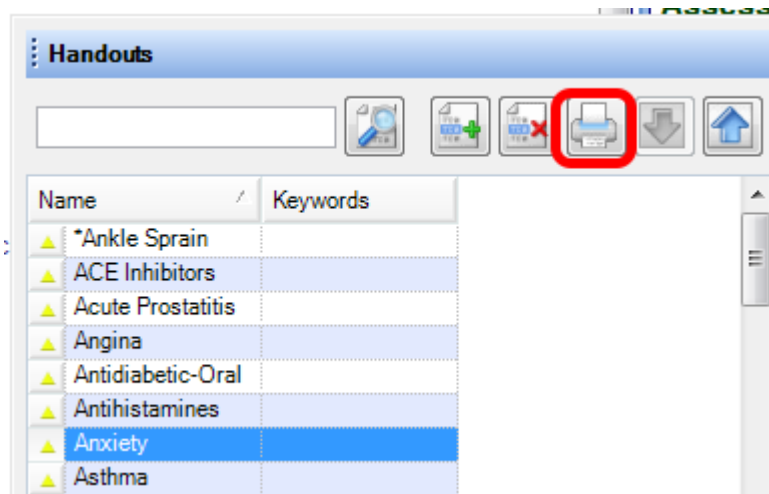
Handouts can be printed individually.

### Select



Select the handout to print. Do this by searching for the handout by keyword, and selecting it from the handouts list.

### Print



After selecting the handout to be printed, Click the Print Handout (or Press Control + Alt + P).

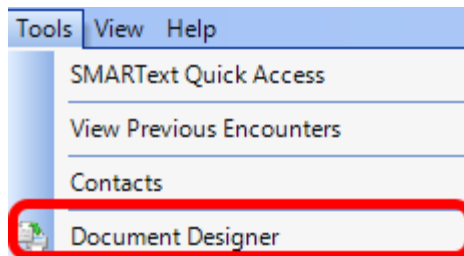
## Print Handouts Alone Automatically

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This lesson will guide the user through the steps necessary to print out handouts alone, automatically, as part of a patient visit.

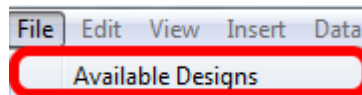
**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Patient Specific Educational Resources](#)**

### Access Document Designer



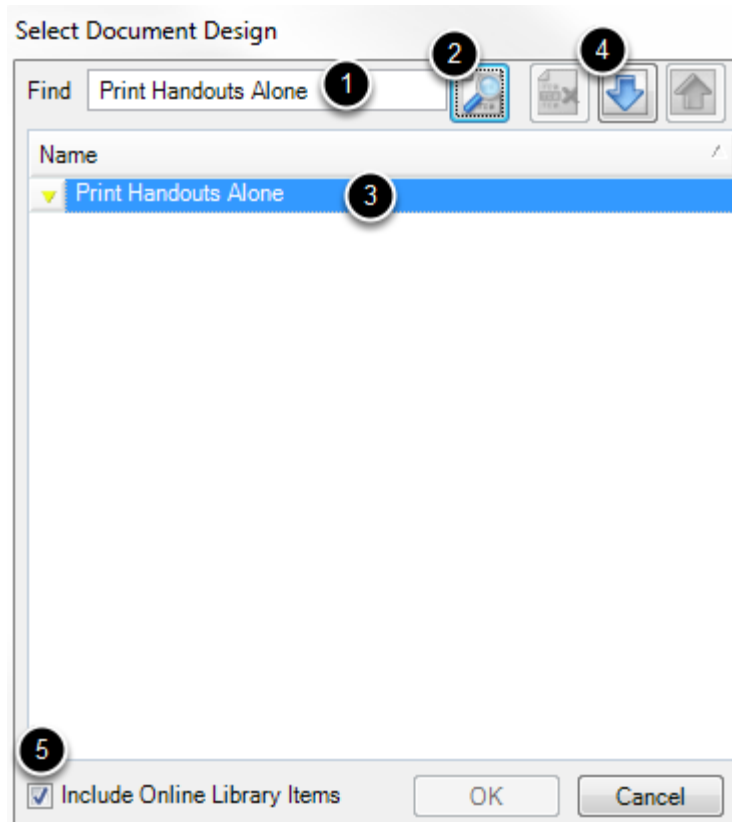
Click Tools > Document Designer from the main menu.

### Search Available Designs



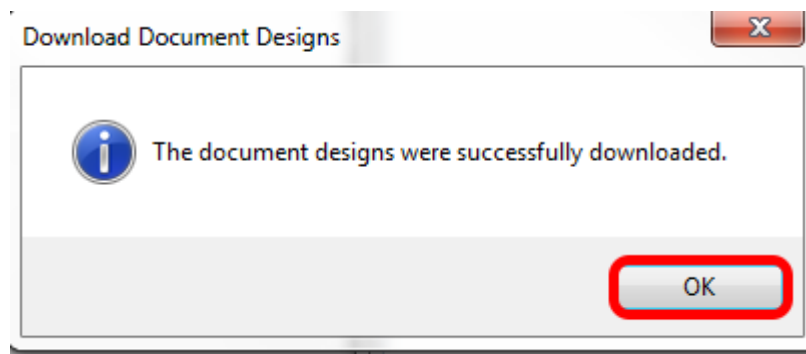
Select File > Available Designs.

## Search for Print Handouts Alone Document Online



1. Type "Print Handouts Alone" into the search box.
2. Click the search button.
3. Highlight the document.
4. Click the blue download button.
5. Be sure to have the "include Online Library Items" box checked.

## Successfully Downloaded



Once the document has been successfully downloaded, Click OK. The document design is now available for use by all users on the network at office.

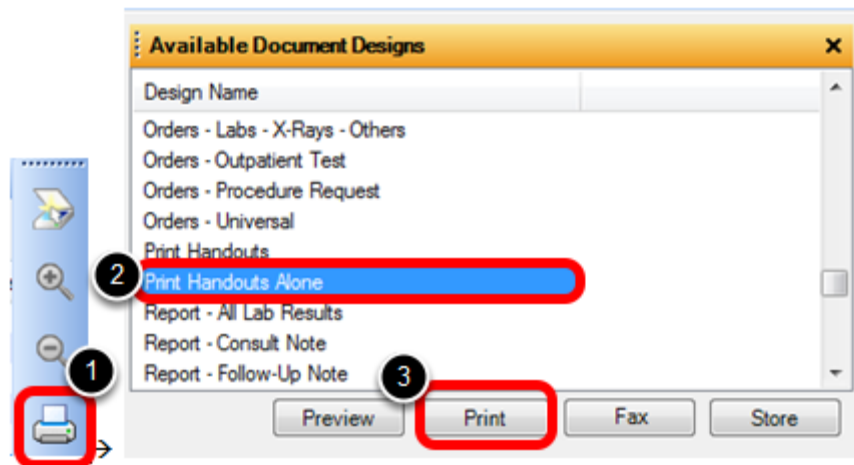
## Selecting Handouts Automatically

SOAPware can look at the current SOAPnote and automatically select and print the appropriate handouts, based on keywords in the Assessment, Plan, and Medication fields.

To review Selecting Handouts Automatically see:

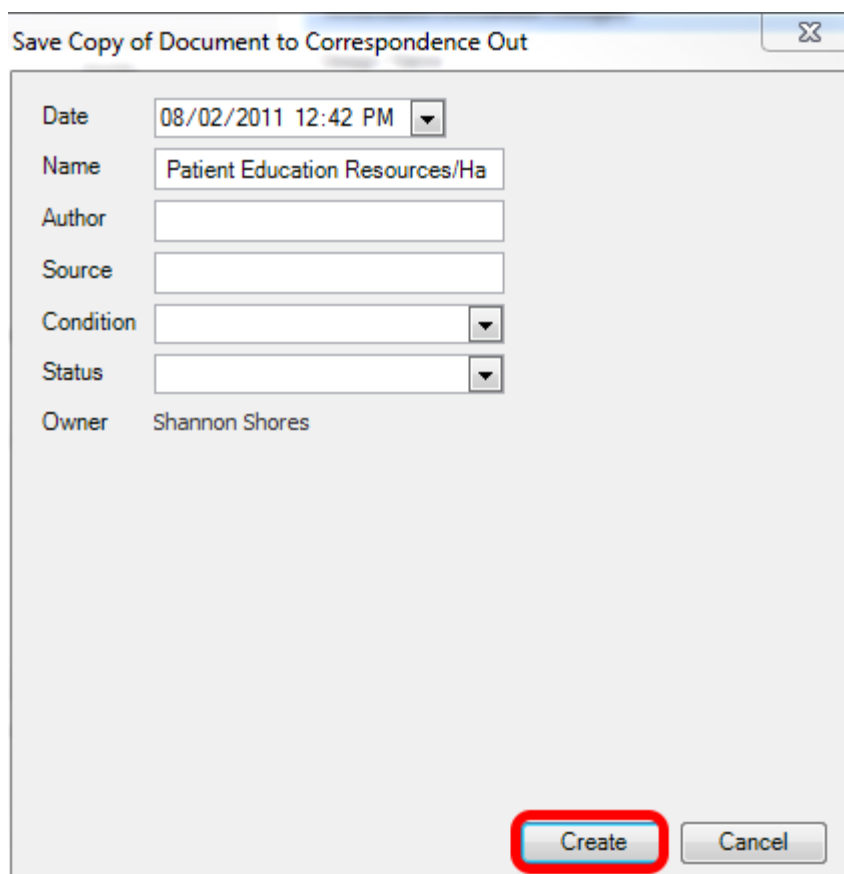
[Selecting Handouts Automatically](#)

## Select the Print Handouts Alone Document



1. Click on the printer button from the Common Toolbar. ( or Click Docutainers > Print)
2. Scroll down and Select the Print Handouts Alone Document Design.
3. Click Print.

## Save to Correspondence Out



Save Copy of Document to Correspondence Out

Date: 08/02/2011 12:42 PM

Name: Patient Education Resources/Ha

Author:

Source:

Condition:

Status:

Owner: Shannon Shores

Create Cancel

Click the Create button to store a copy of this document design in the Correspondence Out chart section.



## Print Handouts Automatically when other Documents are Printed

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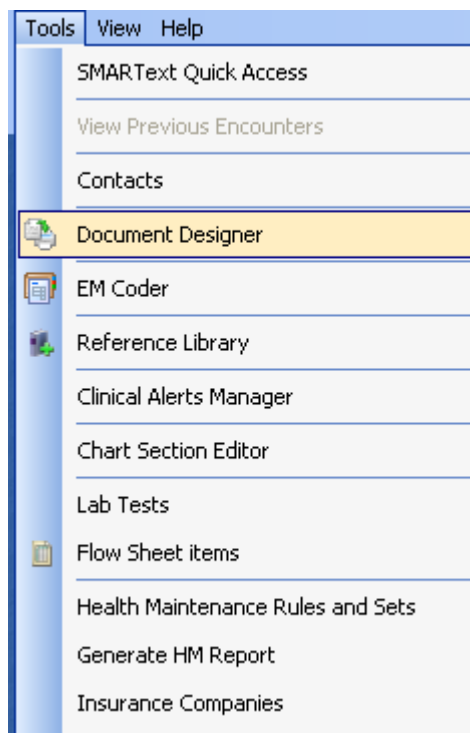
Document Designer allows the user to set up print designs which automatically print associated handouts when the design is printed. For instance, the user can set up the SOAPnote design to also print any handouts selected as a part of the visit.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Patient Specific Educational Resources](#)**

### Patient Meaningful Use Dashboard:

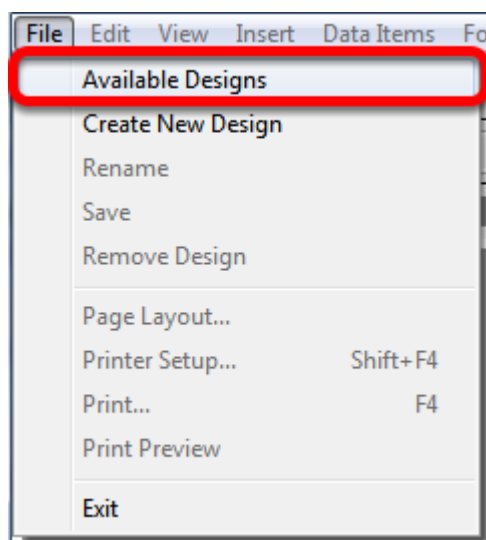
This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

### Open Document Designer

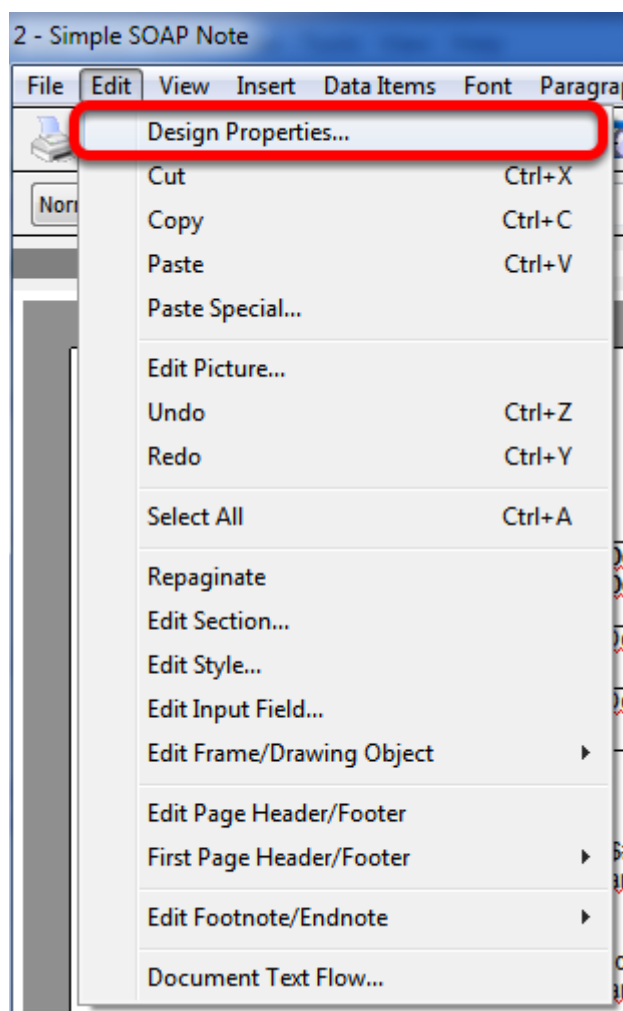


In order for handouts to be printed when a SOAPnote document design is printed, the Print Selected Handouts option must be set in the printed document design. Open the Document Designer (Tools - Document Designer).

## Open a Design

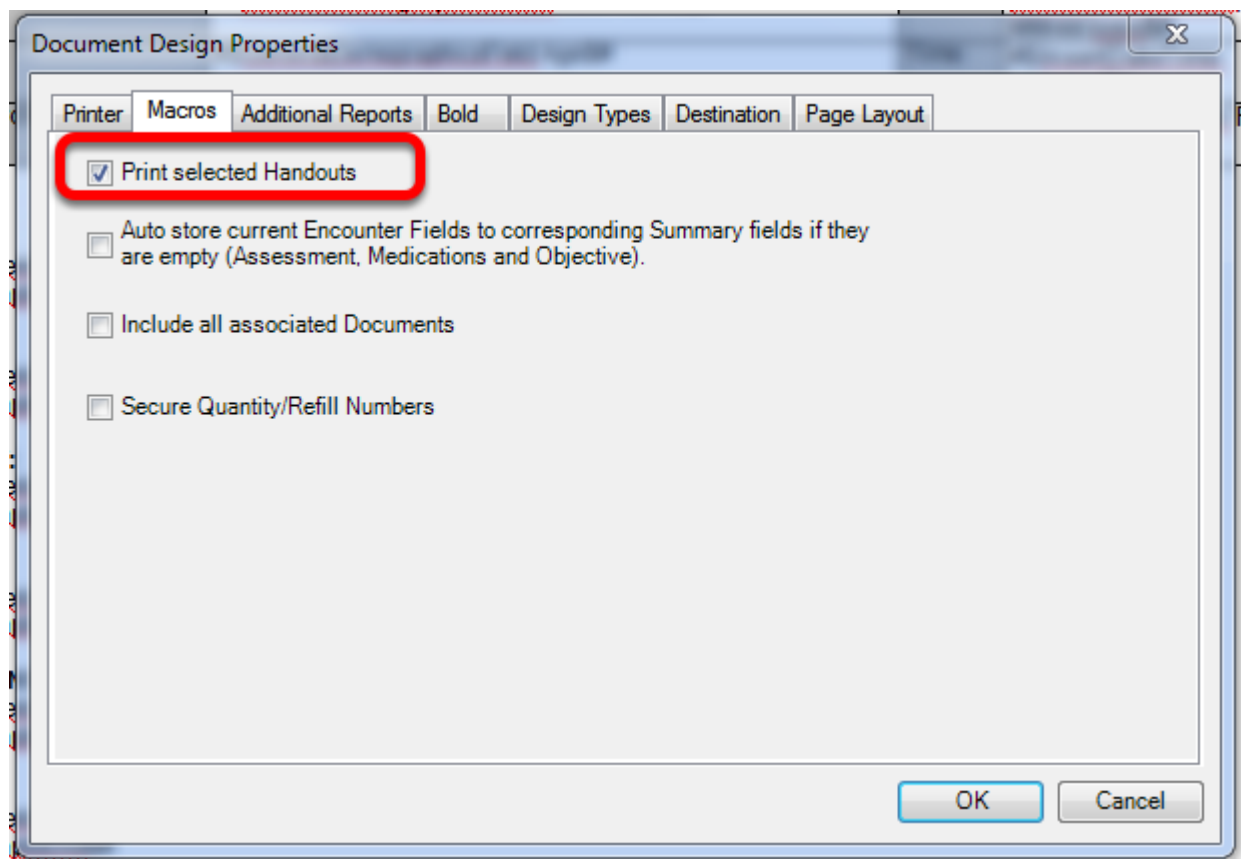


Open a document design or create a new one (File - Available Designs or Create New Design).



Once the user has created or opened a design, view the Document Design Properties (Edit - Design Properties).

## Print Selected Handouts



On the Macros tab, check the box next to Print Selected Handouts.

## Save

Click OK and save the changes. Any time that the document design is printed in the future, the selected handouts will be printed so they can be given to the patient.

## Uploading/Downloading Handouts

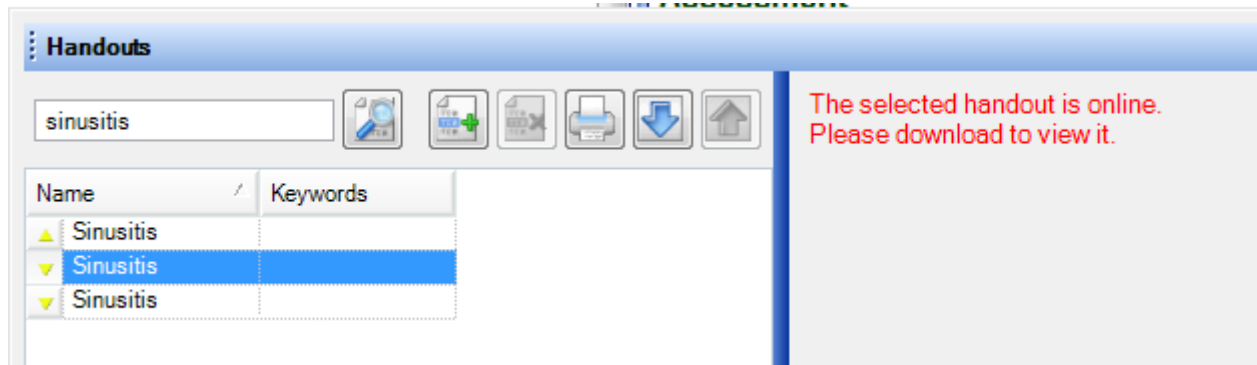
The SOAPware Online Library contains handouts created by SOAPware and users. They can be downloaded for use. Please consider contributing personal handouts for others to download and use.

### Include Online Library Items



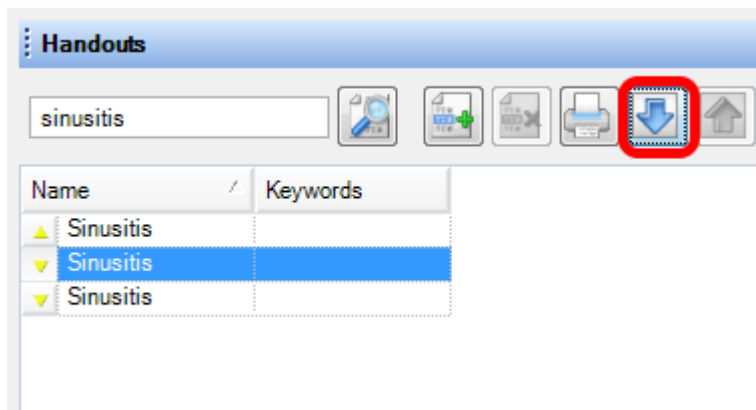
To download a handout from the library, first ensure that the Handouts Manager has been told to include online handouts. To do this, Click the Include Online Library Items checkbox located in the lower left corner of the Handouts Manager.

## Select Handout



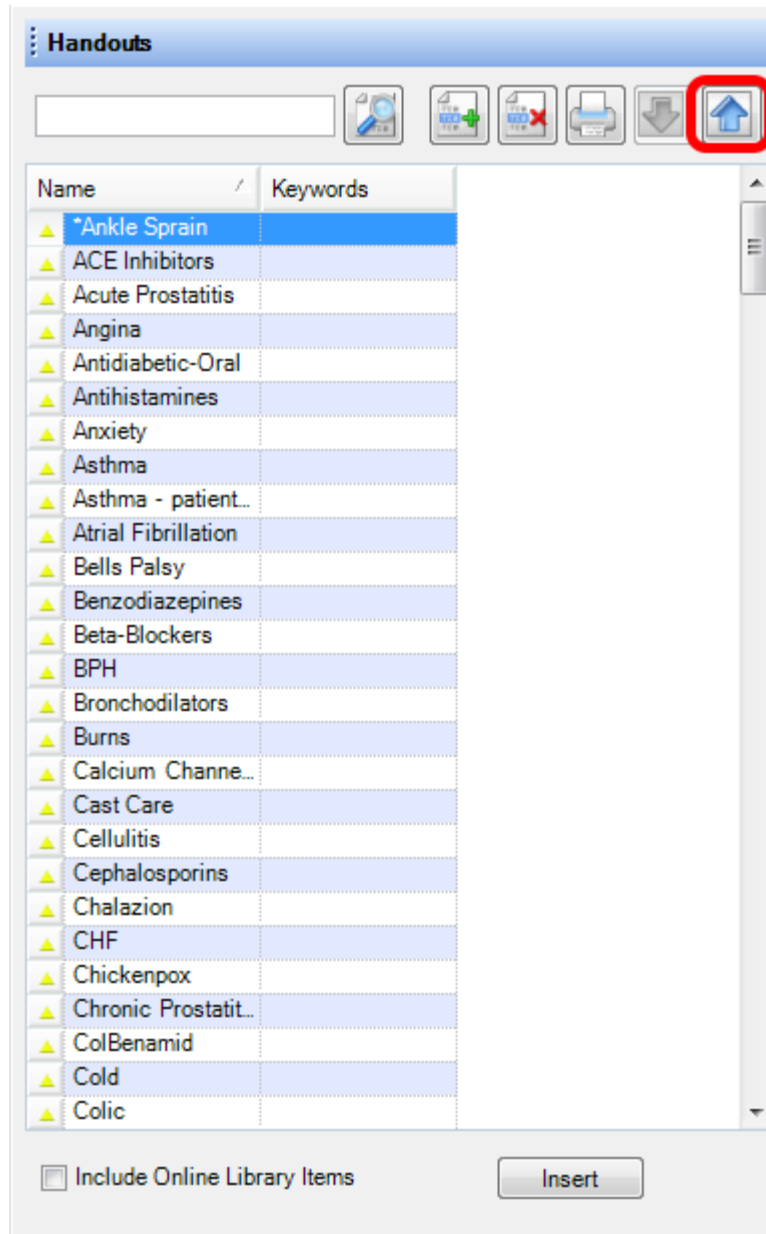
Handouts available for download will display with either a yellow or a green triangle pointing down. Click the name of a handout to download, and notice, in the right side of the dialog, the message - The selected handout is online. Please download to view it.

## Download



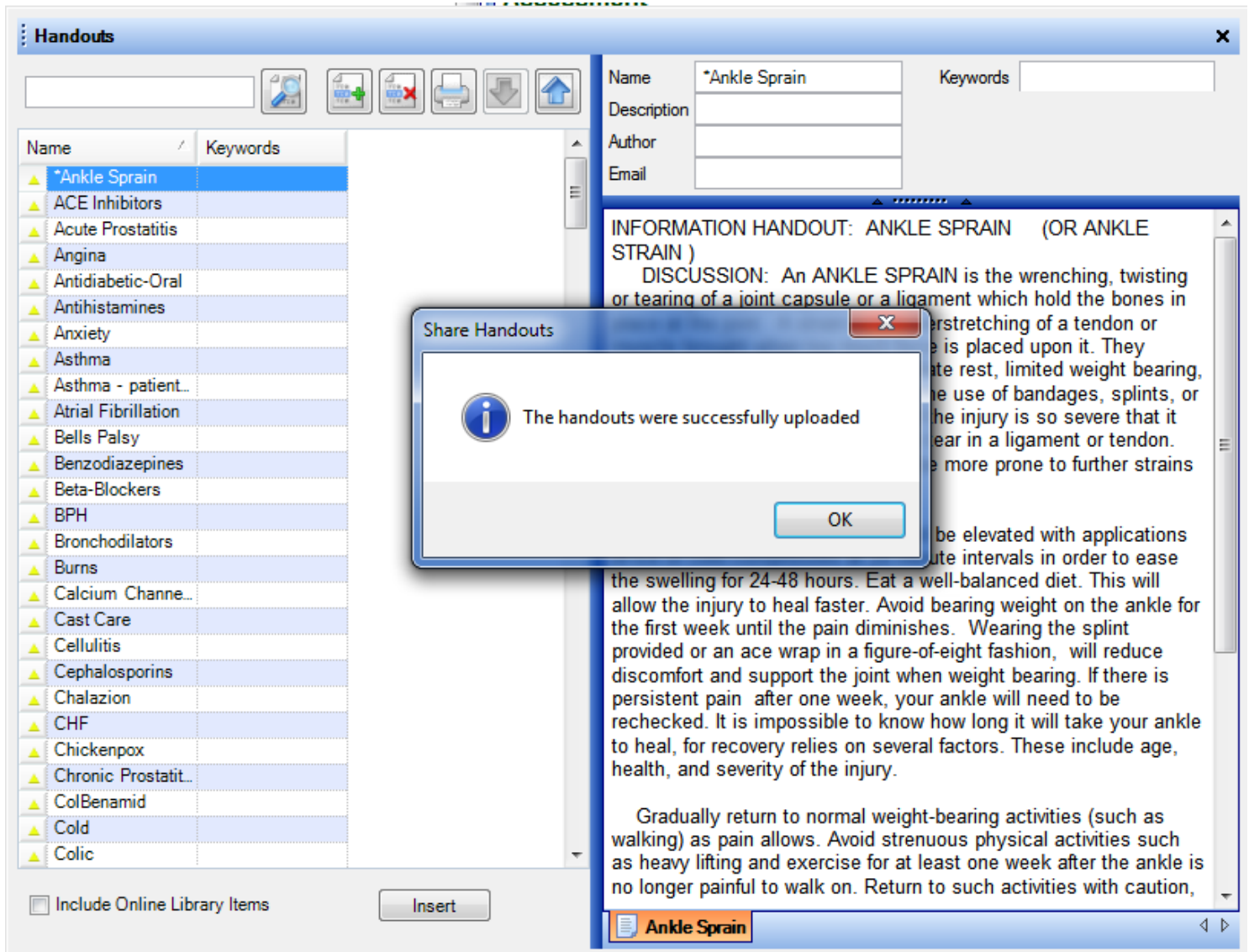
Click the Download button(or Press Control + Alt + D). The selected handout will be downloaded and stored for local use. Notice that the triangle is now pointing up which indicates that it is downloaded to the local database.

## Select Handout



To upload a handout, Click the handout to share/upload, and Click the Upload Handout button.

## Uploading a Handout



SOAPware will confirm the handout has been uploaded.



# Health Maintenance

## Intro to Health Maintenance

---

Health Maintenance is designed to alert and keep track of Preventive health issues. The Health Maintenance section is used anytime a user wishes to add, edit or modify rules that belong to a single patient.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**

- [Patient Reminders](#)

### For Users Converting From Version 4

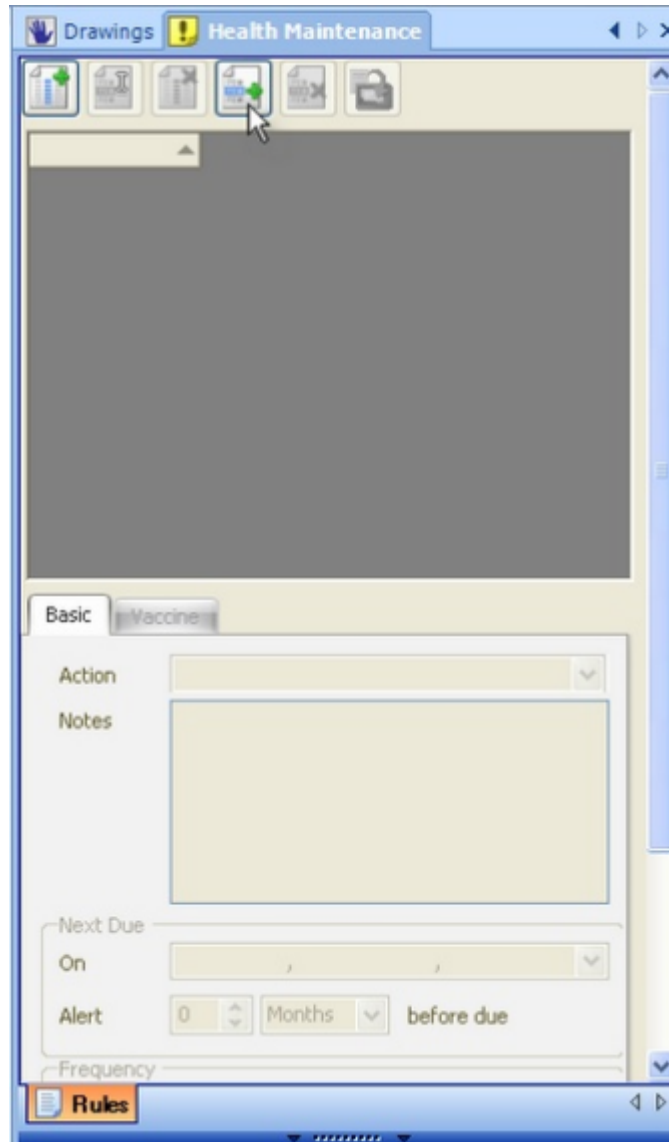
The format for health maintenance in v4 is completely different in versions 2010 and later. The conversion can and does bring over the notes from each rule in v4 patient charts, but the conversion can't reformat the rules to go forward in the new version.

Prior to the conversion, create HM Reports to identify patients due for follow up for health maintenance in the future. Print this report and use it as a back-up reference to ensure issues have been addressed in the future.

We suggest, as patients arrive in the future, update the HM rules in each chart.






### Health Maintenance Rules and Sets

Health Maintenance Rules and Sets allows the user to Create, or Edit Rules and Rule Sets.

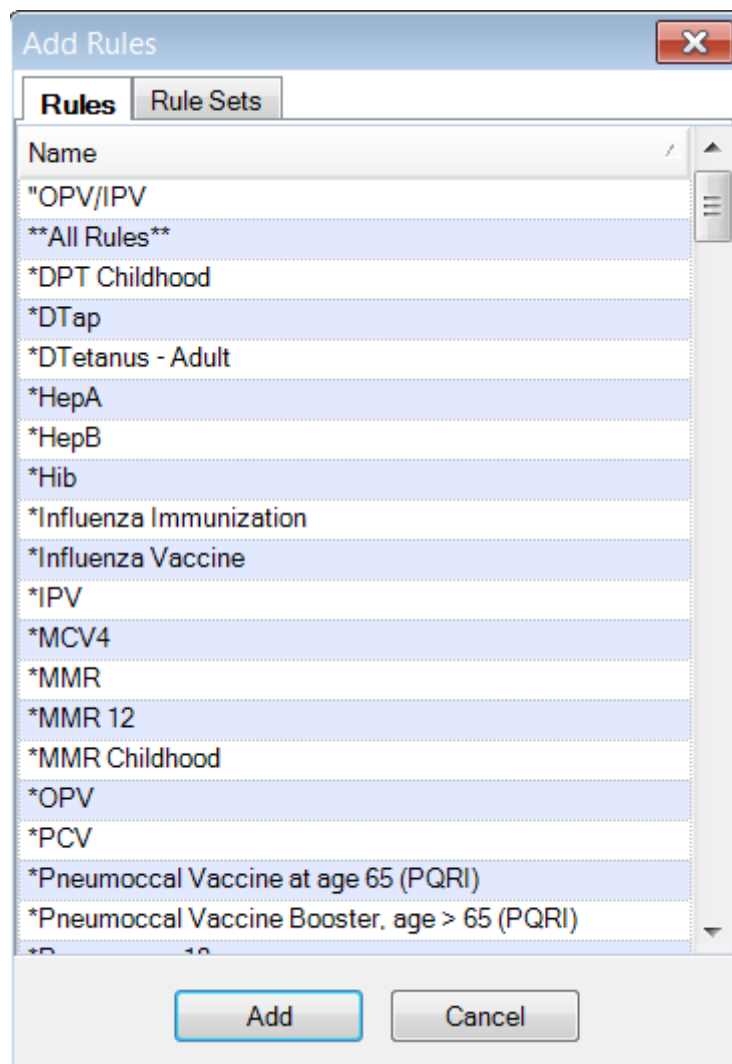


Open a patient chart. Verify the Demographics section of the chart is completed for patient age and gender. Click Chart in the menu bar; Click the Sections menu item, and then Click the Health Maintenance menu item. (or, simply Click on the Chart Navigator docked tab, and Double-click on Health Maintenance) This will add that section to the user's chart layout if it is not there already. Once the tab is included in the chart layout, it can be opened via clicking the Health Maintenance Tab.

## Adding Rules and Rule Sets

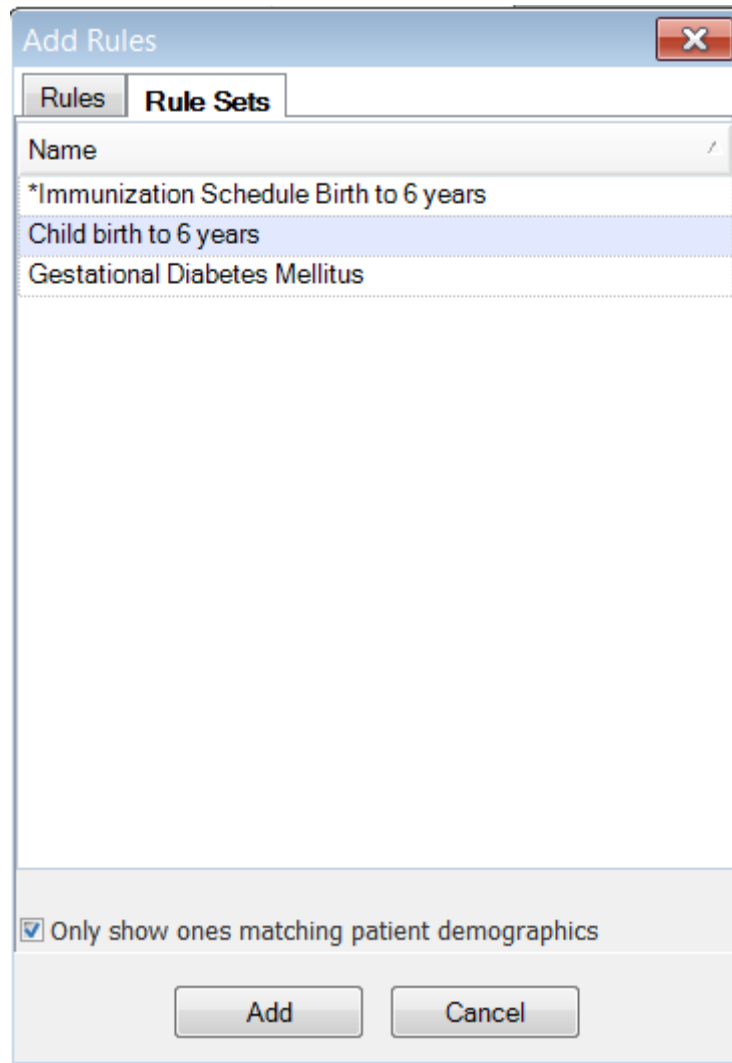
Summary Vital Signs Health Maintenance Demographics Printed			
    			
	11/21/2008 10:48:46 AM	4/29/2009 3:49:12 PM	8/3/2010 9:14:35 .
*DTap	Performed		
*HepA	Performed		
*HepB			
*Hib	Performed		
*Influenza	Performed		
*IPV			
*MCV4			
*MMR		Performed	
*PCV			

To add a Rule or Rule set, Click the Add Rule button (Green +)



Click the Rules tab to add a single rule. In order to select multiple rules (not consecutive), Hold-down the Ctrl key; Click each Rules list item to add; then Click the Add button.

## Add Rule Sets



Click the Rule Sets tab to add a collection or set of Rules. Click the Add button.

For example, Click the Males 35 to 49 Rule set to place the Rules applied to it into the upper region of the Health Maintenance section

## Health Maintenance Color Coding

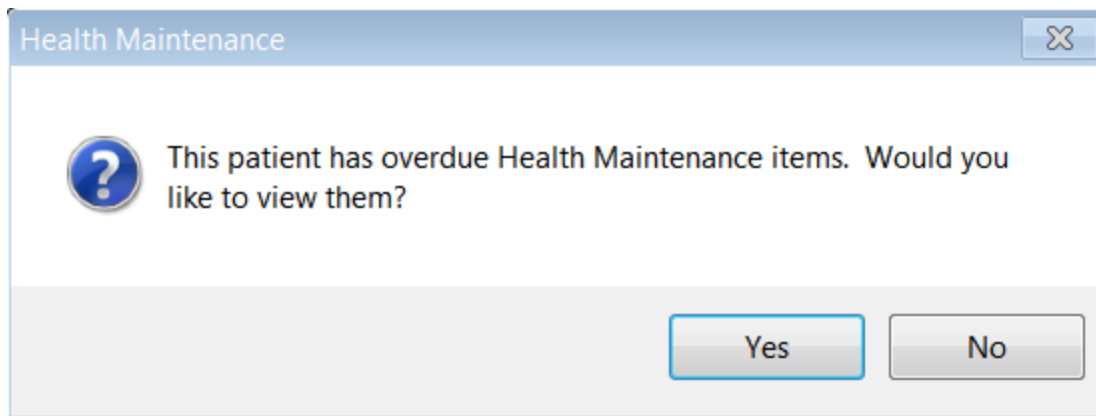
*Rota	
*Varicella	
Anemia	

When a Rule is highlighted in red, the item is overdue or has never been addressed

When a Rule is highlighted in yellow, the rule is not overdue at this point, but past the first day

within the alert period set for the Rule.

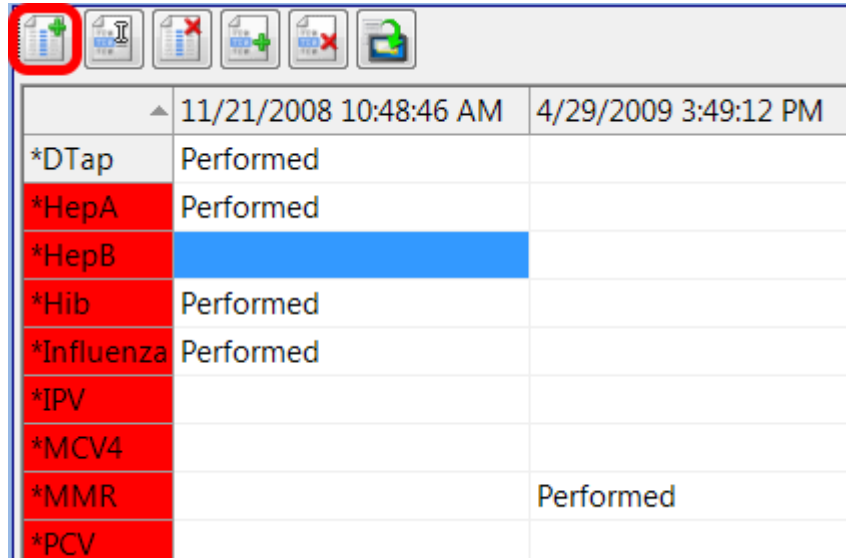
## Health Maintenance Alerts



Once Health Maintenance has been implemented on a patient, an alert window will appear whenever the chart is pulled, letting the user know if Health Maintenance issues need to be addressed. Of course, the user can review this at any time by going to the Health Maintenance tab.

## Addressing a Rule

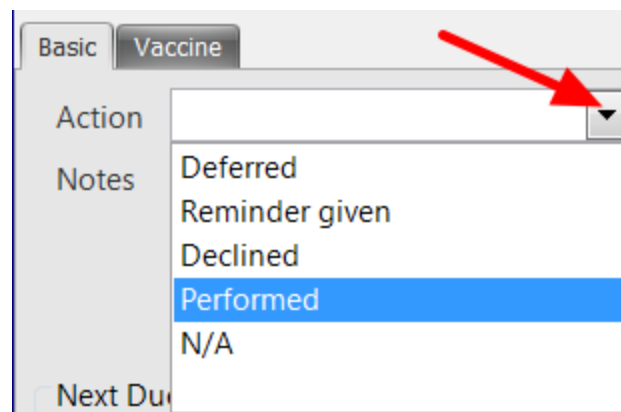
### Add Addressed Date



▲	11/21/2008 10:48:46 AM	4/29/2009 3:49:12 PM
*DTap	Performed	
*HepA	Performed	
*HepB		
*Hib	Performed	
*Influenza	Performed	
*IPV		
*MCV4		
*MMR		Performed
*PCV		

Click the Rule to address, and Click the Add Addressed Date button.

### Select Action



Basic Vaccine

Action

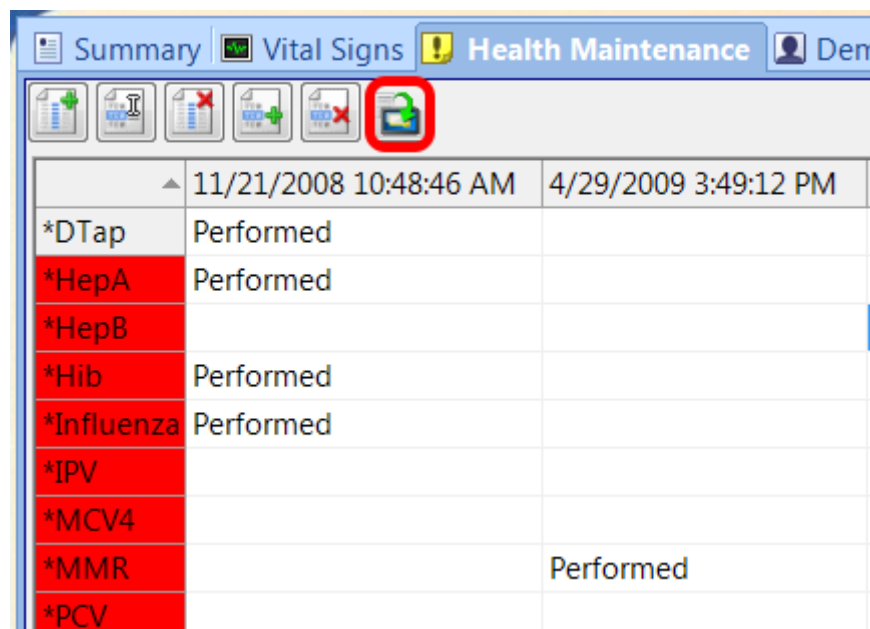
Notes

Next Due

Deferred  
Reminder given  
Declined  
Performed  
N/A

In the lower region of the Health Maintenance section, Click the Action drop-down arrow and Click the appropriate action for that Rule.





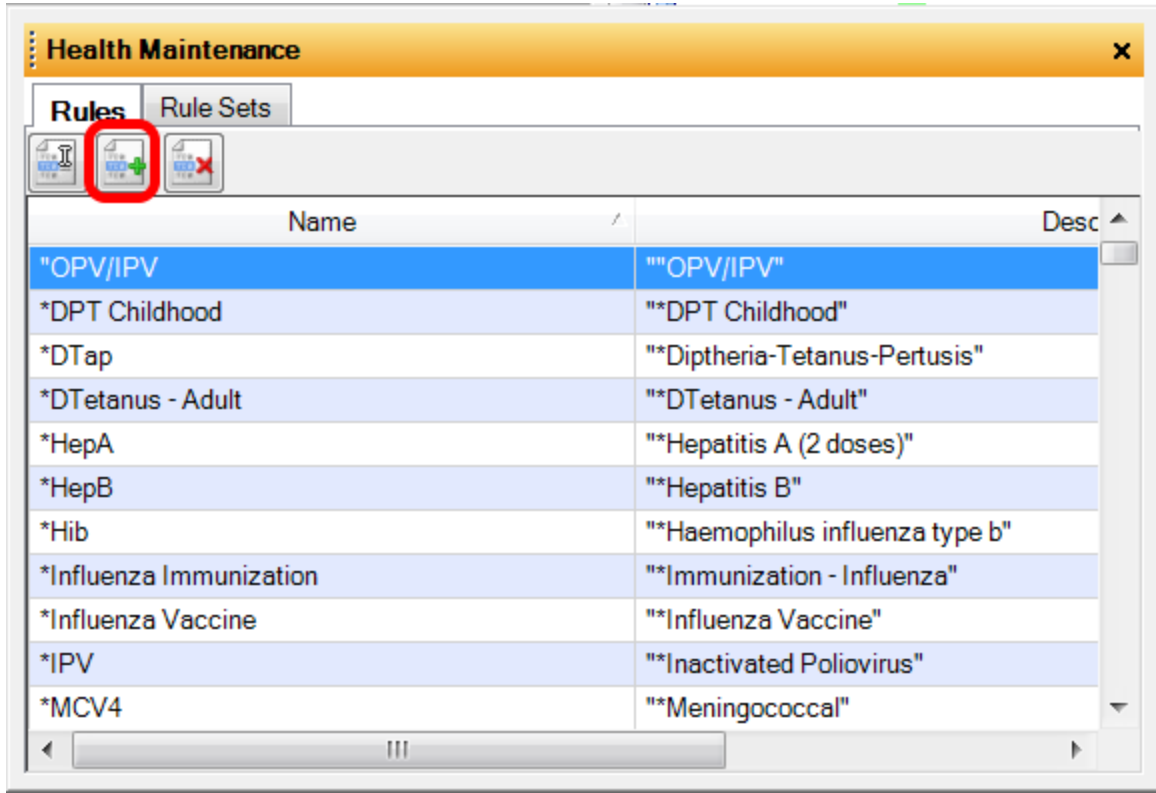
The screenshot shows a software interface with a top navigation bar containing 'Summary', 'Vital Signs', 'Health Maintenance', and a user profile icon labeled 'Dem'. Below the navigation bar is a toolbar with several icons: a green plus sign, a document with a magnifying glass, a document with a red X, a document with a green plus sign, a document with a red X, and a document with a green arrow pointing to a document icon, which is circled in red. Below the toolbar is a table with three columns. The first column contains immunization names, the second column contains the status, and the third column contains the date and time. The table data is as follows:

	11/21/2008 10:48:46 AM	4/29/2009 3:49:12 PM
*DTap	Performed	
*HepA	Performed	
*HepB		
*Hib	Performed	
*Influenza	Performed	
*IPV		
*MCV4		
*MMR		Performed
*PCV		

Once the issues are addressed for that visit, Click the Transfer to SOAPnote button, and the Rules that have been addressed will be added to the Plan field in the current SOAPnote.

## Create a Rule

### Create



Open Health Maintenance by clicking Tools > Health Maintenance Rules and sets and Click on the Create Rule button (Green +)

## Choose Type

The screenshot shows a 'Create Rule' dialog box. The 'Type' dropdown menu is highlighted with a red rectangle and shows 'Basic' selected. Below it are text fields for 'Name' and 'Description'. The 'Alert' section shows '4' in a spinner box, 'Weeks' in a dropdown, and 'before due' text. The 'Frequency' section has an 'Interval' of '0' in a spinner box and 'Months' in a dropdown. Below this is a list box for 'Ages / Dates' which is empty, with 'Edit', 'Add', and 'Remove' buttons to its right. At the bottom is an 'N/A List' dropdown showing 'HM N/A Why'. 'Create' and 'Cancel' buttons are at the very bottom.

Choose either a Basic or Vaccine Rule type. Vaccine Types, by default, allow for documenting the Drug Name, Dose, Site, Manufacturer, Lot # and Expiration Date.

## Select Name and Description

The 'Create Rule' dialog box contains the following fields and controls:

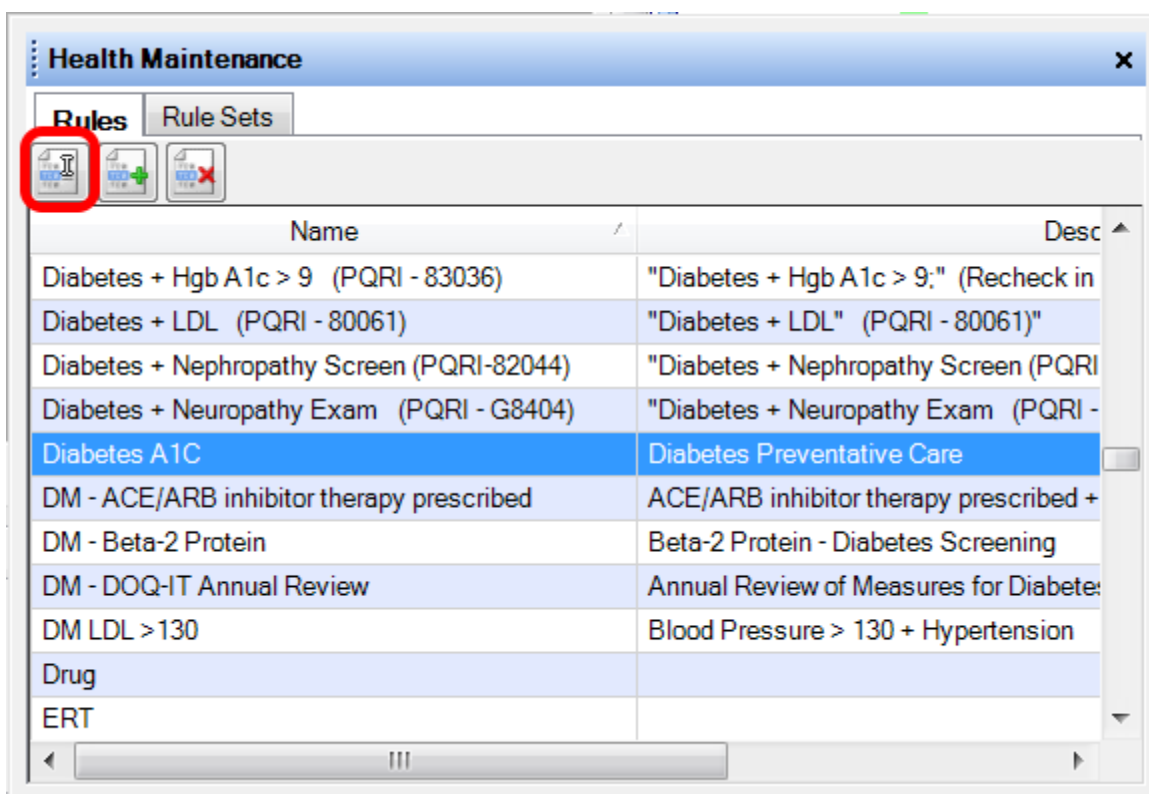
- Type:** A dropdown menu set to 'Basic'.
- Name:** A text input field containing 'Diabetes A1C'.
- Description:** A text input field containing 'Diabetes Preventative Care'.
- Alert:** A numeric input set to '4', a unit dropdown set to 'Weeks', and the text 'before due'.
- Frequency:** A section containing:
  - Interval:** A numeric input set to '1' and a unit dropdown set to 'Years'.
  - Ages / Dates:** An empty list box with 'Edit', 'Add', and 'Remove' buttons to its right.
- N/A List:** A dropdown menu showing 'HM N/A Why'.
- Buttons:** 'Create' and 'Cancel' buttons at the bottom.

Type the Rule Names and Descriptions in their respective fields, and set the Alert interval, Frequency (at weeks, months, years, or at a particular age, etc. Click Create.

**Alert:** How far in advance of the due date does the user want to be alerted that an item is due.

**Frequency:** How often does the user want this issue to be addressed (at regular intervals or at a specific age.

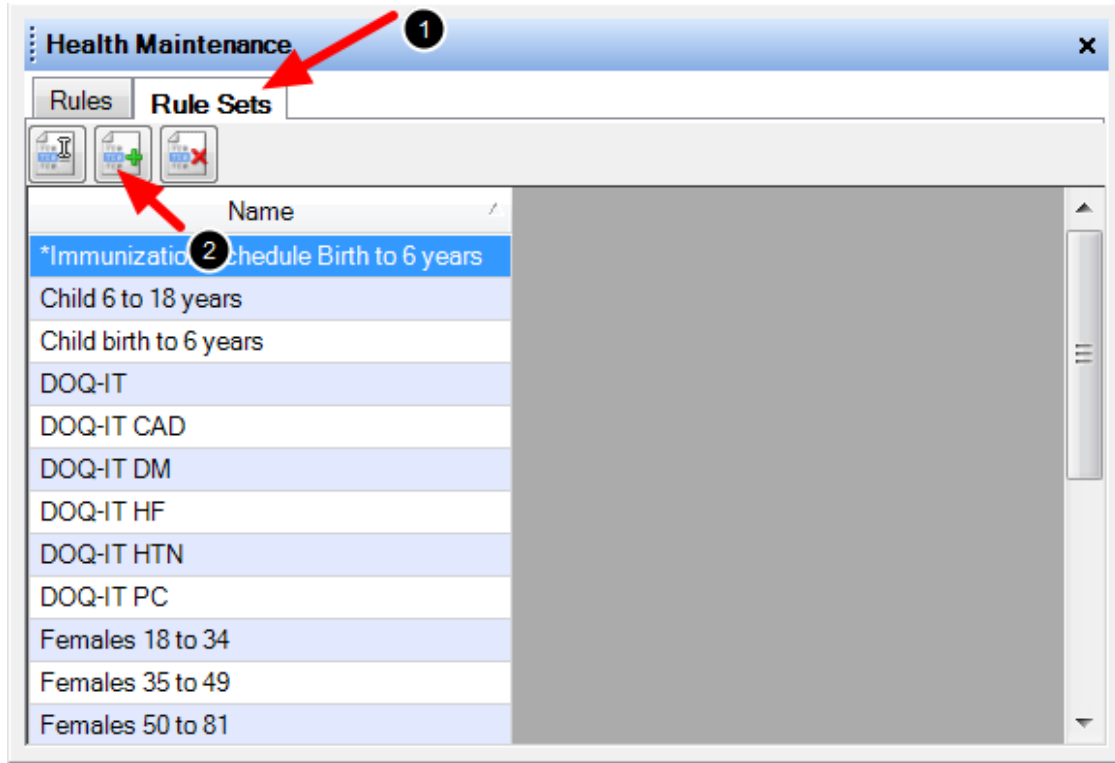
**N/A List:** This will be the exception list for the rule; i.e., why something is performed or not performed



To edit a Rule, Click the Rule to be edited, and then Click the Edit Rule button. This action will bring up the Edit Rule dialog. Make the edits, and Click Save.

## Create a Rule Set

### Create

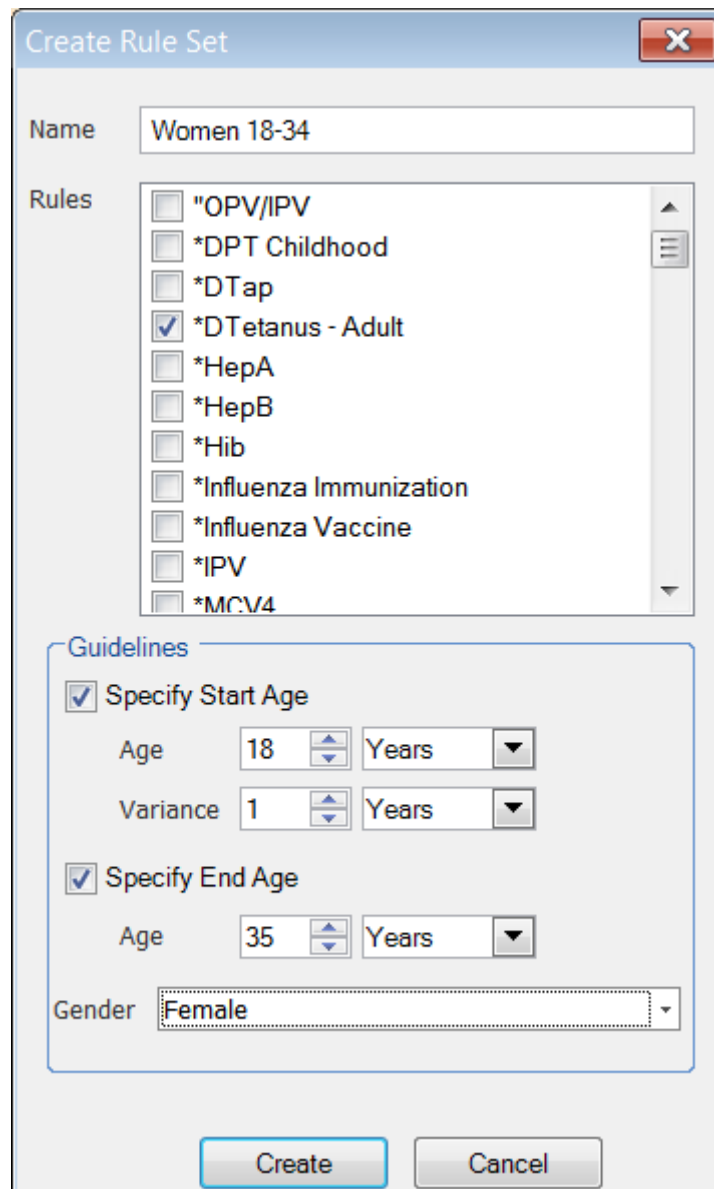


Open Health Maintenance by selecting Tools > Health Maintenance Rules and Sets.

1. Choose the Rule Sets Tab.

2. Click the Create Rule Set button. The Create Rule Set dialog opens.

## Choose Rules



The "Create Rule Set" dialog box is shown. It has a title bar with a close button (X). The "Name" field contains "Women 18-34". The "Rules" list contains the following items with checkboxes: "OPV/IPV", "\*DPT Childhood", "\*DTap", "\*DTetanus - Adult" (checked), "\*HepA", "\*HepB", "\*Hib", "\*Influenza Immunization", "\*Influenza Vaccine", "\*IPV", and "\*MCV4". The "Guidelines" section has two checked options: "Specify Start Age" and "Specify End Age". Under "Specify Start Age", the "Age" is 18 and the unit is "Years". Under "Specify End Age", the "Age" is 35 and the unit is "Years". The "Gender" dropdown is set to "Female". At the bottom are "Create" and "Cancel" buttons.

Create Rule Set

Name: Women 18-34

Rules:

- ☐ "OPV/IPV
- ☐ \*DPT Childhood
- ☐ \*DTap
- ☒ \*DTetanus - Adult
- ☐ \*HepA
- ☐ \*HepB
- ☐ \*Hib
- ☐ \*Influenza Immunization
- ☐ \*Influenza Vaccine
- ☐ \*IPV
- ☐ \*MCV4

Guidelines:

☒ Specify Start Age

Age: 18 Years

Variance: 1 Years

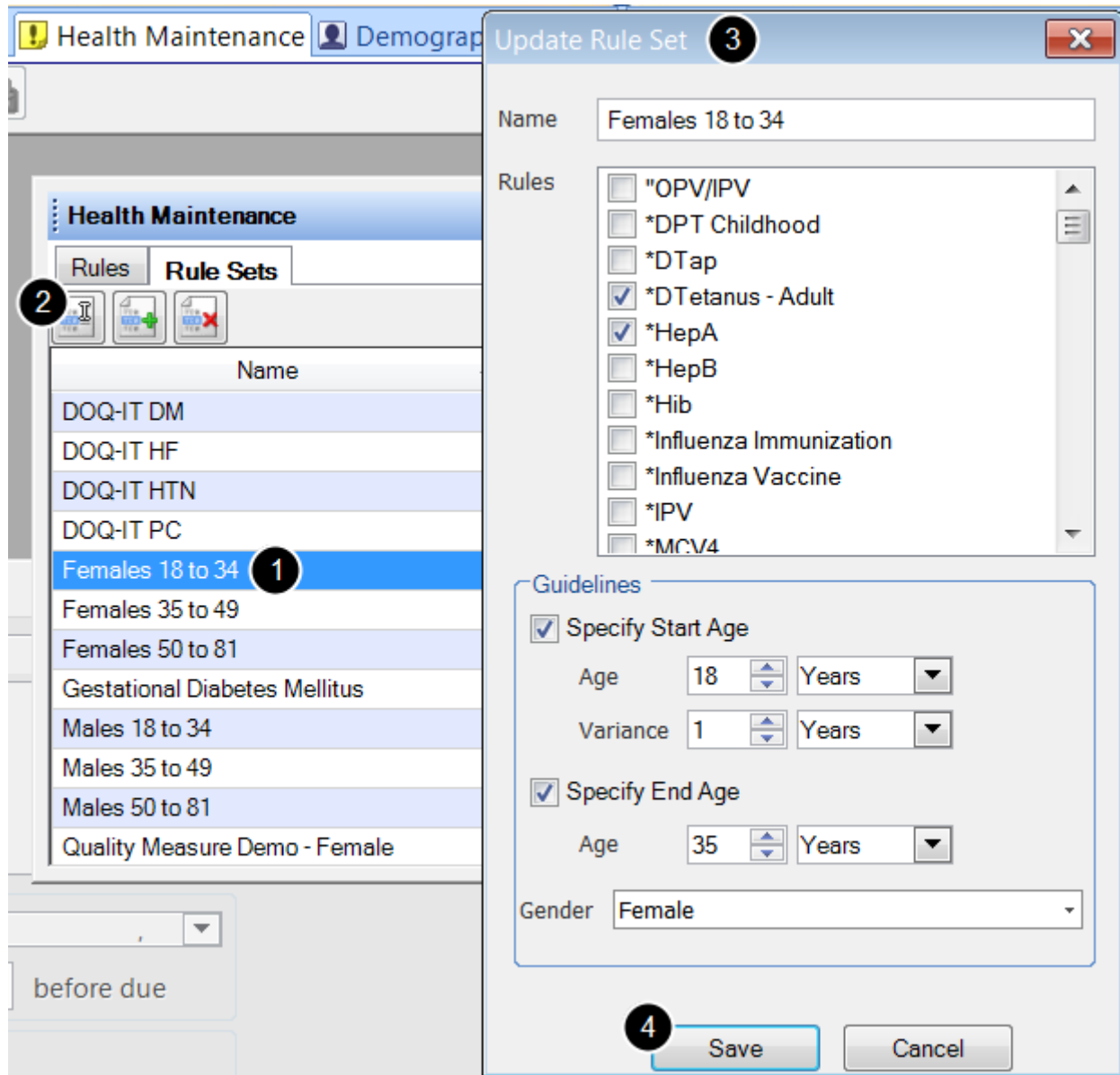
☒ Specify End Age

Age: 35 Years

Gender: Female

Create Cancel

Click the Rule Set check boxes to include them in the Rule Set, and then click the Create button. The checked Rule Set(s) will be added to the list. Also specify the guidelines for what age to begin this rule as well as how often the rule should be addressed. The user can also specify an end age, and gender.



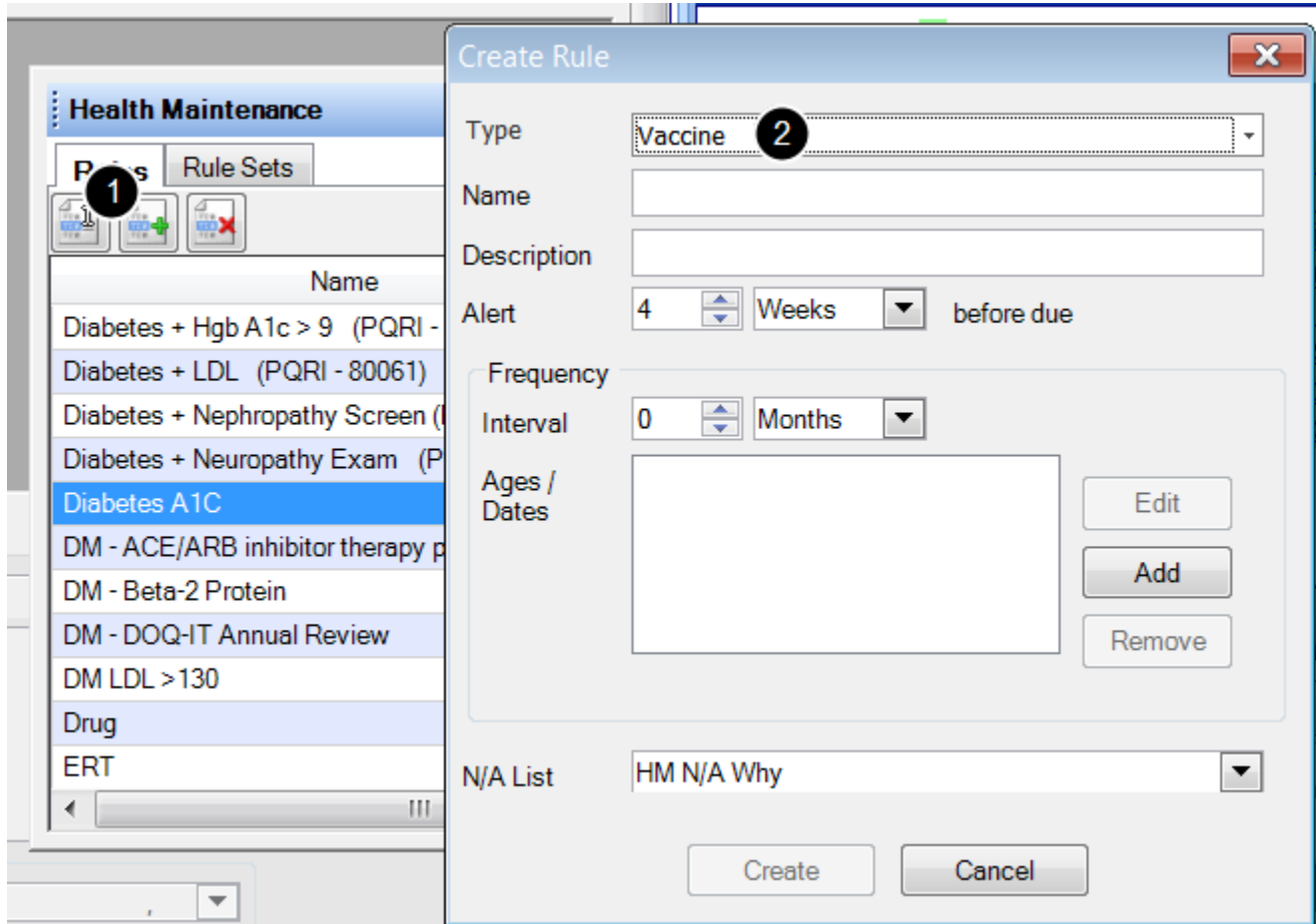
To edit a Rule Set:

1. Click the Rule Set to be edited
2. Click the Edit Rule Set button
3. Make the edits
4. Click Save



## Using the Vaccine Rule Types

### Add Vaccine Type



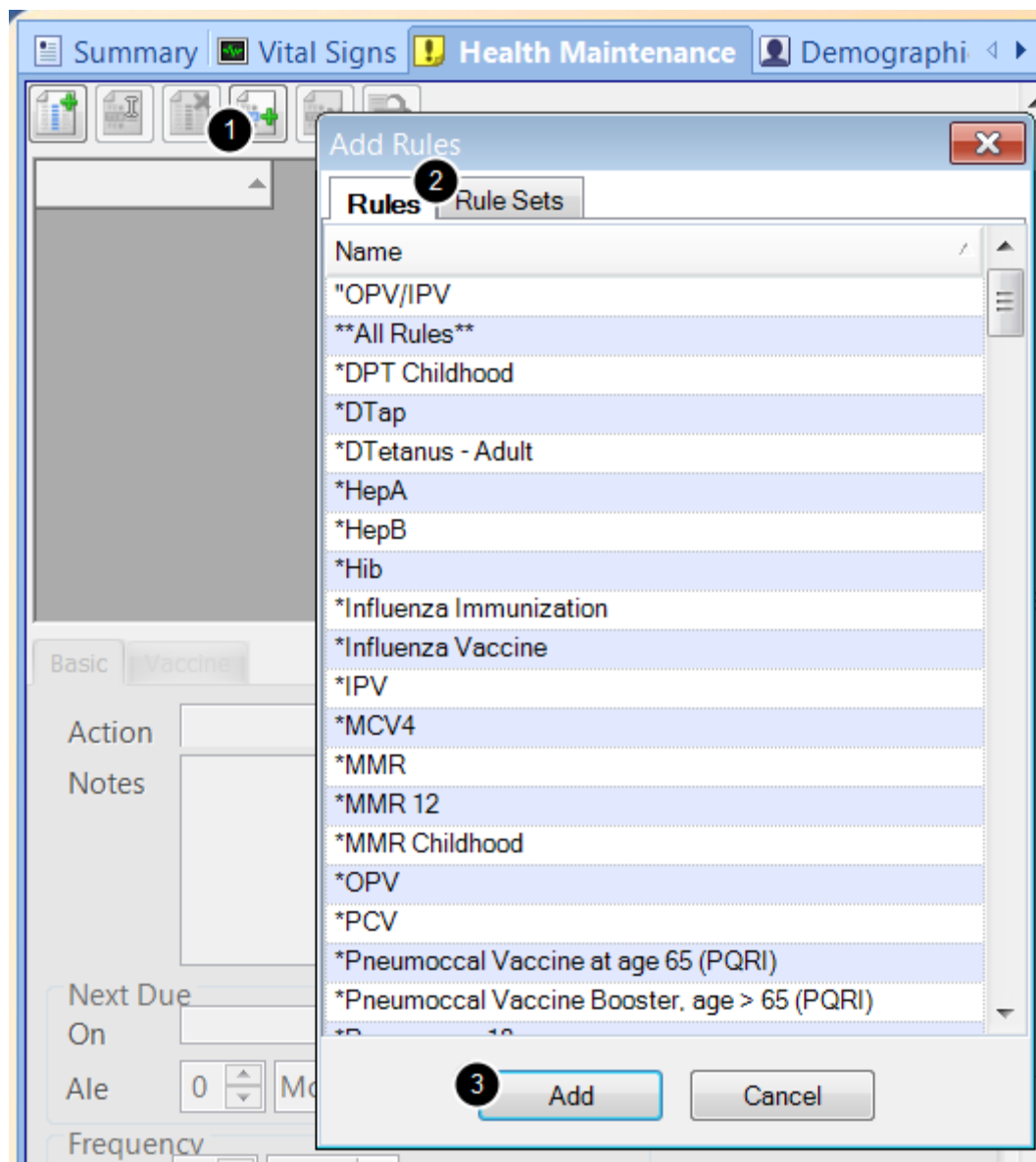
To add a vaccine type Rule, follow the instructions below. This is helpful for creating vaccines not found in the original database.

1. Click on the button to add a New Rule
2. Select a Vaccine Rule Type.

### Creating a Vaccine Rule Set

To create a vaccine rule set (for instance, a set of all childhood shots), see: [Create a Rule Set](#).

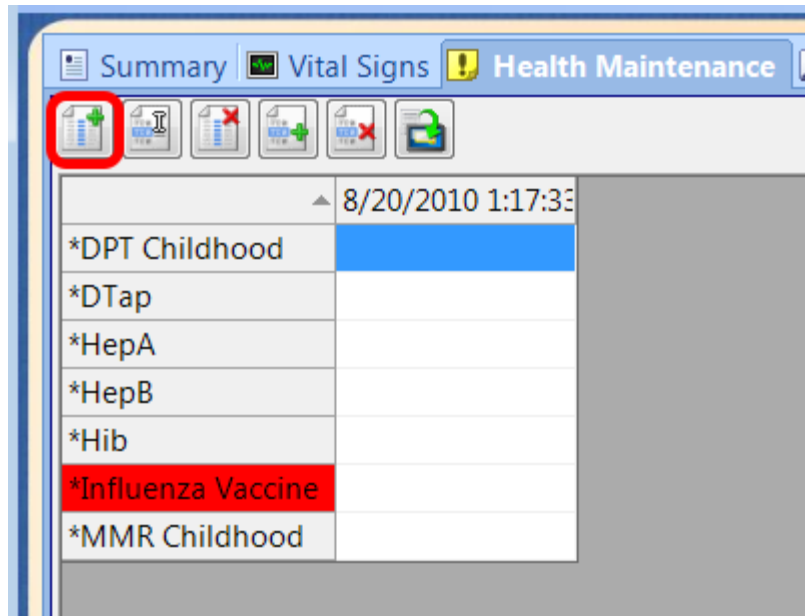
## Add Vaccine Rules to a Chart



To add vaccine rules to a chart:

1. Click the "Add Rules" button in the Health Maintenance chart section
2. Select the rules or rule sets to add
3. Click Add

## Add a Reading Date



Next, add to document vaccines in a chart, Click on the button to add a reading date.

The screenshot shows a medical software interface with a 'Health Maintenance' tab selected. At the top, there are tabs for 'Summary', 'Vital Signs', 'Health Maintenance', and 'Demographi'. Below these are icons for adding, editing, deleting, and viewing records. A table lists various vaccines, with '\*Influenza Vaccine' highlighted in red. Below the table is a 'Vaccine' sub-form with fields for 'Action', 'By', 'Location', 'Notes', 'Next Due On', and 'Alert'.

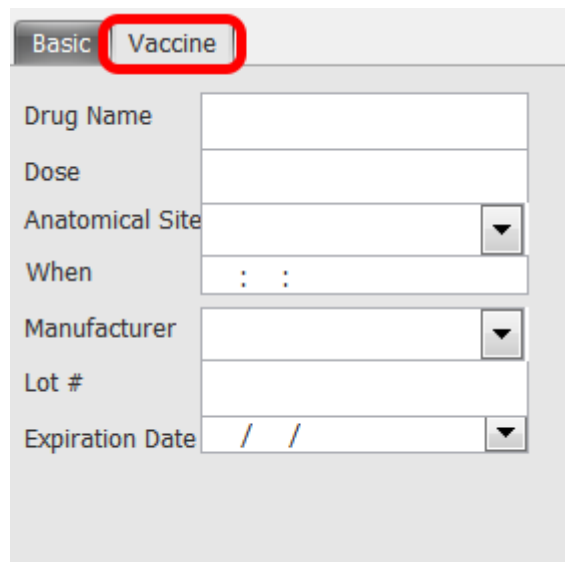
Vaccine	Status
*DPT Childhood	Performed
*DTap	
*HepA	
*HepB	
*Hib	
*Influenza Vaccine	
*MMR Childhood	

**Vaccine Form:**

- Basic | **Vaccine**
- Action:
- By:
- Location:
- Notes:
- Next Due On:
- Alert:  Days before due

Click on the Vaccine tab and fill in the required information. The Next Due On information will determine when the next reminder for this patient will alert the user to a coming due vaccine booster.

## Vaccine Tab



The image shows a software interface with two tabs: 'Basic' and 'Vaccine'. The 'Vaccine' tab is selected and highlighted with a red rectangle. Below the tabs, there are several input fields for recording vaccine information:

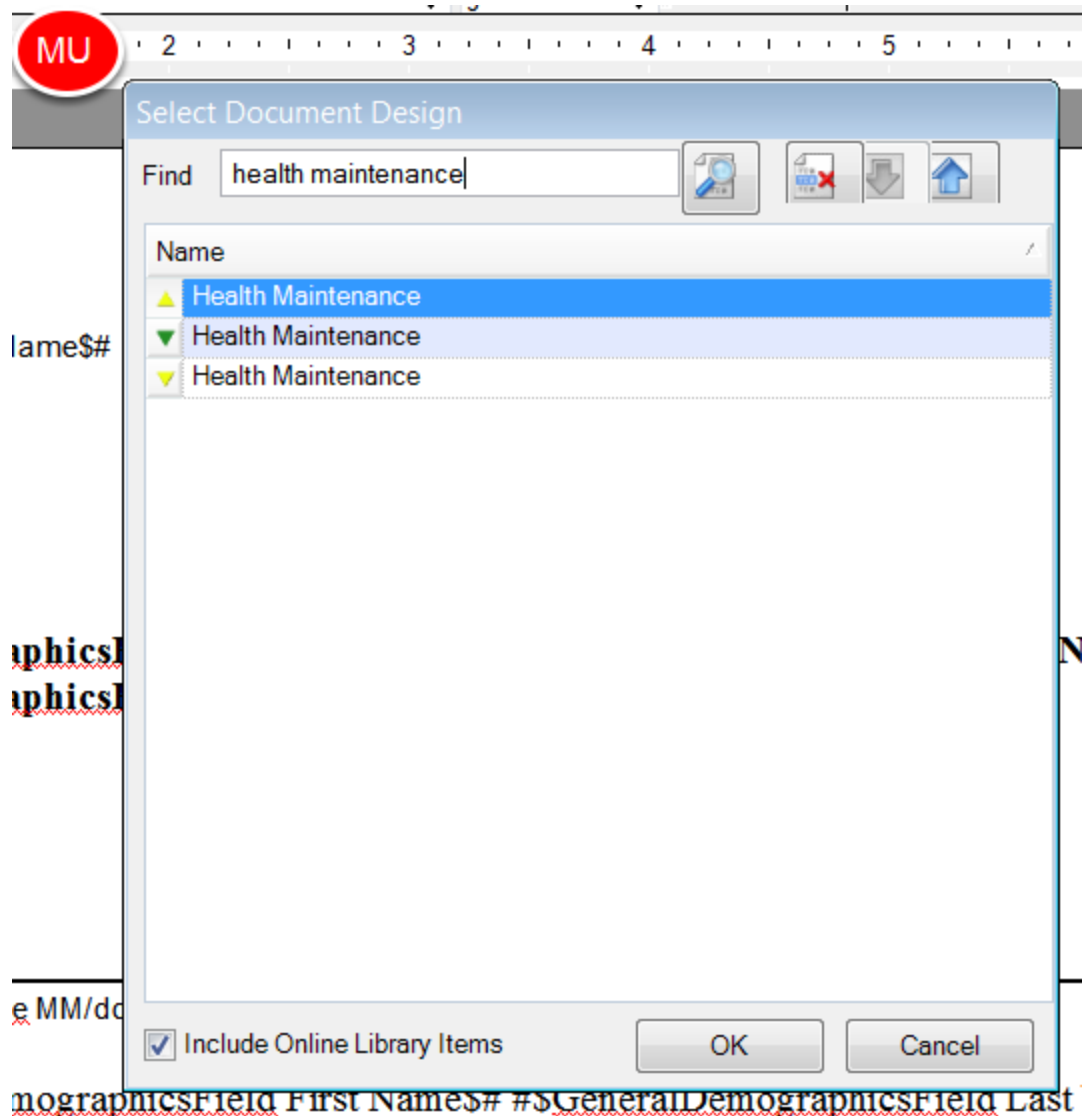
- Drug Name: A text input field.
- Dose: A text input field.
- Anatomical Site: A text input field with a dropdown arrow on the right.
- When: A time input field with two colon-separated boxes.
- Manufacturer: A text input field with a dropdown arrow on the right.
- Lot #: A text input field.
- Expiration Date: A date input field with slashes for month, day, and year, and a dropdown arrow on the right.

Click on the Vaccine tab to see additional information that can be recorded.

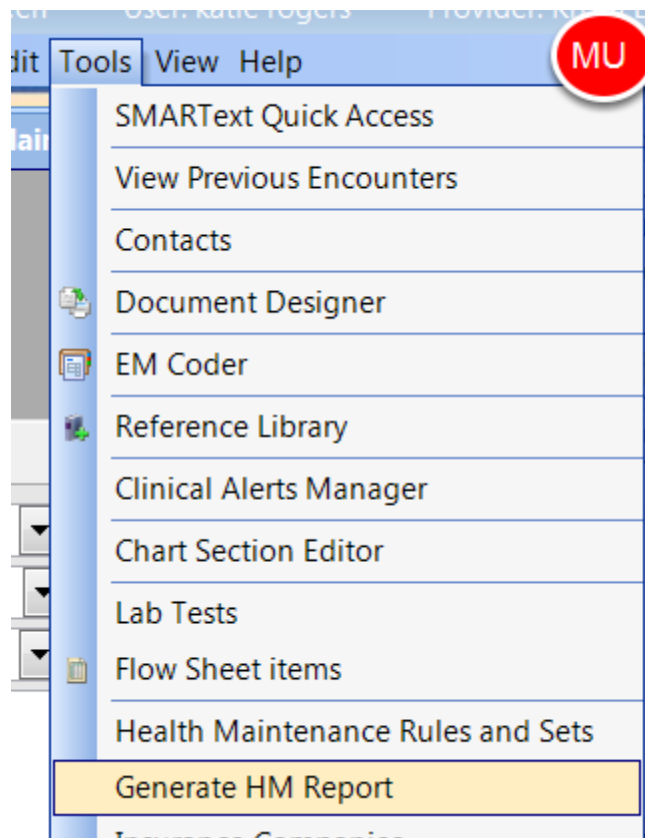
## Generate a Health Maintenance Report

**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)  
- **OR** [Patient Reminders](#)

### Create a Health Maintenance Letter



A user must first create a Health Maintenance Letter in Document Designer before a the report can be printed as Health Maintenance Report. To learn more about Document Designer, see the following link: [Document Designer](#). There is an existing design that can be used for generic Health Maintenance items, which can be found by searching the available designs for "Health Maintenance".



Once the report has been created, go to Tools>Generate HM Report.

## Select Rules

**Health Maintenance Report** [X]

Rules to find: \*\*All Rules\*\* [Browse] Due on or bef: 8/20/2010 [Dropdown] [Printer]

Patient Name

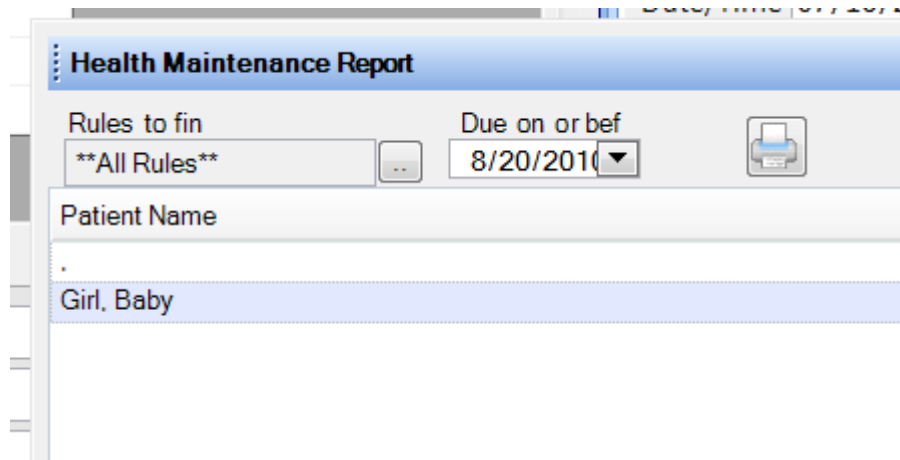
- .
- Girl, Baby

Remo

In the Rules to find field, Click the All Rules list item, or Click the Browse button to select one or more Rules or Rule Sets. A list of patients with selected rule(s) will display.



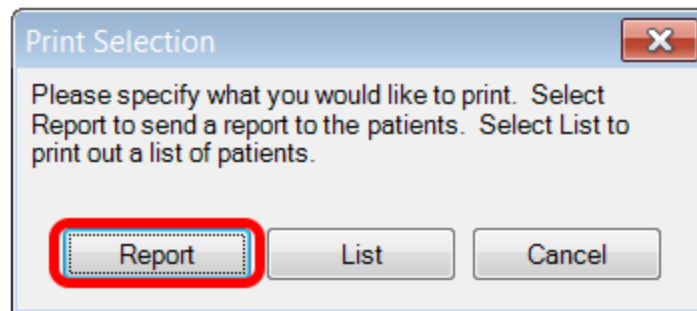
## Choose Dates



The image shows a software window titled "Health Maintenance Report". It contains two input fields: "Rules to fin" with the text "\*\*All Rules\*\*" and a small square button to its right; and "Due on or bef" with the date "8/20/2010" and a dropdown arrow to its right. A printer icon is located to the right of the date field. Below these fields is a "Patient Name" label followed by a text area containing a period "." and a highlighted blue bar with the text "Girl, Baby".

In the Due on or before field, Click the down-arrow, then Click on the date to search for rules due by. Click Print.

## Print



The image shows a "Print Selection" dialog box with a close button (X) in the top right corner. The text inside reads: "Please specify what you would like to print. Select Report to send a report to the patients. Select List to print out a list of patients." At the bottom, there are three buttons: "Report", "List", and "Cancel". The "Report" button is highlighted with a red rectangular border.

To print a letter to the patient, Press the Report button, and Click the Health Maintenance list item in the Select Document Design list. Press the OK button.

The screenshot shows a software window titled 'Correspondence Out' with a menu bar containing 'Flow Sheets', 'Labs', 'SOAP Notes', and 'Correspondence Out'. Below the menu is a toolbar with icons for file operations (New, Open, Save, Print, Find, Copy, Paste, Undo, Redo) and editing (Bold, Italic, Underline). The main text area has a yellow background and contains the following text:

**Date:** 09/05/2007

**Dear** Baby Girl,  
This letter is being mailed to you to inform you that there  
(or immunizations) that are due to be addressed.

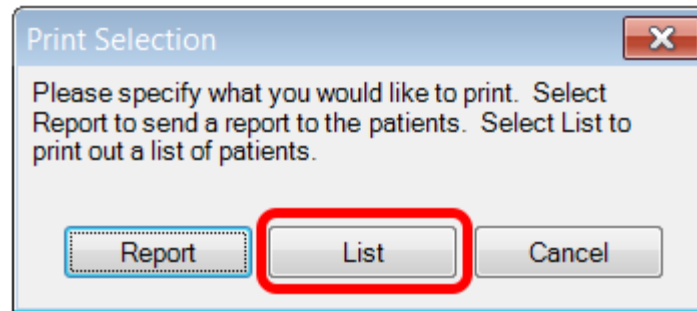
Please call 8004557627 for more information or to make

Sincerely,

Kaye Yocham  
Printed on 09/05/2007 at 11:26

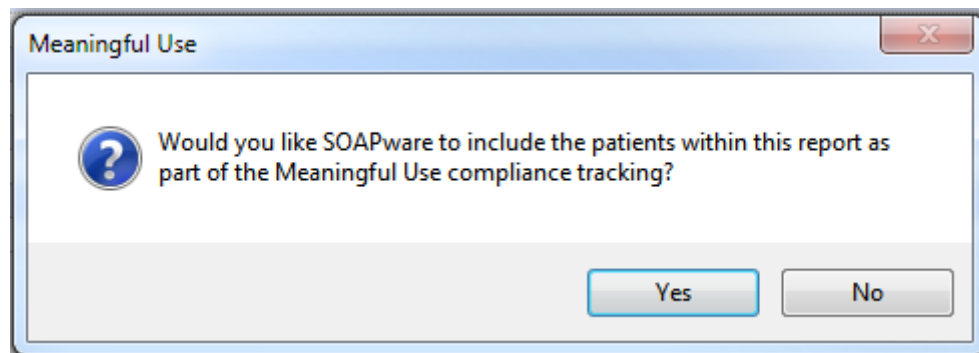
A user will be prompted to Save a Copy of Document to Correspondence Out for each patient listed. Fill in the appropriate fields, and Click the Create button. This will save a copy of the letter in the Correspondence Out section of each selected patient's chart.

## Patient List



To print a list of the patients with Health Maintenance issues to be addressed, press the List button and when the Print Preview dialog opens, Click the Print button.

## Meaningful Use Patient Reminders



When selecting Yes to print a Health Maintenance Report, a prompt will display with the above message regarding to include the listed patients in the numerator of the Meaningful Use Patient Reminder calculations.

# **Document and Chart Management**

## Online Access for Patients

This lesson will explain how to enroll patients for online access. Enrolling Patients for online access will allow patients to view and print their medical record in the CCR (Continuity of Care Record) format.

**\*REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**

- Patient Electronic Access

### Entering Patient's E-mail address

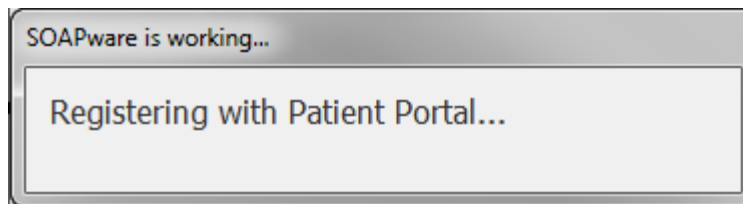
The screenshot shows a software window titled 'Patient Information' with a tabbed interface. The 'Demographics' tab is active. A red circle with 'MU' is in the top left corner. The form contains the following fields and sections:

- Patient Information:** Title, First (Wormie), Middle (0), Last (Catipillar), Suffix.
- SSN:** 555-55-5555
- Birth Date:** 5/5/1975
- Age:** 35
- Chart:** (empty)
- Marital Status:** (empty)
- Gender:** Male
- Related To...** (button)
- Race:** X White
- Ethnicity:** X Not Hispanic or L...
- Language:** X English
- Address:** Street (1234654), City (Fayetteville), State (AR), Zip (72762-\_\_\_)
- Contact Information:** Home Phone ((555) 555-5555), Work Phone (( ) - - - -), Cell Phone (( ) - - - -)
- Email:** wormiecatipillar@yahoo.com (highlighted with a red box and a circled '1')
- Primary Contact:** (empty)
- Secondary Contact:** (empty)
- Exclude From Data Explorer:** (checkbox)
- Enroll for Online Access:** (checkbox, highlighted with a red box and a circled '2')
- Billing Information:** Guarantor (empty), Financial Class (Self Pay), Student Status (empty)

Email address for patients may be entered in the Patient Demographics of the Chart.

1. Enter the patient's e-mail address

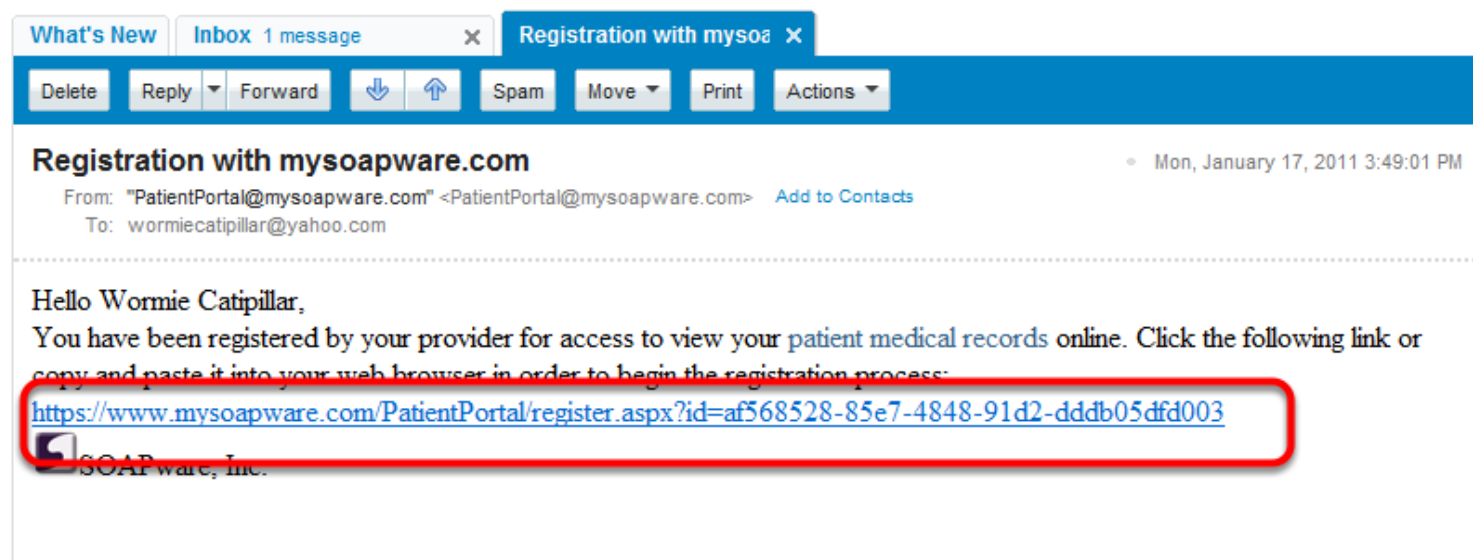
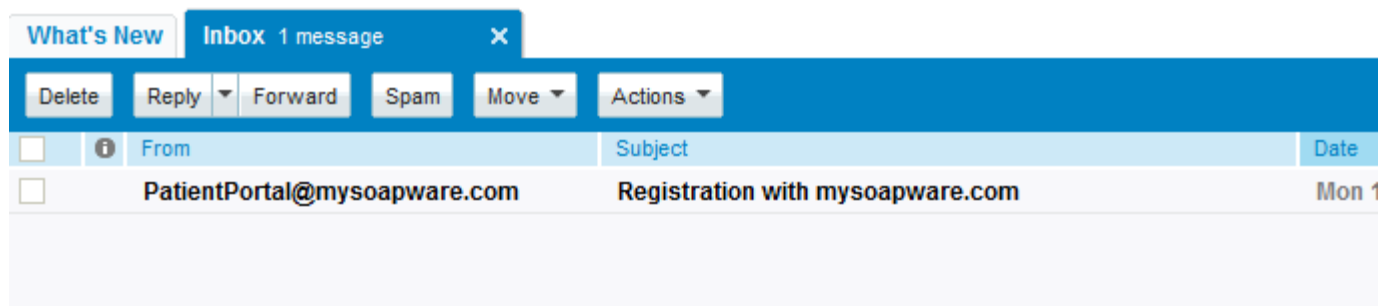
2. Check the "Enroll for Online Access" box.



When the Enroll for online access is checked. A message box will appear that stated SOAPware is Registering with Patient Portal.

This will automatically send an e-mail to the patient's indicated email, in their demographics.

### Patient will Receive an E-mail



The patient will click on the Patient Portal link from the e-mail.

Please enter your registration information.

Registration Information

1

Email

1

Birthday

Pin

Set Password

2

Confirm Password

3

☐ I agree with the [Terms and Conditions](#)

4

Create Account

On the SOAPware Patient Portal home screen, the patient will authenticate with the following:

1. Enter Email, birth date, and social security number for the pin number.
2. Create and confirm a password.
3. Check "I agree with the Terms and Conditions" box.
4. Click Create Account.

## Documents for Wormie Catipillar

File Date	Patient Name	Provider Name
1/17/2011	Catipillar, Wormie	Not Found (98597f08-4f1e-4c2b-864e-7015464a6e58)

### File Information

Date Created	From	To	Purpose
Mon Jan 17, 2011 at 09:49 PM UTC	Jennifer Berg		

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Wormie O. Catipillar	May 05, 1975	Male	SSN 555555555	Home Address 1234654 Fayetteville, AR72762	Home Phone 5555555555

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy			IODINE Comment-		SOAPware 2011.0.105.0 (EHR)
Allergy			MORPHINE:		SOAPware 2011.0.105.0 (EHR)
Allergy			ANTIHISTAMINE (e.g. BENADRYL):		SOAPware 2011.0.105.0 (EHR)
Allergy			CEPHALOSPORIN (e.g. CECLOR)		SOAPware 2011.0.105.0 (EHR)
Allergy			CORTICOSTEROIDS - (e.g. PREDNISONE):		SOAPware 2011.0.105.0 (EHR)

### Problems

Type	Date	Code	Description	Status	Source
Diagnosis		----- (ICD9-CM)	Implantation of automatic cardioverter/defibrillator, total system (AICD)	Inactive	SOAPware 2011.0.105.0 (EHR)

### Procedures

Type	Date	Code	Description	Location	Substance	Method	Position	Site	Status	Source
------	------	------	-------------	----------	-----------	--------	----------	------	--------	--------

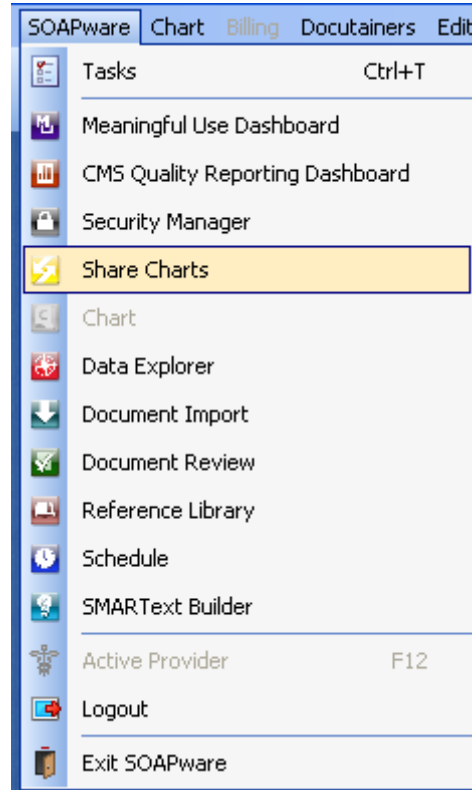
The Patient Portal will display information for the patient to view and print.

The Document contains All information from the Patient Demographics, Summary, Lab Results, Vital Signs, List of Encounters with Description, Assessments and Plan fields.



## Chart Sharing Feature

### Chart Sharing Security & Interface Basics



To open the Chart Sharing workspace, Click SOAPware in the menu bar, and Click the Share Charts menu item.

The Chart Sharing workspace has three main areas. At the top of the screen is the Chart Selection section, where the charts to export/copy are defined; In the middle is the Data Selection section to select the chart sections to be exported; and at the bottom is the Progress section to define the location where the copies of the records (i.e.exported data or copy of the chart) will be placed. It also displays the progress of the export once it begins.

## Selecting Charts to Share

The screenshot shows a software window titled 'Select Items' with a light blue header. At the top, there is a dropdown menu labeled 'Active Provider' with 'All Providers' selected. Below this is a section titled 'Type of Export' with three radio buttons: 'Individual' (selected), 'Pulled Charts', and 'All Charts'. A 'Select' button is next to the 'Individual' radio button. Below this is a 'Search Dates' section with 'Start Date' and 'End Date' fields, each with a date picker. The main area of the window is divided into two columns. The left column, titled 'Select Items', contains a tree view of various chart types, each with a checkbox. The right column, titled 'Sections to Export', contains a list of the same chart types. At the bottom of the window, there is a text field containing the path 'C:\Documents and Settings\rodell\My Documents\ScreenSteps Library\Lessons', a 'Browse' button, and a 'Copy' button. Numbered callouts 1 through 4 are present: 1 points to the 'Active Provider' dropdown, 2 points to the 'Individual' radio button, 3 points to the 'Browse' button, and 4 points to the 'Copy' button.

1 Active Provider: All Providers

Type of Export

2 ☒ Individual ☐ Pulled Charts ☐ All Charts

Search Dates

Start Date: / / : : End Date: / / : :

Select Items

Sections to Export

Advanced Directive: Advanced Directives

Billing Statements Billing Statements

Demographics CCR

Documents Correspondence In

CCR Correspondence Out

Correspondence Demographics

Correspondence Drawings

HIPAA Disclosures Financial

History & Physic. Flow Sheets

Labs Growth Charts

Misc. Health Maintenance

Pathology HIPAA Disclosures

Printed Encount. History & Physicals

Radiology Labs

Drawings Messages

Encounters Misc.

Messages Pathology

SOAP Notes Printed Encounters

Financial Radiology

Flow Sheets SOAP Notes

Growth Charts Summary

Health Maintenance Test Section

Summary Unfiled

Test Section Vital Signs

Unfiled

Vital Signs

C:\Documents and Settings\rodell\My Documents\ScreenSteps Library\Lessons

3 Browse

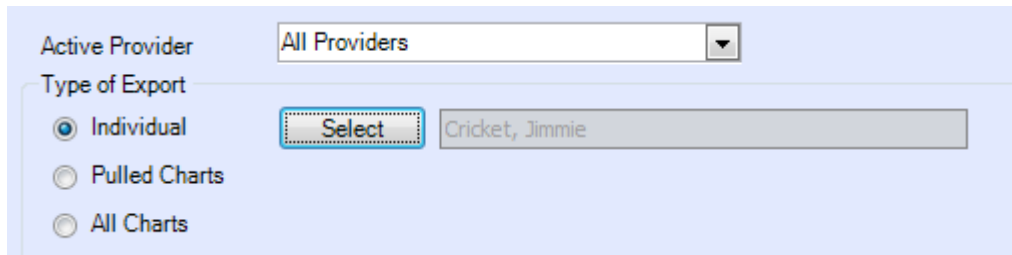
4 Copy

To select the charts for export, use the Chart Selection area, at the top of the Chart Sharing workspace. The options in this area determine the charts selected for export/copy. For instance, to export all charts in SOAPware:

1. Click the All Providers menu item in the Active Provider drop-down menu.
2. Click the All Charts radio button for the Type of Export.
3. Click the Browse button to select the location to export records to the computer.
4. Click the Copy button to begin the export process.

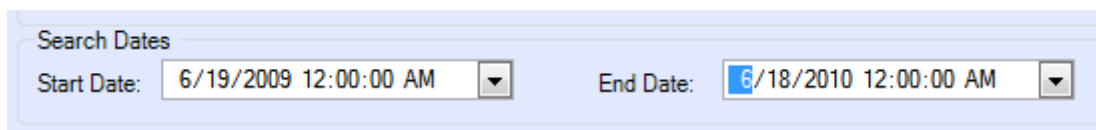
With these settings, all charts in the Chart Rack will be exported.

## Select Charts



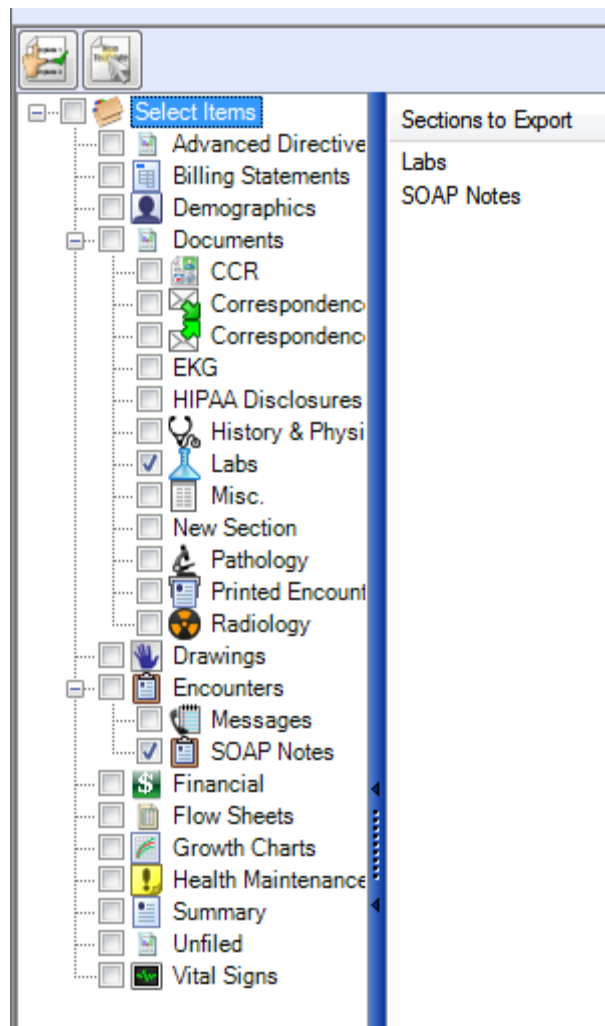
On the other extreme, to export/copy a single chart, Click the Individual radio button in the Type of Export section; then Click the Select button. This opens the Chart Rack for the selection of an individual patient chart.

## Search Dates



Exported information can be limited by setting date parameters. Use the Search Dates area to enter a date or a date range, and SOAPware limits the exported information to items created within the specified date parameters. If search dates are not entered then all documents within the chart sections selected will be exported.

## Selecting Chart Sections to Share



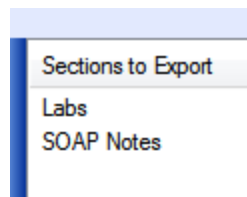
After selecting charts to share (i.e. copy or export), choose the chart sections to share. Selection is accomplished in the middle area of the Chart Sharing workspace.

On the left is a list of chart sections similar to what is displayed in Chart Navigator. On the right, SOAPware lists the chart sections selected to include in the export.

**Note:** By default, everything is selected in order to export the entire chart.

To export less than the entire chart (for example, only SOAPnotes and Labs), the user will need to edit the selected items. To change the selection, Click the "Select Items" checkbox at the top left. This clears the selection list. Next, the user is to place a checkbox in each individual chart section that he/she wishes to export.

## Sections to Export



Select as few as one chart section or check them all. Once the chart sections to export are selected, it's time to export. The selected sections will be displayed to the right under Sections to Export.

## Selecting the Export Location

A screenshot of a software interface showing a 'Location -' field. The field is empty. To the right of the field are two buttons: 'Browse' and 'Copy'.

The last stage in sharing (i.e. copying, exporting) charts is to define the location where the exported information needs to be saved. This is accomplished in the progress section at the bottom of the Share Charts workspace (see above)

## Browse for Location

A screenshot of a software interface showing a 'Location -' field. The field contains the text 'C:\Users\Katie\Desktop'. To the right of the field are two buttons: 'Browse' and 'Copy'. A red arrow points to the 'Browse' button.

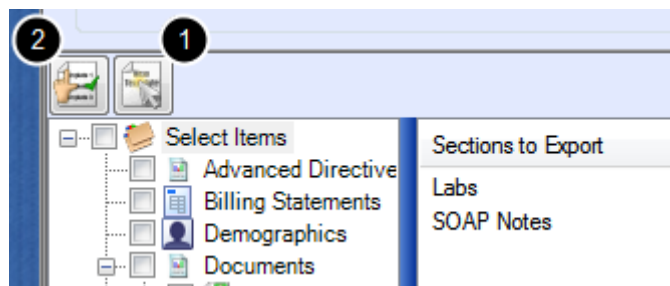
Click the Browse button on the far right. This displays the Browse For Folder dialog where the location is selected for the exported copy. In order to create a new location, Click the Make New Folder button. Once the location is selected, Click OK.

## Export

The last step to share charts is to Click the Copy button. This initiates the export process. After Clicking Copy, settings for the export can't be changed. A green progress bar tracks across the bottom as the export progresses. An export can take seconds to minutes, depending on the size of the file. When it is complete, the green bar is completely full.

At the selected export location, the user will find one copy (i.e. PDF file) for each chart exported. Each is titled with the patient's name, birth date, and chart number in order to make it easier to find specific exported copies.

## Saving Export Formats



The user can save export formats if he/she wants to have it available for use in the future.

1. To save a format, Click the "Create Format" button underneath the search dates section of the workspace.
2. To use a previously saved format, Click the "Insert Format" button.

## HIPAA Regulations (encrypted email)

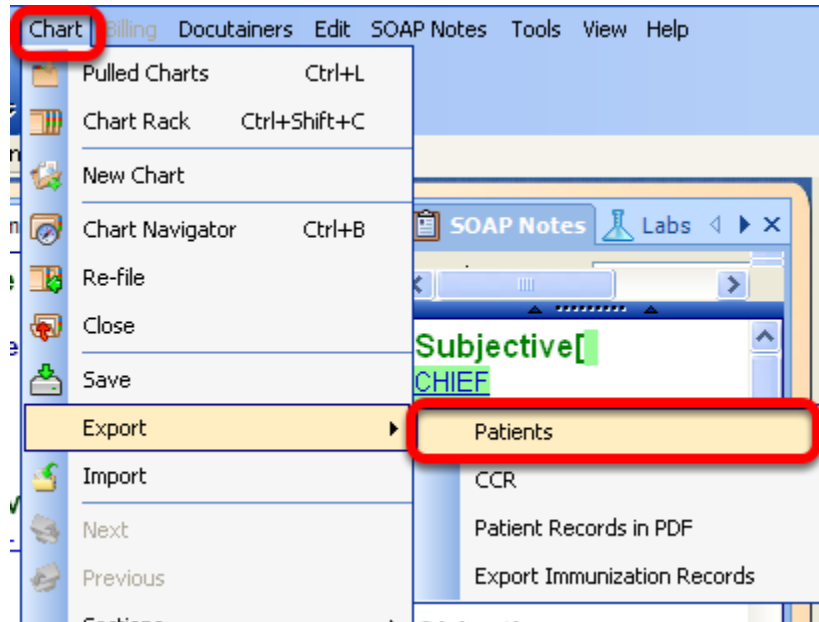
When a user emails any patient records, it is important to remember that the user's email has to be encrypted to meet HIPAA Regulations.

## Exporting a SOAPware Chart

---

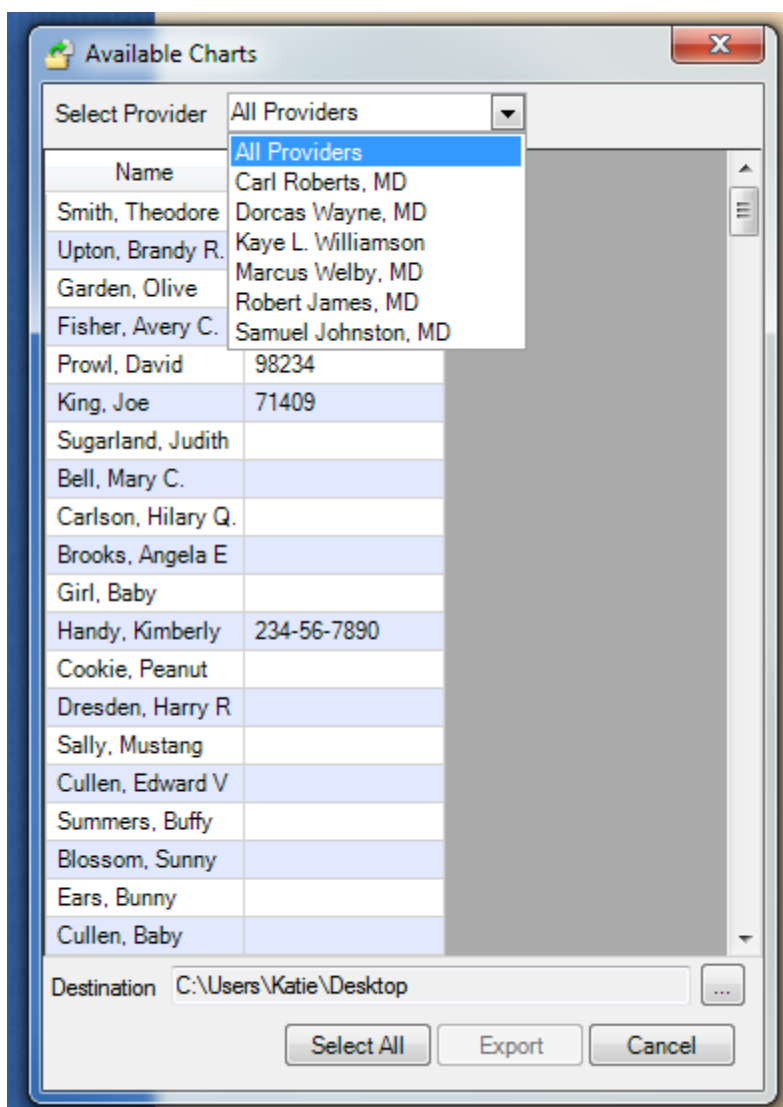
This lesson will walk the user through the steps to export a chart from SOAPware in a format that allows the user to import it into another SOAPware database.

### Export Patients



From the Chart Workspace (SOAPware > Chart), Click on the Chart menu and Select Export > Patients.

## Select Provider

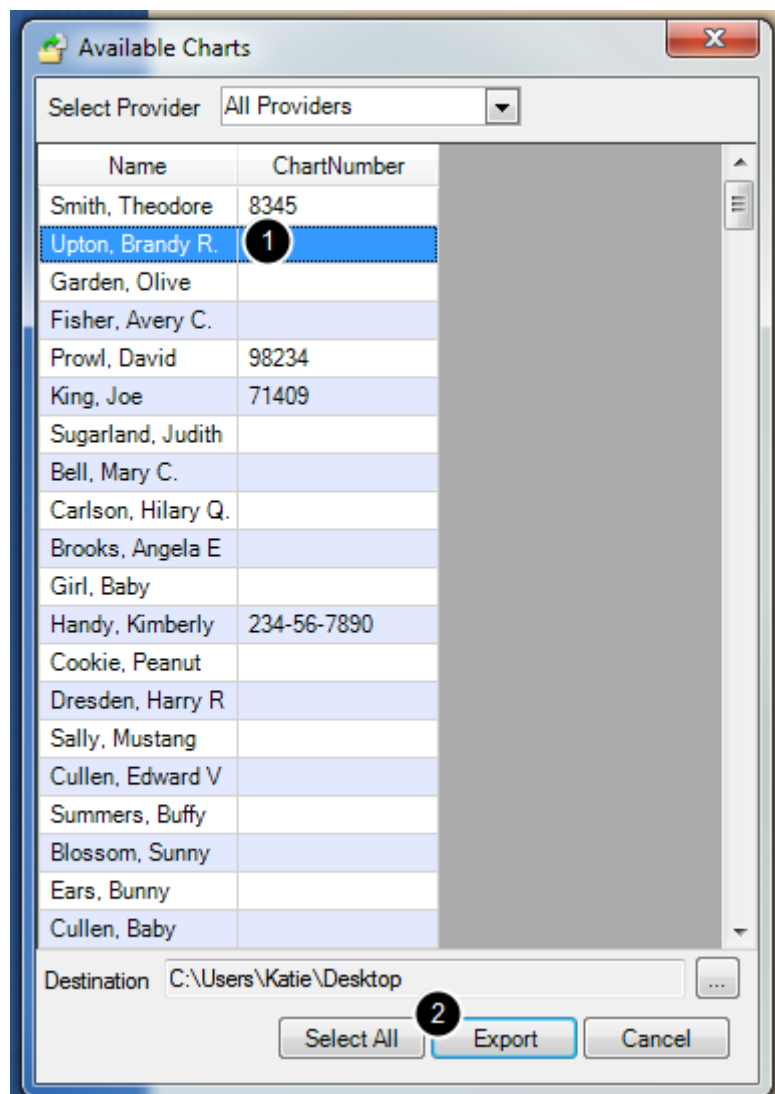


Using the drop-down menu at the top of the window display, the user can select to see all providers' patients or the user can select an individual provider. This is particularly useful if the user will be exporting a physician's entire patient database.

## Select Patients

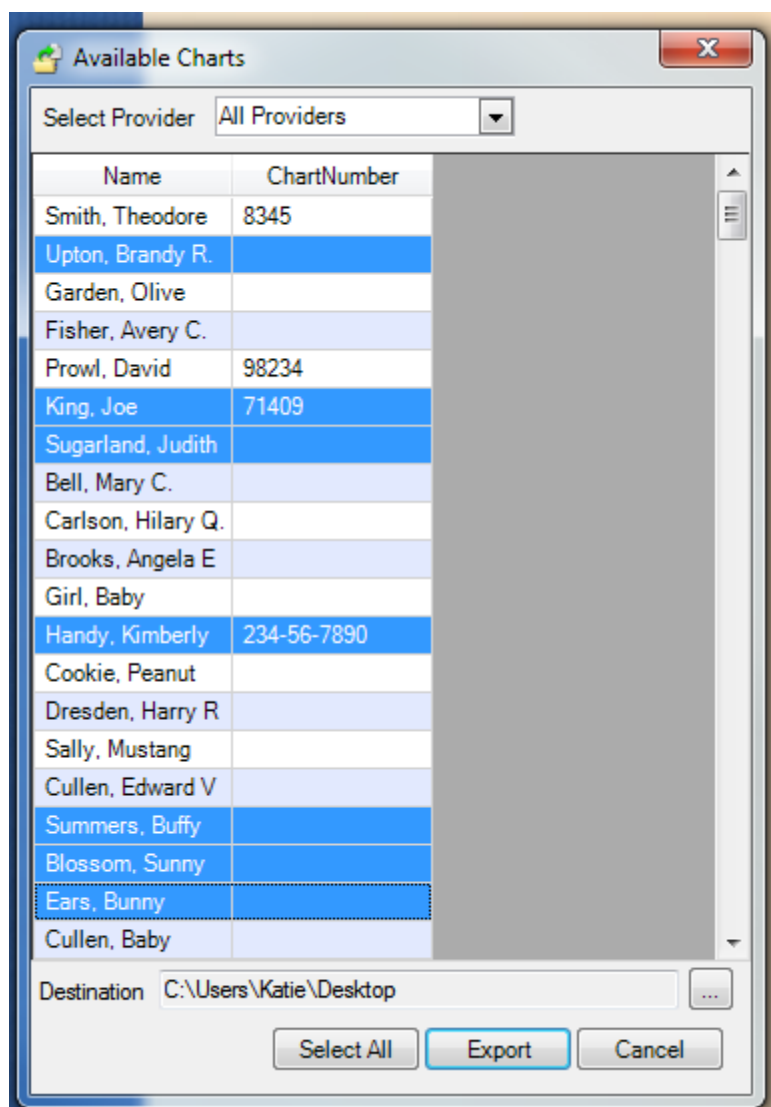
The user can select individual patients, can select a group of patients, or can select all of the patients in the display.





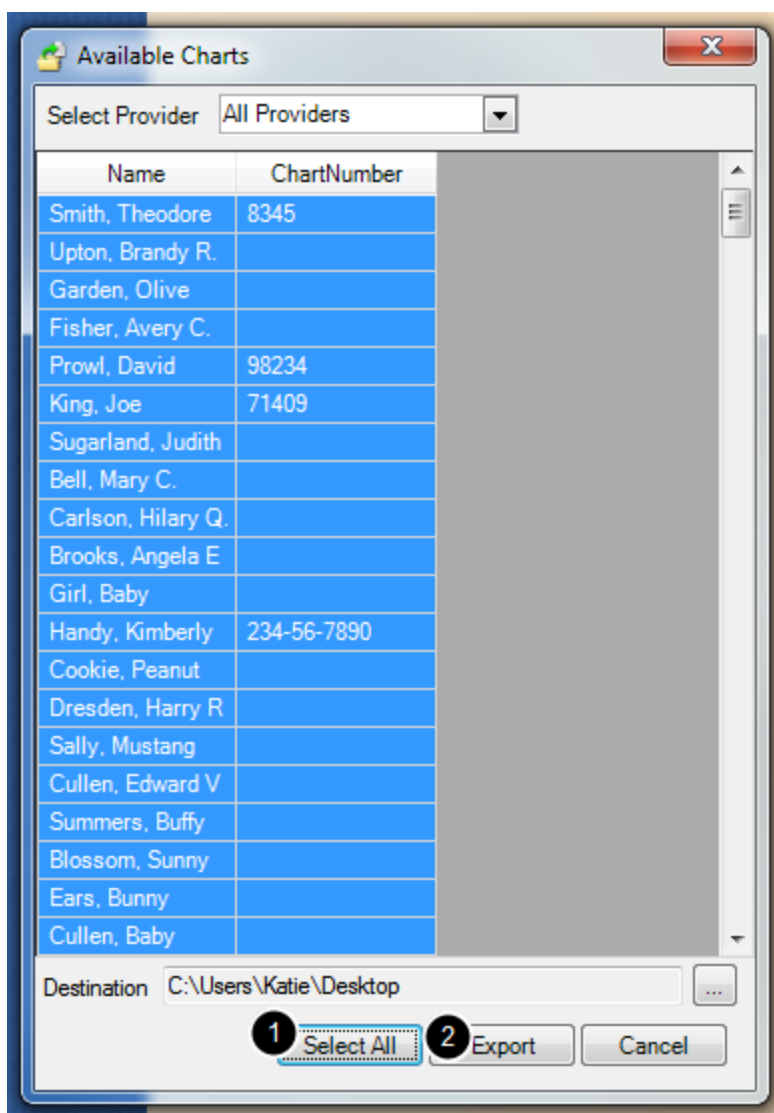
To select an individual patient, simply Click on the patient's name and Click Export.

## Multiple Patients



To select multiple patients, hold the control key on the keyboard and Click on the patients to export. Then, Click Export.

## Select All



To export all of the patients listed, Click the SelectAll button and then Click Export.

## Exported Charts

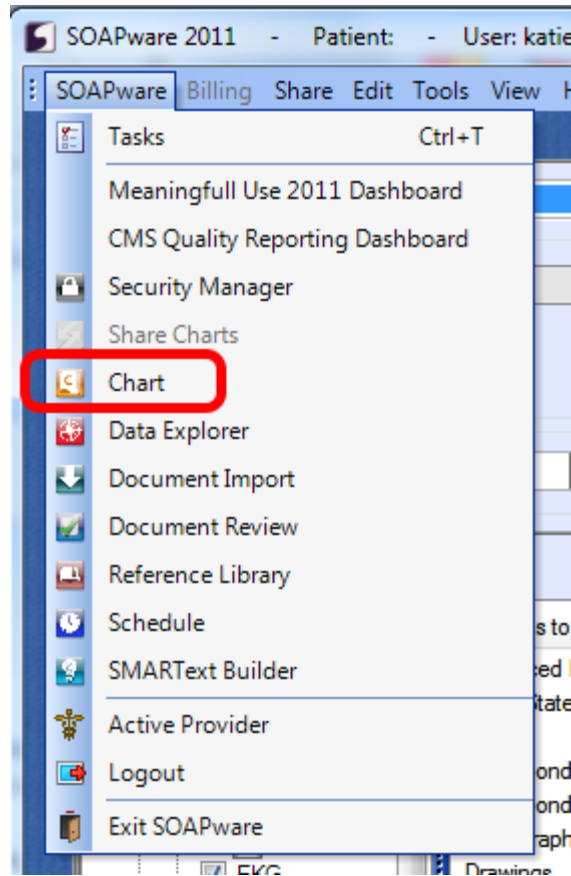
The exported charts will appear on the computer's desktop. The user can take these and place them on a disk drive and then import them on another computer or database, following the instructions for [Importing a Chart](#).

## Importing a SOAPware Chart

---

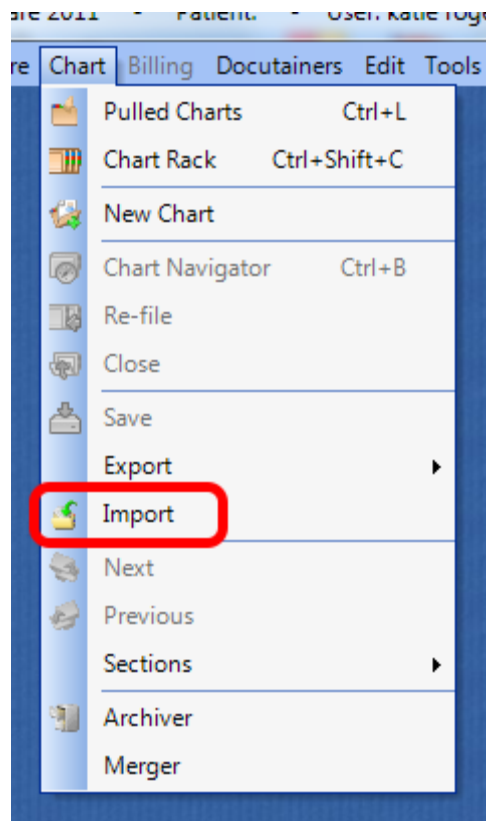
This lesson describes how to import a SOAPware chart from one database to another. This can be done for individual charts as well as a bulk of charts.

### Open the Chart Workspace



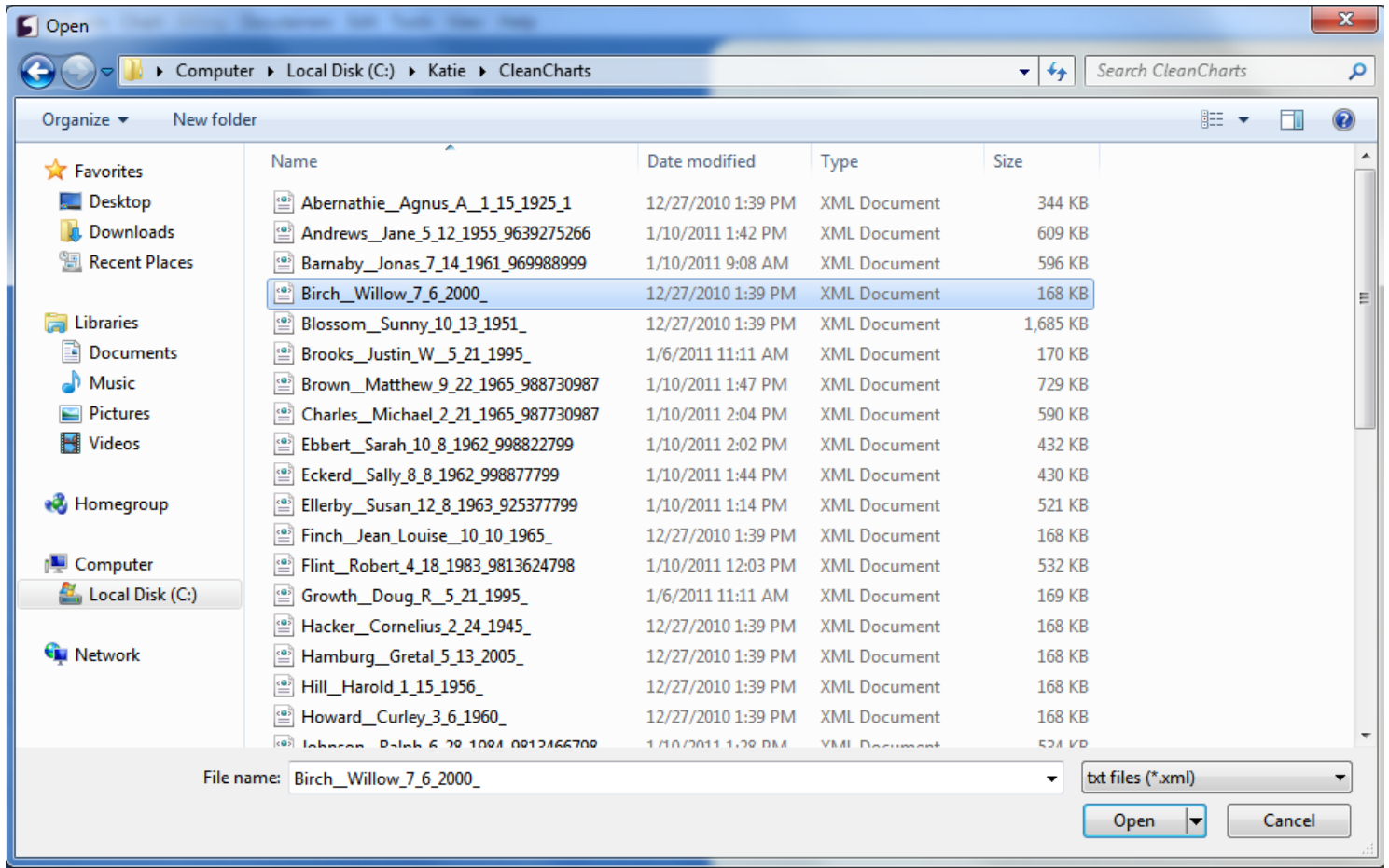
First, the user will need to be in the Chart workspace. Click on SOAPware > Chart.

## Import Menu



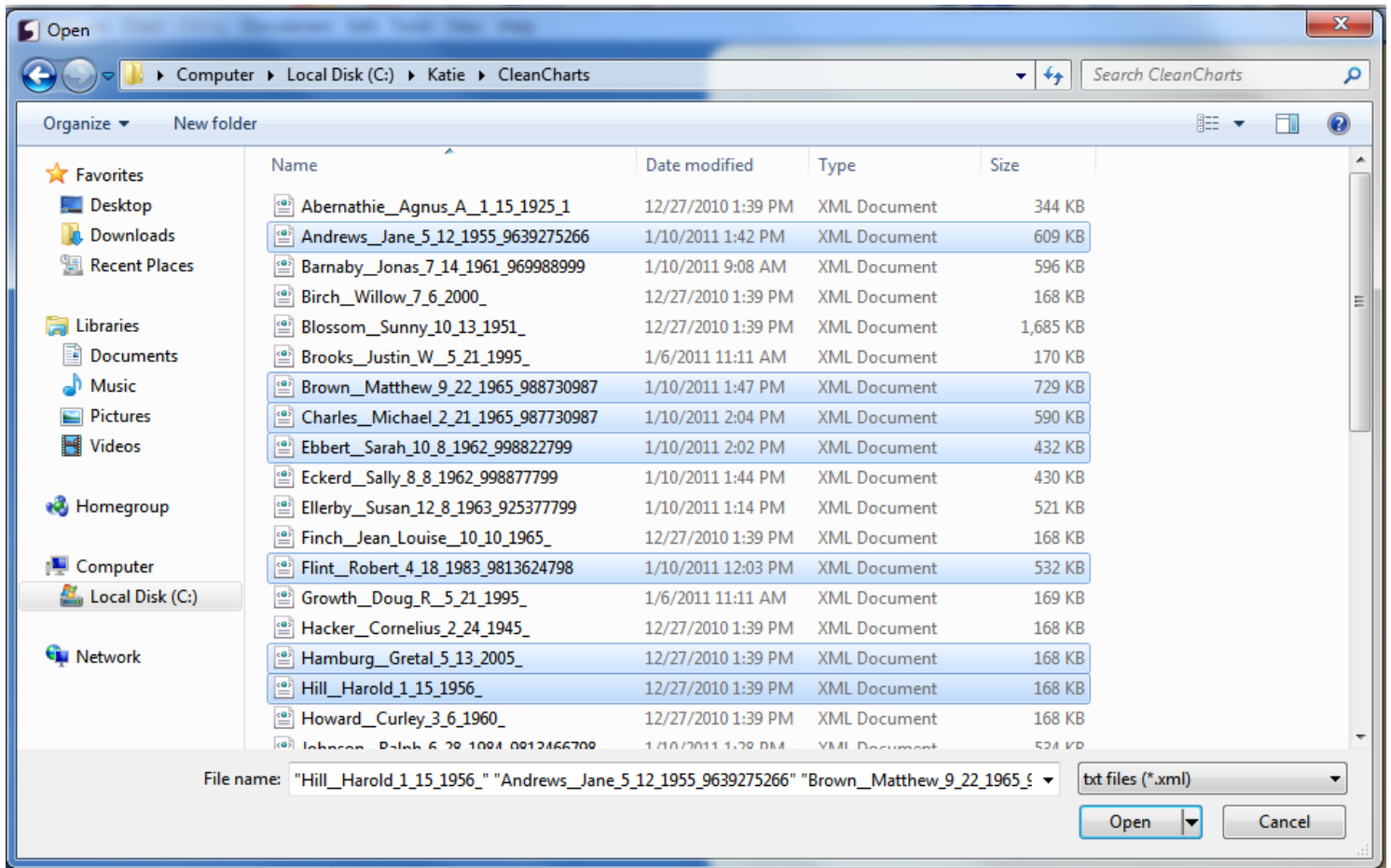
To open the Import Chart option, Click on Chart > Import.

## Locate the Chart to Import



The user will be prompted in the next window to select the location of the chart to import. Locate the chart on the computer. To select an individual chart, simply select the chart to import, and Click "Open."

## Select Multiple Charts



To select multiple charts, the user can click on the individual charts he/she would like to include in the import while holding the "Control" button on the keyboard.

To select all charts, the user can click Control + A on the keyboard, and all of the charts in this folder location will be selected for import.

Click "Open" and all of the selected charts will be imported into the SOAPware chart rack and database.

## Continuity of Care Record (CCR) Feature

---

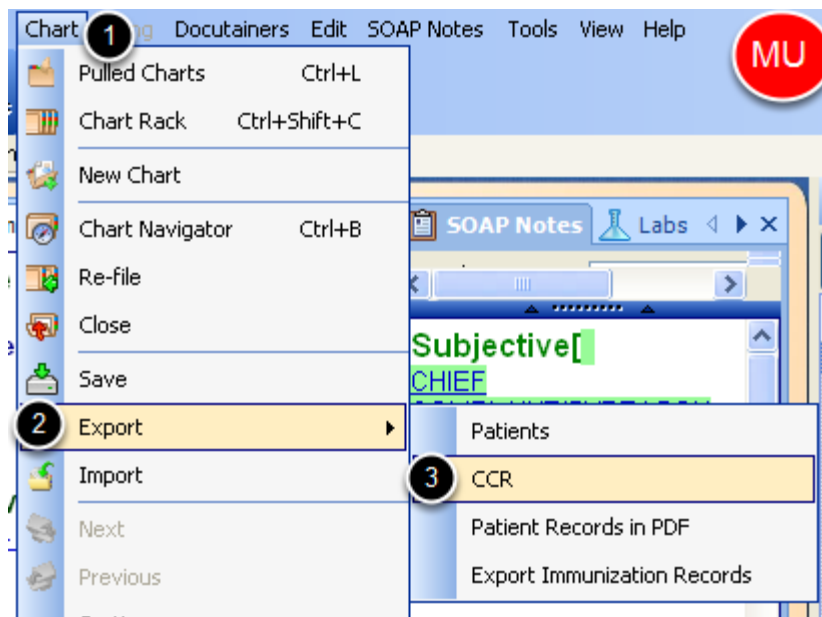
The Continuity of Care Record (CCR), is a patient health summary standard. It is a way to create flexible documents that contain the most relevant and core health information about a patient, and to send this electronically from one care provider to another. The CCR represents a "snapshot" of a patient's health data that is useful at the time of a clinical encounter, or when needing to share information on a patient, with another care provider.

**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)  
- **OR** [Electronic Exchange of Clinical Information](#)

### Patient Meaningful Use Dashboard:

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#)

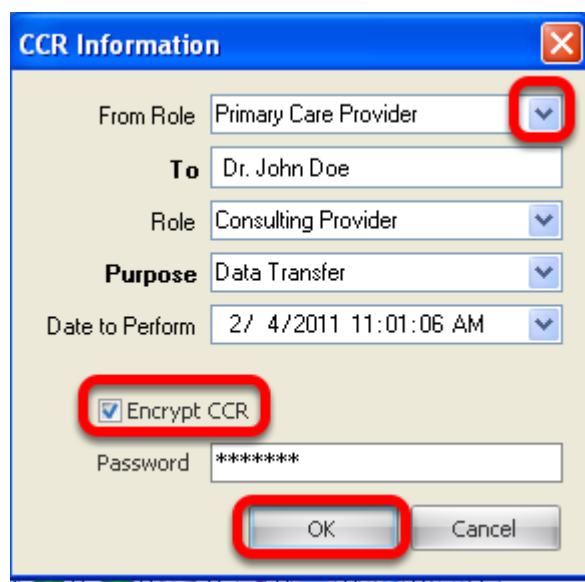
### Accessing CCR



1. With a patient's chart open, Click on Chart from the menu bar.
2. Select Export.
3. Click on CCR.



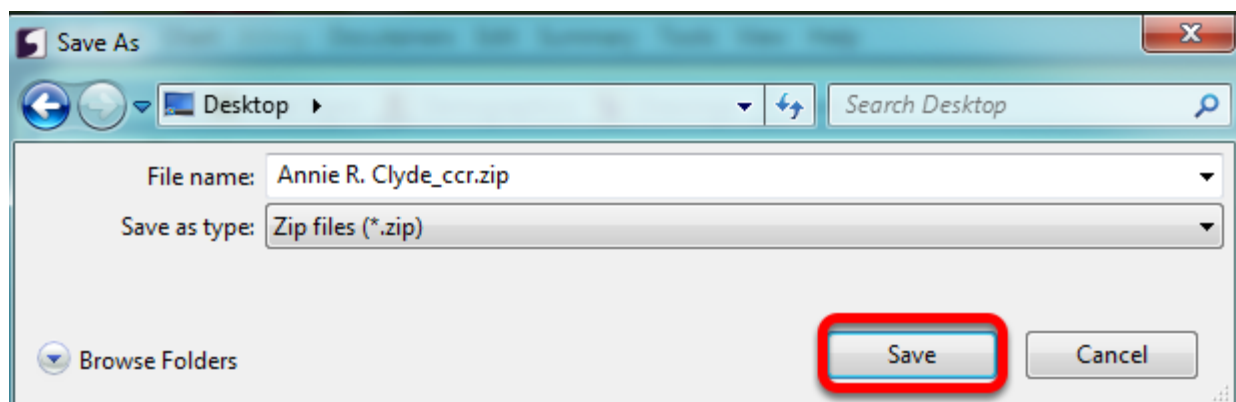
## CCR Information Box



Using the drop-down menu options, fill out the appropriate information. Placing a check mark in the box for Encrypt CCR, will encrypt the content of the patient's records and may only be viewed with the password set by the person creating the CCR. The password will be shared only with the recipient of the CCR.

Click OK when finished.

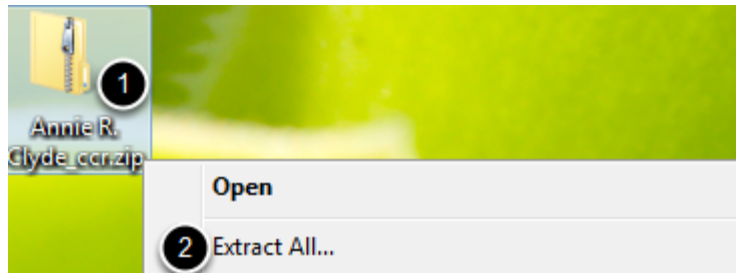
## Save the CCR file



Save the CCR file to the desktop, or a designated folder.

In the screen shot above, the CCR file for the patient, was saved to the desktop.

## Extract the CCR File

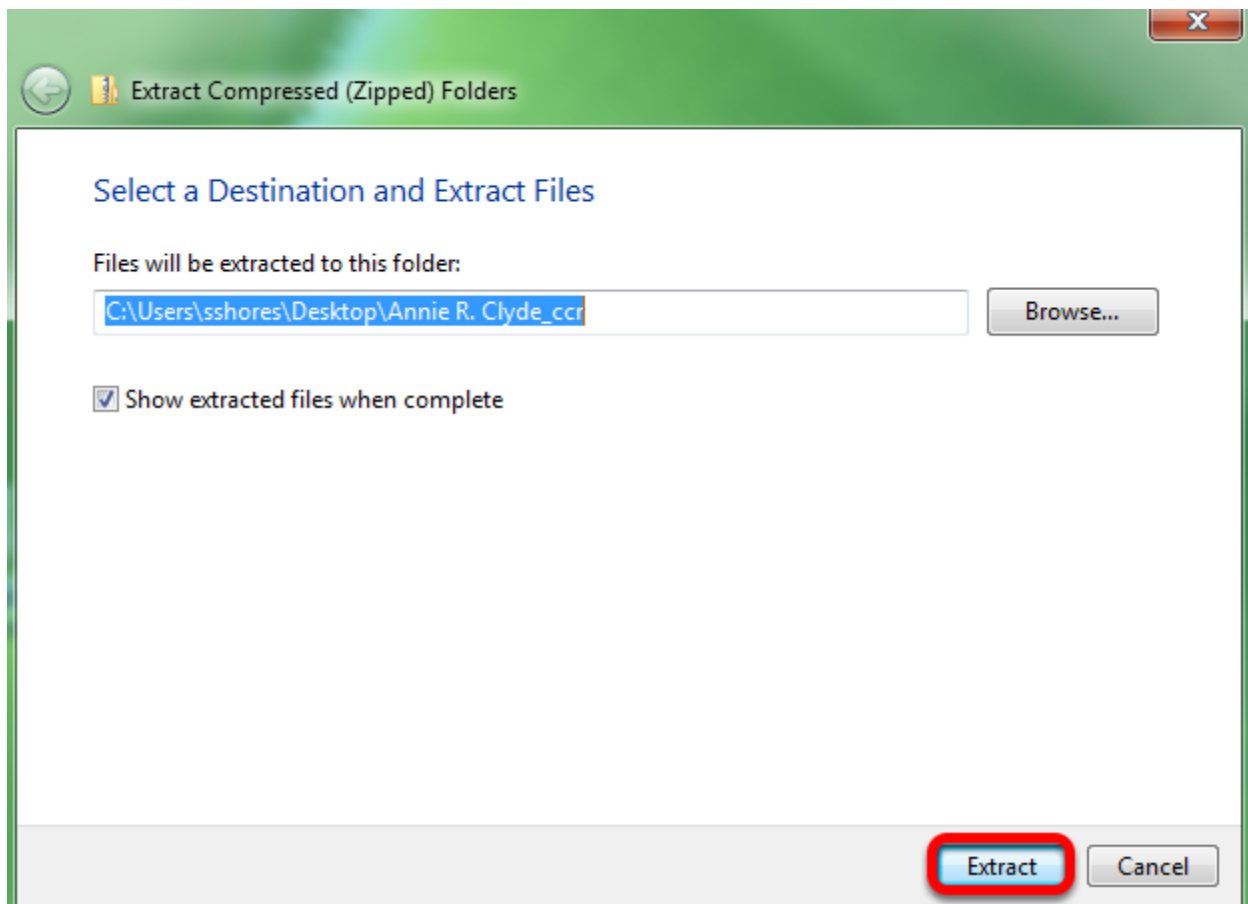


Locate the CCR file where it was saved.

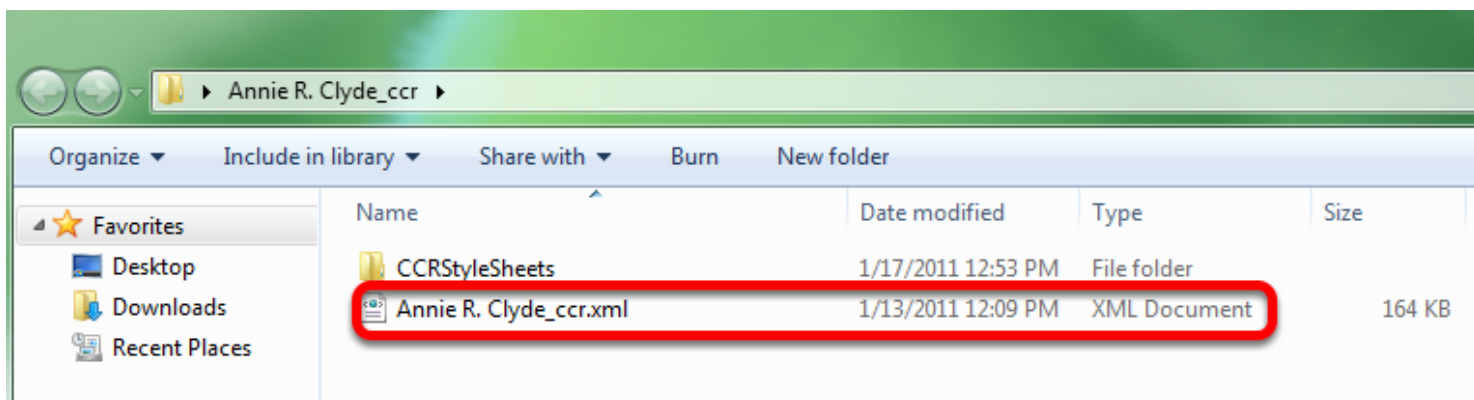
1. Right-click on the zipped file.
2. Select "Extract All."

**\*\* Note:** Users may use any zip utility to unzip the document.

## Compressed File Wizard



Click on the "Extract" button.



Double-click on the XML Document type to view the CCR document.

## The CCR Document

### File Information

Date Created	From	To	Purpose
Thu Jan 13, 2011 at 06:09 PM UTC	Shannon Shores (Primary Care Provider)	Dr. John Doe (Consulting Provider)	Data Transfer

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Annie R. Clyde	May 21, 1945	Female	SSN 789456232	Home Address 315 Maple Ave Springdale, AR72764	Home Phone 5552235656 Work Phone 5552236677

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy			PENICILLIN: rash		SOAPware 2011.0.105.0 (EHR)
Interaction			Drug Allergies: No known. (ID-Ignore)		SOAPware 2011.0.105.0 (EHR)

### Problems

Type	Date	Code	Description	Status	Source
Diagnosis		250.90 (ICD9-CM)	Diabetes - Type 2 - with complications	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		274.01 (ICD9-CM)	Acute gouty arthropathy	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		250.13 (ICD9-CM)	Diabetes - Type 1 - with ketoacidosis, uncontrolled	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		303.90 (ICD9-CM)	Alcohol problems	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		401.1 (ICD9-CM)	Benign hypertension	Active	SOAPware 2011.0.105.0 (EHR)

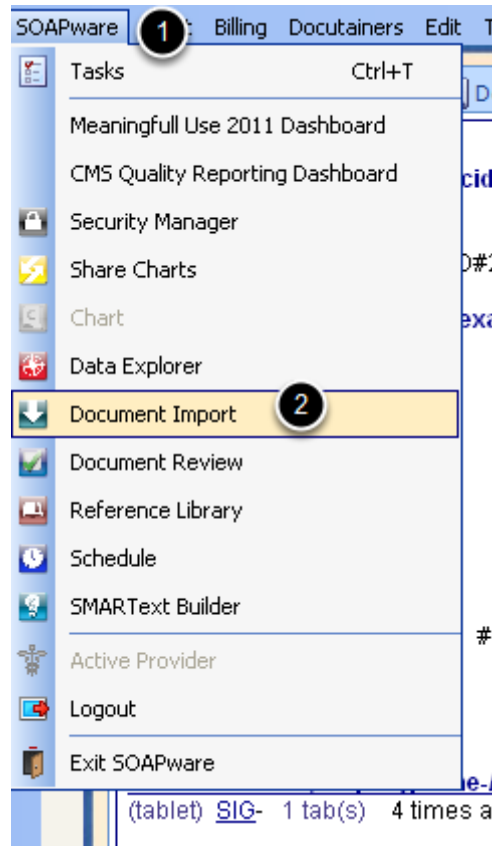
The CCR Document will open in a web browser.

## Importing a CCR/CCD Document

---

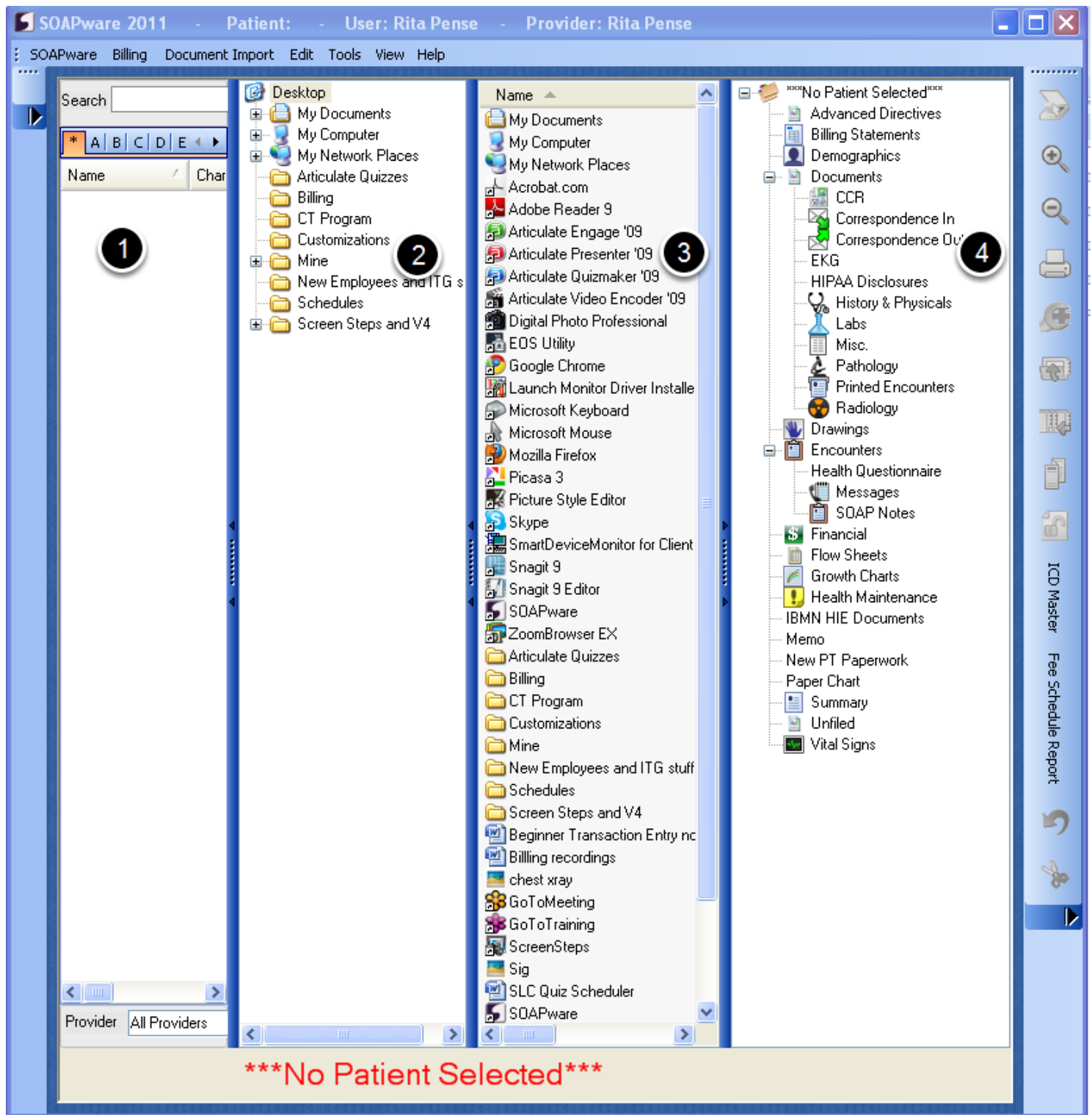
CCR and CCD formatted documents can be imported into the patient's chart using Document Import.

### Accessing Document Import Workspace



1. Click on SOAPware on the menu bar.
2. Click on Document Import.

## Document Import Interface

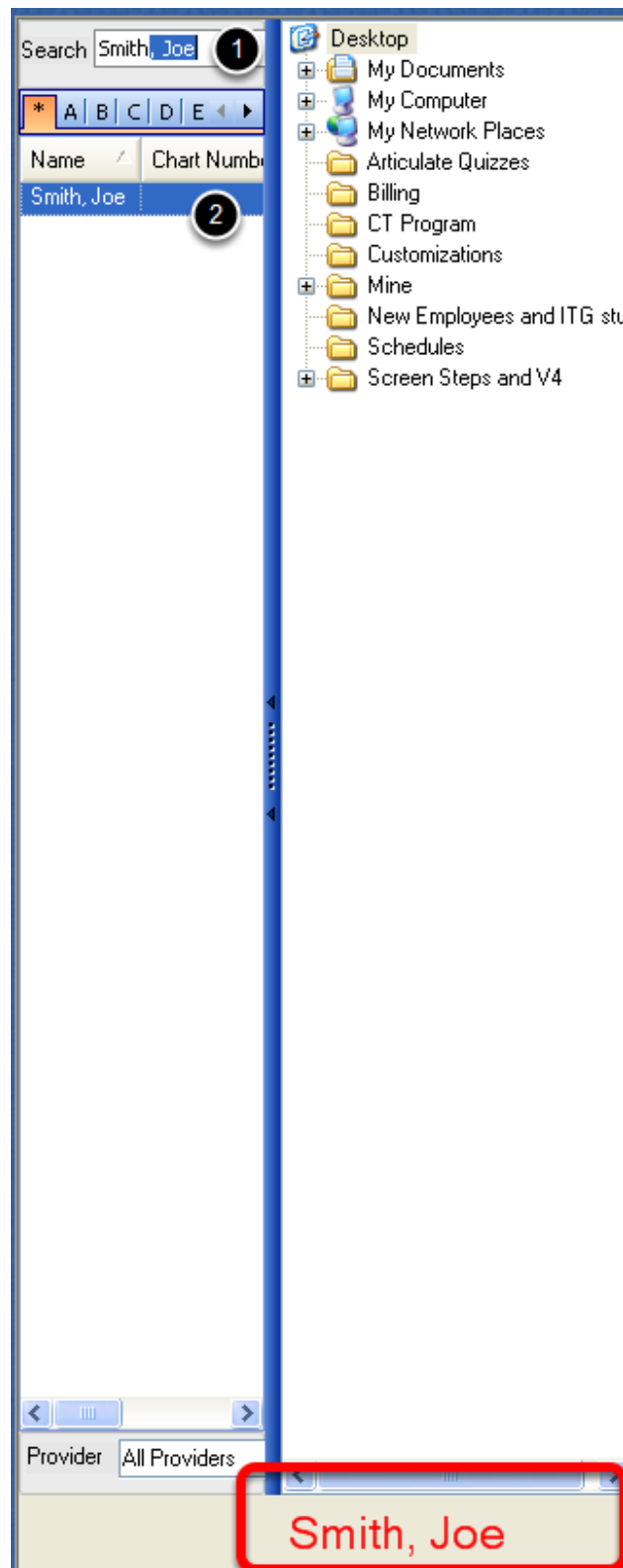


The Document Import consists of 4 panels separated by splitter bars.

1. The Chart Rack
2. The folders located on the computer

3. Content of the folder that was selected in the second window
4. The patient's chart sections located in the Chart Navigator.

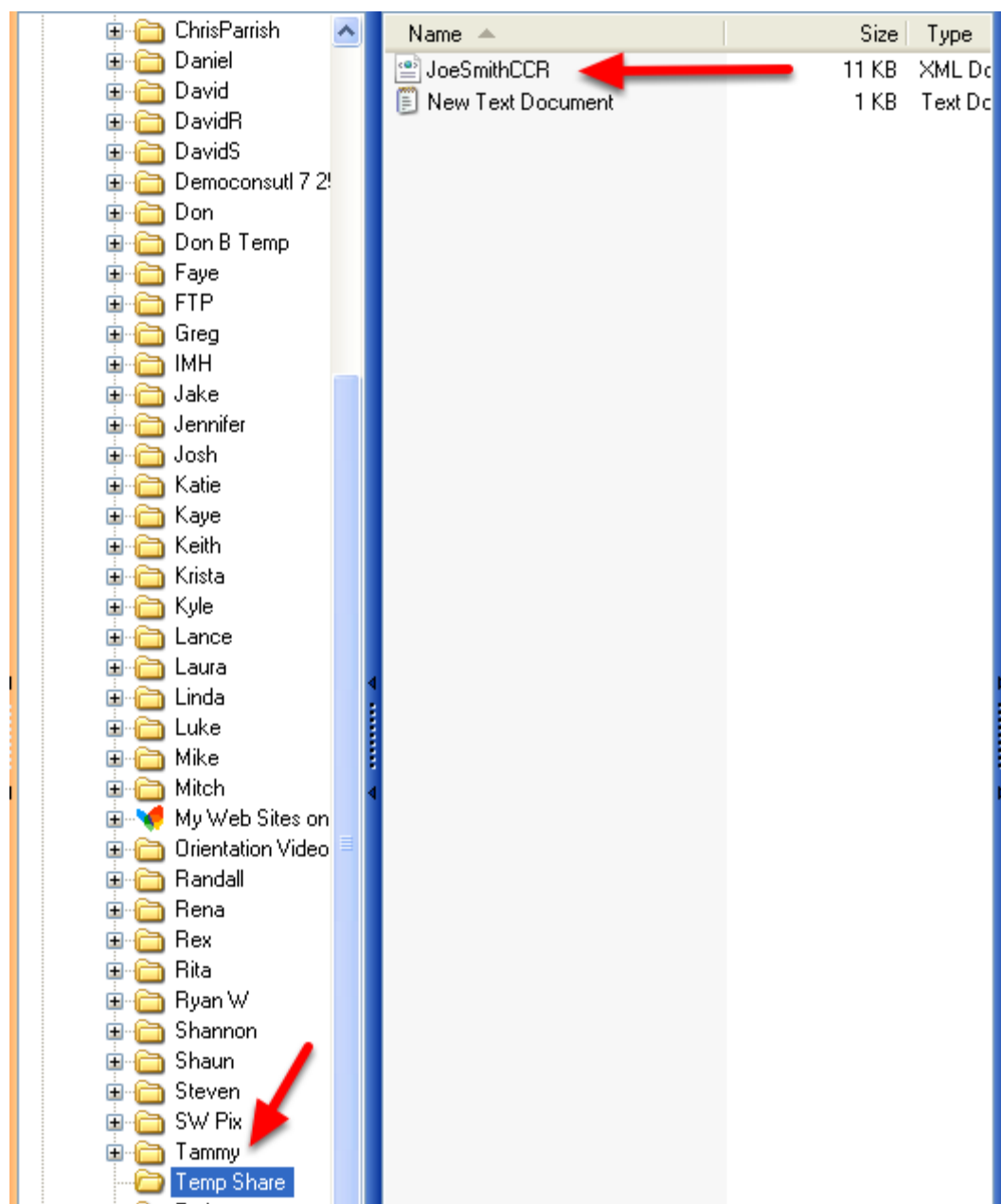
## Selecting a Patient's Chart



1. Type the patient's name in the Search box.
2. Highlight the name to select that patient's chart. When the chart is selected the patient's name

will be displayed in red at the bottom of the screen.

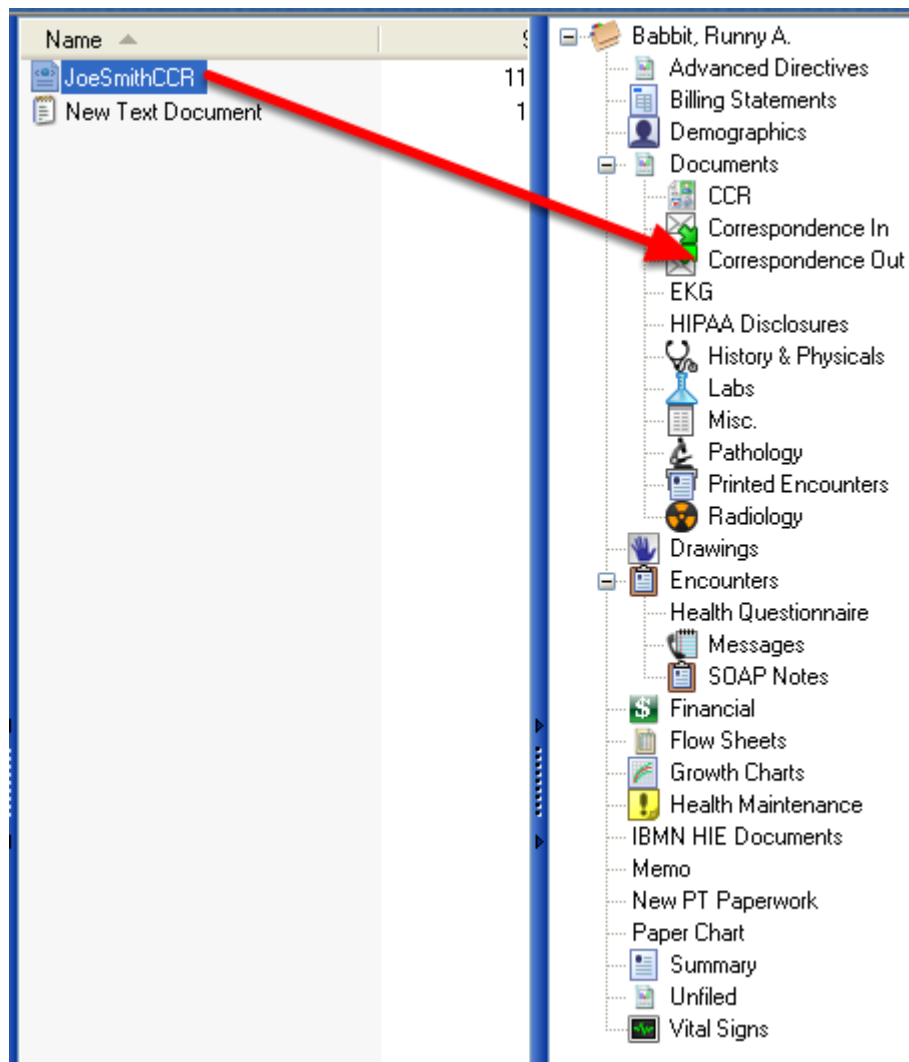
## Accessing the Folder the with the CCR/CCD



1. In the second panel, locate the folder needed and Click to highlight.
2. The contents of the folder will be displayed in the third panel.
3. Click to open the folder and locate the CCR/CCD document.



## Placing the CCR/CCD Document in the Patient's Chart



1. In the third panel, Click to highlight the document.
2. Holding down the left-click, drag the item and drop it in the desired chart section in the fourth panel.

## Add Task Document Task

The screenshot shows the 'Add Document Task' window. It is divided into two main sections: 'Task Info' and 'Docutainer Info'. In the 'Task Info' section, the 'Description' field contains 'JoeSmithCCR.xml', the 'Assigned To' dropdown is set to 'Rita Pense', and the 'Action/Status' dropdown is set to 'Needs Review'. The 'Add' button at the bottom right is circled in red. The 'Docutainer Info' section contains fields for Date, Name, Author, Source, Condition, Status, and Owner, all of which are currently empty or have default values.

Task Info	
Description	JoeSmithCCR.xml
Owner	Rita Pense
Assigned To	Rita Pense
Due	1/13/2011
Priority	Normal
Type	Correspondence Out
Action/Status	Needs Review
Notes	

Docutainer Info	
Date	01/13/2011 10:03 AM
Name	JoeSmithCCR.xml
Author	
Source	
Condition	
Status	
Owner	

☐ Apply To All

**Add** Cancel

The Add Document Task window will appear, allowing the user to assign this document to a provider to be reviewed.

Fill out the Assigned to, Action Status and Click Add.

SOAP Notes | Correspondence Out | Correspondence In

### File Information

Date Created	From	To	Purpose
Wed Feb 10, 2010 at 11:01 PM UTC	Buzz Getwell (Primary Care Physician)		

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Joe William Smith	Mar 23, 1967	Male		Home 1600 Rockville Pike Rockville, MD20847	Home 301-555-1212

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy		1362 (RXNORM)	diphenhydramine HCl	Congestion-Moderate	Buzz Getwell

### Problems

Type	Date	Code	Description	Status	Source
Diagnosis		491.90 (ICD9CM) 63480004 (SNOMED-CT)	Bronchitis, chronic	Resolved	Buzz Getwell

### Procedures

Type	Date	Code	Description	Location	Substance	Method	Position	Site	Status
		71021 (CPT-4)	Chest x-ray						Completed

### Medications

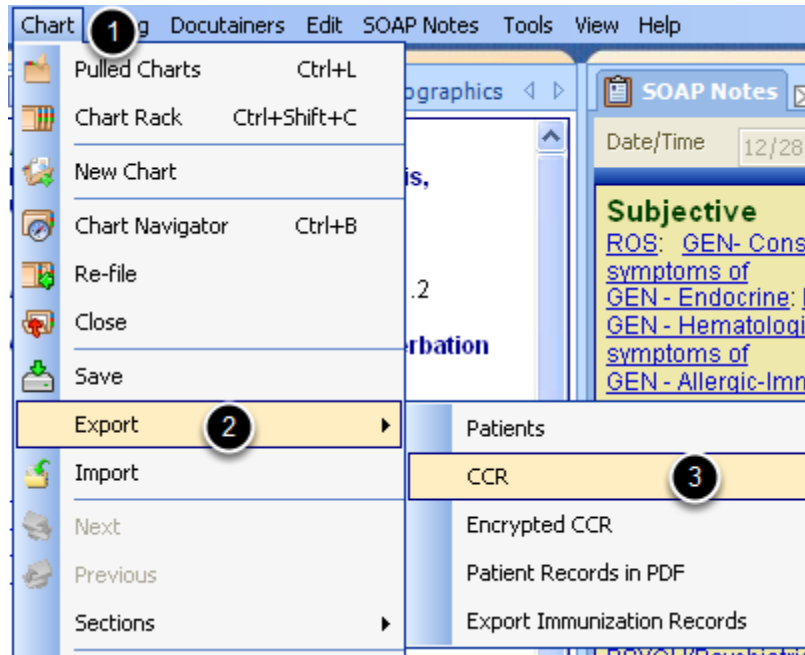
Medication	Date	Status	From	Strength	Quantity	SIG	Indications	Instructions
<div>JoeSmithCCR.xml</div>								

Within the chart workspace, open the patient's chart and view the document.

## Generate CCR Document

In SOAPware version 2011+ is it possible to generate a CCR document in order to share information with other health care providers.

### Accessing the CCR Export



1. With a patient's chart open, Click on Chart on the menu bar.
2. Click Export.
3. Click CCR.

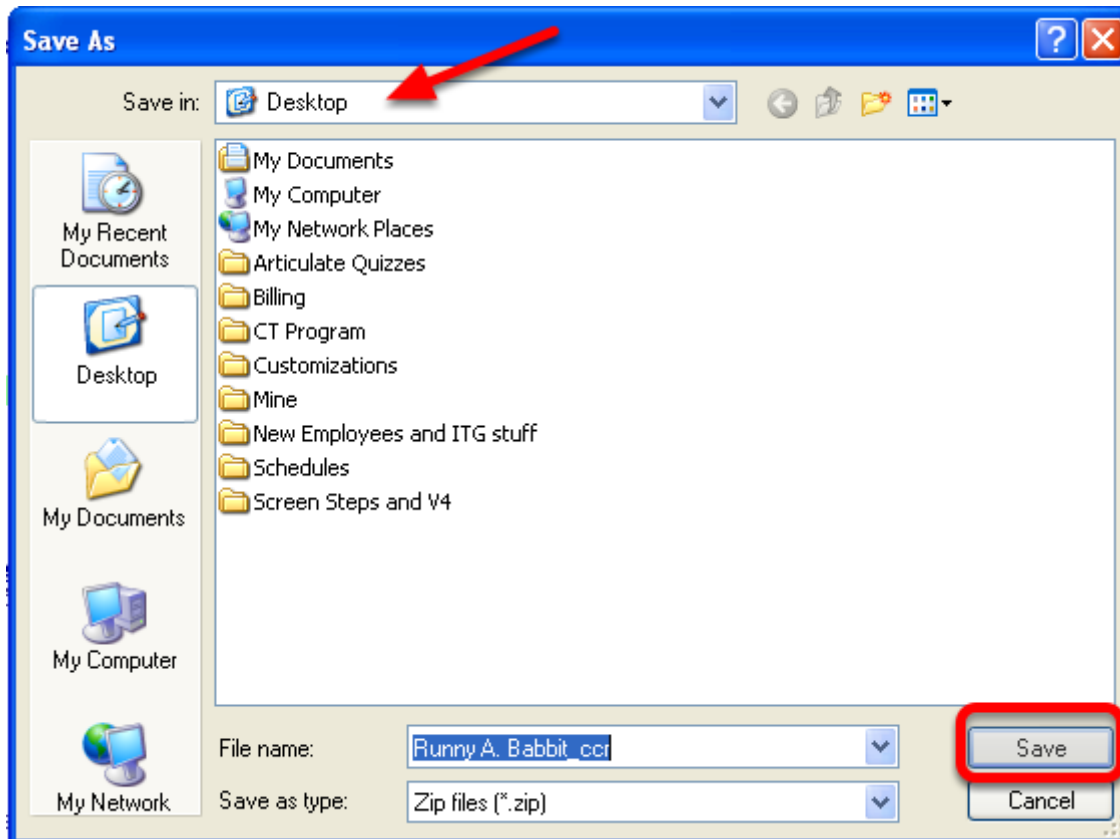
### CCR Information

A screenshot of the 'CCR Information' dialog box. It contains several fields: 'From Role' (Primary Care Provider), 'To' (Dr. John Doe), 'Role' (Consulting Provider), 'Purpose' (Data Transfer), and 'Date to Perform' (2/ 4/2011 11:01:06 AM). There is a checkbox labeled 'Encrypt CCR' which is checked, and a 'Password' field with asterisks. The 'OK' and 'Cancel' buttons are at the bottom. Red circles and arrows highlight the 'From Role' dropdown, the 'Encrypt CCR' checkbox, and the 'OK' button.

Using the drop-down menu options, fill out the appropriate information. Placing a check mark in the box for Encrypt CCR, will encrypt the content of the patient's records and may only be viewed with the password set by the person creating the CCR. The password will be shared only with the

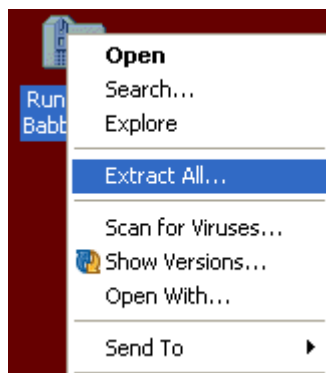
recipient of the CCR.  
Click OK when finished.

## Saving the CCR File



Save the file to the desktop or designated folder.

## Extracting the File



1. Locate the file that was saved.
2. Right-click over the file and choose "ExtractAll."
3. Follow the steps from the wizard to open the document.

Double-click on the icon to view the document

**File Information**

Date Created	From	To	Purpose
Fri Jan 14, 2011 at 02:38 PM UTC	Rita Pense (Physician)	Dr. Smith (Consulting Provider)	Request For Consult

**Patient Demographics**

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Runny A. Babbit	Feb 27, 2010	Female	MRN RB1598 SSN 000000000	Home Address 23324 Raines Rd Siloam Springs, AR72761	Home Phone 5018955612

**Alerts**

Type	Date	Code	Description	Reaction	Source
Allergy			Amoxicillin Chewables:		SOAPware 2011.0.103.0 (EHR)

**Problems**

Type	Date	Code	Description	Status	Source
Diagnosis		250.13 (ICD9-CM)	Diabetes - Type 1 - with ketoacidosis, uncontrolled	Active	SOAPware 2011.0.103.0 (EHR)

A window will display with an icon of the exported CCR document.  
Double-click on the icon to view the document.

**\*\*Note** - Users may use any zip utility to unzip the document.

## Clinical Summaries for Each Office Visit

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Meaningful Use requests that the information include diagnostic test results, patient problem list, medication list, and medication allergy list at a minimum.

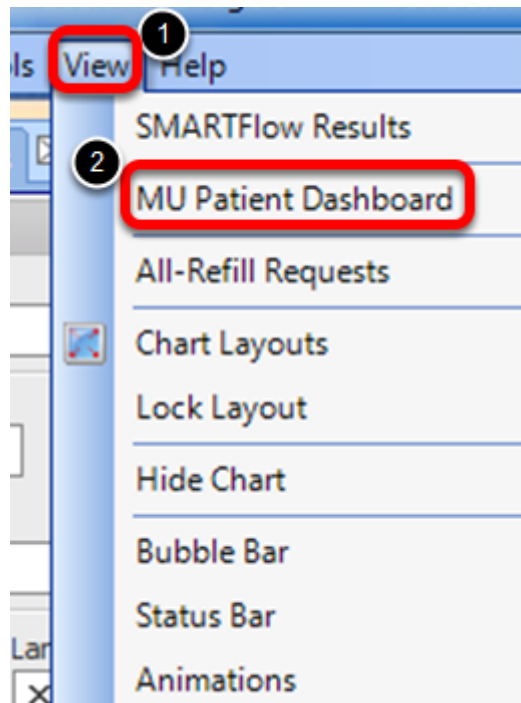
This can be accomplished in SOAPware in two ways. The first involves printing the information in the CCR (Continuity of Care Record) format which includes a "snapshot" of the patient's chart for the last 30 days. The second method will be placing the "Clinical Summary Provided" on a Document Design that includes SOAPnote and Summary information. Both of this methods can be tracked in order to qualify for the Meaningful Use initiatives and will update the MU Patient Dashboard.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Clinical Summaries](#)**

### Patient Meaningful Use Dashboard:

This requirement will be tracked via the [Patient Meaningful Use Dashboard](#).

### Creating/Providing a Clinical Summary CCR Document



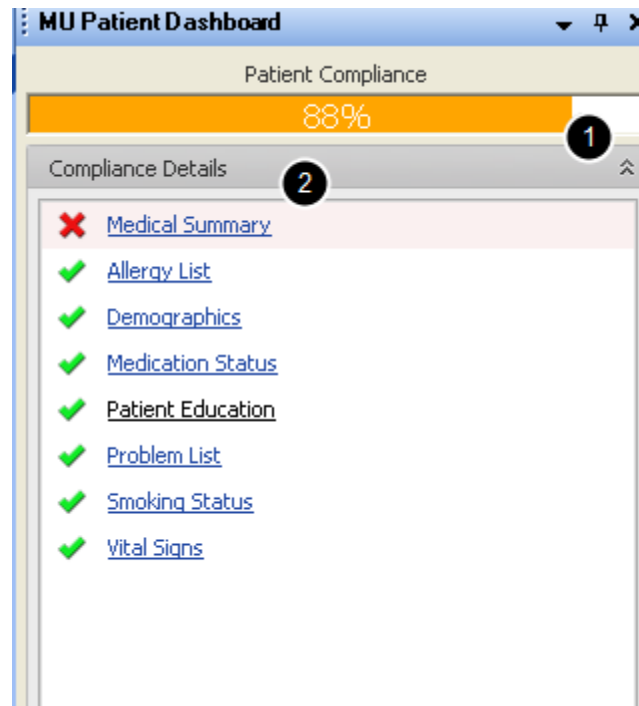
**\*Note-**CCR (Continuity of Care Record) format includes a "snapshot" of the patient's chart for the last 30 days.

With a patient chart open:

1. Click on the View menu item.
2. Click on MU Patient Dashboard.

The MU Patient Dashboard can be docked.  
For instructions on docking tabs, [click here](#)

### Using a CCR to Provide a Clinical Summary

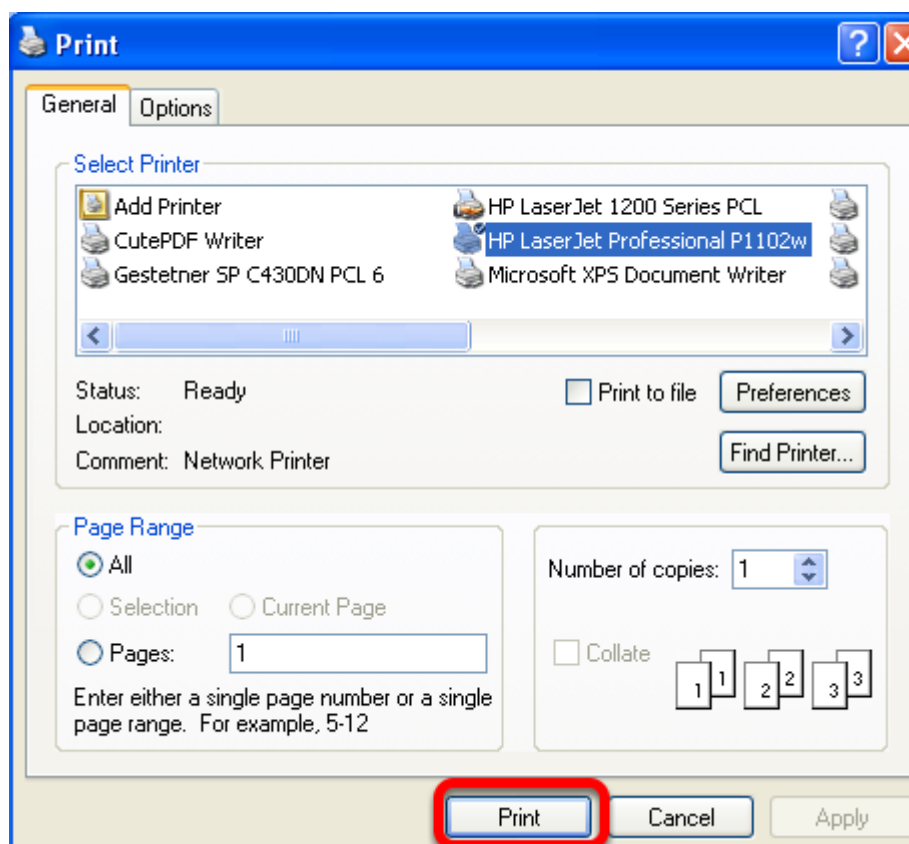


The MU Patient Dashboard allows the user to export a CCR Document while keeping track of the patient compliance measures for Meaningful Use Requirements.

1. Click on the drop down arrows for Compliance Details (if no details are displayed)
2. Click to select Medical Summary.



## Selecting the Printer



The Print dialog box will display. Click to highlight the desired printer and Click on the print button.

C:\Documents and Settings\rpense\Desktop\Runny A. Babbit\_ccr\Runny A. Babbit\_ccr.xml - Windows In...

C:\Documents and Settings\rpense\Desktop\Runny A. Babbit\_ccr\Runny A. Babbit\_ccr.xml

File Edit View Favorites Tools Help

Windows Live Bing What's New Profile Mail Photos Calendar Sign in

Favorites Microsoft CRM 3 SOAPedia Home - SOAPedia Web Slice Gallery

Microsoft CRM 3.0 C:\Documents and S...

### File Information

Date Created	From	To	Purpose
Fri Jan 14, 2011 at 02:38 PM UTC	Rita Pense (Physician)	Dr. Smith (Consulting Provider)	Request For Consult

### Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Runny A. Babbit	Feb 27, 2010	Female	MRN RB1598 SSN 000000000	Home Address 23324 Raines Rd Siloam Springs, AR72761	Home Phone 5018955612

### Alerts

Type	Date	Code	Description	Reaction	Source
Allergy			Amoxicillin Chewables:		SOAPware 2011.0.103.0 (EHR)

### Problems

Type	Date	Code	Description	Status	Source
Diagnosis		250.13 (ICD9-CM)	Diabetes - Type 1 - with ketoacidosis, uncontrolled	Active	SOAPware 2011.0.103.0 (EHR)
Diagnosis		493.9 (ICD9-CM)	Asthma	Active	SOAPware 2011.0.103.0 (EHR)
Diagnosis		281.2 (ICD9-CM)	Anemia, folate deficiency	Active	SOAPware 2011.0.103.0 (EHR)
Diagnosis		491.21 (ICD9-CM)	COPD, Bronchitic with acute exacerbation	Active	SOAPware 2011.0.103.0 (EHR)

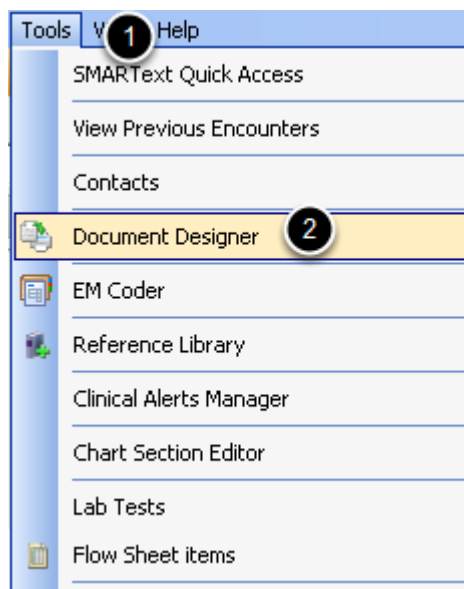
### Medications

Medication	Date	Status	Form	Strength	Quantity	SIG	Indications	Instruction	Refills	So
Darvocet-N 100 (Propoxyphene-Acetaminophen):		Active	tablet	napsylate 650 mg-100 mg	30	1 tab (s) 4 times a			0	So 20 (E

Done My Computer 100%

The CCR format will appear as above when printed.

## Using a Document Design to Provide a Clinical Summary

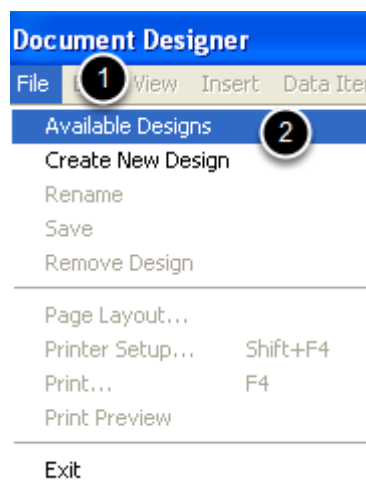


The command to indicate the Clinical Summary was provided to the patient must be placed on the proper Document Design.

To do this:

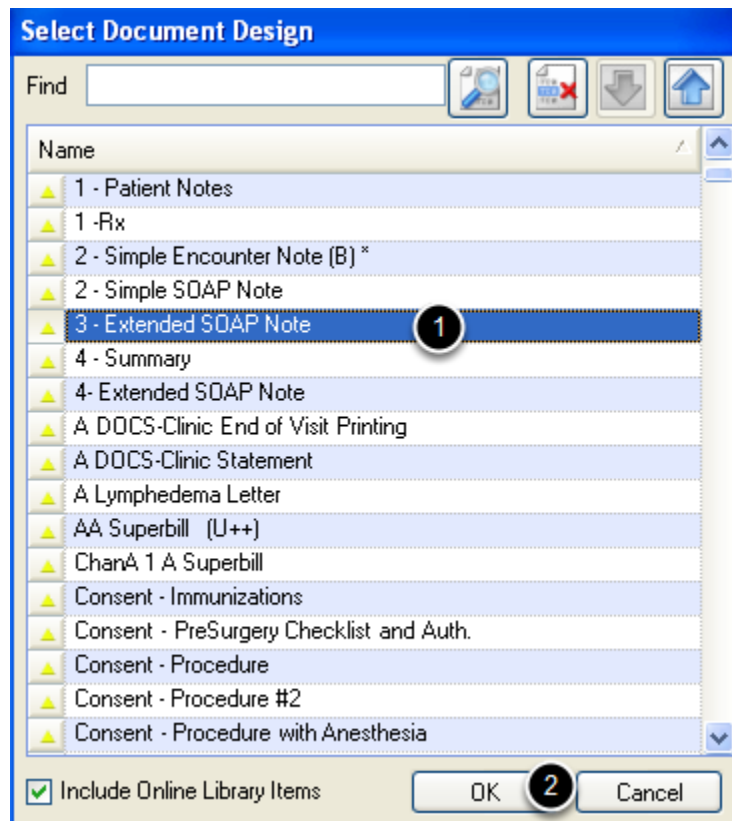
1. Click on Tools.
2. Click on Document Designer.

## File > Available Designs



1. Click on File.
2. Click on Available Designs.

## Selecting the Desired Design



1. Click to highlight the design that includes the Summary **and** SOAPnote information.
2. Click OK.

## Inserting the Command

**3 - Extended SOAP Note**

File Edit View Insert Data Items Paragraph Table Other

Normal

General Demographics  
Misc. Data Items  
SOAP Note  
Summary  
Vital Signs  
Health Maintenance  
Custom Demographics  
Insurance  
Macros  
Rx's  
Orders  
Custom Fields

Insert Chart Section  
Insert CPT Codes  
Empty Block Start  
Empty Block End  
Clinical Summary Provided

Place cursor on design

**1**

**SUBJECTIVE:**  
~~##EncounterField Subjective ,reported,denied##~~  
~~##RemoveIfEmptyEnd##~~~~##RemoveIfEmptyStart##~~  
**ACTIVE PROBLEMS:**  
~~##SummaryField Active Problems ,##~~  
~~##RemoveIfEmptyEnd##~~~~##RemoveIfEmptyStart##~~

Patient's Name	##GeneralDemographicsField First Name## ##GeneralDemographicsField Last Name##	Date	##EncounterField DocumentDateTime, MM/dd/yyyy##
Patient's Age	##GeneralDemographicsField Age##	Time	##InsertDateTime HH:mm##
Medical Record #	##GeneralDemographicsField Chart Number##	Doctor	##CurrentProvider Full Name##

**2**

**3**

**4**

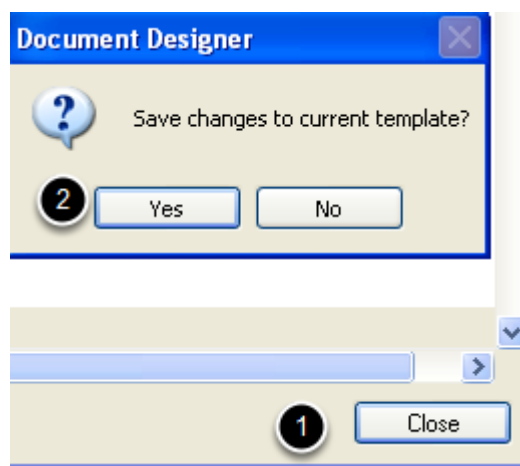
1. Place the cursor on the design. The location of the cursor and subsequent command is not important as the command runs in the background and is not visible when the design is printed.
2. Click on Data Items.
3. Click on Macros.
4. Click on Clinical Summary Provided.

## The Command

<b>Clinic Visit Note</b>			
Patient's Name	##GeneralDemographicsField First Name## ##GeneralDemographicsField Last Name##	Date	##EncounterField DocumentDateTime, MM/dd/yyyy##
Patient's Age	##GeneralDemographicsField Age##	Time	##InsertDateTime HH:mm##
Medical Record #	##GeneralDemographicsField Chart Number##	Doctor	##CurrentProvider Full Name##
##ClinicalSummaryProvided##			
<b>SUBJECTIVE:</b> <del>##EncounterField Subjective ,reported,denied##</del> <del>##RemoveIfEmptyEnd##</del> <del>##RemoveIfEmptyStart##</del>			

The command will not appear on the design.

## Saving the Edit



1. Click on Close.
2. Click Yes.

## Clinical Summary

This lesson has demonstrated the two ways to provide a Clinical Summary for a patient; CCR document and using a Document Design.

Both methods will be reflected in the MU Patient Dashboard and Meaningful Use Dashboard.

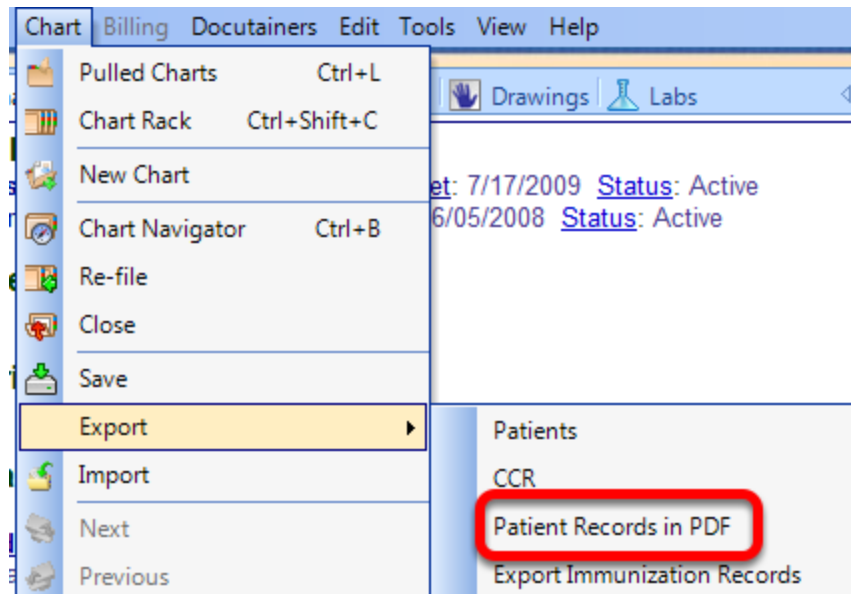
## Patient Requests Copies of Medical Records

---

This lesson will demonstrate the steps necessary to meet the Meaningful Use requirement to Provide Patients Copies of Records.

**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)  
- **OR** [Electronic Copy of Health Information](#)

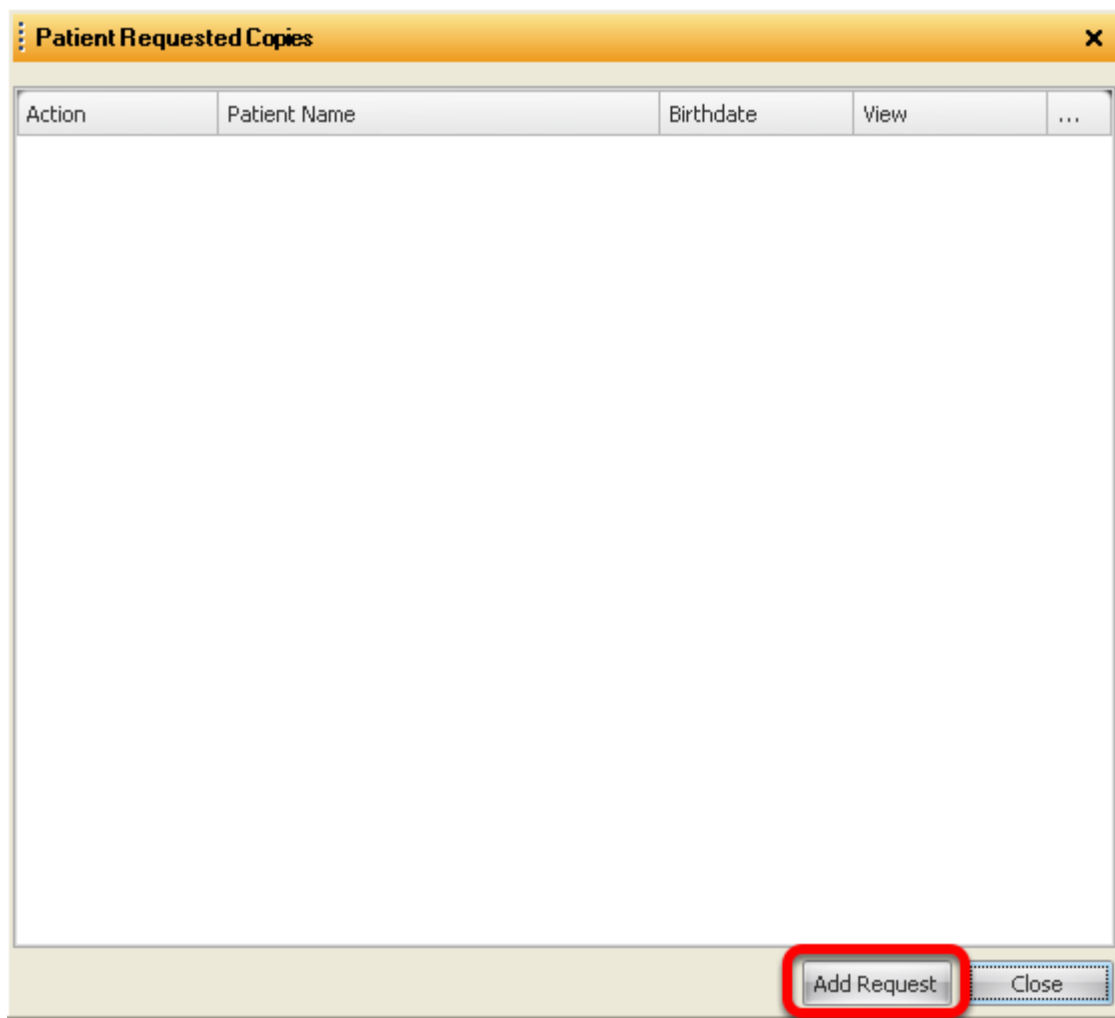
### Access the Patient Requested Copies Manager



When a patient requests a copy of their health information, the following workflow should be used in order to successfully meet the Meaningful Use objective to provide patients with an electronic copy of their health information upon request.

Click on Chart > Export > Patient Records in PDF.

**Note:** The Patient Requested Copies Manager can be docked or left free-floating.



Action	Patient Name	Birthdate	View	...
--------	--------------	-----------	------	-----

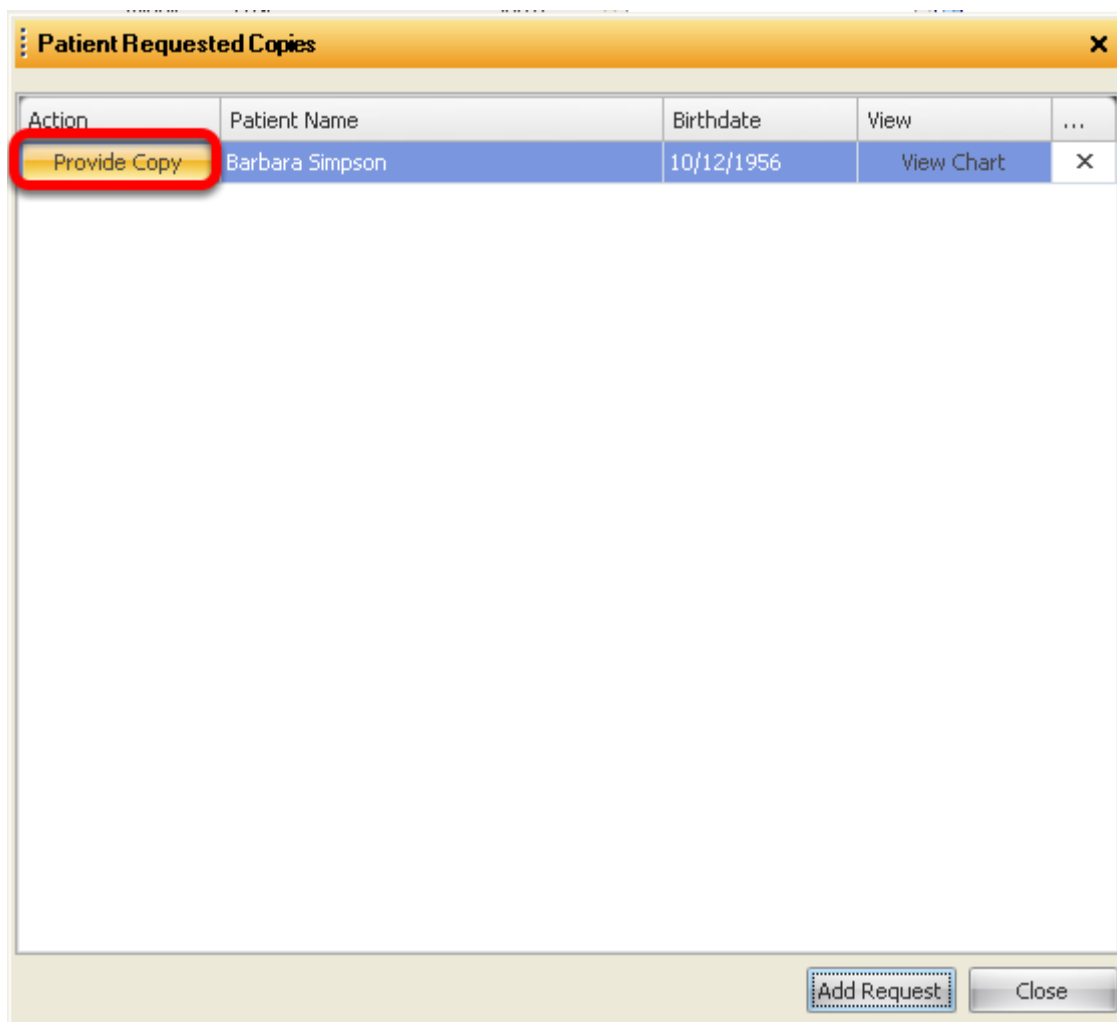
Add Request Close

Select the "Add Request" button to indicate that the selected patient has requested a copy of their medical records.

**Note:** Make sure a patient's chart is open before adding a request. A user is able to add multiple requests at once to the Patient Requested Copies Manager by going to the chart rack and opening up the charts of various patients, then Clicking the "Add Request" button.

The request will be documented for the current patient for the current date.

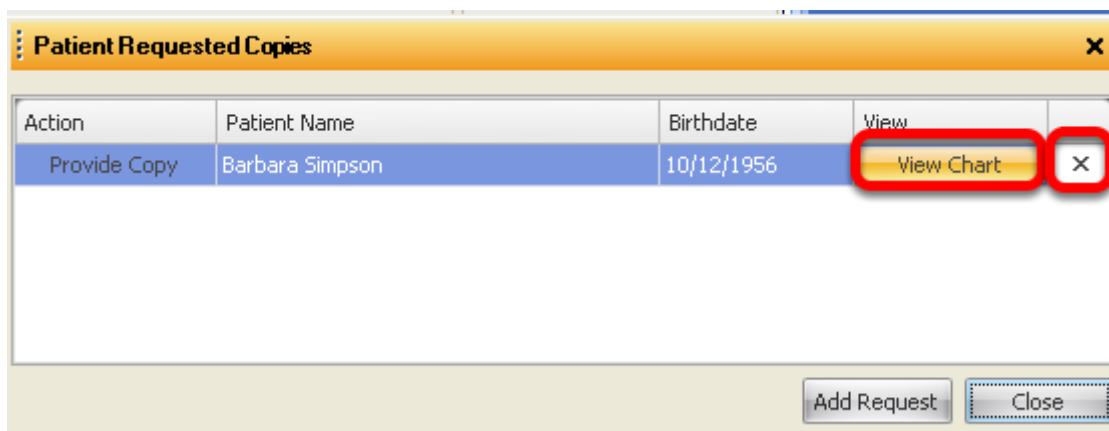




Click on the "Provide Copy" button.

This action will mark this request as responded to with the current date for Meaningful Use reporting purposes. This workflow must be used in order for the information to be tracked within the Meaningful Use dashboard.

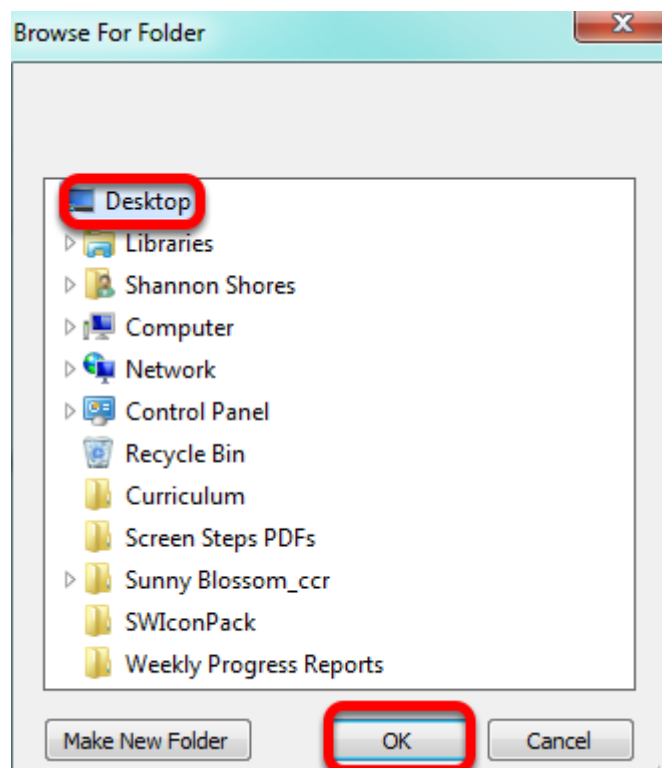
## Misc Commands



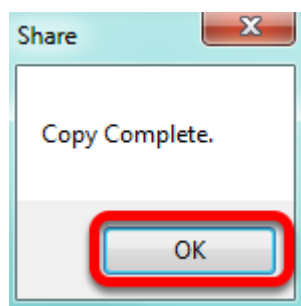
"View Chart" opens the chart related to the request.

"X" deletes the request from the Patient Requested Copies Manager. If the request is deleted, it cannot be retrieved.

## Save the Document



In the screen shot above, the document was saved to the desktop.  
Click OK.

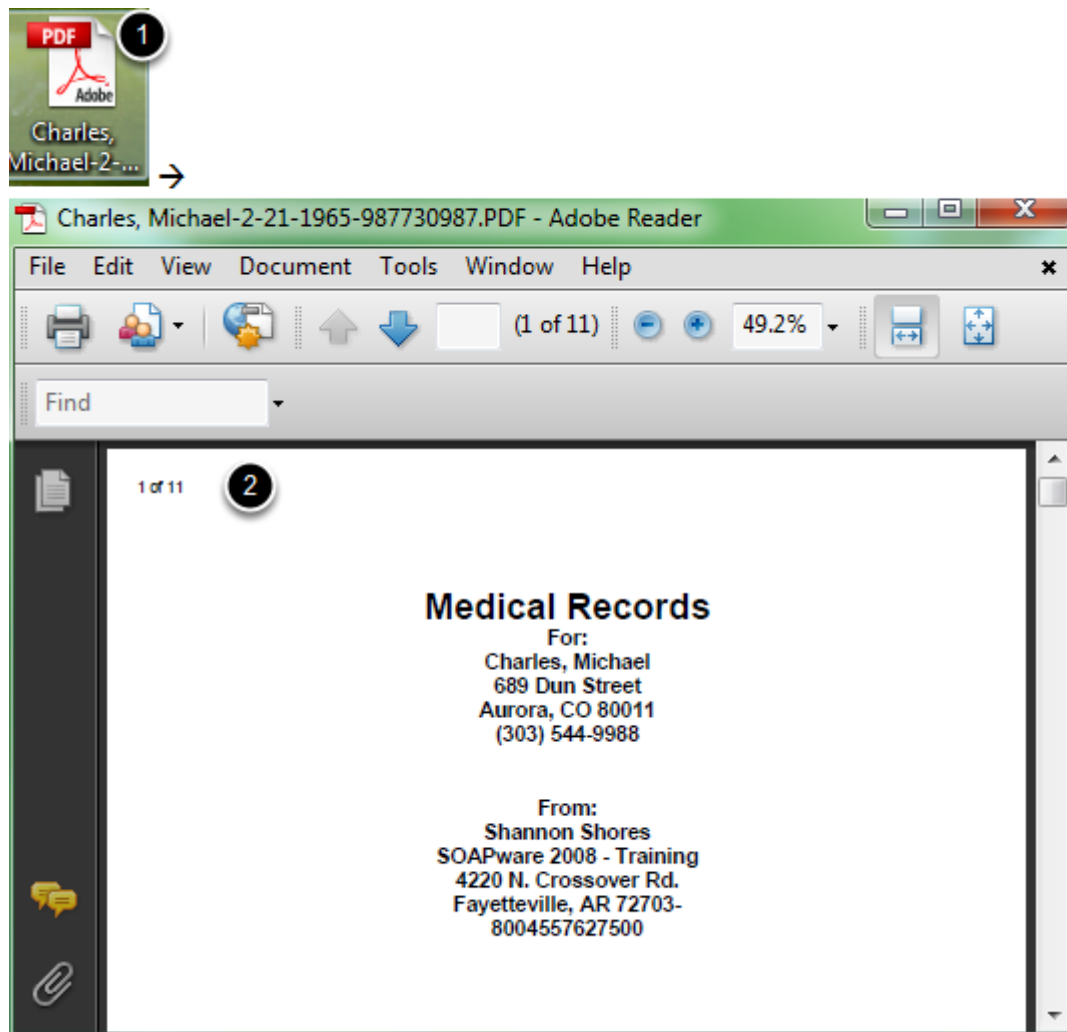


When the document has been sent to the desired location on the computer, the user will receive a copy complete notification.

Click OK.

**Note:** *Once the user clicks OK, the patient will automatically be removed from the Patient Requested Copies Manager.*

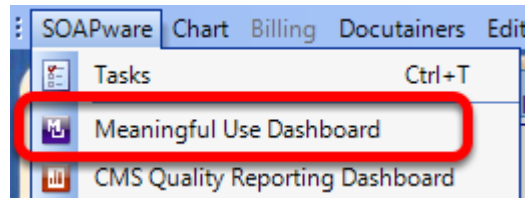
## Locate the Document



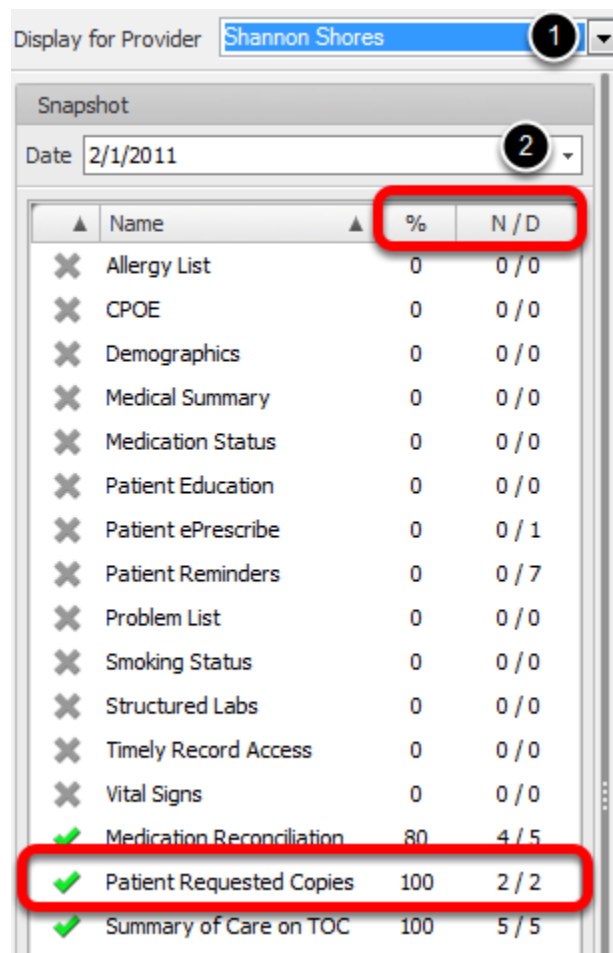
1. Double-click on the file to open.
2. A completed document displayed as a PDF.

## Providing the Patient an Electronic Copy

For more information and requirements on electronically providing the patient a copy of their health information, please refer to the CMS guidelines in the following reference document: see, [CMS Electronic Copy of Health Information](#). Please review this document, as well as the Additional Information section of the document for further explanation.



In order for a provider to check that he or she is meeting the Meaningful Use criteria for Patient Request Medical Copies, Click SOAPware from the menu bar, and Select Meaningful Use Dashboard.



1. Select a provider.

2. Select a "snapshot" date. (**Note:** the statistics displayed will be for the 90 days *previous* to the date selected.)

Agreen check mark indicates that the item has met the Meaningful Use requirements.

Auser is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.

## Chart Merger Feature

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If the user accidentally create two charts for the same patient, this function will allow the user to merge them into one chart.

### Disclaimer statement addressing information that may be lost during Chart Merge process

**VERY IMPORTANT:** Most of the documentation from both charts will be present in the merged chart. However, the Demographics, Insurance, & Custom Demographics, Vital Signs and Summary sections will only be retained in the chart being merged To. The Demographics, Insurance & Custom Demographics, Vital Signs, and Summary of the chart merged From will not be saved. Before the user begins, look carefully at the Demographics, Insurance, & Custom Demographics, Vital Signs, and Summary sections. Copy data from one chart to the other if necessary, to make sure that one of the charts has all the data needed in those sections. It is recommended that the use of this feature be limited, in security, to one person, or a small number of experienced staff.

**Note:** a backup of a user's SOAPware data is recommended prior to merging patient charts.

### Explanation of feature and its use

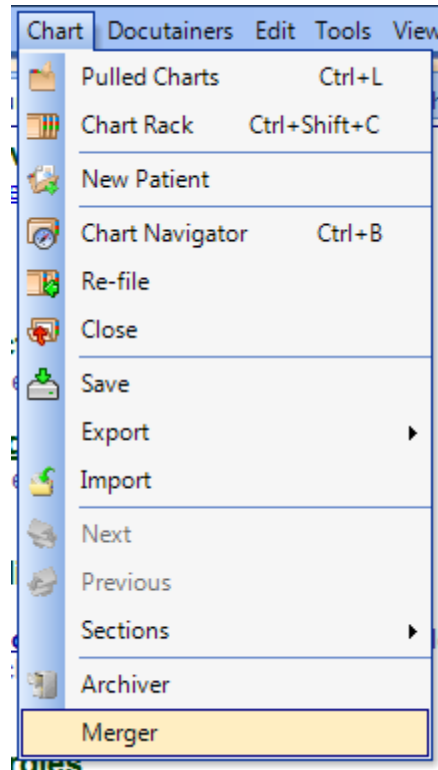
The Chart Merger is a tool that allows the user to merge two patient charts. The user can do this by selecting a chart to merge from and a chart to merge to.

The Demographics and Summary of the chart selected to merge to will be retained, and the documentation from both charts will be present in the merged chart. Note that a backup of the user's SOAPware data is recommended prior to merging patient charts.

### Security Concerns

This is a feature that the user will need to want to restrict access to just one or two people in the clinic, as it is not possible to un-merge charts.

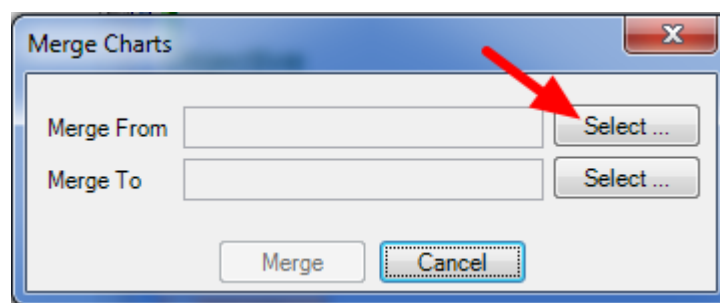
## Directions to Merge Charts



To use the Chart Merger, open it by selecting "Merger" from the Chart menu.

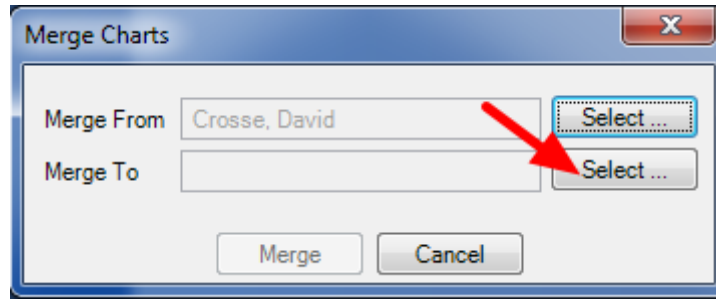
The Merge Charts dialog box will open, allowing the user to select the chart to Merge From and the chart to Merge To.

### Merge From



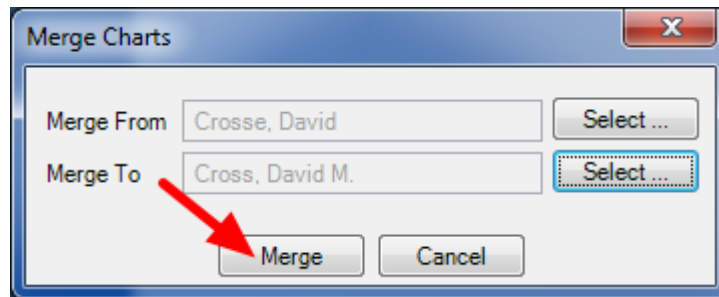
First, select the chart to Merge From. To do this, Click the "Select" button that corresponds to the Merge From field. This will open the Merge From dialog box, which will allow the user to select a patient chart by either typing information into the Search field, or by clicking on a letter and selecting the chart. Once the user has selected the chart to Merge From, Click "Select" at the bottom of the window.

## Merge To



Then, the user will need to select the chart to Merge To. This will open the Merge To dialog box, which will allow the user to select a patient chart by either typing information into the Search field, or by clicking on a letter and selecting the chart. Once the user has selected the chart to Merge To, Click "Select" at the bottom of the window.

## Merge



In the Merge Charts dialog box, the charts the user has selected will be displayed in the Merge From and Merge To fields. Click "Merge" to merge the charts. It is recommended that the user check the chart that was selected in the Merge To field to ensure a complete and accurate merge.



## Chart Archiving Feature

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The ChartArchiver is a tool that allows the user to archive a patient's chart, removing it from the Chart Rack. This is useful for keeping the chart rack cleared of inactive charts, reducing the amount of time the user spends looking for the charts needed.

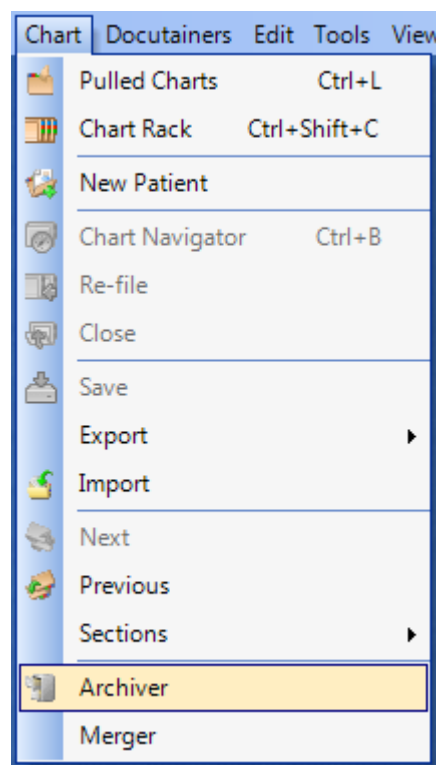
The user can also un-archive a chart at any time using the ChartArchiver, placing it back on the Chart Rack and making it available for use.

**\*\*Auser must sign off all documents in a chart to be able to archive the chart. To check if the chart has any unsigned documents, go to Docutainers > Unsigned. From here, the provider can sign off any documents that need to be signed off.**

### Introduction to Feature and its Purpose

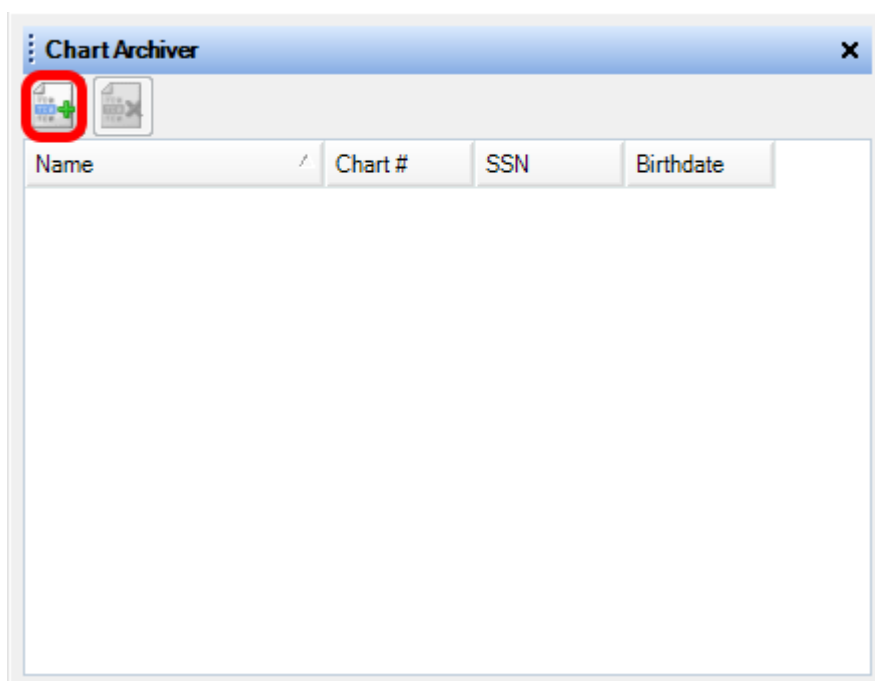
The ChartArchiver displays all charts that have been archived. Above the list of archived charts, there are two buttons: Archive Chart and Un-archive Chart.

### Open Chart Archiver



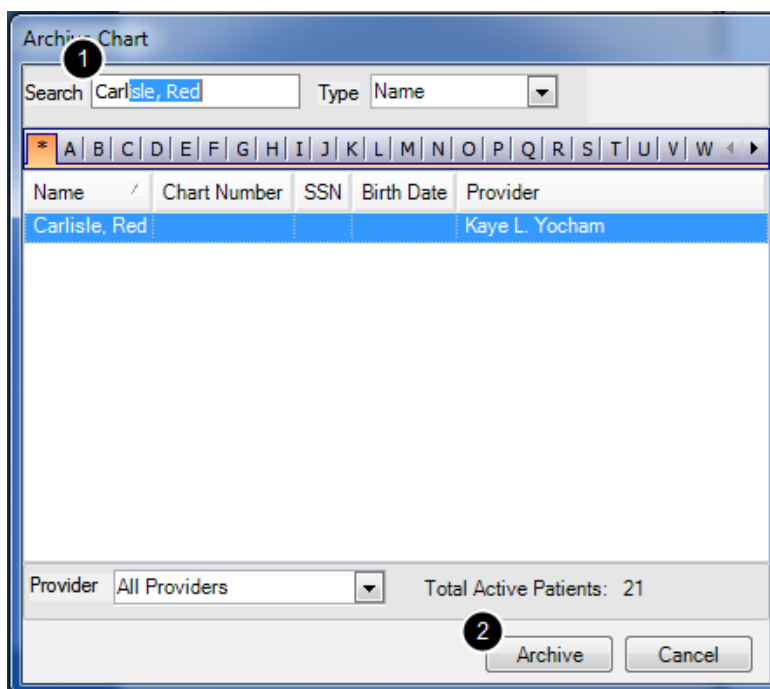
To archive a chart, Click the Archive Chart Button (or press Control + Alt + A). The Archive Chart tool will then open.

## Directions to Archive Charts



Click the Archive Chart button.

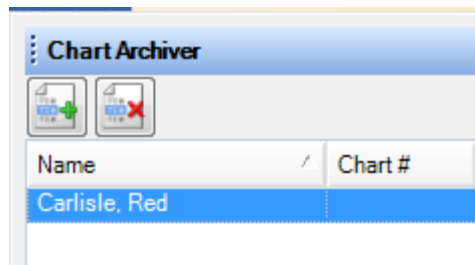
## Select the Chart to Archive



1. Select the chart to archive, either by typing the patient's last name (or another field, chosen from the drop down menu) or by clicking on the appropriate letter and selecting the chart from the list.

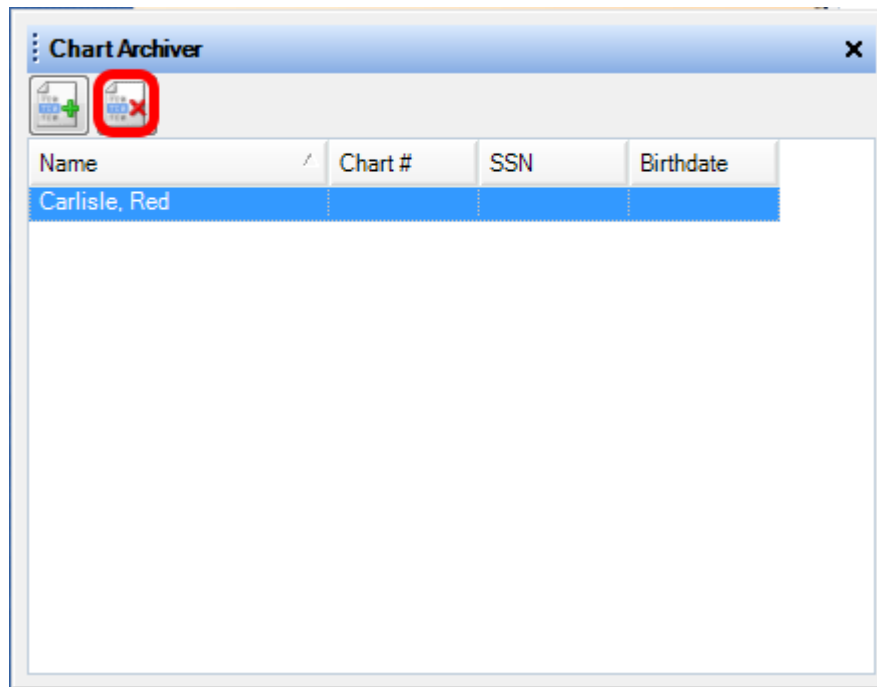
2. Once the user has selected the chart to archive, Click the Archive button. The chart will be removed from the chart rack and placed on the list of archived charts.

## Chart Archiver



After the user has archived the chart, it will appear in the list of archived charts.

## Directions to Un-Archive Charts

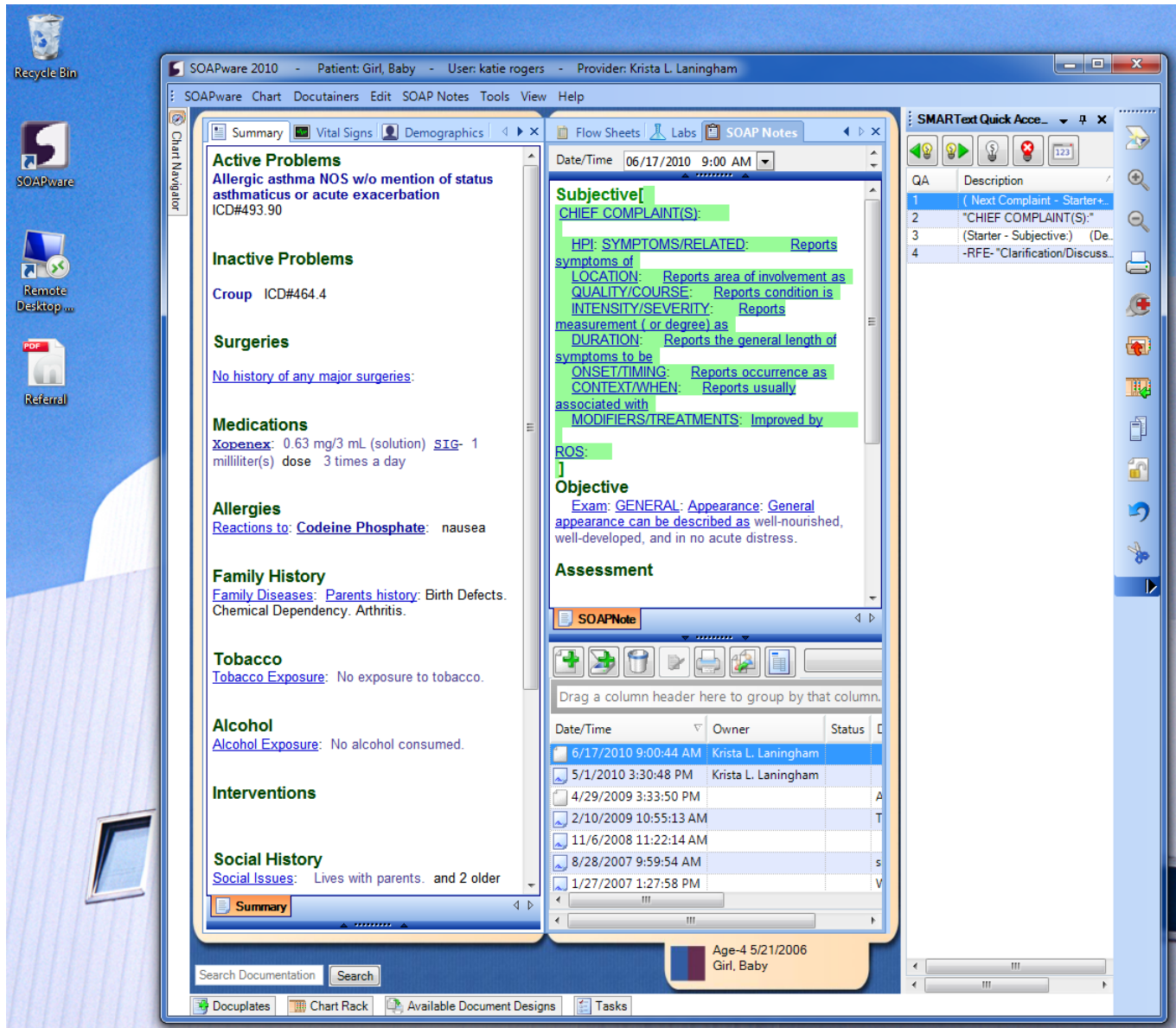


To un-archive a chart, select it from the list of archived charts by Clicking on it and pressing the Un-archive Chart Button (or press Control + Alt + U). The chart will be removed from the list of archived charts and placed back on the Chart Rack.

## Drag and Drop Files into SOAPware

Drag and Drop files into almost any area of the patient chart. The user will have the ability to drop a file by either attaching it to an existing docutainer or the user can drop directly into an open field.

### Restore Down SOAPware



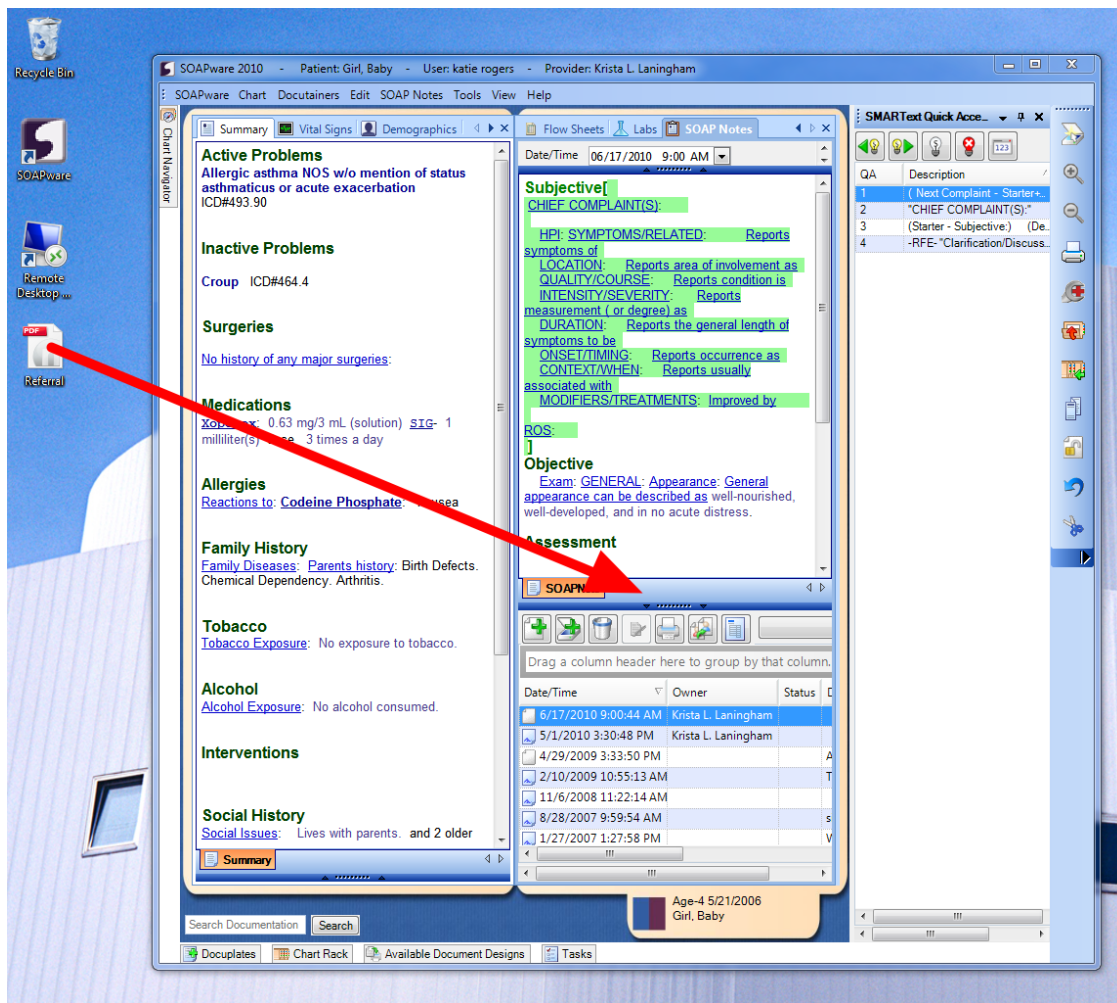
First the user must make SOAPware smaller (make sure to have a chart open) by clicking on the Restore Down button in the upper right-hand corner of the SOAPware screen.

## Choose the File on the Desktop



Choose a file that has been stored on the desktop.

## Drag and Drop to SOAPware



Left-click the mouse button over the file, while continuing to hold the button down, drag the file until the mouse arrow is to the left of the lower tab of the docutainer (in this example we will use a SOAPnote).

The file will look like a black circle with a slash through it.

When the mouse arrow is in the correct location next to the tab, it will look like a small faint box with a small plus. Drop it by removing finger from the mouse button.

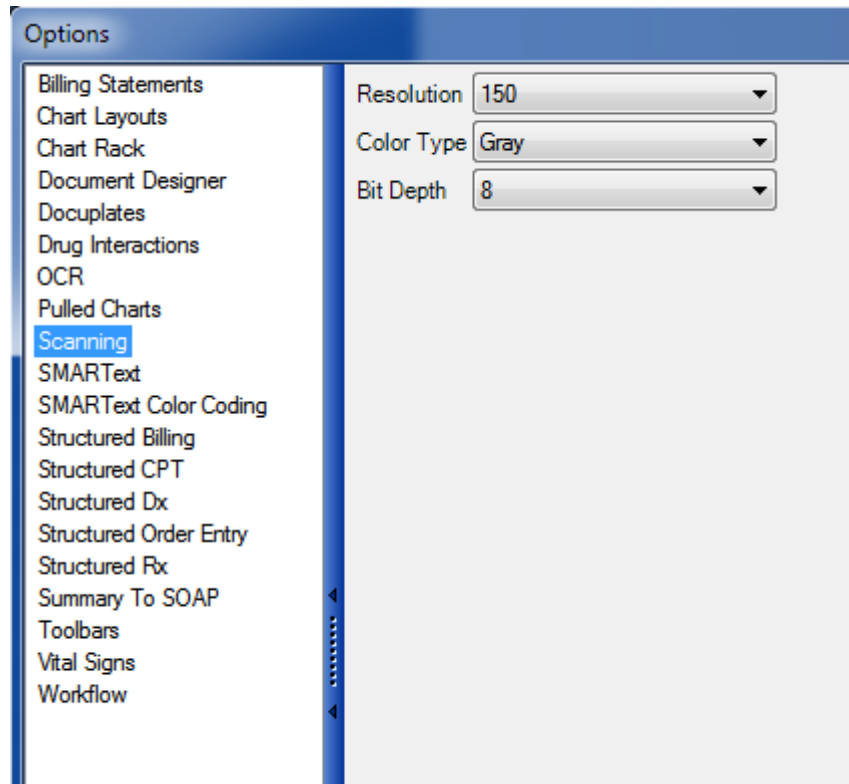
## Scanning Set-Up & Options

---

There are several options that the user can set to customize Scanning settings for his/her needs. To access the Scanning Options area, Click Tools, Options, and Select Scanning from the tree view.

SOAPware Scanning allows the user to initiate an image scan from within SOAPware, and to have the resulting image imported directly into the current Document as a new Document Item.

### Setting Options



These settings determine the quality of scanned images. Remember that the higher resolution set, the clearer the picture, but the slower the scanning time will be. To find these, go to Tools - Options.

**Resolution:** This controls the dots per inch. The higher the resolution is set, the larger a user's database will get.

**Color Type:** The user will be able to select Black and White, Gray or Color. Black and White will be the most accurate and fastest option. If the user wants to convert color documents, the user certainly can. Both Gray and Color will affect the Bit Depth of the conversion as well.

**Bit Depth:** Affects the granularity of the conversion. If the user has a Gray or Color type set, the higher the bit depth selected, the clearer the picture will be.

## Scan Directly into SOAPware



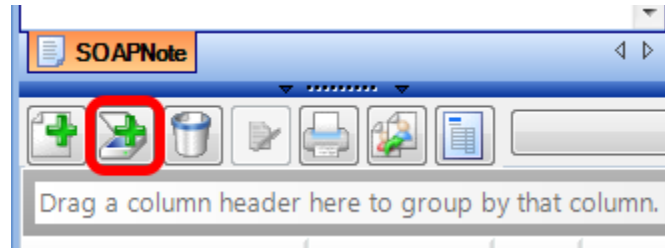
With an unsigned Document open in SOAPware, Click Docutainers, New Image from Scan or Click the scan button in the Common Toolbar. This will launch the scanning software for the default scanner. Follow the manufacturer's directions to scan as usual.

## Scanned Images

After the scan is completed, the new scanned image will appear in the current Document as a new Image Document Item. The ability to rename the scanned image tab is accomplished by Right-clicking over the tab and Selecting rename.



## Scanning as a New Docutainer



If the user would like for a scanned document to have its own docutainer, the user can use the scan button below the splitter bar to scan as a new docutainer.

## Scanning Multi-Paged Documents

If the user has a self-feed scanner, the user will have the option to scan in multi-page documents. To use this, the user can Click the scan button just like with a single page document. When the scan is completed, the user will have one tab per page.

## Scanned Signatures

A handwritten signature in black ink, reading "Randall Oates MD." The signature is written in a cursive style.

The user can also scan in signatures which can be included on document designs. It is recommended that the user scan the signature to the desktop and use Provider Manager to import the signature.

To use this signature on document designs, use the data item found under Misc > Clinician > Signature. This will use the signature stored in Provider Manager.

## Setting Default Font for Image Annotation

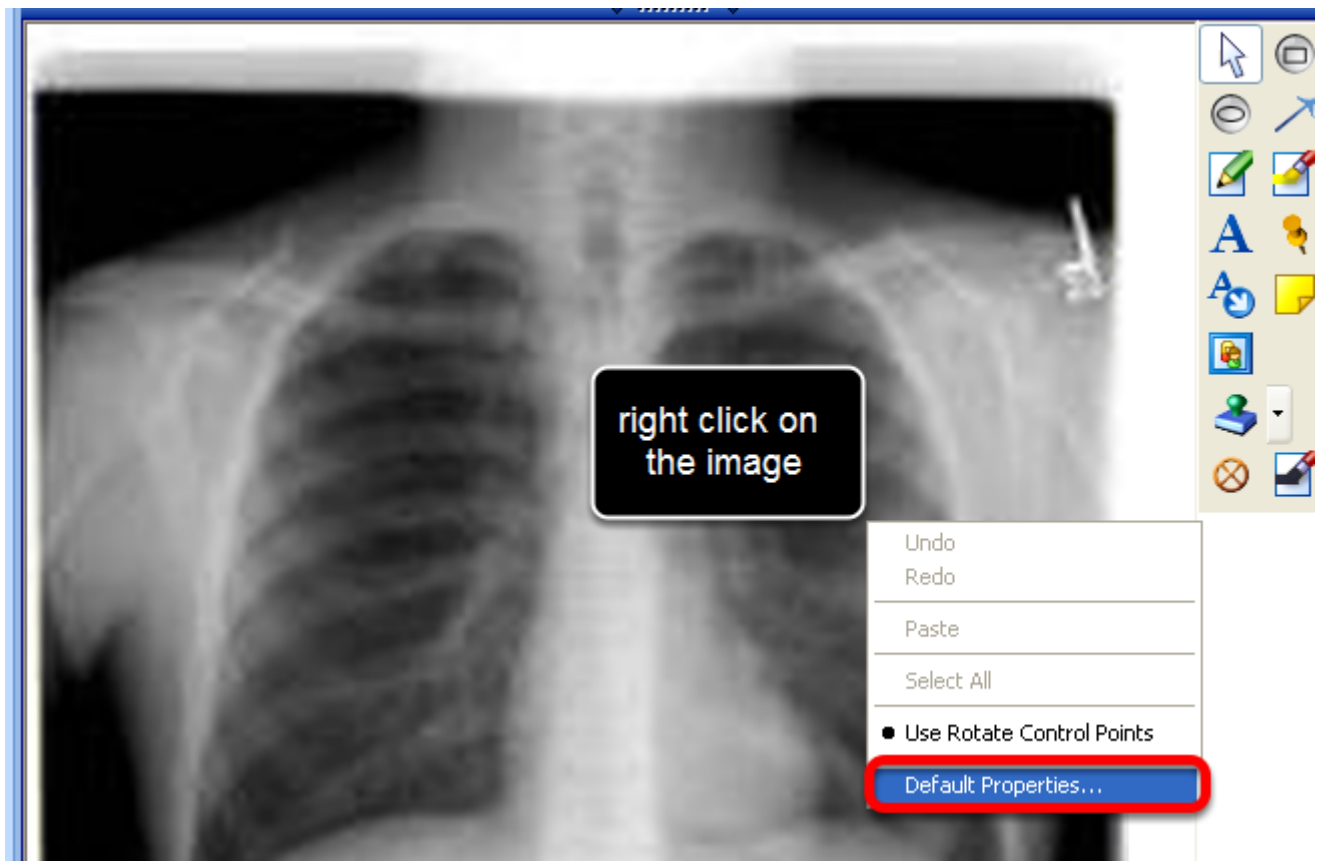
---

This lesson will demonstrate how to set default properties for images that are scanned or imported into SOAPware. This will work for several types of images including TIFF, JPEG, BITMAPs etc.

**Note:** This does not apply to PDF documents.

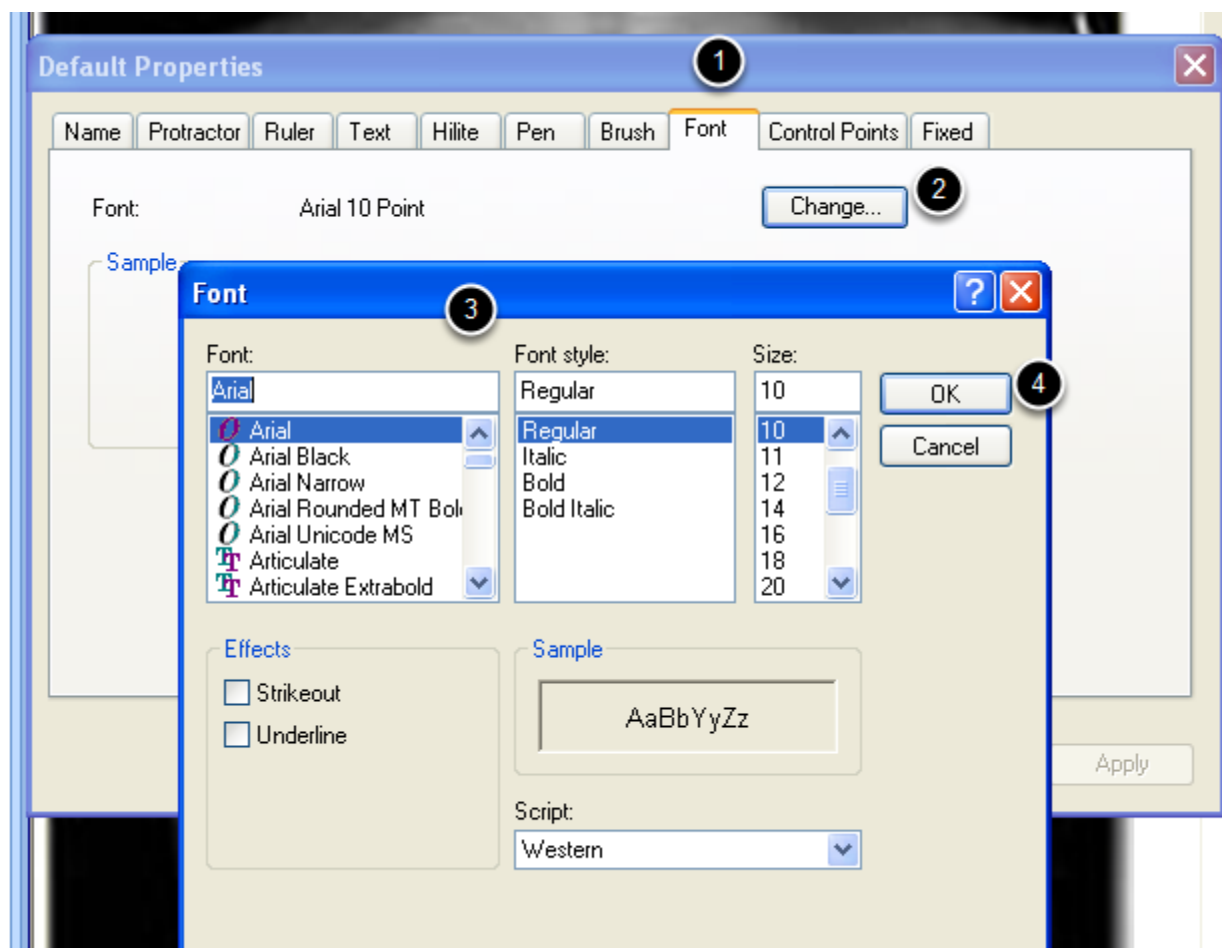
This setting is user-specific.

### Accessing the Properties Settings



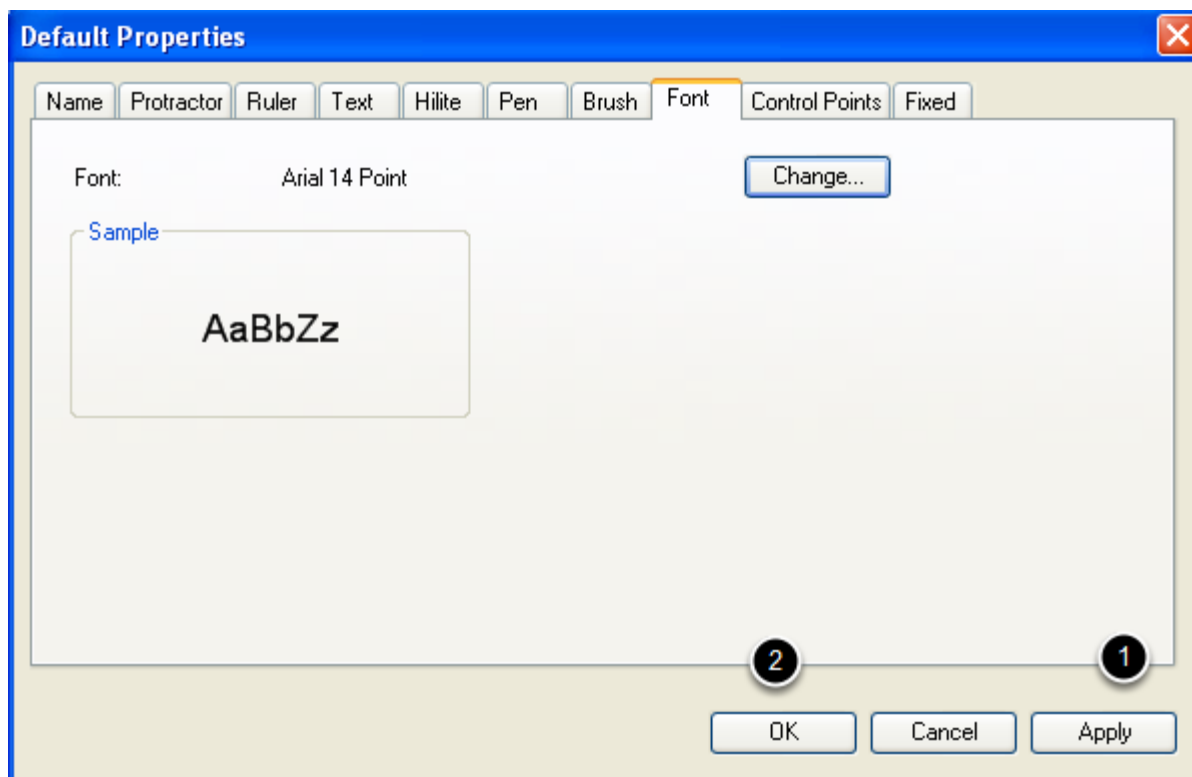
Right-click over the image and choose Default Properties.

## Setting the Defaults



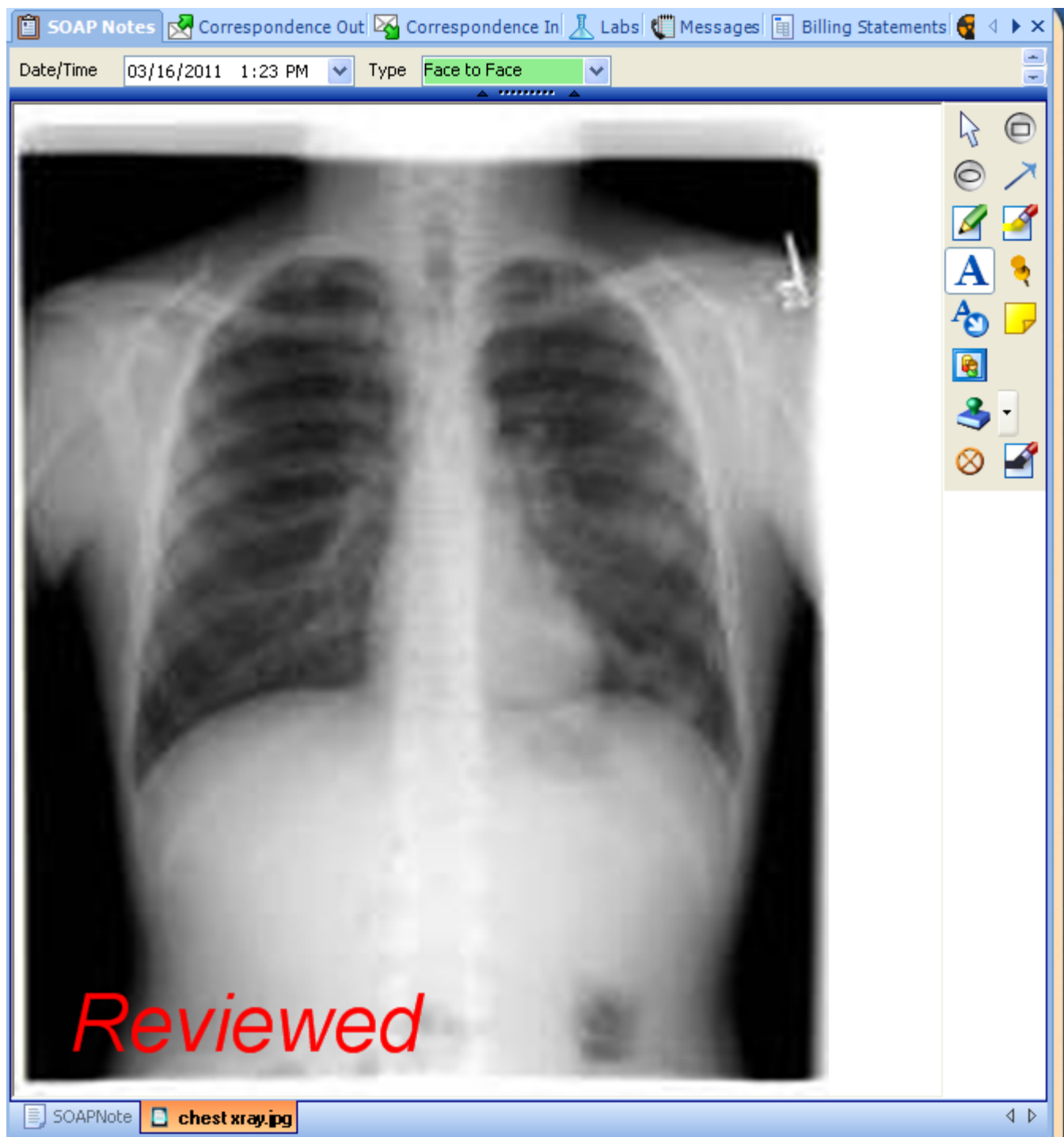
1. Click on the Font tab.
2. Click on Change.
3. Choose the font, font style and size.
4. Click OK.

## Saving the Settings



1. Click Apply.
2. Click OK.

## Results



When the text feature is used, the font is now set for the user to appear the same on all images.

## Drawings

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The SOAPware Drawings section is designed to give an easy way of creating informational pictures, either for reference or to be given to a patient.

SOAPware comes with a large number of pre-made image templates that can be used as a starting point, or simply start with a blank document. Any of the existing templates may be edited or appended at any time.

### Interface

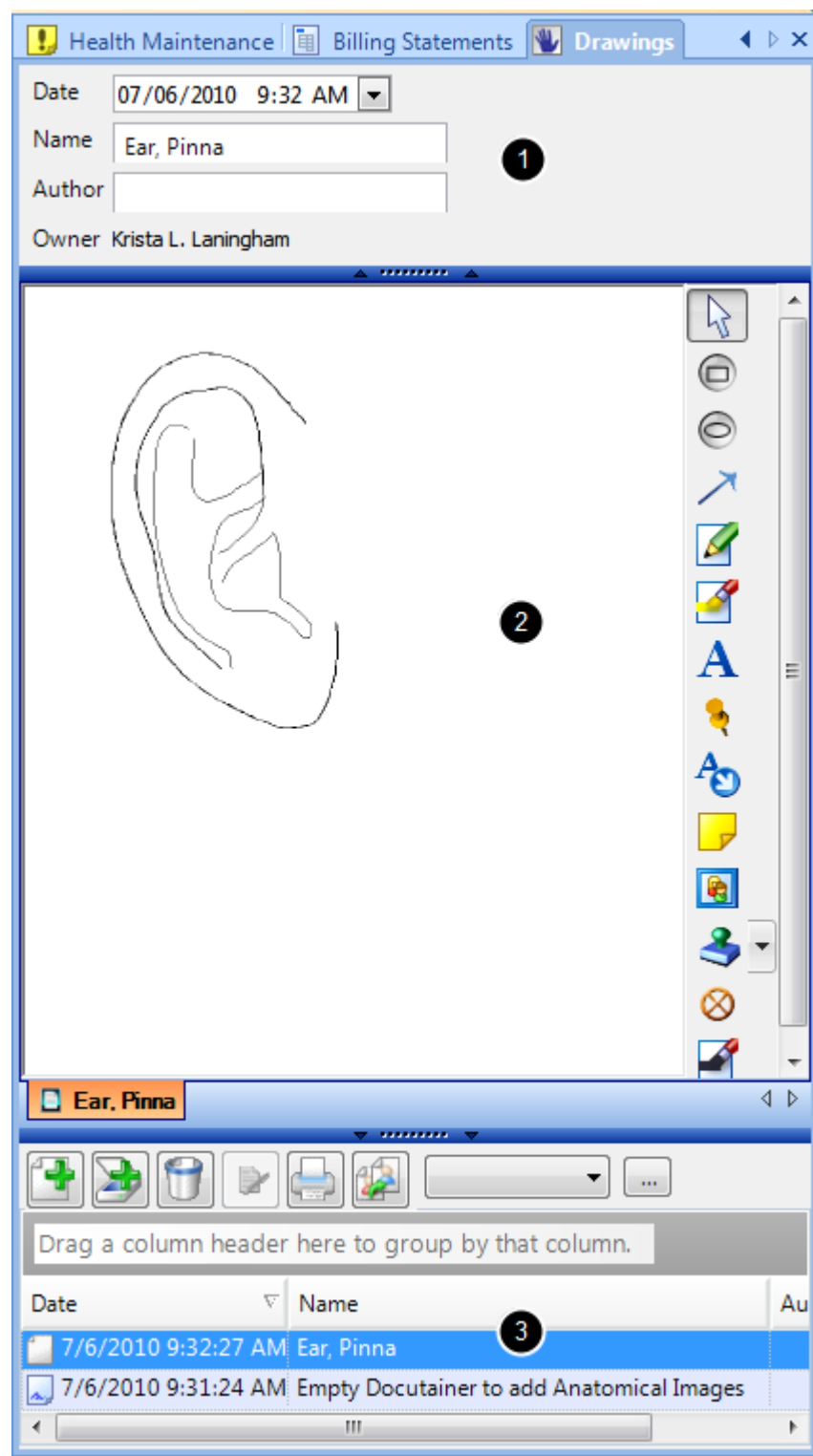
Command buttons are located at the bottom of the Drawings window and have picture buttons that display helpful information when the mouse cursor hovers over them.

There is now a column that contains the name of the owner of the drawing.

Now documents have associated document demographics, accessible by clicking the top splitter bar of the chart section.

Also, by clicking the bottom splitter bar, the user can view a list of all drawings in the current chart.

## Three Interface Areas

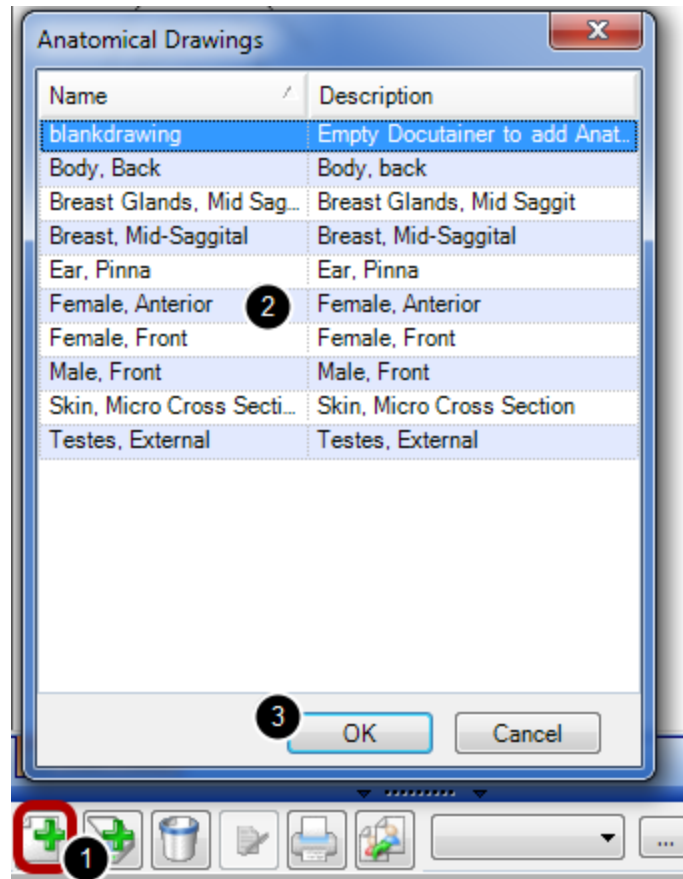


The Drawing window features three main parts:

1. Document demographics, located above the anatomical image.

2. The Drawing window, where the anatomical image and the controls for editing and manipulating it are displayed.
3. The Document list, located below the anatomical image. Here the user will find controls for adding, removing, signing off, printing, and reassigning a drawing.

## Adding New Drawings



To add a new drawing, enter the drawings section of the patient chart:

1. Click the New Drawing Button.
2. The Image Template dialog box will open. Here, the user will see a list of all available image templates for use in SOAPware. Select the image template to use by selecting it.
3. Click Ok. The new Drawing will be created and placed into the chart for the user to edit and annotate as needed.

**NOTE:** The list of drawing templates comes from the available docuplates for drawings. To increase the number of drawings available, the user can download drawings from the online library or the user can create his/her own drawing docuplate.



## Remove Drawings

To remove a drawing from a patient chart, select the drawing to remove and Click the Remove Documents Button.

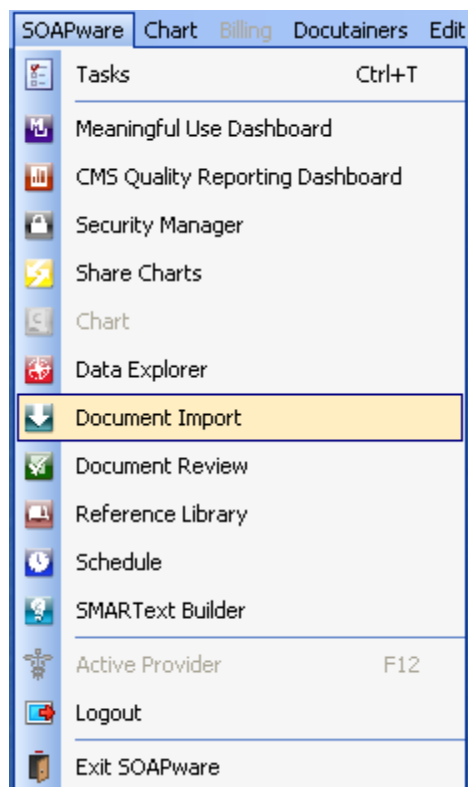
SOAPware will ask the user to confirm that he/she wishes to remove the document. If the user is certain he/she wishes to remove the document, Click Yes, and the drawing will be removed.

## Document Importer

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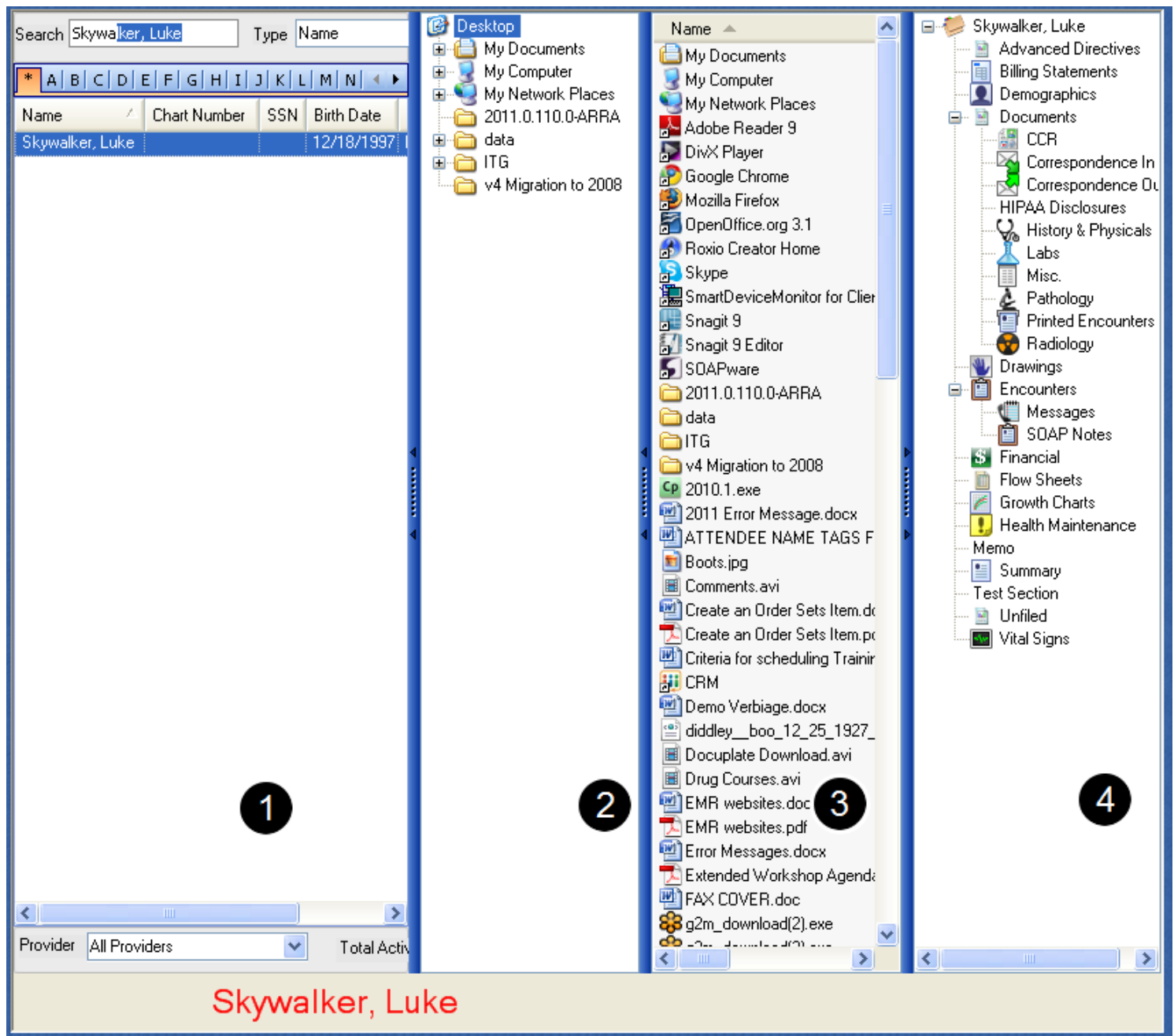
There are 2 main mechanisms for adding outside documents to SOAPware. In each viewer, there is a Scan button allowing for the addition of documents directly into a patient's open SOAPware chart. The Document Import workspace is the second option and is the main mechanism for importing documents into SOAPware. Document Importer is the topic for the rest of this discussion. The Document Import workspace is used for importing documents and files from outside of SOAPware directly into patient charts without having to open each, individual patient chart in the Chart workspace. It is especially useful when dealing with large numbers of files spanning multiple charts, such as when the user needs to import documents created during bulk scanning operations.

### Document Import Workspace



To access Document Import, Click SOAPware in the menu bar, and Click the Document Import menu item. The workspace in Document Import consists of four vertical columns and the patient name panel at the bottom.

## Four Areas

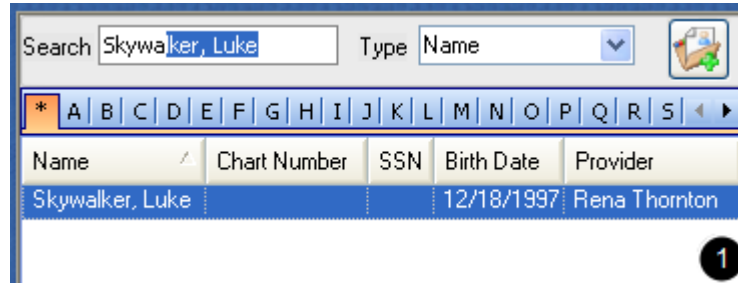


1. Mini-Chart Rack - The first column/panel on the left is a list of patient charts, arranged alphabetically. This is similar in function to the Chart Rack. The name of the patient selected from this list is displayed in the patient name panel at the bottom.
2. Folder Browser - The second column/panel is a folder-browsing column/panel and allows for the finding and selection of folders (i.e. folders containing document to be imported). This is the same view that Windows creates when My Computer or Windows Explorer are selected.
3. Folder Contents - The third column/panel displays the contents of the folder selected in the second column. Right-clicking in this area allows the view or sorting options for the display to be changed.

4. Chart Sections - The fourth column/panel (right-most) shows the chart sections for the active patient whose name is displayed in the patient name panel. This is similar to Chart Navigator.

Click-and-drag the vertical splitter bars between columns to resize or hide the columns.

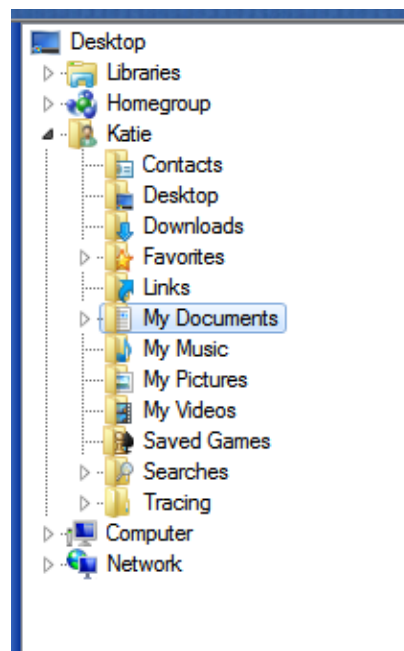
### Select Patients in Mini-Chart Rack



Retrieving patient charts follows the same methods as utilized in the Chart Rack. Patients are usually selected by typing their names or by typing other identifiers into the Search box.

It is also possible to create a new chart by clicking the Create Chart button. The new chart will be automatically selected after creation. Once a chart is selected, the name of the patient will appear in large red letters in the patient name panel at the bottom of the Document Import workspace.

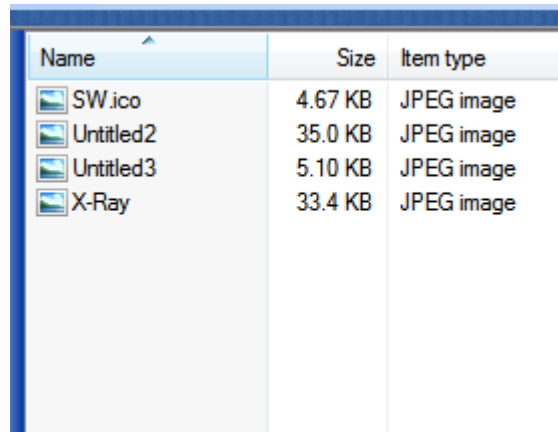
### Select Files for Import



Folder browsing/selection occurs in the second columns/panel. The Folder Browser panel displays a table of contents view of the disks, folders, and network locations available to the current computer. Clicking a folder in the hierarchical list will display its contents in the Folder

Contents panel to the right. Double-click a folder (or Click the + next to it) to expand it to show the sub-folders contained within it.

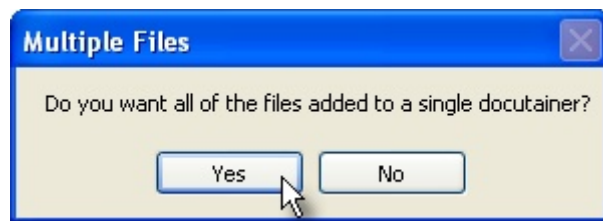
### Select Files to Import in Folder Contents



Name	Size	Item type
SW.ico	4.67 KB	JPEG image
Untitled2	35.0 KB	JPEG image
Untitled3	5.10 KB	JPEG image
X-Ray	33.4 KB	JPEG image

Once a folder is selected, the file or files to import can be found in the Folder Contents panel to the right of the Folder Browser panel. This display can include any/all the files or documents contained in the selected-active folder or disk location.

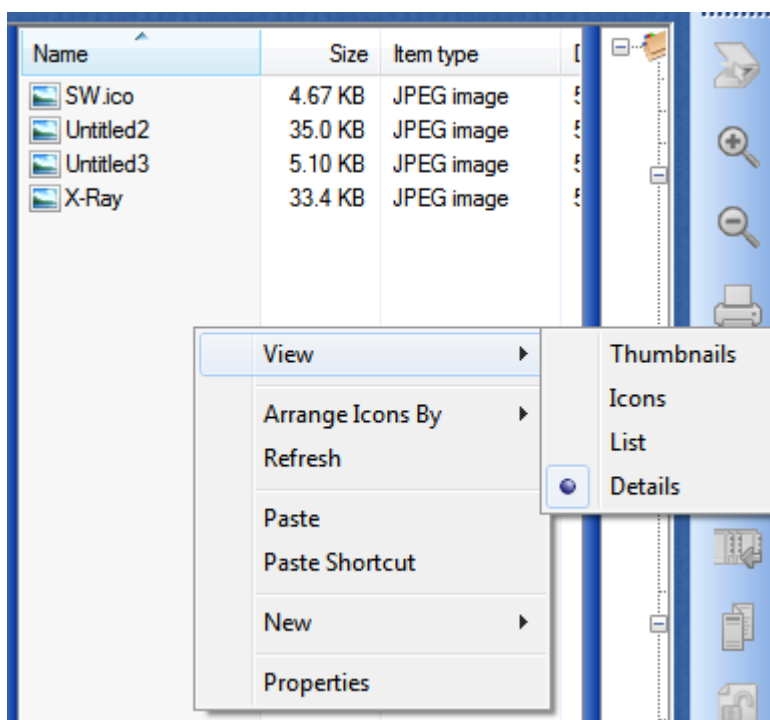
### Selecting Multiple Items for Import



Press and hold-down the Ctrl or Shift keys while Clicking on multiple items in order to select multiple items to import in one step. When importing multiple items, a prompt is presented to choose from 2 options:

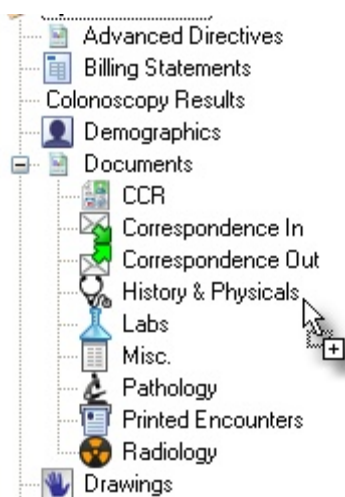
1. Import multiple documents in a single docutainer.
2. Import single documents in separate docutainers. This option offers an opportunity to create a new task for each document.

## View Files Options



By default, the documents/files are displayed in the Details view, but other viewing options are available. Right-click in the Folder Contents panel; Click the View menu item, and Click a menu item for one of the 5 view options (i.e. Thumbnails, Large Icons, Small Icons, List, Details).

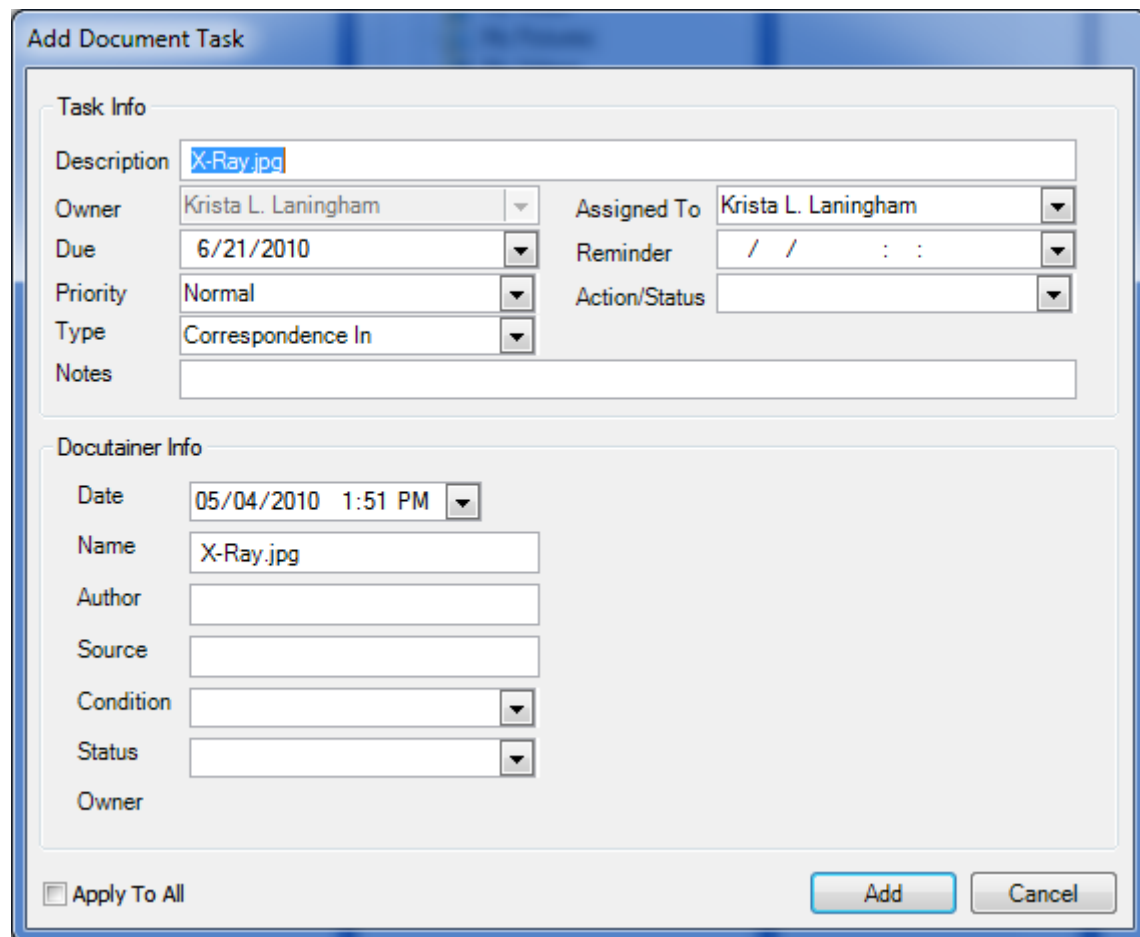
## Select the Chart Section to Receive the Import



Documents/files to import are drag-and-dropped into the appropriate chart section (the 4th or right-most panel). To do this, Click on the document/file to import; Click-hold down the mouse button; drag to the desired chart section, and Release the mouse button to drop the document/file

into the selected chart section. When dragging the document/file across the chart sections, the mouse pointer will change to a plus sign in a box when it is over a chart section that will accept that type of document.

## Create Task List Items for Imports



The "Add Document Task" dialog box is used to create a new task item. It contains two main sections: "Task Info" and "Docutainer Info".

**Task Info**

- Description: X-Ray.jpg
- Owner: Krista L. Laningham
- Assigned To: Krista L. Laningham
- Due: 6/21/2010
- Reminder: / / : :
- Priority: Normal
- Action/Status:
- Type: Correspondence In
- Notes:

**Docutainer Info**

- Date: 05/04/2010 1:51 PM
- Name: X-Ray.jpg
- Author:
- Source:
- Condition:
- Status:
- Owner:

☐ Apply To All

**Add** **Cancel**

When the document/file is dropped into the chart section (i.e. by releasing the mouse button), the Add Document Task dialog appears allowing for the automatic creation of a new task item.

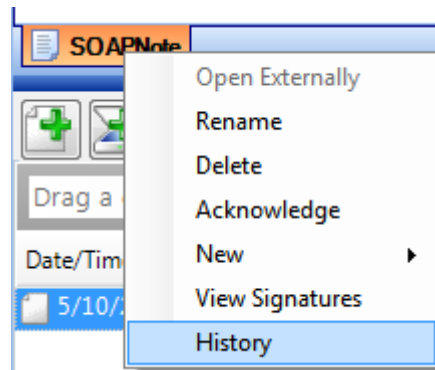
## Document History

---

With the Document History option, the user can view the history of documents in a patient chart. This allows for complete tracking of the changes to a document over time. This includes signatures, added documents, updated fields, etc.

The user can view who changed a document (User column), and when it was changed.

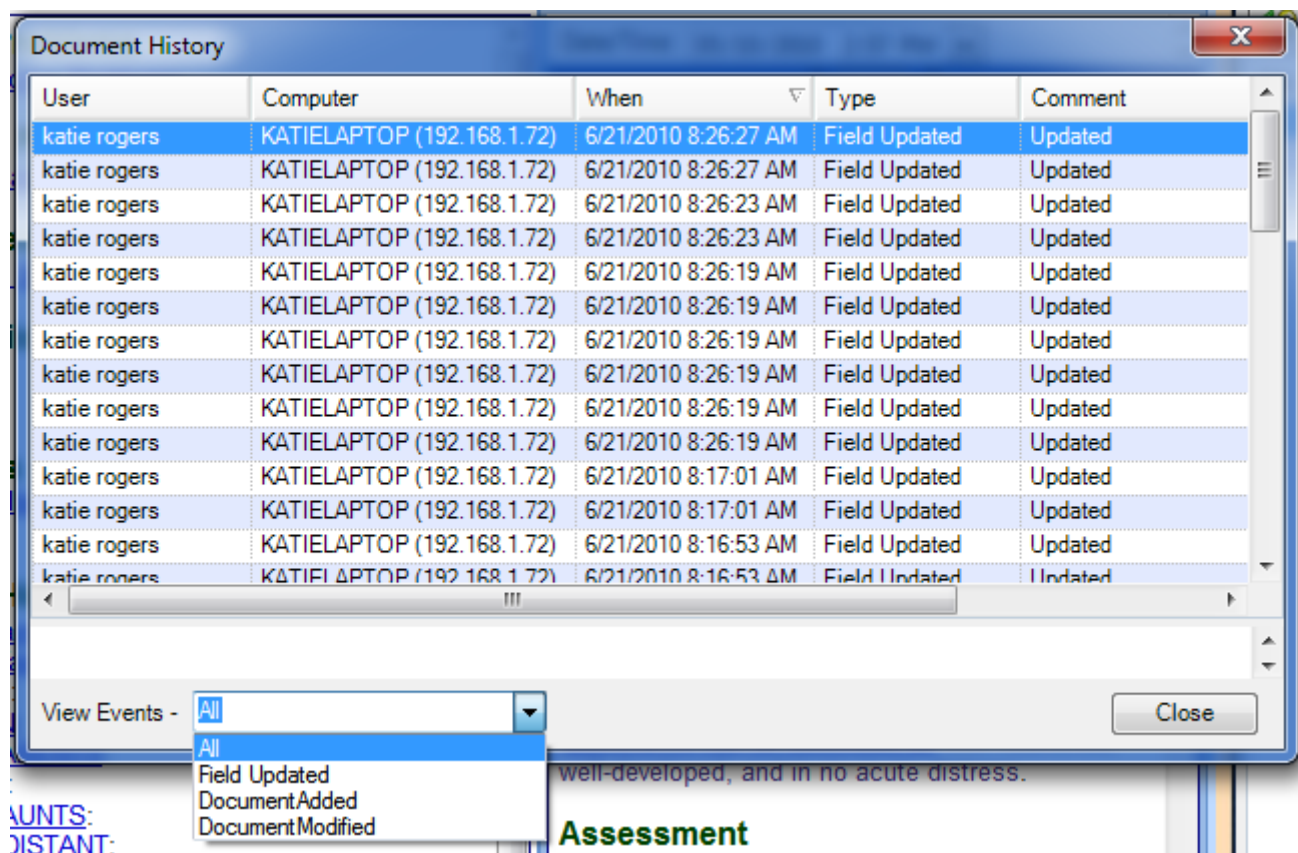
### Access and use of Document History



To access a document's history, open a patient chart, and right-click over the document tab in the lower left. In the screen shot below, we are in the SOAPnote section, outlined in red. When the right-click menu opens, click the History menu item.

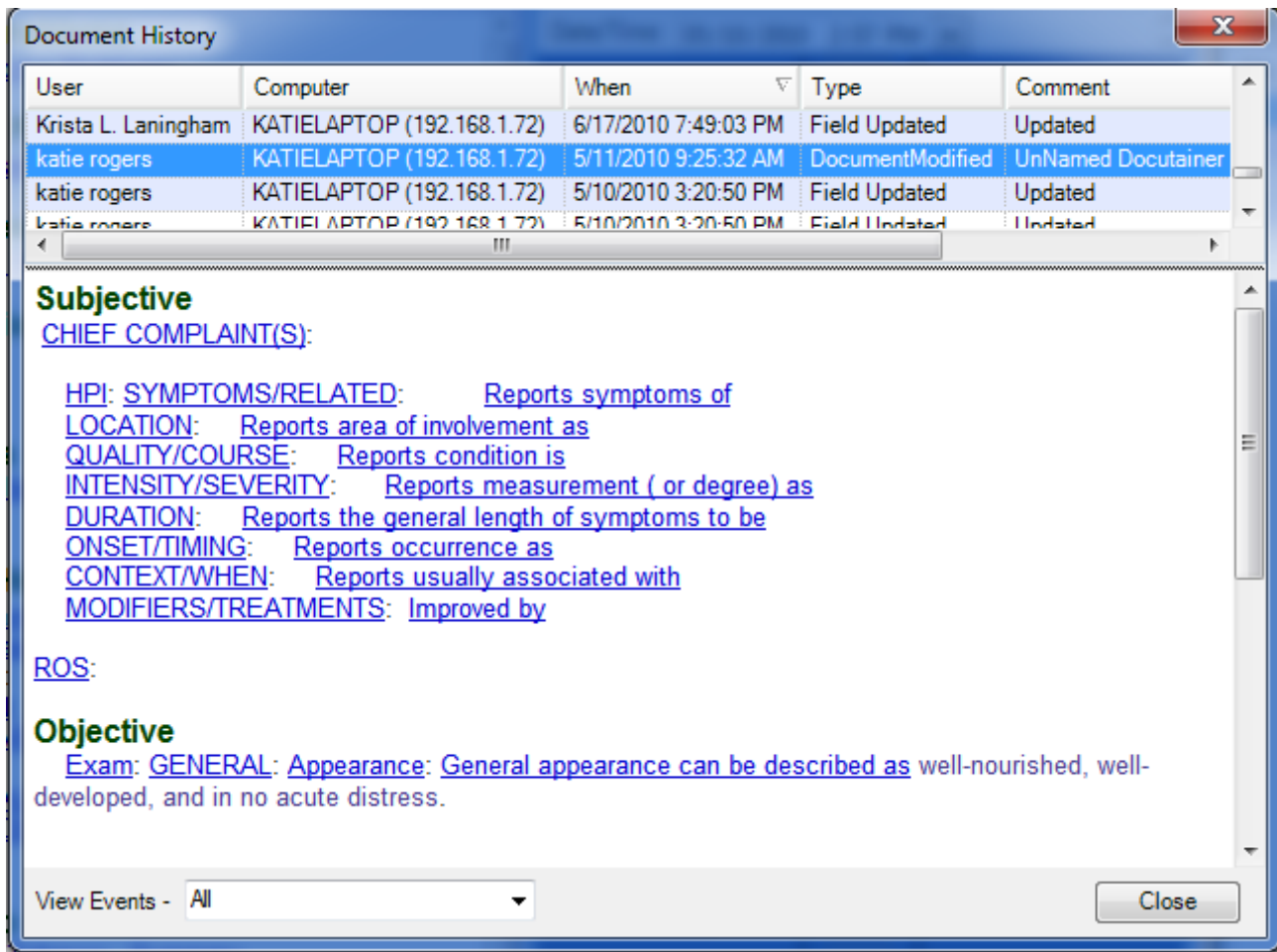


## View Events



Click the View Events drop-down menu to choose the event type.

## View Document



In the screen shot above, we have clicked All, to view all events. Click a list item to select and view its information in the lower section of the Document History dialog.

## Another Option

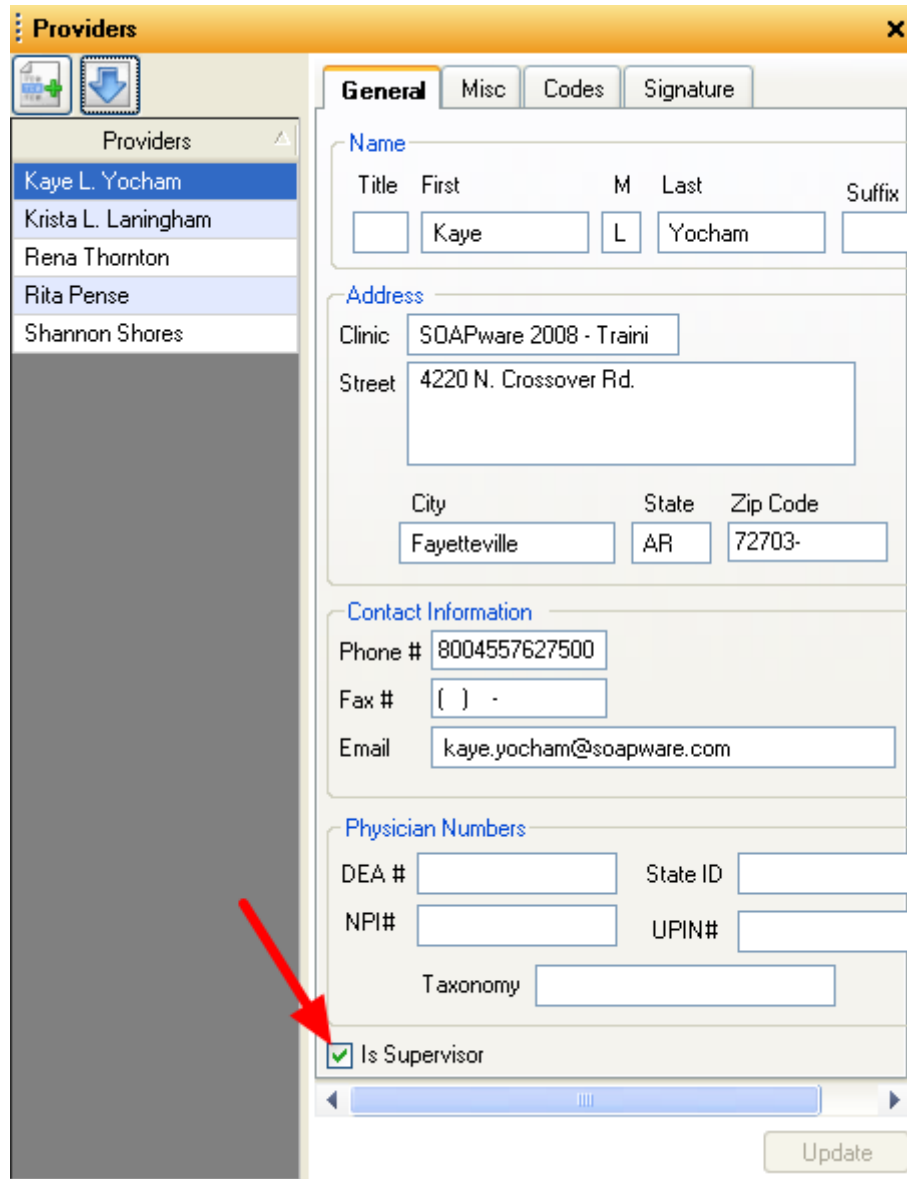


Also, right-click in any field in an open chart to access the document history. When the context menu opens, Click Item History and then Current Document menu items.

## Co-Signatures

Co-Signatures have been implemented for sites that need the ability to have a supervisor signature for providers such as residents.

### Set up Supervisors



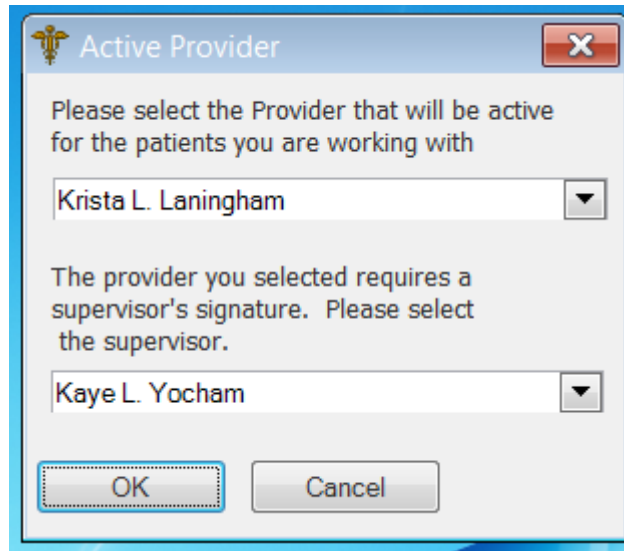
The screenshot shows the 'Providers' dialog box in SOAPware. On the left, a list of providers includes Kaye L. Yocham, Krista L. Laningham, Rena Thornton, Rita Pense, and Shannon Shores. Kaye L. Yocham is selected. The right pane shows the 'General' tab with the following information:

- Name:** Title (empty), First (Kaye), M (L), Last (Yocham), Suffix (empty)
- Address:** Clinic (SOAPware 2008 - Traini), Street (4220 N. Crossover Rd.), City (Fayetteville), State (AR), Zip Code (72703-)
- Contact Information:** Phone # (8004557627500), Fax # ([ ] - ), Email (kaye.yocham@soapware.com)
- Physician Numbers:** DEA # (empty), State ID (empty), NPI# (empty), UPIN# (empty), Taxonomy (empty)
- Is Supervisor:** ☒ (indicated by a red arrow)

An 'Update' button is located at the bottom right of the dialog.

Auser will need at least 2 providers in SOAPware and one of them must NOT be marked as a supervisor. To require a supervisor signature, go to Menu bar > Tools > Provider Manager and uncheck the box at the bottom of the Provider Manager dialog. It is the box in front of Is Supervisor.

## Supervising Signature



When a provider who needs a supervising signature signs into SOAPware, a dialog window will appear that asks the user to select a supervisor.

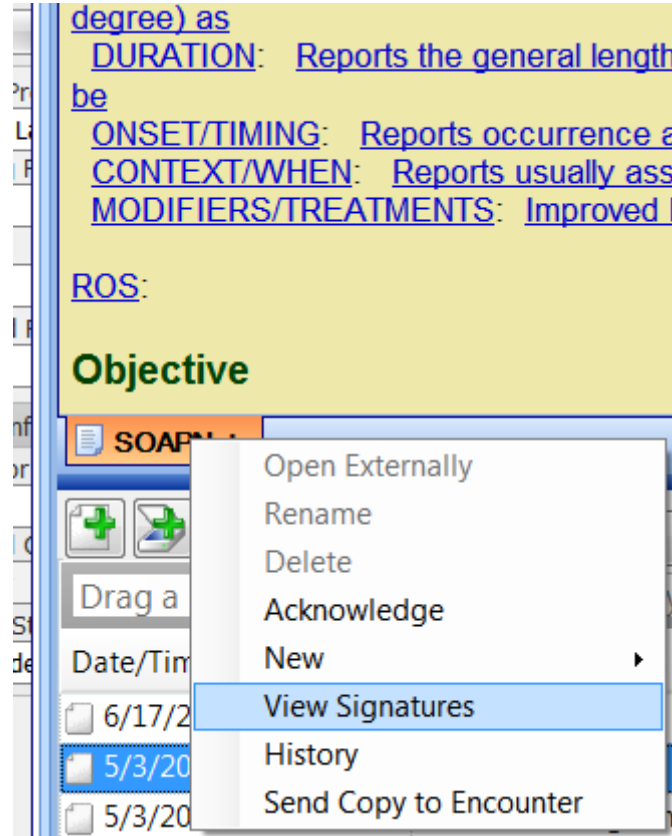
## Signing

The provider needing a supervisor signature will sign off a document. Then a Task will be created for the supervising provider in SOAPware.

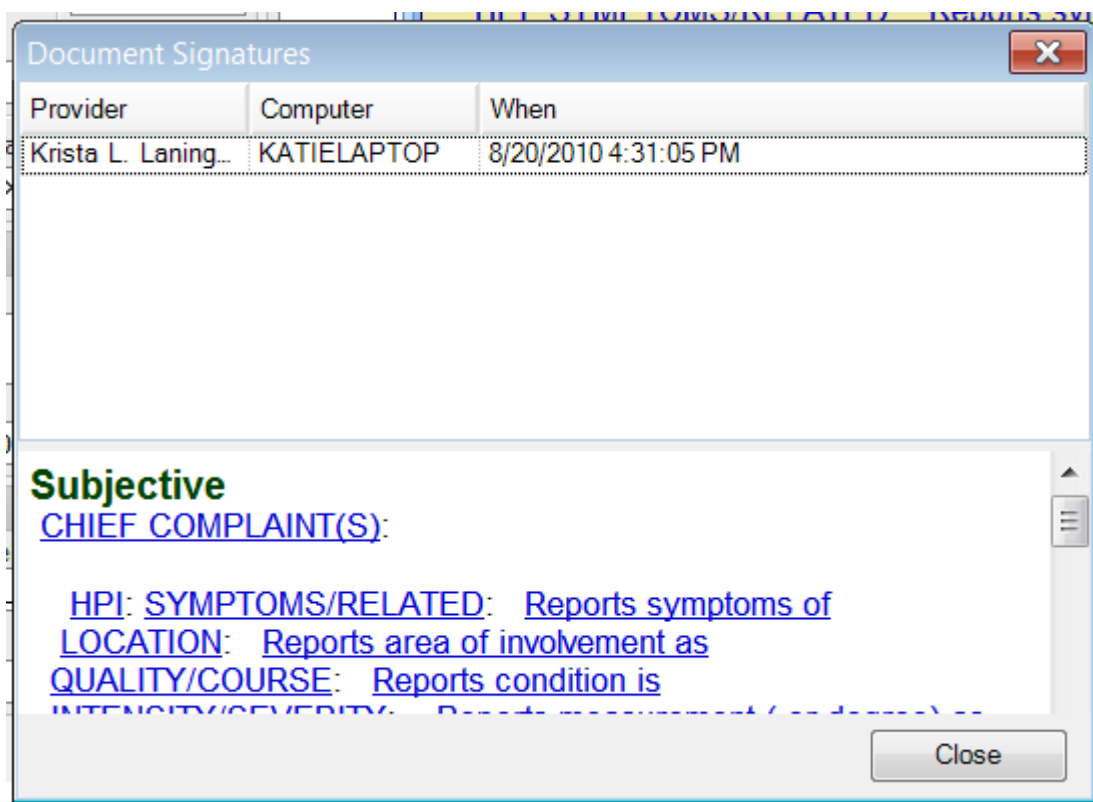
The supervising provider will review and then sign the document.

## Signature History

### View Signatures



After a document is signed off, a user can view the signature(s) on the document. This will show who signed the document and when it was signed. To access this, Right-click on the orange SOAPnote tab at the bottom of the SOAPnote. Select View Signatures.



The Document Signatures window will show the provider, the computer, and the time that the document was signed. It also gives a preview of the document in the lower portion of the window.

# Data Explorer

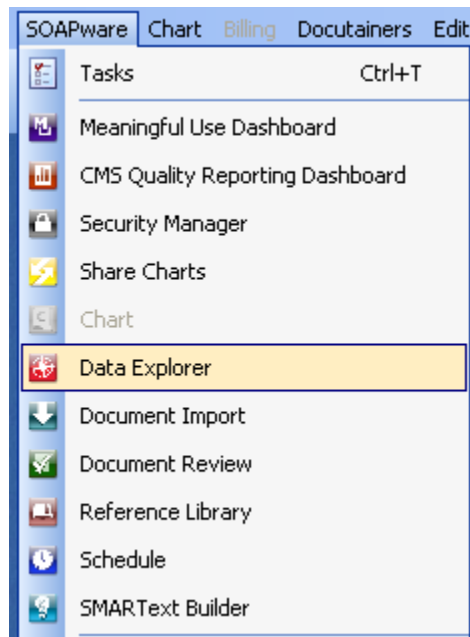
## Data Explorer SOAPnote Medication Search

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This lesson will cover searching databases for structured SMARTtext medication located in the SOAPnote medication field.

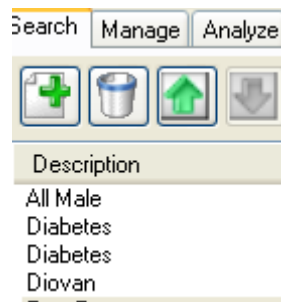
Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

### Accessing Data Explorer



1. Click on SOAPware on the menu bar.
2. Click on Data Explorer.

### Create New Query



To create a new query, Click on the New Query button.



## Name the Query

Search Name: Diovan 7/13/10

Search Chart Section(s): [All Sections for Documents created anytime] for Documents of type

Buttons: Save, Add, Clear

Name the query. It can be helpful to place a date on the query to differentiate between searches.

## Selecting the Chart Section to Search

Search Name: Diovan 7/13/10

Search Chart Section(s): [ SOAP Notes for Documents created anytime for Documents of type ]

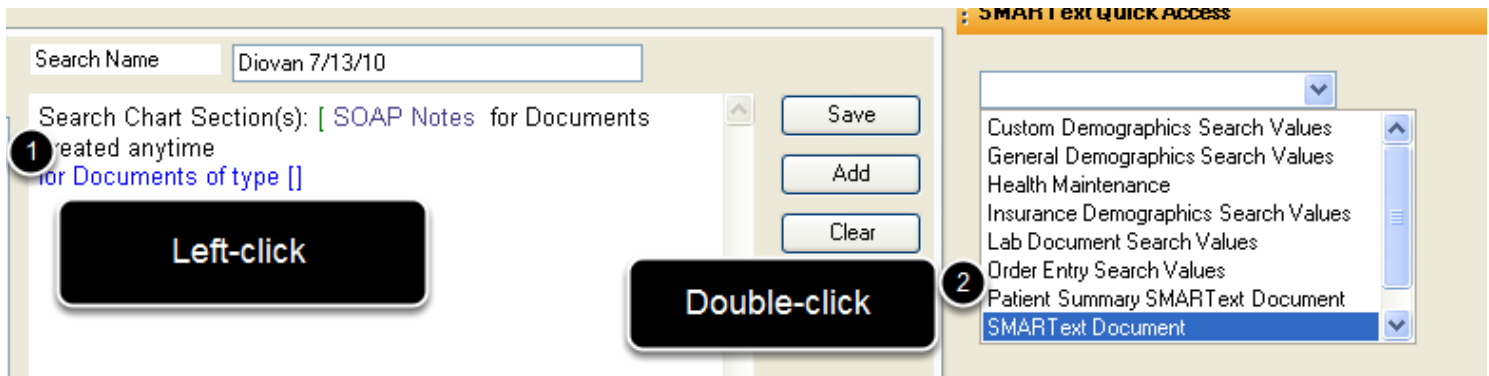
Buttons: Save, Add, Clear

SMARText Quick Access

- ☐ All Chart Sections
- ☐ Advanced Directives
- ☐ Billing Statements
- ☐ Demographics
- ☐ Documents - CCR
- ☐ Documents - Correspondence In
- ☐ Documents - Correspondence Out
- ☐ Documents - EKG
- ☐ Documents - HIPAA Disclosures
- ☐ Documents - History & Physicals
- ☐ Documents - Labs
- ☐ Documents - Misc.
- ☐ Documents - Pathology
- ☐ Documents - Printed Encounters
- ☐ Documents - Radiology
- ☐ Order Entry
- ☐ Drawings
- ☐ Encounters - Messages
- ☒ Encounters - SOAP Notes

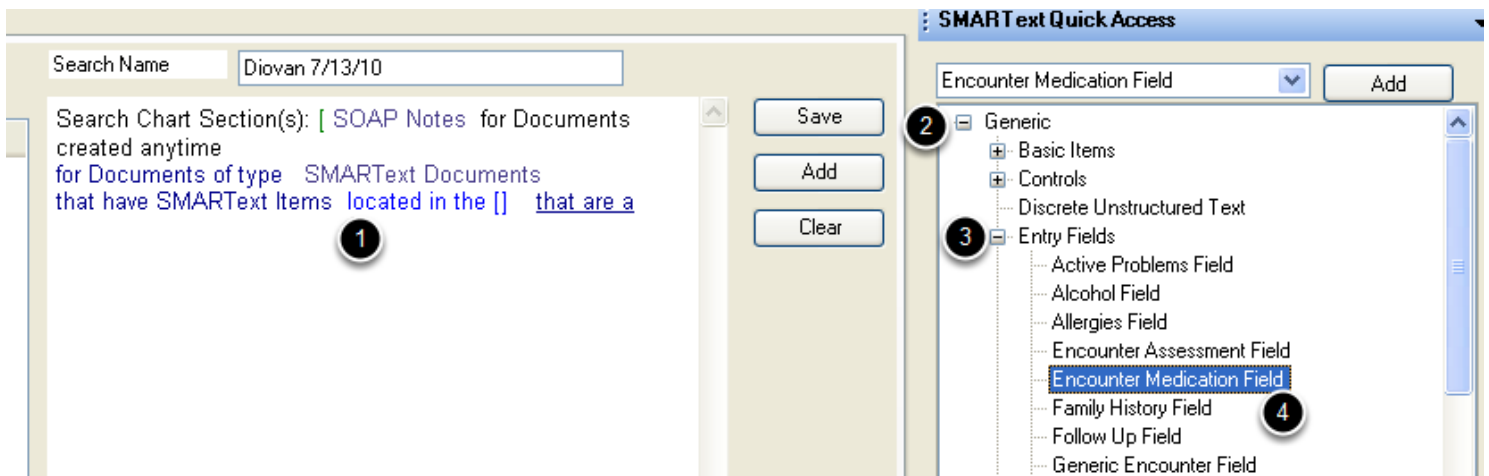
1. Left-click over "Search Chart Sections."
2. Un-check "All Chart Sections" in the SMARText Quick Access.
3. Click to place a check in the box next to Encounters - SOAP Notes.

## Documents of Type



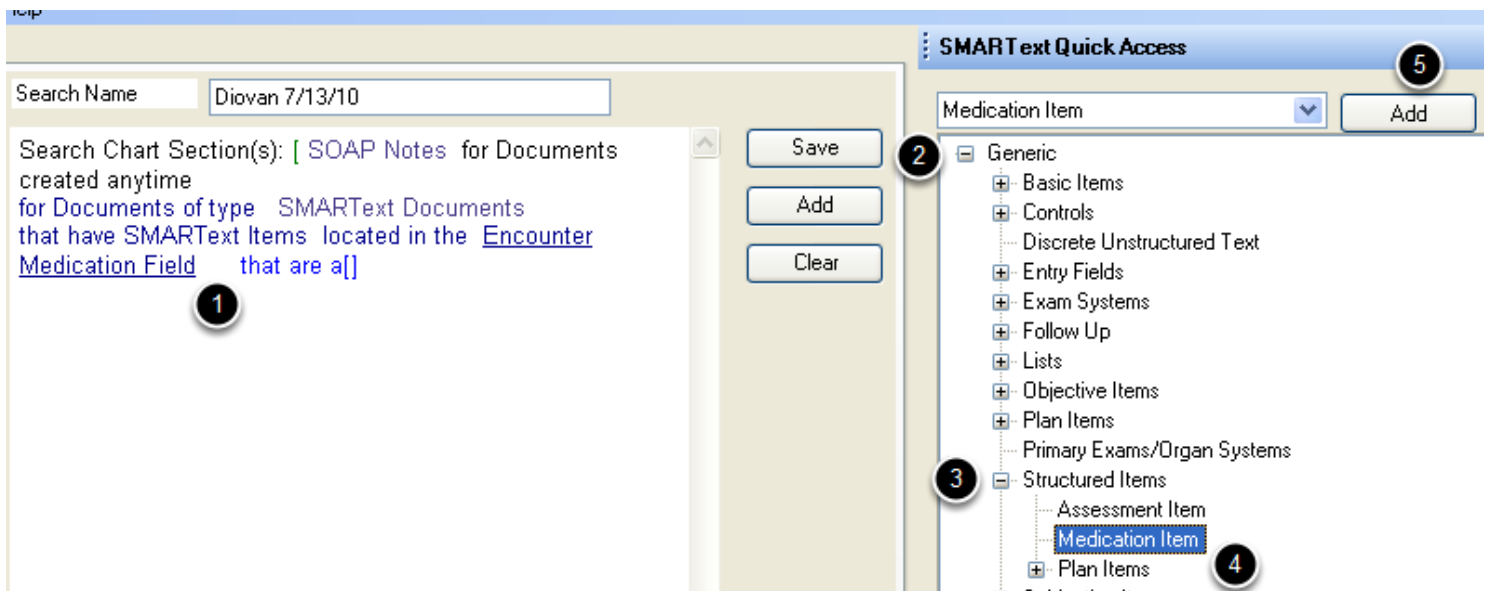
1. Left click over "for Documents fo type."
2. Using the drop-down menu in the SMARTText Quick Access, double-click on "SMARTText Document."

## Search Area



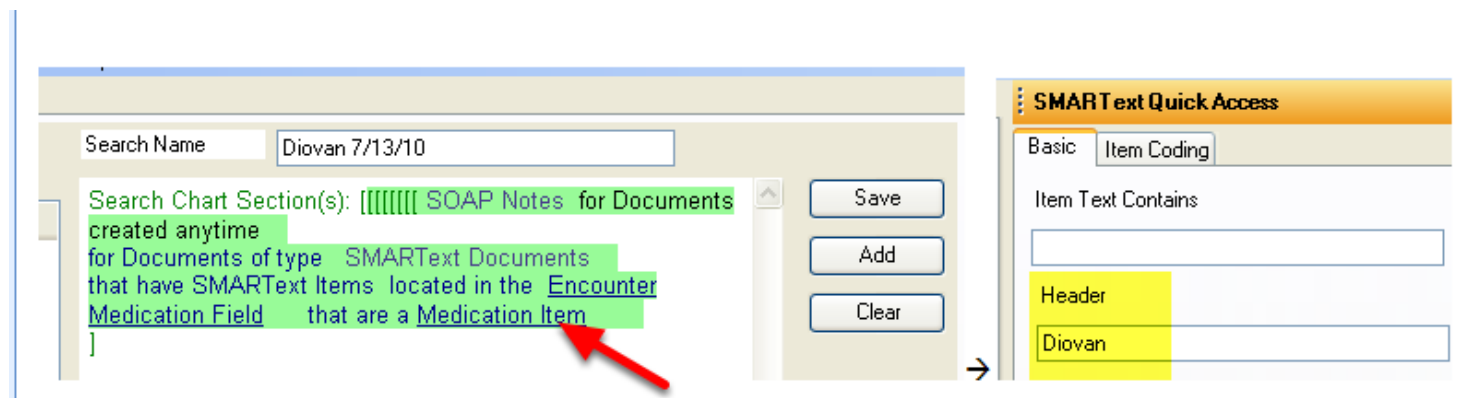
1. Left-click over "located in the."
2. Using the drop-down menu, Click on the plus (expander node) next to Generic.
3. Click on the expander node next to "Entry Fields"
4. Double-click on "Encounter Medication Field."
5. Click the Add button.

## Define the SMARText Item Type



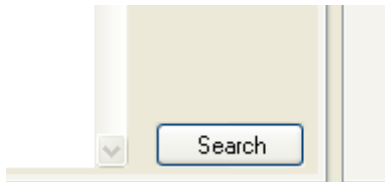
1. Left-click over "that are a."
2. Using the drop-down menu, Click on the expander node next to "Generic."
3. Click on the expander node next to "Structured Items."
4. Double-click on "Medication Item."
5. Click the Add button.

## Choosing the Specific Medication



1. Left-click over "Medication Item."
2. On the Basic tab, type in the header (or name) of the medication.

## Search



When a user's search is completed, Click on the Search button to run the search. Remember, this can take quite some time, so it is recommended to run a search at the end of a workday.

## Search Results

SearchResults				
Patient	Birthdate	Age	Sex	Chart #
Clyde, Annie	5/21/1947	63	F	
Jim, Slim	3/21/1932	78	M	68332
Melt, Patty			F	
Babbit, Runny	2/27/1968	42	F	45654

The search results will be displayed when the search is complete. The user can save these or discard the results.

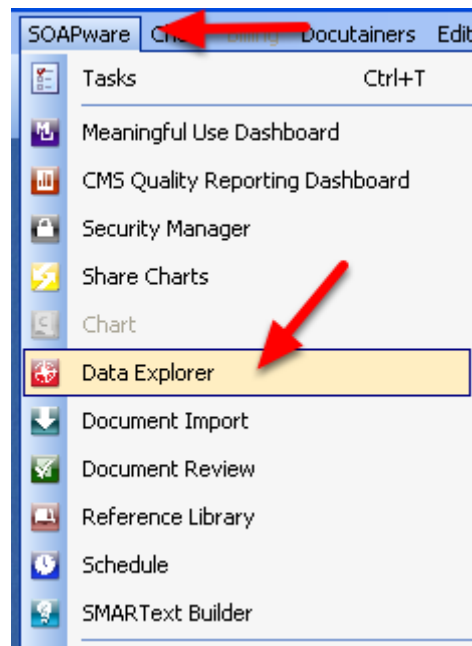
## Data Explorer Summary Diagnosis Search

This lesson will cover searching databases for structured SMARTtext diagnosis located in the SummaryActive Problems.

Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

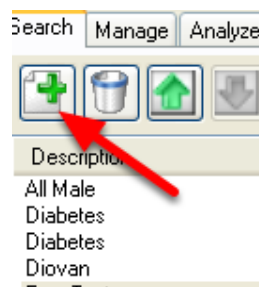
**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Patient Lists](#)**

### Accessing Data Explorer



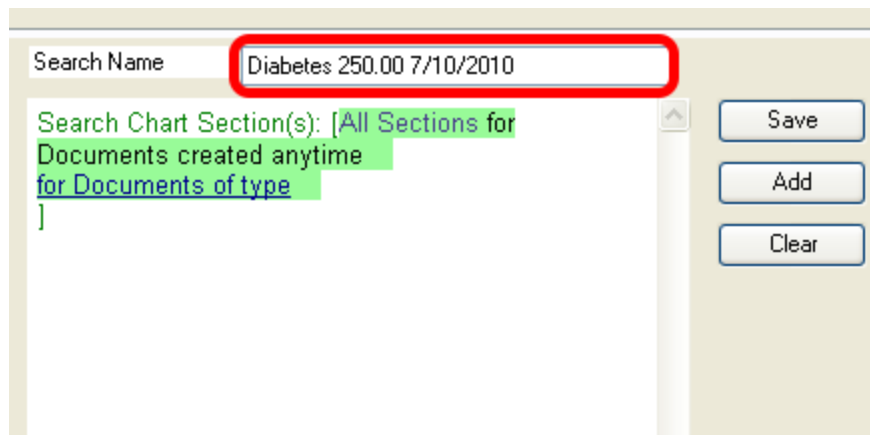
1. Click on SOAPware on the menu bar.
2. Click on Data Explorer.

### Create a New Query



To create a new search, Click on the New Query button.

## Name the Query



The screenshot shows a web-based interface for configuring a query. At the top, there is a text input field labeled "Search Name" containing the text "Diabetes 250.00 7/10/2010". This text is highlighted with a red rectangular border. Below the input field is a text area containing the query definition: "Search Chart Section(s): [All Sections for Documents created anytime for Documents of type ]". To the right of the text area are three buttons: "Save", "Add", and "Clear".

Next, name the Query. It can also be helpful to place a date on the query name to differentiate between searches.

## Select Chart Sections to Search

Search Name: Diabetes 250.00 7/10/2010

Search Chart Section(s): [ Summary for Documents created anytime ] for Documents of type

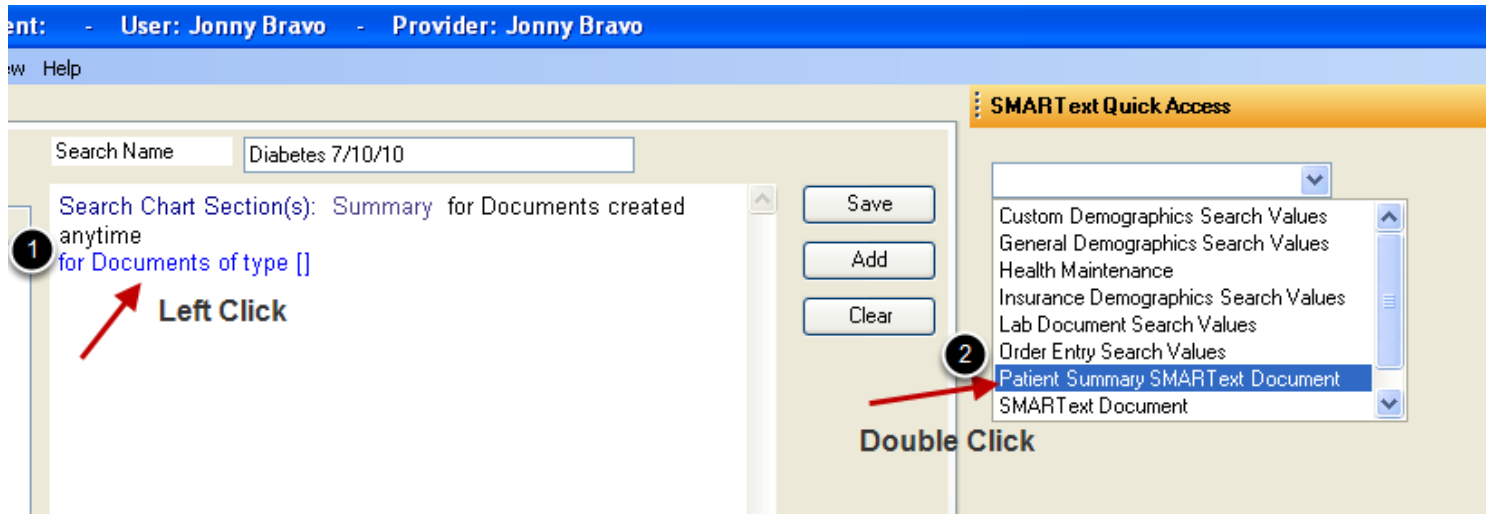
Save Add Clear

**SMARText Quick Access**

- ☐ All Chart Sections
- ☐ Billing Statements
- ☐ Demographics
- ☐ Documents - CCR
- ☐ Documents - Correspondence In
- ☐ Documents - Correspondence Out
- ☐ Documents - EKG
- ☐ Documents - HIPAA Disclosures
- ☐ Documents - History & Physicals
- ☐ Documents - Labs
- ☐ Documents - Misc.
- ☐ Documents - Pathology
- ☐ Documents - Printed Encounters
- ☐ Documents - Radiology
- ☐ Order Entry
- ☐ Drawings
- ☐ Encounters - Messages
- ☐ Encounters - SOAP Notes
- ☐ Order Entry
- ☐ Financial
- ☐ Flow Sheets
- ☐ Growth Charts
- ☐ Health Maintenance
- ☐ Memo
- ☒ Summary
- ☐ Unfiled
- ☐ Vital Signs
- ☐ Order Entry

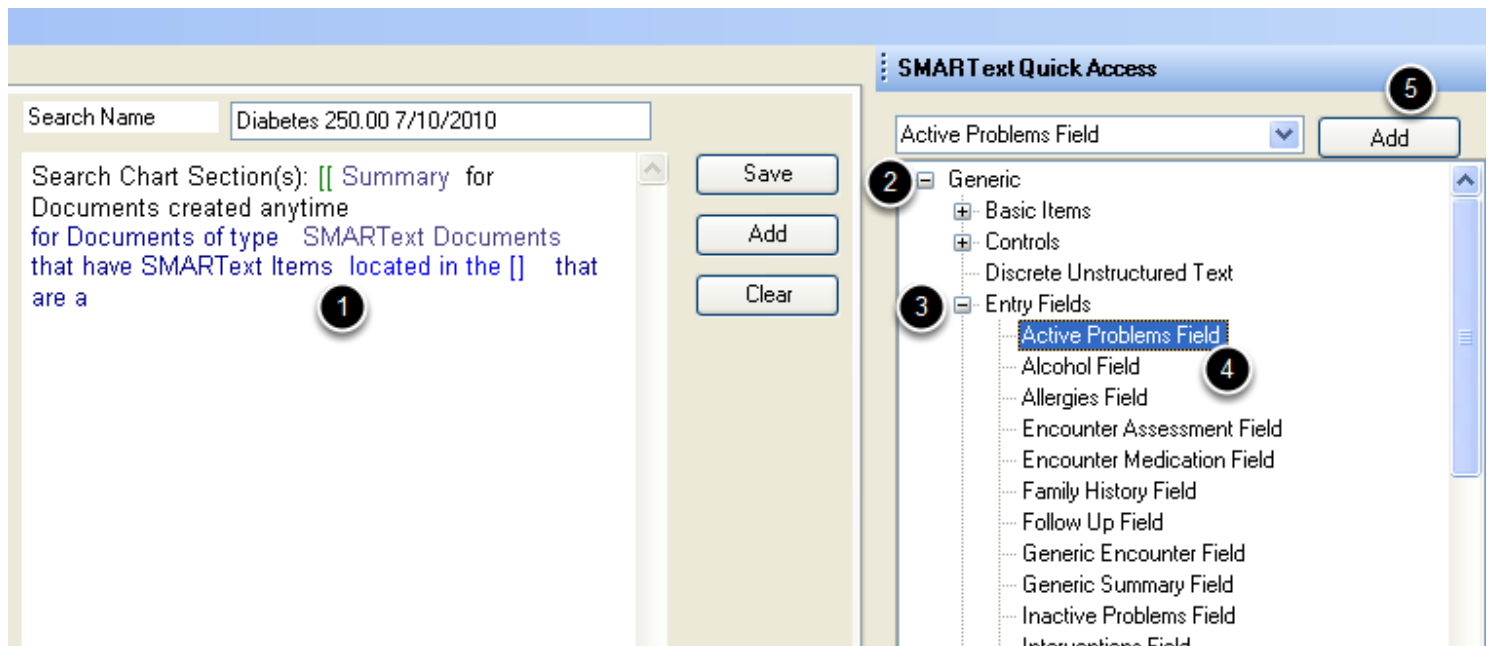
1. Left-click over "Search Chart Sections."
2. Un-check "All Chart Sections" in the SMARText Quick Access.
3. Click to place a check in the box next to Summary.

## Document Type



1. Left-click over "for Documents of type."
2. Using the drop-down menu in the SMARTText Quick Access, double-click on "Patient Summary SMARTText Document."

## Area to Search

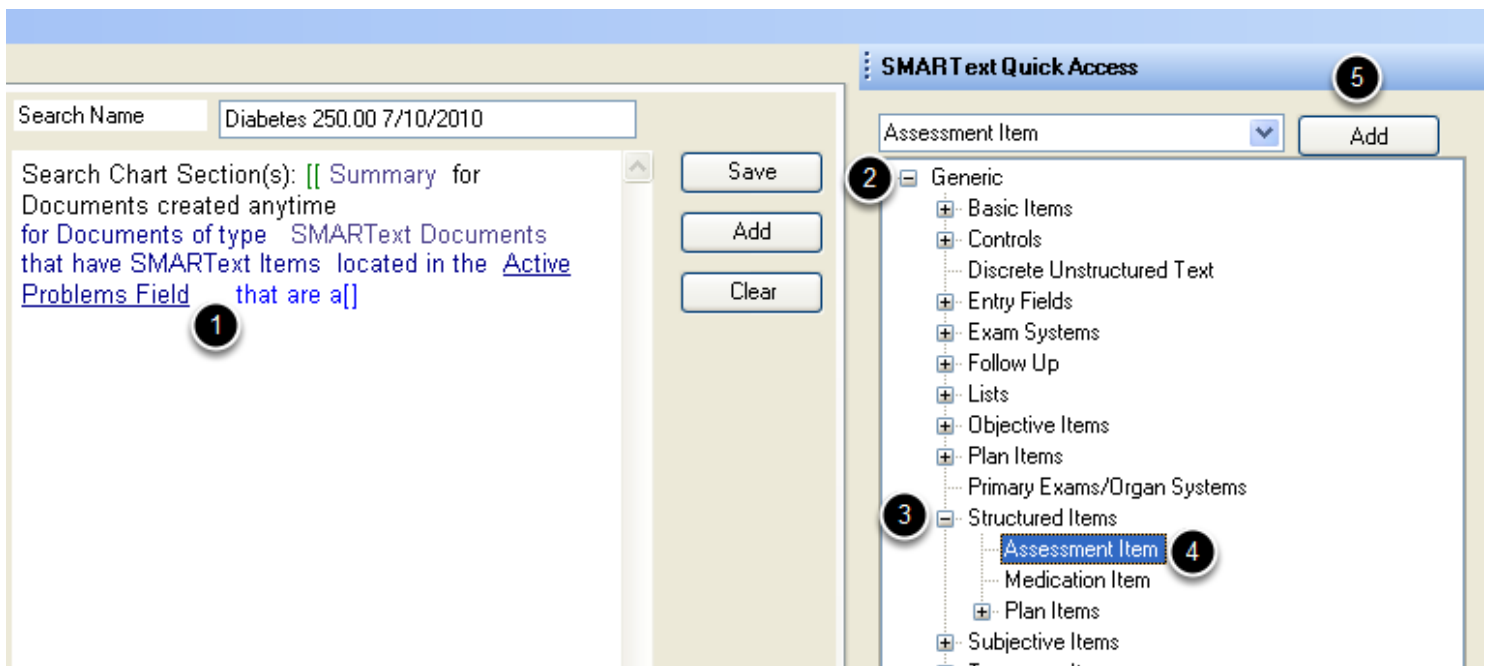


1. Left-click over "located in the."
2. Using the drop-down menu, Click on the plus (the expander node) next to "Generic."
3. Click on the expander node next to "Entry Fields."



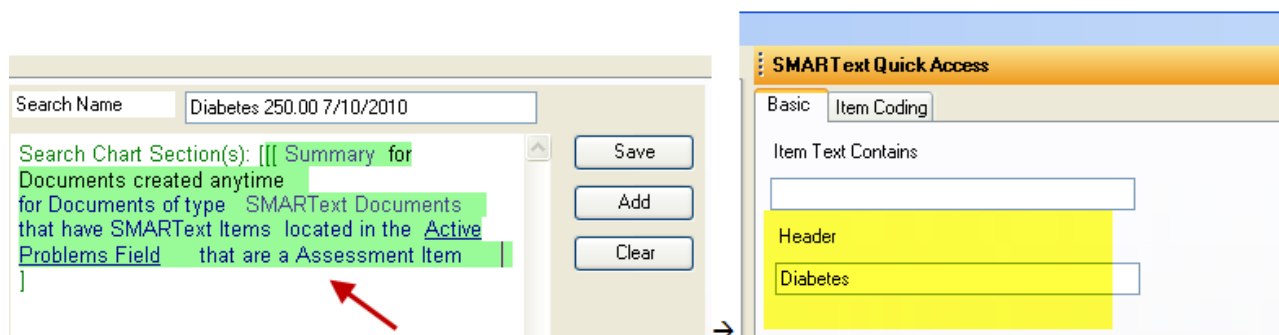
4. Double-click on "Active Problems Field."
5. Click the Add button.

## Defining the SMARText Item Type



1. Left-click over "that are a."
2. Using the drop-down menu, Click on the expander node next to "Generic."
3. Click on the expander node next to "Structured Items."
4. Double-click on "Assessment Item."
5. Click the Add button.

## Choose a Diagnosis



1. Left-click over "Assessment Item."
2. On the Basic tab, type in the Header (or name) of the diagnosis.

## Item Coding Tab (optional)

Search Name: Diabetes 250.00 7/10/2010

Search Chart Section(s): [ Summary for Documents created anytime  
for Documents of type SMARText Documents  
that have SMARText Items located in the Active  
Problems Field that are a Assessment Item[ whose  
header contains 'Diabetes' which is coded with {ICD-  
9 CM = }].

Buttons: Save, Add, Clear

SMARText Quick Access

Basic Item Coding

Coding System

- ICD 9
- ICD 9
- Multum
- ICD 10
- ICD 9 CM

SMARText Quick Access

Basic Item Coding

Coding System

Value
250.00

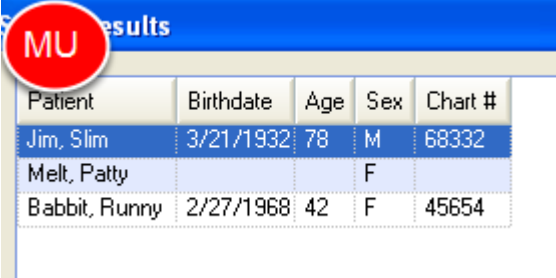
1. Click on the Item Coding tab.
2. Click on the Create tab.
3. Using the drop-down menu under "Coding System", click to select ICD 9.
4. Click under the Value column and type in the ICD 9 being searched for.

## Run the Search

Search

When finished setting up the search, Click on the Search button to run the search.

## Search Results



Search Results				
Patient	Birthdate	Age	Sex	Chart #
Jim, Slim	3/21/1932	78	M	68332
Melt, Patty			F	
Babbit, Runny	2/27/1968	42	F	45654

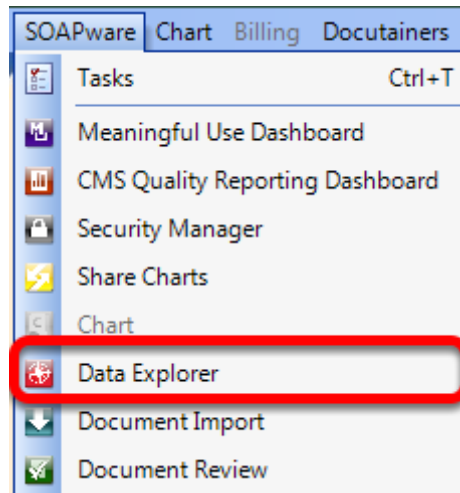
When the search is completed, the search results will be displayed. These can be saved for later viewing or discarded.

## Create a Data Explorer Search for Lab Values

This lesson will explain how to create a Data Explorer search for lab values within a certain range.

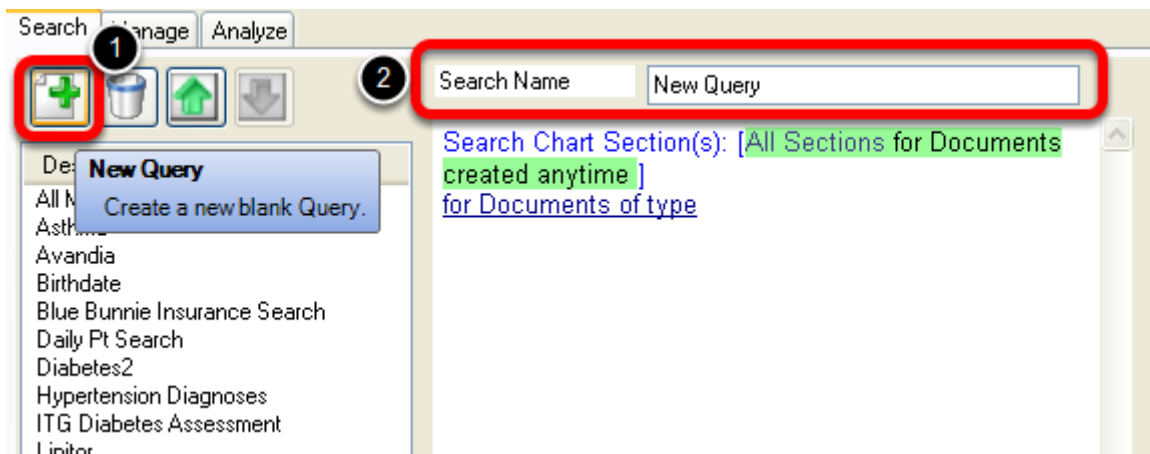
**\*Note:** The following steps are applicable to SOAPware 2011+, despite the difference of versions shown in the following screen shots.

### Open the Data Explorer Workspace

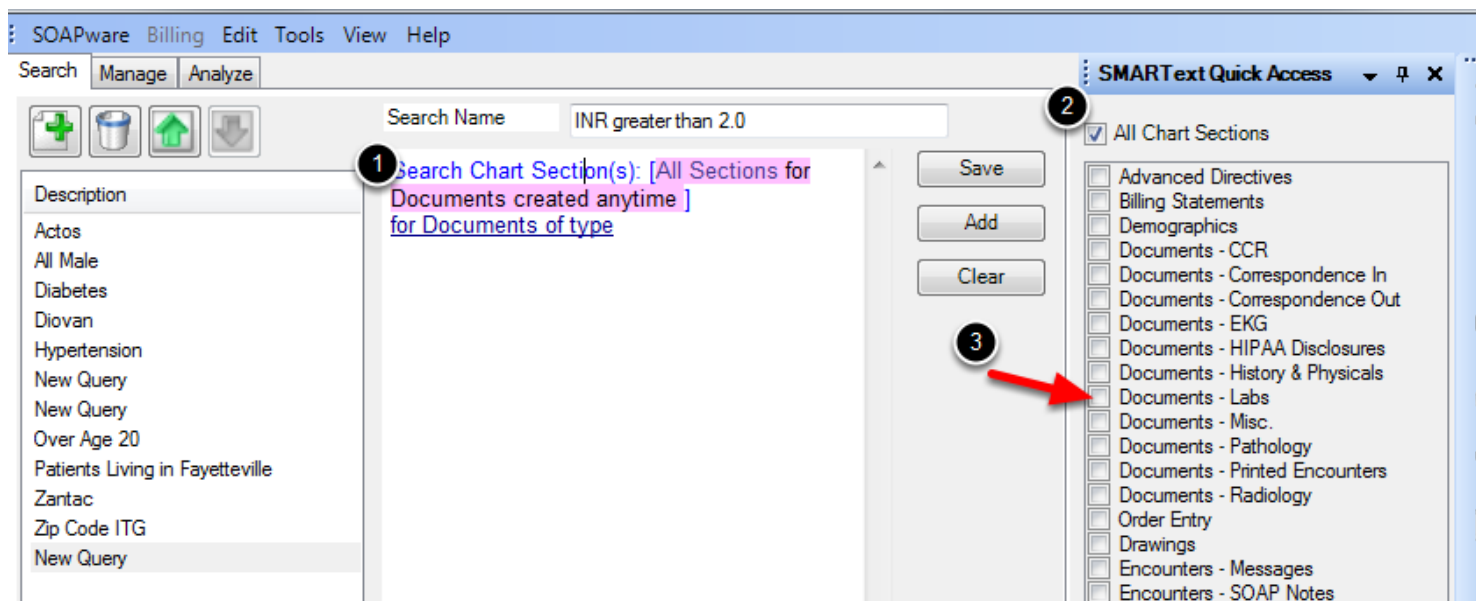


Click on SOAPware from the file menu bar, and Select Data Explorer. This will close the Chart workspace and open the Data Explorer workspace.

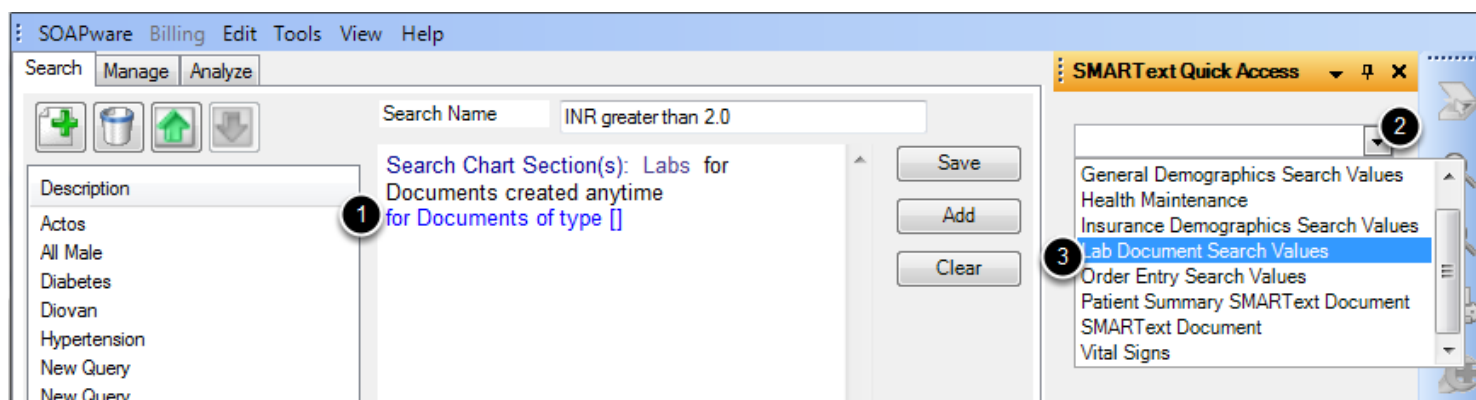
### Creating a New Query



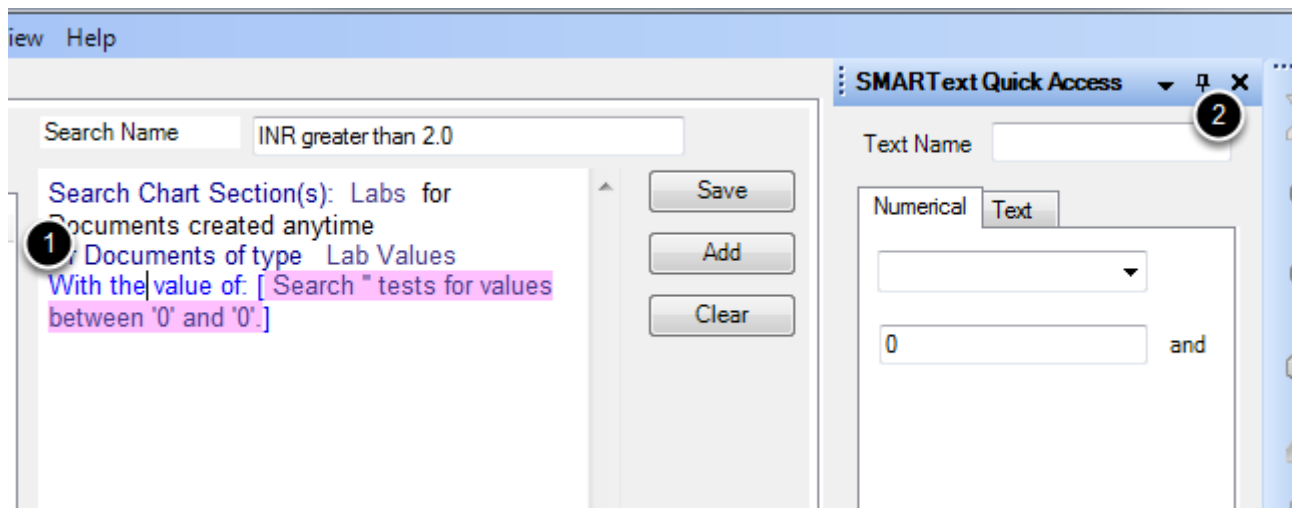
1. Click on the green plus to create a new blank query.
2. Name the new query.



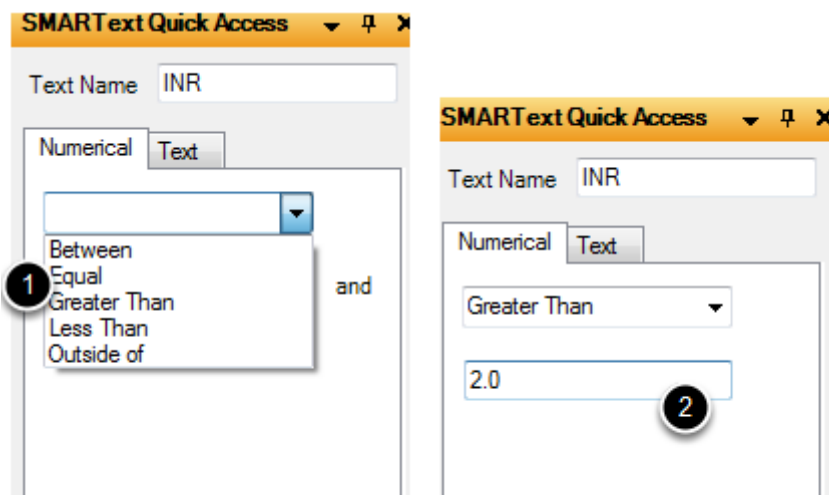
1. Click on "Search Chart Sections."
- In the SMARText Access a list of available chart sections will appear.
2. Uncheck the "All Chart Sections."
- 3 Select "Documents-Labs."



1. Click on "for Documents of type."
2. Click on the drop-down menu from SMARText Quick Access.
3. Select "Lab Document Search Values."



1. Click on "With the value of."
2. Enter the exact name of the test.



1. Select desired option.  
For this example we are selecting "Greater Than."
2. Enter exact value or range.

## Save the Search

The screenshot shows the SOAPware application interface with the 'Search' tab selected. The 'Search Name' field contains 'INR greater than 2.0'. The 'Search Chart Section(s)' field contains 'Labs for Documents created anytime for Documents of type Lab Values With the value of: [ Search 'INR' tests for values greater than '2.0'.]'. The 'Save' button is highlighted with a red circle. The 'SMARText Quick Access' panel on the right shows 'Text Name' as 'INR', 'Numerical' selected, 'Greater Than' as the operator, and '2.0' as the value. The 'Search' button is at the bottom right.

SOAPware Billing Edit Tools View Help

Search Manage Analyze

Search Name: INR greater than 2.0

Search Chart Section(s): Labs for Documents created anytime for Documents of type Lab Values With the value of: [ Search 'INR' tests for values greater than '2.0'.]

Save Add Clear

SMARText Quick Access

Text Name: INR

Numerical Text

Greater Than

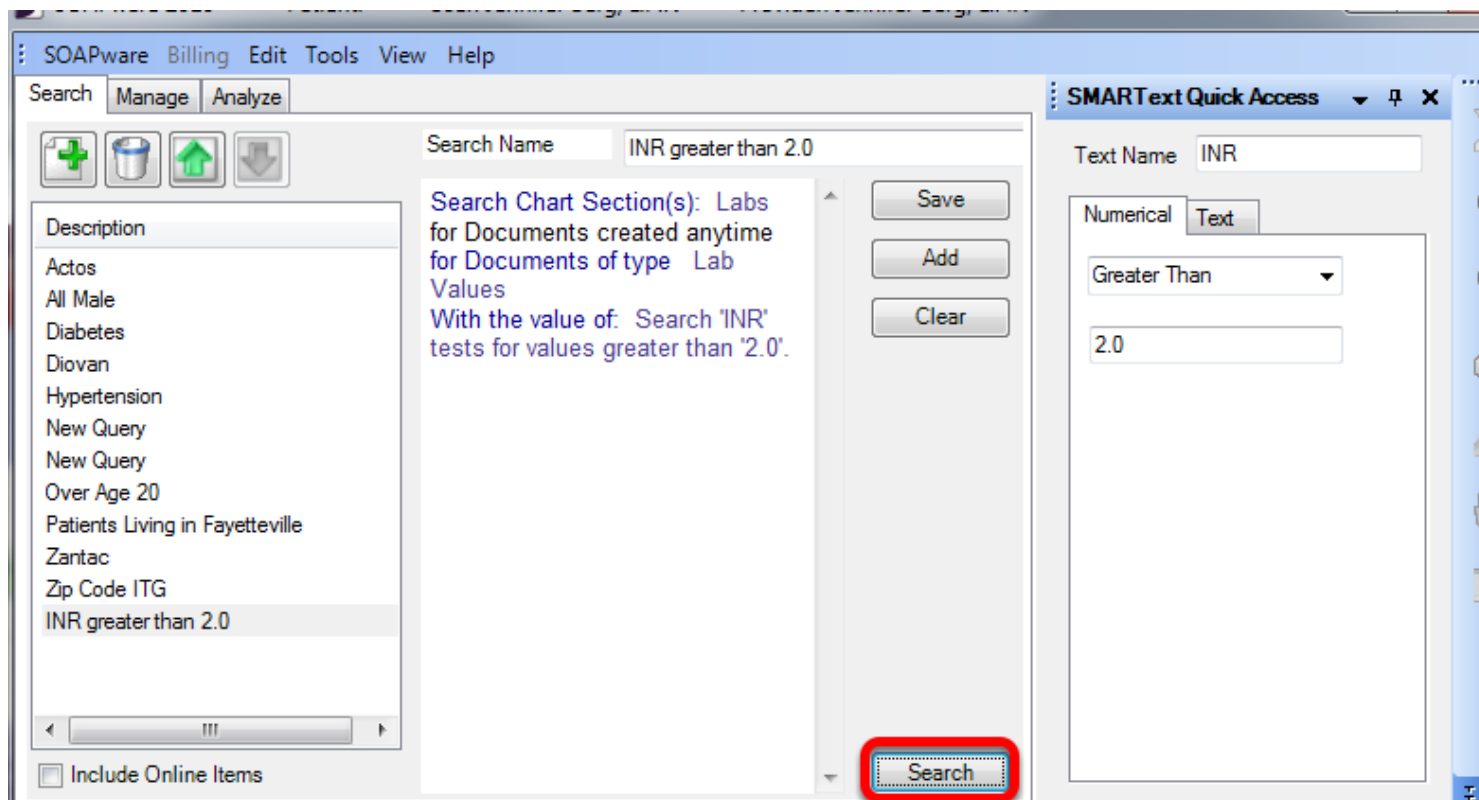
2.0

Search

Include Online Items

After search parameters have been set, Select the Save button.

## Performing Search



To perform the search, Select the Search button at the bottom of the center section. A progress box will appear, showing that SOAPware is performing the search.

When the search is complete, the search results will display in a search results box. The option to print or save the results, will be available at this time.



## Data Explorer Assessment Diagnosis Search

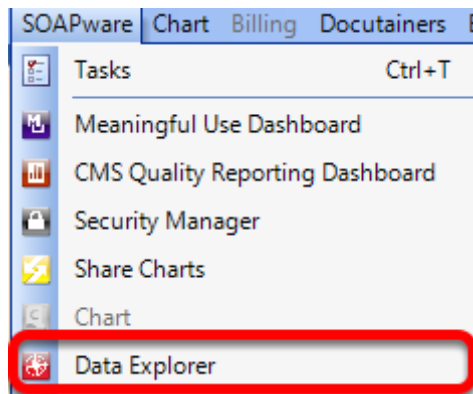
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This lesson will cover searching databases for a structured SMARTText diagnosis located in the SOAPnote Assessment field.

Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

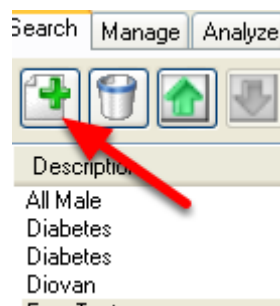
**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
**- [Patient Lists](#)**

### Accessing Data Explorer



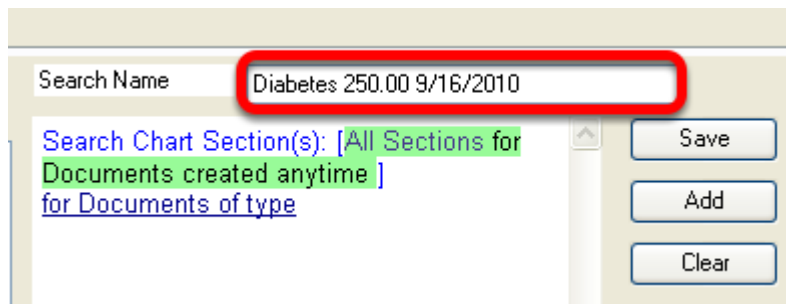
Click on SOAPware on the menu bar.  
Click on Data Explorer.

### Create a New Query



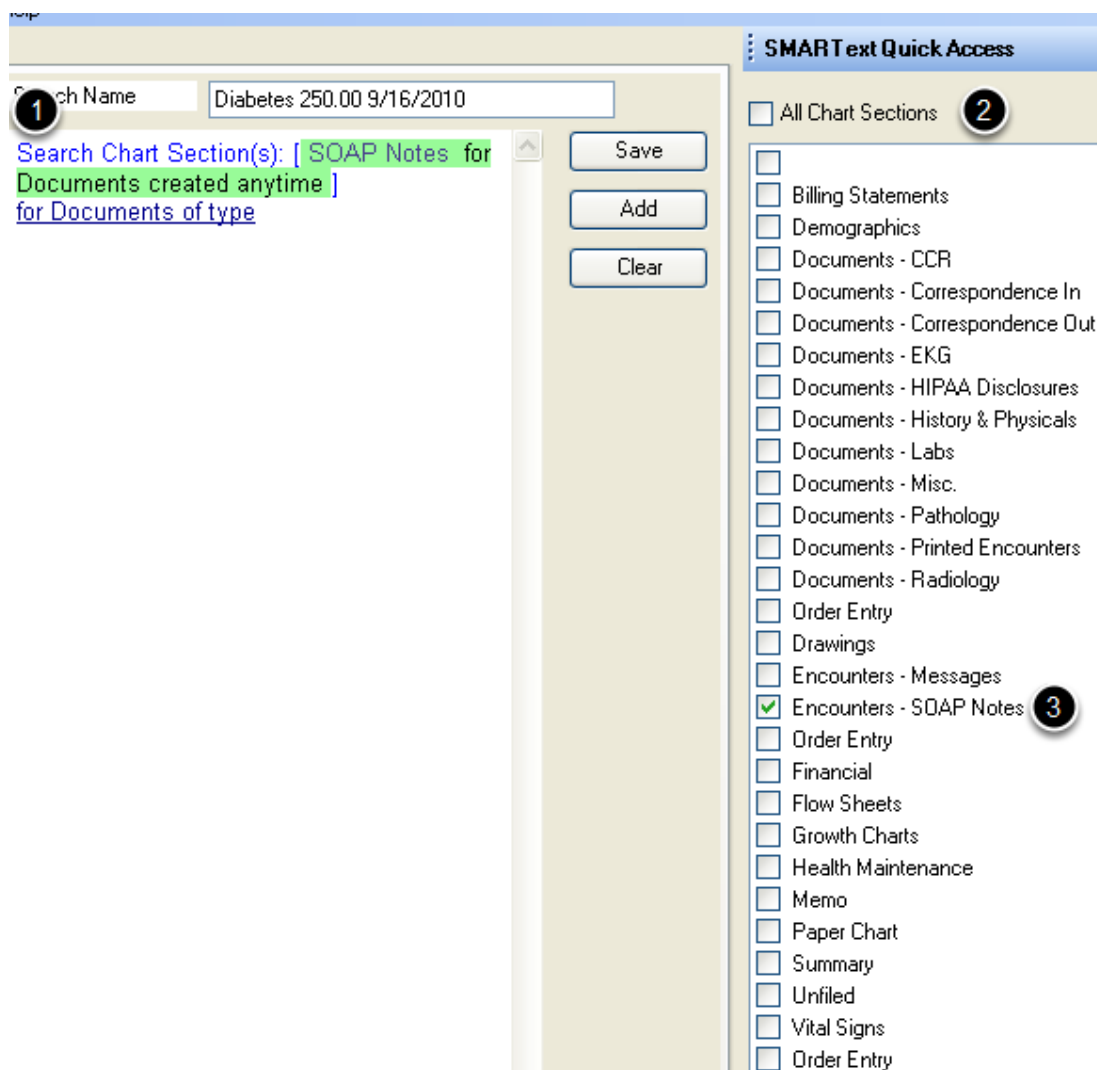
Click on the New Query button.

## Name the Query



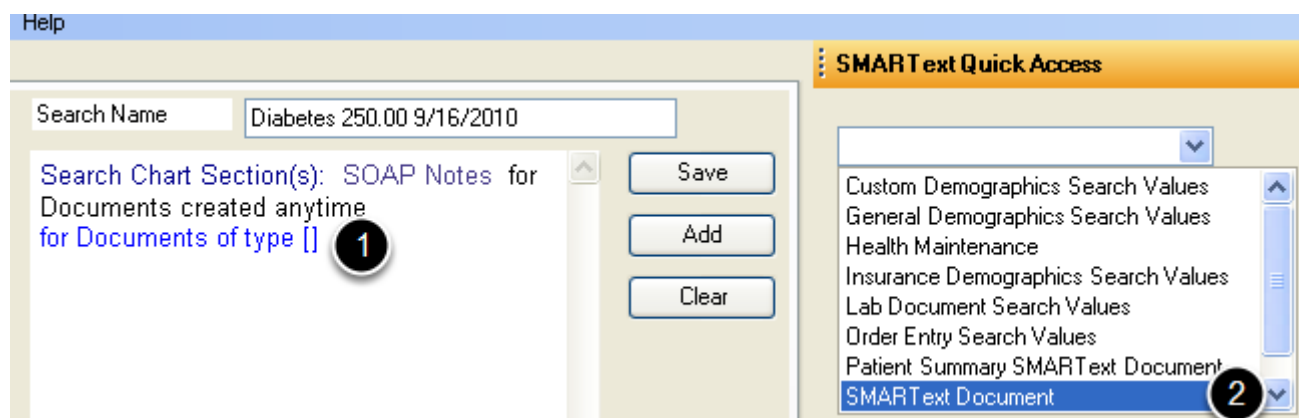
Name the query. It can be helpful to have the data as part of the name of the query.

## Select the Chart Section to be Searched



- 1) Left-click over "Search Chart Sections."
- 2) Un-check "All Chart Sections" in SMARText Quick Access.
- 3) Click to place a check in the box next to Encounters - SOAP Notes.

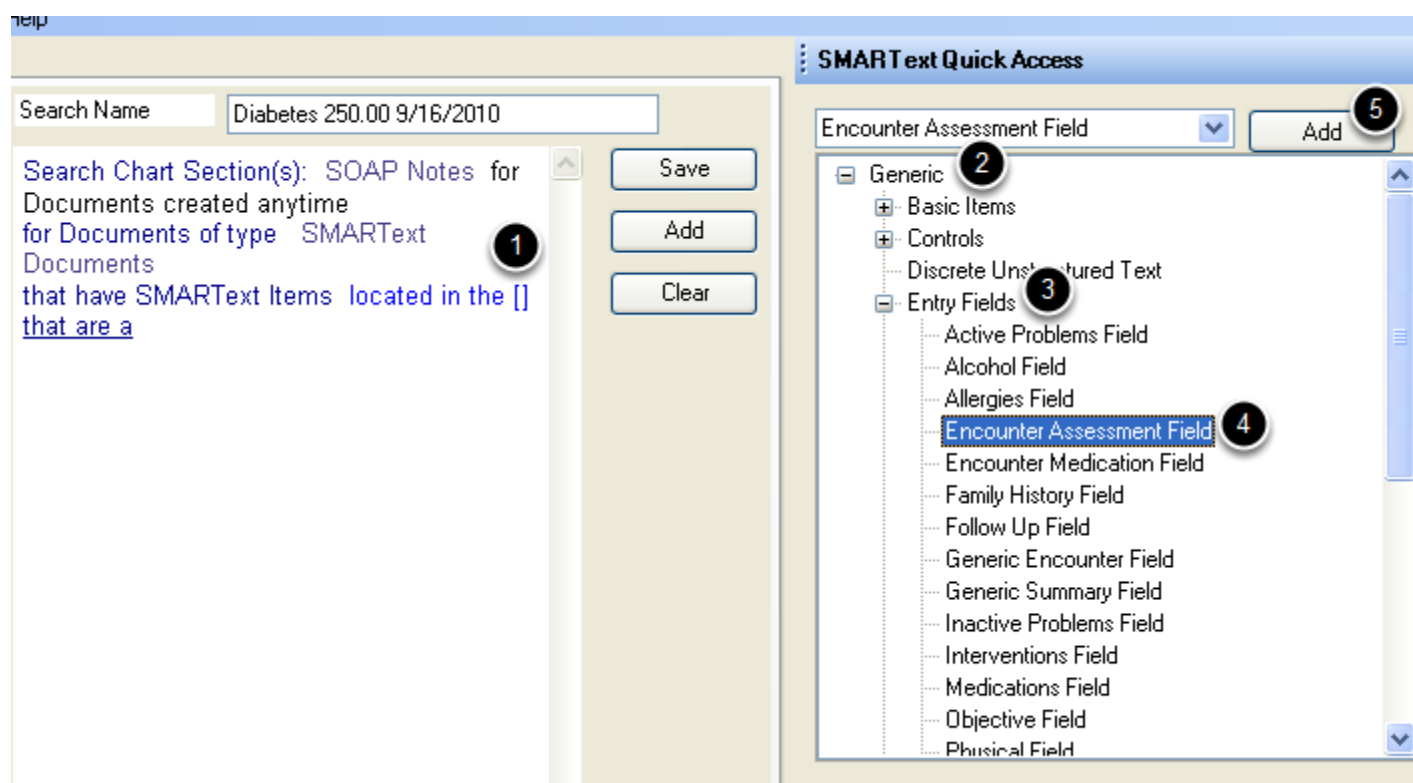
## Type of Document



1) Left-click over "for Documents of type."

2) Using the drop-down menu in SMARText Quick Access, double-click on "SMARText Document."

## Select the Location



1) Left-click over "located in the."

2) Using the drop-down menu, Click on the plus (the expander node), next to "Generic."

3) Click on the expander node next to "Entry Fields."

4) Double-click on "Encounter Assessment Field."

5) Click the Add button.

## Define the SMARText Type

The screenshot displays the SMARTText Quick Access window. On the left, the 'Search Name' field contains 'Diabetes 250.00 9/16/2010'. Below it, the search criteria are listed: 'SOAP Notes for Documents created anytime for Documents of type SMARTText Documents that have SMARTText Items located in the that are a[]'. To the right of this text are three buttons: 'Save', 'Add', and 'Clear'. On the right side of the window, there is a tree view under the heading 'SMARTText Quick Access'. The tree shows a hierarchy of items: 'Generic', 'Basic Items', 'Controls', 'Discrete Unstructured Text', 'Entry Fields', 'Exam Systems', 'Follow Up', 'Lists', 'Objective Items', 'Plan Items', 'Primary Exams/Organ Systems', 'Structured Items', 'Assessment Item', 'Medication Item', 'Plan Items', 'Subjective Items', and 'Temporary Items'. The 'Assessment Item' is highlighted with a blue box. A red circle with the number 1 points to the search criteria text. A red circle with the number 2 points to the 'Generic' item. A red circle with the number 3 points to the 'Structured Items' folder. A red circle with the number 4 points to the 'Assessment Item' folder. A red circle with the number 5 points to the 'Add' button.

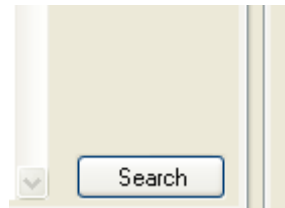
- 1) Left-click over "that are a."
- 2) Using the drop-down menu, Click on the expander node next to "Generic."
- 3) Click on the expander node next to "Structured Items."
- 4) Double-click on "Assessment Item."
- 5) Click the Add button.

### Choose a Specific Diagnosis

The screenshot displays the SMARTText Quick Access interface. On the left, the 'Search Name' field contains 'Diabetes 250.00 9/16/2010'. Below this, the search criteria are listed: 'Search Chart Section(s): SOAP Notes for Documents created anytime for Documents of type SMARTText Documents that have SMARTText Items located in the that are a Assessment Item whose header contains 'Diabetes''. A red circle with the number '1' highlights the search criteria. To the right of the search criteria are three buttons: 'Save', 'Add', and 'Clear'. On the right side of the interface, the 'SMARTText Quick Access' tab is active. Below the tab, the 'Item Text Contains' field is highlighted with a red rectangle. The 'Item Text Contains' field has two entries: 'Header' and 'Diabetes'. A red circle with the number '2' highlights the 'Item Text Contains' field.

- 1) Left-click over "Assessment Item."
- 2) On the Basic tab, type in the Header (or name) of the diagnosis.

## Run the Search



Click on the Search button.

## Search Results

SearchResults				
Patient	Birthdate	Age	Sex	Chart #
Babbit, Runny	2/27/2010	0	F	45654
Pense, Casey	4/9/1979	31	M	
Silly, Ima	3/15/1929	81	F	

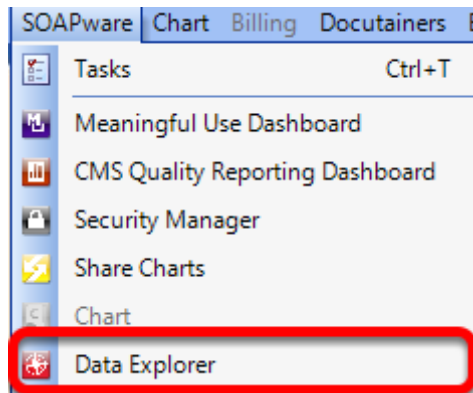
The search results will be displayed. The user can choose to save or print the search results.

## Data Explorer Search for Health Maintenance Rules

In this lesson, we will use Data Explorer to search for patients that have specific Health Maintenance Rules due.

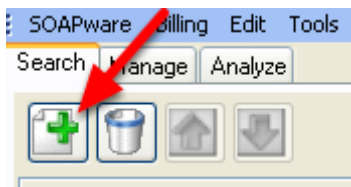
Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

### Access Data Explorer



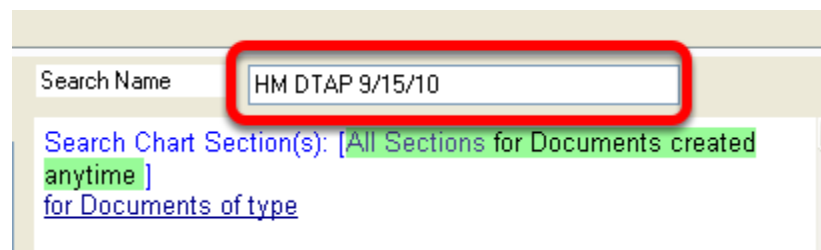
On the menu bar Click on Soapware and choose Data Explorer.

### Create a New Query



Click on the New Query button.

### Name the Query



Type the name of the query in the "Search Name" box. It can be helpful to place a date on the query also.

## Select the Chart Section to be Searched

The screenshot shows the SMARText Quick Access interface. On the left, a search area is labeled '1' and contains a 'Search Name' field with 'HM DTAP 9/15/10'. Below it, the text 'Search Chart Section(s): [ Health Maintenance for Documents created anytime ] for Documents of type' is displayed. To the right of this text are 'Save', 'Add', and 'Clear' buttons. On the right side of the interface, a panel titled 'SMARText Quick Access' is labeled '2'. It contains a list of chart sections with checkboxes. The 'All Chart Sections' checkbox is unchecked. The 'Health Maintenance' checkbox at the bottom is checked, indicated by a green checkmark and a '3' in a circle.

1 Search Name HM DTAP 9/15/10

Search Chart Section(s): [ Health Maintenance for Documents created anytime ] for Documents of type

Save Add Clear

SMARText Quick Access

☐ All Chart Sections

☐ Advanced Directives

☐ Billing Statements

☐ Demographics

☐ Documents - CCR

☐ Documents - Correspondence

☐ Documents - Correspondence

☐ Documents - EKG

☐ Documents - HIPAA Disclos.

☐ Documents - History & Physic

☐ Documents - Labs

☐ Documents - Misc.

☐ Documents - Pathology

☐ Documents - Printed Encoun

☐ Documents - Radiology

☐ Order Entry

☐ Drawings

☐ Encounters - Messages

☐ Encounters - SOAP Notes

☐ Order Entry

☐ Financial

☐ Flow Sheets

☐ Growth Charts

☒ Health Maintenance

1. Left-click over "Search Chart Sections."
2. Un- check "All Chart Sections" in SMARText Quick Access.
3. Click to place a check in the box next to Health Maintenance.

## Type of Document

The screenshot shows the SMARText Quick Access interface. On the left, a search area is labeled '1' and contains a 'Search Name' field with 'HM DTAP 9/15/10'. Below it, the text 'Search Chart Section(s): Health Maintenance for Documents created anytime for Documents of type []' is displayed. To the right of this text are 'Save', 'Add', and 'Clear' buttons. On the right side of the interface, a panel titled 'SMARText Quick Access' is labeled '2'. It contains a drop-down menu with a list of document types. The 'Health Maintenance' option is highlighted with a blue background and a '2' in a circle.

1 Search Name HM DTAP 9/15/10

Search Chart Section(s): Health Maintenance for Documents created anytime for Documents of type []

Save Add Clear

SMARText Quick Access

Custom Demographics Search Values

General Demographics Search Values

Health Maintenance

Insurance Demographics Search values

Lab Document Search Values

Order Entry Search Values

Patient Summary SMARText Document

SMARText Document

1. Left-click over "for Documents of type."
2. Using the drop-down menu in SMARText Quick Access, double-click on Health Maintenance.

## Select the Area to Search

Search Name: HM DTAP 9/15/10

Search Chart Section(s): Health Maintenance for Documents created anytime for Documents of type Health Maintenance

1 Search Health Maintenance: [Performed in last 1 Year]

Save Add Clear

SMARText Quick Access

Rule / Vaccine: DTAP 2

Performed in last 1 3

Years Days Weeks Months

1. Left-click over "Search Health Maintenance."
2. Type in the Rule or Vaccine to search for, **exactly** as it appears in Health Maintenance.
3. Using the arrows, indicate the number and measurement of time.



## Perform the Search

Search Name: HM DTAP 9/15/10

Search Chart Section(s): [ Health Maintenance for Documents created anytime for Documents of type Health Maintenance Search Health Maintenance: Performed in last 1 Year ]

Buttons: Save, Add, Clear, Search

Click the Search button.

## Search Results

### SearchResults

Patient	Birthdate	Age	Sex	Chart #
Clyde, Annie	5/21/1947	63	F	
Girl, Baby	5/21/2010	0	F	

Save

Print

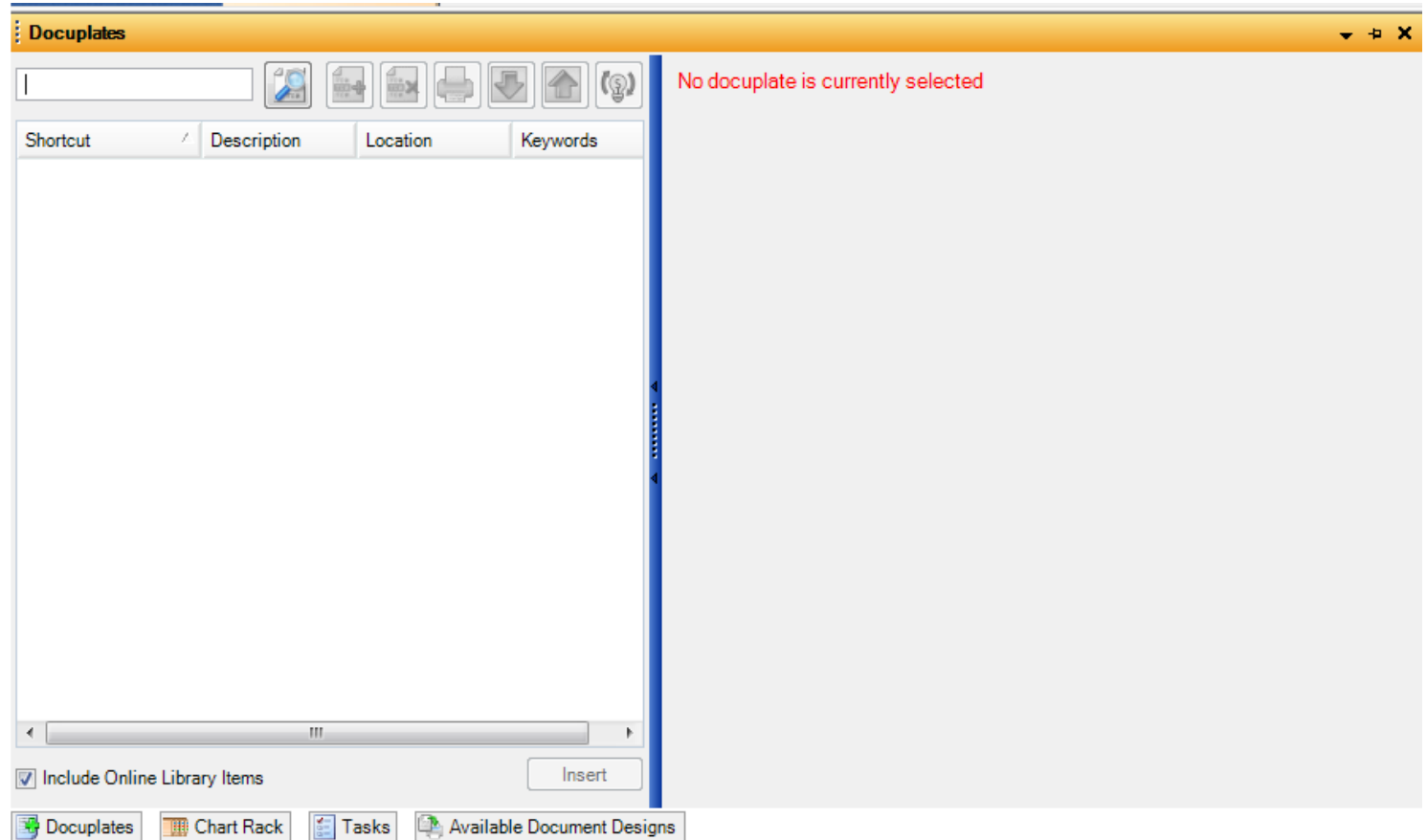
Close

The search results will be displayed and can be saved or printed.

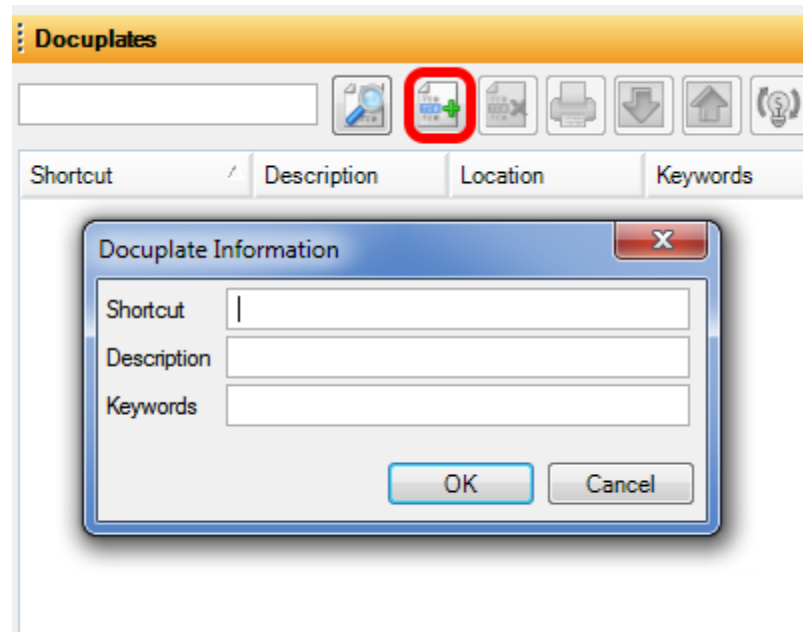
# Flow Sheets

## Creating a New Flow Sheet Docuplate

### Creating a New Flow Sheet in the Docuplate Manager

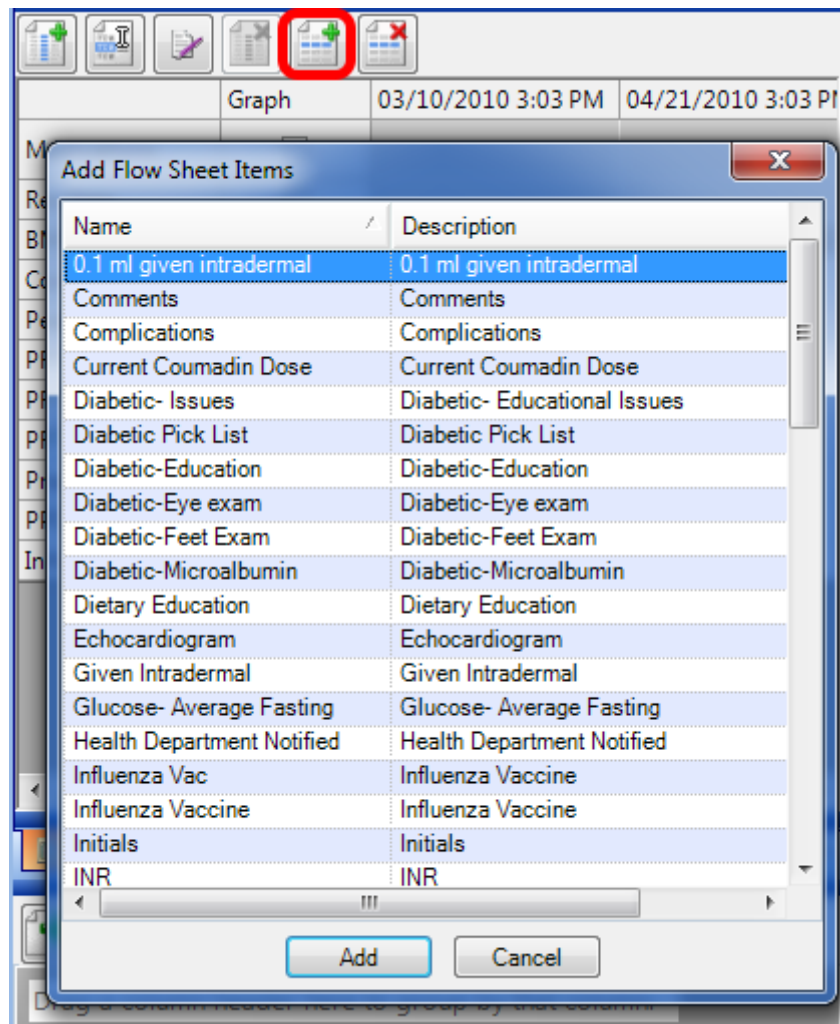


To create a new Flow Sheet in the Docuplate Manager, the user will first create the Flow Sheet requested in a test patient's chart. Then, open the Docuplate Manager (open the docket tab or Press the F6 key). Note that the Docuplate Manager should remain open and in view while the Flow Sheets section of the patient chart is displayed.



Once the Docuplate Manager opens, Click the New Docuplate Button (or Press Ctrl + Alt + N). The Docuplate Information dialog box will open. Give the new Flow Sheet Docuplate a Shortcut, a short Description, and a few relevant Keywords. Click OK. Anew Flow Sheet will be created in the Docuplate Manager.

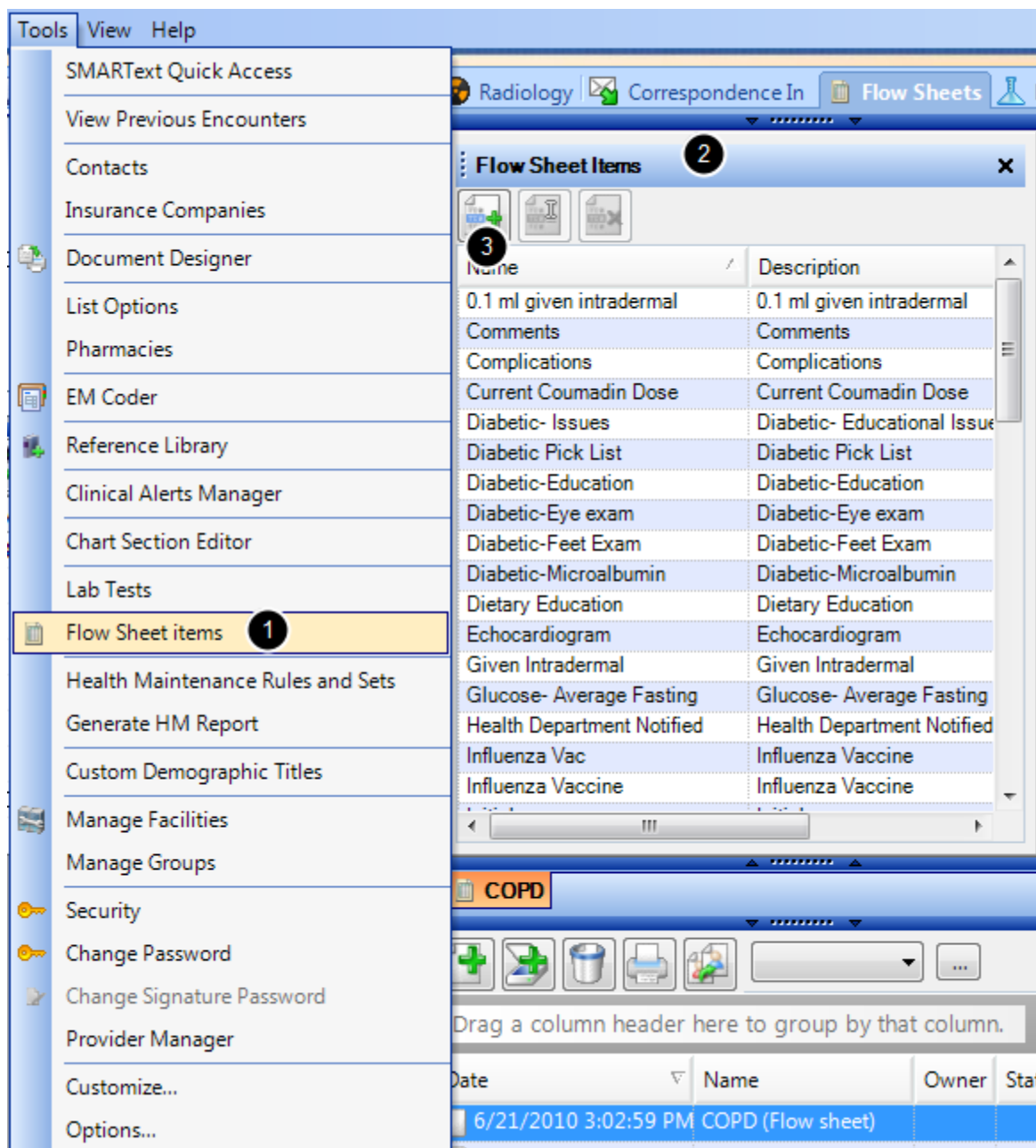
## Insert Flow Sheet Item



To insert Flow Sheet Items for a new Flow Sheet, Click the Insert Flow Sheet Items Button (or Press Ctrl + Alt + I). This will open the Add Flow Sheet Items dialog box.

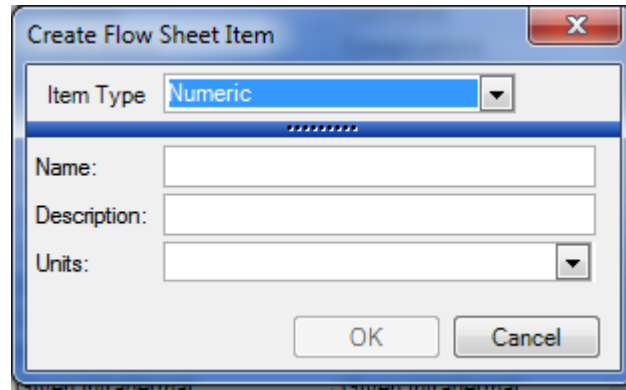
Select the Flow Sheet Item to add by Clicking on it, and then Click Add. The selected Flow Sheet Item will be added to the new Flow Sheet.

## Creating a New Flow Sheet Item



1. To create a new Flow Sheet Item, the user must first access the Flow Sheet Item manager by selecting Flow Sheet Items from the Tools menu, located on the main SOAPware menu bar.
2. The Flow Sheet Item manager will open. To add a new Flow Sheet Item, Click the Add Flow Sheet Item Button (or Press Ctrl + Alt + N). The Flow Sheet Item Editor will open.
3. Click the Add Item button. There are four Types of Flow Sheet Items that can be created. They are Numeric, Pick List, Start/Stop, and Text. Following are instruction for creating an item of each type.

## Creating a Numeric Flow Sheet Item

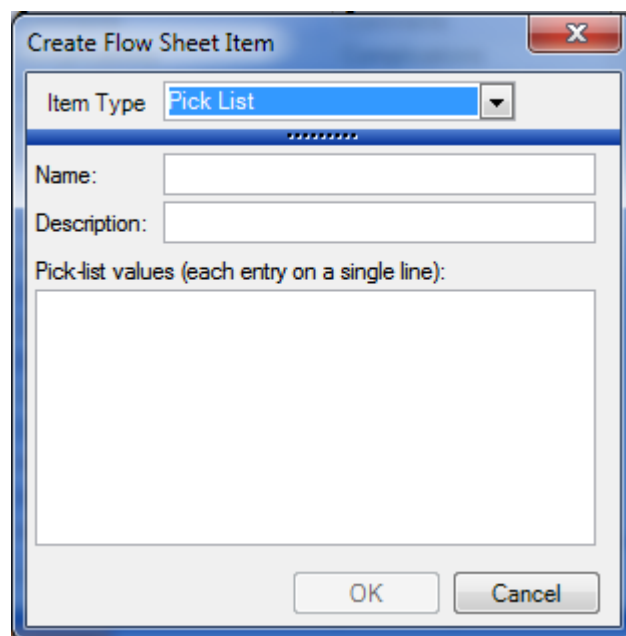


The dialog box is titled "Create Flow Sheet Item". It has a close button (X) in the top right corner. Below the title bar, there is a label "Item Type" followed by a dropdown menu showing "Numeric". Below this is a horizontal separator line. There are three text input fields: "Name:", "Description:", and "Units:". The "Units:" field has a dropdown arrow on its right side. At the bottom of the dialog are two buttons: "OK" and "Cancel".

Give the new Numeric item a name and a short description. Then, using the Units drop down box, choose a unit of measurement for the item.

When this new item has been finished, Click OK. The new item will be added to the list of available Flow Sheet Items.

## Creating a Pick List Flow Sheet Item



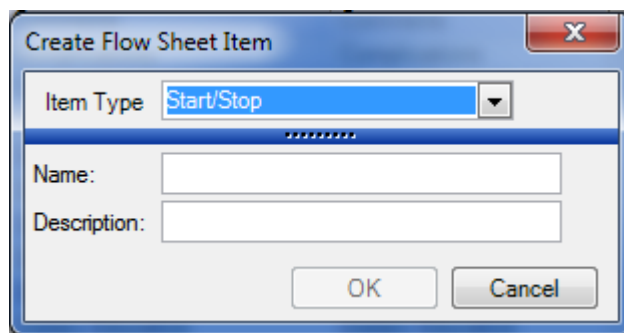
The dialog box is titled "Create Flow Sheet Item". It has a close button (X) in the top right corner. Below the title bar, there is a label "Item Type" followed by a dropdown menu showing "Pick List". Below this is a horizontal separator line. There are two text input fields: "Name:" and "Description:". Below these is a label "Pick-list values (each entry on a single line):" followed by a large text area for entering multiple lines of values. At the bottom of the dialog are two buttons: "OK" and "Cancel".

Give the new Pick List item a name and a short description. Then, type in the desired choices; entering one per line.

When this has been completed, Click OK. The new item will be added to the list of available Flow Sheet Items.



## Creating a Start/Stop Flow Sheet Item

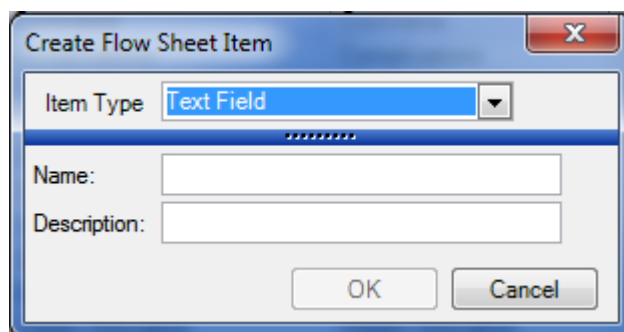


The image shows a 'Create Flow Sheet Item' dialog box. The 'Item Type' dropdown menu is set to 'Start/Stop'. Below this, there are two text input fields labeled 'Name:' and 'Description:'. At the bottom right, there are 'OK' and 'Cancel' buttons. The dialog box has a standard Windows-style title bar with a close button (X) in the top right corner.

Give the new Start/Stop item a name and a short description.

When completed, Click OK. The new item will be added to the list of available Flow Sheet Items.

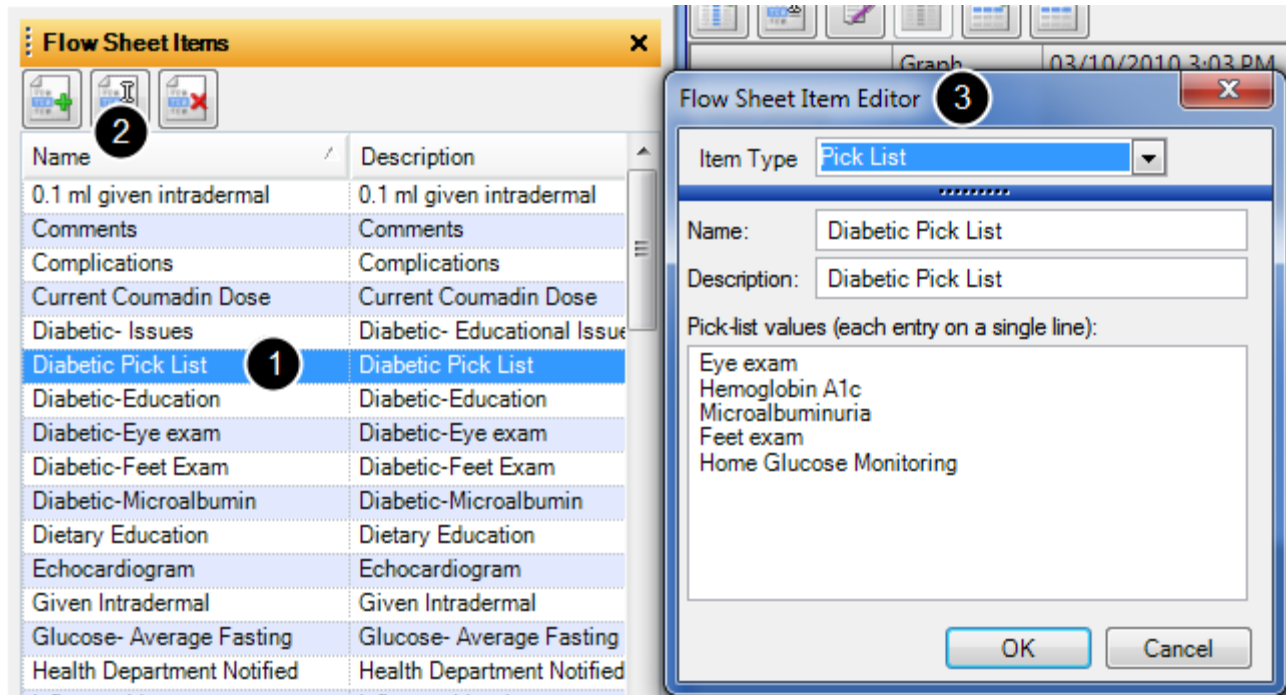
## Creating a Text Field Flow Sheet Item



The image shows a 'Create Flow Sheet Item' dialog box. The 'Item Type' dropdown menu is set to 'Text Field'. Below this, there are two text input fields labeled 'Name:' and 'Description:'. At the bottom right, there are 'OK' and 'Cancel' buttons. The dialog box has a standard Windows-style title bar with a close button (X) in the top right corner.

Give the new Text Field item a name and a short description. When completed, Click OK. The new item will be added to the list of available Flow Sheet Items.

## Editing an Existing Flow Sheet Item



1. Select the Flow Sheet Item to be edited by Clicking on it.
2. Then, Click the Edit Flow Sheet Item Button (or Press Ctrl + Alt + N).
3. The Flow Sheet Item Editor will open. Make any necessary changes and Click OK. Any changes will be applied.

## Creating a Lab Flow sheet

This lesson will show users how to create a lab flow sheet for tracking and graphing labs.

### Open Flow sheets and Lab Chart Sections

The image displays two side-by-side screenshots of a medical software interface. The left screenshot shows the 'Flow Sheets' section, and the right screenshot shows the 'Labs' section. Both sections have a red box highlighting their respective tabs in the top navigation bar.

**Flow Sheets Section (Left):**

The 'Flow Sheets' section displays a table with the following data:

	Graph	008 10:14 AM	02/26/2009 12:00 AM	02/26/2009
INR	<input type="checkbox"/>			1.8
Blood Pressure - Diastolic	<input type="checkbox"/>	80		
Blood Pressure - Systolic	<input type="checkbox"/>	120		
Current Coumadin Dose	<input type="checkbox"/>		2.5mg daily	
Coumadin complications	<input type="checkbox"/>		None	
New Dose	<input type="checkbox"/>		2.5mg SS, 5mg MTWTHF	
Next INR	<input type="checkbox"/>		IN ONE WEEK	
Comments	<input type="checkbox"/>			

The bottom of the section contains a toolbar with icons for adding, deleting, and printing, and a text area that says "Drag a column header here to group by that column."

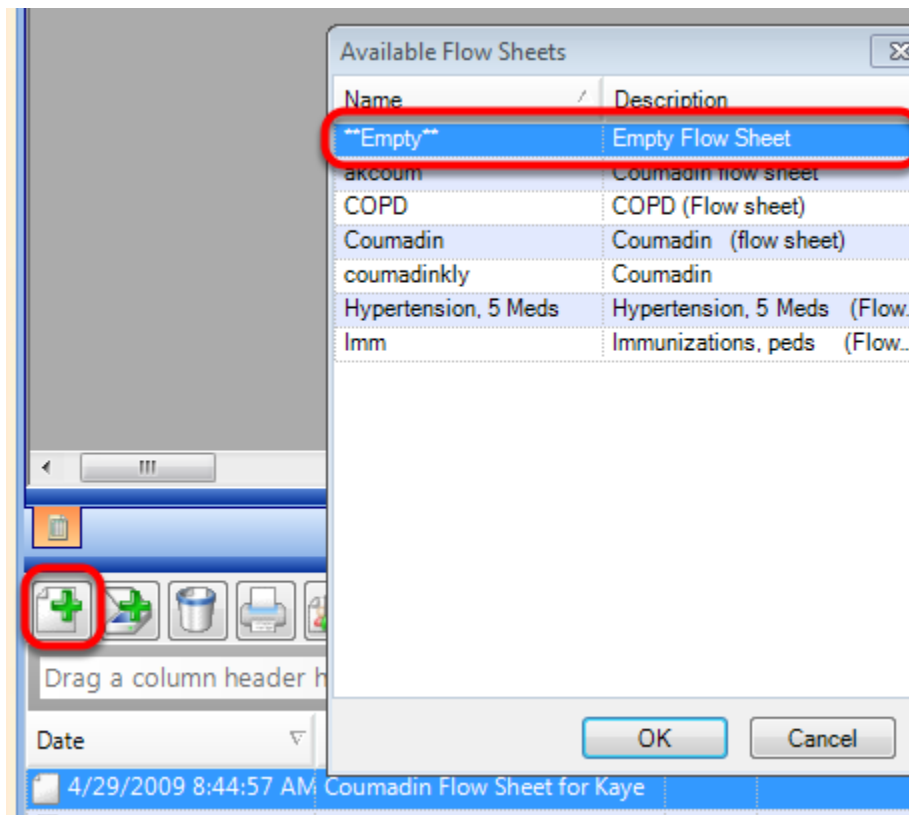
**Labs Section (Right):**

The 'Labs' section displays a table with the following data:

Name	Flags	Value	Range	Units	Status	LOINC	Code	Date	Ra
INR	H	3.6	(2 - 3.5)	ratio				10/29/2009	

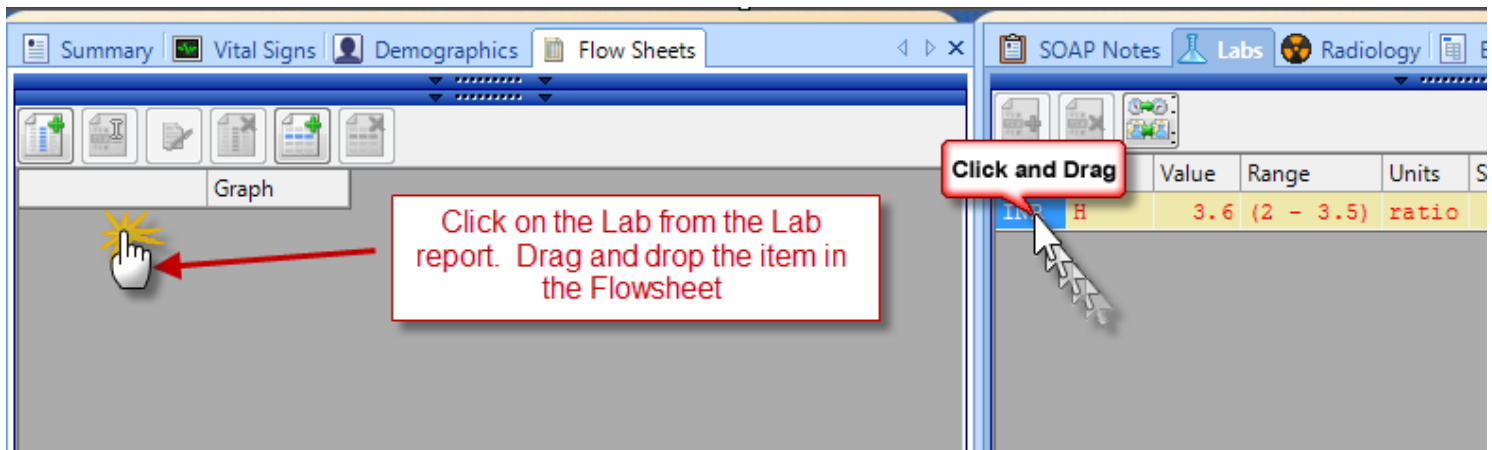
The bottom of the section contains a toolbar with icons for adding, deleting, and printing, and a text area that says "Drag a column header here to group by that column."

## Create a New Empty Flow sheet



To create a new empty flow sheet, Click on the Green Plus in the Flow sheet toolbar. Select Empty Flow Sheet and Click OK.

## Select Labs to be entered on the Flow sheet



1. Click on the Item in the Lab report.
2. Drag and Drop the item in the Flow sheet

Summary

Vital Signs

Demographics

Flow Sheets

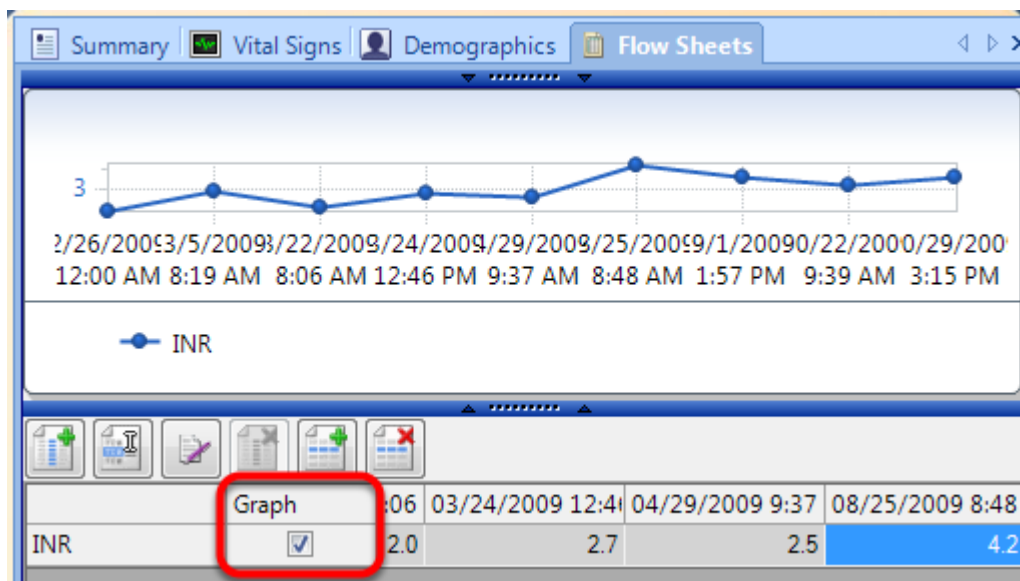
	Graph	03/06	03/24/2009 12:41	04/29/2009 9:37	08/25/2009 8:48
INR	<input type="checkbox"/>	2.0	2.7	2.5	4.2

Item is now placed in the Flow sheet. All results from that specific test are now entered on the flow sheet.

When new test results are entered in the Lab section the Results will automatically appear on the flow sheet.

Labs tests that are entered using a Lab Docuplate or HL7 interface may be placed on a flow sheet. Lab results that have been scanned into the patients chart will not be placed on the flow sheet.

## Graphing Results



Results may be graphed by placing a check mark in the Graph box under each test.

## Using Flow Sheets

### Editing a Flow Sheet Reading Date or Column Header

	Graph	06/17/2010 8:47 AM
Referring Dr.	<input type="checkbox"/>	
Friend/Relative #	<input type="checkbox"/>	
Other Diagnosis	<input type="checkbox"/>	
Other medications	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	
Indication for Coumadin	<input type="checkbox"/>	
Initiation date	<input type="checkbox"/>	
Duration of therapy	<input type="checkbox"/>	
Coumadin Dose (mg)	<input type="checkbox"/>	
Control (sec)	<input type="checkbox"/>	
Patient (sec)	<input type="checkbox"/>	
Ratio	<input type="checkbox"/>	
INR	<input type="checkbox"/>	
Coumadin (new dose)(mg)	<input type="checkbox"/>	

To edit the Reading Date for a column, first select the column to edit by Clicking on it. Then, Click the Edit Reading Date Button (or Press Ctrl + Alt + E).

### Reading Date

Reading Date

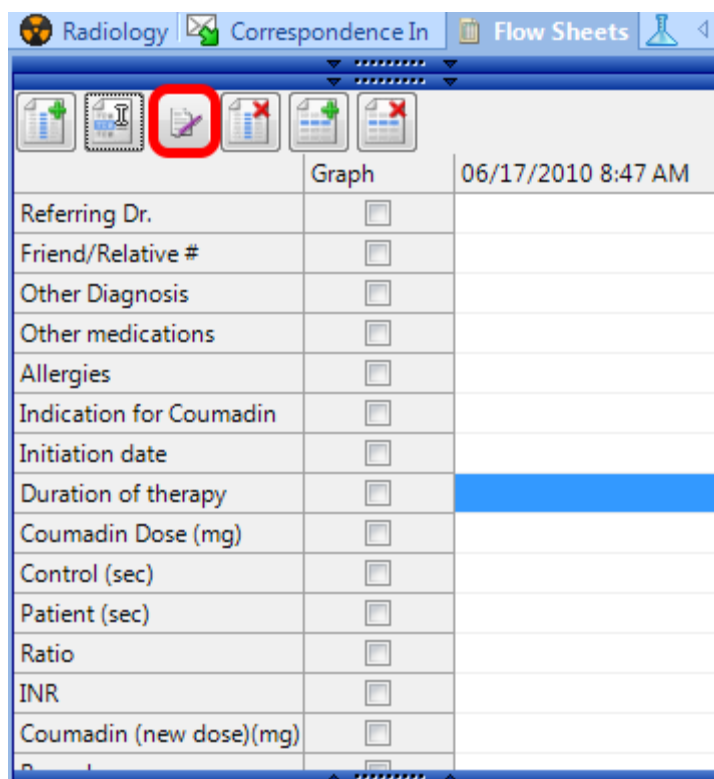
Specify the date and time for the reading

6/17/2010 8:47:11 AM

Update Cancel

The Reading Date dialog box will open. Click the arrow to open the drop down calendar, and select the desired date by Clicking on it. Then, Click the time fields and type in the desired time. When finished, Click Update. Changes will be applied.

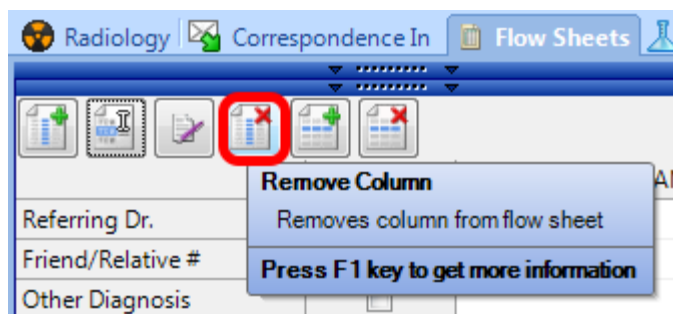
## Signing Off on a Flow Sheet Reading Date



To sign-off on a Reading Date, first select the Reading Date to sign-off by Clicking on it in the Flow Sheet. Then, Click the Sign-Off Reading Date Button (or Press Ctrl + Alt + S).

SOAPware will display the Sign Column dialog box and ask the user to confirm that he/she wishes to sign off on the Reading Date. Click Yes if certain, and the Reading Date will be signed off.

## Removing a Flow Sheet Reading Date or Text Column

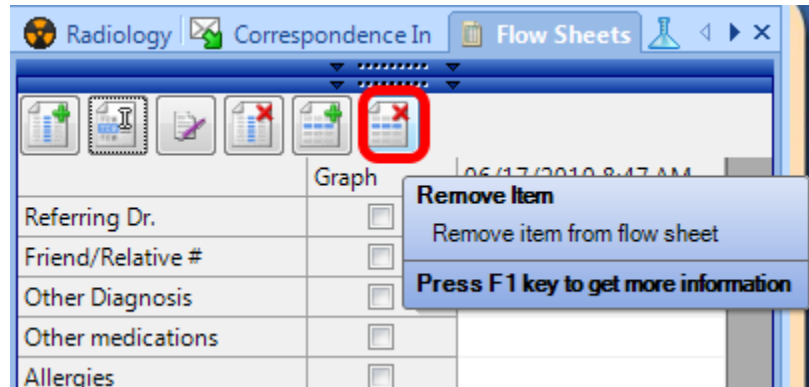


To remove a Reading Date or Text Column from a Flow Sheet, first select the Reading Date or Text Column to remove by Clicking on it in the Flow Sheet. Then, Click the Remove Reading Date Button (or Press Ctrl + Alt + R).

SOAPware will ask the user to confirm that he/she wishes to remove the selected Reading Date or Text Column. Click Yes if certain, and the Reading Date or Text Column will be removed.

Note that if the Reading Date or Text Column has been signed off, it cannot be removed.

### Removing a Flow Sheet Item from the Flow Sheet

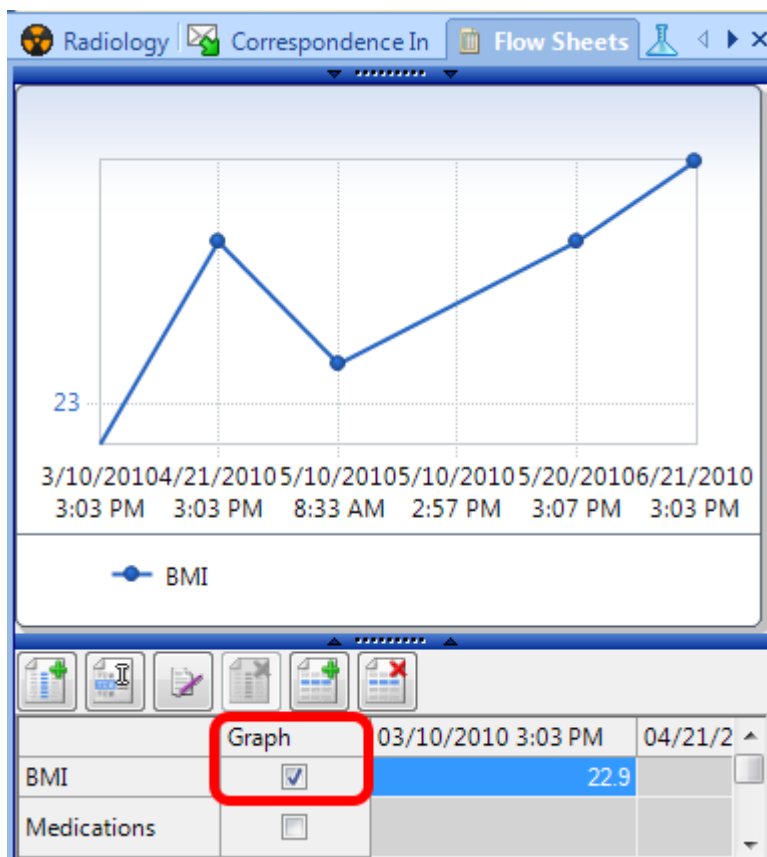


The user can remove Flow Sheet Items from a Flow Sheet within a patient chart. This is useful for special cases in which the final Flow Sheet design is only applicable to a single patient.

However, if the user finds that he/she frequently need to remove Flow Sheet Items from an existing Flow Sheet, the user should create a new Flow Sheet that serves his/her needs using the Docuplate Manager.



## Graphing Data from a Flow Sheet



To graph items from a Flow Sheet, place a check in Graph column box that corresponds with items to view them in a graph. A graph containing the selected items will automatically be created in the graph area of the Flow Sheets section of the patient chart.

Hovering over any part of a particular line on the graph will bring the entire line forward and fade the others into the background. This allows the user to easily view the graph for a particular vital sign, without having to un-select the other graphed readings.

To display the values of a single point on the graph, hover the mouse cursor over a point to view. The item, date, time, and value will be displayed.

## Managing Flow Sheets

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Flow Sheets allow the user to track and study ongoing patient treatment. For example, a user could use Flow Sheets to monitor such things as coagulation therapy, weight loss, and diabetes treatment.

### Tips

Flow Sheets in SOAPware are created as Docuplates, and can be found listed in the Docuplate Manager.

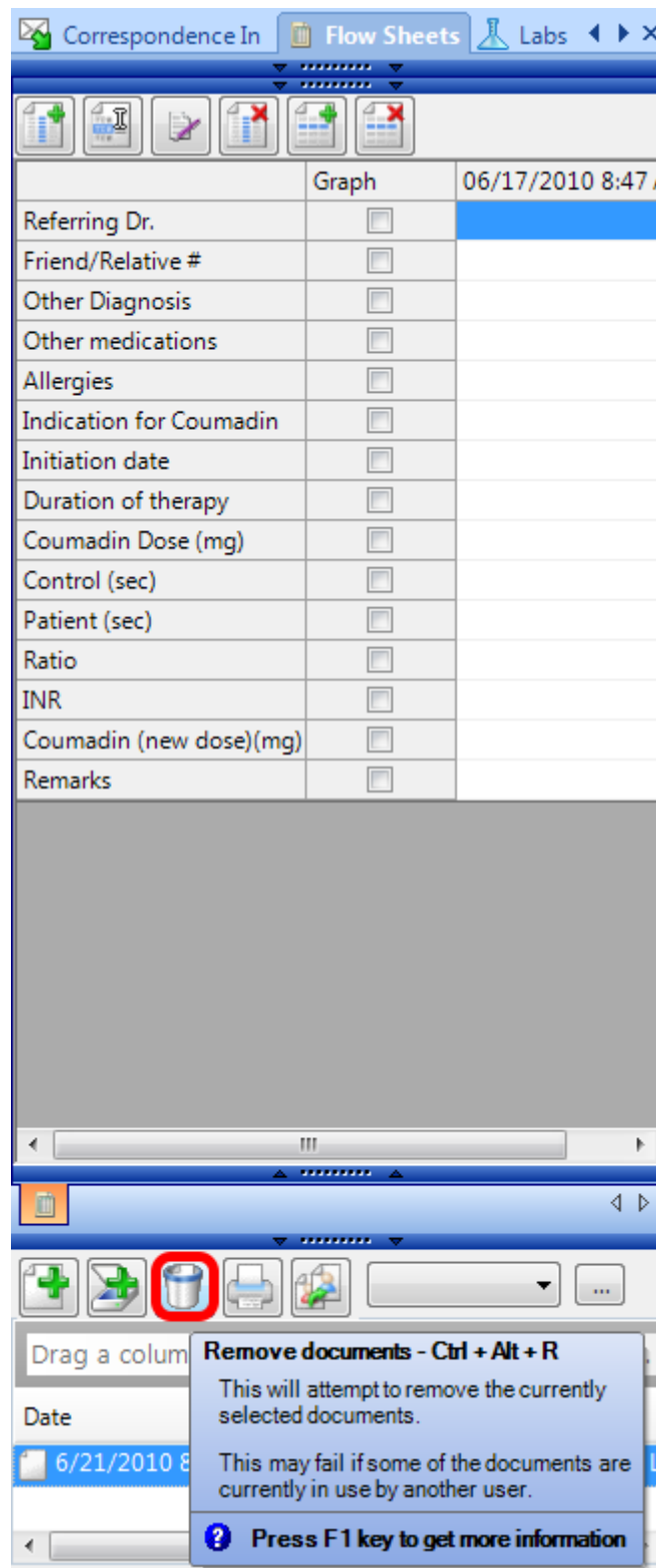
It is now possible to create a Flow Sheets tab that can be saved as part of a Chart Layout.

Plotting graphs has been greatly simplified in SOAPware. A check box has been added to each managed item, which when checked, automatically appears in a graph above the body of the Flow Sheet.

Certain Flow Sheet Items, such as vital signs readings and lab report values, are automatically filled on creation of a new Flow Sheet if data for them exists in the patient chart.

It is possible to drag and drop a vital sign from the Vitals Signs section and add it as an item in a Flow Sheet.

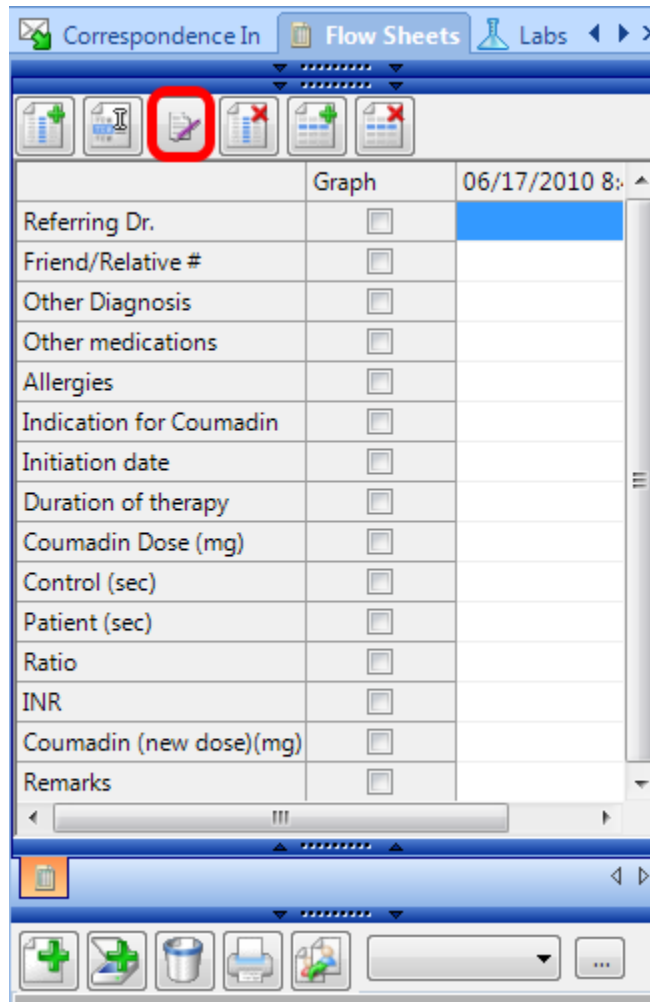
## Removing a Flow Sheet from the Patient Chart



To remove a Flow Sheet from a patient chart, first select the Flow Sheet to remove by Clicking on it in the Flow Sheets list. Then, Click the Remove Document Button (or Press Ctrl + Alt + R). SOAPware will ask the user to confirm that he/she wishes to remove the selected document.

Click Yes, and the Flow Sheet will be removed.

## Signing Off on a Flow Sheet



To sign off on a Flow Sheet, first select the Flow Sheet to sign off by Clicking on it in the Flow Sheets list. Then, Click the Sign Off Document Button (or Press Ctrl + Alt + S).

SOAPware will display the Sign Off Documents dialog box and ask the user to confirm that he/she wishes to sign off on the document. Click Yes, and the Flow Sheet will be signed off.

## Printing a Flow Sheet

Date	Name	Owner
6/21/2010 8:46:58 AM	Coumadin flow sheet	Krista L. L

To print an existing Flow Sheet, first select the Flow Sheet to print by Clicking on it in the Flow Sheets list. Then, Click the Print Document Button (or Press Ctrl + Alt + P).

The Print dialog box will open. Select the printer to use, and Click Print. The selected Flow Sheet will print.

## Reassigning a Flow Sheet

The screenshot shows the SOAPware application window with the 'Flow Sheets' tab active. The 'Coumadin flow sheet' is selected, and the 'Reassign Documents' button (a document with a person icon) is highlighted with a red circle. The flow sheet contains the following fields:

	Graph	06/17/2010 8:
Referring Dr.	<input type="checkbox"/>	
Friend/Relative #	<input type="checkbox"/>	
Other Diagnosis	<input type="checkbox"/>	
Other medications	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	
Indication for Coumadin	<input type="checkbox"/>	
Initiation date	<input type="checkbox"/>	
Duration of therapy	<input type="checkbox"/>	
Coumadin Dose (mg)	<input type="checkbox"/>	
Control (sec)	<input type="checkbox"/>	
Patient (sec)	<input type="checkbox"/>	
Ratio	<input type="checkbox"/>	
INR	<input type="checkbox"/>	
Coumadin (new dose)(mg)	<input type="checkbox"/>	
Remarks	<input type="checkbox"/>	

Below the flow sheet, there is a toolbar with icons for adding, deleting, and printing. The 'Reassign Documents' button is highlighted with a red circle. Below the toolbar, there is a text box that says 'Drag a column header here to group by that column.' and a table with columns 'Date', 'Name', and 'Owner'.

Date	Name	Owner
6/21/2010 8:46:58 AM	Coumadin flow sheet	Krista L. L

To reassign a Flow Sheet, select the Flow Sheet to reassign and Click the Reassign Documents Button (or press Control + Alt + R).

The Document Owner dialog box will be displayed. Use the drop-down menu to choose the user to assign the Flow Sheet to, and Click OK.

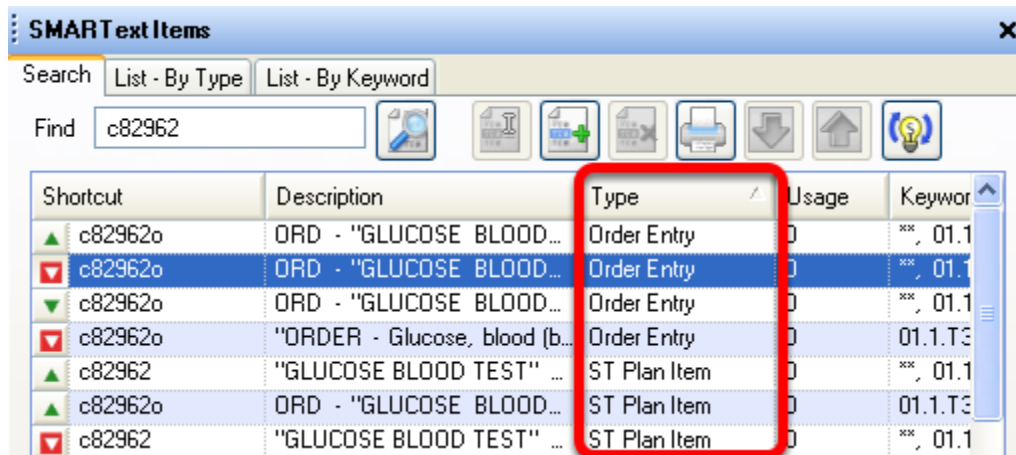
# Order Entry

## Order Entry Set Up and Quick Entry

Order Entry allows the user to place, manage, and track orders and results from within the patient chart. These orders are used in the Plan field. This SMARText Item type will display as Order Entry in the SMARText Manager window when searching. This item type is the base of all Orders in the SOAPware system. It is **IMPORTANT** to understand that the Order Entry item type is different from other SMARText Items.

*In the Security settings, there is an option to cancel the creation of a Task Item. It is generally **Not** a good idea to allow Task Item creation to be canceled. If this option is activated, it is possible to skip creating a Task Item by clicking Cancel. The order will be placed for the patient, but without an associated Task Item.*

### Order Entry SMARText Item Type



The screenshot shows the SMARText Items window with a search for 'c82962'. The table below represents the data shown in the window:

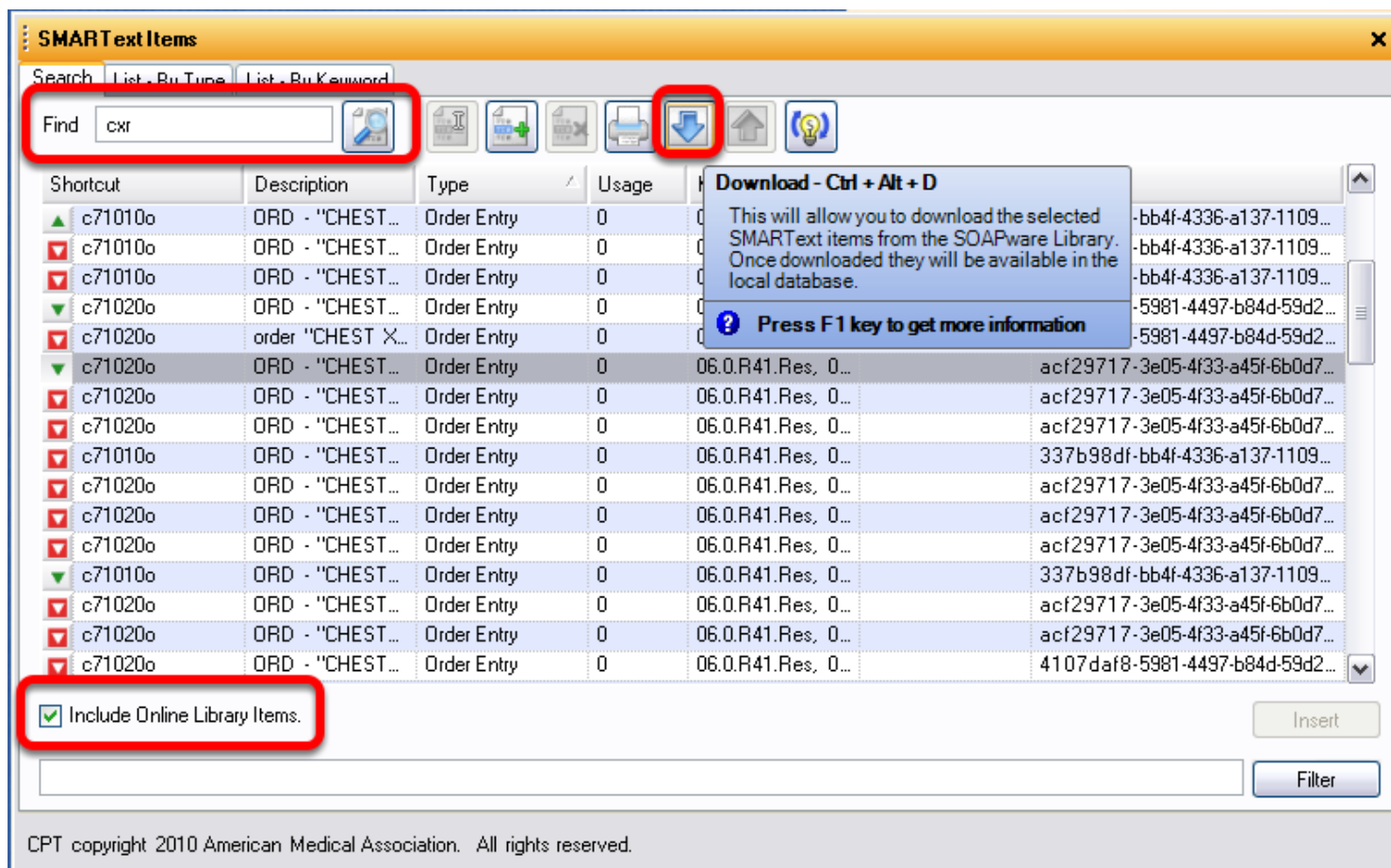
Shortcut	Description	Type	Usage	Keyword
▲ c82962o	ORD - "GLUCOSE BLOOD..."	Order Entry	0	xx, 01.1
▼ c82962o	ORD - "GLUCOSE BLOOD..."	Order Entry	0	xx, 01.1
▼ c82962o	ORD - "GLUCOSE BLOOD..."	Order Entry	0	xx, 01.1
▼ c82962o	"ORDER - Glucose, blood (b..."	Order Entry	0	01.1.T3
▲ c82962	"GLUCOSE BLOOD TEST" ...	ST Plan Item	0	xx, 01.1
▲ c82962o	ORD - "GLUCOSE BLOOD..."	ST Plan Item	0	01.1.T3
▼ c82962	"GLUCOSE BLOOD TEST" ...	ST Plan Item	0	xx, 01.1

Because of the way Order Entry SMARText Items are designed:

- 1) They **cannot** be searched and inserted into the plan field by using F11 or Shift F11.
- 2) They **cannot** be part of a SMARText Pick List.
- 3) They **cannot** be selected from SMARText Quick Access.
- 4) They **cannot** be inserted into the Plan field by using a shortcut macro.



## Downloading Order Entry SMARText Items



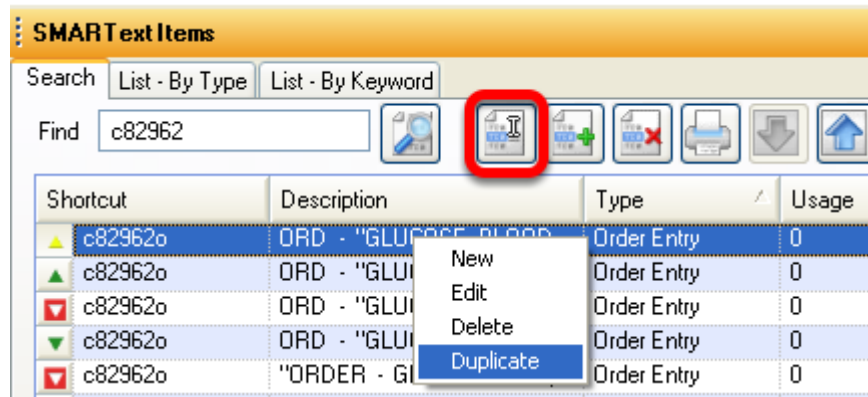
It is necessary to first go to the SMARText Items Manager and download the Order Entry items that will be used in the clinical practice. This can be accessed from Docutainers menu item or pressing the F10 key. Verify the check box for Include Online Library Items is checked.

To download the order entry items that will be used in the clinical practice:

- 1) Make a list of the most frequently used Orders in the practice (Orders are any diagnostic test or procedure that need to be performed inhouse or outside of the clinic).
- 2) Search for all of the Order Entry items in the SMARText Items Manager to download them. Users can search for Order Entry items using the name of the diagnostic test or procedure or by using the CPT code.
  - In the Type column, the Order Entry item can be identified. Clicking on the Type column header will group the SMARText Items together by Type.
- 3) After items have been downloaded, customization of the Order Entry sub-items can be made if needed. Rarely should new items be created.

**\*Note:** Users will not be able to download any CPT codes that have a red downward facing triangle.

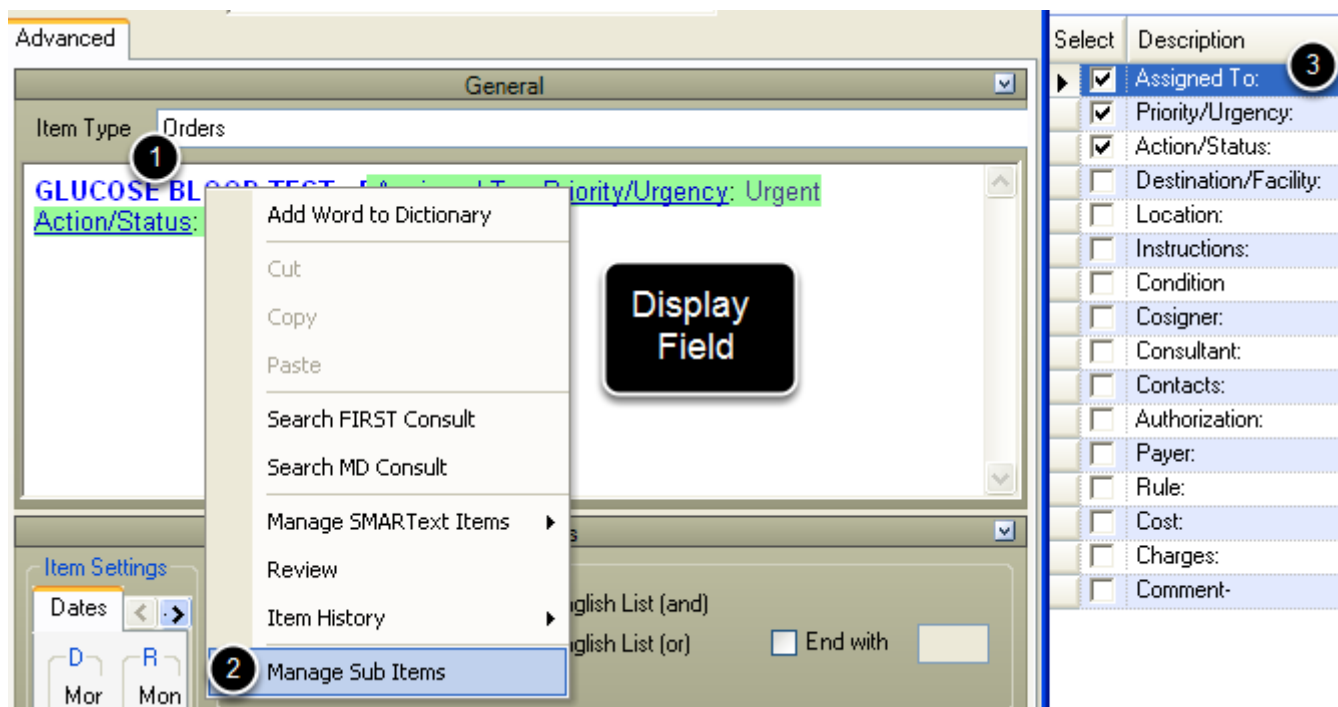
## Customization Order Entry Sub-Items



To display customized Order Entry sub-items in the SMARText Quick Access window follow these steps:

- 1) Duplicate the item to be customized by Right-clicking over the Order Entry Item and Click on Duplicate.
- 2) Click on the edit button to begin the customization.
- 3) Drag the SMARText Designer so that it is next to SMARText Quick Access.

## Selecting Sub-Items To Be Displayed In Order Entry SMARText Items

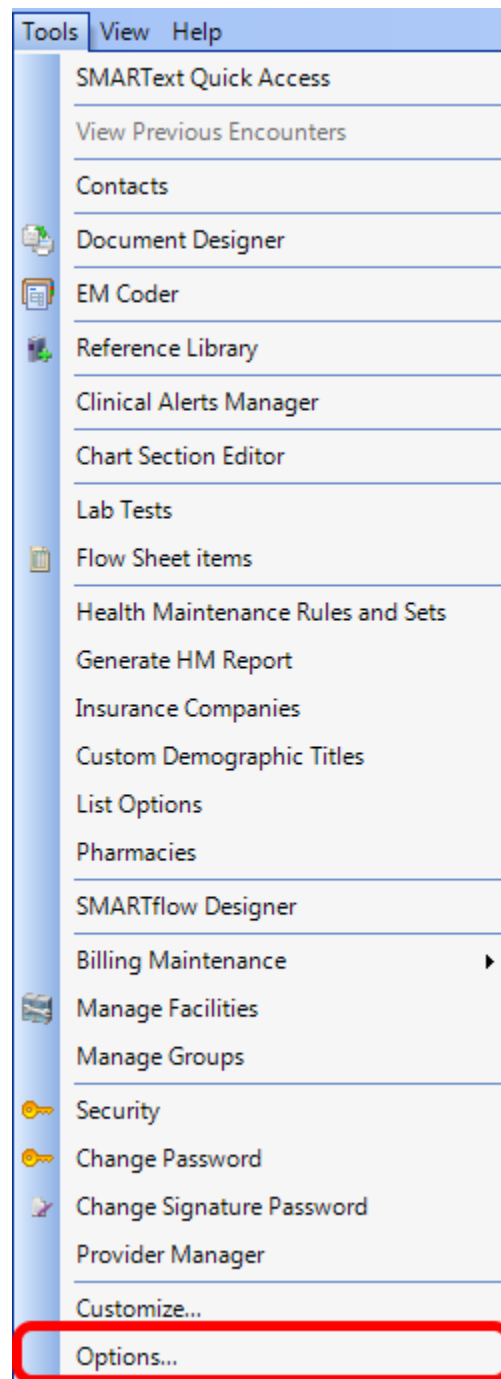


1) Right-click anywhere on the blue/bold words of the Display Header that is shown in the Display field of the SMARText Designer.

2) Click Manage Sub-Items.

3) Select Sub-Items to be used in SMARText Quick Access; For example: Click Assigned To to display a list of users set up for the practice.

## Customize Order Manager and Plan Field Sub-Items



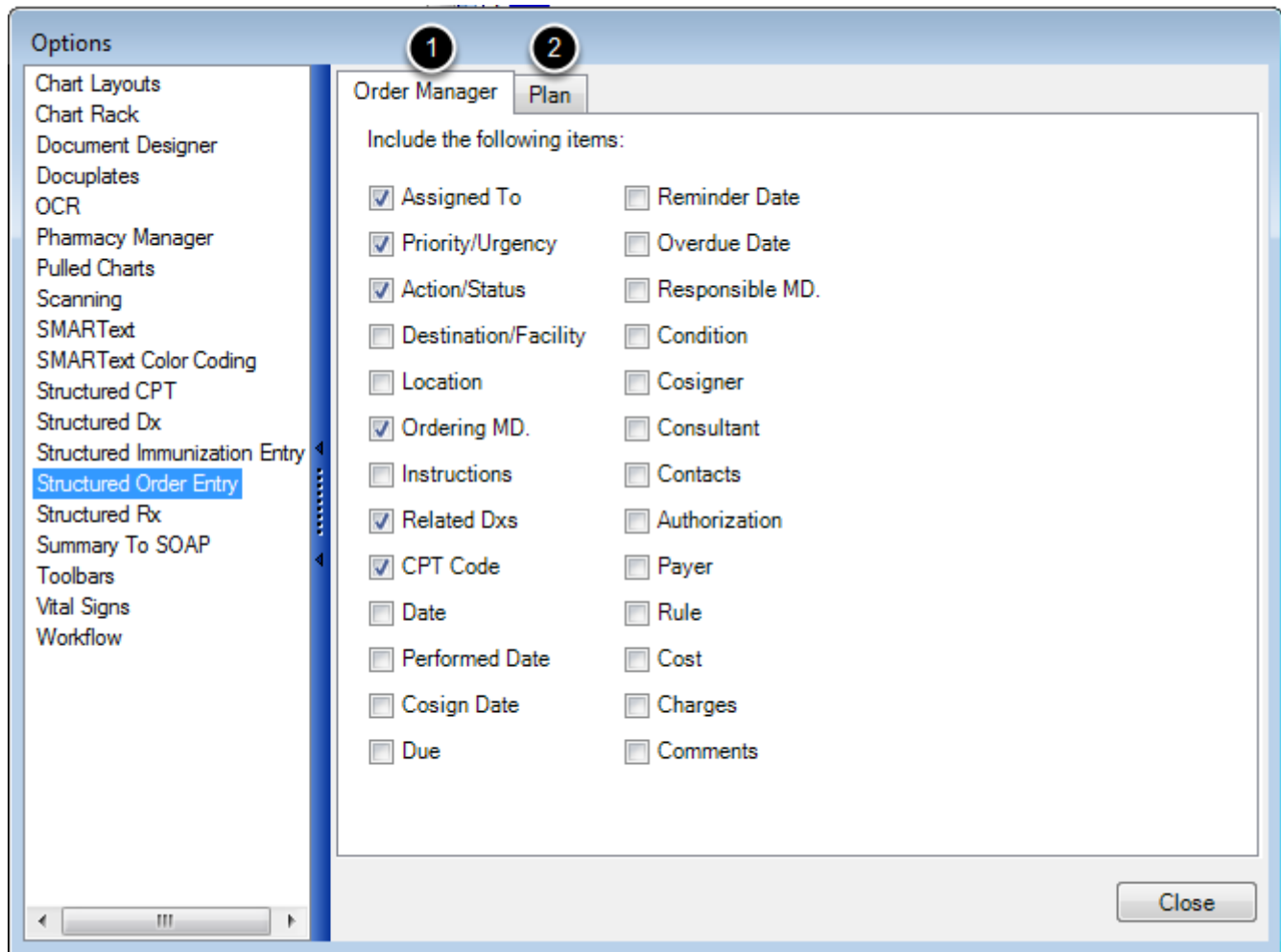
Order Entry sub-items that are displayed in Order Manager can be customized under the Tools menu item.

1) Click the Tools menu item.

2) Click Options.

3) Click Structured Order Entry.

## Structured Order Entry

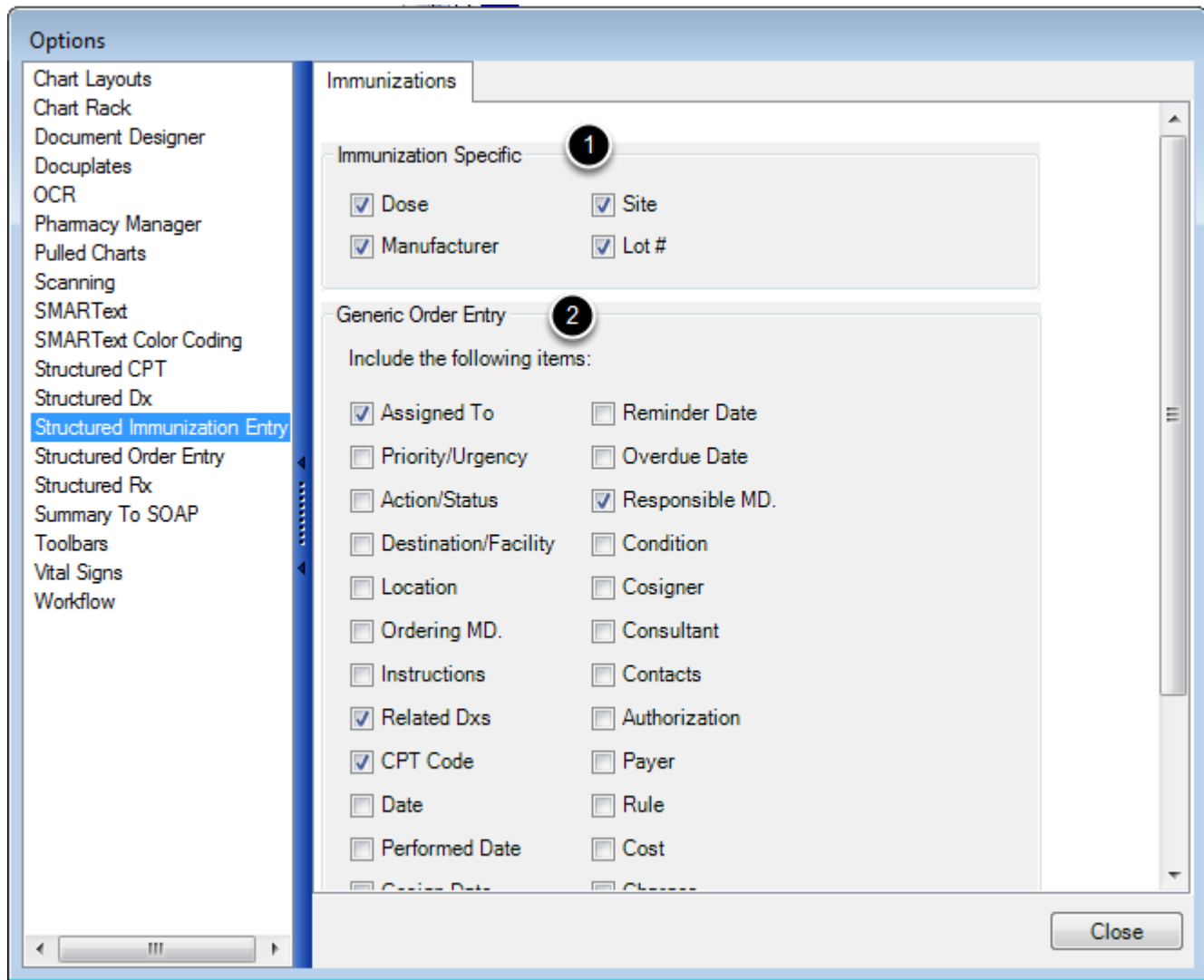


There are two tabs for Structured Order Entry sub-items:

1) Order Manager

2) Plan

Sub-items may be customized for both Order Manager and the Plan field (i.e. after an order is entered into a SOAPnote). Rarely, if ever, would most users want more than 2-4 sub-items displayed. Un-checking a sub-item box in SMARText Quick Access is recommended instead of deleting the sub-item.

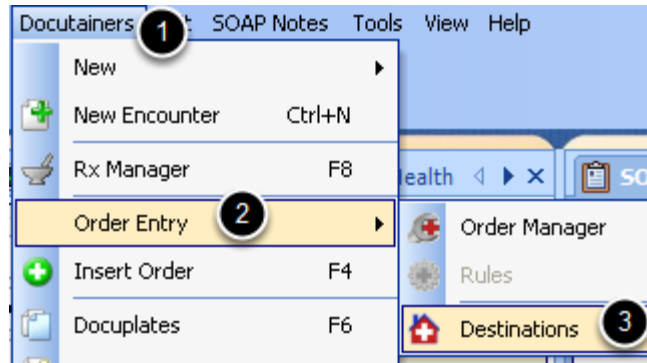


The immunization Entry set up will include 2 areas.

1) Immunization Specific Setup- This will show sub items specific to immunizations. These sub-items are required for reporting to state registries for Meaningful Use.

2) Generic Order Entry Setup- This will show sub-items that will be displayed in the Order Manager.

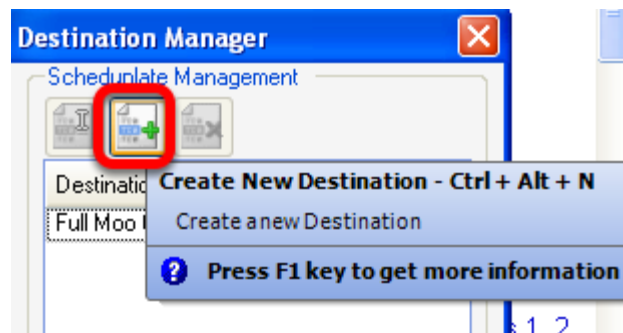
## Order Entry Destination Set Up



Order Entry Destinations are facilities that are user defined where orders can be submitted. For example, Memorial Hospital Lab might be a destination. It is a place to send orders (i.e. tests, labs, studies, procedures, equipment, etc.) to be processed.

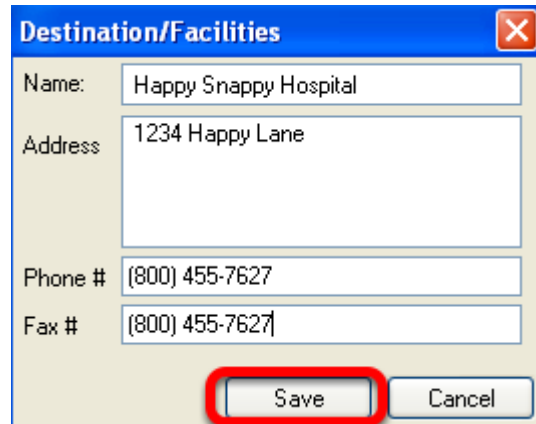
- 1) Click Docuainers.
- 2) Click Order Entry.
- 3) Click Destinations.

## Destination Manager



Click the **Green +** to enter information for a new Destination. Click the edit button to edit the information for a Destination or the remove button to remove the Destination from list.

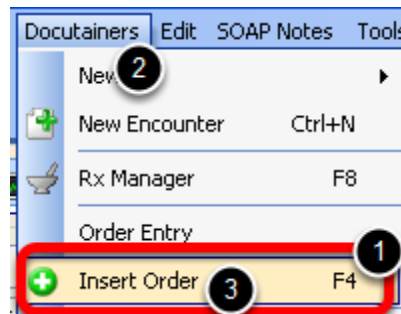
## Destination Demographics



A screenshot of a 'Destination/Facilities' dialog box. It contains four text input fields: 'Name' with 'Happy Snappy Hospital', 'Address' with '1234 Happy Lane', 'Phone #' with '(800) 455-7627', and 'Fax #' with '(800) 455-7627'. At the bottom are 'Save' and 'Cancel' buttons. The 'Save' button is highlighted with a red rectangle.

Enter the demographic information for the new Destination and Click Save.

## Quick Entry for Orders (Insert Order or F4)



There are 2 methods for inserting orders into SOAPnotes. One way is via the Order Manager, and the second is via Quick Entry (Insert Order or F4).

With a patient chart and SOAPnote open:

- 1) Press the F4 key or
- 2) Click on Docutainers menu item.
- 3) Click Insert Order.

**\*NOTE\*** The Quick Entry (F4) will **NOT** place items on the billing statement. **The Quick Entry Method cannot be used when ordering immunizations for reporting to state registries for Meaningful Use.**



## Place Order Dialog

**Place Order**

Find

Shortcut	Description	Type
c82947s	"Schedule - LAB - Glucose (FBS) Serum/Plasma" (CPT#829...	Order Entry
c82947s	"Schedule - LAB - Glucose (Random) Serum or Plasma" (CPT...	Order Entry
c80069o	ORD - "RENAL FUNCTION PANEL" (LAB - Renal Panel - 80...	Order Entry
c82962o	ORD - "GLUCOSE BLOOD TEST" (LAB - Whole Blood, by GL...	Order Entry
c80048o	ORD - "METABOLIC PANEL TOTAL CA" (LAB - BMP/Chem...	Order Entry
c80053o	ORD - "COMPREHEN METABOLIC PANEL" (LAB - CMP/Ch...	Order Entry
c82947o	ORD - "ASSAY, GLUCOSE, BLOOD QUANT" (LAB - FBS, Se...	Order Entry
c82962o	ORD - "GLUCOSE BLOOD TEST" (LAB - Whole Blood, by GL...	Order Entry
c82947o	ORD - "ASSAY, GLUCOSE, BLOOD QUANT" (LAB - Random,...	Order Entry
c82948o	ORD - "REAGENT STRIP/BLOOD GLUCOSE" (LAB - Finger...	Order Entry

The desired orders can be found either by searching in the Find field/box or by scrolling through the Place Order list. To use the Find/Search method, type the **shortcut or keyword** in the Find field, and Click the Search button. *This only searches the local database and does not search the online library.*

## Task Order

**Task Order**

Description:

Owner:

Due:

Priority:

Type:

Notes:

Assigned To:

Reminder:

Action/Status:

Click to select the user the task needs to be assigned to from the Assigned To drop-down menu, and then Press the Select Button.

For Quick Entry to be most efficient, it is advised that the clinician's pre-define and store the Assigned To and other values. If this is done, entering an order can be done in three easy steps:

1) Press F4.

2) Type the order's shortcut.

3) Press Enter.

The order has been placed into the SOAPnote Plan field, and an associated Task Item has been created to track the order.

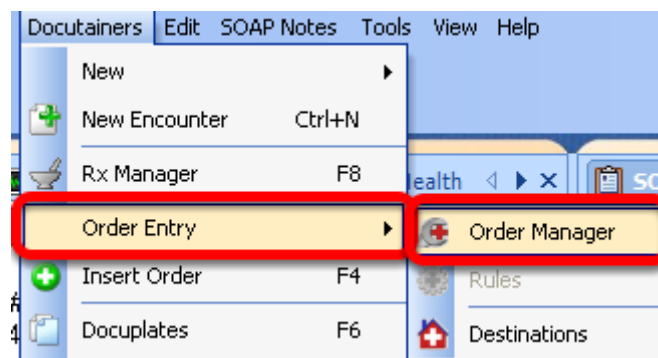
## Order Manager

This section is a continuation of Order Entry Set Up. If Set Up has not been done, please do this first and return to this page before continuing.

The order manager will be used when placing orders for in house tests and procedures as well as tests and procedures to be sent to an outside facility. The Order Manager must be used for immunizations that are to be reported to state registries.

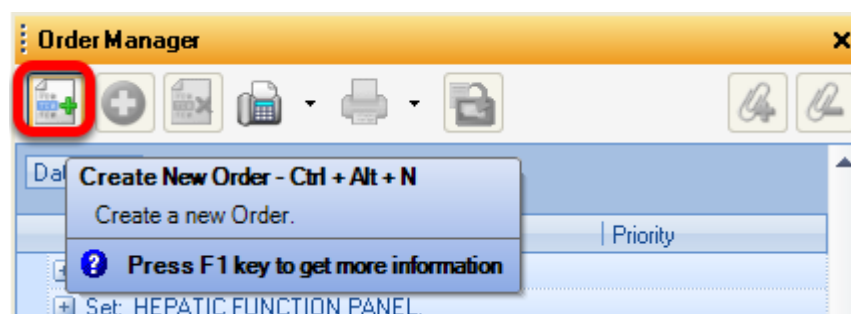
*In the Security settings, there is an option to cancel the creation of a Task Item. It is generally **NOT** a good idea to allow Task Item creation to be canceled. If this option is activated, it is possible to skip creating a Task Item by clicking Cancel. The order will still be placed for the patient, but without an associated Task Item.*

### Placing an Order in Order Manager



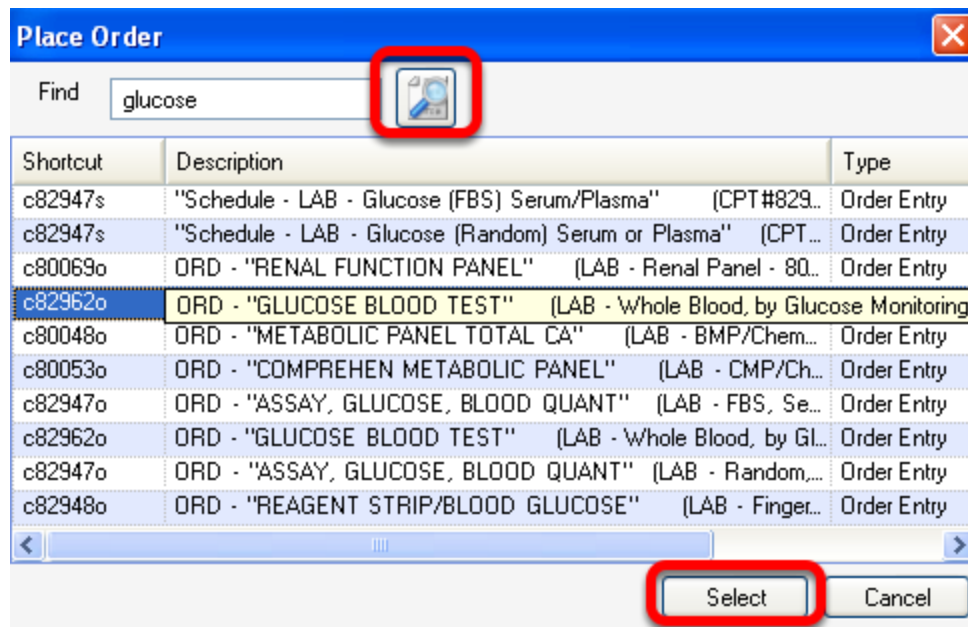
With a patient chart and SOAPnote open, Click Docutainers, Order Entry and then Click Order Manager to place an order.

### Order Manager Display Window




Click the Create new Order button.



## Place Order Display Window



**Place Order**

Find  

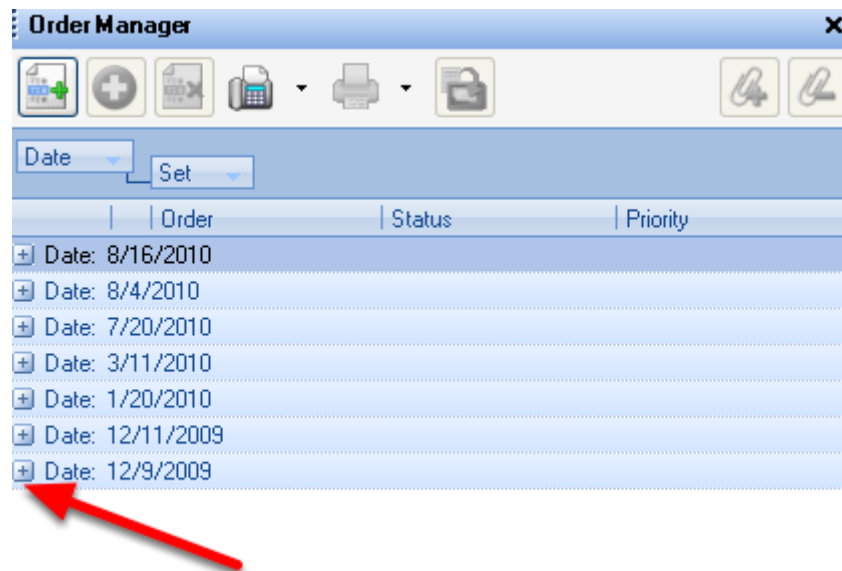
Shortcut	Description	Type
c82947s	"Schedule - LAB - Glucose (FBS) Serum/Plasma" (CPT#829...	Order Entry
c82947s	"Schedule - LAB - Glucose (Random) Serum or Plasma" (CPT...	Order Entry
c80069o	ORD - "RENAL FUNCTION PANEL" (LAB - Renal Panel - 80...	Order Entry
c82962o	ORD - "GLUCOSE BLOOD TEST" (LAB - Whole Blood, by Glucose Monitoring	Order Entry
c80048o	ORD - "METABOLIC PANEL TOTAL CA" (LAB - BMP/Chem...	Order Entry
c80053o	ORD - "COMPREHEN METABOLIC PANEL" (LAB - CMP/Ch...	Order Entry
c82947o	ORD - "ASSAY, GLUCOSE, BLOOD QUANT" (LAB - FBS, Se...	Order Entry
c82962o	ORD - "GLUCOSE BLOOD TEST" (LAB - Whole Blood, by GL...	Order Entry
c82947o	ORD - "ASSAY, GLUCOSE, BLOOD QUANT" (LAB - Random,...	Order Entry
c82948o	ORD - "REAGENT STRIP/BLOOD GLUCOSE" (LAB - Finger...	Order Entry









**Select** **Cancel**

Type the Shortcut or keyword in the Find field, and Click the Search button. *This only searches the local database and does not search the online library.*

When the preferred Order Entry item appears in the list of items, Double-Click the order list item or Click on the order list item and Click the Select button.



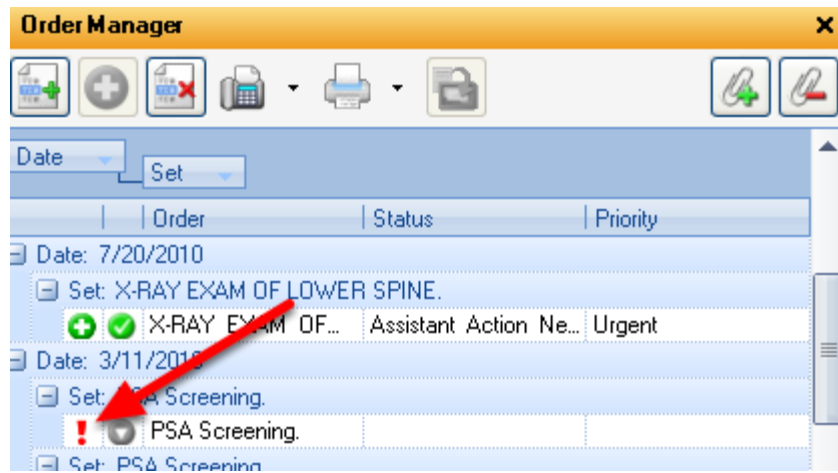
**Order Manager**

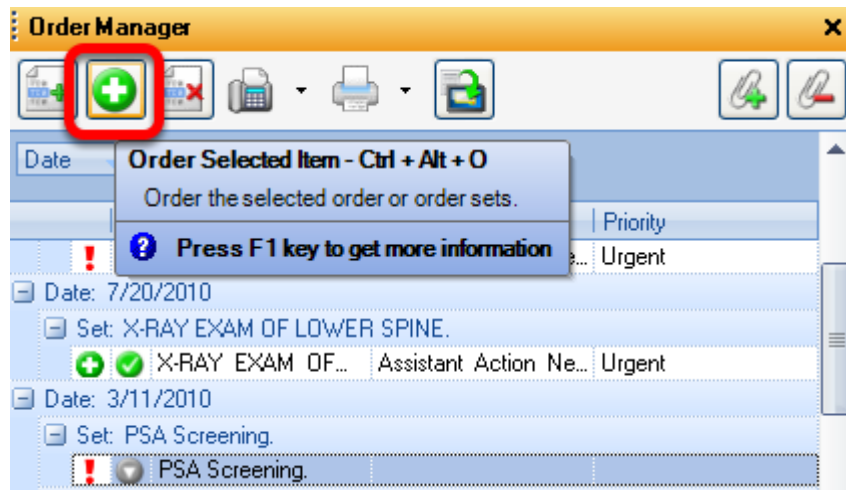
Date  Set

	Order	Status	Priority
+ Date: 8/16/2010			
+ Date: 8/4/2010			
+ Date: 7/20/2010			
+ Date: 3/11/2010			
+ Date: 1/20/2010			
+ Date: 12/11/2009			
+ Date: 12/9/2009			

The first time Order Manager is used Click on the plus sign (+) next to Date.



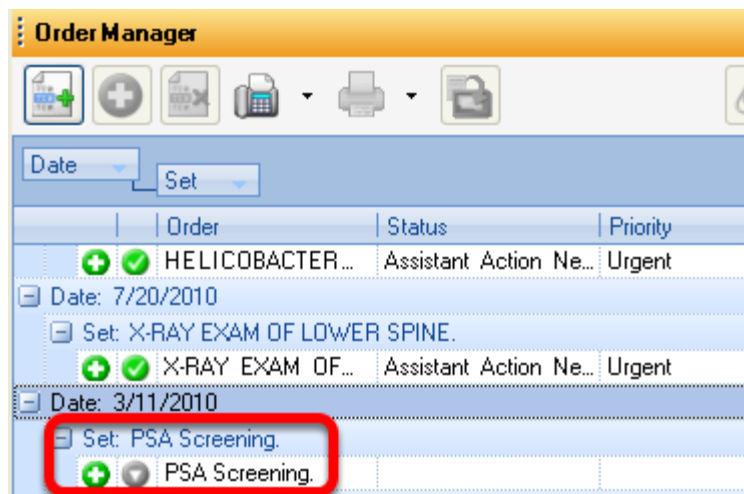
Click on the plus sign (+) next to Set. Notice the "!" in front of the order. This is a warning that the order has not yet been placed or performed.



To place the order, Click the Order Selected Item Button.

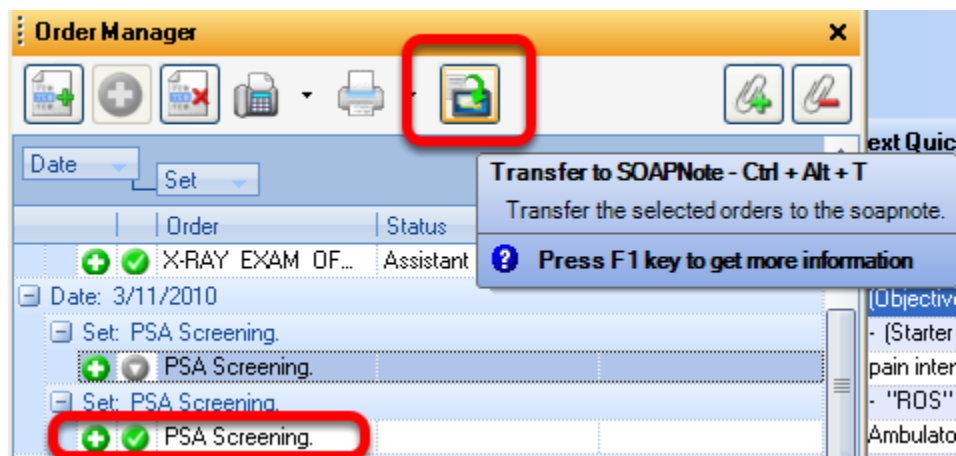
Task Order			
Description	PSA Screening.		
Owner	Rena Thornton	Assigned To	Doodle Bugs
Due	8/16/2010	Reminder	8/16/2010 1:21:02 PM
Priority		Action/Status	
Type	Orders		
Notes			
		Select	Cancel

Click to select the user the task needs to be assigned to from the Assigned To drop-down menu, and then Press the Select button. *This step can be skipped if Assigned To has been pre-defined.*



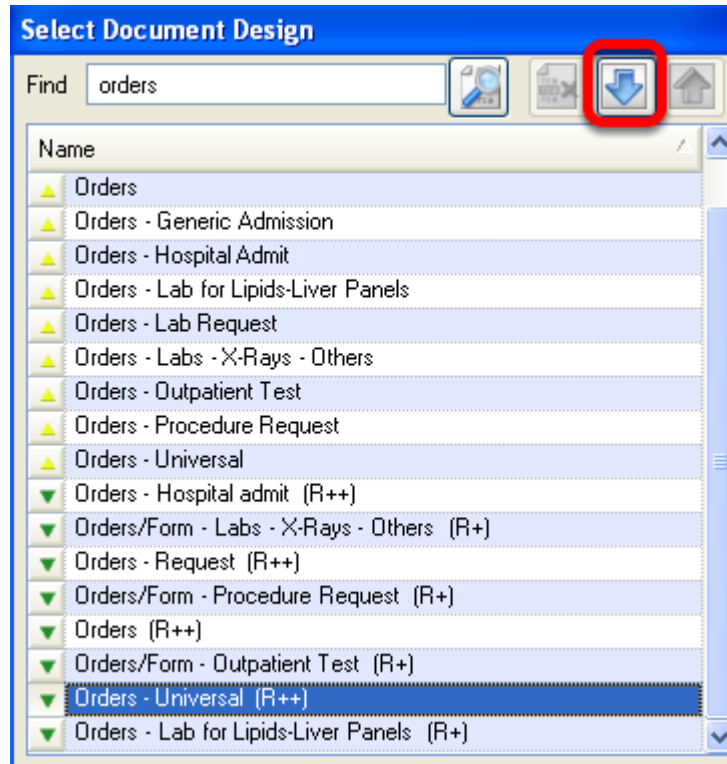
This completes the placing of the order and replaces the "!" with a "+". In most situations, the orders still need to be transferred into the Plan field of the current SOAPnote.

### Transferring an Order to the SOAPnote



Click to highlight the order item to transfer. Next, Click the Transfer to SOAPnote button. A green check mark indicated the order has been transferred to the Plan field of the SOAPnote.

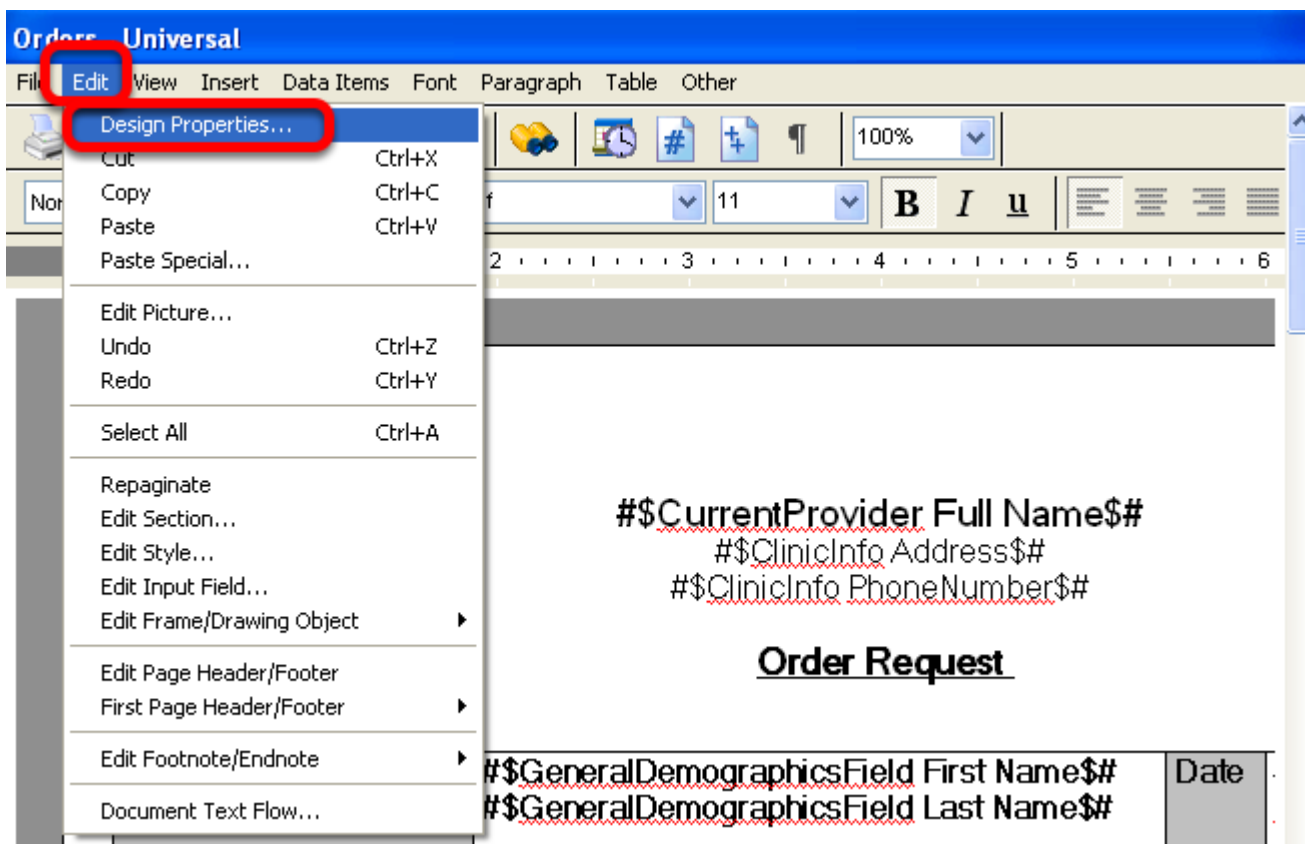
## Selecting an Order Design in Document Designer for Faxing and Printing



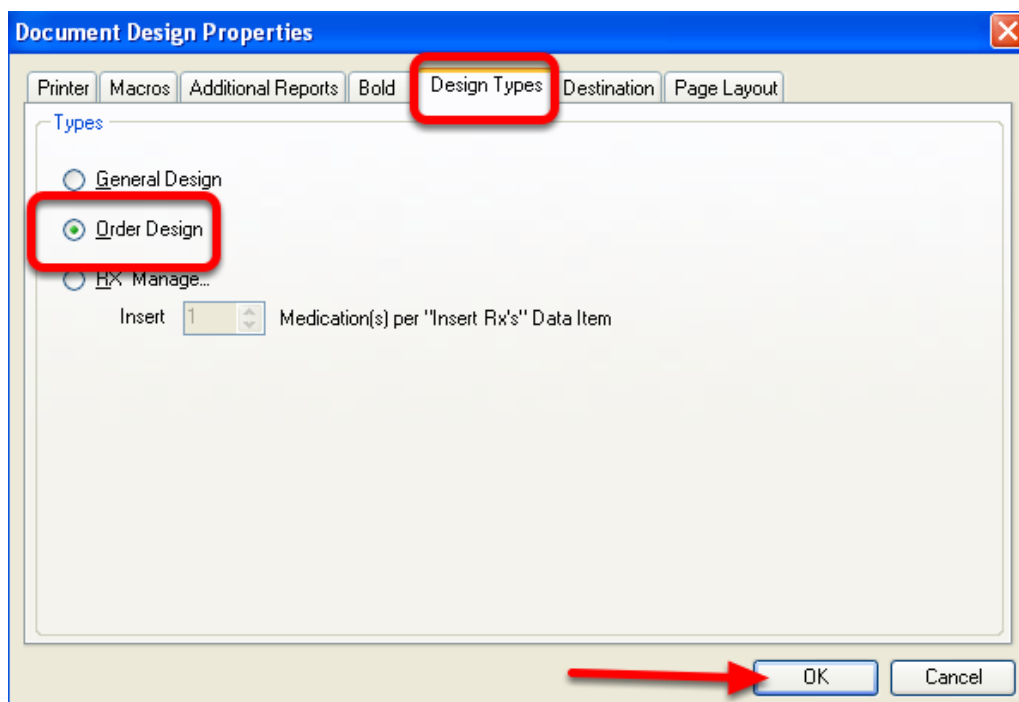
An Order Design will need to be downloaded from Document Design and selected as the Order Design when faxing and printing. This will be done from the Tools menu item and clicking on Document Designer.

In Document Designer:

- 1) Go to the File menu item.
- 2) Click on Available Designs.
- 3) In the Find field, search for Orders. The user will see two Order Design options; Orders and Orders Universal. Preview Design by clicking on the name of the Design to highlight, then Click OK.
- 4) If the triangle next to the Design is facing down, the Design will need to be downloaded before used. Click on the blue facing down arrow to download.

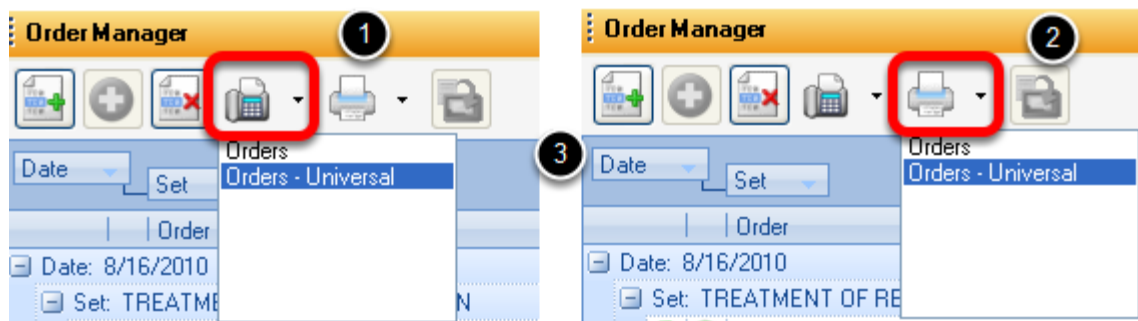


With the Order Design displayed in the window, Click on the Edit menu item. Click on Design Properties.



In the Document Design Properties window, Click on the Design Types Tab and Click the bubble next to Order Design and Click Ok. This will save the selected Order Design to the Order Manager.

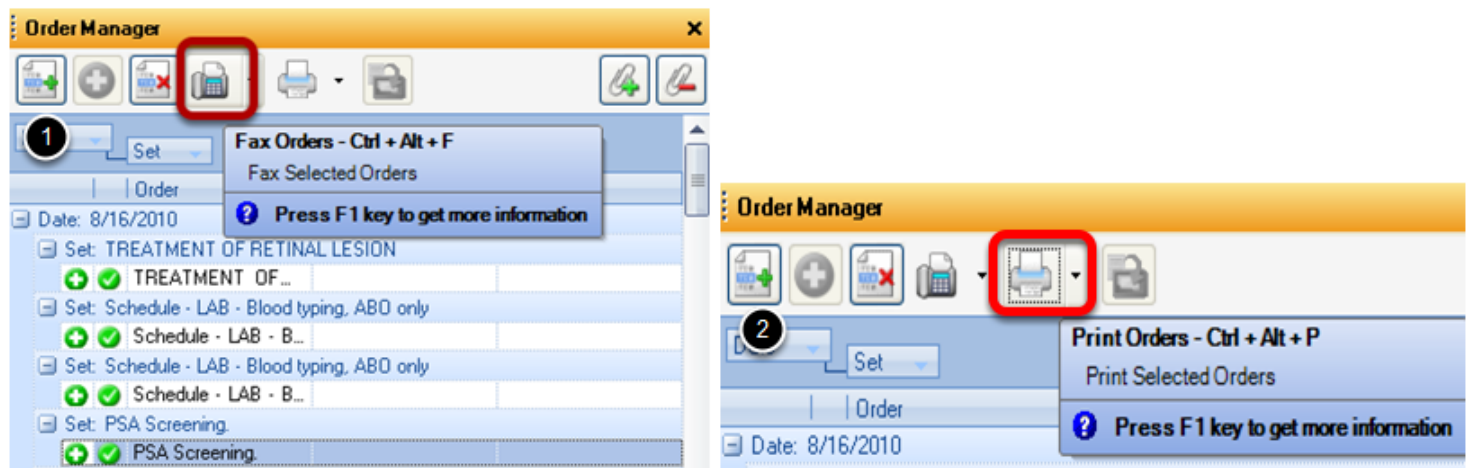




If more than one Design has been chosen to use for faxing or printing, they will be listed when clicking on the drop down arrow on the faxing and printing button to select. The same list will populate for both faxing and printing.

- 1) Faxing drop down menu
- 2) Printing drop down menu

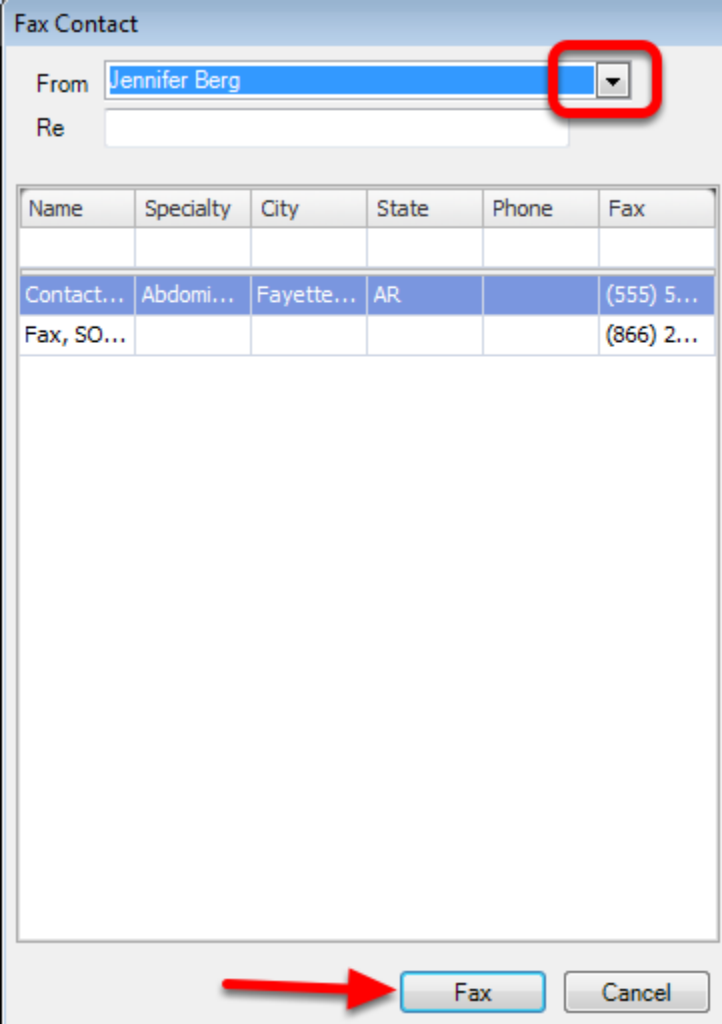
## Faxing and Printing an Order



Click on test or procedure to be faxed to highlight a selection. *Only one selection can be faxed or printed. Multiple selection is not available at this time.*

- 1) Fax Order
- 2) Print Order

## Fax Contact Window



The screenshot shows the 'Fax Contact' window. At the top, there is a 'From' field with a dropdown arrow next to 'Jennifer Berg', which is circled in red. Below it is a 'Re' field. A table with columns 'Name', 'Specialty', 'City', 'State', 'Phone', and 'Fax' is displayed. The table has two rows: 'Contact...' with values 'Abdomi...', 'Fayette...', 'AR', and '(555) 5...'; and 'Fax, SO...' with values and '(866) 2...'. At the bottom, there is a 'Fax' button circled in red with a red arrow pointing to it, and a 'Cancel' button.

Name	Specialty	City	State	Phone	Fax
Contact...	Abdomi...	Fayette...	AR		(555) 5...
Fax, SO...					(866) 2...

In this window the provider that is sending the order can be chosen by using the drop-down arrow. This Fax Contact List will Pull from a user's Contact Manager.  
To fax, Click the Fax button.

For instructions on how to add contacts to the Contact manager [Click Here](#).

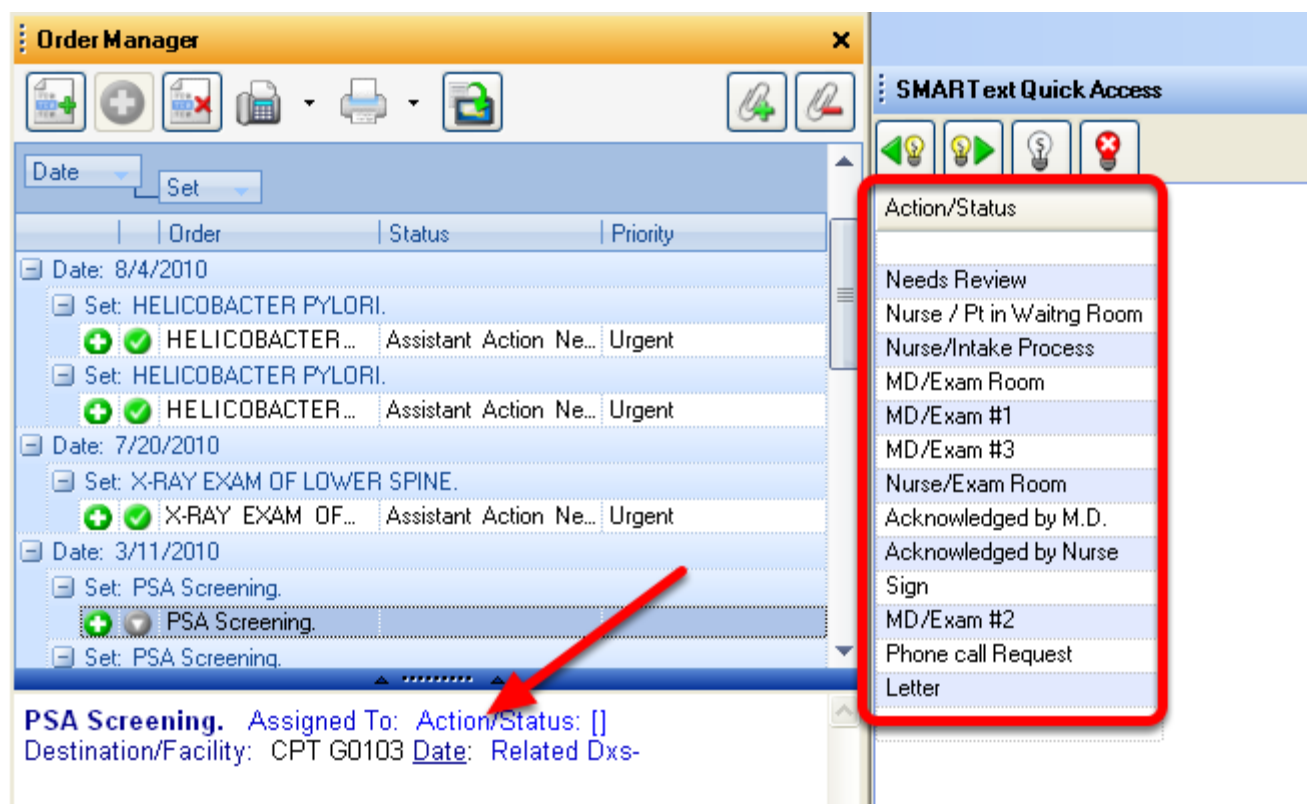
## Adding Order to Billing Statement



Adding orders to the Billing Statement is performed from Order Manger. Click on the **green** plus " + " to add or the **red** minus sign " - " to remove from from the Billing Statement. Only add orders or procedures to the Billing Statement that have been performed in-house for billing purposes.

## Editing an Order

Before placing or performing an order, the user has the option of editing that order. Some order sub-items may be set to default when originally designed. Any of the sub-item default values can be changed within Order Manager prior to placing or performing the order.



Left-click on an order sub-item (i.e. the blue, underlines SMARText Item) in the lower pane of the Order Manager window. This will display the pick list options for the order item in SMARText Quick Access. Click to highlight an Action/Status to be displayed for the order.

This displays a pick list for Action/Status in SMARText Quick Access.

After completing the edits for the sub-items in the order, Click the Order Selected Item button to place or perform the order.

## Order Entry Important Notes

- 1) Order Entry Items can only be entered into charts via the Order Manager or the Quick Insert (F4). They will **NOT** function properly if entered with shortcut codes directly into the SOAPnote Plan field.
- 2) Quick Insert (F4) will not transfer item to the billing statement and cannot be used for immunizations.
- 3) Searching for Order Entry Items that are in the online library is not yet possible from within the Order Manager. Only the items that are in the local database are available. This makes

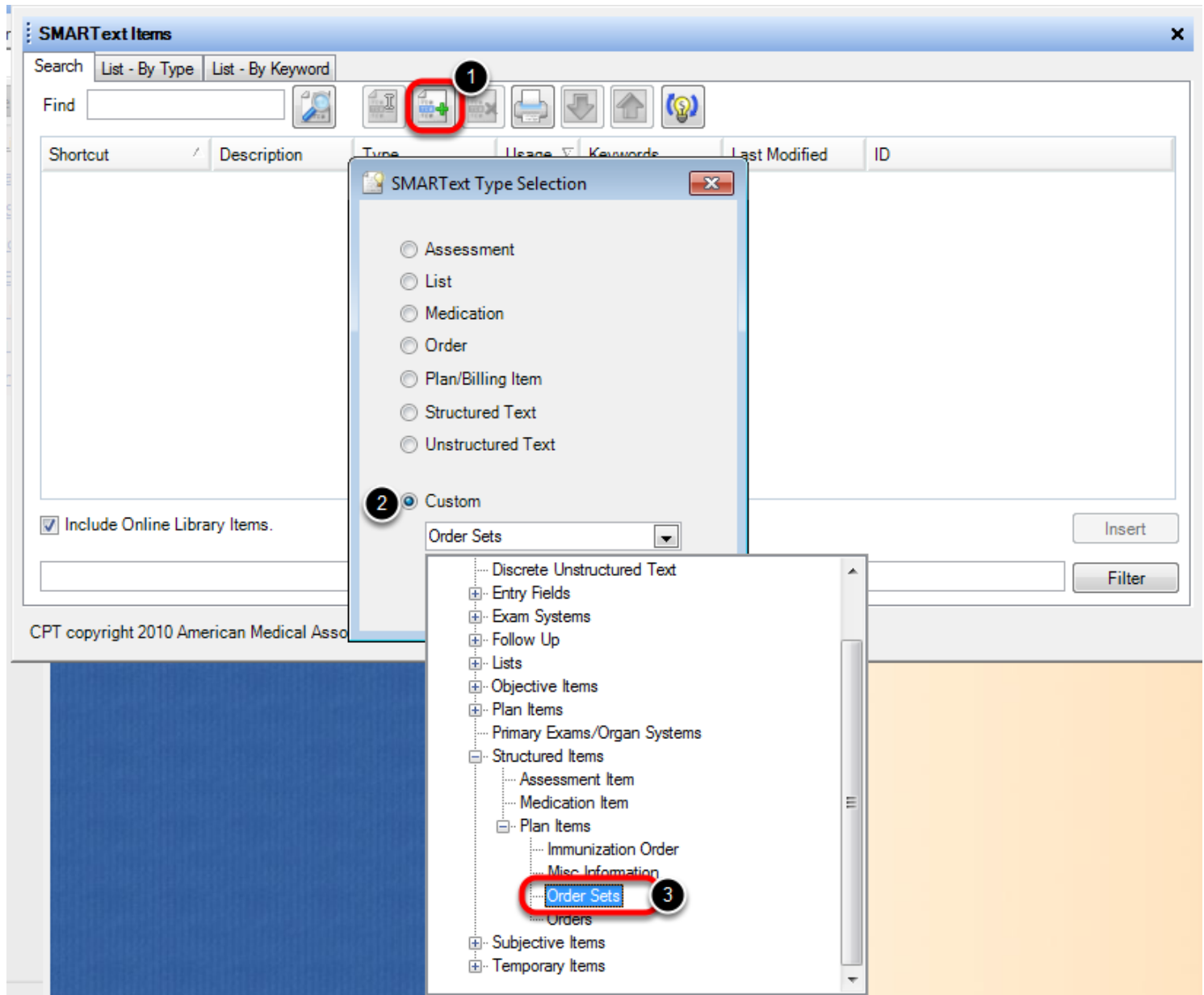
downloading of needed orders necessary from within SMARText Items Manager before searching for them in Orders Manager.

4) Order Entry is currently a first phase implementation. Some functions have yet to be implemented.

## Creating Order Sets

An Order set is a group of multiple orders. When the Order Set is entered the orders within the order set will be entered. This lesson will demonstrate the steps necessary to create an Order Set. Most providers have several, common, standing orders that are repeatedly selected. Order sets allow the provider to enter one order set and multiple orders will be placed.

### Creating the Order Set Item



To Create a new Blank Order Open the SMARTText Items Manager using the keyboard command of F10 or by Selecting Docutainers > SMARTText Items.

1. Create a new Item.

2. Select Custom.
3. Click Order Sets.

Select Create.

SMARTText Designer

Shortcut

Description

Keywords

☒ Display Header  ☐ only when item is empty.

Advanced

General

Item Type

Item Properties

Item Settings

Item Separators

☐ As Is ☐ English List (and)

☐ Separate with  ☐ English List (or) ☐ End with

☒ Separate Lines

☒ Include in EM Coder point calculations.

Remove this item via Remove Unused -

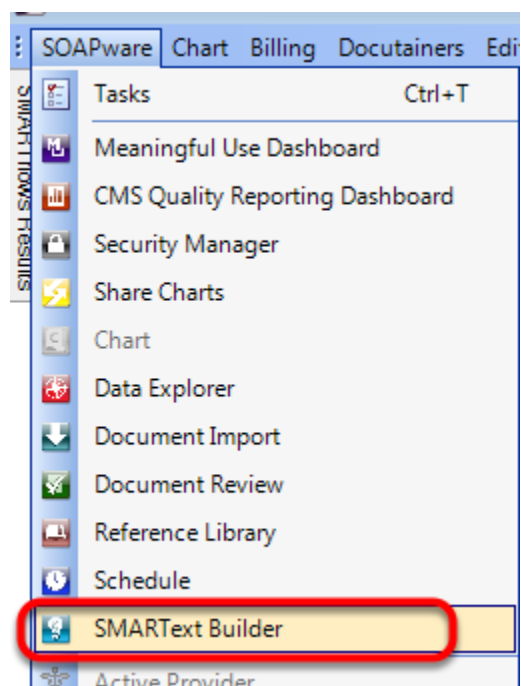
Coding / Notes

Structure Viewer

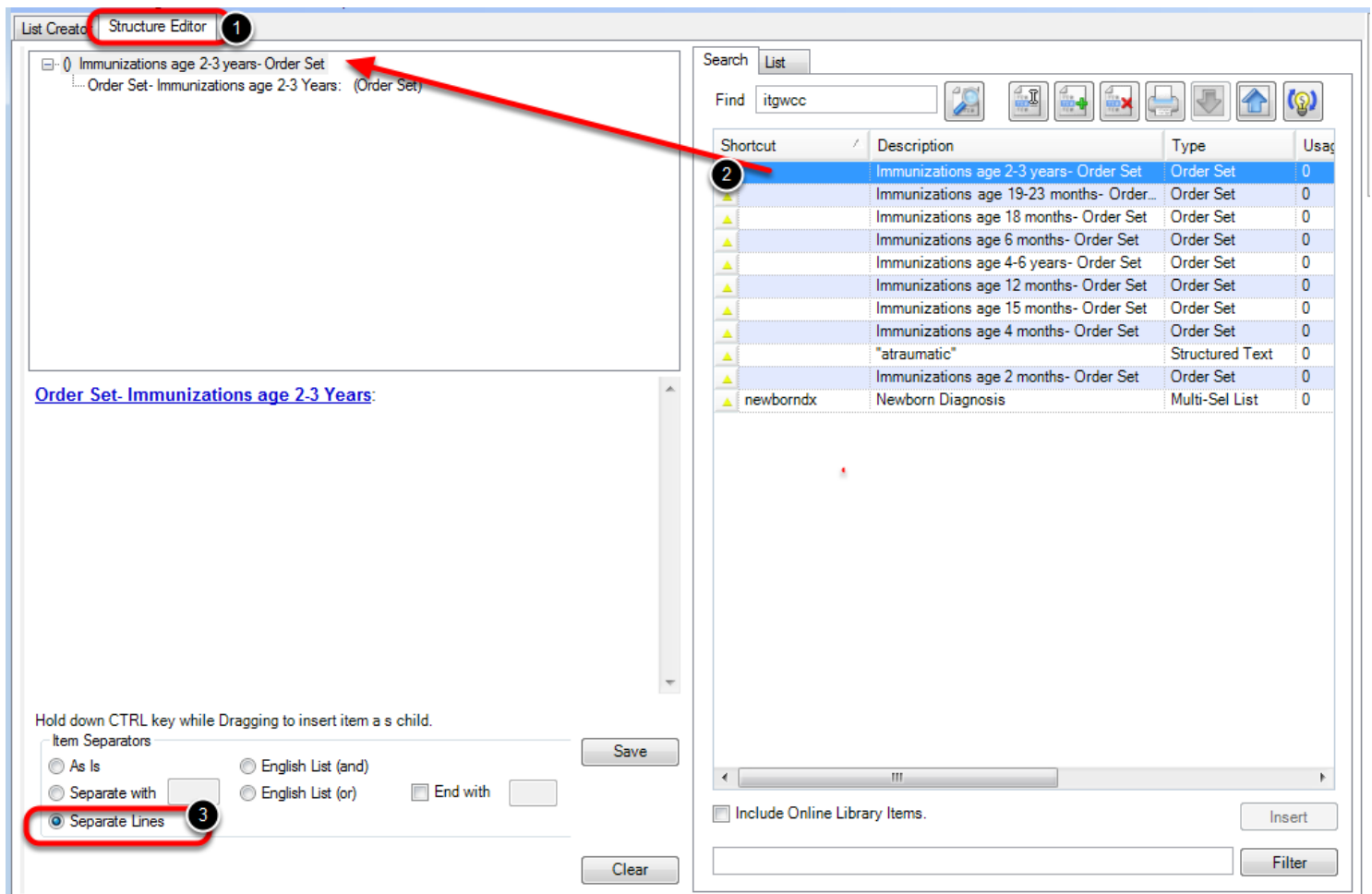
Save Cancel

1. Enter Shortcut, Description, Keywords and Display Header.
2. Select Item Separator of Separate Lines.
3. Click Save.

## Open the SMARText Builder Workspace



Click on SOAPware and Select SMARText Builder.



1. Click on the Structure Editor Tab.
2. Find Order Set create in the previous steps.
3. Drag the item From the Search tab in the Structure Editor Tab. Select Item Separator of "Separate Lines".



## Select Orders for the Order Set

The screenshot shows the 'List Creator' interface with the 'Structure Editor' tab selected. The left pane displays the order set structure for 'Immunizations age 2-3 years - Order Set'. The right pane shows a search for 'pneumococcal' with a list of results. A red box highlights the search results, and a red arrow points from the search results to the 'PNEUMOCOCCAL VACC, PED <5' item in the order set structure. A red box highlights the 'Order Set: Immunizations age 2-3 Years: PNEUMOCOCCAL VACC, PED <5' header in the order set structure.

**Order Set: Immunizations age 2-3 Years: PNEUMOCOCCAL VACC, PED <5.** Assigned To: Priority/Urgency: Action/Status: Destination/Facility: Location: CPT 90669 Ordering MD: Jennifer Berg Instructions: Date: 4/11/2011 Performed Date/Time: Cosign Date: Due: Reminder Date: Overdue Date: Ordering Clinician: Jennifer Berg Condition: Cosigner: Consultant: Contacts: Authorization: Payer: Rule: Cost: Charges: Dose: Manufacturer: Lot #: Site: Related Dx: Comment:

Shortcut	Description	Type	Usage
	Pneumococcal Vaccines Drug Intolerance	Allergy	0
	Pneumococcal Vaccines Drug Allergy	Allergy	0
PnePne	"Pneumococcal pneumonia" (ICD-481)	Dx	0
PneSep	"Pneumococcal sepsis" (ICD-038.2)	Dx	0
c90669oi	ORDi - "PNEUMOCOCCAL VACC, PED...	Immunization Or...	0
c90732oi	ORDi - "PNEUMOCOCCAL VACCINE, L...	Immunization Or...	0
c90670oi	ORDi - "PNEUMOCOCCAL VACC, 13 V...	Immunization Or...	0
PQRlpne	"Pneumococcal vaccination and age 65 o...	Multi-Sel List	0
cG0009o	ORD - "Admin pneumococcal vaccine" ...	Order Entry	0
cG0009o	ORD - "ADMINISTRATION OF PNEUM...	Order Entry	0
c90732o	ORD - "PNEUMOCOCCAL VACCINE" (L...	Order Entry	0
c90669o	ORD - "PNEUMOCOCCAL VACC, PED...	Order Entry	0
c4040F-1P	"Pneumococcal immunization NOT recei...	ST Plan Item	0
cG0009	"Admin pneumococcal vaccine" (G00...	ST Plan Item	0
c90669	"PNEUMOCOCCAL VACC, PED <5" (L...	ST Plan Item	0
cG0009	"ADMINISTRATION OF PNEUMOCOCC...	ST Plan Item	0
c4040F-8P	"Pneumococcal immunization NOT recei...	ST Plan Item	0
c90732	"PNEUMOCOCCAL VACCINE" (INJECT...	ST Plan Item	0
c4040F	"Pneumococcal immunization administer...	ST Plan Item	0

Hold down CTRL key while Dragging to insert item as a child.

Item Separators

☐ As Is ☐ English List (and)

☐ Separate with ☐ English List (or) ☐ End with

☒ Separate Lines

Save Clear

☐ Include Online Library Items. Insert Filter

In the Example above the Order set is for Immunizations for Children ages 2-3 years. The "child" order or sub-item is the Pneumococcal Immunization Order.

1. Search for the Items to be placed in the Order Set.
2. Hold down the Control key on the keyboard, drag and drop order as a child (sub-item) of the order set on the Order Set header
3. Sub-items for this specific order may be entered at this time. Completing sub-items will auto enter information and prevent the user from having to fill these out when the order is placed.

## Adding additional Orders

**List Creator** | **Structure Editor**

**Immunizations age 2-3 years-Order Set**

- Order Set- Immunizations age 2-3 Years: (Order Set)
  - (US)
  - PNEUMOCOCCAL VACC, PED <5. (Immunization Order)
  - (US)
  - HEP A VACC, PED/ADOL, 2 DOSE. (Immunization Order)
  - IMMUNIZATION ADMIN, EACH ADD. (Order Entry)
  - IMMUNIZATION ADMIN. (Order Entry)

**Order Set- Immunizations age 2-3 Years: PNEUMOCOCCAL VACC, PED <5.** [Assigned To:](#) [Priority/Urgency:](#) [Action/Status:](#) [Destination/Facility:](#) [Location:](#) CPT 90669 [Ordering MD:](#) Jennifer Berg [Instructions:](#) [Date:](#) 4/11/2011 [Performed Date/Time:](#) [Cosign Date:](#) [Due:](#) [Reminder Date:](#) [Overdue Date:](#) [Ordering Clinician:](#) Jennifer Berg [Condition:](#) [Cosigner:](#) [Consultant:](#) [Contacts:](#) [Authorization:](#) [Payer:](#) [Rule:](#) [Cost:](#) [Charges:](#) [Dose:](#) [Manufacturer:](#) [Lot #:](#) [Site:](#) [Related Dxs:](#) [Comment:](#)

**HEP A VACC, PED/ADOL, 2 DOSE.** [Assigned To:](#) [Priority/Urgency:](#) [Action/Status:](#) [Destination/Facility:](#) [Location:](#) CPT 90633 [Ordering MD:](#) Jennifer Berg [Instructions:](#) [Date:](#) 4/11/2011 [Performed Date/Time:](#) [Cosign Date:](#) [Due:](#) [Reminder Date:](#) [Overdue Date:](#) [Ordering Clinician:](#) Jennifer Berg [Condition:](#) [Cosigner:](#) [Consultant:](#) [Contacts:](#) [Authorization:](#) [Payer:](#) [Rule:](#)

Hold down CTRL key while Dragging to insert item as a child.

Item Separators

☐ As Is ☐ English List (and)

☐ Separate with  ☐ English List (or) ☐ End with

☒ Separate Lines

[Save](#) [Clear](#)

**Search** [List](#)

Find 90471

Shortcut	Description	Type	Usage
c90471o	ORD - "IMMUNIZATION ADMIN" (INJ...	Order Entry	0
c90471	"IMMUNIZATION ADMIN" (INJECTIO...	ST Plan Item	0

☐ Include Online Library Items. [Insert](#)

[Filter](#)

Repeat the process described in the previous step.

While holding down the Control key on the keyboard, drag and drop the second order on the header of the order set.

Order sets may contain Order Items and Immunization Order Items.

The Order Set may now be entered using Order Manager. For More information on Entering Orders [Click Here](#).

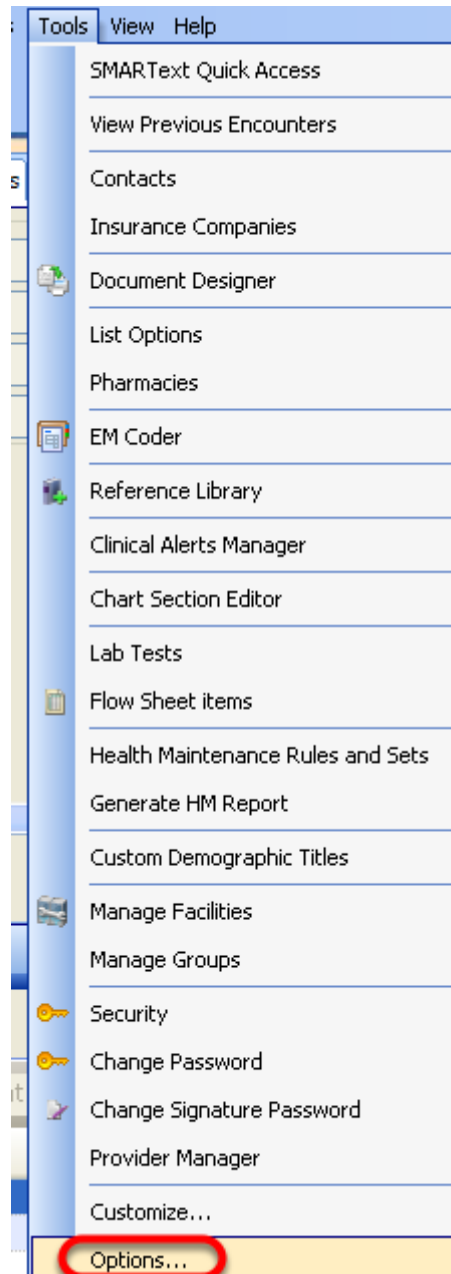
## Immunization Order Items

---

This lesson will discuss customizing and using SMARText Immunization item types.

**\*REQUIRED FOR MEANINGFUL USE: [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)**  
- Immunization Registries Data Submission

### Customize Immunization Order Sub-Items

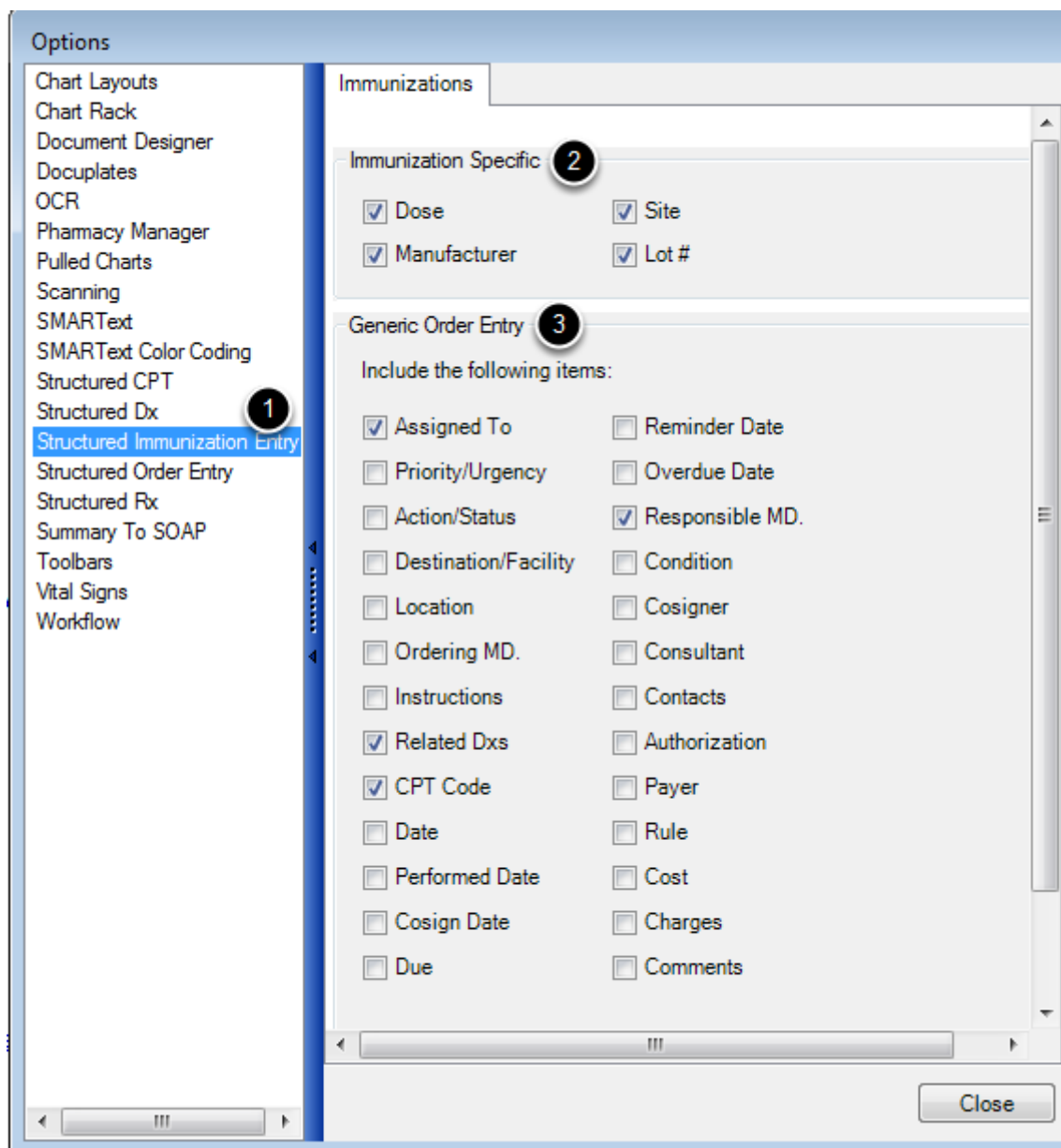


Immunization Order sub-items that are displayed in the Plan field, can be customized under the Tools menu item.

1) Click Tools menu item.

2) Click Options.

## Structured Immunization Entry



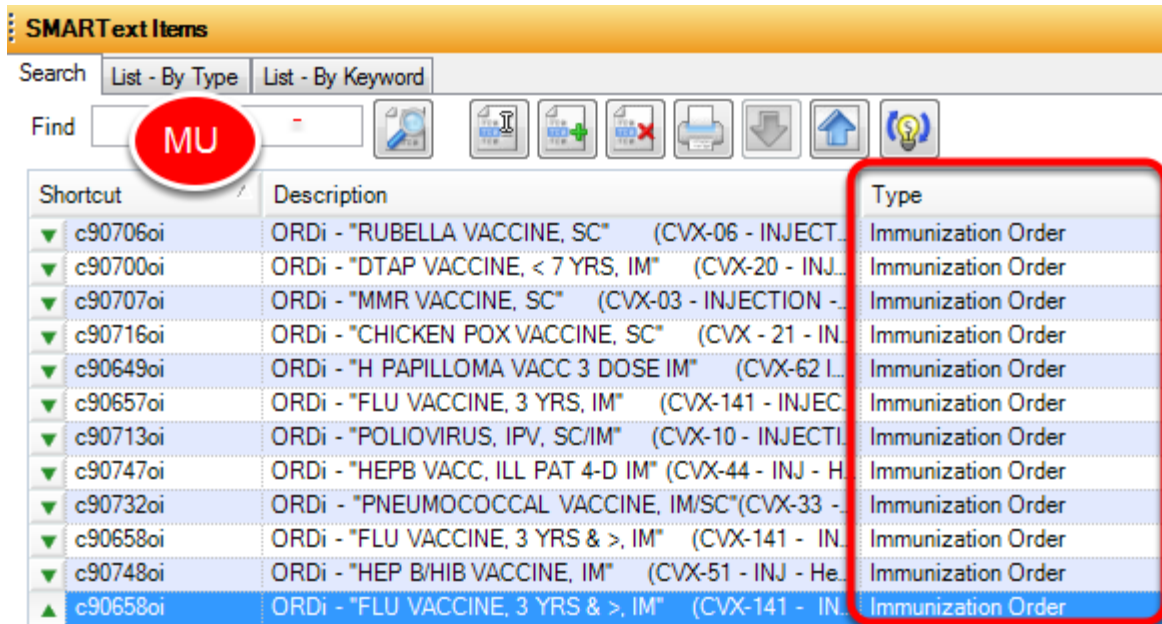
1. Click on Structured Immunization Entry.

2. Select the default Immunization Specific sub items to be displayed when the Immunization Order is entered.

3. Select the default Generic Order Entry Items to be displayed when the Immunization Order is entered.

**\*Note:** This setting is user-specific.

## Immunization Order SMARText Item Type

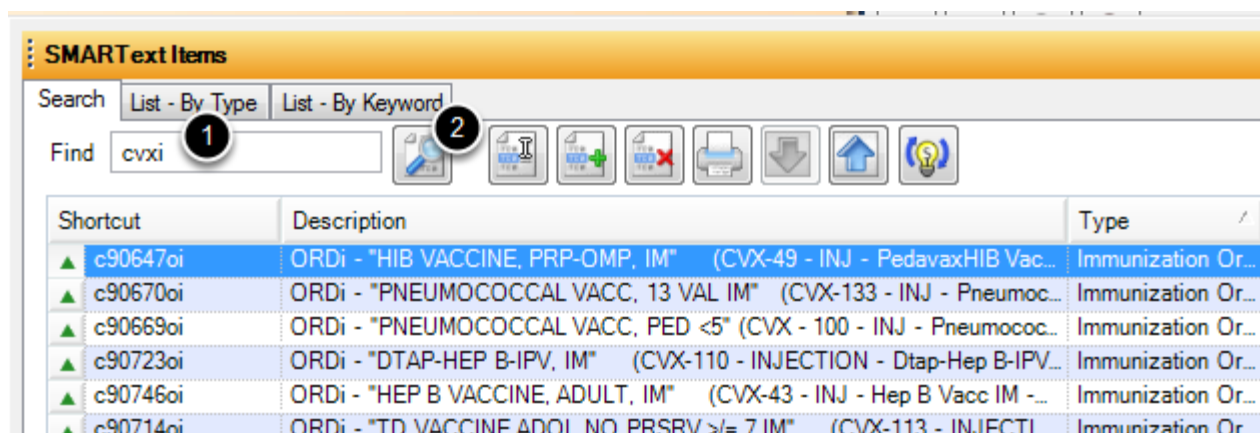


Due to the way Immunization Order SMARText items are designed:

1. They **cannot** be searched and inserted into the plan field by using F11 or Shift F11.
2. They **cannot** be part of a SMARText Pick List.
3. They **cannot** be selected from SMARText Quick Access.
4. They **cannot** be inserted into the Plan field by using a shortcut macro.
5. They **cannot** be inserted using the F4 Quick Entry Method.

**Immunization Orders may only be entered using Order Manager.**

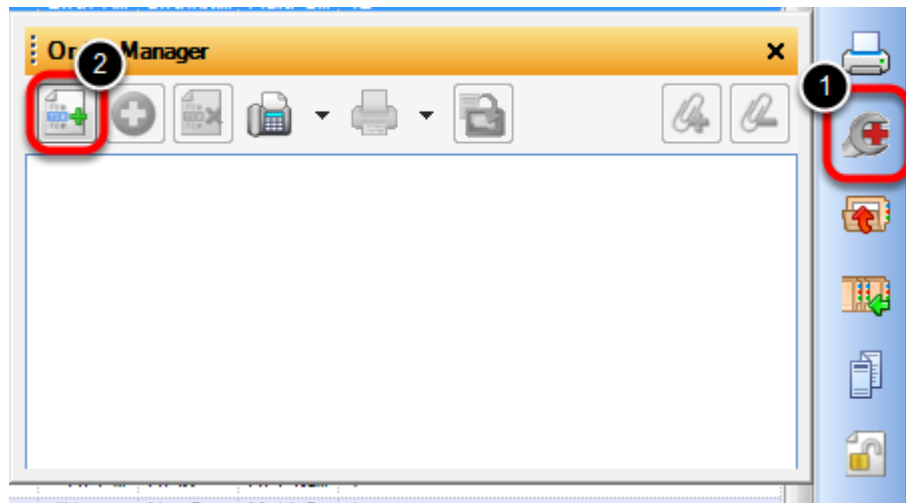
## Search for Immunization Orders



1. Search for Immunization Orders by typing in the keyword, "CVXi," into the Find Box.
2. Click the search button.

**\*Note:** CVXi is the unique identifier that the CDC associates with immunizations.  
For more information on how to download an Immunization Order for use, see: [Order Entry Setup](#)

## Immunization Order in the Order Manager



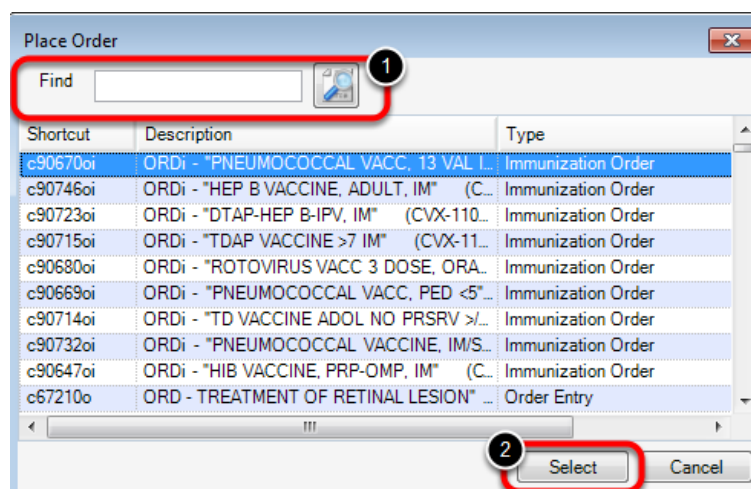
**Immunization Orders may only be entered using the Order Manager.**

To Open the Order Manager:

1. Click on the Order Manager Icon on the Common toolbar or select Docutainers >Order Entry> Order Manager.

To Create a New Immunization Order:

2. Click on the Green Plus button within the Order Manager or order an Immunization.



To Select an Immunization:

1. Enter Keywords into the Find box and Click the Search button or scroll to select the

Immunization.

2. Click Select.

## Documenting Immunization

The screenshot displays the SOAPware Order Manager window. The main area shows an order for "PNEUMOCOCCAL VACC, 13 VAL IM." dated 4/8/2011. A red box highlights the order details, including the assigned CPT code (90670), ordering clinician (Jennifer Berg), dose, manufacturer, lot number, and site. To the right, the SMARText Quick Access dropdown menu is open, showing a list of manufacturers. A red box highlights this menu, which includes options like Abbott Laboratories, Adams Laboratories, Inc., Akorn, Inc., Alpha Therapeutic Corporation, Baxter Healthcare Corporation, Berna Products Corporation, Bioport Corporation, Biotest Pharmaceuticals Corporation, Cangene Corporation, CSL Biotherapies, Inc., DynPort Vaccine Company, LLC, GeoVax Labs, Inc., GlaxoSmithKline, Greer Laboratories, Inc., Immuno-U.S., Inc., Intercell Biomedical, Korea Green Cross Corporation, Massachusetts Biologic Laboratories, MedImmune, Inc., Merck & Co., Inc., NABI, New York Blood Center, Novartis Pharmaceutical Corporation, Novavax, Inc., Organon Teknika Corporation, Ortho-clinical Diagnostics, and Other manufacturer.

**Order Manager**

Date: 4/8/2011  
Set: PNEUMOCOCCAL VACC, 13 VAL IM.  
PNEUMOCOCCAL VA...

**SMARText Quick Access**

Manufacturer

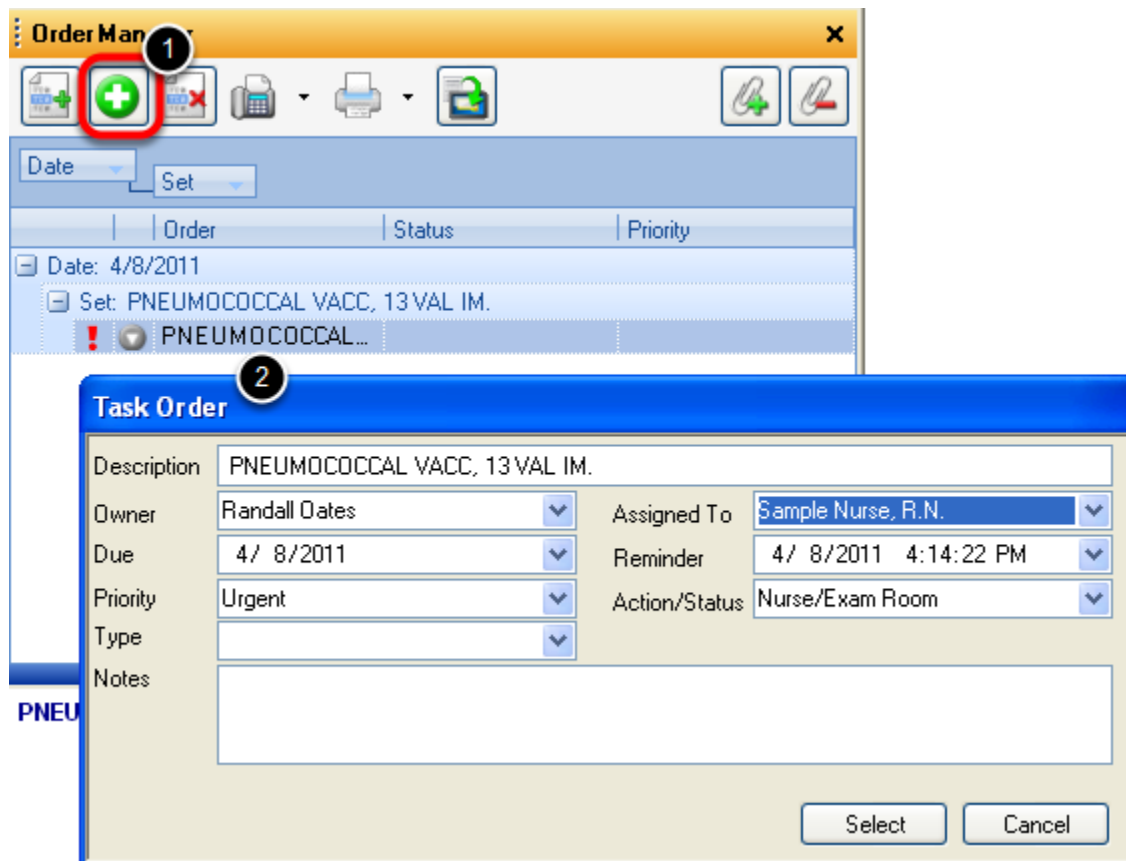
- Abbott Laboratories
- Adams Laboratories, Inc.
- Akorn, Inc.
- Alpha Therapeutic Corporation
- Baxter Healthcare Corporation
- Berna Products Corporation
- Bioport Corporation
- Biotest Pharmaceuticals Corporation
- Cangene Corporation
- CSL Biotherapies, Inc.
- DynPort Vaccine Company, LLC
- GeoVax Labs, Inc.
- GlaxoSmithKline
- Greer Laboratories, Inc.
- Immuno-U.S., Inc.
- Intercell Biomedical
- Korea Green Cross Corporation
- Massachusetts Biologic Laboratories
- MedImmune, Inc.
- Merck & Co., Inc.
- NABI
- New York Blood Center
- Novartis Pharmaceutical Corporation
- Novavax, Inc.
- Organon Teknika Corporation
- Ortho-clinical Diagnostics
- Other manufacturer

**PNEUMOCOCCAL VACC, 13 VAL IM.** Assigned To: CPT 90670  
Ordering Clinician: Jennifer Berg Dose: Manufacturer: Lot #: Site:  
Related Dx:-

The Immunization Order will appear in the Order Manager. Sub-items listed are determined by what the user has selected under Tools > Options > Structured Immunization Entry.

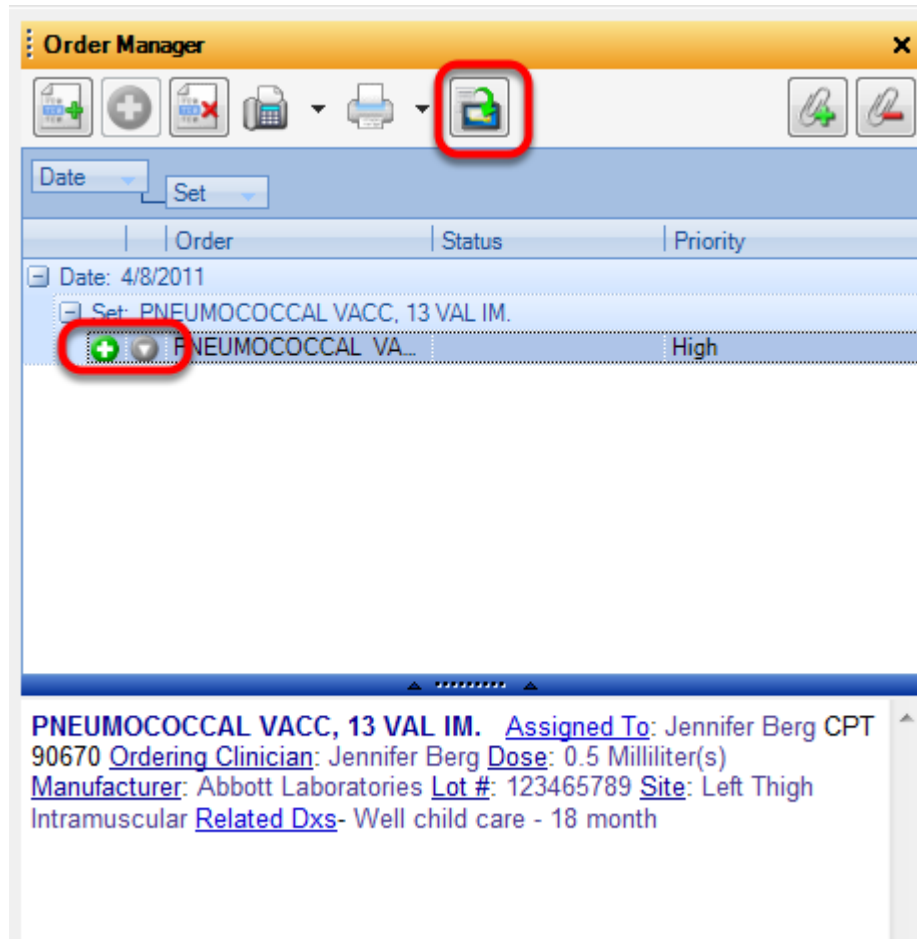
Fill in the appropriate sub items including Related Diagnosis, Dose, Manufacturer, Lot #, and Site using the SMARText Quick Access.

## Place the Order



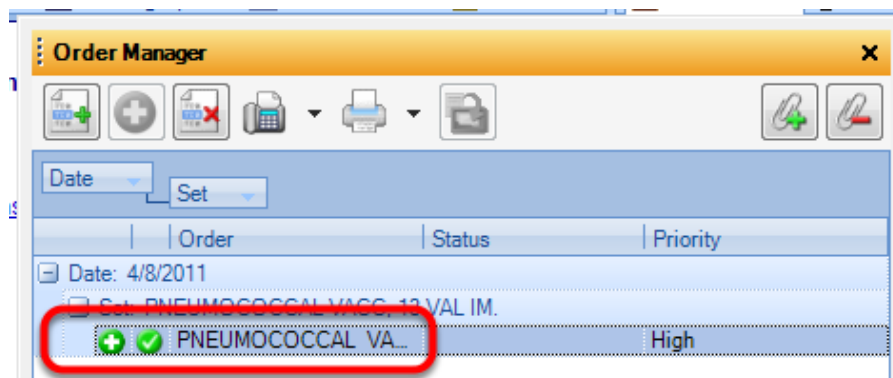
1. After all sub-items have been completed the user will place the order by Clicking on the button with green/white plus (see screen shot above).
2. Placing the order will create a Task Item to be sent to the Assigned To's task list to perform. Enter any desired information on the Task Item then Click Select.





After the order has been placed the Red exclamation sign will change to a Green + sign. This indicates that the Order has been placed and sent to the appropriate staff to complete.

The order now needs to be transferred to the SOAPnote. This is indicated by the Gray downward facing arrow. Click on the Transfer to SOAPnote button to document the Immunization in the SOAPnote.



This order is now complete.

## Immunization Displayed in the Plan Field

### Plan

Actions:   Orders: PNEUMOCOCCAL VACC, 13 VAL IM. \* Dose: 0.5  
Milliliter(s) Manufacturer: Abbott Laboratories Lot #: 123465789 Site:  
Left Thigh Intramuscular Related Dxs- Well child care - 18 month CPT  
90670

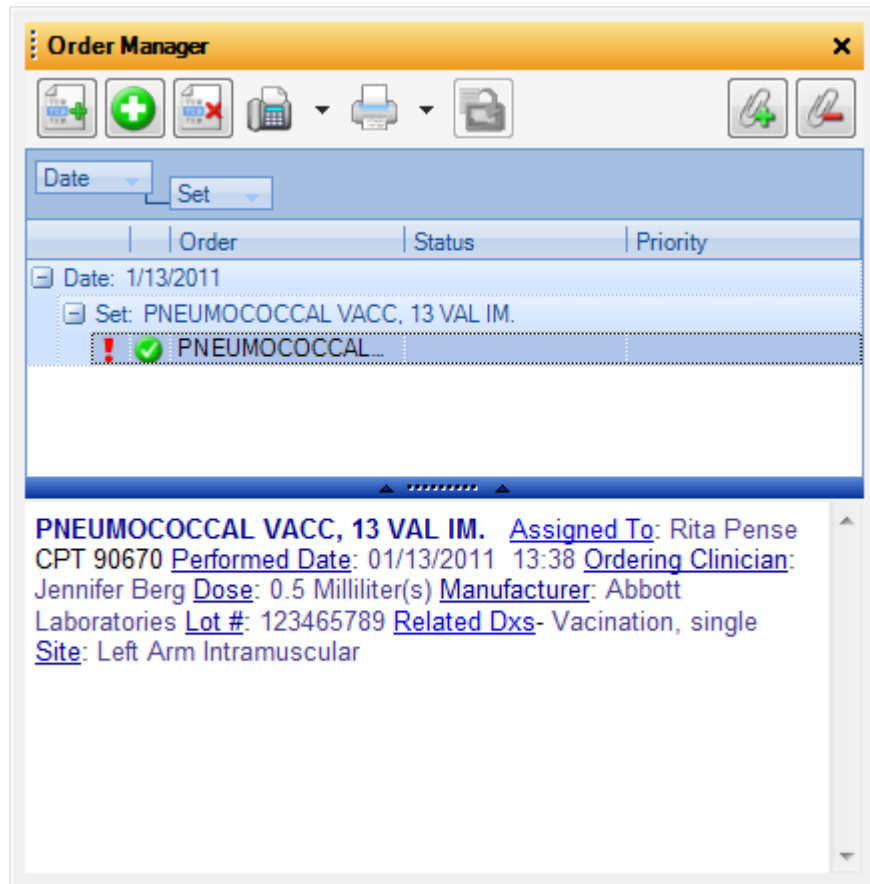
The Immunization will display in the Plan field once the order has been transferred to the SOAPnote. Sub-Items displayed will be determined by what the user has set under Tools >Options > Structured Order Entry.

## Record and Submit Immunizations

This lesson will discuss how to export an immunization record to submit to a state registry.

**\*REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**  
**- OR** [Immunization Registries Data Submission](#)

### Documenting the Immunization



The screenshot shows the 'Order Manager' window. At the top is a toolbar with icons for adding, deleting, and printing orders. Below the toolbar is a table with columns for Date, Order, Status, and Priority. The table contains one row for 'PNEUMOCOCCAL VACC, 13 VAL IM.' with a status of '!' and a priority of '1'. Below the table is a text area containing details for the order: 'PNEUMOCOCCAL VACC, 13 VAL IM. Assigned To: Rita Pense CPT 90670 Performed Date: 01/13/2011 13:38 Ordering Clinician: Jennifer Berg Dose: 0.5 Milliliter(s) Manufacturer: Abbott Laboratories Lot #: 123465789 Related Dxs- Vaccination, single Site: Left Arm Intramuscular'.

Illustration above displays an immunization order entered using the Order Manager. For more information on Order Manager, see: [Order Manager](#).

Due to the way Immunization Order SMARTText items are designed:

1. They **cannot** be searched and inserted into the plan field by using F11 or Shift F11.
2. They **cannot** be part of a SMARTText Pick List.
3. They **cannot** be selected from SMARTText Quick Access.
4. They **cannot** be inserted into the Plan field by using a shortcut macro.
5. They **cannot** be inserted using the F4 Quick Entry Method.

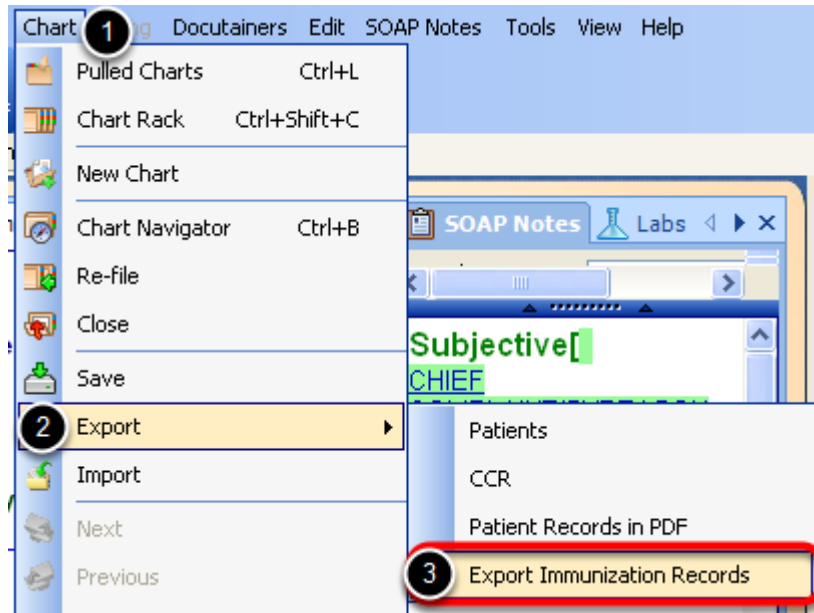
**Immunization Orders may only be entered using Order Manager.**

## Plan

Orders: PNEUMOCOCCAL VACC. 13 VAL IM. ? Dose: 0.5 Milliliter(s) Manufacturer: Abbott Laboratories Lot #: 123465789 Site: Left Arm Intramuscular Related Dxs- Vaccination, single CPT 90670

Orders transferred to the SOAPnote from Order Manager appear as above.

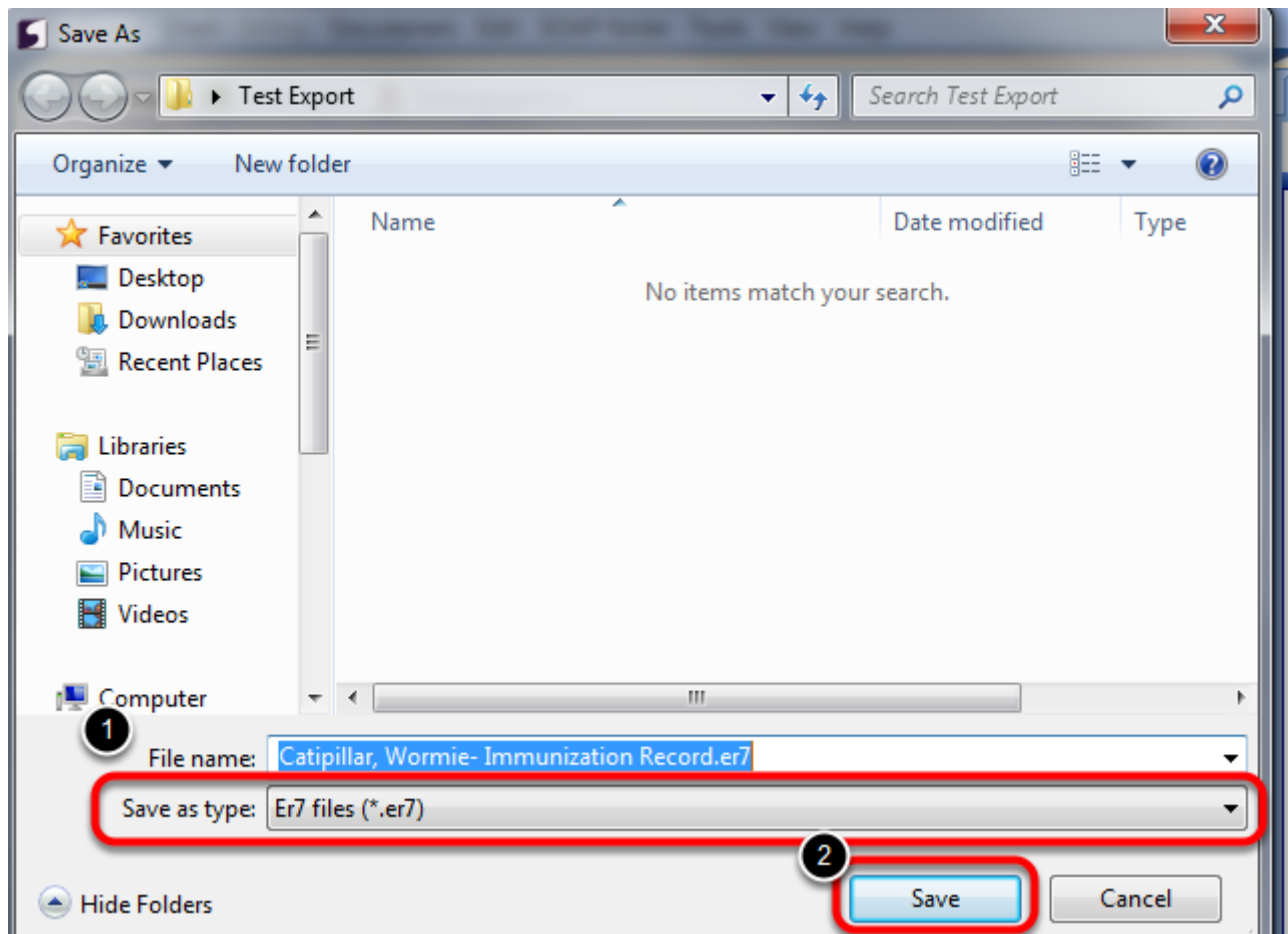
## Submitting Immunizations



To Submit an Immunization Record:

1. Click on Chart.
2. Select Export.
3. Select Export Immunization Records.

## Save the File



1. Select the desired location on the local computer to save this to and name the file. The file must be saved as an .er7 file.

2. Then Select Save.

The file has now been exported from SOAPware and is ready to submit to the registries.

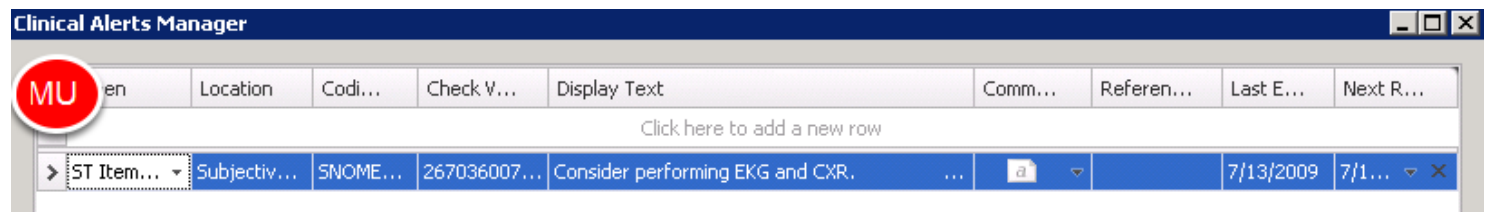
# Clinical Alerts

## Clinical Alerts

Clinical Alerts are a simple way to have SOAPware display text based prompts/reminders when a defined value is found in a specific location within the chart. Clinical Alerts are automatic. When one is triggered, a small pop-up will display, and then slowly fade out after a few moments. The basics of an alert are defined by When, Location, Coding Type, Check Value, and Display Text.

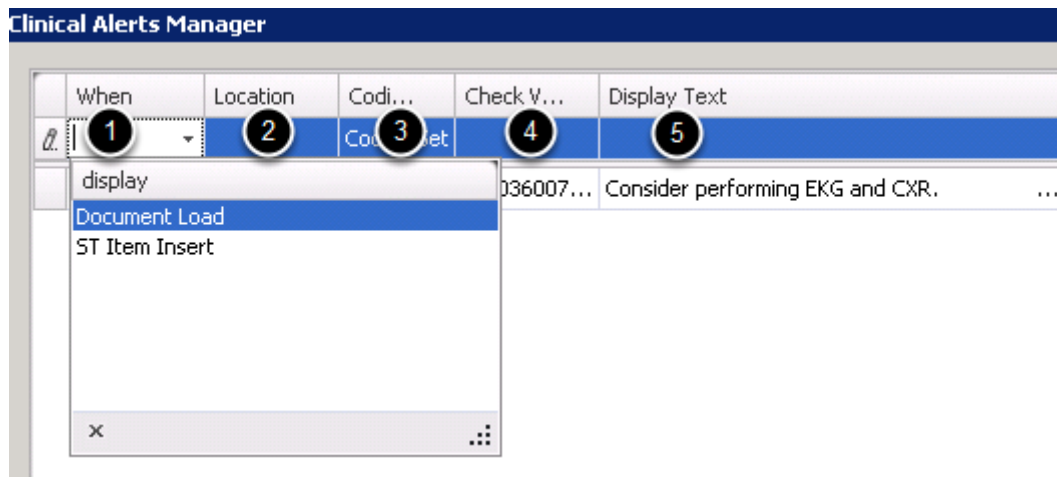
**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)  
- **OR** Clinical Decision Support Rule

### How To Access Clinical Alerts



Click Tools in the menu bar, and Click Clinical Alerts Manager, to display the Clinical Alerts Manager.

### How To Create a Clinical Alert



To add a new rule, Click in the top row of the display. The next step will be to define the basics of the alert:

**1. When-** Defines when (i.e. the trigger) the alert is presented (e.g. when opening a document or when inserting a SMARText Item).

**2. Location-** The name of the SOAPnote or Summary field in which to watch for entry of the

code/word/trigger (Assessment, Plan, Inactive Problems, etc.). Select the drop down list of standard fields, or type in the name of a custom field.

**3. Coding Type-** The match can be to text or to any of the coding systems (e.g. ICD-9, CPT, SNOMED-CT, LOINC, SWICPC, etc.) SOAPware supports the Codes/Notes sections of the SMARText Item Editor.

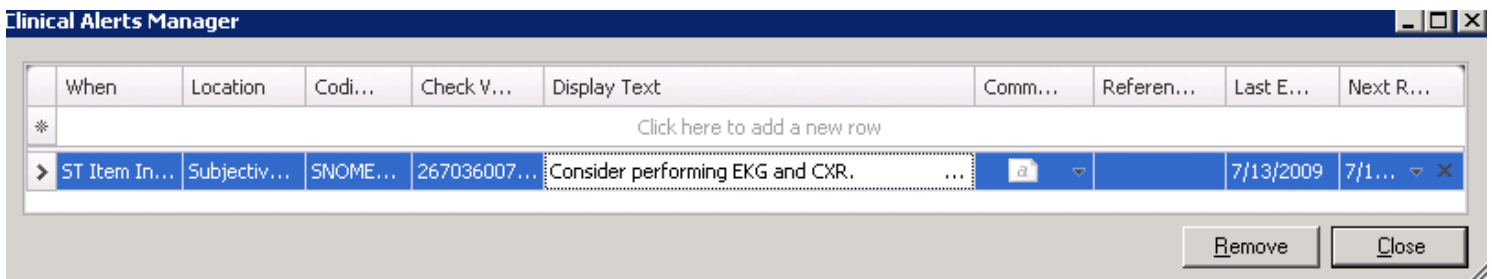
**4. Check Value-** This is the value SOAPware looks for to match. In the case of text, it is case insensitive.

**5. Display Text-** This is the text that will be displayed to alert users when a positive match is found.

Complete each field and Click the Close button to save.

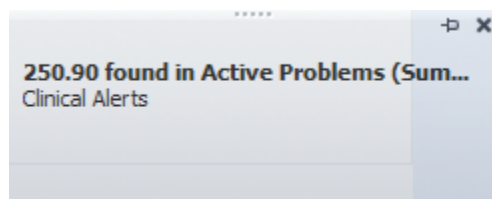
Any pending alerts can be displayed, on demand, for the current chart by Clicking "View" in the main menu, and Selecting Clinical Alerts.

## Removing a Clinical Alert



Click to highlight the line item, and then Click on the Remove button.

## Clinical Alerts Display



The alert results is a pop-up that notifies the user that a new workflow result is pending-meaning, a clinical alert has been triggered. Auser is able to click on "Clinical Alerts," which will then take the user to the Workflow Display Manager.



Workflow	Category	Details	Result	Reference Link
90658 found in Plan (Encounter)			Consider administering an H1N1 vaccine as well	
Clinical Alerts				
d00749 found in Medications (Summary)			Consider a Nebulizer treatment as well	
Clinical Alerts				
250.90 found in Active Problems (Summary)			Consider prescribing Onglyza	...
Clinical Alerts				

× ☒ [Category] = 'Clinical Alerts' Edit Filter

1. Auser is able to sort results by Category by clicking on the column header. Auser can also group items through the category column, based on the user's interests.
2. The top line displays the core information.
3. Details are displayed in the second column.

**\*\*Note:** The Workflow Display Manager can be docked tab and moved to any of the four edges of the Chart workspace. Users can also leave the Workflow Display Manager floating if desired.

# Clinical Quality Measures

## Clinical Quality Measures

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In SOAPware 2011+, many of the Meaningful Use Clinical Quality Measures (CQMs) now have pick lists available to assist users with the necessary structured data entry. Below, are all 44 Clinical Quality Measures sorted by those that are Core, Alternate Core and Additional measures. Each measure noted below includes a shortcut code for the SMARTText item that will assist with the structured documentation. In addition, the steps also include a link to more detailed step-by-step instructions on the documentation that is required for reporting on each of the measures.

The shortcut codes and documentation steps will assist SOAPware users with reporting Clinical Quality Measures to CMS or States. For more information about this Meaningful Use Core requirement, please click the link below.

**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)  
- [Report Clinical Quality Measures \(CQMs\) to CMS/States](#)

### Clinical Quality Measure Manual

[Click here to view the full User Manual for Clinical Quality Measures.](#)

### Core Clinical Quality Measures

**NQF 0013 (Core):** [Hypertension: Blood Pressure Measurement](#)

**NQF 0028 (Core):** Preventative Care and Screening Measure Pair (*includes 0028a & 0028b*)

\* **0028a:** [Preventive Care and Screening Measure Pair: \(a\) Tobacco Use Assessment](#)

The shortcut code that has been created for this measure is "PQRltob".

\* **0028b:** [Preventive Care and Screening Measure Pair: \(b\) Tobacco Cessation Intervention](#)

The shortcut code that has been created for this measure is "PQRlqui".

**NQF 0421/PQRI 128 (Core):** [Adult Weight Screening and Follow Up](#)

The shortcut code that has been created for this measure is "PQRlbmi."

### Alternate Core Clinical Quality Measures

**NQF 0024 (Alternate Core):** [Weight Assessment and Counseling for Children and Adolescents](#)

The shortcut code that has been created for this measure is "PQRlwei".

**NQF 0038 (Alternate Core):** [Childhood Immunization Status](#)

**NQF 0041/PQRI 110 (Alternate Core): Preventative Care and Screening: Influenza Immunization for Patients  $\geq$  50 Years Old**

The shortcut code that has been created for this measure is "InfQM".

### Additional Clinical Quality Measures

**NQF 0001/ PQRI 64: Asthma Assessment**

The shortcut code that has been created for this measure is "PQRlastAss".

**NQF 0002/PQRI 66: Appropriate Testing for Children with Pharyngitis**

The shortcut code that has been created for this measure is "PQRlpha".

**NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement**

The shortcut code that has been created for this measure is "PQRlche".

**NQF 0012: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)**

The shortcut code that has been created for this measure is "PQRlpreHIV".

**NQF 0014: Prenatal Care: Anti-D Immune Globulin**

The shortcut code that has been created for this measure is "PQRlantD".

**NQF 0018: Controlling High Blood Pressure**

**NQF 0027/PQRI 115: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies**

The shortcut code that has been created for this measure is "TobQM".

**NQF 0031/PQRI 112: Breast Cancer Screening**

The shortcut code that has been created for this measure is "MamQm".

**NQF 0032: Cervical Cancer Screening**

The shortcut code that has been created for this measure is "CerCanQM".

**NQF 0033: Chlamydia Screening for Women**

The shortcut code that has been created for this measure is "PQRlchl".

**NQF 0034/PQRI 113: Colorectal Cancer Screening**

The shortcut code that has been created for this measure is "PQRlpreCol".

**NQF 0036: Use of Appropriate Medications for Asthma**

The shortcut code that has been created for this measure is "PQRlastThe".

**NQF 0043/PQRI 111:** [Pneumonia Vaccination Status for Older Adults](#)

The shortcut code that has been created for this measure is "PQRlpne".

**NQF 0047/ PQRI 53:** [Asthma Pharmacologic Therapy](#)

The shortcut code that has been created for this measure is "AstQm".

**NQF 0052:** [Low Back Pain: Use of Imaging Studies](#)

The shortcut code that has been created for this measure is "PQRllowBacl".

**NQF 0055/PQRI 117:** [Diabetes: Eye Exam](#)

The shortcut code that has been created for this measure is "PQRldmEye".

**NQF 0056/PQRI 163:** [Diabetes: Foot Exam](#)

The shortcut code that has been created for this measure is "PQRldmFoo".

**NQF 0059/PQRI 1:** [Diabetes: HbA1c Poor Control](#)

The shortcut code that has been created for this measure is "PQRldmA1c".

**NQF 0061/PQRI 3:** [Diabetes: Blood Pressure Management](#)

**NQF 0062/PQRI 119:** [Diabetes: Urine Screening](#)

The shortcut code that has been created for this measure is "PQRldmNep".

**NQF 0064/PQRI 2:** [Diabetes: LDL Management & Control](#)

The shortcut code that has been created for this measure is "PQRldmLDL".

**NQF 0067/PQRI 6:** [Coronary Artery Disease \(CAD\): Oral Antiplatelet Therapy Prescribed for Patients with CAD](#)

The shortcut code that has been created for this measure is "PQRl cadPla".

**NQF 0068/PQRI 204:** [Ischemic Vascular Disease \(IVD\): Use of Aspirin or another Antithrombotic](#)

The shortcut code that has been created for this measure is "PQRl ivd".

**NQF 0070/PQRI 7:** [Coronary Artery Disease \(CAD\): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infraction \(MI\)](#)

The shortcut code that has been created for this measure is "PQRl cadBB".

**NQF 0073/PQRI 201:** [Ischemic Vascular Disease \(IVD\): Blood Pressure Management](#)

The shortcut code that has been created for this measure is "PQRl ivd".

**NQF 0074/PQRI 197:** [Coronary Artery Disease \(CAD\): Drug Therapy for Lowering LDL-Cholesterol](#)

**NQF 0075: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control**

The shortcut code that has been created for this measure is "PQRlivd".

**NQF 0081/PQRI 5: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)**

The shortcut code that has been created for this measure is "PQRlhACE".

**NQF 0083/PQRI 8: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)**

The shortcut code that has been created for this measure is "PQRlhBB".

**NQF 0084/PQRI 200: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation**

The shortcut code that has been created for this measure is "PQRlhgWar".

**NQF 0086/PQRI 12: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation**

The shortcut code that has been created for this measure is "GlaQM".

**NQF 0088/PQRI 18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**

The shortcut code that has been created for this measure is "PQRldmEye".

**NQF 0089/PQRI 19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**

The shortcut code that has been created for this measure is "DiaRetCom".

**NQF 0105/PQRI 9: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment**

The shortcut code that has been created for this measure is "PQRldepMed".

**NQF 0385/PQRI 72: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients**

The shortcut code that has been created for this measure is "PQRlcol".

**NQF 0387/PQRI 71: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer**

The shortcut code that has been created for this measure is "PQRibreCan".

**NQF 0389/PQRI 102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients**

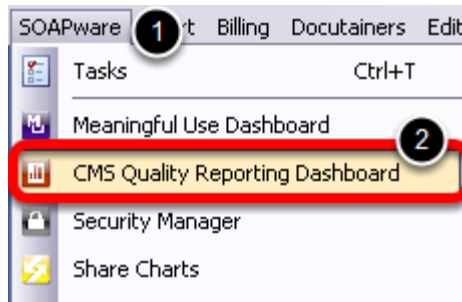
The shortcut code that has been created for this measure is "PQRlproBon".

**NQF 0575:** [Diabetes: HbA1c Control \(<8%\)](#)

## How to Use the CMS Quality Reporting Dashboard

This lesson is designed to walk the user through the steps of exporting Quality Measures data for reporting.

### CMS Quality Reporting Workspace



1. Click on the SOAPware Menu
2. Select the "CMS Quality Reporting Dashboard"

### Clinical Quality Measures Export

SOAPware Billing Edit Tools View Help	
CMS Quality Measure	Export
NQF 0001 - Asthma Assessment	Export
NQF 0002 - Appropriate Testing for Children with Pharyngitis	Export
NQF 0004 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Export
NQF 0012 - Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Export
> NQF 0013 - Hypertension: Blood Pressure Management	Export
NQF 0014 - Prenatal Care: Anti-D Immune Globulin	Export

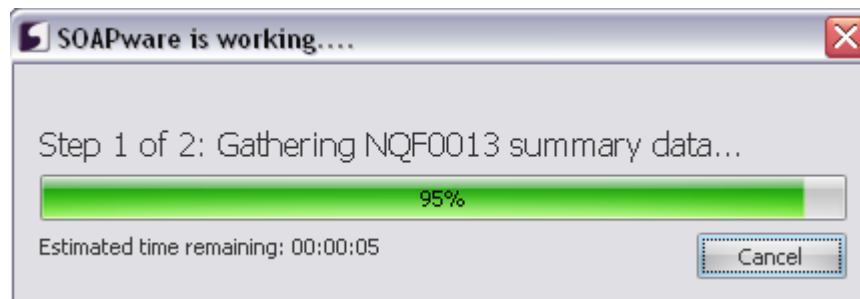
To export the data for a specific clinical quality measure, locate the quality measure to export and Click the Export button.



## Select the Reporting Period

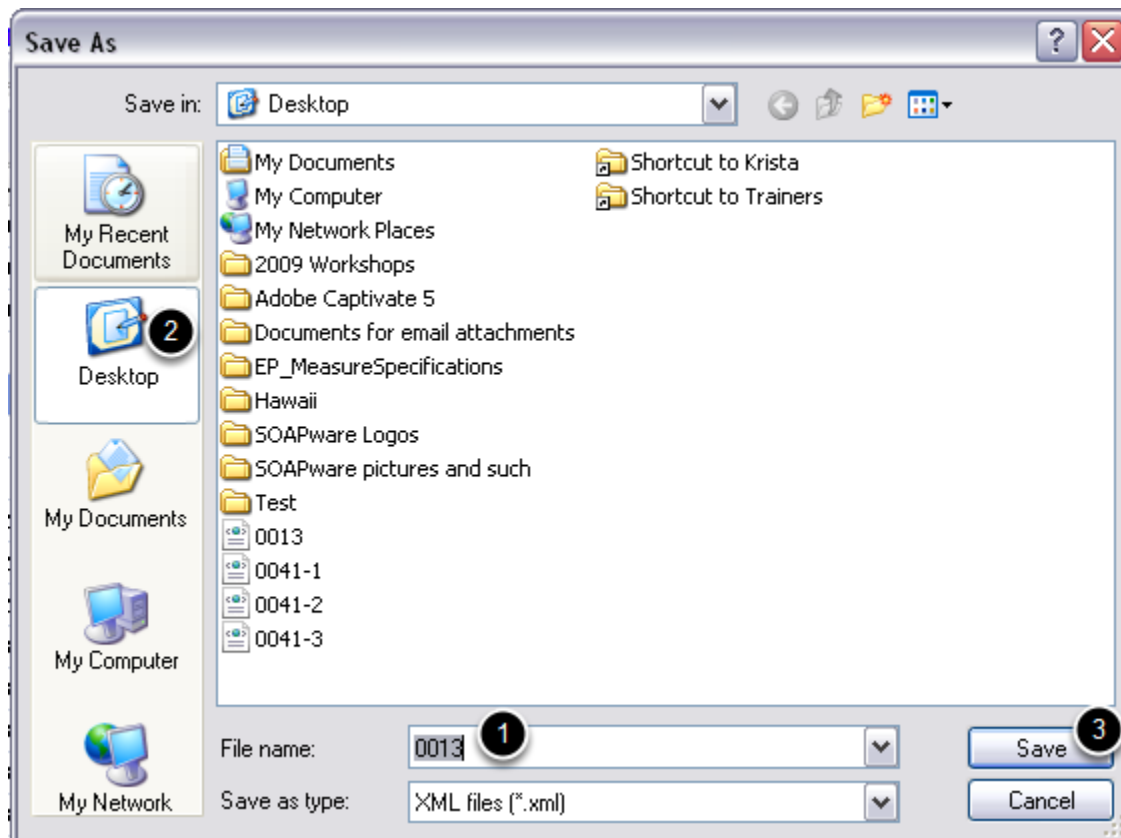


1. To select the reporting period for the export, choose the Custom option and enter the desired reporting period.
2. Click the Create button to begin the export.



While the report is running, the user will see a progress bar similar to the one shown above.

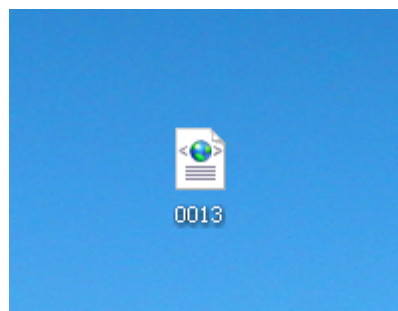
## Saving the Export Results



To save the export results:

1. Name the file.
2. Choose the desired destination.
3. Click the Save button.

## Viewing the Report



To view the clinical quality measure report, locate the file that was saved and simply double-click on the icon.

```

<?xml version="1.0" encoding="UTF-8" ?>
- <submission type="PQRI-REGISTRY" version="3.0">
- <file-audit-data>
  <create-date>06-29-2011</create-date>
  <create-time>11:23</create-time>
  <create-by>SOAPware</create-by>
  <version>1.0</version>
  <file-number>1</file-number>
  <number-of-files>1</number-of-files>
</file-audit-data>
- <registry>
  <registry-name>Test Registry</registry-name>
  <registry-id>01234</registry-id>
  <submission-method>B</submission-method>
</registry>
- <measure-group ID="X">
- <provider>
  <npi>4567894561</npi>
  <encounter-from-date>01-01-2011</encounter-from-date>
  <encounter-to-date>06-30-2011</encounter-to-date>
- <pqri-measure>
  <pqri-measure-number>NQF0013</pqri-measure-number>
  <eligible-instances>2</eligible-instances>
  <meets-performance-instances>1</meets-performance-instances>
  <performance-exclusion-instances>0</performance-exclusion-instances>
  <performance-not-met-instances>1</performance-not-met-instances>
  <reporting-rate>100</reporting-rate>
  <performance-rate>50</performance-rate>
</pqri-measure>
</provider>
</measure-group>
- <measure-group ID="X">
- <provider>
  <npi>9876543210</npi>
  <encounter-from-date>01-01-2011</encounter-from-date>
  <encounter-to-date>06-30-2011</encounter-to-date>
- <pqri-measure>
  <pqri-measure-number>NQF0013</pqri-measure-number>
  <eligible-instances>3</eligible-instances>
  <meets-performance-instances>3</meets-performance-instances>
  <performance-exclusion-instances>0</performance-exclusion-instances>
  <performance-not-met-instances>0</performance-not-met-instances>
  <reporting-rate>100</reporting-rate>
  <performance-rate>100</performance-rate>
</pqri-measure>
</provider>
</measure-group>

```

Providers NPI Number

Reporting Period Selected

Eligible Instances/  
Denominator

Meets Performance  
Instances/ Numerator

Performance Rate/  
Percentage

SOAPware exports the Clinical Quality Measure file in XML format. At this time, CMS does not require that the user upload the XML document during the attestation process. However, this may be a requirement in future Meaningful Use Stages.

The XML export contains the following information:

- Providers NPI Number
- Selected reporting period
- Clinical Quality Measure NQF or PQRI number
- Eligible Instances/Denominator
- Meets Performance Instances/Numerator
- Performance Exclusion Instances (*\*Note: SOAPware does not report exclusions at this point in time. This number will always be 0*)
- Performance Not Met Instances
- Reporting Rate
- Performance Rate (the Numerator divided by the Denominator)

Please see the above screenshot for a visual explanation of how to read the XML document. The above screenshot can be resized for easier viewing (simply click on the picture to view a larger version).

# **HIPAA Disclosures**

## Record of Disclosures

---

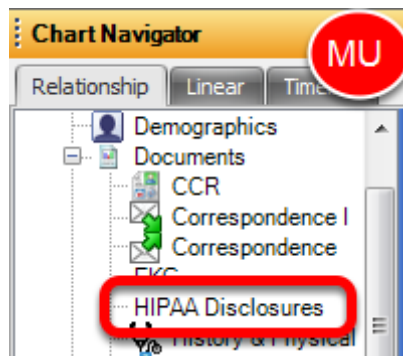
This lesson will demonstrate the necessary steps to meet the Meaningful Use requirement for Record of Disclosures.

**\*REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP](#)

- **OR** [Protect Electronic Health Information](#)

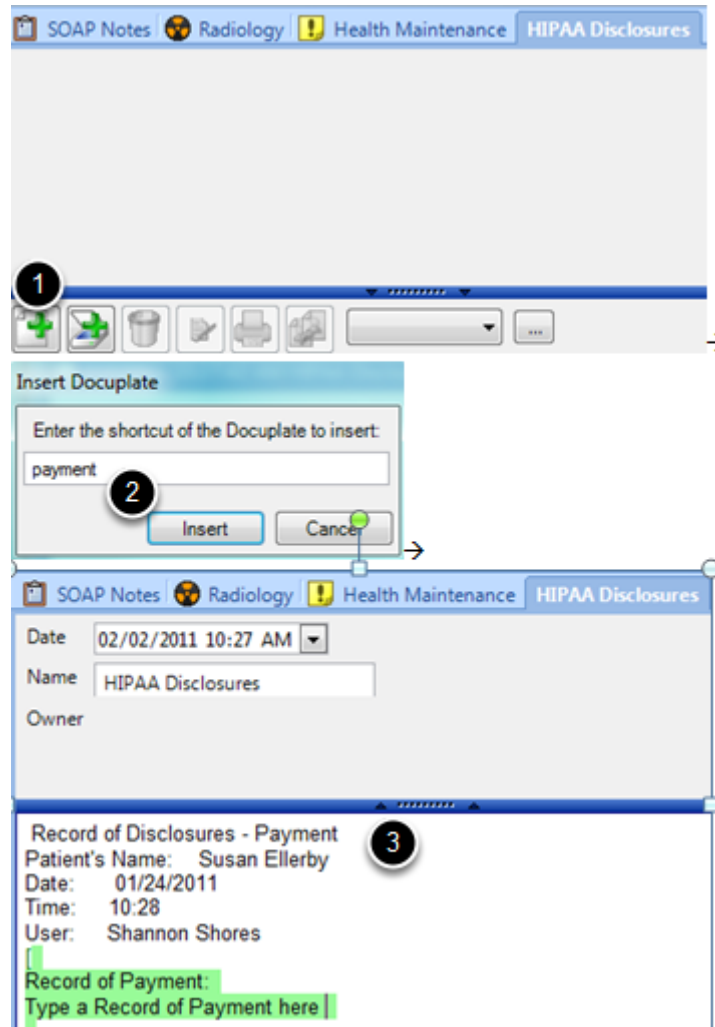
**\*\*Note:** Please download the following docuplates into the database first, before proceeding with these steps.....Search using the following keywords: payment, treatment, and health care ops.

### Open the HIPAA Disclosures Chart Section



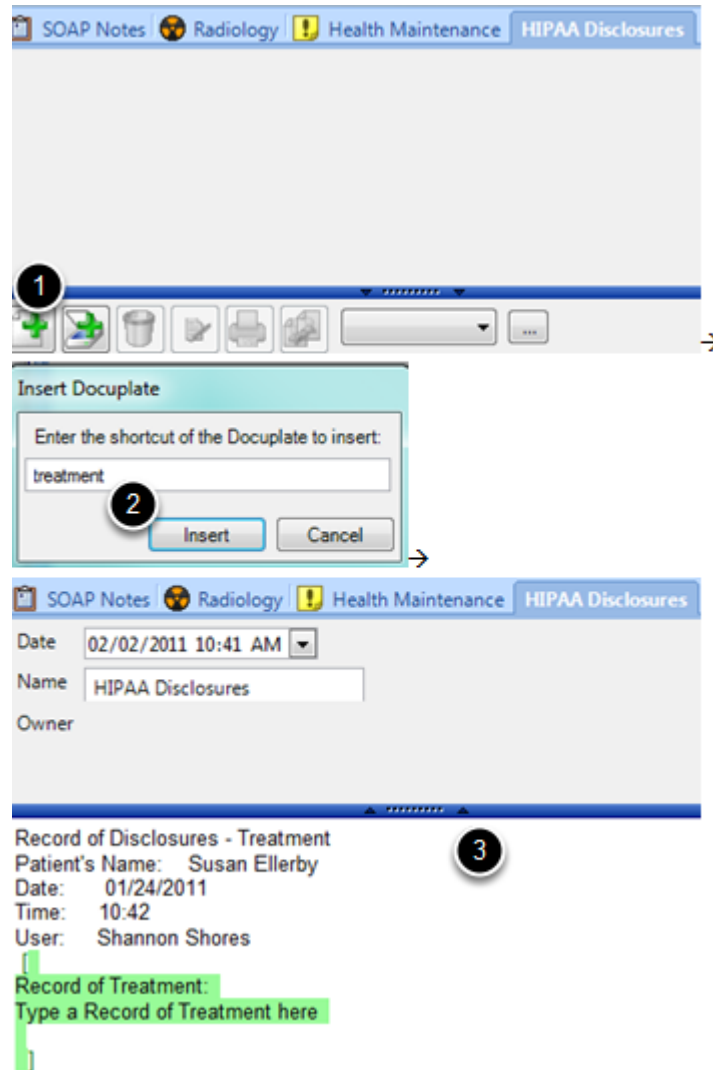
With a patient's chart open, access Chart Navigator, and double-click on "HIPAADisclosures" to insert this chart section.

## Record of Payment



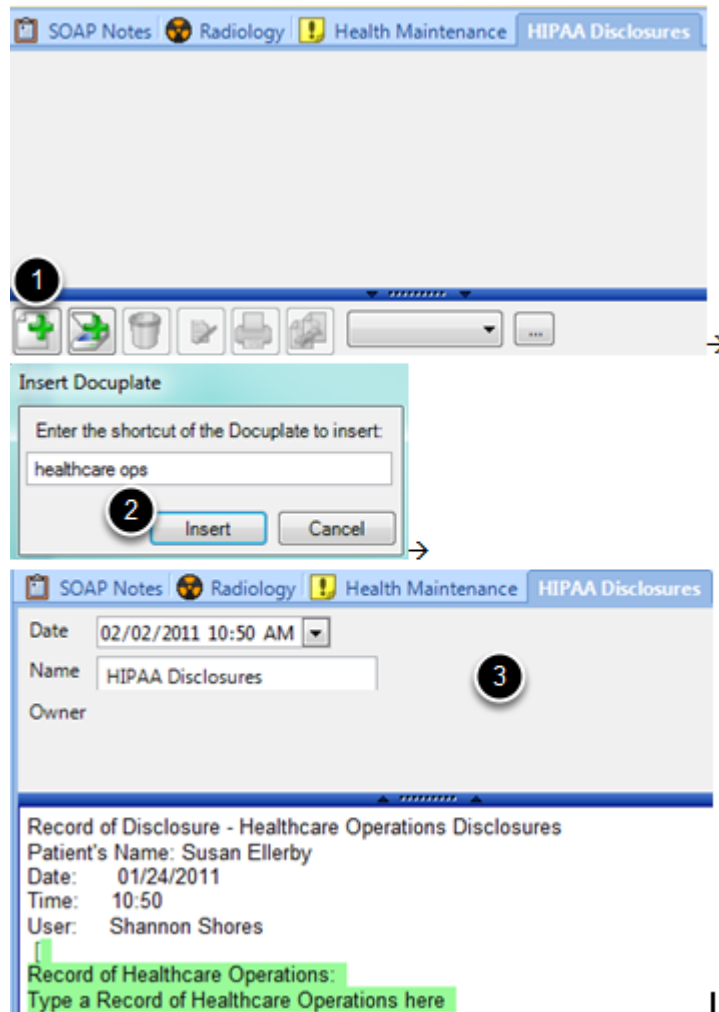
1. Click the create a new docutainer button while in the HIPAADisclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "payment," then Click on the "Insert" button.
3. This docuplate will automatically display the Patient ID, Date of the active encounter, Time, User ID, and a Record of Payment, which the user can use to type in some payment notes-for disclosure purposes.

## Record of Treatment



1. Click the create a new docutainer button while in the HIPAADisclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "treatment" then Click on the "Insert" button.
3. This docuplate will automatically display the Patient ID, Date of the active encounter, Time, User ID, and a Record of Treatment, which the user can use to type in some treatment notes-for disclosure purposes.





1. Click the create a new docutainer button while in the HIPAADisclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "health care ops" then Click on the "Insert" button.
3. This docuplate will automatically display the Patient ID, Date of the active encounter, Time, User ID, and a Record of Health care Operations, which the user can use to type in some health care operation notes-for disclosure purposes.

# Reference

## Meaningful Use

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To learn the recommended workflows to meet Meaningful Use, see: [Meaningful Use Roadmap](#).

## Upgrades and Updates

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### Updates

Drug DB Updates are handled with the same update from Multum/Cerner. The updates are applied to the central, SOAPware drug information server on a monthly basis. SOAPware Drug Interaction checking takes place at our data center and is accessed automatically from the SOAPware client via secure web services. A history of Drug Data updates is made available on our publicly available web site.

Drug DB Updates come in two forms - the first is making new "structured" drugs available for download by our users and the second is ensuring that the drug interaction engine has the latest data. In both cases, this is handled with the same update from Multum/Cerner.

<http://www.multum.com/>

The updates are applied to the central, SOAPware drug information server on a monthly basis. To make sure that items on the local database are up to date, it is recommended that the user update SMARText once a month.

SOAPware Drug Interaction checking takes place at our data center and is accessed automatically from the SOAPware client via secure web services. Thus, users have no need to apply drug updates nor do they have to be concerned they are out of date.

### Upgrades

To keep up with the latest SOAPware version, see: [Downloads](#).