Clinical 2012 User Manual

SOAPware, Inc.

Clinical 2012 User Manual

Welcome to SOAPware

Welcome to SOAPware

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

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 create a new training ticket.

Support

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

Auser can submit a ticket to our Technical Support Team here.
Auser 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 Roadmap

* Register for Meaningful Use
  - Registration Walkthrough Video
  - Registration Walkthrough PDF

* ONC-ATCB Certification Details

* Standards and Certification Info from HIT

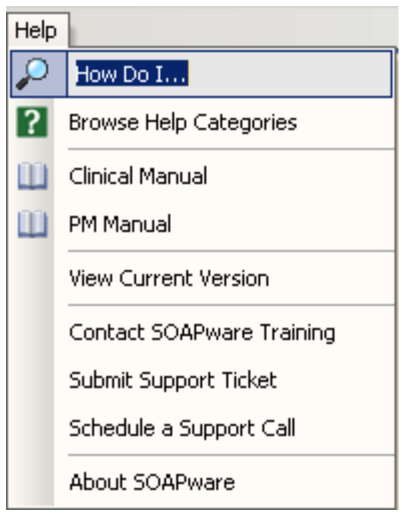
* Randall Oates, MD, Blog

* SOAPware Community Forums

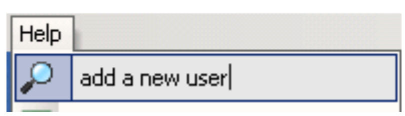
Help Menu: Activity Based Training Resources

New training resources are now available to users through the Help menu. These new help resources have been developed to allow users to find simple steps to completing some of the common workflow activities within SOAPware. The help menu resources include instructional lessons that can be accessed through an easy to access docked tab within SOAPware. The instructional lessons include simple, step-by-step workflow instructions and short video tutorials.

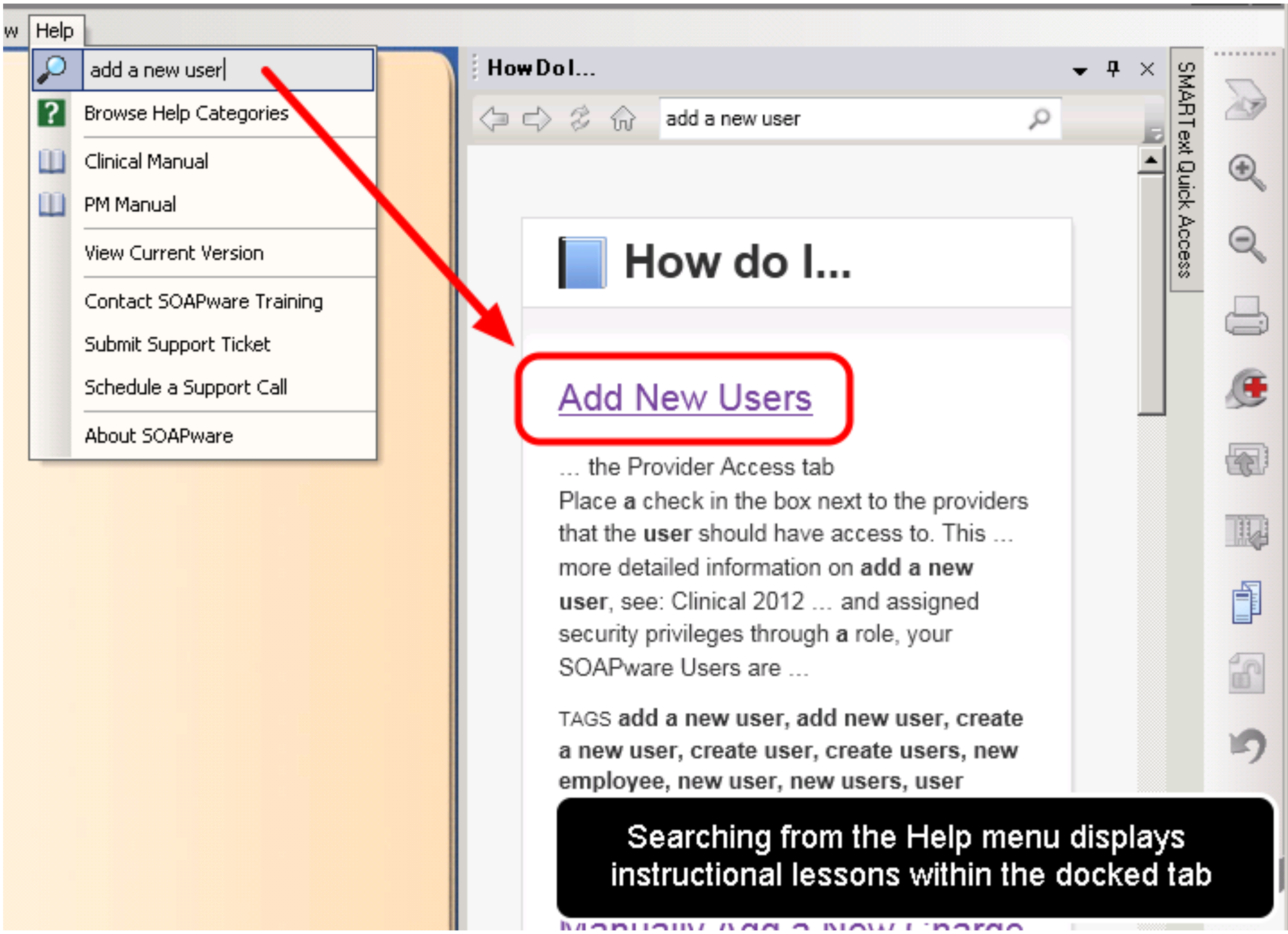
Search for a "How Do I..." Lesson



The searchable "How Do I..." dialog will allow a user to type in a keyword or topic to search on. Click on the **Help** menu, then place the cursor into the searchable "**How Do I...**" field.

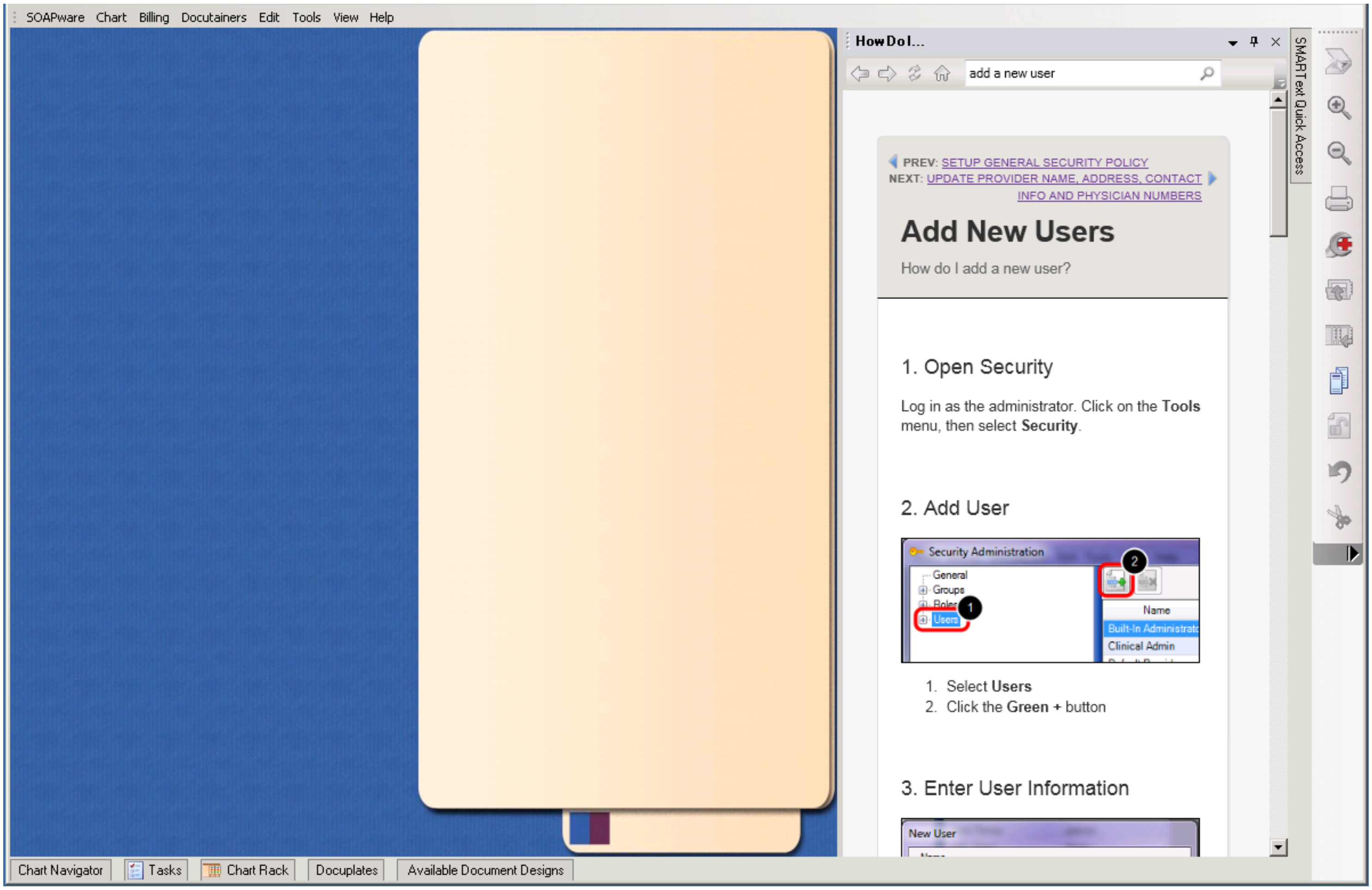


Enter a keyword or topic to search (ex: add a new user, dock a tab, omit a paid charge, etc.), then press the **Enter** key to search.



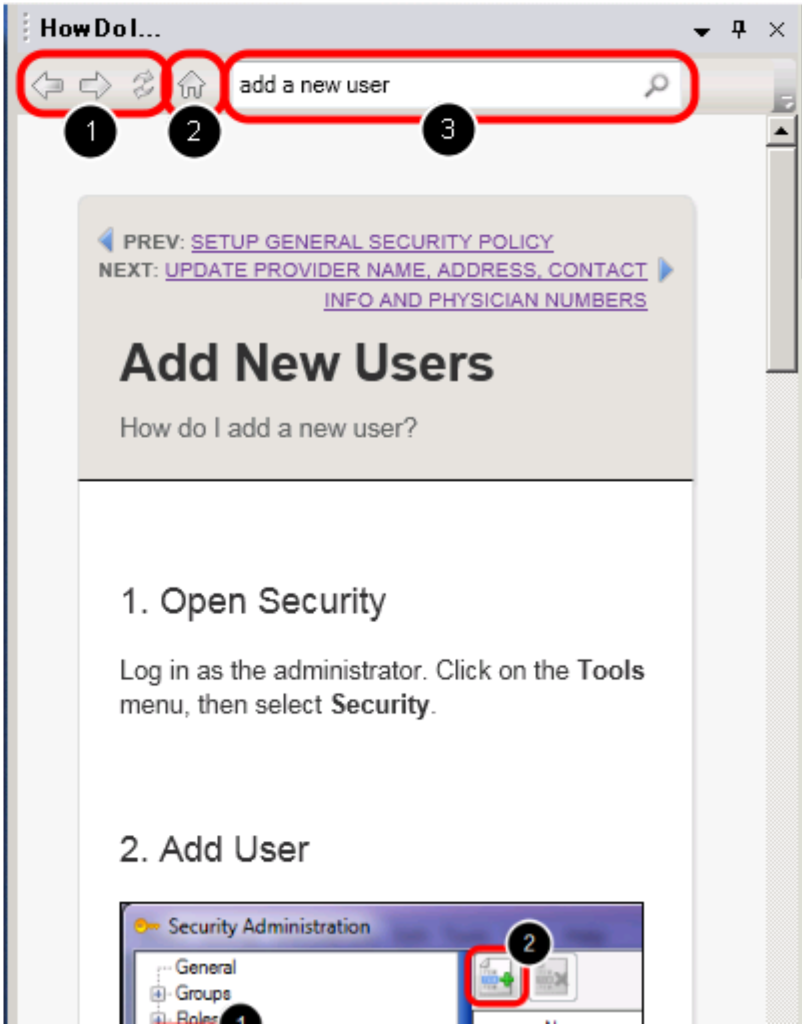
After pressing the Enter key, the How Do I... window will appear inside of SOAPware to display the search results. In most cases, this window will be docked to the right side of the users screen (however, this window can be moved, docked elsewhere, or closed by the user, See: [Docked Tabs]).

Within the search results, click on a specific lesson to view the instructions for that topic.



The simple and step-by-step instructions will be displayed for the user inside of the docked tab.

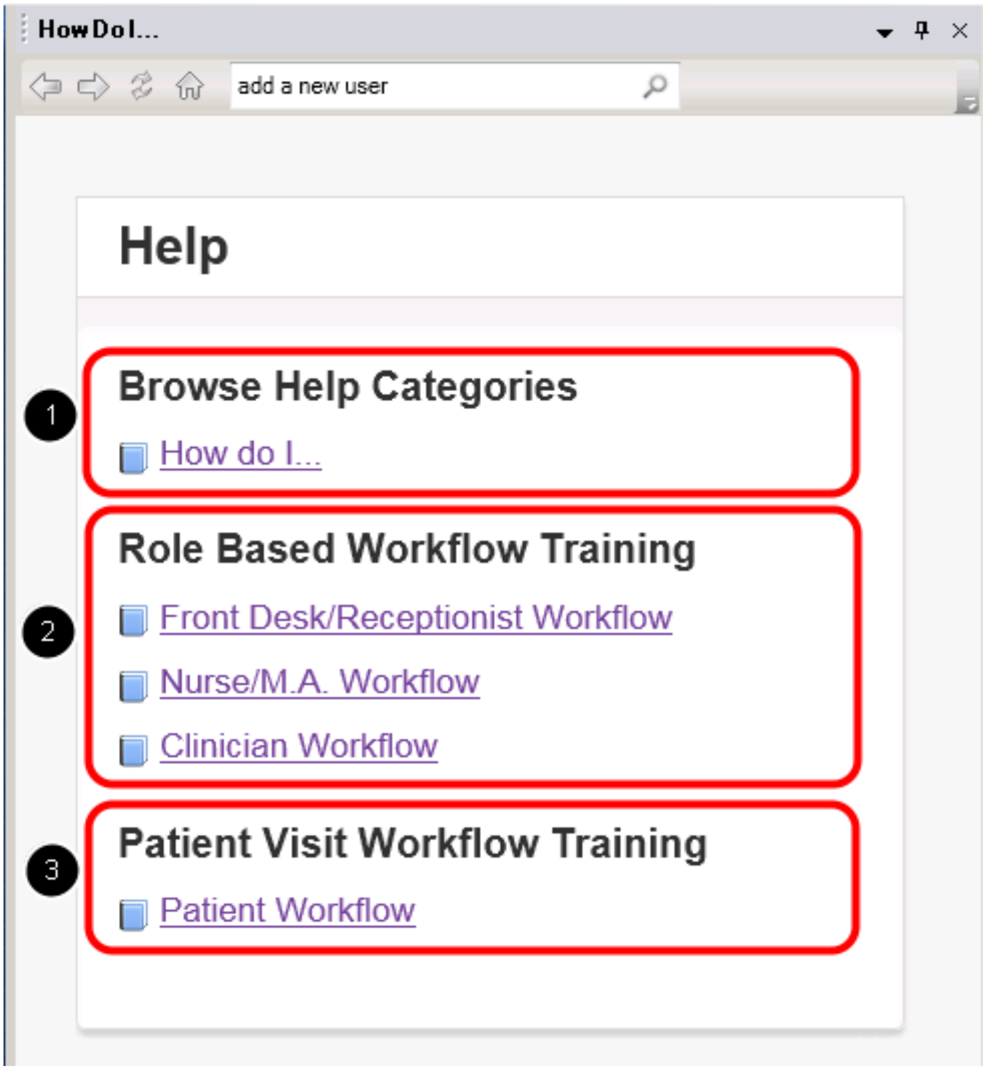
Several of the instructional lessons will include short demonstration videos. If a video is available for the lesson, it will be located at the bottom of the lesson. The videos are sized to be viewable within the docked tab window, but can be re-sized or transitioned into full screen for easier viewing.



The How Do I... help window includes the following browser controls:

1. **Back/Forward/Refresh**: To move back to a previously viewed lesson, click the back button. To more forward to a previously viewed lesson, click the forward button. Click the refresh button to refresh the lesson on screen.
2. **Home**: The home button will direct the user to a listing of available help resources. These resources include the ability to browse available How Do I... lessons, role based workflow training lessons, and patient visit workflow training lessons. These resources are discussed in more detail later in this documentation.
3. **Search**: The search dialog allows the user to type in another keyword or topic to search the How Do I... documentation.

Help - Home Button

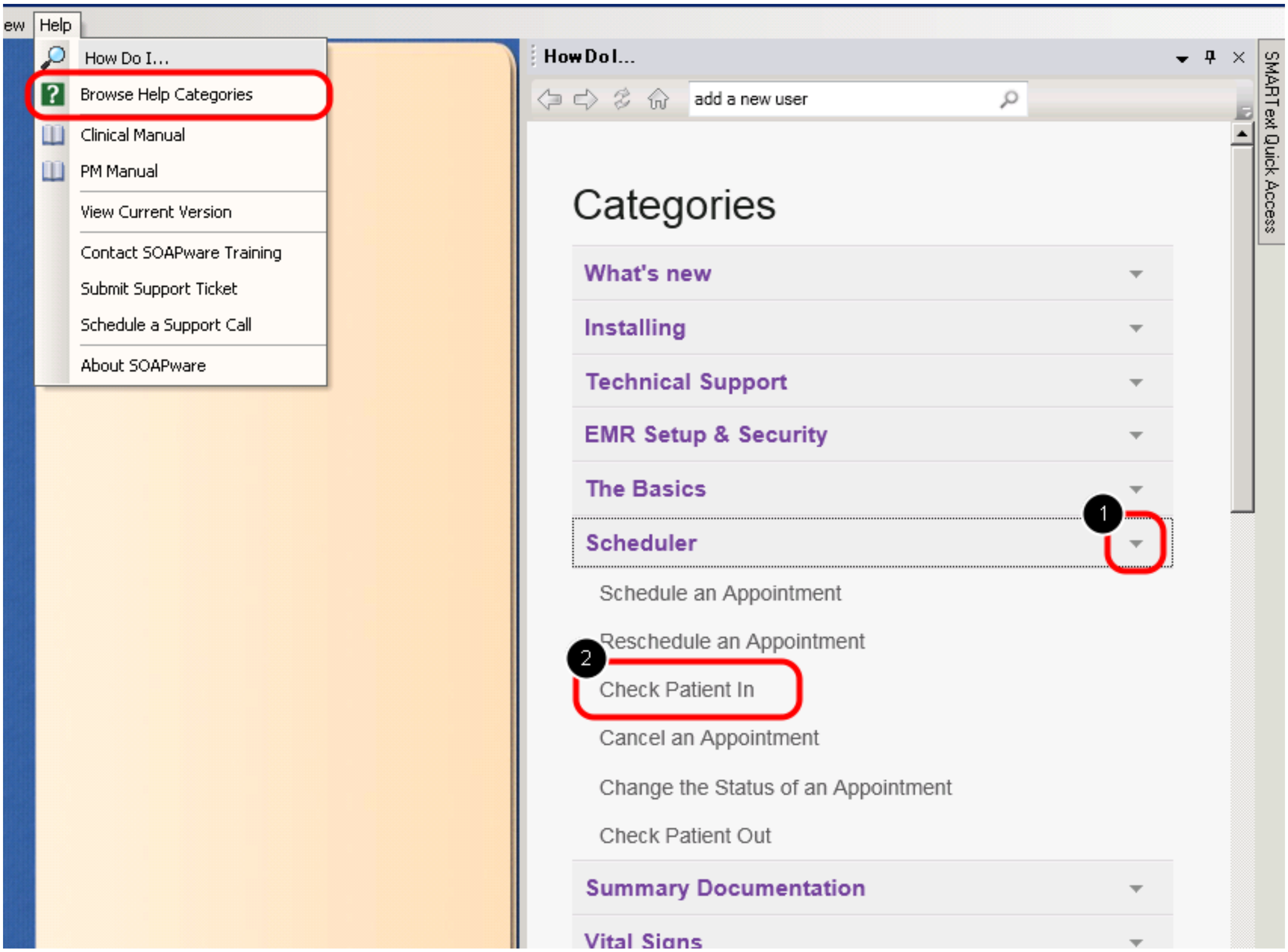


Clicking the Home button on the How Do I... window will direct the user to a listing of available help resources:

1. **Browse Help Categories**: Clicking the "How Do I..." link will allow the user to browse a listing of Help lessons.
2. **Role Based Workflow Training**: The role based workflow training exercises present training lessons that are based upon each role's typical workflow. Click the desired role to view the instructional workflow exercises.

3. **Patient Visit Workflow Training**: The patient visit workflow training exercises present training lessons that are organized based up the typical workflow of a patient visit. Click the "Patient Workflow" link to view the exercises.

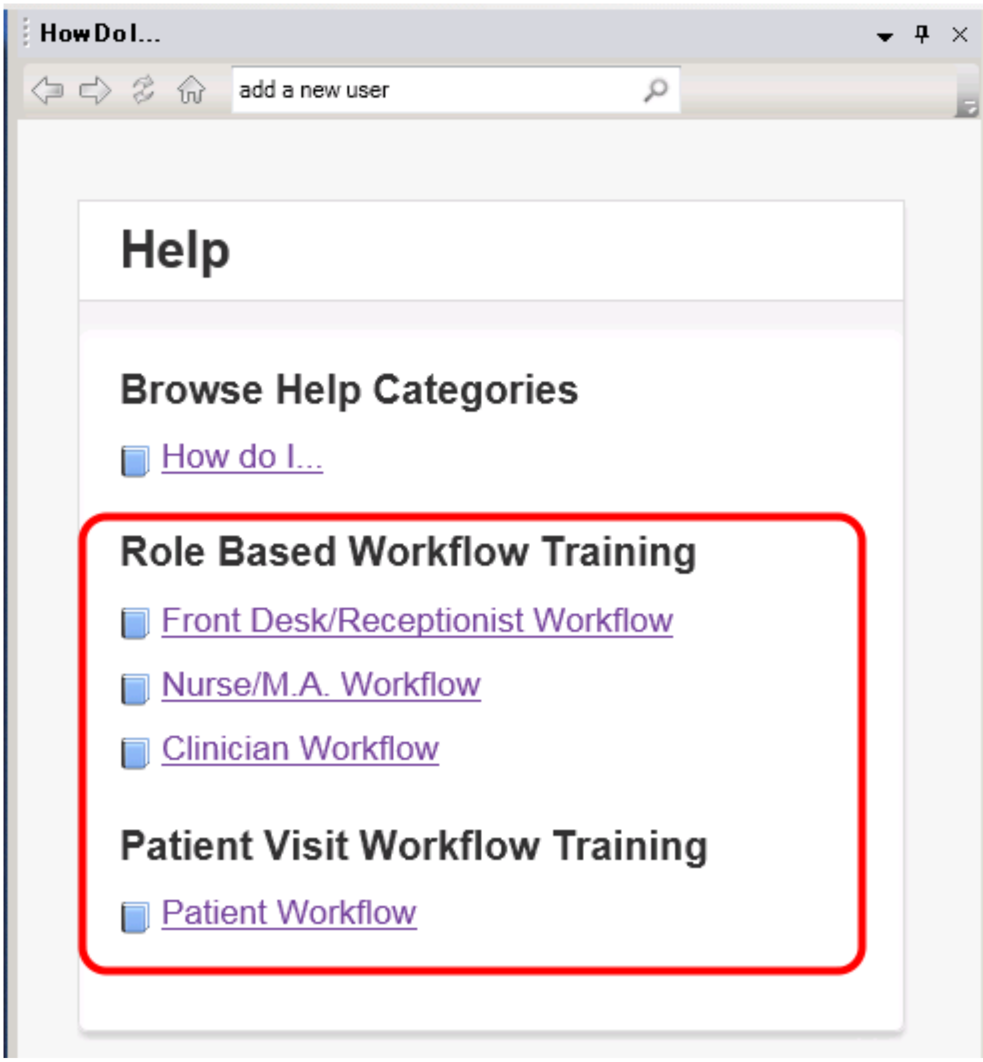
Browse Help Categories: How Do I...



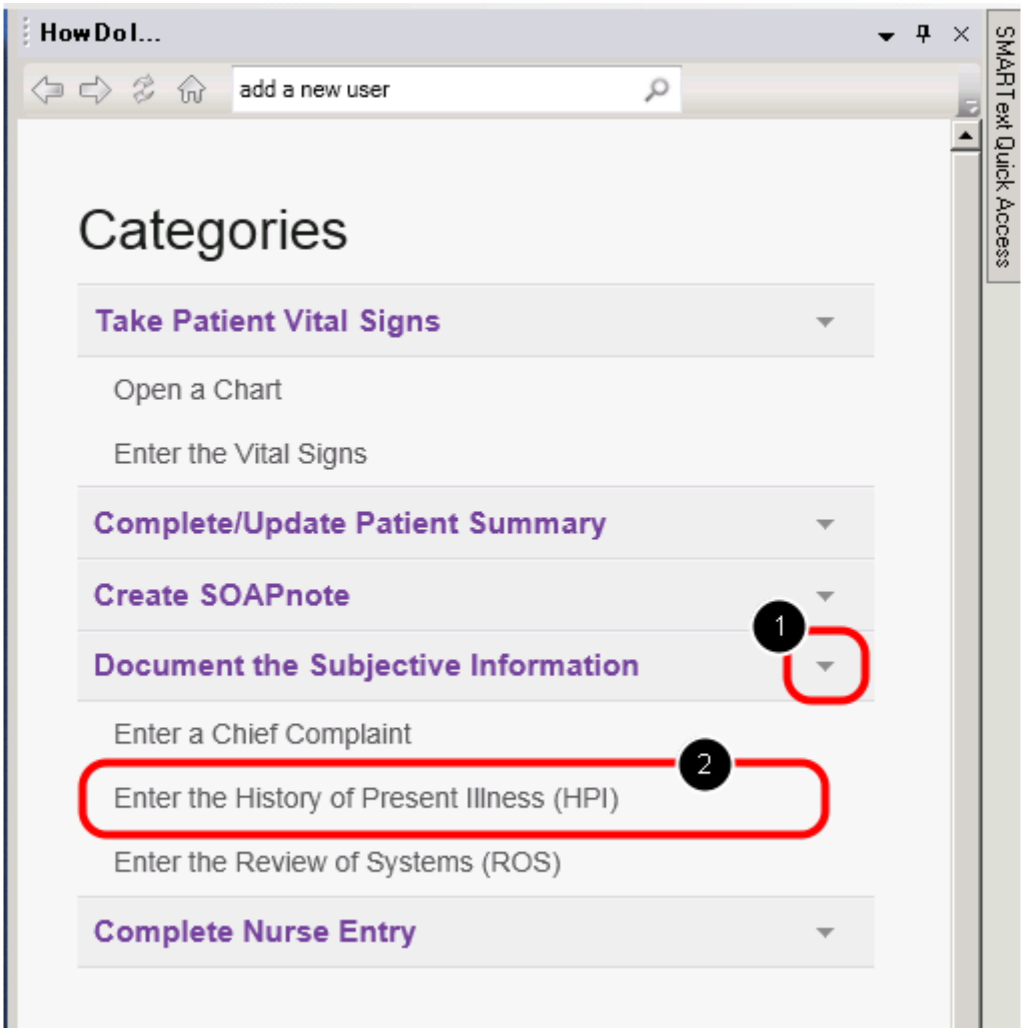
The user can click the "How Do I..." link located on the Help Home page (or go to Help > Browse Help Categories) to browse a listing of help categories. To view lessons within each category:

1. Click on the category name to view the available training topics.
2. Click on the topic name to open the instructional lesson.

Role Based & Patient Visit Workflow Training Exercises



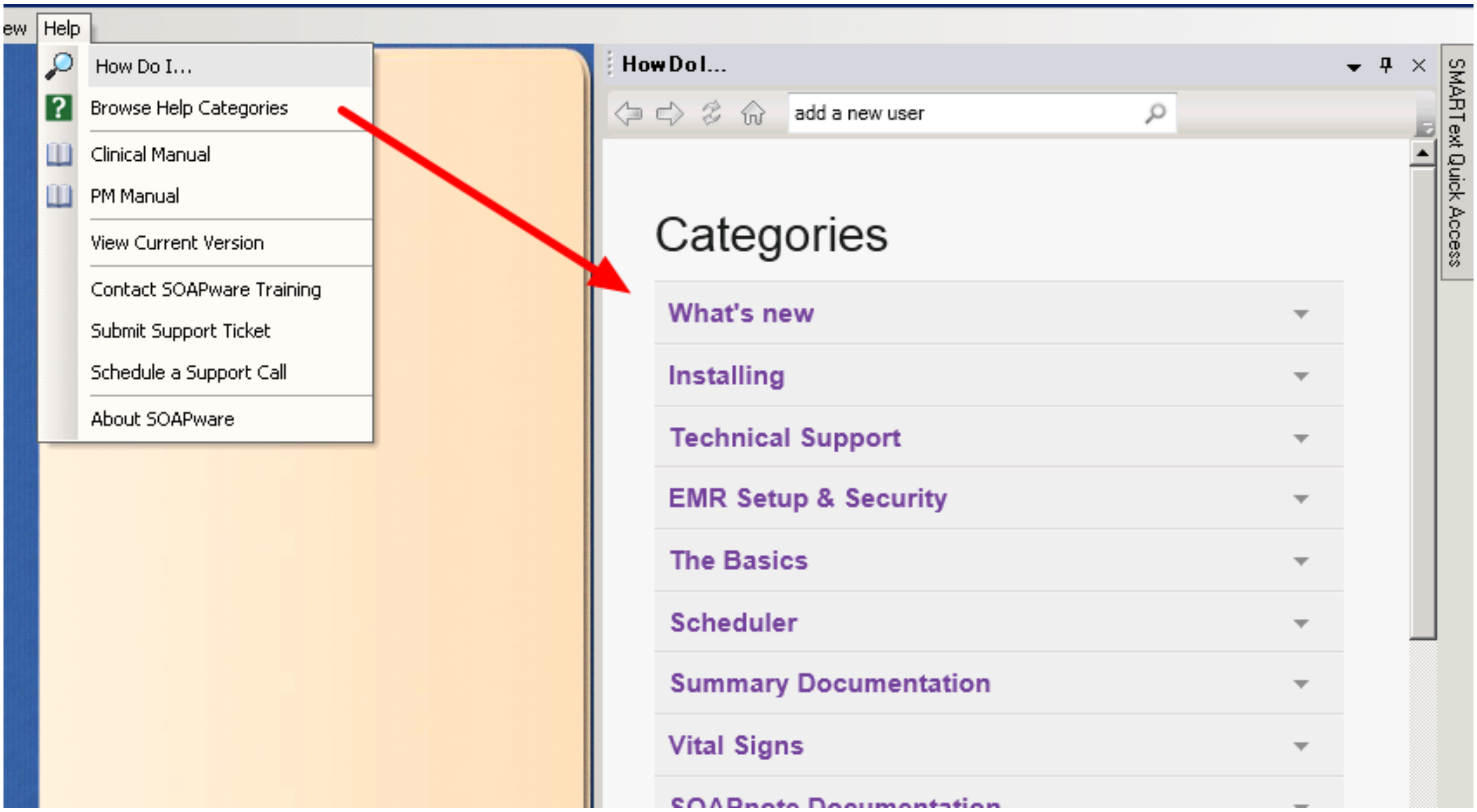
The user can click any of the Role Based or Patient Visit Workflow Training links to view a listing of training topics organized by workflow.



When the Nurse/M.A. Workflow link is clicked, the user is presented with categories of workflows (ie: take patient vital signs, complete/update patient summary, etc.).

1. Click on the category to view the available training topics.
2. Click on the topic name to open the instructional lesson.

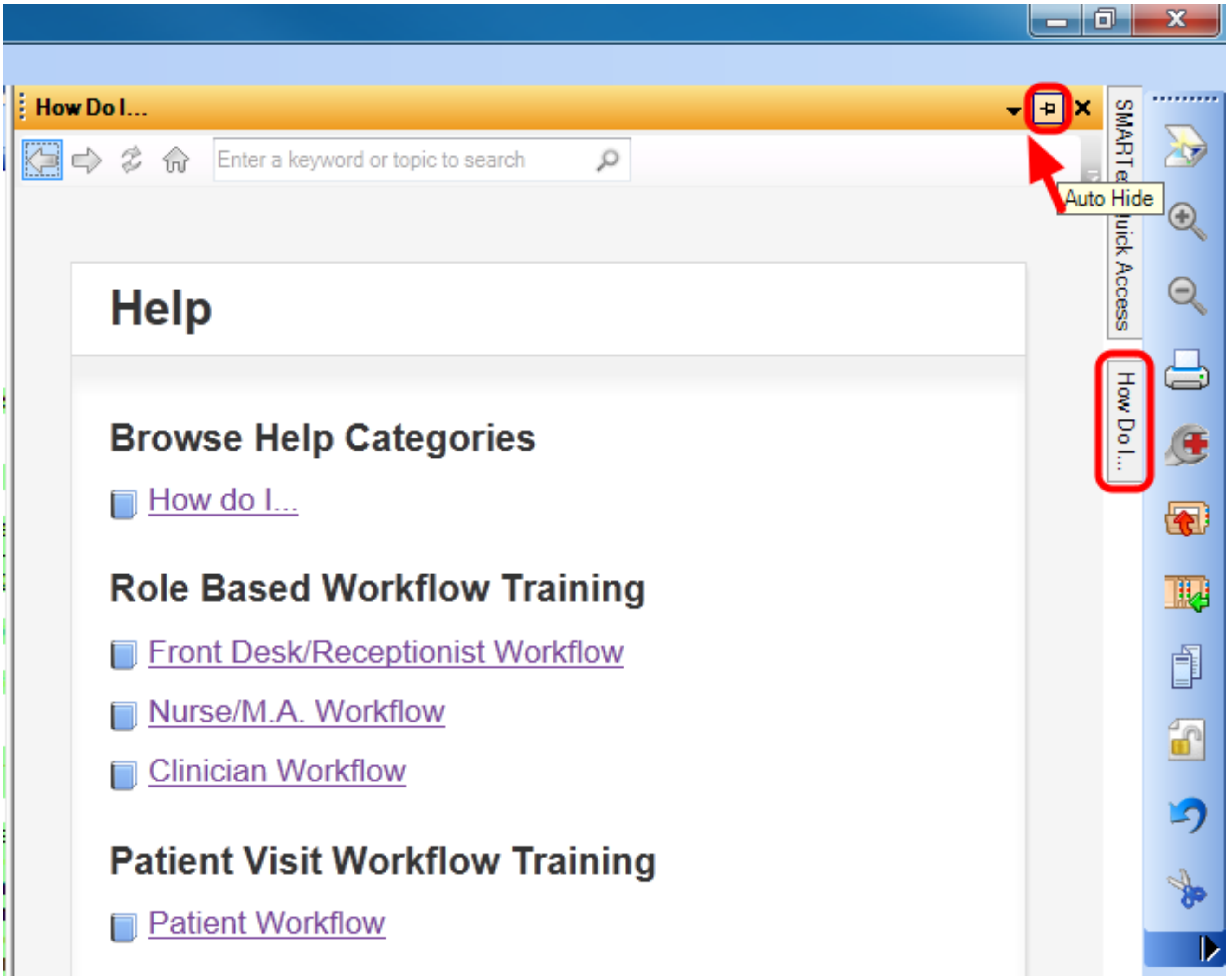
Help Menu: Browse Help Categories



In addition to the "How Do I..." search dialog within the Help menu, there is a button to Browse Help Categories.

Click on the **Help** menu, then select **Browse Help Categories**. This will open the How Do I... docked tab and allow the user to browse through the list of available help categories.

Closing the How Do I... Window



To close the How Do I... window, simply click the Auto Hide button (push pin icon). This will create a new tab located on the right side of your screen (the push pin icon will face to the left). Any time you need to search for a help topic or keyword, simply click on the tab to access the How Do I... documentation.

Clicking the push pin icon again (the push pin icon will then face downward) will pin the window open allowing you to view the documentation while working inside of SOAPware.

Backing Up SOAPware Data

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 newer versions of the 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 on the install file and choose “Run as administrator."

Log In

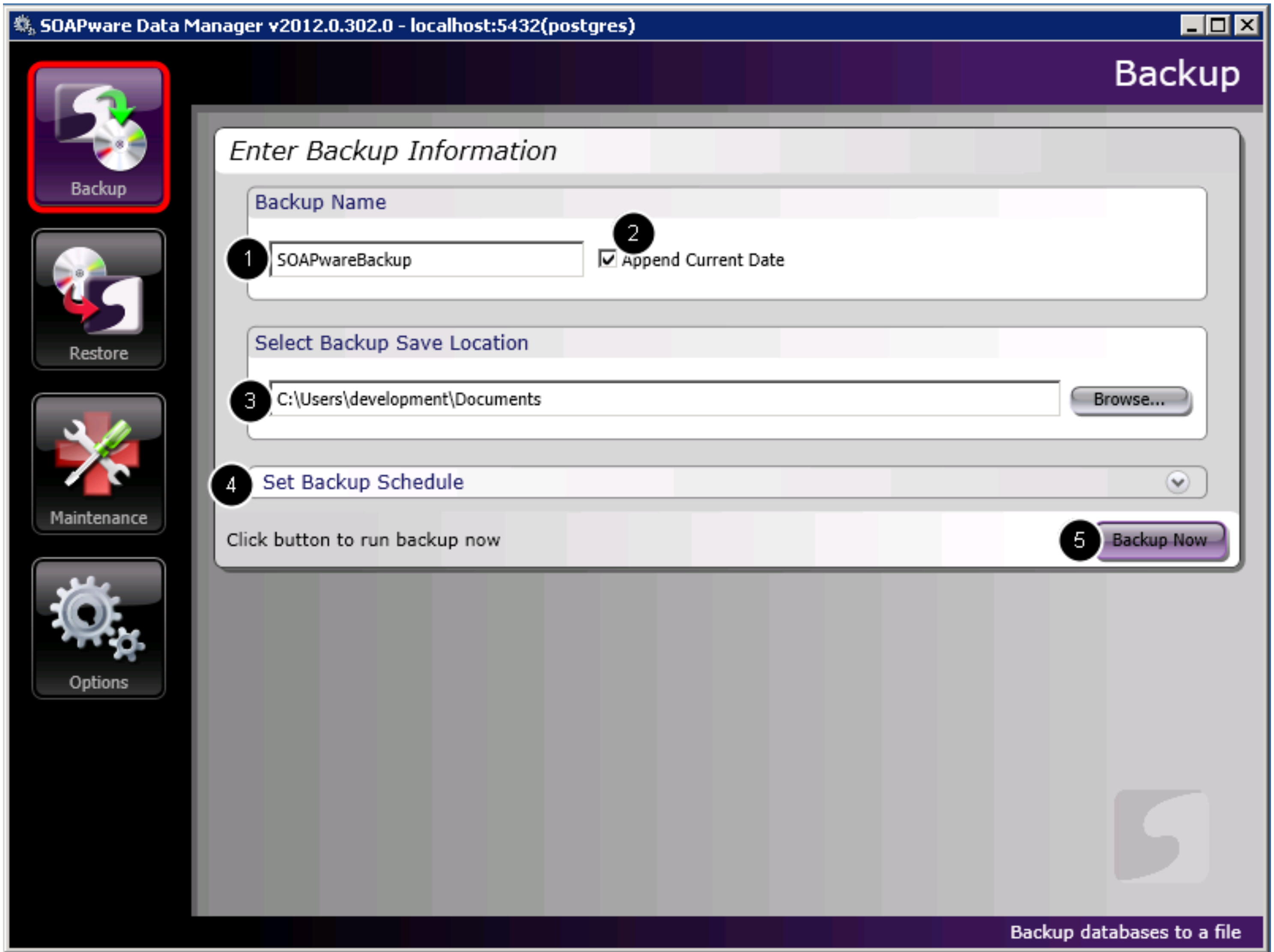
When a user starts DataManager, the user must log in with the database administrator password. This defaults to the PostgreSQL user account on the database. (This is the second set of passwords created during the SOAPware Data Server installation).

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

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

- **Server**: Host name or IP address where the database is running. The default is "localhost".
- **Port**: Port number where the database is listening. The default is port 5432.
- **User Name**: The administration user on the database. User must have administration privileges. The default setting is PostgreSQL.

Enter Backup Information



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.

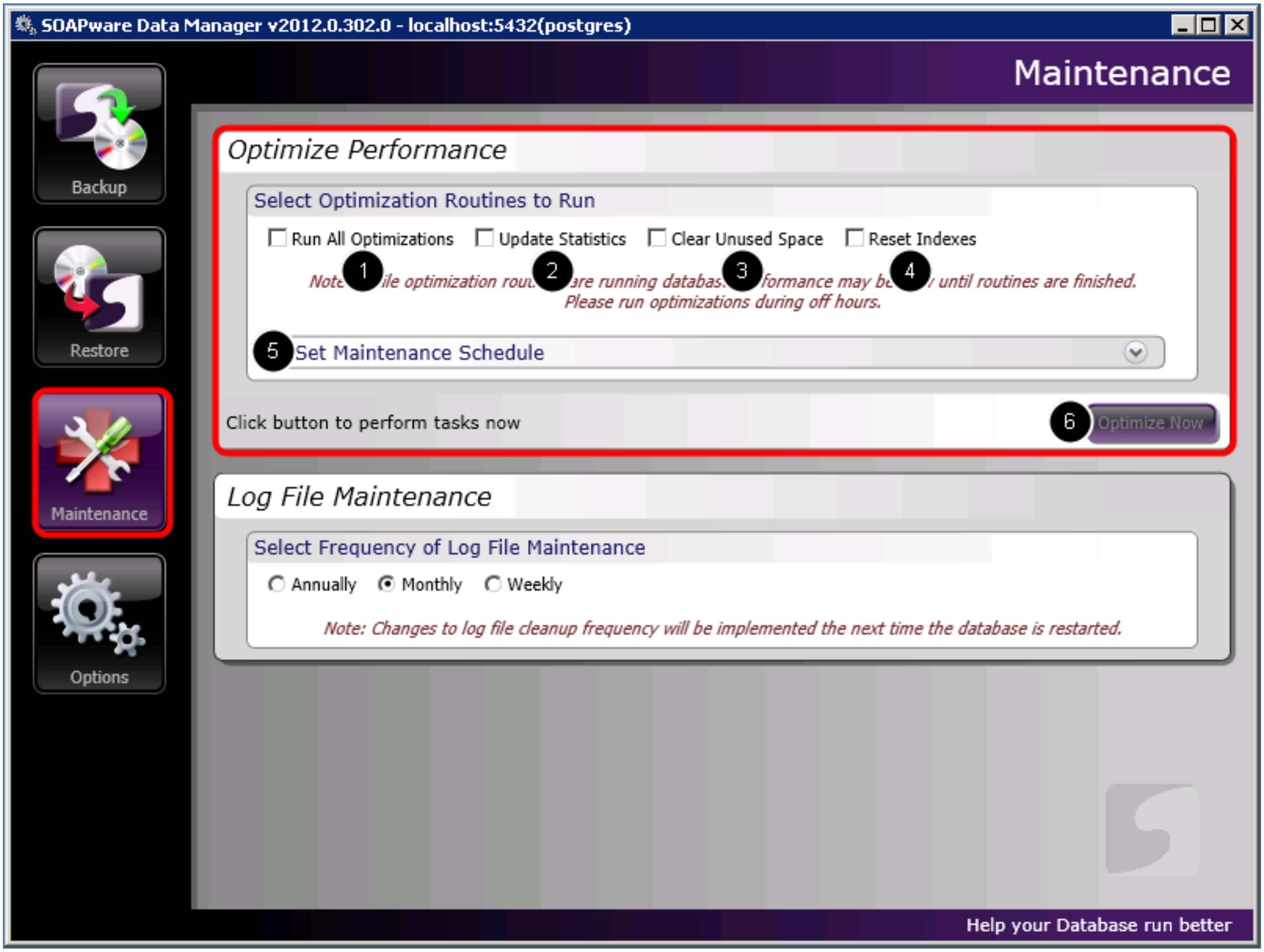
Backup file sizes can range from about 50 MB to many Gigabytes, depending on database size and compression options.

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.**

1. **Backup Name:** Users should choose a meaningful backup name that can be easily remembered.
2. **Append Current Date:** This will attach a date stamp of when the backup was run. If checked, new backup files will be created each day, which in turn will create multiple backups. This helps ensure the user's data, but the 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.
3. **Select Backup Save Location:** Choose the folder where the backup file will be placed.
4. **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.
5. **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 the database will not be affected. If a backup is canceled, go to Start > Programs > PostgreSQL 8.x, and Click "Start Service".*

Maintenance: Optimize Performance



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 once a month.

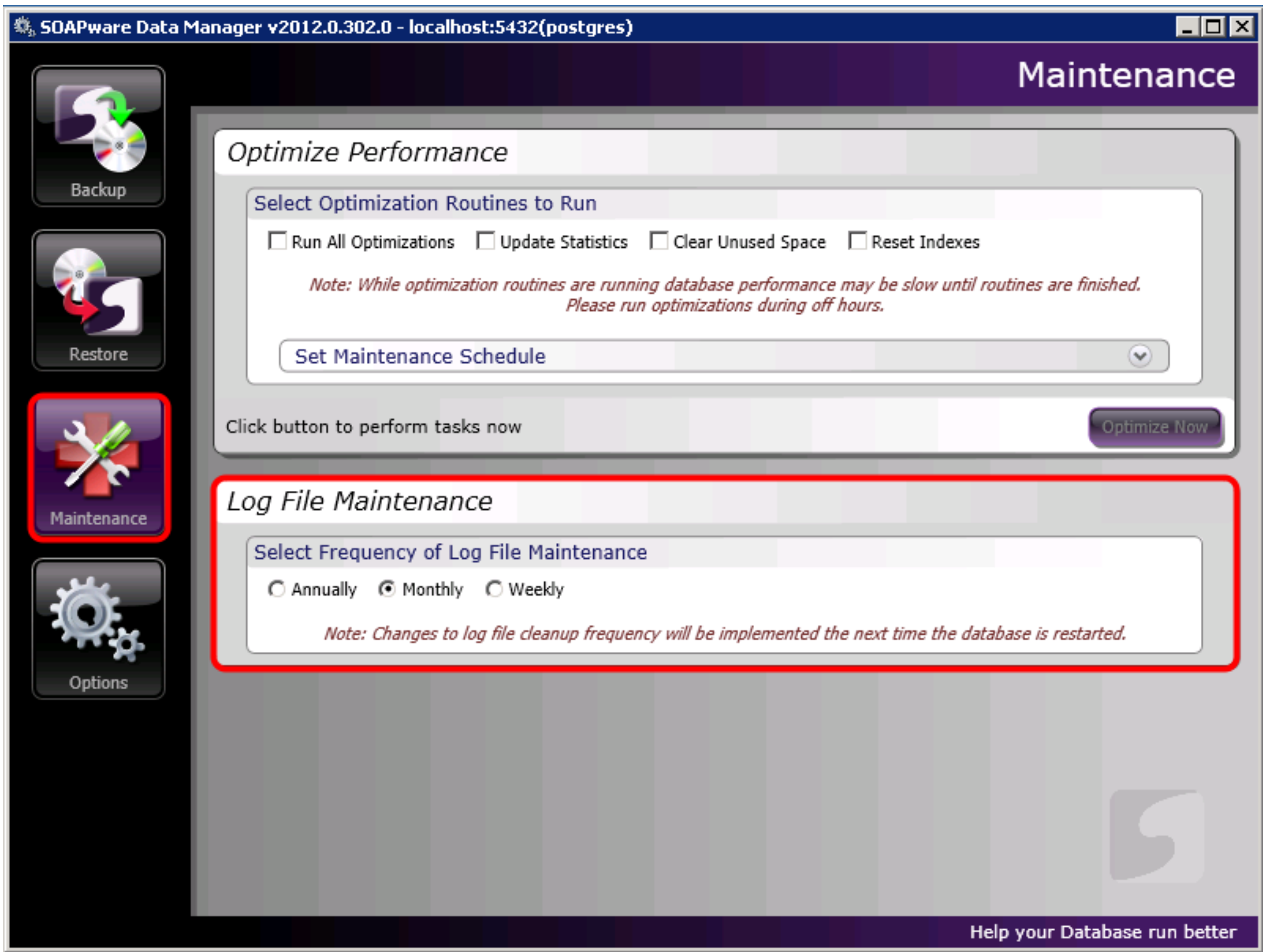
Optimizations may take from 30 minutes to several hours to complete.

1. **Run All Optimizations:** Perform each optimization (Recommended)
2. **Update Statistics:** Resets all table statistics, row counts, etc.
3. **Clear Unused Space:** This is useful after multiple deletions to reclaim space left behind.

4. **Reset Indexes:** Refreshes table indexes to help data retrieval.
5. **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.
6. **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.*

Maintenance: Log File Maintenance



The Log File Maintenance feature within DataManager allows the user to effectively control the number of log files that will be stored in the "pg_log" folder.

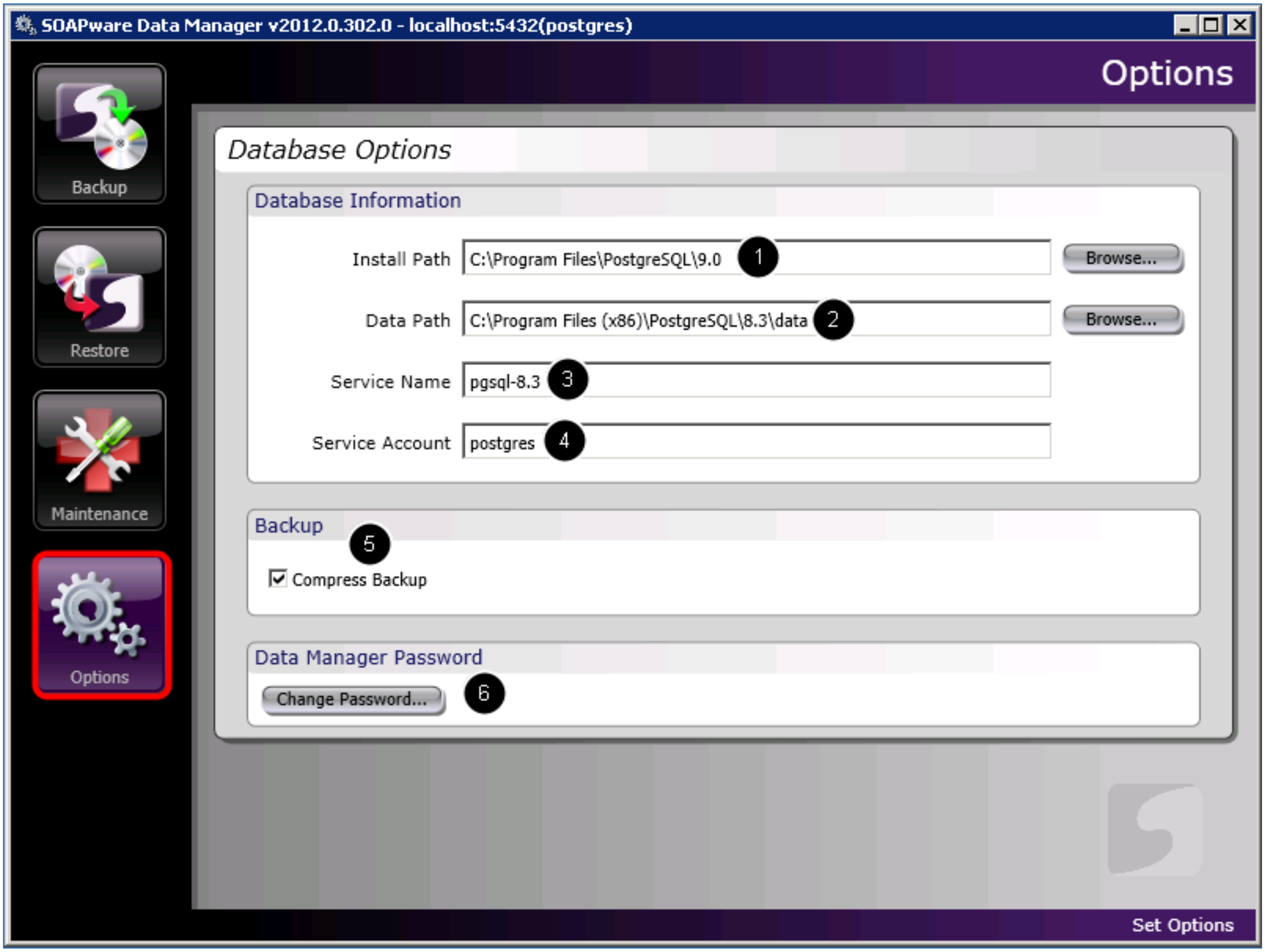
The user can select the frequency of the log file maintenance by choosing annually, monthly, or weekly.

- **Weekly**: If the "weekly" option is selected, the files will be kept for up to one week before being overwritten with new files for the following week.
- **Monthly**: If the "monthly" option is selected, the files will be kept for 30 days before being overwritten with new files for the following month.
- **Annually**: If the "annually" option is selected, the files will be kept for 365 days before being overwritten with new files for the following year.

The user should choose whichever option will best suit the database. The default setting will be set to "Monthly".

***Note:** *Please note that any changes to log file maintenance will be implemented the next time the database is restarted.*

Options: Database Options

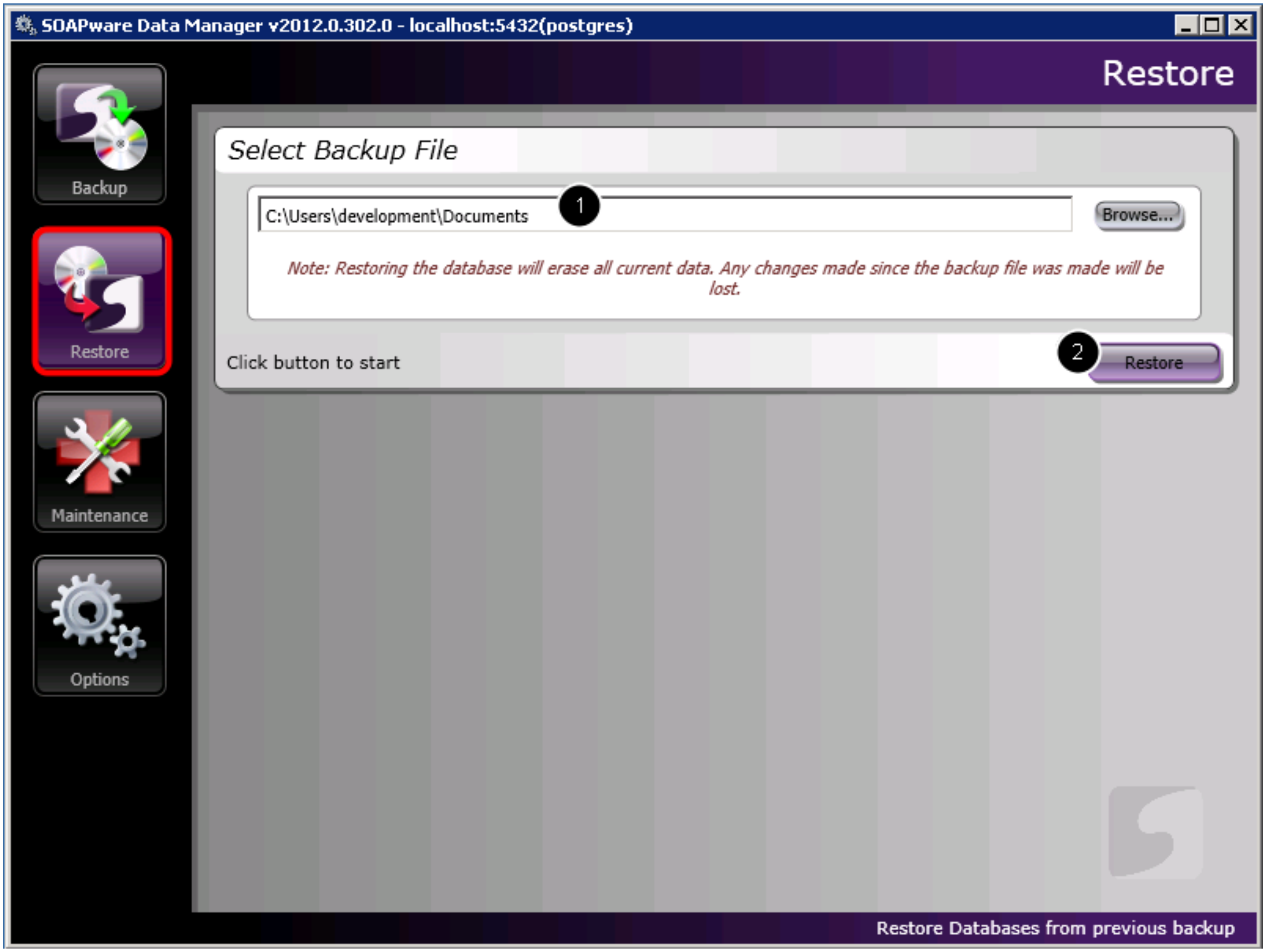


1. **Install Path:** The DataManager uses Postgres utilities for backup and restore. This path should not be changed unless the Postgres install path is different than listed.
2. **Data Path:** This section is used to point the DataManager to the location where the data is stored in order to backup. By default the path will be C:\Program Files (x86)\PostgreSQL\8.3\data.
3. **Service Name:** The service name is the name of the SOAPware PostgreSQL Data Server service. Typically, this will be pgsql-8.3. To check, 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 the user has.

4. **Service Account:** This is the windows user that starts the SOAPware PostgreSQL Data Server after the backup is complete. This should always be postgres.
5. **Compress Backup:** This option compresses the backup file as it is being written. Use this option to keep file sizes at a minimum.
6. **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 PostgreSQL database.*

Restore



The DataManager can take a previously made backup file and restore the database to its original state.

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

1. **Select Backup File:** Choose the backup file created by the DataManager to run a restoration.
2. **Restore Button:** Click this button to start the restoration.

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 restoration is attempted and there proves to be insufficient disk space, the process 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 that drive.

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

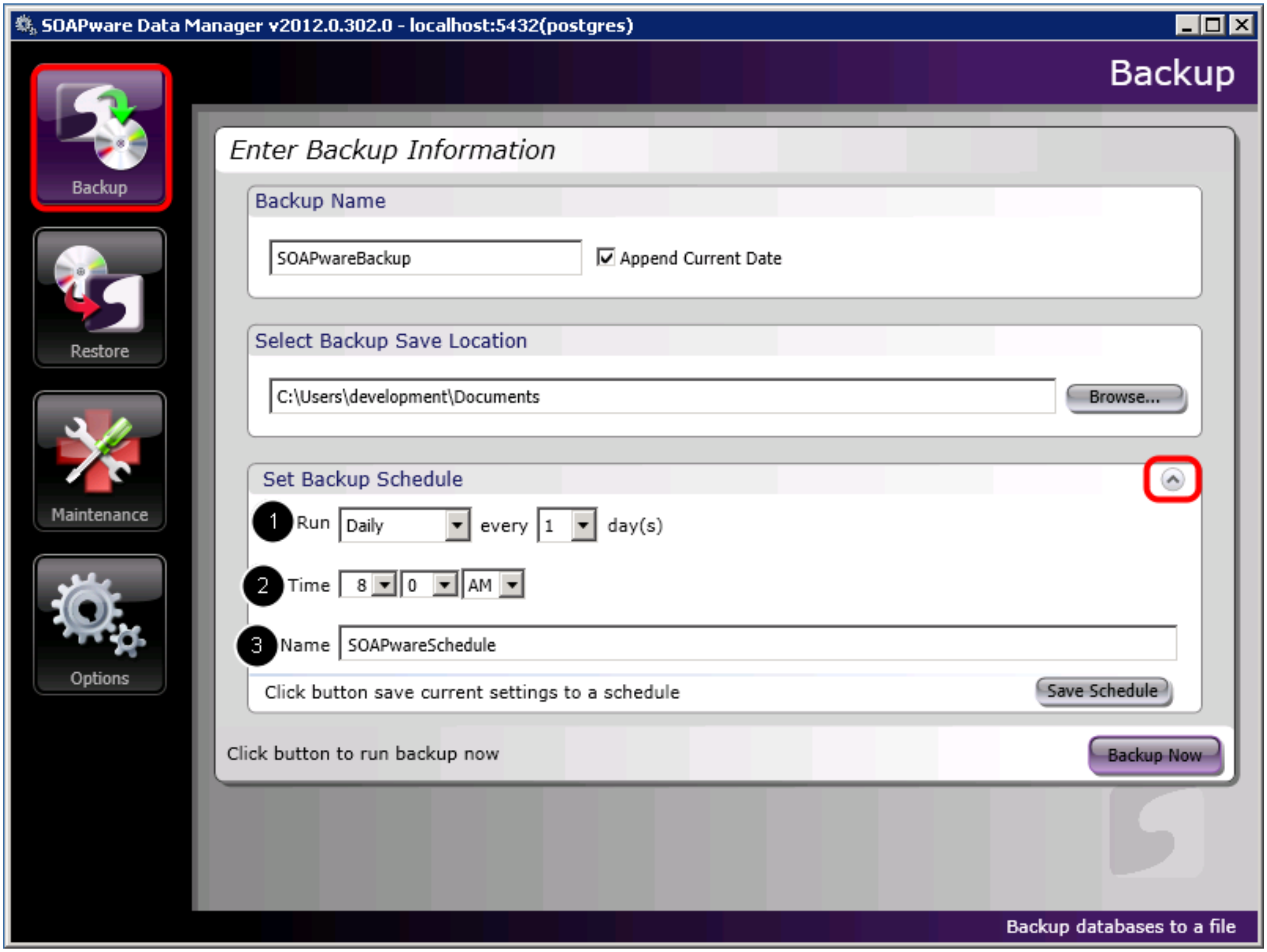
WARNING: Running a restore will replace all the data and table structures within the database. The old database will be deleted. This process cannot be canceled.

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.

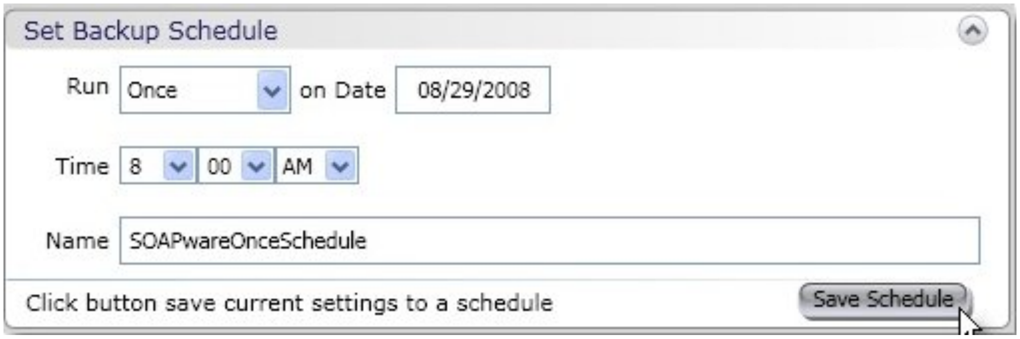
Create a New Scheduled Task



After setting the backup or maintenance information, click on the "Backup" button in the top left hand corner. Expand the "Set Backup Schedule" tab by clicking on the down arrow icon.

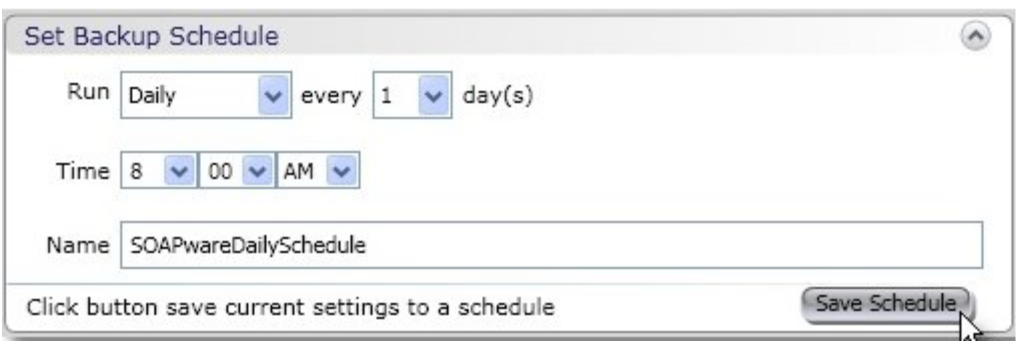
1. **Run:** Under the Run drop down, you may choose the schedule run type from Once, Daily, Weekly or Monthly. Different options will appear depending on the type of schedule selected.
2. **Time:** Set the time for the task to run. This should be a time when there is no database activity.
3. **Name:** Name the schedule so that it will be unique within the Windows Task Manager. If there is already a task with the same name, it will ask if you would like to overwrite the existing task.

Run Once



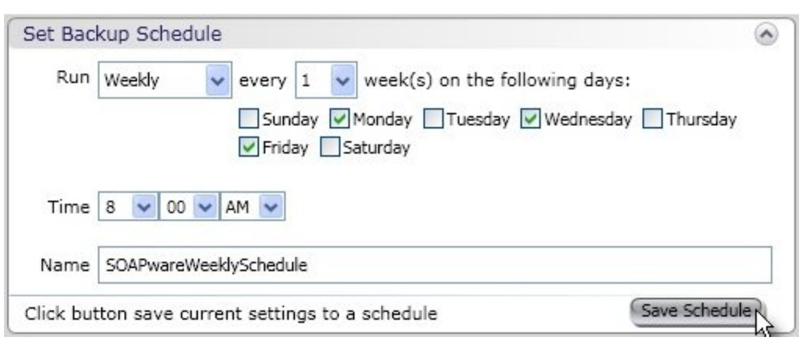
This option will run the task only once on the specified day and time.

Run Daily



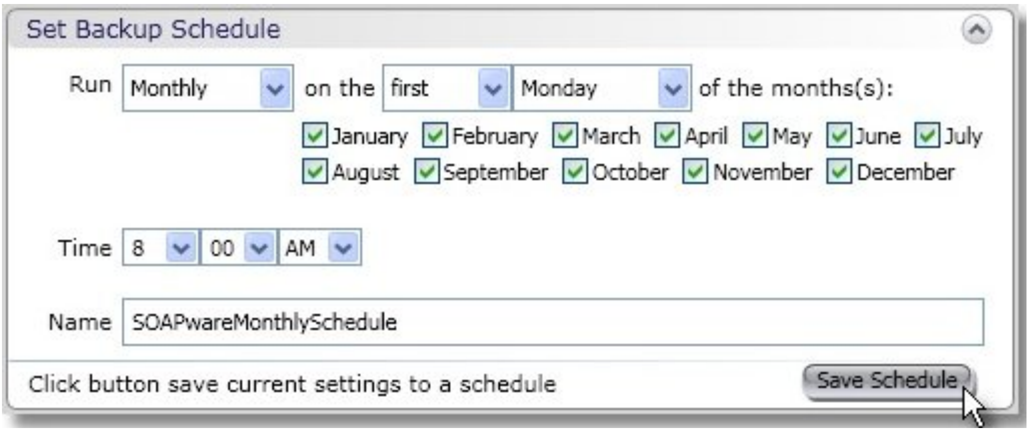
This option will run the task daily. A user can choose to skip a number of days.

Run Weekly



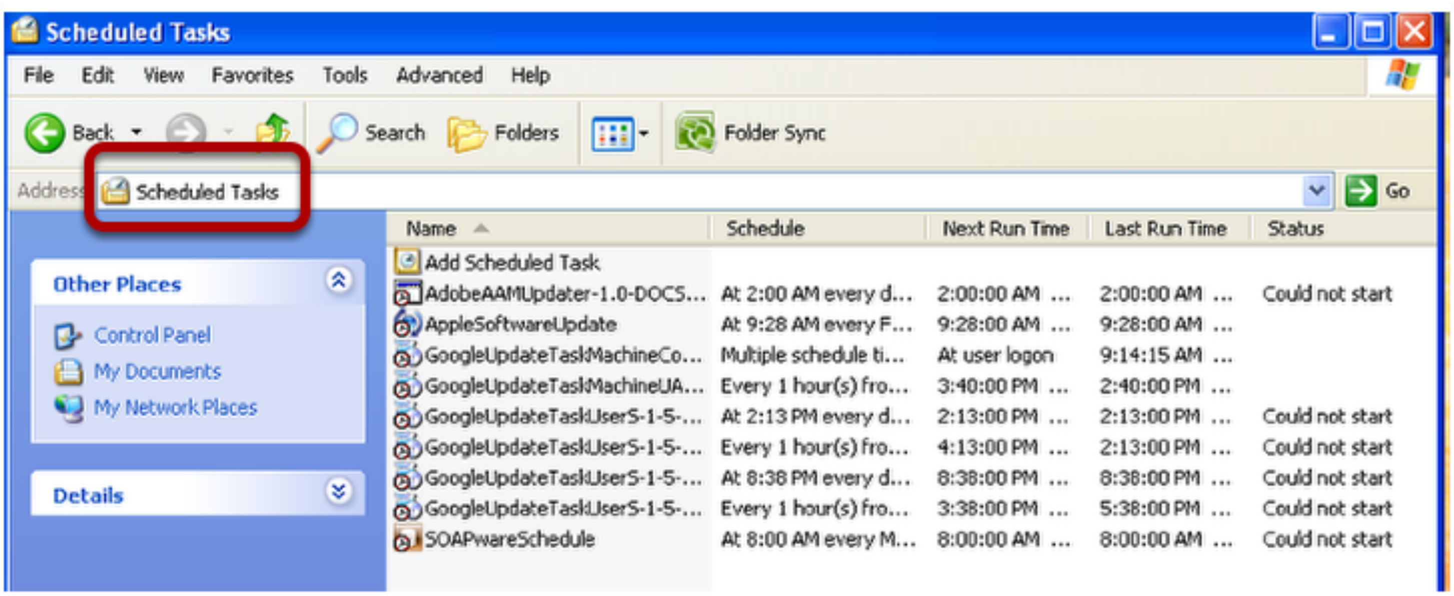
Running a task weekly allows a user to choose which days of the week to run. A user may also skip weeks.

Run Monthly



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.

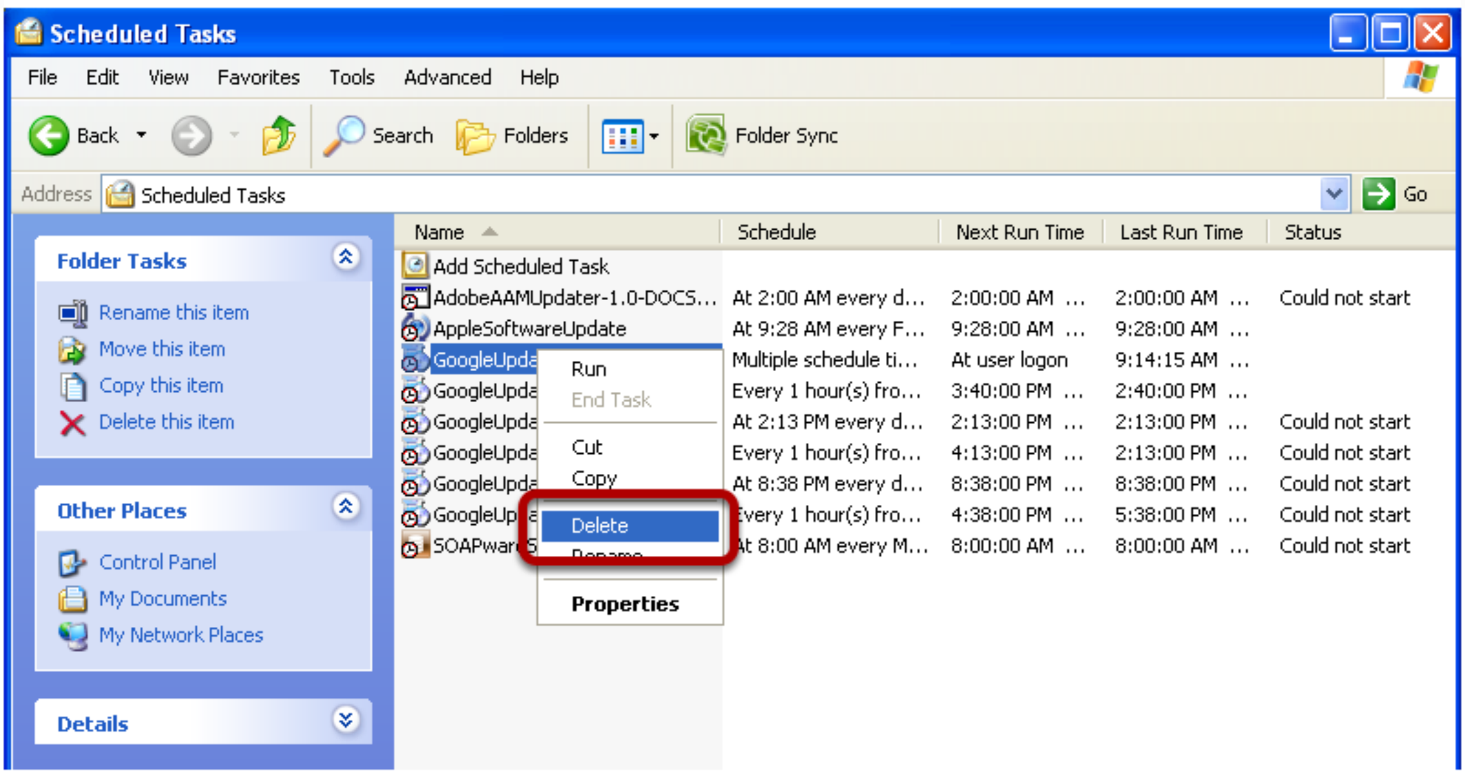
Change Existing Schedule



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.

Terminology

Glossary Terms

Glossary Terms (A-C)

About SOAPware - Amenu 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 a 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 - Aqueue 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 days visit.
Available Document Designs - An area that lists all available print reports. This area can either be docked, accessed from the Docutainers 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) - Astandardized 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 patients chart section without the need to open each individual chart.
Document Management - Allows the clinic to store the patients X-rays, paper reports, Lab reports etc. Document Management includes scanning, dragging and dropping directly into the patients 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 speeder documentation.
Document Designer - An area that allows for documents to be created for printing, faxing or storing in the patients 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, Mediation 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 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 SMARText 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 SMARText Header) - The first word or description of a SMARText 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.
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 (Meaningul 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 SMARText Items - Structured SMARText 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 SMARText item in which a shortcut code has a list of SMARText 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 SMARText 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 - Aworkspace 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 - Aworkspace 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 - Aworkspace which allows the user to export all or portions of a medical record to a PDF file.
Shortcut Code - ASMARText shortcut code that enters a SMARText item or block of text quickly when typed in field and the spacebar is pressed.
Signature Password - Signature Password, when enabled, will require passwords to sign off documents and to have multiple providers co-sign on the same documents.
SMARText - Atool to create, edit and use structured documentation that is both searchable and reportable. There are several different types of SMARText items such as diagnosis, CPTs, Medications and pick lists.
SMARText Builder - An advanced workspace which will allow the user to create SMARText Item Clusters and SMARText Item Groupers.
SMARText Color Coding - Asetting located under the Tools menu which allows the user to color code specific SMARText items such as pick lists, field headers, and the active background.
SMARText Designer - The area in which a SMARText item is created or the original SMARText item is edited.
SMARText Location Pick List - Auser-specific pick list that will display previously used SMARText

items in the SMARText Quick Access depending on what field the cursor is active in.
SMARText Manager - Located under the Docutainers menu, this area is for searching for SMARText items and opening the SMARText Designer to create or edit a SMARText item.
SMARText Quick Access - Located under the Tools menu, this dialog box is used in conjunction with pick lists, SMARText location pick lists, and SMARText 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- Areminder 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. Aprevious encounter, or part of it, can also be added to the new encounter if desired.
View Signatures - Aright-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 Journeys (2012)

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

Education Journey for Users Upgrading from SOAPware 2010

The 2010 to 2012 Education Journey is an educational path for users who are upgrading from SOAPware 2010 to SOAPware 2012. The Journey will guide users through a step-by-step introduction to the new features and Meaningful Use in SOAPware 2012.

2010 to 2012 Education Journey

Education Journey for Users Converting from Version 4

The Version 4 to 2012 Education Journey is an educational path for users who are converting from SOAPware Version 4 to SOAPware 2012. The Journey will guide users through a step-by-step learning process while preparing for the conversion.

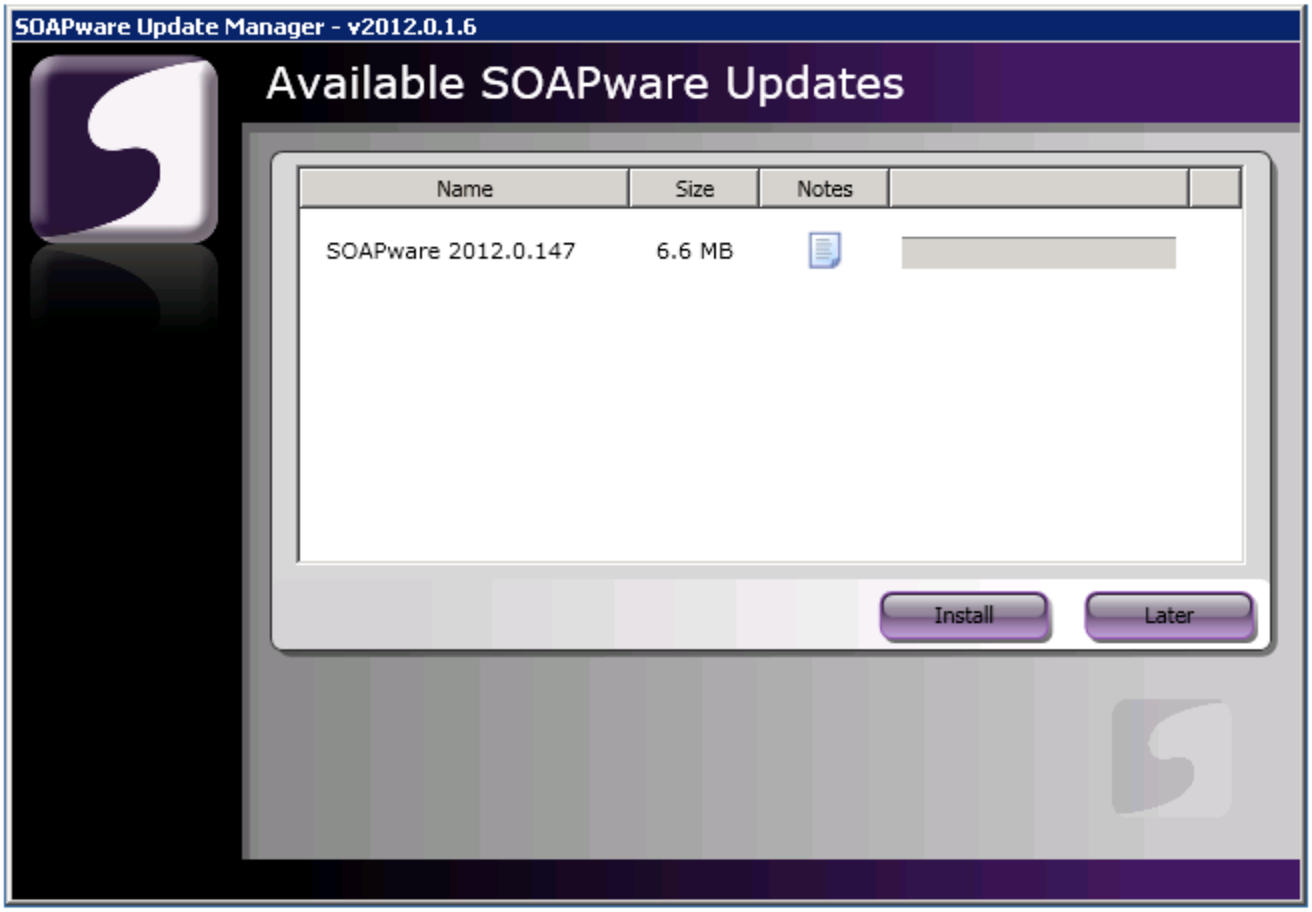
Version 4 to 2012 Education Journey

SOAPware 2012 New Features

2012 New Features

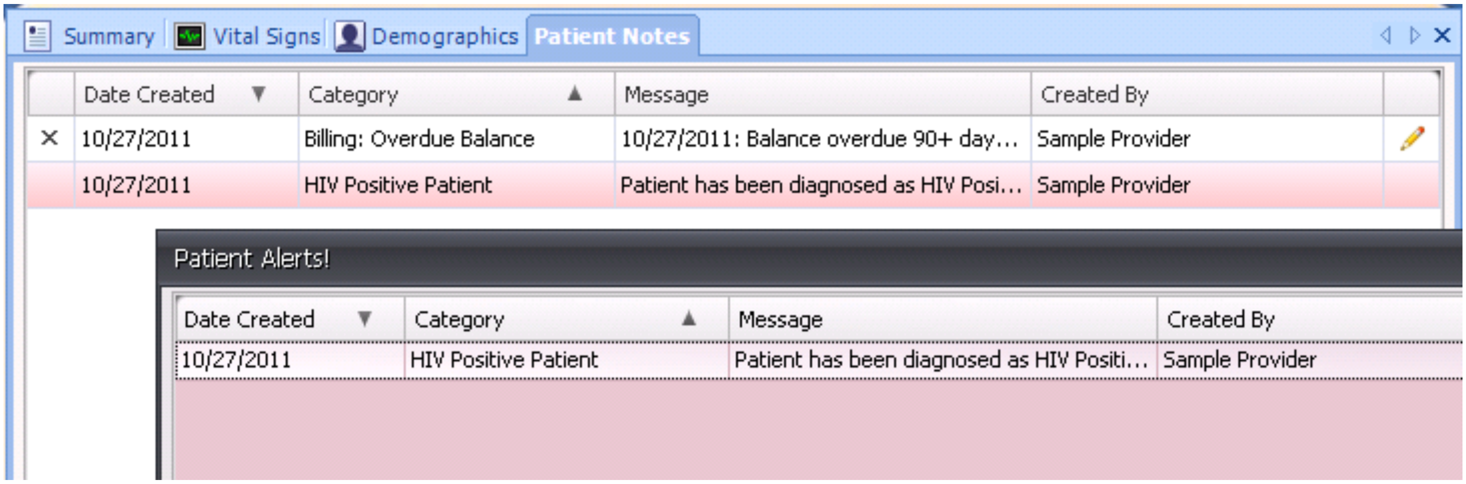
The following is a list of some of the exciting new features that are available in SOAPware 2012.

Automatic Update Functionality



After the upgrade to SOAPware 2012, users will now be notified of SOAPware updates through our new Automatic Update functionality. The SOAPware Updates Manager will allow the user to perform updates through a simple, automatic update process on each computer.

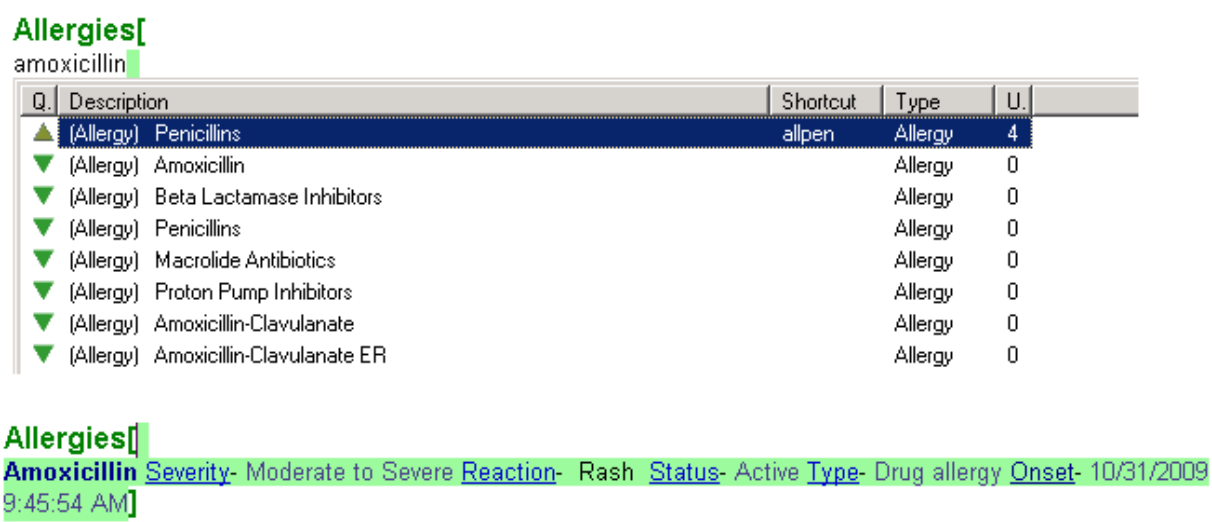
Patient Flags/Notes



The new Patient Flags/Notes function will allow users to create and record patient flags (alerts) or notes that will warn the SOAPware user when the patient's chart or account is opened.

2012 New Features - Clinical

Allergy SMARText Items



SMARText Allergy Items

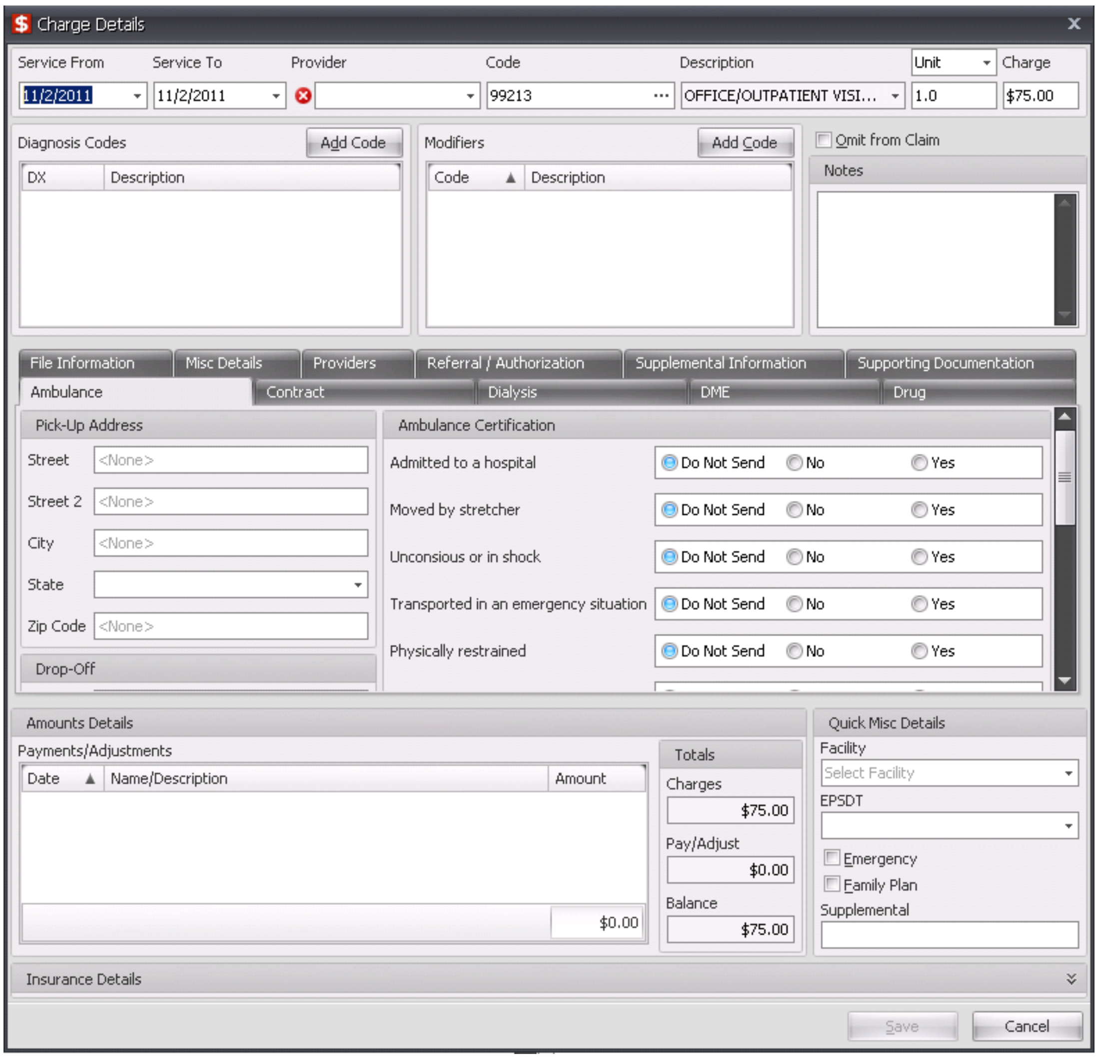
SOAPware 2012 now contains a new SMARText Item Type called "Allergy". The SOAPware Online

Library contains allergy items for all drug allergies/intolerances and all allergy categories (ie: NSAIDS, Penicillins, etc).

The SMARText Allergy items contain several sub-items that allow the user to quickly document the allergy severity, reaction, status, type and onset date.

2012 New Features - Practice Management

5010 Implementation

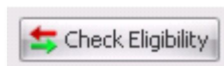


SOAPware 2012 includes full 5010 claim format implementation, affecting changes in the following areas:

- Facilities

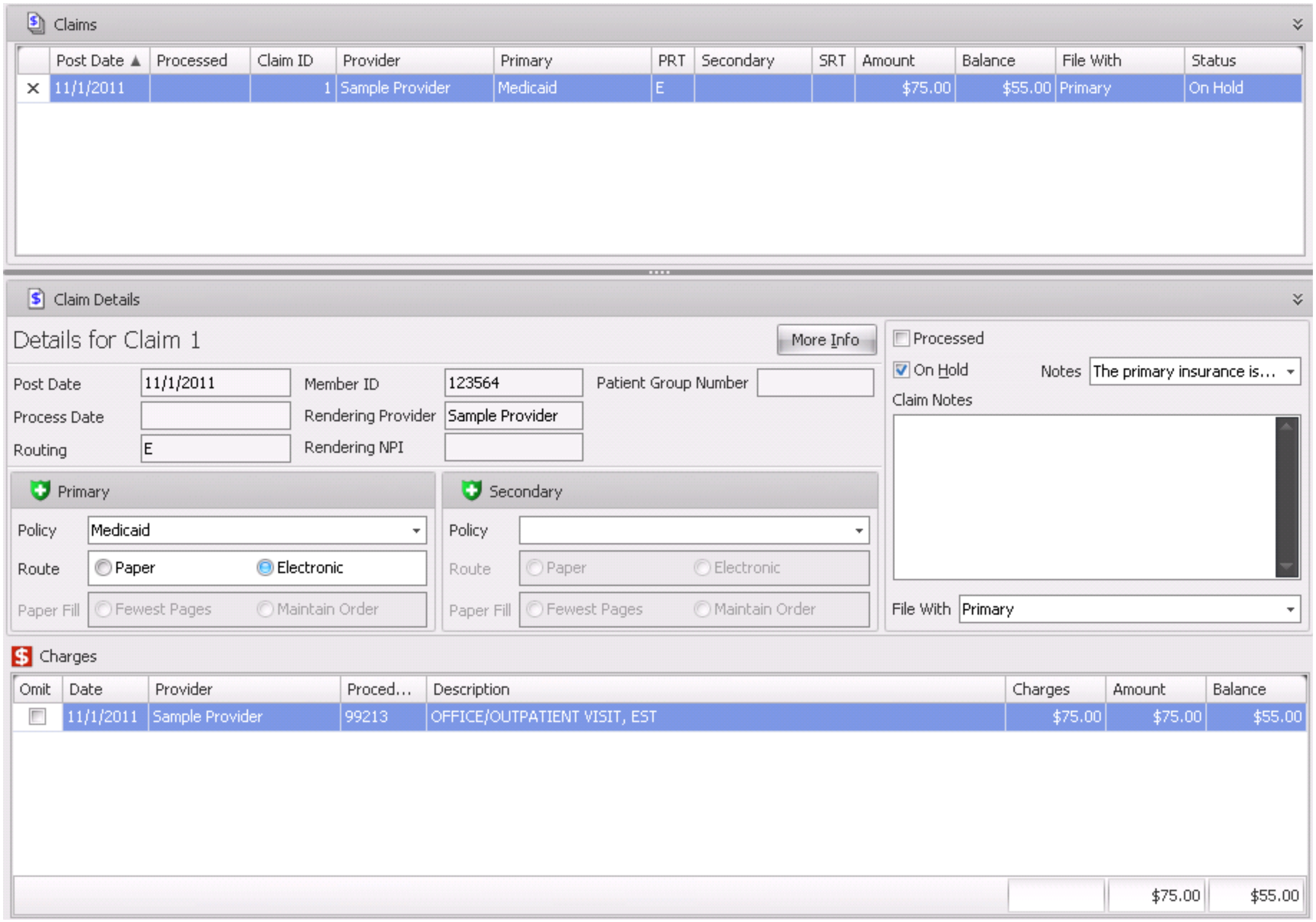
- Groups
- Contacts
- Insurance Companies
- Insurance Policies on Patient Accounts
- Charge Details
- Claim Details

New Integrations with Gateway EDI



- **Insurance Eligibility Checking:** Users will now be able to receive insurance policy eligibility information through Gateway EDI directly into SOAPware.
- **Patient Statement Integration:** Users will also be able to submit statements electronically to Gateway EDI for patient mail out.

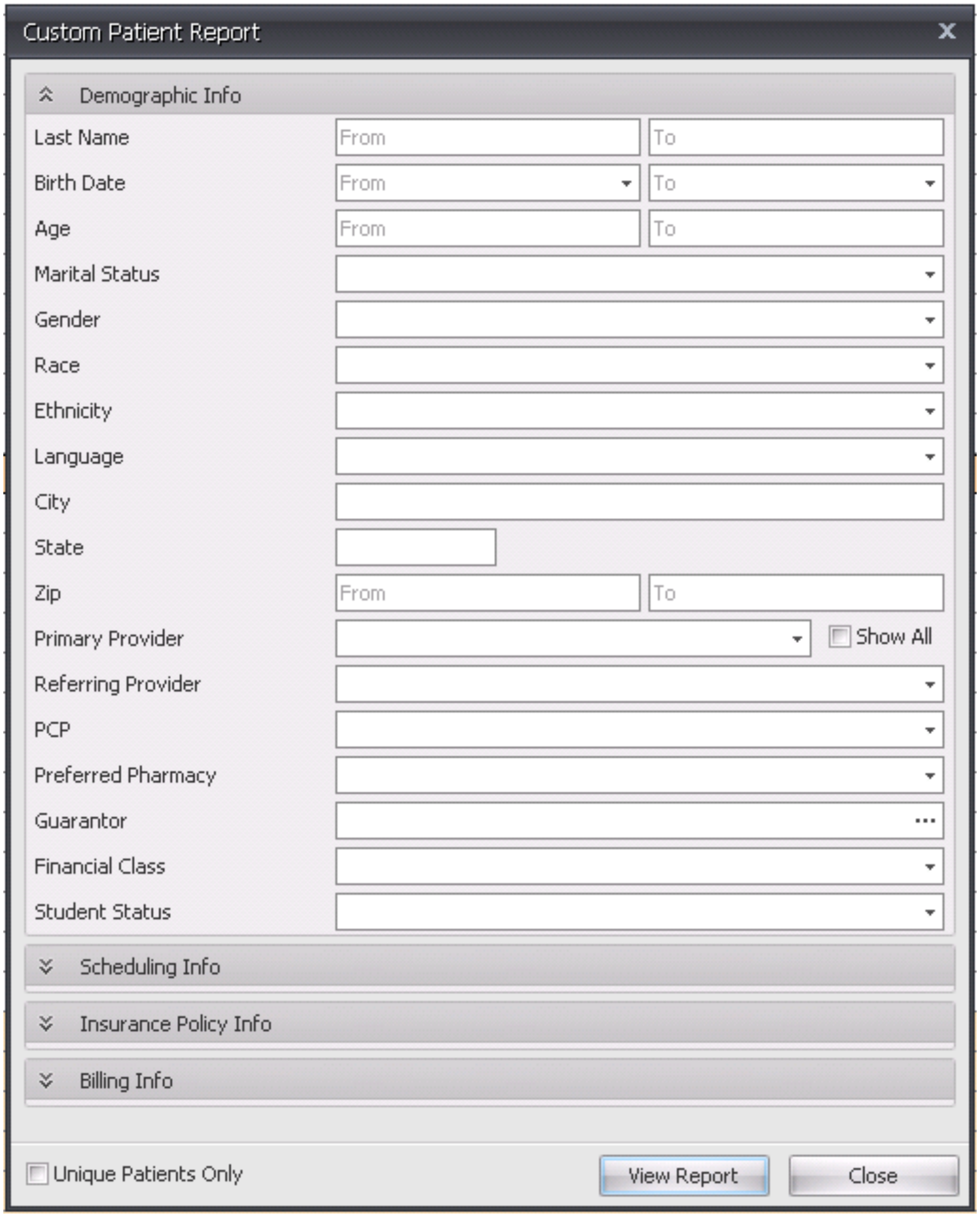
Claims Improvements



SOAPware 2012 includes the following improvements to claims:

- The ability to select Paper or Electronic routing at the claim level. This will no longer be tied to the Insurance Company setting.
- The ability to route claims back to Primary or Secondary insurance companies without the next action being tied to the posting of insurance payments.
- The ability to mark a claim as Processed (Patient Responsibility) without the next action being tied to the posting of insurance payments.

Custom Patient Report



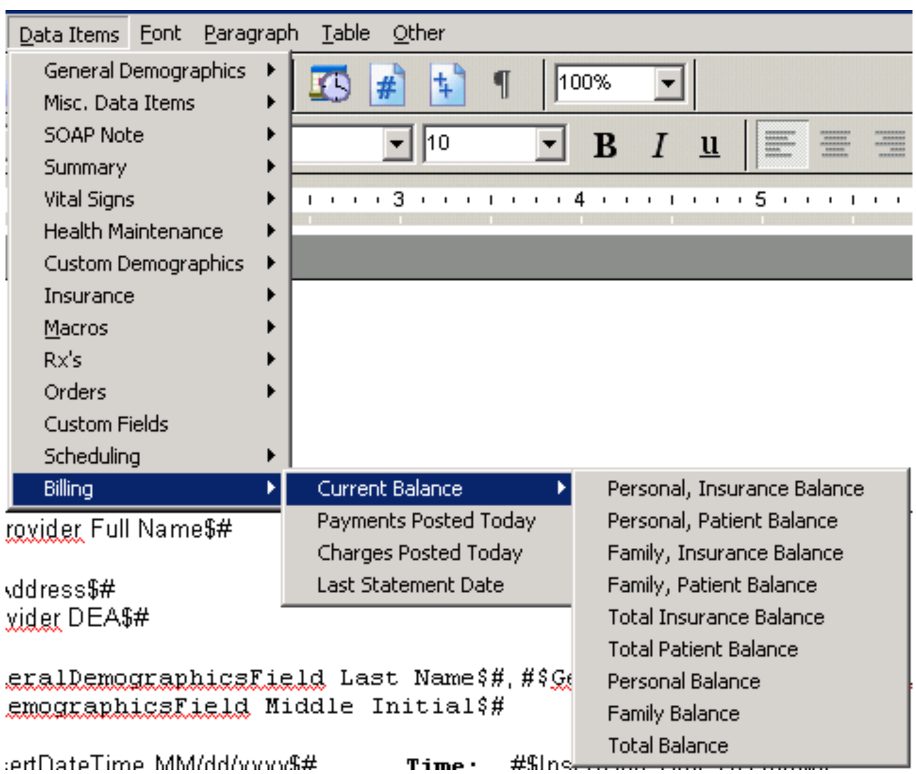
SOAPware 2012 includes a new custom patient report that allows custom searches of patient information and counts, based on multiple criteria.

Patient Balance Breakdown

The patient balance information in the top right of the Patient Account will include the following changes:

- Patient - Personal and Insurance separated
- Family - Personal and Insurance balances separated

Document Designer

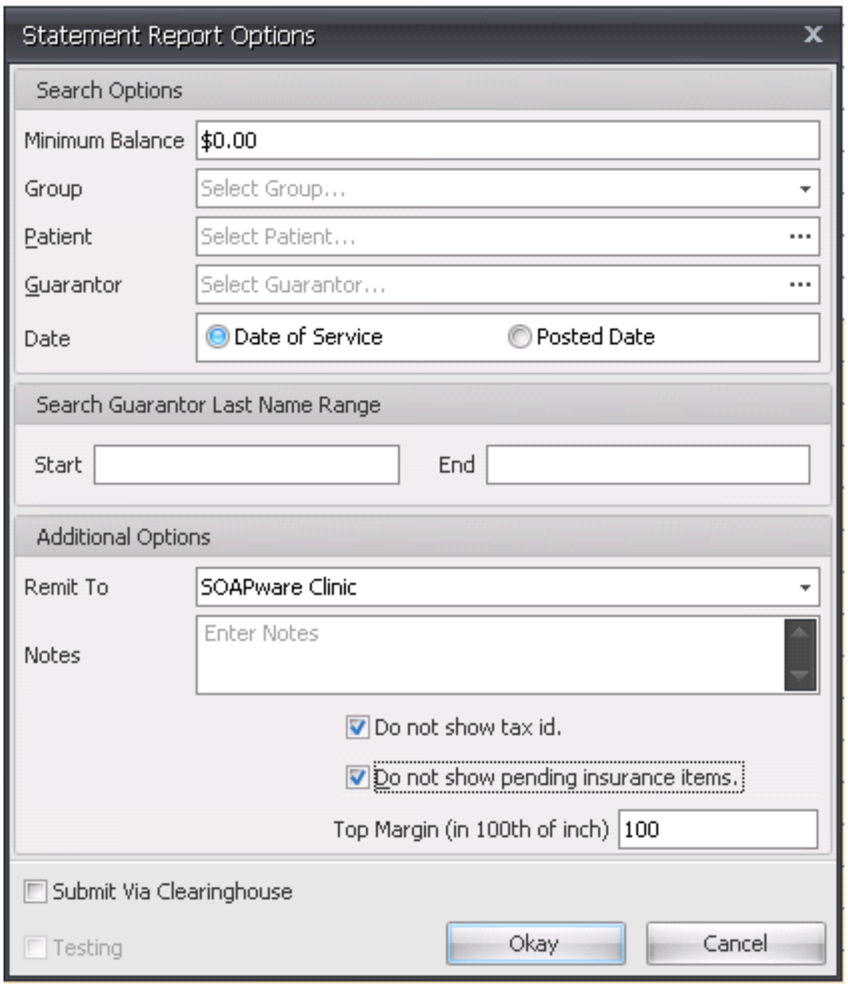


Document Designer now includes several Scheduling and Billing related Data Items, including the following:

- Next and previous appointment times

- Current patient and insurance balances
- Payments posted today
- Charges posted today
- Last billing statement date

Statement Changes



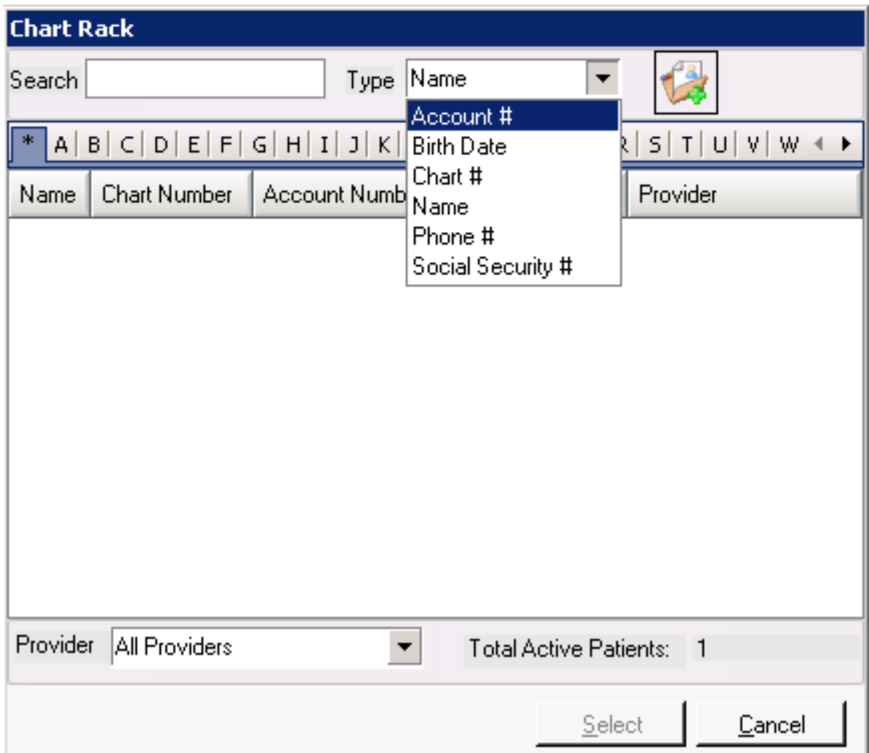
The following changes will be available for Statements in SOAPware 2012:

- The ability to remove the Tax ID from statements
- Anew Summary page preceding batch statements that indicates total amounts sent out in statements and associated A/R amounts.
- Statements will no longer be tied to the Active Facility in Scheduler. ARemit Facility can now

be selected from the Statement Report dialog.

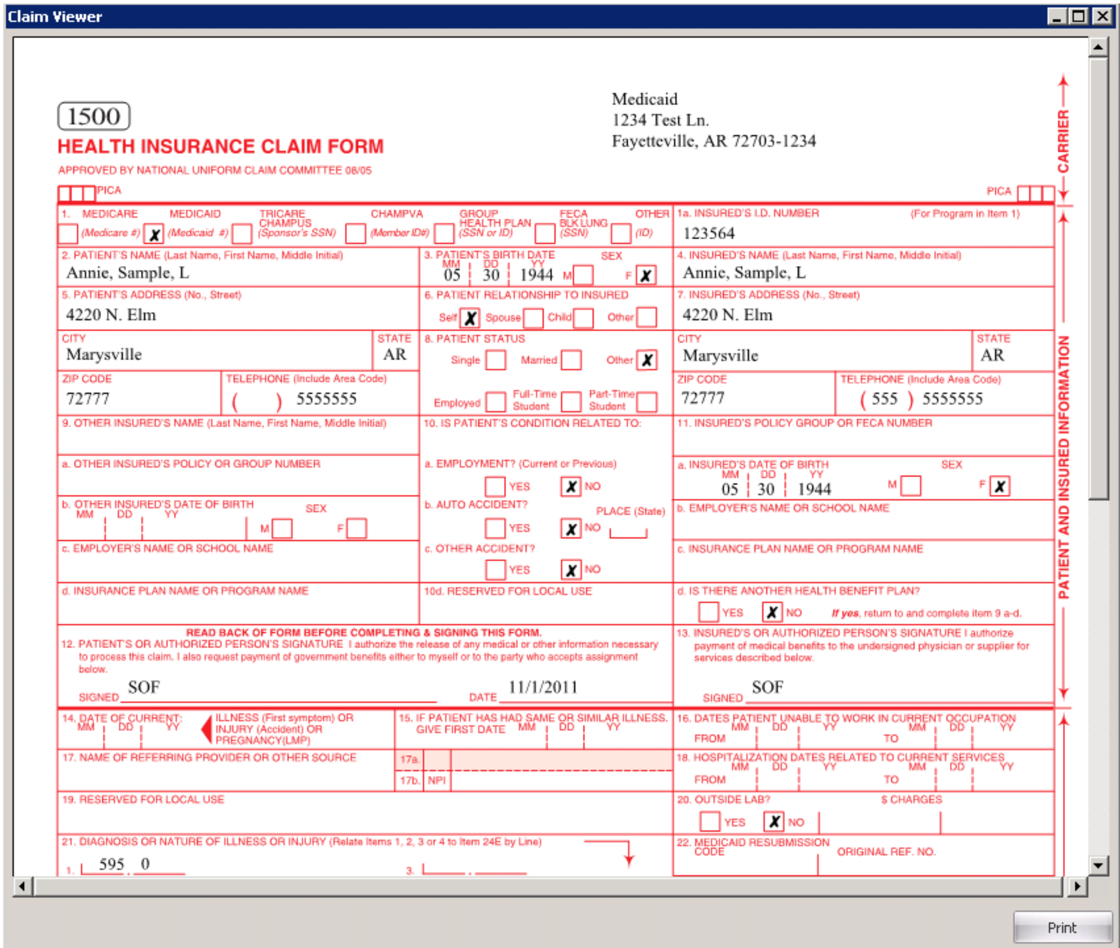
- The ability to confirm updating each patient account with a copy of each statement sent out. SOAPware will not automatically update each patient unless the user indicates to do so.

Chart Rack Search



The ability to search for a patients chart or patient account by Account Number.

Changes to the CMS 1500


Claim Viewer

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid
1234 Test Ln.
Fayetteville, AR 72703-1234

CARRIER

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) X TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123564
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Annie, Sample, L
3. PATIENT'S BIRTH DATE MM DD YY: 05 30 1944 SEX M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Annie, Sample, L
5. PATIENT'S ADDRESS (No., Street): 4220 N. Elm
6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 4220 N. Elm
CITY: Marysville STATE: AR
8. PATIENT STATUS: Single Married Other X
CITY: Marysville STATE: AR
ZIP CODE: 72777 TELEPHONE (Include Area Code): ( ) 5555555
Employed Full-Time Student Part-Time Student
ZIP CODE: 72777 TELEPHONE (Include Area Code): (555) 5555555
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO X
a. INSURED'S DATE OF BIRTH MM DD YY: 05 30 1944 SEX M F X
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO X PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SOF DATE: 11/1/2011
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SOF
PATIENT AND INSURED INFORMATION
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO X $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 595 0 3.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

Print

- SOAPware 2012 now prints out multiple claim forms if the number of diagnosis or CPT/HCPCS codes exceed the number of allowable per form.
- The ability for users to decide to print out the fewest number of pages or to keep the order of the CPT/HCPCS codes the same.

Additional 2012 Updates

Other Practice Management Updates

- Claims options - Anew security setting to lock down editing of fields by anyone not approved.
- Scrubber rule removed for not having a Facility with a visit.
- Demographics can be printed from the Patient Account, without having to go to the Chart.
- Removed the Outstanding Insurance Report and added a new A/R Carrier Report.

Performance Improvements

- Users will see improved performance when starting SOAPware, opening large charts, switching between chart sections, exporting charts to CCR, bulk signing tasks, and other areas.

Analytics Tracking

- SOAPware will begin gathering various product measures in order to continuously improve our product. This information is completely anonymous and is not related back to specific users or clinics.
- Examples of information that will be gathered includes: number of charts, meaningful use statistics, number of times a menu has been selected, and performance information related to various operations in SOAPware.
- The tracking of analytics data is turned ON by default. Users can turn off analytics tracking under Tools > Options > Logging.

For more information on the bug fixes in 2012, please see: **2012 Release Notes.**

For Users Converting from SOAPware Version 4 to SOAPware 2012

Version 4 Conversion to 2012

Click here to view the documentation for users converting from SOAPware Version 4

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

Activate Licenses

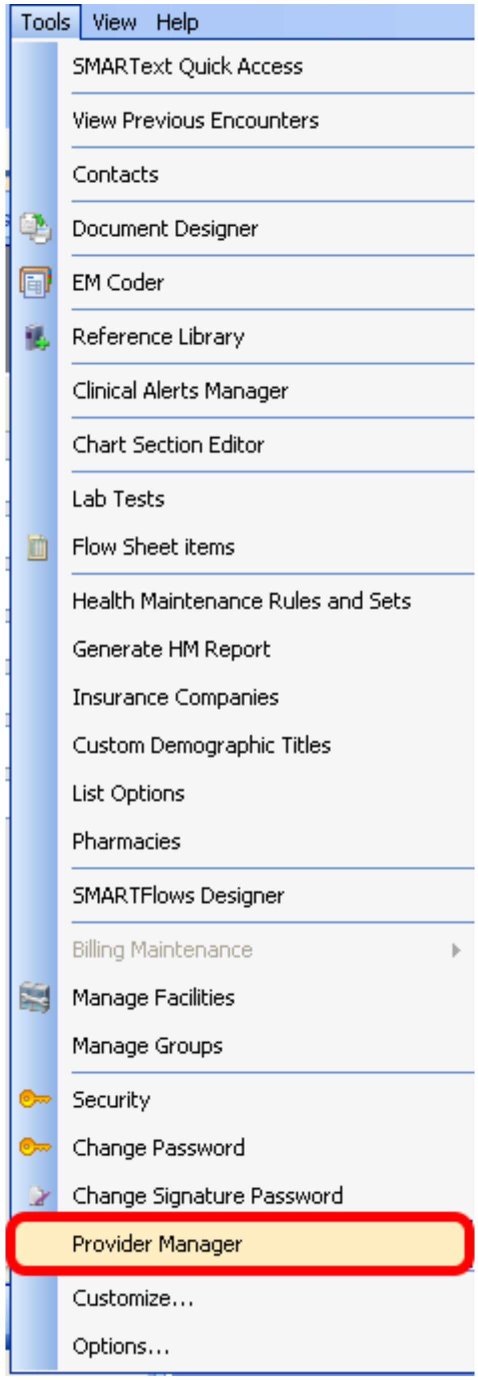
Clinic provider licenses are normally activated during the installation process. If this is not the case, please consult the SOAPware Installation Guide for instructions.

ePrescribing

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

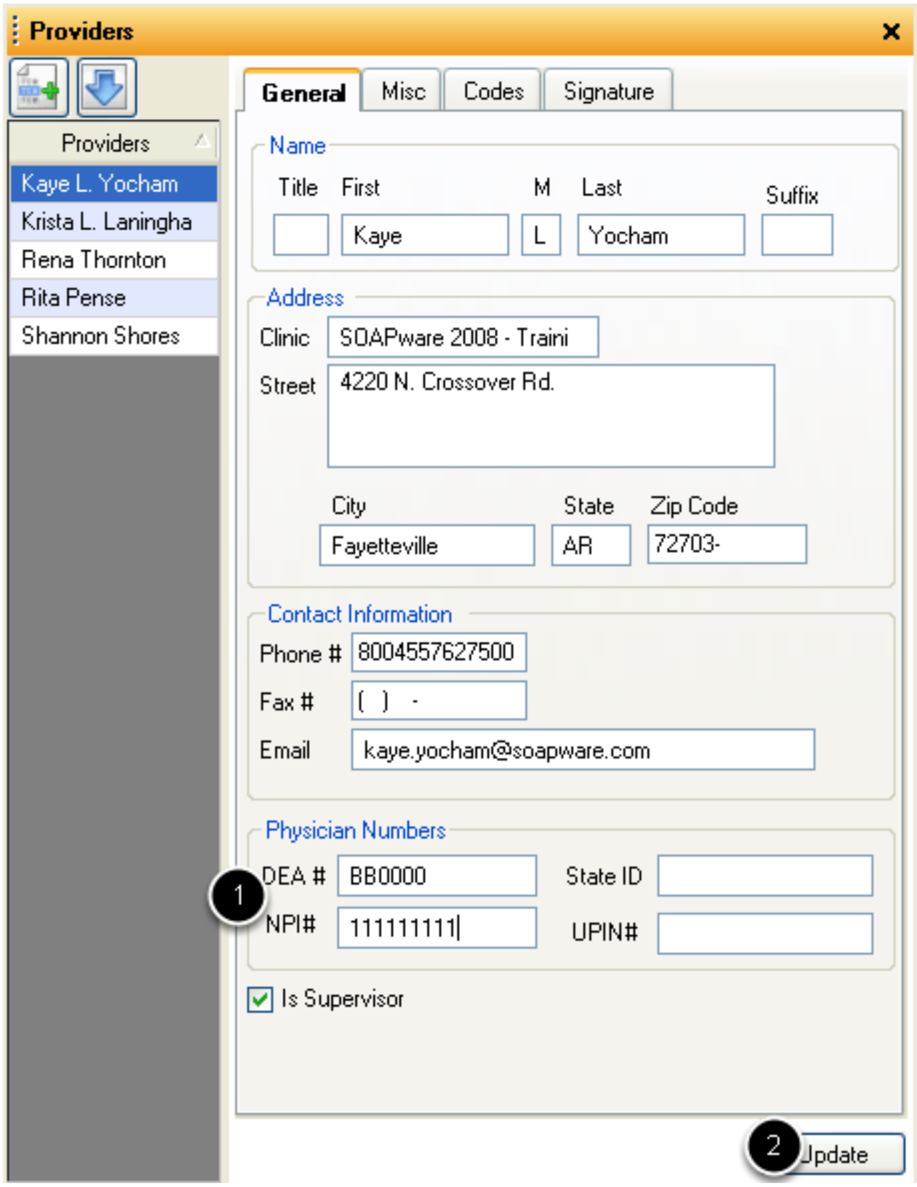
***Note:** A Nurse Practitioner without a DEA number must enter their NPI number.*

Tools - Provider Manager



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

Update Provider Information



1. Enter in the provider(s) information (including DEAand 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:\ProgramData\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:

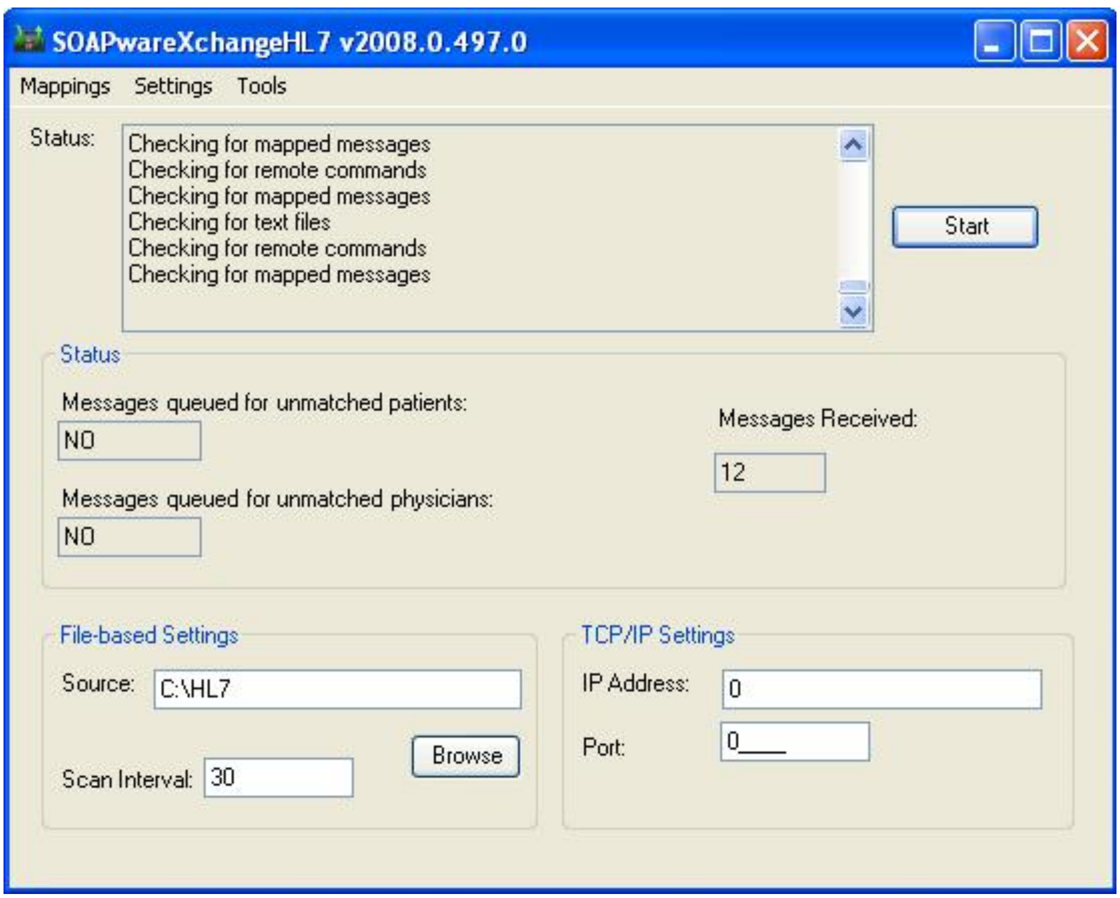
1. With SOAPwareXChange open, Click Outbox Settings. If a user is going to be posting Superbills from SOAPware to a billing system, Click the Post Superbill checkbox.

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.

***SOAPware, Inc. recommends the use of Ambir scanners for scanning and document management, especially for SCS clients. Learn more about Amibr scanners at www.ambir.com/soapware.**

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)

Auser 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 or call 800-455-7627 ext. 200.

Dragon Naturally Speaking (additional product)

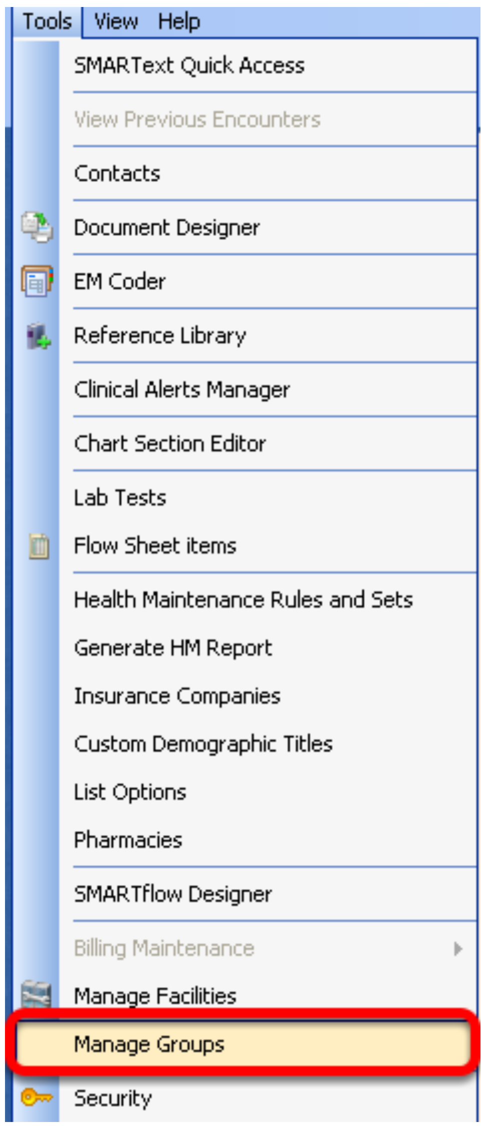
Dragon Naturally Speaking must be installed in order to use it with SOAPware. SOAPware, Inc. does not provide Dragon Naturally Speaking, but it does allow the user to use Dragon Naturally Speaking with SOAPware. Open Dragon Naturally Speaking first, then open SOAPware. Once SOAPware is open, go to a desired chart section then speak to type. This action will enable the mic/recording on the Dragon toolbar.

***Note**: SOAPware is only compatible with Dragon Medical Version 10. SOAPware is NOT compatible with Dragon Medical 360 or Dragon Naturally Speaking 11 or above.*

Manage Groups

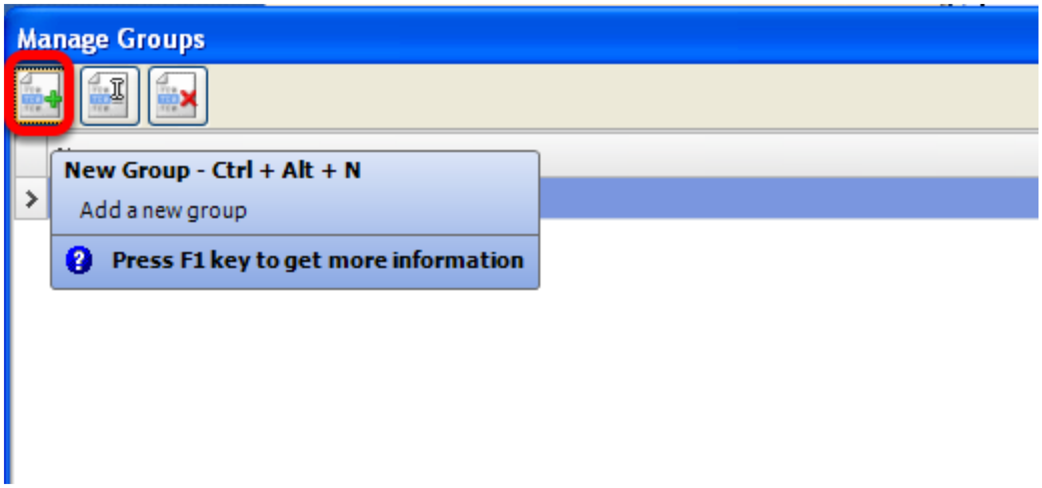
A Group is used to define a business entity or individual within a clinic. This information will be useful for populating information to the CMS 1500 form. Newly added Groups may contain more than one provider, but a provider may only be associated with one group.

Access Manage Groups



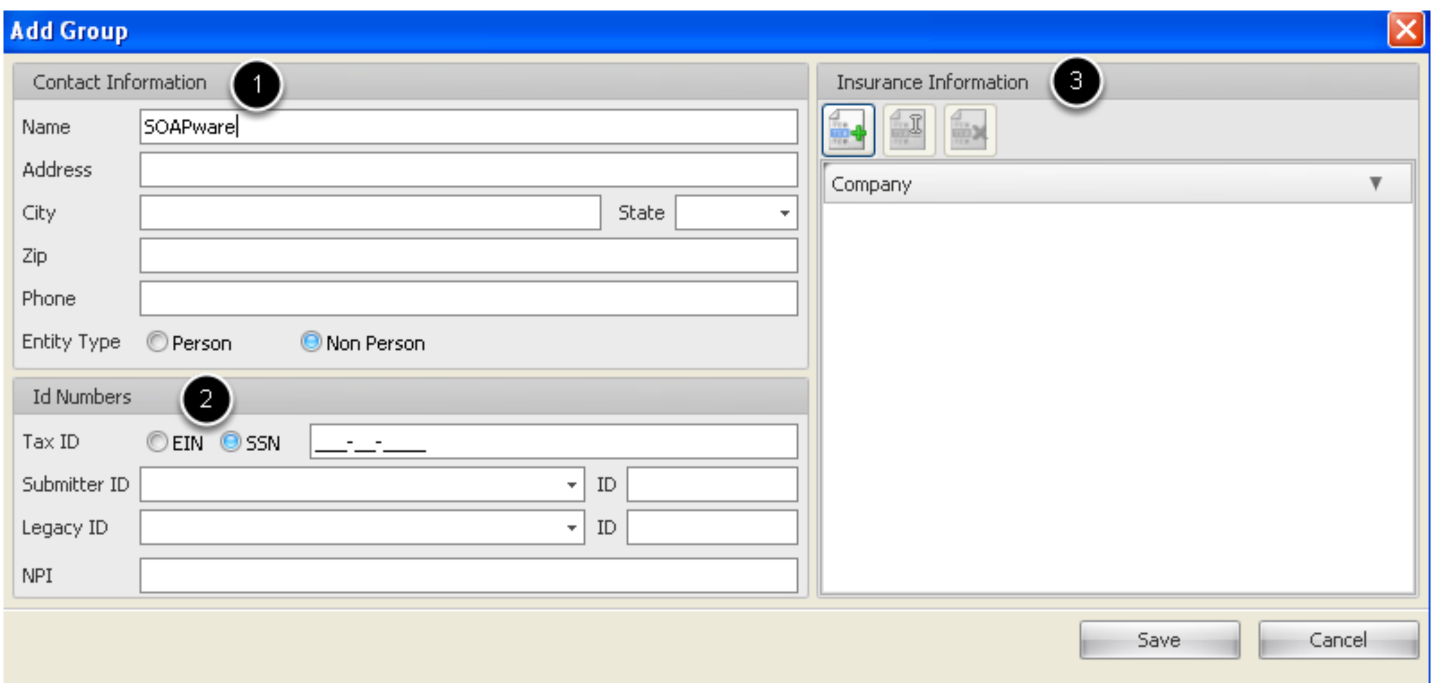
Click on the Tools menu item > Manage Groups.

Create New Group



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

Add Group



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.

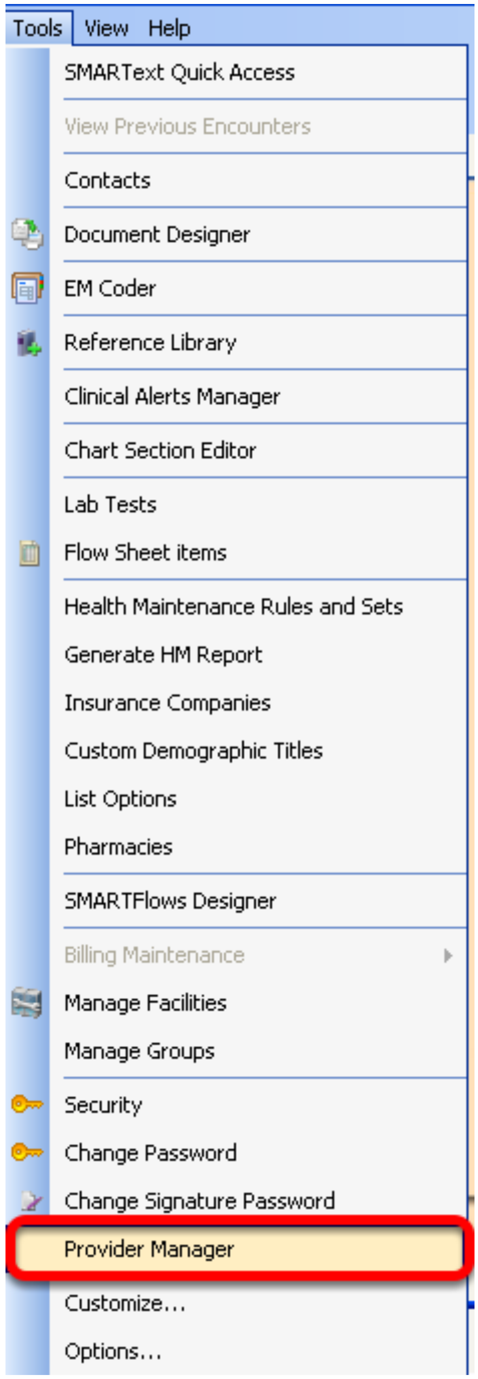
1. **Contact Information**- Enter the basic demographic information for the group.
2. **ID Numbers**- Enter the appropriate ID numbers for each field.
3. **Insurance Information**- Insurance Companies need to be set up first before taking advantage of this area.

Click here for more information from the Practice Management User Manual for detailed information for set up.

Click the Save button to save changes.

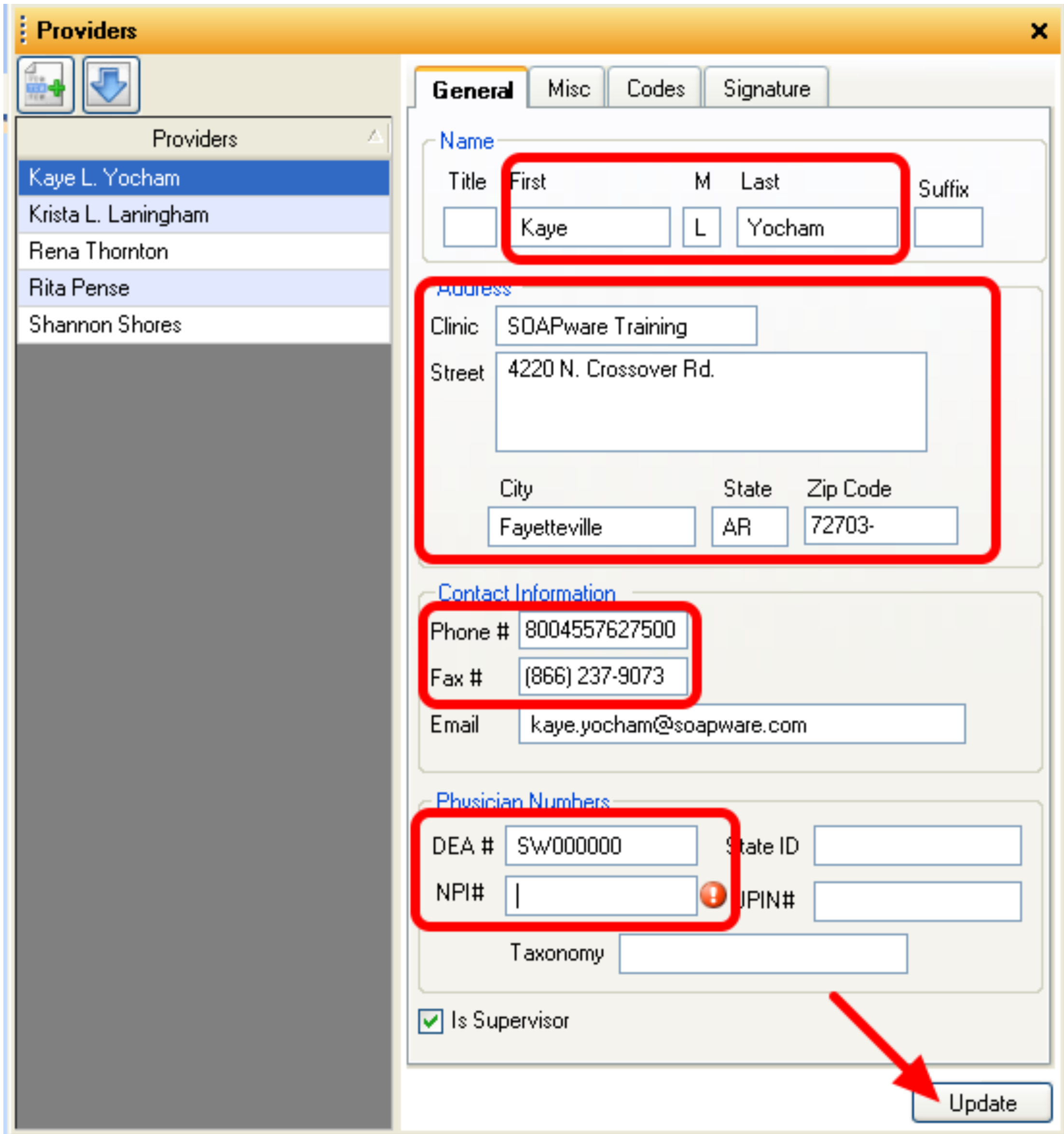
Provider Manager

Accessing Provider Manager



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

General Tab

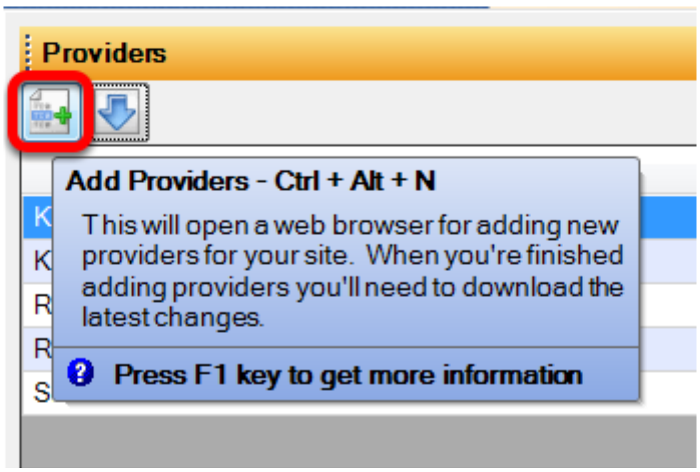


The General tab will display the providers demographic information including Name, Address, Contact information (phone, fax and email address) and Physician numbers (DEA, NPI, State ID, UPIN)

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.**

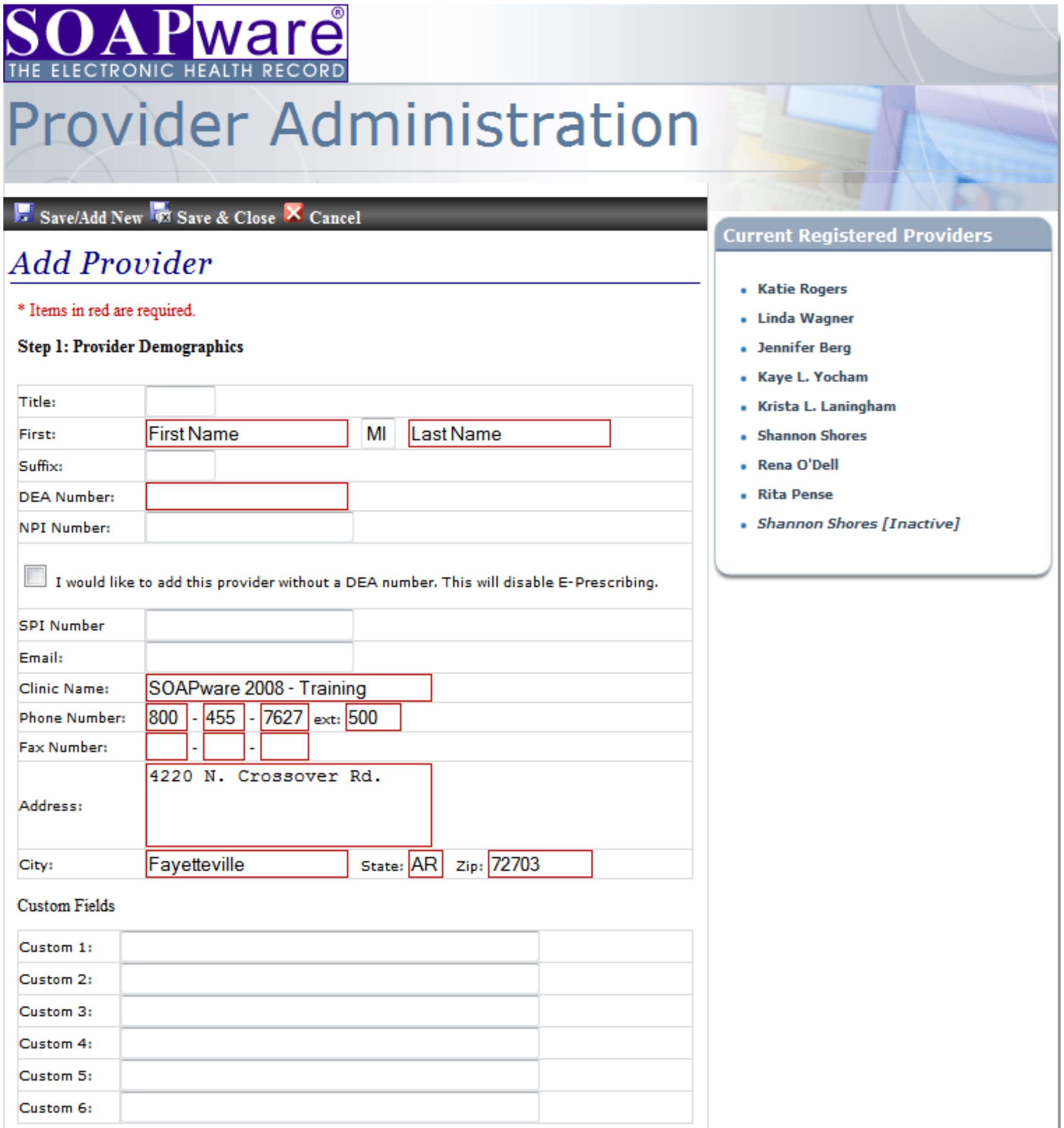
Fields that are marked red in the screen shot are required fields for ePrescribing. Add all required provider demographics and Click the Update button at the bottom of the window. If a required field is missing, it will be indicated with a warning icon.

Adding a Provider



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.



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

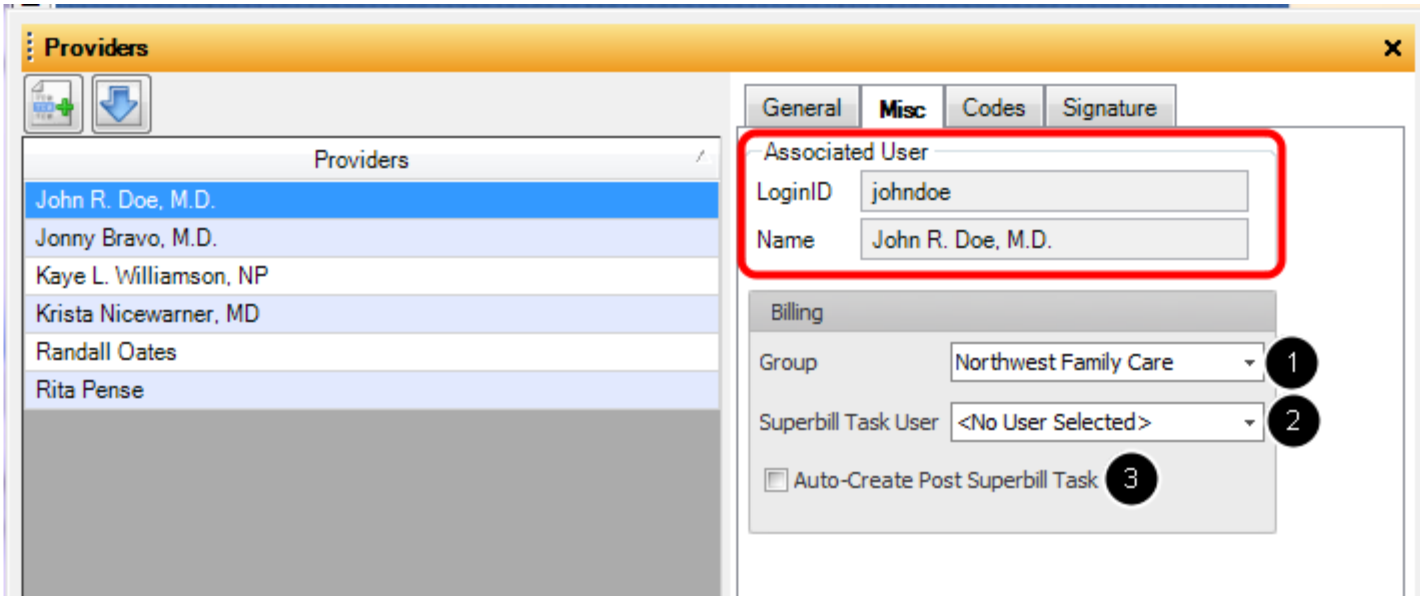
Save and Close

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.

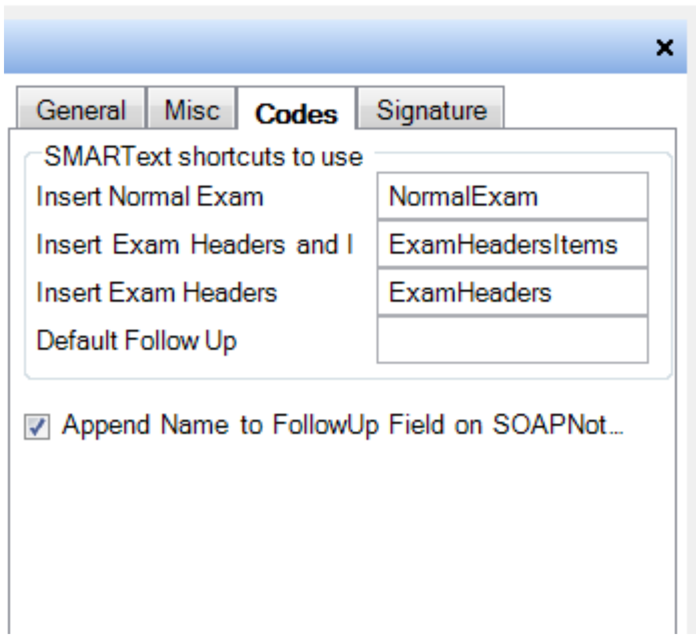
The Billing section will need to be completed by SOAPware Practice Management users.

1. **Group**: Click the drop down arrow to display a list of available Groups. Select the appropriate Group to associate to the Provider.
2. **Superbill Task User***: The user selected in this drop down box will be the default user assigned tasks from the selected physician when superbills are posted.
3. **Auto-Create Post Superbill Task:** Checking this box will allow a task to be auto created and automatically assigned (to the user selected in step 2 above) every time a superbill is posted, without requiring the physician to manually click to add the task each time.

*Until a specific user is selected in this drop down box, the physician will be listed as the default user for the task created when a superbill is posted. If a group of staff members within the clinic process superbills, post charges and create claims for each provider, and there is not one designated person who does this for a specific provider, a generic user can be set up under Security to which to assign these tasks. Staff members needing to see the newly posted superbills can then simply pull up the task list for the generic user created.

Please see our Practice Management manual for PM Set Up requirements.

Codes Tab

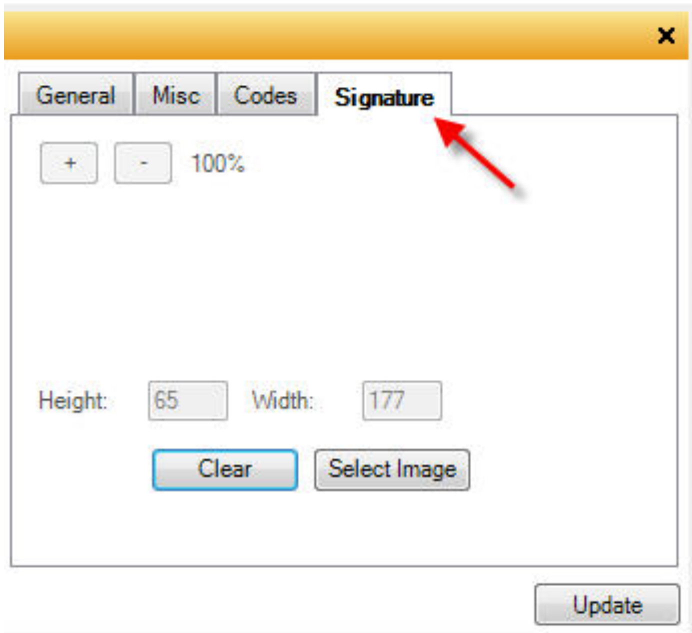


The Codes Tab in Provider Manager allows users to set default menu items for the Objective field menu, a default follow up statement for an encounter note, as well as giving users the option to have the provider's name appear in every new encounter that is created.

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.

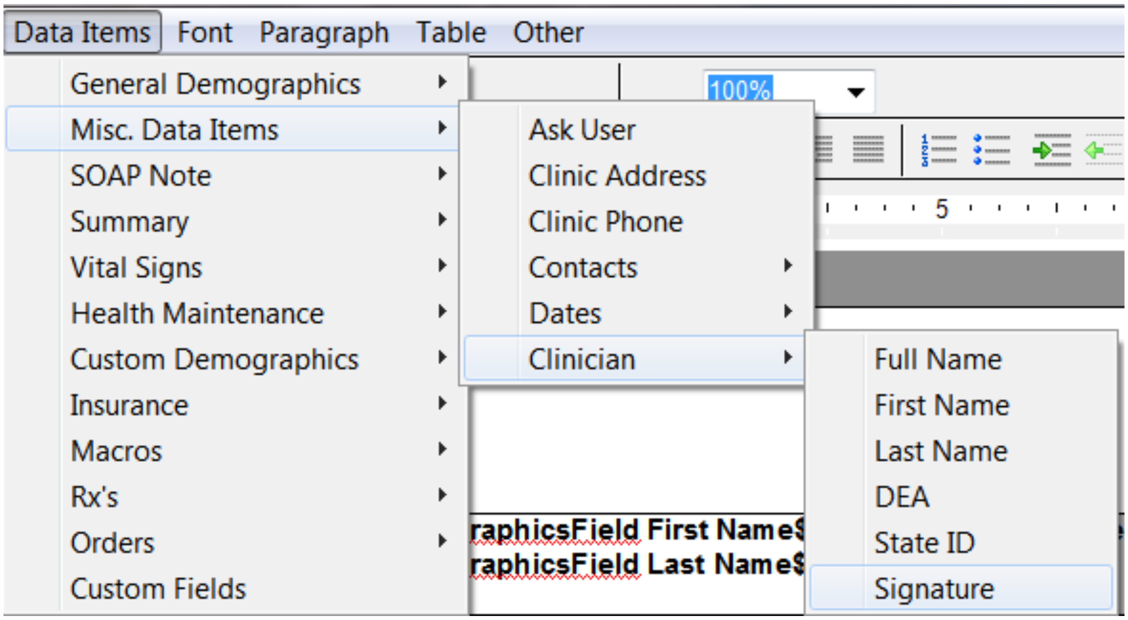
Signature Tab



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.

Signatures & Document Design



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.**

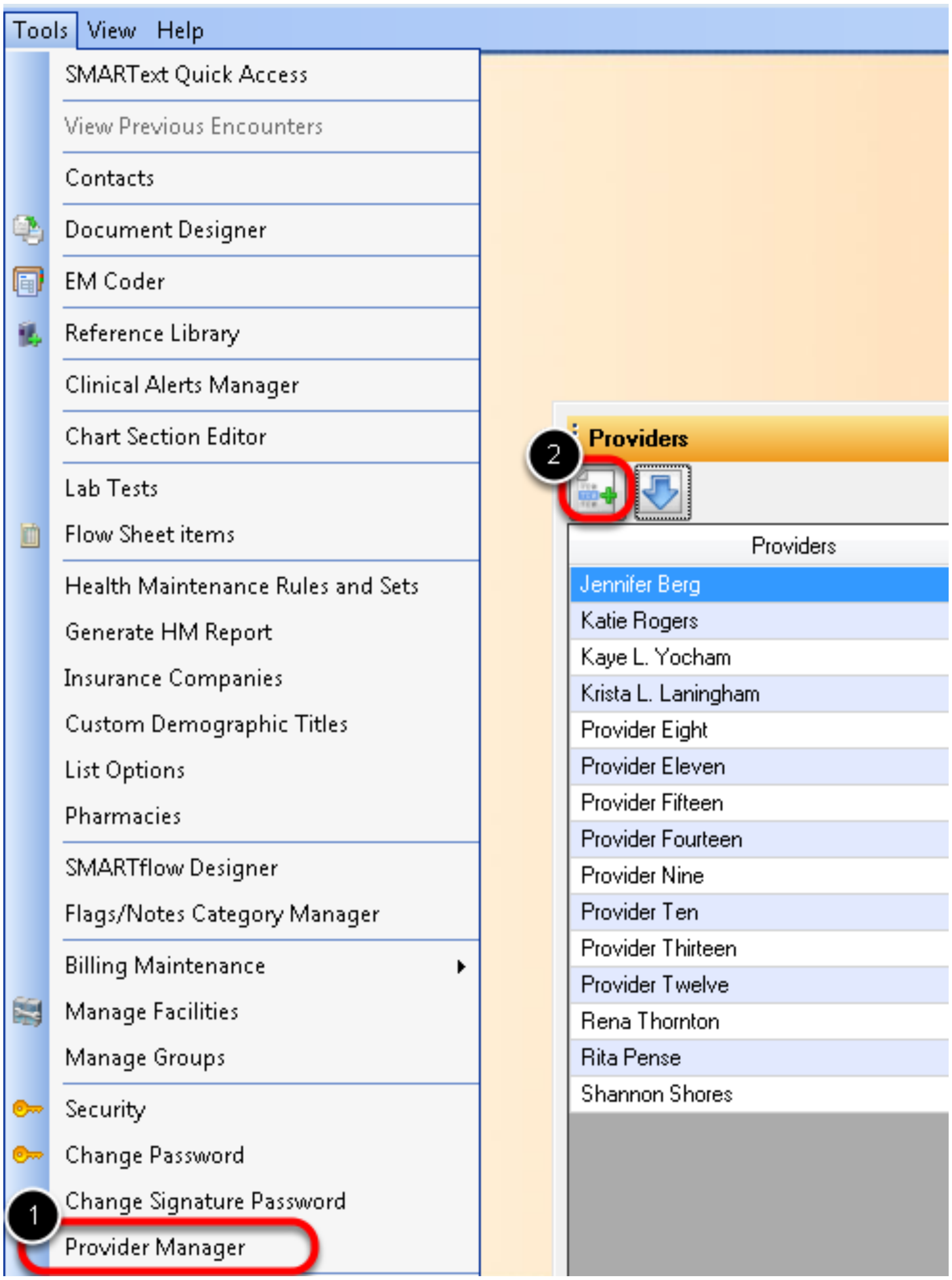
Removing a Provider

This lesson will demonstrate how to deactivate a provider from the network.

The providers listed in provider manager are linked to the owners of documents and charts within SOAPware as well as the Security audits. Providers in the provider manager are also set up with Sure Scripts for ePrescribing. Therefore, if a provider needs to be removed from SOAPware, the following steps must be taken.

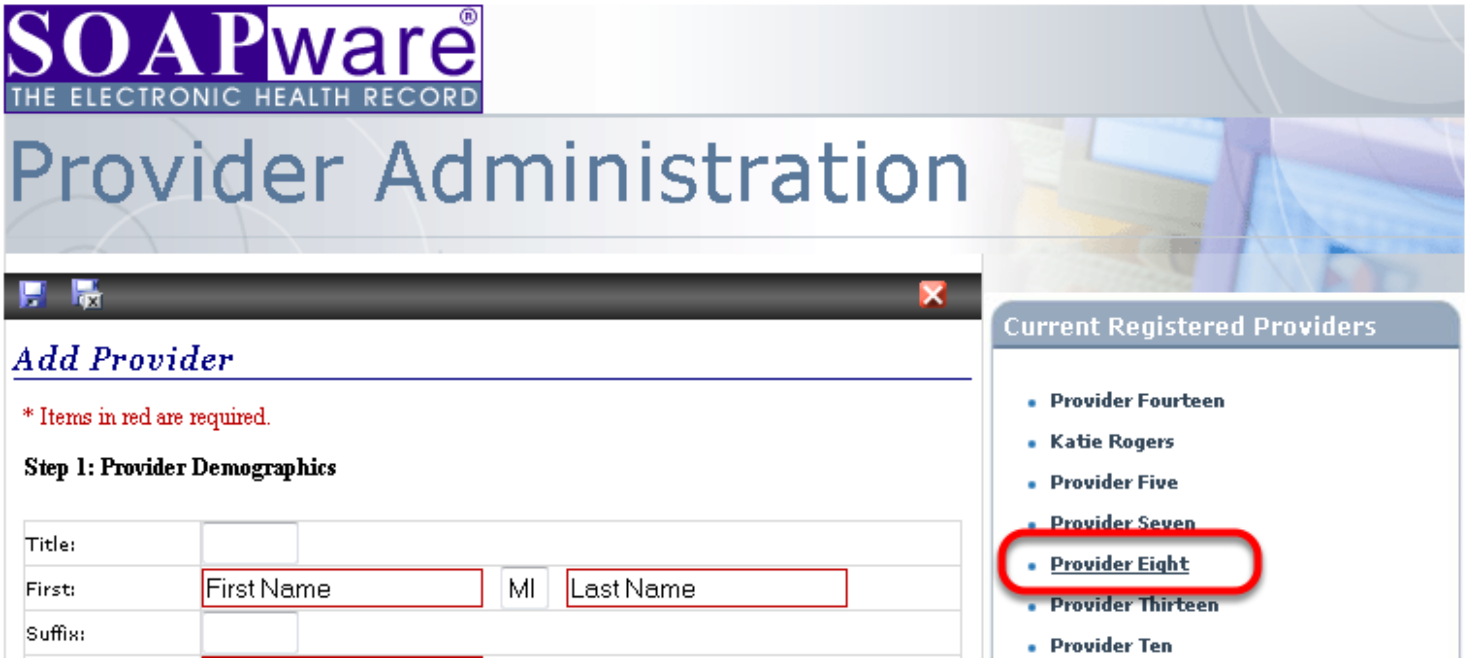
Note: A user SHOULD NOT simply change the name of an inactive provider to the name of a new provider. The old provider should be removed, then a new provider added. If the name is changed on an existing provider, all previous document that were owned by that provider, all charts and all security audit logs will be changed to the new provider's name. This is why it is important to follow the steps detailed below in order to deactivate a provider. After deactivating the old provider, the user may use that license to add a newly hired provider to the SOAPware system.

Open Provider Administration

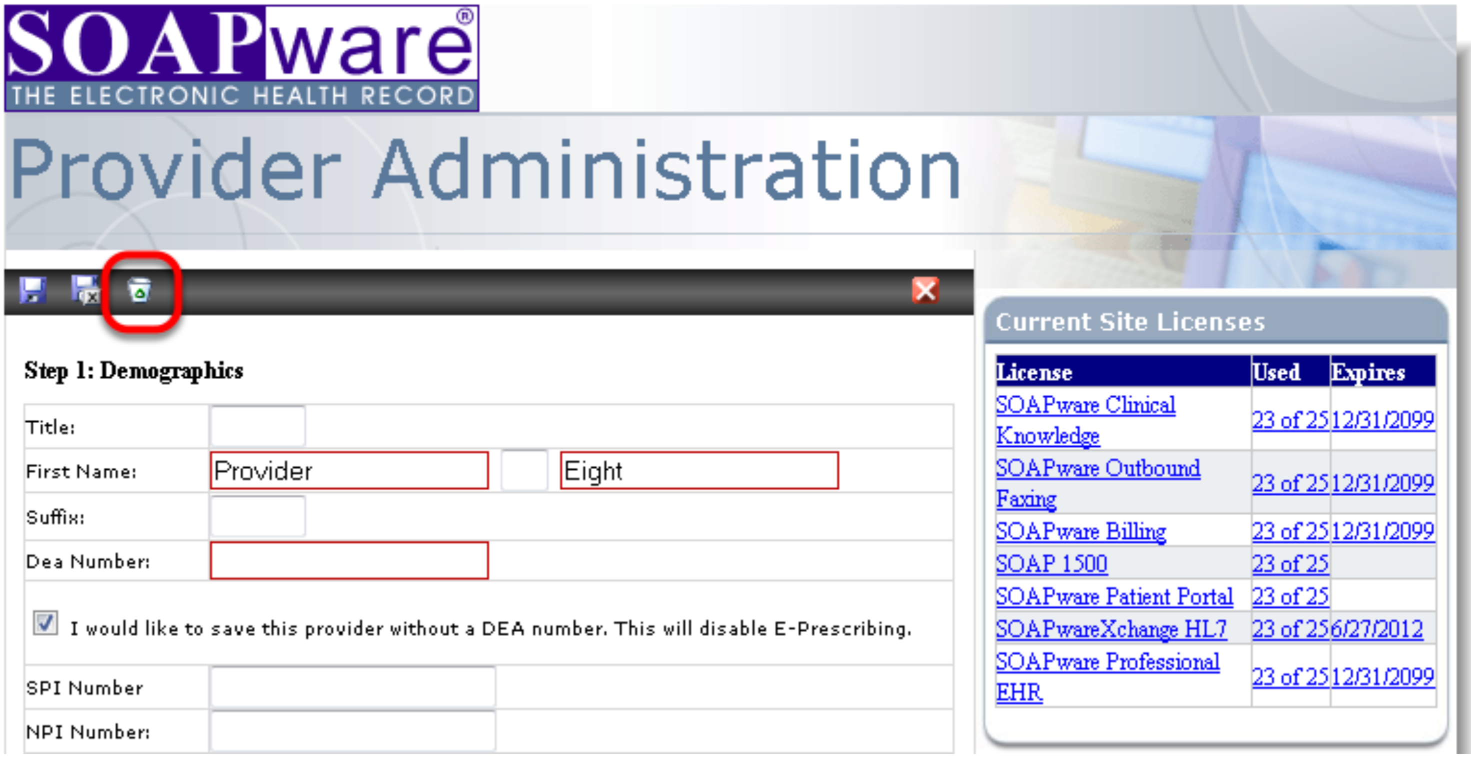


1. Open the Provider Manager (Tools > Provider Manager)
2. Click on the Green + to open the Provider Administration page.

Select Provider



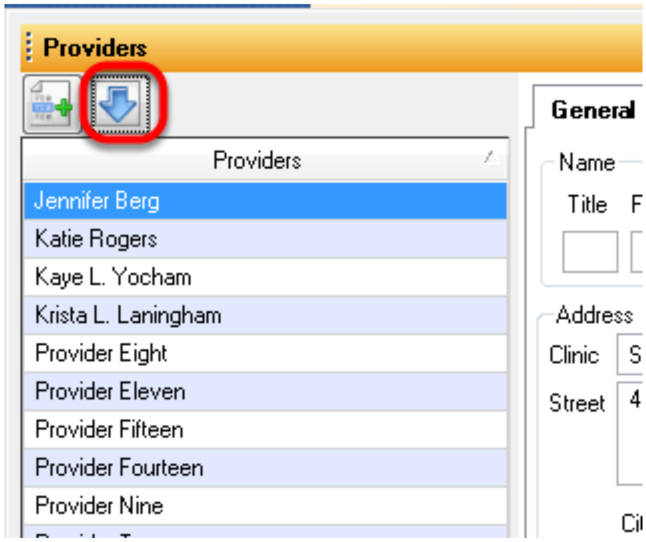
Select the provider to be deactivated from the network.



Click the Deactivate button.

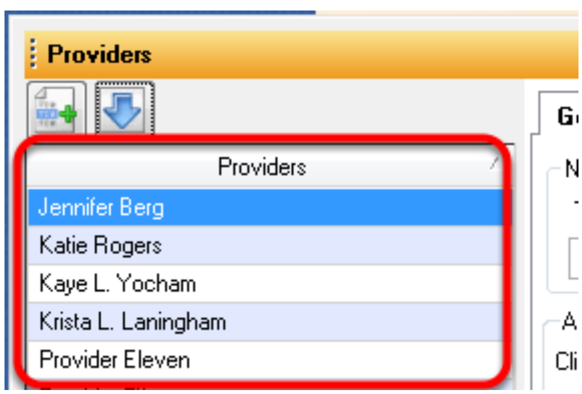
The provider now is listed as Inactive.

Download Providers



After a provider is deactivated the updated information will need to be downloaded into SOAPware.

1. Ensure that all users are logged out of SOAPware.
2. In Provider Manager, Click the Blue downward facing arrow to download changes.



Provider Eight has been removed from the provider manager within SOAPware.

**Note: This will not remove the user ID that is automatically created when a provider is added to SOAPware.*

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)
* SMARText 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.

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.

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 SMARText 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 SMARText is searched.

To download these items, Click Docutainers in the menu bar, and Click the SMARText 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/Hightlight 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

SMARText 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, SMARText is a Lego set for medical information. Just like the Lego's of a user's youth, SMARText has many different pieces that can be put together in almost limitless ways. The "pieces" in SMARText are called items and they are of many differing types.The Type defines what the SMARText 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 SMARText items for immediate use when creating documentation.

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

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

10. More Data Entry Options

Pick Lists

SMARText 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 SMARText 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 SMARText

It is not usually apparent, when starting, that almost any clinician can use SMARText items and have the final appearance of the documentation appear exactly as they prefer. For example, the Chief Complaint SMARText 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. A user can create as many or as few docuplates as needed. It is all up to the user. A user 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.

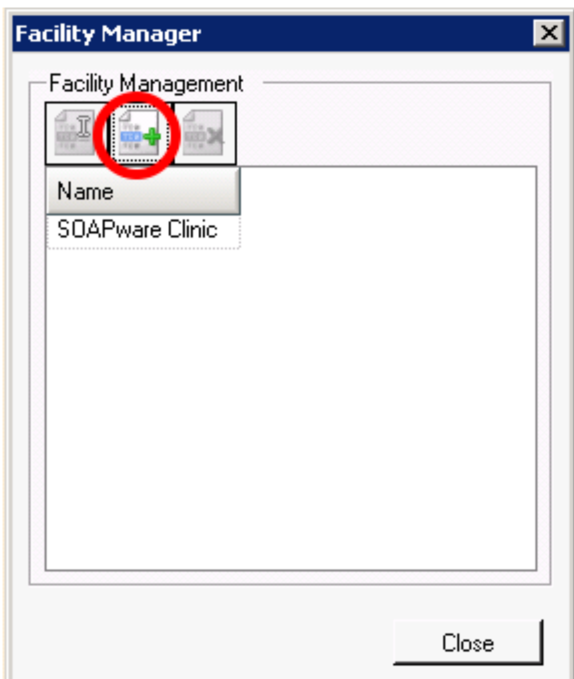
To see all of the options settings, see: Tools - Options

Manage Facilities (2012)

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



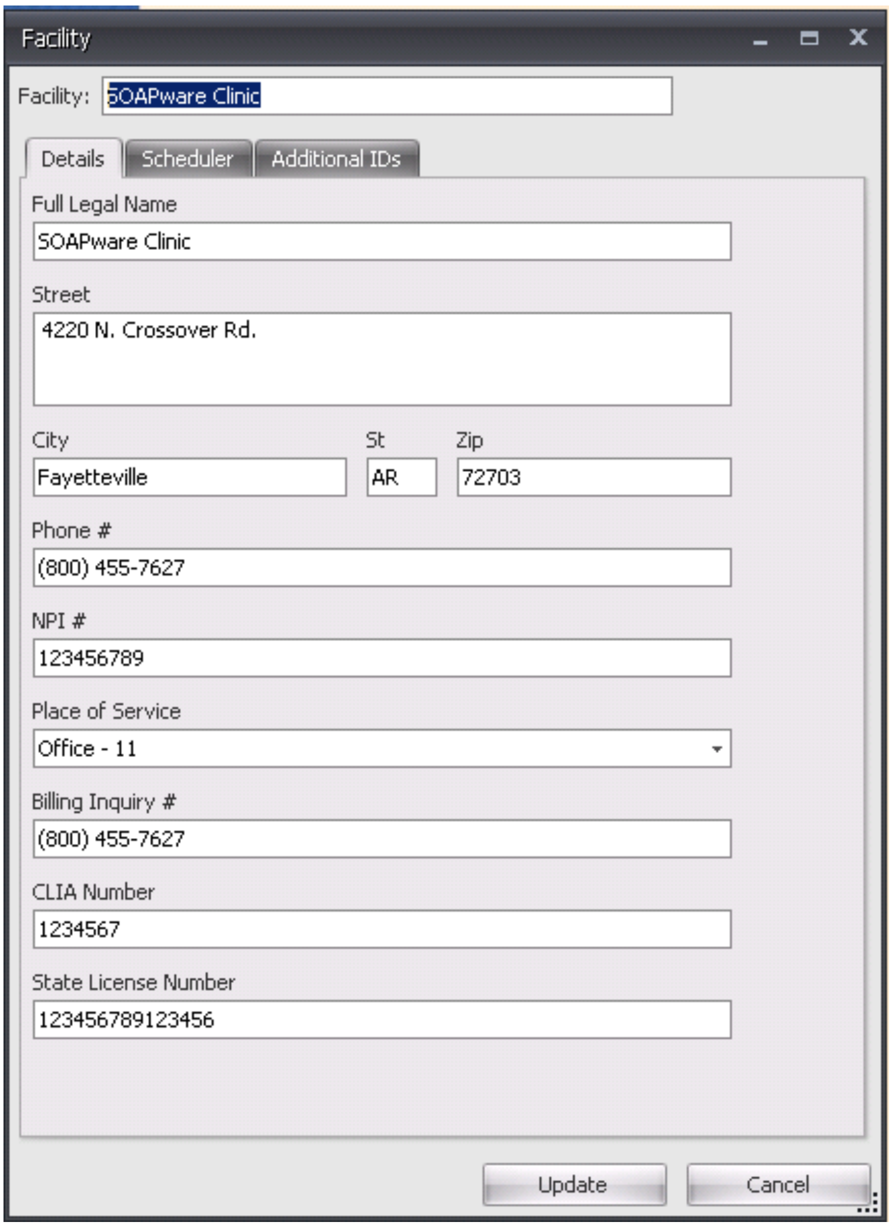
The Facility Manager provides the backbone to the overall set-up and workflow of the clinic(s) and provider(s). This will be the general name for the facility that will need to be easily recognizable by staff. The name entered here will also be the one that is displayed on Scheduler.

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



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.

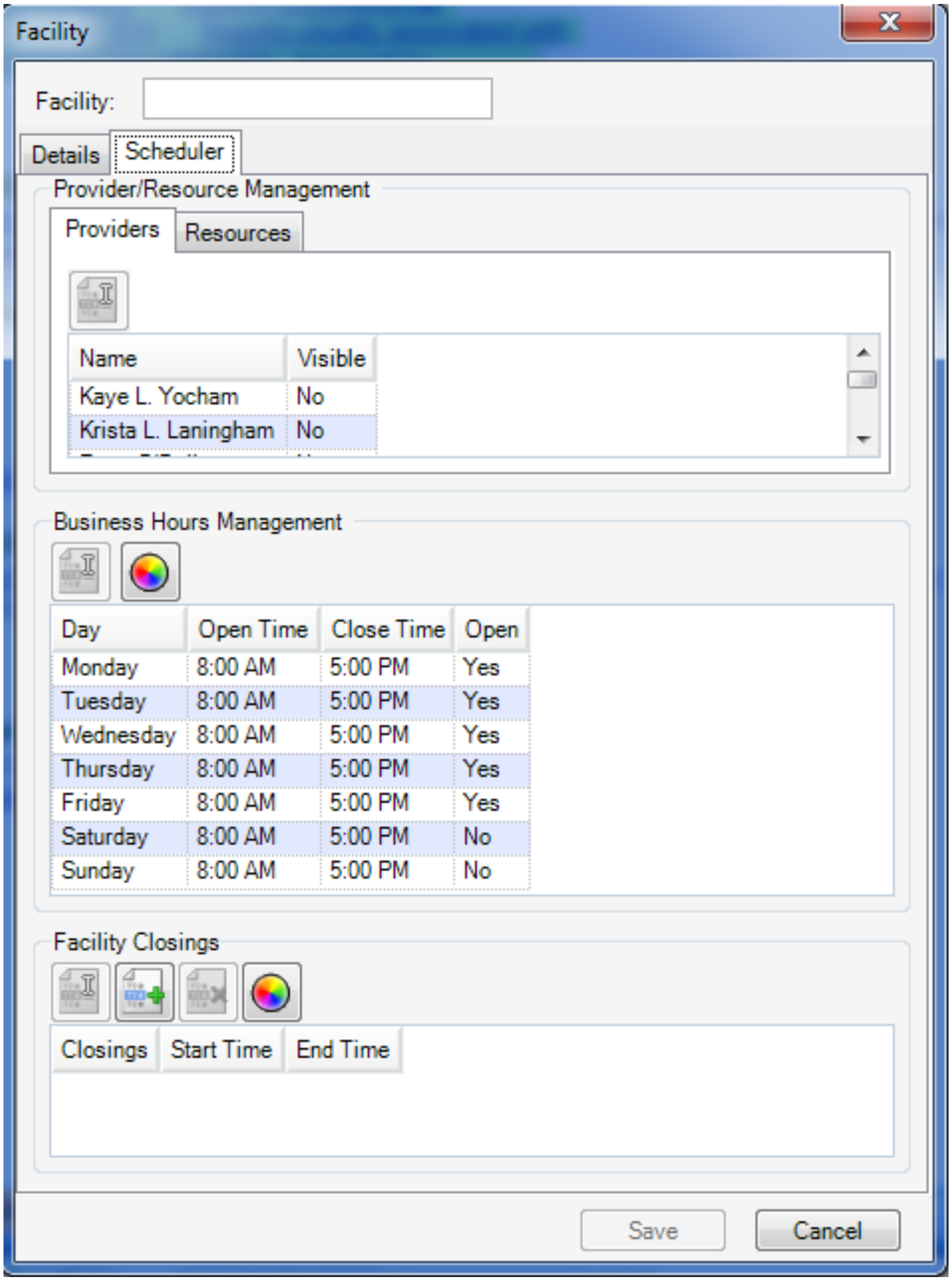
g. CLIA Number

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

State License Number

The state license number for the facility can be entered if needed.

2. Scheduler Tab

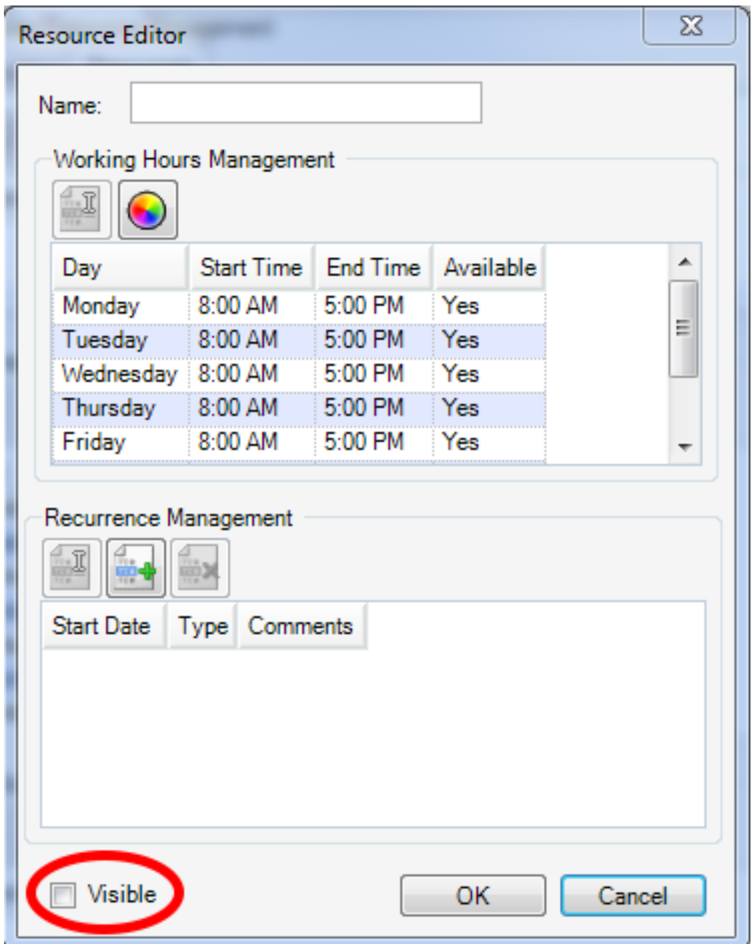


This is the location for the functional details of facilities in the Scheduler. Three main sections here: Provider/Resource Management, Business Hours Management, and Facility Closings.

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



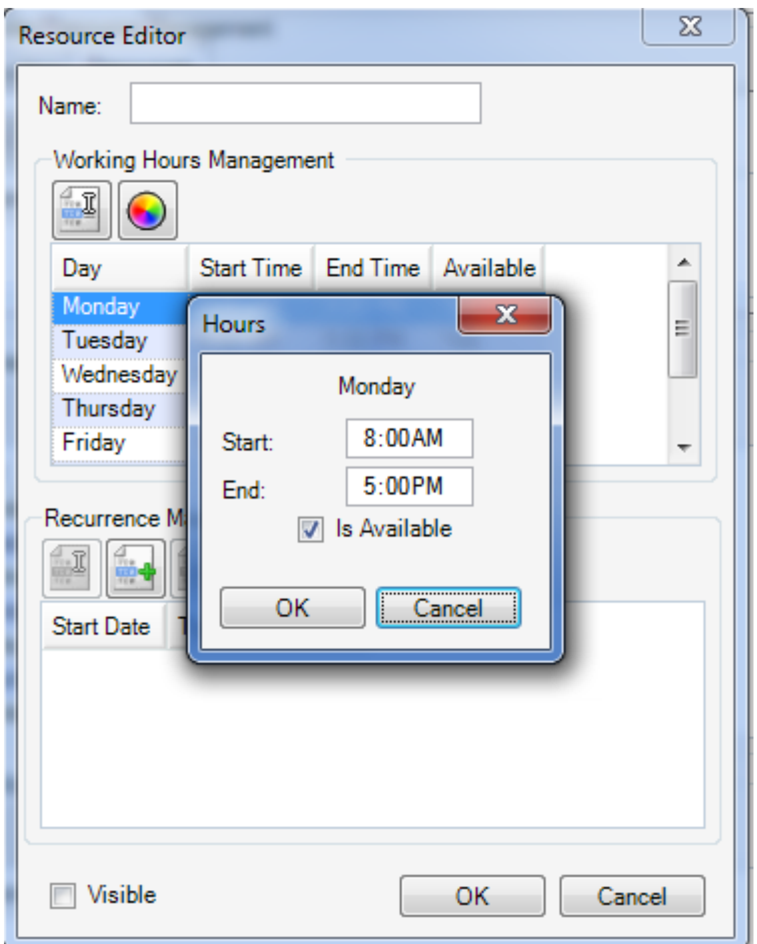
Note: This is available only in SOAPware Professional.

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.

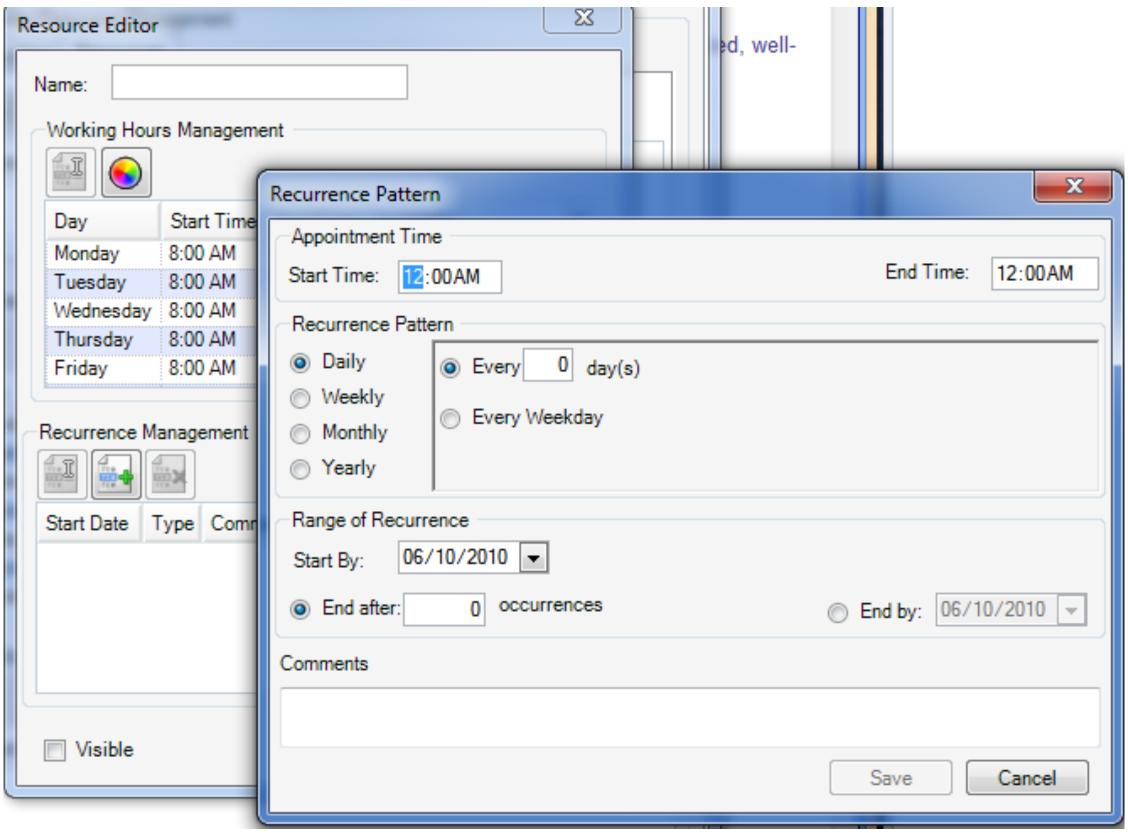
To edit each day's working hours, Double-click a time, or Select a line, and Click the Edit button.

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

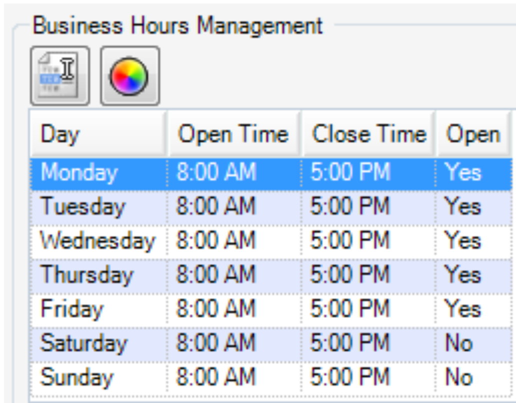
This allows the blocks to start on a set date, and have them reoccur a certain number of occurrences, or end by a certain date. If this is set to end after 0 occurrences, the block will not have an end date.

h. Comments

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

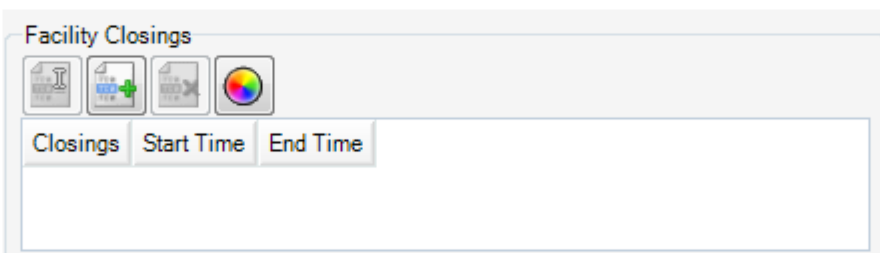
Click Save when finished setting the block, and the display returns to the Facility dialog's Scheduler tab.

i. Business Hours Management



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



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

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.

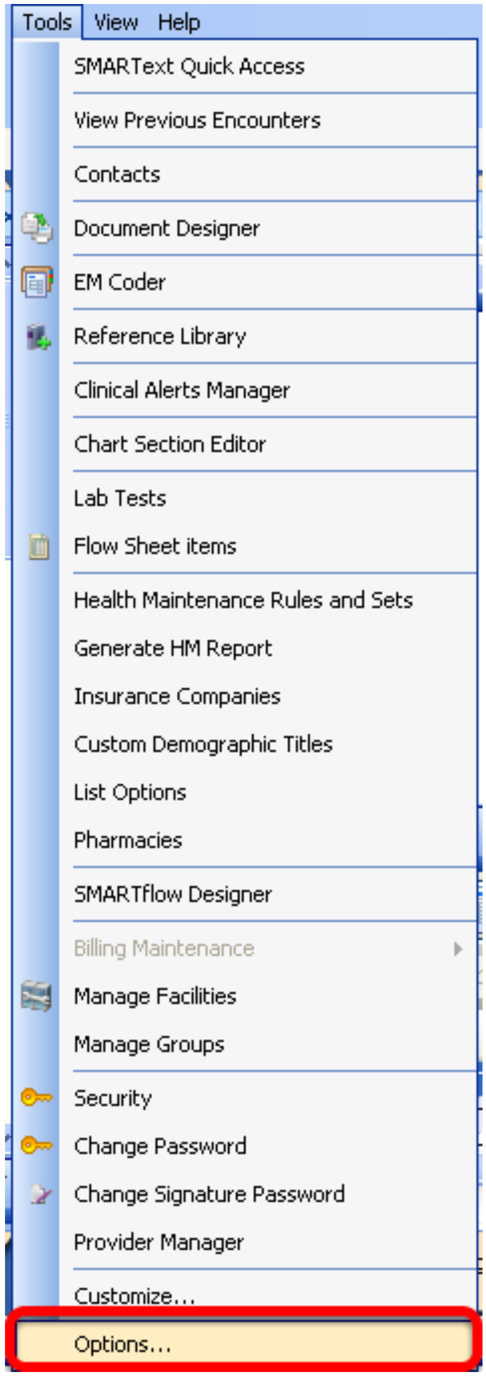
To access the Options area:

1. Click on Tools.
2. Click on Options.

Below are brief descriptions of each item in the Tools-Options menu.

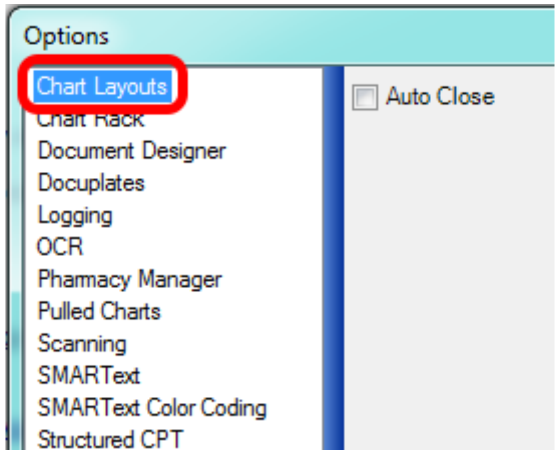
****Note**: Any menu options which are grayed out are options currently turned off or unavailable.*

Accessing Tools - Options



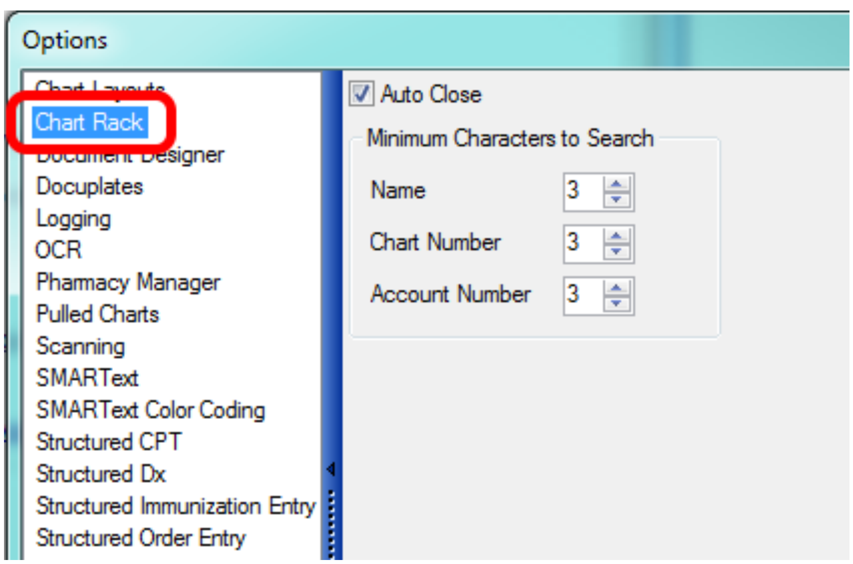
To open Tools - Options, go to the **Tools** Menu and choose **Options** from the bottom of the list.

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.

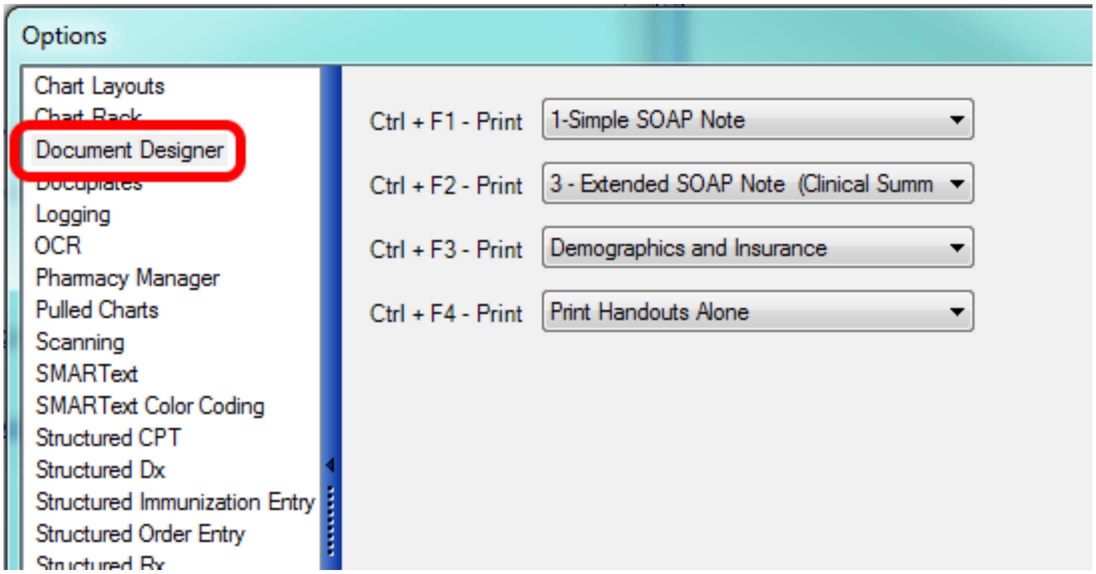
Chart Rack



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, Chart Number or Account Number.

Document Designer



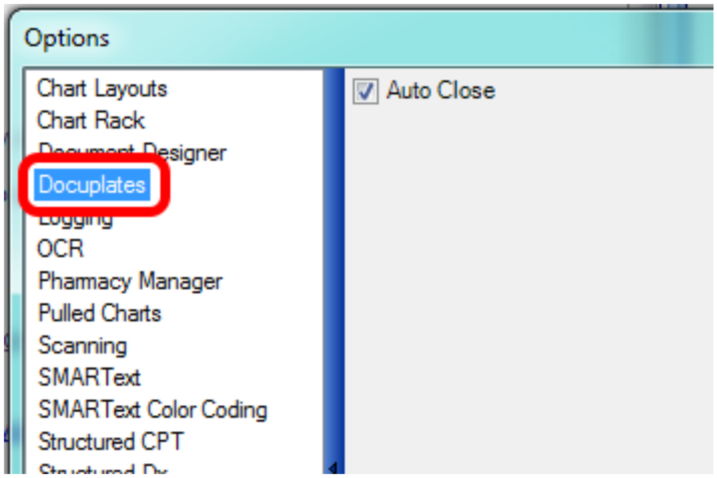
When in a chart, the user can default particular documents to be created off of the active SOAP Note, by using one of the keyboard shortcuts listed. To select a report to be printed when the shortcut key is pressed, use the drop-down box next to the appropriate key. The user will be able to set these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

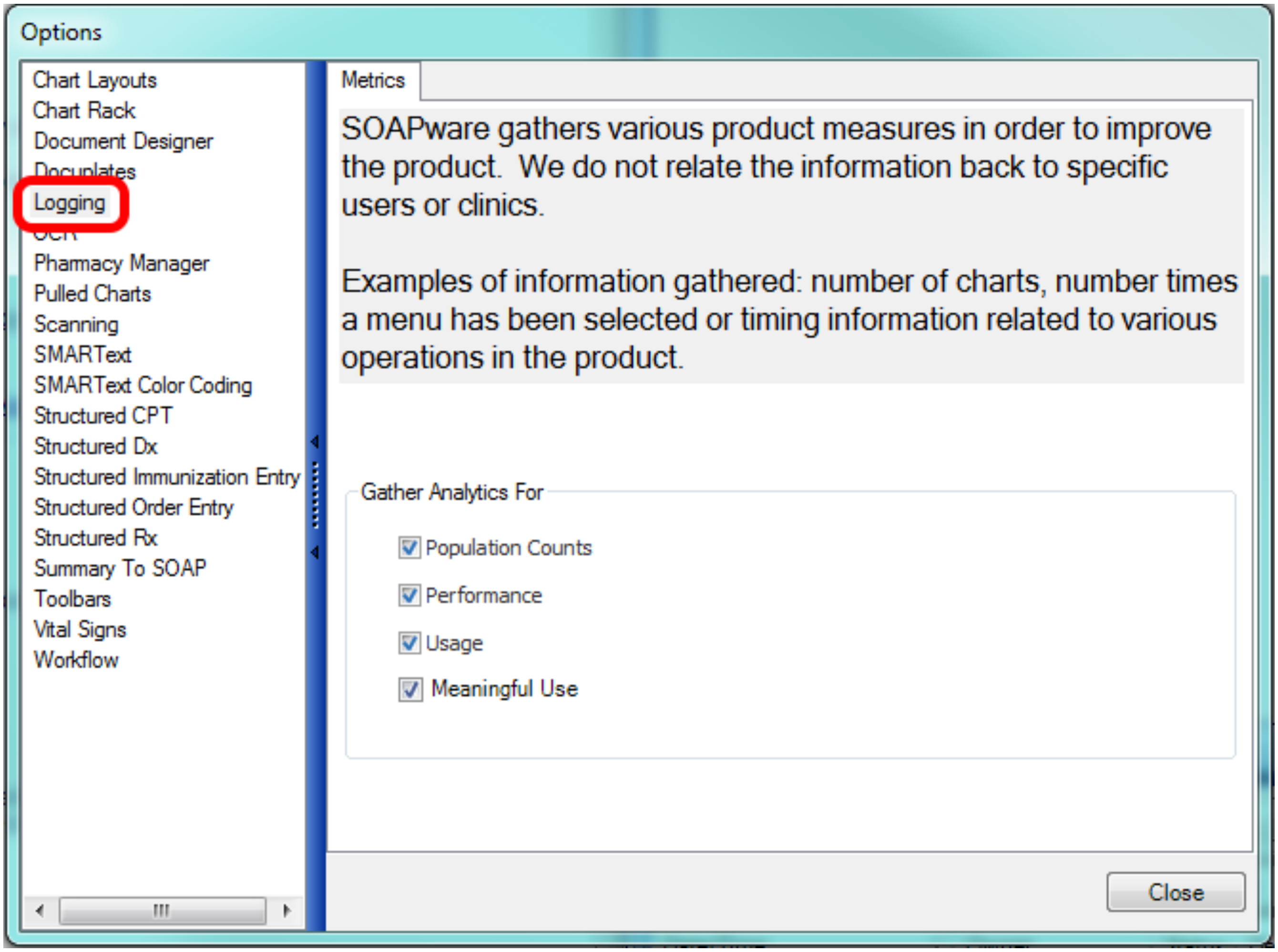
Note: *Do not set up printing of a prescription as a Quick Print Key Command. Print prescriptions from Rx Manager. This is because printing prescriptions otherwise through the Print option does not store the prescription under the Rx History tab in Rx Manager. By always printing prescriptions from Rx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

Docuplates



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.

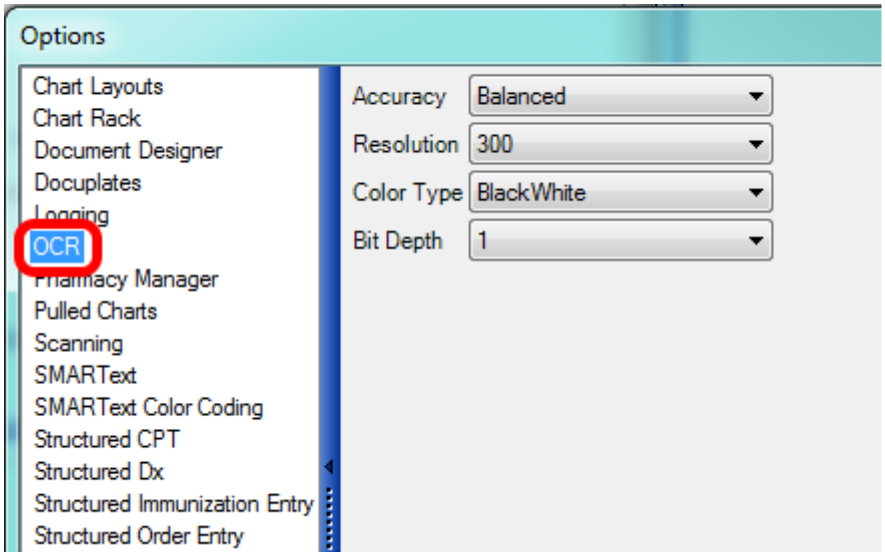
Logging



Logging: SOAPware gathers various product analytics to help us improve the quality of our software. The analytics gathered include item such as: population counts, performance analytics, usage statistics and meaningful use statistics. If the user wishes to disable analytics gathering for their clinic, the check boxes may be unchecked.

The analytics information gathered is completely anonymous and is not related back to the specific user or clinic.

OCR



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.

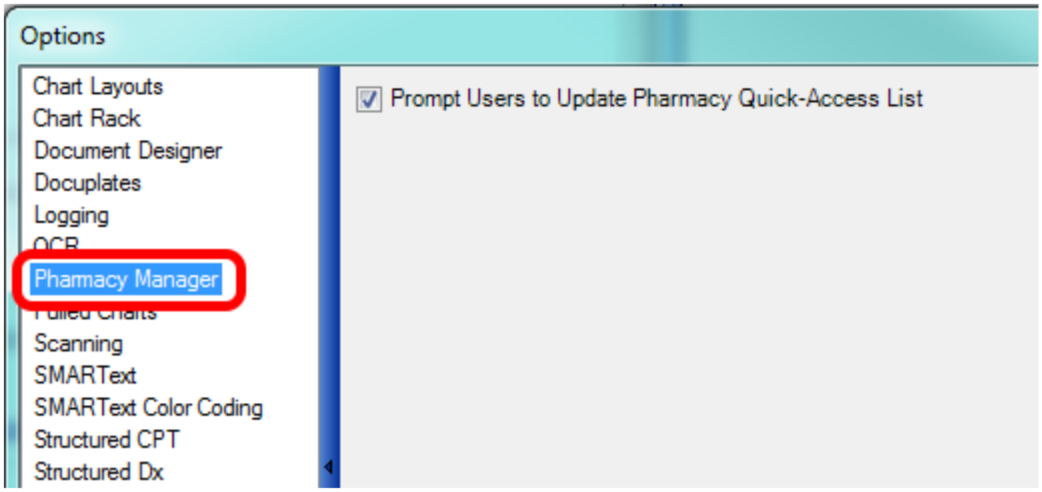
Accuracy: The user's options are Accurate, Balanced and Fast. If the user selects Accurate, it will take a longer amount of time to convert a document, but it will be most accurate in its conversion. Balanced will give a decent amount of accuracy and still convert in reasonable amount of time. Fast will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

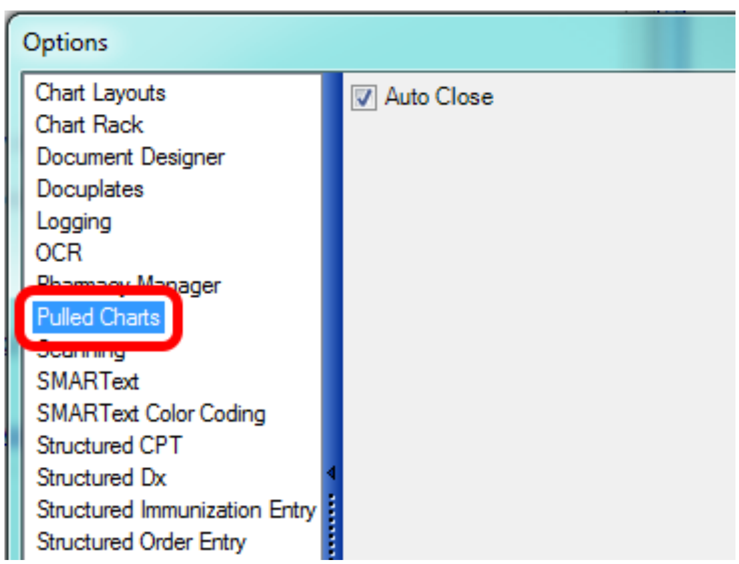
Bit Depth: Affects the granularity of the conversion. If the user has a Gray or Color type set, the higher the bit depth the user selects, the clearer the picture will be.

Pharmacy Manager



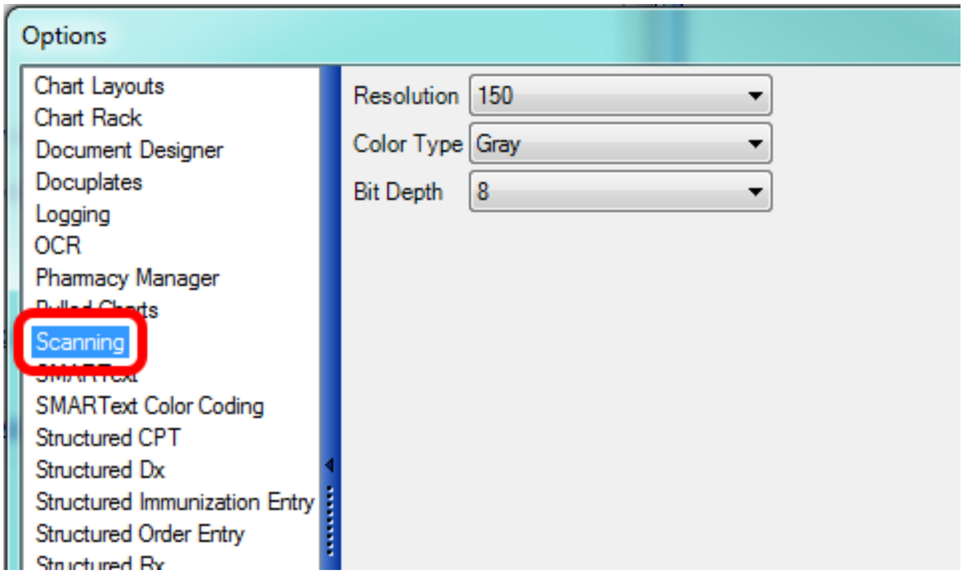
Prompt Users to Update Pharmacy Quick-Access List: Check this option and SOAPware will prompt users to update the Pharmacy Quick-Access list each time the Pharmacy Manager is launched.

Pulled Charts



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

Scanning



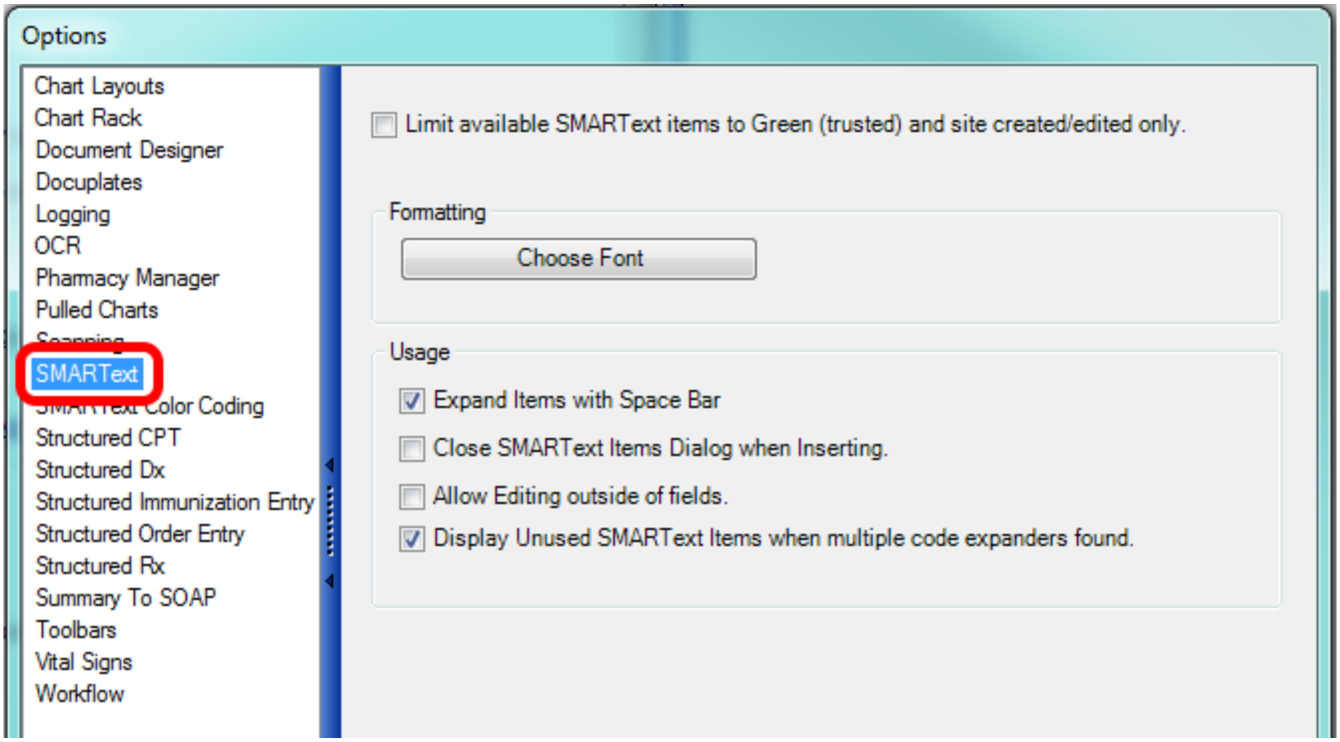
These settings determine the quality of the user's scanned images. Remember that the higher resolution that is set, the clearer the picture, but the slower the scanning time will be.

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.*

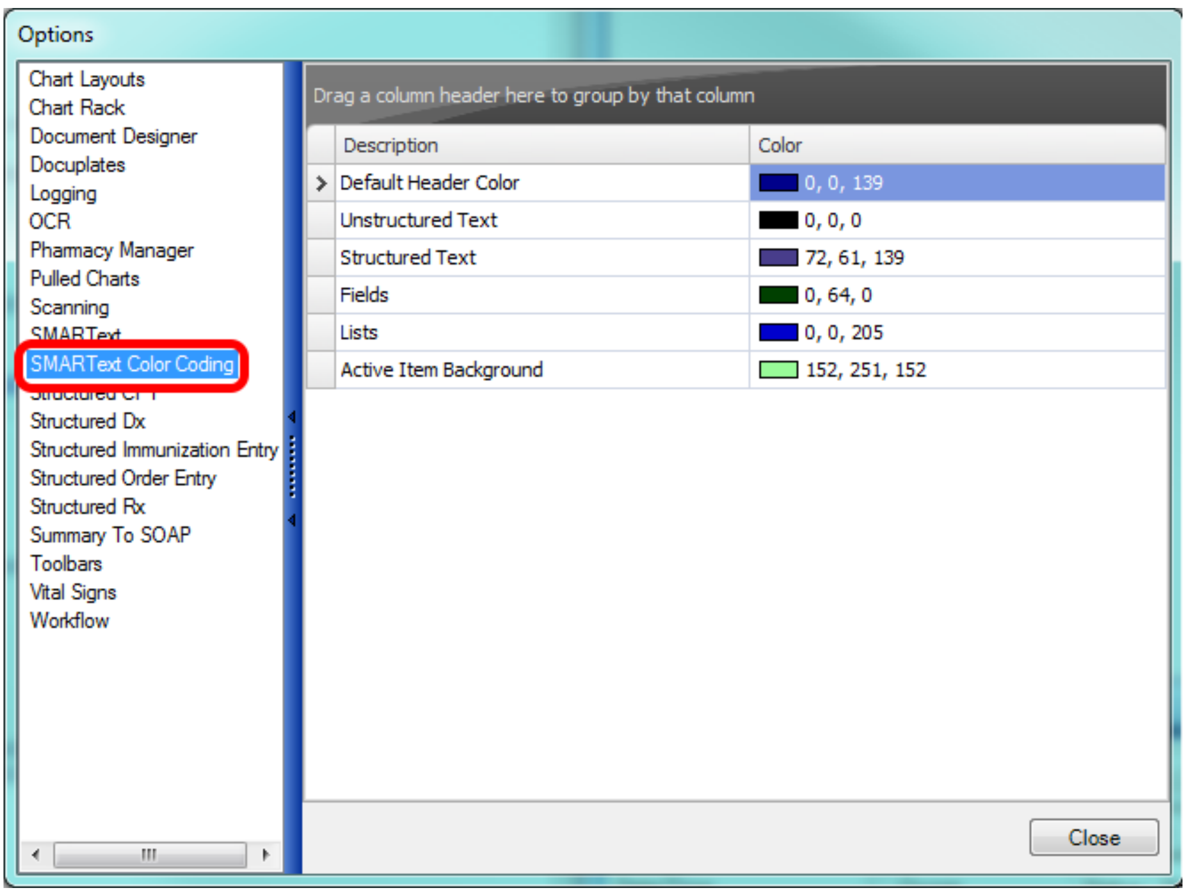
Expand Items with Space Bar: Allows the user to set whether a SMARText Item expands to full length when the user presses the space bar. To enable this feature, check the box. To disable this feature, uncheck the box.

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.

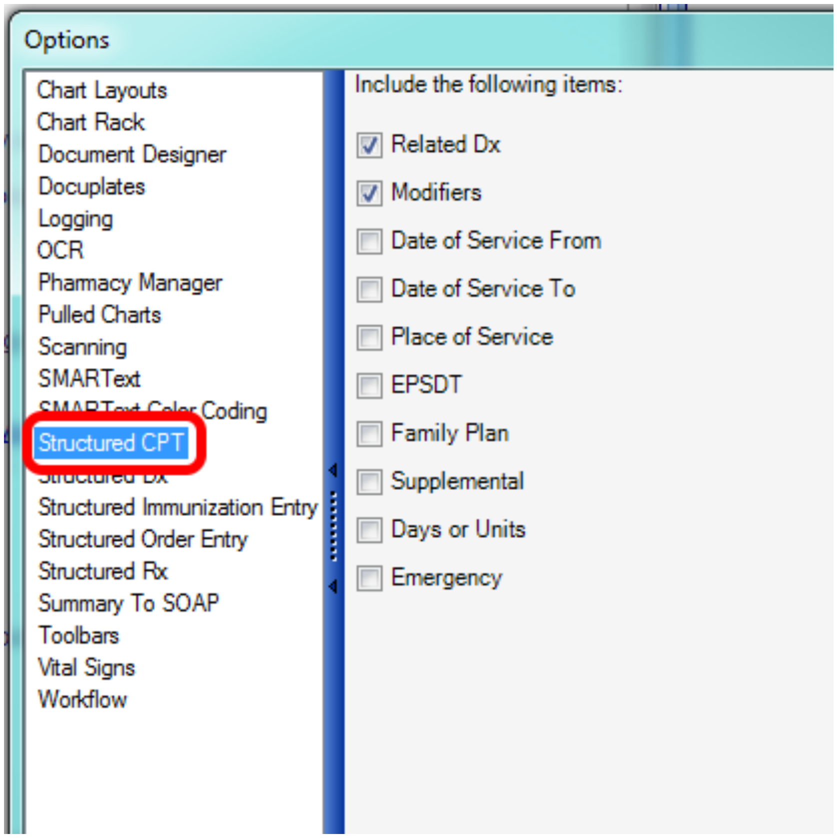
Display Unused SMARText Items: Display Unused SMARText Items when multiple shortcut codes are found - allows the user to set to show SMARText item sections that are not used. When this setting is off, sections that the user never use will be hidden from view.

SMARText Color Coding



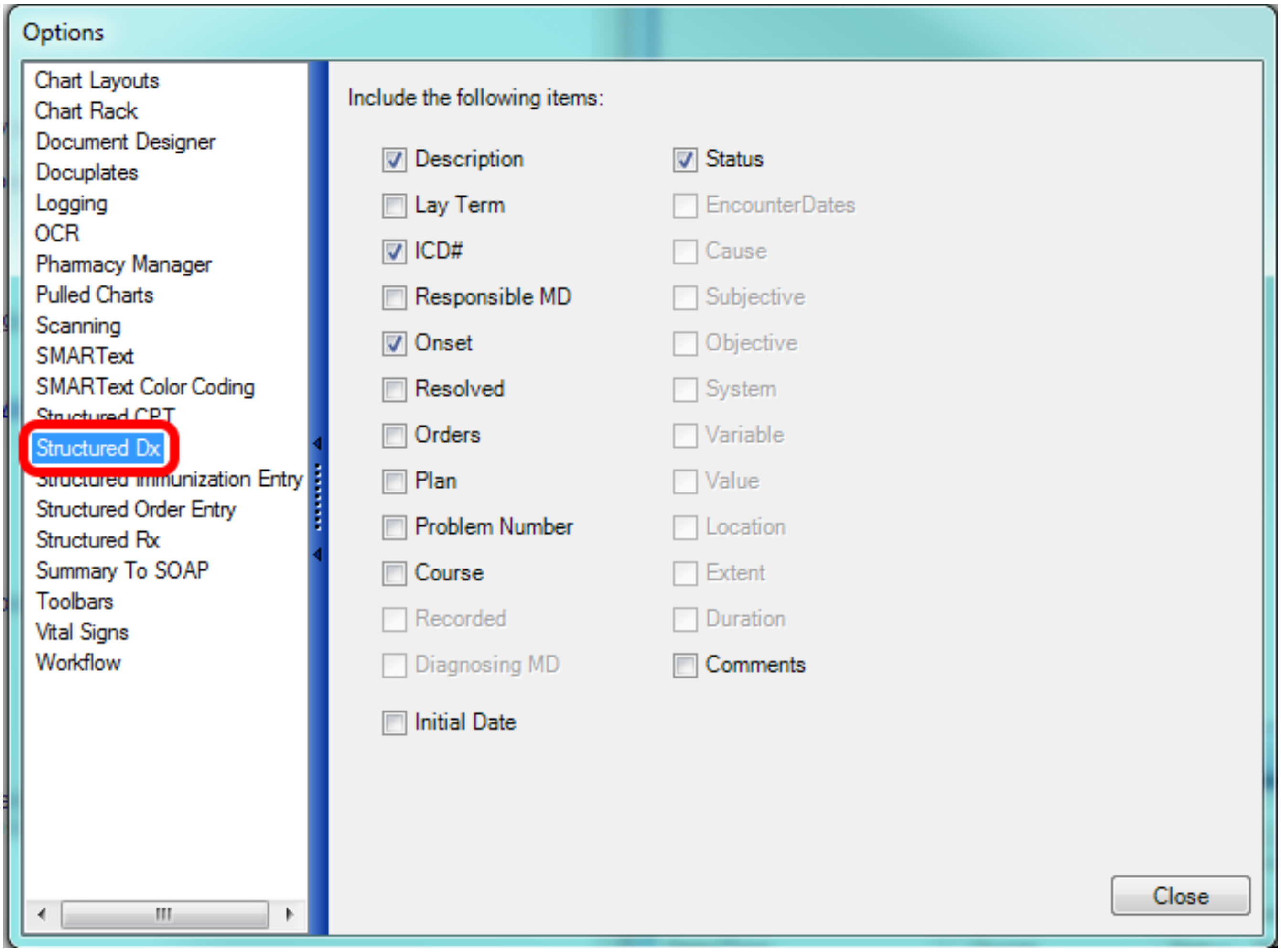
This setting gives the user the option to color code different types of SMARText for easy recognition.

Structured CPT



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

Structured Dx



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

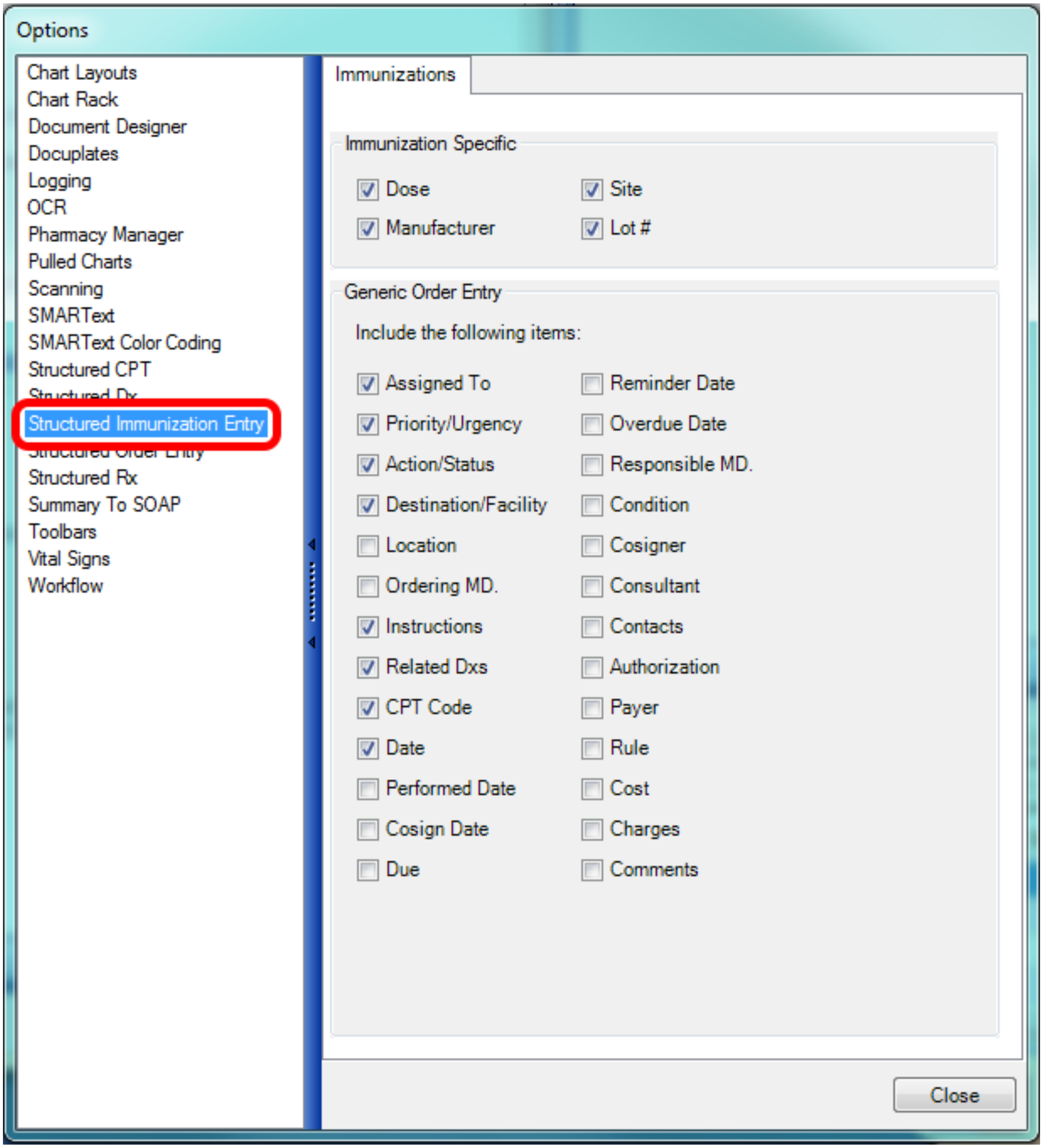
Course: Related to E&M Coder calculation

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.

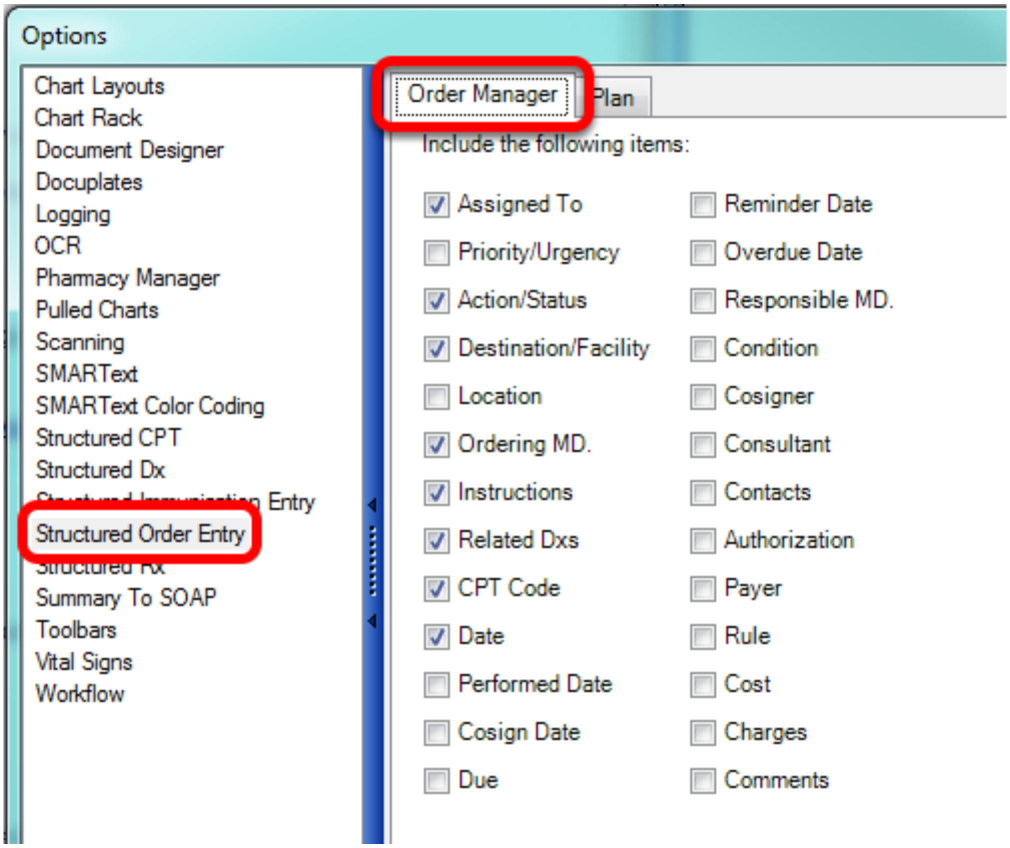
Comments: Allows any further details concerning the diagnosis to be entered.

Structured Immunization Entry



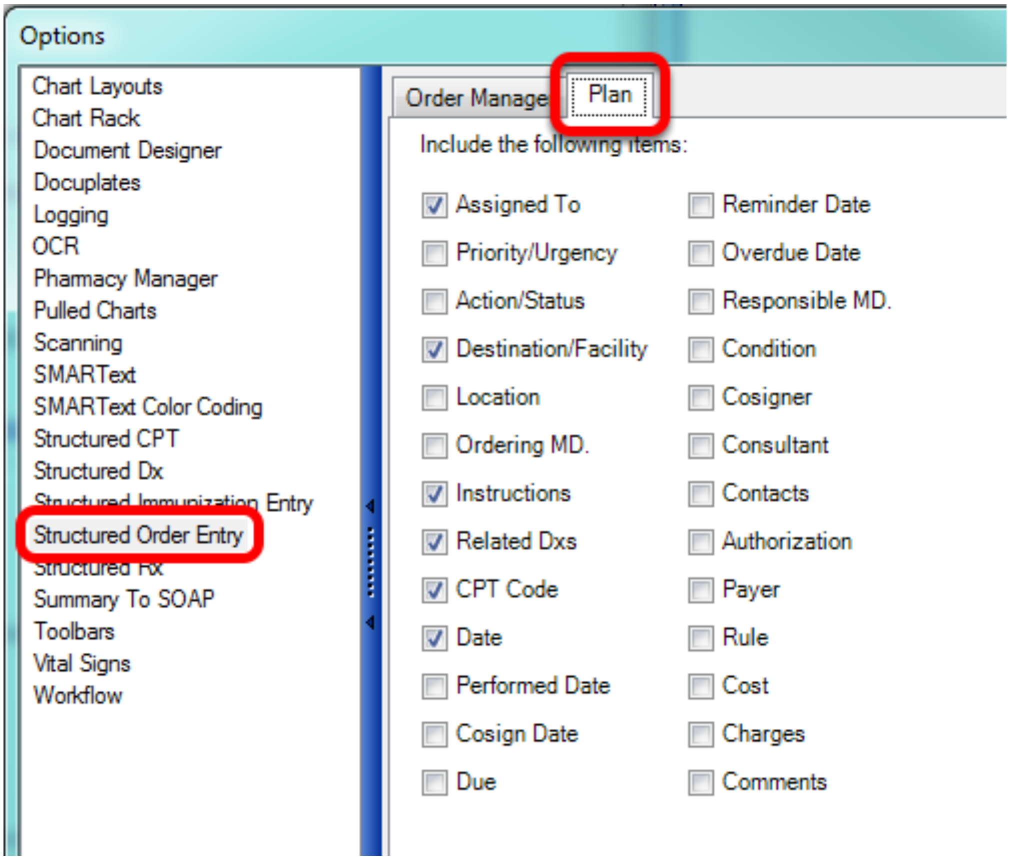
Select the sub-items to be entered when using Immunization Order Entry items. When immunization orders are transferred to the Plan field via either Order Manager or with the Quick Entry (i.e. F4 method), the sub-items that are checked (see screen shot above), will be displayed.

Structured Order Entry: Order Manager



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.

Plan Options



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.

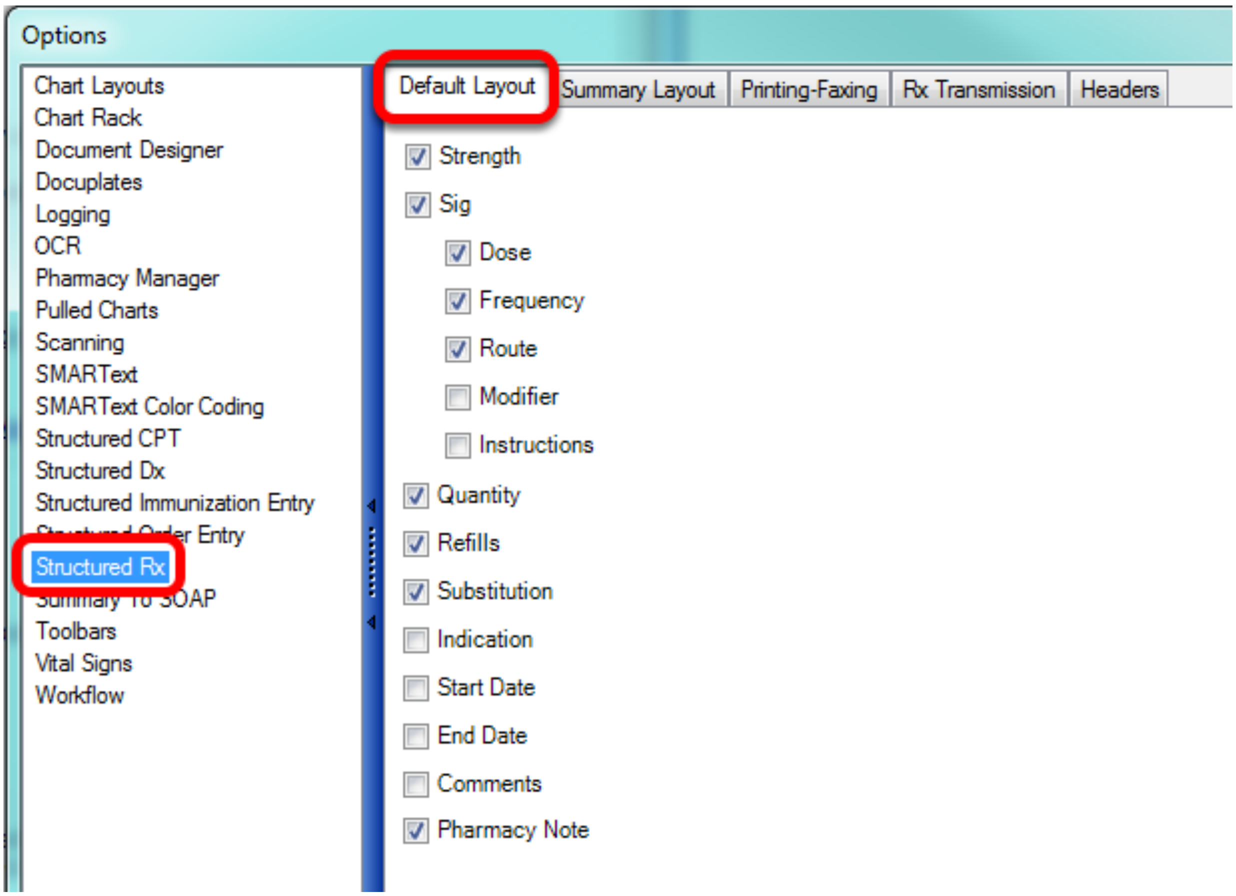
Due - Defines when an order is considered as due, or when it should have been completed.

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.

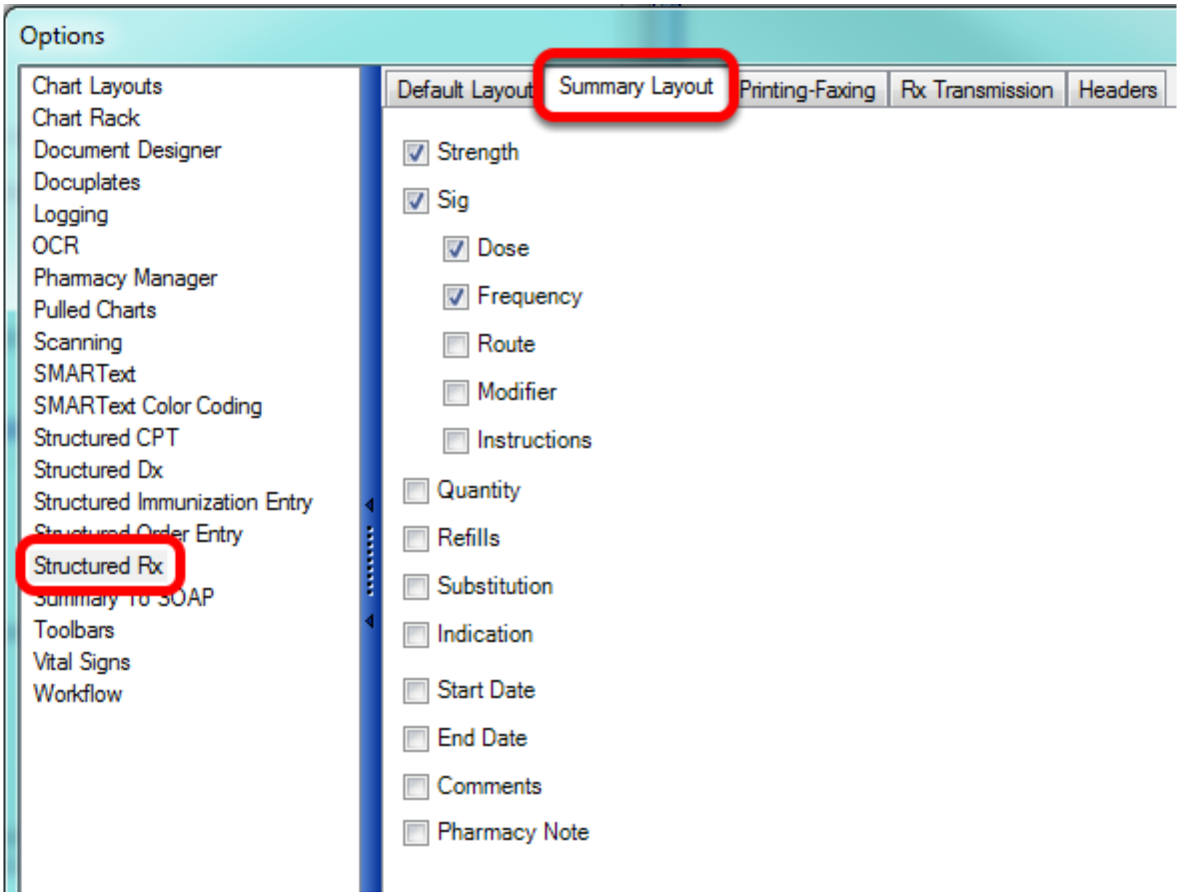
Structured Rx - Default Layout



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

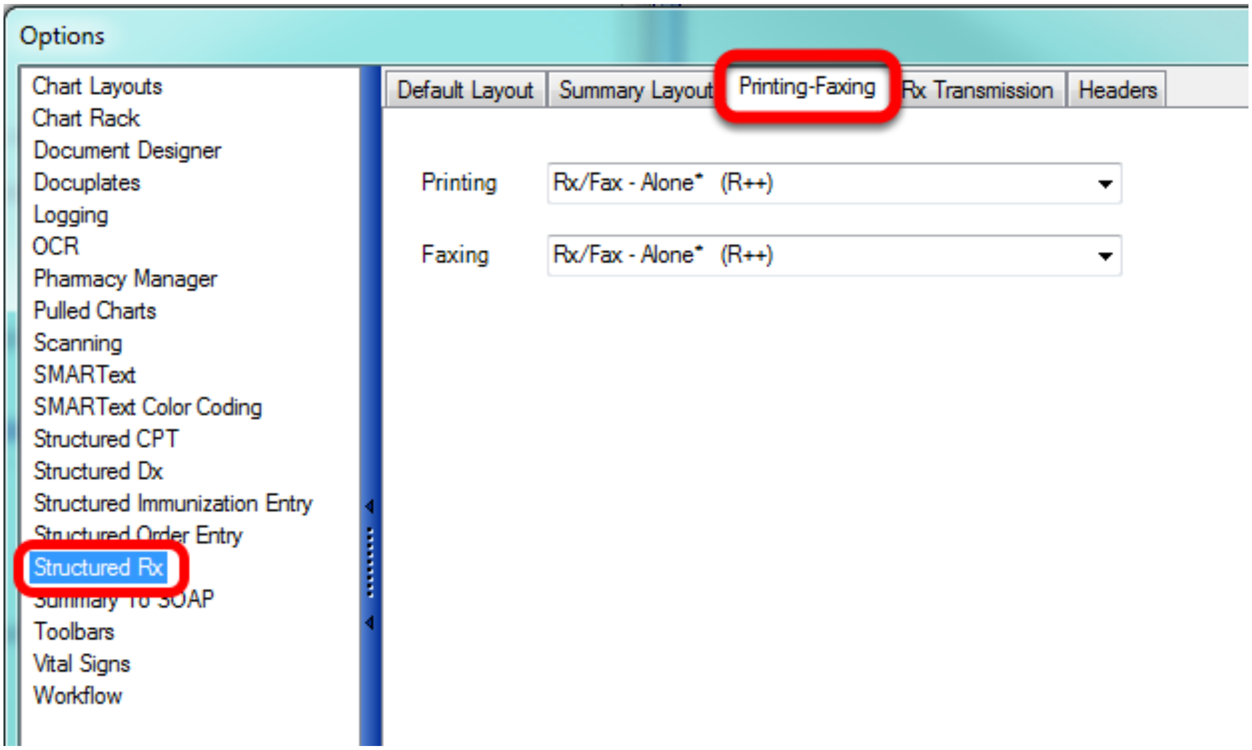
The Default choices affect the Structured Prescription as it appears in the SOAPnote.
Select the boxes of the items that would be filled out when prescribing a medication.

Structured Rx - Summary Layout



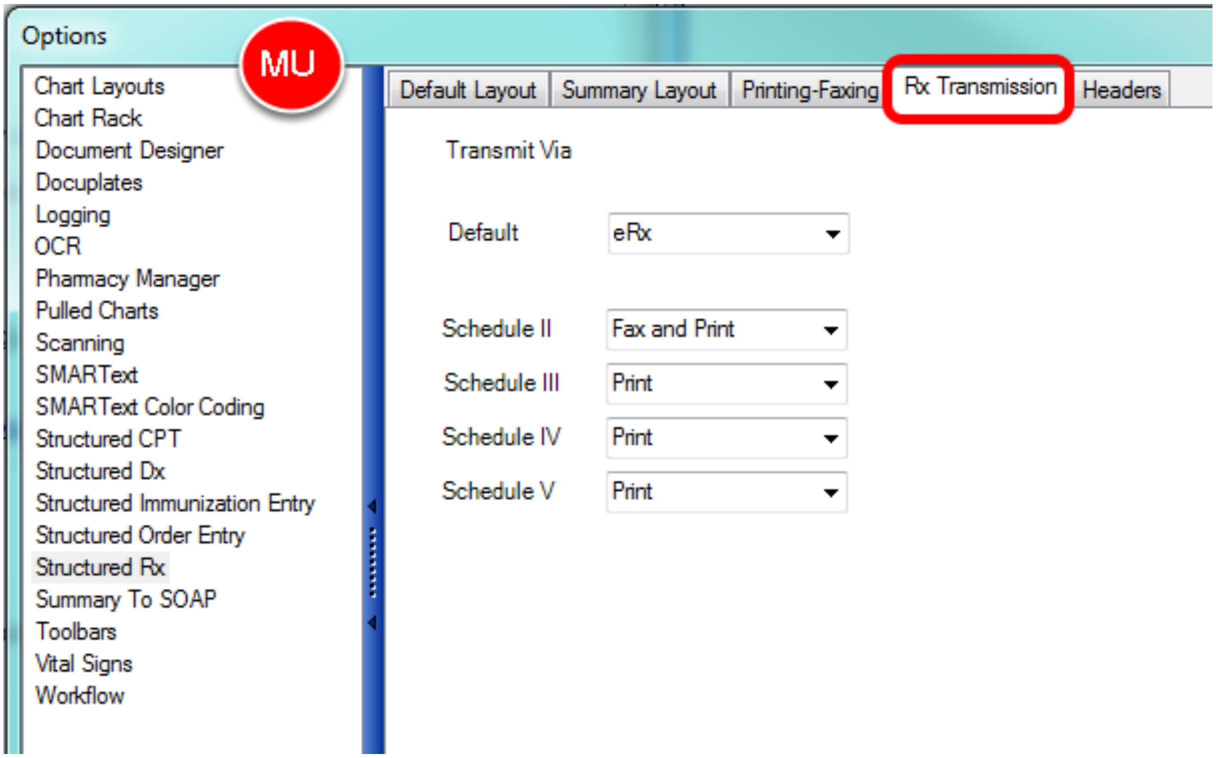
The Summary Medications Field choices affect the Structured Prescription as it appears in the summary or when transferred to the Summary via SOAP to Summary, Drag and Drop, etc.

Structured Rx - Printing-Faxing



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

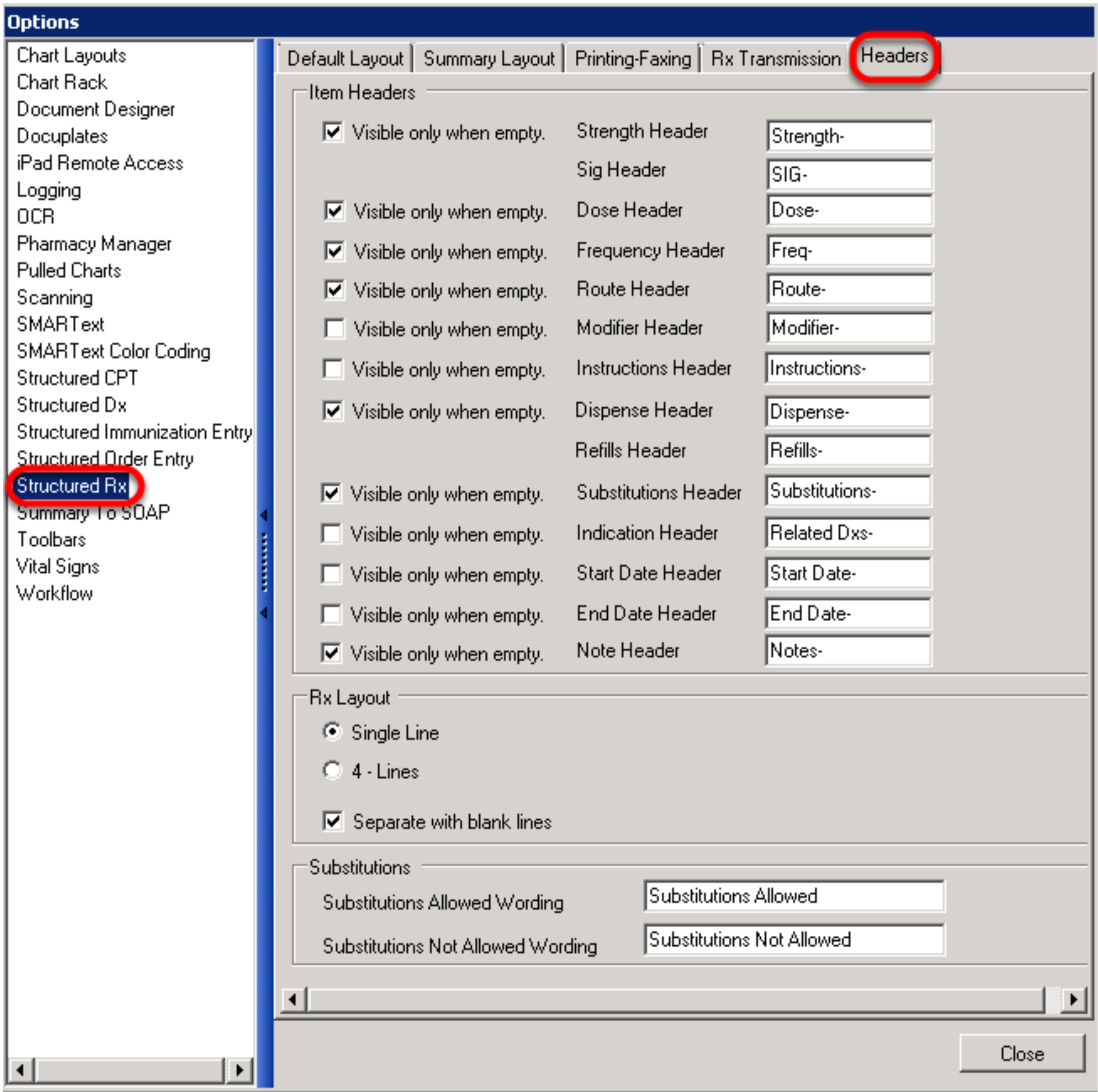


Rx Transmission is the default settings for how prescriptions submit from Rx Manager.

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

[Click here to view Meaningful Use Criteria]

Structured Rx - Headers



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

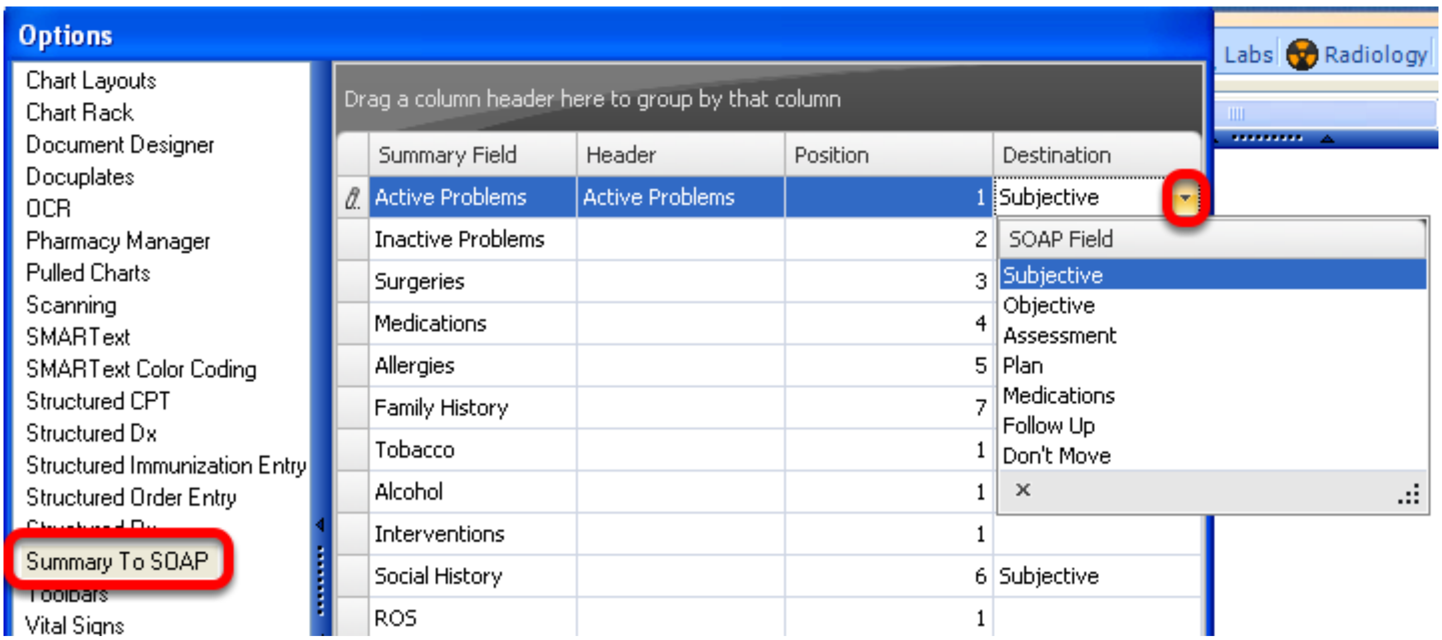
screen due to space limitations.

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.

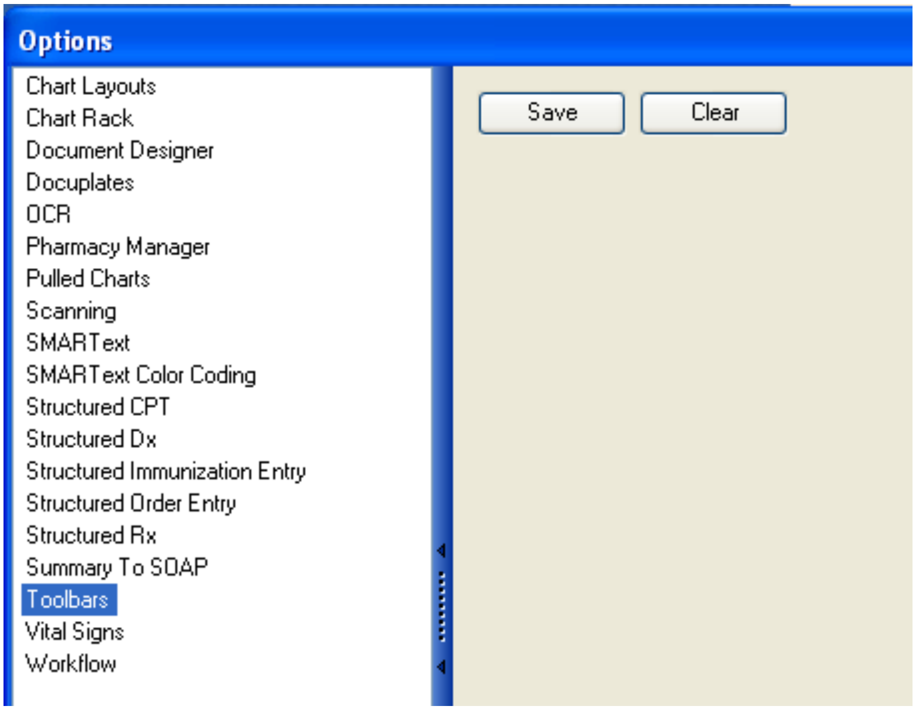
Substitutions Wording: This box allows the user to enter custom text that will be used when the user chooses to allow or deny substitutions in a prescription. To change the text, replace the default wording by typing it into the box.

Summary to SOAP



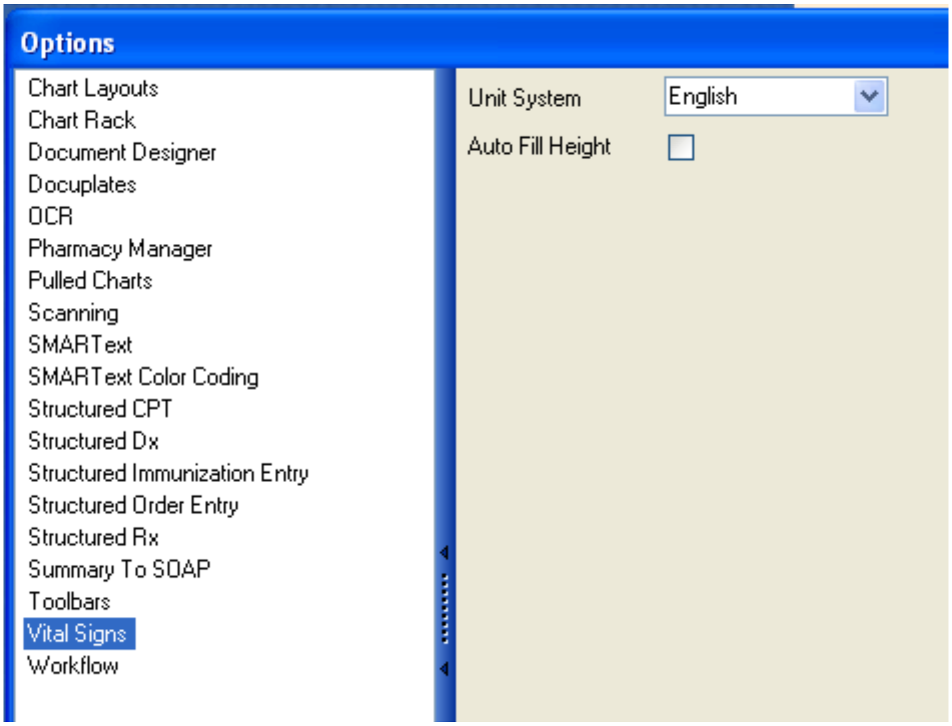
Allows for pulling over information under any field header in the Summary section to any area in the SOAP Note.

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.

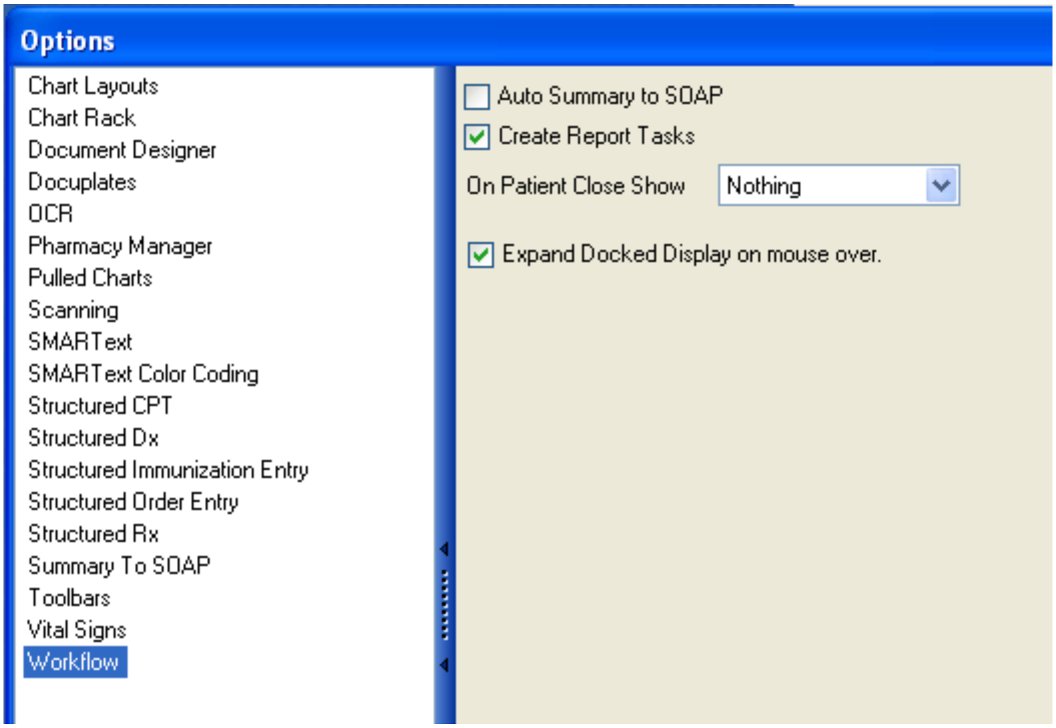
Vital Signs



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



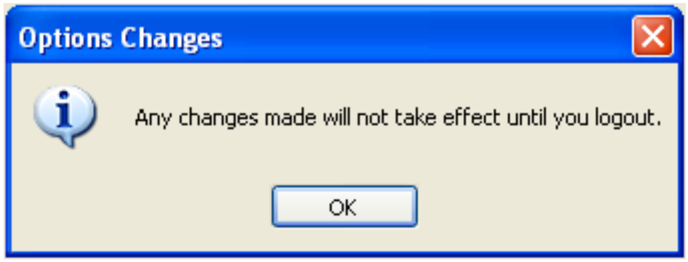
Auto Summary to SOAP: Checking this box will automatically pull the user's Summary findings into every new SOAPnote created.
It moves the Summary Physical section to the Encounter/SOAPnote Objective section, the Summary Active Problems section to the SOAPnote Assessment section, and the Summary Medications section to the SOAPnote Medications Section.

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

On Patient Close Show: Any time 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.

Logout

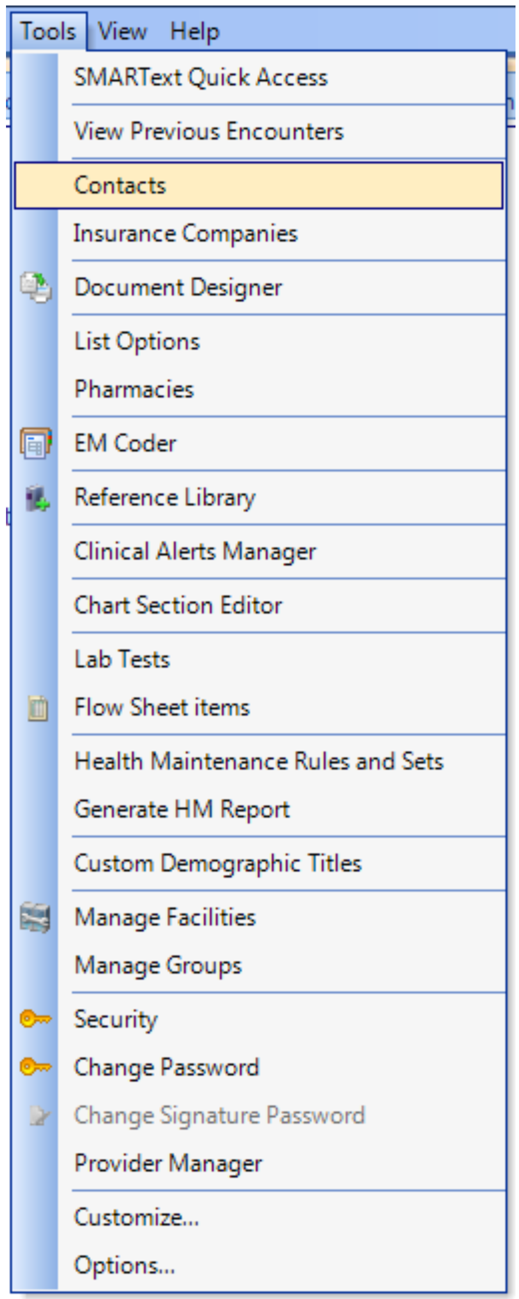


Any time a user makes a change under the Tools > Options menu, SOAPware requires the user to logout and log back in before the change will take effect.

Contacts

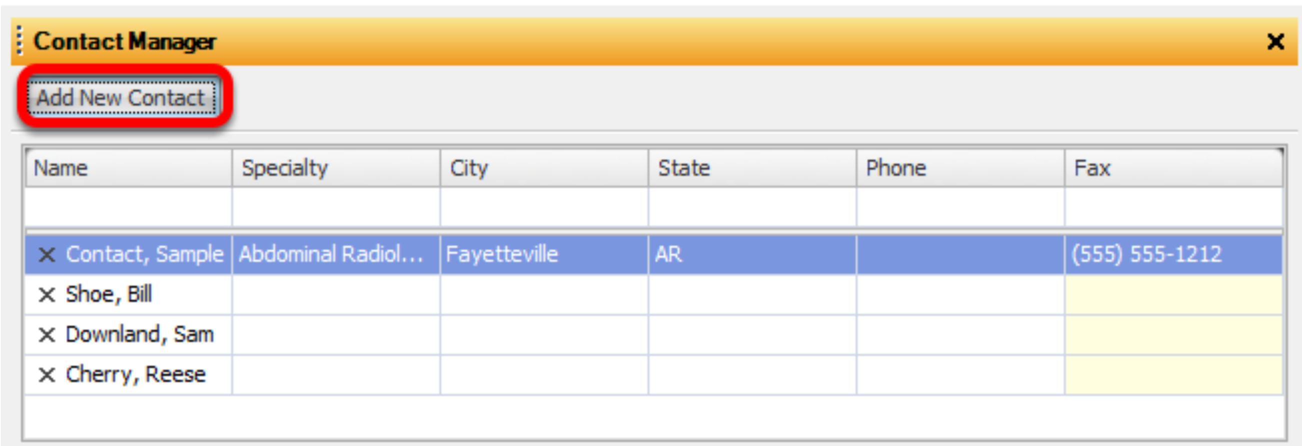
SOAPware can maintain a list of frequently used contacts along with their basic demographic information. SOAPware's document designs can then pull this information to create personalized documents such as referral letters. The contact list is also used to maintain frequently used names and addresses.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

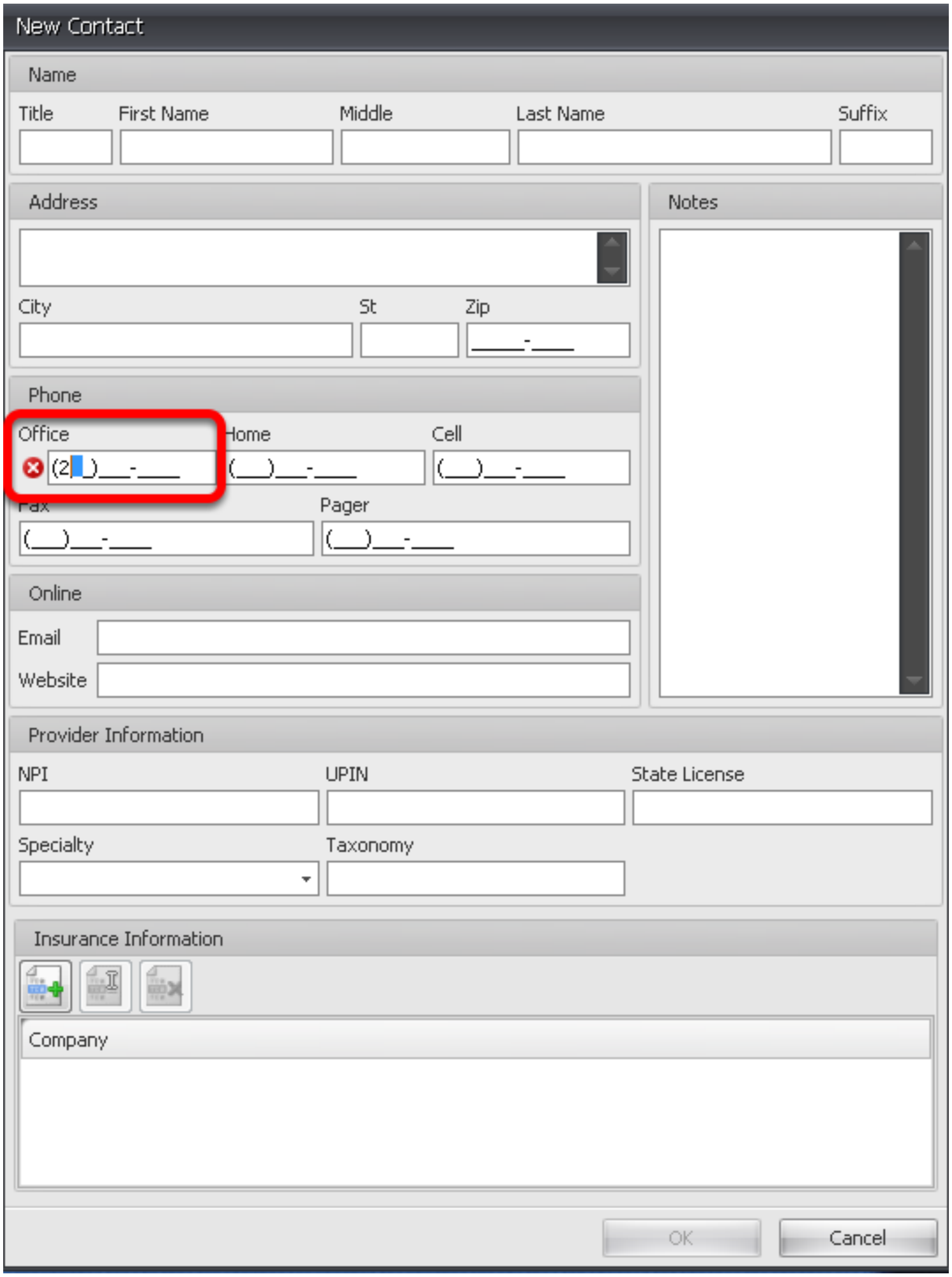
Adding Contacts



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.

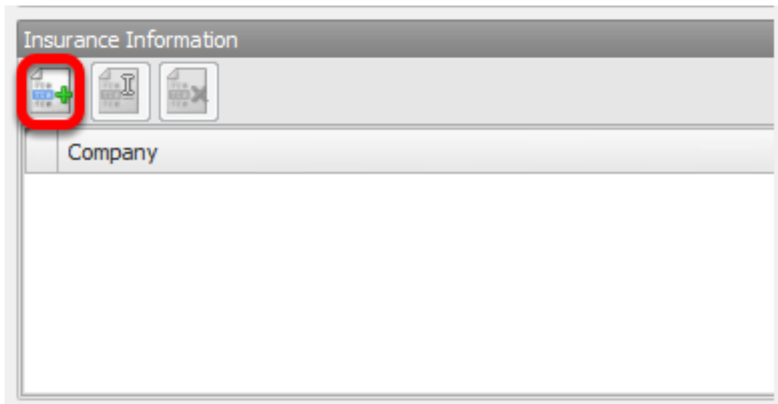
New Contact



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.

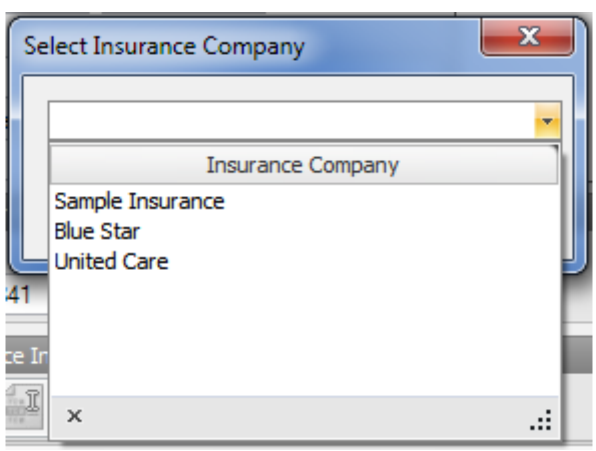
If data is entered in the highlighted fields, it must be a valid phone number. Awarning icon will prompt the user if the number is invalid.

Insurance Mapping



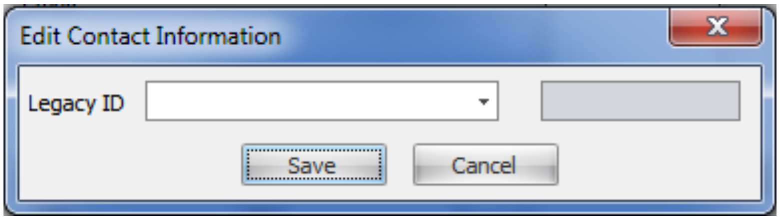
Click the New Insurance Mapping button in the Insurance Information section. The Select Insurance Company dialog displays.

Insurance Company Manager



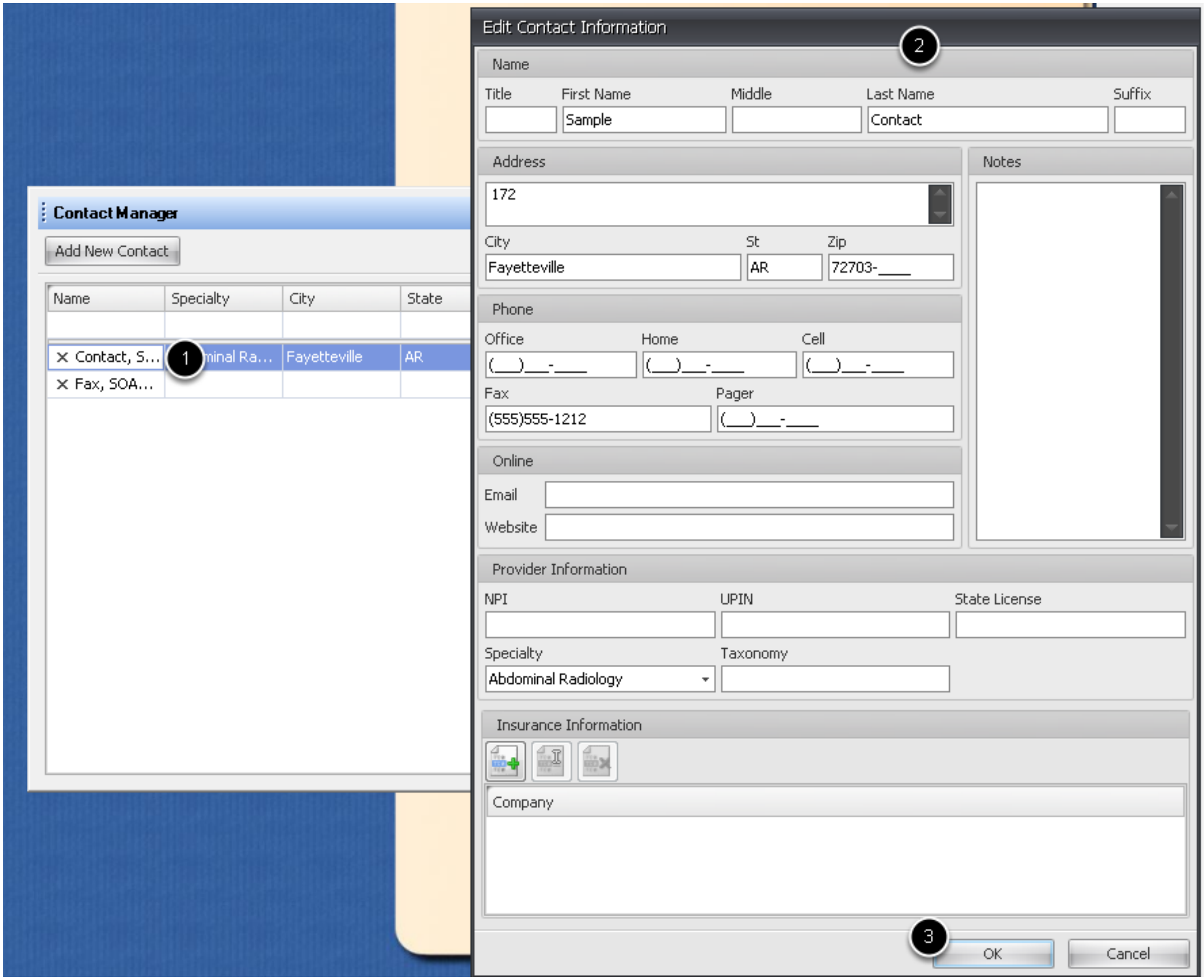
Click the Drop-down menu to display a list of insurance companies from the Insurance Company Manager.

ID Number



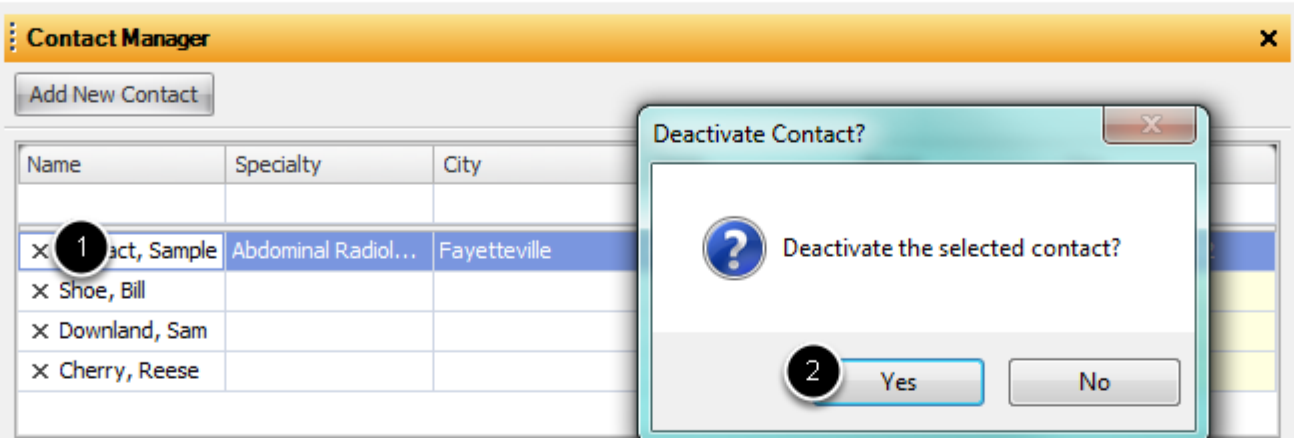
Click the Drop-down button to display the list of different types of legacy numbers, followed by the legacy number ID Qualifier. Type the contact/Referring Provider Medicare legacy number and Click Save.

Updating/Editing Contacts



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

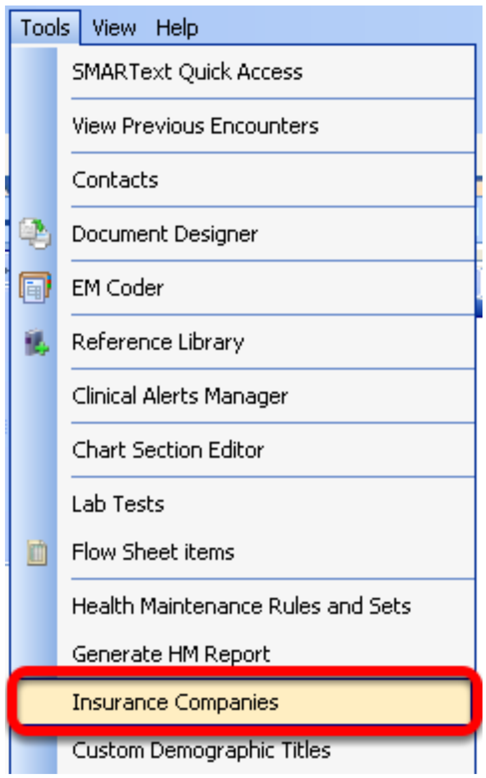


1. Do delete.remove a contact, Click on the **X** next to the contact name.
2. Click the Yes button when asked to verify the deactivation. Click Cancel to return to the Contact Manager viewer.

Insurance Company Manager

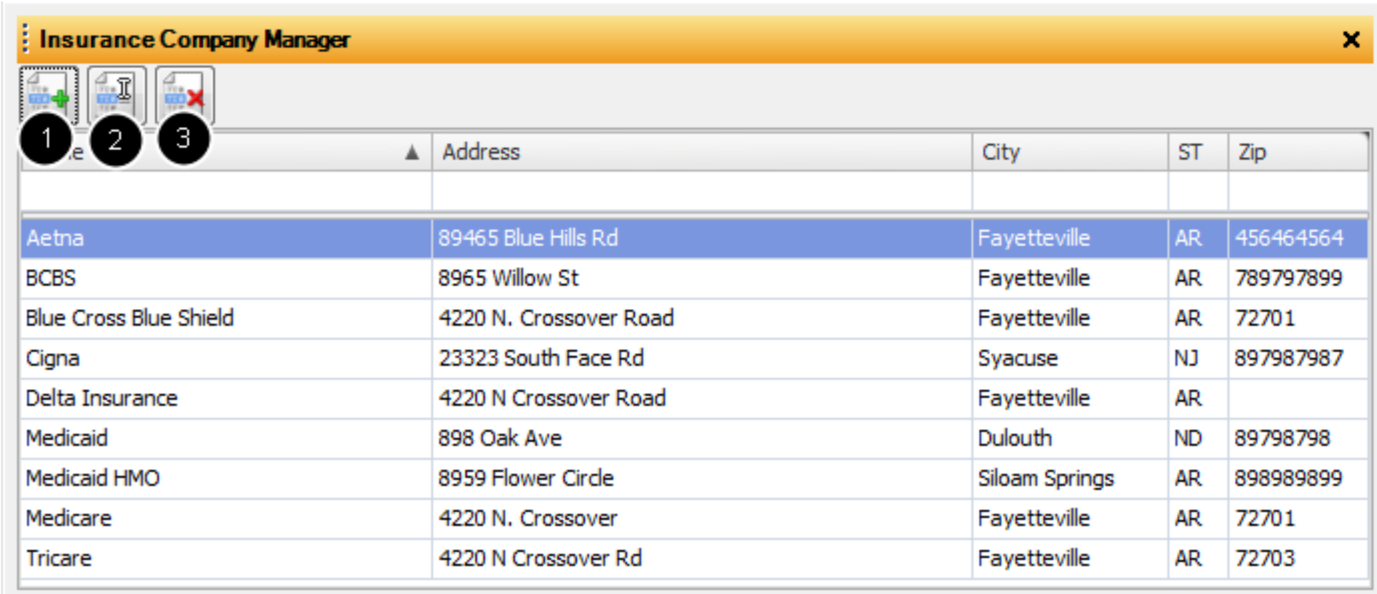
Adding Insurance Companies for the Drop list will be created with this tool. The user will fill in the appropriate information for the Insurance Company.

Insurance Company Manager



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

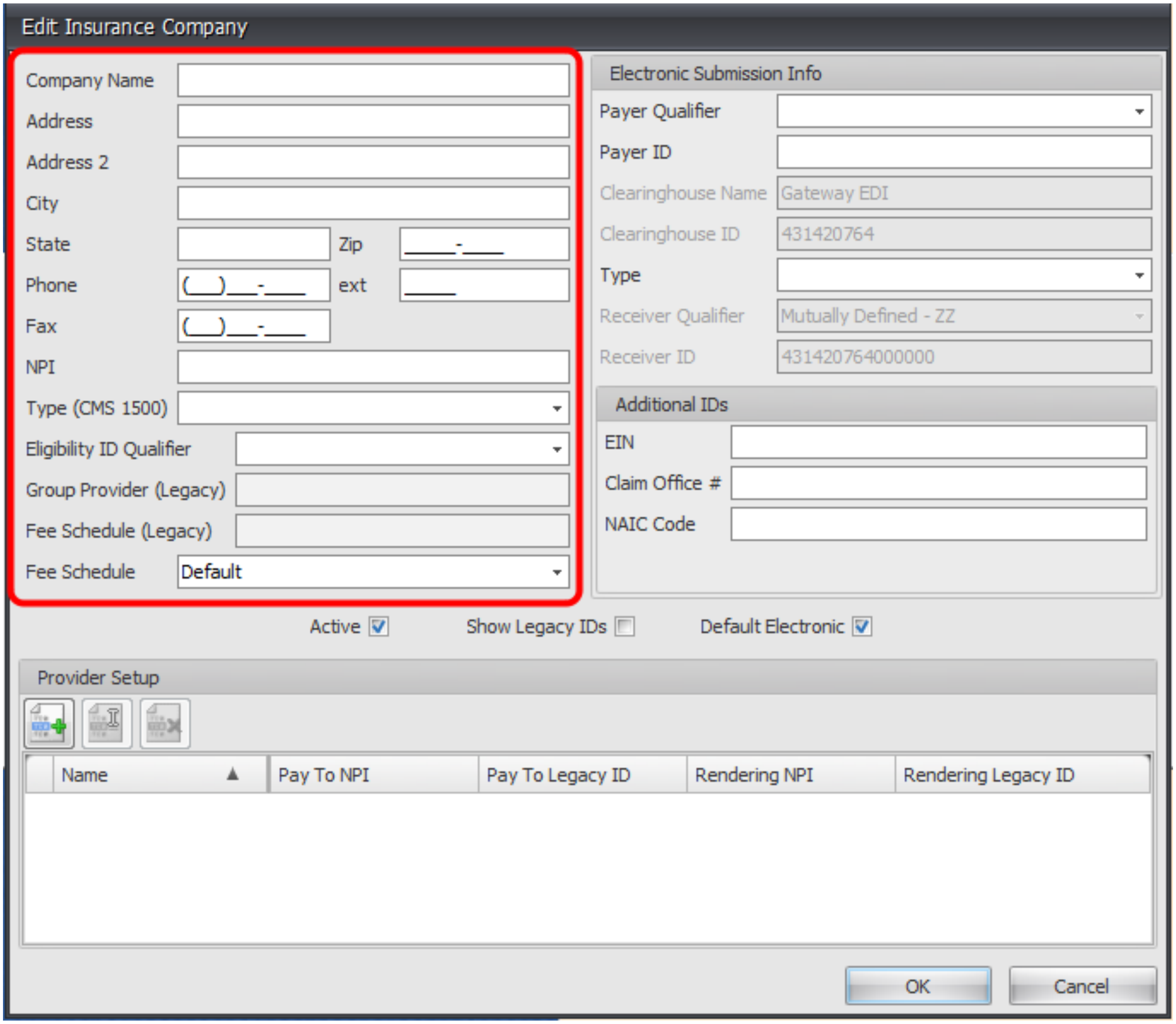
Creating/Editing/Removing Insurance Companies in Insurance Company Manger



e	Address	City	ST	Zip
Aetna	89465 Blue Hills Rd	Fayetteville	AR	456464564
BCBS	8965 Willow St	Fayetteville	AR	789797899
Blue Cross Blue Shield	4220 N. Crossover Road	Fayetteville	AR	72701
Cigna	23323 South Face Rd	Syacuse	NJ	897987987
Delta Insurance	4220 N Crossover Road	Fayetteville	AR	
Medicaid	898 Oak Ave	Dulouth	ND	89798798
Medicaid HMO	8959 Flower Circle	Siloam Springs	AR	898989899
Medicare	4220 N. Crossover	Fayetteville	AR	72701
Tricare	4220 N Crossover Rd	Fayetteville	AR	72703

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

Adding/Editing Insurance Company Demographics



Enter in the information for the Insurance Company in applicable fields.

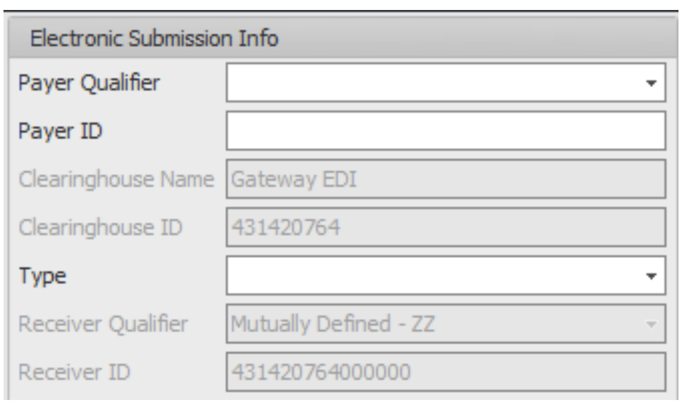
- **Insurance Company Information:** Add Insurance Company Name, mailing address, phone and fax (optional)

For SOAPware Practice Management:

- **NPI:** Payer NPI, if required.

- **Type:** This will be used to determine which box to check in Block 1 on the CMS 1500 form.
- **Eligibility ID Qualifier:** This will be used to identify the type of Receiver ID used for checking insurance eligibility for patients. Payers that require a legacy ID need to have the ‘Prior Identifier Number - Q4’ option selected in the Eligibility ID Qualifier drop down on the Insurance Company dialog. Payers that require a tax ID need to have the ‘Federal Taxpayer Identification Number TJ’ option selected; the field can be left empty for all other payers. There are several other options in the drop down but they’re currently not used. If the tax ID option is selected then the Receiver ID field is automatically populated from the group’s tax ID info.
- **Group Provider (Legacy):** If the Insurance Company requires a Legacy number in addition to a NPI number, Type the Group/Pay To number here.
- **Fee Schedule (Legacy):** This is for information purposes only, any Legacy Fee Schedules previously assigned to this Payer.
- **Fee Schedule:** Use the Drop Down option to select a Fee Schedule from the list in Fee Schedule Maintenance, or leave blank and it will use the Default fee schedule

Insurance Electronic Submission Info

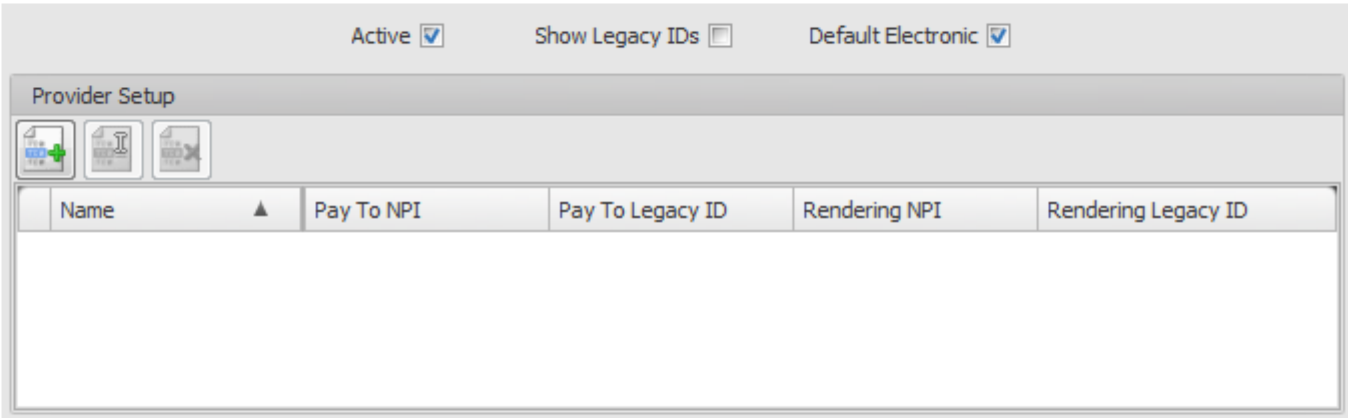


The Electronic Submission Info section will only need to be completed by customers using the SOAPware Clinical Suite (Billing) software. For more information on completing the Electronic Submission Info area, please see: **Insurance Company Manager.**

Additional IDs

The Additional Ids section will only need to be completed by customer using the SOAPware Clinical Suite (Billing) software. For more information on completing the Additional IDs area, please see: **Insurance Company Manager.**

Provider Setup



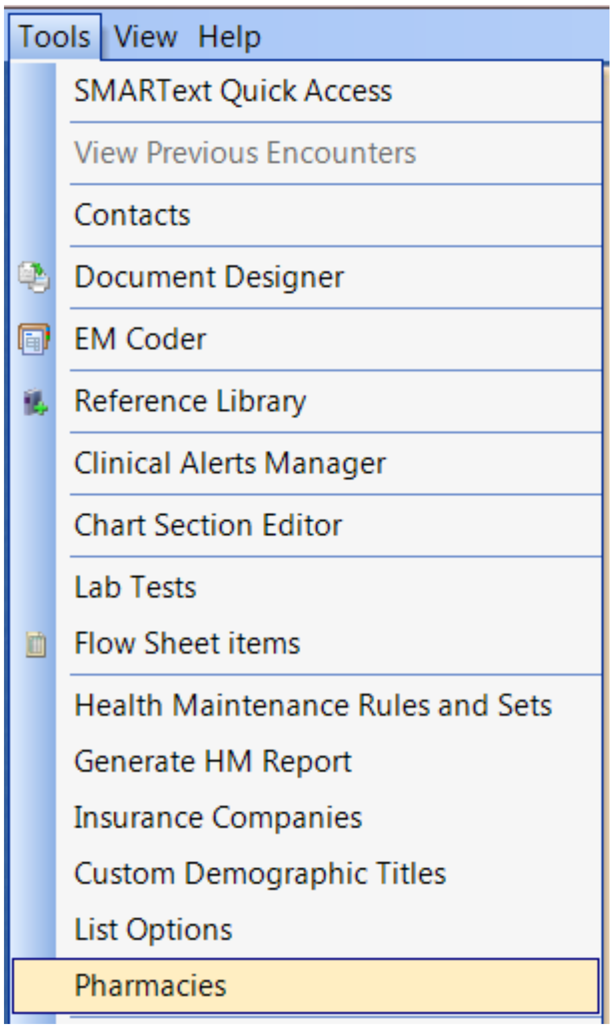
The Provider Setup window will be an area to select Provider(s) within a user's network that are under contract with that Insurance Company. Clicking on the Green + will display a window with a user's network Providers to choose from. Click OK after completion.

This section is important for customers to complete if using the SOAPware Clinical Suite (Billing) software. For more information on completing the Provider Setup section, please see: **Insurance Company Manager.**

Pharmacy Setup

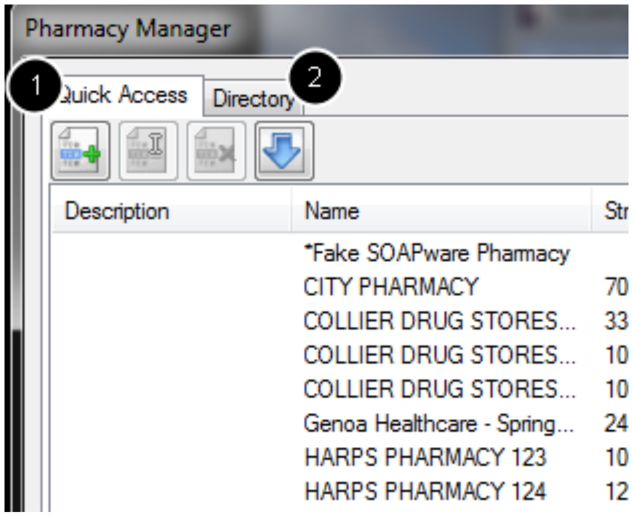
Prior to sending prescriptions electronically or faxing to a participating pharmacy, Pharmacies must be set up in the Pharmacy Manager.

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.

Two Tabs

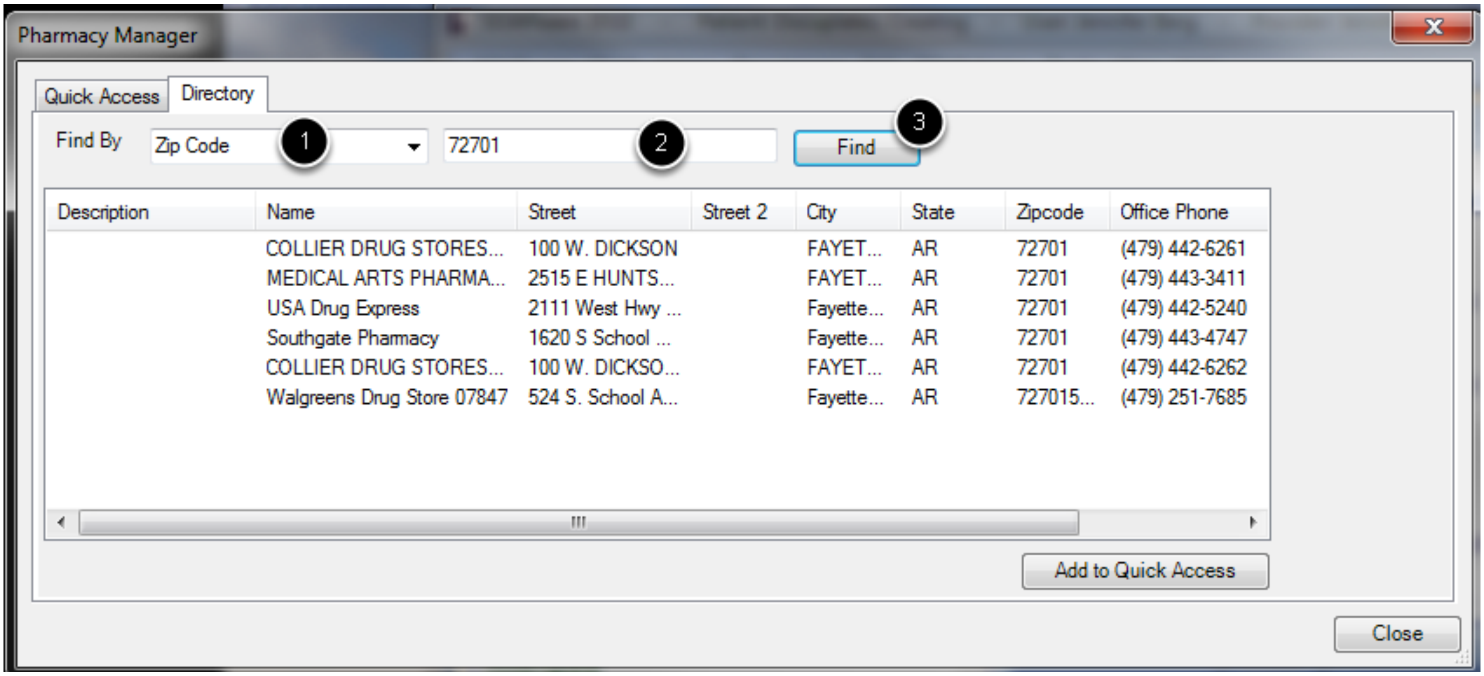


There are two tabs in the Pharmacy Manager:

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

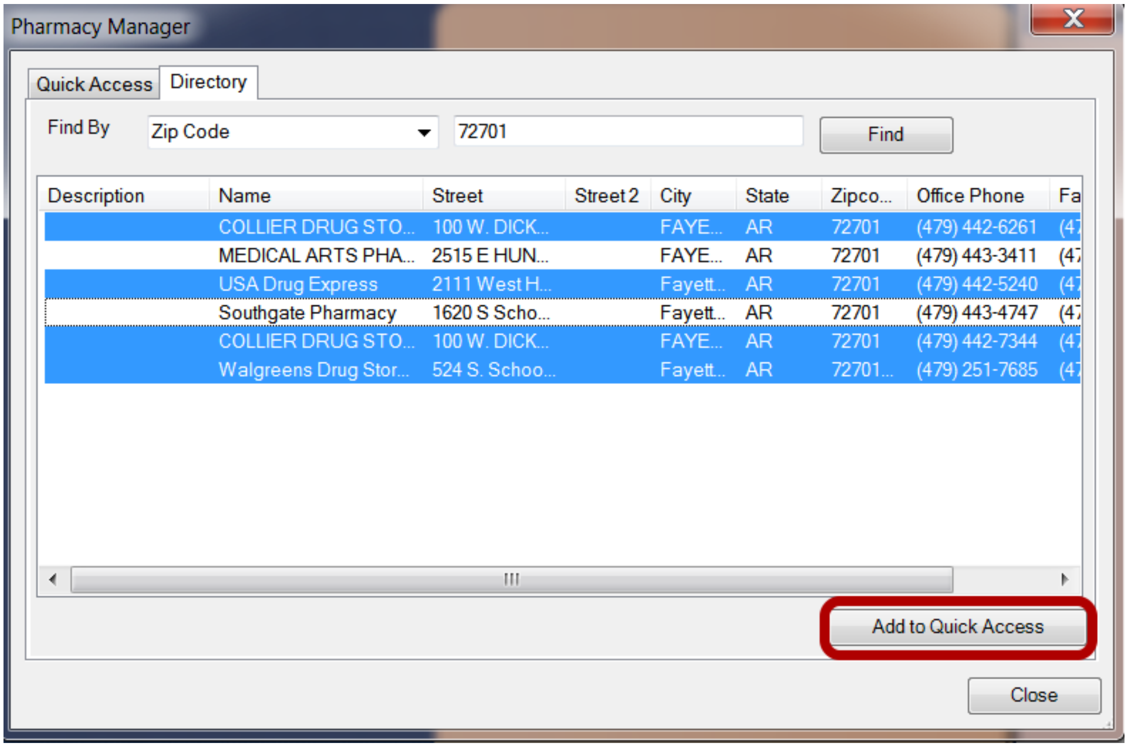


ePrescribing pharmacies are found via searching options in the Directory tab allows.

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.

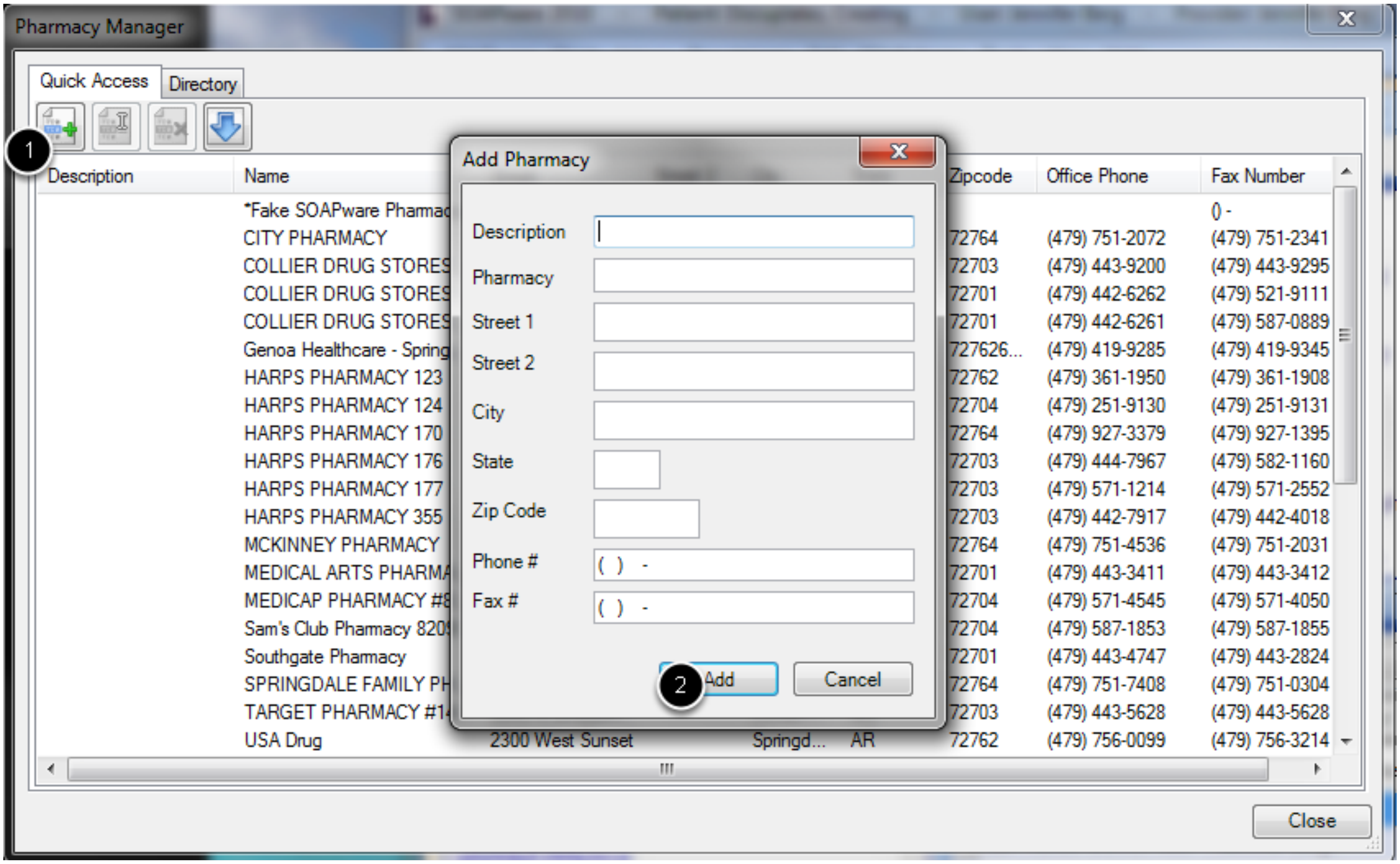
2. To select a group of pharmacies, all of which are contiguous, Click on the first pharmacy in the list. Then, Press and hold-down the shift key while Clicking on the last pharmacy. This select-highlights all pharmacies between the first and the last.

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

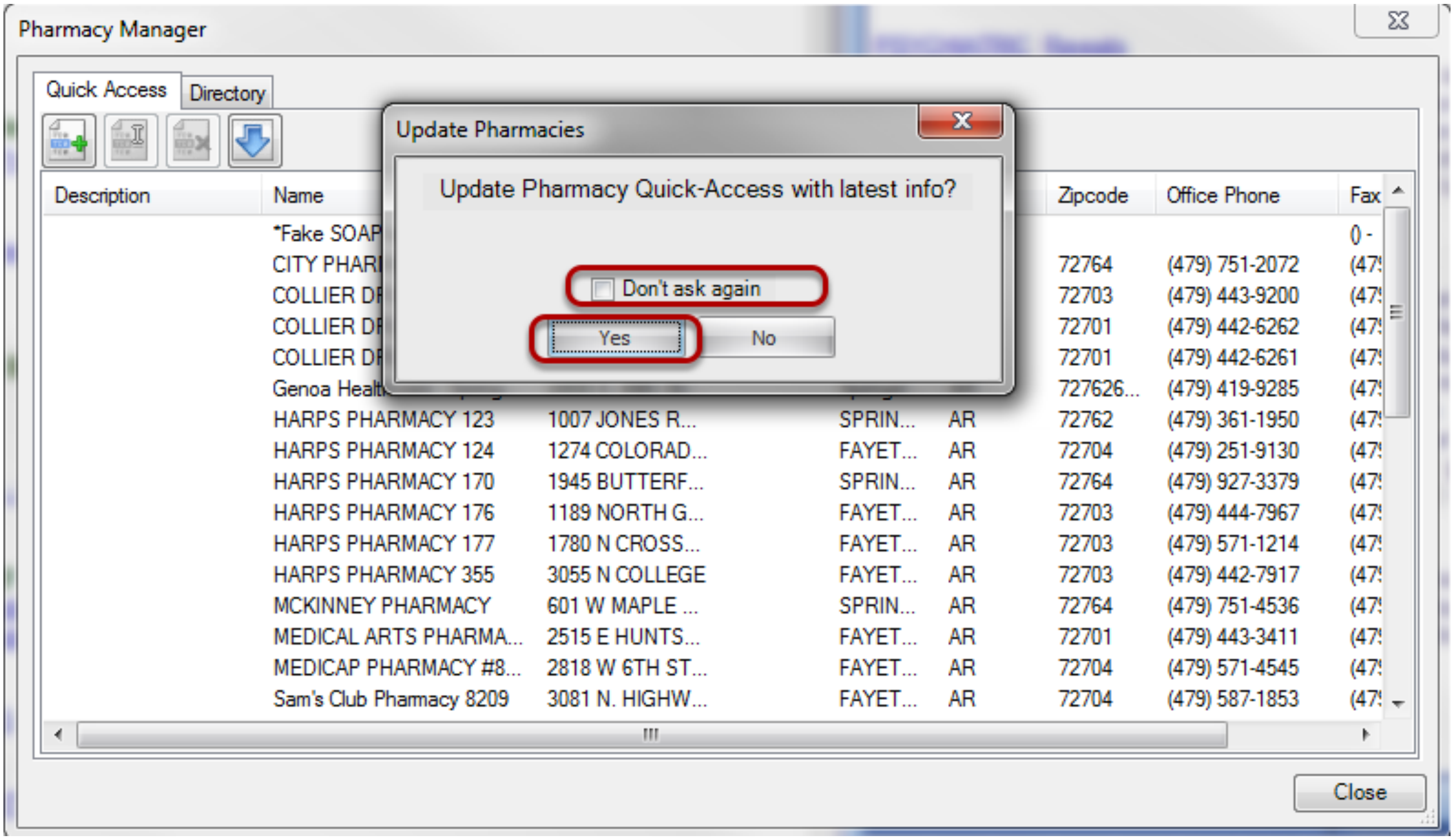


Pharmacies not found searching in the Directory tab can be manually added in the Quick Access tab. **A user will only be able to print or fax the prescription when a pharmacy is added using the Quick Access tab.** (Please refer to the directions above to add an ePrescribing pharmacy.)

1. Click the Create button at the top left.

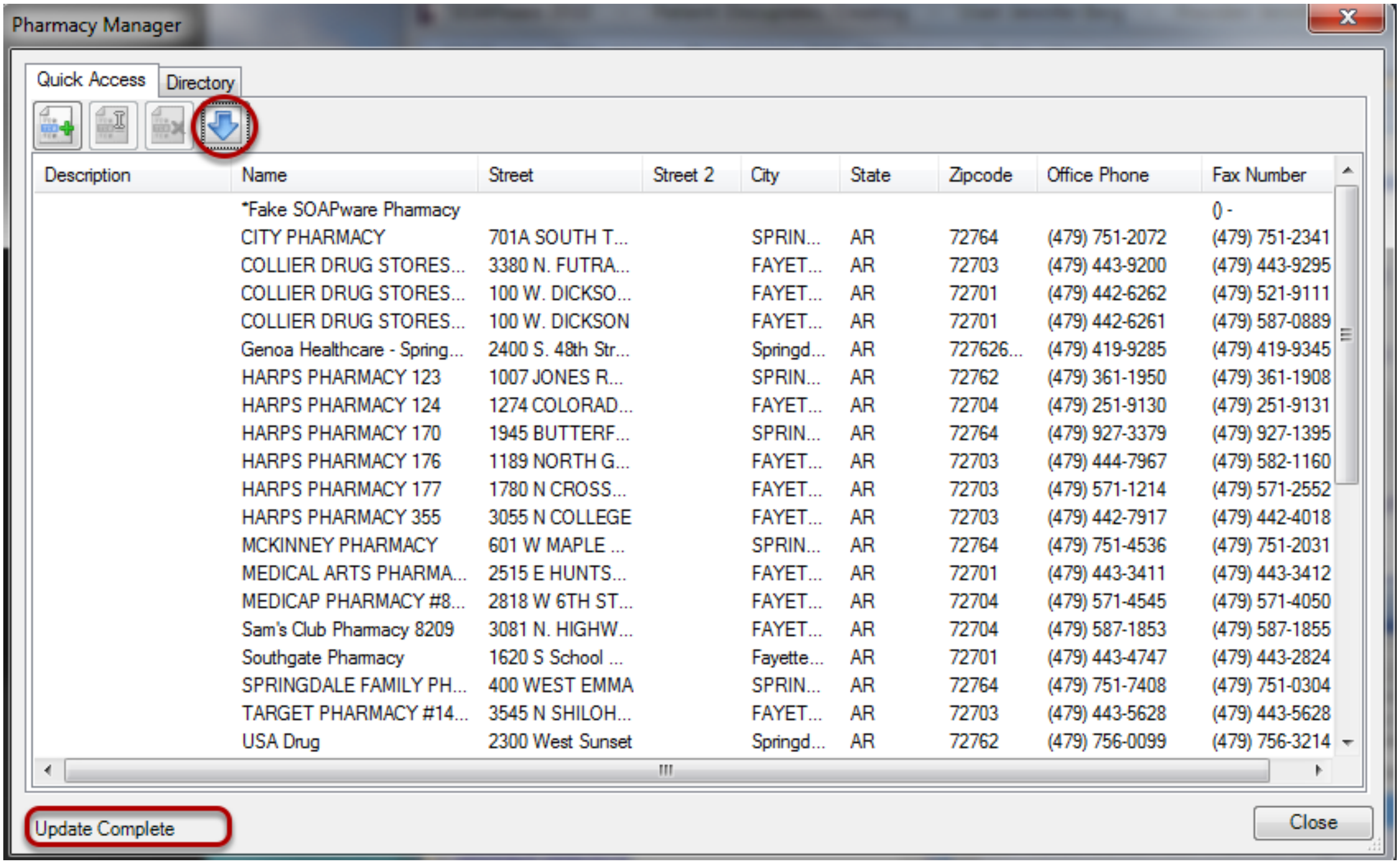
2. Type the pharmacy information into the Add Pharmacy dialog as in screen shot, and Click the Add button. When adding or editing a pharmacy, a user must input a valid 10 digit fax number. A warning symbol will display, once they Add button has been clicked, if this entry is invalid.

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.

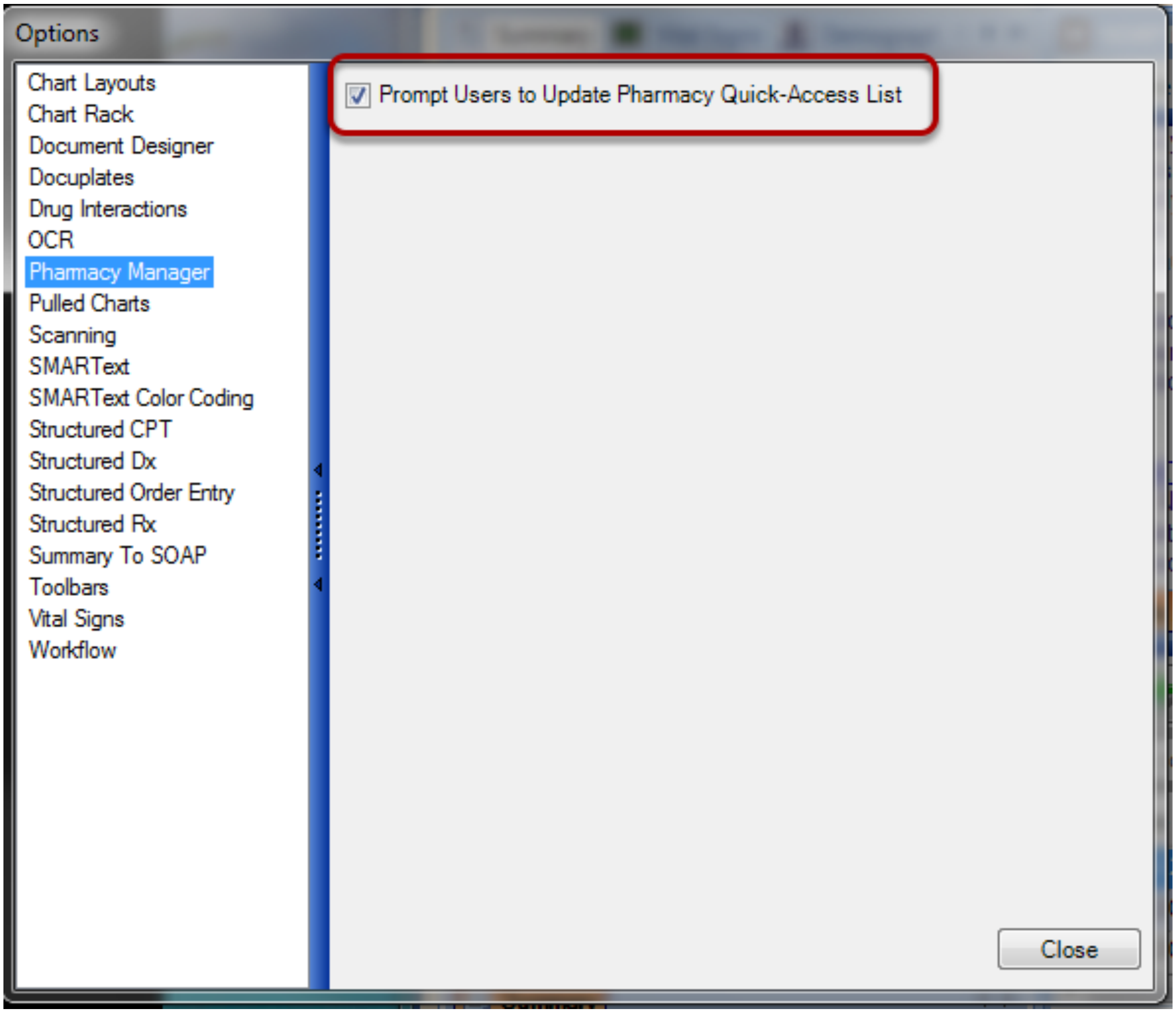
Updating Pharmacy Information



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".

Pharmacy Manager Options



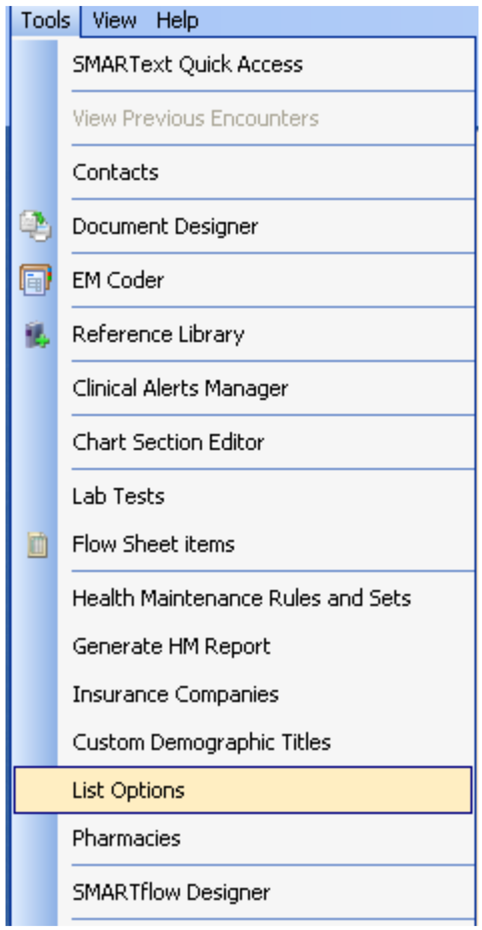
The Update Pharmacy dialog pop up box is a customizable feature that is set under Tools > Options.

Check this option and SOAPware will again prompt users to update the Pharmacy Quick-Access list when Pharmacy Manager is launched.

List Options

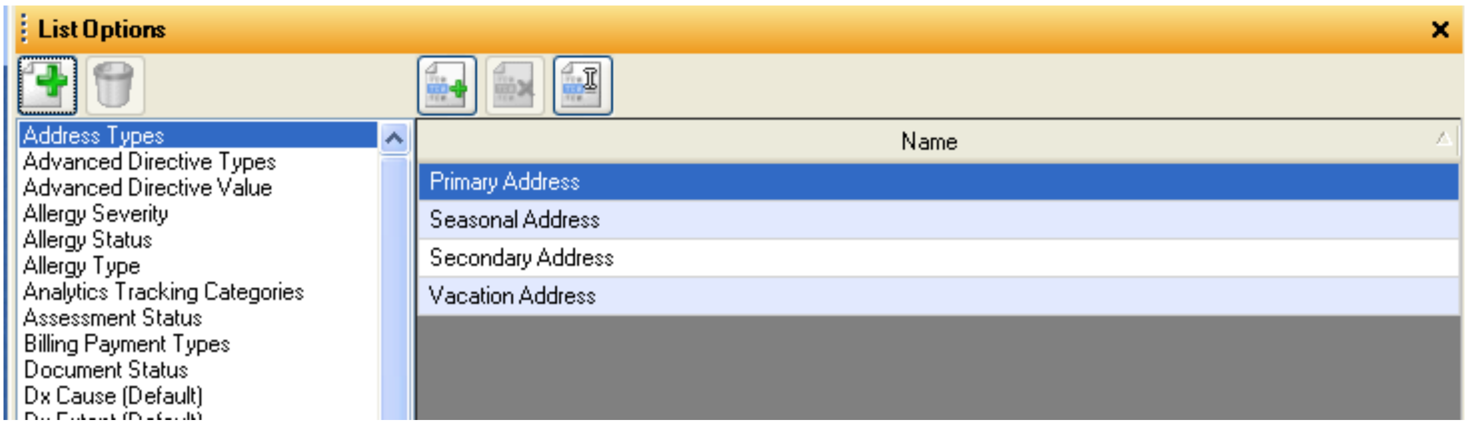
In many areas, there are Drop-Down Menu Lists from which items can be selected. Therefore, these are usually referred to as menu lists rather than pick lists. These are not related to SMARText Items, but are set up for all users to have in common. These are defaulted with SOAPware, but can be customized in List Options.

List - Options



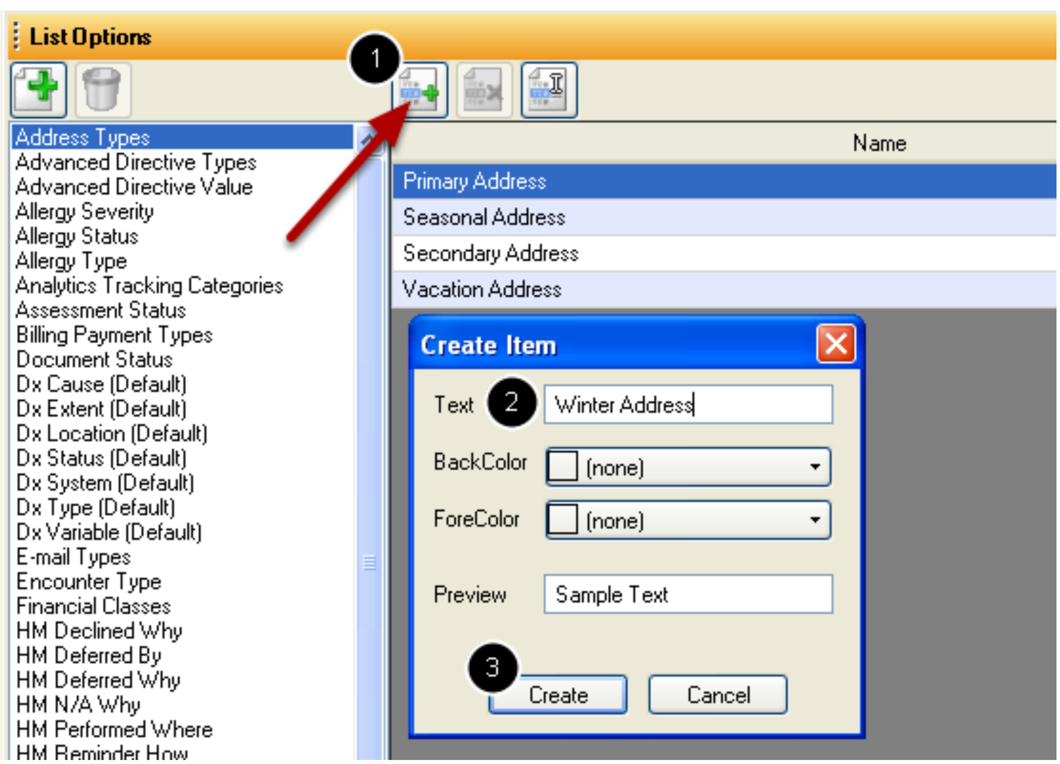
To change these lists, Click Tools > List Options. This will provide the user with all of the drop-down lists that a user is able to customize.

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

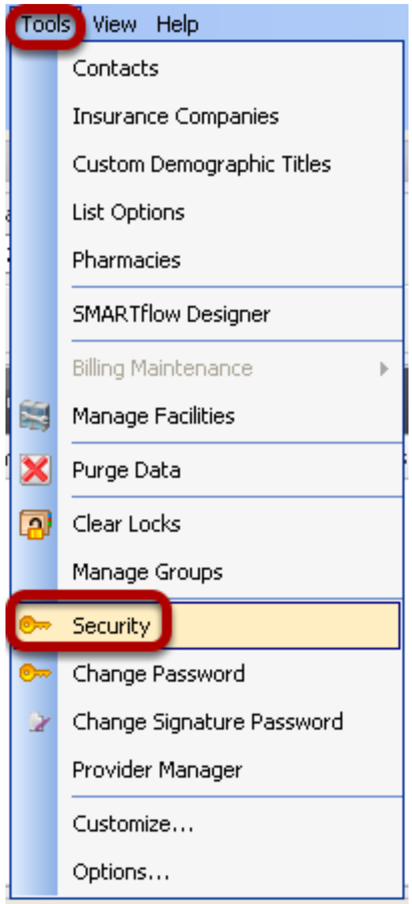
Intro to Security

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.

Accessing Security



1. Click on the Tools menu
2. Click on Security

Security Settings

***THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT - PROTECT ELECTRONIC HEALTH INFORMATION**

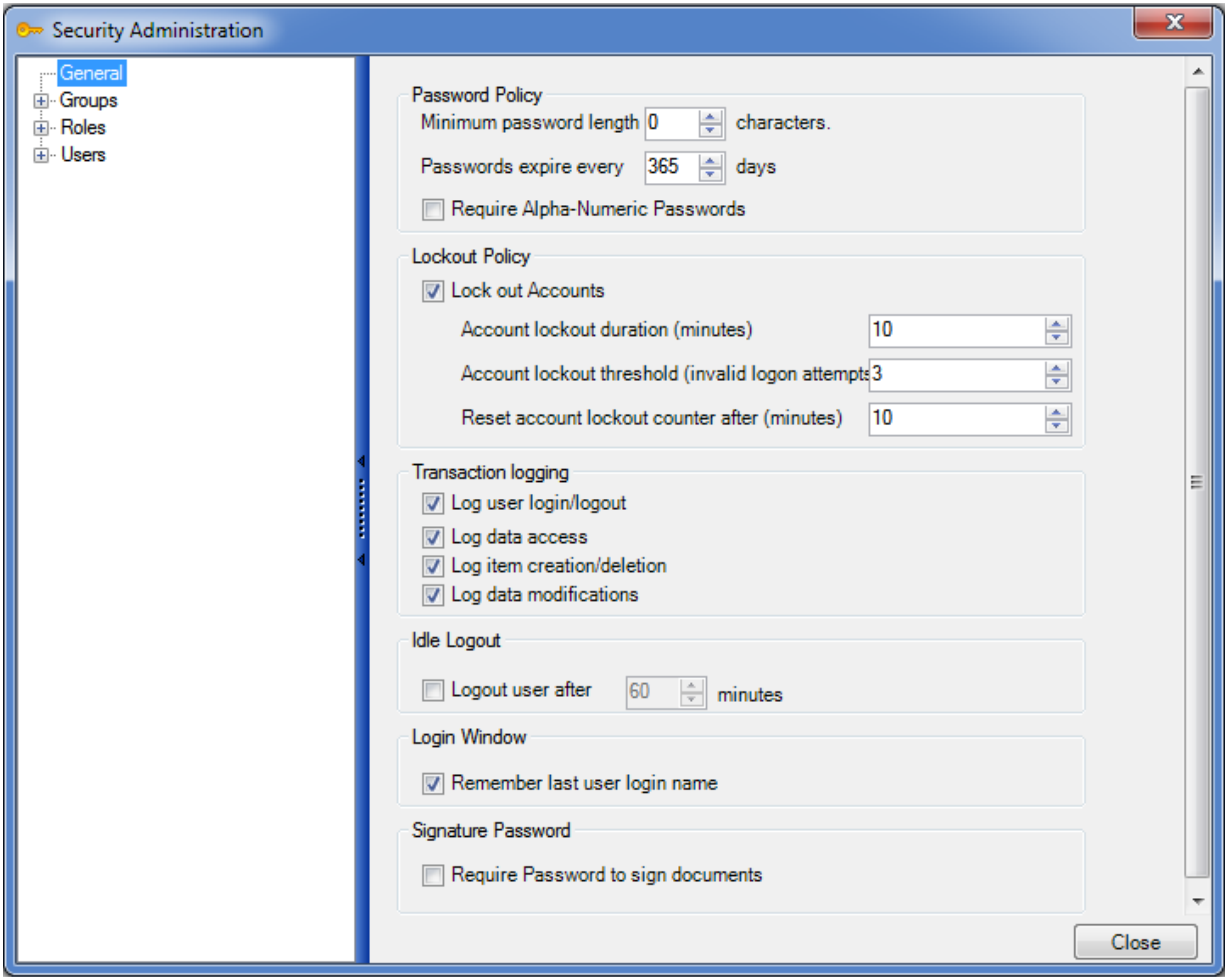
To gain access to Security, a user must be granted the access rights of a System Administrator. Before beginning to assign security settings, the System Administrator should become familiar with the functions related to Groups, Roles and Users.

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 Security Administration 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.



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.

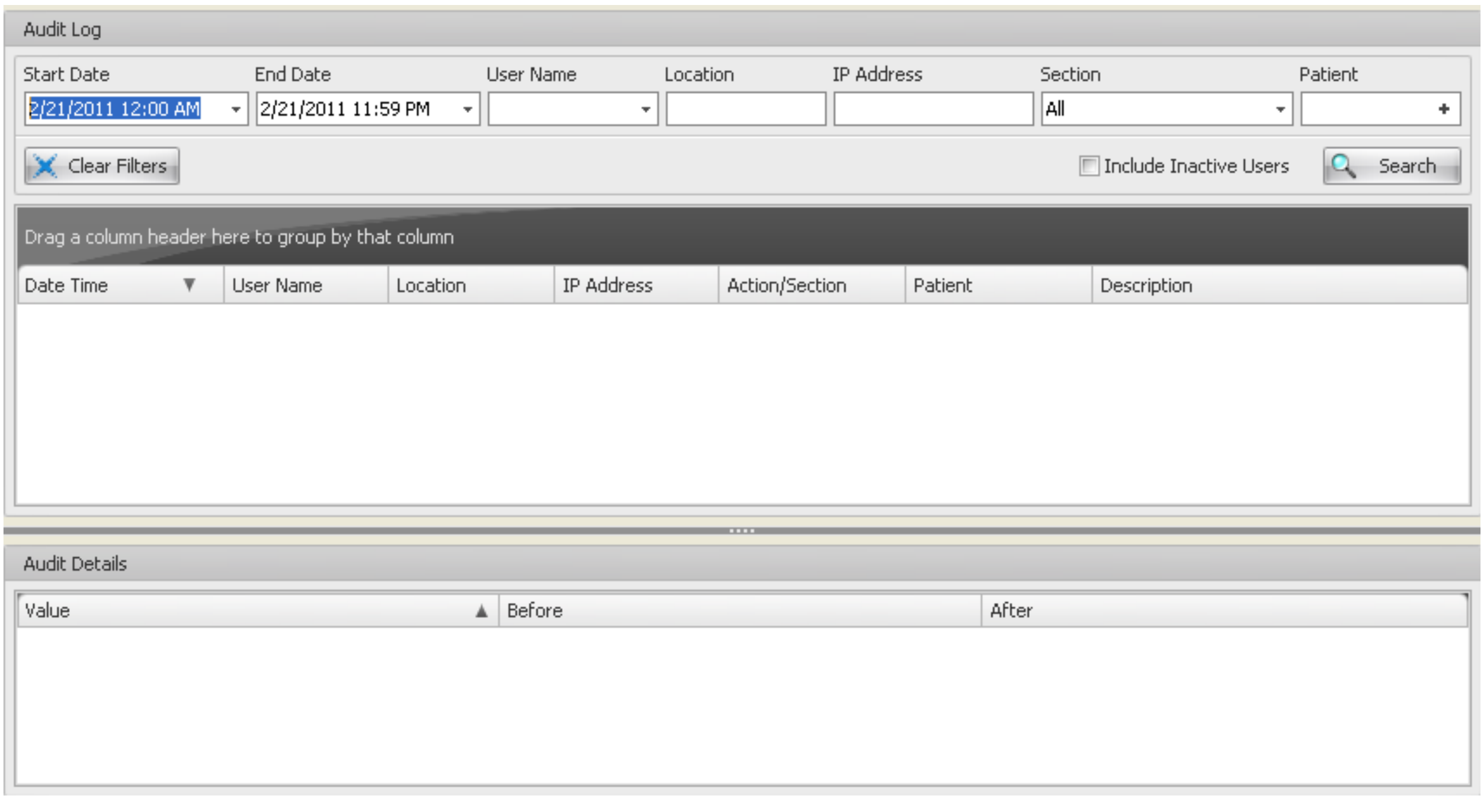
c. Auto Log-Out

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



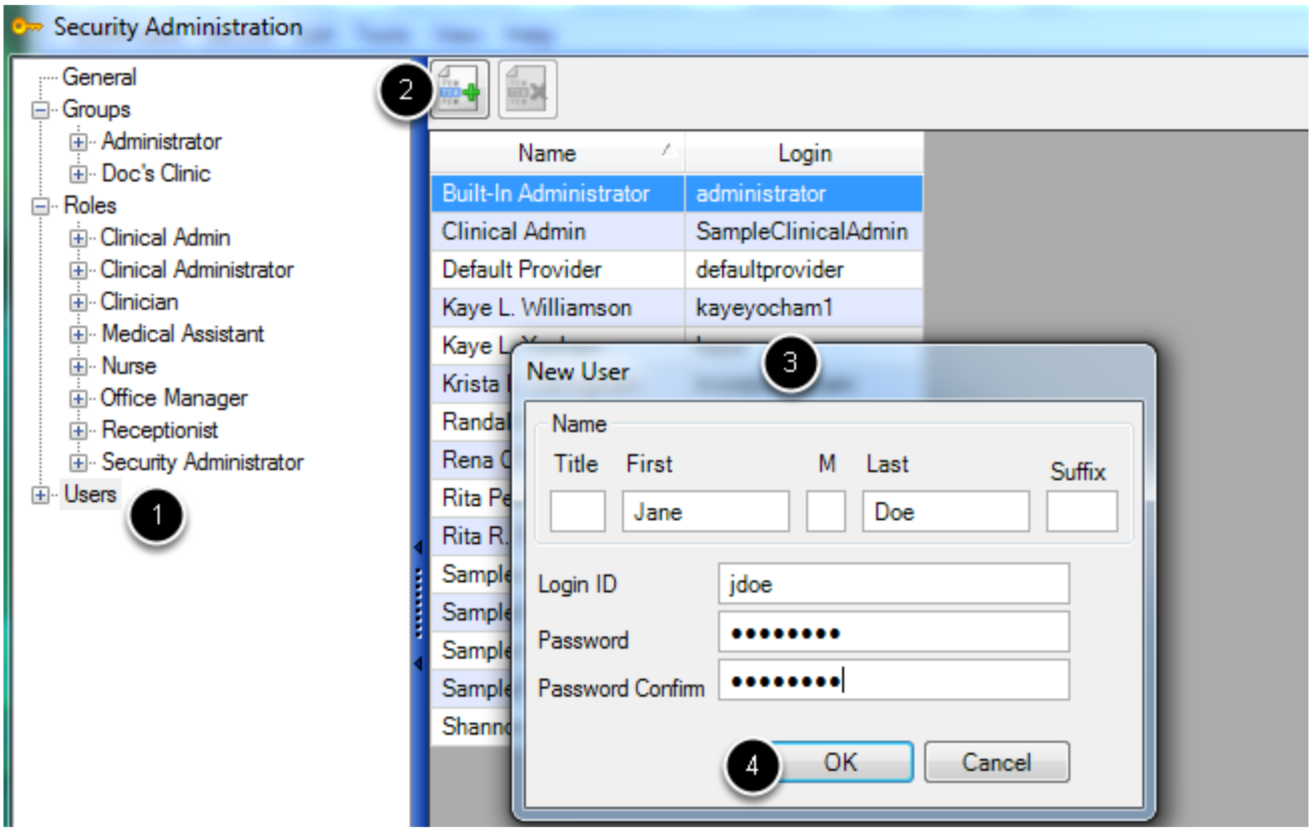
Audit Logs are the way SOAPware tracks changes and events in the system such as users logging in and patient information being modified. When a user logs in as the administrator, he/she will see the Search Audit Log window. Notice the main display has some fields at the top. To demo, use these fields 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

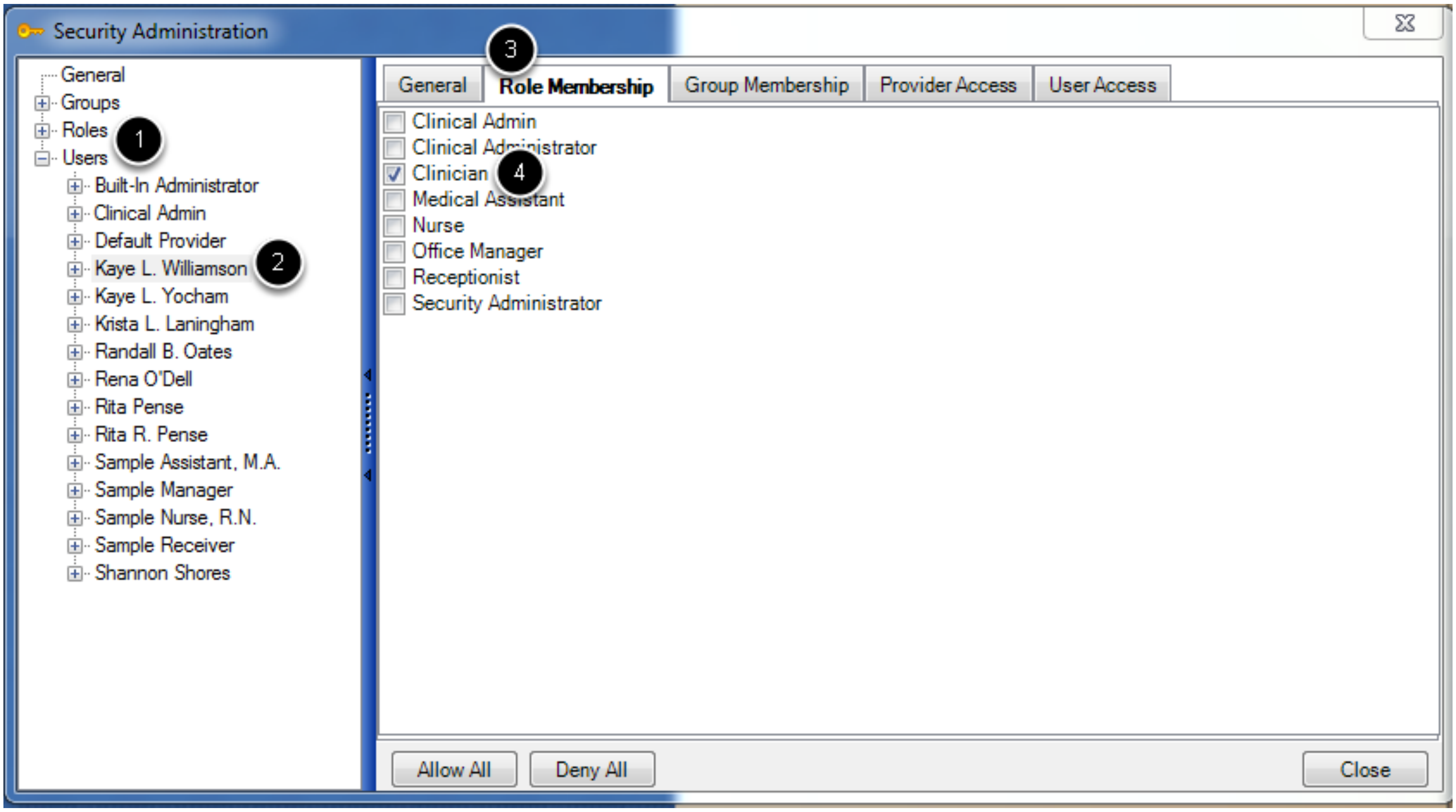
Users are the individuals accessing SOAPware. So, everyone needing access to SOAPware will need to be set up as a specific, individual User.

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

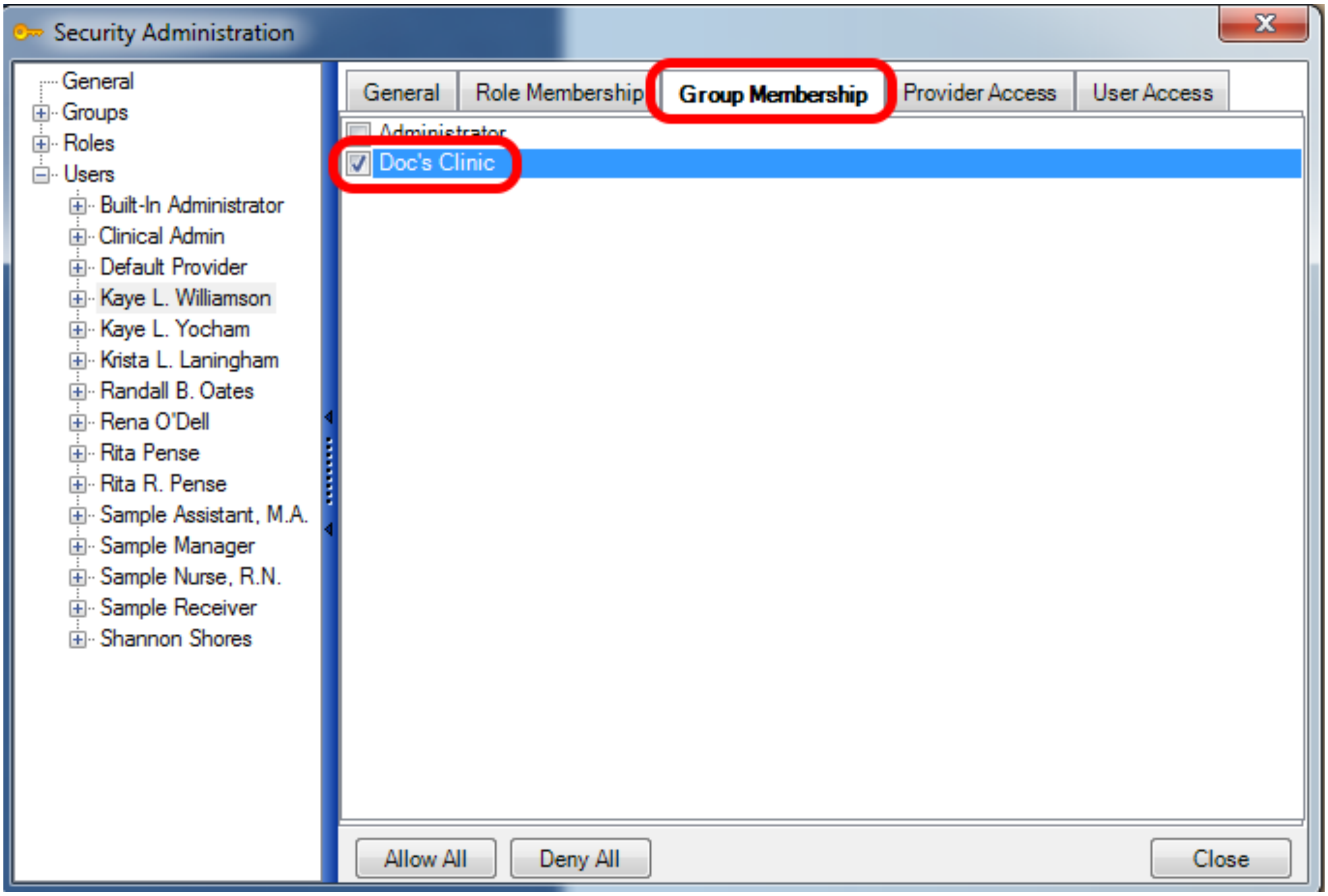
Setting Up a New User and Assign a Role



***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)

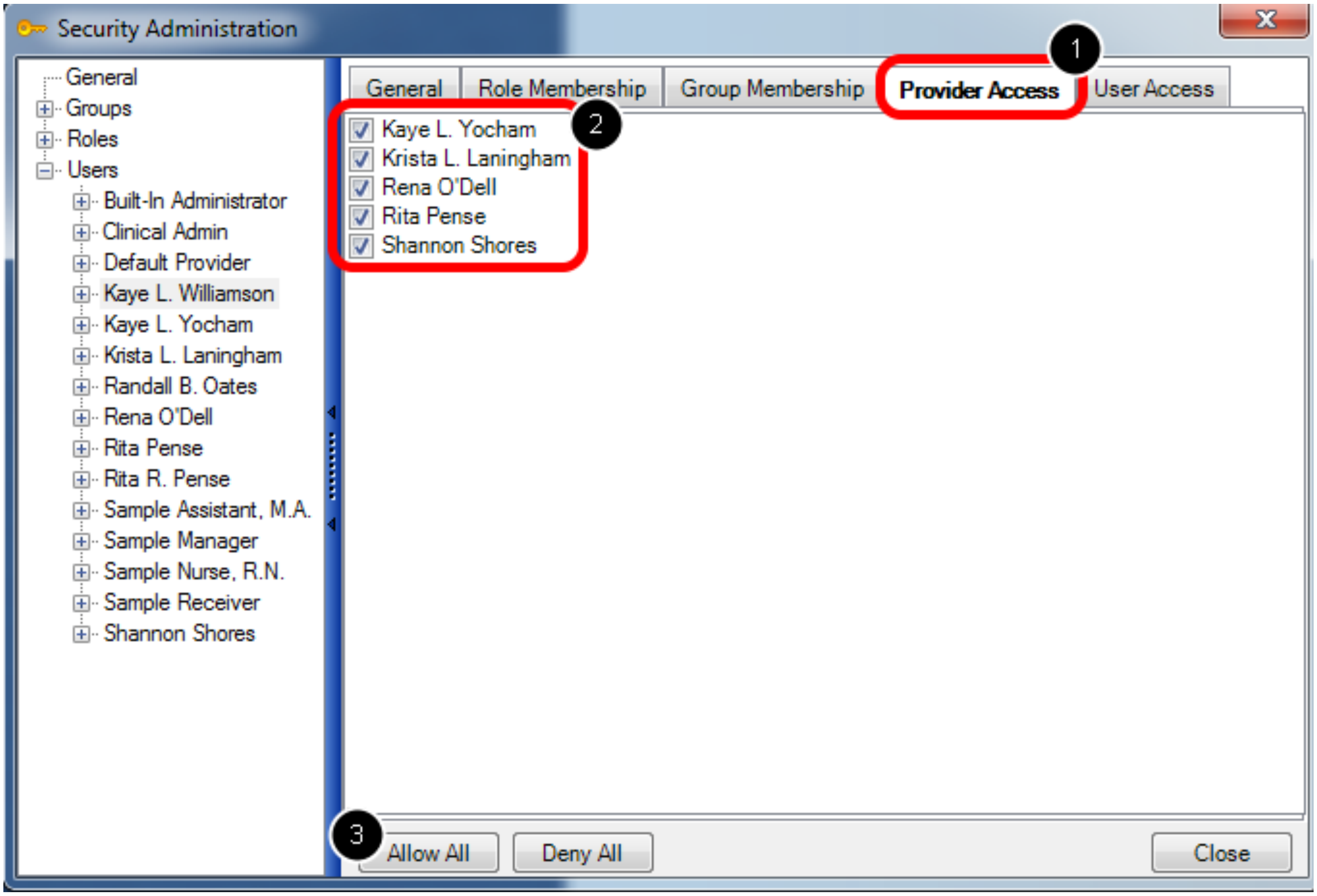
Assign a New User to a Group



Click on the Group Membership tab.

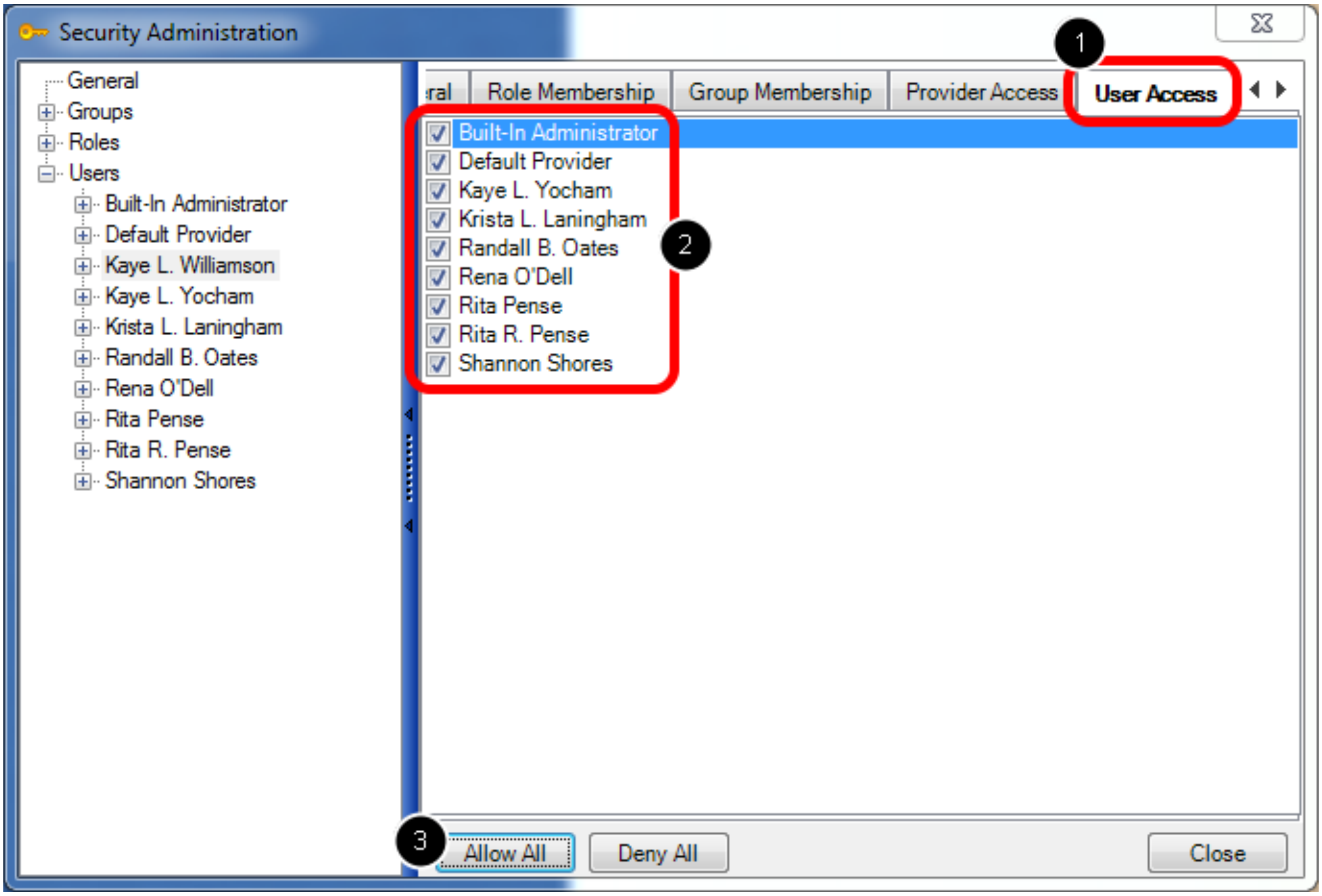
Place a check next to the Group that the User will be a member of **(Administrator Group is a default and does not need to be selected unless the user is an Administrator in the facility)**

Assigning Provider Access for a New User



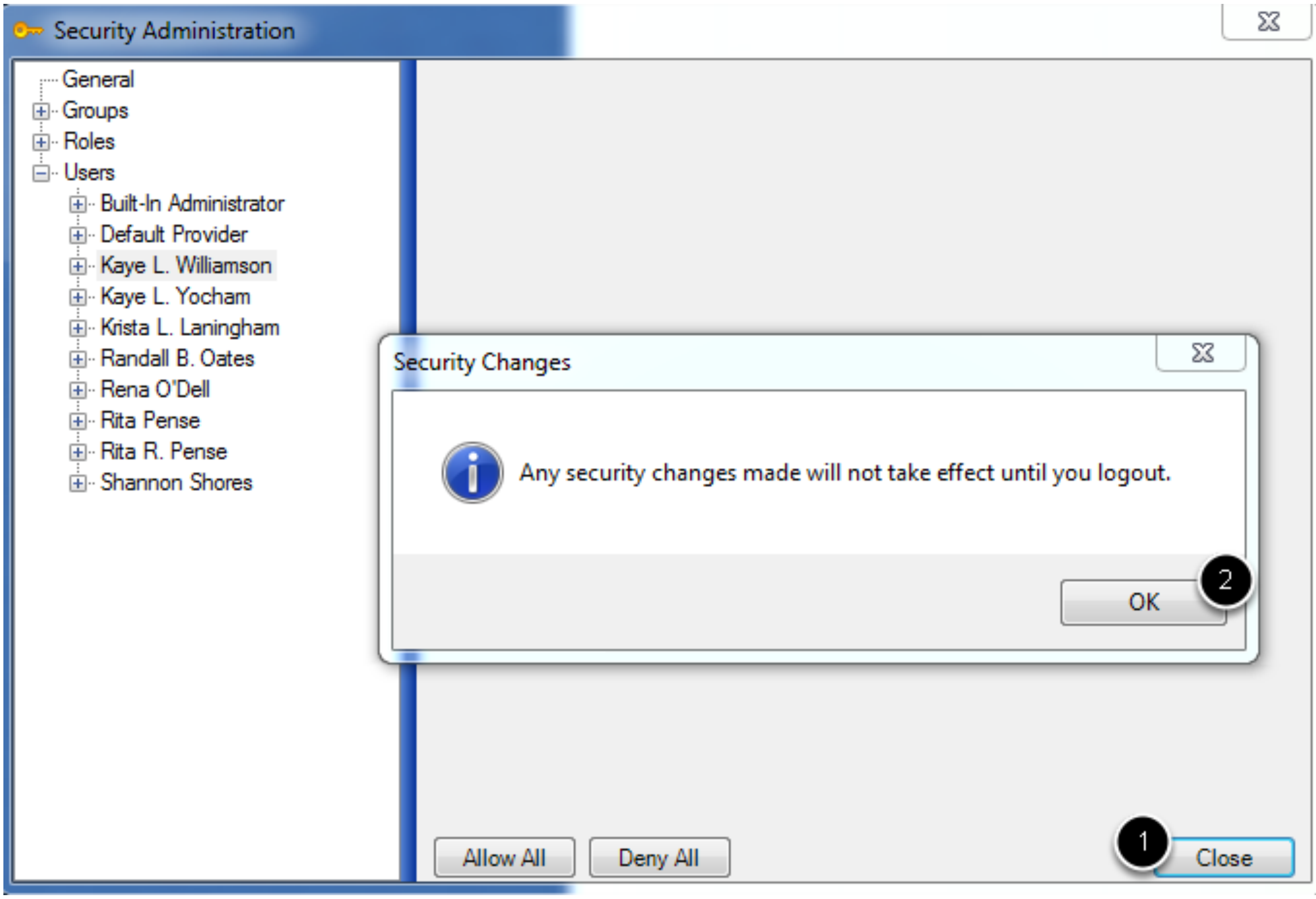
1. Click on the Provider Access tab (a User will not have access to patient charts in the Chart Rack unless Provider Access is given).
2. Place a check next to the Providers name whose charts the User will be accessing (most clinics Click Allow All).
3. If you wish to allow access to all the providers on the list, simply click the Allow All button.

Assigning User Access for a New User



1. 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)**.
2. Place a check next to the User names that the new User will need to send Tasks to **(most clinics Click on Allow All)**.
3. If you wish to give the new user access to send tasks items to all other users, simply click the Allow All button.

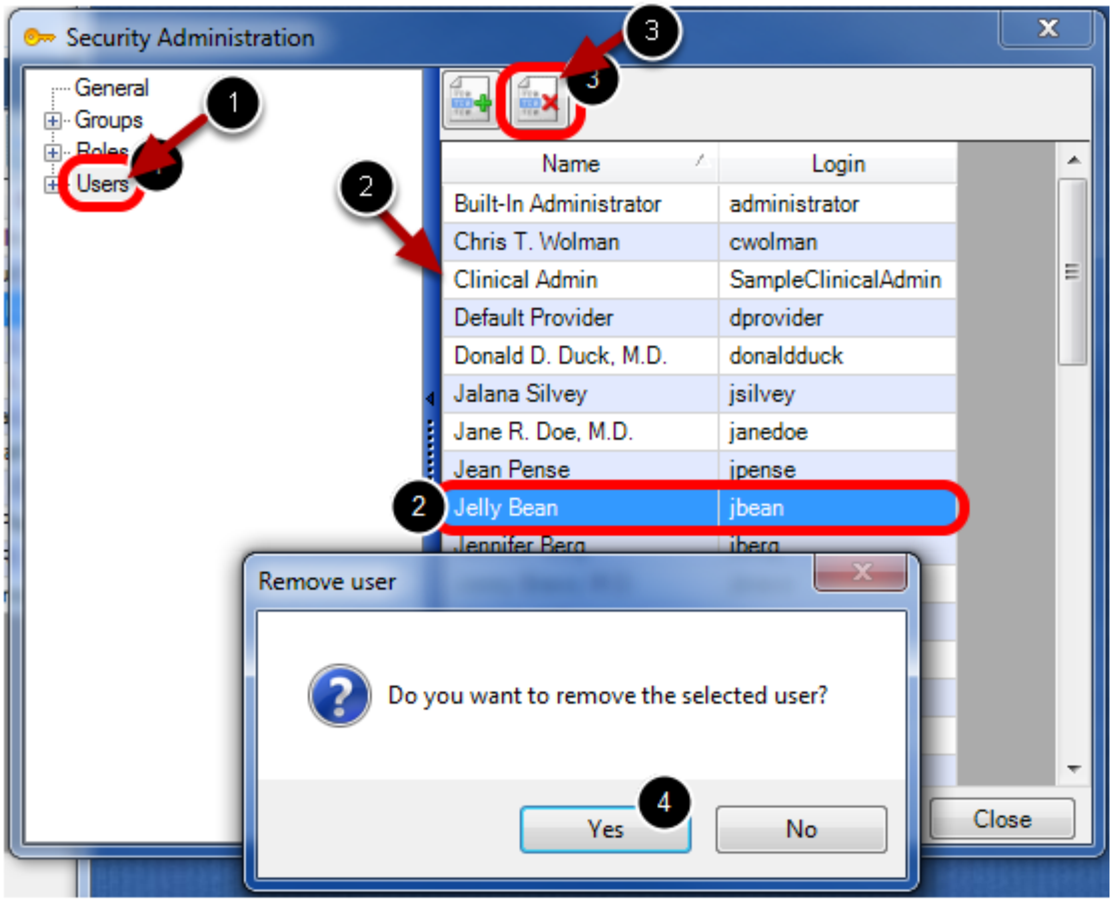
Saving Changes in Security



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

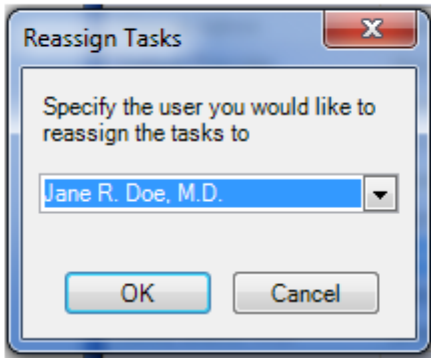


Important: A clinician with a SOAPware license cannot be deleted/removed from SOAPware Security. The license must be made Inactive in Site Administration. Removing all permissions in Security and un-checking their name in the Group, Provider Access, and Users tabs will make them invisible.

To remove a user from SOAPware:

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
4. Click on Yes to remove the selected User

Reassign Tasks



After confirming that you wish to remove the selected user, you will be prompted to specify a user that you would like to reassign the deleted users task items to.

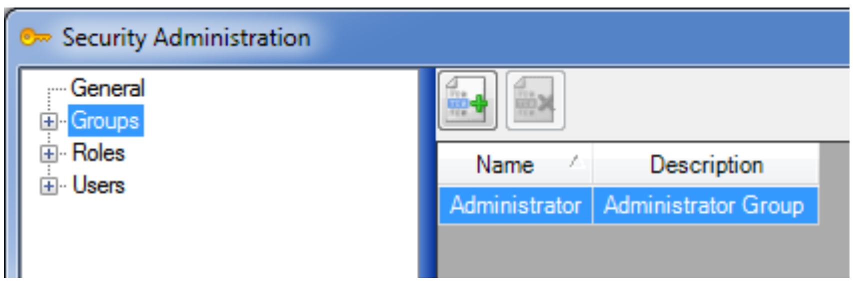
1. Using the drop-down menu, select the desired user.
2. Click OK.

Groups and Roles in Security

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

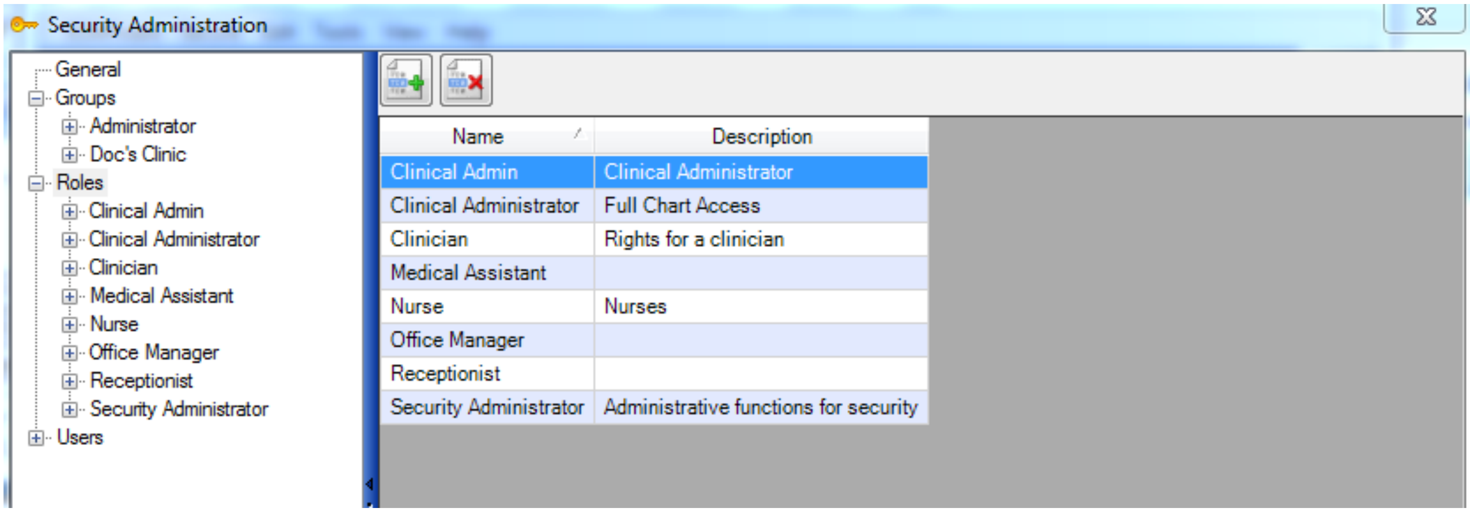


Think of a Group as being very similar to a department within the clinic. For example, there is commonly a clinical user group and a front office user group. Within each of these groups, there are, typically, different Roles. For instance, in a clinical group, there may be an R.N. and a clinical assistant. 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.

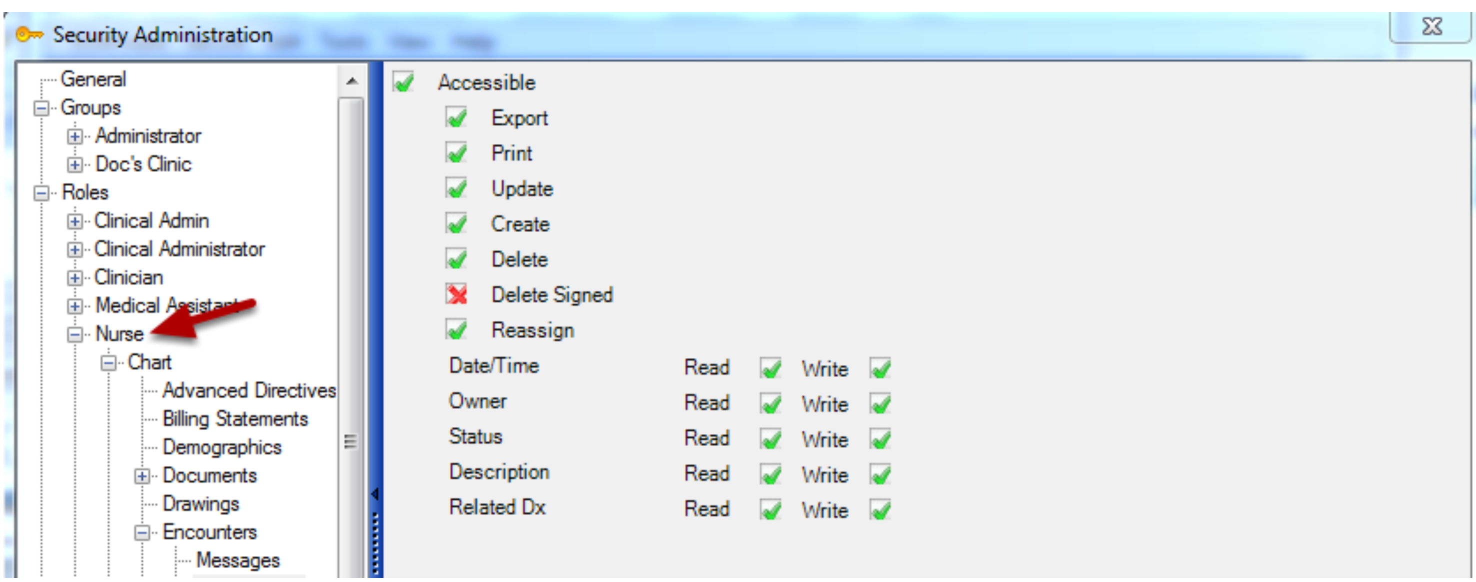
Make a list of the members of clinic staff and sort into the relevant groups. Then sort further by defining the roles. Use this sorted list of Groups and Roles to define access rights for each individual that is based upon what they have in common to each Group and Role. It is easy to add users to groups/roles, 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***

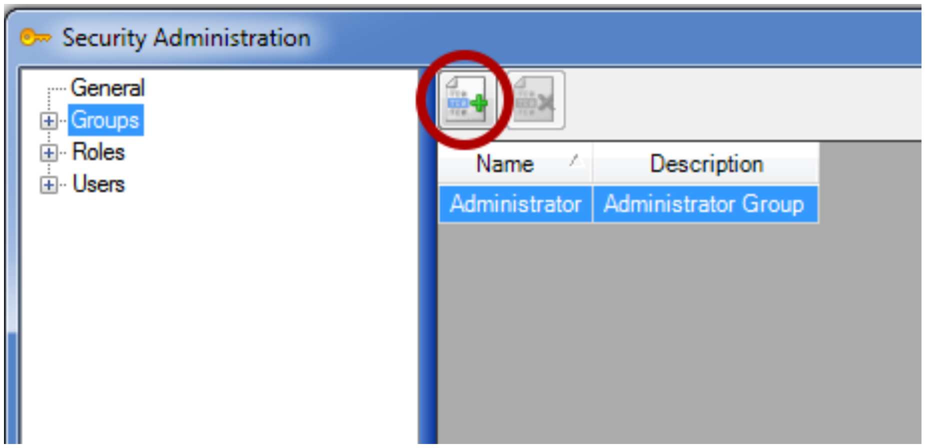
Example of pre-set security Role (Nurse)



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)

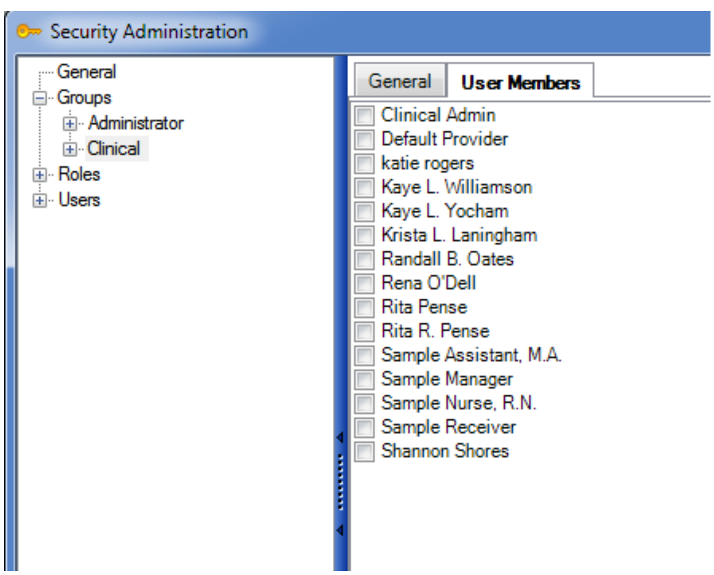
or permission denied (red X).

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.

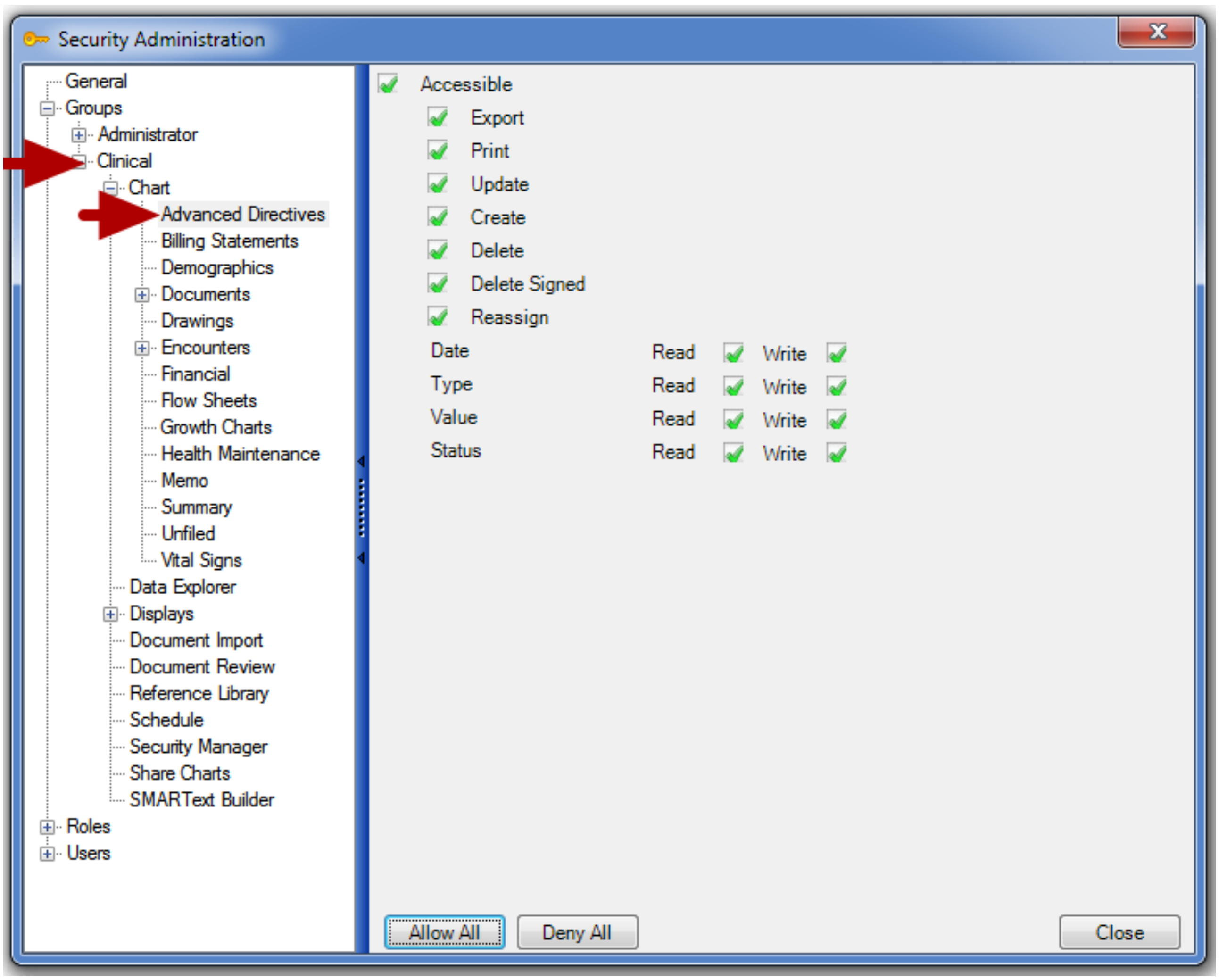
Editing Groups/Roles



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



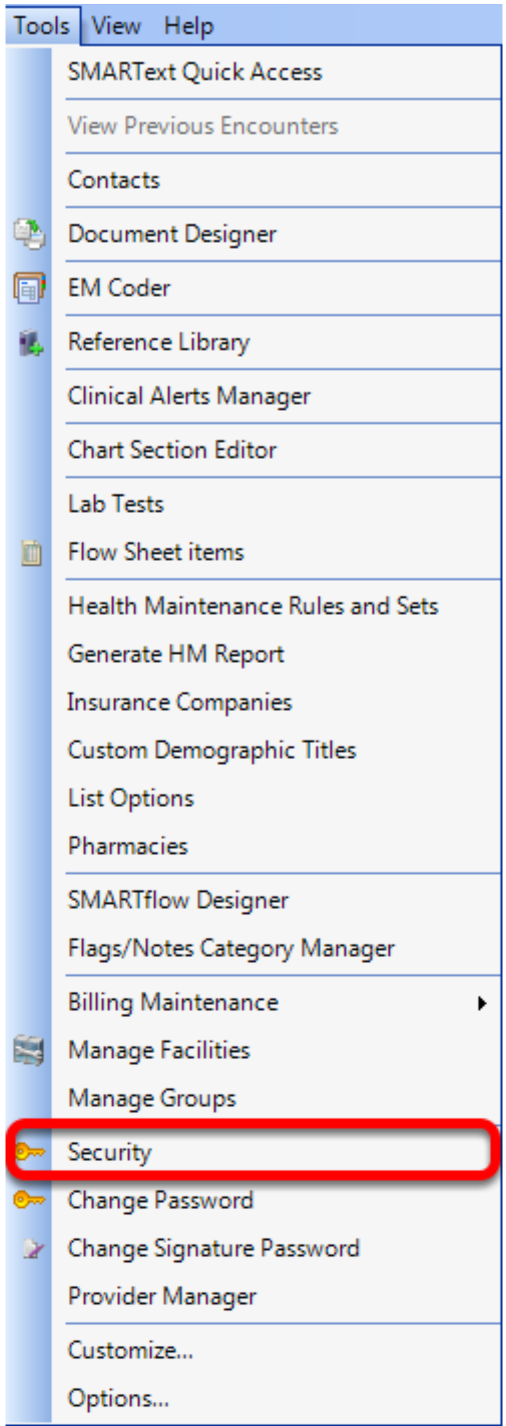
To change security privileges for groups and roles, Click the plus sign to the left of the group. This will expand all of the security areas for this group. From here, the user can Click on the areas he/she wishes to edit and use the window on the right to customize the security settings. Agreen check 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

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.

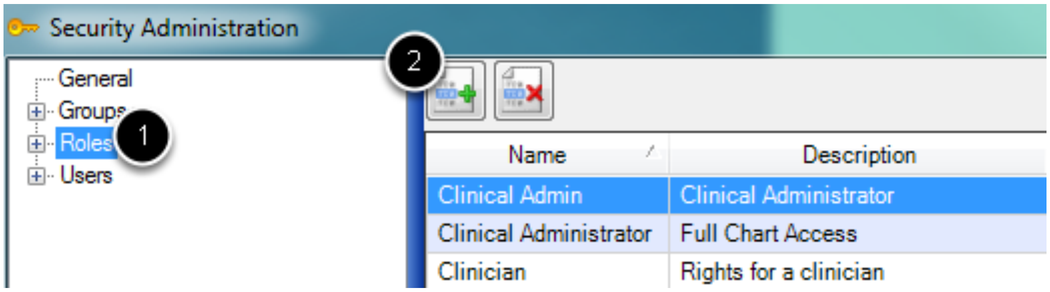
***THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT - PROTECT ELECTRONIC HEALTH INFORMATION**

Access Security

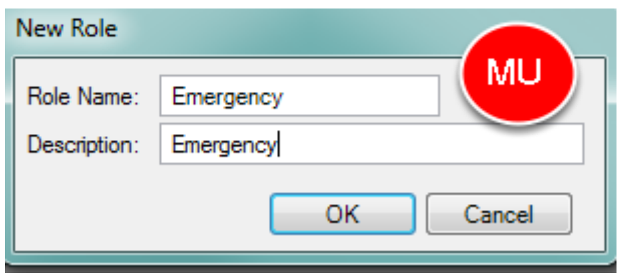


As the system administrator, access the Security Administration dialog by Selecting Tools > Security.

Create an Emergency Role

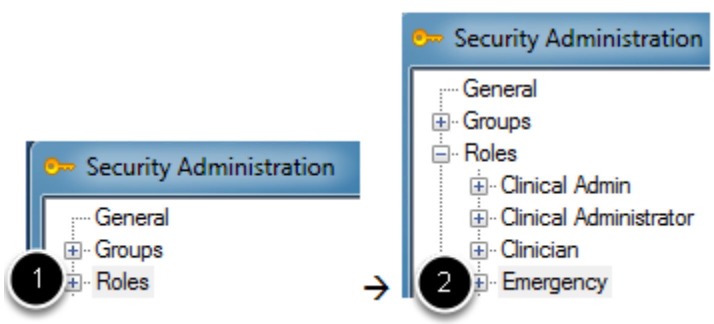


1. Click to highlight the word, "Roles."
2. Click on the new role button.



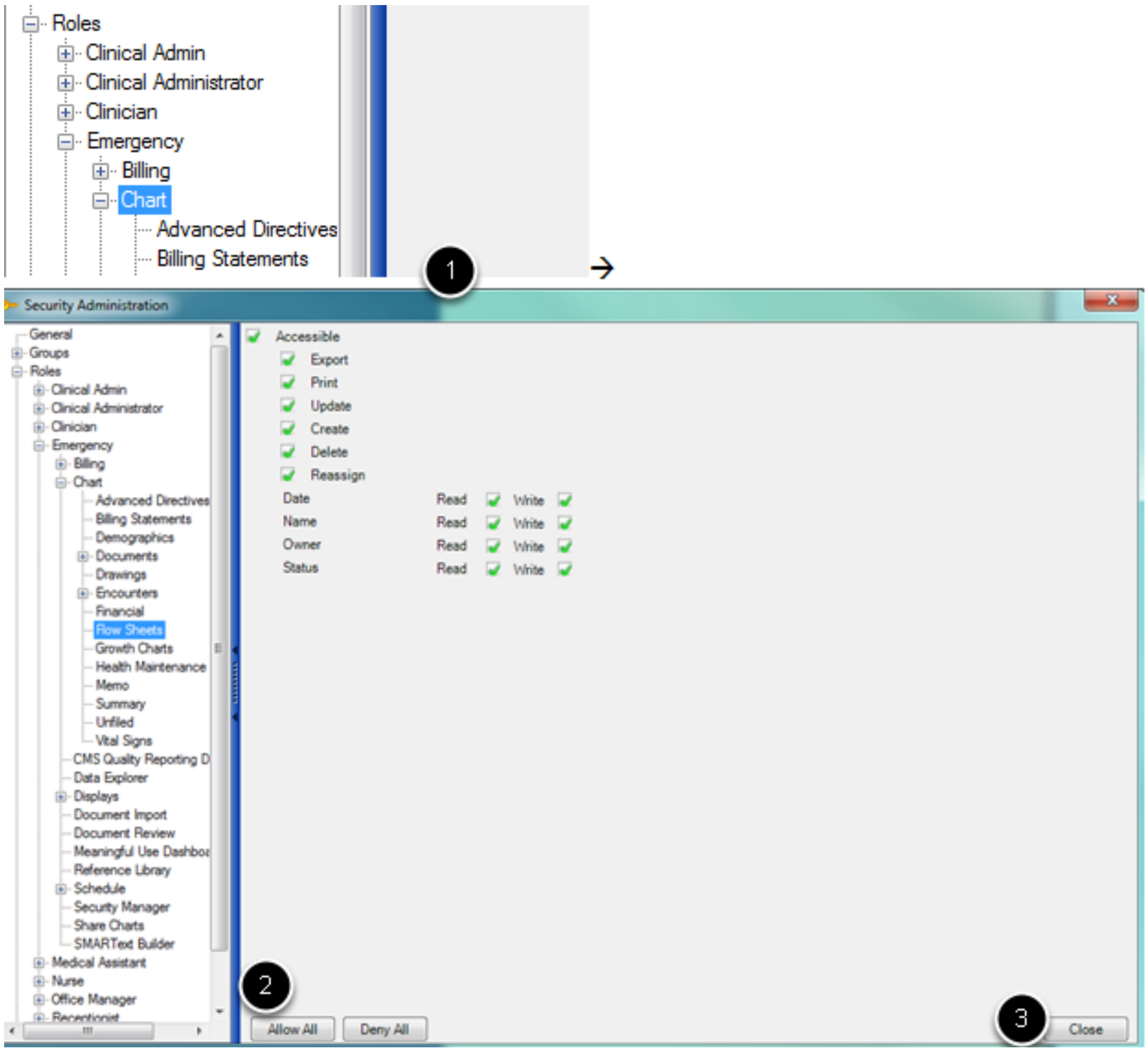
Fill in the Role Name and a Description for the new role. Then Click OK.

Find the Emergency Role



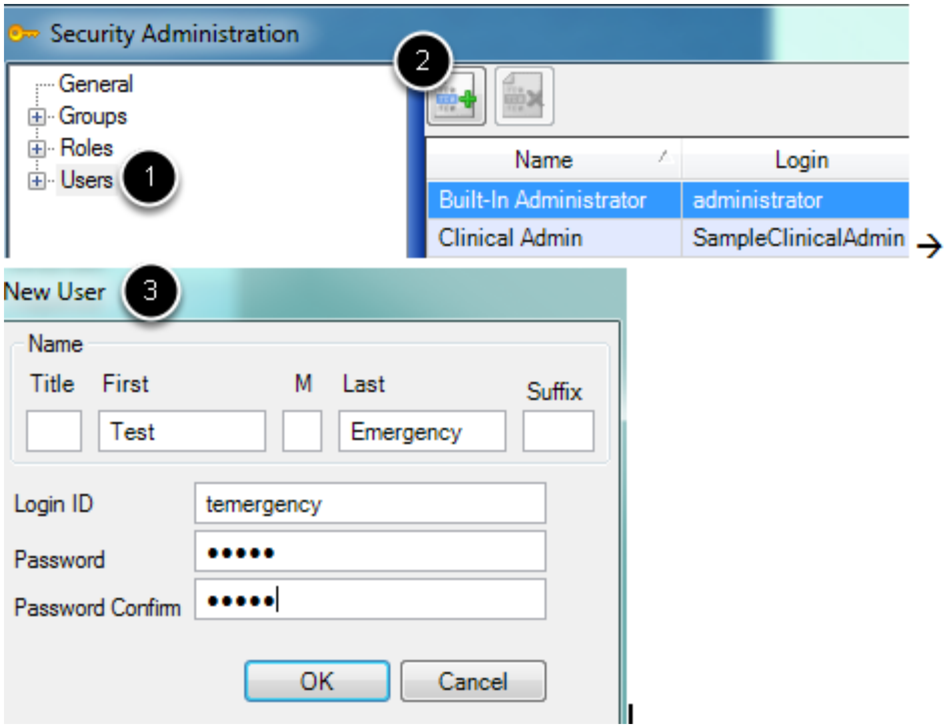
1. Click on the plus sign next to "Roles" to expand.
2. Click on the plus sign next to "Emergency" to expand.

Define Emergency Role Access



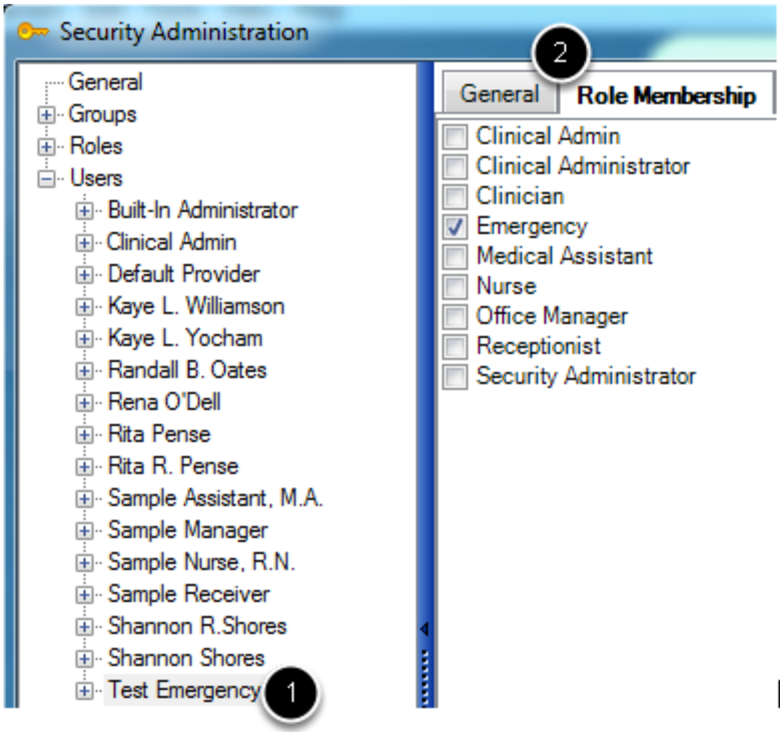
1. Drill down each area in SOAPware that a user can be given access, to define what is deemed necessary in an emergency situation. This will vary based on the clinic's needs.
2. As a time saver, remember, one can click on the "Allow All" or "Deny All" buttons.
3. Select "Close."

Create an Emergency User



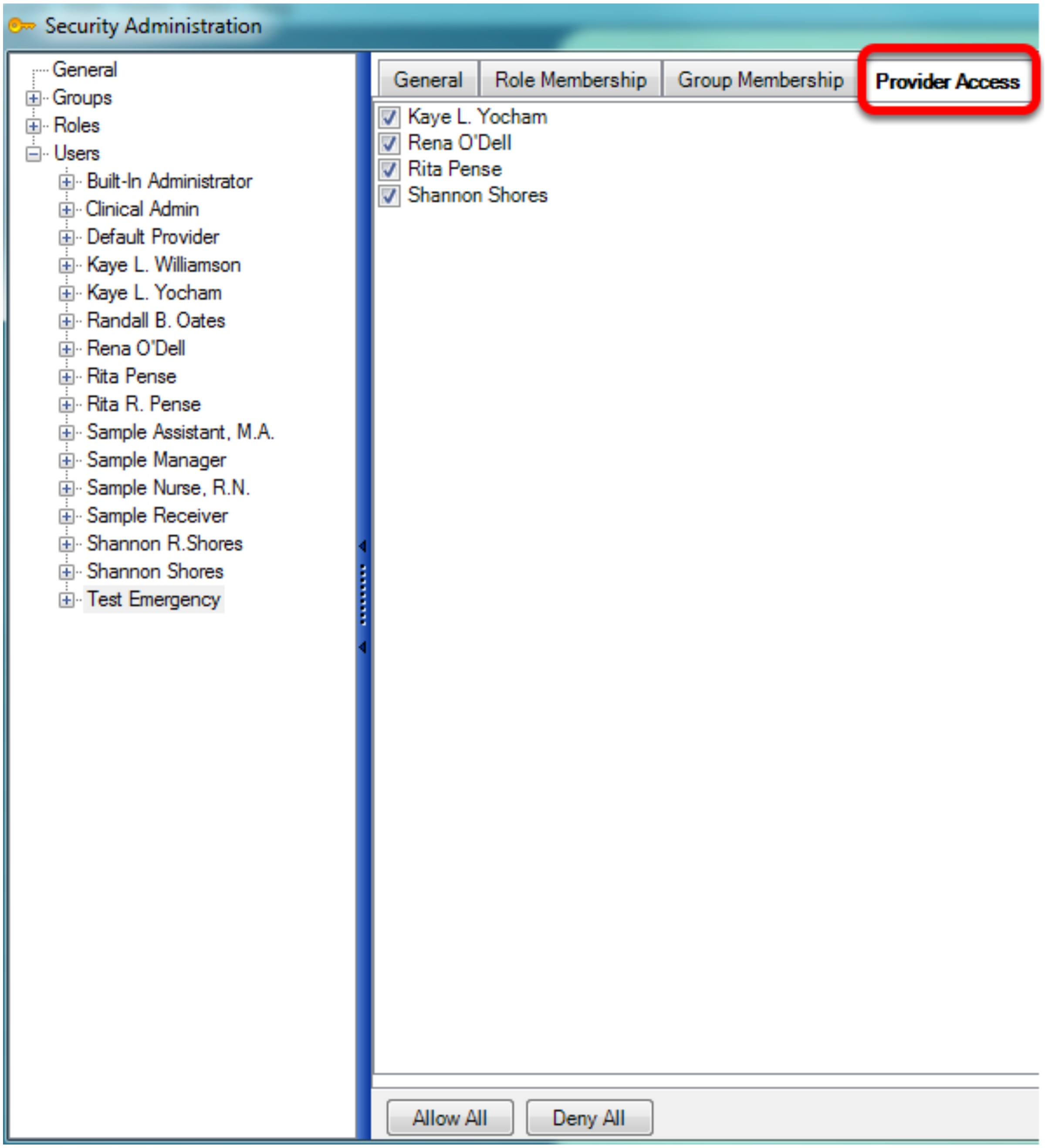
1. Click to highlight the word, "Users."
2. Click on the new user button.
3. Fill out the boxes shown and Click OK.

Assign the Emergency User Emergency Access - Role Membership Tab



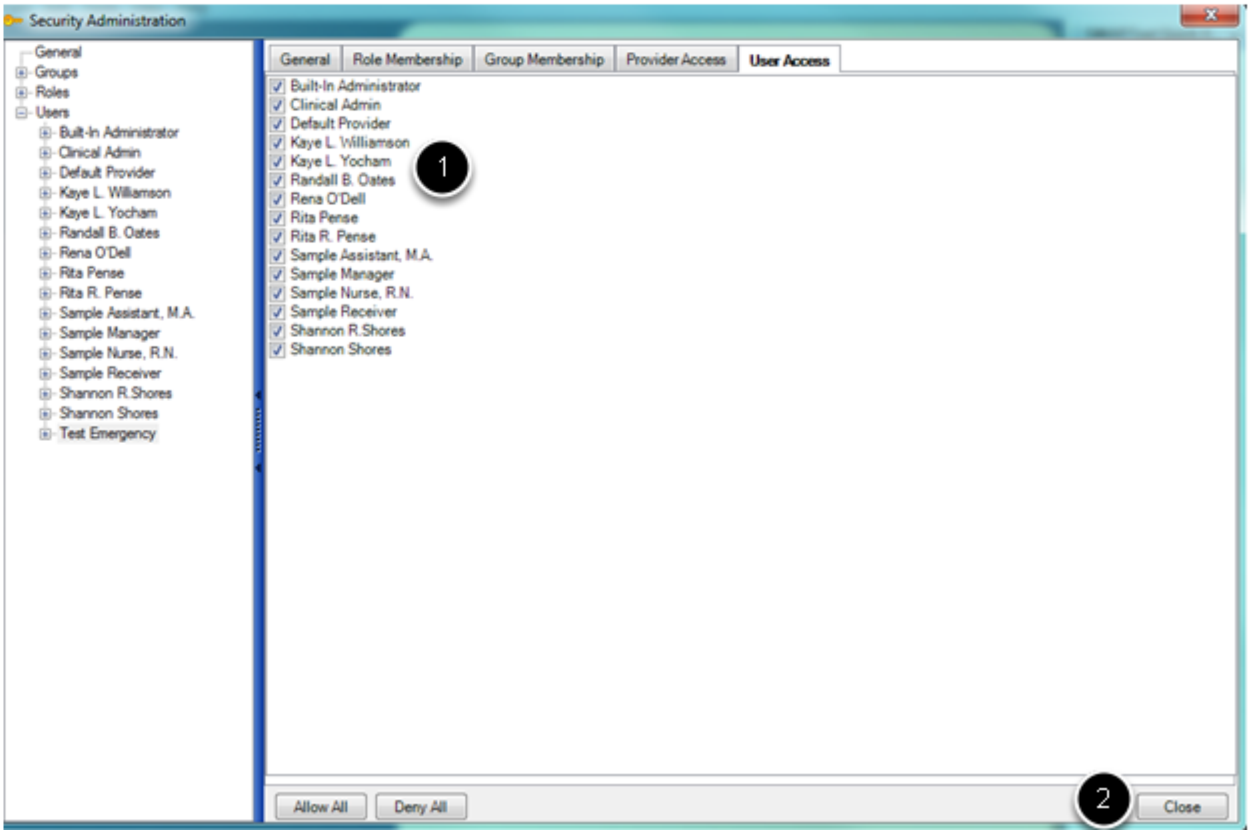
1. Click to highlight the user.
2. Click on the "Role Membership" tab and place a check mark next to the Emergency role previously created.

Assign the Emergency User Emergency Access - Provider Access Tab



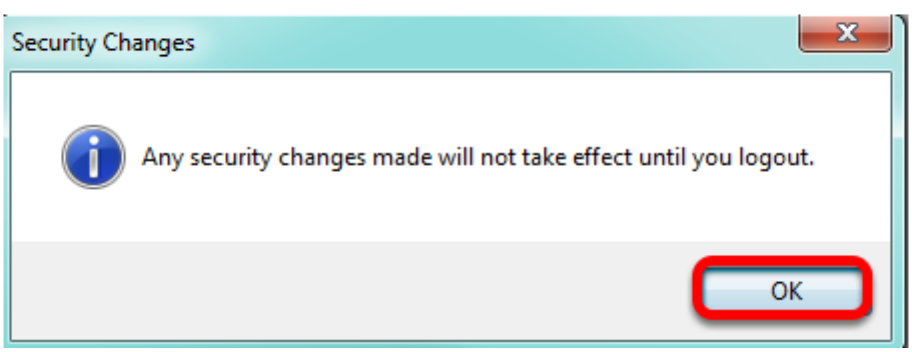
Click on the "Provider Access" tab and select which provider(s) this user will have access to, to view their patients charts.

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.

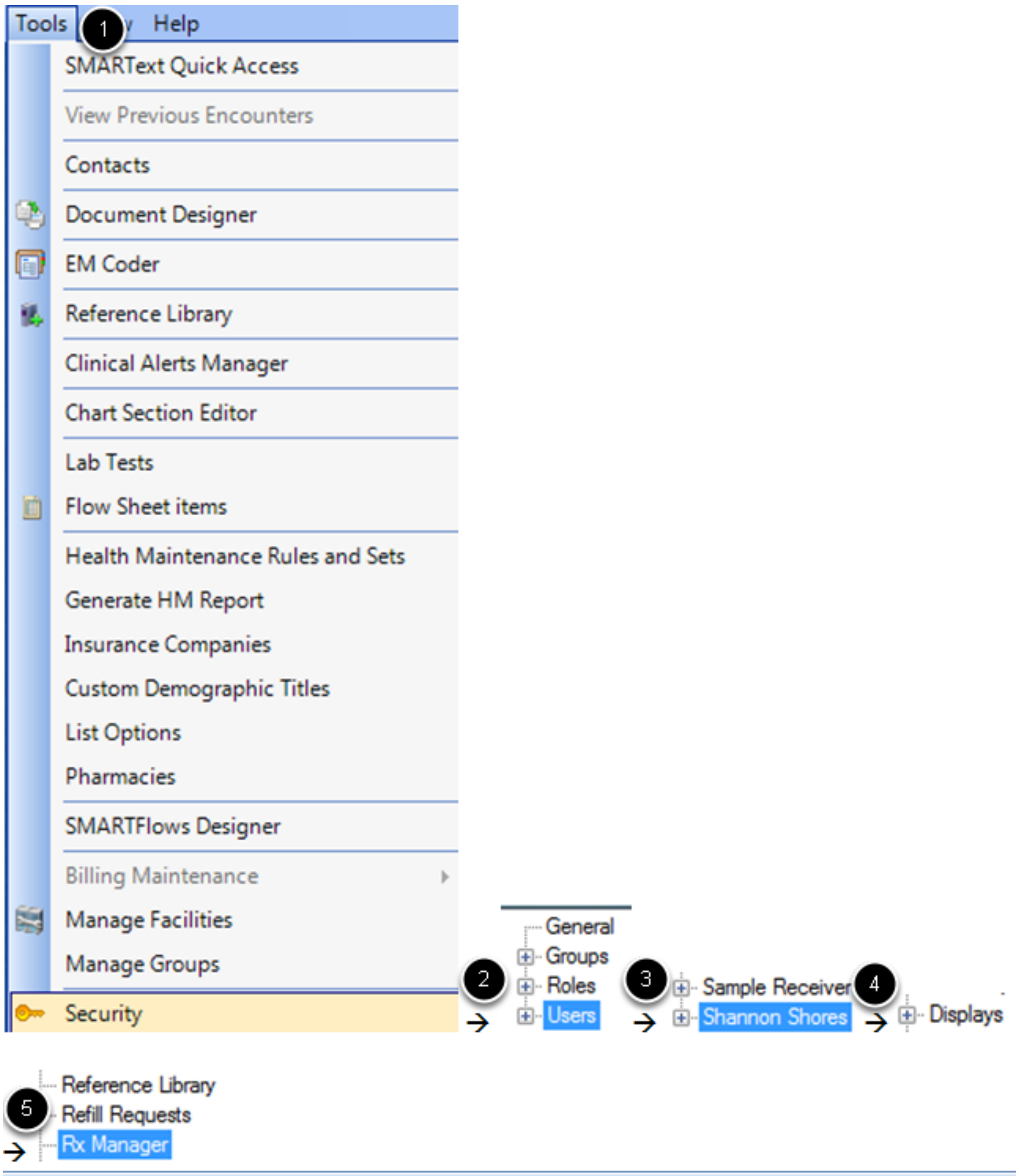
Note: SOAPware will require the user to change their password the first time they log in.

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

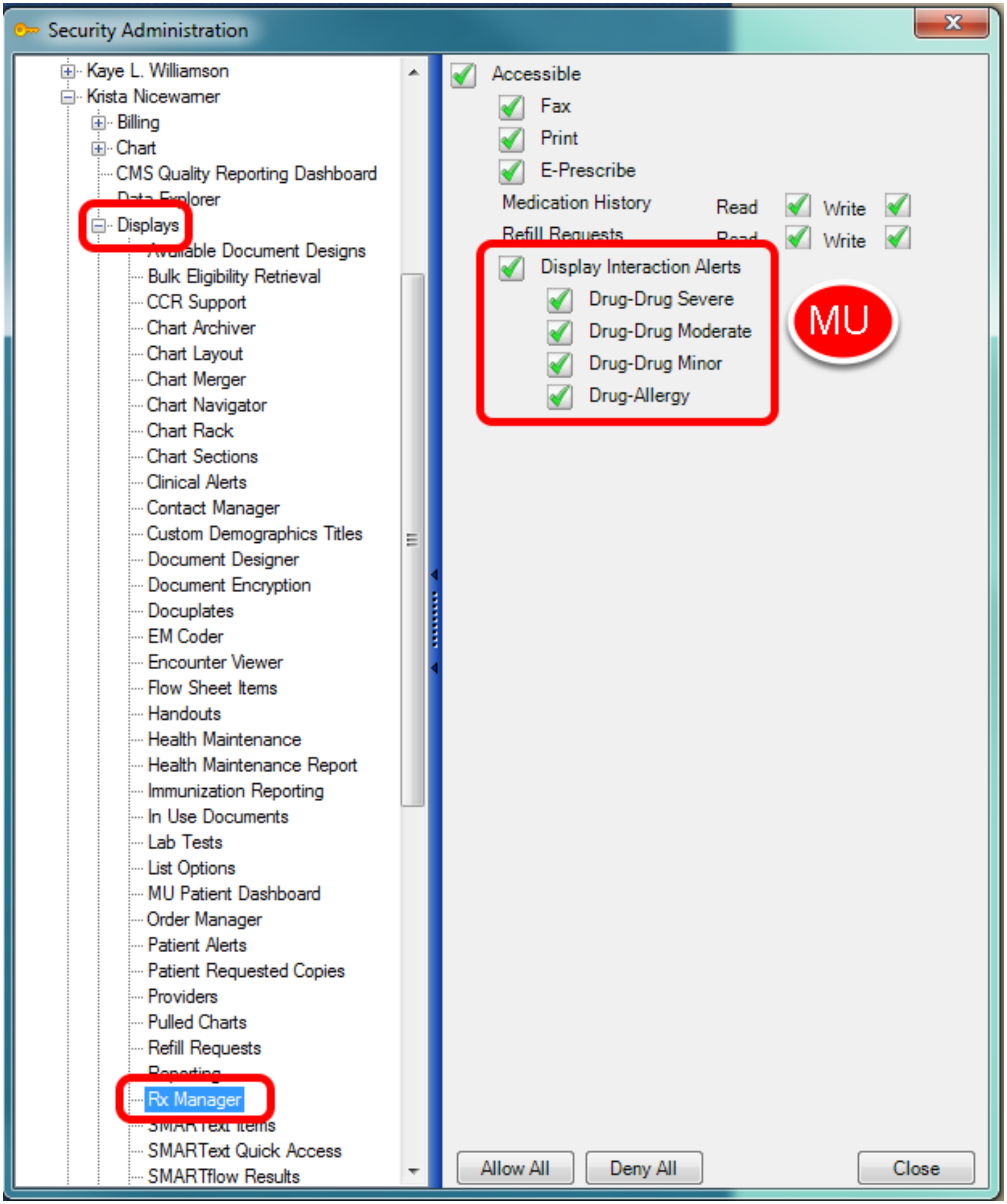
Security Privileges - Interaction Alerts



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.

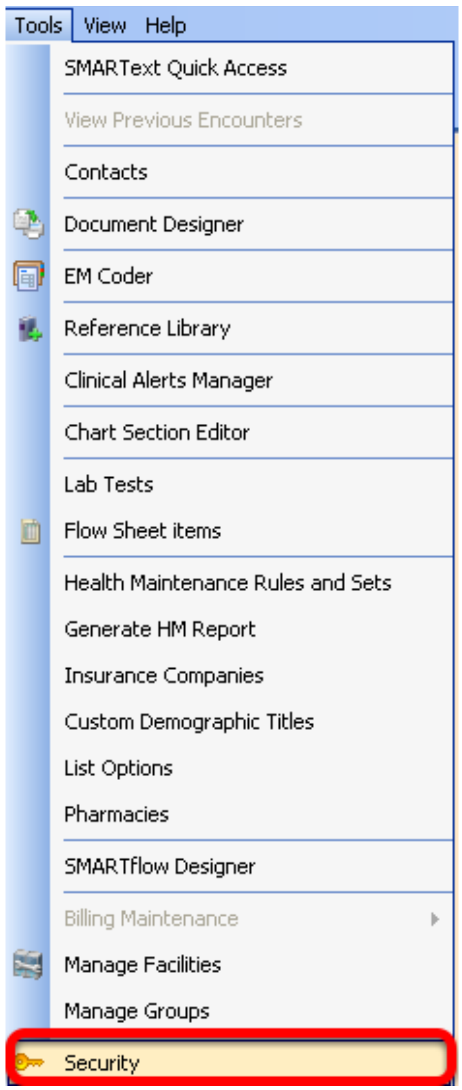
- Agreen check mark indicates the user will receive drug/allergy interaction alert pop-ups.
- Ared X indicates the user will not receive drug/allergy interaction alert pop-ups.
- Click the "Close" button when finished.

*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.

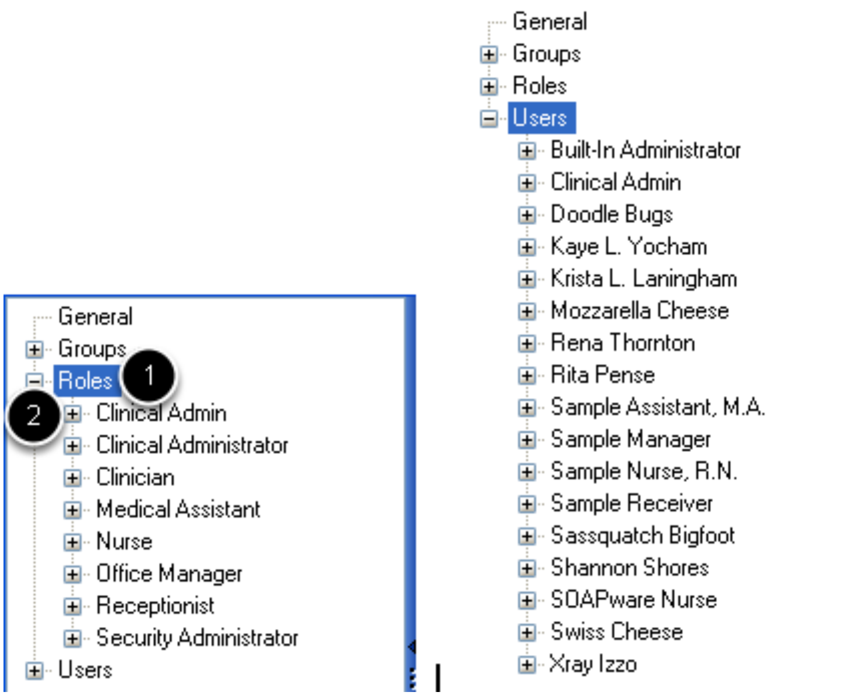
Access Security



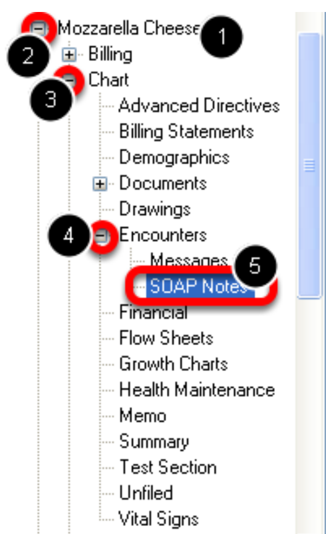
To access Security, Click on Tools>Security

Note: Only users with Administrative Rights may access Security.

Selecting Roles or Users

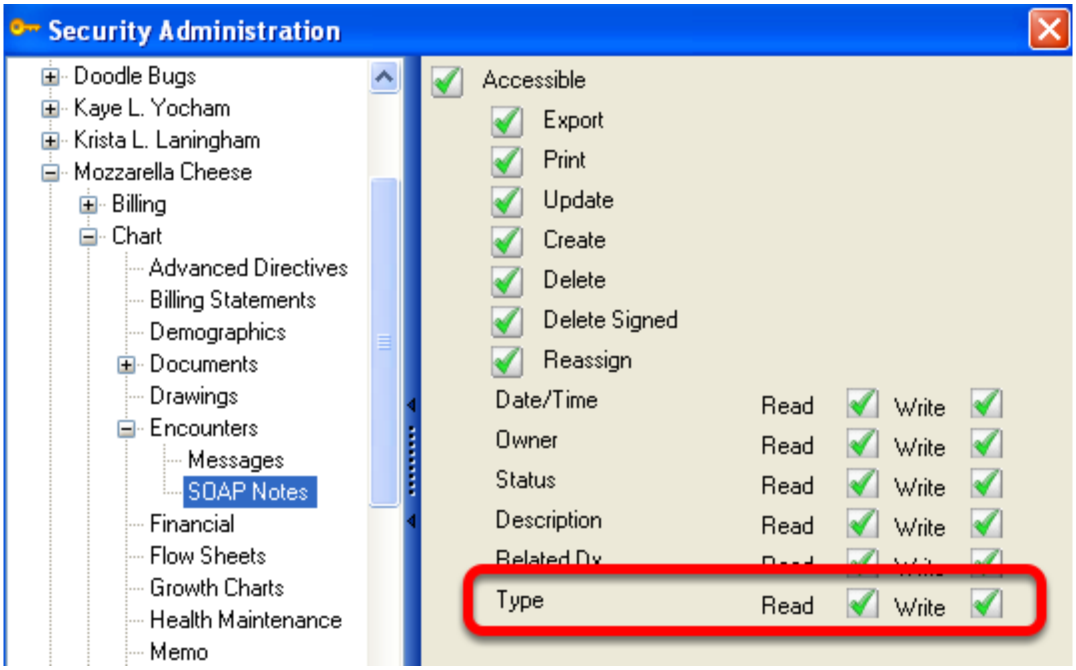


1. Click to highlight Roles or Users to set security privileges.
2. Click the "+" or node next to Roles or Users.



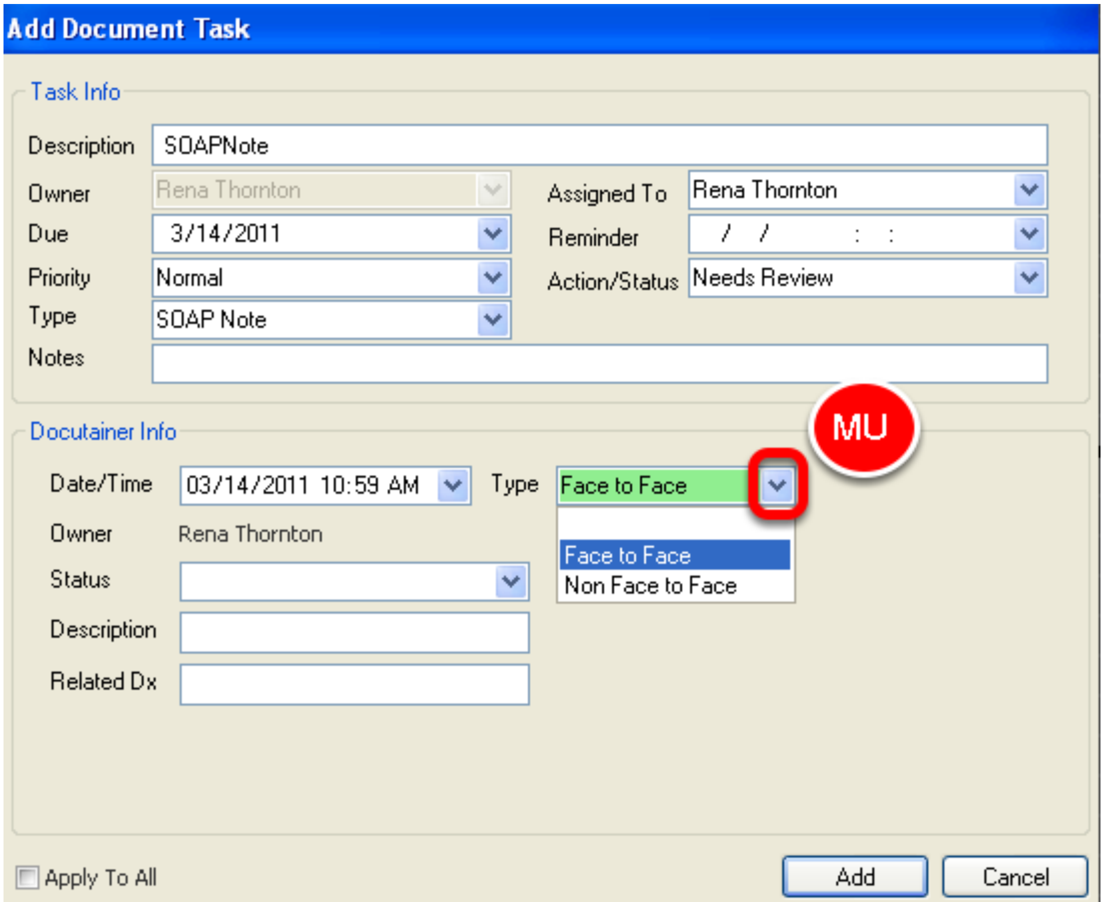
1. Locate the User.
2. Click the "+" or node next to the User's name
3. Click the "+" or node next to Chart. This will expand different Chart Sections in SOAPware.

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



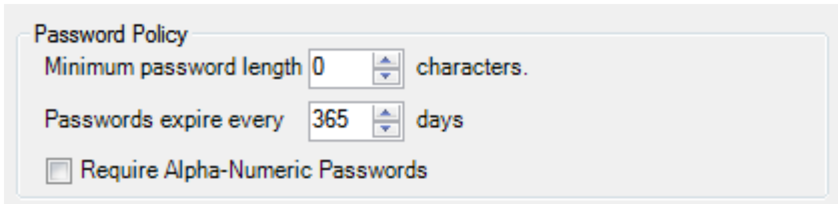
Once a user creates a new encounter, the Add Document Task window will appear. The encounter type may be selected at this time by Clicking on the drop down arrow. By default, encounters will be flagged as a Face to Face encounter.

For more information on Encounter Type, **Click here.**

RECORDING THE APPROPRIATE ENCOUNTER TYPE IS REQUIRED FOR MEANINGFUL USE.

Setting Practice Security Defaults

Password Policy

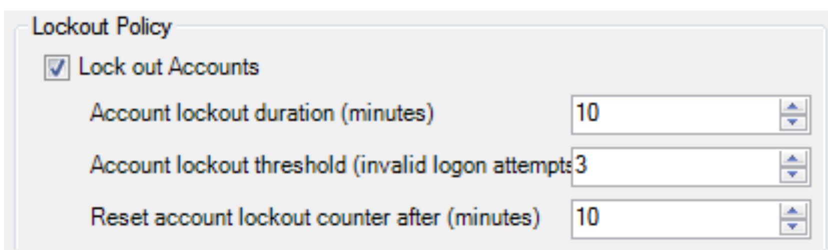


Minimum Password Length
Sets a minimum requirement for password length.

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



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.

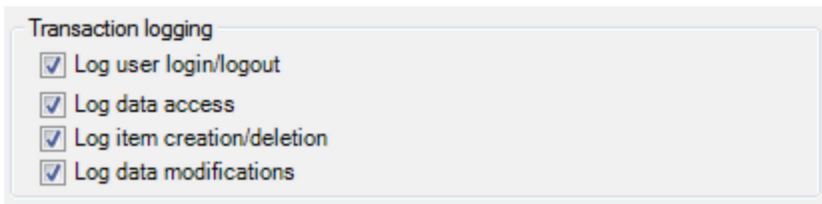
Account Lockout Duration
Sets the amount of time, in minutes, that the user account will be locked out.

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



This section defines the kind of user activity that will be tracked/logged within the system. Check all that apply.

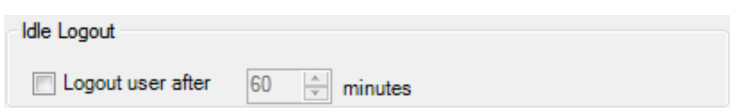
Log User Log in/Logout
This setting will track the time that users log in and logout.

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.

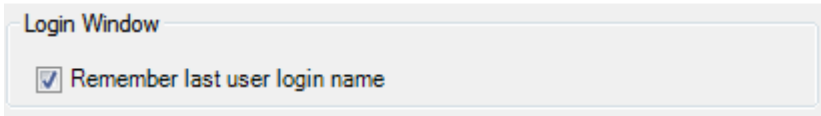
Log Data Modifications
Any time information is changed or edited, it will be tracked and the time shown for the time of the change.

Idle Logout



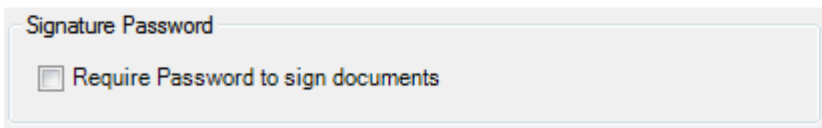
This setting determines how long a computer can be idle, until a user is logged-out. This is a security setting that helps prevent non-staff/non-employees from accessing patient records illegally.

Login Window



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.

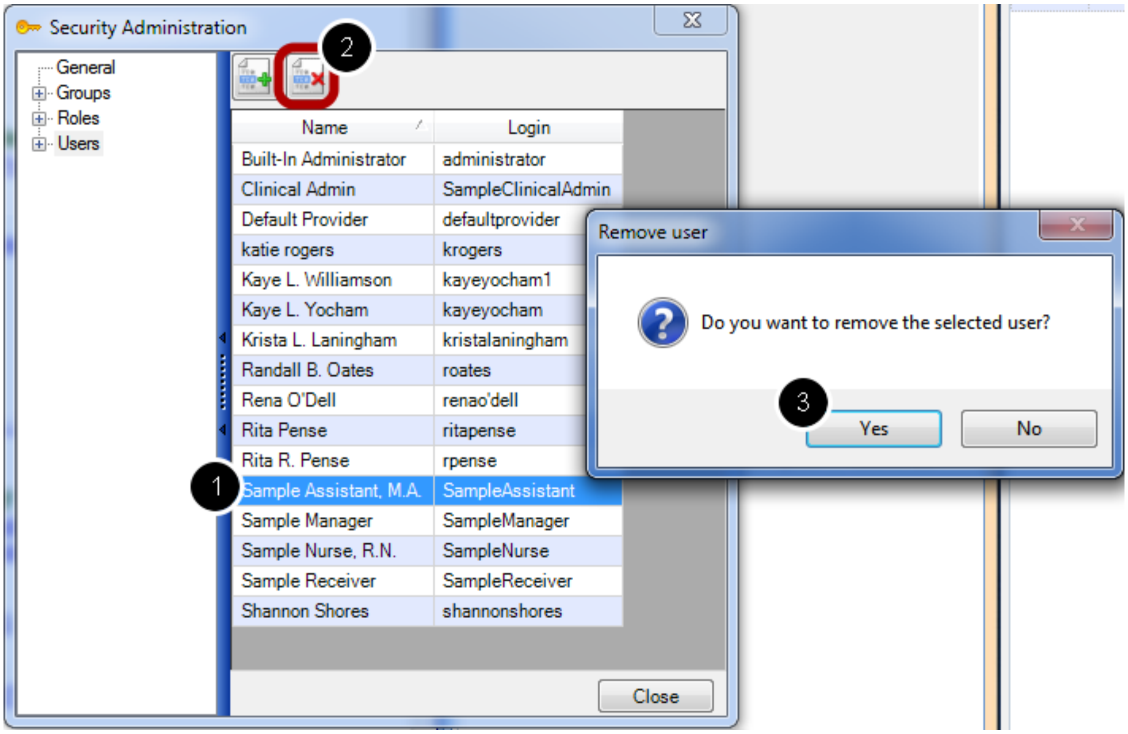
Signature Password



Specifies whether a password is necessary to sign-off documents.

Deleting Users & Reassign Tasks

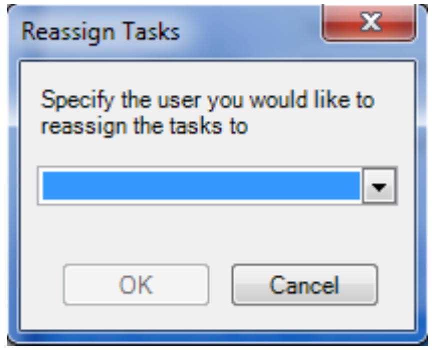
Delete User



Auser can delete Users in Security by going to Tools, Security. This will bring up the Security Administration window.

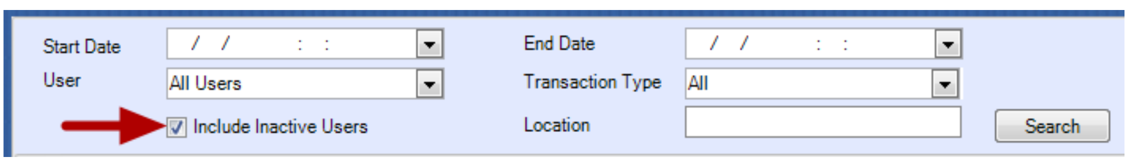
1. Highlight the name of the user to delete
2. Click the delete button
3. Aprompt window will display to verify this action. Select "Yes" or "No".

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

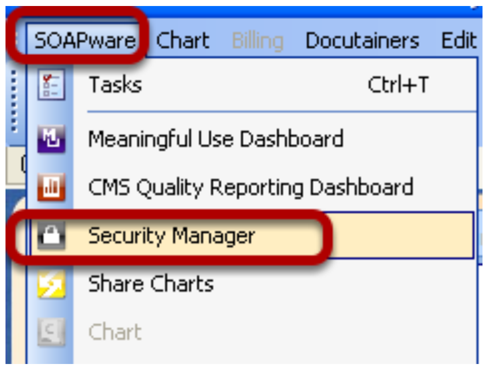


After deleting a User, their SOAPware activity may still be viewed in the audit log located in the Security Manager workspace. To do so, log in as the administrator and Click on the SOAPware menu item, then Click on Security Manager. A user will check the "Include Inactive Users" box.

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.*

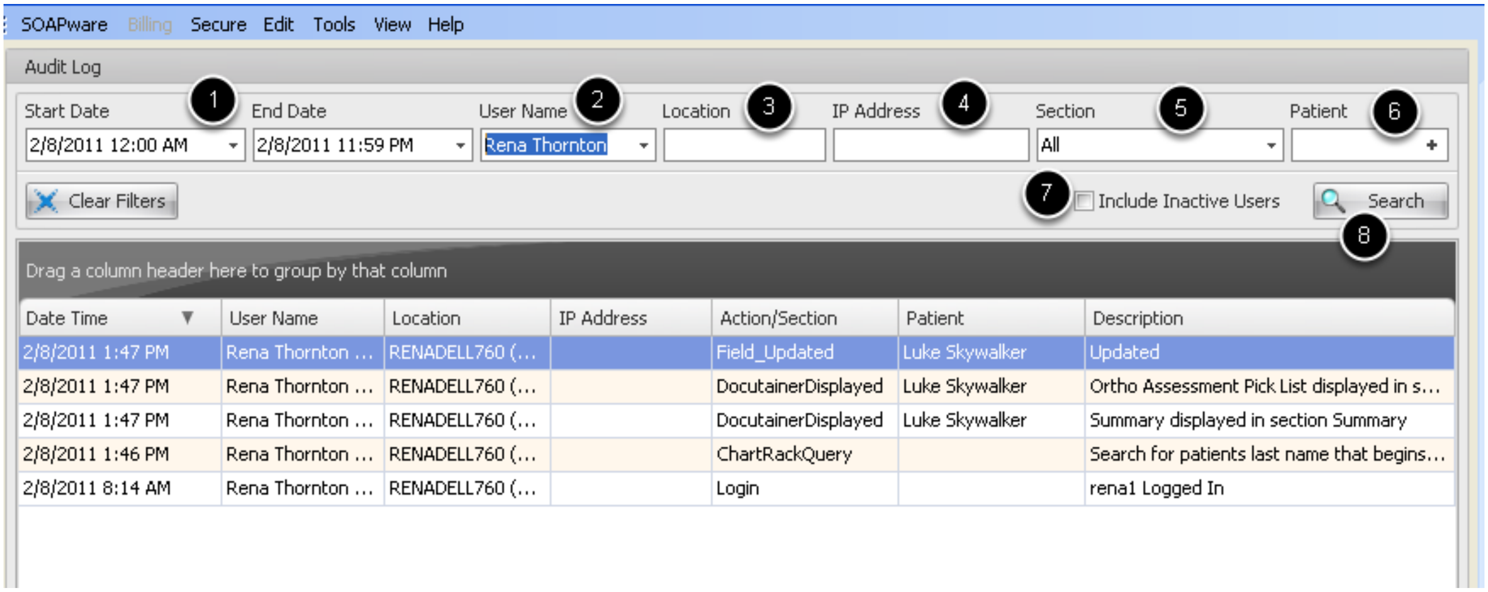
How to access Security Manager



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



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

-Alist of activities will display

Exploring SOAPware

Open and Log In to SOAPware

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

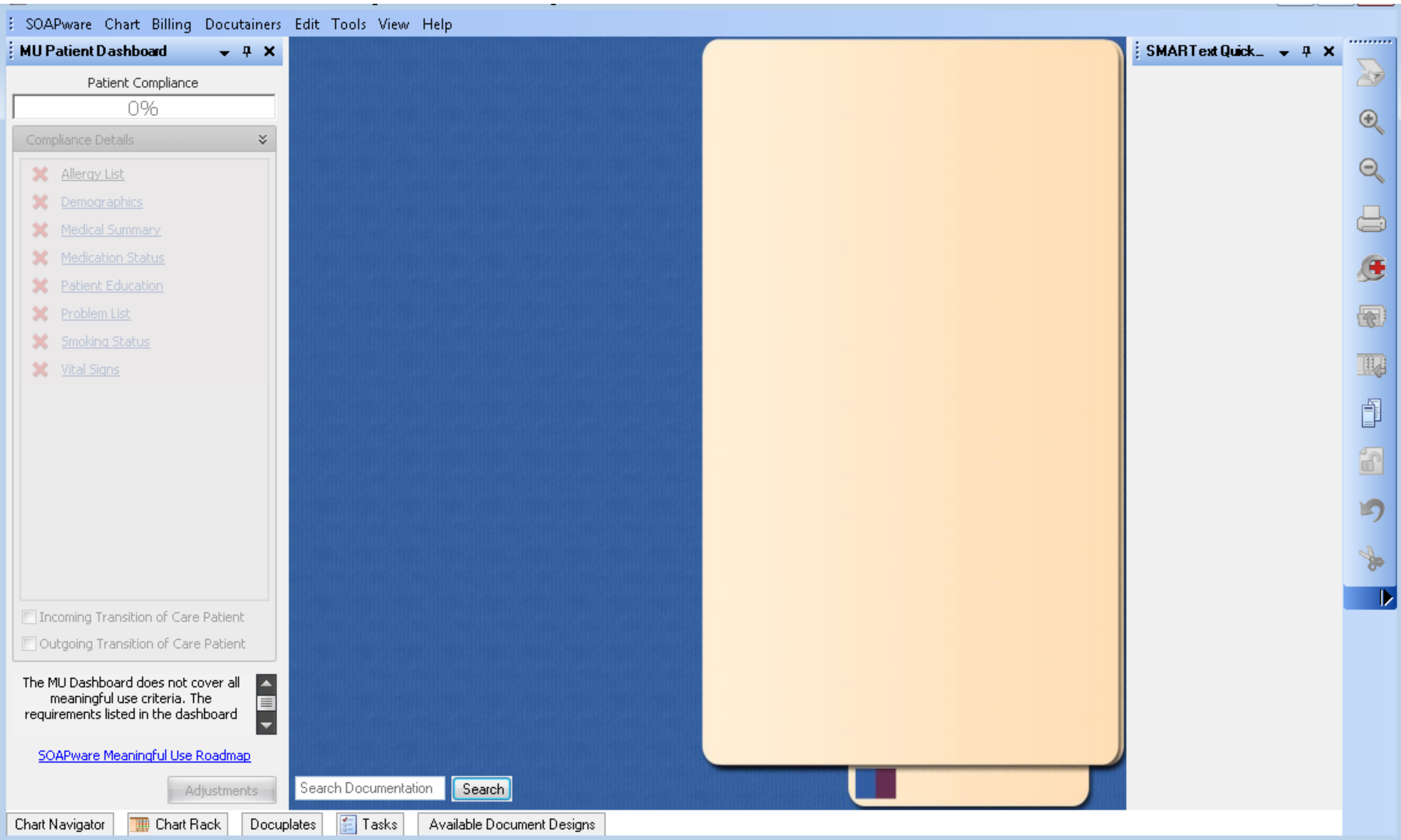
SOAPware opens with the User Log-In dialog.

Log In

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.

SOAPware Opens



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.

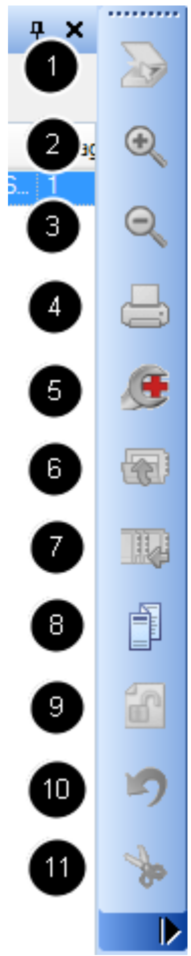
6. Tools
The Tools menu is an area where users will do a lot of set up for their SOAPware workflow. For example, a user would want to come to this menu option to set up insurance companies, pharmacies, and contacts.

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.

Common Toolbar

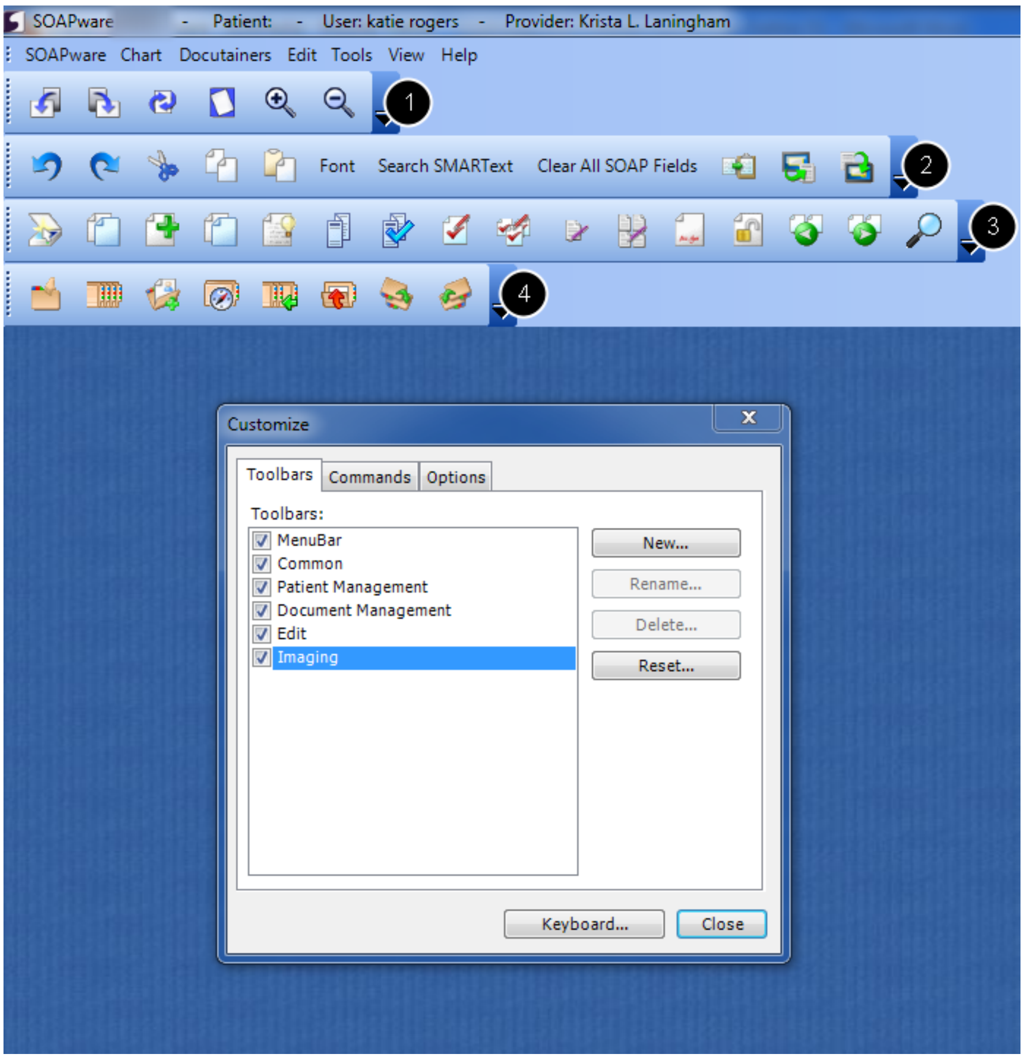


The Common Toolbar provides quick access to many frequently used tools in SOAPware. Instead of having to search using the primary tool, Click on the buttons on the toolbar to perform the following actions:

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

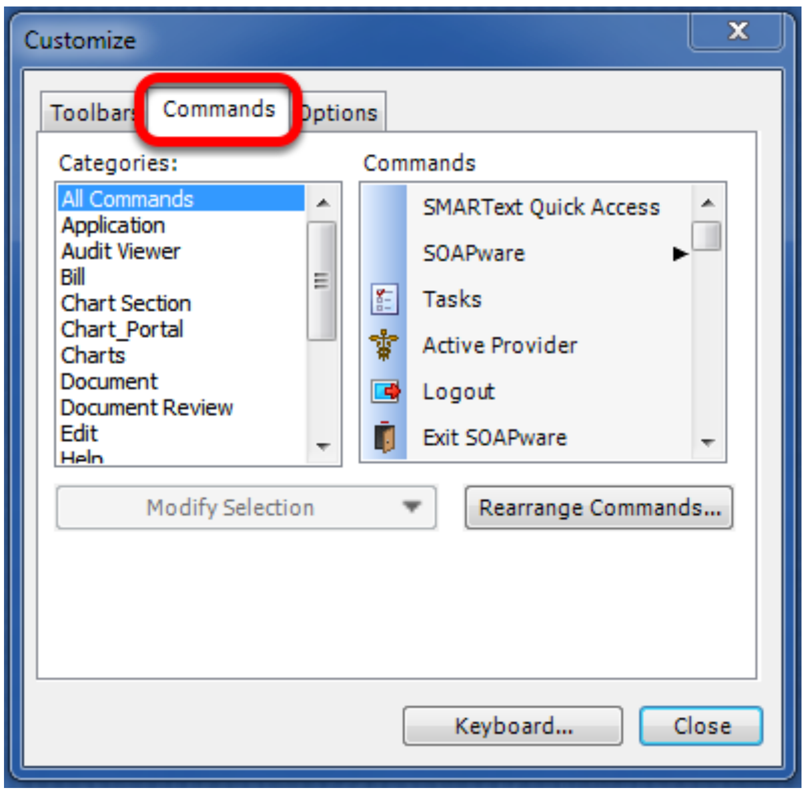


In addition to the Common Toolbar, there are several additional toolbars available. To view these, Click on the Tools Menu and select "Customize". This will bring up the Customize window above. Click each individual toolbar wished to be displayed.

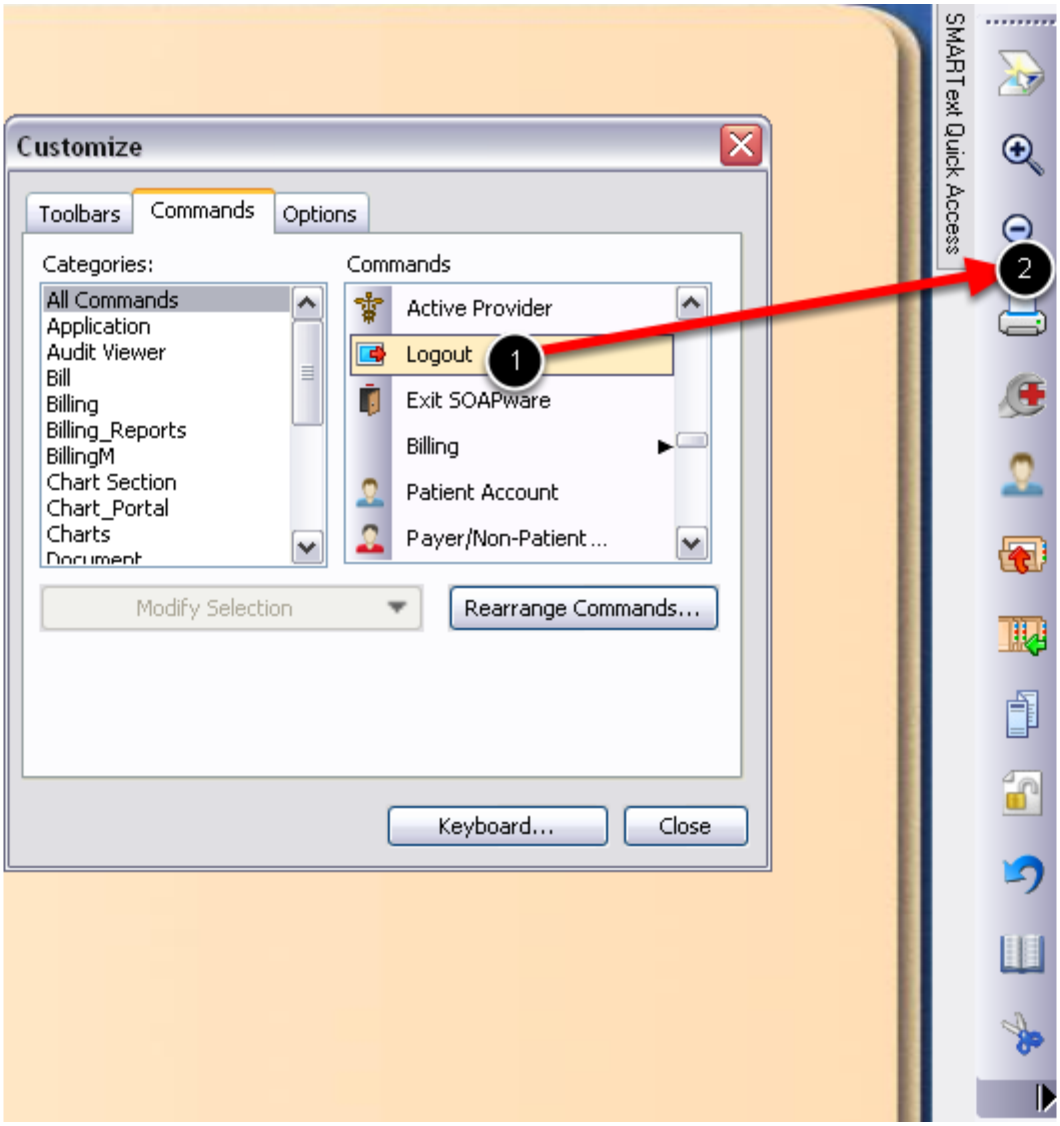
The additional toolbars are:
1. Imaging
2. Edit
3. Document Management
4. Patient Management

Users may also Click "New" to create their own customized toolbar, and may Click Reset to reset the toolbars to the default settings.

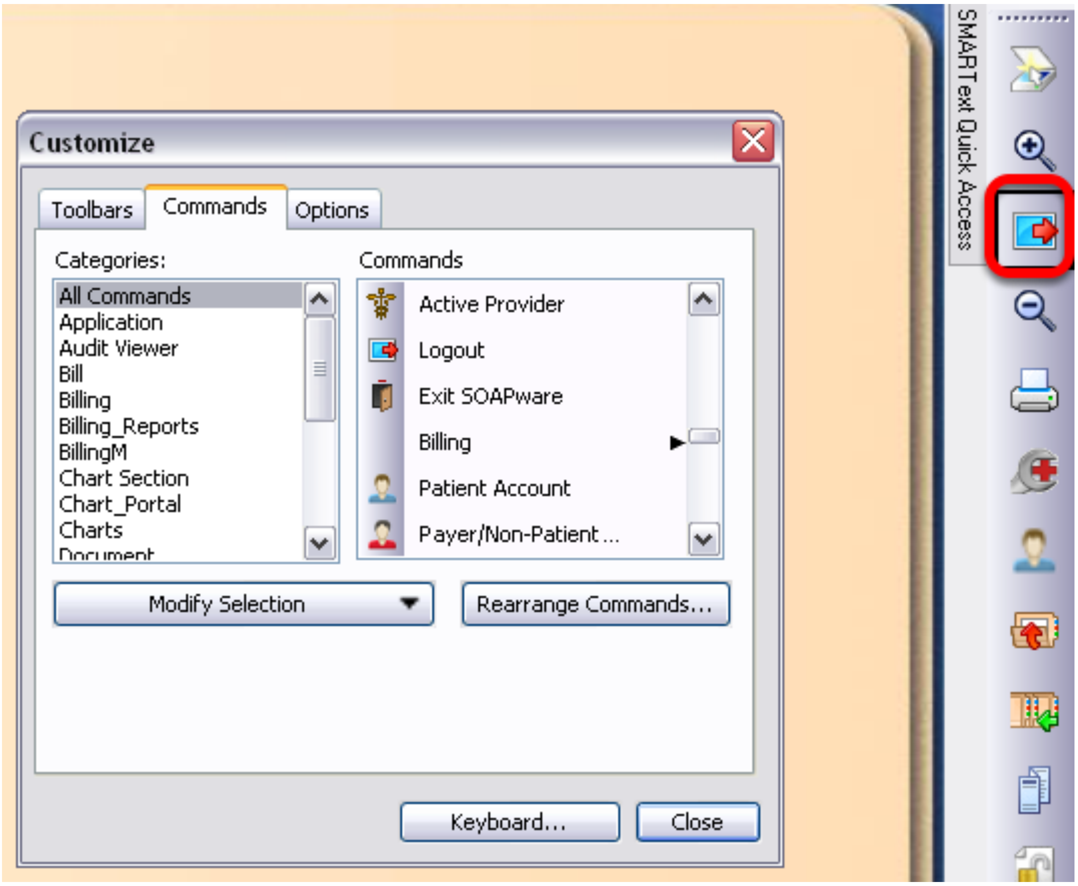
Customizing Toolbars



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.

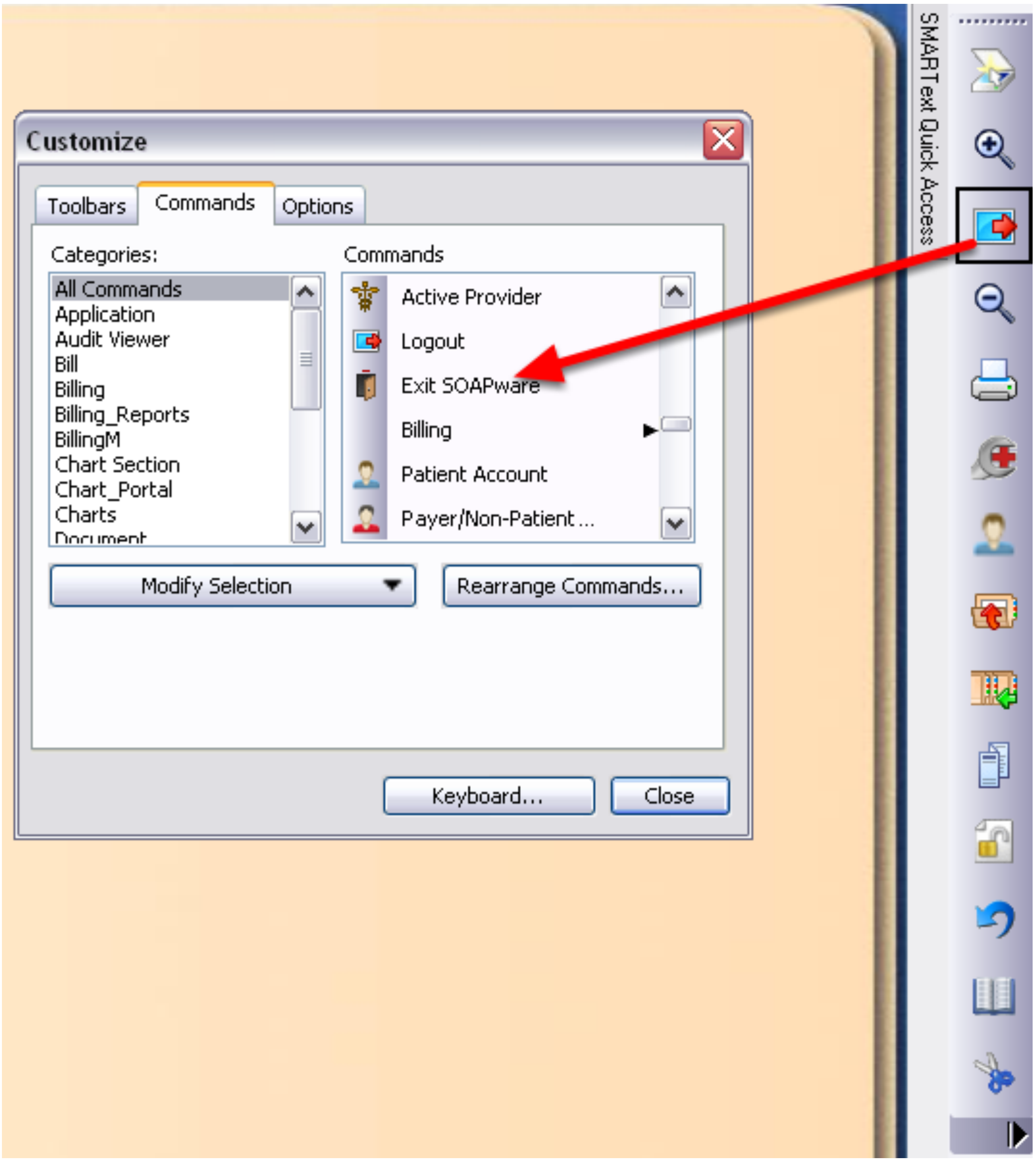


1. To add commands to a toolbar, locate the command to add. To locate the commands a user would like to include, Click on "All Commands", or browse by category, such as "Chart Section" or "Edit".
2. Next, Click and hold on the command in the "Command" section of the window and drag it to the toolbar 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.



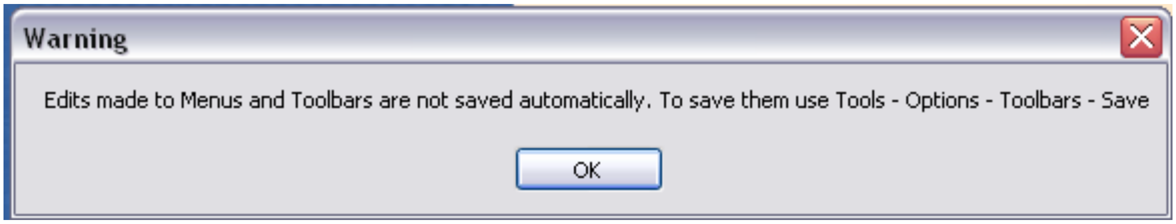
Once the command is dropped, a new button will be placed on the users toolbar.

Removing a Command from the Toolbar

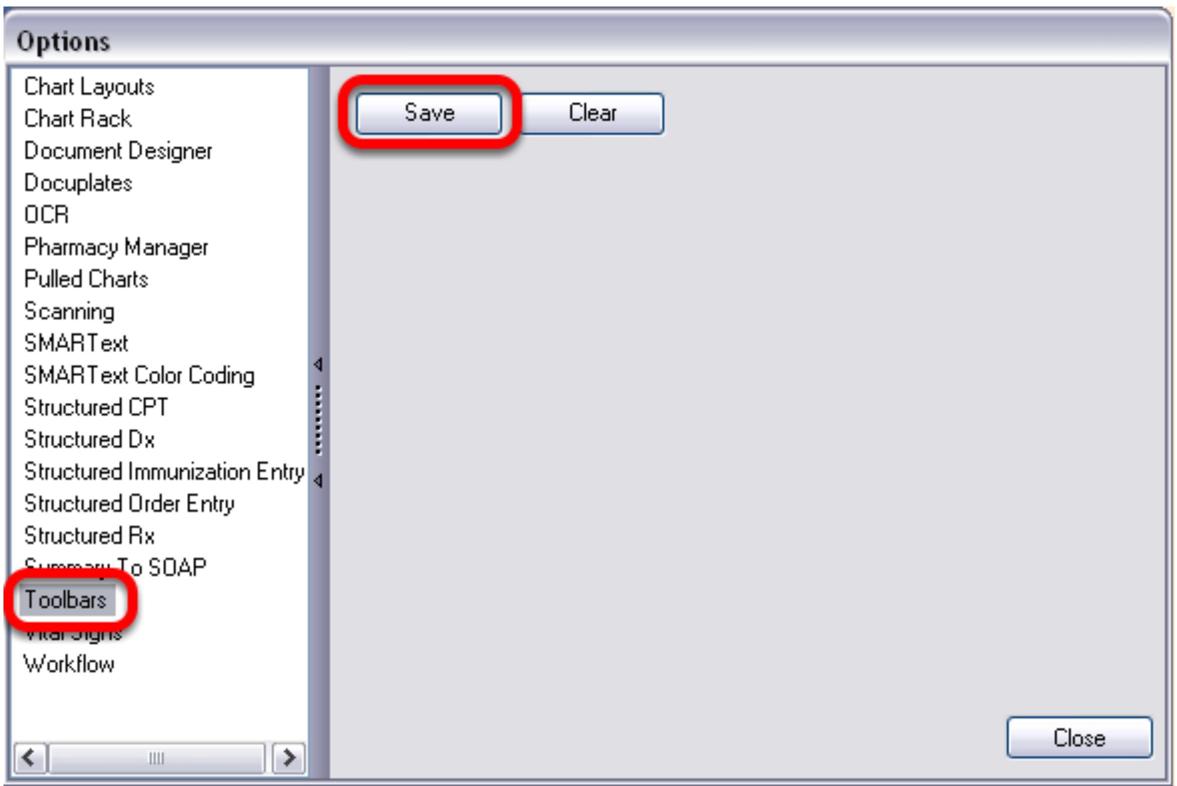


To remove a command from a toolbar, with the command window above still open, Click and hold the button on the toolbar and drag it to the command window and drop it. This will remove it from the toolbar. Users may also use this method to rearrange the commands on the toolbars by dragging them to another 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.

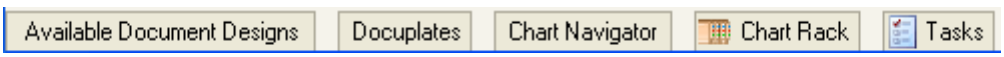


Anytime a user makes changes to their toolbar, they must save their changes by going to Tools > Options > Toolbars > Save.

Exploring the SOAPware Interface - Docked Tabs

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

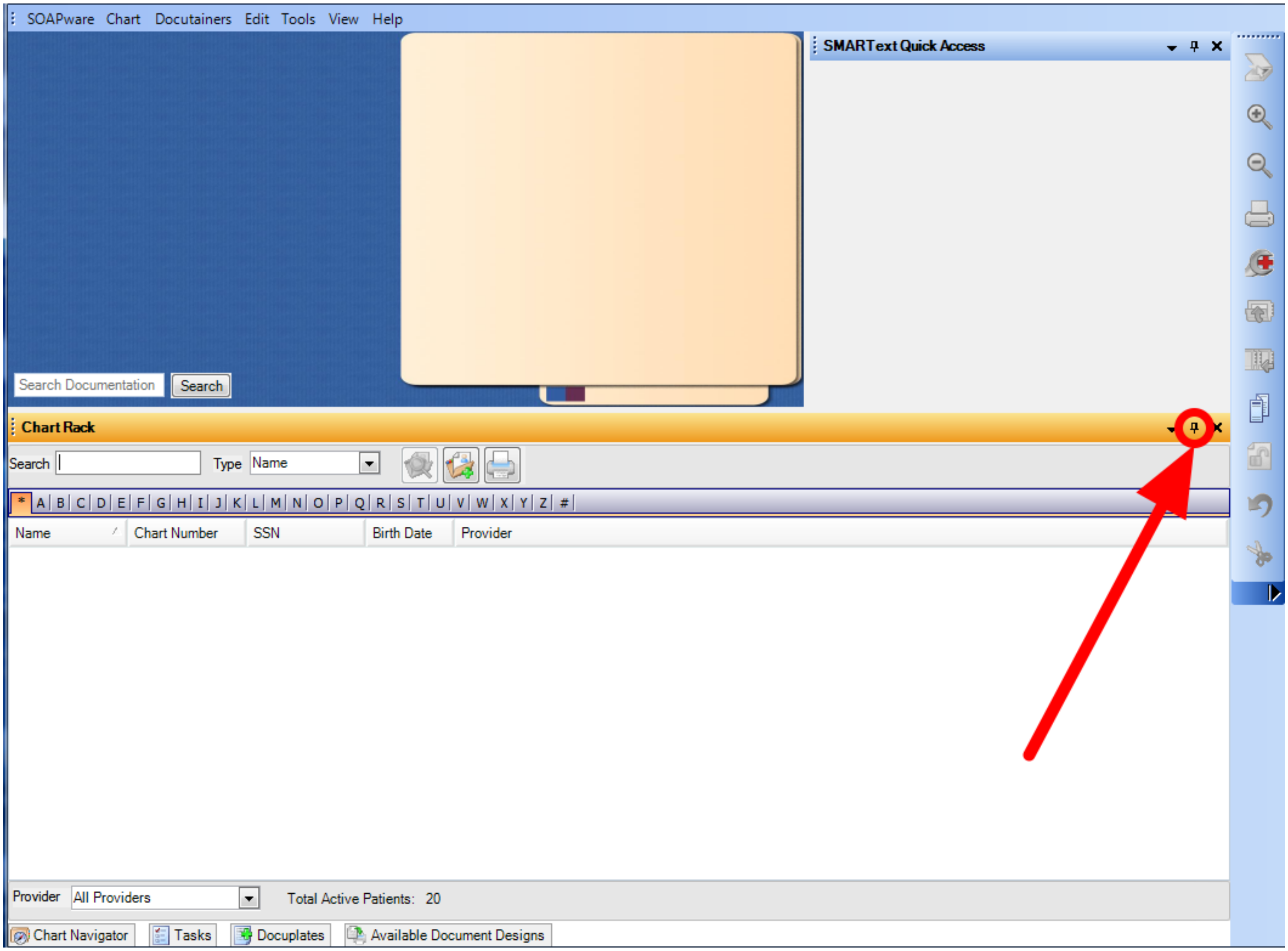


These five docked tabs come defaulted with SOAPware. A user may Click on each of the tabs to expand them, or have them expand automatically when moused over or hovered over.

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 un docked, so that they can float anywhere.

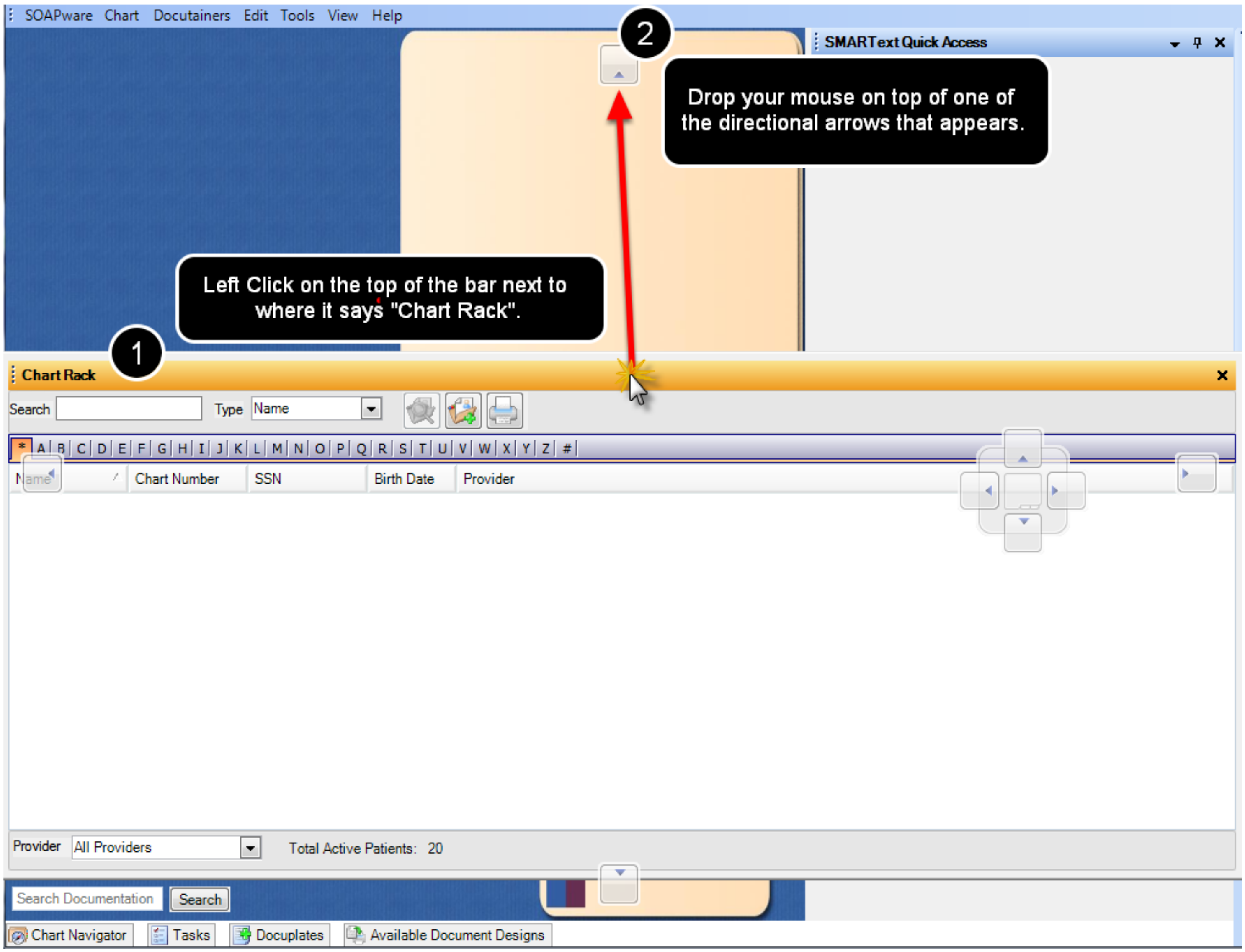
Pin-Open Docked Tabs



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



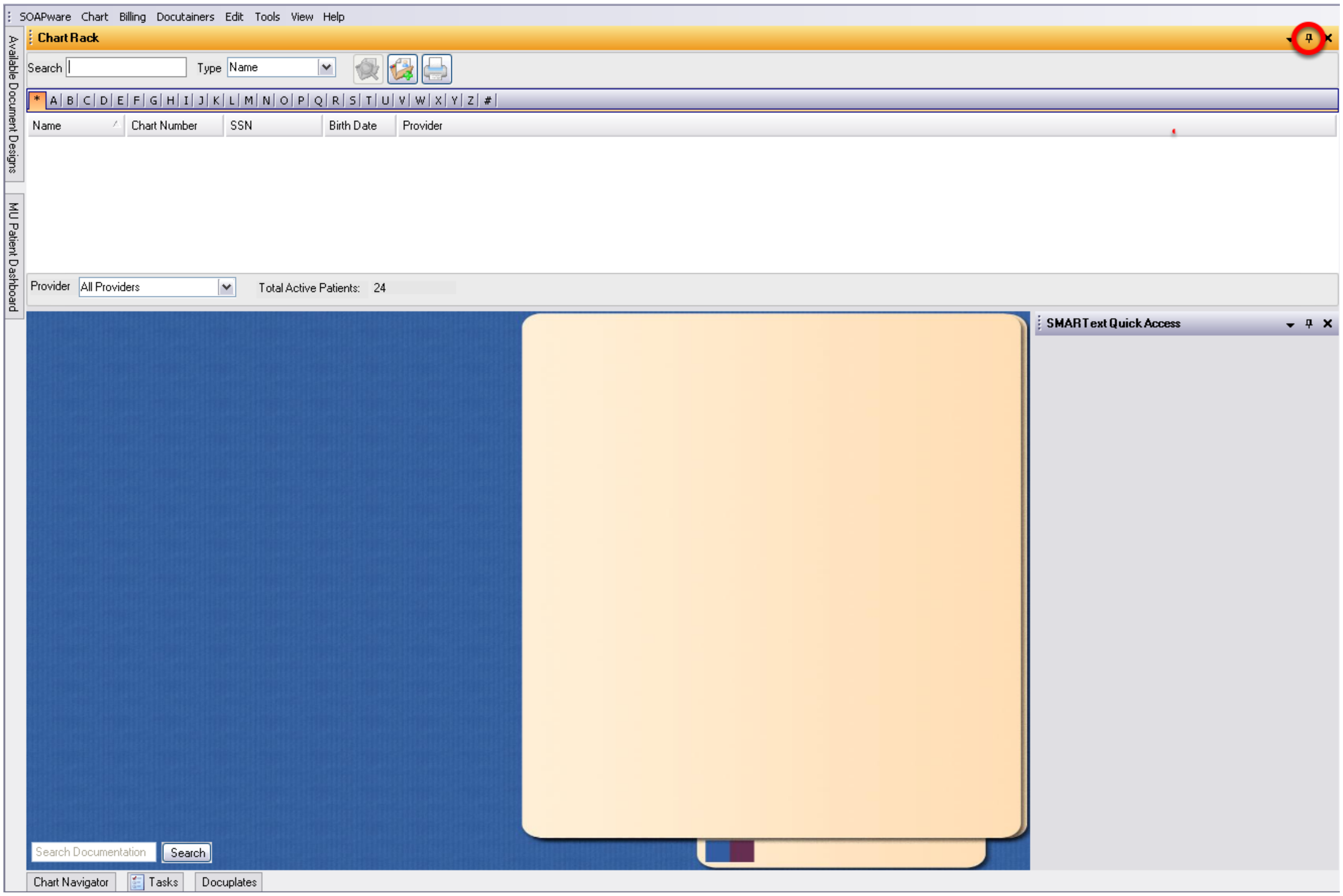
To move a docked tab the users first action will be to pin it open using the instructions above for pinning open a docked tab.

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.

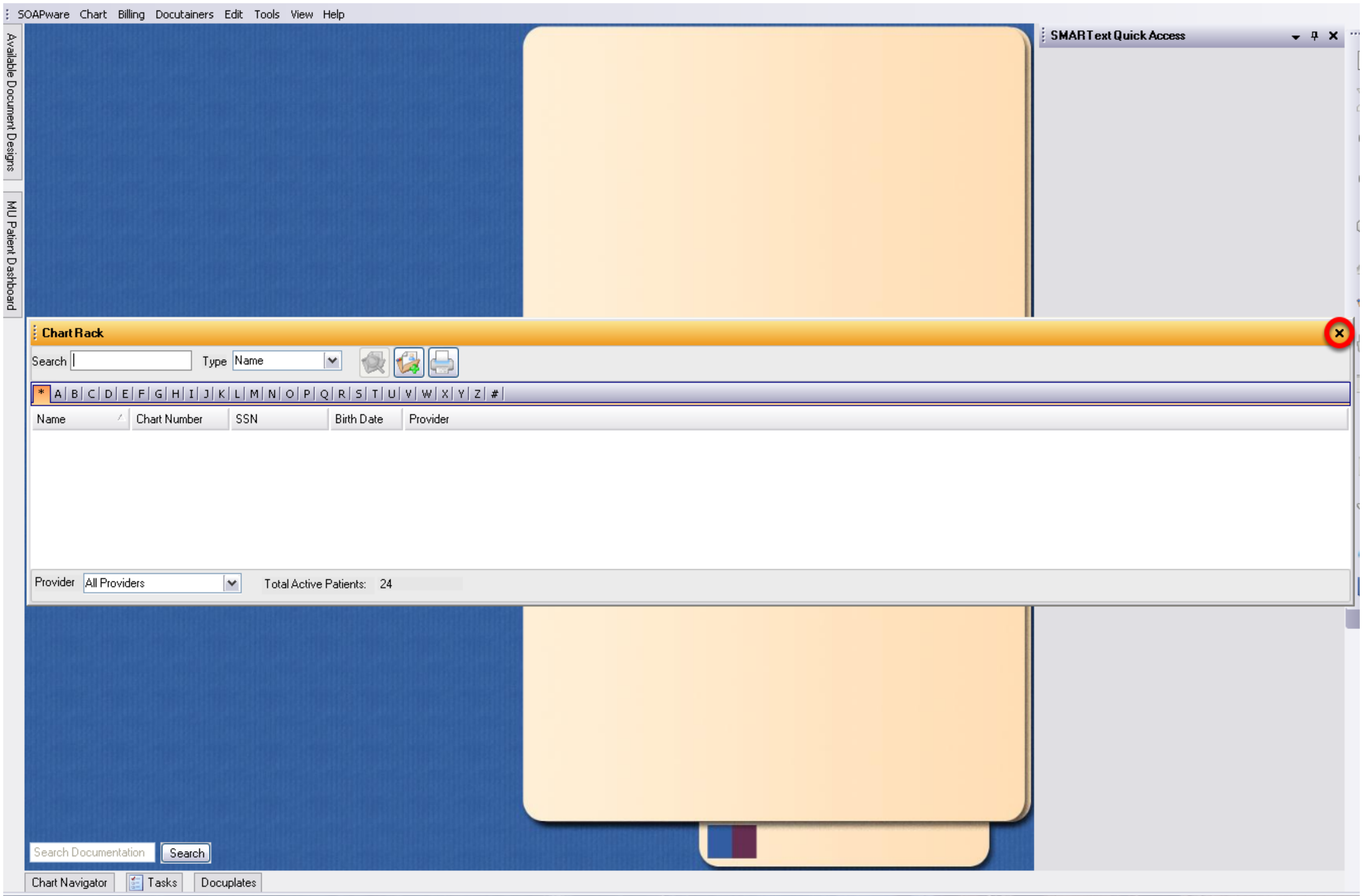
Un-Pin the Docked Tab



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

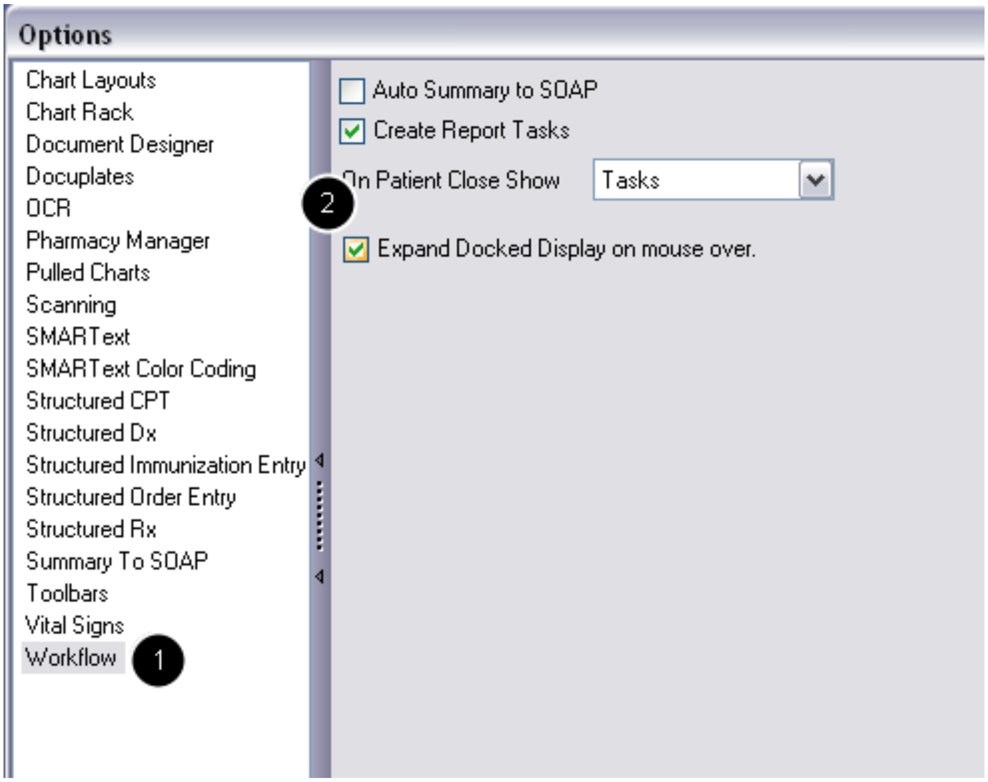


To leave a tab free-floating so that it is no longer docked, Click on a docked tab to expand the tab, and pin the window open as shown above.

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

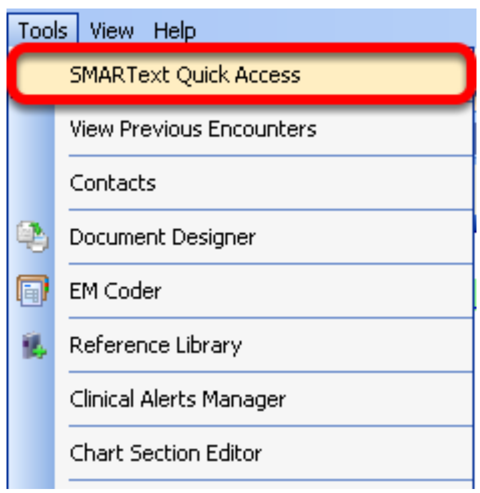
While Pulled Charts is a docked tab option, using Pulled Charts is not recommended in SOAPware. It is only available as a legacy item for customers converting from Version 4. SOAPware recommends using the Task List to manage all task items/unsigned charts.

TIP - Docking SMARText Quick Access

In this lesson we will describe how to dock the SMARText Quick Access window.

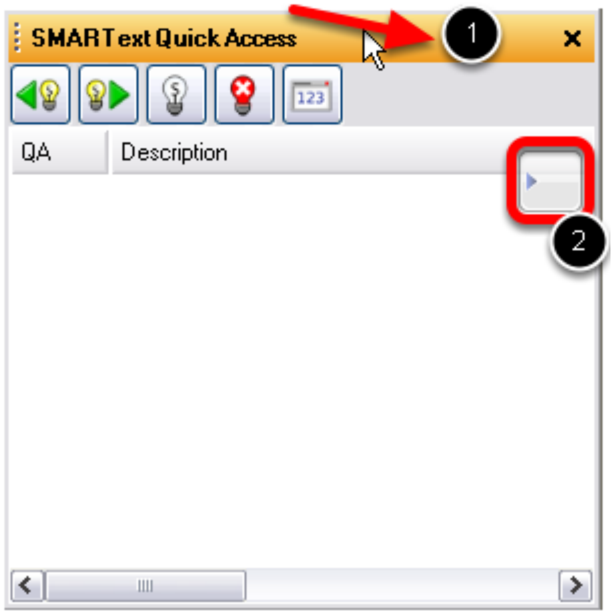
The SMARText Quick Access window is used when working with SMARText and Location Pick Lists. A user can dock the SMARText Quick Access window on any side of a computer screen, however we suggest that the SMARText Quick Access be docked on the right hand side of the screen for easy retrieval of the Pick List items.

Retrieving the SMARText Quick Access Window



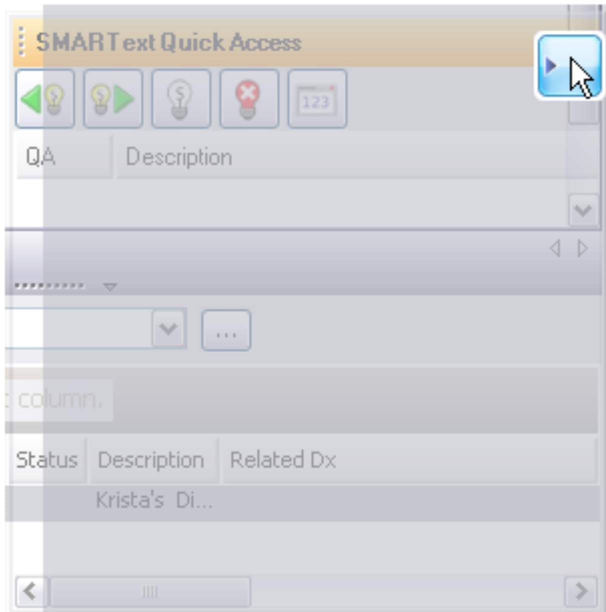
1. Click on Tools in the Menu bar.
2. Select SMARText Quick Access

Dragging the SMARText Quick Access Window



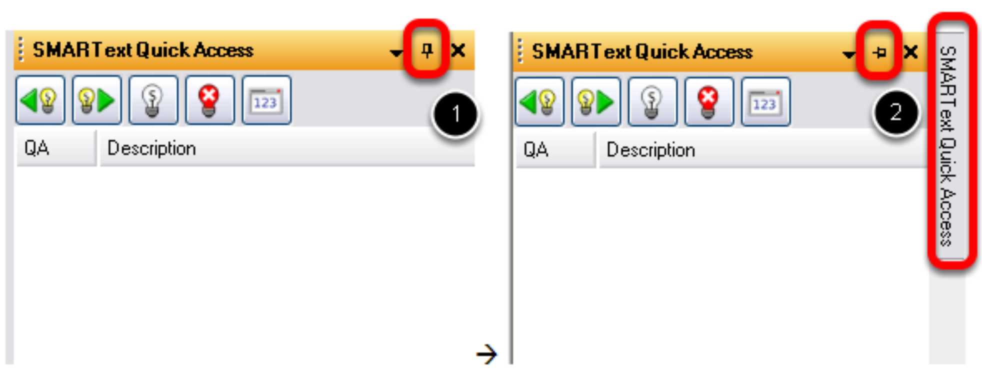
1. Left-Click on the SMARText Quick Access title bar (orange bar at the top of the window).
2. While holding the left-click, begin dragging the SMARText Quick Access window towards the blue arrow box on the right side of thescreen (see above).

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).

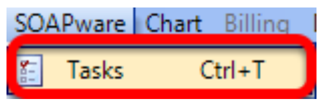
2. The push pin button will now be pointing to the side and the SMARText Quick Access docked tab will appear.

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.

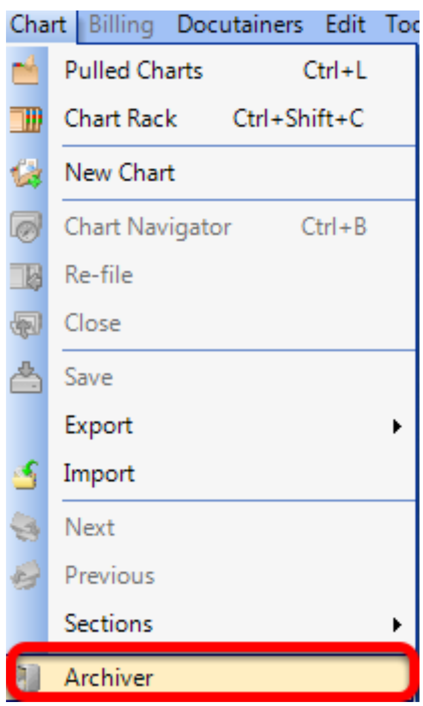
Note: A user can dock an item to the top, bottom, right, or left side of the SOAPware Interface. A user is also able to leave the item free floating .

SOAPware- Tasks



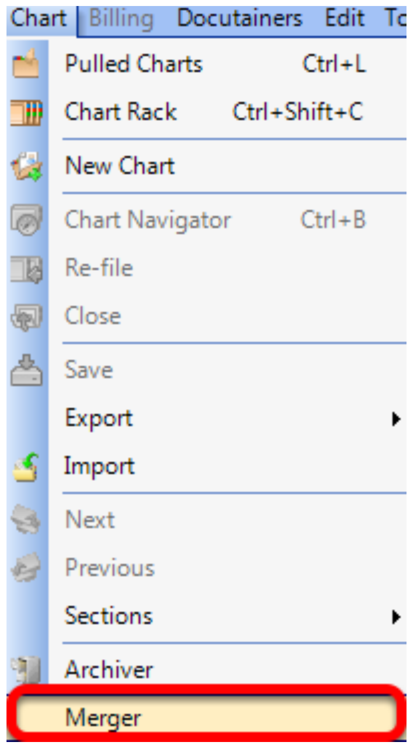
To dock Tasks, Click SOAPware > Tasks.

Chart - Archiver



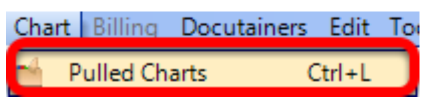
To dock Chart Archiver, Click Chart > Archiver.

Chart - Merger



To dock Chart Merger, Click Chart > Merger.

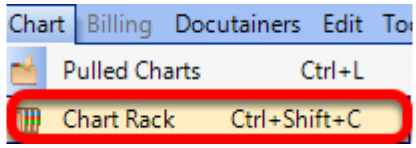
Chart - Pulled Charts



To dock Pulled Charts, Click Chart > Pulled Charts.

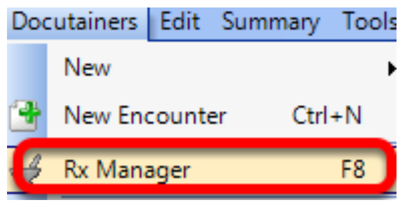
Note: While Pulled Charts is a docked tab option, using Pulled Charts is not recommended in SOAPware. It is only available as a legacy item for customers converting from Version 4. SOAPware recommends using the Task List to manage all task items/unsigned charts.

Chart - Chart Rack



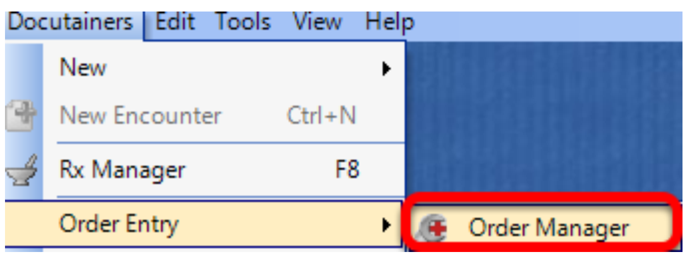
To dock the Chart Rack, Click Chart > Chart Rack.

Docutainers - Rx Manager



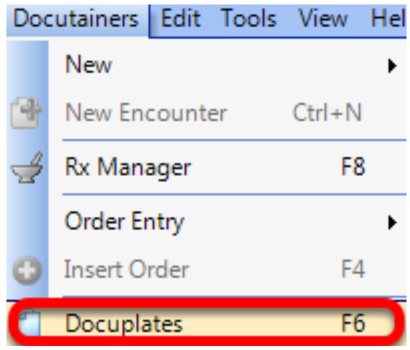
To dock Rx Manager, Click Docutainers > Rx Manager.

Docutainers - Order Manager



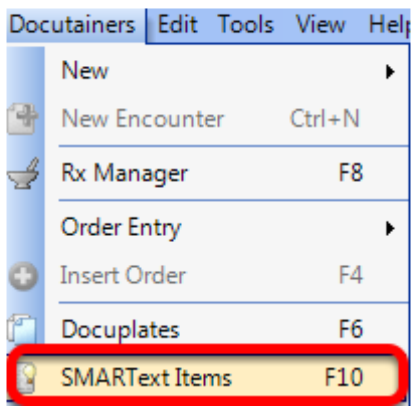
To dock Order Manager, Click Docutainers > Order Entry > Order Manager.

Docutainers - Docuplates



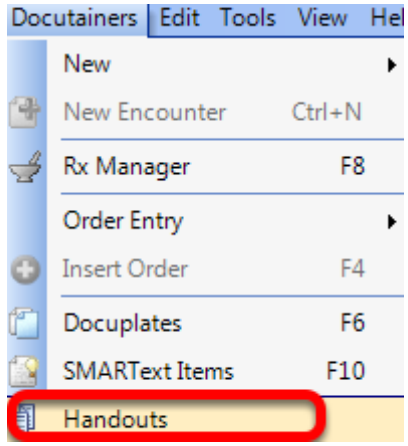
To dock Docuplates, Click Docutainers > Docuplates.

Docutainers - SMARText Items



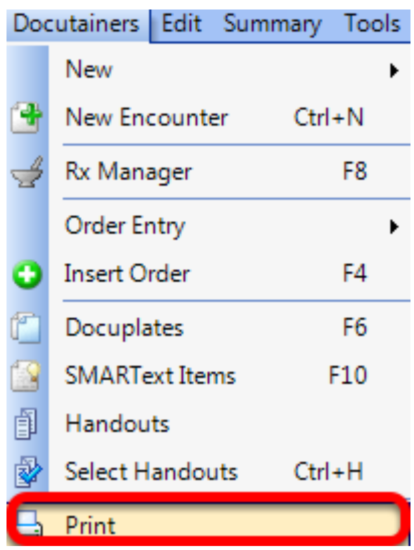
To dock SMARText Items, Click Docutainers > SMARText Items.

Docutainers - Handouts



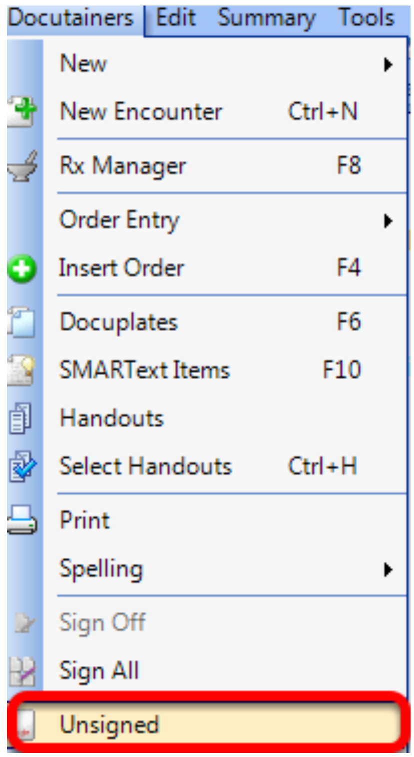
To dock Handouts, Click Docutainers > Handouts.

Docutainers - Print Available Document Designs



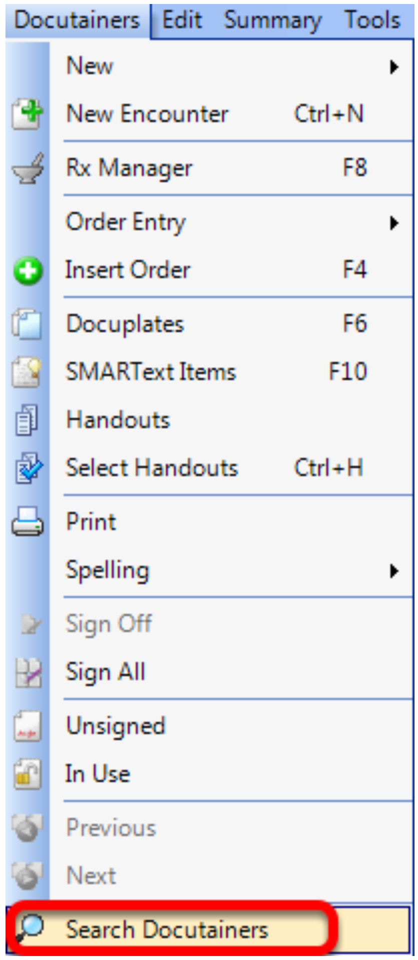
To dock Print, Click Docutainers > Print.
Note: The Print item is a list of a user's Available Document Designs.

Docutainers - Unsigned



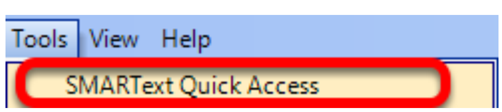
To dock Unsigned, Click Docutainers > Unsigned.
Note: This item brings up the "Unsigned Documents" dialog.

Docutainers - Search Docutainers



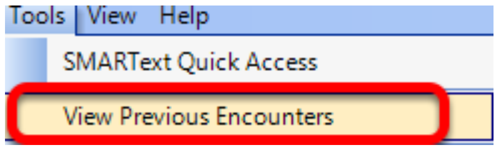
To dock Search Docutainers, Click Docutainers > Search Docutainers.

Tools - SMARText Quick Access



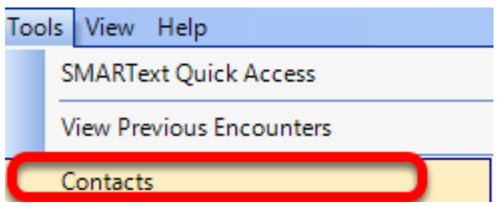
To dock SMARText Quick Access, Click Tools > SMARText Quick Access.
To view more information on docking SMARText Quick Access, Click here.

Tools - View Previous Encounters



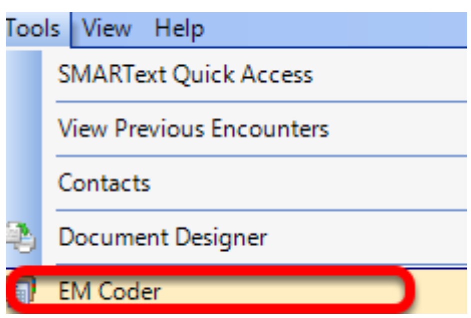
To dock View Previous Encounters, Click Tools > View Previous Encounters.

Tools - Contacts



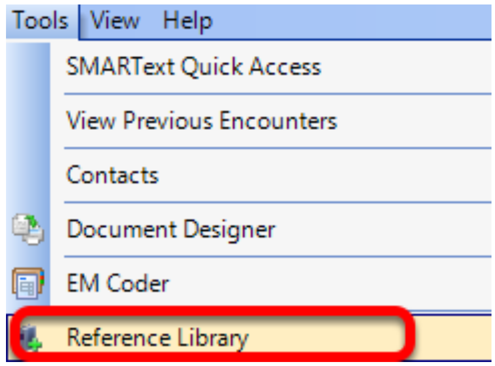
To dock Contacts, Click Tools > Contacts.

Tools - EM Coder



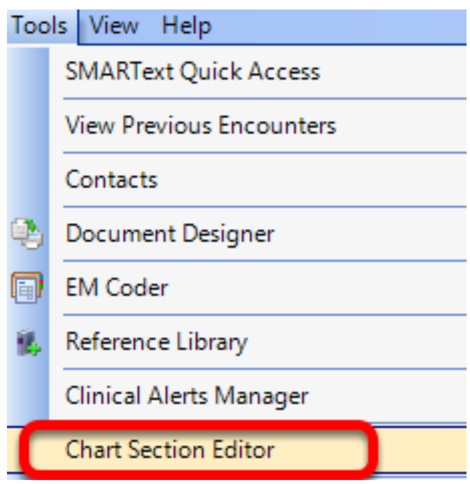
To dock EM Coder, Click Tools > EM Coder.

Tools - Reference Library



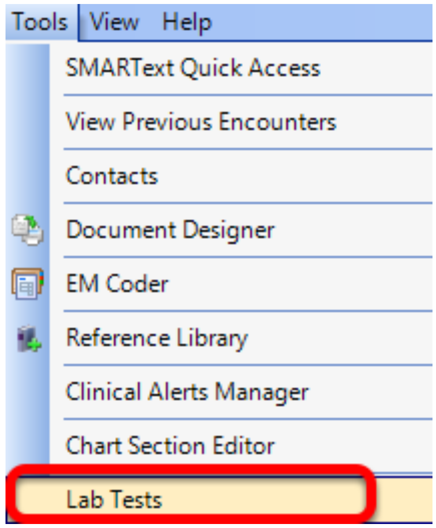
To dock the Reference Library, Click Tools > Reference Library.

Tools - Chart Section Editor



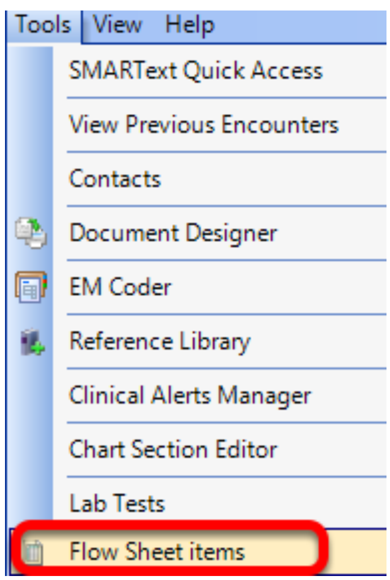
To dock Chart Section Editor, Click Tools > Chart Section Editor.

Tools - Lab Tests



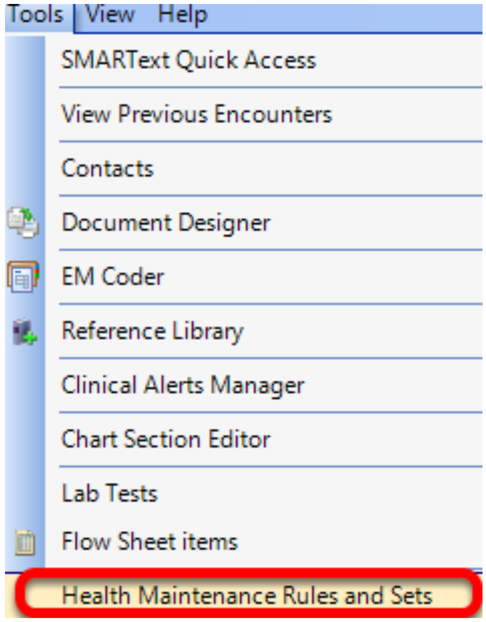
To dock Lab Tests, Click Tools > Lab Tests.

Tools - Flow Sheet Items



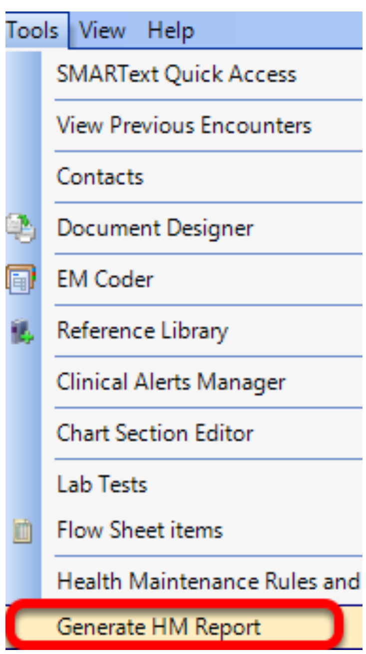
To dock Flow Sheet items, Click Tools > Flow Sheet items.

Tools - Health Maintenance Rules and Sets



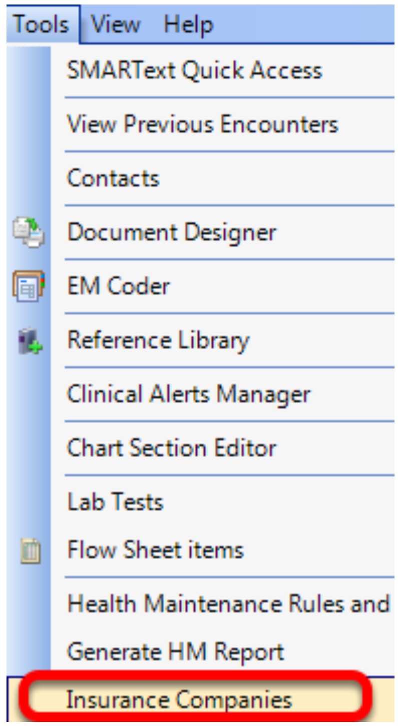
To dock Health Maintenance Rules and Sets, Click Tools > Health Maintenance Rules and Sets.

Tools - Generate HM Report



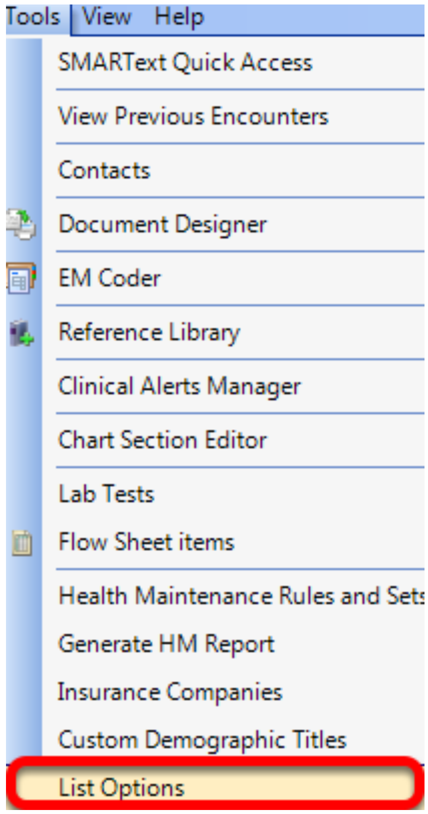
To dock the Generate Health Maintenance Report dialog, Click Tools > Generate HM Report.

Tools - Insurance Companies



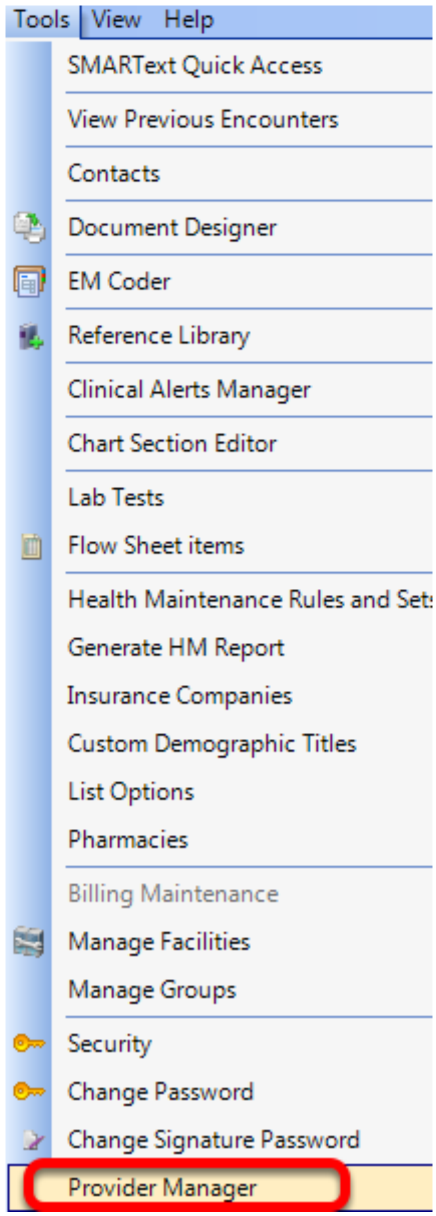
To dock Insurance Companies, Click Tools > Insurance Companies.

Tools - List Options



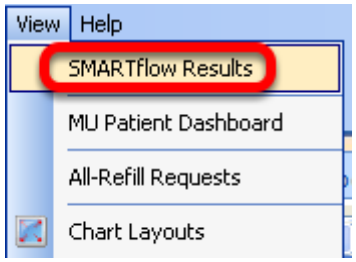
To dock List Options, Click Tools > List Options.

Tools - Provider Manager



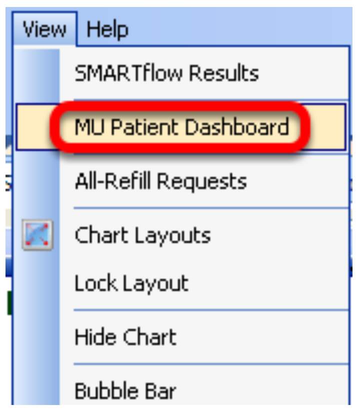
To dock Provider Manager, Click Tools > Provider Manager.

View- SMARTflow Results



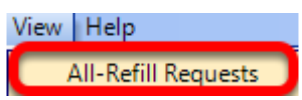
To dock SMARTflow Results, Click View> SMARTflow Results.

View- MU Patient Dashboard



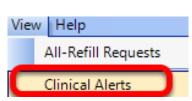
To dock MU Patient Dashboard, Click View> MU Patient Dashboard.

View - All Refill Requests



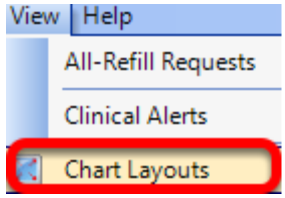
To dock All Refill Requests, Click View > All Refill Requests.

View - Clinical Alerts



To dock Clinical Alerts, Click View > Clinical Alerts.

View - Chart Layouts

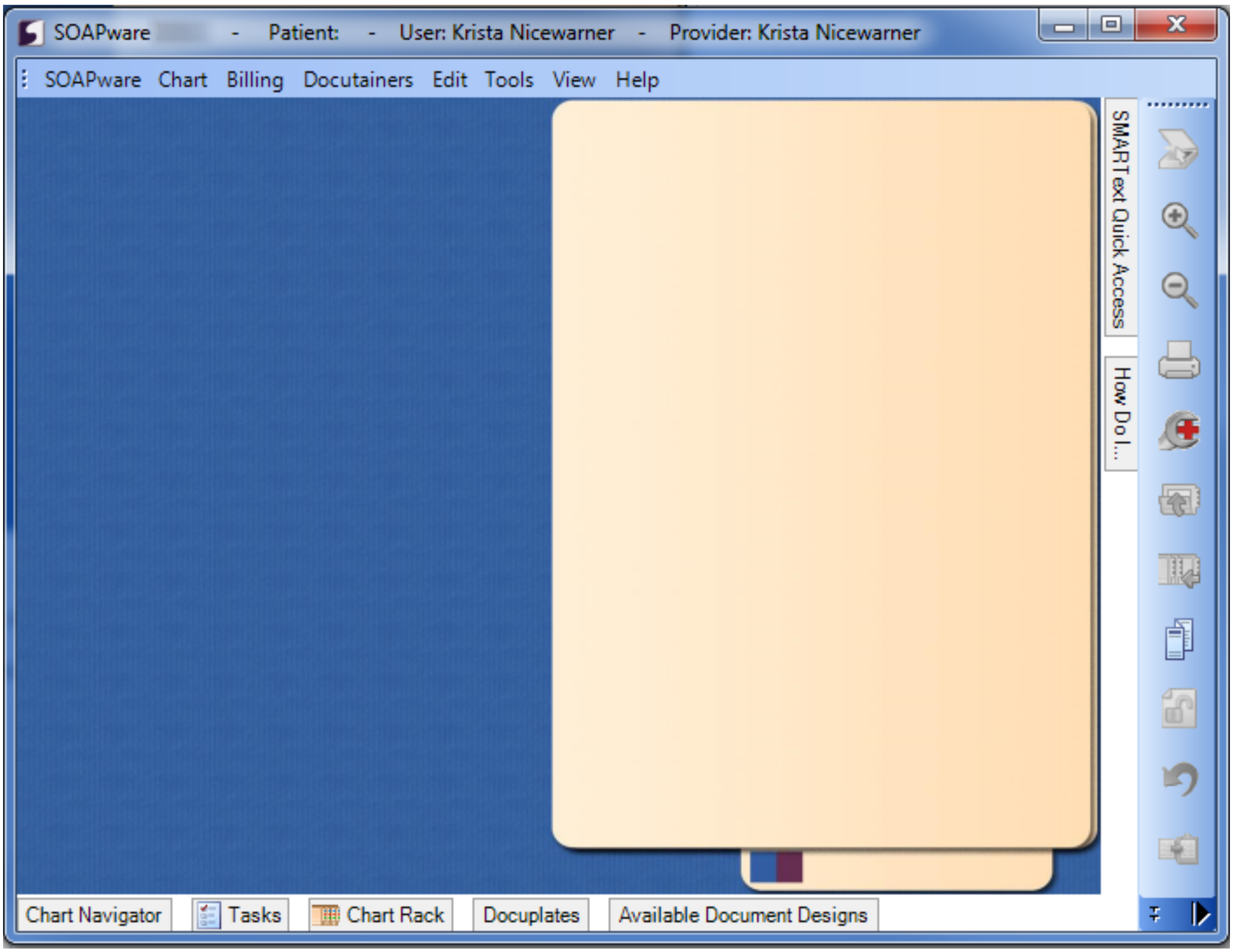


To dock Chart Layouts, Click View > Chart Layouts.

SOAPware Workspaces

This introductory lesson is designed to teach the user how to change workspaces when working in SOAPware.

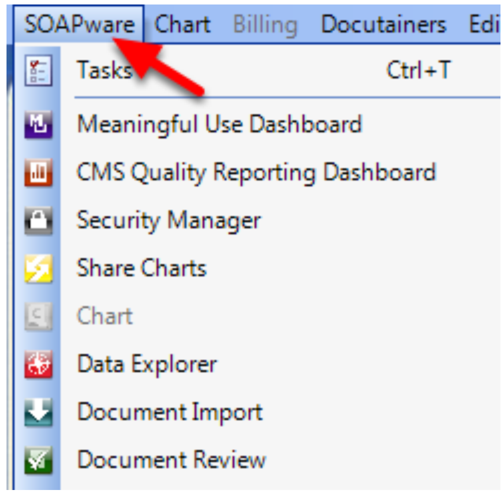
Charts Workspace



When users first log in to SOAPware, users are in the Charts workspace.

Auser knows he/she is in the chart workspace because the user will see a manila file folder.

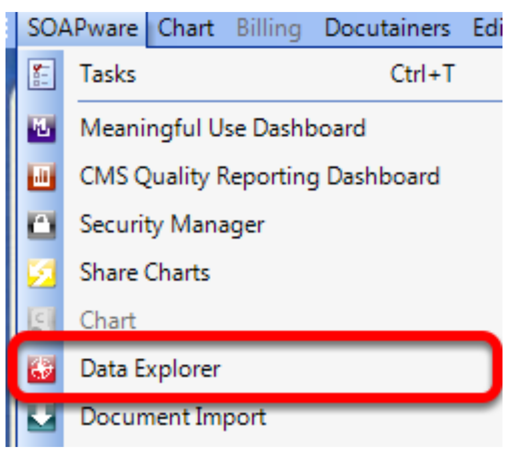
SOAPware Menu



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.

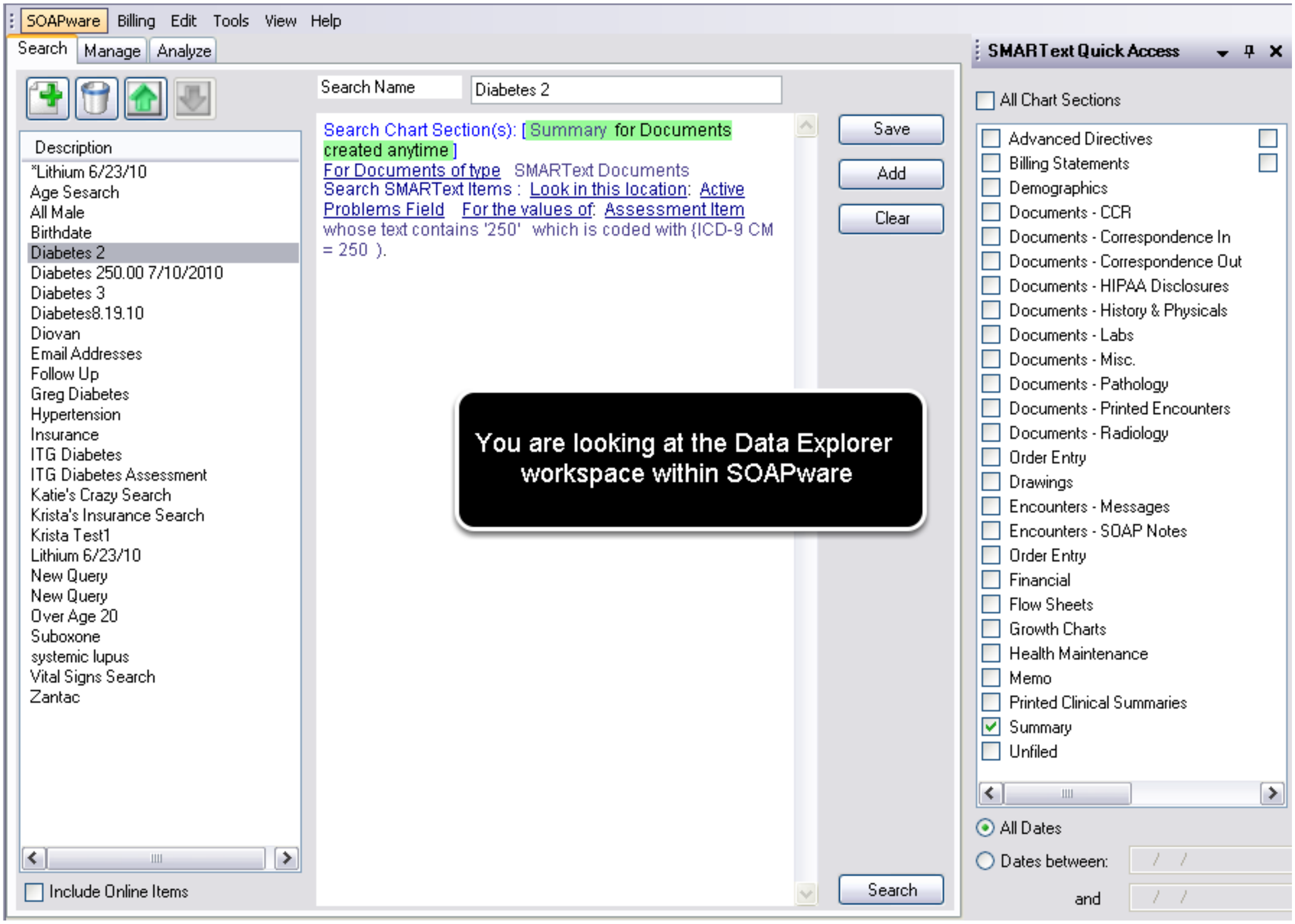
To change the workspace that the user is viewing, Click on the SOAPware menu.

Changing Workspaces

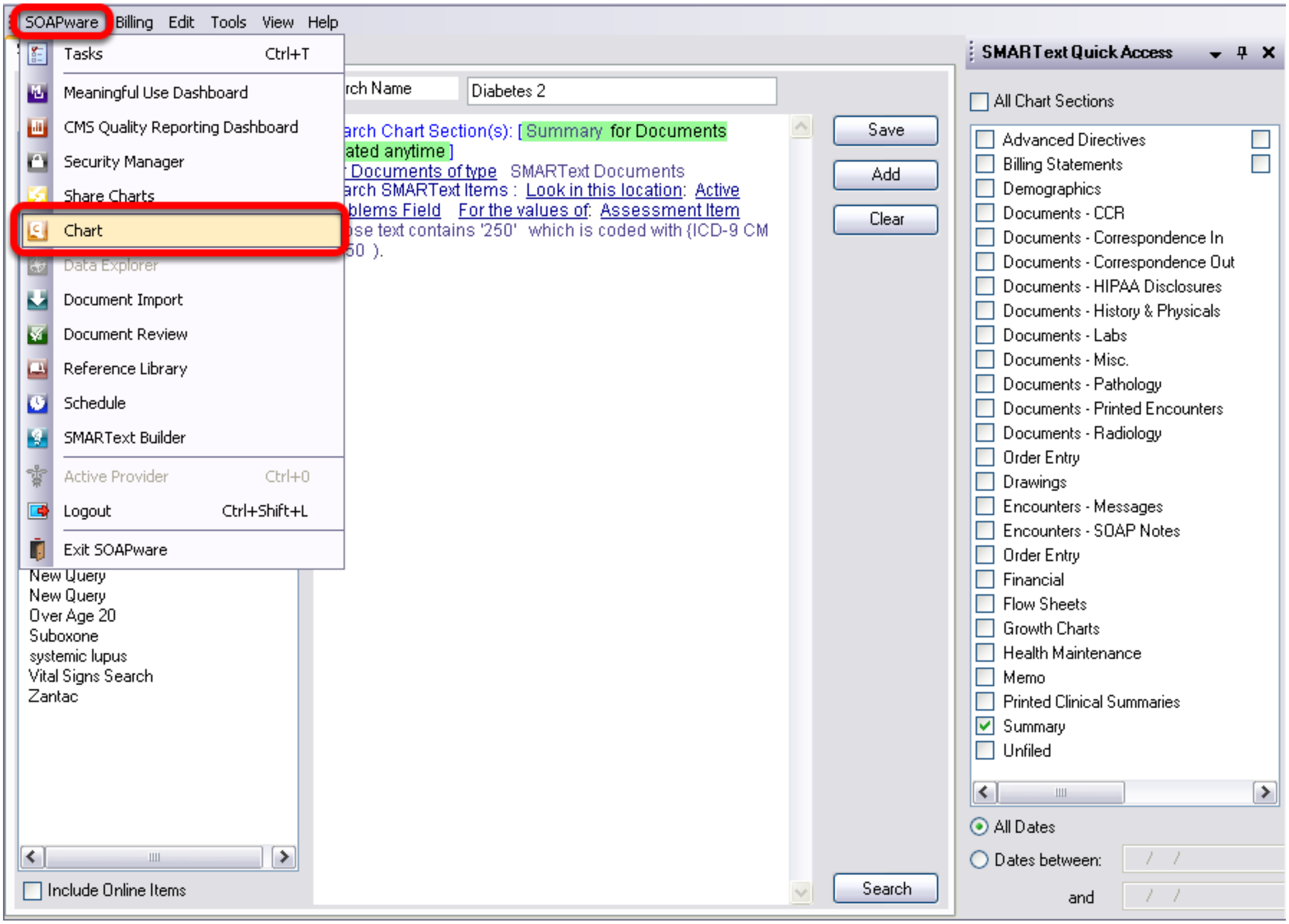


To view a different workspace, simply select the desired workspace from the SOAPware menu.

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

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.

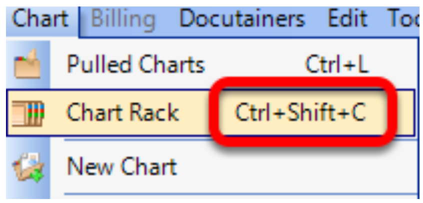
The Alt Key

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** Aredo 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 SMARText 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 shortcut codes
* **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 shortcut code, 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 shortcut code. This command is useful if the spacebar expand command is turned off.

SOAPnote Specific

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

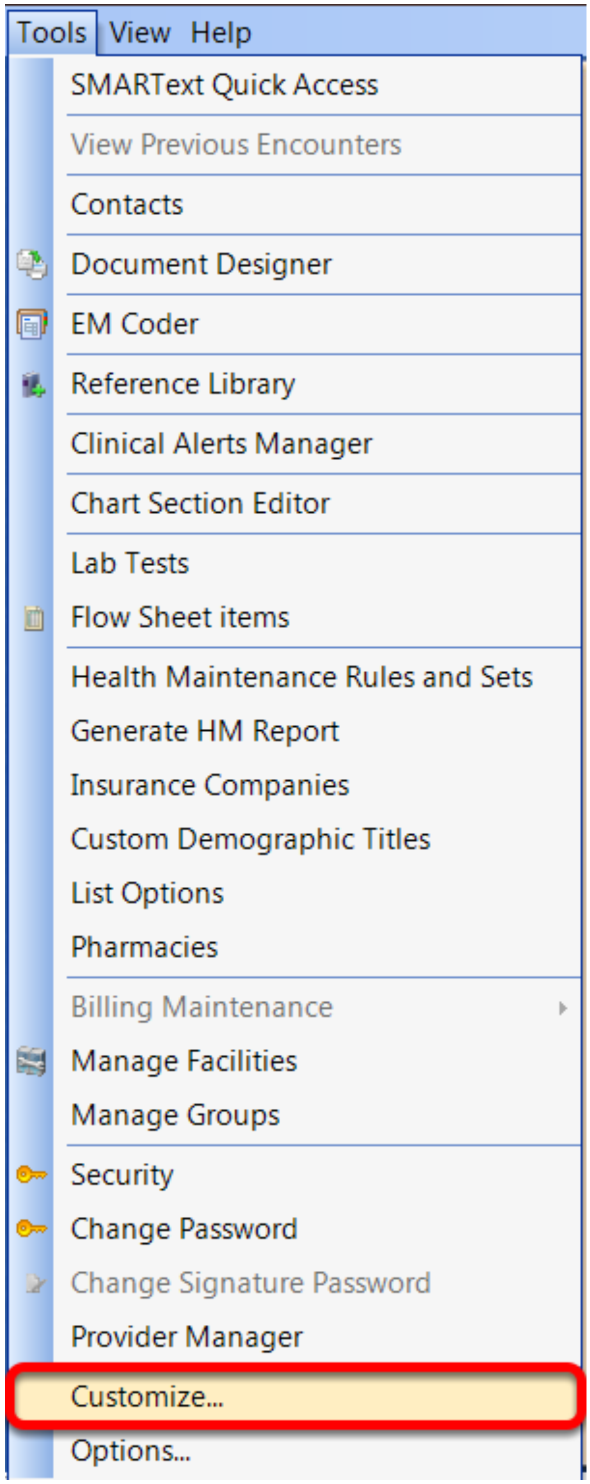
The Rx Pad list includes:

* **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

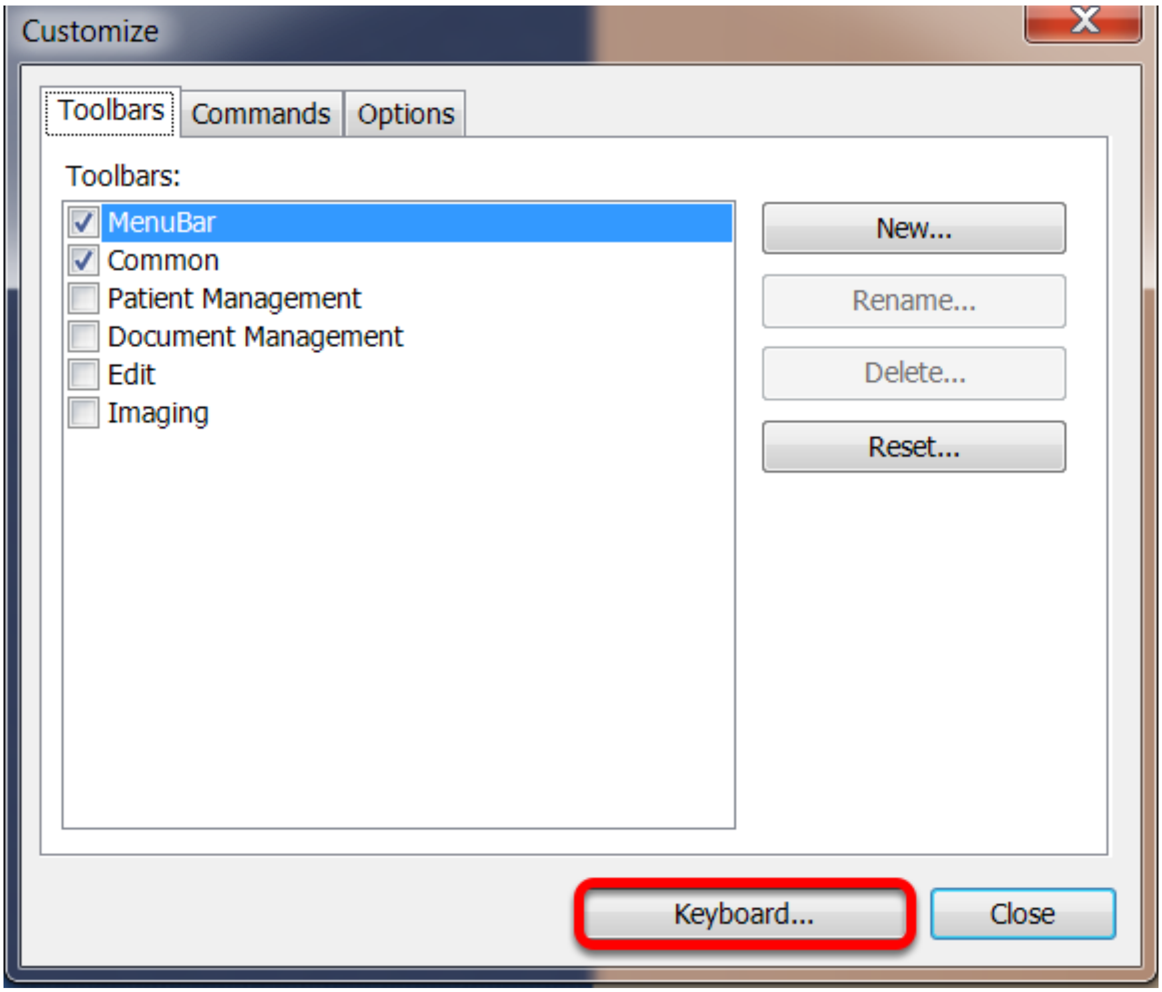
The Customize Keyboard tool allows shortcut key-command to be assigned for use within SOAPware. This can greatly increase productivity by making it faster and easier to access the SOAPware functions. Keyboard commands are user-specific in SOAPware.

Open the Customize Window.



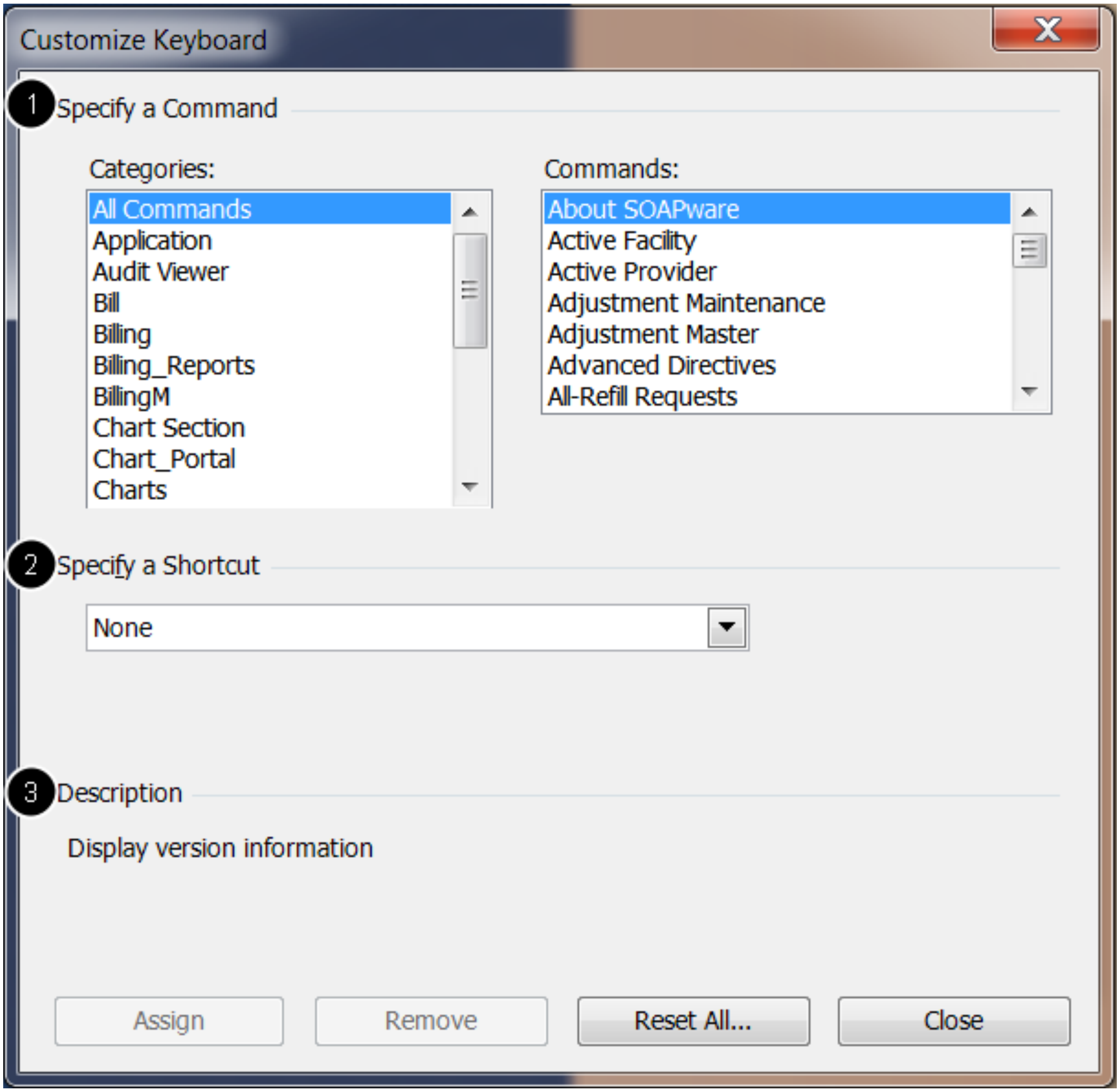
Open the Key Command Customization tool by selecting Tools > Customize.

Select the Commands Window



Next, select the Keyboard button.

Customize Keyboard Window



The Customize Keyboard dialog has three main areas which work together in setting-up keyboard commands.

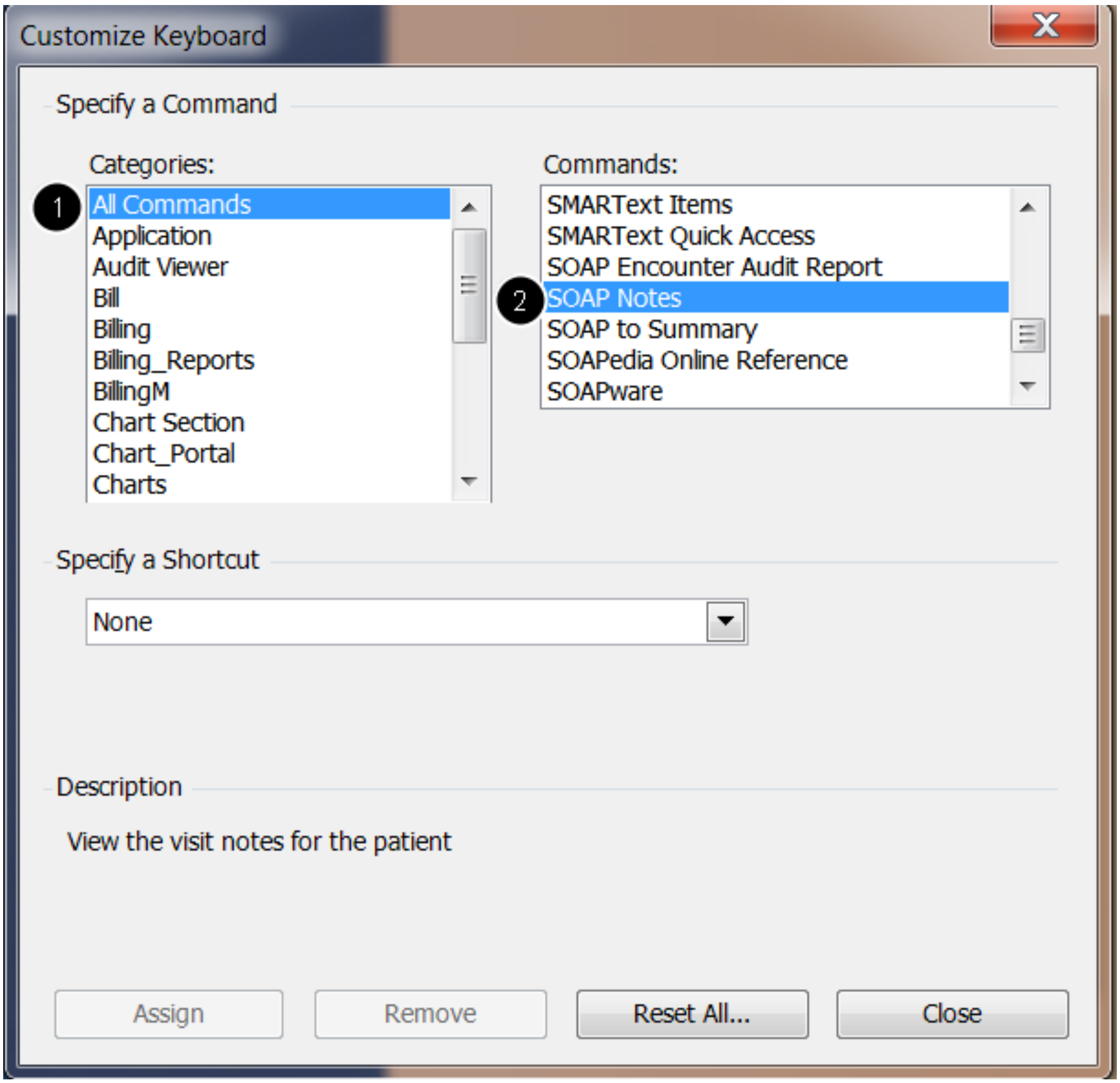
1. The top section, Specify a Command, allows for the selection of a command to assign to a key-command shortcut.

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



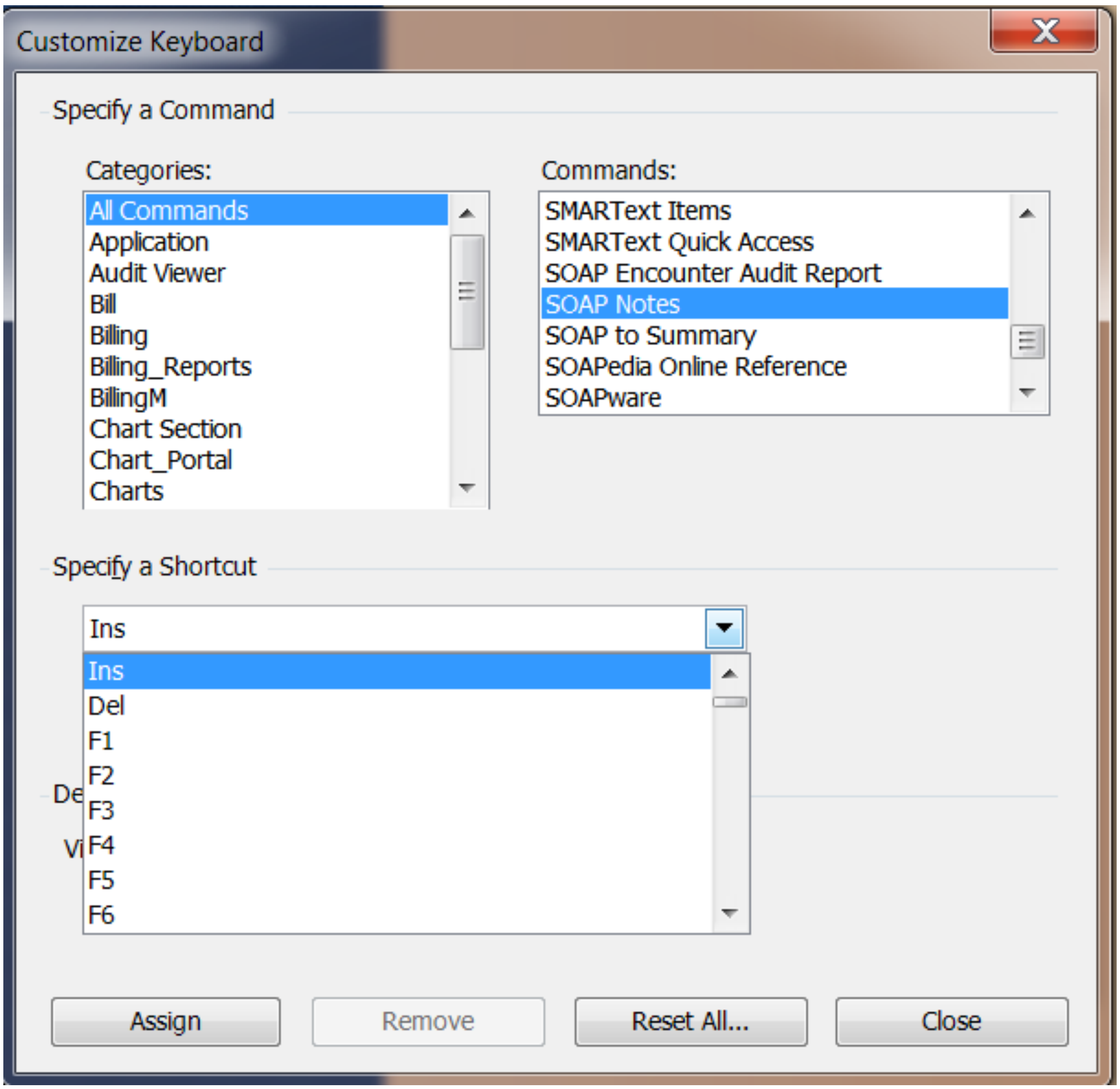
To assign a key-command shortcut to a SOAPware command:

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.

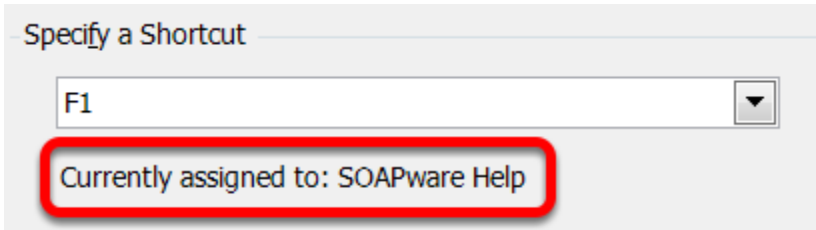
Specify a Shortcut



Once a command is selected, click the specify a Shortcut drop down list to choose a key-command shortcut.

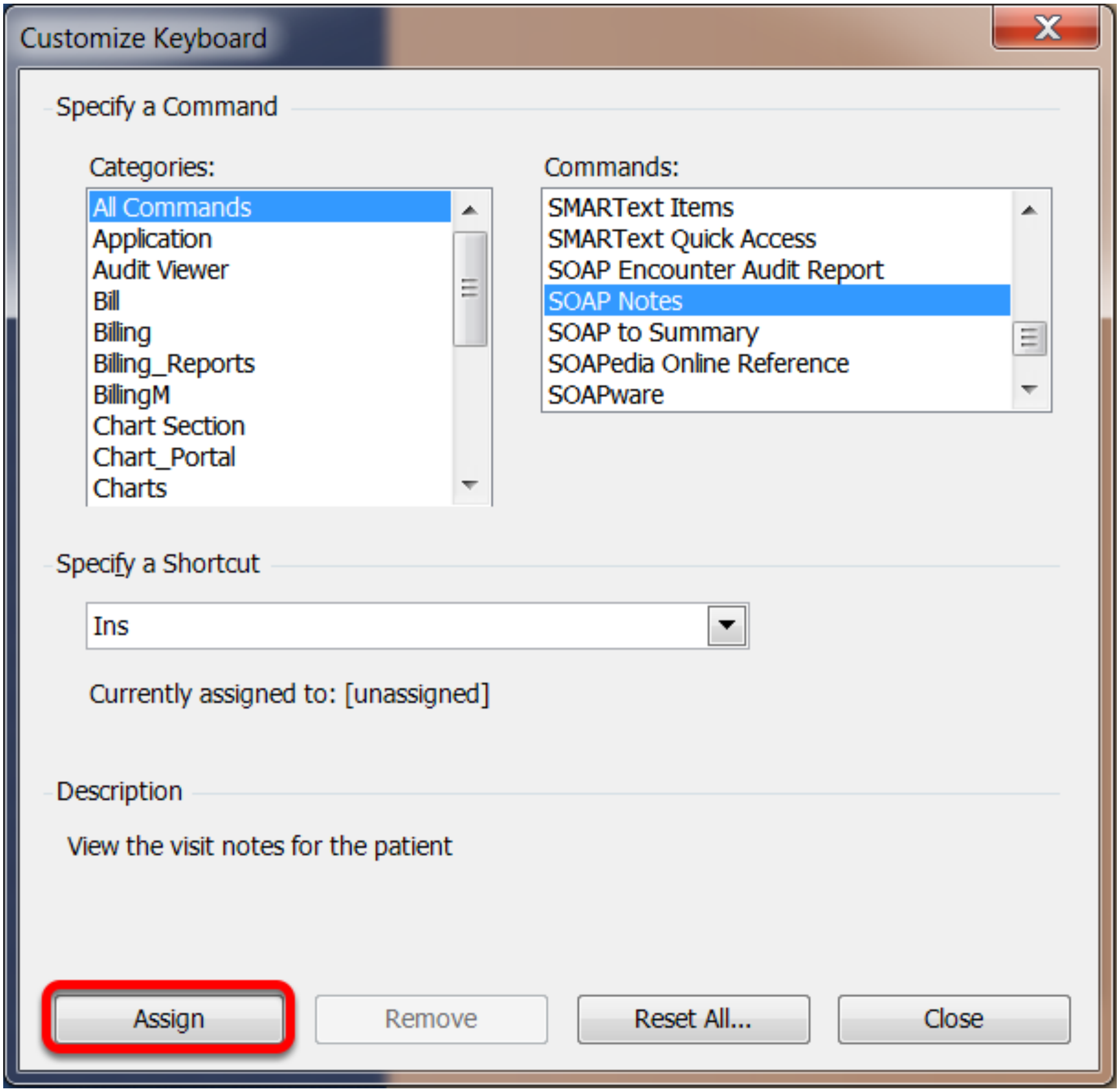
In the example above, it specifies that Pressing the Insert key causes the SOAP Notes chart section to open.

When Shortcuts are Already Assigned



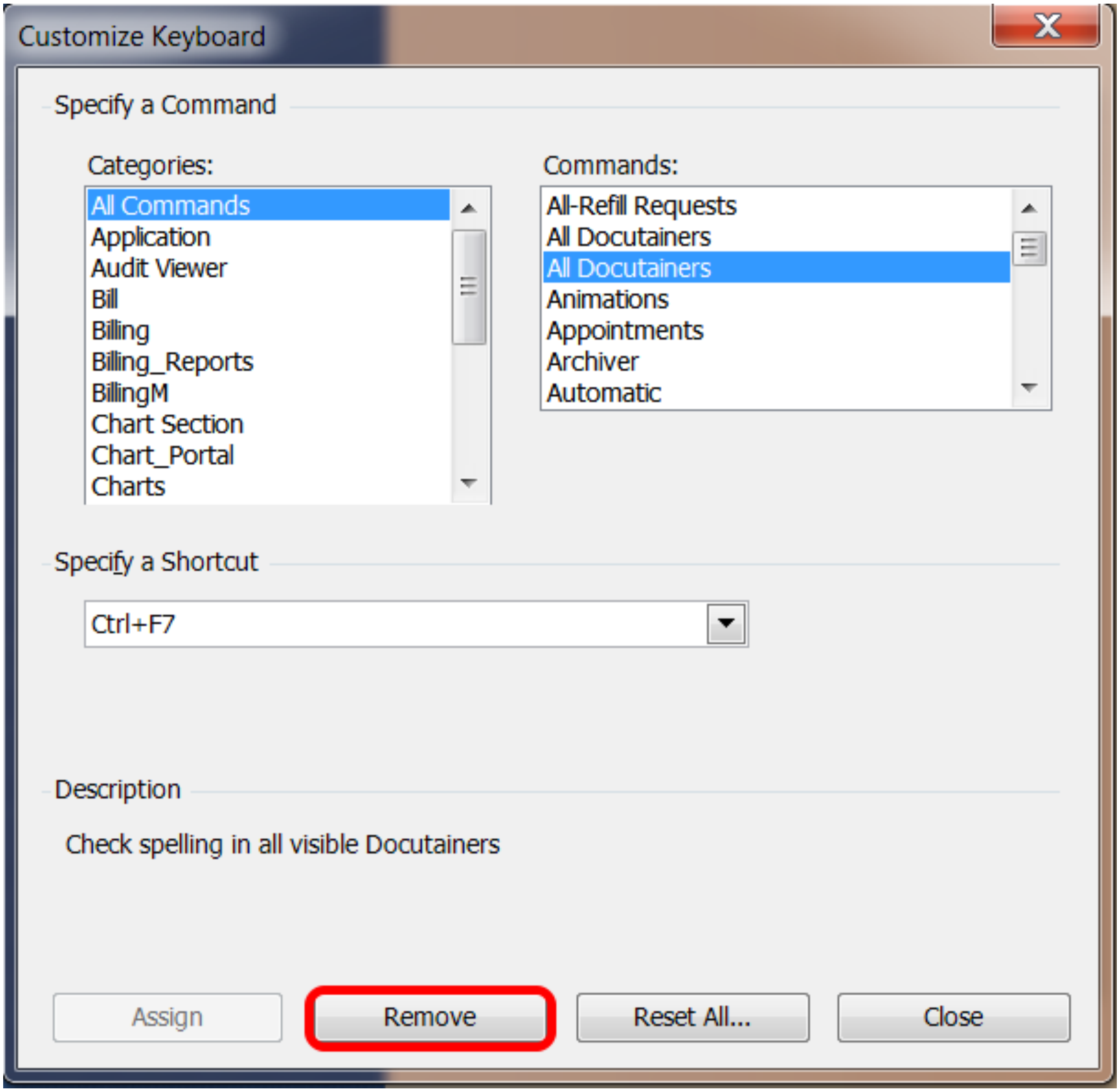
NOTE: If the selected keyboard shortcut is already assigned to another command, SOAPware warns by displaying a message in the Specify a Shortcut field.

Assign



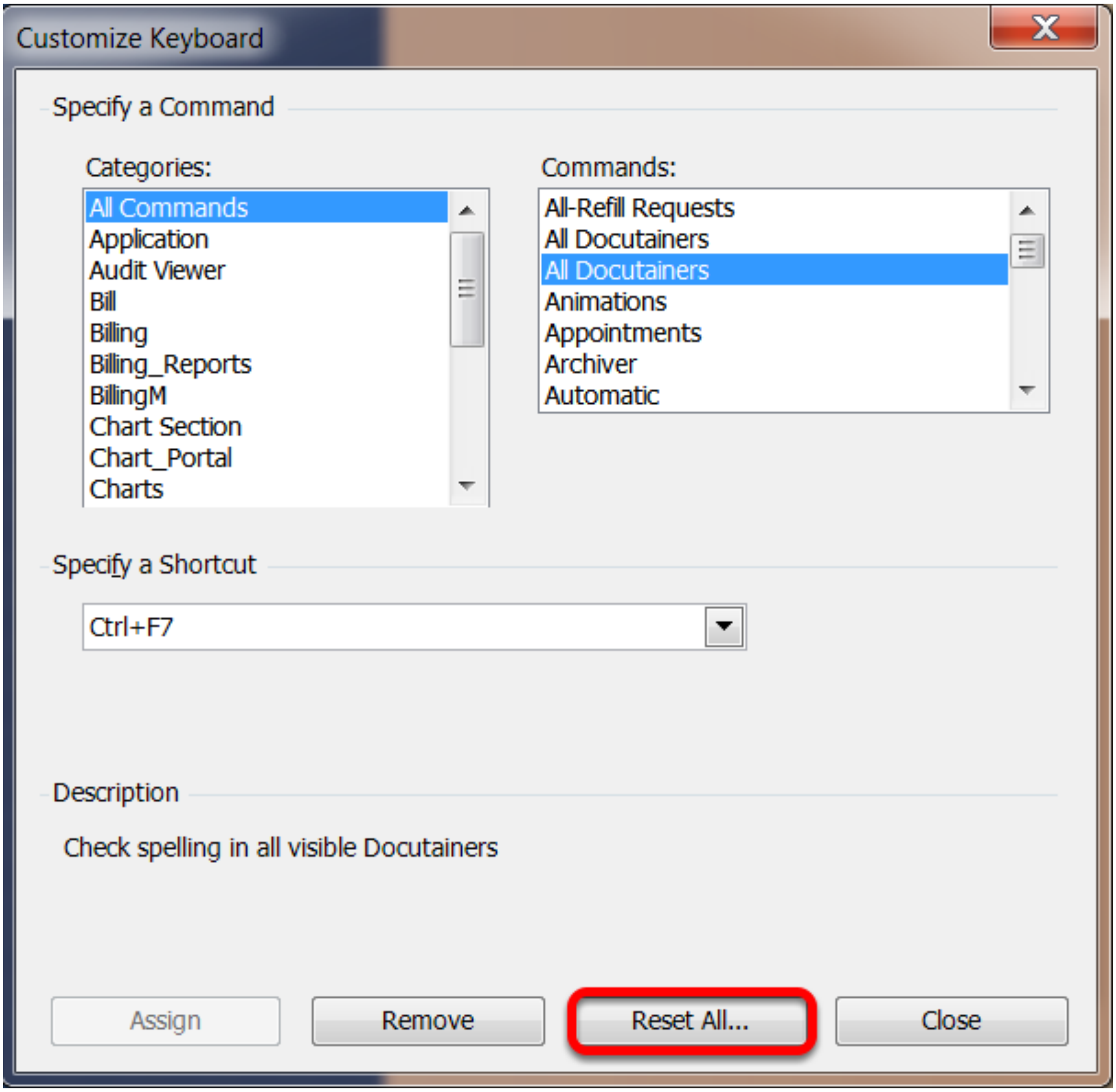
Finally, click the Assign button located at the bottom to assign the selected key-command shortcut to the specified SOAPware command.

Removing a Keyboard Shortcut from a Command



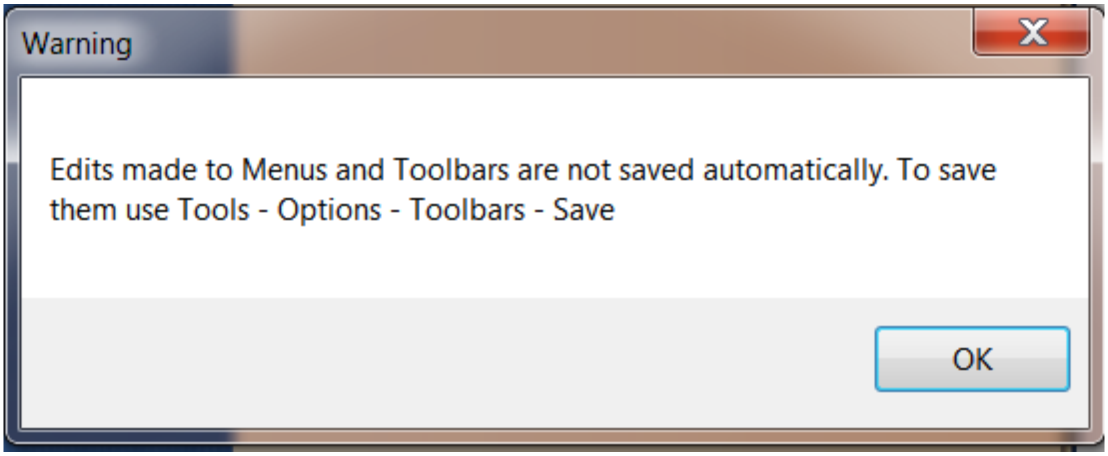
To remove a previously assigned key-command shortcut from a SOAPware command, click the Category list item, then click the command list item, and click the specified Shortcut list item to modify. Once the command is selected, click the Remove button located at the bottom. The shortcut will be removed from the selected command.

Resetting all Keyboard Shortcuts



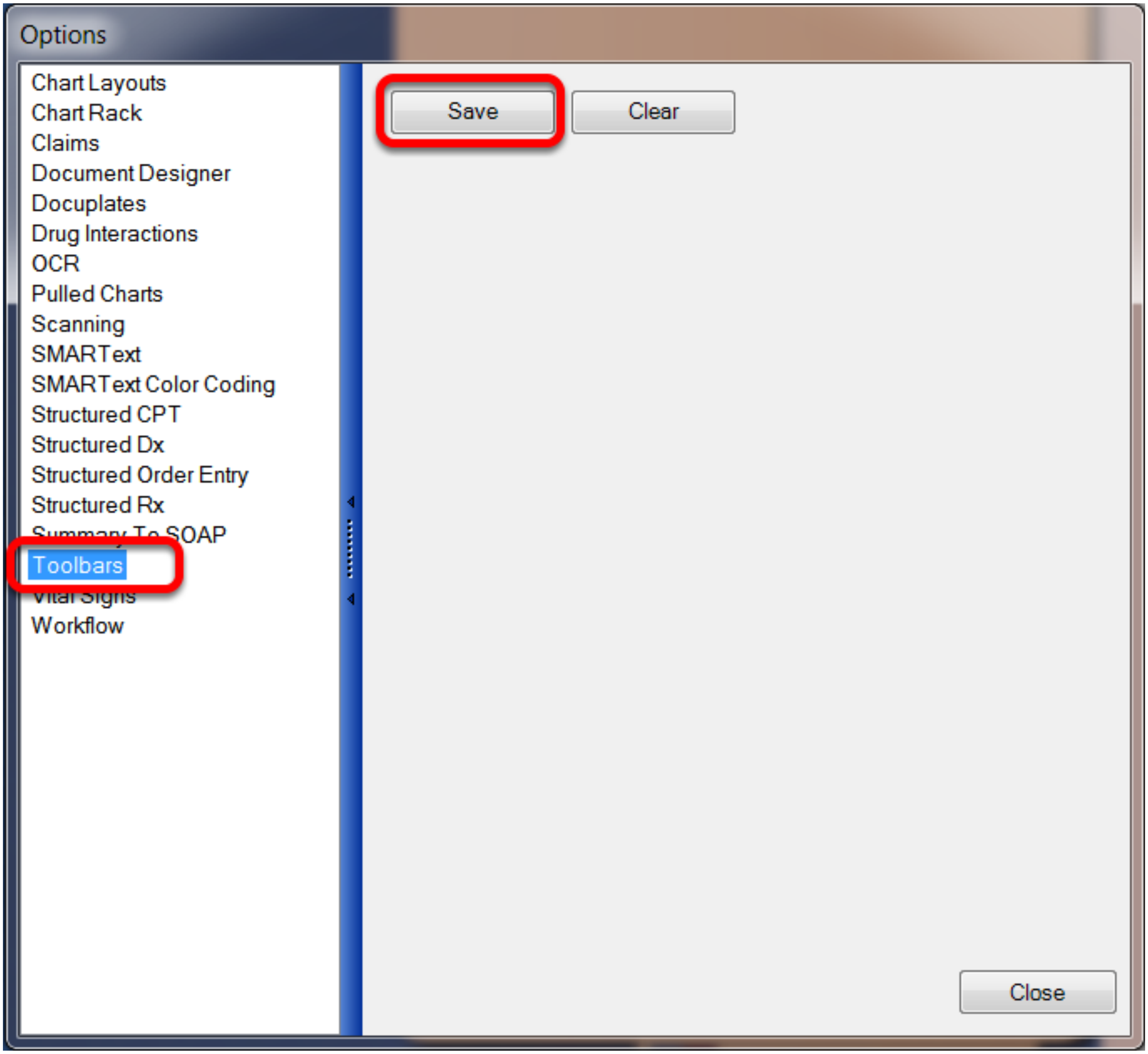
To reset all keyboard shortcuts to their default commands, Click the Reset All... button located at the bottom. SOAPware asks for confirmation. Click Ok to do so, and all key-command shortcuts will be reset to their defaults.

Saving the Changes



Once finished customizing Key Commands, it is necessary to save the changes manually.

Tools - Options



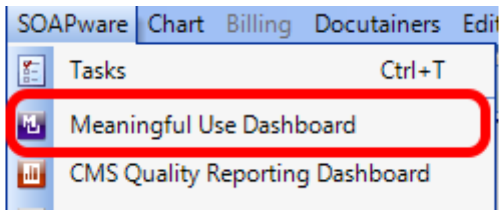
To do this, go to Tools > Options > Toolbars, and click Save. The user must log out and log back into SOAPware to save the changes.

Meaningful Use Dashboard

Meaningful Use Dashboard

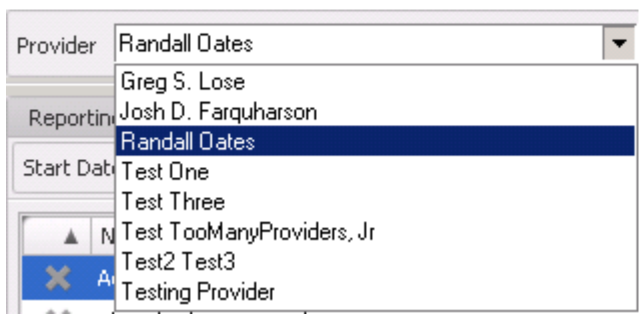
The Meaningful Use Dashboard allows Providers to view, export and trend Meaningful Use usage statistics.

Access the Meaningful Use Dashboard



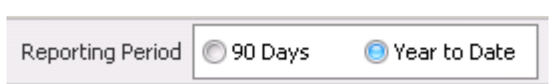
To open then Meaningful Use Dashboard, click on the **Soapware** menu then select **Meaningful Use Dashboard**.

Select a Provider to View



Using the drop-down menu, select the Provider that you wish to view meaningful use statistics for.

Select a Reporting Period Type (90 Day or Year to Date)

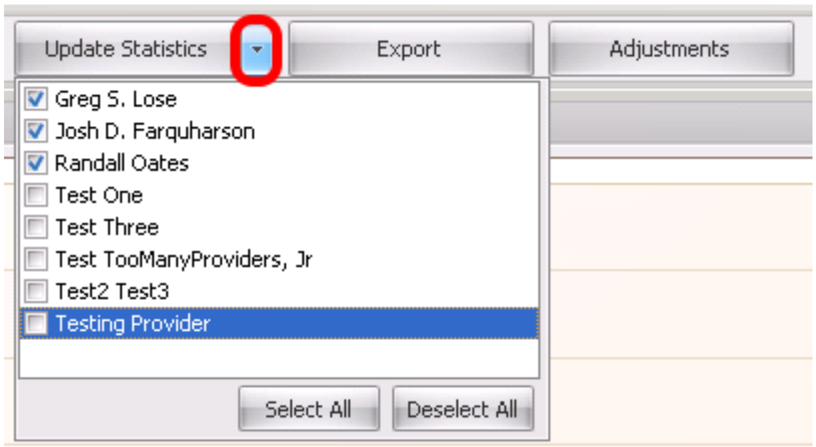


Statistics can be updated for a 90 day reporting period or a Year to Date reporting period. Select the desired option by clicking the radio button located to the left of the desired selection.

- Users who are in their first year of Meaningful Use attestation should select the 90 Days

button.
- Users who are in their second or subsequent years of Meaningful Use attestation should select the Year to Date button to view statistics for January 1st to the current date.

Select Providers to Update Statistics

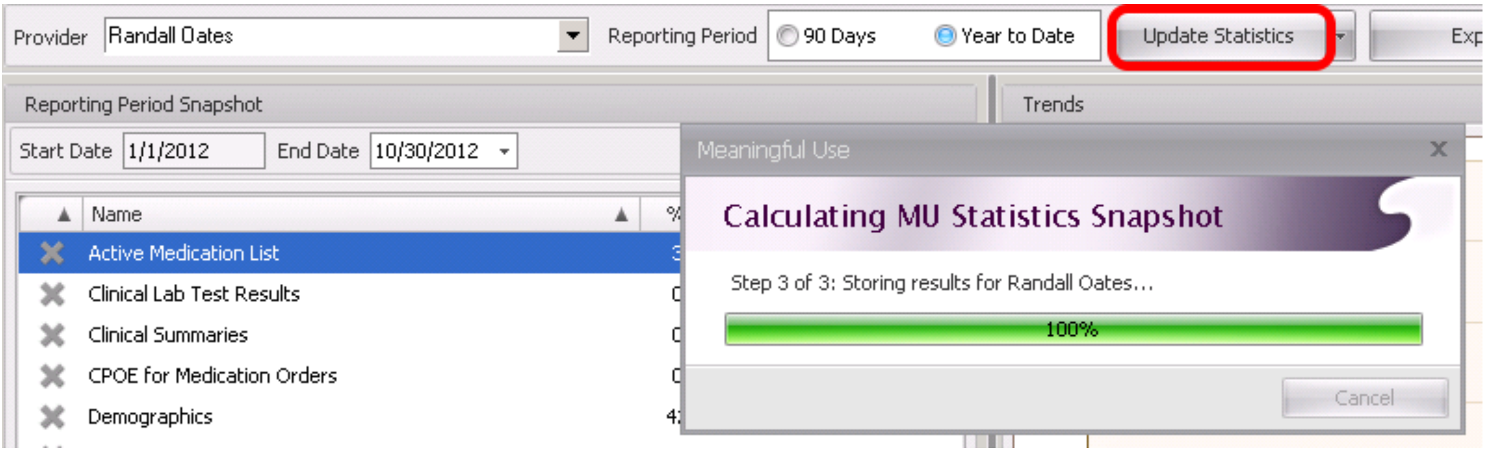


Statistics can be updated for an individual provider, multiple selected providers, or for all providers in the clinic:

- **Individual Provider:** To update the meaningful use statistics for an individual provider, click the drop down menu next to the Update Statistics button and place a check mark next to the inidividual providers name.
- **Multiple Selected Providers:** To update the meaningful use statistics for multiple selected providers, click the drop down menu next to the Update Statistics button and place a check mark next to each providers name that you wish to udpate statistics for.
- **All Providers:** If you wish to update the statistics for all providers in the clinic, click the drop down menu next to the Update Statistics button and then click the Select All button.

By default, this setting will be set to update statistics for All Providers. Once a user had made changes within the Update Statistics drop-down menu, the new settings will be saved for the user so that each time they return to the Meaningful Use dashboard, the Update Statistics provider selections will remain the same.

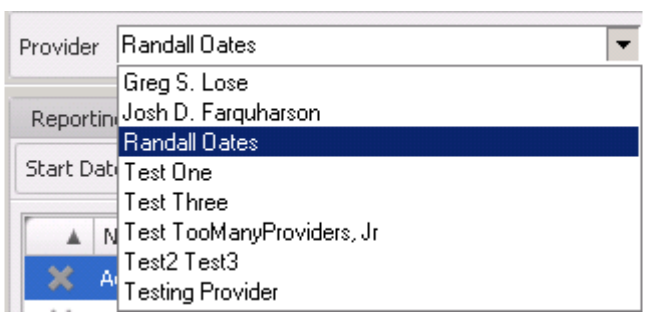
Update Statistics



Click the **Update Statistics** button to run the report. SOAPware will scan the database to report the appropriate statistics.

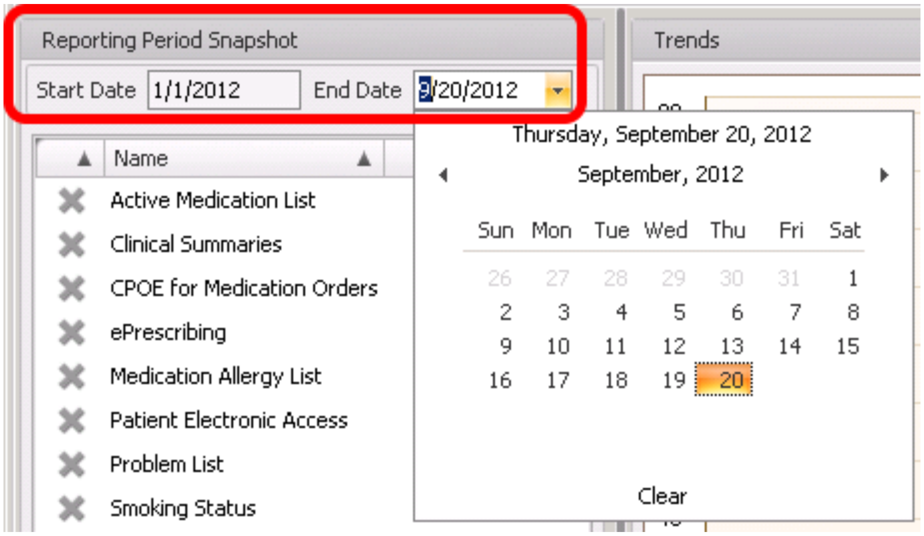
IMPORTANT: Update Statistics must be run for each provider on the final day of the provider's reporting period. If the statistics are not run on the final day of the provider's reporting period, the statistics will not be accurate.

Switching Providers to View



If a user would like to view the Meaningful Use statistics for another provider, simply select the provider using the drop-down menu.

Reporting Period Snapshot Date



The Reporting Period Snapshot will display the Start Date and End Date for the meaningful use statistics that are displayed. The Start Date field is not editable. When a user selects an End Date, the dashboard will automatically calculate the Start Date for the reporting period.

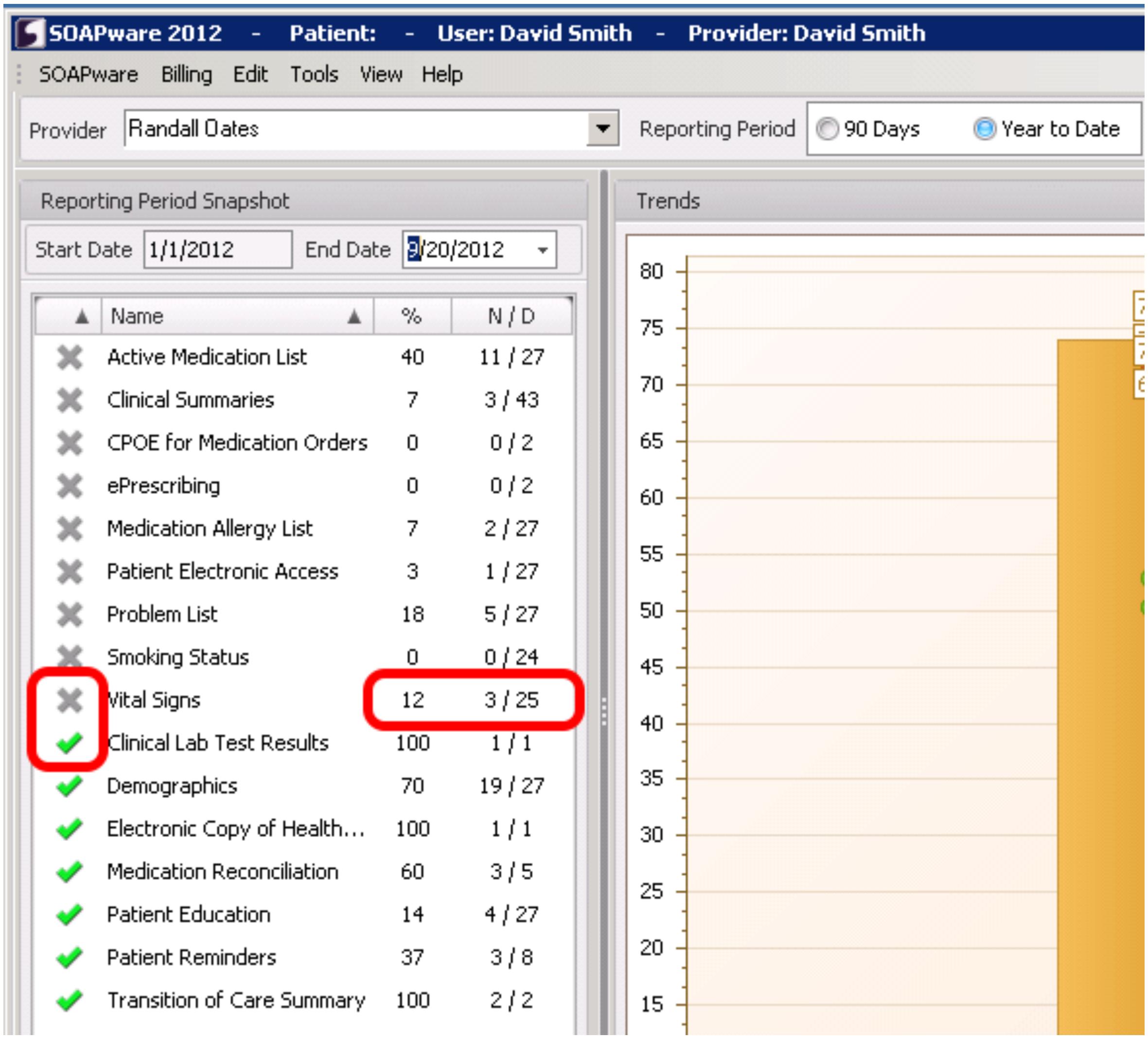
The Start Date will be calculated based on the provider's Reporting Period selection (90 days or Year to Date):

- **90 Days**: The Start Date is 90 days prior to the End Date. The End Date is the current date.
- **Year to Date**: The Start Date is January 1st of the current year. The End Date is the current date.

The Update Statistics function can ONLY be run for the current date. Users cannot select an End Date from the past and update statistics for that previous reporting period. Therefore, it is VERY important that the provider click the Update Statistics button on the final day of their selected reporting period.

If the user wishes to view a snapshot that was run on a previous day, use the calendar drop-down menu to select the snapshot date that you wish to review. Dates that are bolded indicate a snapshot was run on that date and can be viewed.

Meaningful Use Items List

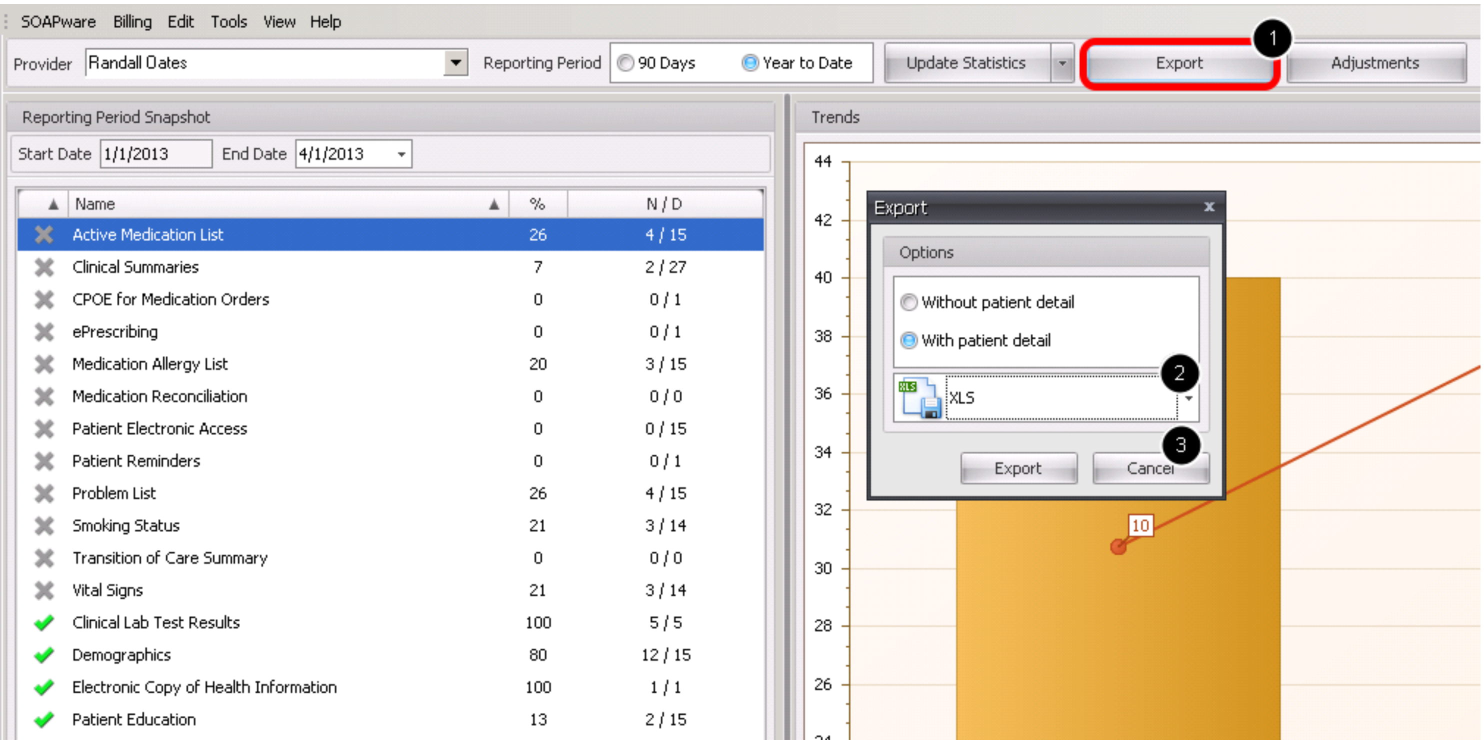


Under the reporting period snapshot date, meaningful use items will be listed.

- **Green Check:** Indicates that the selected provider has met the required threshold for the meaningful use objective.
- **Gray X:** Indicates that the selected provider has not met the required threshold for the meaningful use objective.

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 the Meaningful Use Report



It is recommended that the provider export a copy of the final meaningful use statistics that will be used during attestation. To export the provider's meaningful use statistics for the selected reporting period:

1. Click the **Export** button.
2. Select to export the report **Without patient detail** or **With patient detail**. If you select to export the report with patient detail, this will export two separate files in XLS or CSV format. The first file will contain a report that includes a Summary of the provider's MU statistics. The second file will contain a patient detail report that lists detail for each patient included in all MU numerators/denominators. See the steps below for more information on this report.
3. Using the drop-down menu, select the **File Type** for the export. For the "Without patient detail" report, users may choose between XLS (Excel), PDF, HTML, or CSV. For the "With patient detail" report, users may choose between XLS or CSV.
4. Click **Export** to generate and export the report.

It is recommended that all providers export a copy of the Meaningful Use statistics on the final day of their reporting period. This report should be stored with the providers Meaningful Use documentation in case of an audit.

MU Statistics Export Without Patient Detail

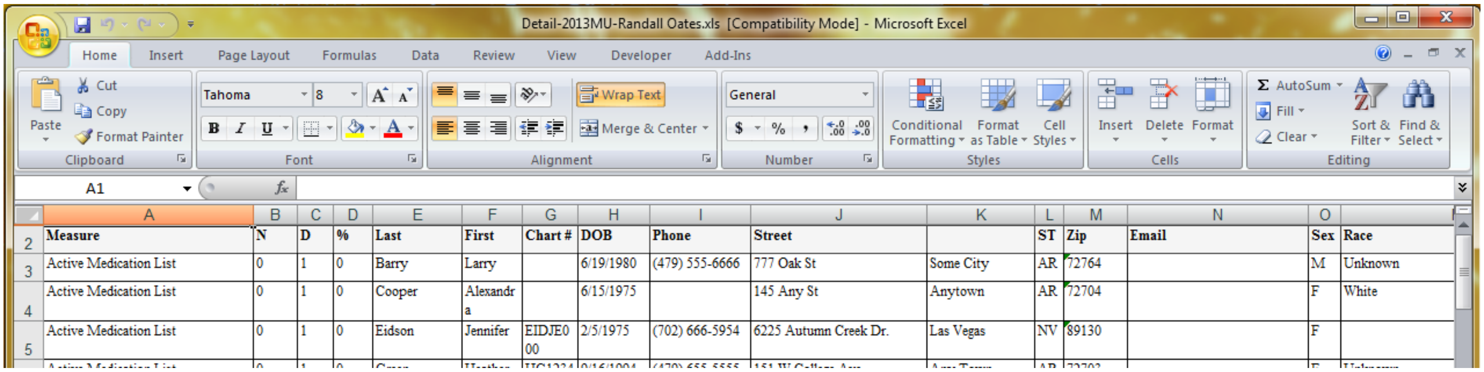
Report Date Range:	1/1/2013 - 4/1/2013
Provider:	Randall Oates

Meaningful Use Measure	Numerator	Denominator	Percentage
Active Medication List	4	15	26.7
Clinical Lab Test Results	5	5	100
Clinical Summaries	2	27	7.4
CPOE for Medication Orders	0	1	0
Demographics	12	15	80.0
Electronic Copy of Health Information	1	1	100
ePrescribing	0	1	0
Medication Allergy List	3	15	20.0
Medication Reconciliation	0	0	0
Patient Education	2	15	13.3
Patient Electronic Access	0	15	0
Patient Reminders	0	1	0
Problem List	4	15	26.7
Smoking Status	3	14	21.4
Transition of Care Summary	0	0	0
Vital Signs	3	14	21.4

The above image is an example of an exported MU Statistics report that does not include patient detail. This report will include the selected report date range, provider name, and a list of each MU measure with the corresponding numerator, denominator and percentage.

This report should be exported at the end of the Eligible Provider's reporting period and stored with the provider's Meaningful Use documentation in case it is needed for audit.

MU Statistics Export With Patient Detail

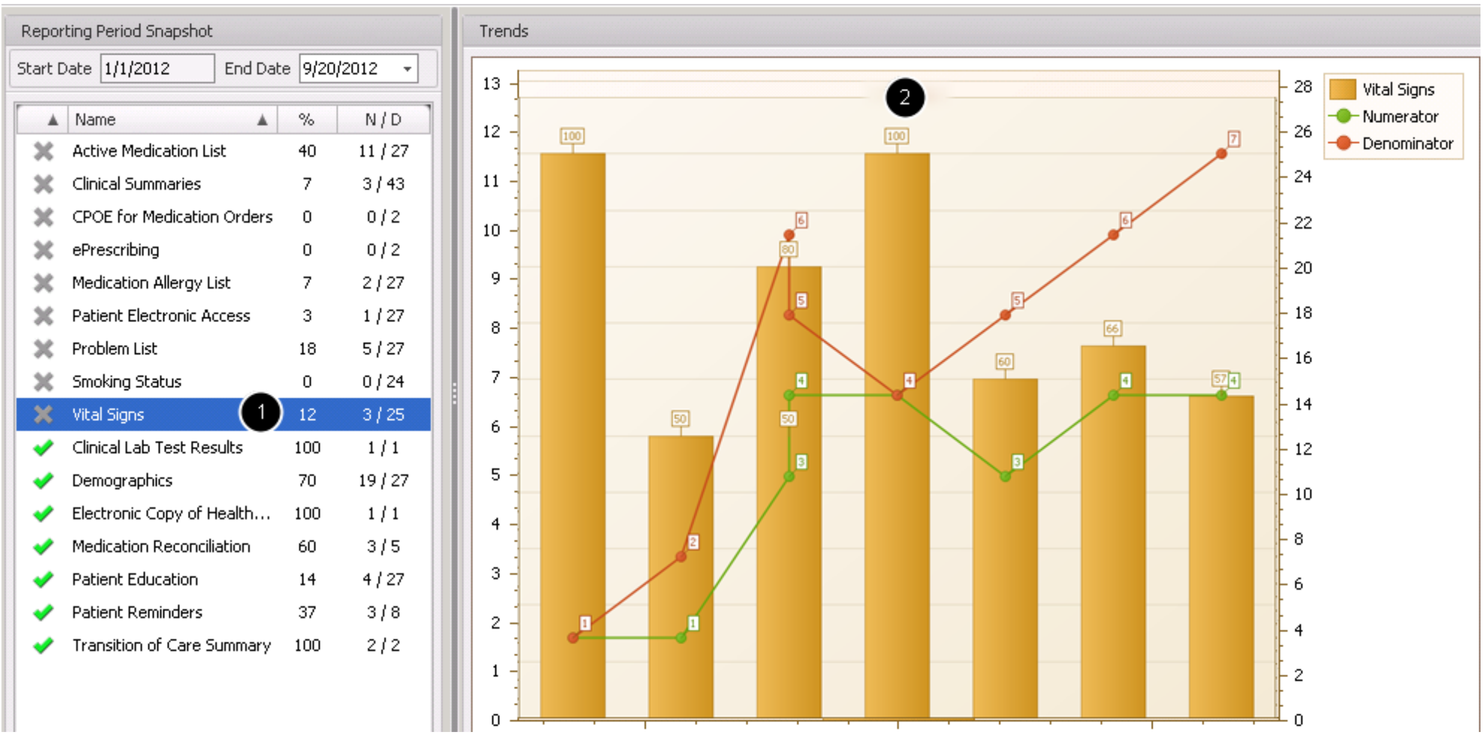


Measure	N	D	%	Last	First	Chart #	DOB	Phone	Street		ST	Zip	Email	Sex	Race
Active Medication List	0	1	0	Barry	Larry		6/19/1980	(479) 555-6666	777 Oak St	Some City	AR	72764		M	Unknown
Active Medication List	0	1	0	Cooper	Alexandra		6/15/1975		145 Any St	Anytown	AR	72704		F	White
Active Medication List	0	1	0	Eidson	Jennifer	EIDJE000	2/5/1975	(702) 666-5954	6225 Autumn Creek Dr.	Las Vegas	NV	89130		F	

The above image is an example of an exported MU Statistics report that includes patient detail. This export will include a Summary report, as well as a Patient Detail report. The Summary report and Patient Detail report are exported as separate files.

1. **Summary Report:** The summary report includes the selected report date range, provider name, and a list of each MU measure with the corresponding numerator, denominator and percentage. This report should be exported at the end of the Eligible Provider's reporting period and stored with the provider's Meaningful Use documentation in case it is needed for audit.
2. **Patient Detail Report:** The patient detail report includes a list of Meaningful Use measures along with the patient information for patients included in the numerator or the denominator for that measure. The patient detail information includes the following items: numerator, denominator, %, Last name, First name, Chart #, DOB, Phone, Street, City, ST, Zip, Email, Sex, Race, Ethnicity, Language, Last Encounter date and time, Primary Insurance.

Trend Graph

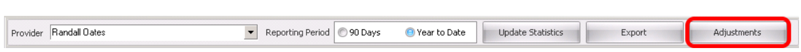


The Meaningful Use Dashboard allows users to view a graph of the trend for each meaningful use requirement that is listed on the dashboard. To view the graph:

1. Highlight the Meaningful Use measure that you wish to view a trend graph for.
2. The trend graph will display based on the measure and reporting period snapshot dates selected.

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

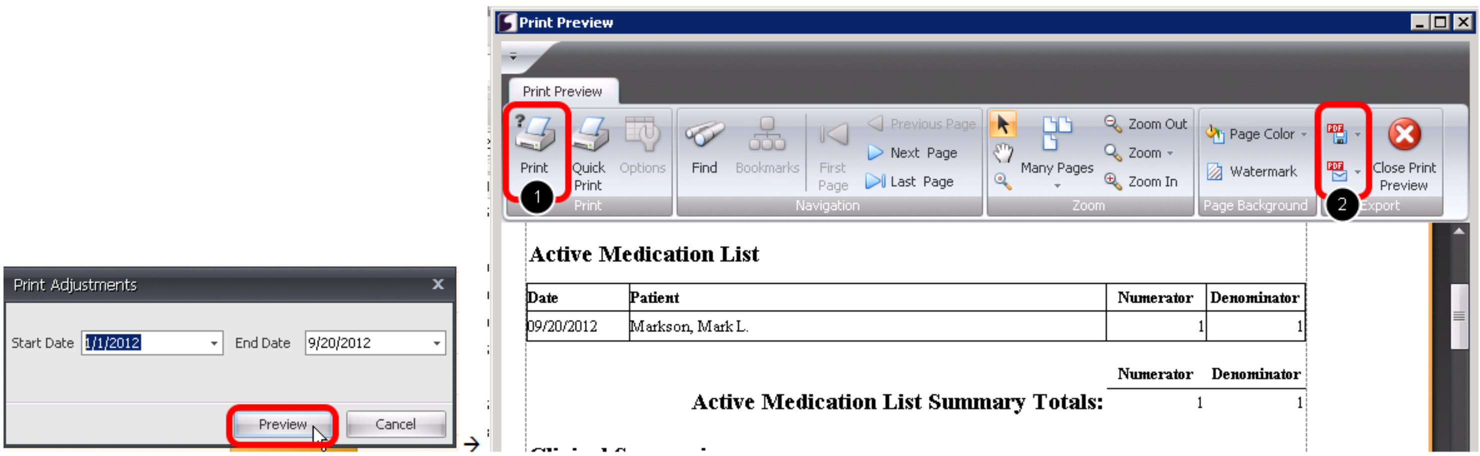


The MU dashboard will automatically calculate each MU criteria as interpreted by the actions and documentation performed in SOAPware. In some instances providers might interpret a measure differently. Adjustments are made on the Patient MU dashboard within the Chart workspace at the point of care.

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.** The eligible provider will be responsible for manually making adjustments at the time of self attestation and will be responsible in tracking the manual adjustment made, along with the reason they were made, in case of a future audit.

To view and export adjustments made at the point of care, select a Provider, then click on the **Adjustments** button.

Printing Adjustments



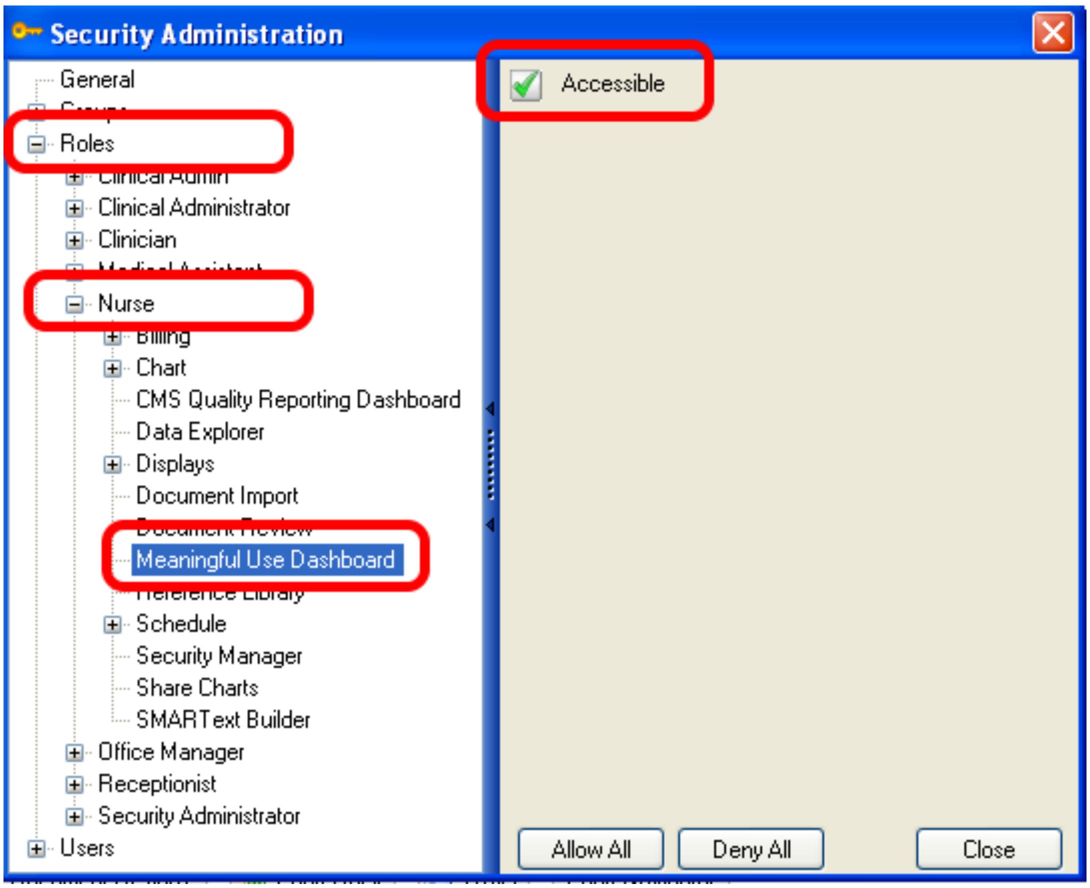
After the Adjustments button is clicked, the user is now presented with the Print Adjustments dialog where the Start Date and End Date for the adjustments report can be selected. By default, the Start Date and End Date will be populated with the provider's selected reporting period (90 day or Year to Date). After verifying the dates for the report, the user can preview the report prior to printing by clicking the **Preview** button.

Adjustments will display the date that the adjustments was entered, along with the patient name and numerator/denominator adjustment.

1. To print the report click on the **Print** button.
2. If the user wishes to export the report (to PDF, CSV, etc.) click the drop down menu and select the desired method of export.

If adjustments are recorded, this report should be generated at the end of the Eligible Provider's reporting period and stored with the provider's Meaningful Use documentation in case it is needed for audit.

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 on changing security privileges for Roles/Groups.

Keeping Support Documentation for Meaningful Use Audits

Providers who attest to Meaningful Use for either the Medicare or Medicaid EHR Incentive Program may potentially be selected for an audit.

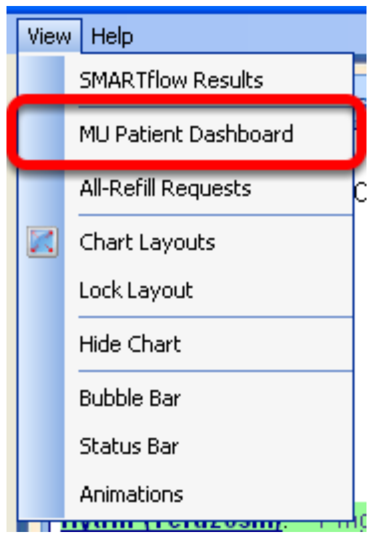
It is the providers responsibility to maintain supporting documentation in case of a future audit. For more information on maintaining the appropriate supporting documentation for audits, please refer to the following guidance from CMS: **EHR Incentive Programs Supporting Documentation for Audits.**

Meaningful Use Patient Dashboard

Patient Meaningful Use Dashboard

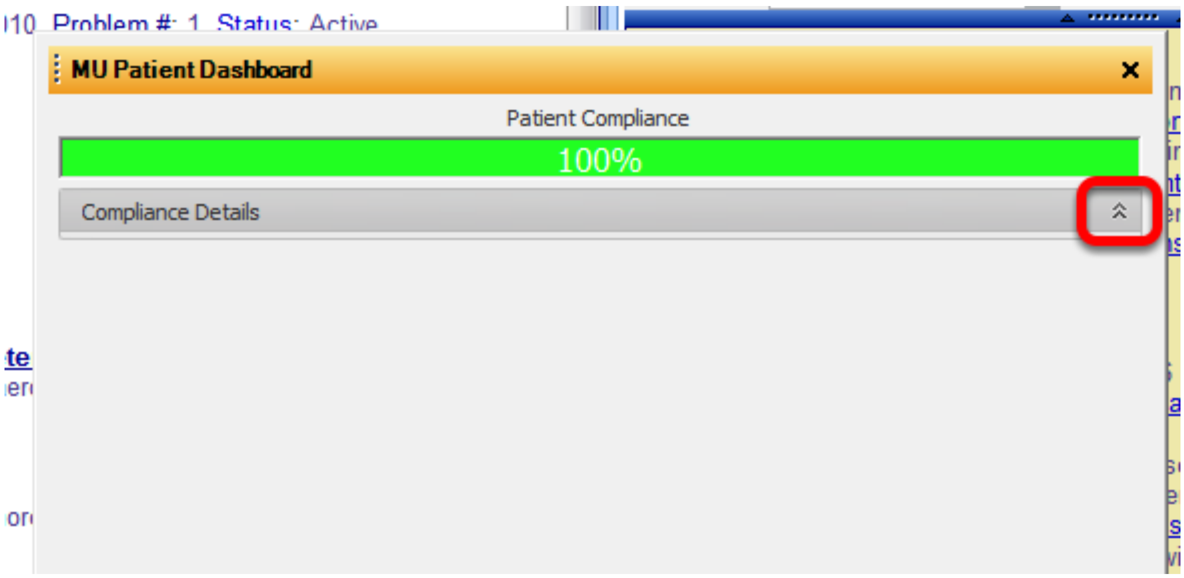
The MU Patient Dashboard is a tool used to track the compliance of an individual patient with Meaningful Use requirements as well as a location to trigger the Meaningful Use work flows. This lesson focuses on highlighting how to use the dashboard and what information is being represented for this patient.

Opening the Dashboard



To access the MU Patient Dashboard, begin by opening the patient's chart. Then, Click on View > MU Patient Dashboard.

Dashboard

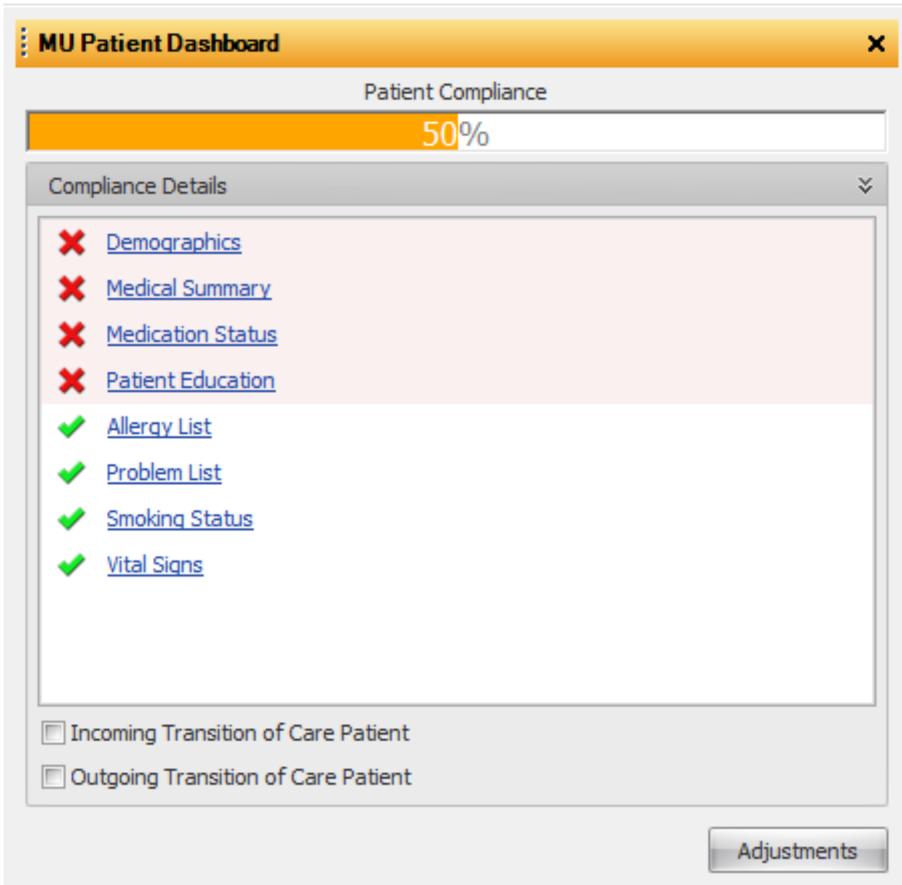


When the dashboard first opens, the patient compliance displays, represented by a percentage. To view the individual areas of compliance, the user may need to Click on the small arrows to the right of the compliance details to drop-down the additional information.

Compliance Details

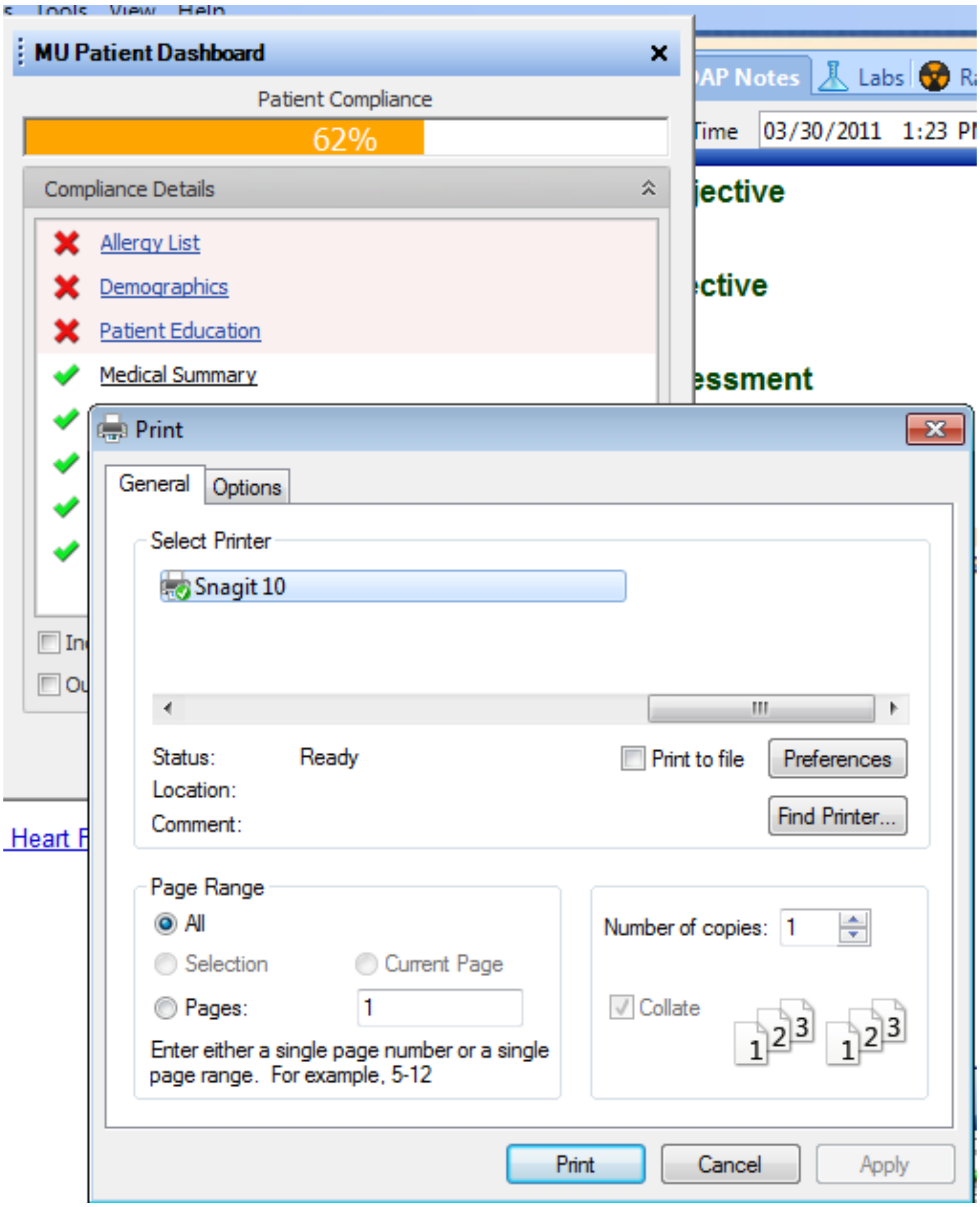
The detailed list displays the areas of Meaningful Use for this patient. To record any of the necessary information, simply click on the underlined item. The above example shows a patient whom is currently meeting all of the MU Requirements.

Areas Not Met



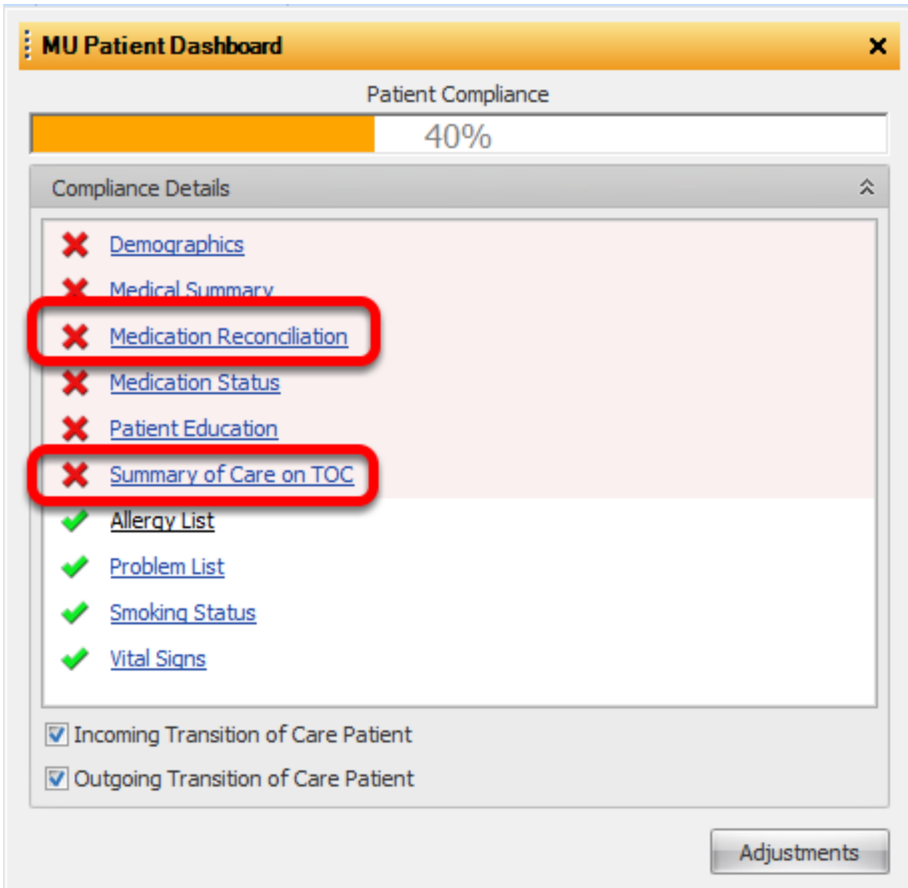
If an area of Meaningful Use is not met for this patient, the item will be represented with a red X next to the underlined item, with a red highlight behind it. The Patient Compliance percentage will also reflect that the patient is not meeting 100% of the patient-specific Meaningful Use requirements.

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

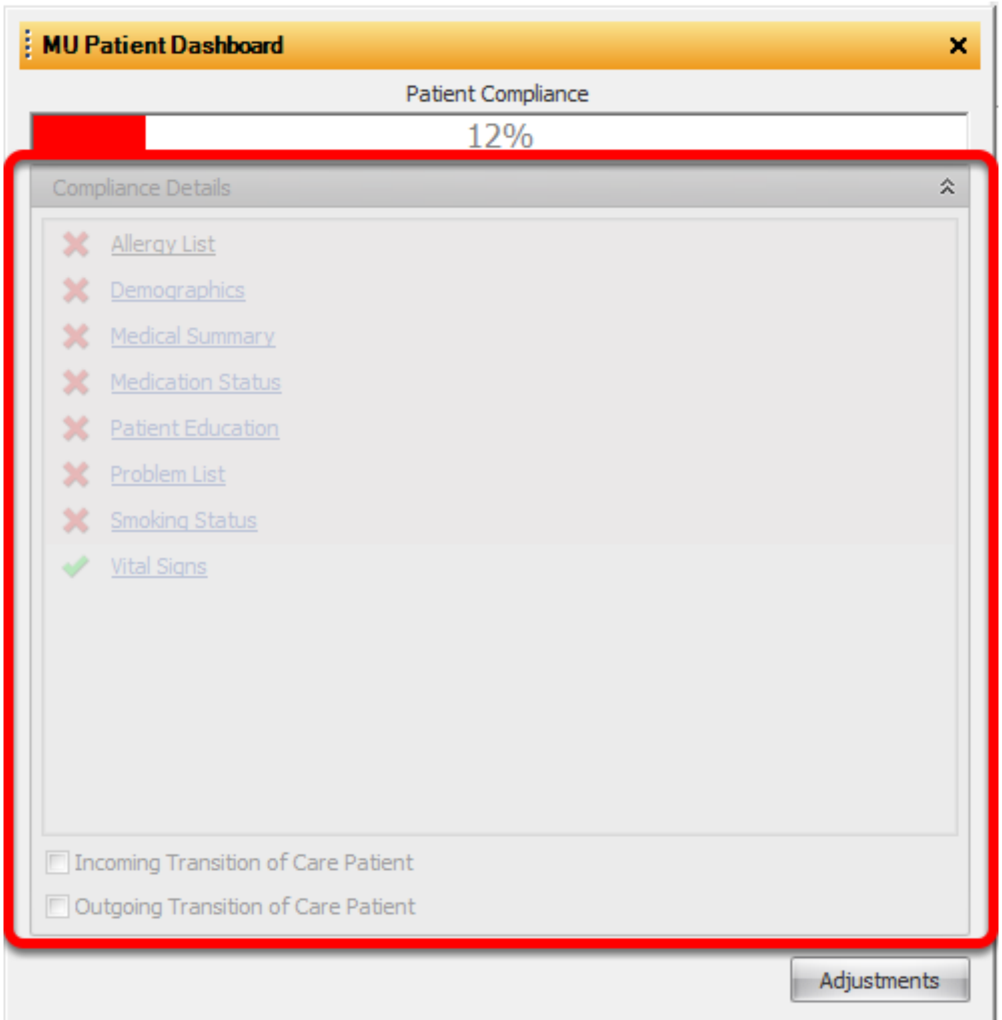


In addition, notice the Incoming and Outgoing "Transition of Care Patient" boxes at the bottom. These will both default to be unchecked, but checking each box will add additional items for "Summary of Care on TOC" and for "Medication Reconciliation" to the above list.

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.

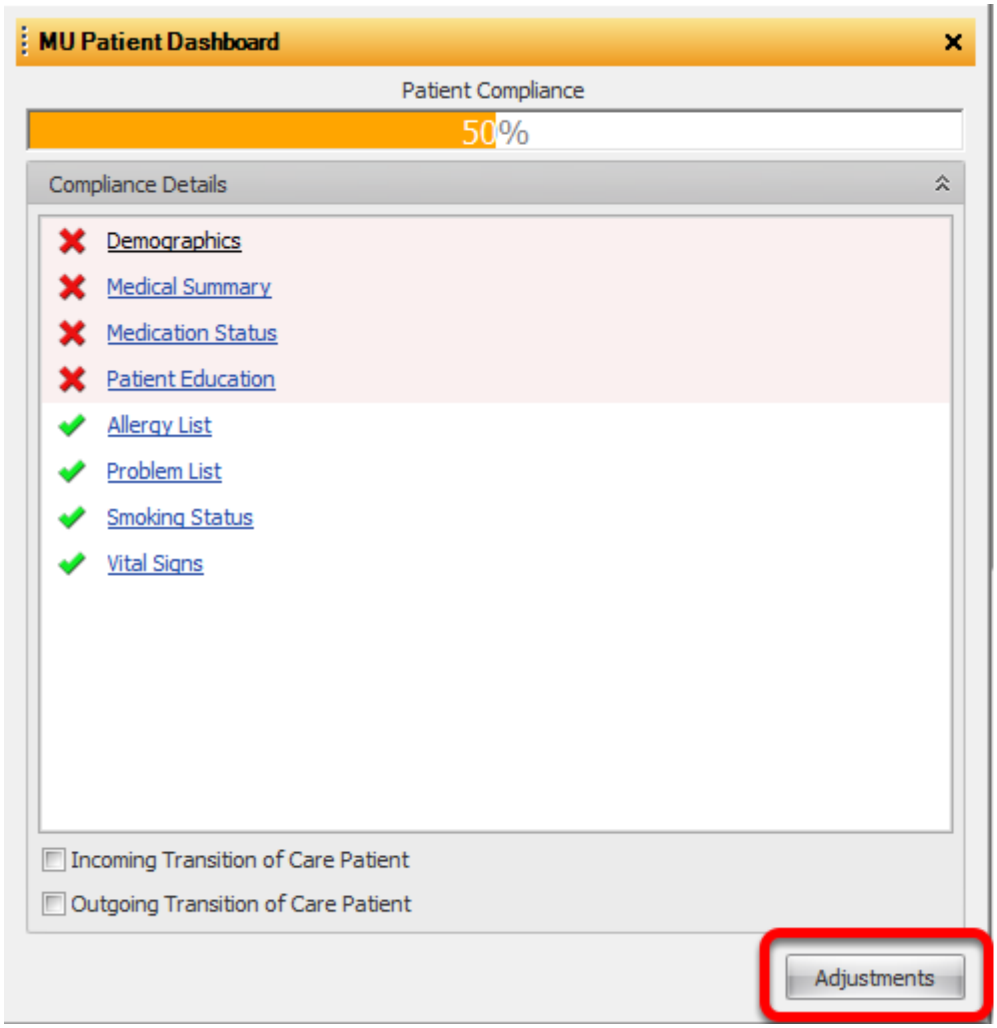
Patient MU Dashboard Grayed Out



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.

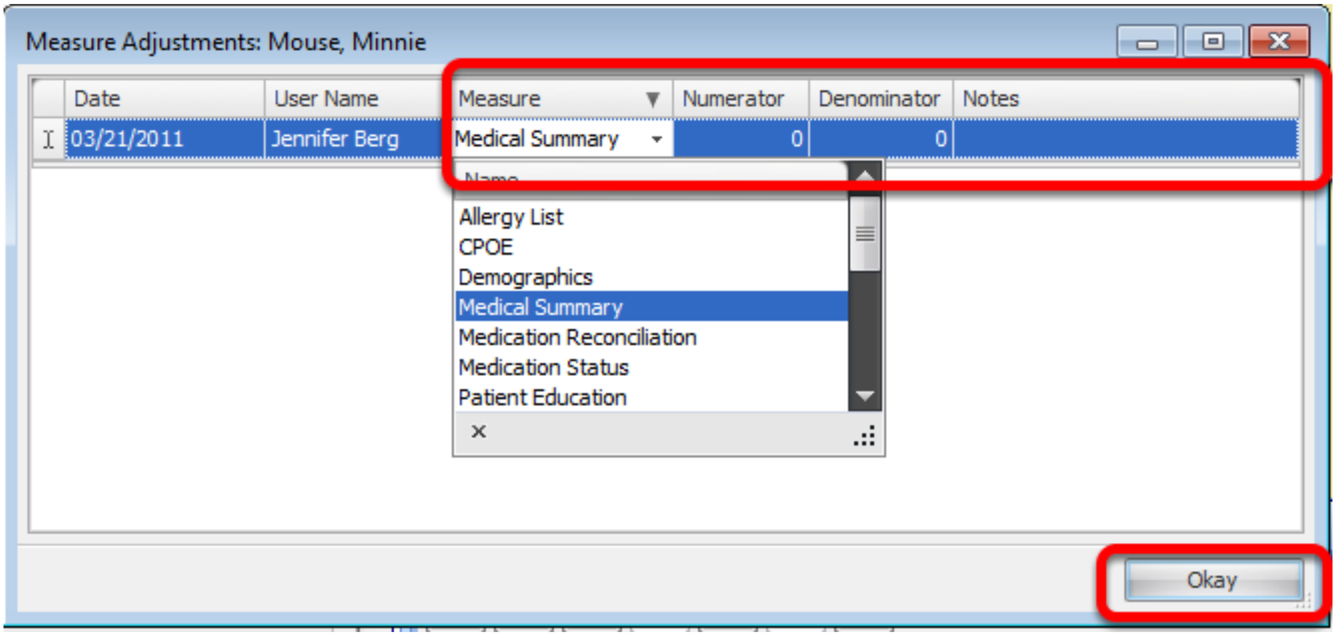
Adjustments



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.

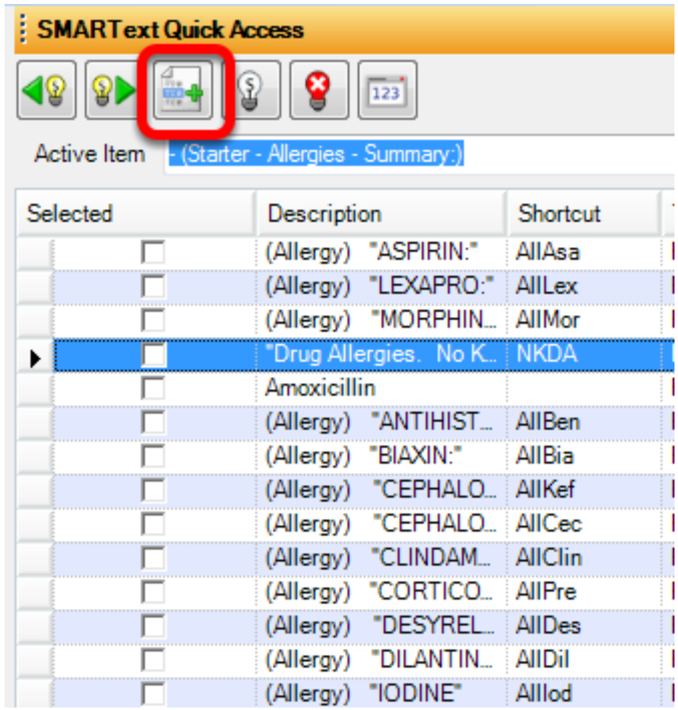
Entering Adjustments



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.

Allergy List



Items entered using the pick list all- or via the F11/ Shift F11 Method will calculate on the Patient MU Dashboard.

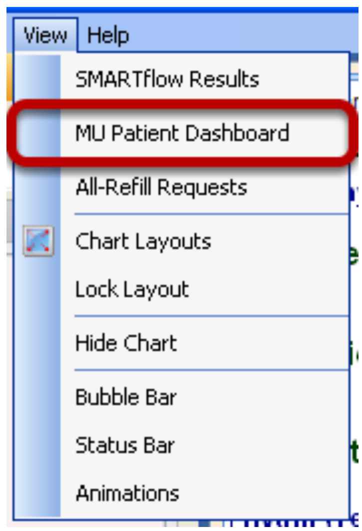
If Allergies have been added to the All- pick list using the Quick Entry Method in the SMARText Quick Access, these items when selected WILL NOT Trigger the Patient MU Dashboard. To add allergy items to the All- Pick list this will need to be edited in the SMARText Items Manager. Allergy Items must be 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

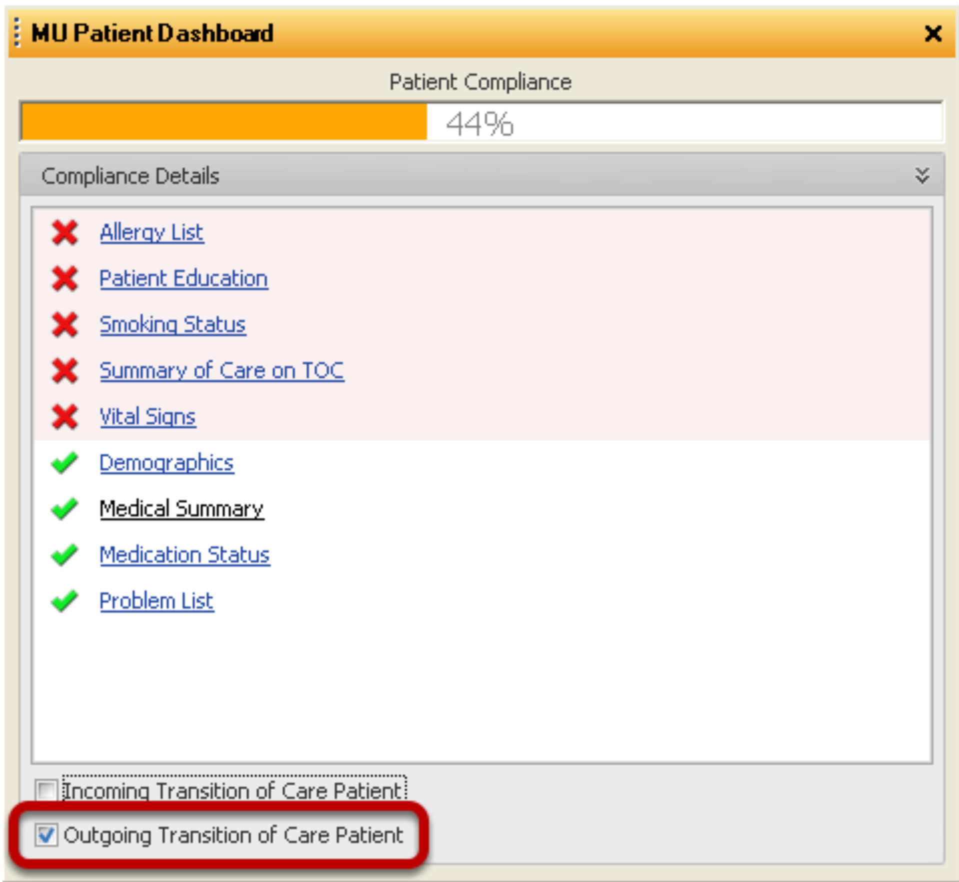
Opening the MU Patient Dashboard



Click on View > MU Patient Dashboard.

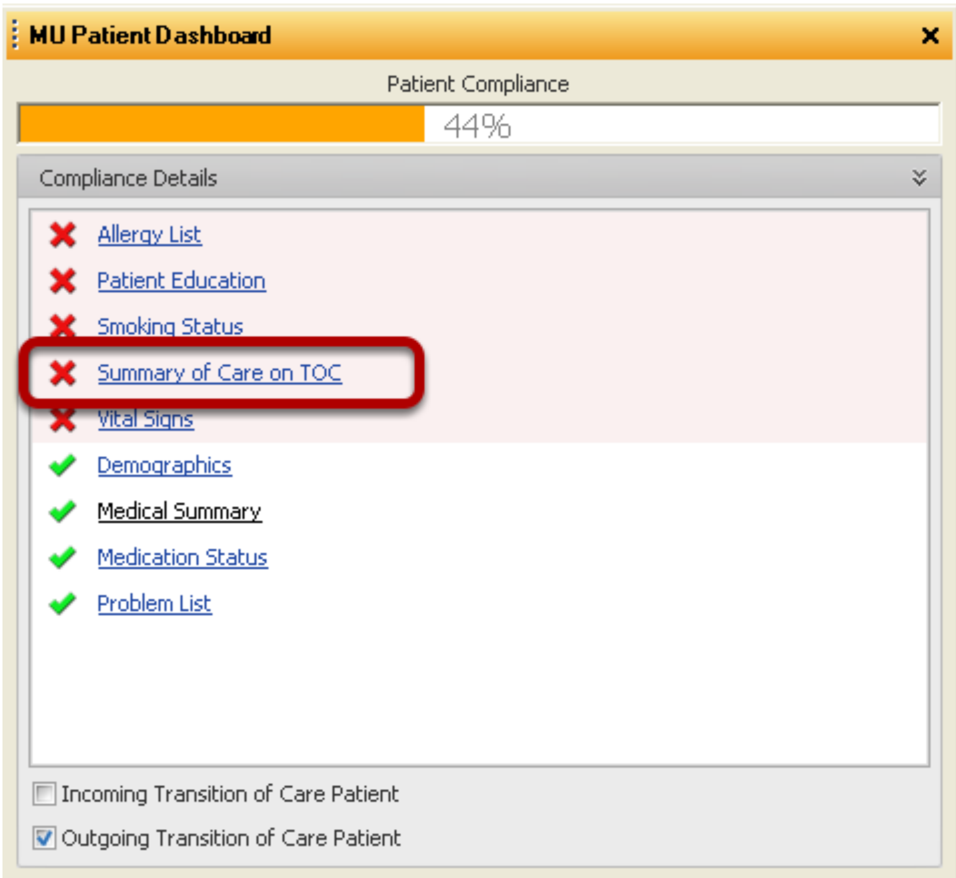
***Note**: Make sure that a patient's chart is open and that the patient has an active encounter during the time period the analytics are being gathered.

MU Patient Dashboard - Outgoing Transition of Care Patient



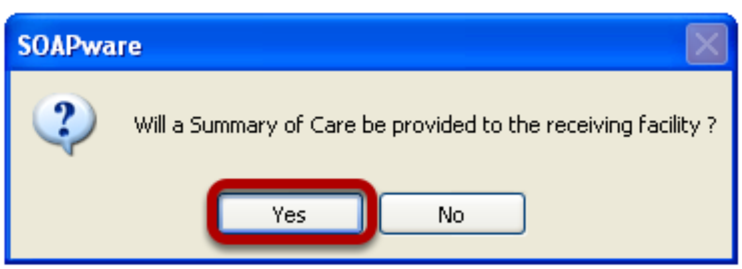
At the bottom of the MU Patient Dashboard, Click in the box next to "Outgoing Transition of Care Patient" to indicate that this patient is being transitioned or referred to another setting of care or provider of care.

Printing a Transition of Care (TOC) Summary



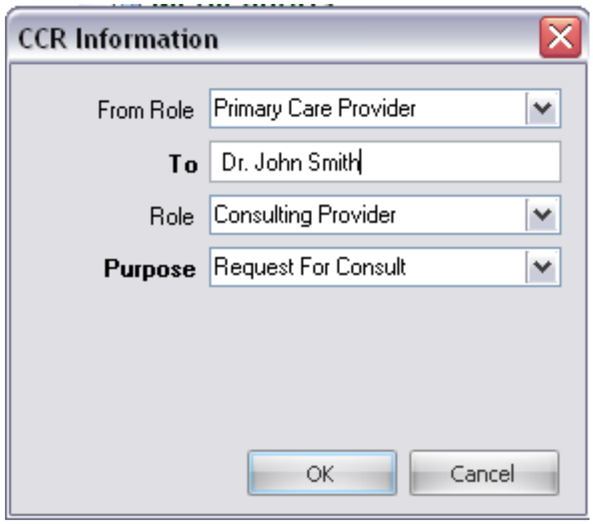
After checking the "Outgoing Transition of Care Patient" box, a new item will appear in the MU Patient Dashboard. Click on the words "Summary of Care on TOC."

Printing a TOC Summary: Verification Prompt



Click "Yes" to indicate that a Transition of Care Summary is being provided to the receiving facility.

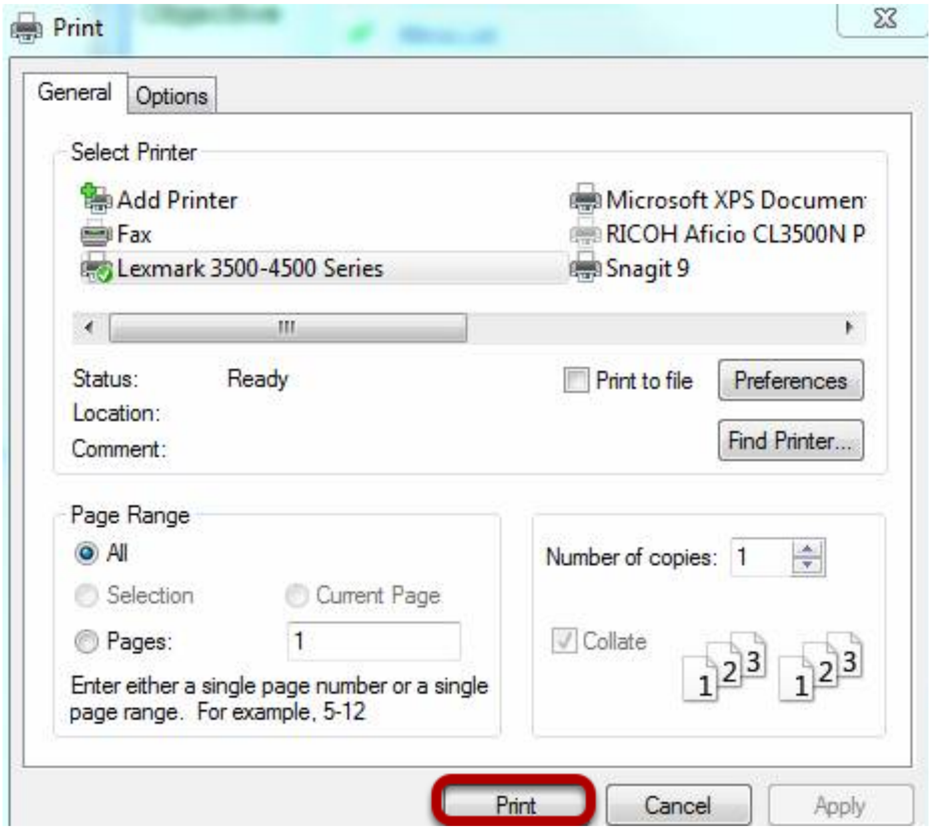
Printing a TOC Summary: CCR Information



Using the drop-down menu options, fill out the appropriate information.

Click OK when finished.

Printing a TOC Summary: Print Dialog



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

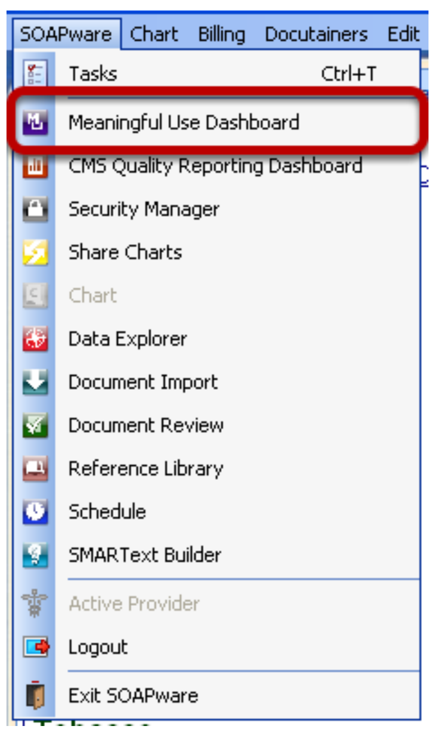
Date Created	From	To	Purpose
Wed Jul 13, 2011 at 07:54 PM UTC	Krista Laningham (Primary Care Provider)	Dr. John Smith (Consulting Provider)	Request For Consult

Patient Demographics

Name	Date of Birth	Gender	Identification Numbers	Address	Phone
Slim A. Jim	Mar 21, 2006	Male	MRN 68332 SSN 999999999	Home Address 1539 COUNTY LINE RD Home Town, AR72711	Home Phone 5015557110 Work Phone 5015559000

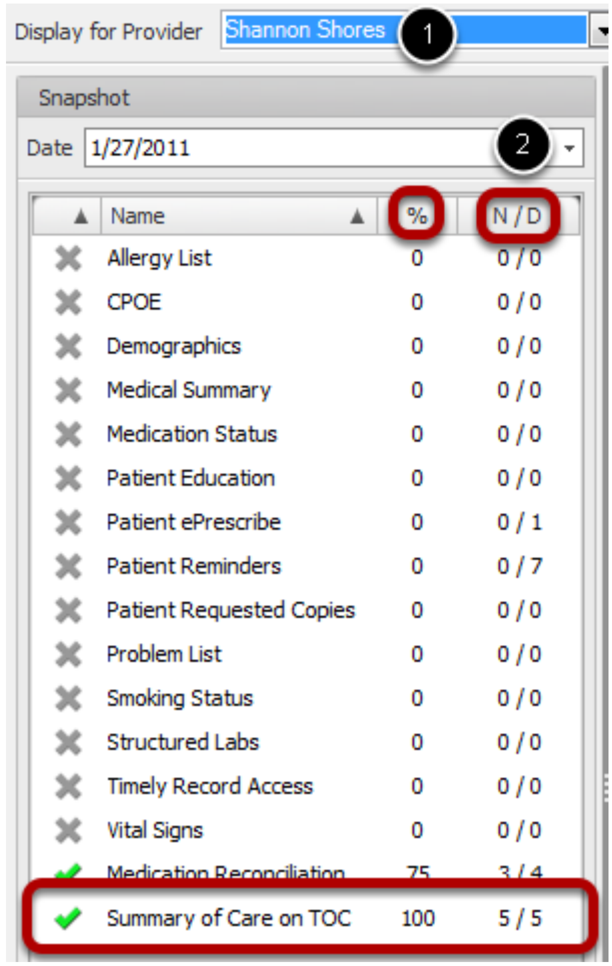
Above in an example of the beginning of the printed TOC Summary in CCR format.

Meaningful Use Dashboard - Outgoing Transition of Care



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



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. Agray X means that the meaningful use requirement has not yet been met.

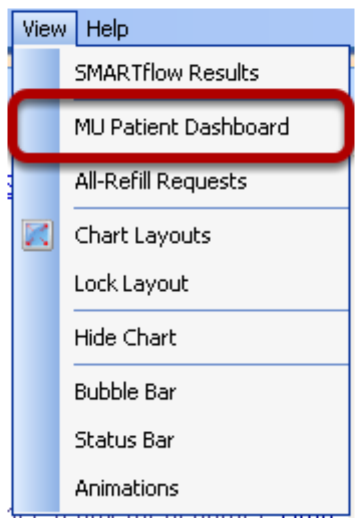
Auser is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.

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.

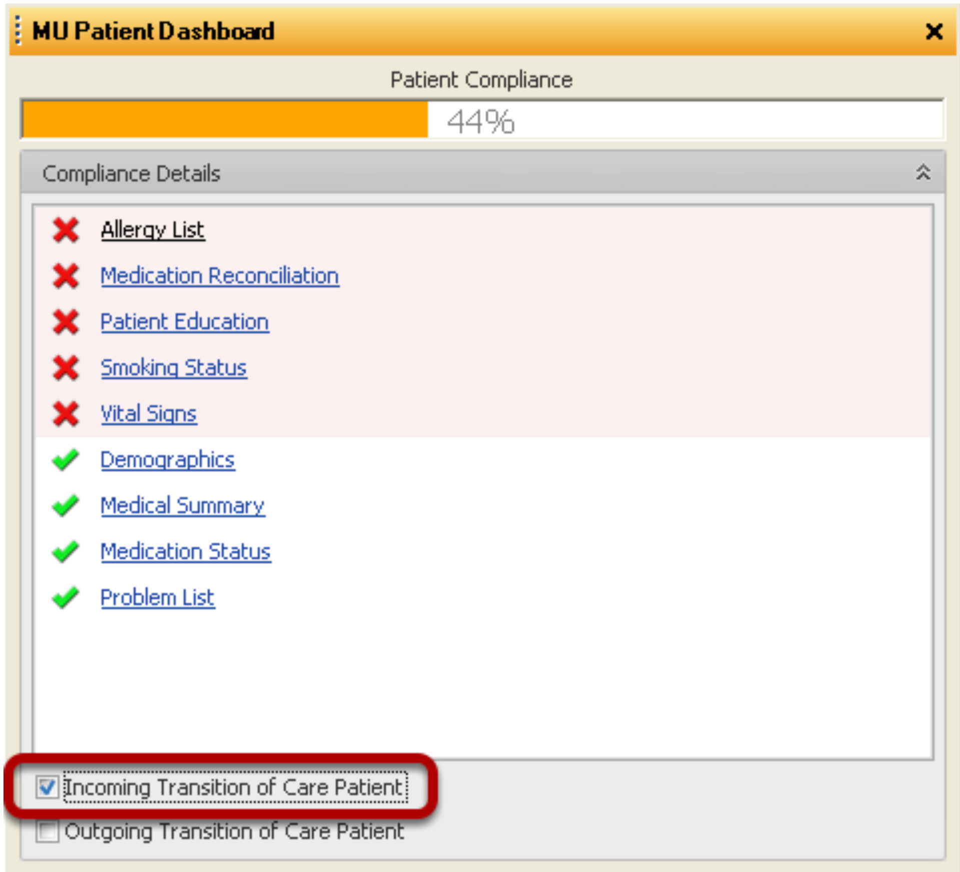
Opening the MU Patient Dashboard



Click View > MU Patient Dashboard.

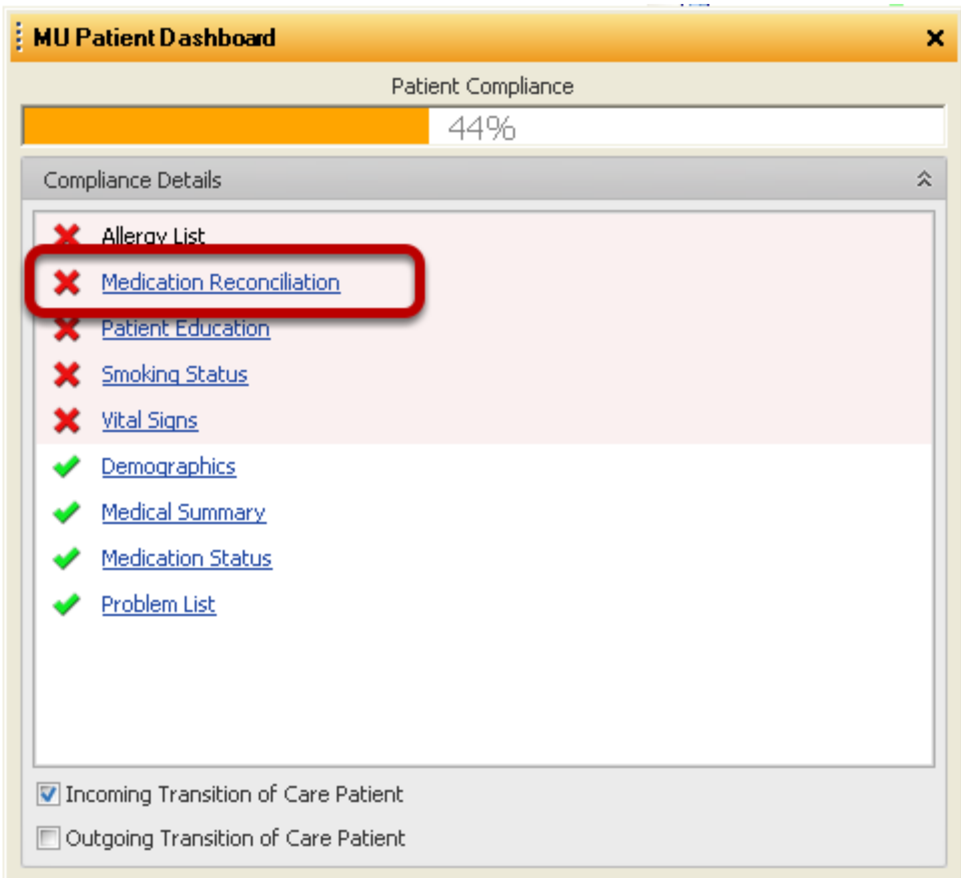
***Note**: Make sure that a patient's chart is open and that the patient has an active encounter during the time period the analytics are being gathered.

MU Patient Dashboard - Incoming Transition of Care Patient



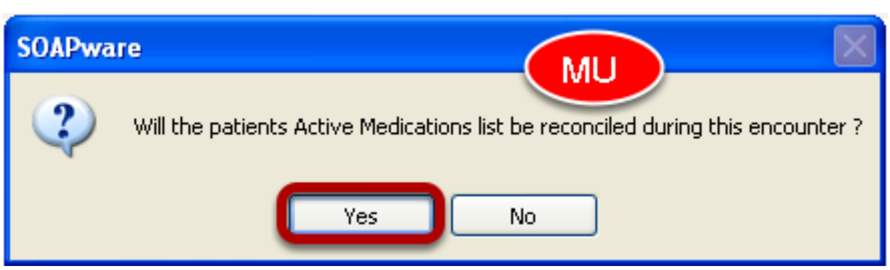
At the bottom of the MU Patient Dashboard, Click in the box next to "Incoming Transition of Care Patient" to indicate that this patient is being received from another setting or provider of care.

Indication that Medication Reconciliation has Been Performed



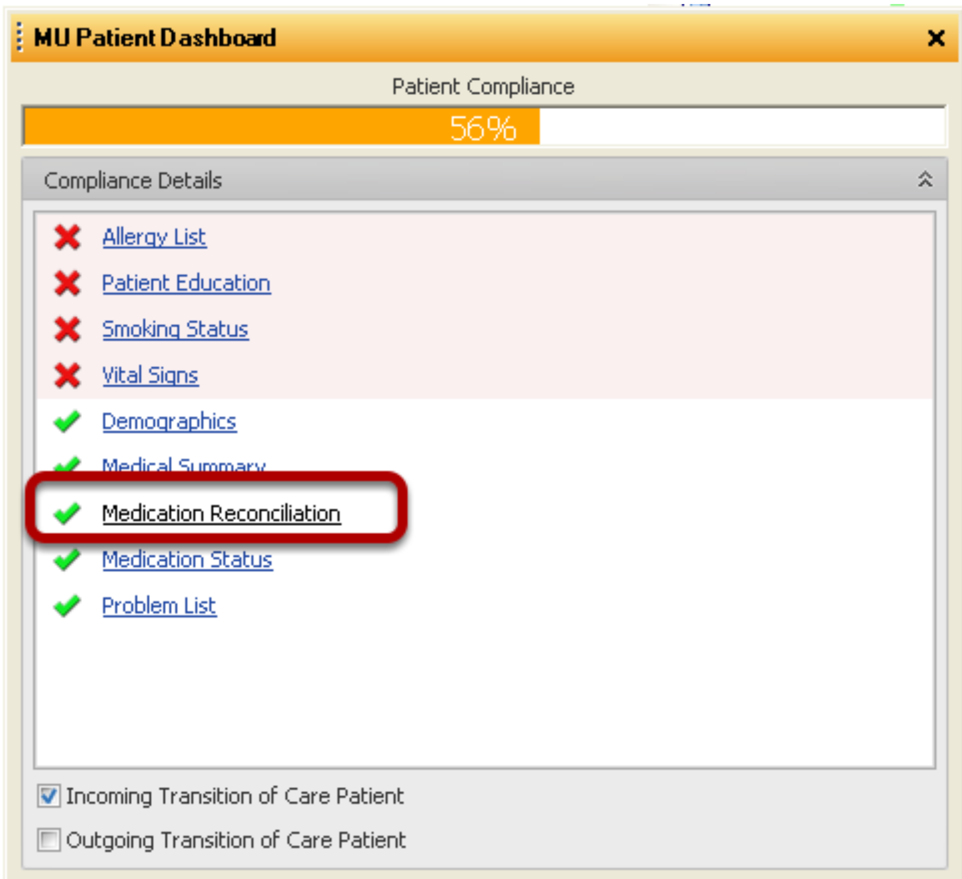
After checking the "Incoming Transition of Care Patient" box, a new item will appear in the MU Patient Dashboard. Click on the words "Medication Reconciliation".

Medication Reconciliation Prompts



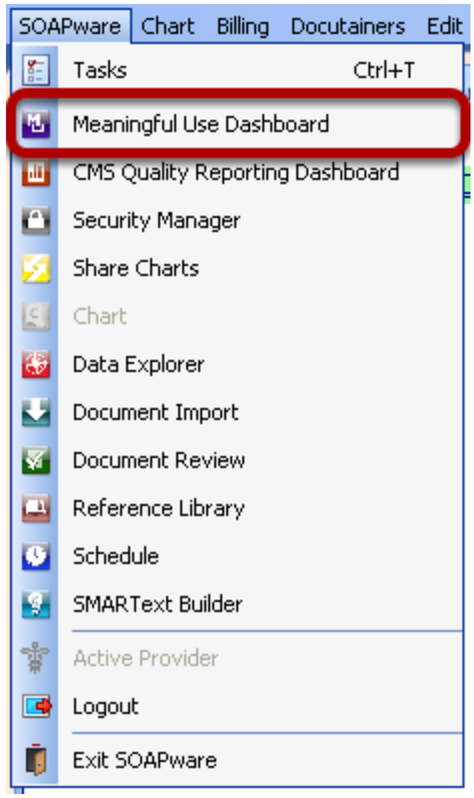
Click "Yes" to indicate that the active medications list will be reconciled during the encounter.

Confirmation within the MU Patient Dashboard



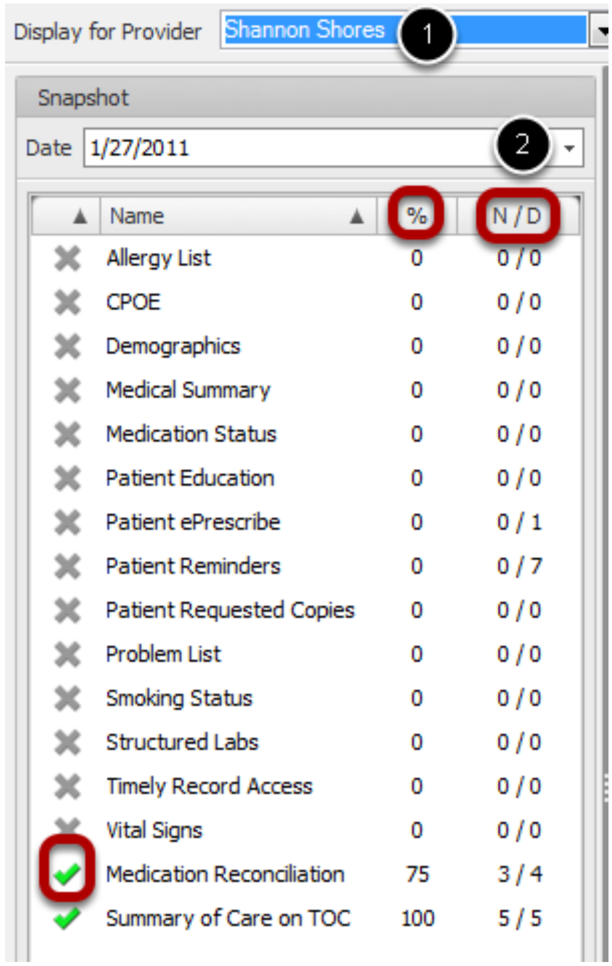
Agreen check mark will replace the red X, to the left of Medication Reconciliation, once the user has acknowledged that the patients Active Medications list will be reconciled during the encounter.

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



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.

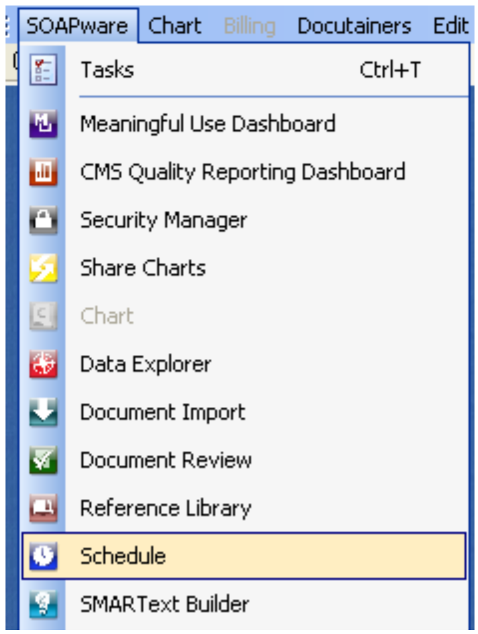
Auser is also able to view the percentage met for a particular provider, as well as the numerator and denominator, to the right of the Meaningful Use item.

Schedule

Intro to Schedule

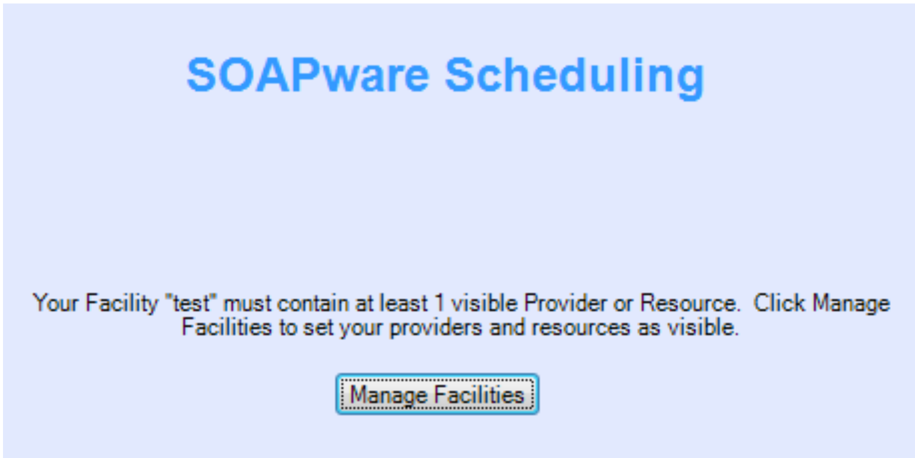
SOAPware Schedule is an integrated scheduling application that shares information with SOAPware as needed. Therefore, the SOAPware Schedule workspace runs inside of SOAPware.

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

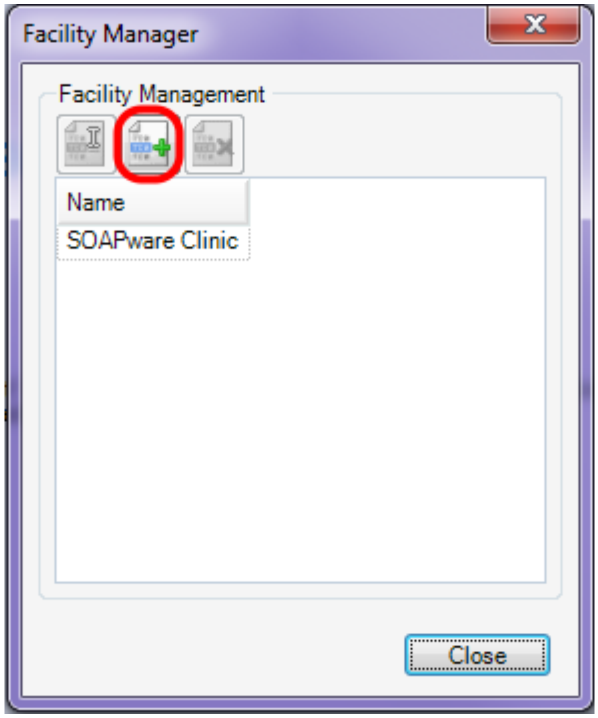


The first time that the user enters SOAPware Schedule, the user will be prompted to create a facility. If so, Click on the "Manage Facilities" button.

***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.*

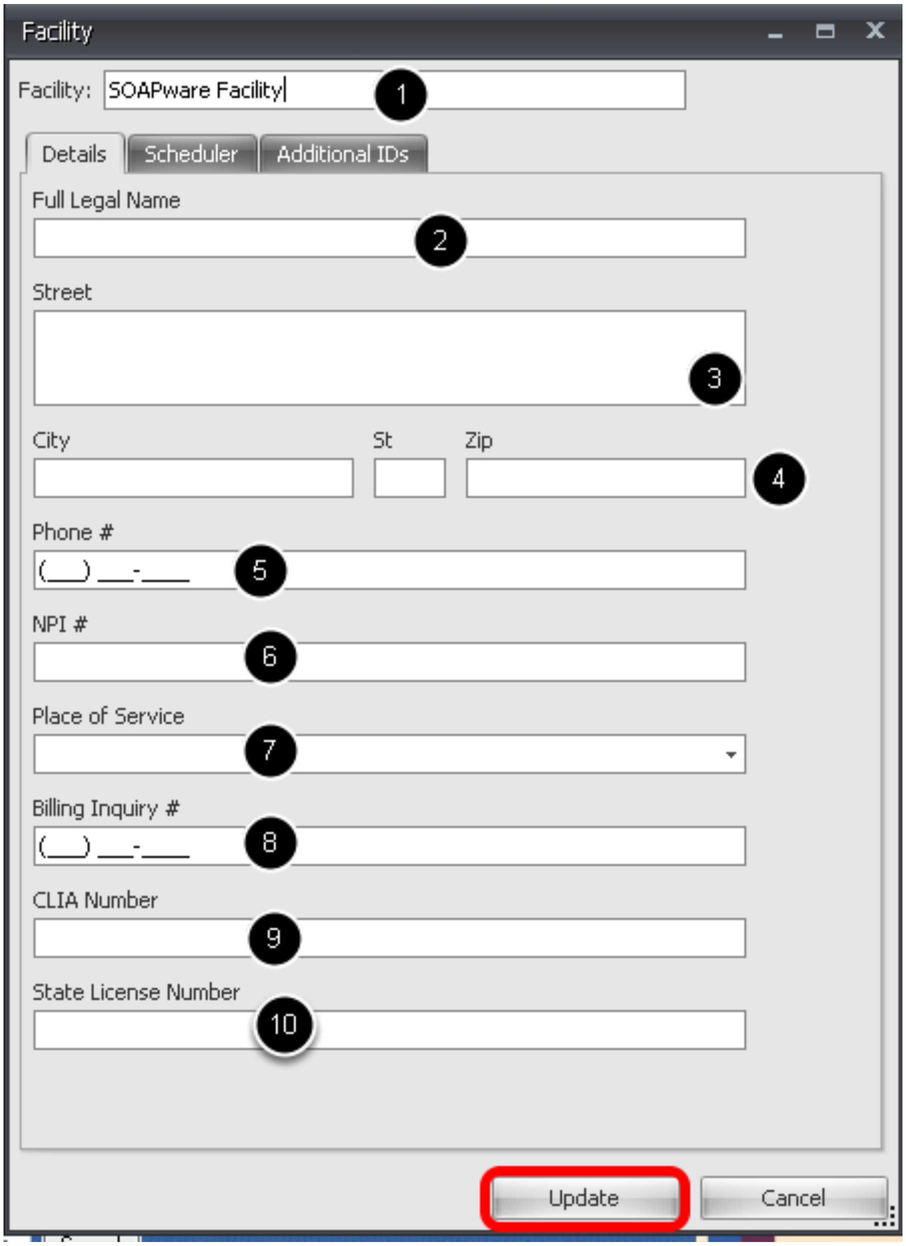
Facilities represent the office. SOAPware Schedule is able to handle any number of facilities or offices that the user wants to define. Some users may want to define a single facility for all their offices, but this is not advised. A user will later find that having a facility defined for each of the 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** (green +) button.

Facility - Details Tab



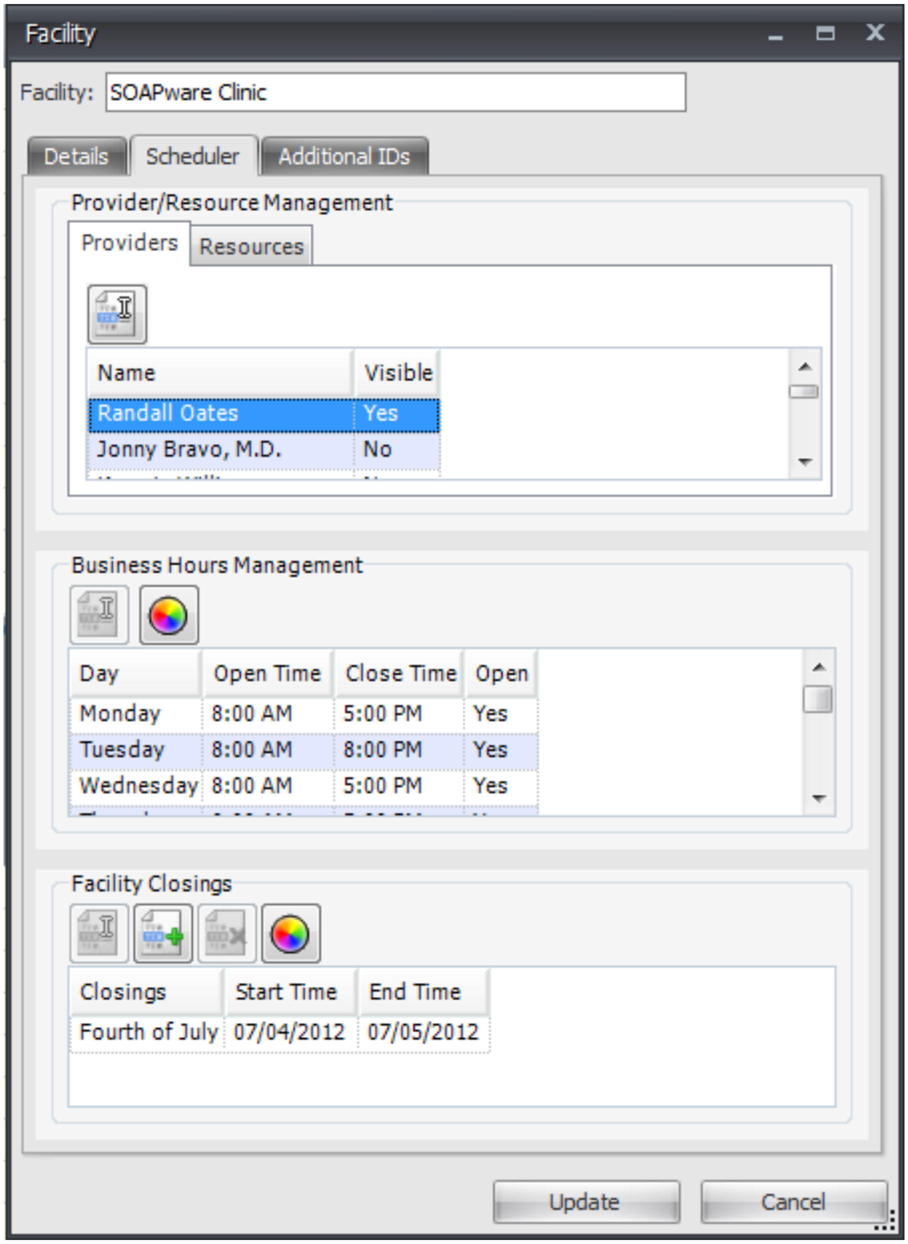
Steps 1-5 identify the Place of Service-Block 32

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. CLIANumber (if applicable)
10. State License Number

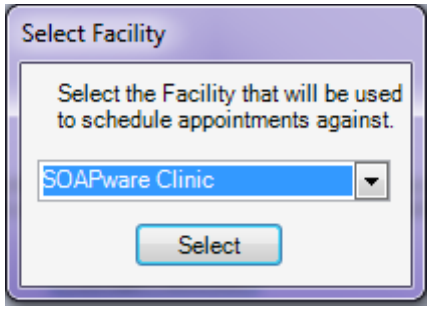
Click on the Update button to save all changes.

Facility - Scheduler Tab



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 provider's 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



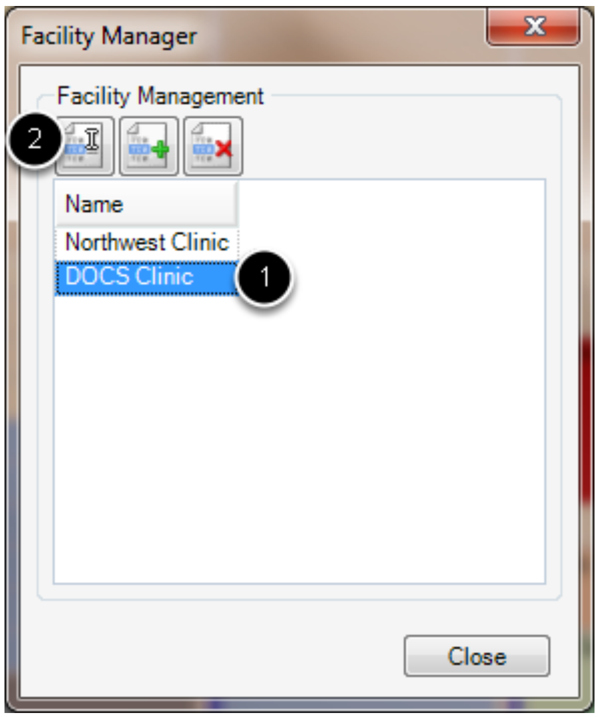
After setting up the Facility, SOAPware Schedule will prompt the user to select the active facility. The user should choose the facility he/she would like to use and Click Select.

Entering Facility Business Hours

This lesson will demonstrate the steps needed to set up the hours of operation for a facility.

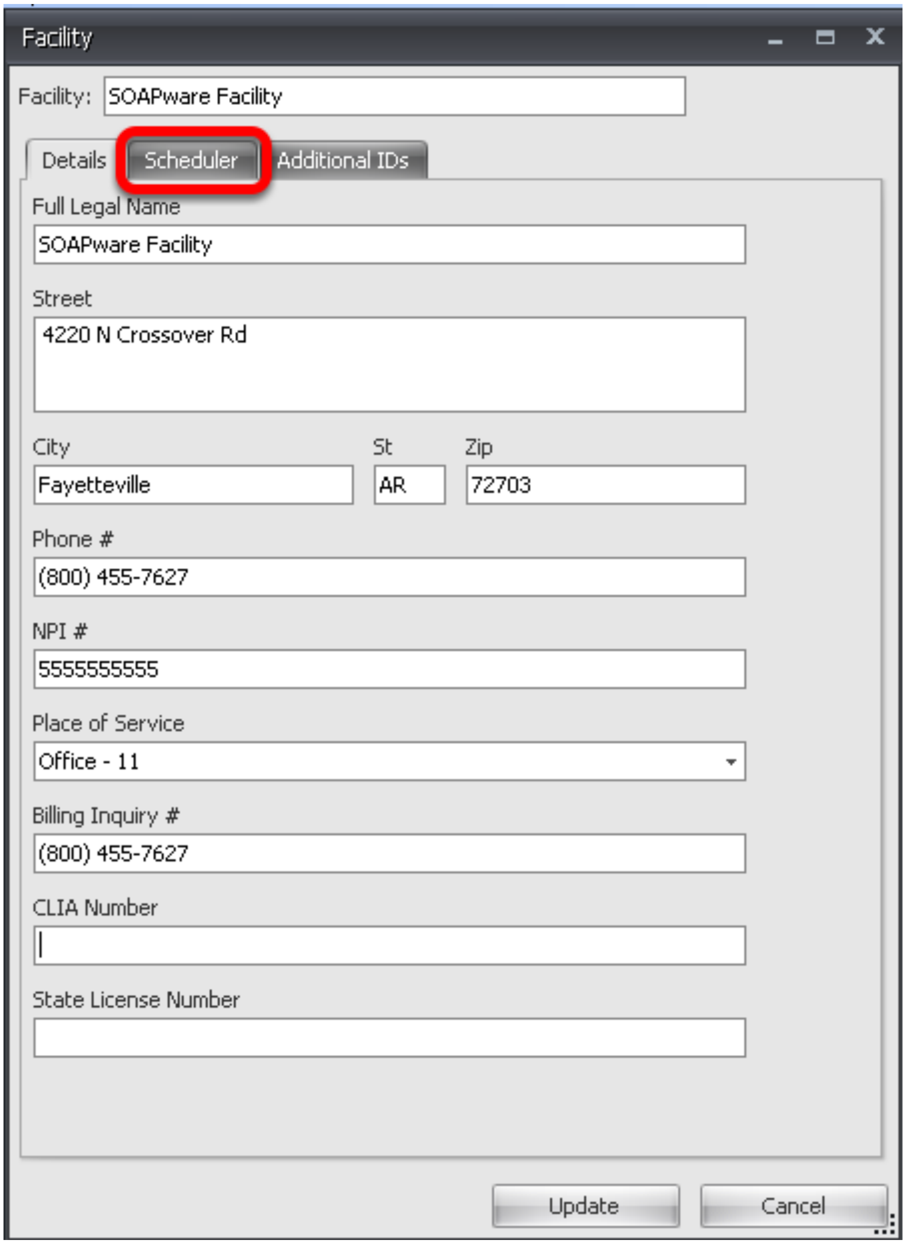
First Click Tools > Manage Facilities, to open the "Facility Manager" dialog.

Open the Facility



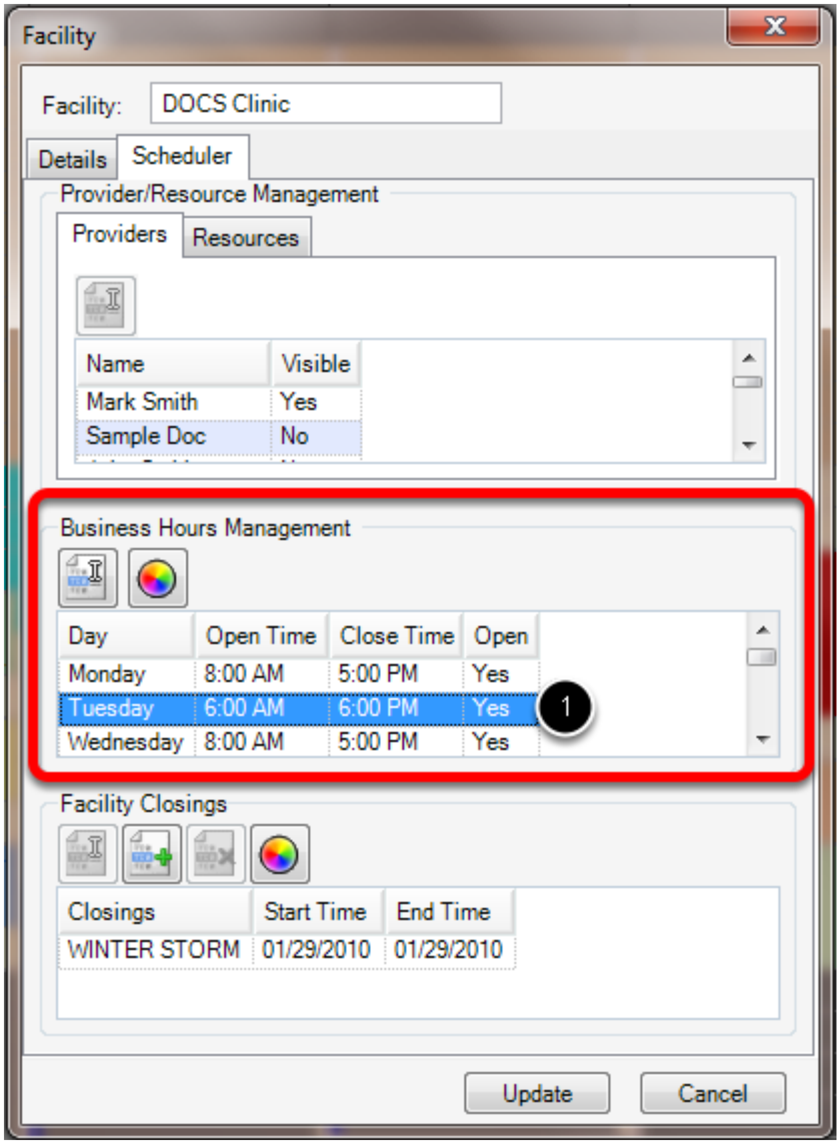
1. Select the Facility
2. Click Edit

Scheduler



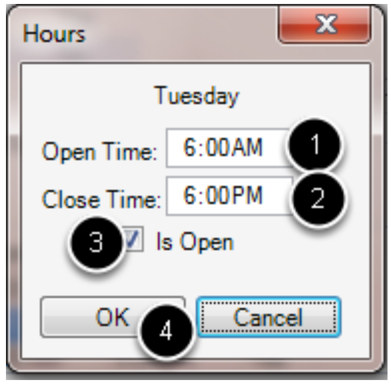
Click the Scheduler Tab.

Edit Business Hours



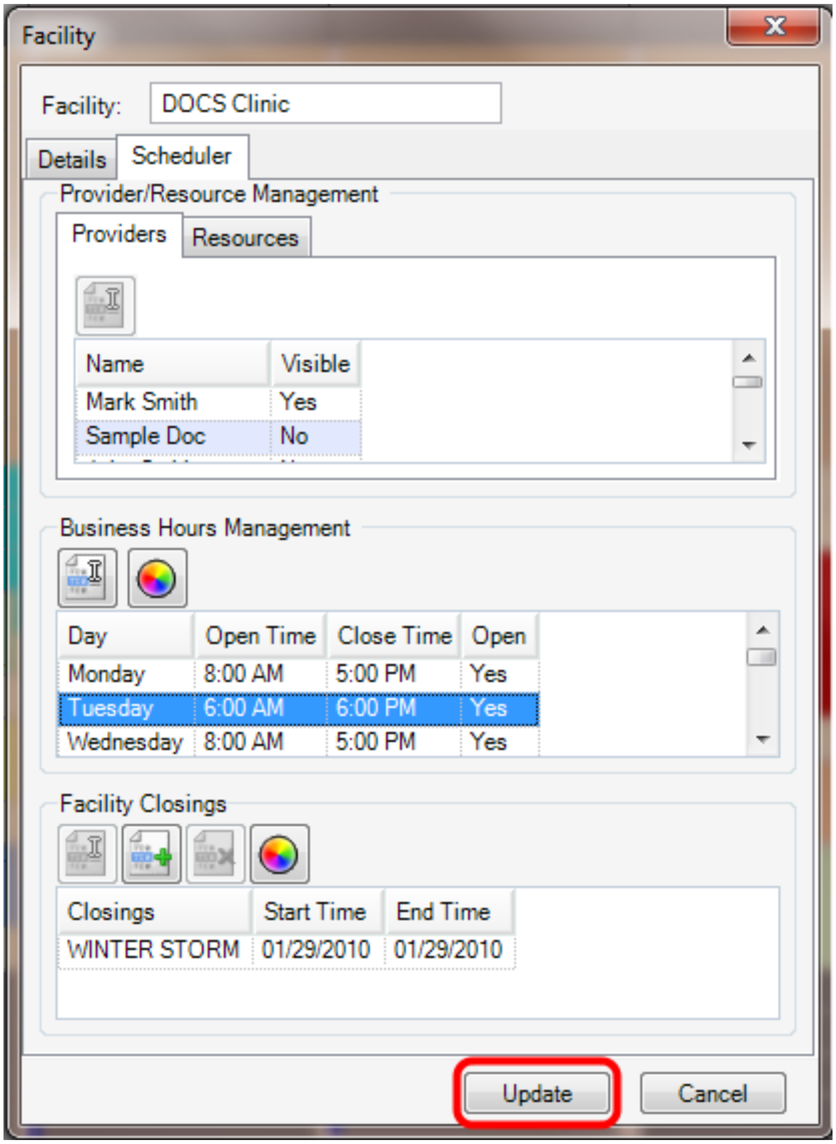
1. Select the day of the week that needs to be edited

Edit the day



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



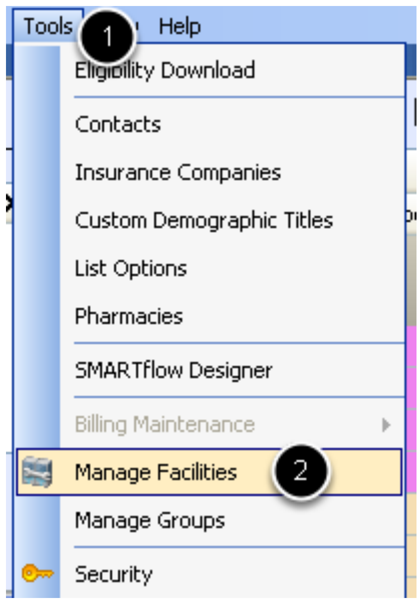
Click the Update button to update the Schedule with the new business hours.

Activate Providers/Resources for a Facility

This lesson will demonstrate the steps that are necessary to add a provider and/or a resource to a facilities scheduler.

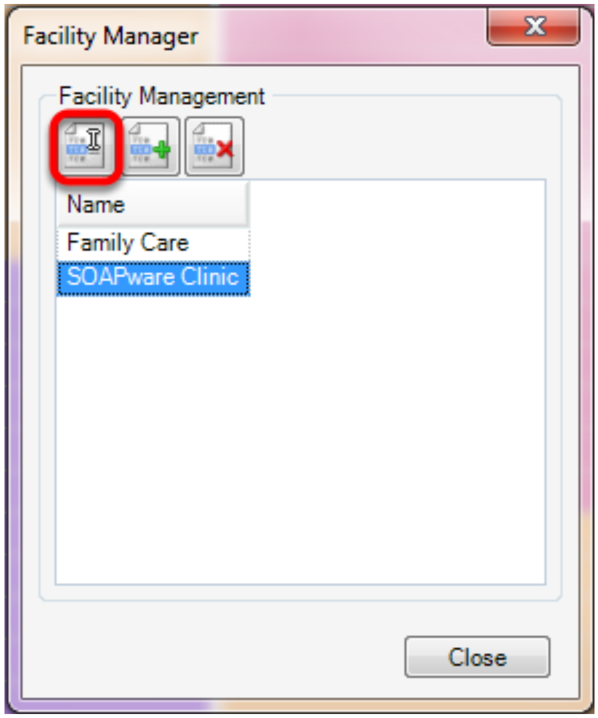
To access the Scheduler workspace, go to the SOAPware menu and Click Schedule.

Add a Facility



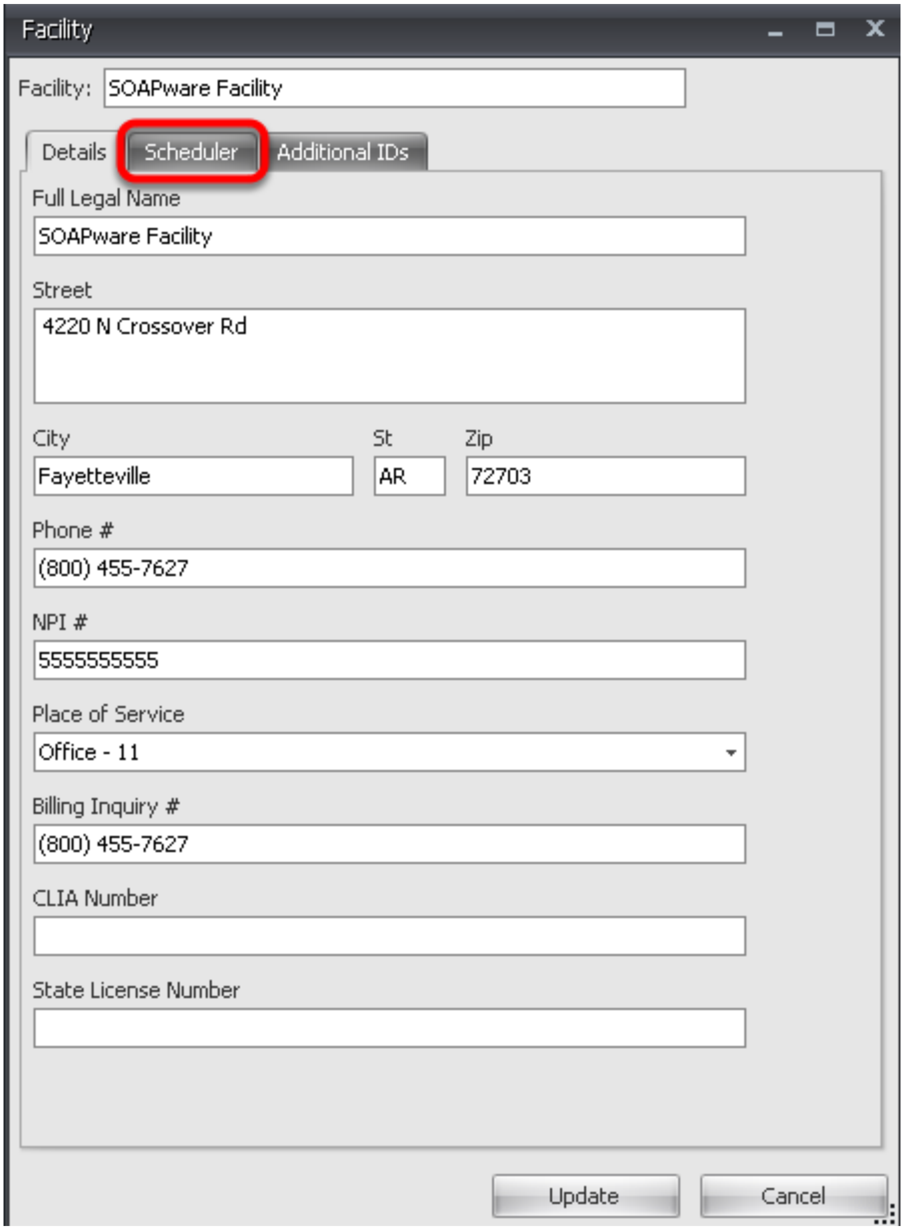
1. Click on the Tools menu
2. Select Manage Facilities

Edit the Facility



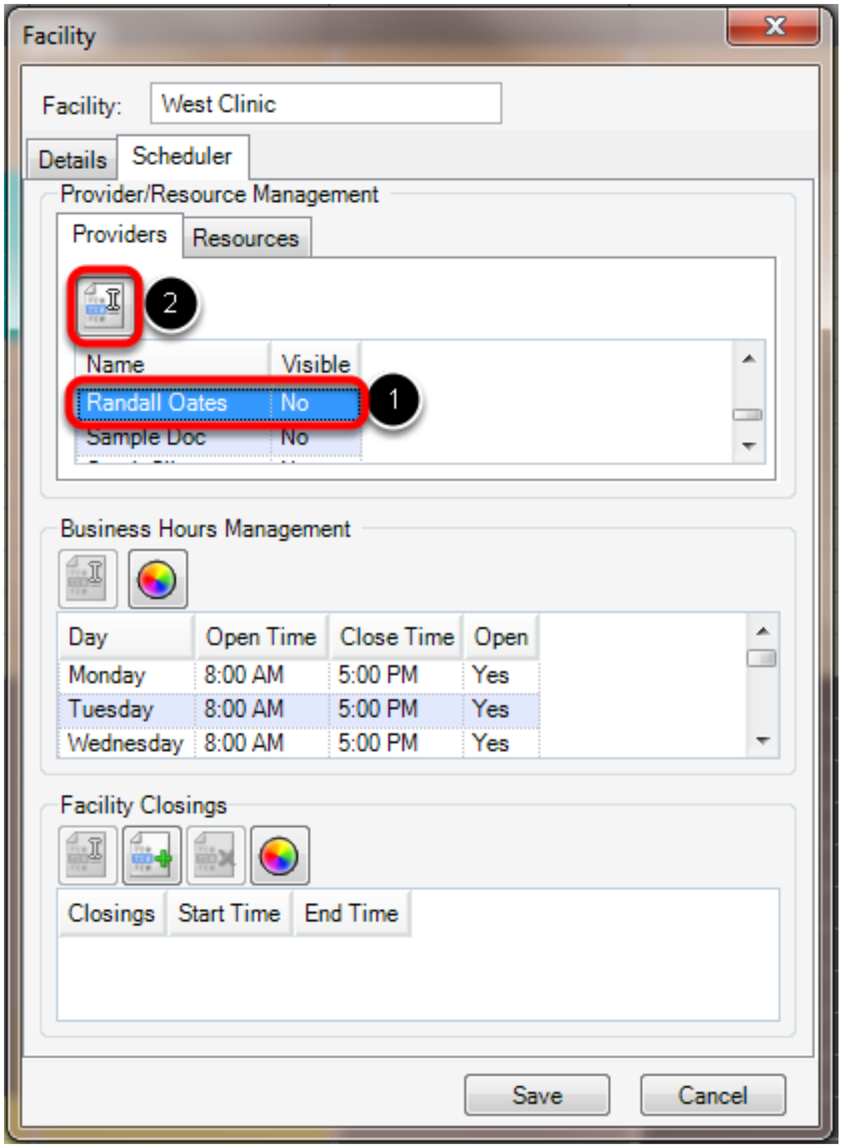
To make a provider/resource visible on a facilities schedule, select the desired facility, then click the Edit button.

Scheduler Tab



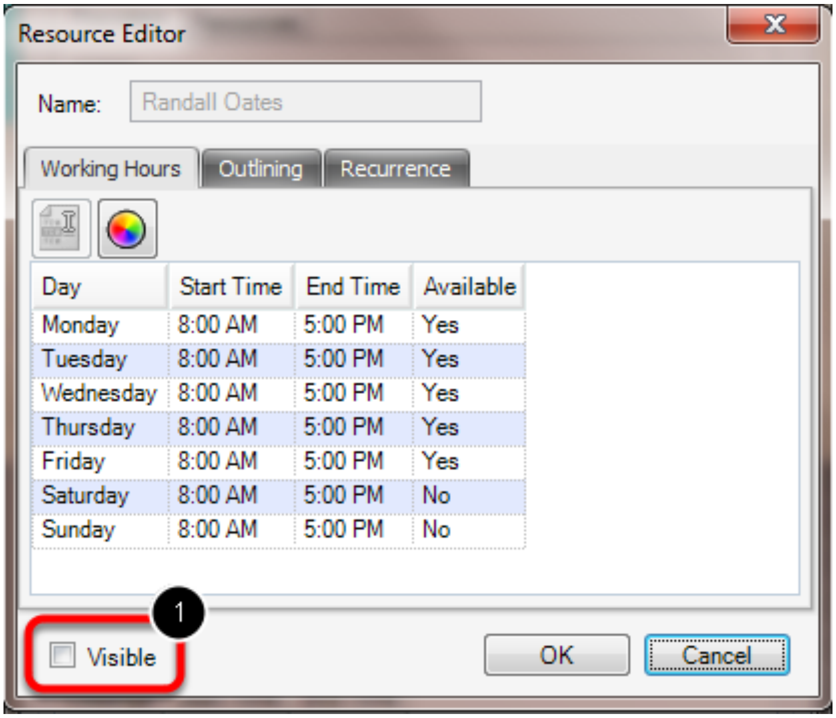
Click the Scheduler tab.

Provider/Resource Management



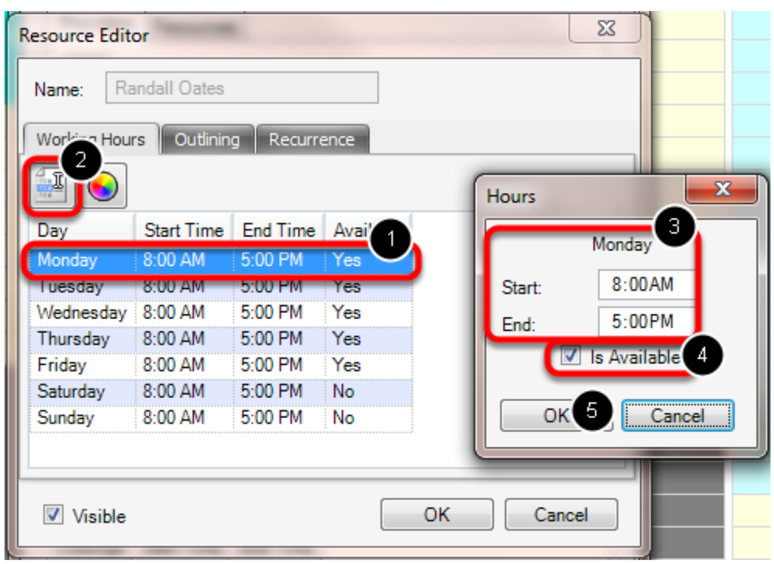
To make a provider visible on the facilities schedule:

1. Select the Provider's name
2. Click the Edit button



1. Check the box next to "Visible" to activate the provider for the selected facility.

Set Working Hours for the Provider



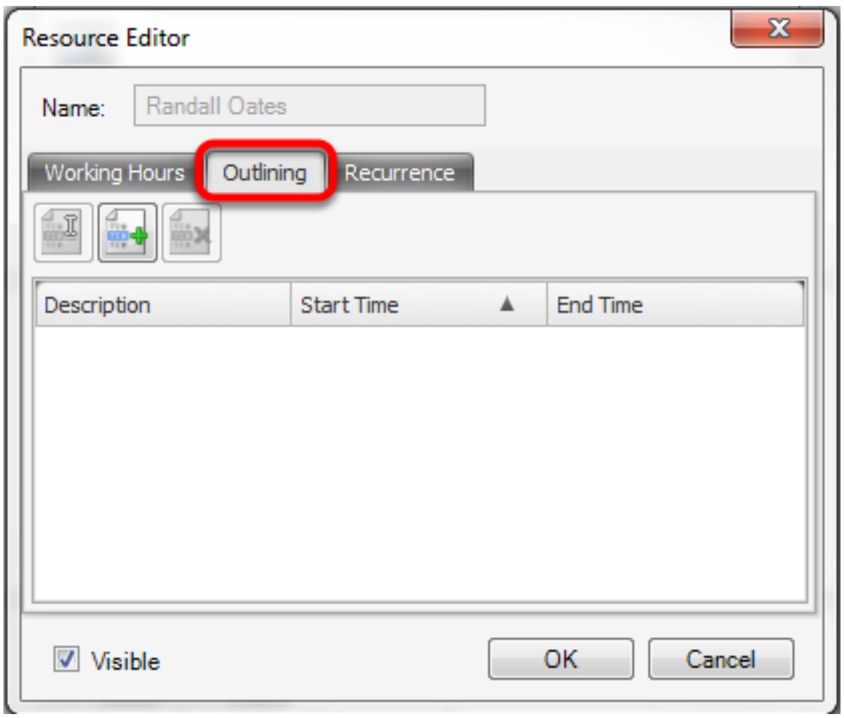
In addition, the provider's working hours can be customized. To do this:

1. Select a day of the week

2. Click the Edit button
3. Enter the Start and End Times.
4. Check the "Is Available" box to make the provider available for appointments (OR uncheck the "Is Available" box to indicate that the provider does not work on the selected day).
5. Click OK.

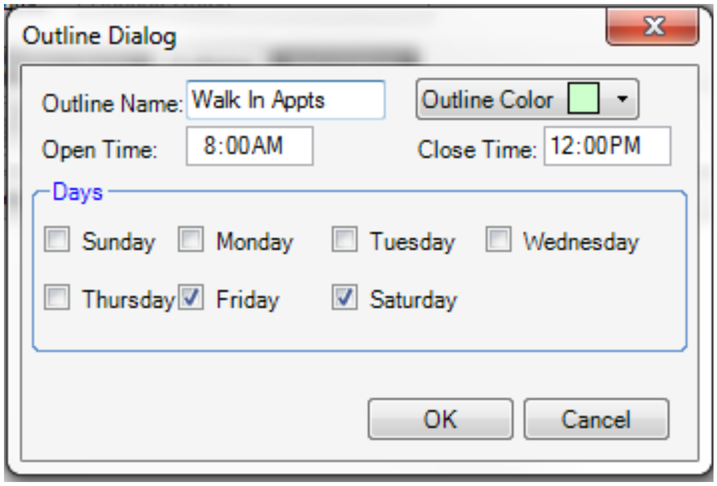
Repeat the steps above to customize the provider's working hours.

Provider Outlining



The Outlining tab can be used to create color coded scheduling outlines for providers/resources.

1. Click the Outlining tab
2. Click the Add Outline (green +) button to create a new outline for the provider/resource



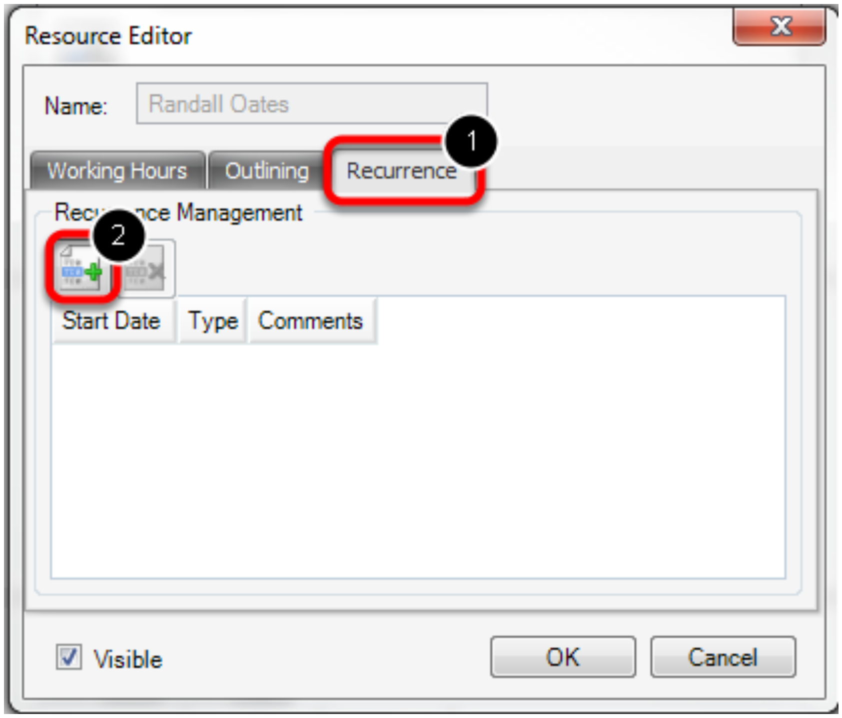
The Outline Dialog box will appear. Complete the Outline Name, Color, Open Time, Close Time and Days of the week.

Some examples of how outlining can be used includes:

- Creating a color coded outline to show what times the provider accepts walk in appointments
- Creating a color coded outline to show what times the provider schedules surgeries
- Creating a color coded outline to show what times the provider schedules new patient appointments

Click the OK button to save the new Outline.

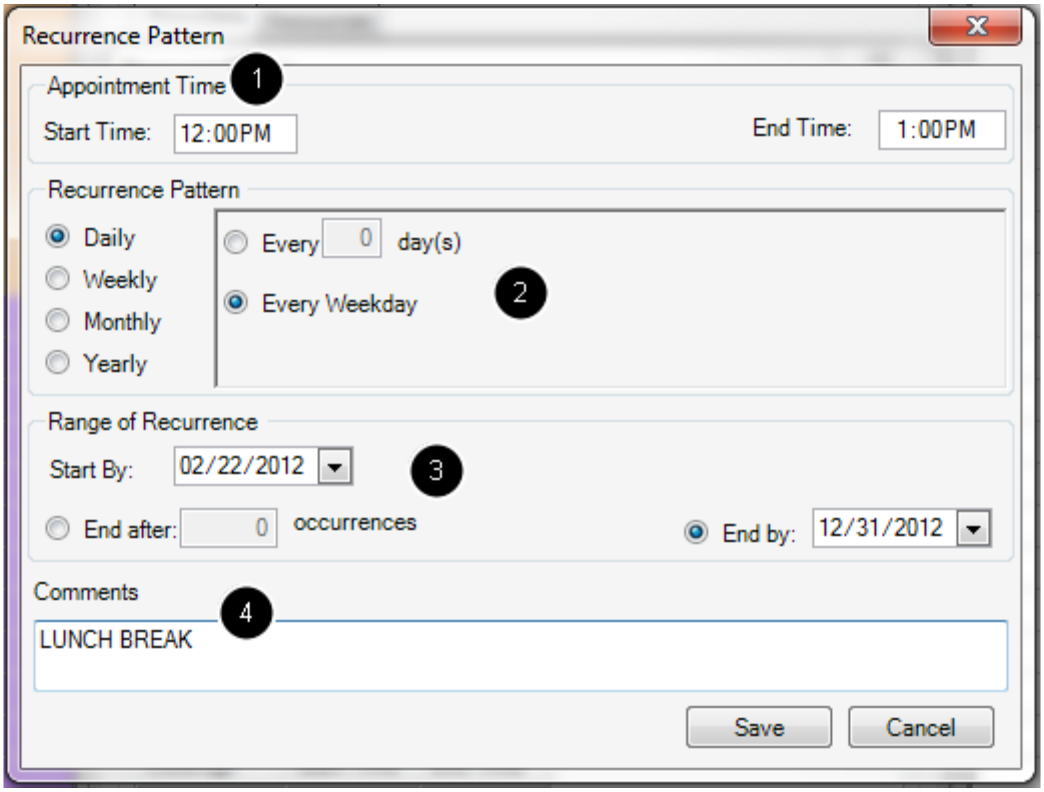
Recurring Appointments for Providers/Resources



Recurring appointment can also be created for both providers and resources. Recurring appointment can be helpful to create lunch break appointments or other commonly recurring meetings.

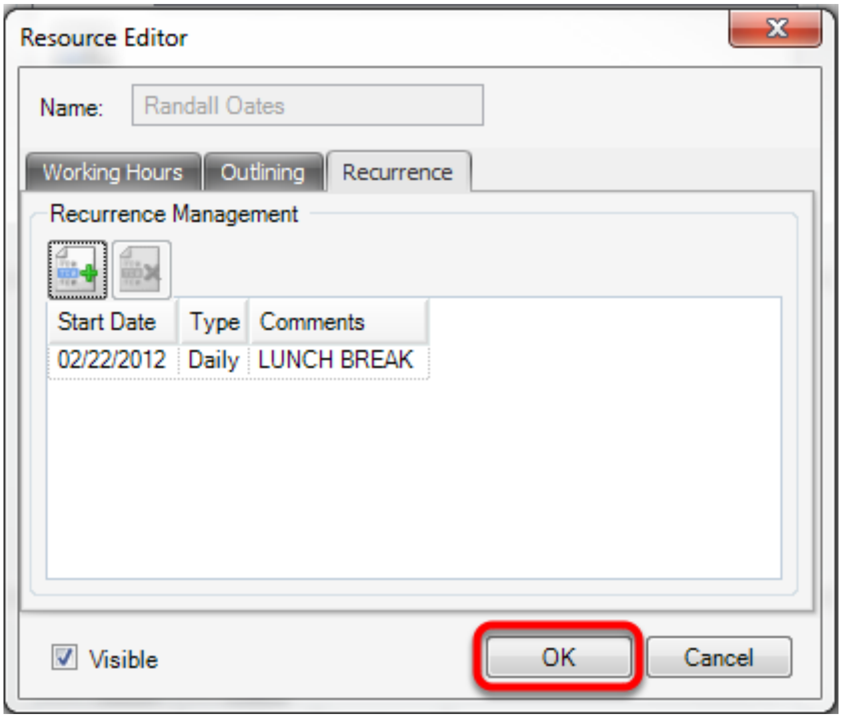
To create a new recurring appointment:

1. Select the Recurrence tab
2. Click the Create Recurrence (green +) button



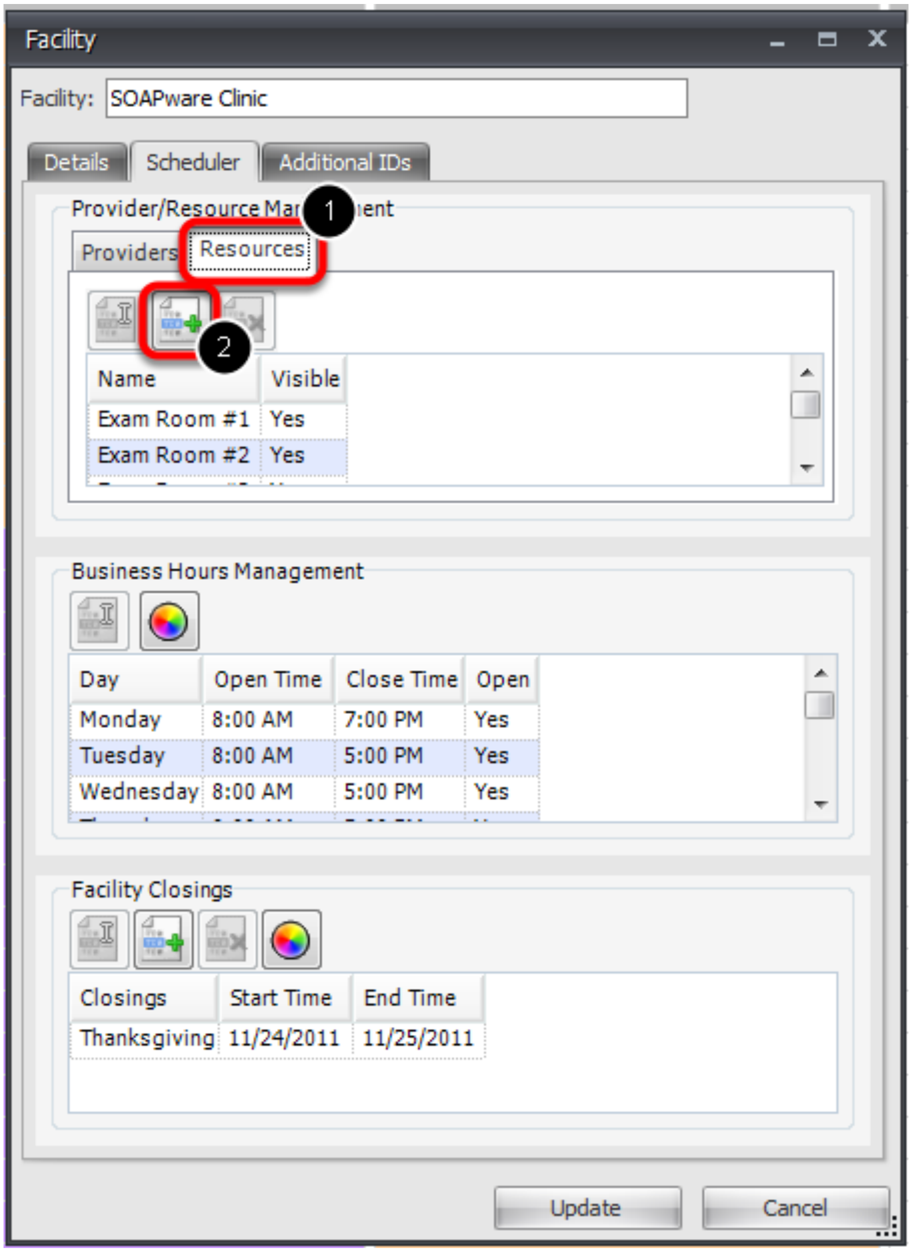
1. **Appointment Time:** Enter the Start Time and End Time for the recurring appointment.
2. **Recurrence Pattern:** Select the frequency of the recurrence. For example, if the recurrence occurs every Monday-Friday, select "Daily" and "Every Weekday".
3. **Range of Recurrence:** Select the "End date" for the recurrence. Users can select the recurrence to end after a certain number of occurrences or to end by a certain date.
4. **Comments:** Enter the reason for the recurrence. The text entered into the Comments box will display on the schedule.

Saving the Provider/Resource Changes



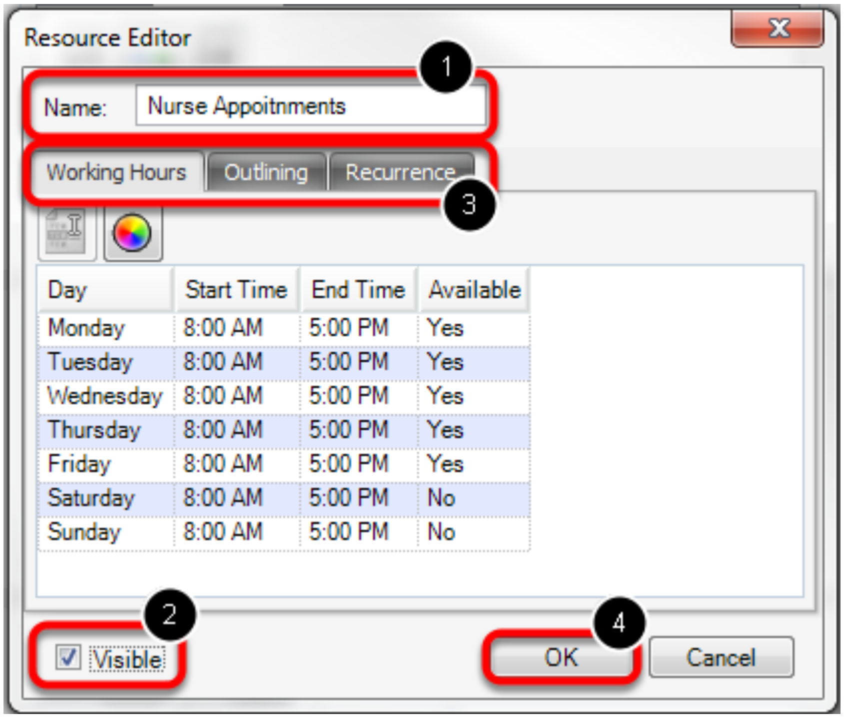
After making the provider/resource visible and editing the working hours, outlining, and recurrence tabs; Click the OK button to save the changes.

Creating a New Resource for the Facility

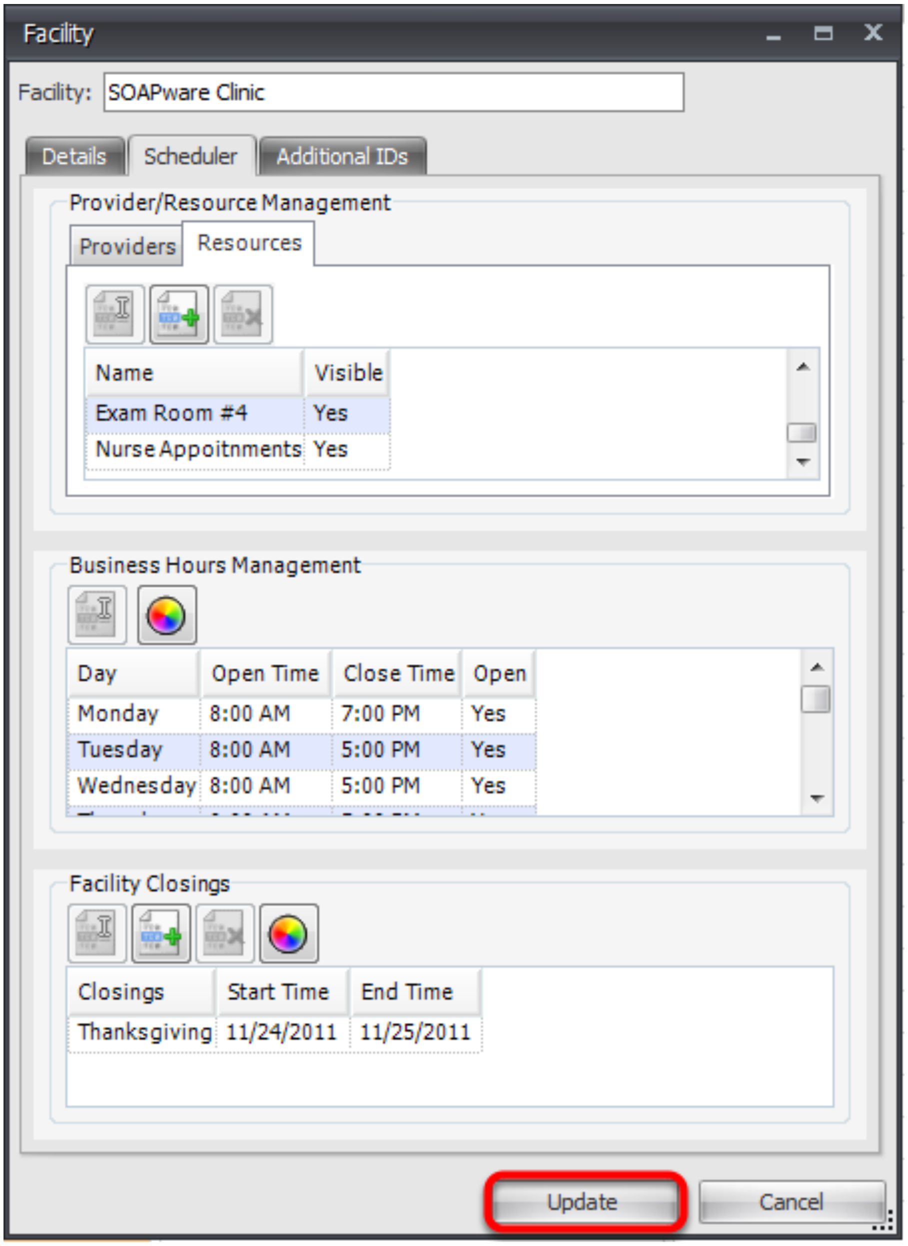


Resources can be created for the facility. This will allow the clinic to create a calendar or schedule for other resources within the clinic. For example, the clinic may want a calendar for the in house lab or the clinic may need a calendar for the Nurse appointments, etc.

1. To create a new Resource, Click the Resources tab under Provider/Resource Management.
2. Click the Add Resource button (green +).



1. Enter the Name of the Resource (ex: Nurse Appointments, In-House Lab, etc.)
2. Check the box to make the new resource Visible on the facility schedule
3. Edit the working hours, outlining and recurrence appointments as desired.
4. Click OK to save the new resource



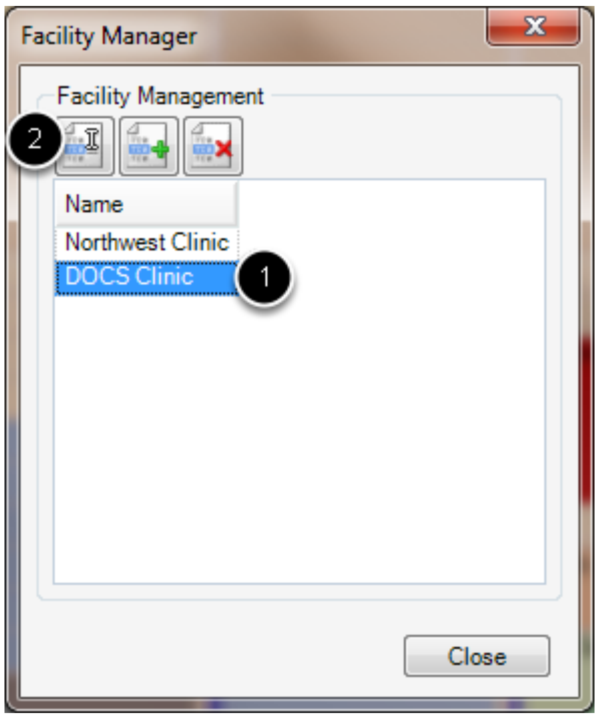
Click the Update button to save all changes.

Creating Holidays/Closings

This lesson will demonstrate the steps required to set up the days the facility will be closed.

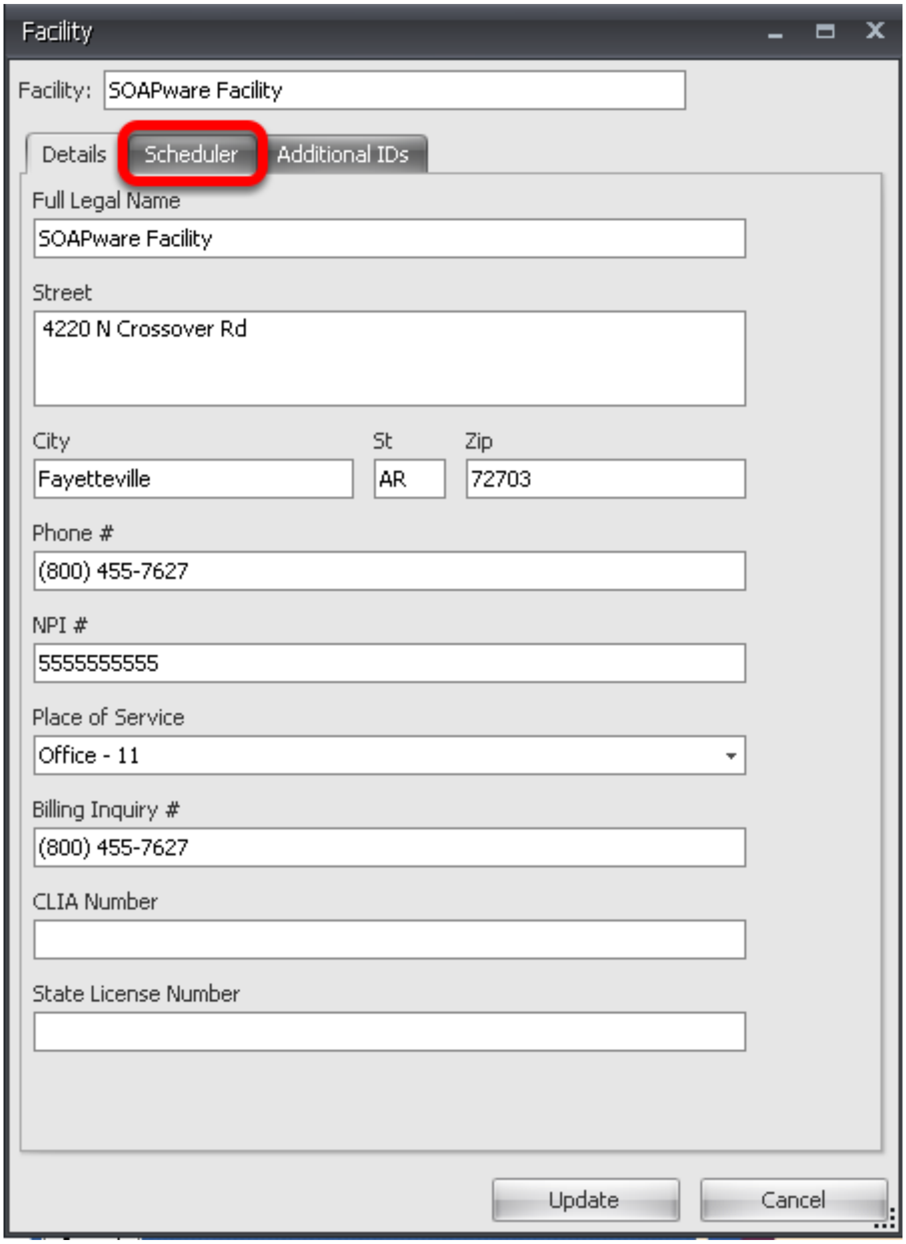
First Click Tools > Manage Facilities, to access the "Facility Manager" dialog.

Open the facility



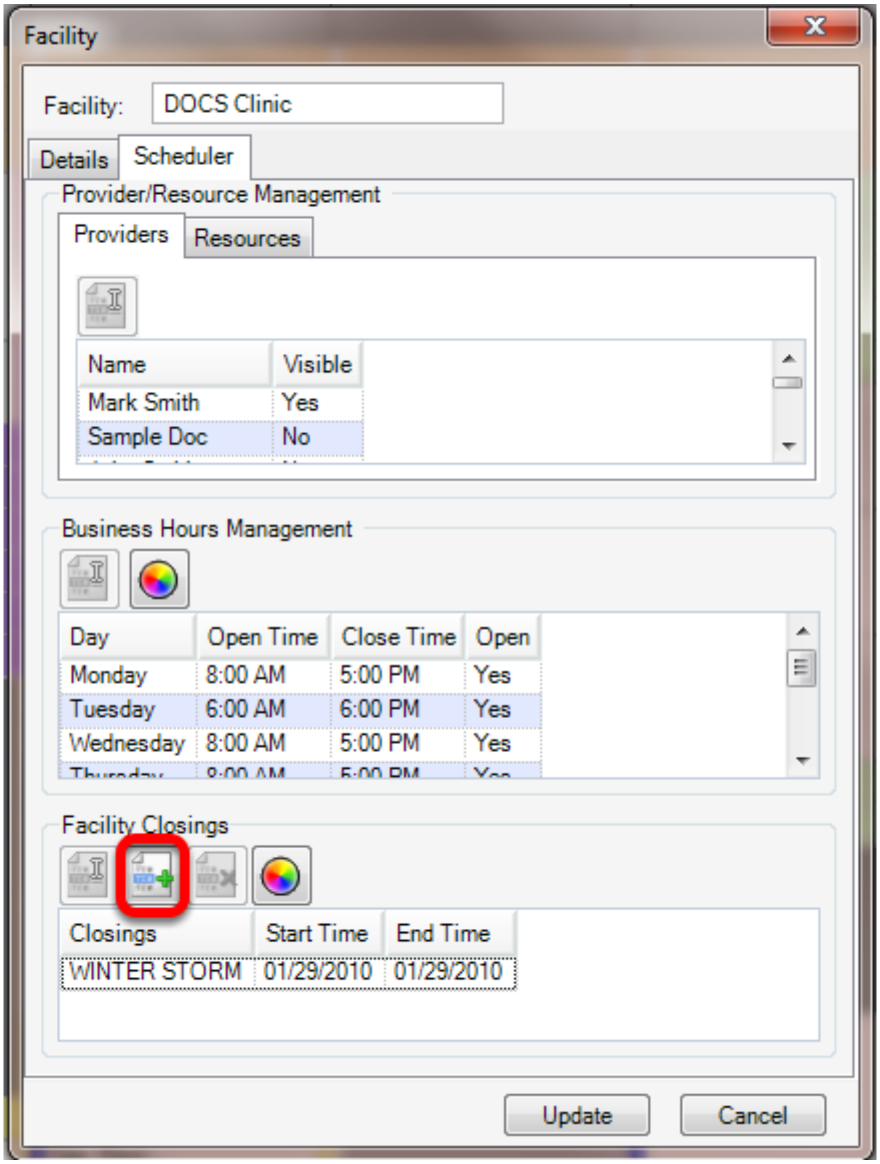
1. Select the Facility
2. Click Edit

Click Scheduler



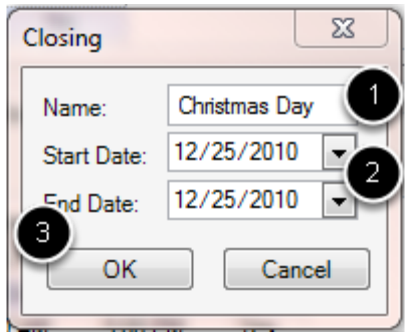
Click the Scheduler Tab.

Create Facility Closings



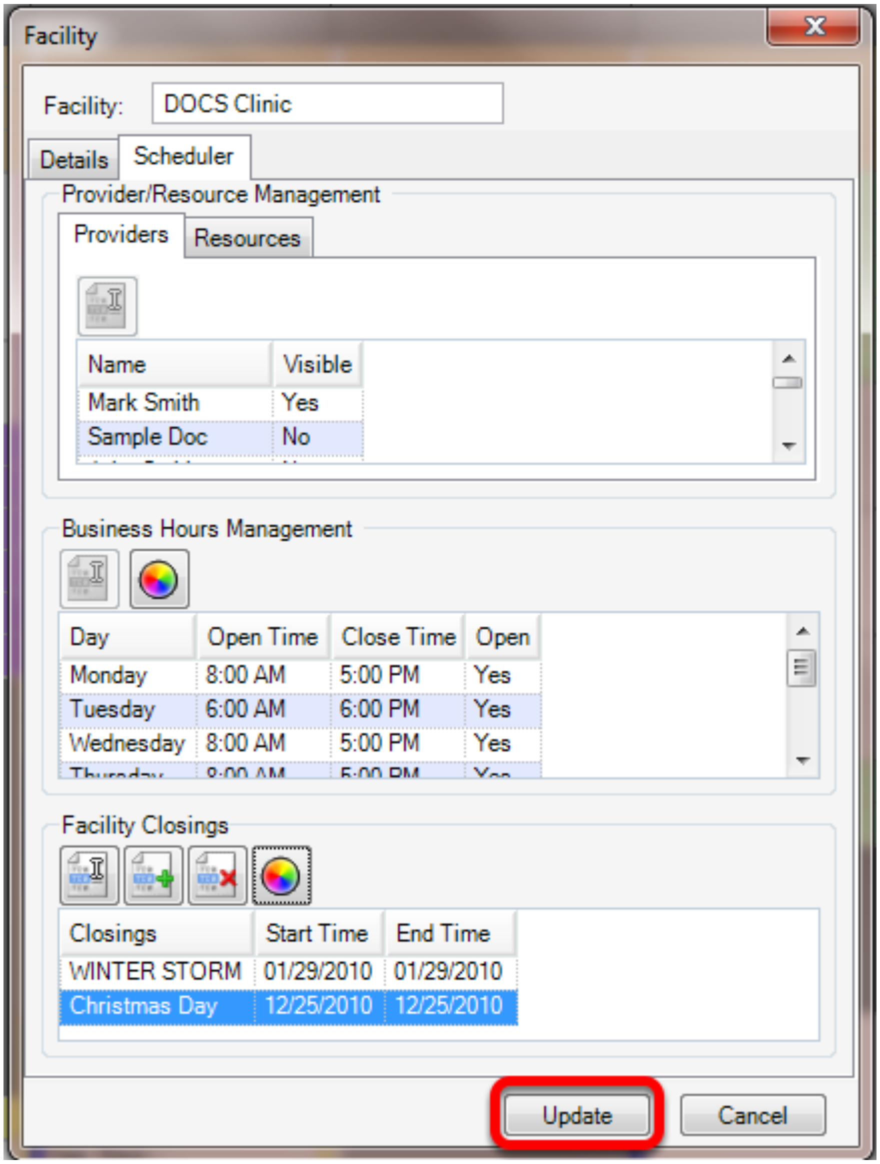
1. Click the Add Closing button (green+)

Edit the Day



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

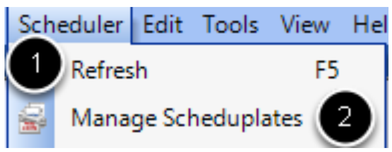


Click the Update button to update the Schedule.

Creating Scheduplates

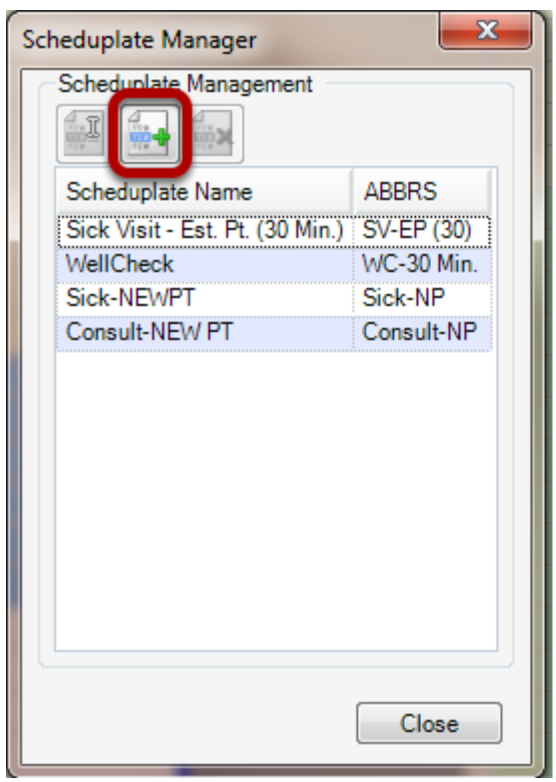
This lesson will demonstrate the steps needed to set up various facility appointment types.

Open the Scheduplate Manager



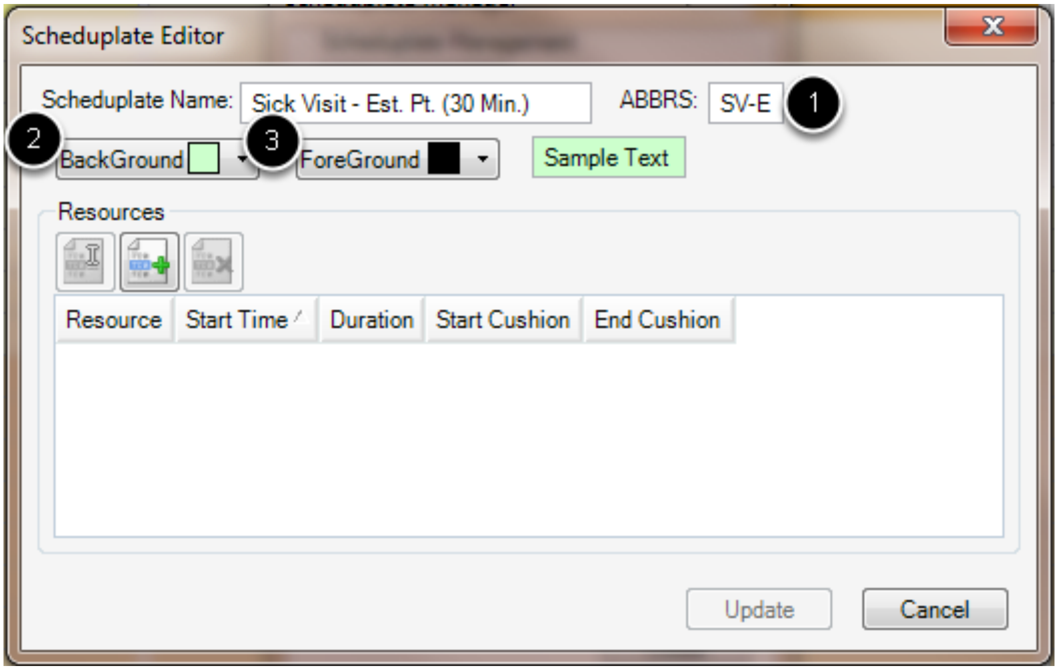
1. Click on the Scheduler menu.
2. Select Manage Scheduplates.

Add a Scheduplate



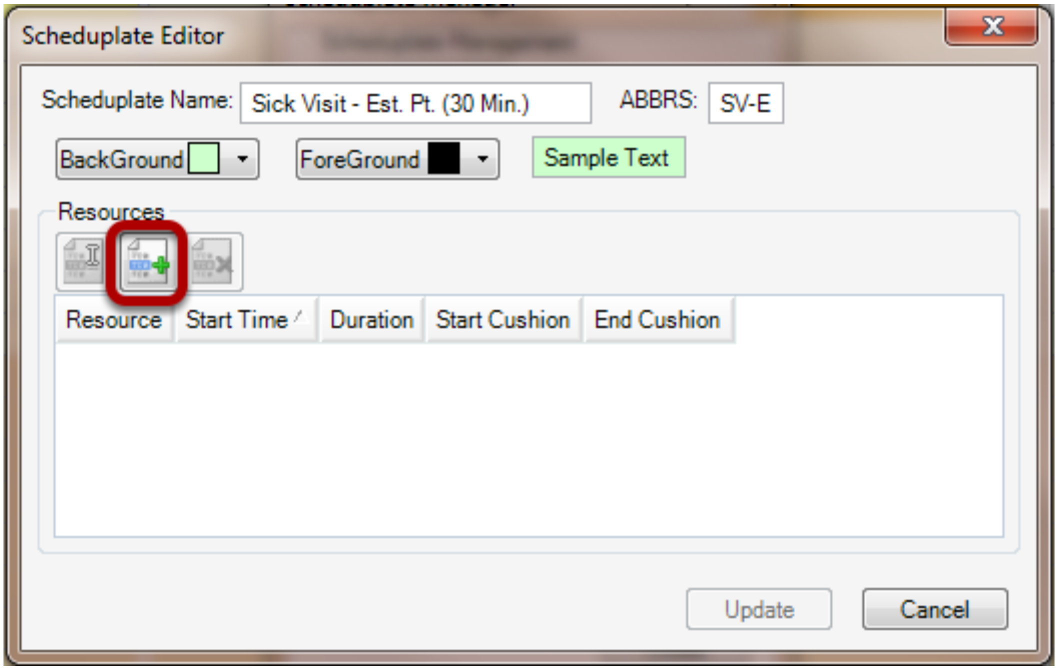
Click the Create New Template button.

Enter Scheduplate information



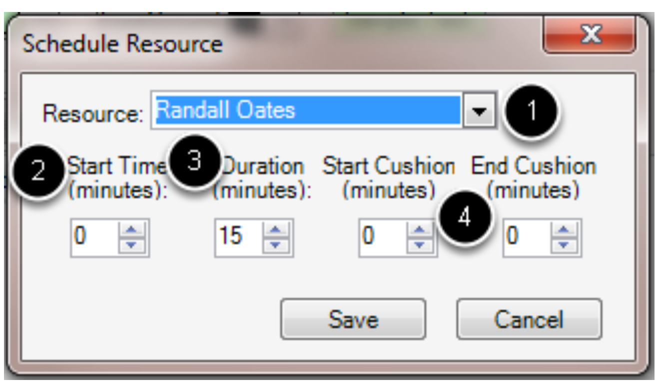
1. Type in a Scheduplate Name and Abbreviation. The abbreviation will be shown on the appointment at a glance, and the full scheduplate name will be helpful in selecting the correct appointment type.
2. Select a Background color to show on the appointment.
3. Select a Foreground color for the text displayed. (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

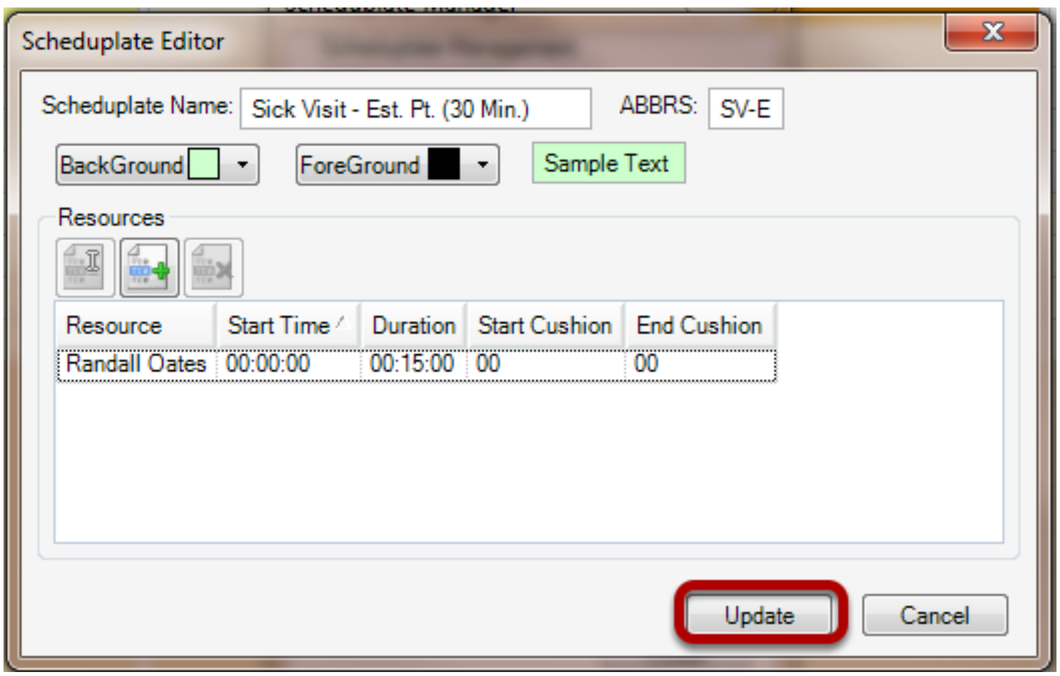


1. Select the Resource to whom the scheduplate will apply.
-Note: Selecting Pick Resource from the drop down list will allow users to select the Resource for the Scheduplate at the time the appointment is scheduled.
2. Enter the number of minutes needed, prior to the patient being seen by the Provider/Resource.
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

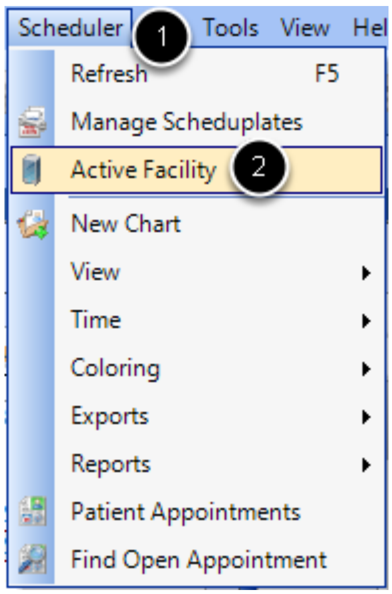


Click Update to save the Scheduplate.

Change the Active Facility

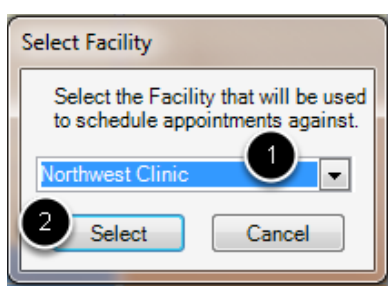
This lesson will demonstrate the steps to change the active facility, if a clinic is part of a multiple site practice.

Open Active Facility



1. Click on Scheduler.
2. Select Active Facility.

Select the new Active Facility

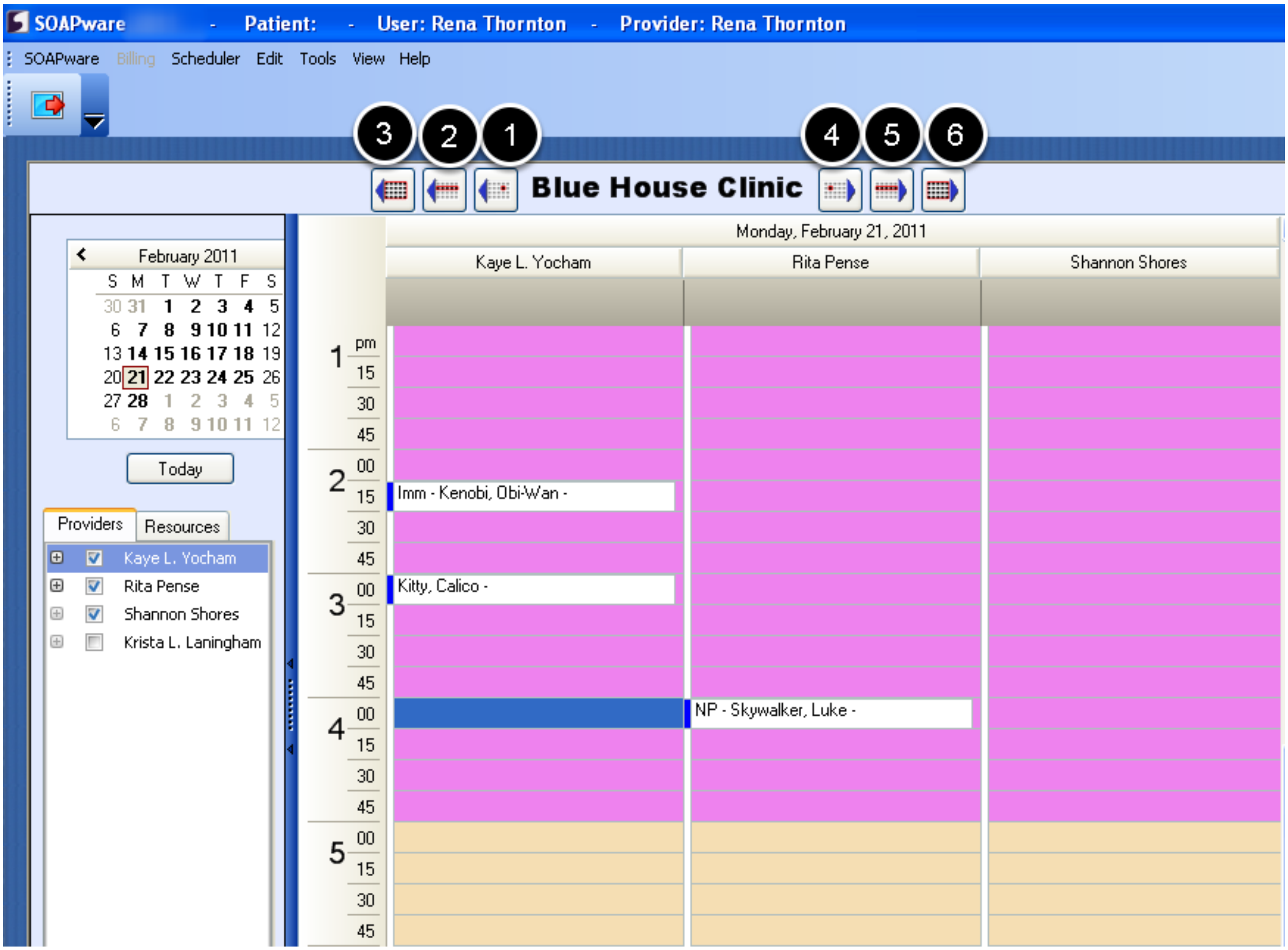


1. Click the drop down menu to find the desired facility.
2. Click Select.

Navigation

This lesson will show the various ways to navigate in the Schedule workspace.

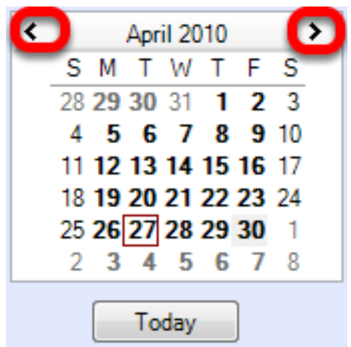
Move Quickly between Days, Weeks, and Months



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



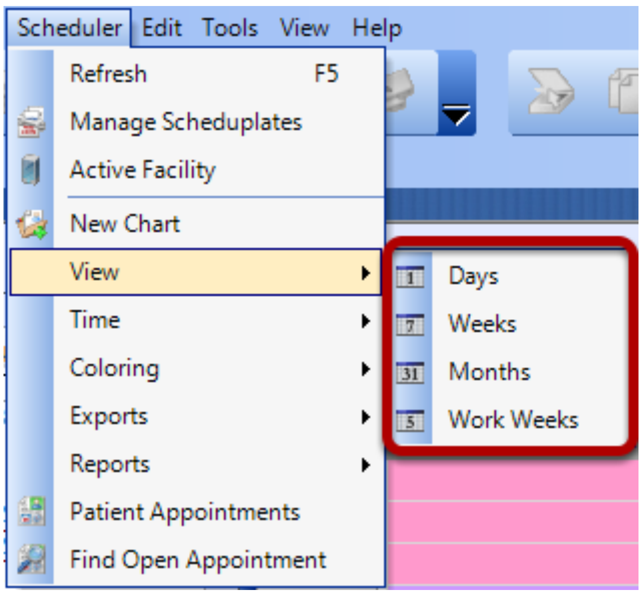
Click the arrows to move quickly to the month desired.

Views

View the Schedule as Days, Weeks, Months, or Work Weeks.

First Select Scheduler > View.

Select the Schedule View



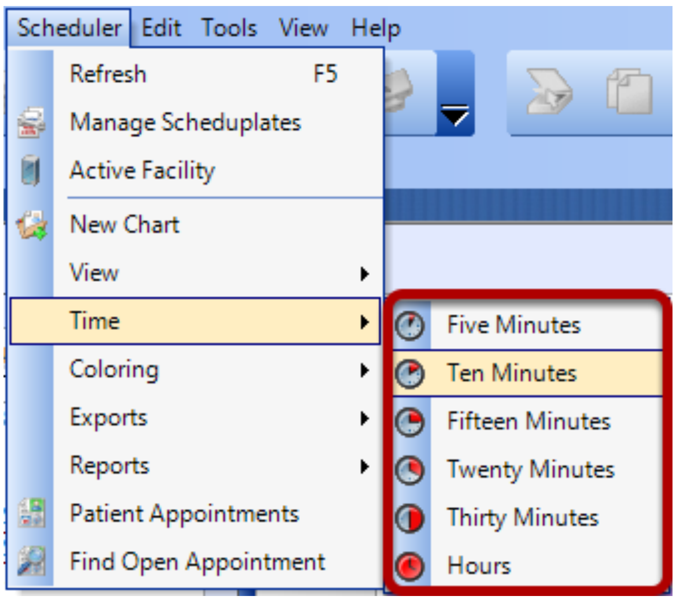
Select the preferred view.

Time Increments

This lesson will show how to set the time increments shown on the Schedule.

First Select Scheduler > Time.

Select the Time Increment

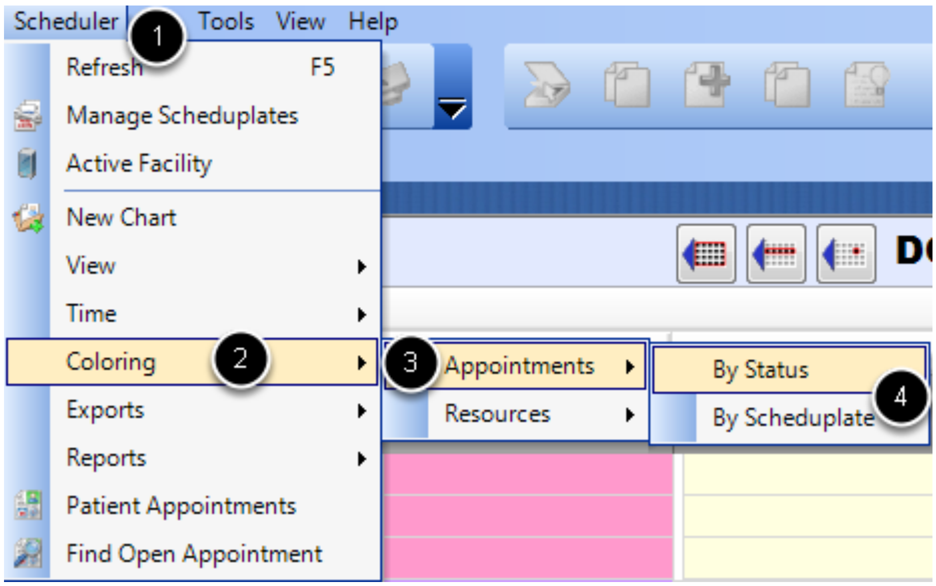


Choose the option that best fits the practice's scheduling needs. The time increment selected here will be displayed to the left of the schedule.

Coloring

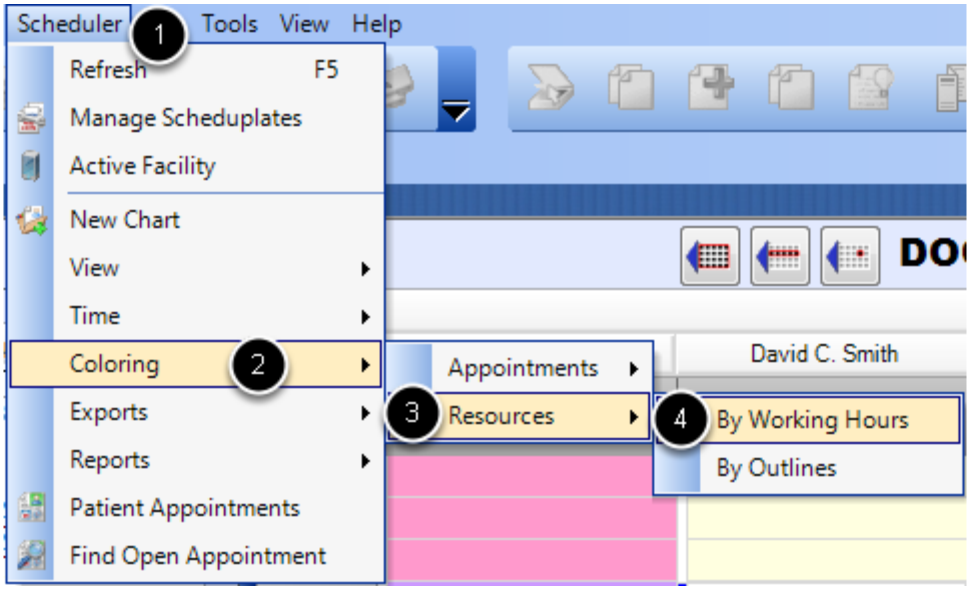
This lesson will show how to set the coloring for Appointments and Resources.

Coloring for Appointments



1. Click on Scheduler.
2. Select Coloring.
3. Select Appointments.
4. Select either **By Status** or **By Scheduplate**. If "By Status" is selected, the scheduler will display color coding by appointment status. If "By Scheduplate" is selected, the schedule will display color coding based on the designated Scheduplate of the appointment.

Coloring for Resources

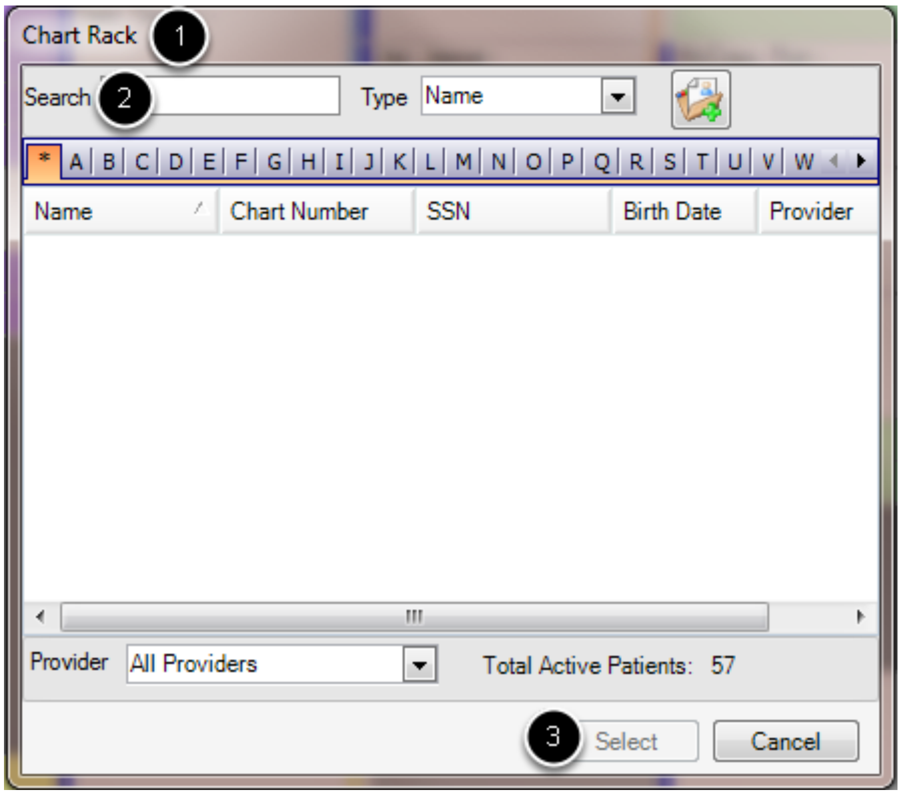


1. Click on Scheduler.
2. Select Coloring.
3. Select Resources.
4. Select either **By Working Hours** or **By Outlines**. If "By Working Hours" is selected, the scheduler will display color coding based on the providers working hours. If "By Outlines" is selected, the scheduler will display color coding based on the providers outlines.

Scheduling an Appointment

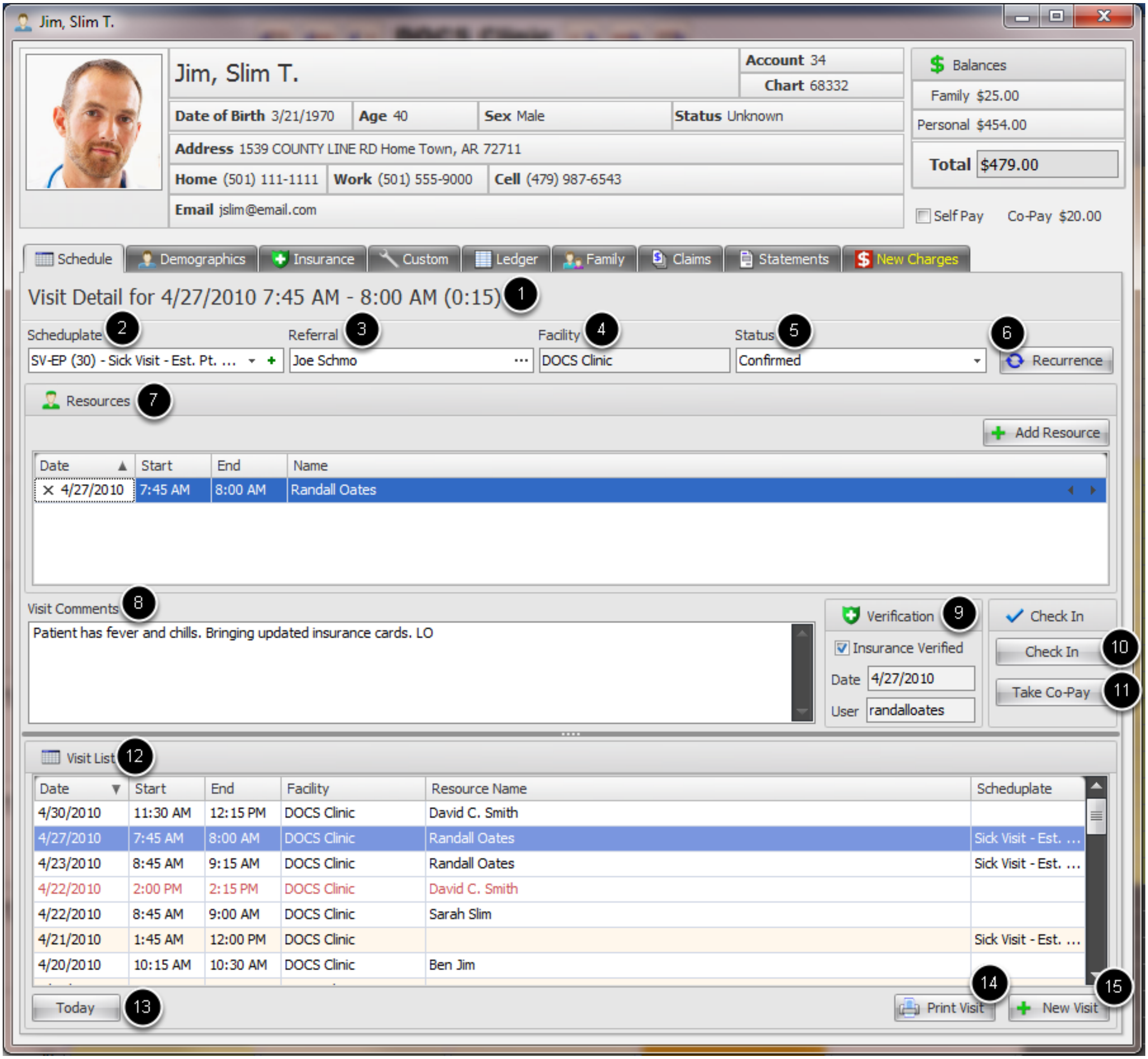
This lesson will demonstrate how to schedule a patient appointment.

Double Click on a Needed Time Slot



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



Enter the Appointment information, as needed:

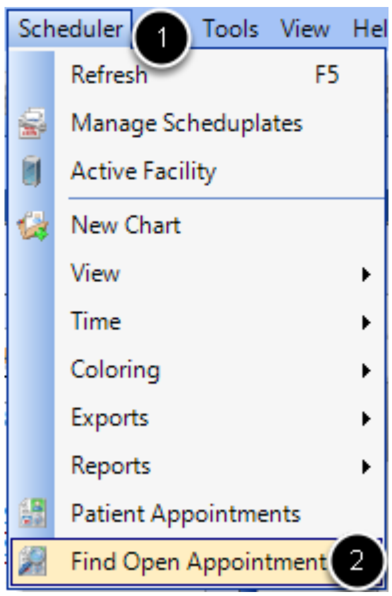
1. **Visit Detail:** Summary of the overall length of the appointment

2. **Scheduplate:** The appointment type
3. **Referral:** Referring Provider
4. **Facility:** Place of Service
5. **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

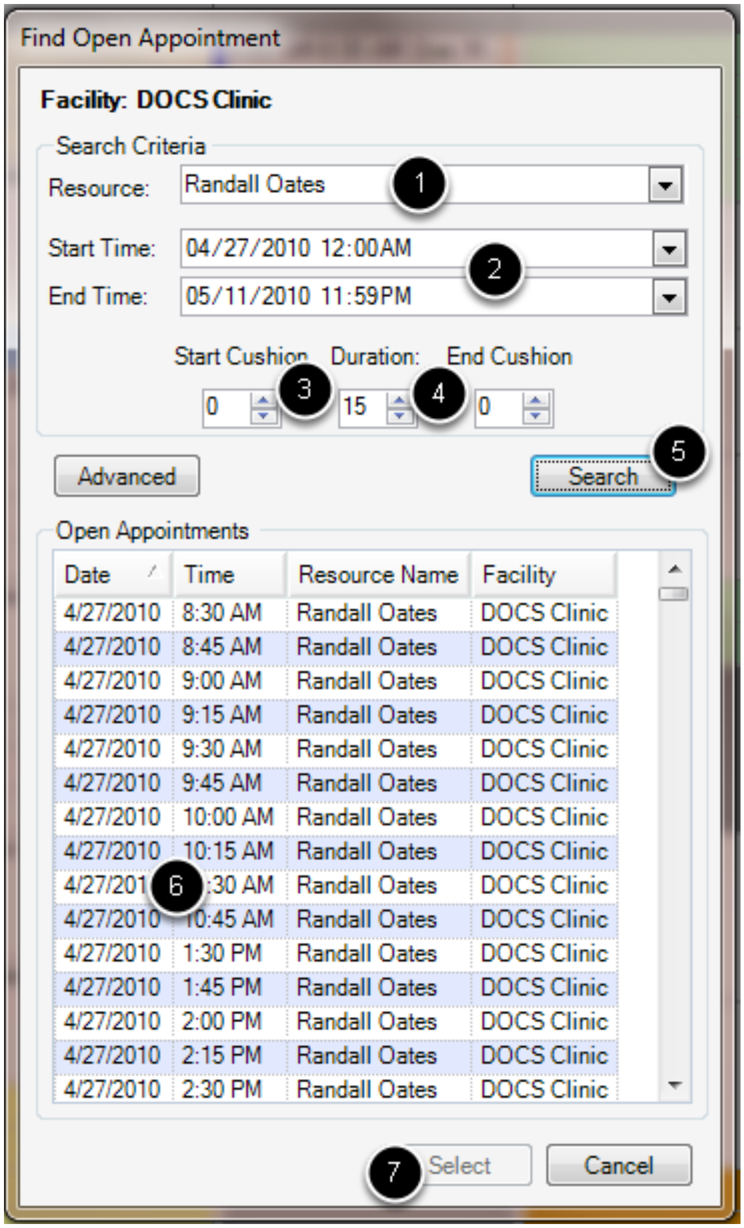
This lesson will show how to search for open appointments.

Find an Open Appointment



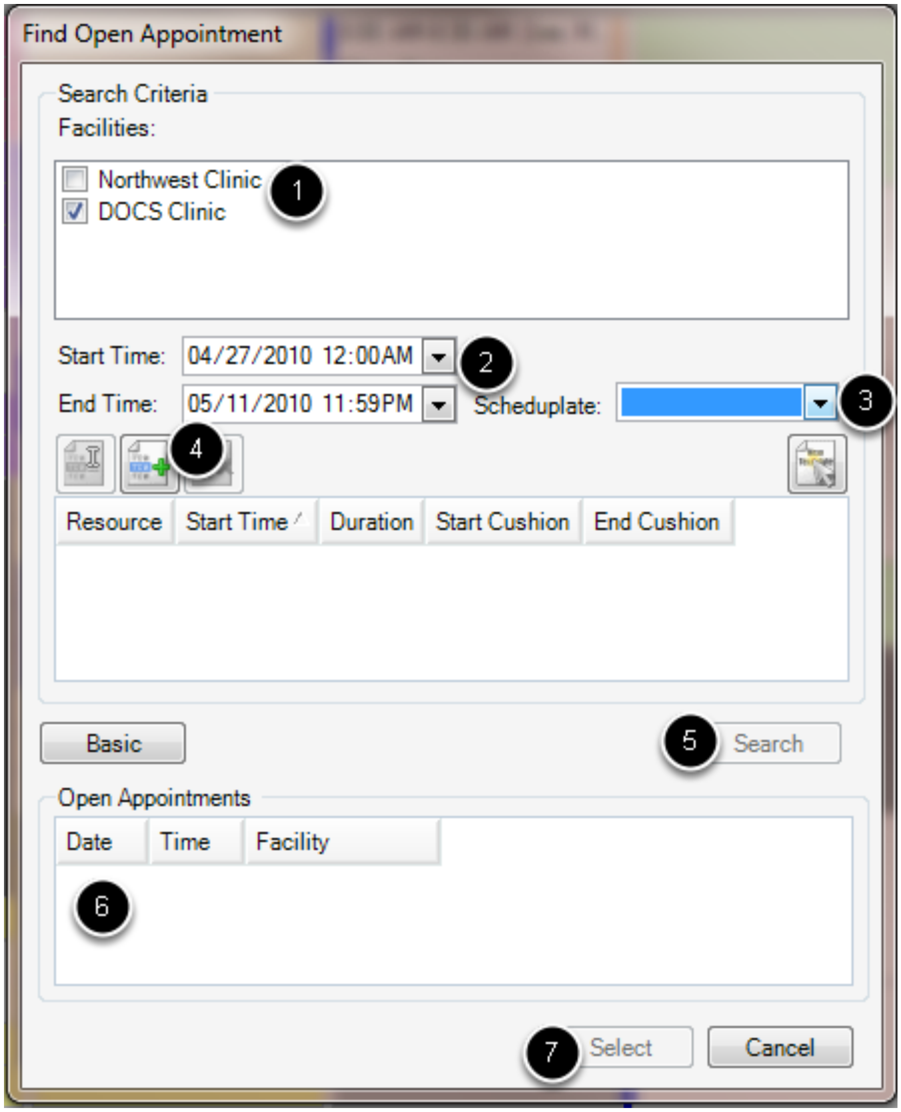
1. Click on Scheduler.
2. Select Find Open Appointment.

Enter Basic Search Criteria



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.**

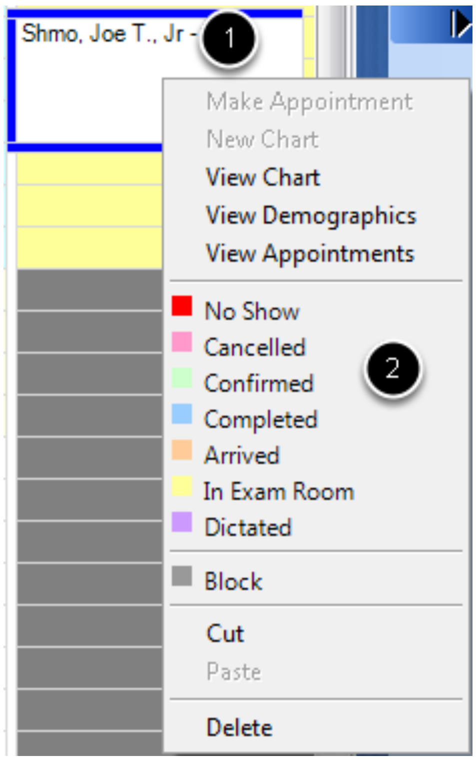
Enter Advanced Search Criteria



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, S**elect the appointment time.**
7. Click **Select.**

Change the Appointment Status

This lesson will demonstrate how to change an appointment status.

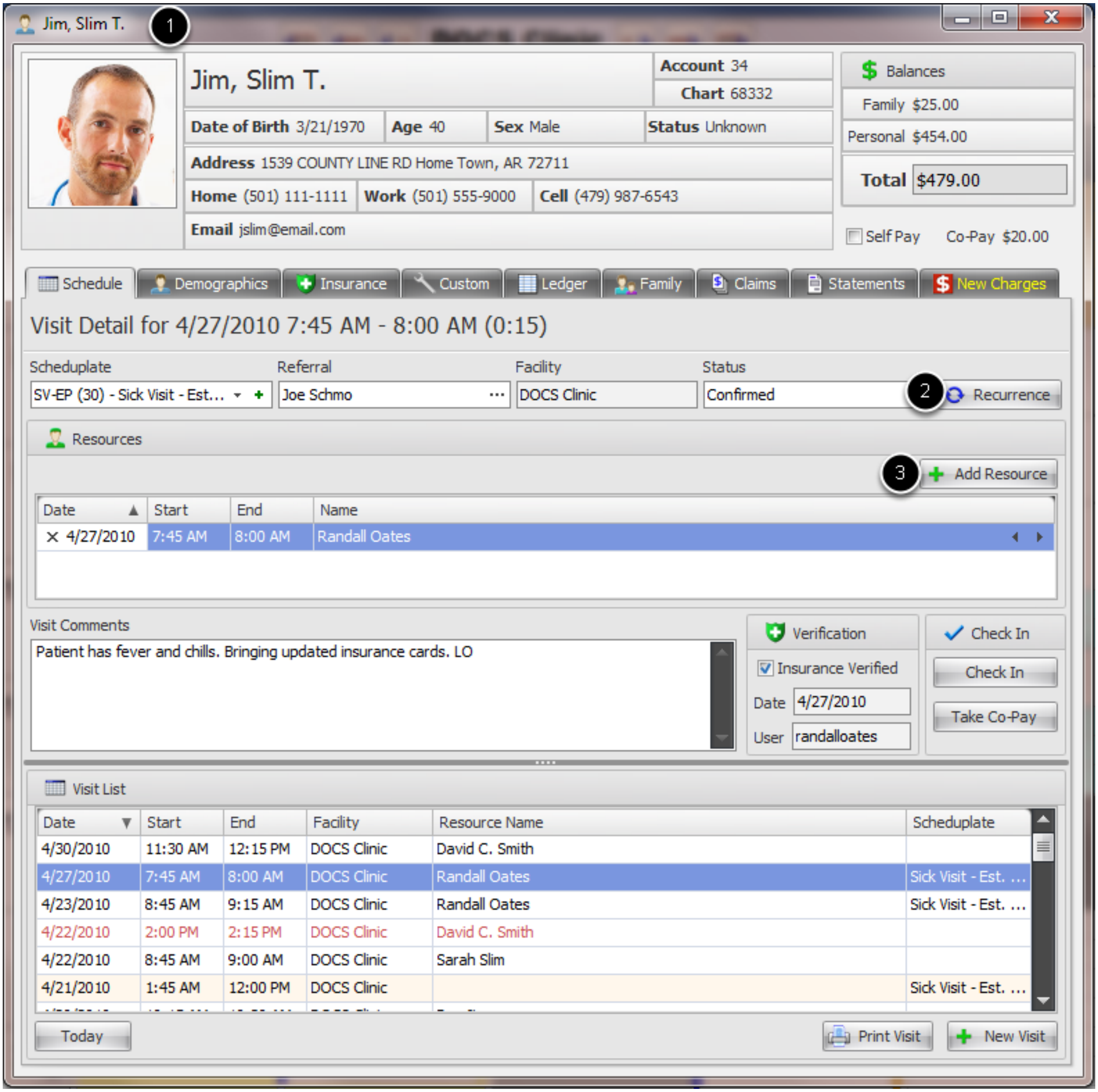


1. Right click on the desired appointment.
2. Select the needed status for the appointment. (The status should be updated automatically on the Schedule, and in the patient's visit list.)

Scheduling Repeat Appointments

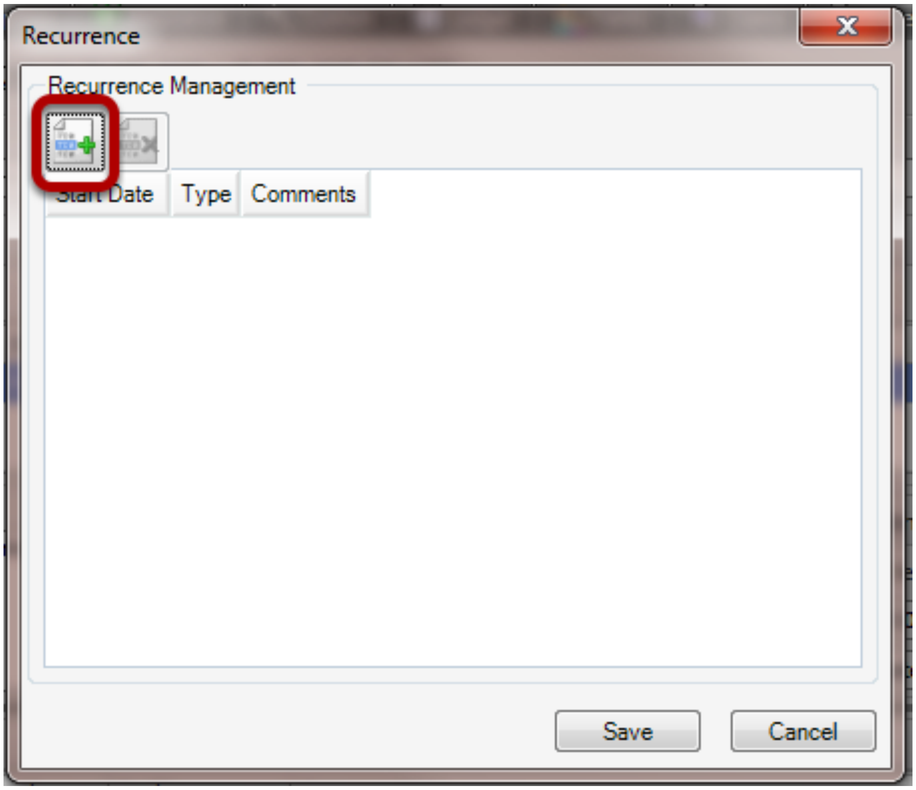
This lesson will show how to set up repeat appointments for patients.

Open the Patient Account



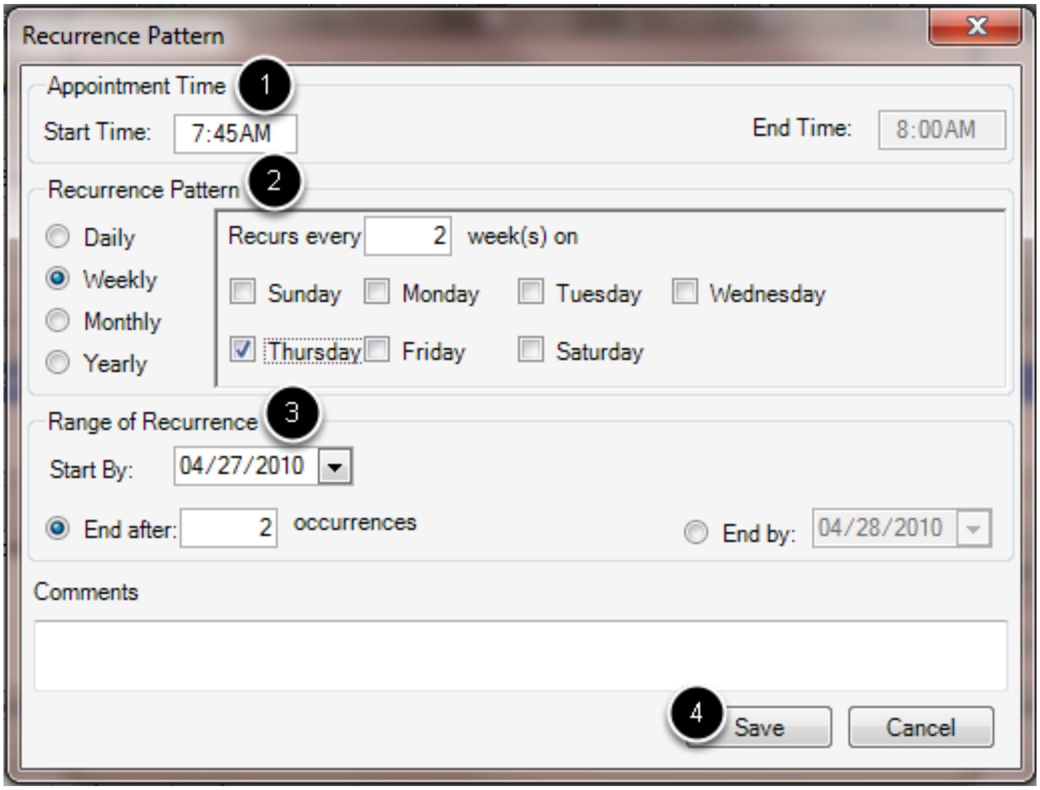
1. Double Click the appointment, needing to be repeated. This will open the patient's account dialog window.
2.On the Schedule tab, Click Recurrence.

Recurrence Management



Click the Create Recurrence button.

Set the Recurrence Pattern



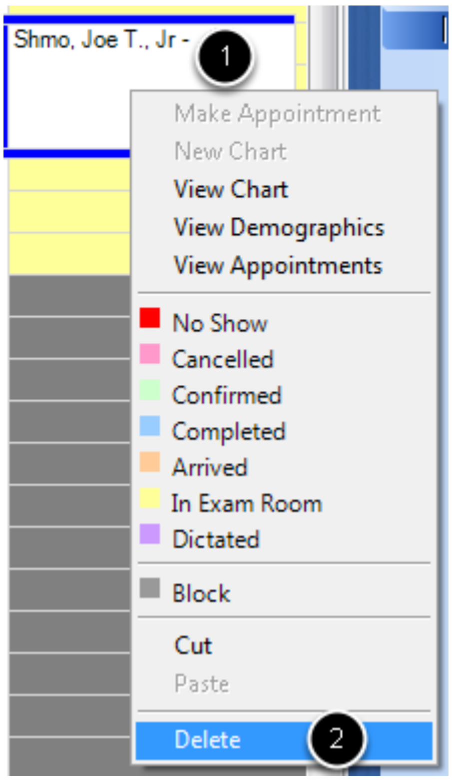
1. Enter the appointment time.
2. Select whether the appointment will be on a **Daily, Weekly, Monthly or Yearly** basis.
3. Indicate how long the recurrence will take place. **Select the Start Date**, as well as either the **number of occurrences** for the appointment or an **End Date** for the recurrence.
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

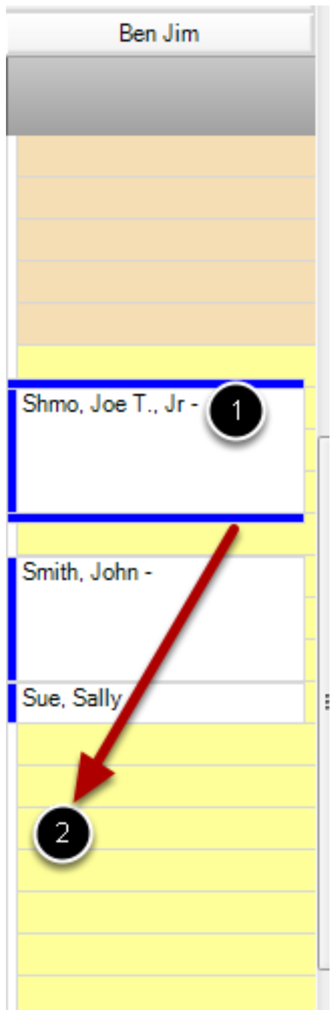


1. Click to select the appointment.
2. Right click on the appointment and select Delete, or Click Delete on the keyboard. (Awarning will pop up to make sure the appointment is to be deleted. Click Yes to continue, or No to cancel.)

Moving an Appointment

This lesson will demonstrate how to move an appointment to a different time slot.

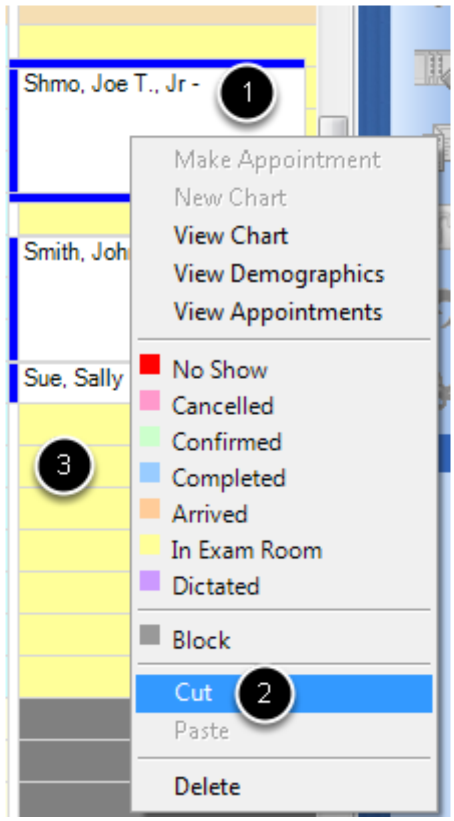
Dragging and Dropping



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

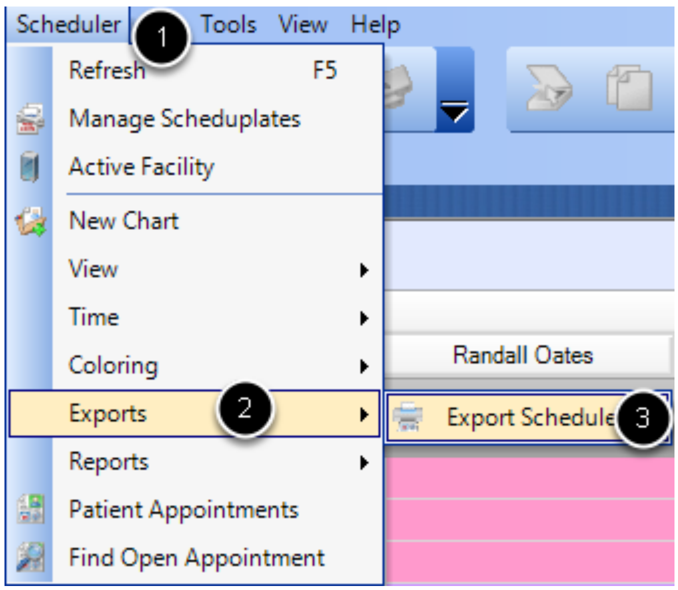


1. Click to select the appointment.
2. Right click on the desired appointment, and Select cut.
3. Click the desired time slot. Right click on the mouse and select Paste. The appointment should then be placed at a new time, and the patient's appointment details updated automatically.

Export the Schedule

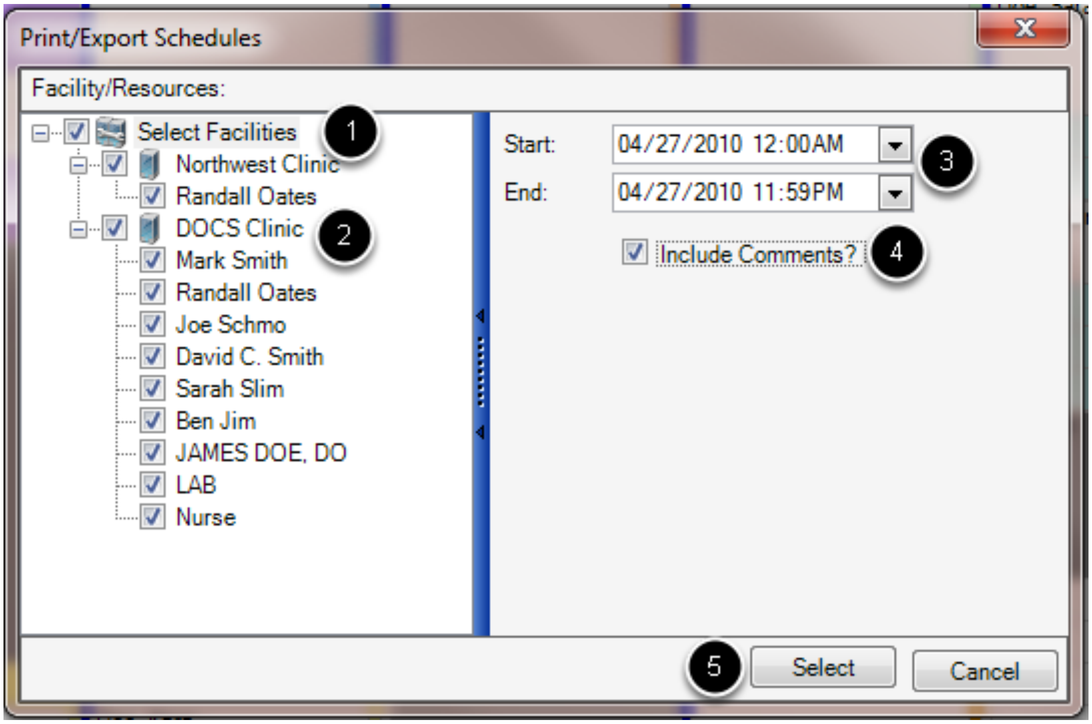
This lesson will demonstrate how to export the clinic's schedule.

Export the Schedule



1. Select Scheduler.
2. Click on Exports.
3. Select Export Schedule.

Select the Facilities/Resources to Export

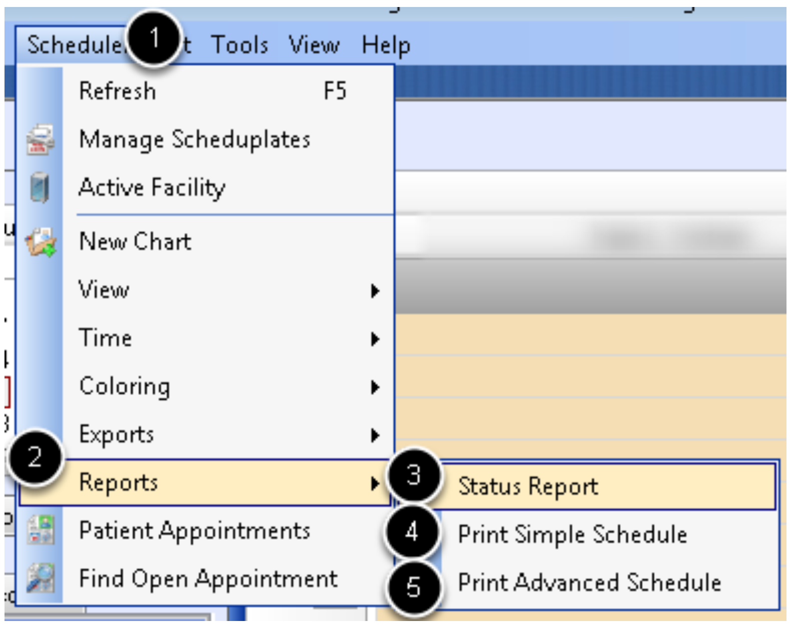


1. Check the boxes of the Facilities to be shown.
2. Select the Resources whose schedules need to be exported.
3. Enter the range of dates to be exported.
4. Check to include the visit comments on the report as reference, if needed.
5. Click Select. The file will be exported as a CSV file.

Schedule Reports

This lesson will demonstrate how to access reports on the Schedule data.

Print various Schedule Reports



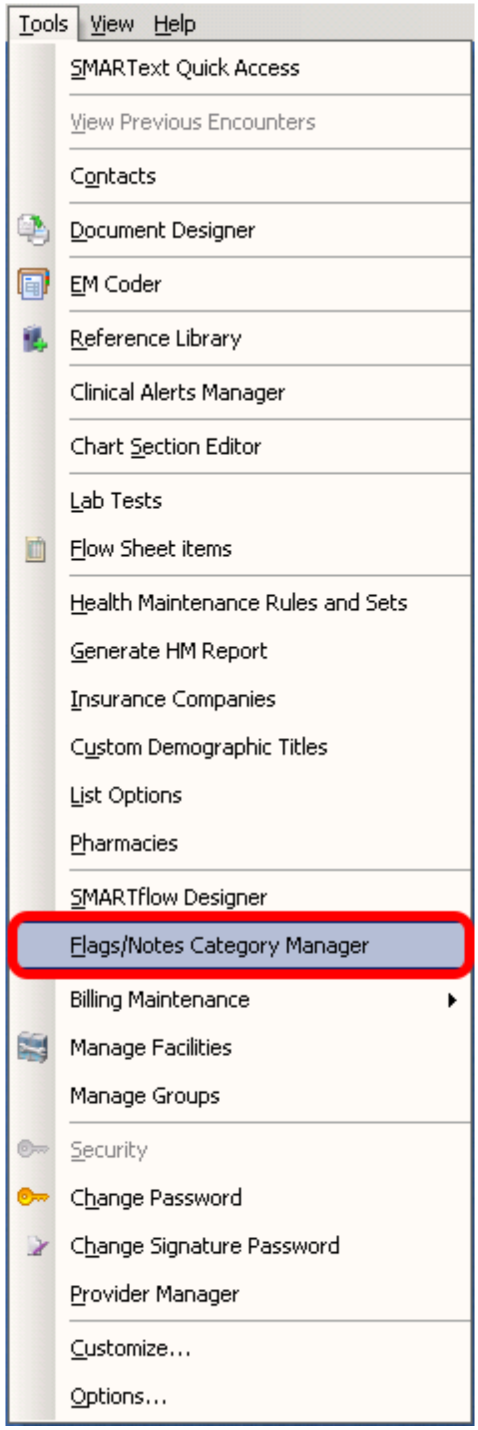
1. Click on Scheduler.
2. Click on Reports.
3. Status Report: View a summary of patients based on their appointment status.
4. Print Simple Schedule: Provides a summary of the appointments scheduled by Provider. Indicates the Time, Patient Name, Phone Number, Scheduplate, Status and visit Comments.
5. Print Advanced Schedule: Provides a summary of appointments scheduled across Facilities and Resources. Time, Patient Name, Phone Number, Scheduplate, Status and visit Comments.

Patient Flags & Notes

Set Up: Patient Flags/Notes

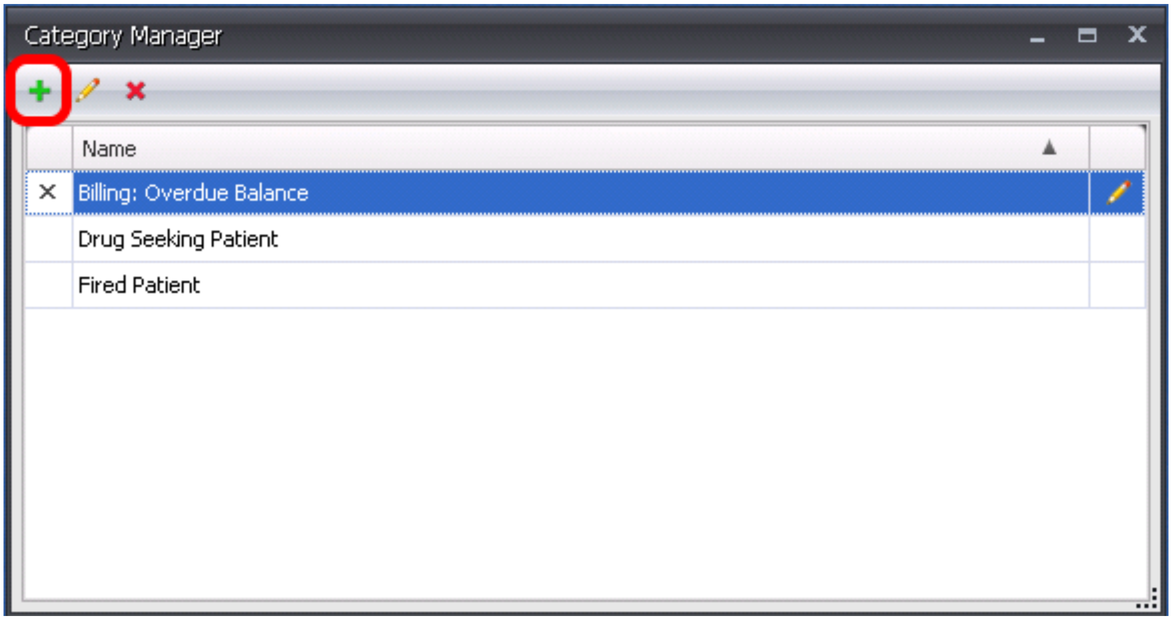
In SOAPware 2012+, users will now have a chart section called Patient Flags & Notes which can be used to record patient flags/alerts or billing notes that will alert the user when a patient's chart is opened.

Setting Up Flags & Notes



To set up the clinics flags & notes categories, Click on the Tools menu > Notes Category Manager.

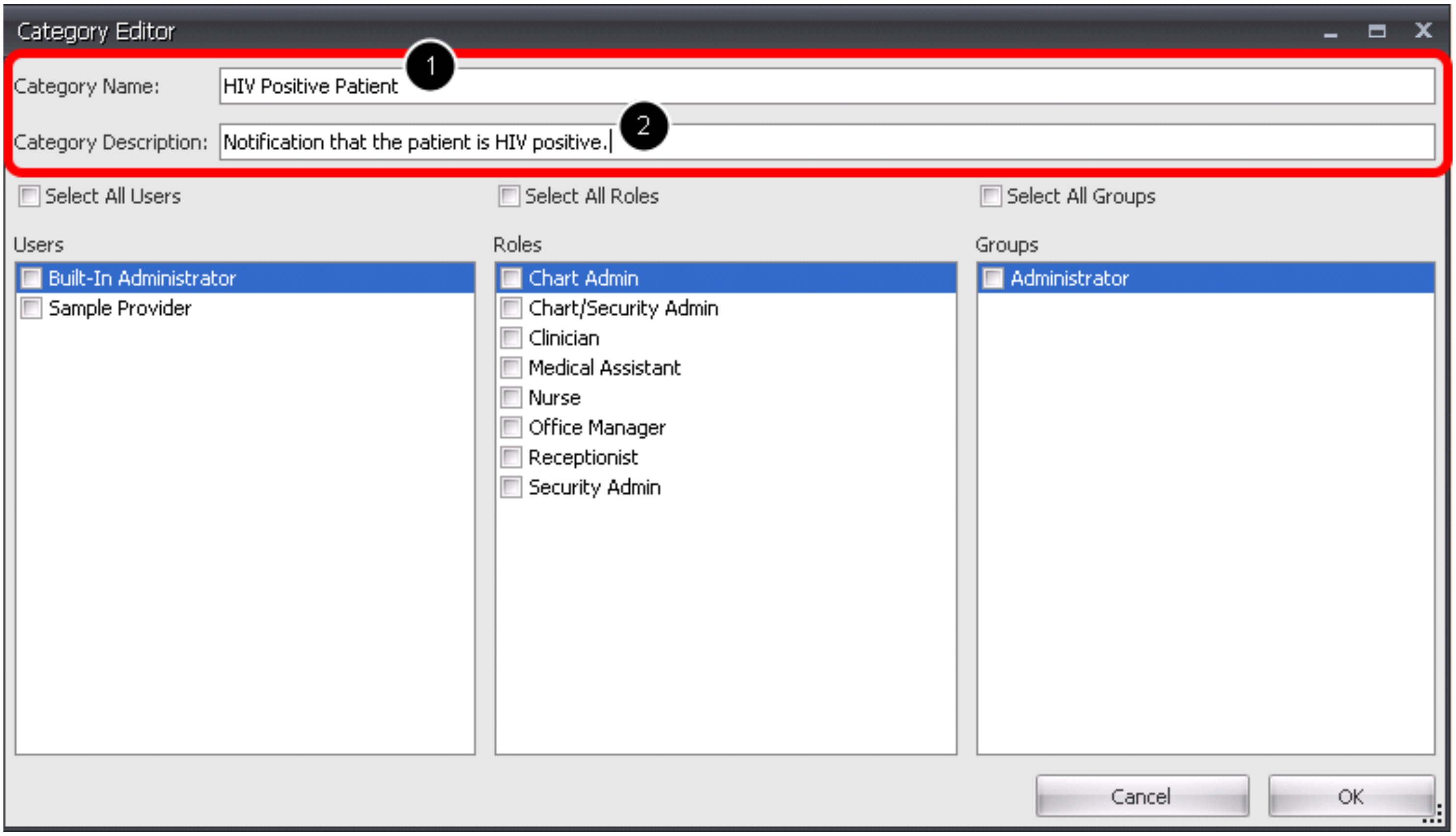
Creating a New Flags/Notes Category



To create a new Flags/Notes Category, Click the **Green Plus** button.

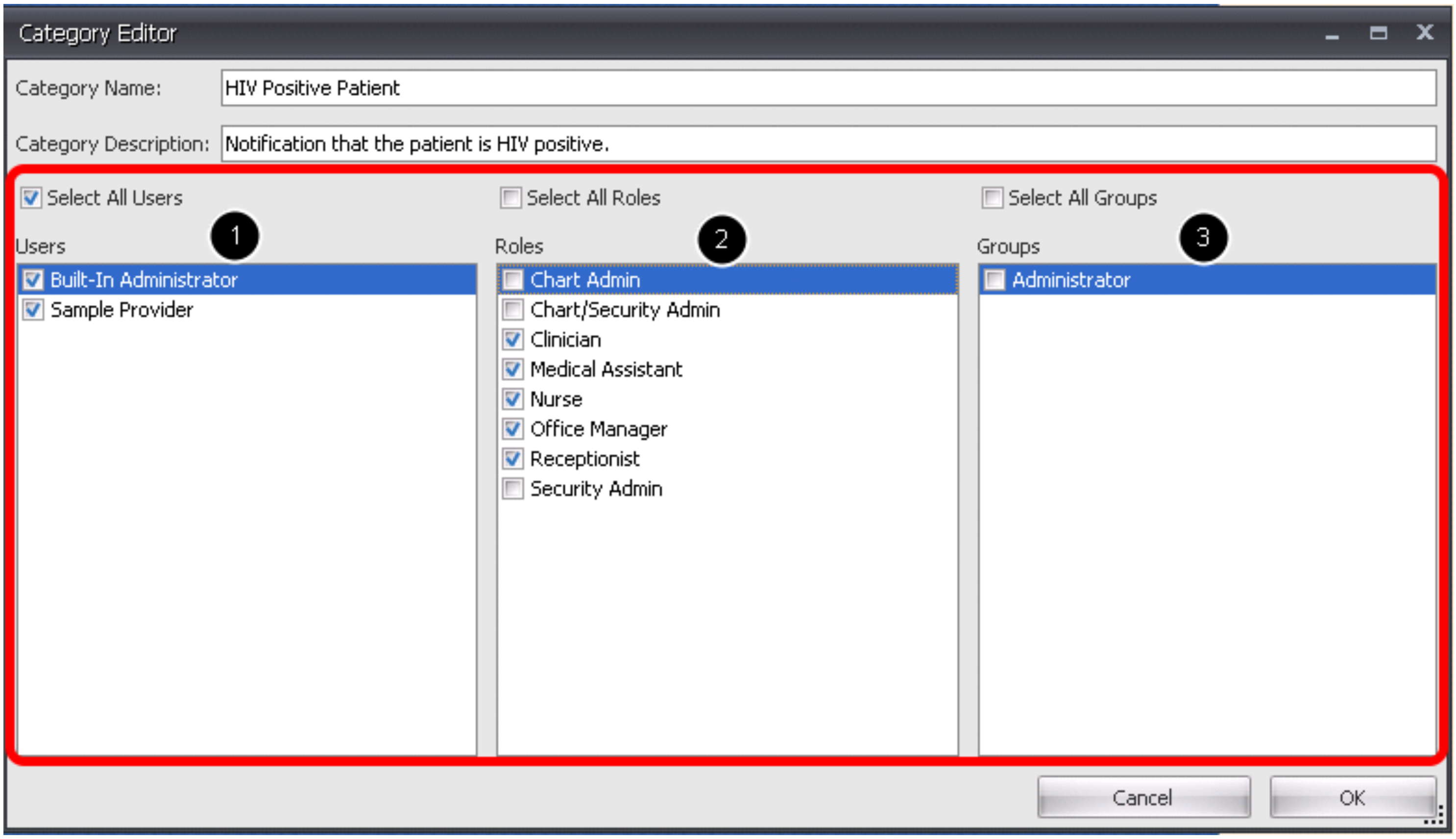
This will open the Category Editor.

Category Editor



To create a new category for Flags/Notes, fill in the following information:

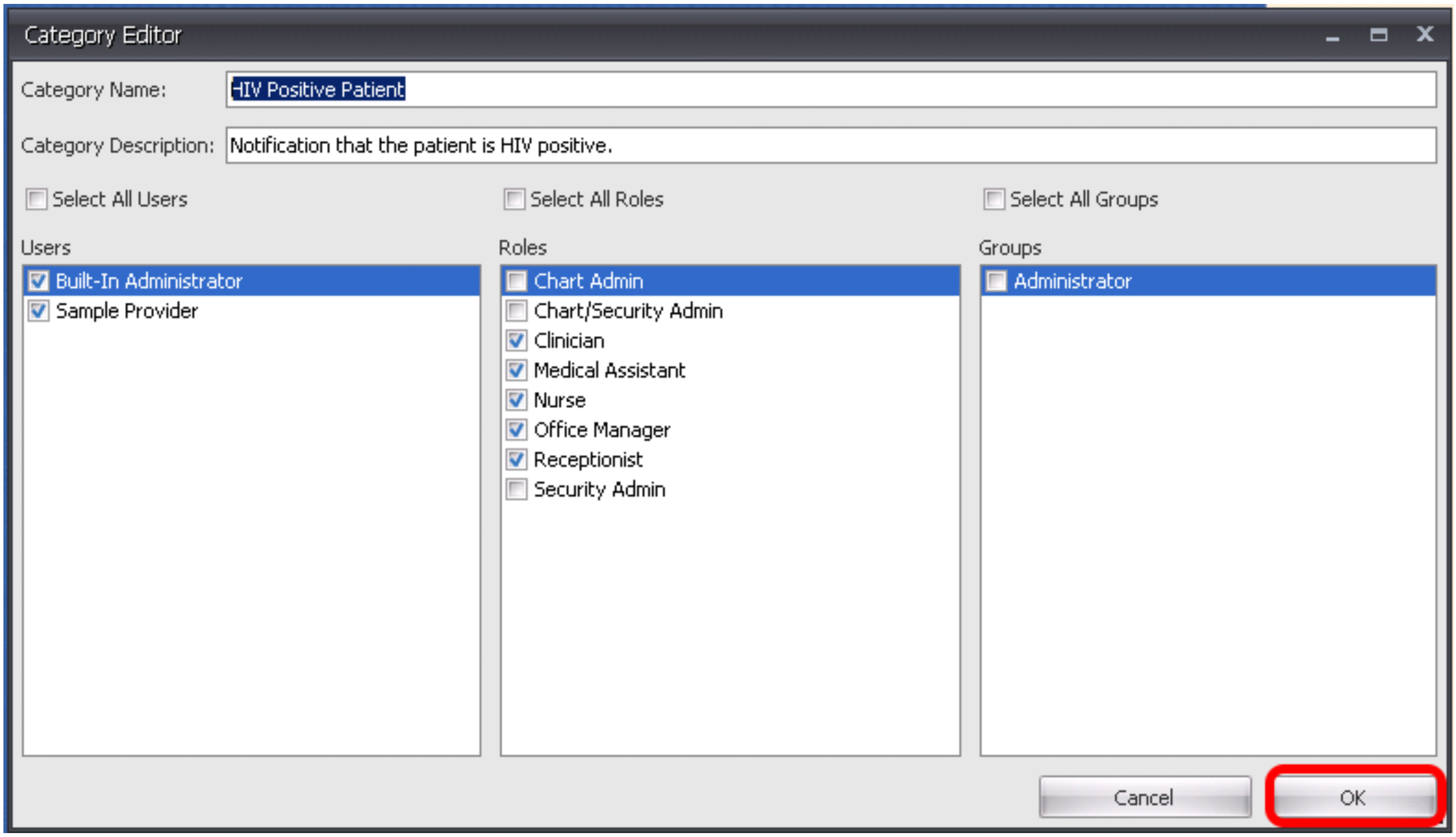
1. **Category Name:** Enter the name of the category (i.e. HIV Positive Patient, Drug Seeking Patient, Fired Patient, etc...).
2. **Category Description:** Enter a brief description of the category.



Select the Users, Roles and Groups that should have the ability to view the flag when the patients chart is opened.

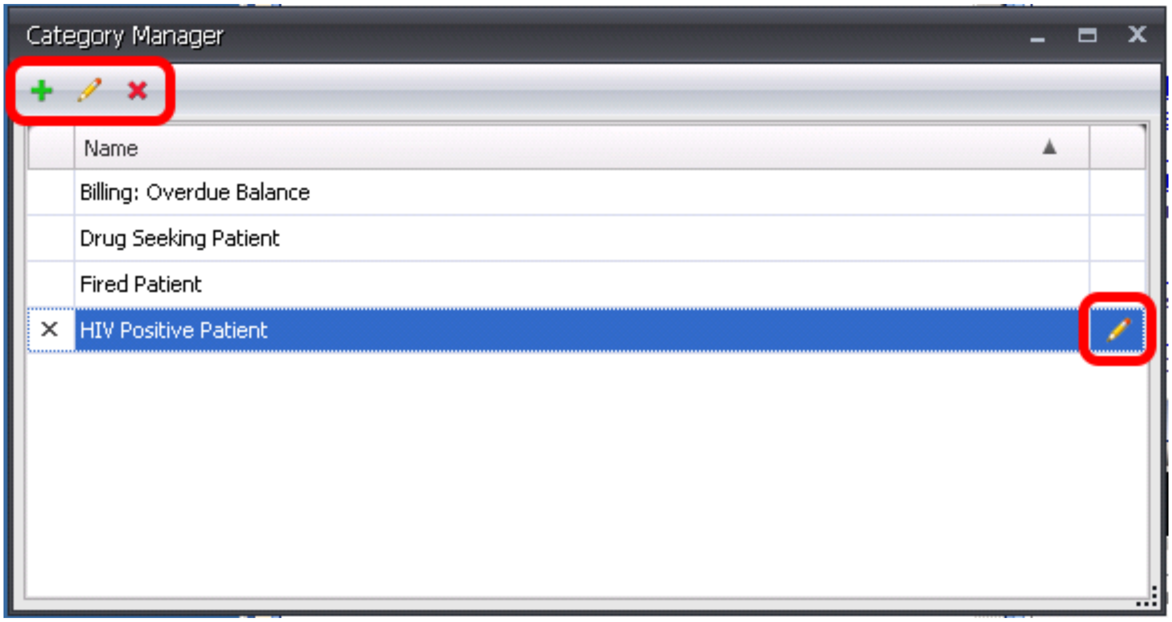
1. **Users:** Place a check mark in the box next to the Users that should receive an alert upon opening a flagged chart.
2. **Roles:** Place a check mark in the box next to the Roles that should receive an alert upon opening a flagged chart.
3. **Groups:** Place a check mark in the box next to the Groups that should receive an alert upon opening a flagged chart.

The Select All Users, Select All Roles & Select All Groups boxes can be check to indicate that all Users, Roles and Groups should receive an alert upon opening a flagged chart.



Click the OK button to save the new category.

Editing and Removing Existing Categories



As mentioned above, the **Green Plus button** will allow the user to create a new Flags/Notes category.

The **Pencil icon button** will allow the user to edit the currently selected category.

The **Red X button** will allow the user to remove/delete the currently selected category. If a category is deleted, it will not delete any flags/notes that were previously entered in a patients chart and tied to the deleted category.

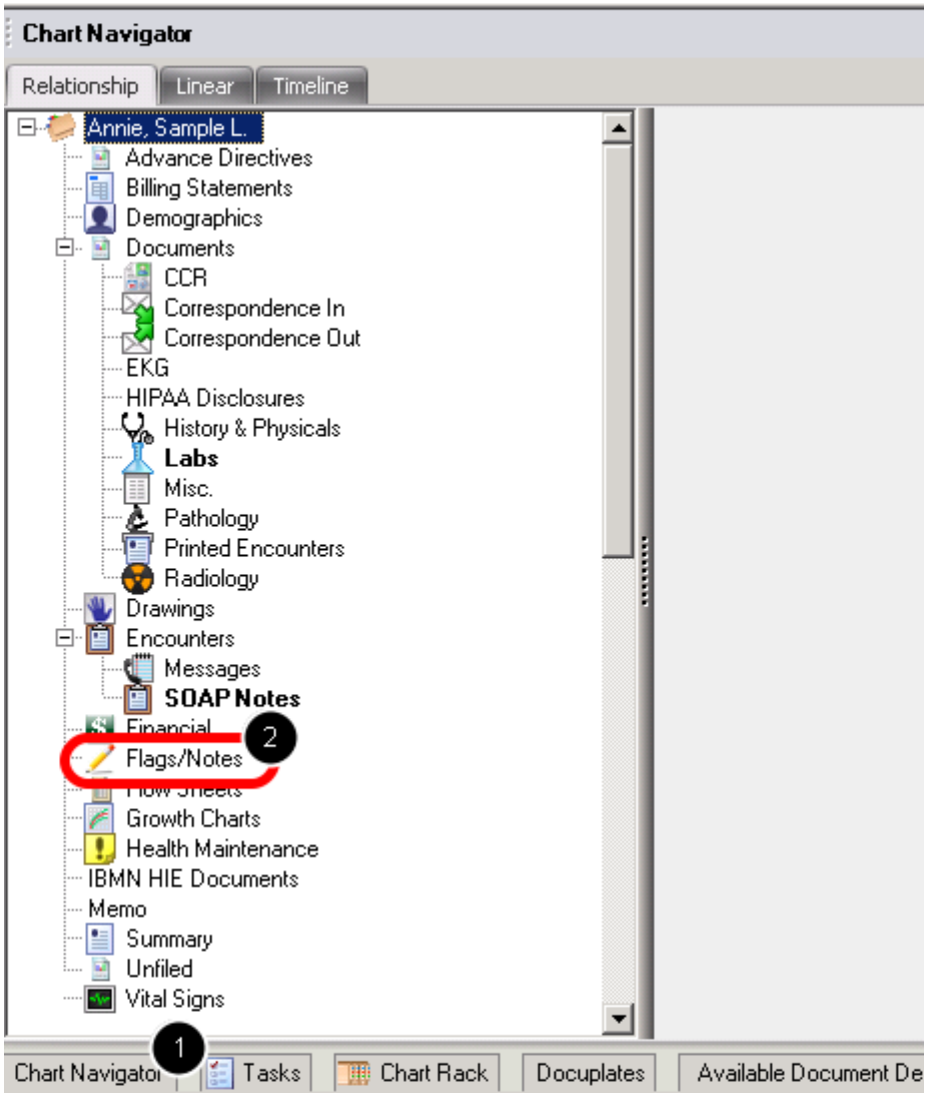
Adding Flags/Notes to a Patient's Chart

About Flags/Notes

The Flags/Notes chart section can be used to record patient flags (alerts) or billing notes that will alert the user when a patient's chart is opened.

The Flags/Notes chart section should not be used for documentation purposes. Flags/Notes are not a permanent part of the patient record and will not be included when the medical record is exported using Share Charts. The Flags/Notes section can be used to keep track of important patient alerts or billing notes and to flag a patients chart to alert clinic staff of patient specific items. Some examples of flags/notes would be to alert the clinic staff that a patient is HIV positive or has demonstrated drug seeking behavior or also to note that the patient has an overdue balance.

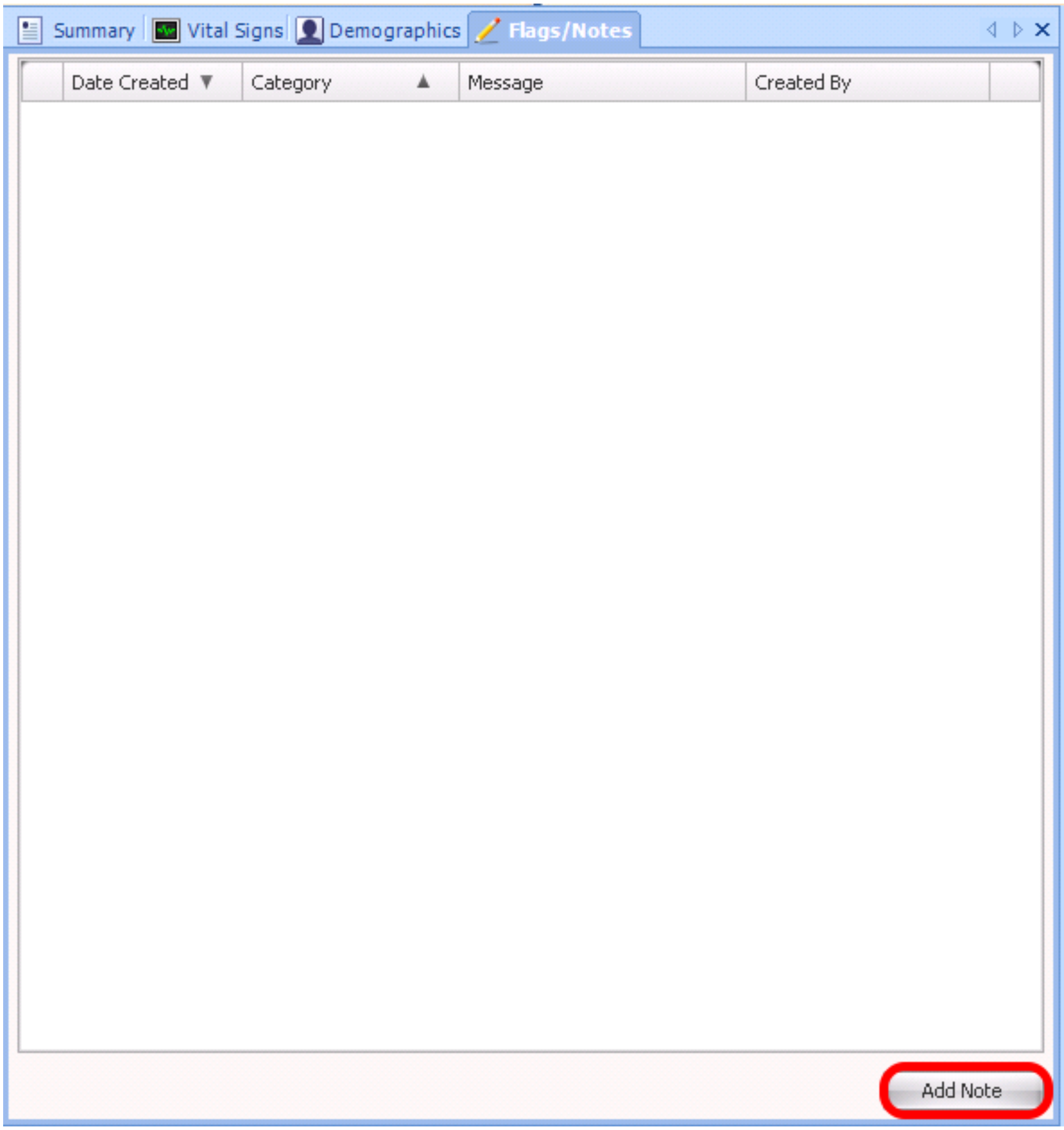
Opening the Patient Flags/Notes Chart Section



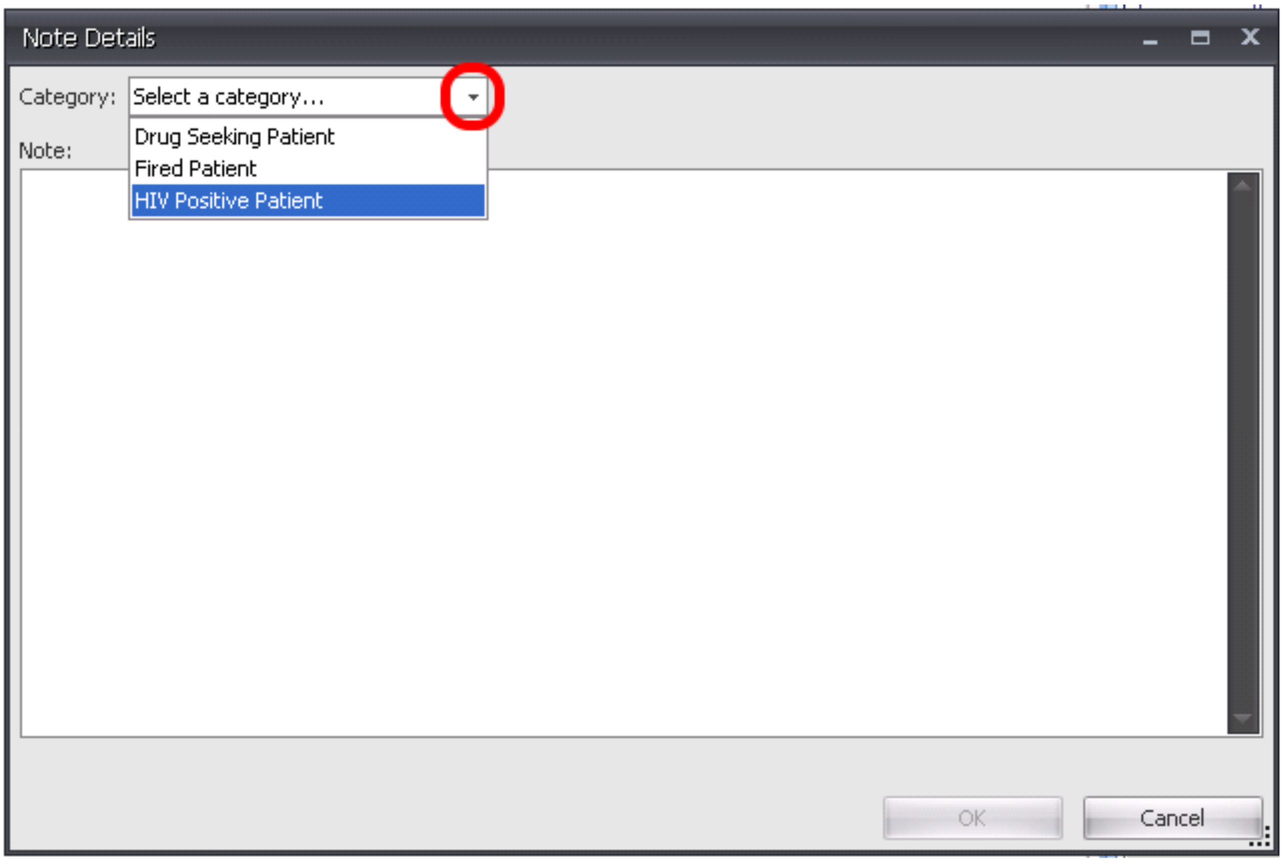
Flags/Notes can be created for a individual patient using the Patient Flags/Notes chart section. To open the chart section:

1. Click on the Chart Navigator docked tab.
2. Double Click on the Patient Flags/Notes chart section.

Adding a New Flag/Notes

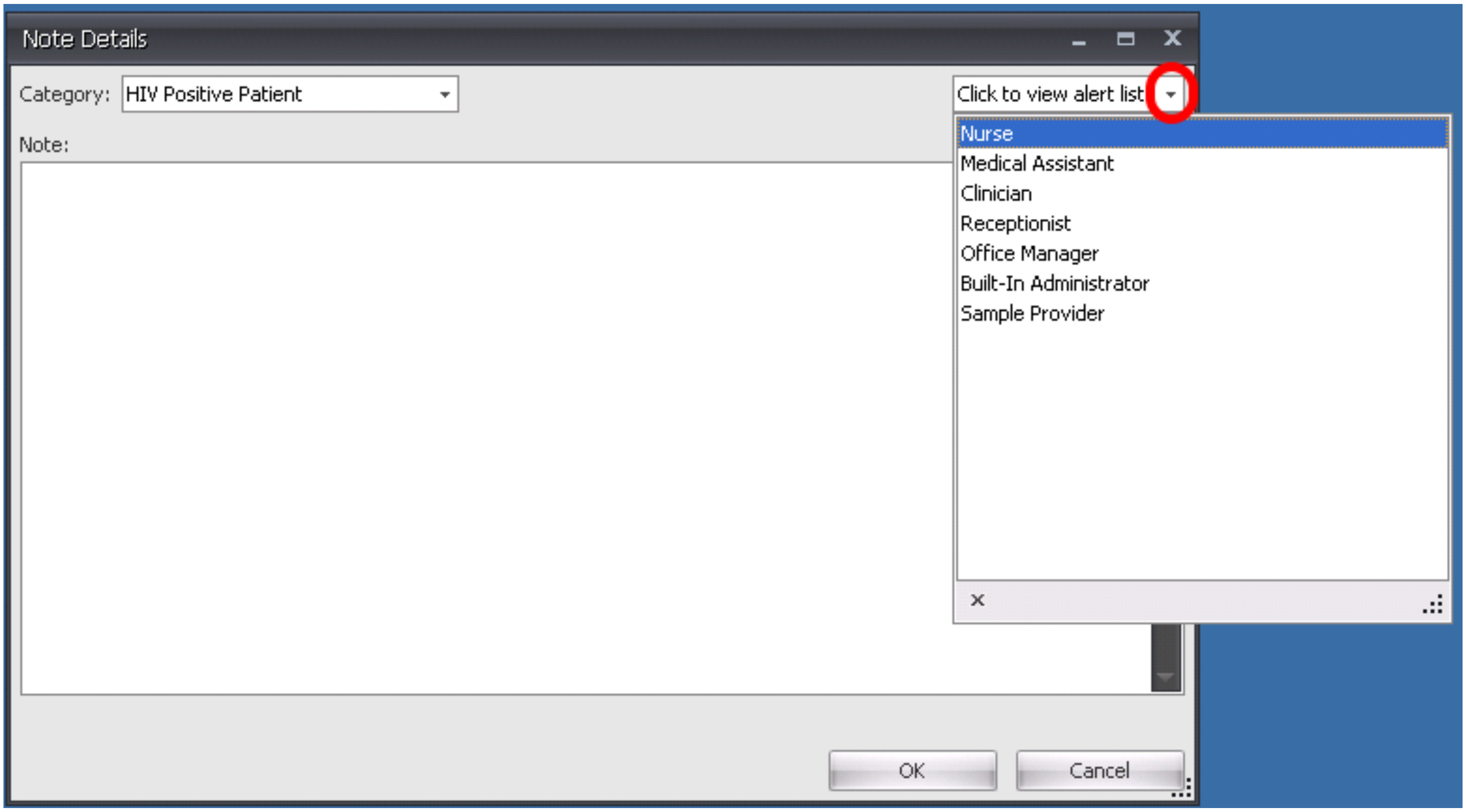


To add a new flag/note to an individual patient chart, Click the **Add Note button**.



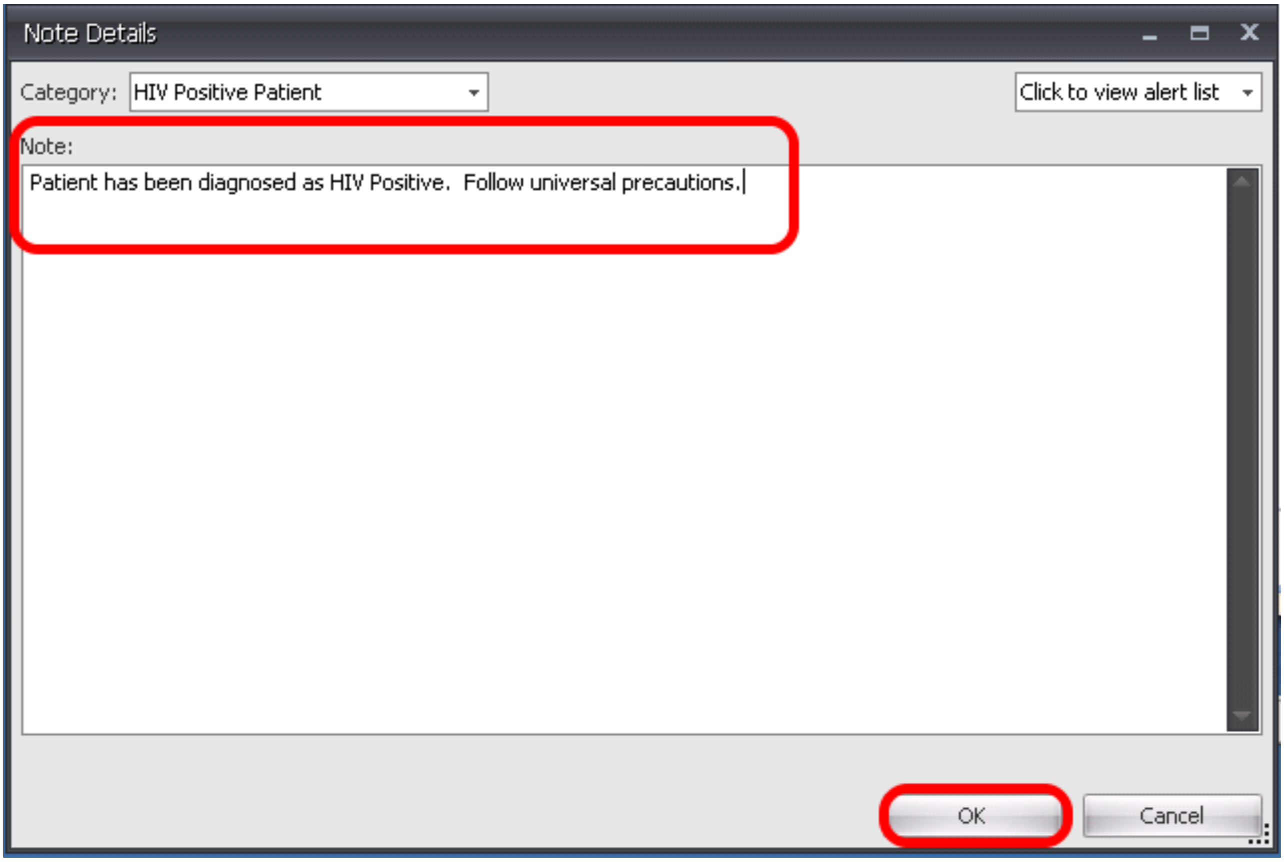
Next, select the appropriate category for the Flag/Note using the drop down menu.

Viewing a List of Flagged Users



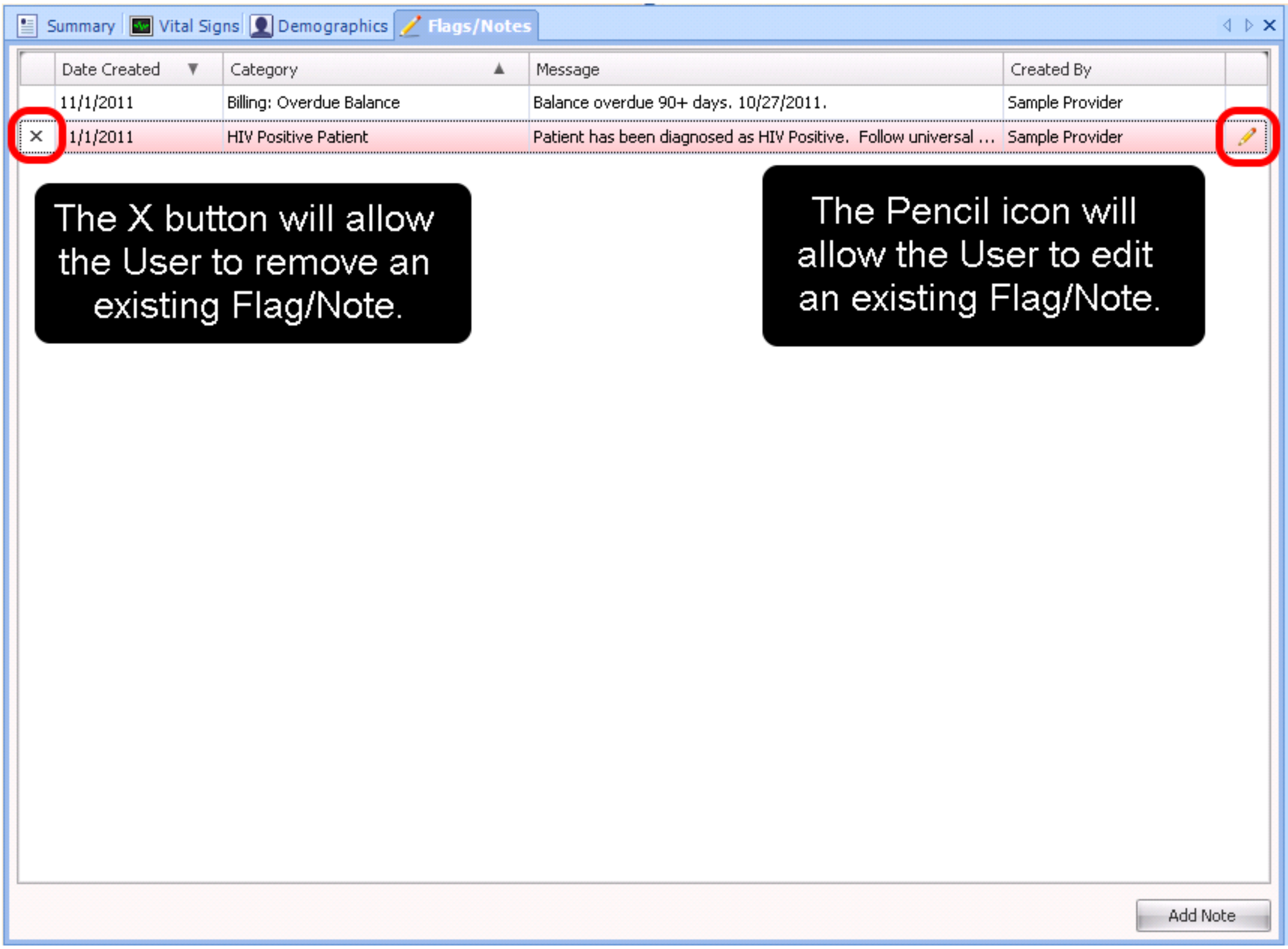
Once a category for the new flag/note has been selected, if the user wishes to view a list of users that will be alerted when this patient's chart is opened, Click the View Flagged Users drop down menu.

Completing and Saving the Flag/Note



Enter any notes within the text box, then Click the OK button to save.

Viewing, Editing & Removing Patient Flags/Notes



Once the flag/notes has been saved to the patient's chart, it will be displayed within the Flags/Notes chart section.

- **Flags:** Items that will flag/alert a SOAPware User upon opening the patient's chart will be shaded red.
- **Notes:** Items that do not have a flag/alert attached to them will be colored white. These items will not alert any users upon opening the patient's chart.
- Double Click on the line item to view more detail.

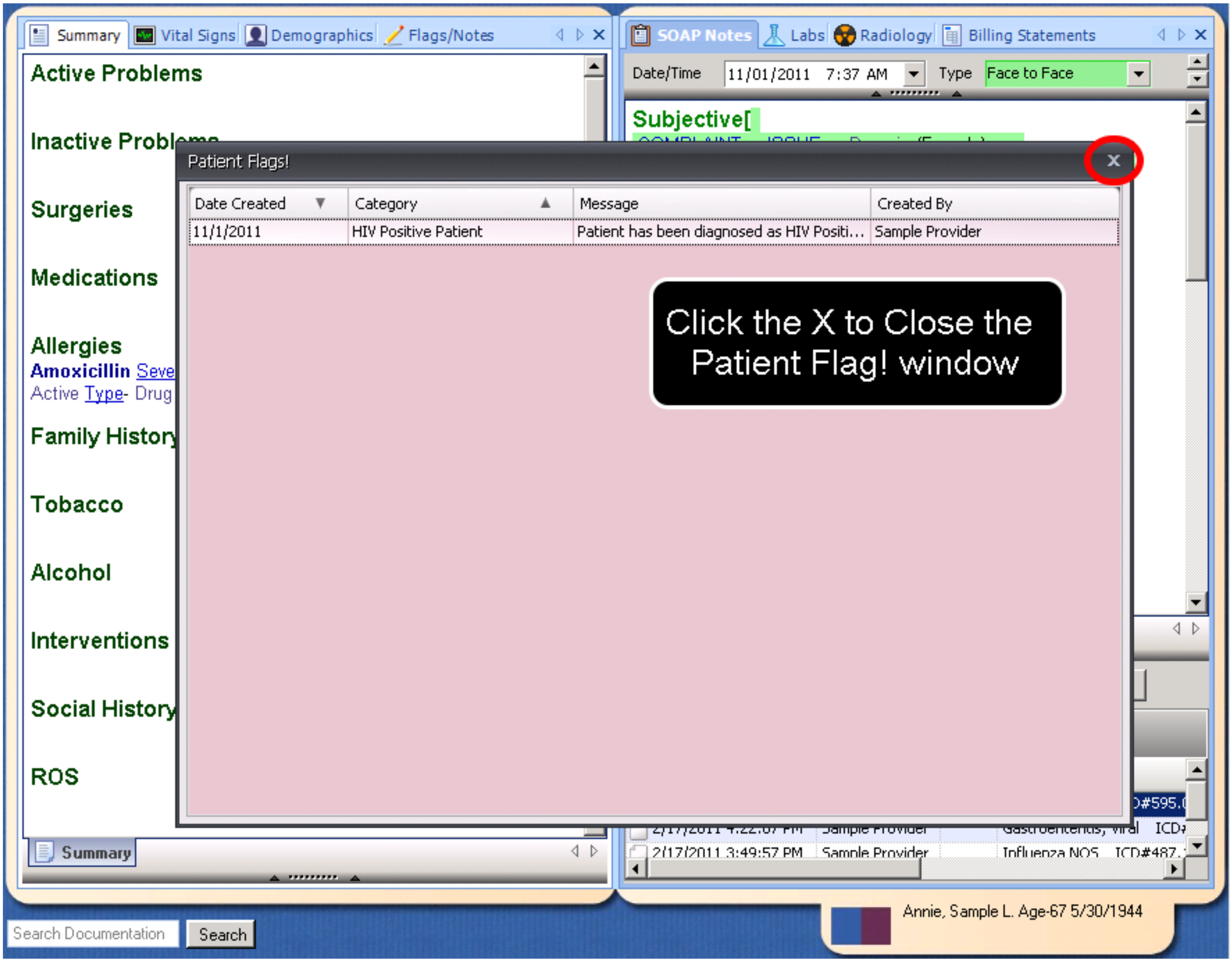
<u>Removing/Deleting an Existing Flag/Note</u>

Click the X button located to the left of the line item to remove or delete an existing flag/note.

Editing an Existing Flag/Note

Click the Pencil icon located to the right of the line item to edit an existing flag/note.

Viewing the Patient Flag

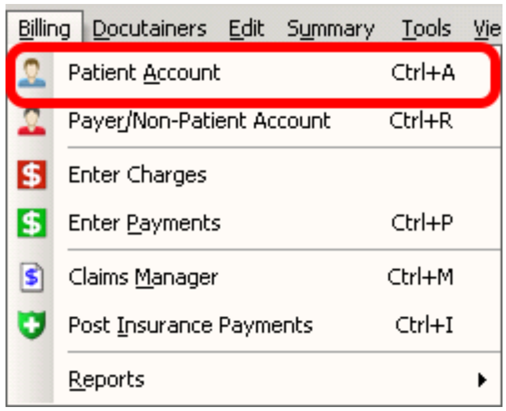


When the patient's chart is opened, the designed Users/Roles/Groups will receive the "Patient Flags!" pop-up (as seen in the screenshot above).

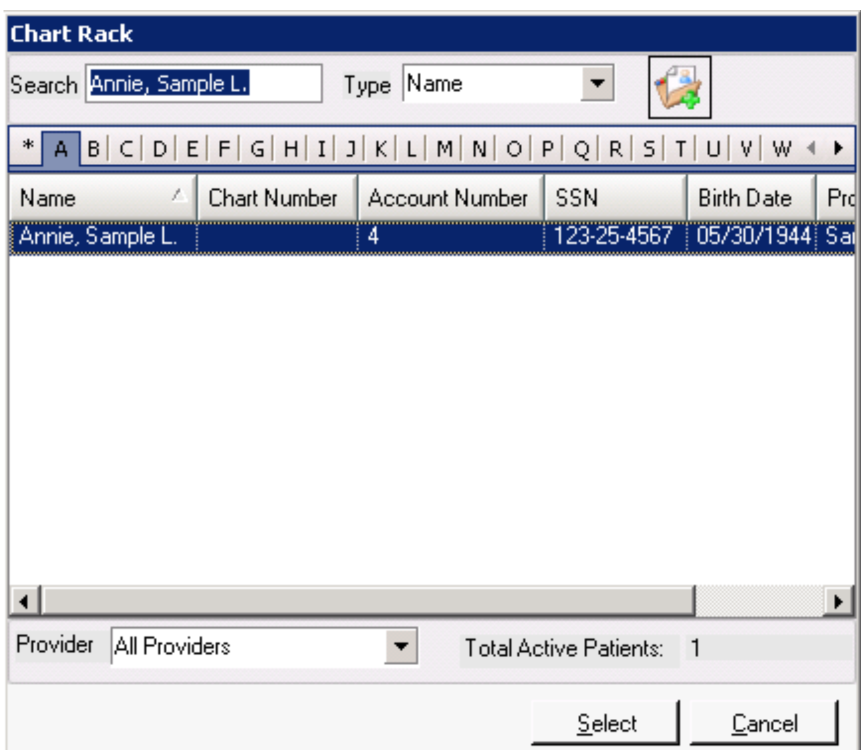
This pop-up window allows the imported flagged message to be viewed by the User before they are able to access the chart. To Close the Patient Flags! window, click the X button.

Patient Account: Flags/Notes Tab

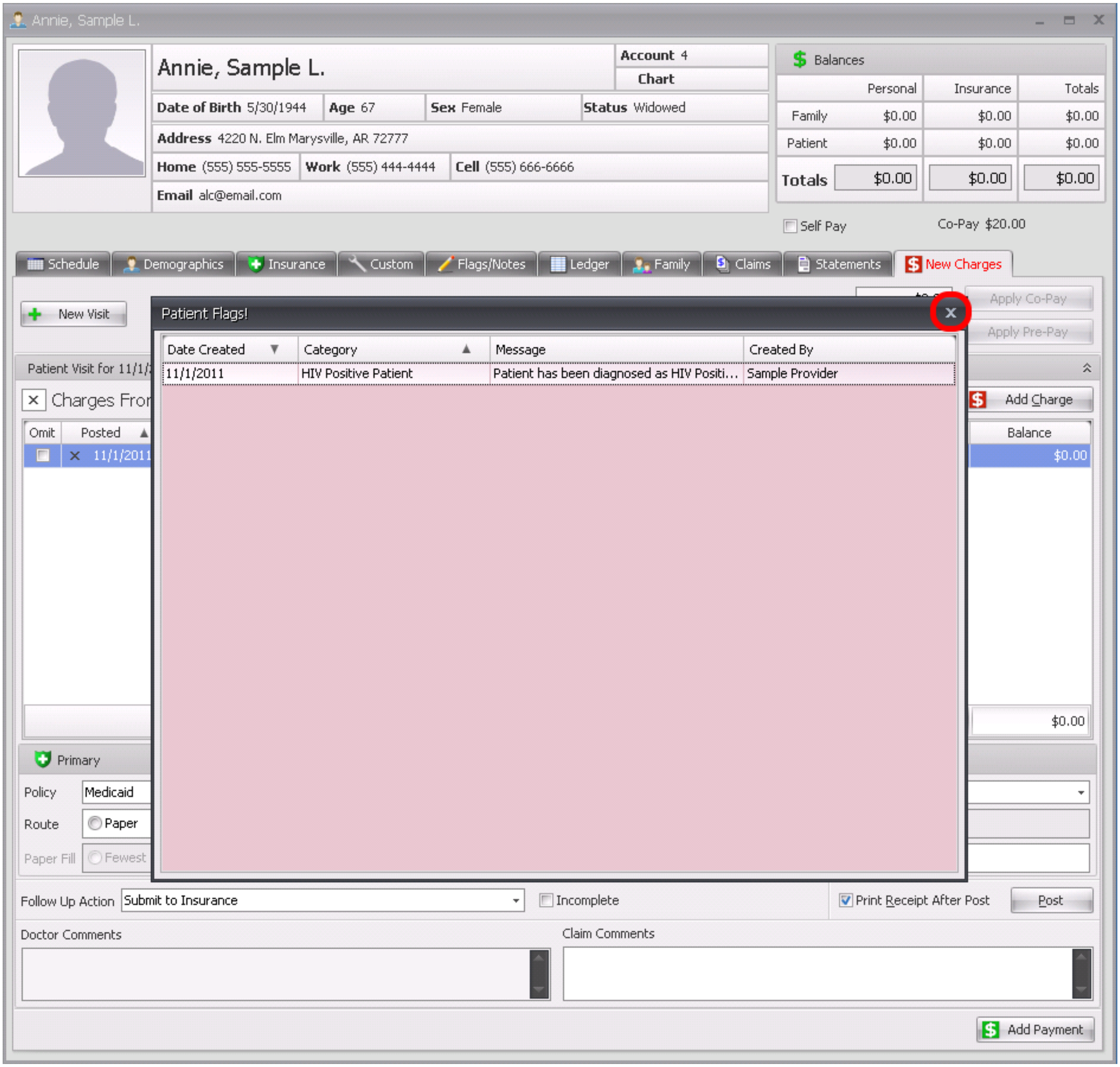
Patient Account: Flags/Notes



Flags/Notes can also be created, edited and viewed within the Patient Account (for Clinical Suite customers). To open the Patient Account, Click Billing > Patient Account.

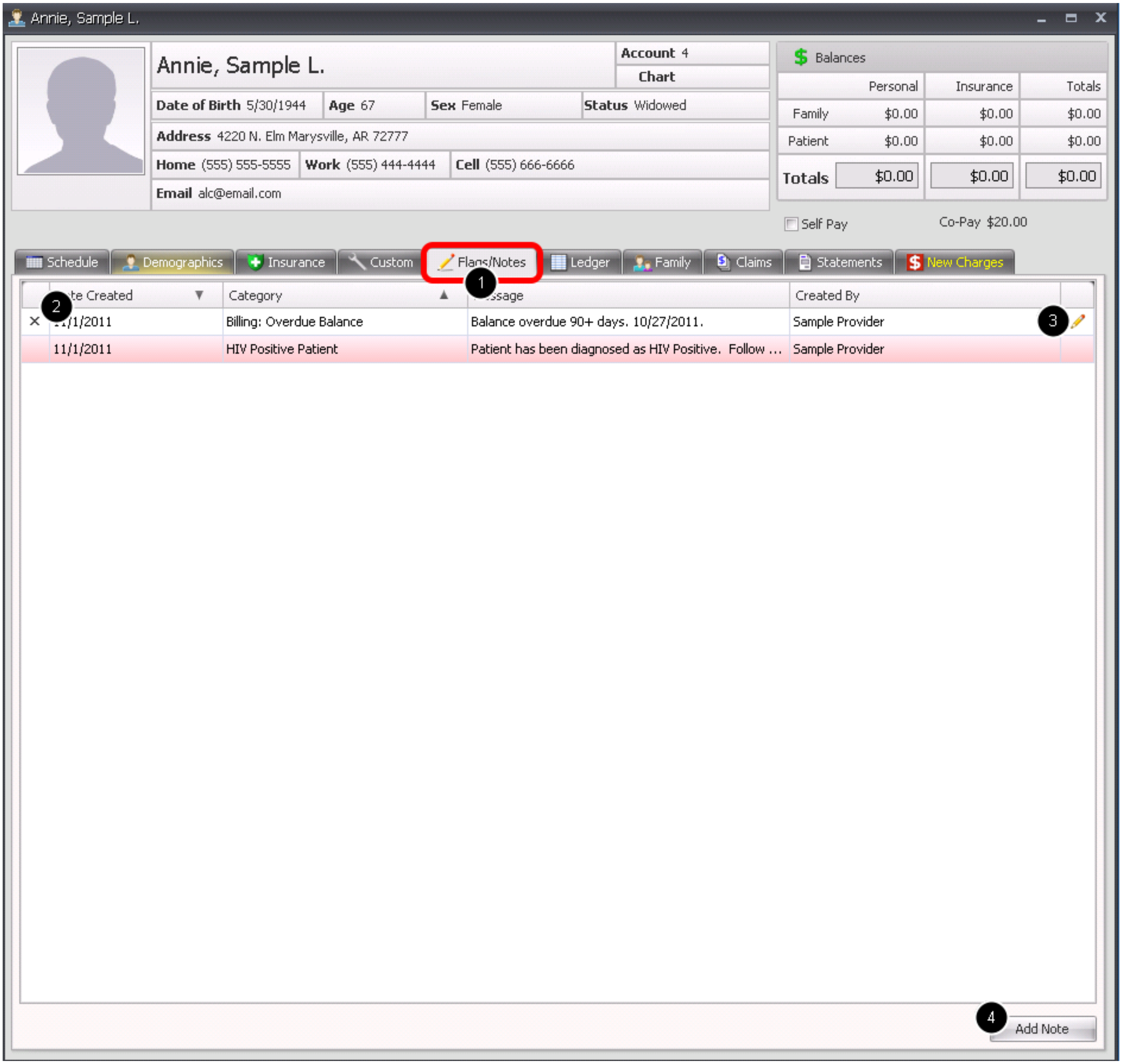


Select the desired chart from the Chart Rack and click the Select button to open the Patient Account.



When the Patient Account is opened, the Patient Flag! alerts window will display for authorized Users/Roles/Groups.

Click the X in the top right corner of the Patient Flags! window to close the window.



1. Click the **Flags/Notes tab** to view the patient's list.
2. The **X button** will allow you to remove/delete an existing flag/note from the patient's chart/account.
3. The **Pencil icon** will allow you to edit the existing flag/note.

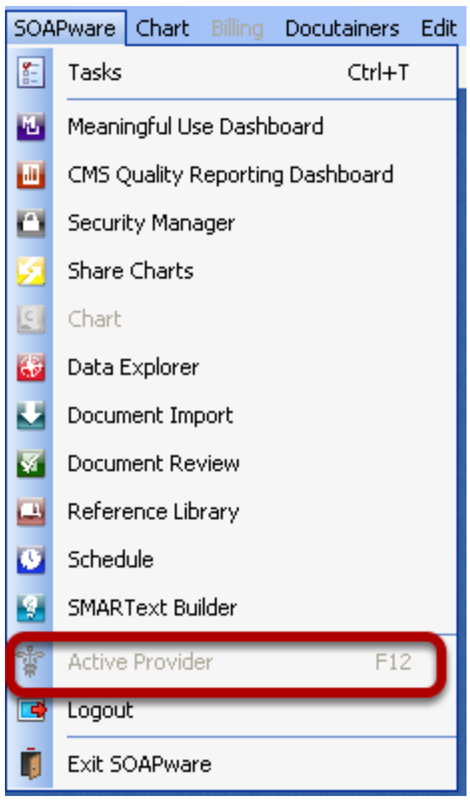
4. The **Add Note button** will allow the user to add a new flag/note to the patient's chart/account.

Workflow Considerations

Active Provider

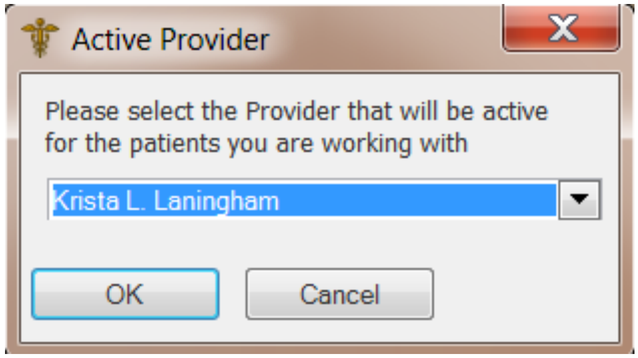
The Active Provider dialog allows the user to switch the currently selected Active Provider in SOAPware. Switching the Active Provider in SOAPware allows the user to access the selected Provider's Chart Rack, and the create, edit and sign off items in SOAPware created under the selected Provider's name.

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.

Updox for SOAPware

Updox for SOAPware 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 Updox for SOAPware, such as secure messaging to non-patient contacts, screen capture, PDF editing and generation, and scanned document uploads. Updox for SOAPware provides tracking of fax and e-mail communications and provides configurable individual and shared views to inboxes and sent items. Updox for SOAPware has been developed for SOAPware by Updox.

Interface

Updox for SOAPware is viewed through popular browsers, such as Internet Explorer, Google Chrome, Firefox and Safari. Depending on a user's configuration, Updox 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 Updox for SOAPware 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 Updox for SOAPware 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.

***SCS Customers:** If users are using the SOAPware Cloud Service (formarly SOAPware Hosting Service), users will follow the same instructions below on the VPS and not on the local PC.

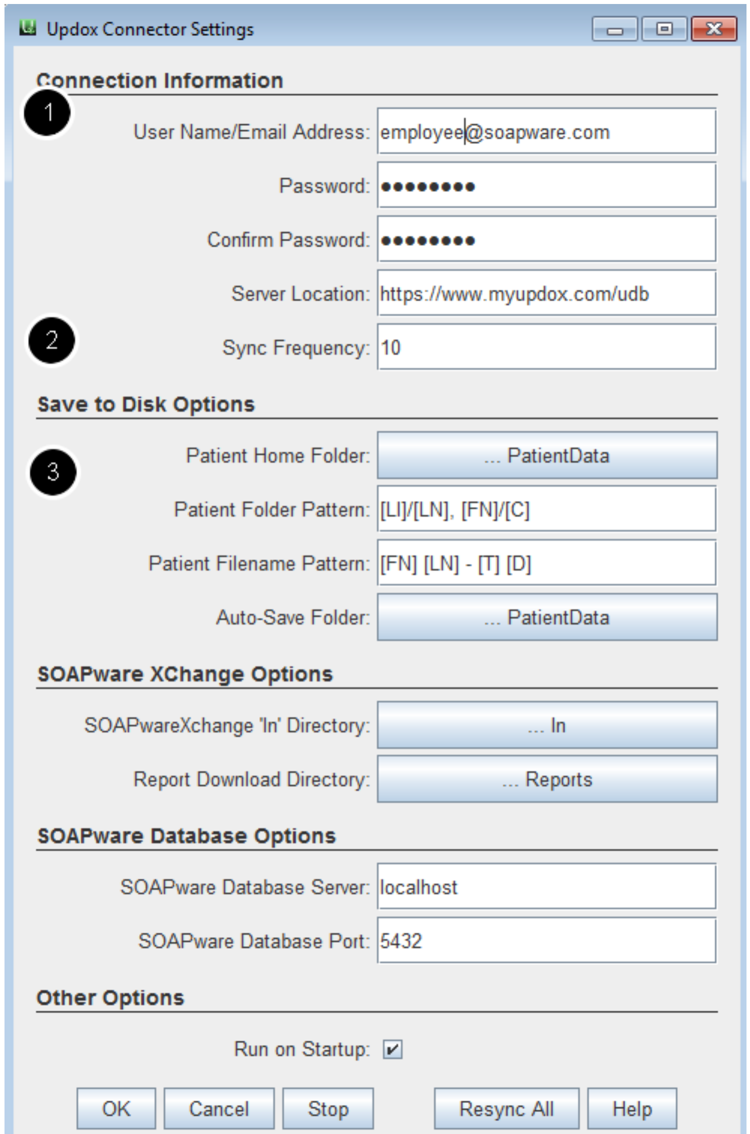
Requirements

Requirements = Java version 6, SOAPwareXchange 2010.1.X or above
Click Here, verify that all the aspects of the interface are installed & configured.

Updox for SOAPware Connector

When creating a Updox for SOAPware 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 & Updox, called the Updox for SOAPware Connector. The connector is a file (soapware_hosted.jnlp) that is ran by Java, installed to Start > Programs > Updox Connector and has several settings that can be adjusted to assist the user with personal & EMR interaction with Updox for SOAPware.

The Connector



The Connector creates the link between the Updox Service Database & SOAPwareXchange. The application logs into the account on Updox 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 Updox. 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 Updox Connector to SOAPwareXchange for processing.

Updox for SOAPware

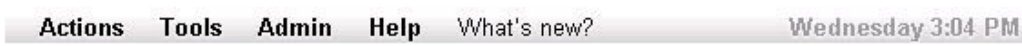
After the user's Updox Account is created, when the user goes to login at http://www.Updox.com the user will be prompted to select the EMR, SOAPware in our case, then a file will begin to download (soapware_hosted.jnlp). This file will be ran by Java & start the "Updox for SOAPware"

Helper which includes all the same tools mentioned below in "Main Menu Explained" & a few others.

1. Open Updox Browser will take users to the login page of the practice Updox 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 Updox" function (default = C:\Documents and Settings\USER\SendToDocu-Portal).

Main Menu



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 Updox enabled Practice.

Add File allows users to upload any file to the Updox 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 Updox.

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 Updox.

Tools

Change Password allows users to create a new password for the users' Updox User ID.

My Profile allows users to edit the Name, Address, Time Zone, Email, & Signature Image of the users' Updox User ID.

Usage Information allows users to view the usage & limits associated with the users' Updox 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 Updox Practice.

Practice Profile allows users to view or edit the practice information associated with Updox; 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) 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 Updox. 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' Updox 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) for a document describing the Updox acount usage.

Setup References links to the following 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 Updox for SOAPware.

FAQ links to the following PDF (http://myupdox.com/udb/files/help/faq_soapware.pdf) describing many functions of the Updox for SOAPware.

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) where the user can find new features & bug fixes being added to Updox.

Changing Settings: User Specific, Computer Specific, and Global Settings

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

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.

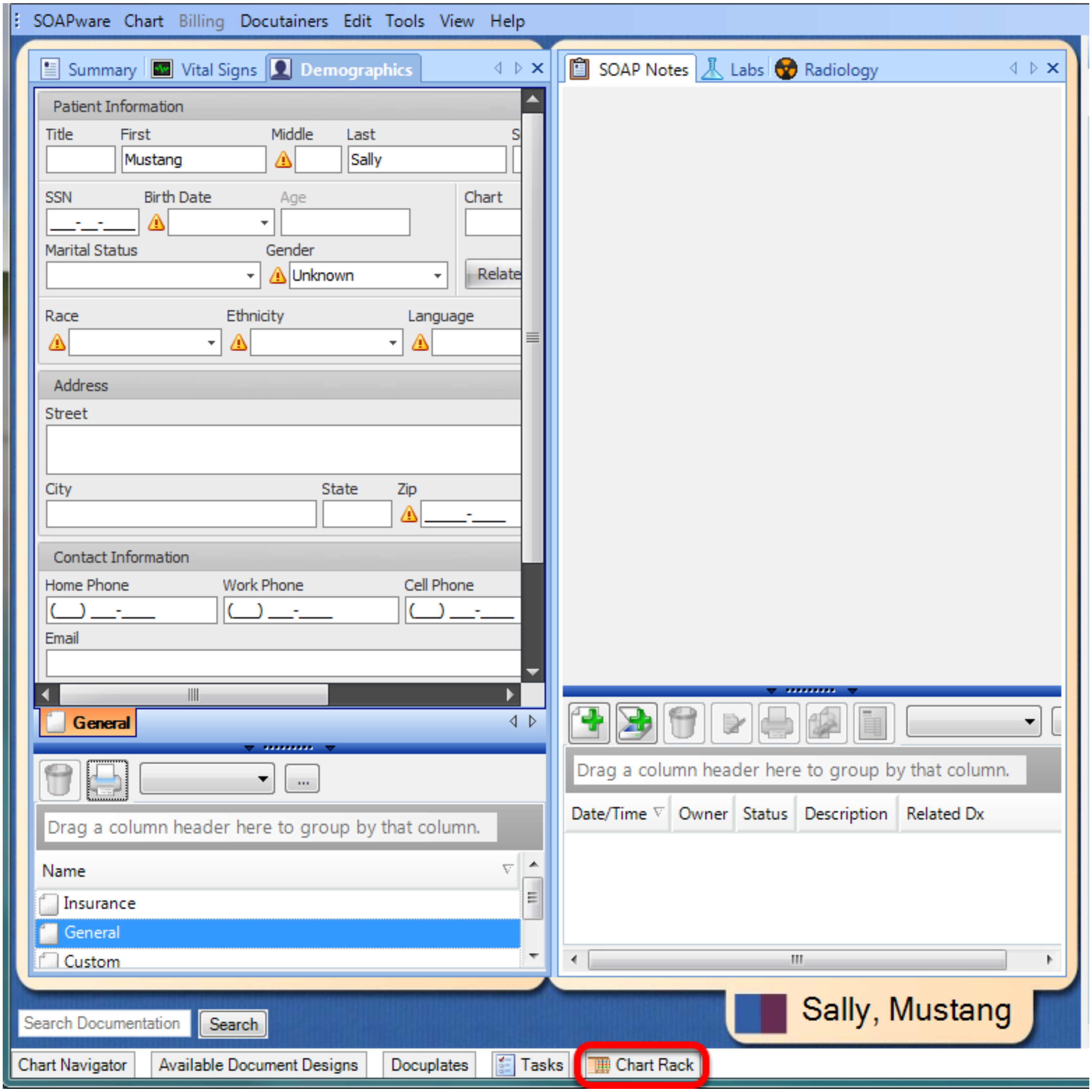
More on Layouts

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 (2012)

The Chart Rack is used to search for a patient chart.

Accessing the Chart Rack

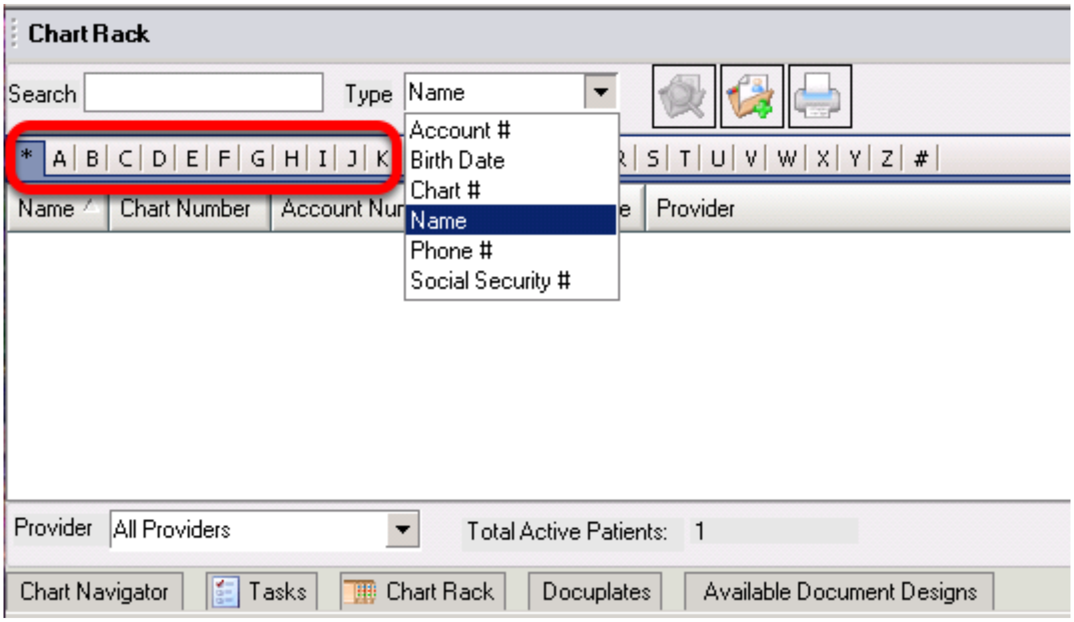


To open the Chart Rack, use one of the following methods:

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

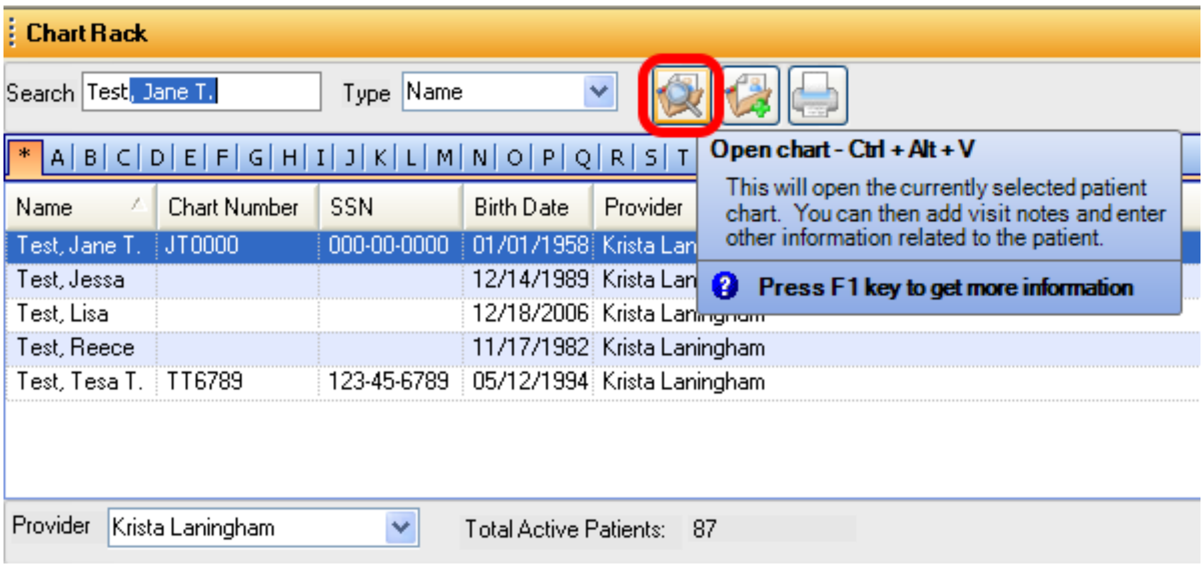


A chart can be retrieved and opened by searching for a patient by any one of the following:

- Billing Account Number (for Clinical Suite customers)
- Birth Date
- Chart Number
- Name
- Phone Number
- Social Security Number

Also, a chart may be retrieved by using the Alphabet bar by clicking on the corresponding letter of the patient last name.

Open Chart



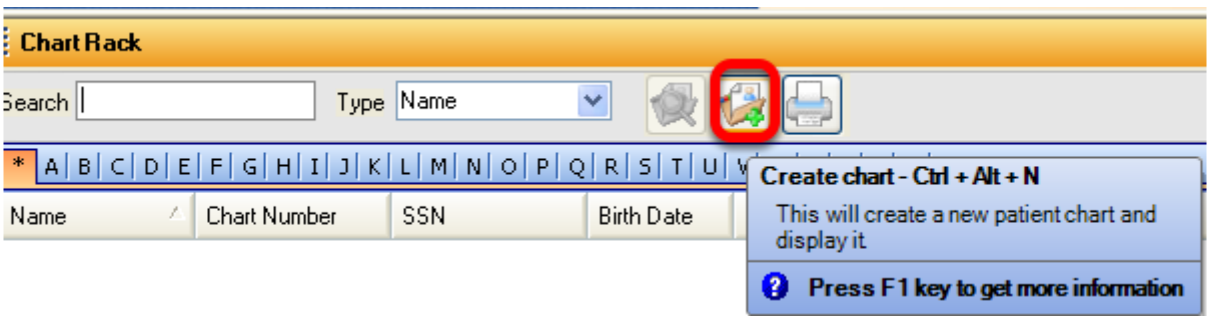
A chart can be opened by taking one of the following actions:

1. Double click on the highlighted patient name
2. Press the enter key
3. Click the Open Chart button

Creating A New Chart

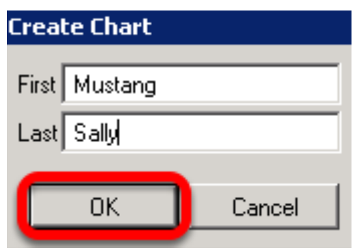
Anew chart can be created from within the Chart Rack.

How to Create a New Chart



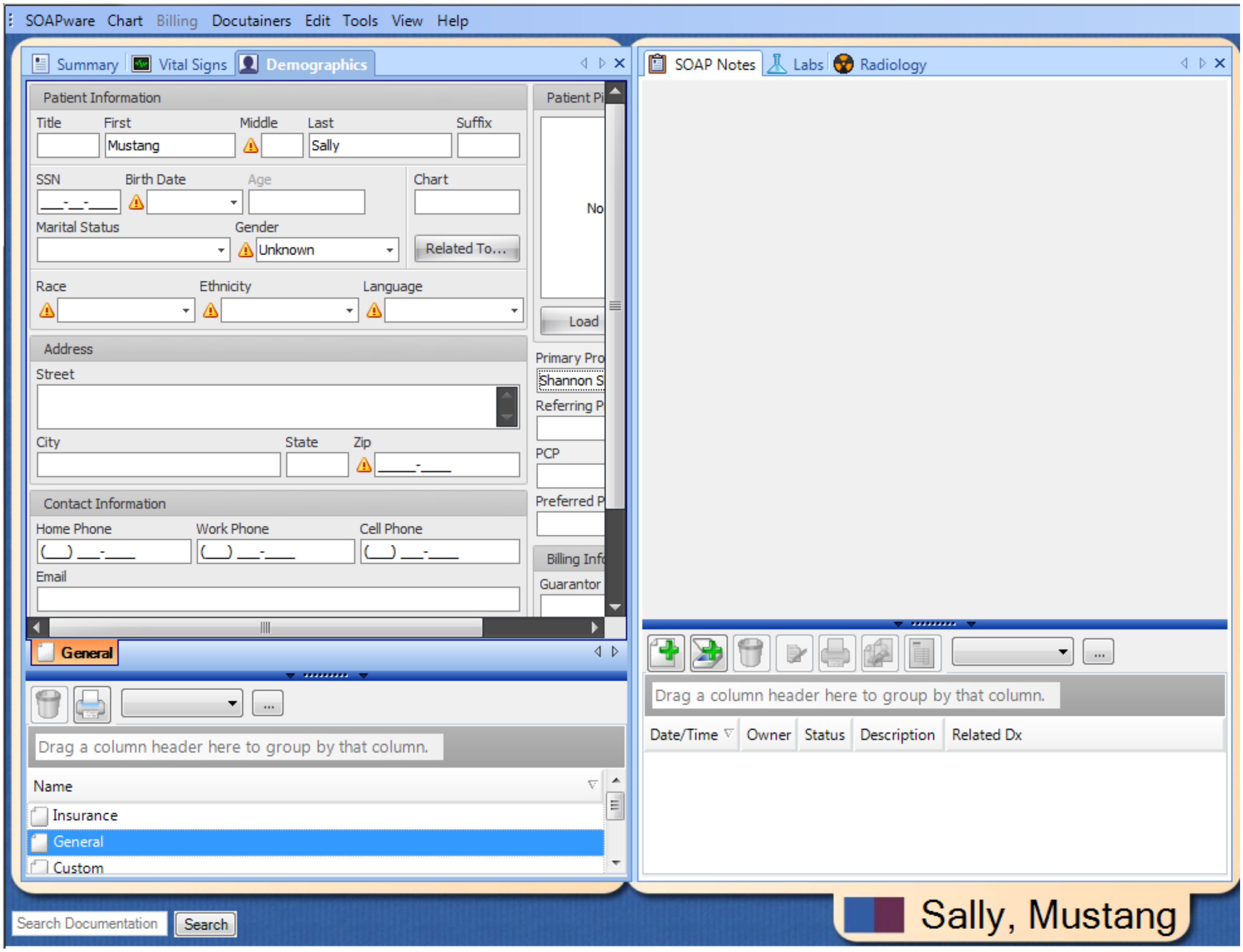
To create a new chart, the user will click on the Create chart button.

Creating a New Chart



Enter the first and last name of the patient, then Click OK.

New Chart has been Created



Anew 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.

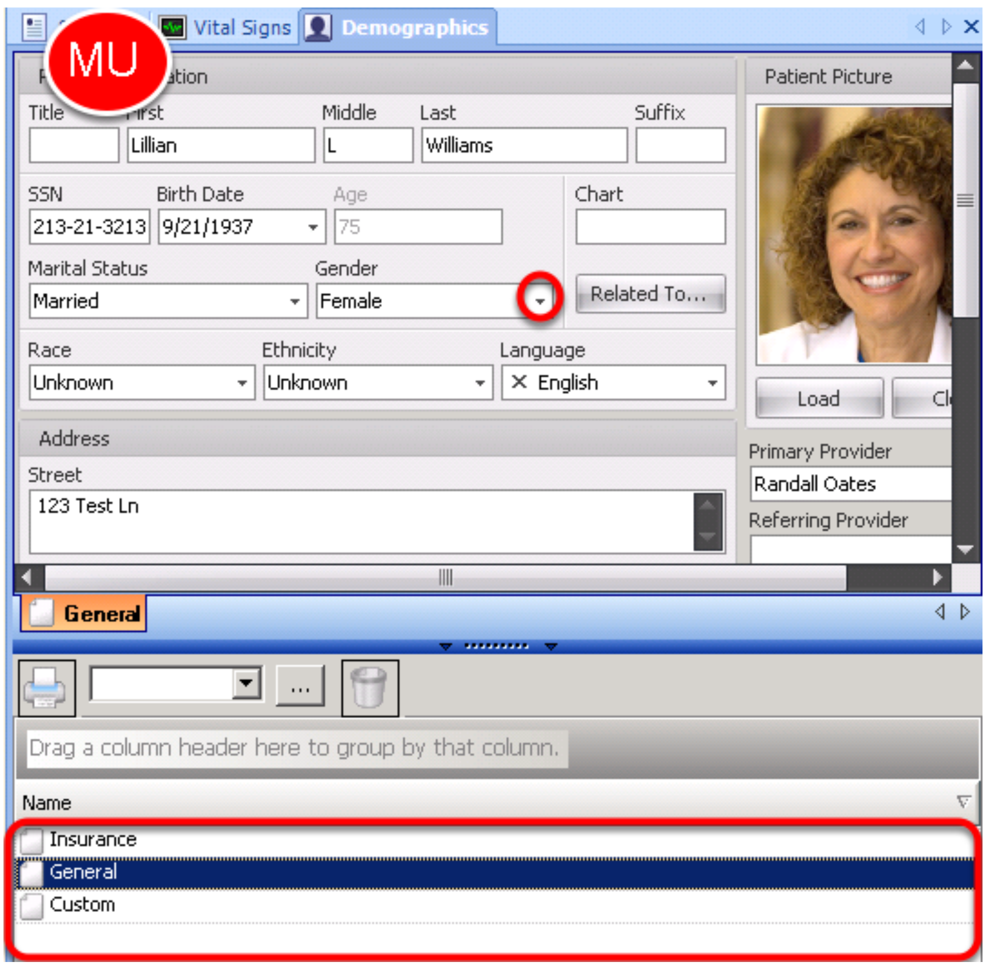
Entering Demographics

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

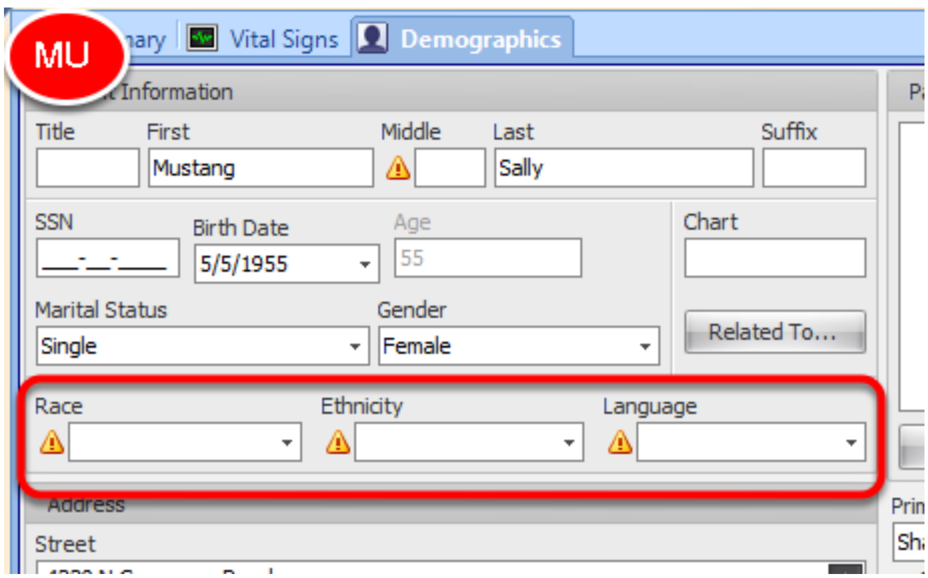


Yellow Warning icons indicate that these items are required in order to successfully retrieve eligibility for the patient and report meaningful use data. When valid data is entered, the icon will disappear.

Auser 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.

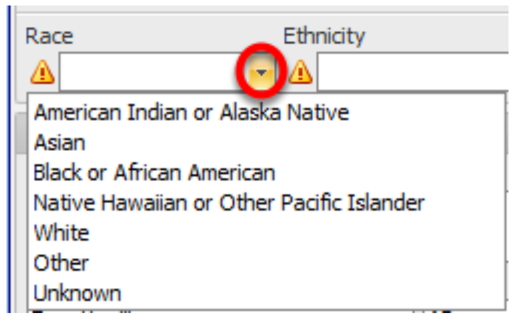
Race, Ethnicity and Language



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

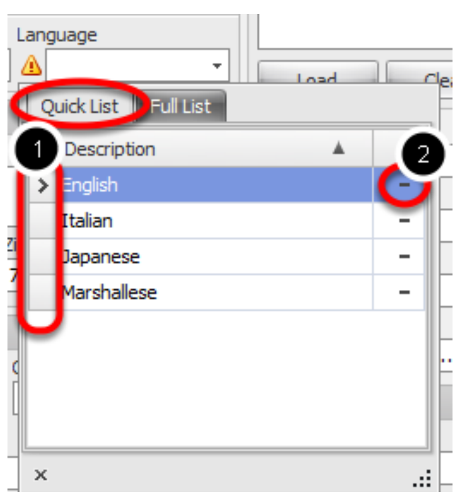


To enter Race and Ethnicity:

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.*

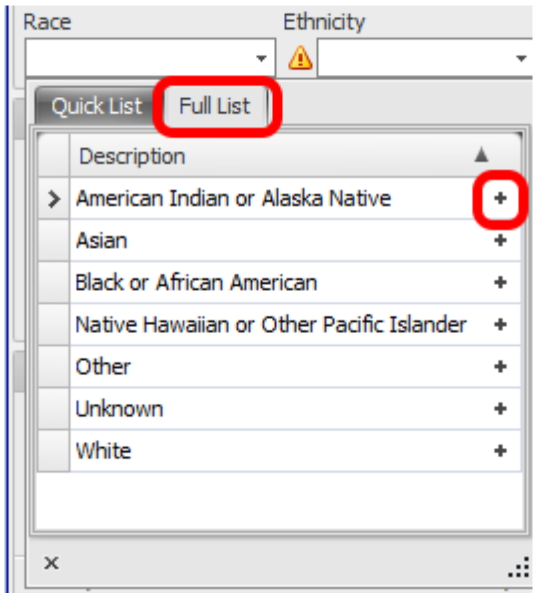
Language Quick List



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.

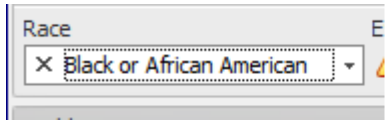
Language- Full List



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.*

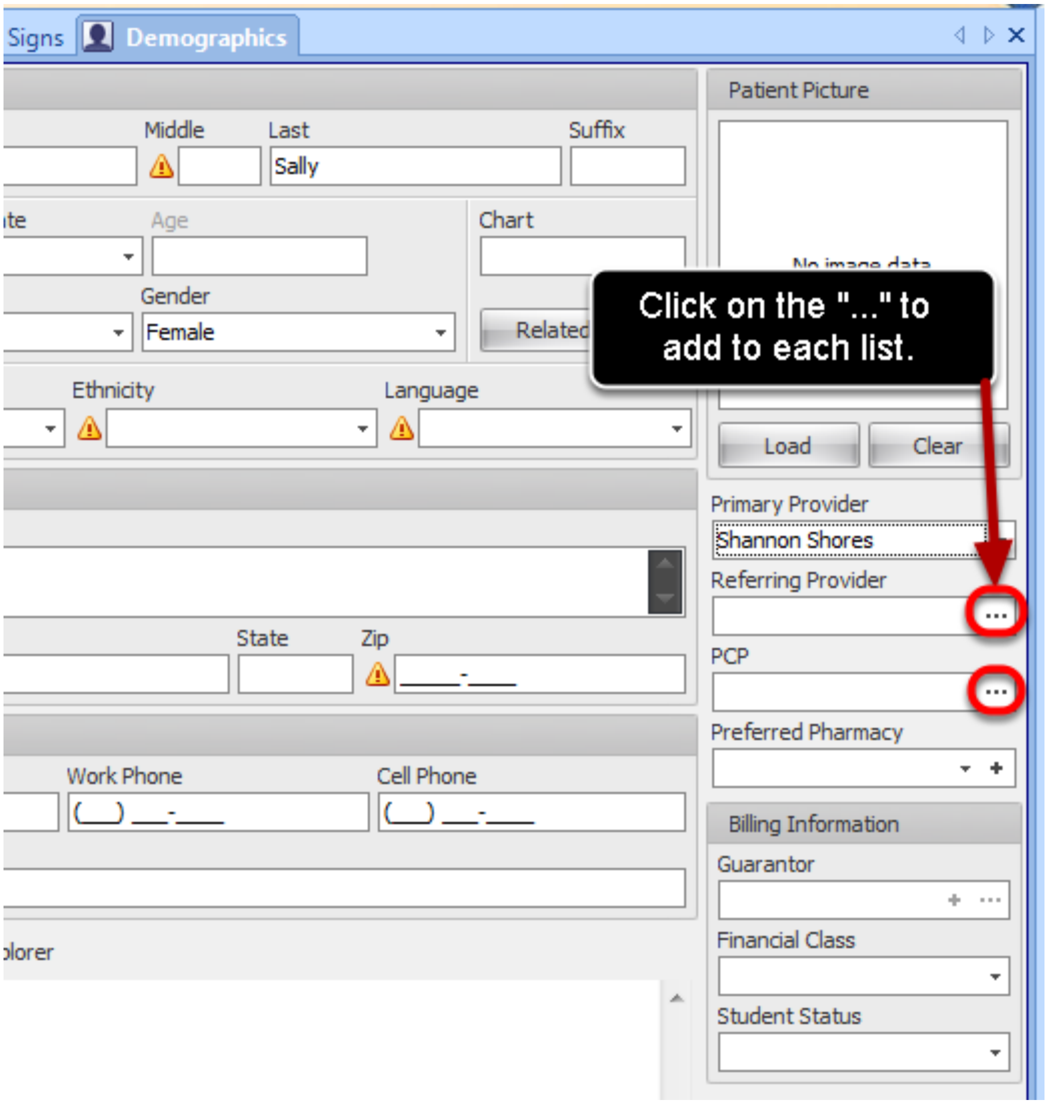
Clearing Patient Language/Ethnicity/Race



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.

General Demographics - PCP and Referring Provider

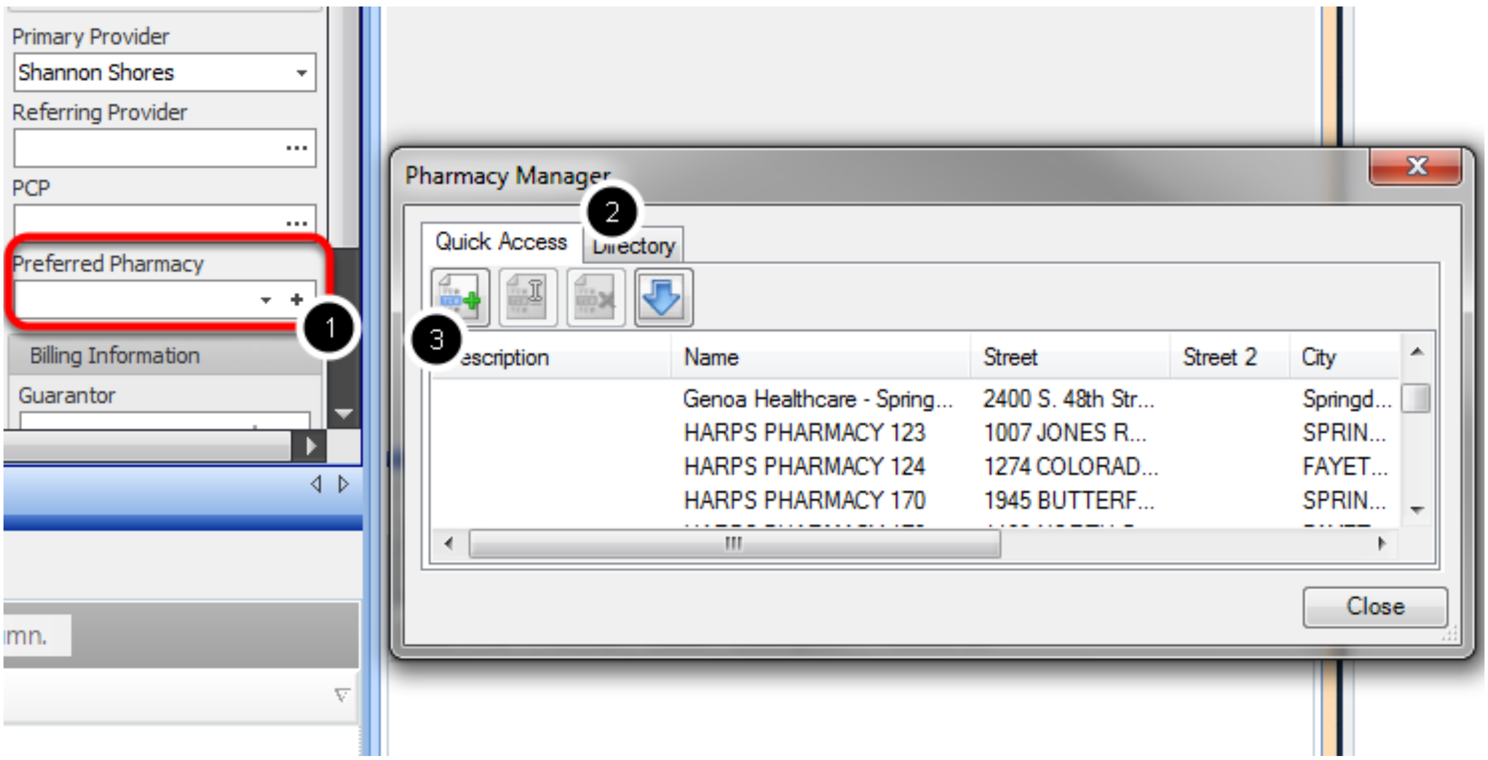


These two drop-down menus are used to select the patient's Primary Care Physician, and/or a Referring Physician.

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



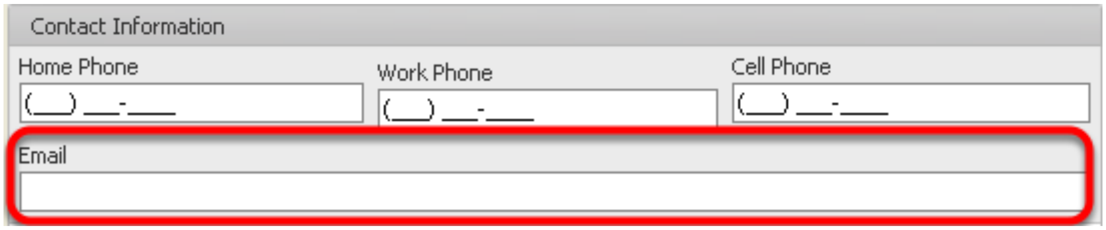
This drop-down list box is used to select the patient’s preferred pharmacy. This will automatically populate on this patient's Rx Manager when the user chooses to ePrescribe medications. By setting a default preferred pharmacy in demographics, the Rx Manager will also have a default pharmacy. The drop-down 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.

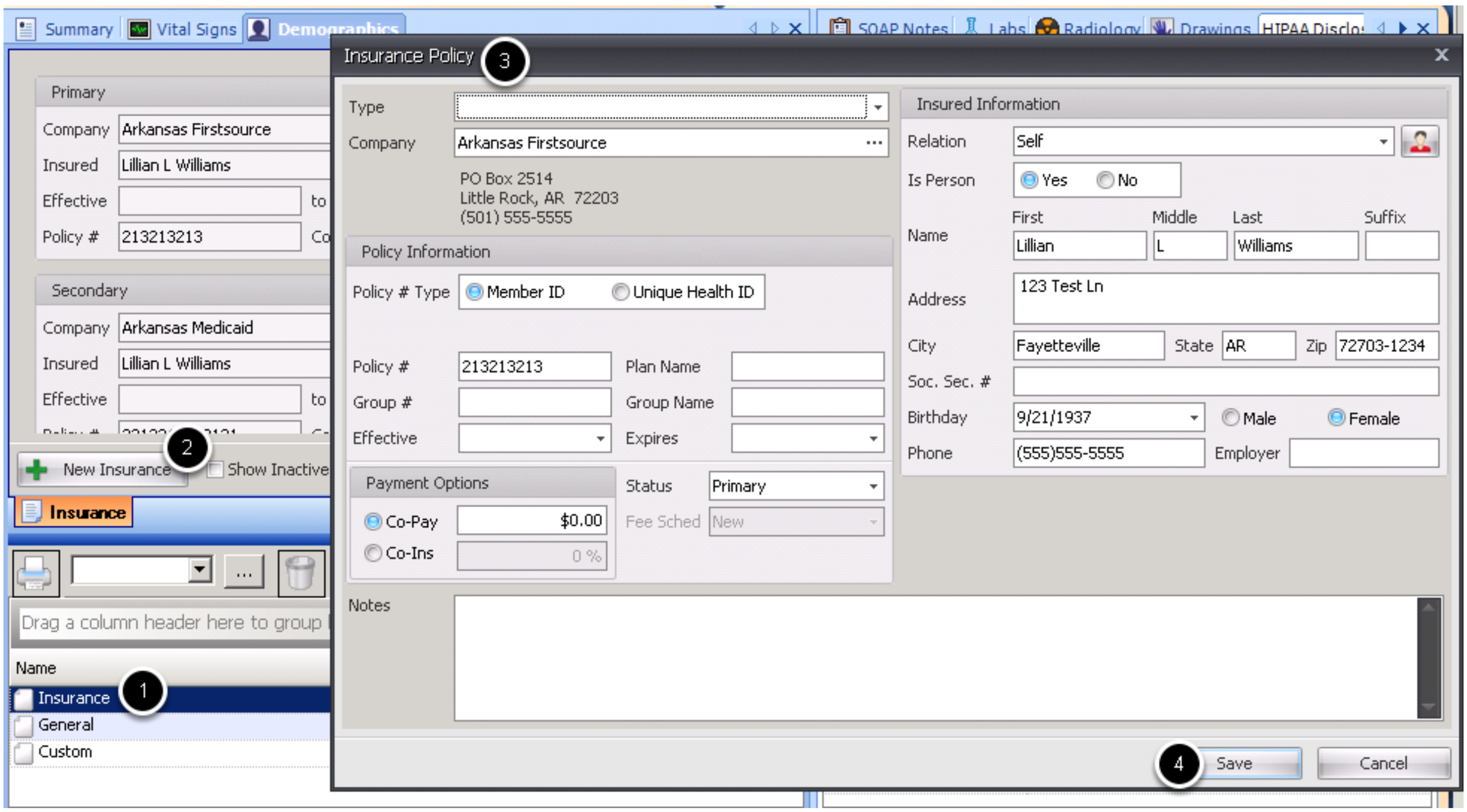
Email



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.

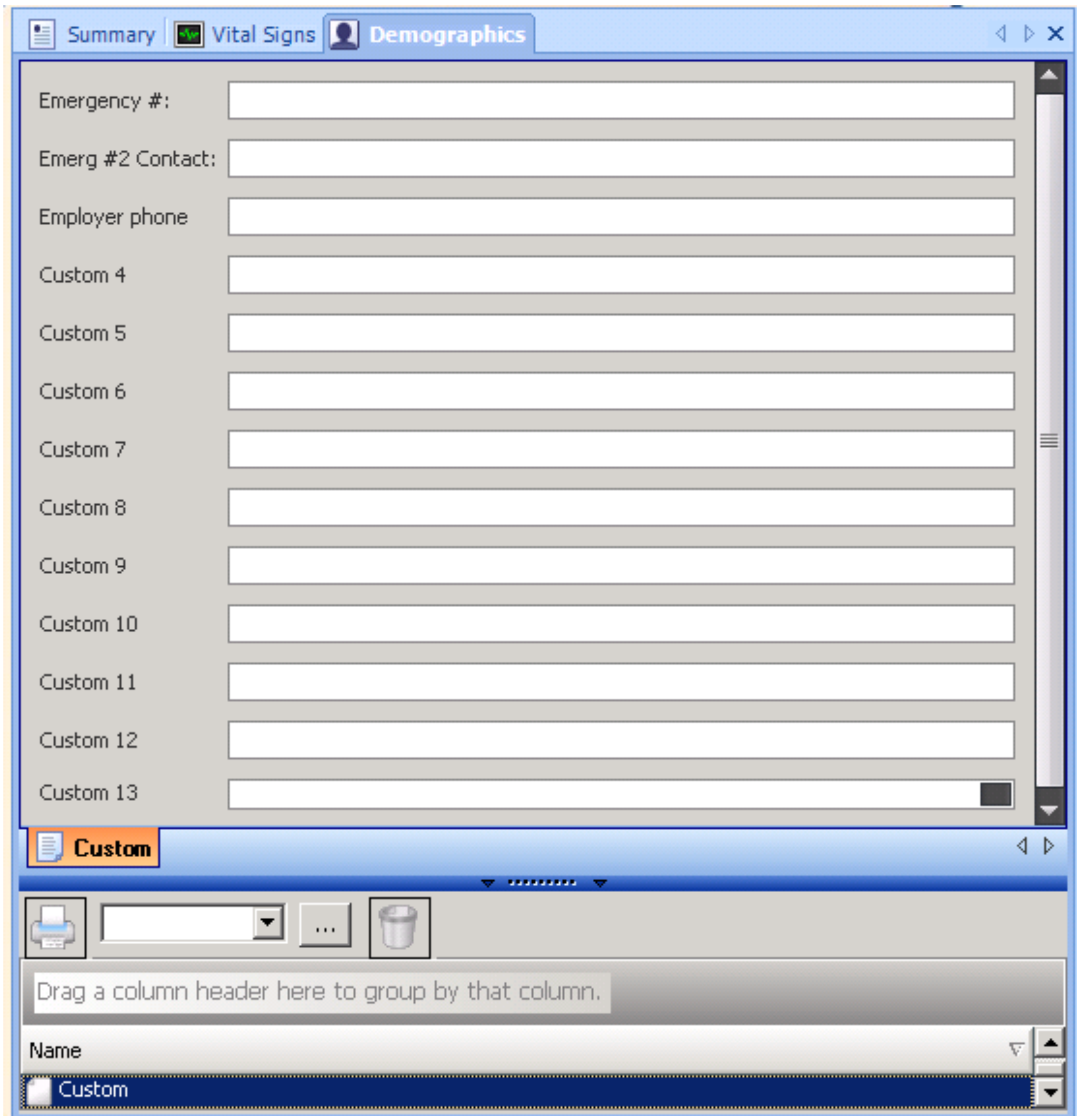
Insurance Demographics



To add and edit patient's insurance information:

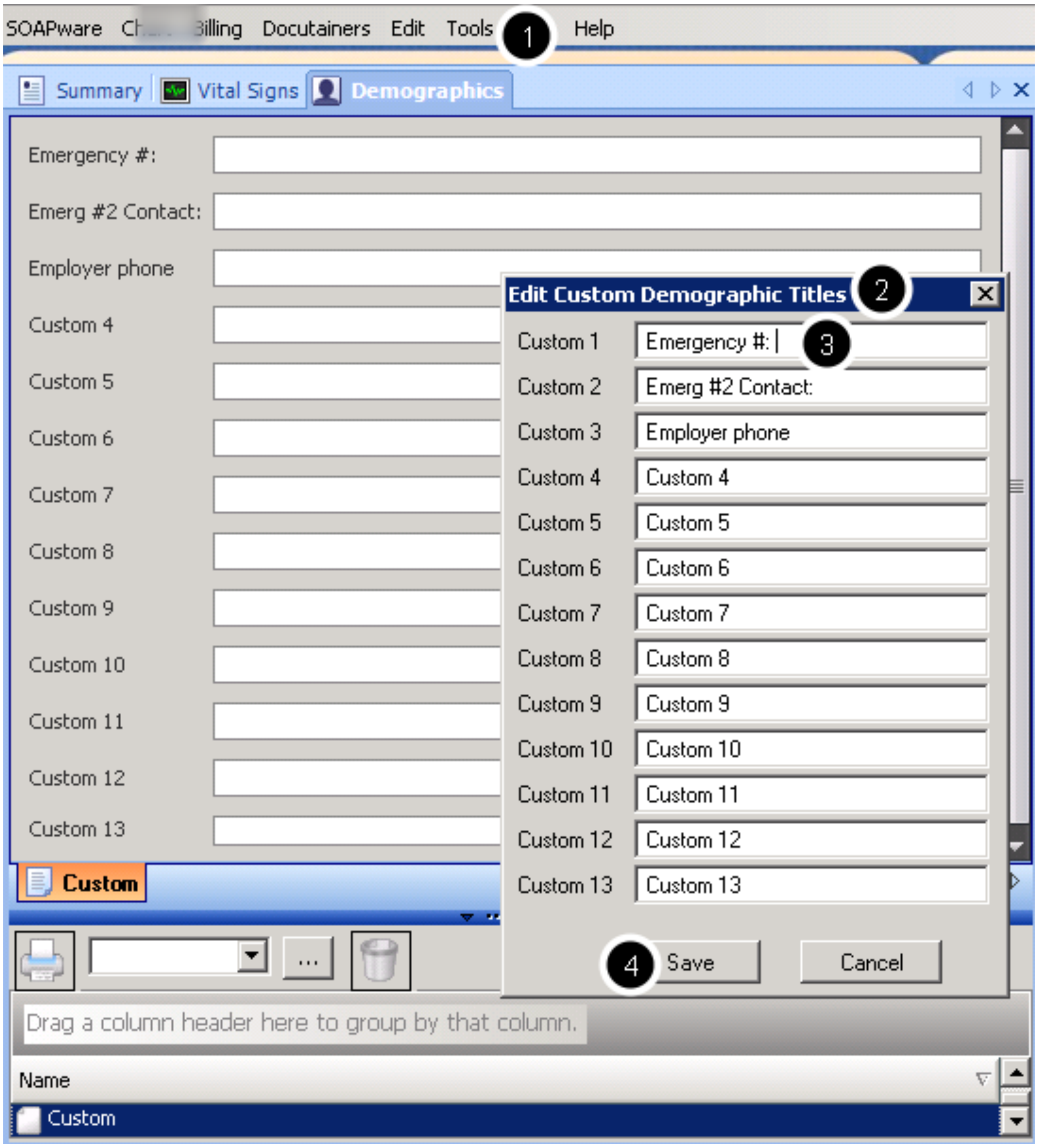
1. Click on the "Insurance" tab at the bottom of the demographics section.
2. Click the button with the green plus.
3. This will bring up a window where a user will type in the insurance information.
4. Click Save and a user will see the patient's insurance information listed at the top of the demographics window. Items with a red X must be completed before insurance policy is saved.

Custom Demographics



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.

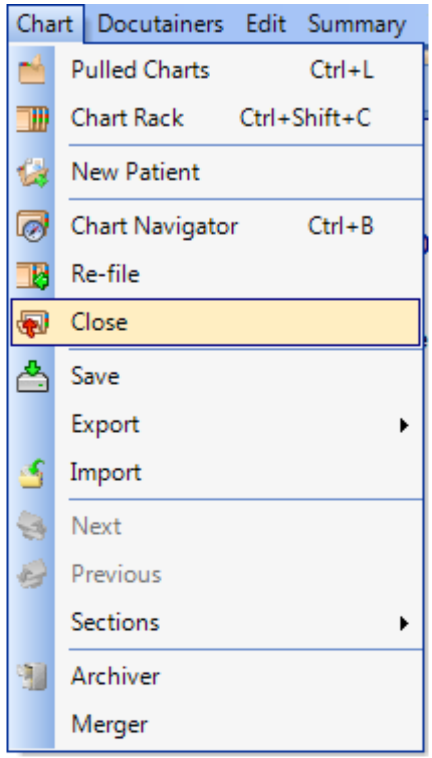
Note: *This setting will change the titles of all custom demographic fields on all patients in the database.*

Closing A Chart

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.

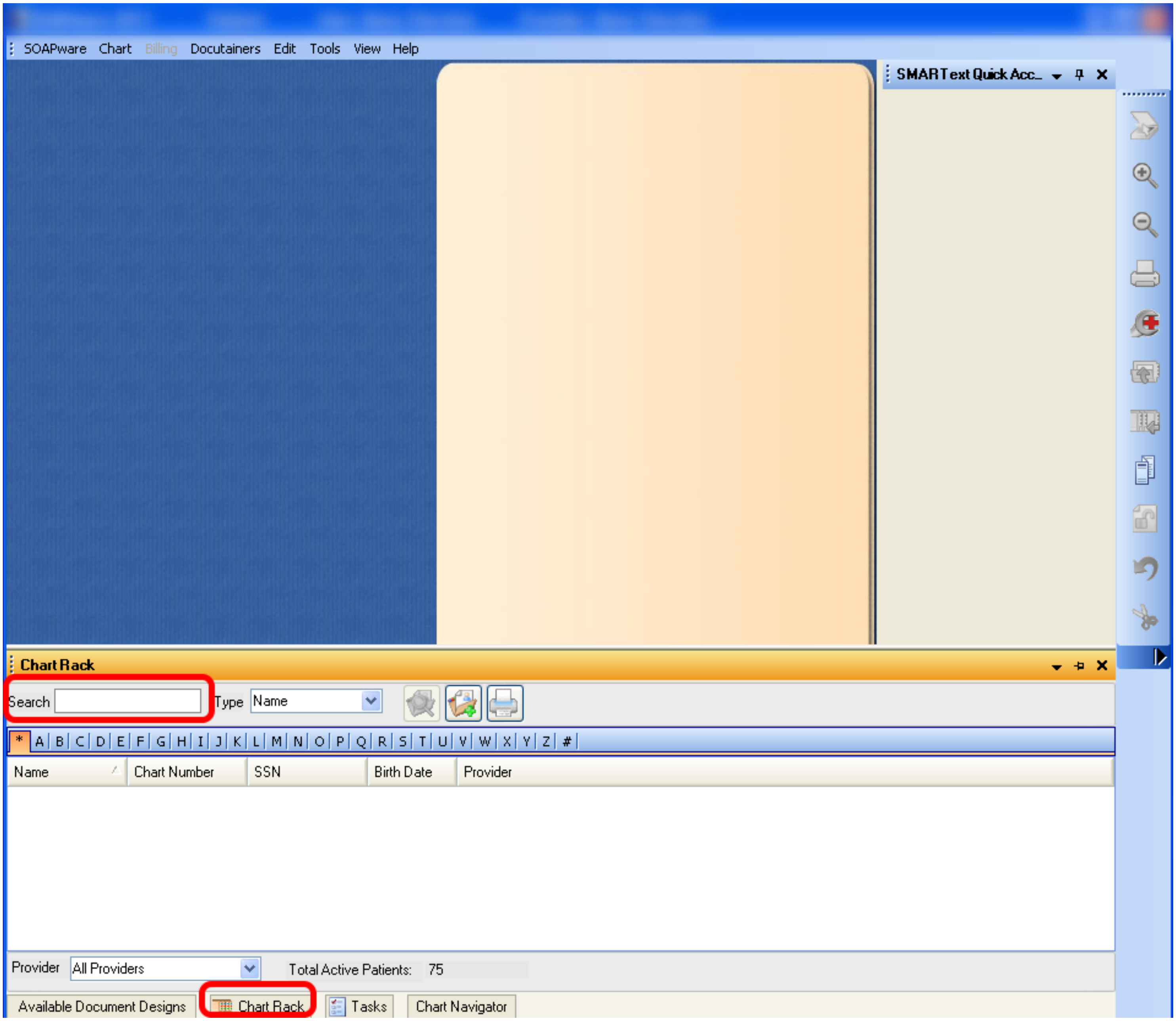
Workflow Options

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 (2012)

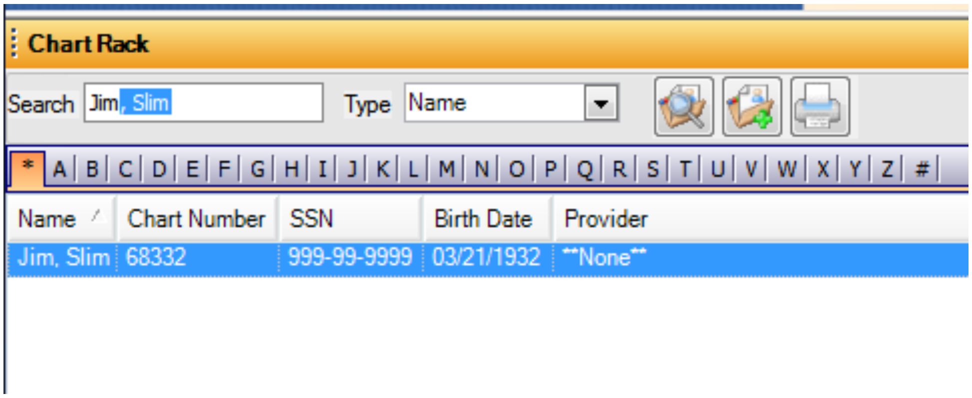
Chart Rack is very similar to a user's chart room.

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



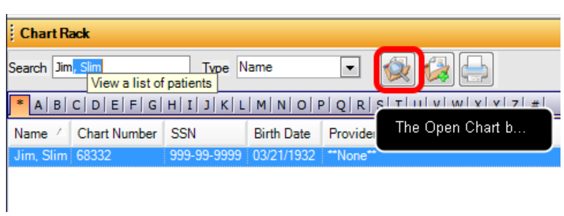
A specific chart can be retrieved via 6 methods:

1. Billing Account Number (for Clinical Suite customers)
2. Birth Date
3. Chart Number
4. Name
5. Phone Number
6. 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



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

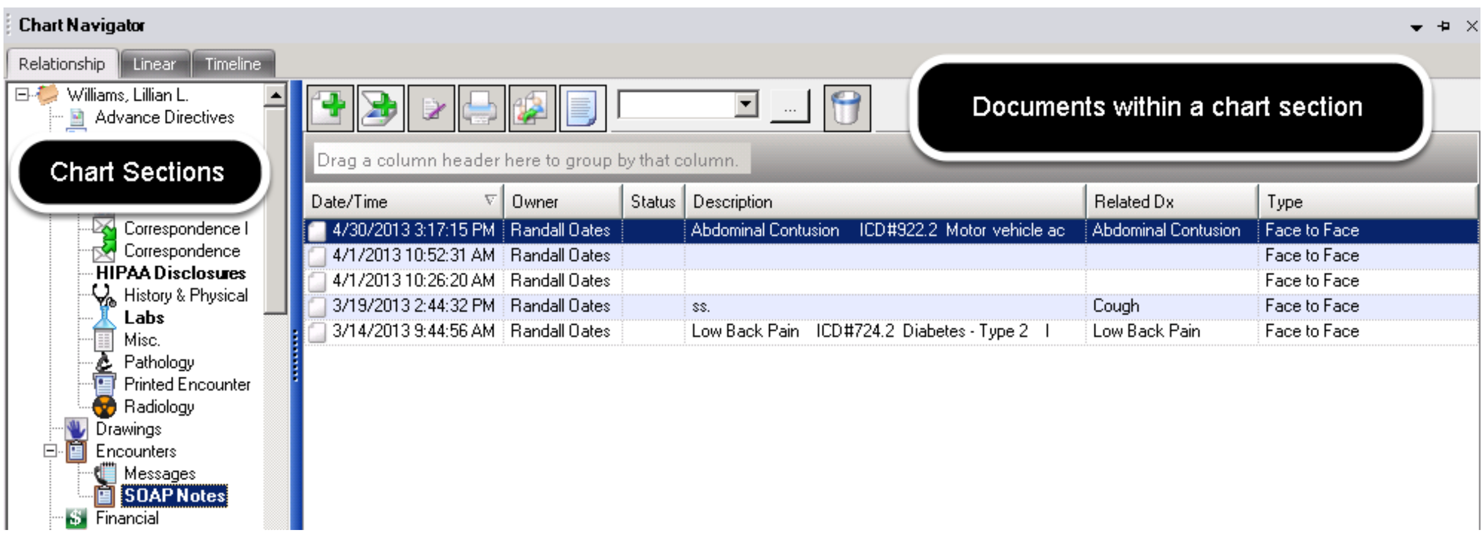
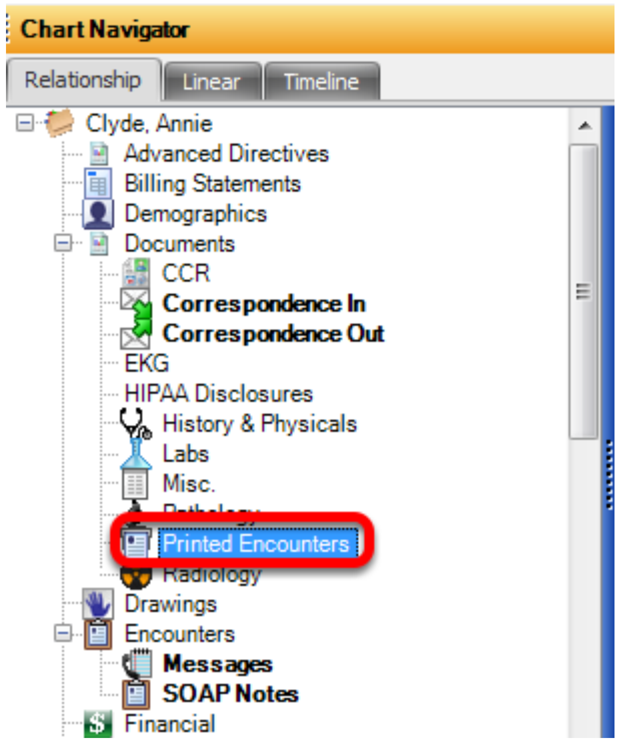


Chart Navigator is divided into two main regions: the left side is a list of all the chart sections, and the right side will display what documents are within a particular chart section.

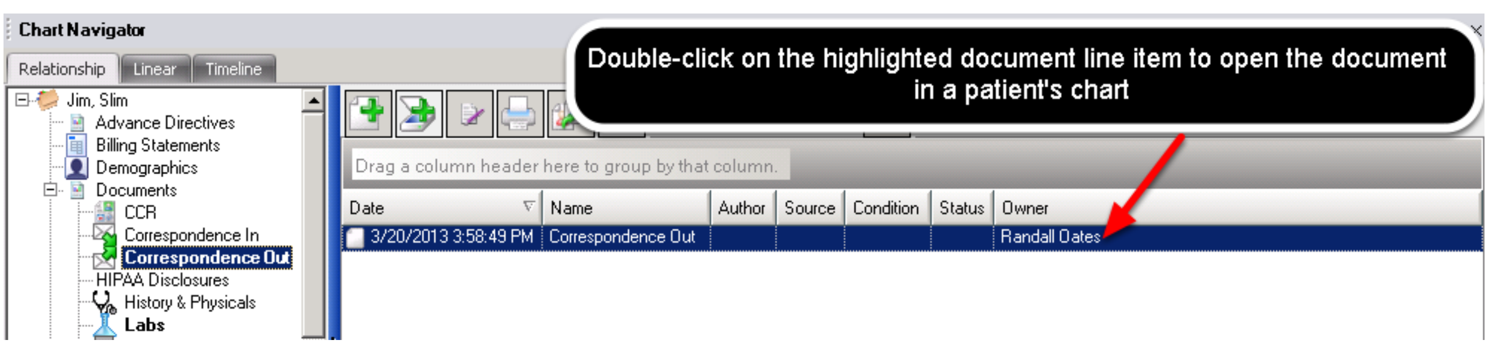
Helpful hint to the user: a chart section will be bold black if there are unsigned documents within the chart section.

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. Sign off a document if the user is a clinician.
4. Print off a document in a chart section.
5. Reassign a document to another clinician if the document is not already signed off.
6. View the selected document.
7. Remove a document from a chart section.

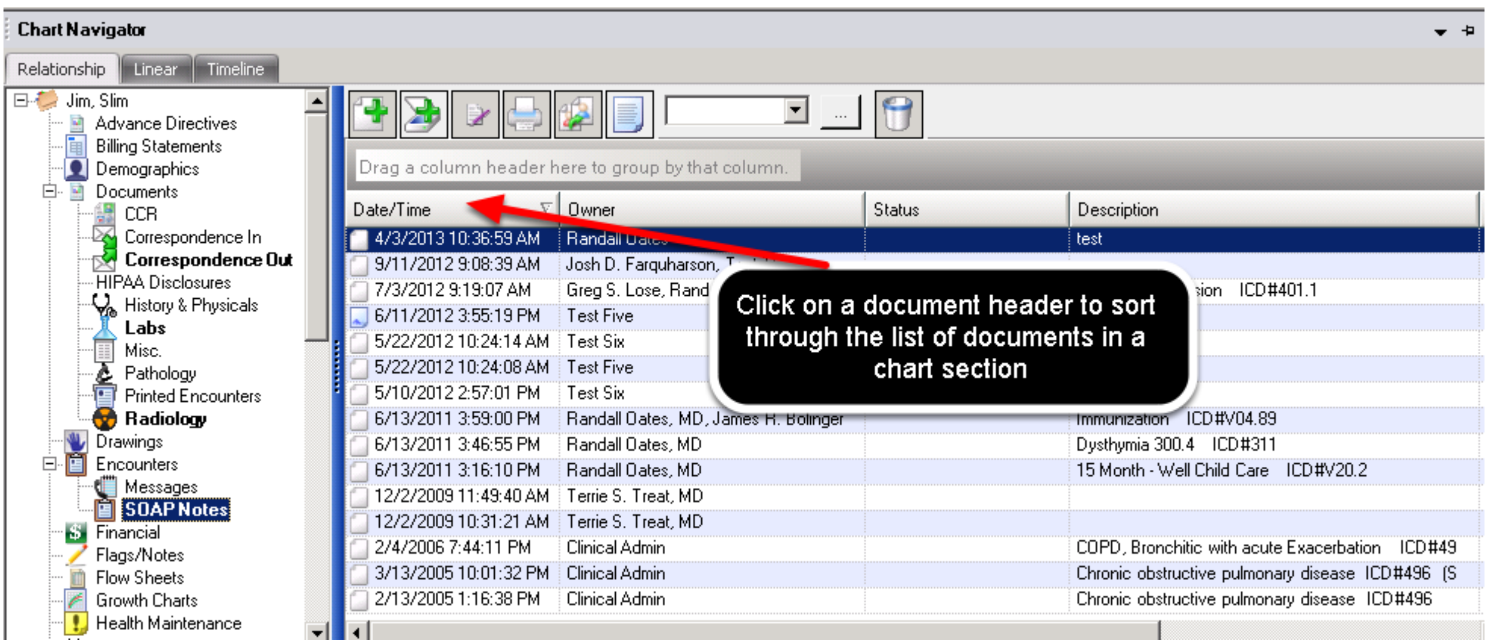
Chart Navigator Views

In this lesson, the user will learn about the 3 different chart navigator view options.

Access Chart Navigator

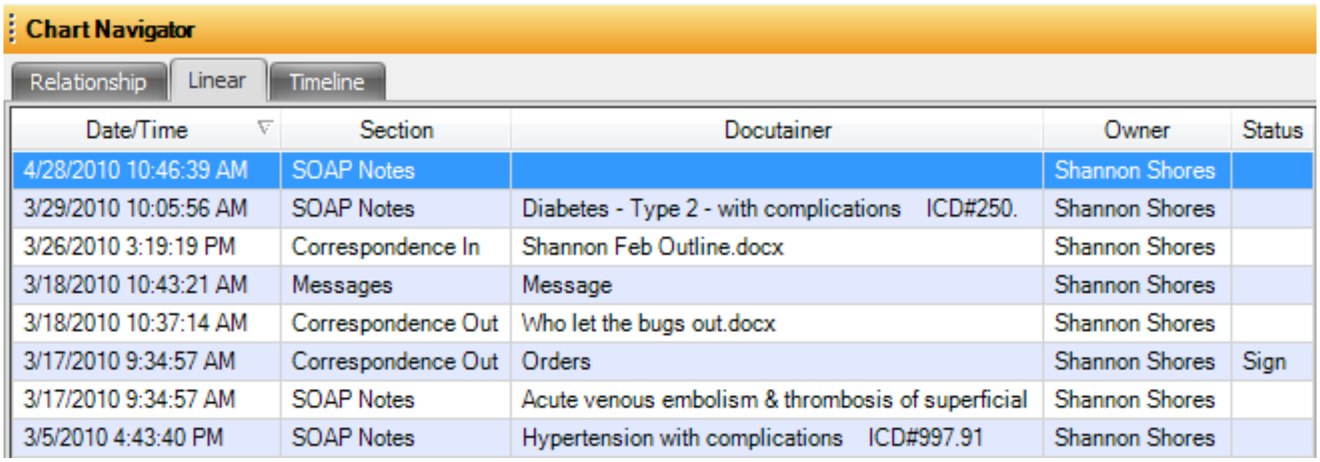
1. Click on the Chart Navigator tab docked at the bottom of the screen.
2. If Chart Navigator is not docked at the bottom, Click on Chart in the main menu toolbar, and Click on Chart Navigator.
3. Press Control + B on the keyboard.

Chart Navigator Views: Relationship



The 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.

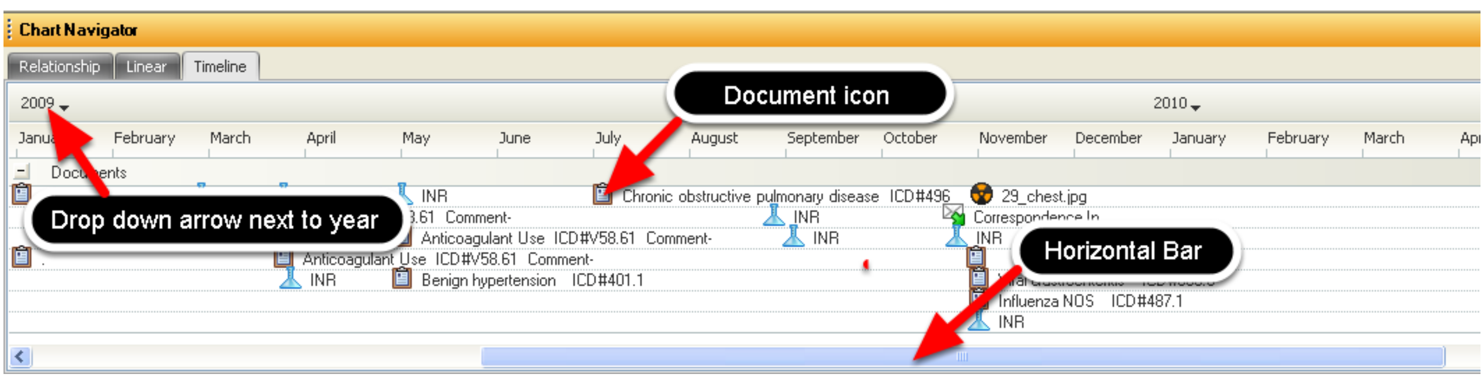
Chart Navigator Views: Linear



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.

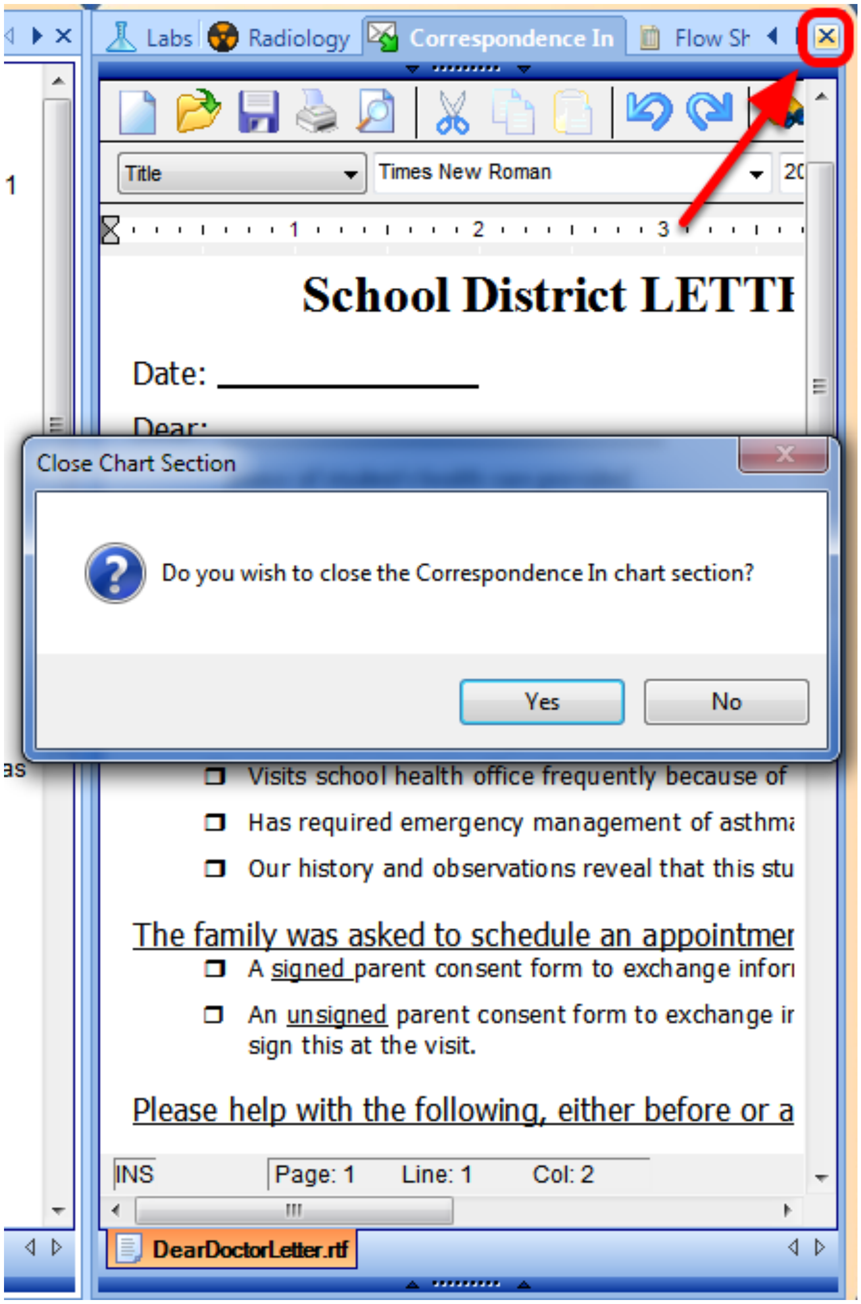
Chart Navigator Views: Timeline



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

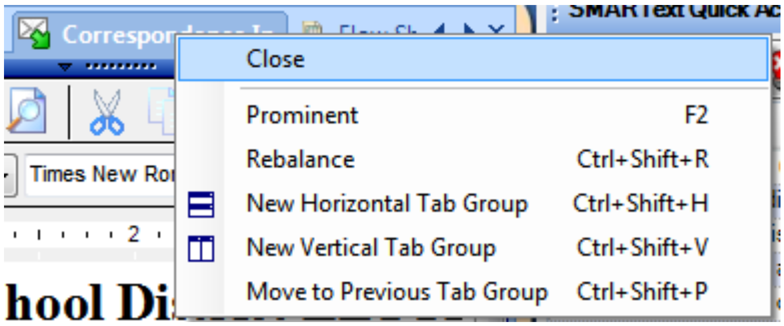
Closing Chart Sections - Click on the X



In order to close out or remove a chart section viewer from a chart layout, Click on the X at the top right corner.

Awindow will appear asking for confirmation from the user that he/she wishes to close this section.

Closing Chart Sections - Section Menu

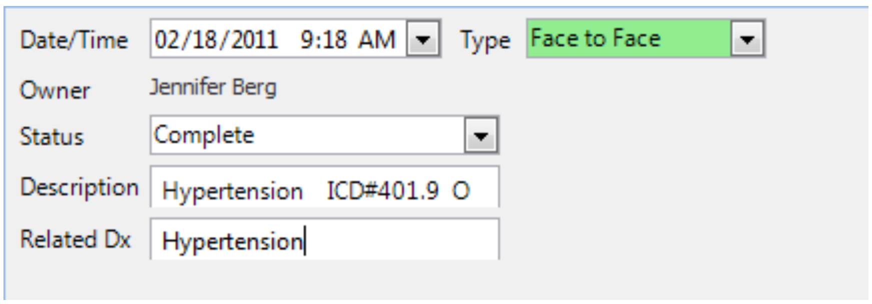


Alternatively, Right-click the Section tab, and Select Close.

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.

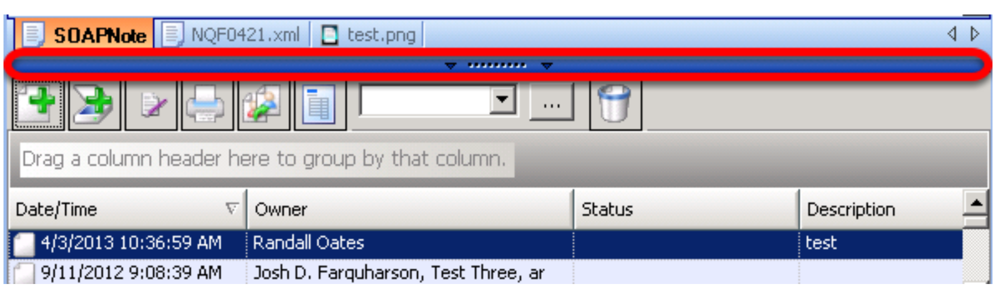
Upper Splitter Bar



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



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.

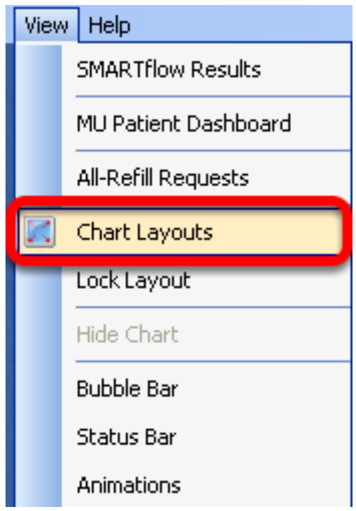
Using Splitter Bars

For more information on how to use splitter bars, see: Splitter Bars.

Default Chart Layouts

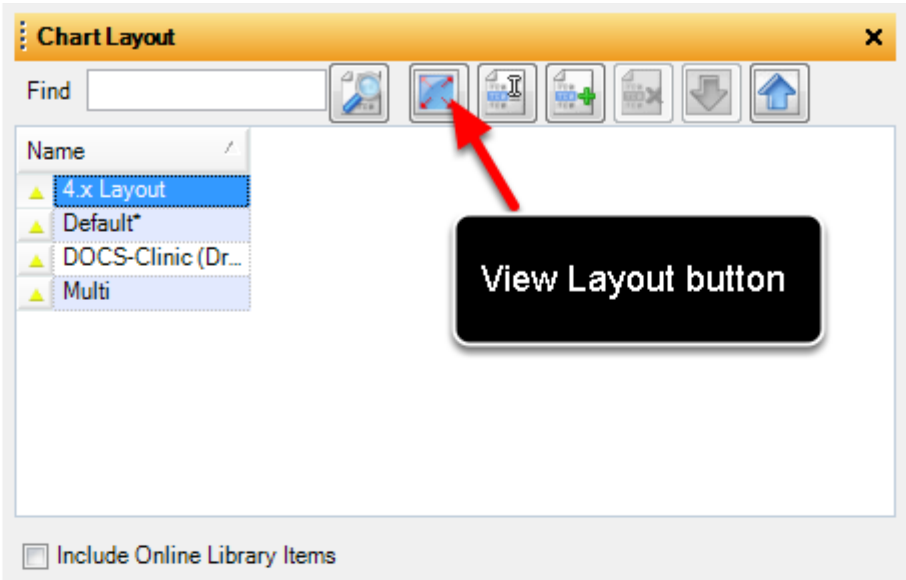
There are several different possible layouts a user can pick from for their chart layout. Auser can even modify a chart layout and save it as their own.

Pre-defined Chart Layouts



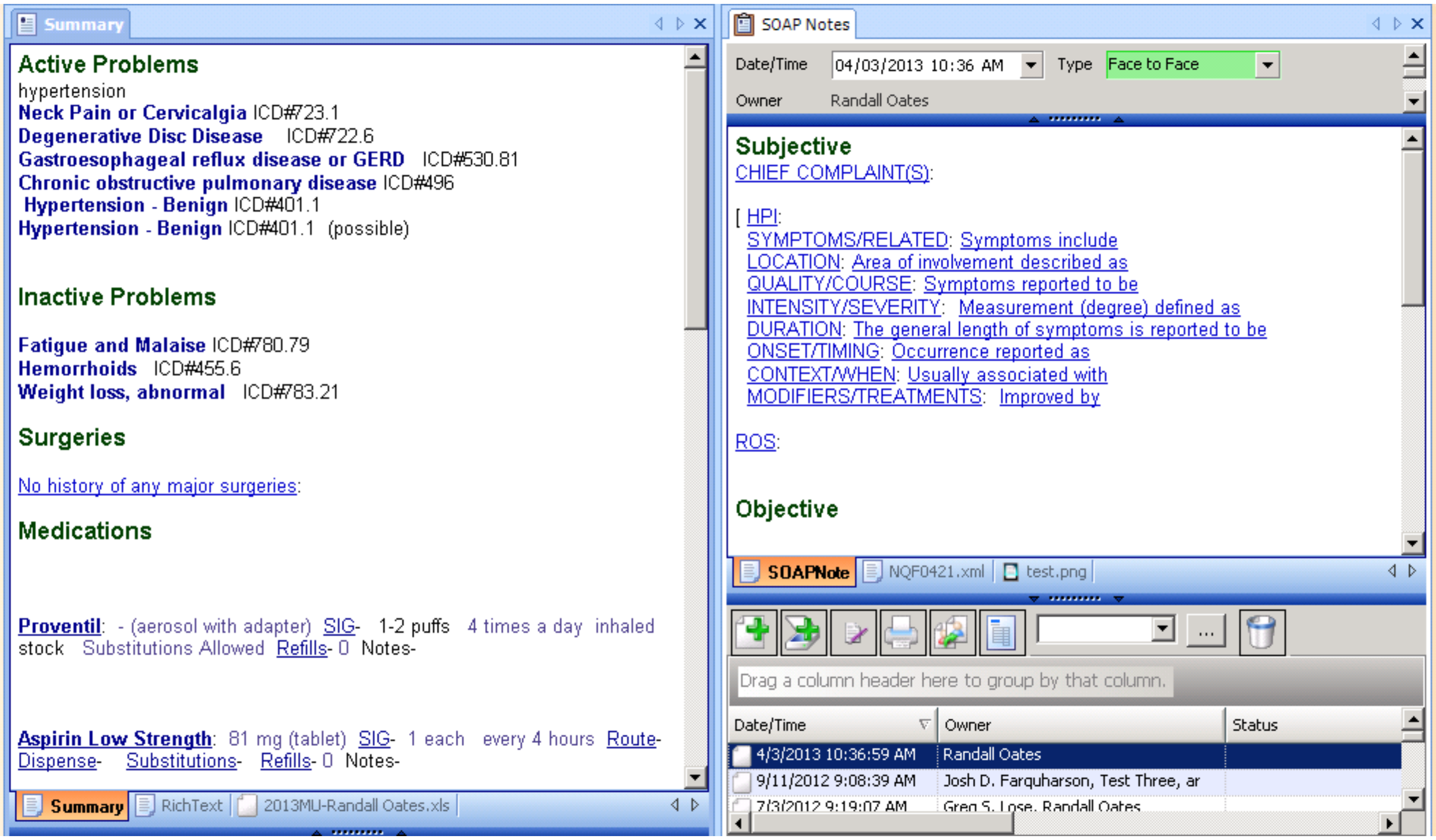
To find these chart layouts, Click on View in the main menu bar at the top of the screen, and Click on Chart Layouts.

View Layout



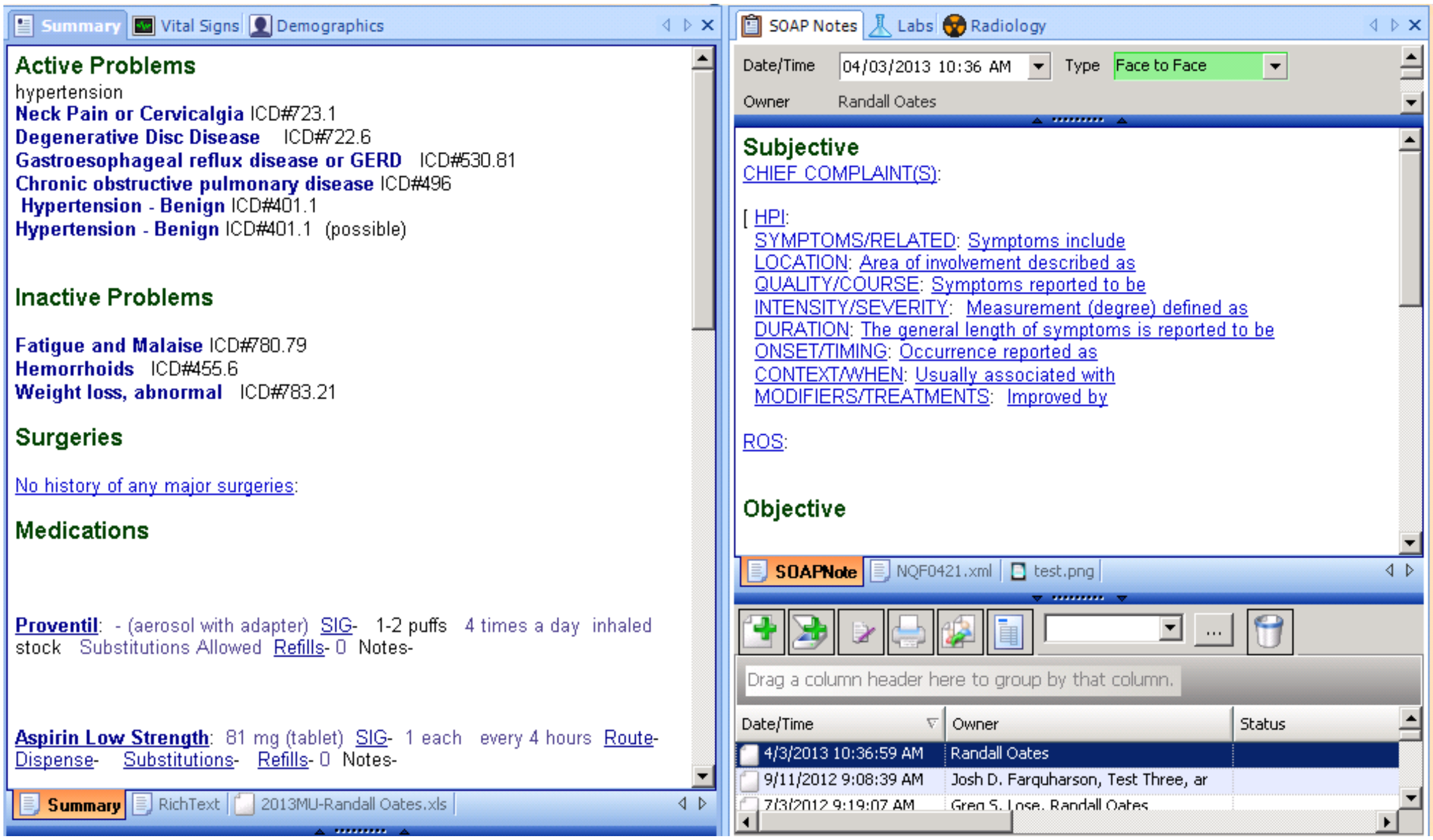
In the image above, the user will see four chart layout choices that come defaulted with SOAPware. To preview each chart layout, the user will need to be sure to have a patient's chart open. If the user wants to preview the 4.x Layout--the user will highlight that title from our list and Click on the "View Layout button."

V4 Classic Layout



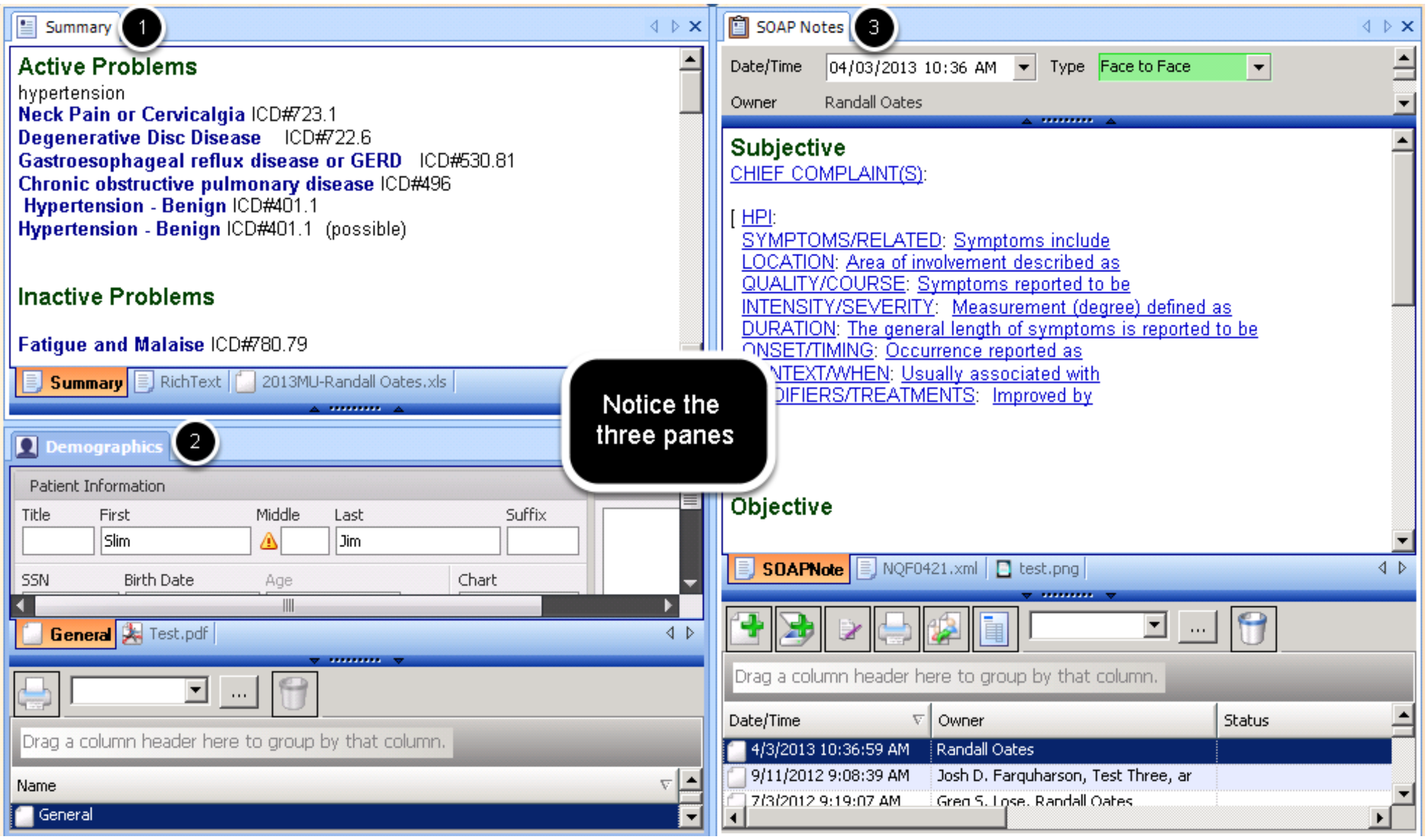
This layout is one of the simplest options for users....as it only displays the Summary Chart Section to the left, and the SOAPnote Chart Section to the right.

Default Layout



The Default Layout shows that a user can have multiple chart sections on the left and right of their chart layout.

Multi-Layout

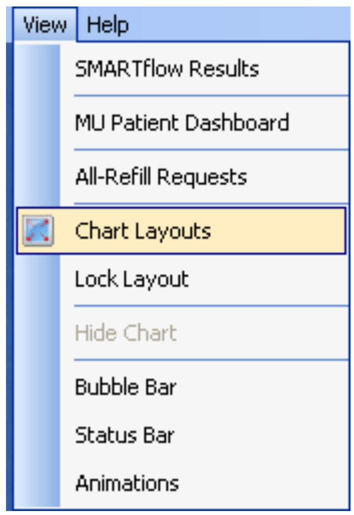


The Multi-Layout splits the chart workspace into 3 panes.

View Chart Layouts from Online Library

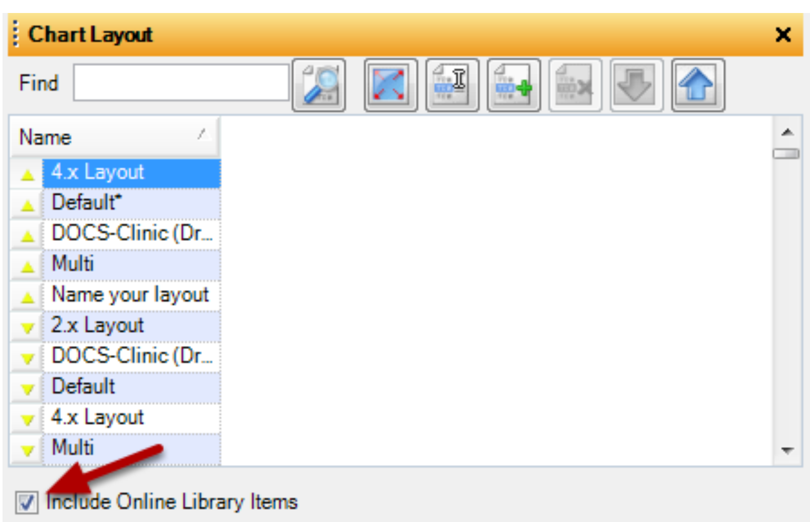
In this lesson, the user will learn how to view chart layouts from the online library.

View Chart Layouts from online library



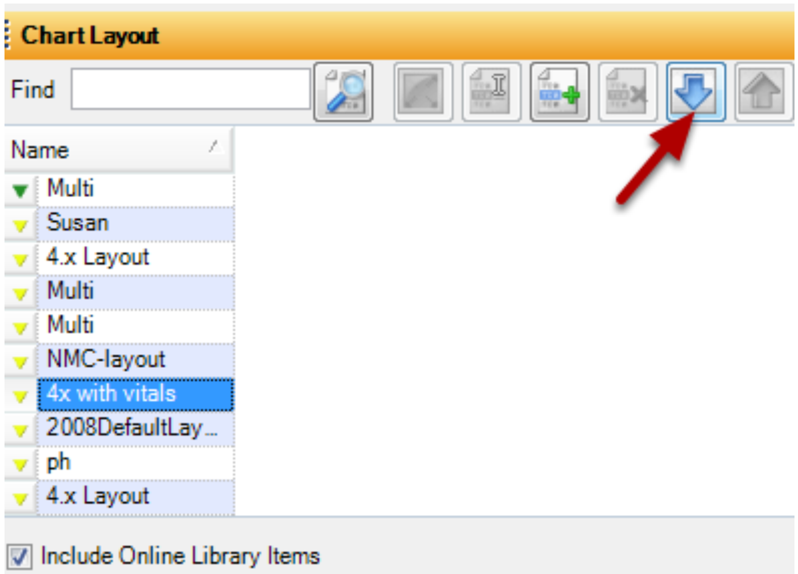
Click on View > Chart Layouts.

Chart Layouts



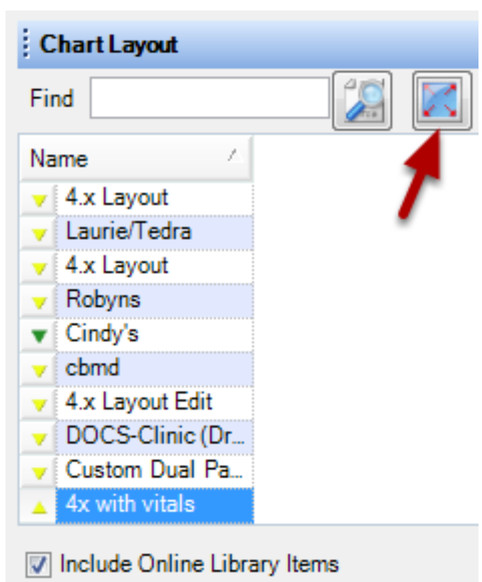
Check the "include online library items box." The user will now be able to view all the layouts created and uploaded to the online library.

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

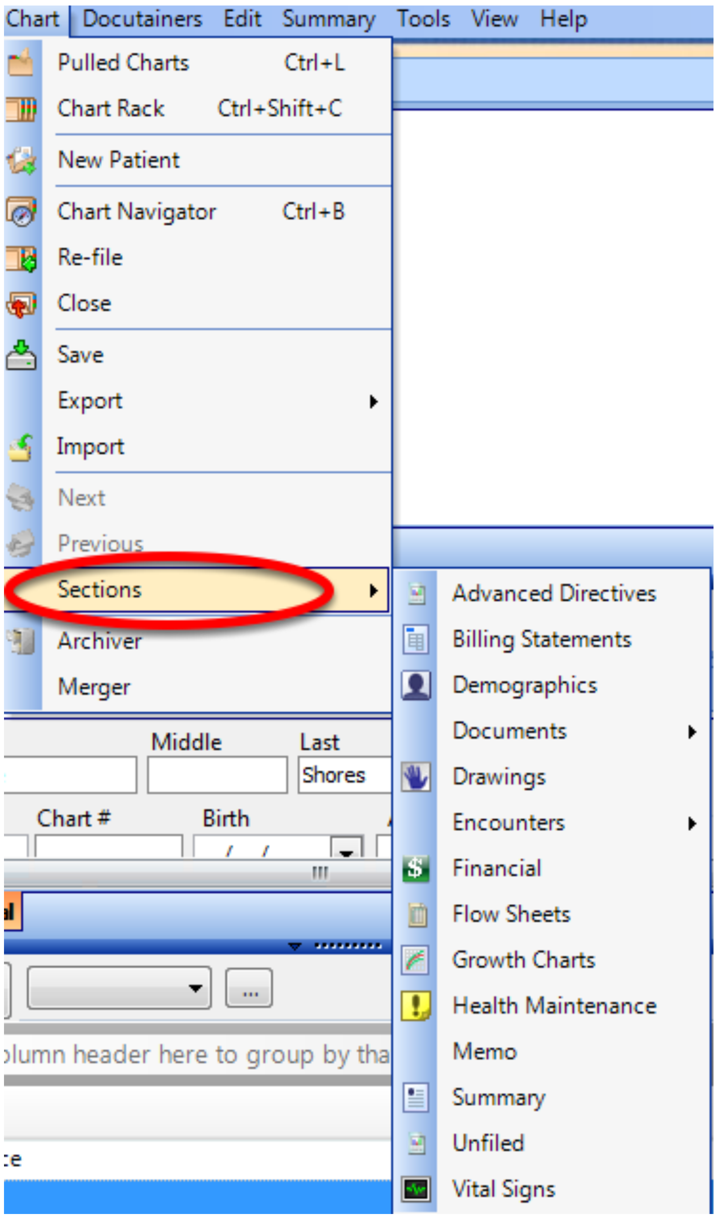


Lastly, Click on the view layout button.

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

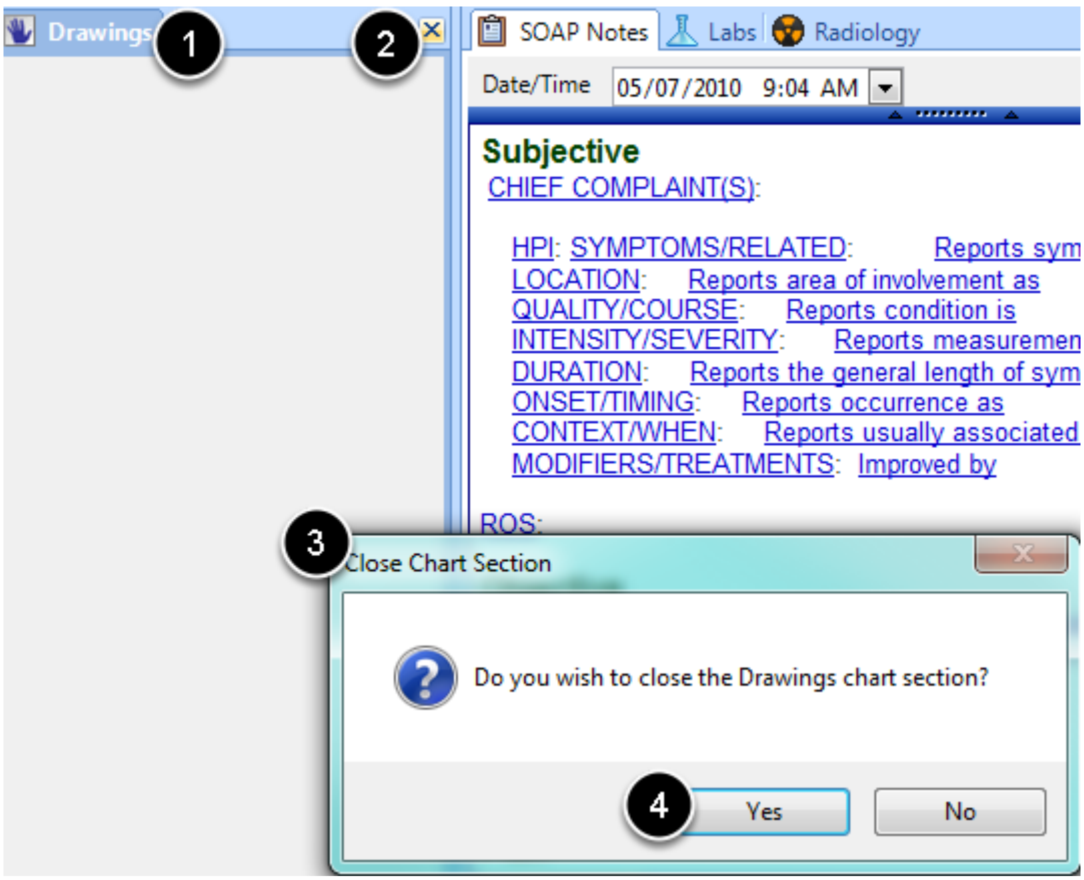


Click on Chart > Sections, and then choose from a variety of chart sections.
As a helpful hint for the user: the chart section will insert into the user's chart layout on the side where the cursor was last placed.

Remove a Chart Section

In this lesson, the user will learn how to remove a chart section.

Remove a Chart Section

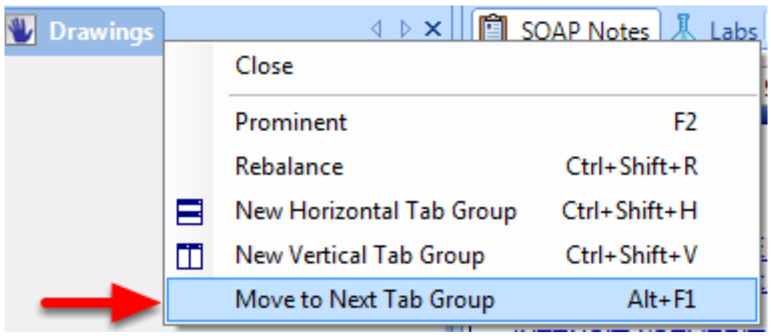


1. Click on the tab to be removed-notice the chart section tab will be blue when selected.
2. Click on the X.
3. The user will be prompted, "Do you wish to close the chart section?"
4. Click Yes.

Move a Chart Section

In this lesson, the user will learn how to move a chart section.

Move a Chart Section

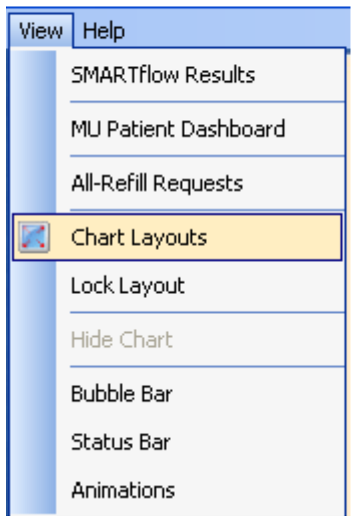


Once a chart section has been inserted, a user can right-click on the top chart section tab, and Click "Move to Next Tab Group." This action would take the chart section from the left side of the user's layout, to the right side of the user's layout. If a user wanted to make the chart section a new horizontal tab group, the user would right-click on the chart section tab and Choose "New Horizontal Tab Group."

Saving Chart Layouts

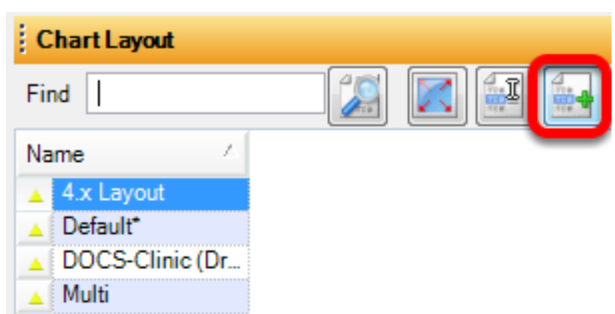
In this lesson, a user will learn how to save a chart layout.

Save a Chart Layout



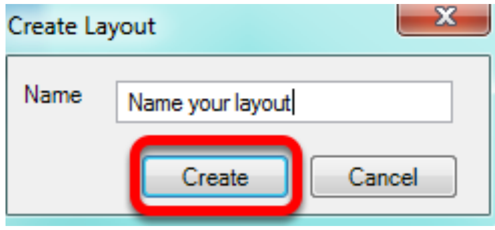
Once the preferred chart layout has been selected, Click View > Chart Layouts.

Add the Layout



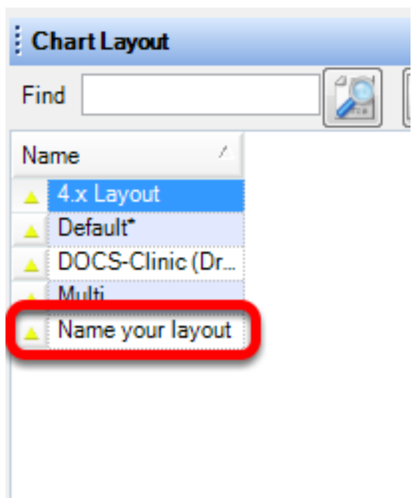
Click on the green plus.

Name the Layout



Type in the name of the layout and Click CREATE.

Select the Layout

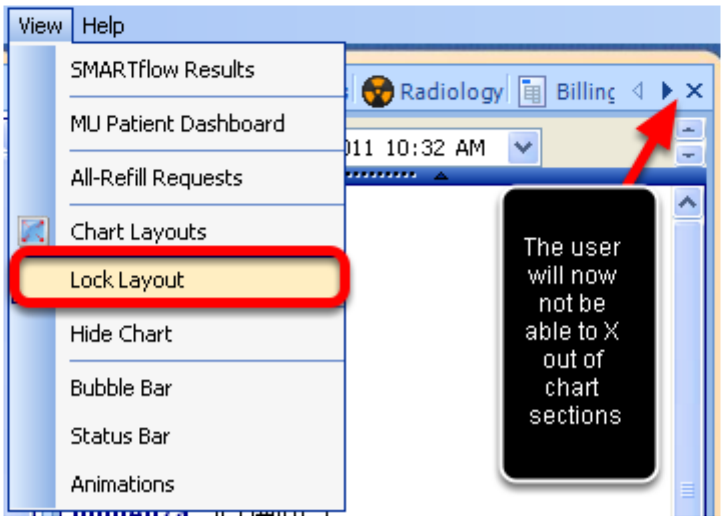


Auser's layout will now be listed with the four default layouts.
Helpful hint for the user: do not X out of SOAPware (meaning do not hit the red X at the top right of the screen as a means to log off or exit SOAPware), as this could cause a user's specific layout to not automatically display when he/she logged in each day.

Locking Chart Layouts

In this lesson, the user will learn how to lock a chart layout.

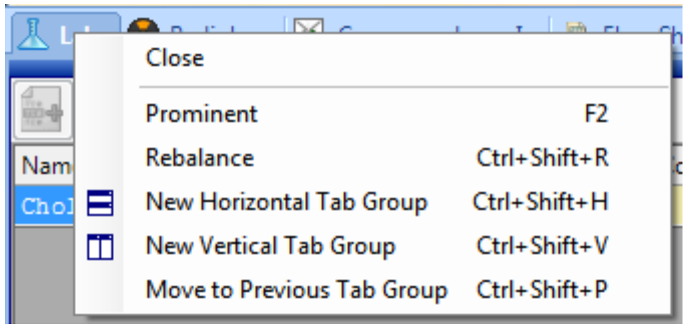
Lock Chart Layout



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.

Additional Layout Options

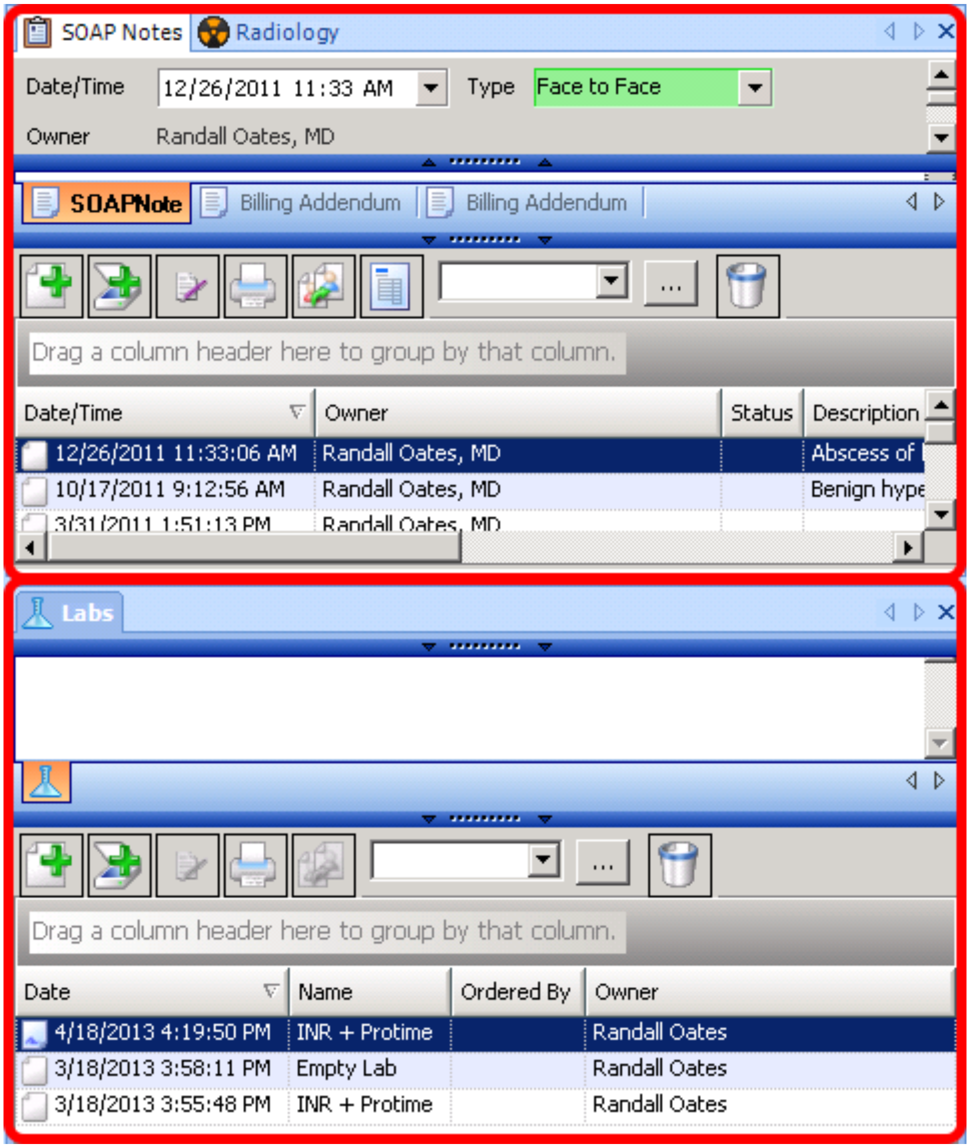
Prominent and Rebalance



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.

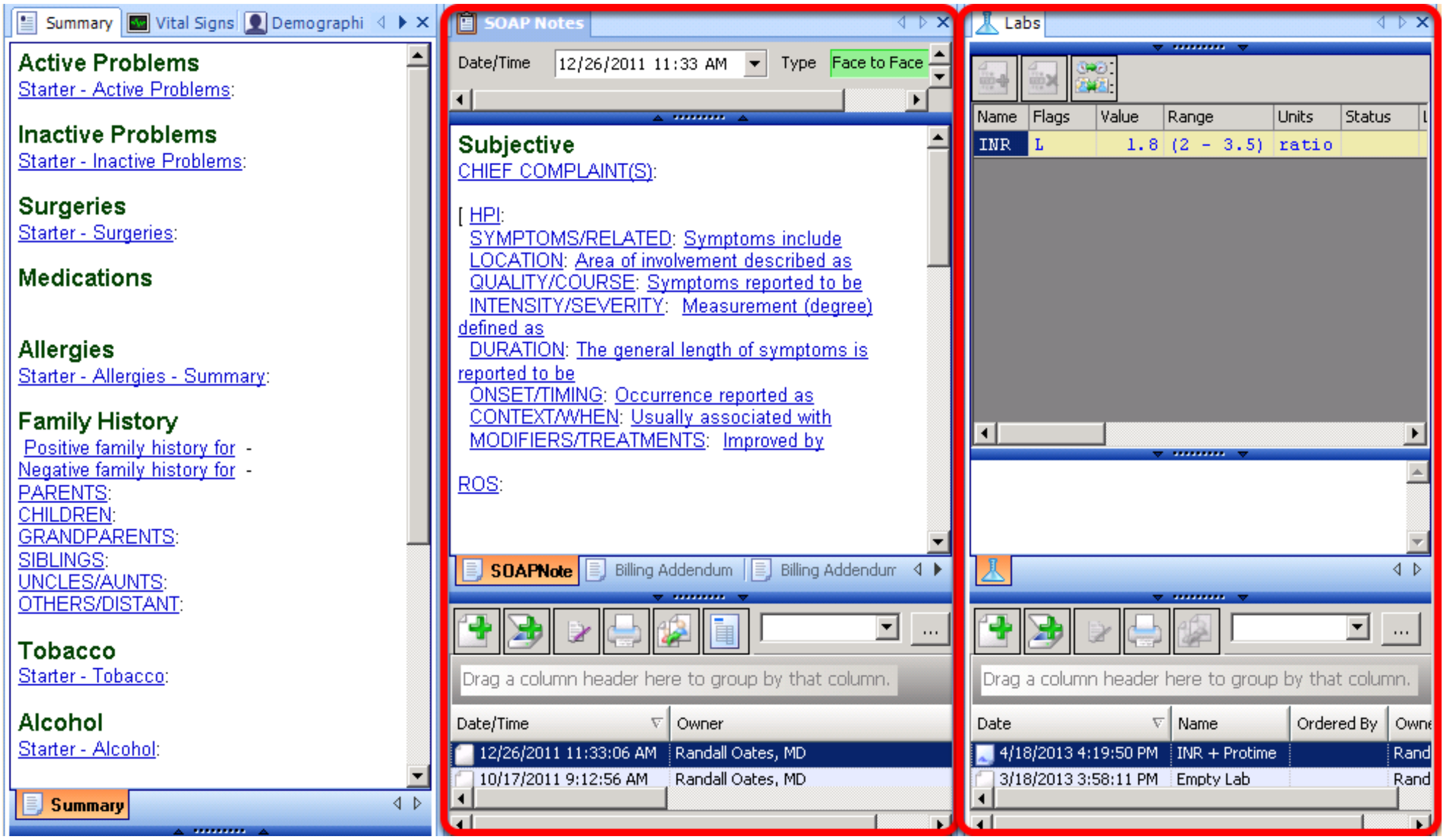
Add a Horizontal Separator to a Chart Layout



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



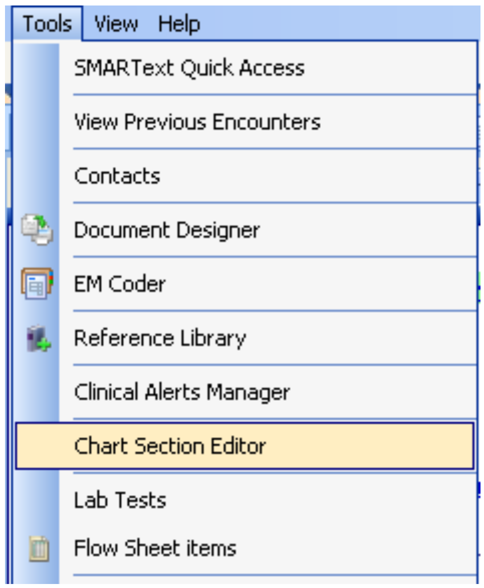
New Vertical Tab Group will split the layout vertically. In the example above, Labs was selected as a new Vertical Tab Group so that now there are three vertical tab groups instead of two.

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

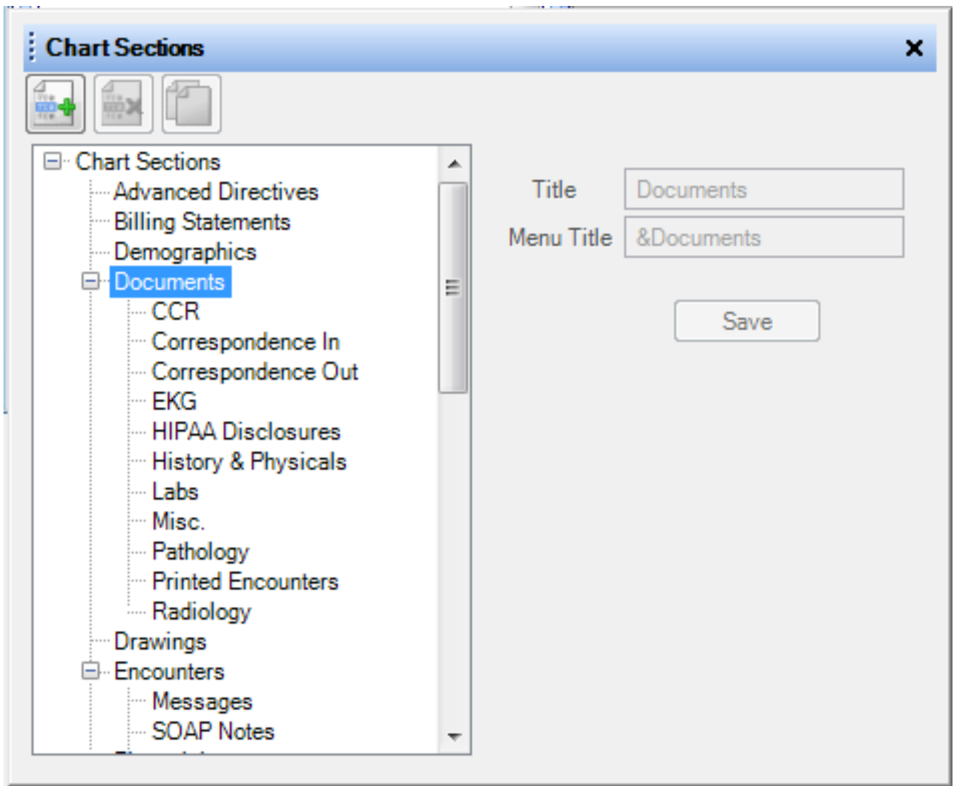
These instructions will show how to create new chart sections within Chart Navigator.

Open the Chart Section Editor



Click Tools, and Click Chart Section Editor.

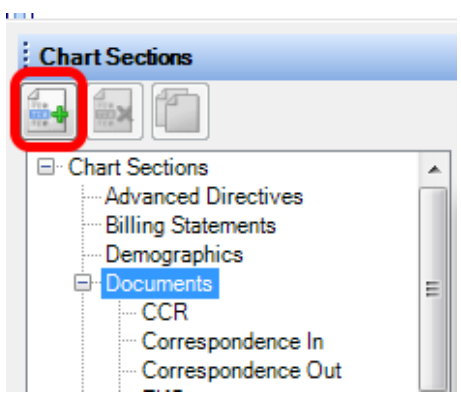
Locate the Parent Section



Click on the area that you wish to add a Chart Section.

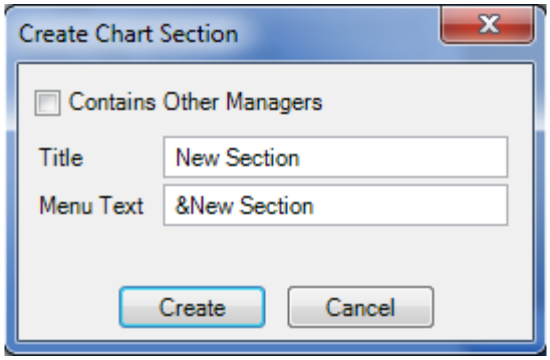
In this example we are adding to the Documents section.

Click the Add Button



Click the Add button (i.e. the green +).

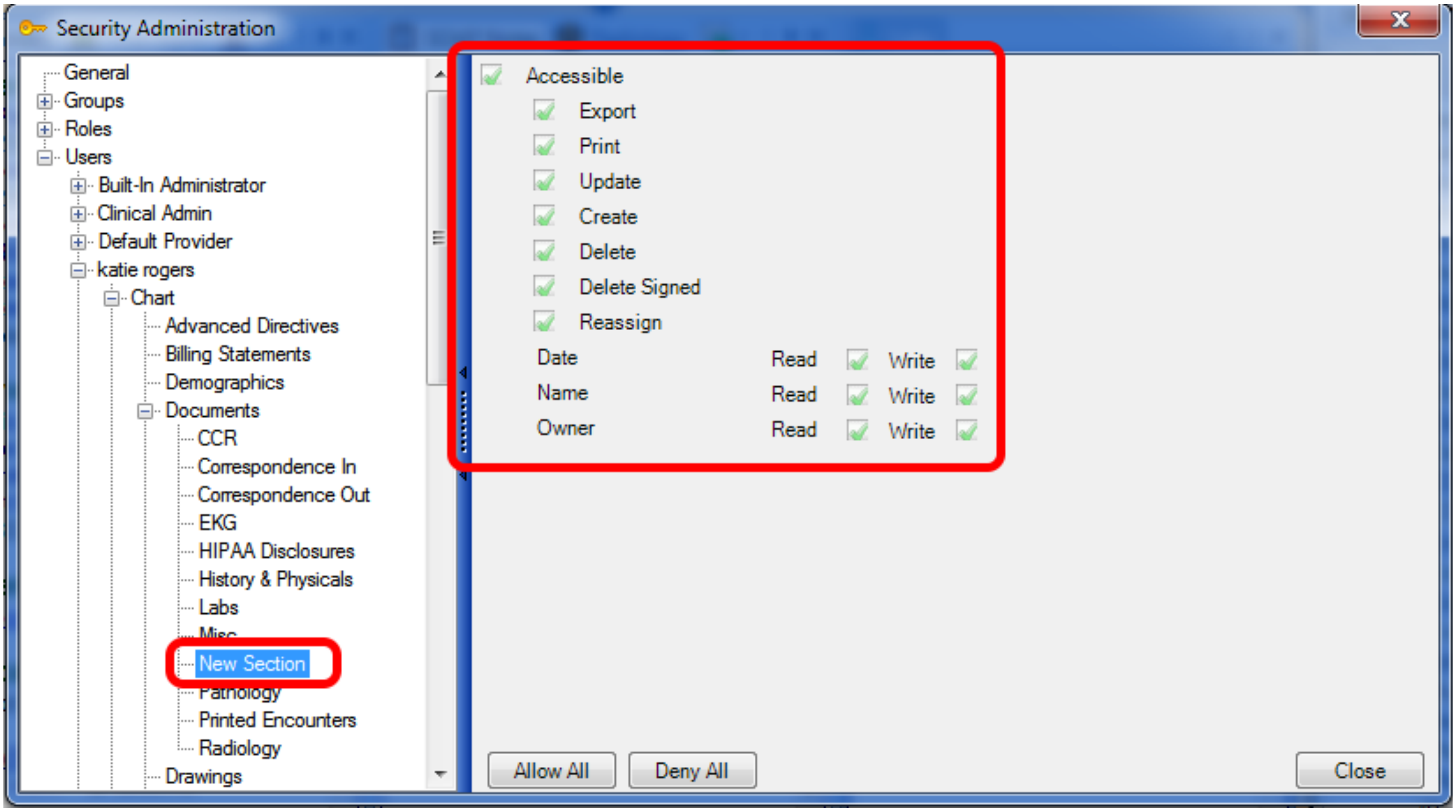
Type the Name



Type the name of the new chart section to add in both the Title and the Menu field/boxes and Click Create.

Awindow will appear letting you know that you need to restart SOAPware.

User Privileges



After the new chart section has been added, users within SOAPware must be given Security Administration rights to access the new chart section. To do this, follow the steps below:

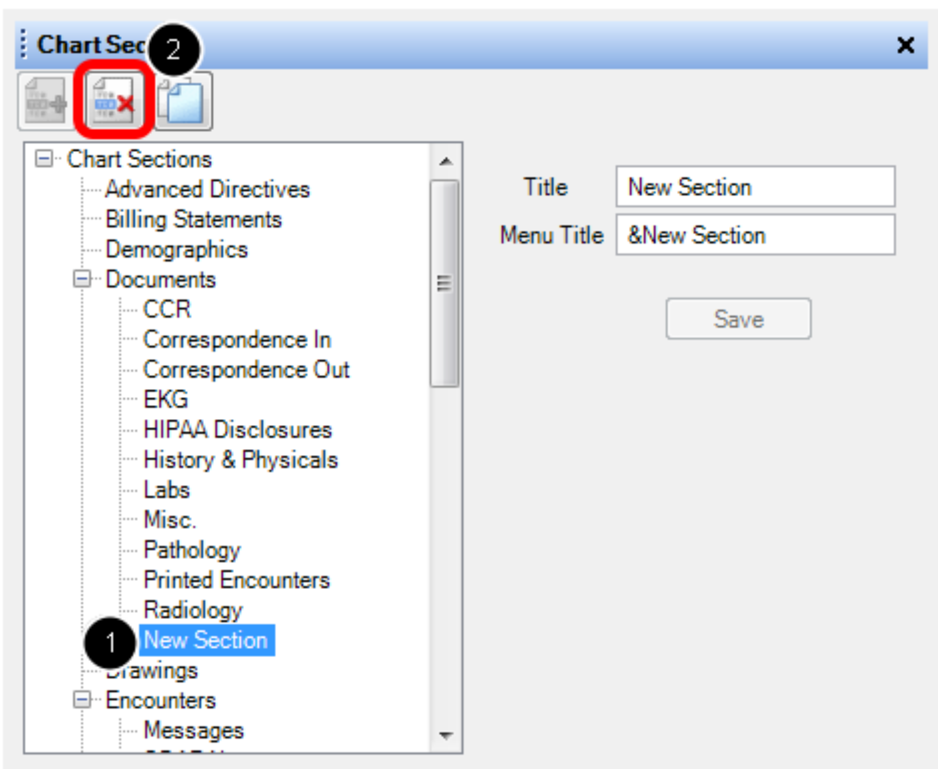
1. Using the Administrator login, Click **Tools** > **Security**.
2. Click the + sign next to the user's name that you wish to give access to.
3. Click the + sign next to Charts. Click the + sign next to Documents. Highlight the new Chart Section name.
4. Assign security privileges to the new chart section as desired (green check means privilege granted, red X means the privilege is denied).
5. PERFORM THIS FOR EACH USER THAT WILL NEED ACCESS TO THIS NEW SECTION.
6. Click the Close button to exit Security Administration. The user should now logout of SOApware and back in for the new settings to take place.

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

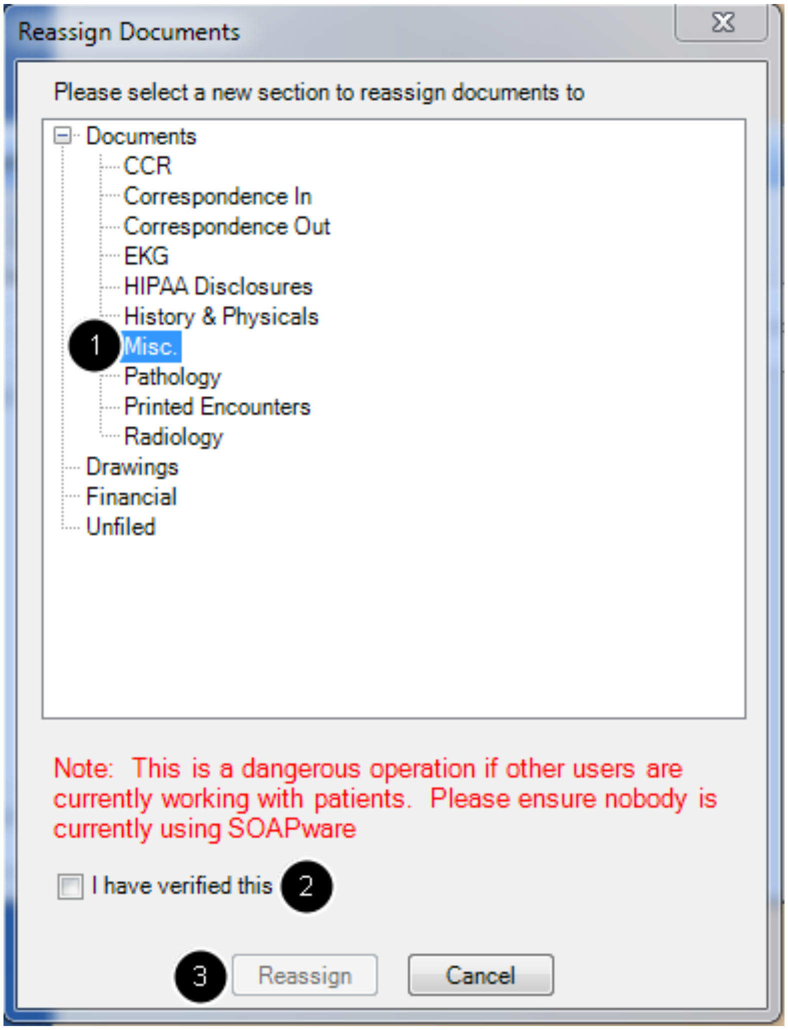


To remove a Chart Section:

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.

Reassigning Documents



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

SMARText Introduction

***THE USE OF SMARTEXT IS REQUIRED FOR MEANINGFUL USE:** Click here to view Meaningful Use Roadmap.

For instructions on how to update SMARText Items, Click here.

Importance of SMARText

Exclusive to SOAPware, SMARText is the backbone for medical documentation using our EMR. SMARText entries replace and extend macros to auto-enter blocks of text data that are specially designed to be searchable by computer.

Because SMARText 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 SMARText 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 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. Previously used (SOAPware 2010) No Known SMARText Item Types in these fields will not calculate properly for Meaningful Use. **A user must update all SMARText Items** within SMARText Items Manager to capture newly created or changed SMARText 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 SMARText 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 SMARText Items Types in the Summary.
Active Problems- "NoPro"
Surgeries- "SurNo"
Medications- "NoMeds"
Allergies- "NKDA"

What is SMARText

Pieces of information or objects, including text; CPT codes; medication items; images; photos; videos and audio files; can be combined to form SMARText items. Entered using a combination of shortcuts and keystrokes, multiple SMARText 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.

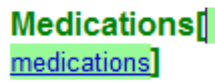
Examples:
htn = hypertension
ver = verbalizes understanding at this time

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



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.

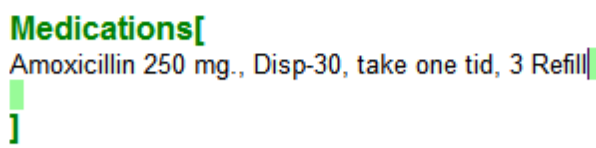
Examples of Free Text vs. Structured Text

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

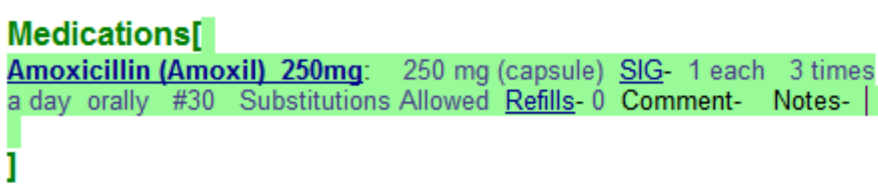
When typed using free-text, Amoxicillin and moAcXllicin appear the same to the computer -- both letter groupings are equally meaningless. In contrast, objects in SOAPware can include multiple letters and/or numbers that as a group have been identified and are recognizable to the computer. SOAPware displays the start and end points of a SMARText 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 above is a free-text medication. While this entry is functional, it is not considered "meaningful data."

Structured Text



The image above shows the same information, but in a SMARText format that allows the information to easily be inserted into the chart, ePrescribed, and read by a computer.

Added Value

With SMARText, a user will be able to:

Quickly and easily associate information that needs to be grouped together (i.e. a SMARText item of the appropriate type)
Do it all in one location (i.e. a SMARText item of the appropriate type)
Save the item for reuse in the future (save it in the SMARText library)

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)
SMARText 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?

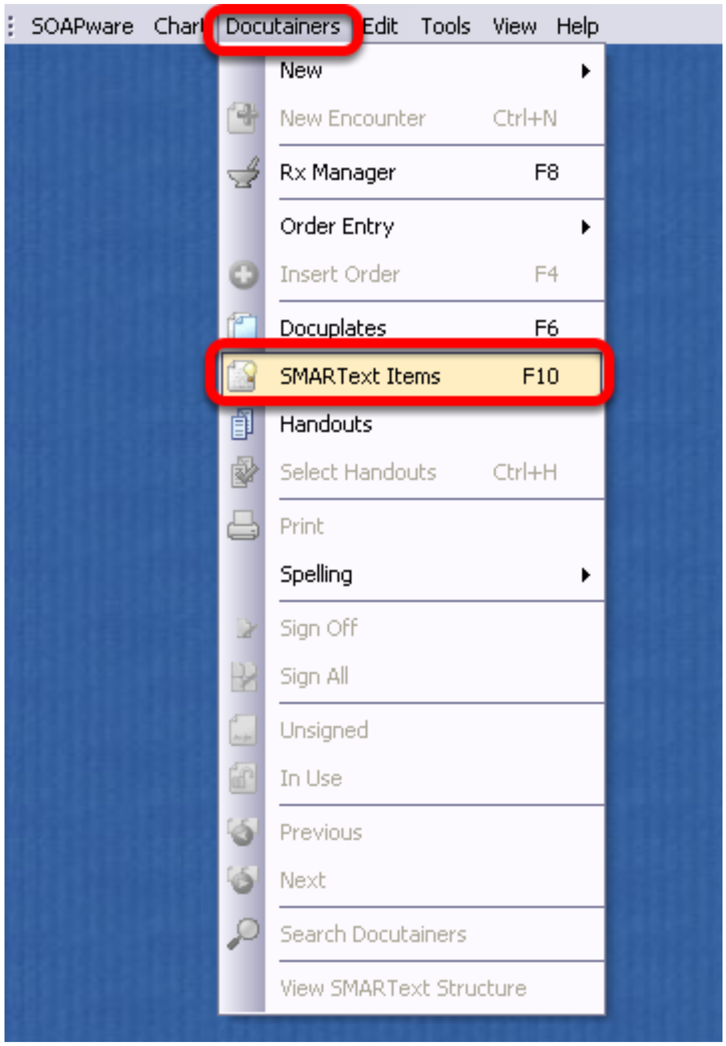
Reasons to Use Structured Data

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.

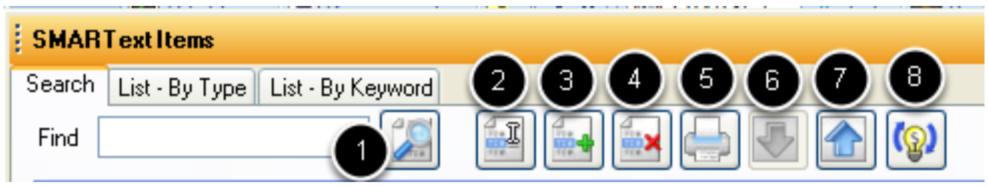
Find SMARText Items

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.

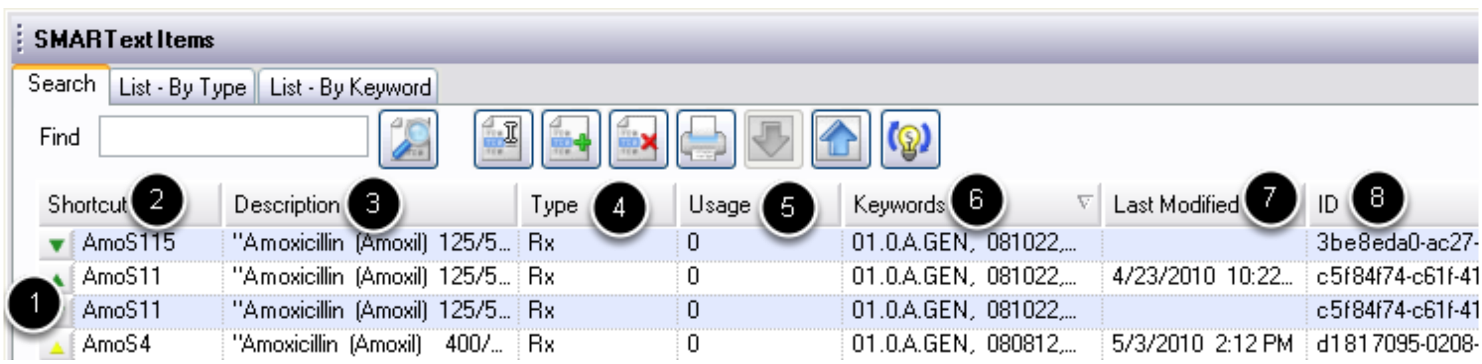
5. Print button- Allows the user to print a list of the SMARText Items that are currently displayed.

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 any where 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



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.

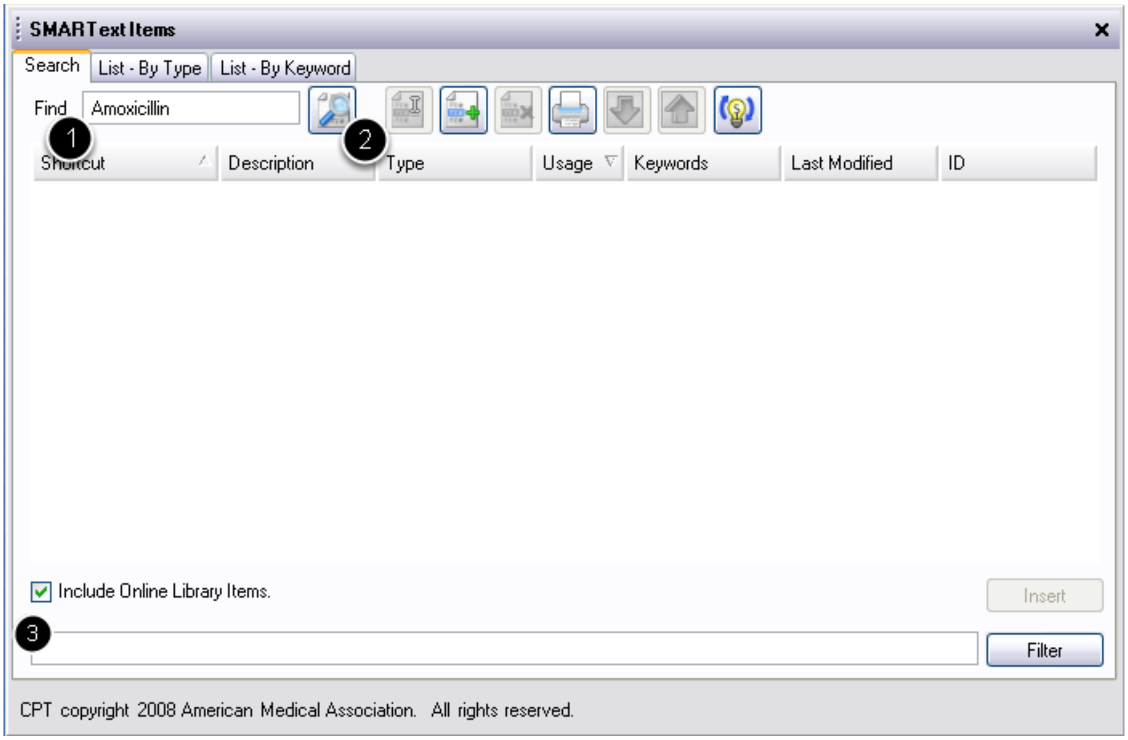
Column #7: Last Modified

* 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.

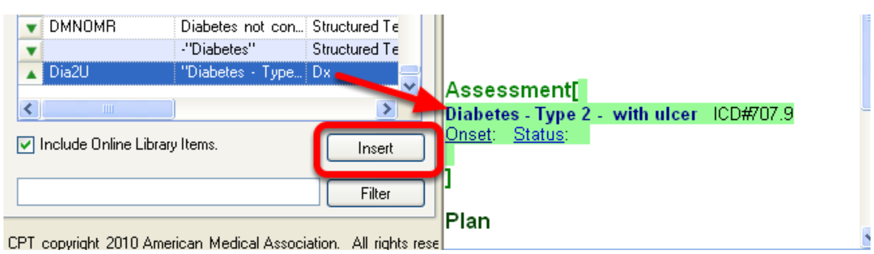
Searching within SMARText Items Manager



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".

SMARText Data Entry Methods

This lesson will demonstrate the various ways to search for and use SMARText in the patient's documentation.

Various SMARText Data Entry Methods

The various data entry methods include:
* SMARText Items Manager
* Shift + F11
* F11
* Shortcut Code
* Quick Access Location Pick List
* Quick Access SMARText 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 SMARText to Document for Meaningful Use

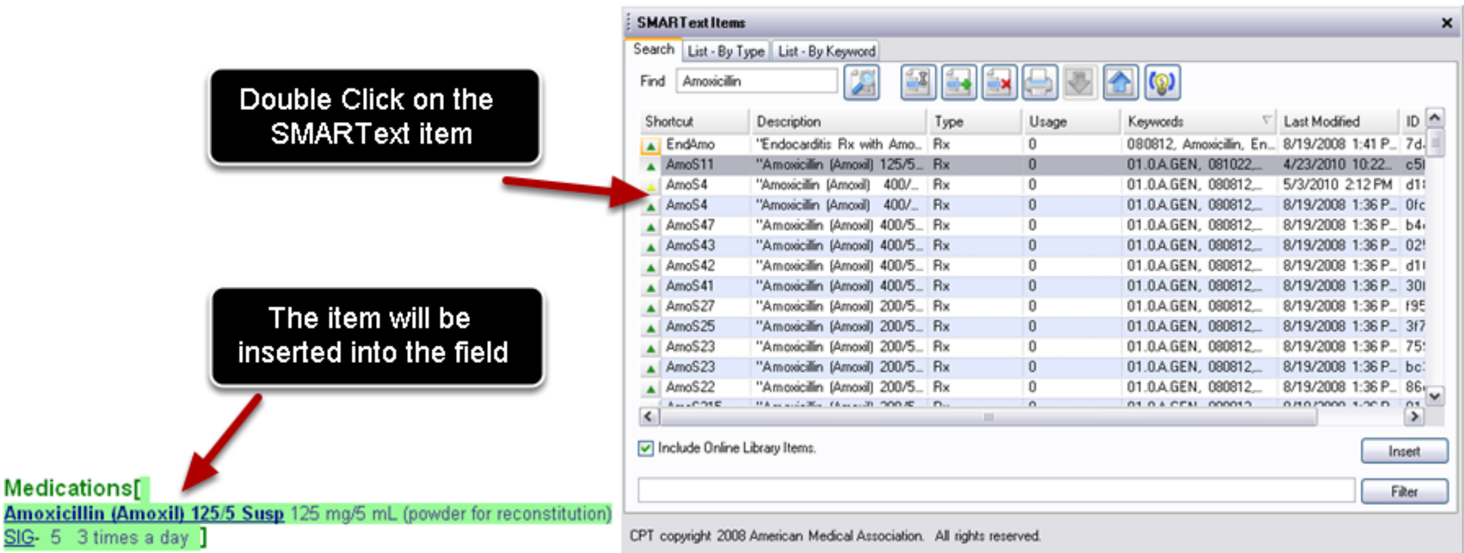
Using SMARText structured items for documentation in the fields listed below will assist clinics with documenting to meet meaningful use requirements:

Demographics
Active Problems
Summary Medications
Allergies
Tobacco
Assessment
SOAPnote Medications
Plan
Vital Signs
Labs

SMARText is a type of data entry that 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.

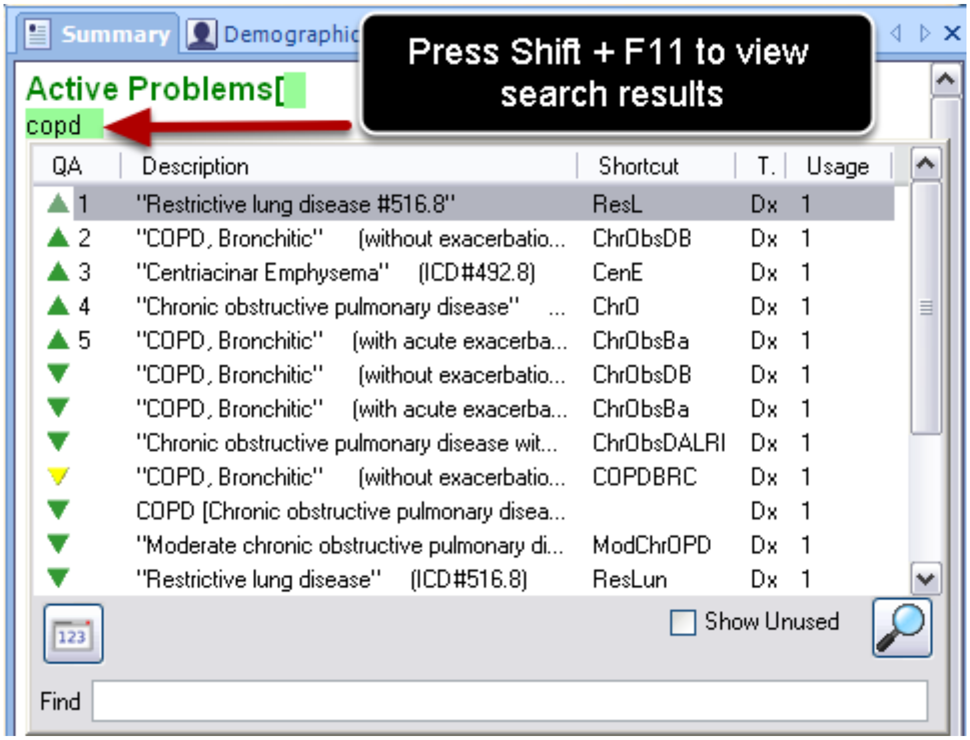
Inserting Items with SMARText Items Manager



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

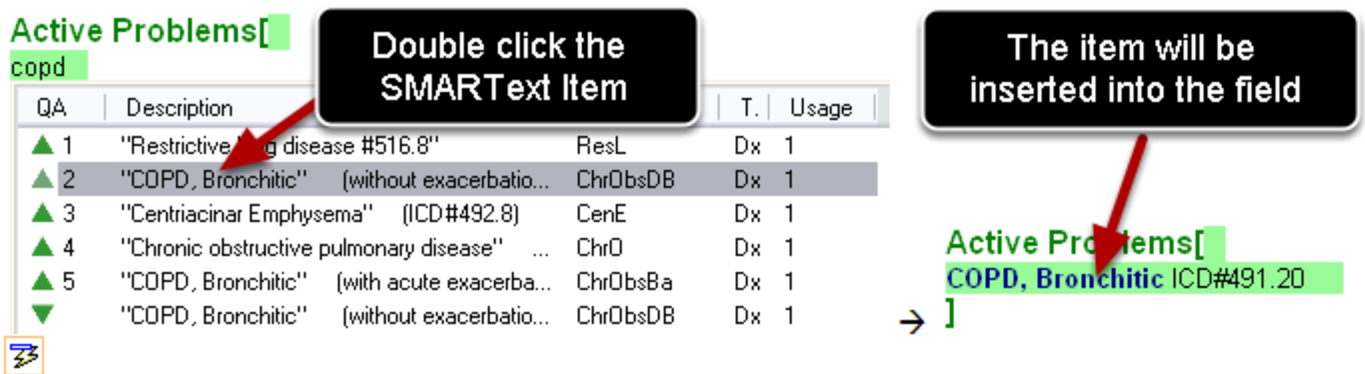


SMARText items may be searched within each field. A "Shift + F11" search will display a list of SMARText items that are located on the SOAPware Online Library and the users local database. To conduct a "Shift + F11" search:

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.

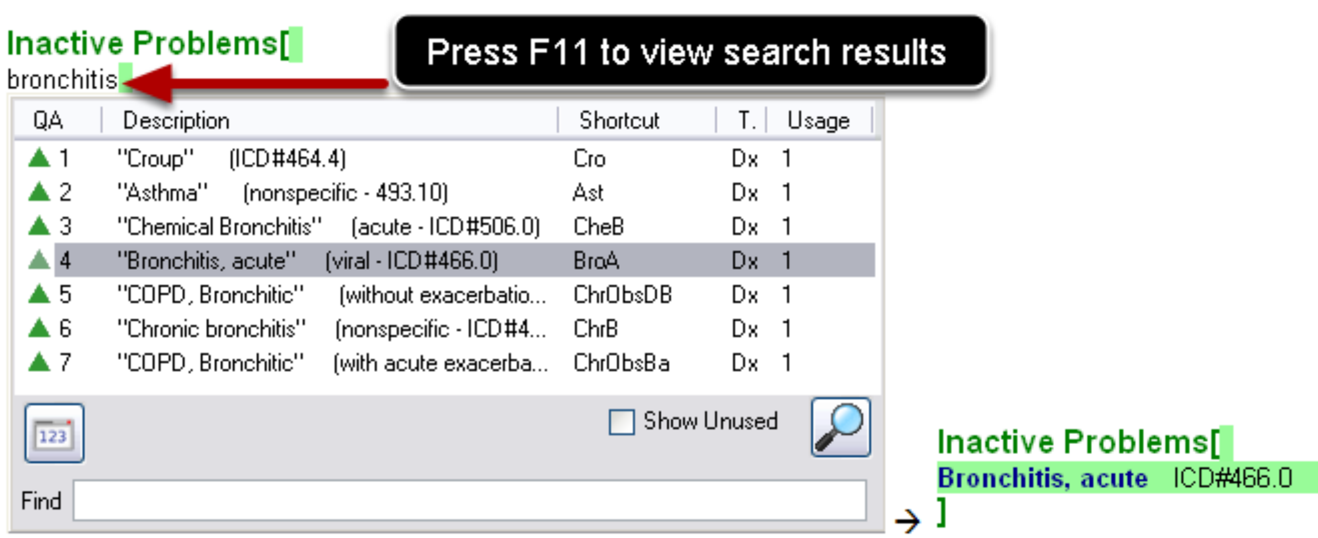
Inserting an Item From a Shift + F11 Search



To insert a SMARText Item into an active field using a Shift + F11 search:

1. Left Click on the desired SMARText Item to highlight it.
2. Double Click on the item to insert it into the field.

F11 Entry Method



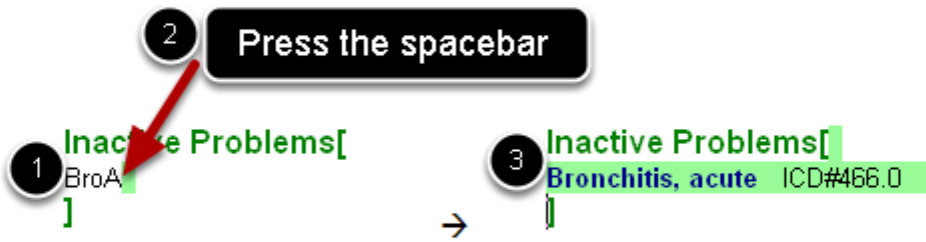
An "F11" search will display a list of SMARText items that are located on the users local database. To conduct an "F11" search:

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 SMARText 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.

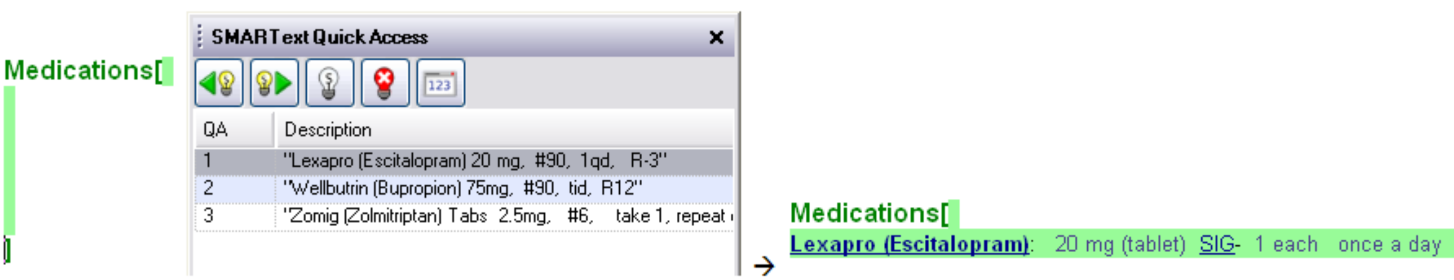
Shortcut Code Entry Method



If the shortcut code to a SMARText 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 SMARText item to insert.
2. Press the spacebar on the keyboard.
3. The SMARText item will expand.

Quick Access Location Pick List Entry Method



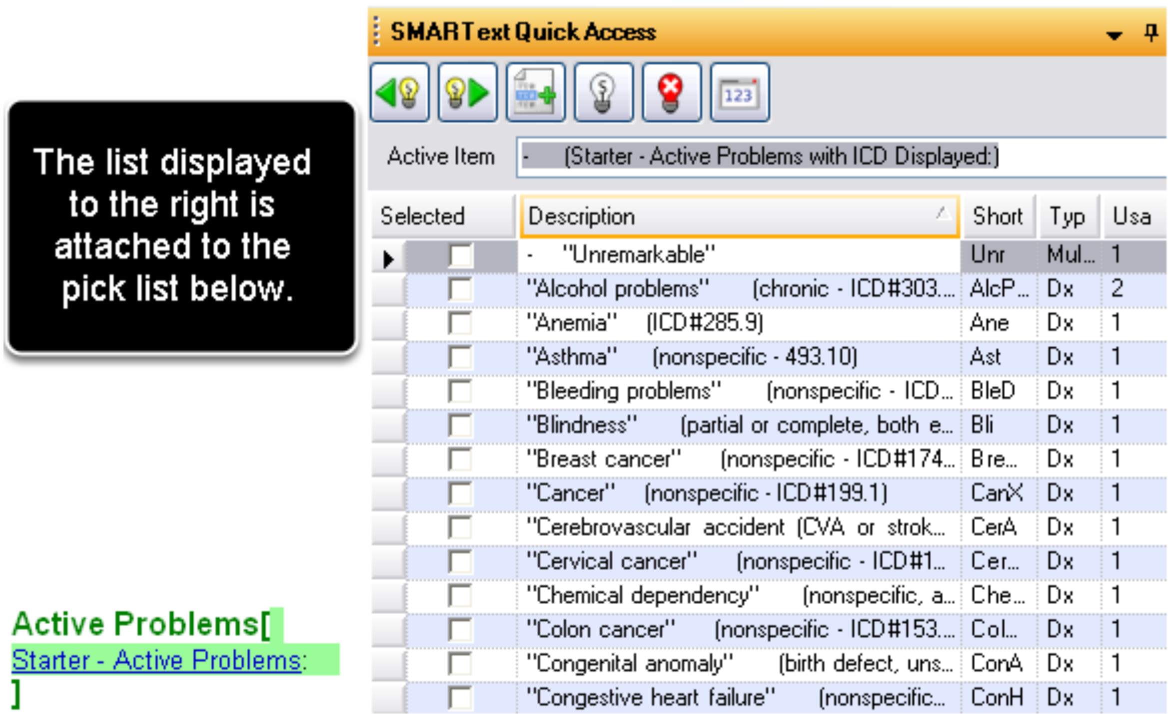
Clicking in most fields causes a list of SMARText items that were previously used in that field (in any patients chart) to be presented in the SMARText Quick Access dialog box. The Quick Access Location pick list is User specific and allows for inserting a previously used item without conducting a search.

To insert a item from the Quick Access Location Pick List, simply double Click on the item in the

SMARText 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



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

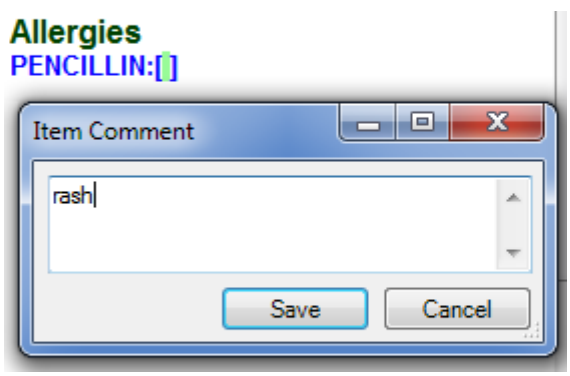
* Social History

* 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 SMARText items within a user's documentation.

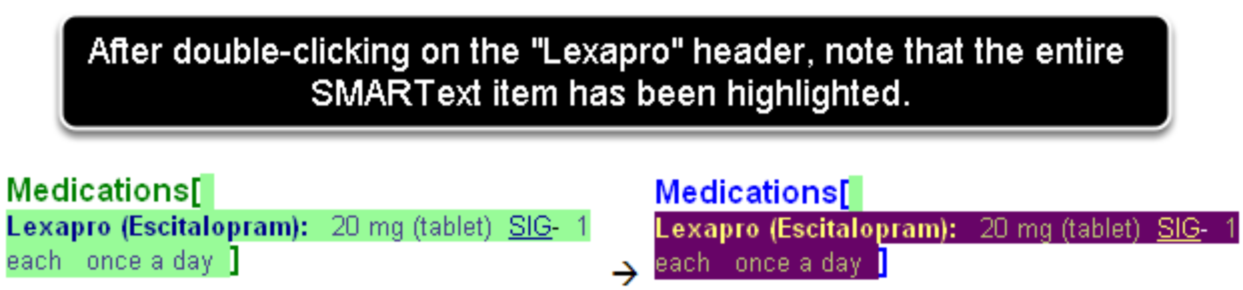
Even though SMARText appears similar to free-text, SMARText has hidden information associated with the words and phrases used in documentation. As a result, the documentation is able to be identified electronically and read by the computer thus making a user's documentation more searchable. Therefore, when editing SMARText items a user should follow the rules described in this lesson.

Highlighting & Selecting SMARText Items

At times a user may find it necessary to highlight a SMARText item so a user can drag & drop it into another field. When highlighting and selecting a SMARText item it is important that the cursor be at the beginning or end of the SMARText 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 SMARText item. We will discuss this method below.

Double-Click Method for Selecting SMARText Items

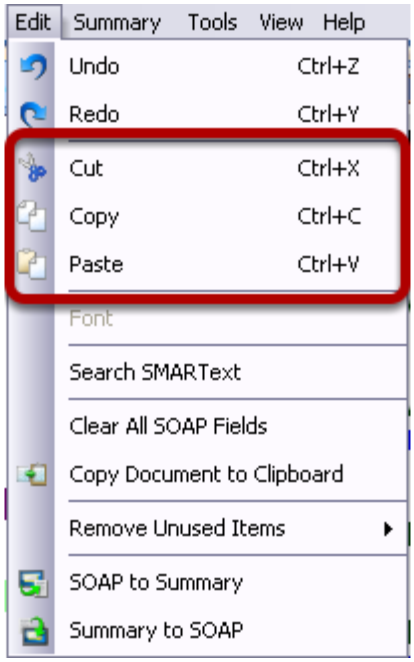


To select the SMARText item, double-click on the item header (ie: the name of the medication, name of the diagnosis, etc.).

This will highlight the all of the items associated with the SMARText 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 SMARText 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.

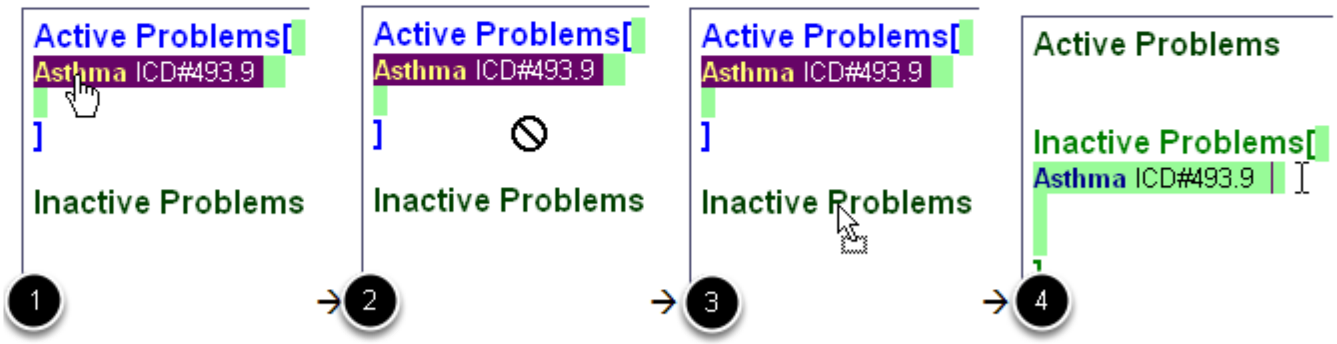
* To cut a SMARText item, select Edit then Cut from the Menu bar or press Ctrl + X on the keyboard.
* To copy a SMARText item, select Edit then Copy from the Menu bar or press Ctrl + C on the keyboard.
* After cutting or copying an item the user can then paste the item into a field. To paste a SMARText 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:

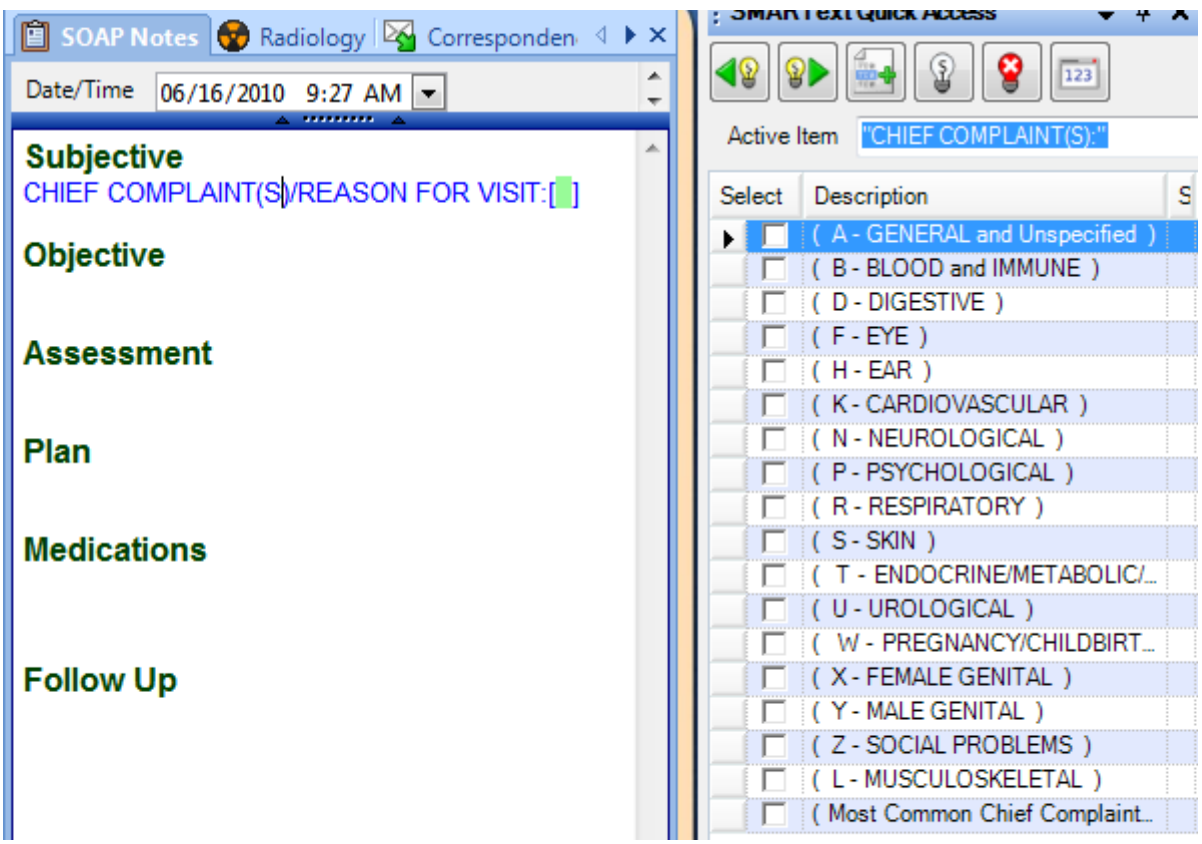
1. Highlight and select the item by using one of the methods that was previously described.
2. While holding a left-click, begin dragging the item to another field. The user will see a circle with a line through it indicating that he/she can not yet drop the item.
3. Place the cursor directly over the 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.

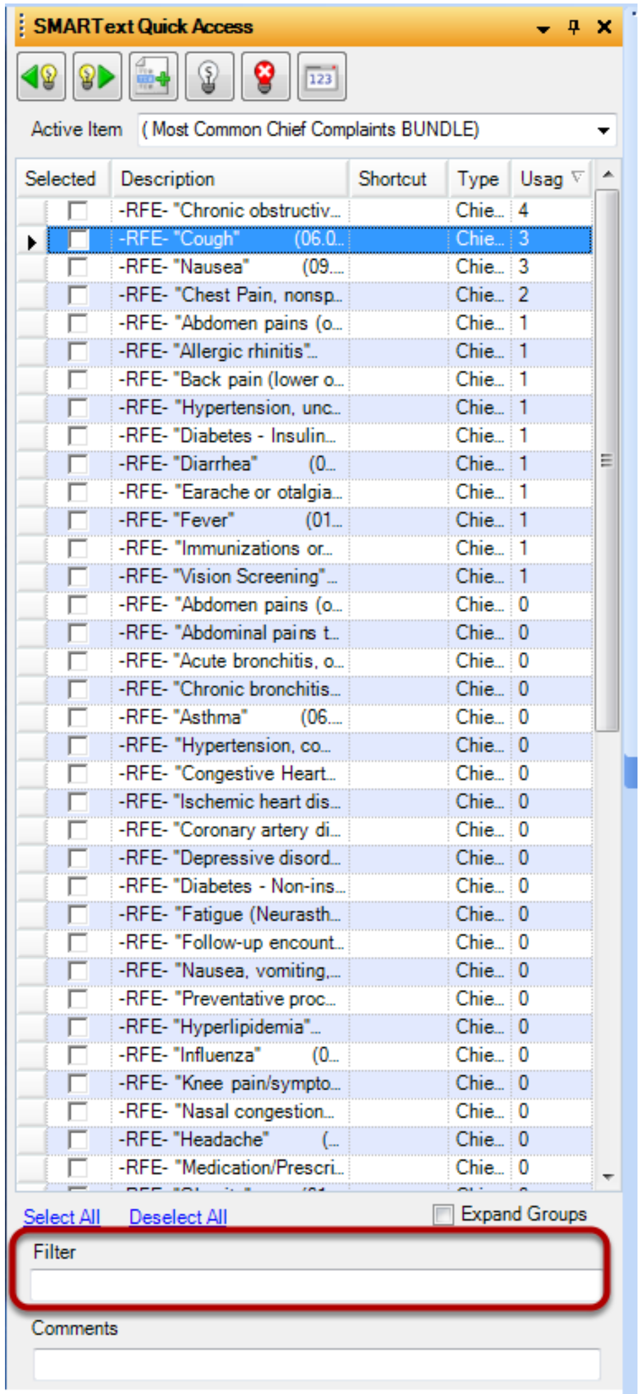
Customized pick lists are one of the most efficient data entry methods. Creating custom pick lists that contain the items that the user commonly and repeatedly utilize, allows data entry to be performed quickly and efficiently via a click for insertion into documentation.

Pick Lists



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



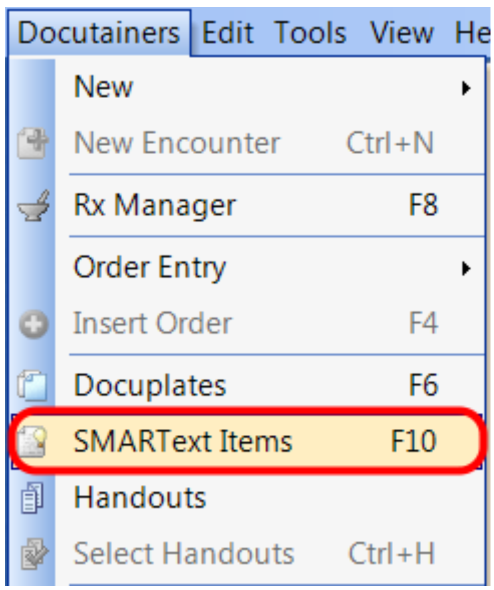
The SMARText Quick Access display for Multi Select and Toggle items now has a "Filter" option available located at the bottom of the display. When text is entered here ONLY items that have a keyword that starts with the entered filter will be displayed.

Creating SMARText Items

Shortcut Code

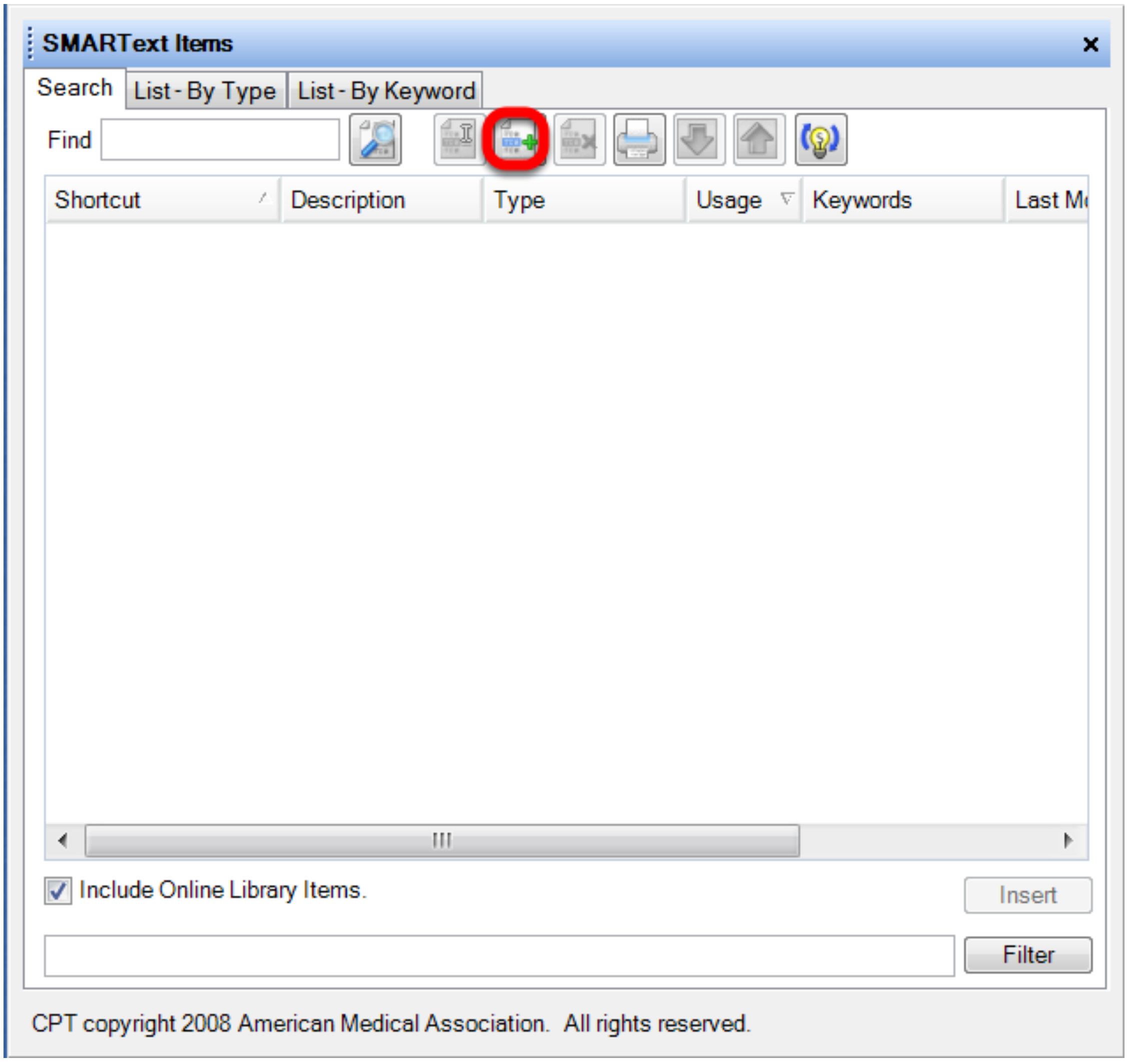
A shortcut code can be very helpful when inserting strings of unstructured text that a user types on a regular basis. By creating a shortcut code, the user can quickly insert this text without having to type the entire string of text.

Open SMARText Items



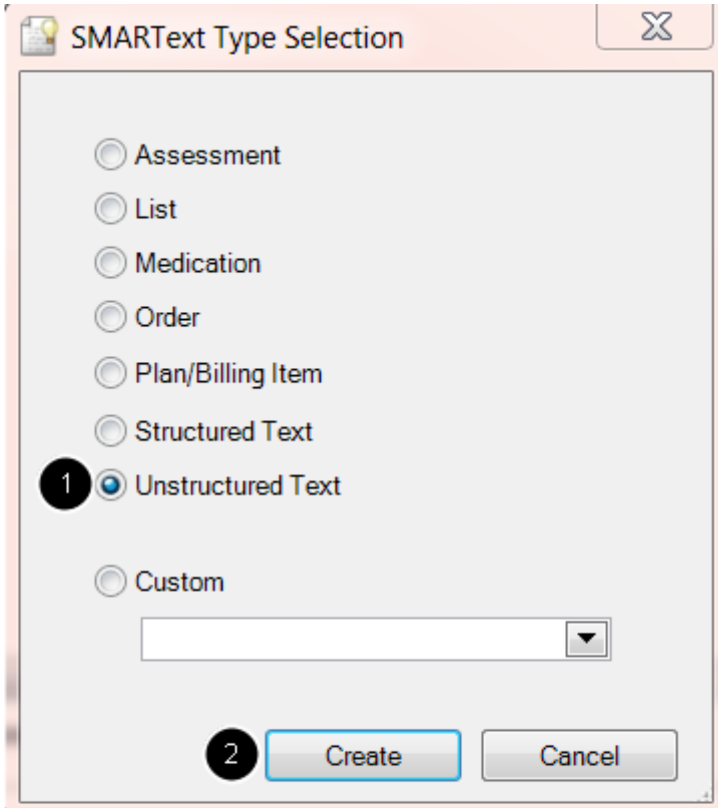
Go to Docutainers > SMARText Items.

Add an Item



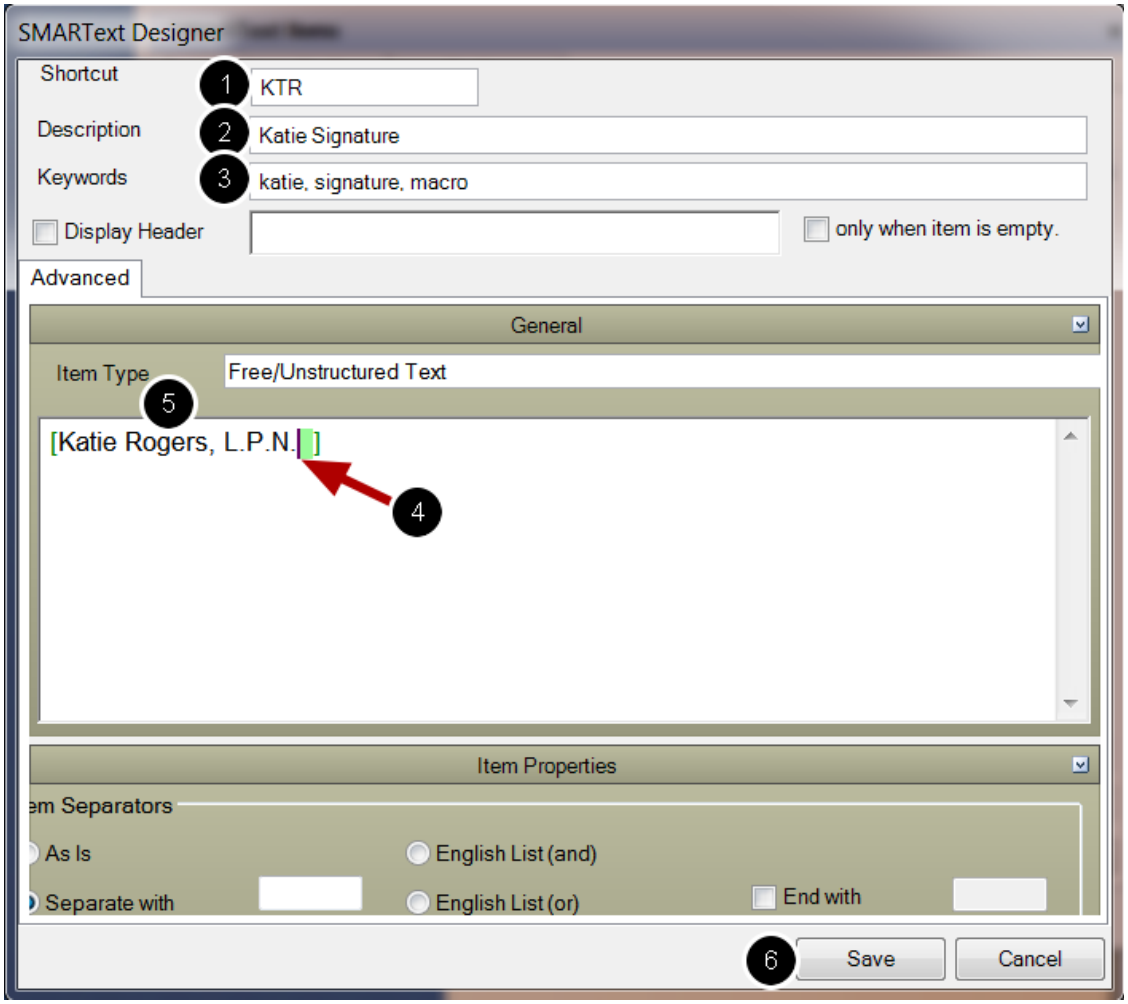
Click on the Create button.

Choose Item Type



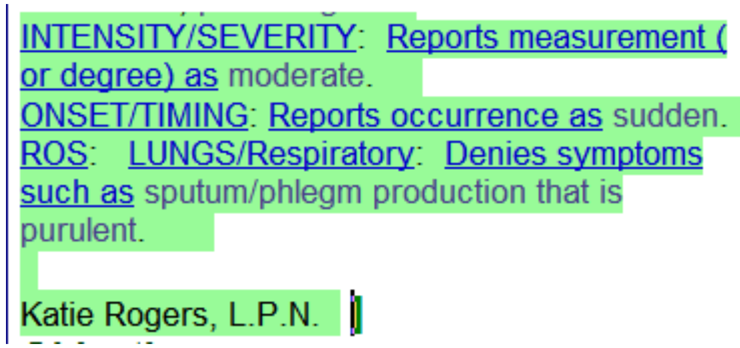
1. Choose Unstructured Text
2. Click Create

Create the Item



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 shortcut 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.

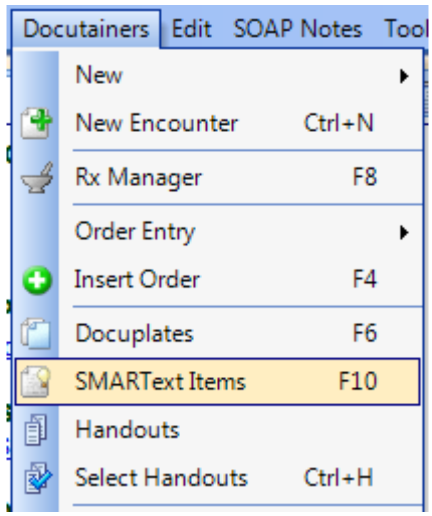
Inserting the Shortcut Code



Now, the user can type his/her shortcut code into a SOAPnote or Summary and hit the space bar. The shortcut 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.

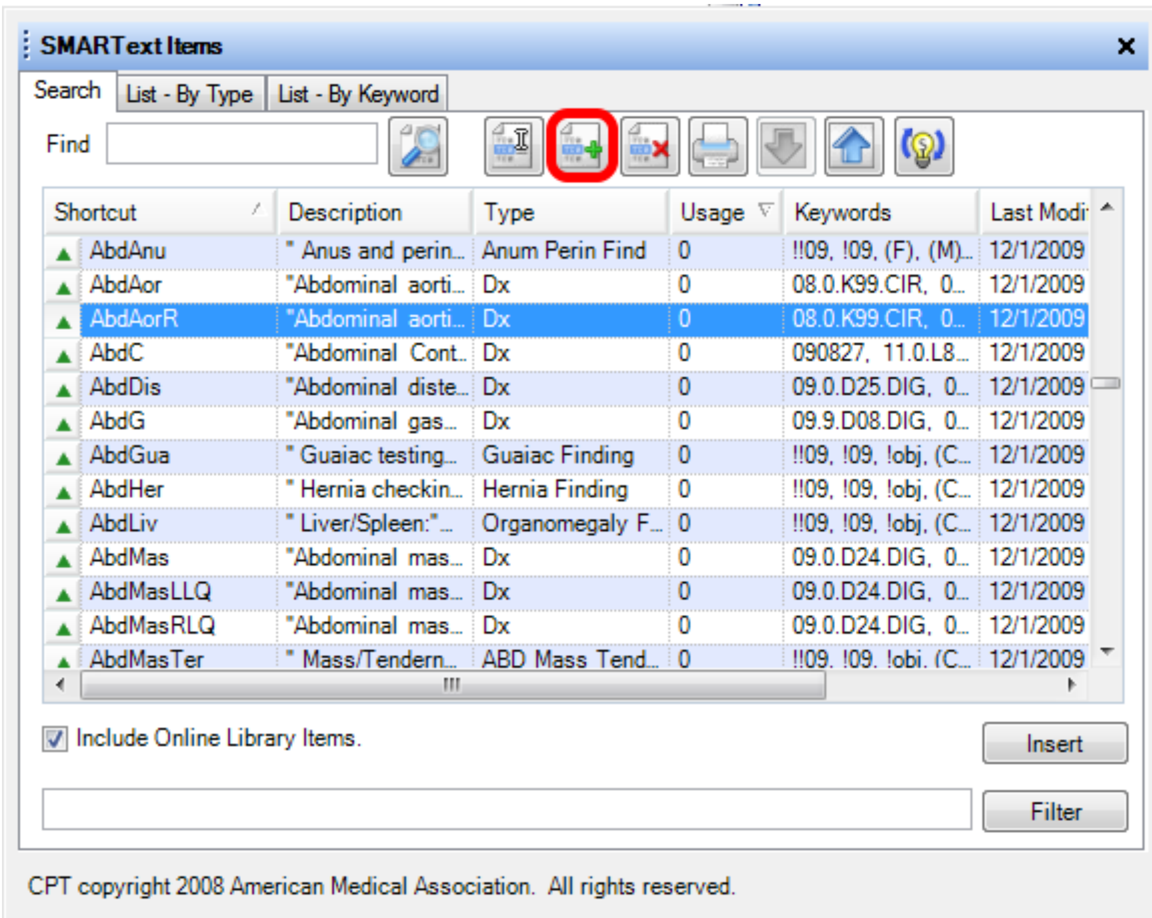
Creating and Editing SMARText Items in the SMARText Items Manager

SMARText Manager



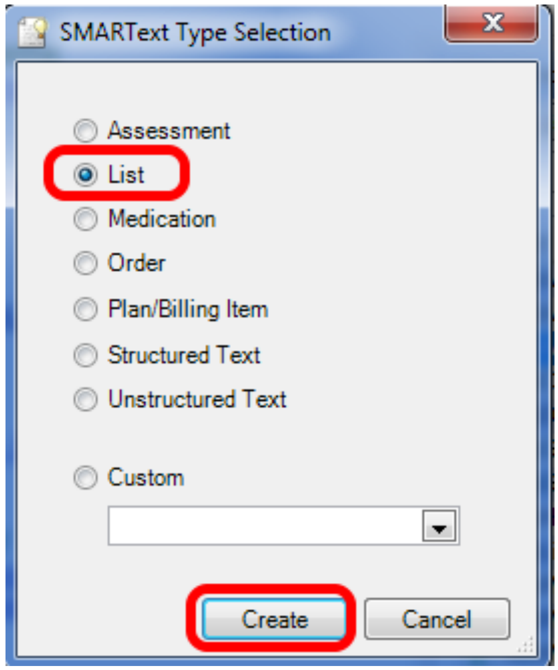
Open the SMARText Manager by going to Docutainers - SMARText Items

Create New



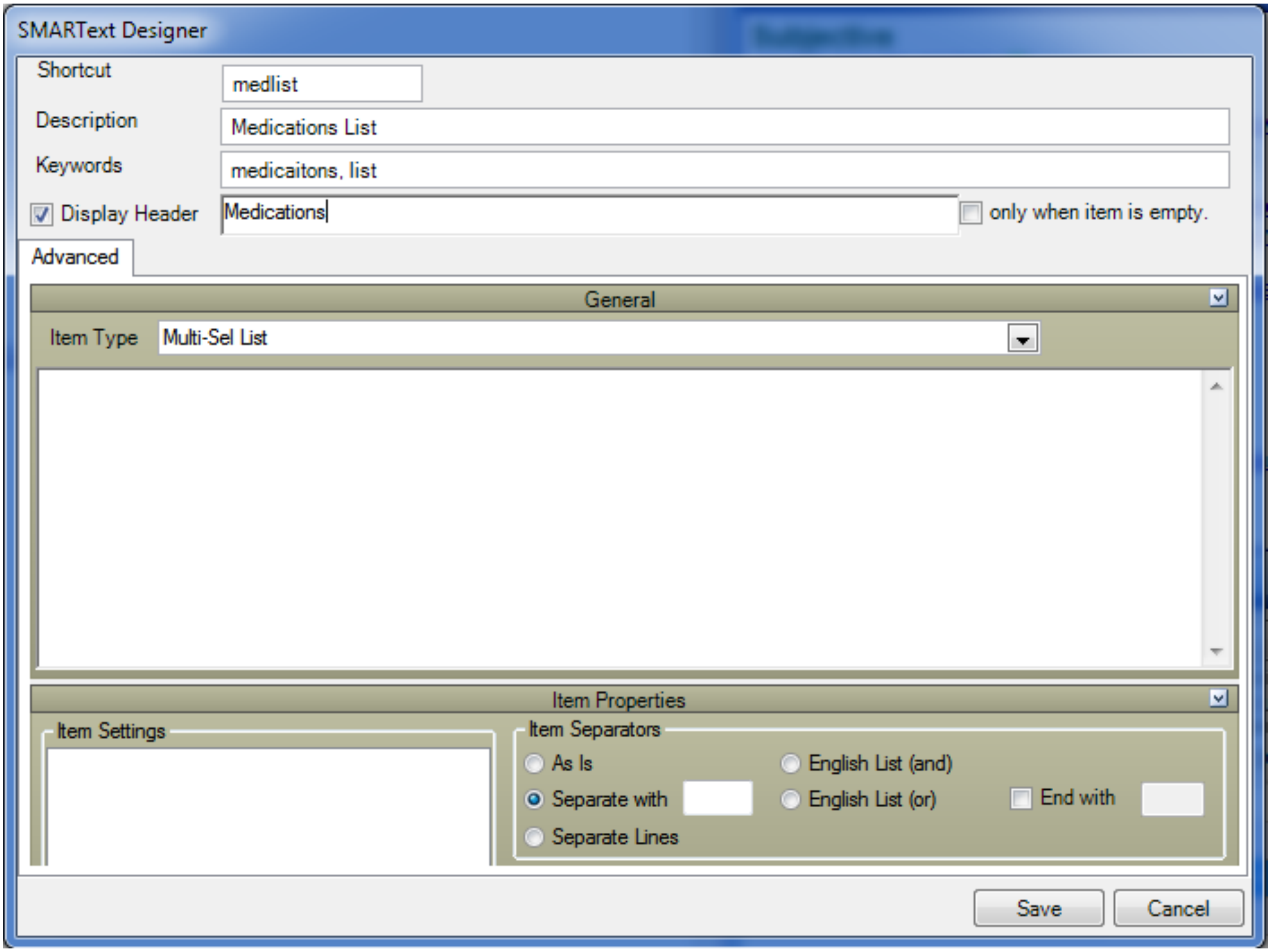
Click the create new button.

Item Type



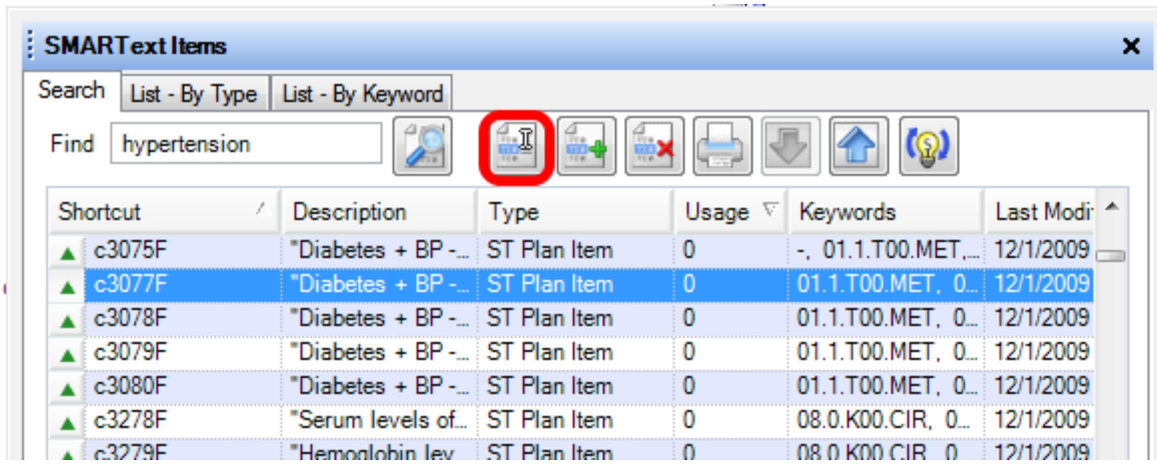
Choose the item type and Click create.

SMARText Designer



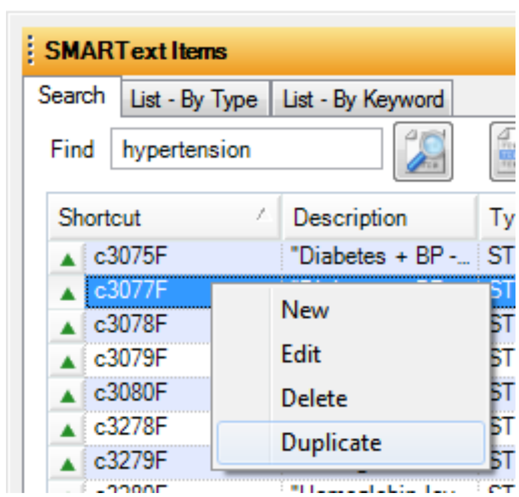
Use the SMARText Designer to assign a shortcut, description, keywords, and a Display Header. Click Save.

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

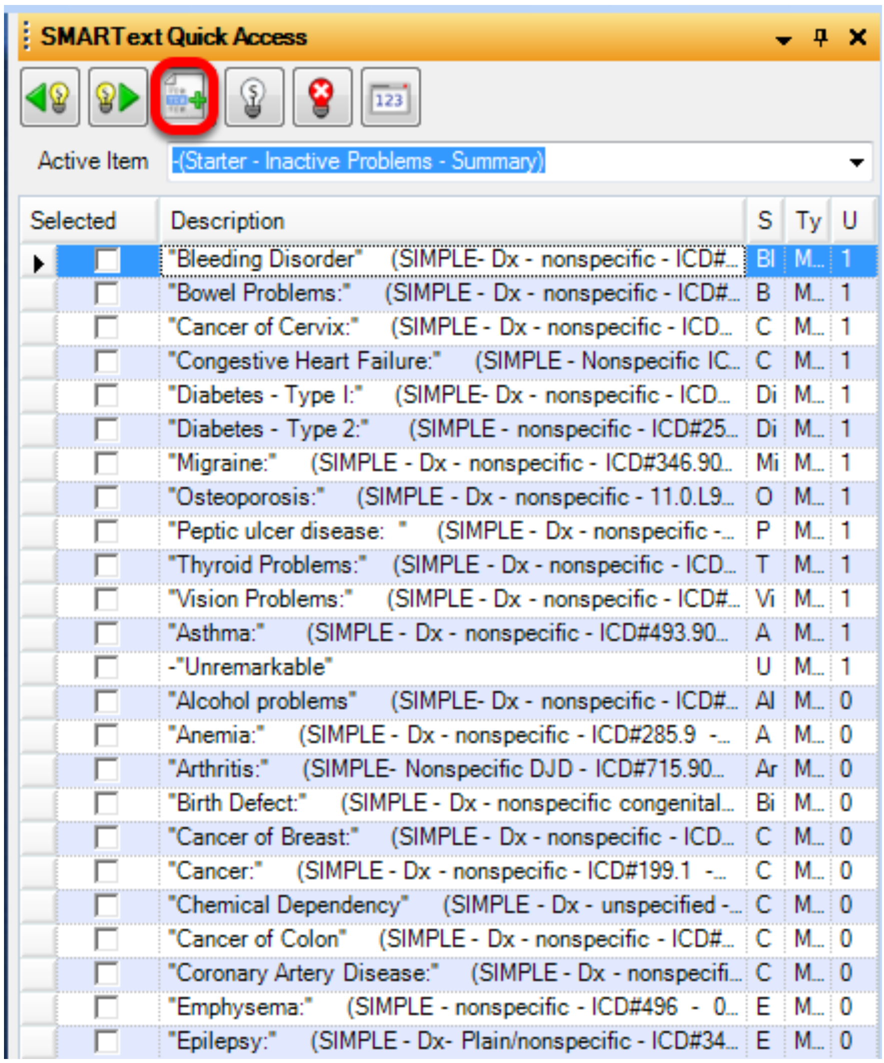


A user can also duplicate SMARText items to edit them without modifying the original item. To do this, right-click an existing SMARText item in the manager and Click Duplicate. This item will have a green triangle and a yellow triangle SMARText Item. The yellow item is now user created and may be edited, 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

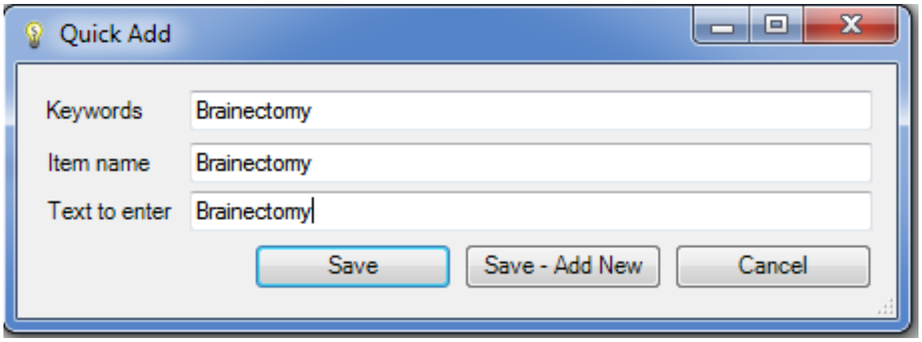
Most users will want to add and remove items from pick lists. This demo will show an easy means to add items to any pick list, anywhere.

Quick Add



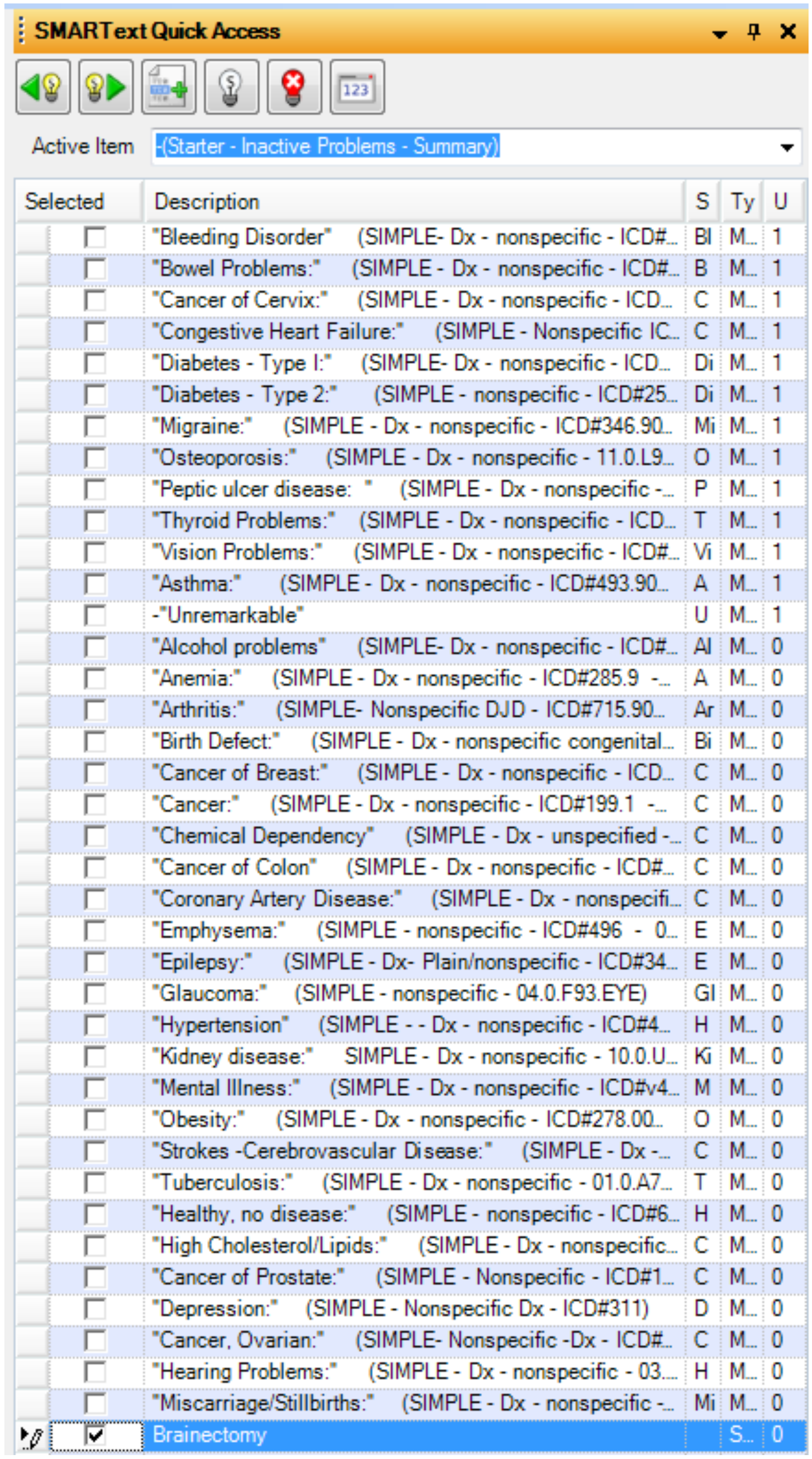
In Quick Access, Click the Add button on the mini toolbar at the top to present the Quick Add dialog as shown below.

Assign Keywords, Description, and Value



Type the Keyword, Description and Text to enter. Click Save.

Using the Newly Added Item



The newly created item will appear at the bottom of the list.

Structured SMARText Item

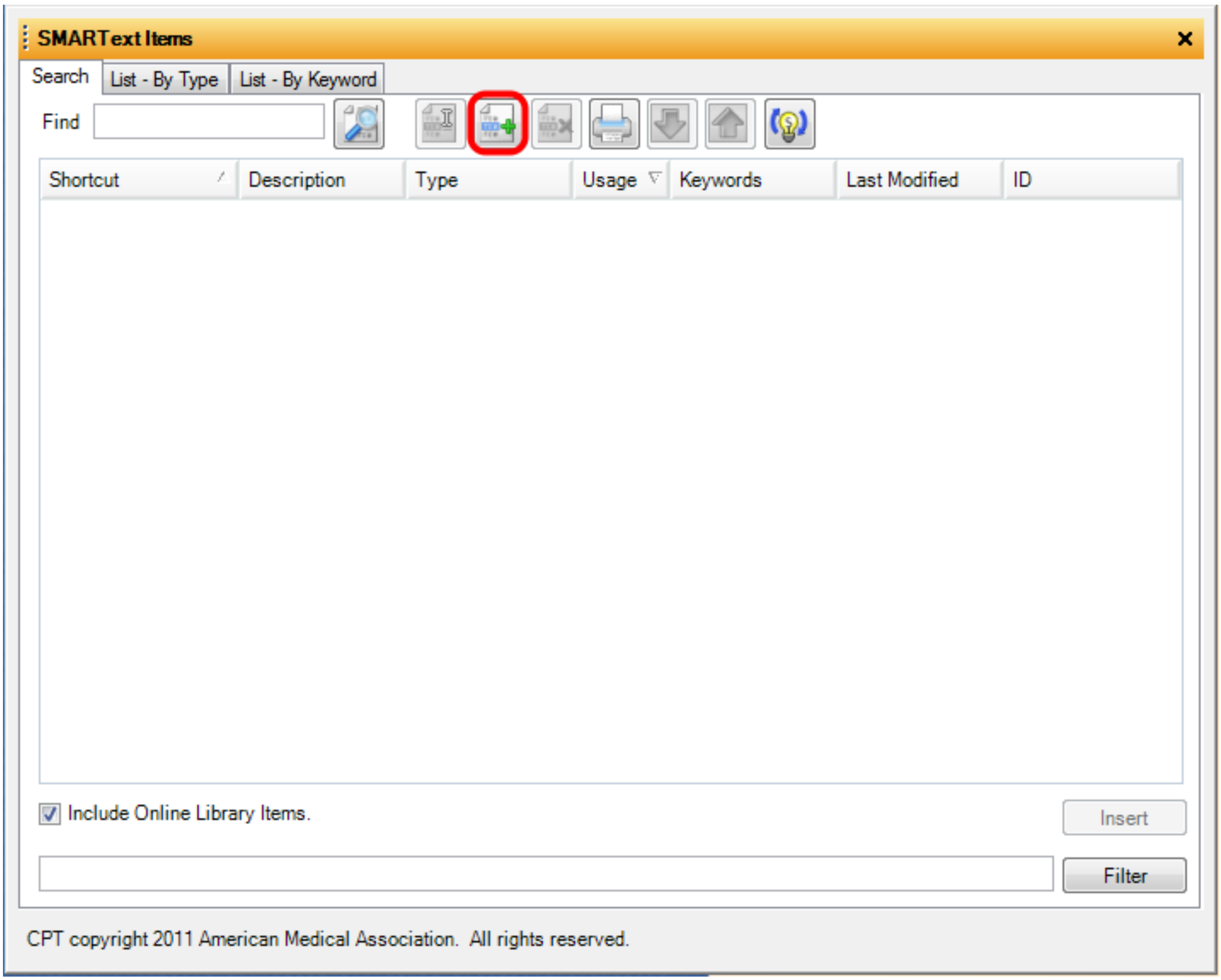
Surgeries
[Brainectomy]

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

This lesson will describe how to create a SMARText Pick List.

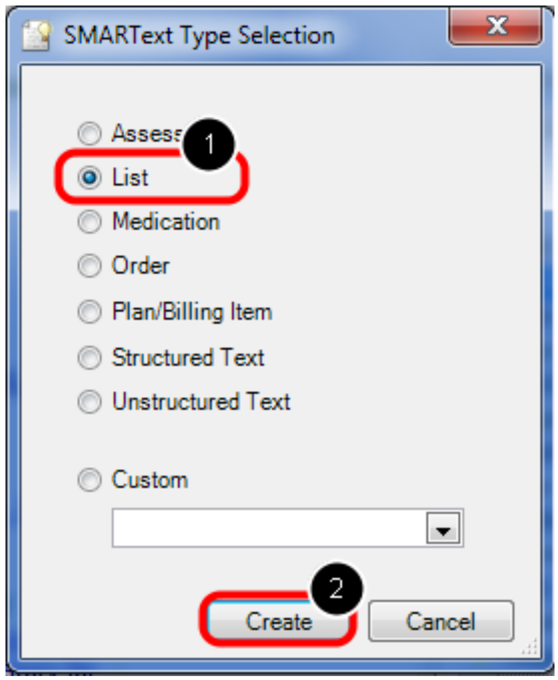
Open the SMARText Items Manager



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.

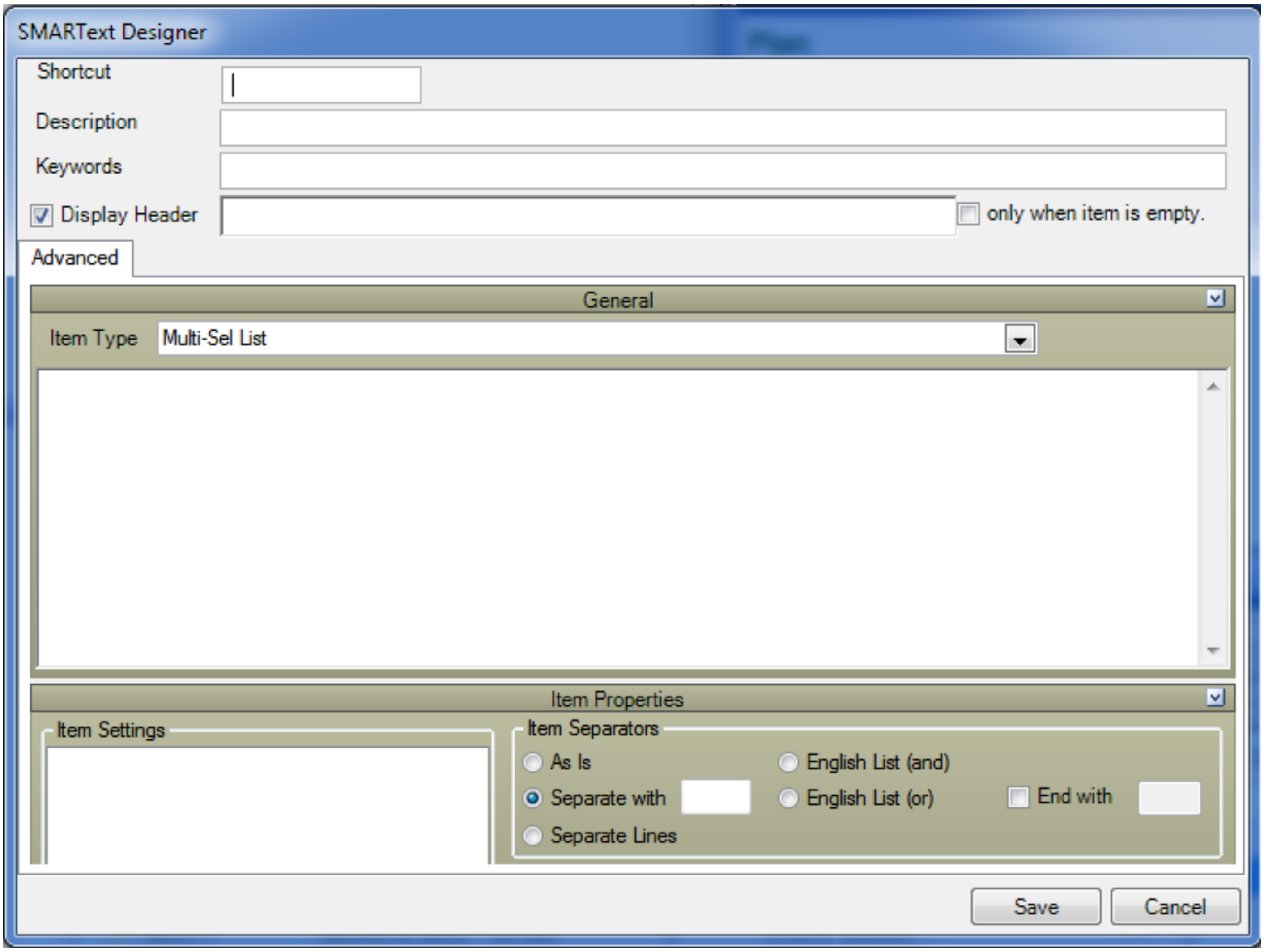
1. Open the SMARText Items Manager by clicking Docutainers > SMARText Items (or Press F10 on the keyboard).
2. Click the Create New Item button (Green +) as shown in the above screenshot.

Create a New List Item



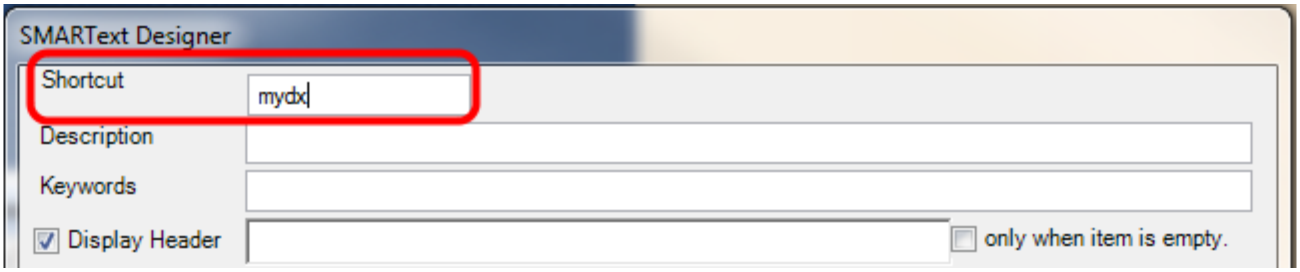
1. Select the List item
2. Click the Create button

SMARText Designer



This will open the SMARText Designer window where we will create our new pick list (or Multi-Select List).

Create a Shortcut

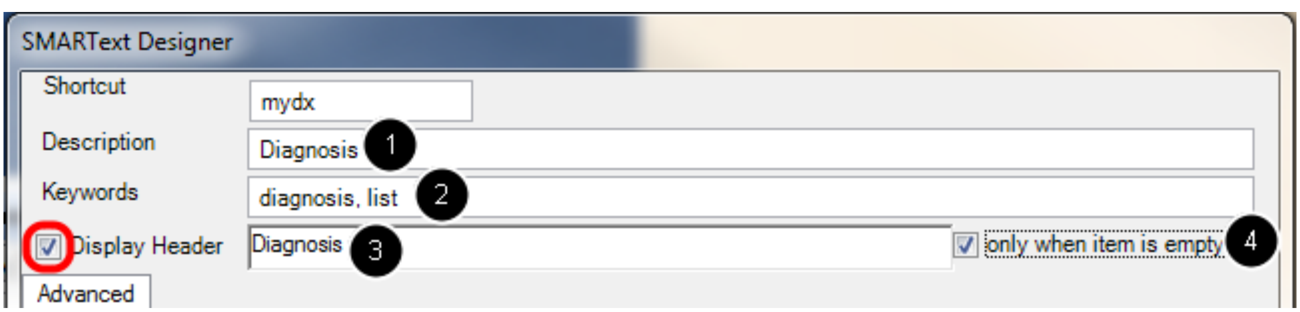


First, type in the pick list Shortcut code.

When creating documentation, this shortcut can be used (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.)

***Note:** SOAPware suggests that users never create Shortcuts that are actual words or medical abbreviations. If actual words or medical abbreviations are used for shortcuts, every time that word or abbreviation is typed and the spacebar is pressed, the SMARText item will expand.*

Item Description, Keywords, Display Header



Next, complete the item Description, Keywords and Display Header:

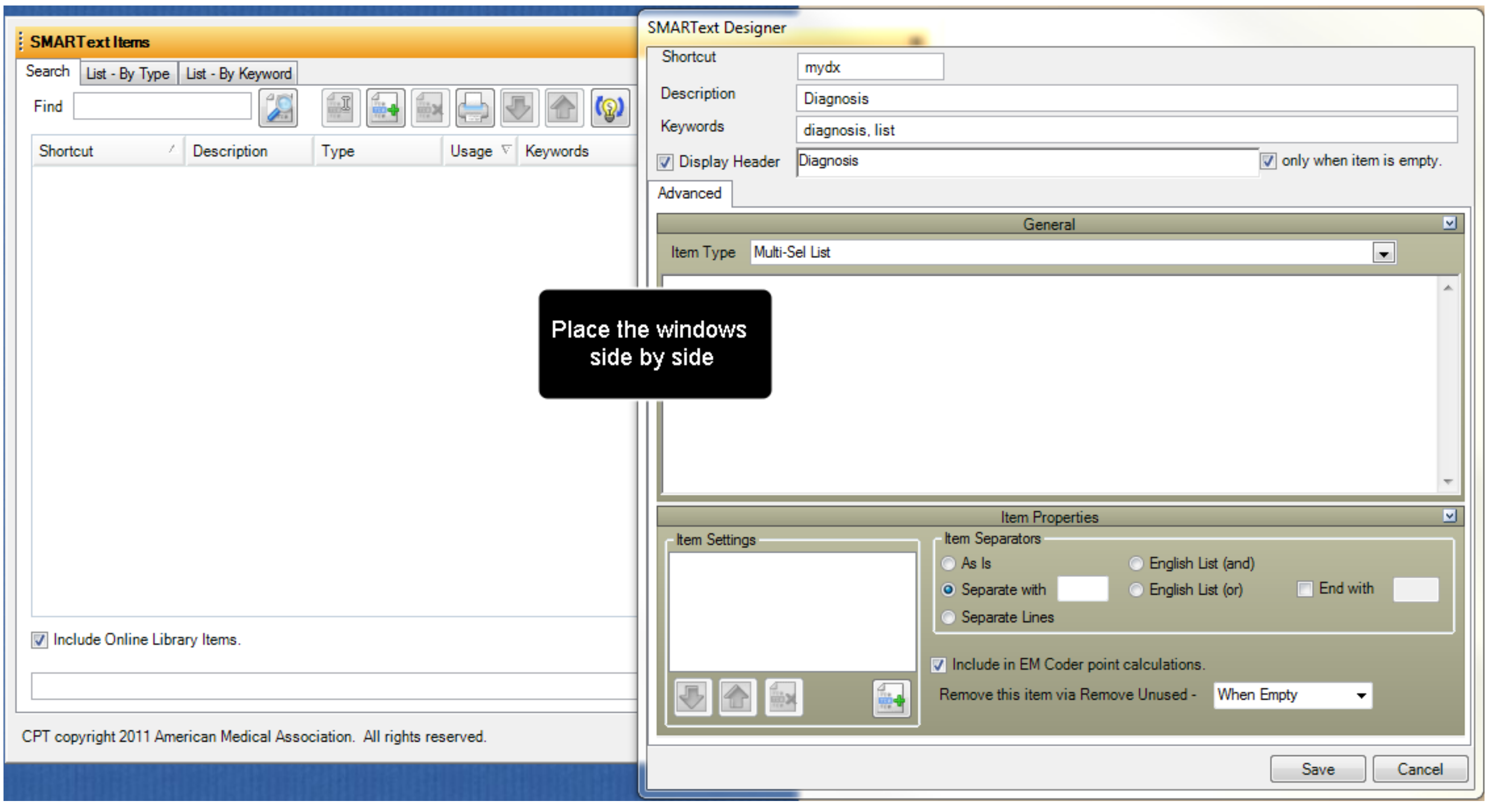
1. Description: Enter a description for the pick list to help identify the item. In our example, we'll enter "Diagnosis" for our description.
2. Keywords: Enter keywords for the pick list. Keywords will aid the user when doing a search for the SMARText item in the future (e.g. in the SMARText Items Manager).
3. Display Header: Enter a display header for the new pick list. The display header is what will

appear in blue/underlined text when the item is inserted into the documentation.

4. Check the box for "only when item is empty". This makes the Display header a "place holder" for the pick list until an item has been selected. In other words, when once a diagnosis has been selected from the pick list, the display header text of "Diagnosis" will be removed.

Add SMARText List Items

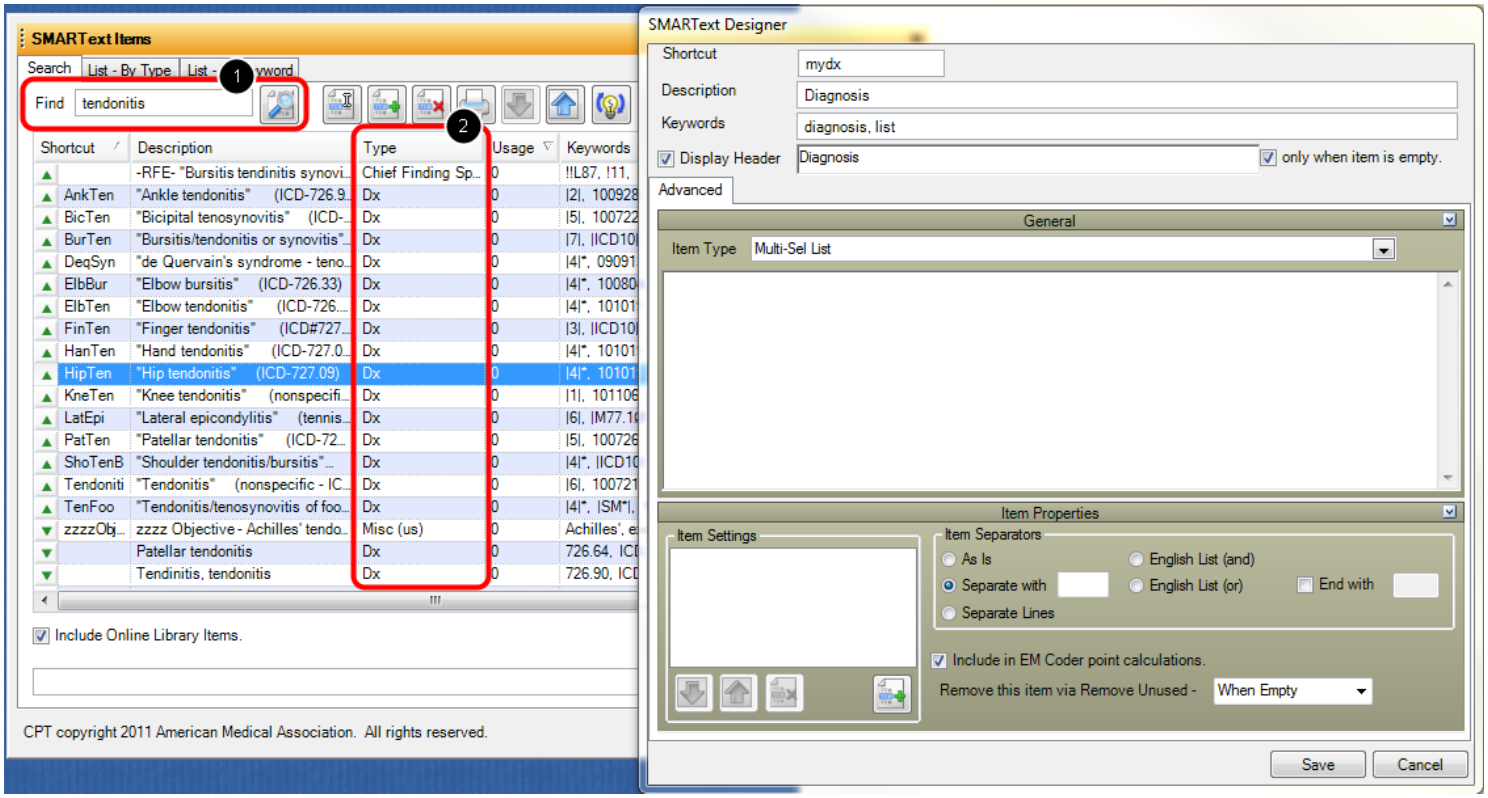
We are now ready to add SMARText items to our pick list.



Items can now be added to the pick list by searching for the item in the SMARText Items Manager, then dragging and dropping them into the SMARText Designer.

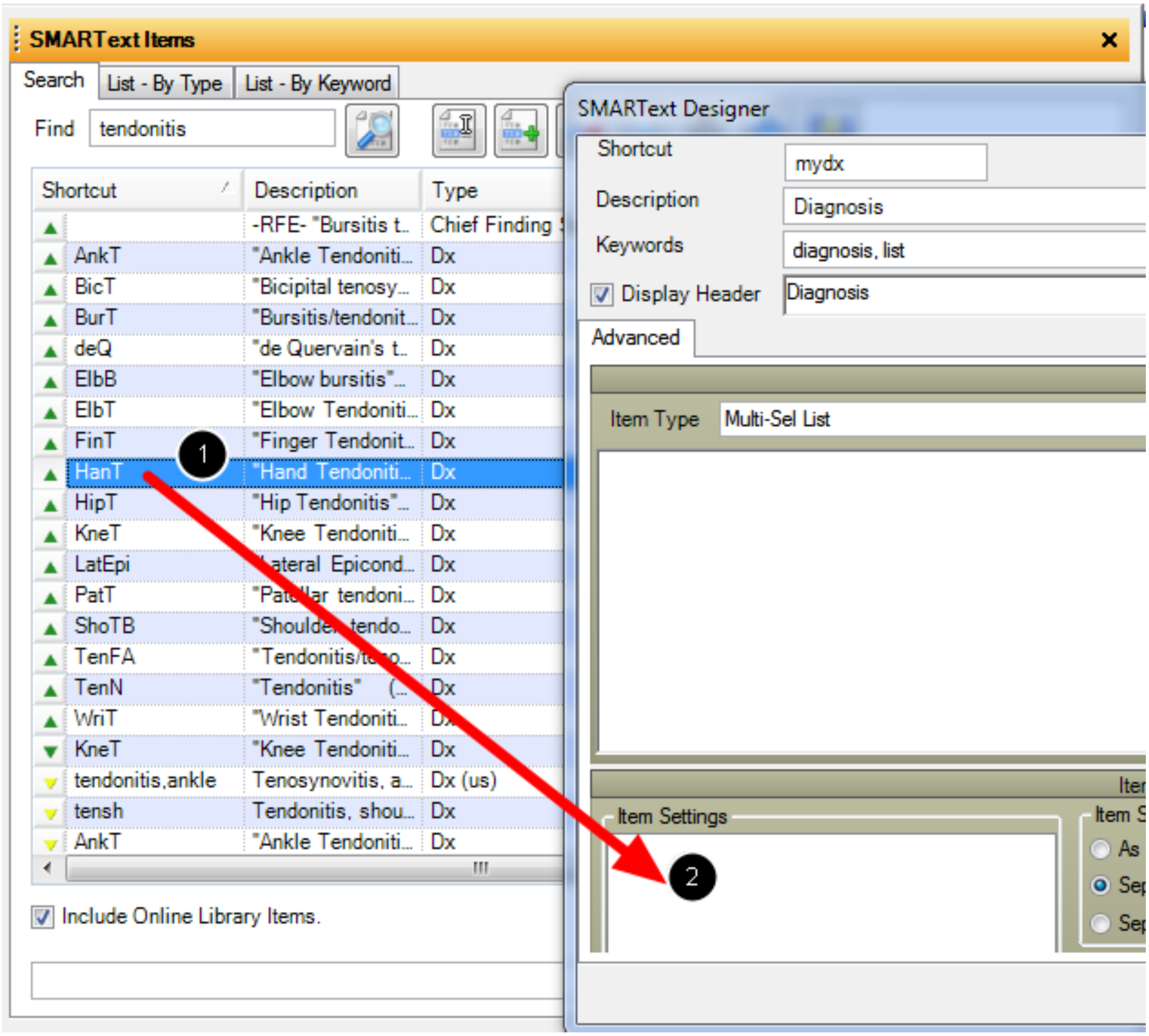
In order to do this, we will need to place our SMARText Items Manager and our SMARText Designer windows next to each other, so both windows can be used (as shown above).

Search for List Items



1. In the SMARText Items Manager (shown on the left), search for the items that need to be added to the pick list. In our example, we will search for "tendinitis" diagnosis items. Press the Enter key or click the Search button to search for SMARText items.
2. Ensure that the Type of SMARText items display is appropriate for the pick list (if creating a Diagnosis pick list, ensure that items selected are Dx item). Users can click on the Type column header to group all common types together.

Drag and Drop Items into Pick List

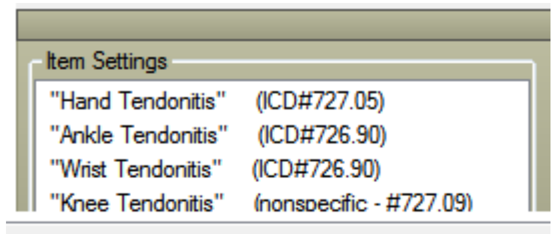


Scroll through the search results and locate the items that will be placed into the pick list.

To place an item into the pick list:

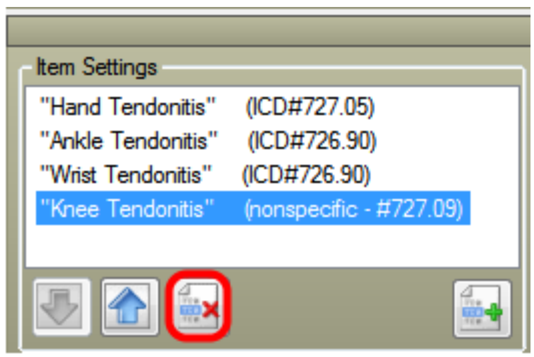
1. Click the desired SMARText item and begin dragging it towards the SMARText Designer window
2. Drag the item directly over the "Item Settings" box, then drop it into the box (see screenshot above)

Repeat this for each item that the user wants to add to the pick list.



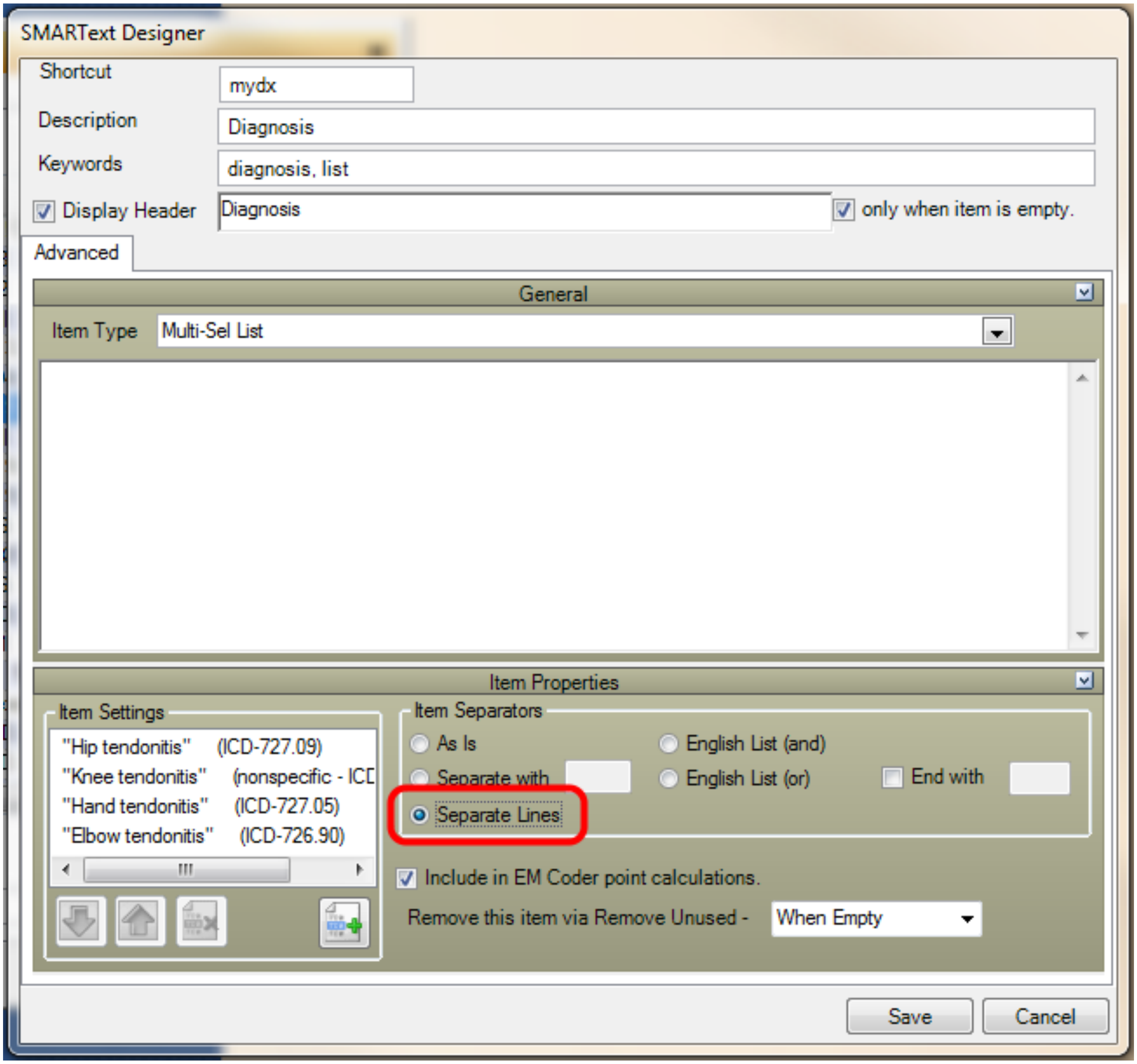
The items will be listed in the Item Settings box after dragging and dropping the items there.

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.

Item Separators



Next, we will need to select the Item Separators.

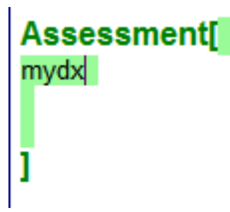
Choose the preferred Item Separator:

- **As Is:** When multiple items are selected from the pick list, they will be inserted into the documentation "as is" with now separators (commas, lines, etc).
- **Separate with:** When multiple items are selected from the pick list, they will be inserted into the documentation with a separator defined by the user (enter the preferred separator; e.g.

comma, | , space, etc.)

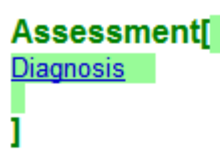
- **Separate Lines:** When multiple items are selected from the pick list, they will be inserted into the documentation on separate lines. This method is recommended for pick Diagnosis, Medication and CPT code pick lists.
- **English List (and):** When multiple items are selected, they will be inserted in the following format: ***item1, item2 and item3.***
- **English List (or):** When multiple items are selected, they will be inserted in the following format: ***item1, item2 or item3.***

Add a Pick List Header to Documentation



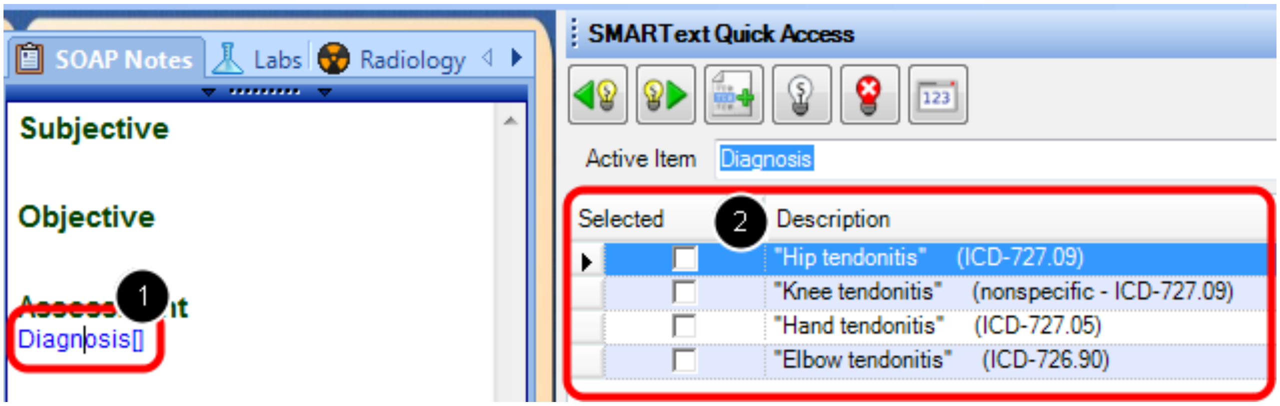
This new pick list item is now ready for actual use. Type "mydx" into an encounter note, and press the space bar. This inserts the header (i.e. diagnosis) into the document. Click diag. in the document to display the items added to the newly created pick list in the SMARText Quick Access dialog (usually 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



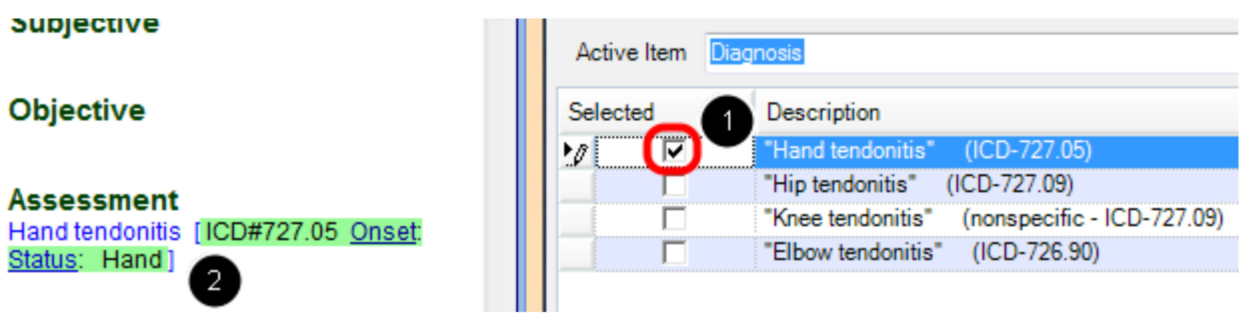
Next, the space bar is pressed. This causes the header for the newly created pick list to be inserted. In other words, pressing the space bar after typing the shortcut "mydx" causes this pick list item's header, Diagnosis., to be inserted into the documentation.

Display the Pick List



1. Click on the diagnosis header
2. This will display the pick list items within the SMARText Quick Access

Choose Pick List Items



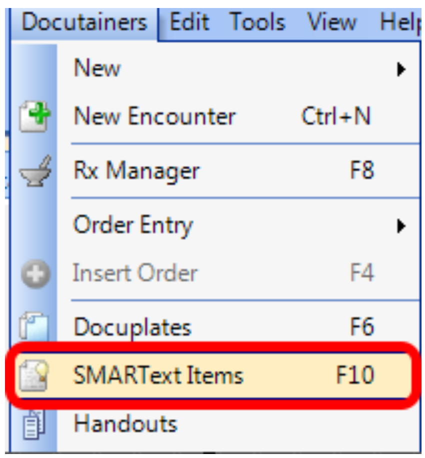
1. Insert a item by Clicking the check box next to each item.
2. This action places a check in the box, and the checked item will be inserted into the Assessment field.

Using the Quick Add Method in the SMARText Items Manager

This lesson will demonstrate how to create a pick list that includes structured text items in the SMARText Items Manager. Structured text pick lists are helpful when the user wishes to create a list of items (not Dx, Rx or CPT) to choose from. For example, the user may want to create a structured text pick list to enter the patients reason for encounter or chief complaint. This method would not be used to create a pick list for Assessments, Medications or CPT codes.

For more information on the various SOAPware data entry methods, see: **Free Text or Structured Data?**

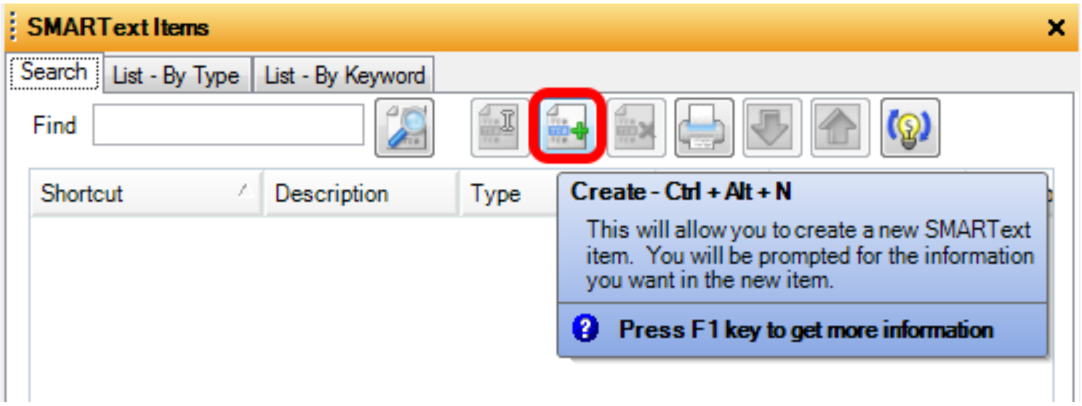
Access SMARText Items Manager



To open the SMARText Items Manager, press the F10 keyboard command, OR:

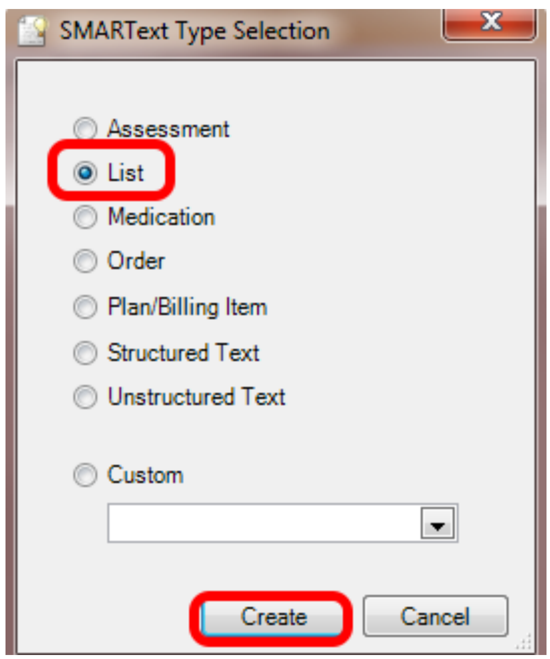
1. Go to the Docutainers menu Item
2. Select SMARText Items

Create a New SMARText Item



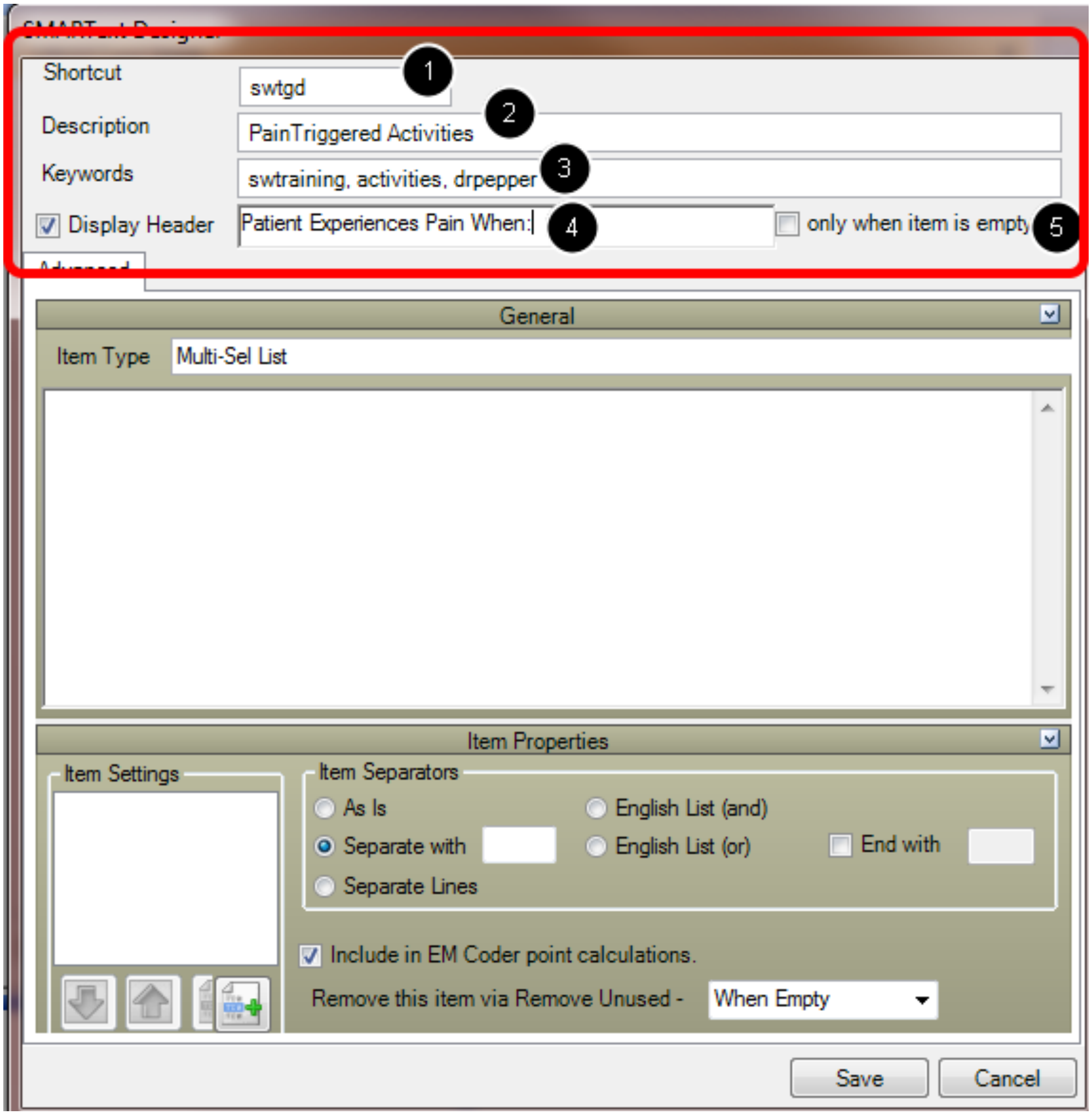
Click the button with the green plus to Create a New SMARText Item.

Select the Item Type



1. Click the radio button to select the List SMARText Type.
2. Click the Create button.

SMARText Designer



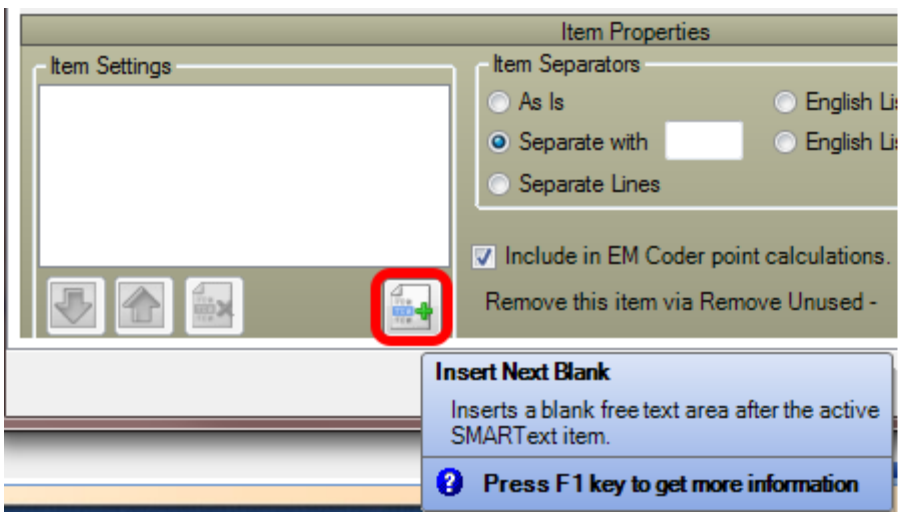
Use the SMARText Designer to assign a Shortcut, Description, Keywords, and a Display Header for the new pick list.

1. **Shortcut:** Enter a shortcut code that can be used to insert the new pick list.
2. **Description:** Enter a Description to help identify this item.
3. **Keywords:** Used to search for this SMARText Item (e.g. in the SMARText Items Manager).
   Note: *Keywords must be single words separated with a comma and space. Unique keywords specific to the user are recommended (clinic name, clinic name initials, the clinician's initials*

or name).

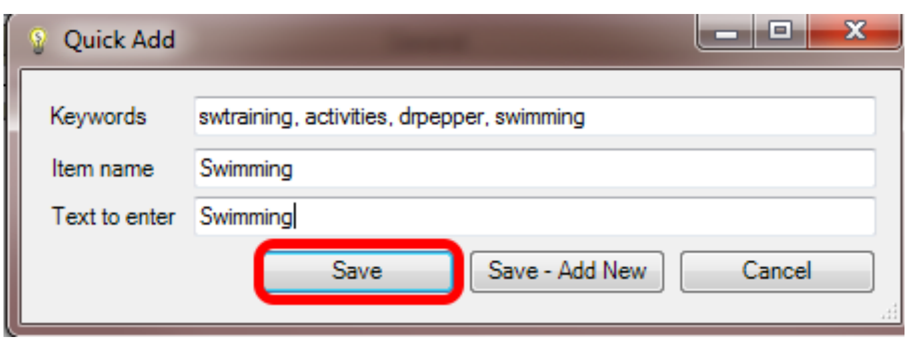
4. **Display Header:** This is what will display, as the header of the item when the item has been inserted and expanded into the documentation. Check the box next to Display Header to insure that the header will be displayed.
5. Check the box for **"only when item is empty"** to display the header *only* until an item is chosen from the list in Quick Access.

Adding Quick Add Items to the Item Settings Box



In the Items Setting box, Click the Create New button.

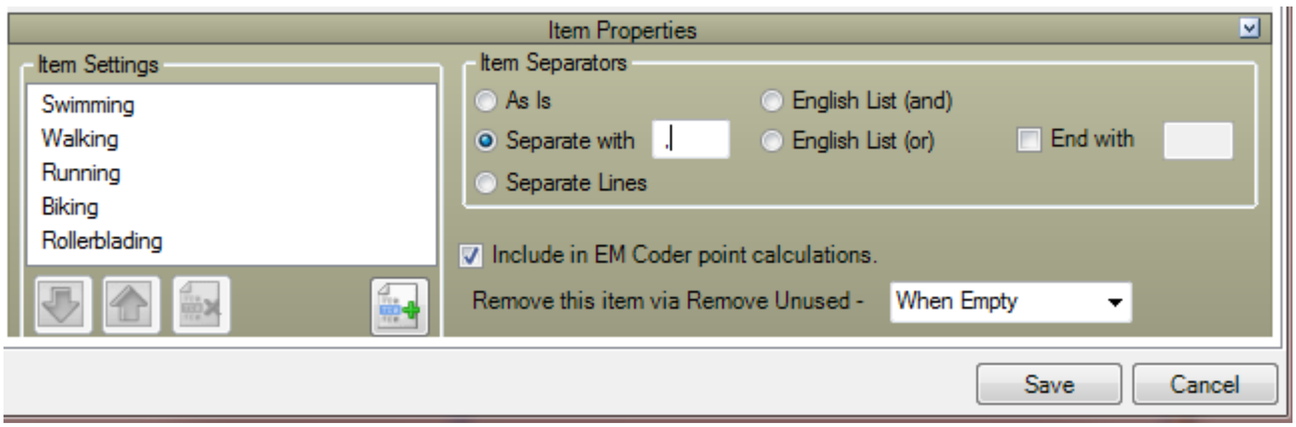
Quick Add Window



Use the Quick Add window to enter Keywords, Item name, and Text to enter for the new item. Click Save. Repeat Step to add additional items to the pick list.

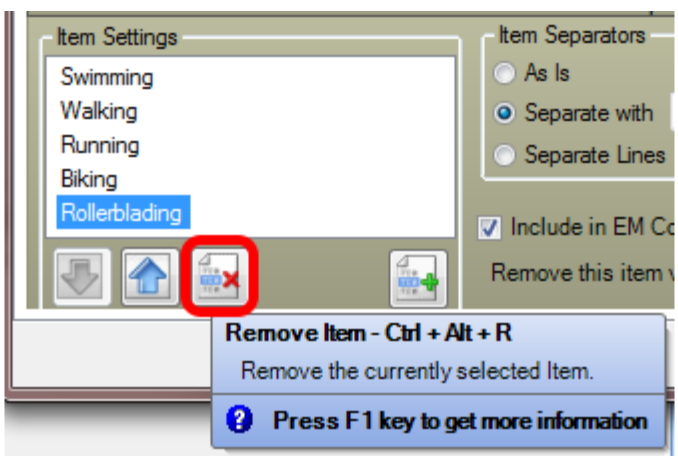
Hint: *Copy the keywords from the SMARText Designer window before clicking the Create New button and paste into the keywords field of the Quick Add window. Include additional keywords when needed.*

Setting Item Properties



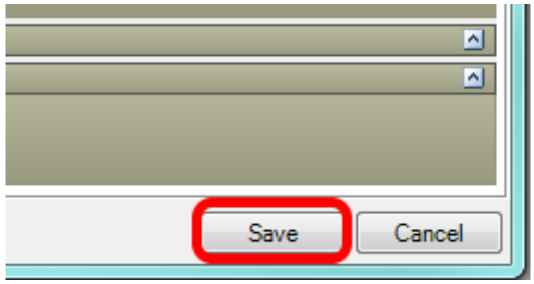
A user may set Item Properties if needed. For this example, a comma has been added for "Separate with".

Remove Items from Pick List



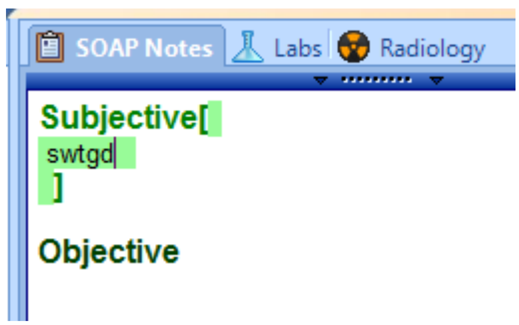
To remove any items, Select the item the user wishes to remove, and Click the Remove Item button located below Item Settings.

Save the Pick List

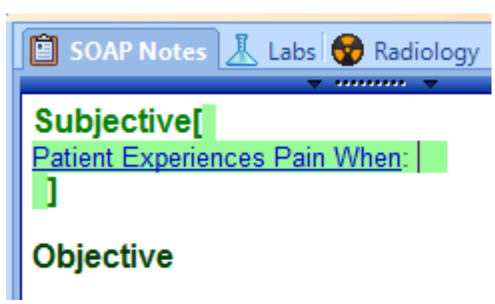


Click the Save button to save this pick list.

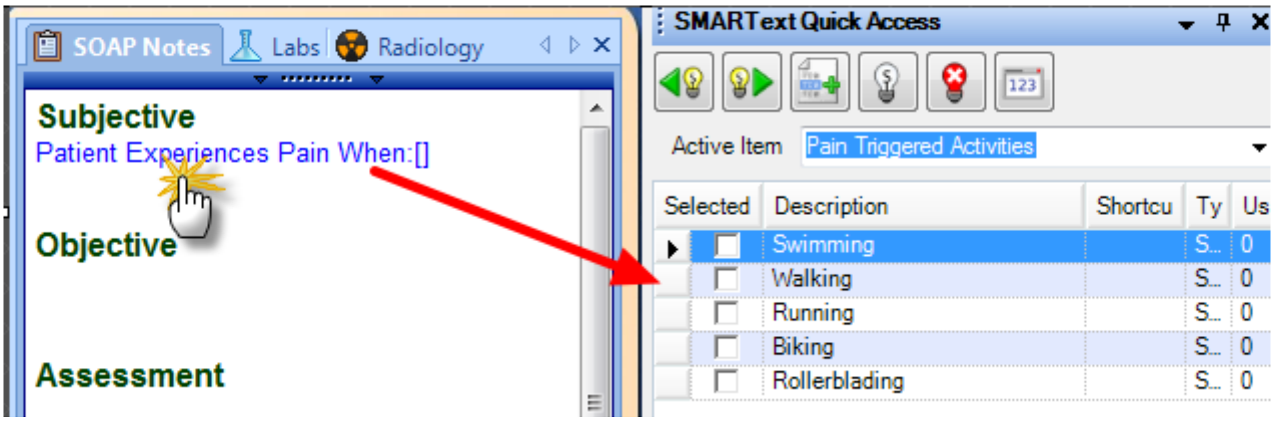
Add a Pick List Header to Documentation



This new pick list is now ready for use. Type the pick list shortcut code into an encounter note, then press the space bar to enter the pick list. This will insert the Display Header for the pick list.

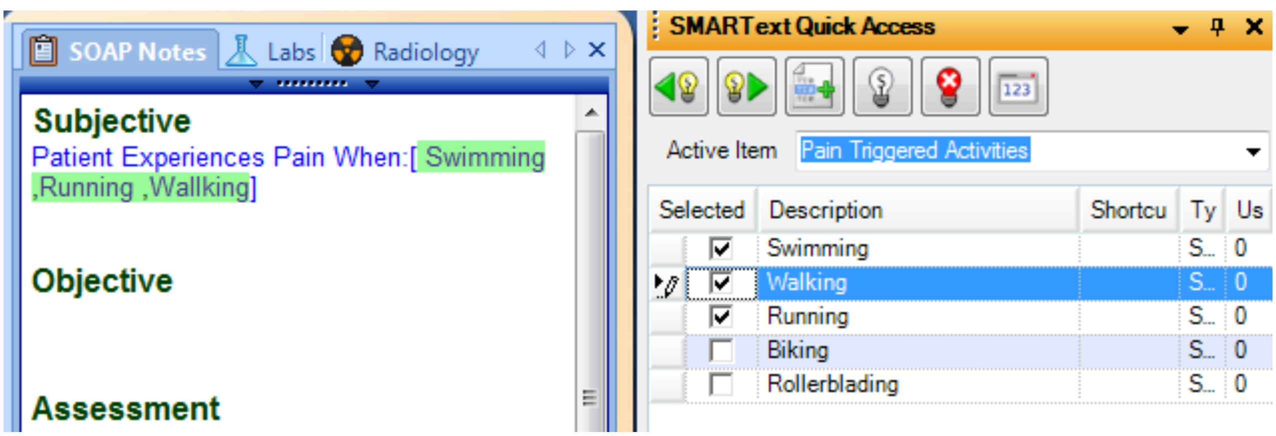


Display the Pick List



Left Click on the Display Header to view the pick list items in the SMARText Quick Access window for selection.

Pick List Item Selection

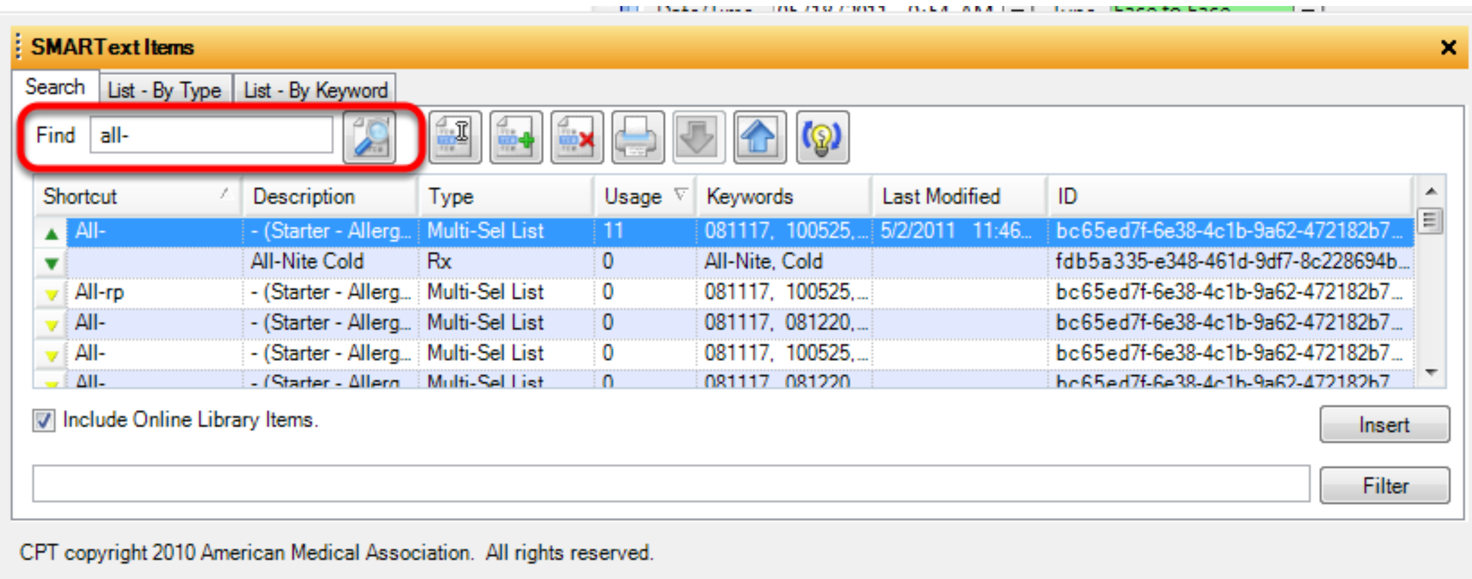


Place a check in the box next to an item to insert it into the SOAPnote.

Editing Pick Lists

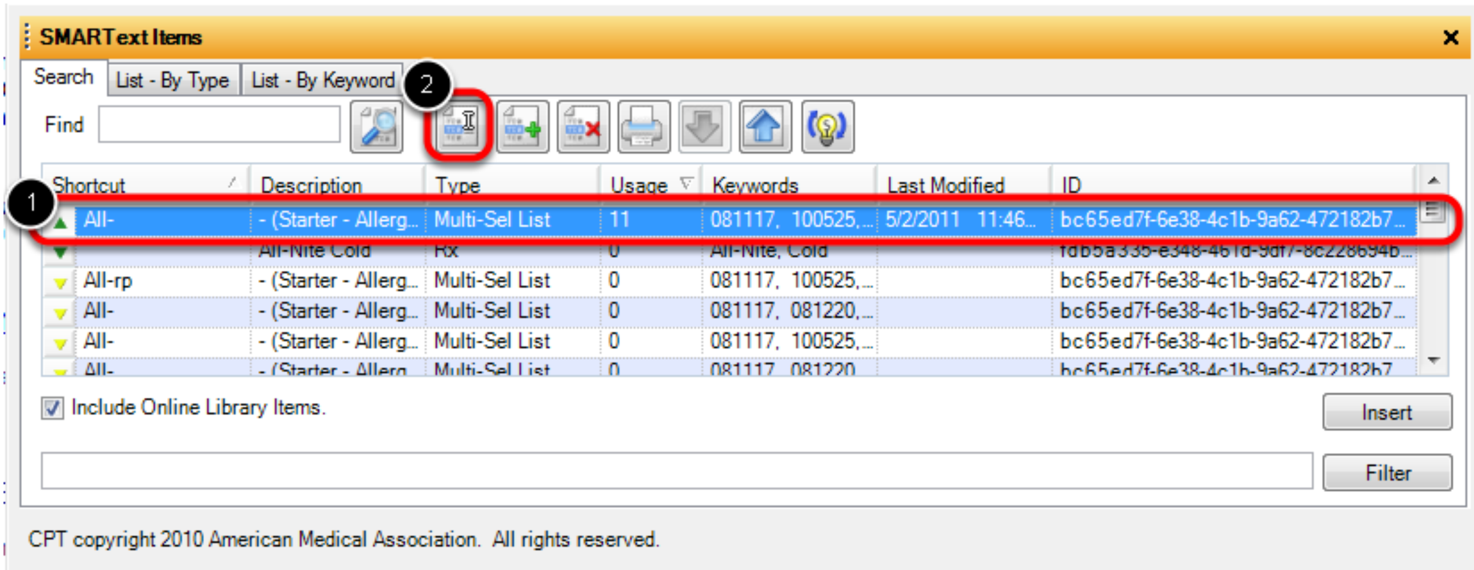
Any SOAPware user with appropriate security access can edit any SMARText item created by SOAPware or by a SOAPware user. When an item is edited by a SOAPware user the item will then display with a yellow arrow rather than a green arrow. This lesson will demonstrate how to Edit a pick list available the local database.

Searching for a Pick list



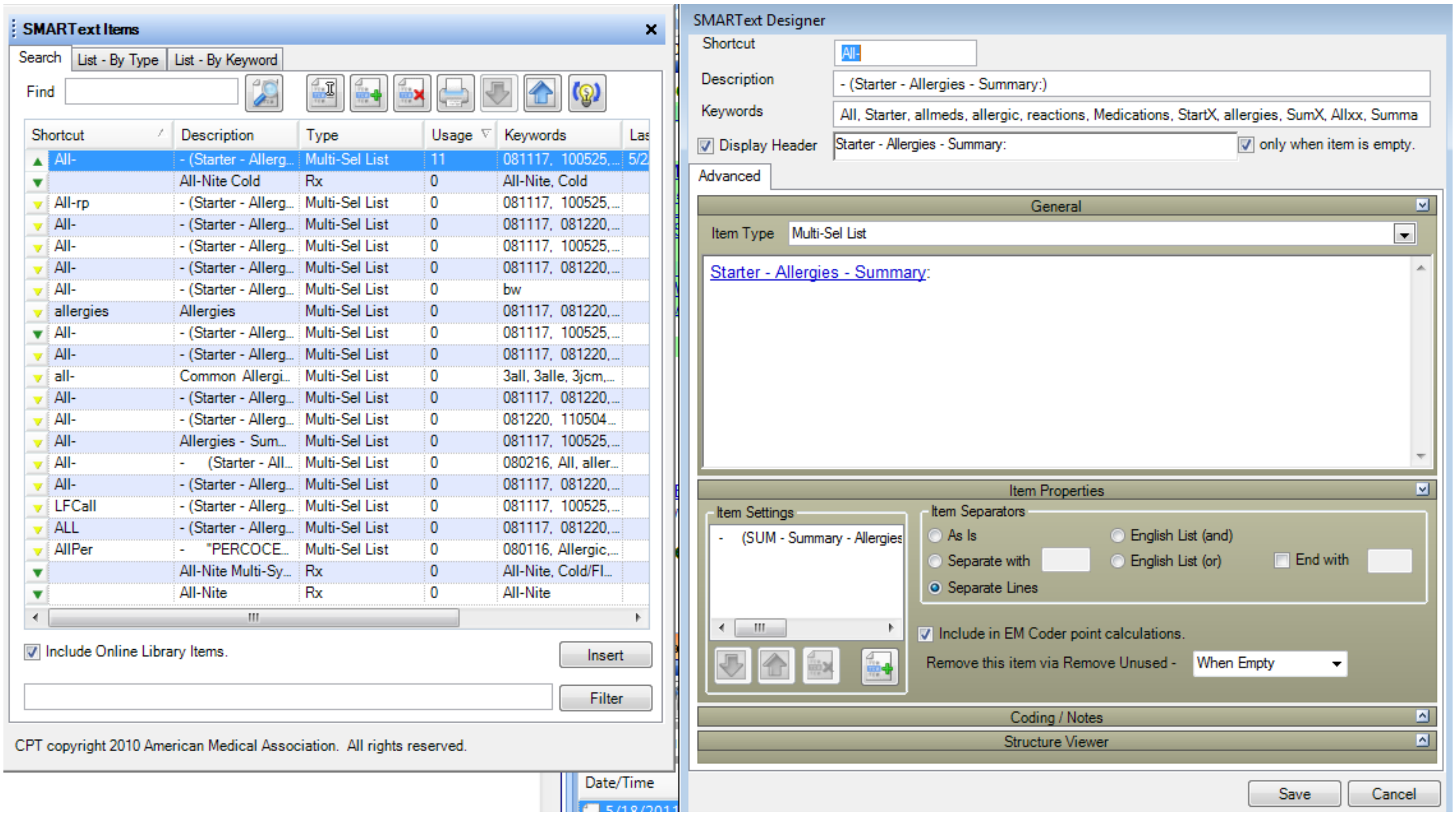
To search for a pick list type the shortcut or keyword in the find box and click on the Find button.

Edit the Item



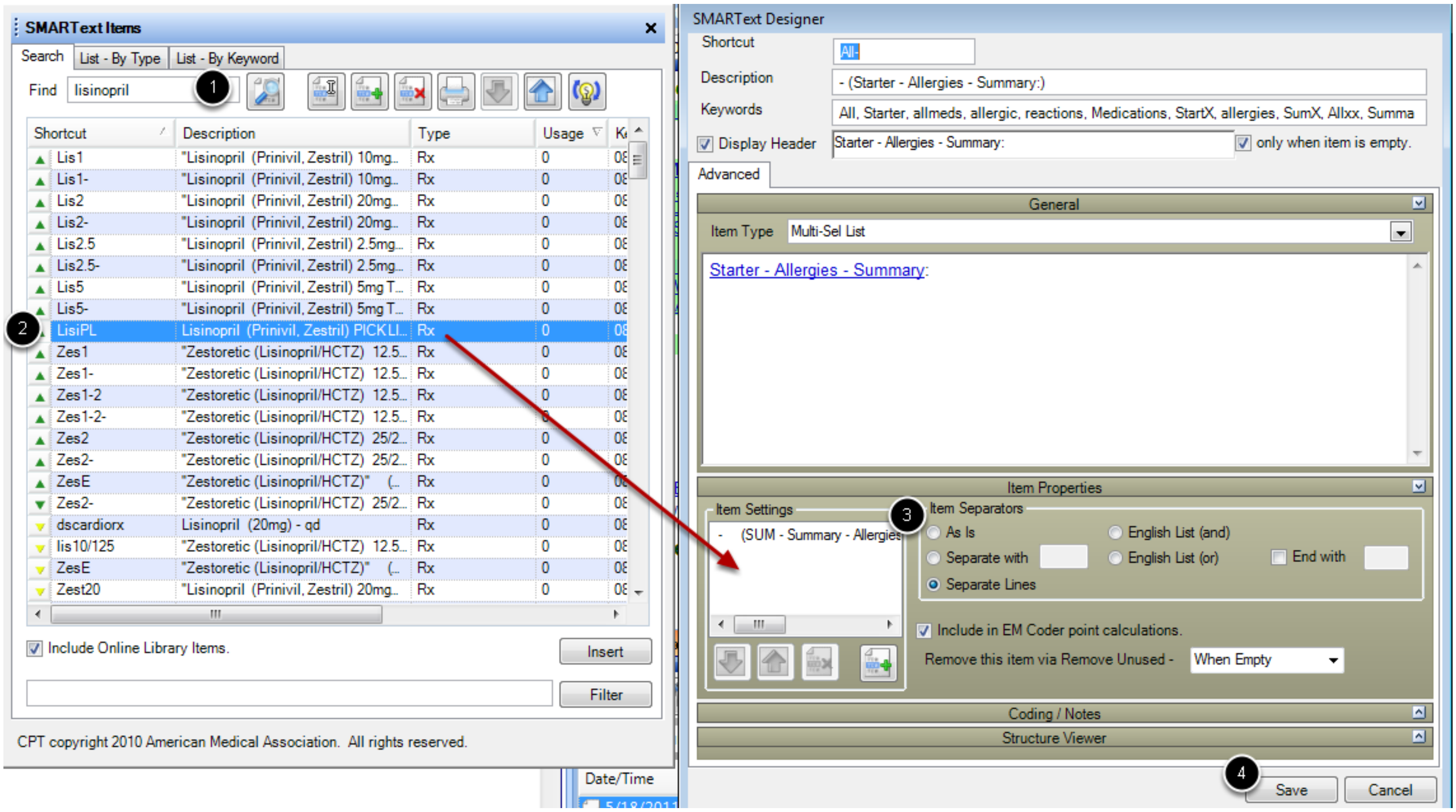
1) Highlight the item to be edited.
2) Click on the Edit button

Arrange the boxes



Place the SMARText Items Manager box and the SMARText 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 SMARText Items Manager.
2) Click on the Item
3) Drag and Drop the item into the Items Settings box of the SMARText 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.

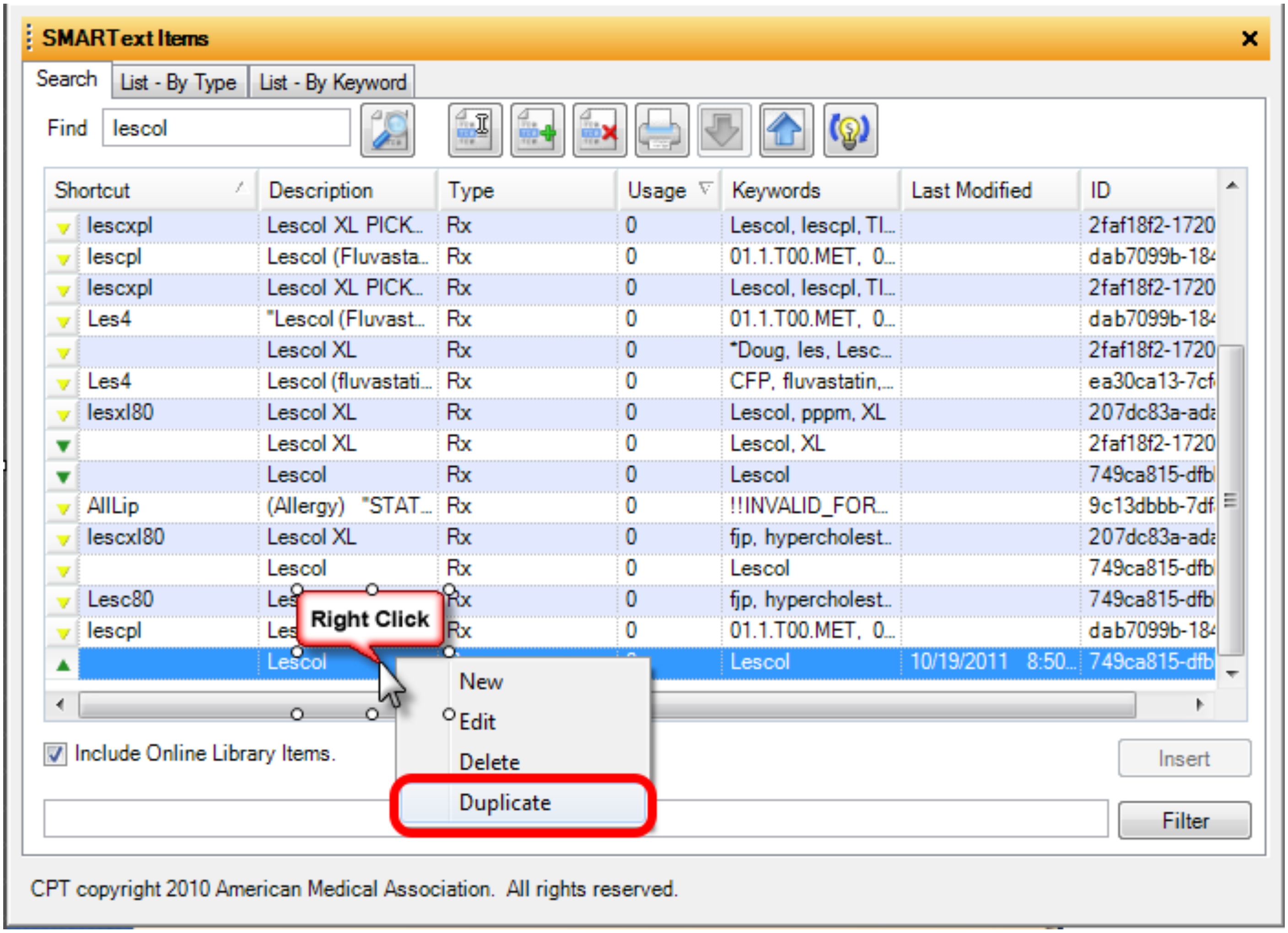
SMARText Medications

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.

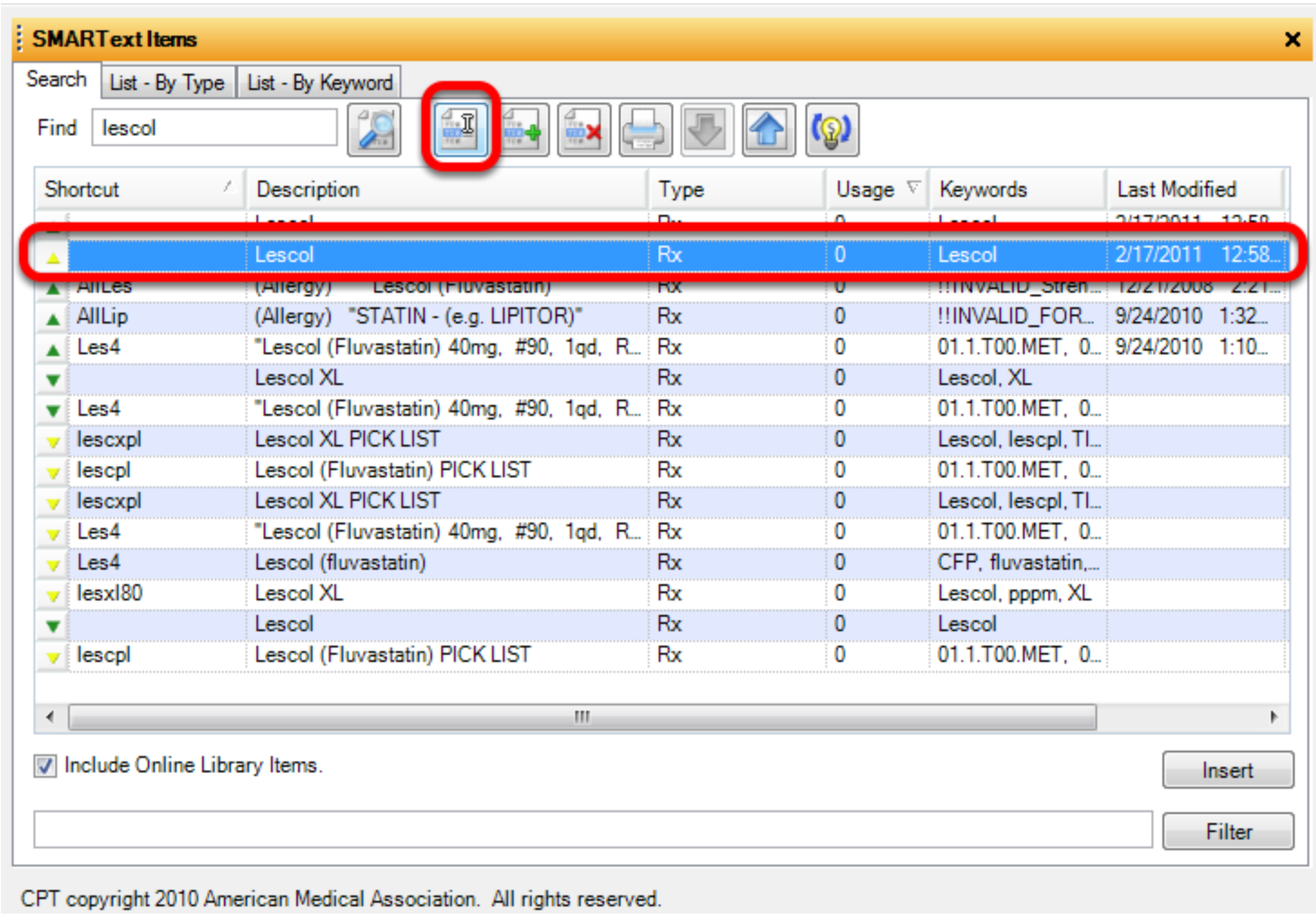
Duplicating the Item in the SMARText items Manager



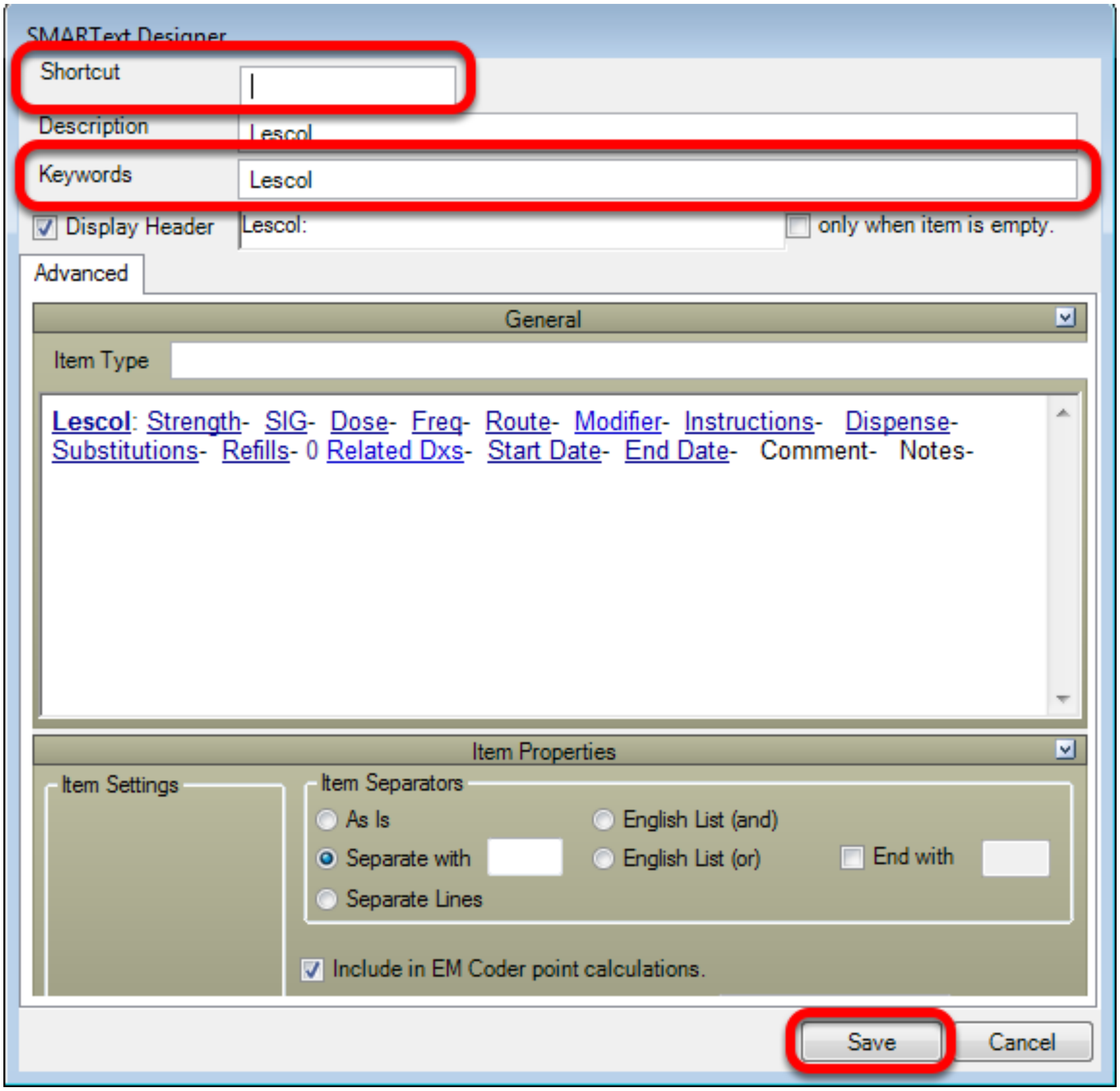
Right-click over a green item and Select Duplicate.

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

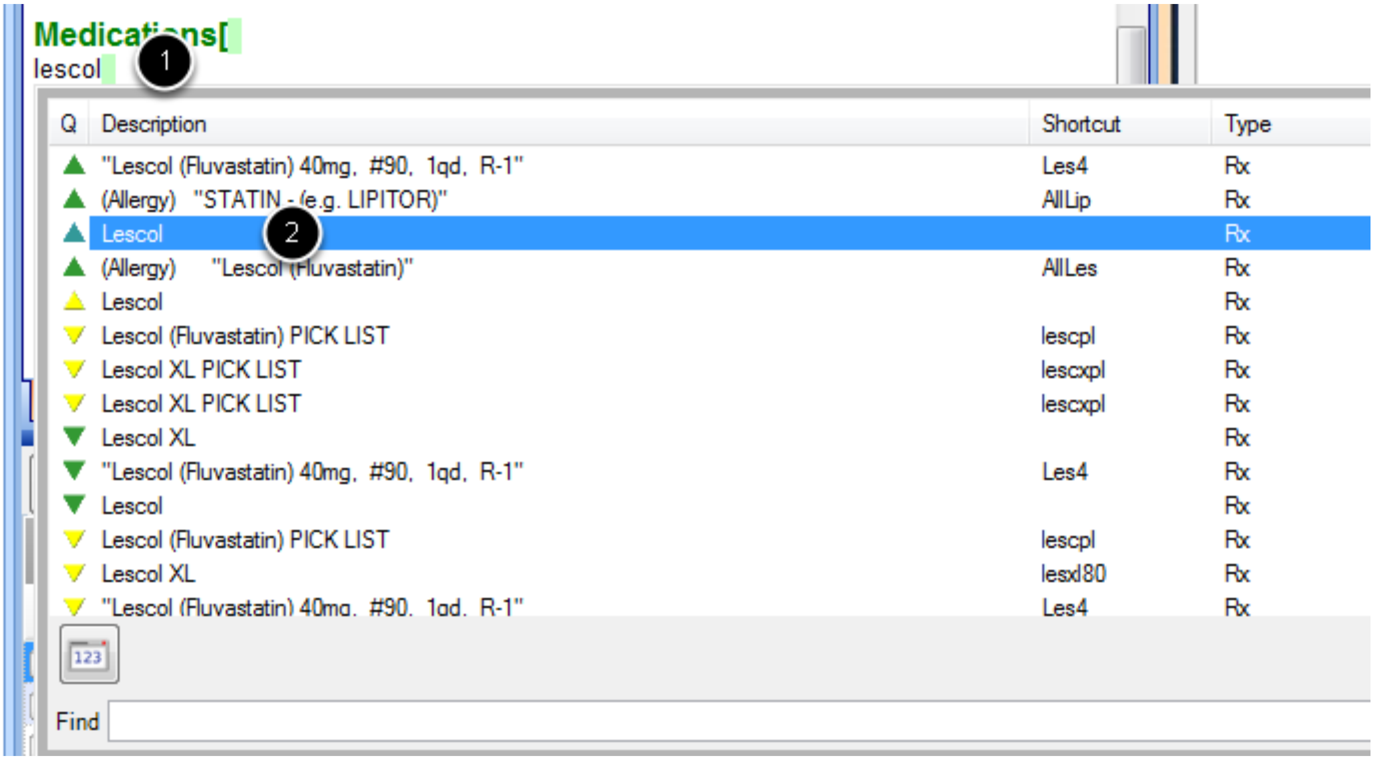


Highlight the newly created medication and Click the Edit button.



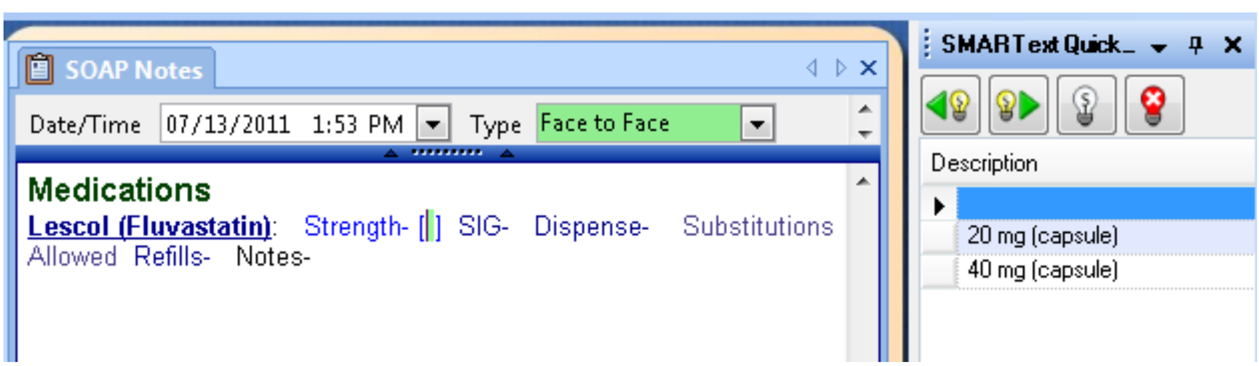
Customized shortcuts and keywords can now be added. The description and header should not be changed. Click the Save button.

Duplicating the item within the Chart



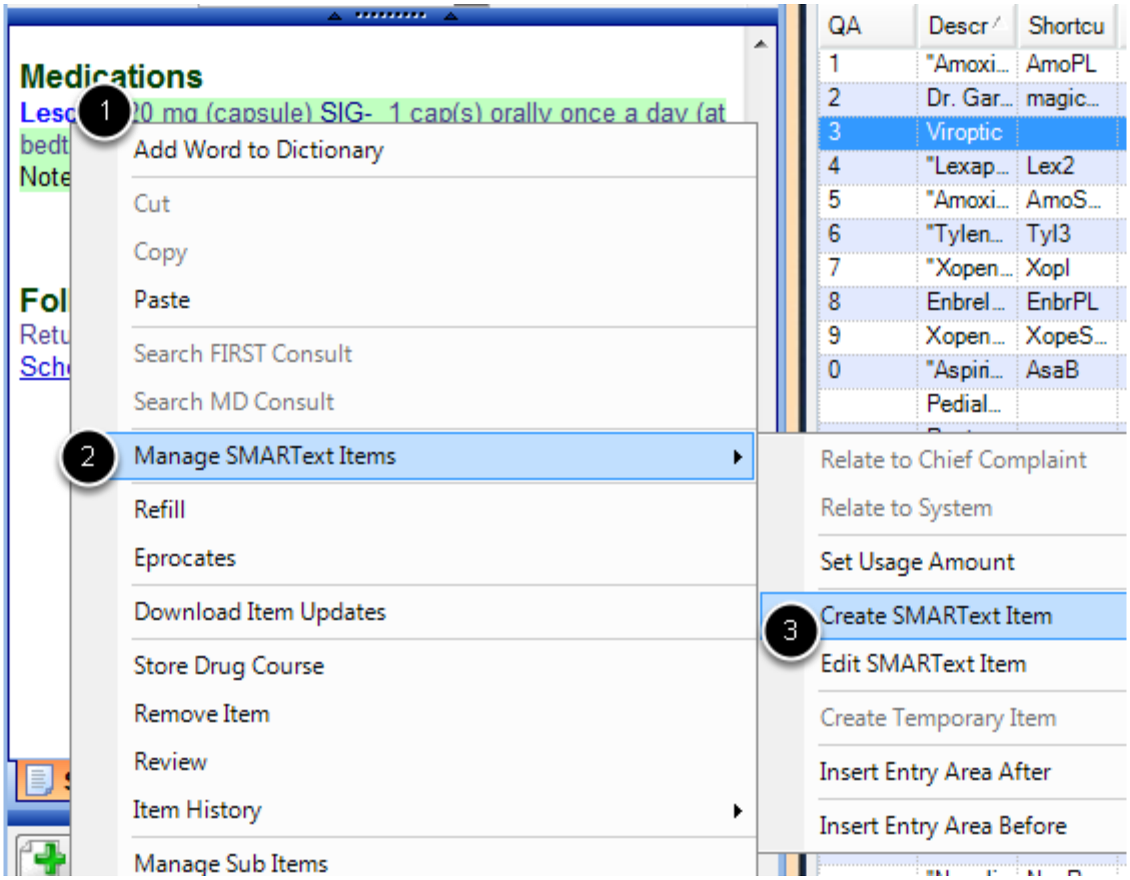
Medication items can also be edited and created in the patient's chart using a Shift F11 search.

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.



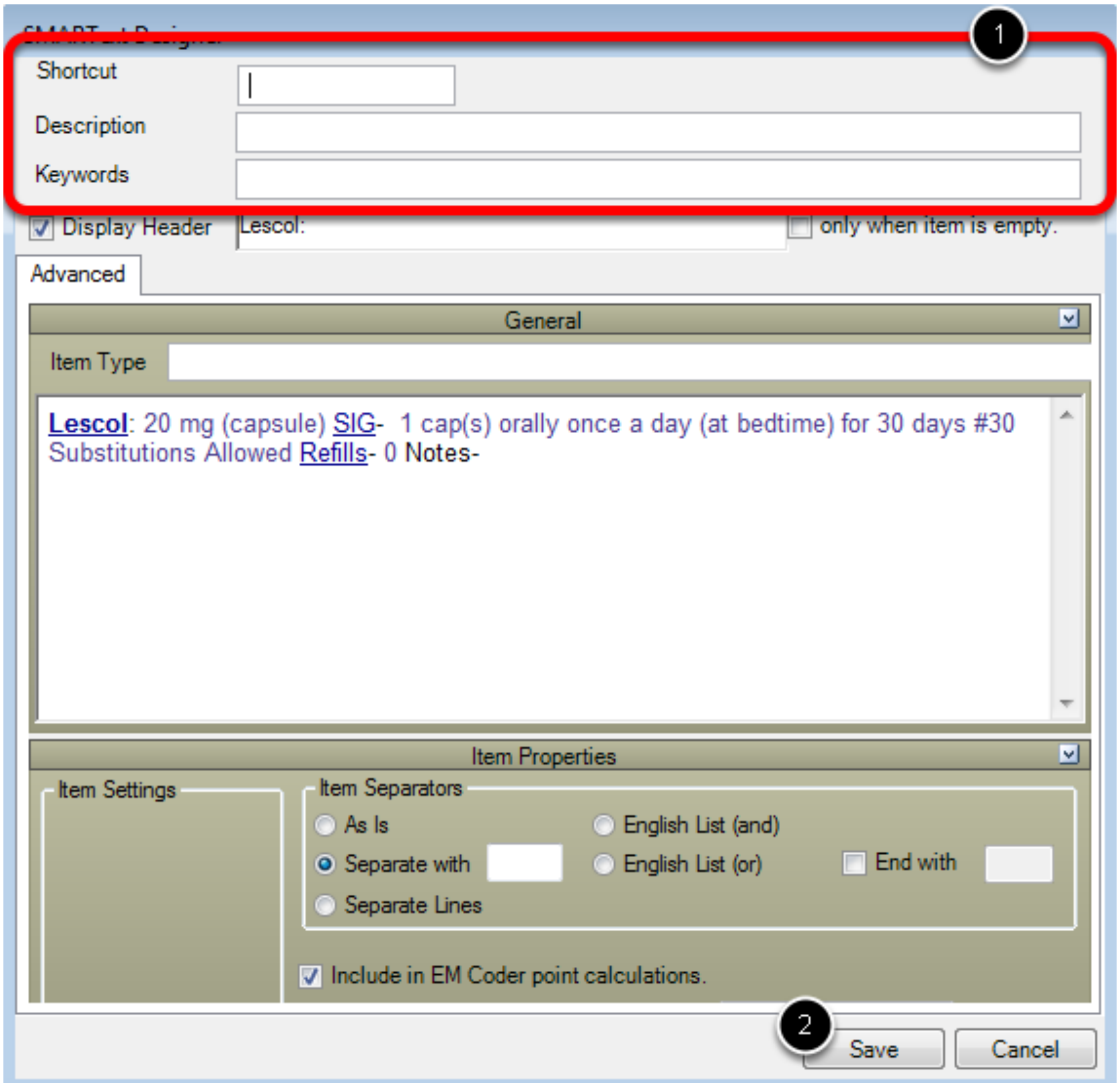
Perform desired edits to item. Edits made will display when the item is inserted into the patients chart. It is advised that the user enter the most common way of prescribing the medication at this time.

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.



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.

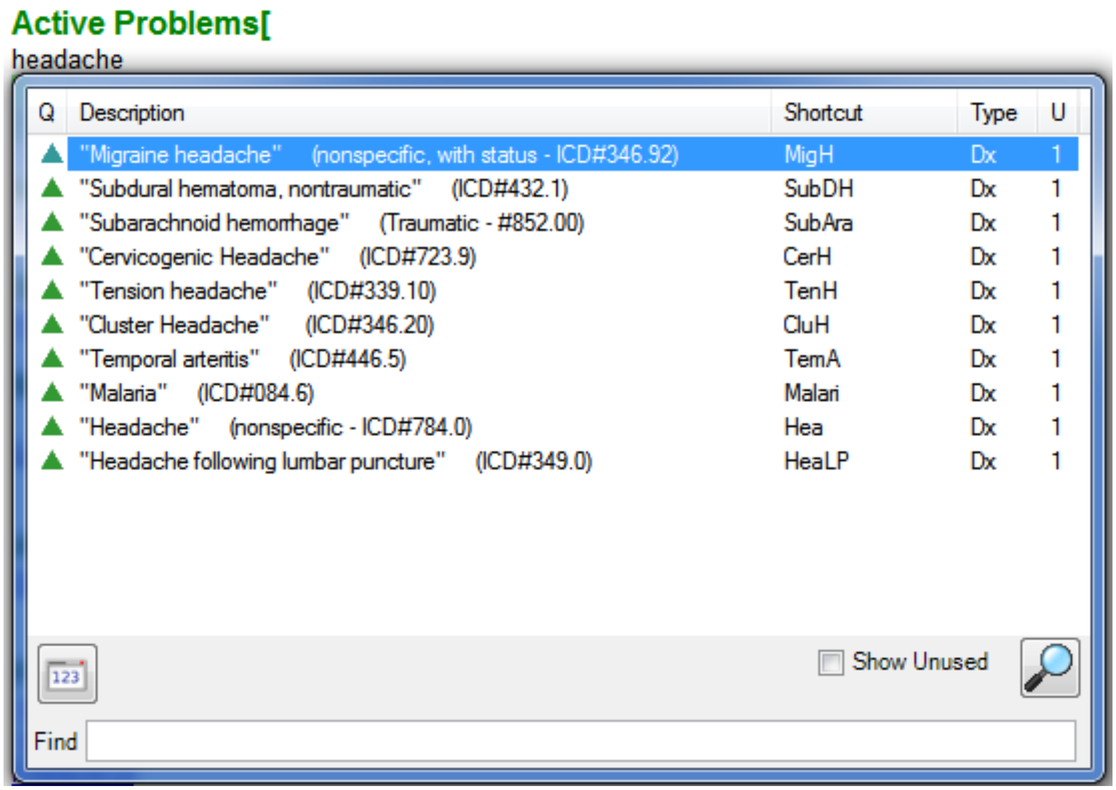
Shift + F11 Pop-Up: Enter a keyword (or a few letters); CPT code; or ICD code, and press Shift + F11 to get a pop-up list of local and online items.

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.

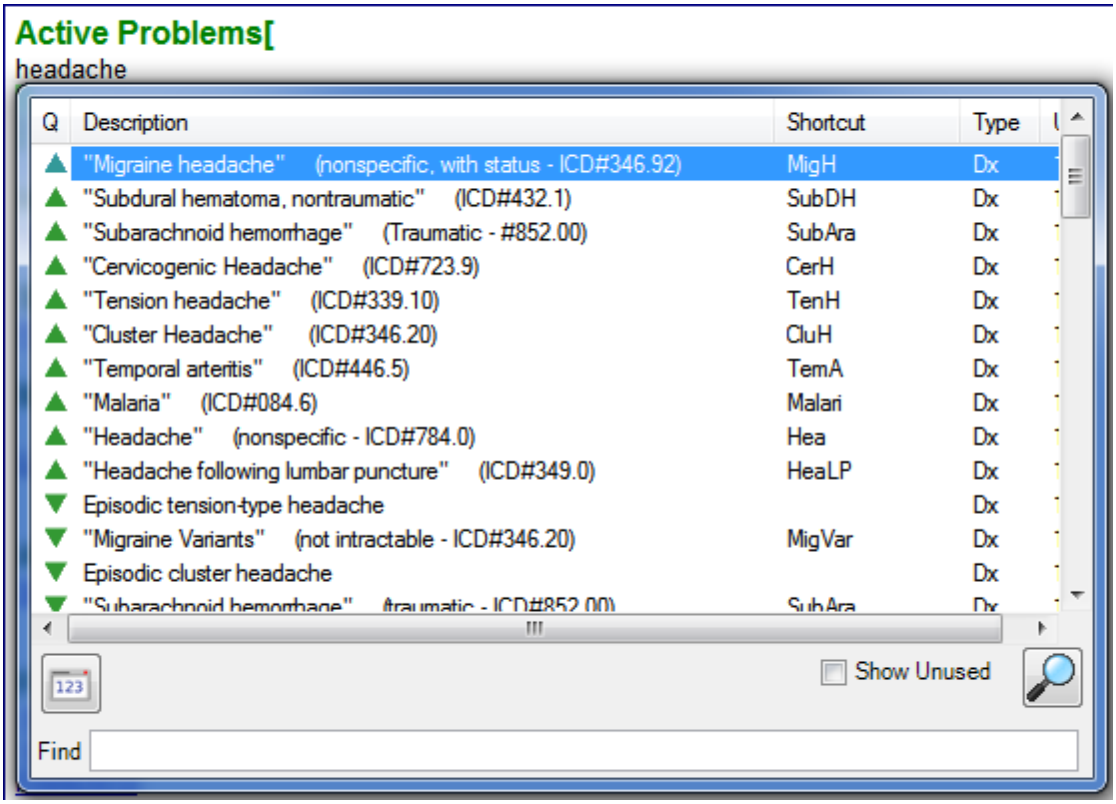
SMARText - Quick Access: Click on a ST item header and various types of pick lists are presented in the Quick Access dialog.

F11 Pop-Up



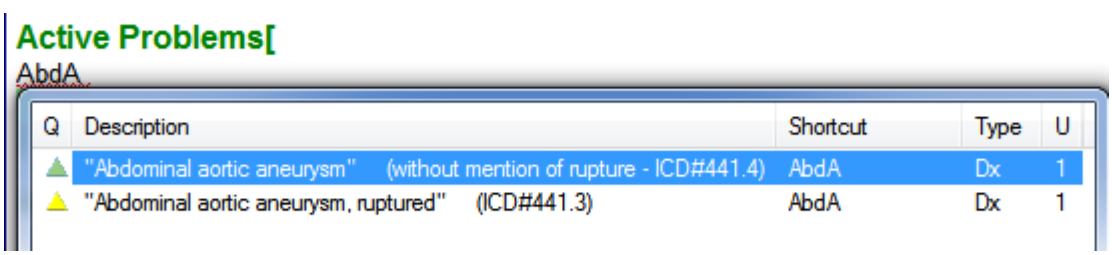
Enter a keyword (or a few letters); CPT code; or ICD code, and press F11 to get a pop-up list of local items.

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

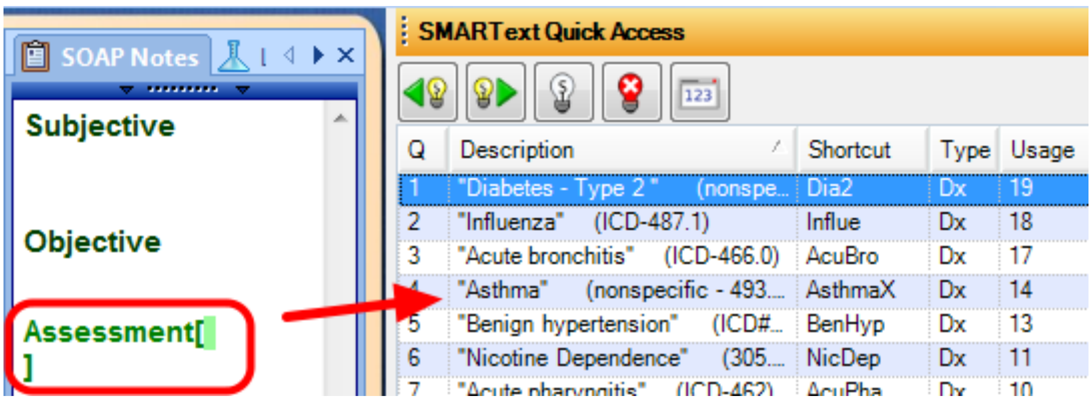


Enter a shortcut and press space bar; if more than one SMARText item has a shortcut matching the group of letters, then a list of those items is presented. If only one ST item has an exact Shortcut match, it is automatically inserted.

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.

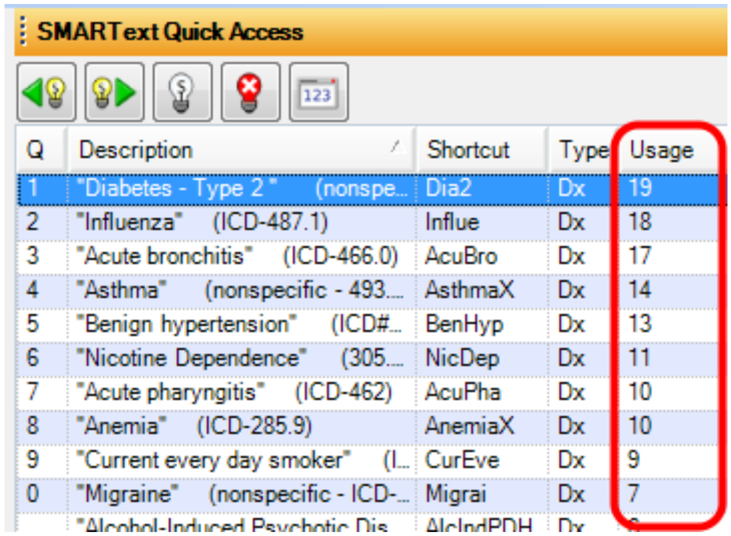
Favorites List: Pick Lists Based on Location



After using SOAPware for some time, the user may notice that when clicking into a field (ie: Assessment field), SOAPware immediately presents the user with a list of SMARText Items in the SMARText Quick Access window. SOAPware remembers the SMARText Items that are used by the user in each field and saves them onto this "favorites list". Any time the user clicks to activate a field, the favorites list will be presented in the SMARText Quick Access window sorted by usage (most used to the top).

To insert a SMARText Item from the favorites list, simply double-click on the desired item.

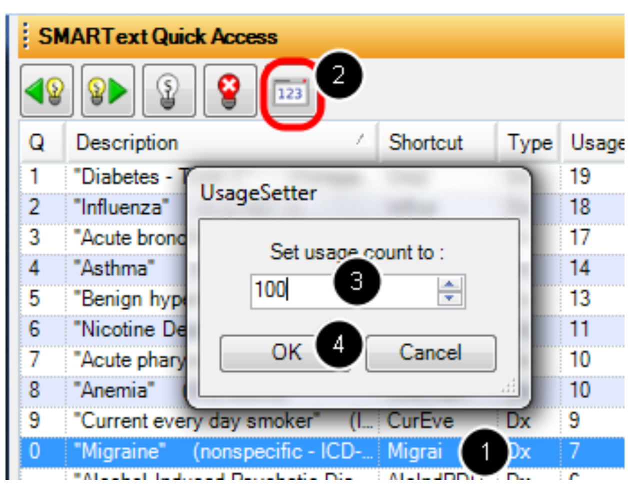
-Customizing the Usage Counter



When working with SMARText Quick Access "favorites list", the items that appear will be automatically sorted by Usage. The most used items will be placed at the top of the list.

The Usage counter for each SMARText item can be customized so the user is able to organize the list in the order of their preference.

-Editing the Usage Count



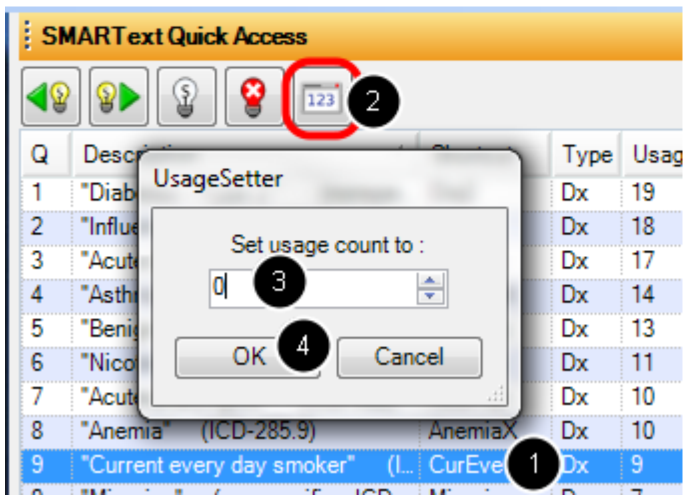
To edit the usage count or bring a SMARText Item to the top of the list:

1. Highlight the SMARText item.
2. Click the **Set Usage** button.

3. In the "Set usage count to:" box, enter the desired usage count.
4. Click **OK**.

After refreshing the favorites list, this will set the usage count for the selected item to the number entered.

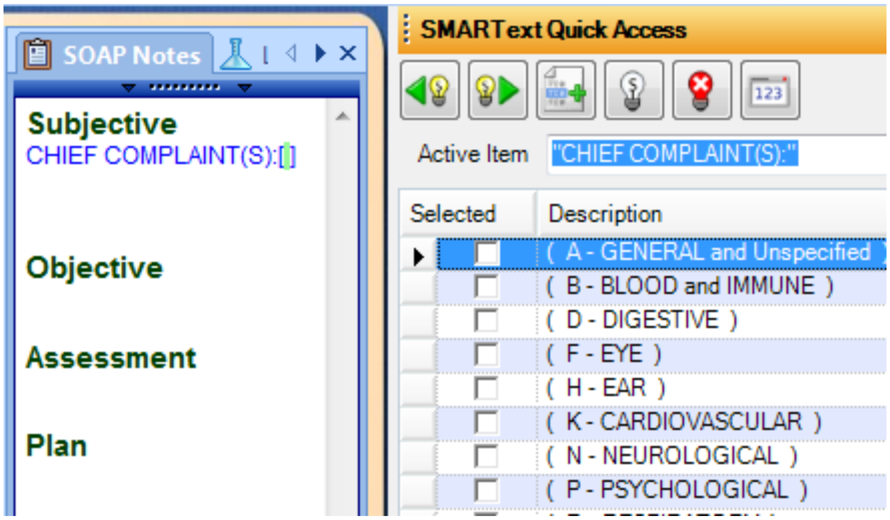
-Removing an Item from the Favorites List



To remove a SMARText Item from the "favorites list":
1. Highlight the SMARText item.
2. Click the **Set Usage** button.
3. In the "Set usage count to:" box, enter a usage count of 0.
4. Click **OK**.

After refreshing the favorites list, this will remove the SMARTet item from the list.

Pick Lists in Quick Access from Clicking a SMARText Header



Many SMARText Items offer pick lists (e.g. Chief Complaint, and HPI Items). 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

Intro to Docuplates

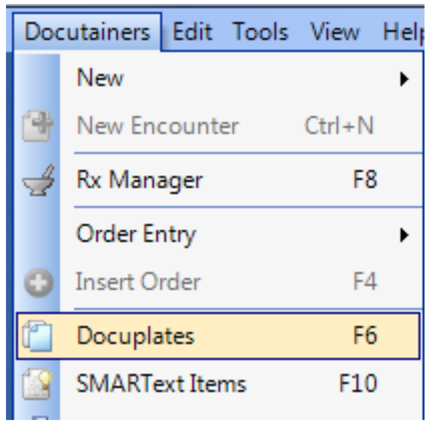
What are Docuplates?

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.

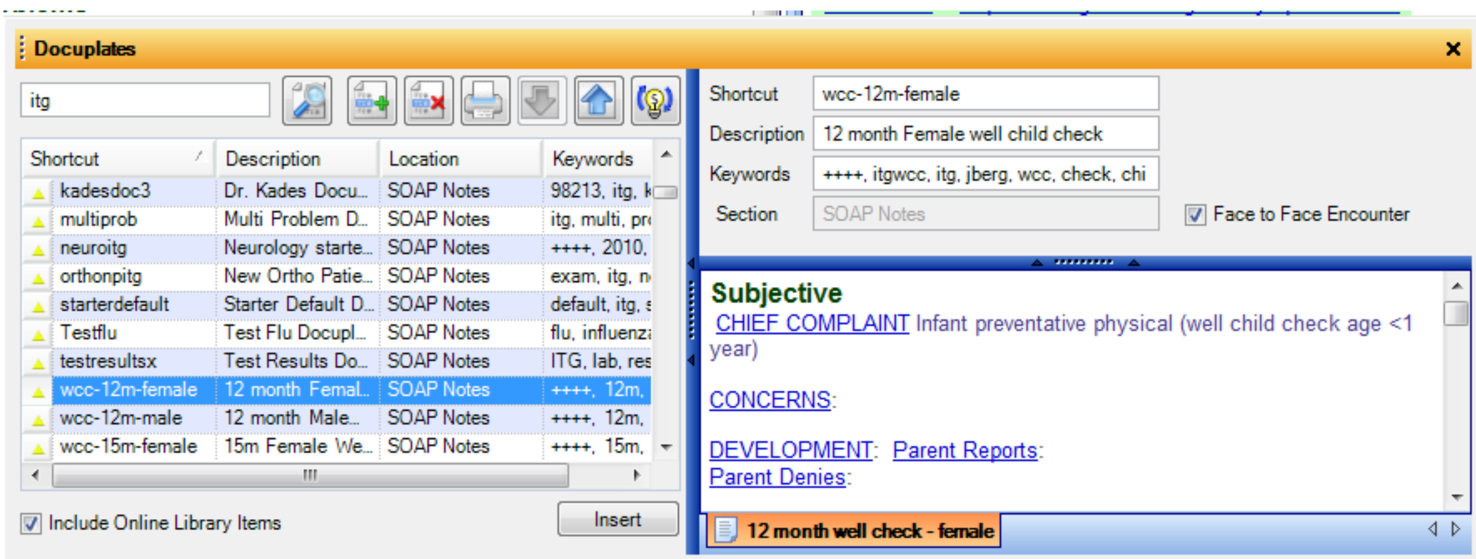
Accessing Docuplates

Finding Docuplates



1. Go to the Docutainers menu
2. Click on Docuplates (or press F6 on the keyboard)

The Docuplates Interface

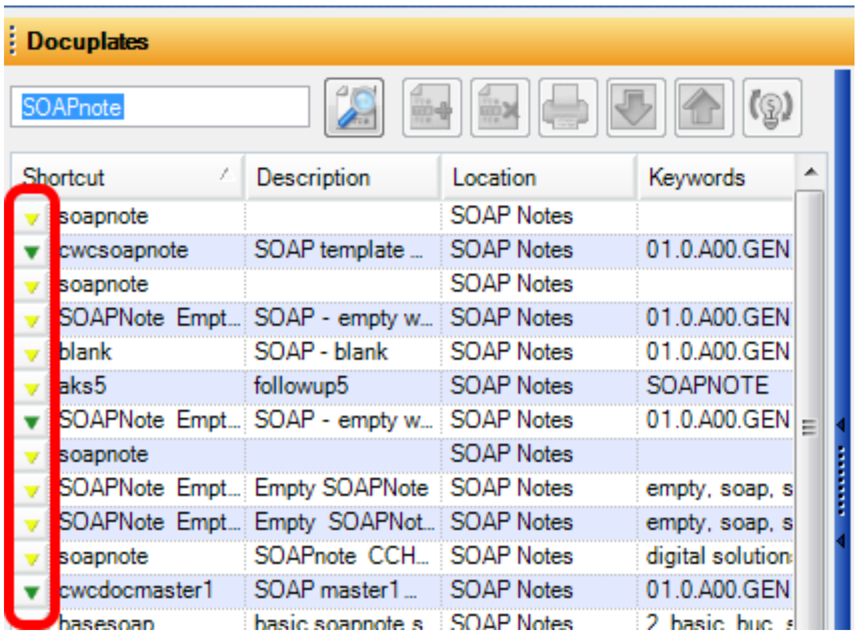


The interface has the ability to search for existing docuplates, including those online (by checking the Include Online Library Items box). Once docuplates have been downloaded on your a user's library, they may be previewed in the window to the right.

Docuplate Controls

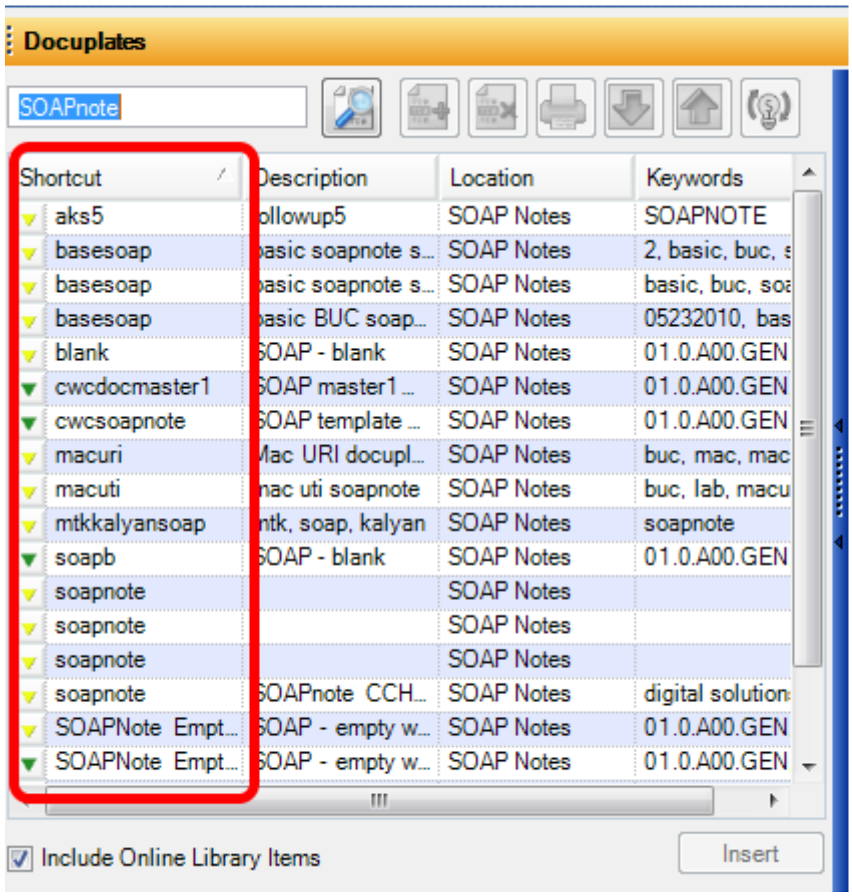
The docuplate library now contains thousands of docuplates, containing tens of thousands of keywords to assist with searching-finding. When reviewing docuplates, consider the following.

Green and Yellow Triangles



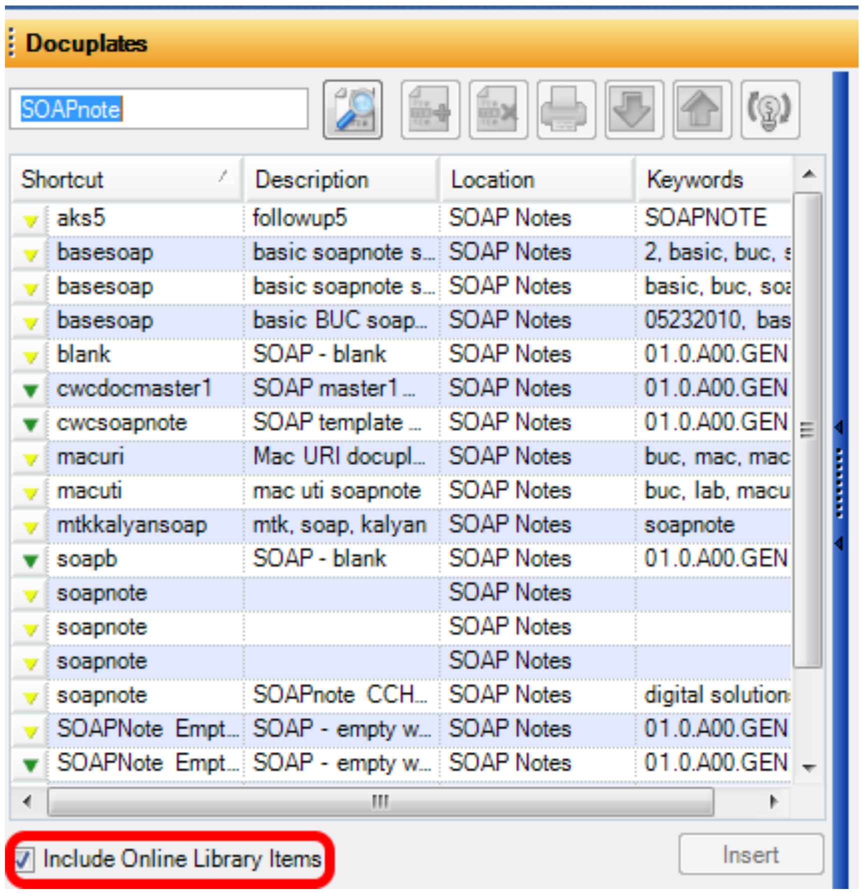
Docuplates with green triangles have been created by SOAPware, Inc. as appropriate for others to download. Docuplates with yellow triangles have been created or edited by a SOAPware user.

Shortcut Column



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.

Include Online Library



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.

Sorting

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.

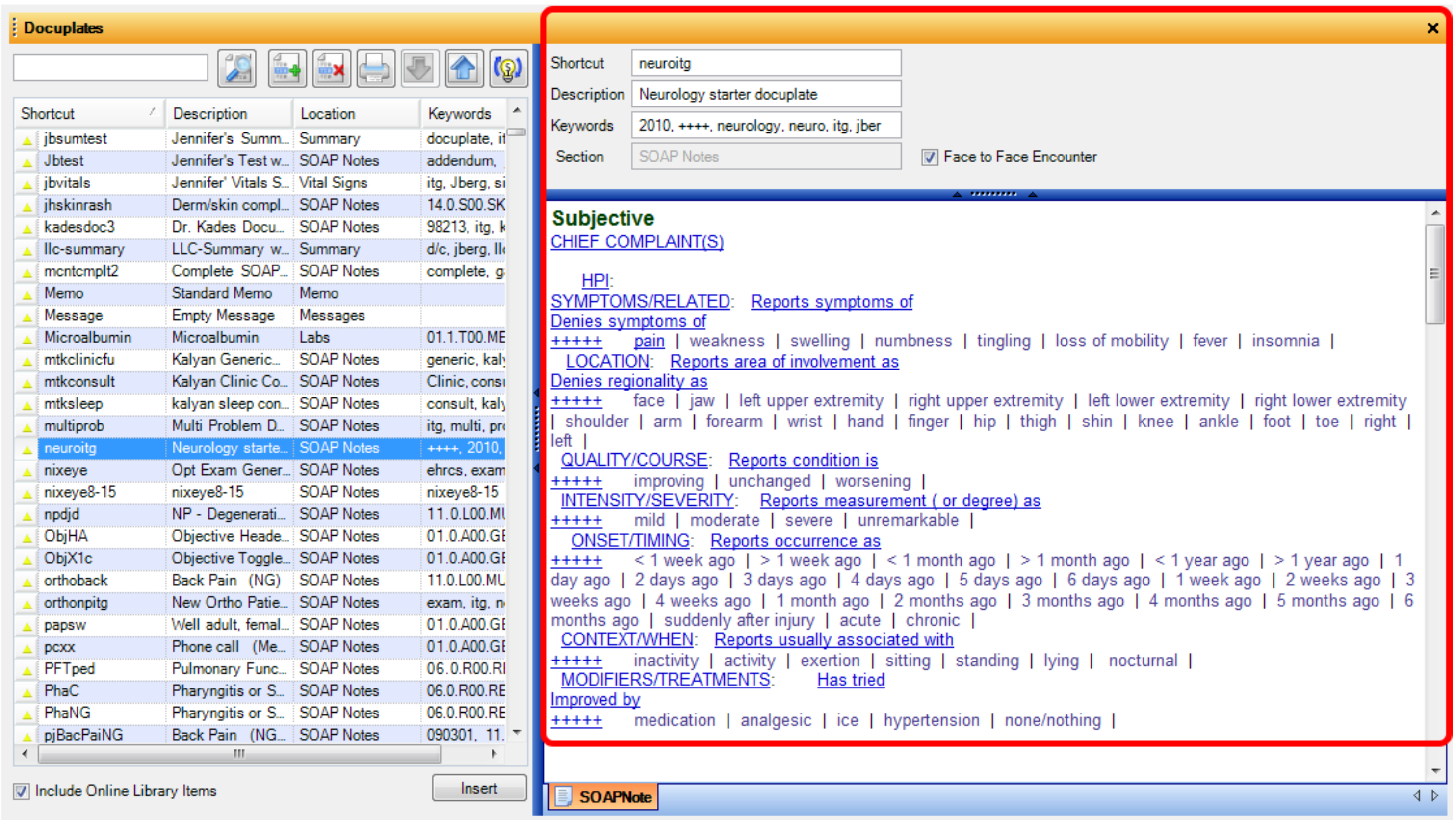
1. Drawings
2. Flow Sheets

3. Labs
4. SOAPnotes

Docuplate Actions

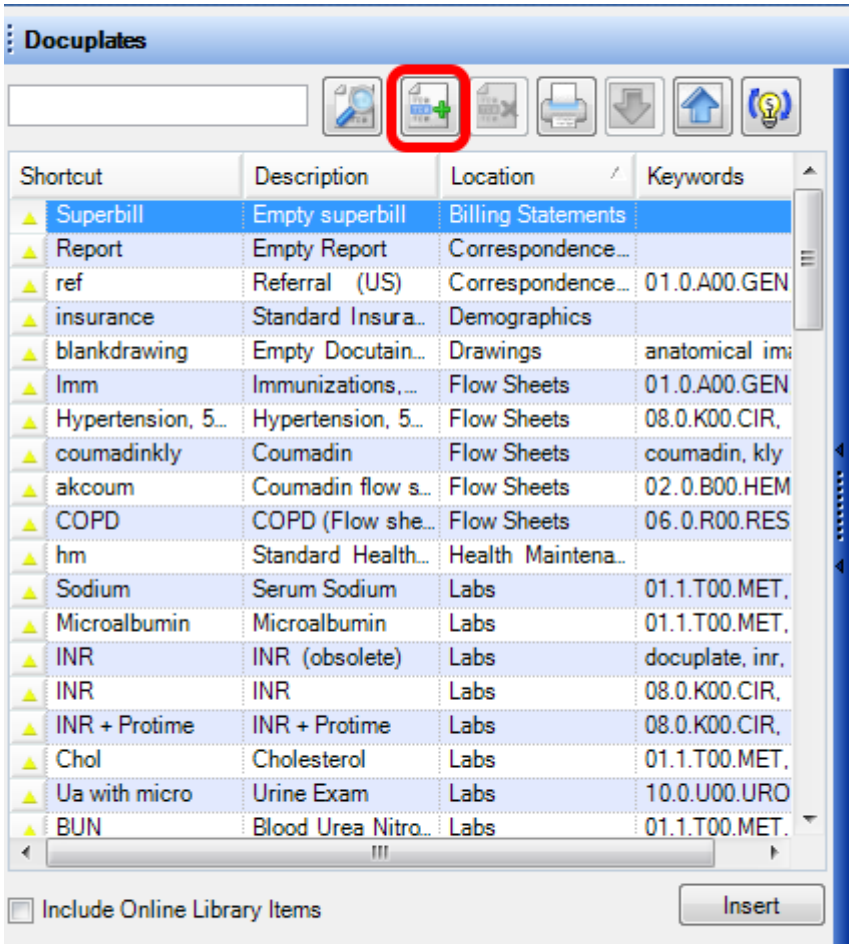
At the top of the List view, above the list, are the control buttons for Docuplates. They are Edit, Add, and Remove the currently selected Docuplate.

Edit



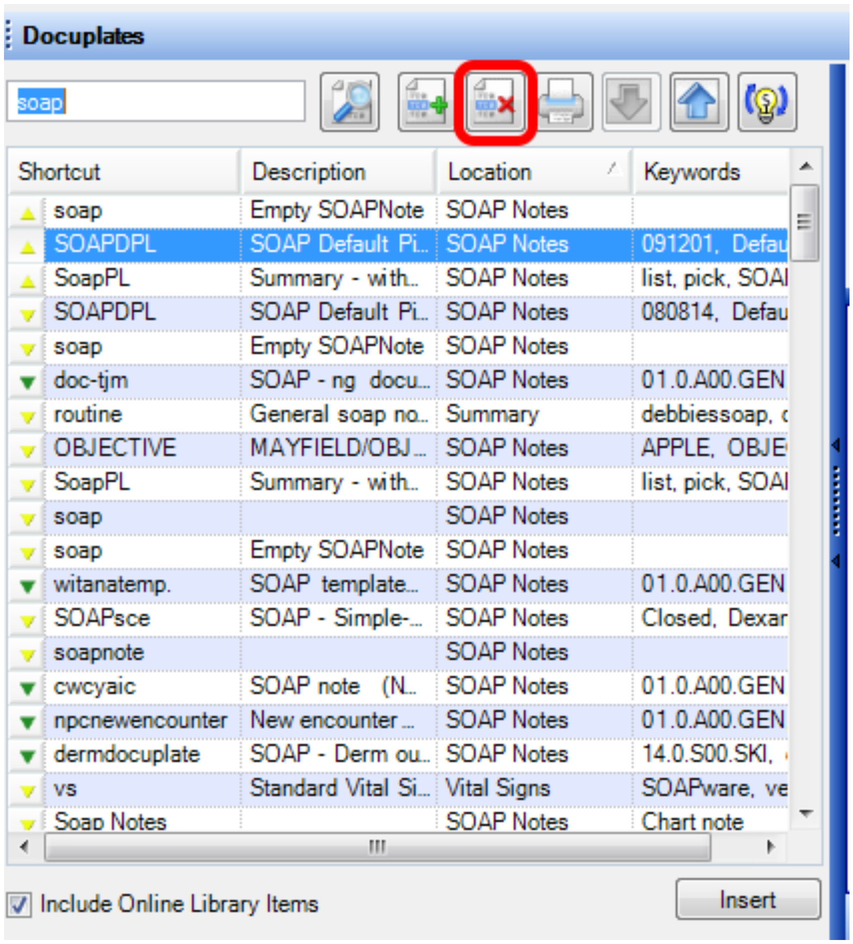
Selecting a docuplate on the user's local library opens the Docuplate for editing. The window to the right provides a preview of any docuplate selected once the docuplate has been downloaded. In this window, the user can edit the docuplate and the changes will be auto-saved.

Add Button



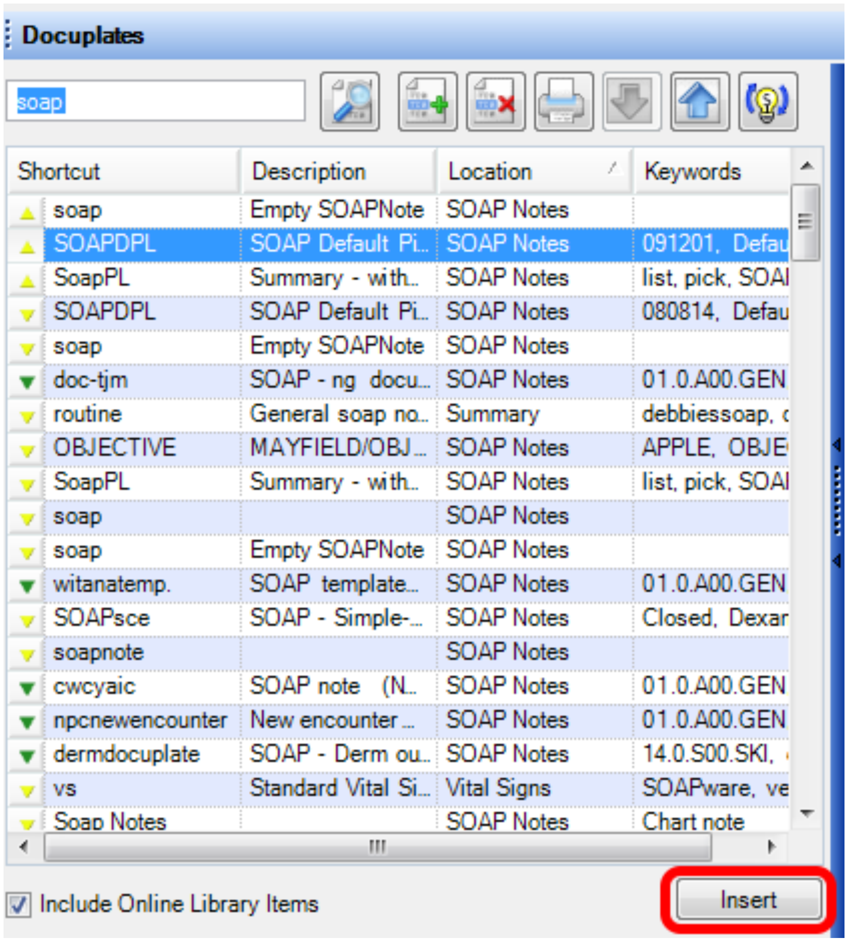
The button with the green plus allows users to create a docuplate from what has been created in a patient's chart.

Remove Button



To remove a docuplate from a user's local library, the user can use the Remove Docuplate button.

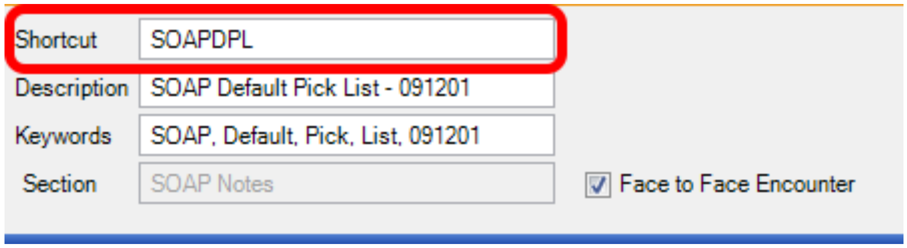
Insert Button



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.

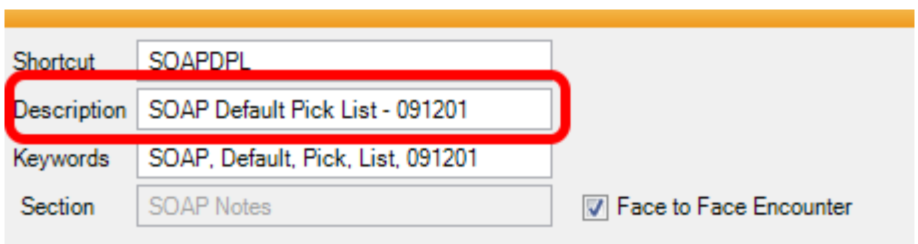
Docuplate Information

Shortcut



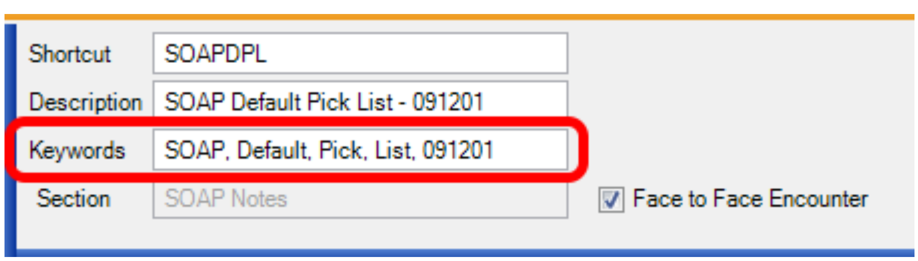
The Shortcut is a shortcut code that can be typed to immediately add a Docuplate to a Document.

Description



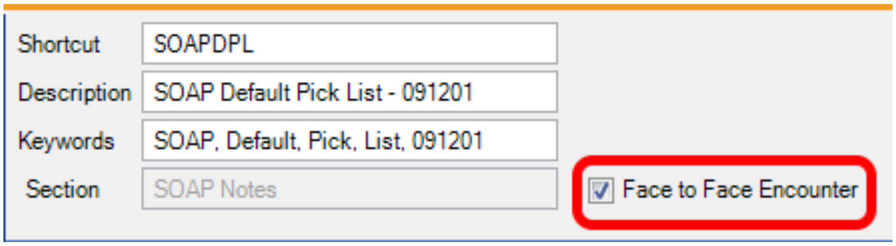
The Description provides a brief explanation of the intended use of the Docuplate.

Keywords List



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



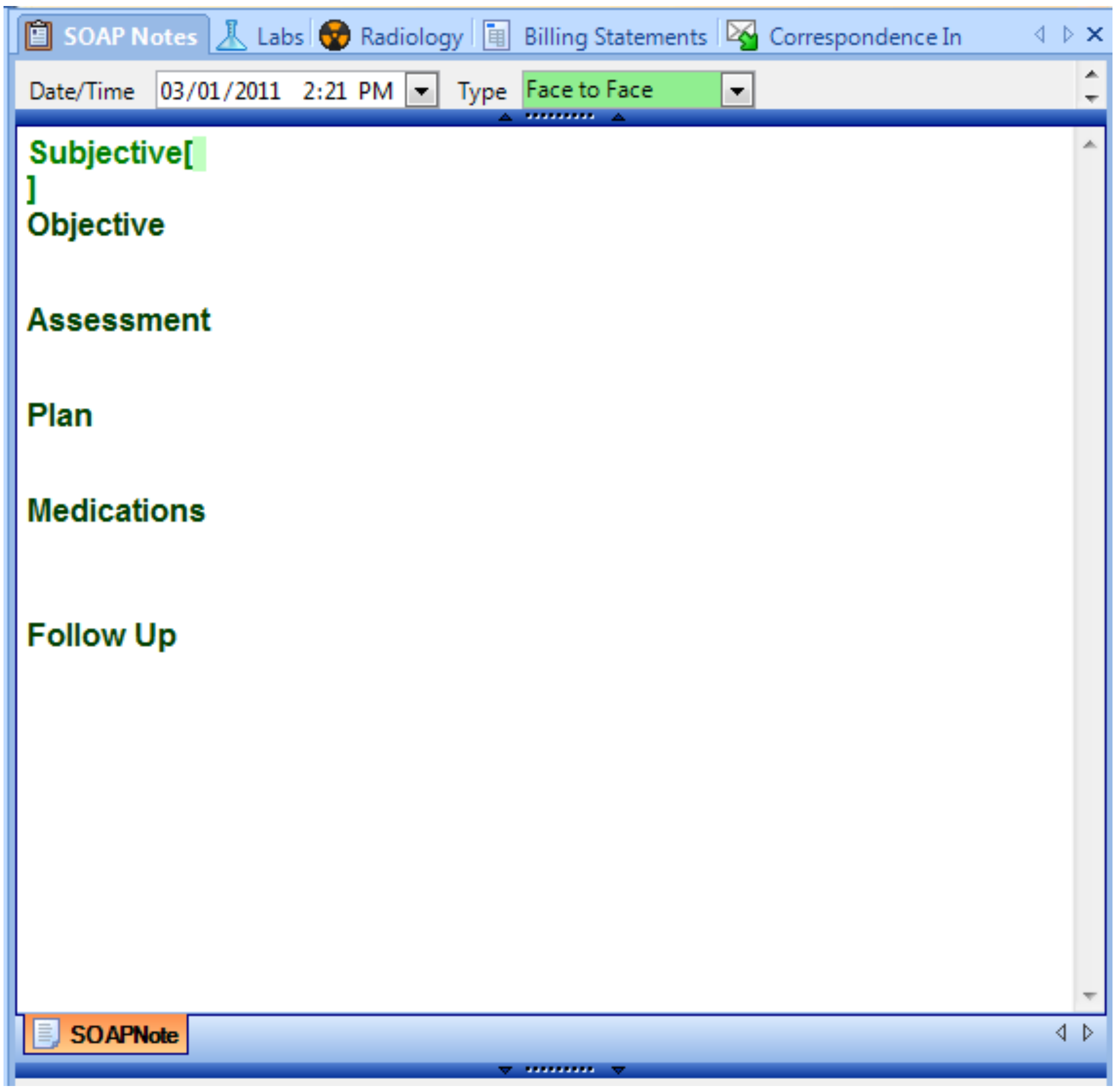
This check box indicates whether the selected docuplate is used for a Face to Face encounter or a Non Face to Face encounter. When the selected docuplate is inserted by the user, the active SOAPnote will default to a Face to Face encounter if the box is checked. If the box is not checked, the active 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

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.

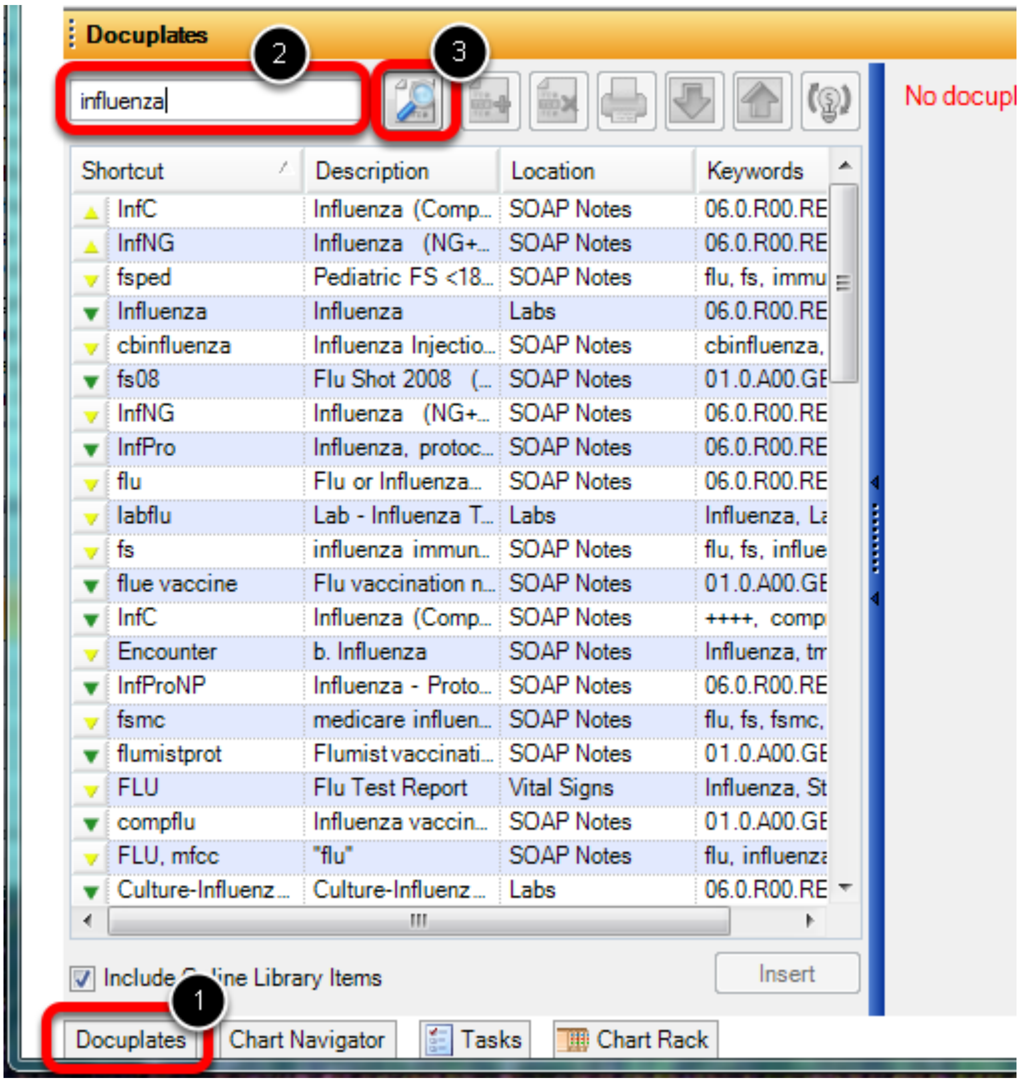
Create a Docuplate from an Existing Docuplate



Begin with an empty document in a test patient chart. To clear out the contents of a SOAPnote, Select Edit > Clear All SOAP Fields.

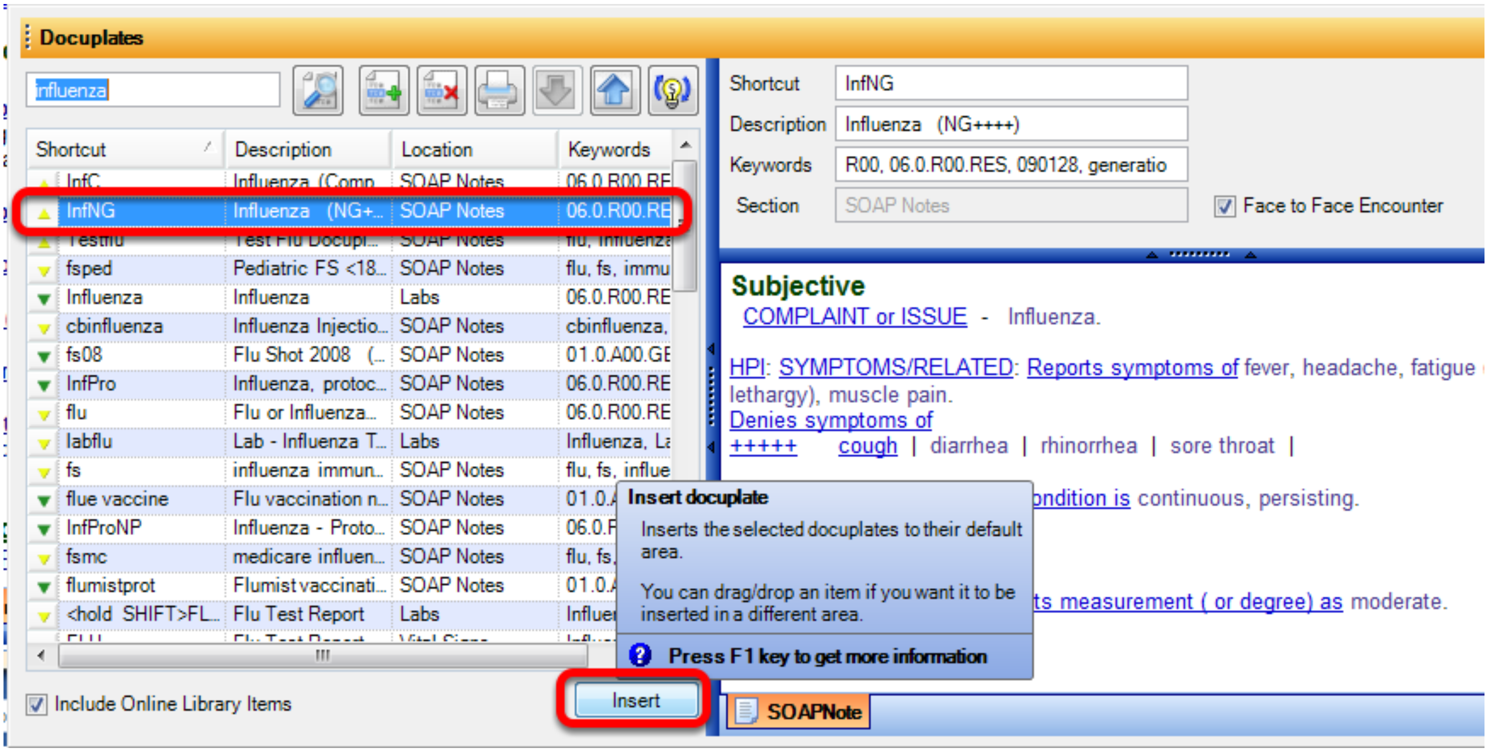
__Note:__ Due to HIPAA requirements, do not put "real world" patient data in docuplates that you or others may store on the on-line library.

Inserting a Docuplate



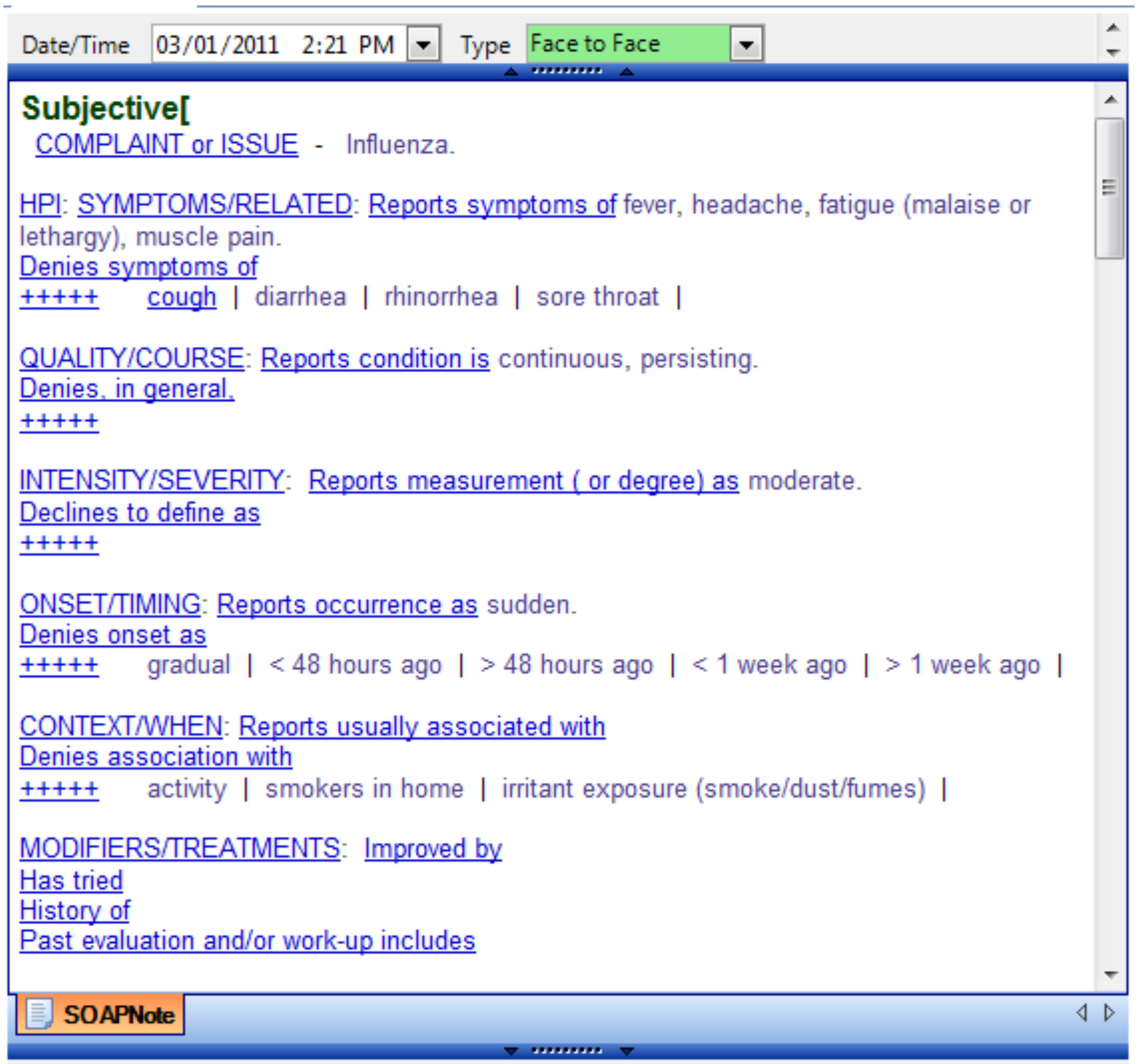
To insert an existing docuplate:

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.



Click to highlight the desired docuplate, and Click the "Insert" button .

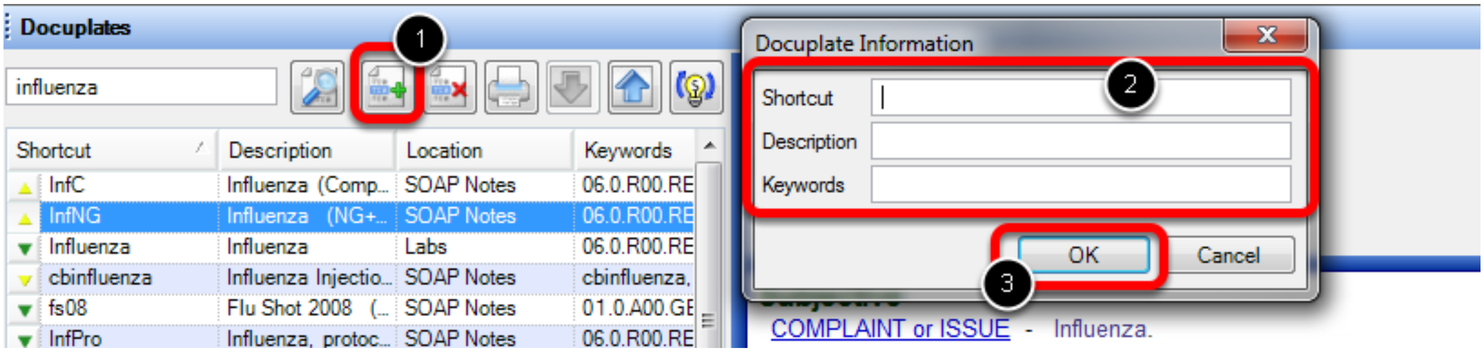
Editing the Docuplate



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).

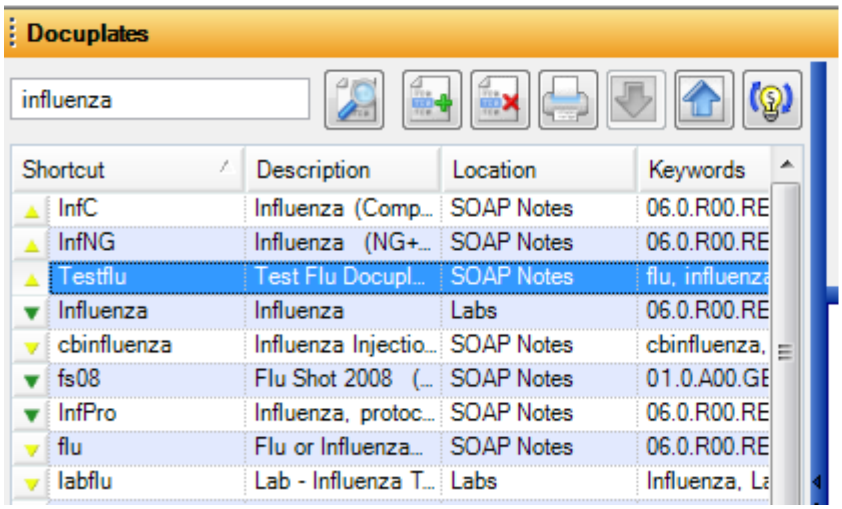
1. Click on the Green + to create the new docuplate.
2. Enter a Shortcut, Description and Keywords in the Docuplate Information dialog.
3. Select OK.

***Note:** Due to HIPAA requirements, do not put "real world" patient data in docuplates that you or others may store on the on-line library.*

Setting a Docuplate Type

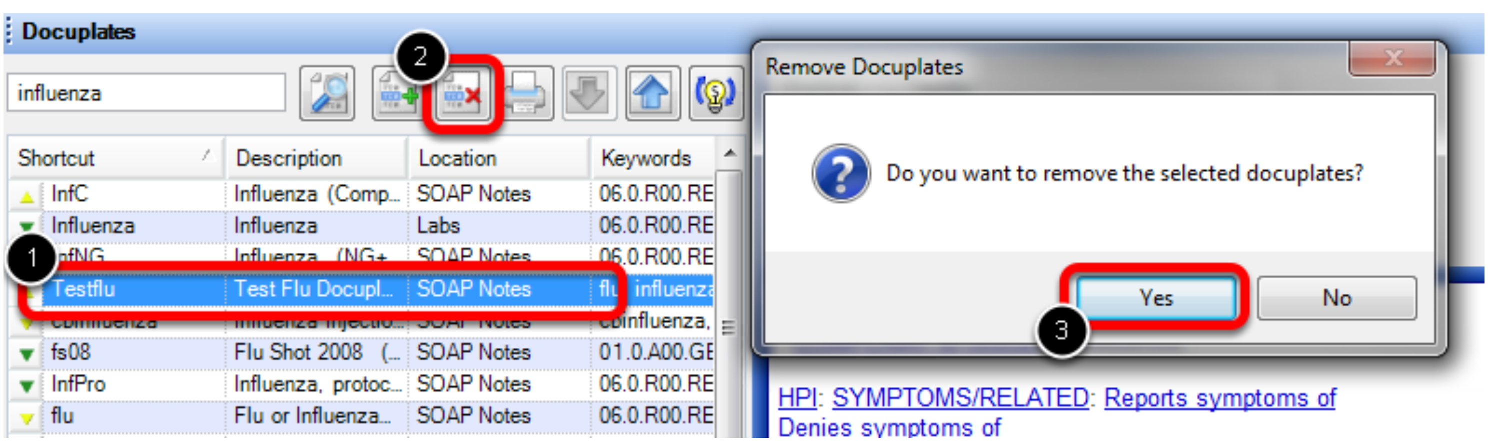
The Face to Face Encounter check box indicates whether the selected docuplate is used for a Face to Face encounter or a Non Face to Face encounter. When the selected docuplate is inserted by the user, the active SOAPnote will default to a Face to Face encounter if the box is checked. If the box is not 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 meainingful use office visits if the SOAPnote Type is set to Face to Face.



The new docuplate will display, as well as the original docuplate, within the Docuplates dialog.

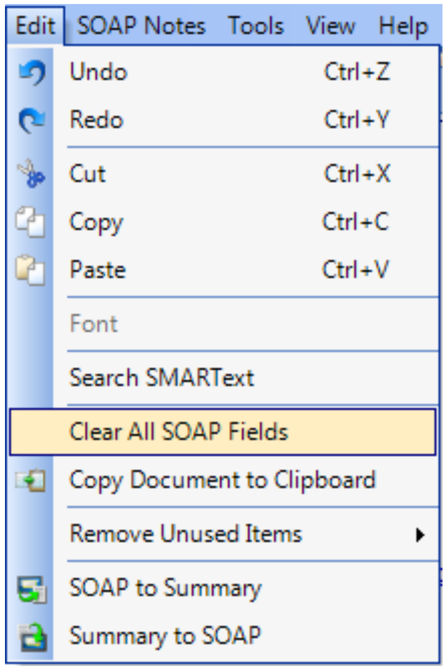
Delete a Docuplate



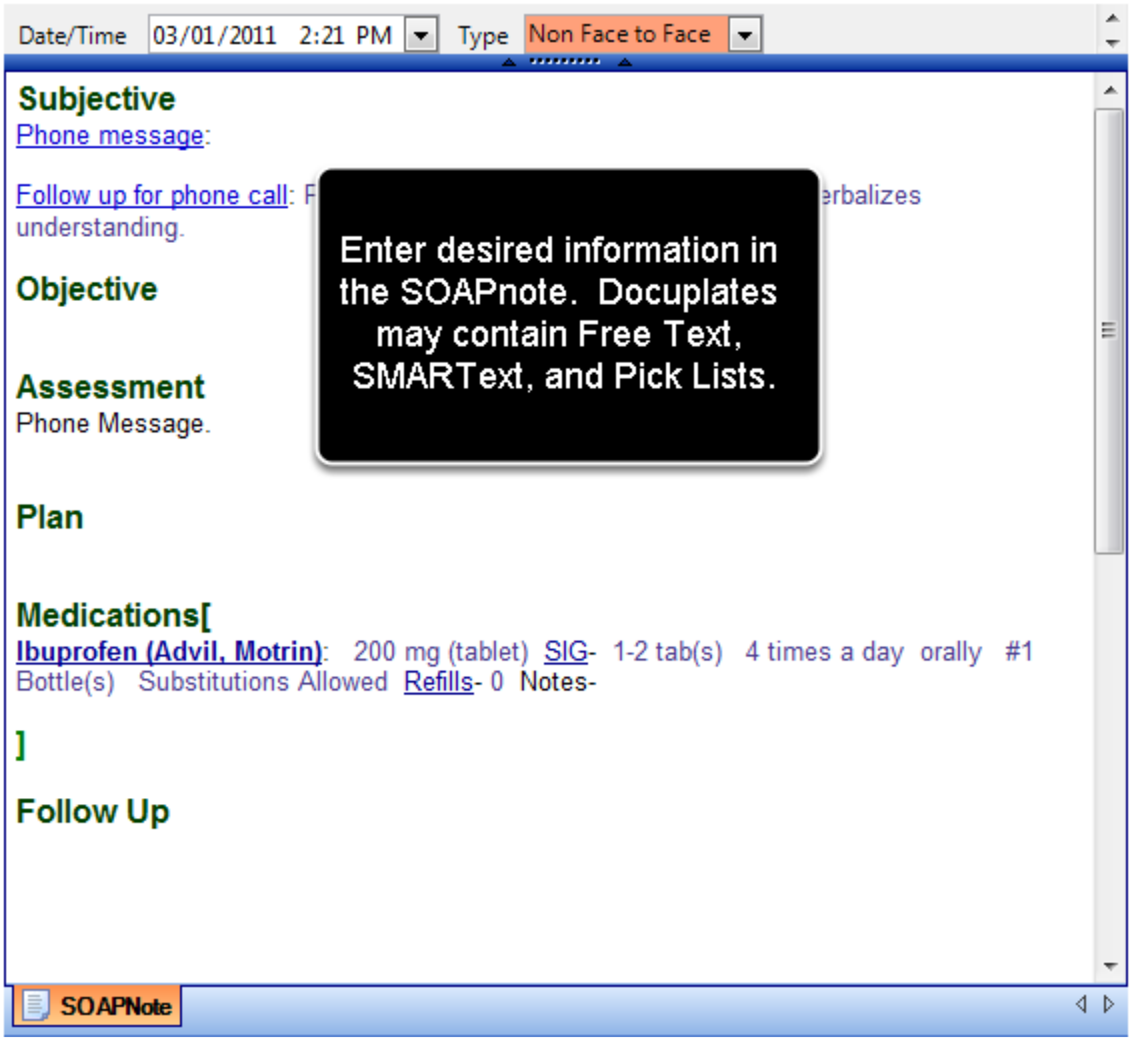
To delete a docuplate:
1. Highlight the desired docuplate.
2. Click the delete button.

3. Confirm the action of removing the selected docuplate by Clicking the "Yes" button.

Create a Docuplate from Scratch

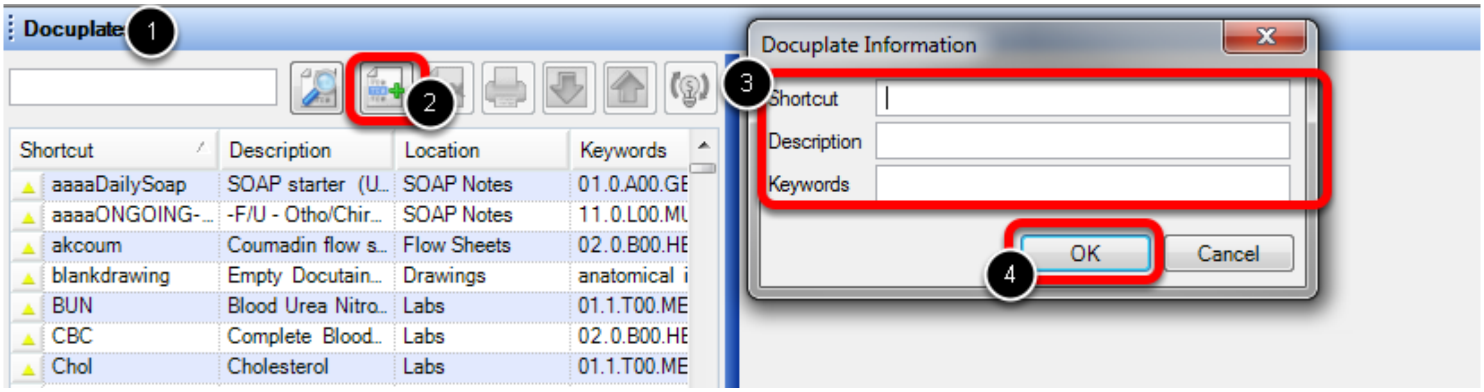


To create a docuplate without using an existing docuplate, begin with an empty document in a test patient chart. Select Edit > Clear All SOAP Fields, from the Menu Bar.



Add the desired document items to be displayed in the docuplate. Docuplates may contain Free Text, SMARText, and Pick Lists.

***Note:** *Due to HIPAA requirements, do not put "real world" patient data in docuplates that you or others may store on the on-line library.*

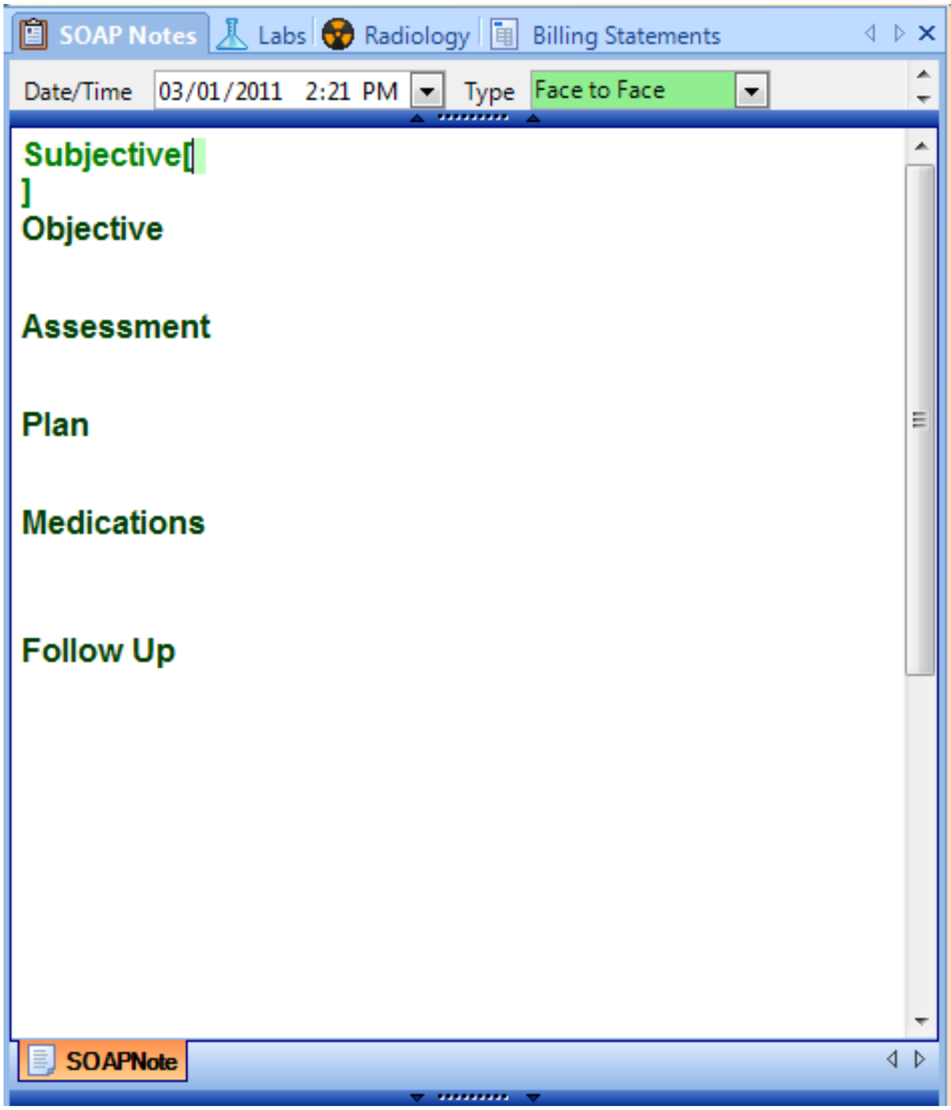


To save the docuplate:

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

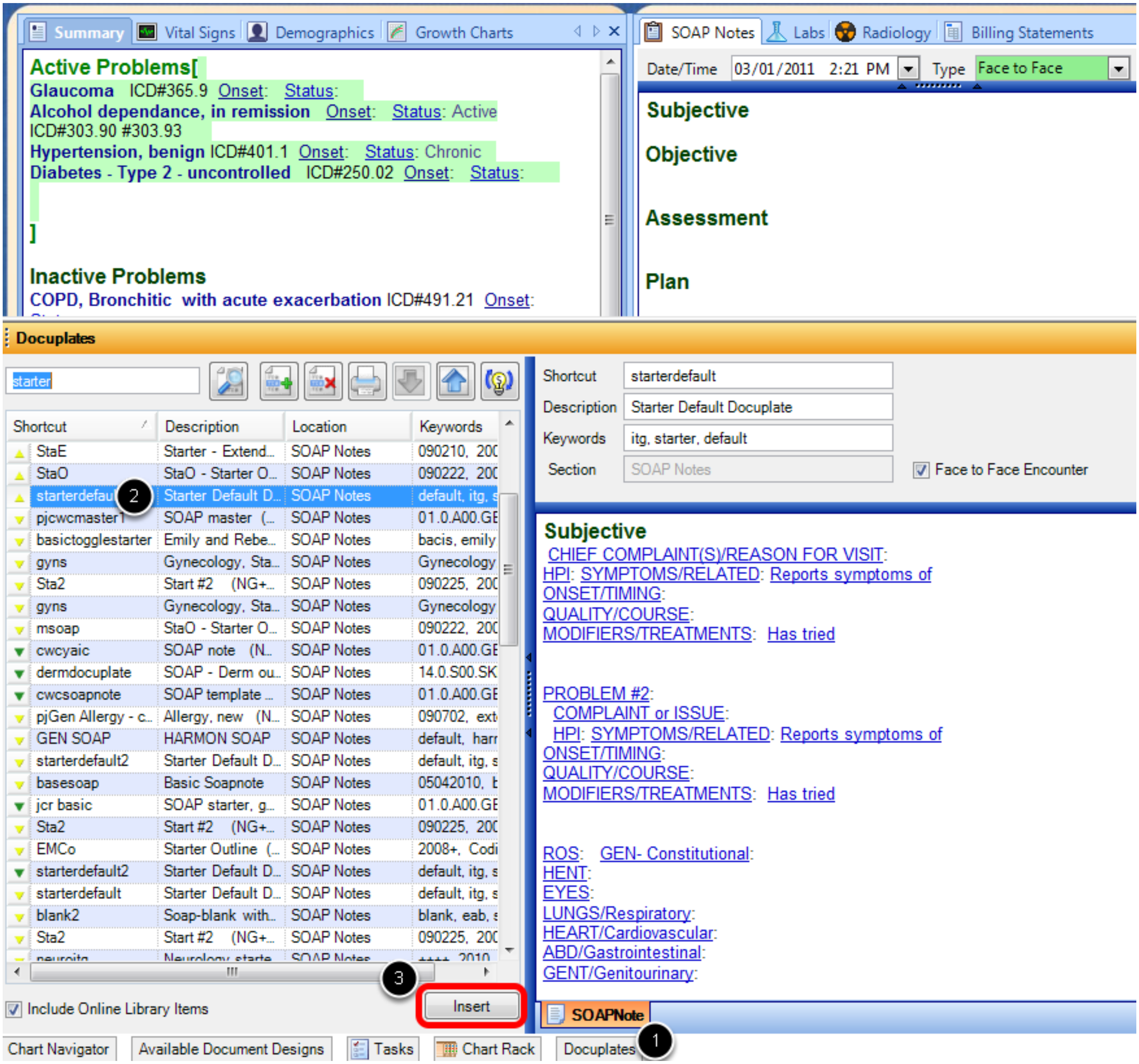
Open Document



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.

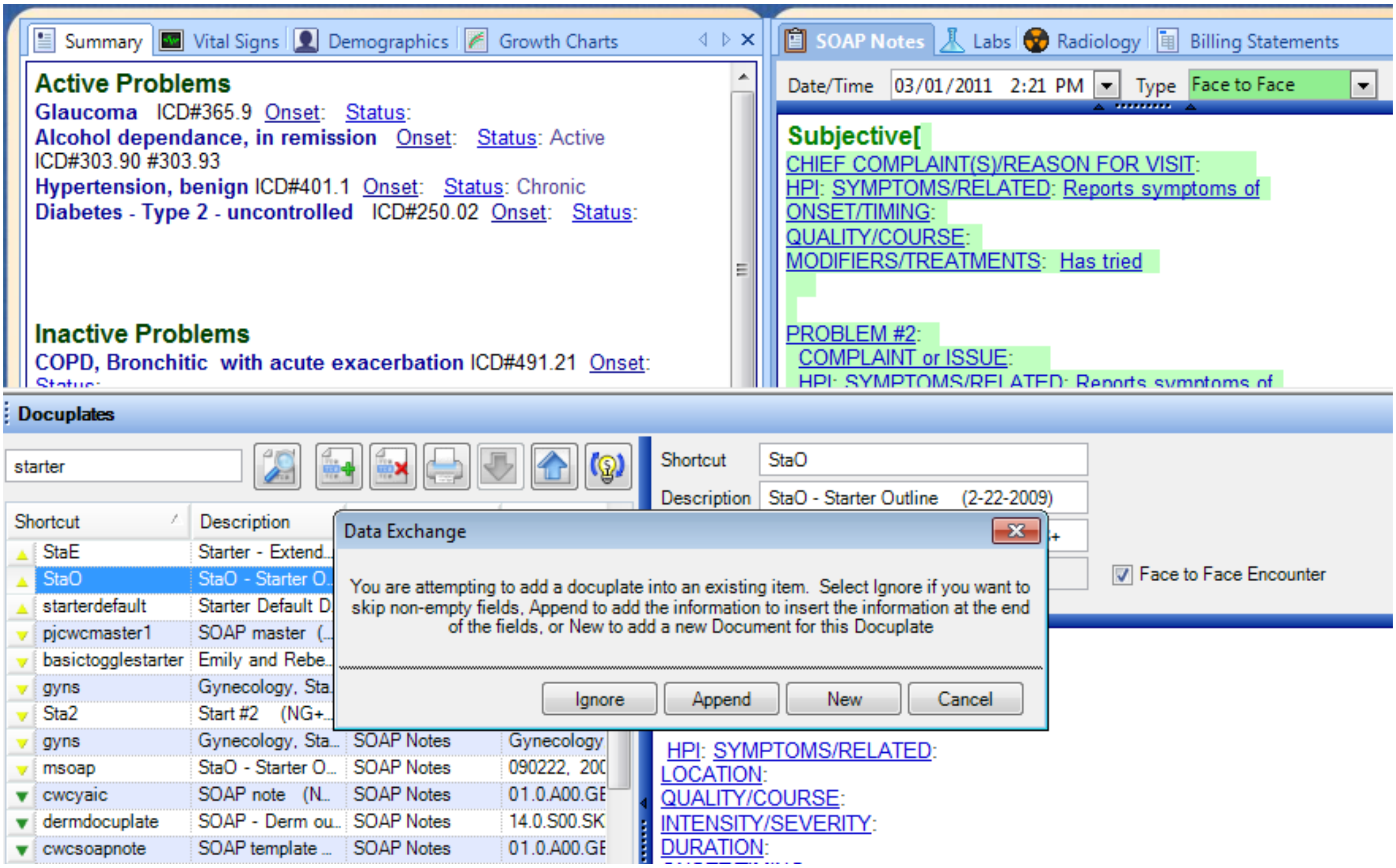
If a blank document is not available, a prompt will display with several options on how to insert the docuplate.

Search and Insert



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



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.

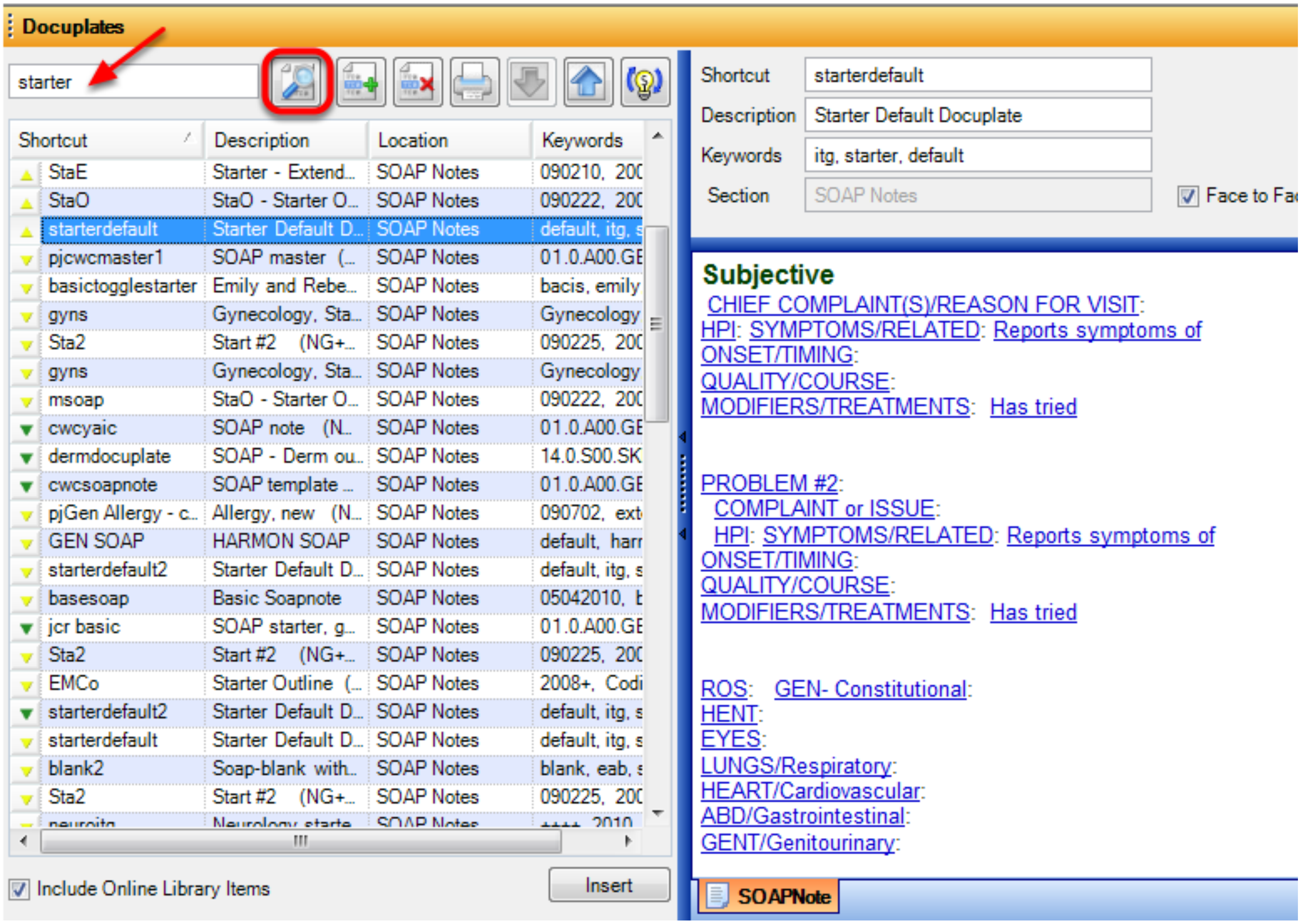
Append to add the docuplate information after any existing content in SOAPnote fields.

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 Doculplate

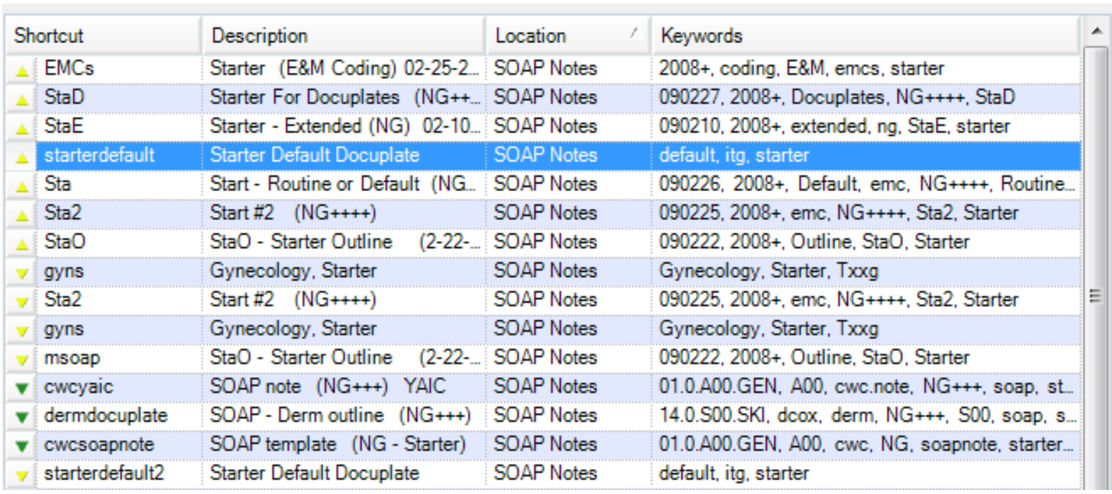
Search



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.

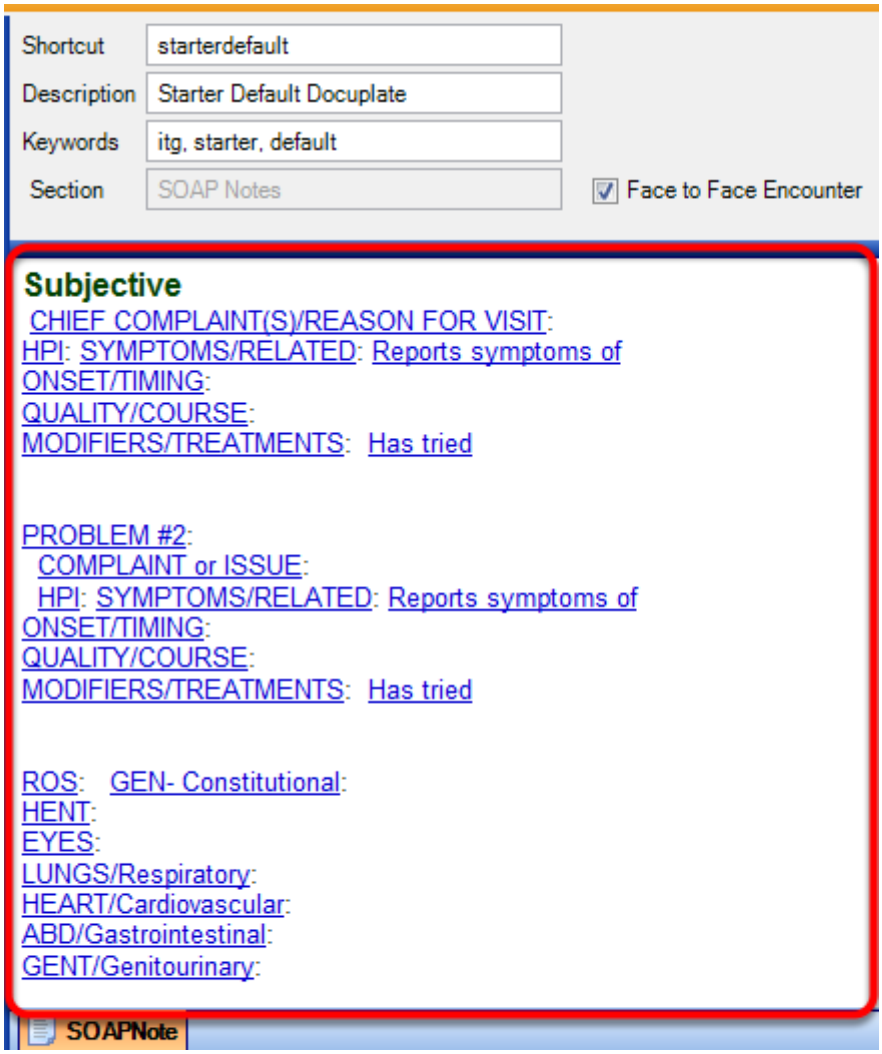
Search Results



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
gyns	Gynecology, Starter	SOAP Notes	Gynecology, Starter, Txxg
Sta2	Start #2 (NG++++)	SOAP Notes	090225, 2008+, emc, NG++++, Sta2, Starter
gyns	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



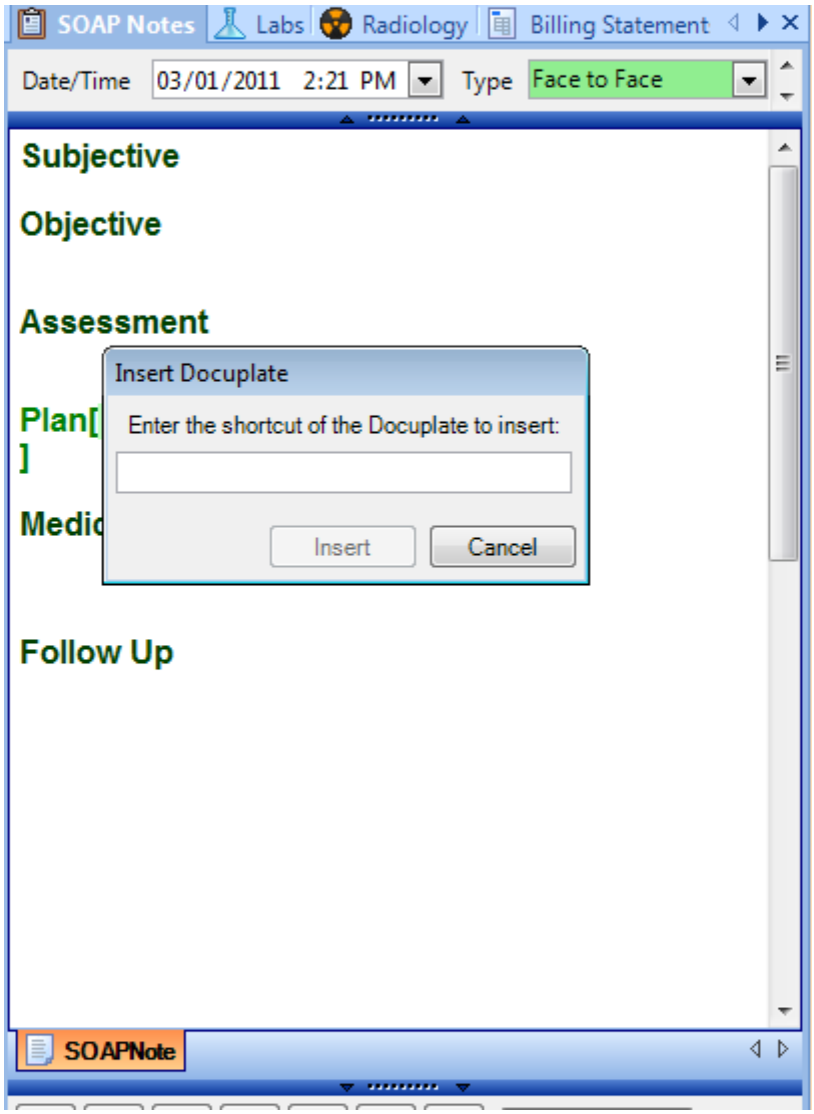
Click the docuplate list item for the desired docuplate, and the docuplate is displayed on the right side of the Docuplates viewer. Edit the docuplate's data elements as needed.

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



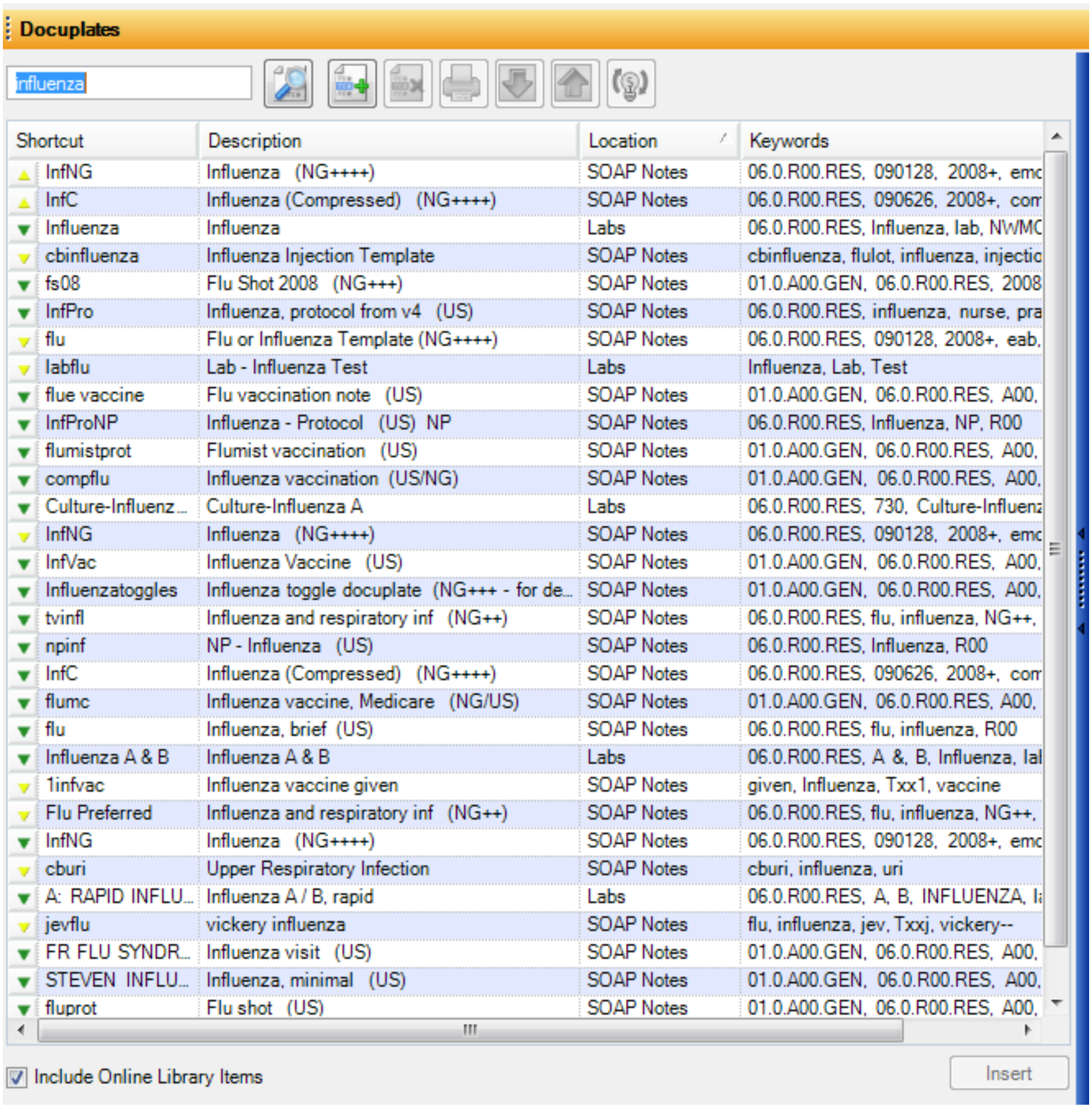
For those docuplates used on a regular basis, any SOAPware users find it convenient to use a keyboard shortcut to enter those most commonly-used - Press the F5 key, and type the Shortcut for the docuplate.

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)


Docuplates

influenza

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+, com
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+, com
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, lal
1infvac	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.

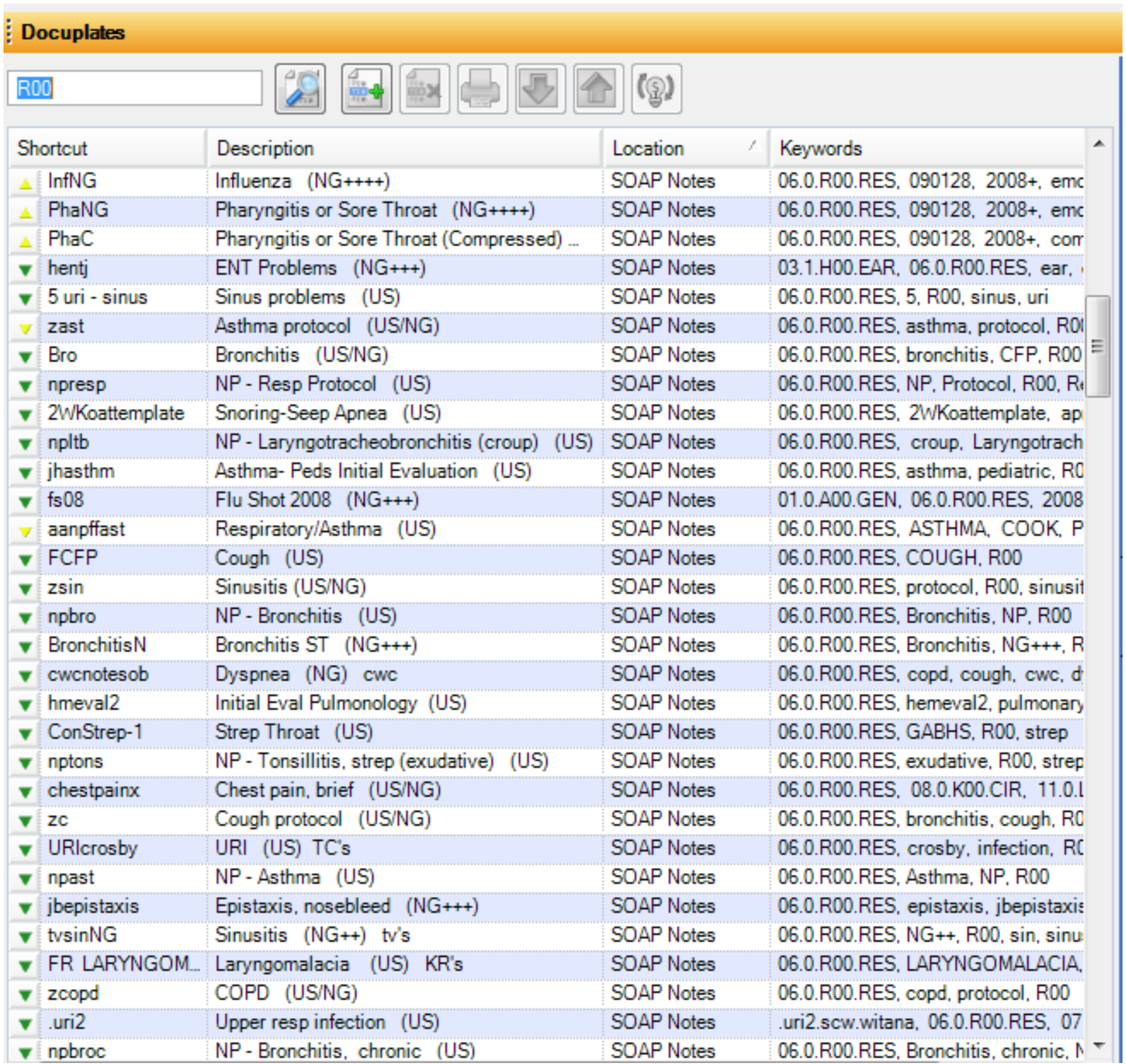
(NG+) - Mostly New Generation, but some free-text is present.
(NG++) - Less free-text.
(NG+++) - Little remaining, free-text.
(NG++++) - Majority of content is New Generation.

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
A00	General
T00	Metabolic, Endocrine
B00	Blood, Blood Forming
H00	Ear
F00	Eye
R00	Respiratory
K00	Circulatory
D00	Digestive
U00	Urinary
W00	Pregnancy, Family Planning
X00	Female genital
Y00	Male genital
L00	Musculoskeletal
N00	Neurological
P00	Psychological
Z00	Social
S00	Skin

Use one of these codes to review docuplates by one of 17 systems.



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+, com
hentj	ENT Problems (NG+++)	SOAP Notes	03.1.H00.EAR, 06.0.R00.RES, ear,
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, R0
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
2WKoattemplate	Snoring-Seep Apnea (US)	SOAP Notes	06.0.R00.RES, 2WKoattemplate, 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, sinusi
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+++, R
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, hemeval2, 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.I
zc	Cough protocol (US/NG)	SOAP Notes	06.0.R00.RES, bronchitis, cough, R0
URIcrosby	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

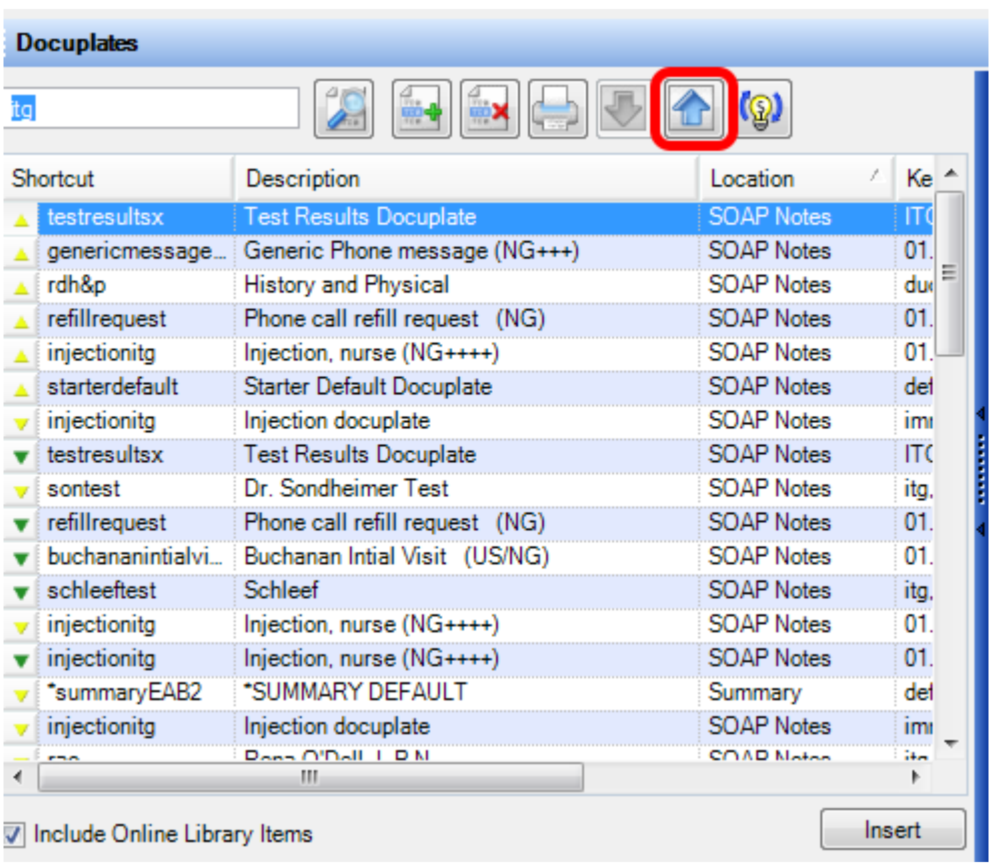
For example, a Pulmonologist or Allergist would like to only retrieve respiratory docuplates, search with R00 (R + zero + zero).

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.

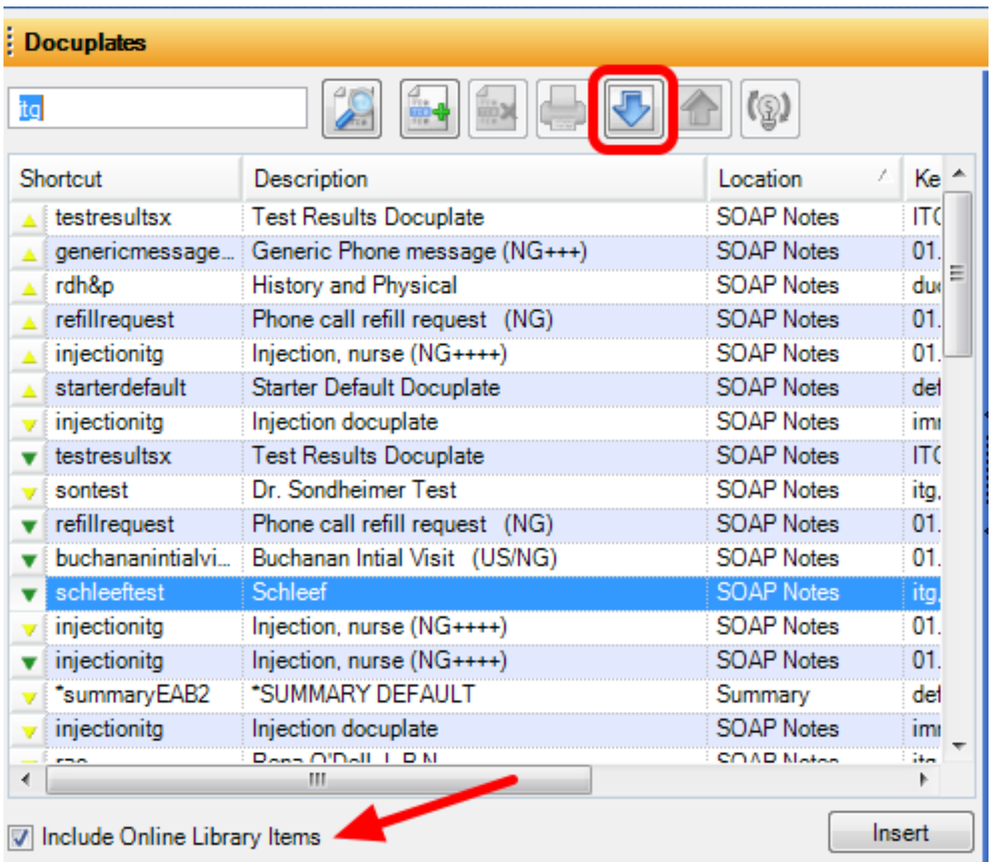
Upload



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.

__Note:__ Due to HIPAA requirements, do not put “real world” patient data in docuplates that you or others may store on the on-line library.

Download

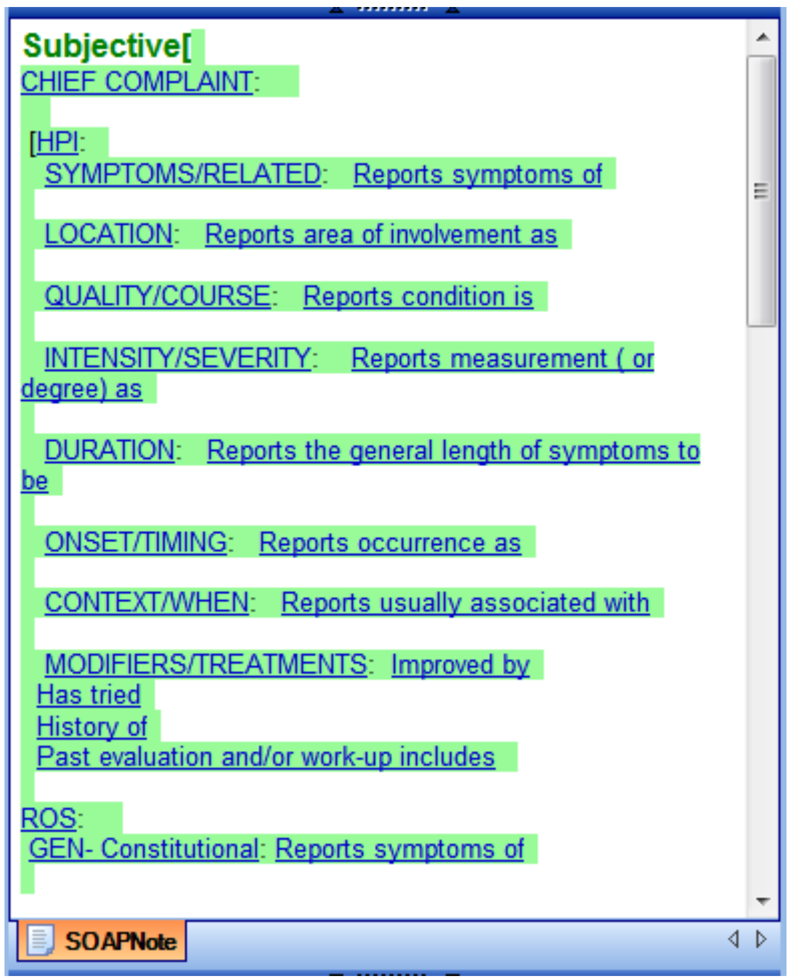


To download a docuplate, Click the Download button in the library column of the desired docuplate. Include Online Library Items must be checked in order to view and download online docuplates.

Docuplate Toolkit - Getting Started with Documentation

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



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

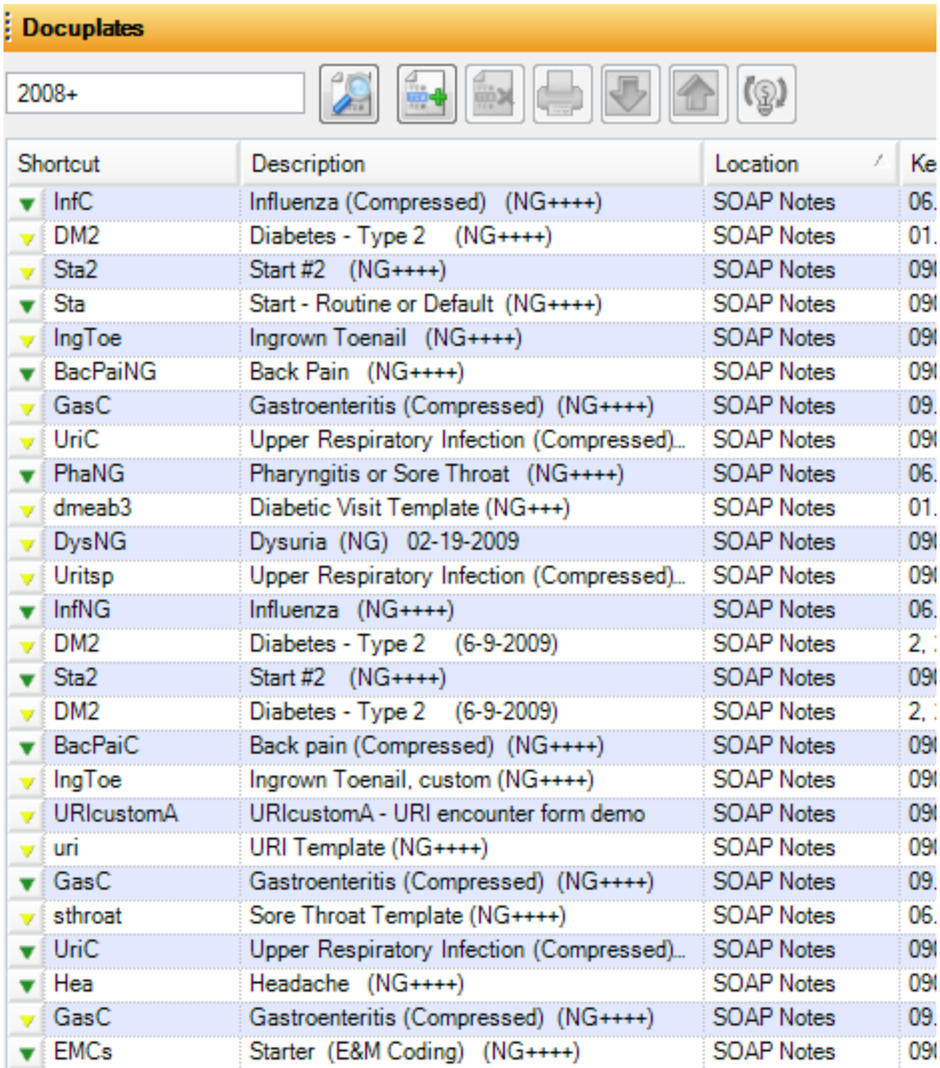
To use these shortcuts, simply type the shortcut into the corresponding field, then press the spacebar. This will expand the shortcut.

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, nexd and nexs
Objective: Obj-, Objs, Objn, ObjX, ObjX1c, ObjX1n and ObjHA
Plan: Pla-
Follow Up: Fol-

Starter Docuplates



Docuplates

2008+

Shortcut	Description	Location	Ke
InfC	Influenza (Compressed) (NG++++)	SOAP Notes	06.
DM2	Diabetes - Type 2 (NG++++)	SOAP Notes	01.
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta	Start - Routine or Default (NG++++)	SOAP Notes	09
IngToe	Ingrown Toenail (NG++++)	SOAP Notes	09
BacPaiNG	Back Pain (NG++++)	SOAP Notes	09
GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
UriC	Upper Respiratory Infection (Compressed)...	SOAP Notes	09
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	09
Uritsp	Upper Respiratory Infection (Compressed)...	SOAP Notes	09
InfNG	Influenza (NG++++)	SOAP Notes	06.
DM2	Diabetes - Type 2 (6-9-2009)	SOAP Notes	2,
Sta2	Start #2 (NG++++)	SOAP Notes	09
DM2	Diabetes - Type 2 (6-9-2009)	SOAP Notes	2,
BacPaiC	Back pain (Compressed) (NG++++)	SOAP Notes	09
IngToe	Ingrown Toenail, custom (NG++++)	SOAP Notes	09
URIcustomA	URIcustomA - URI encounter form demo	SOAP Notes	09
uri	URI Template (NG++++)	SOAP Notes	09
GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
sthroat	Sore Throat Template (NG++++)	SOAP Notes	06.
UriC	Upper Respiratory Infection (Compressed)...	SOAP Notes	09
Hea	Headache (NG++++)	SOAP Notes	09
GasC	Gastroenteritis (Compressed) (NG++++)	SOAP Notes	09.
EMCs	Starter (E&M Coding) (NG++++)	SOAP Notes	09

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)

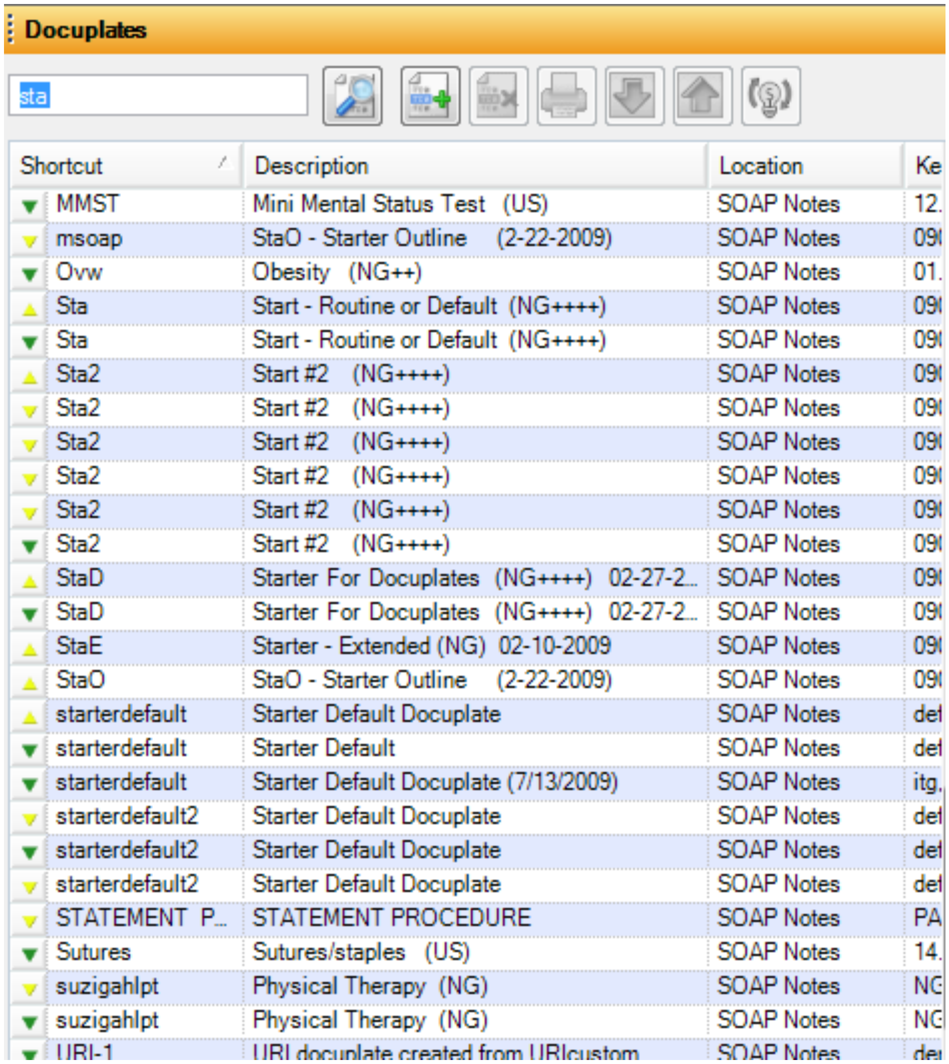
DysC - Dysuria (Compressed) Female Cystitis
IngToe - Ingrown Toenail (Compressed)

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 SMARText Items.

General Purpose Starters


Docuplates

sta

Shortcut	Description	Location	Ke
MMST	Mini Mental Status Test (US)	SOAP Notes	12.
msoap	StaO - Starter Outline (2-22-2009)	SOAP Notes	09
Ovw	Obesity (NG++)	SOAP Notes	01.
Sta	Start - Routine or Default (NG++++)	SOAP Notes	09
Sta	Start - Routine or Default (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
Sta2	Start #2 (NG++++)	SOAP Notes	09
StaD	Starter For Docuplates (NG++++) 02-27-2...	SOAP Notes	09
StaD	Starter For Docuplates (NG++++) 02-27-2...	SOAP Notes	09
StaE	Starter - Extended (NG) 02-10-2009	SOAP Notes	09
StaO	StaO - Starter Outline (2-22-2009)	SOAP Notes	09
starterdefault	Starter Default Docuplate	SOAP Notes	de
starterdefault	Starter Default	SOAP Notes	de
starterdefault	Starter Default Docuplate (7/13/2009)	SOAP Notes	itg,
starterdefault2	Starter Default Docuplate	SOAP Notes	de
starterdefault2	Starter Default Docuplate	SOAP Notes	de
starterdefault2	Starter Default Docuplate	SOAP Notes	de
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	de

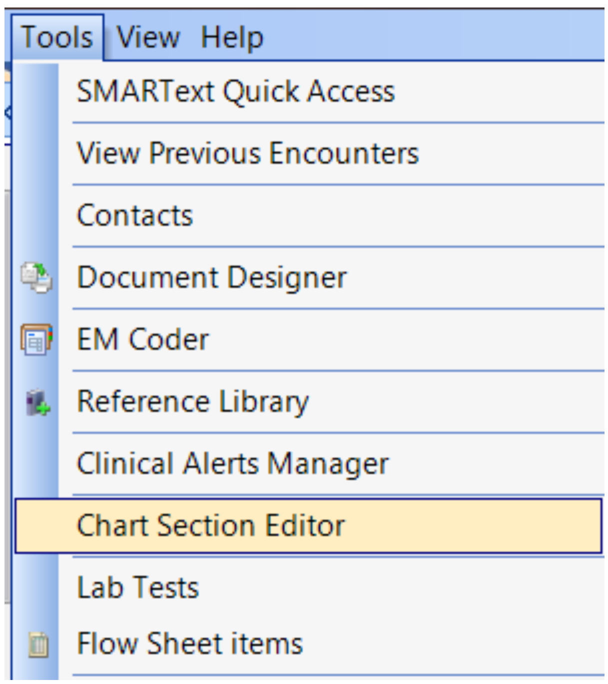
Also download the docuplate/template that has "Sta" as a Shortcut and Start-Routine or Default as the Description. This can serve as a plain or generic starter for any type of encounter.

Setting the Default Docuplate

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.

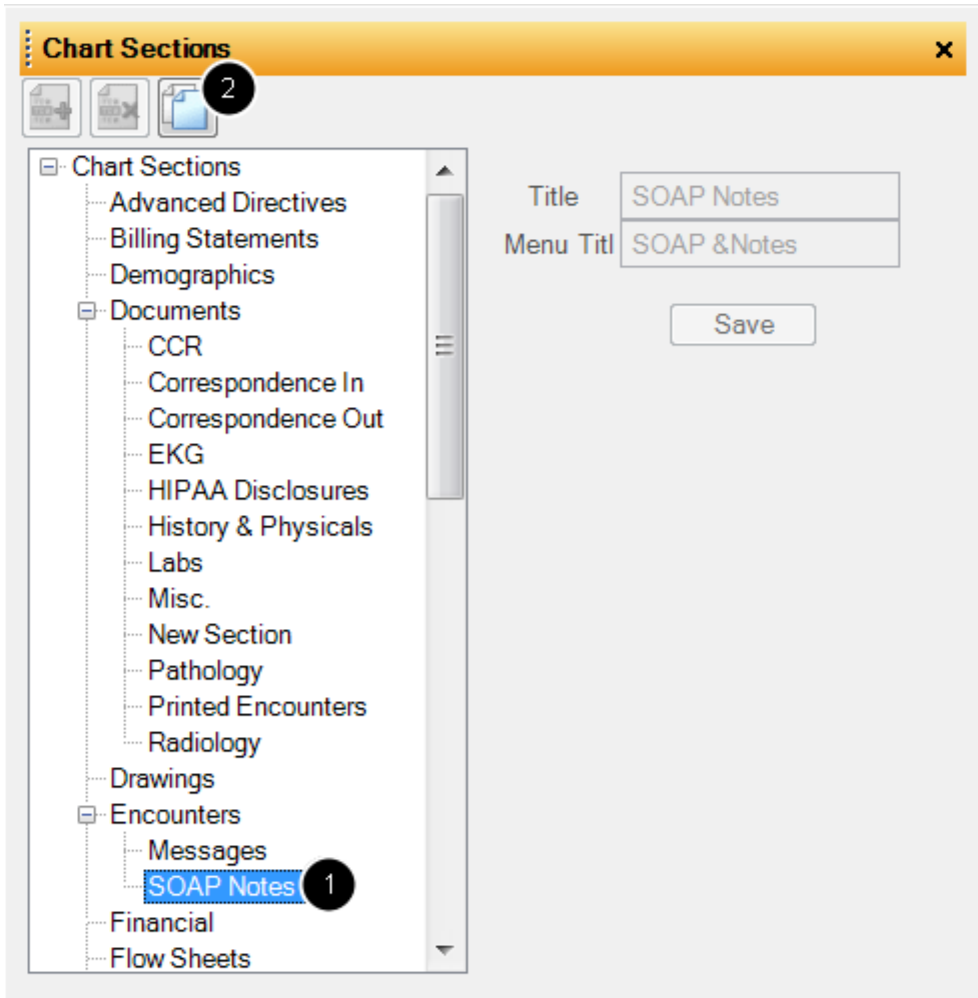
NOTE: The default SOAPnote docuplate when SOAPware is installed is for Getting Started or Introduction purposes only. It needs replacement once users have completed the initial Introduction to SOAPware.

Open the Chart Section Editor



Click Tools > Chart Section Editor

Select the Chart Section

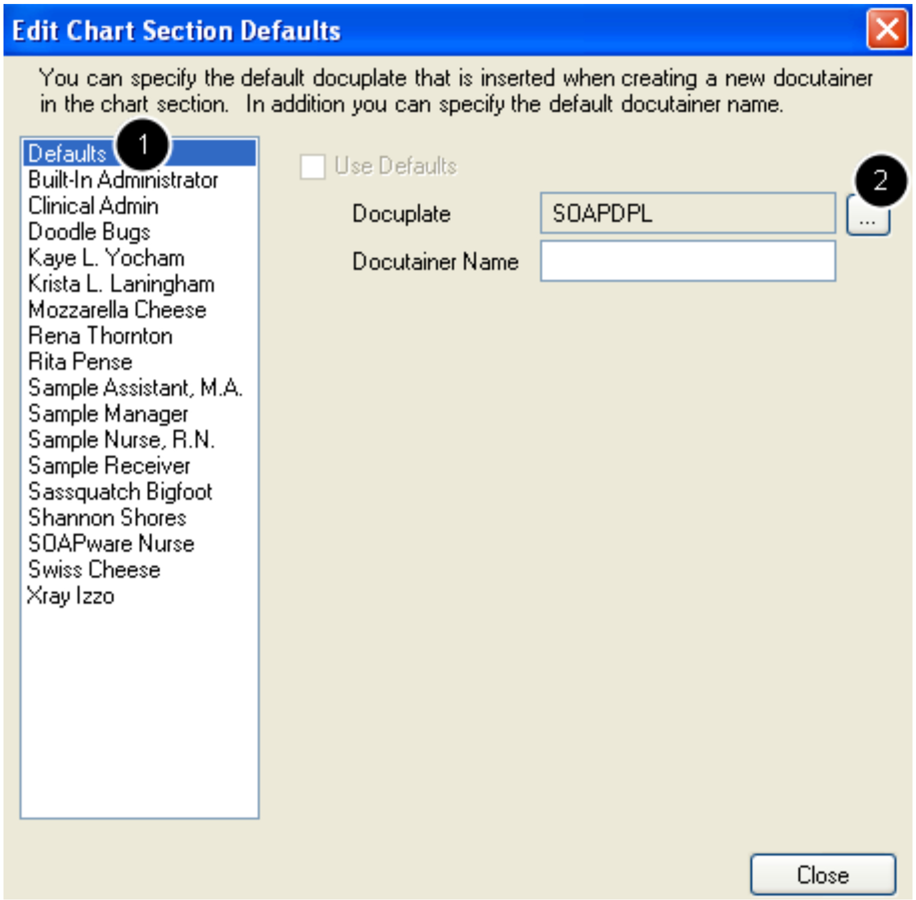


In order to select a chart section for editing

1. Click the chart section list item of choice.

2. Then, Click Edit Section Defaults.

Set Defaults

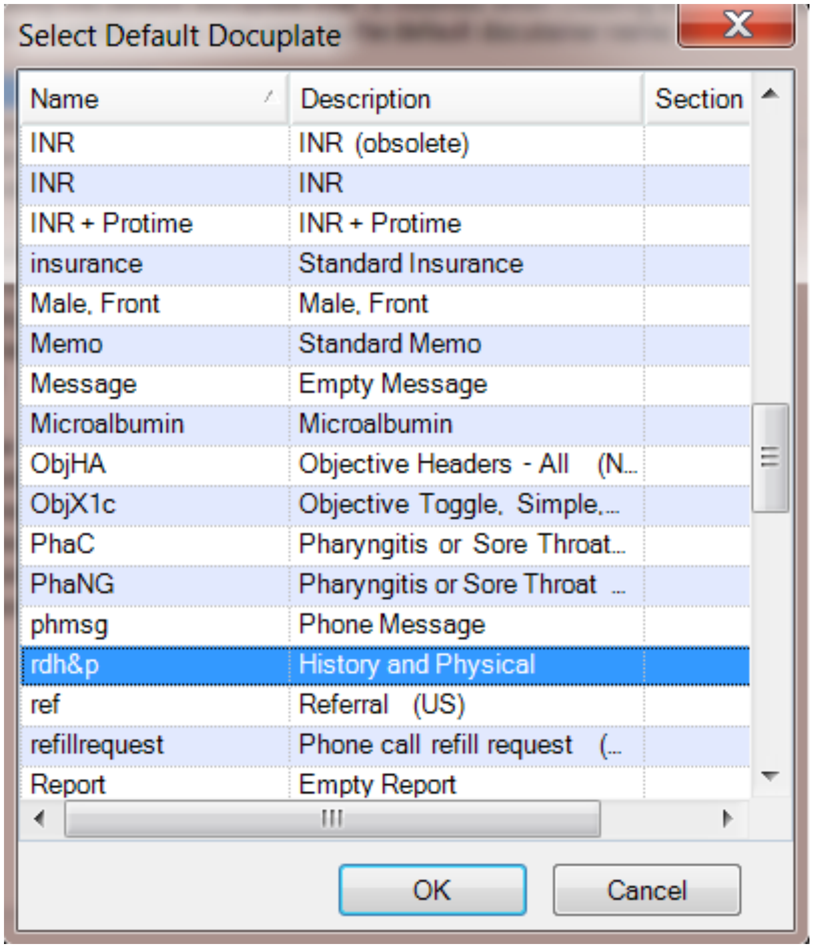


1. Click on the Defaults list item on the left to establish the default docuplates for the entire network (all users).

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.

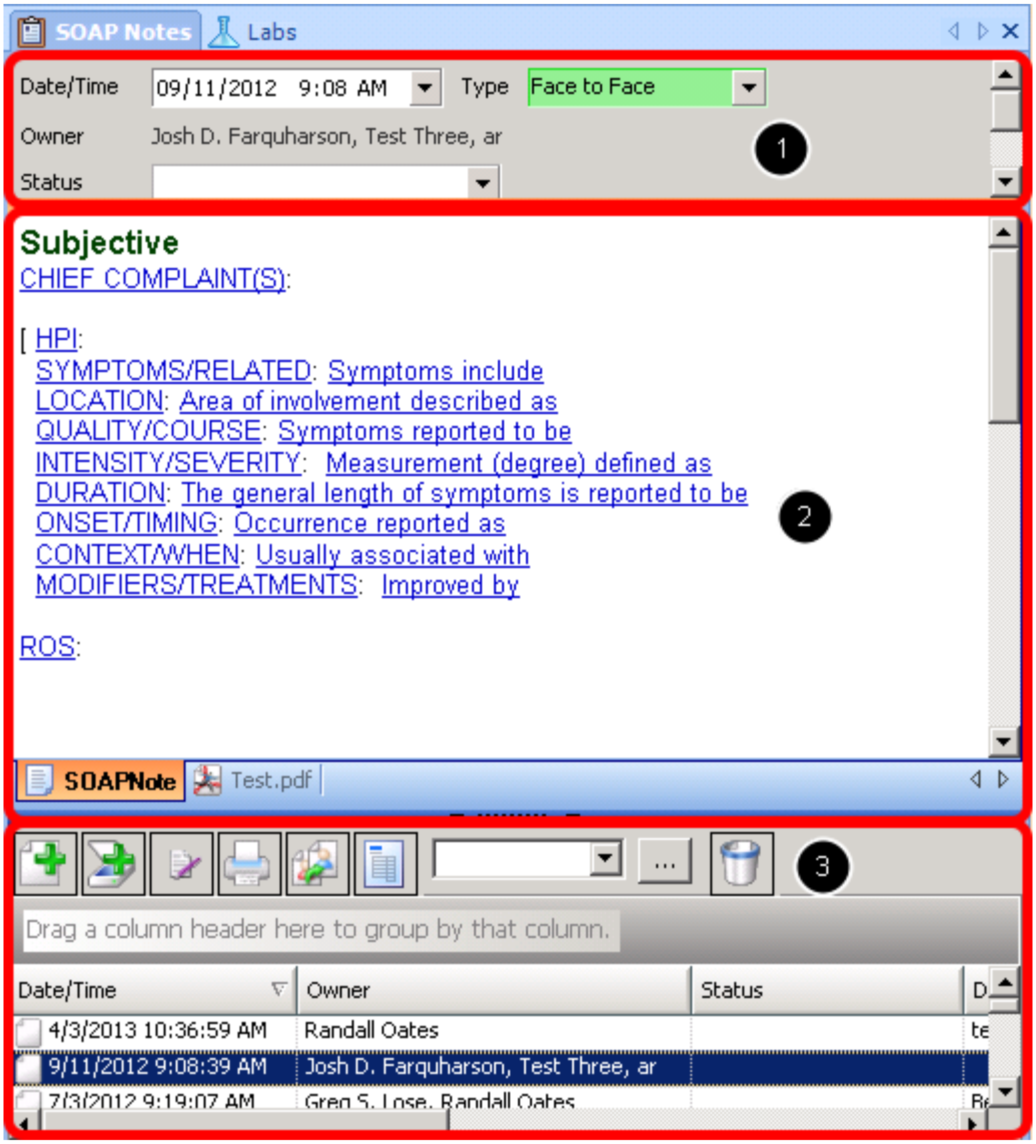
Docutainers

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.

Functionality



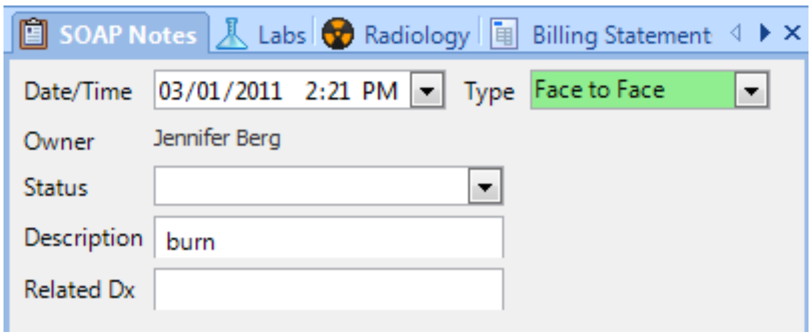
Although the exact functionality of a docutainer varies depending on the specific type and purpose, the one thing all docutainers have in common is that they act as containers and managers for documents.

Most Docutainers consist of three parts:

1. Adocument info sliding panel at the top
2. Adocument list sliding panel at the bottom
3. Adocument 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.

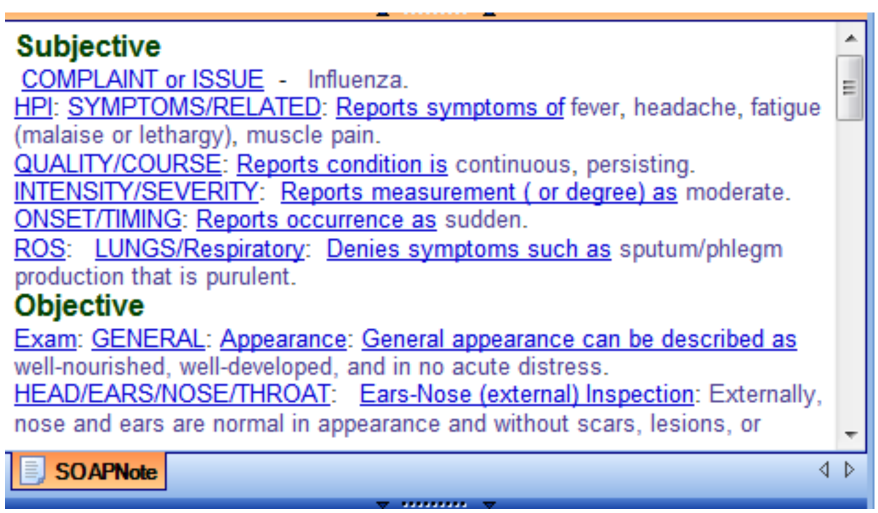
Document Info Panel



The document demographic panel displays information about the specific document that is currently open. It appears as a bar at the top of the Docutainer.

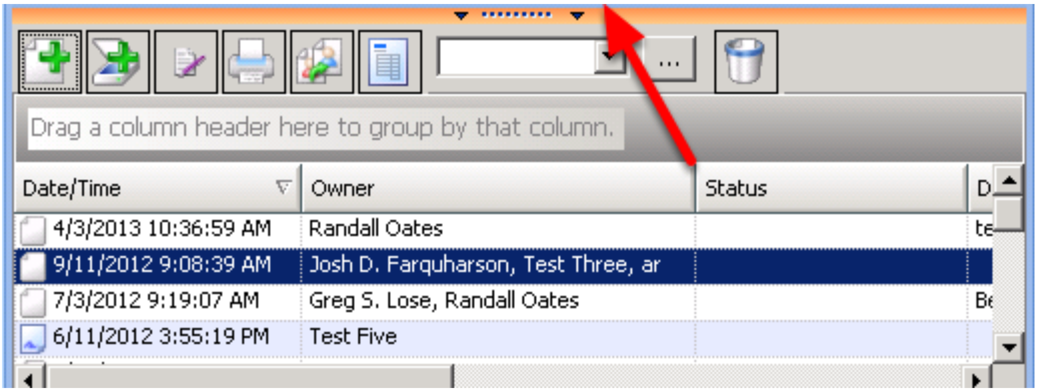
Pointing the cursor at the bar will cause it to expand, and Clicking the pin will lock it in the open position. The information displayed depends upon the specific document type. (For details, refer to the documentation for the specific type of document.)

Document Viewer



The 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



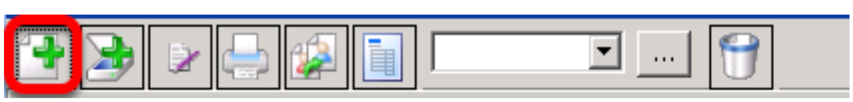
The document list panel displays a list of documents along with some basic document details. This list is used to select and display document details, the document list panel appears as a bar at the bottom of the Docutainers, with the name of the document type.

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

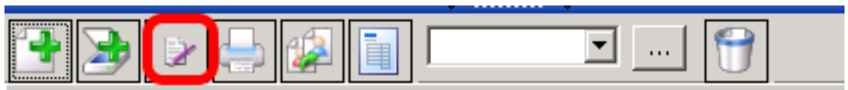
Above the docutainer list is a set of action buttons in a mini-toolbar.

Create Document



The button highlighted above is used to add a new docutainer of the current type (chart section).

Sign Documents

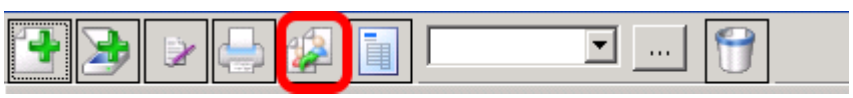


Used to sign one or more selected docutainers from the list. The user can select multiple docutainers by holding down the control or shift key while Clicking on docutainers in the list.

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.

Remove Documents

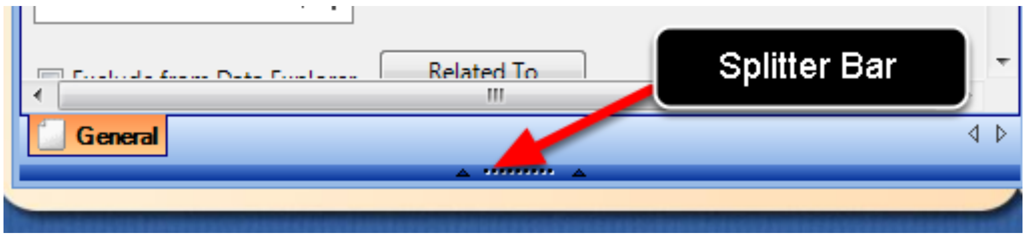
Used to remove one or more selected docutainers from the list or current docutainer. The user can select multiple docutainers by holding down the control or shift key while Clicking on docutainers in the list.

****Note:*** *Only unsigned docutainers may be removed.*

Splitter Bars

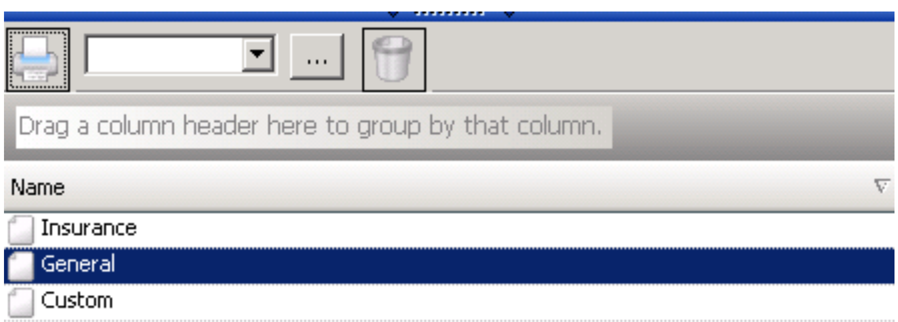
Splitter Bars are blue bars with arrows and dots in the center of them. When clicked on, they will collapse or expand to display more information, buttons, document lists, etc. They are also designed where the user can click on them to resize them.

Lower Splitter Bar



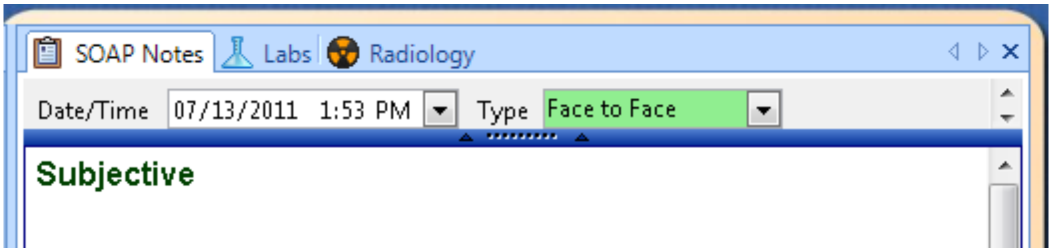
In the image above, we are looking at the lower splitter bar at the bottom of the Demographics chart section. Notice that the arrows in the center of the splitter bar are pointed upwards. This is a visual indicator that when we left click on the splitter bar, the bar will move upwards, and will display hidden features. See image below.

Change Docutainer View



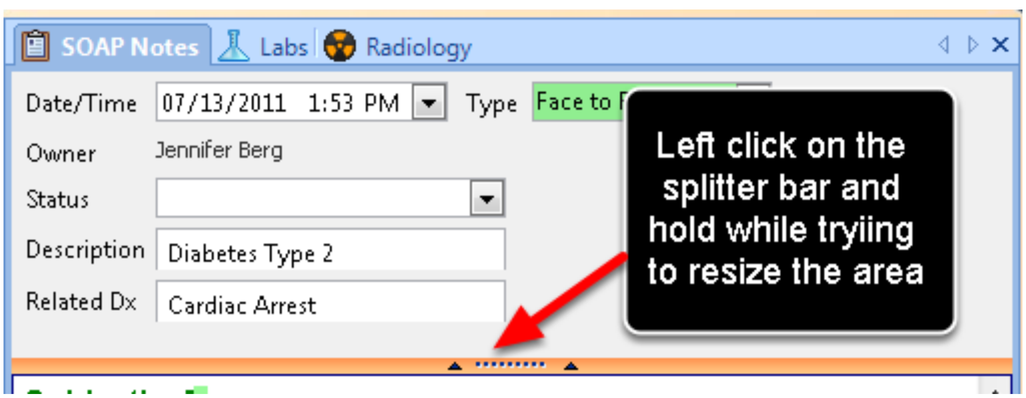
We are now able to change the Demographics view from "General" to "Insurance" or "Custom", and can even print out Demographics. Notice that the arrows on the lower splitter bar are now pointed down. This is a visual indicator that when we left click on the splitter bar, the bar will collapse back down.

Upper Splitter Bar



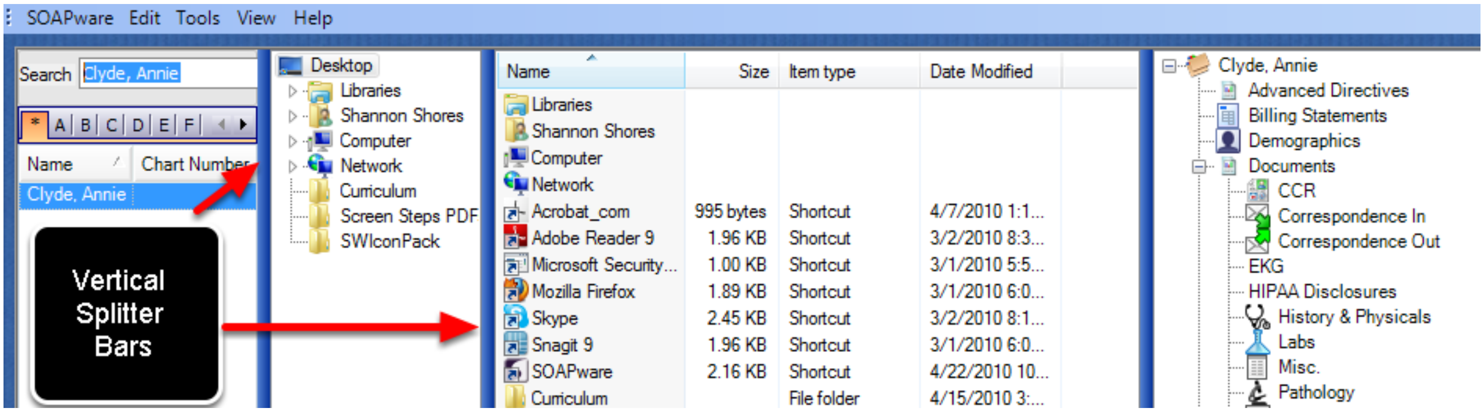
The above image displays an upper splitter bar in the SOAPnotes chart section. Currently, we are able to view the date and time this encounter note was created. If we left click once on the splitter bar, the splitter bar will move upwards and hide this information. If we left click on the splitter bar and drag our mouse down, we will resize the area and be able to view more document/doctainer 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

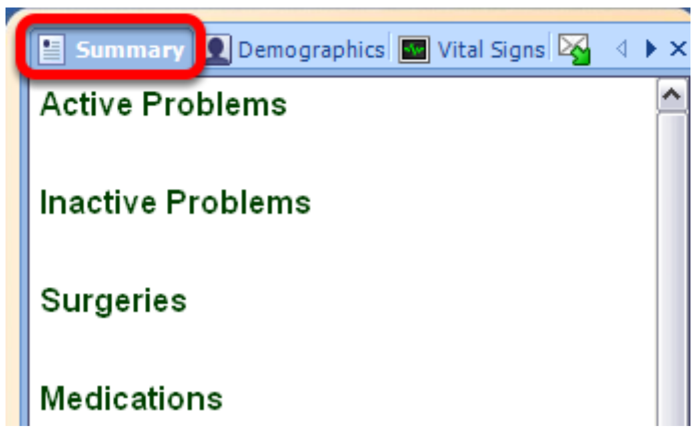
Intro to Summary

***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:

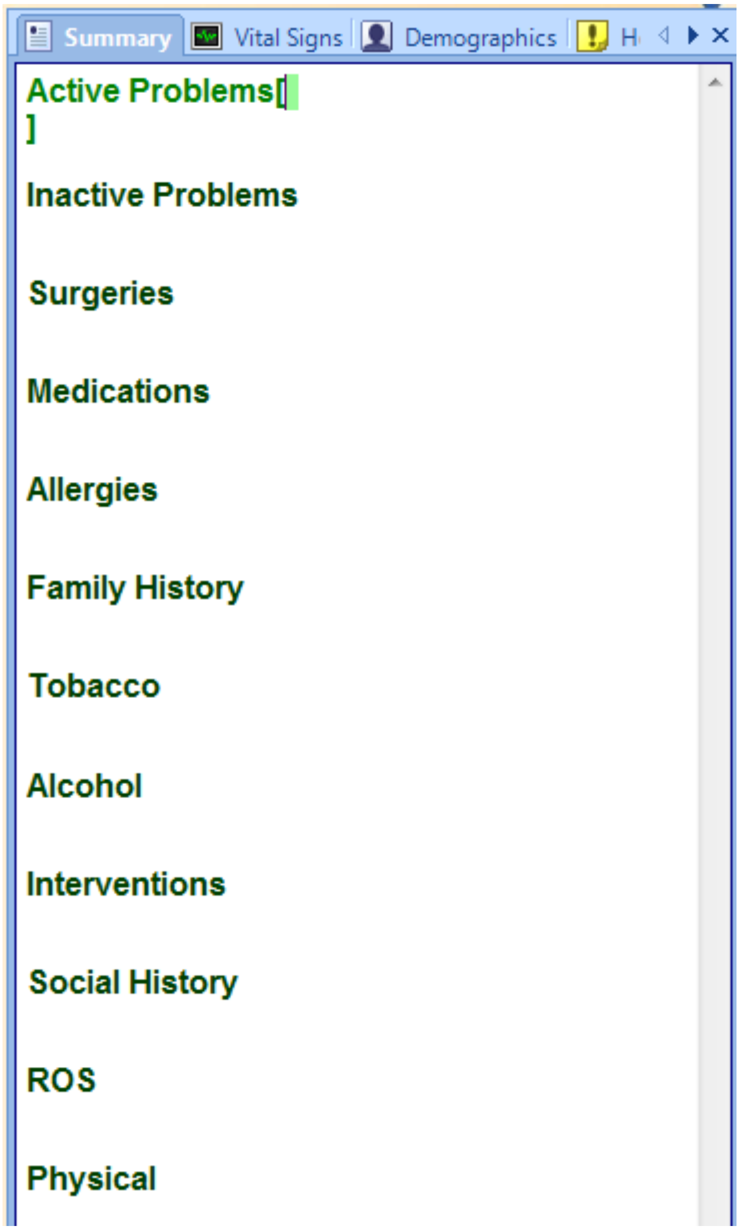
* **Active Problems:** Current or active medical problems.
* **Inactive Problems:** Previous or inactive medical problems.
* **Surgeries:** List of surgeries and/or procedures.
* **Medications:** Current or active medications.
* **Allergies:** List of drug and non-drug allergies.
* **Family History:** 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.
* **ROS:** Stores a review of systems related to the various organ systems.
* **Physical:** Stores a physical examination for easy retrieval.

* **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 SMARText Item appropriate for each field. Meaningful Use requires that the involved fields have structured data recorded. Please see: Using No Known SMARText 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.

Default Summary Fields

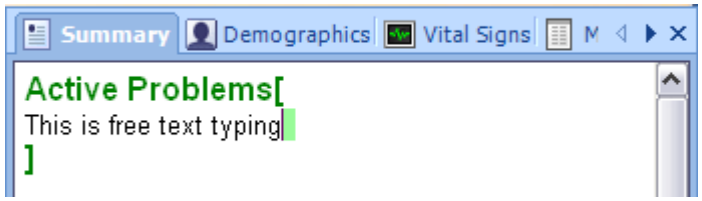


Summary Documentation

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.

TIP: Docking SMARText Quick Access

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

This lesson will demonstrate how to document in the Summary Active Problems field.

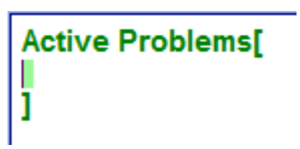
***REQUIRED FOR MEANINGFUL USE:**
- Maintain Problem List
- Patient Lists

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 used to record an up-to-date problem list of current and active diagnoses for the patient.

Placing of the Insertion Point

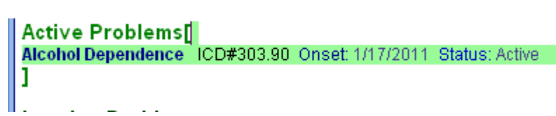


With a patient chart open and the Summary chart section visible:

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.

Entering a Problem Using Shortcut Codes

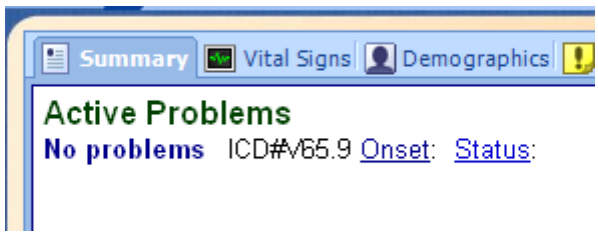


To enter a diagnosis using a SMARText Shortcut Code, type the diagnosis shortcut code and then press the space bar (example: type "AlcDep", then press the spacebar to insert *Alcohol Dependence ICD#303.90*).

Regarding Shortcut Codes:

1. A SMARText item can only have one Shortcut Code.
2. Not all SMARText items have Shortcuts Codes.
3. Users can add, change and customize all SMARText Shortcut Codes.

Recording "No Problems"

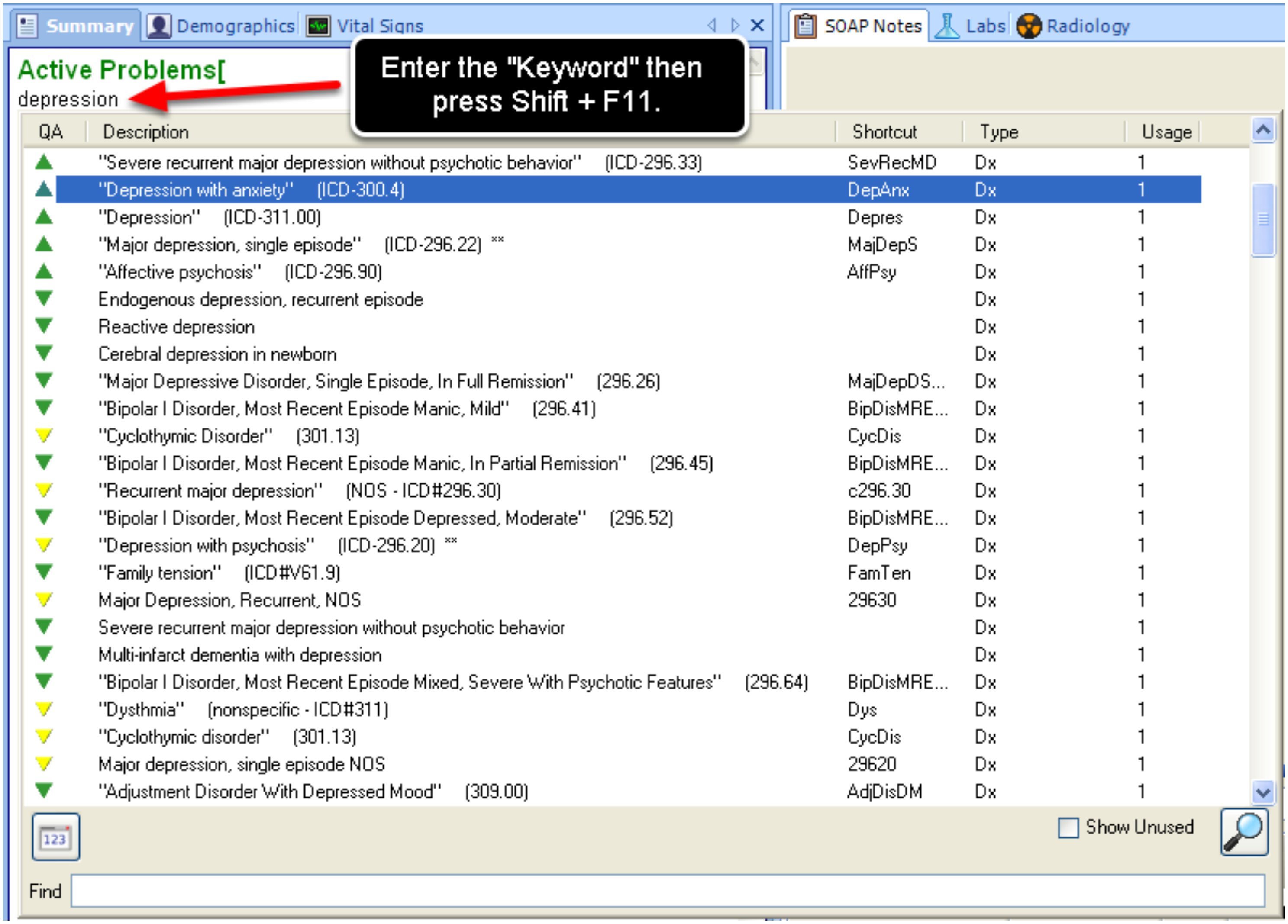


When a patient has a negative history for Active Problems, documentation must be entered as structured data by using the SMARText Item for "No Problems".

Type the shortcut code "NoPro" into the Active Problems field and the hit the space bar. This will expand into the SMARText item that is required to record that there are no current or active diagnoses for the patient.

Note: SOAPware users from older versions 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 Diagnosis Using Keywords



To search for a SMARText diagnosis item by using a one word keyword, type the keyword into the Active Problems field (ex: "depression") and then press the Shift + F11 keys on the keyboard. 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.

***Note:** Shift + F11 and F11 searches can only be performed on one word at a time. For example, if you are searching for Chronic Pain, perform your Shift + F11 or F11 search on either "chronic" or* *"pain". You can then filter your results if needed.*

Regarding Keywords:

1. 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.

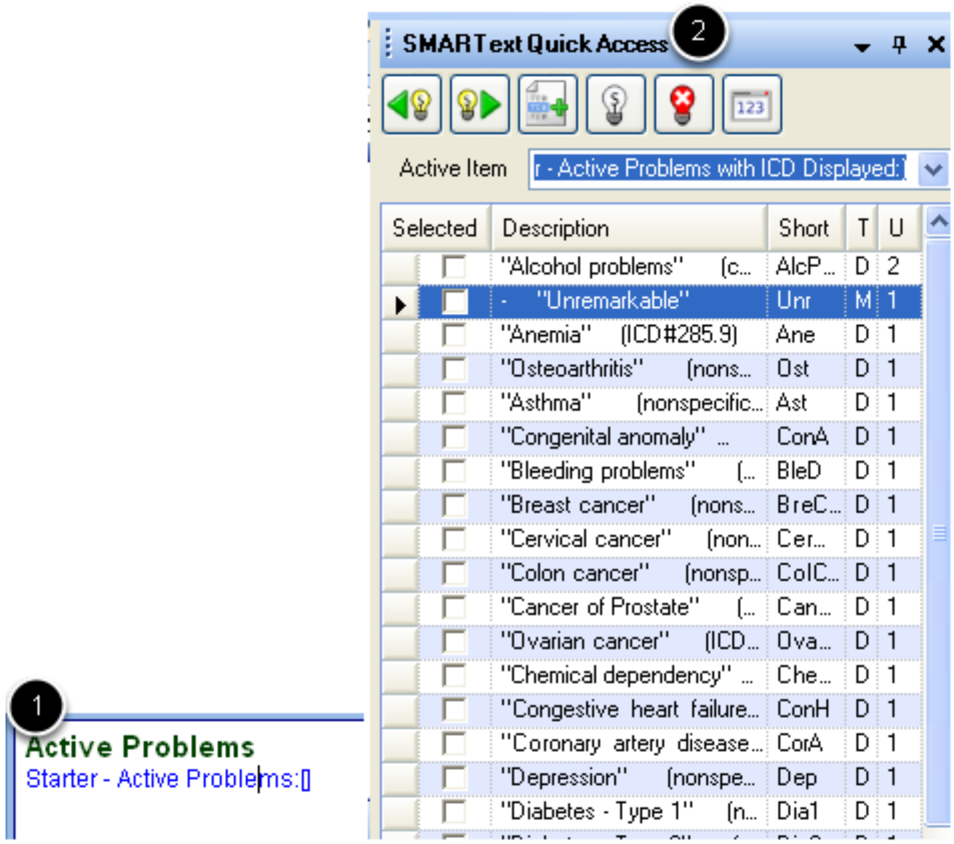
Entering a Diagnosis using a Starter Pick List

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.*

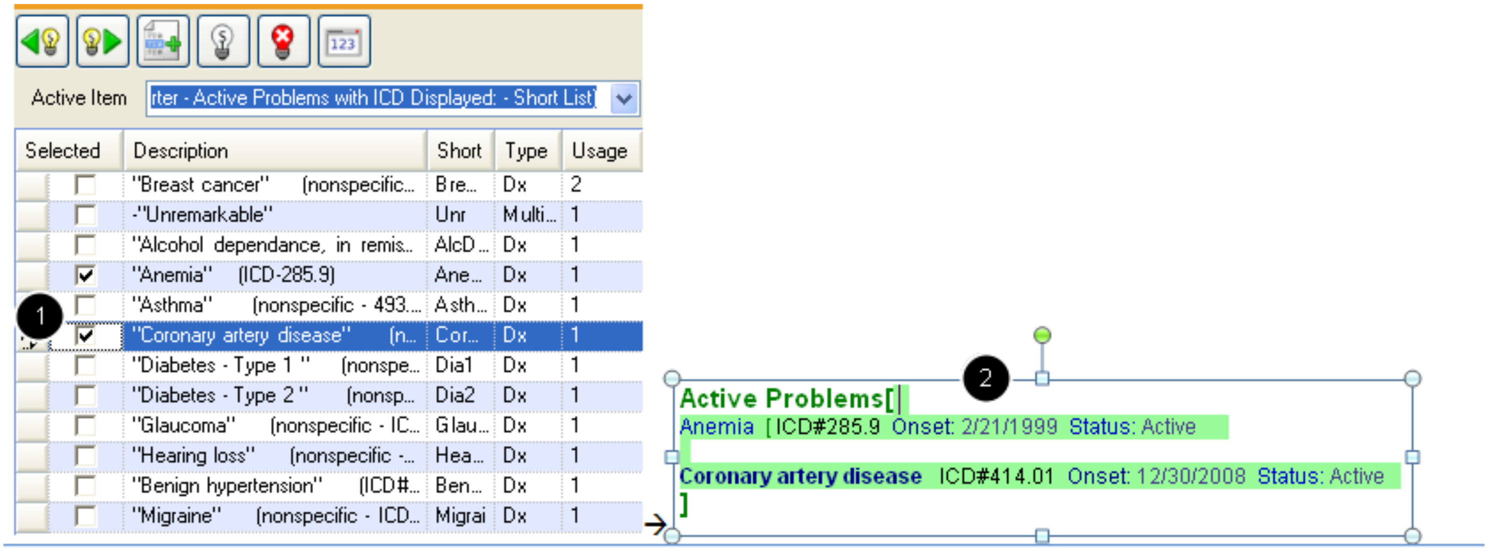
Accessing the Active Problems Pick List



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 - Active Problems)
2. A list of diagnosis items will appear in the SMARText Quick Access window.

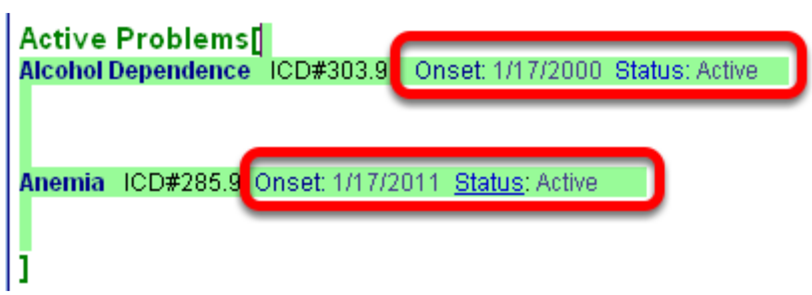
Choosing Items from the Active Problems Pick List



With the Active Problems pick list displayed in the SMARText Quick Access window:

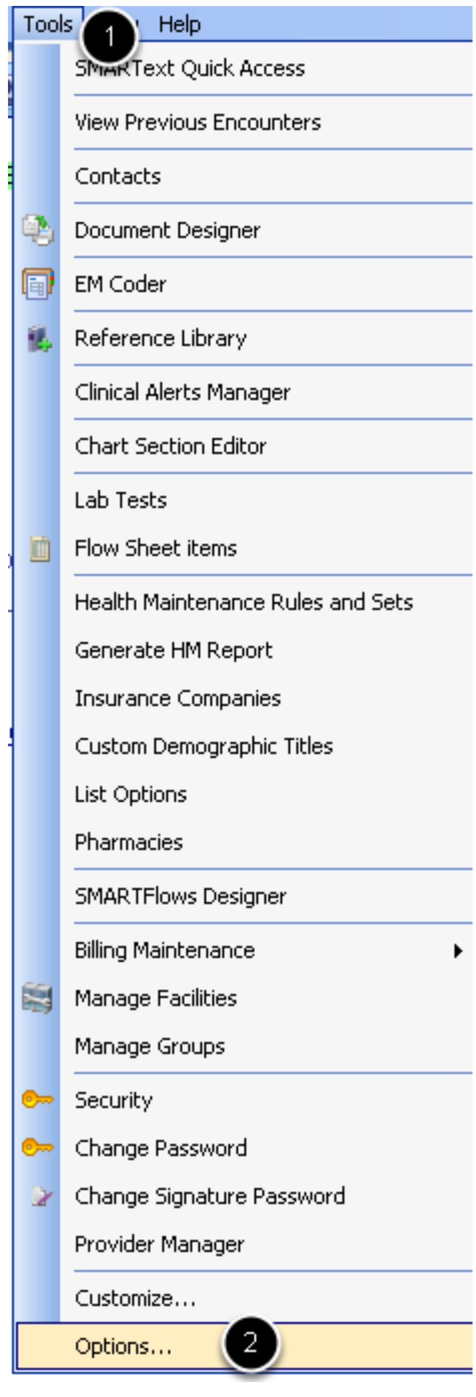
1. Users should Click in the box in the "Selected" column next to each of the items that he/she wants to insert into the Active Problems field.
2. When the items are inserted, the Starter Active Problems header will disappear.

Optional Sub Items



In SOAPware 2011+, the user can now use some new sub-items to assist with maintaining the Active Problems list. The Onset and Status sub-items are optional for the user.

Setting Default Sub Items: Tools > Options

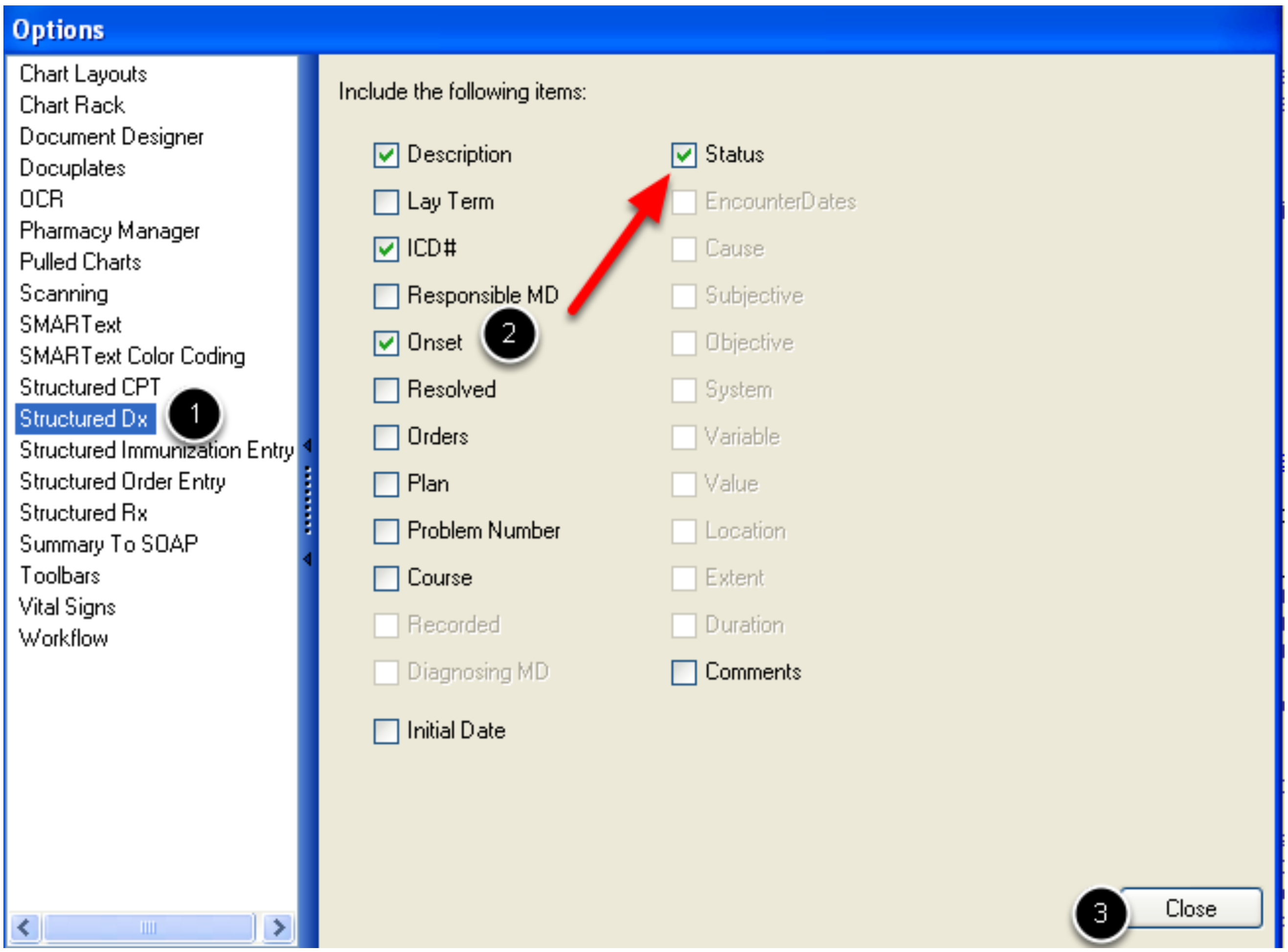


If a user wishes to utilize any of the optional sub-items within the Active Problems list, the desired sub-items must be defined in the users Options.

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

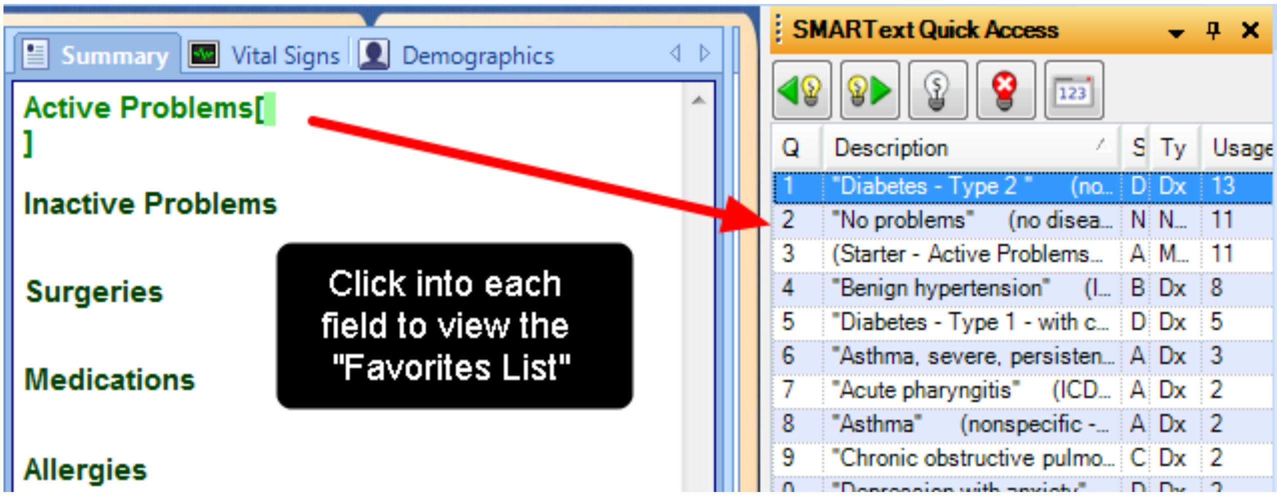
SOAPware will then require the user to log out and log back in to save the changes. Once the user has logged back in, the newly selected sub-items will now appear by default each time a

SMARText diagnosis item is entered.

This is a user-specific setting.

SOAPware Learns Users' Preferences

Building a SOAPware Favorite's List



SOAPware users will notice that over time, SOAPware continuously builds a "Favorites List" for the user within each Summary and SOAPnote field. The "Favorites List" is specific to the User that is logged into SOAPware. When the user clicks into a specific field in the Summary or SOAPnote sections of the chart, their "Favorites List" will be displayed within the SMARText Quick Access window.

SOAPware will track usage of each SMARText Item by the user and SOAPware also automatically ranks the SMARText items in the list accordingly (most used is displayed towards the top of the list).

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 document in the Summary Inactive Problems field.

Summary Inactive Problems Field

The Inactive Problems field in the Summary is used to record all of the patients inactive or resolved diagnoses.

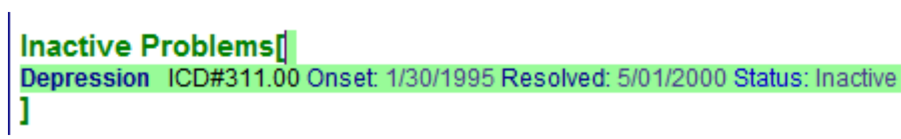
Placing of the Insertion Point

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.

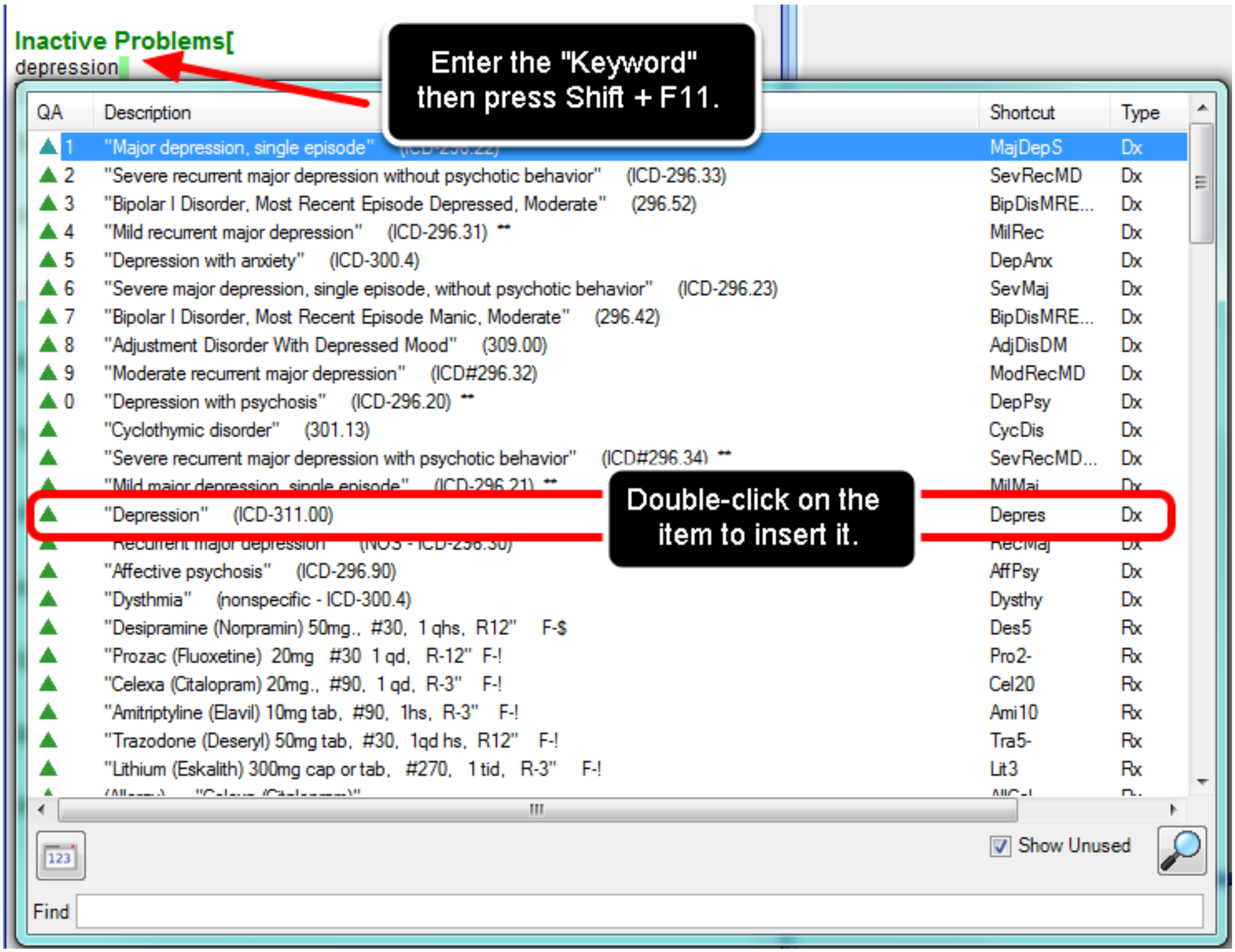
If the bold green brackets appear (as shown above), then the field is active and ok to begin entering data.

Entering an Inactive Problem Using Shortcut Codes



To enter a diagnosis using a SMARText Shortcut Code, type the diagnosis shortcut code and then press the space bar (example: type "Depres", then press the spacebar to insert *Depression ICD#311.00*).

Entering a Diagnosis Using Keywords (Shift + F11 or F11 Searches)

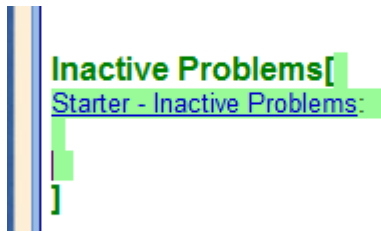


To search for a SMARText diagnosis item by using a one word keyword, type the keyword into the Inactive Problems field (ex: "depression") and then press the Shift + F11 keys on the keyboard. The Shift + F11 search will allow the user to view list of diagnosis items that are located on the local library 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 Inactive Problems field.

****Note:** Shift + F11 and F11 searches can only be performed on one word at a time. For example, if you are searching for Chronic Pain, perform your Shift + F11 or F11 search on either "chronic" or "pain". You can then filter your results if needed.*

Entering a Diagnosis using a Starter Pick List



The Inactive Problems starter pick list contains a list of some of the most common diagnosis items.

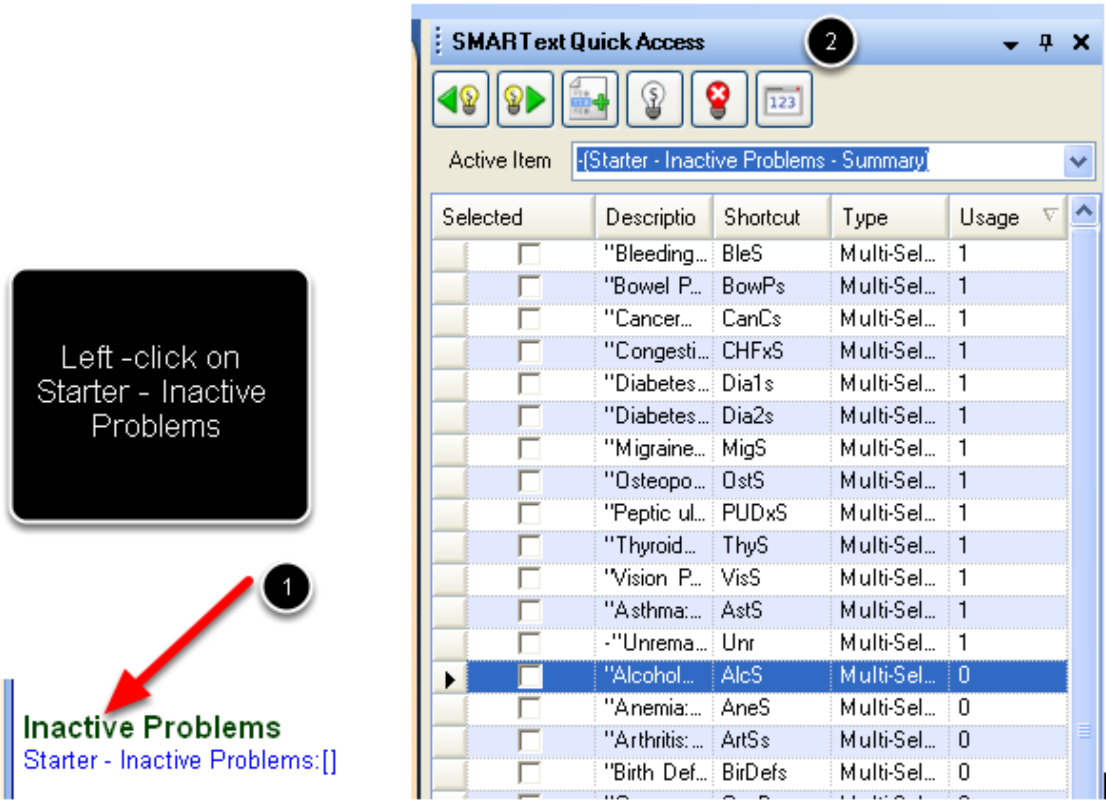
To insert the Starter Pick List for the Inactive Problems, type the shortcut code **"ina-"** into the Inactive Problems field then press the spacebar.

The Active Problems pick list may also be used within this field if the users wishes for the ICD9 code to be inserted along with the diagnosis. To insert the Starter Pick List for Active Problems, type the shortcut code **"act+"** then press the spacebar to expand the pick list.

***Note:** The first time this pick list is used, it must be downloaded from the SOAPware Online Library. To download the pick list, Type "ina-" into the Inactive 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.*

See this link for searching instructions: SMARText Data Entry Methods.

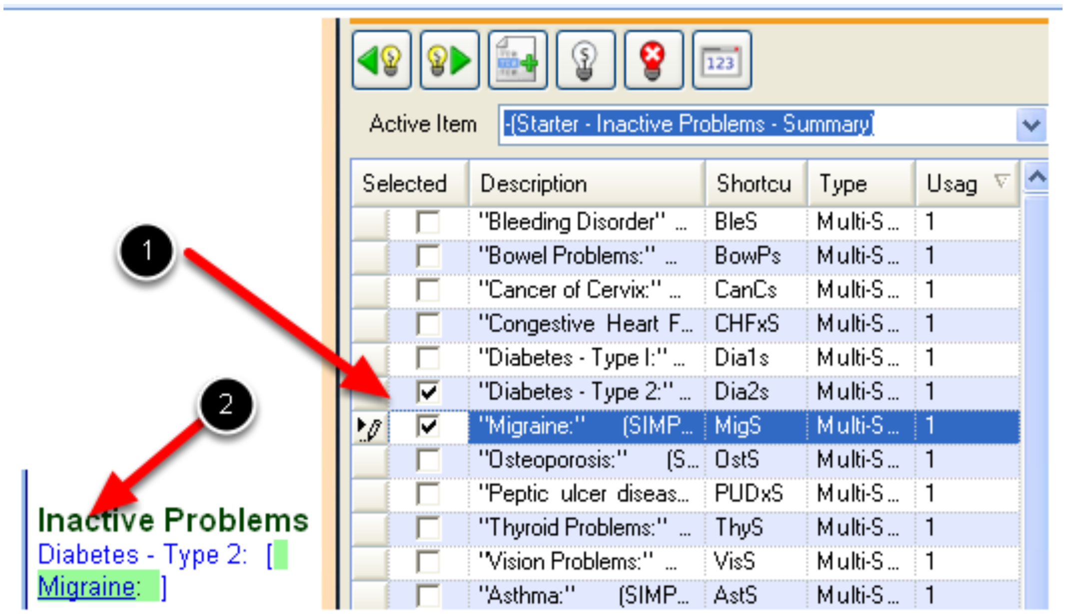
Accessing the Inactive Problems Pick List



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

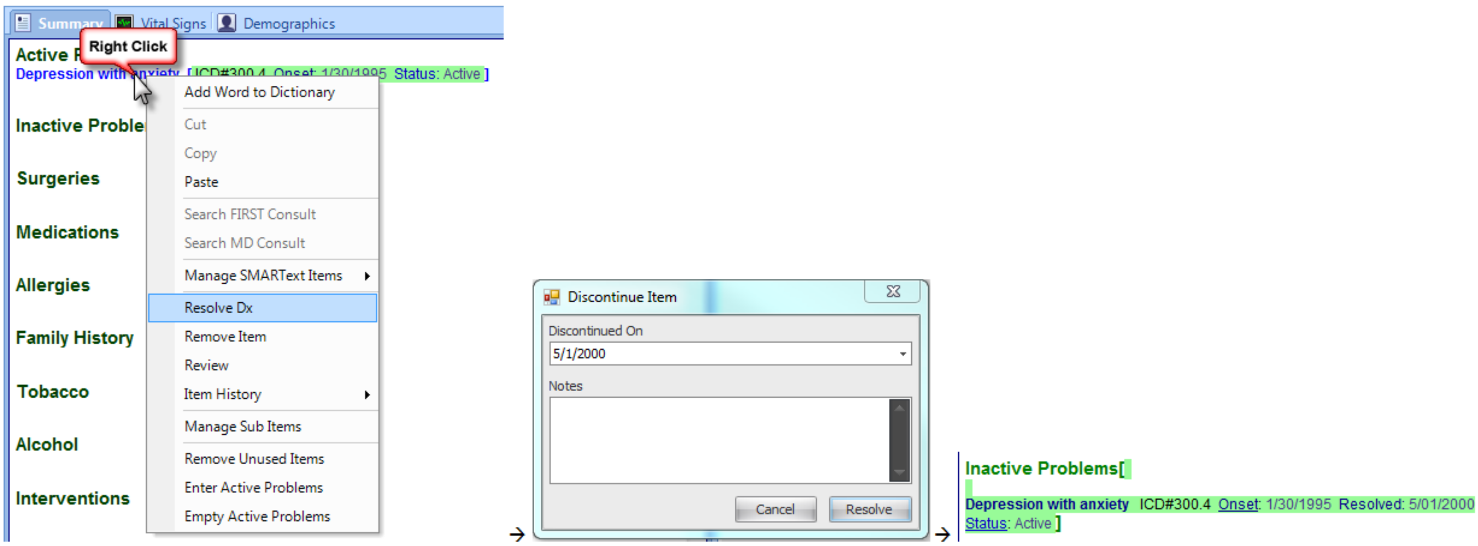
Choosing Items from the Inactive Problems Pick List



With the Inactive Problems pick list displayed in the SMARText 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.

Resolving an Active Diagnosis



In SOAPware 2011+, users can select a menu item to Resolve an Active Problem diagnosis.

1. Right click on the diagnosis within the Active Problems field
2. Select "Resolve Dx"
3. Enter the Resolved Date and any Notes to be associated with the Dx
4. Click the Resolve button

Once the above steps are taken with the diagnosis, it will be automatically moved from the Active Problems field to the Inactive Problems field.

***Note:** SMARText diagnosis can also be Cut & Pasted from the Active Problems field to the Inactive Problems field instead of using the above method, if desired.*

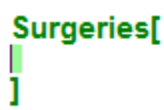
Surgeries

This lesson will demonstrate how to document in the Summary Surgeries field.

Summary Surgeries Field

The Surgeries field in the Summary is used to record all of the patients past surgical and procedural history.

Placing of the Insertion Point

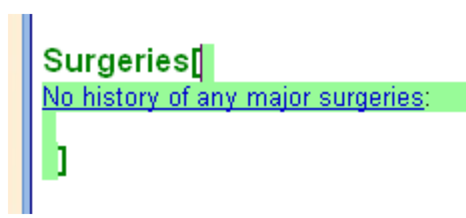


With a patient chart open and the Summary chart section visible:

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.

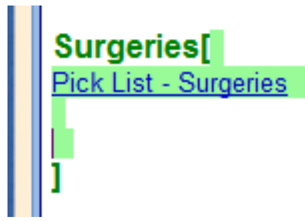
Recording "No history of any major surgeries" for a Patient



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 SMARText Item Types in the Summary]

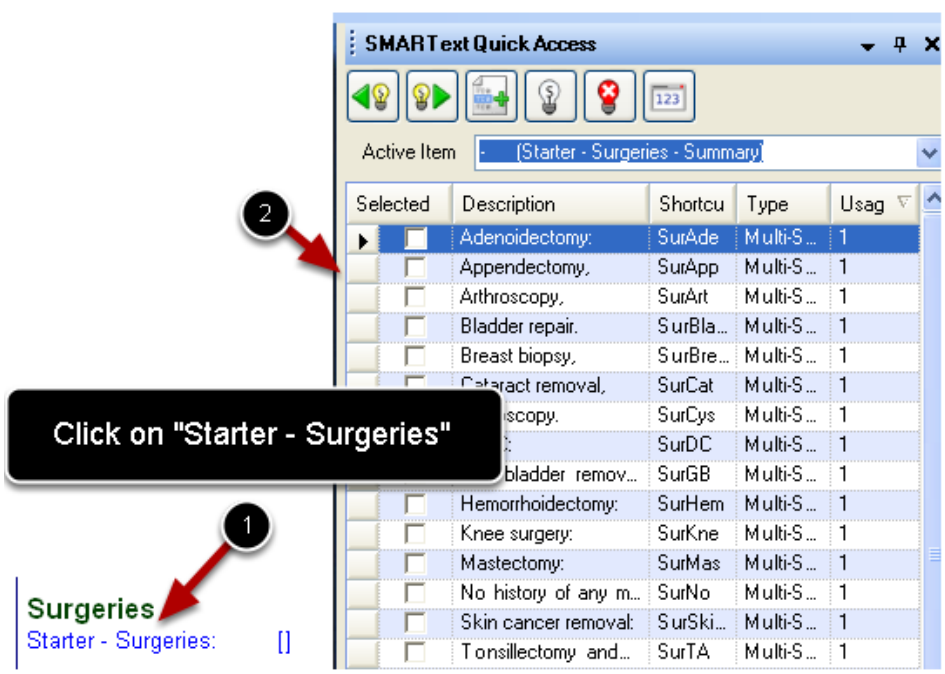
Entering Surgeries using a Starter Pick List



To enter the Starter pick list for Surgeries, type the shortcut **"sur-"** into the Surgeries 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 "sur-" into the Surgeries 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.*

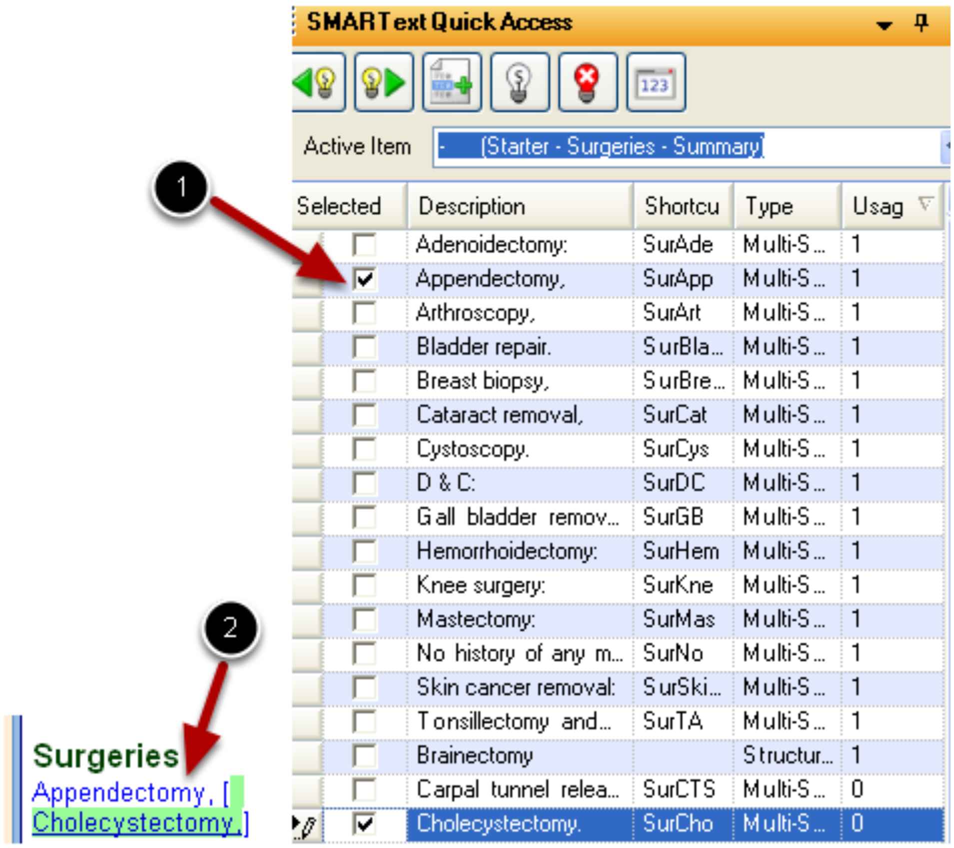
Accessing the Surgeries Pick List



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 - Surgeries)
2. A list of items will appear in the SMARText Quick Access Dialog

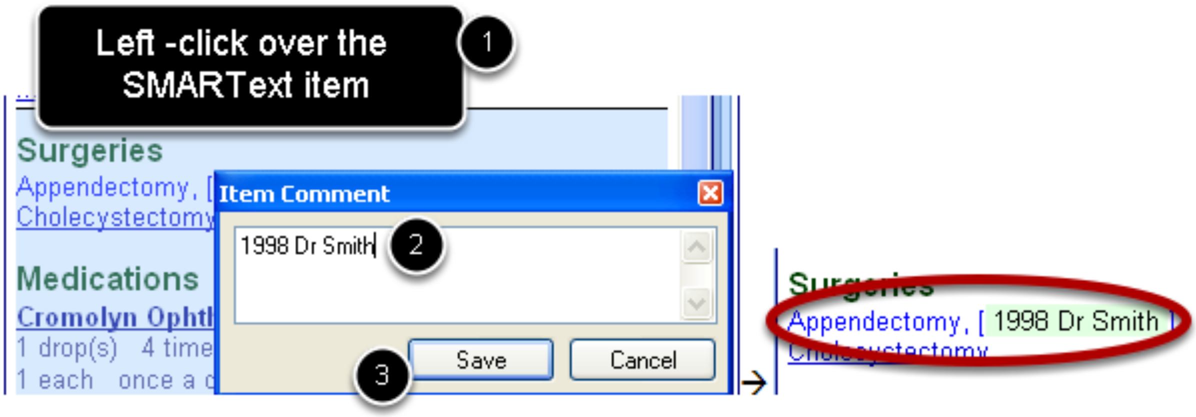
Choosing Items from the Starter Surgeries Pick List



With the Surgery pick list displayed in the SMARText Quick Access Dialog, check in the box in the "Selected" column to insert the item into 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 SMARText item:

1. Left-click on top of the SMARText 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 document in the Summary Medications field.

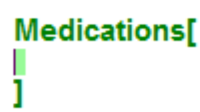
***REQUIRED FOR MEANINGFUL USE:**
- Active Medication List
- CPOE for Medication Orders
- Medication Reconciliation

Meaningful Use Dashboard
This measure is tracked within the Patient Meaningful Use Dashboard and the Meaningful Use Dashboard workspace.

Summary Medications Field

The Medications field in the Summary is used to record an active medication list for the patient.

Placing of the Insertion Point

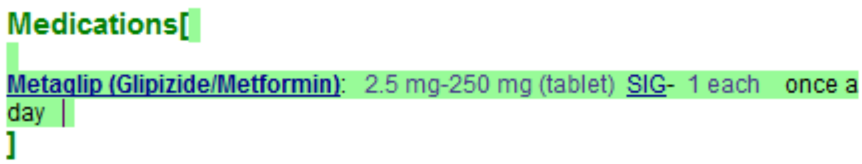


With a patient chart open and the Summary chart section visible:

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.

Entering a Medication Using Shortcut Codes



To enter data into the Medications field, Click next to or just below the Medications field header in the Summary.

To enter a medication using a SMARText Shortcut Code, type the medication shortcut code and then press the space bar (example: type "Met2", then press the spacebar to insert *Metaglip 2.5mg-250mg tablet*).

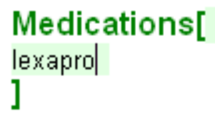
Recording "Current Meds: None"

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.

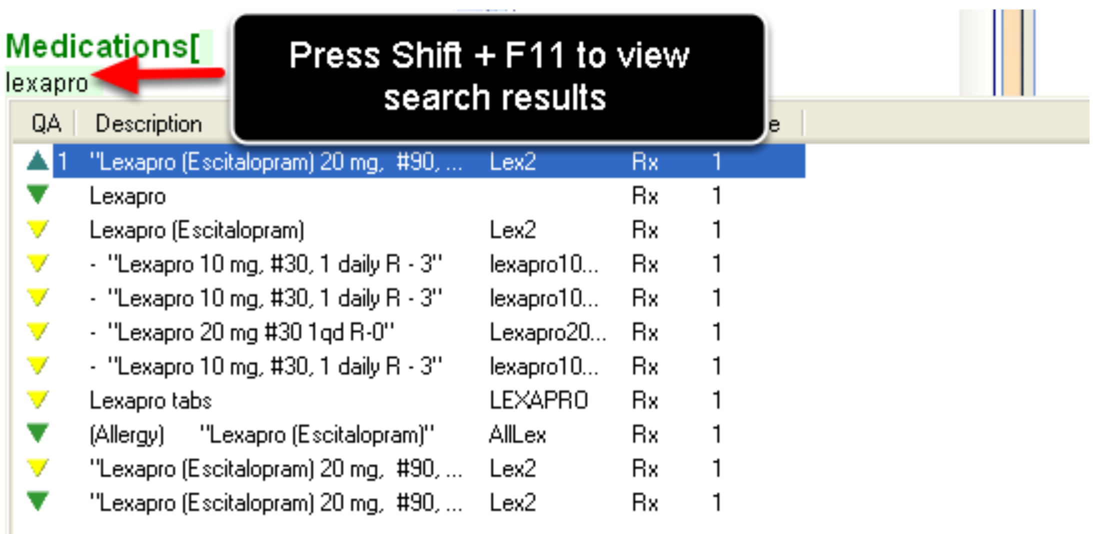
***Note**: Users will need to re-download the "NoMeds" SMARText Item for use within SOAPware. For instructions on re-downloading this item, please see: Using No Known SMARText Item Types in the Summary.

Entering a Medication Using Keywords



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).

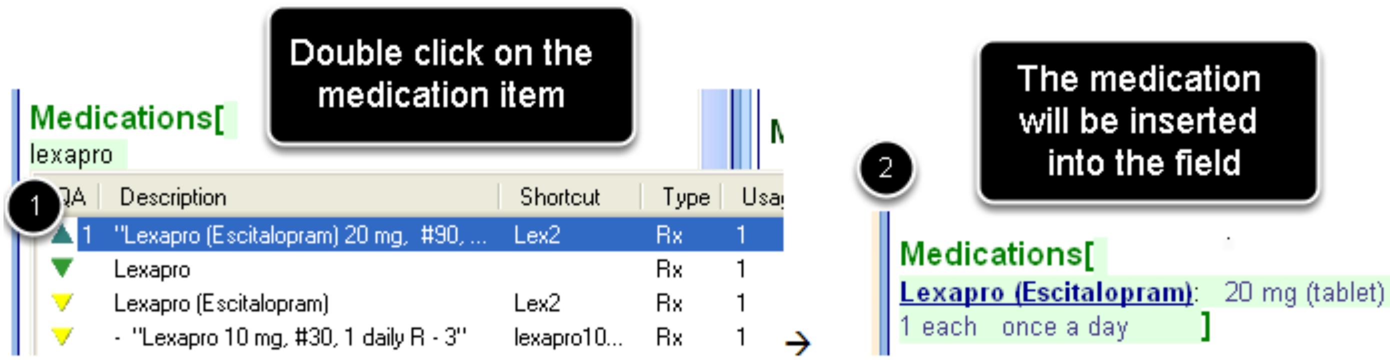
Conducting a Shift + F11 Search to Enter a Medication



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. Asearch results dialog box will be displayed (as shown above).

Inserting the Medication



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.

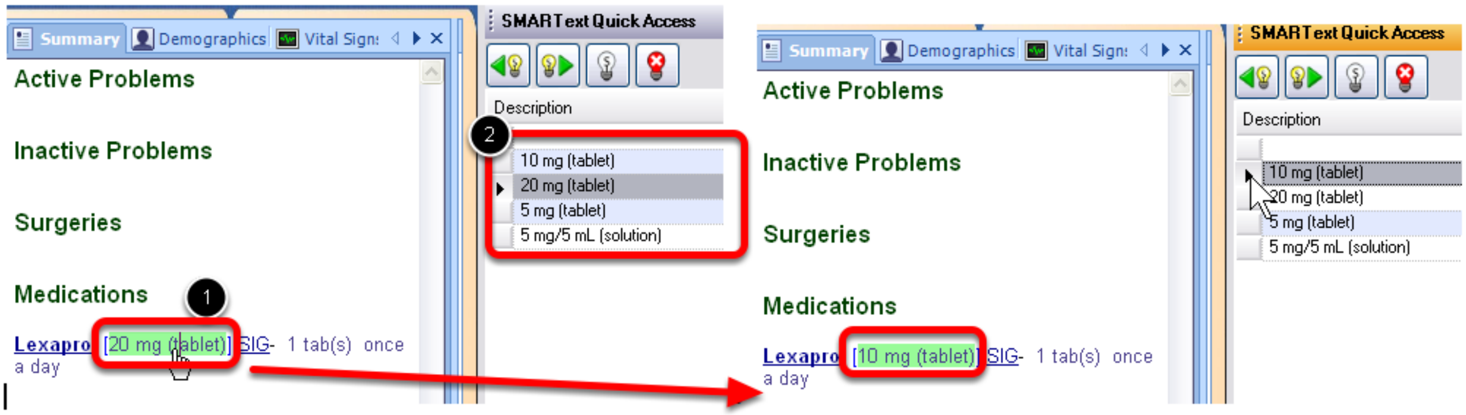
Medication Sub-Items

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



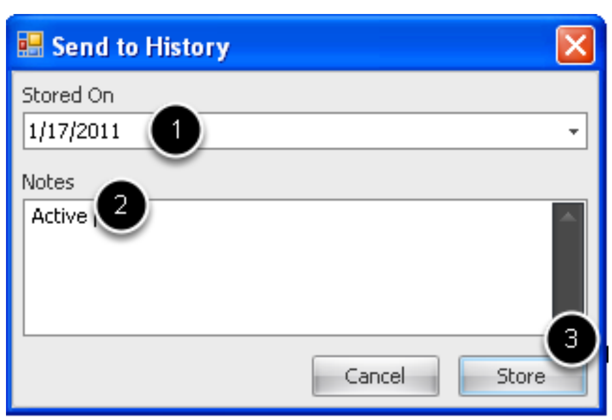
To change or edit a sub-item of a medication:

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

Sending a Summary Medication to the Rx Manager History

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

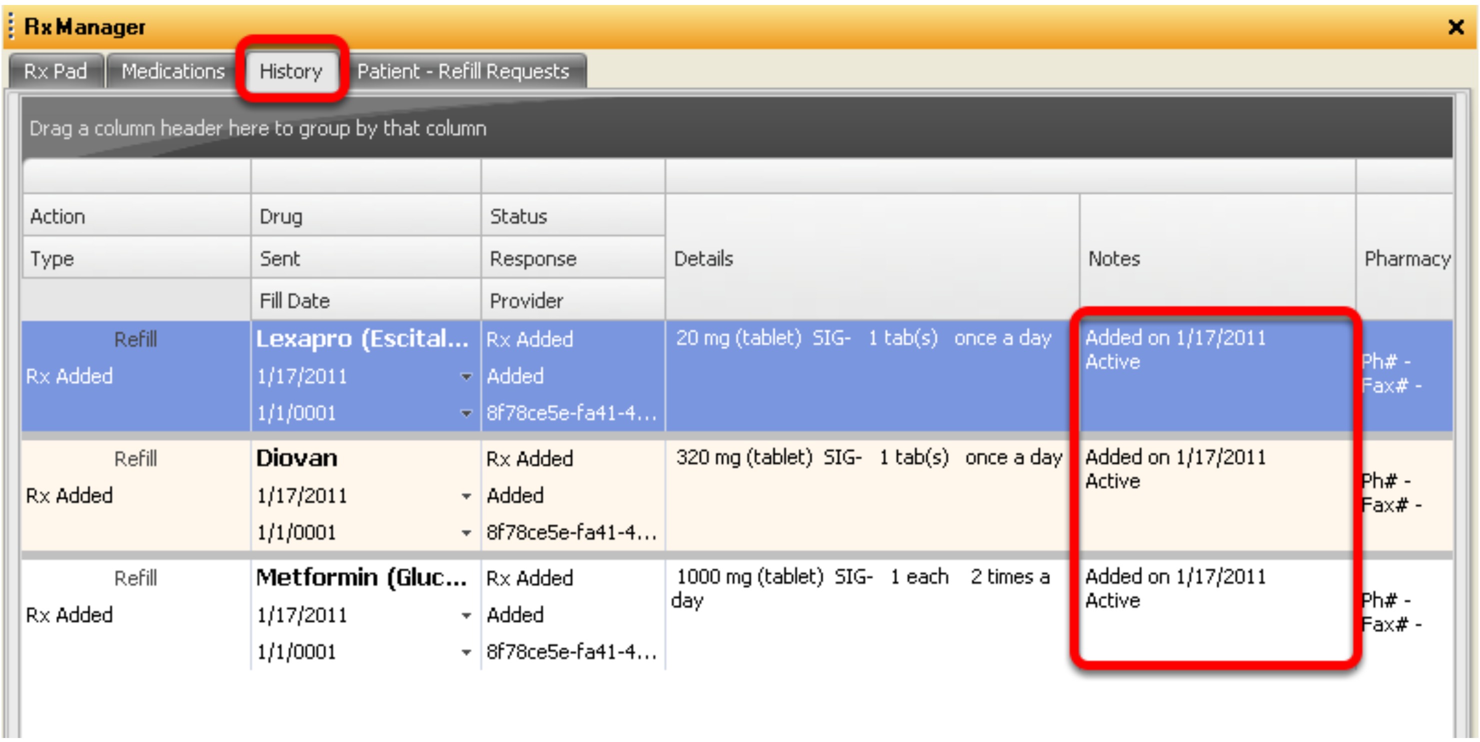


Send to History Date & Notes window:

1. Today's date will be defaulted for "Stored On"

2. Type "Active" in the notes area
3. Click Store

Viewing the Medication History



Press F8 on the keyboard to open the Rx Manager. Within the Rx Manager, on the History tab, the stored medications will be displayed with the date stored.

Family History

This lesson will demonstrate how to document in the Summary Family History field.

Summary Family History Field

The Family History field in the Summary is used to record the patient's family medical history.

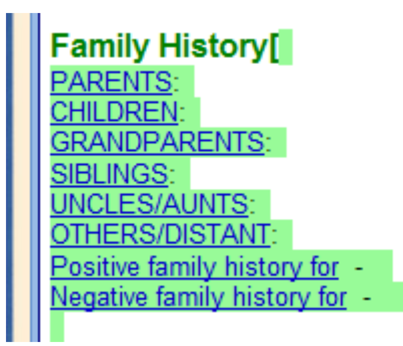
Placing of the Insertion Point

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.

Entering the Family History Pick List

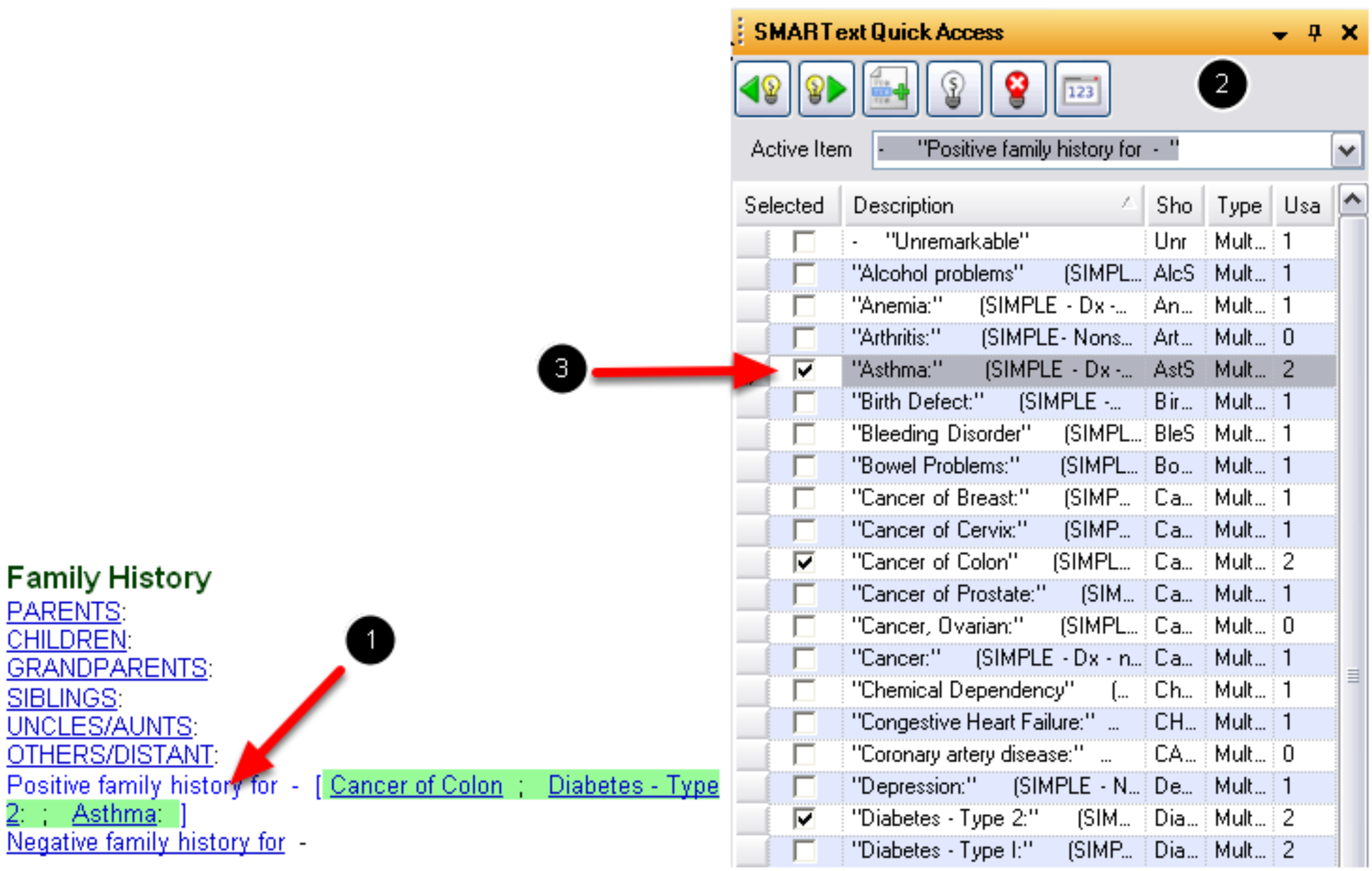


To enter the Starter Pick List for Family History, Type the shortcut code **"fam-"** into the Family History field then press the spacebar.

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.

Note: *The first time this pick list is used, it must be downloaded from the SOAPware Online Library. To download the pick list, Type "fam-" into the Family History 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.*

Choosing Items from the Family History Pick List



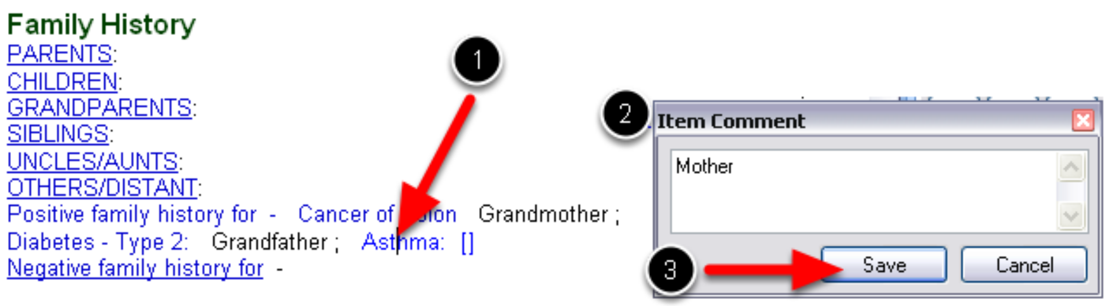
In SOAPware, text that appears Blue and Underlined indicates that a Pick List is attached to the SMARText Item.

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 SMARText 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 an Item Comment to Family History



To attach a free text comment to the SMARText item:

1. Left-click on top of the SMARText 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 SMARText item (see example above).

Tobacco

This lesson will demonstrate how to document in the Summary Tobacco field.

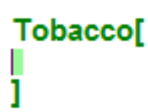
***THIS LESSON CONTAINS A MEANINGFUL USE (MU) CORE REQUIREMENT**
- Record Smoking Status

Patient Meaningful Use Dashboard:
This requirement will be tracked via the Patient Meaningful Use Dashboard

Summary Tobacco Field

The Tobacco field in the Summary is used to record the patient's past and present tobacco use history. This field is also used to record smoking status and tobacco cessation counseling for Meaningful Use.

Placing of the Insertion Point

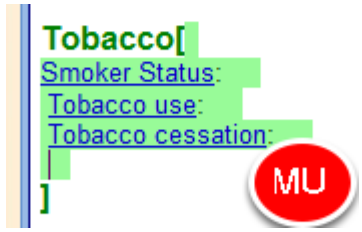


With a patient chart open and the Summary chart section visible:

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.

Recording Smoker Status and Tobacco Use & Cessation for Meaningful Use

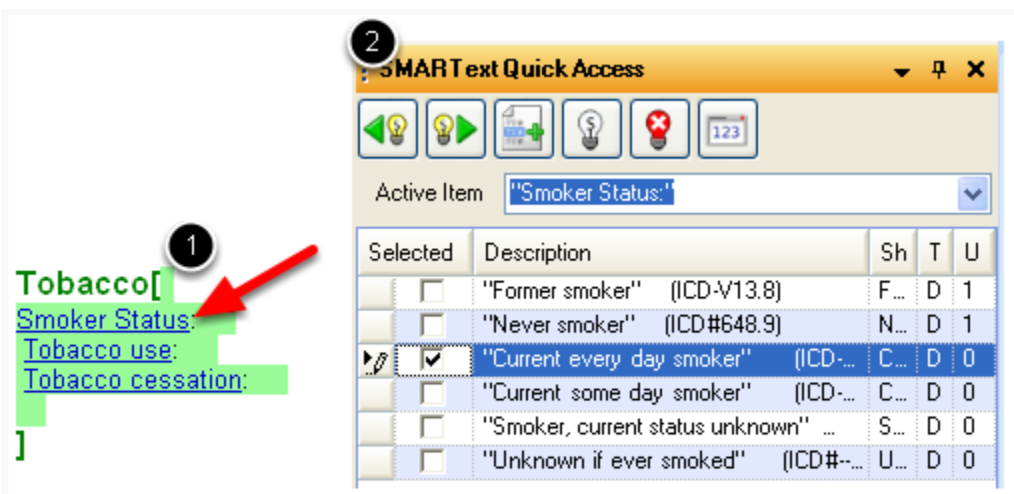


To enter the pick list for Tobacco, type **"tobmu"** into the Tobacco field then press the spacebar.

The Tobacco 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 a specific Clinical Quality Measures.

Note: *The first time this pick list is used, it must be downloaded from the SOAPware Online Library. To download the pick list, type "tobmu" into the Tobacco 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.*

Accessing the Tobacco Pick List



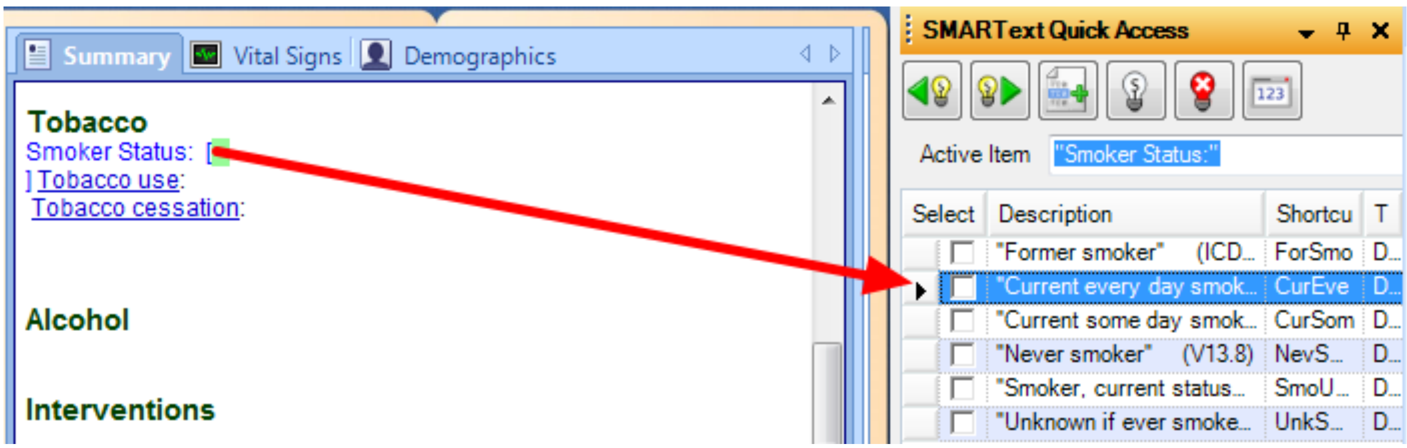
In SOAPware, text that appears Blue and Underlined indicates that a pick list is attached to the SMARText item.

1. Left click on the pick list header (ie: Smoker Status)

2. A list of items will appear in the SMARText Quick Access Dialog.

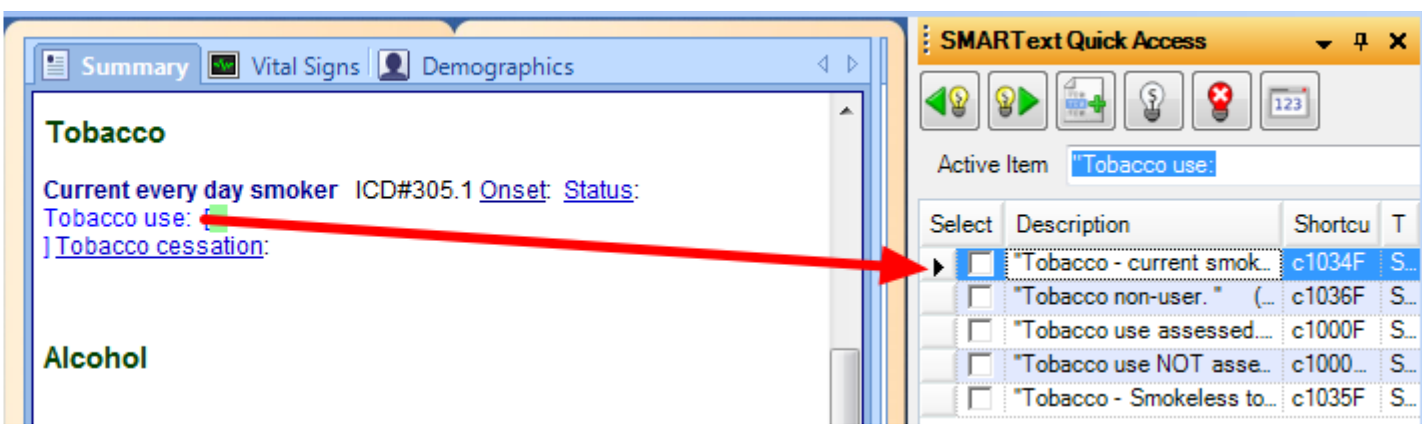
Left clicking on each pick list header seen above, will display a list of items in the SMARText Quick Access Dialog.

Choosing the Patient's Smoking Status



To insert the patient's smoking status for Meaningful Use, Click on the "Smoker Status" pick list header and select the appropriate response from the SMARText Quick Access list.

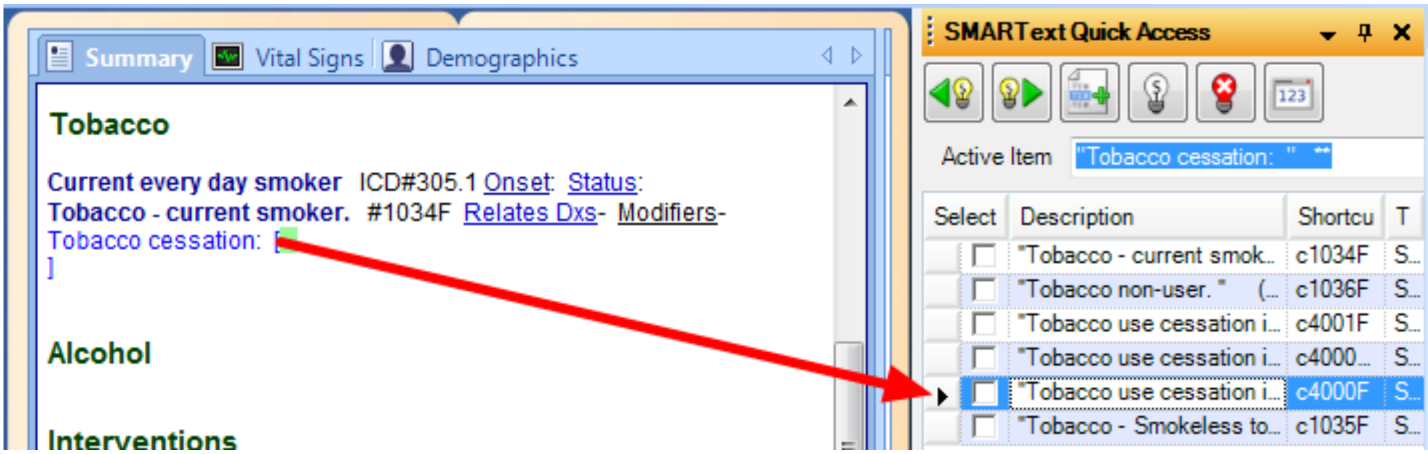
Choosing the Patient's Tobacco Use



To insert the patient's tobacco use to document for the Clinical Quality Measure NQF 0028a, Click on the "Tobacco use" pick list header and select the appropriate response from the SMARText Quick Access List.

Please click here to view the documentation workflow instructions for NQF 0028a.

Recording Tobacco Cessation Counseling



To record tobacco cessation to document for the Clinical Quality Measure NQF 0028b, Click on the "Tobacco cessation" pick list header and select the appropriate response from the SMARText Quick Access List.

Please click here to view the documentation workflow instructions for NQF 0028b.

Allergies (New Allergy Items Available in 2012)

This lesson will demonstrate how to document in the Summary Tobacco field.

***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

Summary Allergies Field

The Allergy field in the Summary is used to maintain an active allergy list for the patient.

New SMARText Type: Allergy

Shortcut	Description	Type
	(Allergy) Penicillin G Sodium	Allergy
	(Allergy) Penicillin G Potassium (obsolete)	Allergy
	(Allergy) Penicillin G Sodium (obsolete)	Allergy
	(Allergy) Penicillin V Potassium (obsolete)	Allergy
	(Allergy) Penicillin G Procaine	Allergy
	(Allergy) Penicillin G Sodium	Allergy
	(Allergy) Penicillin V Potassium	Allergy
	(Allergy) Penicillin G Potassium	Allergy
	(Allergy) Penicillins	Allergy
	(Allergy) Ester-Type Local Anesthetics	Allergy
	(Intolerance) Penicillins	Allergy

In SOAPware 2012, there is a new SMARText Item Type for drug allergies and intolerance called "Allergy". Users will now be able to insert allergy SMARText items in addition to the allergy categories.

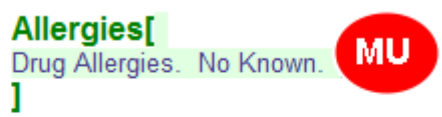
Placing of the Insertion Point

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.

Documenting "No Known Drug Allergies" in SMARText

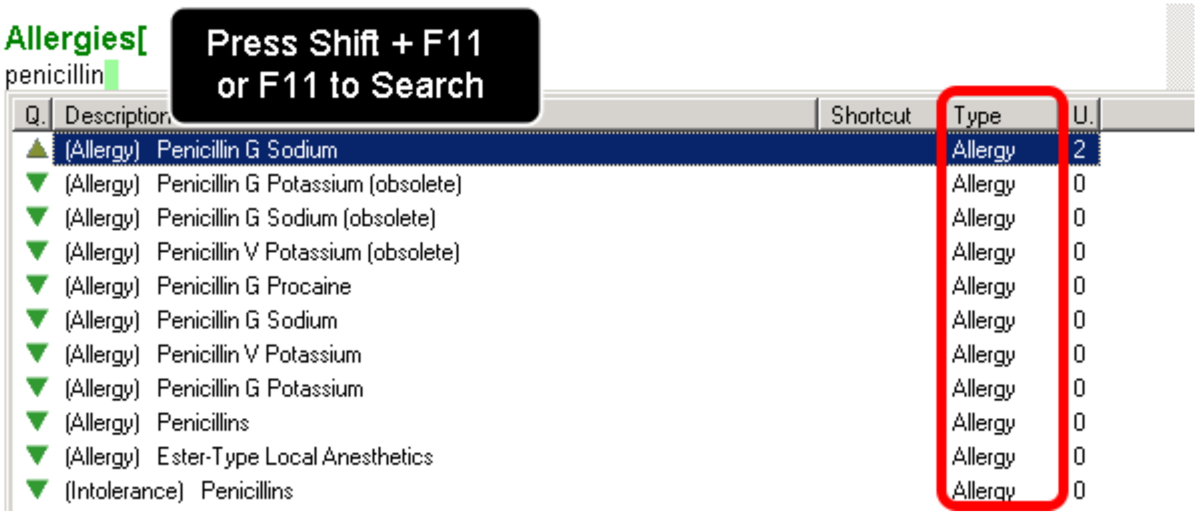


When a patient has no known drug allergies, documentation must be entered as structured data by using the SMARText Item for "Drug Allergies: No Known".

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" 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 an Drug Allergy using Keywords



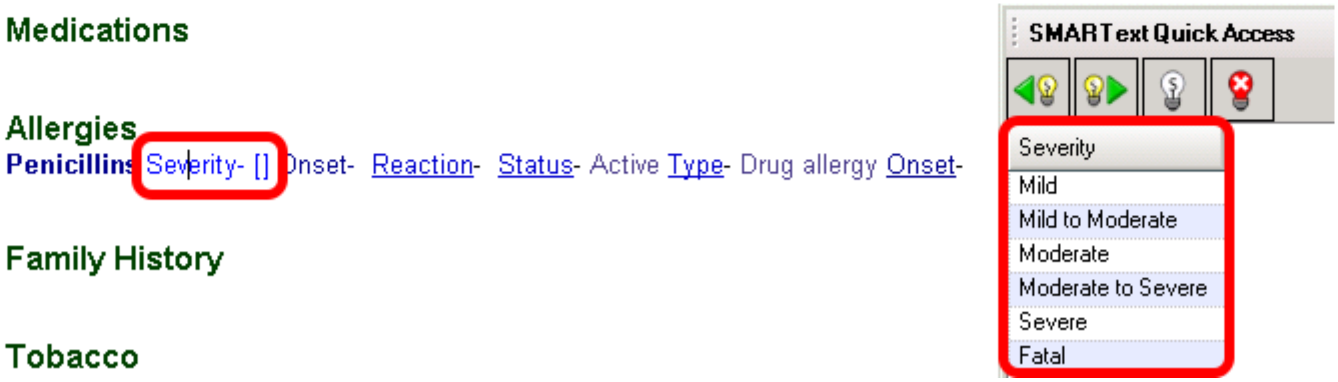
To search for a SMARText allergy/intolerance item by using a keyword, type the keyword into the Allergies field (ex: "penicillin") and then press **Shift + F11** on the keyboard to view the search results. The Shift + F11 search will allow the user to view list of allergy items that are located on the 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 Allergies 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.

Completing the Allergy Sub-Items

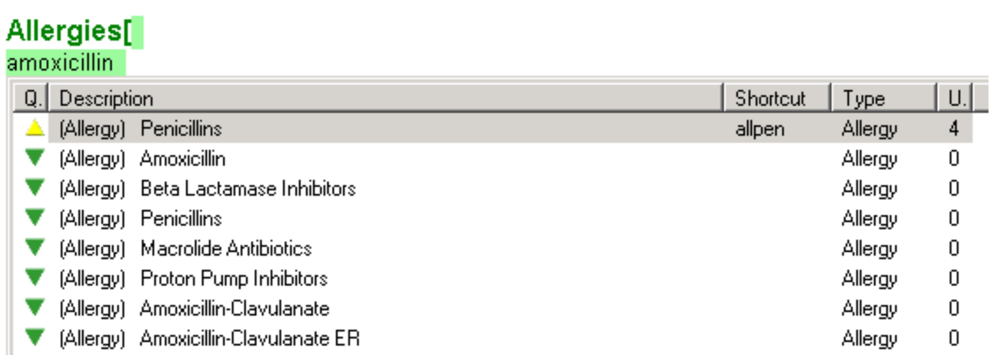


The new SMARText Allergy Items contain sub-items that can be completed for the allergy. These include the following:

- Severity
- Reaction
- Status
- Type
- Onset

Click on any of the sub-items to select the appropriate response from the SMARText Quick Access window.

Allergy Items for Medications & Medication Categories

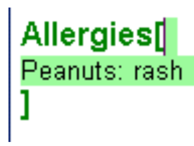


Individual medication allergy items and allergy item categories are now available in SMARText. For example, if you do a Shift + F11 search for Amoxicillin, the search will reveal both the Allergy item for Amoxicillin and the Allergy item for its category of Penicillins.

Using Rx SMARText Items in the Allergies Field

Any Rx SMARText item may also be used within the Summary Allergies field to record a medication allergy.

Entering Non-Drug Related Allergies



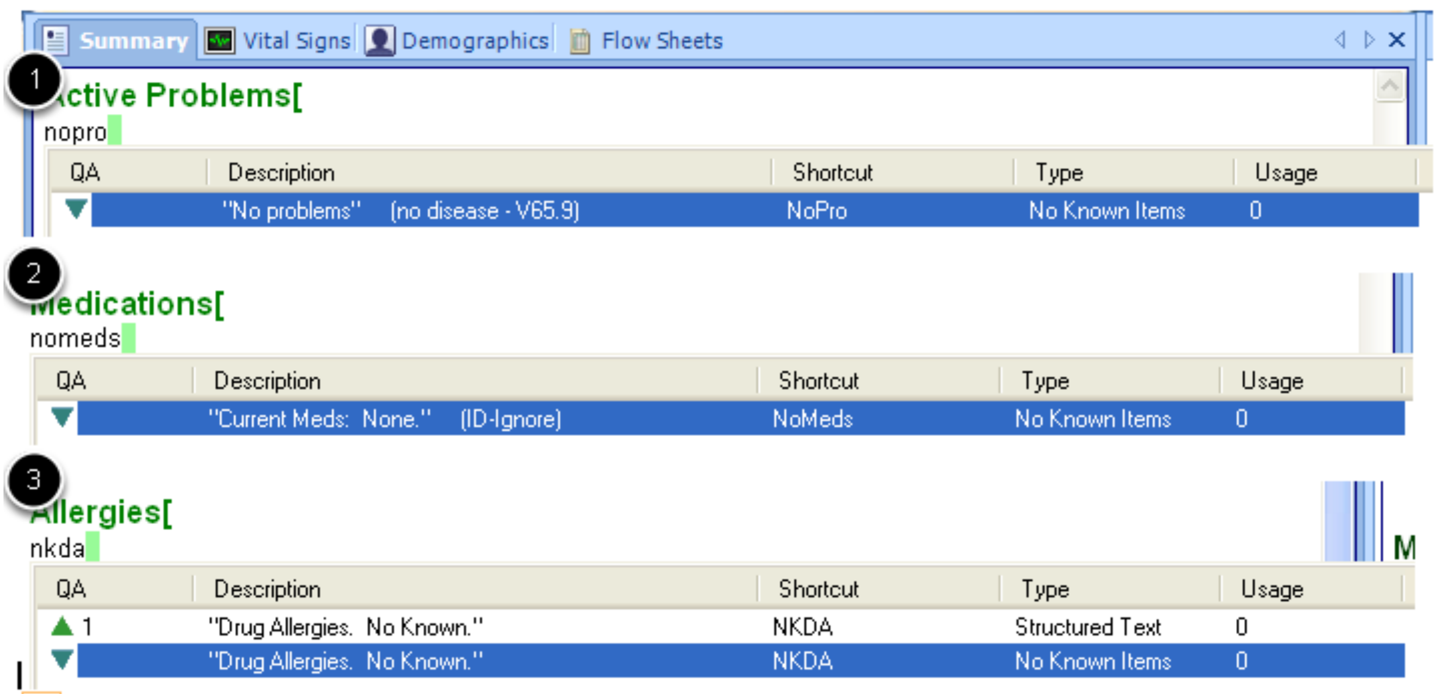
SMARText items are only available for medication allergies. As a result, there will be a need to add non-drug related allergies such as food intolerance, in a free text fashion. To enter free text non-drug related allergies, simply free-text type the intolerance into the allergy field (as shown above).

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

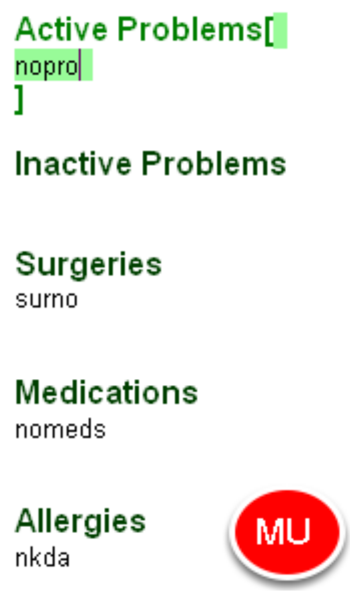


Previously used (SOAPware 2010 and earlier) Structured Text items for "No Problems", "No Medications" and "No Known Allergies" will not calculate properly for Meaningful Use. **A user must update or re-download these SMARText Items** to capture the newly created "No Known Items" that are required for 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

Entering Shortcut for No Known SMARText Items



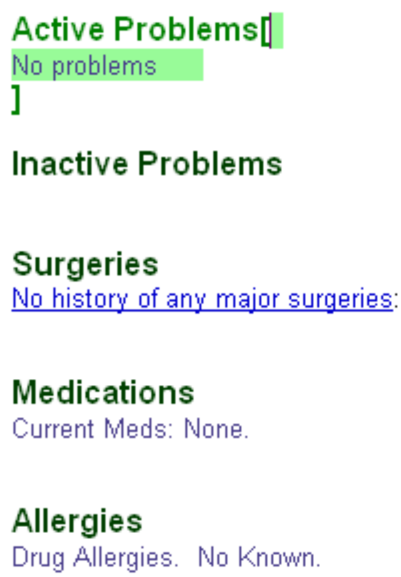
The Active Problems, Surgeries, Medications, and Allergies field of the Summary may not be left blank. Even if a patient has a negative history for these specific fields, it must be documented that No Known history has been determined.

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 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

Expanded No Known SMARText Items in the Summary



Using No Known SMARText Item Types will record documentation as structured data.

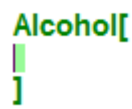
Alcohol

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.

Summary Alcohol Field

The Alcohol field in the Summary is used to record the patients current and past alcohol usage.

Placing of the Insertion Point

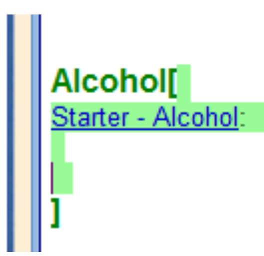


With a patient chart open and the Summary chart section visible:

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.

Entering Alcohol Items using a Starter Pick List

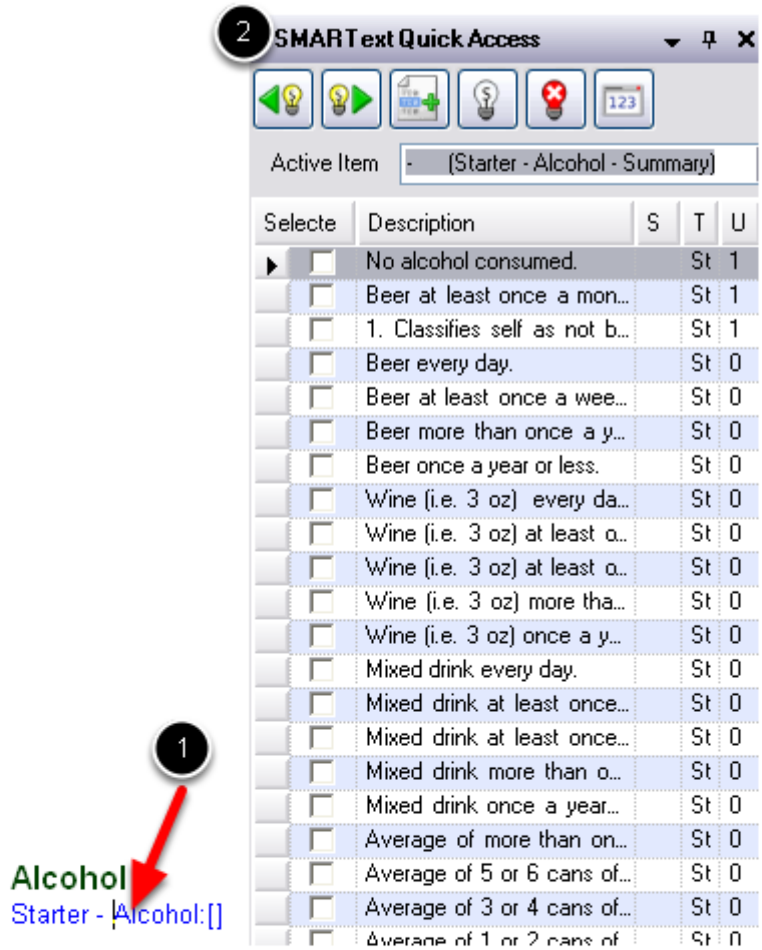


To insert the Starter Pick List for Alcohol, Type the shortcut " **alc-**" into the Alcohol field then Press the spacebar.

The Alcohol Starter Pick List is used to record past and present alcohol use. It may not contain all the items used while charting.

Note: *The first time this Pick List is used, it must be downloaded from the SOAPware Online Library. To download the pick list, Type "alc-" into the Alcohol 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.*

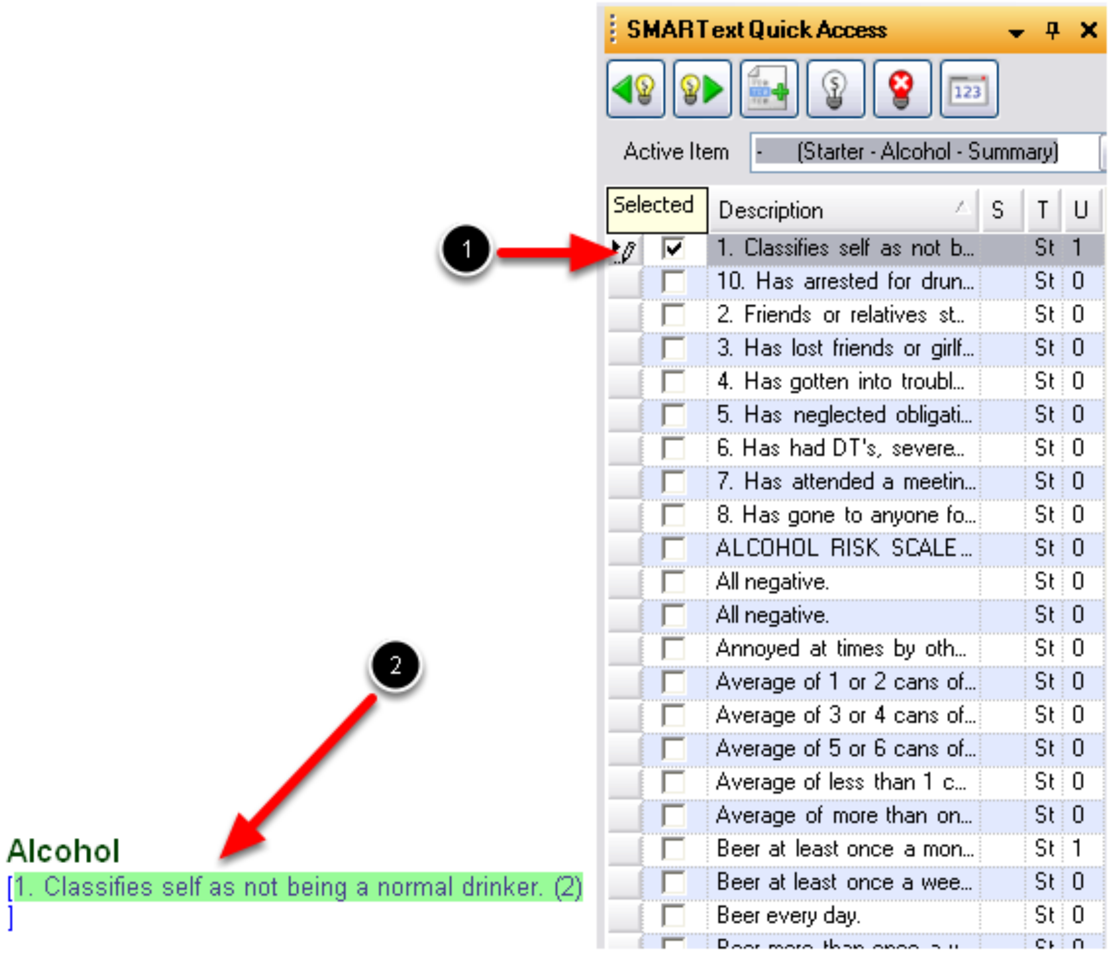
Accessing the Alcohol Pick List



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 - Alcohol:) and a list of items will appear in the SMARText Quick Access Dialog.

Choosing Items from the Alcohol Pick List



With the Alcohol pick list displayed in the SMARText 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.

Summary Interventions Field

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.

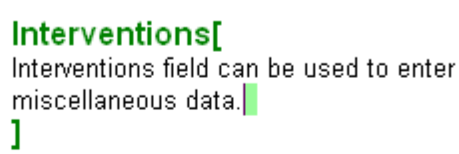
Placing the Insertion Point

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.

Entering Free Text Data into the Interventions field



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.

Summary Social History Field

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.

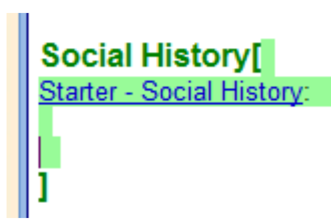
Placing the Insertion Point

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.

Entering Social History Items using the Starter Pick List



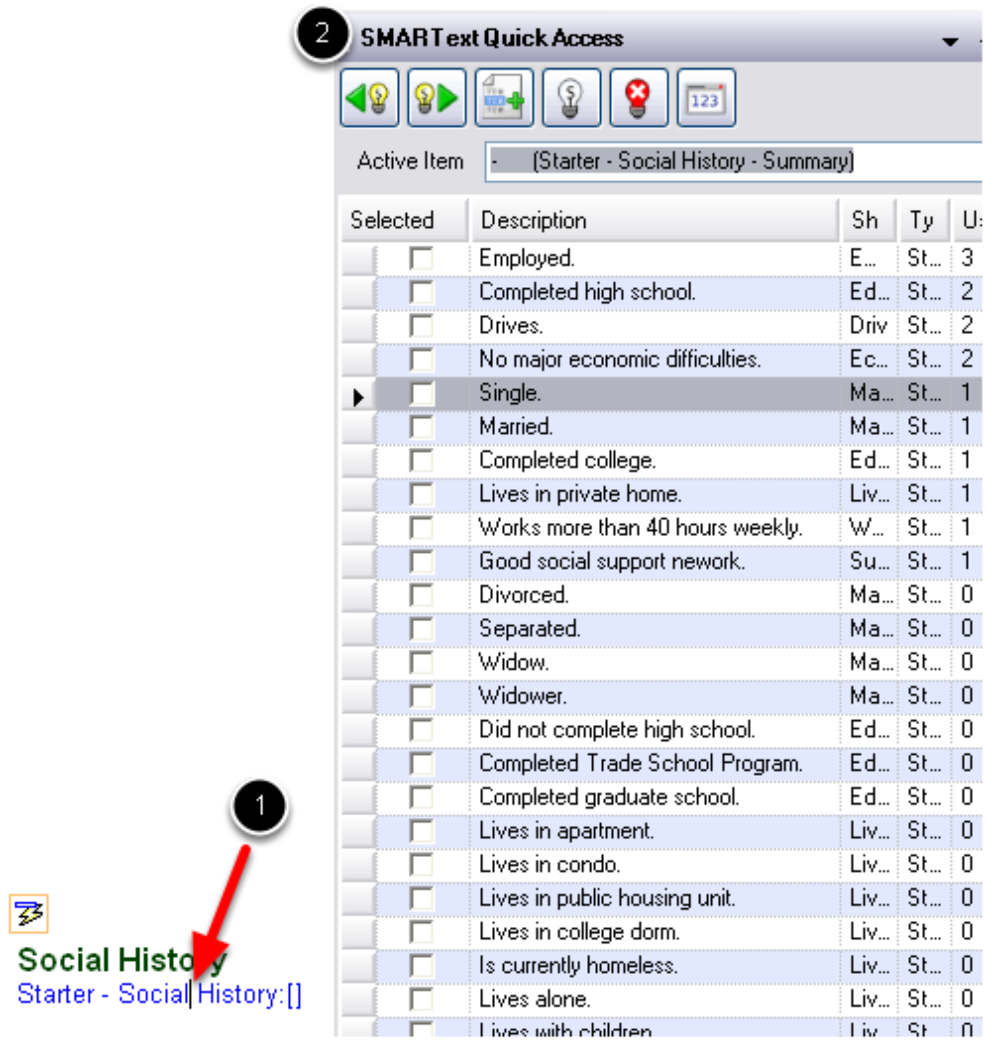
To insert the Starter Pick List for Social History, Type the shortcut "**soc-**" into the Social History field then press the spacebar.

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.

Note: *The first time this Pick List is used, it must be downloaded from the SOAPware Online Library. To download the pick list, Type "soc-" into the Social History 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.*

See this link for searching instructions: [SMARText Data Entry Methods.]()

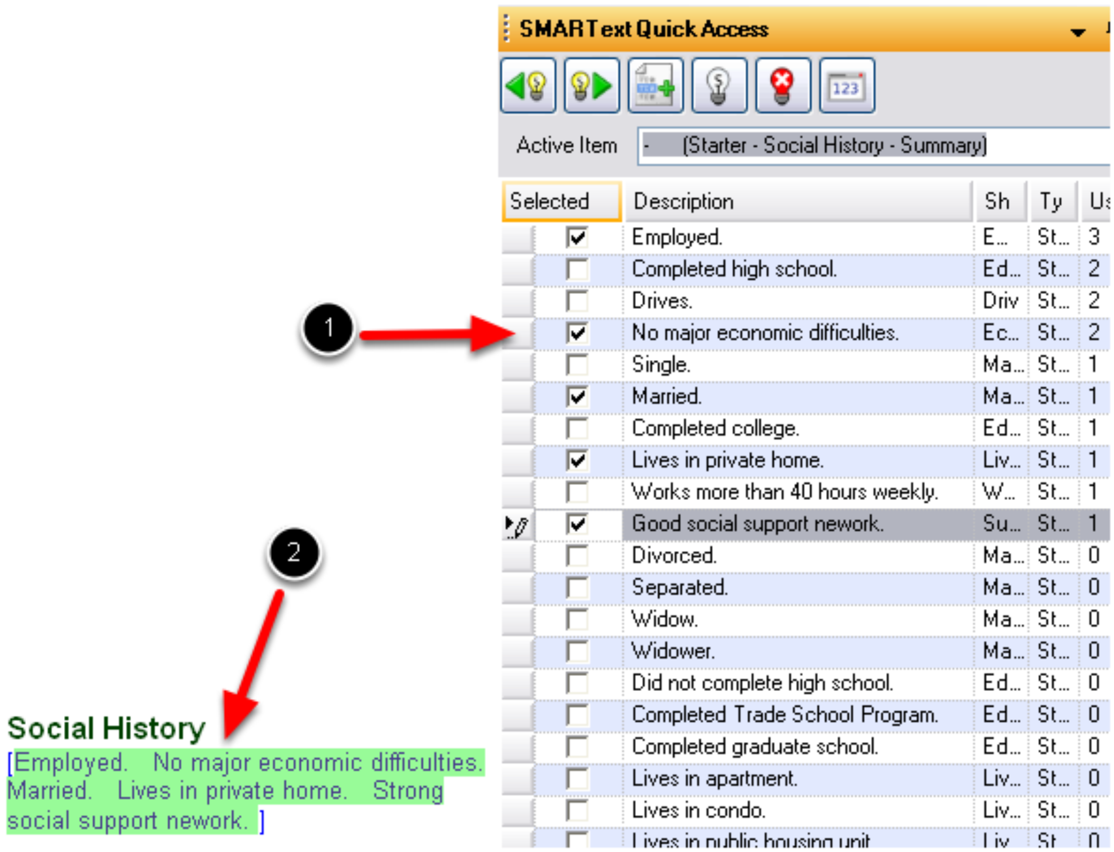
Accessing the Social History Pick List



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



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.

ROS & Physical

This lesson will describe how to document in the Summary ROS field.

Summary ROS & Physical Fields

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.

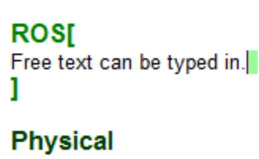
Placing the Insertion Point

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.
3. Begin entering desired data using free text.

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 ROS or Physical Fields



At this time there is not a Pick List available for the ROS or Physical fields, 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.

Vital Signs Section

Introduction to Vital Signs

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

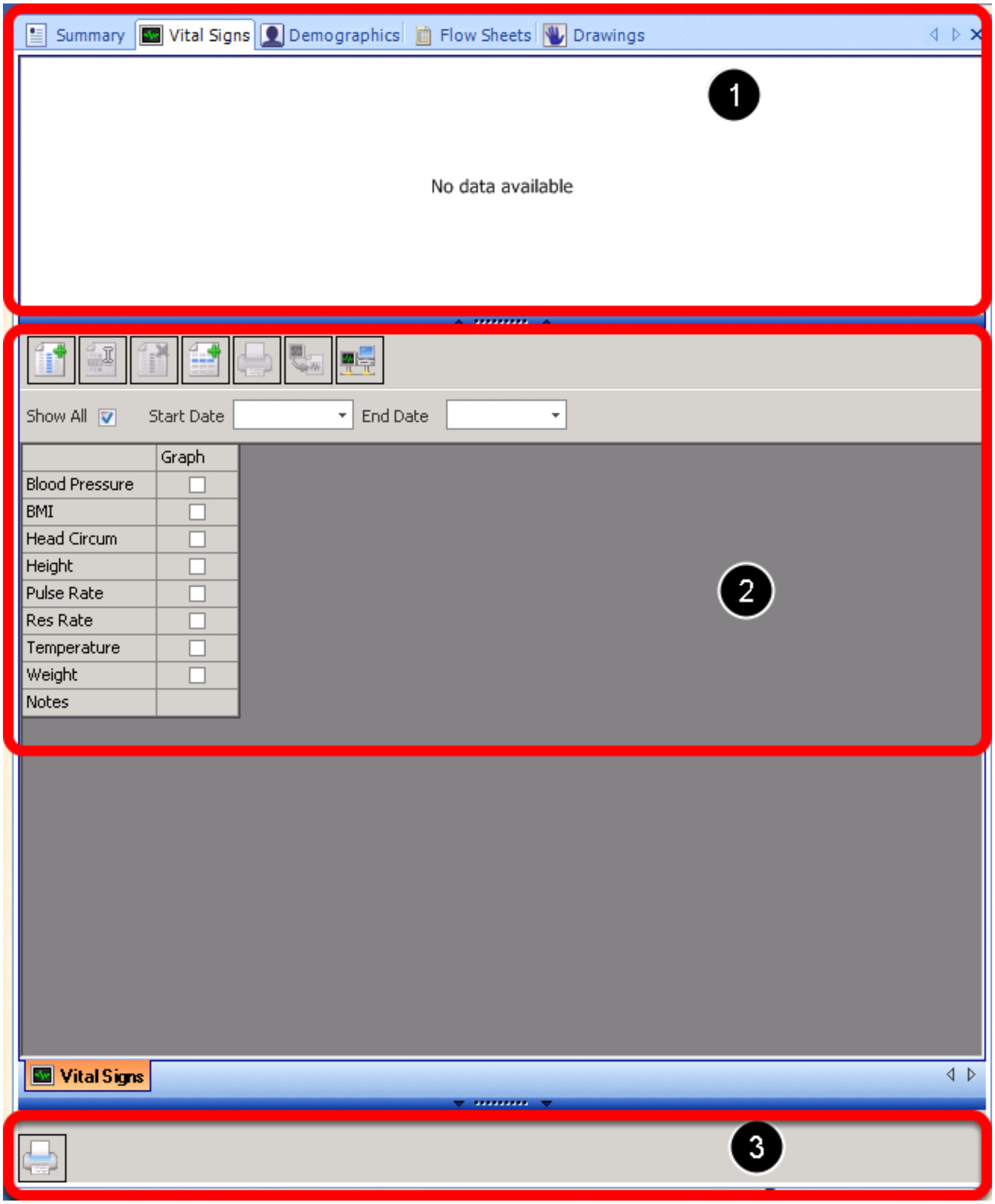
Paper Connection

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.

Interface



The Vital Signs section consists of three areas.

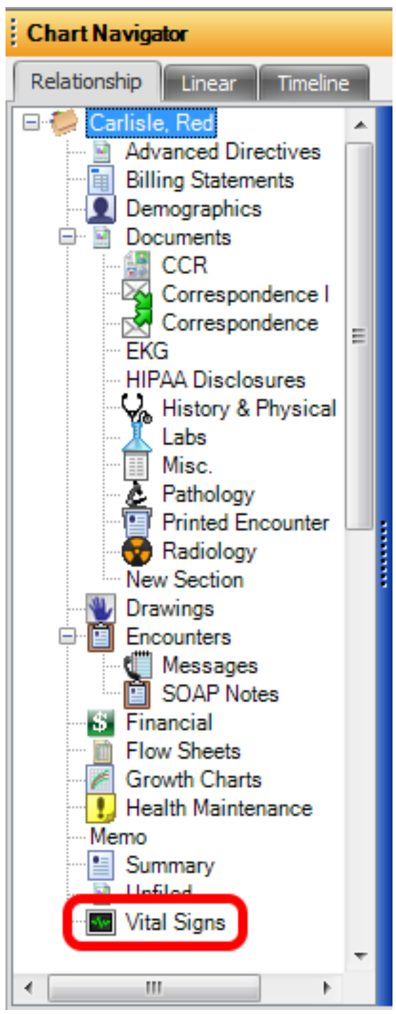
1. The top section is where a graph is displayed when data is selected for graphing.

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. A user can also define a custom date range to limit the view of vital sign readings for a patient.

3. The bottom section has a printer button.

A 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**: Apatient chart must be open in order to access the Vital Signs section.

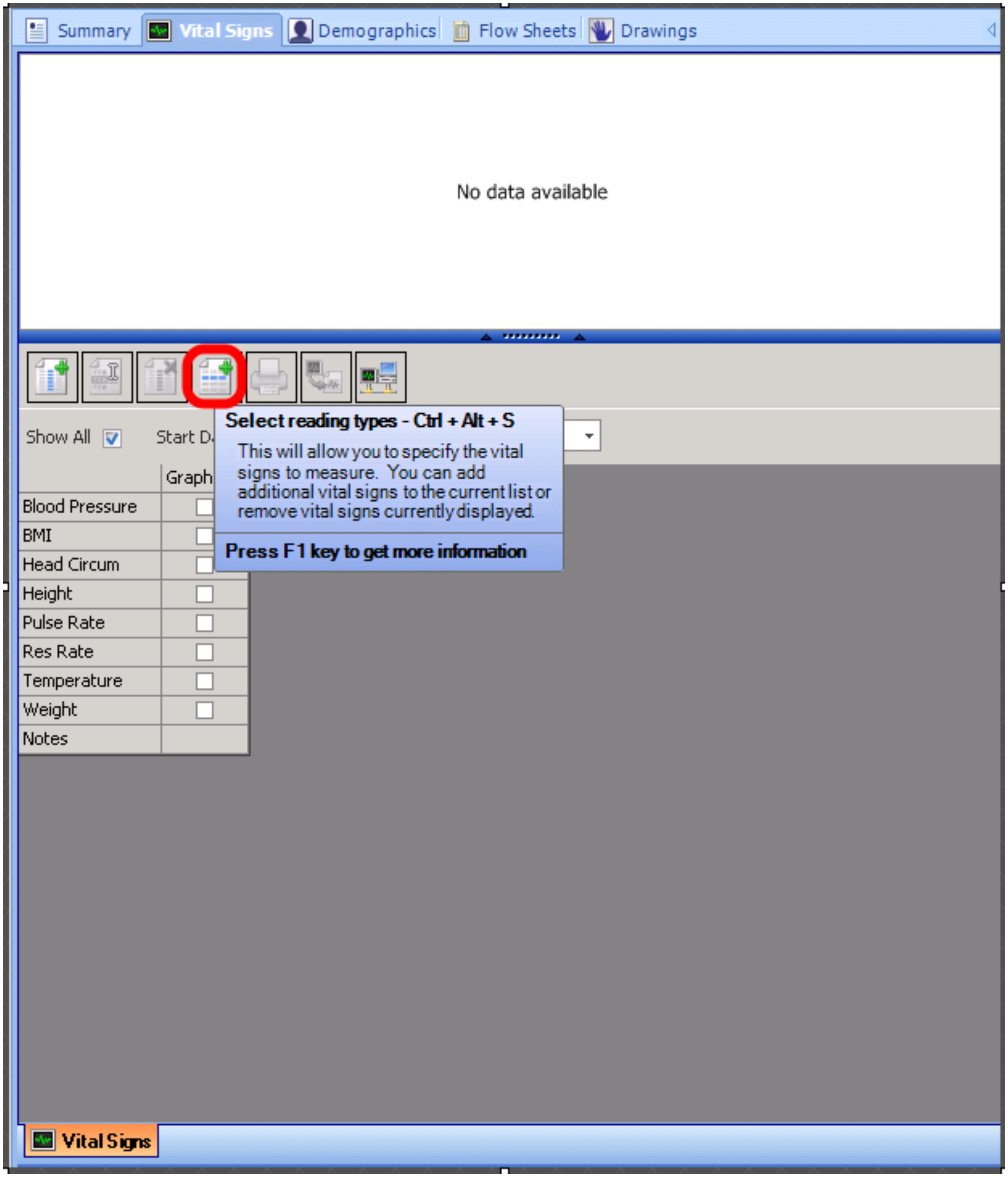
Customizing Vital Signs View and Unit System

Auser 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**

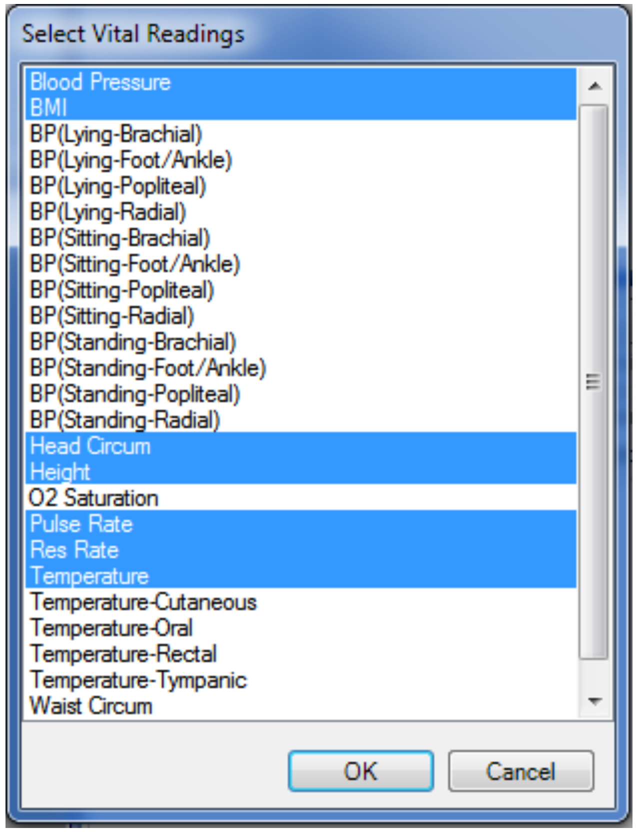
- Record Vital Signs

Select Reading Types



Click on "Select Reading Types" icon.

Choose the Vitals Readings



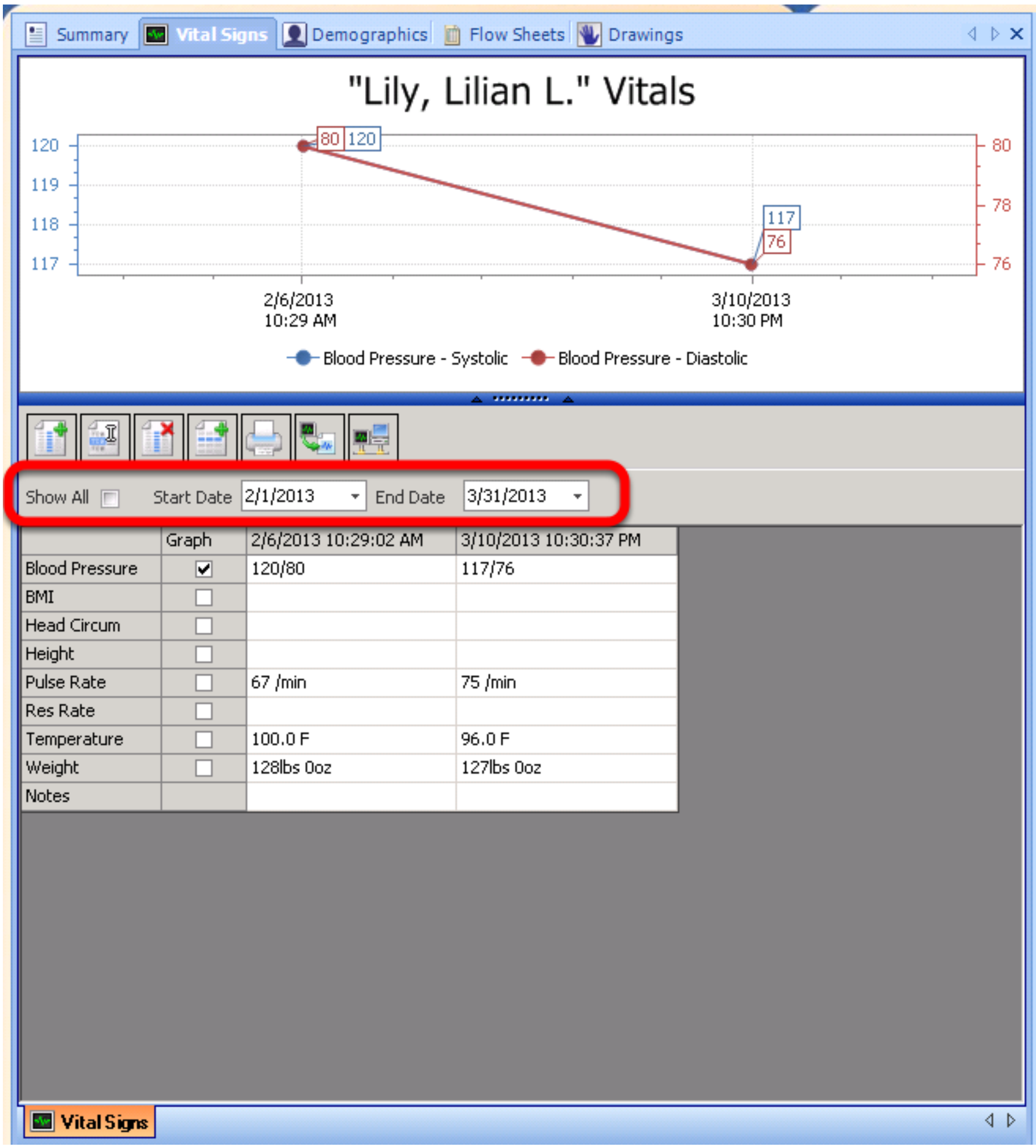
Click to highlight the vital signs to be included. There is no need to hold control or shift while doing this, simply left-clicking on a new selection will add it to the reading types to be included.

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 <u>per patient</u>.**

Customizing the Vital Signs Filter Options

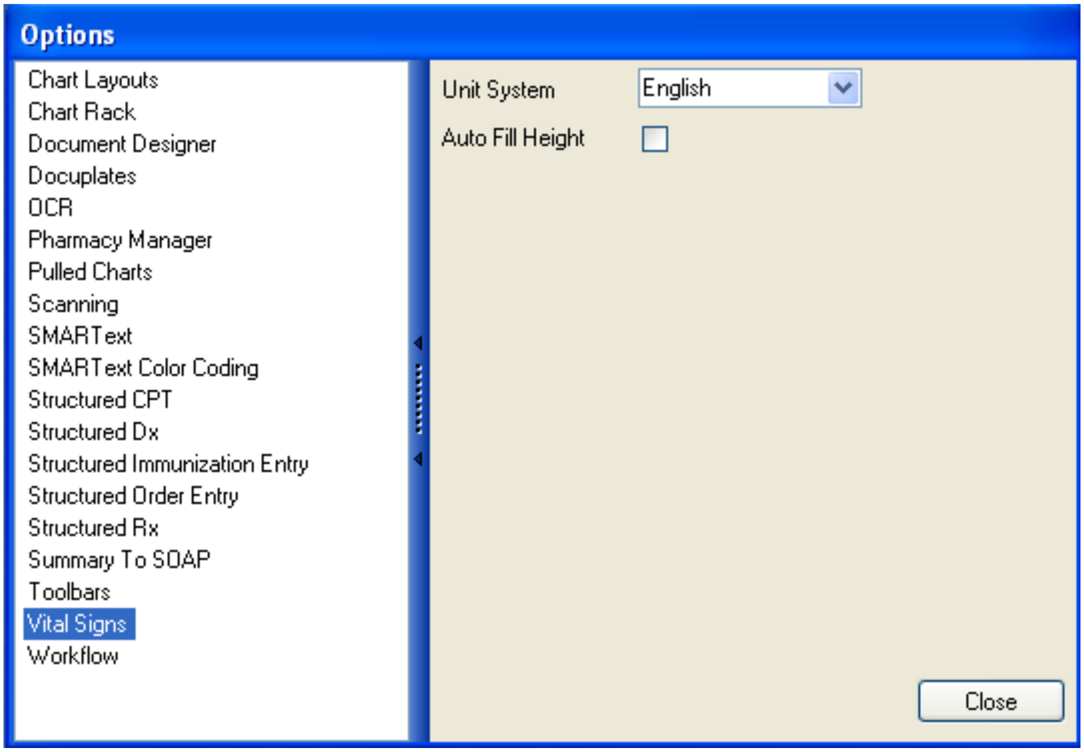


	Graph	2/6/2013 10:29:02 AM	3/10/2013 10:30:37 PM
Blood Pressure	☑	120/80	117/76
BMI	☐		
Head Circum	☐		
Height	☐		
Pulse Rate	☐	67 /min	75 /min
Res Rate	☐		
Temperature	☐	100.0 F	96.0 F
Weight	☐	128lbs 0oz	127lbs 0oz
Notes			

Auser has the option of filling in a start date and an end date to filter his or her view of a patient's vital sign readings based on the date parameters set. Auser can also check the box next to "Show All" to display all of the patient's vital sign readings.

Auser also has the option of changing the view of the graph within vital signs, depending on what filter options have been specified.

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.

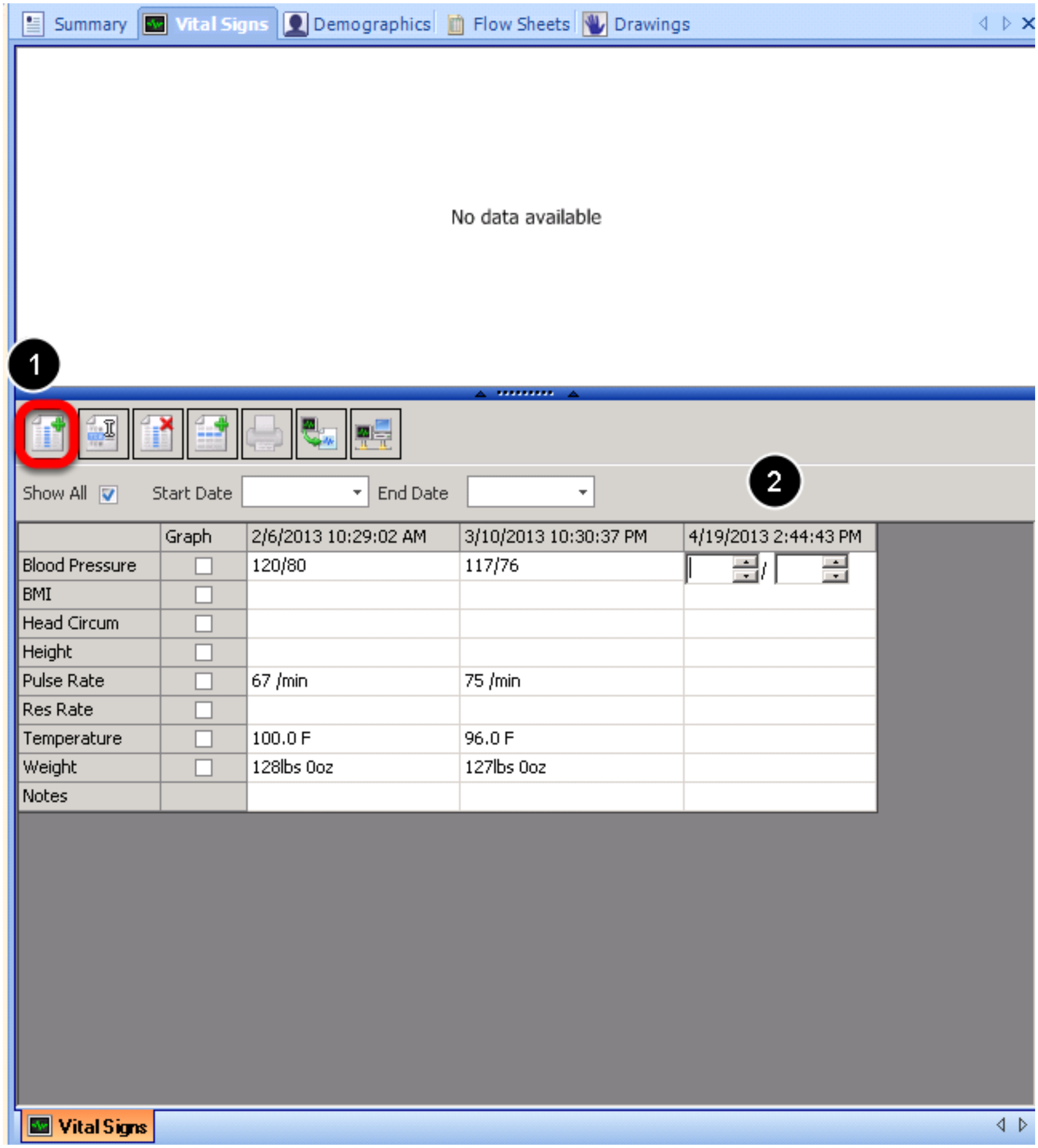
This option allows the user to choose English or Metric for the Unit System. In addition the Auto Fill Height options can be activated.

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

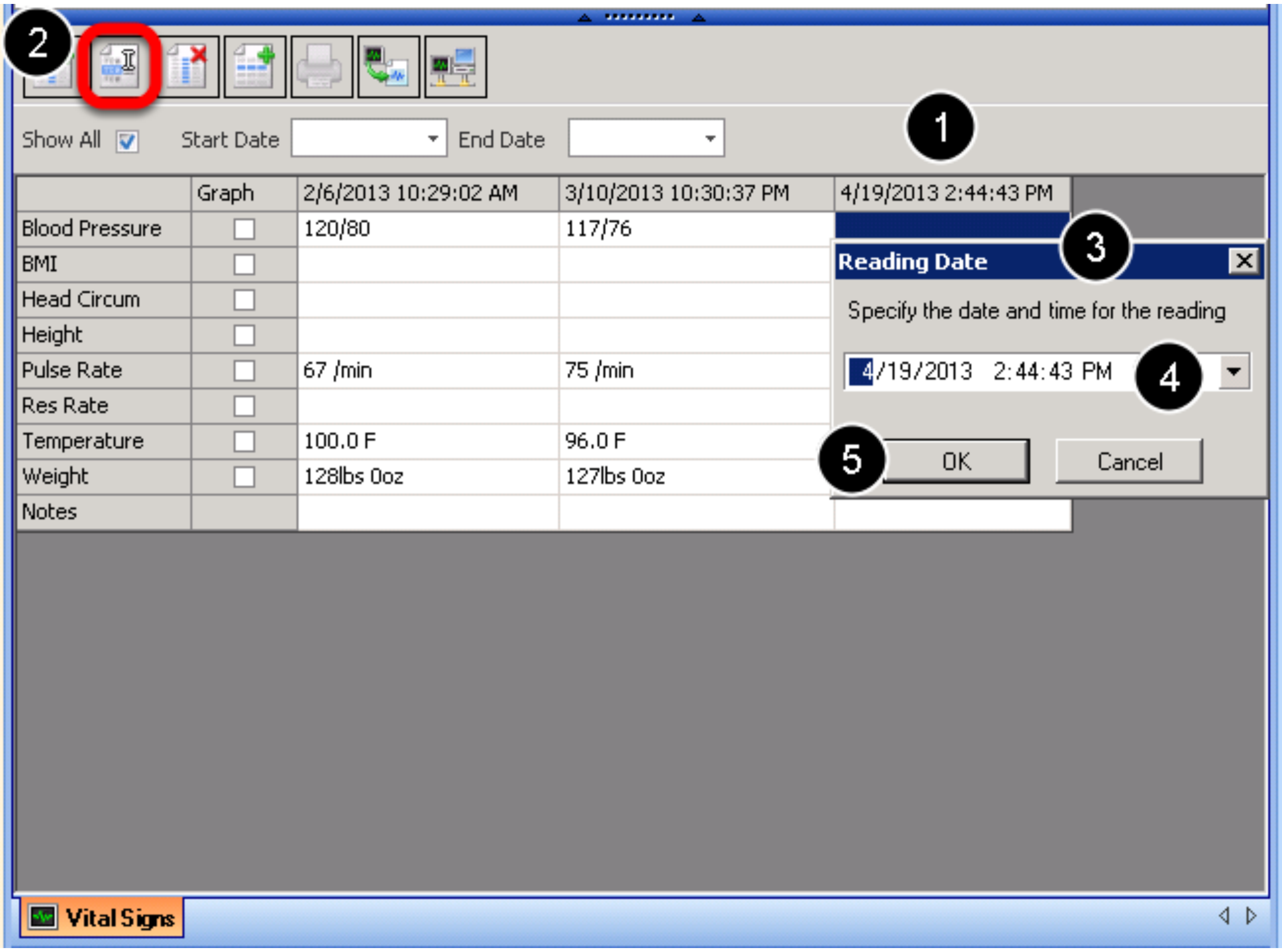
Add a Reading Date



To add a reading date:

1. Click the Add Reading Date Button (or press Control + Alt + N).
2. Anew column will be created with the current date and time displayed at the top.

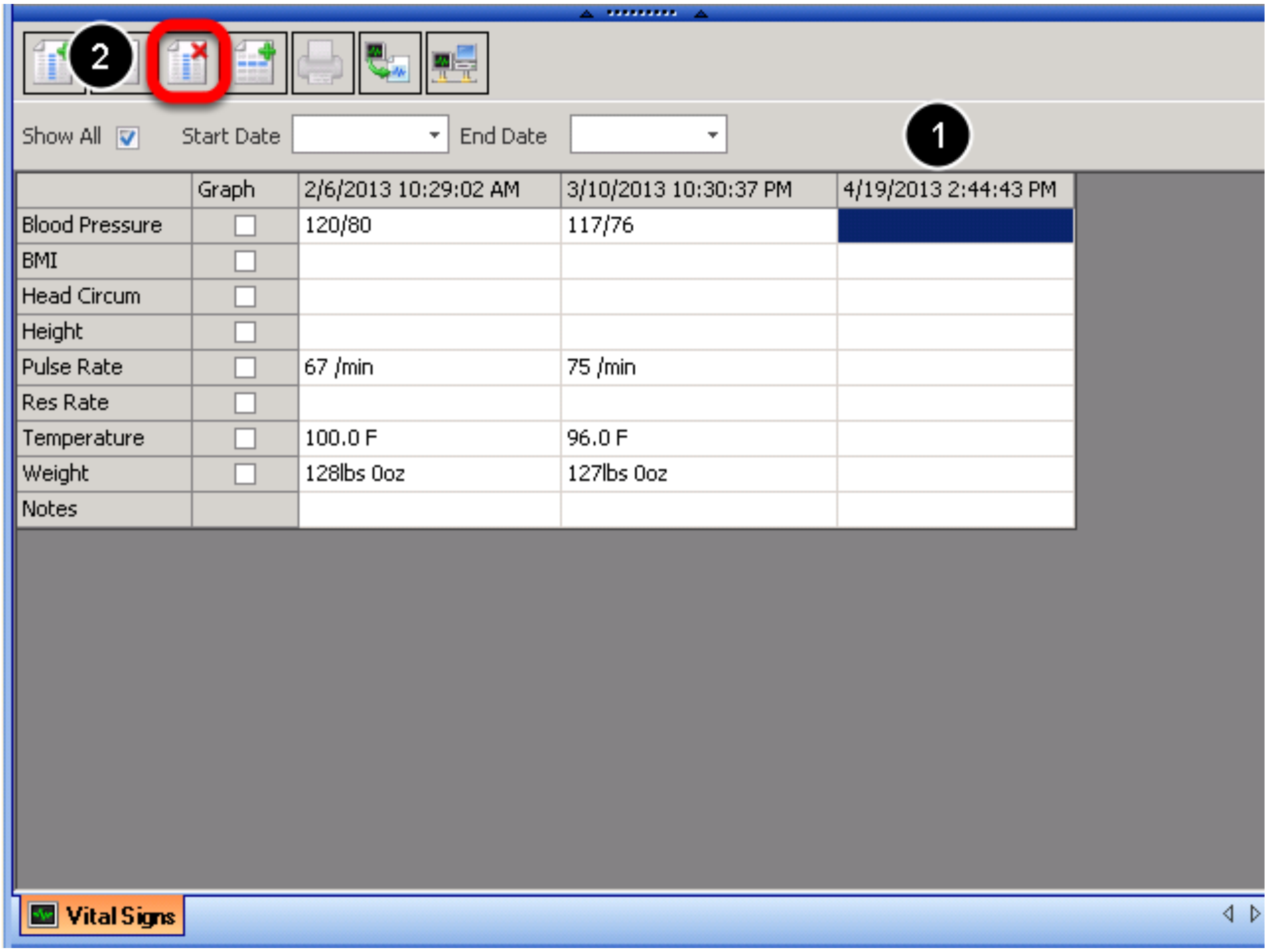
Edit a Reading Date



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.

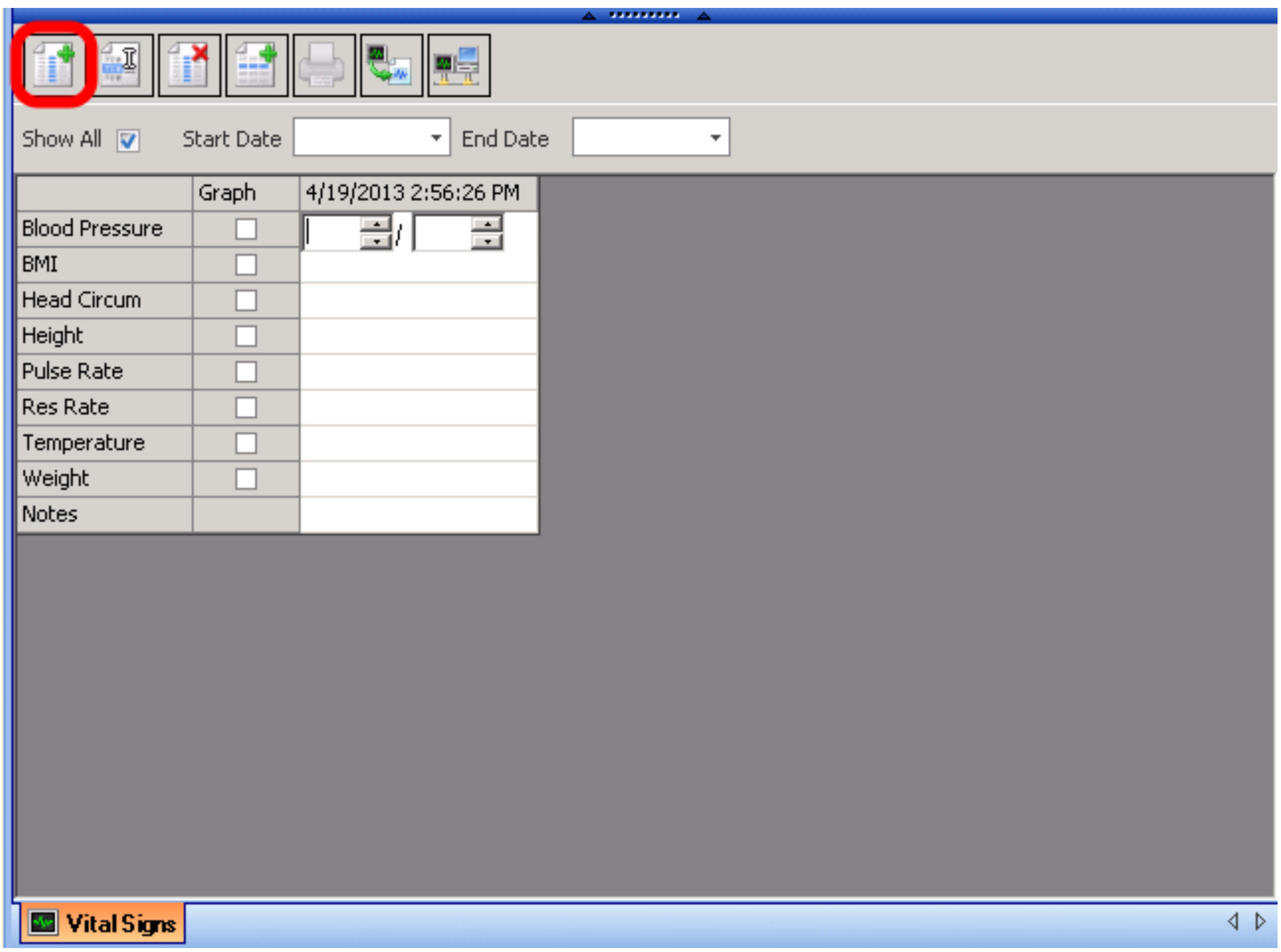
Inserting Vital Signs

*** REQUIRED FOR MEANINGFUL USE**
- Record Vital Signs

Open Vital Signs

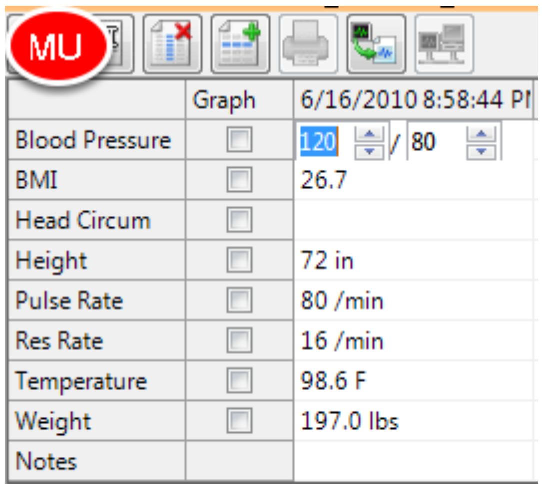
Click on the Vital Signs tab in the patient's chart (OR) Click on Chart in the SOAPware menu bar > Chart Navigator > Vital Signs.

Add a Reading Date



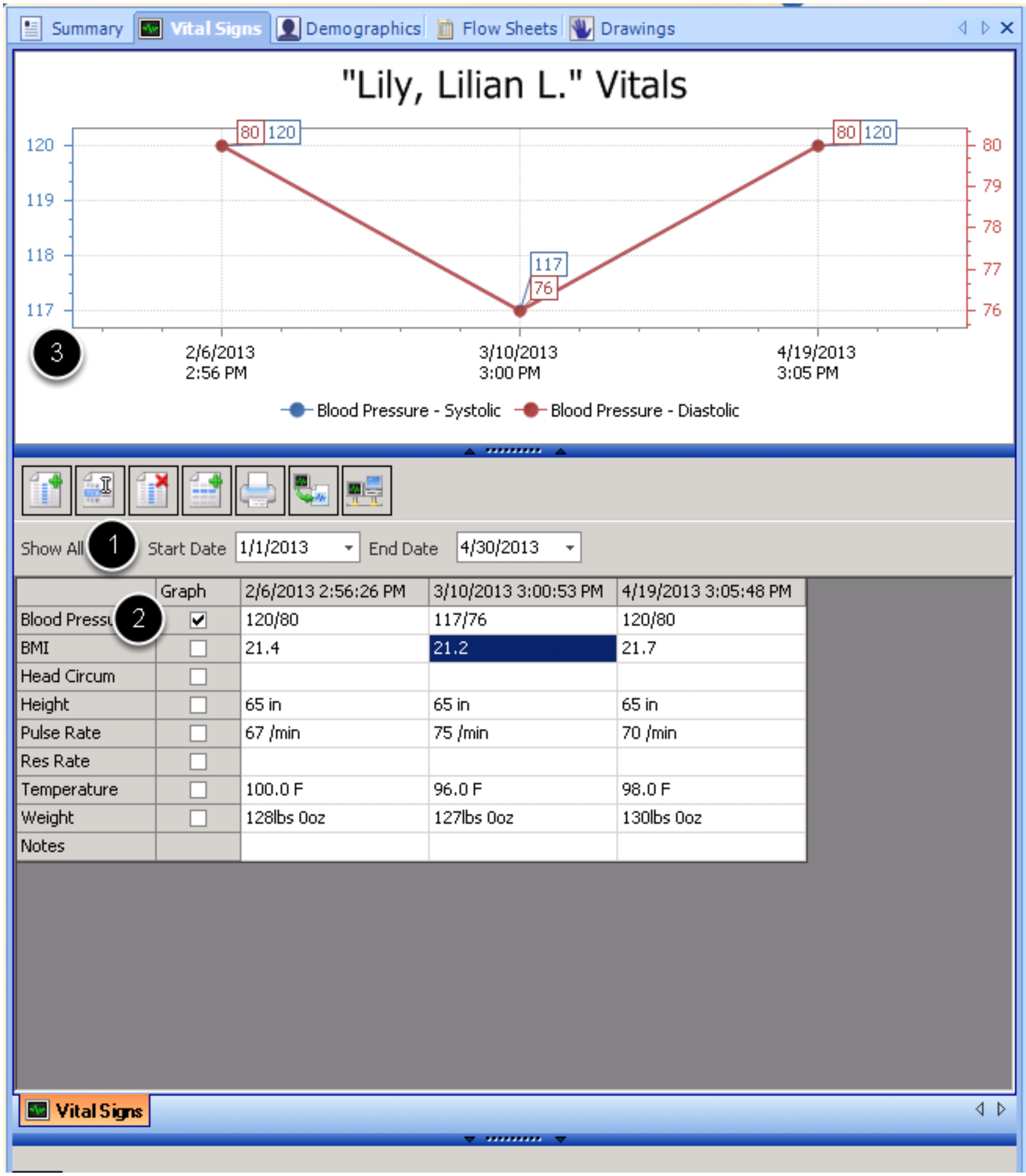
Click on the "Add Reading Date" icon.
To change the reading date/time, see: Add / Edit Vital Reading Date

Insert Vital Signs



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).

Select Vitals to Graph



To graph vital signs:

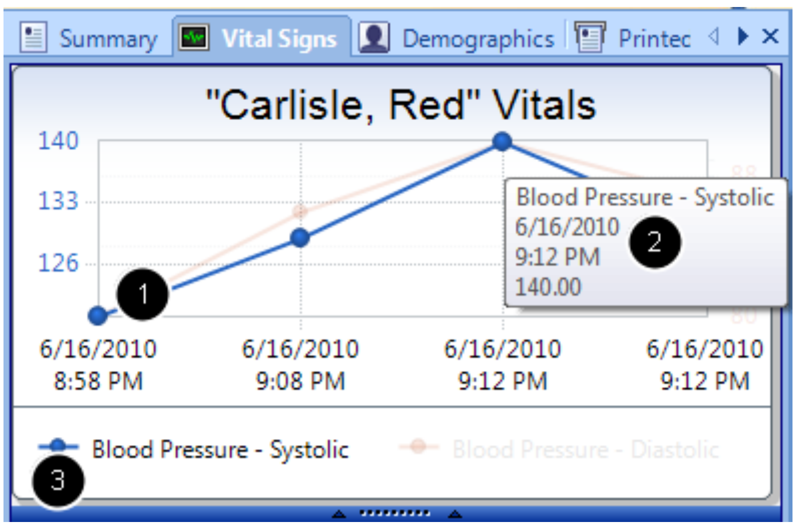
1. Users will set date parameters to filter the view of a patient's vital sign readings, or check the

"Show All" box to display every vital sign reading that is in his/her chart.
2. Users simply place a check in the box next to the readings that he/she wishes to see displayed as a graph.
3. 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

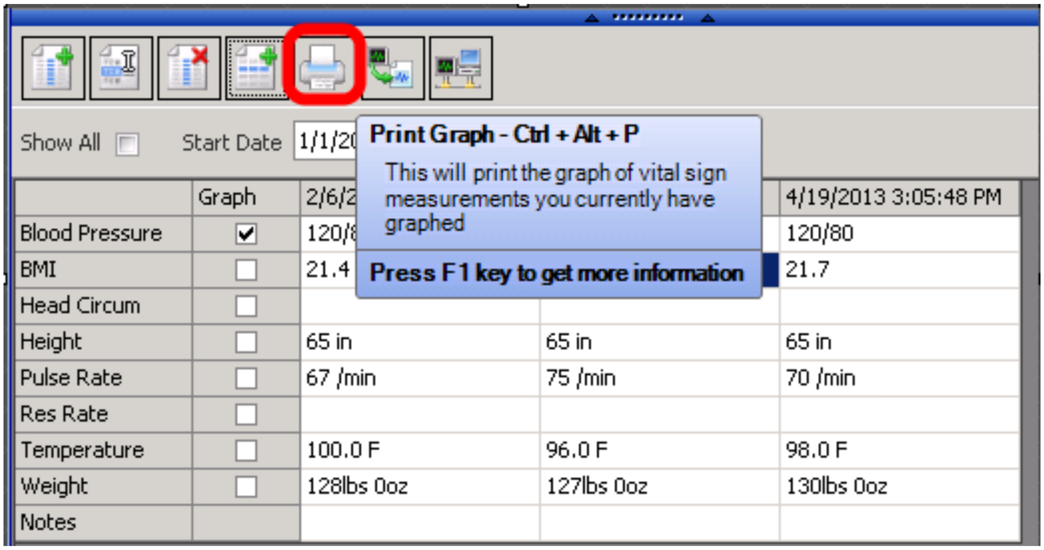


1. Hovering over any part of a particular line on the graph will bring the entire line forward and fade the others into the background. This allows the user to easily view the graph for a particular vital sign, without having to de-select the other graphed readings.

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.

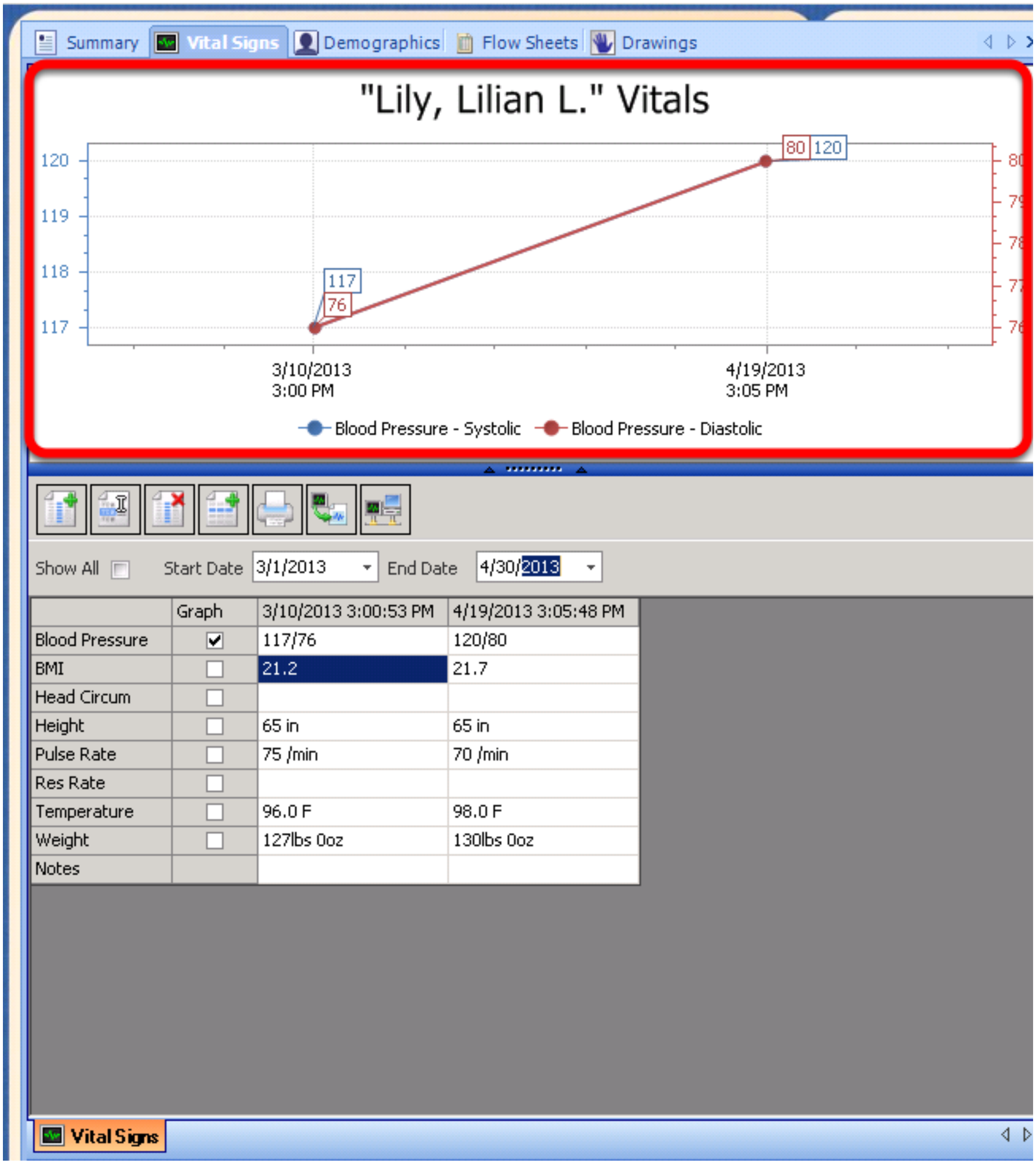
Printing a Graph



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.

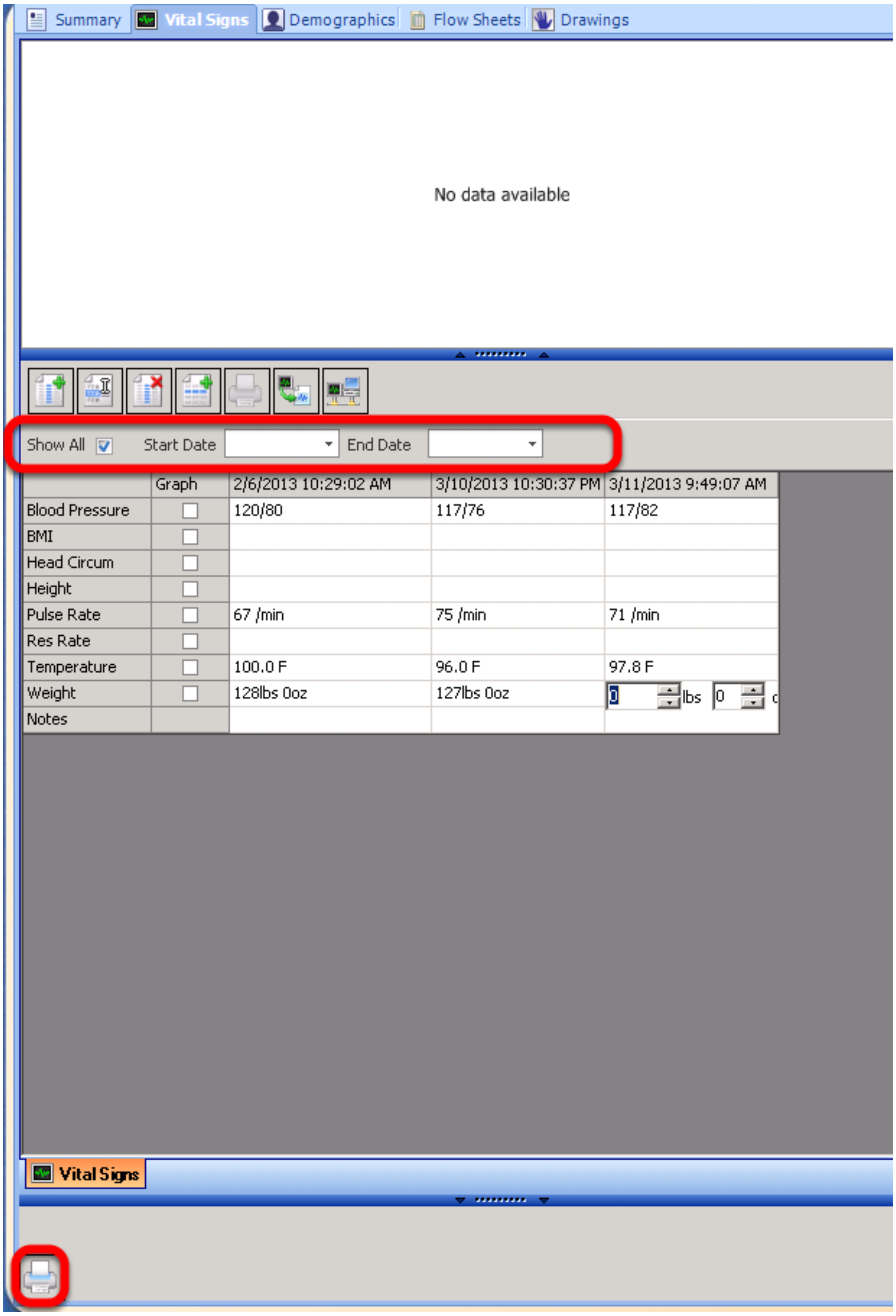
Filtering the Graph



A user has the option of changing the view of the graph within vital signs, depending on what filter options have been specified (whether that be a start and end date set, or the "Show All" box checked to show all the vital sign readings for a patient).

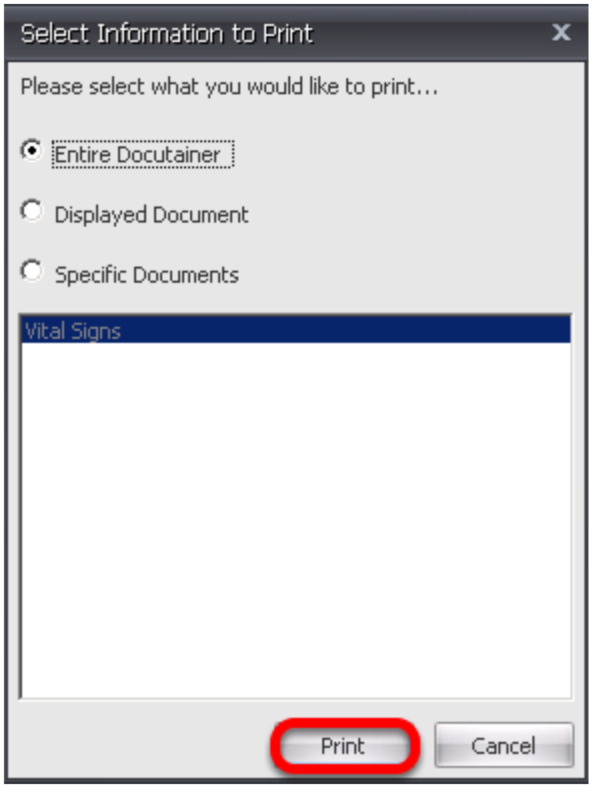
Printing Vital Signs

Filter Settings



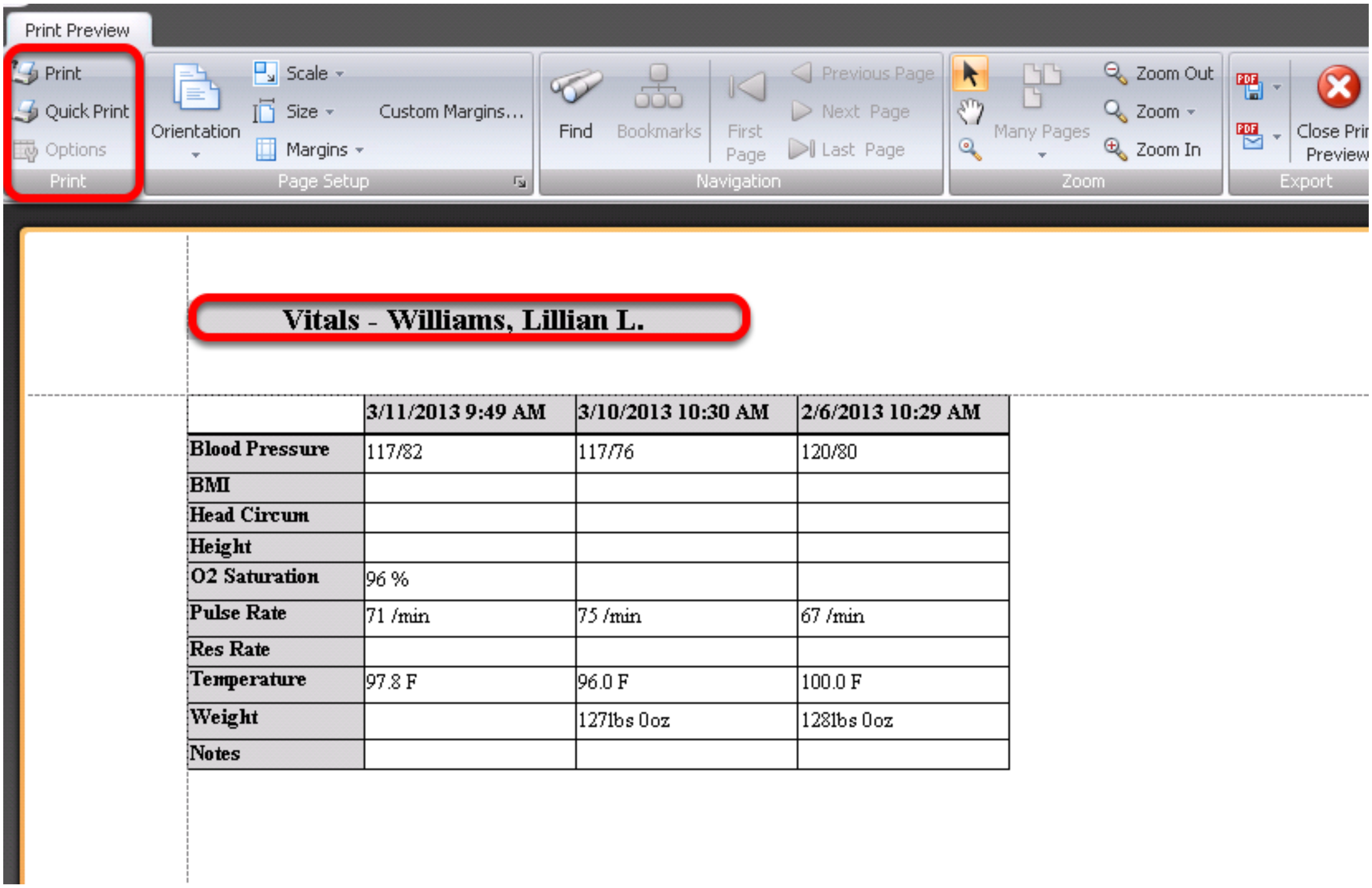
The filter options specified at the top of the vital signs chart section ("Show All" has been selected in this screenshot), will determine what will print when a user selects the print button found under the lower splitter bar, beneath the vital signs tab.

Select Information to Print



A user will be prompted to select if he or she would like to print the entire docutainer, the current displayed document, or specific documents. The entire docutainer option will be the default for printing. Once the user selects what will be printed from the three options, Click Print.

Print Preview- Print Options

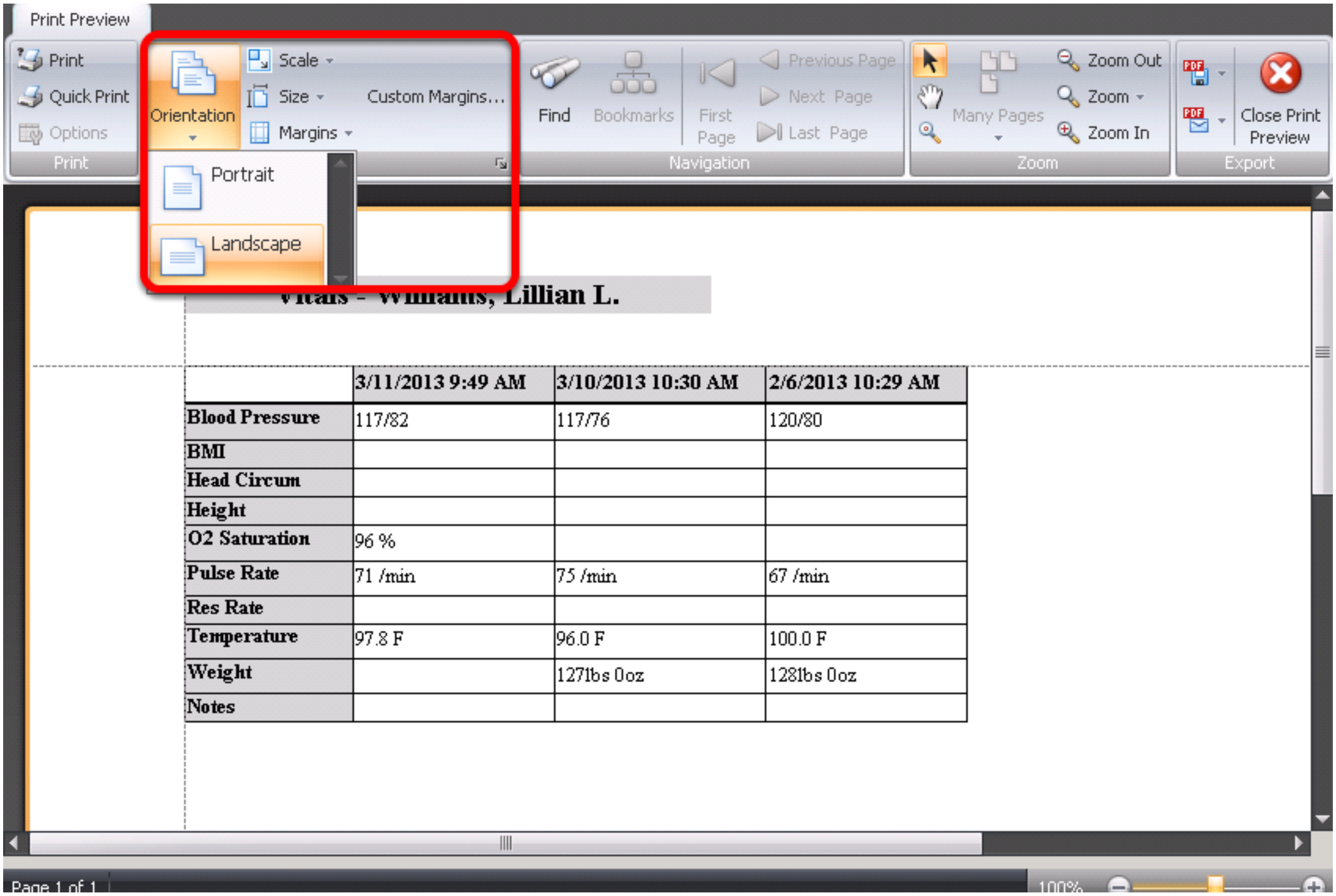


Print- Auser can select a printer, number of copies, as well as select a few other printing options.

Quick Print- Auser has the option to set a default printer so that he/she can quickly send a document to a specified printer.

***Note**: There is a header at the top of the information displayed, which indicates we are looking at vitals, as well as gives the patient's name.

Print Preview- Page Setup



Orientation- Auser has the option of selecting portrait or landscape prior to printing the vital signs document. Landscape will be the default.

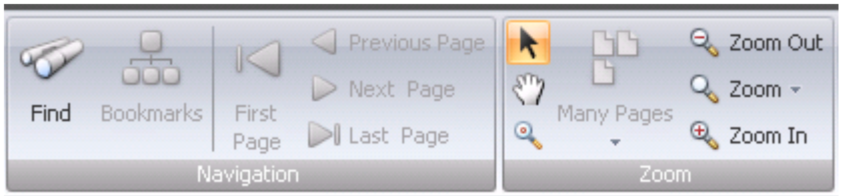
Scale- Stretch or shrink the information displayed on the document.

Size- Select the paper size.

Margins- Select the margin sizes for the entire document.

Custom Margins- Auser has the option to indicate custom margin sizes for the entire document.

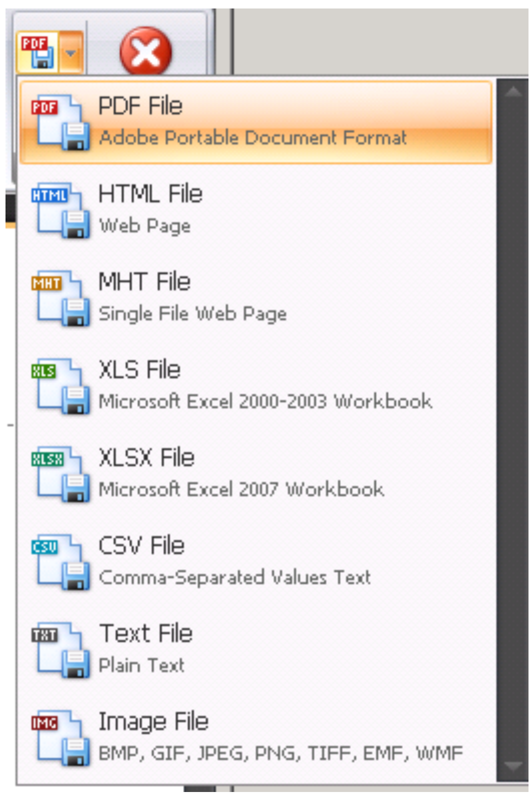
Print Preview- Navigation and Zoom



Navigation- Auser is able to quickly navigate between pages of a docutainer should there be multiple.

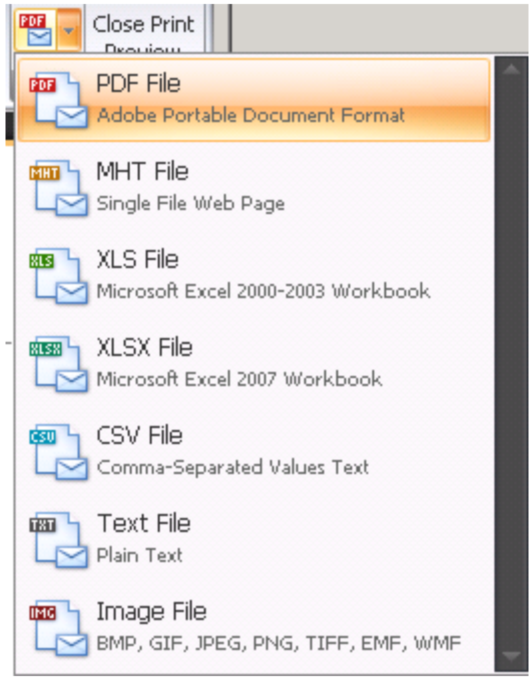
Zoom- Auser is able to zoom in, out, specify a percentage to zoom the document to, as well as utilize the magnifier and hand tools.

Print Preview- Export to



Auser has several options of the export type he or she would like to perform.

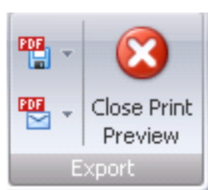
Print Preview- Email to



Auser has numerous file types he or she can convert a document to before emailing.

***Note**: Please ensure that a recipient's email address is HIPAA Compliant prior to sending Patient Health Information.

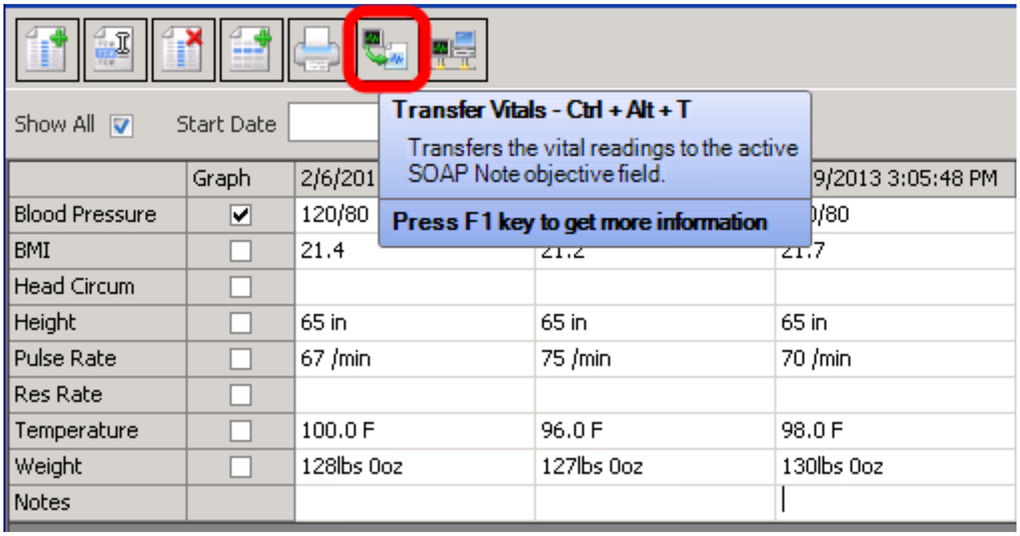
Print Preview- Close



Auser can close out of the print preview window at any time by clicking the red X.

Transferring Vital Signs to the Active SOAPnote

Transfer Vitals

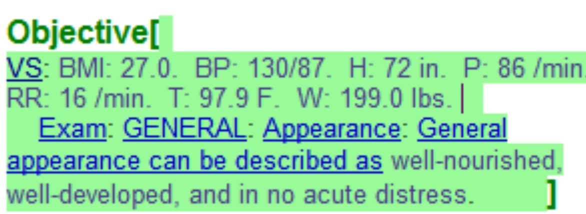


To transfer vital signs to the Objective field of the active SOAPnote:

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.

Vital Sign Readings in the SOAPnote



Vital Sign readings are now located in the SOAPnote, within the 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 date 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.

Welch Allyn Vitals

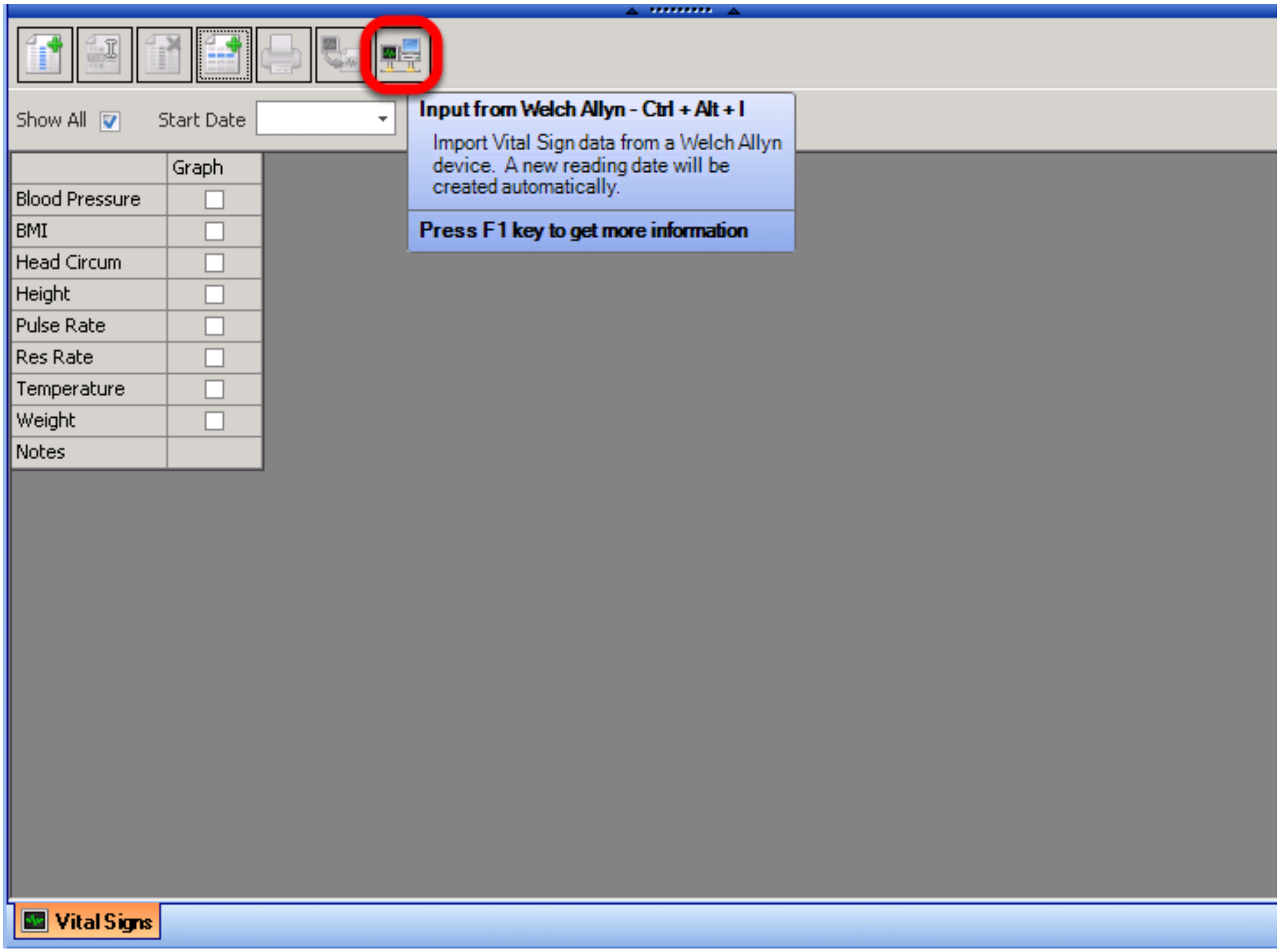
Welch Allyn Vitals device integration

SOAPware 2012.0.3061* supports integration with several Welch Allyn Vitals devices that will allow you to import certain vitals directly into SOAPware. The compatible devices are:

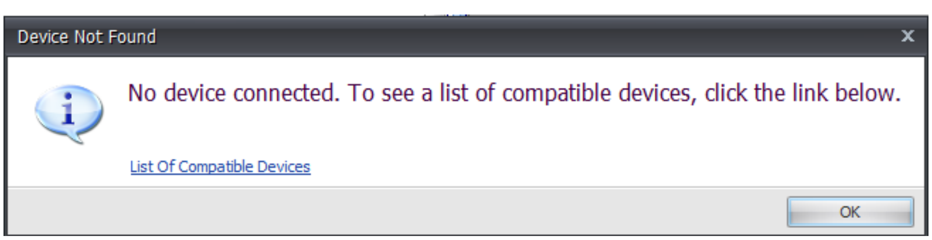
- Spot LXi
- Spot 420 Series**
- VSM 300 Series**

*The integration currently does not work in a hosted enviroment. SCS clients will have to manually input the vitals.

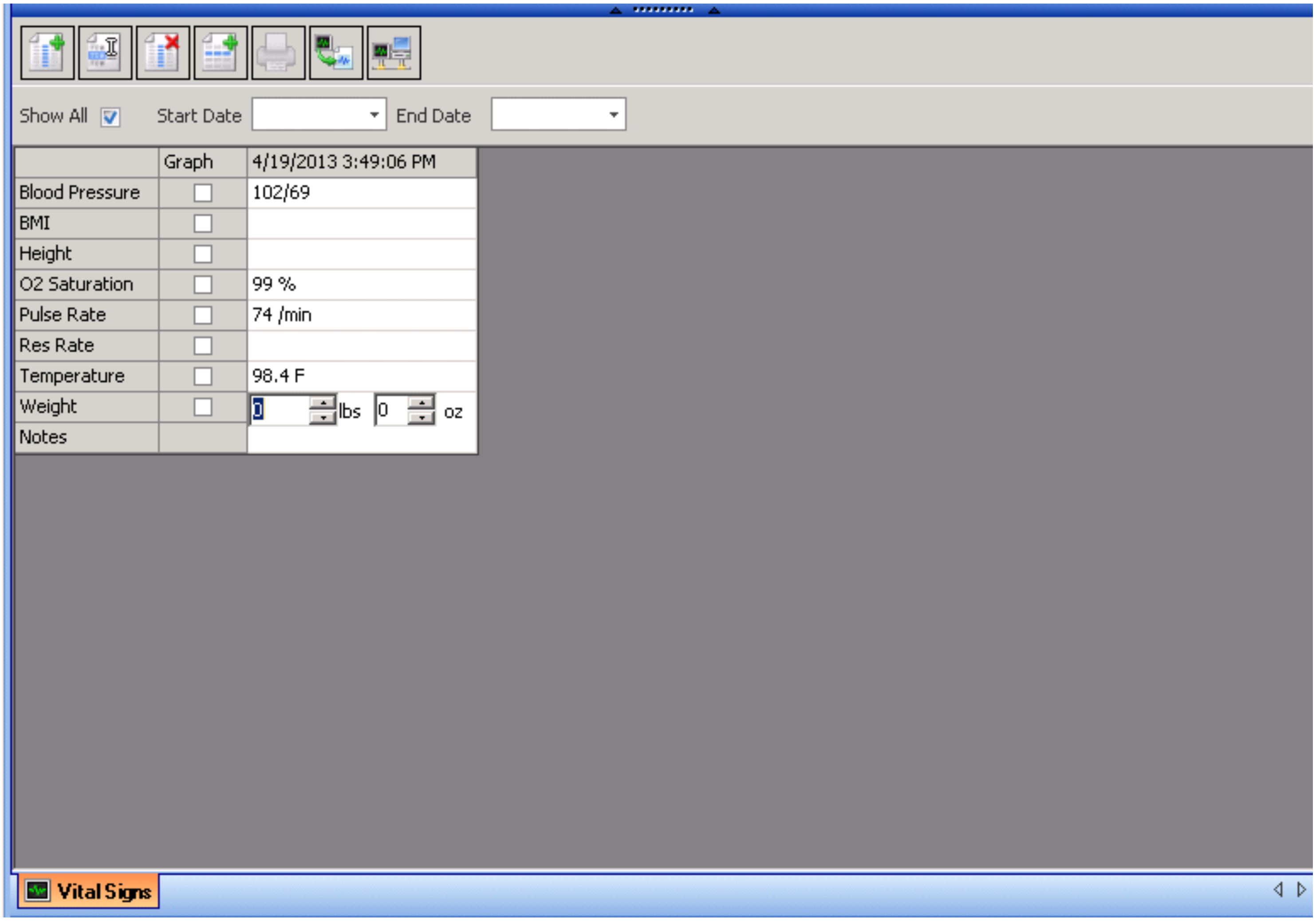
**Additional connectors/parts may be required to interface with your local PC. Contact your local distributor for more information.



You will notice in the Vital Signs section of SOAPware there is a button that will allow you to input from a Welch Allyn device.



If you click the button and do not have a compatible Welch Allyn vitals device or do not have it plugged in, you will see the message above. There is also a link to the Welch Allyn website that lists the compatible devices with SOAPware.



After you have taken the patients vitals with a compatible device, ensured it is connected to the PC where SOAPware is running, and clicked the button to "Input from Welch Allyn", the vitals are populated in the correct fields in SOAPware.

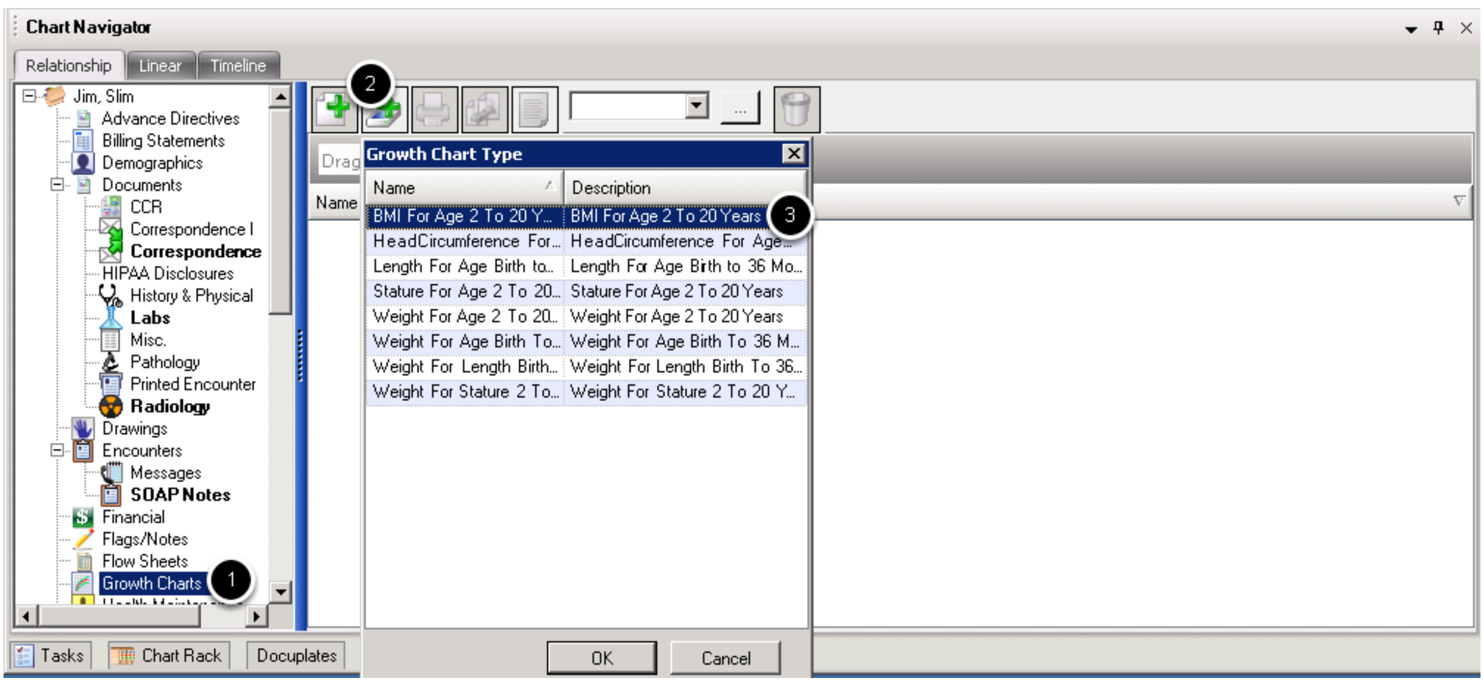
Growth Charts Section

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](#)

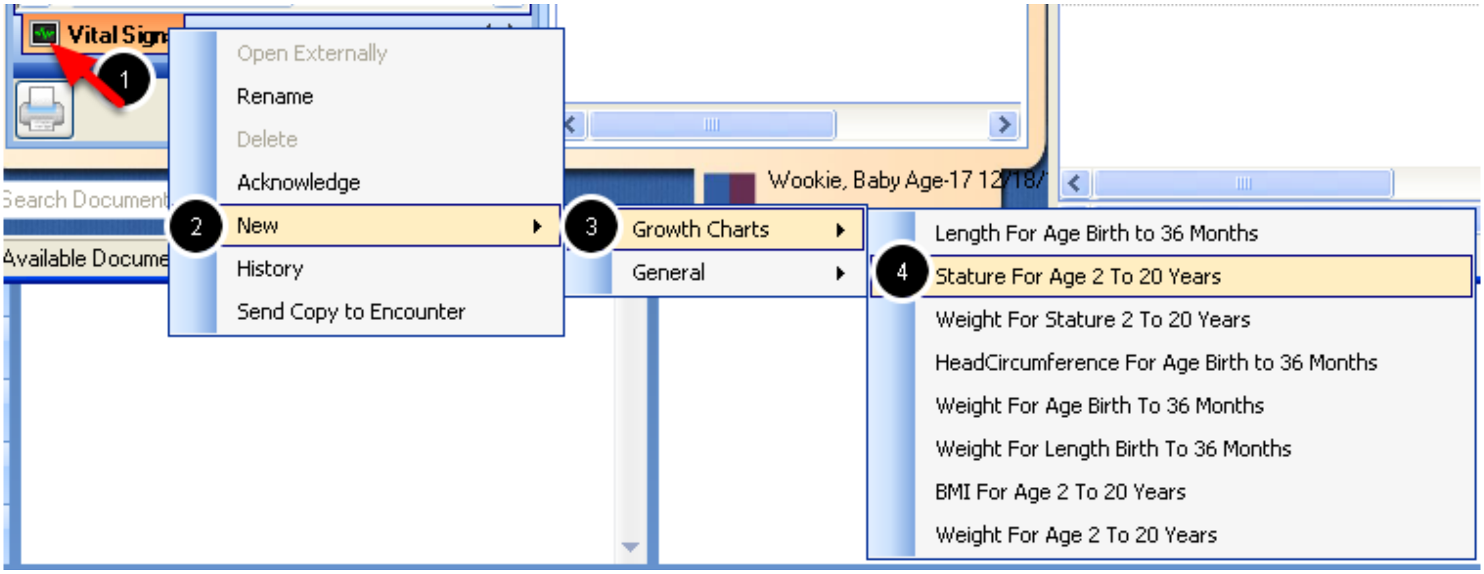
Accessing Growth Charts from Chart Navigator



Click on Chart Menu > Chart Navigator.

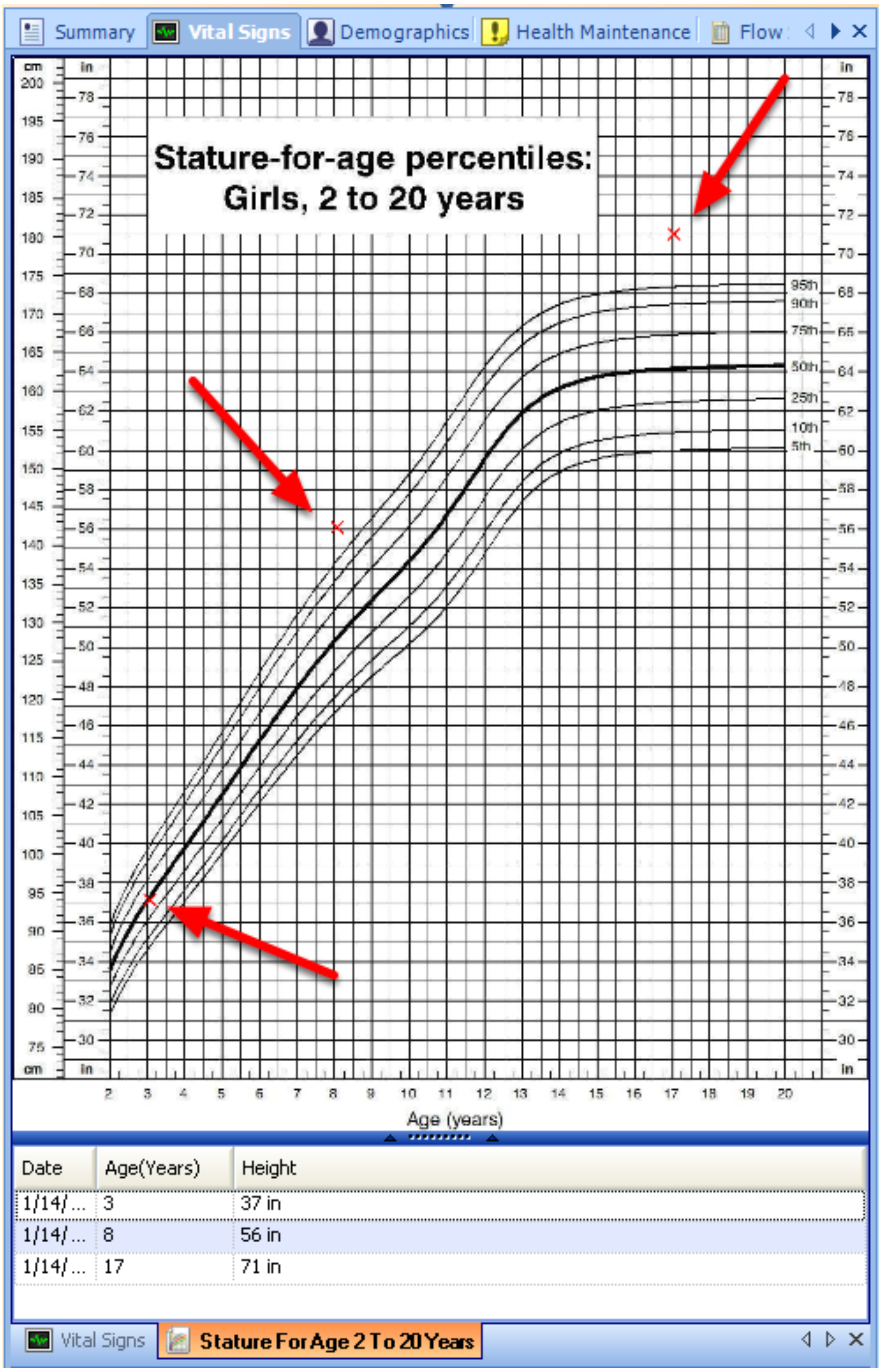
1. Choose Growth Charts.
2. Click the Create Docutainer button in the window to the right.
3. Select the desired Growth Chart Type.

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.

View Graph



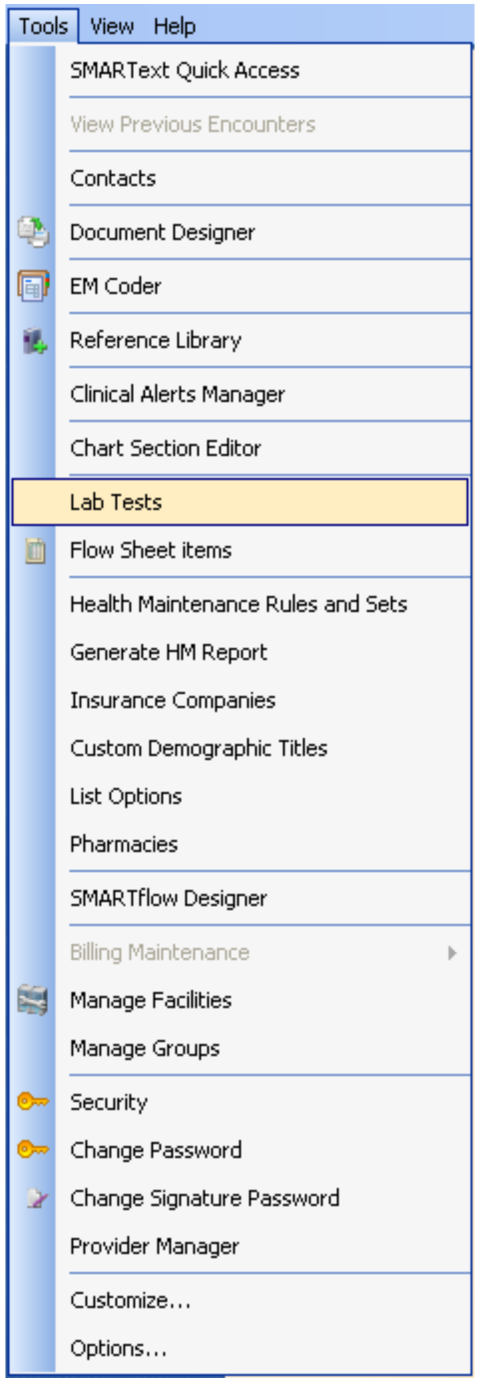
SOAPware will automatically plot the values on the chart using red X's and will continue to plot the Vital Signs by sequential dates.

Labs

Creating and Editing Lab Tests

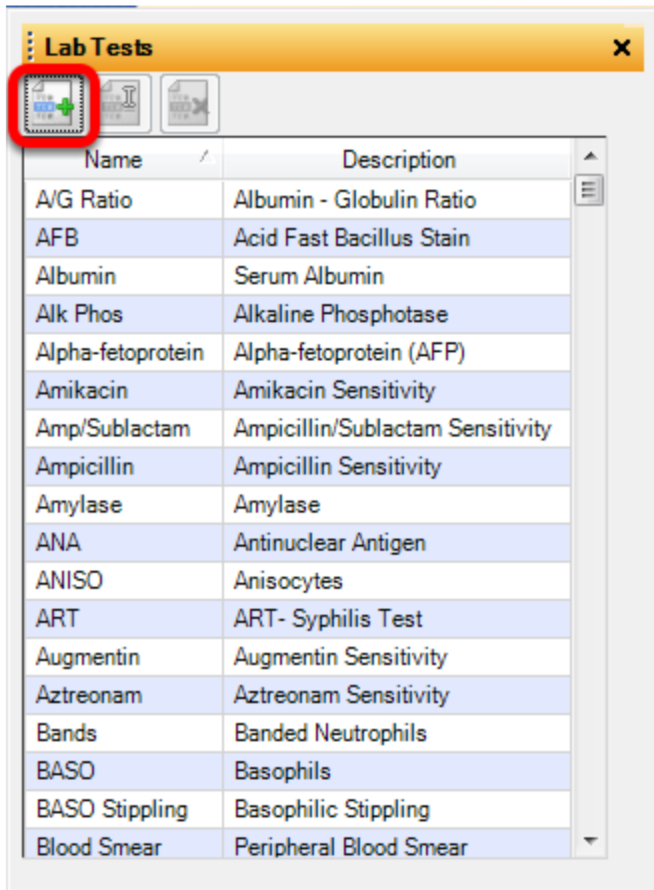
This lesson will explain how to create individual lab tests with reference ranges. These lab tests can be pulled into lab docuplates for documentation of lab results in the clinic Lab docuplates will be discussed in the next lesson.

Lab Tests



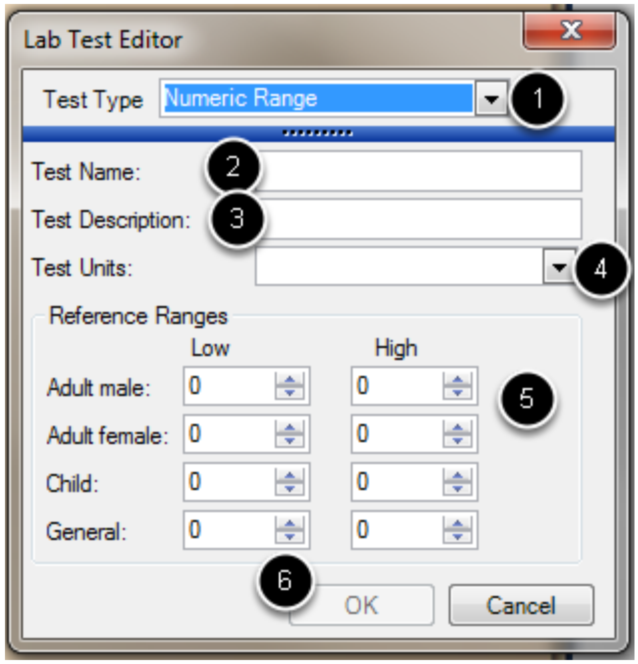
1. Go to the Tools Menu.
2. Click on Lab Tests.

Add a Lab Test



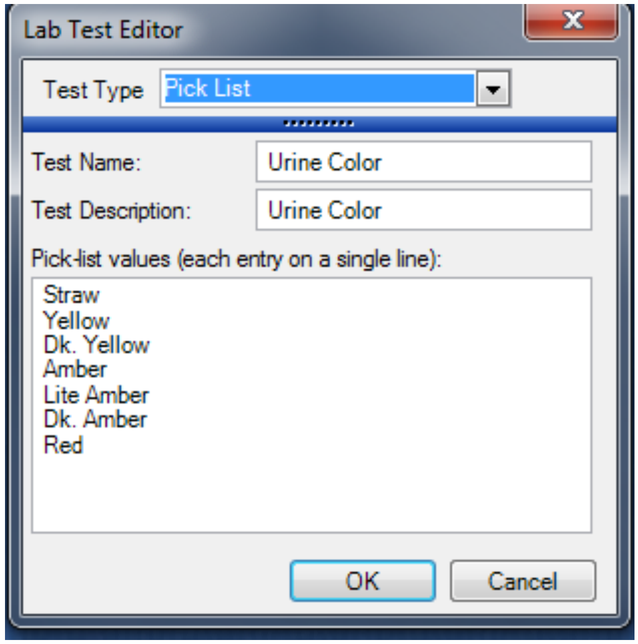
To create a specific lab test the user will click on the green (+). This will bring up the Lab Test editor.

Create Labs with Numeric Ranges



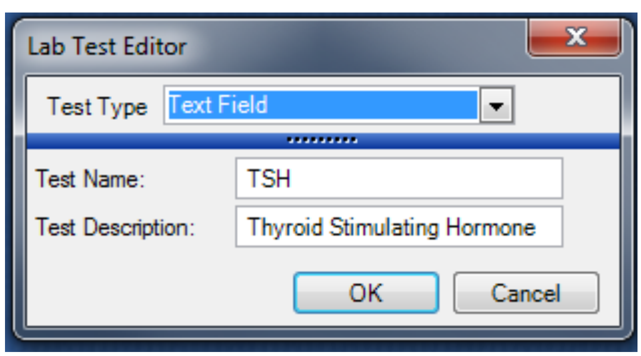
1. Select Test Type.
2. Enter Test Name.
3. Enter Test Description.
4. Select Test Units.
5. Enter Reference Ranges for Adult Male, Adult Female, Child and General.
6. Click OK.

Create Labs with Pick List Values



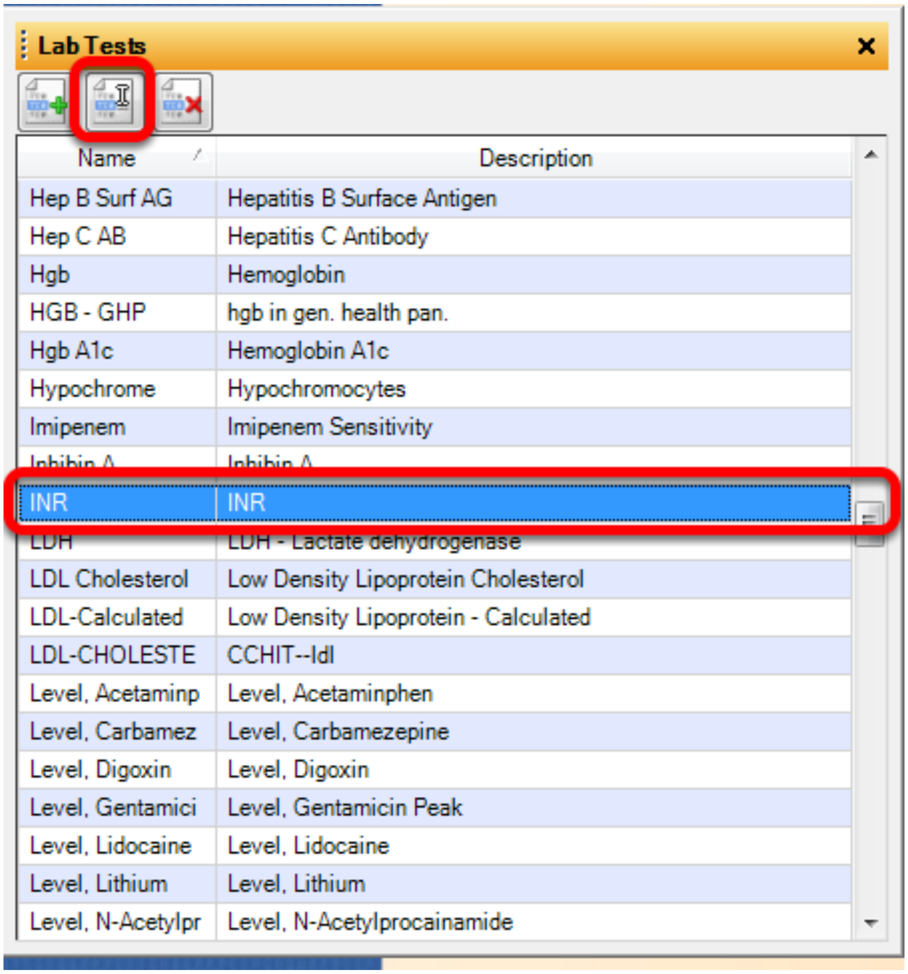
1. Select Test Type.
2. Enter Test Name.
3. Enter Test Description.
4. Enter Pick list value press the "Enter key" and enter second Value. Press the "Enter Key" and enter third value. Continue until all values are entered in this box.
5. Press OK to save this lab test.

Create Labs with Text Fields



Text Field labs allow the user to free text lab findings into the lab docuplate. These are not graph-able.

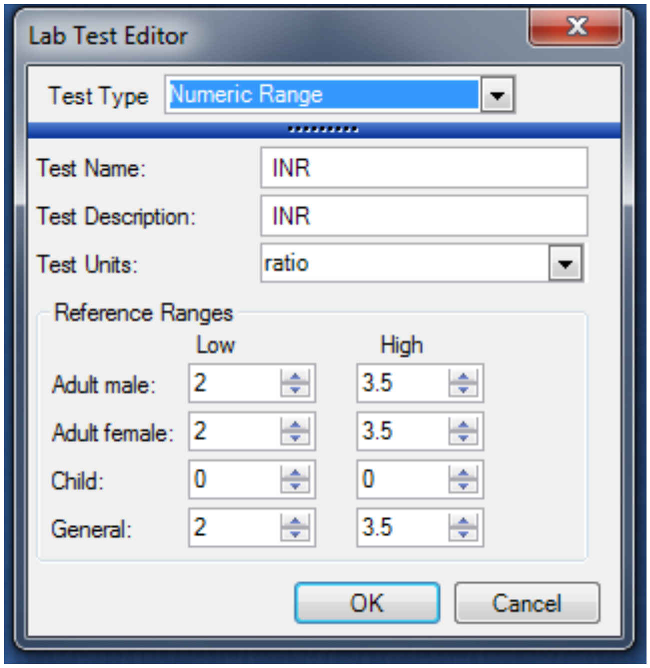
Edit



To Edit an Existing Lab:

1. Highlight lab to edit.
2. Click on the Edit Icon.

Numeric Range



Make necessary changes to Lab Test and press OK to save.

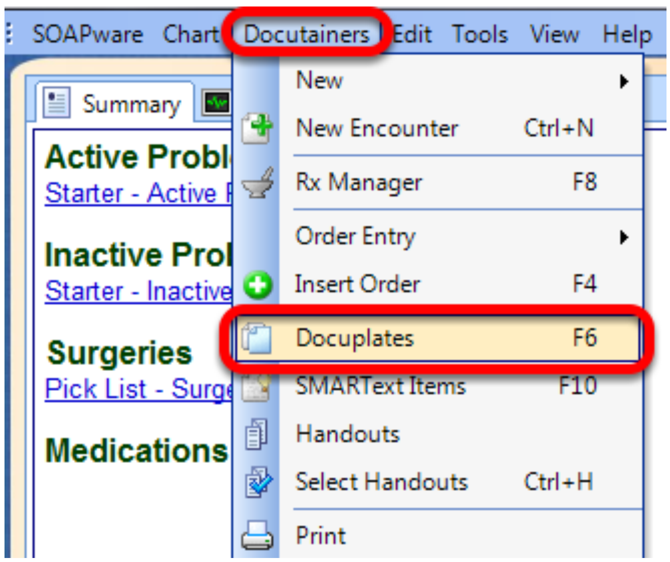
Lab Docuplates

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.

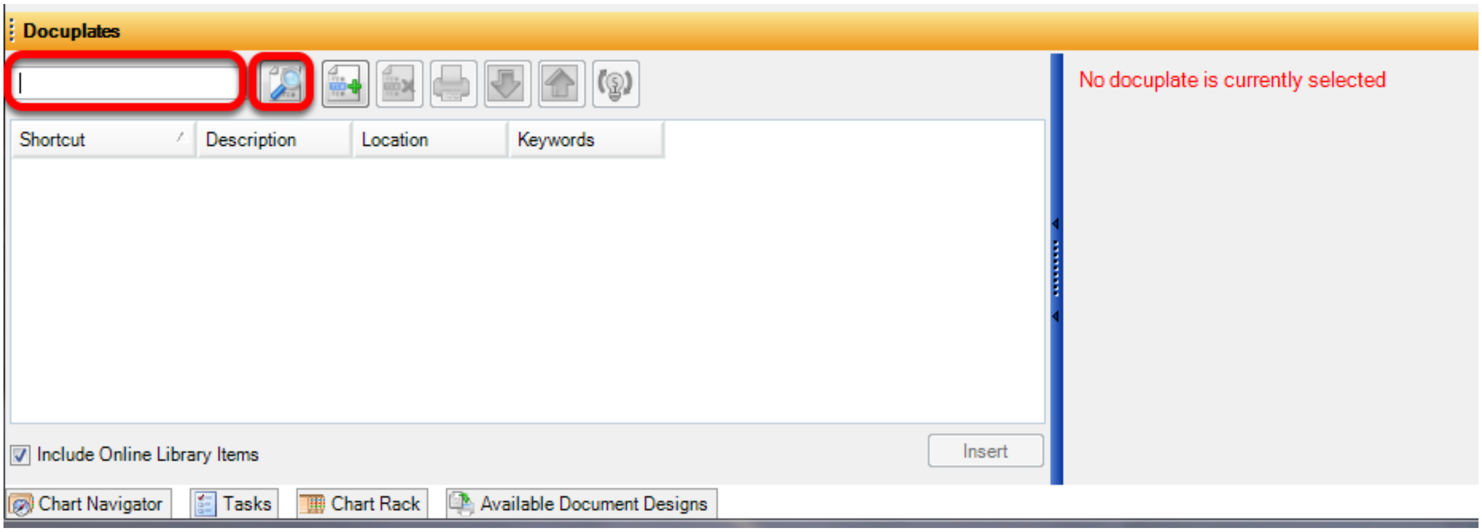
*** REQUIRED FOR MEANINGFUL USE**
- Clinical Lab Test Results

Searching for Lab Docuplates



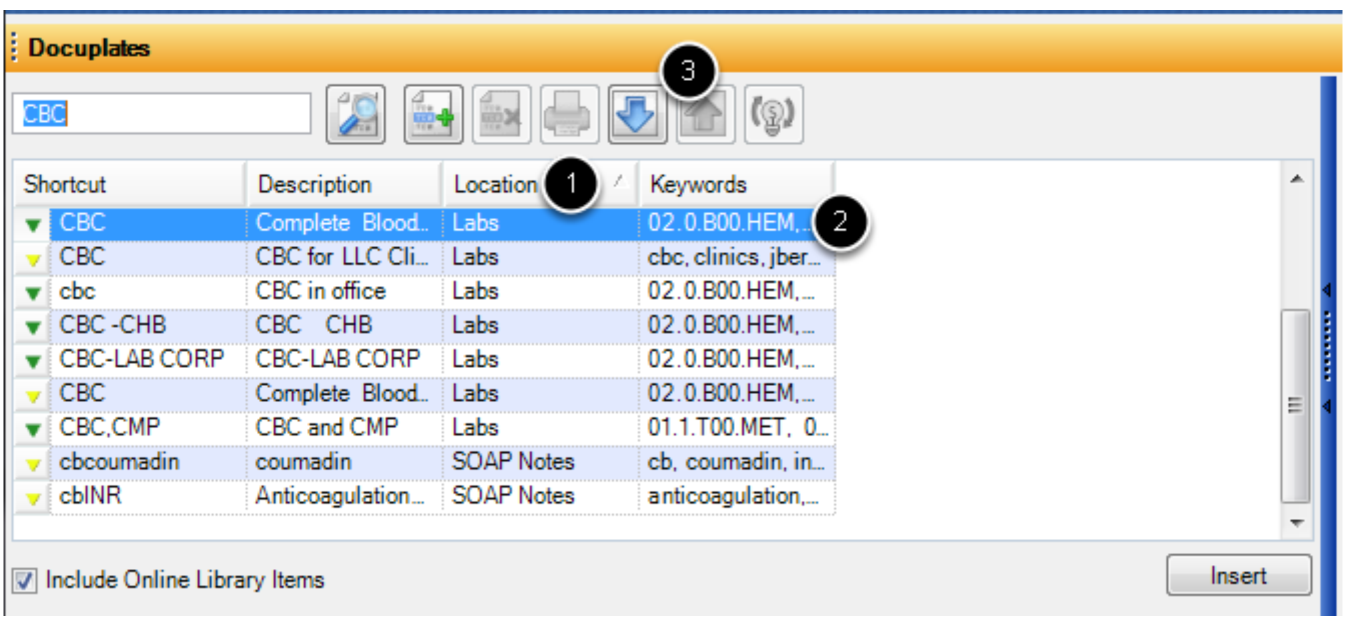
Many lab docuplates are pre-built by SOAPware. To search for available lab docuplates, click on the Docuplates tab docked at the bottom of the screen or click in the menu bar Docutainers > Docuplates

Search



To search for a docuplate, enter a keyword and Click on the Search button.

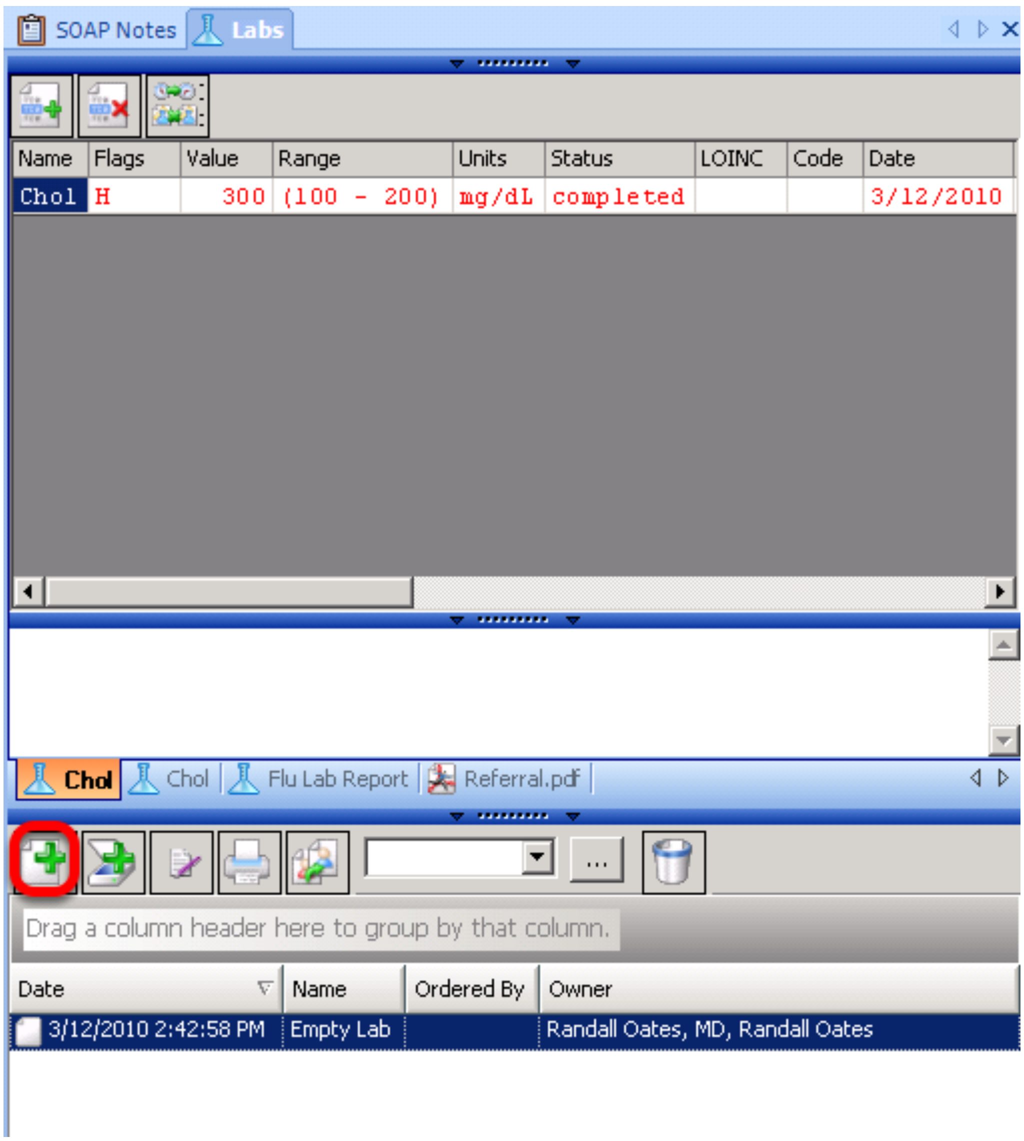
Download Docuplate



1. Click on Location to sort the docuplates.
2. Find docuplates in the Labs location.
3. Download the docuplate to the local library.

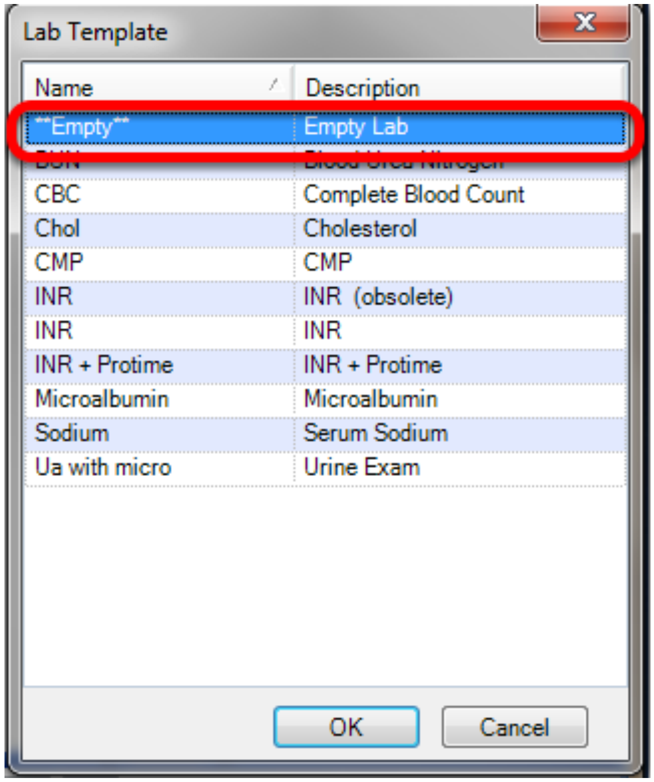
The docuplate is now ready to use within the network.

Creating New Lab Docuplates



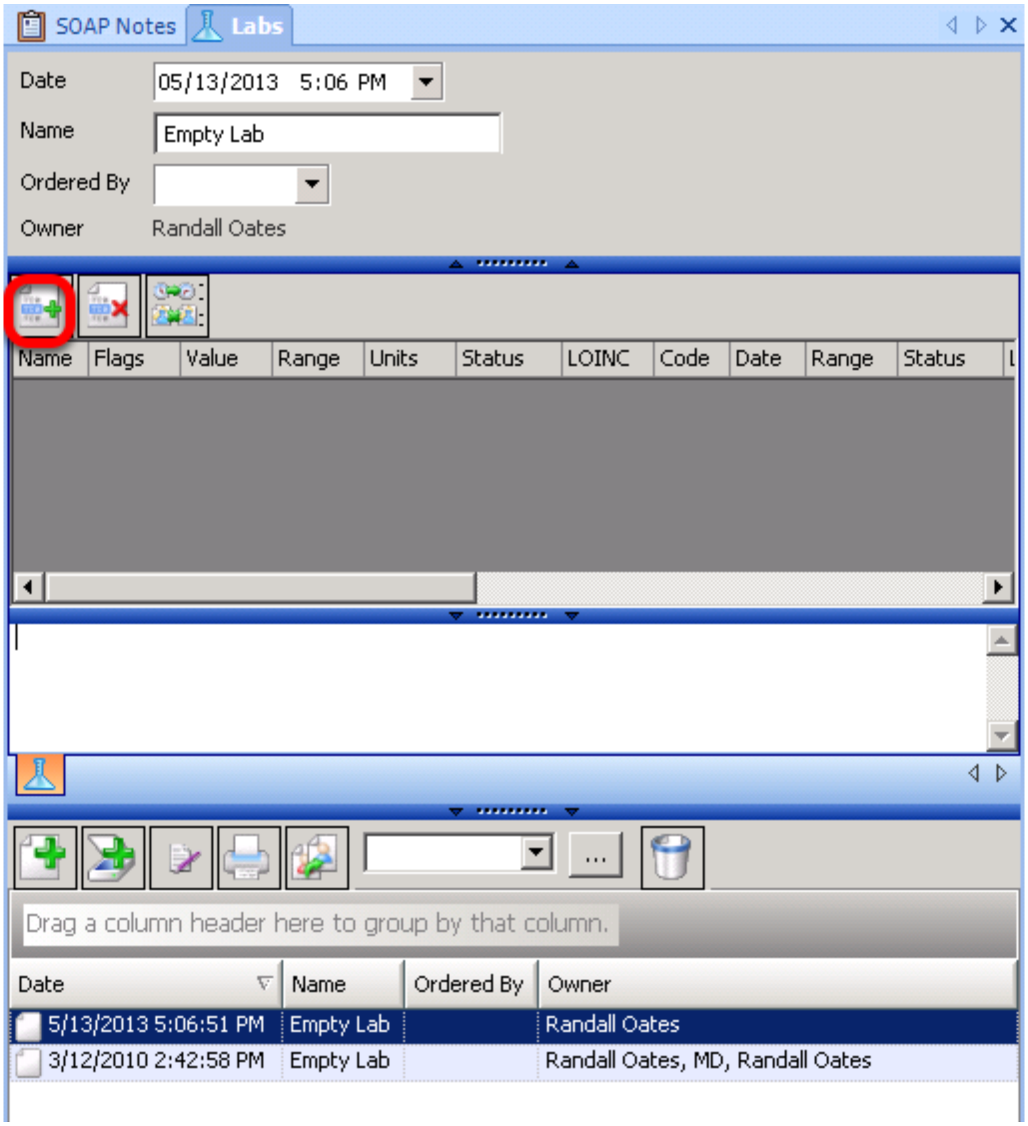
To Create a lab docuplate:
1. Open a "test" chart.
2. Open the Lab Chart section.
3. Click on the green + to create a new lab docutainer.

Select Empty



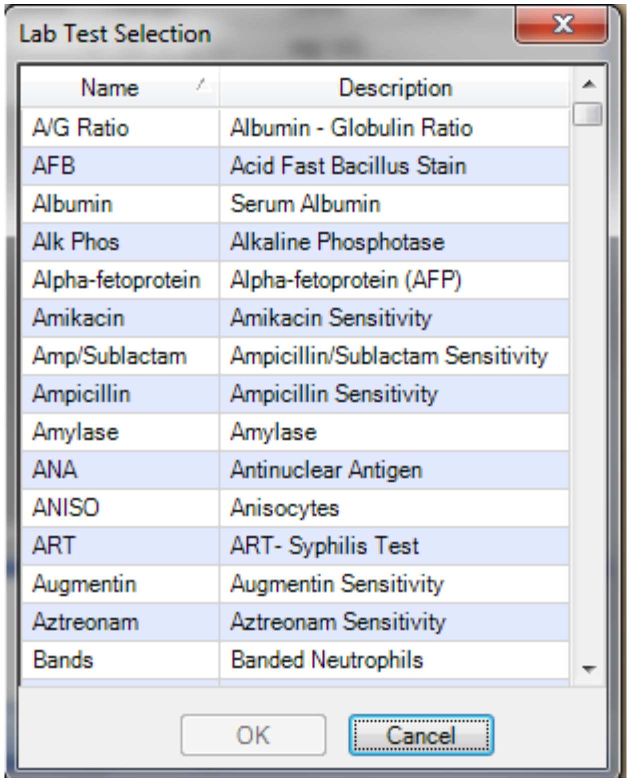
Select the Empty Lab template and click OK.

To Add a Lab Test



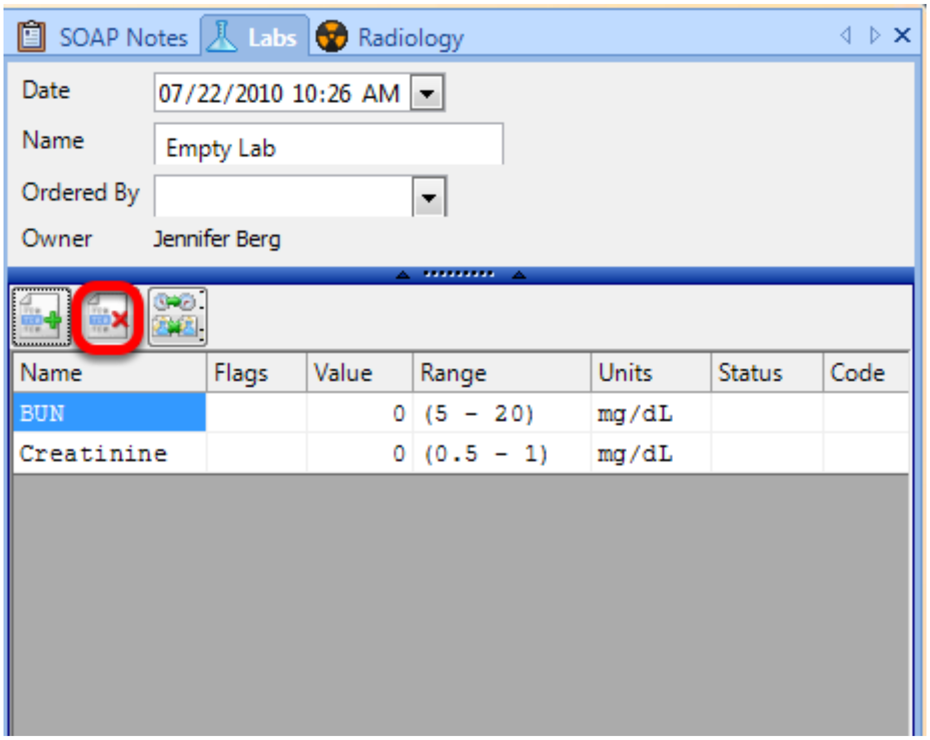
Click on the green + at the top of the Lab Encounter to enter lab tests.

Select Lab Tests



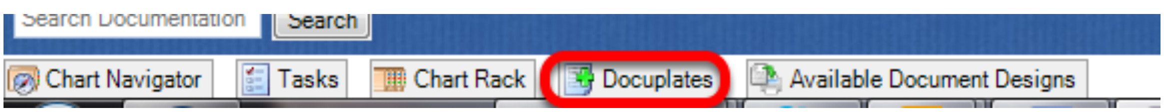
A user is to highlight the lab tests he/she wants to include and Click OK. To highlight multiple lab tests, Click and hold down the Control key on the keyboard and select the lab tests to add. The lab tests will display in the order they are selected. These cannot be moved up or down.

To Remove a Lab Test



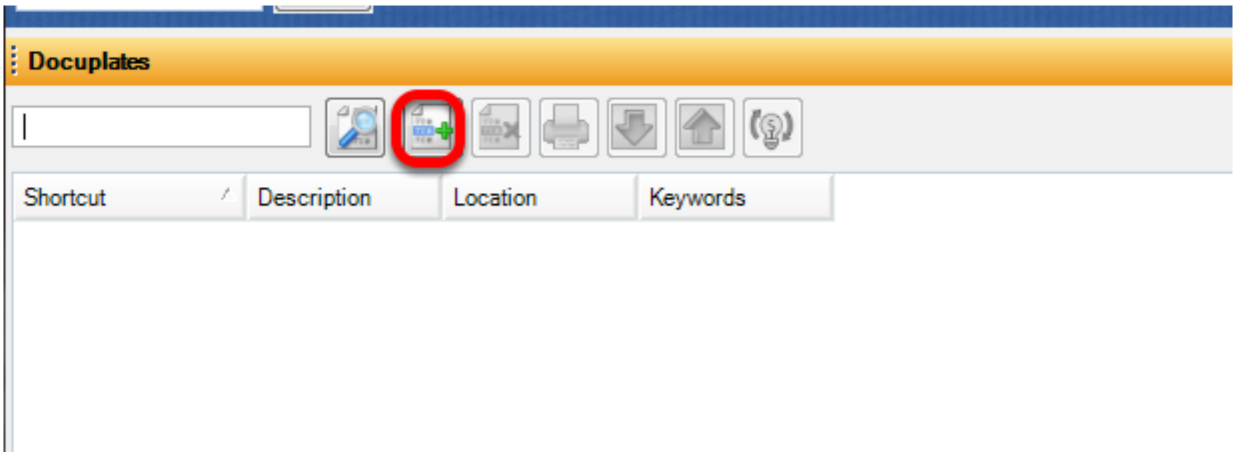
If a test needs to be removed, Click on the red X button.

Creating the Docuplate



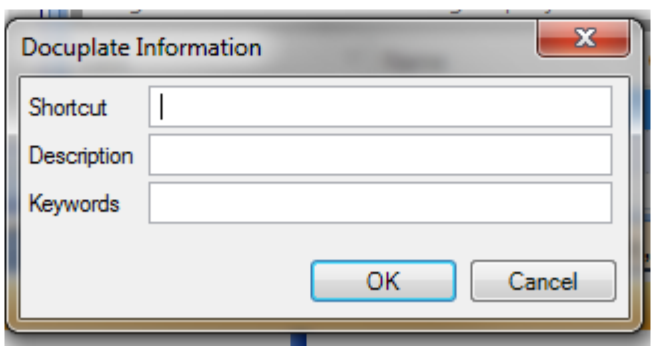
Click on the Docuplates tab docked at the bottom of the screen or select Docutainers > Docuplates from the menu bar.

Create a New Docuplate



To create the new docuplate, Click on the green + in the Docuplates Menu.

Enter Docuplate Information



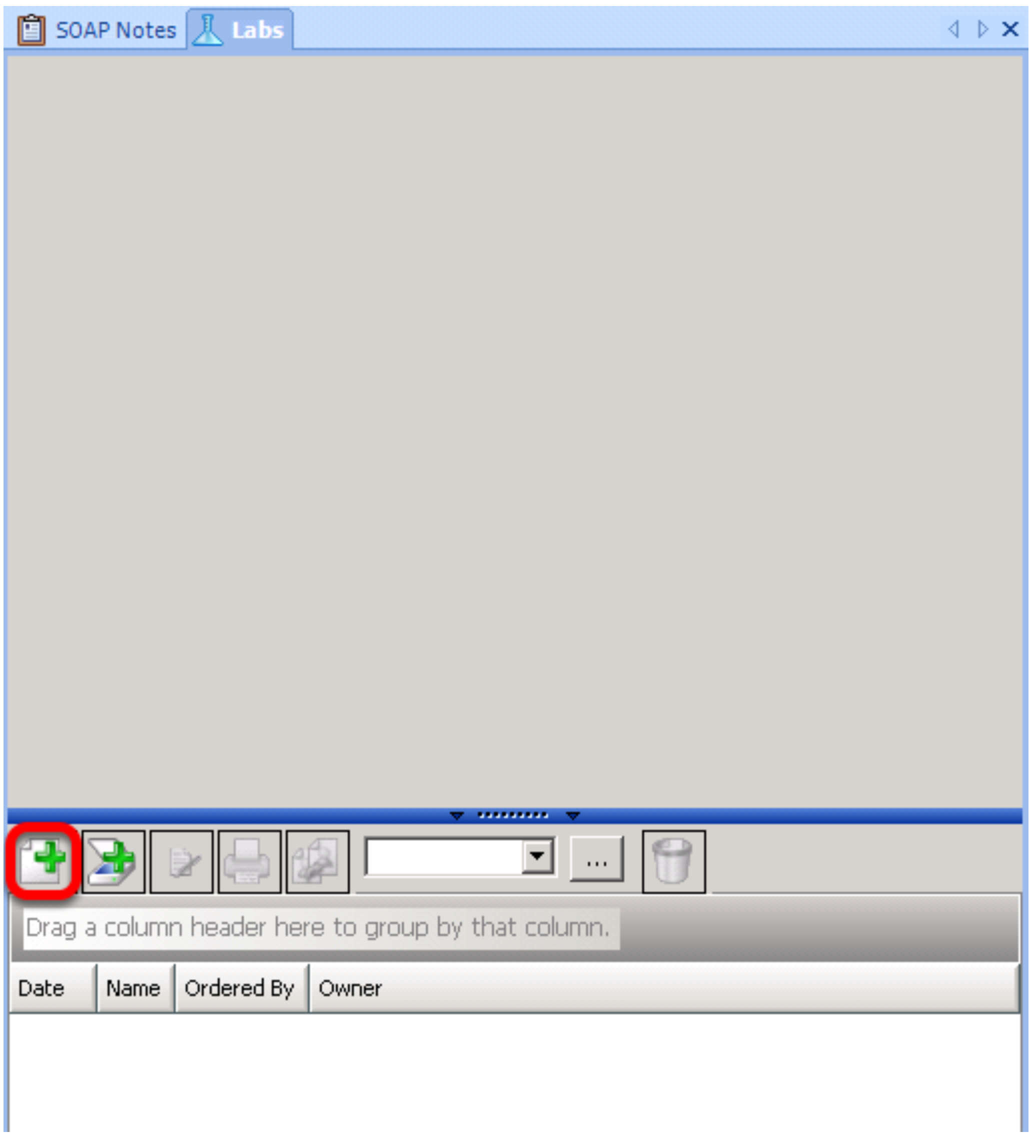
1. Give the docuplate a shortcut.
2. Enter a description for the docuplate.
3. Enter key words for the docuplate.

Documenting Labs

This lesson with walk through the workflow of entering Lab results.

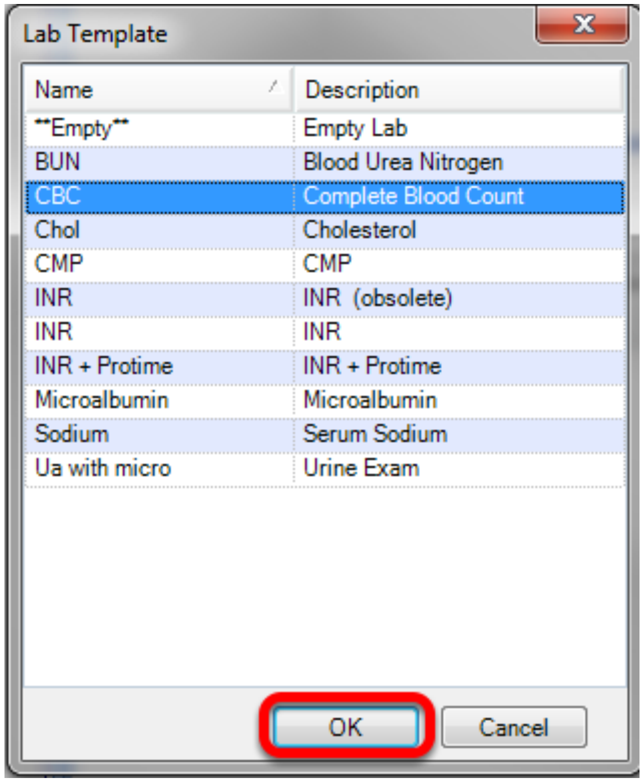
*** REQUIRED FOR MEANINGFUL USE**
- [Clinical Lab Test Results](#)

Creating a New Lab Result.



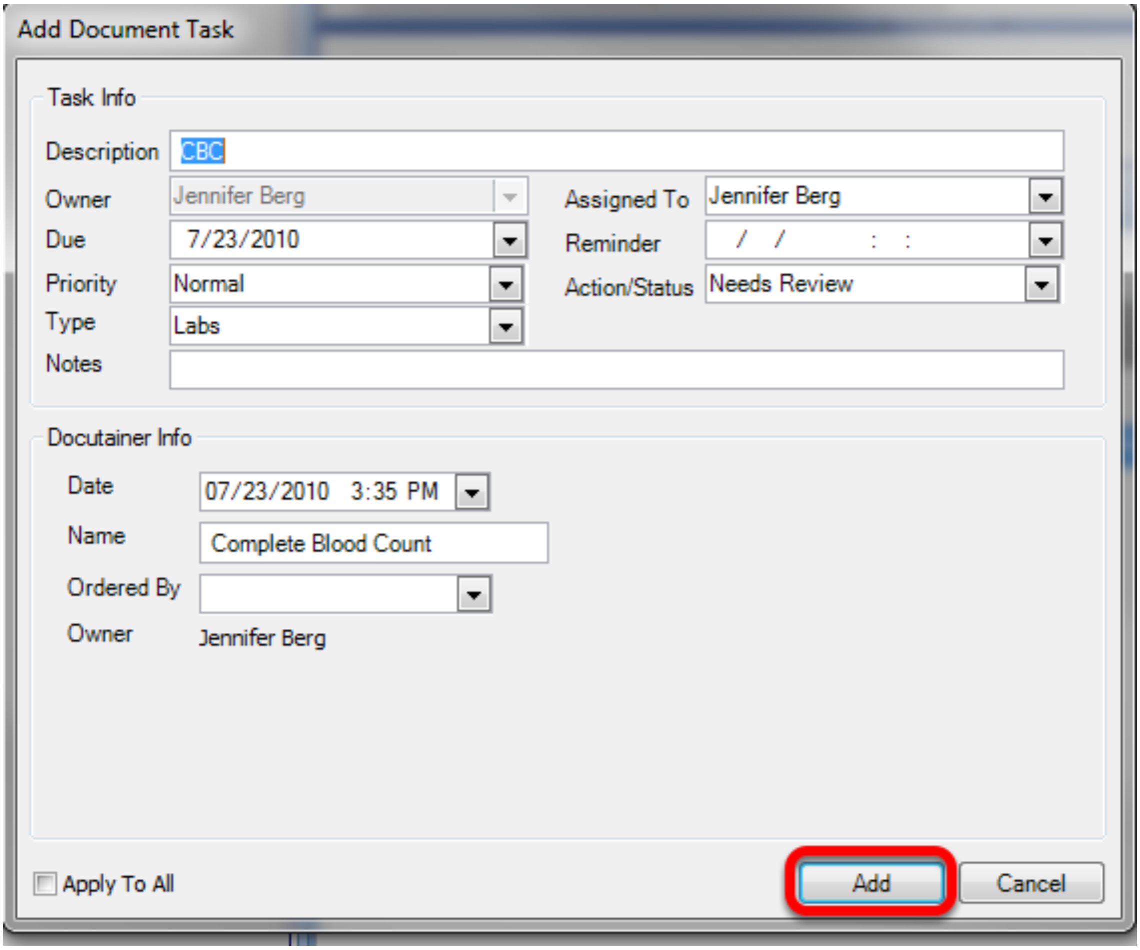
Click on the green + in the Labs Chart Section.

Select Template



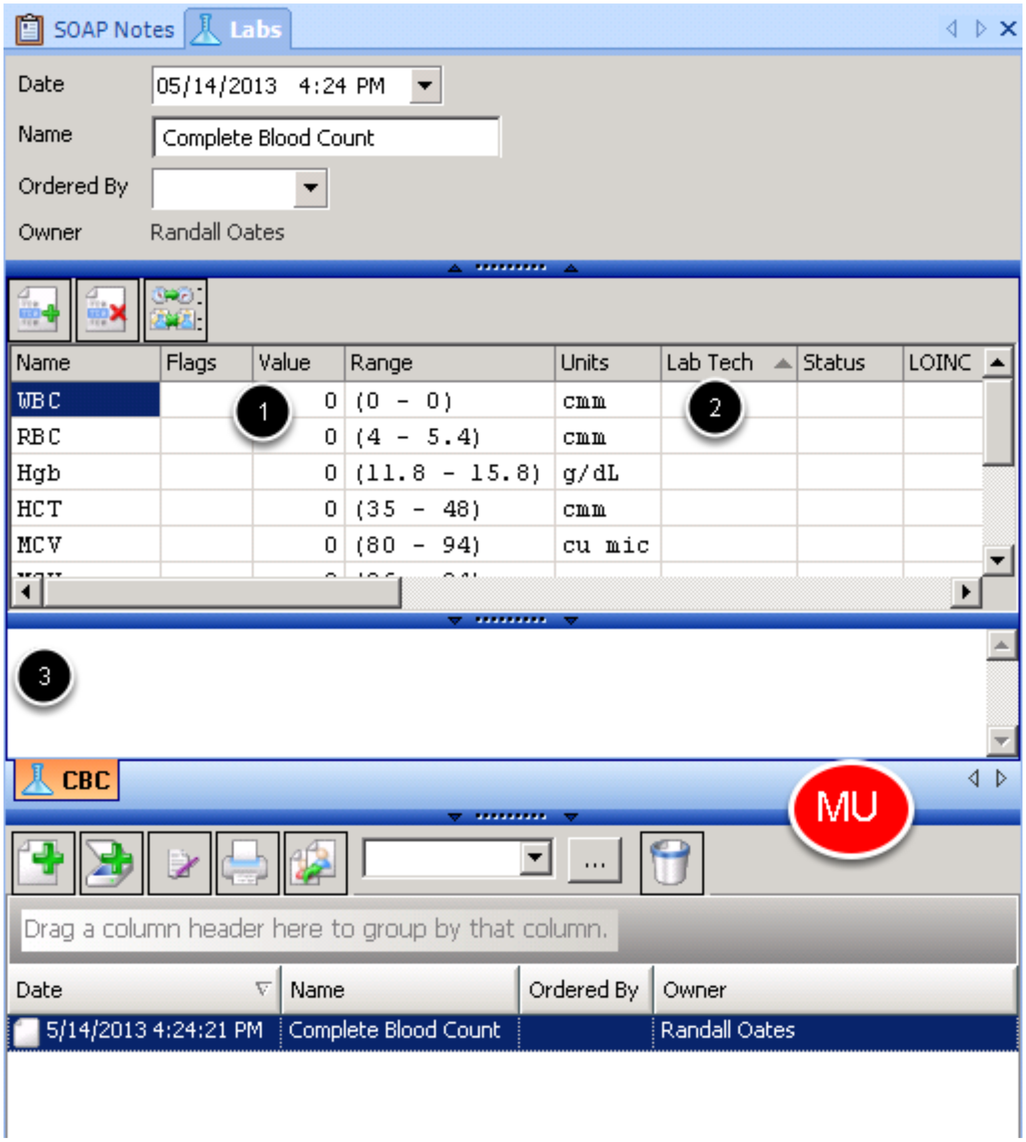
To alphabetically sort list click on the header Name or Description. The name of the lab is the information that was entered into the shortcut box when lab docuplate was created. The description of the lab is information that was entered into the description box when the lab docuplate was created. Highlight the desired lab template and select OK.

Document Task



This will automatically create a Document Task item. Click Add.

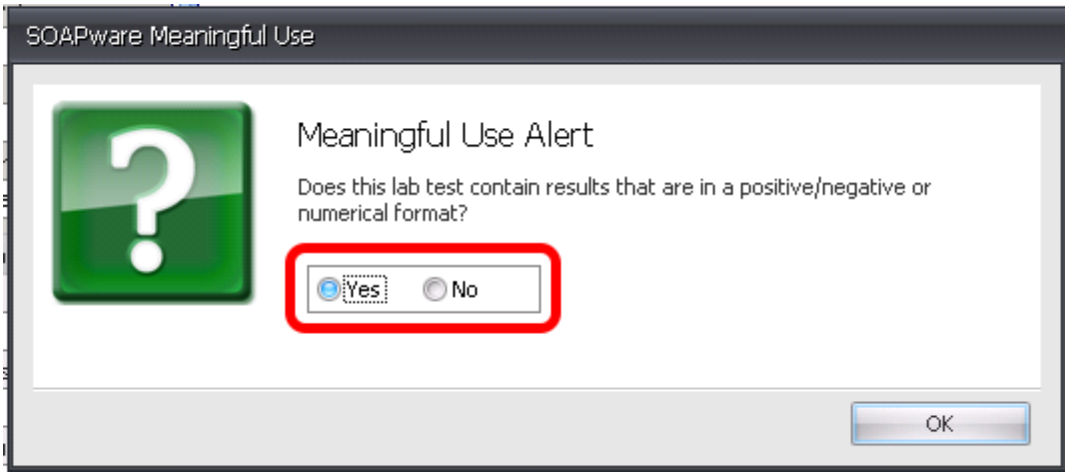
Enter Results



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.

Note*: The above method of documenting labs is considered structured data for the Meaningful Use requirement. For further information on this Meaningful Use Requirement, please see:* [*Clinical Lab Test Results.***]()

Scanning Labs Into the Labs Chart Section



Scanning a patient's lab result into the Labs chart section will not count as a structured lab to meet the meaningful use requirement. When a document is scanned into the Labs chart section, users will be prompted with a Meaningful Use alert (see screenshot above).

Users must select Yes or No to indicate if the lab test contains results that are in a positive/negative or numerical format on the scanned lab. This will allow SOAPware to properly calculate the total number of labs during the EHR reporting period whose results are either in a positive/negative or numerical format and are incorporated as unstructured data.

Scanning labs into SOAPware will increase the provider's denominator for this measure (the numerator will not increase unless the lab is incorporated as structured data).

To review this Meaningful Use requirement, see: **Clinical Lab Test Results.**

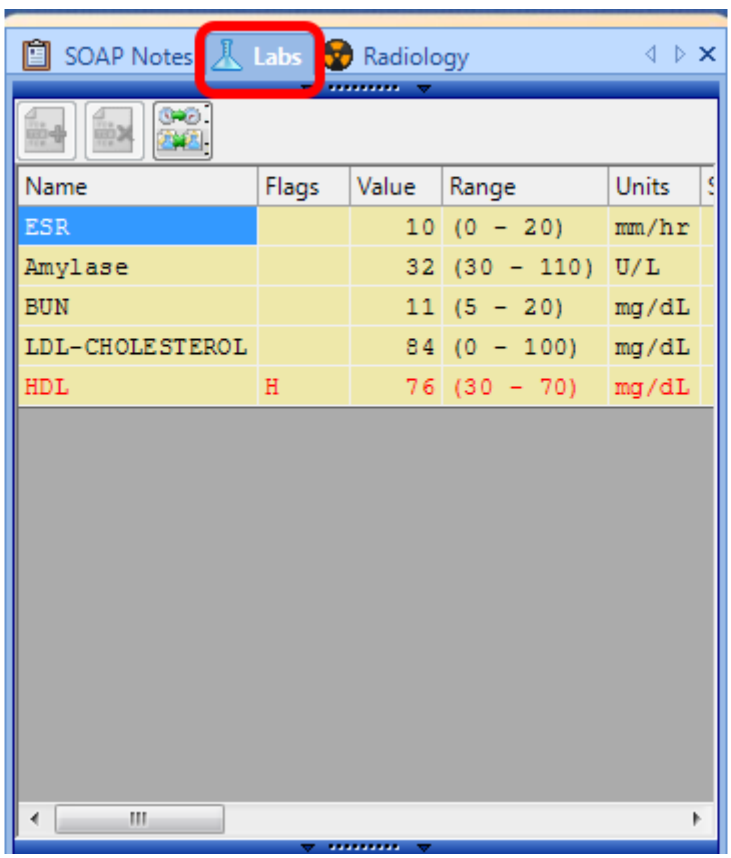
Comparing Lab Results

This lesson contains steps on how to compare lab results within the Labs chart section. Labs can only be compared if they were documented using structured lab tests in SOAPware. Scanned lab results cannot be compared.

For instructions on how to document lab results, see: Documenting Labs

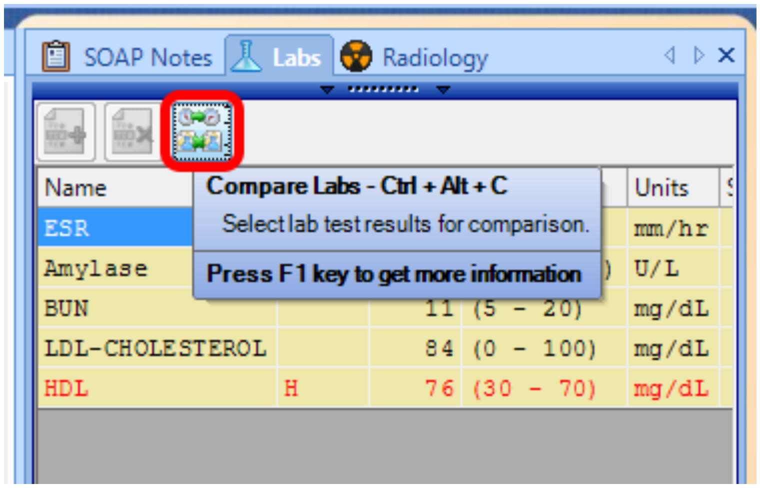
Note: *The instructions contained in the above link for documenting labs is considered structured data for the Meaningful Use requirement. For further information on this Meaningful Use Requirement, see:* Clinical Lab Results

Accessing Labs Chart Section



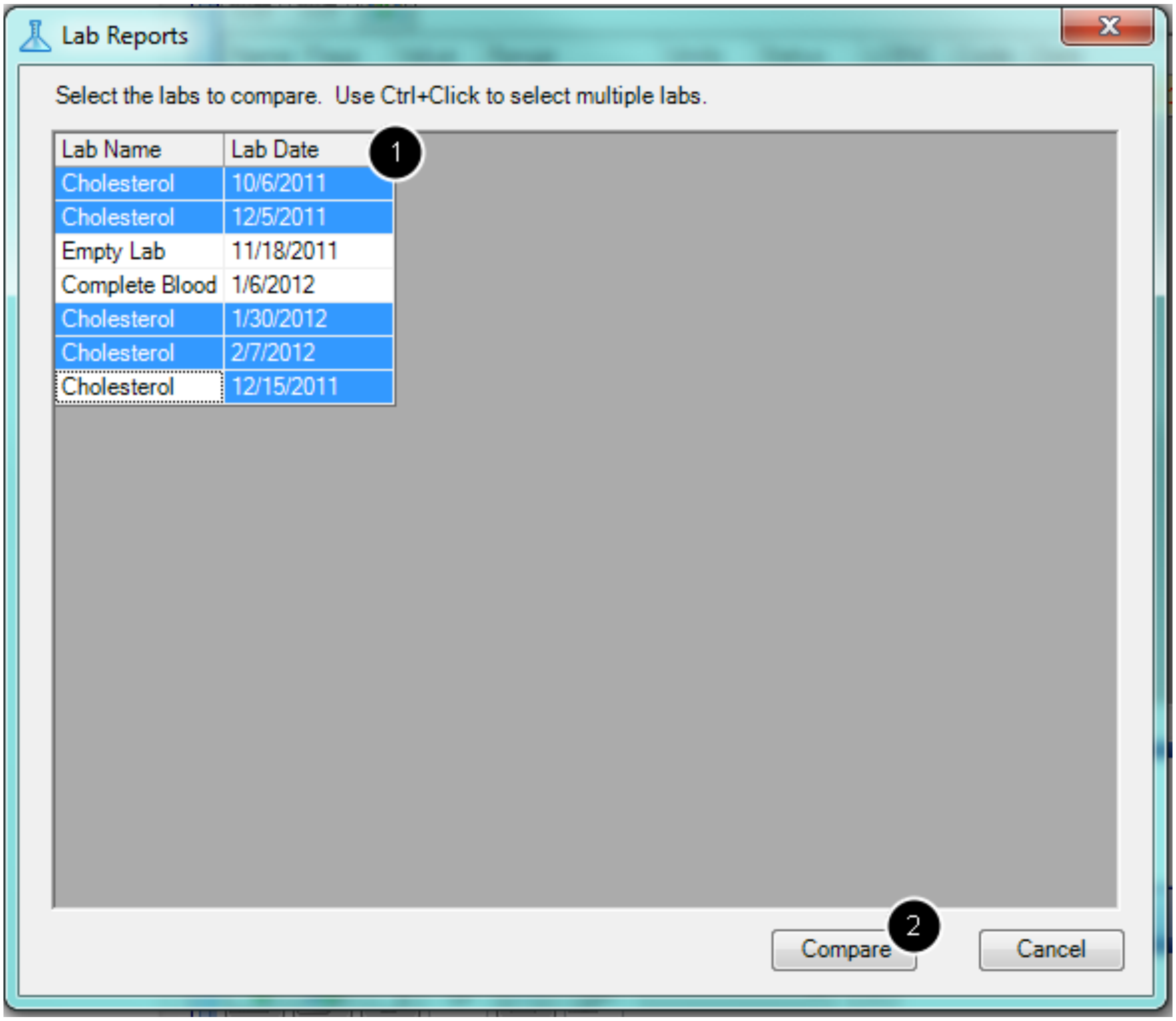
Click on the Labs tab to view the chart section.

Compare Labs Button

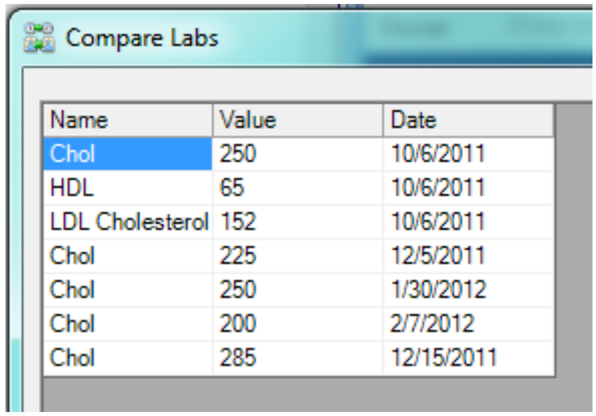


To begin comparing multiple labs, Click on the Compare Labs button.

Select Lab Tests For Comparison



1. Click to Select each lab that the user wishes to compare. Auser may select multiple labs at one time for comparison by using Ctrl + Click keyboard command.
2. Click the Compare button to display comparison of lab results.



Name	Value	Date
Chol	250	10/6/2011
HDL	65	10/6/2011
LDL Cholesterol	152	10/6/2011
Chol	225	12/5/2011
Chol	250	1/30/2012
Chol	200	2/7/2012
Chol	285	12/15/2011

After clicking the Compare button, the selected labs test and values will be displayed for the user (see example above).

Introduction to HL7 Labs

HL7 Labs are lab reports received electronically from outside lab facilities. To receive lab results electronically, a "SOAPwareXchangeHL7" Lab Interface license must be purchased.

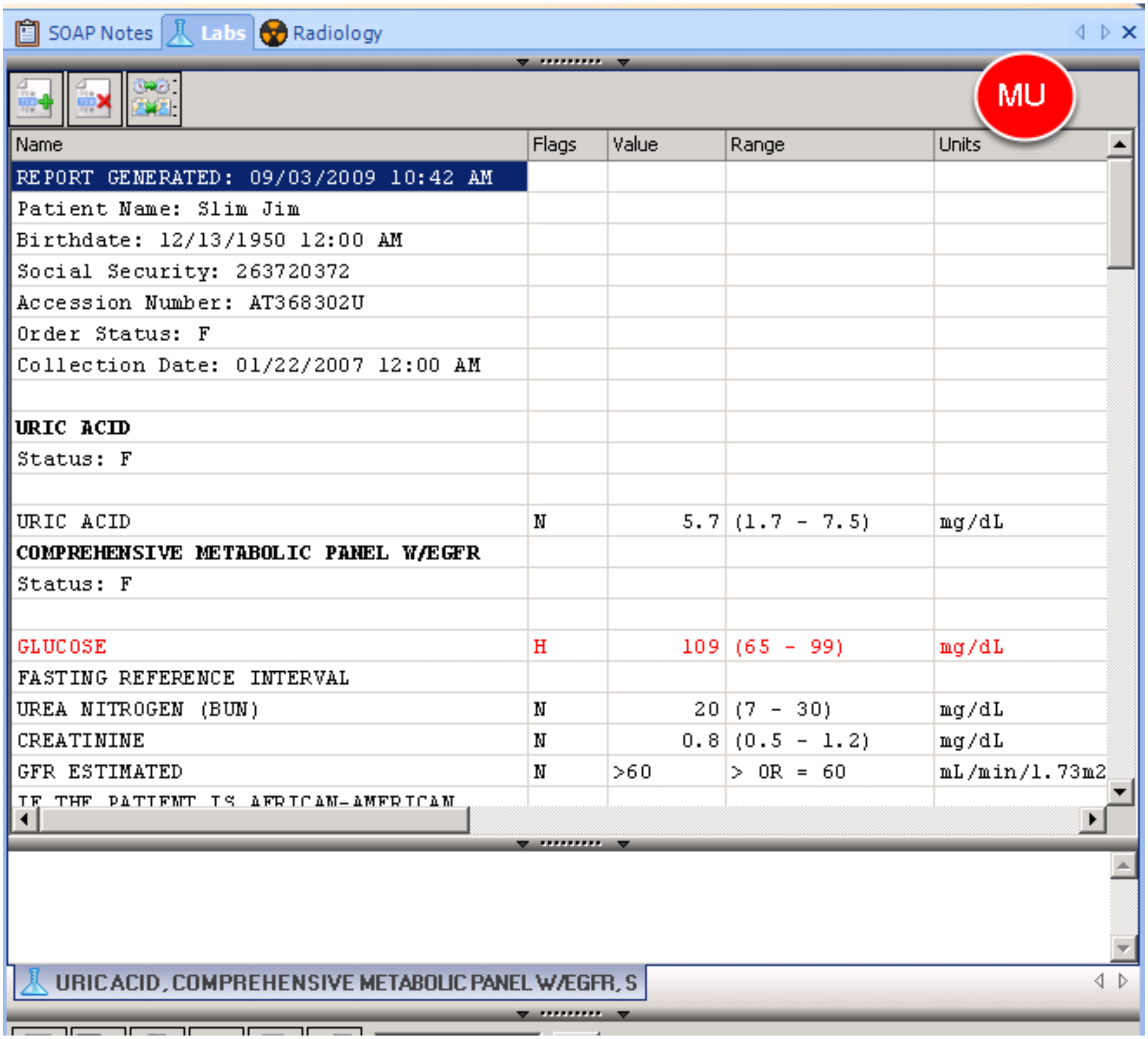
*** MEANINGFUL USE:** Clinical Lab Test Results

What is HL7?

The HL7 Lab Interface allows the clinic to establish a direct interface to automatically receive lab, pathology, radiology, even transcription reports and have them automatically filed into the patient’s chart in SOAPware with the powerful SOAPwareXchangeHL7 Interface Module. The module reads the demographic information in the report, finds the matching chart in SOAPware, transfers the report and notifies the provider all automatically.

Click Here for a list of Lab Systems that are compatible with SOAPwareXchangeHL7.

HL7 Labs in Patient Charts



Labs sent from outside facilities to SOAPware will display in a patient's Chart.

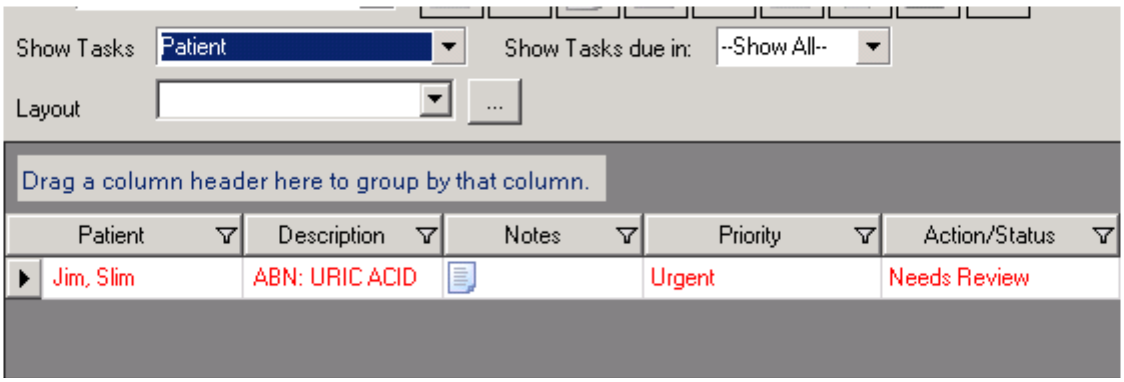
In addition to the lab values and reference ranges, HL7 labs will contain other information within the report:

- 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



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".

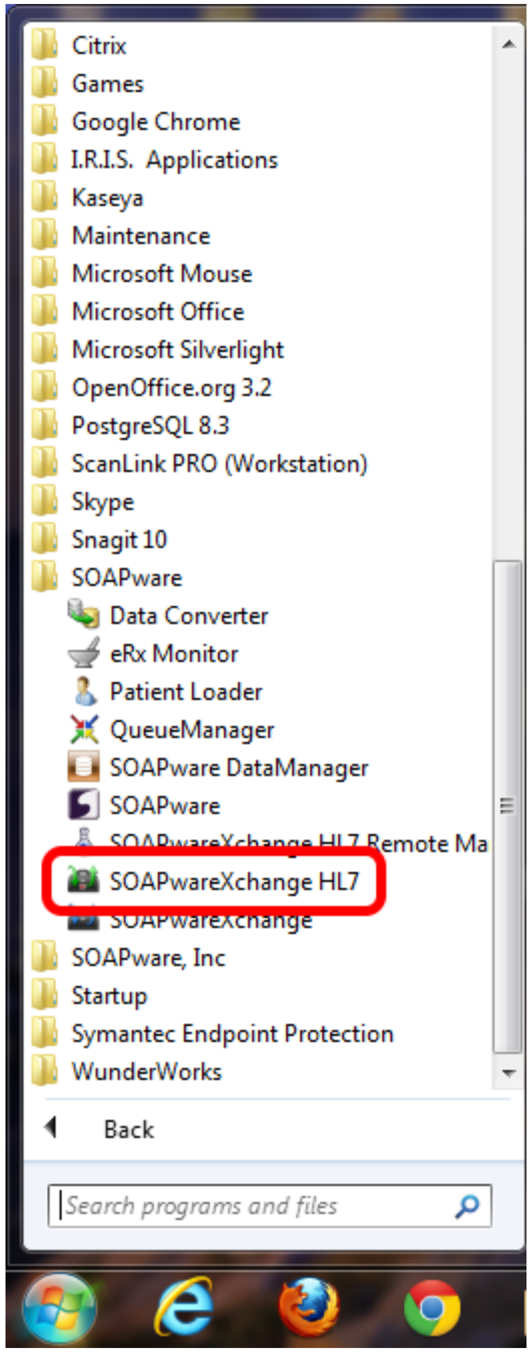
Receiving HL7 Lab Results

This lesson will describe how to log in and receive HL7 lab results. This requires a SOAPwareXchangeHL7 Lab Interface license.

The HL7 Lab Interface allows the clinic to establish a direct interface to automatically receive lab, pathology, radiology, even transcription reports and have them automatically filed into the patient’s chart in SOAPware with the powerful SOAPwareXchangeHL7 Interface Module. The module reads the demographic information in the report, finds the matching chart in SOAPware, transfers the report and notifies the provider all automatically.

Click Here for a list of Lab Systems that are compatible with SOAPwareXchangeHL7.

1. Log In to SOAPwareXchangeHL7



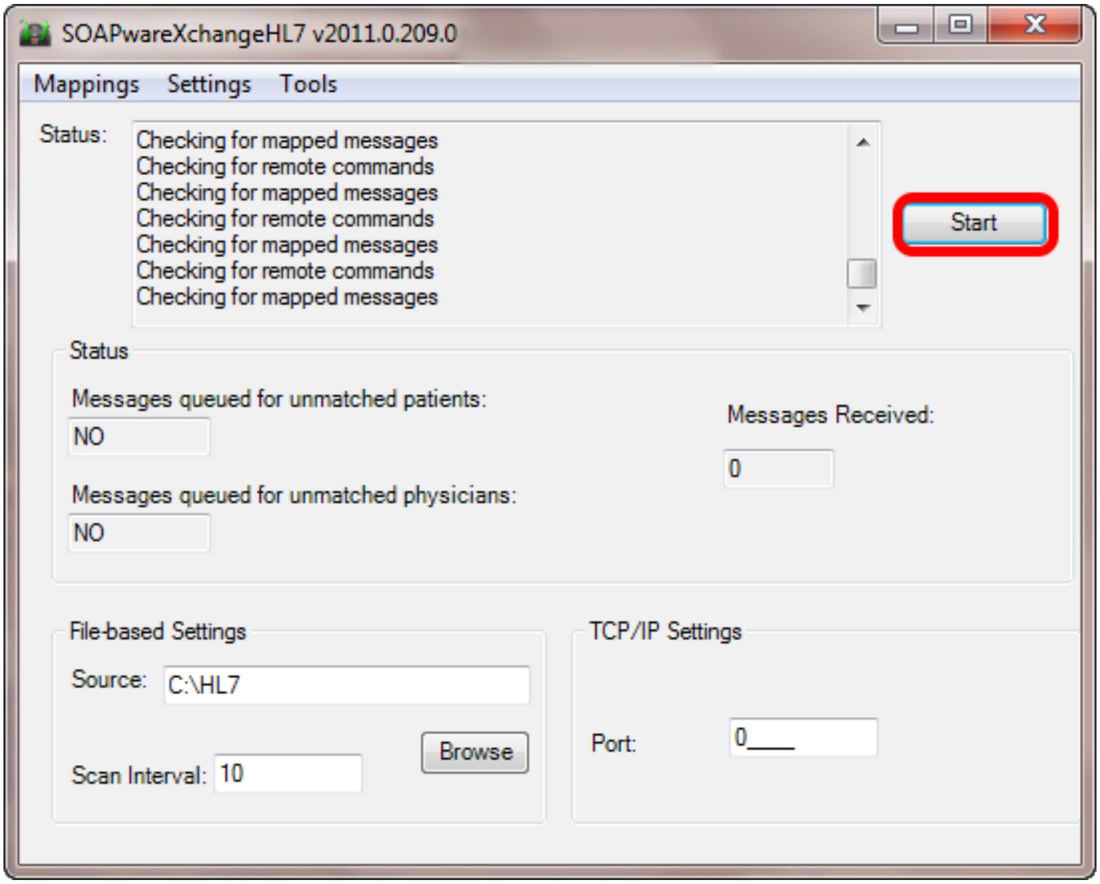
One clinic staff member must open and start the SOAPwareXchange HL7 program each day. To open and login to SOAPwareXchangeHL7, follow the steps below:

1. Click the Windows Start menu.

2. Select All Programs.
3. Select the SOAPware folder.
4. Click on SOAPwareXchangeHL7.

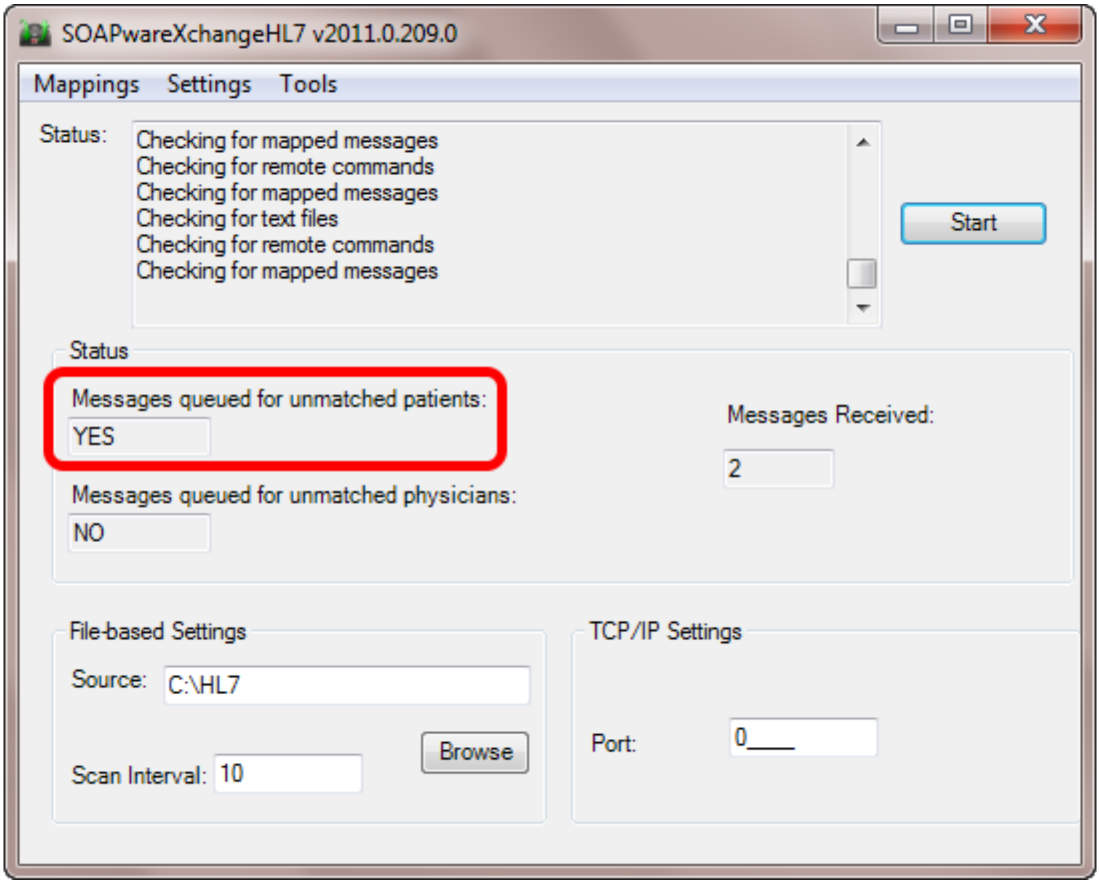
The SOAPware User Login window will appear. Enter your User ID and Password (same as your SOAPware login), then click the Log In button.

2. Start the HL7



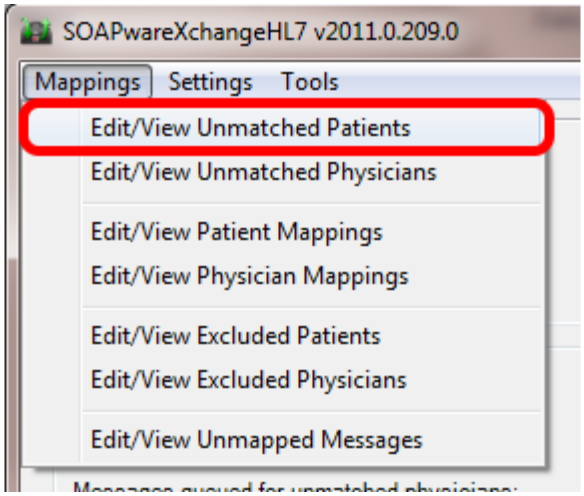
The HL7 main screen will now open. To begin receiving HL7 messages for the day, you must start the HL7 process. To do this, simply click the **Start** button.

3. Check for Unmatched Patients



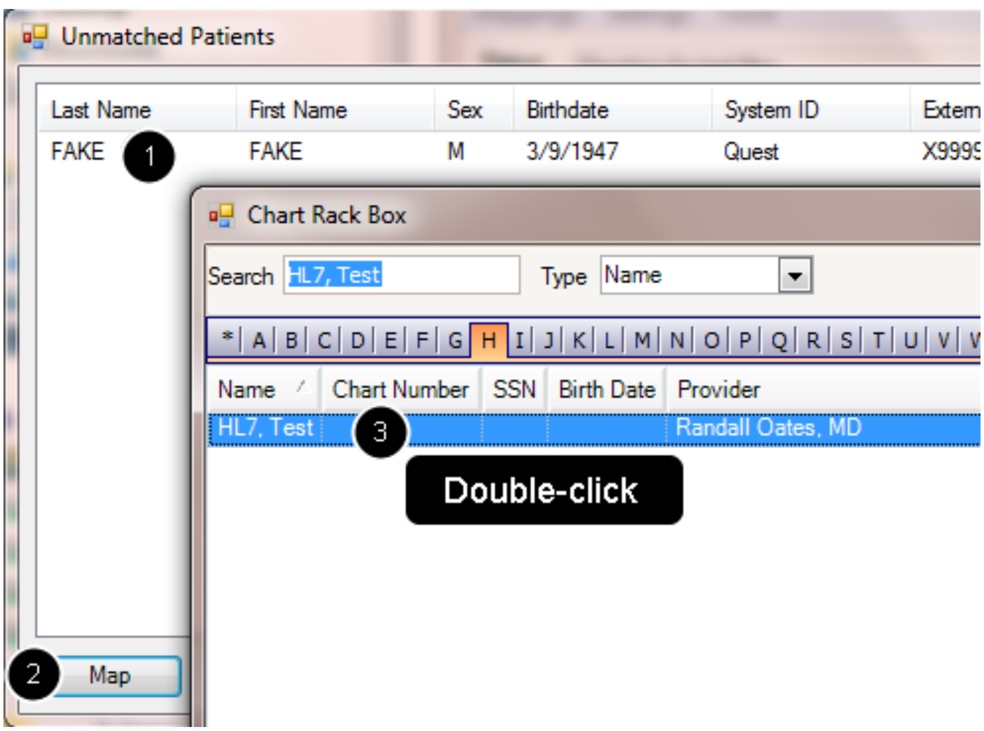
As HL7 messages are received throughout the day, the clinic staff should periodically check the status of messages that are being received.

If a message is received and SOAPware cannot identify the patient, a YES will appear in the box labeled "Messages queued for unmatched patients:".



If a YES appears in this box, follow the steps listed below to Match the patient.

1. Click on the Mappings menu.
2. Select Edit/View Unmatched Patients.

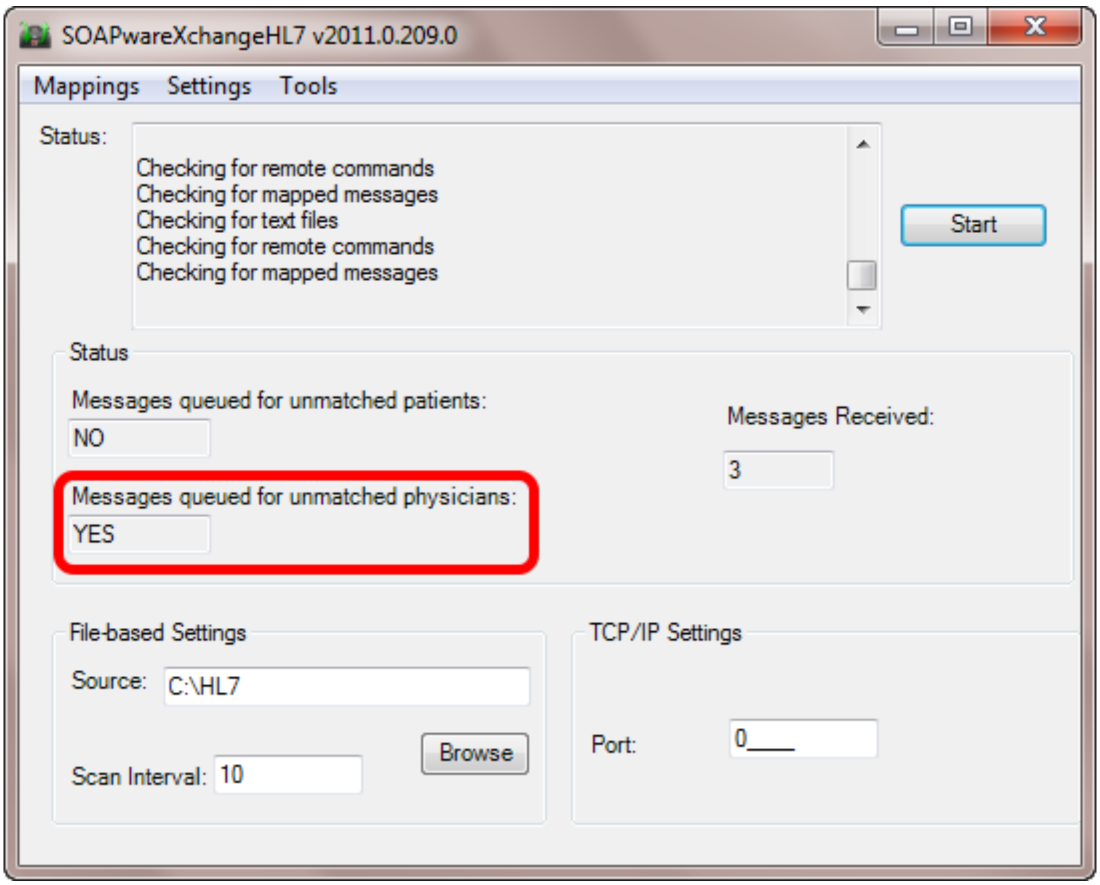


The Unmatched Patients window will appear with a list of patient who have not yet been Matched to a patient's SOAPware chart. To match the patient with a SOAPware chart, follow the steps below:

1. Highlight the patients name by clicking on it.
2. Click the Map button. The Chart Rack window will appear.
3. Find the appropriate patient within the Chart Rack, then double-click on the patients name to select it. This will Match/Map the incoming lab results with the patients SOAPware chart.

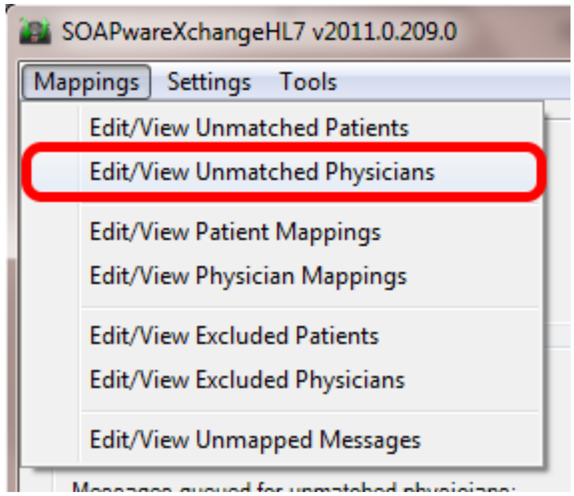
Close the Unmatched Patients window once all patients have been matched to a SOAPware chart using the steps above.

4. Check for Unmatched Physicians



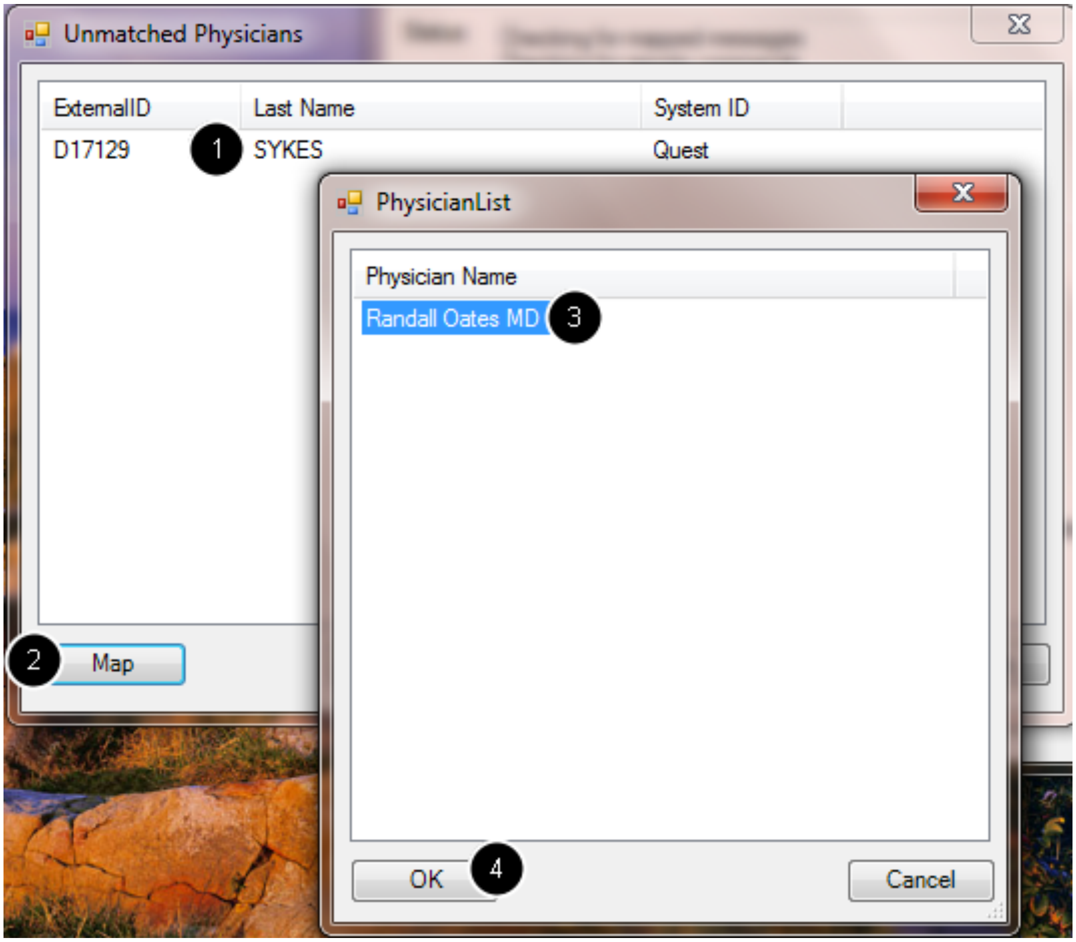
As HL7 messages are received throughout the day, the clinic staff should periodically check the status of messages that are being received.

If a message is received and SOAPware cannot match the patient with a physician, a YES will appear in the box labeled "Messages queued for unmatched physicians:".



If a YES appears in this box, follow the steps listed below to Match the physician.

1. Click on the Mappings menu.
2. Select Edit/View Unmatched Physicians.



The Unmatched Physicians window will appear with a list of patient lab results that have not yet been Matched to a SOAPware physician. To match the patient's lab results with a SOAPware physician, follow the steps below:

1. Highlight the patient's lab results line item to select it.
2. Click the Map button. The Physician List window will appear.
3. Select the appropriate physician, then click the OK button. This will Match/Map the incoming patient's lab results with the appropriate SOAPware physician.

Close the Unmatched Physician window once all lab results have been matched to the appropriate SOAPware physician using the steps above.

5. Lab Results are Imported into Patient Charts

Once the lab results have been mapped to the appropriate patient and physician, the results will be imported directly into the patient's chart.

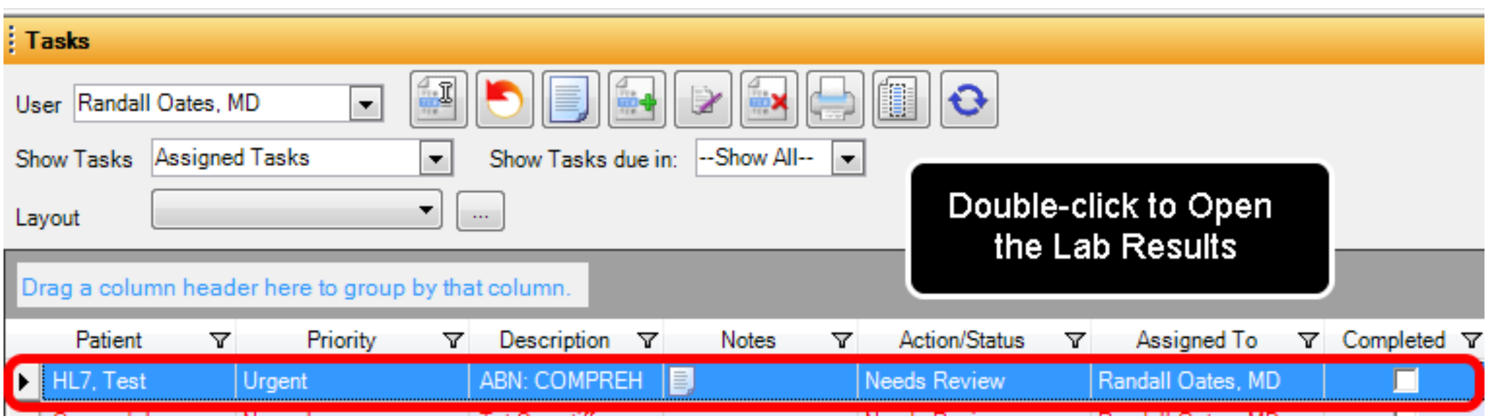
Reviewing HL7 Lab Results

This lesson will describe how to review HL7 lab results after they have been received and imported into the patients chart. This requires a SOAPwareXchangeHL7 Lab Interface license.

The HL7 Lab Interface allows the clinic to establish a direct interface to automatically receive lab, pathology, radiology, even transcription reports and have them automatically filed into the patient's chart in SOAPware with the powerful SOAPwareXchangeHL7 Interface Module. The module reads the demographic information in the report, finds the matching chart in SOAPware, transfers the report and notifies the provider all automatically.

Click Here for a list of Lab Systems that are compatible with SOAPwareXchangeHL7.

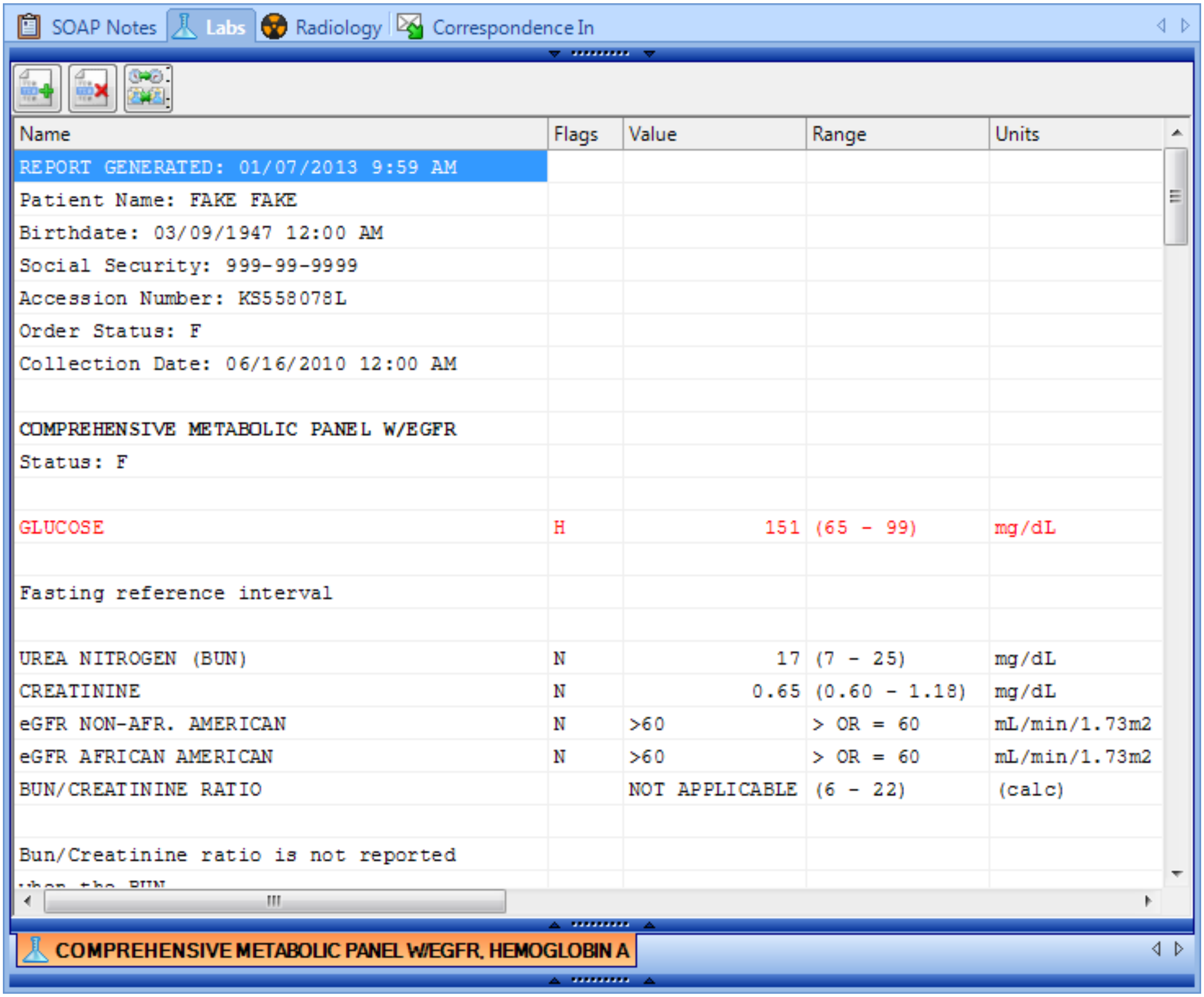
1. Task Item Notification



When lab result HL7 messages are received from the lab companies, they will be automatically imported into the appropriate patients chart. In addition, the ordering provider will be notified that the lab results have been received through the Task Manager.

Anew task item will be placed on the appropriate provider's task list. To view the lab results, the provider should double-click on the task item to open them for viewing.

2. Review Lab Results



Name	Flags	Value	Range	Units
REPORT GENERATED: 01/07/2013 9:59 AM				
Patient Name: FAKE FAKE				
Birthdate: 03/09/1947 12:00 AM				
Social Security: 999-99-9999				
Accession Number: KS558078L				
Order Status: F				
Collection Date: 06/16/2010 12:00 AM				
COMPREHENSIVE METABOLIC PANEL W/EGFR				
Status: F				
GLUCOSE	H	151	(65 - 99)	mg/dL
Fasting reference interval				
UREA NITROGEN (BUN)	N	17	(7 - 25)	mg/dL
CREATININE	N	0.65	(0.60 - 1.18)	mg/dL
eGFR NON-AFR. AMERICAN	N	>60	> OR = 60	mL/min/1.73m2
eGFR AFRICAN AMERICAN	N	>60	> OR = 60	mL/min/1.73m2
BUN/CREATININE RATIO		NOT APPLICABLE	(6 - 22)	(calc)
Bun/Creatinine ratio is not reported				

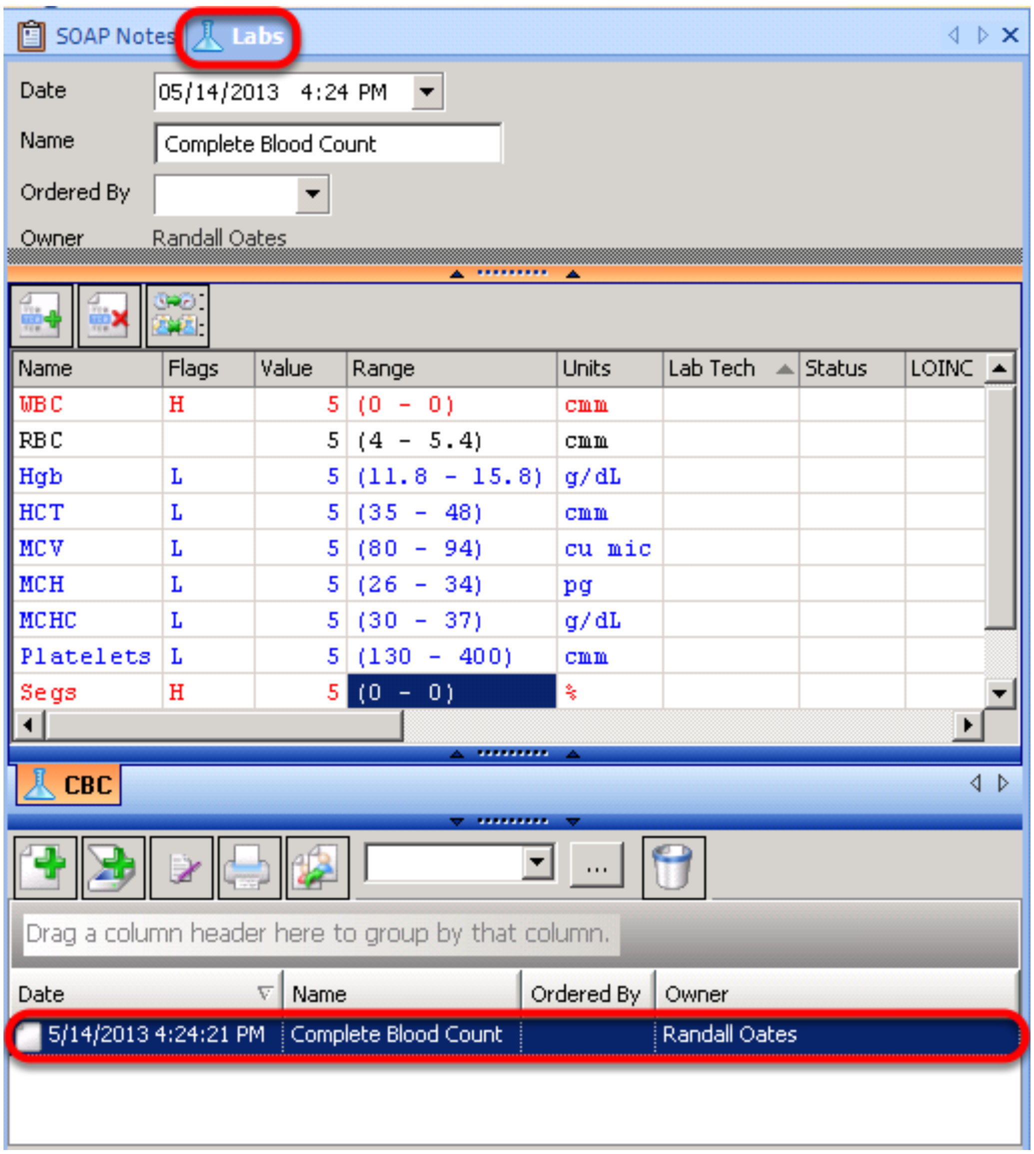
The lab results will appear within the patient's chart inside the Labs chart section. They can be reviewed and signed off from this area as well.

Transferring Labs to the SOAPnote

When performing lab results or discussing lab results at the time of an encounter, many users wish to have a copy of the lab attached to the SOAPnote Docutainer.

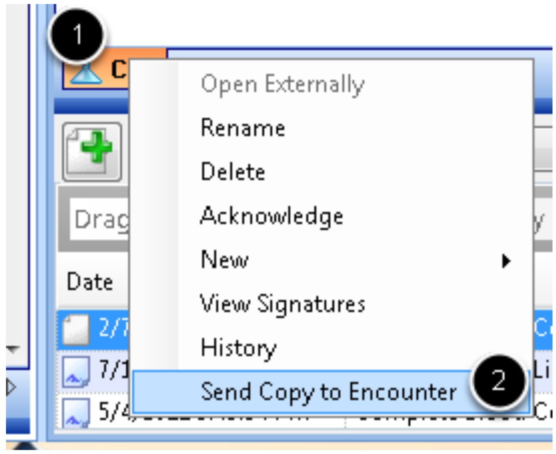
To attach a copy of the Lab results to the SOAPnote, follow the steps detailed below.

Open the Lab

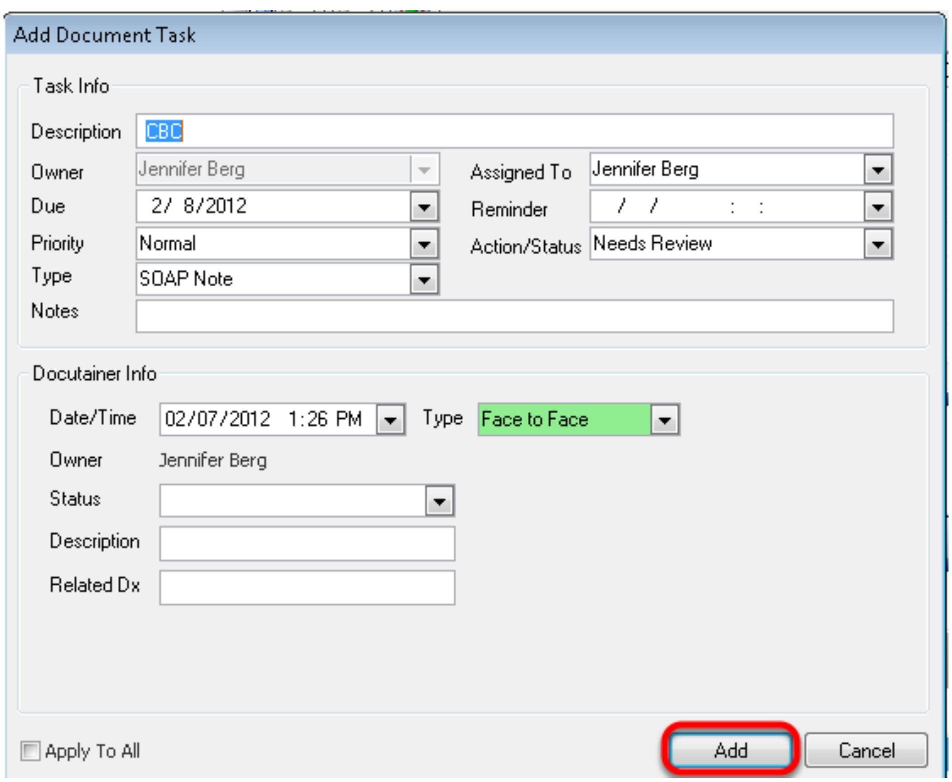


Open the Lab chart section and display lab to be transferred to the SOAPnote.

Transfer the Lab to the Encounter

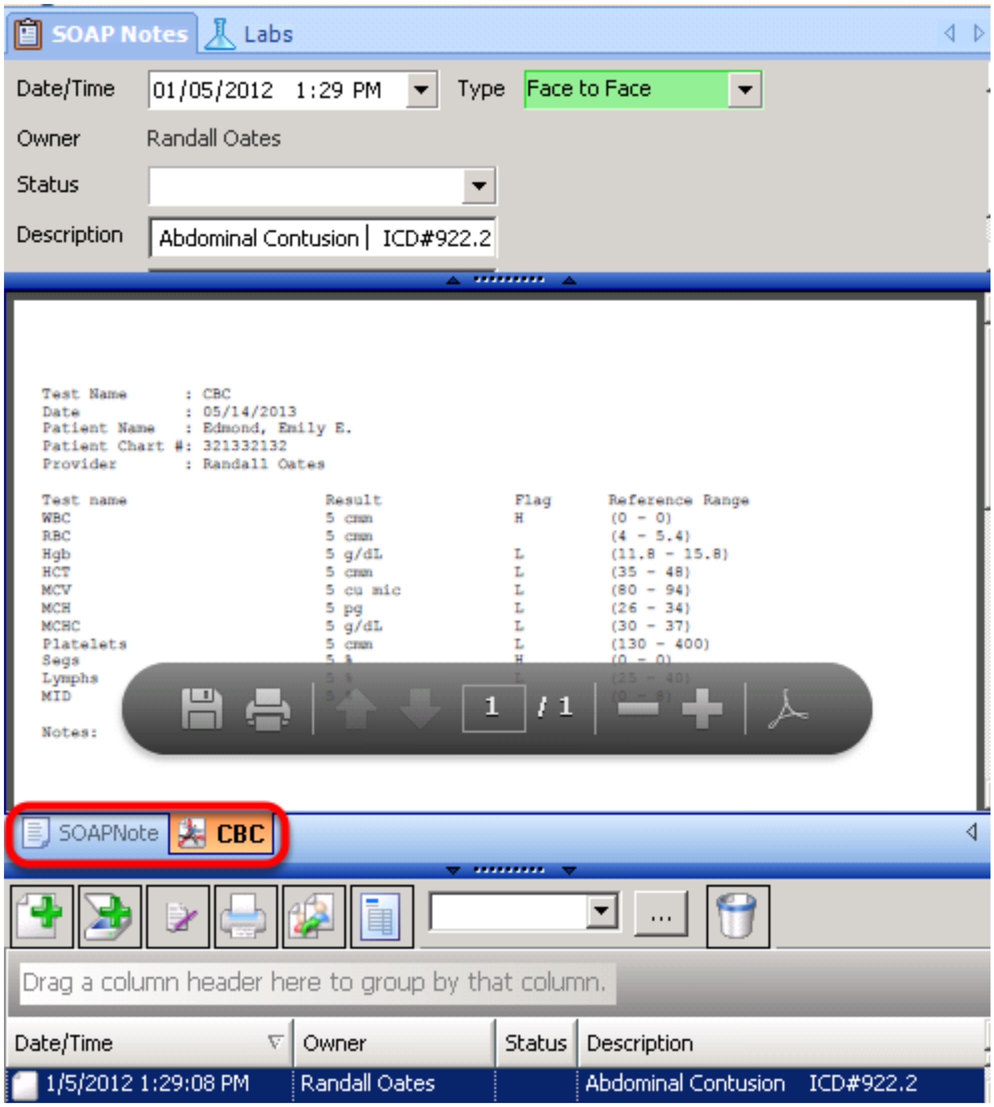


1. Right Click on the Lab icon for the desired lab result.
2. Select "Send Copy to Encounter"



Anew document is being added and will need to be signed off. An "Add Document Task" dialog box will appear.

Edit any details of the task as desired, then Click the Add button to create the task.



A PDF document with the lab results is now attached to the SOAPnote.

Because the Lab result is attached to the SOAPnote, the result may be printed or faxed with an Available Document Designs.

Patient Visit Documentation - SOAPnotes Encounter Notes

SOAP Charting

SOAPware derives its name from the SOAP format used for encounter documentation (i.e. **Subjective**, **O**bjective, **A**ssessment and **P**lan).

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 itake 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 Dxs- 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[

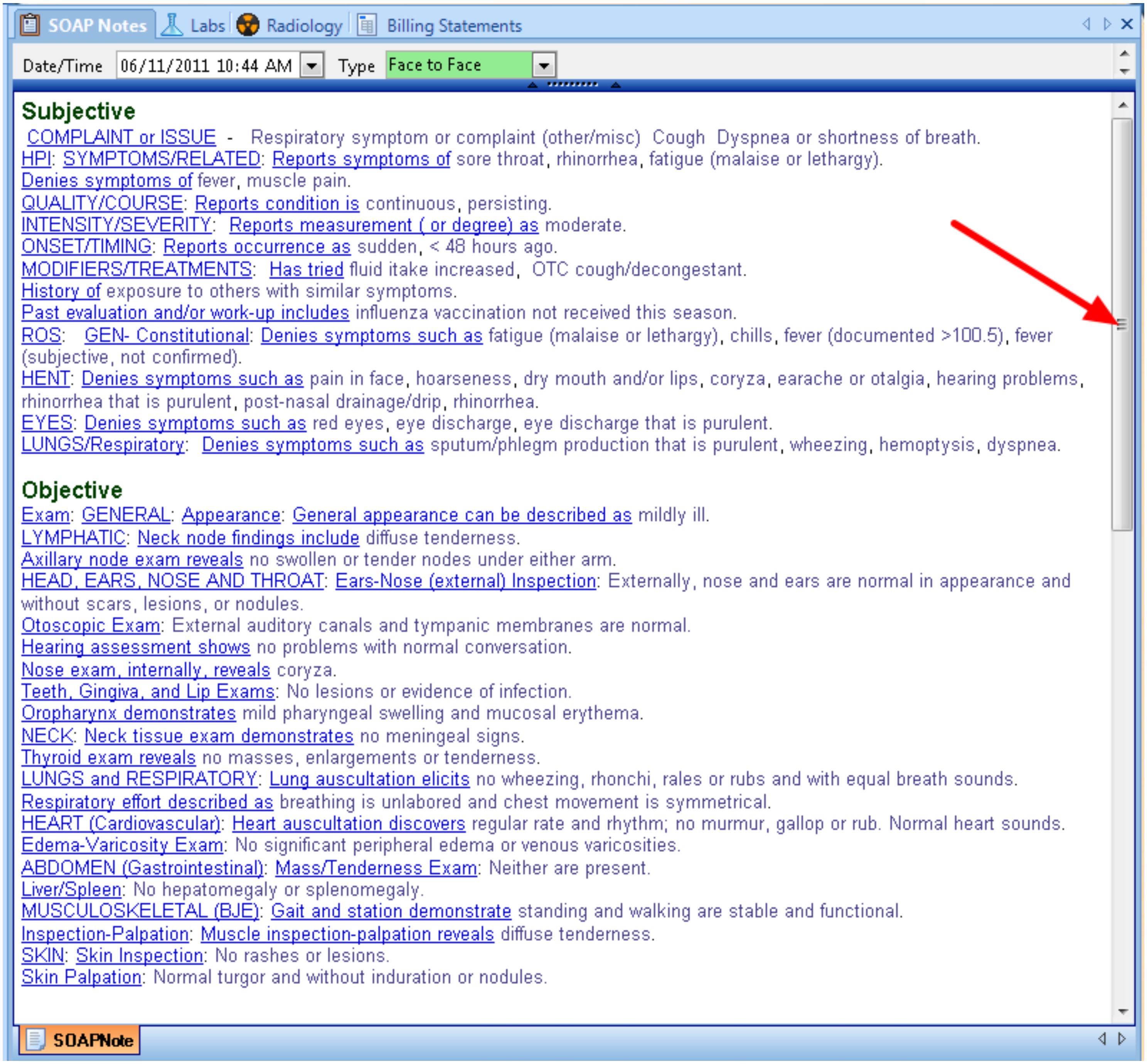
Return in 3 to 5 days if not improved and sooner if worsening symptoms or signs indicative of secondary bacterial infection (Temp>100.5 continuous discolored sputum/nasal drainage, worsening facial pain, etc. If your symptoms are not beginning to improve in 4-5 days, let your doctor know. If you develop worsening breathing difficulty or shortness of breath, please return to clinic.

Electronically Signed By: Randall Oates, M.D.

]

The follow-up instructions.

Scroll to see the entire SOAPnote

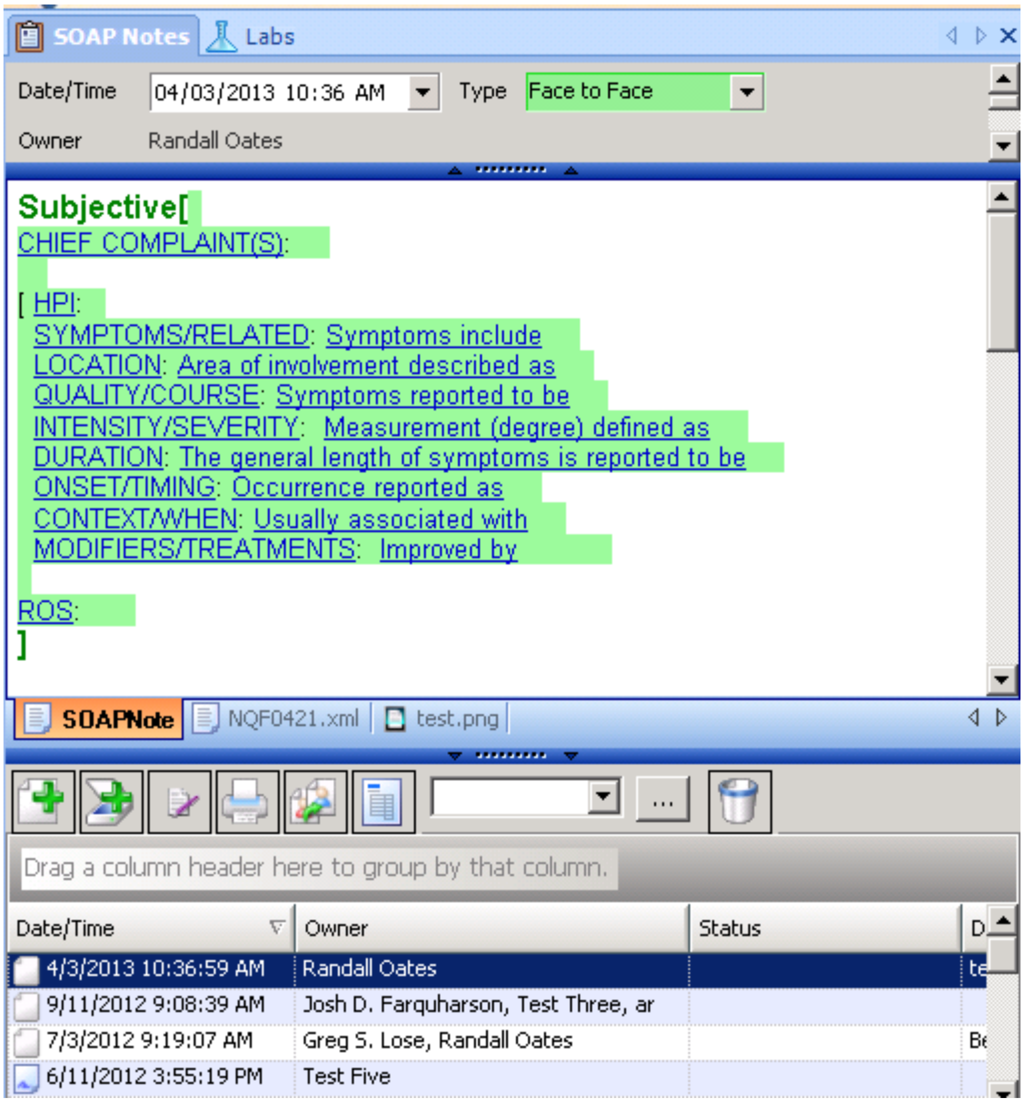


Depending upon the size of the monitor used for the display and/or the amount of information contained within the SOAPnote fields, all the information within the six SOAP fields may not visible in a single view. In order to view additional SOAP field information, click the **Up or Down Arrows** in the vertical scroll bar located on the right side of the SOAPnote workspace.

Creating a SOAPnote

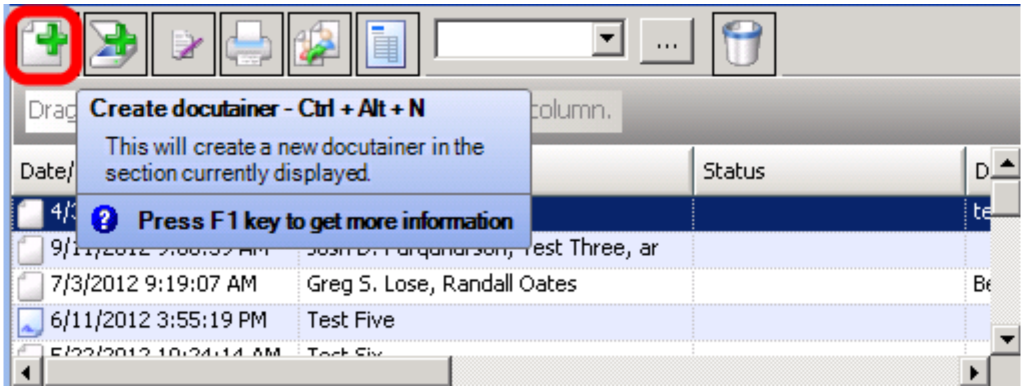
This lesson discusses creating a SOAPnote.

Open the SOAPnote Chart Section



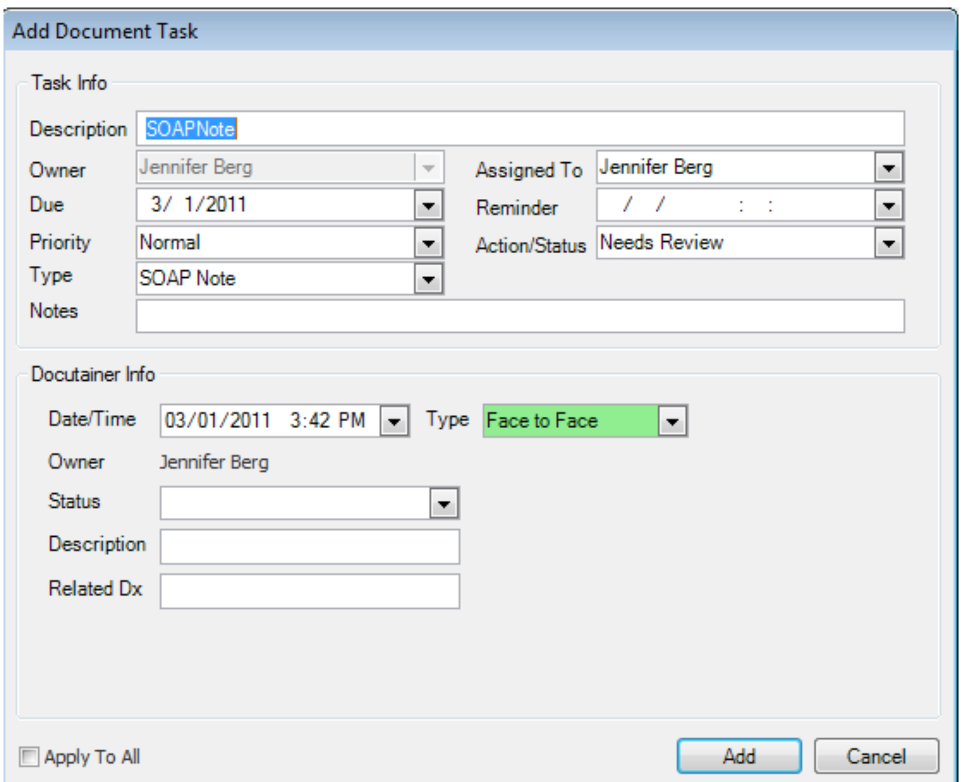
To create a new SOAPnote, open the SOAPnote chart section. Here, the user will be able to view previous visits as well as create, sign off, print, and reassign encounters.

Create Docutainer



Using the toolbar below the lower splitter bar, Click the Create docutainer button.

Add Document Task



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.

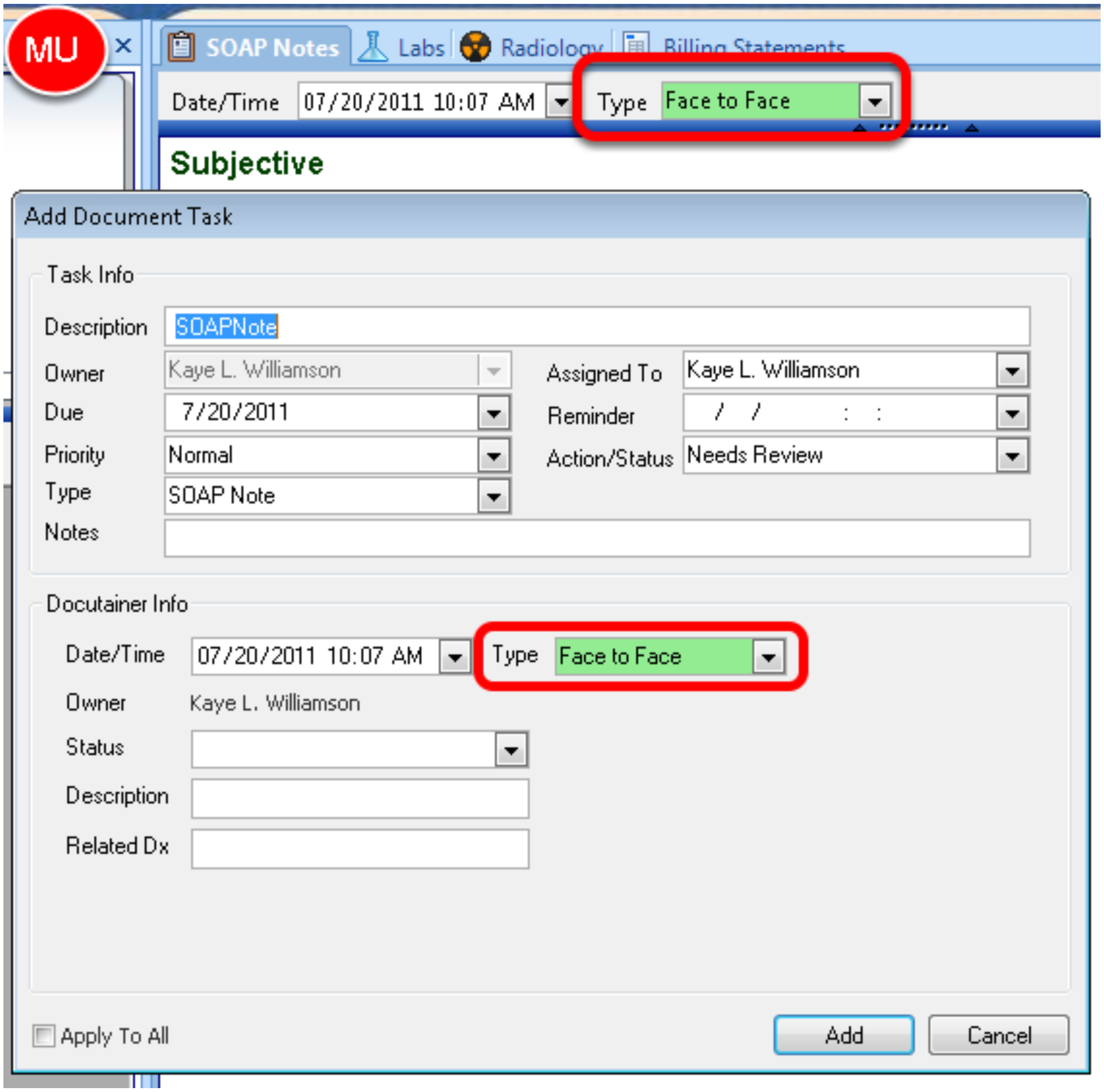
This document task for a SOAPnote will be associated with the encounter we are creating and can be set to have a particular action/status, indicating what needs to be addressed before the task is completed. The task can also have a reminder set, and can be assigned to anyone in the clinic.

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



SOAPware now has an added field for the encounter "Type" that is used for Meaningful Use purposes. A user 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.

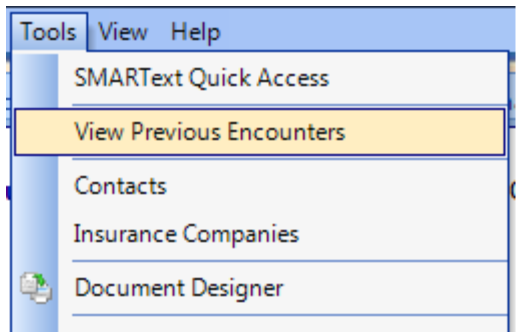
***Only encounters flagged as "Face to Face" will trigger the inclusion of a patient in the Meaningful Use statistics for the reporting period selected by the provider.**

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

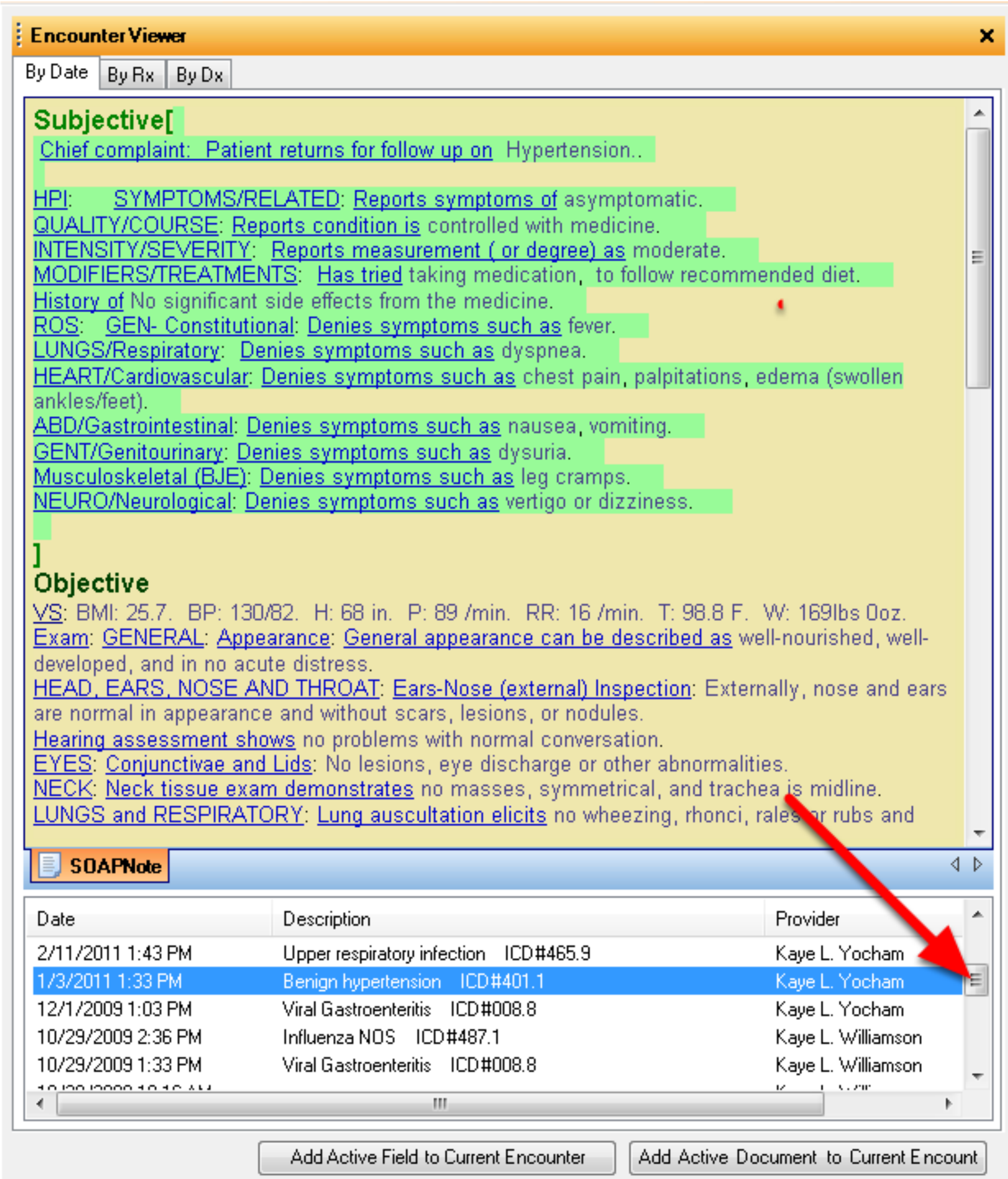
The View Previous Encounters window allows users to view all past patient encounters/SOAPnotes while viewing a current SOAPnote. This provides easy reference to past encounters and the ability to add past SOAPnote information to the current SOAPnote visit documentation.

Open the View Previous Encounters Viewer



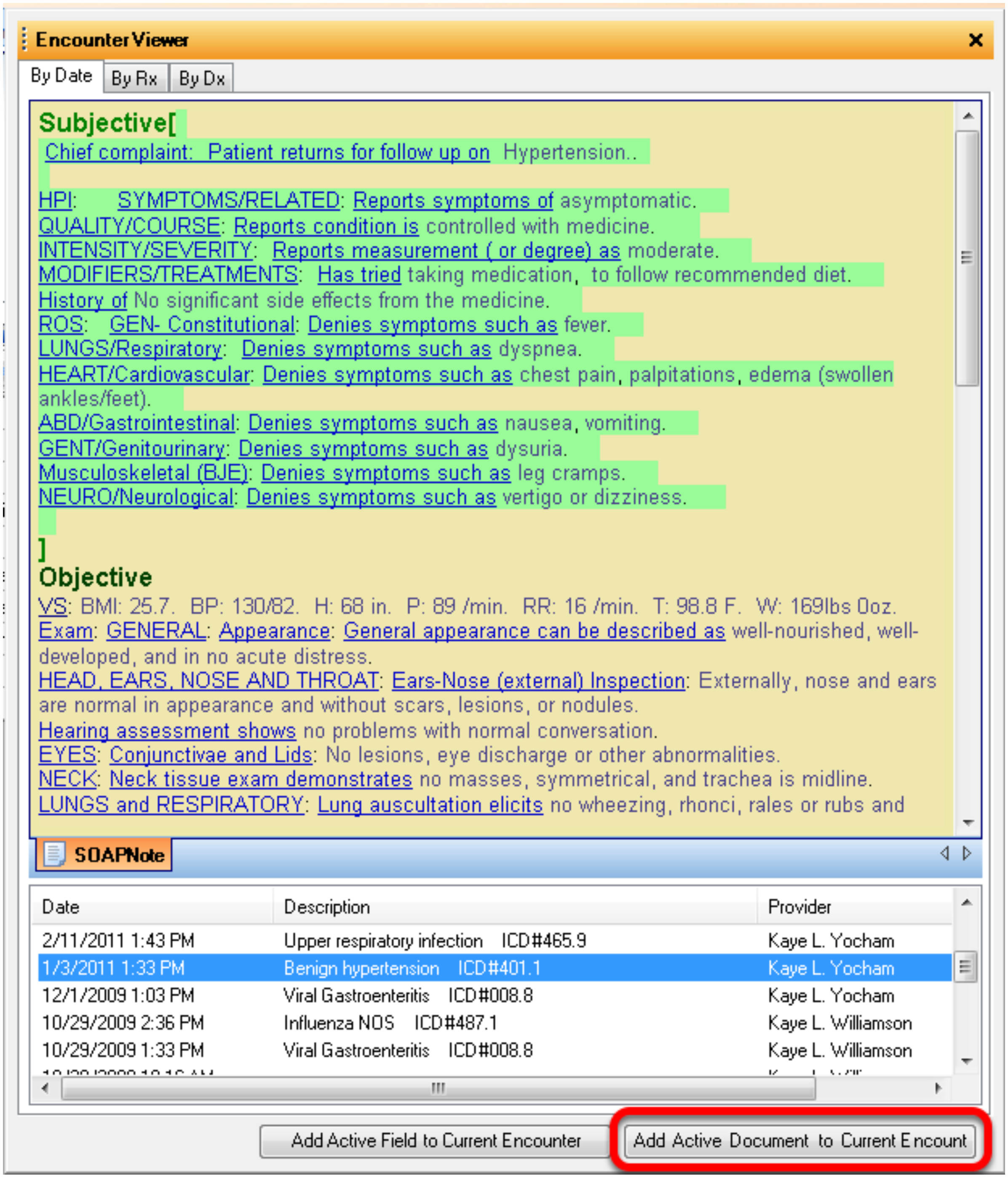
Click Tools and choose View Previous Encounters.

Locating a Past 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.

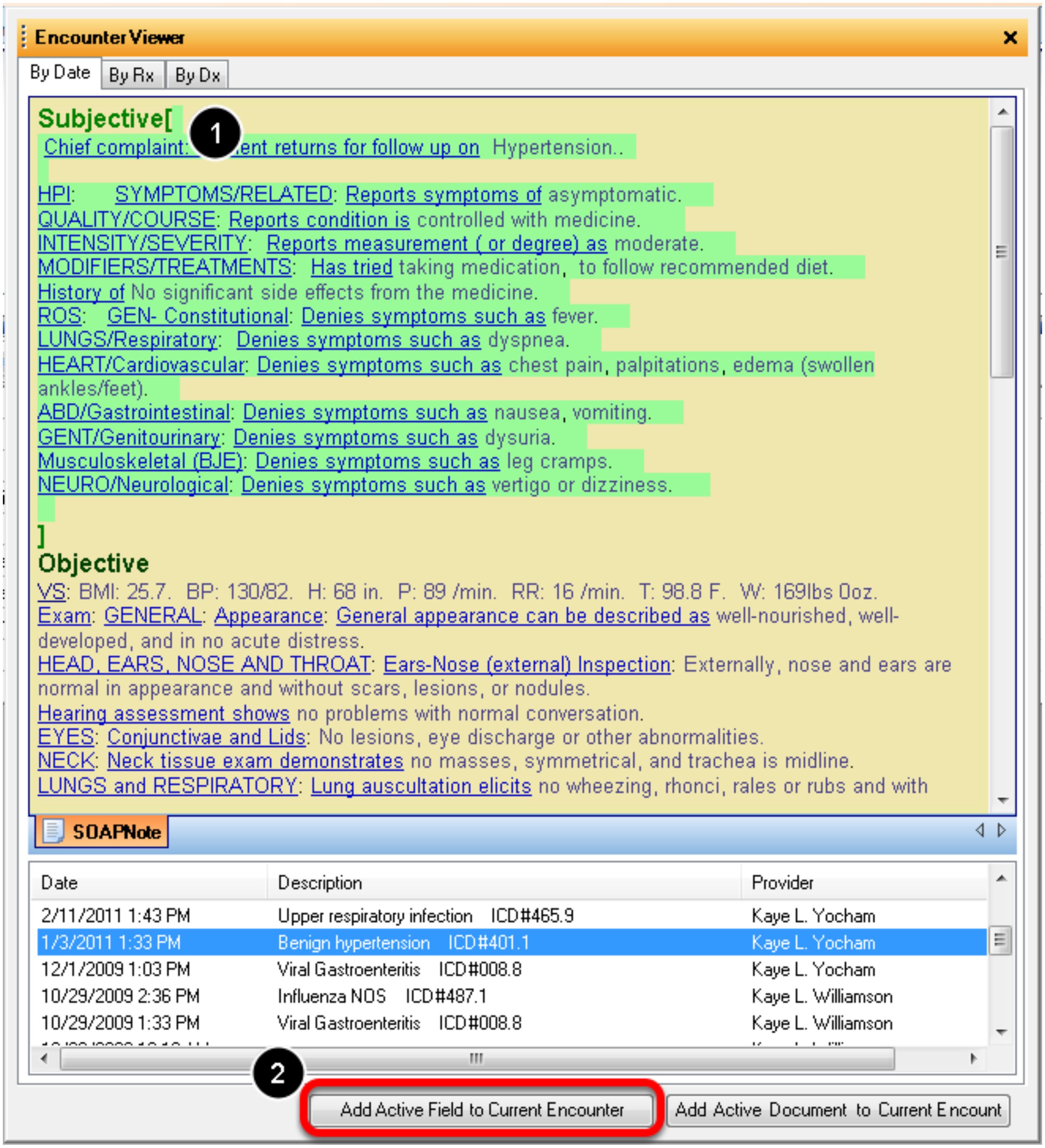
Copy the Previous Encounter to the Current SOAPnote



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.

Copy a Field to the Current SOAPnote



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

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

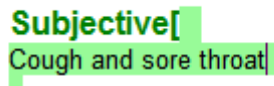
Follow Up
Return if problems develop or worsens.
Schedule: Krista L. Laningham

SOAPDPL is a good starter docuplate that allows for an introduction to using SMARText 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 availalbe template.

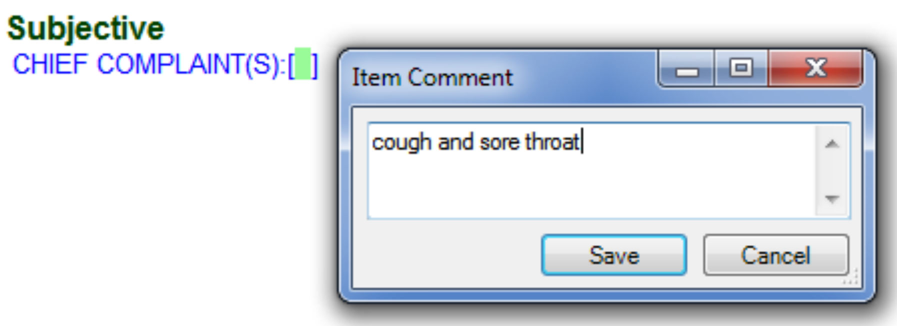
Subjective Entry

Free Text



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.

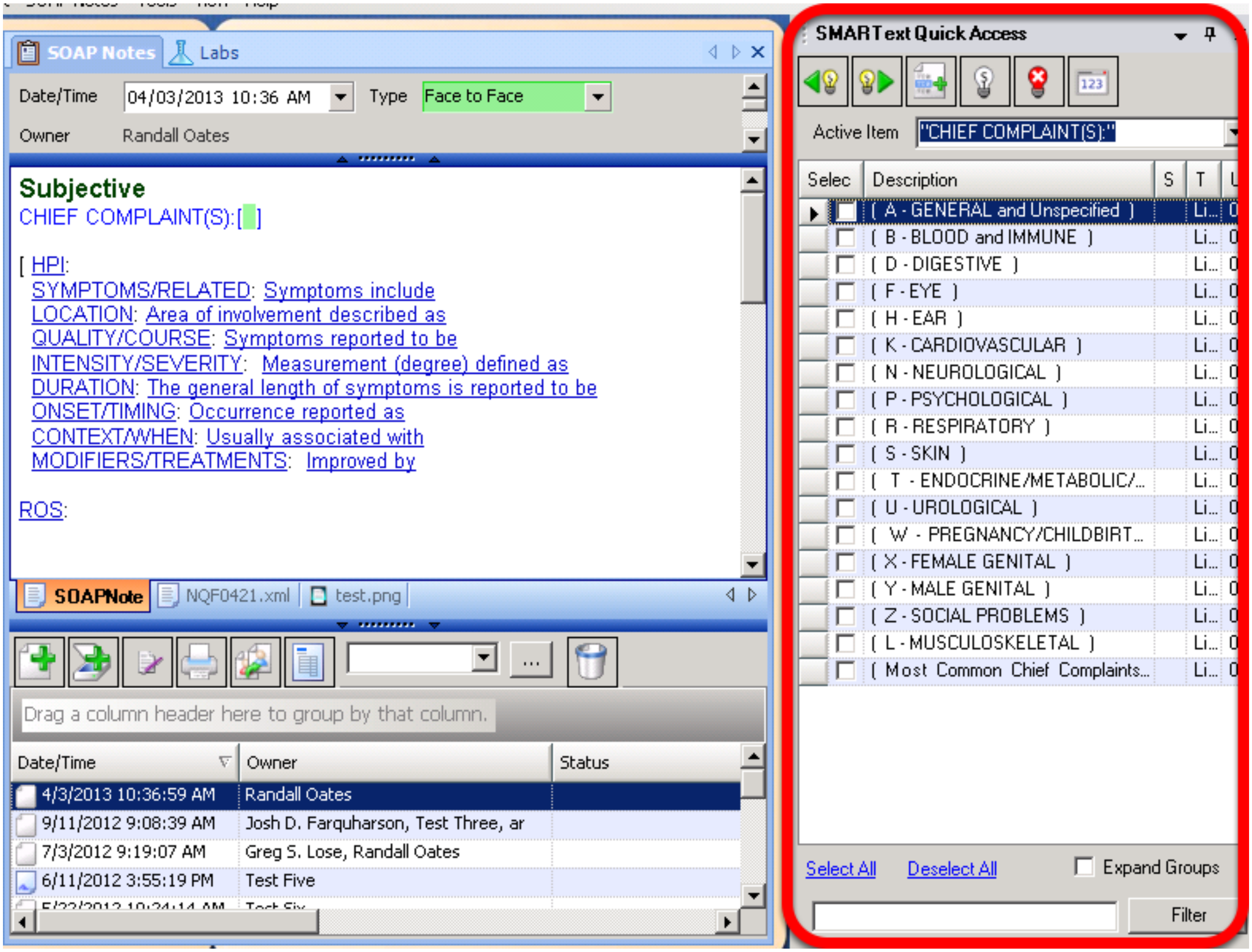
Comment Box



Using the Item Comment will attach a free-text comment to a SMARText 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 SMARText item and that if the user starts typing in these brackets, the user's comment will be associated with the SMARText 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.

Structured Text and Quick Access



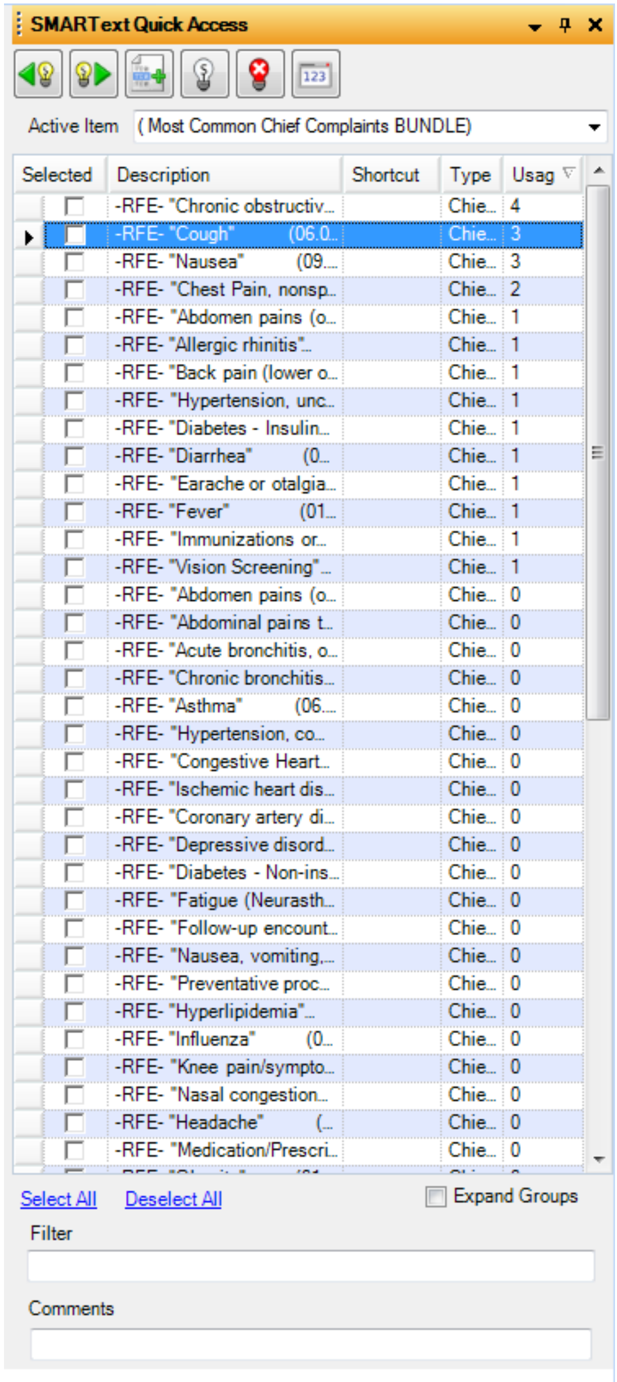
Click on the CHIEF COMPLAINT(S), again, and notice the pick list displayed in the SMARText Quick Access dialog. The second column in the pick list is the Description. If the Description column is not wide enough, it can be expanded, or the user can point the cursor at the items and the user will see 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
	(A - GENERAL and Unspecified)		L...	0
	(B - BLOOD and IMMUNE)		L...	0
	(D - DIGESTIVE)		L...	0
	(F - EYE)		L...	0
	(H - EAR)		L...	0
	(K - CARDIOVASCULAR)		L...	0
	(N - NEUROLOGICAL)		L...	0
	(P - PSYCHOLOGICAL)		L...	0
	(R - RESPIRATORY)		L...	0
	(S - SKIN)		L...	0
	(T - ENDOCRINE/METABOLIC/NUTRITIONAL)		L...	0
	(U - UROLOGICAL)		L...	0
	(W - PREGNANCY/CHILDBIRTH/FAMILY PLAN...		L...	0
	(X - FEMALE GENITAL)		L...	0
	(Y - MALE GENITAL)		L...	0
	(Z - SOCIAL PROBLEMS)		L...	0
	(L - MUSCULOSKELETAL)		L...	0
	(Most Common Chief Complaints BUNDLE)		L...	0

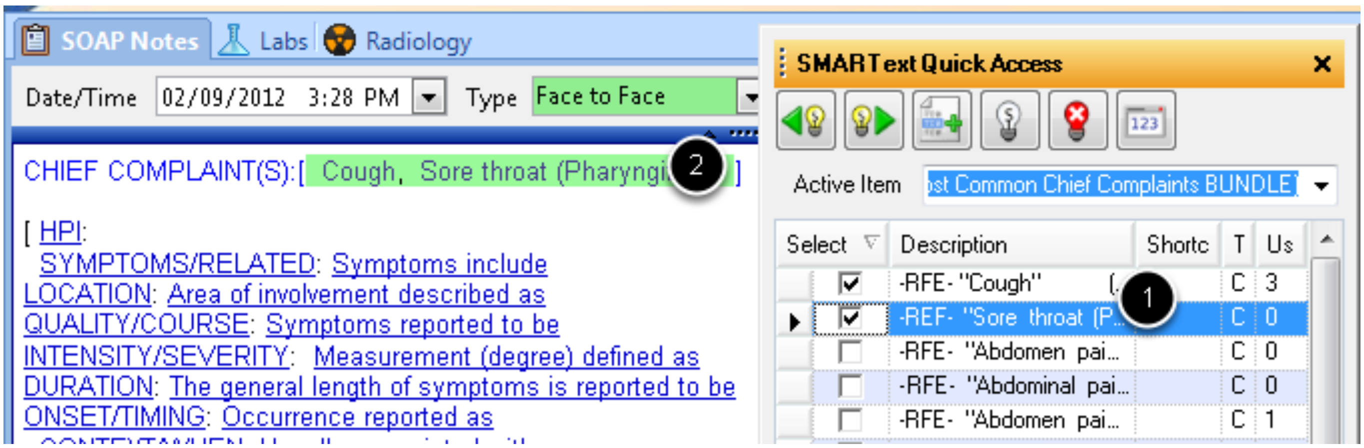
The user will see in SMARText Quick Access "Pick List" that the Chief Complaint items are listed by system, and that there is an additional item for Most Common Chief Complaints. When the user clicks on any of these lists using the "Select" box, this will display another list if items in the SMARText Quick Access dialog.

Using Pick List Items



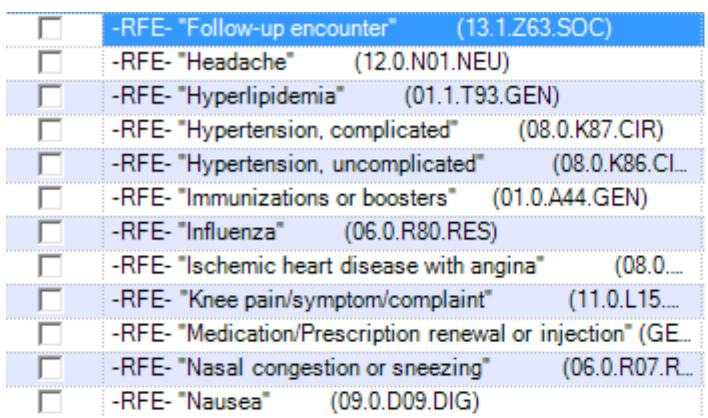
In this second list (Most Common Chief Complaints), Click the Description column header to sort alphabetically. The user can click any column header to sort by that column to easily find the item needed.

Selecting a Pick List Item



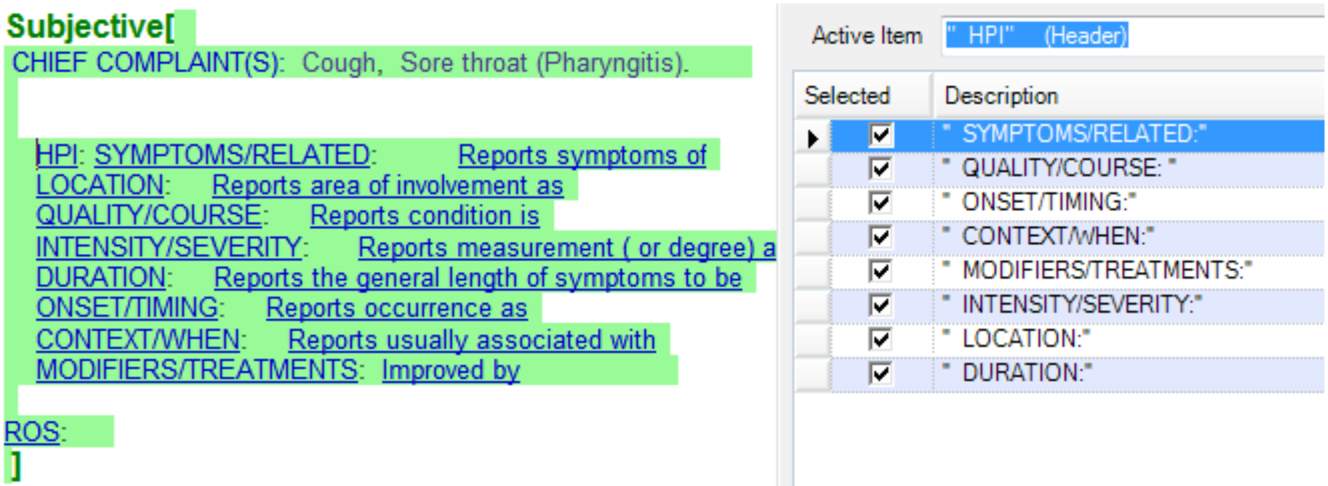
When the user (1) selects an item, the user will notice that it (2) inserts between the brackets of the CHIEF COMPLAINT(S) data entry area. All of these lists are completely customizable. Each clinician can create their preferred lists of commonly used Chief Complaints.

RFE: Reason for Encounter



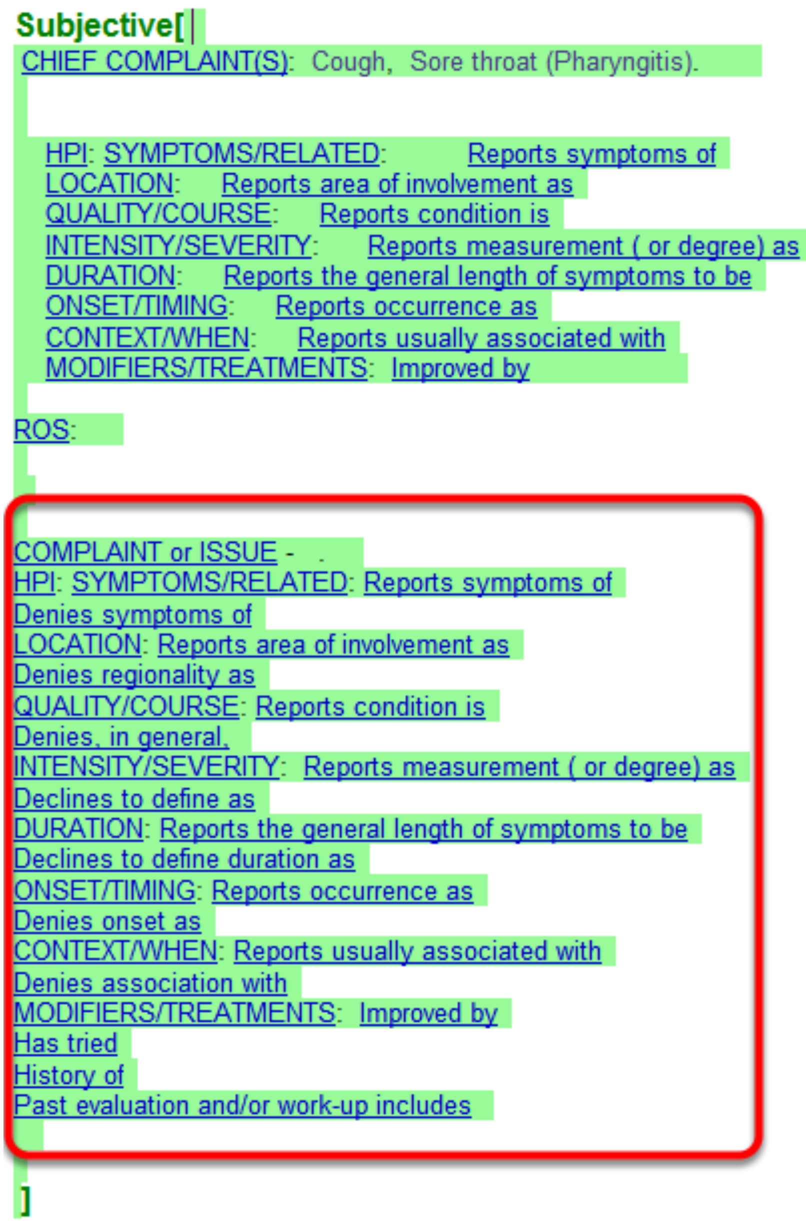
Many visits don't really involve a complaint, but there is always a Reason For the Encounter, and this may or may not be a true complaint. The user will notice that in the description column of Quick Access, many of the items are also RFE items.

HPI: History of Present Illness



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.

Complaints 2 and 3



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.

Multiple Complaints Docuplate

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:
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 SMARText 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 SMARText 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.

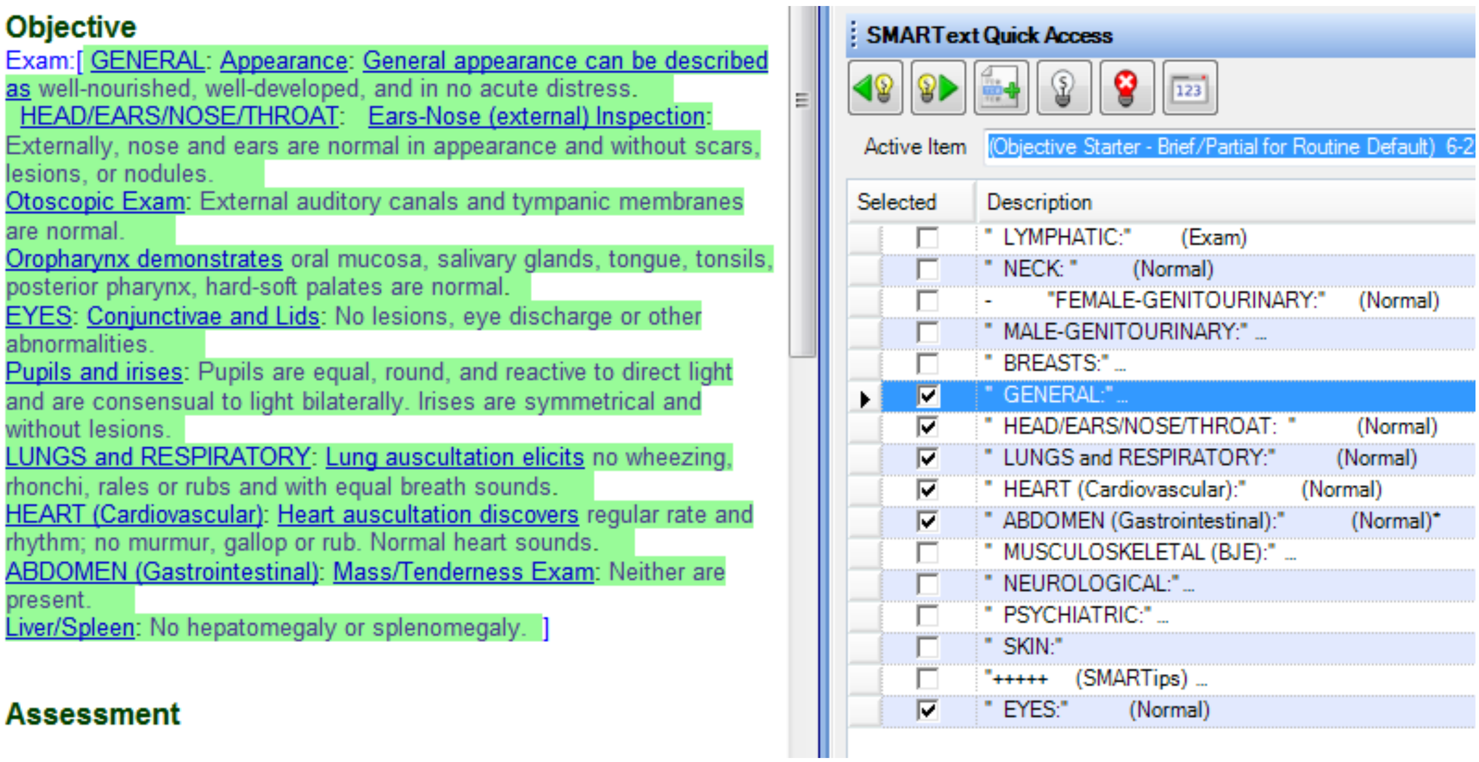
Growth Charts

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

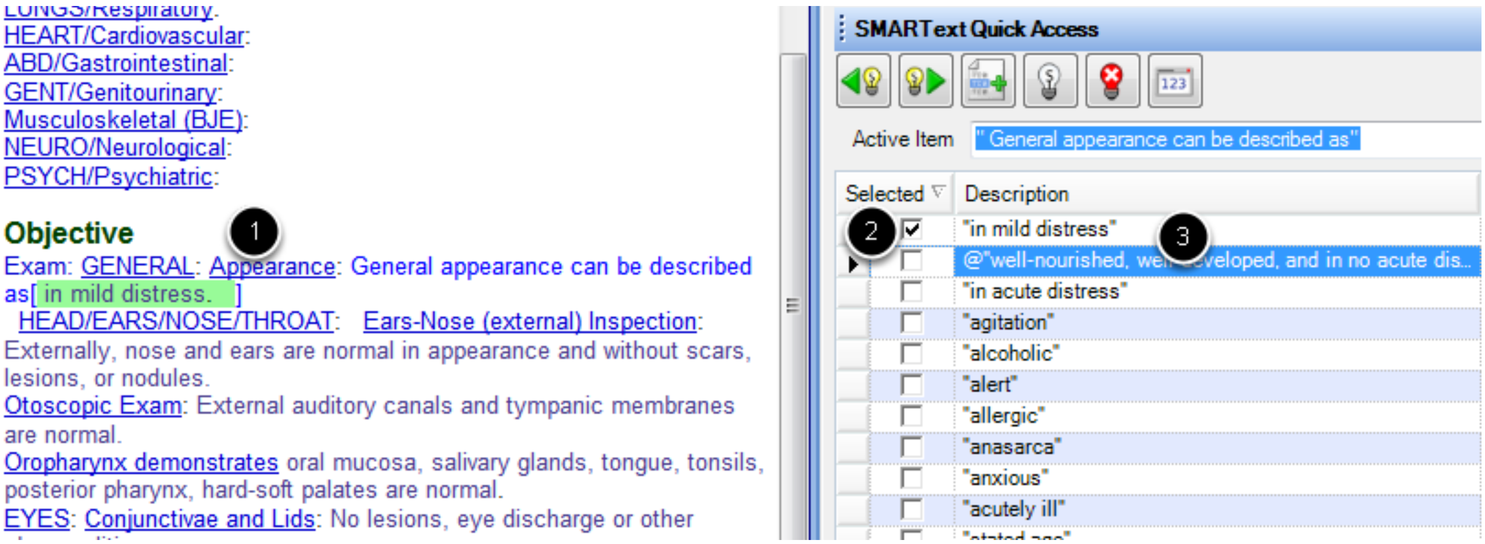
Click the Exam pick list header in the Objective field. A list of exam systems will appear in the Quick Access dialog. The default for this demonstration only displays 1 of the 14 exam systems, the GENERAL system.

Exam Systems Data Entry



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



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.

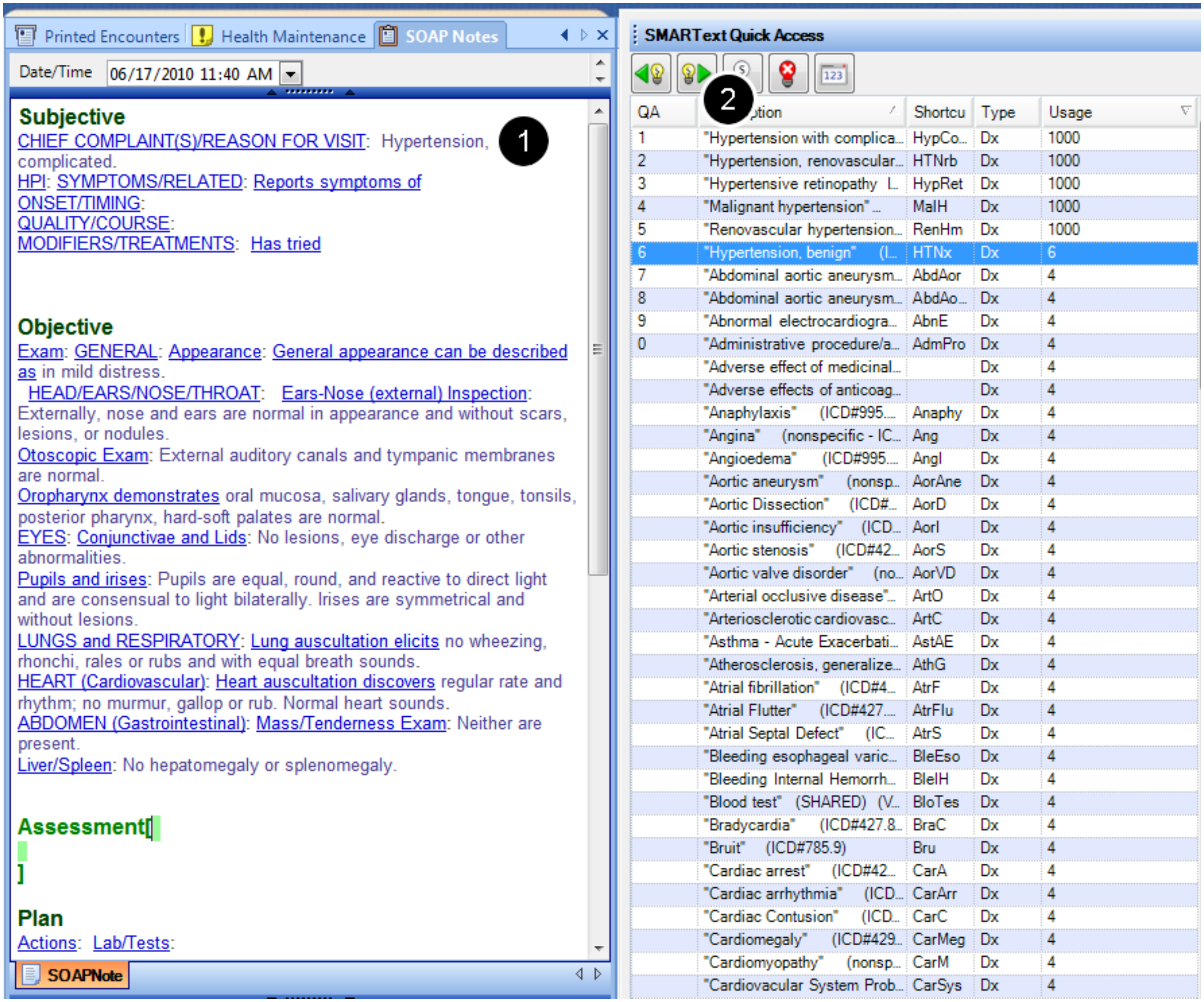
Customizing Exams

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

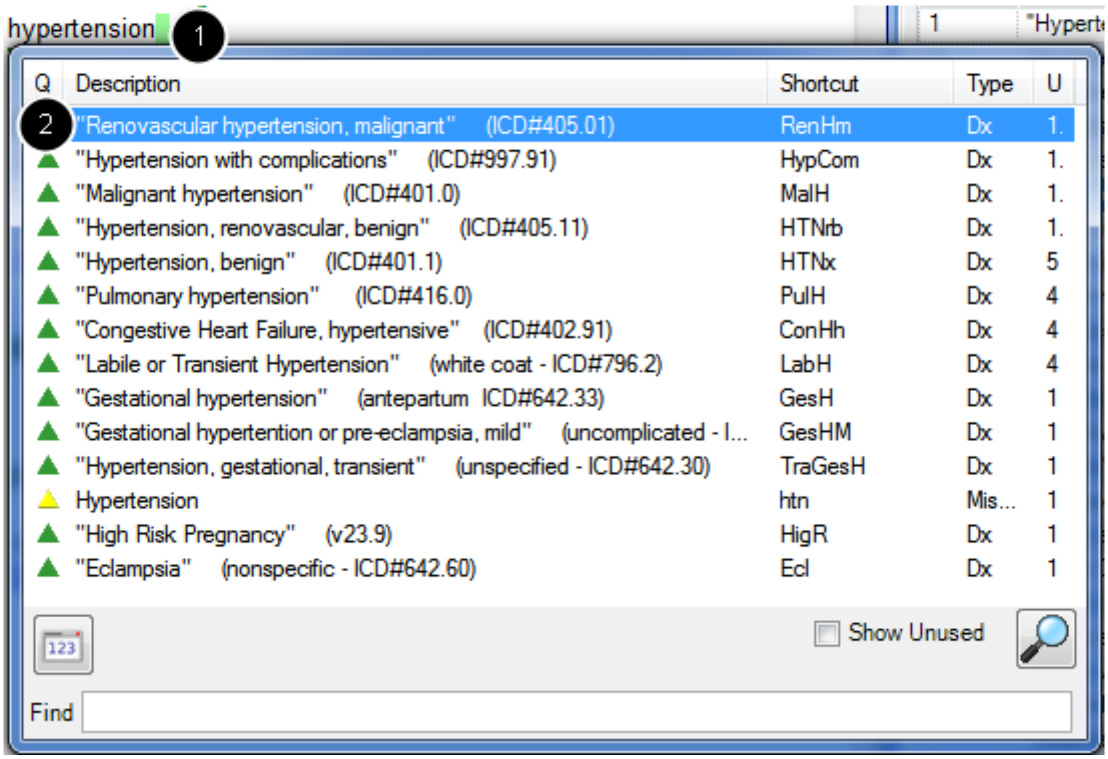
Location Pick List



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 SMARText 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.

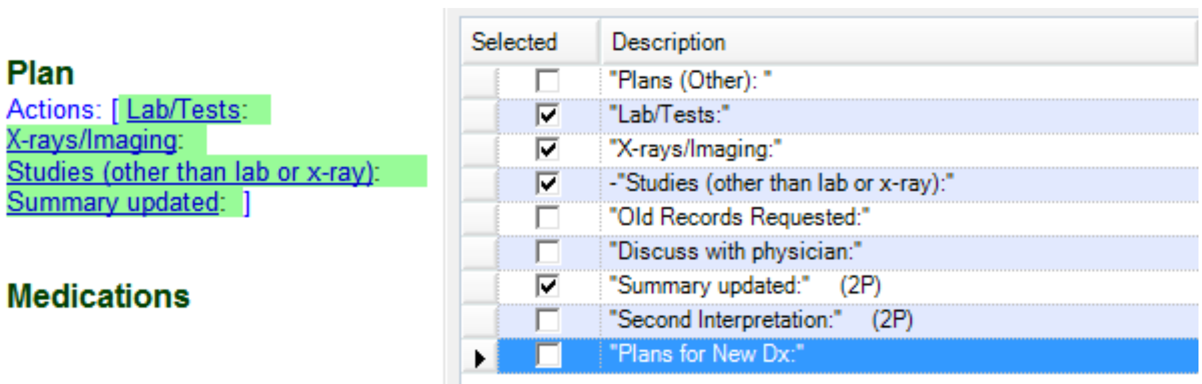
Pick List Selection

Assessment[
Hypertension with complications ICD#997.91
]

When selecting a SMARText Assessment item, SOAPware will also insert the ICD code as well as several behind the scenes codes, making reporting and searching data much easier.

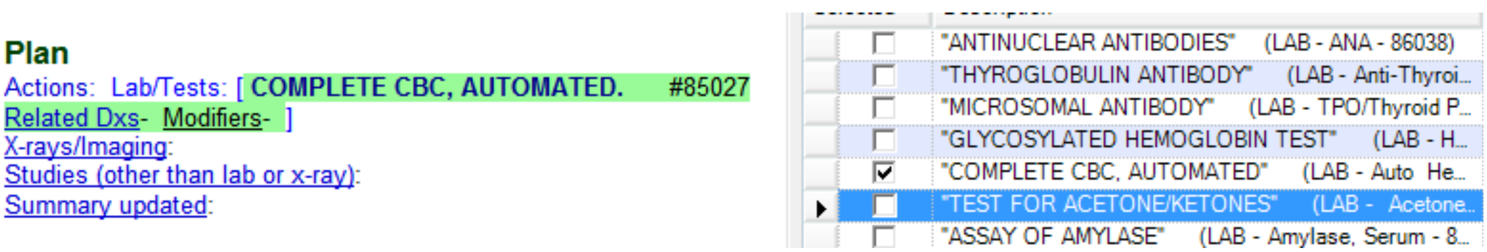
Plan Entry

***MEANINGFUL USE:** VISIT THE MEANINGFUL USE ROADMAP
- Patient Specific Educational Resources



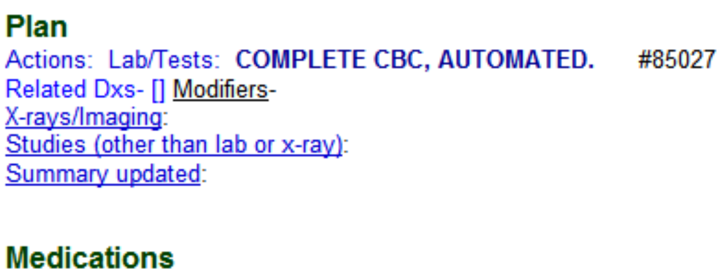
The Actions pick list will display in the Plan field for assisting in documentation data entry. Or, the user can Click the sub-item to choose the specific action item. In this example, the user sees Lab/Tests, X-Rays/Imaging, Studies, and Summary updated have all been included as a part of the Plan field.

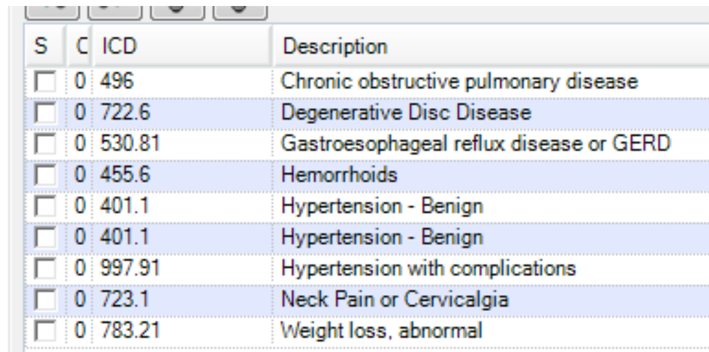
Lab Tests



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





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 SMARText 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 SMARText Quick Access dialog. Select the appropriate Assessment/diagnosis item to associate it to the Plan item.

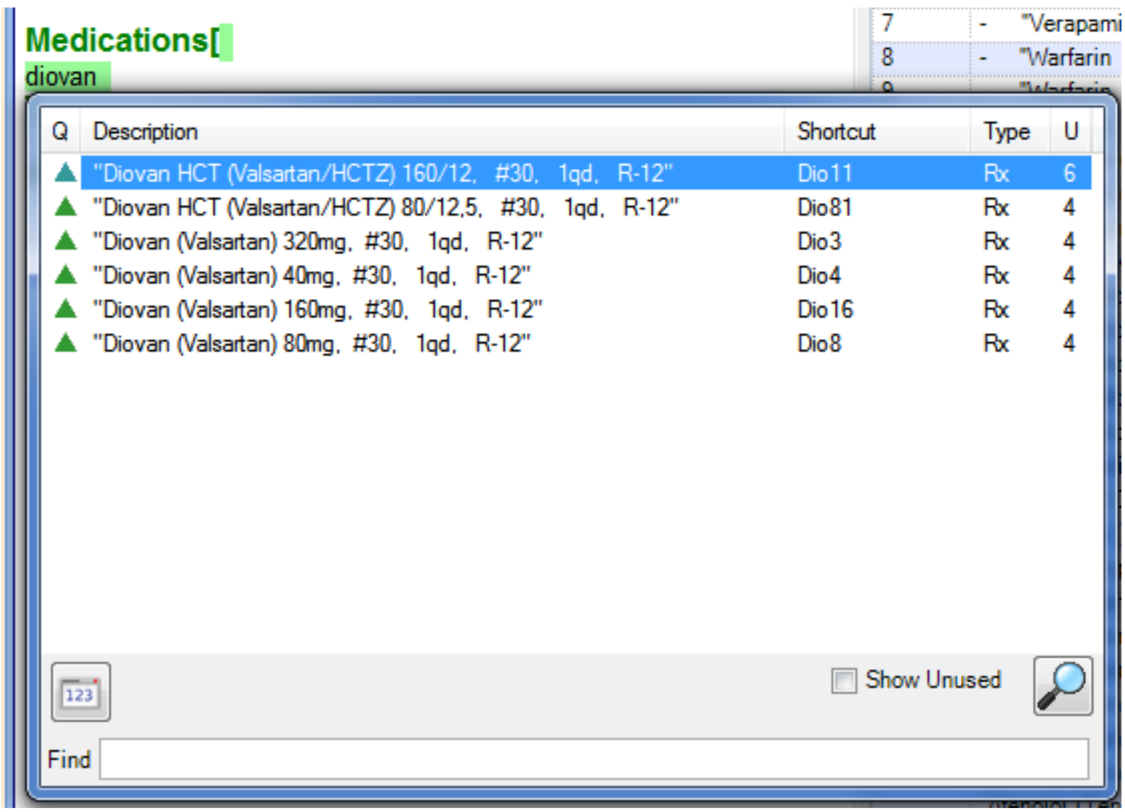
Handouts

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]

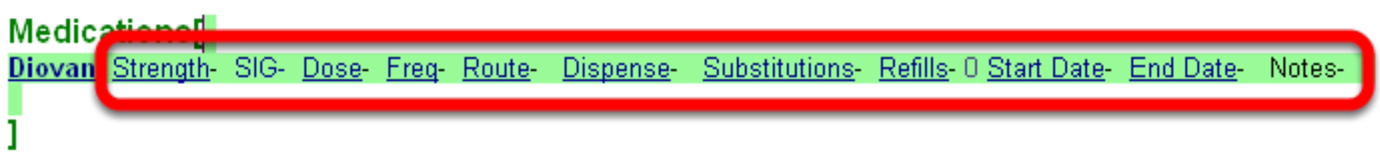
Search for Medications



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.

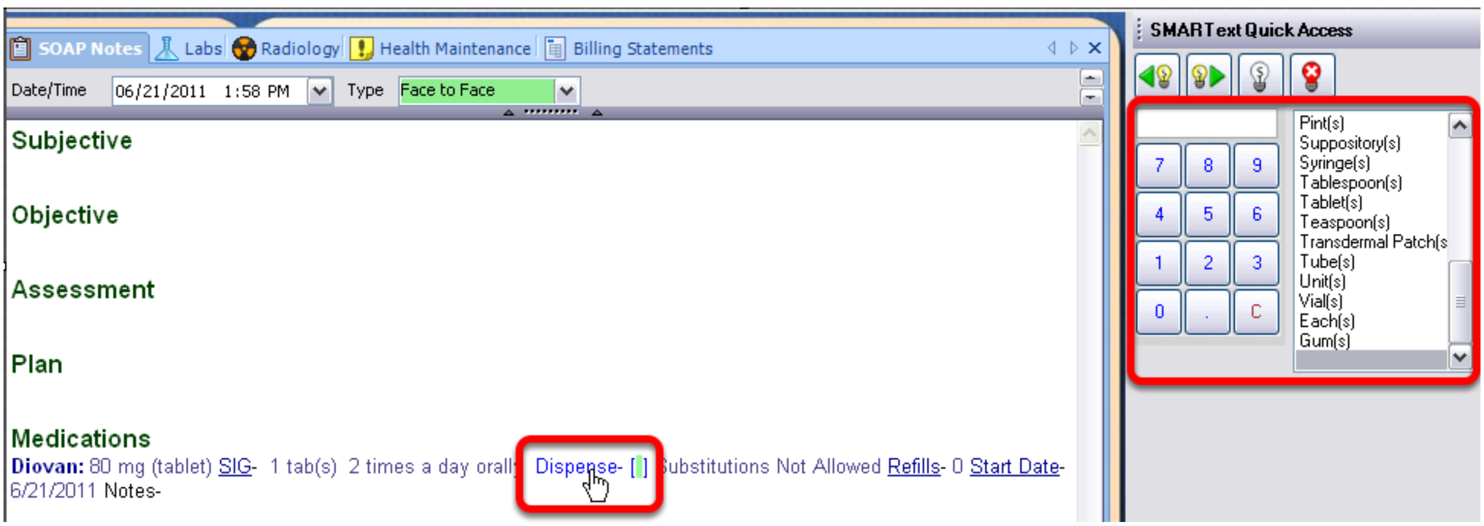
Medication Sub-Items



All SMARText Items, including Medication SMARText 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.**

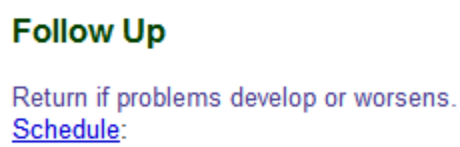
ePrescribing

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

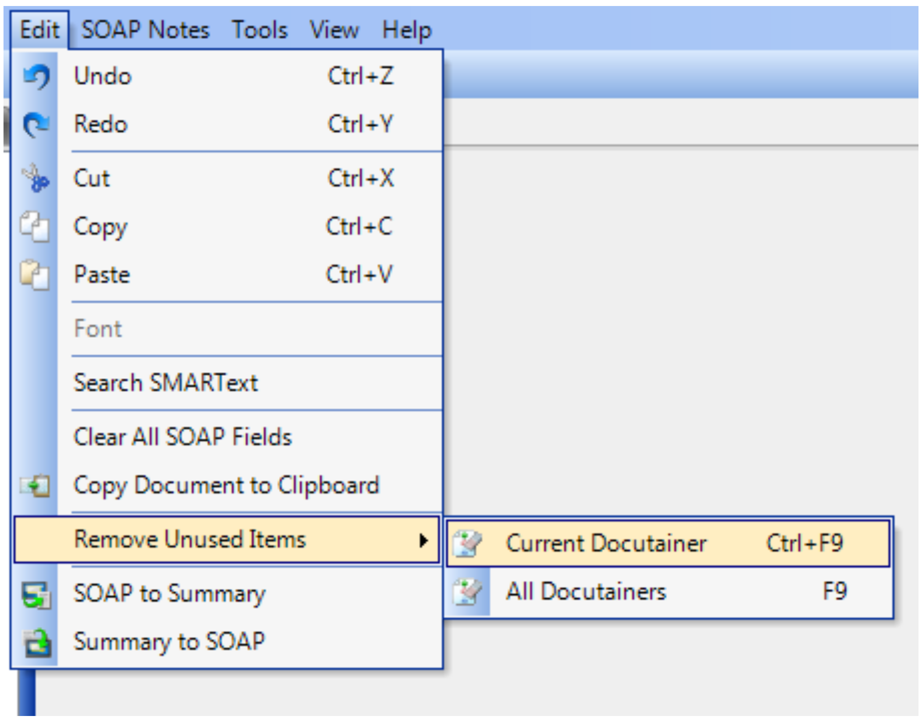


Notice that "Return if problems develop or worsens" has been entered into the Follow up by default. However, this default can be changed and/or additional information could be typed in a free text fashion. The user can also click on the link for "Schedule" to choose to have the patient return at a specific interval.

Remove Unused Items

SOAPware has a convenient command to clean up documentation called Remove Unused Items. This command removes any SMARText items that have not been used, and also removes extra spaces.

Remove Unused Items



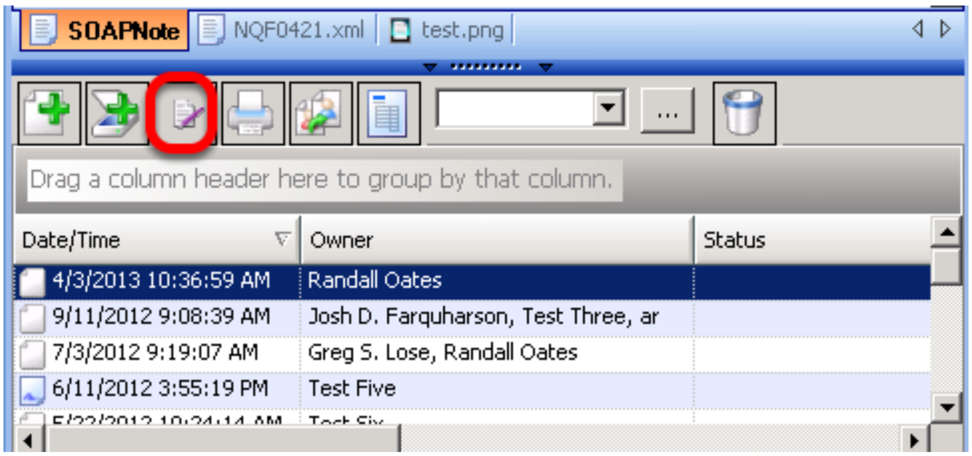
1. Click Edit in the menu bar.
2. Click the Remove Unused menu item
3. Click the Current Docutainer menu item.

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 SMARText 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

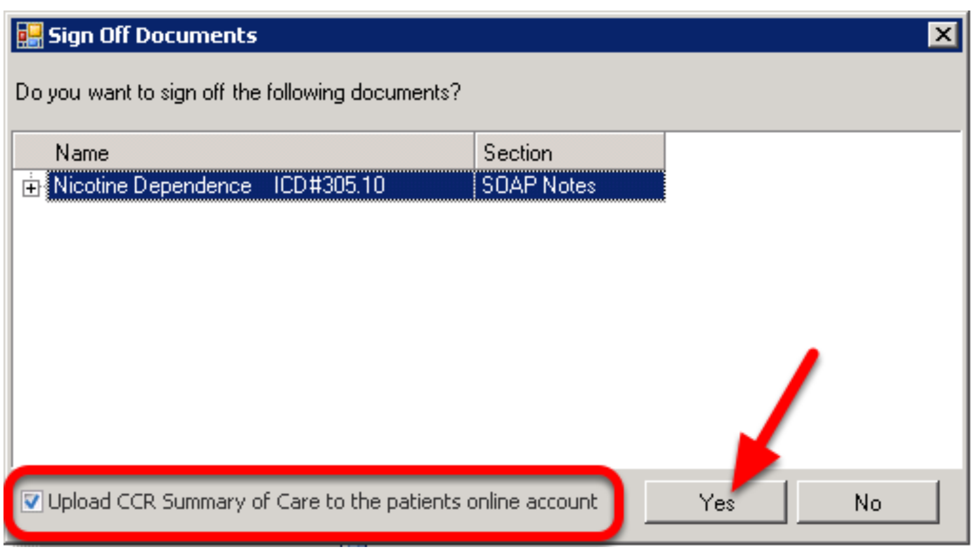
***Note:** Only providers have the security rights to sign off a document.

Sign Off Documents Button



Click the Sign Off Documents button.

Confirm Signing

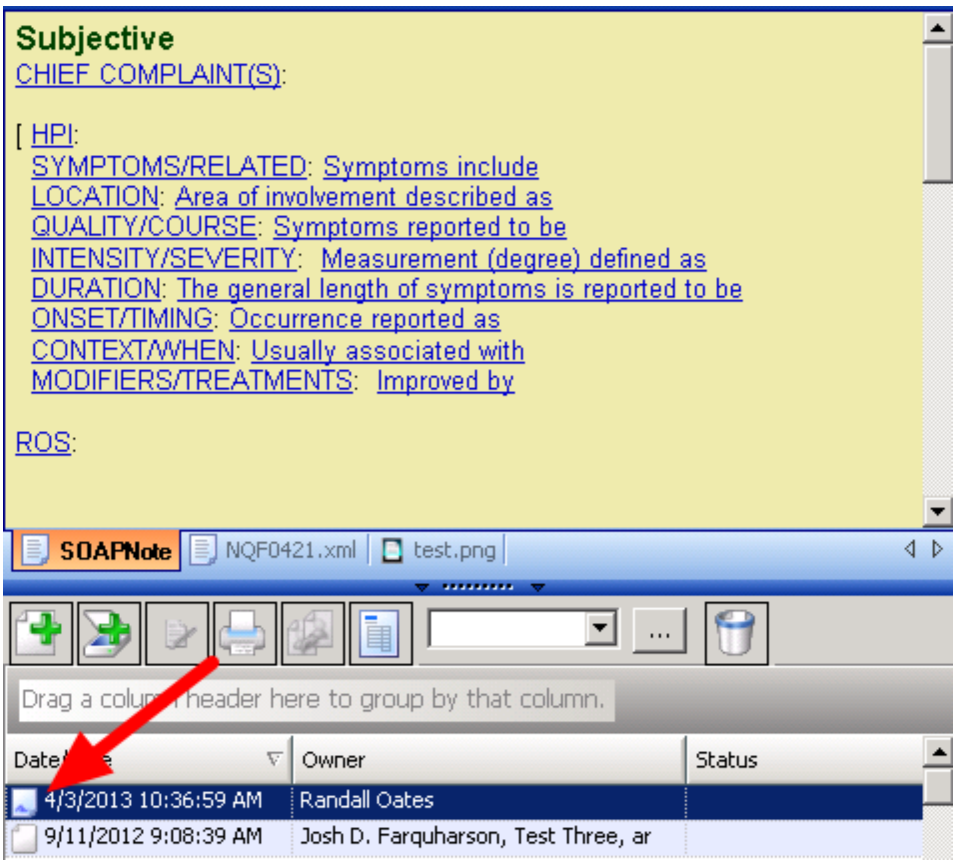


Adialog box will display asking "Do you want to sign off the following documents?" Click Yes.

***Important:** Once the user has signed off the document, it is locked and unalterable.

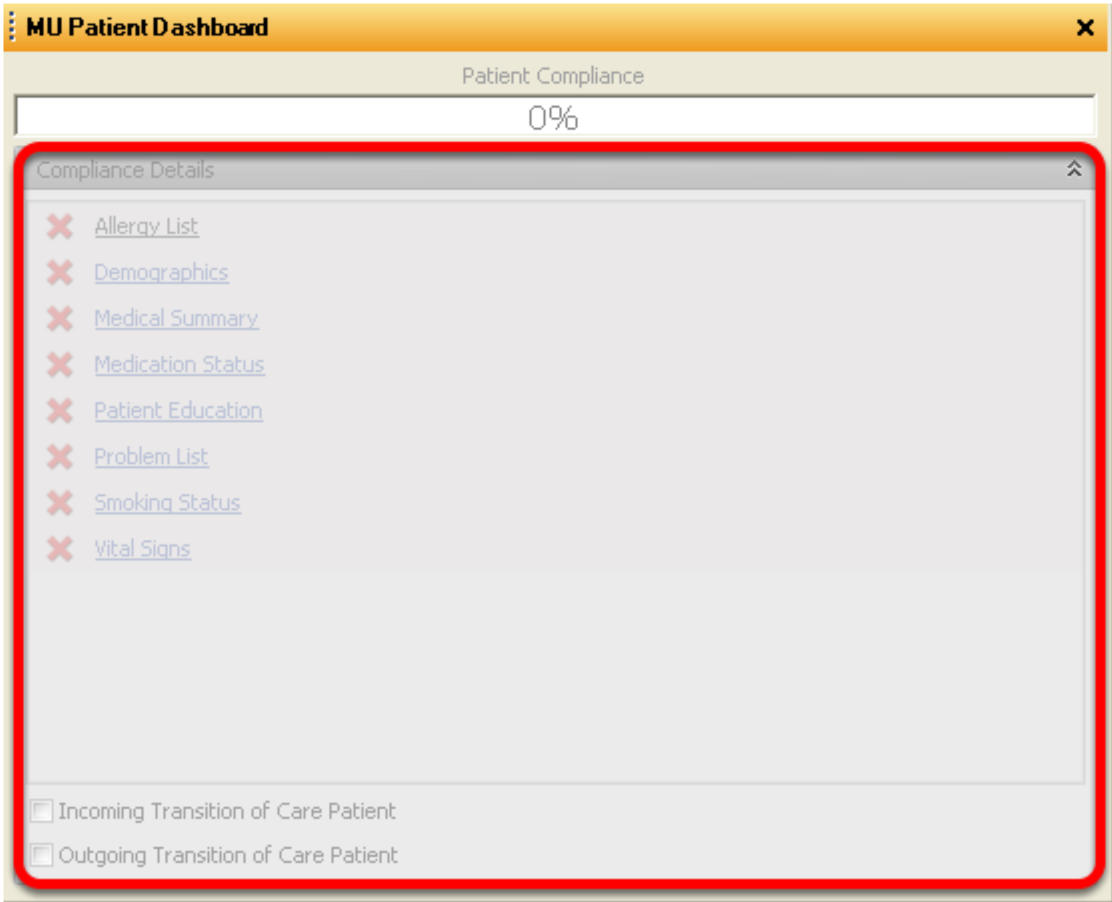
In this window, users will now be able to check the "Upload CCR Summary of Care to the patients online account". If this box is checked, a new summary of care document will be uploaded to the SOAPware Patient Portal after the new encounter is signed off (if unchecked, the new summary of care will not be uploaded). This box will be grayed out if the patient is not registered for the SOAPware Patient Portal.

Signed Off Documents



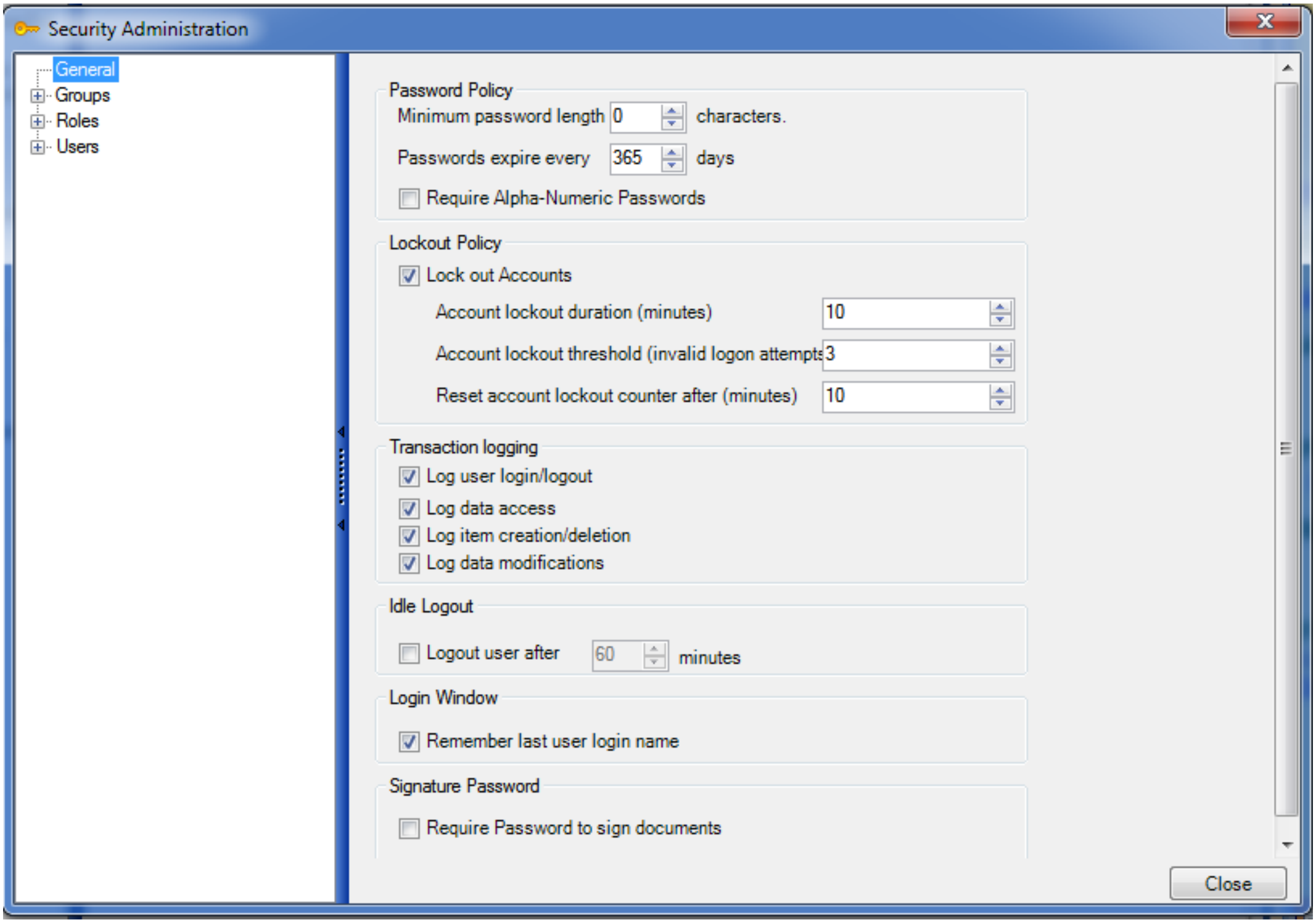
Now, the document will turn yellow indicating that it has been signed off and is unalterable. Note that the icon in the encounter list has changed to denote a signed off document.

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:

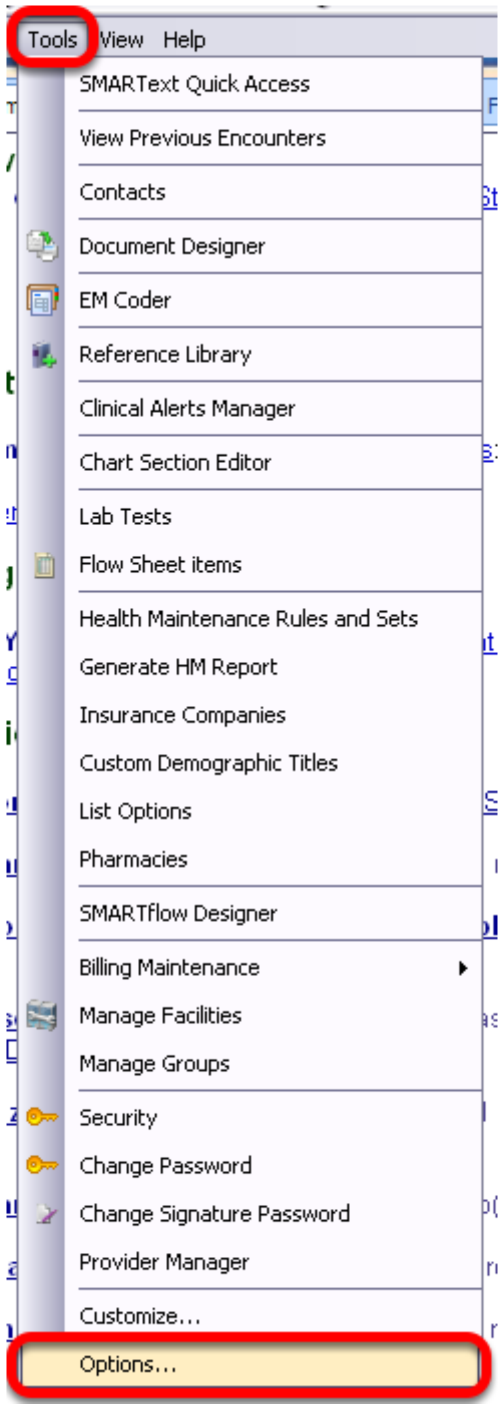
1. Click on Tools > Security in the menu bar.
2. At the bottom of the dialog window, check the box to Require Password to sign documents.

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

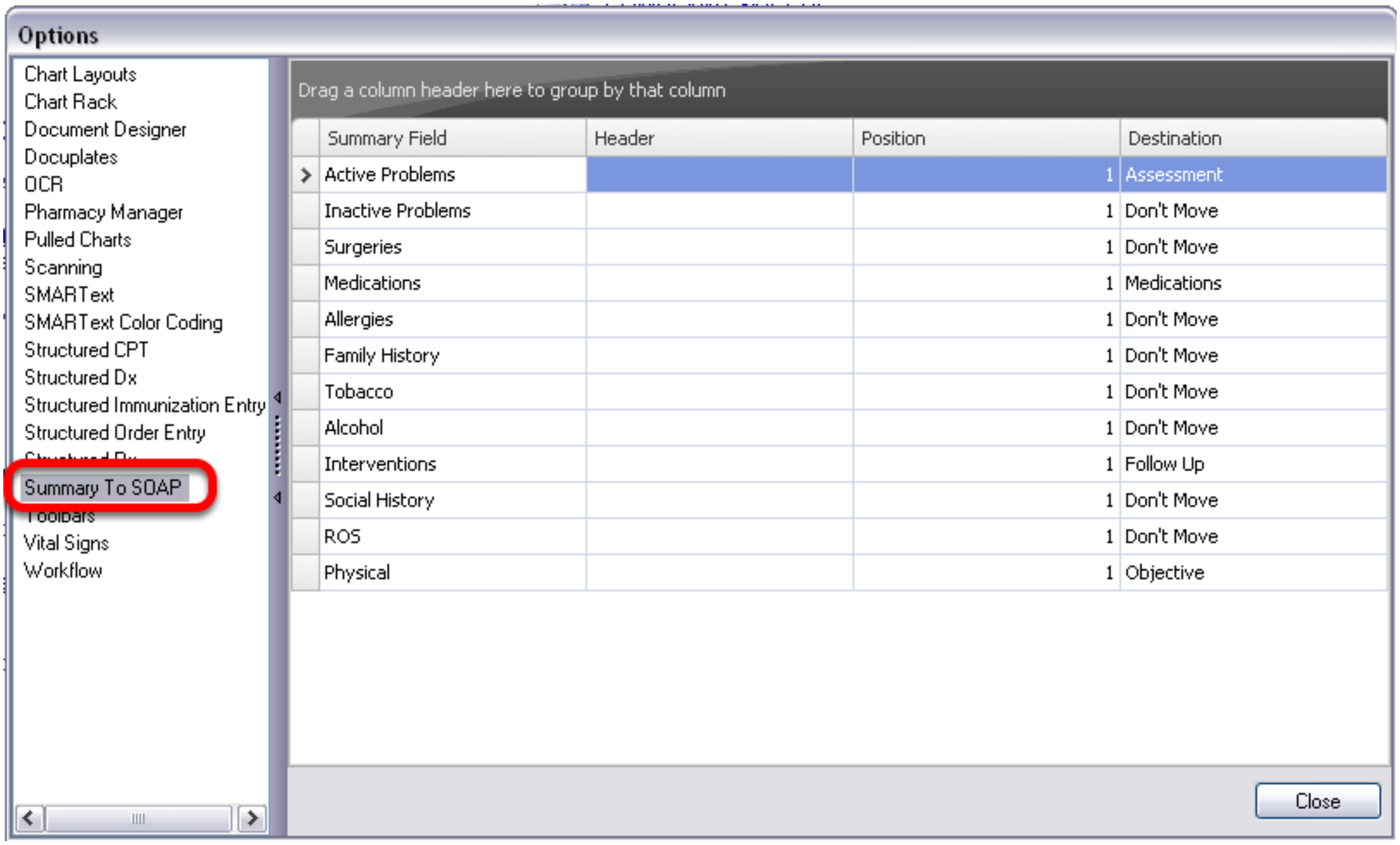
This lesson will describe how to set up the Summary to SOAP option, which will allow users to set Summary fields to transfer documentation to a new SOAPnote that has been created.

Tools - Options



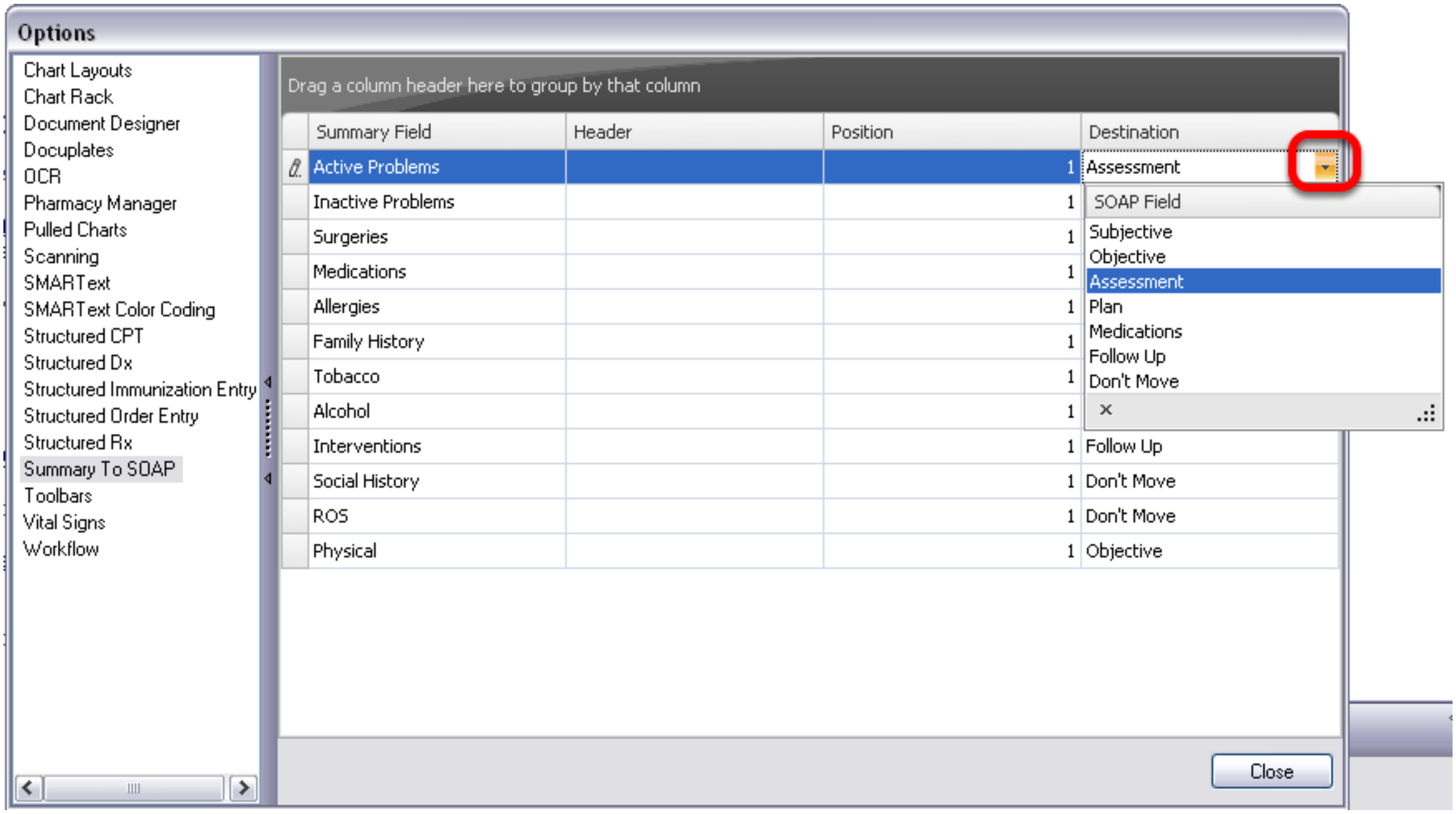
To set up the Summary to SOAP options, go to Tools > Options.

Summary to SOAP



Select the Summary To SOAP item within the left side menu.

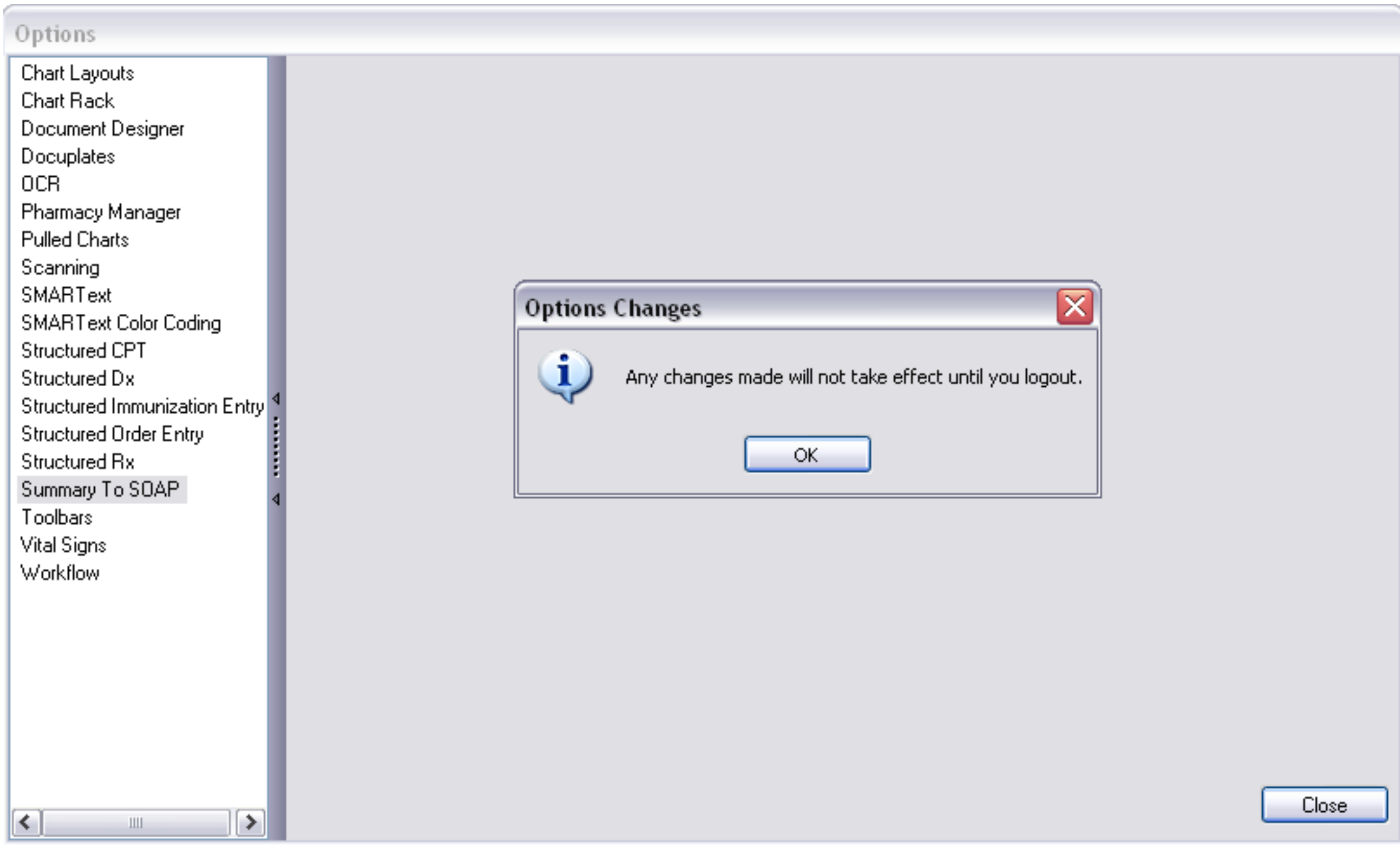
Selecting the Destination



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).

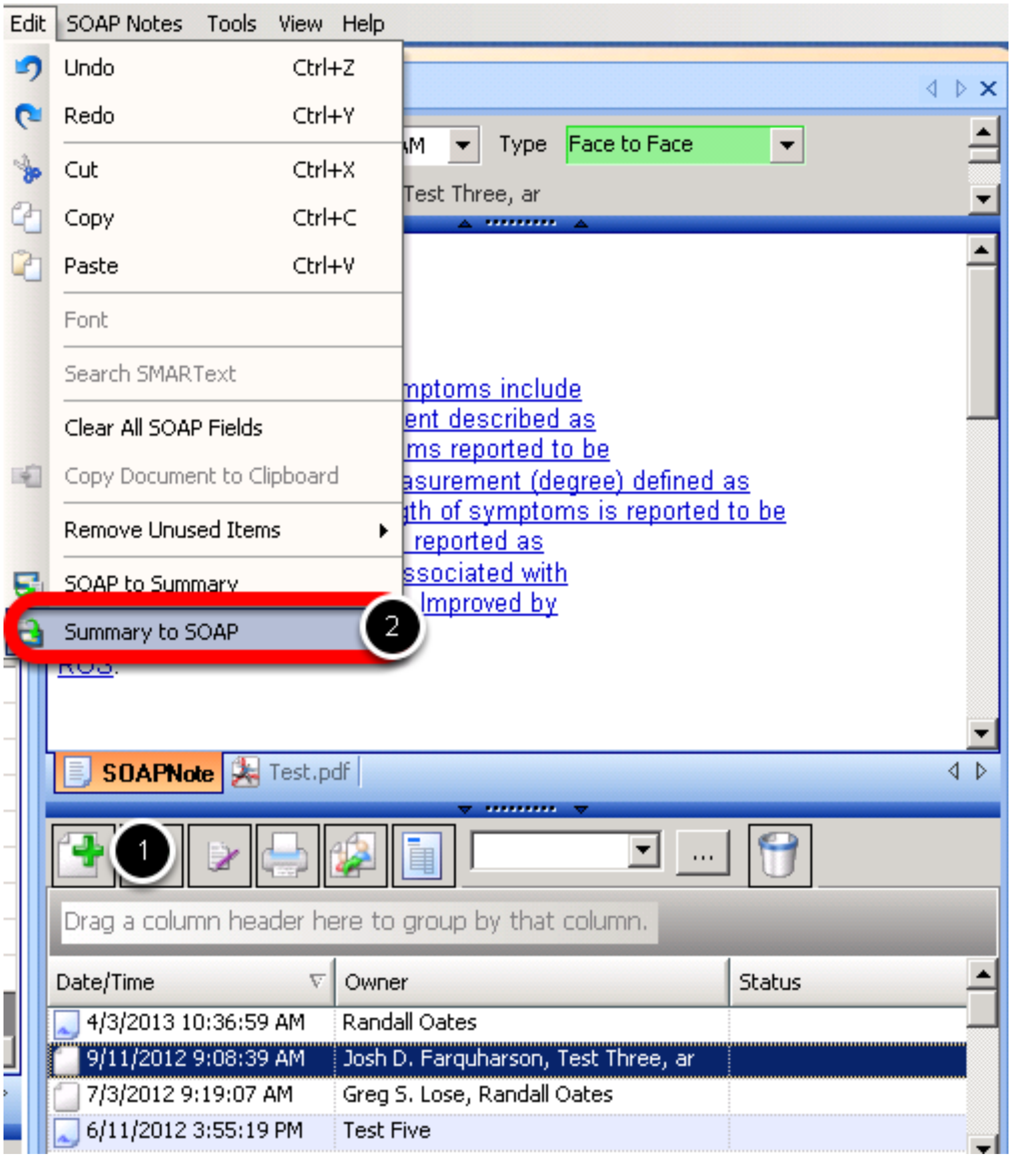
If the user does not wish for a field to be copied into a new SOAPnote, select "Don't Move".

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.

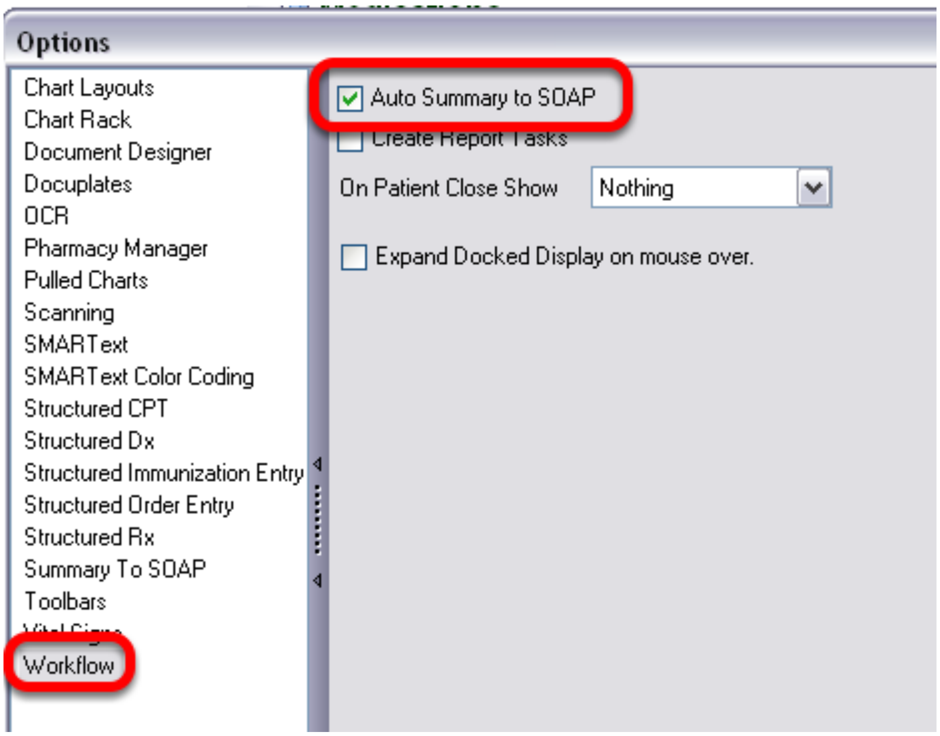
Manual Summary to SOAP



To manually transfer our Summary to SOAP documentation:

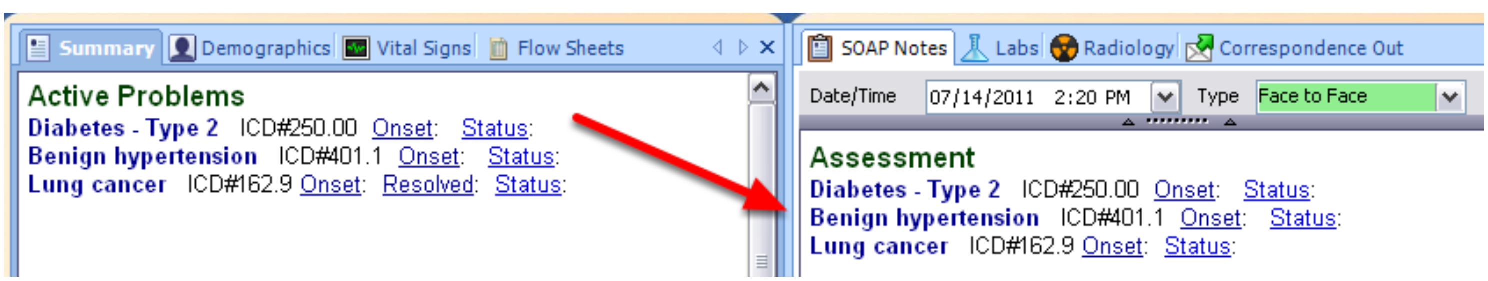
1. Create a new SOAPnote.
2. Click Edit > Summary to SOAP.

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

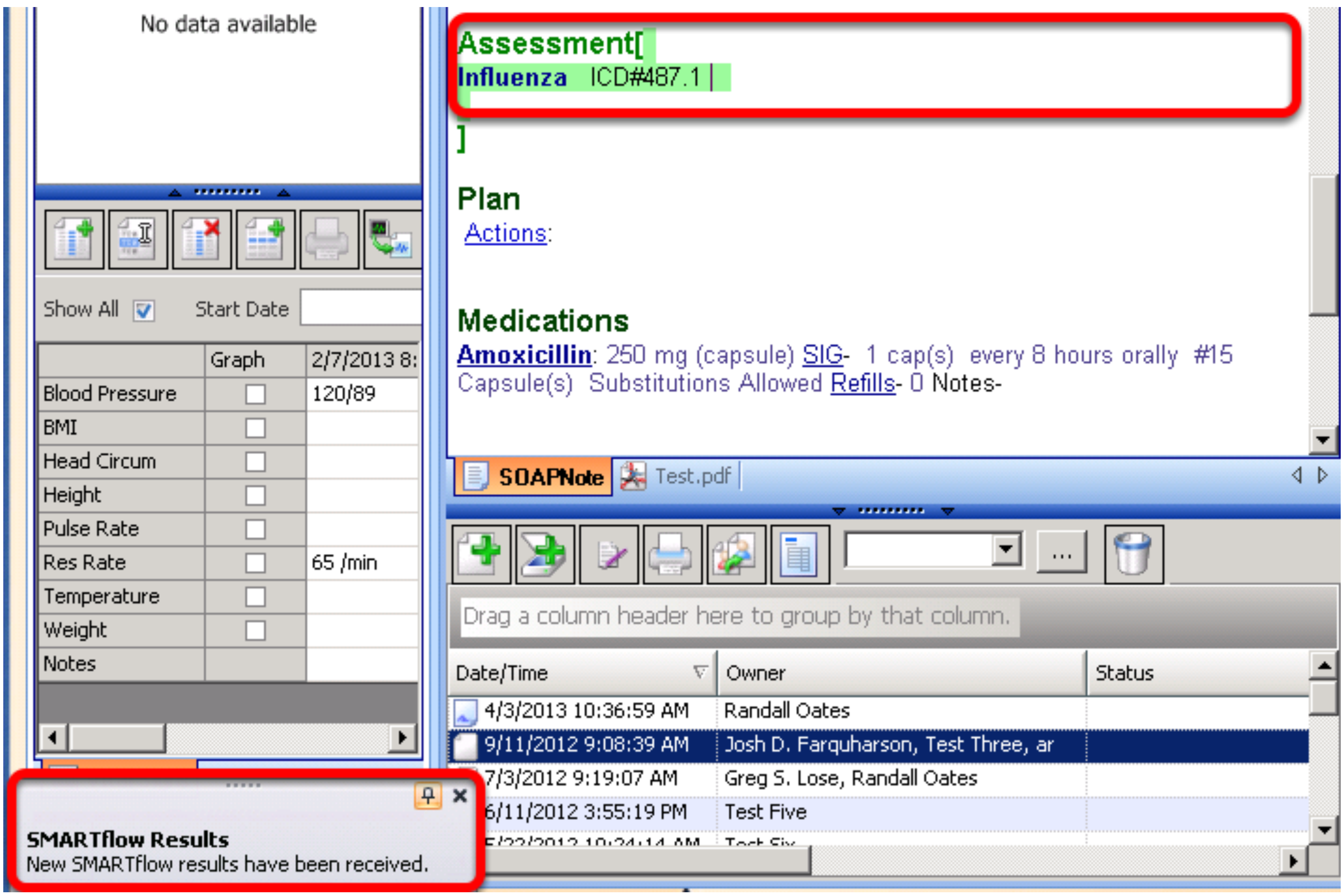
The Summary to SOAP option is user-specific.

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

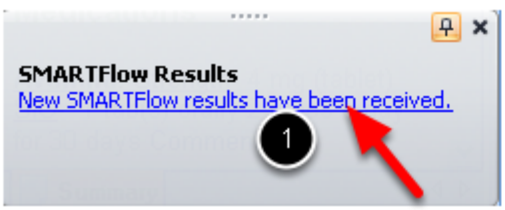


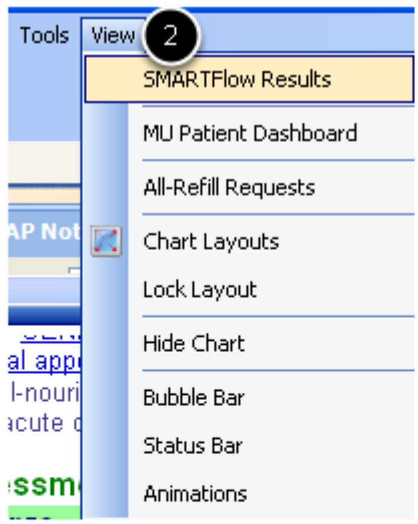
When entering a reportable diagnosis SMARText item into the Assessment field of the SOAPnote, the SMARTFlow Results window will display. This window will prompt the user to review and save this information to their computer for future use if needed.

For instance, if Influenza (SMARText 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

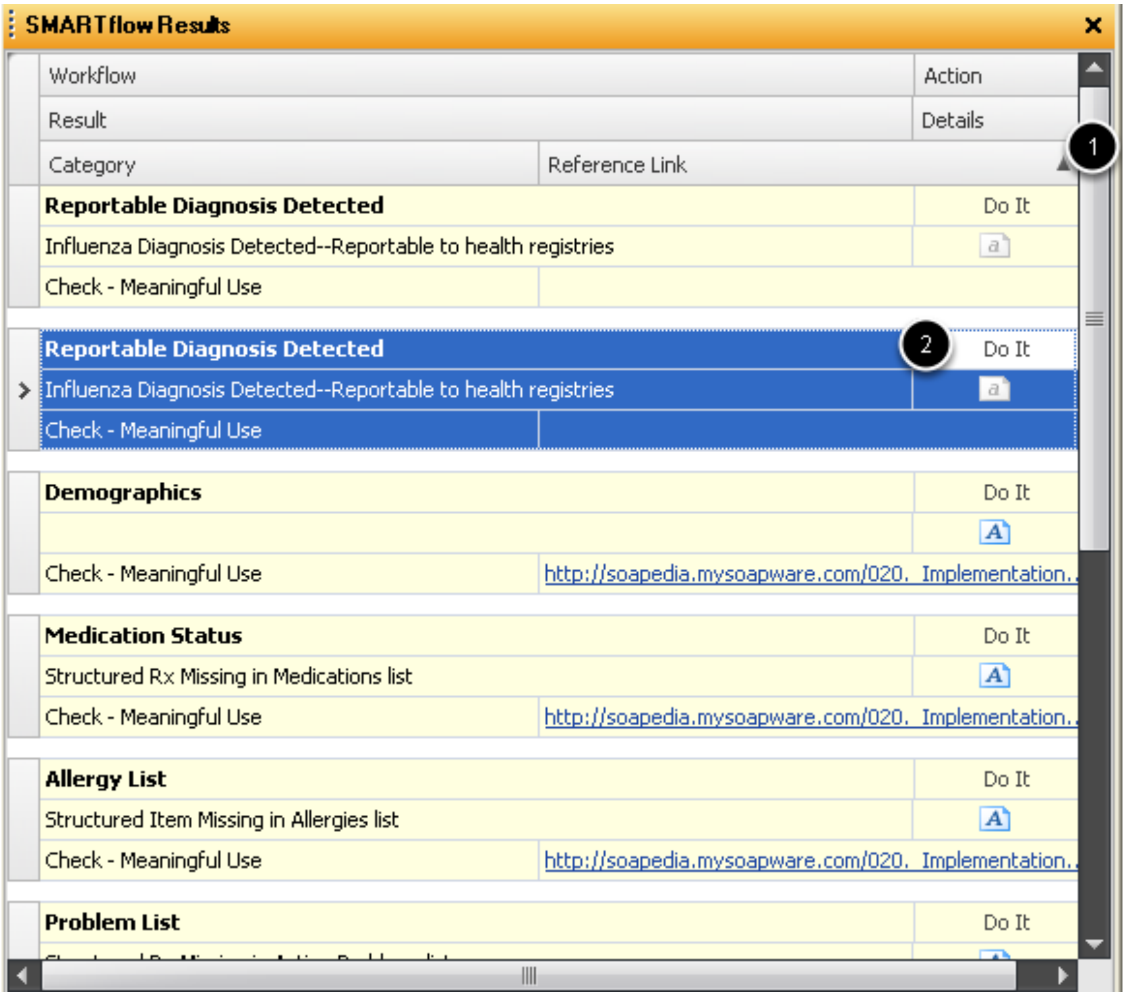




To view the SMARTFlow Results:

1. Click the underlined text-*New SMARTFlow results have been received.*
2. Click View > SMARTFlow Results if the pop-up window was missed.

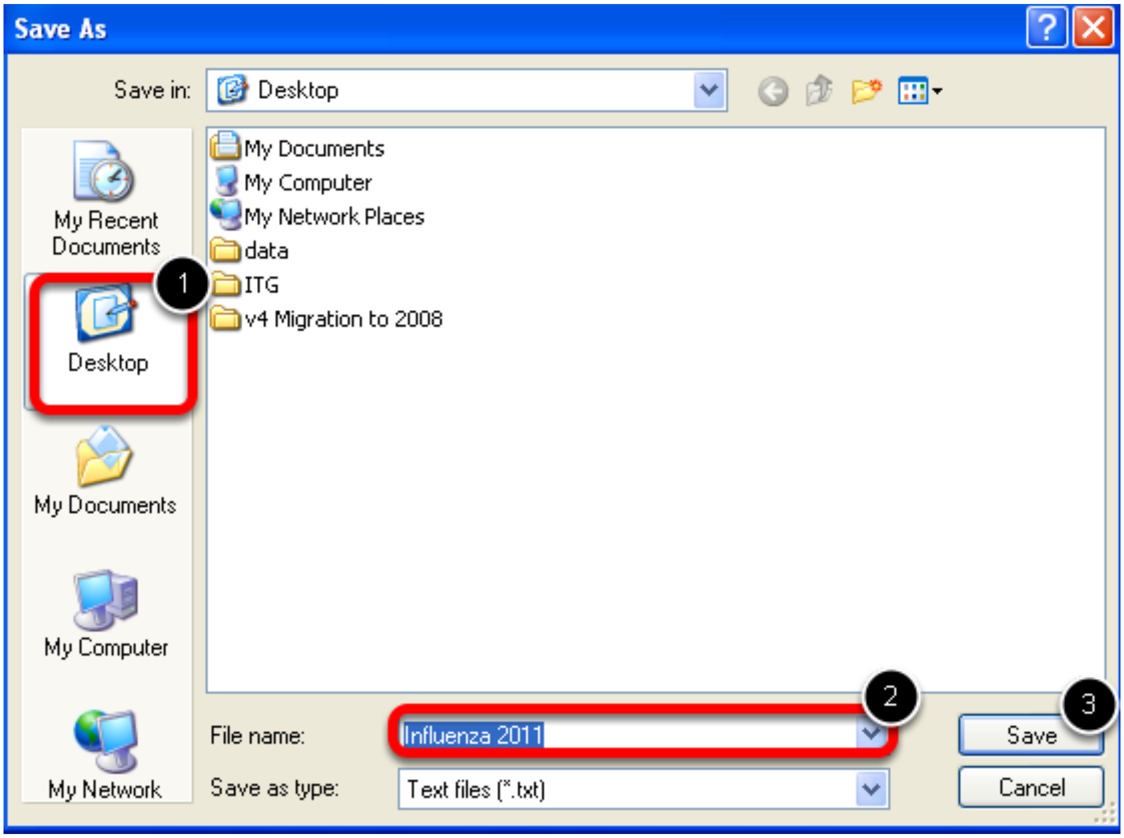
SMARTFlow Results



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.

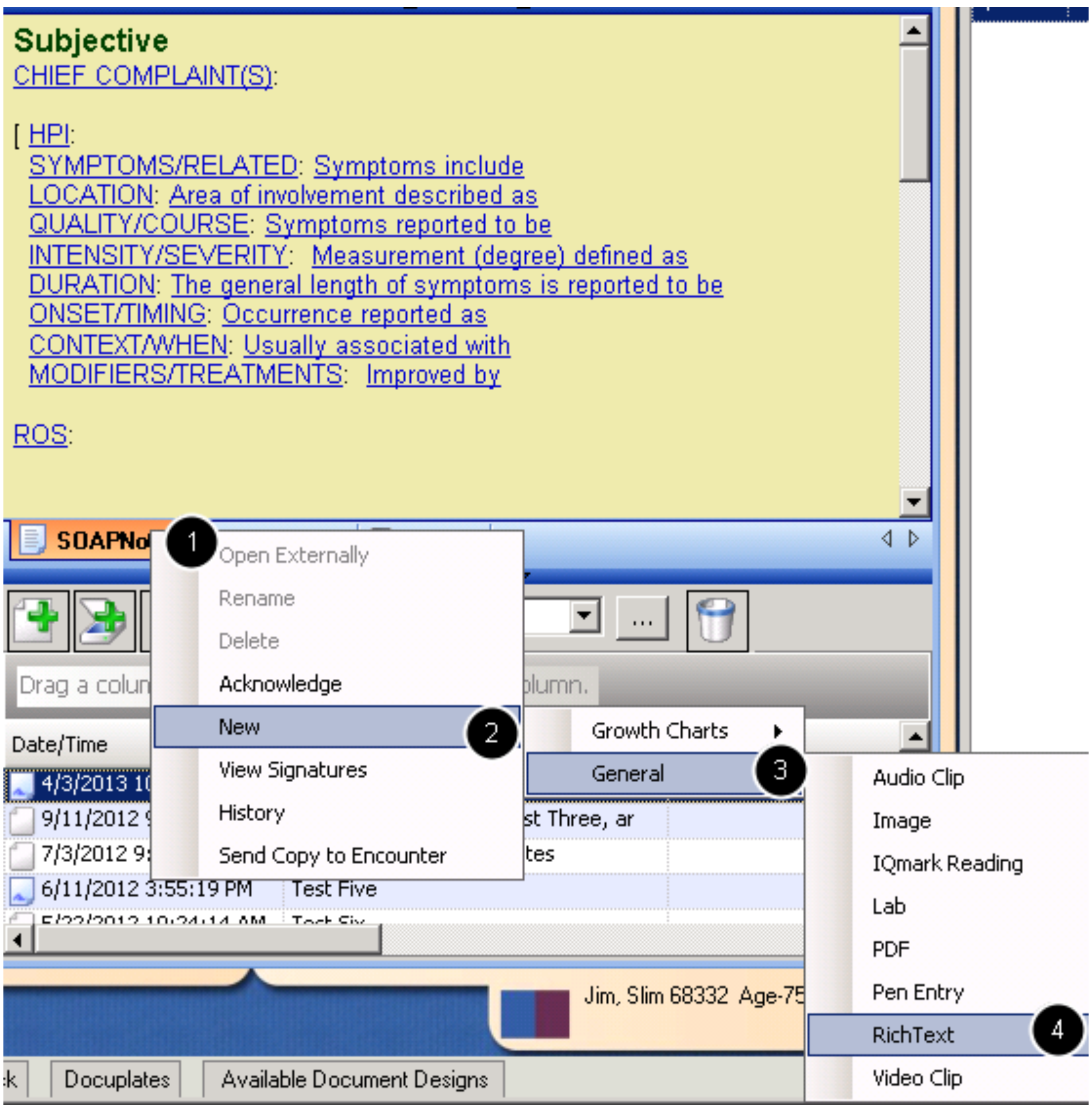
1. Select the location to create a file to save the Reportable Diagnosis Detected.
2. Give the file a name-i.e. the name of the Reportable Diagnosis.
3. Click Save.

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

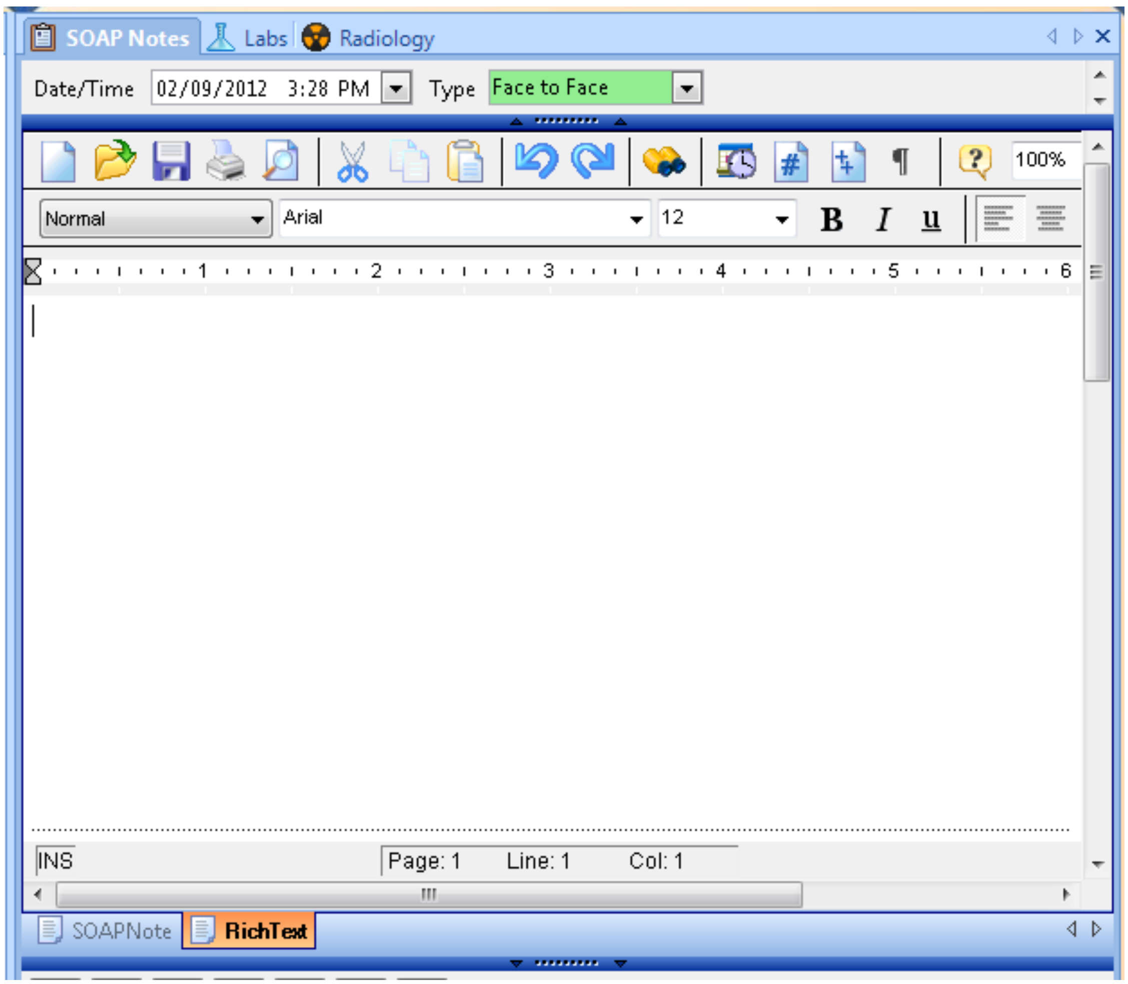


To do this:

1. Right-click on the lower SOAPnote tab (just above the lower splitter bar).

2. Amenu will appear and the user will choose New.
3. Choose General.
4. Choose Rich Text.

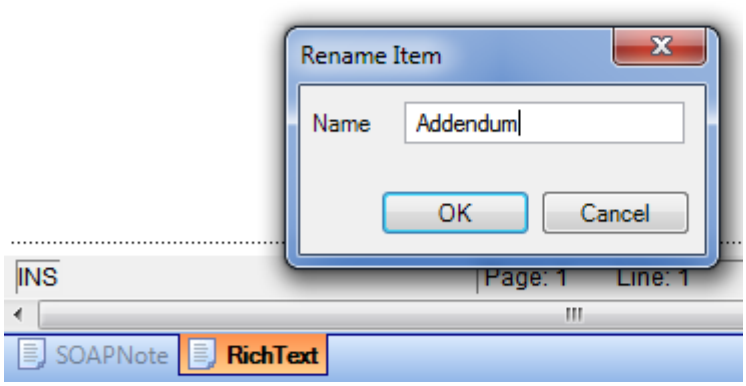
Addendum is attached to the SOAPnote



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".

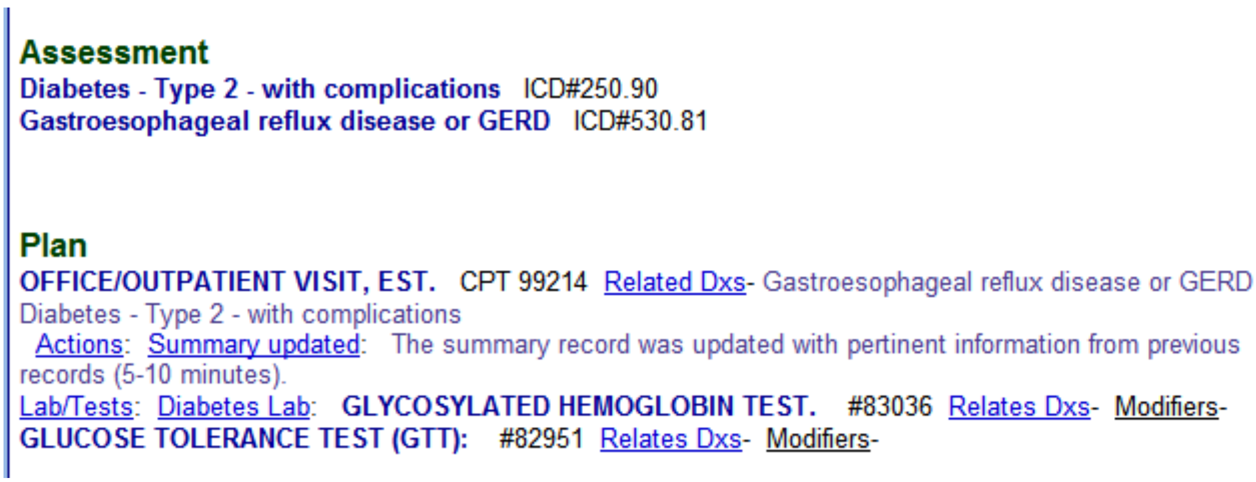
Billing Statements

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).

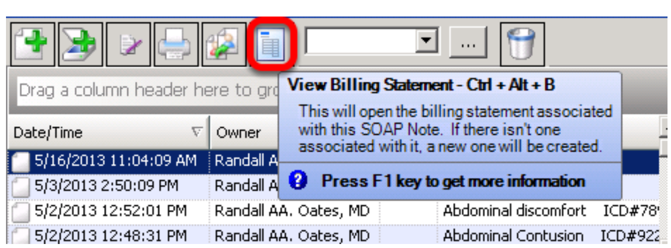
Structured Data Entry



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.

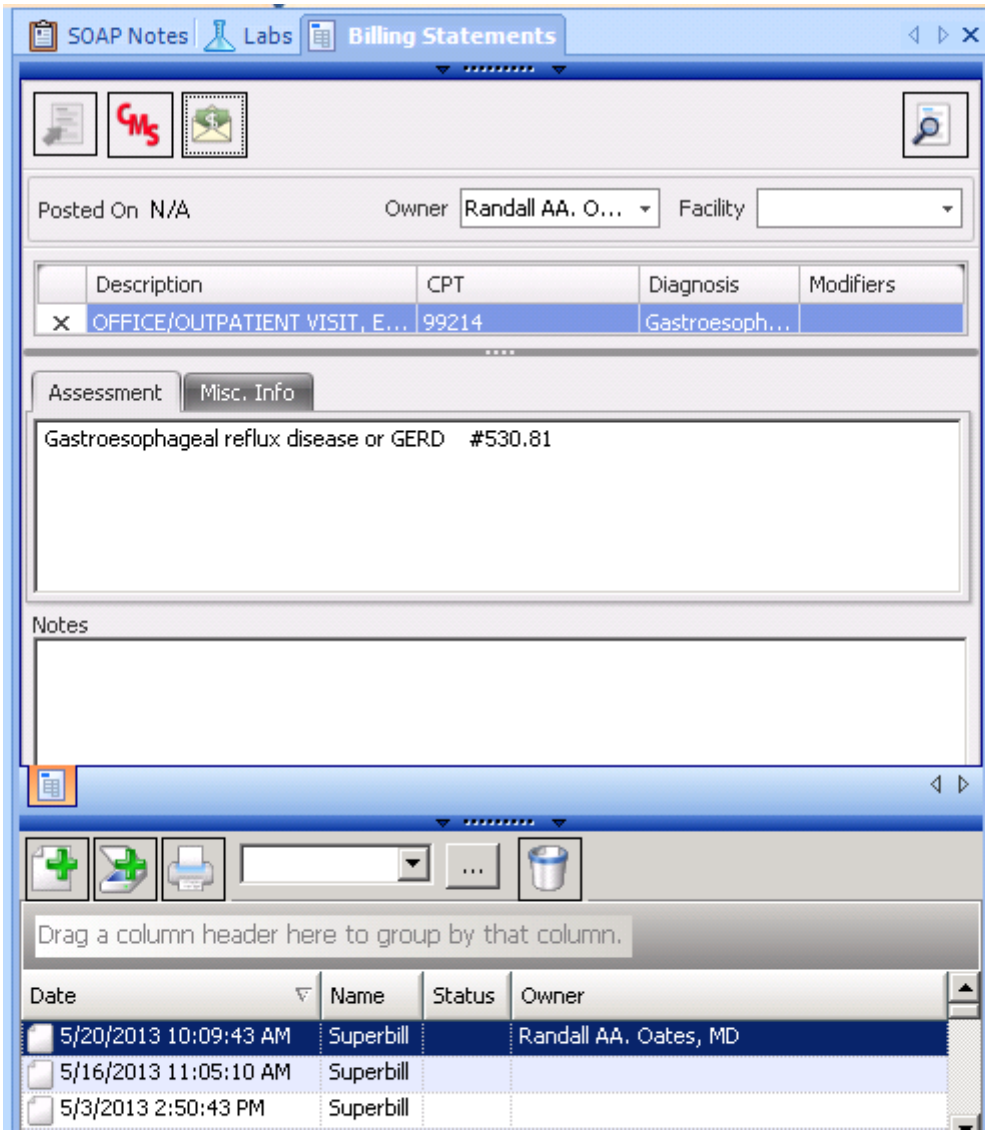
Also, the Plan field needs to contain a Structured Plan Item type of SMARText item that is associated to a related diagnosis.

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

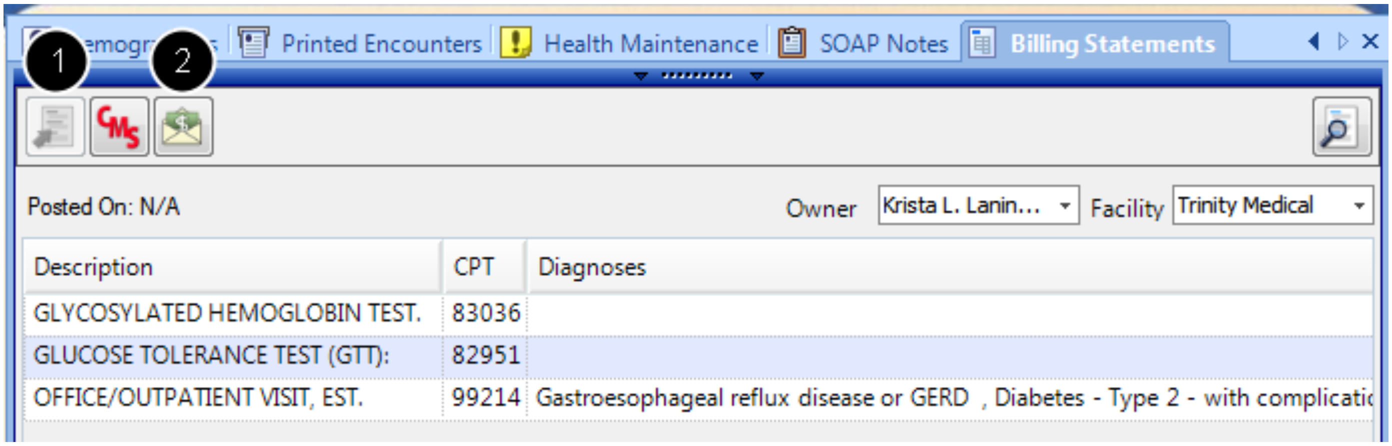


An Add Document Task dialog box will display.

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

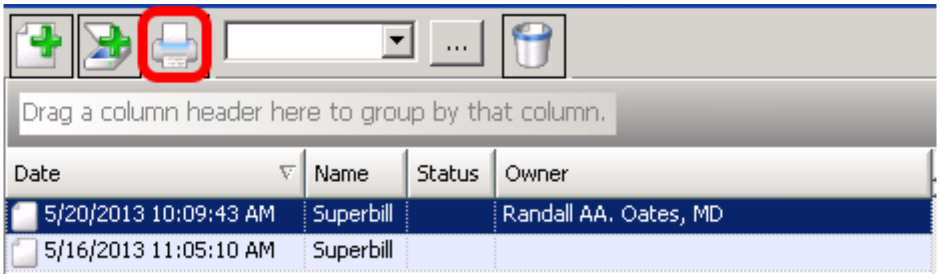


1. Click the Associate button
2. Then Click on the Post Superbill button

SOAPware sends the billing statement to the practice management system.

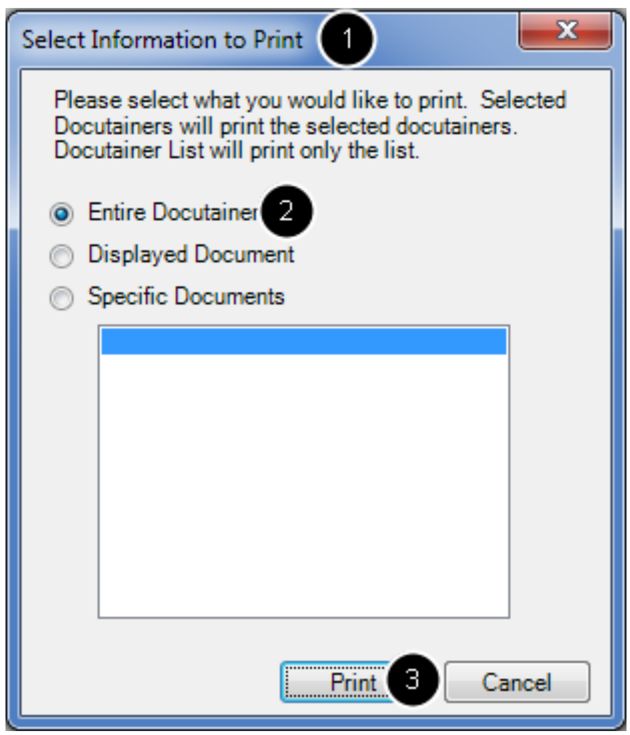
Printing a Billing Statement

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

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.

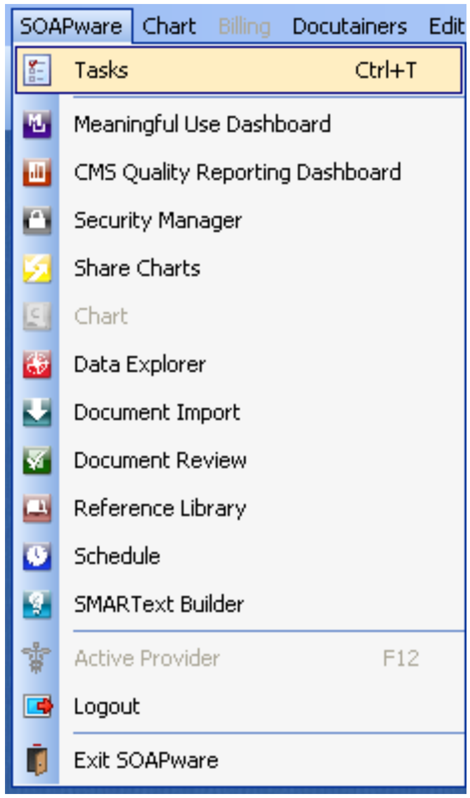
The Task Manager has two key functions:

1. Track the status of all tasks.
2. Send messages or reminders to various users.

Interface

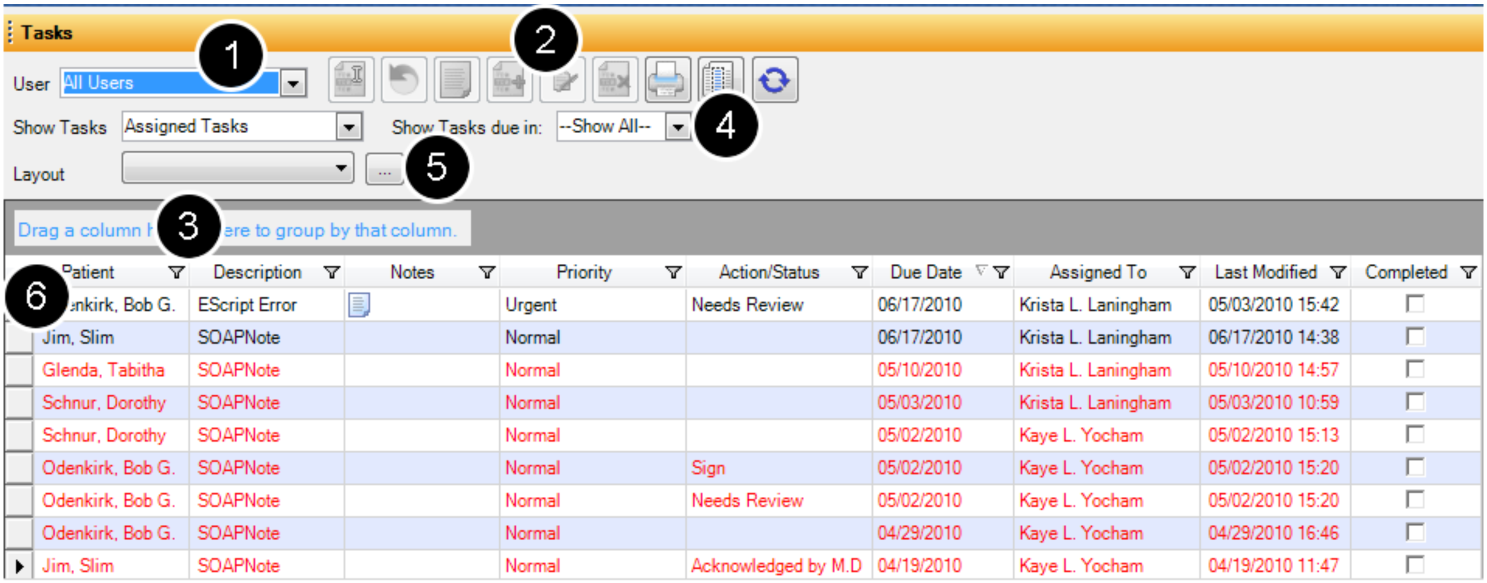
IMPORTANT: The Task lists section is not to be used for documentation purposes. Tasks are not a permanent part of the patient record. It is to keep track of tasks for the patient and to send messages or reminders to other users in the workplace.

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).

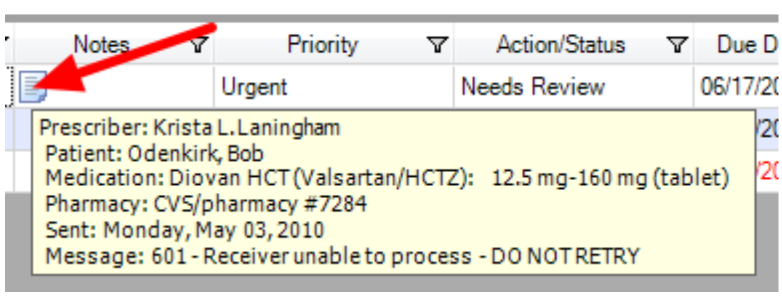
Task Manager



The 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



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

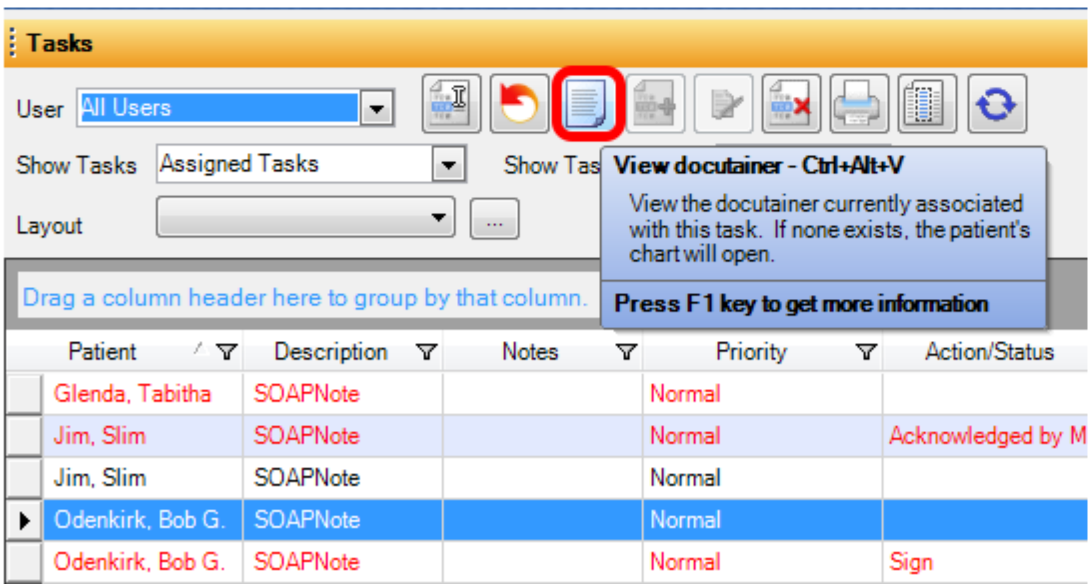
The Tasks information area at the bottom of the Task Manager displays one task item per line/row, and various task characteristics organized/displayed in columns. The tasks characteristics that are displayed can be customized.

* 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.

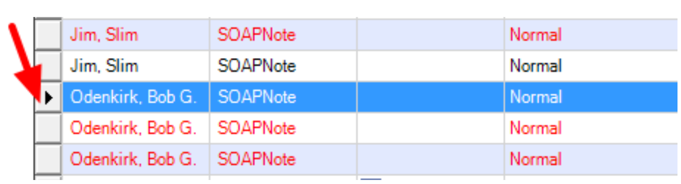
Viewing an Associated Document



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.

A SOAPnote has been selected in this example, so the SOAPnote docutainer in the patient's chart opens for viewing.

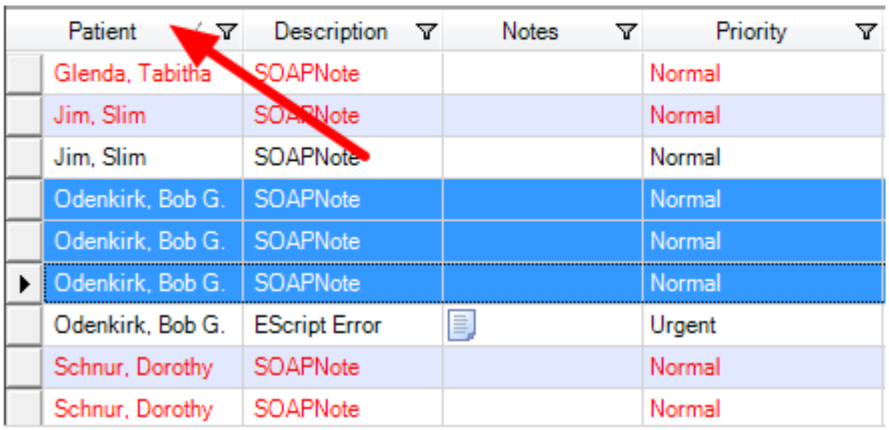
Using Task Manager to Retrieve Charts



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 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

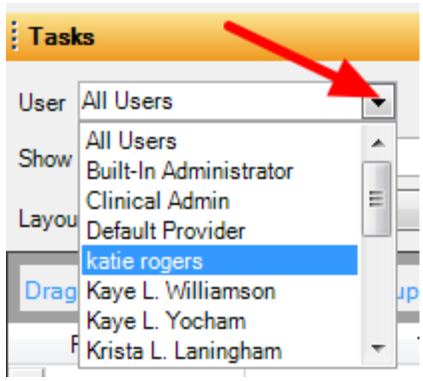
To group task items together, the user can sort by column header. For instance, the user can click on the patient column header to sort by patient and group all tasks related to a particular patient together.

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.

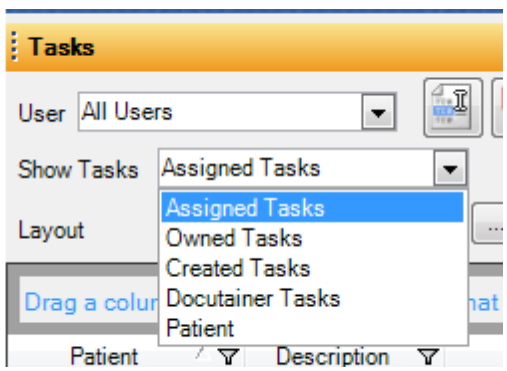
Task List Functions

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.

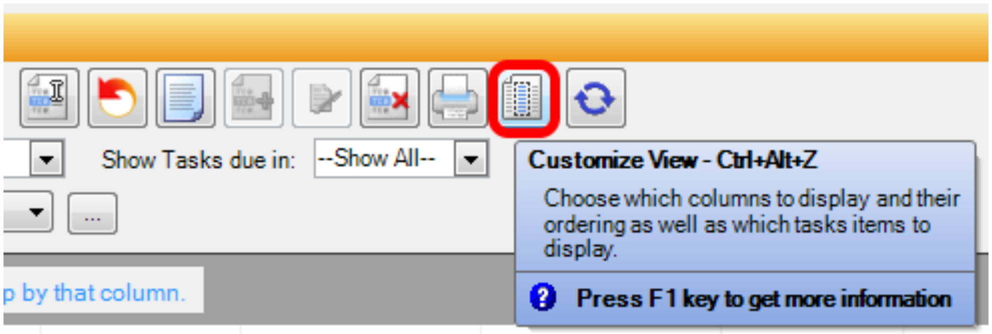
Choosing Task Type



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)

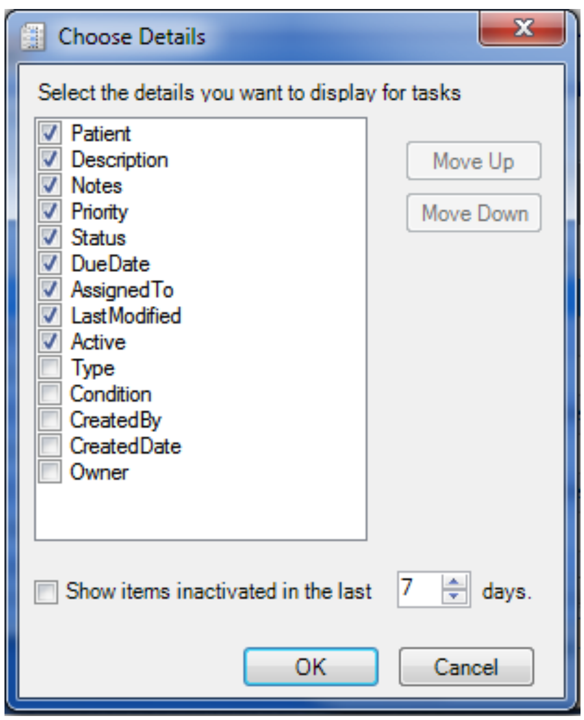
Customize Task View



It is possible to customize the view of the Task Information area **per user** preference.

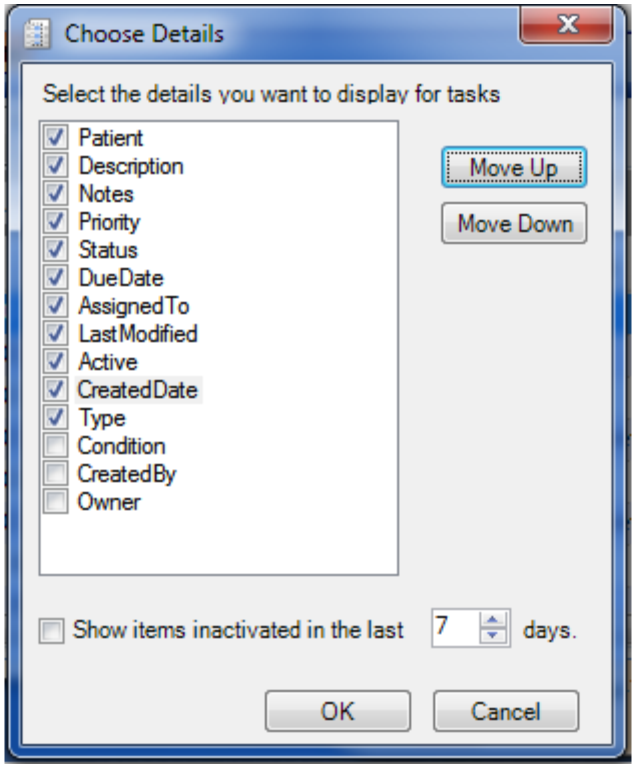
1. Click the Customize View button (or Press Control + Alt + Z) to display the Choose Details dialog.

Customize Task View - Choose Details



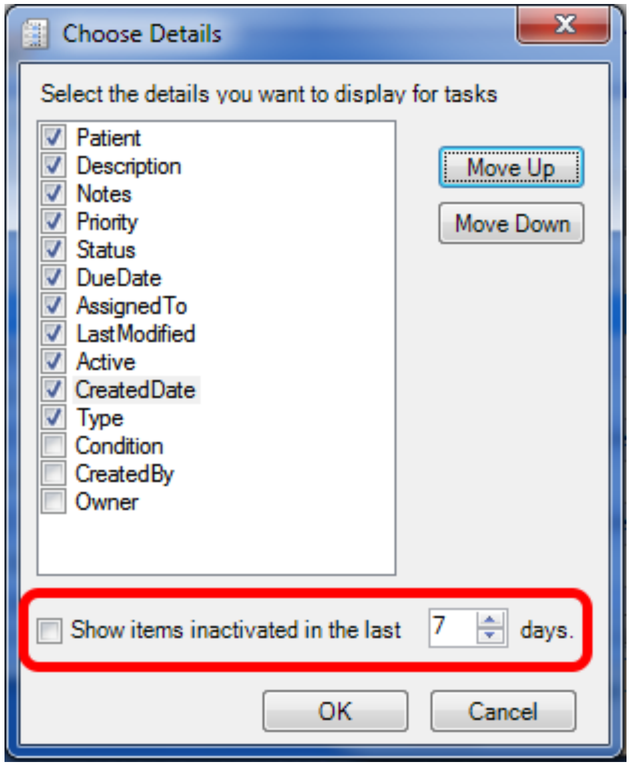
Click the check boxes to the left of the various columns available. This is the mechanism to select the columns displayed in the task list area of the Tasks Manager. Click to uncheck any items that are not to be displayed in the task list area.

Rearrange Task Item Details



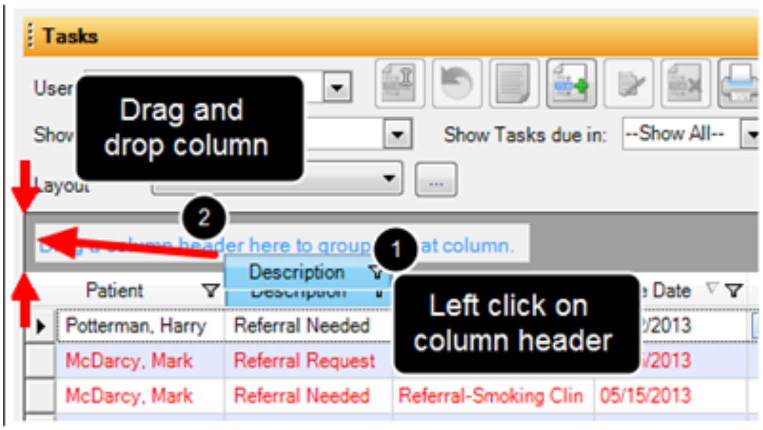
Click a Choose Details item, and Click the Move Up or Move Down buttons to rearrange the columns in the Task Manager. Click OK to save changes.

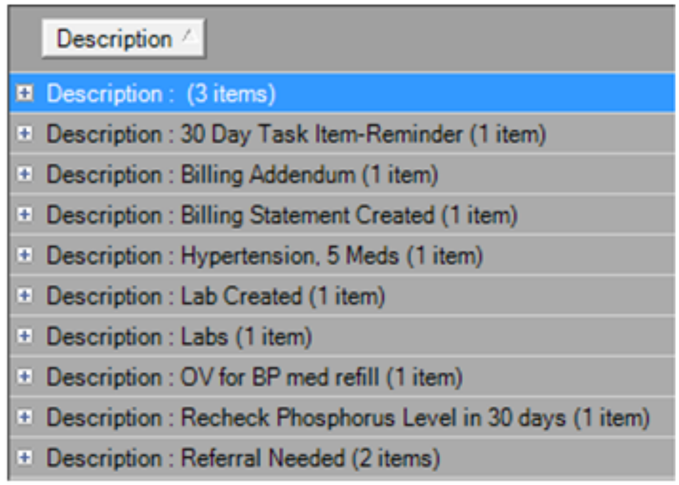
Show Inactive Task Items



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 completed or inactivated (up to 99 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.

Group Task Items by Column

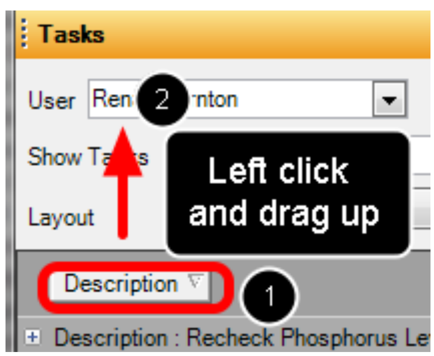




To group a task item by a column:

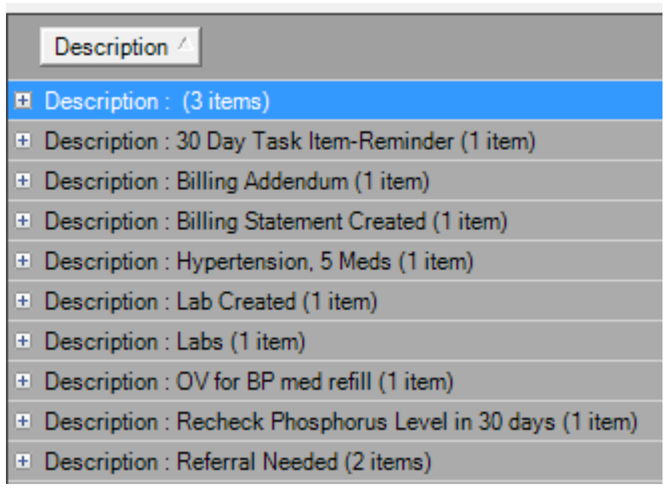
1. Left click on the desired column to group
2. Drag and drop column header between red arrows displayed in the left corner of task list

Reset Task Item Column

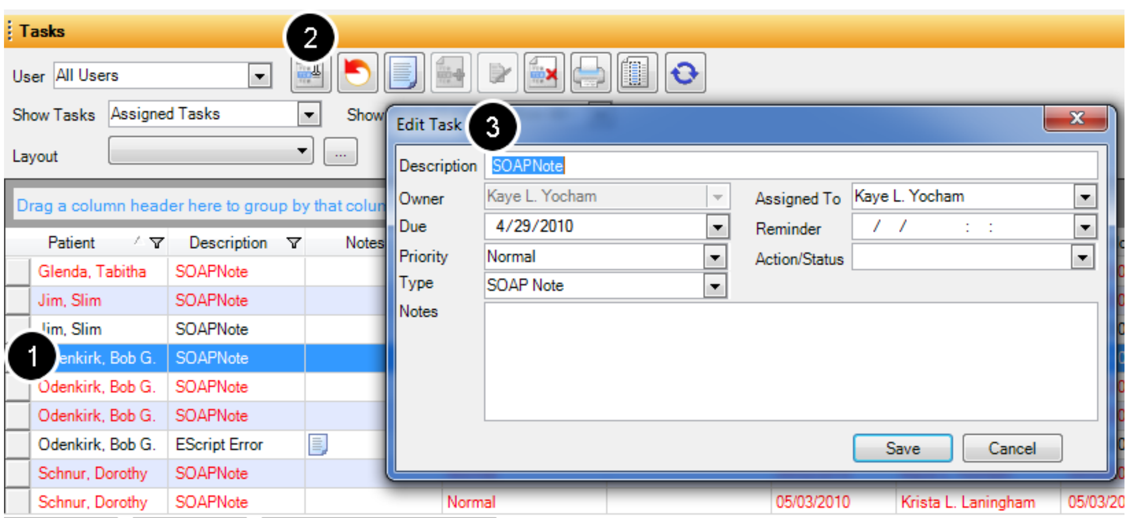


To reset the column from a group list :

1. Left Click on the column header
2. Drag column header up



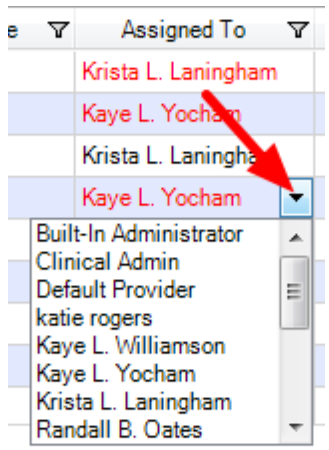
Editing a Task



In order to edit a task from the Task Manager:

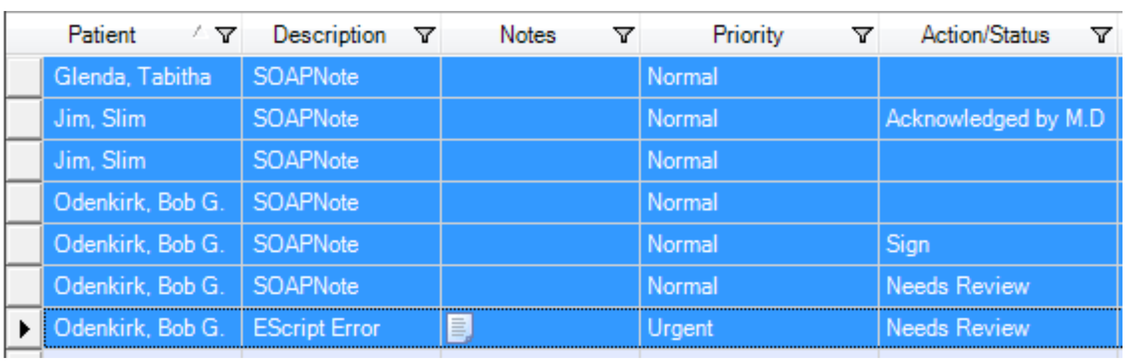
1. Click the selection box containing the black triangle to the left of the task item.
2. Click the Edit button.
3. The Edit Task window will open, allowing the user to edit the task information.

Editing a Task - Option 2



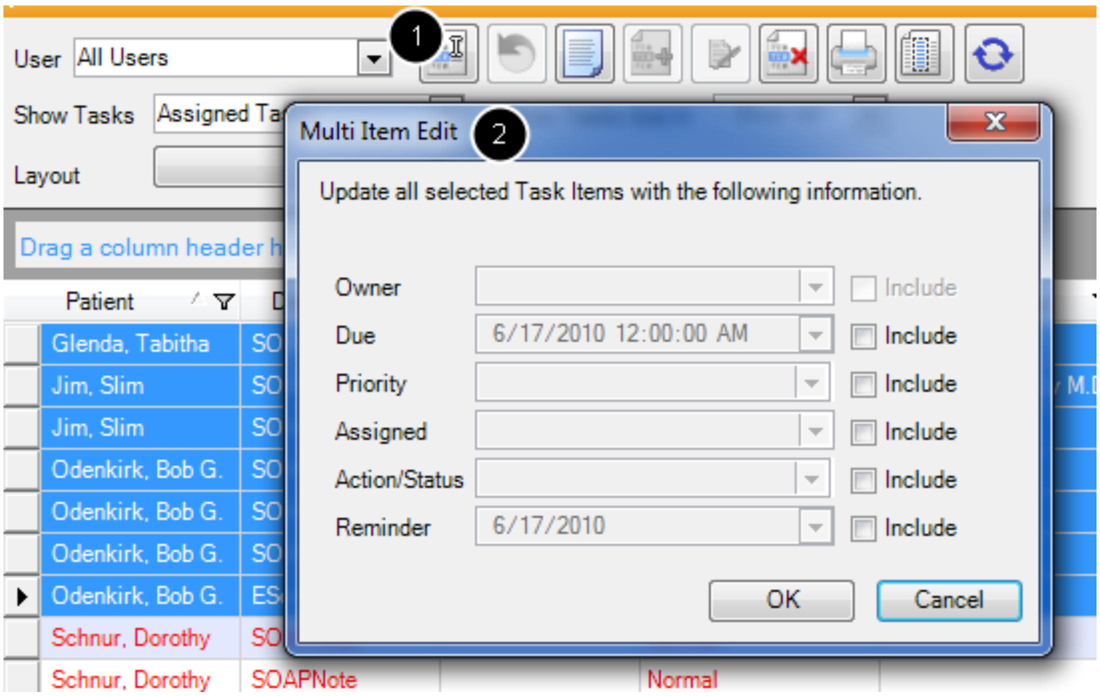
The user can also edit a Task one section at a time. To do this, Click the drop-down menu next to the item and select another option for the task item.

Editing Multiple Items



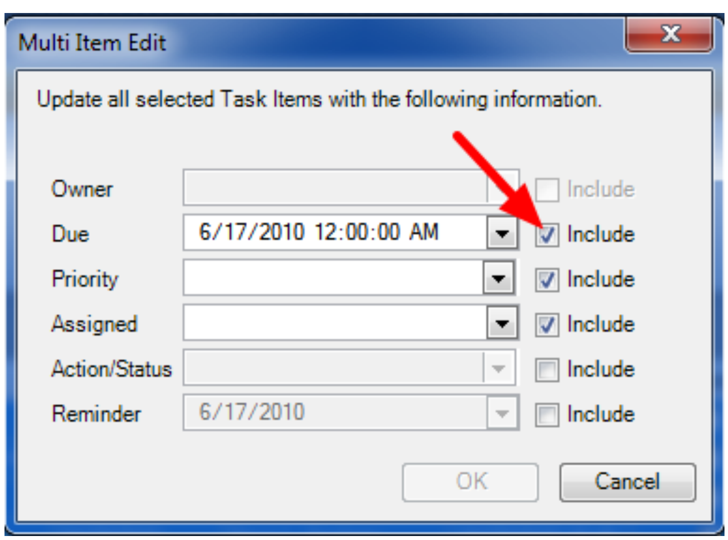
To make edits to multiple tasks all at once, first select the group of tasks to edit. Always Click the selection box containing the black triangle to the left of the task item whenever selecting tasks.

Performing Edits



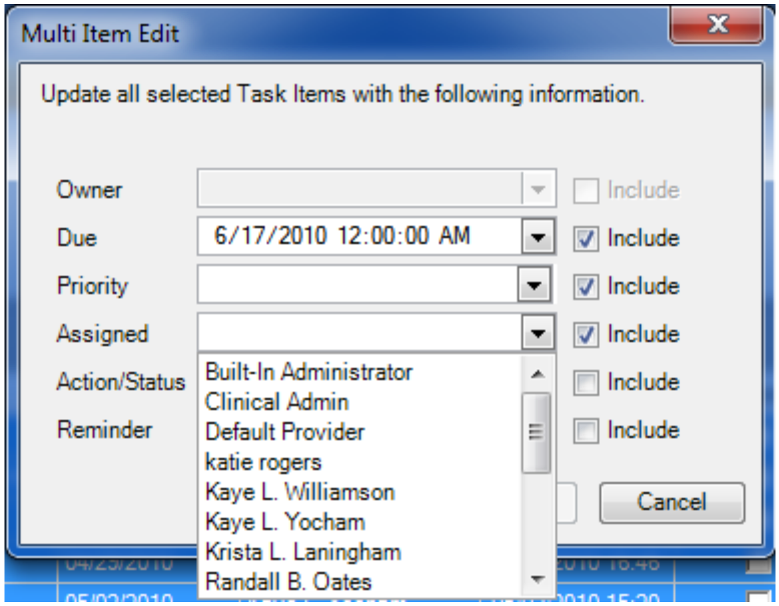
1. Once the tasks to edit are selected-highlighted, Click the Edit Task button.
2. This displays the Multi-Item Edit dialog.

Include



Click the Include check boxes corresponding to the edits desired.

Select New Choices



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

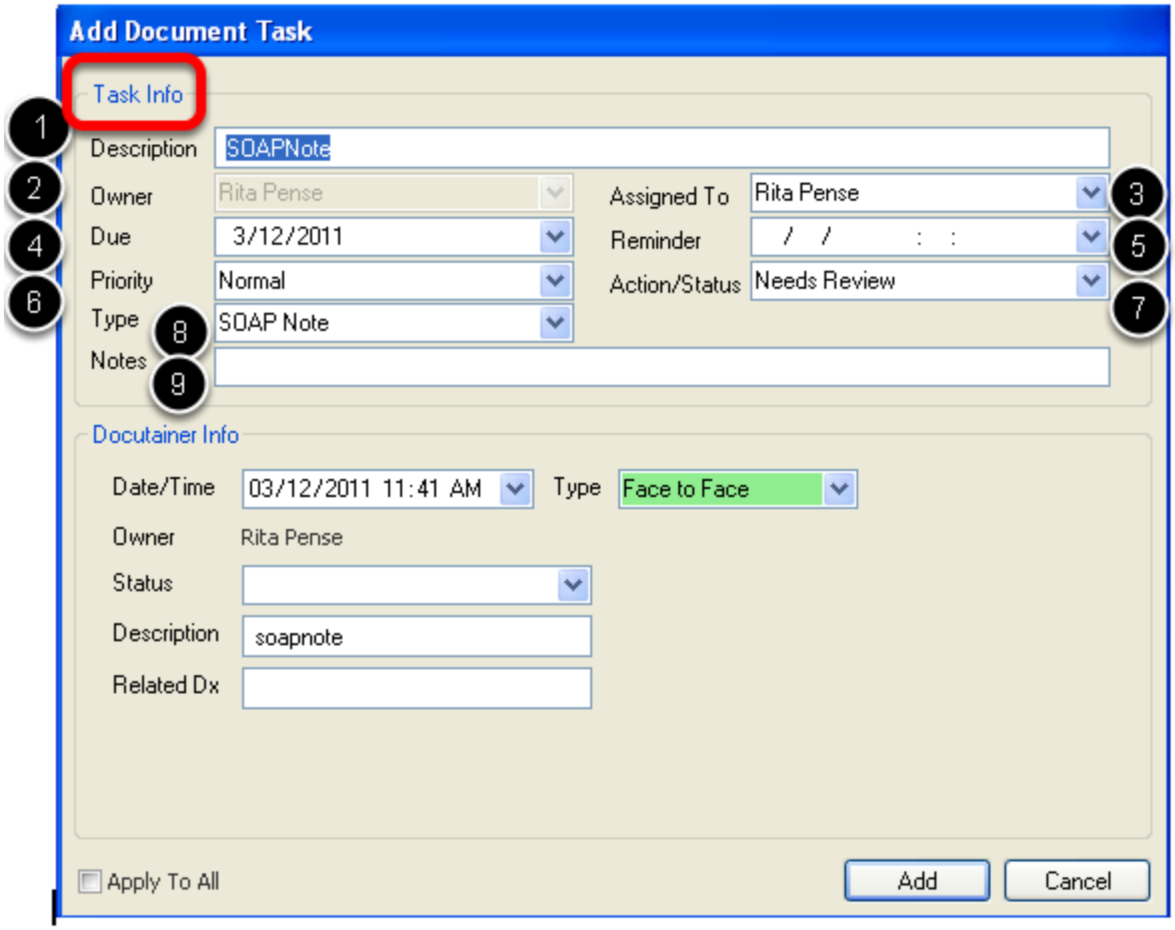
This lesson will discuss the creation and management of auto created Tasks.

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 came 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

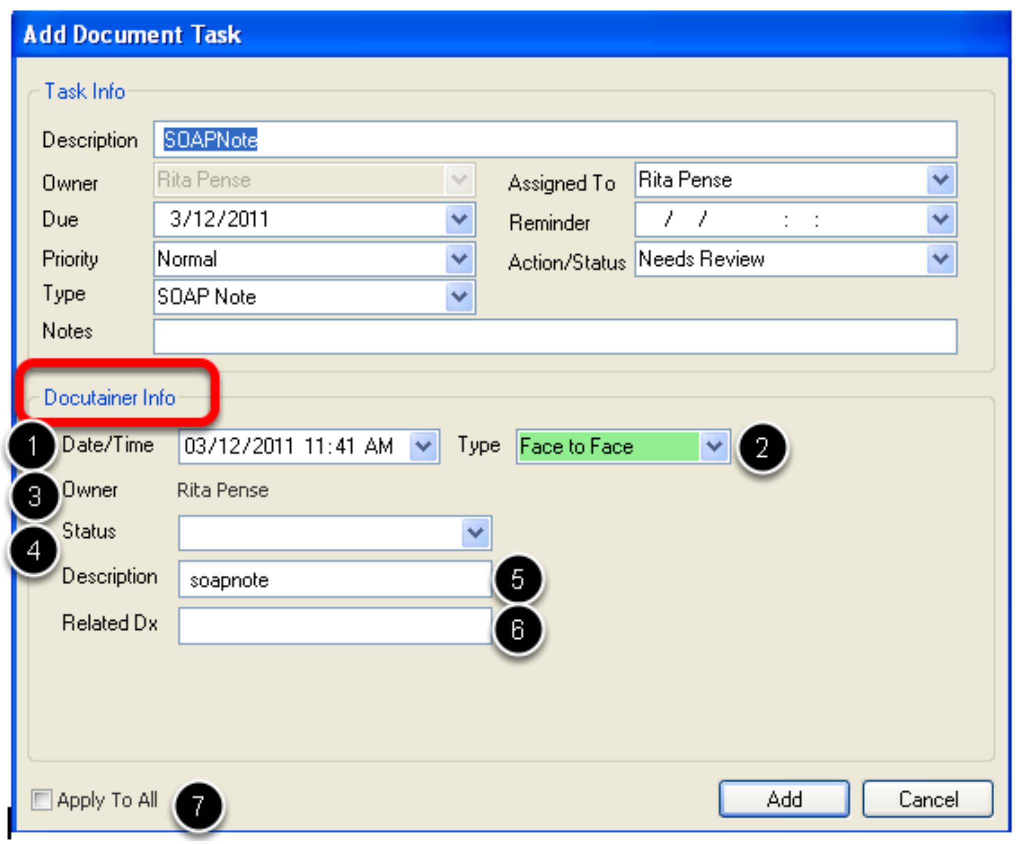


When a new docutainer or document is created or imported in SOAPware the Add Document Task window will display.

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 Task - Docutainer Info Interface



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 SMARText diagnosis from the SOAPnote Assessment Field.
6. **Related Dx** - The SMARText 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 mulit 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.

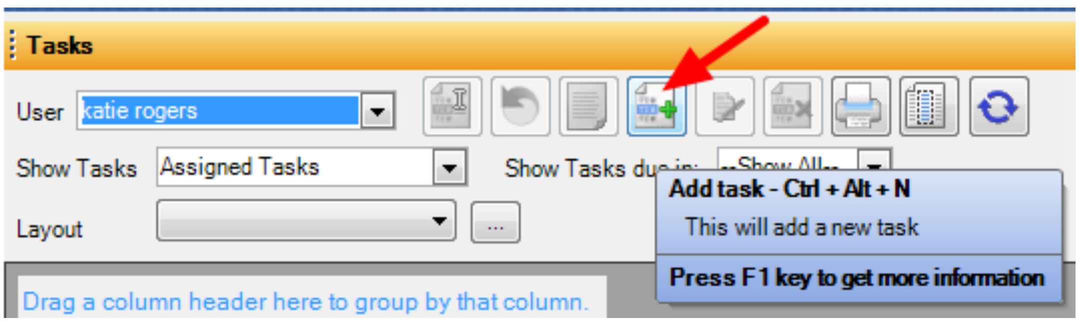
When the Task info section and the Docutainer info section (if needed) are filled out click Add to place this item on the users Task List in the "Assigned To" box. If a Task is not needed Cancel can be pressed but we highly recommend all items created or scanned in are put onto a Task List.

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).

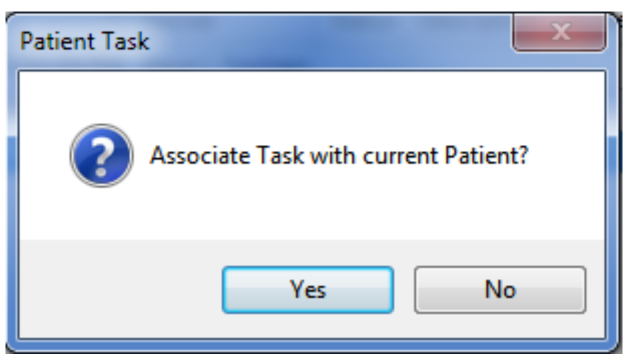
NOTE: Manually added tasks cannot be signed off due to not being attached or associated with a docutainer. Therefore, manually created tasks will need to be "completed" within the Tasks Manager, not "signed off" .

Add Task



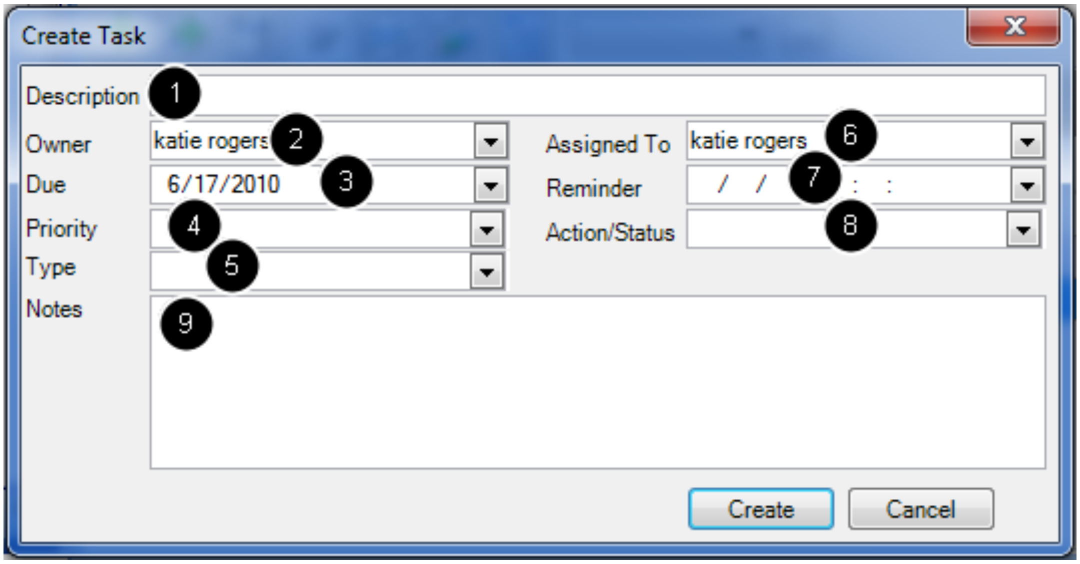
Manually add a new task directly to the Tasks Manager by Clicking the Add Task button.

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

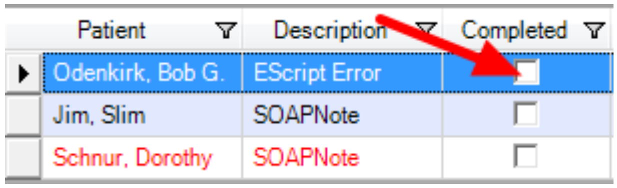


The Create Task dialog opens. Add appropriate information to the new task, and Click the Create button.

The information the user can include is:

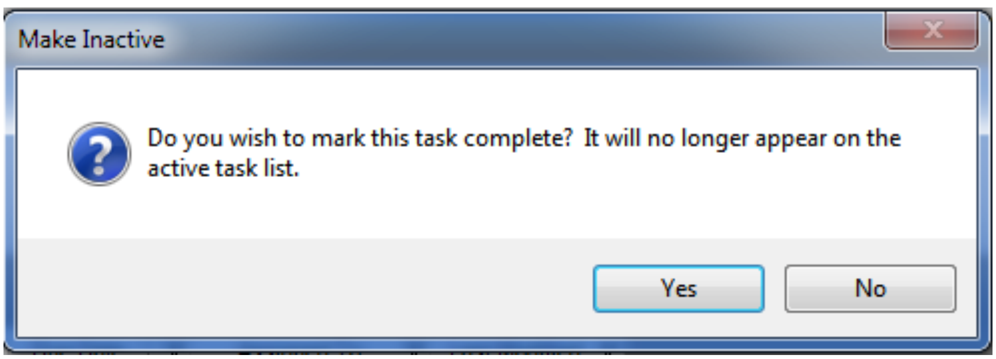
1. **Description** - this will be the description that shows up in the task list and will help the user identify what this document is.
2. **Owner** - this will always be the active provider for an automatic task, but will be the user when creating a manual task that is not associated with a patient's 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



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

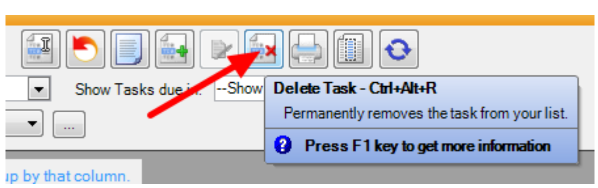


The user will be prompted to confirm. Click Yes.

Task Removed

The task will then be removed from the list. If the user clicks No, the user will be returned to Task Manager.

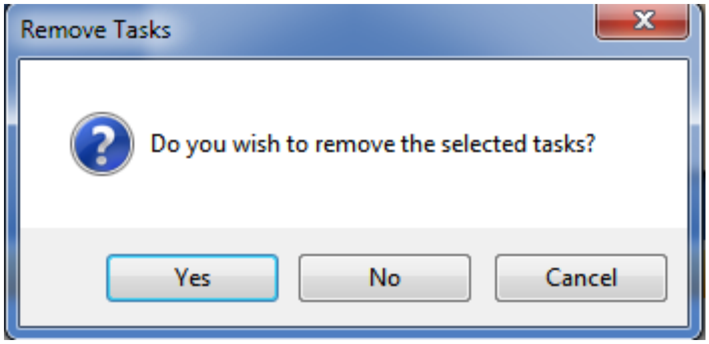
Deleting a Task



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).

Confirm Deletion



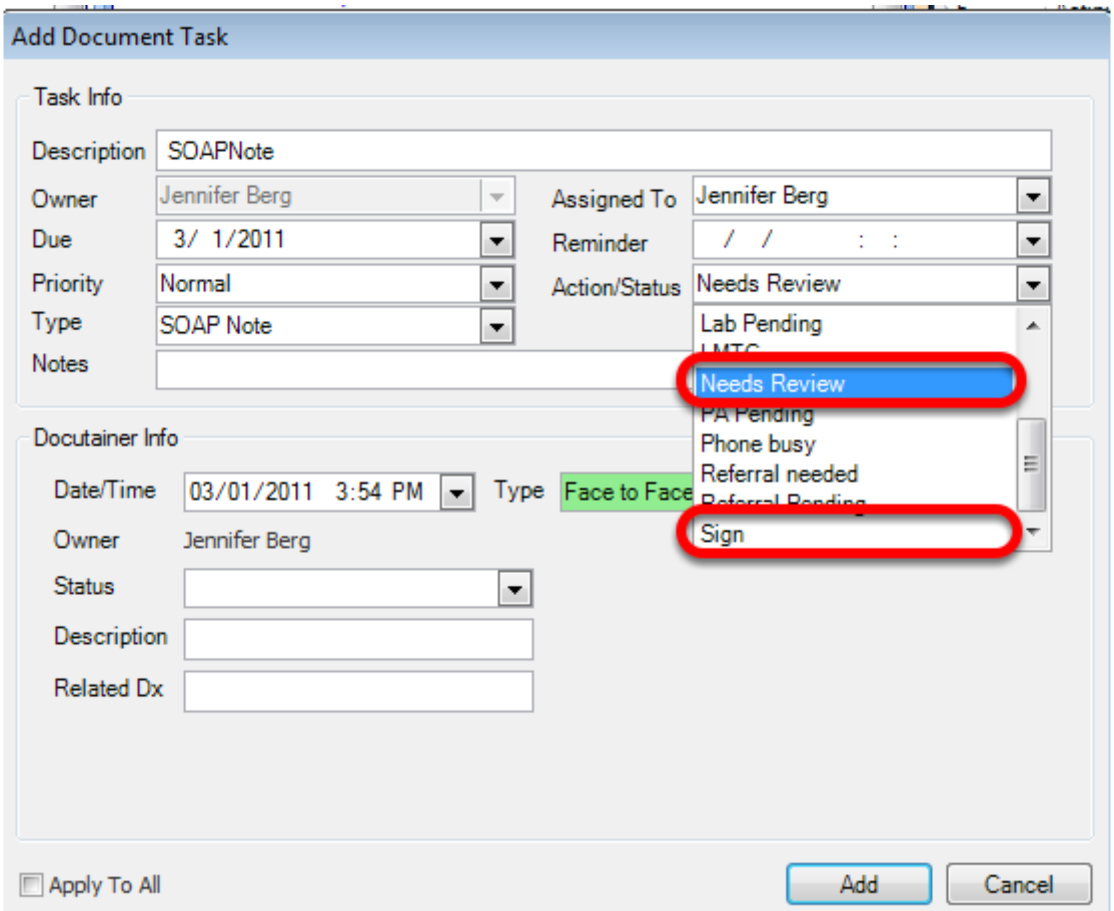
Adialog is presented that asks the user to confirm that they wish to review the selected task (as shown in the screen shot above). Click 'Yes' to remove the selected task or Click 'No' to return to the Task Manager.

Removing a task item from Task Manager does not remove the related document from a patient chart.

Sign and Needs Review Task Items

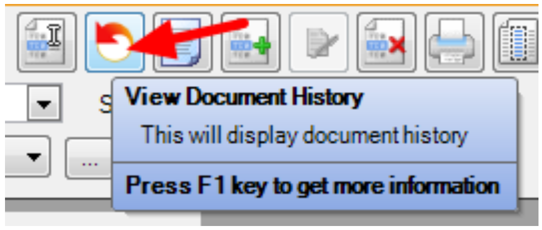
This lesson will discuss the Action/Status settings needed for the Task to be **auto removed** from the Task list when the associated docutainer or document is signed off.

Add Task as Sign/Needs Review



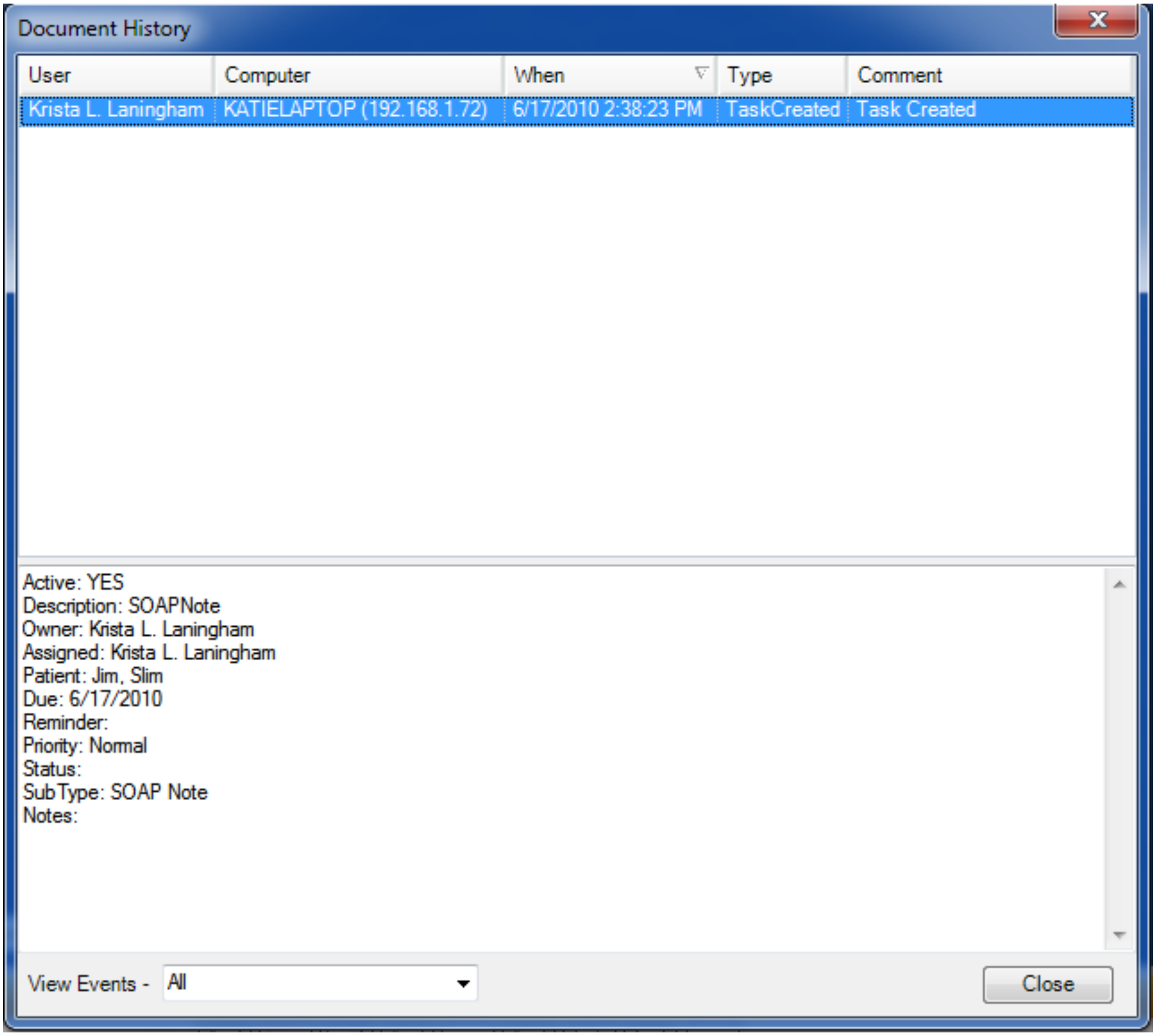
When adding a task, if the user selects the Action/Status item "Sign" or "Needs Review," the Task list item will be automatically removed when its related document is signed off. Otherwise, the Task List Item will remain on the task list until manually completed.

View Document History



Click the View Document History button to view the history of a document in Task Manager.

Document History Window



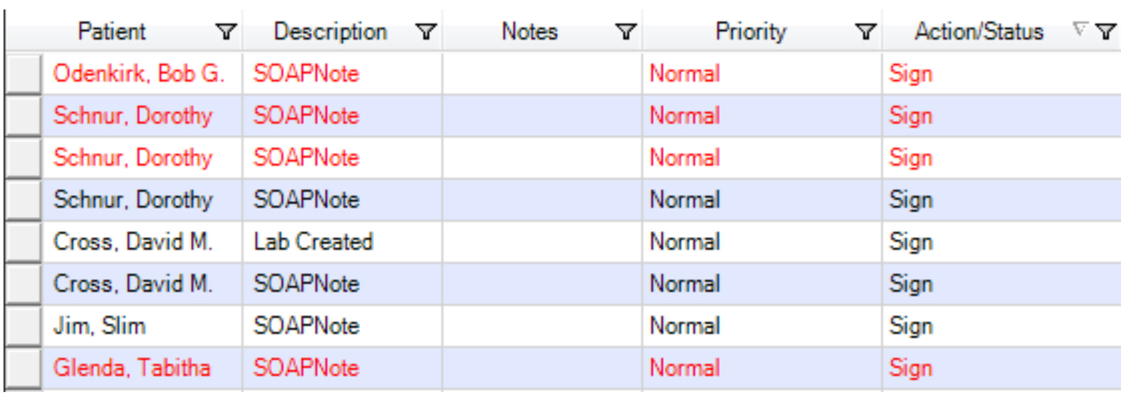
Included in this History are the Users that have accessed the task, the Computers from which the task has been accessed, the When (i.e. Date/Time) of accesses, the Type of accesses, and a Comment.

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
Odenkirk, Bob G.	SOAPNote		Normal	Sign
Schnur, Dorothy	SOAPNote		Normal	Sign
Schnur, Dorothy	SOAPNote		Normal	Sign
Schnur, Dorothy	SOAPNote		Normal	Sign
Cross, David M.	Lab Created		Normal	Sign
Cross, David M.	SOAPNote		Normal	Sign
Jim, Slim	SOAPNote		Normal	Sign
Glenda, Tabitha	SOAPNote		Normal	Sign

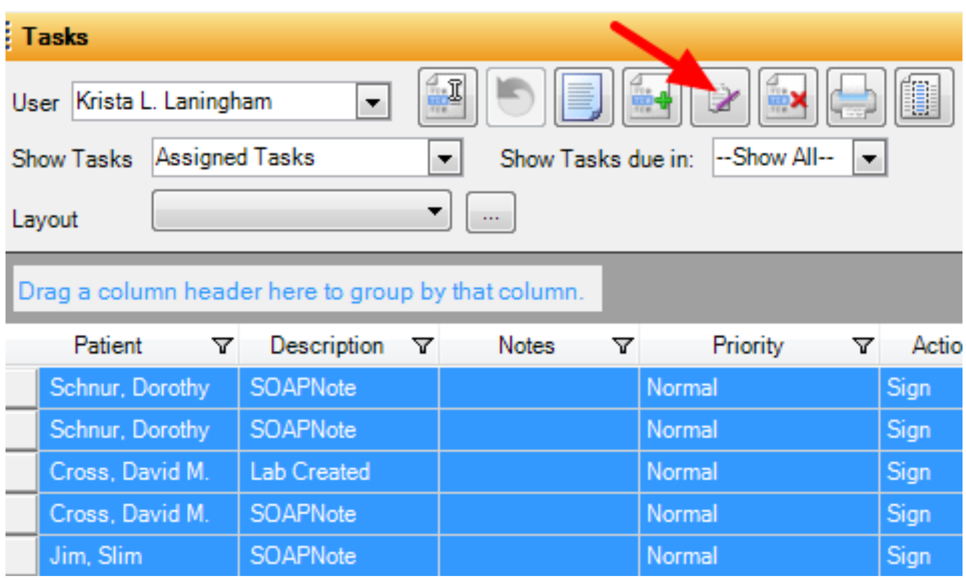
Establish work flows so that any documents that need to be signed in bulk have a common characteristic in one of the Tasks Manager columns. For example, it could simply be to select Sign as the option in the Action/Status column. Then, Clicking on the Action/Status header will group all the documents that need to be signed.

Group Items

Patient	Description	Notes	Priority	Action/Status
Schnur, Dorothy	SOAPNote		Normal	Sign
Schnur, Dorothy	SOAPNote		Normal	Sign
Cross, David M.	Lab Created		Normal	Sign
Cross, David M.	SOAPNote		Normal	Sign
Jim, Slim	SOAPNote		Normal	Sign
Glenda, Tabitha	SOAPNote		Normal	Sign
Odenkirk, Bob G.	SOAPNote		Normal	Sign
Schnur, Dorothy	SOAPNote		Normal	Sign

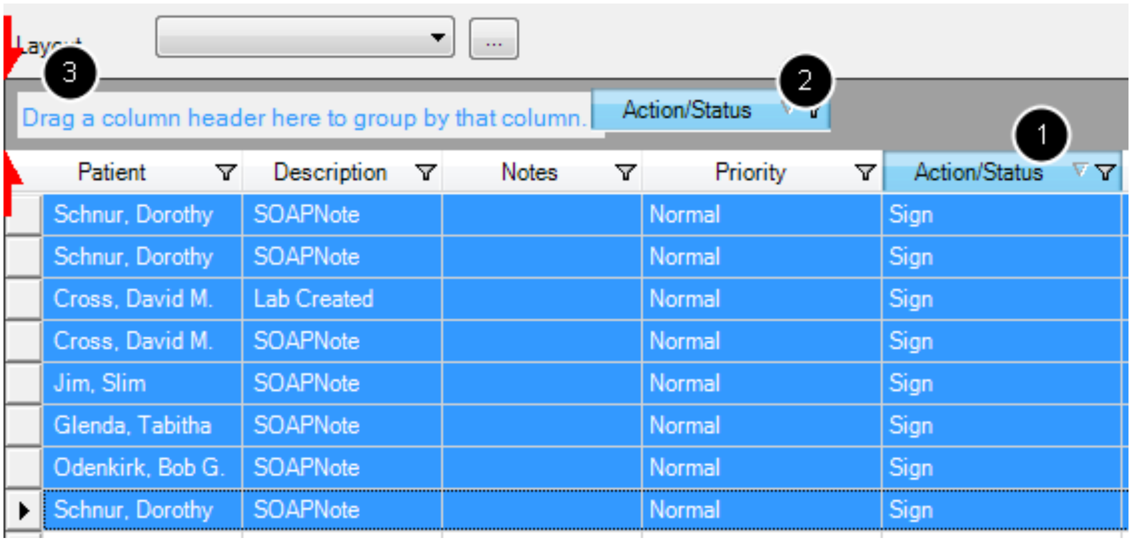
Once the items that need to be signed-off as a group are clustered together, the next step is to select all of them. To do this, Click in the gray box at the far left of the first row. Next, hold down the shift key and Click in the gray box at the far left on the last item in the group. Doing this selects all the items between the two clicks (while holding down the shift key).

Sign



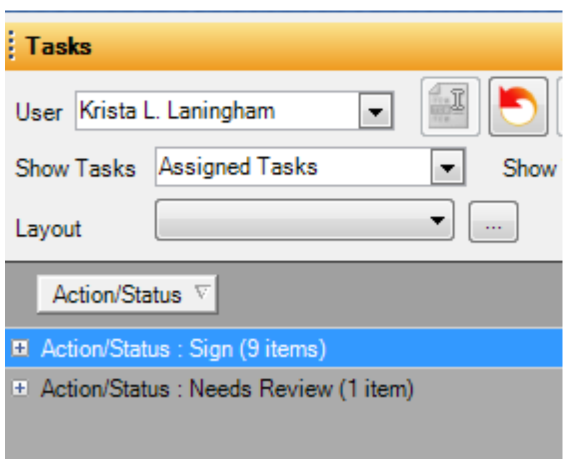
Once all the items to sign-off are selected, then Click on the Sign-off button. This results in all of the selected documents being signed off in one action.

Group by Column



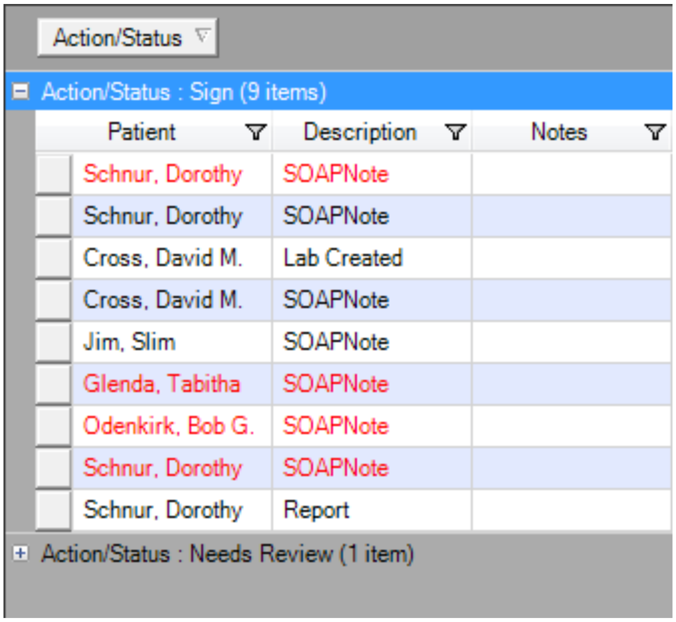
Simply drag the Action/Status Column up to the location of "Drag a colum header here to group that by column" and the items are instantly grouped for selection and sign-off.

Task Sorted by Type



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



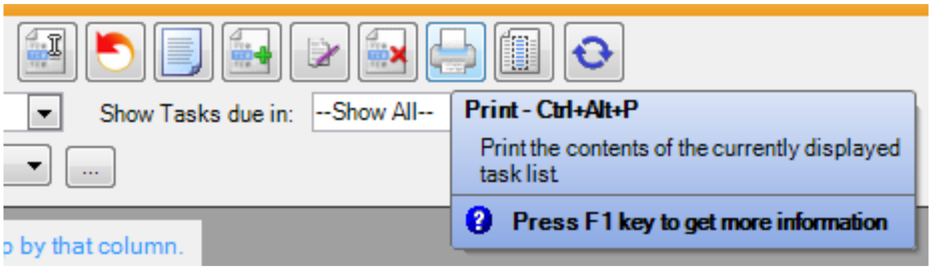
To see all of the items of one type (i.e. Sign), Click the expander node next to the Type and a list of the items of that group will drop down into view.

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.

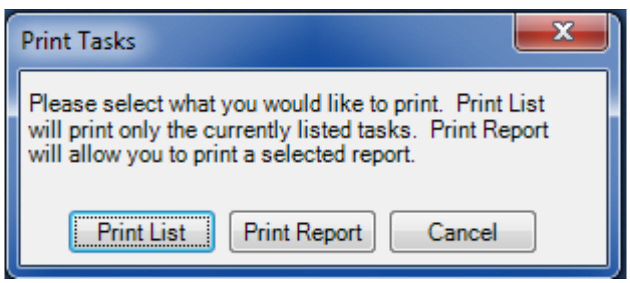
Printing Task Manager Lists

Click the Print Button



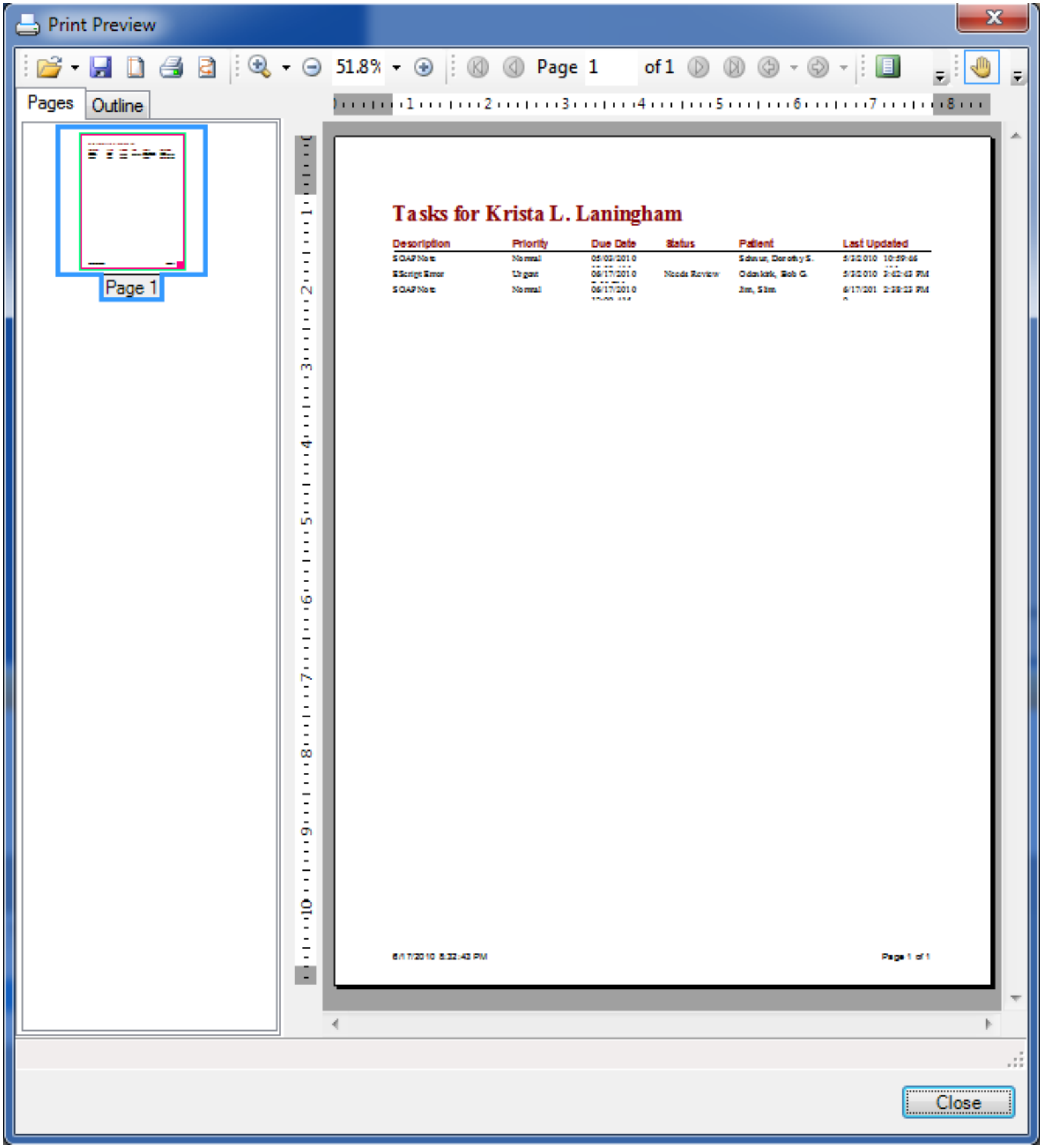
At any time, Click the Print button (or Press CTRL + Alt + P) to print a task manager list that is displayed.

Choose List or Report



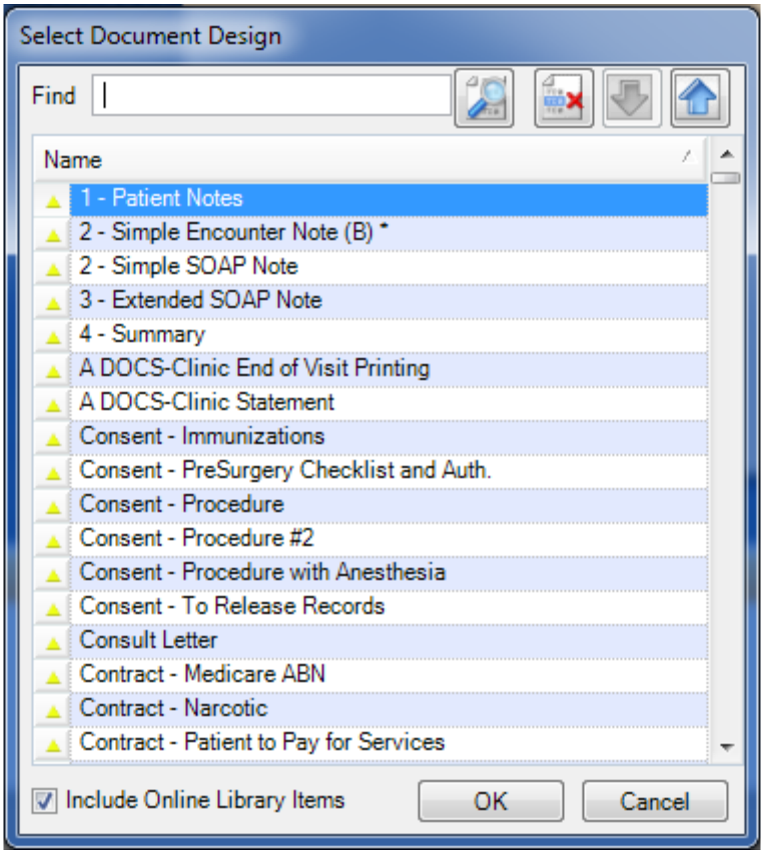
Click either the Print List or the Print Report buttons in the Print Tasks dialog.

Print List



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

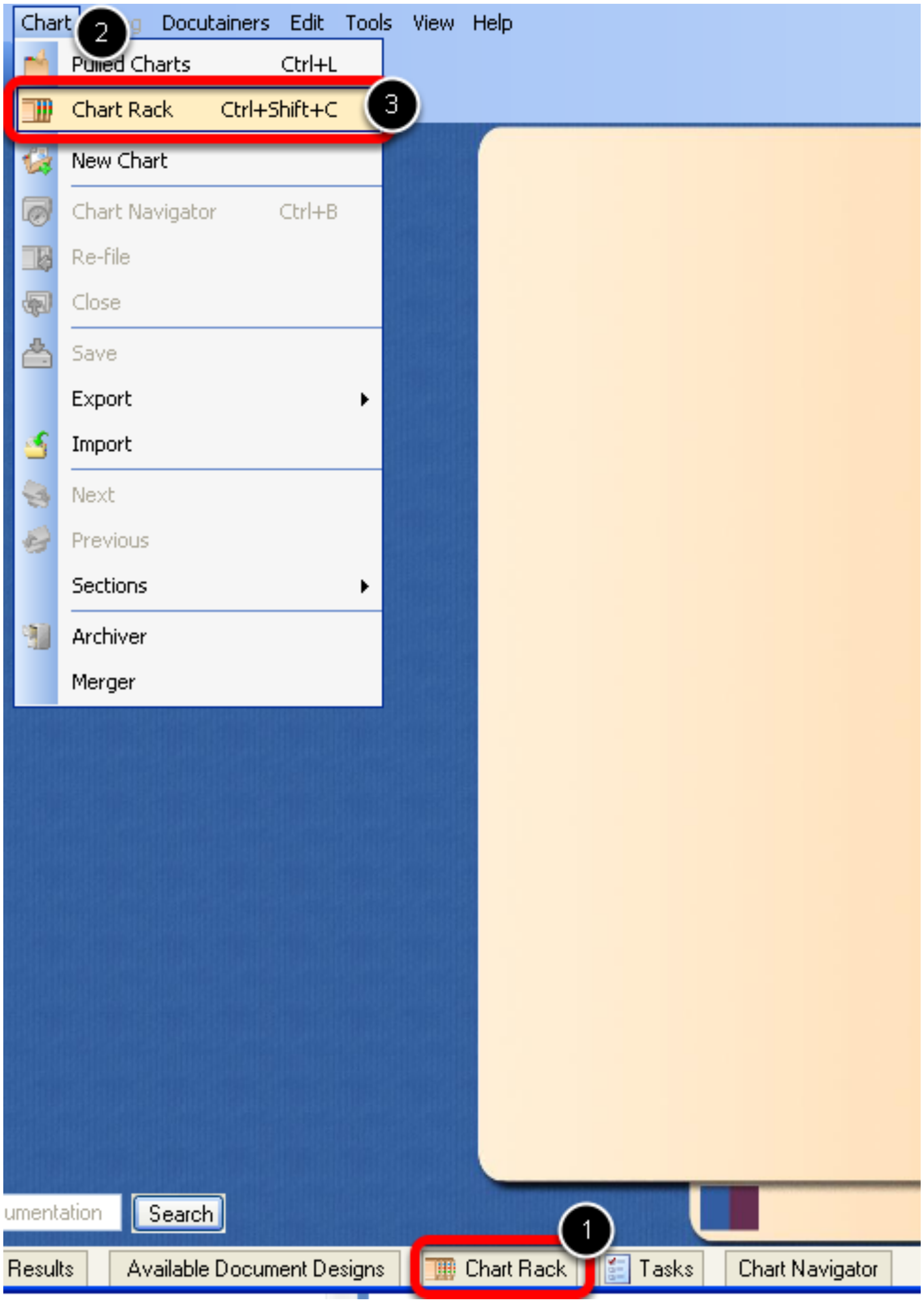


Print Report will prompt the user to choose a design to print with the task list information.

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.

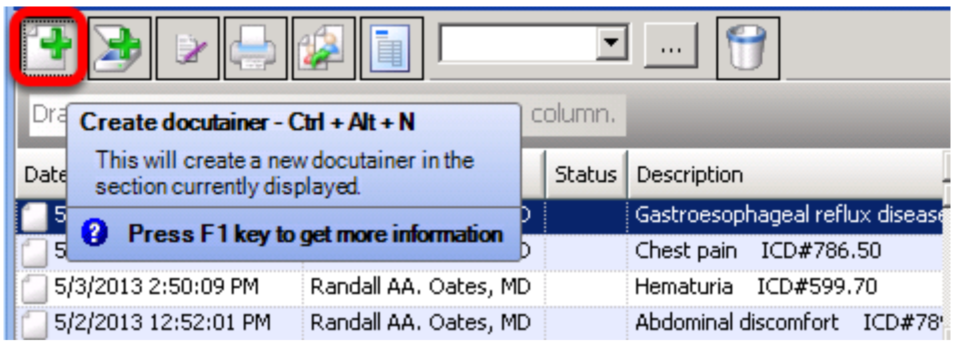
Phone Call Received from Patient



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:

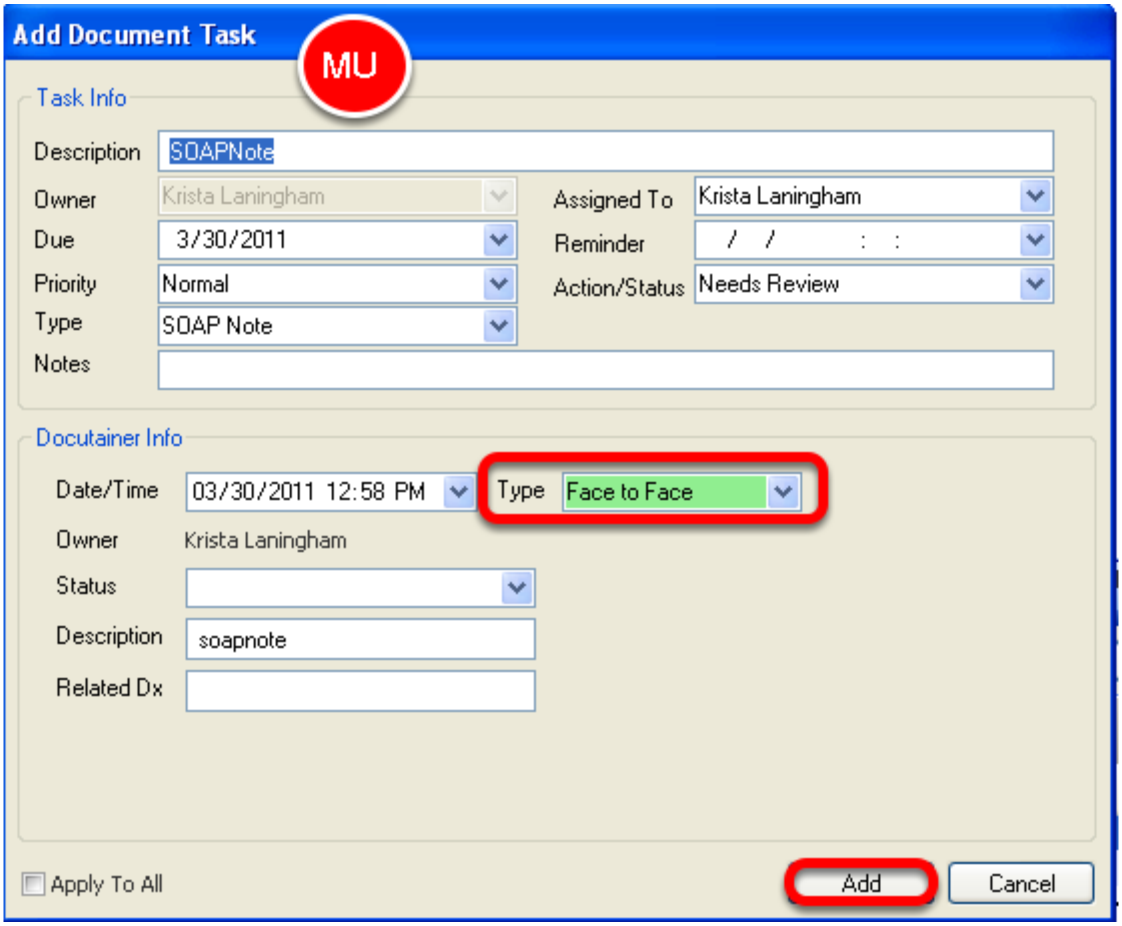
1. Click on the Chart Rack docked tab.
2. Or, Chart menu item > Chart Rack.
3. Or, Use the keyboard command Control + Shift + C.

Create a New SOAPnote Docutainer



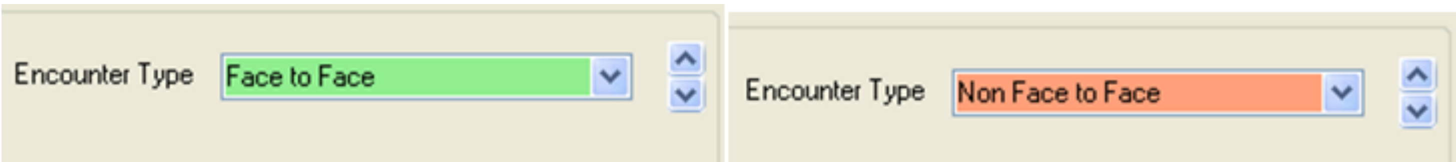
Creating a new docutainer will allow the user to document the phone call to make this patient interaction part of the permanent medical record.

Add Document Task



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".

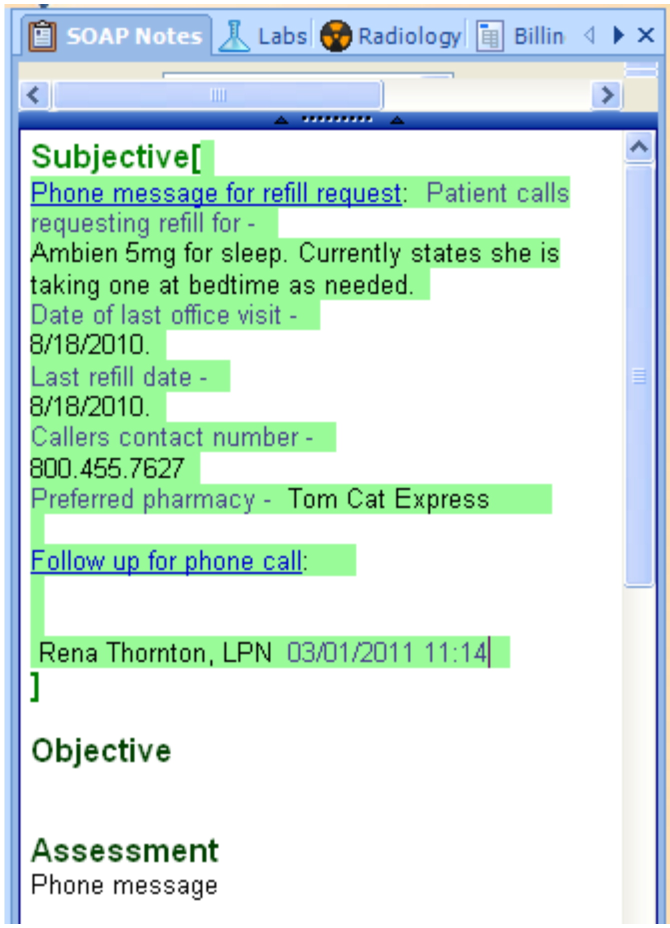
Encounter Types



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.

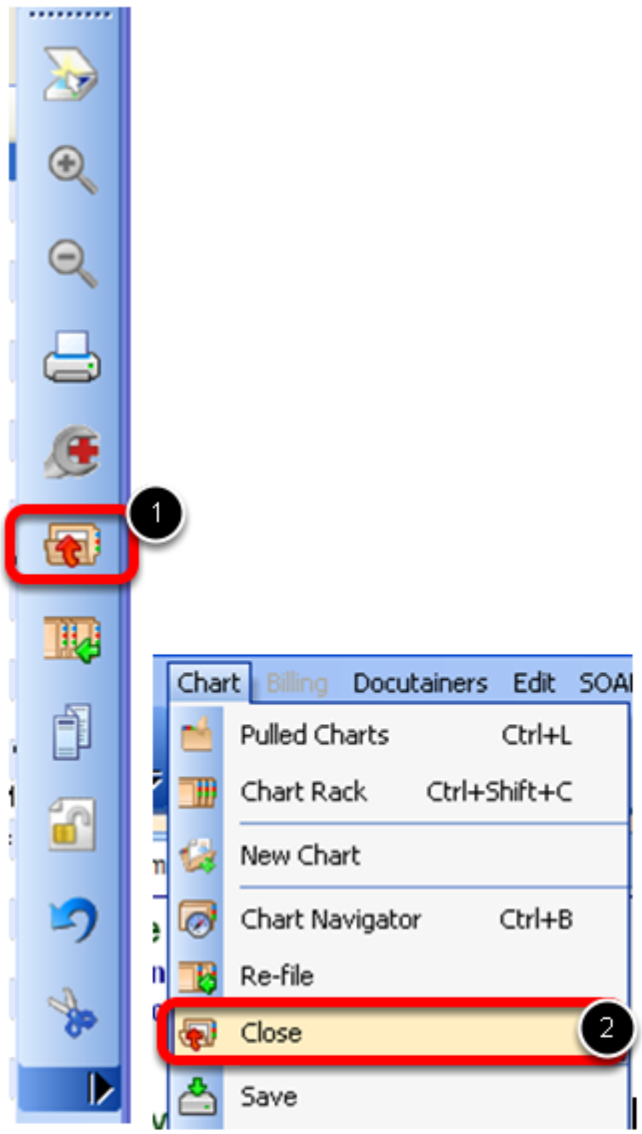
Click here for more information regarding Encounter Types.

Document Phone Call in SOAPnote



The phone call has been documented into the current SOAPnote which will be part of the patient's permanent record.

Close Chart

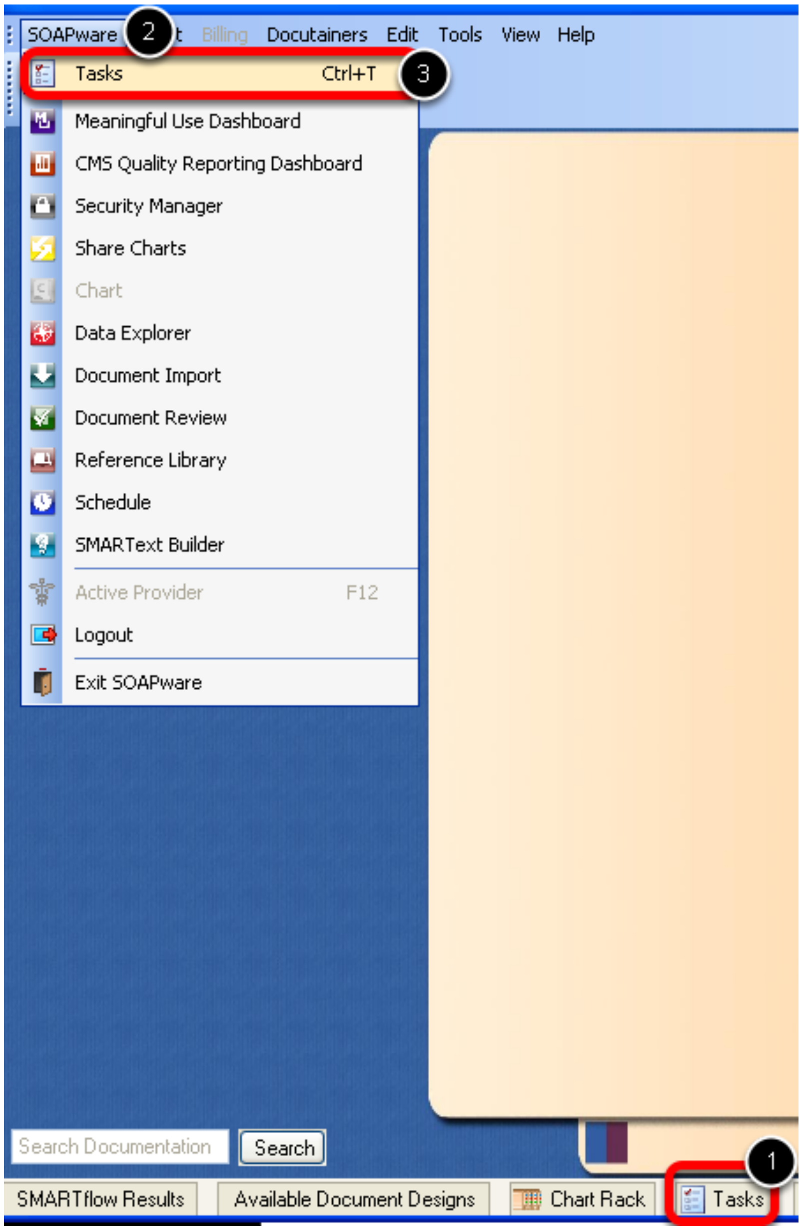


The user should close the patient chart once documentation has been completed with the patient's refill request information. Closing the electronic patient chart has the same benefits as closing the paper chart of a patient. Apatient's paper chart should not be left open on a desk and it should not be 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

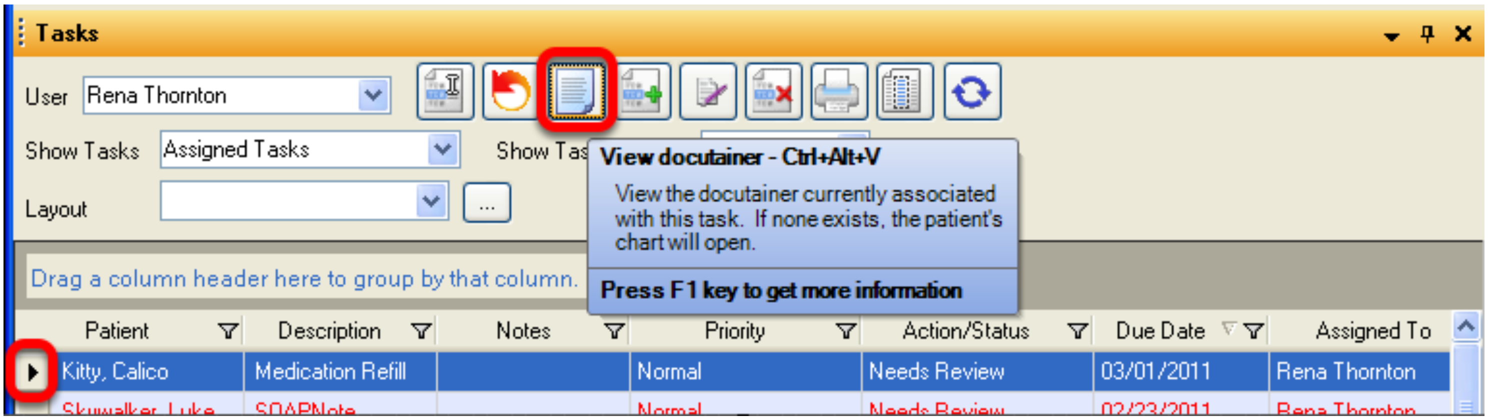


The provider will access their Task List to review any pending Task Items.

To access Task Manager:

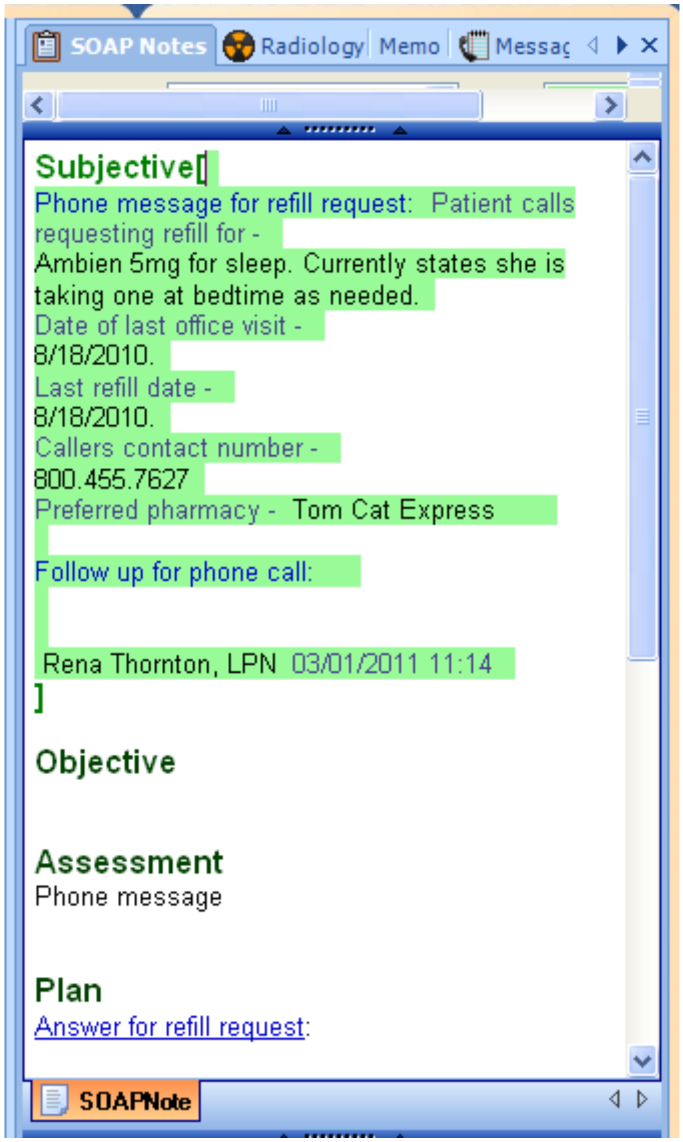
1. Click on the Tasks docked tab.
2. SOAPware menu item > Tasks.
3. Use the keyboard command Control + T.

Review Task Items



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

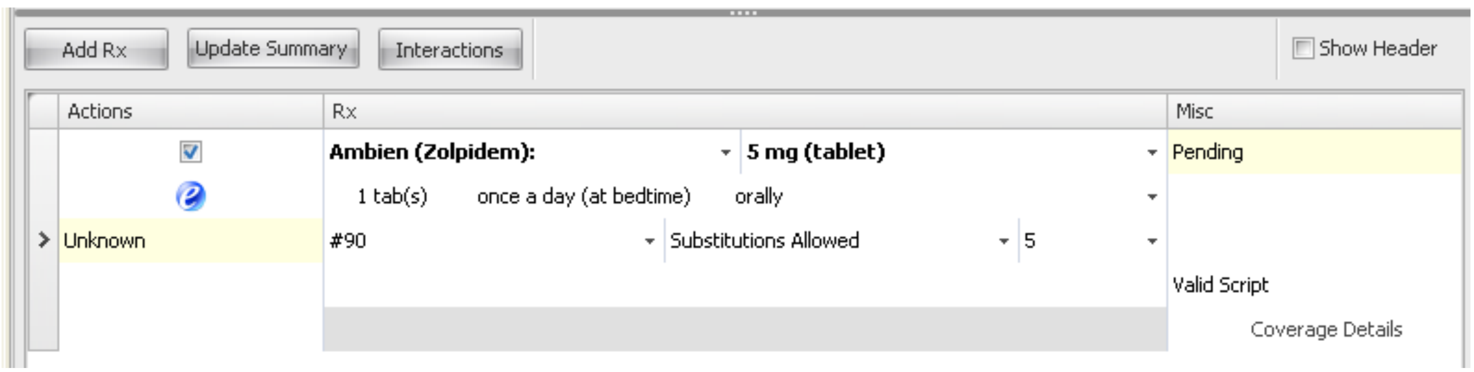


The provider will review the documentation on the current SOAPnote that is associated with the Task Item and enter the instructions, approval for the refill request, place the medication into the Medication field of the SOAPnote, need for office visit, etc. into the SOAPnote and reassign Task Item back 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

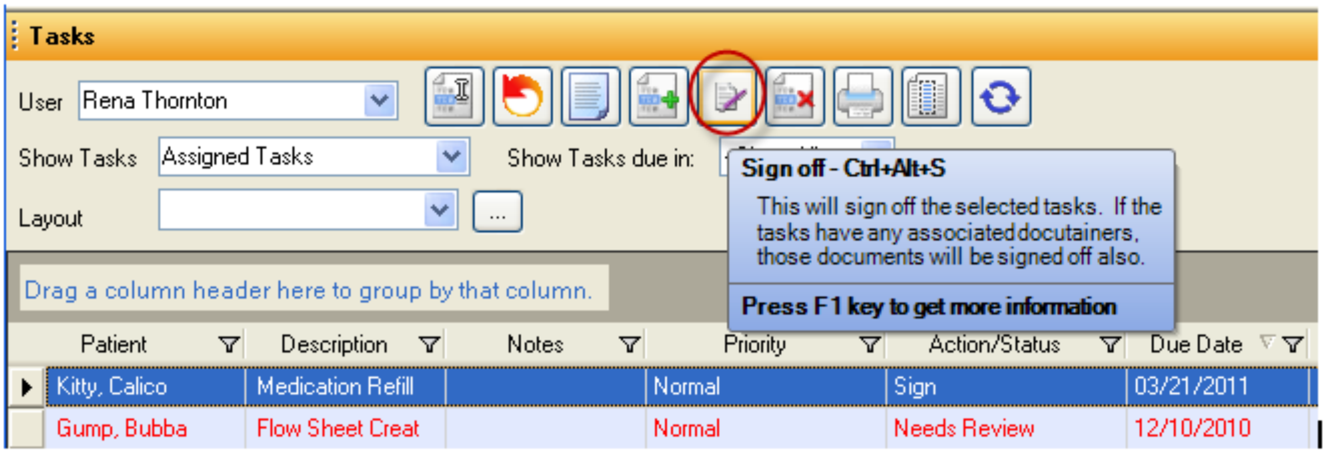


The nurse or other user will use Rx Manager to transmit the refill request medication for the patient. This will allow the user to ePrescribe, print, fax, or note that samples have been given to the patient.

SOAPnote Documentation

The nurse or other user will complete their documentation in the current SOAPnote. The user will reassigned 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



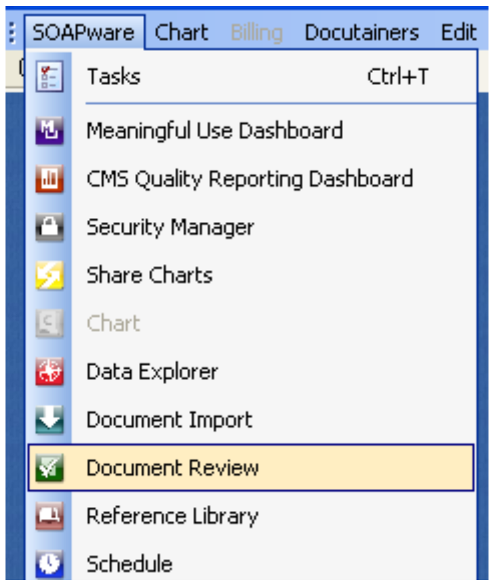
The provider will sign off the Task Item which will remove it from the Tasks List. Aprovider has the ability to sign off multiple items at once in Tasks Manager. See Sign Off Multiple Documents, Multiple Patients

***Note:** Manually created Task Items cannot be signed off. They can only be marked as "Completed". See Manually Created Tasks

Document Review Workspace

Document Review is a workspace in SOAPware where users can review tasks and documents associated those tasks without opening each patient chart.

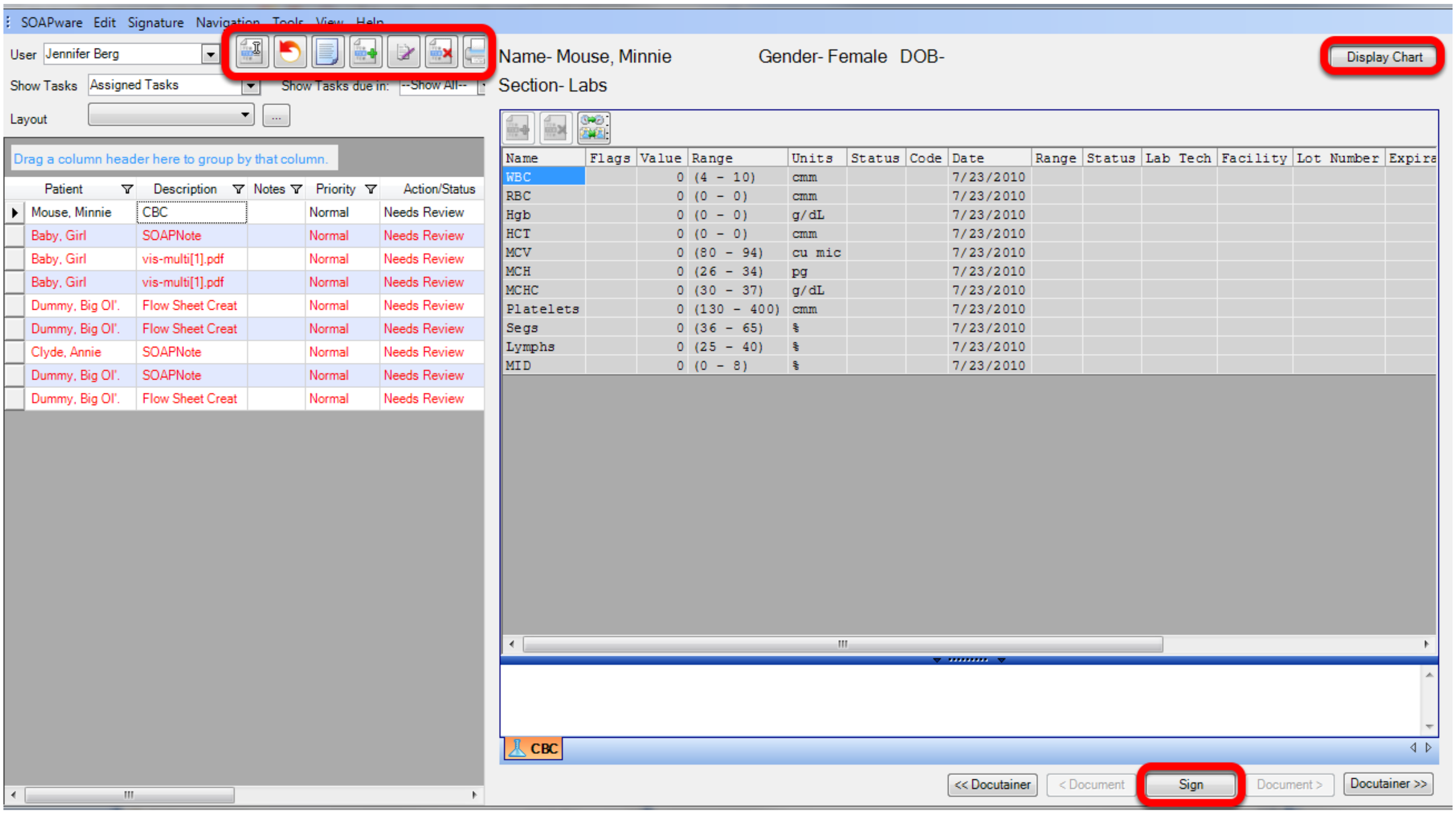
Document Review Workspace:



To open the Document Review Workspace, Click SOAPware and select Document Review.

This will close the Chart workspace and open Document Review.

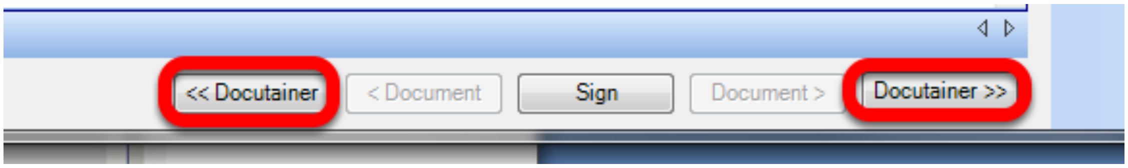
Interface



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.

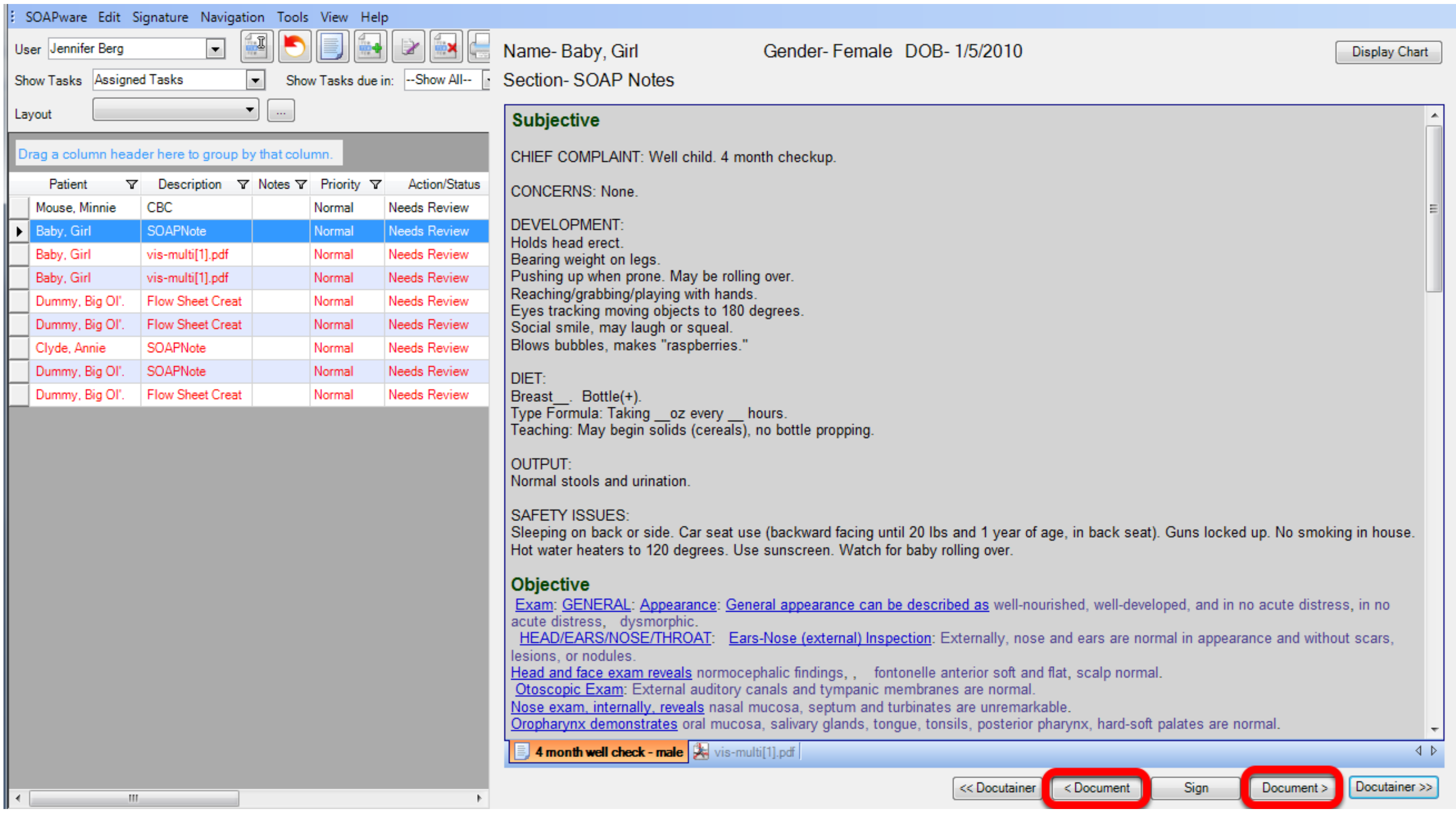
On the right side of the screen, the document associated to the task selected displays. Items can be signed off from this section by clicking on the Sign button at the bottom of the screen. Documents associated with tasks can be displayed for review but cannot be edited from this workspace. To edit the 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.

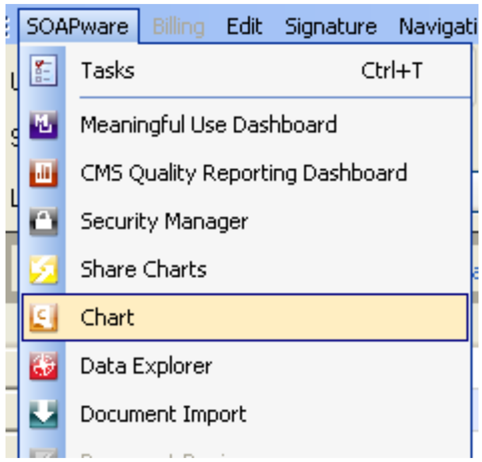
Display



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



Click on SOAPware and Select Chart.

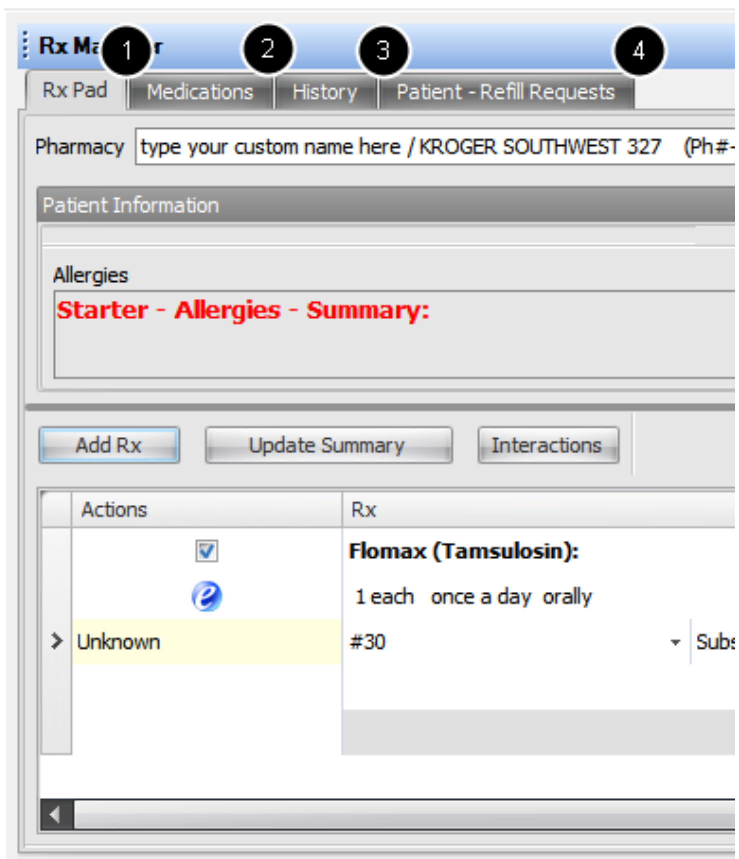
E-Prescribing

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 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** - Asequential, 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.

Ohio Based ePrescribing Entities

Click on each of the following links for more information regarding Ohio Prescribing requirements:

- **Setting Up SOAPware for the Ohio Prescribing Requirements**
- **Printing and Faxing Ohio Prescriptions**
- **Prescriber Authentication Report**
- **Report Reminder System**

Rx Manager - Rx Pad

***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.

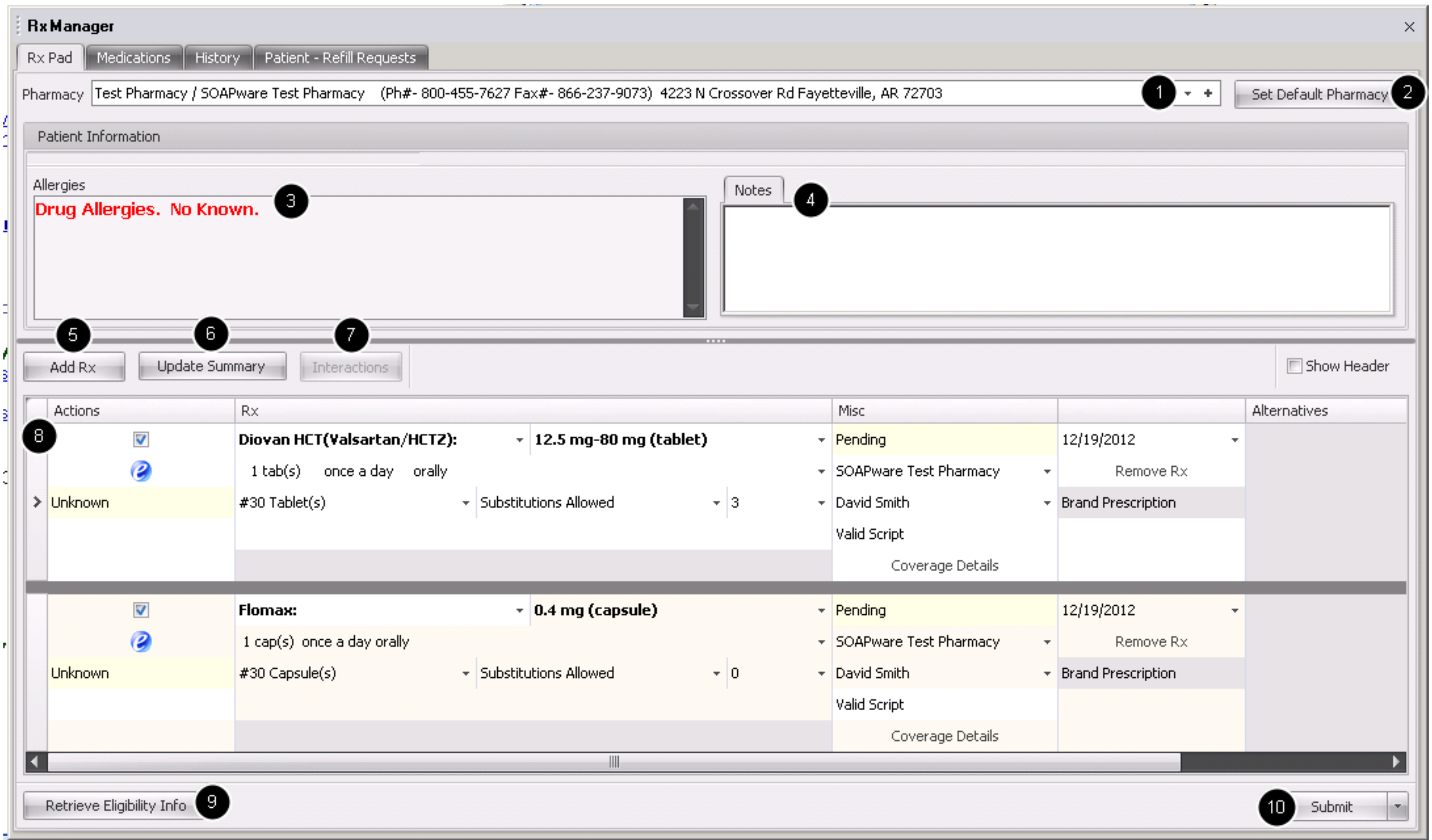
Rx Manager

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.

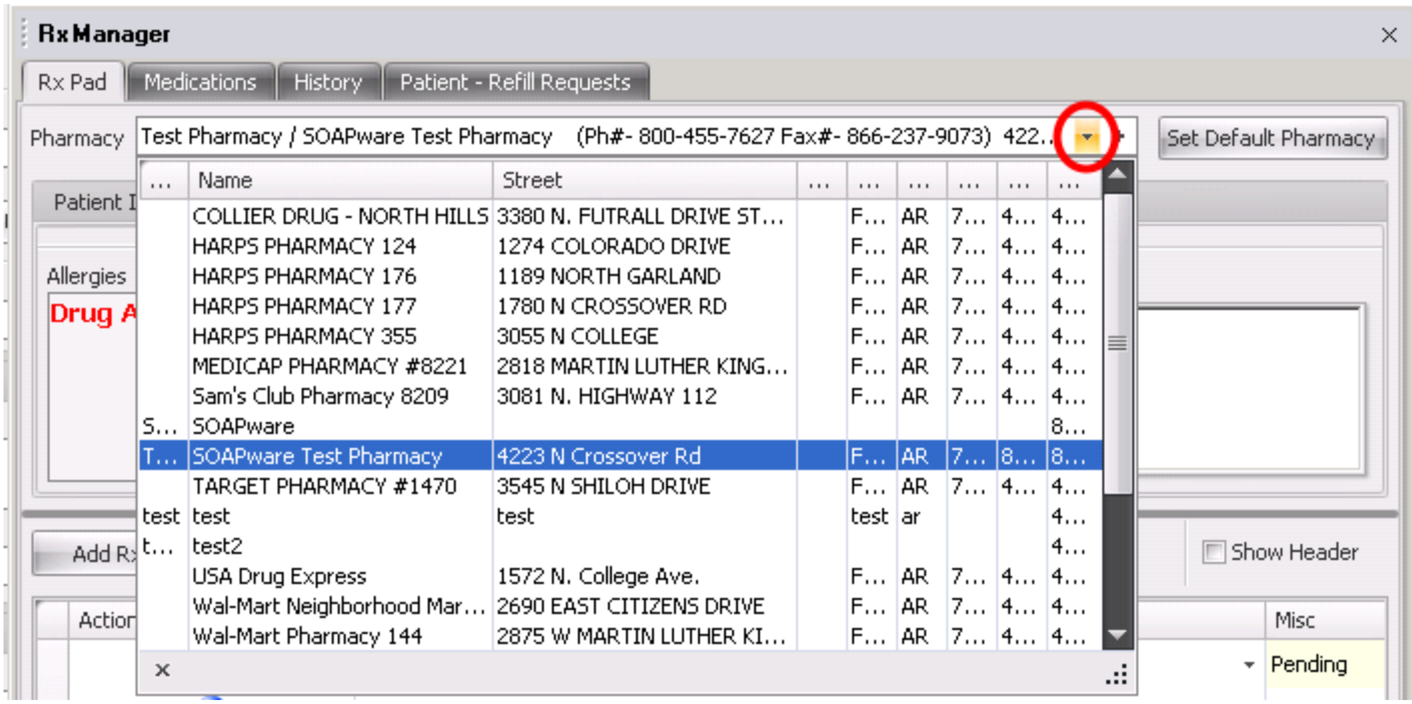
Rx Manager now allows new prescriptions to be created from within the manager itself. In other words, any/all prescriptions can be created just within the Rx manager which subsequently updates the encounter note.

Rx Pad Overview



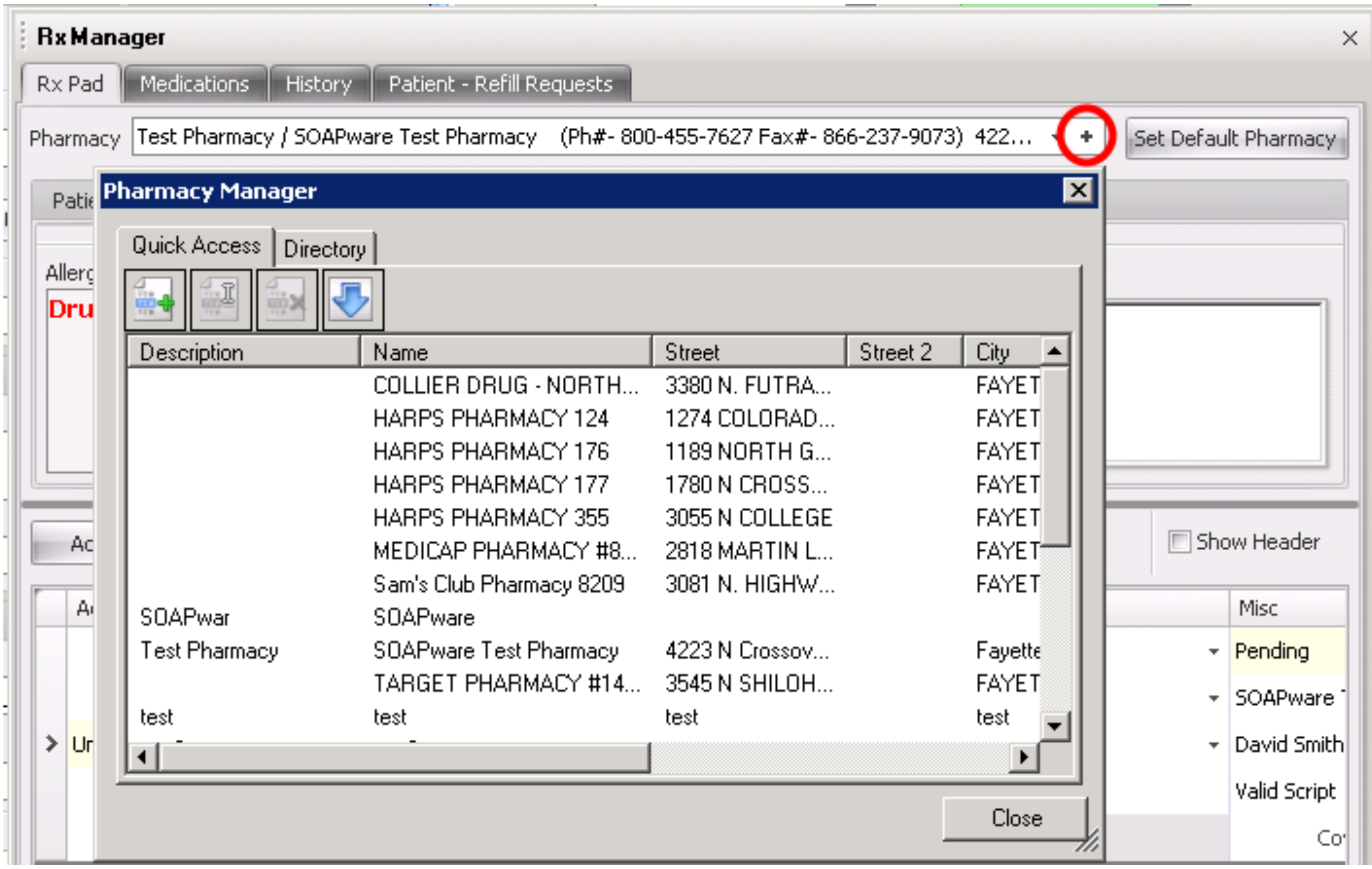
1. Pharmacy Selection
2. Set Default/Preferred Pharmacy for the Patient
3. Allergies
4. Eligibility Information
5. Add Rx
6. Update Summary
7. Interactions Summary
8. Prescription(s)
9. Retrieve Eligibility Information
10. Submit Rx

Change Pharmacy Selection



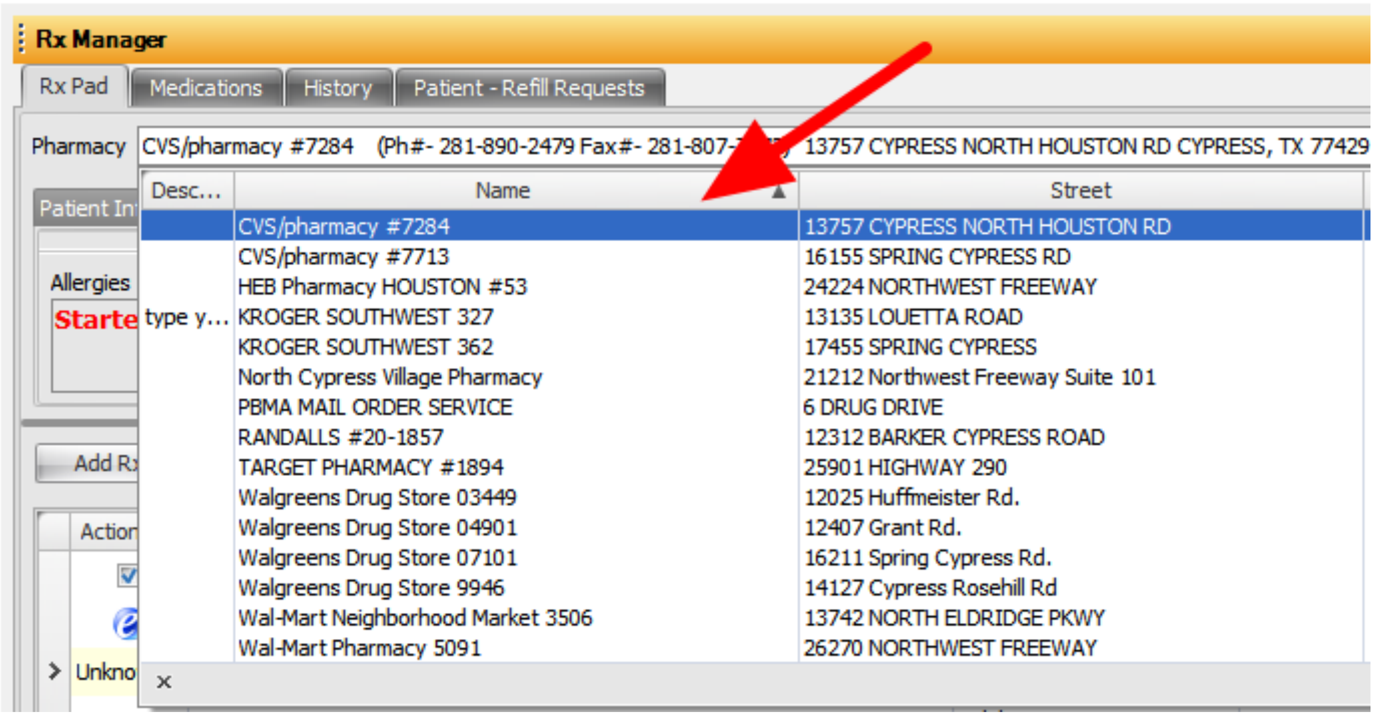
To change the pharmacy while within Rx Pad, click the drop-down menu (i.e. at the right in the Pharmacy field), and choose a pharmacy from the list.

Add Pharmacy Selection



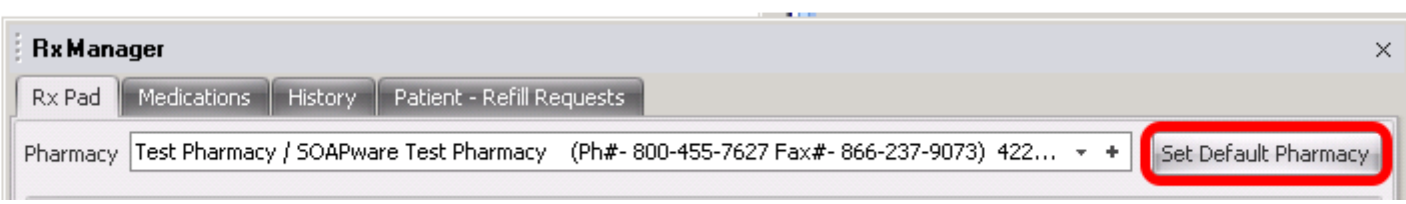
To add a new pharmacy to the local, Quick Access pharmacy list, click the Add button (i.e. plus sign at the far right) and then follow the steps in the following link to add a new pharmacy: **Adding Pharmacies**.

Sort Pharmacies



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.).

Preferred/Default Pharmacy Selection

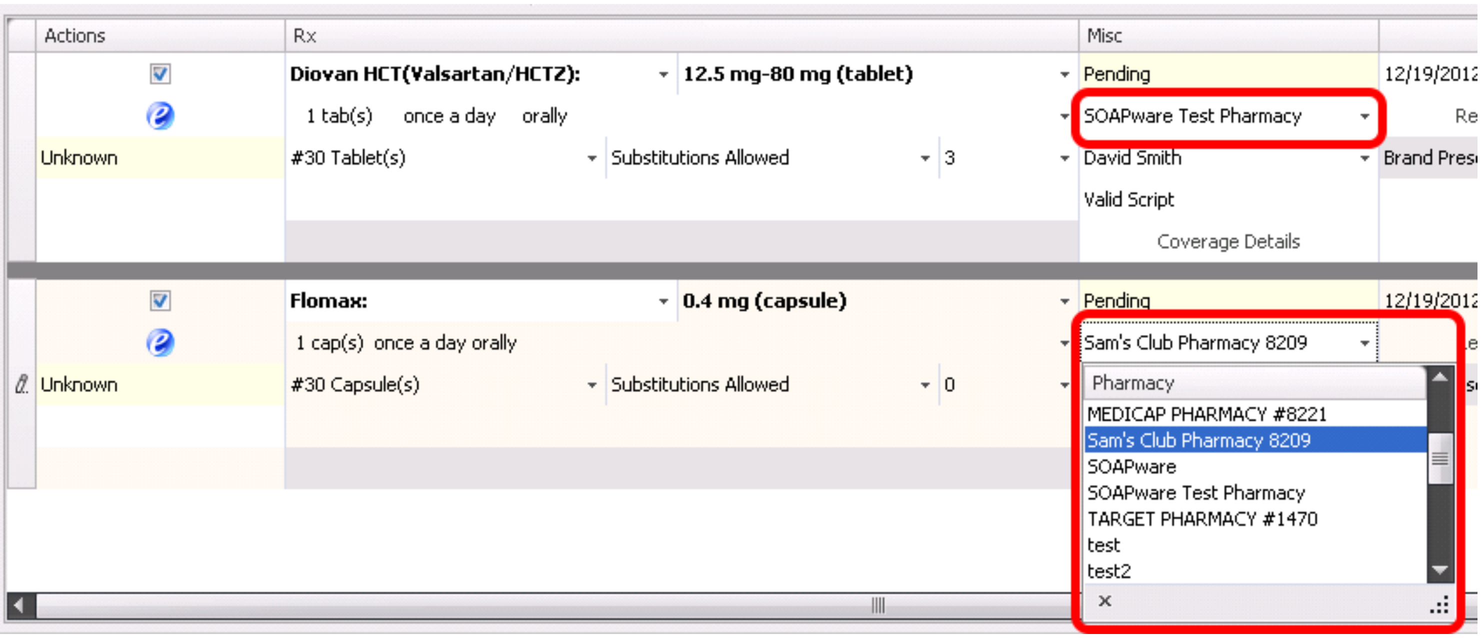


The patient's preferred/default pharmacy can be set in two areas.

In the patient's Demographics chart section, the patient's preferred pharmacy can be selectd by using the drop-down menu. The pharmacy that is selected as the patient's preferred pharmacy 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.

In addition, the patient's preferred/defult pharmacy can also be set directly from the Rx Manager. After selecting the preferred/default pharmacy by using the drop-down menu, click the Set Default Pharmacy button to save the selected pharmacy as the patient's preferred pharmacy. This will overwrite the preferred pharmacy within the patient's Demographics chart section.

Pharmacy Selection Based on Individual Medications (Available Only in 2012.0.5044+)

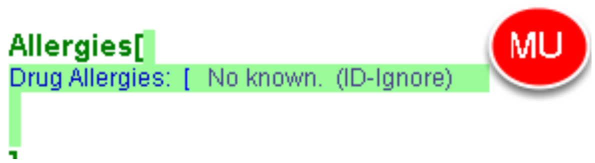


In SOAPware version 2012.0.5044+, users will have the ability to select and submit individual medications to separate pharmacies. **Note:** *This feature is not available in versions prior to 2012.0.5044.*

Within the Rx Manager, users can select a unique pharmacy for each individual medication that is listed within the Rx Pad by using the drop down menu. SOAPware will submit the medications to the unique pharmacy that has been selected for each medication once the Submit button has been clicked.

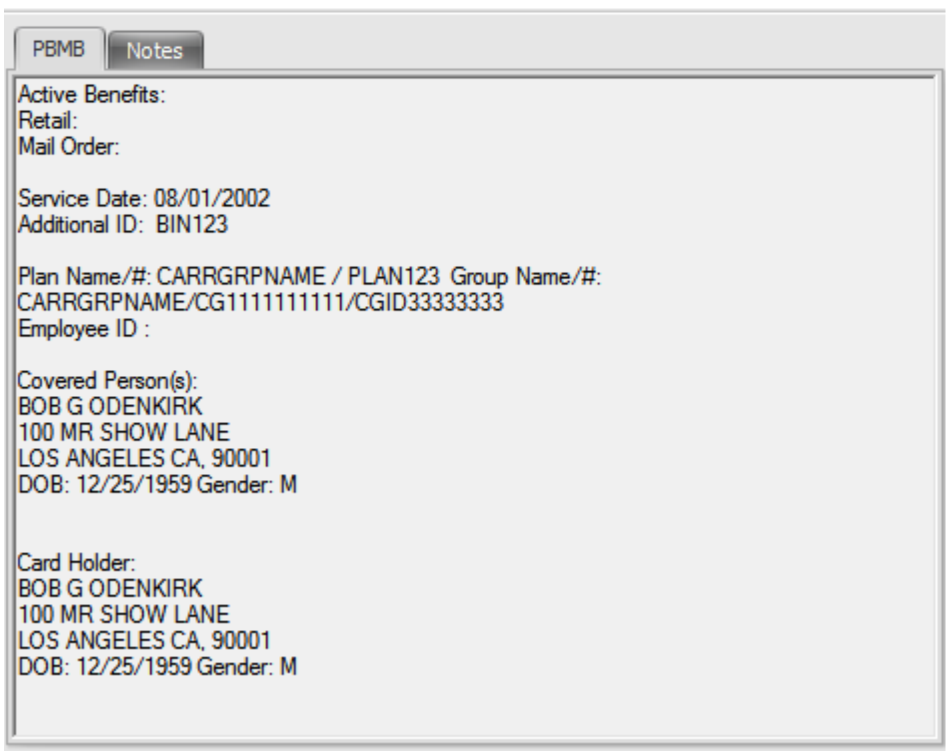
***Note:** If the user selects a new default pharmacy for the patients using the Pharmacy drop-down menu located at the top of the Rx Manager window, this will reset all medications to use the newly selected default pharmacy.

Allergies / Eligibility



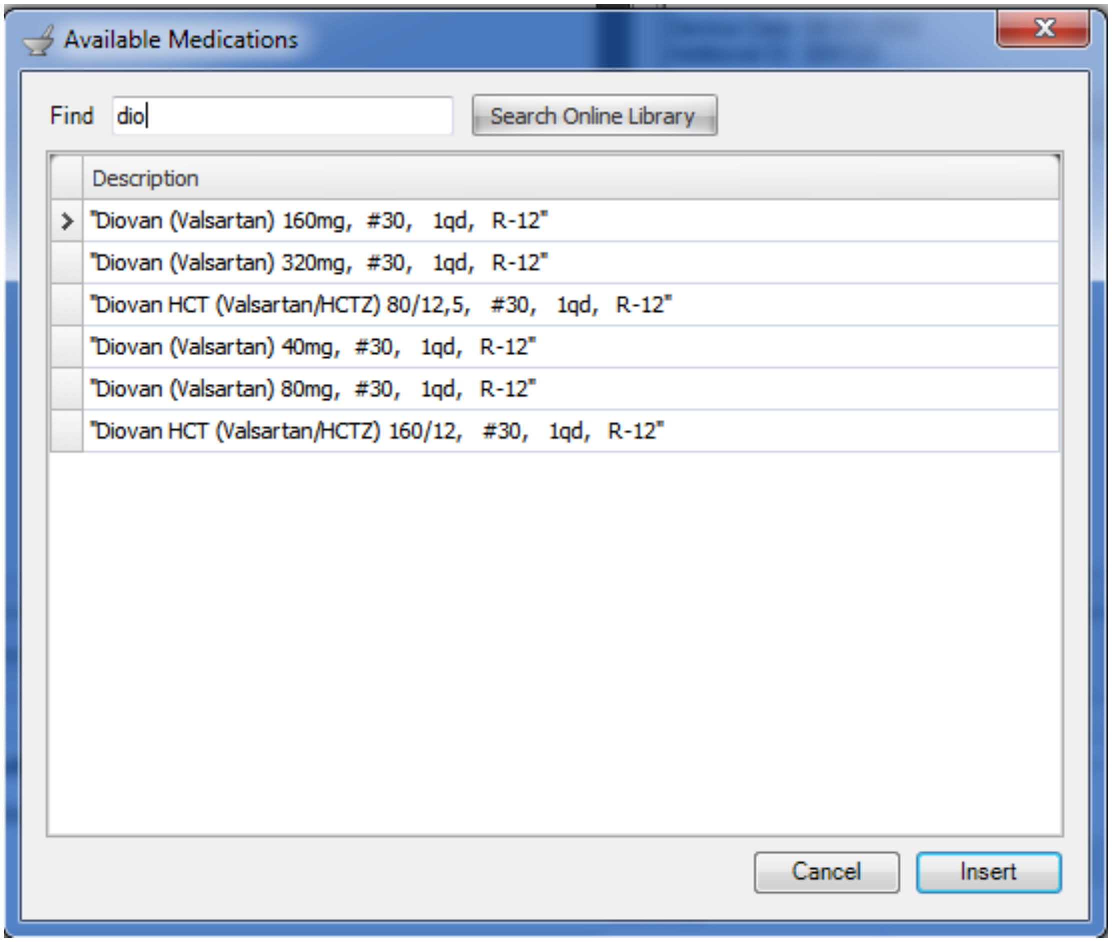
The Allergies field in Rx Pad displays a copy of the contents from the Summary Allergies field. If the patient has no allergies the SMARText Item "Drug Allergies: No Known) must be displayed to meet Meaningful Use criteria.

Eligibility



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 plan 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

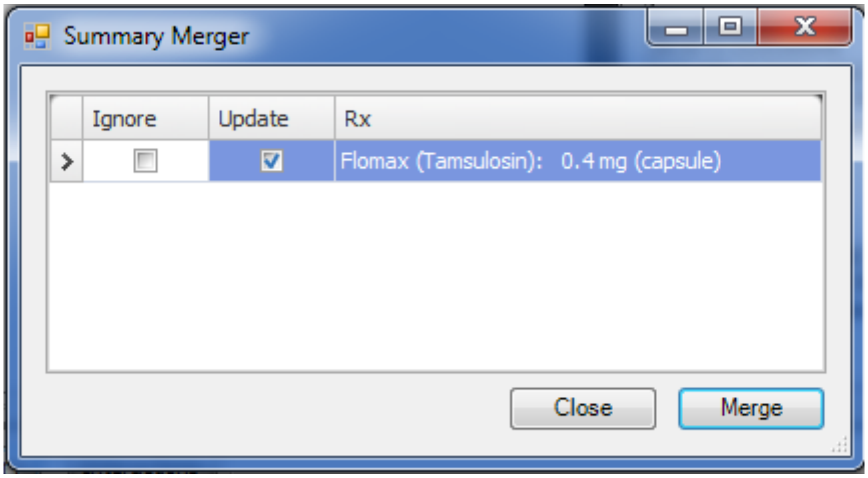


The Add Rx button displays an Available Medications dialog. Type in a drug name, and a list of matching prescriptions is automatically displayed. Double-clicking a prescription in the list adds it to the Medication list in Rx Pad.

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.

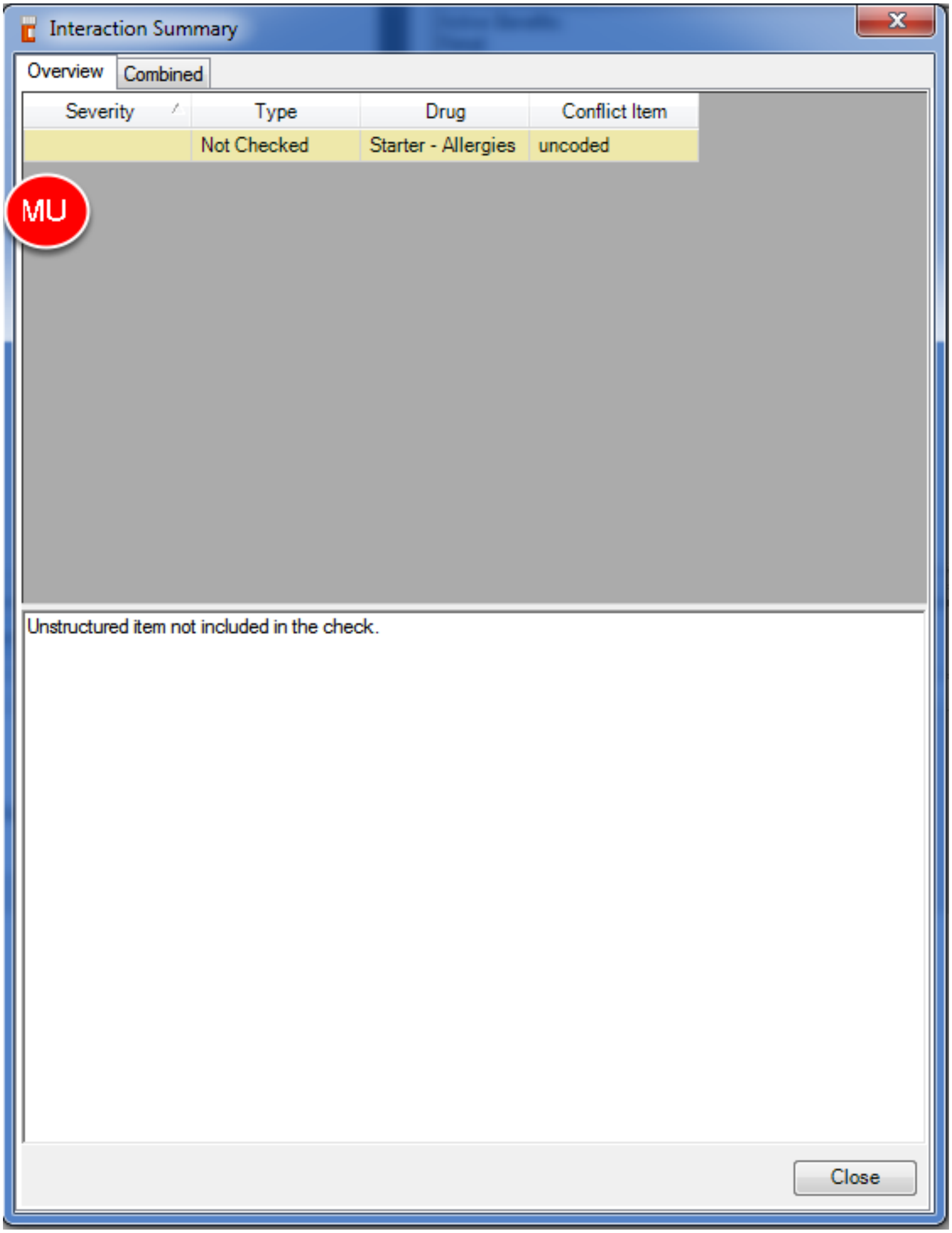
Alternatively, Click the prescription in the list once, then Click Insert. Only Structured Rx SMARText items that exist in the local library system will be displayed in this viewer. This list can contain a user's pre-defined, most commonly prescribed medications and his/her default values. Each user has their own list.

Update Summary Button



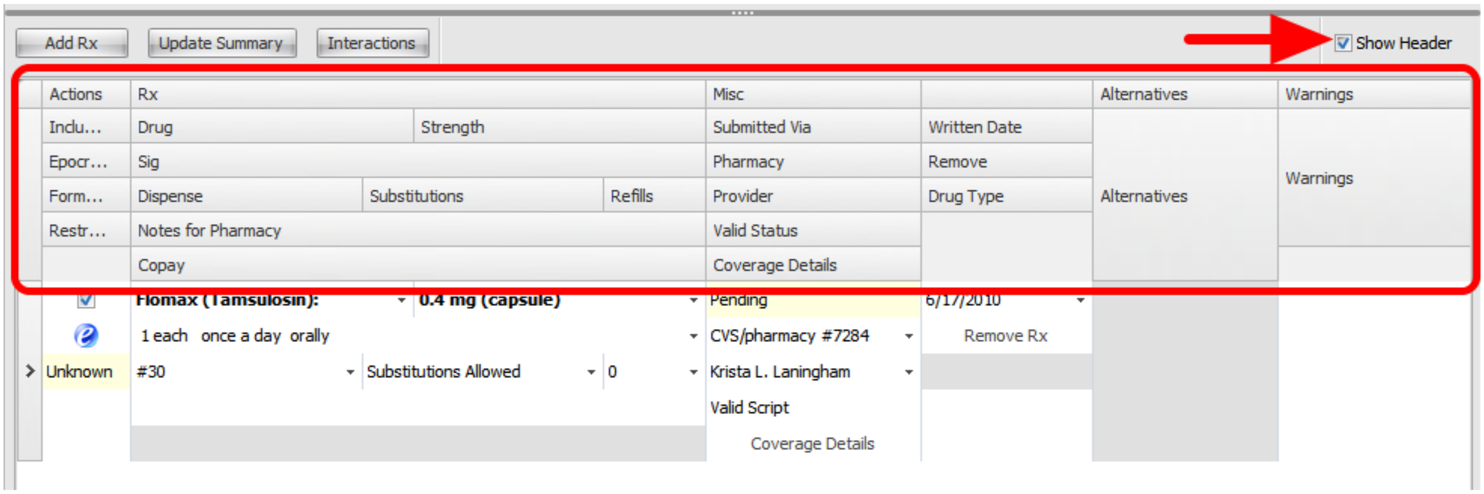
The Update Summary button displays a Summary Merger dialog. This dialog allows for the merging of prescriptions in the Medication List in Rx Pad to the Summary Medications field. That is, it allows the user to specify whether or not to update/add a particular prescription to the Summary Medications list of on-going or chronic medications.

Interactions Button



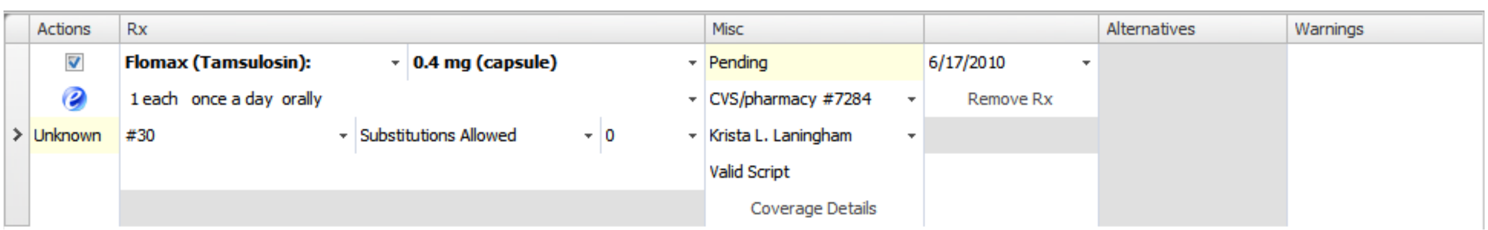
The Interactions button is grayed-out unless interactions are found. Clicking it displays the Interactions.

Show Header Checkbox



The 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.

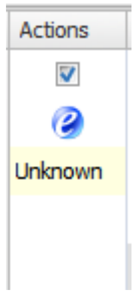
Medication List



The 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).

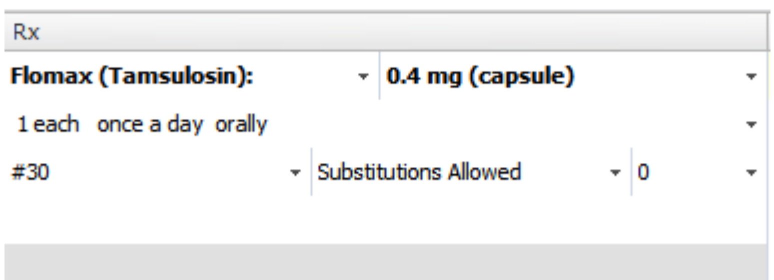
Clicking on the drug name drops-down a list of predefined Drug Courses for automatic Sig/data entry.

Actions Column



The 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

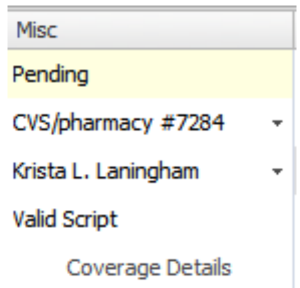


The Rx column displays multiple fields offering detailed information about the prescription.

* 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.

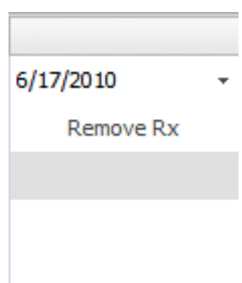
Misc Column



The Misc column displays status information such as:

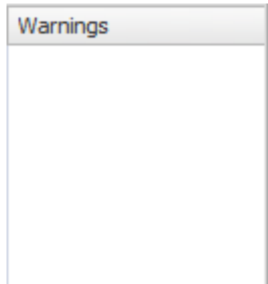
* Submitted Via - This will say pending until sent, then it will be replaced by e-Rx, faxed, written (printed), or samples.
* Pharmacy - the destination pharmacy name.
* Provider - the clinician responsible for the prescription.
* Valid Status - indicates whether the prescription can be sent electronically (this has nothing to do with faxing).

Remove Column



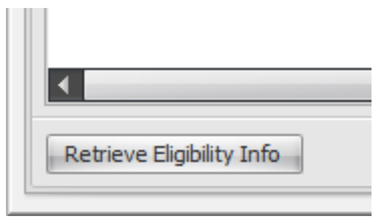
The last column on the right is the Remove column. It allows prescriptions to be removed from the Medications List. (and it subsequently removes it from the active SOAP encounter note if present there).

Warnings Column



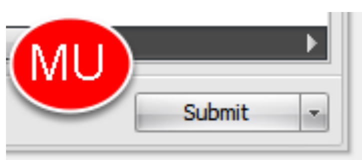
This column displays an alert when scheduled drugs are found.

Retrieve Eligibility Information



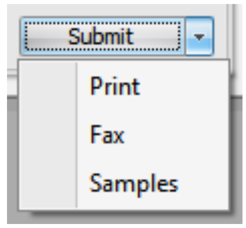
This button retrieves/updates the eligibility information for this patient. If no eligibility is displayed upon opening Rx Manager, use this button to update the eligibility information.

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

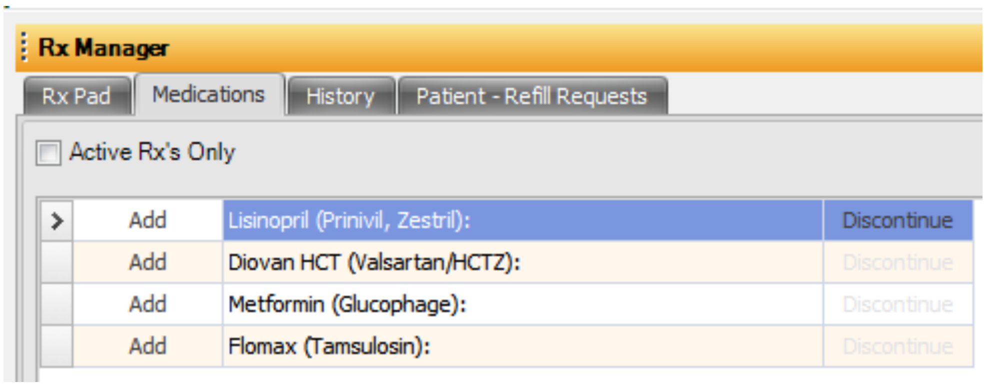


The user can also use the drop-down menu to the right of the Submit button to choose to send the prescription by printing, faxing, or by marking that the user gave samples.

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

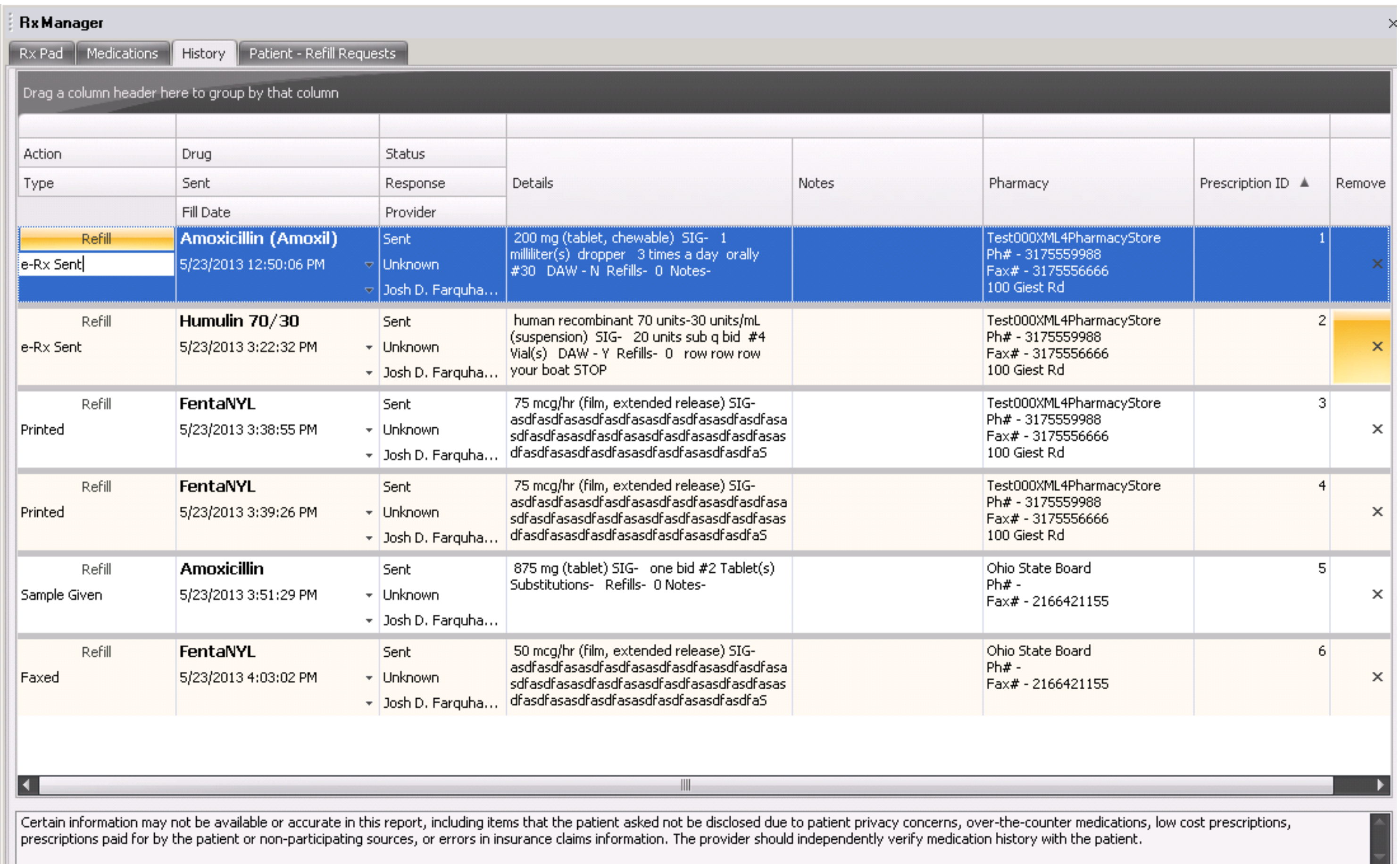


A user can also choose to view Active Rx's Only, as well as to discontinue a medication or add it to the Rx Pad.

Rx Manager - History Tab

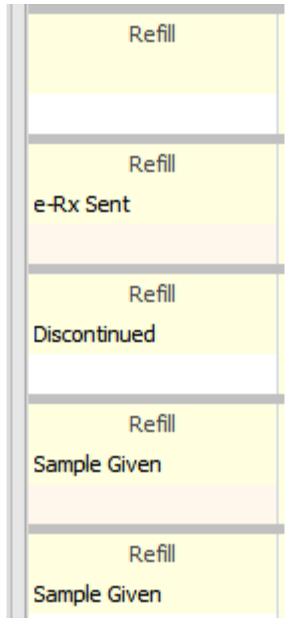
The area under the History tab displays a complete list of all prescribing actions-transactions (refills, add/remove, start/stop, print, fax edits etc.) performed in Rx Manager. It distinguishes refills from new prescriptions. It also lists whether prescriptions were sent electronically (i.e. eRx), printed, 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 Rx Pad. 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



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.

Rx Hub Medications



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.

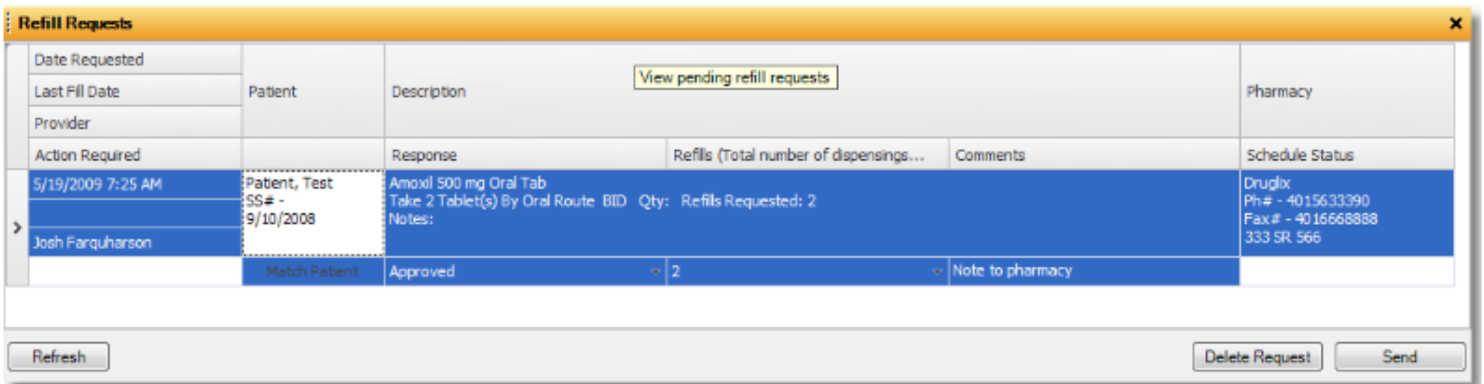
Important Tip

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



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.

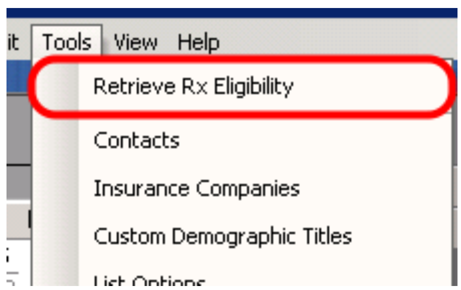
Checking Patient Rx Eligibility

This lesson will discuss checking the patient's prescription eligibilty/formulary.

There are two ways to process Rx eligibility for a patient:
1. Bulk Download of Rx Eligibility Information
2. Individual Patient Download

***REQUIRED FOR MEANINGFUL USE MENU SET OBJECTIVE: FORMULARY CHECKS:** Click here for Meaningful Use Criteria

1. Bulk Download of Rx Eligibility Information

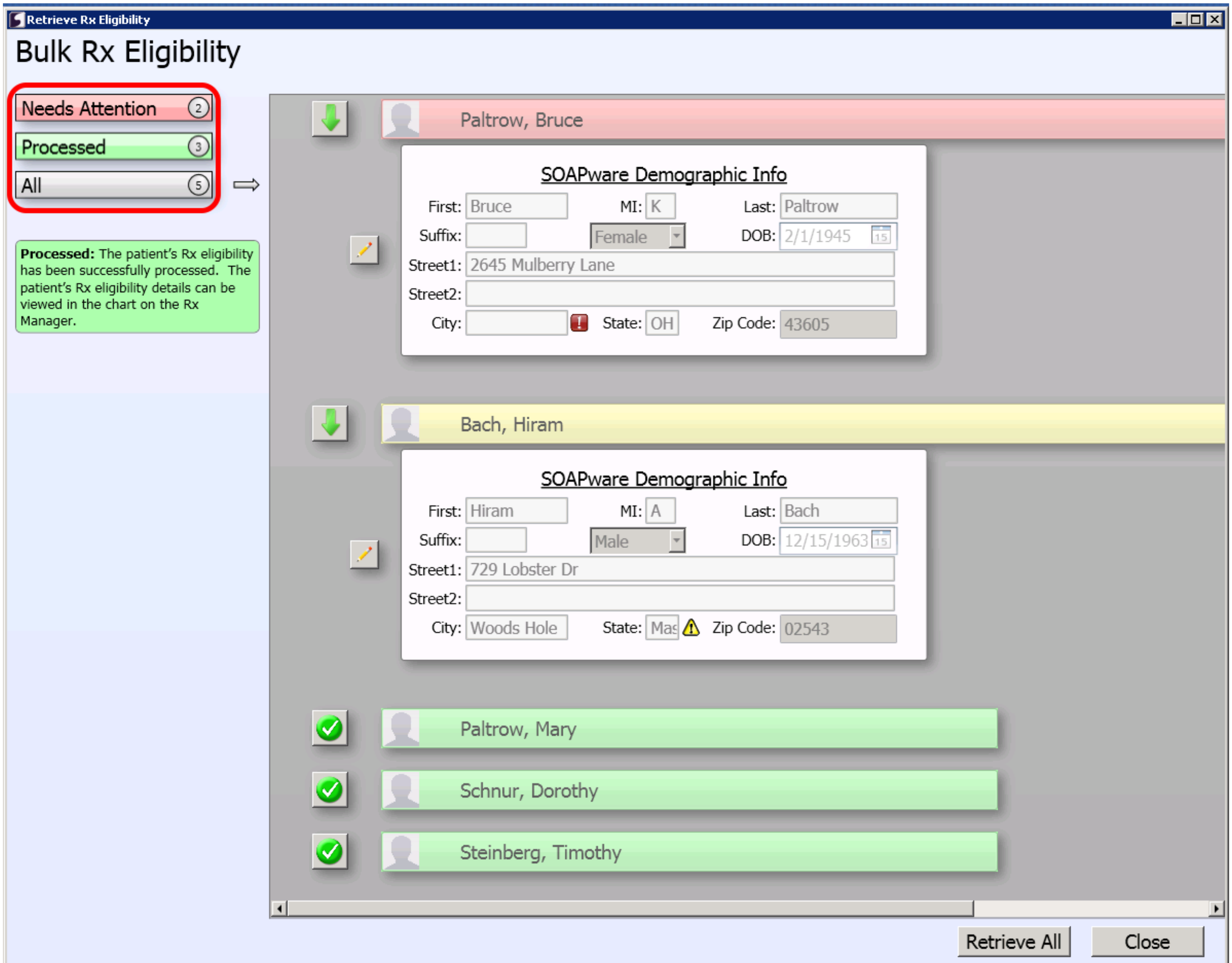


Rx eligibility can be retrieved in bulk through the Scheduler workspace. When the Bulk Rx Eligibility window is opened, SOAPware will begin processing Rx formulary eligibility for all patients listed on the schedule for the current date.

To process Rx eligibility from the Scheduler workspace click on the **Tools** menu and then select **Retrieve Rx Eligibility**.

Processing Eligibility

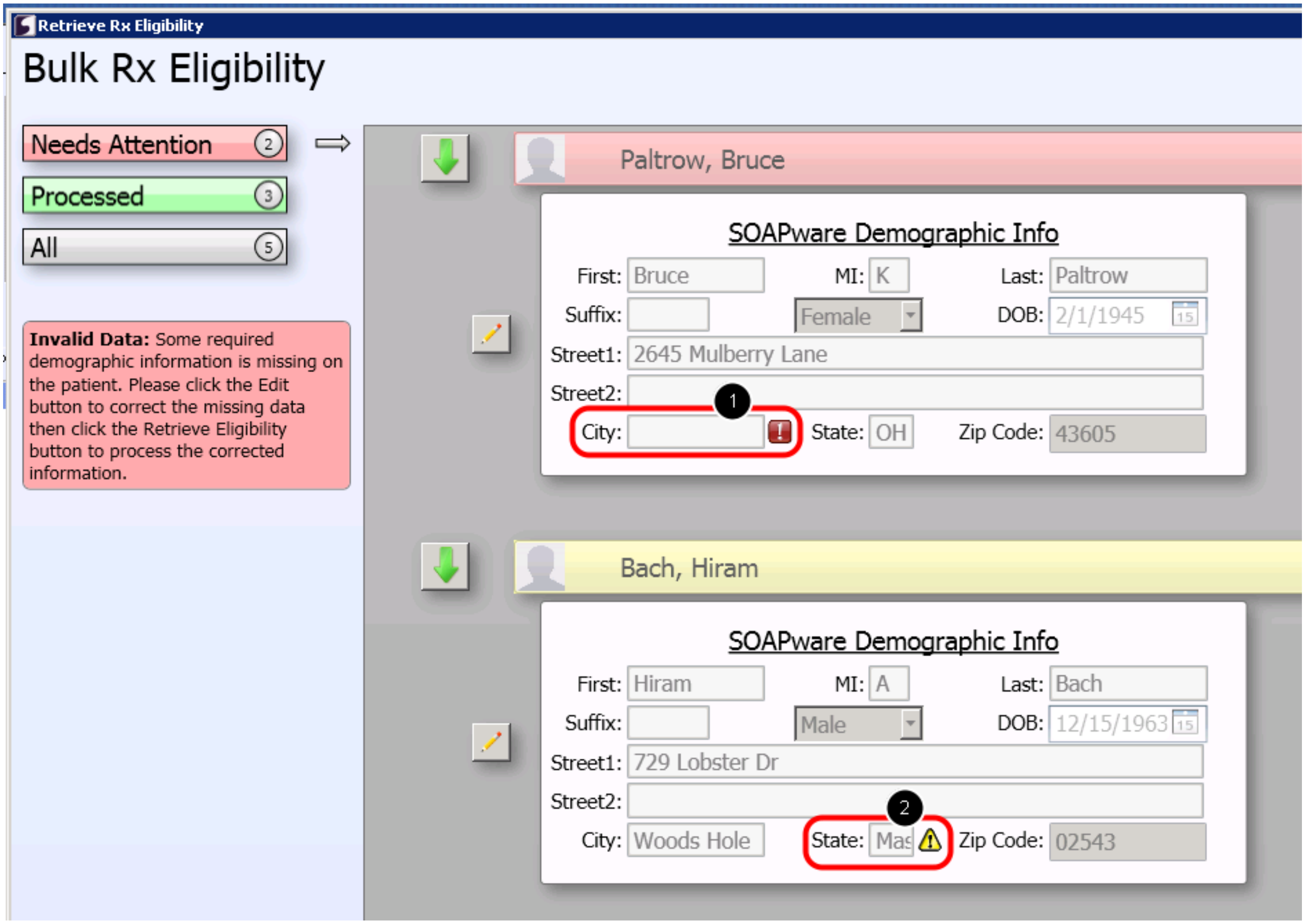
When the Bulk Rx Eligibility window is opened, SOAPware will begin processing Rx formulary eligibility for all patients listed on the schedule for the current date.



After processing, each patient will be displayed along with the result that was received. The results will be displayed in three tabs:

- **Needs Attention**
- **Processed**
- **All**

Needs Attention Tab

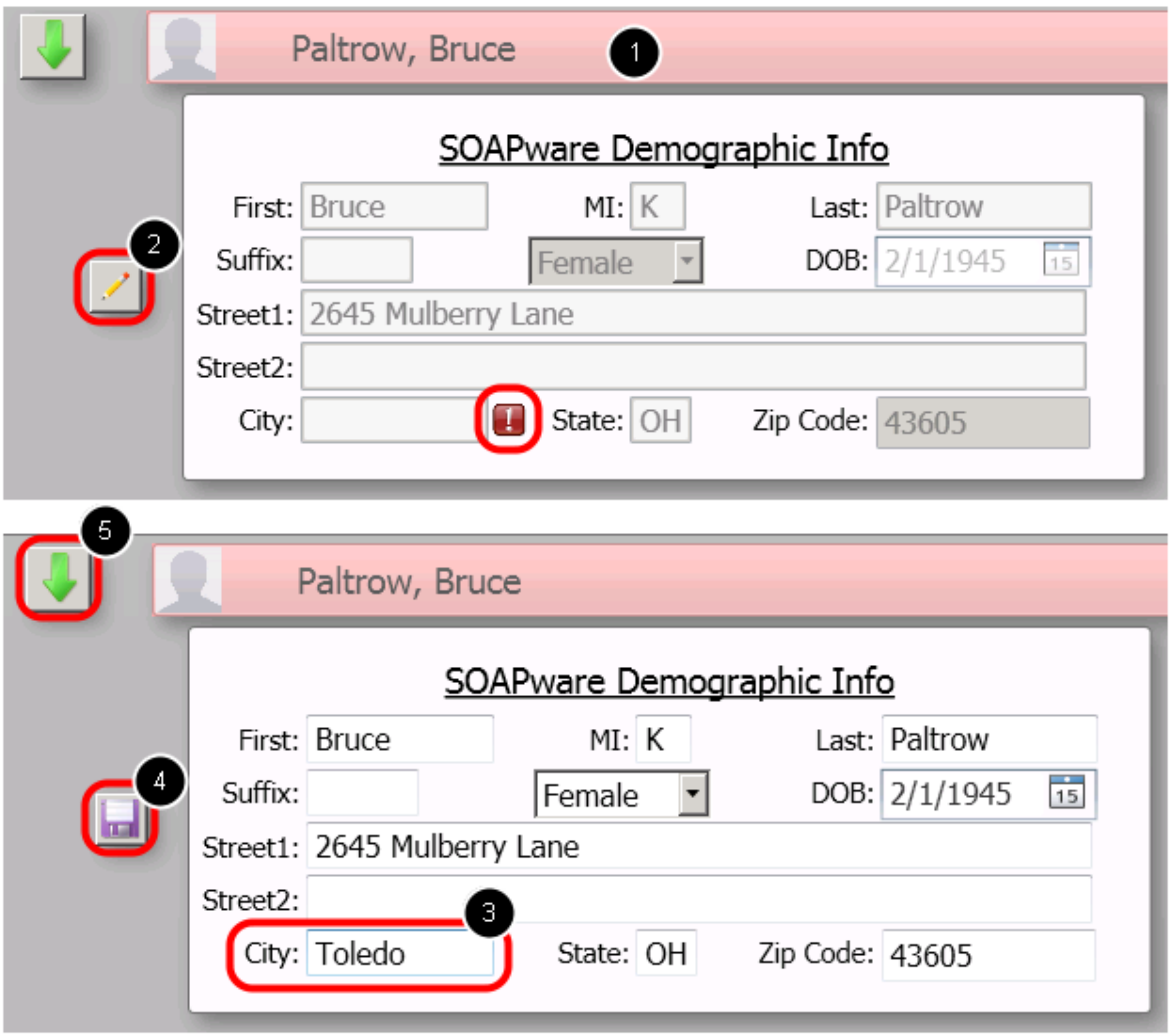


The Needs Attention tab will display the patients that need to be corrected or reviewed prior to retrieving their Rx eligibility. There are 3 types of results that will be displayed in this tab:

1. **Red Exclamation icon (Invalid Data):** Indicates that there is some required demographics information missing on the patient. This information must be entered prior to retrieving eligibility.
2. **Yellow Exclamation icon (Shortened Data):** Indicates that some of the required demographic information has exceeded the maximum character length for Rx eligibility requests. The information can still be submitted for eligibility, but will be truncated when processed. Rx eligibility can be retrieved based on the truncated information by clicking the Retrieve Eligibility button.

3. **Red X icon (Error):** Indicates that an error occurred while attempting to retrieve eligibility on the patient. To view the error details, the user may hover the mouse over the error icon.

- Correcting Invalid Data



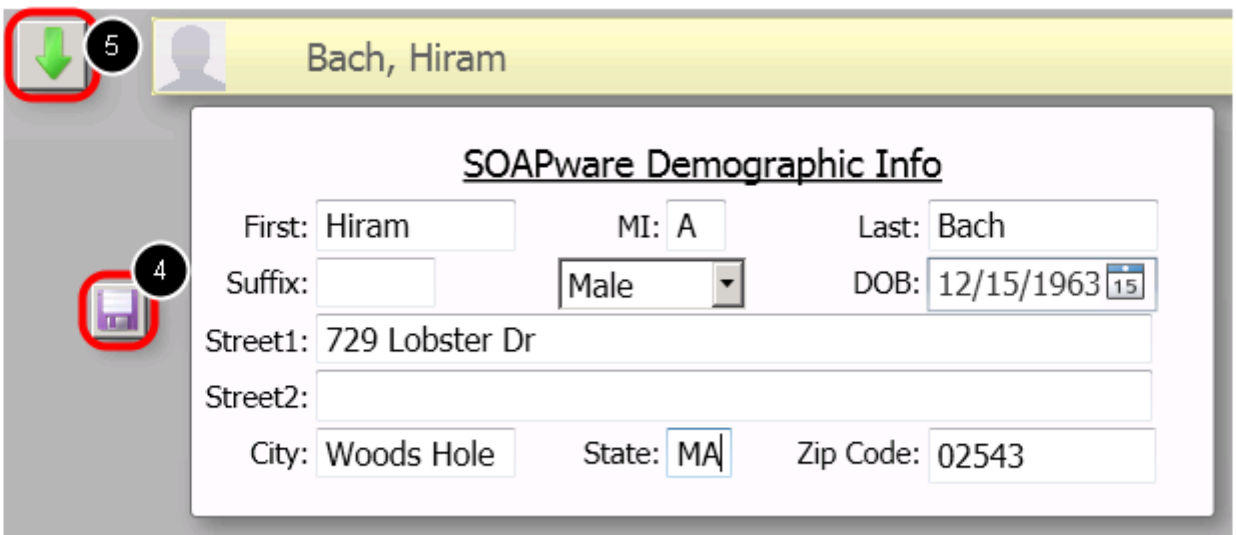
To correct a patient's invalid demographic information, follow the steps below:

1. **Red Shading:** The red shading of the patient name indicates that the patient has some invalid demographic data that must be corrected prior to retrieving eligibility.
2. **Edit:** Click the Edit button to unlock the patient's demographics. If another user is currently in

the same patient's demographics section, a dialog will pop-up to indicate that the demographics cannot be edited at this time. Once the other user has closed the patient's demographics section, the Edit button will then allow the demographics to be edited from this window.

3. **Correct Invalid Data:** A red exclamation icon will be placed next to each field that requires data to be corrected. Once the appropriate information has been entered, the icon will disappear.
4. **Save**: Once all invalid data has been corrected, click the Save button to save the demographic changes. This will update the demographics in the patient's chart and the patient account.
5. **Retrieve Eligibility:** After all invalid data has been corrected and saved, click the Retrieve Eligibility button to reprocess the patient's Rx eligibility.

- Reviewing Shortened Data



To review or edit a patient's truncated demographic information, following the steps below:

1. **Yellow Shading:** The yellow shading of the patient name indicates that the patient has some data that exceeds the maximum character requirements for retrieving eligibility. The information can still be submitted for eligibility, but will be truncated when processed.
2. **Edit (Optional):** If the user wishes to edit the patient's demographic information to shorten it, click the Edit button to unlock the patient's demographics.
3. **Review/Correct Data:** A yellow exclamation icon will be placed next to each field that has exceeded the maximum character requirements. This information can be edited if desired.

If the user does not edit the flagged information, SOAPware will simply truncate the data when eligibility is retrieved.

4. **Save**: Click the Save button to save any demographics changes. This will update the demographics in the patient's chart and the patient account.
5. **Retrieve Eligibility:** Click the Retrieve Eligibility button to process the patient's Rx eligibility using the truncated data (or corrected data if edited).

- Errors

There are some errors that could occur while processing a patient's Rx eligibility. A red X icon will be located next to the patient's name if an error occurred during processing. To view the details of the error, hover the mouse over the error icon.

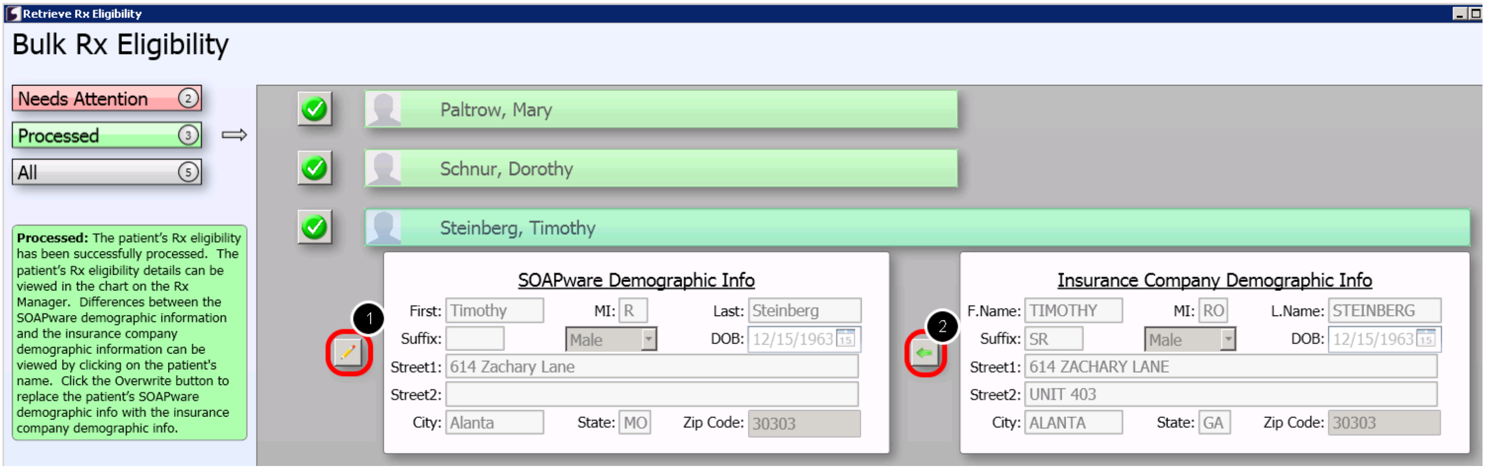
Below is a list of two types of errors that may commonly occur:
1. Unable to load patient. Please try again later.
2. Unable to connect to the web server. Please check your internet connection or visit www.soapwarestatus.com to check for a SOAPware Internet Service outage.

Processed Tab

The Processed tab will display the list of patients whose eligibility has been successfully retrieved. Successful retrieval of eligibility includes patients who were found in the Surescripts database, as well as patient's that were not found. ***Note:** The information received when a patient's eligibility is checked is determined by the information released by the insurance company.

If there are any differences between the SOAPware demographic information and the insurance company demographic information, they can be viewed by clicking on the patient's name.

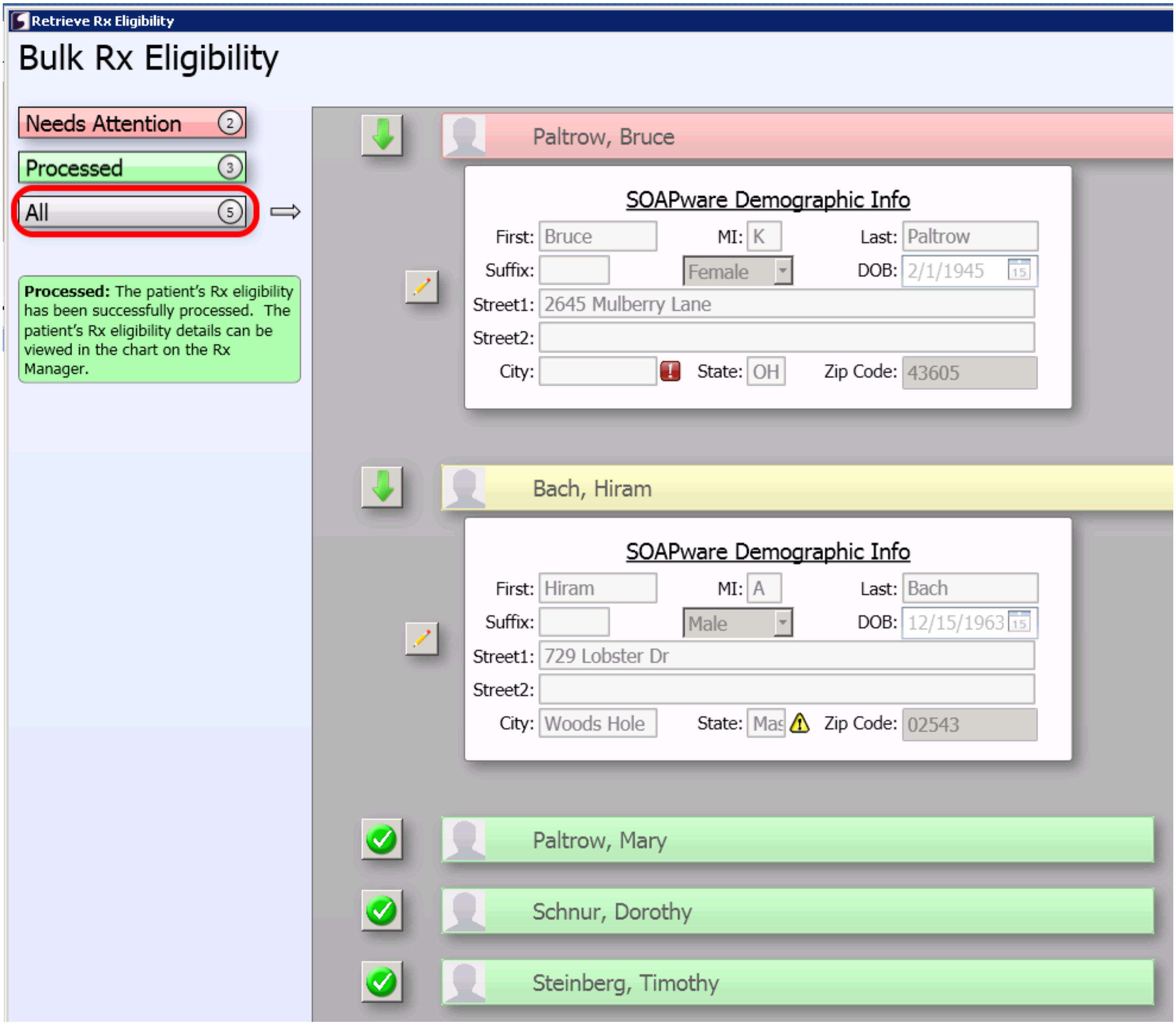
- Overwrite SOAPware Demographic Info with Insurance Company Demographic Info



To overwrite the SOAPware demographics information with the demographics information from the insurance company:

1. Click the **Edit** button.
2. Click the **Overwrite** button to replace the patient's SOAPware demographic info with the insurance company demographic info.

All Tab



The All tab will display all patients who are on the schedule for the current date along with the color coded status of each patients eligibility retrieval.

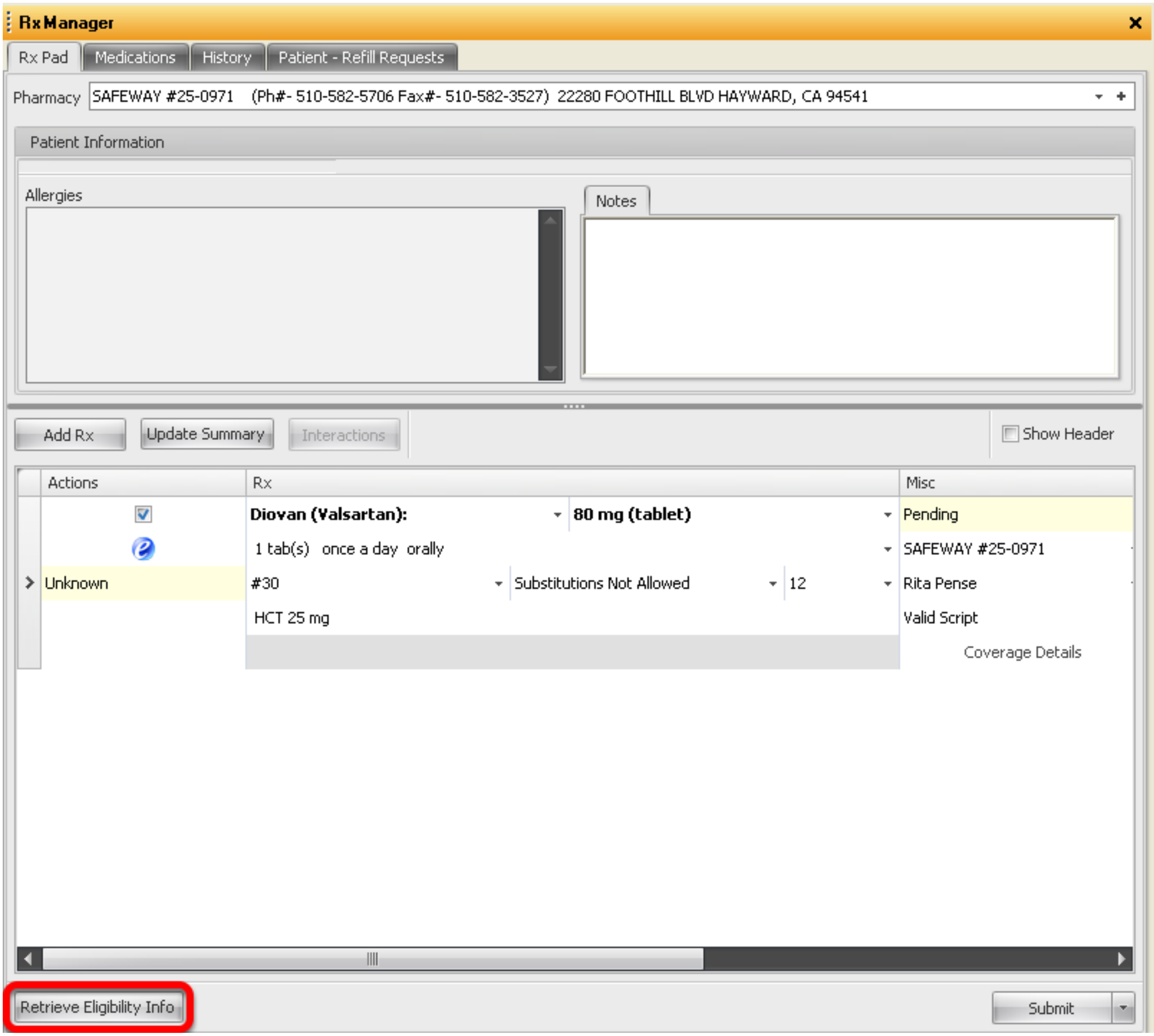
Patients whose demographics need attention will be displayed in red or yellow and their demographics will be automatically expanded. Hovering the mouse over each patient's name will display a description and instructions for the patient.

Retrieve All

If several edits have been made within the Bulk Rx Eligibility window, click the **Retrieve All** button to re-process all items marked as Needs Attention.

Click the **Close** button to close the Bulk Rx Eligibility window.

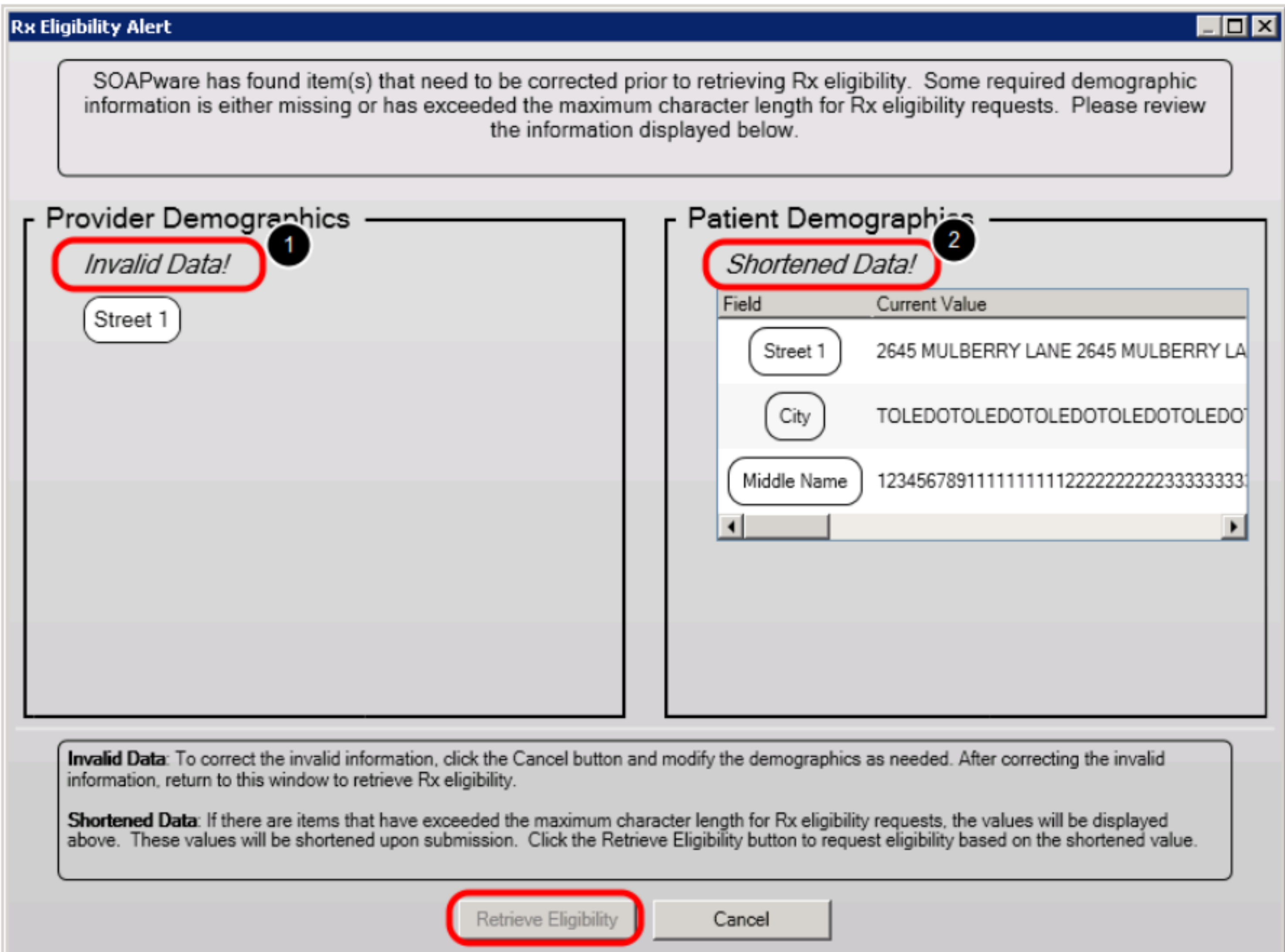
2. Individual Download - Single Patient Matching



Eligibility can also be checked from the individual patient's chart in the Rx Manager. To check the eligibility on a individual patient, 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 clinician seeing the patient.*

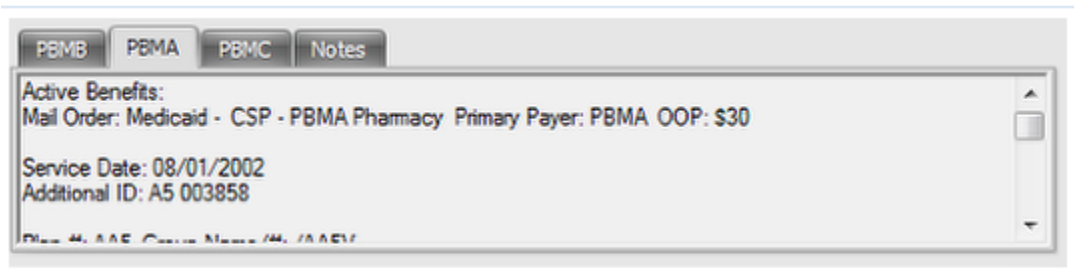
Rx Eligibility Alert



SOAPware will review the patient demographic and provider information. If there are items that need to be corrected prior to retrieving Rx eligibility, the above dialog will appear. This alert means that some required demographic information is either missing or has exceeded the maximum character length for Rx eligibility requests.

1. **Invalid Data:** To correct the invalid information, click the **Cancel** button and modify the information for the patient or provider as needed. After correcting the invalid information, return to this window to retrieve Rx eligibility.
2. **Shortened Data:** If there are items that have exceeded the maximum character length for Rx eligibility requests, the values will be displayed. These values will be shortened upon submission. Click the **Retrieve Eligibility** button to request eligibility based on the shortened value.

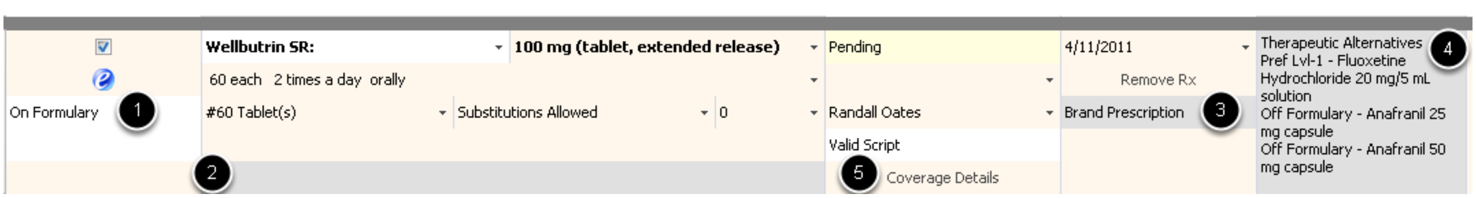
The Eligibility Tabs



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

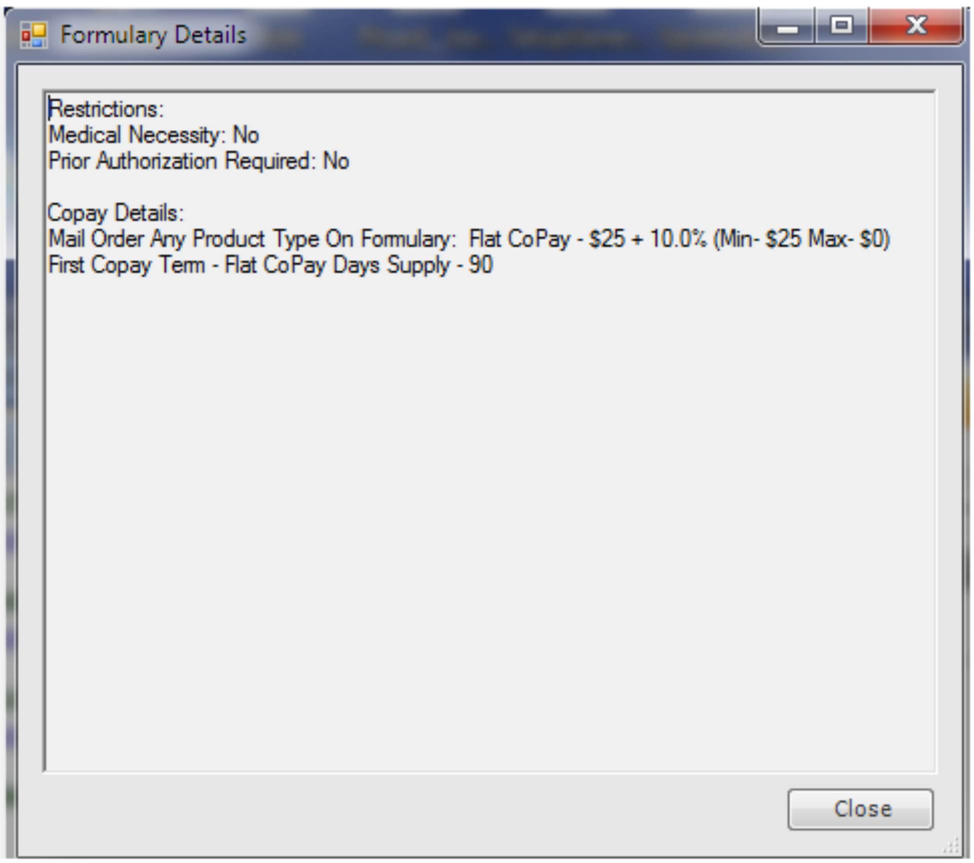


1. Displays the formulary status for the prescription. In this case it is "On Formulary".
2. A summary of the cost for the medication may be displayed in this section.
3. Information as to OTC/brand and generic/prescription status.

4. Alternative drugs supported by the selected coverage.
5. Displays an additional window that may contain more detailed formulary information.

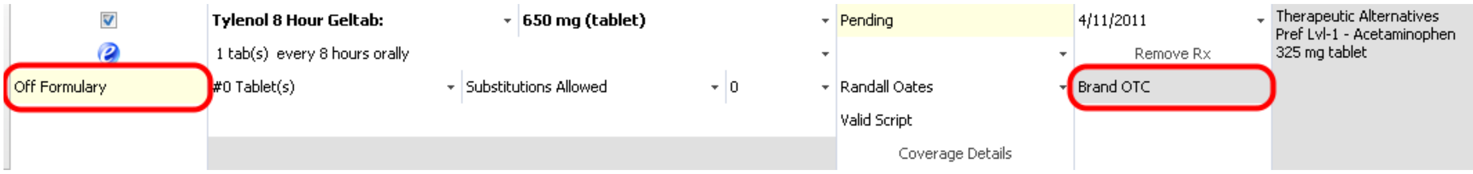
*__Note:__ The information received when a patient's eligibility is checked is determined by the information released by the insurance company.

Additional Formulary Details



To view more detailed formulary information, click on the "Coverage Details" button (#5 above).

Off Formulary Medications



This above drug is not covered under the selected coverage and displays as "Off Formulary" and "Brand OTC".

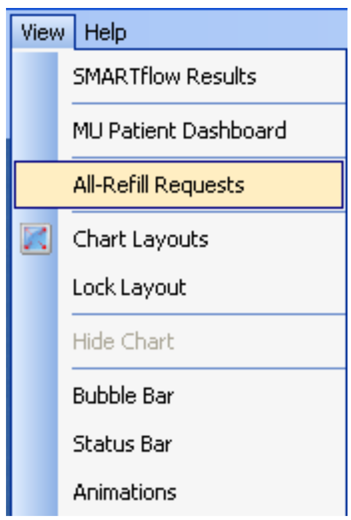
Electronic Refill Requests

This lesson will demonstrate the steps necessary to receive and respond to electronic refill requests in SOAPware.

eRx Monitor

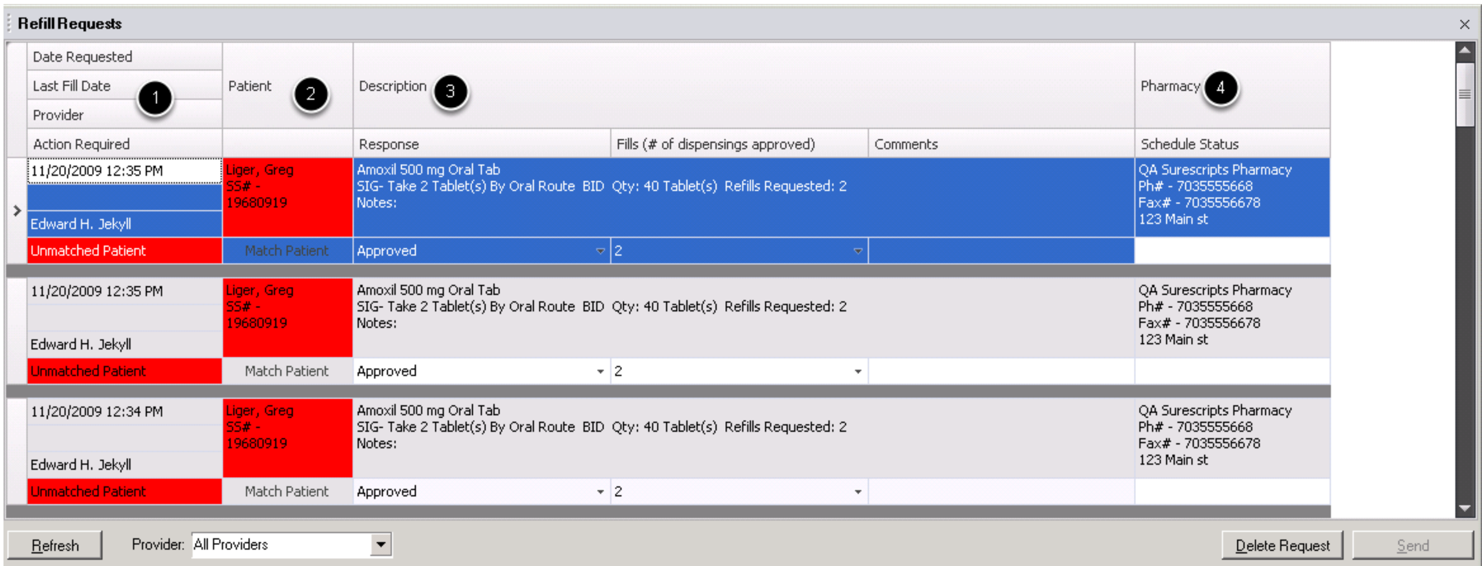
In order to receive electronic refill requests in SOAPware, the user will need to run the eRx Monitor. For instructions on running the eRx Monitor see: eRx Monitor.

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

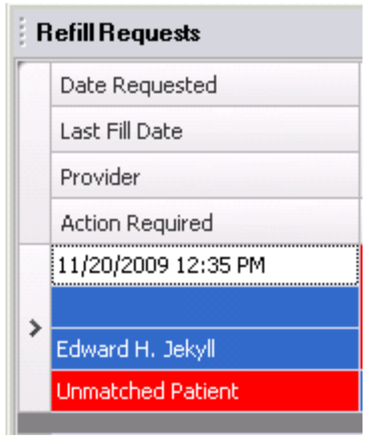


The display is horizontally divided into 4 general areas (from left to right).

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

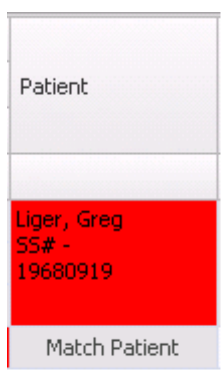


The first, or left-most, area of each refill request is the Refill Notice region and can contain Date Requested, Last Fill Date, Provider, and Action-Status rows (i.e. Ready, Scheduled Drug, Unmatched Patient etc.) When the refill request is complete and valid the Status will turn Green.

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 request that it be disabled.

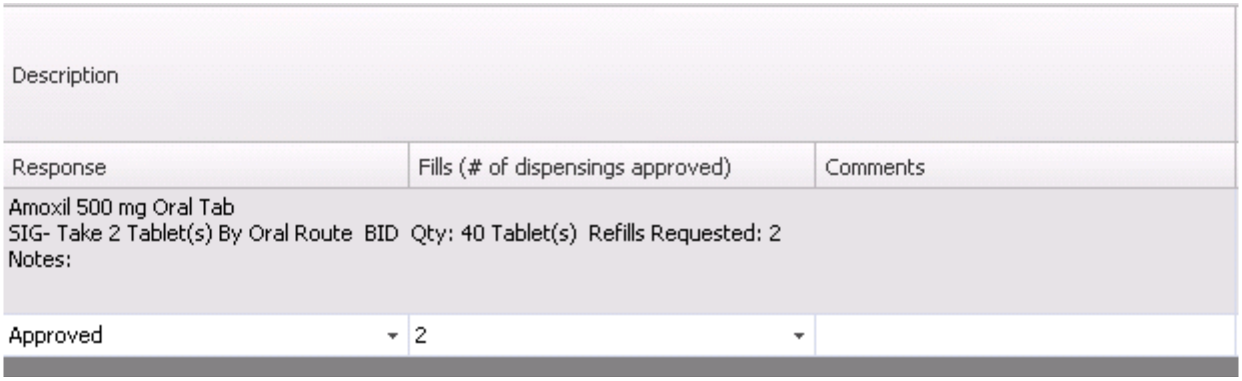
Patient Information



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.

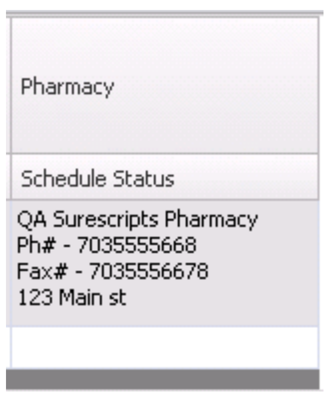
Description



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

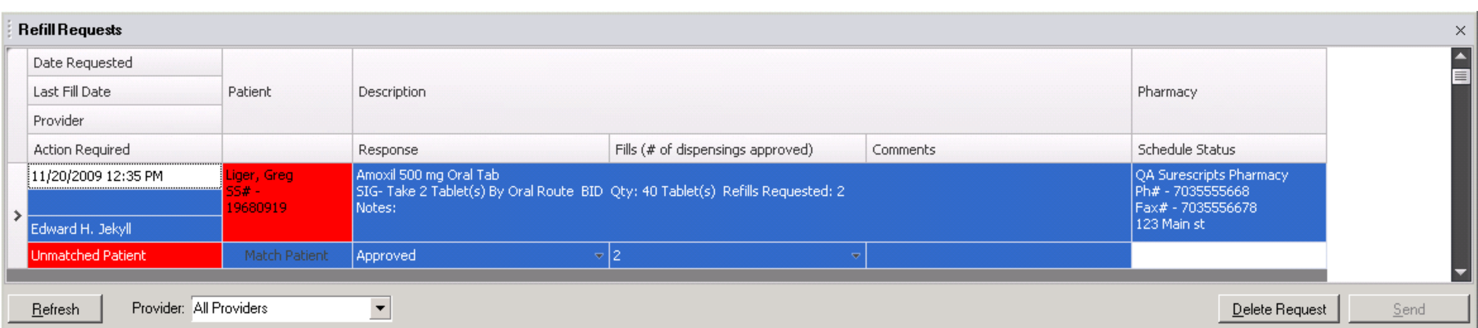
Refresh
The Refresh button checks for any new refill requests.

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.

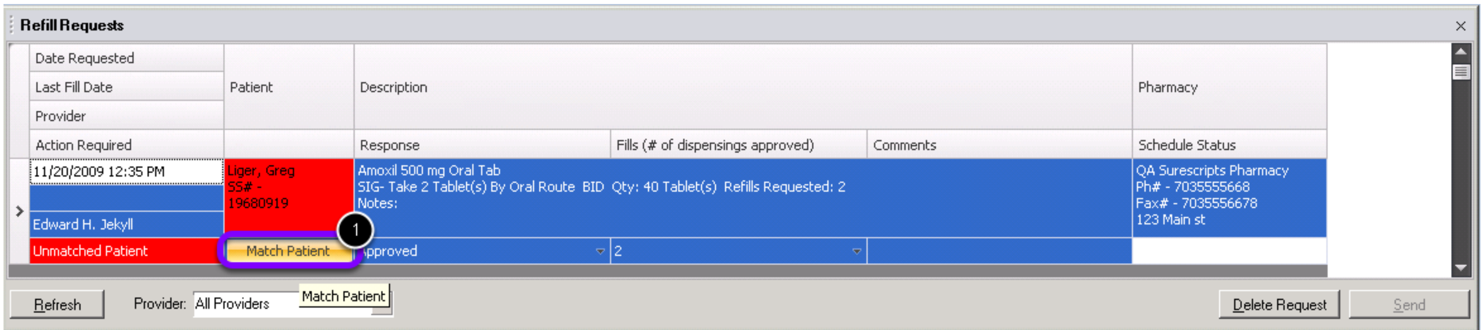
Send
The Send button sends a response for the currently selected refill request.

Matching a Patient



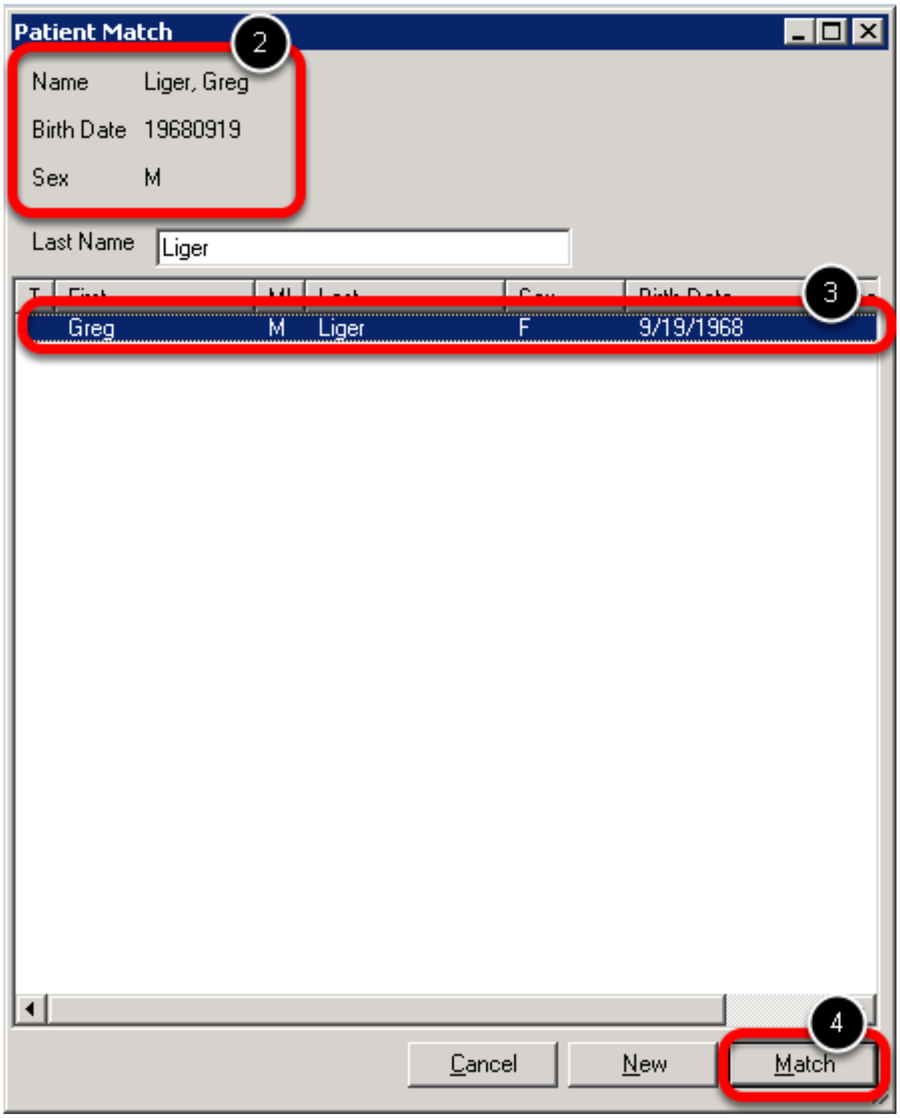
When an electronic refill request is sent for a patient for the first time, the SOAPware user will need to match the patient with a SOAPware chart. If a clinic received a faxed refill request from the pharmacy on a patient, the clinic staff would verify that the patient's name, date of birth and SSN 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".

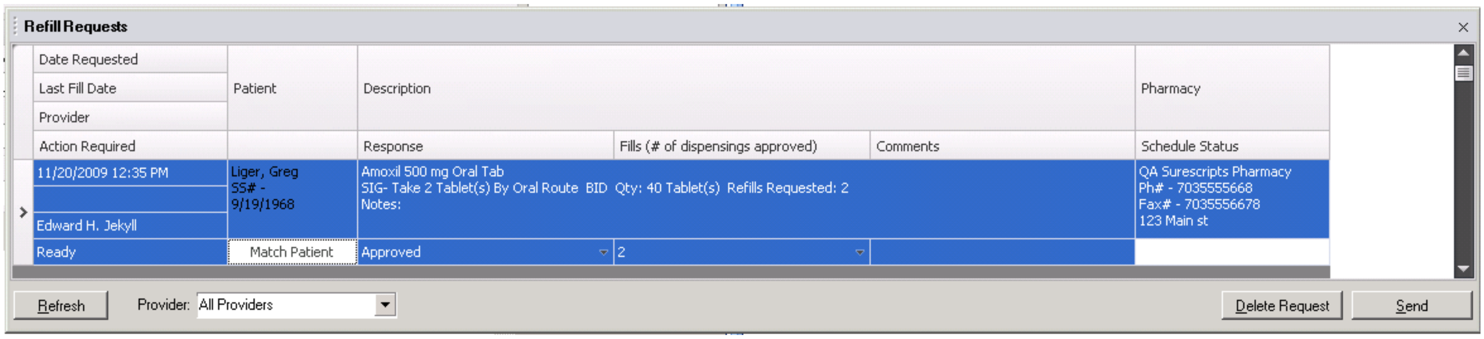


To match the electronic refill request with a patient's chart:

1. Click the Match Patient button

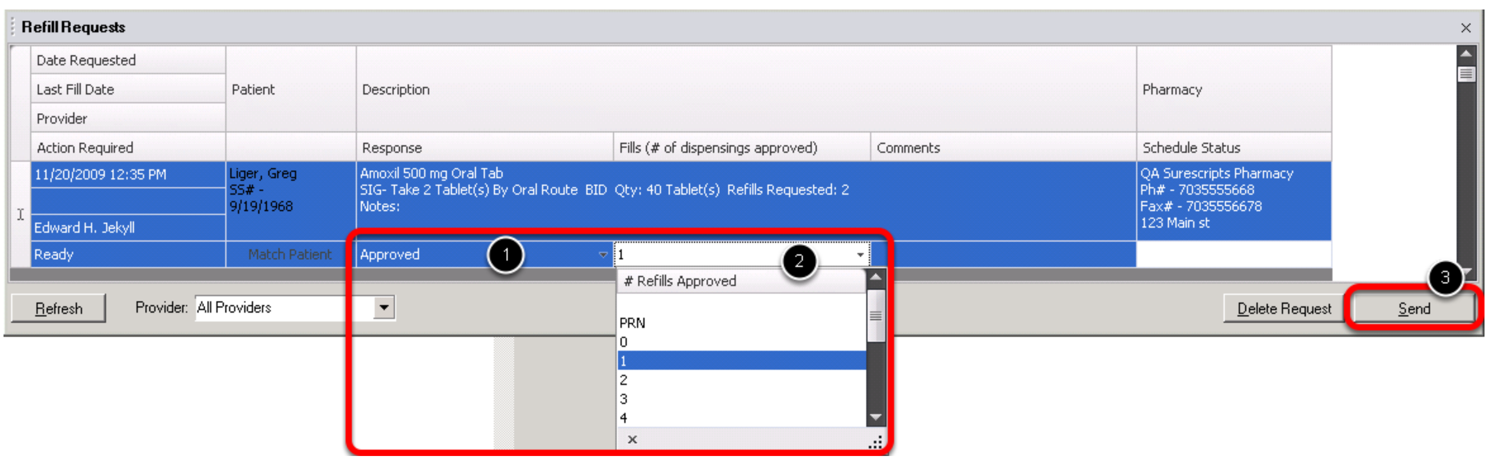


2. The patient's Name, Birth Date and Sex as submitted by the pharmacy will display at the top of the Patient Match window
3. SOAPware will search for a patient that has a matching last name in SOAPware and the results will be displayed. Click on the correct patient after verifying the patient's information.
4. Click the Match button to indicate that this refill request matches the selected patient.



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



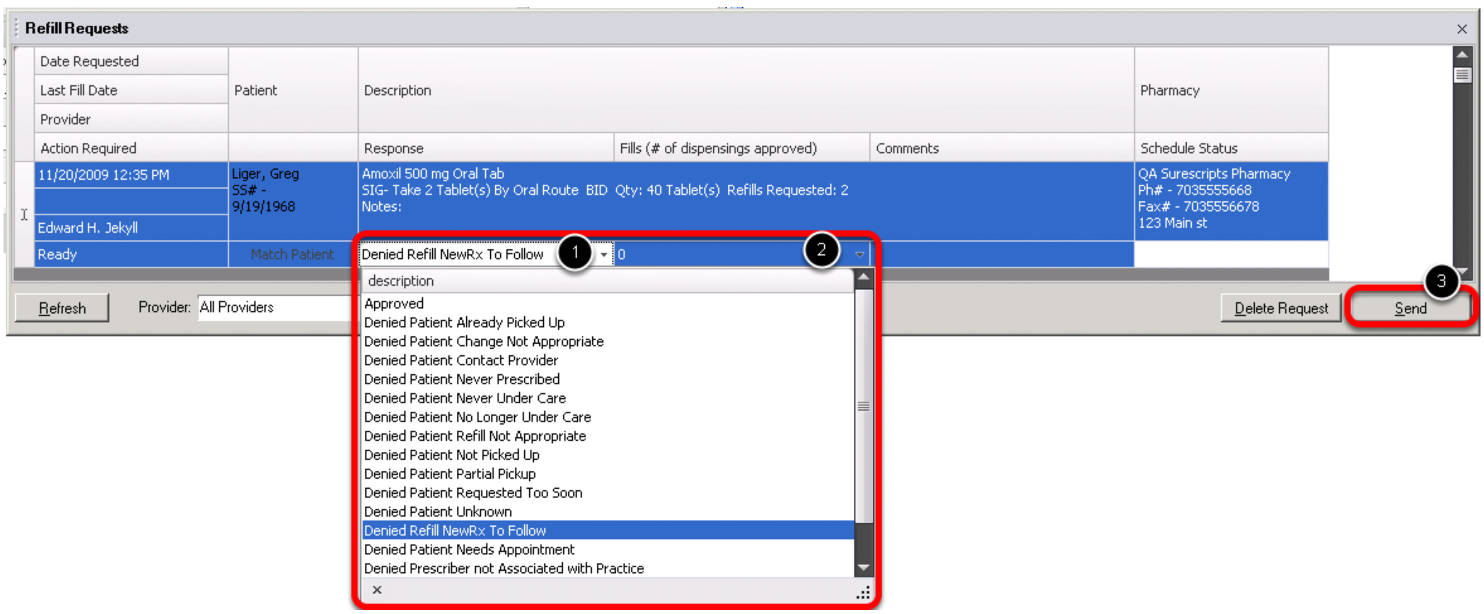
To approve a refill request:

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



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

In order for the drug interaction check to work, the patient's Summary medications and allergies must be documented in the SMARText format.

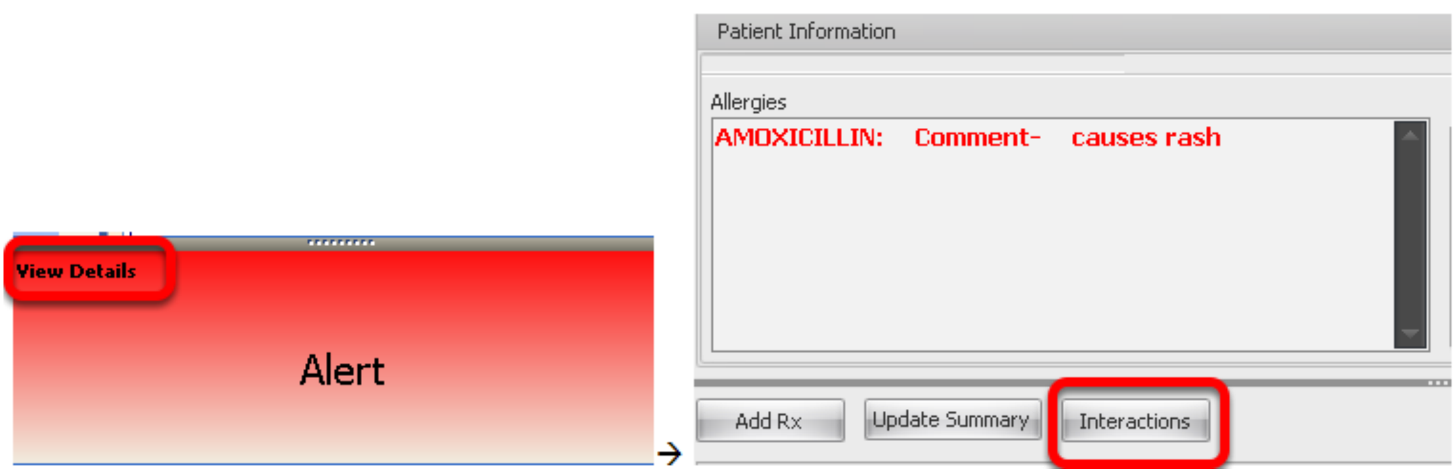
If the patient has no allergies the SMARText Item "Drug Allergies: No Known" must be displayed to meet Meaningful Use criteria.

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.

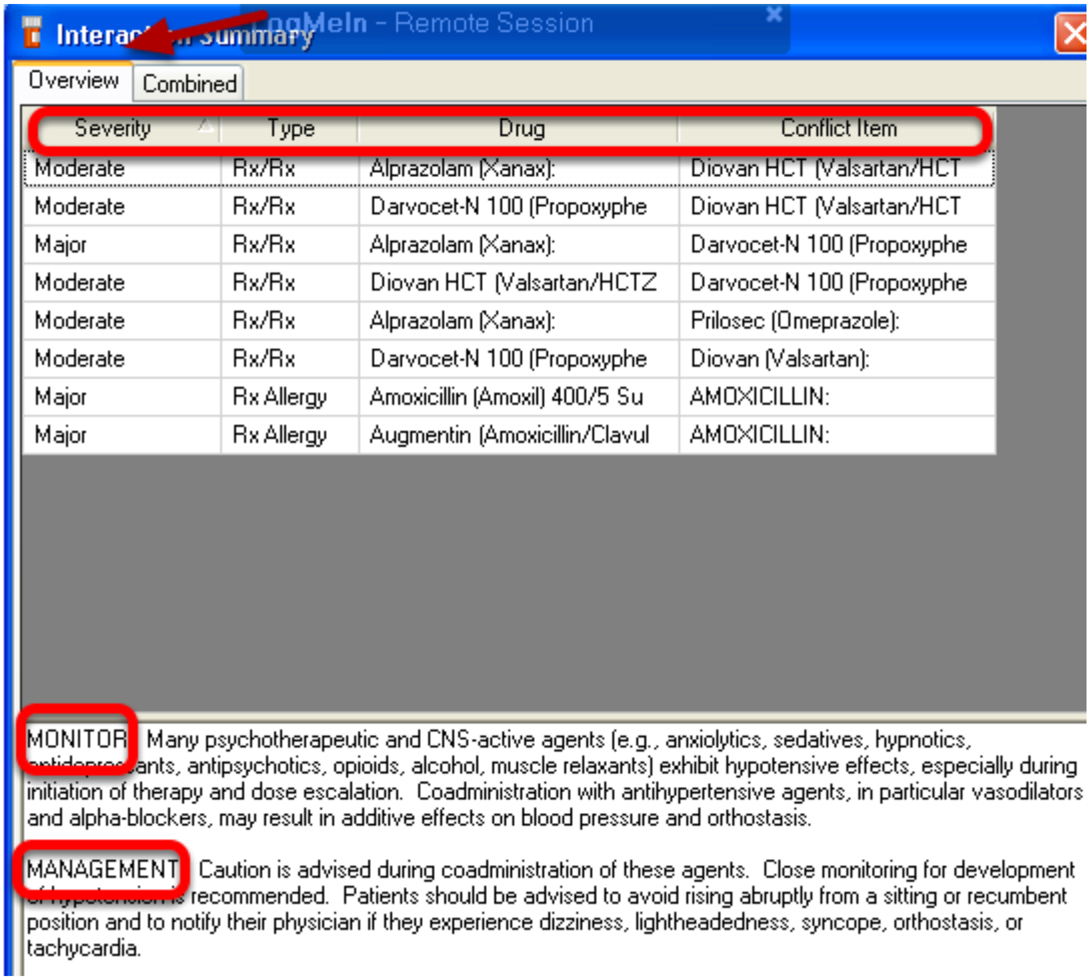
*Red - Major Interaction
*Yellow - Moderate interaction
*Green - Minor Interaction

Viewing the Interactions



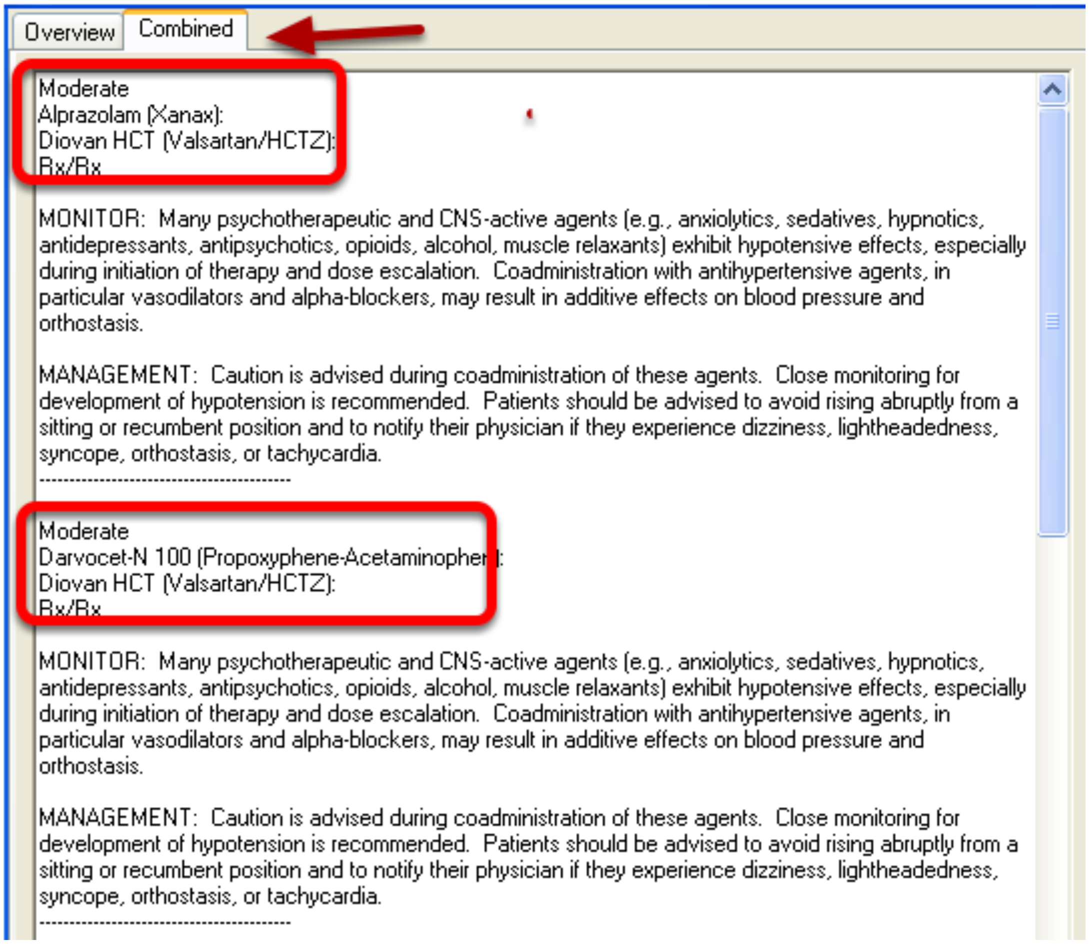
The interactions can be viewed by either clicking on the View Details in the alert pop up or by clicking on the interaction button on the Rx Pad

Interaction Information - Overview Tab



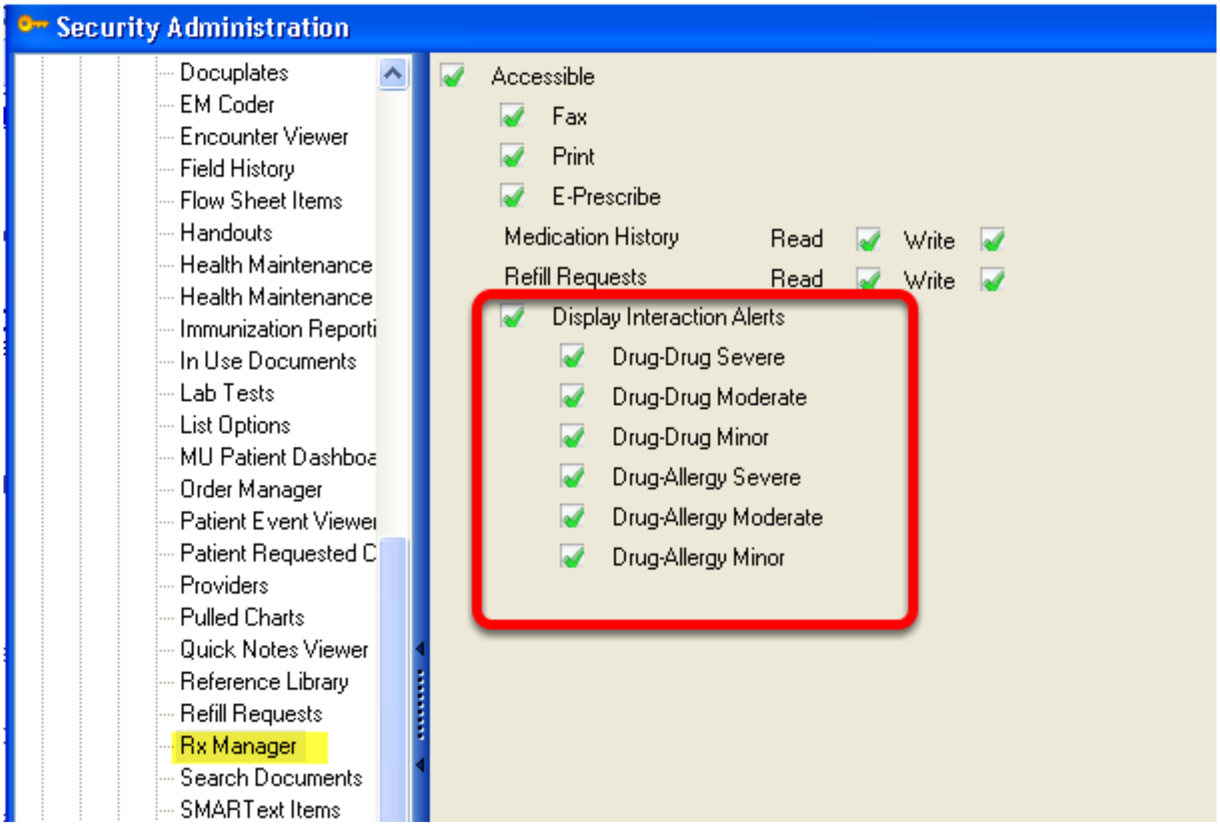
The Overview tab will display
*The severity of the interaction
*The type of interaction (e.g. drug/drug or drug/allergy)
*The drug and conflict item
*An overview on monitoring and management

Interaction Information - Combined Tab



The 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.

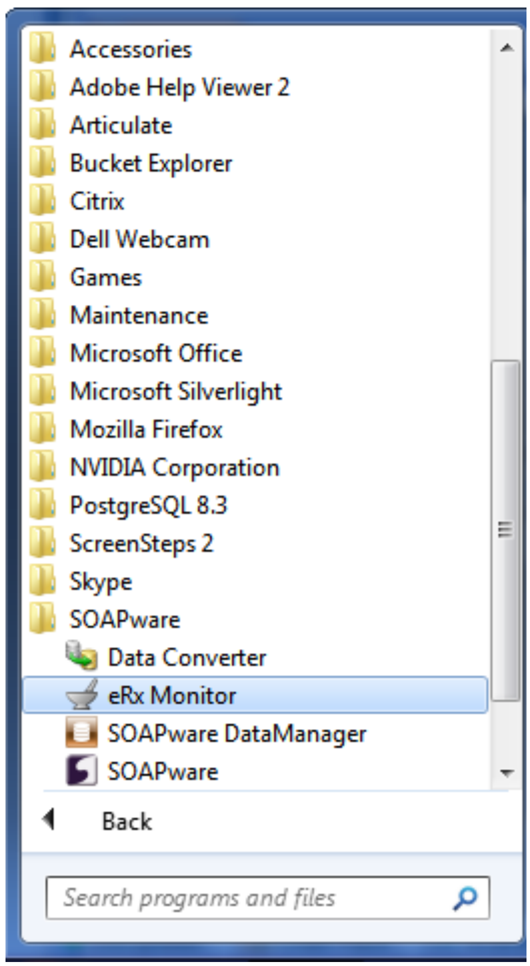
For more information see: Security - Drug Interaction Filtering.

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

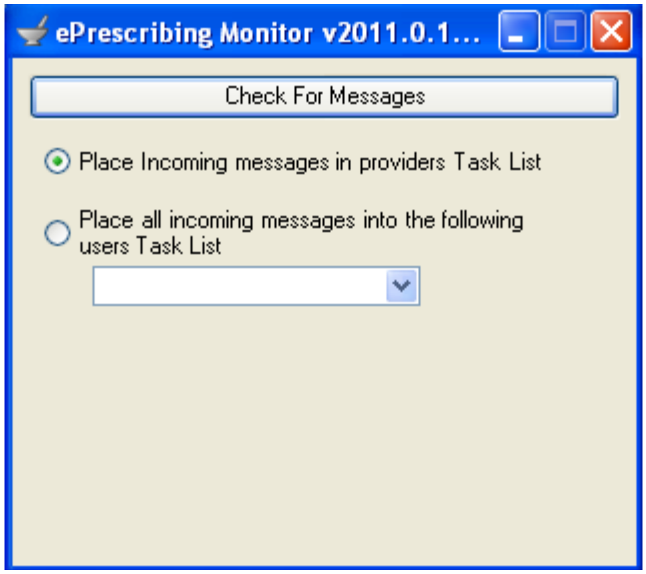


1. Click the Windows Start button.
2. Click the All Programs menu item.
3. Click the SOAPware menu item.
4. Click the ERx Monitor menu item.

Signing In

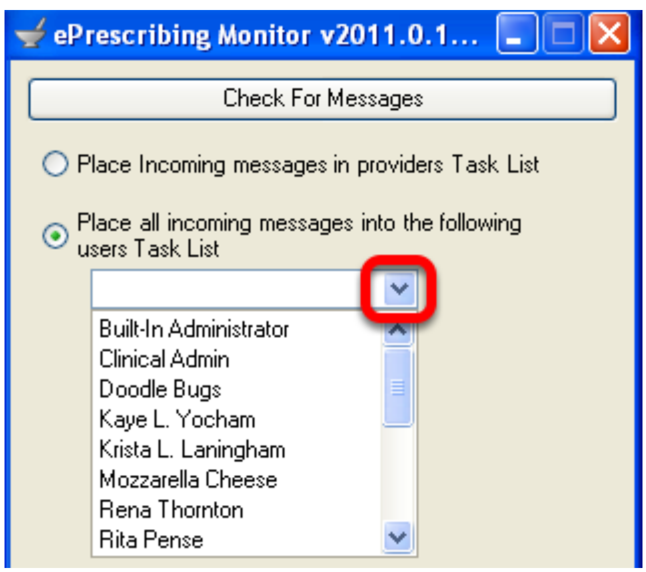
Sign in as usual with a SOAPware log-in.

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.

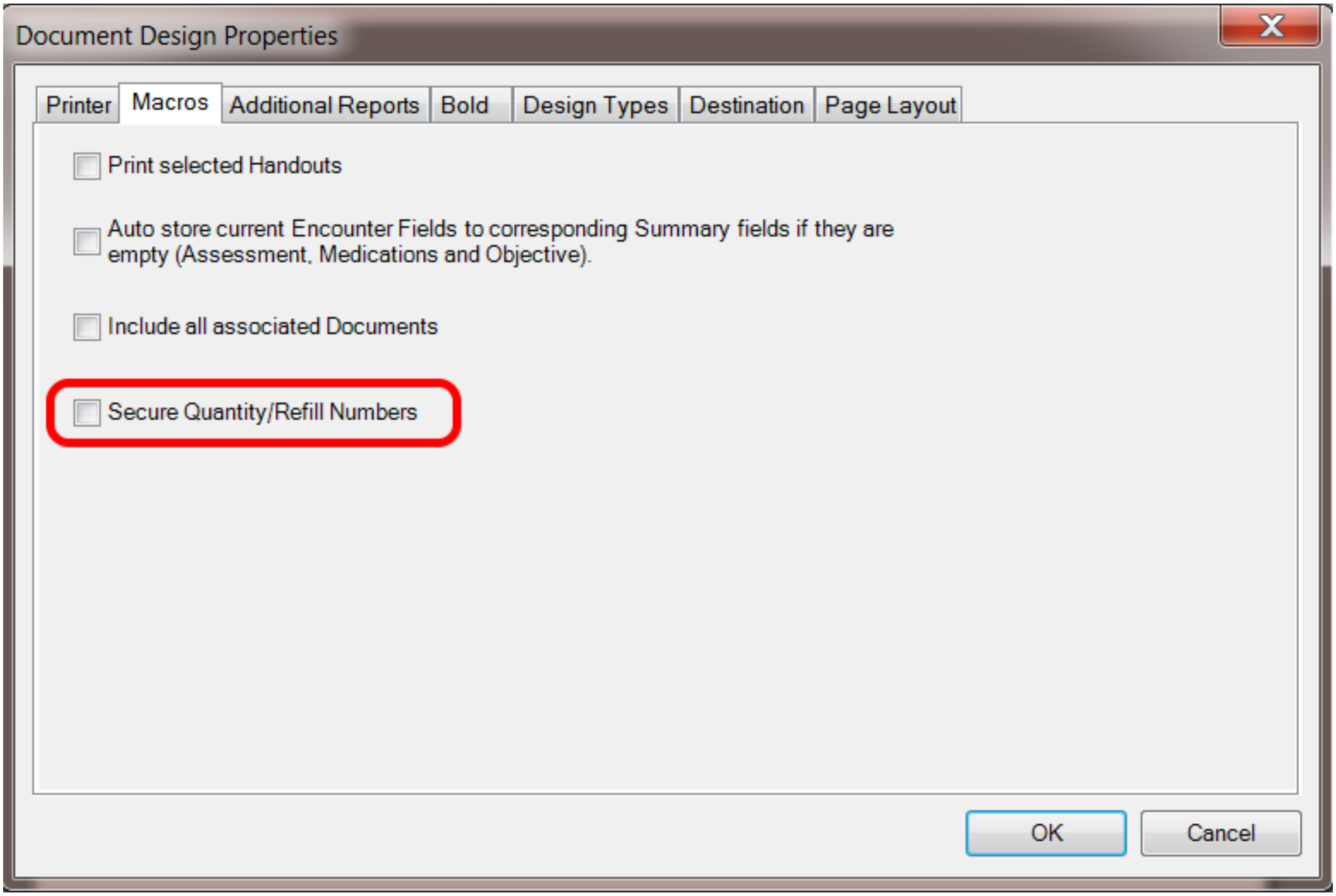
Printing a Secure Rx from SOAPware

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

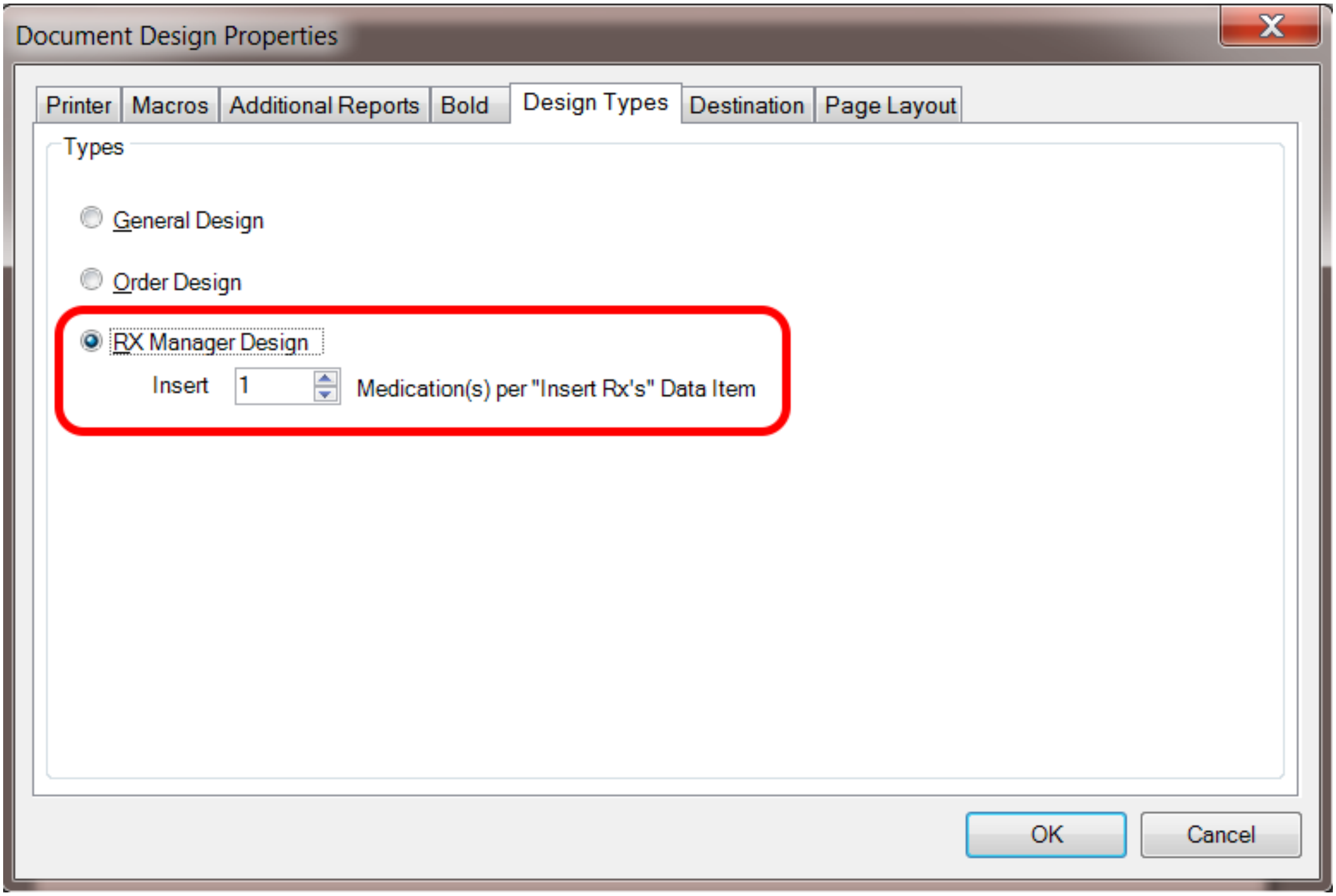
Micro-printing simply means the printing of a defined text string in a font too small to be copied (when it's copied it's either unreadable or appears as a line). Technically, it's defined as a font that is .5 points in size or smaller and requires 5x magnification or greater to read. The potential gotcha 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



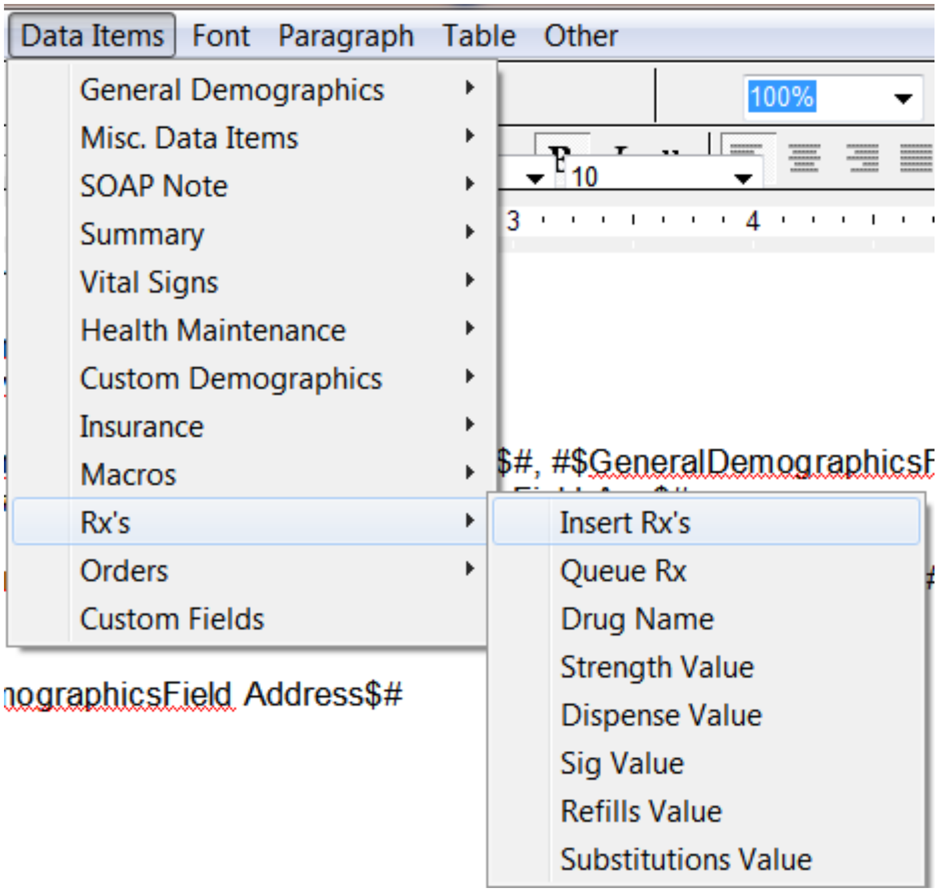
1. Open existing Document Design (Tools > Document Designer; Then choose File > Available Designs)
2. Display Document Design Properties (Edit > Design Properties)
3. Click on the 'Macros' Tab and check the box labeled - Secure Quantity/Refill Numbers

Design Types



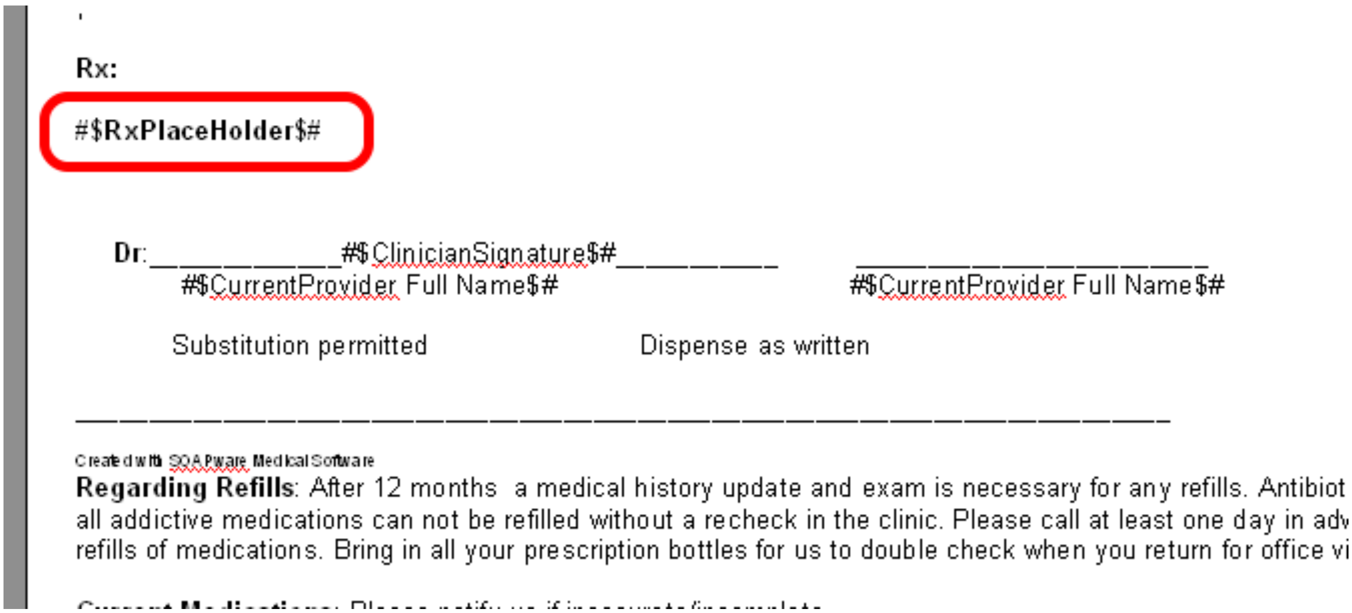
Select the Design Types tab and make sure Rx Manager Design is selected. The user can also select the number of Rx's per page to print.

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.

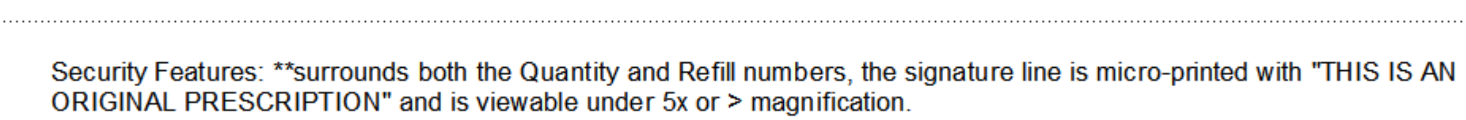
Signature Line



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



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

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

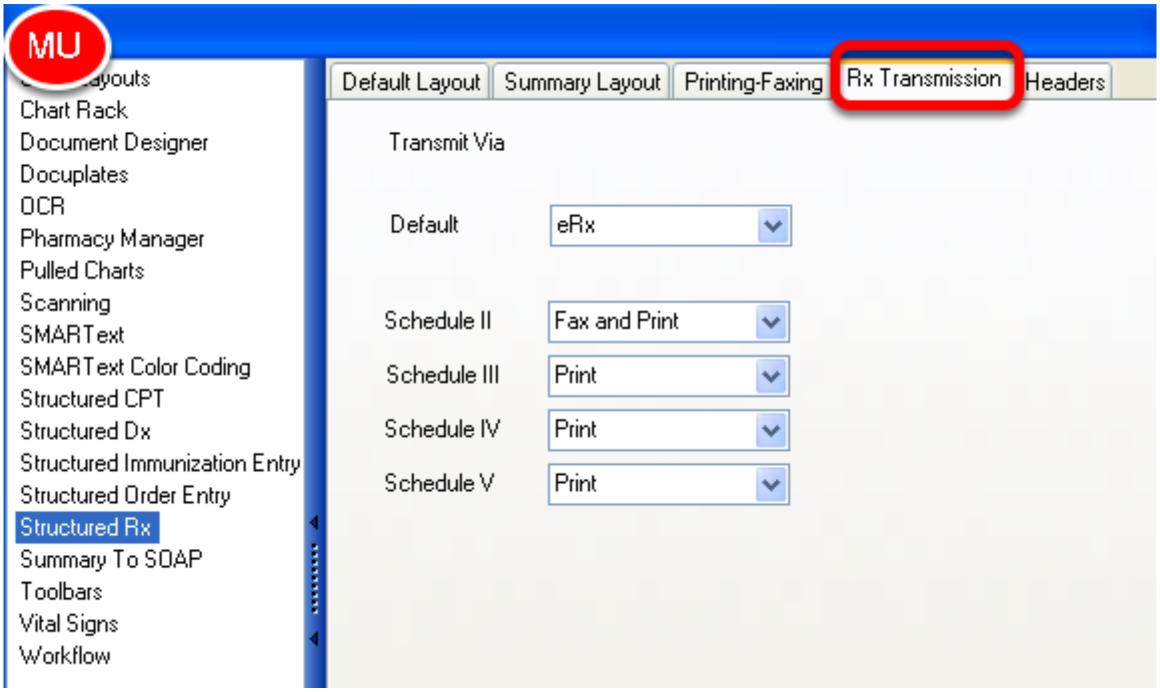
Tools > Options

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.

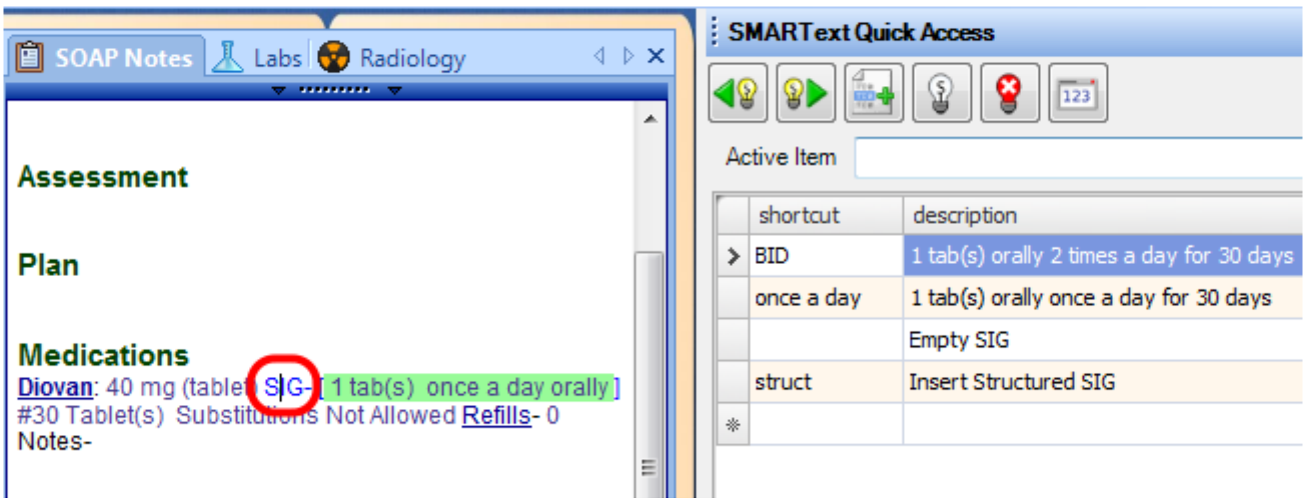
Faxing of a scheduled medication or narcotic in all 50 states, requires a hand-written, fresh signature. However, some pharmacies, in some states will often accept a faxed prescription of a scheduled med that contains an image of a signature.

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

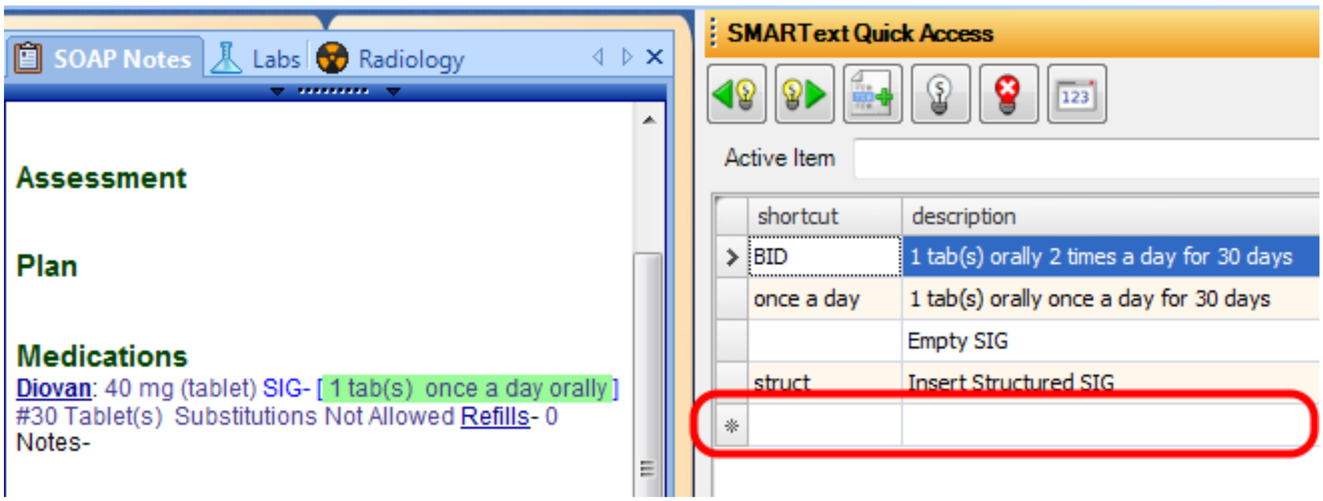
In SOAPware, most medications have pre-built Sigs that cover the most common prescribing scenarios. If the user was a previous SOAPware user, the user will need to update the existing Rx's so that they contain the latest settings. This is easily accomplished via the Update SMARText command in the SMARText Items Manager

Viewing Custom SIGs



Available Sigs are accessed via the Quick Access display. Click on the SIG- header to view available SIGs. Clicking on the Sig list item in the Quick Access list inserts it into the prescription item.

Creating a New Custom SIG

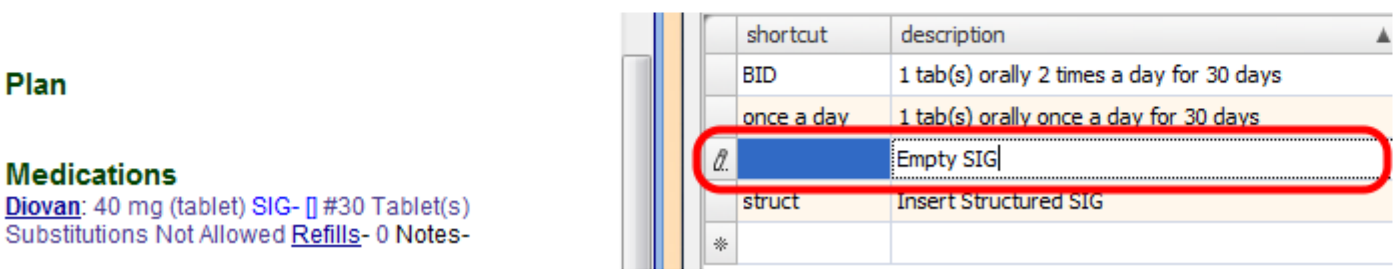


SOAPware allows users to modify the existing SIGs or add new ones at anytime.

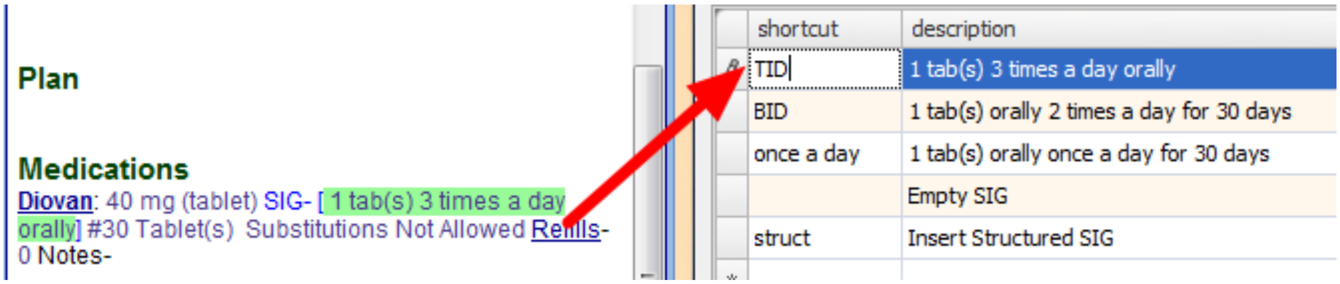
To add a new custom SIG:

1. Click in the empty sig line with the asterisk to the left.
2. Type a shortcut into the first column if desired (ex: TID)
3. Type the Dose, Frequency and Route instructions into the description column (ex: take 1 tab three times a day orally). We recommended that you do not use apothecary terms (BID, TID, etc) within the SIG description. Surescripts will be moving away from the use of apothecary terms. Please type out the entire SIG in the description box.

NOTE: The Dispense/Quantity element does not automatically update based on the Sig.

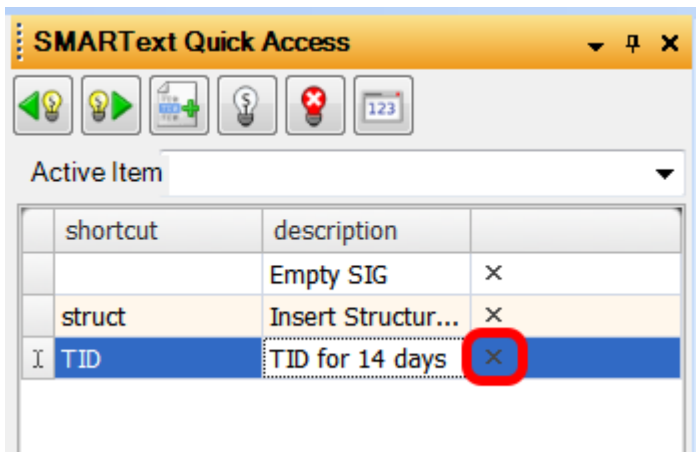


After typing in the new SIGs shortcut and description, Click on the Empty SIG line. This step will save the new SIG that was just created.



To insert the new SIG into the SOAPnote medication, Click on the custom SIG within the SMARText Quick Access.

Removing a Custom SIG



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.

eRx Workflow

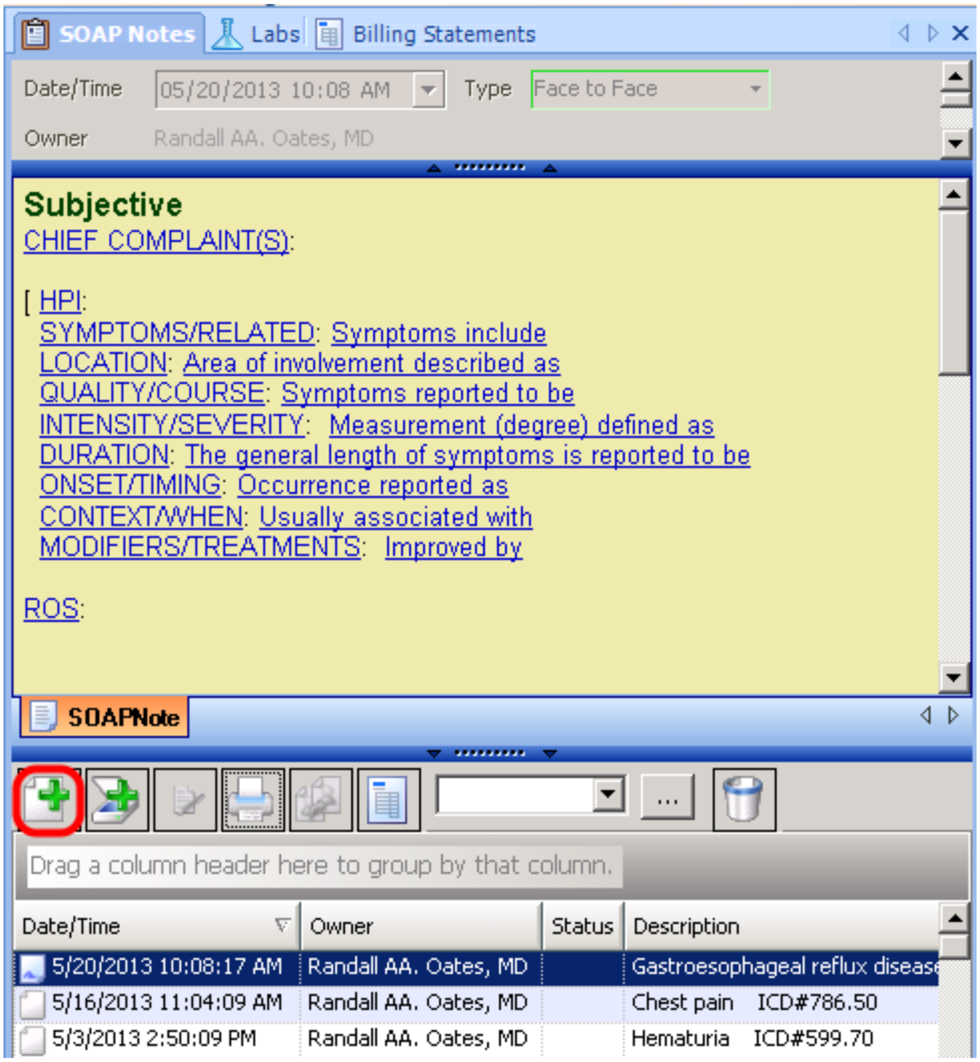
This lesson will describe the workflow that is required to ePrescribe a medication in SOAPware.

**__Note__: SMARText medications must be entered in 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**

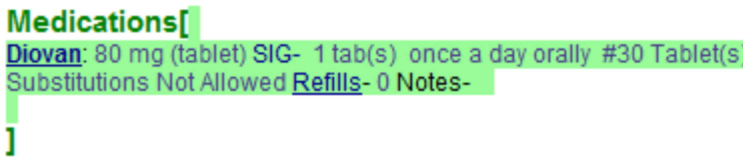
- ePrescribing (eRx)
- CPOE for Medication Orders

1. Create a New SOAPnote



The first step to submitting an electronic prescription is to create a new SOAPnote for the patient. To create a new SOAPnote, Click the **New Docutainer button (Green +)**.

2. Enter the Medication to Prescribe



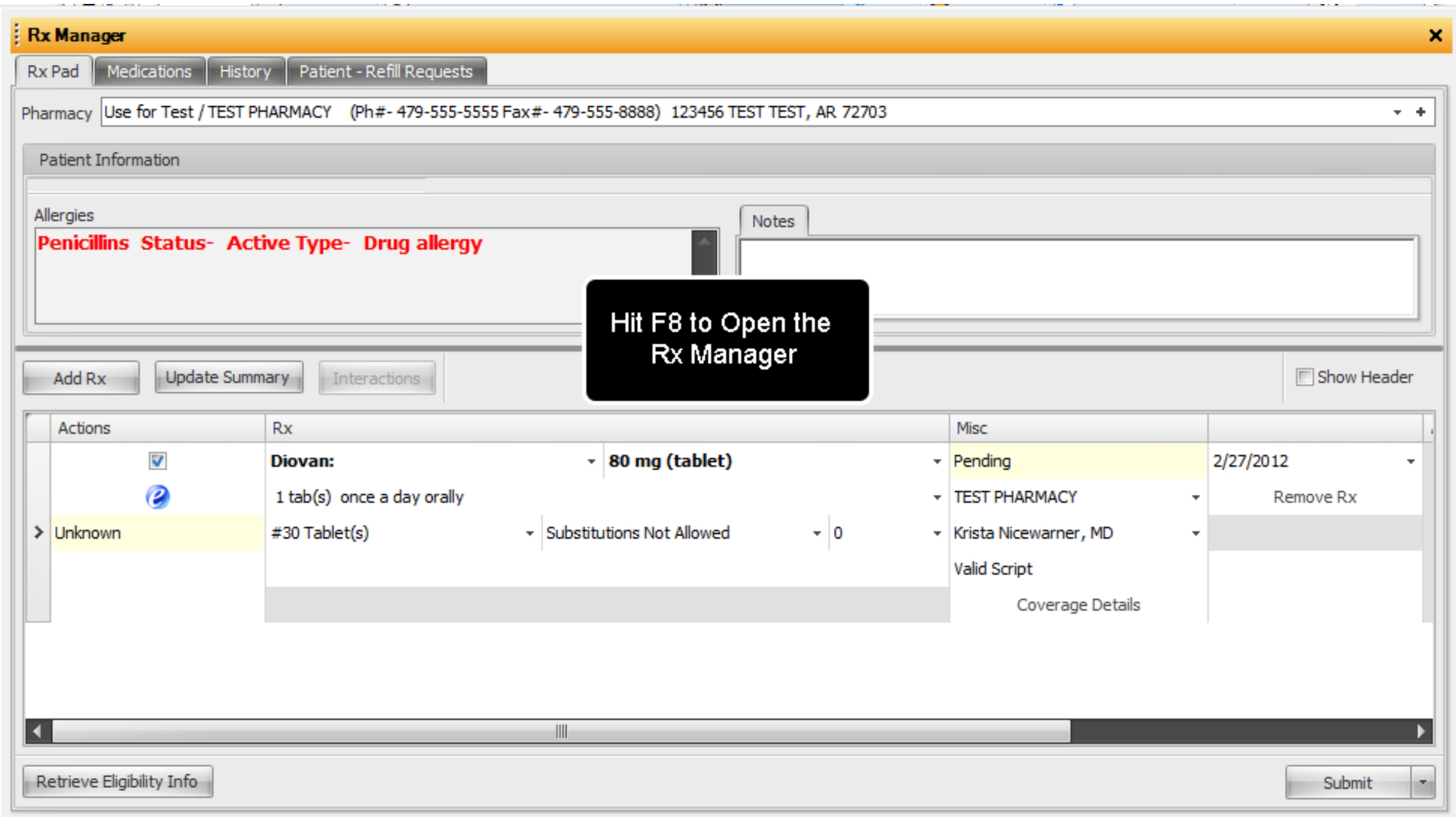
Next, the user will enter the medication to prescribe into the SOAPnote. Enter the medication using one of the following SMARText Data Entry methods:

1. SMARText Items Manager (F10)
2. F11 Search
3. Shift + F11 Search
4. Shortcut Code
5. Quick Access Favorites List
6. Pick List

For information on the above SMARText data entry methods, please see: **SMARText Data Entry Methods.**

For help on entering medications using SMARText, please see: **SOAPnote Medication Entry.**

3. Open the Rx Manager

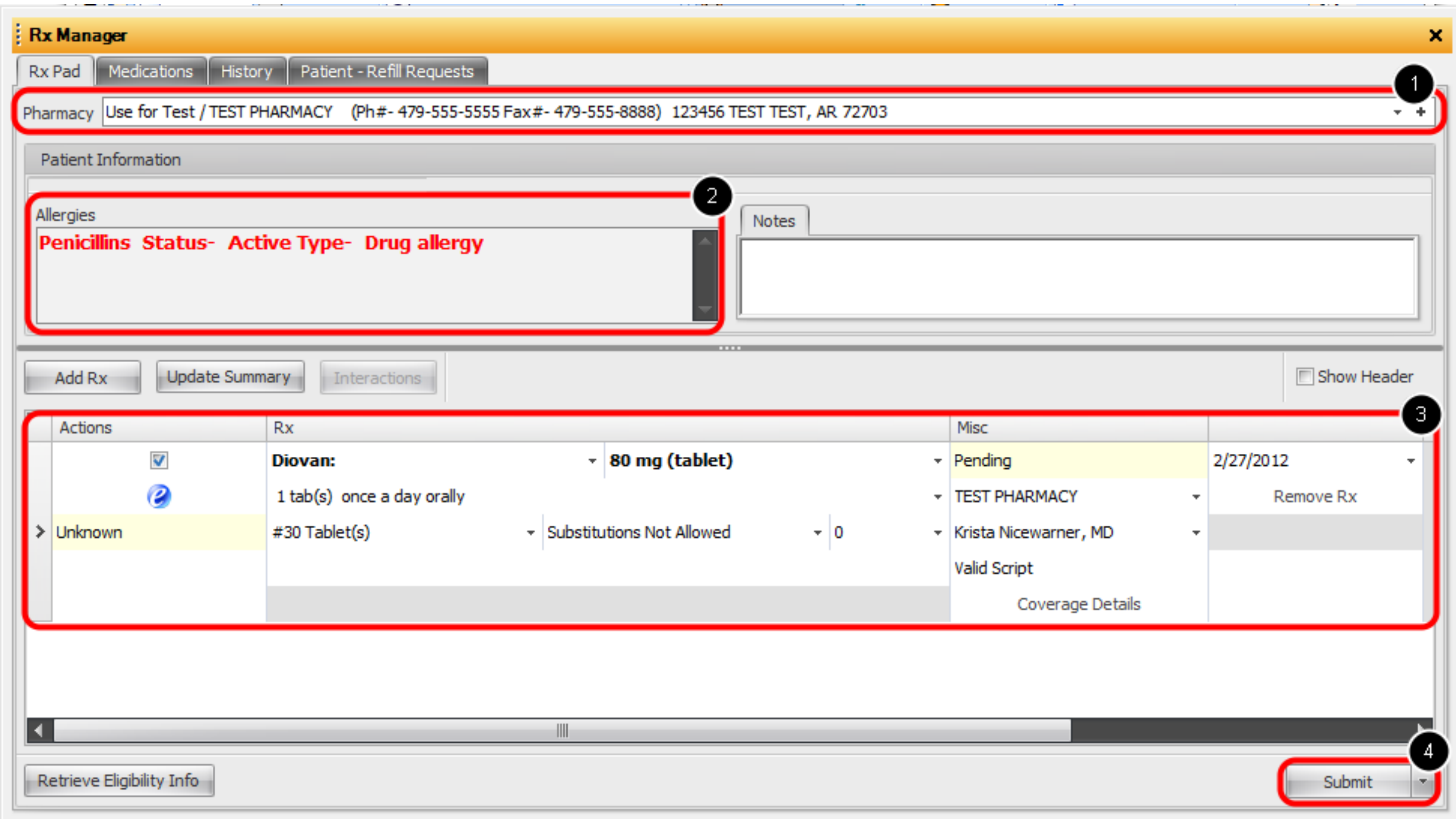


After entering the Medication, open the Rx Manager.

To open the Rx Manager the user can use any of the following methods:

- Hit **F8** on the keyboard.
- Right click on the Medications field, then select **Rx Manager**.
- Click **Docutainers** > **Rx Manager**.

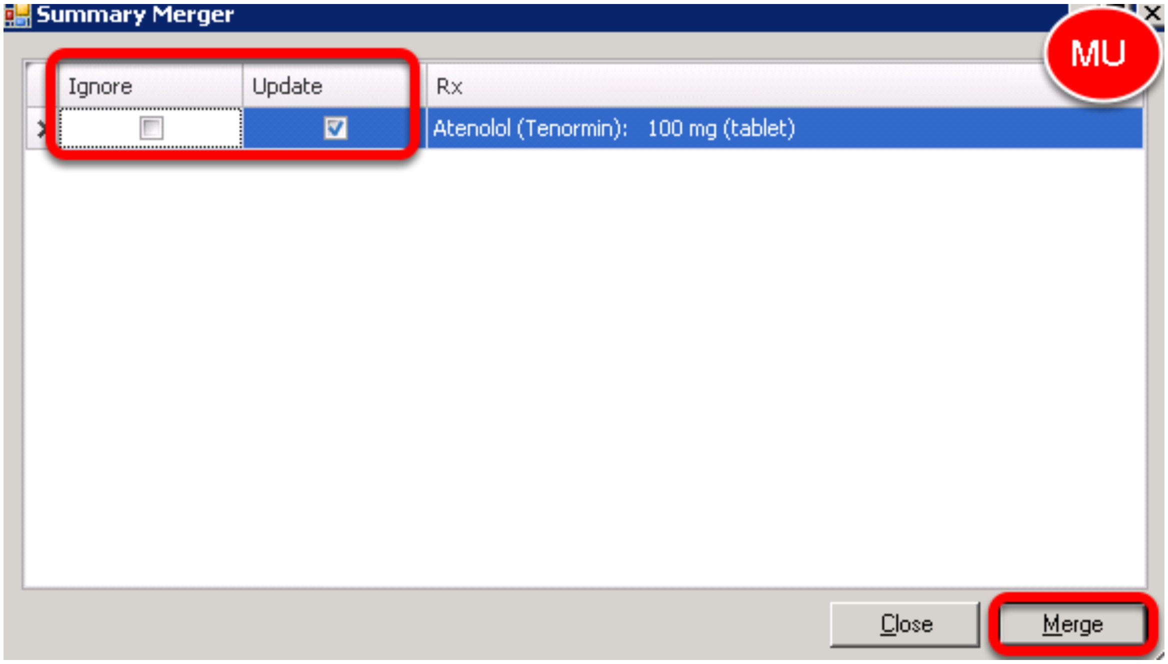
4. Verify the Pharmacy, Medication and Submit



With the Rx Manager open:

1. Select the desired pharmacy by using the drop-down menu.
2. Review the patient's allergies.
3. Verify the medication and make any necessary changes.
4. Click the Submit button to send the prescription to the pharmacy.

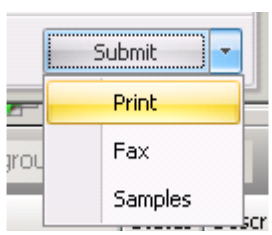
5. Update the Patient's Summary



After submitting a medication, the Summary Merger window will appear.

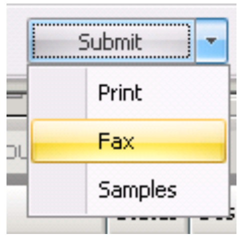
To update the patient's Summary Medications list with the newly prescribed medications, click the **Merge** button. If the user does not wish to update the patients Summary Medications list, the "Ignore" box for the medication can be selected.

Printing a Prescription from Rx Manager



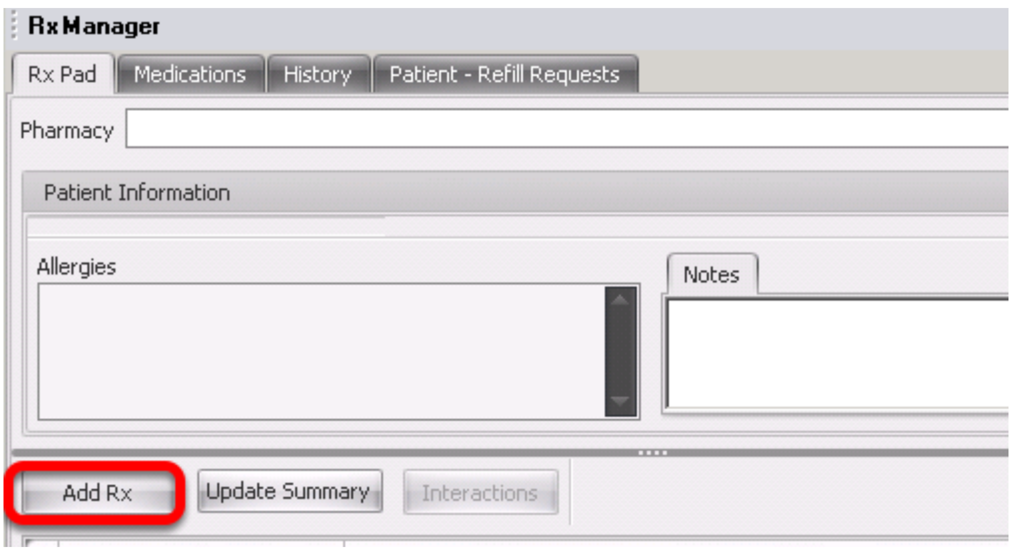
Click the drop-down arrow next to the Submit button and select **Print**.

Faxing a Prescription from Rx Manager

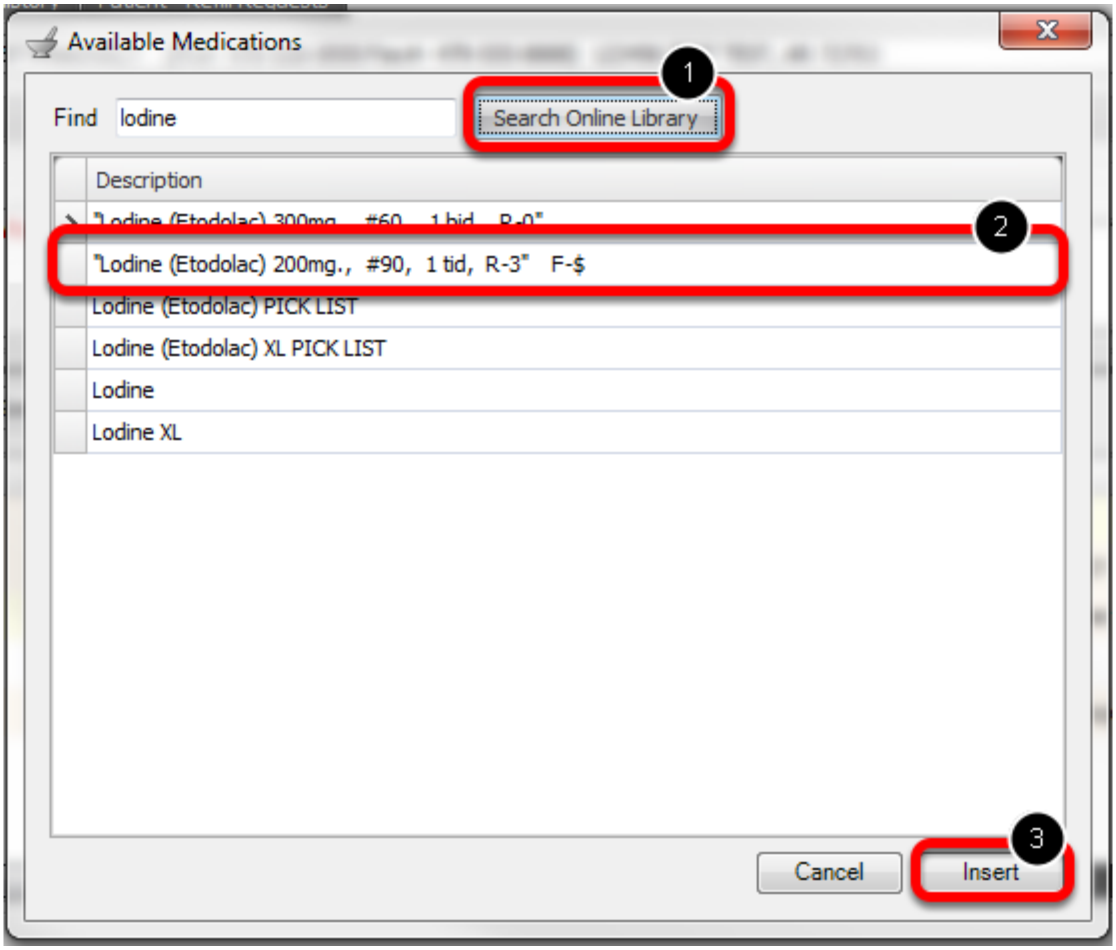


Click the drop-down arrow next to the Submit button and select **Fax**. To note that samples were given to a patient, select **Samples**.

Adding a Prescription in Rx Manager

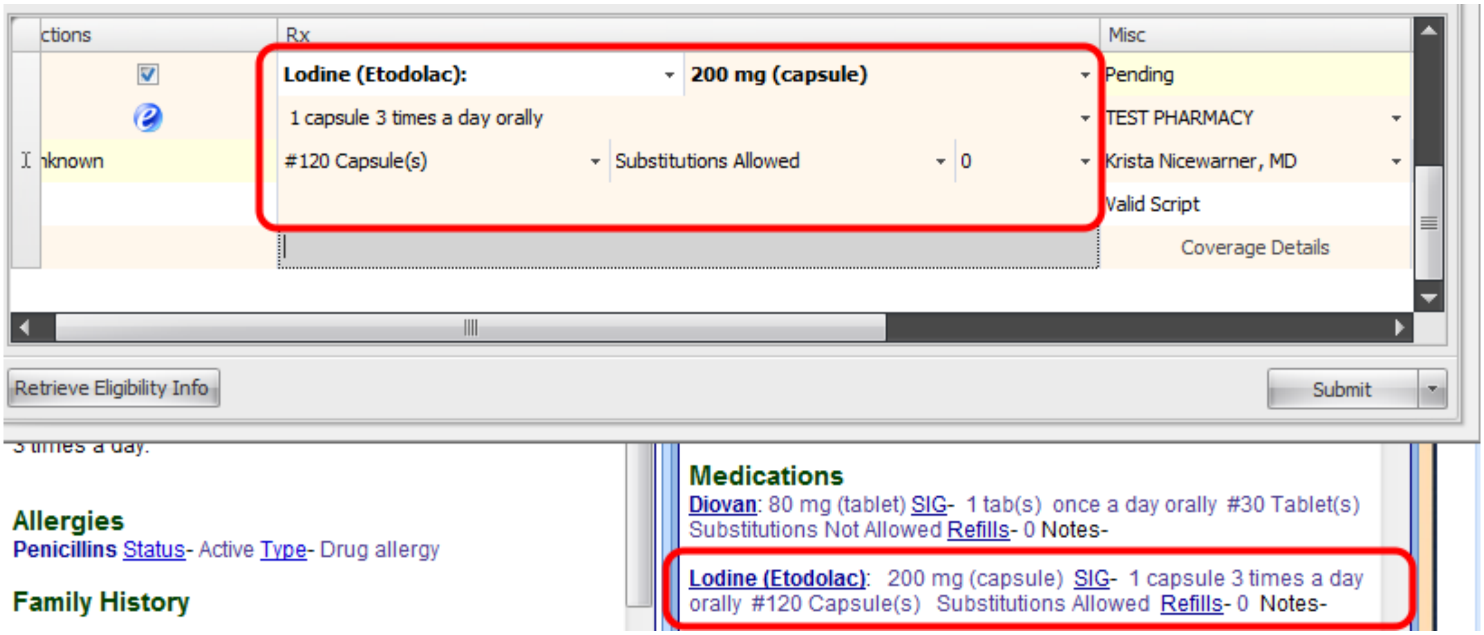


To add a new prescription from within the Rx Manager, Click the **Add Rx** button.



In the Find box, type the medication name to perform a search. This will reveal a list of medications that are on the users local library.

1. If you wish to search the SOAPware Online Library for additional search results, Click the **Search Online Library** button. A list will populate related to the entered medication.
2. Click to highlight the desired medication.
3. Click Insert to place on Rx Pad.



The new prescription will be placed on the Rx Pad and on the active SOAPnote.

Ohio Based ePrescribing Entities

Click on each of the following links for more information regarding Ohio Prescribing requirements:

- **Setting Up SOAPware for the Ohio Prescribing Requirements**
- **Printing and Faxing Ohio Prescriptions**
- **Prescriber Authentication Report**
- **Report Reminder System**

G-Codes for Medicare Electronic Prescribing Bonus

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.

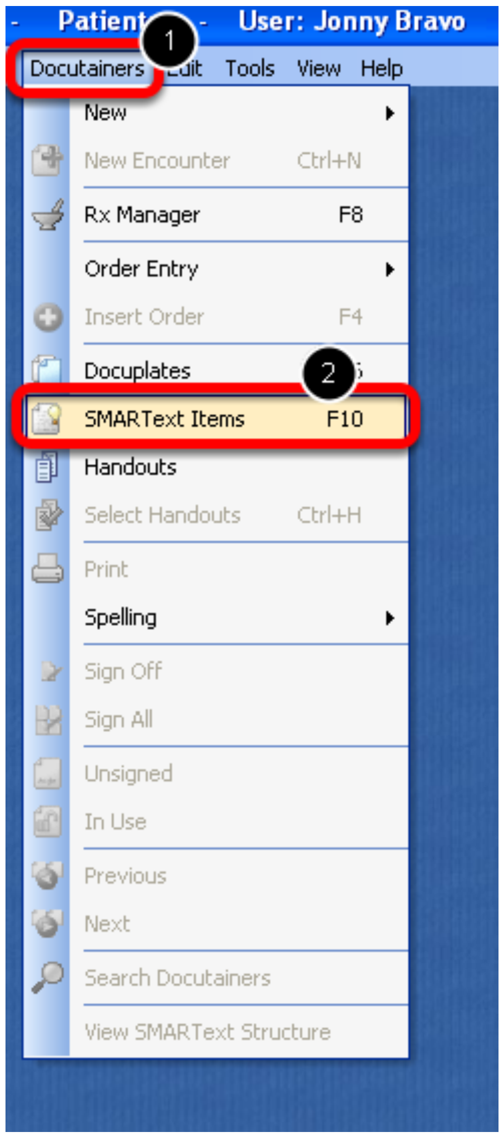
* (New Patient) 99201, 99202, 99203, 99204, 99205
* (Established Patient) 99211, 99212, 99213, 99214, 99215
* (Consultations) 99241, 99242, 99243, 99244, 99245
* (Psych Services) 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809
* (Behavioral Assessment) 96150, 96151, 96152
* (Screening & Diabetic Training) G0101, G0108, G0109.
* (Eye Codes) 92002, 92004, 92012, 92014

Creating SMARText Prescriptions for Durable Medical Supplies

Durable Medical Supplies can now be created as SMARText Items and **printed or faxed** from the Rx Manager.

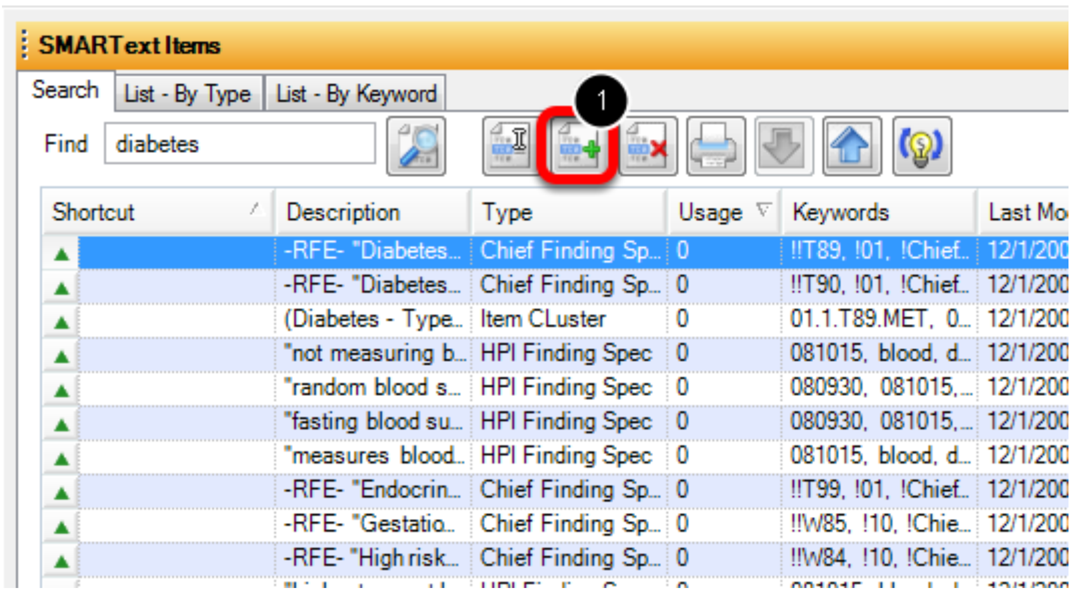
In this lesson we are going to create a prescription for Lancets.

Accessing the SMARText Items Manager

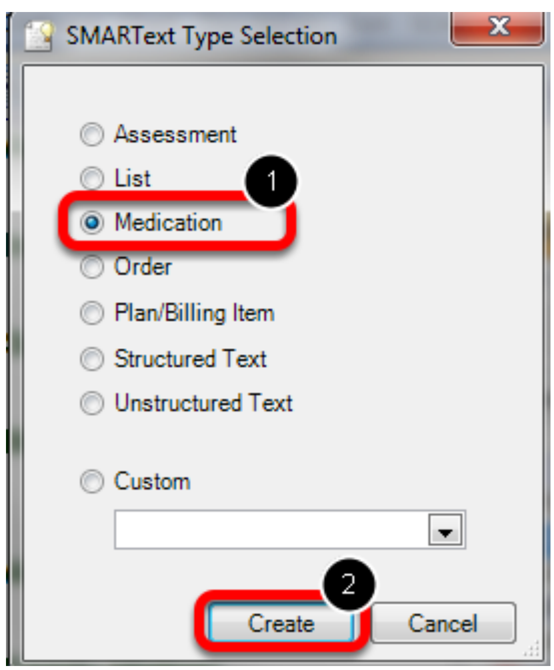


1. Click on **Docutainers** on the MenuBar.
2. Select on **SMARText Items**.

Creating a New Item

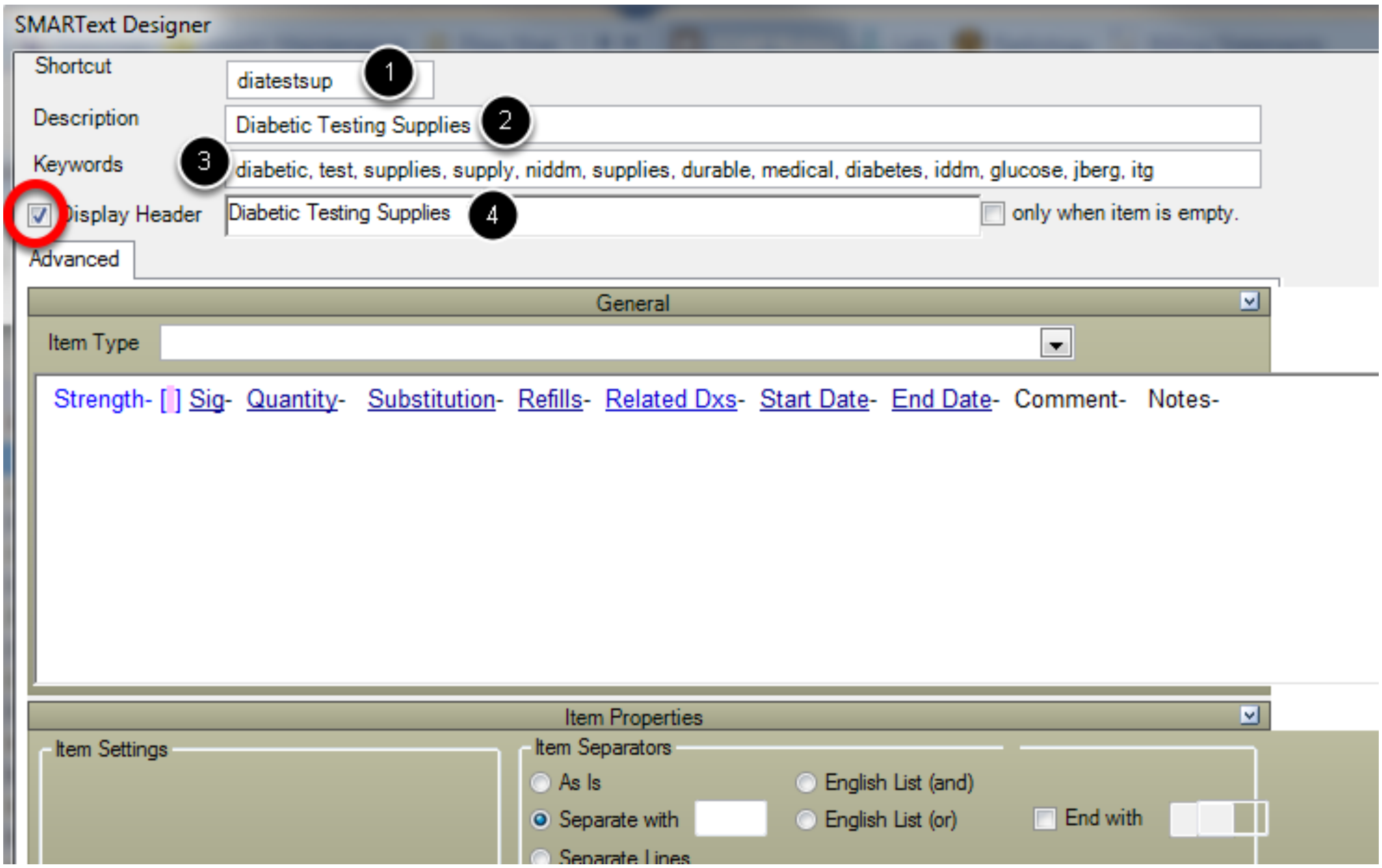


1. Click on the **Create** (green +) button to create a Medication Item.



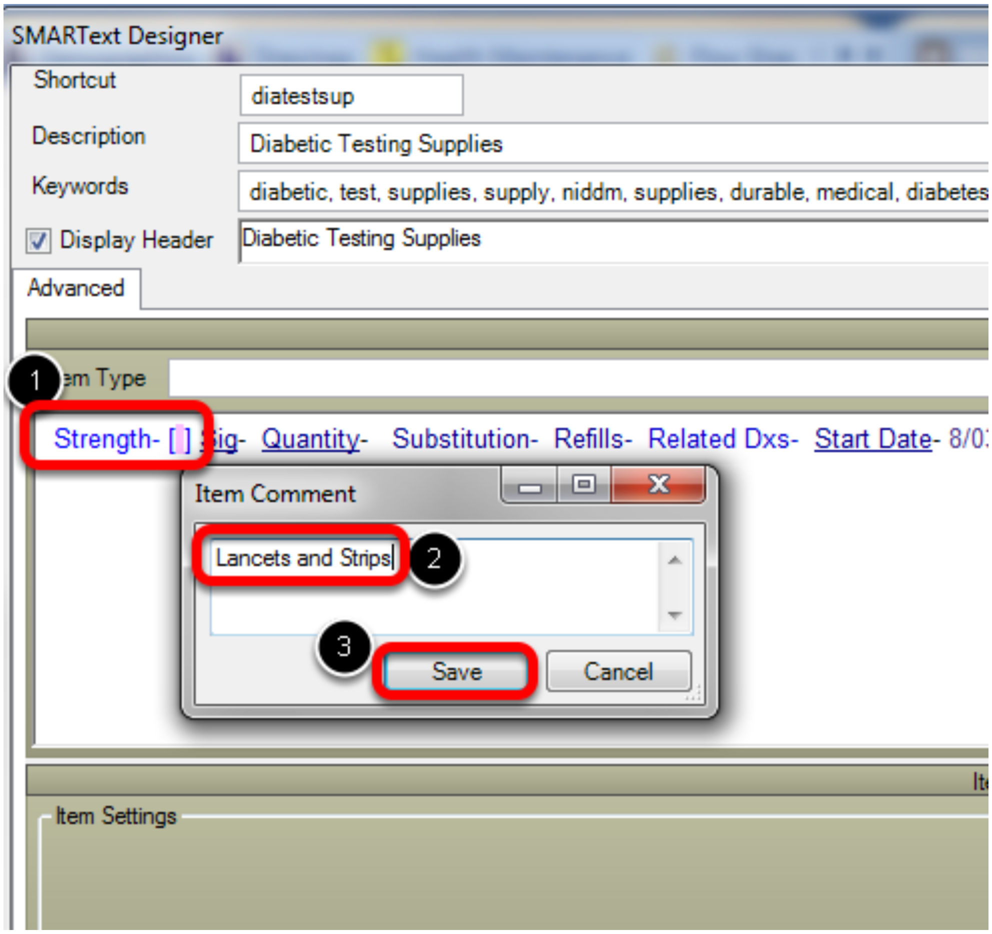
1. Select the **Medication** radio button.
2. Click **Create** button.

Note*: this should only be done when creating DME Items. Prescription medications should be duplicated and then edited. Please see: ***Creating SMARText Items in the SMARText Items Manager*.*



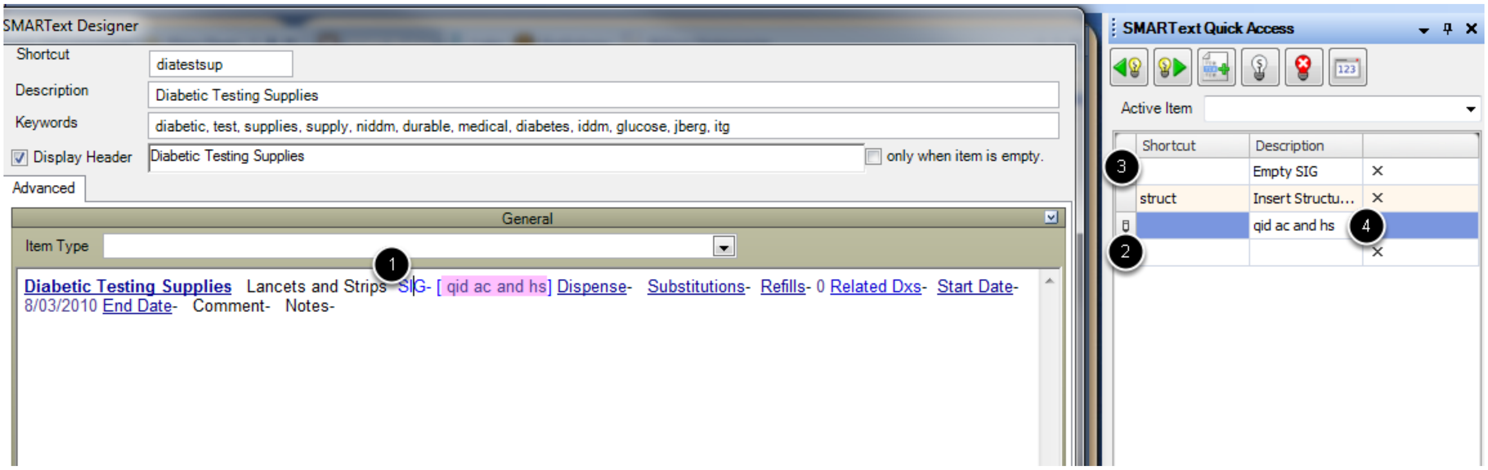
1. Enter a Shortcut.
2. Enter a Description.
3. Enter the Keywords.
4. Click the check box next to Display Header and enter "Diabetic Testing Supplies" (or your preferred display header).

Entering the Strength



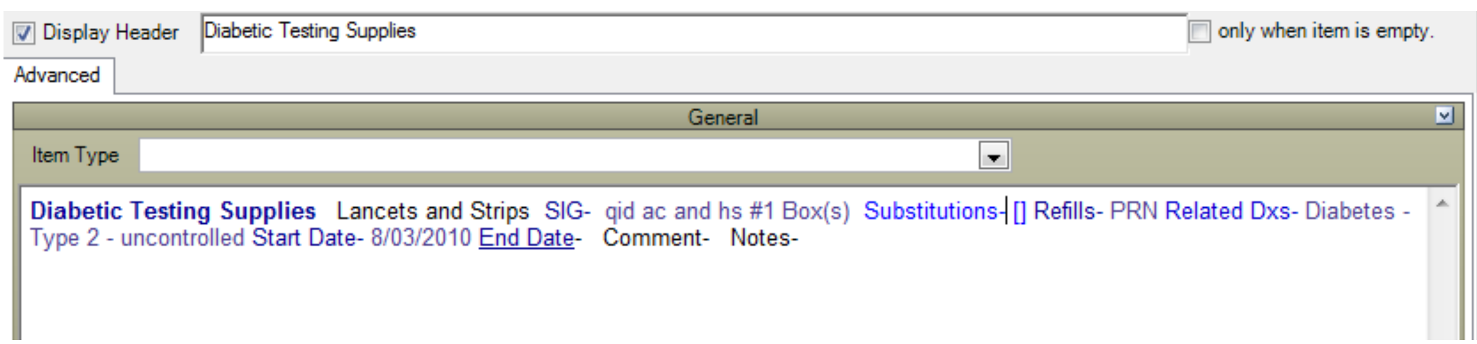
1. Left-click on Strength to bring up the Item Comment box.
2. Type in the Item Comment box "Lancets and Strips."
3. Click Save.

Entering the Sig



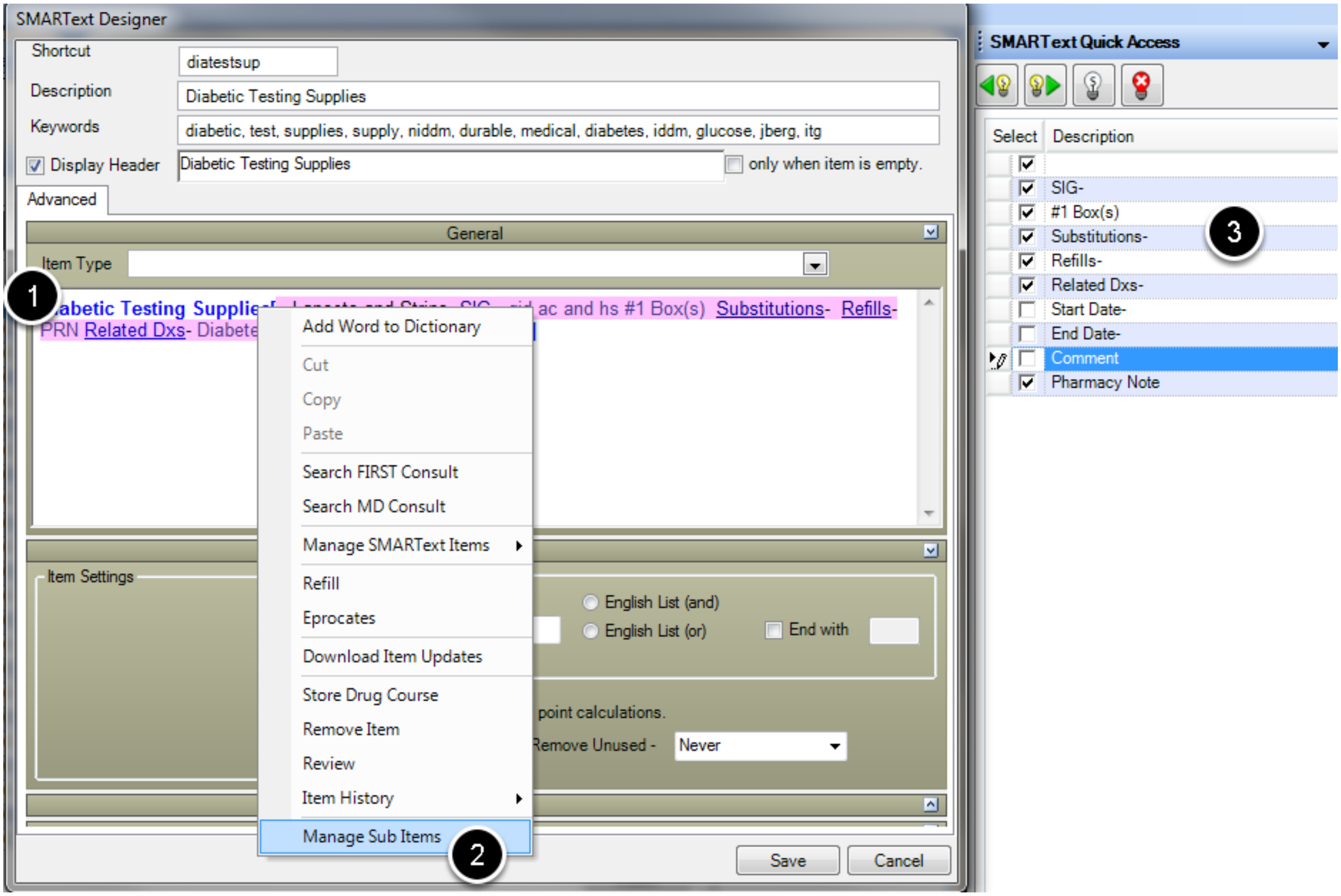
1. Click on the **SIG-** header.
2. Create a new Sig by clicking in the blank sig line in the SMART Quick Access and enter your preferred SIG.
3. Click on the Empty SIG line to save the newly created SIG.
4. Click on the SIG created to insert this into the SMARText item.

Fill out Remaining Items



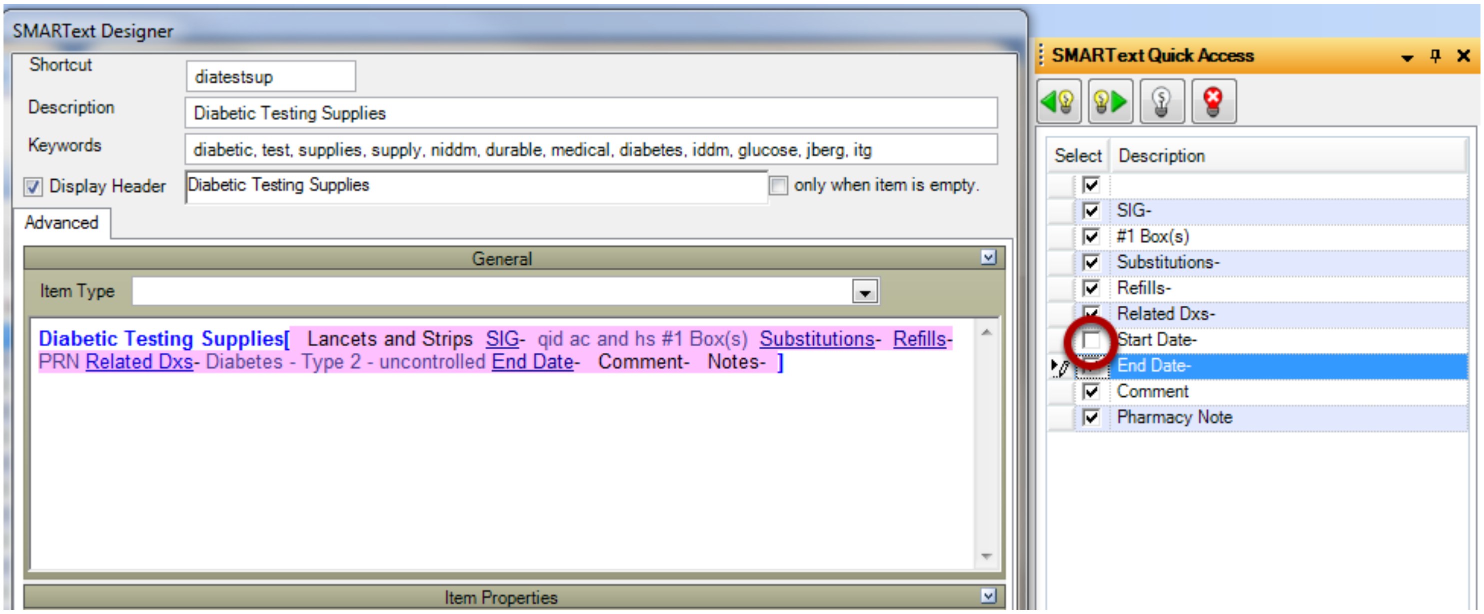
Fill in the Dispense number, Substitutions, and Refills by clicking on each item and selecting the appropriate option from the SMARText Quick Access window.

Removing Sub Items



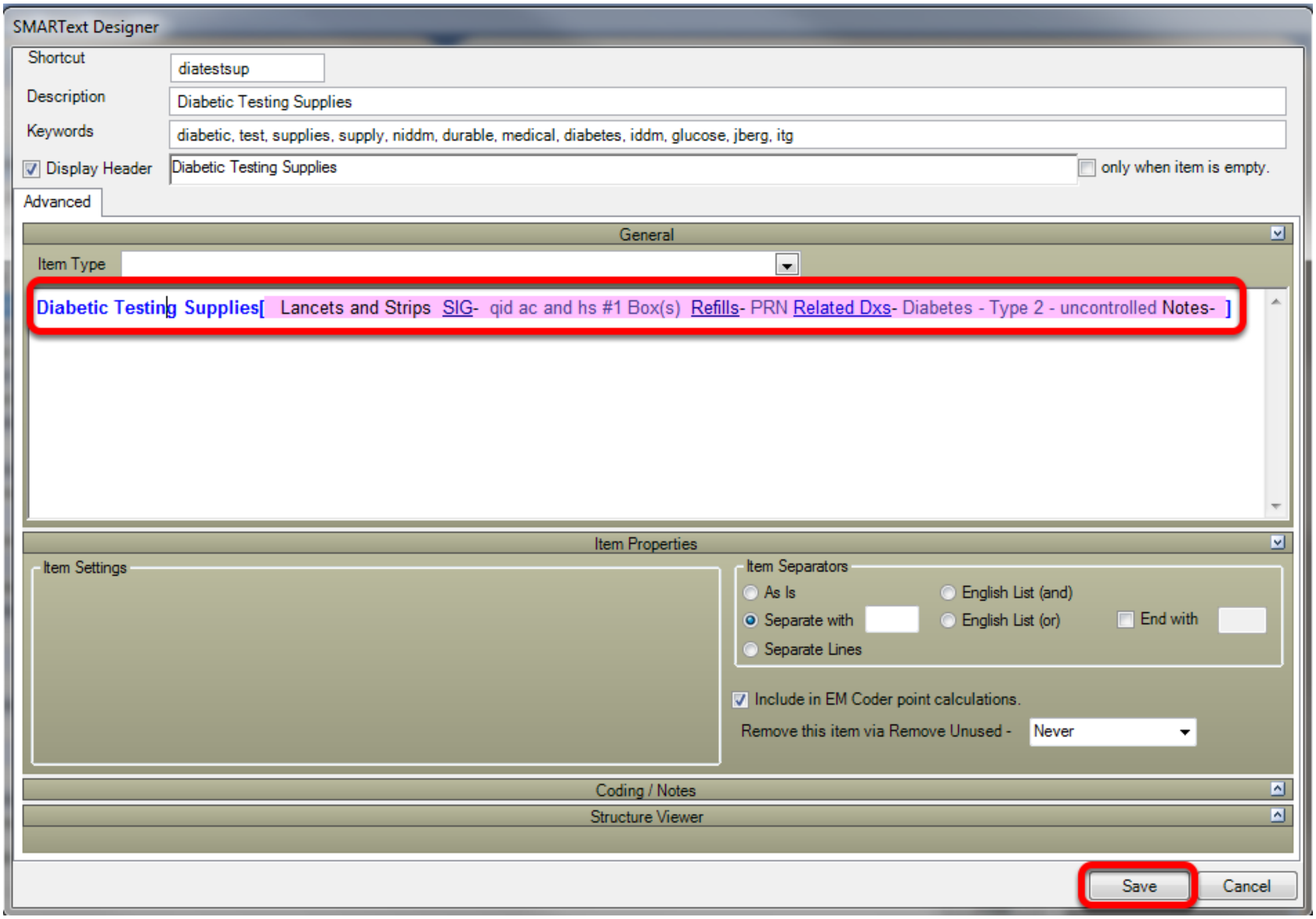
The SMARText item will have sub items associated with a medication.
 To remove the sub items not needed:

1. Right-click over the SMARText header.
2. Choose "Manage Sub items."
3. In the SMARText 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.

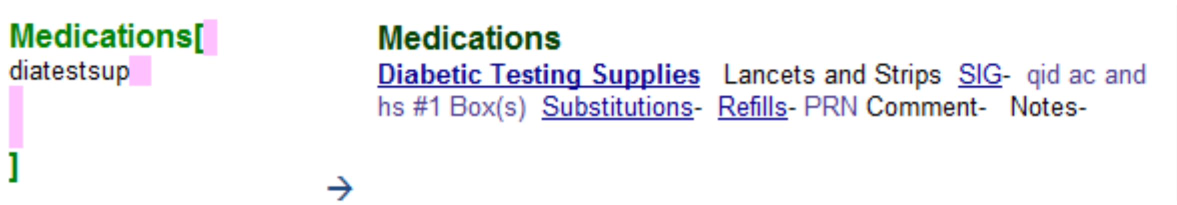
Saving the Item



Complete the item and ensure that the item looks as it should be prescribed.

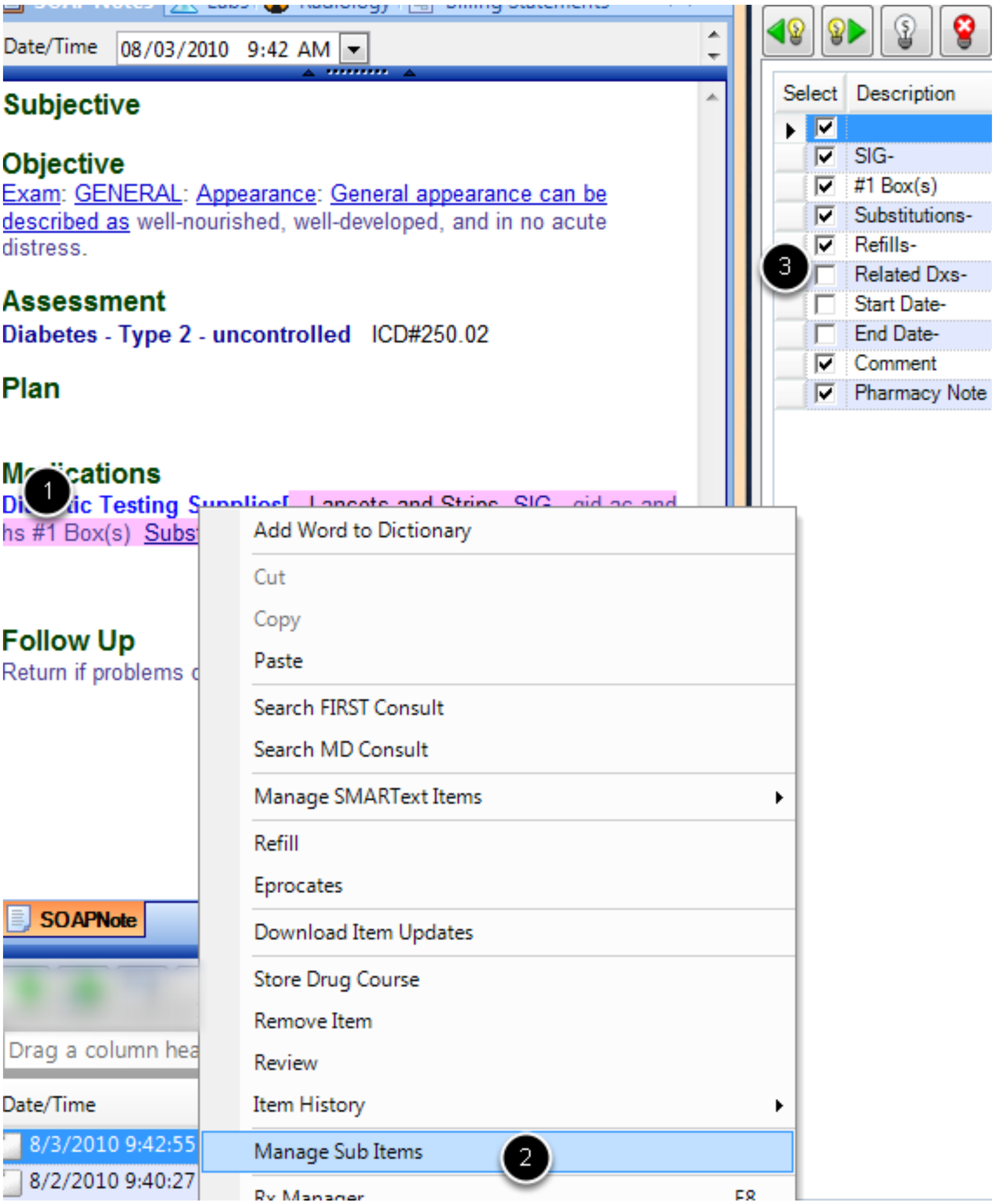
Click the **Save** button.

Inserting the Prescription into the Chart



In the Medication field of the SOAPnote, enter the shortcut, followed by the space bar.

Related Diagnosis



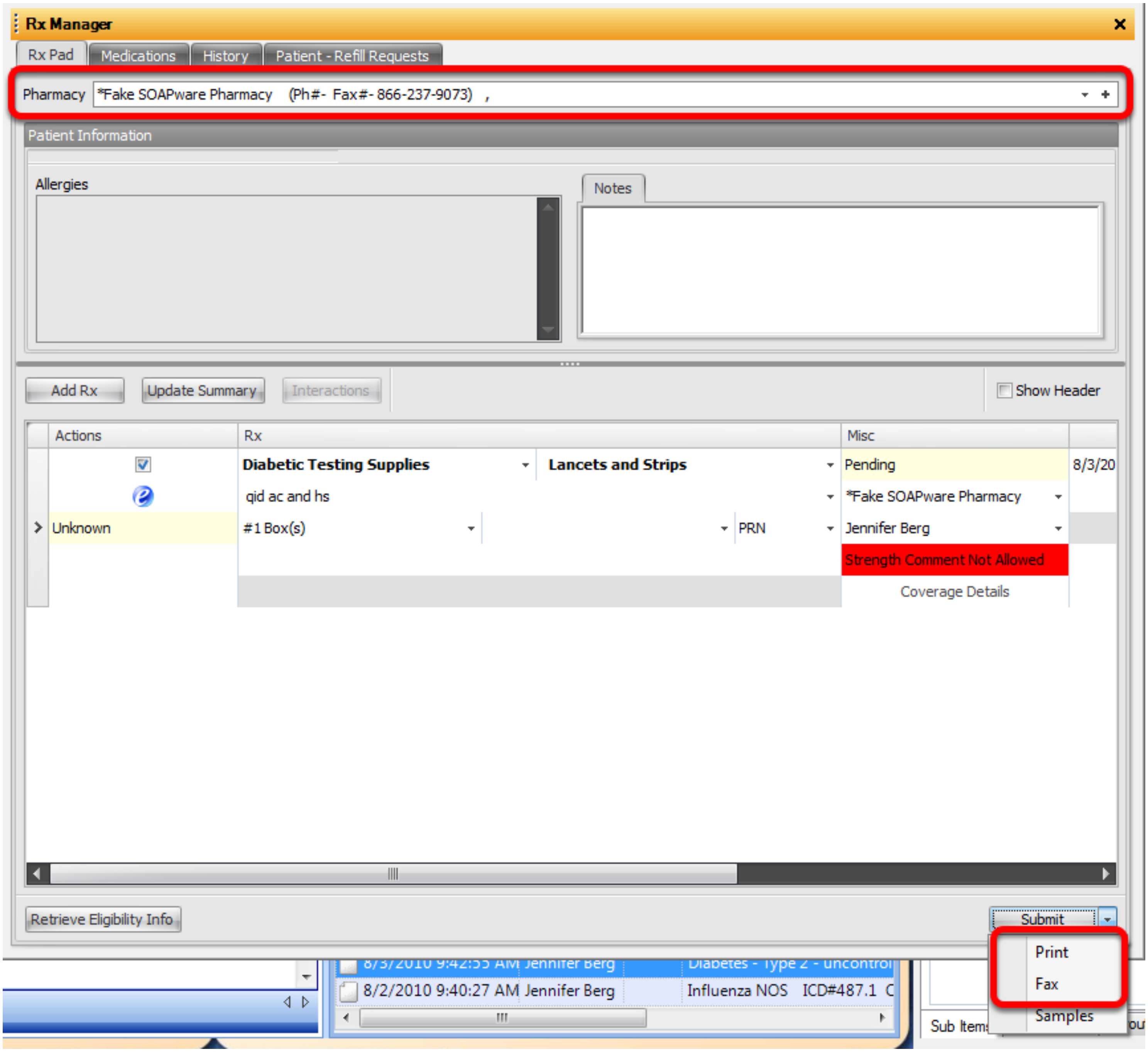
If the patient, insurance or pharmacy require a Related diagnosis:

1. Right-click on the Item Header.

2. Select "Manage Sub Items."
3. Check "Related Dxs" in the SMARText Quick Access.

***Note:** 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.*

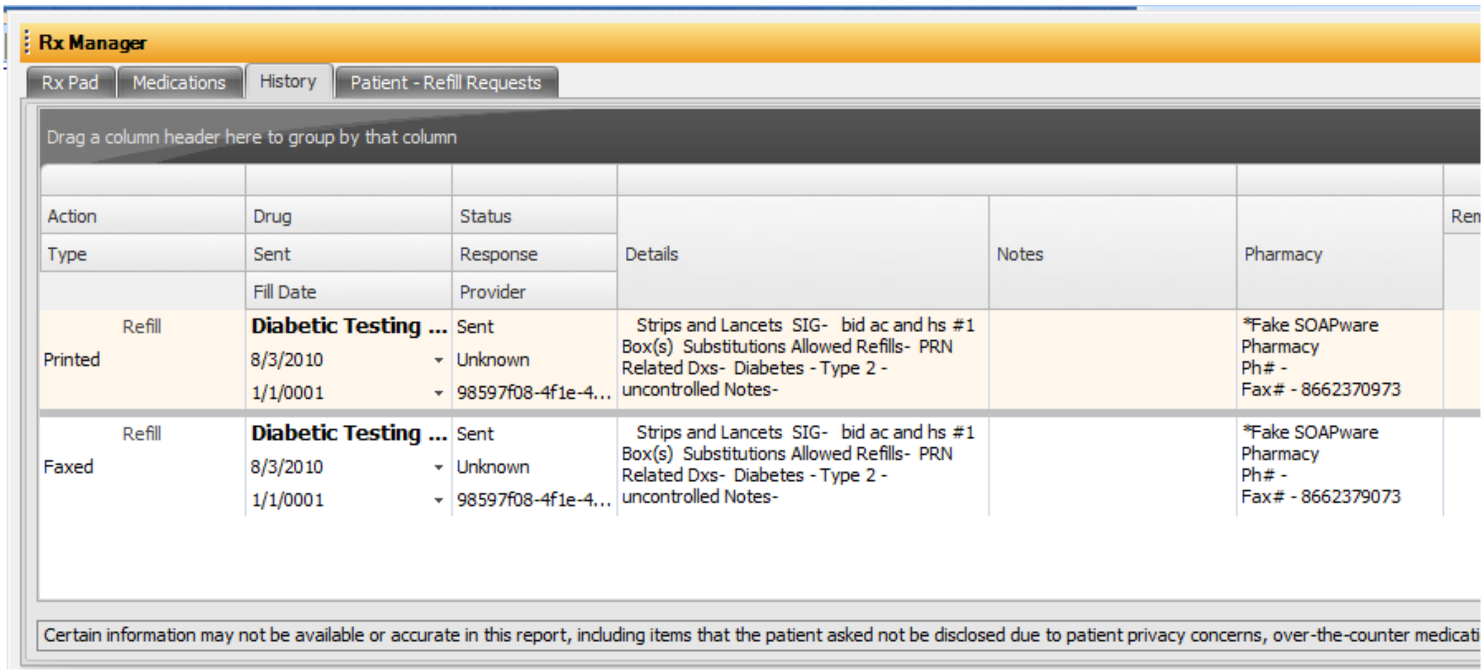
Printing or Faxing the Prescription



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



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.

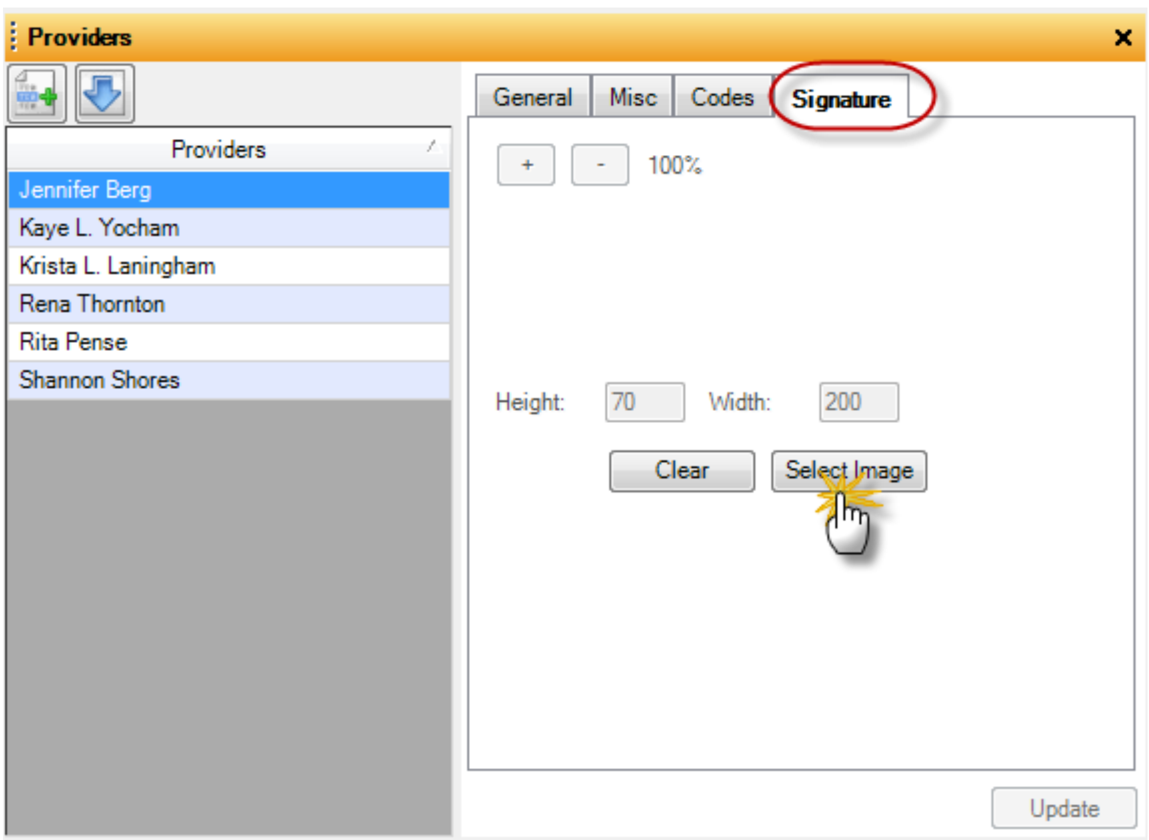
Faxing and Printing from Rx Manager

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**

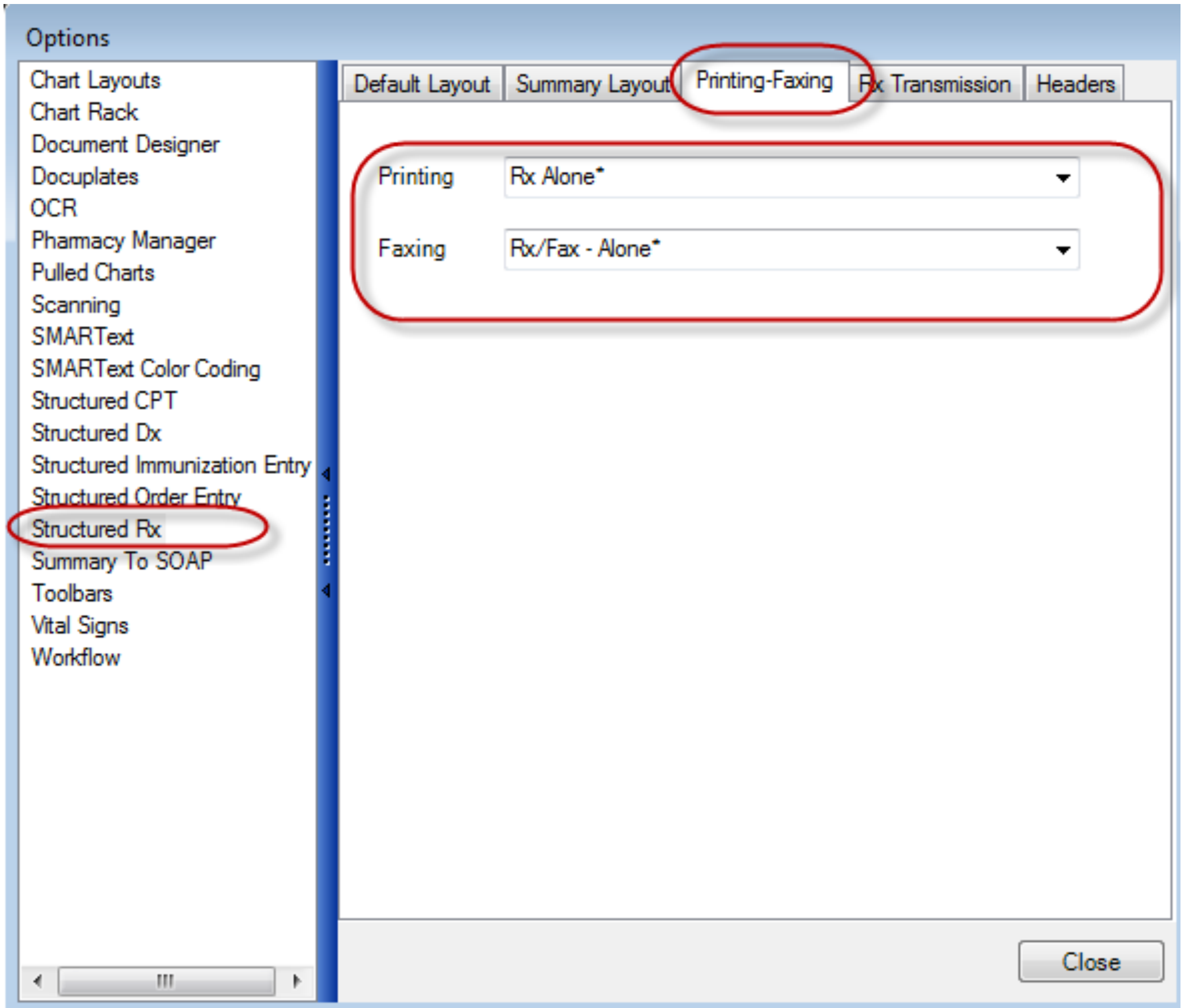
- ePrescribing (eRx)
- CPOE for Medication Orders

Store the provider's signature in SOAPware.



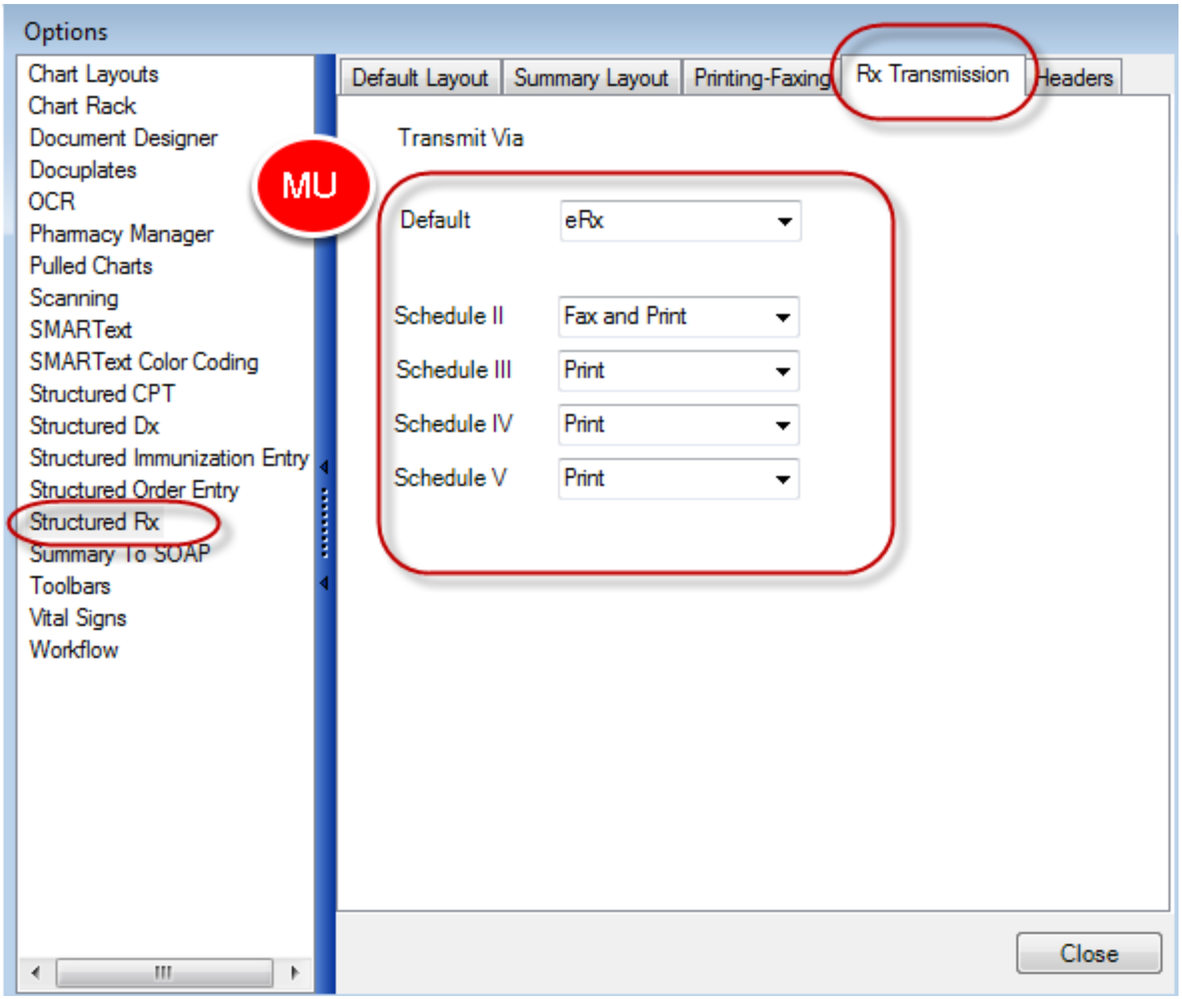
Prescriptions that will be faxed from SOAPware will need to have the provider's signature on the document design. The first step is to store the provider's signature in the Provider Manager. For more information, see: Provider Manager.

Setting the Document Designs



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



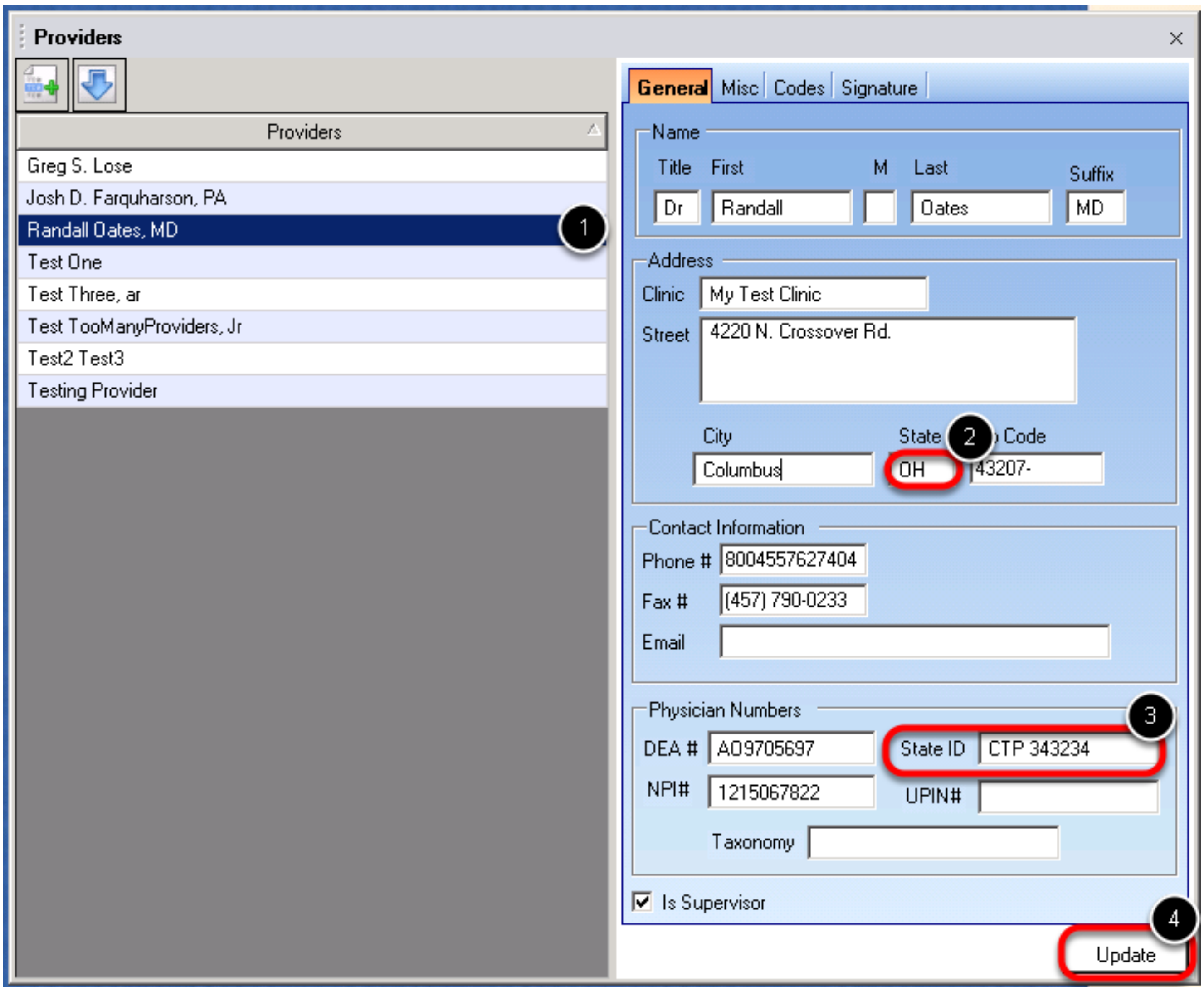
Within the Rx Manager, SOAPware has the ability to perform multiple actions when the submit button is clicked based on each user's personalized preferences. This is set under Tools > Options. With this example all non-scheduled medications will be ePrescribed to the pharmacy, scheduled II medications 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.

Ohio Prescribing Requirements

Setting Up SOAPware for the Ohio Prescribing Requirements

For further information on the Ohio Prescribing requirements, please contact the Ohio Board of Pharmacy, or refer to the following Ohio Administrative Codes: OAC 4729-5-01(N) and OAC 4729-5-30.

Provider Manager Setup

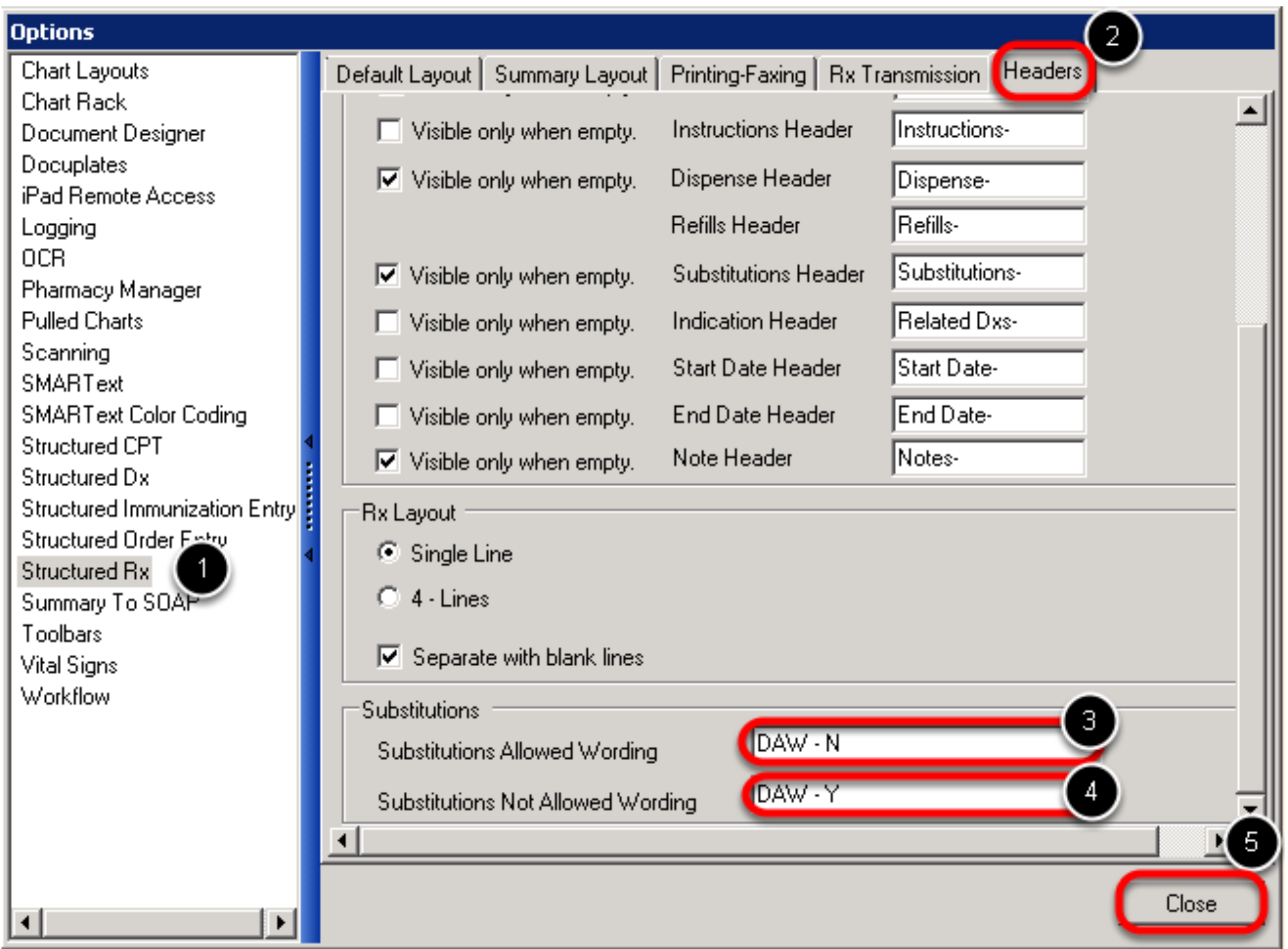


To meet the requirements of the Ohio State Board, additional data must be entered in Provider Manager.

1. Click on **Tools** > **Provider Manager**, then click to highlight the name of the the clinician.
2. Ensure that every provider practicing in the state of Ohio has OH listed in the State field.
3. If the provider has a CTP number, it needs to be entered in the State ID field.
4. Whenever data is changed or entered for the first time, click the **Update button** to save changes.
5. Repeat these steps for each clinician listed in Provider Manager.

****Note**: This is a system-wide setting which only needs to be performed on one computer in the clinic.*

Structured Rx Setup



Prescriptions that are faxed must have specific wording to indicate whether or not to allow substitutions.

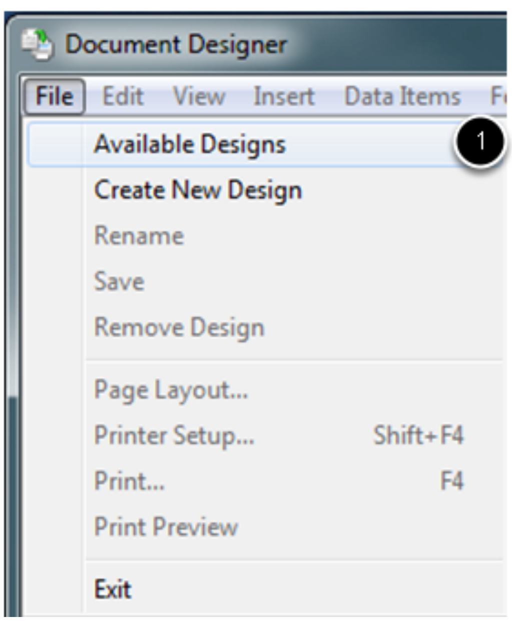
1. Go to **Tools** > **Options** and click on **Structured Rx**.
2. Click the **Headers** tab and scroll down to the bottom of the window.
3. In the box next to Substitutions Allowed Wording type **DAW - N**.
4. In the box next to Substitutions Not Allowed Wording type **DAW - Y**.
5. Click **Close** then log out and log back in for this change to take effect.
6. These steps should be repeated under the login of every user who will utilize Rx Manger. This is a user and computer-specifc setting which needs to be performed on every computer used for prescribing.

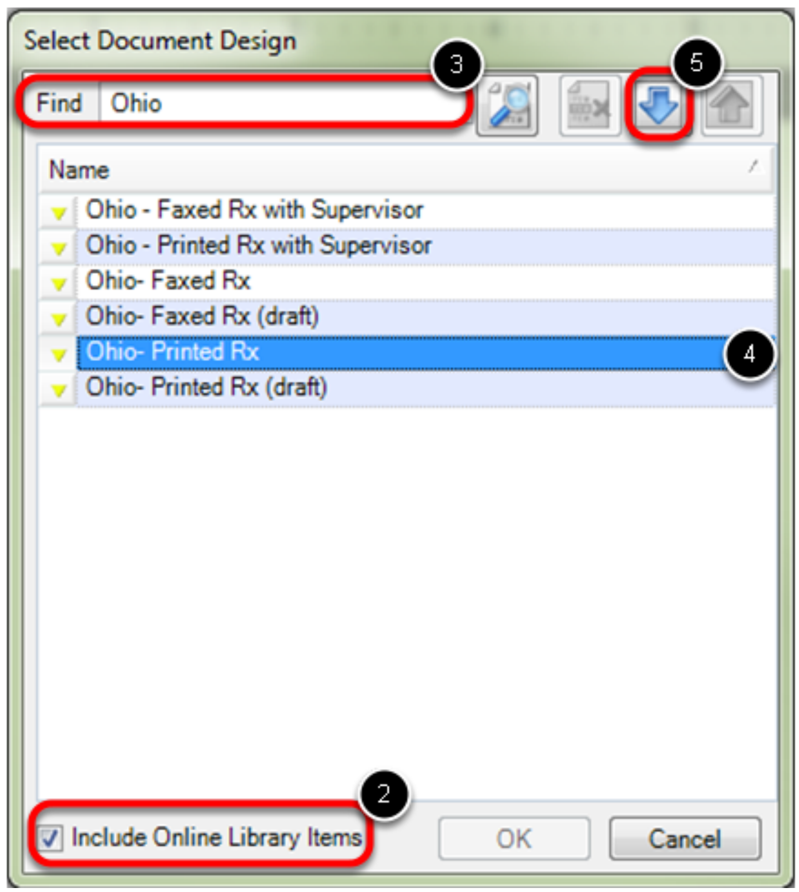
Printing and Faxing Ohio Prescriptions

To comply with the requirements of the Ohio State Board of Pharmacy, all prescriptions must be printed, faxed, or ePrescribed through Rx Manager.

For further information on the Ohio Prescribing Requirements, please contact the Ohio Board of Pharmacy, or refer to the following Ohio Administrative Codes: OAC 4729-5-01(N) and OAC 4729-5-30.

Download Ohio Rx Designs





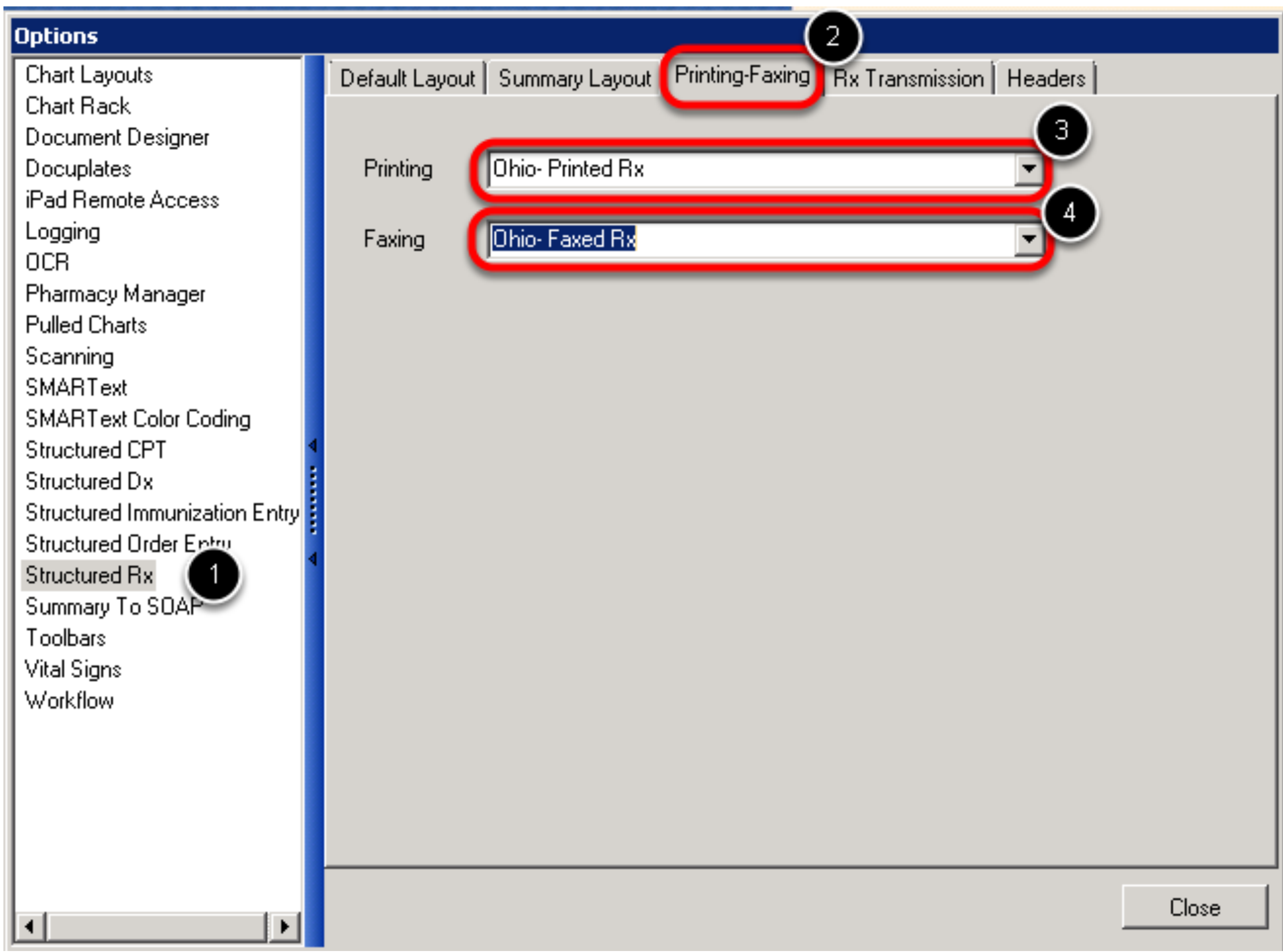
To meet the requirements of the Ohio Board of Pharmacy, users will need to first download document designs created specifically for Ohio prescribers.

1. Click on **Tools** > **Document Designer**, then choose **File** > **Available Designs**.

2. Check the box next to Include Online Library Items.
3. In the Find box type **Ohio** and press the **Enter** key.
4. Click to highlight **Ohio - Printed Rx**.
5. Click the **blue arrow** to download and repeat steps 4 & 5 for Ohio - Faxed Rx.

****Note** : If you are a mid-level prescriber who requires a supervising signature on prescriptions, you will need to download both the Ohio-Faxed Rx with Supervisor and Ohio Printed Rx with Supervisor designs.*

Rx Printing/Faxing Setup



Each user who will be utilizing Rx Manager needs to set it up so that these designs will be printed or faxed when certain prescriptions are submitted.

1. Click on **Tools** > **Options**, then click to highlight **Structured Rx**.
2. Click on the **Printing-Faxing** tab.
3. From the drop down menu for Printing, choose **Ohio-Printed Rx**.
4. From the drop down menu for Faxing choose **Ohio-Faxed Rx**.
5. These steps should be repeated under the login of every user who will utilize Rx Manger. This is a user and computer-specifc setting which needs to be performed on every computer used for prescribing.

***Note** : If you are a mid-level prescriber who requires a supervising signature on prescriptions, choose the Ohio designs that include "with Supervisor."*

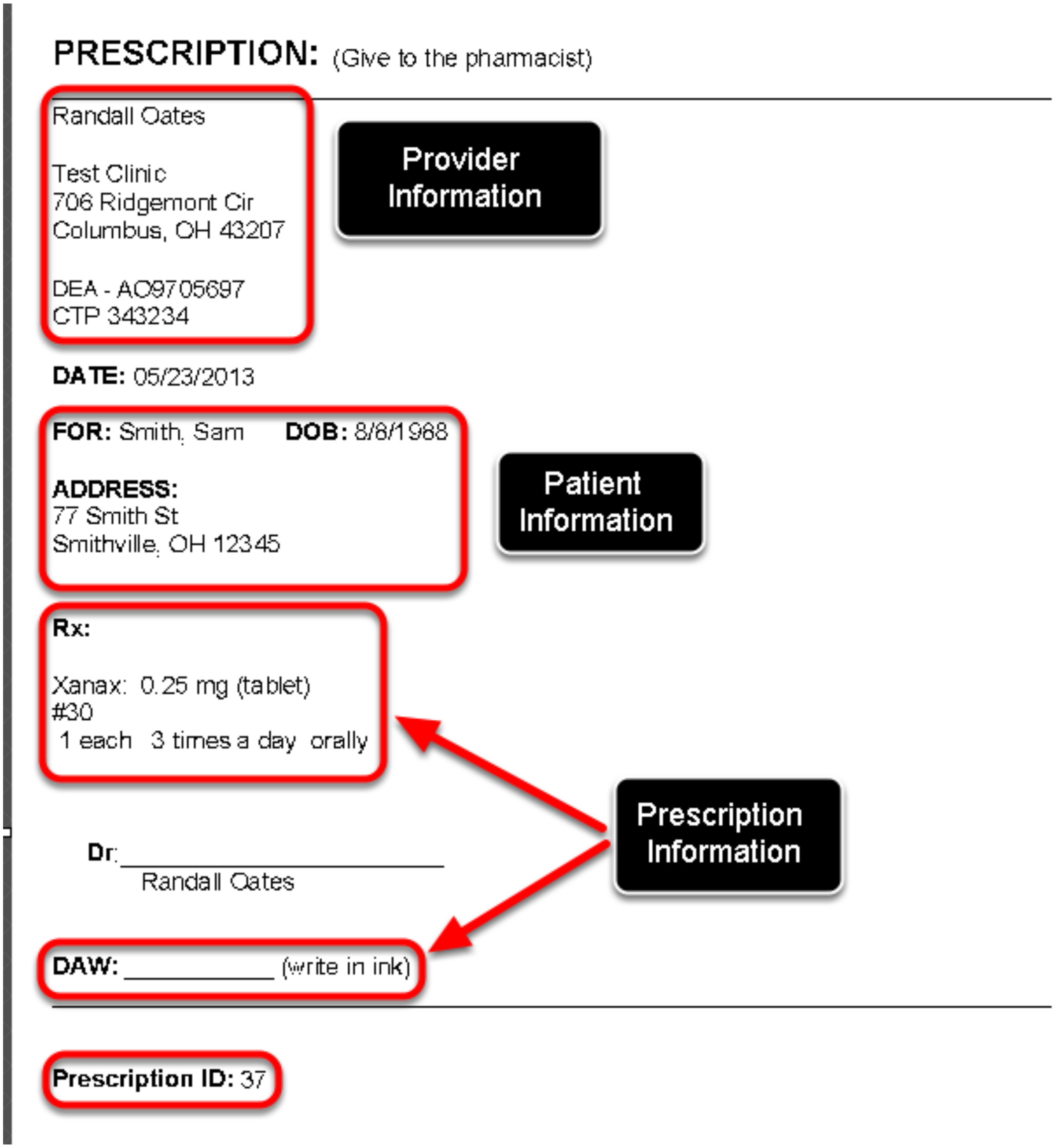
Quantity and DAW Requirements for Printed Prescriptions

- **On printed prescriptions for controlled medications, the quantity *must also be written in words.***

***Note:** This process will be automated in future versions of SOAPware.*

- Next to DAW, write the letter Y in ink if substitutions are *not* allowed, meaning the pharmacy must dispense as written.
- Next to DAW, write the letter N in ink if substitutions *are* allowed, meaning the pharmacy does not need to dispense as written.

Printed Rx Designs for Ohio


PRESCRIPTION: (Give to the pharmacist)

Randall Oates

Test Clinic
706 Ridgemont Cir
Columbus, OH 43207

DEA - AO9705697
CTP 343234

DATE: 05/23/2013

FOR: Smith, Sam **DOB:** 8/8/1988

ADDRESS:
77 Smith St
Smithville, OH 12345

Rx:

Xanax: 0.25 mg (tablet)
#30
1 each 3 times a day orally

Dr: ____________________
Randall Oates

DAW: __________ (write in ink)

Prescription ID: 37

Required items to be included on Ohio prescriptions:

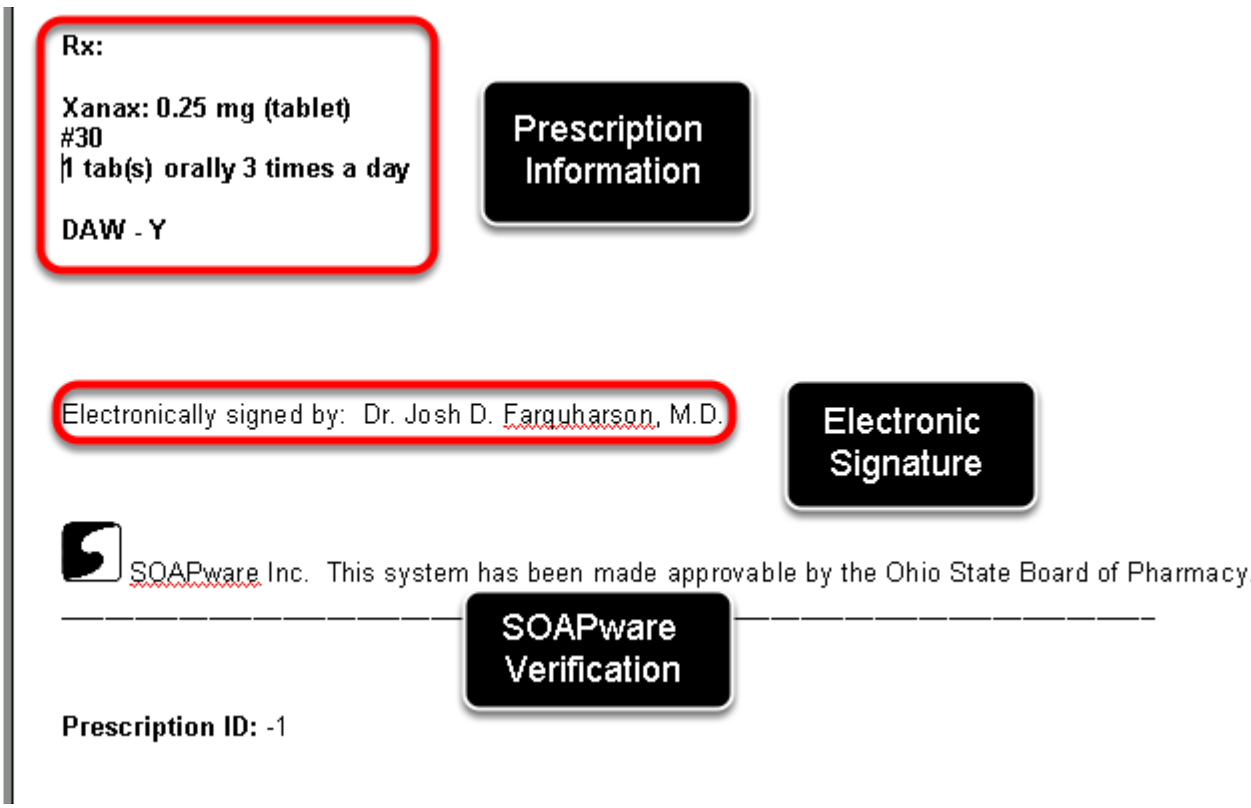
- **Provider ID Information:** contains name, address, DEA, and CTP numbers.
- **Patient Information:** contains name, date of birth, and address.
- **Prescription information:** printed on 4 lines, with the first line containing drug name and

strength, the second line containing quantity, the third line containing the SIG, and the fourth line containing DAW.

***Note :** The blank next to DAW must be filled in with ink. Y indicates that the Rx should be dispensed as written, and N indicates that substitutions are allowed.*

- **Prescription ID:** Every Rx that is printed, faxed, or ePrescribed through Rx Manager will contain a unique Prescription ID number.
- **On printed prescriptions for controlled medications, the quantity *must also be written in words.*** ***Note:** This process will be automated in future versions of SOAPware.*

Faxed Rx Designs for Ohio



The same required items will appear on prescriptions that are electronically faxed with only a few changes:

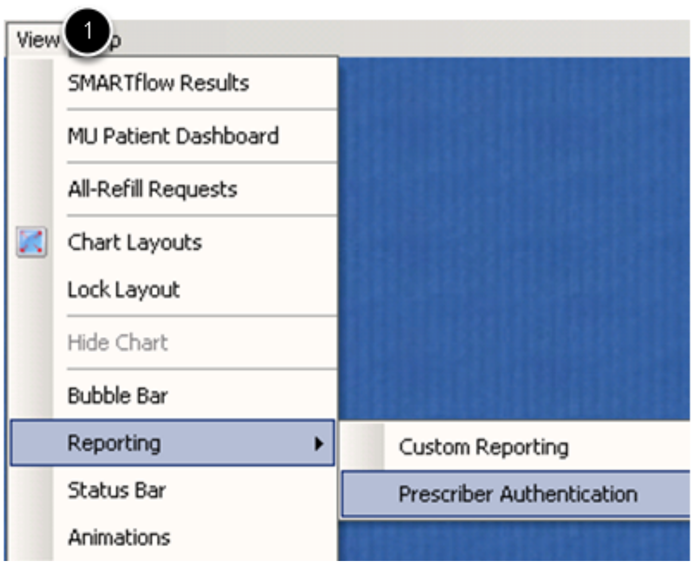
- **Prescription Information:** The substitution item has been added to the faxed Rx.
- **Electronic Signature:** The faxed Rx will not have a wet signature.
- **SOAPware Verification:** This has been added to verify the Rx was sent from a system certified by the Ohio State Board.

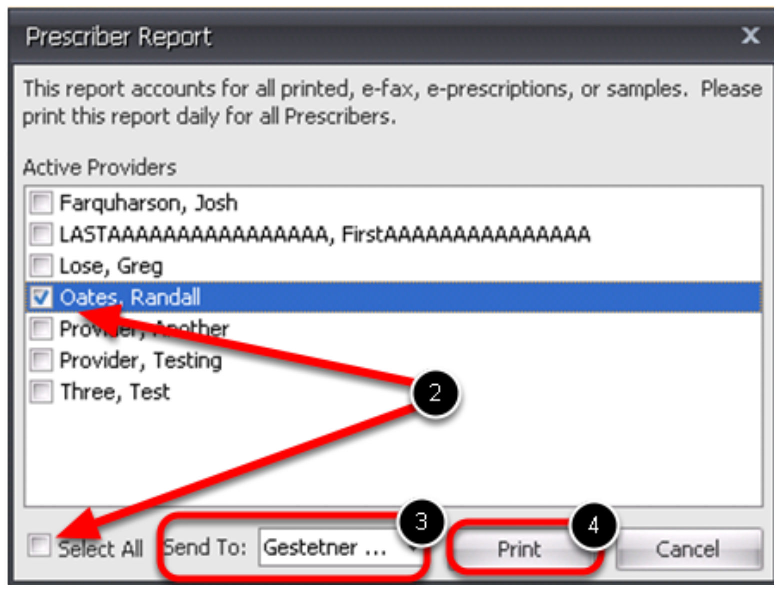
****Note** : The image above is only a print preview of the Ohio - Faxed Rx design. When prescriptions are faxed or printed through available document designs rather than Rx Manager, the **Prescription ID** will be null and the Rx will **not** be included in the Prescriber Authentication Report.*

Prescriber Authentication Report

For further information on the Ohio Prescribing Requirements, please contact the Ohio Board of Pharmacy, or refer to the following Ohio Administrative Codes: OAC 4729-5-01(N) and OAC 4729-5-30.

Print the Prescriber Authentication Report





The Presciber Authentication Report provides a list of all medications that were printed, e-faxed, ePrescribed, or that were given as samples. The first time this report is printed, it will account for all prescriptions given through Rx Manager since the update to SOAPware 2012.0.8xxx. Each subsequent report will list all prescriptions since the last report was printed. SOAPware recommends printing this report on a daily basis, so if the user follows this recommendation, each report will have a time frame from one business day to the next.

1. Click **View** > **Reporting** > **Prescriber Authentication**.
2. A user may select one provider's report to print, or select all to print a separate report for each provider at the same time.
3. Choose the printer where the report will be printed.
4. Click **Print.**

Prescriber Authentication Report for Randall Oates
Time Frame of Report (Begin Date/Time: 5/21/2013 8:29:38 AM)
Time Frame of Report (End Date/Time: 5/24/2013 10:19:06 AM)
** This report accounts for all printed, e-fax, e-prescriptions, or samples for this prescriber and Date/Time period **

Patient	Prescription	Type	Status	Refill(s)	User	Notes
Smith, Sam	Azithromycin (Zithromax or Z-pak): 250 mg (tablet) SIG- 2 each the first day, then 1 daily once a day orally #6 Substitutions Allowed Refills- 0 Notes- "Z-pak"	Non-Controlled	Printed	0	Group, Trainers	
Jackson, Jack	Xanax: 0.5 mg (tablet) SIG- 1 each 3 times a day orally #30 Substitutions Allowed Refills- 0 Notes-	Controlled	Printed	0	Group, Trainers	
Terry, Test	Lisinopril (Prinivil, Zestril): 5 mg (tablet) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 0 Notes-	Non-Controlled	Printed	0	Group, Trainers	
Terry, Test	Micardis: 20 mg (tablet) SIG- 1 each once a day orally #30 Substitutions- Refills- 0 Notes-	Non-Controlled	Printed	0	Group, Trainers	
Smith, Sam	Xanax: 0.25 mg (tablet) SIG- 1 each 3 times a day orally #30 Substitutions Allowed Refills- 0 Notes-	Controlled	Printed	0	Group, Trainers	

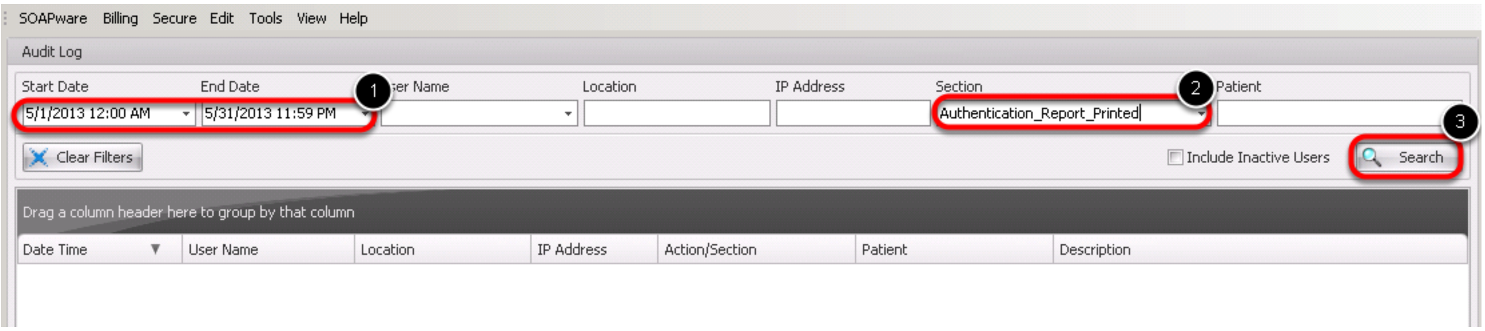
- **Header:** Every page of the authentication report will include the provider's name and the date range of the report. ***Note** : Each time this report is generated, it will list all prescriptions sent since the last prescriber authentication report was printed for that provider.*
- **Patient:** The first column lists all the patients who received prescriptions during the date range.
- **Prescription:** The second column lists all medications that were prescribed during the date range.
- **Type:** The third column displays if each medication is controlled or not.
- **Status:** This column displays how each prescription was sent. In the example above, all were printed, but the other statuses that will display are Faxed, eRx Sent, and Sample Given.
- **Refills:** This column shows the number of refills that were sent with the original prescription.
- **User:** This column shows the name of the user who actually submitted the prescription in SOAPware.
- **Notes:** This column will display any notes that were sent to the pharmacy for each medication.

Signing the Report

Signature of Prescriber:_______________________________
Date of Signature:__________________
By signing, I acknowledge and attest to the review and accuracy of this report.

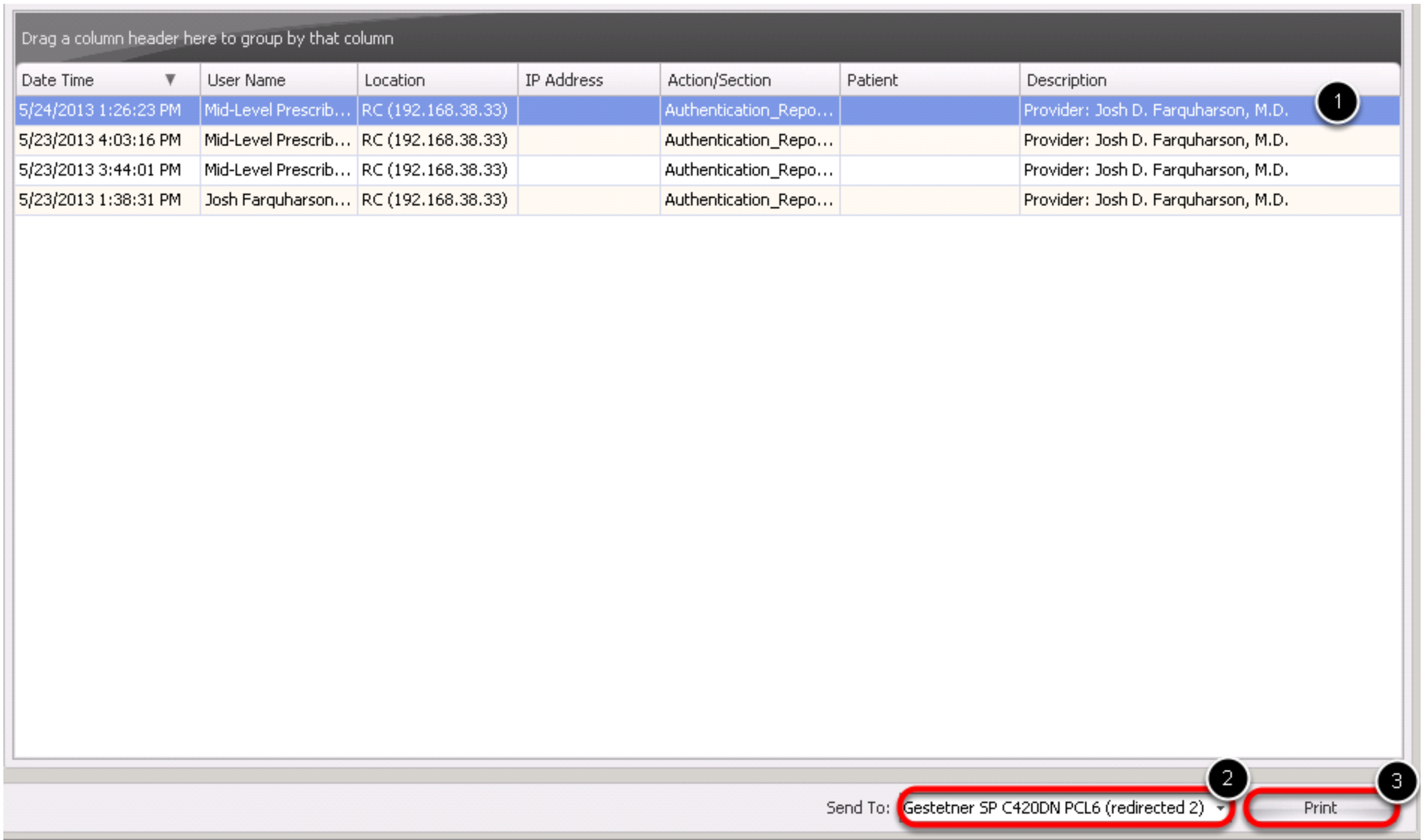
Each page of this report includes an area that must be signed by the Provider to meet the requirements of the Ohio State Board.

Reprint the Report



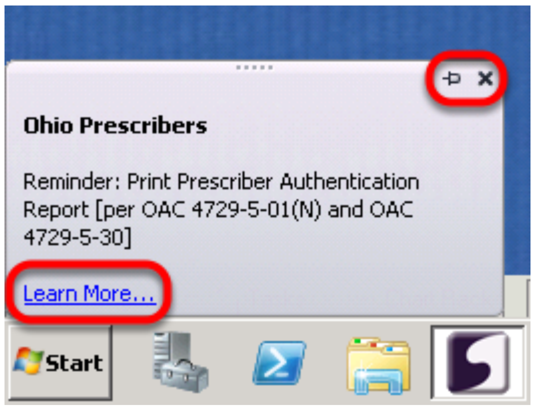
If these reports ever need to be reprinted, a user may do so from SOAPware's Audit Log.

1. Go to **Tools** > **Security Manager**, and select the date range of the reports to reprint.
2. Under the Section header, start typing "**Authentication**," and the appropriate section name will populate that field.
3. Click **Search.**



1. Click to highlight the report to be reprinted.
2. Select the appropriate printer to send the report.
3. Click **Print**.

For further information on the Ohio Prescribing Requirements, please contact the Ohio Board of Pharmacy, or refer to the following Ohio Administrative Codes: OAC 4729-5-01(N) and OAC 4729-5-30.



Each time an Ohio user logs into SOAPware, a reminder box will pop up in the lower left corner of the SOAPware screen. See image above.

- The Learn More link will take the user to lessons in our online manual specifically for Ohio users. This includes instructions on how to print the Prescriber Authentication Report, which SOAPware recommends printing on a daily basis.
- You may close this reminder by clicking on the **X** or you may leave it open by clicking the **push pin** button. Otherwise the reminder fades away after a few seconds.
- This reminder will also be shown whenever the user changes active providers. For more information, please see: **Active Provider**.

Note** - If you are an Ohio user who does not receive this reminder, please see: **Setting up SOAPware for Ohio Prescribing.

Introduction to Document Designer

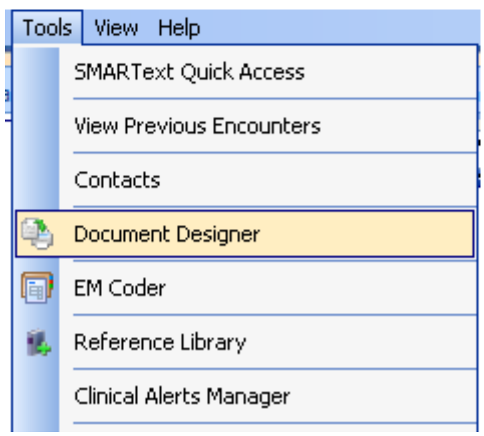
About Document Designer

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

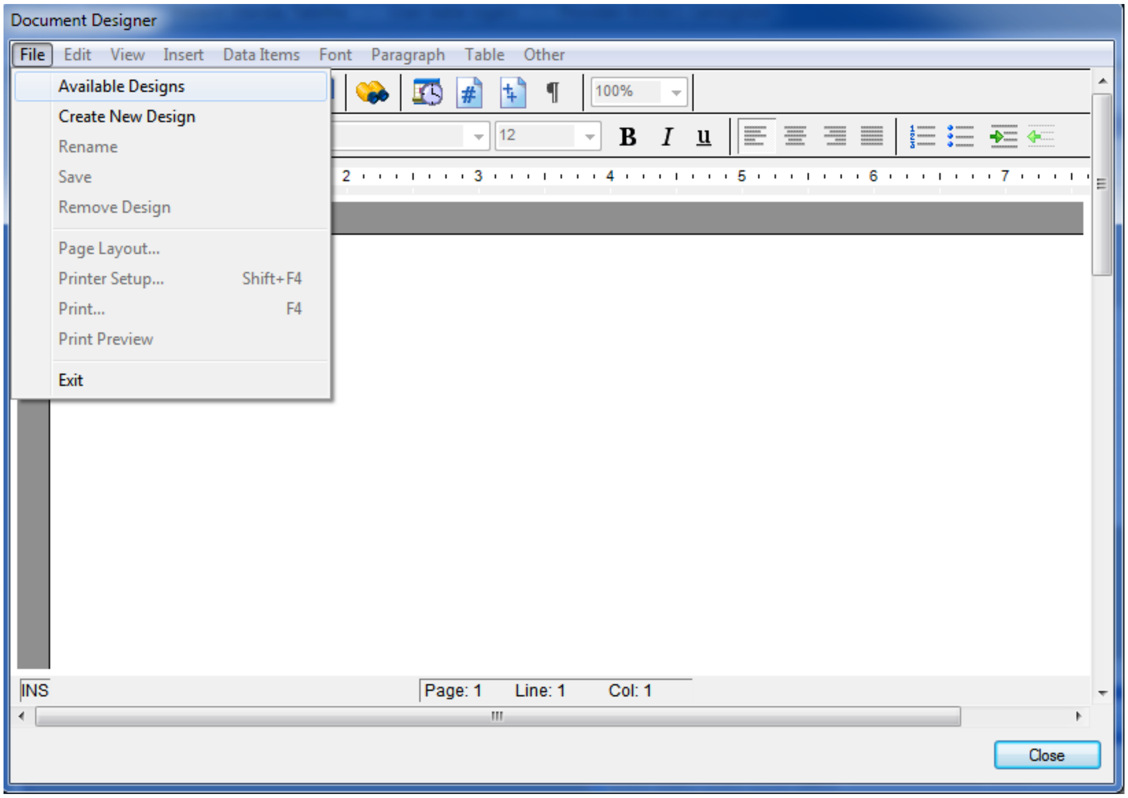
The Demographics, Provider Manager, and Contacts section of the patient chart needs to be filled out completely in order for information from these areas to be pulled onto a final document design.

Using Document Designer



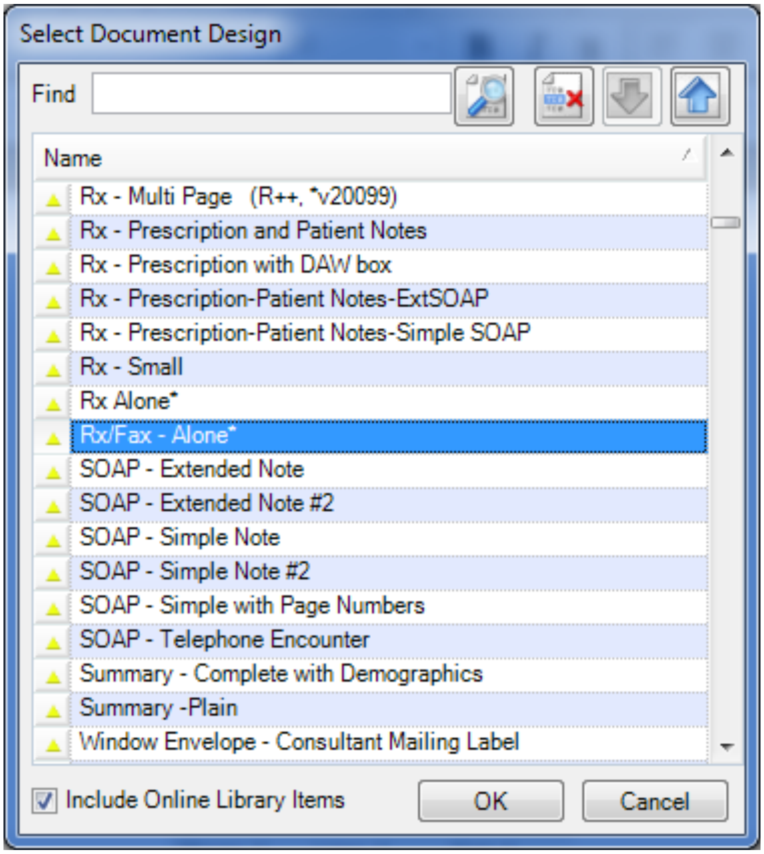
To access Document Designer, Click Tools in the menu bar, and then Click the Document Designer menu item.

Available Designs



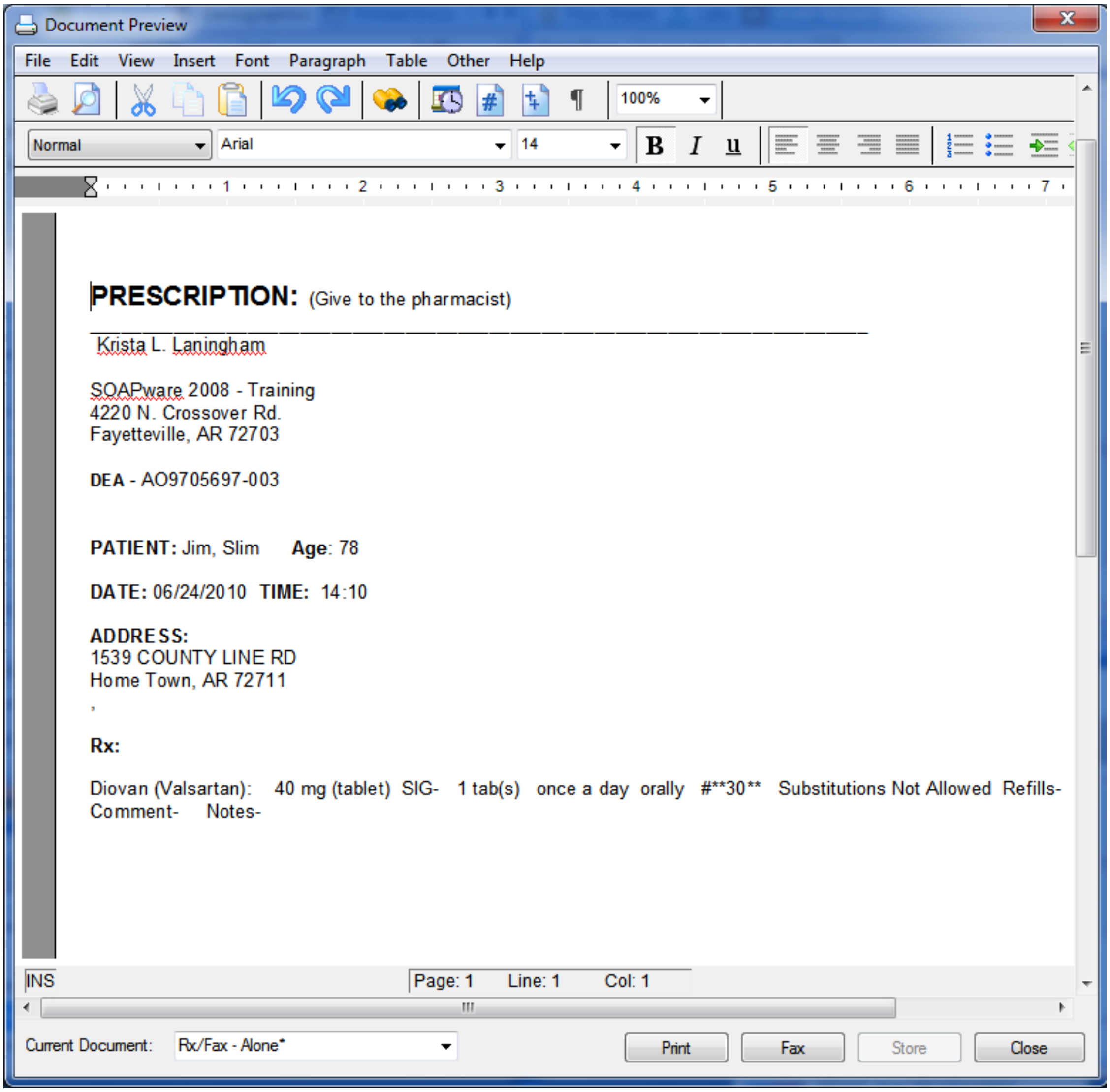
Click File, and then Click the Available Designs menu item. The available document designs will be displayed.

Select Design



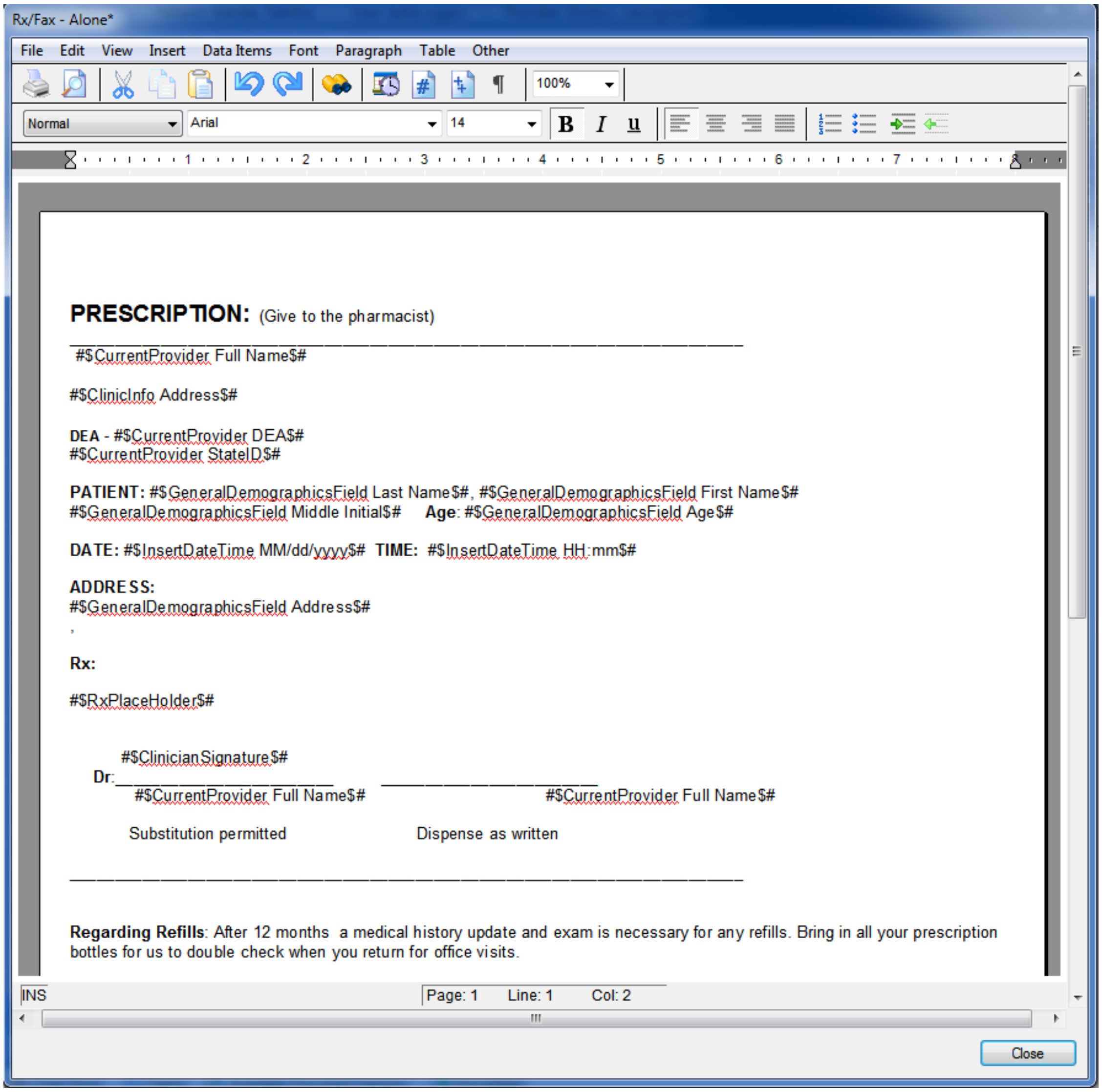
To view a particular design, Click a document design in the list (i.e. select/highlight), and Click the OK button. For example, Rx/Fax - Alone* is one of items in the list of document designs.

Examples of a Document Design



Here is an example of a prescription to be printed.

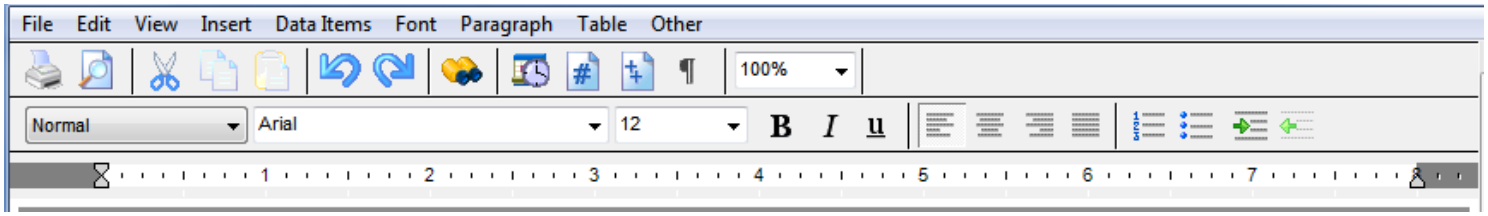
The Design View



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.

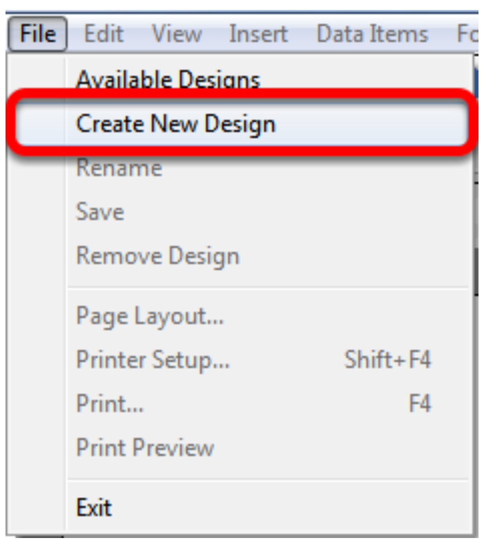
Creating a Basic Document Design

User Interface



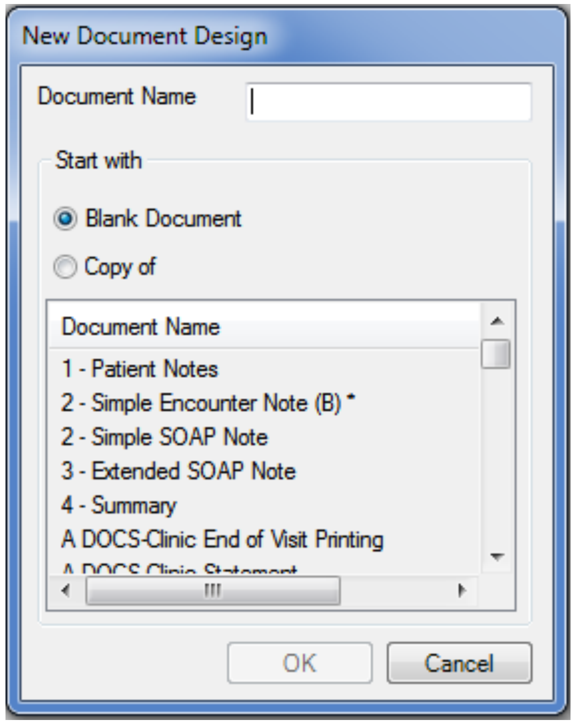
The menus and action buttons available allow the user to create or edit a design. Note that many of the functions within Document Designer resemble Microsoft Word, and allow easy customization to any design. To see what each action button represents, point to it with the mouse. A text balloon will appear 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.

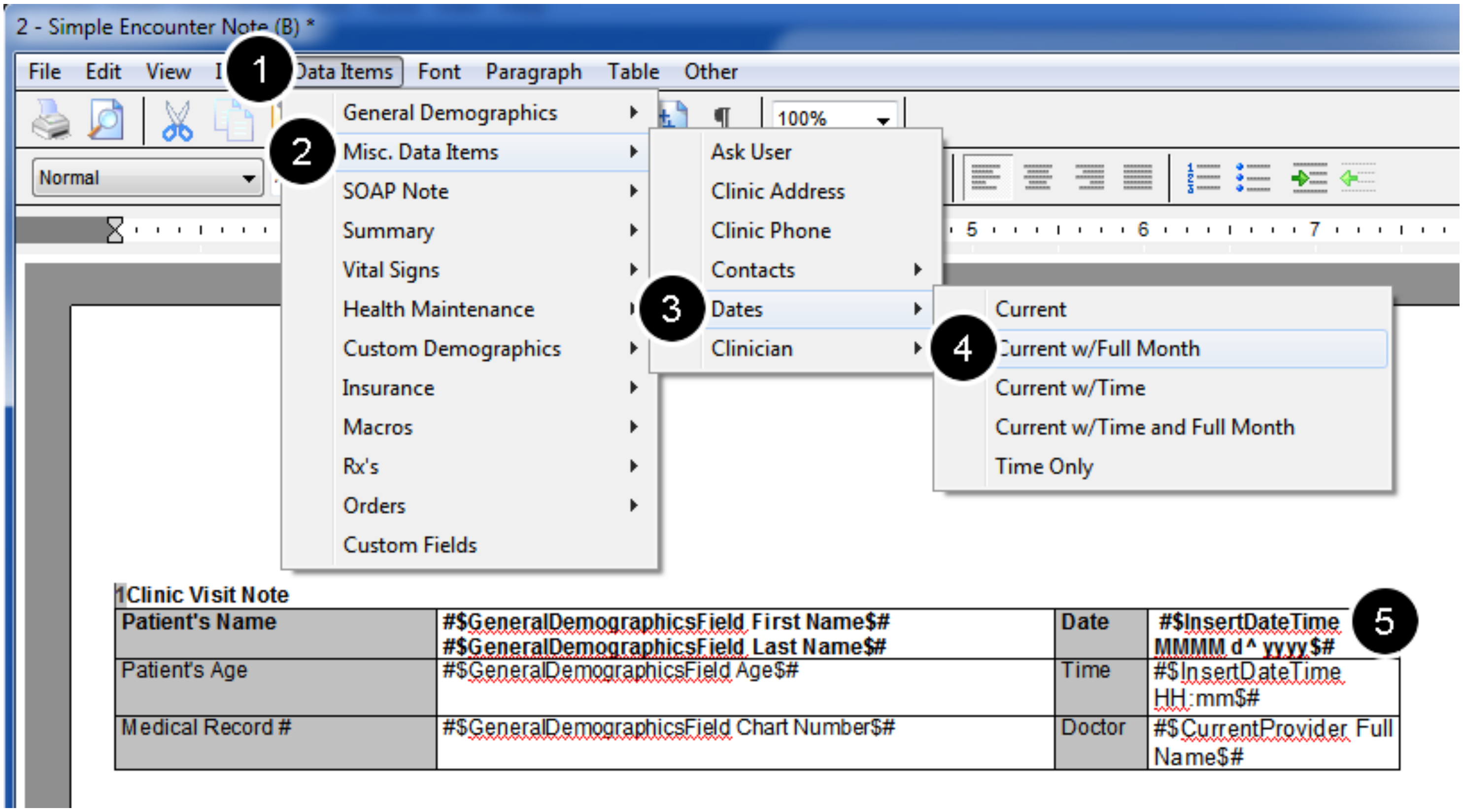
New Design Recommendations

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

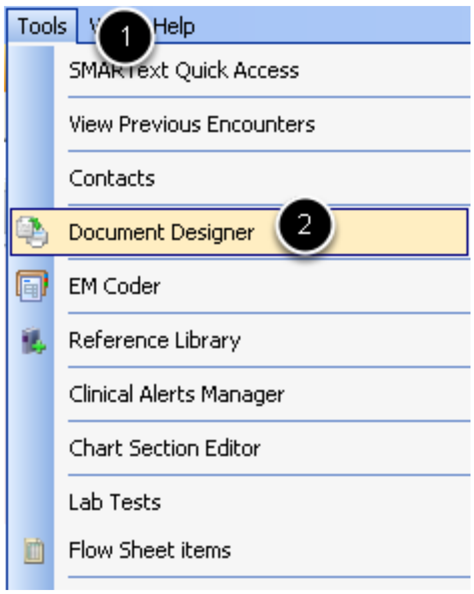
Using a Document Design to Print a Clinical Summary

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

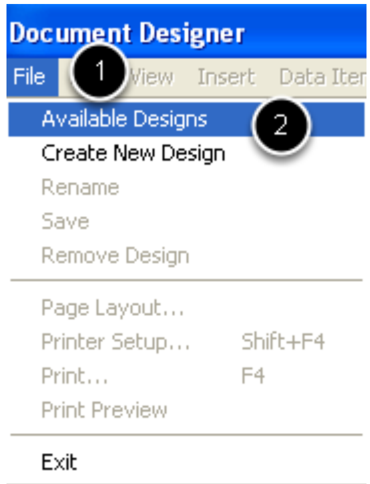
Using a Document Design to Provide a Clinical Summary



The command to indicate the a Clinical Summary was provided to the patient, must be placed on the proper Document Design.

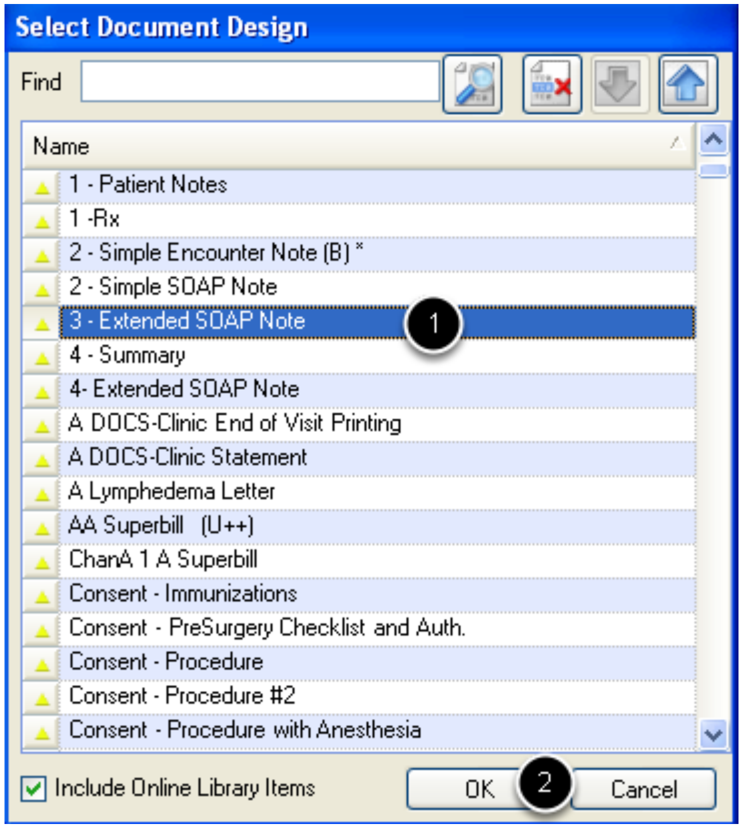
To do this:
1. Click on Tools
2. Click on Document Designer

File > Available Designs



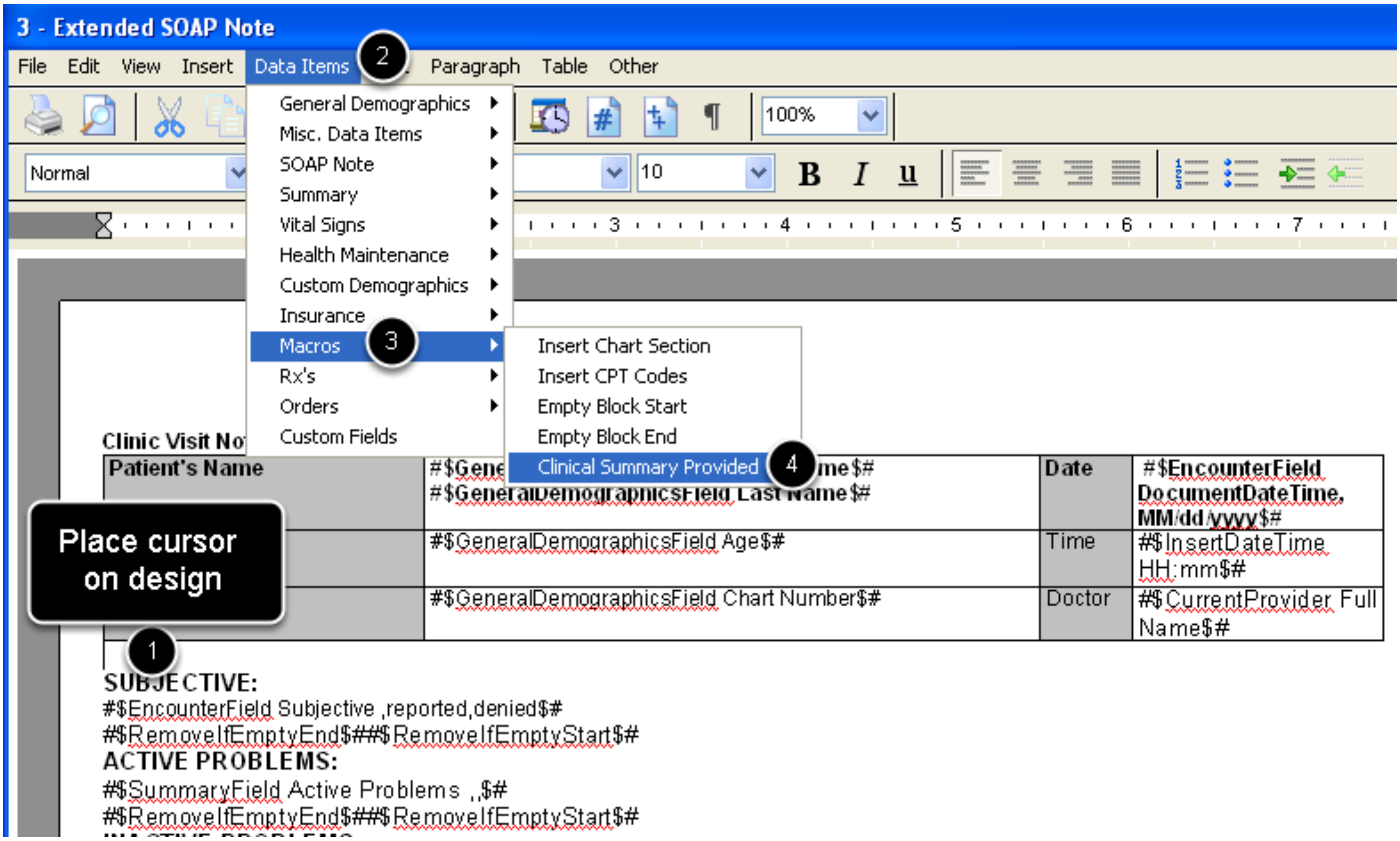
1. Click on File
2. Click on Available Designs

Selecting the Desired Design



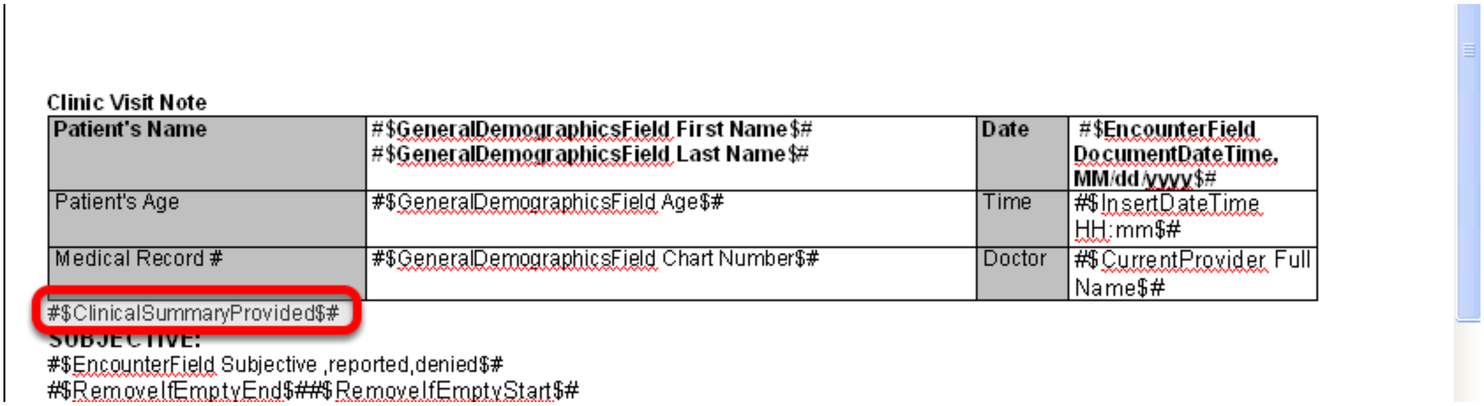
1. Click to highlight the design that includes the Summary **and** SOAPnote information
2. Click Ok

Inserting the Command



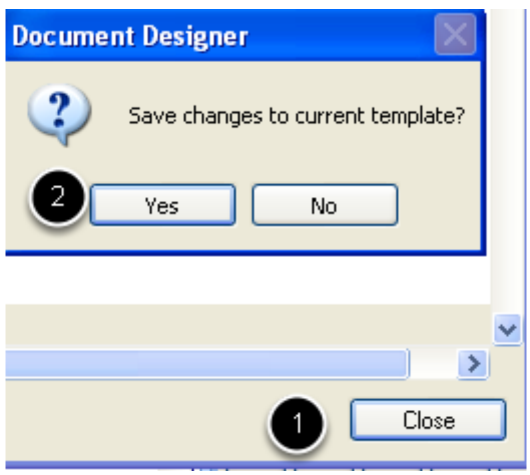
1. Place the cursor on the design. The location of the cursor and subsequent command is not important as the command runs in the background and is not visible when the design is printed.
2. Click on Data Items
3. Click on Macros
4. Click on Clinical Summary Provided

The Command



The command will not appear on the design.

Saving the edit



1. Click on Close
2. Click Yes

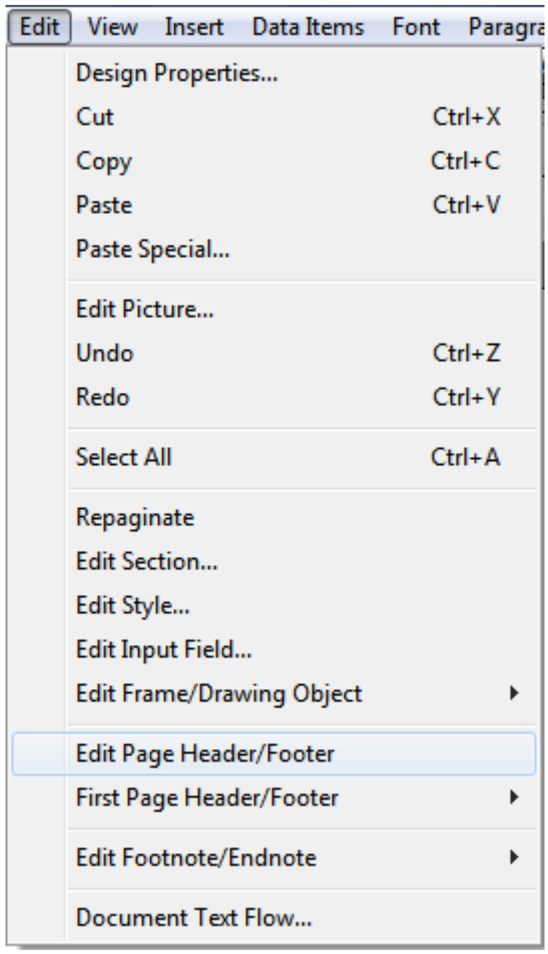
Clinical Summary

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.

Advanced Document Design

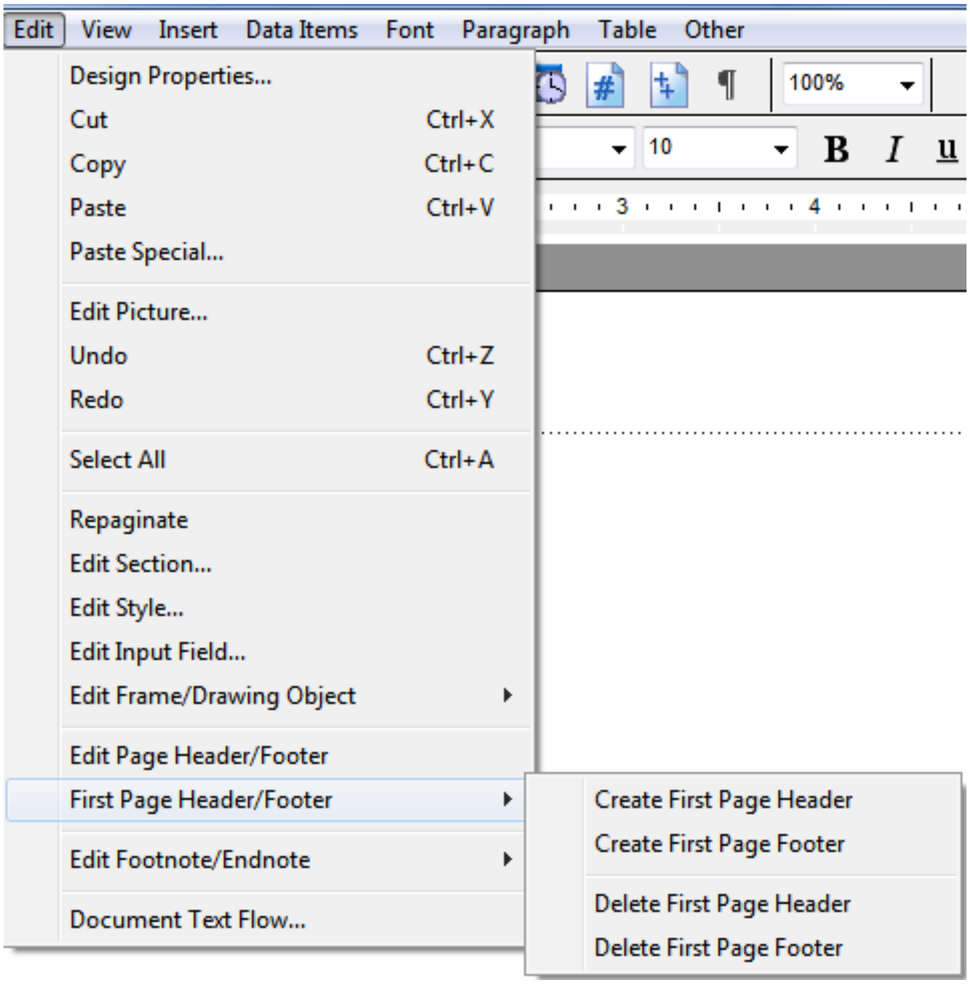
Headers and Footers



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



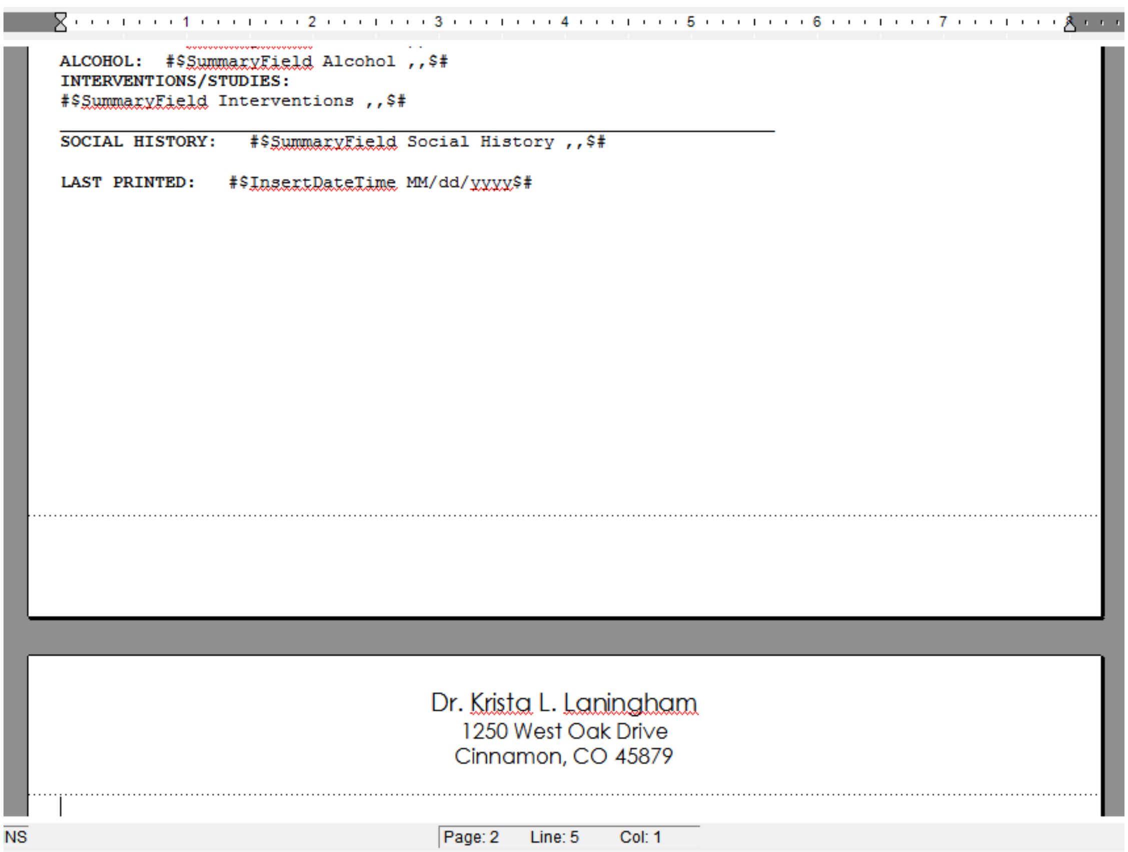
Adotted line will appear across the top and the bottom of the document design delineating the area to place the header or footer.

Now, Click Edit in the menu bar again. Click First Page Header/Footer>Create First Page Header (or Footer).

Editing the Header

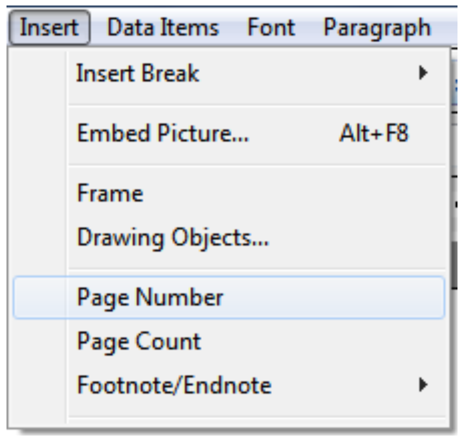
Insert the information for the header or footer, and then make the changes to the font, justification, font size, etc.

Creating a Second Page Header/Footer



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

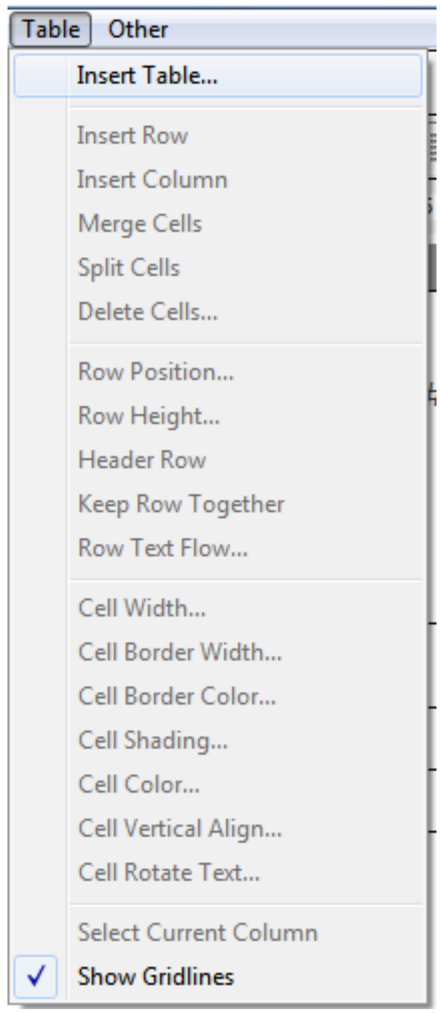
The Empty Block Start and Empty Block End commands, available from the Insert menu, allow the user to have SOAPware leave out a section of the report when printing if that section doesn’t contain any information. To use this command, "wrap" the commands around the section to ignore when empty.

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:

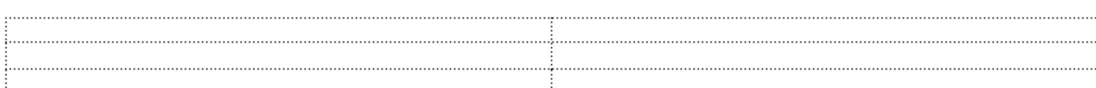
#$RemoveIfEmptyStart$#
MEDICATION:
#$EncounterField Medications ,,$#
#$RemoveIfEmptyEnd$#

Creating Tables



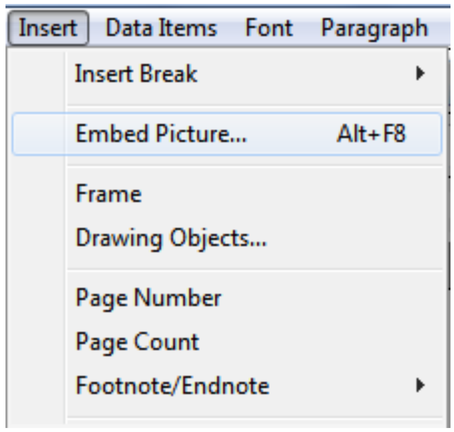
Using tables are ideal for formatting text that needs to be in columns/rows. To insert a table, Click Table in the menu bar, and then Click the Insert Table menu item. Indicate the number or rows and columns.

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

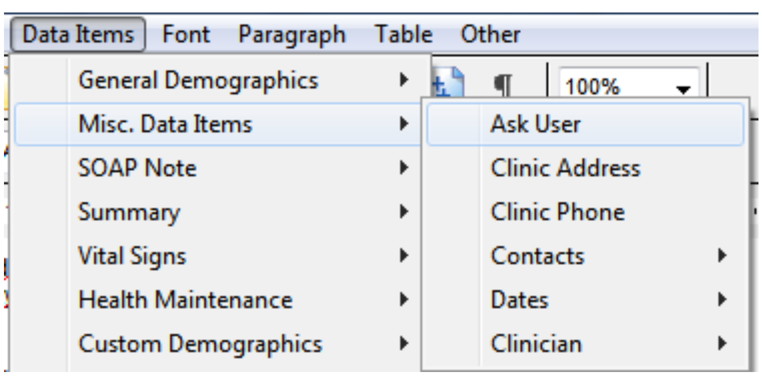


To insert an image, such as a logo, Click Insert, and then Click Embed Picture. Select the Image, and then Click Open. Once the image has been embedded, click on the image and then resize as needed.

Inserting a Signature

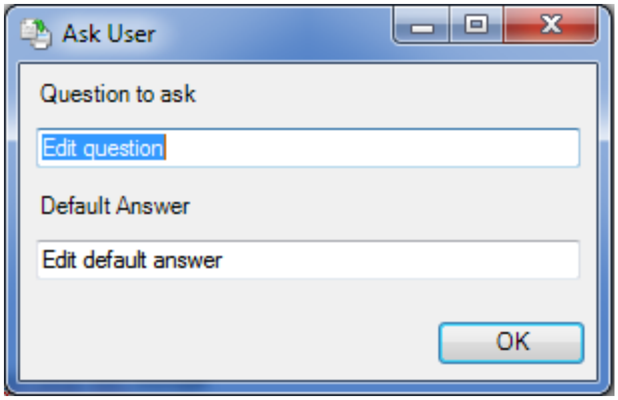
To embed a signature, scan the signature to a file on the computer and then follow the same instructions as for inserting an image (above).

Ask User



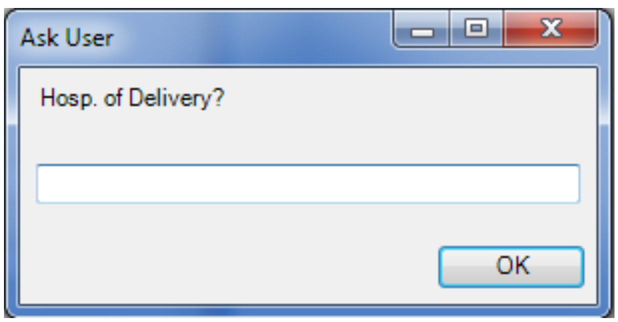
The Ask User commands allows the user to add unique, auto-populating commands, that are not available in the Data Items menu. This command inserts a custom question that can be used to insert additional information before printing the design. Click Data Items in the menu bar; Click Misc. Data Items, 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

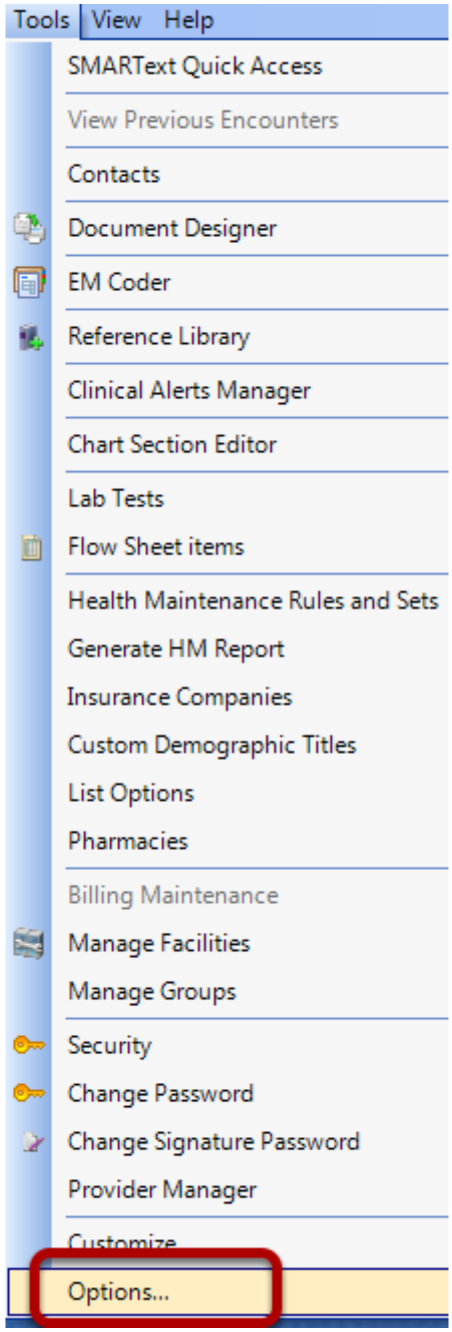
To save time when printing the four most commonly used document designs, it is recommended to set up Quick Print key commands. The following key commands can be designated to directly print a document design, without having to scroll through the print menus.

Quick Print Key Commands

The Quick Print list includes:

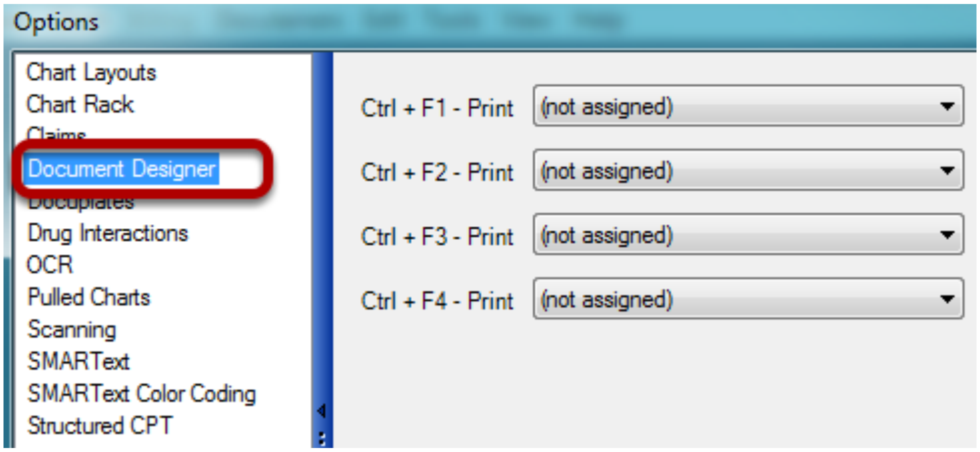
* **Ctrl + F1**
* **Ctrl + F2**
* **Ctrl + F3**
* **Ctrl + F4**

Tools -Options



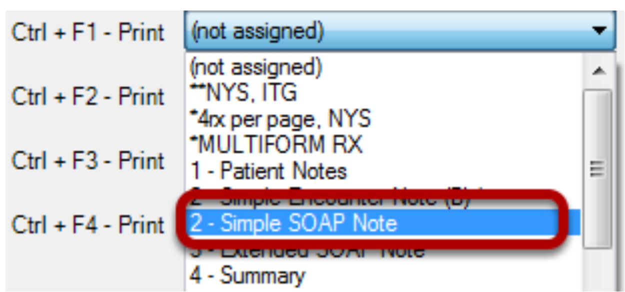
Click on Tools > Options.

Options Dialog



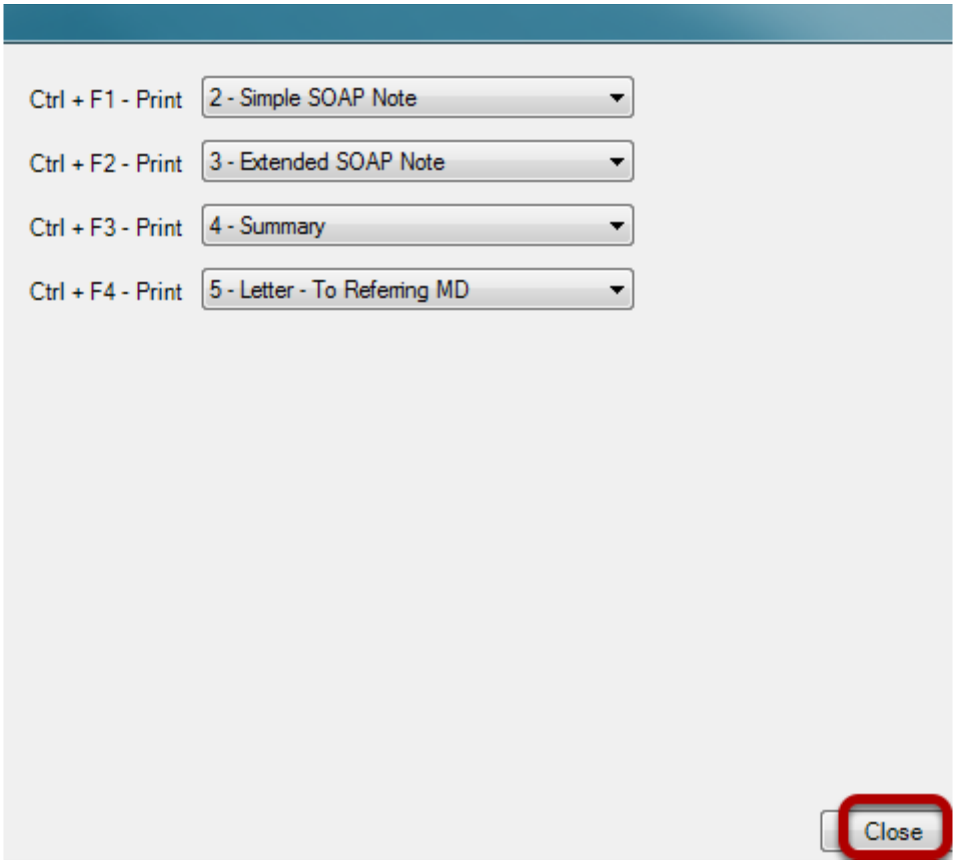
Click the Document Designer list item.
On the right side of the Options dialog, all four Quick Print commands are listed. Each is associated with a drop-down list of available document designs.

Designate Document Designs



Select document designs to print for each Quick Print key command.

Save Changes made within the Options dialog



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.

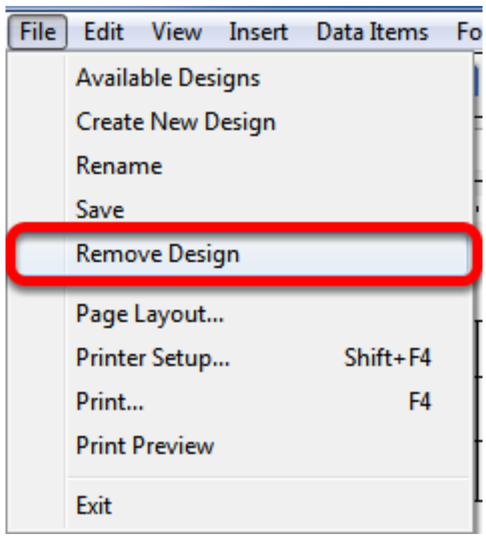
Note: Do not set up printing of a prescription as a Quick Print key command. We recommend printing prescriptions from Rx Manager to ensure that an account of each prescription printed is stored under the Rx history tab in the Rx Manager. For more information, see: Default Rx Print Designs.

Saving and Printing a Document Design

Saving a Document Design

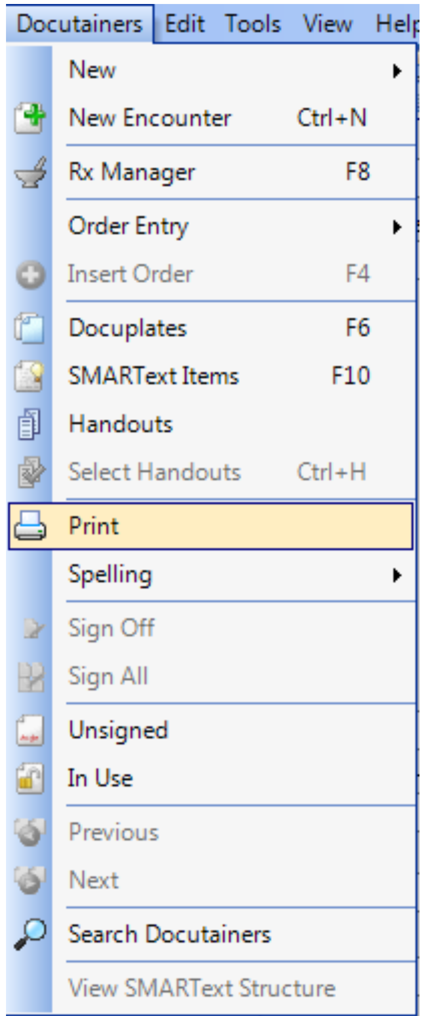
To save an edited document design, Click File in the menu bar, and then Click Save. It is always a good idea to close Document Designer, and then test by printing the document.

Deleting a Document Design

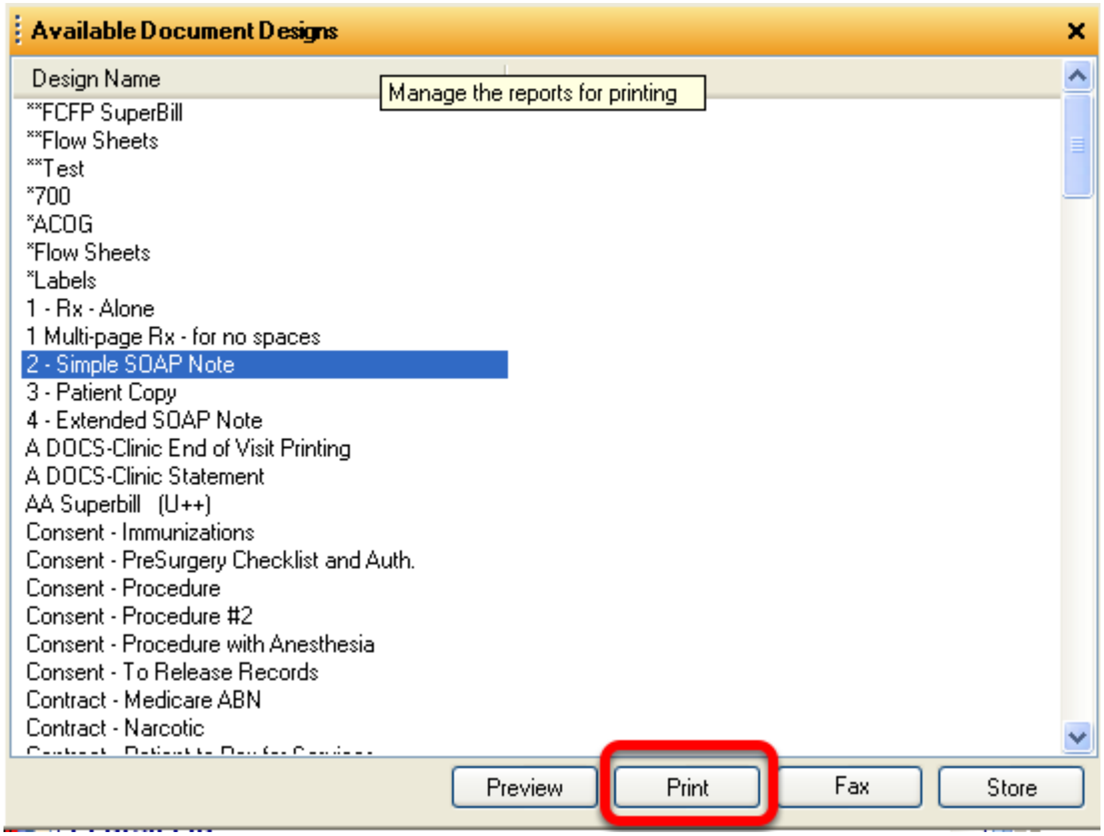


To delete a document design, Click File and choose Remove Design.

Printing a Document Design

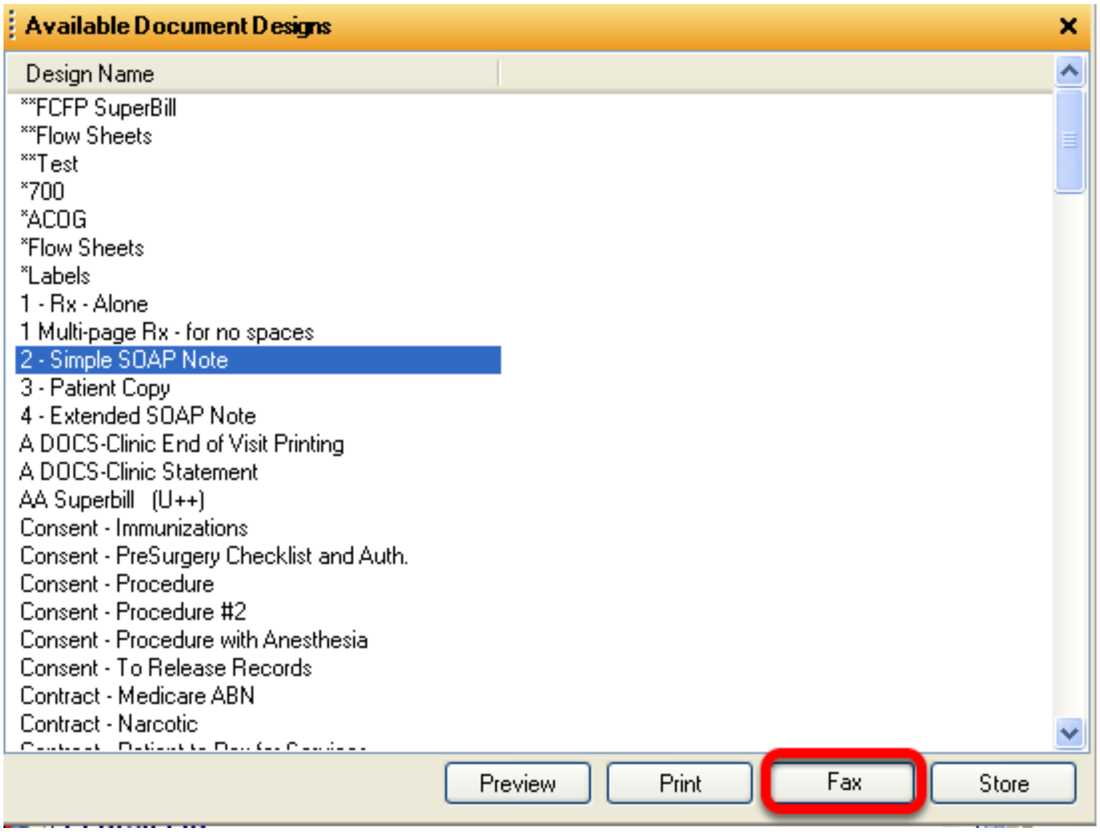


To print a document design, go to Docutainers - Print. This will pull up the available document designs, where the user can choose which design he/she would like to print.



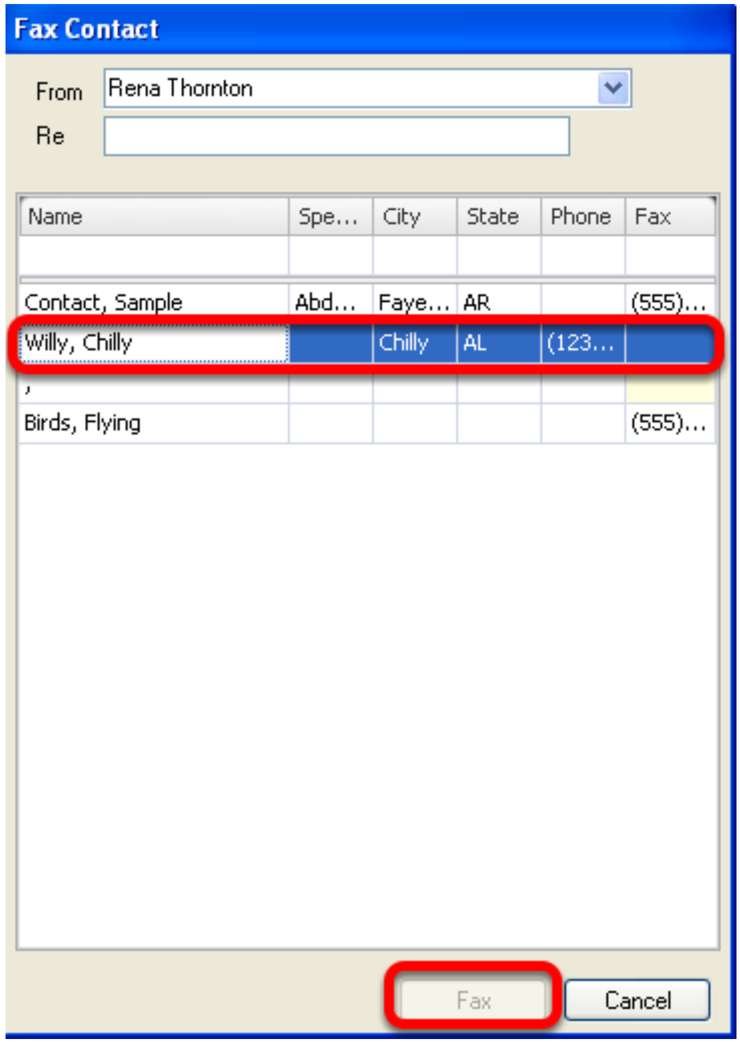
Click to highlight the Document Design to Print. Click the Print button.

Faxing a Document Design



Auser 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.

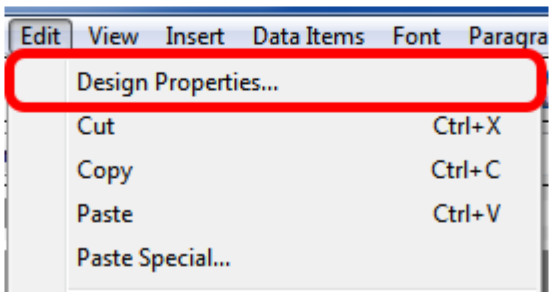


The Fax Contact window will display to select the Contact from Contacts Manager. Click the Contact of choice and then Click the Fax button.

Document Designer Properties

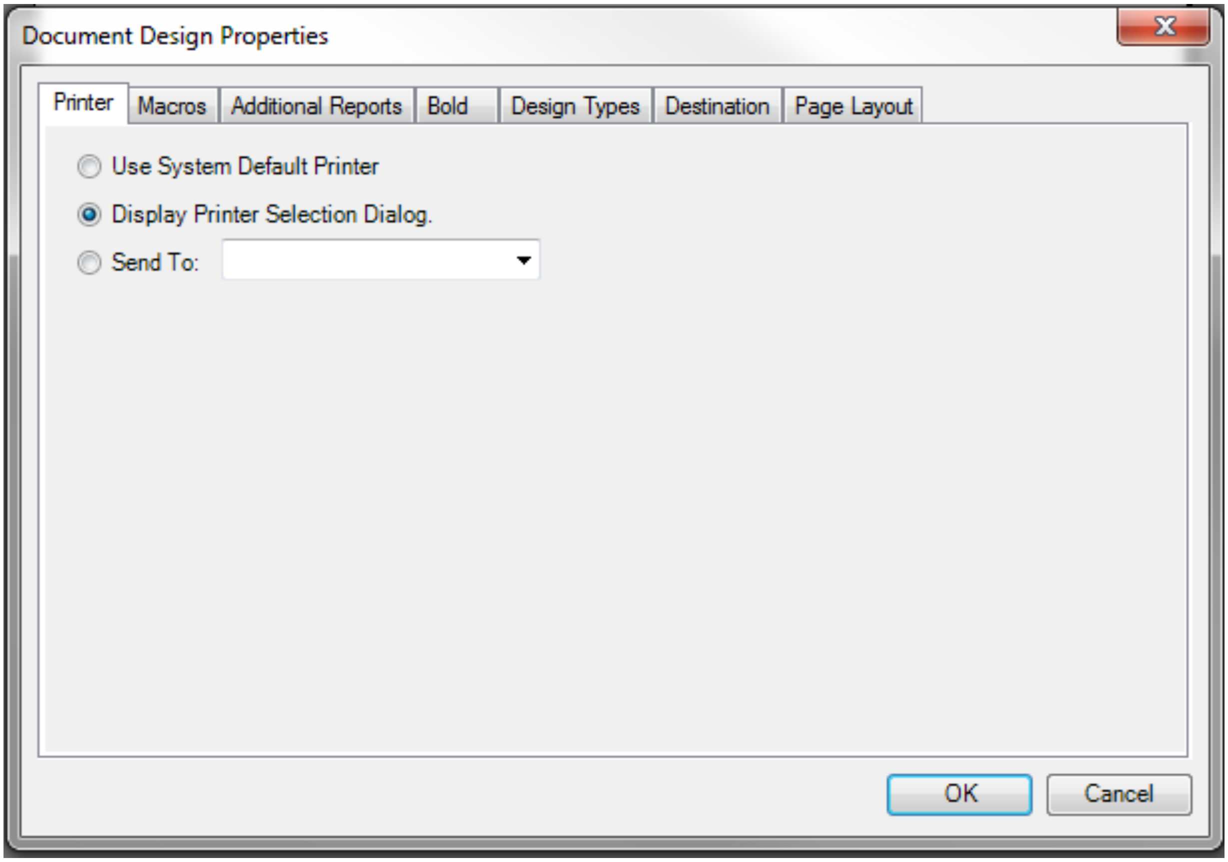
Once the document has been completed, there will be other, very important commands that the user will need to consider adding to a document. These commands are hidden in the background, but are embedded within the design. The Design Properties dialog offers the user a variety of options for controlling 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



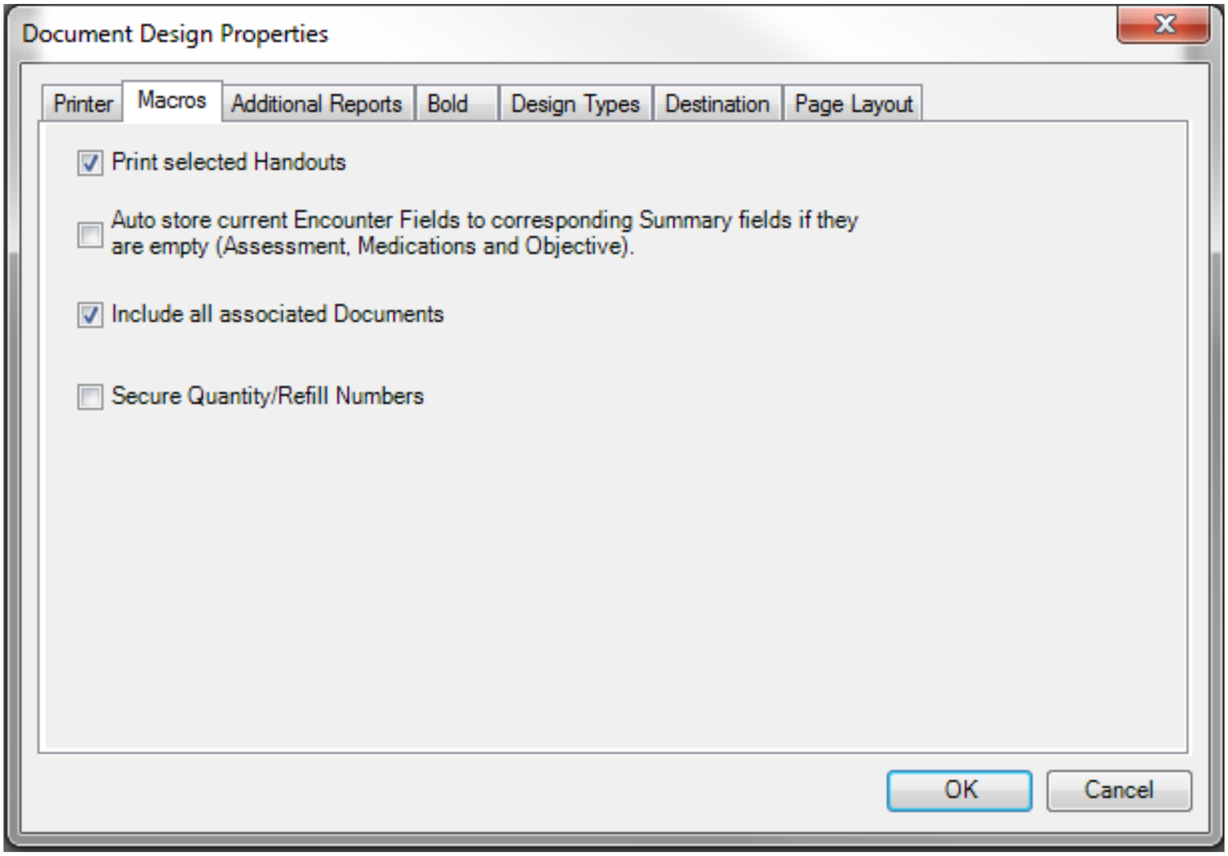
To access the Design Properties dialog, Click Edit in the menu bar, and then Click the Design Properties menu item.

Printer



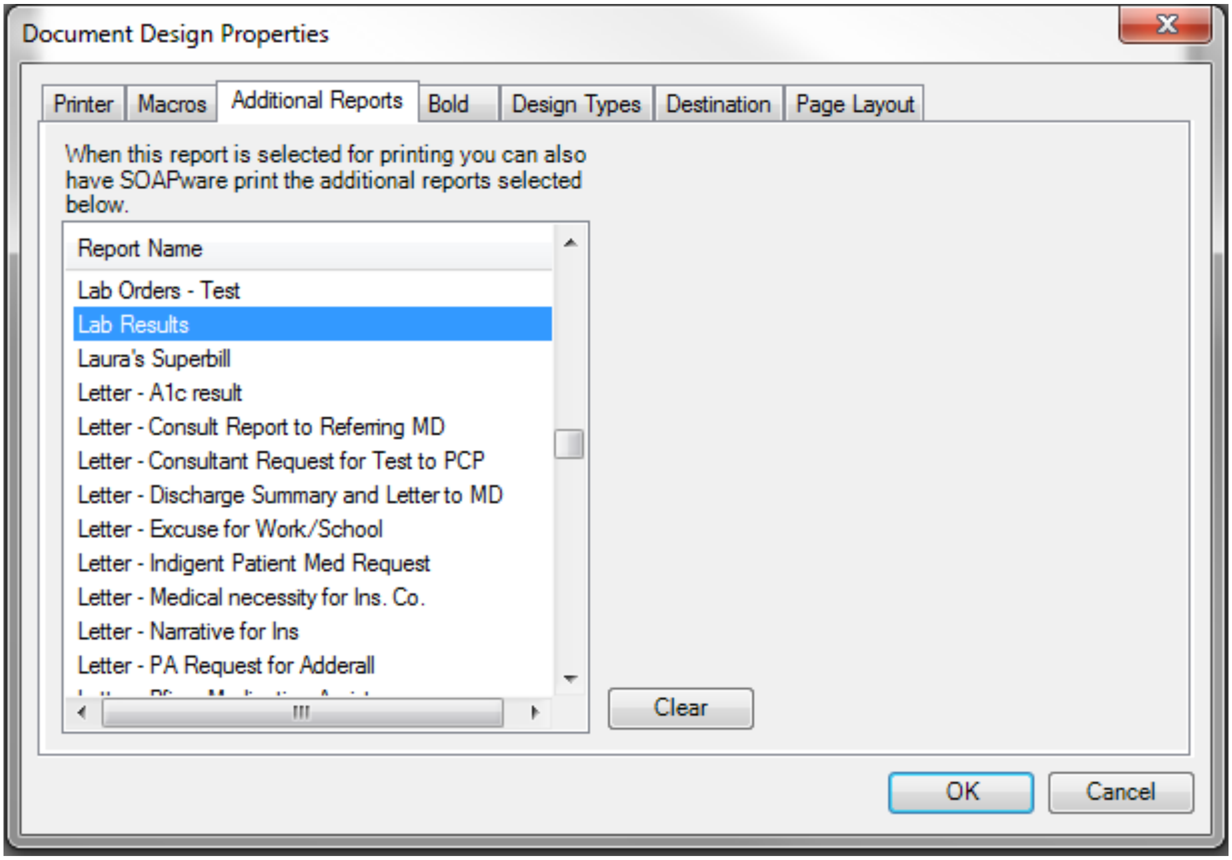
- **User System Default Printer**: tells SOAPware to send the document deign to the default printer.
- **Display Printer Selection Dialog**: allows the user to choose a local printer to send document.
- **Send to**: sends the document to the selected designated printer or fax.

Macro



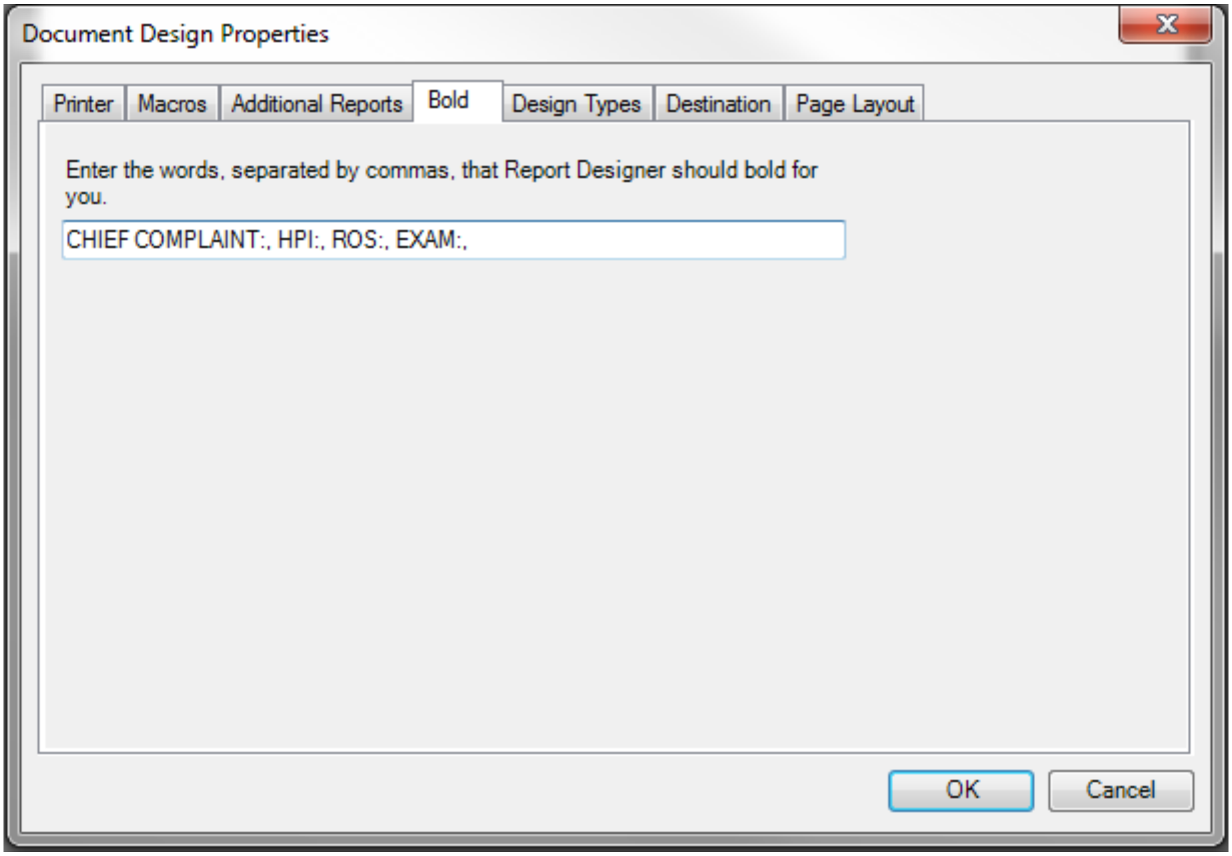
- **Print Selected Handouts**: when a user prints the report, any handouts selected in the Plan field of the SOAPnote will also print.
- **Auto Store Current Encounter Fields to corresponding Summary fields if they are empty** (Assessment, Medications and Objective): sets SOAPware to transfer information 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.

Additional Reports



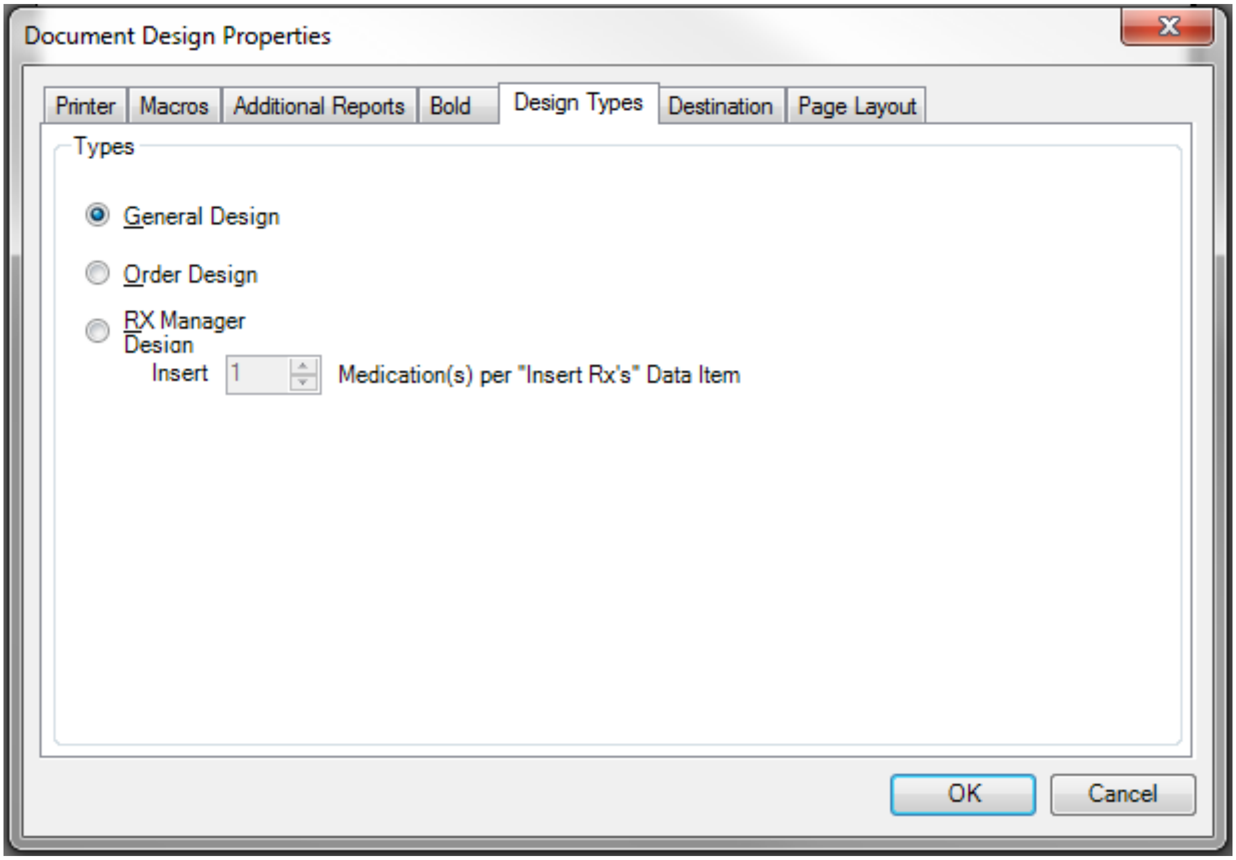
The selected additional document designs will print when this design is printed. For example, when a referral letter is printed a soap encounter note could be printed simultaneously.

Bold



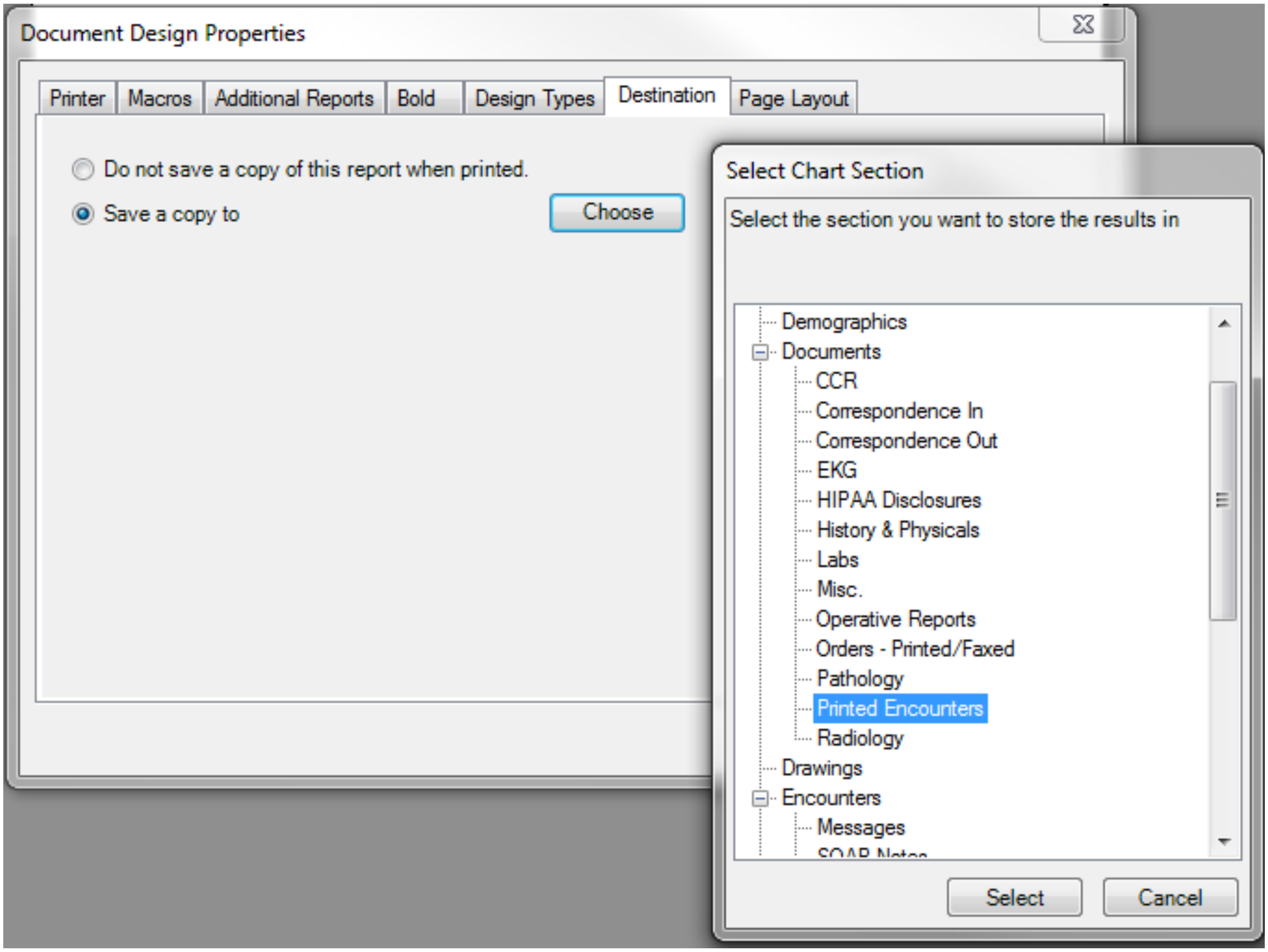
This setting allows the user to automatically apply bold formatting to specific words. To specify the words to be made bold, enter them in the text box separated by commas.

Design Types



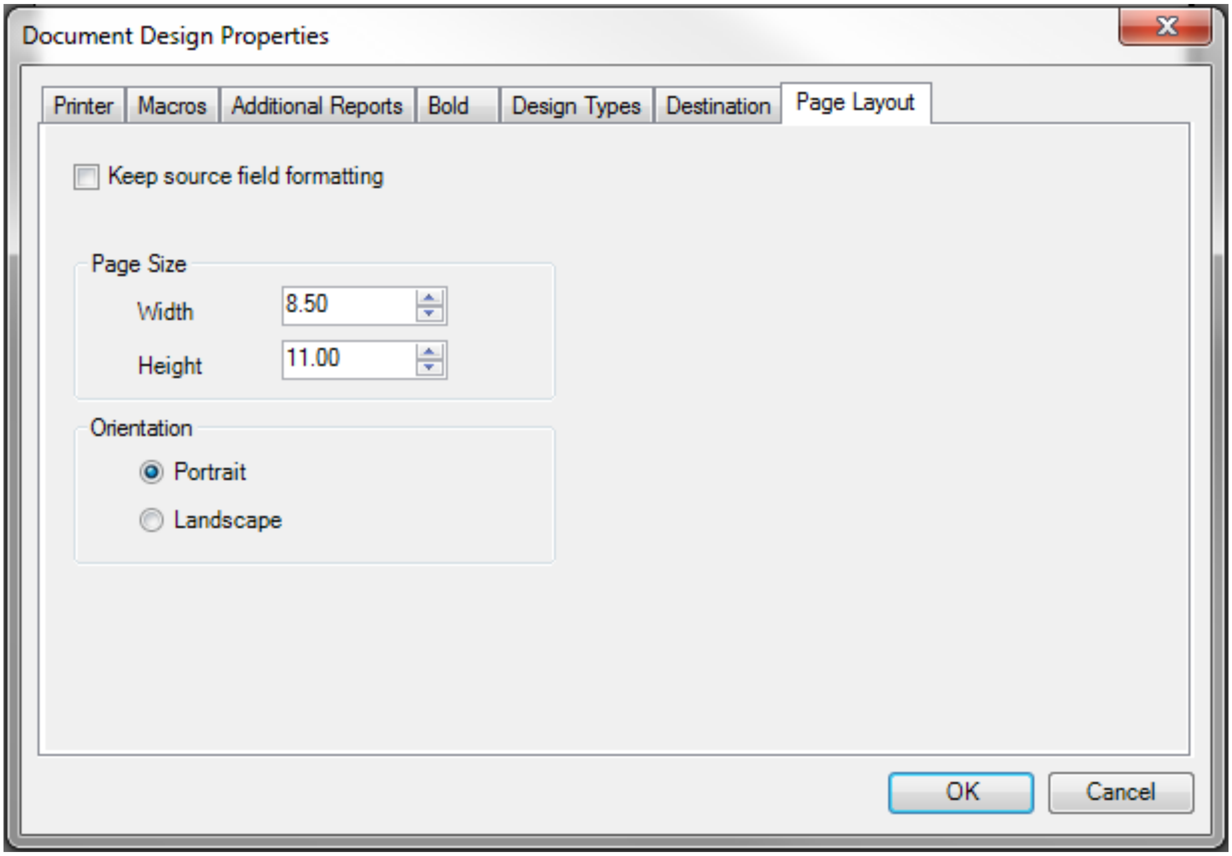
- **General Design:** applies to all print designs other than Order or Rx Manager.
- **Order Design**: applies to any design that is created to be used within Order Manager.
- **Rx Manger**: applies to an prescription design that needs to specify how many prescriptions will print per page.

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."

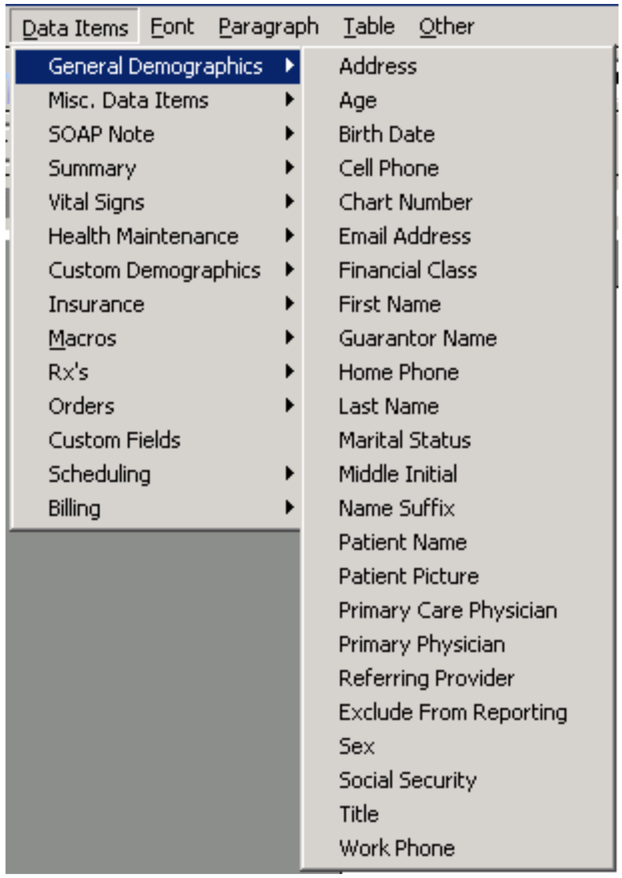
Page Layout



- **Keep source field formatting**: Source field formatting will be preserved that exists in the original docutainer.
- **Page Size:** Define the paper size.
- **Orientation:** Select Portrait or Landscape.

Document Designer Commands (2012)

Data Items - General Demographics

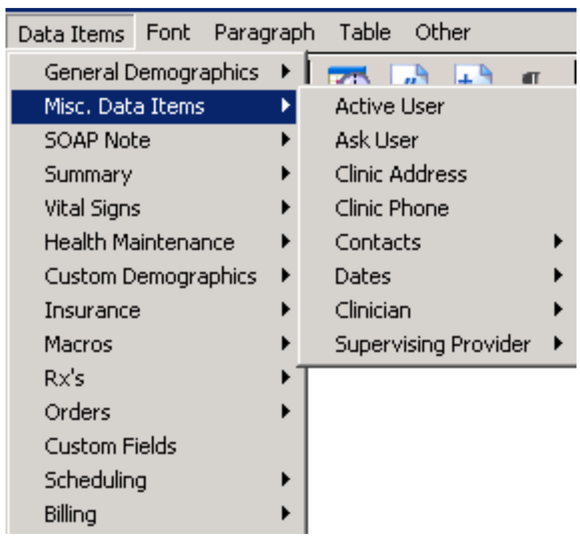


The General Demographics data item list includes:

- **Address** - inserts the patient's address
- **Age** - inserts the patient's age
- **Birth date** - inserts the patient's date of birth
- **Chart Number** - inserts the patient's chart number
- **E-Mail Address** - inserts the patient's email address
- **First Name** - inserts the patient's first name
- **Home Phone** - inserts the patient's home phone number
- **Last Name** - inserts the patient's last name
- **Marital Status** - inserts the patient's marital status
- **Middle Initial** - inserts the patient's middle initial
- **Name Suffix** - inserts the patient's name suffix (ex: Dr., Ms., Mrs., etc.)

- **Patient Name** - inserts the patient's full name (ex: Last, First M.)
- **Primary Physician** - inserts the patient's primary physician
- **Sex** - inserts the patient's gender
- **Social Security** - inserts the patient's Social Security number
- **Title** - inserts the patient's title
- **Work Phone** - inserts the patient's work phone number

Miscellaneous Data Items



The Misc. Data Items list includes:

- **Active User** - inserts the name of the SOAPware user who prints the design
- **Ask User** - allows a question to be asked to the User when the document design is printed (ex: Question: When can the patient return to work?)
- **Clinic Address** - inserts the clinic's full address and provider's name
- **Clinic Phone** - inserts the clinic's phone number

<u>**Contacts:**</u>

- **Address** - inserts the selected contact's address
- **Fax** - inserts the selected contact's fax
- **First Name** - inserts the selected contact's first name
- **Last Name** - inserts the selected contact's last name
- **Name** - inserts the selected contact's full name
- **Phone** - inserts the selected contact's phone number
- **Select** - not properly functioning at this time

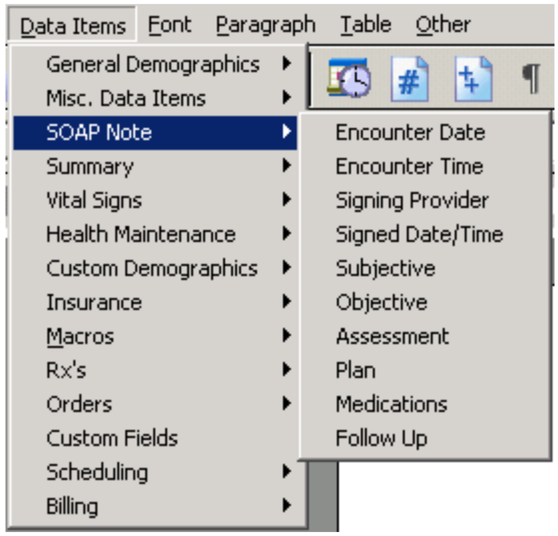
- **Suffix** - inserts the selected contact's name suffix
- **Specialty** - inserts the selected contact's specialty

__Dates__:
- **Current Date** - inserts the current date (ex: 11/09/2011)
- **Current Date with Full Month** - inserts the current date will full month (ex: November 9, 2011)
- **Current w/Time** - inserts the date along with the time (ex: 11/09/2011 14:42)
- **Current w/Time and Full Month** - inserts the date, time with full month (ex: November 9, 2011 14:42)
- **Time** - inserts the current time (ex: 14:42)

__Clinician__:
- **Full Name** - inserts the clinician's full name
- **First Name** - inserts the clinician's first name
- **Last Name** - inserts the clinician's last name
- **DEA** - inserts the clinician's DEAnumber
- **State ID** - inserts the clinician's State ID number
- **Signature** - inserts the clinician's signature

__Supervising Provider:__
- **Full Name** - inserts the supervising provider's full name
- **First Name** - inserts the supervising provider's first name
- **Last Name** - inserts the supervising provider's last name
- **DEA** - inserts the supervising provider's DEAnumber
- **State ID** - inserts the supervising provider's State ID number
- **Signature** - inserts the supervising provider's signature

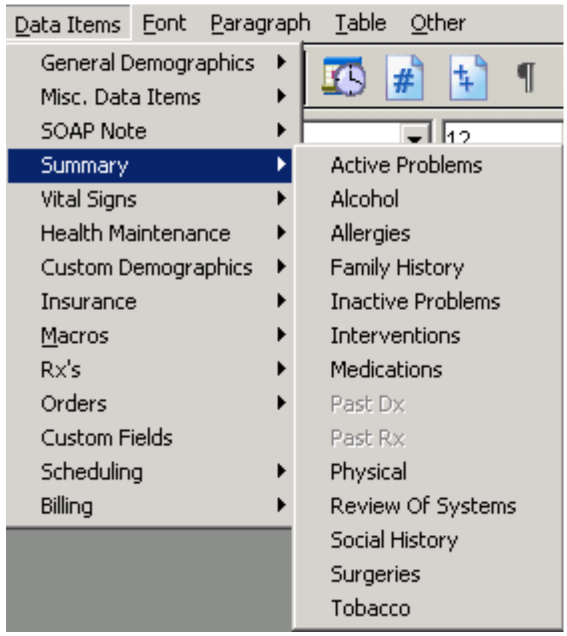
SOAPnote



The SOAPnote data item list includes:

- **Encounter Date** - inserts the encounter date
- **Encounter Time** - inserts the encounter time
- **Subjective** - inserts the encounter subjective field
- **Objective** - inserts the encounter objective field
- **Assessment** - inserts the encounter assessment field
- **Plan** - inserts the encounter plan field
- **Medications** - inserts the encounter medications field
- **Follow Up** - inserts the encounter follow up field

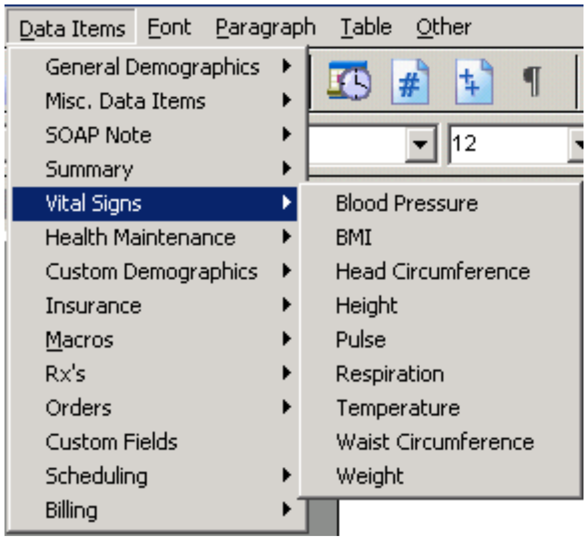
Summary



The Summary data item list includes:

- **Active Problems** - inserts the summary active problems
- **Alcohol** - inserts the summary alcohol field
- **Allergies** - inserts the summary allergies
- **Family History** - inserts the summary family history field
- **Inactive Problems** - inserts the summary inactive problems
- **Interventions** - inserts the summary interventions field
- **Medications** - inserts the summary medications
- **Physical** - inserts the summary physical field
- **Review of Systems** - inserts the summary ROS field
- **Social History** - inserts the summary social history field
- **Surgeries** - inserts the summary surgeries field
- **Tobacco** - inserts the summary tobacco field

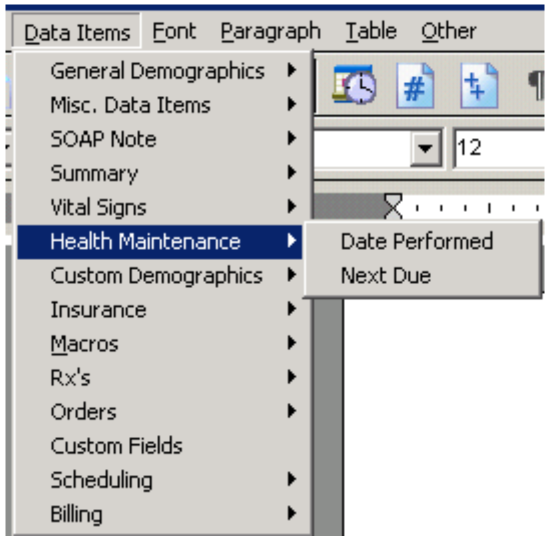
Vital Signs



The Vital Signs data item list includes:

- **Blood Pressure** - inserts the patient's blood pressure
- **BMI** - inserts the patient's BMI
- **Head Circumference** - inserts the patient's head circumference
- **Height** - inserts the patient's height
- **Pulse** - inserts the patient's pulse
- **Respiration** - inserts the patient's respiration
- **Temperature** - inserts the patient's temperature
- **Weight** - inserts the patient's weight

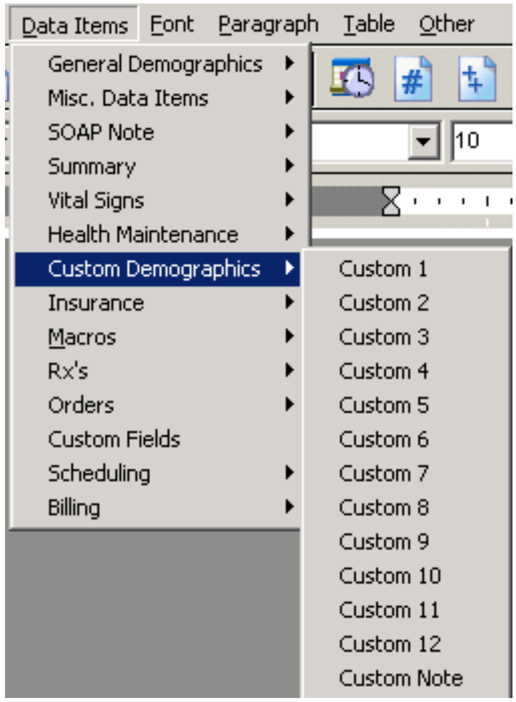
Health Maintenance



The Health Maintenance data item list includes:

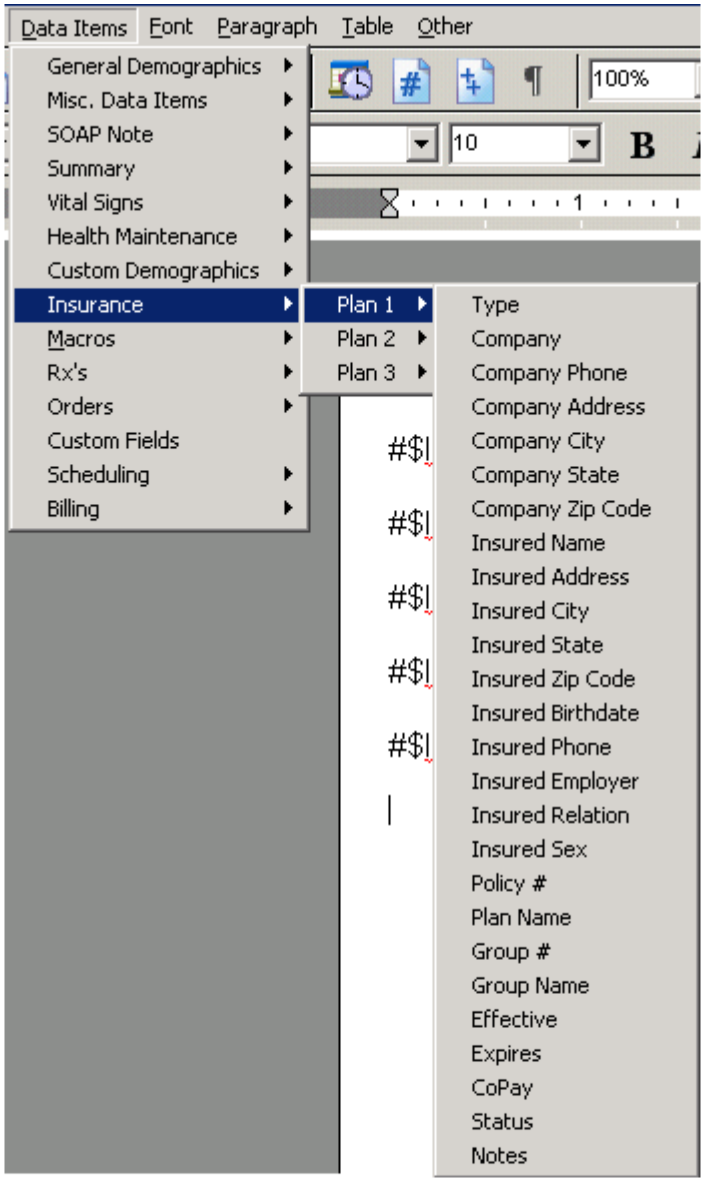
- **Date Performed** - inserts the date the health maintenance item was performed
- **Next Due** - inserts the date the health maintenance item is next due

Custom Demographics



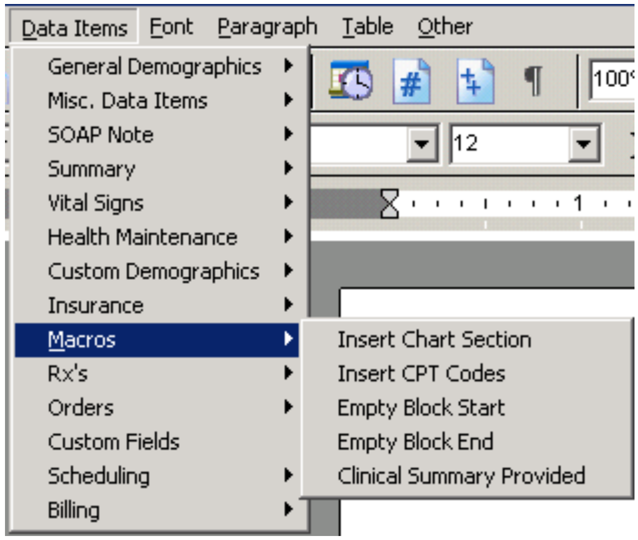
The Custom Demographics data items will allow the user to insert information from any of the custom demographics fields.

Insurance



The Insurance data items will allow the user to insert information about the patients insurance policies.

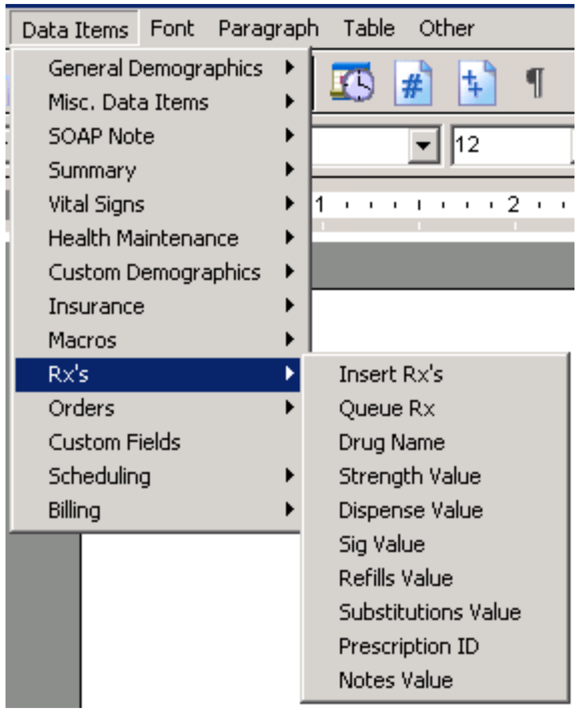
Macros



The Macros list includes:

- **Insert Chart Section** - inserts the entire chart section
- **Insert CPT Codes** - inserts the CPT codes
- **Empty Block Start** - start command to remove a field if empty
- **Empty Block End** - end command to remove a field if empty

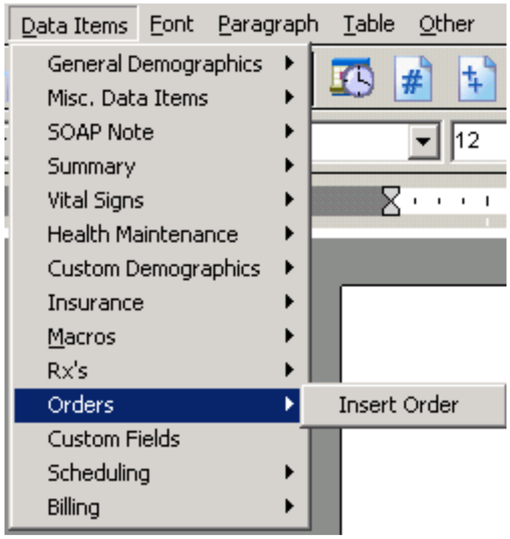
Rx's



The Rx data items list includes:

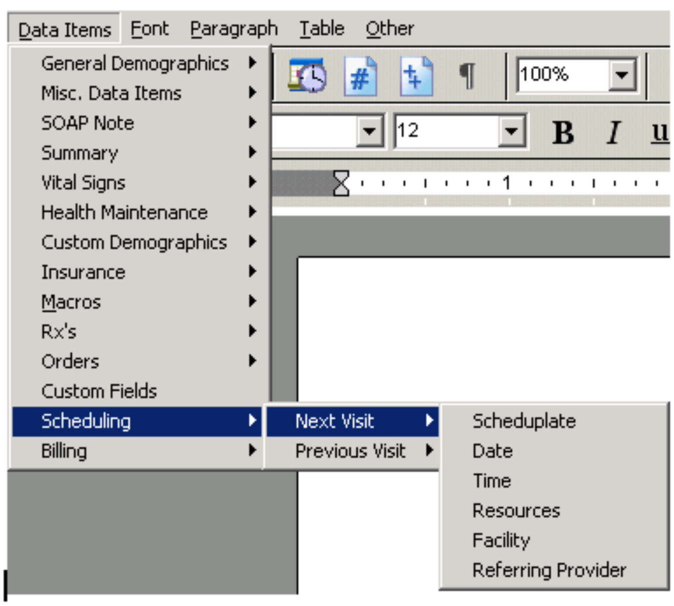
- **Insert Rx's** - inserts the medications that are inserted into the patient's SOAPnote Medications field
- **Queue Rx** - this data item is not functioning properly at this time
- **Drug Name** - inserts the medication name
- **Strength Value** - inserts the medication strength
- **Dispense Value** - inserts the medication dispense number
- **Sig Value** - inserts the medication dose, frequency and route
- **Refills Value** - inserts the medication refills
- **Substitutions Value** - inserts "Substitutions Allowed" or "Substitutions Not Allowed"
- **Prescription ID** - inserts a unique ID number for each prescription that is printed or faxed through Rx Manager. **Note:* This data command will present a null value on prescriptions printed through Available Document Designs.*
- **Notes Value** - inserts the notes to the pharmacy

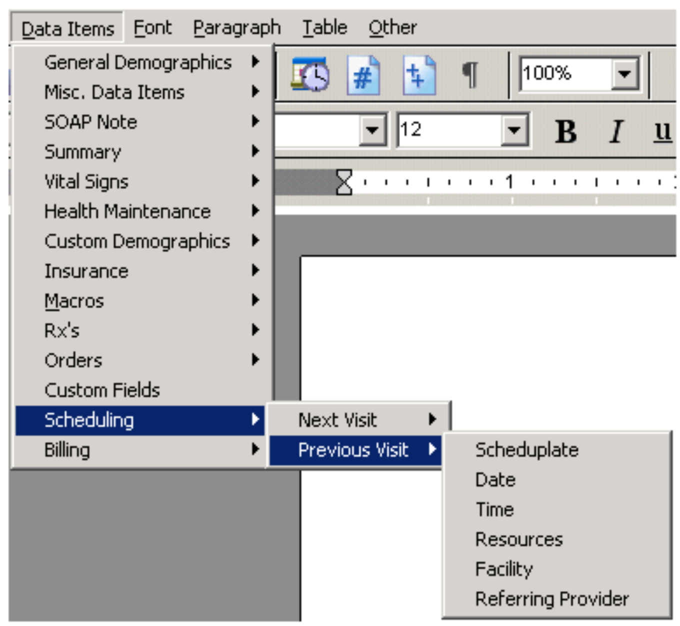
Orders



The Insert Order data item allows the orders that are listed in Order Manager to be inserted.

Scheduling





The Scheduling data items include:

Next Visit

- **Scheduplate** - inserts the scheduplate for the patient's next visit
- **Date** - inserts the date of the patient's next visit
- **Time** - inserts the time of the patient's next visit
- **Resources** - inserts the resources selected for the patient's next visit (ex: Dr. Randall Oates or Lab, etc.)
- **Facility** - inserts the facility for the patient's next visit
- **Referring Provider** - inserts the referring provider selected for the patient's next visit

Previous Visit

- **Scheduplate** - inserts the scheduplate for the patient's last visit
- **Date** - inserts the date of the patient's last visit
- **Time** - inserts the time of the patient's last visit
- **Resources** - inserts the resources selected for the patient's last visit (ex: Dr. Randall Oates or Lab, etc.)
- **Facility** - inserts the facility for the patient's last visit
- **Referring Provider** - inserts the referring provider selected for the patient's last visit

Creating Patient Education Handouts

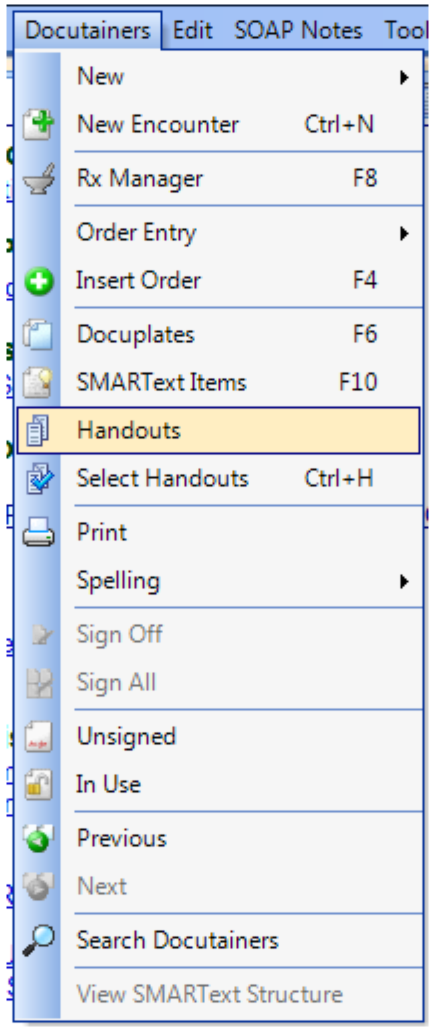
Handouts Manager

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. A user can select and print handouts manually, or have SOAPware automatically print them, and insert a notice of printing into the current encounter note.

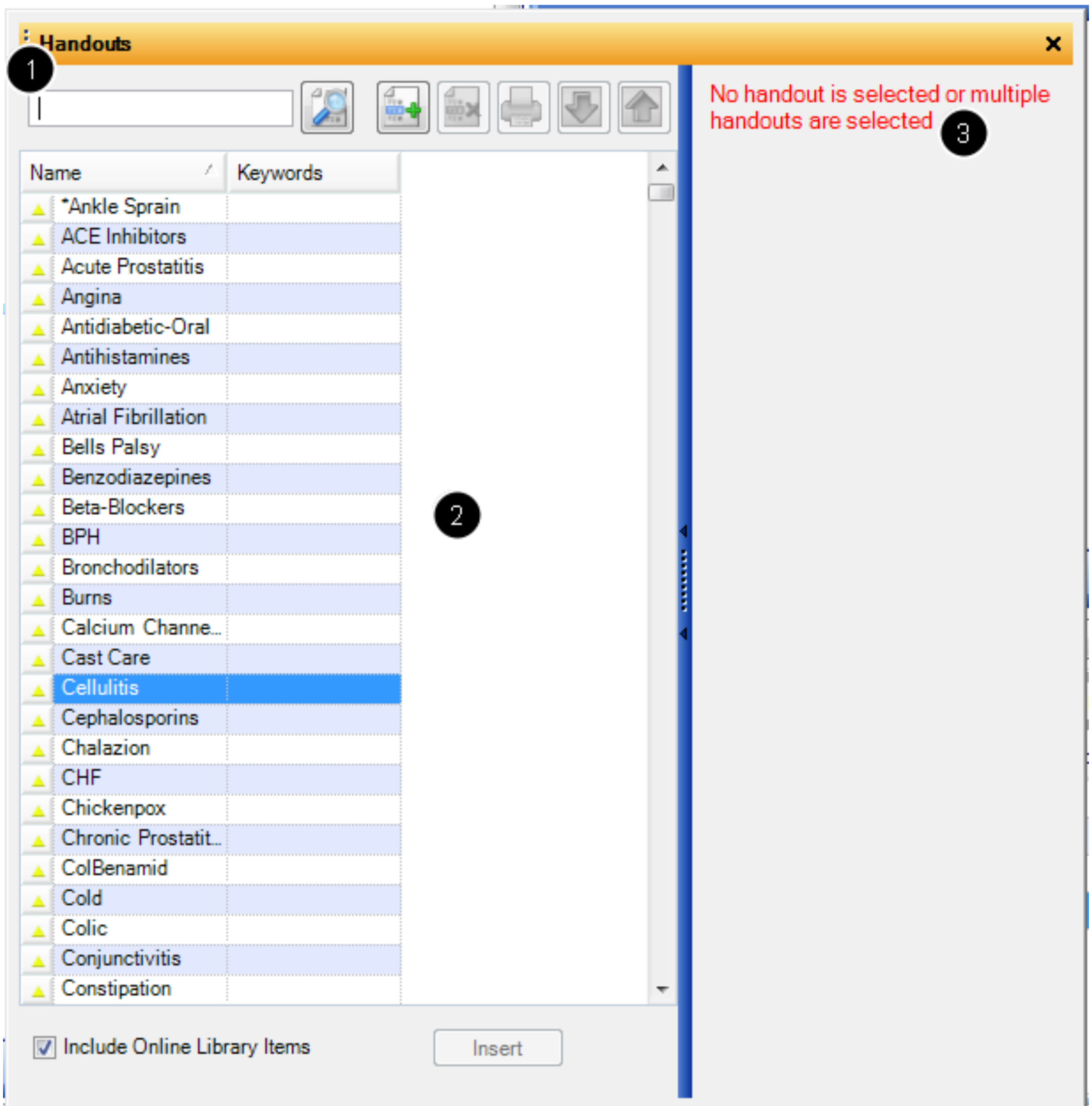
***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Patient Specific Educational Resources

Open the Handouts Manager



To open the Handouts Manager, Click Docutainers on the menu bar, and select the Handouts menu item.

Handouts Manager



The Handouts Manager has 3 main areas.

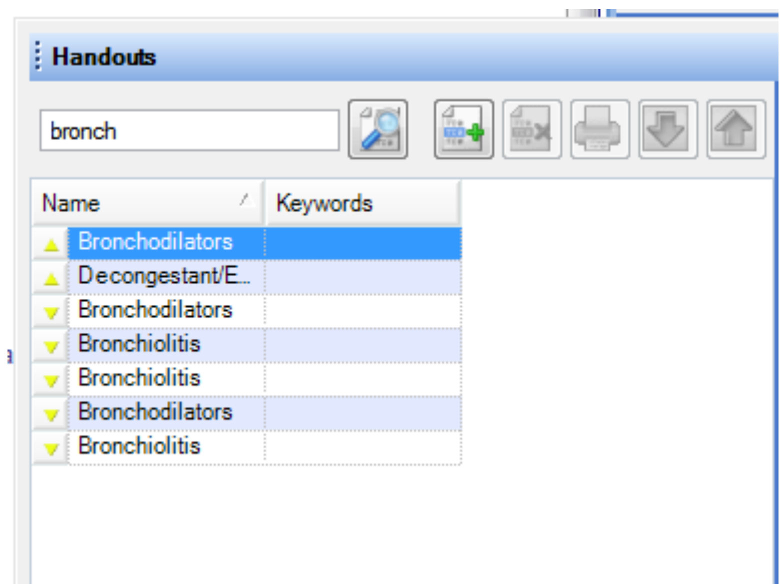
1. The left side of the Handouts Manager has a search field/box used for searching by keywords. This area also contains the mini-toolbar buttons (e.g. New Handout, Remove Handout, Print Handout, Download, and Upload).

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.

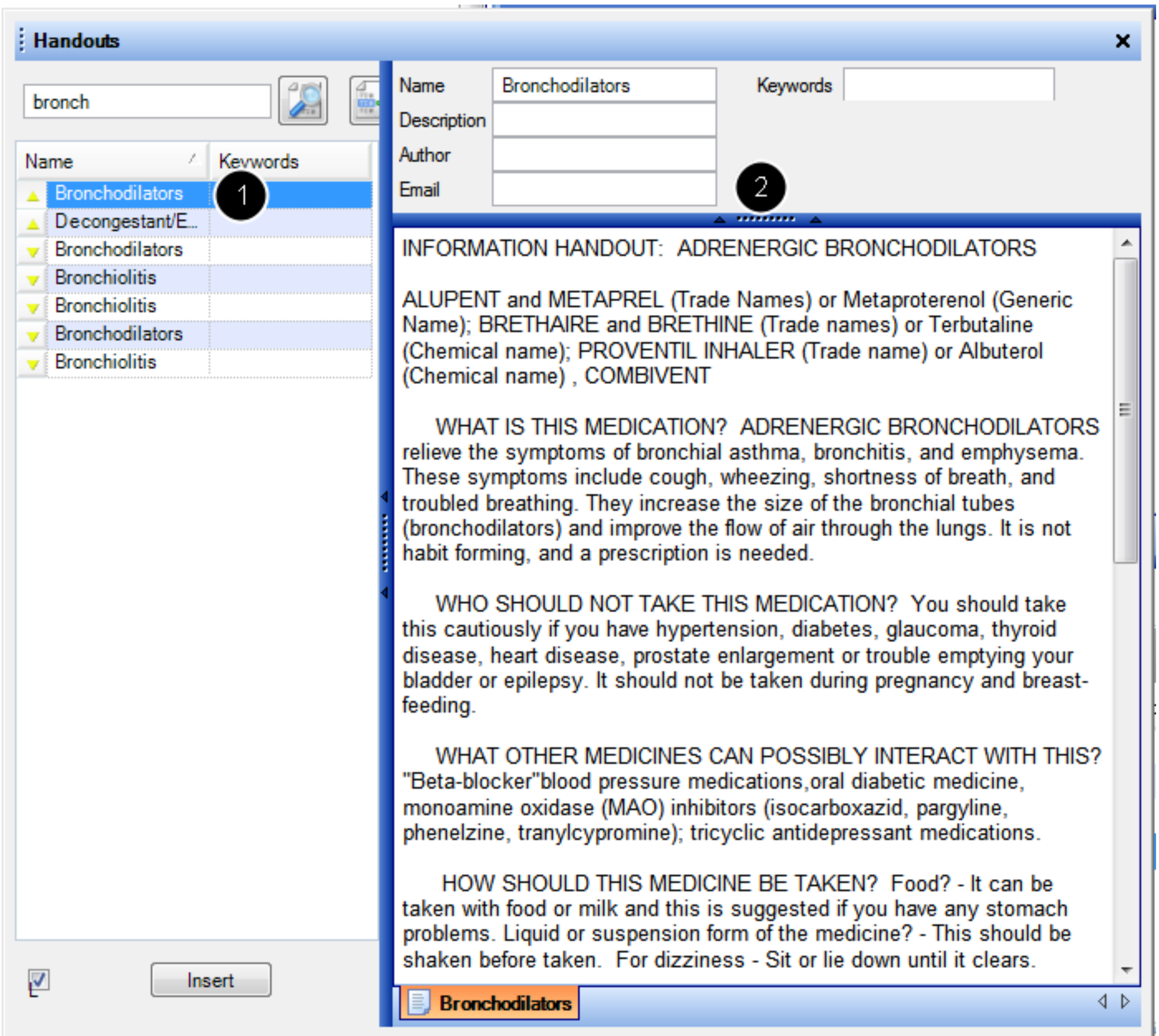
3. Finally, the lower right area of the Handouts Manager contains a preview window that displays the content of the handout currently selected in the handout list. Not only can the Handouts Manager itself be resized, but the individual sections within the Handouts Manager can be resized using the splitter 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 bronch. Once the keyword is entered into the search field, either Press the Enter key, or Click the Search button.

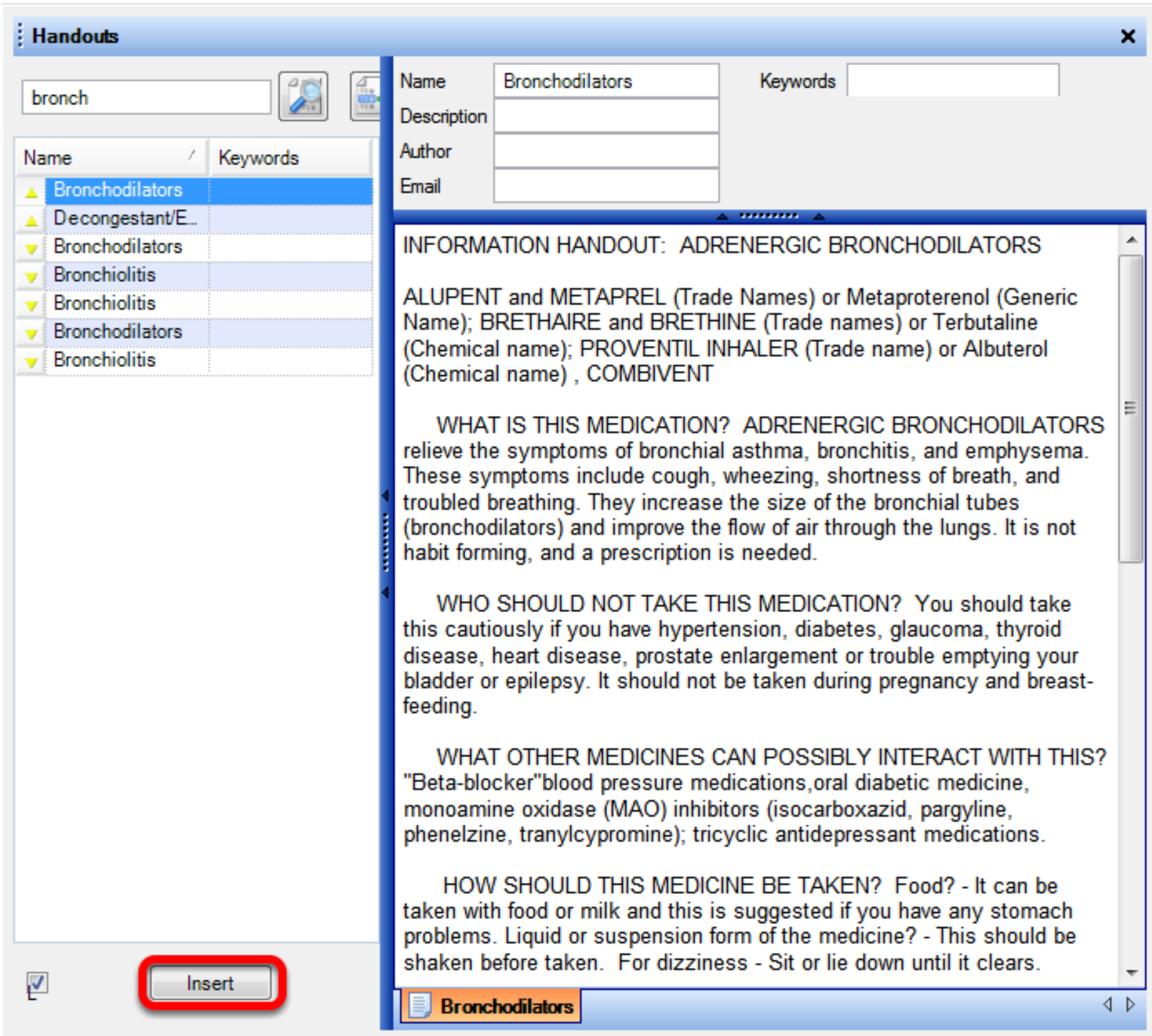
Select a Handout



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. Apreview of the handout will appear in the right side of the Handouts Manager.

Insert



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.

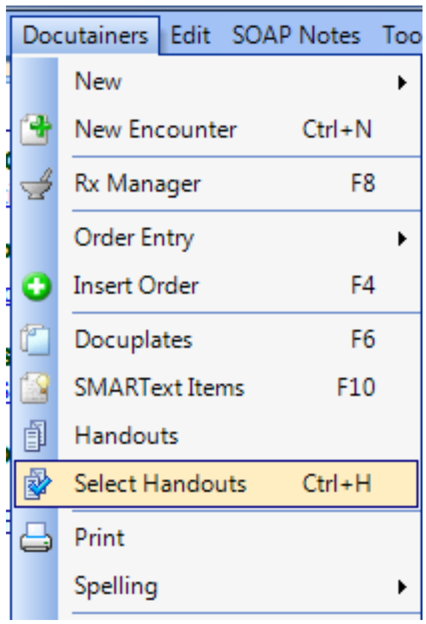
***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Patient Specific Educational Resources

Patient Meaningful Use Dashboard:
This requirement will be tracked via the Patient Meaningful Use Dashboard

Assessment and Medication

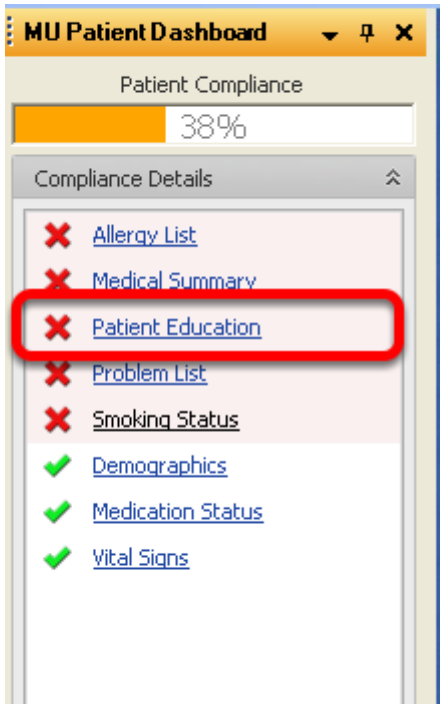
In this example, notice Allergic rhinitis is in the Assessment field and Albuterol is in the Medications field.

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).

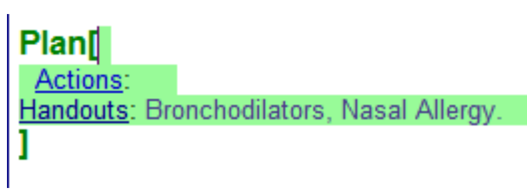
Select Handouts using the MU Patient Dashboard



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



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.

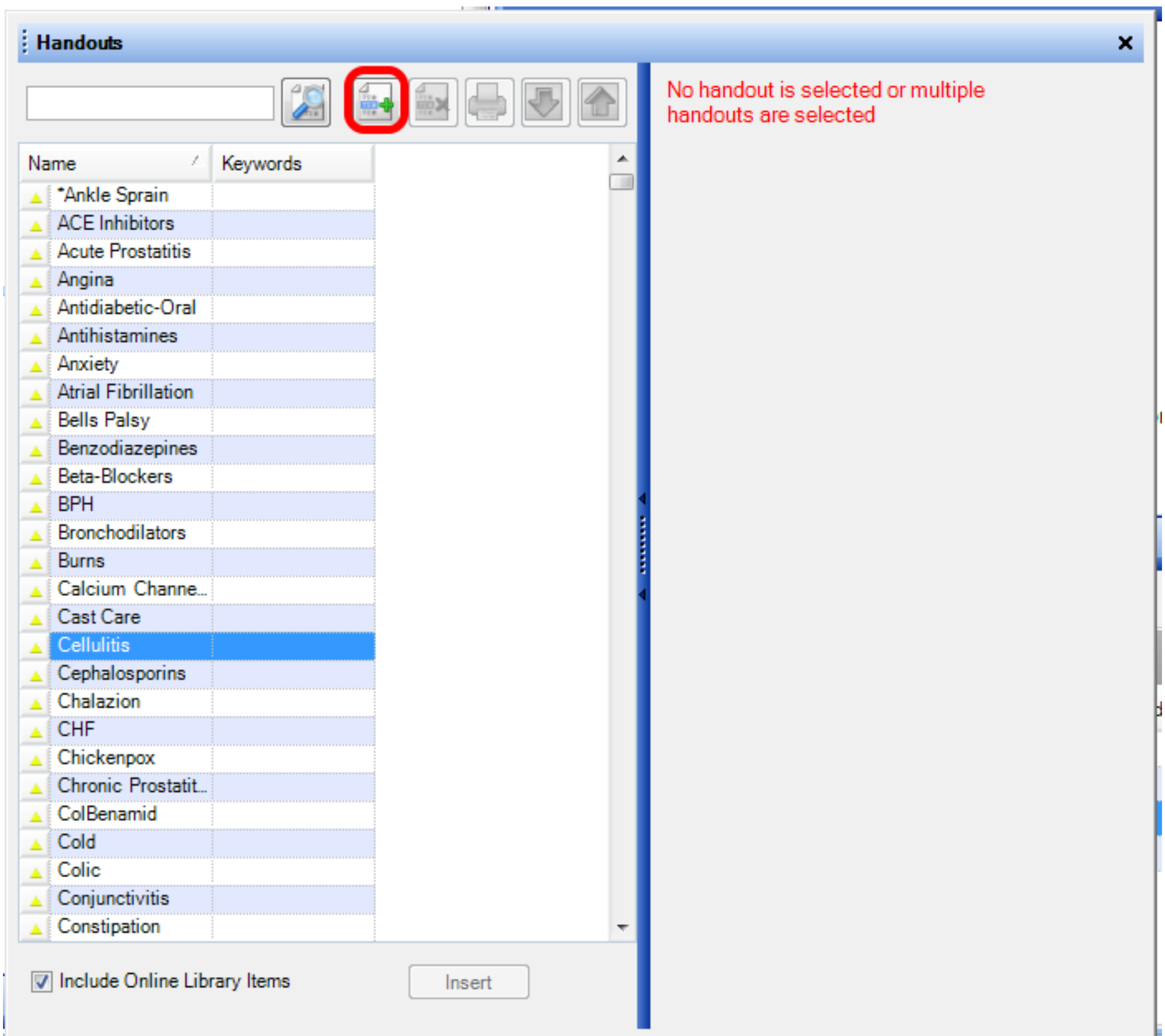
Tips

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

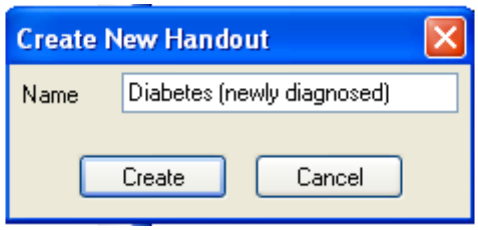
If the user needs to create a custom handout, or a handout on a topic not covered by an existing handout, the user can create his/her own.

New Handout



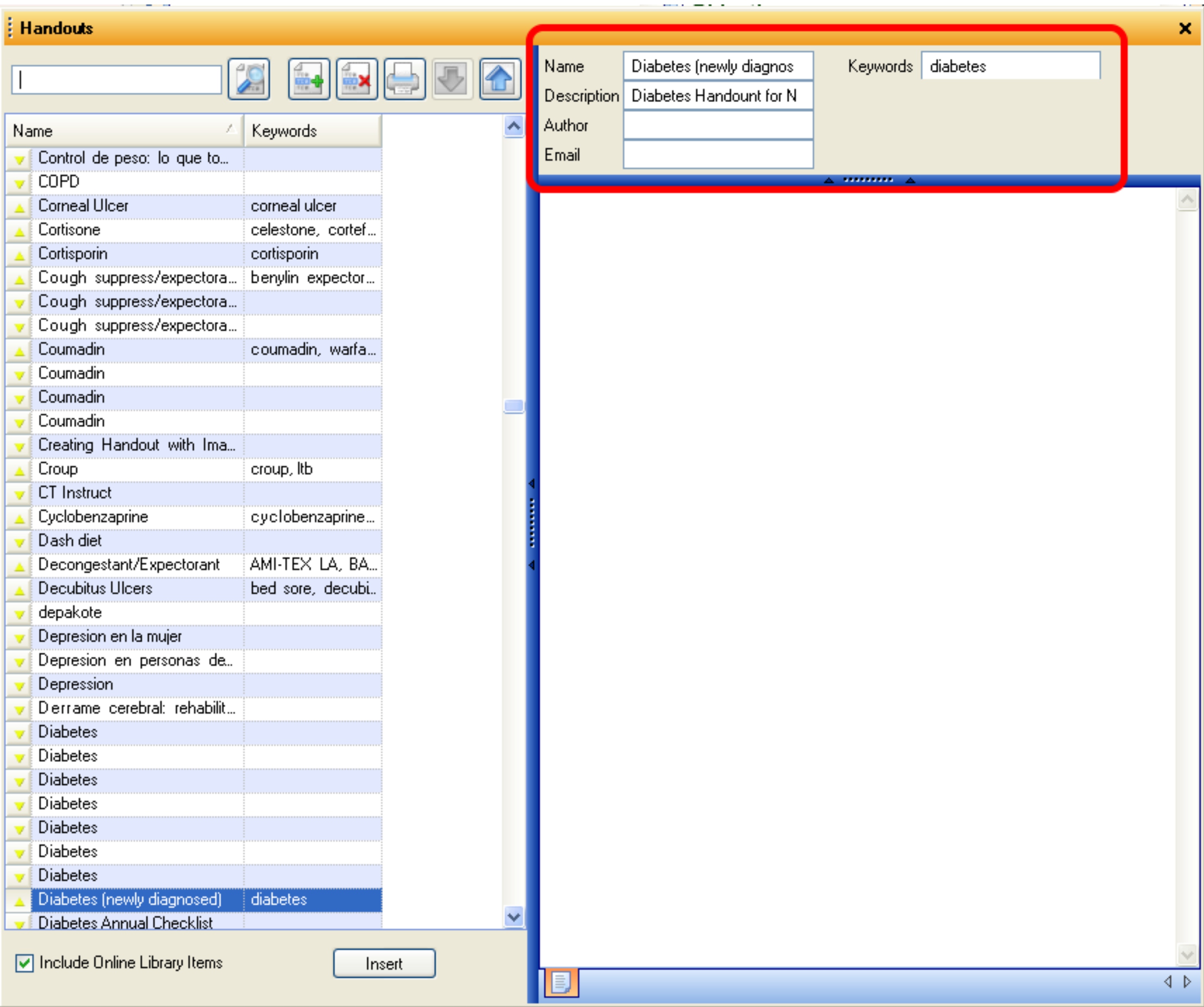
New handouts can be created in the Handouts Manager by Clicking the New Handout button (or by Pressing Control + Alt + N).

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.

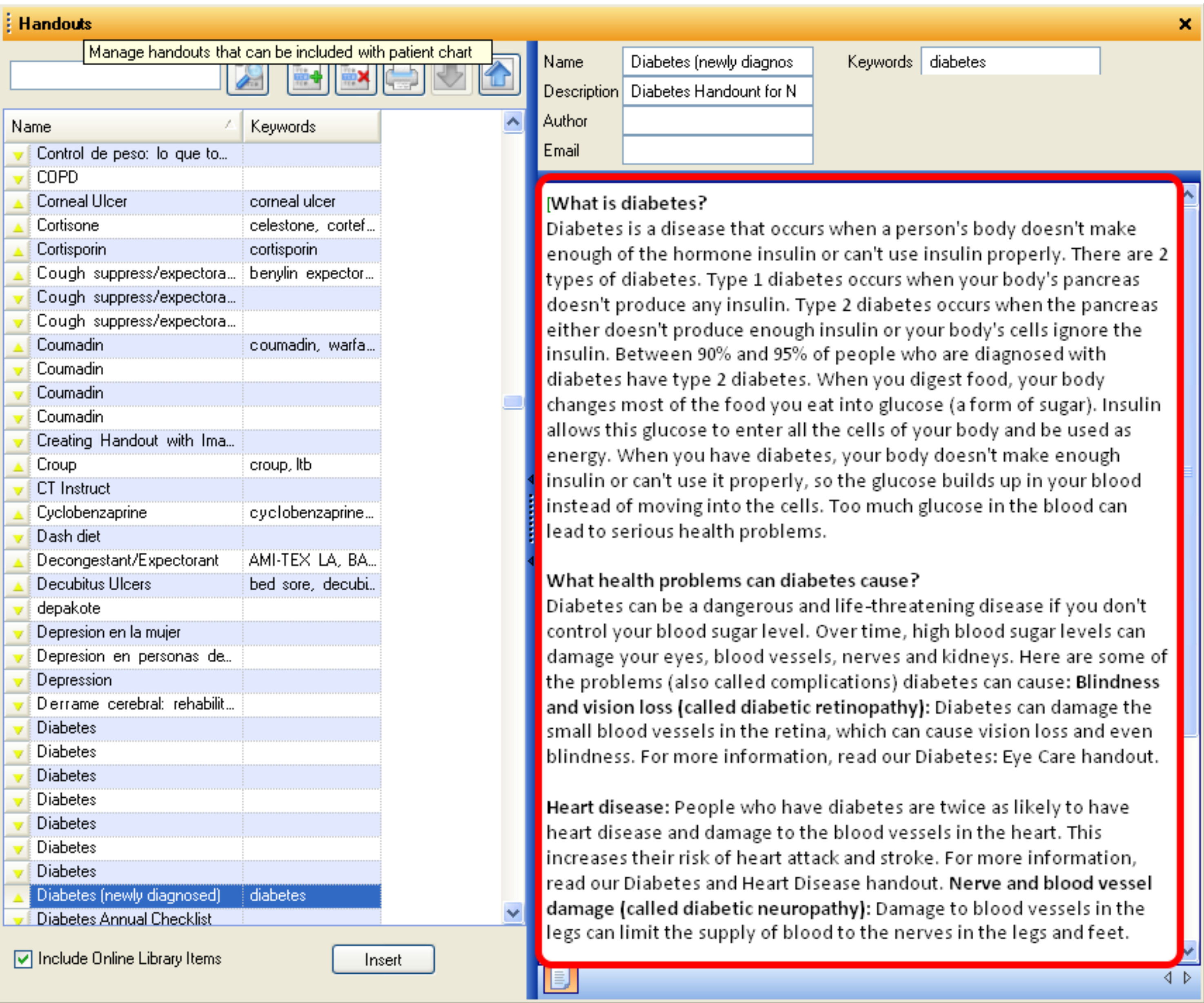
Handout Demographic Information



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.

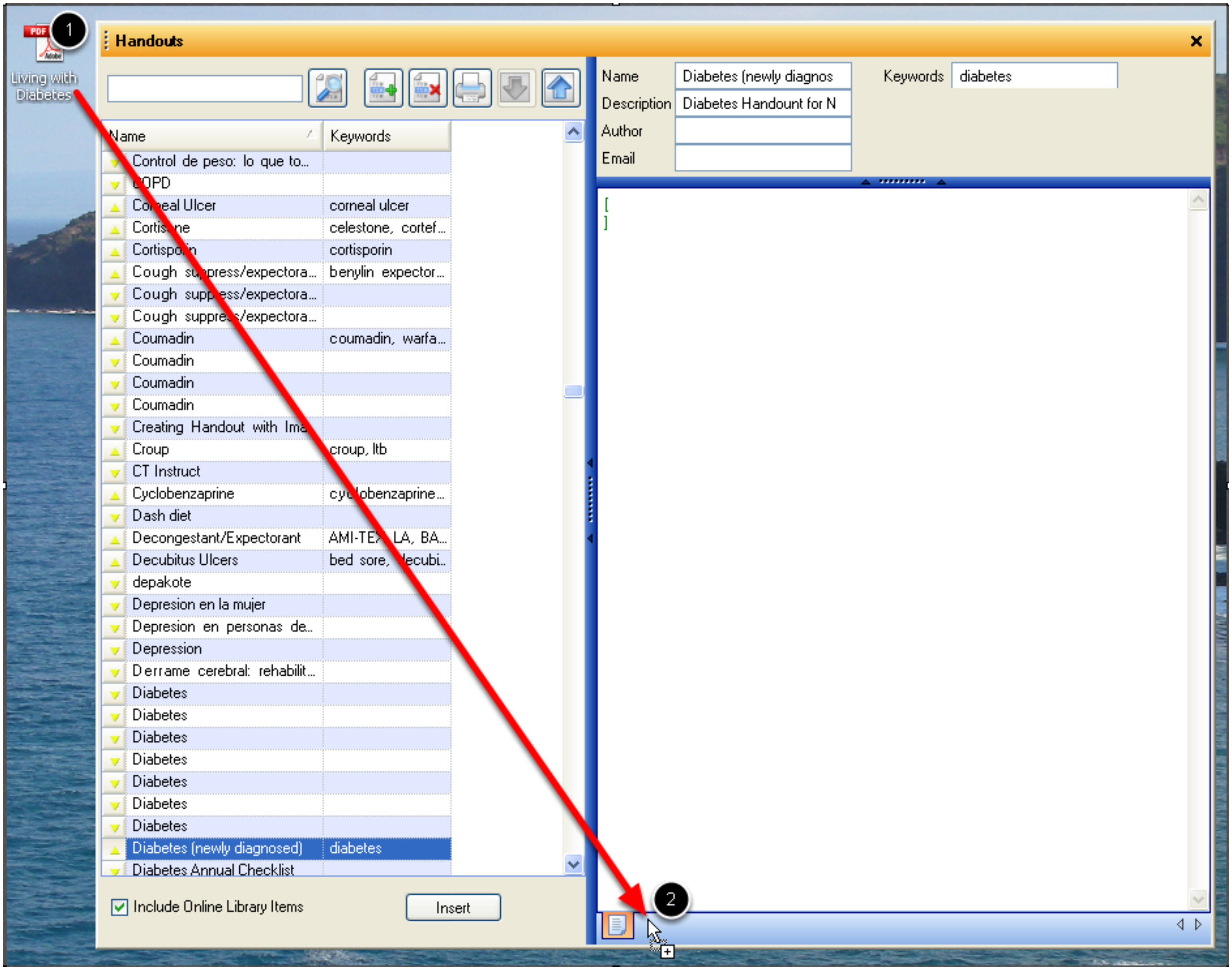
***Note**: The Keywords are what SOAPware uses to find handouts, so be sure to include any keywords that are related to the handout. Also note that the keywords need to be either a medication name or a diagnosis.

Creating a Text Handout



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

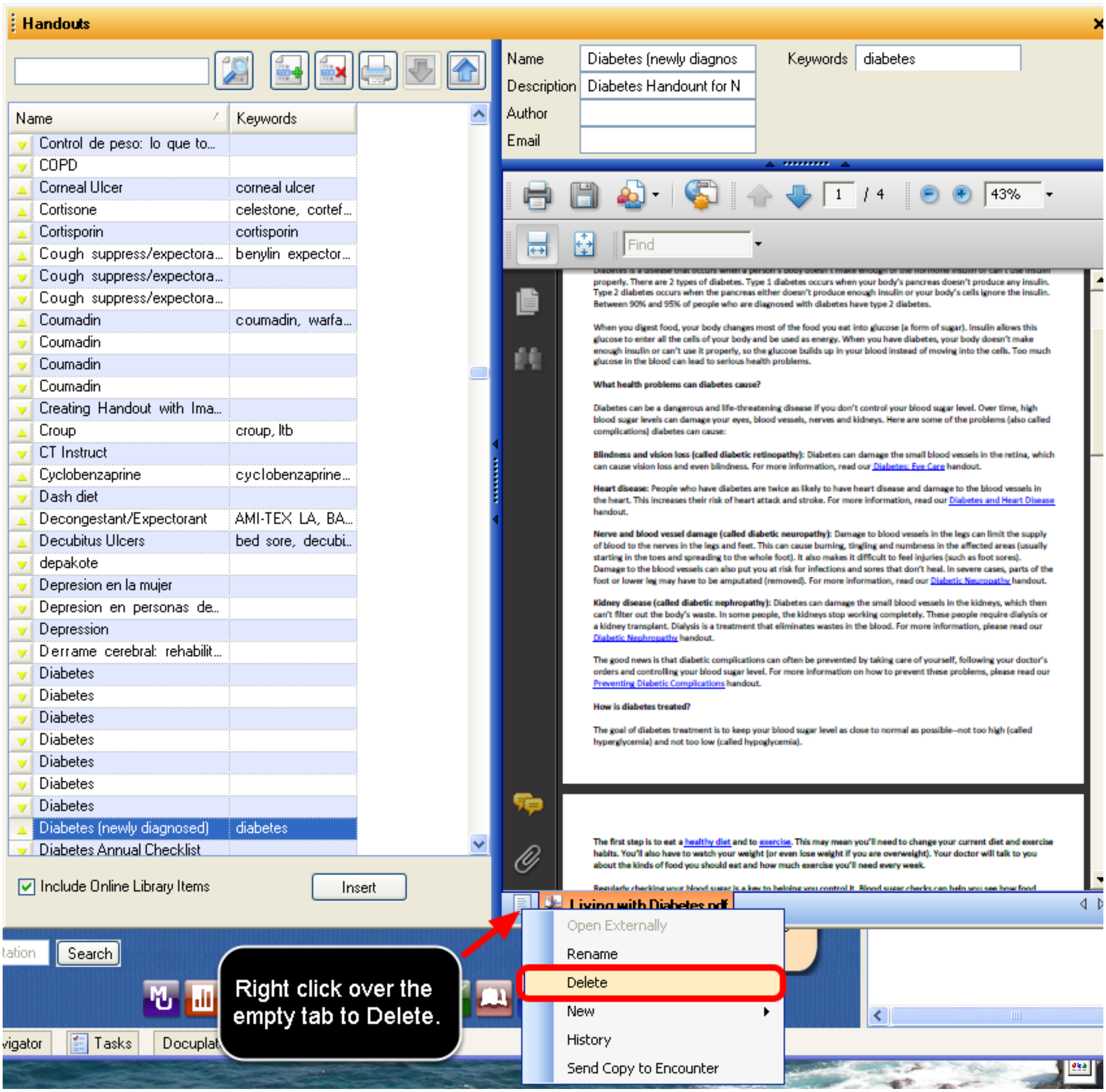


To create a PDF handout, follow the steps below:

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

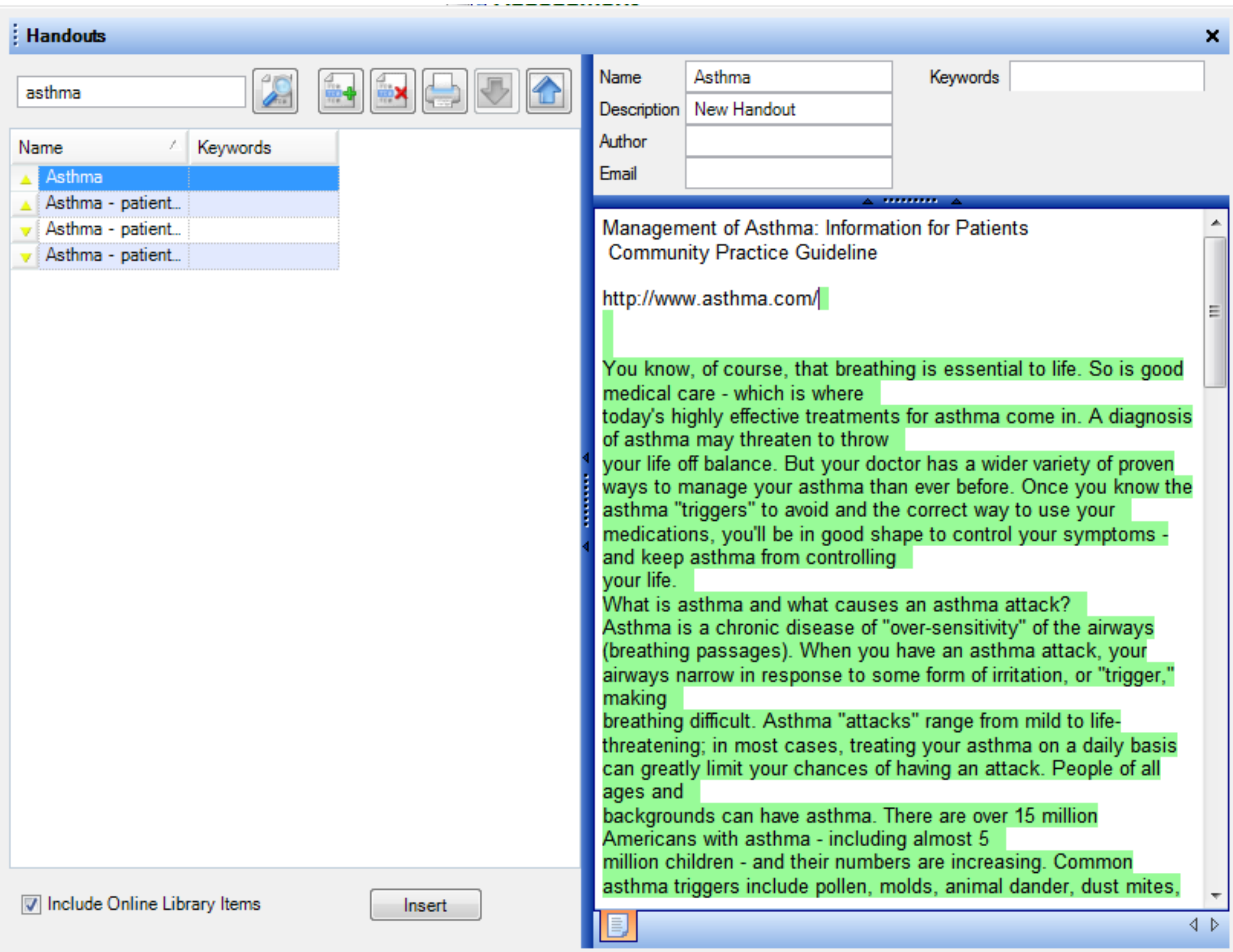


After the user has imported the PDF handout, the blank text handout tab will need to be deleted. To do this, Right-click on top of the empty tab and Select Delete.

Editing Existing Handouts

It is easy to modify existing handouts to keep them up to date and comprehensive.

Editing Handouts

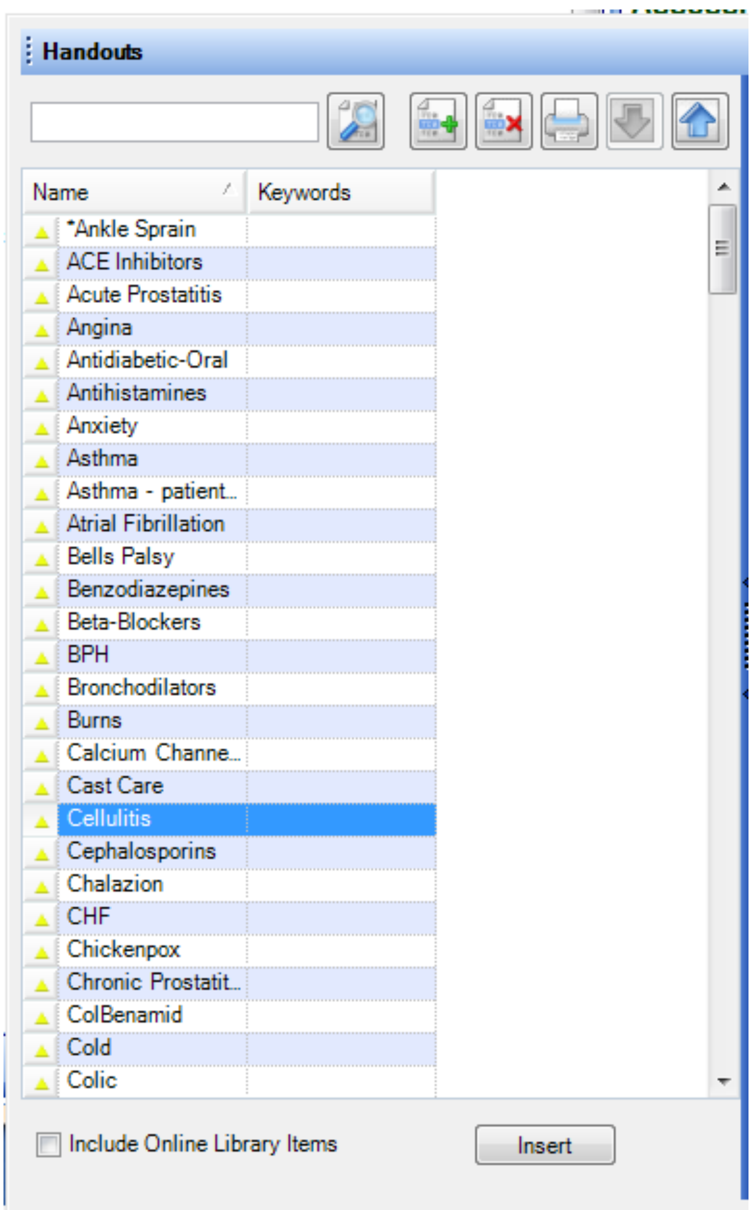


To modify or customize an existing handout, first select that handout to make it appear in the preview window on the right. The user is to make any changes to the handout in the same way that he/she would if creating a new handout, and close the Handouts Manager. The handout will now appear with any edits or modifications made.

Deleting Existing Handouts

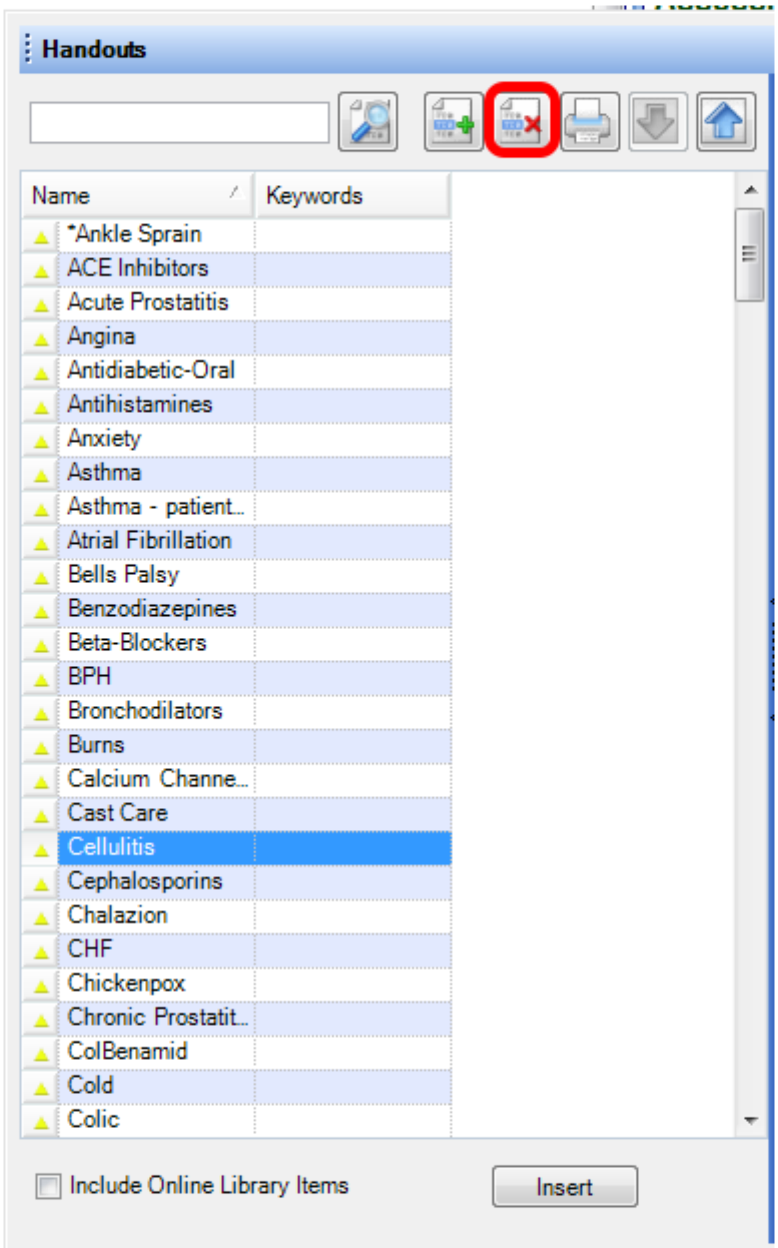
Deleting Handouts from the local library is a good way to keep them easy to use so that only the most current handouts are included with the Select Handouts Automatically option.

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

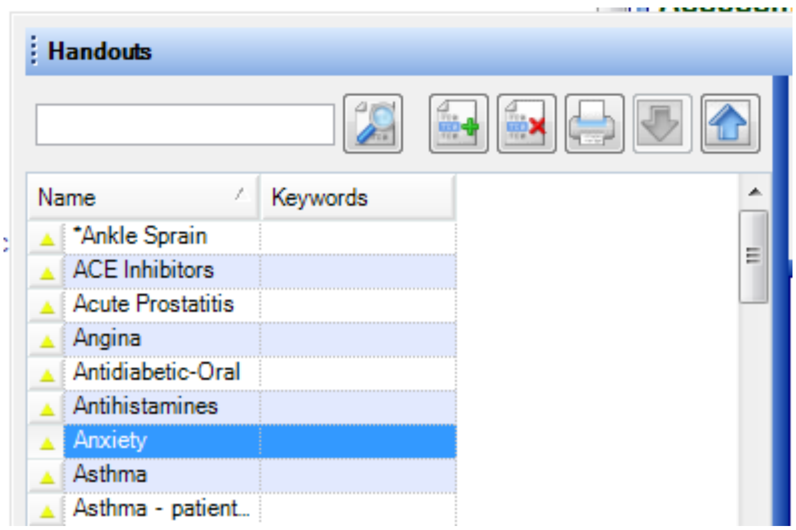


After selecting the handout to be deleted, Click the Remove Handout button (or Press Ctrl+Alt+R). SOAPware will ask for confirmation to delete the handout. Click Yes, and the handout will be removed from the list. Otherwise, Click No.

Printing Individual Handouts

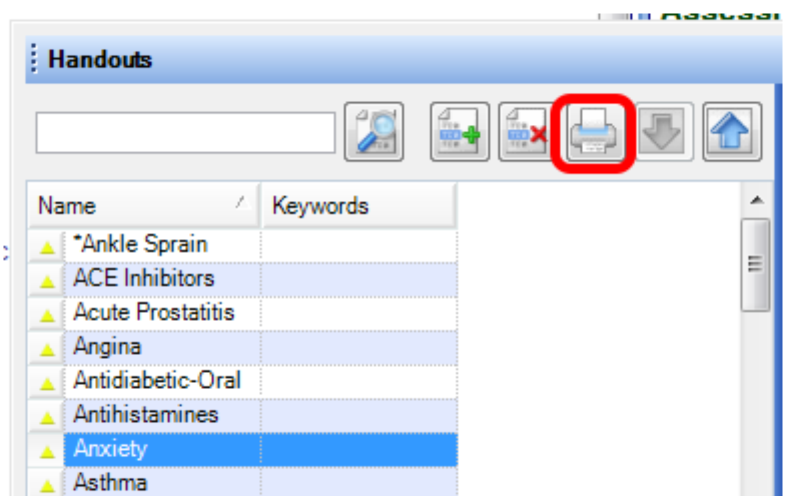
Handouts can be printed individually.

Select



Select the handout to print. Do this by searching for the handout by keyword, and selecting if from the handouts list.

Print



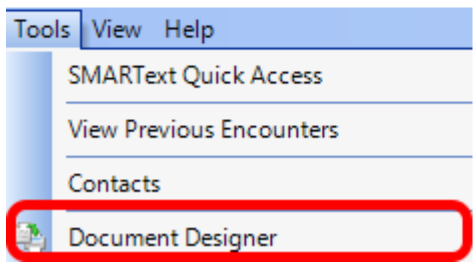
After selecting the handout to be printed, Click the Print Handout (or Press Control + Alt + P).

Print Handouts Alone Automatically

This lesson will guide the user through the steps necessary to print out handouts alone, automatically, as part of a patient visit.

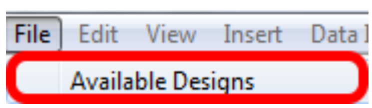
***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Patient Specific Educational Resources

Access Document Designer



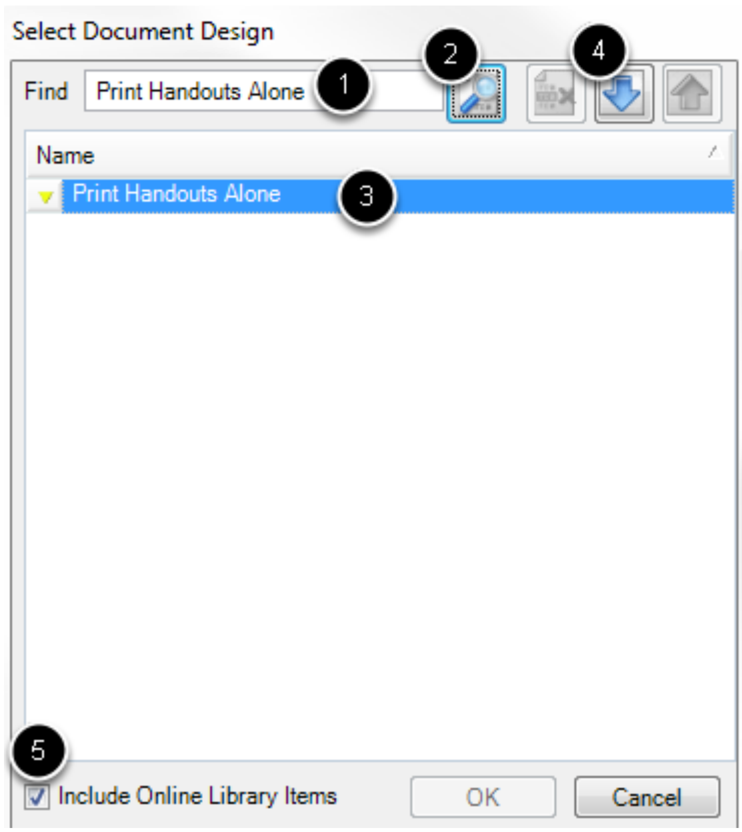
Click Tools > Document Designer from the main menu.

Search Available Designs



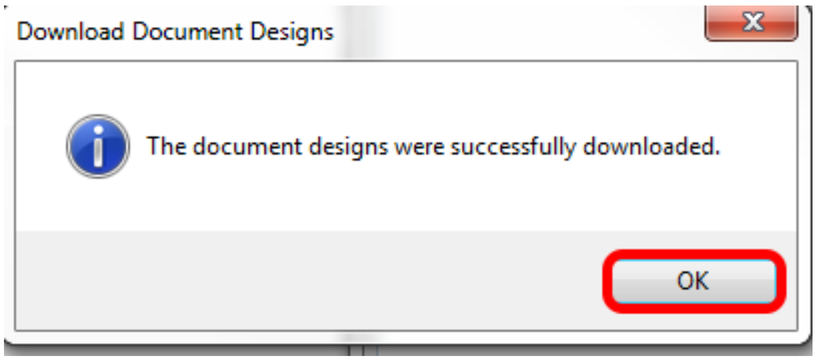
Select File > Available Designs.

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.

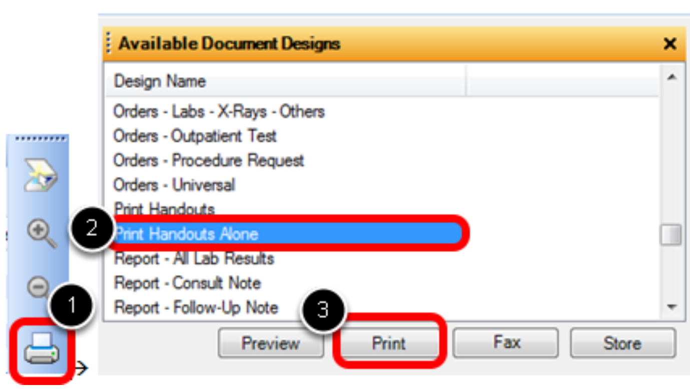
Selecting Handouts Automatically

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:

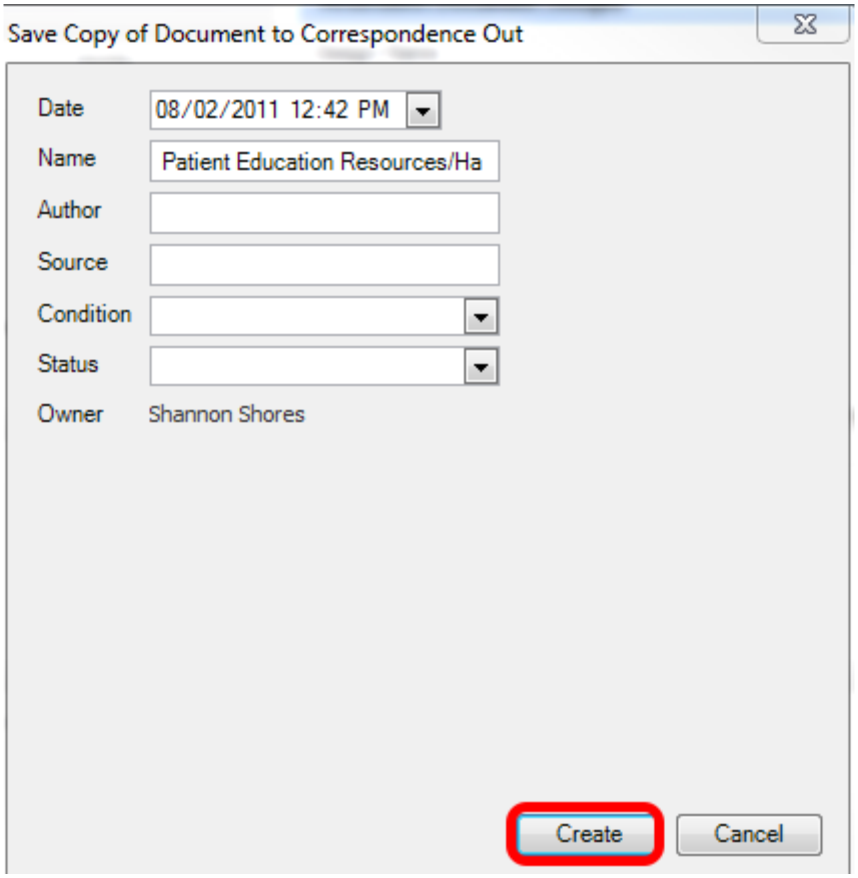
Selecting Handouts Automatically

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



Click the Create button to store a copy of this document design in the Correspondence Out chart section.

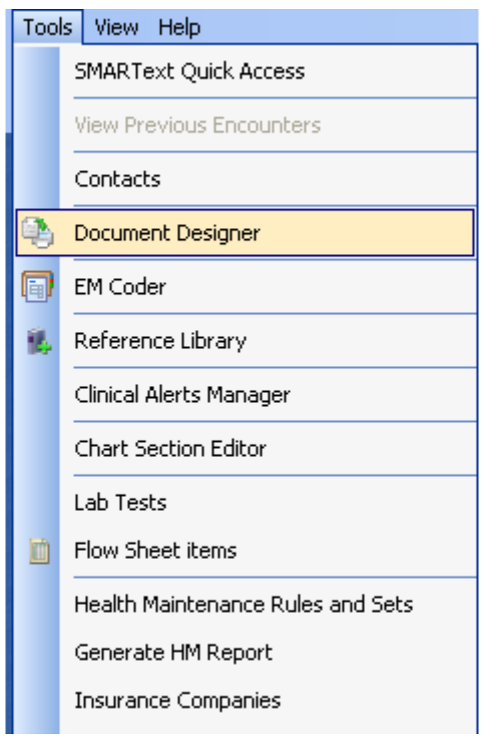
Print Handouts Automatically when other Documents are Printed

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

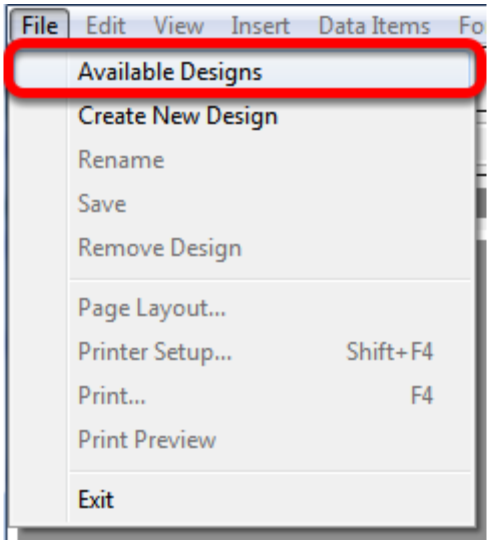
Patient Meaningful Use Dashboard:
This requirement will be tracked via the Patient Meaningful Use Dashboard

Open Document Designer



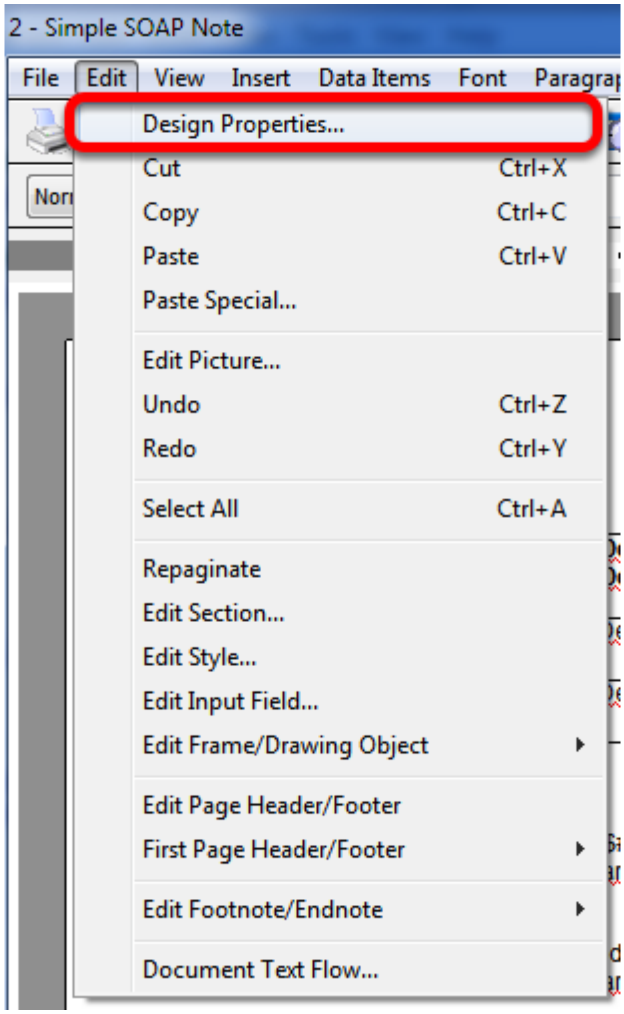
In order for handouts to be printed when a SOAPnote document design is printed, the Print Selected Handouts option must be set in the printed document design. Open the Document Designer (Tools - Document Designer).

Open a Design



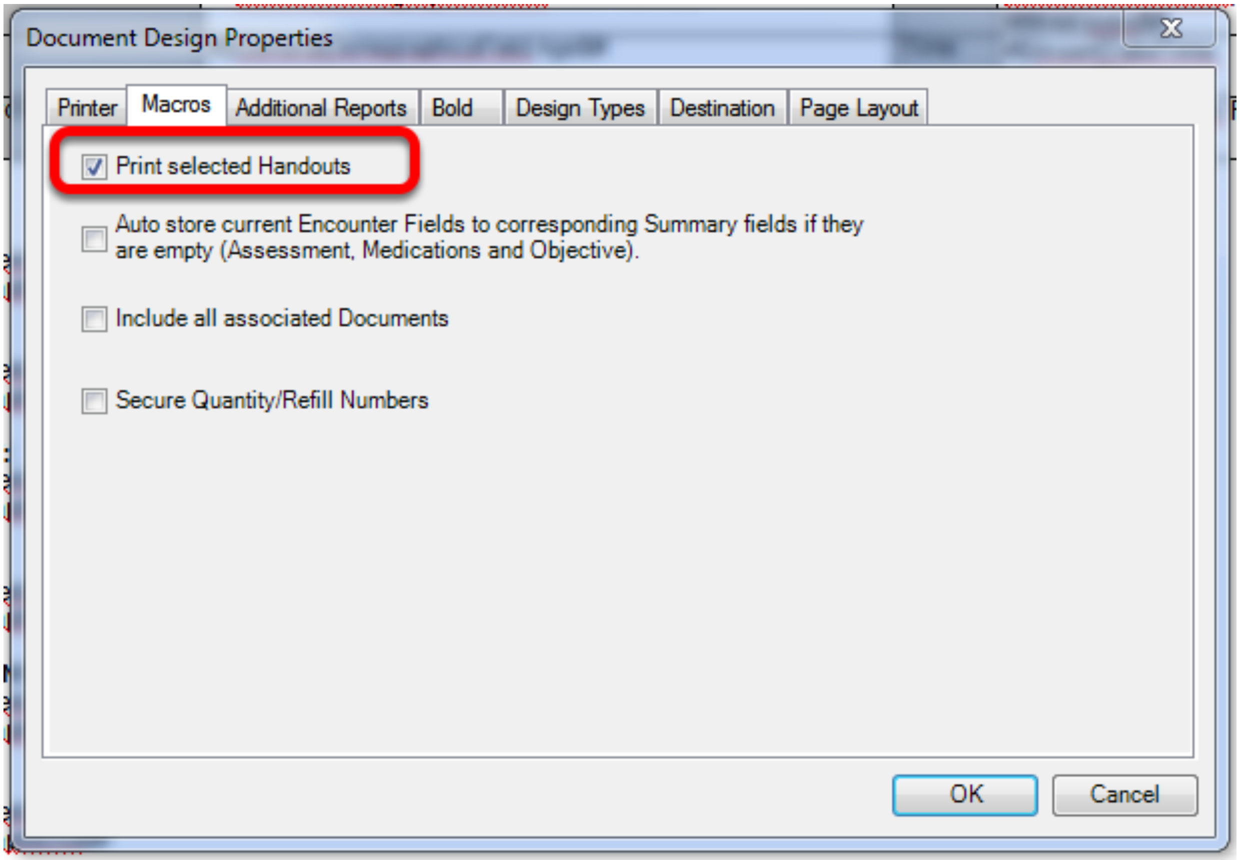
Open a document design or create a new one (File - Available Designs or Create New Design).

Design Properties



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.

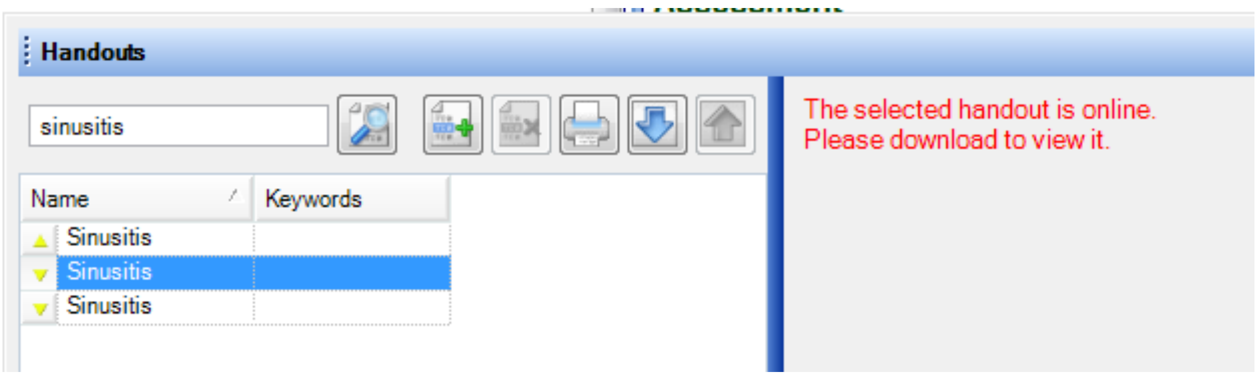
Uploading/Downloading Handouts

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

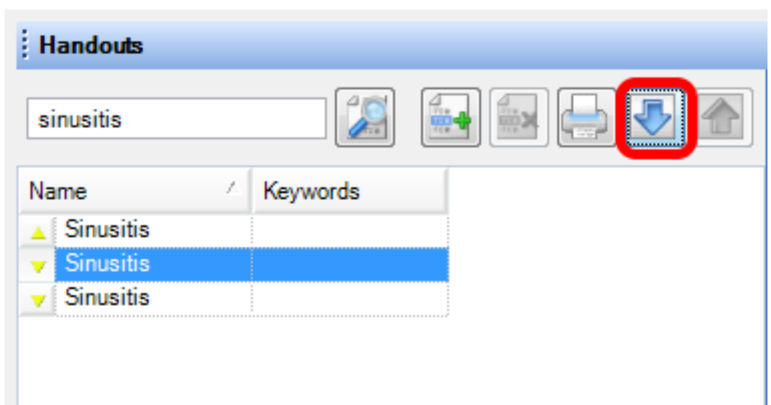
To download a handout from the library, first ensure that the Handouts Manager has been told to include online handouts. To do this, Click the Include Online Library Items checkbox located in the lower left corner of the Handouts Manager.

Select Handout



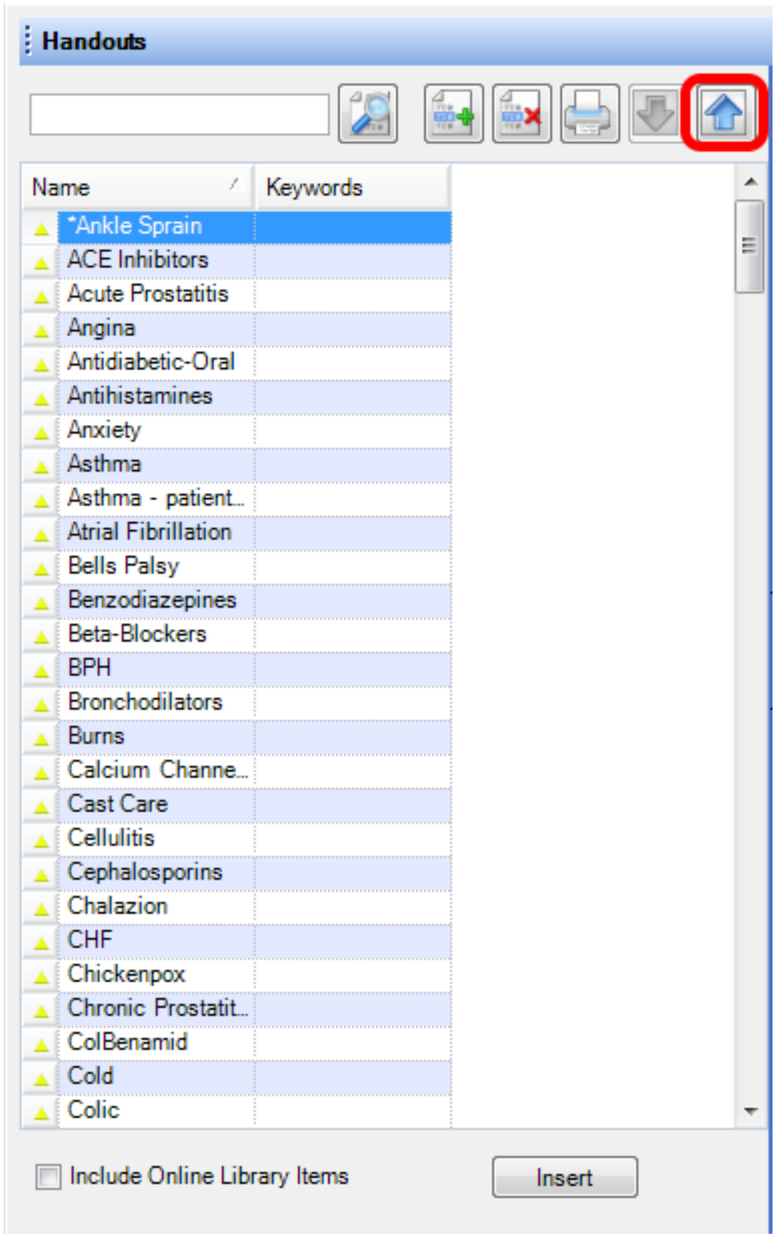
Handouts available for download will display with either a yellow or a green triangle pointing down. Click the name of a handout to download, and notice, in the right side of the dialog, the message - The selected handout is online. Please download to view it.

Download



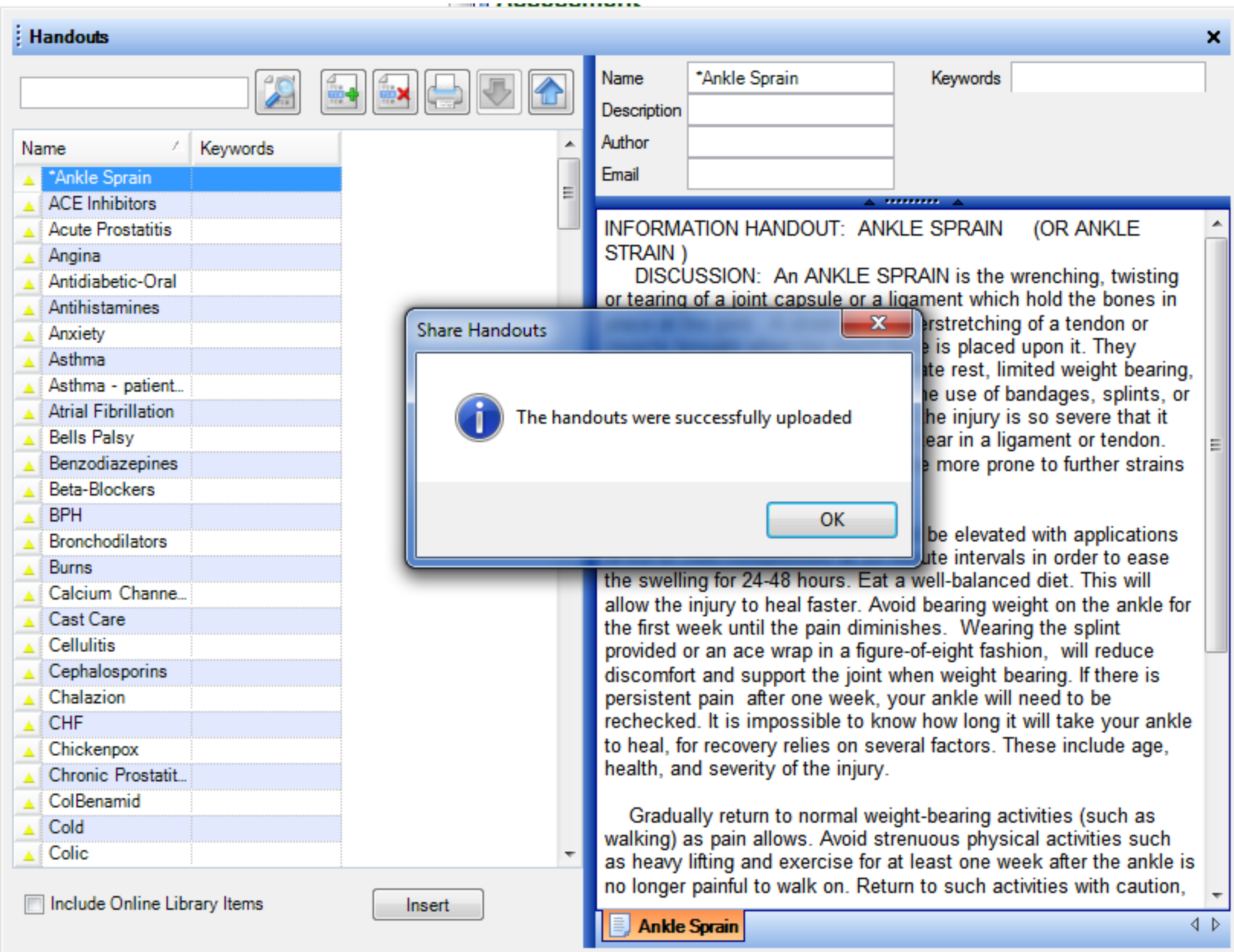
Click the Download button(or Press Control + Alt + D). The selected handout will be downloaded and stored for local use. Notice that the triangle is now pointing up which indicates that it is downloaded to the local database.

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.

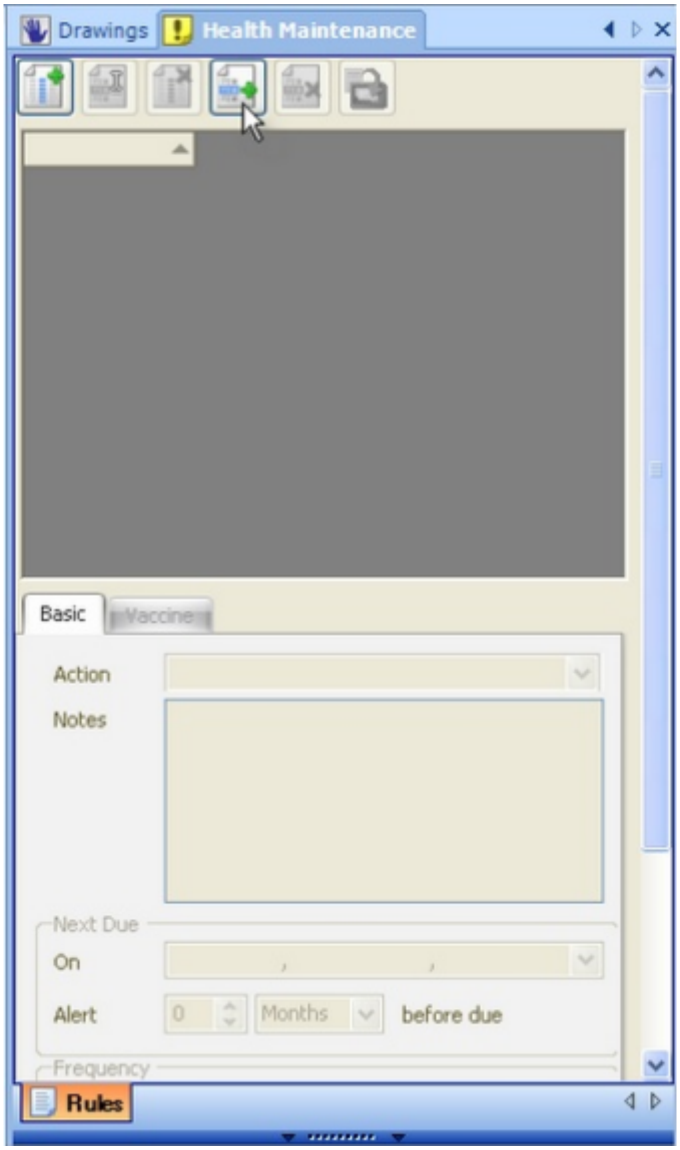
Prior to the conversion, create HM Reports to identify patients due for follow up for health maintenance in the future. Print this report and use it as a back-up reference to ensure issues have been addressed in the future.

We suggest, as patients arrive in the future, update the HM rules in each chart.

Health Maintenance Rules and Sets

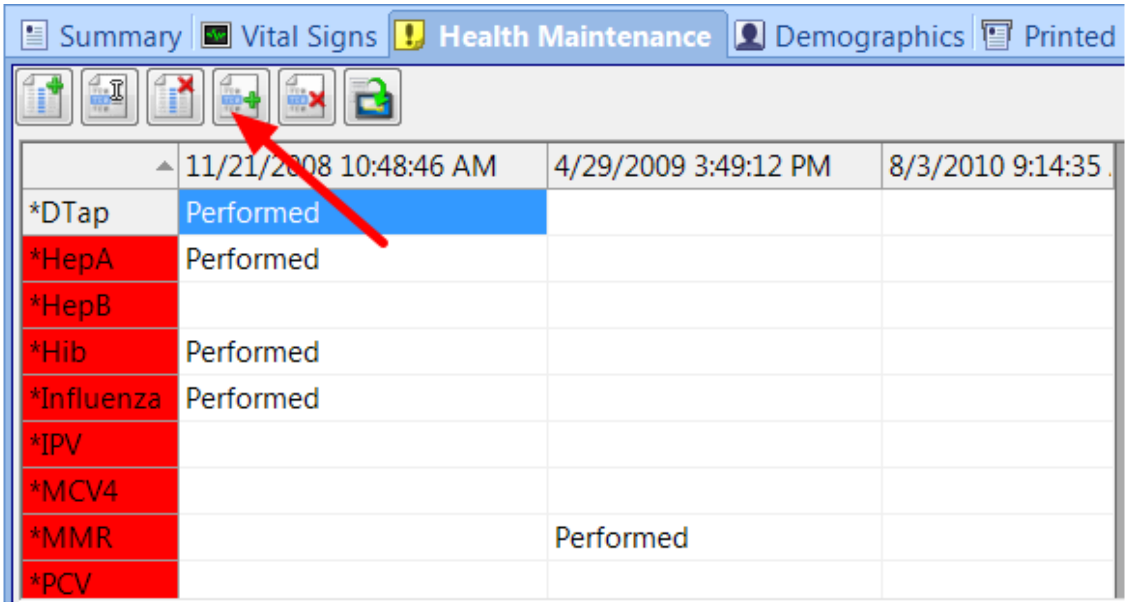
Health Maintenance Rules and Sets allows the user to Create, or Edit Rules and Rule Sets.

Health Maintenance



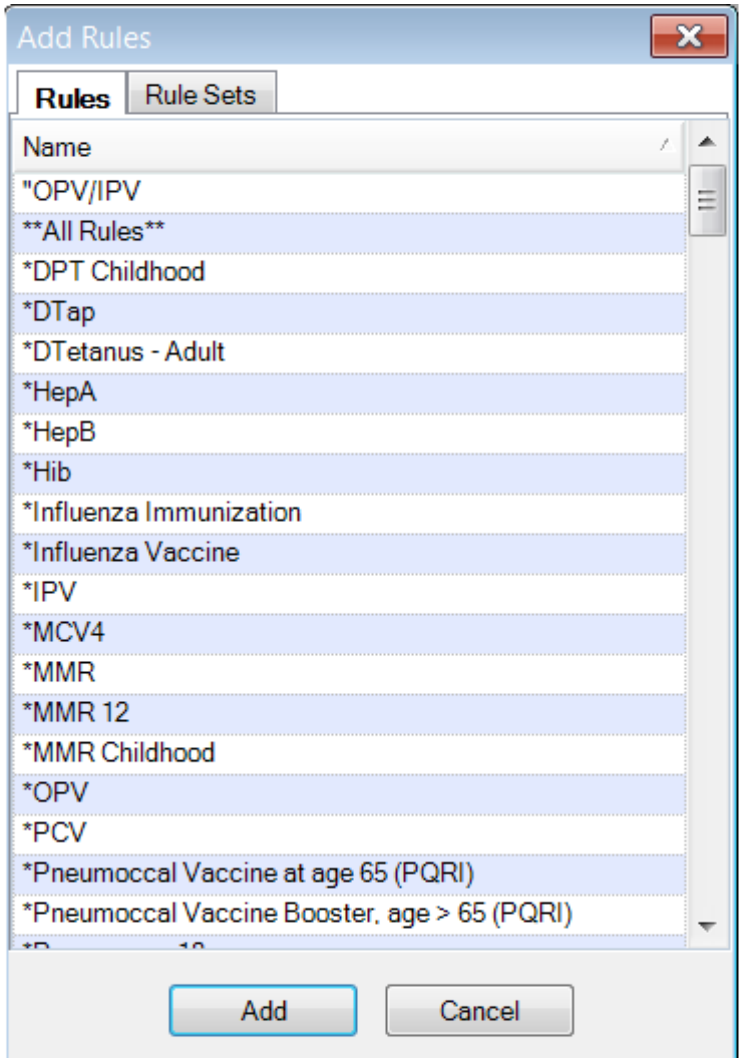
Open a patient chart. Verify the Demographics section of the chart is completed for patient age and gender. Click Chart in the menu bar; Click the Sections menu item, and then Click the Health Maintenance menu item. (or, simply Click on the Chart Navigator docked tab, and Double-click on Health Maintenance) 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



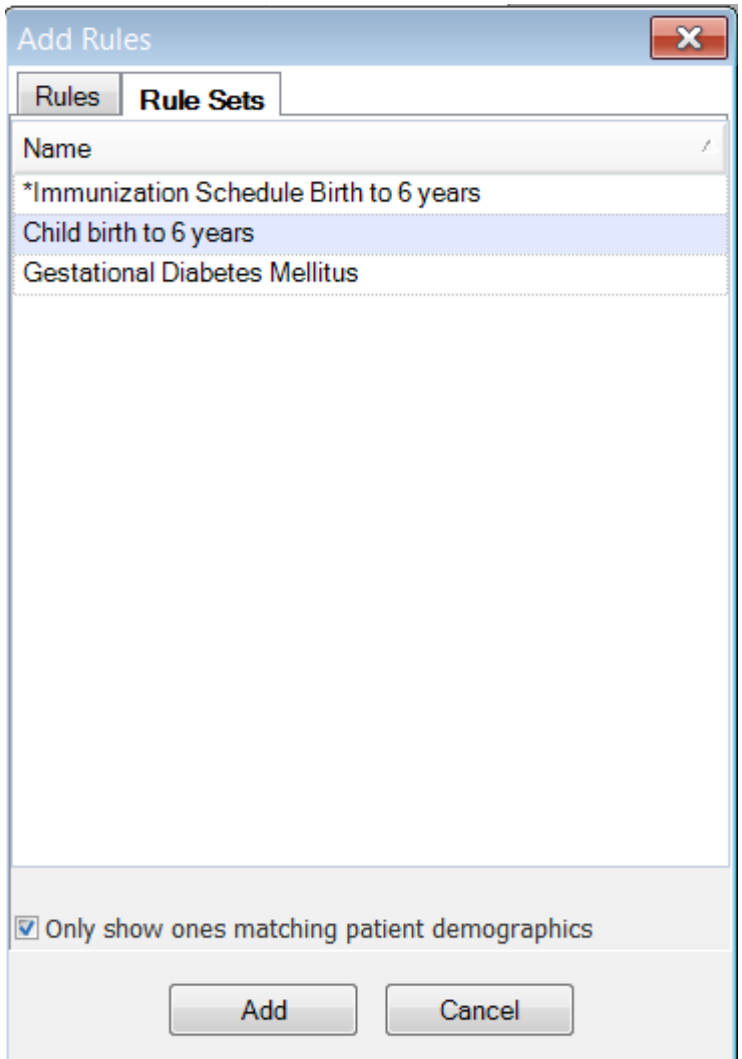
To add a Rule or Rule set, Click the Add Rule button (Green +)

Add Rules



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.

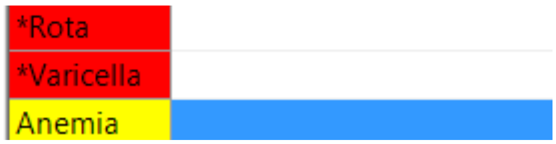
Add Rule Sets



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

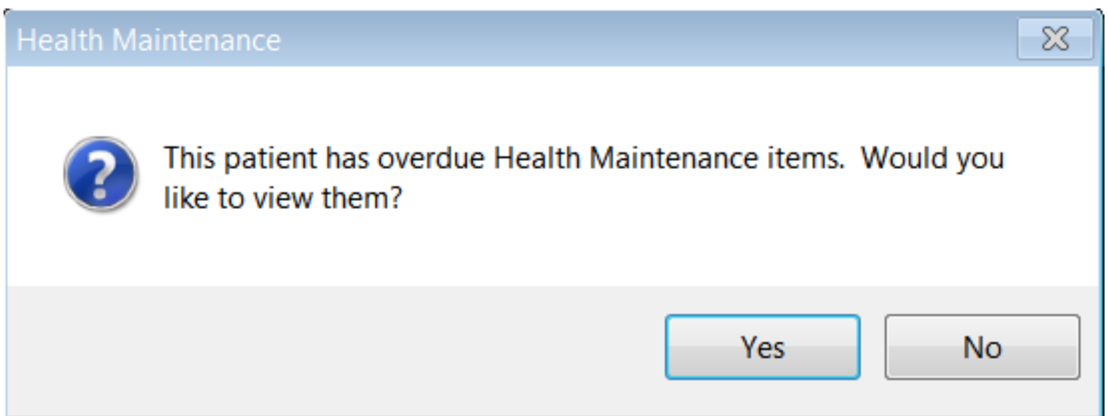
Health Maintenance Color Coding



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.

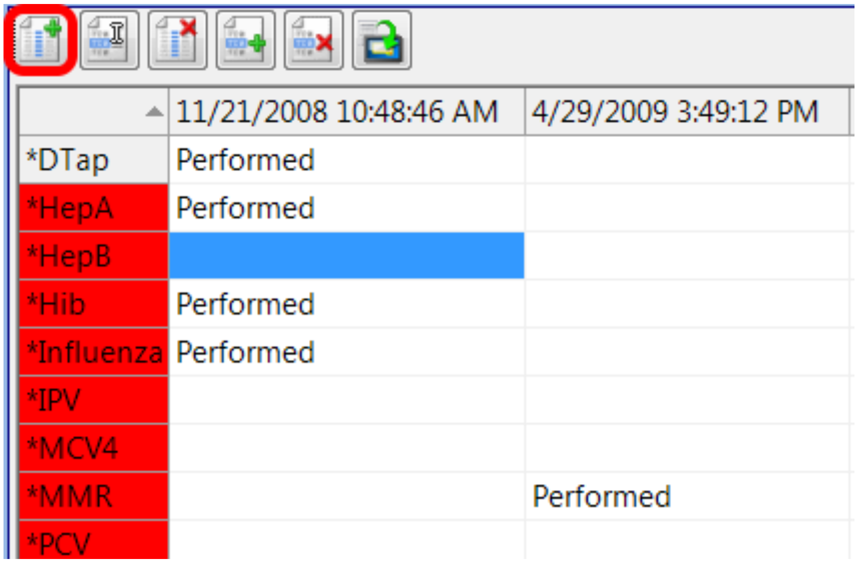
Health Maintenance Alerts



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.

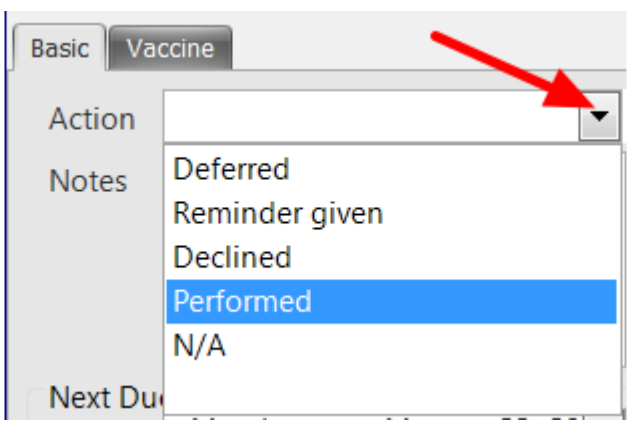
Addressing a Rule

Add Addressed Date

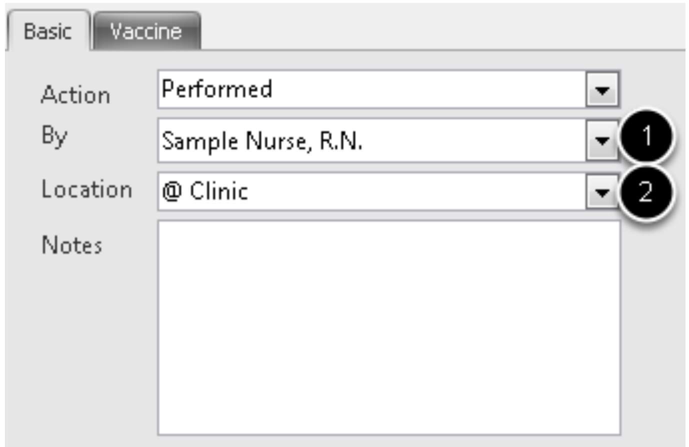


Select the rule that will be addressed. Then click the **Add Addressed Date** button.

Select Action



In the lower region of the Health Maintenance section, click the **Action** drop-down arrow and select the appropriate action for the rule.

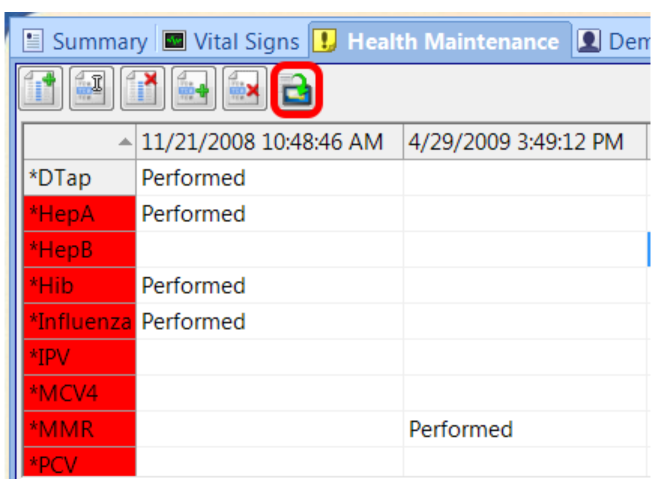


When a specific action is selected the items displayed in the basic section will change.

Choosing the action of "Performed" will display:
1. Adrop down box to select the clinic staff member that performed the rule
2. Adrop down to select where the item was performed

- Selecting the Action " Deferred" will display who deferred the item and why it was deferred.
- Selecting the Action "Reminder given" will display how the reminder was given.
- Selecting the Action "Declined" will display why this item was declined.

Transfer to SOAPnote

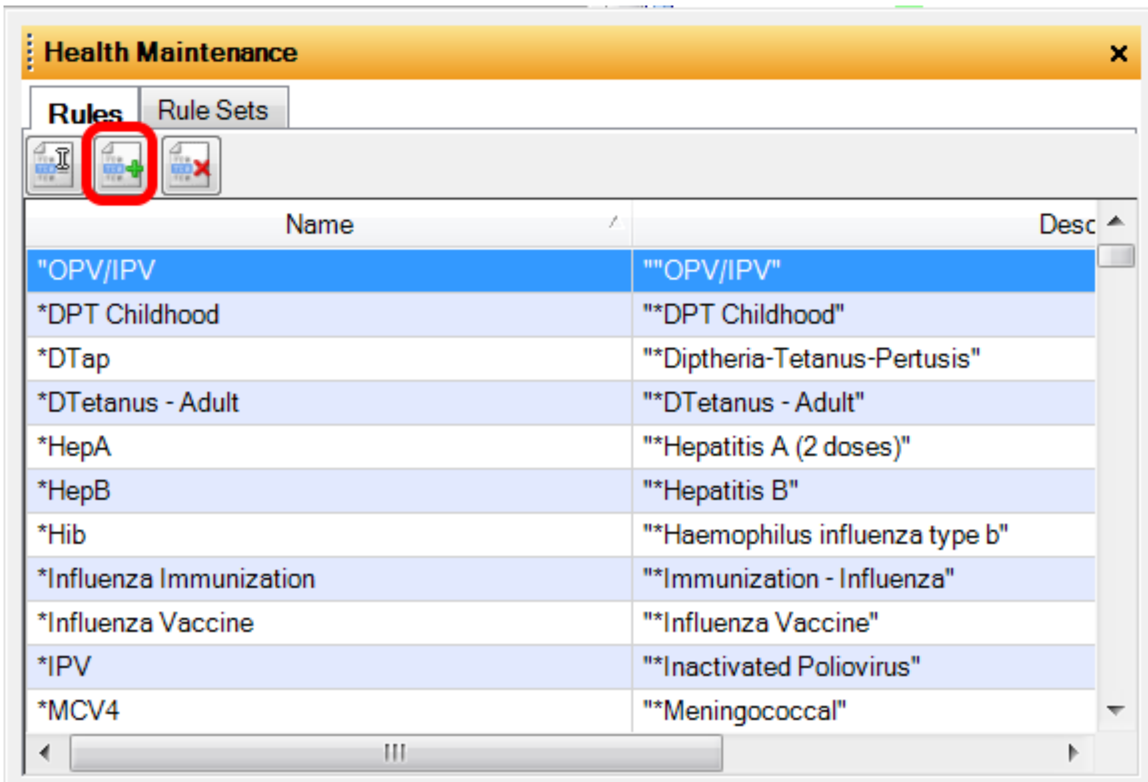


Once the issues are addressed for the visit, click the **Transfer to SOAPnote** button. Documentation of the rules that have been addressed will be added to the Plan field in the current SOAPnote.

Create a Rule

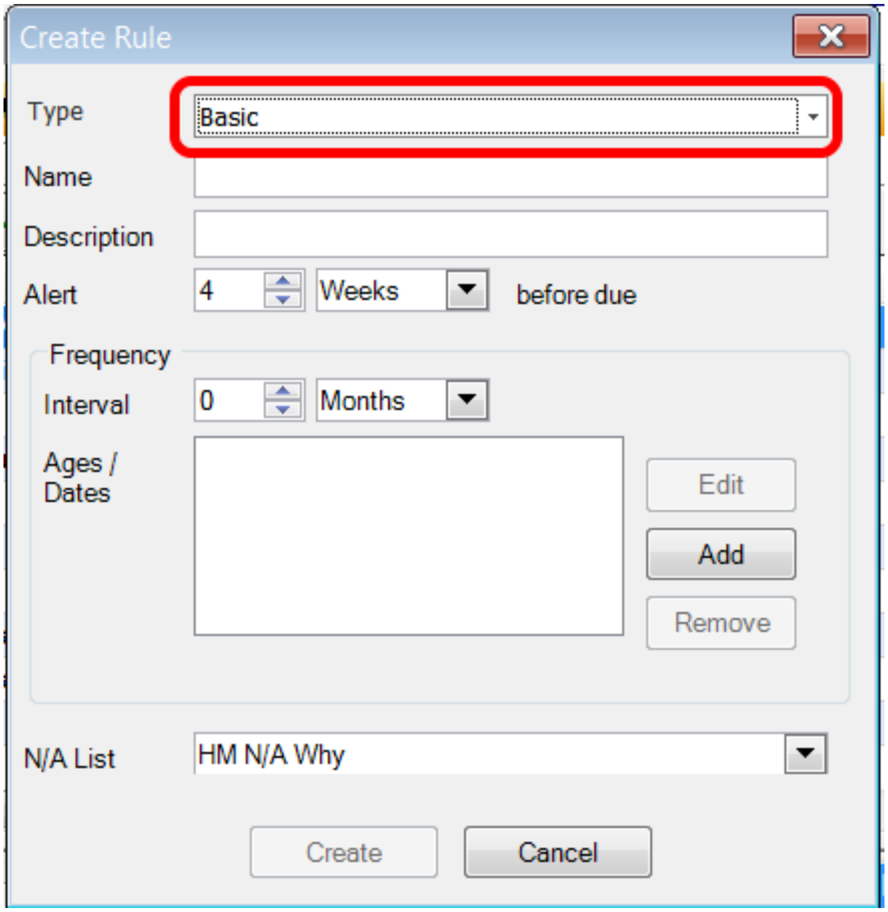
Health Maintenance rules may be created to place individually in the patient's chart or to be placed in Rule Sets. When Health Maintenance rules are created, they will be available network wide. This means that once the Health Maintenance rule is created the rule will be accessible for all providers and users in the clinic. Networks with more than 1 provider should consider creating standardized rules to be used in within the network.

Create



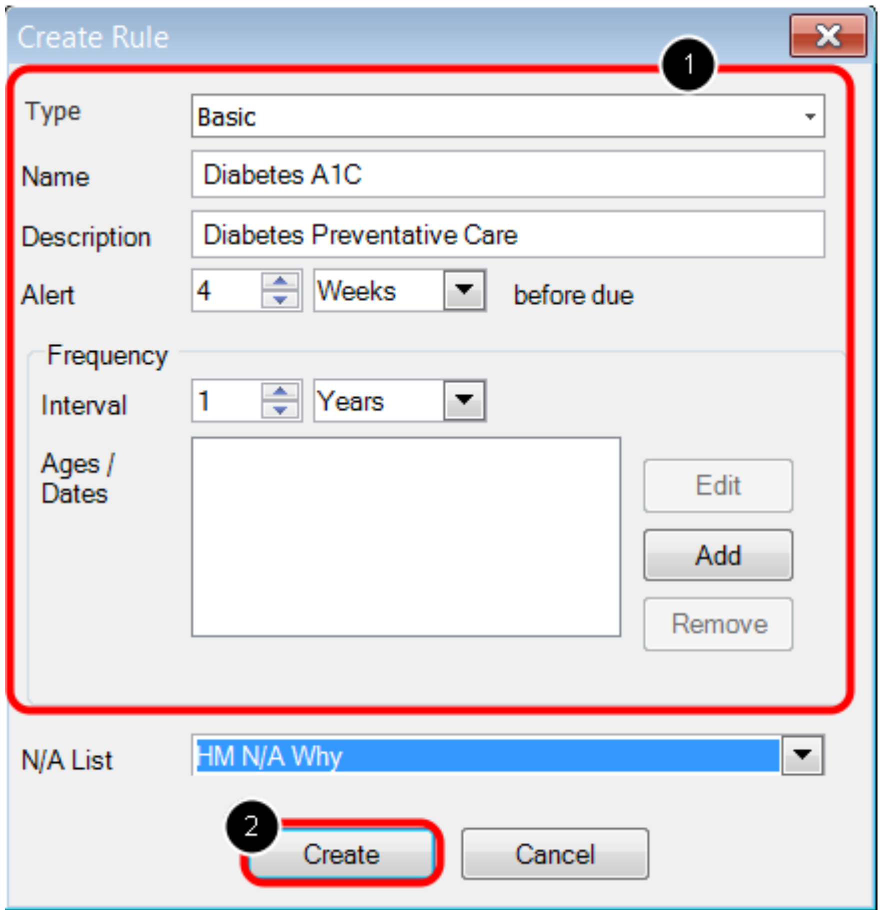
Open Health Maintenance by clicking **Tools > Health Maintenance Rules and Sets** and click on the **Create Rule** button (Green +).

Choose Type



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



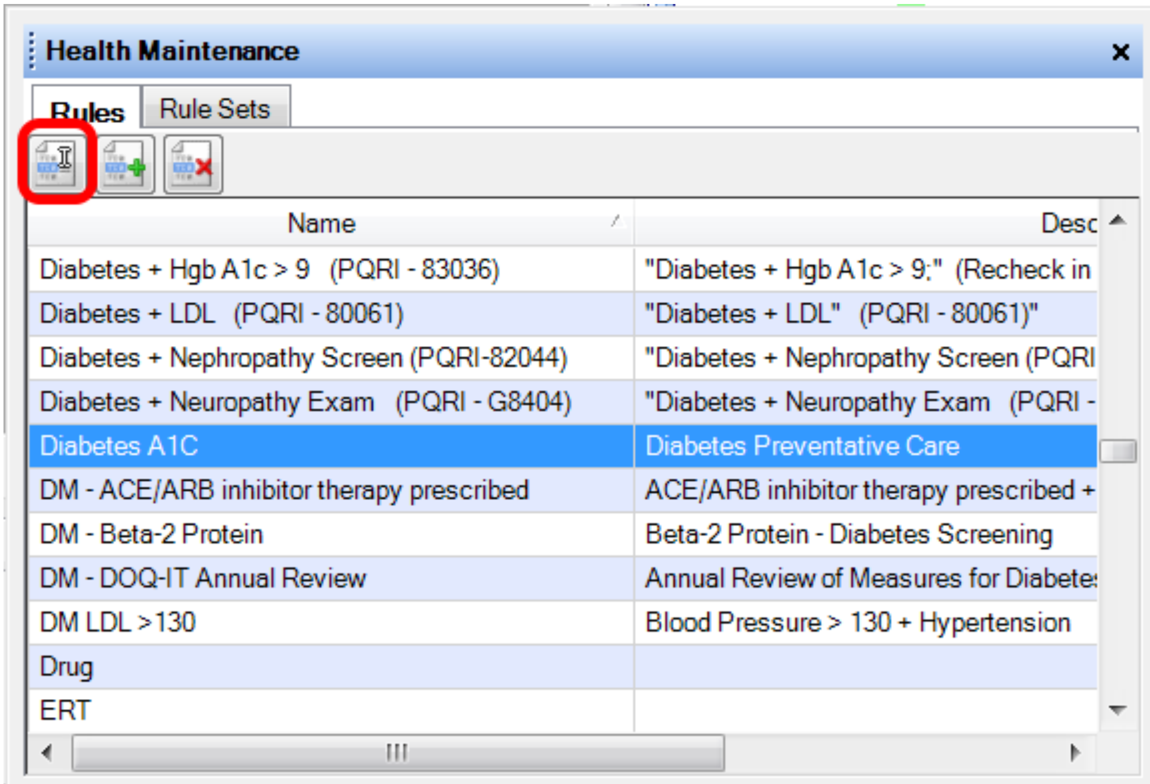
1. Type the rule names and descriptions in their respective fields, and set the alert interval, frequency (at weeks, months, years, or at a particular age).
2. Click **Create**.

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).

Editing a Rule

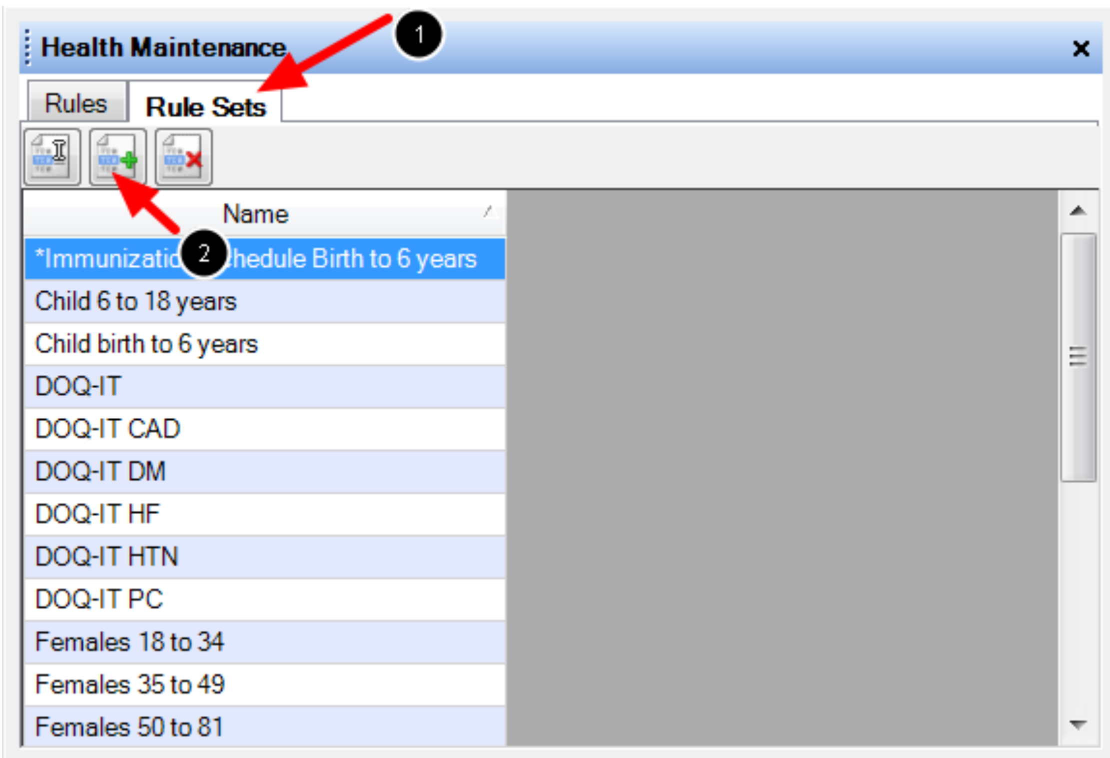


To edit a rule, select the rule that will be edited, and then Click the **Edit Rule** button. This action will bring up the Edit Rule dialog. Make the desired edits, then Click **Save**.

Create a Rule Set

ARule Set a is a group of Health Maintenance rules, which allows multiple rules to be inserted to the patient's chart at one time. Some of the most common rule sets are created for patients within a specific demographic or patients with a specific diagnosis.

Create

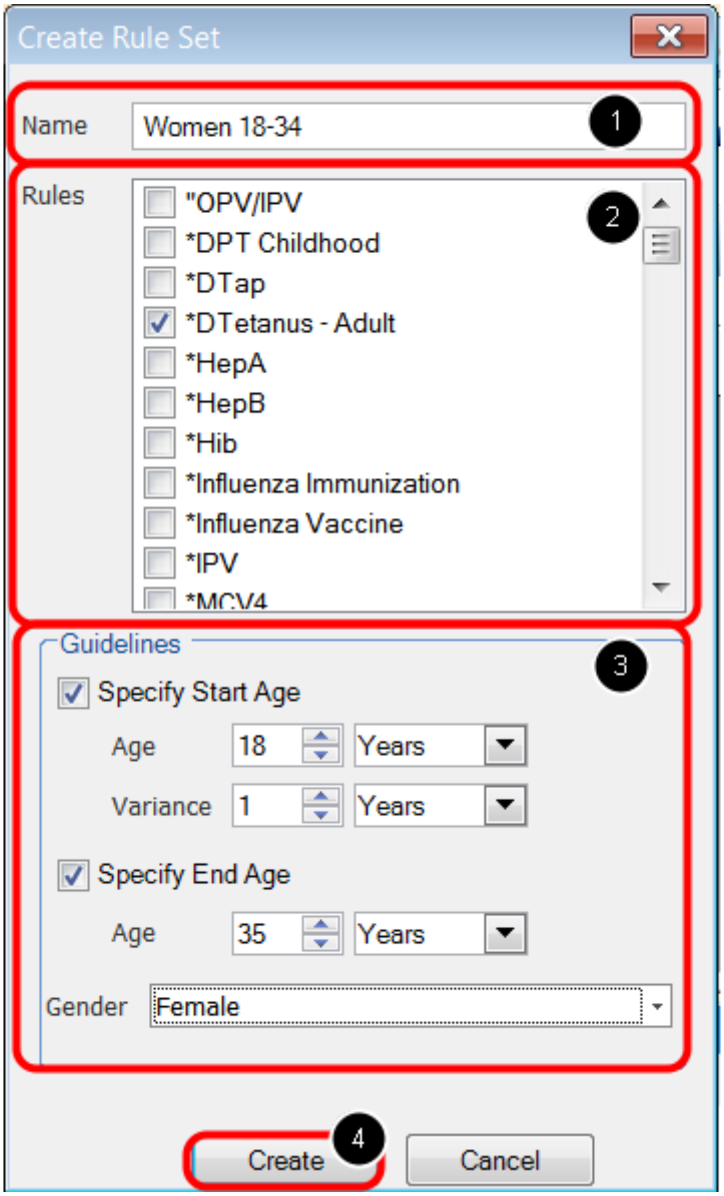


Open Health Maintenance by selecting **Tools > Health Maintenance Rules and Sets.**

1. Choose the Rule Sets tab.

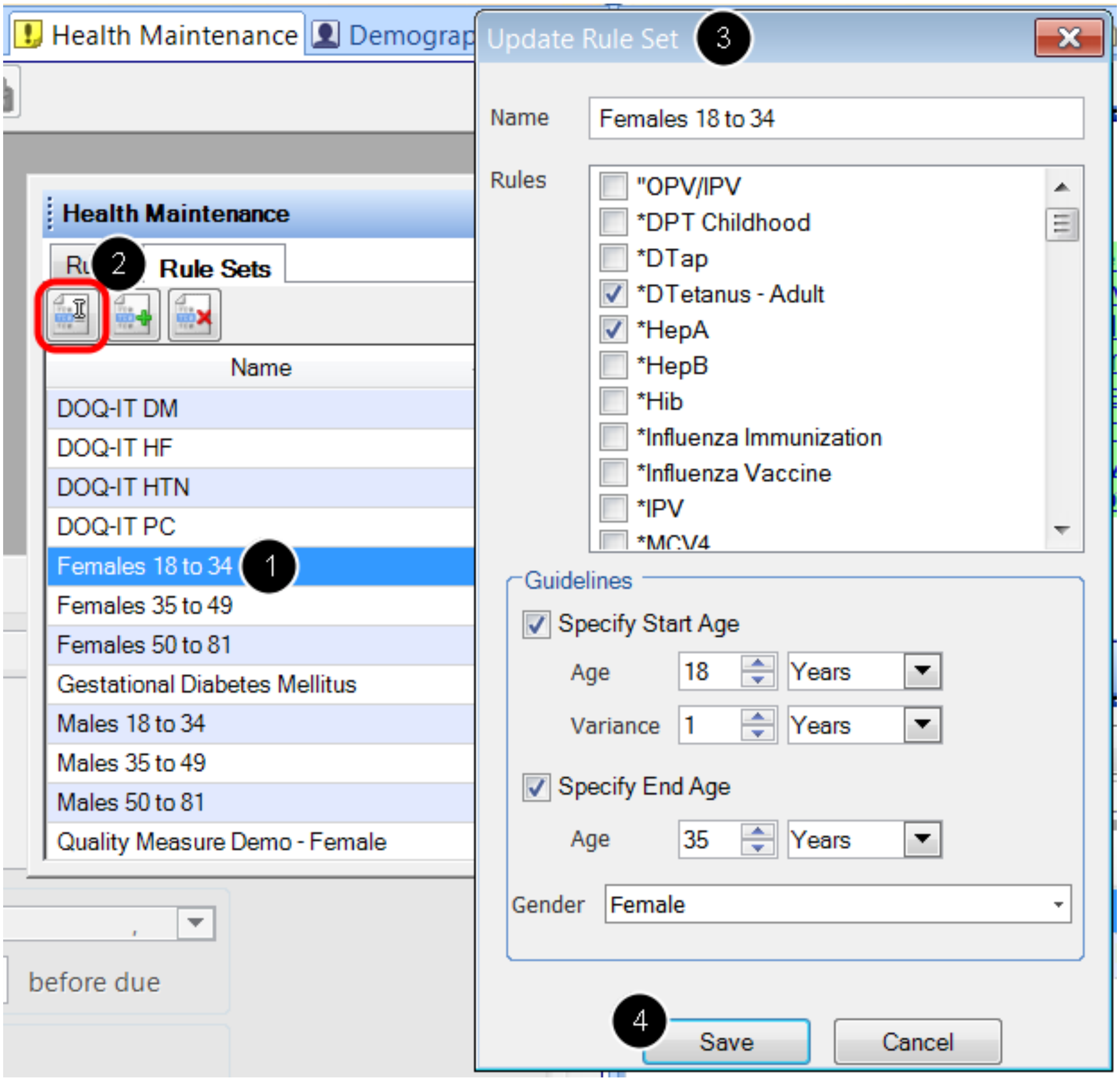
2. Click the **Create Rule Set** button (Green +). The Create Rule Set dialog opens.

Choose Rules



1. Name: Enter a name for the rule set.
2. Rules: Place a check next to each rule that will be included in the rule set.
3. Guidelines: Specify the guidelines for the rule set. If the rule set is being created for a specific age range, select the start age and end age. Select the variance for how often the rule set is due. In addition, specify a gender if the rule set is specific to a gender.
4. Click Create to save the new rule set.

Edit a Rule Set

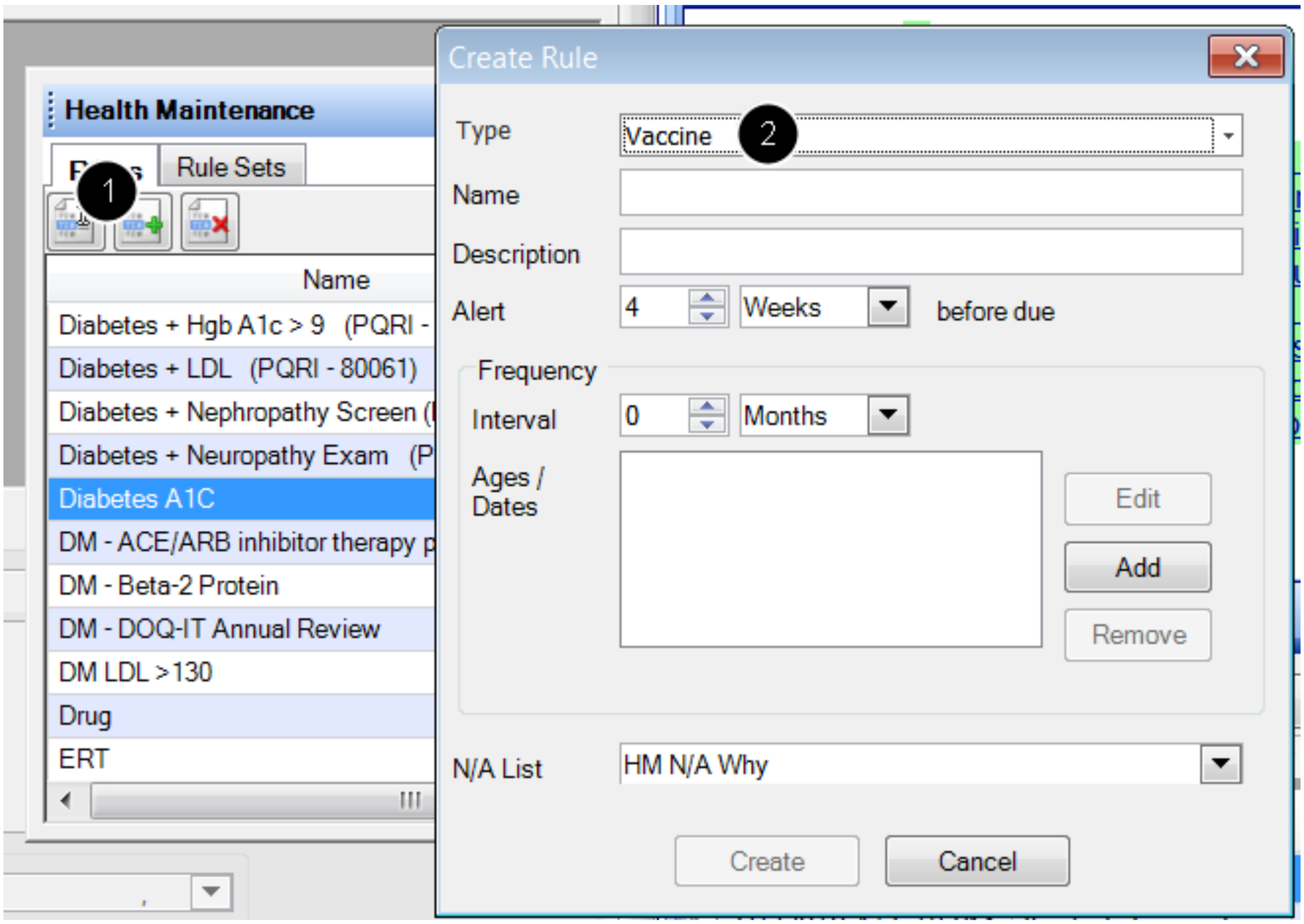


To edit a Rule Set:

1. Select the Rule Set that will be edited
2. Click the **Edit Rule Set** button
3. Make the edits
4. Click **Save**

Using the Vaccine Rule Types

Create a New Vaccine Rule



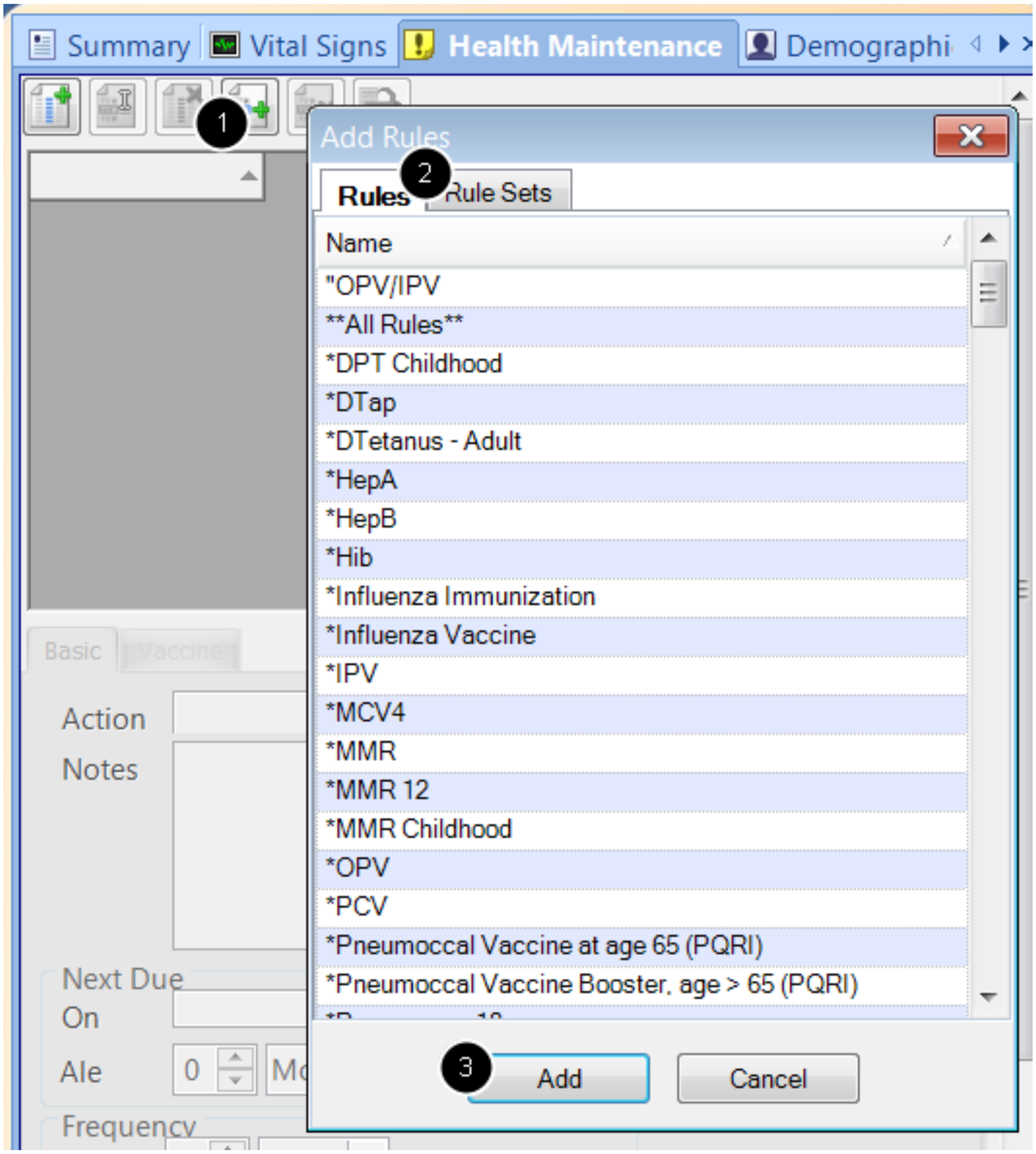
To add a vaccine type Rule, follow the instructions below. This is helpful for creating vaccines not found in the original database.

1. Click on the **New Rule** button (Green +) to create a rule.
2. In the Type drop-down, select **Vaccine**.

Creating a Vaccine Rule Set

To create a vaccine rule set (for instance, a set of all childhood immunizations), see: **Create a Rule Set.**

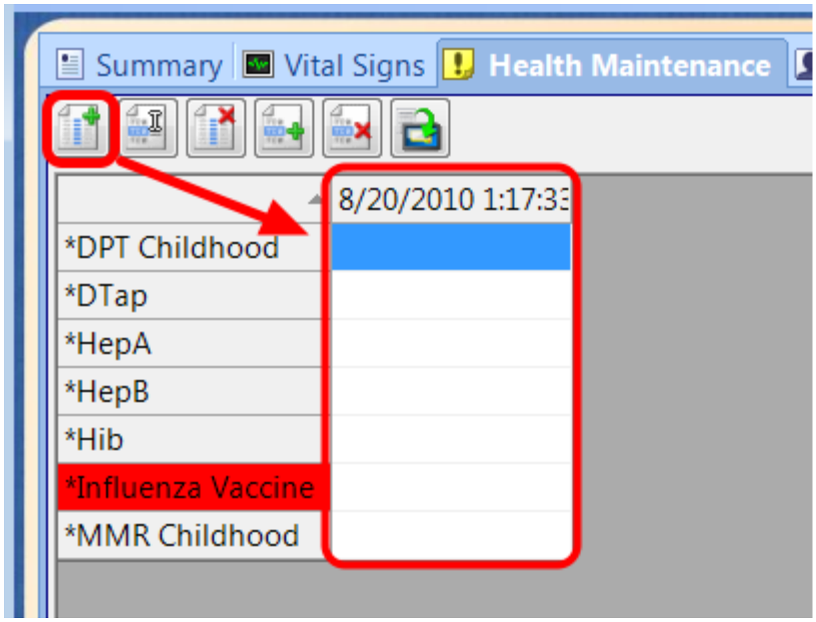
Add Vaccine Rules to a Chart



To add vaccine rules to a chart:

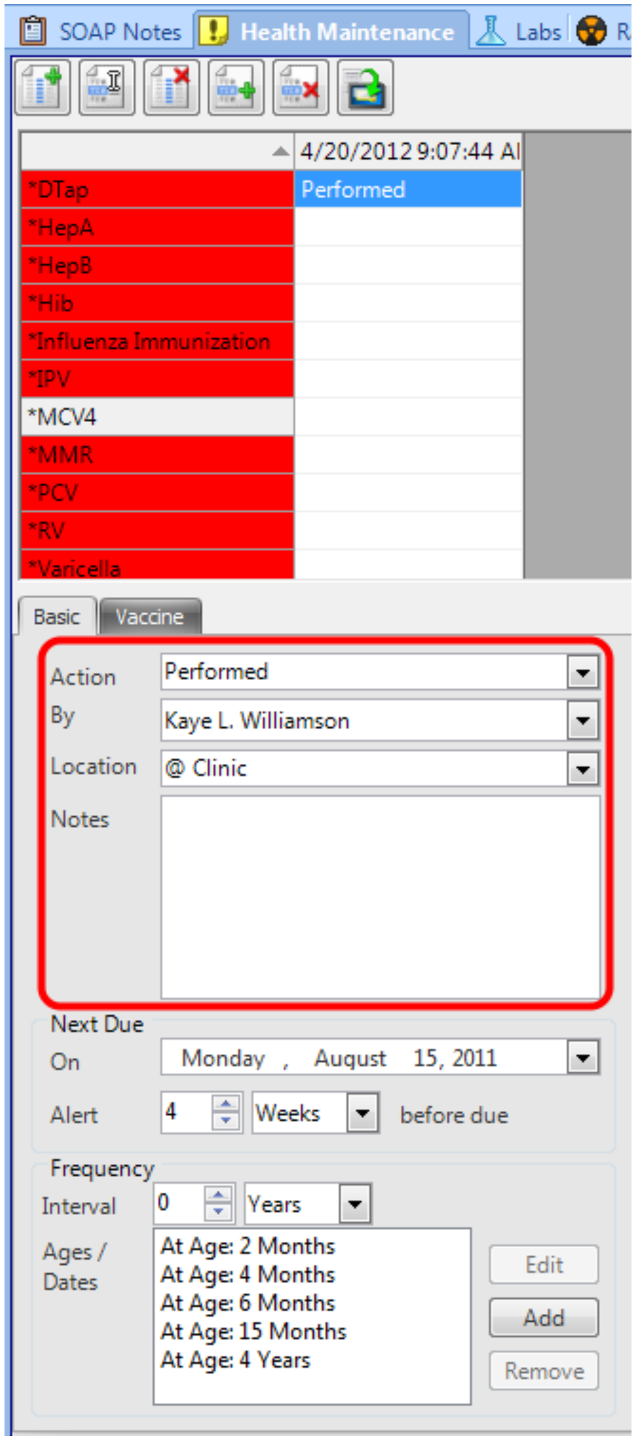
1. Click the **Add Rules** button (2nd Green + button) in the Health Maintenance chart section
2. Select the rules or rule sets to add
3. Click **Add**

Add a Addressed Date



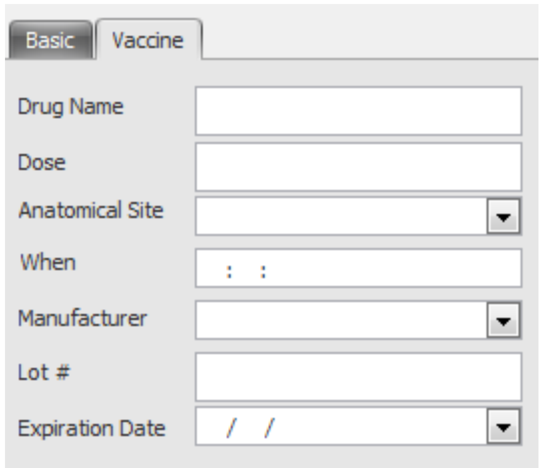
To address the rules that have been added to the chart, Click the **Add Addressed Date** (first Green + button). This will add a column with the current date to the chart.

Complete Information



Complete the information on the Basic tab. The "Next Due On" section will display the next due date, how long before the due date that the alert will appear, and the frequency of the selected rule.

Vaccine Tab

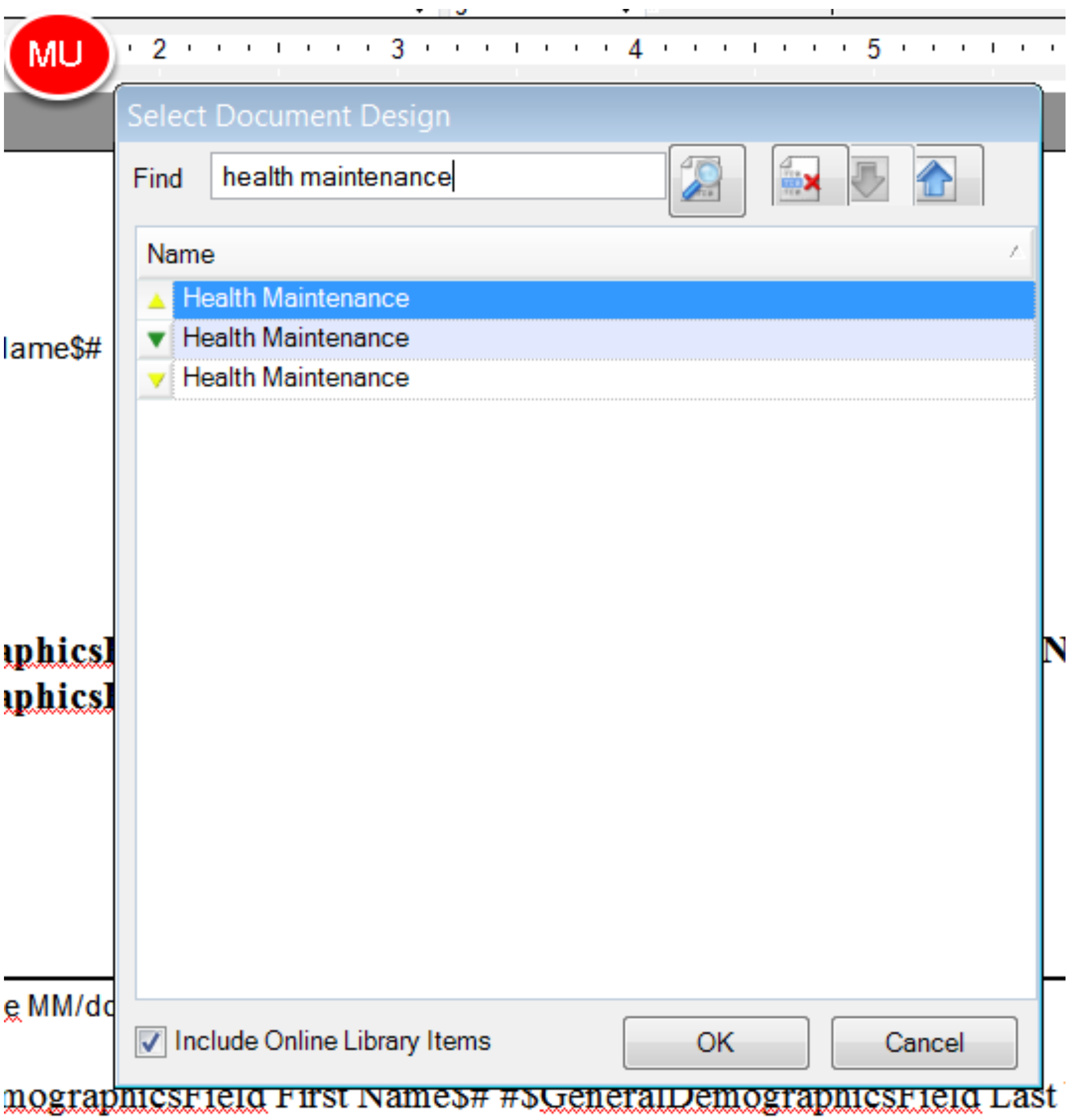


Click on the Vaccine tab to see additional information that can be recorded.

Generate a Health Maintenance Report

***REQUIRED FOR MEANINGFUL USE:** [CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP]
- OR [Patient Reminders]

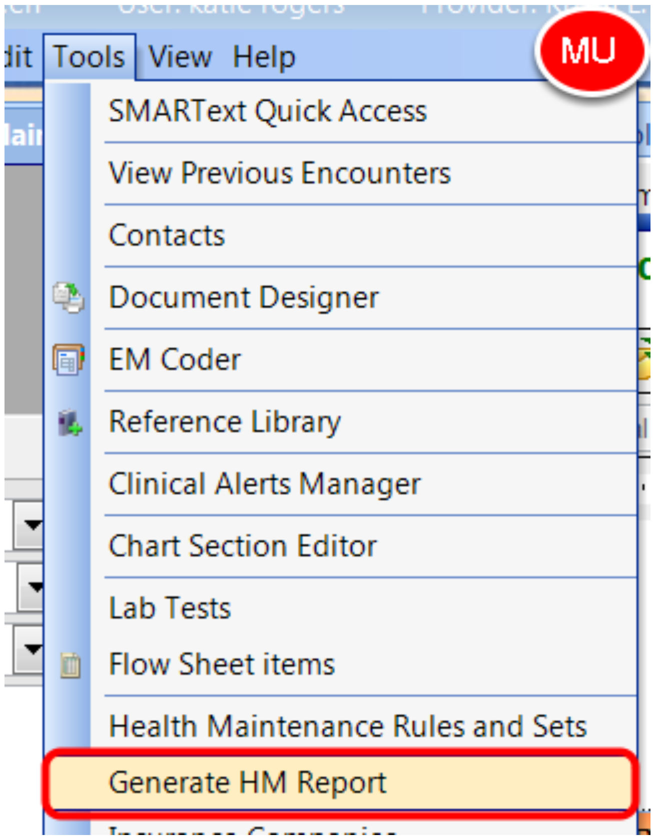
Create a Health Maintenance Letter



Auser 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

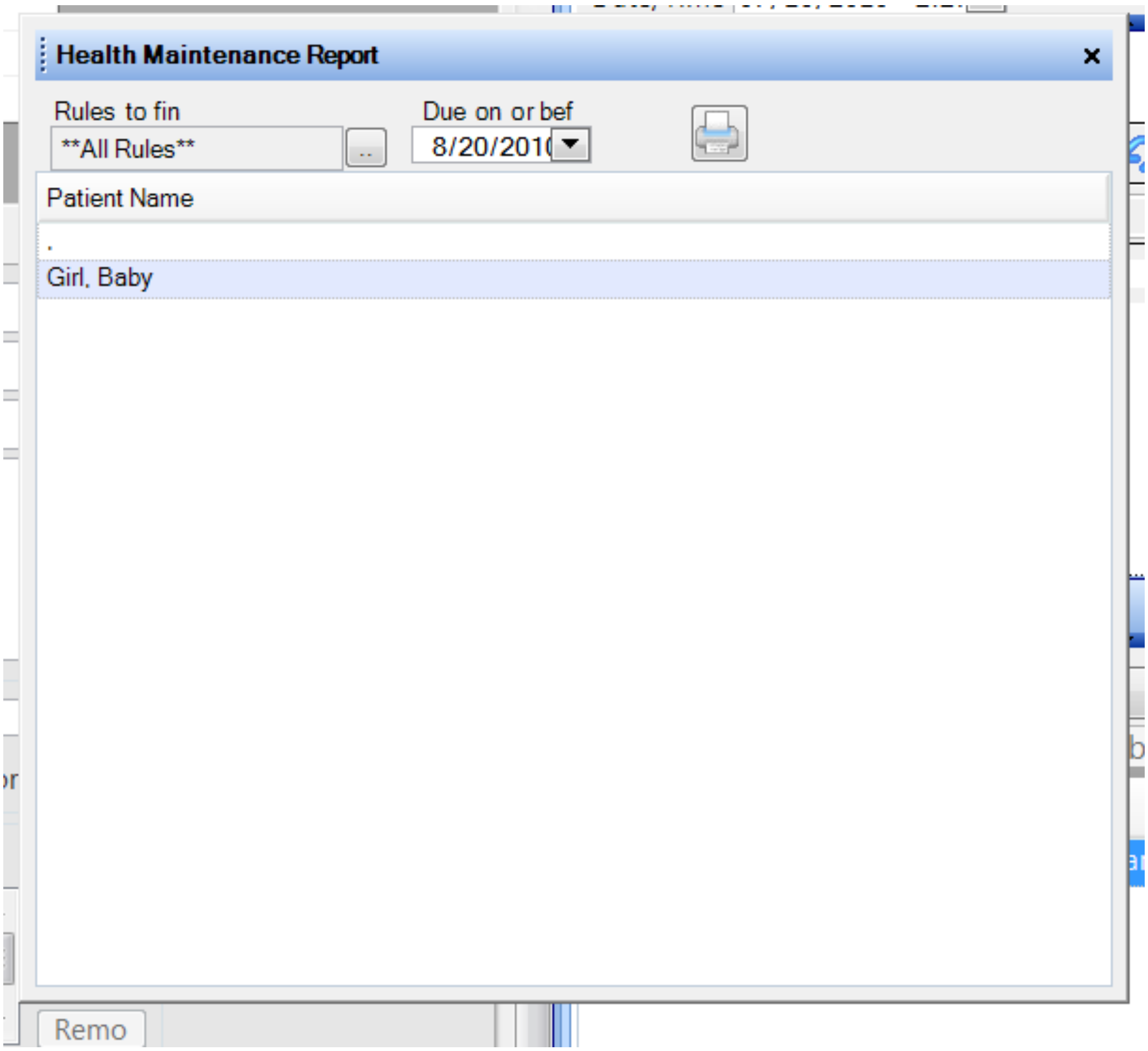
Maintenance".

Generate Report



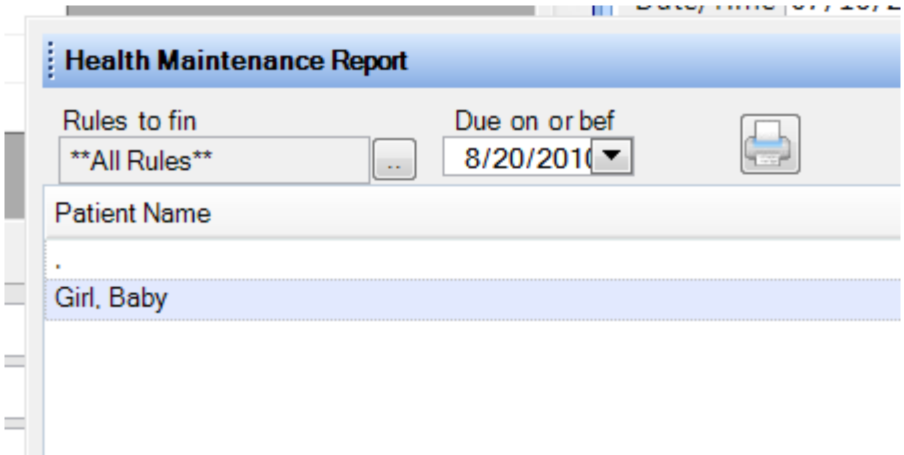
Once the report has been created, go to Tools > Generate HM Report.

Select Rules



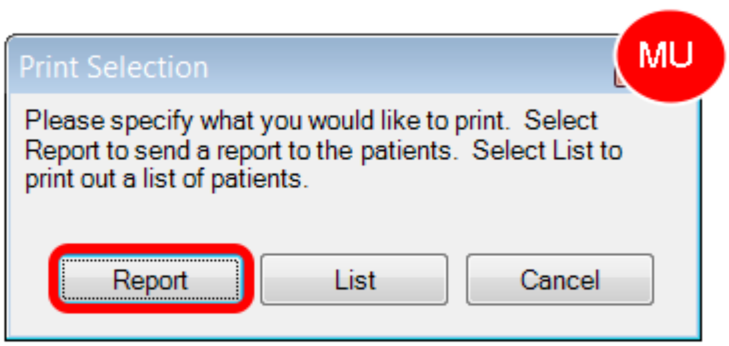
In the Rules to find field, Click the All Rules list item, or Click the Browse button to select one or more Rules or Rule Sets. A list of patients with selected rule(s) will display.

Choose Dates



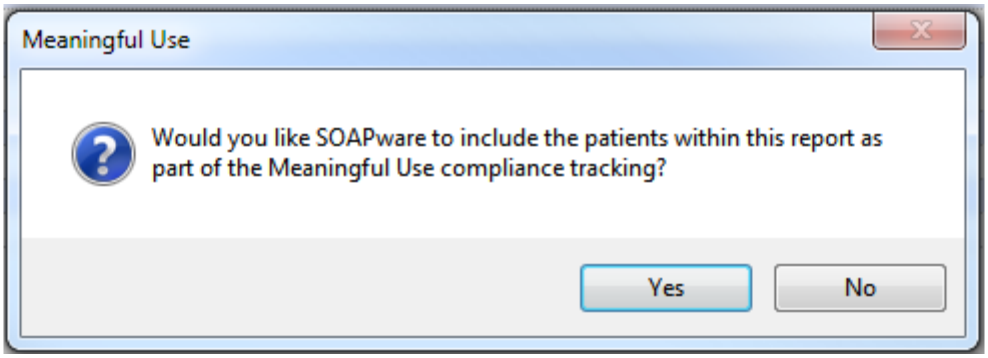
In the Due on or before field, Click the down-arrow, then Click on the date to search for rules due by. Click Print.

Print Patient Report



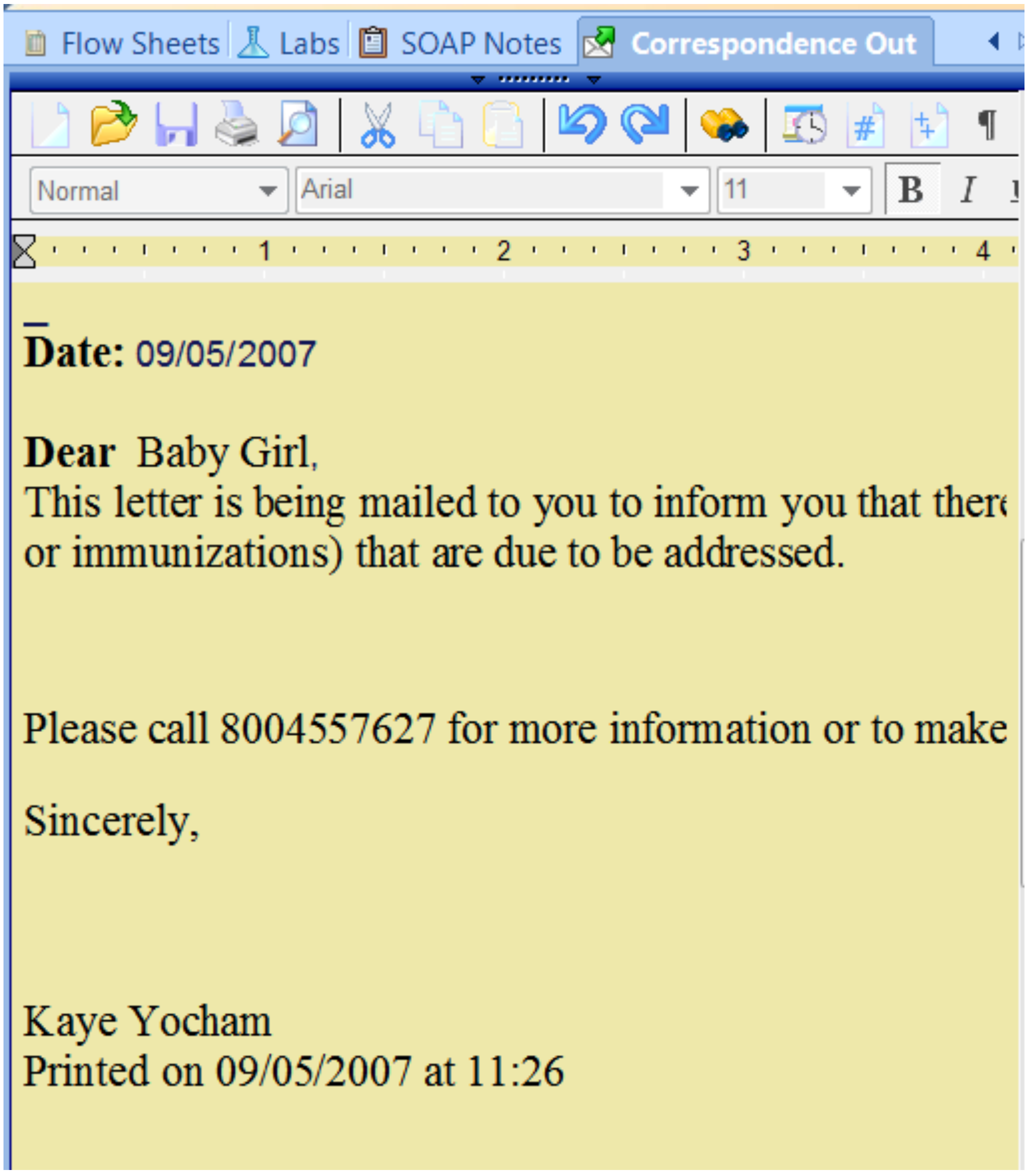
To print a letter to the patient, Press the Report button, and Click the Health Maintenance list item in the Select Document Design list. Press the OK button to being printing the patient letters.

For Meaningful Use, a provider can print the Report (letter to patients) to increment the Meaningful Use statistics. *Note: Printing a "List" will not increment the provider's Meaningful Use statistics.



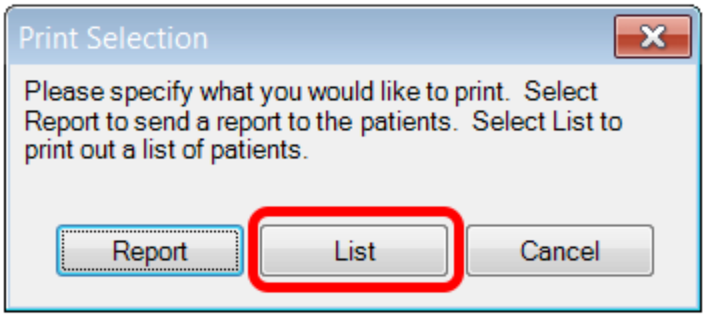
After printing a Health Maintenance "Report", a prompt will display with the above message. If the provider selects "Yes", this will include the patients in the report as a part of the Meaningful Use compliance tracking.   If the provider selects "No", the patients will not be included as a part of the Meaningful Use compliance tracing.

Save a Copy



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.

Printing a "List" will not increment the provider's Meaningful Use statistics. The Report option must be selected in order to increment Meaningful Use statistics.

Document and Chart Management

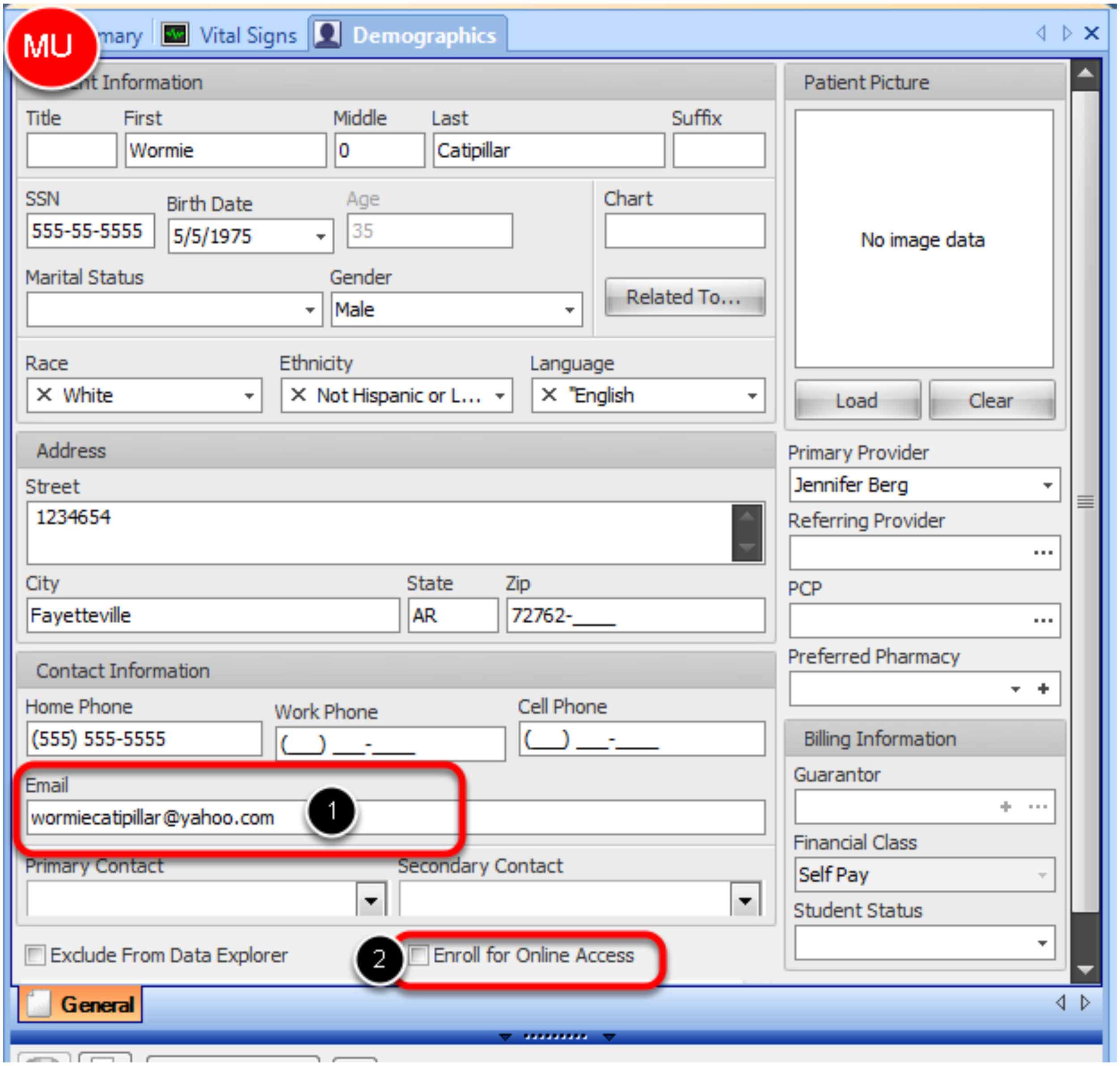
Online Access for Patients

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**

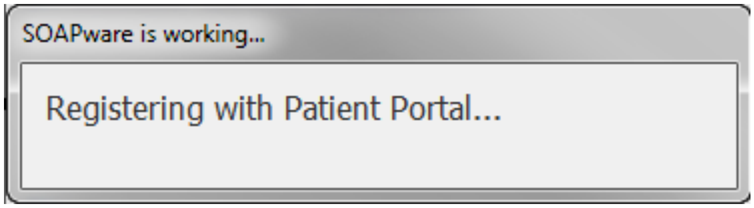
- Patient Electronic Access

Entering Patient's E-mail address



Email address for patients may be entered in the Patient Demographics of the Chart.

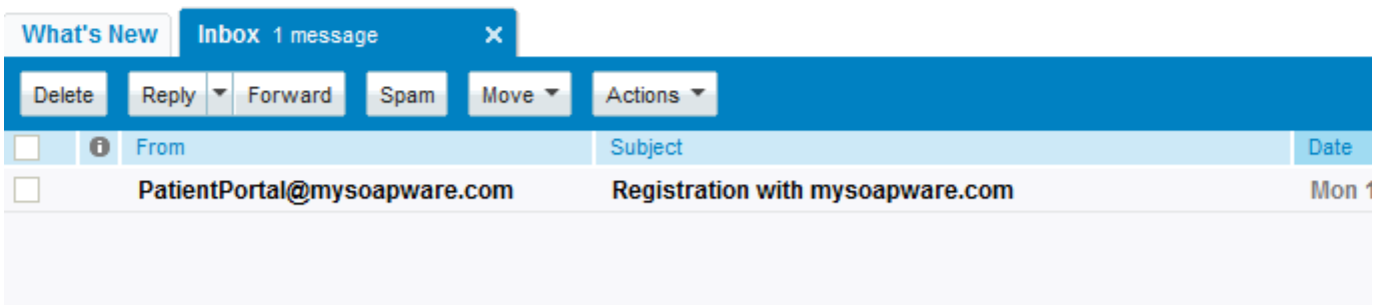
1. Enter the patient's e-mail address
2. Check the "Enroll for Online Access" box.

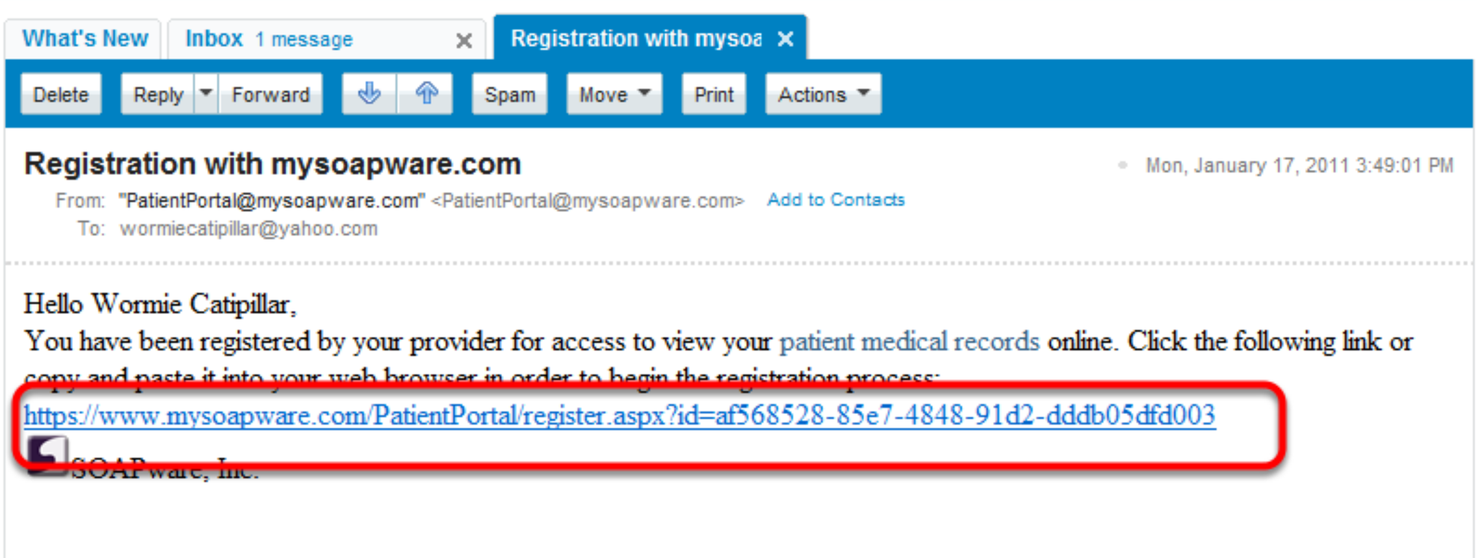


When the Enroll for online access is checked. A message box will appear that stated SOAPware is Registering with Patient Portal.

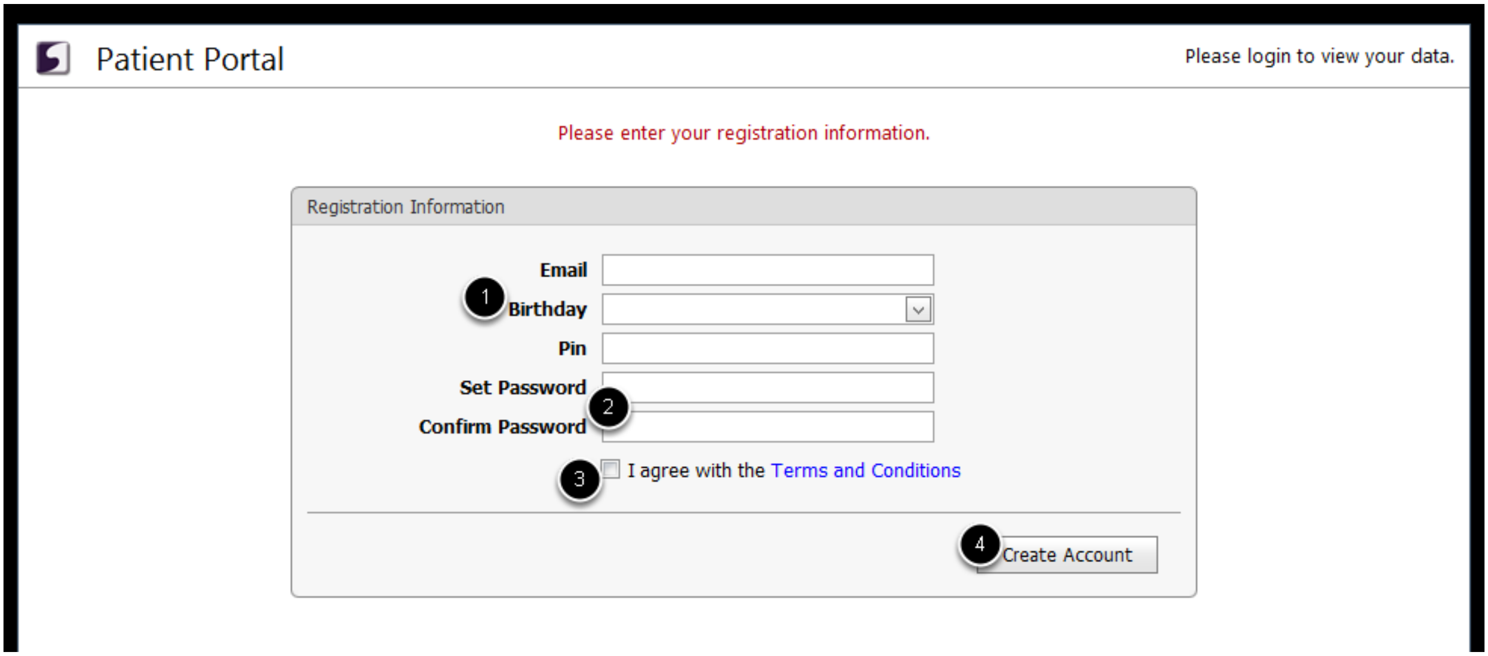
This will automatically send an e-mail to the patient's indicated email, in their demographics.

Patient will Receive an E-mail





The patient will click on the Patient Portal link from the e-mail.



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.

Patient Portal

Wormie Catipillar is logged in. Logout

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 0. 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

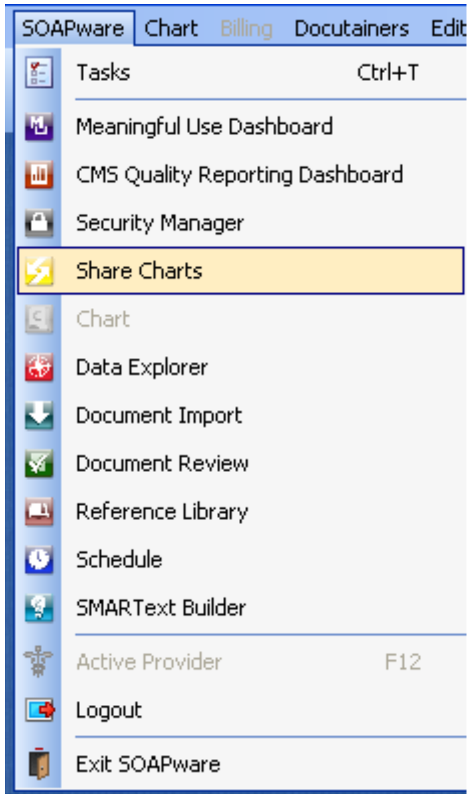
Type	Date	Code	Description	Location	Substance	Method	Position	Site	Status	Source

The Patient Portal will display information for the patient to view and print.

The Document contains All information from the Patient Demographics, Summary, Structured Lab Results for the past 30 days , Vital Signs for the past 30 days, List of Encounters with Description, Assessments and Plan fields.

Chart Sharing Feature

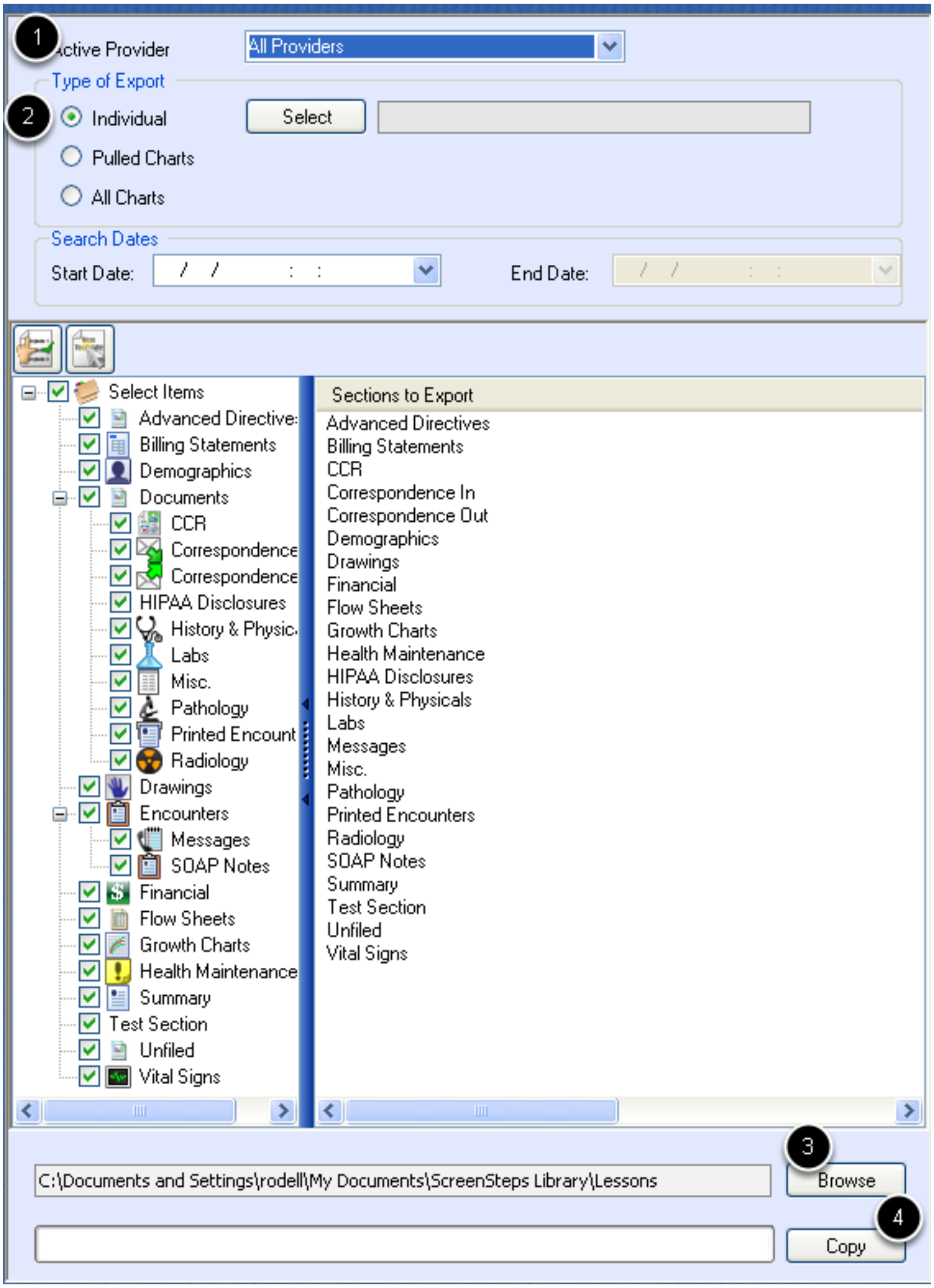
Chart Sharing Security & Interface Basics



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



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:

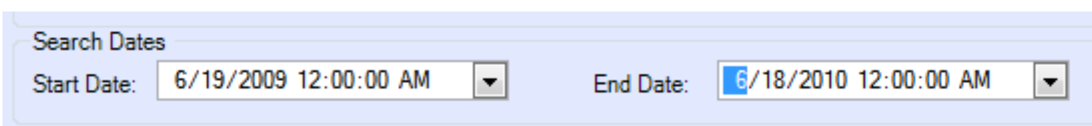
1. Click the All Providers menu item in the Active Provider drop-down menu.
2. Click the All Charts radio button for the Type of Export.
3. Click the Browse button to select the location to export records to the computer.
4. Click the Copy button to begin the export process.

With these settings, all charts in the Chart Rack will be exported.

Select Charts

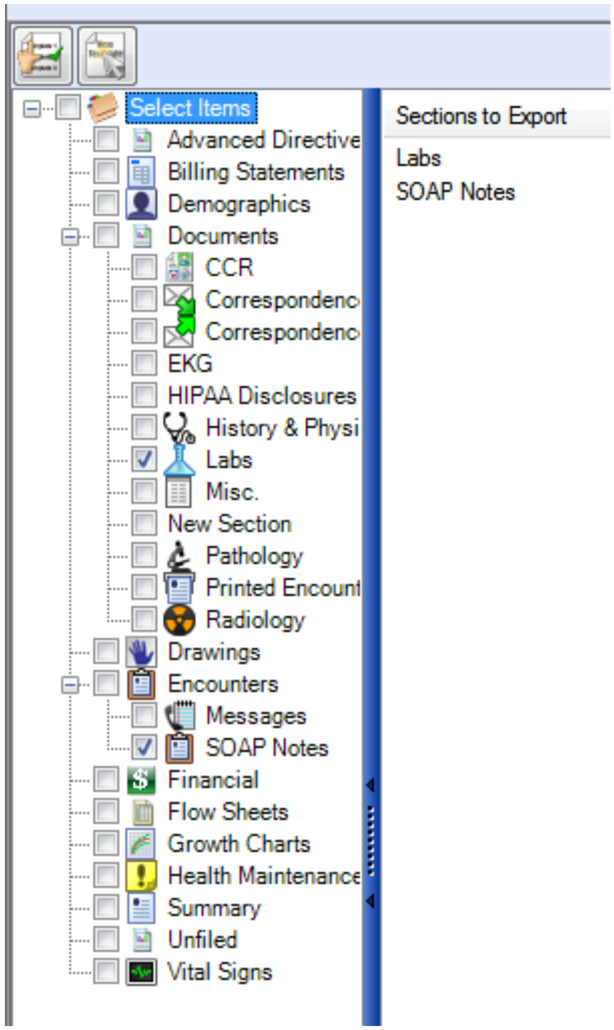
On the other extreme, to export/copy a single chart, Click the Individual radio button in the Type of Export section; then Click the Select button. This opens the Chart Rack for the selection of an individual patient chart.

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



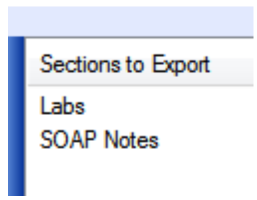
After selecting charts to share (i.e. copy or export), choose the chart sections to share. Selection is accomplished in the middle area of the Chart Sharing workspace.

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.

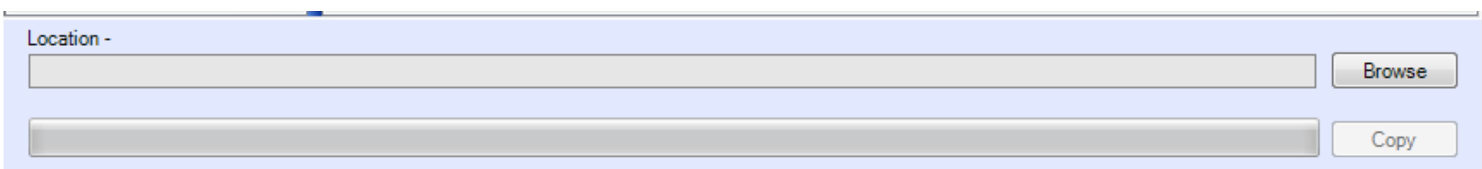
To export less than the entire chart (for example, only SOAPnotes and Labs), the user will need to edit the selected items. To change the selection, Click the "Select Items" checkbox at the top left. This clears the selection list. Next, the user is to place a checkbox in each individual chart section that he/she wishes to export.

Sections to Export



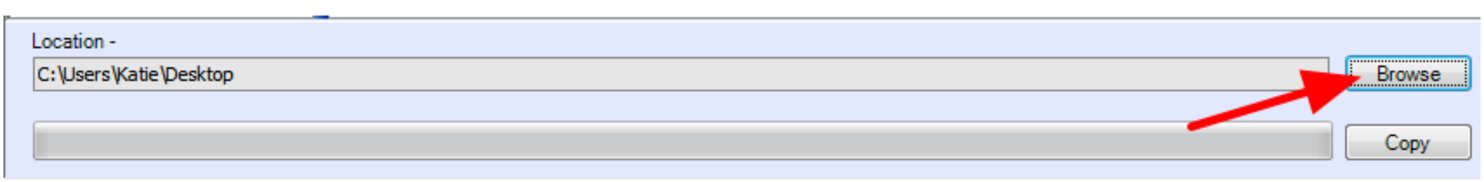
Select as few as one chart section or check them all. Once the chart sections to export are selected, it's time to export. The selected sections will be displayed to the right under Sections to Export.

Selecting the Export Location



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



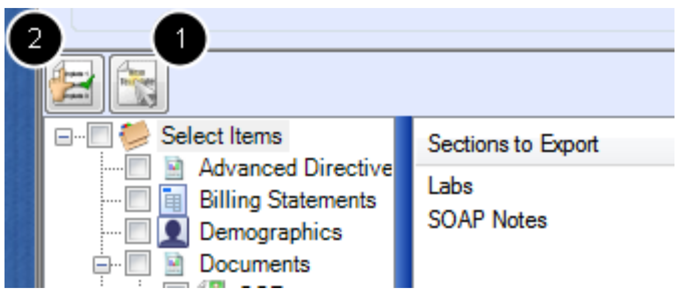
Click the Browse button on the far right. This displays the Browse For Folder dialog where the location is selected for the exported copy. In order to create a new location, Click the Make New Folder button. Once the location is selected, Click OK.

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.

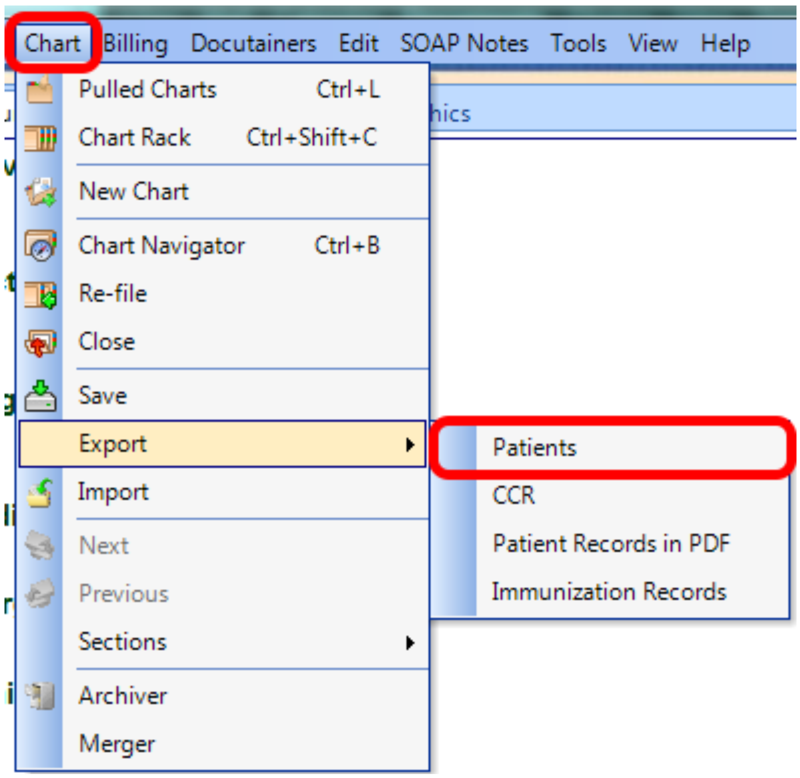
HIPAA Regulations (encrypted email)

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

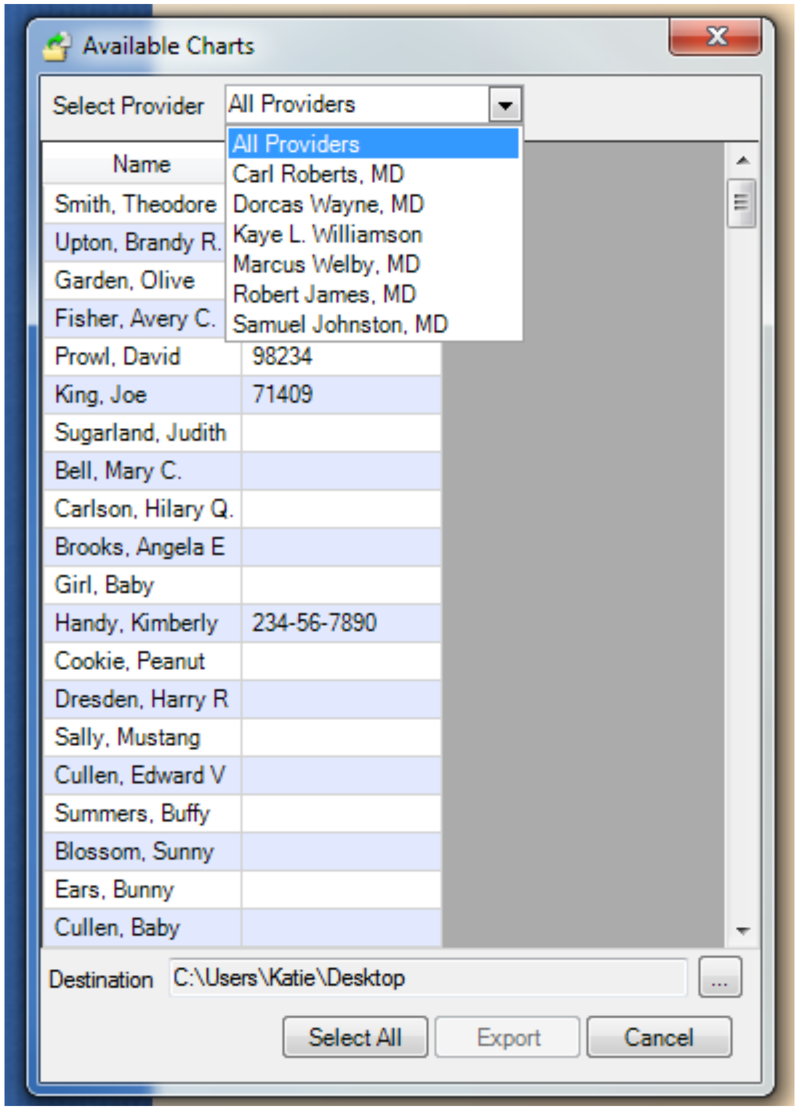
This lesson will walk the user through the steps to export a chart from SOAPware in a format that allows the user to import it into another SOAPware database.

Export Patients



From the Chart Workspace (SOAPware > Chart), Click on the Chart menu and Select Export > Patients.

Select Provider



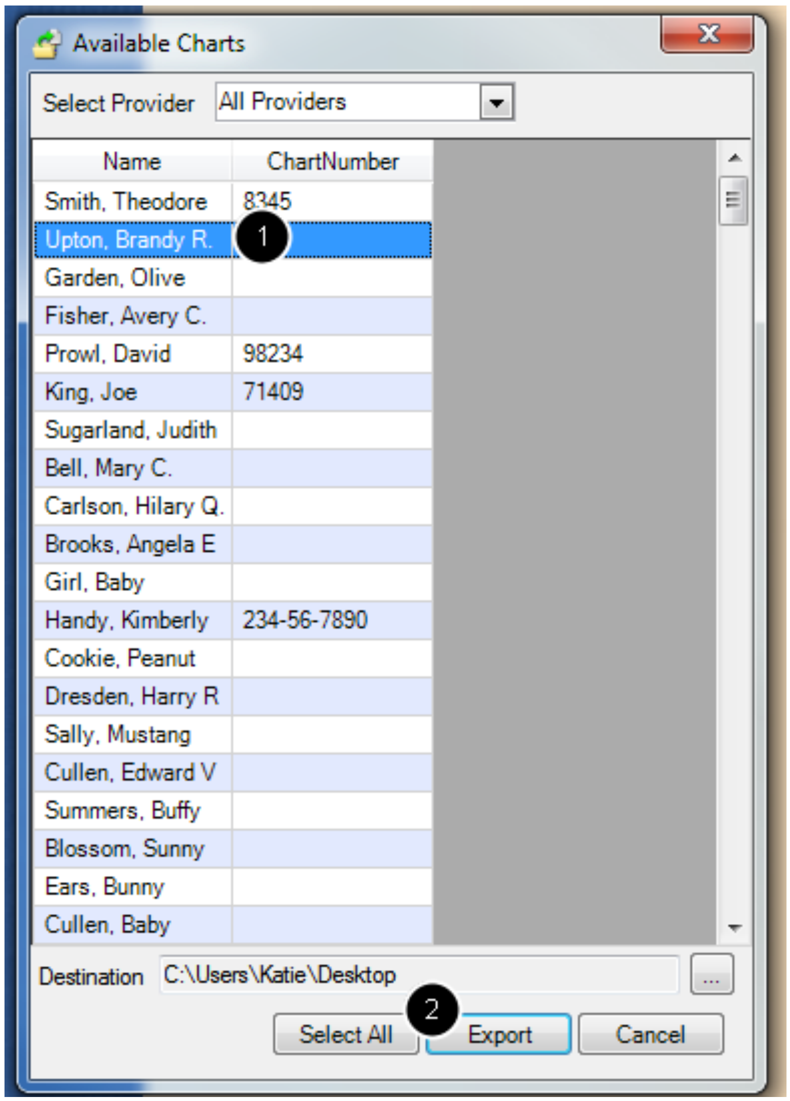
Using the drop-down menu at the top of the window display, the user can select to see all providers' patients from Pulled Charts or the user can select an individual provider. This is particularly useful if the user will be exporting a physician's entire patient database.

Note: The displayed patient names are only from Pulled Charts and not from Chart Rack.

Select Patients

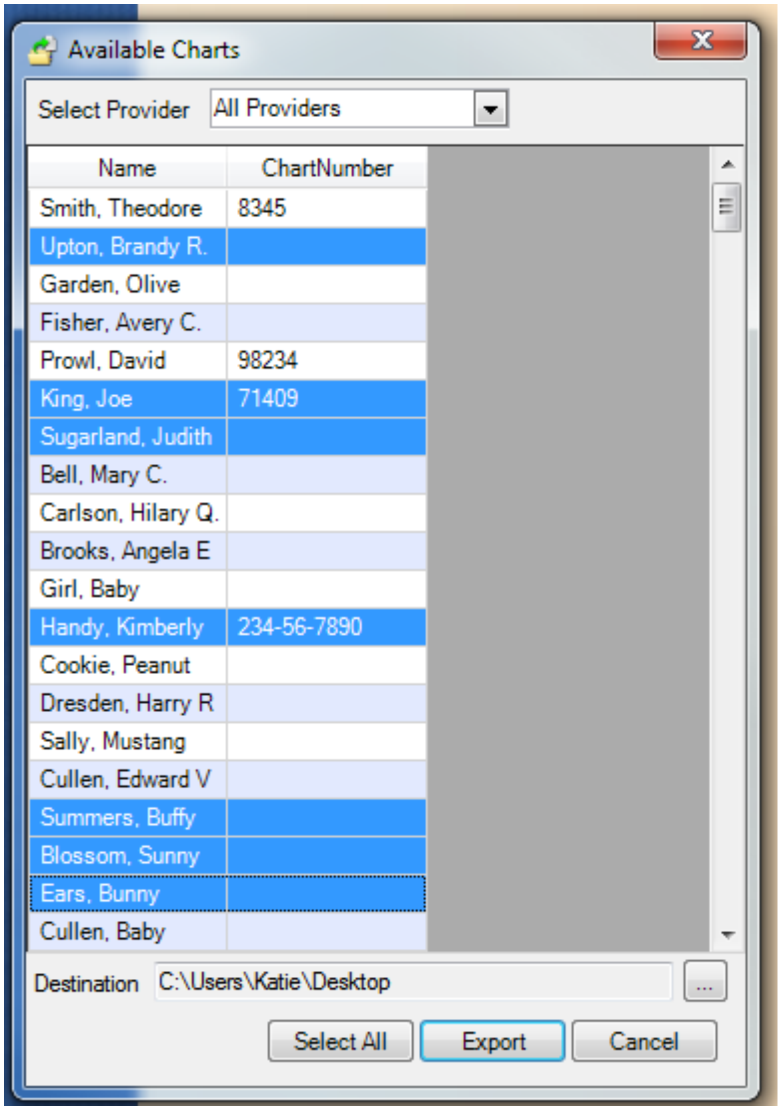
The user can select individual patients, can select a group of patients, or can select all of the patients in the display.

Individual Patient



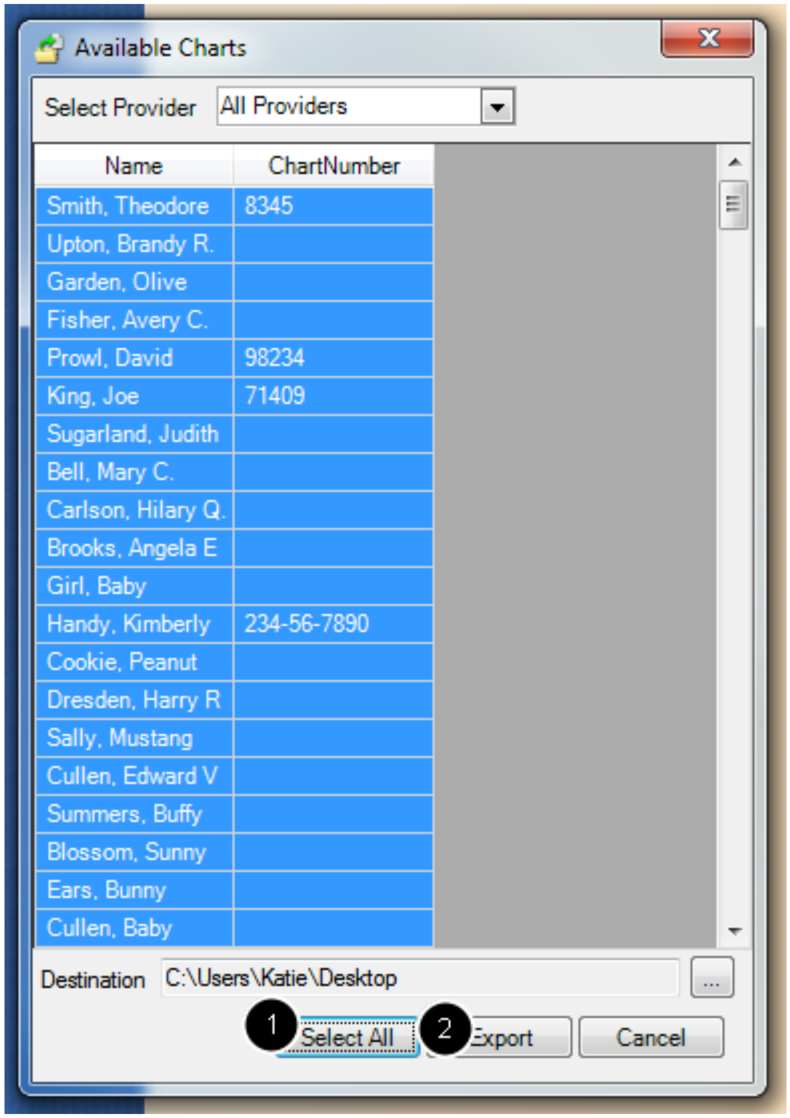
To select an individual patient, simply Click on the patient's name and Click Export.

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 Select All 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 SOAPware database, following the instructions for Importing a Chart.

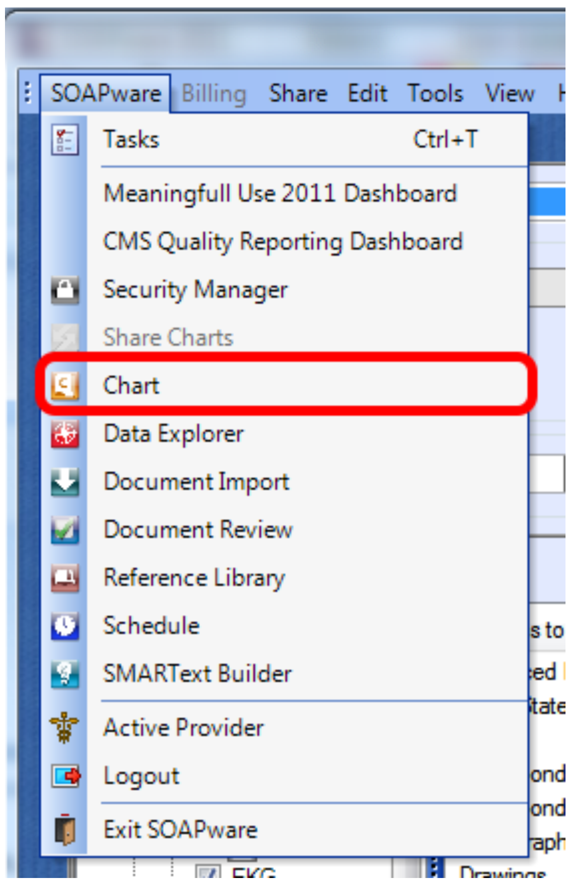
Importing a SOAPware Chart

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.

IMPORTANT WARNING

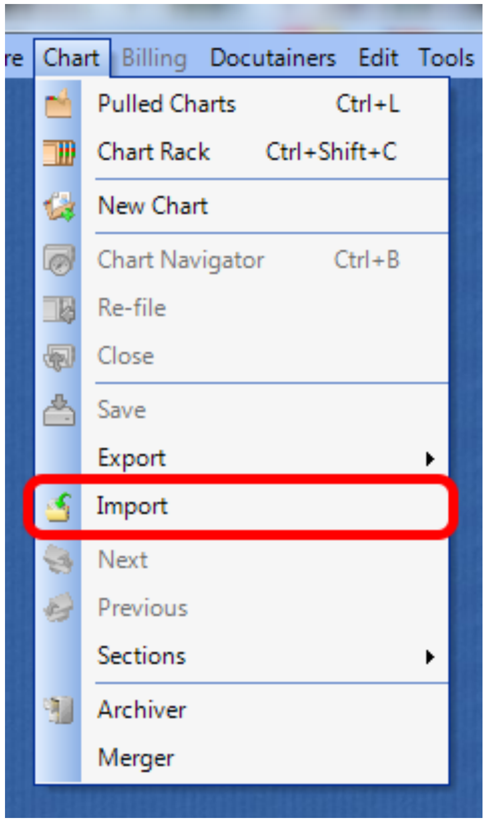
If importing a chart that has the same First and Last name as an existing chart in the database, SOAPware will replace the existing chart with the new chart that is being imported. Before importing a chart, it is important that you ensure there are no other patients with the same First and Last name in the database that you do not want to replace.

Open the Chart Workspace



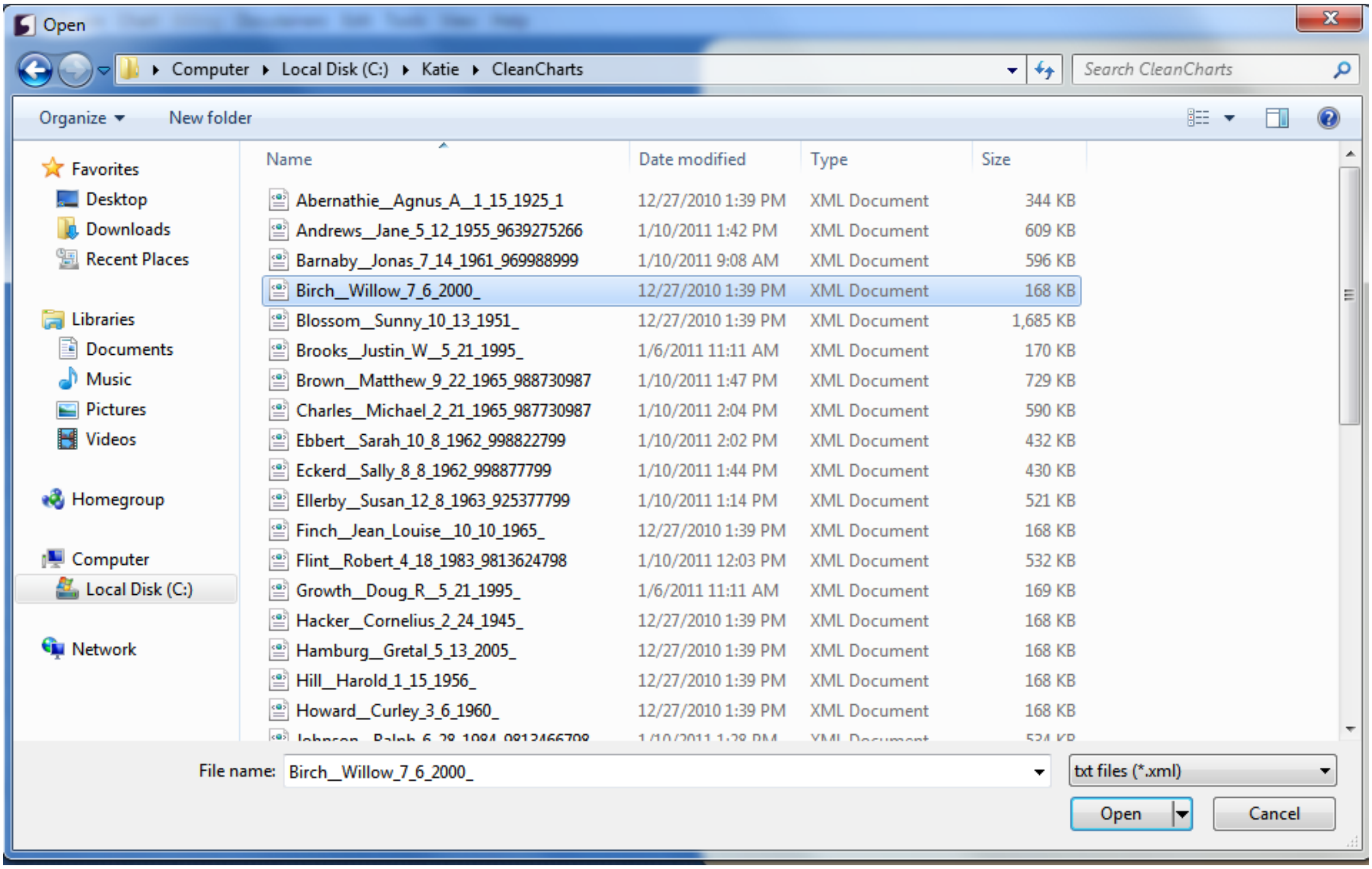
First, the user will need to be in the Chart workspace. Click on SOAPware > Chart.

Import Menu



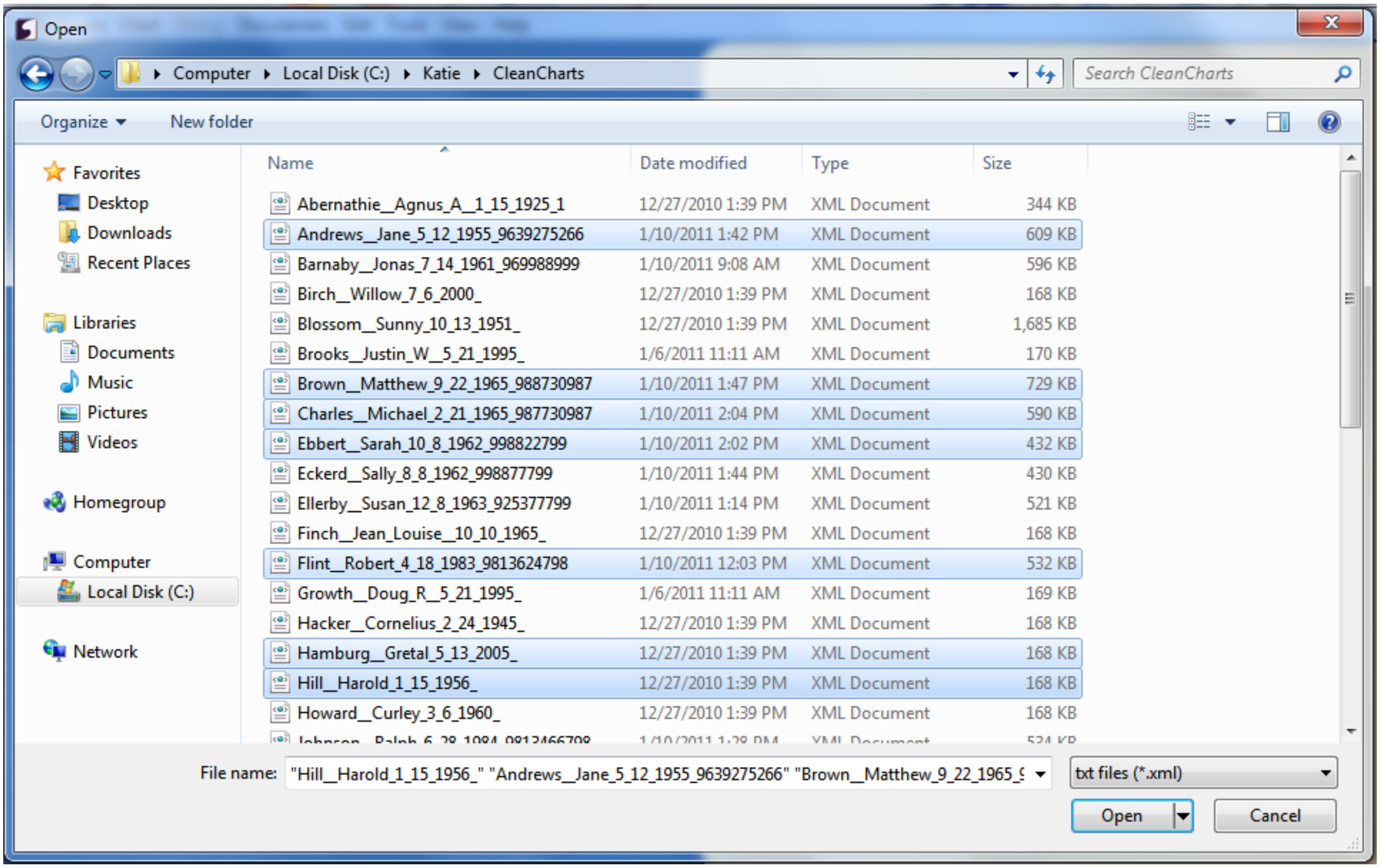
To open the Import Chart option, Click on Chart > Import.

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 + Aon 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.

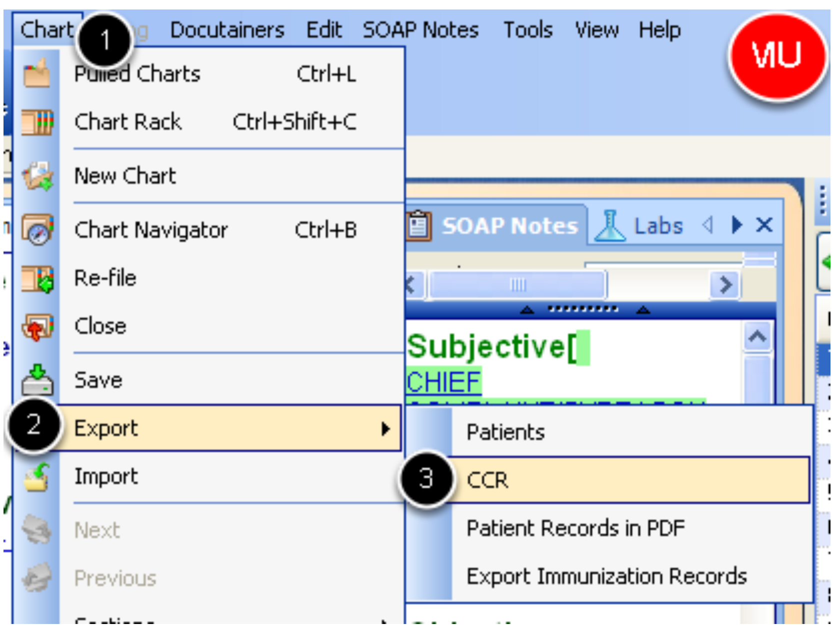
Continuity of Care Record (CCR) Feature

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

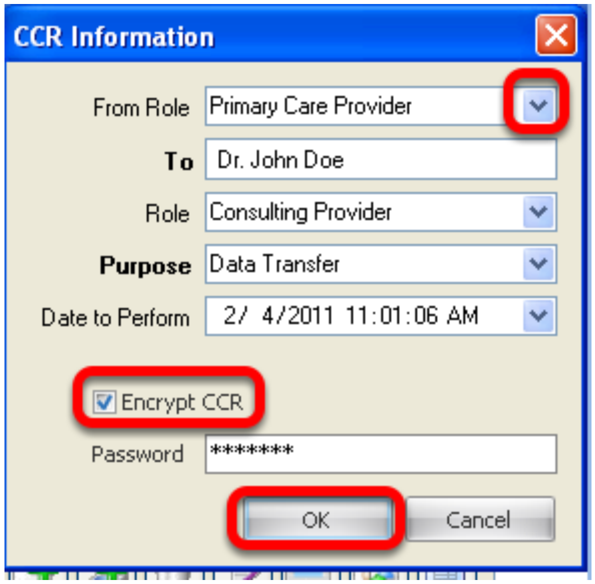
Patient Meaningful Use Dashboard:
This requirement will be tracked via the Patient Meaningful Use Dashboard

Accessing CCR



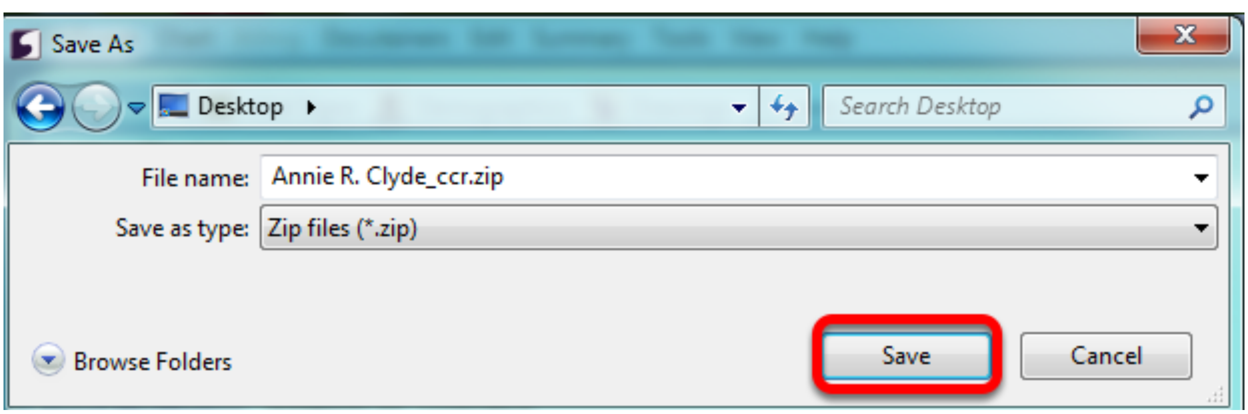
1. With a patient's chart open, Click on Chart from the menu bar.
2. Select Export.
3. Click on CCR.

CCR Information Box



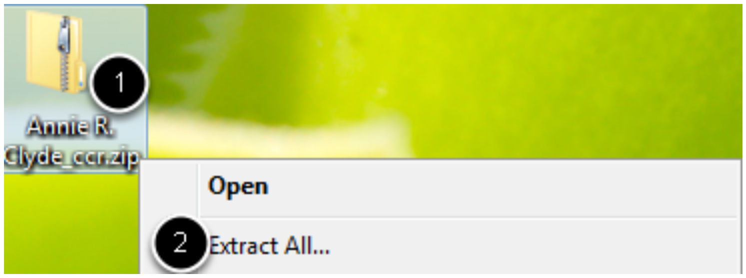
Using the drop-down menu options, fill out the appropriate information. Placing a check mark in the box for Encrypt CCR, will encrypt the content of the patient's records and may only be viewed with the password set by the person creating the CCR. The password will be shared only with the recipient of 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

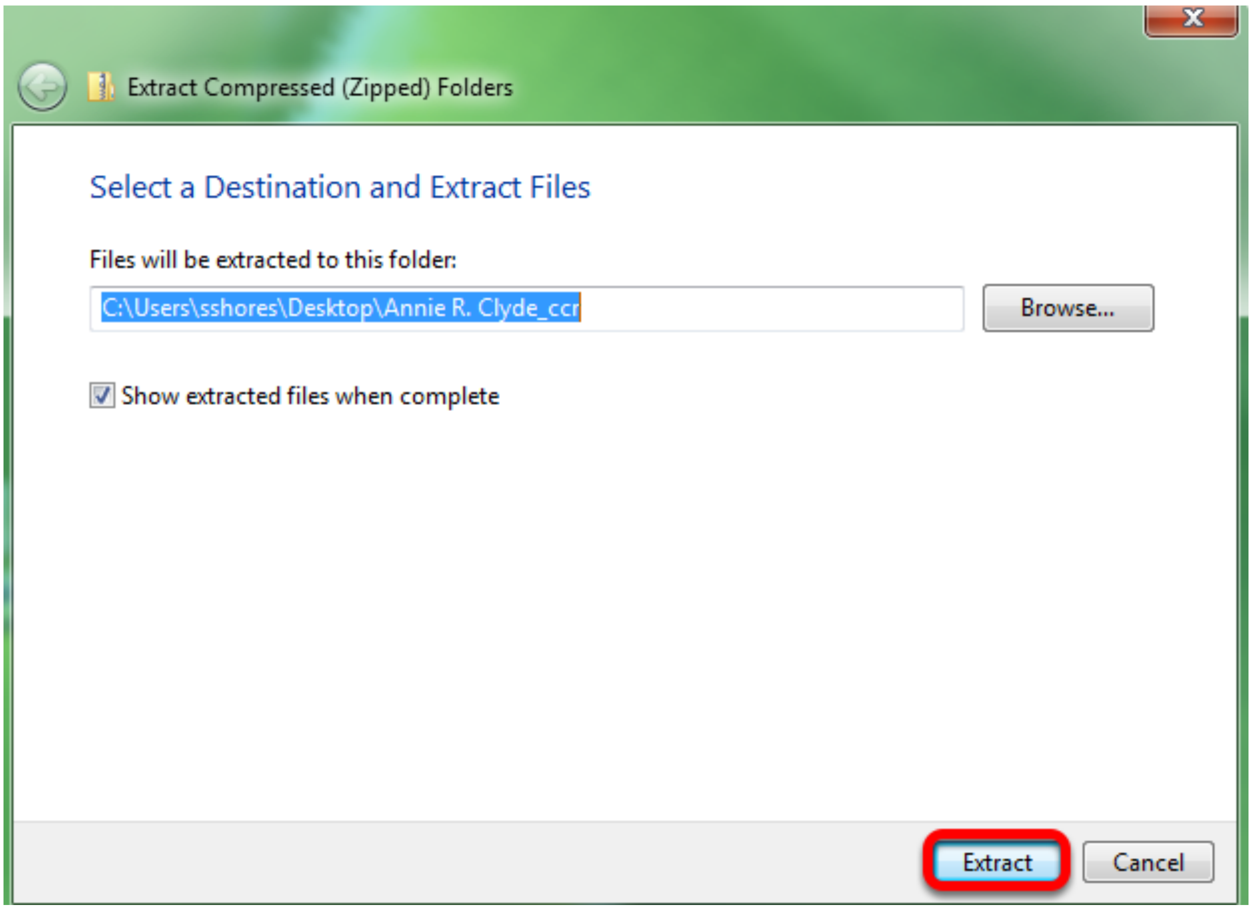


Locate the CCR file where it was saved.

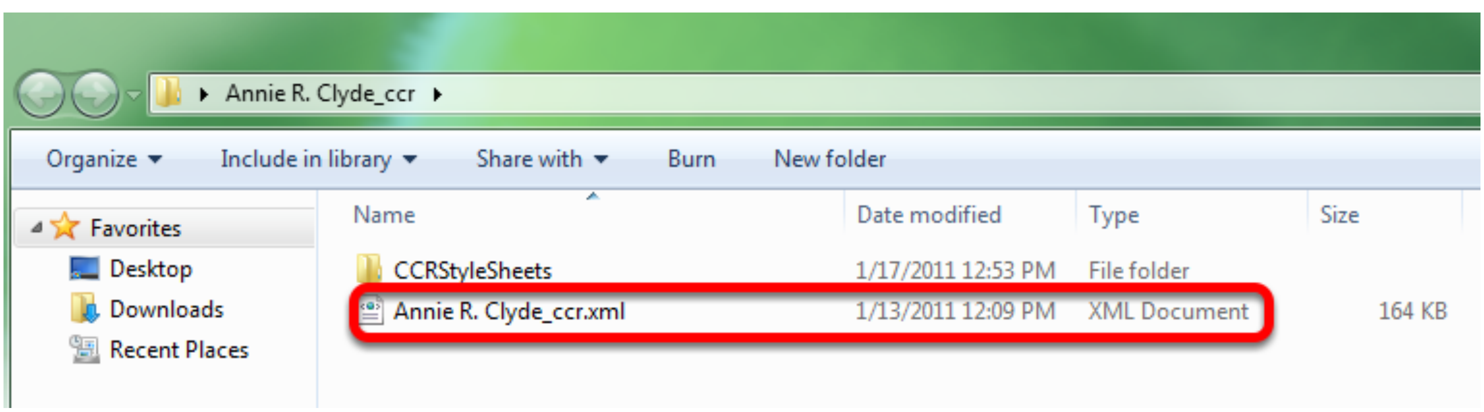
1. Right-click on the zipped file.
2. Select "Extract All."

** **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

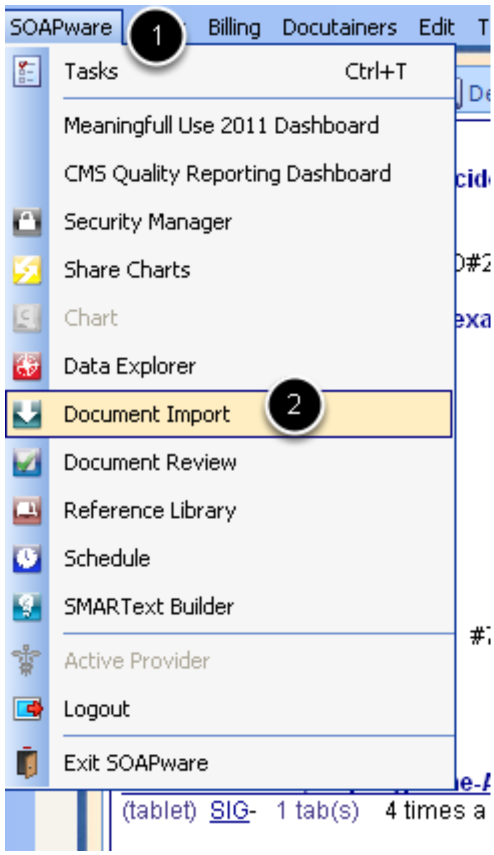
Type	Date	Code	Description	Status	Source
Diagnosis		250.90 (ICD9-CM)	Diabetes - Type 2 - with complications	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		274.01 (ICD9-CM)	Acute gouty arthropathy	Active	SOAPware 2011.0.105.0 (EHR)
Diagnosis		250.13 (ICD9-CM)	Diabetes - Type 1 - with ketoacidosis, uncontrolled	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

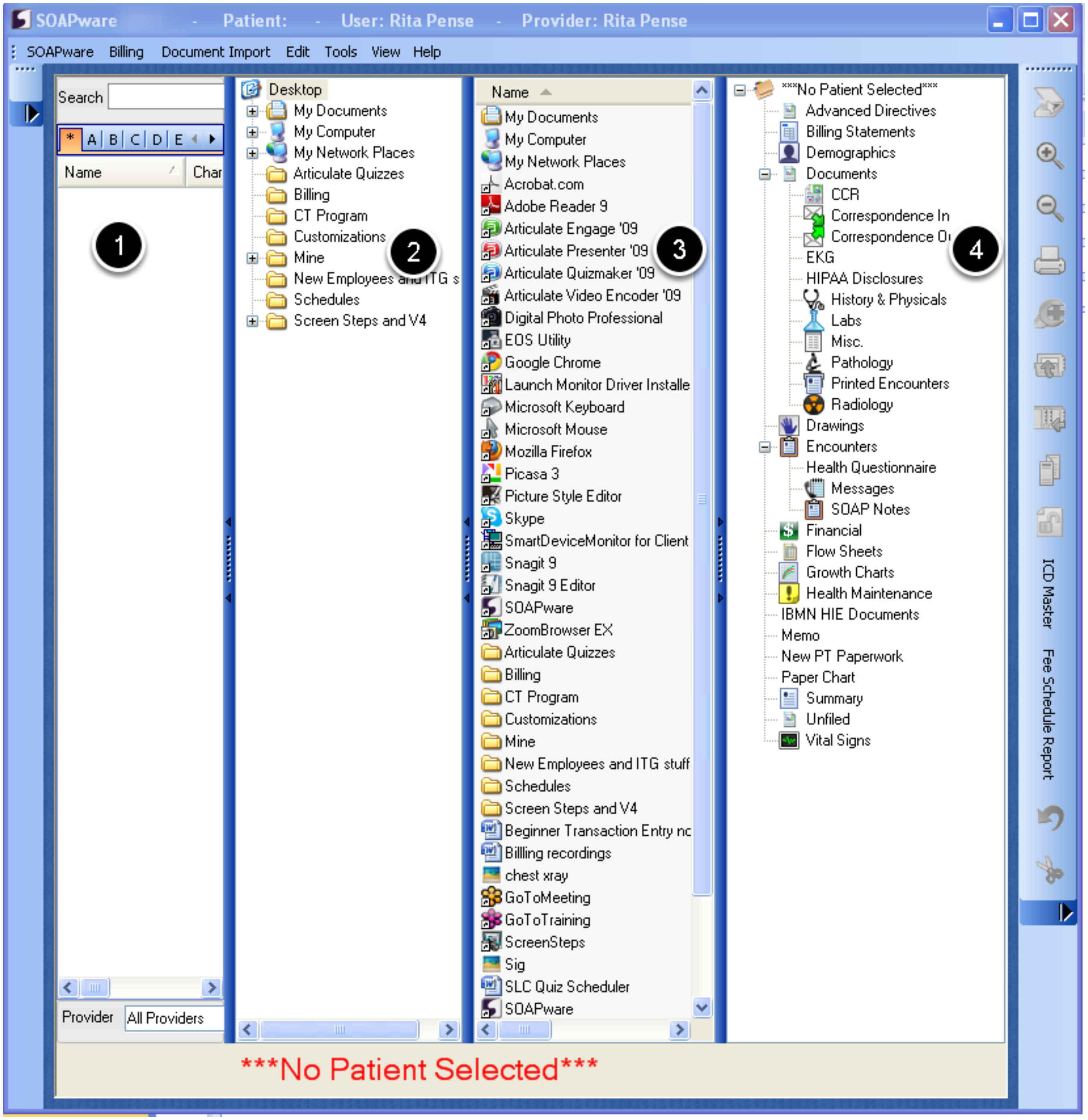
CCR and CCD formatted documents can be imported into the patient's chart using Document Import.

Accessing Document Import Workspace



1. Click on SOAPware on the menu bar.
2. Click on Document Import.

Document Import Interface

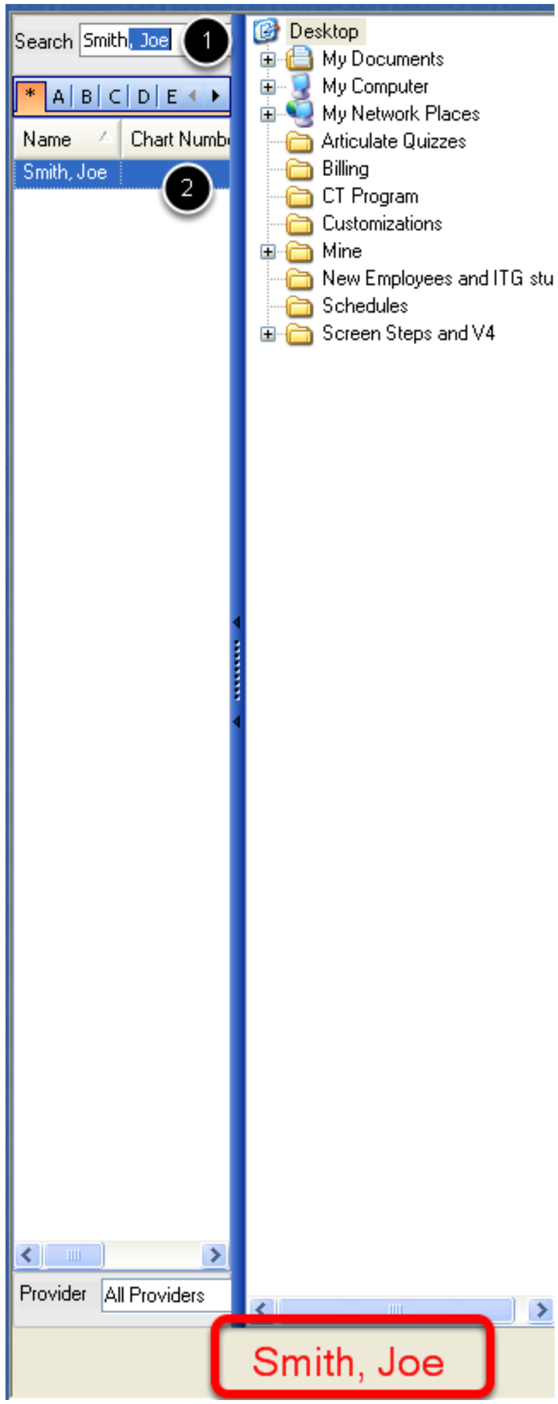


The Document Import consists of 4 panels separated by splitter bars.

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.

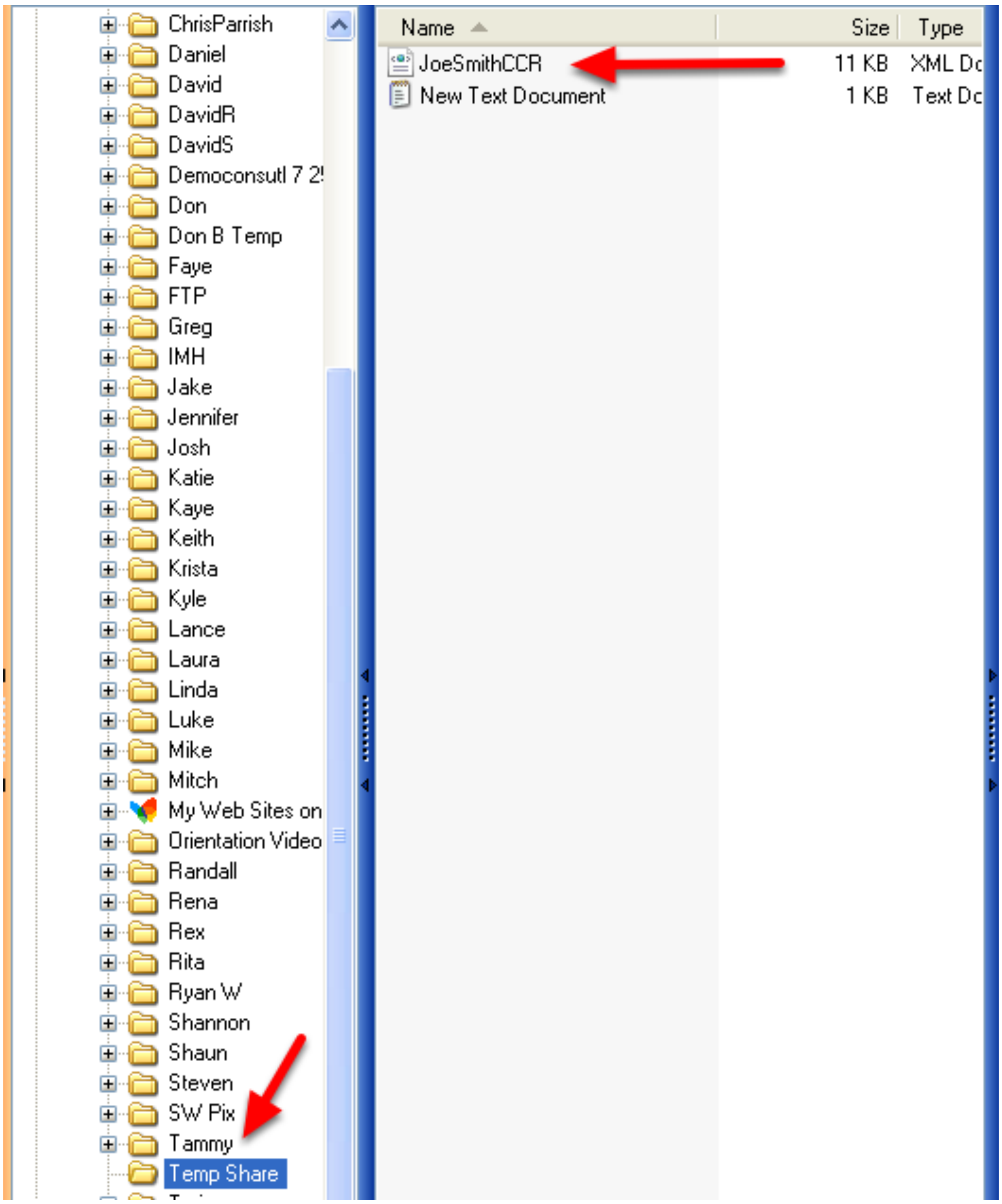
Selecting a Patient's Chart



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

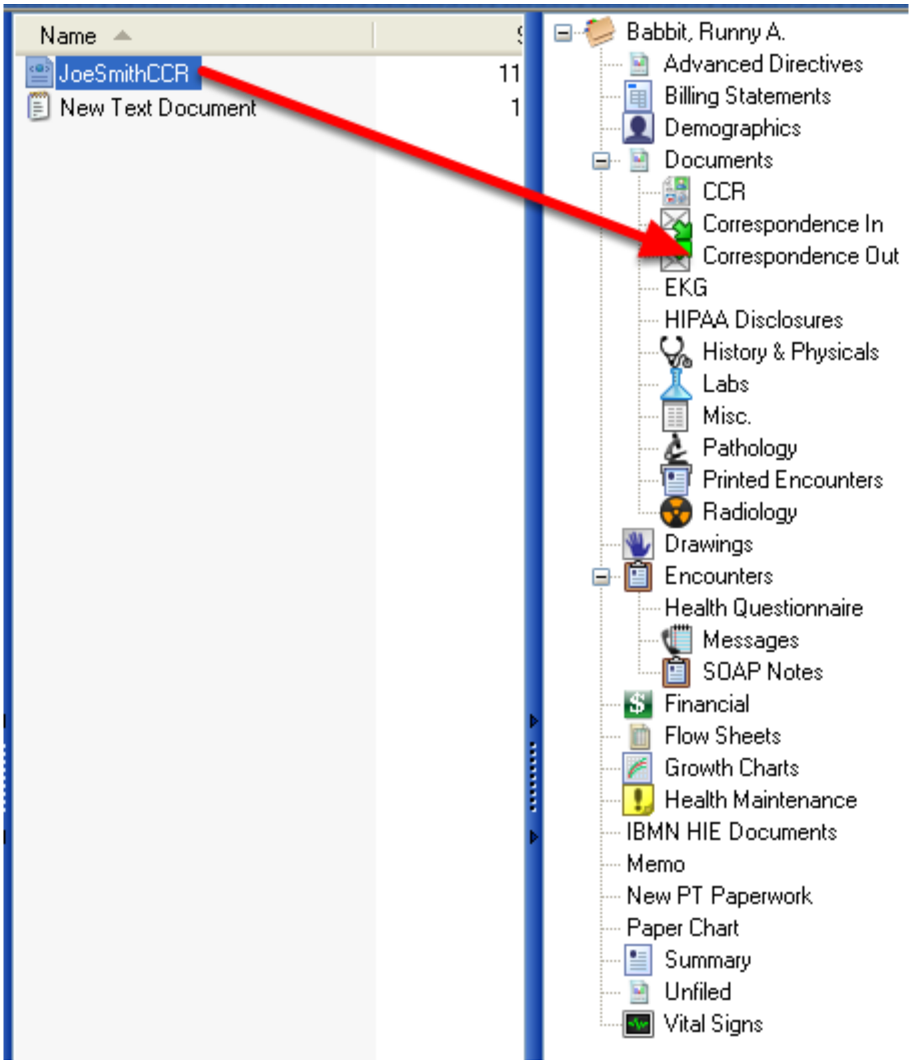
name will be displayed in red at the bottom of the screen.

Accessing the Folder the with the CCR/CCD



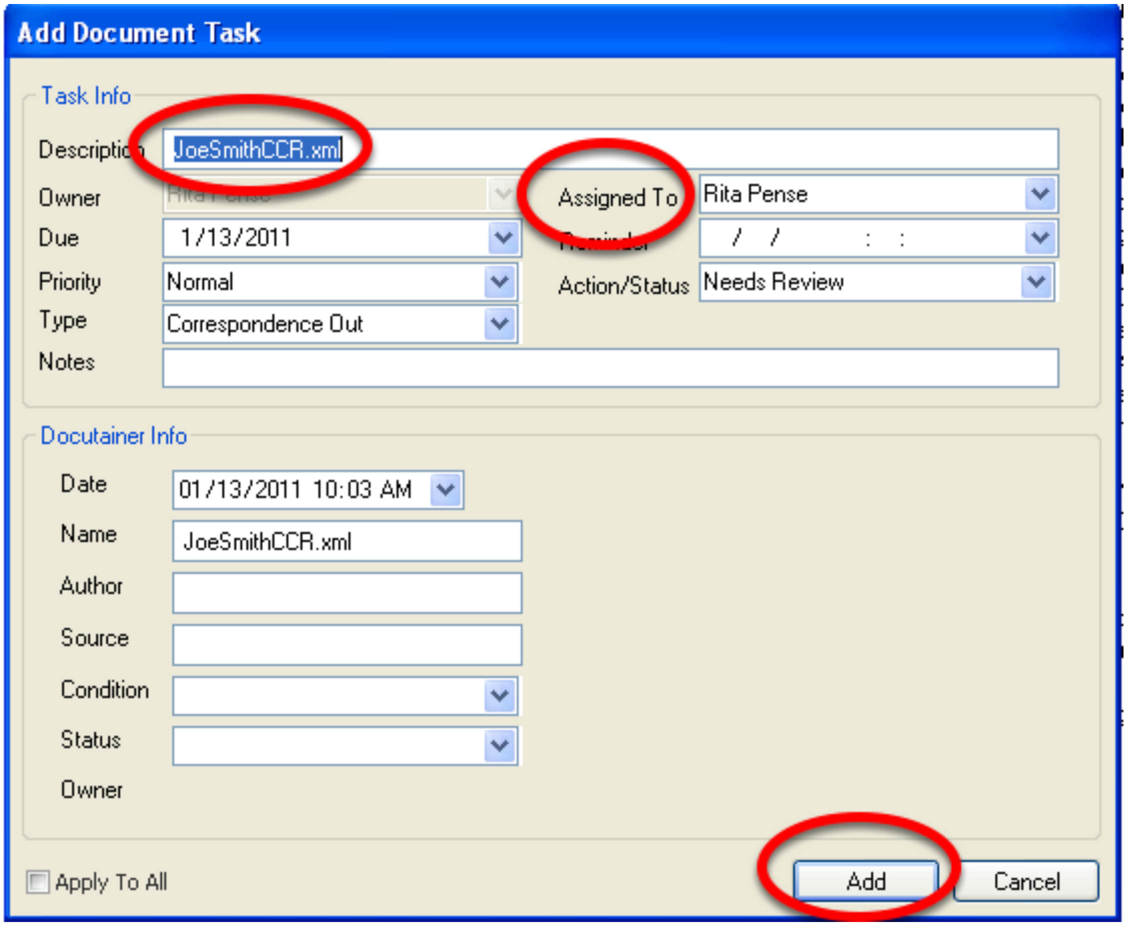
1. In the second panel, locate the folder needed and Click to highlight.
2. The contents of the folder will be displayed in the third panel.
3. Click to open the folder and locate the CCR/CCD document.

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.

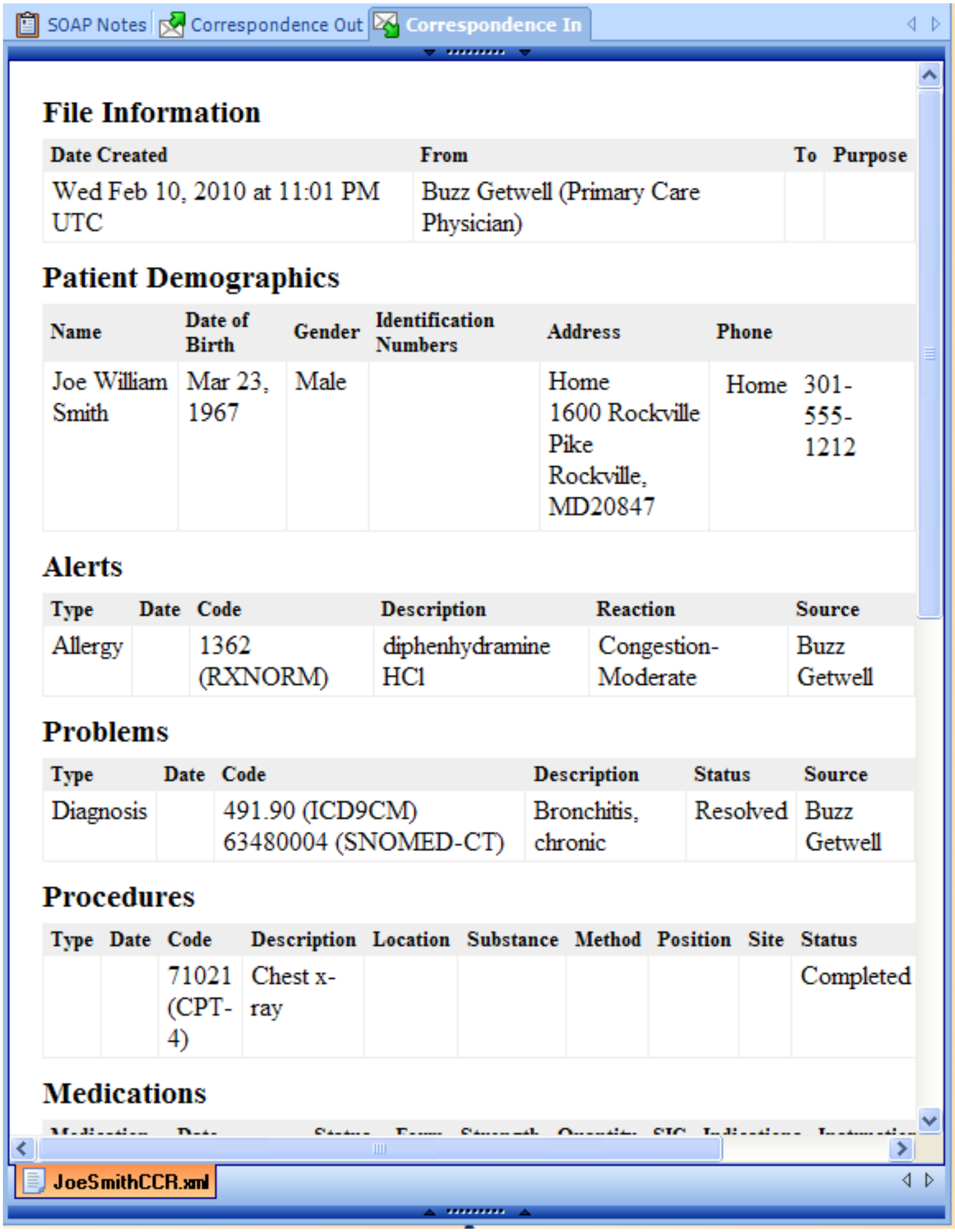
Add Task Document Task



The 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.

Viewing the Document in the Patient's Chart



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

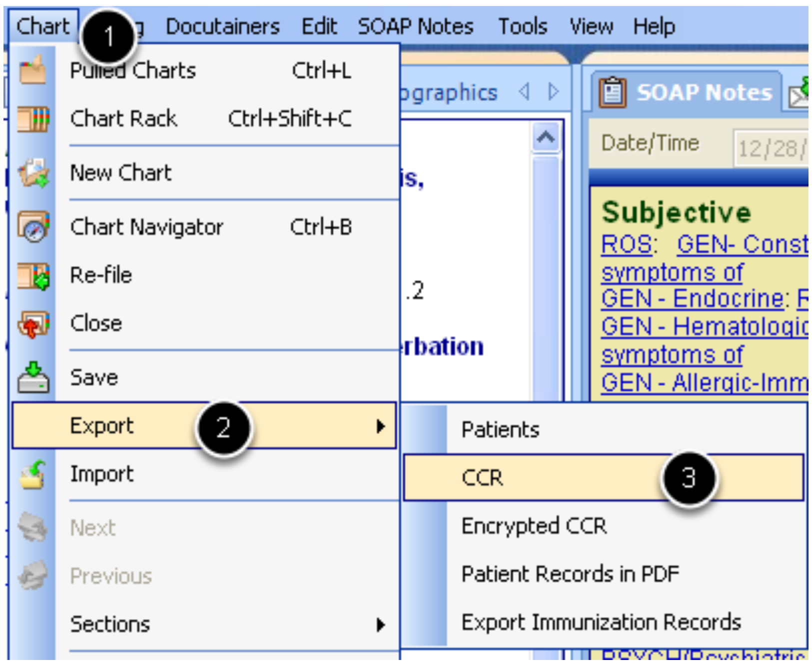
Medications

Within the chart workspace, open the patient's chart and view the document.

Generate CCR Document

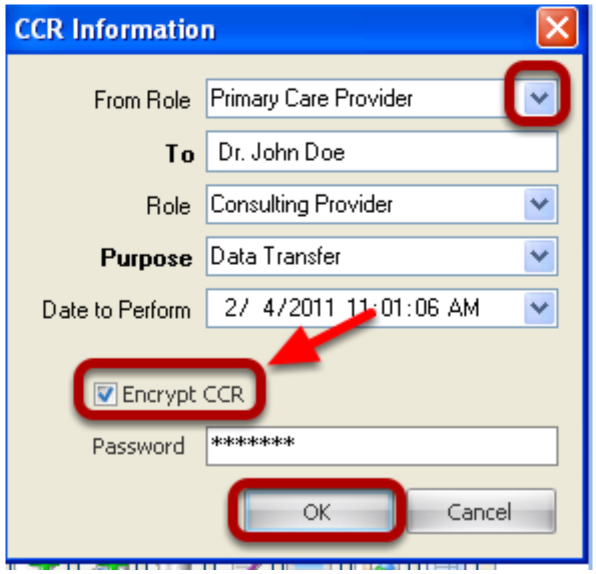
In SOAPware version 2011+ is it possible to generate a CCR document in order to share information with other health care providers.

Accessing the CCR Export



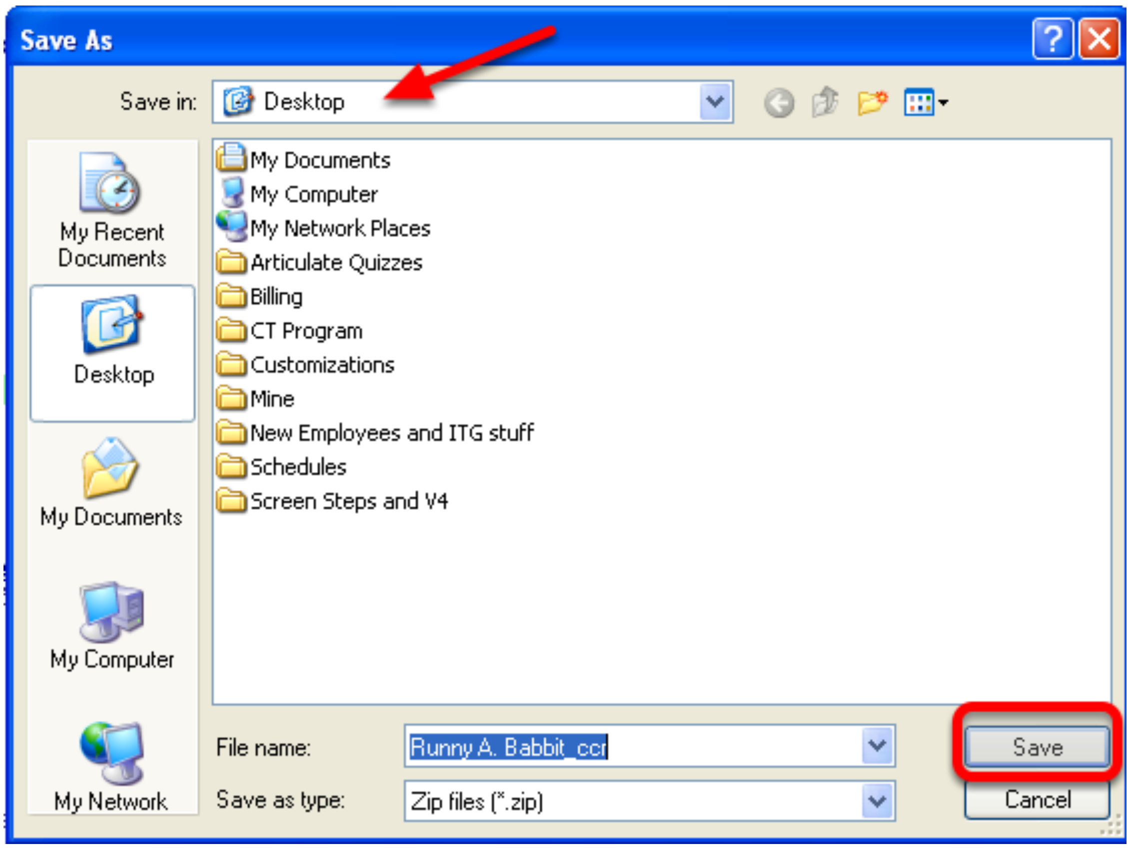
1. With a patient's chart open, Click on Chart on the menu bar.
2. Click Export.
3. Click CCR.

CCR Information



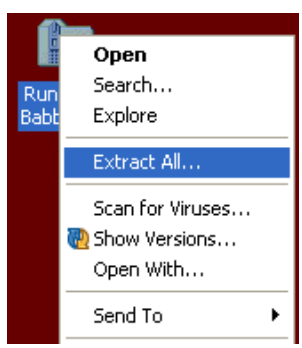
Using the drop-down menu options, fill out the appropriate information. Placing a check mark in the box for Encrypt CCR, will encrypt the content of the patient's records and may only be viewed with the password set by the person creating the CCR. The password will be shared only with the recipient of the CCR.
Click OK when finished.

Saving the CCR File



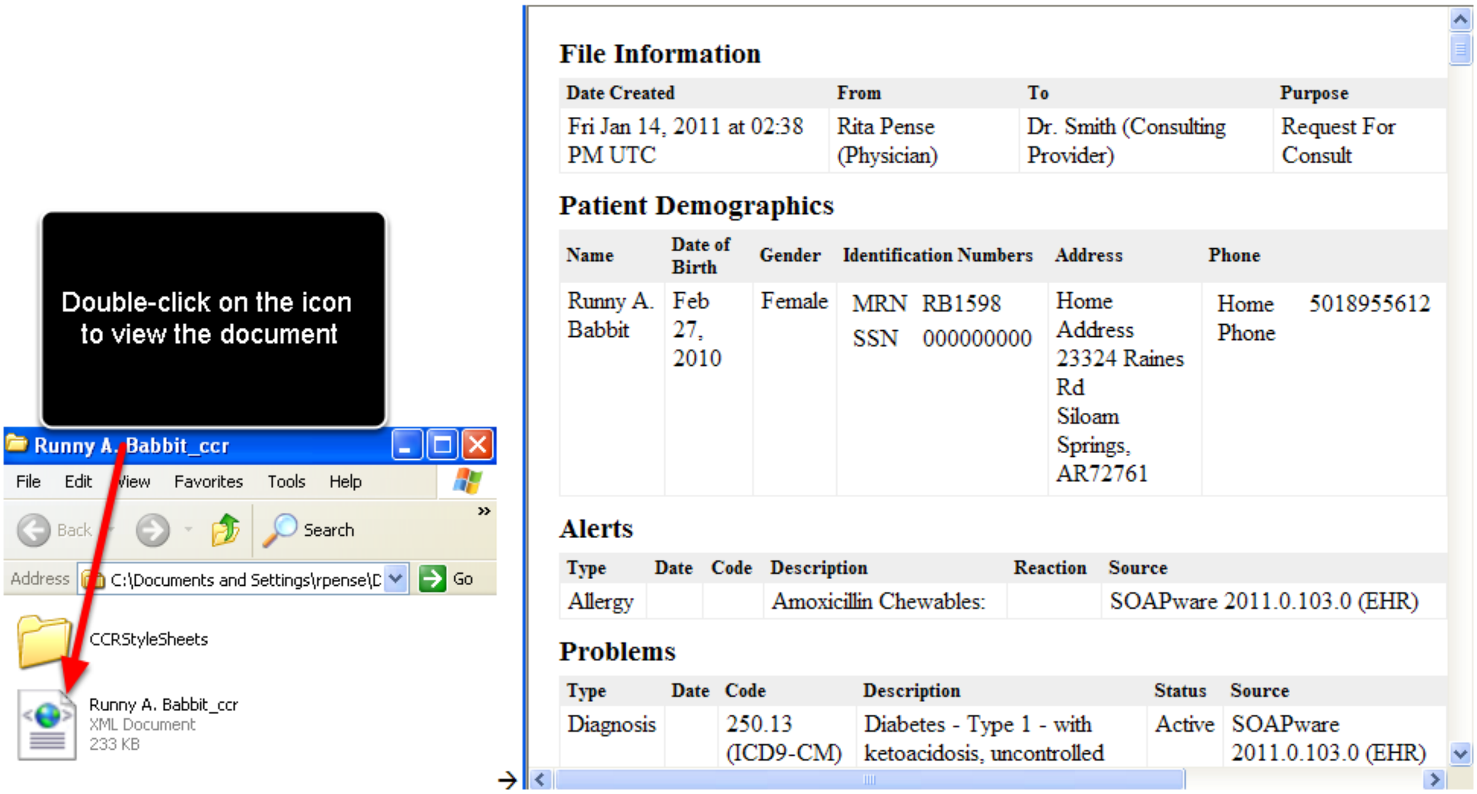
Save the file to the desktop or designated folder.

Extracting the File



1. Locate the file that was saved.
2. Right-click over the file and choose "Extract All."
3. Follow the steps from the wizard to open the document.

Viewing the Document



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

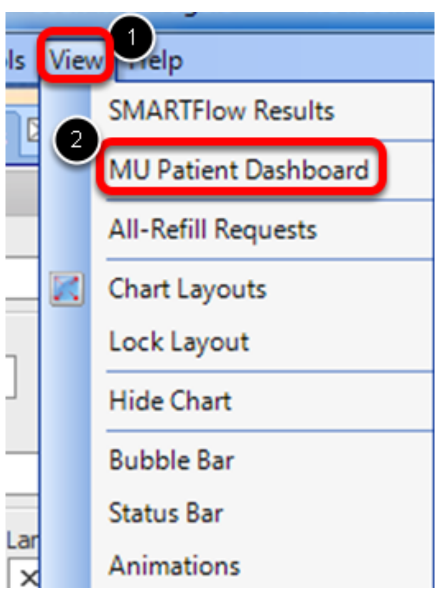
Meaningful Use requests that the information include diagnostic test results, patient problem list, medication list, and medication allergy list at a minimum.

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



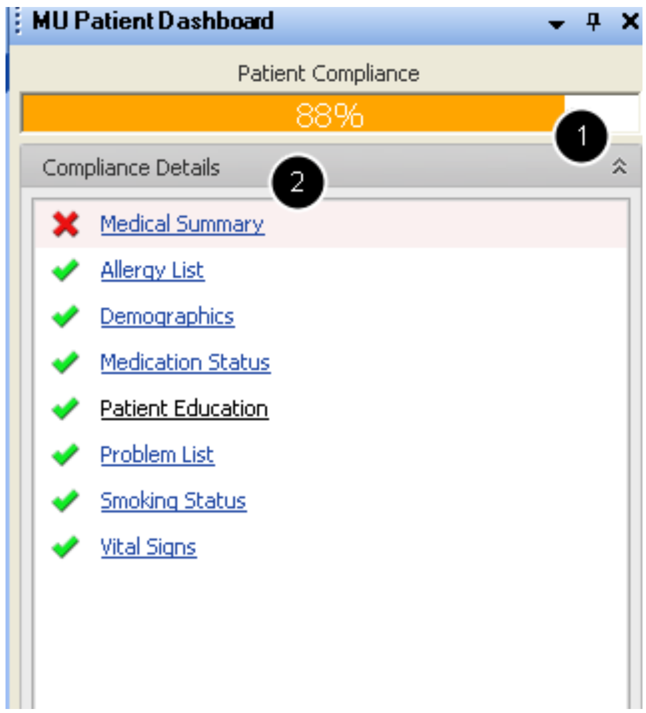
***Note**-CCR (Continuity of Care Record) format includes a "snapshot" of the patient's chart for the last 30 days.

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](#)

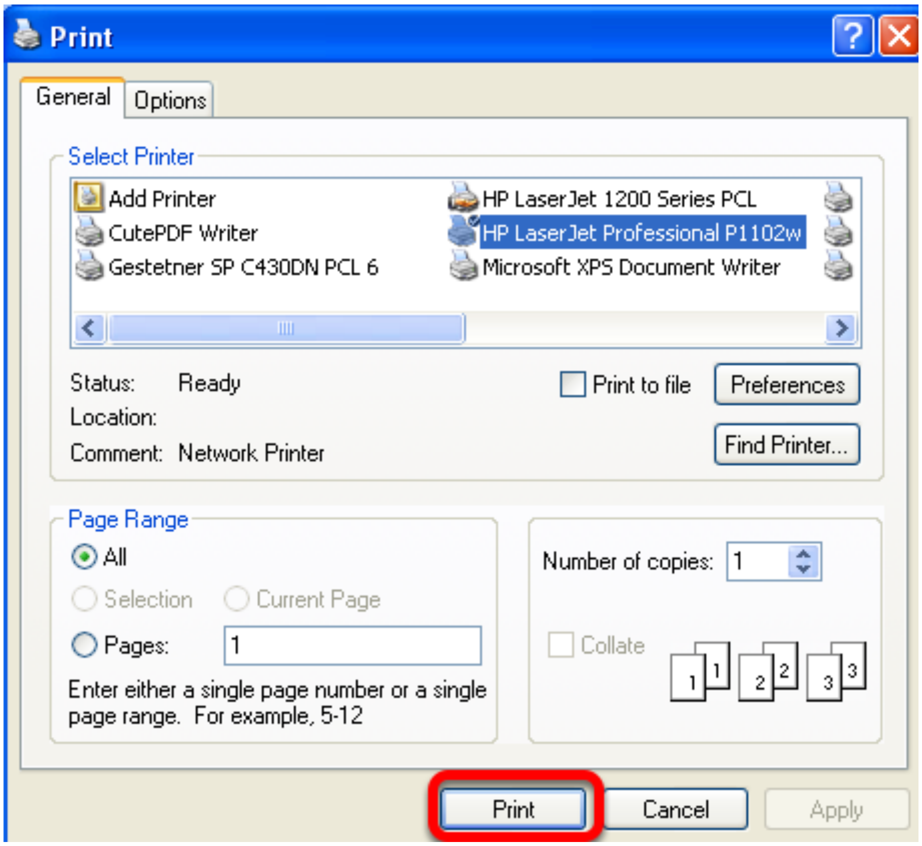
Using a CCR to Provide a Clinical Summary



The MU Patient Dashboard allows the user to export a CCR Document while keeping track of the patient compliance measures for Meaningful Use Requirements.

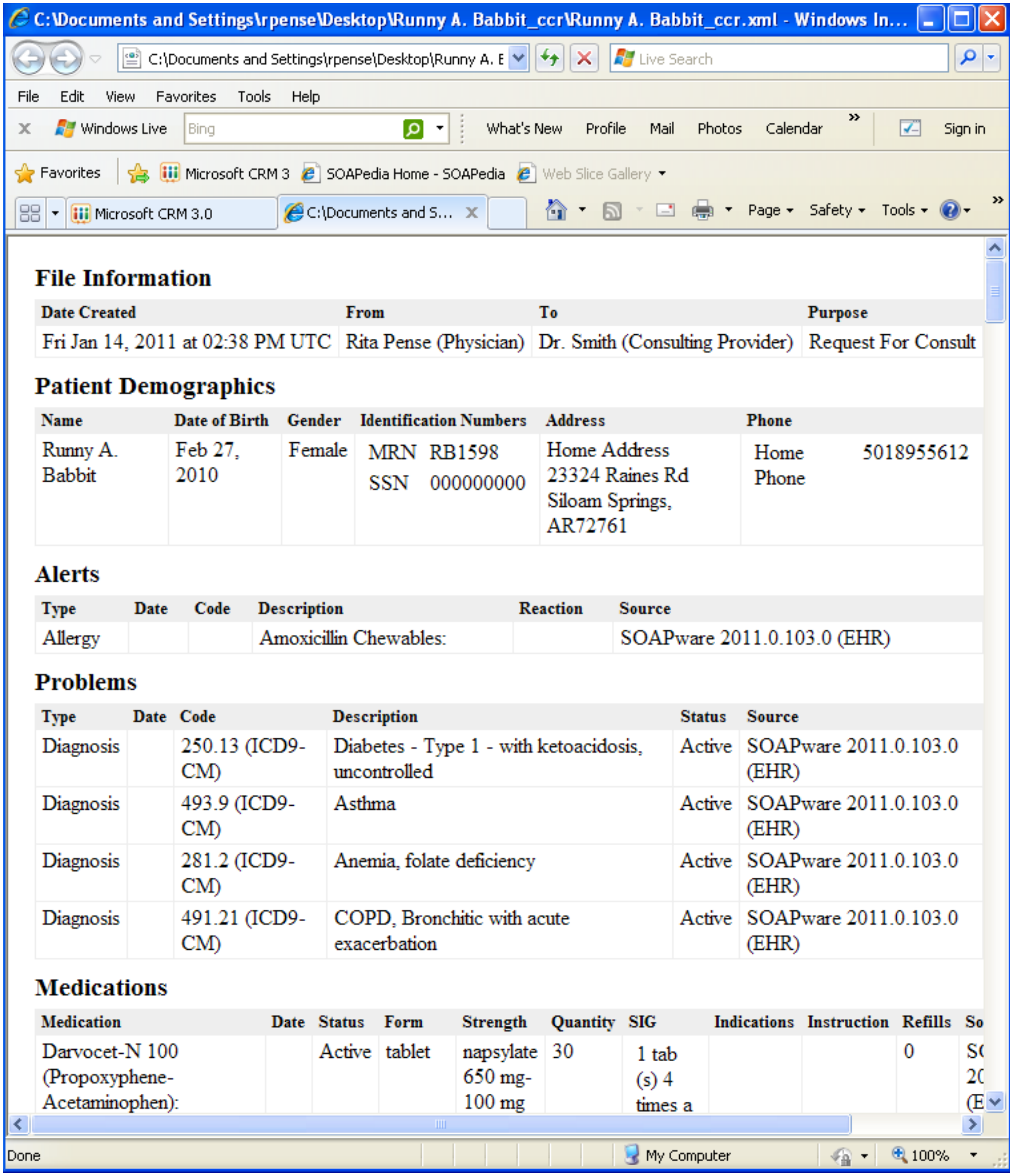
1. Click on the drop down arrows for Compliance Details (if no details are displayed)
2. Click to select Medical Summary.

Selecting the Printer



The Print dialog box will display. Click to highlight the desired printer and Click on the print button.

CCR Format



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

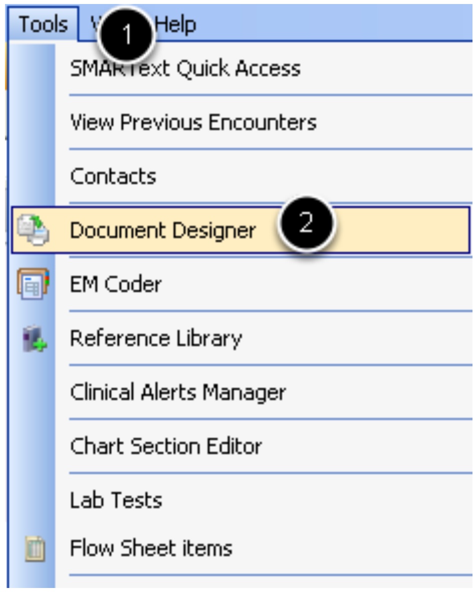
Type	Date	Code	Description	Status	Source
Diagnosis		250.13 (ICD9-CM)	Diabetes - Type 1 - with ketoacidosis, uncontrolled	Active	SOAPware 2011.0.103.0 (EHR)
Diagnosis		493.9 (ICD9-CM)	Asthma	Active	SOAPware 2011.0.103.0 (EHR)
Diagnosis		281.2 (ICD9-CM)	Anemia, folate deficiency	Active	SOAPware 2011.0.103.0 (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	S(2((E

The CCR format will appear as above when printed.

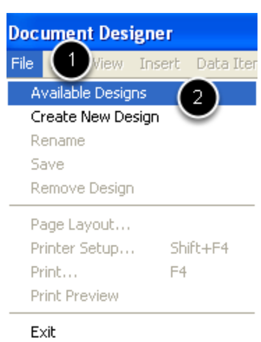
Using a Document Design to Provide a Clinical Summary



The command to indicate the Clinical Summary was provided to the patient must be placed on the proper Document Design.
To do this:

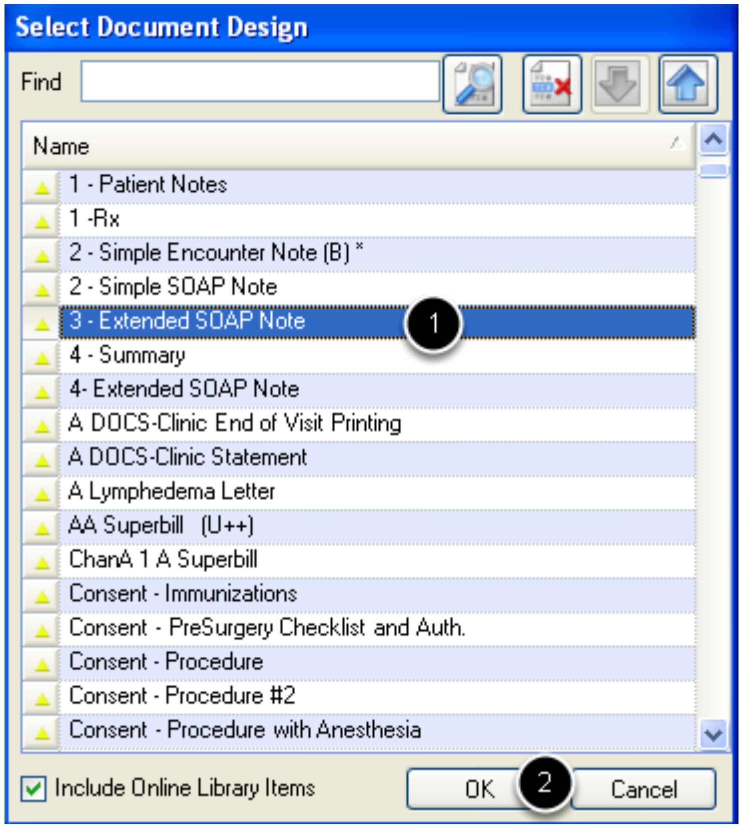
1. Click on Tools.
2. Click on Document Designer.

File > Available Designs



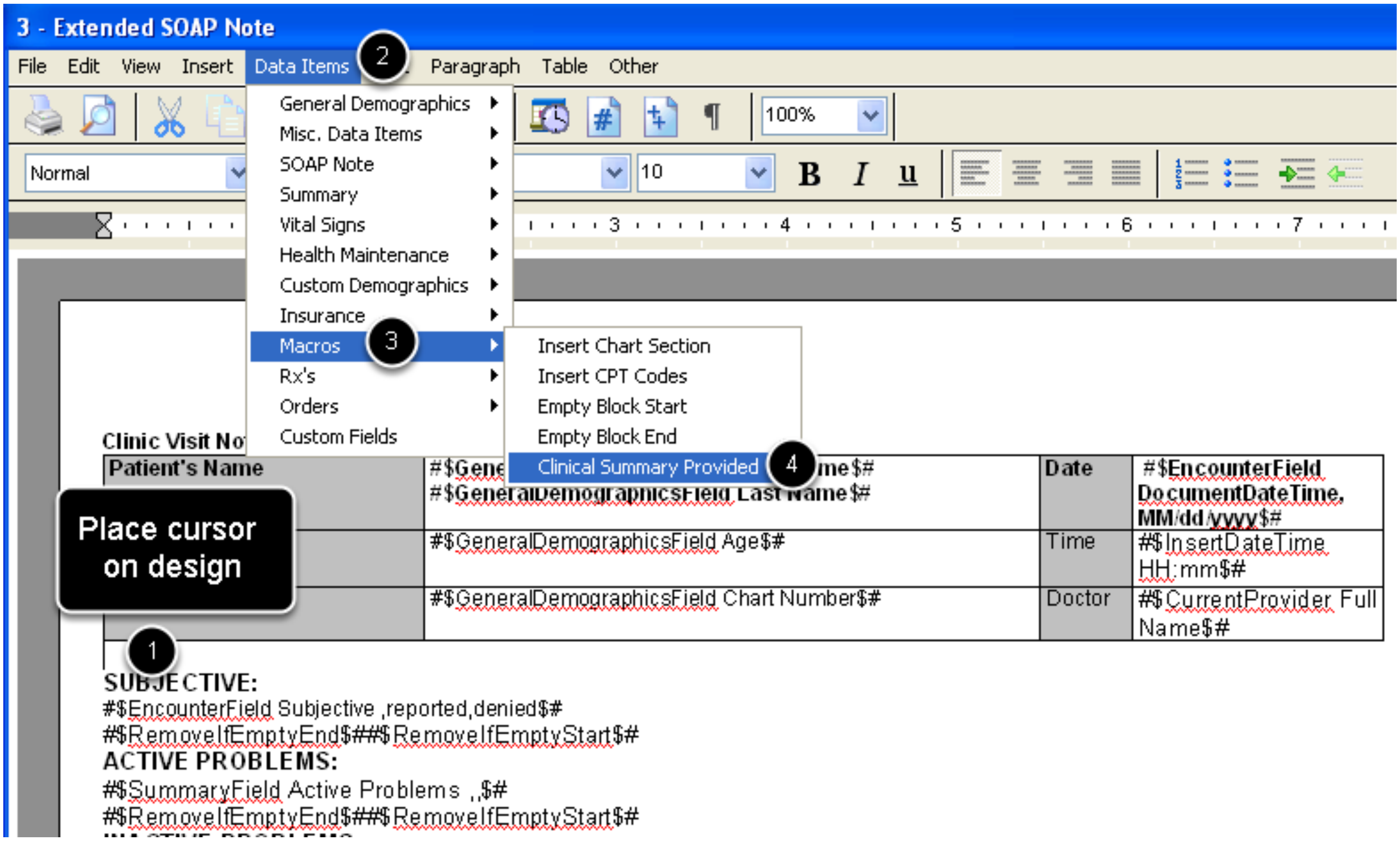
1. Click on File.
2. Click on Available Designs.

Selecting the Desired Design



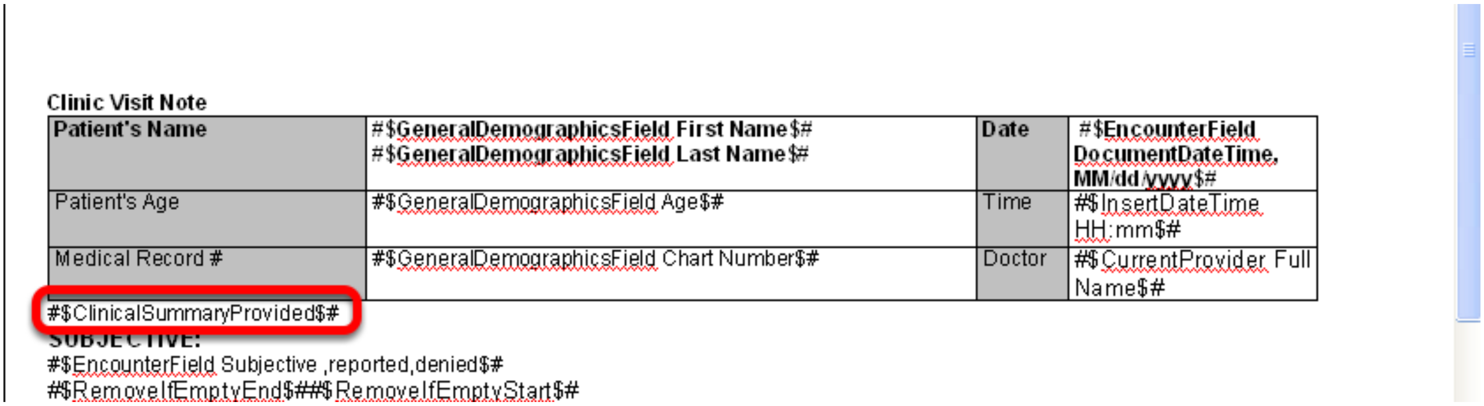
1. Click to highlight the design that includes the Summary **and** SOAPnote information.
2. Click OK.

Inserting the Command



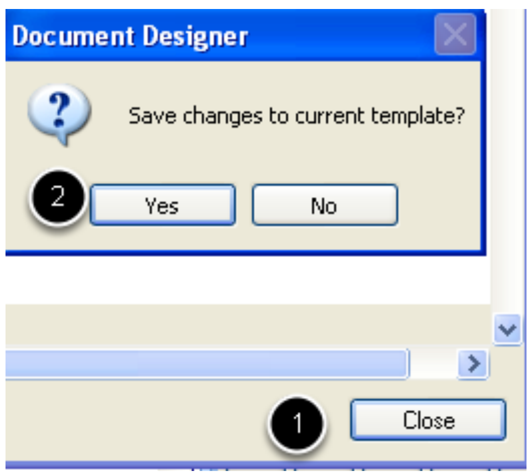
1. Place the cursor on the design. The location of the cursor and subsequent command is not important as the command runs in the background and is not visible when the design is printed.
2. Click on Data Items.
3. Click on Macros.
4. Click on Clinical Summary Provided.

The Command



The command will not appear on the design.

Saving the Edit



1. Click on Close.
2. Click Yes.

Clinical Summary

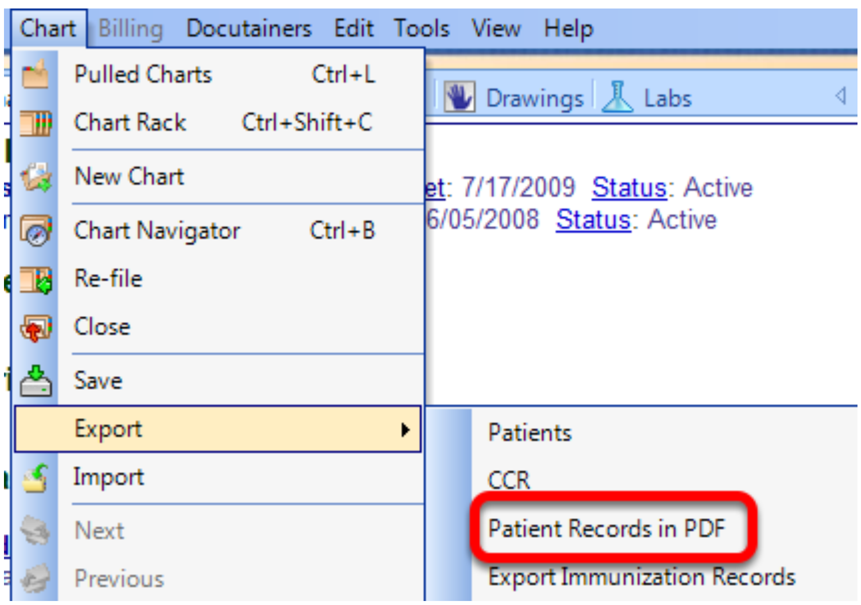
This lesson has demonstrated the two ways to provide a Clinical Summary for a patient; CCR document and using a Document Design.
Both methods will be reflected in the MU Patient Dashboard and Meaningful Use Dashboard.

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

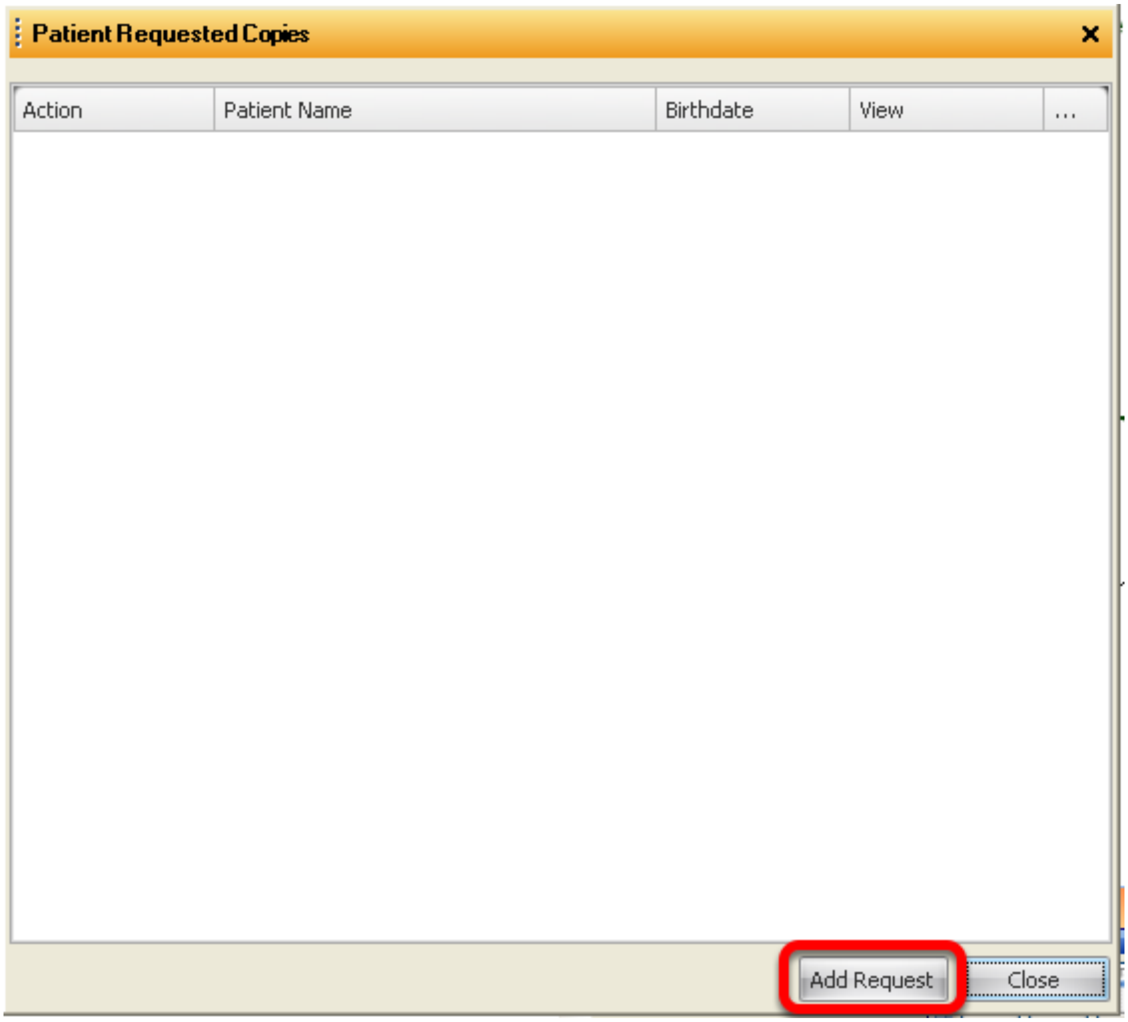


When a patient requests a copy of their health information, the following workflow should be used in order to successfully meet the Meaningful Use objective to provide patients with an electronic copy of their health information upon request.

Click on Chart > Export > Patient Records in PDF.

Note: *The Patient Requested Copies Manager can be docked or left free-floating.*

Add Request

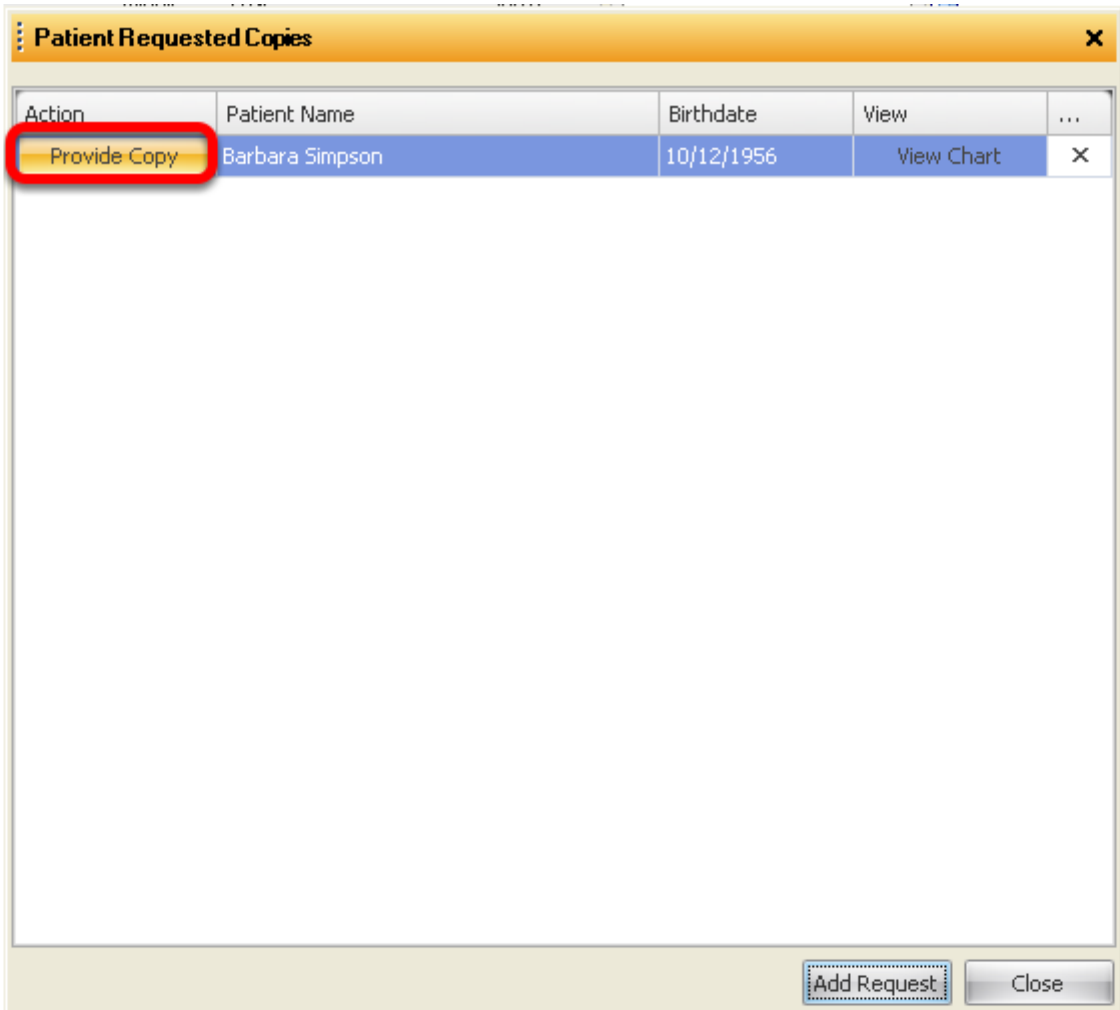


Select the "Add Request" button to indicate that the selected patient has requested a copy of their medical records.

Note: Make sure a patient's chart is open before adding a request. Auser 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.

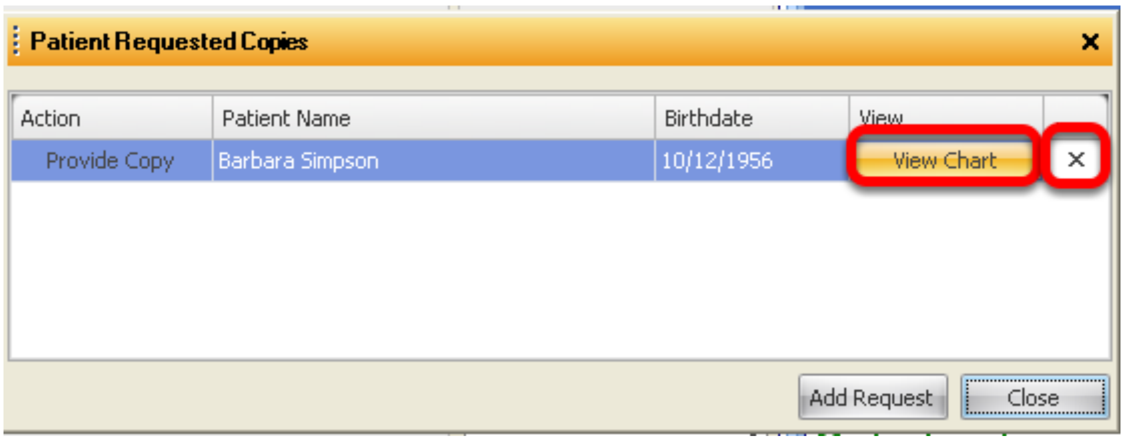
Provide Copy



Click on the "Provide Copy" button.

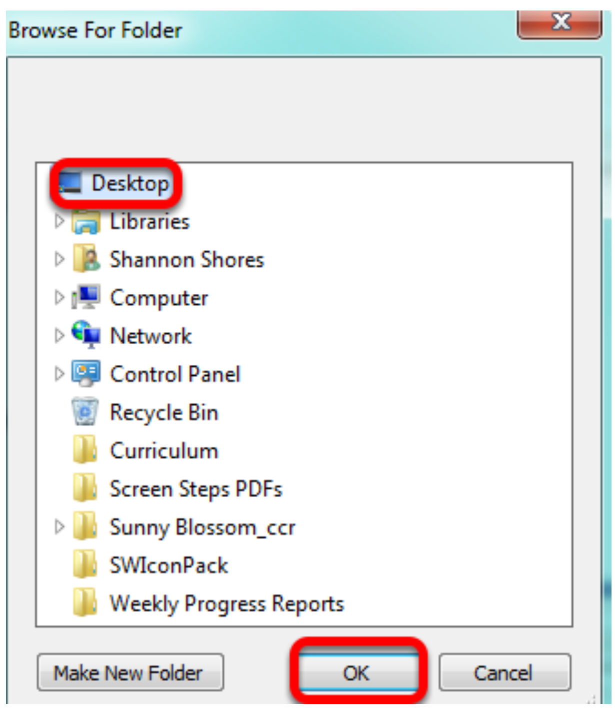
This action will mark this request as responded to with the current date for Meaningful Use reporting purposes. This workflow must be used in order for the information to be tracked within the Meaningful Use dashboard.

Misc Commands



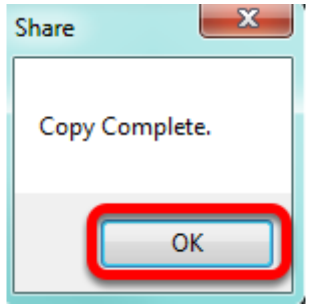
"View Chart" opens the chart related to the request.
"X" deletes the request from the Patient Requested Copies Manager. If the request is delete, it cannot be retrieved.

Save the Document



In the screen shot above, the document was saved to the desktop.
Click OK.

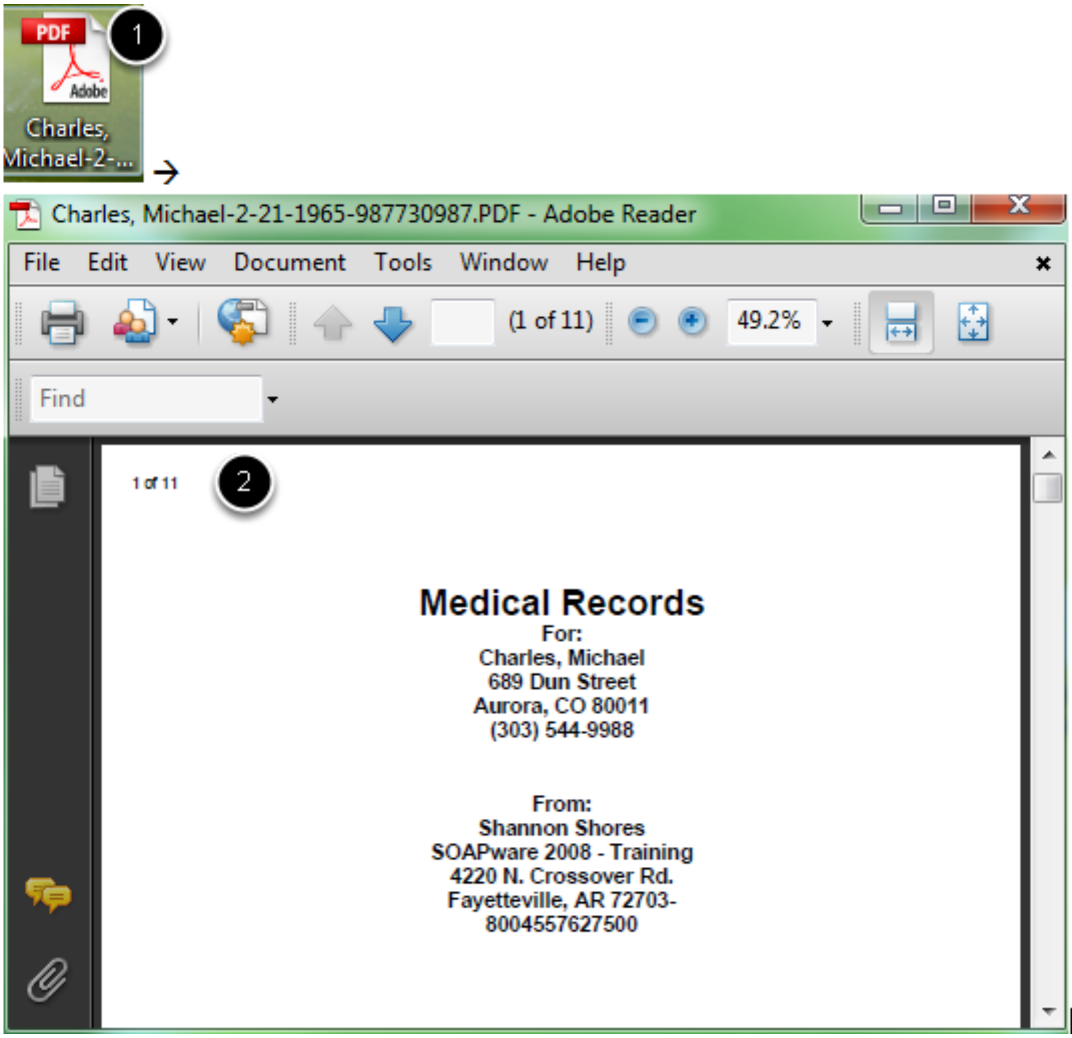
Copy Complete Notification



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

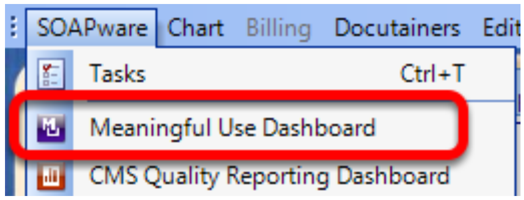


1. Double-click on the file to open.
2. A completed document displayed as a PDF.

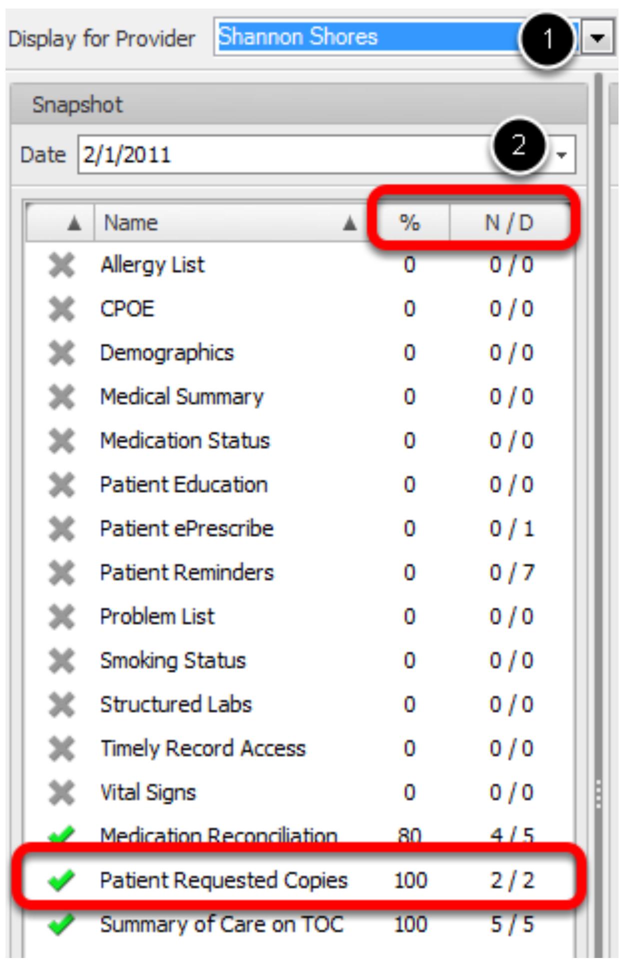
Providing the Patient an Electronic Copy

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.

Meaningful Use Tracking



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

If the user accidentally created two charts for the same patient, this function will allow the user to merge them into one chart.

Explanation of Feature

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.

Chart Merger Warning

VERY IMPORTANT: Most of the documentation from both charts will be present in the merged chart. However, there are certain sections of the chart that will only be retained from the chart being merged to. These sections include:

- Demographics
- Insurance
- Custom Demographics
- Vital Signs
- Health Maintenance
- Memo
- Clinical Suite customers: Financial Data/Claims/Statements
- ***Optional***: Summaries can be merged if desired (only in 2012.0.3063+; in versions prior to this the Summaries will not merge)

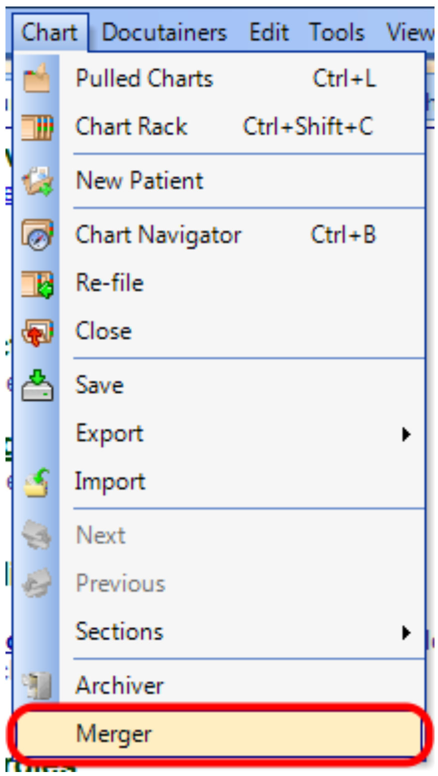
These sections will not be saved from the "Merge From" chart. Before the user begins, look carefully at each of these sections. Copy data from the "Merge From" chart to the "Merge To" charge, to make sure that the "To" chart has all the data needed in those sections.

In 2012.0.3063+ the Summaries from the "Merge From" and "Merge To" chart can be combined. In versions prior to 2012.0.3063, the Summaries will not merge therefore data must be copied to the "To" chart prior to performing a merge.

Security Concerns

It is not possible to un-merge two charts, therefore it is recommended that the use of this feature be limited in security, to one person, or a small number of experienced staff. A backup of a user's SOAPware data is recommended prior to merging patient charts.

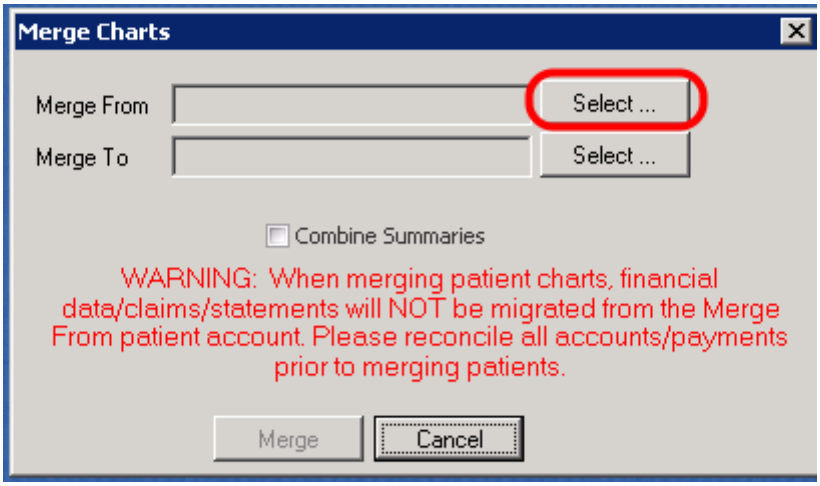
Directions to Merge Charts



To use the Chart Merger, click on the **Chart** menu, then select **Merger**.

The Merge Charts dialog box will open, allowing the user to select the chart to Merge From and the chart to Merge To.

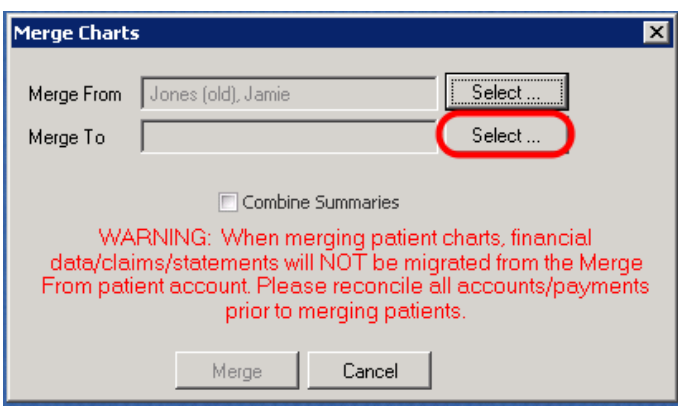
Merge From



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.

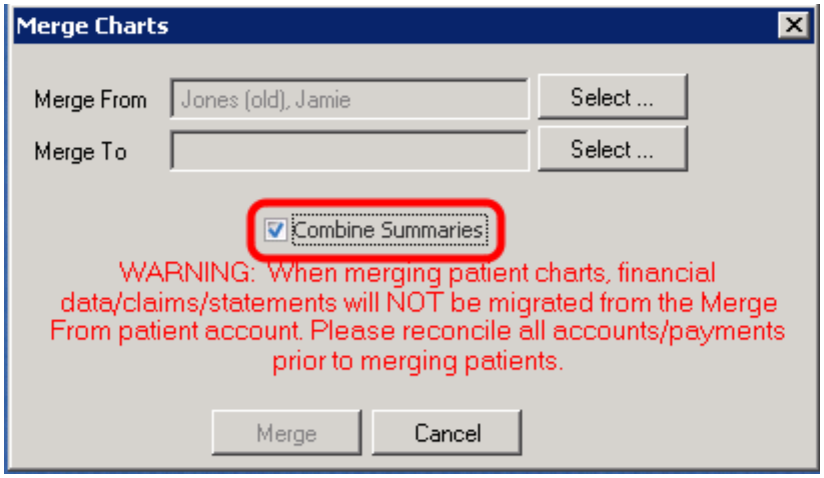
**Note: Data from some sections of the "Merge From" chart will be lost. Please see the "Chart Merger Warning" above.*

Merge To



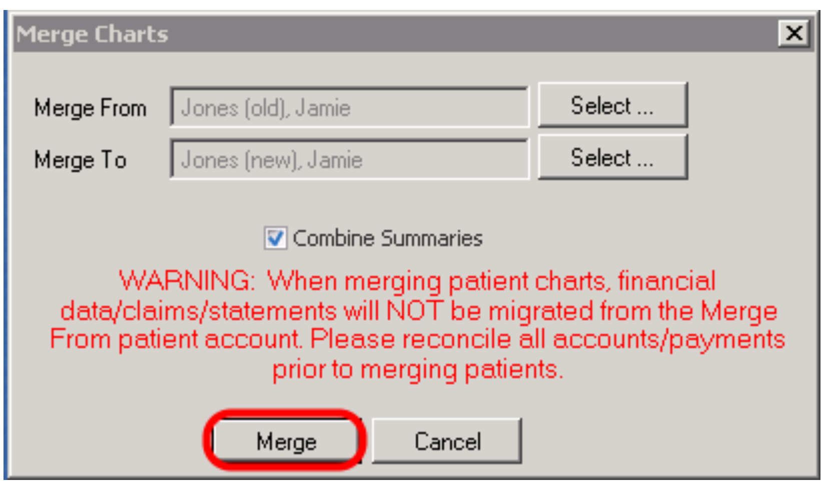
Next, select the chart to **Merge To**. This will open the Merge To dialog box, which will allow the user to select a patient chart by either typing information into the Search field, or by clicking on a letter and selecting the chart. Once the user has selected the chart to Merge To, Click "Select" at the bottom of the window.

Combine Summaries



If you wish to combine the Summary from the "Merge From" chart into the "Merge To" chart, check the box next to Combine Summaries.

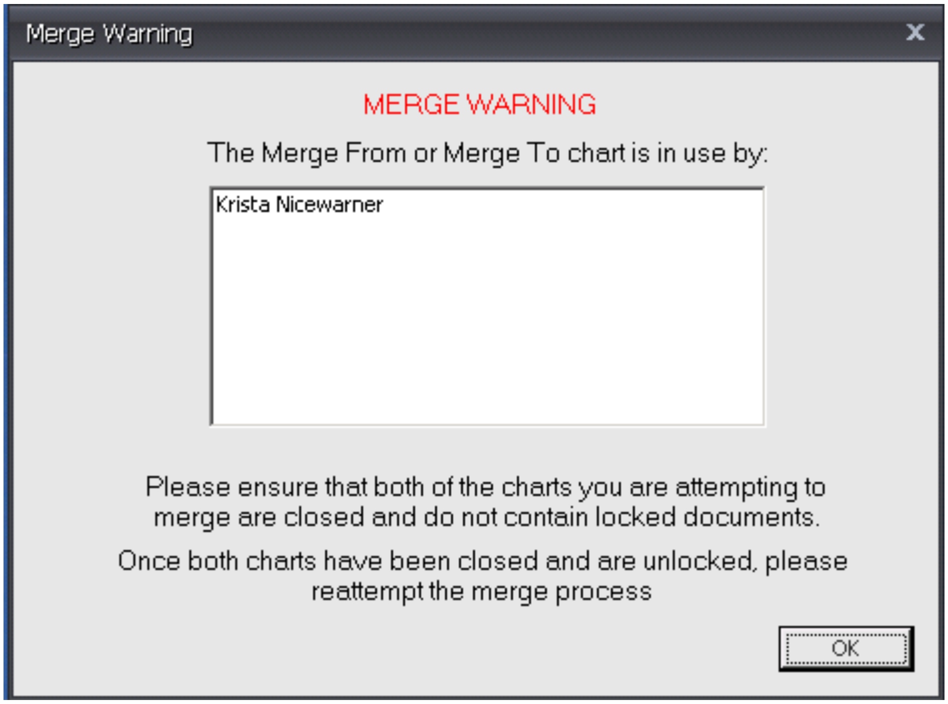
Merge



In the Merge Charts dialog box, the charts the user has selected will be displayed in the Merge From and Merge To fields. Prior to merging the charts, ensure that both of the charts you are attempting to merge are closed and do not contain locked documents. After verifying this, click the "**Merge**" button to merge the charts.

**Note*: It is recommended that the user check the chart that was selected in the Merge To field to ensure a complete and accurate merge.*

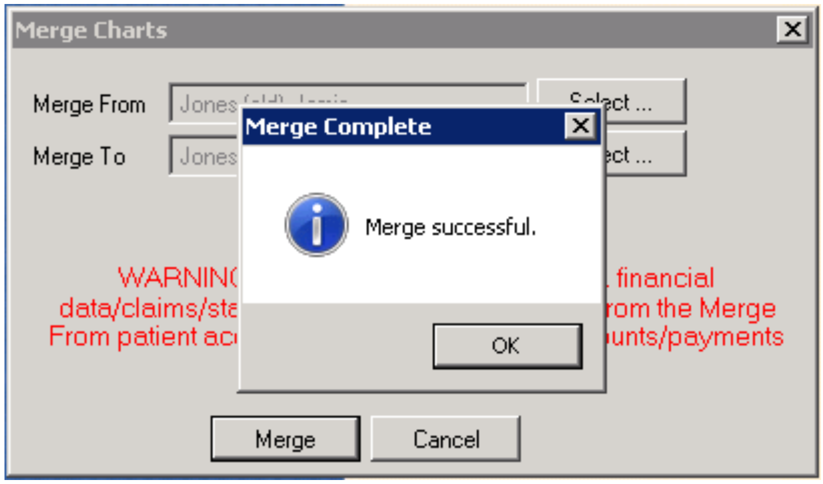
Merge Warning



The user will be presented with a Merge Warning if you are attempting to merge a charge that is currently in use. If one of the charts is open by another user or if the chart contains a locked document, the merging process cannot be completed.

Once both charts have been closed and are unlocked, please reattempt the merge process.

Merge Complete



As the merge process completes, a progress bar will be displayed. The "Merge successful" message will display once the merging of the charts has been completed.

Chart Archiving Feature

The Chart Archiver 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.

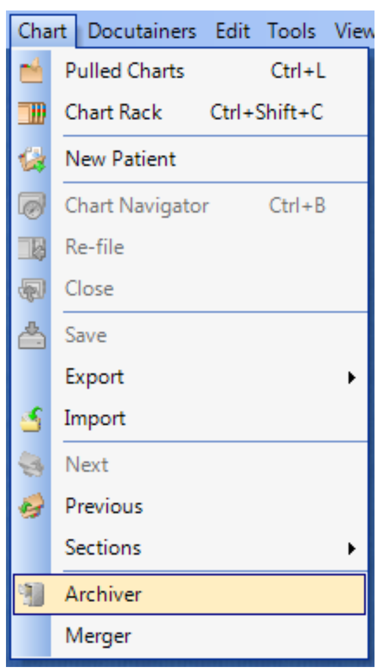
The user can also un-archive a chart at any time using the Chart Archiver, placing it back on the Chart Rack and making it available for use.

**A user 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

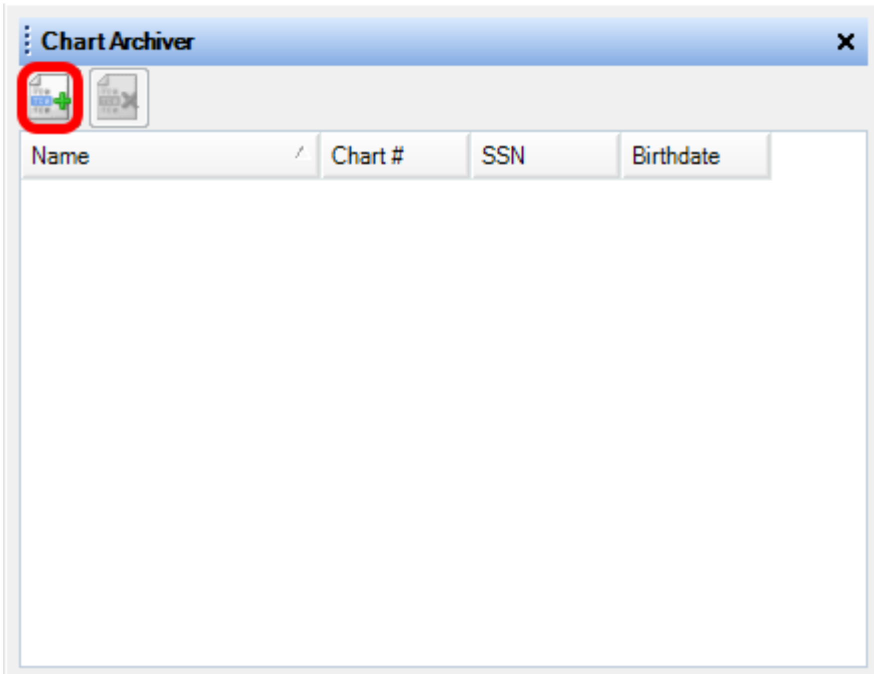
The Chart Archiver displays all charts that have been archived. Above the list of archived charts, there are two buttons: Archive Chart and Un-archive Chart.

Open Chart Archiver



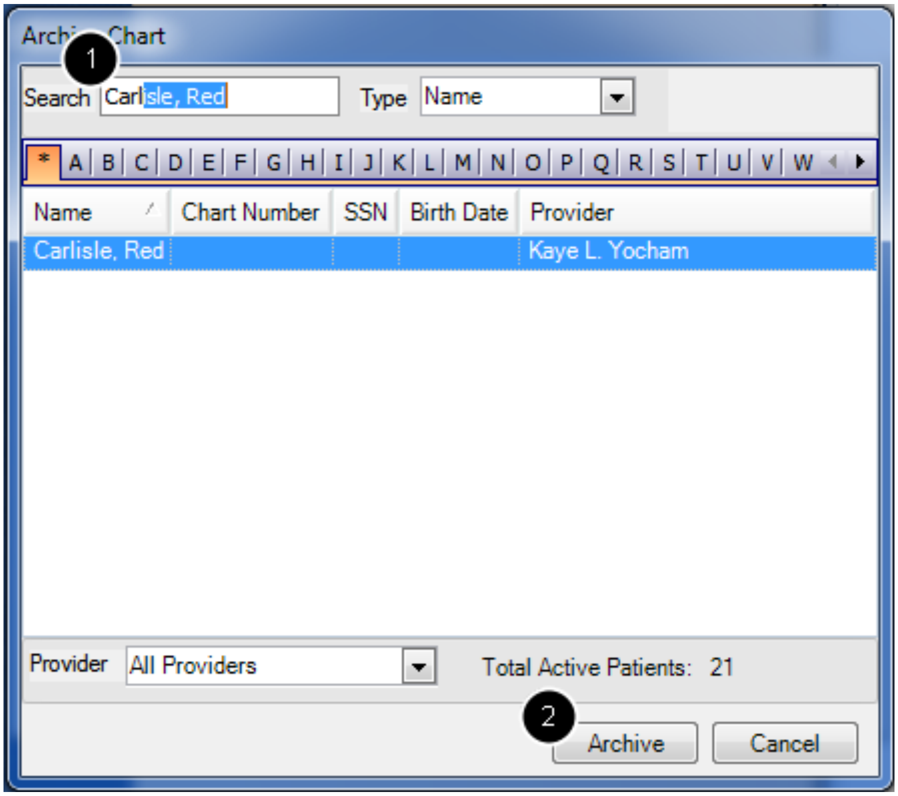
To archive a chart, Click the Archive Chart Button (or press Control + Alt + A). The Archive Chart tool will then open.

Directions to Archive Charts



Click the Archive Chart button.

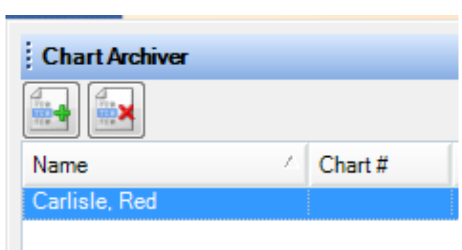
Select the Chart to Archive



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.

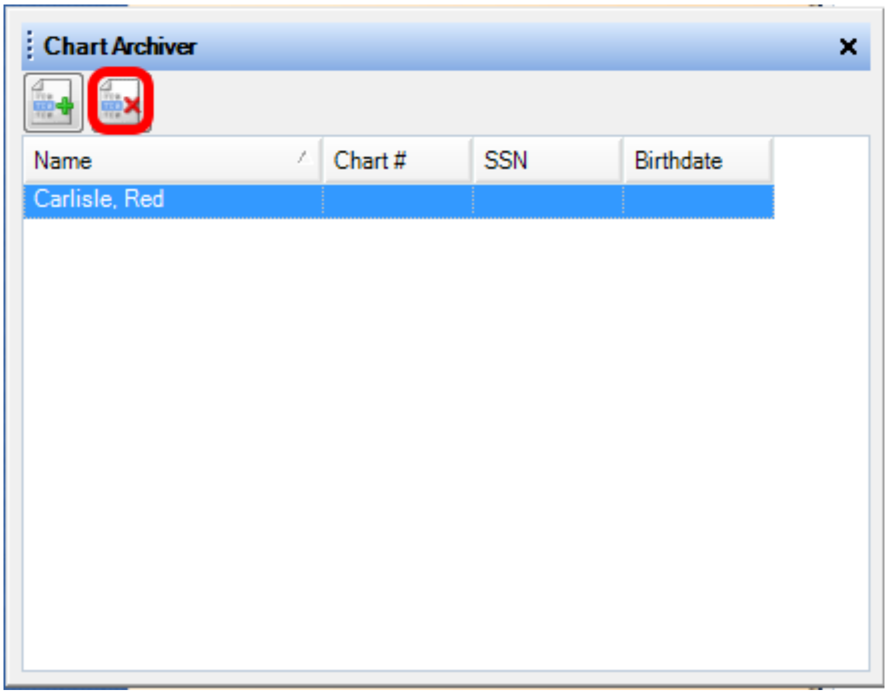
2. Once the user has selected the chart to archive, Click the Archive button. The chart will be removed from the chart rack and placed on the list of archived charts.

Chart Archiver



After the user has archived the chart, it will appear in the list of archived charts.

Directions to Un-Archive Charts

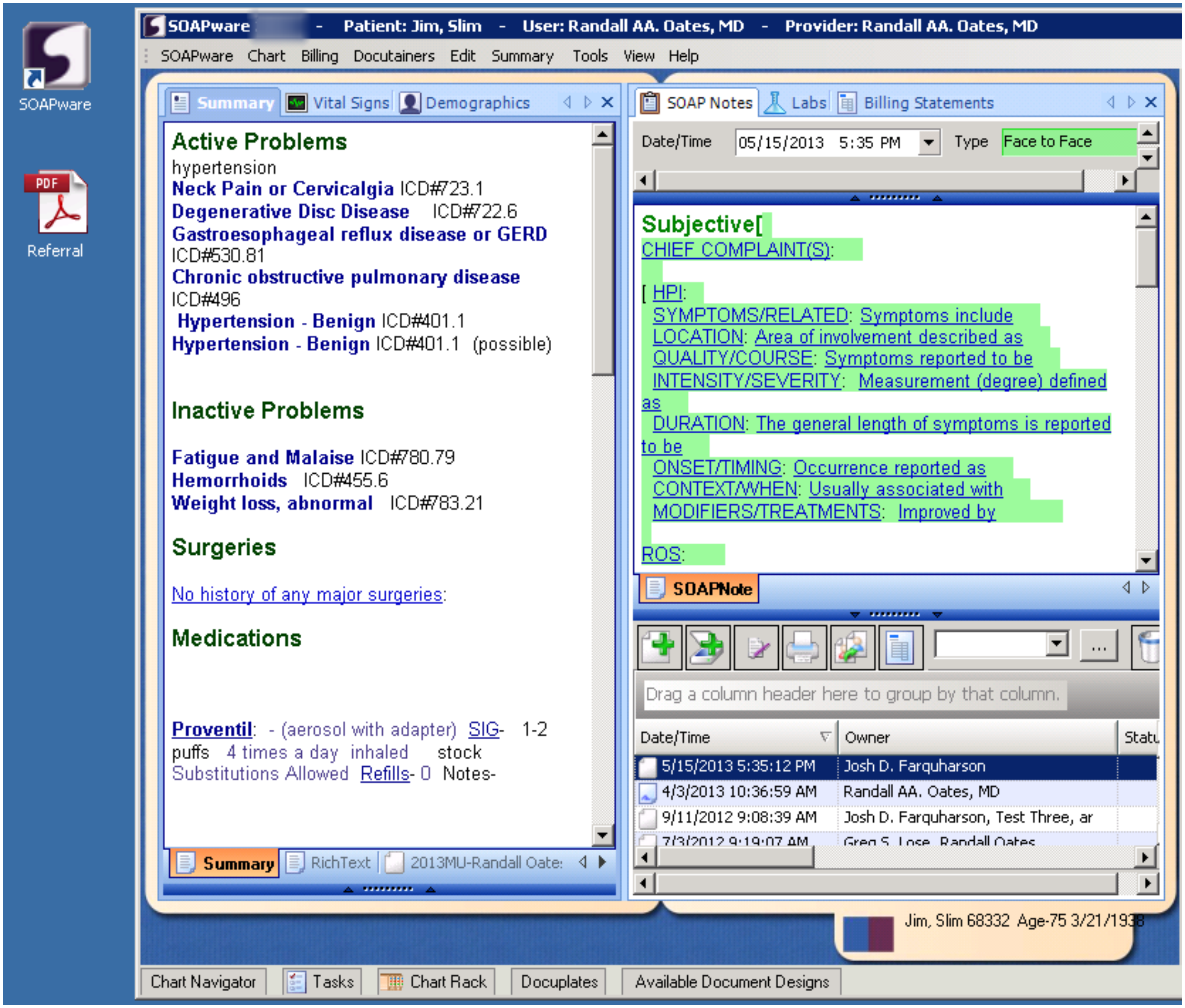


To un-archive a chart, select it from the list of archived charts by Clicking on it and pressing the Un-archive Chart Button (or press Control + Alt + U). The chart will be removed from the list of archived charts and placed back on the Chart Rack.

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

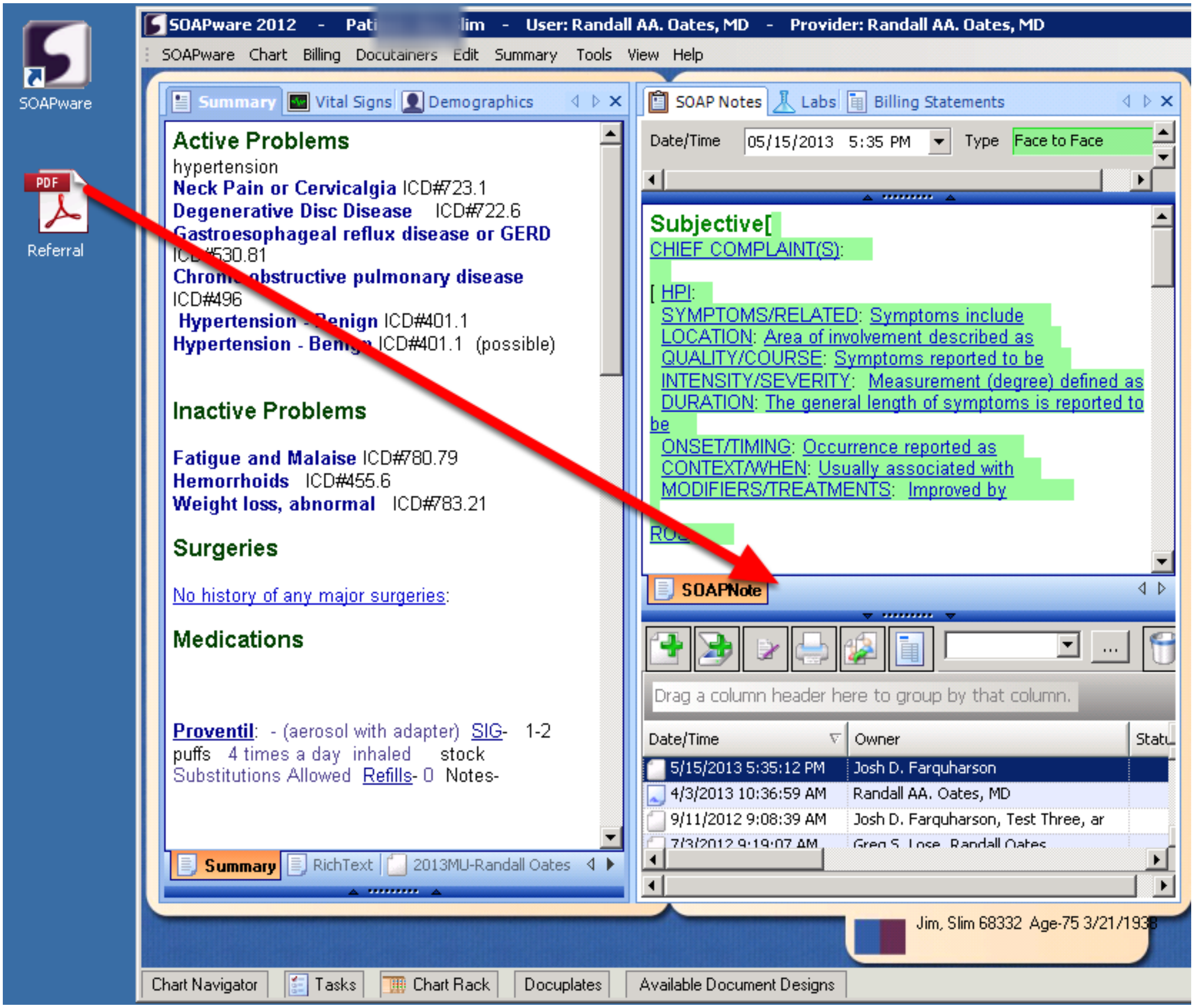


First the user must make SOAPware smaller (make sure to have a chart open) by clicking on the Restore Down button in the upper right-hand corner of the SOAPware screen.

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.

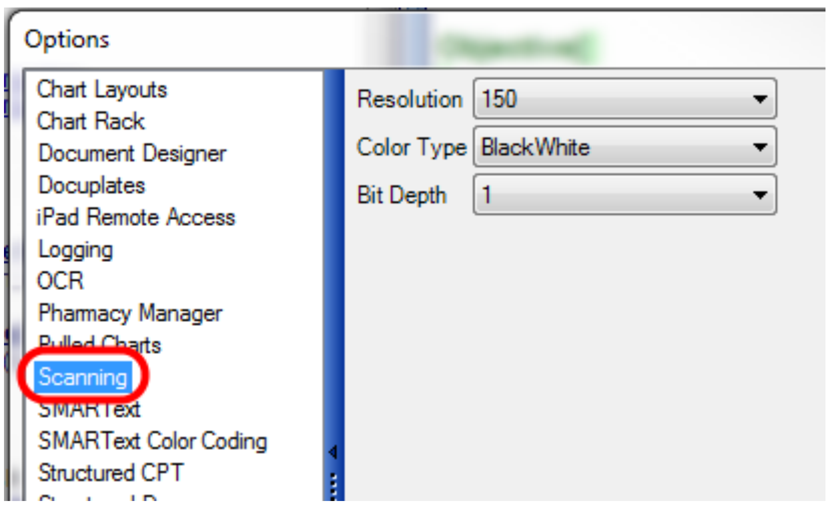
When the mouse arrow is in the correct location next to the tab, it will look like a small faint box with a small plus. Drop it by removing finger from the mouse button.

Scanning Into SOAPware

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 list.

SOAPware scanning allows the user to initiate an image scan from within SOAPware, and to have the resulting image imported directly attached to a current Docutainer and as a new Docutainer Item.

Setting Scanning Options



The scanning options in SOAPware will allow the user to define some default settings to apply to the scanner when scanning images into the chart. To set the default scanning options, go to **Tools** > **Options > Scanning**.

Below is a list of recommended default settings which will provide a significantly smaller image file size and will allow for a more efficient chart sign off.

- **Resolution:** This controls the dots per inch. The higher the resolution is set, the larger a user's database will be. **SOAPware recommends that this setting be set to 150 or lower.**
- **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. **SOAPware recommends that this setting be set to BlackWhite.**

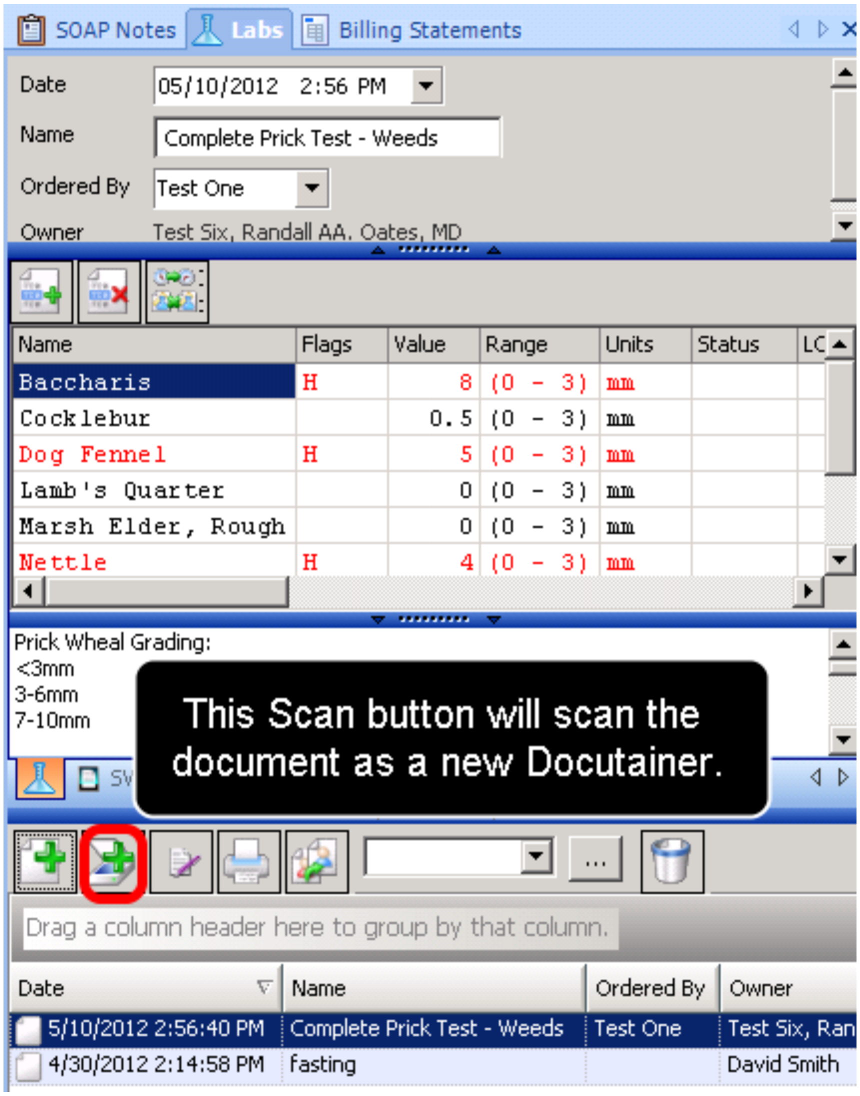
- **Bit Depth:** Affects the granularity of the conversion. If the user has a Gray or Color type set, the higher the bit depth selected, the clearer the picture will be. **SOAPware recommends that this setting be set to 8 or lower.**

Not all scanners correctly recognize the SOAPware settings found in Tools > Options. Please be sure your actual scanner settings are also set to the desired or recommended options.

SOAPware strongly recommends the default settings for scanners be set at the following:

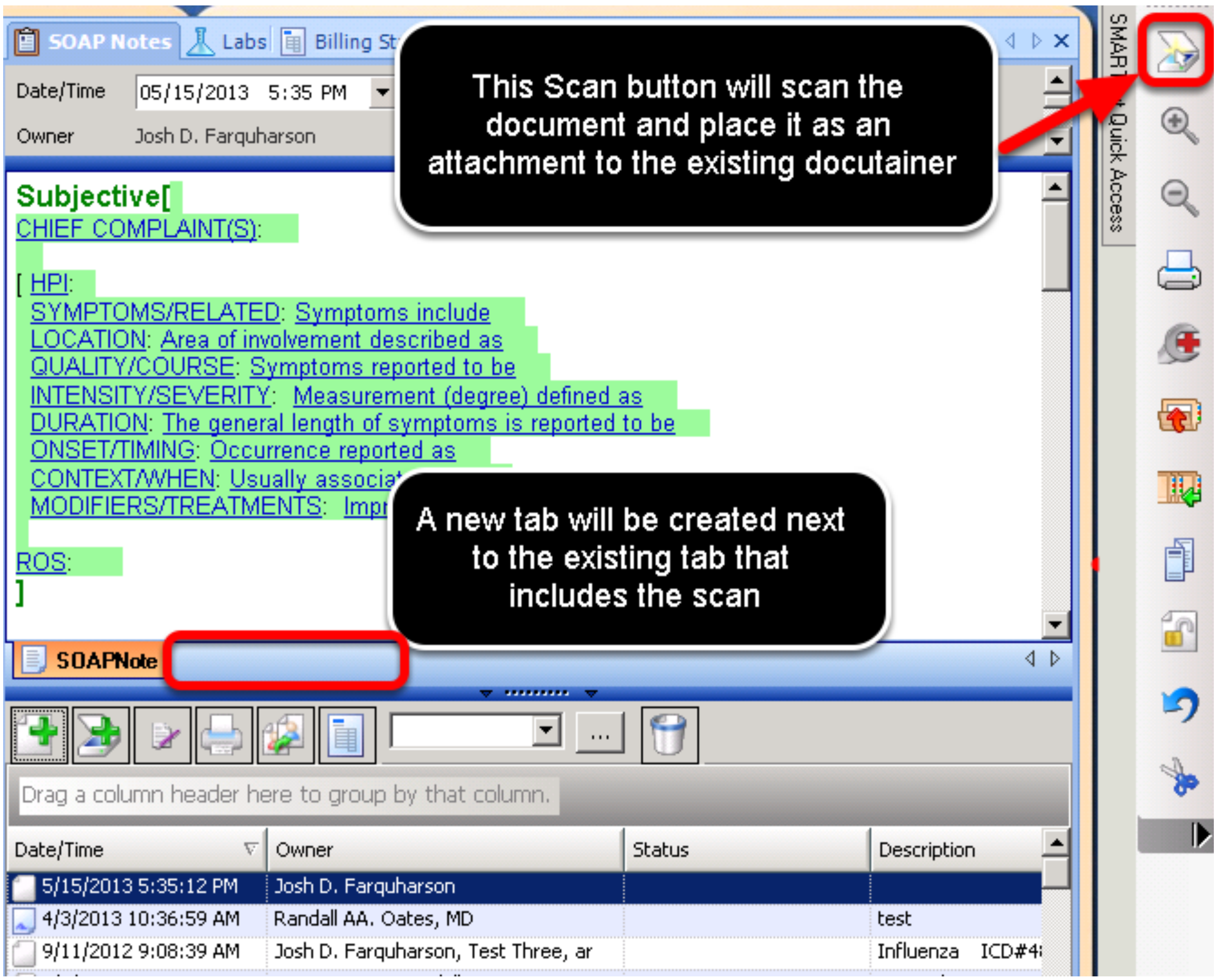
- No greater than 150 dpi resolution.
- Black and white color type. **Note: Xrays are the exception and can be set to gray scale.*
- Images should be imported as .jpg files.
- Bit depth should be set to 8 or lower.

Scanning Into SOAPware as a New Docutainer



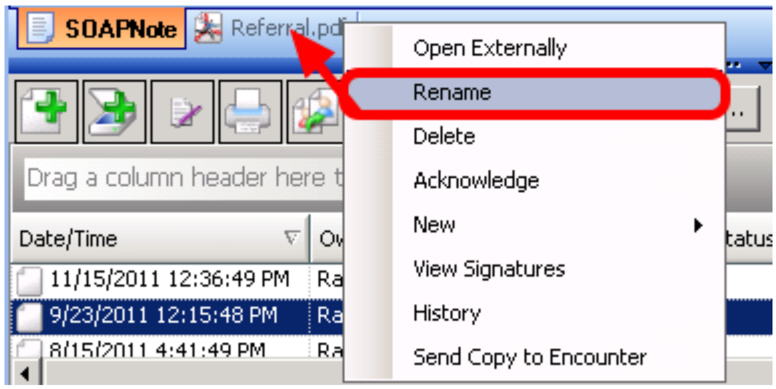
If the user would like for a scanned document to have its own docutainer (and date & time stamp), the user can use the scan button below the splitter bar to scan as seen in the screenshot above.

Scanning Into SOAPware as an Attachment to an Existing Docutainer



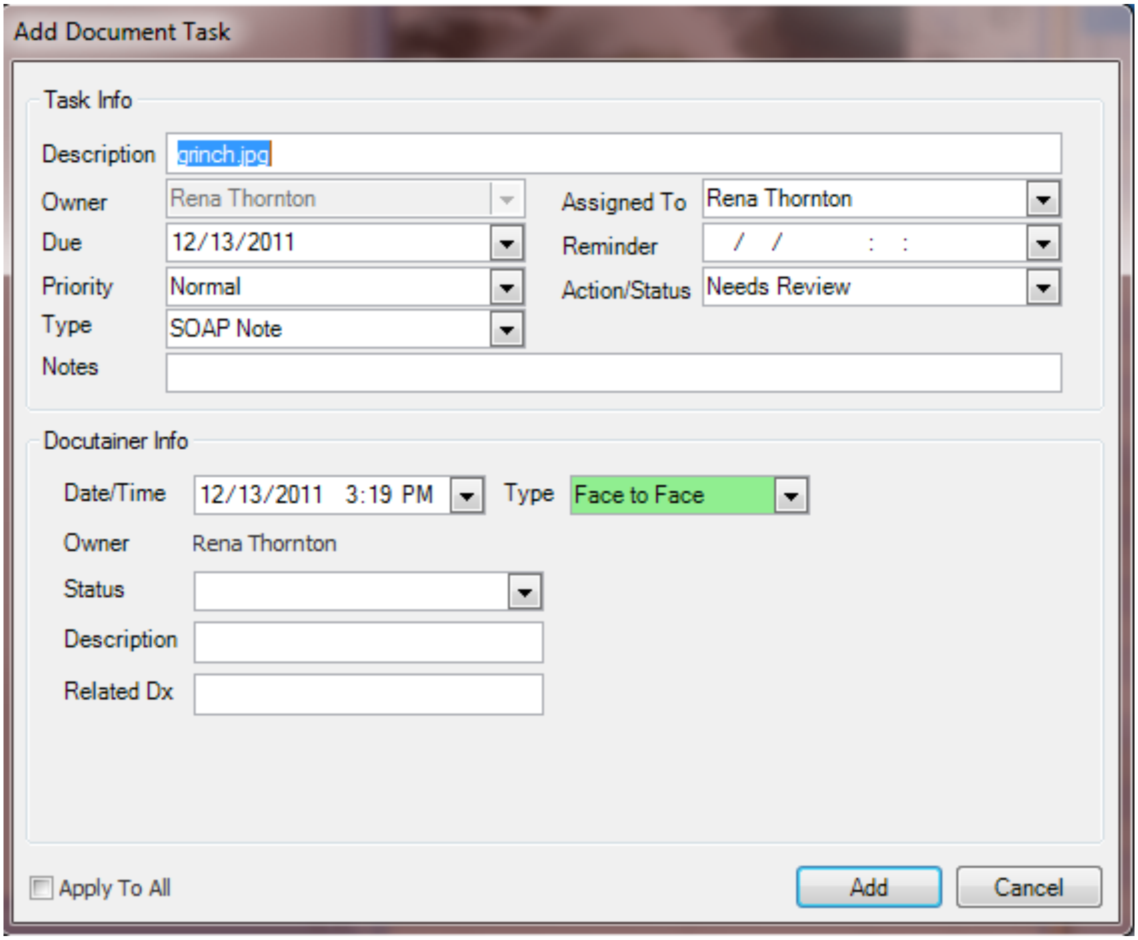
With an unsigned Docutainer open in SOAPware, Click Docutainers > New Image from Scan or Click the scan button located in the Common Toolbar (see screenshot above). This will launch the scanning software for the default scanner. For scanner instructions, follow the manufacturer's instructions included that will should include image file options when available.

Scanned Images



After the scan is completed, the new scanned image will appear attached to the current Docutainer as a new Image Docutainer Item. The ability to rename the scanned image tab is accomplished by Right-Clicking over the tab and Selecting Rename.

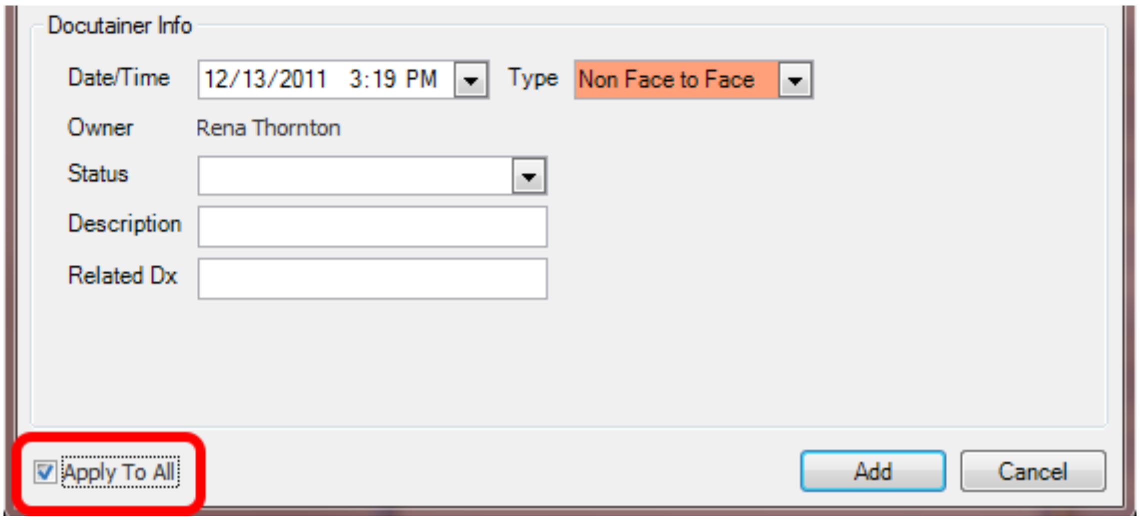
Scanned Docutainer-Add Document Task



An Automatic Document Task Item will be created when scanning documents into SOAPware. By default, new Task Items are automatically created when a new Document is added to a patient chart.

For more information on how to manage an automatically generated Task Item., see: **Auto Created Tasks.**

Scanning Multi-Paged Documents



With many scanners, 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.

It is recommended to Check the box for "Apply To All" in the Add Document Task window when scanning multi-page documents. The "Apply to All" check box will allow the user to apply all task item settings to every page of the scanned document. The provider will also need to sign off on each page of the scanned document.

Scanned Signatures

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 or embed the signature/image from within Document Designs, see: **Advanced Document Design/Using Images-Inserting Signature.**

Scanning with SOAPware Cloud Solution

This lesson will describe how to scan into SOAPware using the SOAPware Cloud Solution.

SCS Scanning Options

Due to limitations with Windows, document scanners cannot directly scan into the SOAPware Cloud Solution. However, there are some options:

Option #1
Scanners from Ambir Technology (an approved SOAPware Partner) are specifically designed to work with the SOAPware Cloud Solution. These scanners have been tested and verified to work in the SOAPware Cloud Solution environment. For more information, visit http://www.ambir.com/SOAPware.

Option#2
Scanning can be done on the users local computer and imported into the SOAPware chart. For instructions on how to scan locally & import your Document(s) over to your SCS server, please see the instructions detailed below.

Option #3
There is third party software available that gives Windows Remote Desktop the ability to access a scanner from your local computer. The software programs listed below are currently being used by a number of SCS Users and SOAPware, Inc. has no complaints concerning their usage.

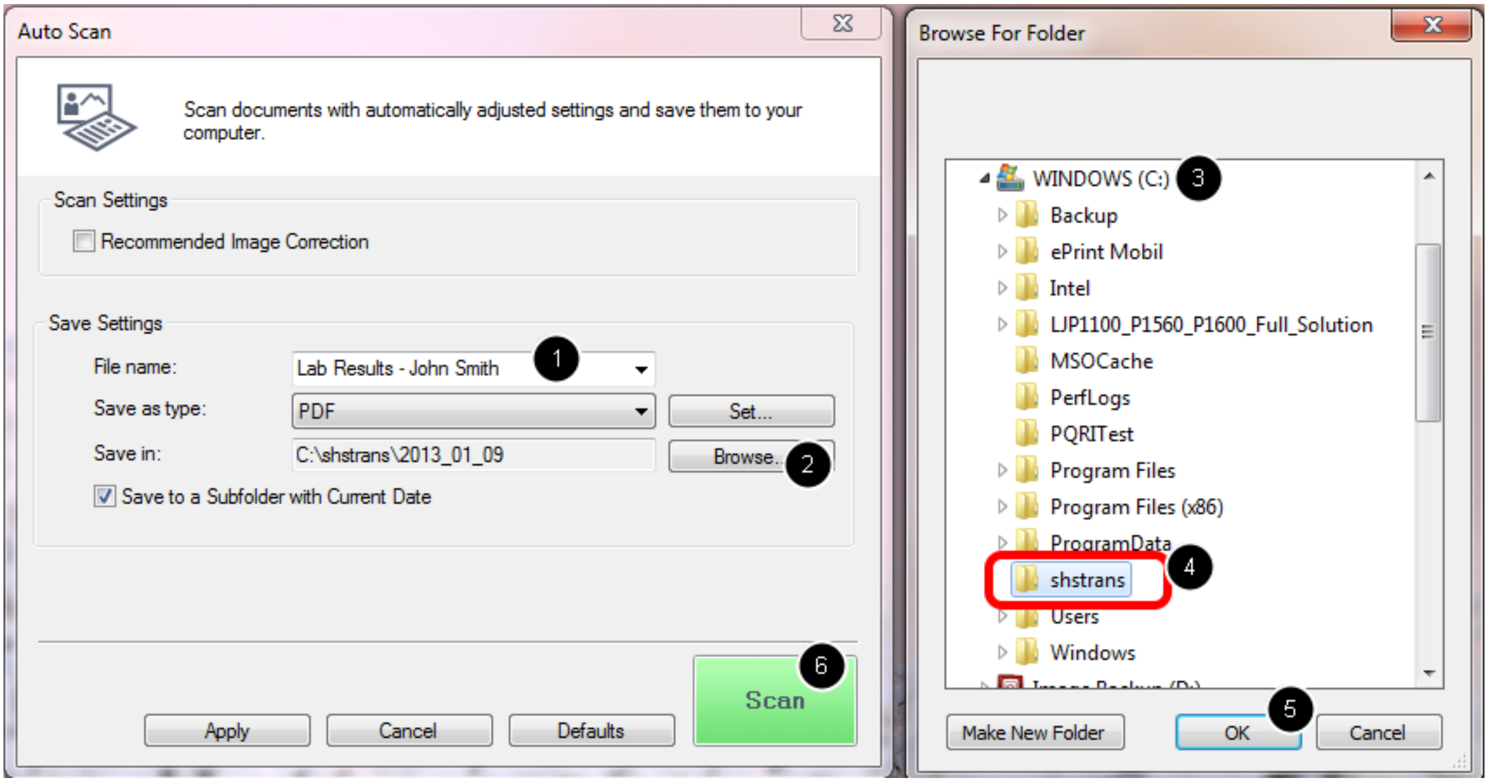
- TSScan - Remote Desktop Scanning by Terminal Works.
- RemoteScan by RemoteScan Corporation.

Scanning Into the Local Computer and Importing into SOAPware

The concept of importing images is very simple. This process is documented for end-users who wish to transfer files from their local computer (client) to the SCS server (server), to import into SOAPware, or to utilize their virtual server as an online repository for documents. In response to this need, we have responded with a utility called “DocTrans”. This small utility transfers files from the client’s computer to the server.

Configurations: For instructions on configuring the "DocTrans" utility, please **click here**.

1. Scan Document into Computer



To scan documents into the SOAPware Cloud, begin by scanning the document into your computer. Use your scanning software to enter the following information for the scan:

1. When scanning the document in, give it a File name that contains the type of scan and patient name (ie: Lab Results - John Smith).
2. The new scan must be saved to a specific folder, click the Browse button to select the correct folder.
3. Click on the **C:** drive.
4. Select the folder titled "**shstrans**".
5. Click OK to save the new scan to **C:\shstrans**.
6. Click the Scan button to save the new scan.

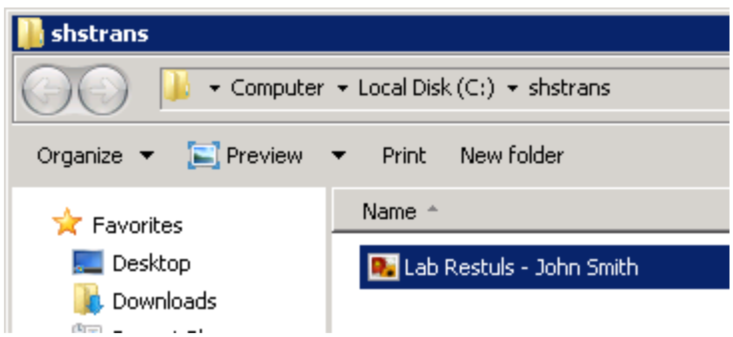
2. Log In to SOAPware SCS and SOAPware

Next, log in to the SOAPware Cloud and SOAPware.

3. Double-Click on DocTrans Icon

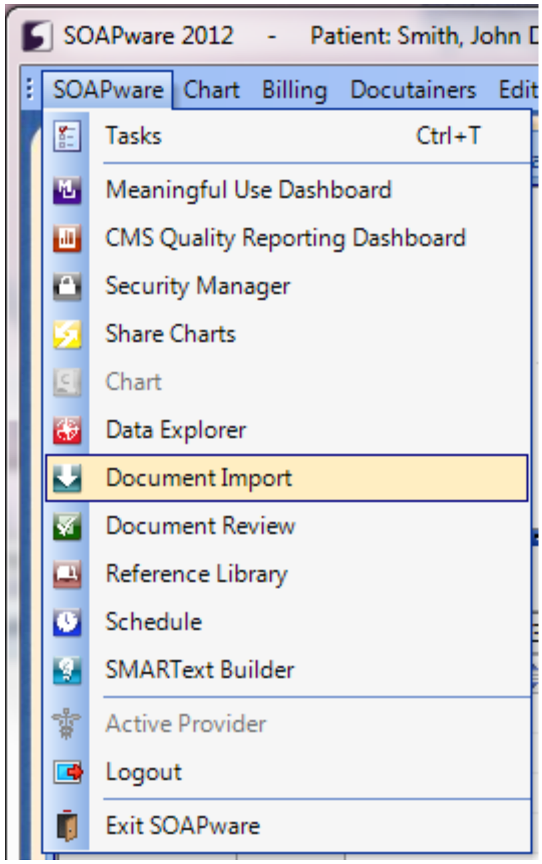
Import the newly scanned documents into the SOAPware Cloud by double-clicking on the DocTrans icon located on the SOAPware Cloud desktop.

4. Shstrans Folder Opens Containing Scanned Files

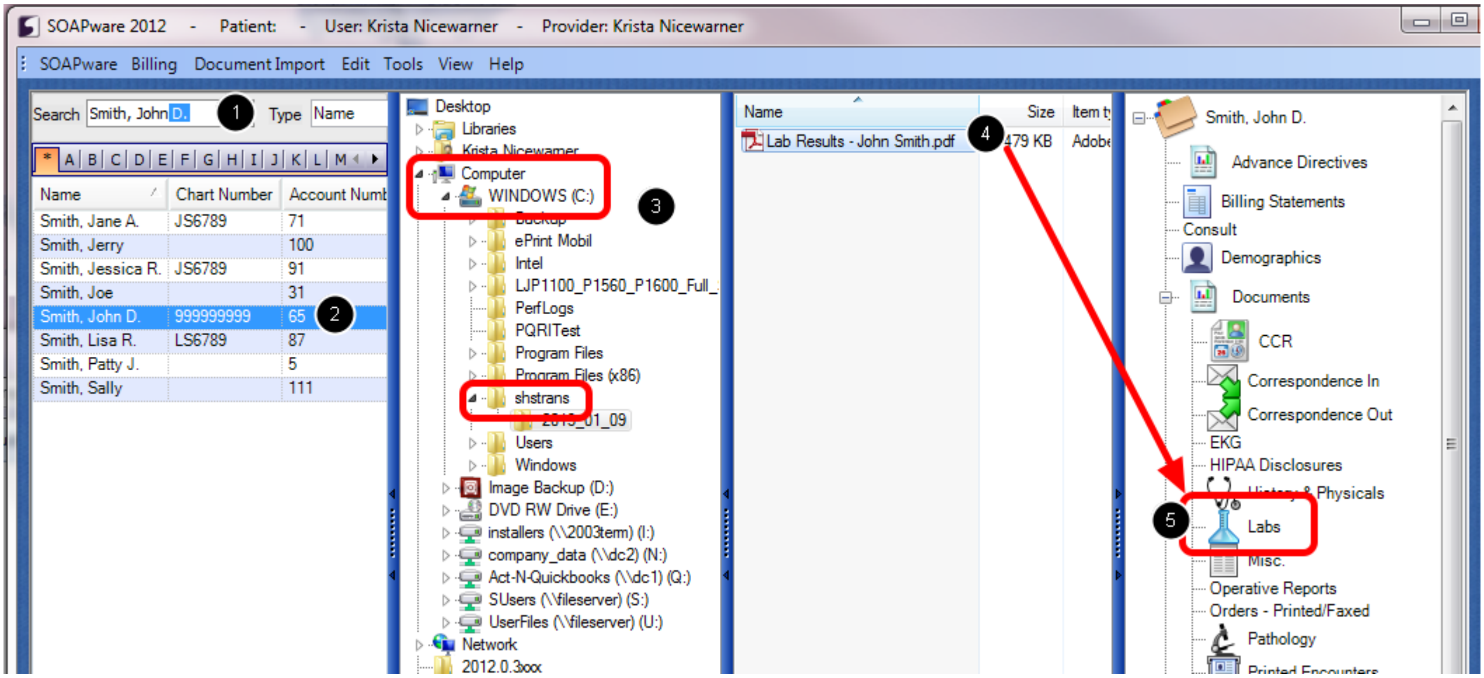


After the importing process has completed, the shstrans folder will automatically open and it will contain your newly scanned documents.

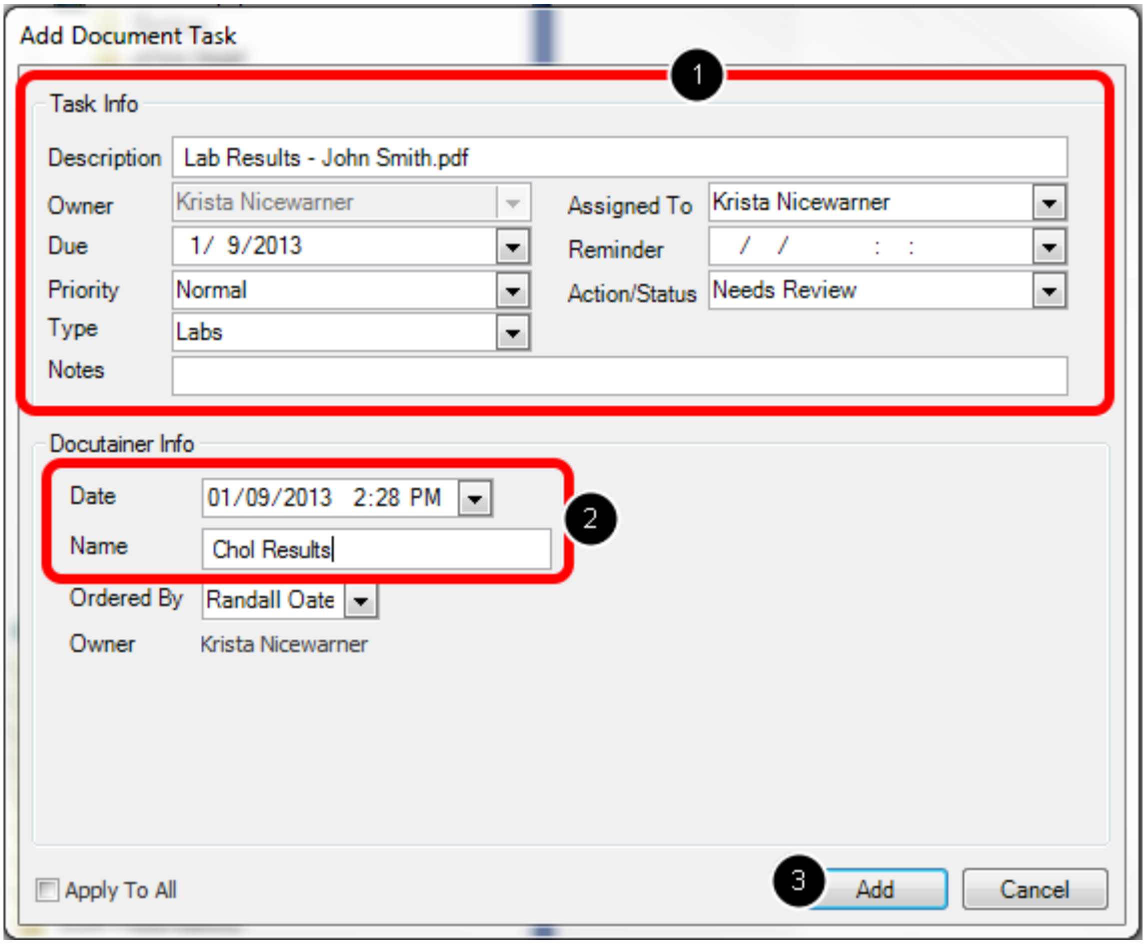
5. Import Document into the Patient Chart



To import the scanned documents into the patients chart, click on SOAPware > Document Import.



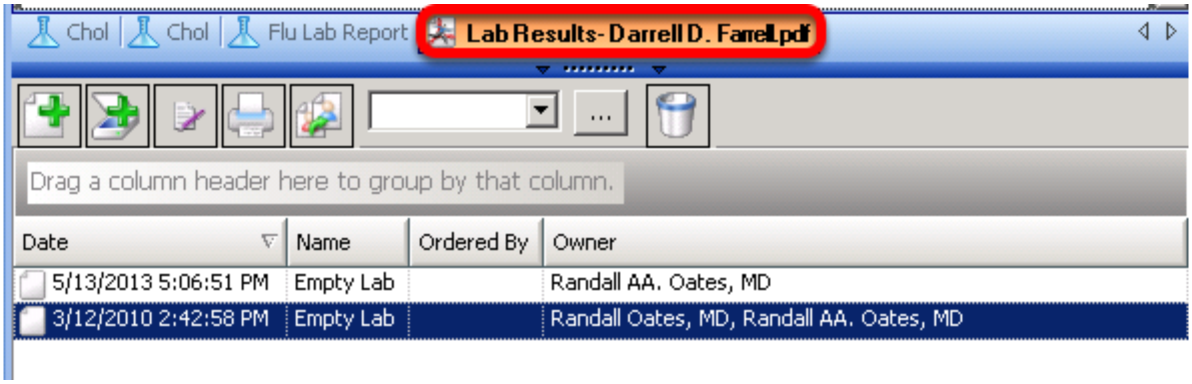
1. Search for the appropriate patient chart using the Chart Rack on the left.
2. Select the chart by highlighting it.
3. In the second window, locate the shstrans folder by opening the following: Computer > WINDOWS C: > shstrans.
4. Your scanned items will be displayed in the third window. Click to highlight the scan that you wish to import, then begin dragging and dropping the item.
5. Drag and drop the item into the appropriate chart section (ex: Labs).



After dragging and dropping the scanned document into the appropriate chart section, the Add Document Task window will appear.

1. Complete the Task Info as desired.
2. Complete the Docutainer Info including the Date for the scan and the Name of the scan.
3. Click **Add**.

6. Document has been Imported into the Chart



The newly scanned document has now been imported into the patient's chart.

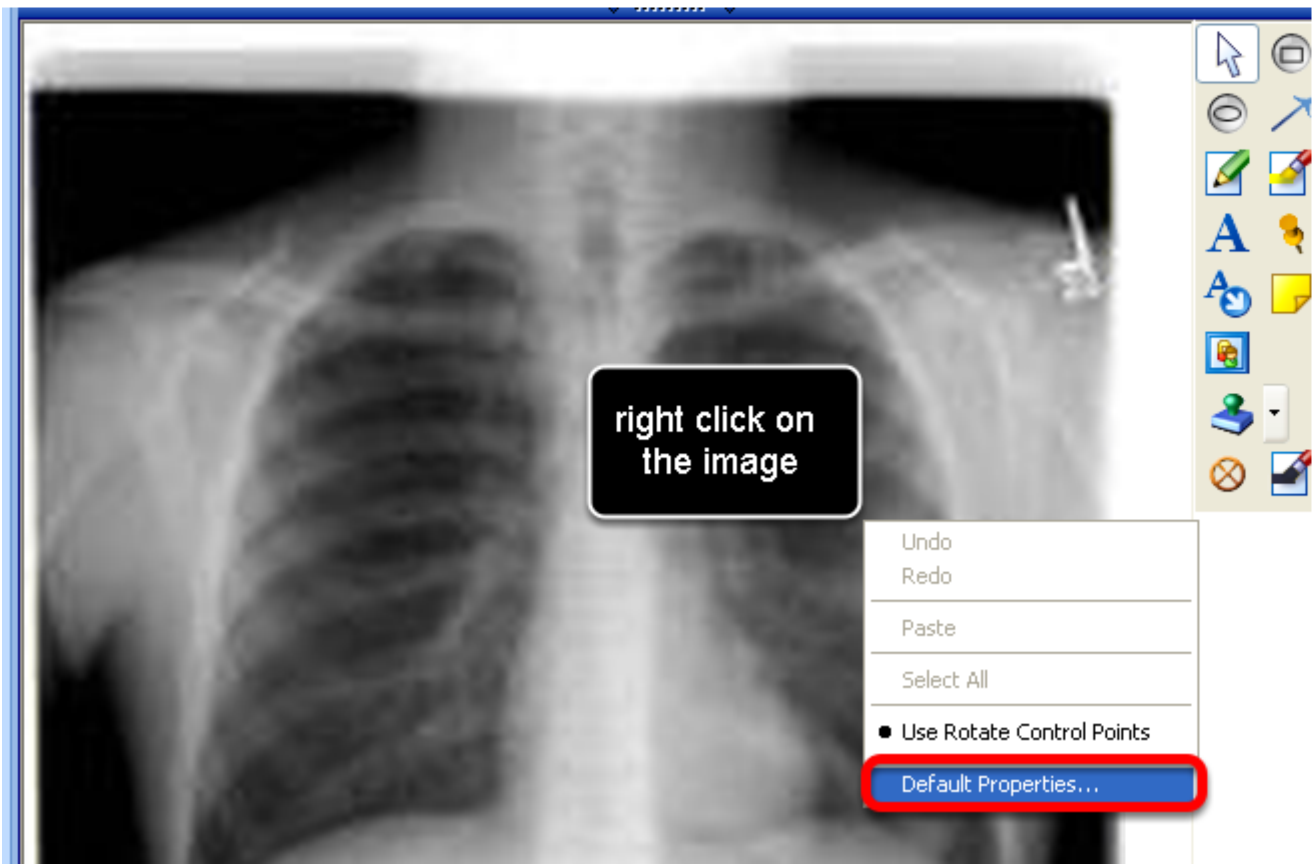
Setting Default Font for Image Annotation

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.*

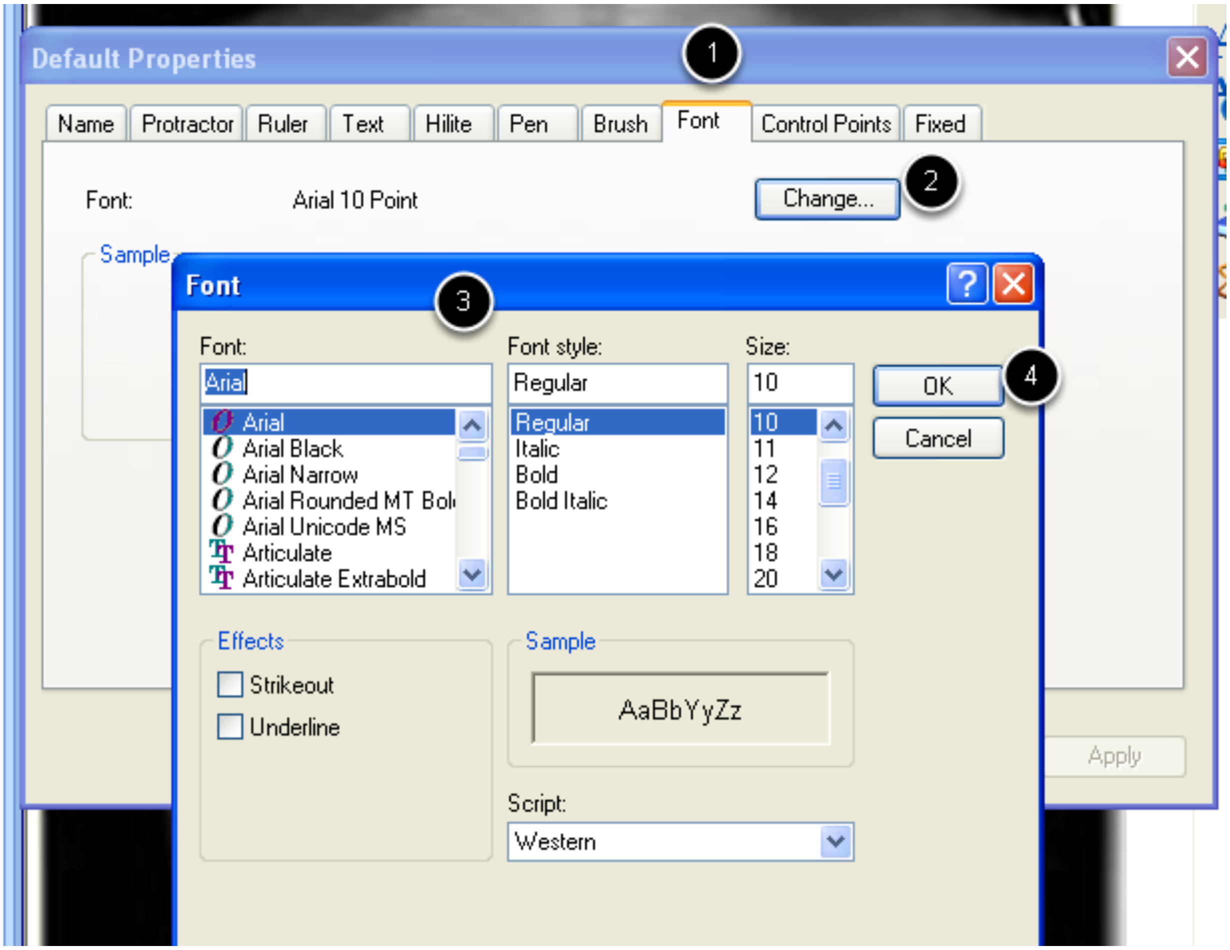
This setting is user-specific.

Accessing the Properties Settings



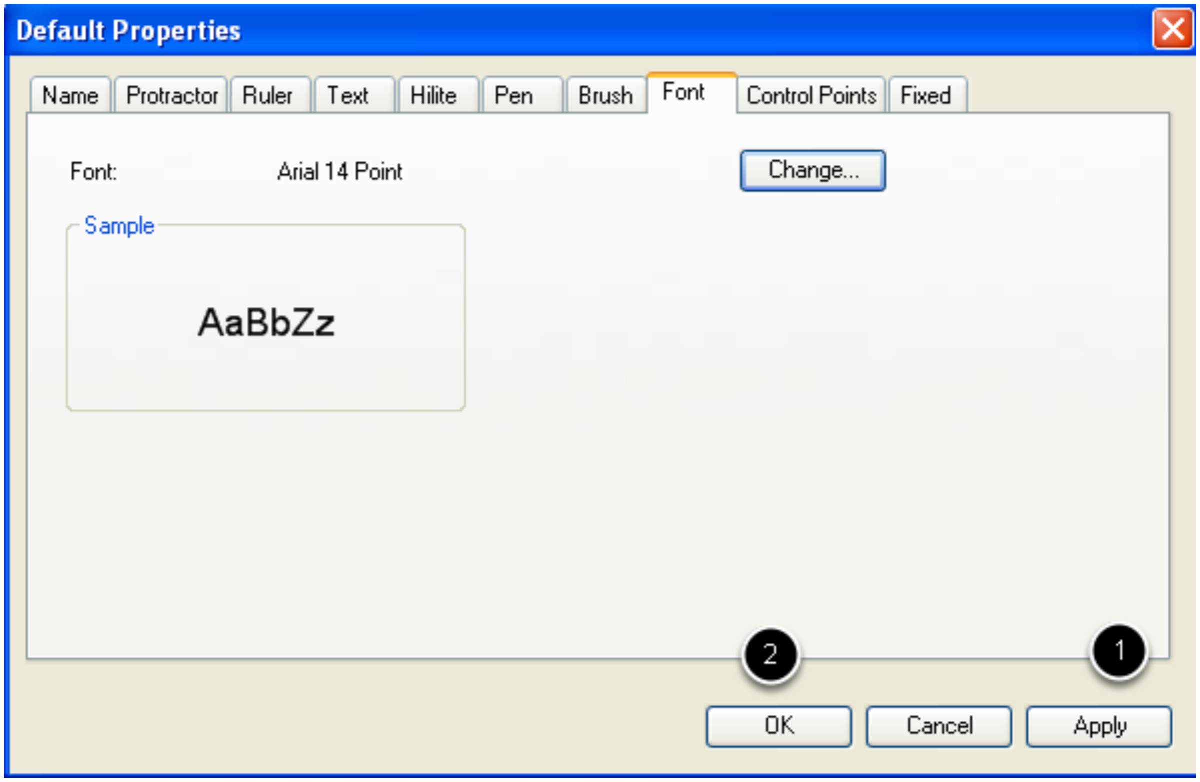
Right-click over the image and choose Default Properties.

Setting the Defaults



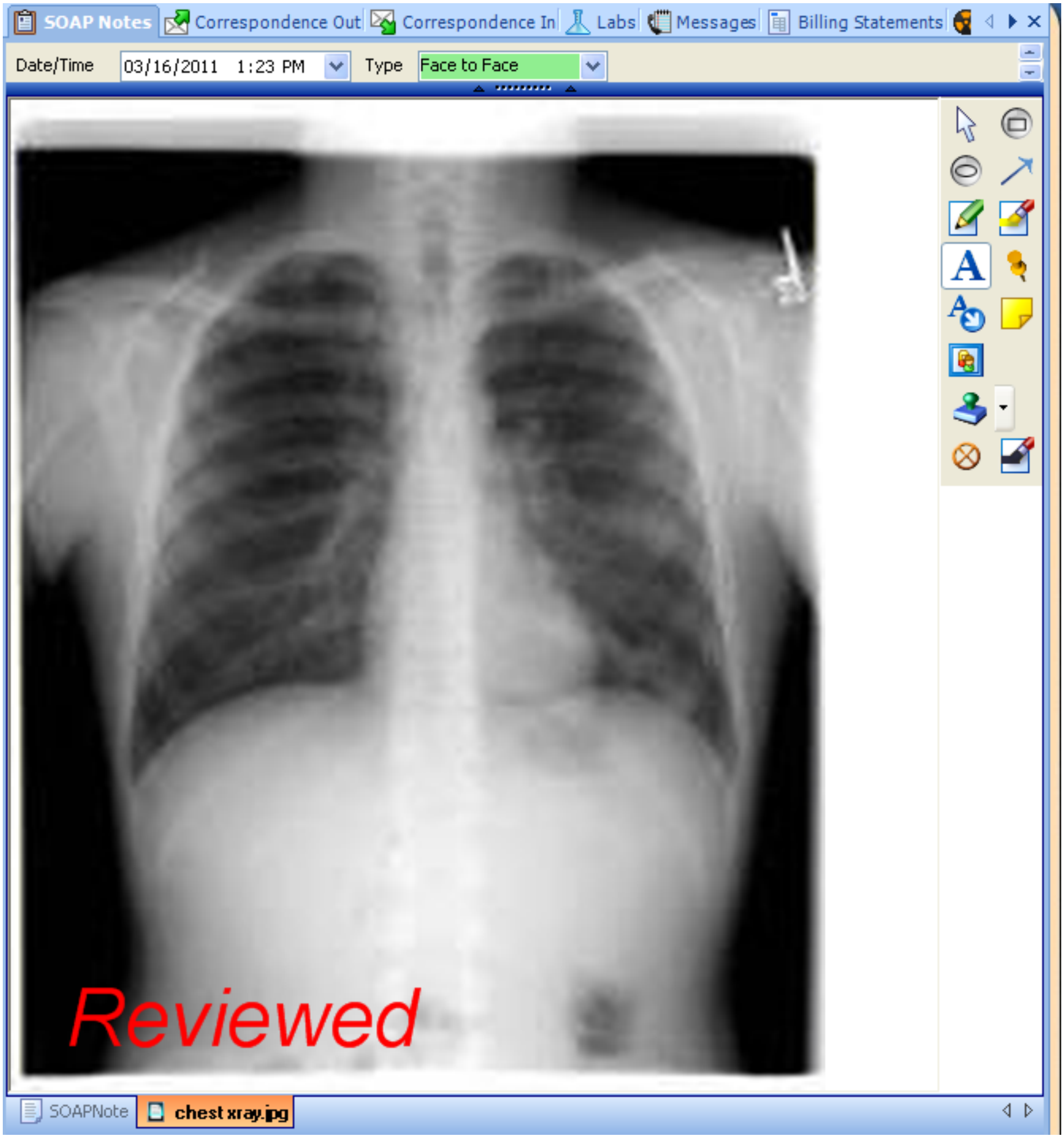
1. Click on the Font tab.
2. Click on Change.
3. Choose the font, font style and size.
4. Click OK.

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

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

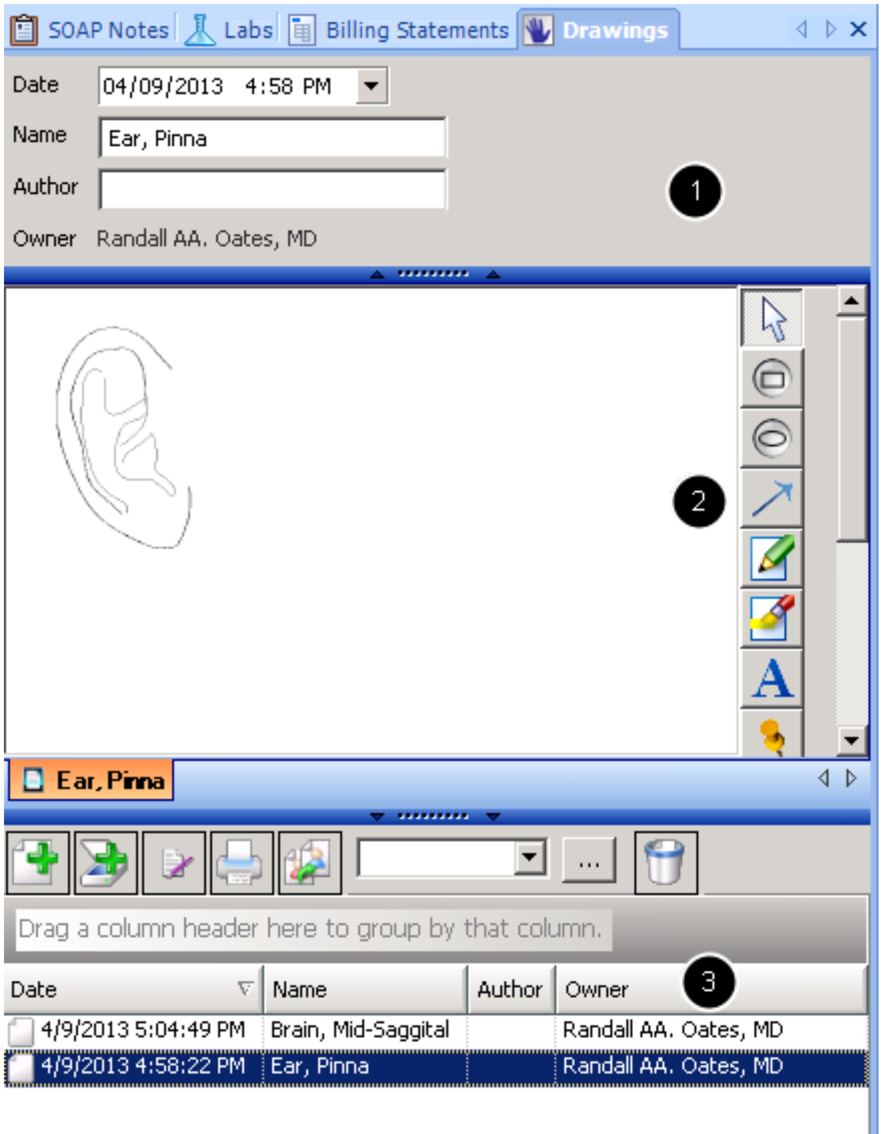
Command buttons are located at the bottom of the Drawings window and have picture buttons that display helpful information when the mouse cursor hovers over them.

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



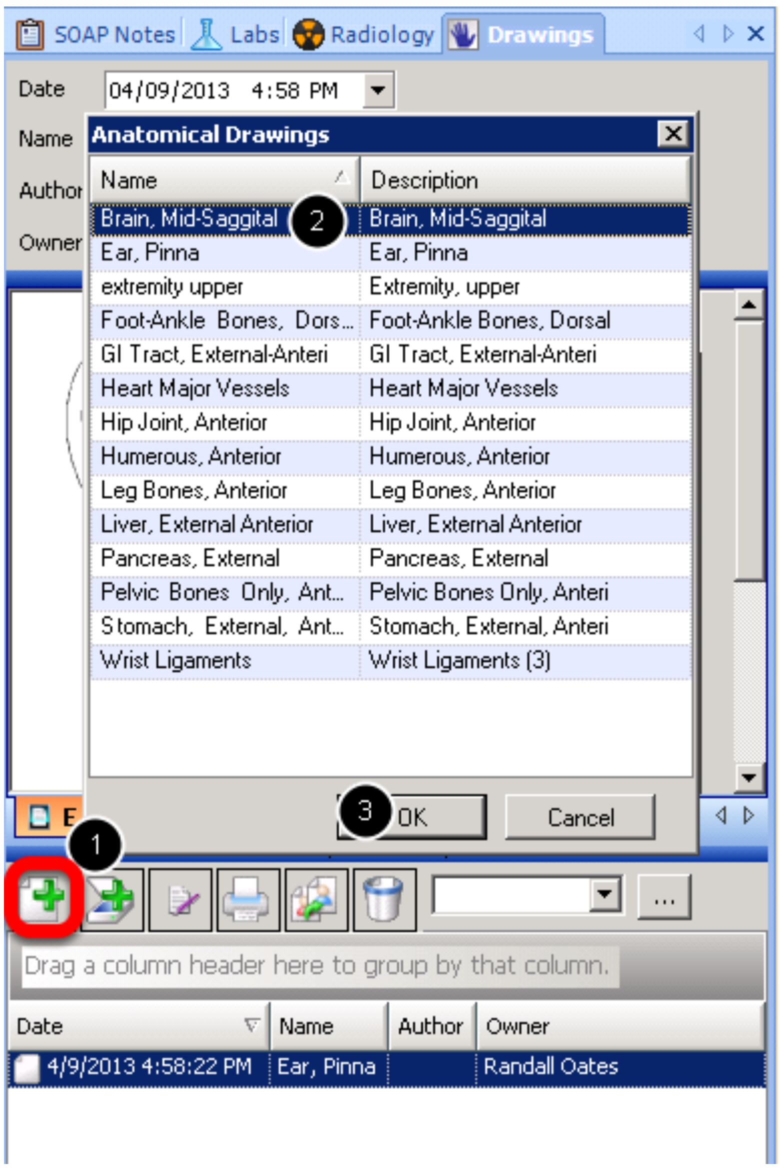
The Drawing window features three main parts:

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

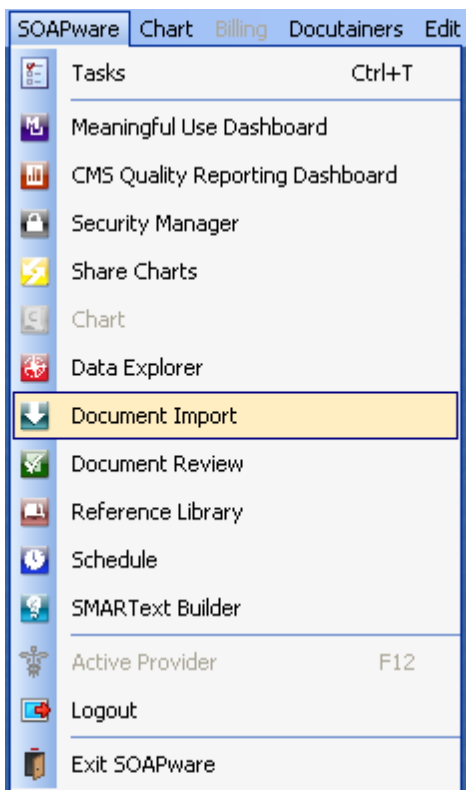
To remove a drawing from a patient chart, select the drawing to remove and Click the Remove Documents Button.

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

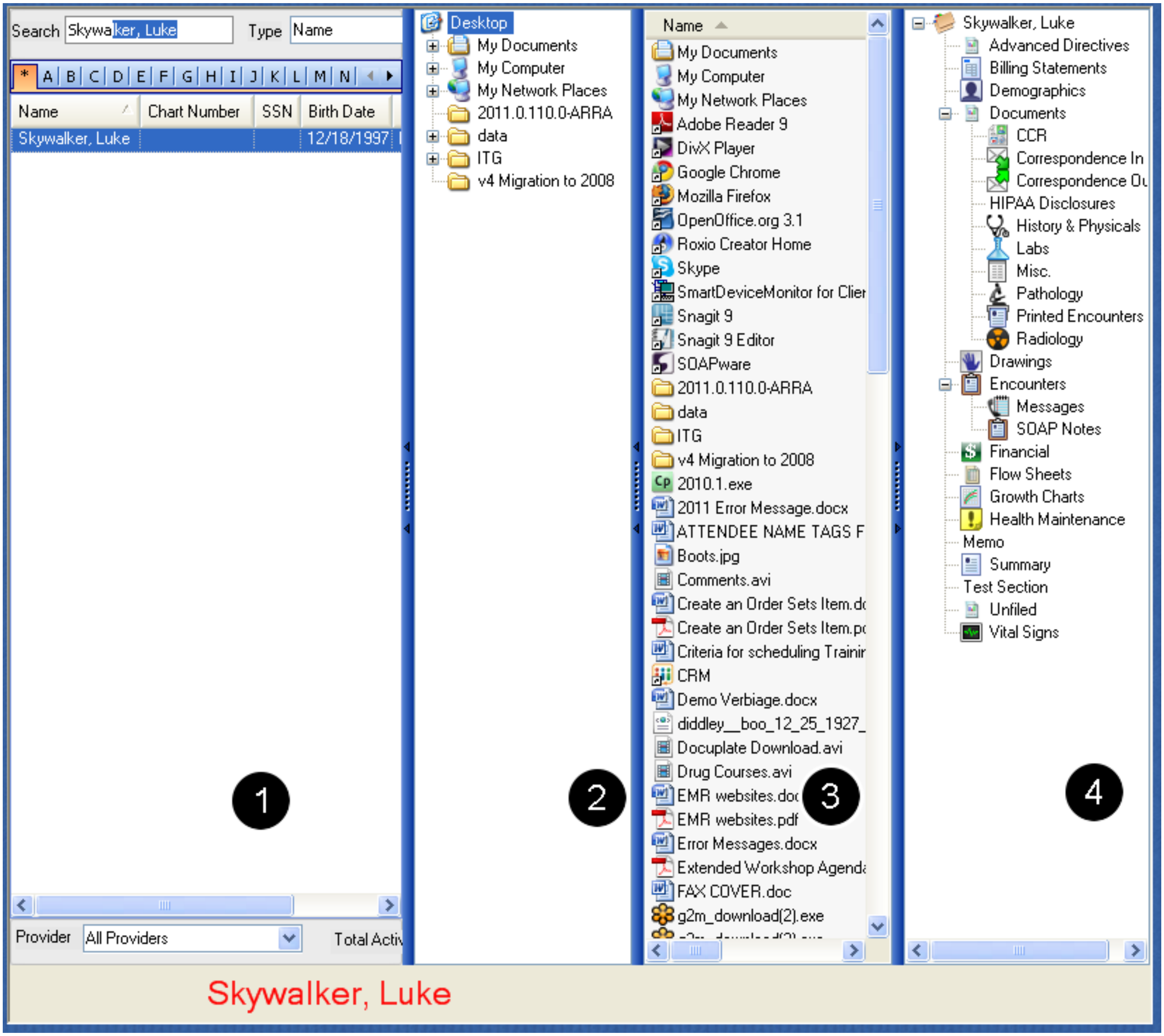
There are 2 main mechanisms for adding outside documents to SOAPware. In each viewer, there is a Scan button allowing for the addition of documents directly into a patient's open SOAPware chart. The Document Import workspace is the second option and is the main mechanism for importing documents into 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

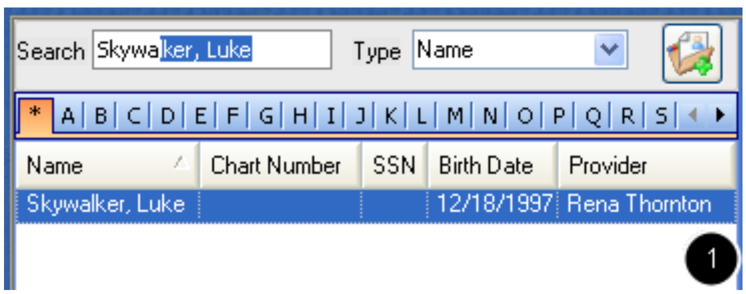


1. Mini-Chart Rack - The first column/panel on the left is a list of patient charts, arranged alphabetically. This is similar in function to the Chart Rack. The name of the patient selected from this list is displayed in the patient name panel at the bottom.
2. Folder Browser - The second column/panel 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.

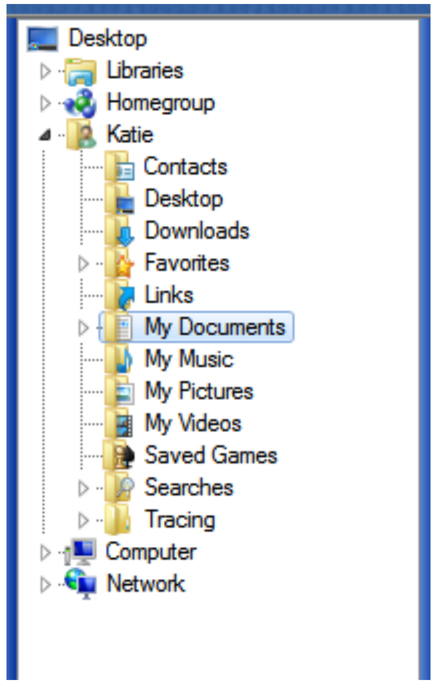
Select Patients in Mini-Chart Rack



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.

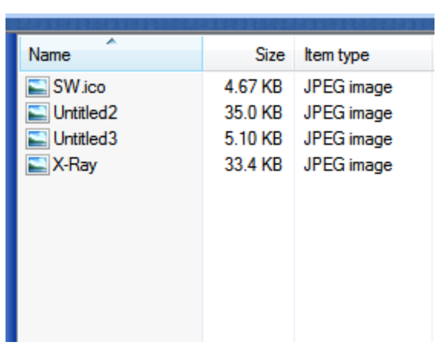
It is also possible to create a new chart by clicking the Create Chart button. The new chart will be automatically selected after creation. Once a chart is selected, the name of the patient will appear in large red letters in the patient name panel at the bottom of the Document Import workspace.

Select Files for Import



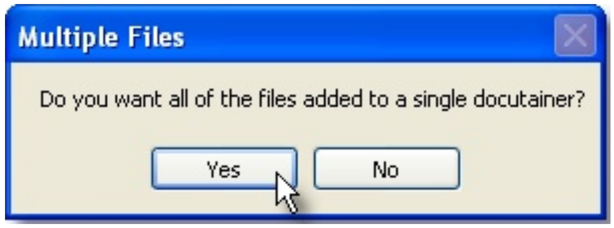
Folder browsing/selection occurs in the second columns/panel. The Folder Browser panel displays a table of contents view of the disks, folders, and network locations available to the current computer. Clicking a folder in the hierarchical list will display its contents in the Folder Contents panel to 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



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.

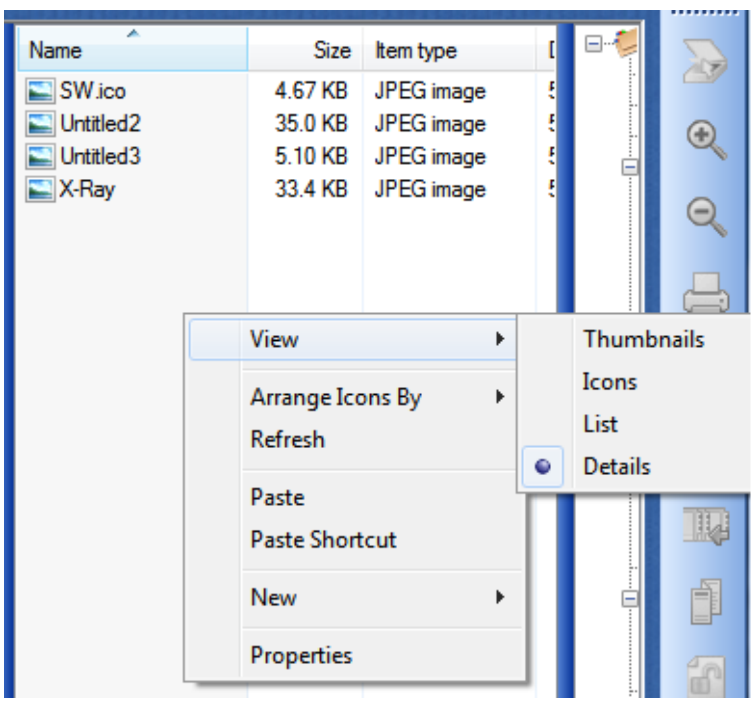
Selecting Multiple Items for Import



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:

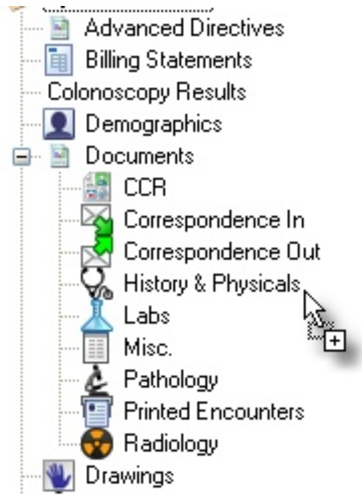
1. Import multiple documents in a single docutainer.
2. Import single documents in separate docutainers. This option offers an opportunity to create a new task for each document.

View Files Options



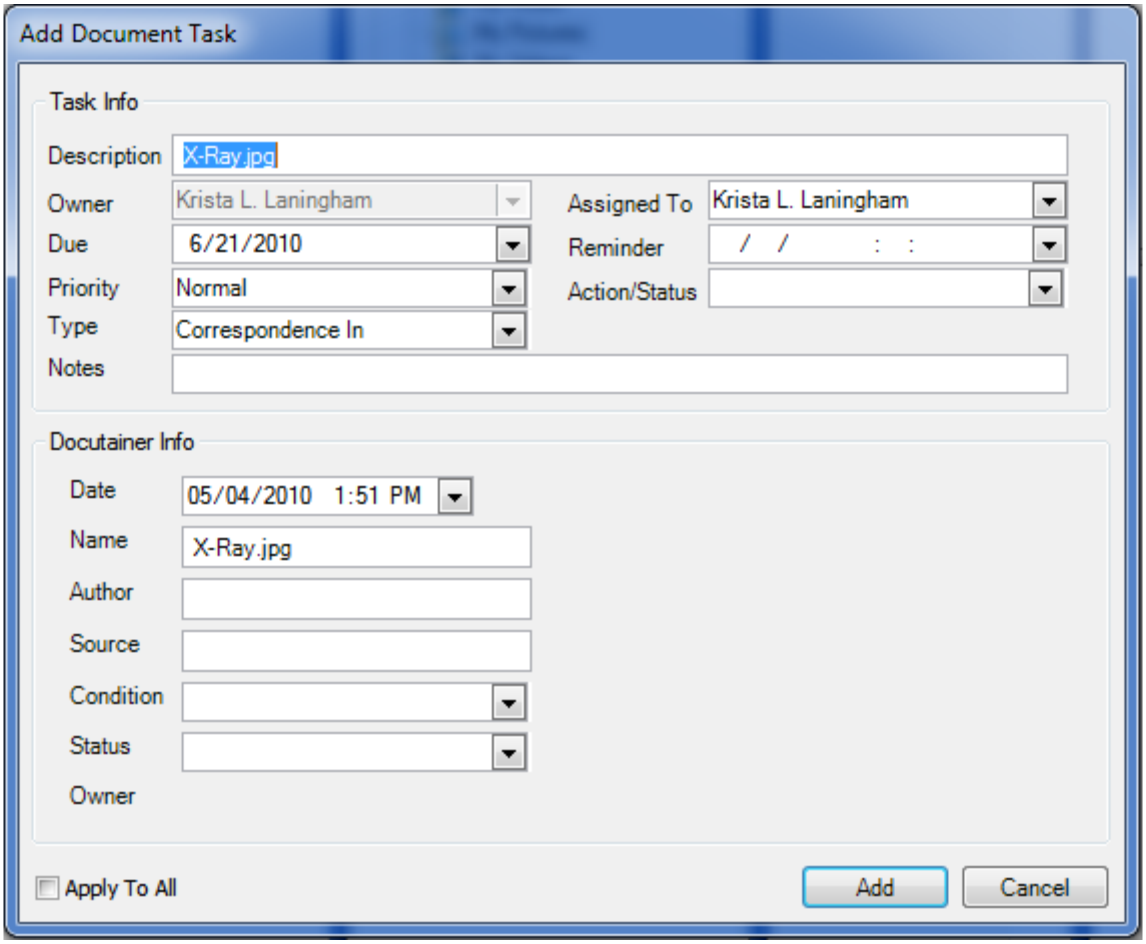
By default, the documents/files are displayed in the Details view, but other viewing options are available. Right-click in the Folder Contents panel; Click the View menu item, and Click a menu item for one of the 5 view options (i.e. Thumbnails, Large Icons, Small Icons, List, Details).

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



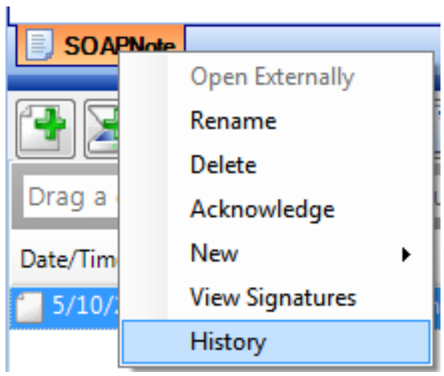
When the document/file is dropped into the chart section (i.e. by releasing the mouse button), the Add Document Task dialog appears allowing for the automatic creation of a new task item.

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.

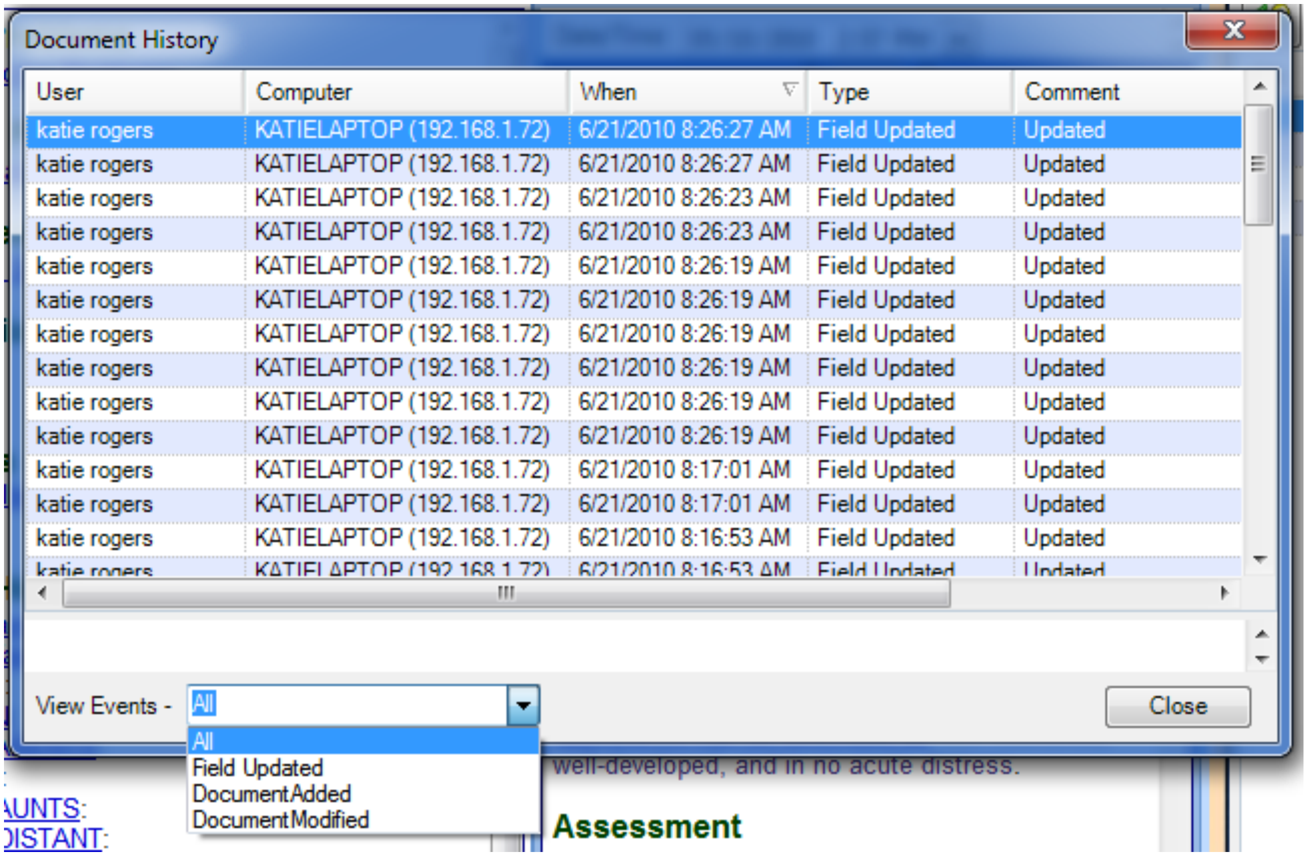
The user can view who changed a document (User column), and when it was changed.

Access and use of Document History



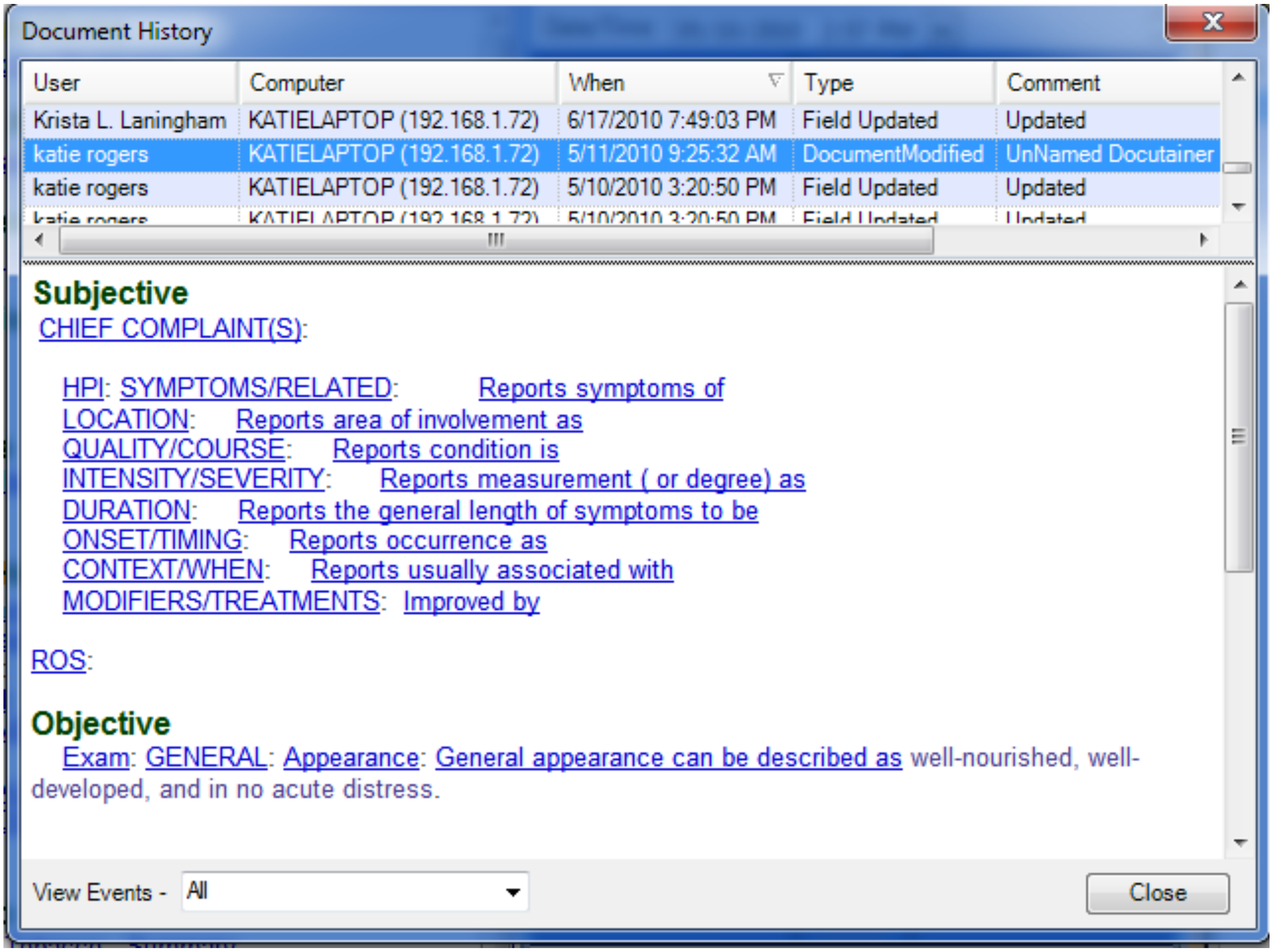
To access a document's history, open a patient chart, and right-click over the document tab in the lower left. In the screen shot below, we are in the SOAPnote section, outlined in red. When the right-click menu opens, click the History menu item.

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.

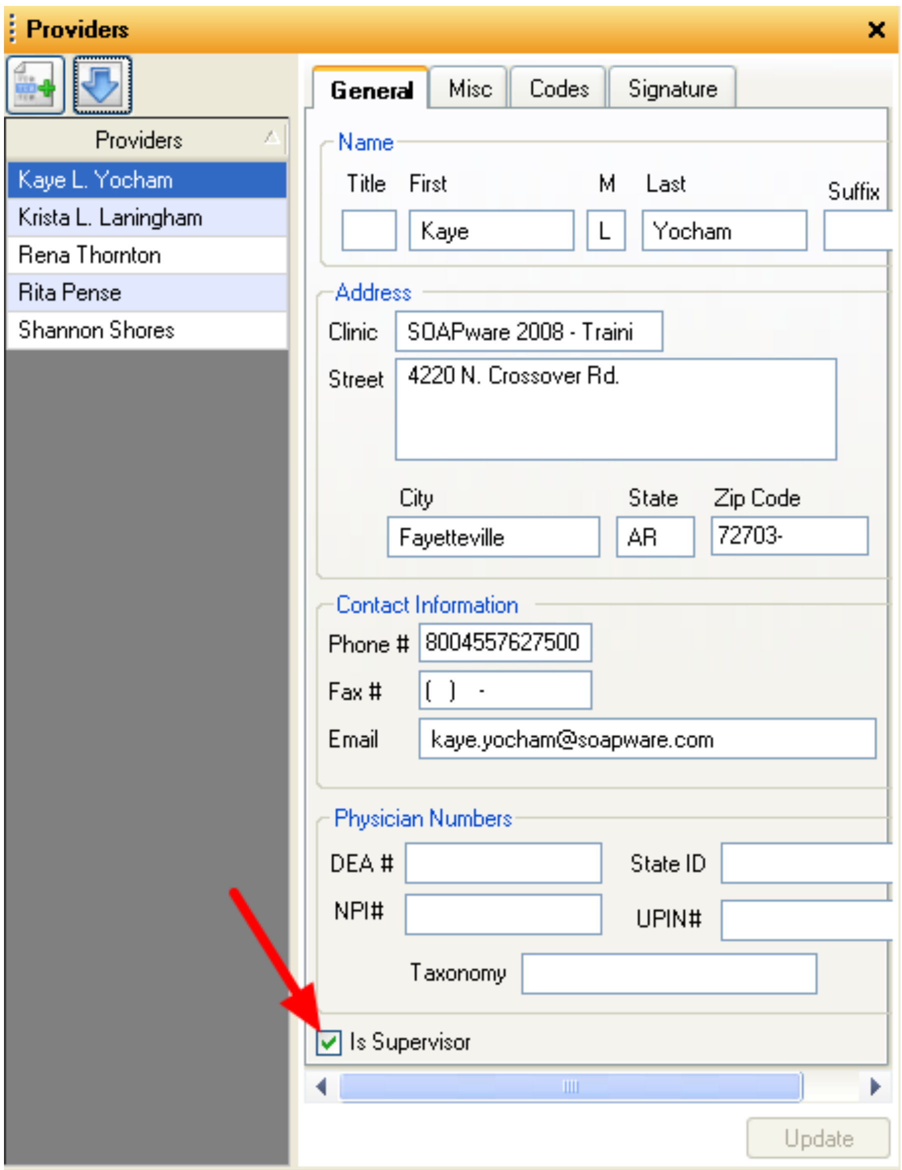
Another Option

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

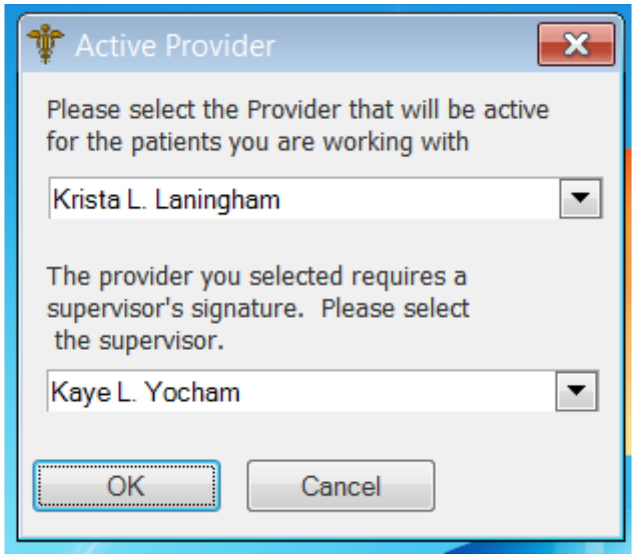
Co-Signatures have been implemented for sites that need the ability to have a supervisor signature for providers such as residents.

Set up Supervisors



A user 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.

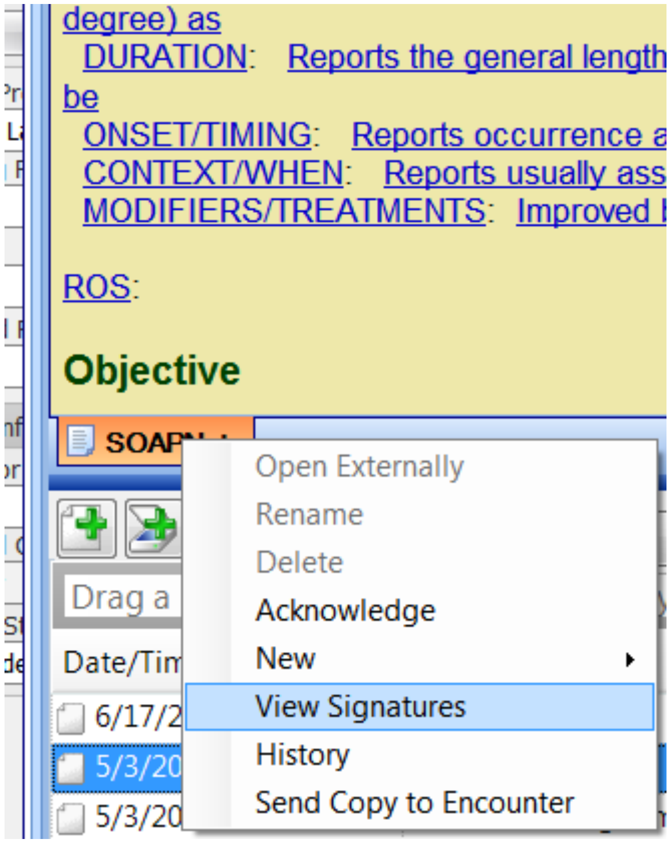
Signing

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.

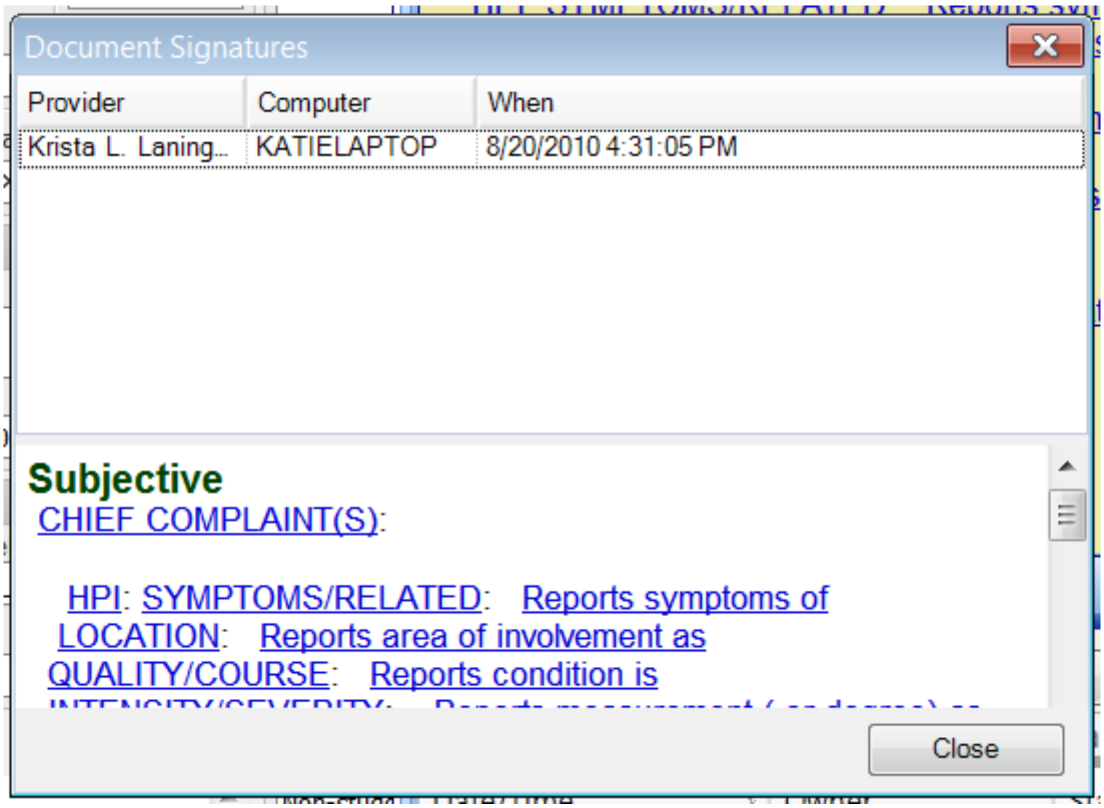
Signature History

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.

Signature



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

Introduction to Data Explorer

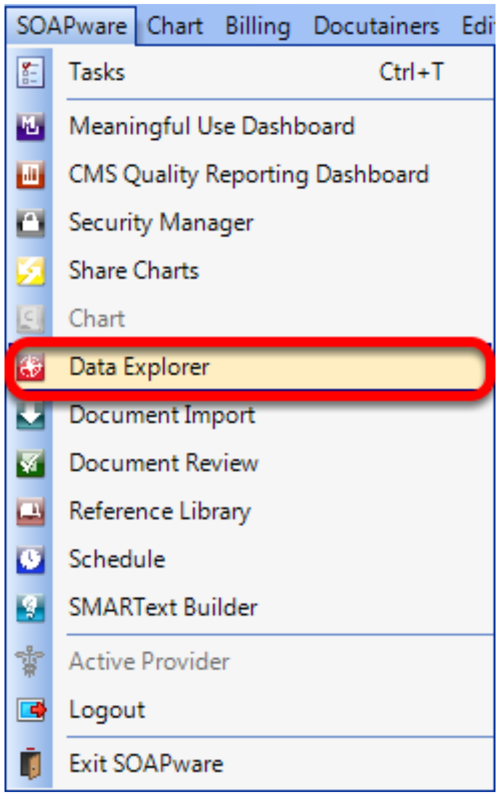
Introduction

SOAPware Data Explorer is used to search through all patient charts and report the findings. Search results can be used to generate many types of reports. Some of the common types of reports that are run in Data Explorer include:

- A SOAPnote medication search to search for all patients who have been prescribed a certain medication
- A Summary diagnosis search to search for all patients who have a certain active diagnosis
- A SOAPnote assessment search to search for all patients who have been diagnosed with a certain diagnosis
- A lab value search to search for all patients that have a lab value within a specific range
- A health maintenance search to search for all patients who have had health maintenance items performed with a specified time frame

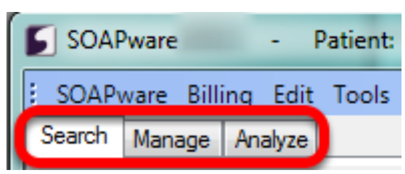
***Note:** Depending on the size of the users database, the search time can be lengthy. We recommend that you do not perform a data explorer search during clinic hours.

Accessing Data Explorer



To open the Data Explorer workspace, Click on the **SOAPware** menu and select **Data Explorer**.

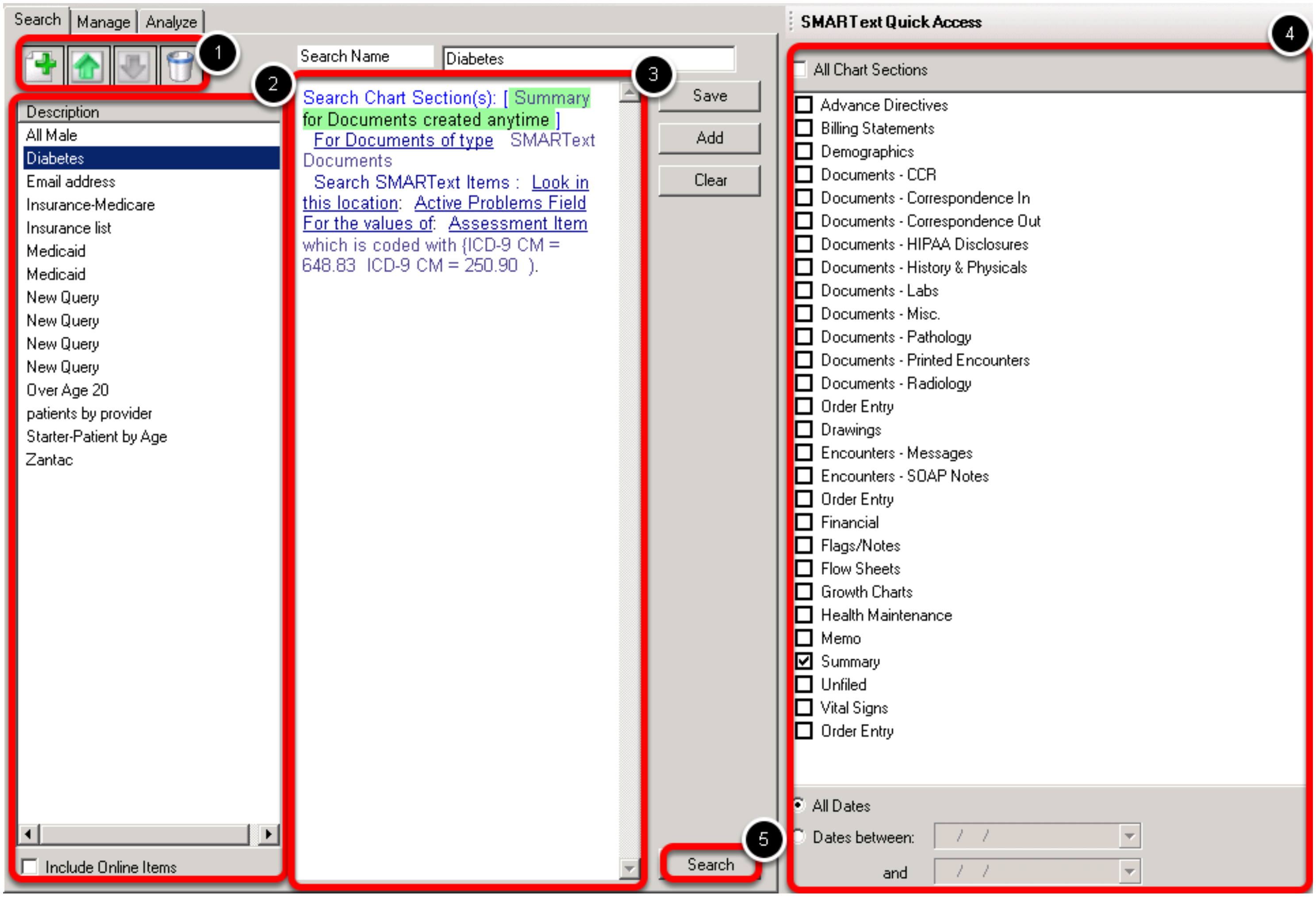
Data Explorer Workspace



The Data Explorer workspace contains three tabs:

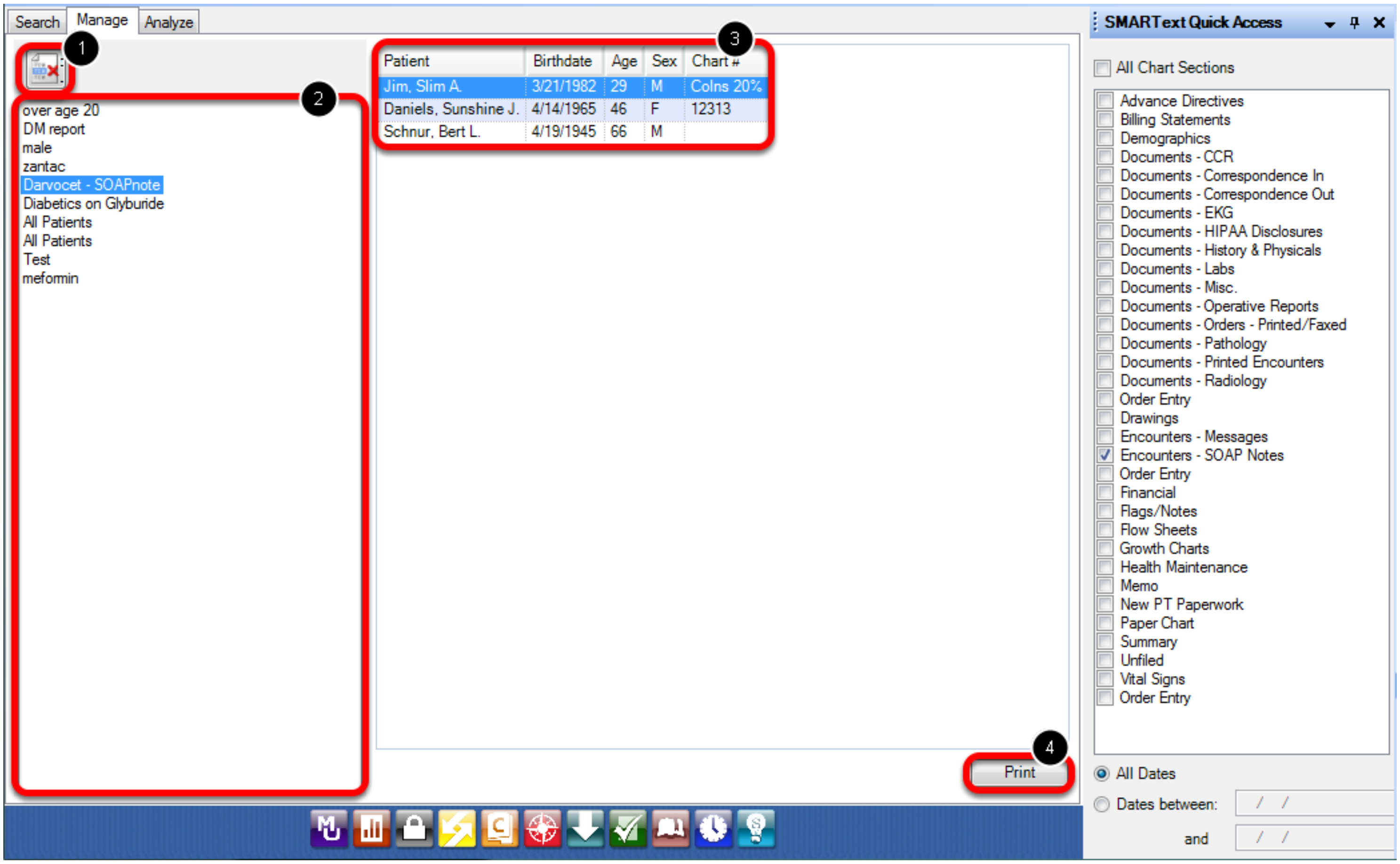
- **Search tab:** This area is used to create, edit and run queries against the SOAPware database. The results of the queries can be printed and/or saved.
- **Manage tab:** This tab displays saved results from prior searches. This section allows you to review, print and delete saved search results sets.
- **Analyze tab:** This tab is currently not used.

Data Explorer Interface - Search Tab



1. **Mini-Toolbar:** The mini-toolbar allows the user to create a new query, delete and existing query, and upload or download a query from the SOAPware Online Library.
2. **Query List:** This section displays a list of the user existing query's. The "Include Online Items" box can be checked if the user wishes to view queries that have been created and uploaded by other SOAPware users.
3. **Query Details:** This section displays the query details. This section is also used to build a query.
4. **SMARText Quick Access:** When a query is being built, this section is used to select items for the query.
5. **Search Button:** This button can be pressed to run a query against the users database.

Data Explorer Interface - Manage Tab



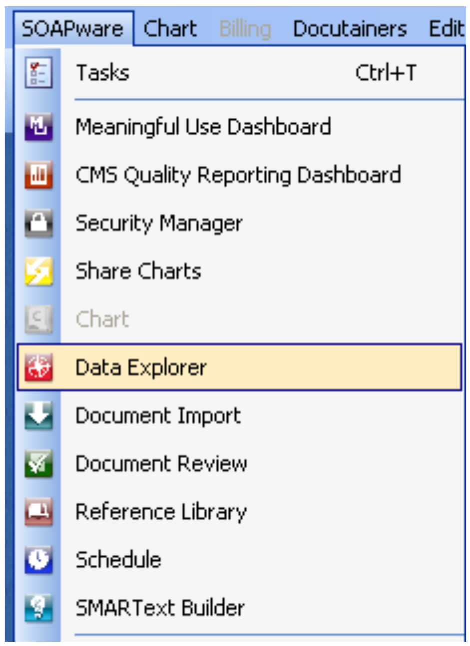
1. **Mini-Toolbar:** The mini-toolbar allows the user to delete a previously saved search result
2. **List of Saved Search Results:** This section presents the user with a list of their previously saved search results.
3. **Search Results:** This section display the patient information that resulted from the previously saved search.
4. **Print Button:** This button allows the user to print off the previously saved search results.

Data Explorer SOAPnote Medication Search

This lesson will cover searching databases for structured SMARText medication located in the SOAPnote medication field.

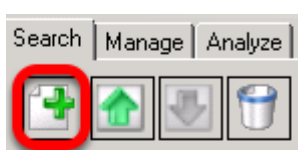
Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

Accessing Data Explorer



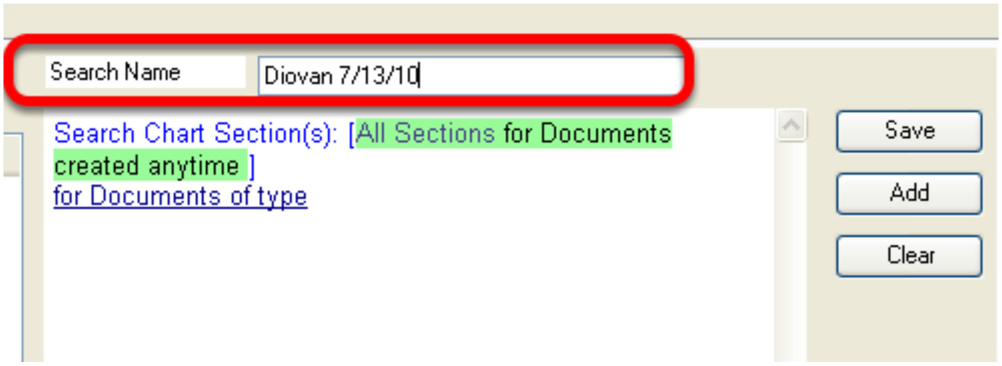
1. Click on SOAPware on the menu bar.
2. Click on Data Explorer.

Create New Query



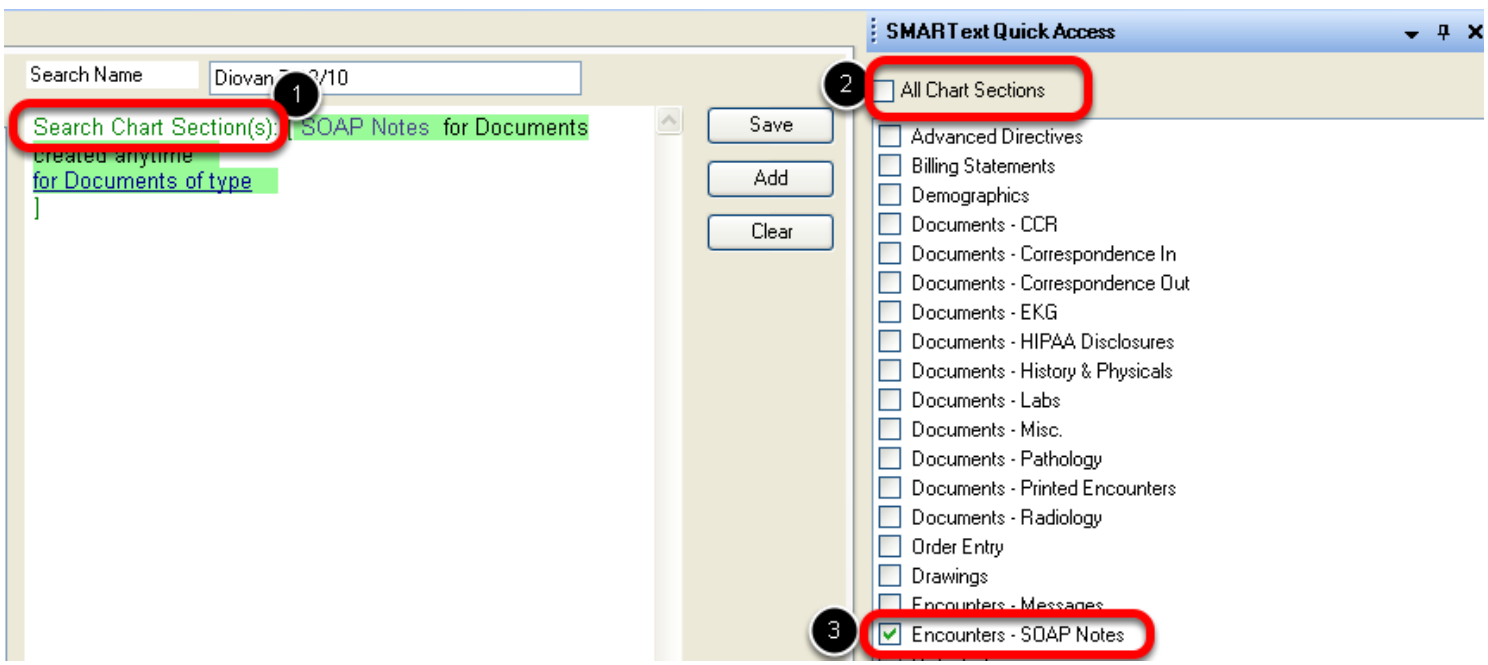
To create a new query, Click on the New Query button.

Name the Query



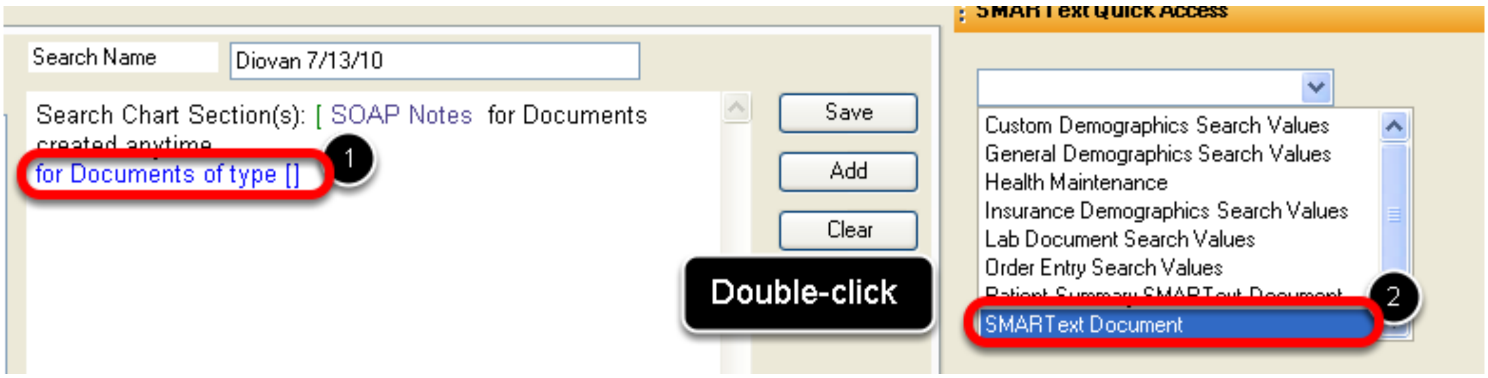
Name the query. It can be helpful to place a date on the query to differentiate between searches.

Selecting the Chart Section to Search



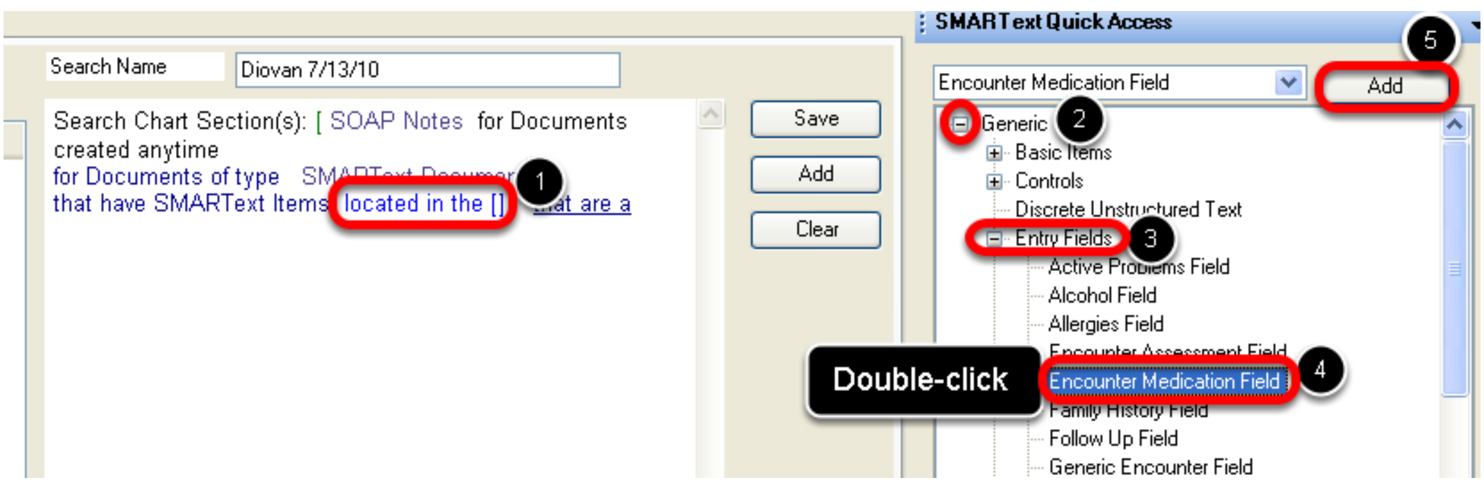
1. Click on "Search Chart Sections."
2. Un-check "All Chart Sections" in the SMARText Quick Access.
3. Click to place a check in the box next to Encounters - SOAP Notes.

Documents of Type



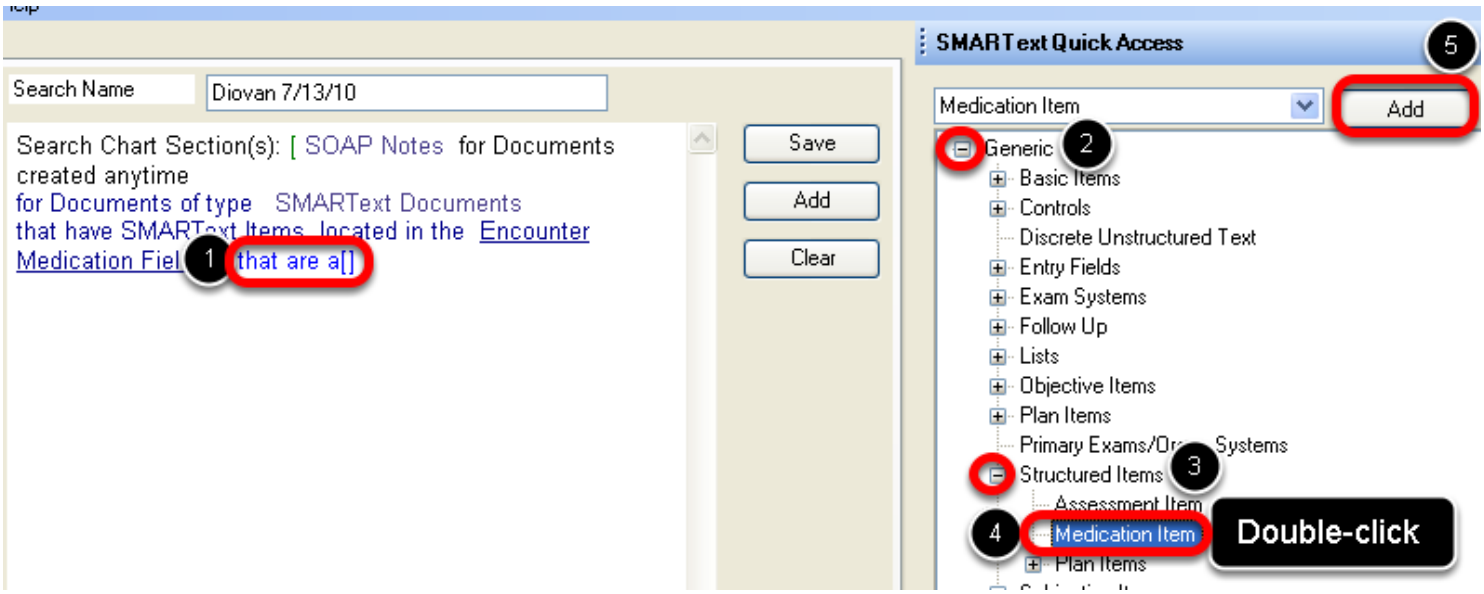
1. Click over "for Documents fo type."
2. Using the drop-down menu in the SMARText Quick Access, double-click on "SMARText Document."

Search Area



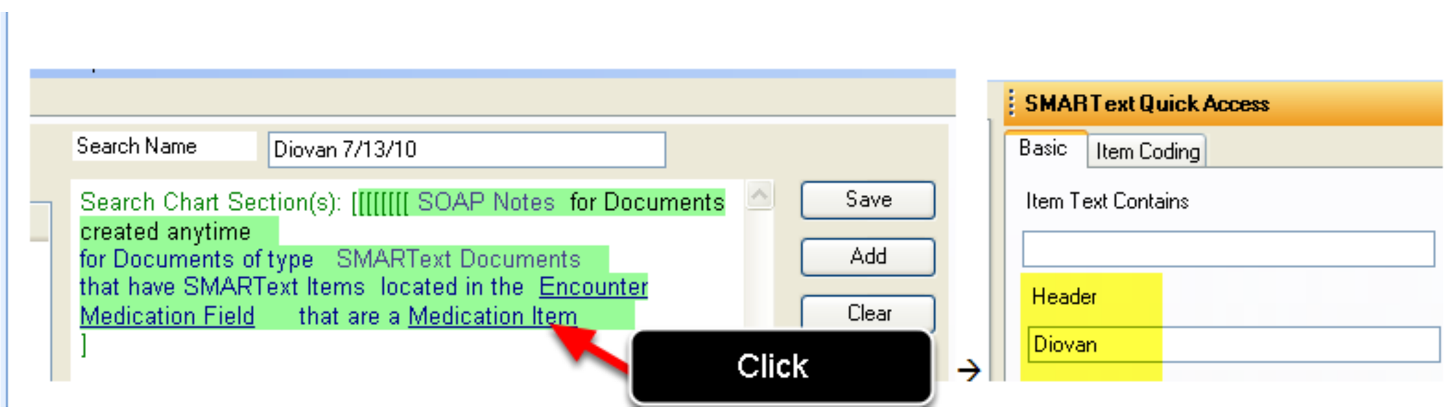
1. Click on "located in the."
2. Using the drop-down menu, Click on the plus (expander node) next to Generic.
3. Click on the expander node next to "Entry Fields"
4. Double-click on "Encounter Medication Field."
5. Click the Add button.

Define the SMARText Item Type



1. Click on "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

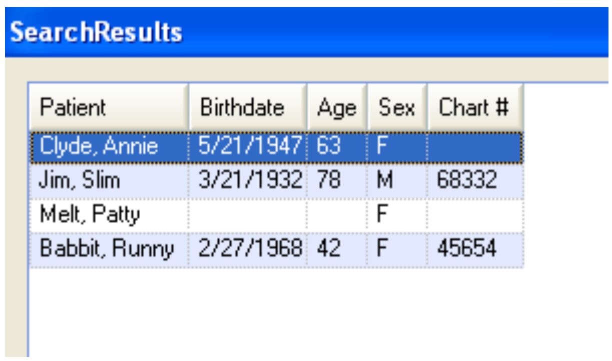


1. Click on "Medication Item."
2. On the Basic tab, type in the header (or name) of the medication.

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



The search results will be displayed when the search is complete. The user can save these or discard the results.

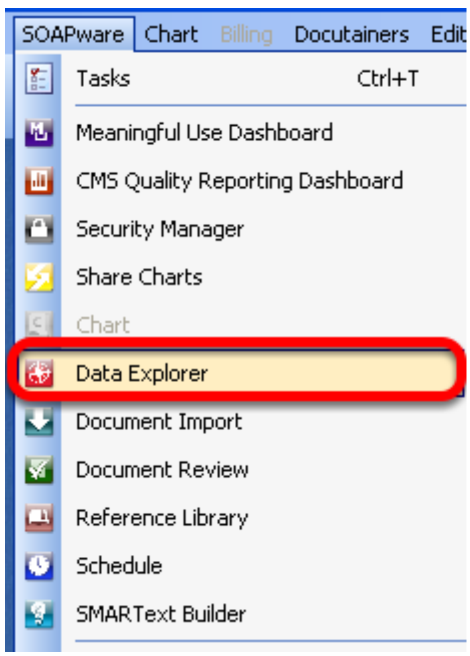
Data Explorer Summary Diagnosis Search

This lesson will cover searching databases for structured SMARText diagnosis located in the Summary Active Problems.

Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

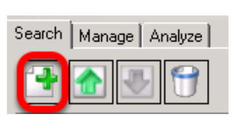
***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Patient Lists

Accessing Data Explorer



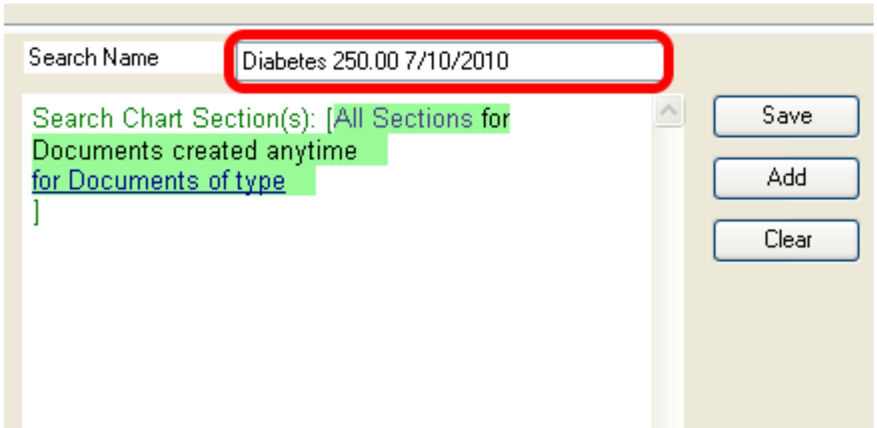
1. Click on SOAPware on the menu bar.
2. Click on Data Explorer.

Create a New Query



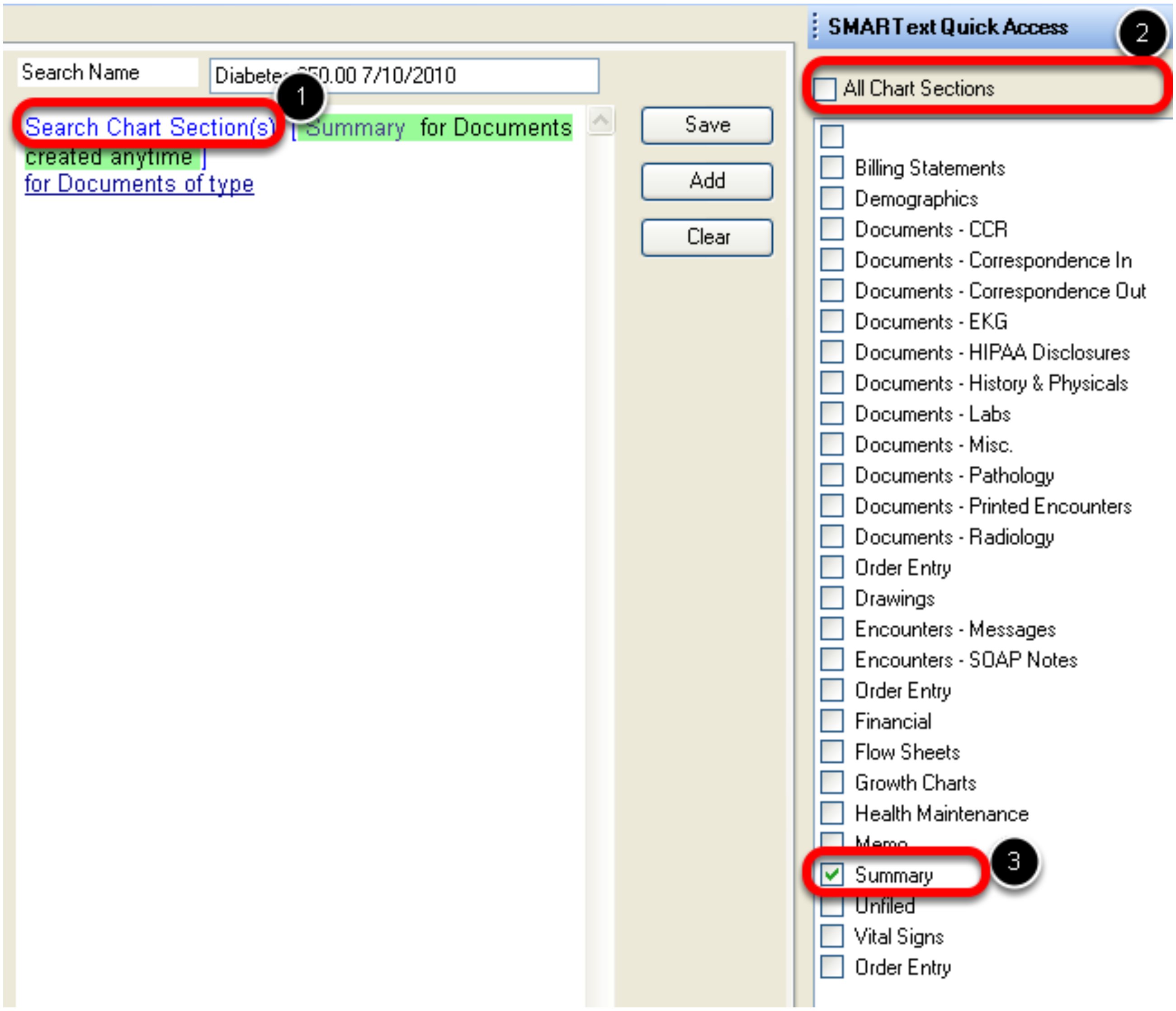
To create a new search, Click on the New Query button.

Name the Query



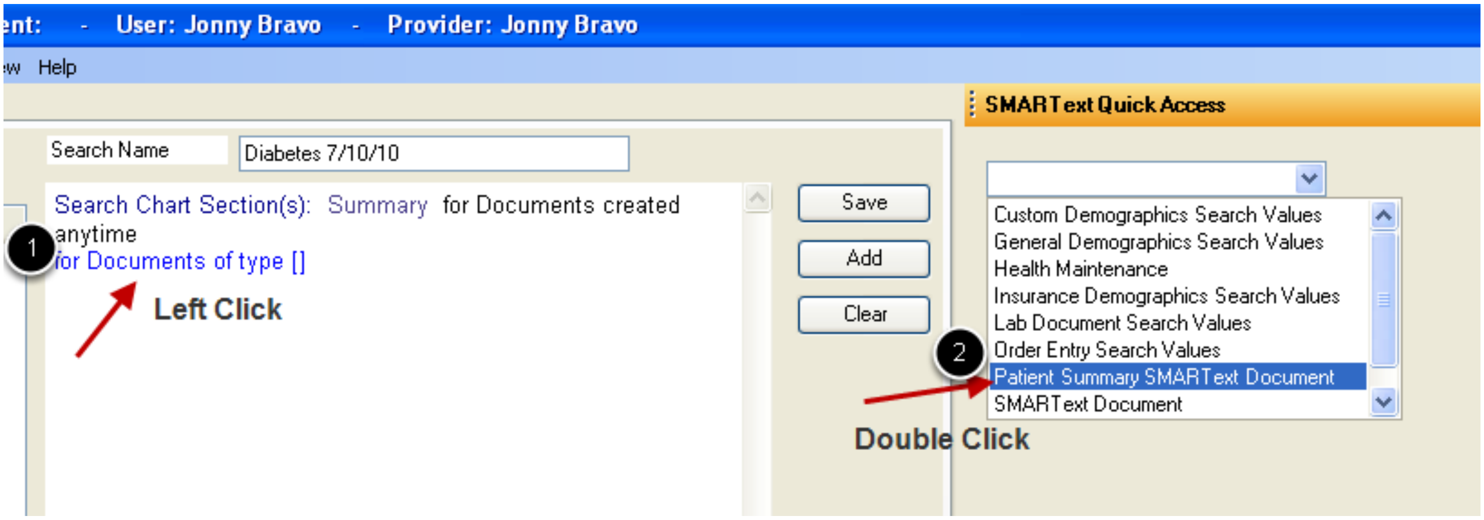
Next, name the Query. It can also be helpful to place a date on the query name to differentiate between searches.

Select Chart Sections to Search



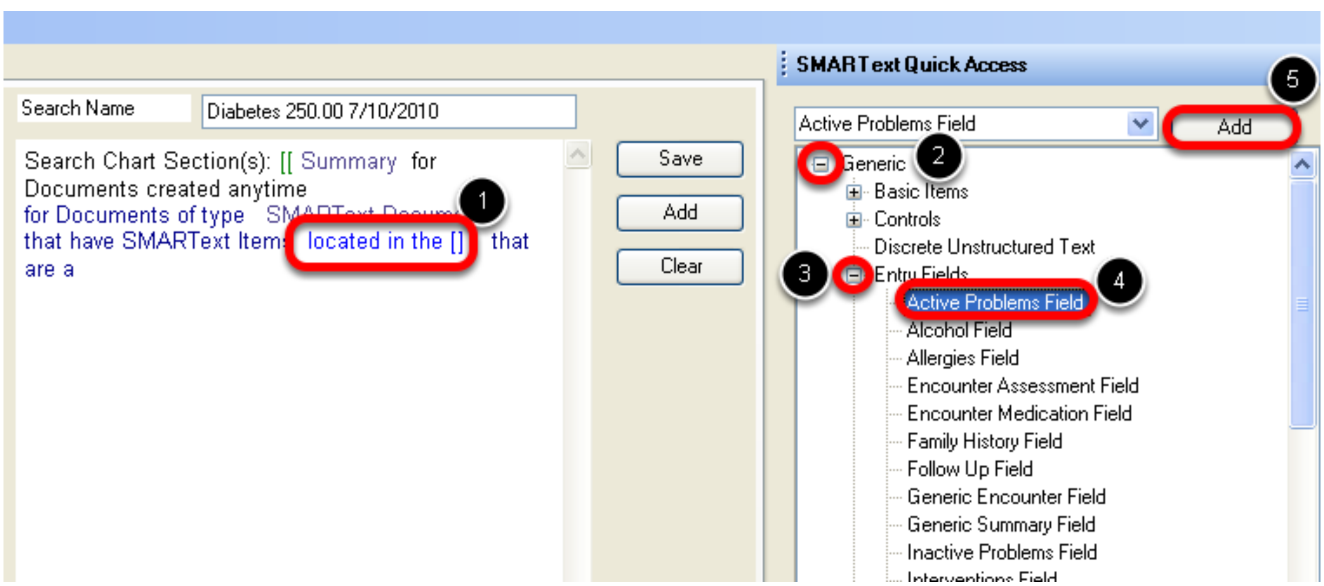
1. Click on "Search Chart Sections."
2. Un-check "All Chart Sections" in the SMARText Quick Access.
3. Click to place a check in the box next to Summary.

Document Type



1.Click on "for Documents of type."
2. Using the drop-down menu in the SMARText Quick Access, double-click on "Patient Summary SMARText Document."

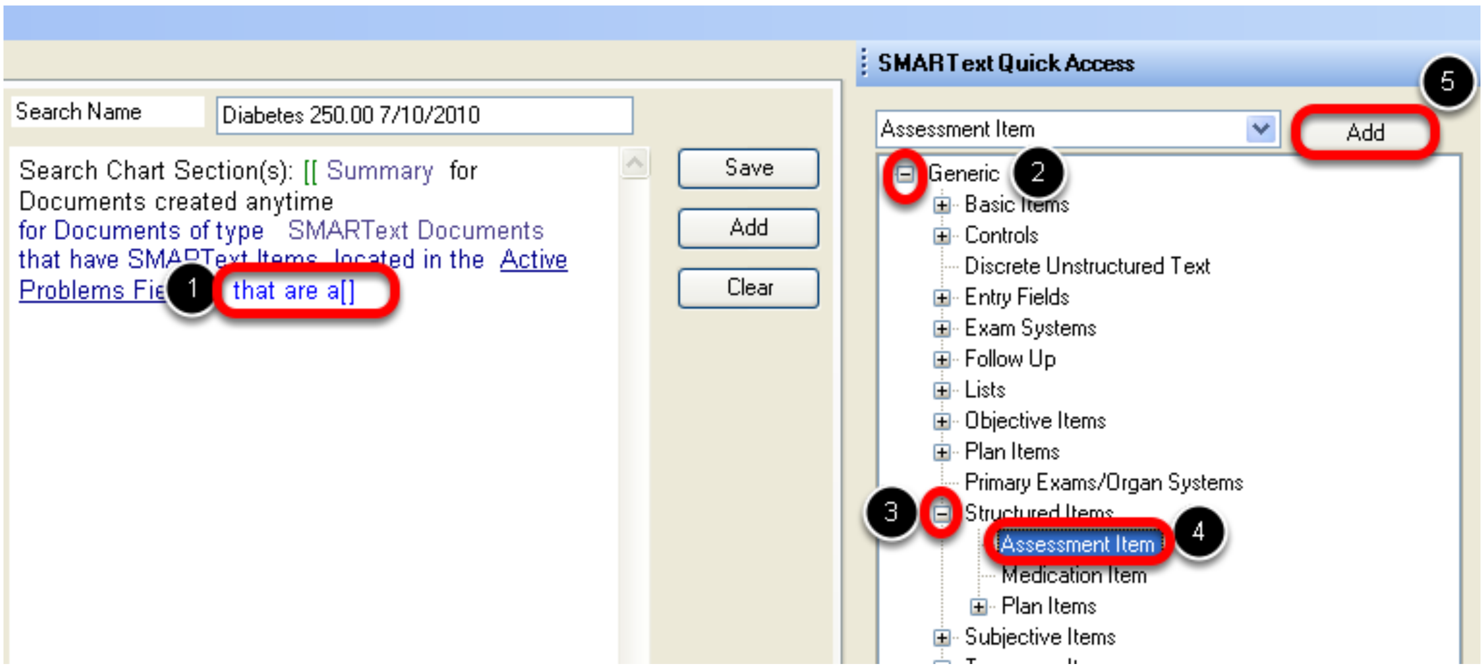
Area to Search



1. Click on "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."

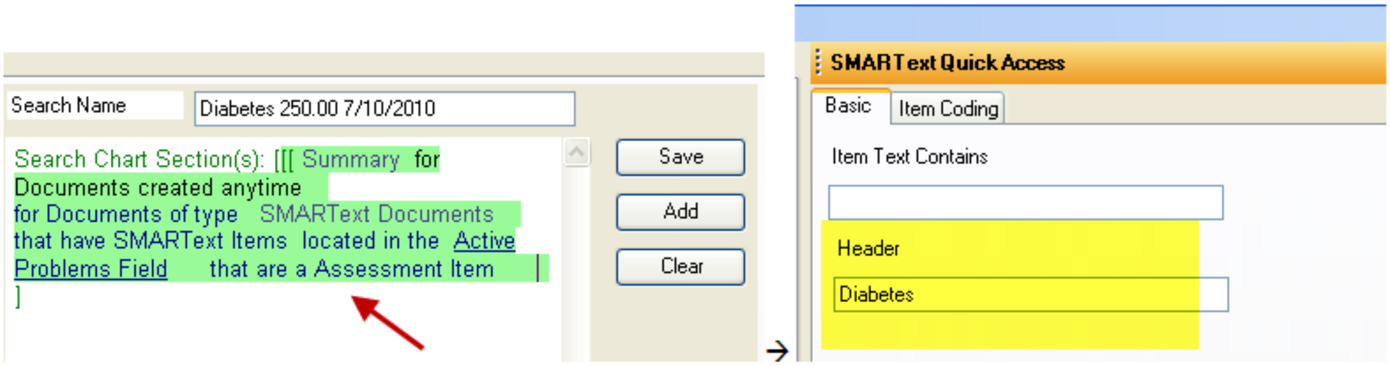
4. Double-click on "Active Problems Field."
5. Click the Add button.

Defining the SMARText Item Type



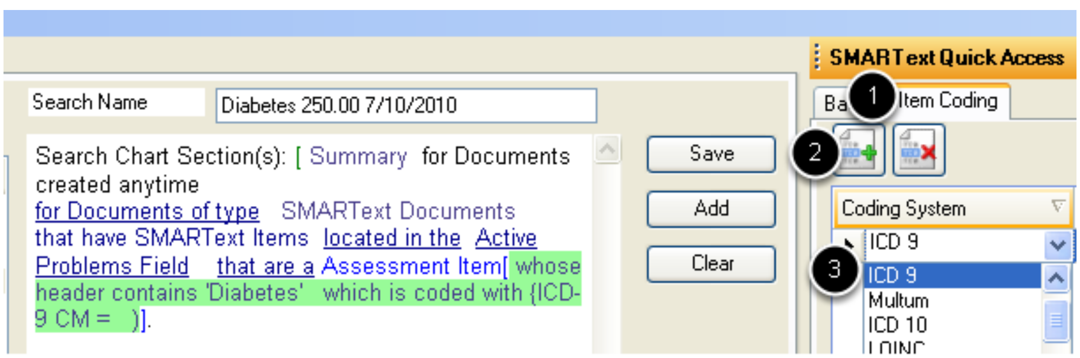
1. Click over "that are a."
2. Using the drop-down menu, Click on the expander node next to "Generic."
3. Click on the expander node next to "Structured Items."
4. Double-click on "Assessment Item."
5. Click the Add button.

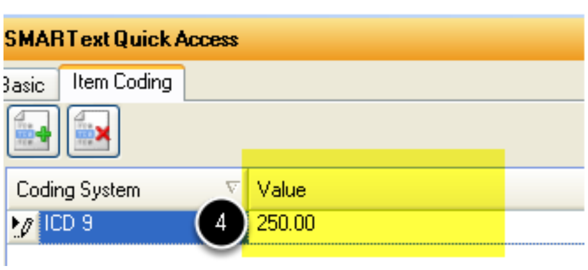
Choose a Diagnosis



1. Click on "Assessment Item."
2. On the Basic tab, type in the Header (or name) of the diagnosis.

Item Coding Tab (optional)





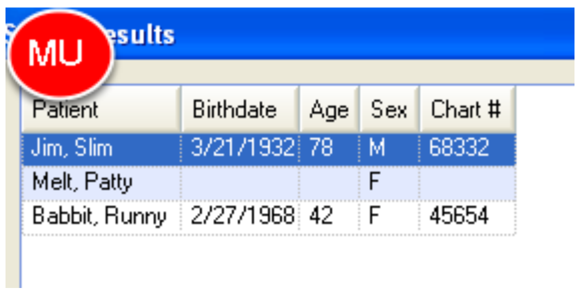
1. Click on the Item Coding tab.
2. Click on the Create tab.
3. Using the drop-down menu under "Coding System", click to select ICD 9.

4. Click under the Value column and type in the ICD 9 being searched for.

Run the Search

When finished setting up the search, Click on the Search button to run the search.

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

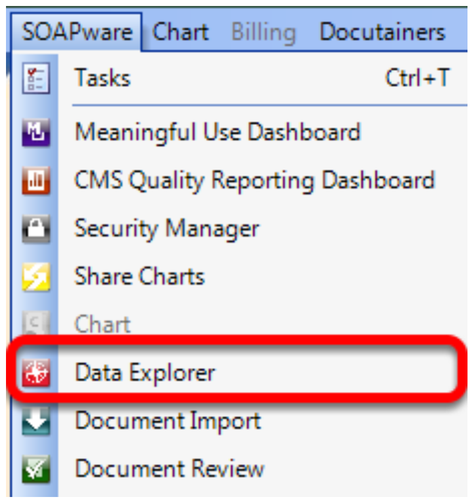
When the search is completed, the search results will be displayed. These can be saved for later viewing or discarded.

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.

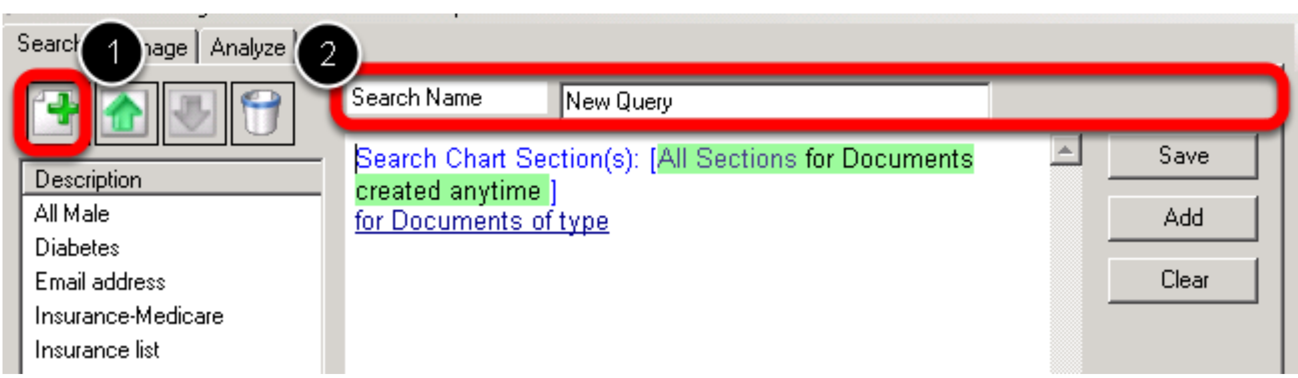
****Note**: The following steps are applicable to SOAPware 2011+, despite the difference of versions shown in the following screen shots.*

Open the Data Explorer Workspace

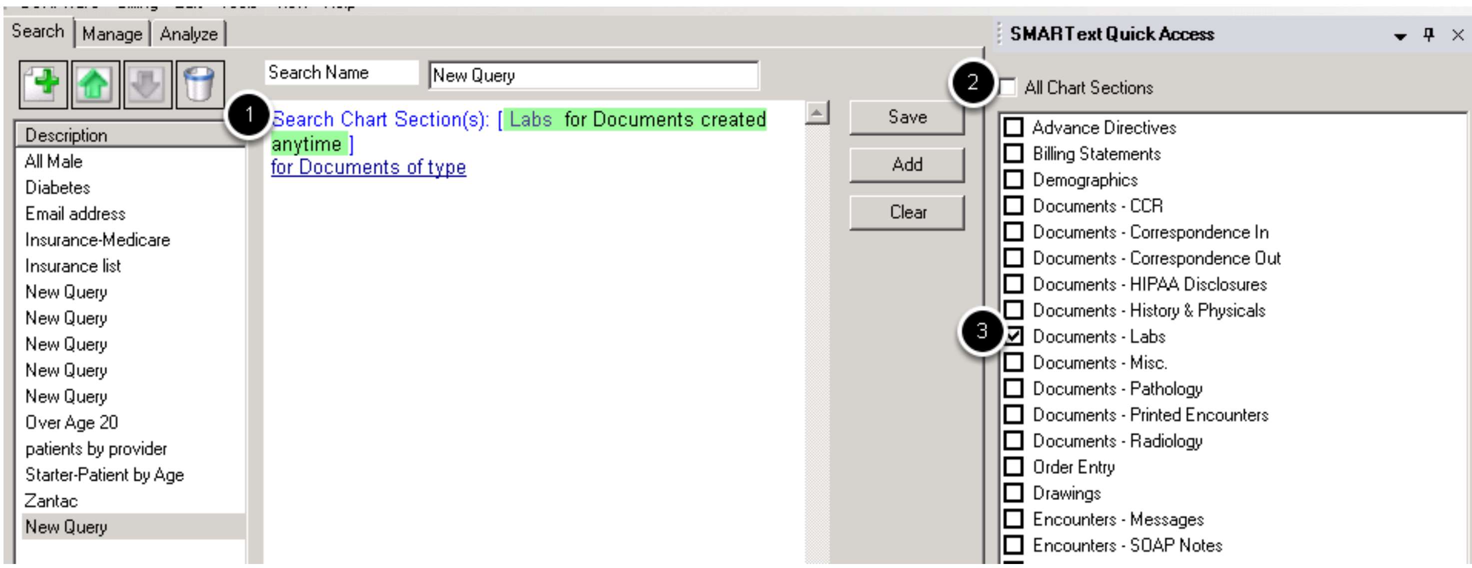


Click on SOAPware from the file menu bar, and Select Data Explorer. This will close the Chart workspace and open the Data Explorer workspace.

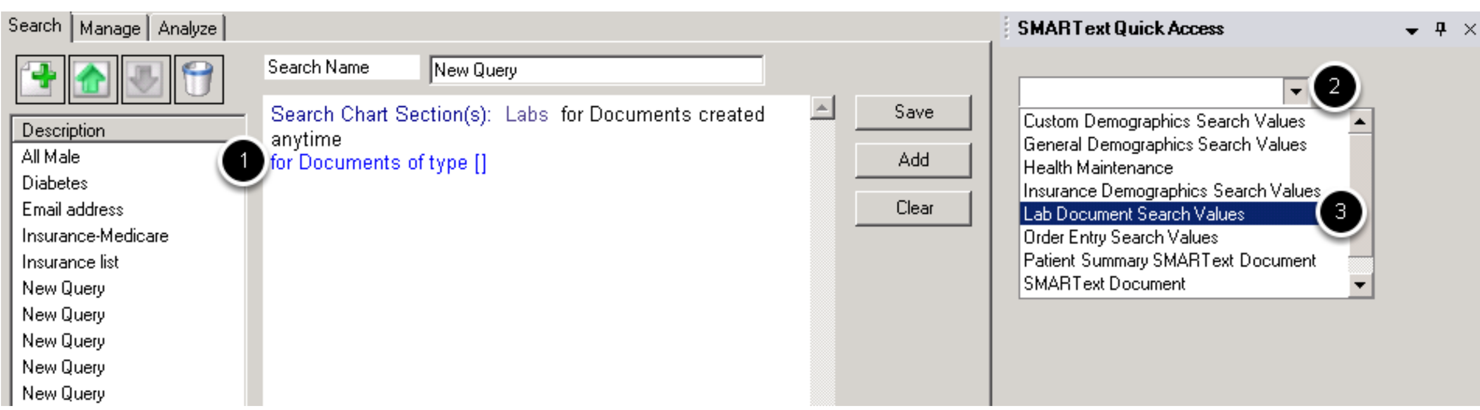
Creating a New Query



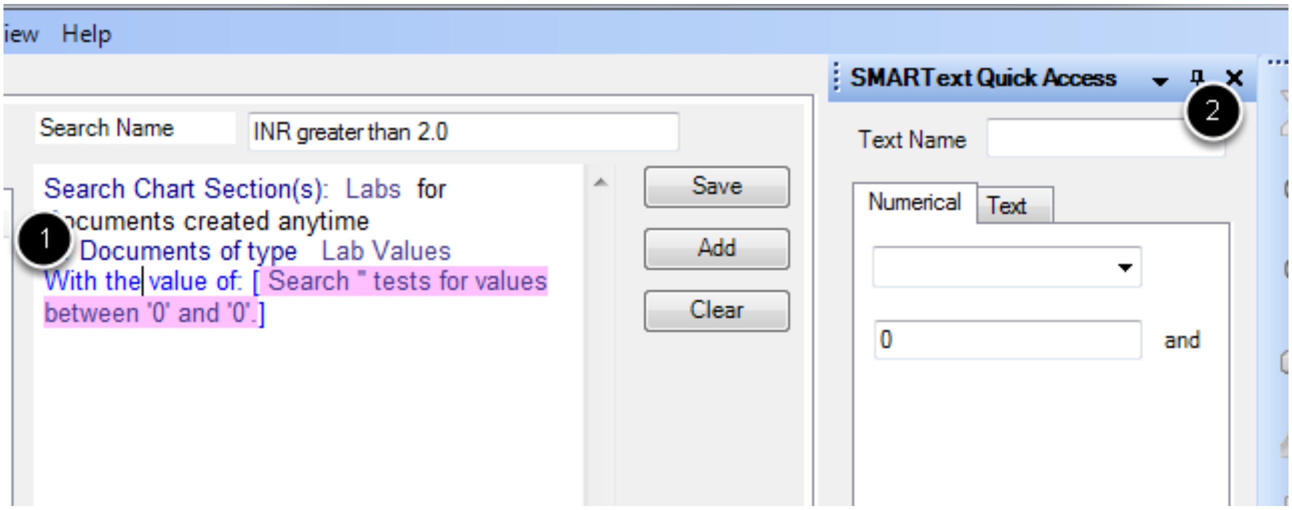
1. Click on the green plus to create a new blank query.
2. Name the new query.



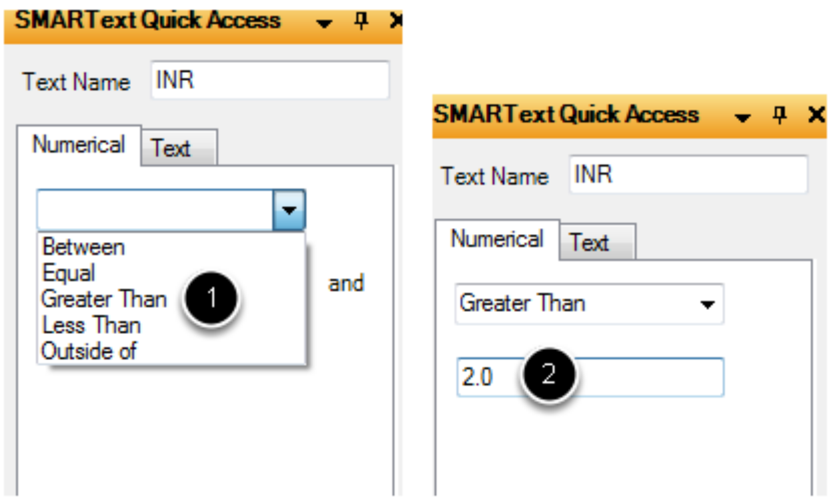
1. Click on "Search Chart Sections."
In the SMARText Access a list of available chart sections will appear.
2. Uncheck the "All Chart Sections."
3 Select "Documents-Labs."



1. Click on "for Documents of type."
2. Click on the drop-down menu from SMARText Quick Access.
3. Select "Lab Document Search Values."

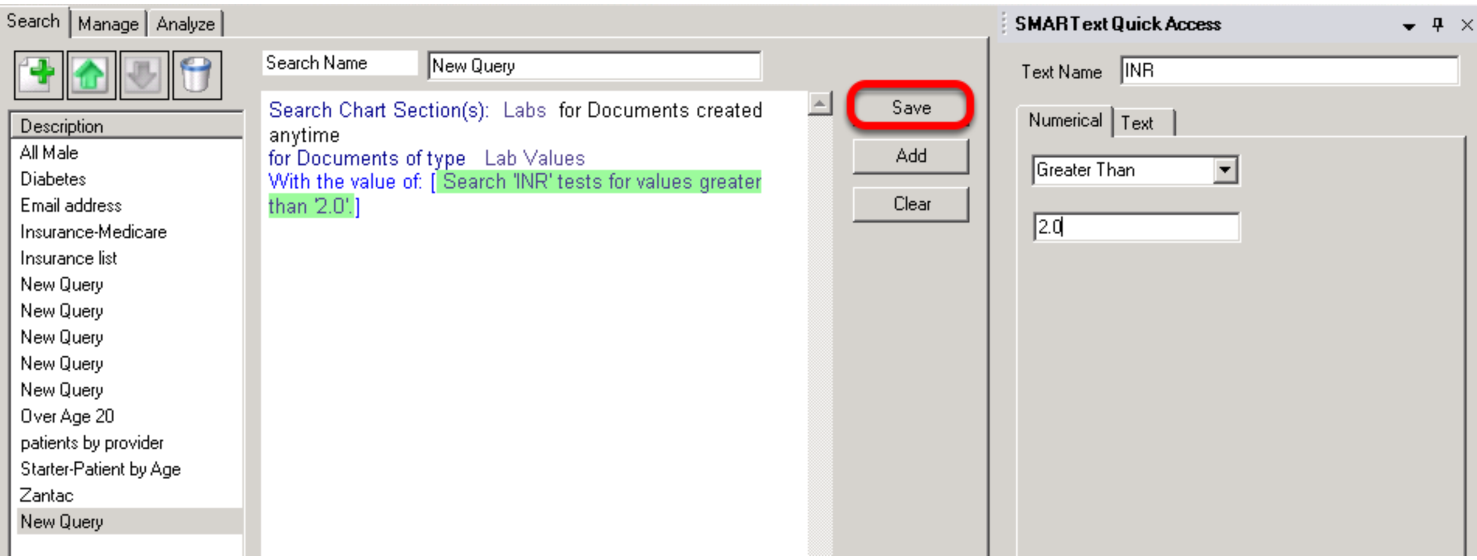


1. Click on "With the value of."
2. Enter the exact name of the test.



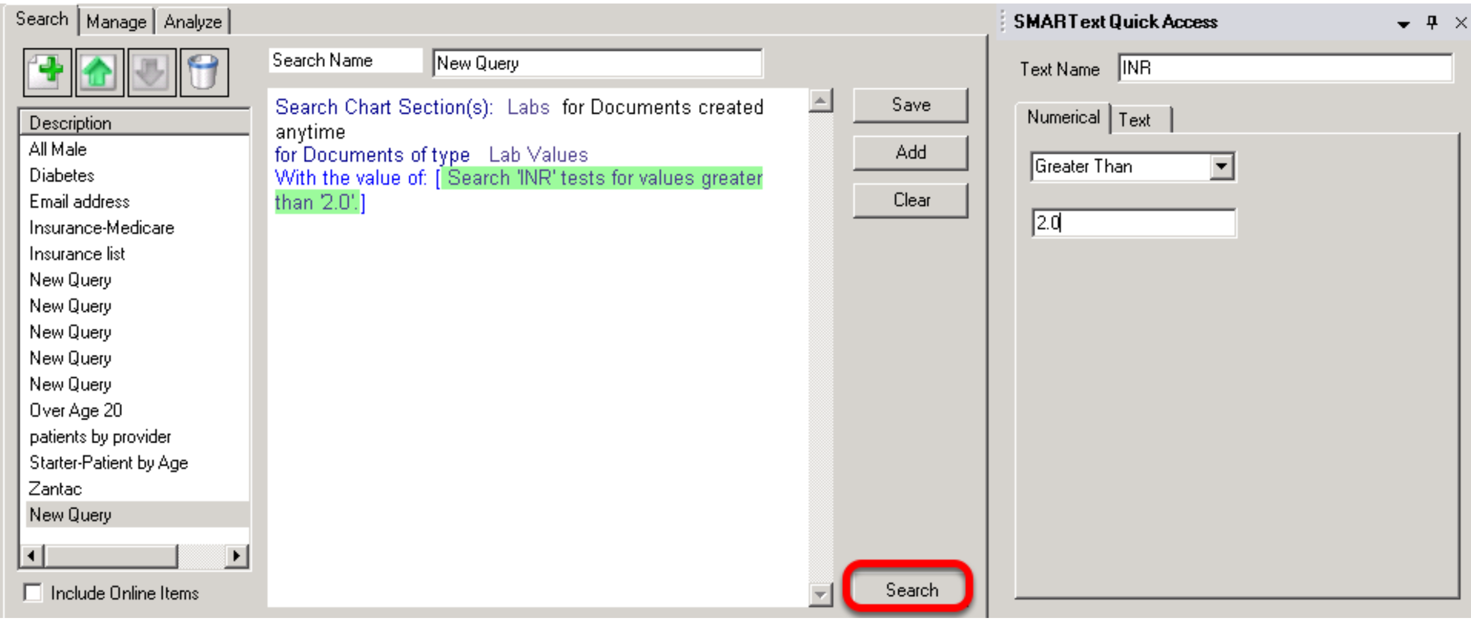
1. Select desired option.
   For this example we are selecting "Greater Than."
2. Enter exact value or range.

Save the Search



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. Aprogress 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.

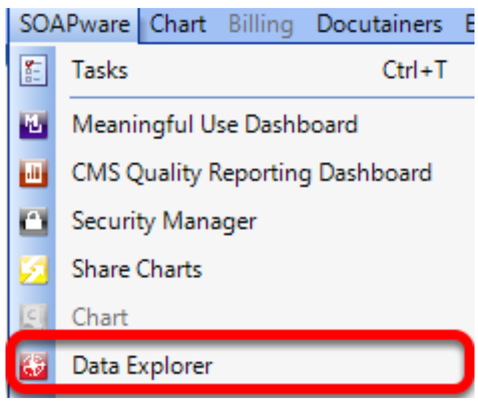
Data Explorer Assessment Diagnosis Search

This lesson will cover searching databases for a structured SMARText 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.

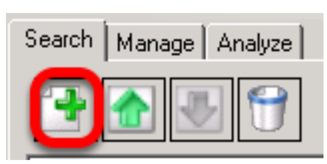
***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Patient Lists

Accessing Data Explorer



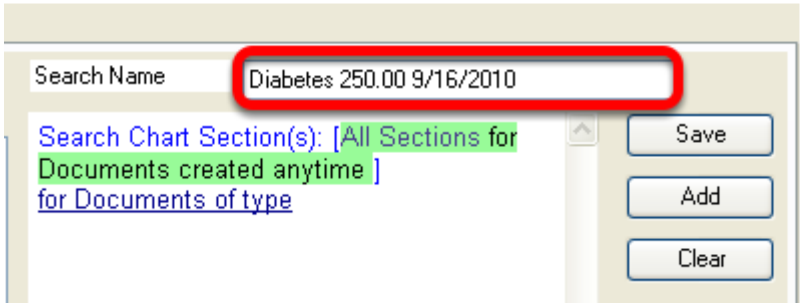
Click on SOAPware on the menu bar.
Click on Data Explorer.

Create a New Query



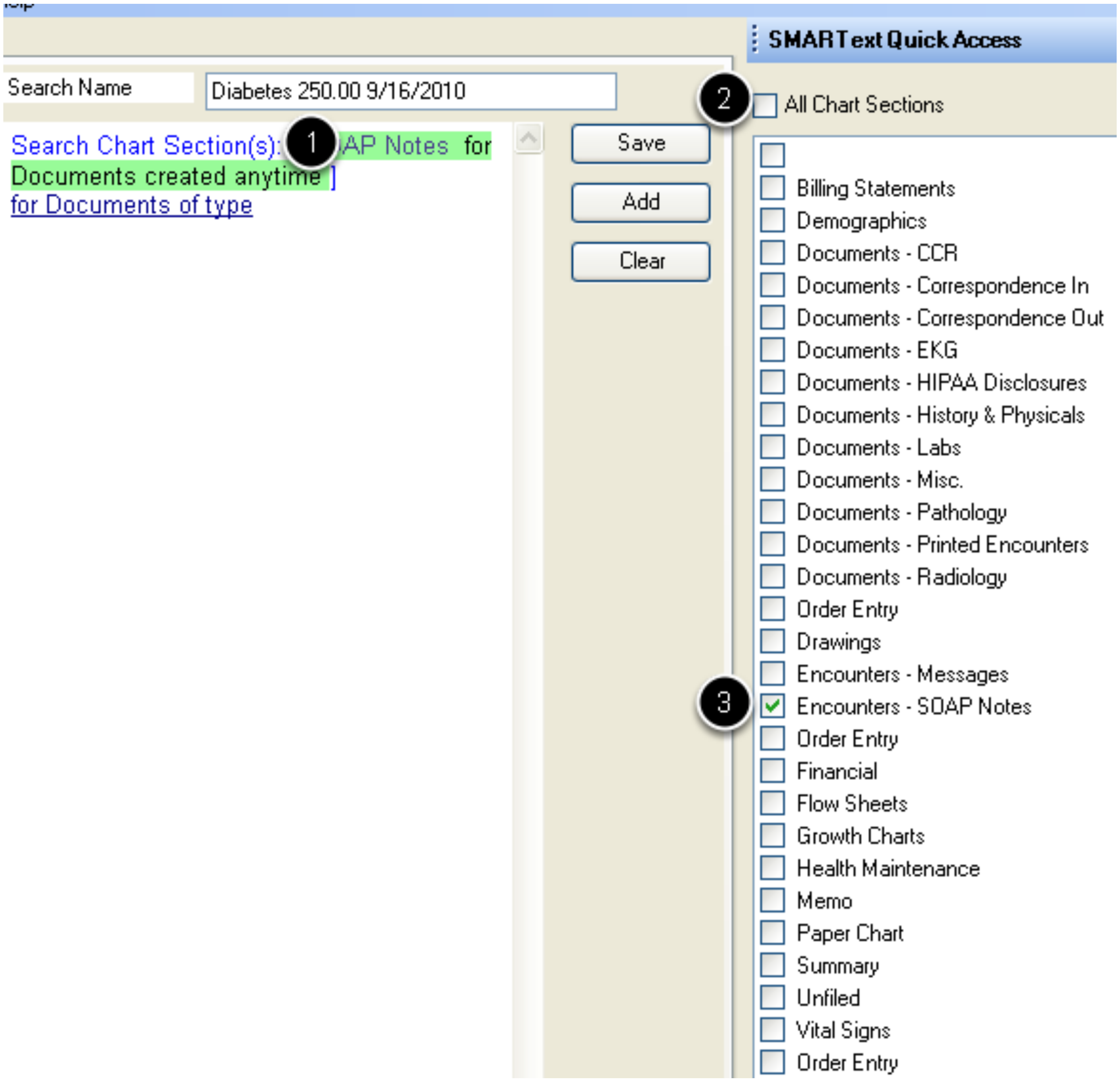
Click on the New Query button.

Name the Query



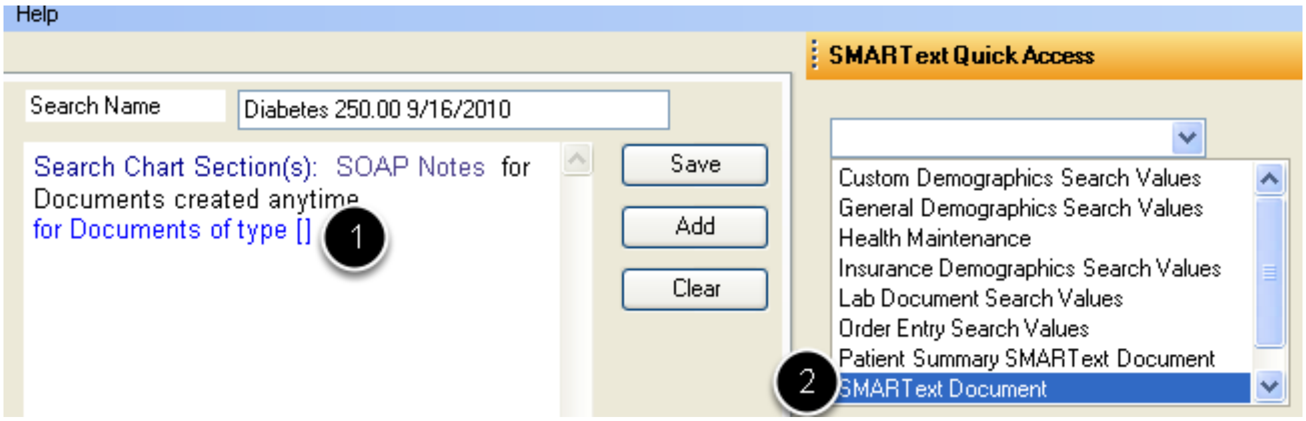
Name the query. It can be helpful to have the data as part of the name of the query.

Select the Chart Section to be Searched



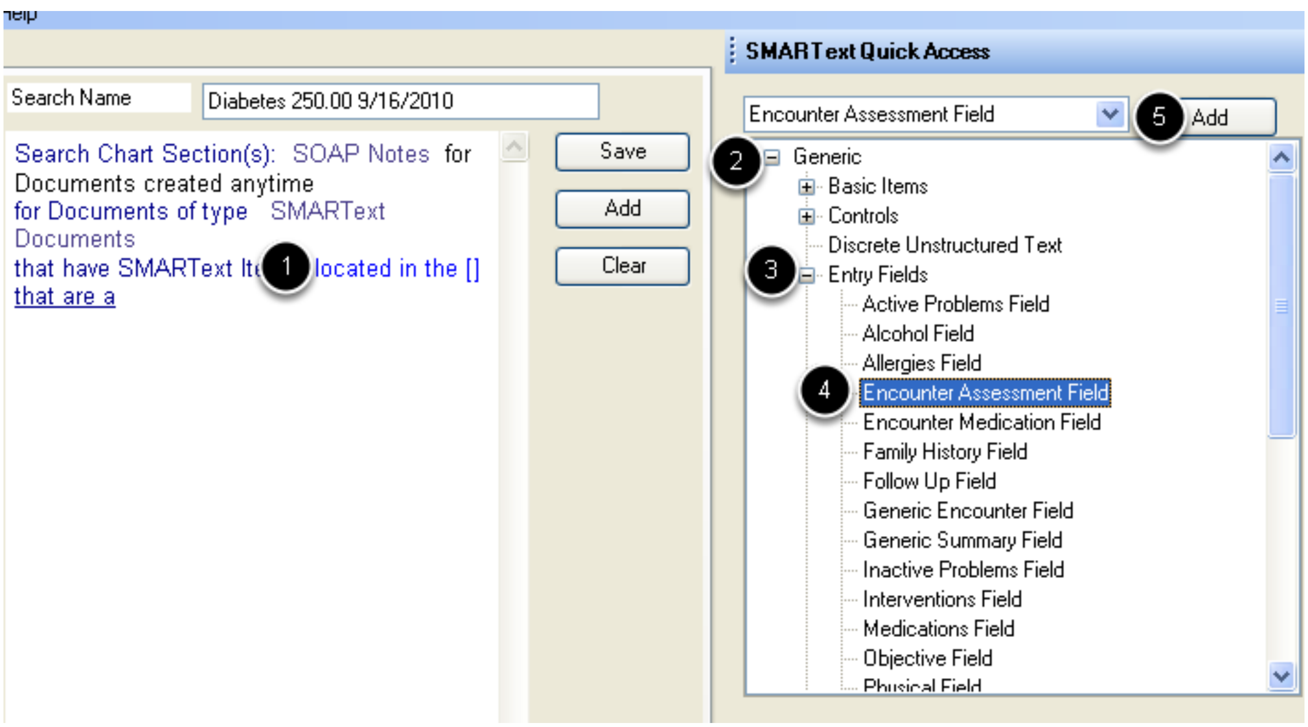
1) Click on "Search Chart Sections."
2) Un-check "All Chart Sections" in SMARText Quick Access.
3) Click to place a check in the box next to Encounters - SOAP Notes.

Type of Document



1) Click on "for Documents of type."
2) Using the drop-down menu in SMARText Quick Access, double-click on "SMARText Document."

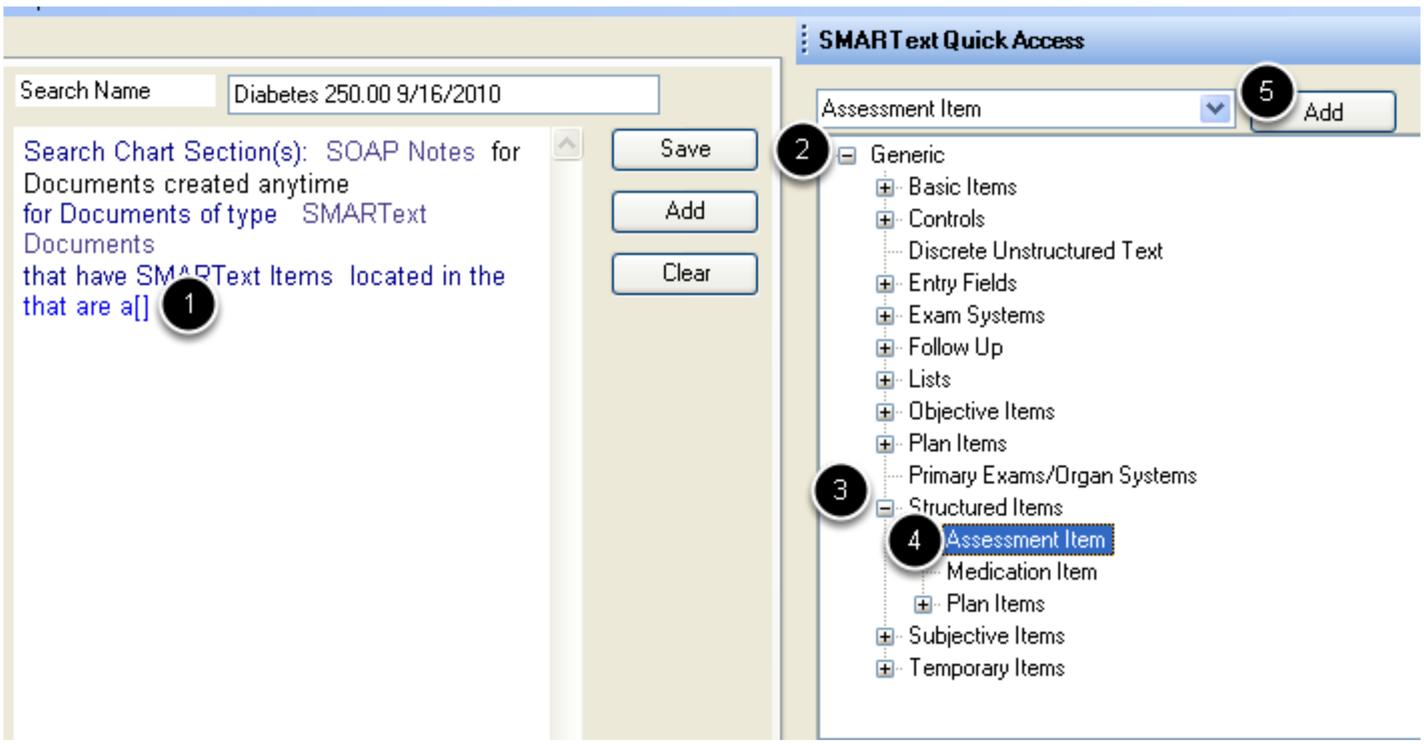
Select the Location



1) Click on "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."

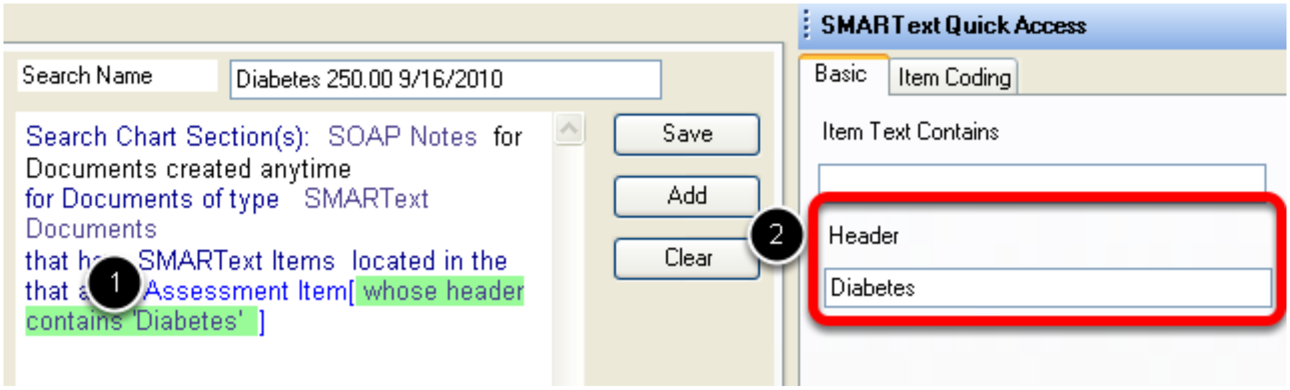
4) Double-click on "Encounter Assessment Field."
5) Click the Add button.

Define the SMARText Type



1) Click on "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

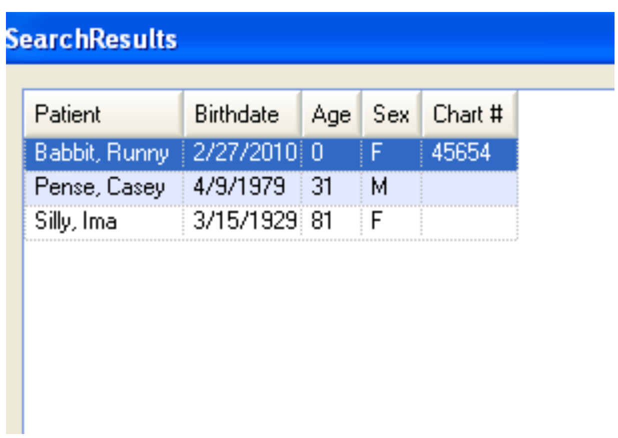


1) Click on "Assessment Item."
2) On the Basic tab, type in the Header (or name) of the diagnosis.

Run the Search

Click on the Search button.

Search Results



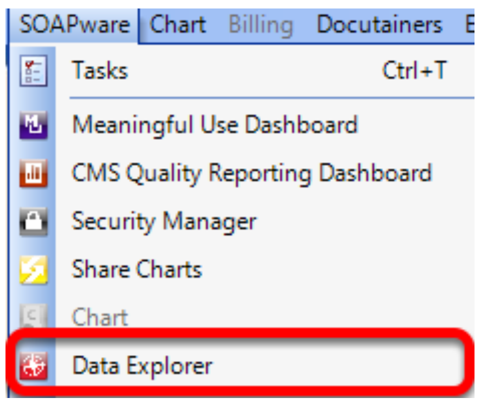
The search results will be displayed. The user can choose to save or print the search results.

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.

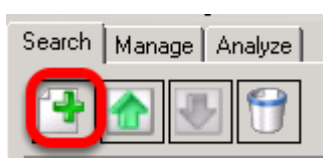
Depending on the size of the database, this search could take several minutes. We do not recommend running database searches during business hours.

Access Data Explorer



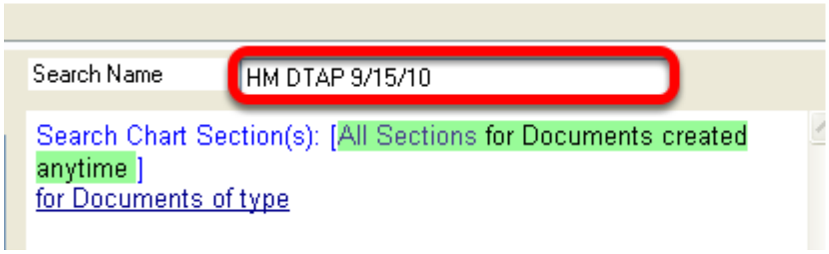
On the menu bar Click on Soapware and choose Data Explorer.

Create a New Query



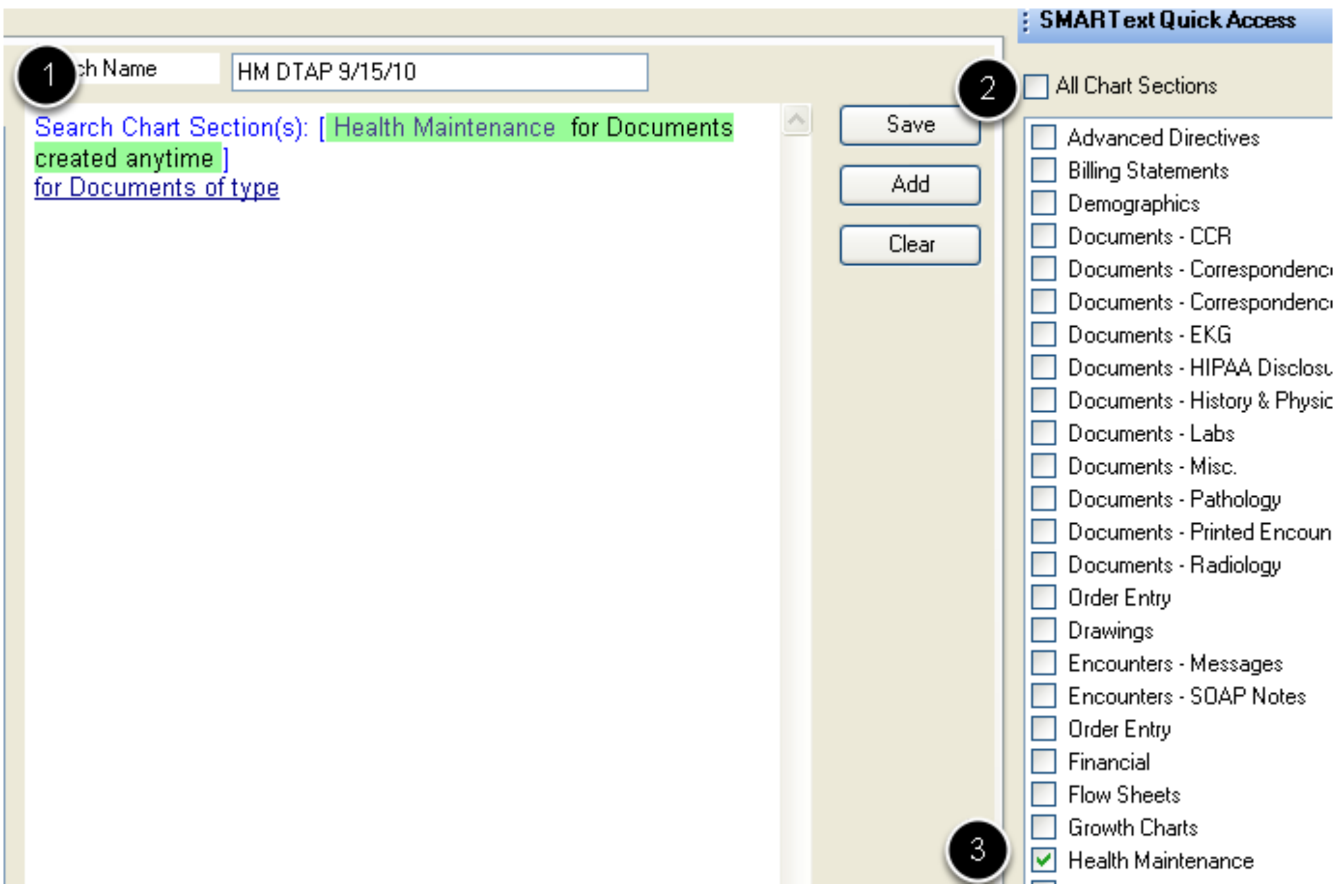
Click on the New Query button.

Name the Query



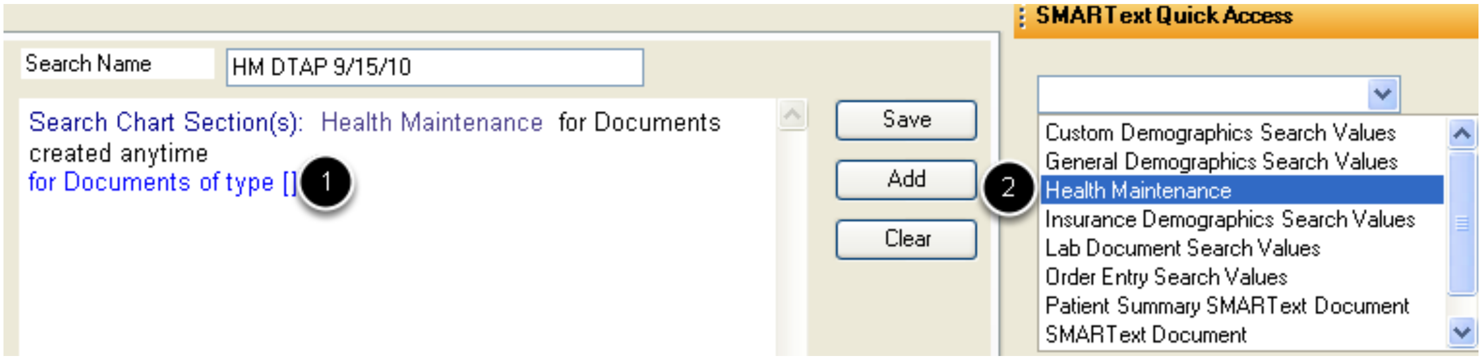
Type the name of the query in the "Search Name" box. It can be helpful to place a date on the query also.

Select the Chart Section to be Searched



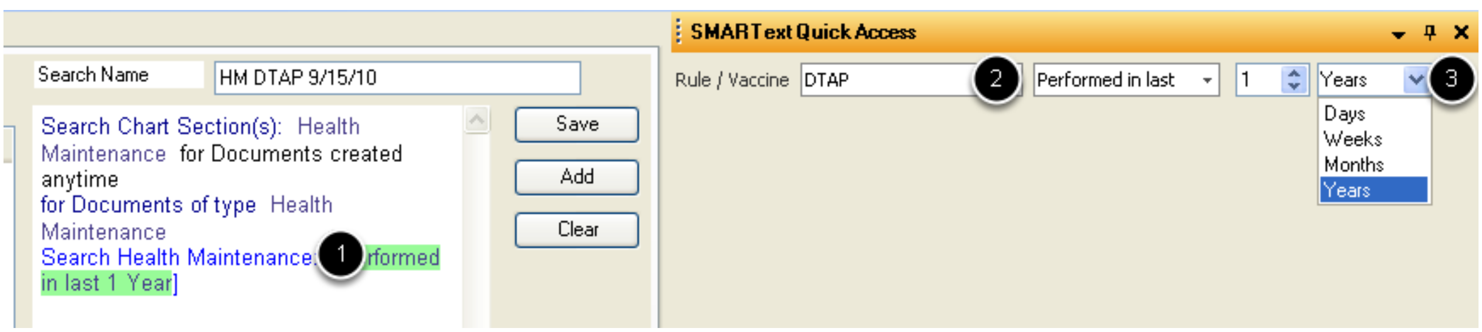
1. Click on "Search Chart Sections."
2. Un- check "All Chart Sections" in SMARText Quick Access.
3. Click to place a check in the box next to Health Maintenance.

Type of Document



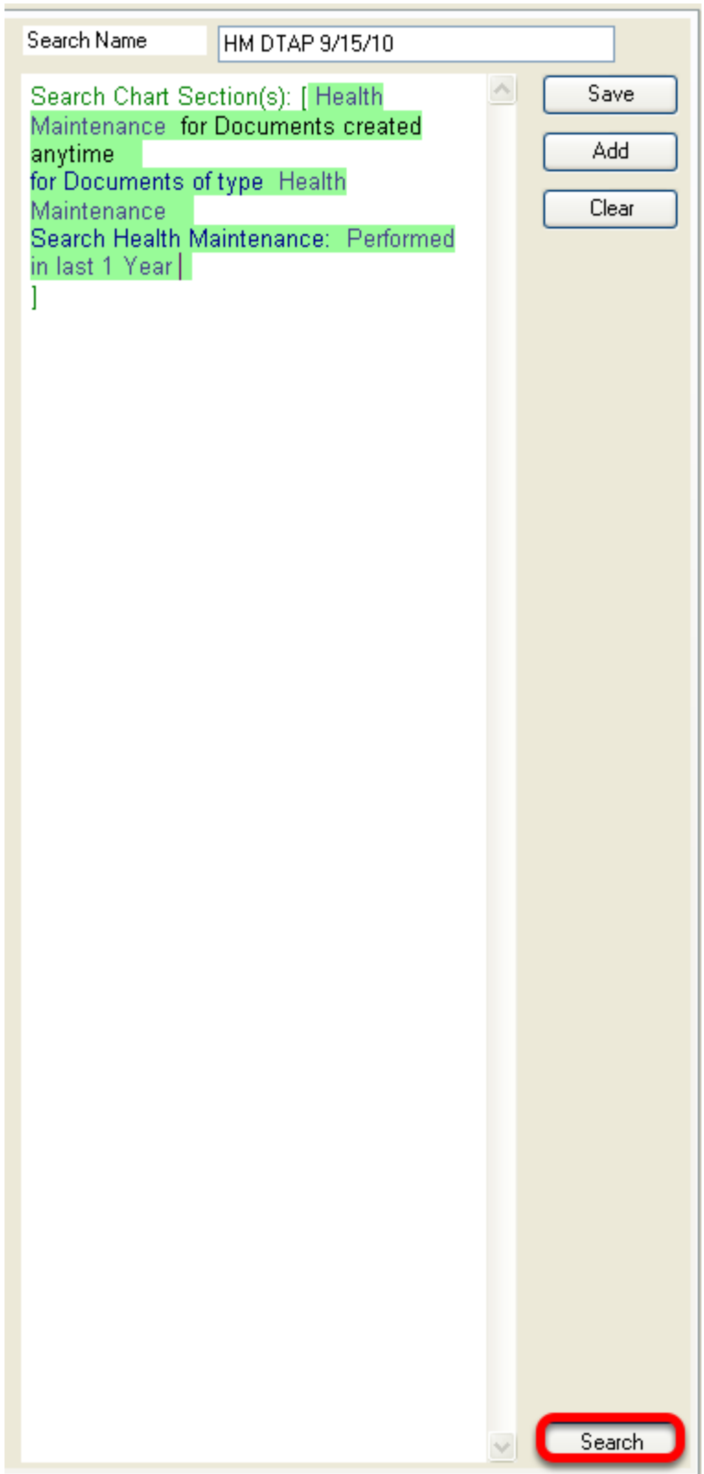
1. Click on "for Documents of type."
2. Using the drop-down menu in SMARText Quick Access, double-click on Health Maintenance.

Select the Area to Search



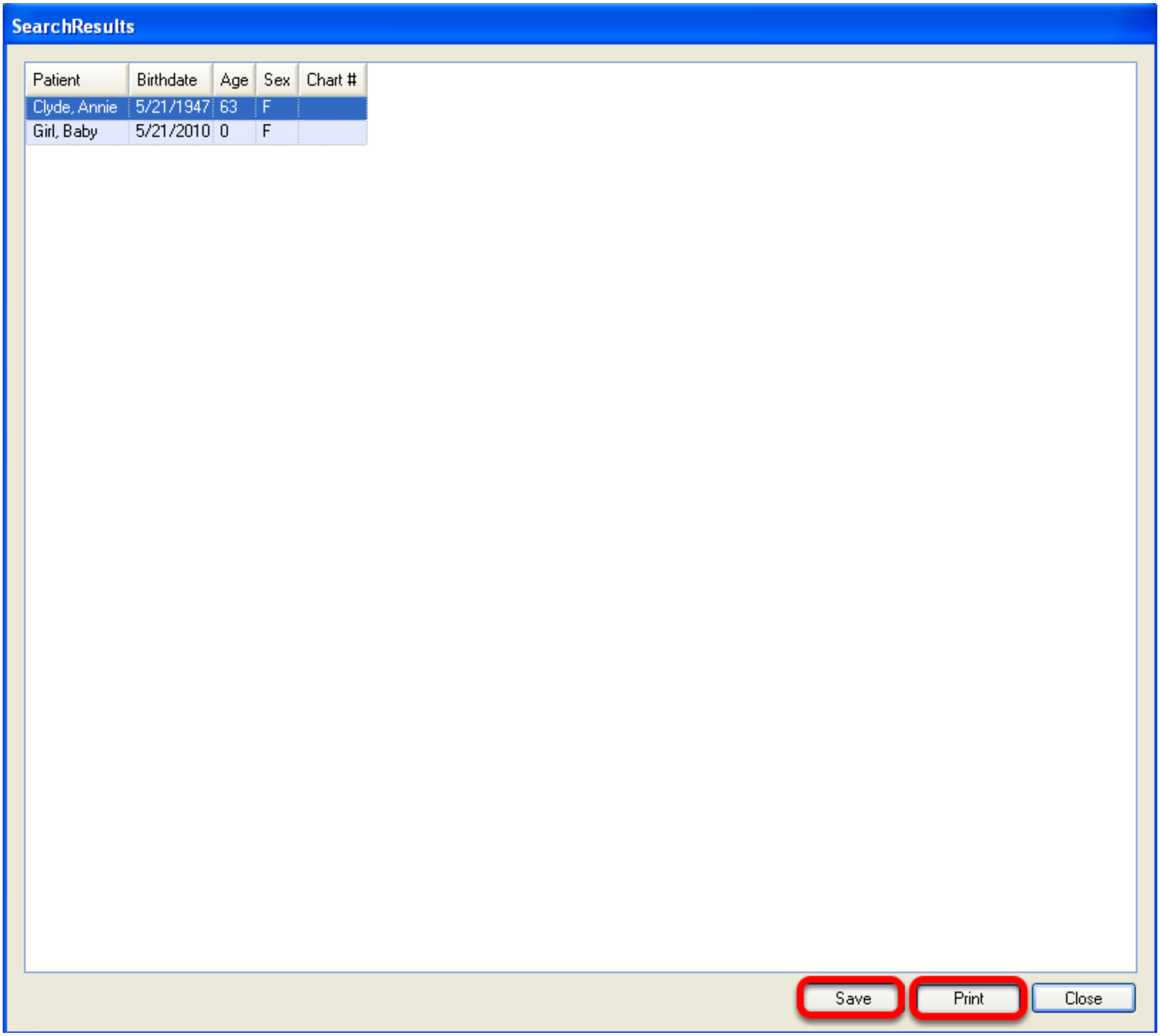
1. Click on "Search Health Maintenance."
2. Type in the Rule or Vaccine to search for, **exactly** as it appears in Health Maintenance.
3. Using the arrows, indicate the number and measurement of time.

Perform the Search



Click the Search button.

Search Results



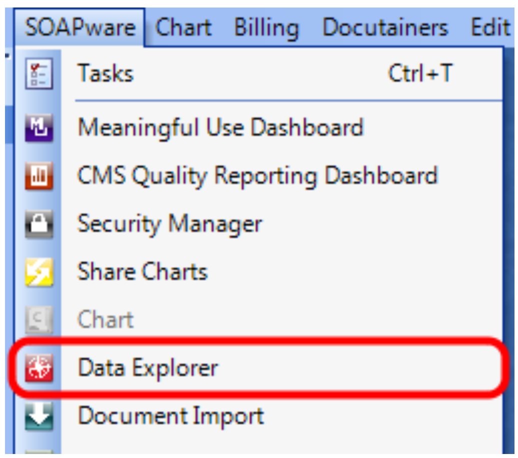
The search results will be displayed and can be saved or printed.

Data Explorer Search for Patients with a Specific Insurance Carrier

This lesson will explain how to create a Data Explorer search to search for patients that have a specific insurance carrier.

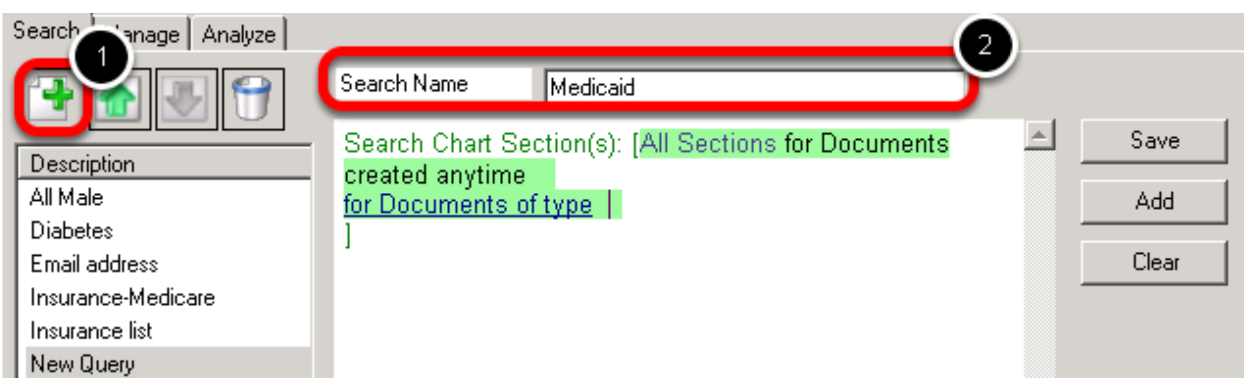
**__Note__: Depending on the size of the users database, the search time can be lengthy. We recommend that you do not perform a data explorer search during clinic hours.*

Open the Data Explorer Workspace

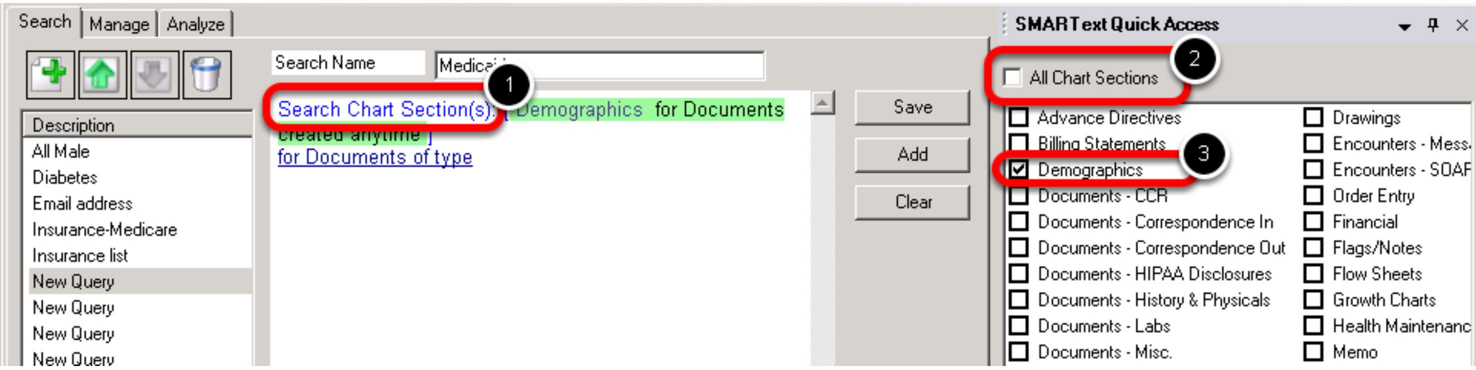


Click on SOAPware from the file menu bar, and Select Data Explorer. This will close the Chart workspace and open the Data Explorer workspace.

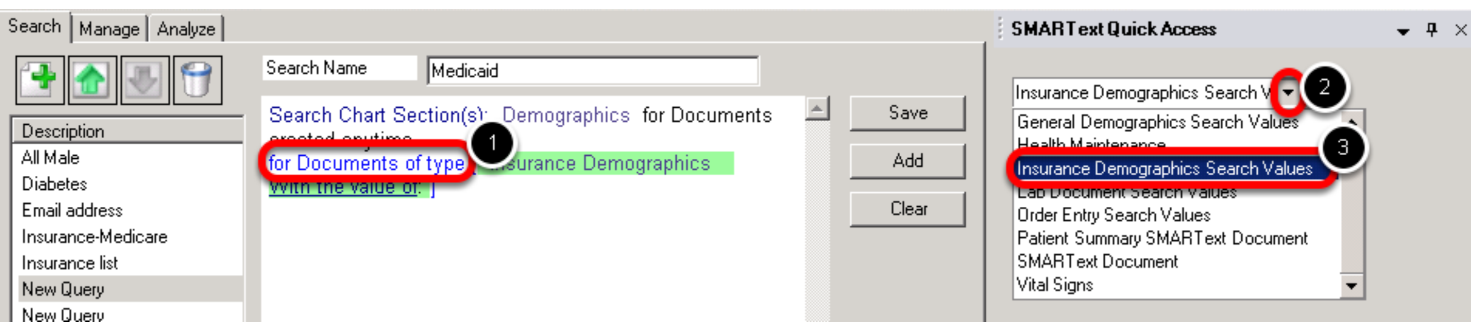
Creating a New Query



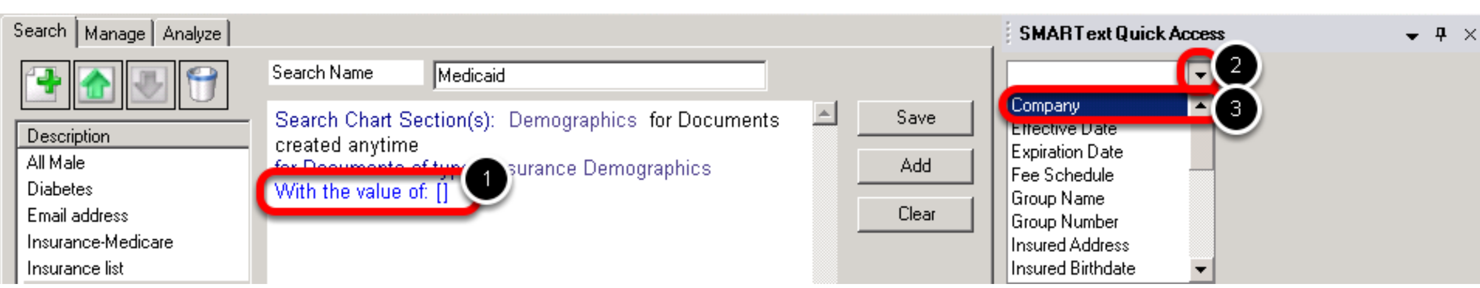
1. Click on the Green Plus button to create a new blank query.
2. Name the query.



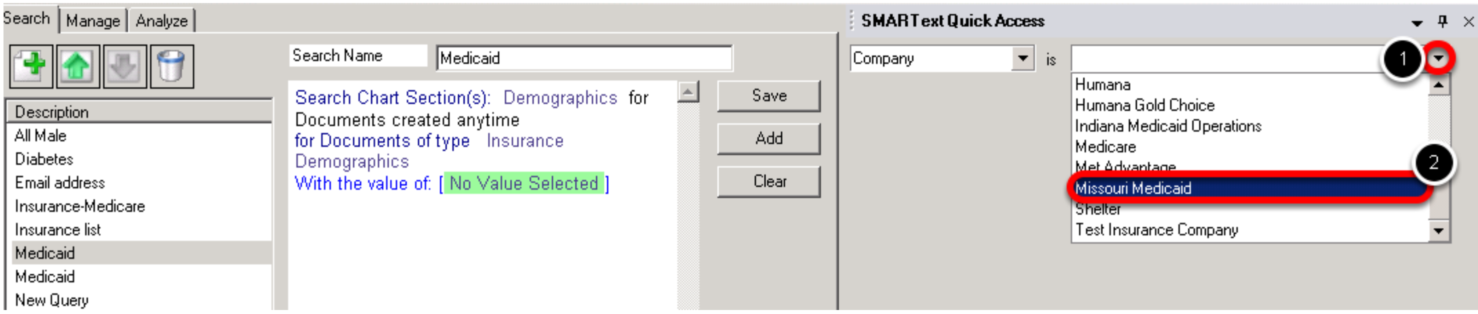
1. Click on "Search Chart Sections" to display a list of available chart section in the SMARText Quick Access window.
2. Un-check the "All Chart Sections" box.
3. Check Demographics.



1. Click on "for Documents of type."
2. Click on the drop-down menu in the SMARText Quick Access.
3. Select "Insurance Demographics Search Values."



1. Click on "With the value of."
2. Click on the drop-down menu in the SMARText Quick Access.
3. Click to select "Company."

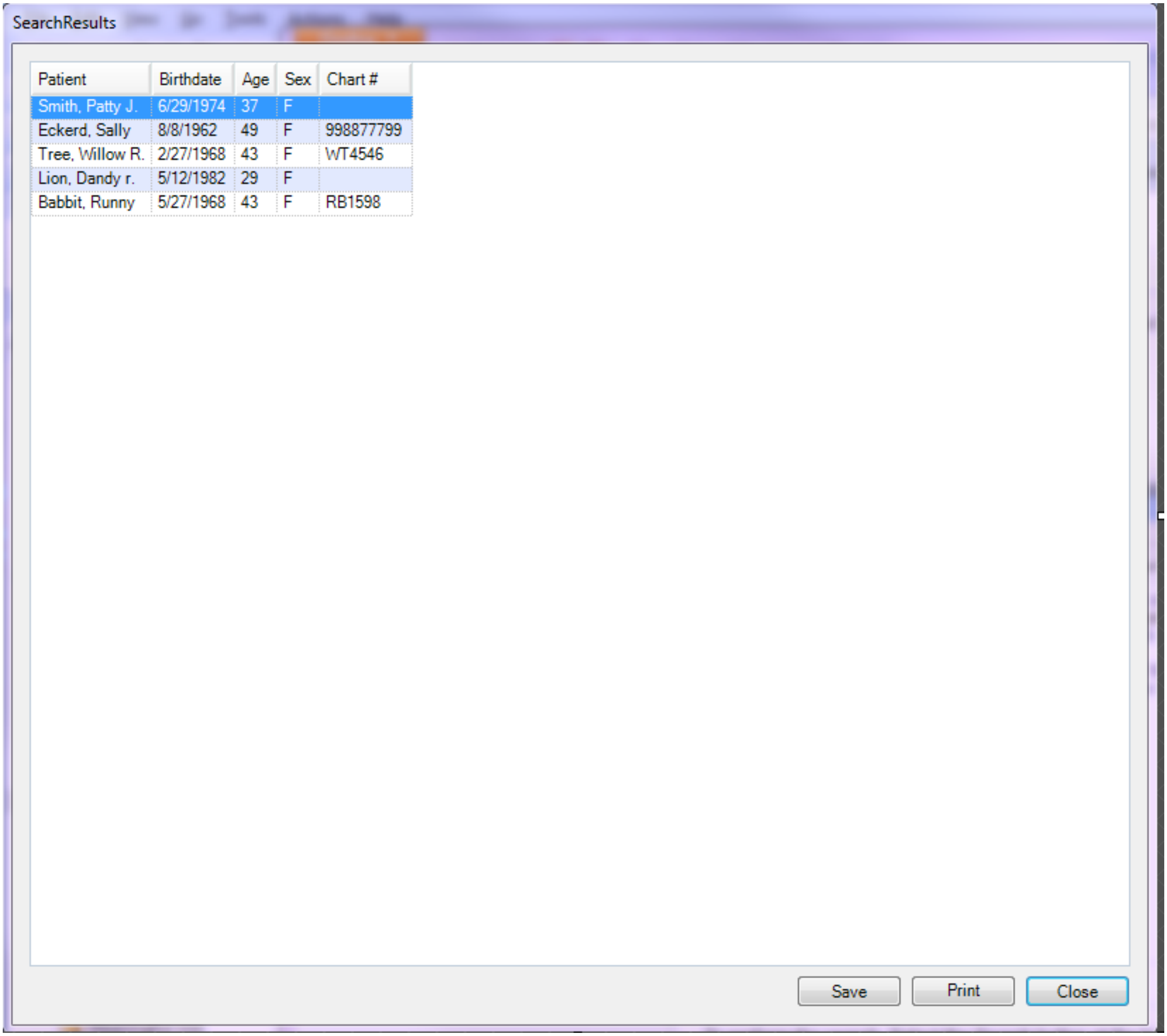


1. Click on the drop-down menu in the SMARText Quick Access
2. Choose the insurance you are searching for.

To begin searching the database, Click the Search button located in the bottom right hand corner of the Data Explorer workspace.

***Note:** Depending on the size of the users database, the search time can be lengthy. We recommend that you do not perform a data explorer search during clinic hours.*

Search Results



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.

Flow Sheets

Accessing & Creating Flow Sheets

Flow Sheets provide a graphical representation of various clinical data elements. They also help show how the data elements all relate to each other. For example, users may want to visually trace a patient's INR, Protime, A1C or a lipid panel.

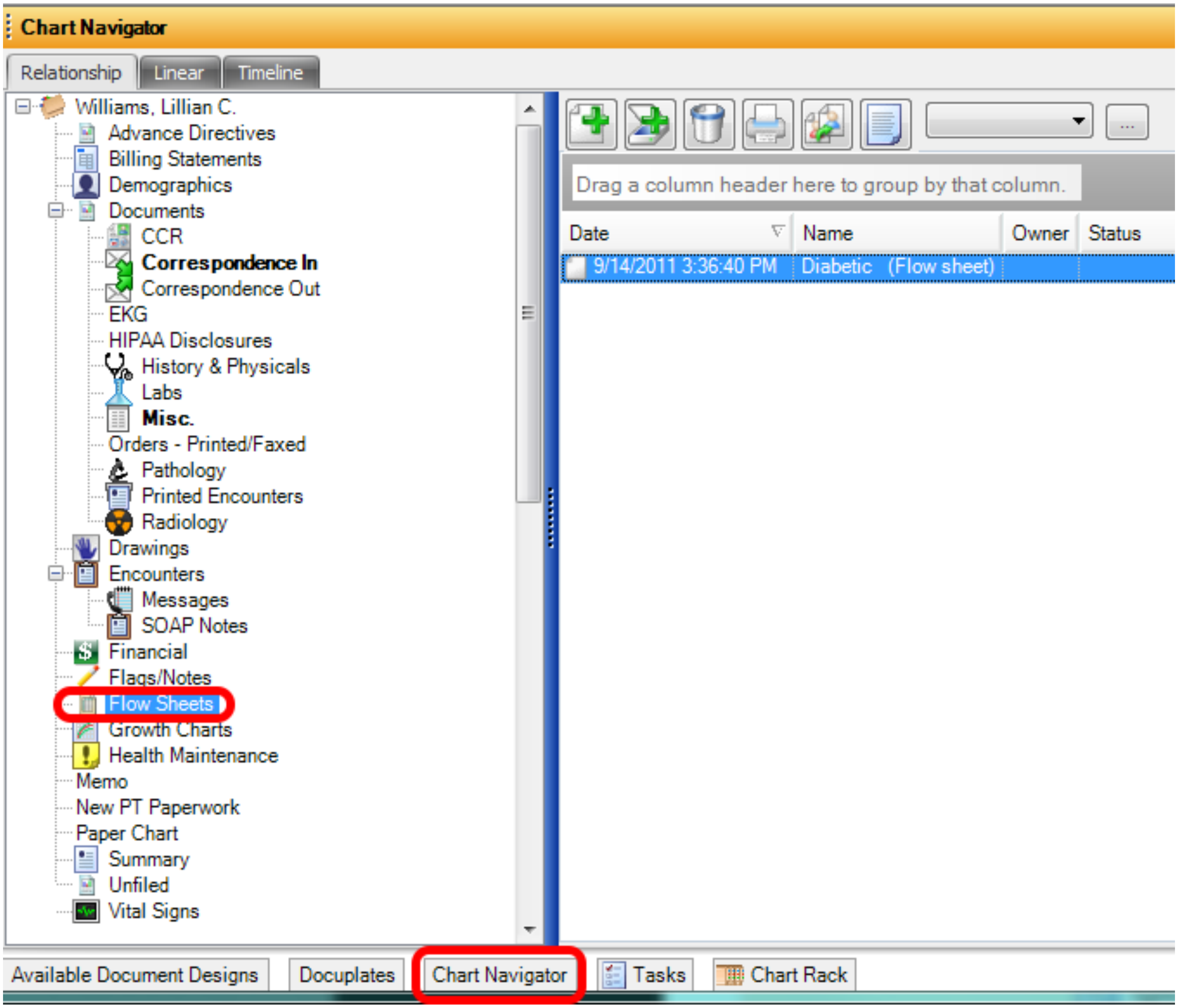
Notes

Flow Sheets in SOAPware are created as Docuplates, and can be found listed in the Docuplate Manager.

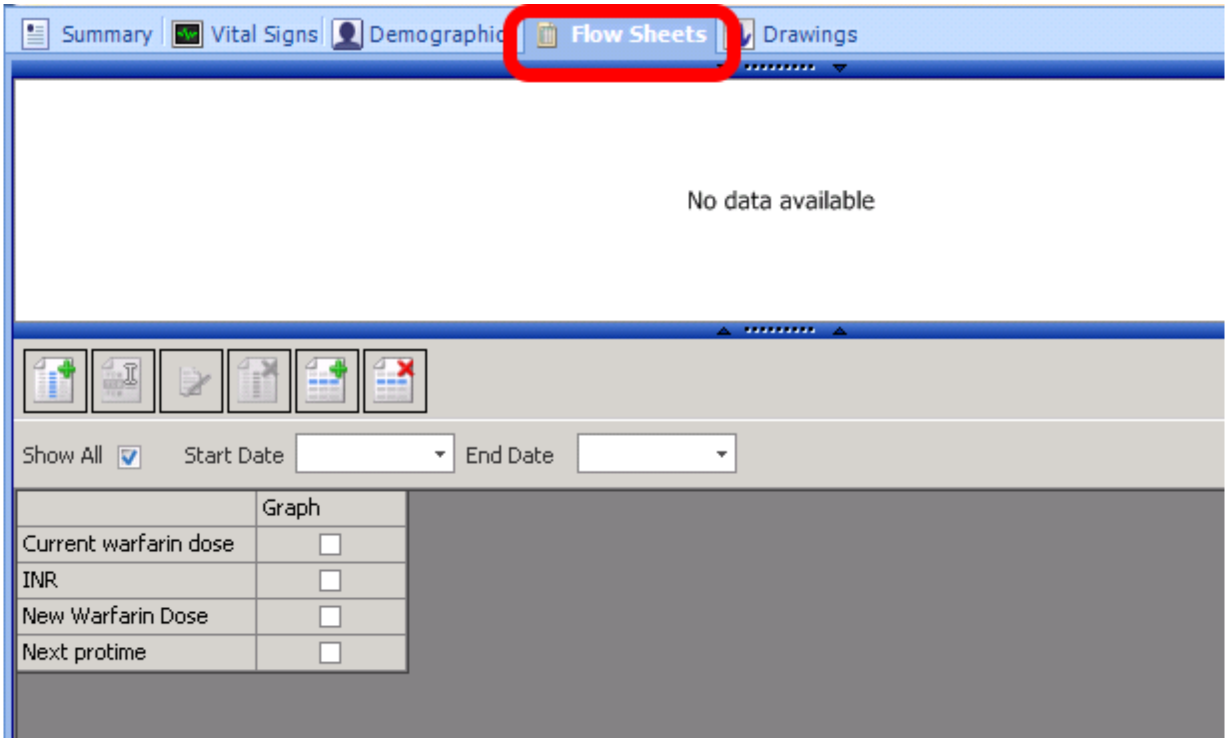
Plotting graphs has been greatly simplified in SOAPware. A check box has been added to each managed item, which when checked, automatically appears in a graph above the body of the Flow Sheet.

Certain Flow Sheet Items, such as vital signs readings and lab report values can be 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.

Opening the Flow Sheets Chart Section

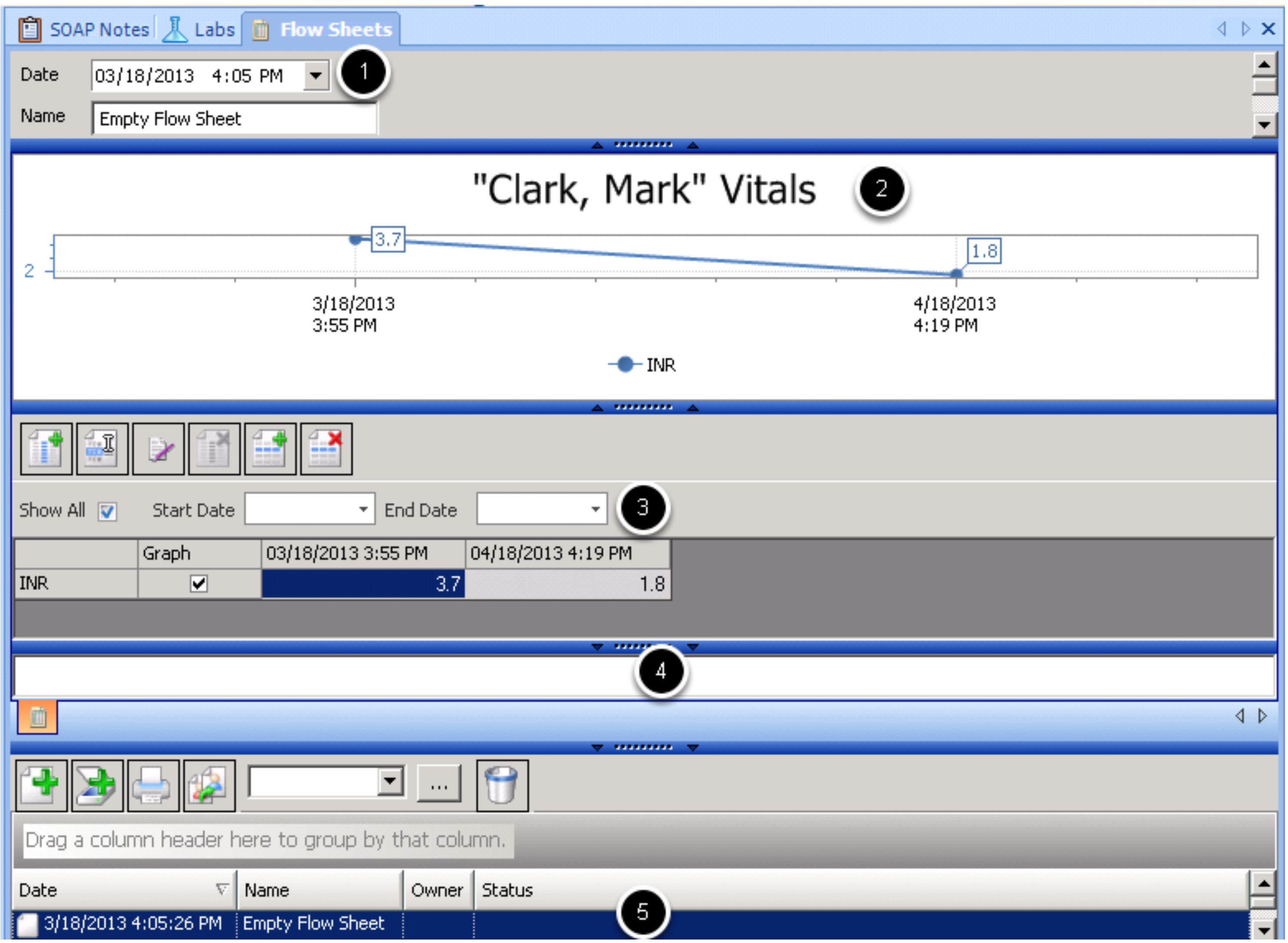


To access Flow Sheets, Click on the **Chart Navigator** Docked tab, then double click on **Flow Sheets.**



This presents the Flow Sheets chart section.

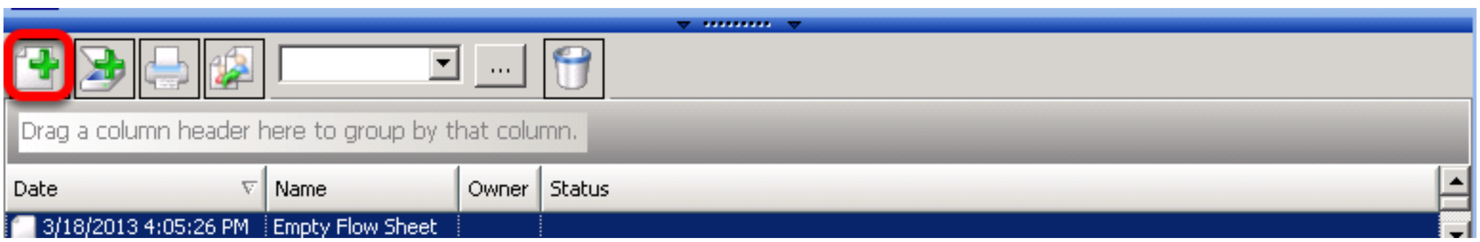
Flow Sheets Chart Section



1. **Date/Time Stamp:** This section contains the date/time stamp for when the flow sheet was created, the name of the flow sheet, owner and status.
2. **Graph:** This section displays a graph of the flow sheet items when selected. Remember that you will need a Numeric Item type in order for the numbers entered to graph correctly. For more information see: **Creating Flow Sheet Items**.
3. **Flow Sheet Items/Filter:** This section contains the flow sheet items along with the date and time of the flow sheet items and the mini-toolbar which allows the user to edit the displayed flow sheet. This section also contains a filter option where a user can limit the view of readings for a patient by putting in a start and end date, or check the "Show All" feature to display all readings for a patient for a particular test.

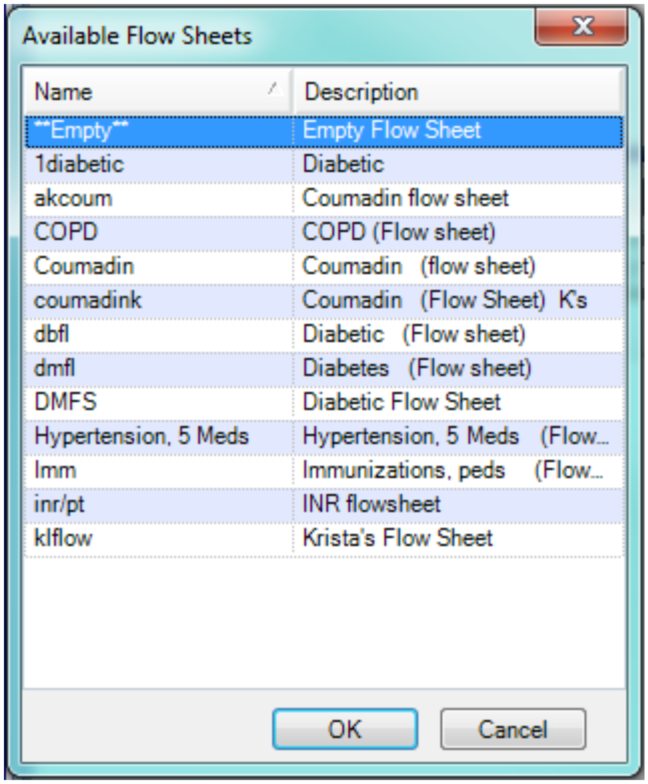
4. **Notes:** This section can be used as a blank text box to insert notes.
5. **Flow Sheet List:** This section contains the list of Flow Sheets that are being followed for the current patient, as well as the mini-toolbar which allows the user to add or remove a flow sheet.

Creating a New Flow Sheet within a Patient's Chart



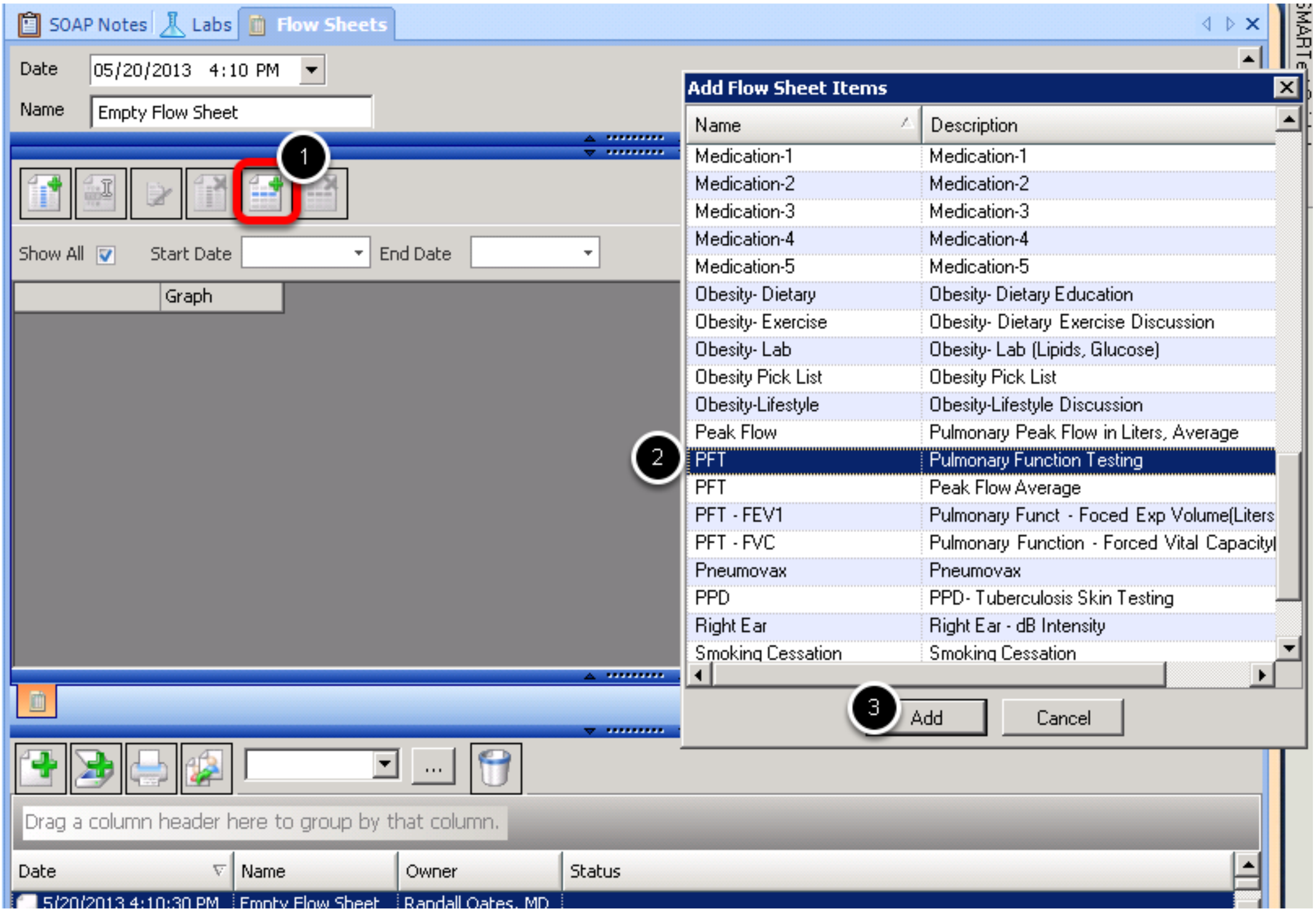
To create a new flow sheet within a patients chart, Click the **Create Docutainer** button (green plus).

Select an Available Flow Sheet



The Available Flow Sheets dialog will present the user with a list of Flow Sheet docuplates that have been created or downloaded by the user. Select the desired flow sheet docuplate or select the Empty Flow Sheet item to create a new flow sheet. Click OK.

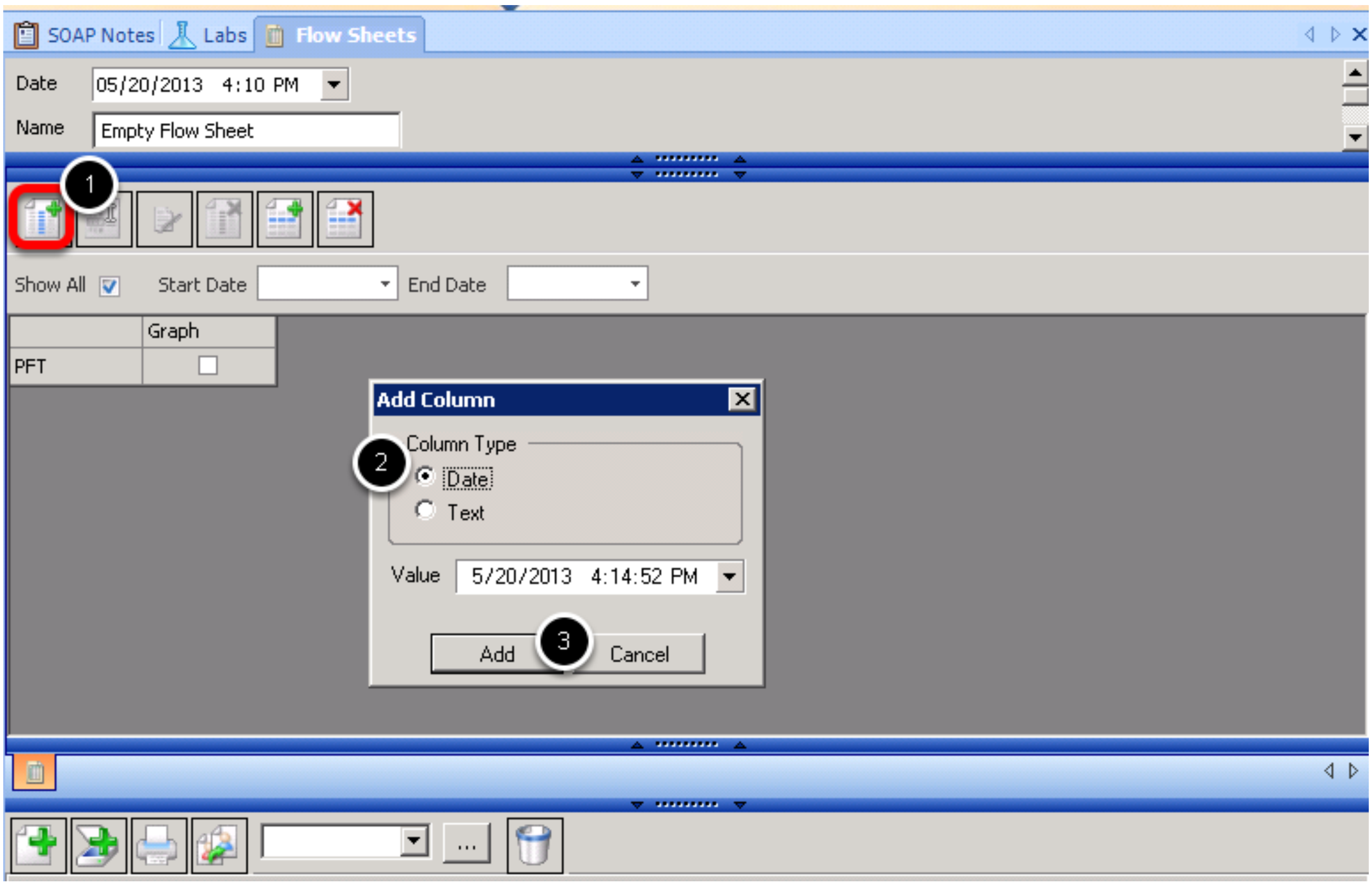
Adding a Flow Sheet Item to the Chart



To add a new item to the flow sheet:

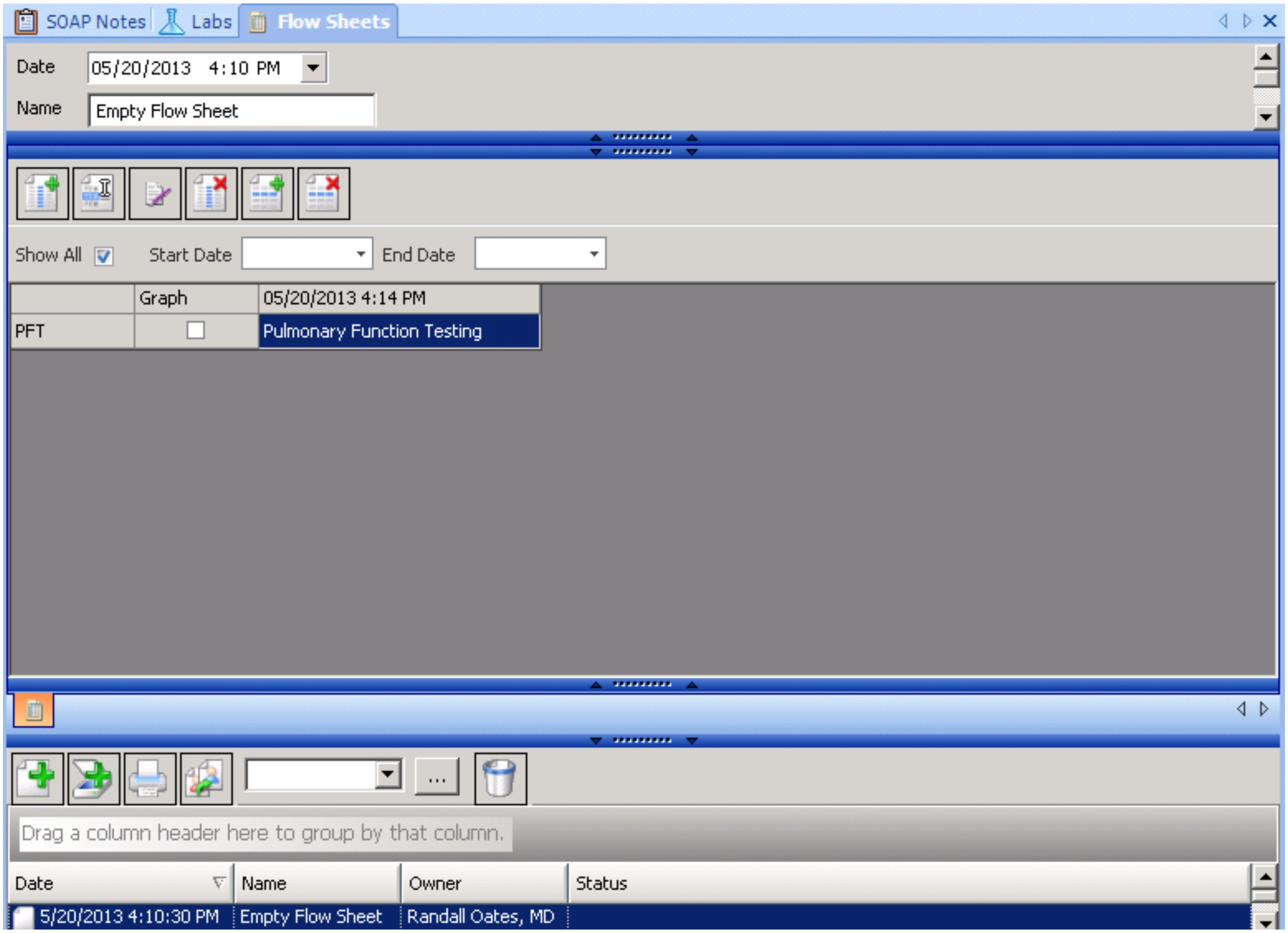
1. Click the Add Item button
2. Select the desired flow sheet item (ex: PFT)
3. Click the Add button

Adding a Flow Sheet Reading Date



To add a new reading date to the flow sheet:

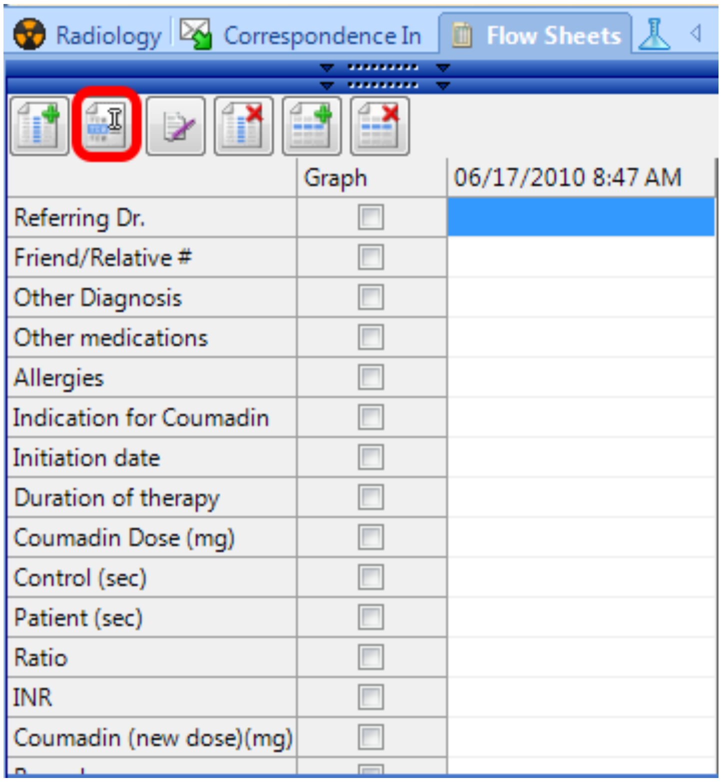
1. Click the Add Reading Date button
2. Select the desired column type (Date or Text)
3. Click Add



The patient's flow sheet readings can now be documented and tracked within the chart.

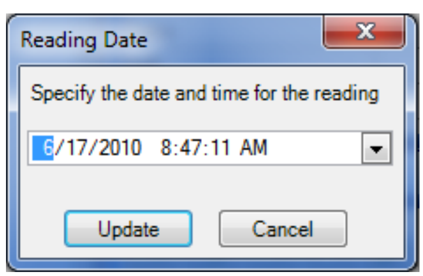
Using Flow Sheets

Editing a Flow Sheet Reading Date or Column Header



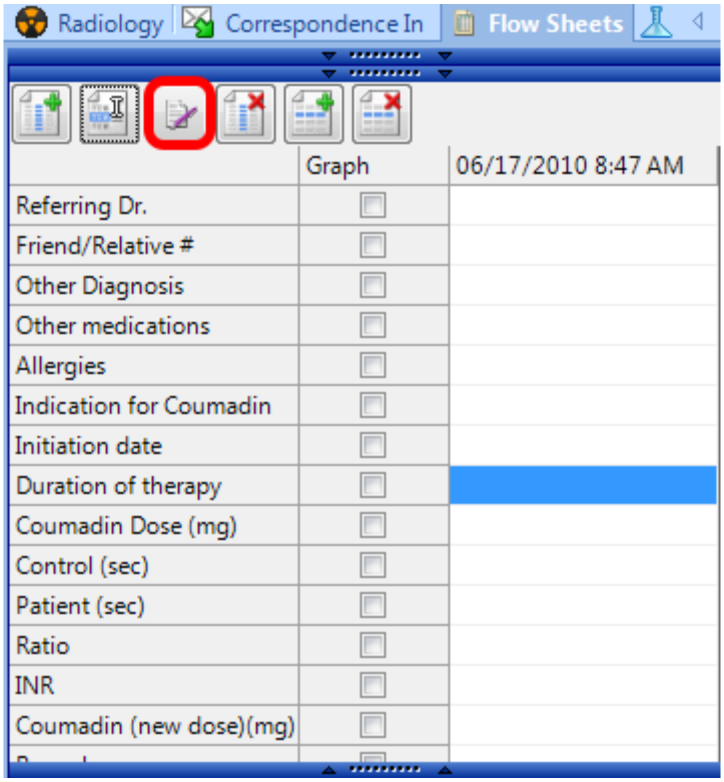
To edit the Reading Date for a column, first select the column to edit by Clicking on it. Then, Click the Edit Reading Date Button (or Press Ctrl + Alt + E).

Reading Date



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.

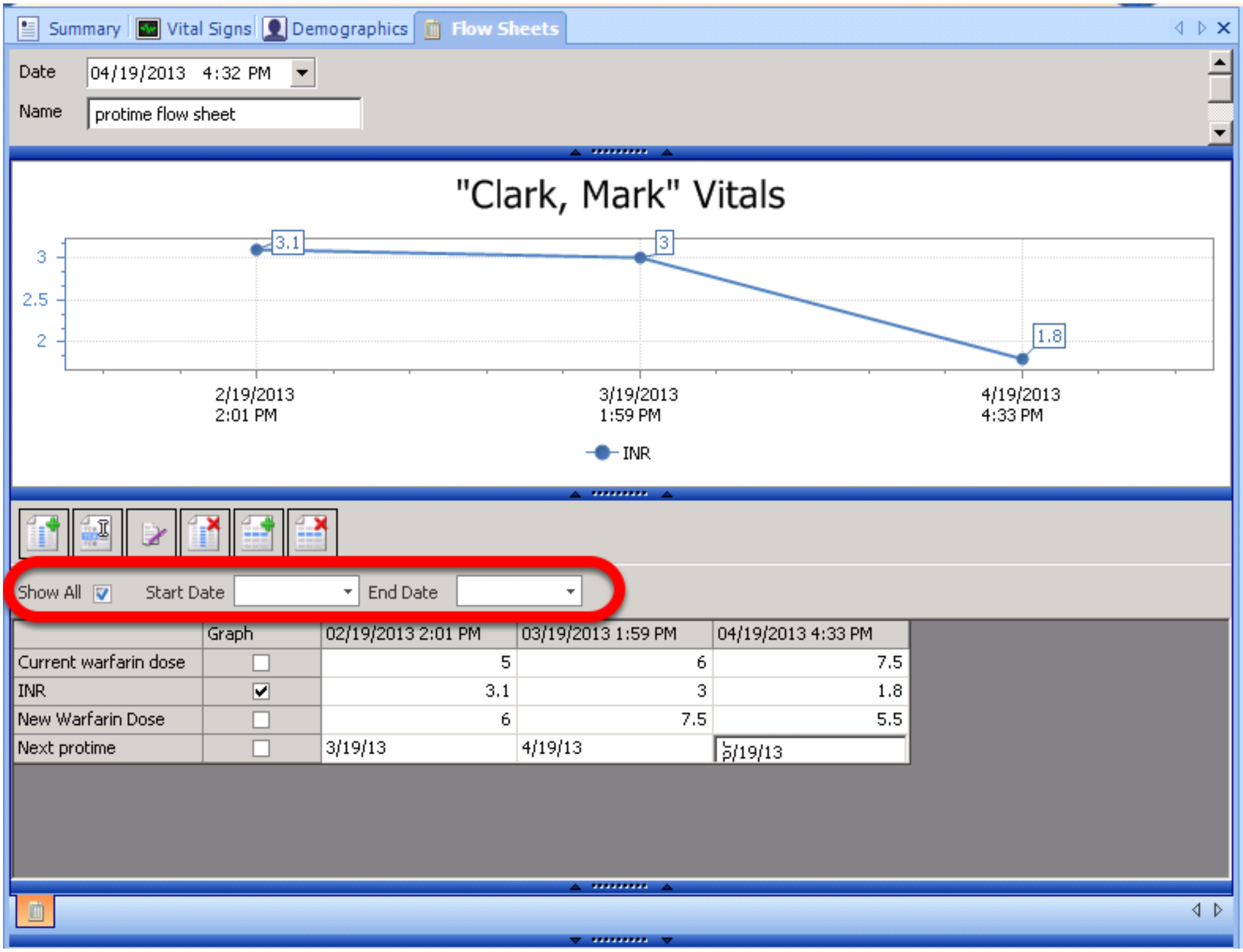
Signing Off on a Flow Sheet Reading Date



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).

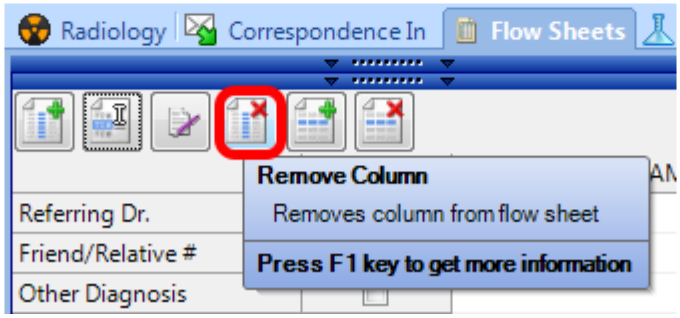
SOAPware will display the Sign Column dialog box and ask the user to confirm that he/she wishes to sign off on the Reading Date. Click Yes if certain, and the Reading Date will be signed off.

Filtering a Flow Sheet



Auser has the option of filling in a start date and an end date to filter his or her view of a patient's flow sheet readings based on the date parameters set. Auser can also check the box next to "Show All" to display all of the patient's flow sheet readings.
Auser also has the option of changing the view of the graph within flow sheets, depending on what filter options have been specified.

Removing a Flow Sheet Reading Date or Text Column

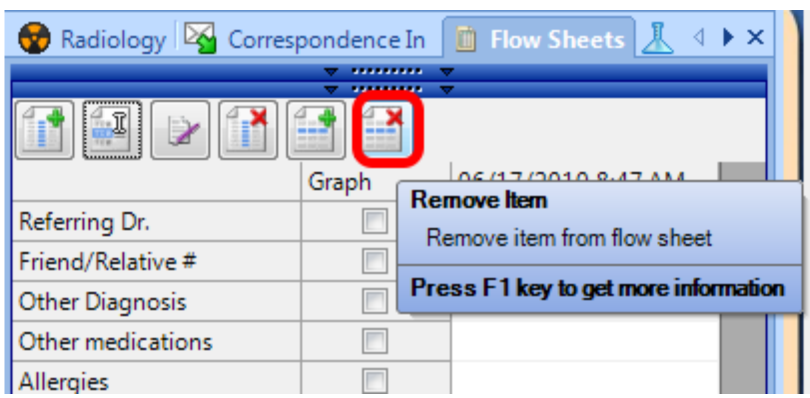


To remove a Reading Date or Text Column from a Flow Sheet, first select the Reading Date or Text Column to remove by Clicking on it in the Flow Sheet. Then, Click the Remove Reading Date Button (or Press Ctrl + Alt + R).

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.

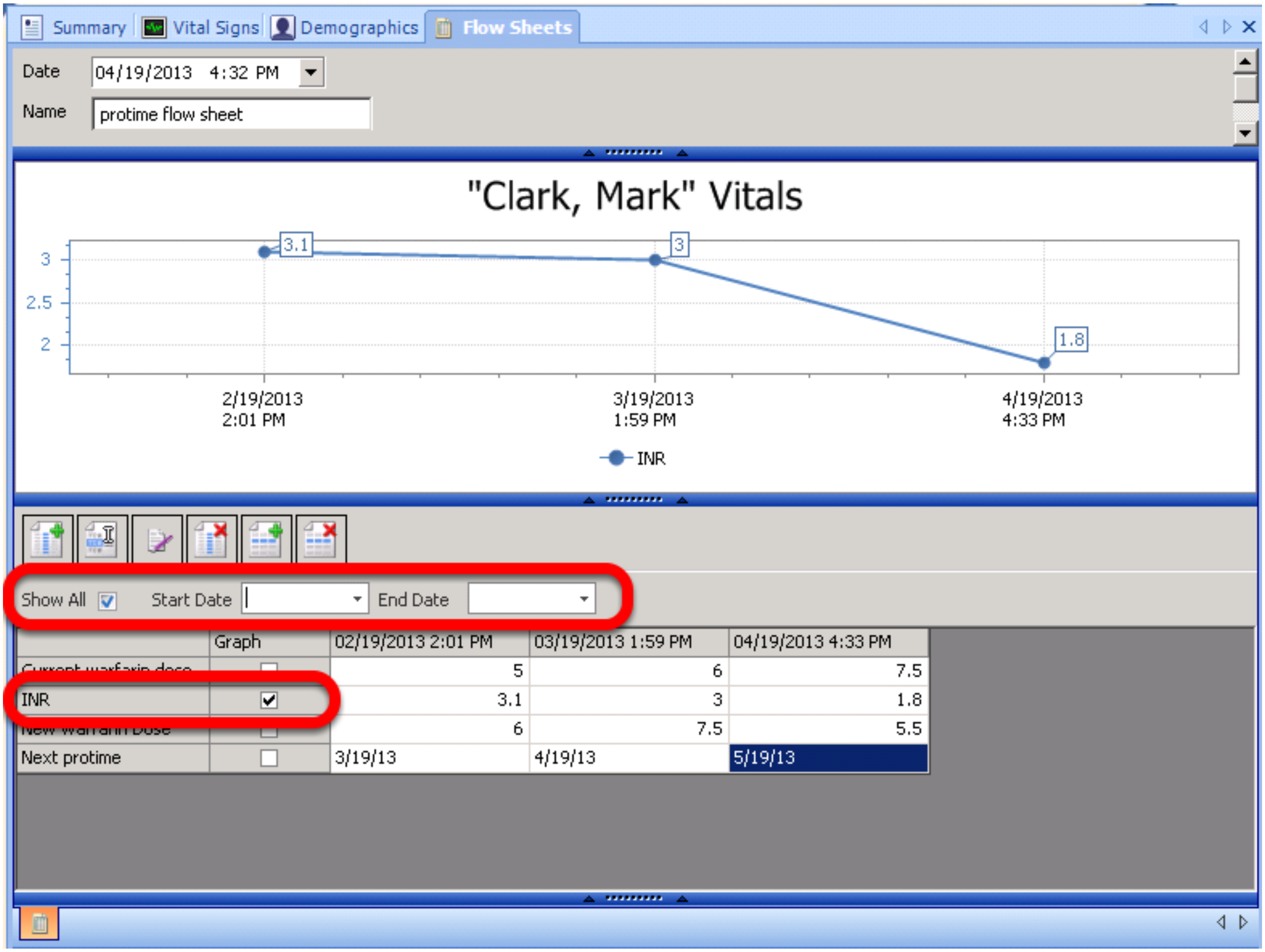
Removing a Flow Sheet Item from the Flow Sheet



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



A user has the option of changing the view of the graph within flow sheets, depending on what filter options have been specified (whether that be a start and end date set, or the "Show All" box checked to show all the flow sheet data readings for a patient).

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.

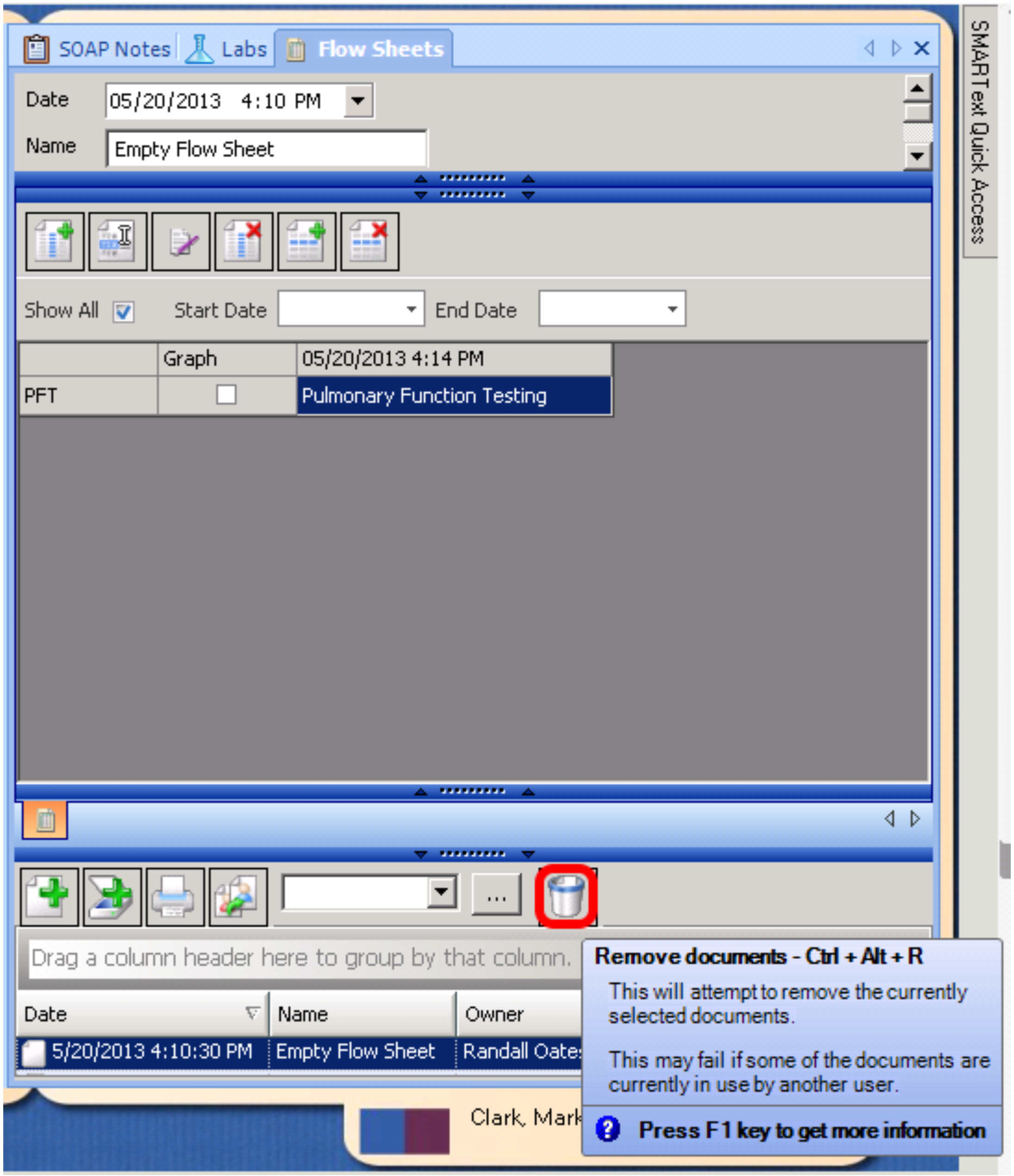
Hovering over any part of a particular line on the graph will bring the entire line forward and fade the others into the background. This allows the user to easily view the graph for a particular vital sign, without having to un-select the other graphed readings.

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.

***Note: Users must select a reading with multiple reading dates in order to view a graph of the selected vital sign(s).**

If several flow sheet items 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.

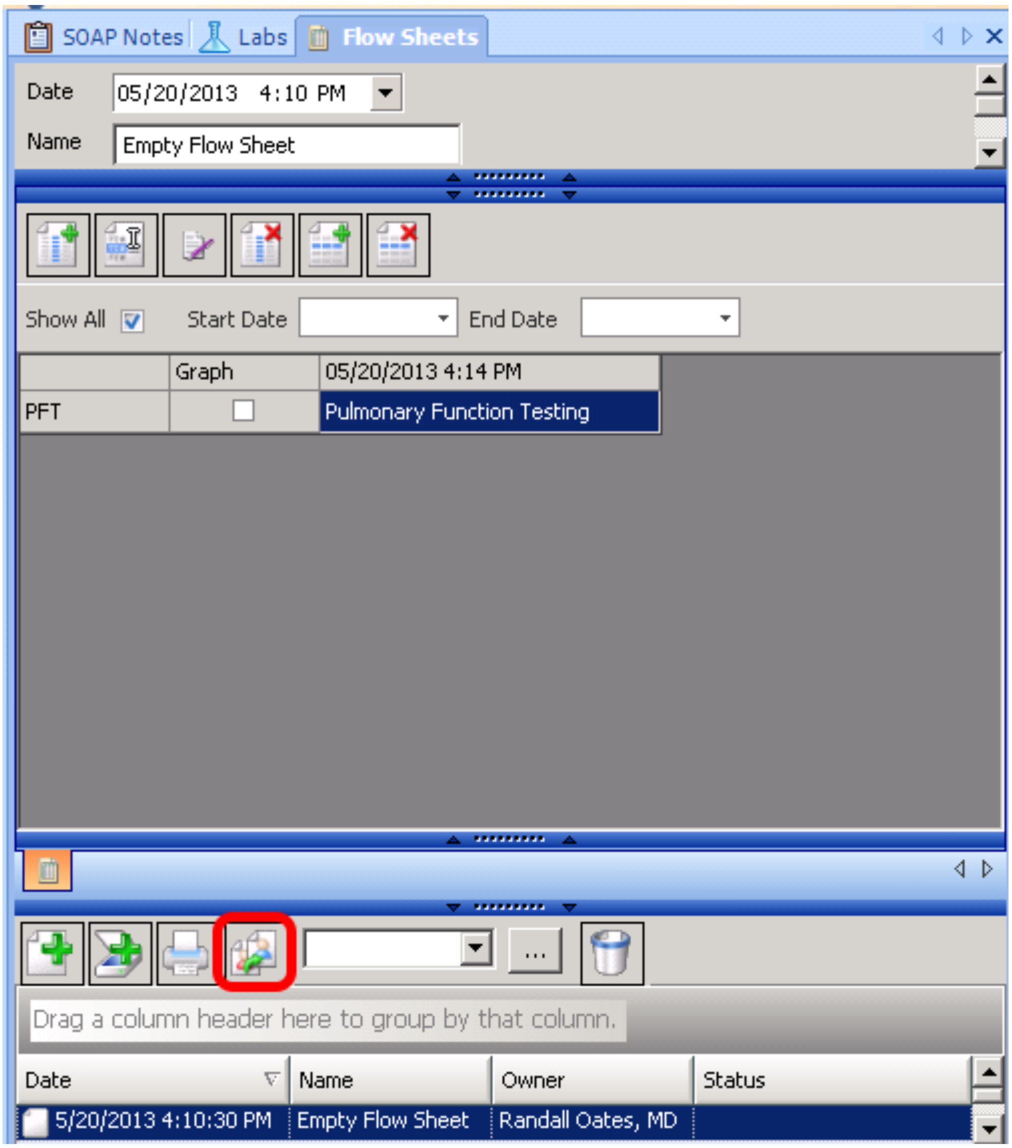
Removing a Flow Sheet from the Patient Chart



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.

Reassigning a Flow Sheet

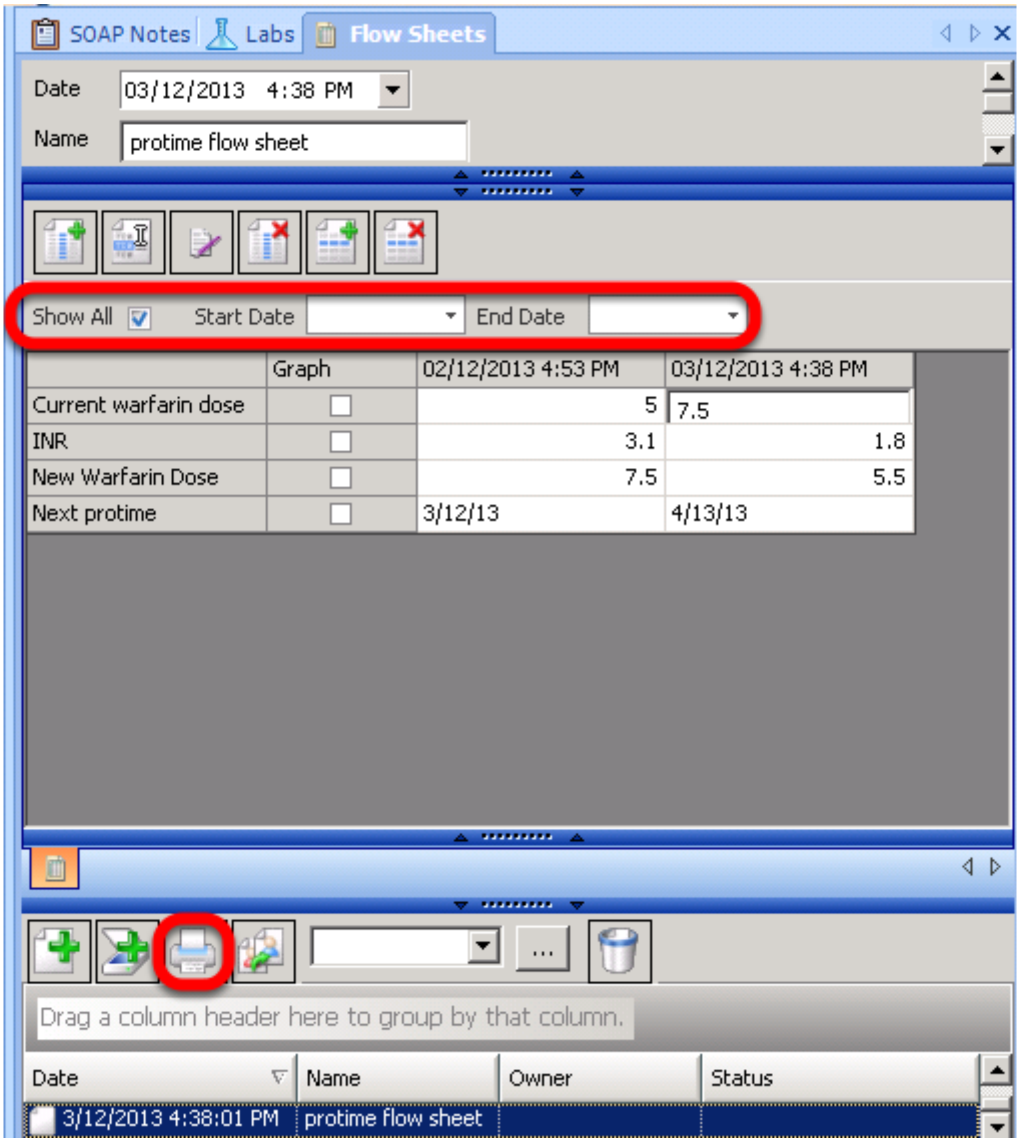


To reassign a Flow Sheet, select the Flow Sheet to reassign and Click the Reassign Documents Button (or press Control + Alt + R).

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.

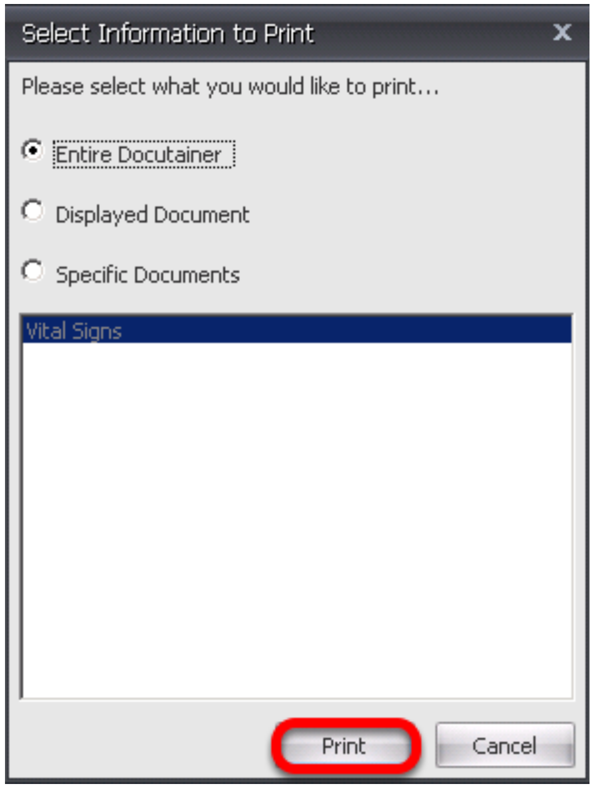
Printing Flow Sheets

Filter Settings



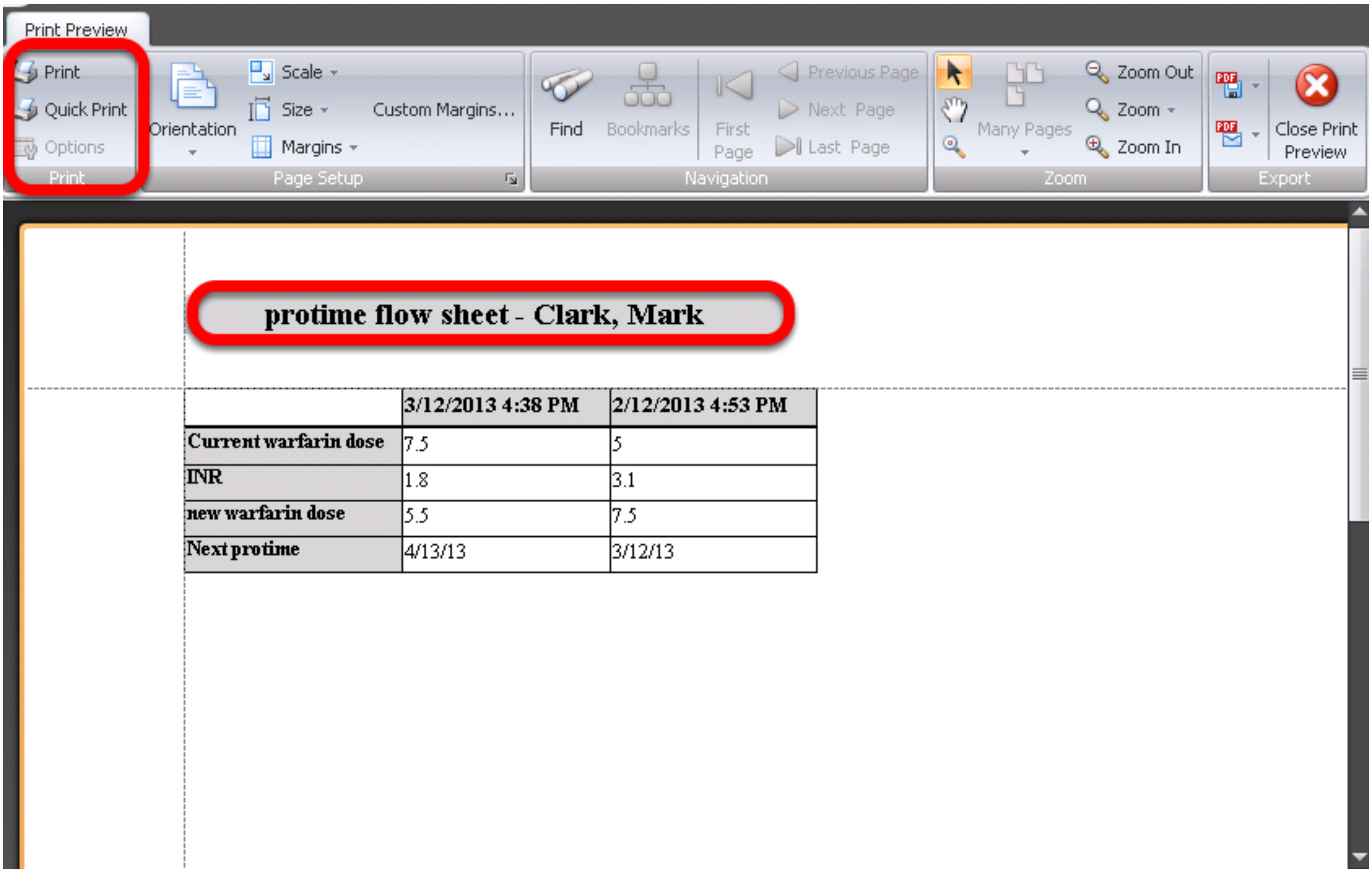
The filter options specified at the top of the flow sheets chart section ("Show All" has been selected in this screenshot), will determine what will print when a user selects the flow sheet to print by clicking on it in the Flow Sheets list, then clicking on the print button found under the lower splitter bar (or Press Ctrl + Alt + P).

Select Information to Print



Auser will be prompted to select if he or she would like to print the entire docutainer, the current displayed document, or specific documents. The entire docutainer option will be the default for printing. Once the user selects what will be printed from the three options, Click Print.

Print Preview- Print Options



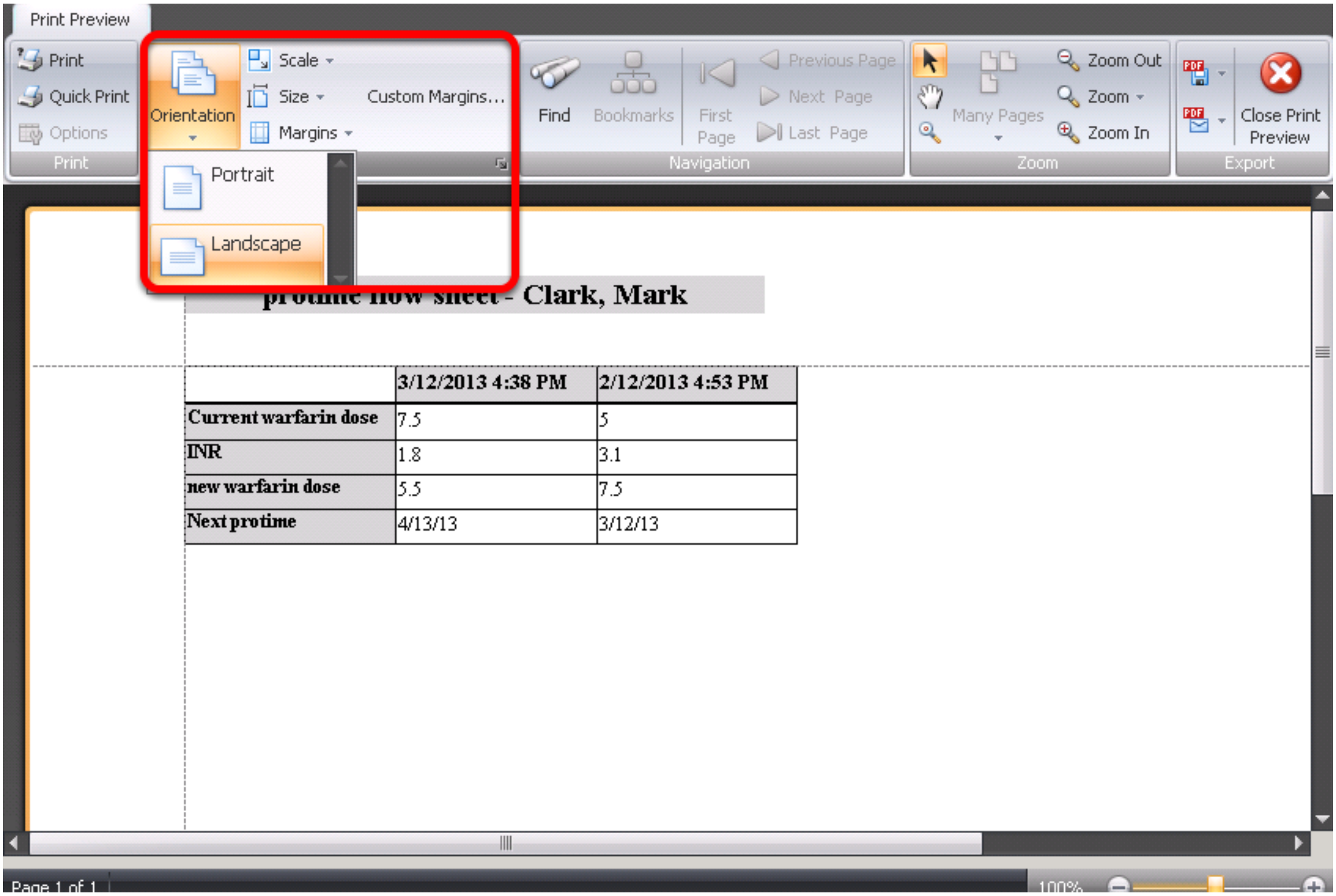
	3/12/2013 4:38 PM	2/12/2013 4:53 PM
Current warfarin dose	7.5	5
INR	1.8	3.1
new warfarin dose	5.5	7.5
Next protime	4/13/13	3/12/13

Print- Auser can select a printer, number of copies, as well as select a few other printing options.

Quick Print- Auser has the option to set a default printer so that he/she can quickly send a document to a specified printer.

***Note**: There is a header at the top of the information displayed, which indicates we are looking at a protime flow sheet in particular (which is the name of the actual flow sheet docutainer), as well as gives the patient's name.

Print Preview- Page Setup



Orientation- Auser has the option of selecting portrait or landscape prior to printing the flow sheets document. Landscape will be the default.

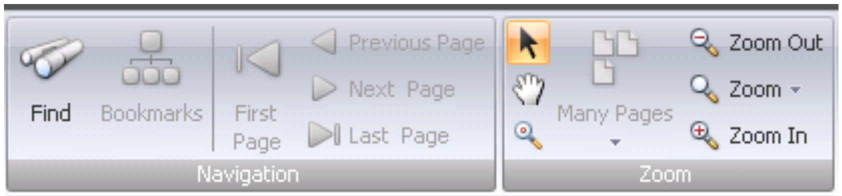
Scale- Stretch or shrink the information displayed on the document.

Size- Select the paper size.

Margins- Select the margin sizes for the entire document.

Custom Margins- Auser has the option to indicate custom margin sizes for the entire document.

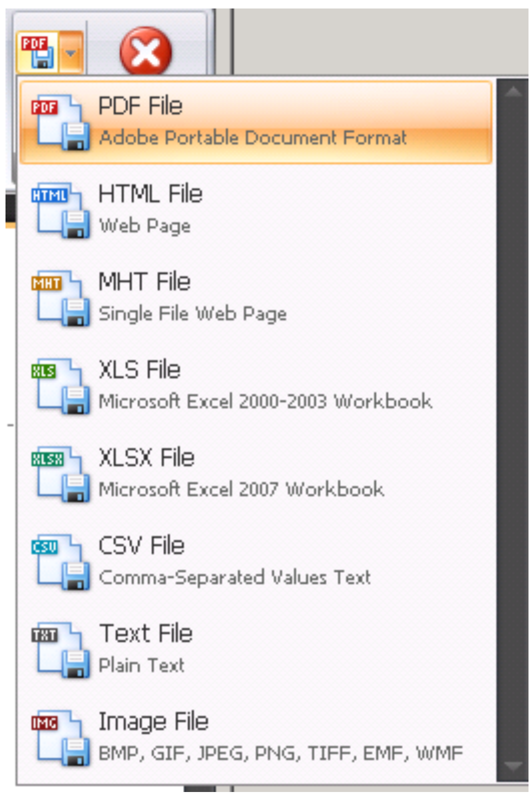
Print Preview- Navigation and Zoom



Navigation- Auser is able to quickly navigate between pages of a docutainer should there be multiple.

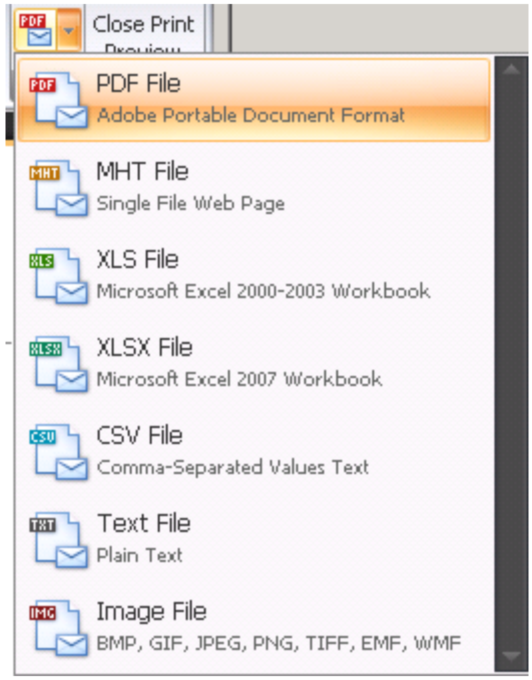
Zoom- Auser is able to zoom in, out, specify a percentage to zoom the document to, as well as utilize the magnifier and hand tools.

Print Preview- Export to



Auser has several options of the export type he or she would like to perform.

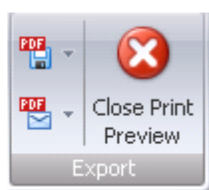
Print Preview- Email to



A user has numerous file types he or she can convert a document to before emailing.

**__Note__: Please ensure that a recipient's email address is HIPAA Compliant prior to sending Patient Health Information.*

Print Preview- Close

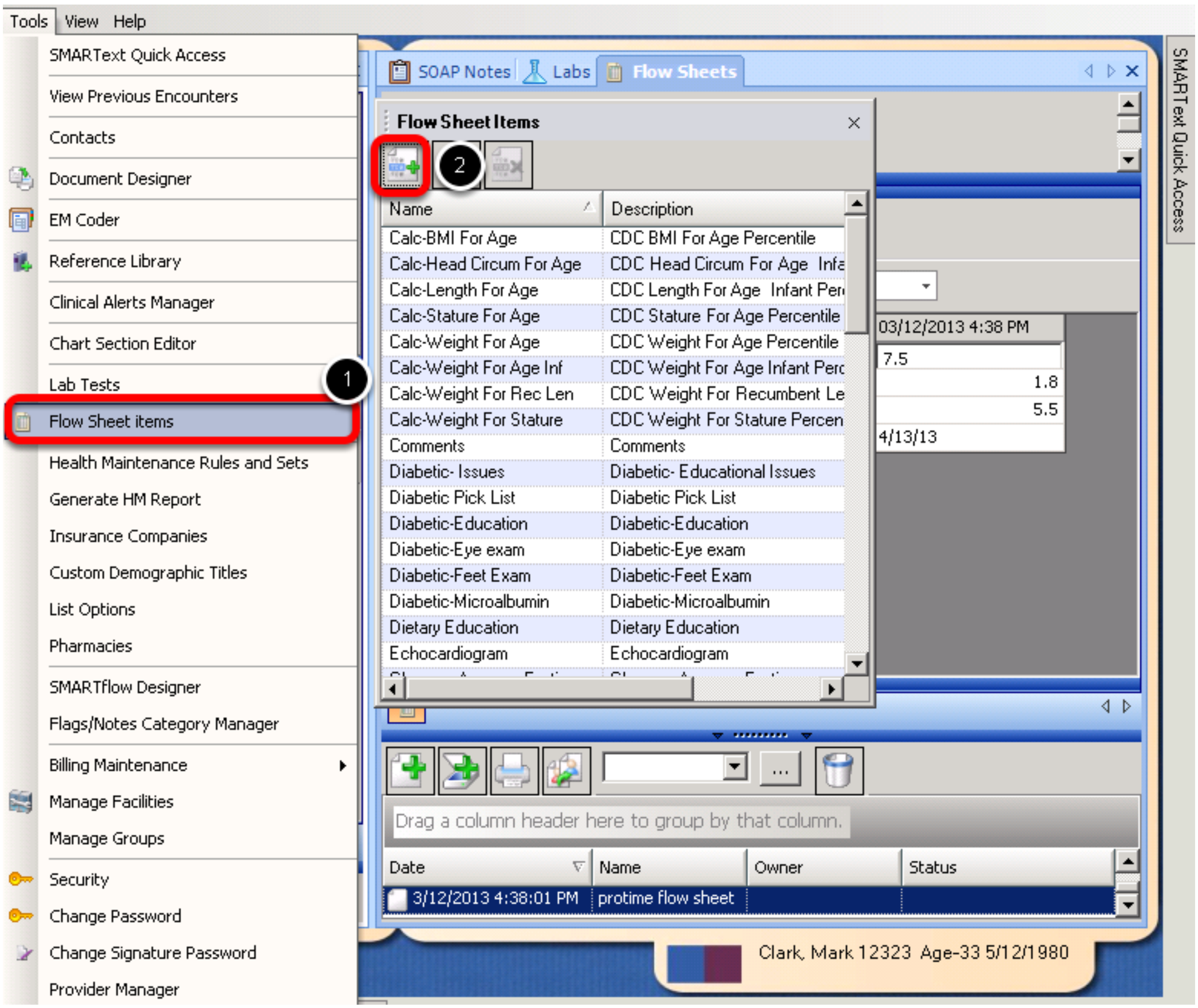


A user can close out of the print preview window at any time by clicking the red X.

Creating Flow Sheet Items

Flow Sheet items can be created in SOAPware.

Creating a New Flow Sheet Item



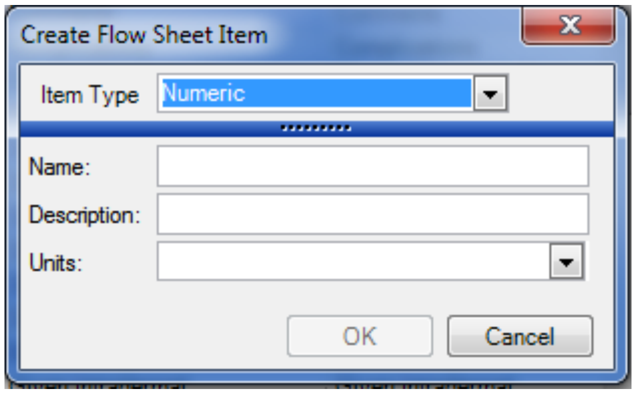
To create a new flow sheet item:

1. Click Tools > Flow Sheet Items

2. Click the Add Item button (or Press Ctrl + Alt + N).

There are four types of flow sheet items that can be created. They are Numeric, Pick List, Start/Stop, and Text. The following are instructions for creating an item of each type.

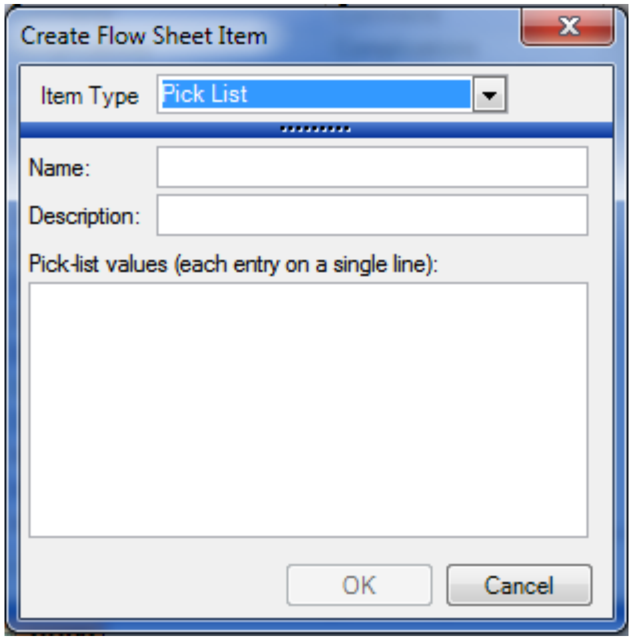
Creating a Numeric Flow Sheet Item



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.

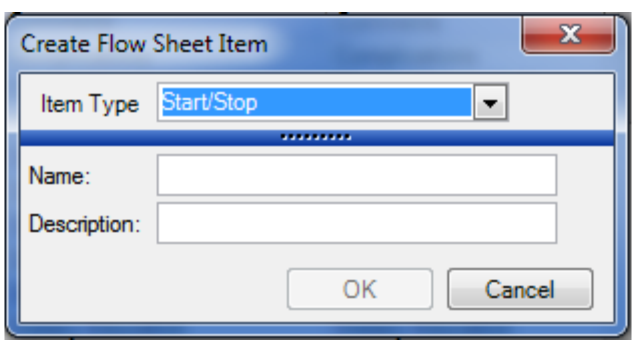
Creating a Pick List Flow Sheet Item



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.

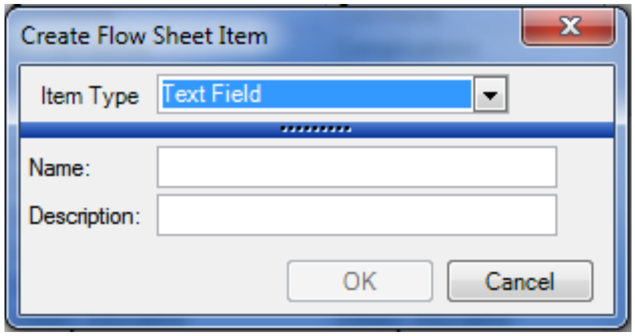
Creating a Start/Stop Flow Sheet Item



Give the new Start/Stop item a name and a short description.

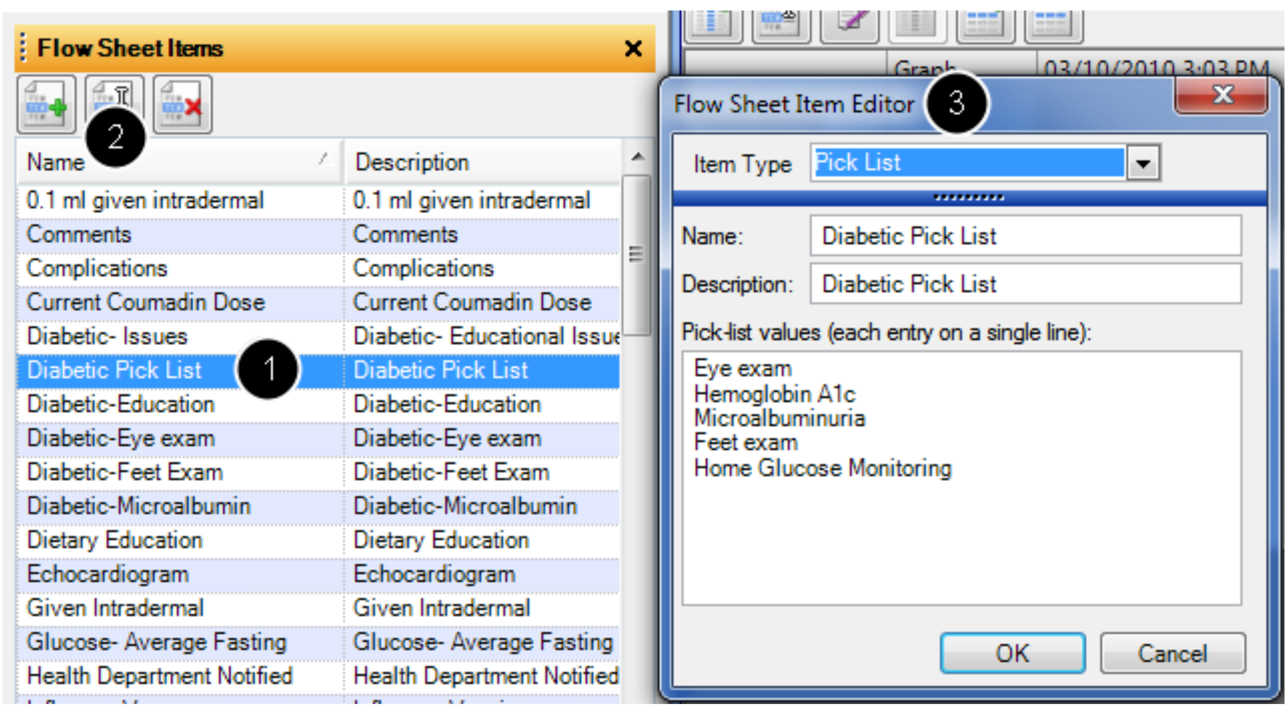
When completed, Click OK. The new item will be added to the list of available Flow Sheet Items.

Creating a Text Field Flow Sheet Item



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.

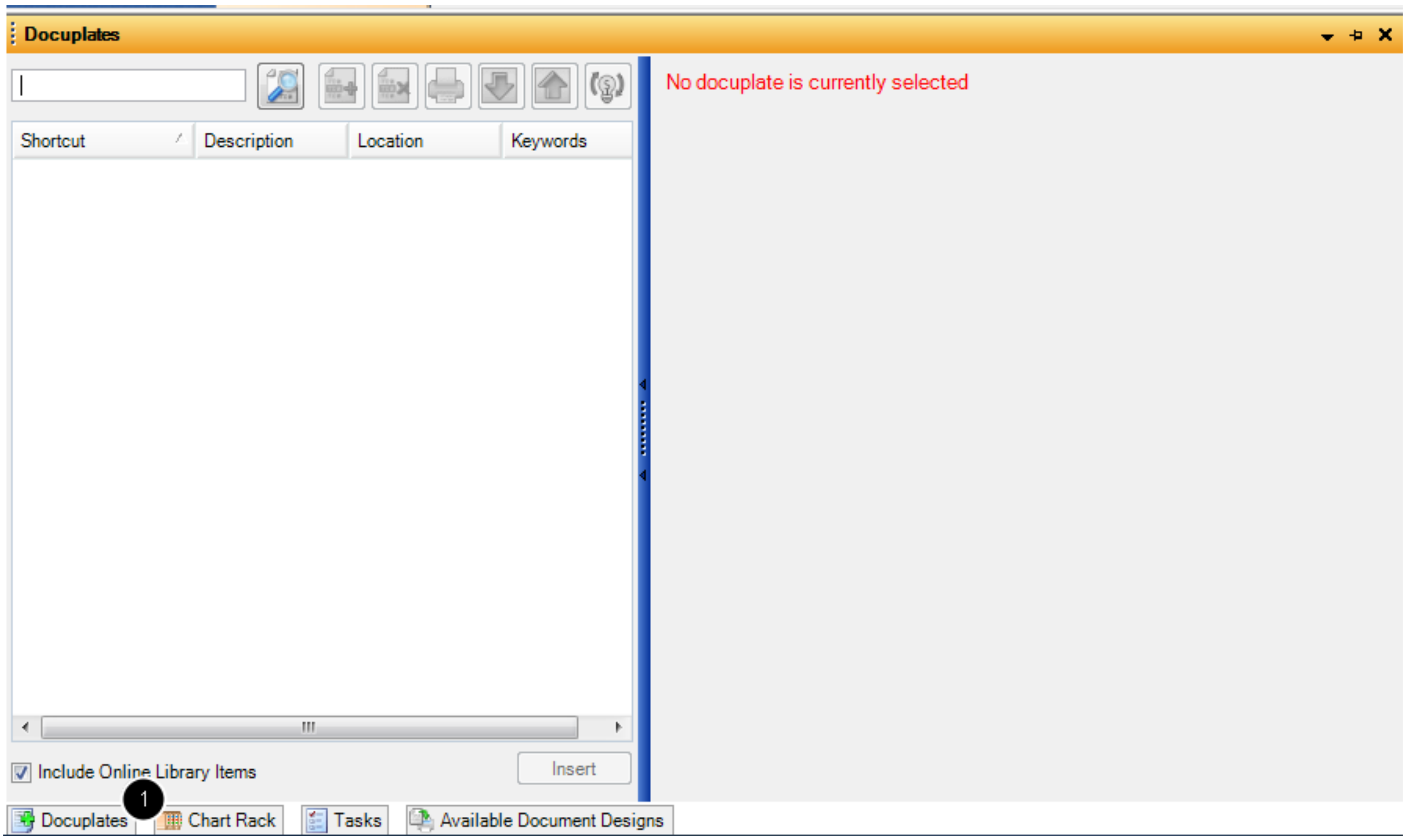
Editing an Existing Flow Sheet Item



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 New Flow Sheet Docuplate

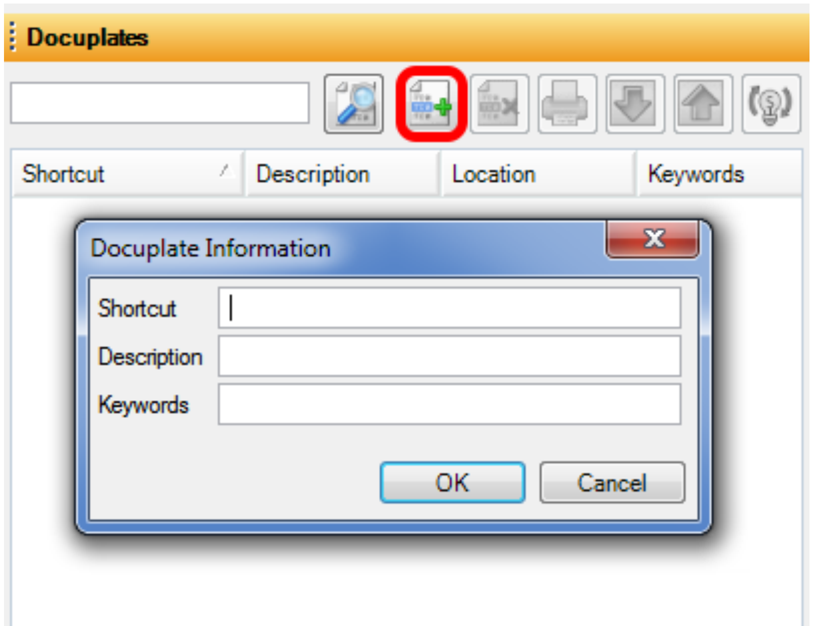
Creating a New Flow Sheet in the Docuplate Manager



To create a new Flow Sheet Docuplate:

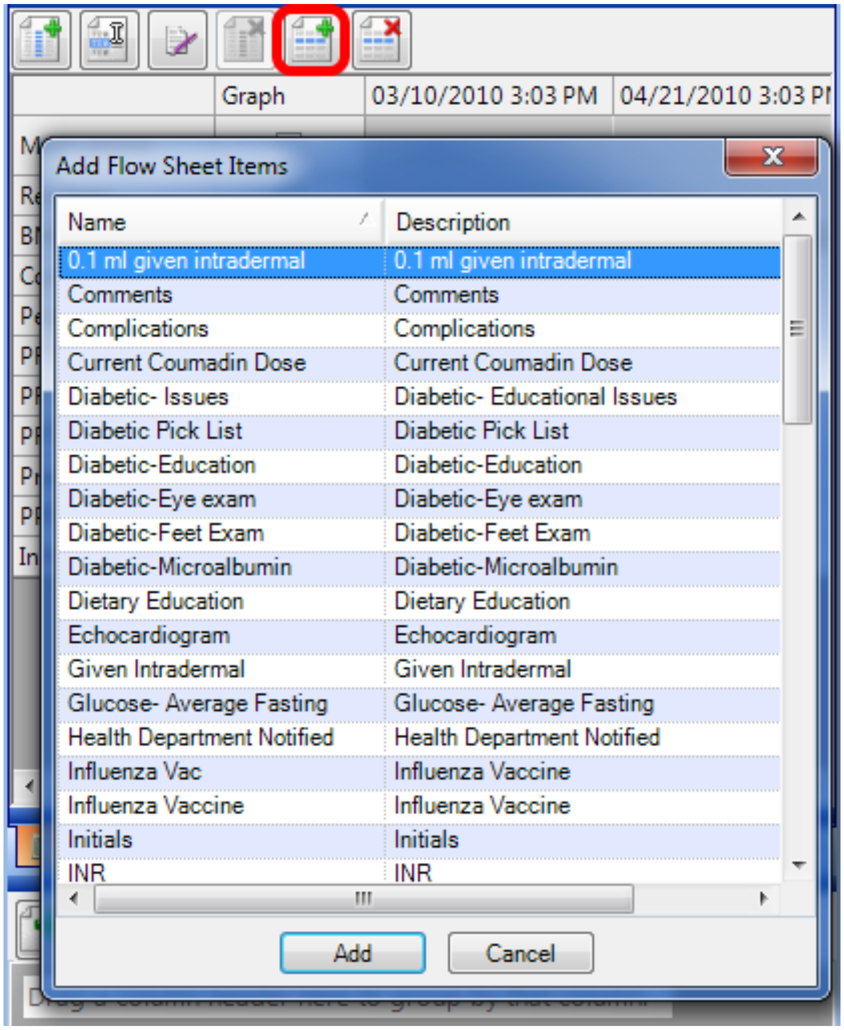
1. Open the Docuplates window by click on the Docuplates Docked Tab or by pressing F6 on the keyboard

New Docuplate



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



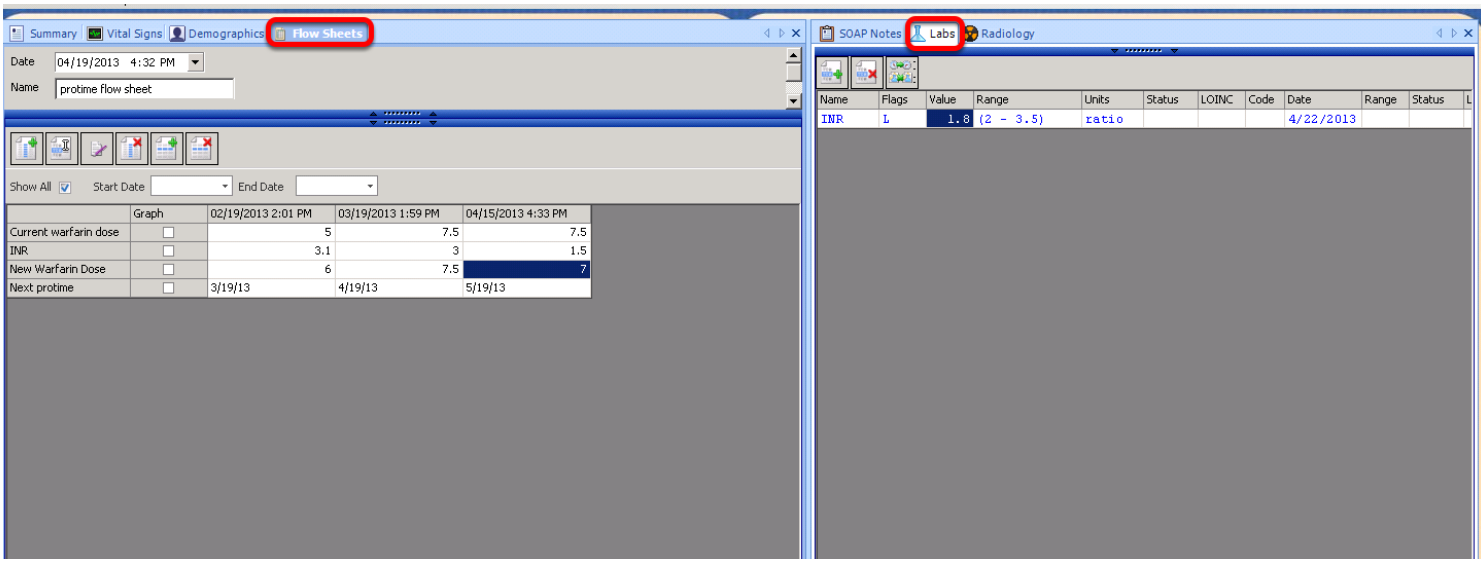
To insert Flow Sheet Items for a new Flow Sheet, Click the Insert Flow Sheet Items Button (or Press Ctrl + Alt + I). This will open the Add Flow Sheet Items dialog box.

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 Lab Flow Sheet

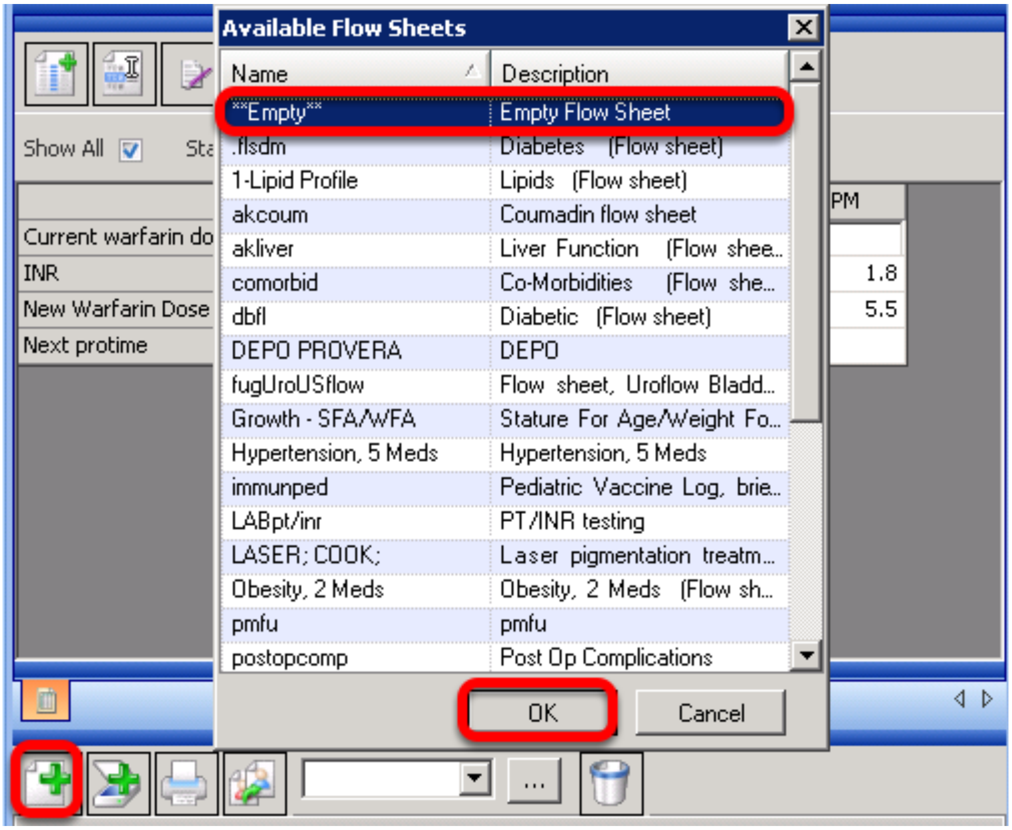
This lesson will show users how to create a lab Flow Sheet for tracking and graphing labs.

Open Flow Sheets and Lab Chart Sections



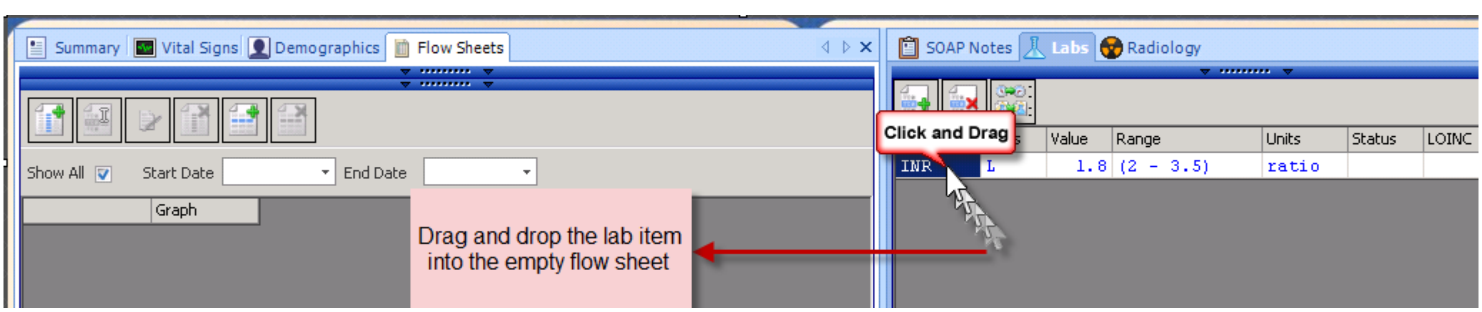
Open the Flow Sheets and Lab chart sections in a patient's chart.

Create a New Empty Flow Sheet

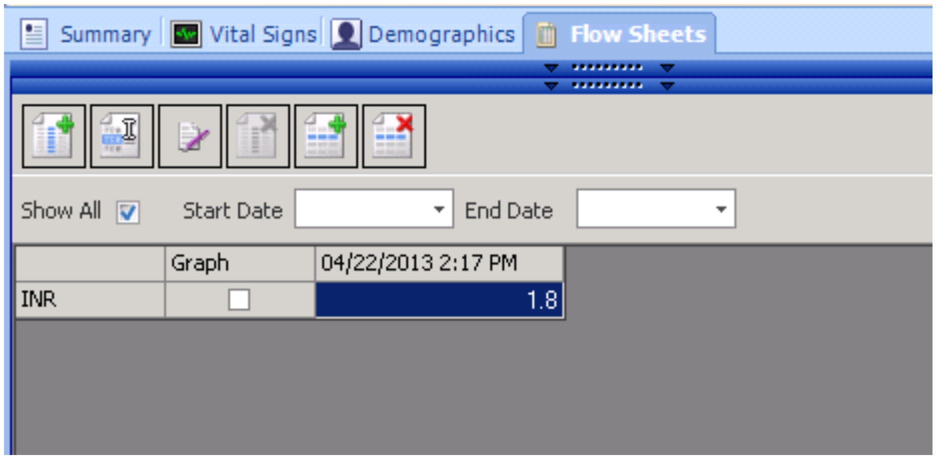


To create a new empty Flow Sheet, Click on the Green Plus in the Flow Sheet toolbar. Select "Empty Flow Sheet" and Click OK.

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.

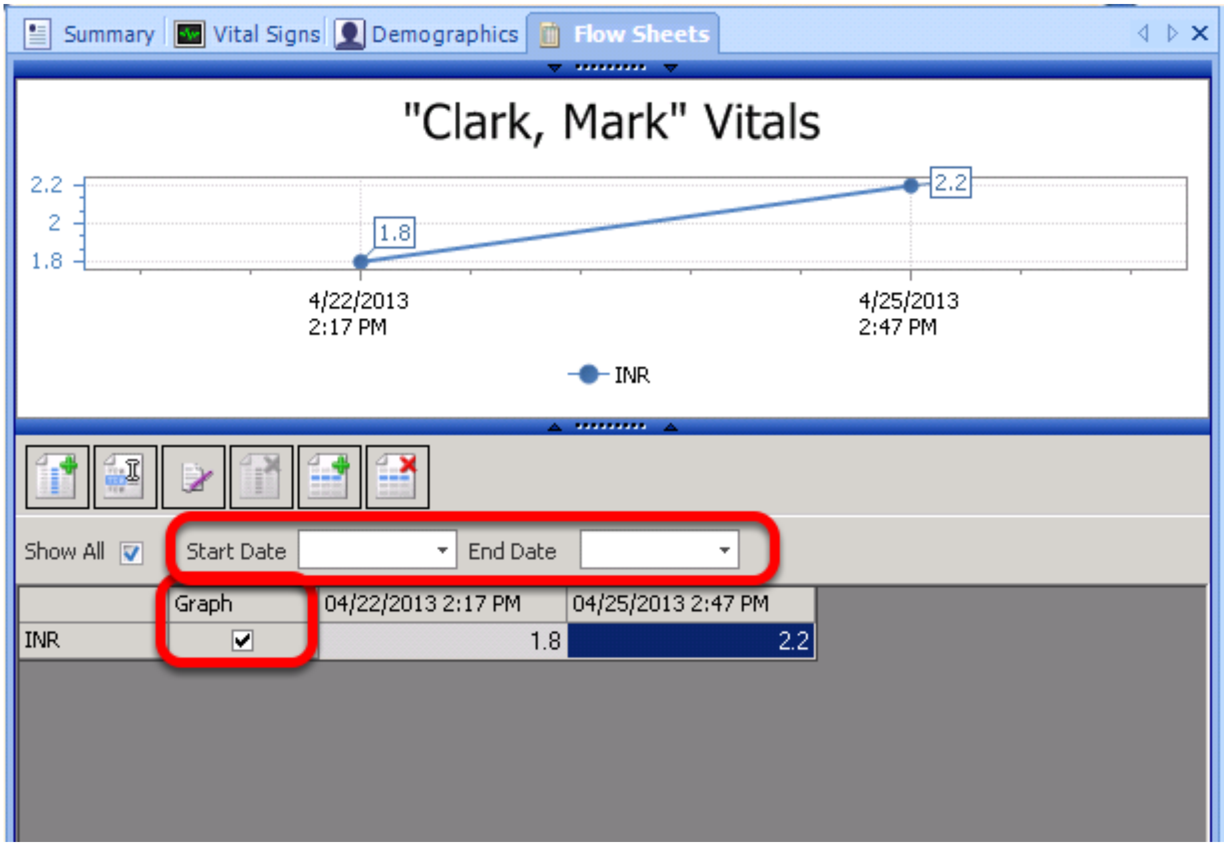


The lab item is now placed in the Flow Sheet. All results from that specific test are now entered on the Flow Sheet.

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 the HL7 Interface, may be placed on a Flow Sheet. Lab results that have been scanned into the patient's chart will not be placed on the Flow Sheet.

Graphing Results



Results may be graphed by placing a check mark in the Graph box next to a particular test.

***Note**: The graph will display what filter options are specified-such as a start and end date, or in the example above, the graph is displaying all the patient's results for INR due to the "Show All" box being checked.

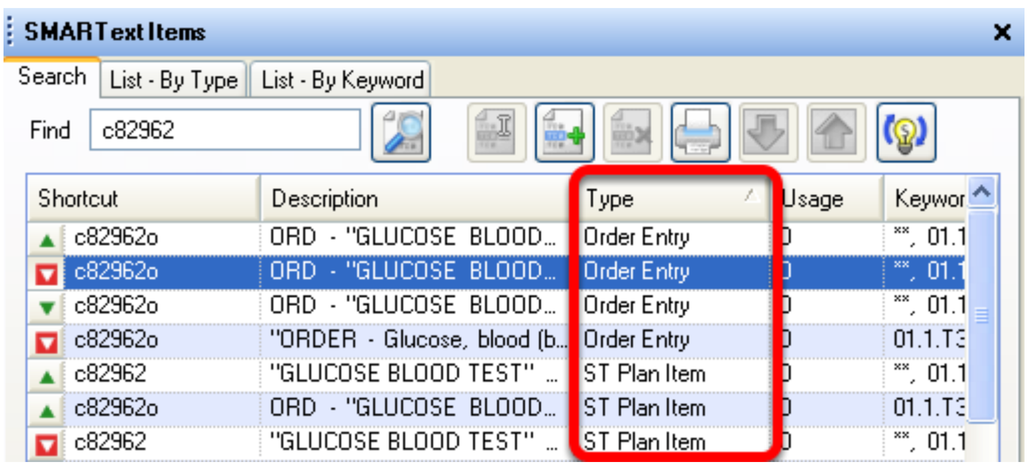
Order Entry

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.

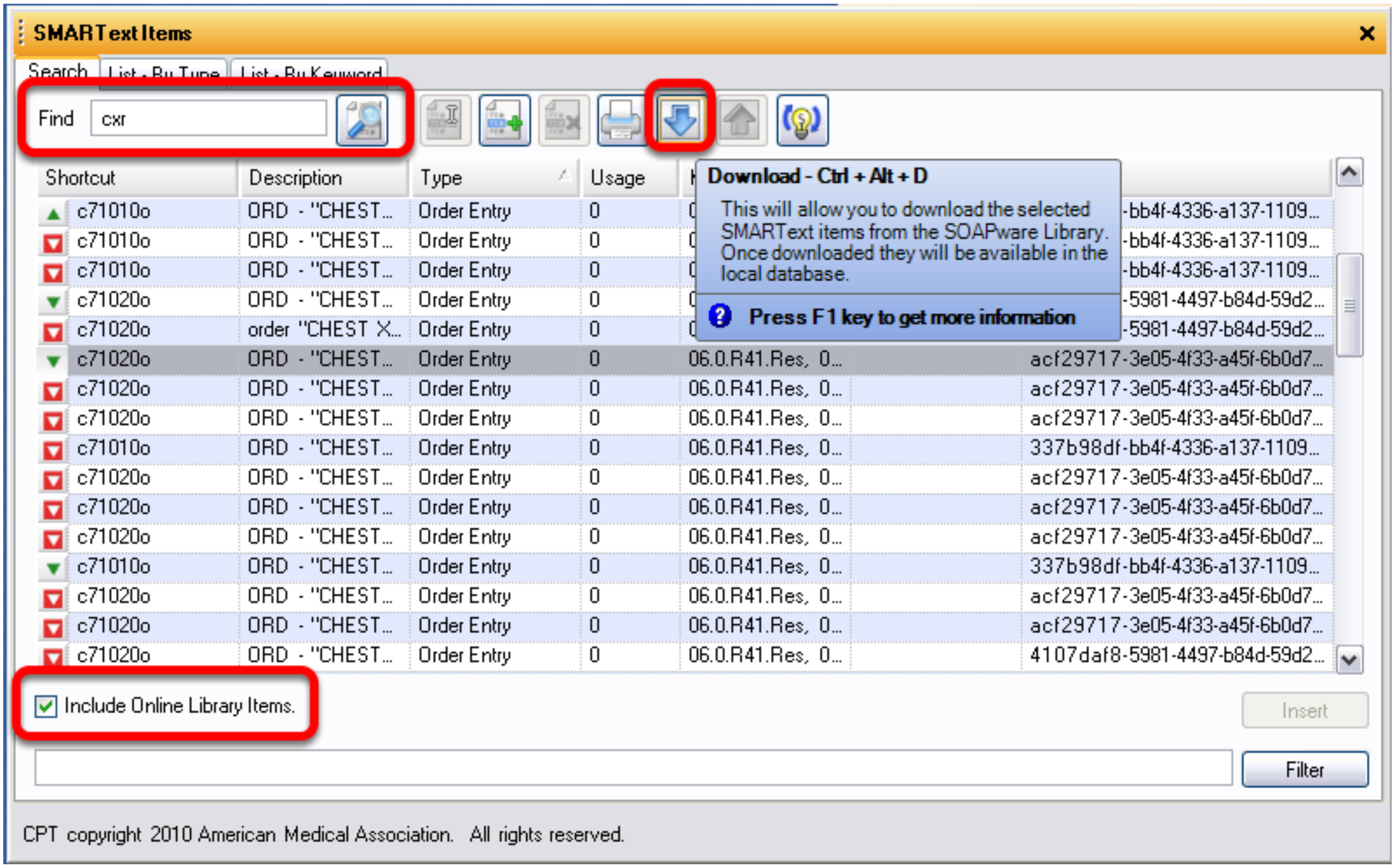
*In the Security settings, there is an option to cancel the creation of a Task Item. It is generally **Not** a good idea to allow Task Item creation to be canceled. If this option is activated, it is possible to skip creating a Task Item by clicking Cancel. The order will be placed for the patient, but without an associated Task Item.*

Order Entry SMARText Item Type



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 code.

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 <u>Include Online Library Items</u> is checked.

To download the order entry items that will be used in the clinical practice:

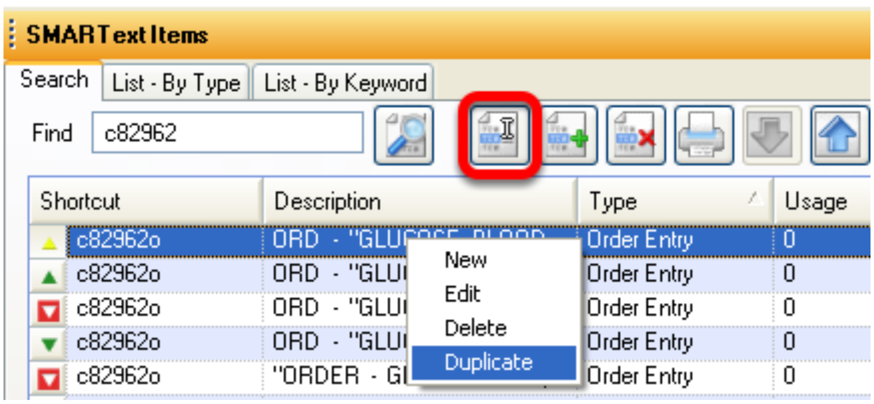
1) Make a list of the most frequently used Orders in the practice (Orders are any diagnostic test or procedure that need to be performed inhouse or outside of the clinic).

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 <u>Type</u> column, the <u>Order Entry item</u> 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



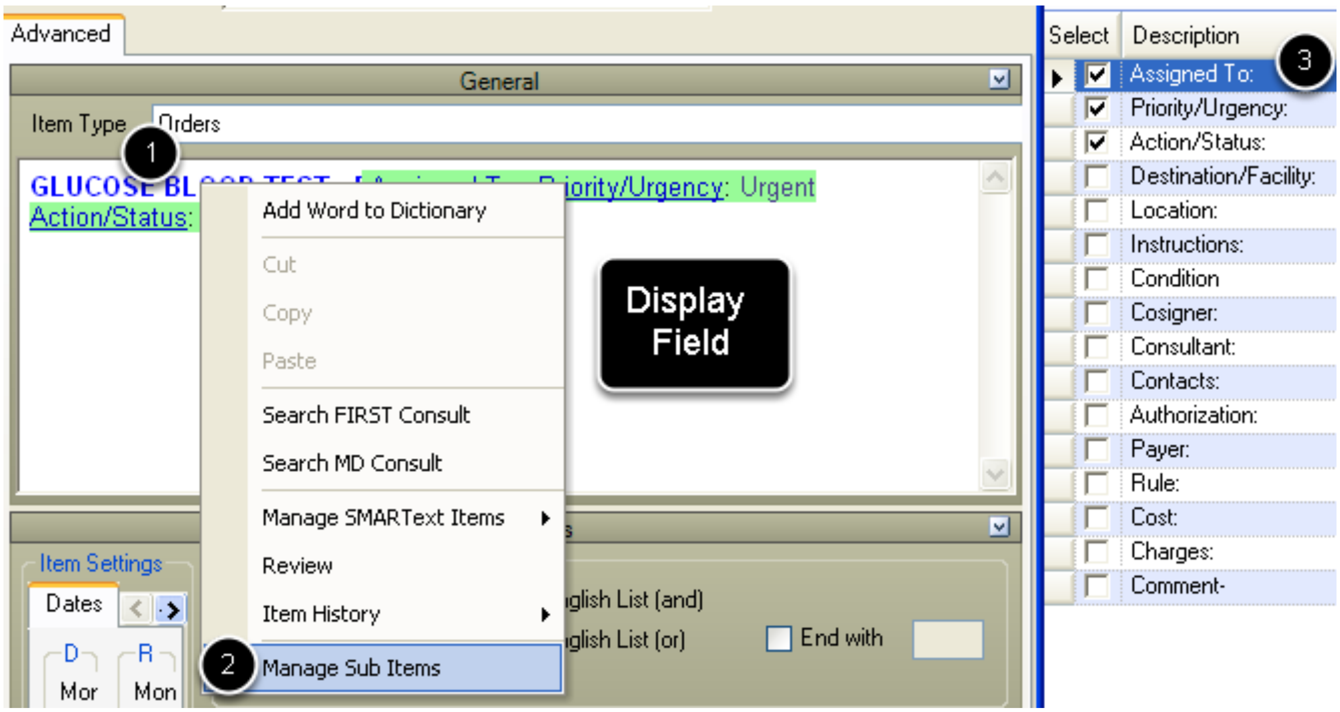
To display customized Order Entry sub-items in the SMARText Quick Access window follow these steps:

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

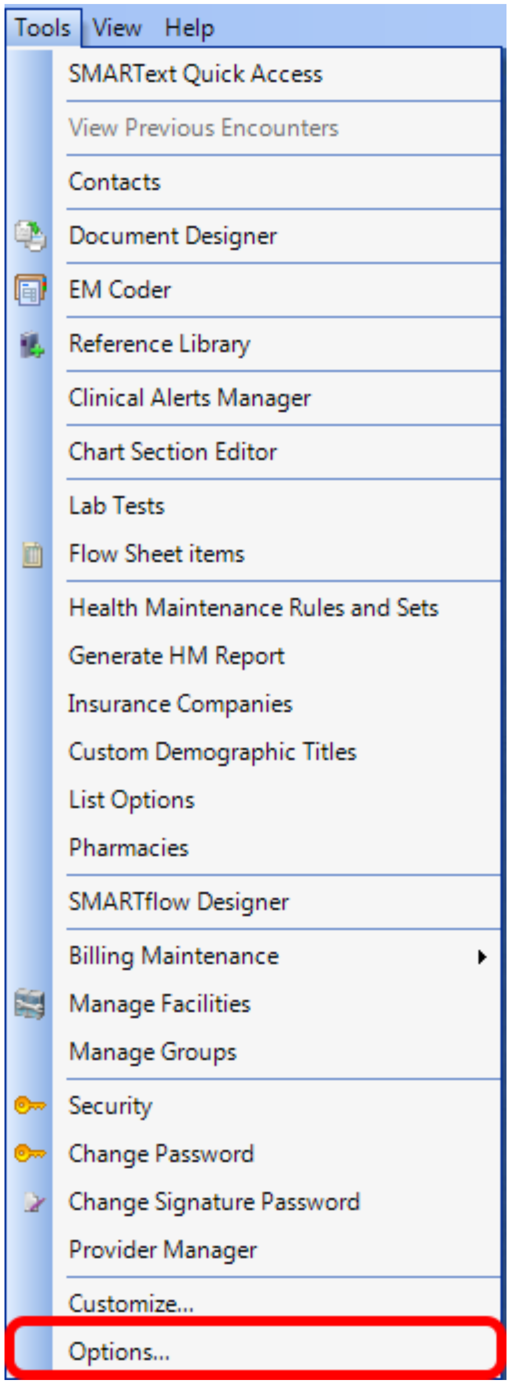


1) Right-click anywhere on the blue/bold words of the Display Header that is shown in the Display field of the SMARText Designer.

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



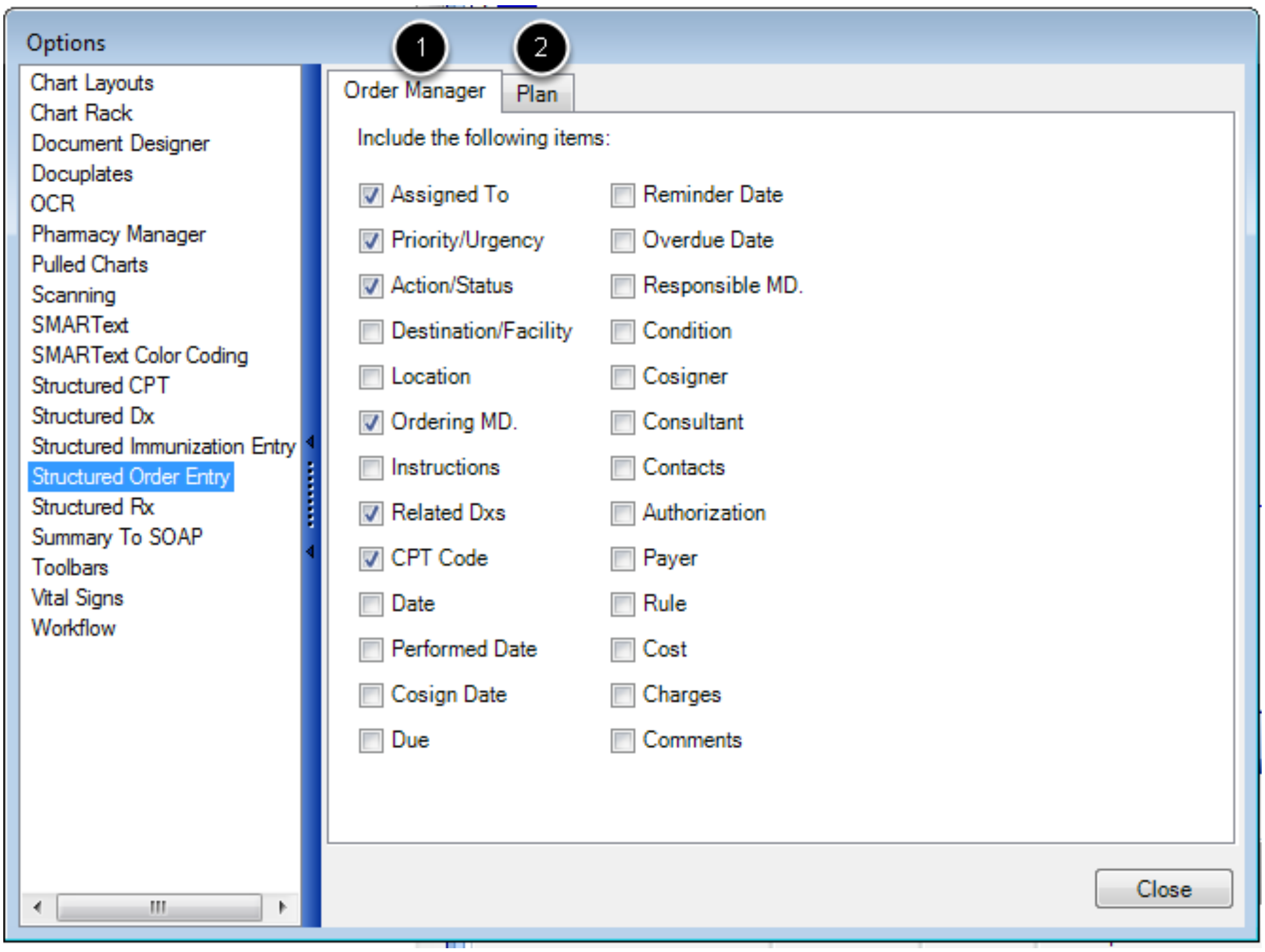
Order Entry sub-items that are displayed in Order Manager can be customized under the Tools menu item.

1) Click the Tools menu item.

2) Click Options.

3) Click Structured Order Entry.

Structured Order Entry

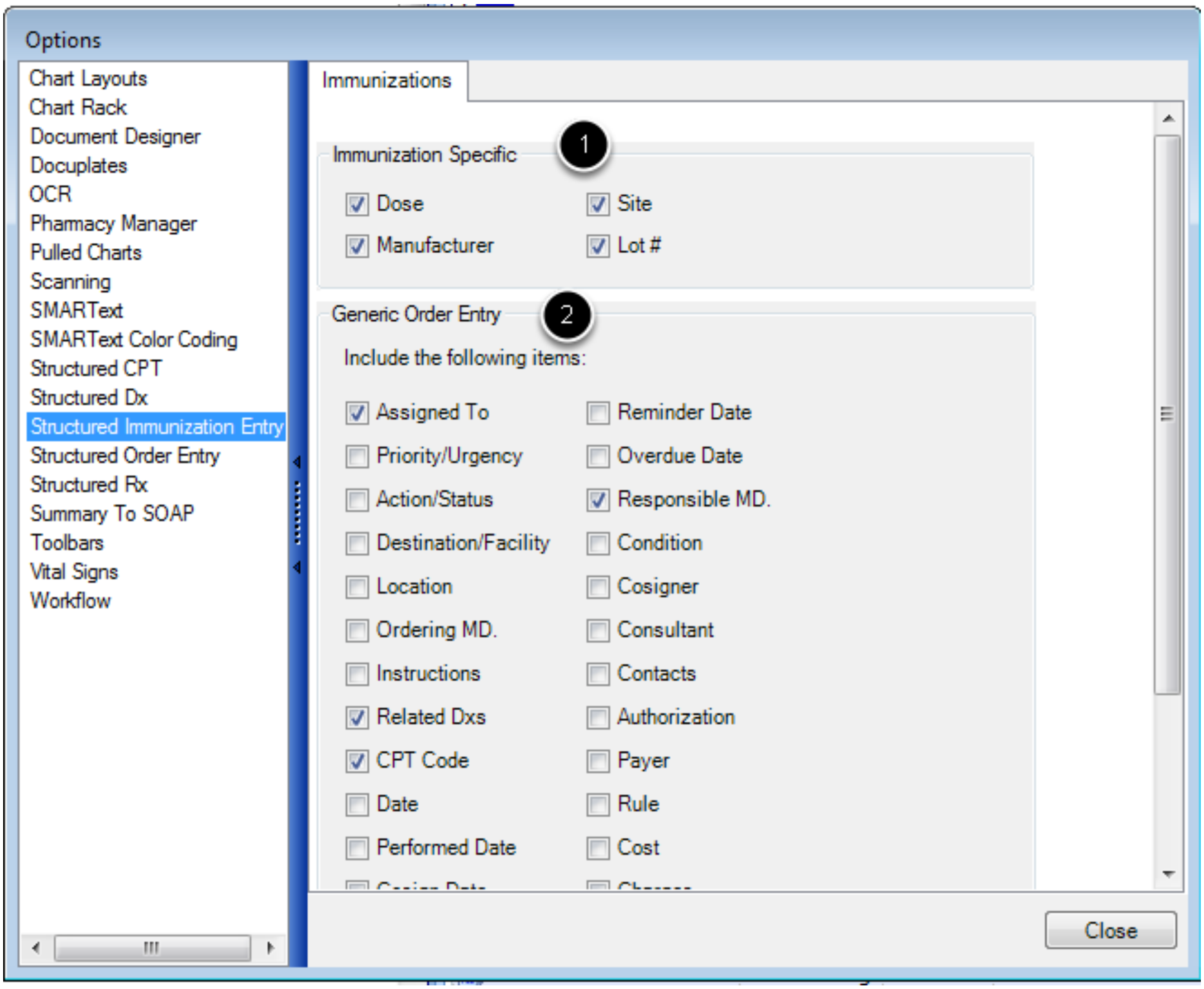


There are two tabs for Structured Order Entry sub-items:

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.

Structured Immunization Entry

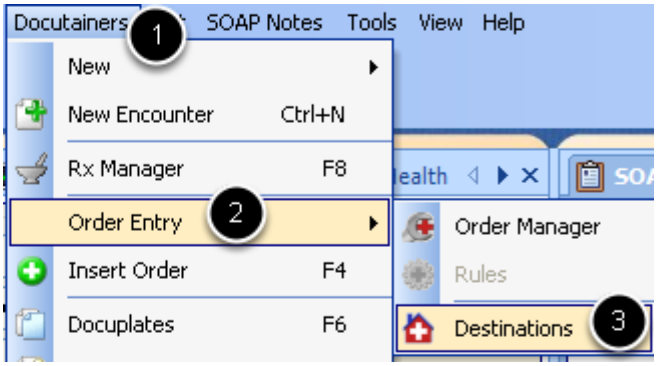


The immunization Entry set up will include 2 areas.

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



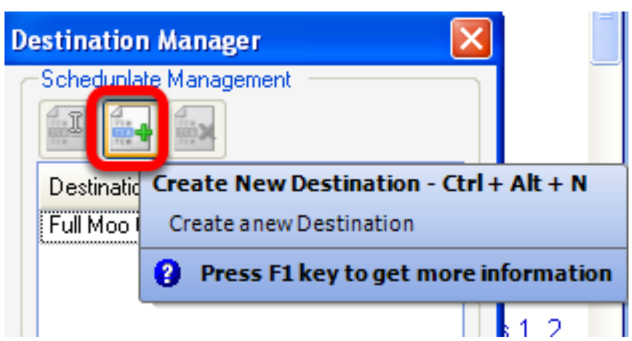
Order Entry Destinations are facilities that are user defined where orders can be submitted. For example, Memorial Hospital Lab might be a destination. It is a place to send orders (i.e. tests, labs, studies, procedures, equipment, etc.) to be processed.

1) Click Docutainers.

2) Click Order Entry.

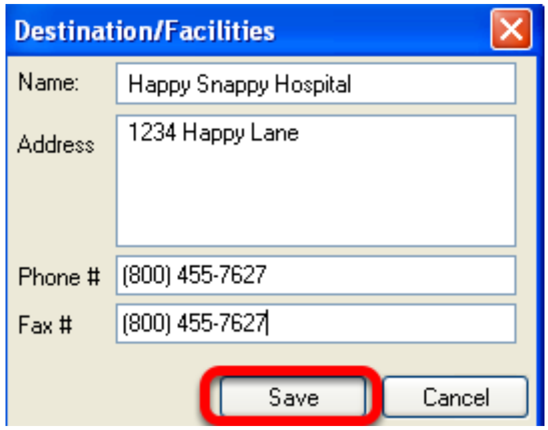
3) Click Destinations.

Destination Manager



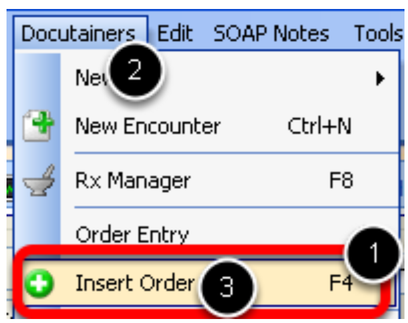
Click the Green + to enter information for a new Destination. Click the edit button to edit the information for a Destination or the remove button to remove the Destination from list.

Destination Demographics



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:

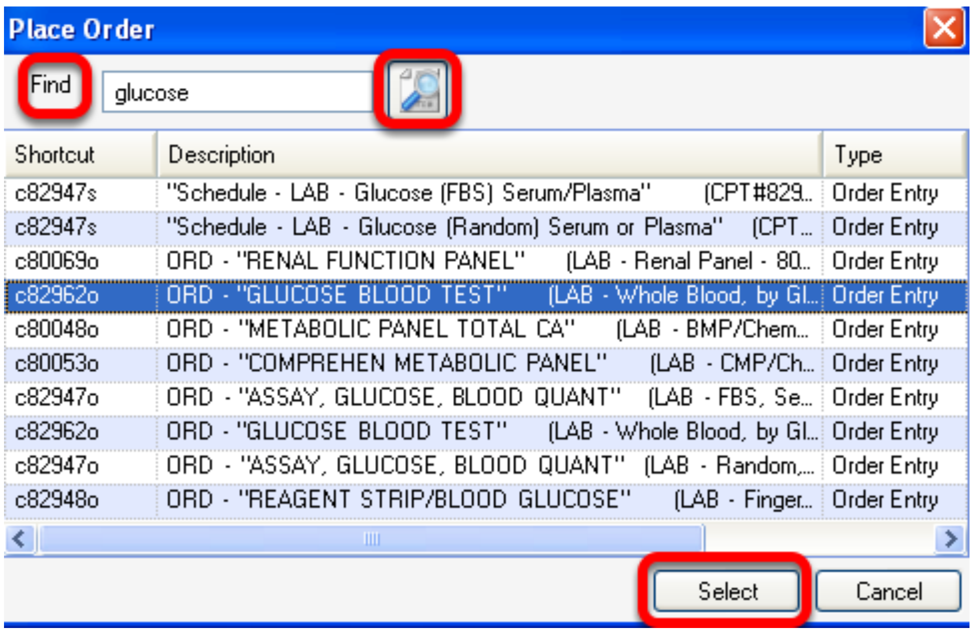
1) Press the F4 key or

2) Click on Docutainers menu item.

3) Click Insert Order.

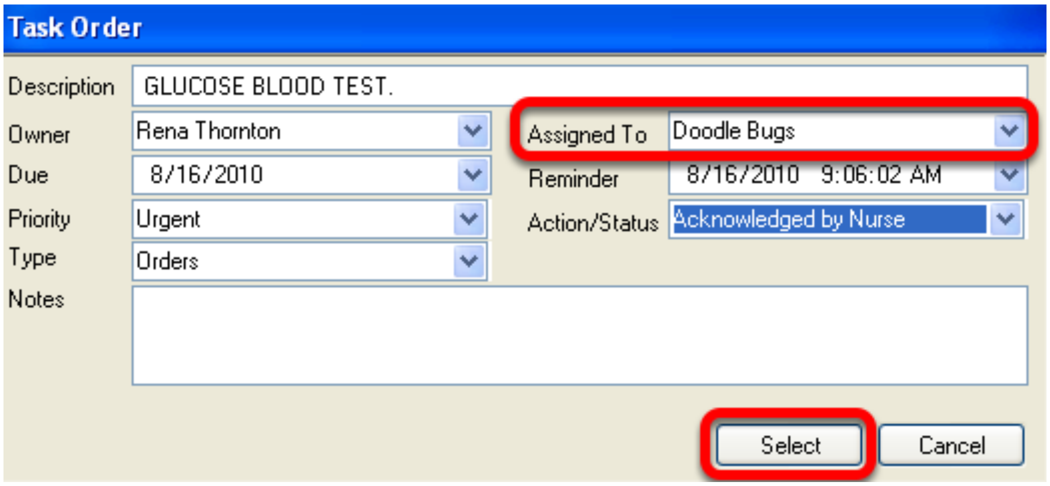
NOTE The Quick Entry (F4) will NOT place items on the billing statement. **The Quick Entry Method cannot be used when ordering immunizations for reporting to state registries for Meaningful Use.**

Place Order Dialog



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 code 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



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 code.

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.

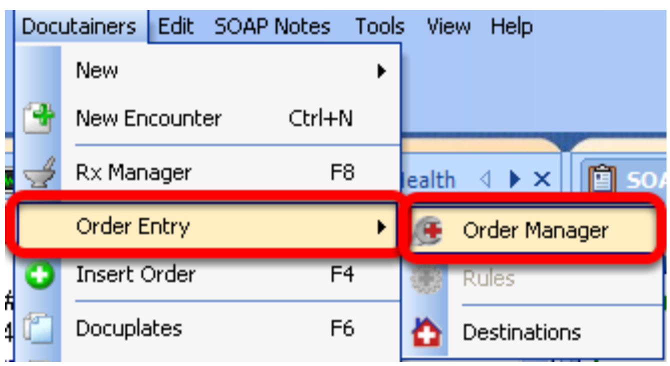
Order Manager

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.

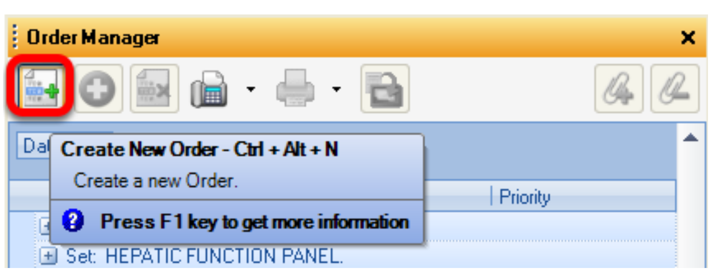
*In the Security settings, there is an option to cancel the creation of a Task Item. It is generally **NOT** a good idea to allow Task Item creation to be canceled. If this option is activated, it is possible to skip creating a Task Item by clicking Cancel. The order will still be placed for the patient, but without an associated Task Item.*

Placing an Order in Order Manager



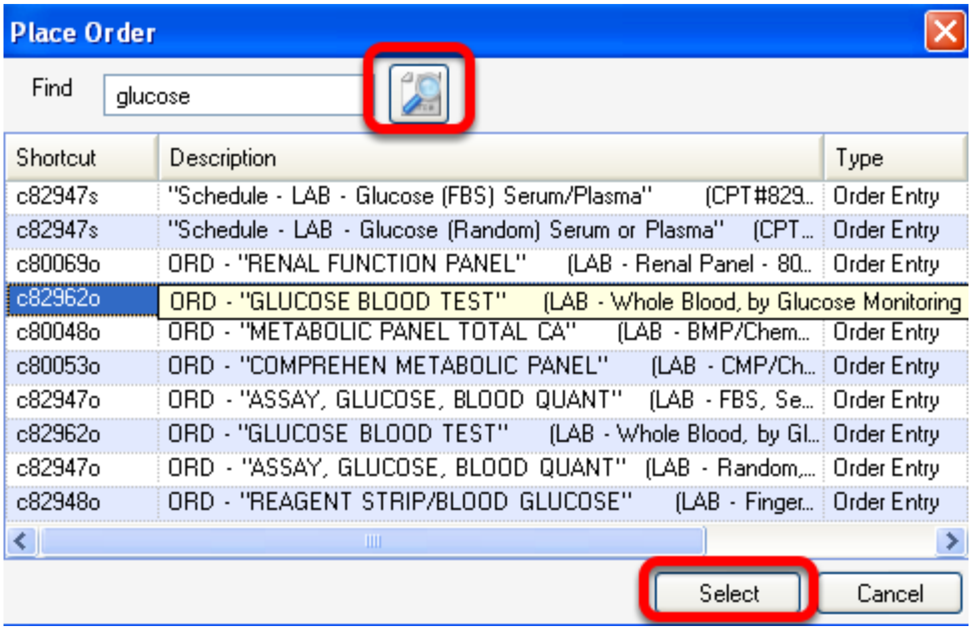
With a patient chart and SOAPnote open, Click Docutainers, Order Entry and then Click Order Manager to place an order.

Order Manager Display Window



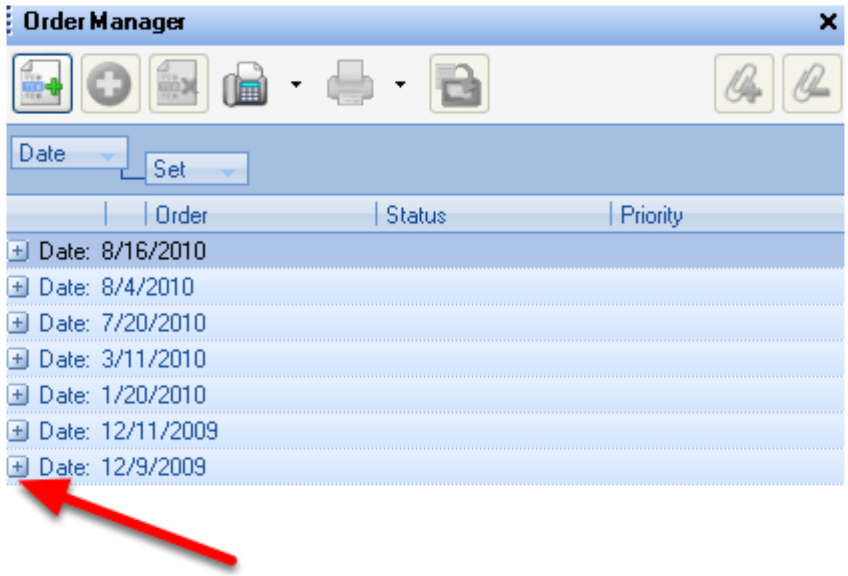
Click the Create new Order button.

Place Order Display Window

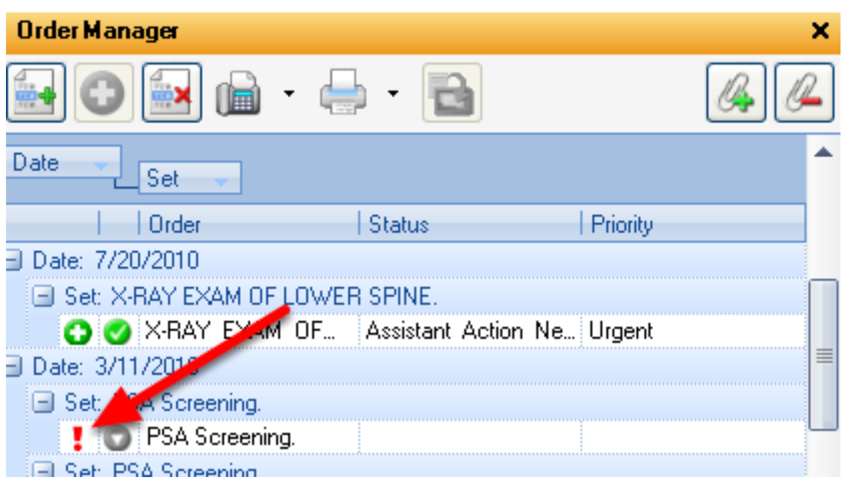


Type the Shortcut or keyword in the Find field, and Click the Search button. *This only searches the local database and does not search the online library.*

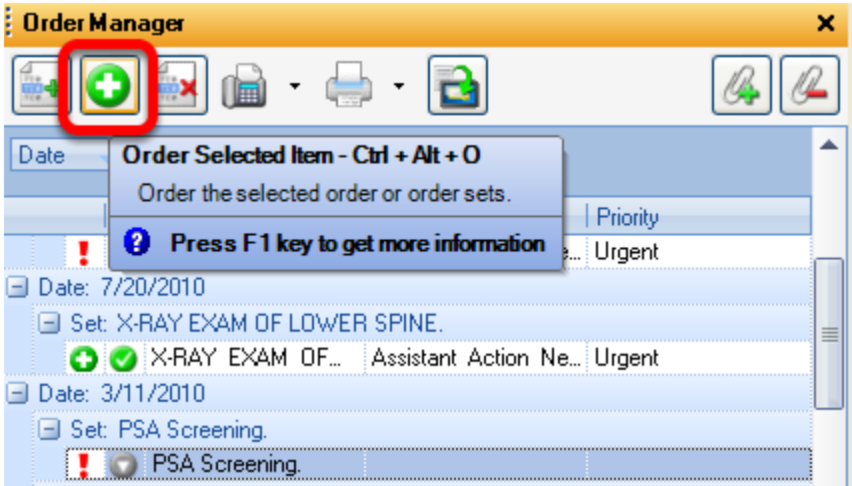
When the preferred Order Entry item appears in the list of items, Double-Click the order list item or Click on the order list item and Click the Select button.



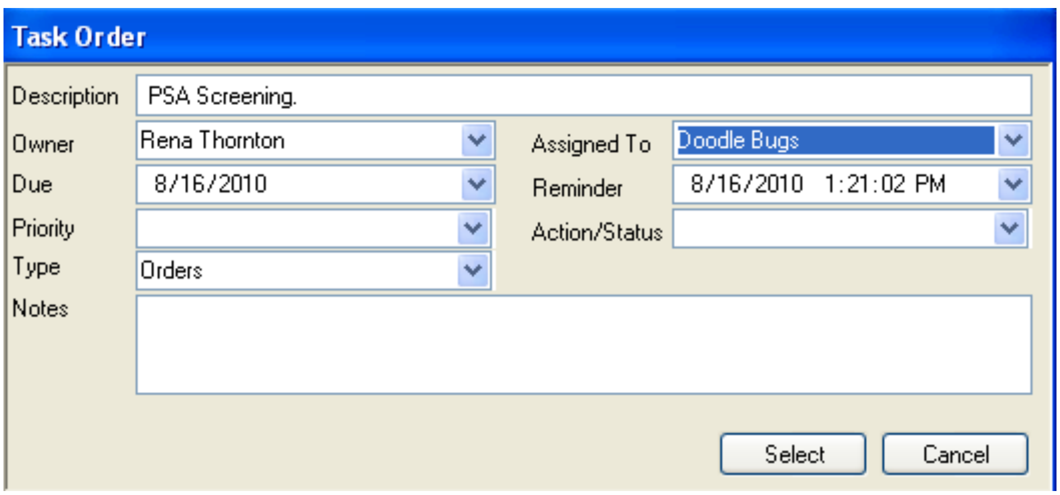
The first time Order Manager is used Click on the plus sign (+) next to Date.



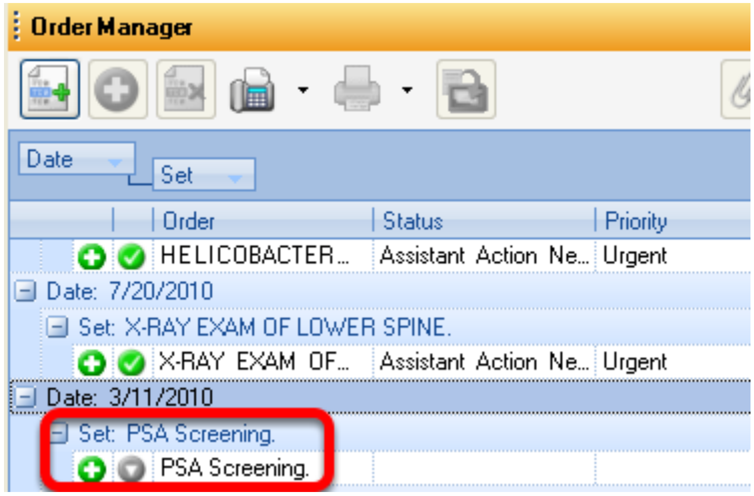
Click on the plus sign (+) next to Set. Notice the " ! " in front of the order. This is a warning that the order has not yet been placed or performed.



To place the order, Click the Order Selected Item Button.

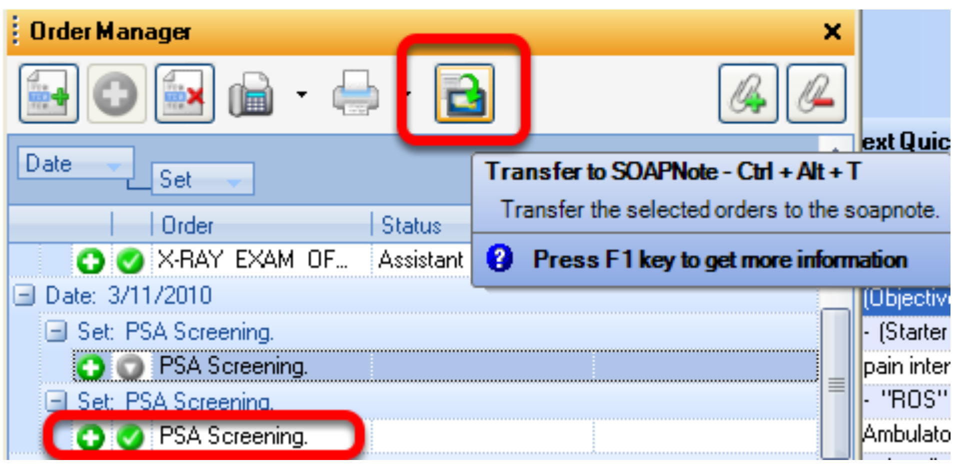


Click to select the user the task needs to be assigned to from the Assigned To drop-down menu, and then Press the Select button. *This step can be skipped if Assigned To has been pre-defined.*



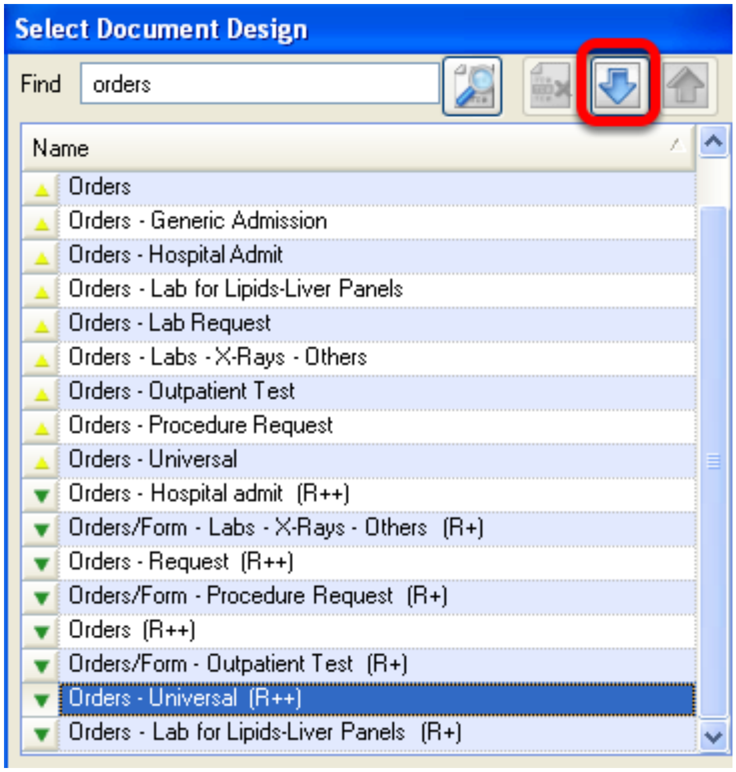
This completes the placing of the order and replaces the " ! " with a " + ". In most situations, the orders still need to be transferred into the Plan field of the current SOAPnote.

Transferring an Order to the SOAPnote



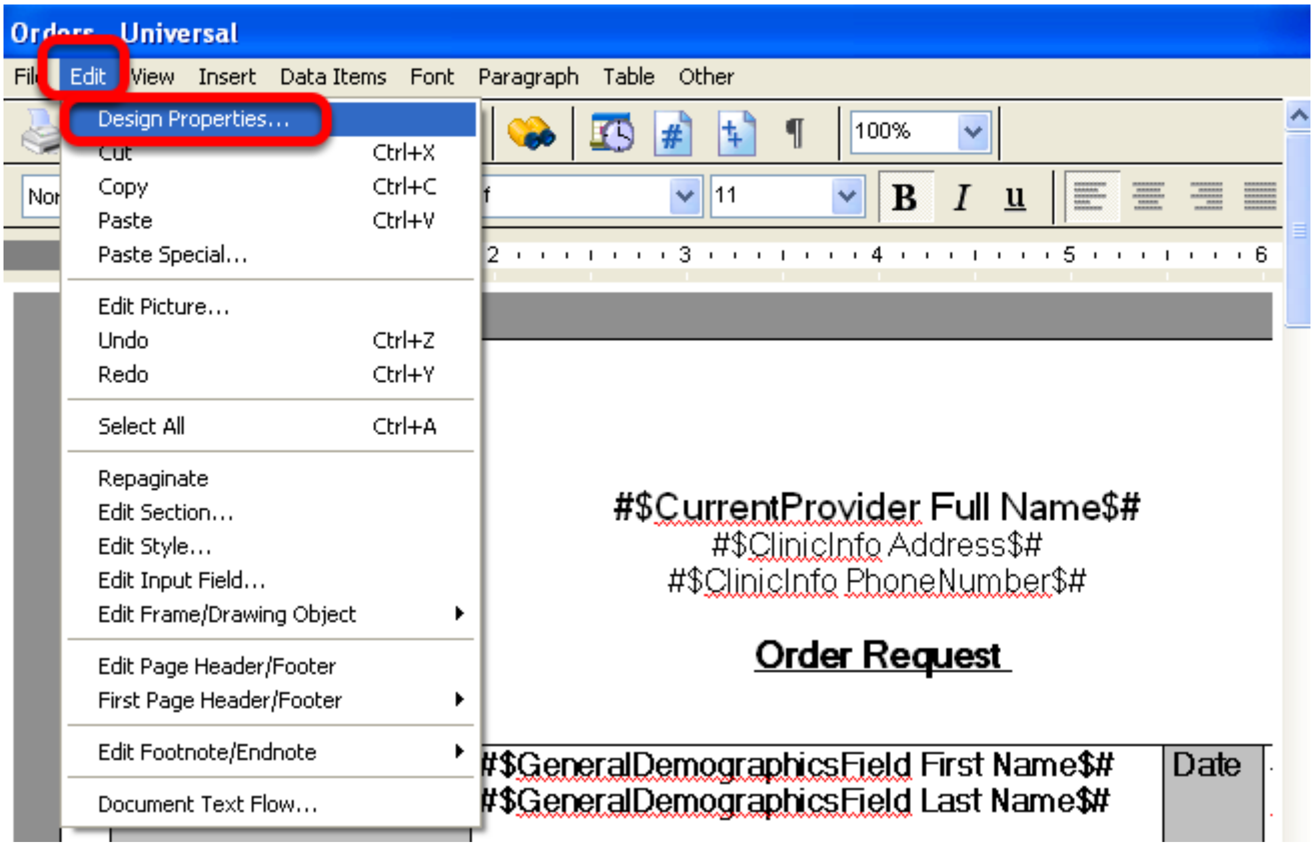
Click to highlight the order item to transfer. Next, Click the Transfer to SOAPnote button. A green check mark indicated the order has been transferred to the Plan field of the SOAPnote.

Selecting an Order Design in Document Designer for Faxing and Printing

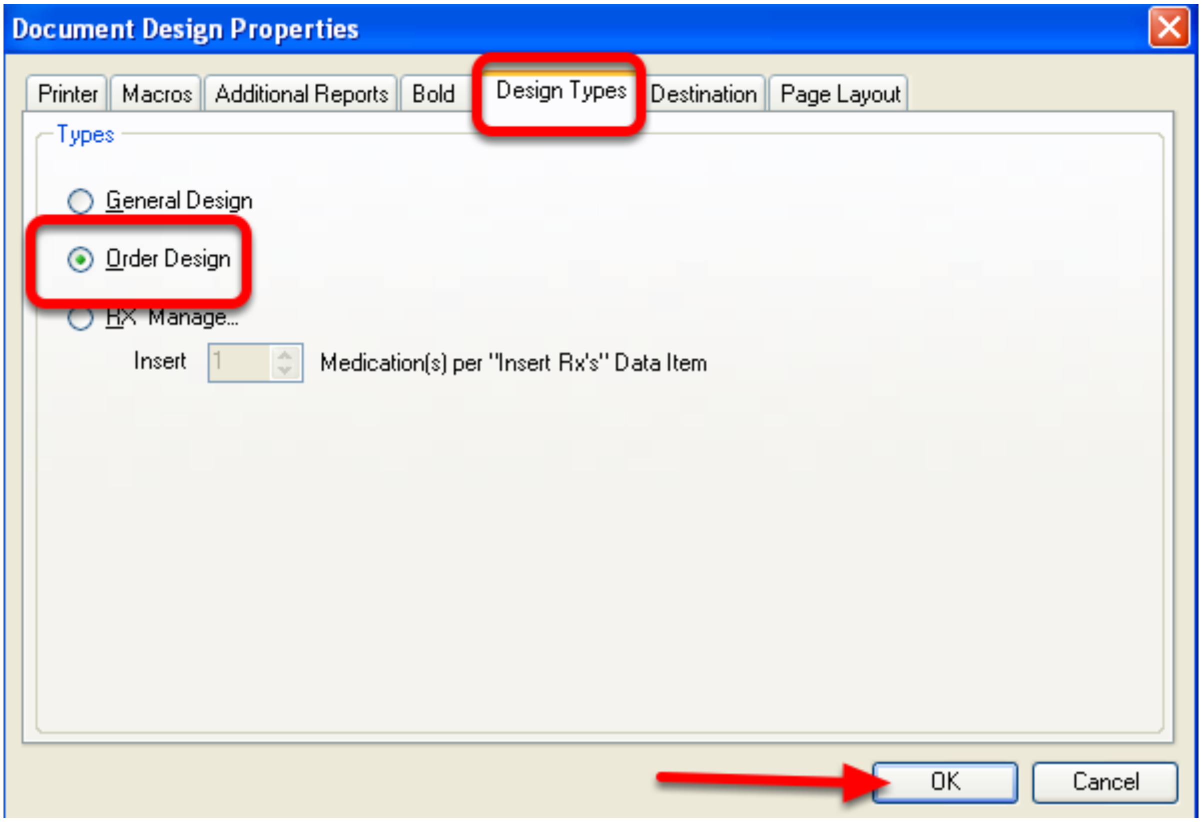


An Order Design will need to downloaded from Document Design and selected as the Order Design when faxing and printing. This will be down from the Tools menu item and Clicking on Document Designer.

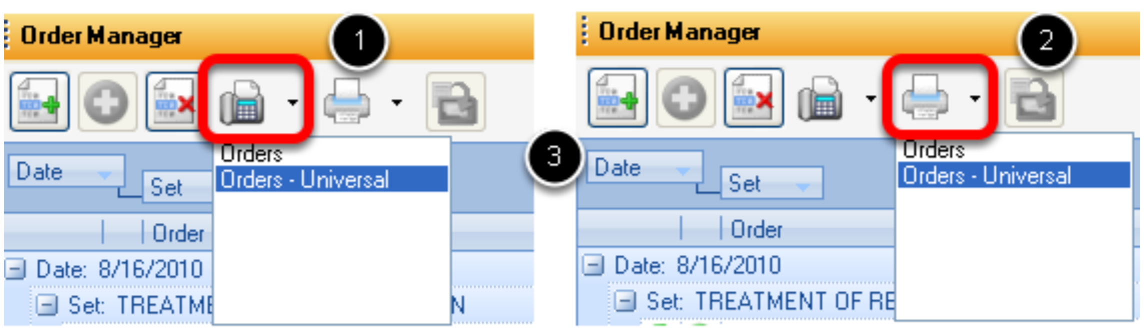
In Document Designer:
1) Go to the File menu item.
2) Click on Available Designs.
3) In the Find field, search for Orders. The user will see two Order Design options; Orders and Orders Universal. Preview Design by Clicking on name of Design to highlight, then Click OK.
4) If the triangle next to the 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.



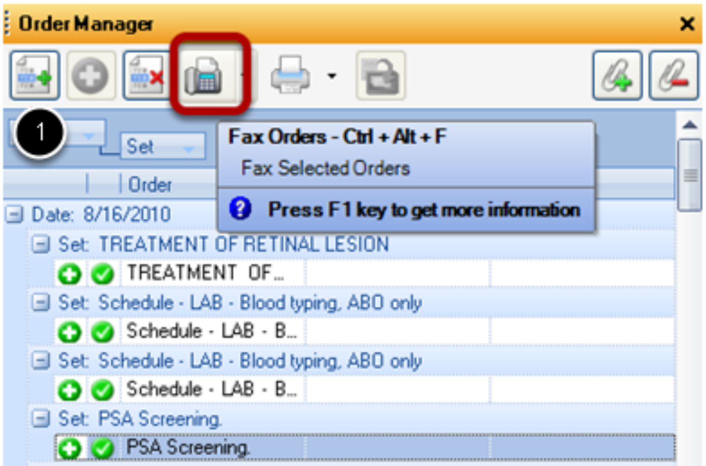
In the Document Design Properties window, Click on the Design Types Tab and Click the bubble next to Order Design and Click Ok. This will save the selected Order Design to the Order Manager.

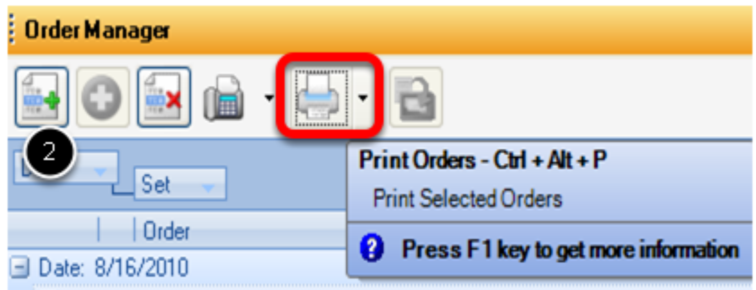


If more than one Design has been chosen to use for faxing or printing, they will be listed when clicking on the drop down arrow on the faxing and printing button to select. The same list will populate for both faxing and printing.

1) Faxing drop down menu
2) Printing drop down menu

Faxing and Printing an Order

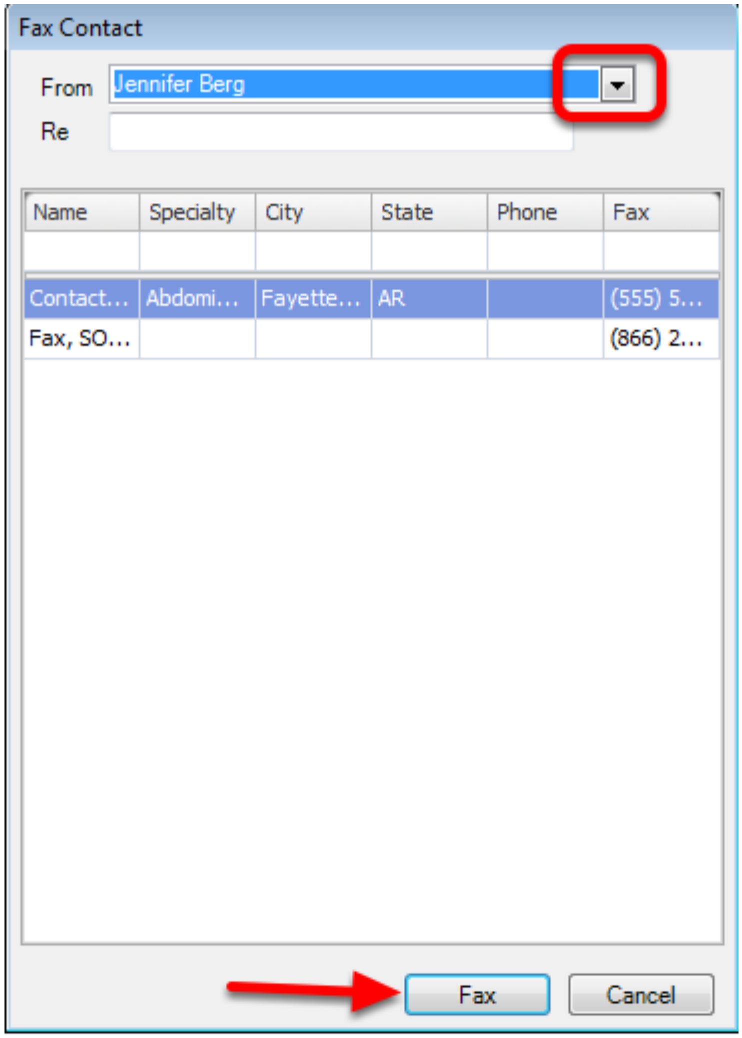




Click on test or procedure to be faxed to highlight a selection. *Only one selection can be faxed or printed. Multiple selection is not available at this time.*

1) Fax Order
2) Print Order

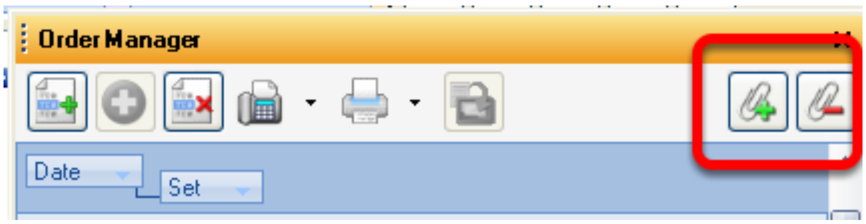
Fax Contact Window



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.

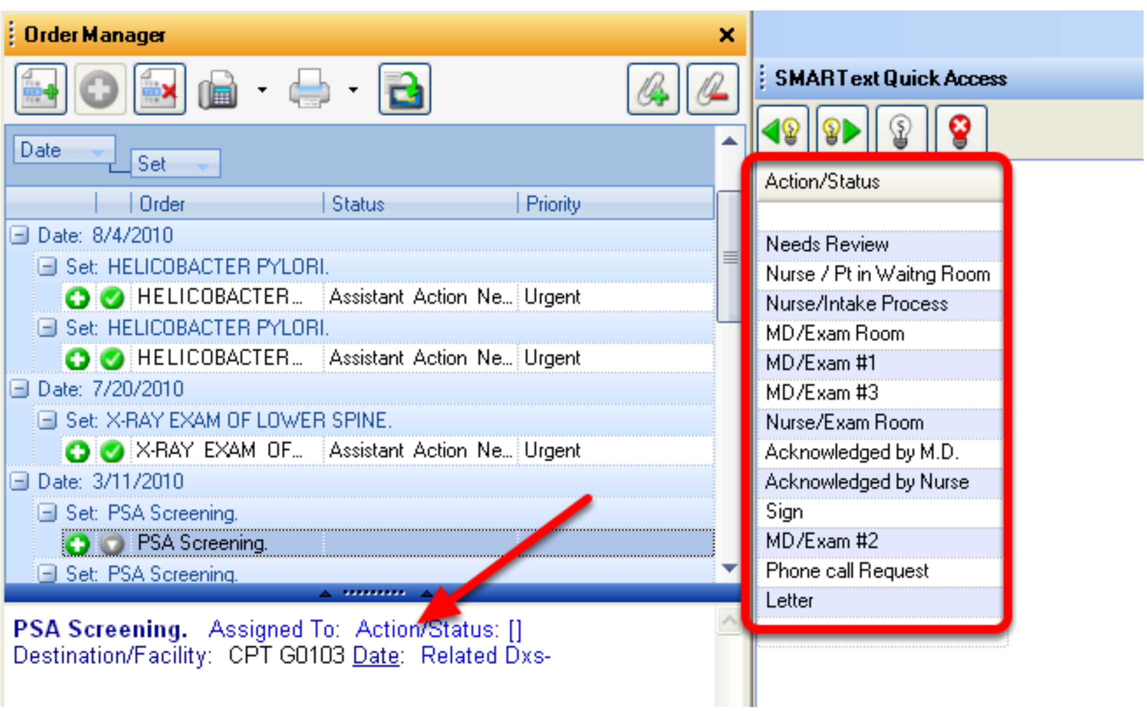
Adding Order to Billing Statement



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.

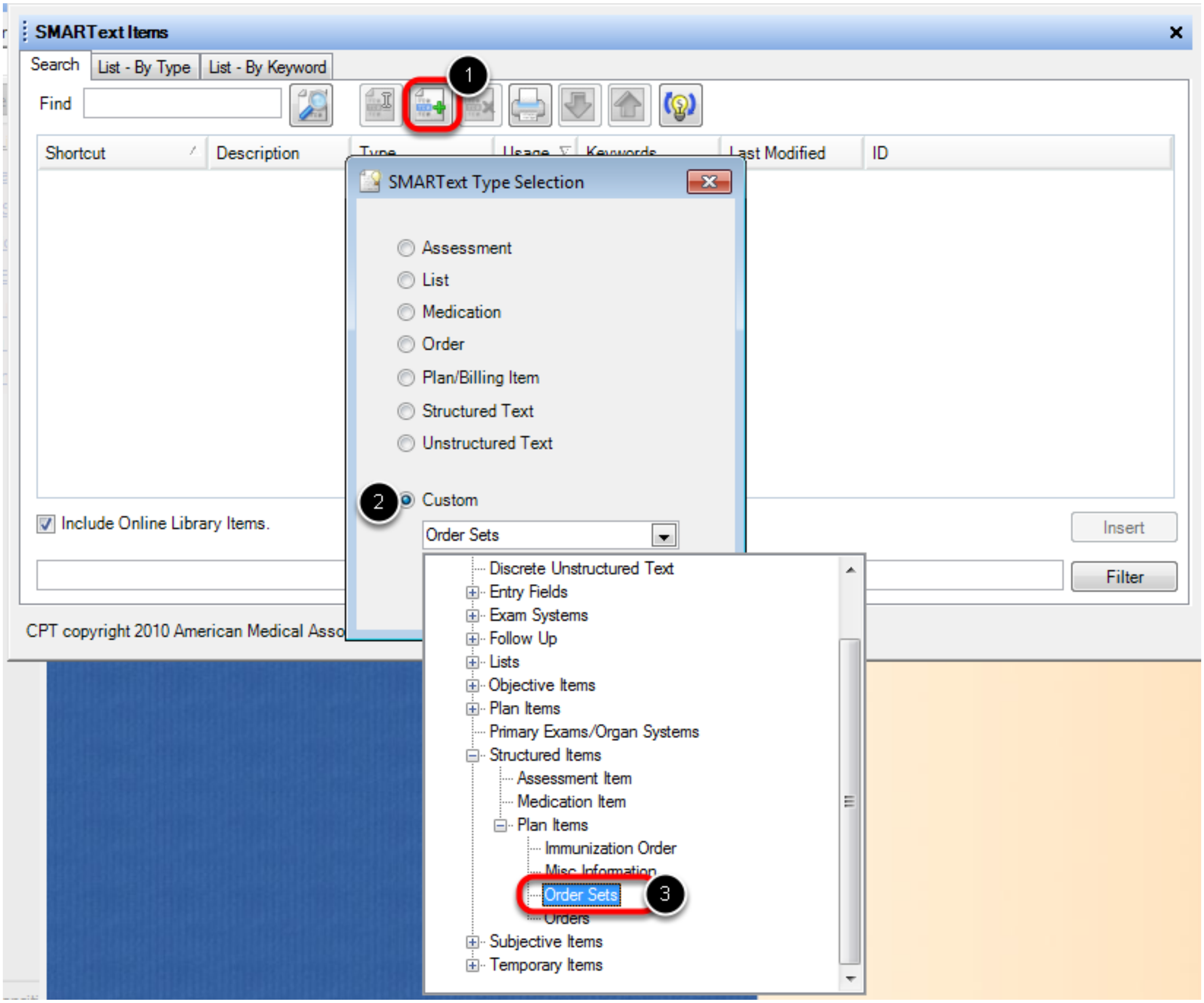
Order Entry Important Notes

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

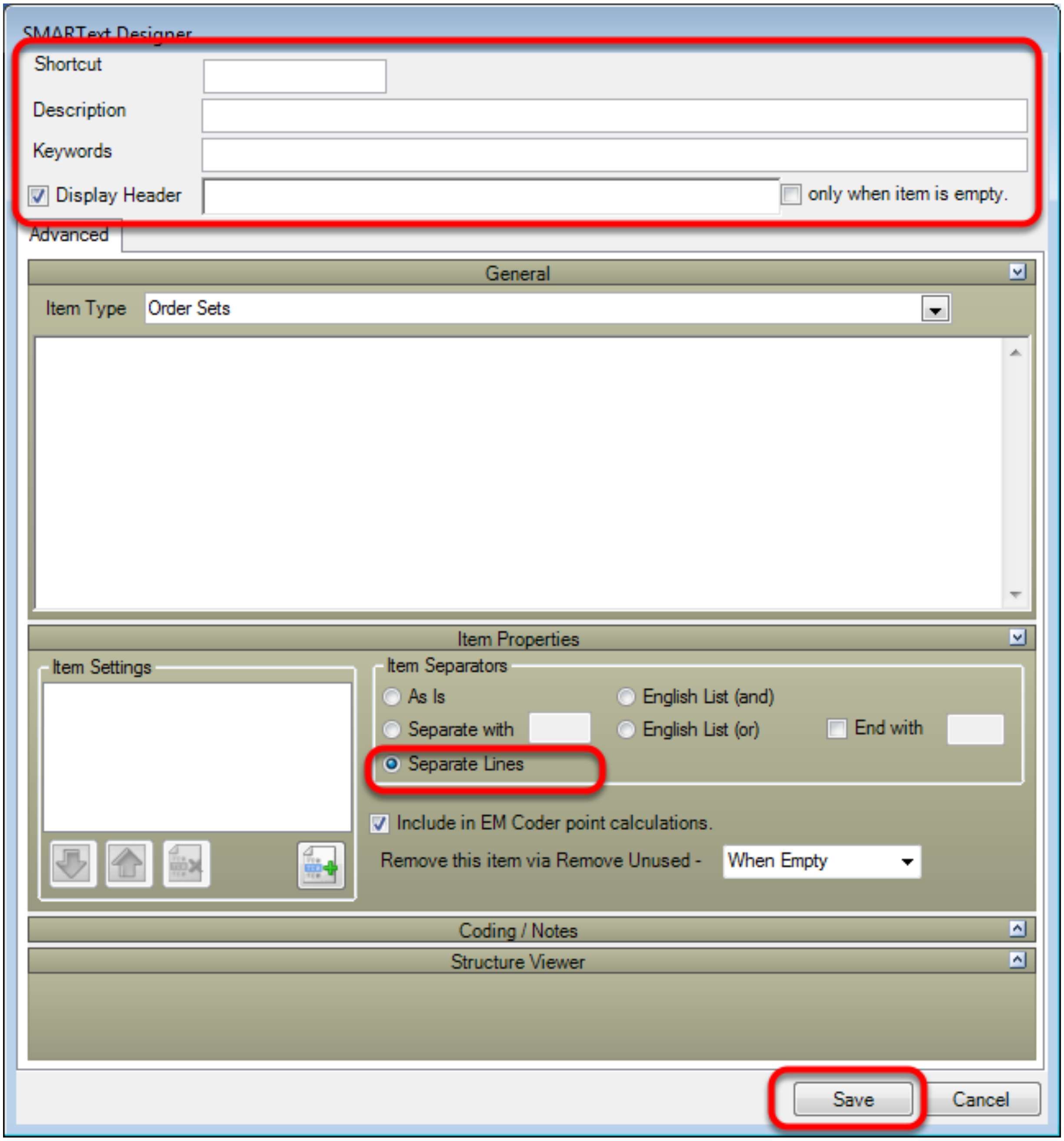


To Create a new Blank Order Open the SMARText Items Manager using the keyboard command of F10 or by Selecting Docutainers > SMARText Items.

1. Create a new Item.
2. Select Custom.

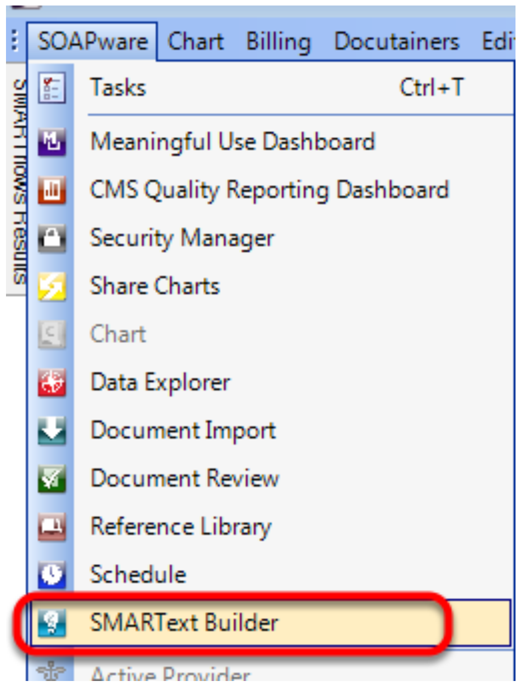
3. Click Order Sets.

Select Create.

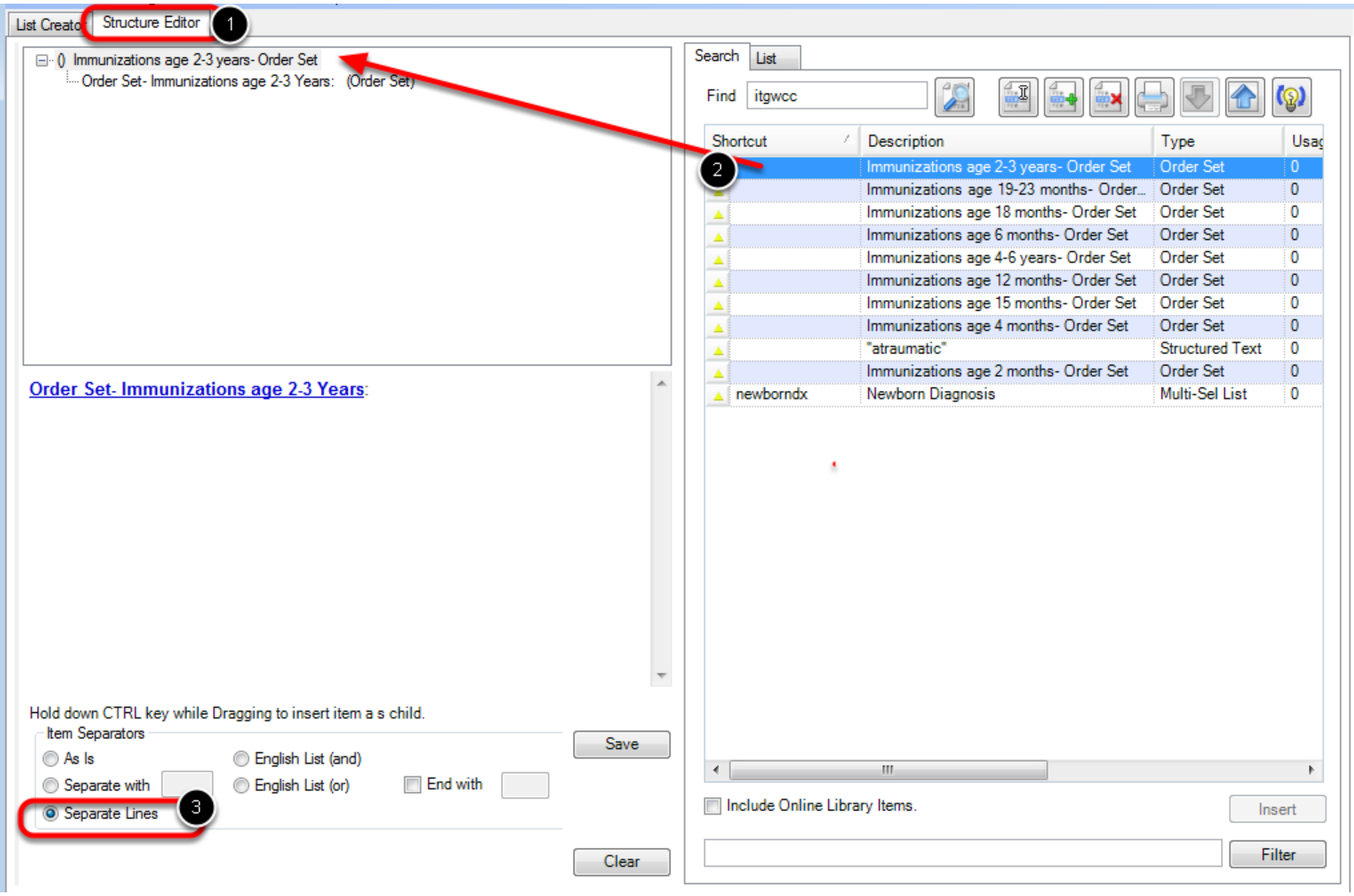


1. Enter Shortcut, Description, Keywords and Display Header.
2. Select Item Separator of Separate Lines.
3. Click Save.

Open the SMARText Builder Workspace

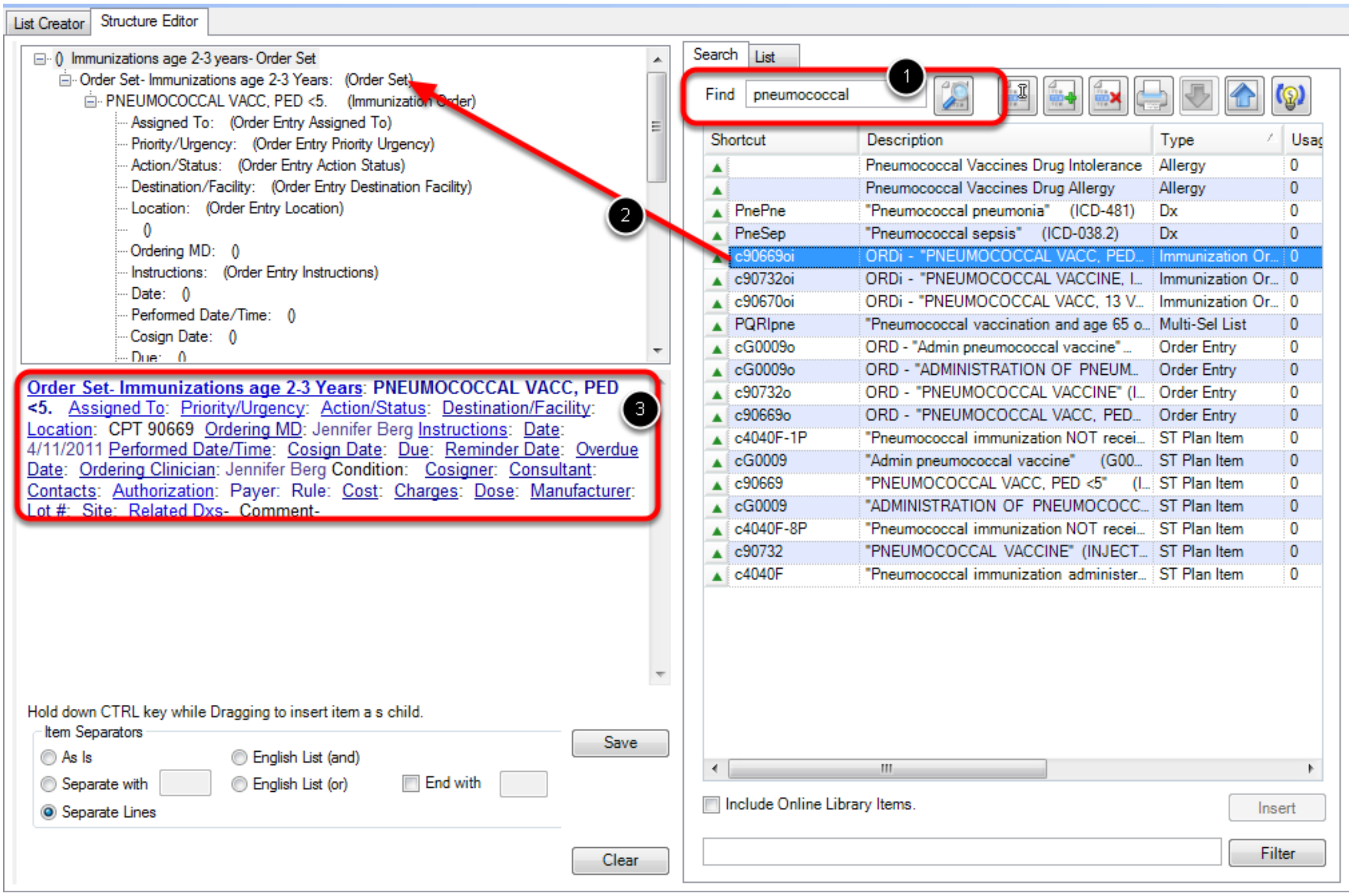


Click on SOAPware and Select SMARText Builder.



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".

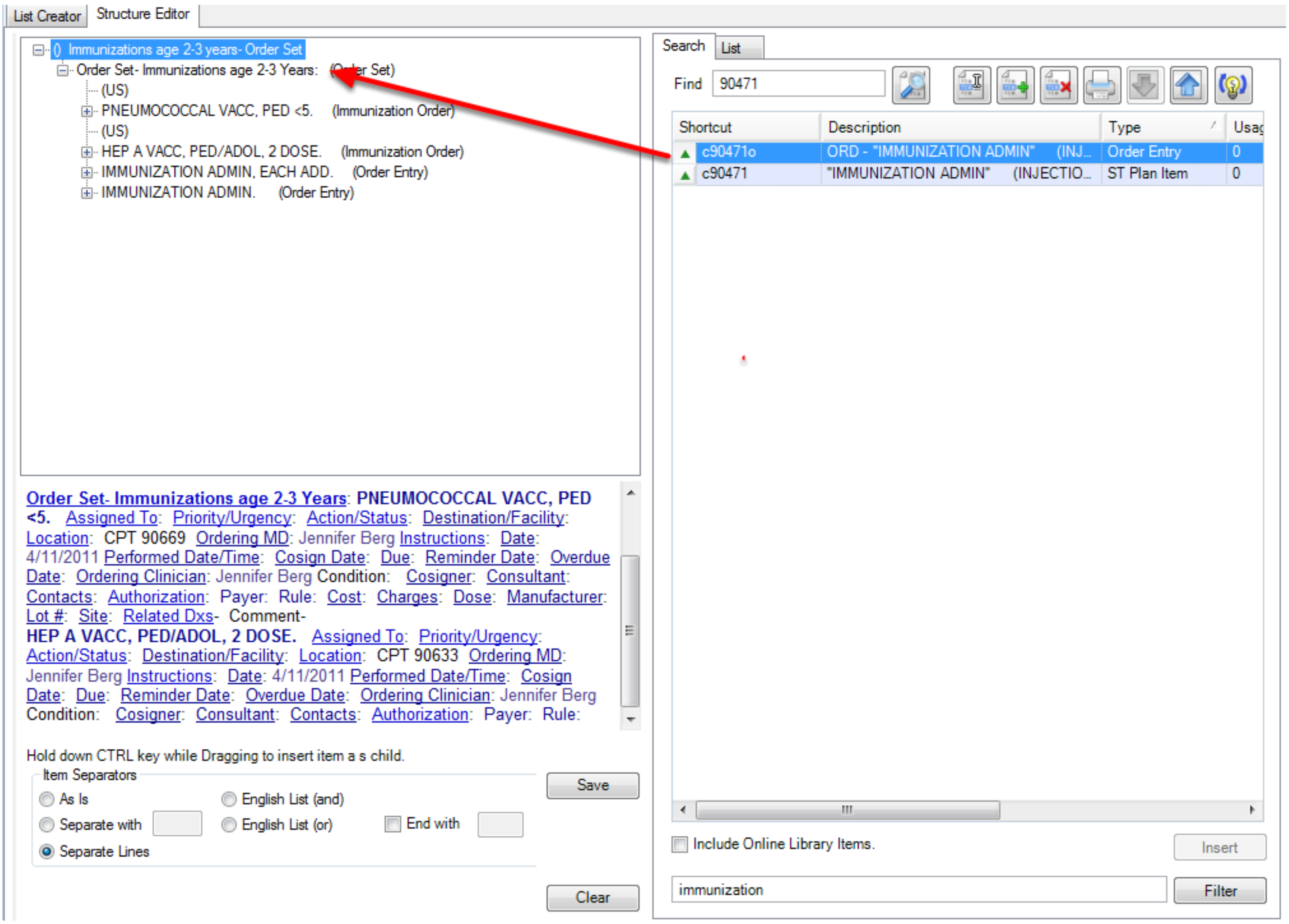
Select Orders for the Order Set



In the Example above the Order set if for Immunizations for Children ages 2-3 years. The "child" order or sub-item is the Pneumococccal 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



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.

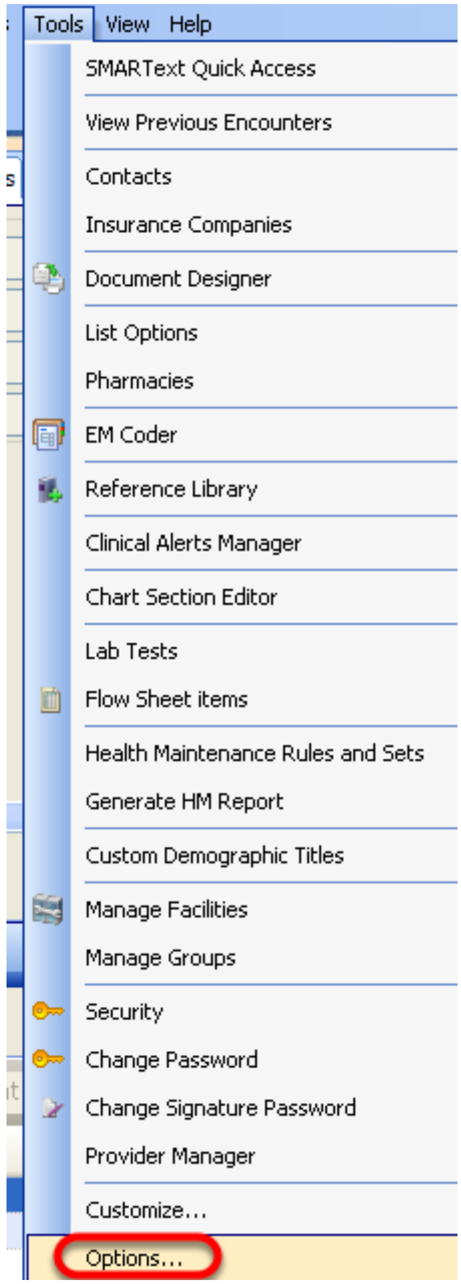
The Order Set may now be entered using Order Manager. For More information on Entering Orders Click Here.

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

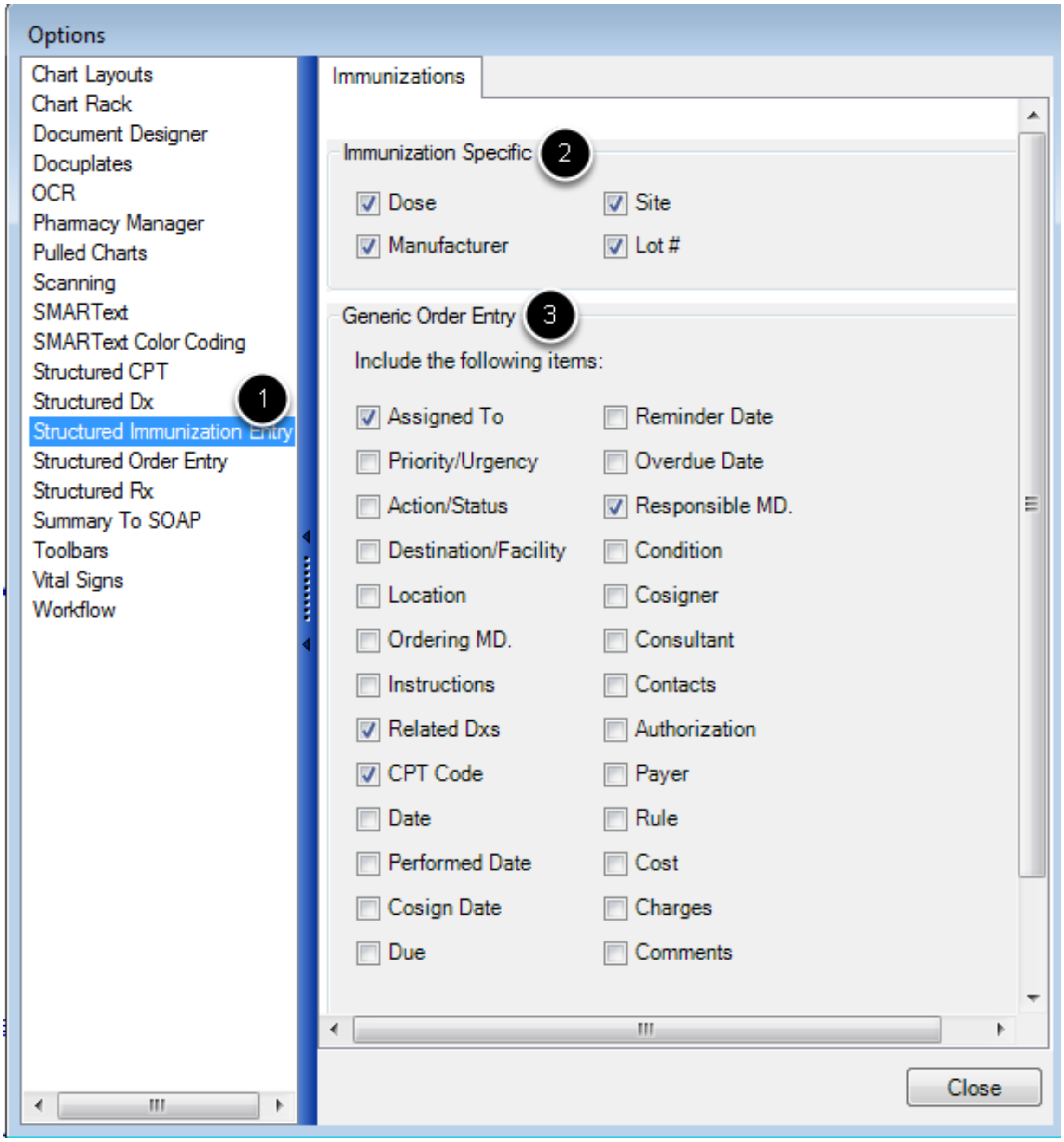


Immunization Order sub-items that are displayed in the Plan field, can be customized under the Tools menu item.

1) Click Tools menu item.

2) Click Options.

Structured Immunization Entry

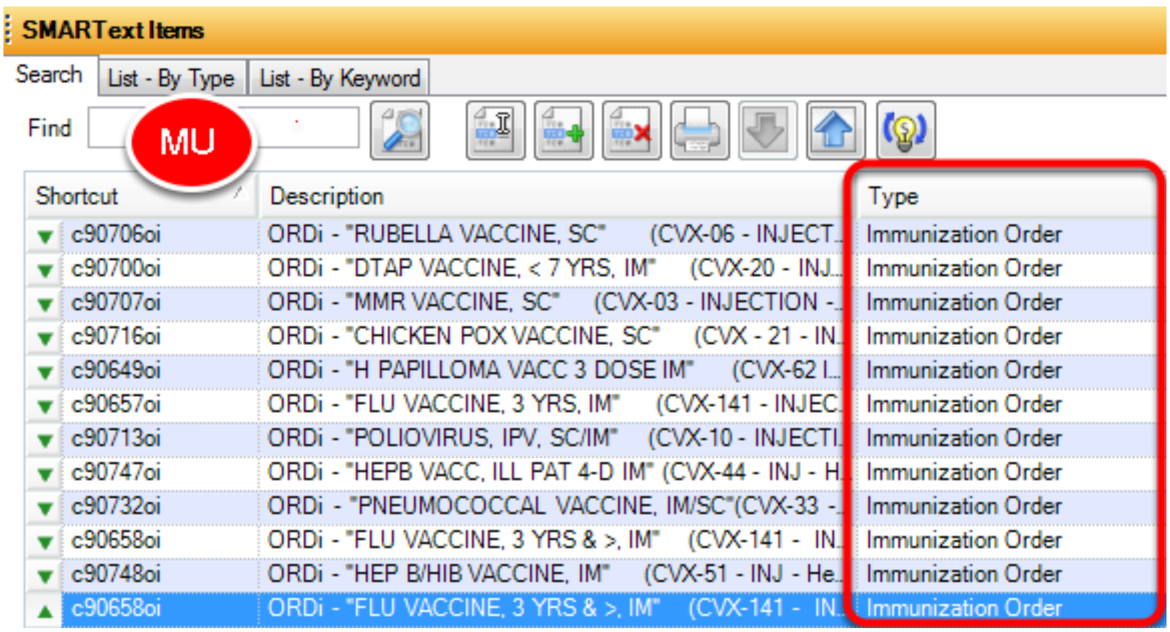


1. Click on Structured Immunization Entry.

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-specfic.

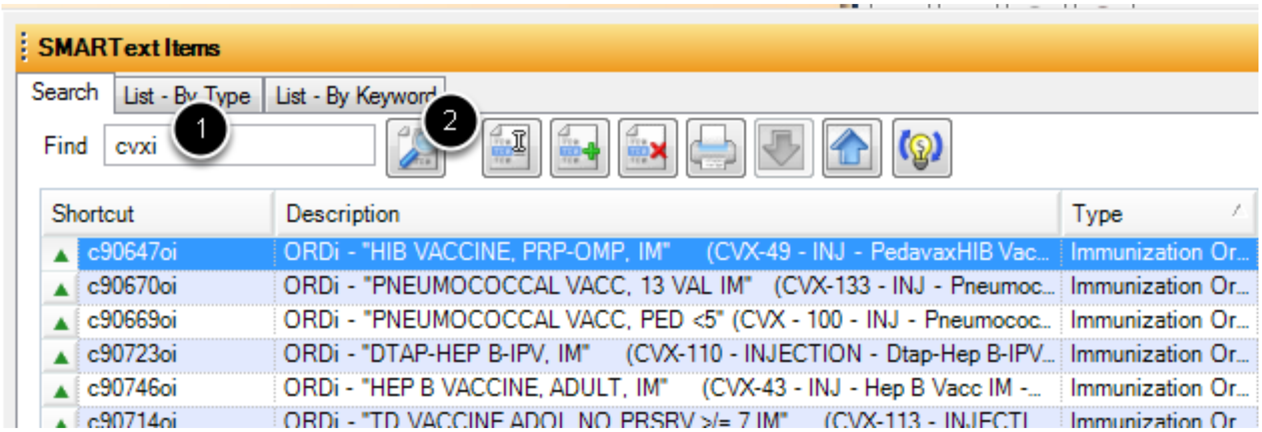
Immunization Order SMARText Item Type



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 code.
5. They **cannot** be inserted using the F4 Quick Entry Method.

<u>Immunization Orders may only be entered using Order Manager.</u>

Search for Immunization Orders

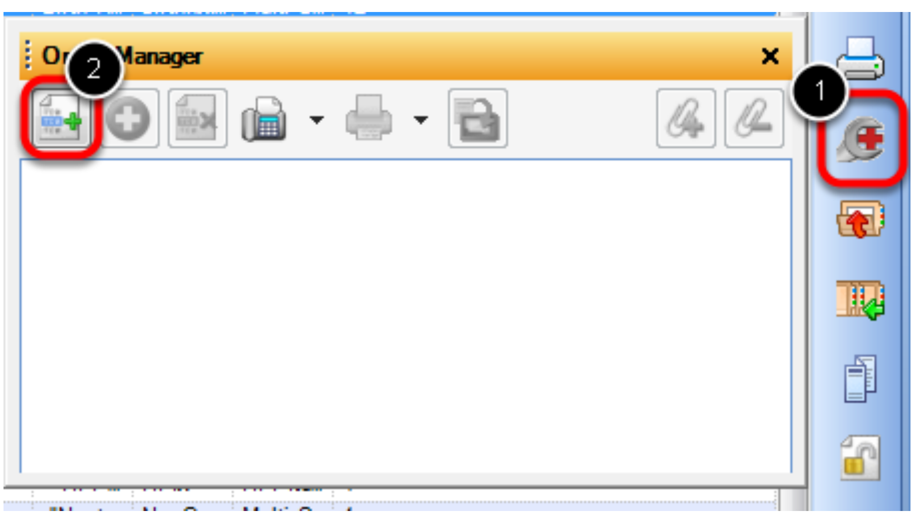


1. Search for Immunization Orders by typing in the keyword, "CVXi," into the Find Box.

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

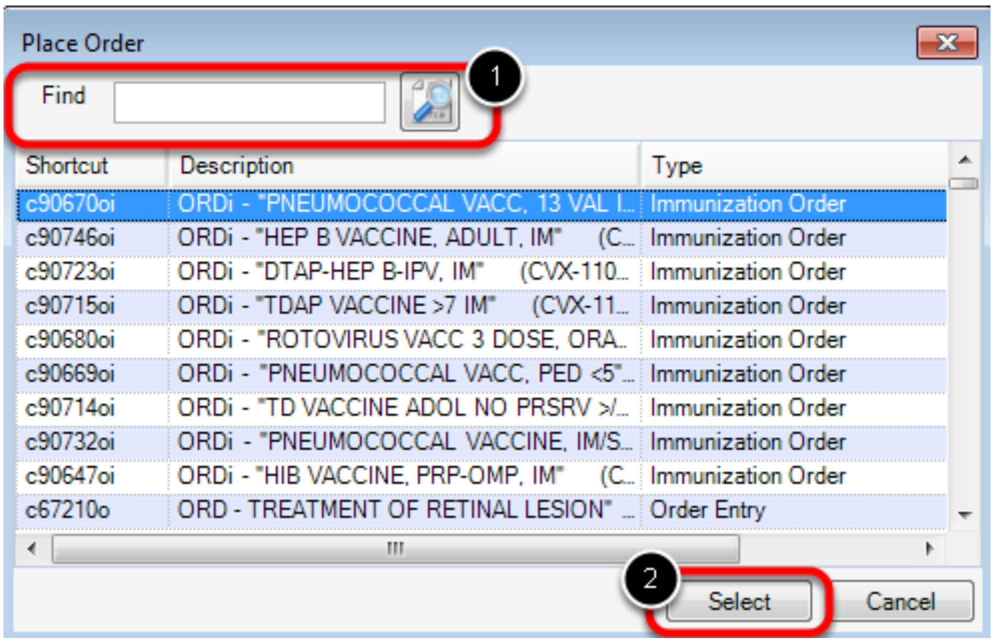


Immunization Orders may only be entered using the Order Manager.

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.

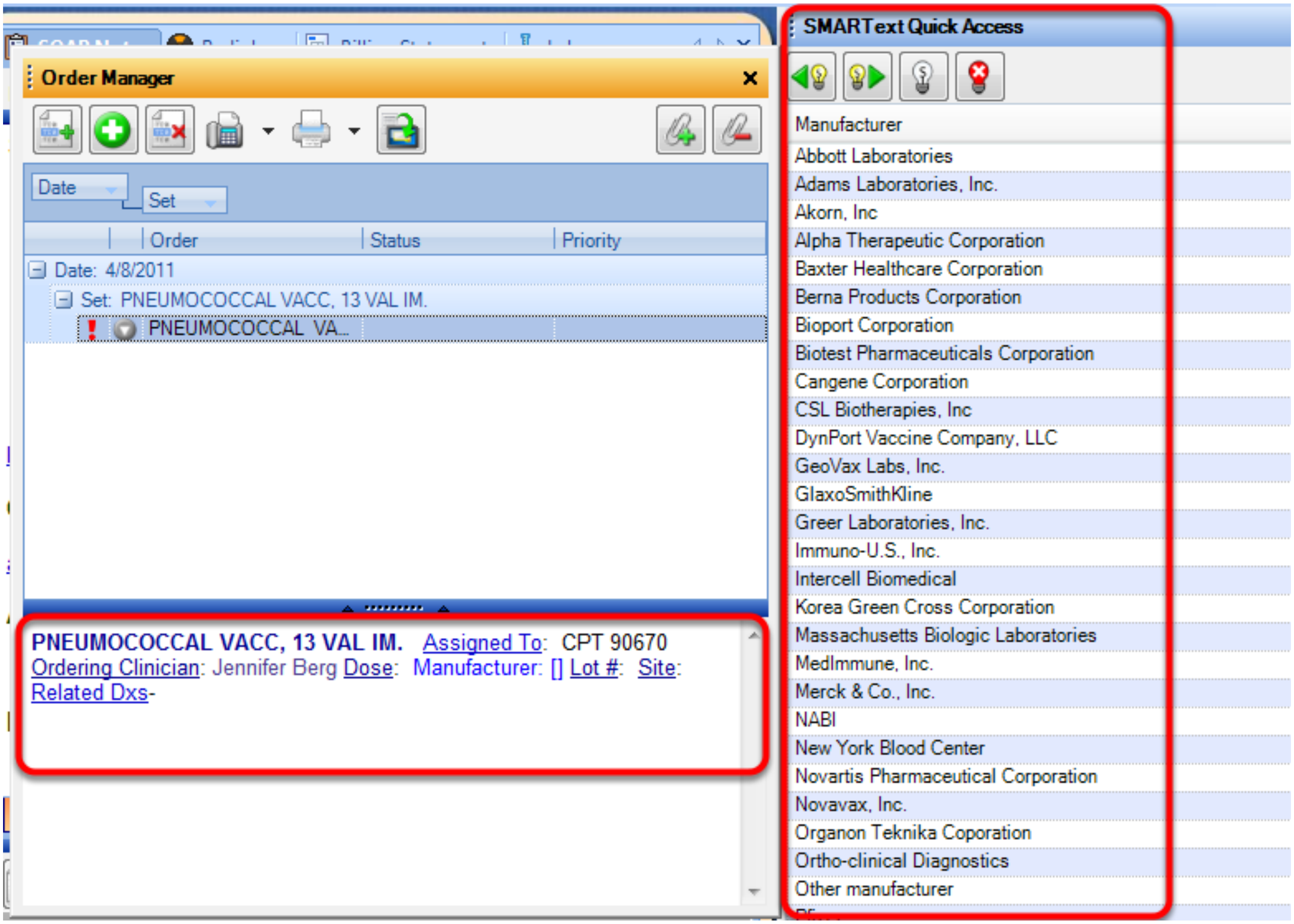


To Select an Immunization:

1. Enter Keywords into the Find box and Click the Search button or scroll to select the Immunization.

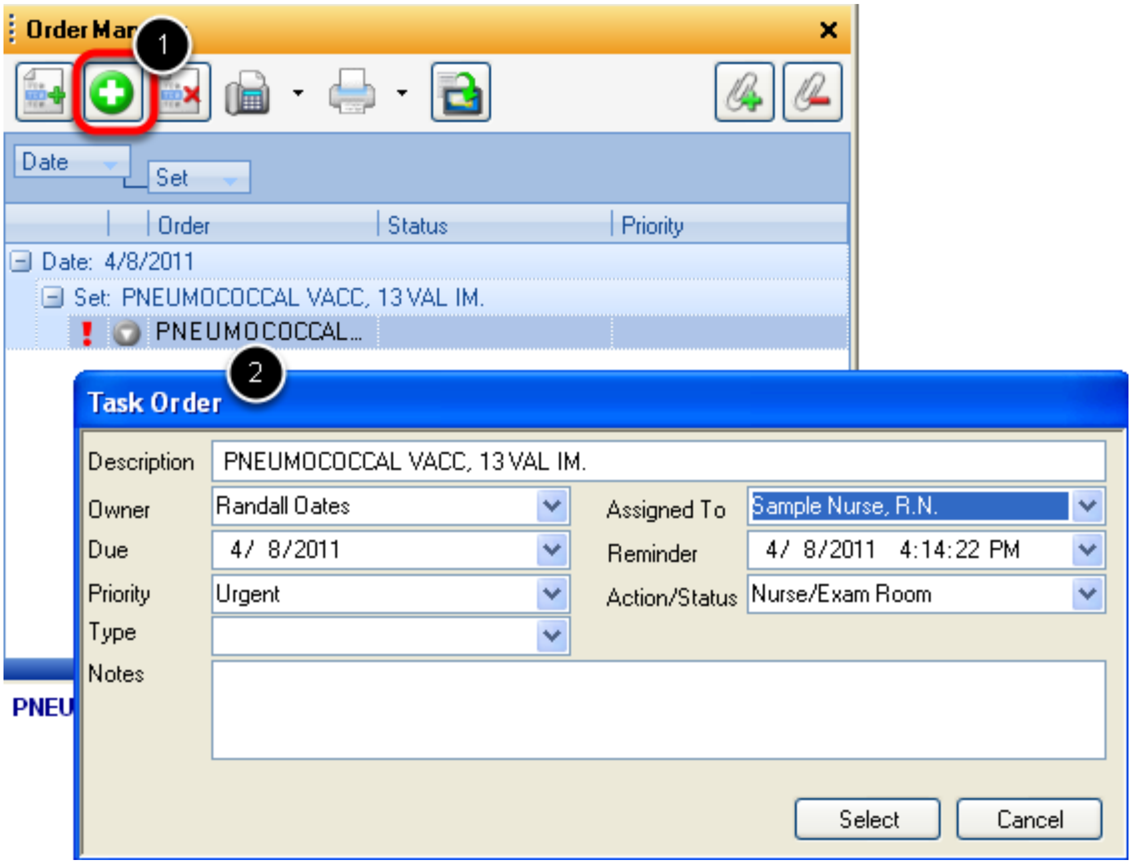
2. Click Select.

Documenting Immunization



The 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.

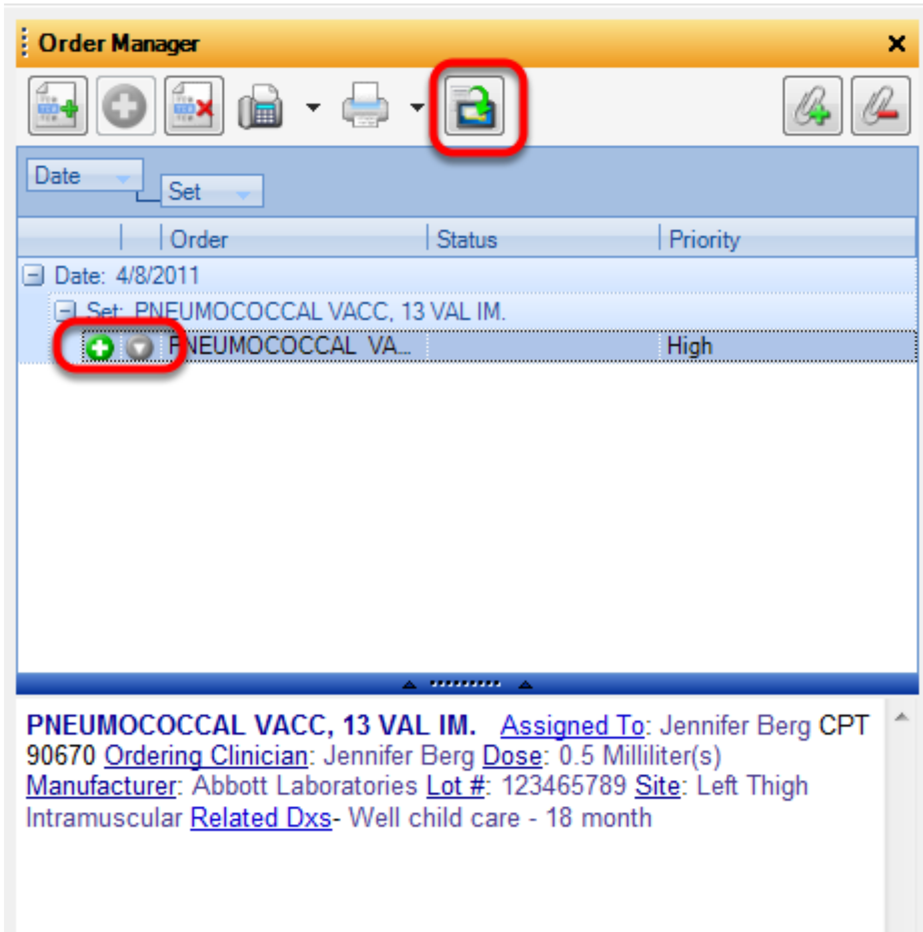


Place the Order

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).

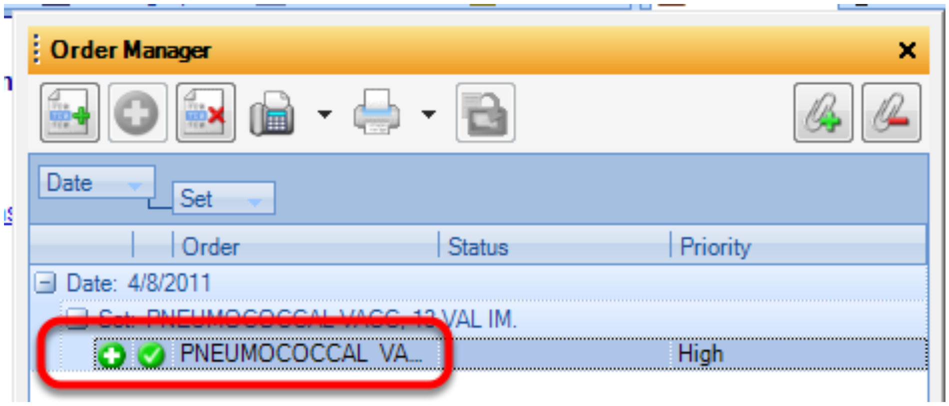
2. Placing the order will create a Task Item to be sent to the Assigned To's task list to perform. Enter any desired information on the Task Item then Click Select.

Transfer to SOAPnote



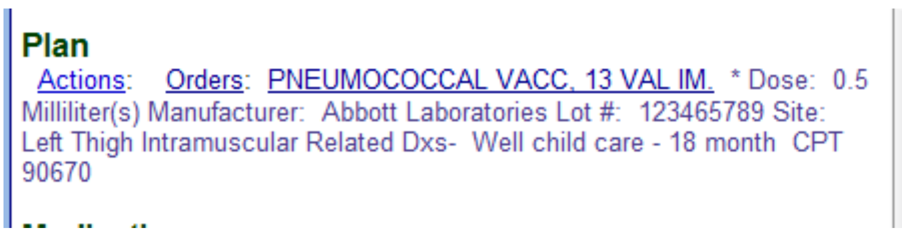
After the order has been placed the Red exclamation sign will change to a Green + sign. This indicates that the Order has been placed and sent to the appropriate staff to complete.

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



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

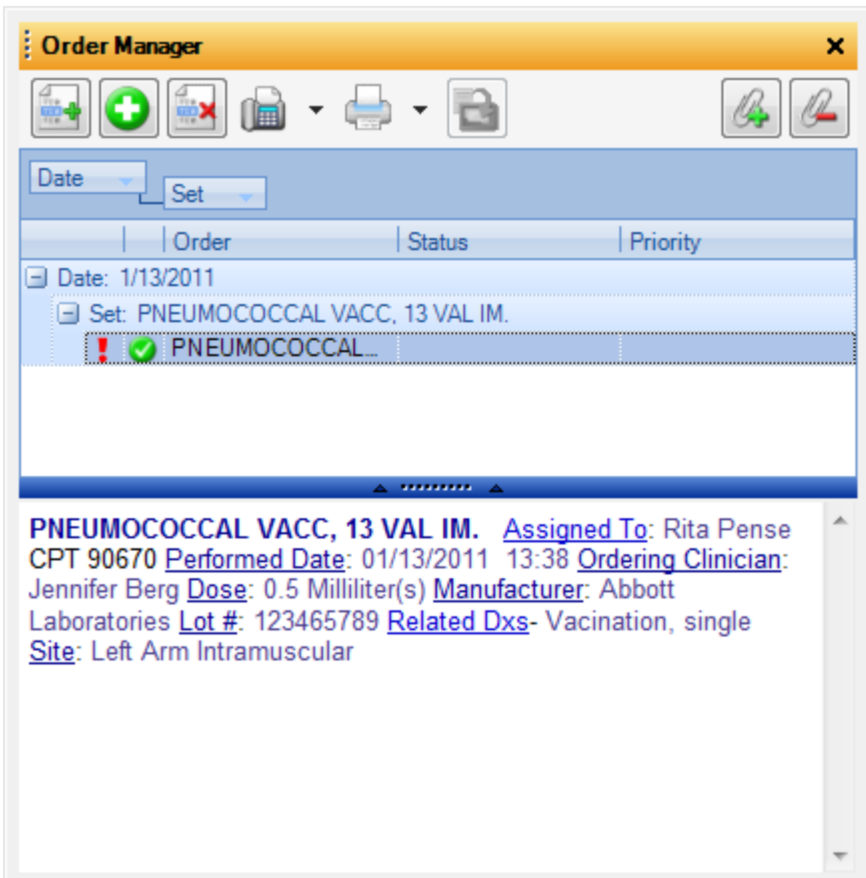
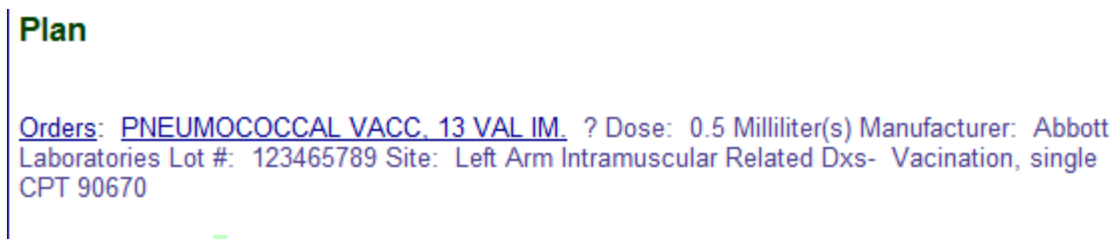


Illustration above displays an immunization order entered using the Order Manager. For more information on Order Manager, see: Order Manager.

Due to the way Immunization Order 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.

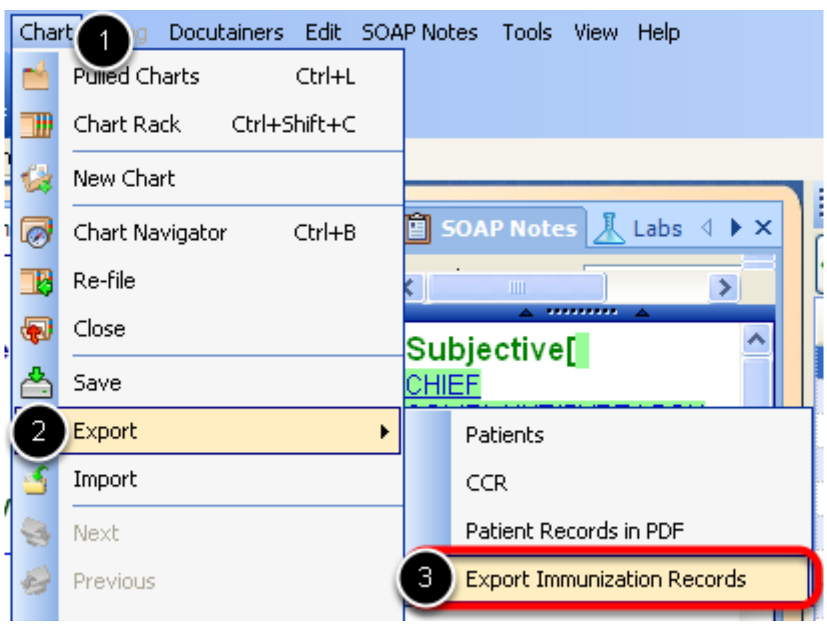
4. They **cannot** be inserted into the Plan field by using a shortcut code.
5. They **cannot** be inserted using the F4 Quick Entry Method.

Immunization Orders may only be entered using Order Manager.



Orders transferred to the SOAPnote from Order Manager appear as above.

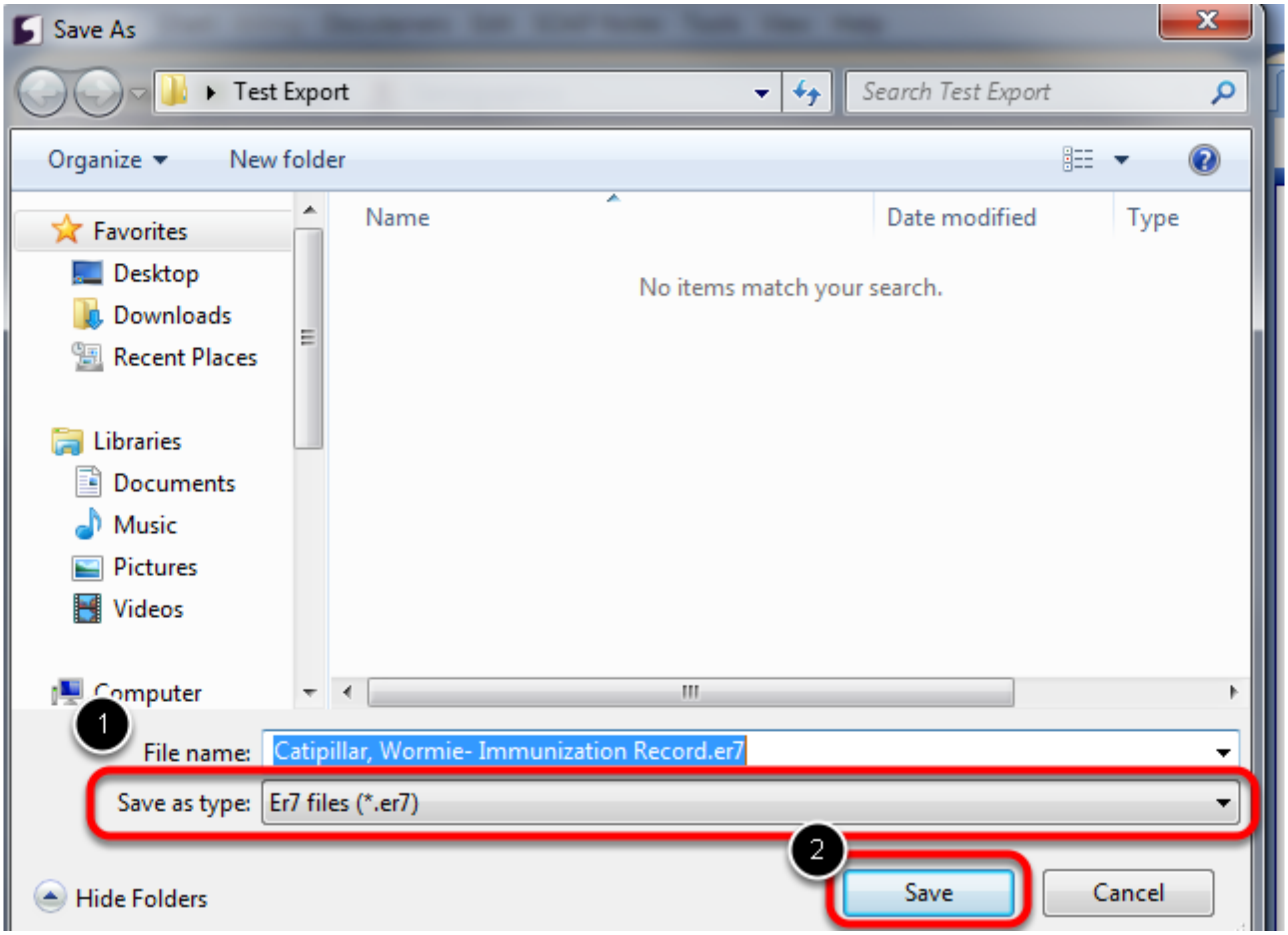
Submitting Immunizations



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.

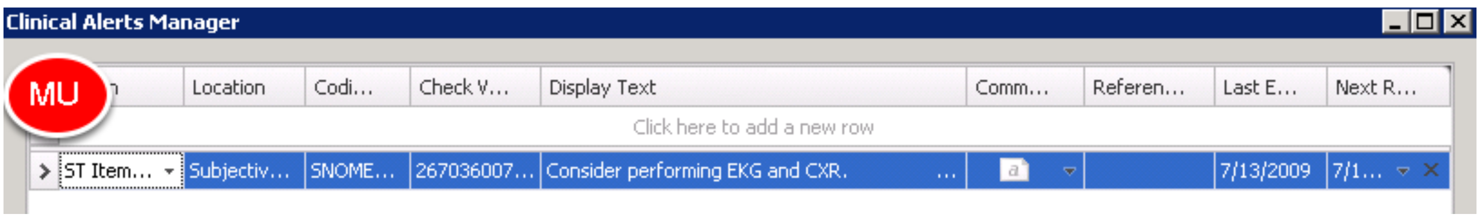
Clinical Alerts

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.

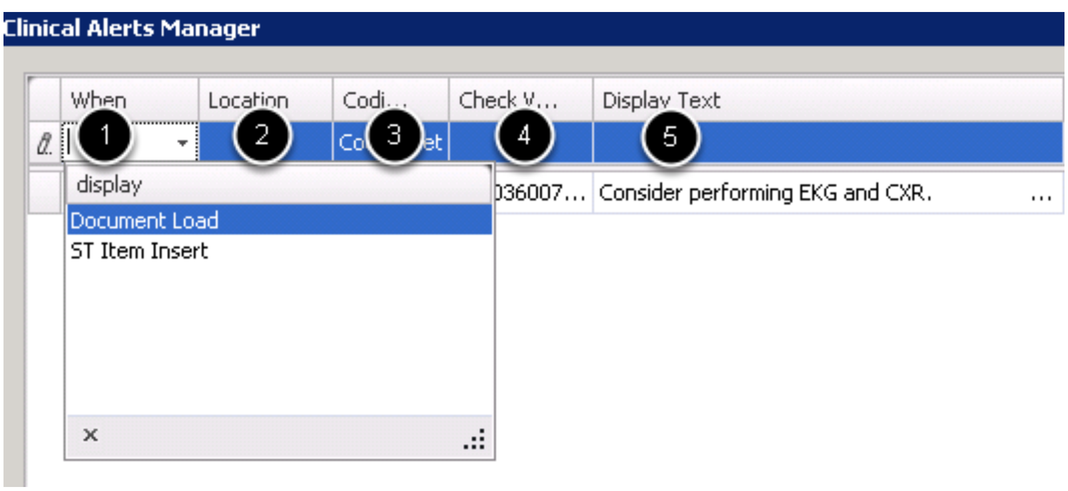
***REQUIRED FOR MEANINGFUL USE:** CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP
- OR Clinical Decision Support Rule

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.

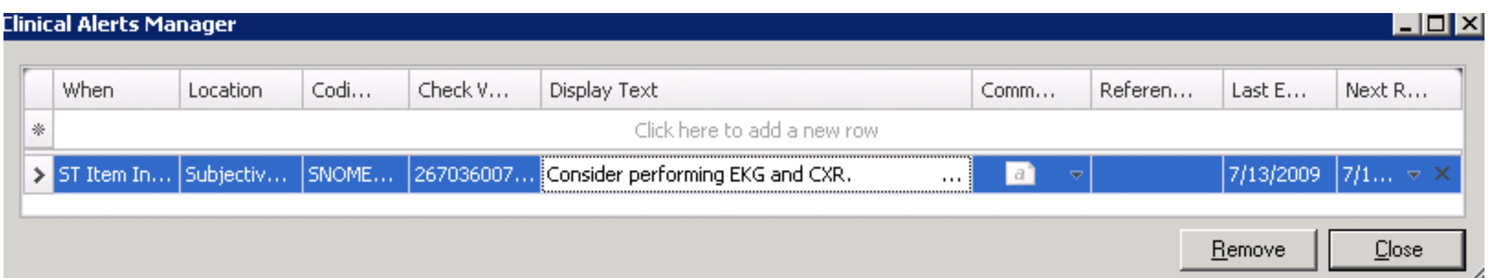
4. Check Value- This is the value SOAPware looks for to match. In the case of text, it is case insensitive.

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.

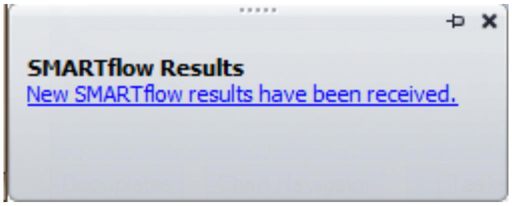
Any pending alerts can be displayed, on demand, for the current chart by Clicking "View" in the main menu, and Selecting Clinical Alerts.

Removing a Clinical Alert



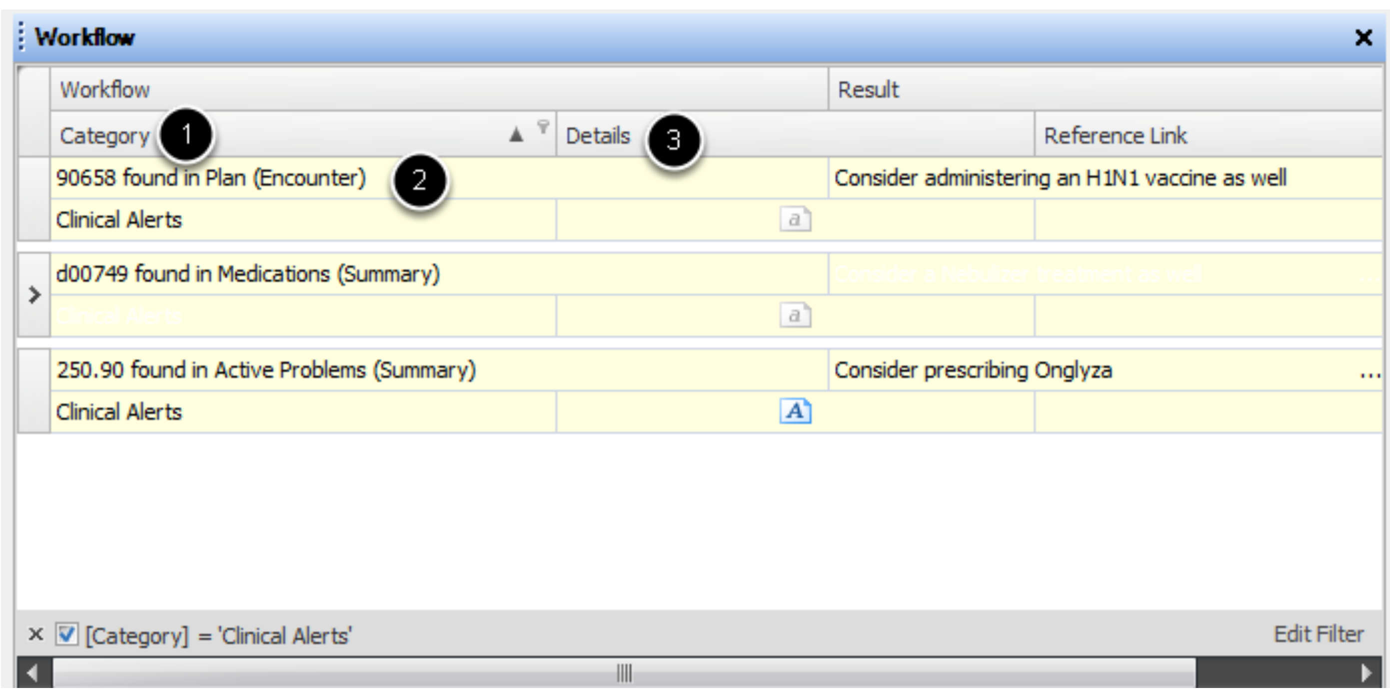
Click to highlight the line item, and then Click on the Remove button.

Clinical Alerts Display



The alert results as a pop-up notifying the user of new SMARTflow Results, meaning a clinical alert has been triggered. Auser is able to click on "New SMARTflow results have been received" which will then take the user to the Workflow Display Manager.

SMARTflow Results



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

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 SMARText 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 "PQRItob".

* **0028b:** Preventive Care and Screening Measure Pair: (b) Tobacco Cessation Intervention
The shortcut code that has been created for this measure is "PQRIqui".

NQF 0421/PQRI 128 (Core): Adult Weight Screening and Follow Up
The shortcut code that has been created for this measure is "PQRIbmi."

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 "PQRIwei".

NQF 0038 (Alternate Core): Childhood Immunization Status

NQF 0041/PQRI 110 (Alternate Core): Preventative Care and Screening: Influenza Immunization for Patients > 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 "PQRIastAss".

NQF 0002/PQRI 66: Appropriate Testing for Children with Pharyngitis
The shortcut code that has been created for this measure is "PQRIpha".

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 "PQRIche".

NQF 0012: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
The shortcut code that has been created for this measure is "PQRIpreHIV".

NQF 0014: Prenatal Care: Anti-D Immune Globulin
The shortcut code that has been created for this measure is "PQRIantD".

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 "PQRIchl".

NQF 0034/PQRI 113: Colorectal Cancer Screening
The shortcut code that has been created for this measure is "PQRIpreCol".

NQF 0036: Use of Appropriate Medications for Asthma
The shortcut code that has been created for this measure is "PQRIastThe".

NQF 0043/PQRI 111: Pneumonia Vaccination Status for Older Adults
The shortcut code that has been created for this measure is "PQRIpne".

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 "PQRIlowBacl".

NQF 0055/PQRI 117: Diabetes: Eye Exam
The shortcut code that has been created for this measure is "PQRIdmEye".

NQF 0056/PQRI 163: Diabetes: Foot Exam
The shortcut code that has been created for this measure is "PQRIdmFoo".

NQF 0059/PQRI 1: Diabetes: HbA1c Poor Control
The shortcut code that has been created for this measure is "PQRIdmA1c".

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 "PQRIdmNep".

NQF 0064/PQRI 2: Diabetes: LDL Management & Control
The shortcut code that has been created for this measure is "PQRIdmLDL".

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 "PQRIcadPla".

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 "PQRIivd".

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 "PQRIcadBB".

NQF 0073/PQRI 201: Ischemic Vascular Disease (IVD): Blood Pressure Management
The shortcut code that has been created for this measure is "PQRIivd".

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 "PQRIivd".

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 "PQRIhfACE".

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 "PQRIhfBB".

NQF 0084/PQRI 200: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
The shortcut code that has been created for this measure is "PQRIhfWar".

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 "PQRIdmEye".

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 "PQRIdepMed".

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 "PQRIcol".

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".

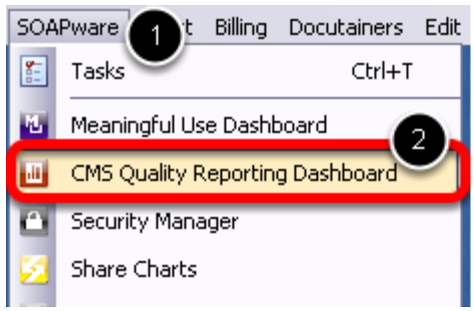
NQF 0389/PQRI 102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
The shortcut code that has been created for this measure is "PQRIproBon".

NQF 0575: Diabetes: HbA1c Control (<8%)

How to Use the CMS Quality Reporting Dashboard

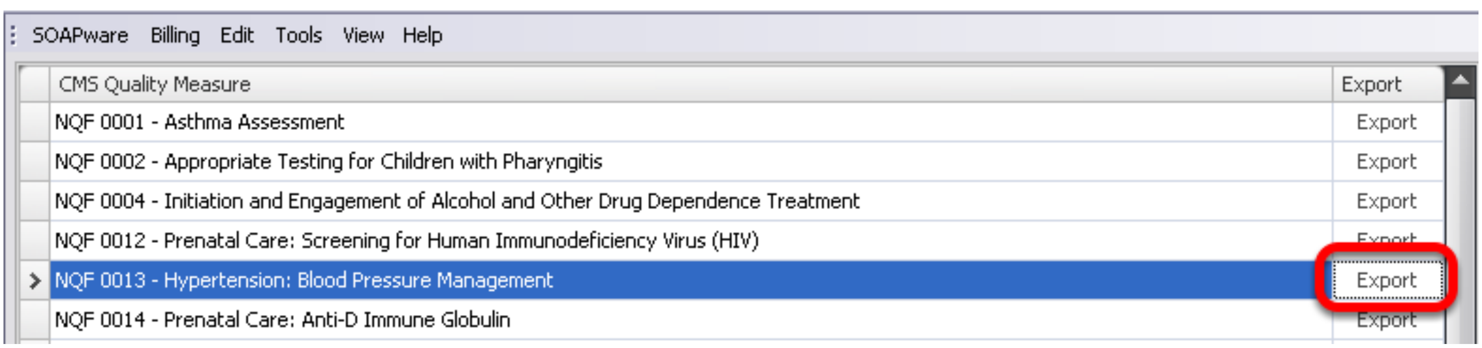
This lesson is designed to walk the user through the steps of exporting Quality Measures data for reporting.

CMS Quality Reporting Workspace



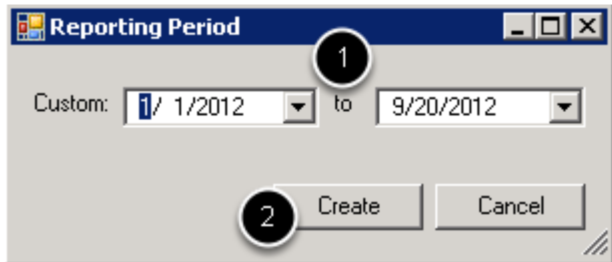
1. Click on the SOAPware Menu
2. Select the"CMS Quality Reporting Dashboard"

Clinical Quality Measures Export

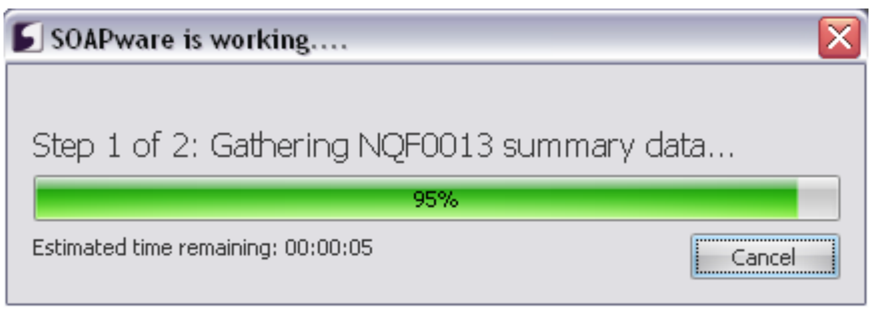


To export the data for a specific clinical quality measure, locate the quality measure to export and Click the Export button.

Select the Reporting Period

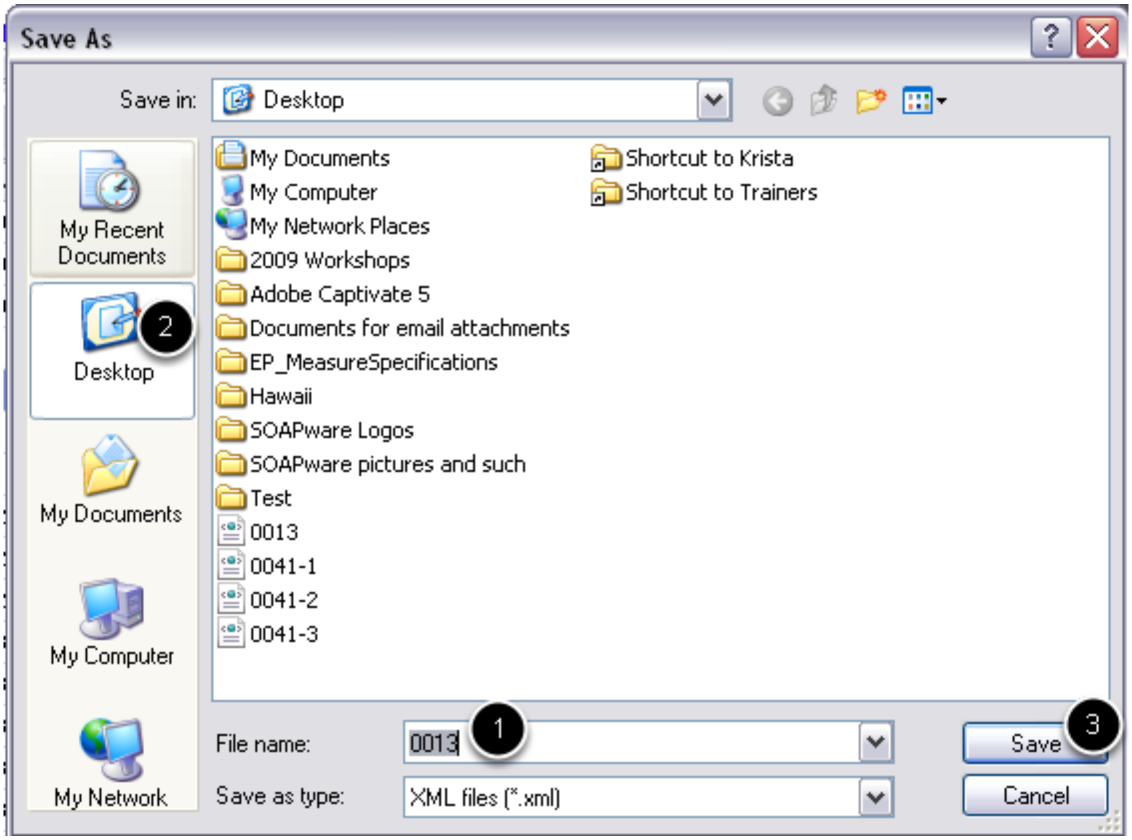


1. To select the reporting period for the export, choose the Custom option and enter the desired reporting period.
2. Click the **Create** button to begin the export.



While the report is running, the user will see a progress bar similar to the one shown above.

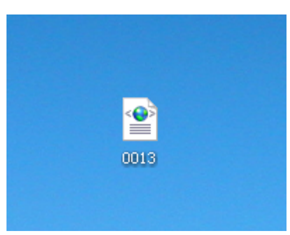
Saving the Export Results



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.

Reading the XML File


```
<?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

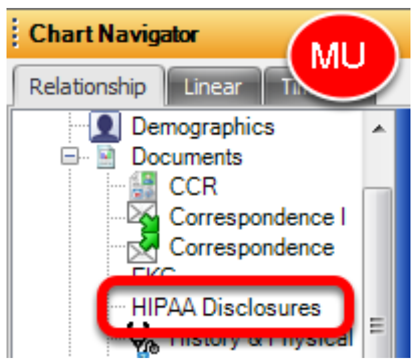
Record of Disclosures

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

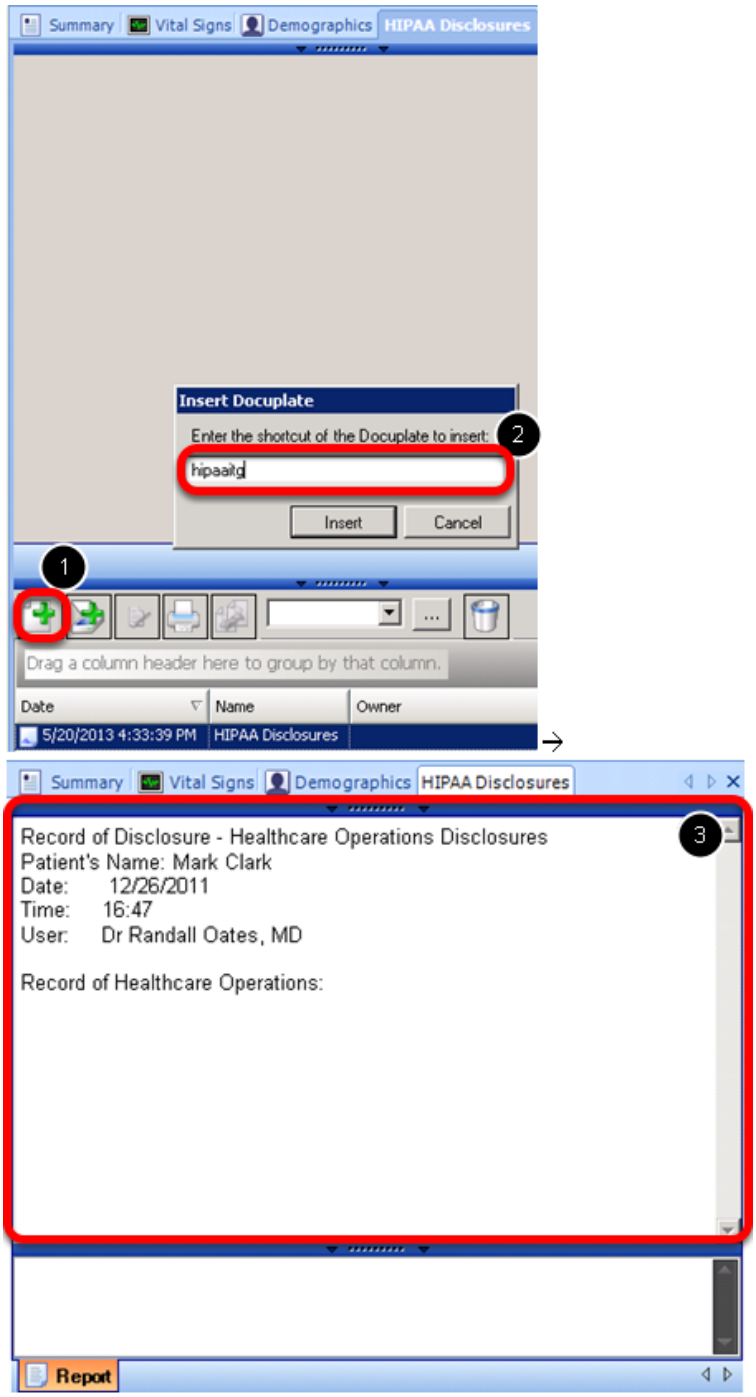
***Note**: Please download the following docuplates into the database first, before proceeding with these steps.......Search using the following keywords: payment, treatment, and health care ops.*

Open the HIPAA Disclosures Chart Section



With a patient's chart open, access Chart Navigator, and double-click on "HIPAA Disclosures" to insert this chart section.

Record of Payment

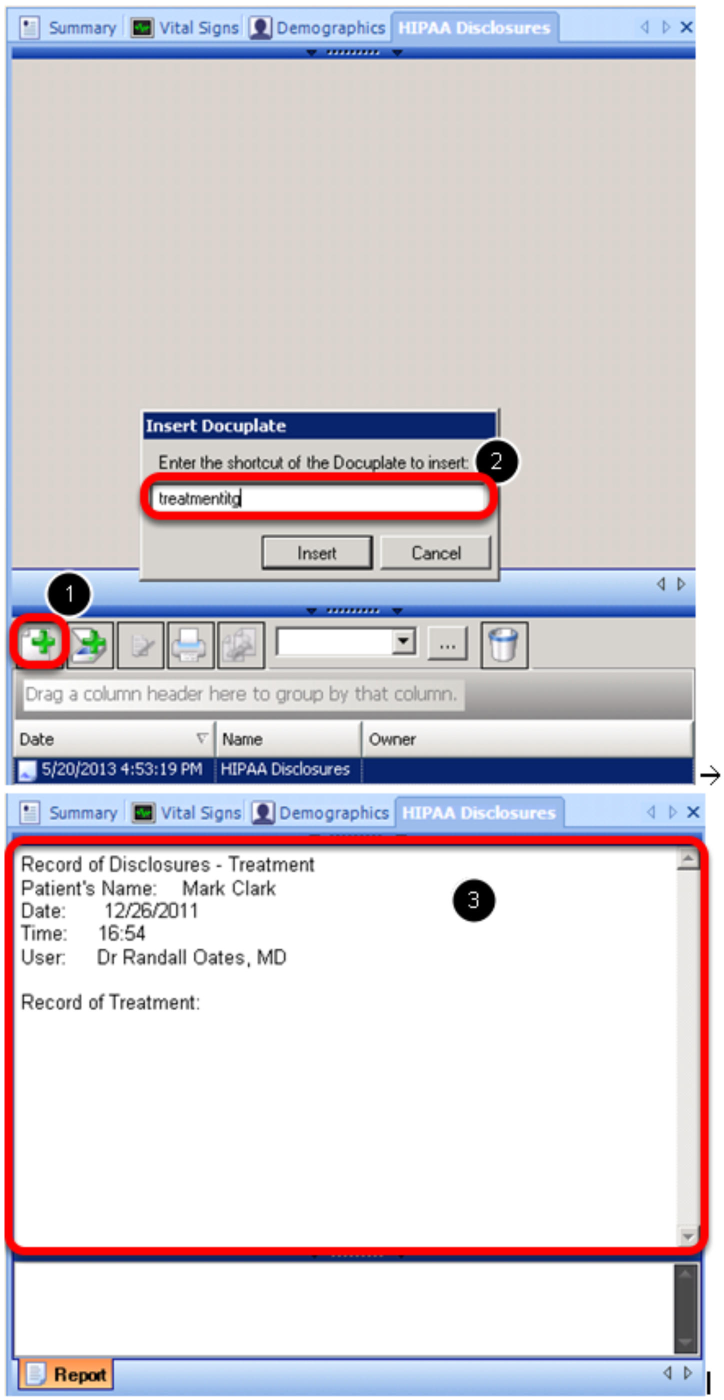


1. Click the create a new docutainer button while in the HIPAA Disclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "HIPAAitg," then Click on the "Insert" button. ***Note:*** *Before inserting the docuplate, you must first download the docuplate. Search for and*

download the docuplate using "HIPAAitg".

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

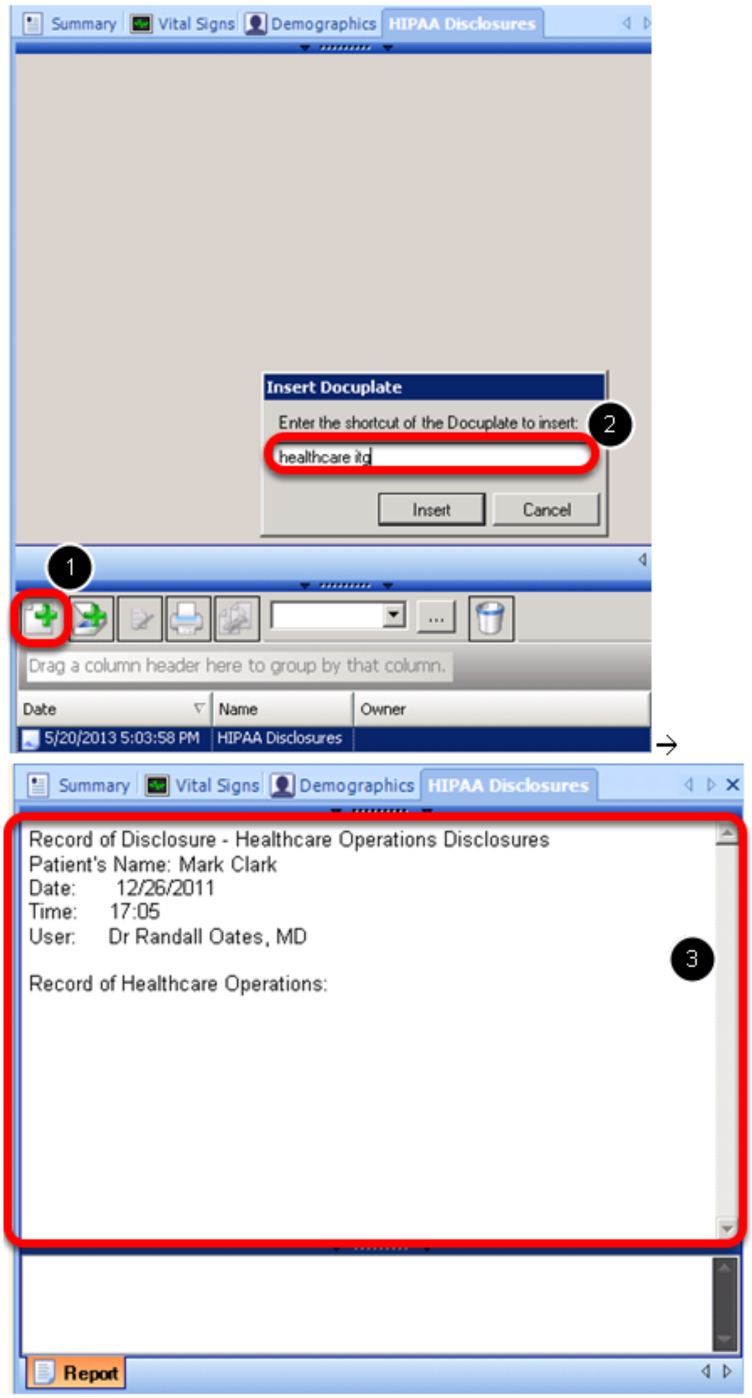


1. Click the create a new docutainer button while in the HIPAA Disclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "treatmentitg" then Click on the "Insert" button.

***Note:** Before inserting the docuplate, you must first download the docuplate. Search for and* *download the docuplate using "treatmentitg".*

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.

Record of Health Care Operations



1. Click the create a new docutainer button while in the HIPAA Disclosures chart section.
2. Hit F5 on the keyboard, type in the shortcut "healthcare itg" then Click on the "Insert" button.

***Note:** Before inserting the docuplate, you must first download the docuplate. Search for and* *download the docuplate using "healthcare itg".*

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

To learn the recommended workflows to meet Meaningful Use, see: Meaningful Use Roadmap.

Upgrades and Updates (2012+)

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

Following the release of 2012, SOAPware customers will have the ability to install updages through the Automatic Update process. For instructions on using Automatic Update, please see: **Automatic Updates.**