

Clinical Reconciliation is a process used to verify clinical data that is received from outside EMR's. Continuation of Care Documents will be imported into the chart. During a patient intake, the following components within the Ambulatory Workflow may require reconciliation: Problems, Procedures, Allergies, Home Medications, and Immunizations. Outside records will be indicated by purple diamonds.

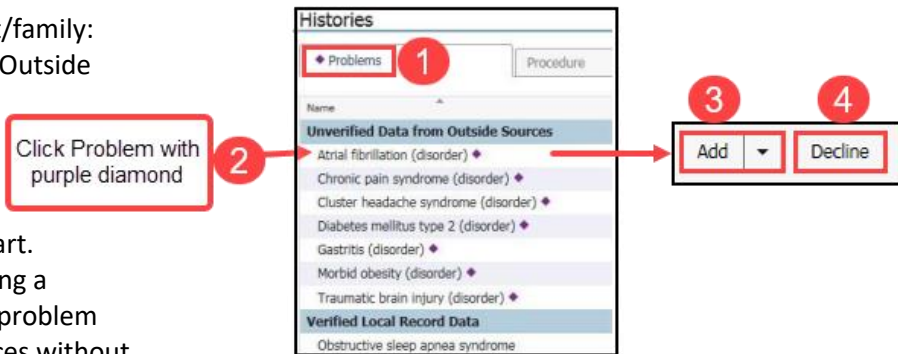
Histories

In the Histories component of the Ambulatory Workflow, Unverified Data from Outside Sources may be present with purple diamond icons in the Problems and Procedures tabs, indicating they need to be reconciled.

Problems Reconciliation:

Verify each Problem and Procedure with the patient/family:

1. Select the Problems in Unverified Data from Outside Sources.
2. Click on each Problem with a purple diamond.
3. Selecting Add if the history is verified. This will add the outside record to the patient chart.
4. Select Decline if patient/family declined having a history of the problem. This will remove the problem from the Unverified Data from Outside Sources without adding the problem to the patient's chart.
5. Complete steps 2-4 for each problem with a purple diamond.
6. Select the Procedures tab and complete steps 2-5.
7. Click back on the Problems tab and click Complete Reconciliation to indicate all information has been reviewed and reconciled.



[Complete Reconciliation](#)

Note: When no outside records are present, Reconciliation still needs to be completed.

8. Select No Chronic Problems from the list if the patient has no chronic problems.

Note: The provider is responsible for managing the problem list. If the patient/family is not certain of any problems/procedures leave unverified data from the outside resources, for the provider to complete.


Allergies

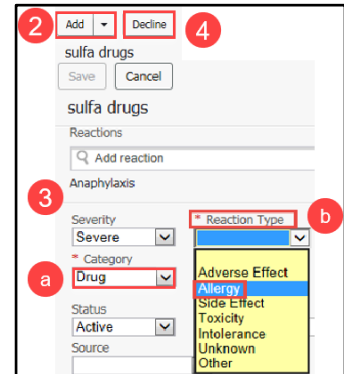
Navigate to the Allergies component from the Ambulatory Workflow. Purple diamonds are present if outside records are unverified.

To **verify** each purple diamond:

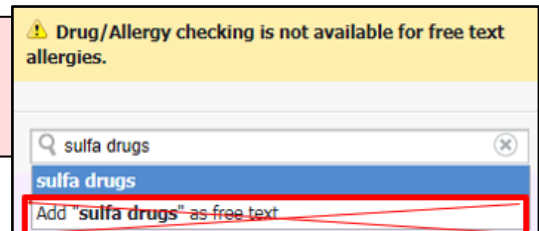
1. Select each substance with a purple diamond.

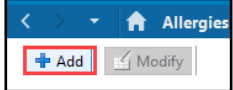

Substance	Mismatches Identified	Reactions	Severity
Unverified Data from Outside Sources			
1. sulfa drugs	new Drug allergy found	Anaphylaxis	Severe
atropine-diphenoxylate	New Drug allergy found	Cutaneous eruption	--
eggs	New Food allergy found	Cutaneous eruption	--
Verified Local Record Data			
nitrofurantoin	--	--	Severe

2. If the outside record is verified by the patient/family, select Add to include Allergy to the patient's chart.
3. Complete each required field:
 - a. Category.
 - b. Click the down arrow to select the Reaction Type.
 - c. Click Save. 
4. Select Decline if patient/family declined the allergy. This will remove from the allergy list.
5. Leave any Unverified Data from Outside Resources, for the provider to complete.



NOTE: Never select free text when entering an Allergy. Always select a coded option. Drug/Allergy checking is **not** available for free text allergies.



6. Once outside records are confirmed/denied, add any additional allergies by selecting Add. 
 7. Click Complete Reconciliation. 
- For more information on allergies: see the Allergies Component Overview on the Clinical EHR Education Website.

• Allergy Tips

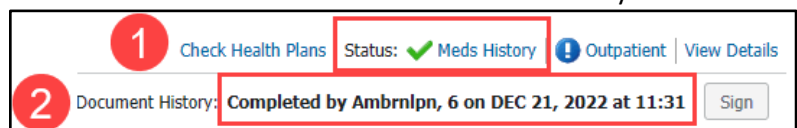
1. When the patient has no known allergies
 - a. Within the Allergies tab select No Know Allergies
2. When the patient has environmental or food allergies, but no know medication allergies:
 - a. Within the Allergies tab select No Known Medication Allergies.



Home Medications

The intake process includes patients home medication review and compliance documentation and is performed at each visit within Document Medication by History

1. The Reconciliation Status bar will display a green checkmark to indicate the home medication entry has been completed. This meets the regulatory requirement for entering home medications.
2. A time stamp indicates the entry and reconciliation has been completed.

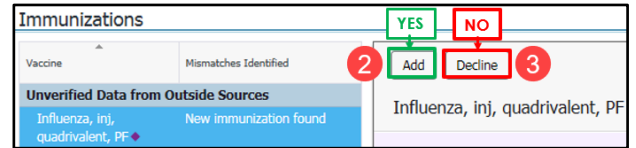


For more information on Home Medication compliance, see Documenting Medications by History on the Clinical EHR Education Website.

Immunizations

Verifying outside immunization records:

1. After verifying with the patient/family click the immunization name.
2. Select Add to include the immunization to the patient's chart.
3. Select Decline if patient/family declines the immunization history, this will remove the immunization from the list.



Note: There is no reconciliation button for immunizations.

4. A MICR query may be completed to view immunizations and import the information to PowerChart if needed.

For more information see the Immunization Manual on the Clinical Education Website for further information on immunizations.

