McKESSON Canada

propel Rx

NEWFOUNDLAND & LABRADOR DRUG INFORMATION SYSTEM (DIS) USER GUIDE

PHARMACY TECHNOLOGY SOLUTIONS
A DIVISION OF McKESSON CANADA

Revision History

To maintain the accuracy of this document, any changes made will be noted in the table below. Please refer to this section before using this document to ensure no updates were made to the content you may be referencing.

Date	Revision
December 19, 2023	Addition of the All Failed EHR checkbox in the Pick Up/Delivery tile.

Helpful Links

Need more information on how to use Propel Rx? Refer to the Propel Rx Online Help.

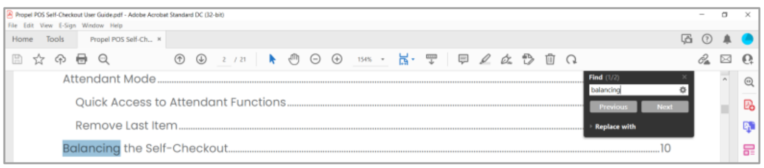
How to Use this User Guide

To navigate this user guide quickly, use the **Table of Contents** to find your topic or search for a keyword using one of the following features:

- **Find Feature** – Searches the PDF for your keyword and displays one result at a time in sequential order.
- **Advanced Search Feature** – Searches the PDF for your keyword and displays all the pages that contain that key word on the left side. You can click on any page from the panel, and it will display the content on the side.

To use the Find Feature:

1. Select **Edit** > **Find**. The **Find** window appears.

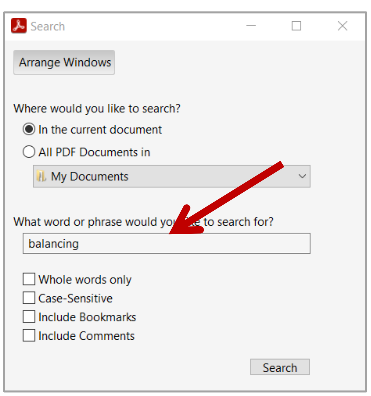


2. Enter in the keyword you want to search (e.g., balancing).
3. Select **Next** to view the next page that contains the keyword you searched.

TIP: The **Find** window can also open by selecting **Ctrl + F** on the keyboard.

Using the Advanced Search Feature:

1. Select **Edit** > **Advanced Search.** The **Search** window opens.



2. Enter in the keyword you want to search (e.g., balancing).
3. Select **Search**.
4. From the *Results* returned, select the page you want to view.

TIP: The **Search** window can also open by selecting **Shift + Ctrl + F** on the keyboard.

Contents

Getting Started

If you are new to Drug Information System (DIS)/Electronic Health Record (EHR) integration, or you would like to refresh your memory on various aspects of the EHR, review the information outlined in this User Guide. Before you begin transmitting claims to the EHR, it is important you read and understand the information provided in this User Guide.

Introduction to eHealth

The Newfoundland and Labrador Pharmacy Network (NLPN) is a provincial online Drug Information System (DIS), which provides authorized health professionals with comprehensive medication profiles for all patients.

In many provinces, the Prescription Drug Act requires pharmacies to submit all dispenses on behalf of provincial residents to the EHR. This process allows a patient's medication profile, also known as an Electronic Health Record (EHR), to be complete with vital clinical information that is necessary for appropriate and timely care. The NLPN connects pharmacists, physicians, nurse practitioners, and other authorized health professionals with a patient's EHR to allow this information to aid in effective health planning, evaluation, and research.

Since the NLPN is not in any way connected to the Newfoundland and Labrador Prescription Drug Program (NLPDP) system, it contains only clinical information concerning a patient.

ALERT: All personal health information is subject to statutory protection under the Health Information Protection Act (HIPA). As a result, access to patient data for all EHR enabled provinces are limited to those who are authorized and for security purposes by their organization, within user-defined roles.

Client and Provider Registry

The Client Registry (CR)and Provider Registry (PR) are provincial registries that interact seamlessly with NLPN. The CR maintains client identifiers and demographic information and is the source for validation of patient information. The PR maintains identification, demographic, and credential information of health service providers.

In Newfoundland, pharmacies are one of the source systems to the provincial CR. Patient records maintained within Propel Rx (retail and non-retail) must be synchronized with the CR to ensure local patient information is added to the CR.

At this time, Propel Rx is not integrated with the PR. Provider information can however be sourced from a prepopulated list using MD Match.

Glossary of Terms

Terminology	Translation
Adverse Drug Reaction (ADR)	Any adverse event associated with the use of a drug, whether considered drug related or not, including the following: • An adverse event that can occur after using a drug. • An adverse event occurring from drug overdose. • An adverse event occurring from drug withdrawal.
Animal	Patient Status to indicate the patient is not an active patient, but perhaps a family pet. An Animal record will have no provincial health number. Prescriptions for animals are not transmitted to the EHR. Patients that have had EHR activity will not be entitled to change their Status to an Animal.
Client Registry	A comprehensive registry of residents that contain patient client demographic information. This information can be reviewed by all users that have EHR Access.
Consent	For a health professional to view a patient's EHR data that has been masked, consent must be provided by the patient. Consent can be given in the means of either a Keyword or Break-the Glass (override consent).
Create and Dispense	The portion of the prescription that is recorded on the EHR. The Create is the original prescription information from the prescriber (either created electronically by the prescriber or transcribed by the pharmacist). The Dispense is the act of dispensing the prescription.
Detected Issue	The list of clinical conflicts that have been detected and recorded involving a patient's drug administration. Issues can be managed in NL.
Device	An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory. In Newfoundland, all DEVICE products use a Product Identification Number (PIN). These PINs are identified on the OPINIONS PIN List.
Drug Information System (DIS)	A single, secure repository where health professionals can view all the drugs dispensed to patients, regardless of the location or prescriber.

Terminology	Translation
Electronic Health Record (EHR)	A patient medication profile that resides on the DIS. The EHR checkbox throughout Propel Rx indicates whether the information resides on the DIS.
Issue Management	When a Detected Issue is brought to the attention of a health professional, it may be necessary to deal with it by entering an Issue Management(s). The Issue Management provides information to other health professionals regarding the actions or outcomes taken to resolve the Detected Issue(s).
Masked	Indicates that a patient profile has been protected from viewing. Only authorized health professionals will be granted consent to view masked data.
National Association of Pharmacy Regulatory Authorities (NAPRA)	A voluntary association of provincial and territorial pharmacy regulatory bodies, as well as the Canadian Forces Pharmacy Services. NAPRA regulates the practice of pharmacy and operation of pharmacies in their respective jurisdictions in Canada. Their primary mandate is to protect the public.
Newfoundland and Labrador Health Services	A crown corporation of the government of Newfoundland and Labrador responsible for developing and implementing the province's confidential and secure Electronic Health Record (EHR).
Newfoundland and Labrador Pharmacy Network (NLPN)	A province-wide system that links pharmacies to a record of a patient's medications.
Other Medication Record	A record of a drug the patient is taking but was not prescribed through the system. This could be a recommended OTC product or a dispense that occurred out of province. This could also be used when a patient is provided a medication sample.
Out of Province	A patient Status that indicates the patient does not reside in this province and has no provincial health number.
Patient Medication Profile	The portion of a patient's record that contains specific information regarding drug therapy. The profile includes all medications prescribed and dispensed for the patient that resides on the DIS.
Personal Health Number (PHN)	A unique identification number assigned to a resident of a province. This number is used to store and retrieve all personal information, including

Terminology	Translation
	their demographics, medication history and eligibility for publicly funded health care. **NOTE:** In Newfoundland, this is called a Medical Plan Number (MCP). To maintain consistency, MCP will be referred to as PHN throughout this User Guide.
Pharmacist ID	Pharmacist Identification number refers to the dispensing pharmacist's license number.
Pickup	To comply with the Act and Regulations, it is important that claims are marked Picked Up in Propel Rx at the time the customer physically picks up the medication, not at the time the prescription is dispensed. Pickup identifies that the prescription is in the patient's possession.
Synchronized	When local patient demographics is synchronized with the information on the CR.

Logging into Propel Rx

Only authorized users will be permitted to connect to the NLPN. Every user will be issued unique eHealth credentials, which will be transmitted with each EHR query. After logging into Propel Rx with your Propel Rx User Name and Password, an EHR User Login window will appear, allowing you to input your EHR Password. Users will still be able to log into Propel Rx without entering their EHR password, however no activity will be permitted with the EHR (e.g., transmitting prescriptions to the EHR, viewing patient EHR Profiles, etc.).

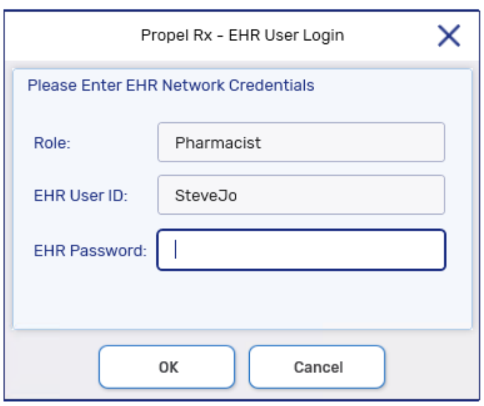
Logging in with the Propel Rx and EHR Password

To log into Propel Rx and the EHR:

1. Double-click the Propel Rx icon on your desktop.
2. In the **User Name** field, enter your Propel Rx user initials.
3. In the **Password** field, enter your Propel Rx password.

> **NOTE:** If a Biometric Fingerprint Reader exists in your pharmacy and you have already set up your fingerprint for your account, skip steps 2 – 3 by scanning your fingerprint to populate your login credentials.

4. If applicable, select the Pharmacist's initials from the dropdown.
5. Select **Login**. The EHR User Login window opens.



6. In the **EHR Password** field, enter your EHR password.
7. Select **OK**. Propel Rx launches and the user is granted EHR access.

Once logged into Propel Rx, the user's login initials are visible in the top right of the title bar, as shown below. This gives all Propel Rx users visibility of which user is currently logged in and processing prescriptions.

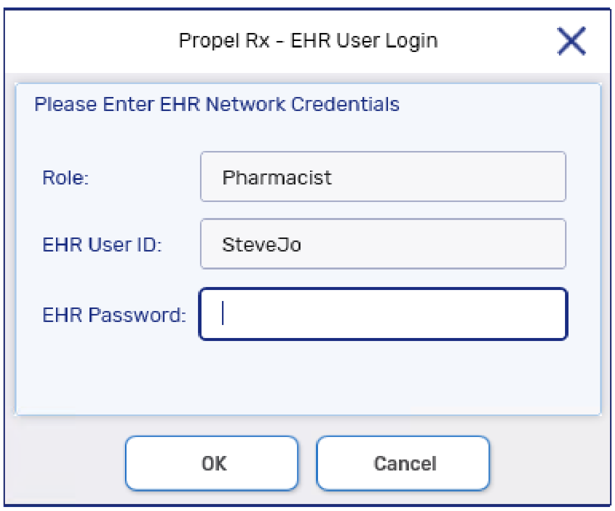
NOTE: Logging into Propel Rx as the Administrator (ADM) user only launches the Security Administration Facility window. The ADM user does not have access to any other area of Propel Rx and cannot fill prescriptions.

Entering the EHR Password After Login

The EHR password is not required to successfully log into Propel Rx but it is required to successfully transmit DIS messages and queries. If the user's EHR password was not entered at login, the user is presented with the EHR User Login window.

To enter the EHR password after login:

1. Select **More (…)** > **EHR** > **Network Login**. The EHR User Login window opens.
2. In the **EHR Password** field, enter your EHR password.



3. Select **OK**.

ALERT: It is imperative that users <u>do not</u> share their Propel Rx or EHR password as all EHR activity is recorded in the Patient Folder History tab, along with the corresponding user.

Managing User Accounts

Propel Rx supports role-based access control, allowing different users to have different levels of access depending on their job functions. For example, certain users can be authorized to view Prescriber Folders but not alter them. By mapping such access privileges to a small set of work-related roles, and then assigning users to those roles, the task of administering user privileges is considerably simplified. It also prevents security mistakes that might otherwise occur if each type of access or service had to be directly mapped to each user.

The **Security Administration Facility** window allows authorized users to add or remove users and customize existing user access options. All Propel Rx user accounts can be managed through this window, which is accessed through the **Security** button within the **More** (**...**) menu, or by logging into Propel Rx as the Administrator (ADM) user. The **Security Administration Facility** window has two tabs: Users and Role Types.

The ADM user, or a user with administrator security access, can assign one of the following access types to the various areas/reports listed for each user:

Access Type	Permissions
Full Access	User can view, modify, and edit the specified folder/window.
Read Only Access	User cannot modify or edit but can view the specified folder/window. In some instances, the user can modify their own settings only (e.g., Password, EHR Password, Narcotic Code).
No Access	User cannot view, modify, or edit the specified folder/window.

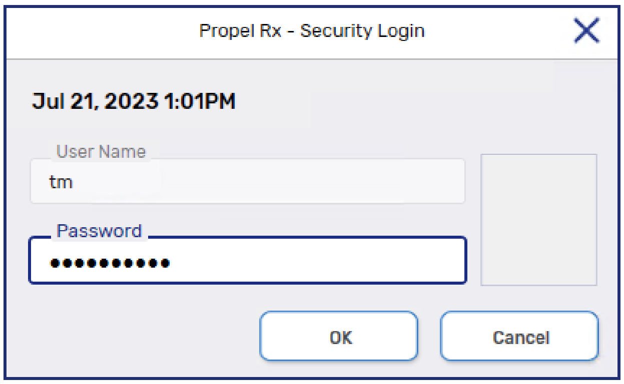
NOTE: For Reports Access, you can only select either Full Access or No Access. There is no Read Only Access for reports.

Upon upgrade to Propel Rx, all users have the same permissions and access they had prior to the upgrade. Any new users added after the Propel Rx upgrade has permissions based on their Role Type. User access for specific Role Types can be seen in the **Role Types** tab of the **Security Administration Facility** window**.**

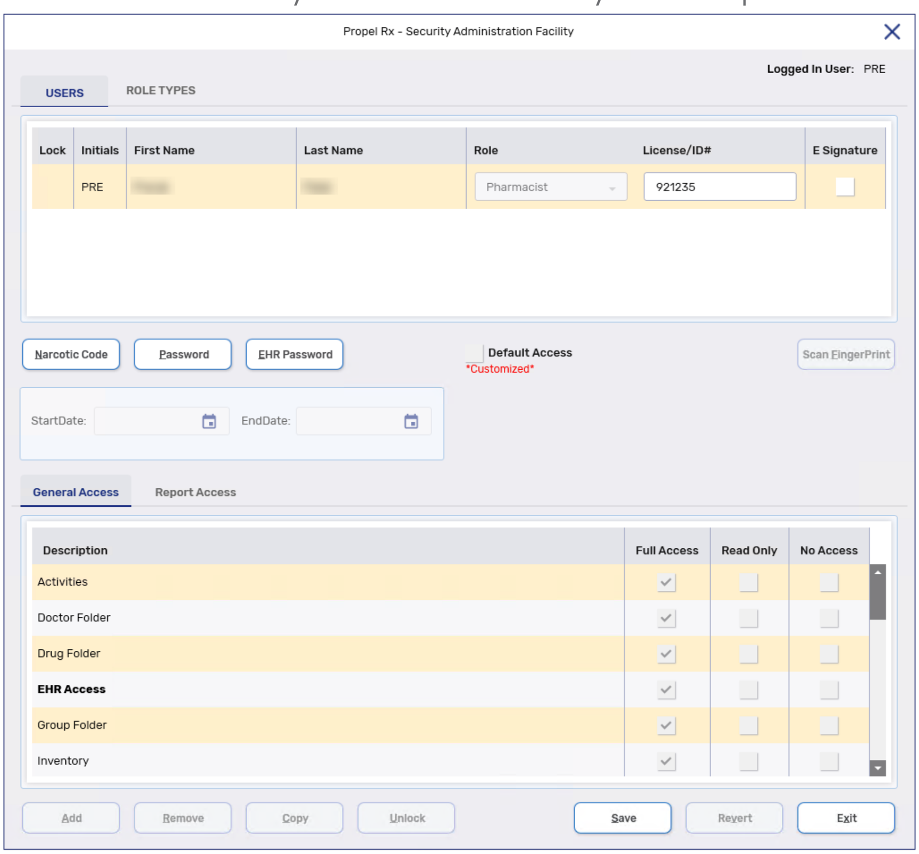
Accessing the Security Window

To access the Security Administration Facility window:

1. Select **More (...)** > **Security**. The Security Login window opens.
2. Enter the Propel Rx login credentials of the user who wishes to access the Security window.



3. Select **OK**. The Security Administration Facility window opens.



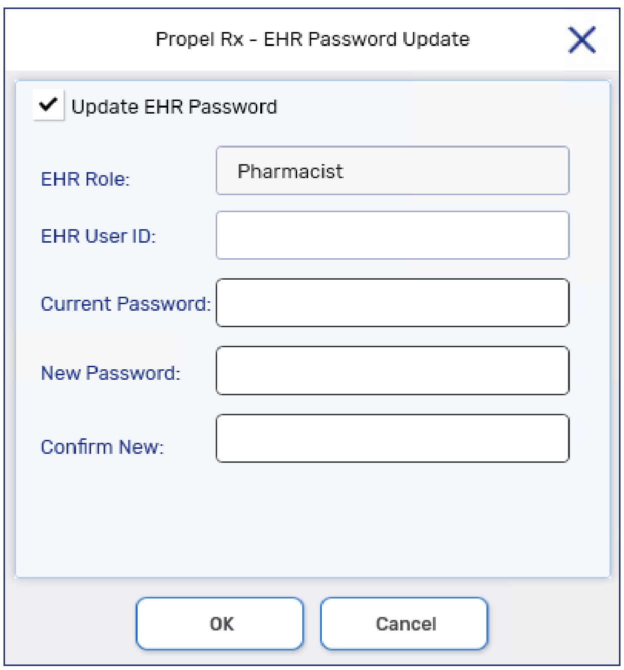
NOTE: A user must have Full Access to the Security Folder to manage all user accounts. The ADM user can assign this privilege to other users within Propel Rx.

Setting Up Users with EHR Access

All Propel Rx users must be registered and have an NLPN account to use the Pharmacy Network services. If a user does not have an NLPN account, you must contact the Newfoundland and Labrador Health Services Help Desk. To set up a user with EHR access in Propel Rx, the user must log in and enter their EHR password. **Once the EHR username and password are entered, the user has EHR access**. For new users or users with no EHR access, it is necessary to enter your EHR password to get EHR access.

To set up EHR access for your user account:

1. Log into Propel Rx using your username and password. The EHR Password window opens.
2. Bypass the EHR User Login window by selecting **Cancel**.
3. Select **More (...)** > **Security**. The Security Login window opens.
4. Log in using your Propel Rx password. The Security Administration Facility window opens.
5. Select **EHR Password**. The EHR Password Update window opens.



6. Enter your **EHR User ID**.
7. Enter your EHR password in the **Current Password** field.
8. Enter a desired updated password in the **New Password** and **Confirm New** fields.
9. Select **OK**.

Once you have correctly entered your EHR User ID and Password, the EHR Access checkbox in the Users tab is selected, indicating you now have EHR access. The *Customized* indicator also appears below the Default Access checkbox.

Changing the EHR Password

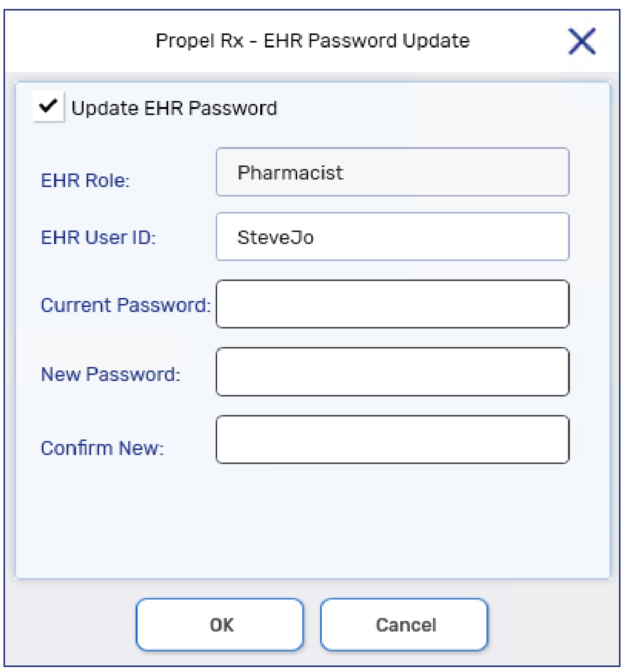
All Newfoundland and Labrador Propel Rx users must register with the NL DIS. Once registered the user is provided with an EHR password.

- New users must change the temporary issued password upon logging into Propel Rx and prior to interacting with the EHR.
- Existing NLPN users with a valid EHR user ID and password can add their current password without creating a new one.

As per NLPN requirements, Propel Rx also prompts users to **change their EHR password every 90 days**. The EHR password must be at least eight characters in length and must contain both alpha and numeric based characters. If your EHR password has expired, upon login, a prompt displays indicating this.

To update your EHR password:

1. Select **More (...)** > **Security**. The Security Login window opens.
2. Log in with your Propel Rx password. The Security Administration Facility window opens.
3. If more than one user is listed at the top, select your user account.
4. Select **EHR Password**. The EHR Password Update window opens.
5. Select the **Update EHR Password** checkbox.



6. Enter your EHR credentials in the **EHR User ID** and **Current Password** fields.
7. Enter a desired updated password in the **New Password** and **Confirm New** fields.
8. Select **OK**.

Adding New Propel Rx Users

When adding new users, it is imperative that all user credentials are updated to reflect their Role Type and licensing ID. The ADM user cannot be used to process claims. Refer to the Pharmacy Board requirements as some interactions with the EHR cannot be performed by the Technician and must be performed by the Pharmacist.

To add a new user:

1. Log into Propel Rx as the Administrator (User Name = ADM). The Security Administration Facility window opens.
2. Select **Add**. The Add User window opens.
3. Enter the following information for the new user.
    - Initials
    - First Name
    - Last Name
    - Role Type
    - License/ID # (if applicable)
    - New Password (this is a temporary password for Propel Rx which is reset on the first login)
4. Select **OK**.
5. Select **Save**.
6. Select **Exit** to return to the login window.
7. Have the new user that was just created log in using the temporary password created above.
8. Upon login, the user is prompted to change their Propel Rx password. Select **OK** to open the Change Password window.
9. Enter a new password.
10. Select **OK**.

The steps outlined above adds the user to Propel Rx but does not configure the user for EHR access. Follow the steps in Setting Up Users for EHR Access if the user requires EHR access.

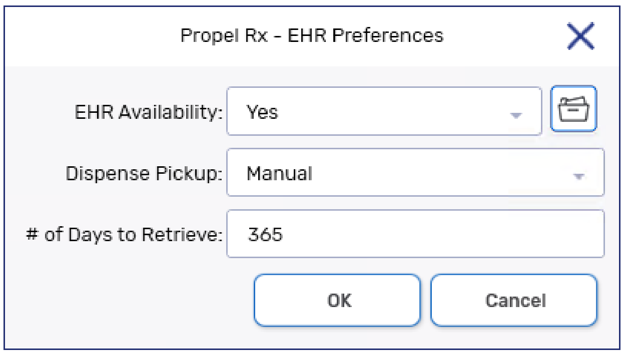
Setting EHR Preferences

The EHR Preferences define various aspects of EHR processing.

Overview of EHR Preferences

To access EHR Preferences:

1. Select **More (...)** > **EHR** > **Preferences**. The EHR Preferences window opens.



What is the EHR Preference?	What is it used for?
EHR Availability	When the connection to the EHR is lost, or the network is down for an extended period, the EHR Availability can be set to No. This automatically places EHR transactions in the EHR Queue for later processing (see EHR Queue for more information). An audit trail is created each time this preference is modified.
Dispense Pickup	Determines the type of Dispense Pickup that occurs. For non-POS stores, the default option is Manual. For POS integrated stores, the option is POS integration. • **POS Integration**: Dispense Pickup is transmitted when the prescription sale is scanned at the POS. • **Manual**: Dispense Pickup is transmitted when the Workflow status is changed from the Pick Up/Delivery tile or Rx Detail EHR tab.
# Days to Retrieve	Used to determine how much historical information should be retrieved with the EHR-All queries. A value must be specified. This field is defaulted to 365 days (12 months). All the prescriptions returned in a patient's EHR Profile query is based on the number of days indicated in this field. By default, all active prescriptions are included, even if they are outside the date range specified.

	This field does not apply when performing an EHR-Query from the following tabs: • Clinical • Notes However, when performing an EHR-All query, this field applies to the above tabs.

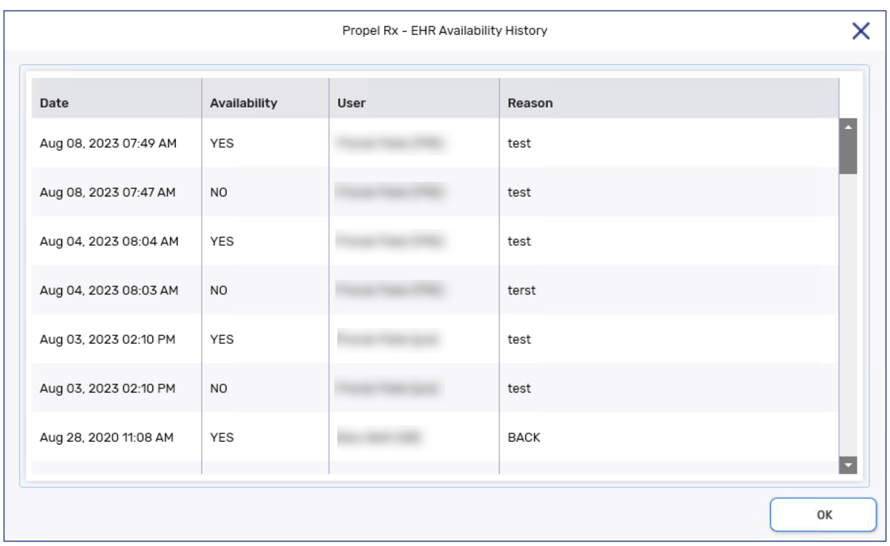
Viewing EHR Availability History

When the EHR Availability is changed, the following information is recorded in Propel Rx:

- Date the change was made
- The setting that the EHR Availability was changed to (i.e., Yes or No)
- User who made the change
- Reason for the change

To view the change history:

1. Select **More (…)** > **EHR** > **Preferences**. The EHR Preferences window opens.
2. Select the folder button located beside the EHR Availability field. The EHR Availability History window opens.

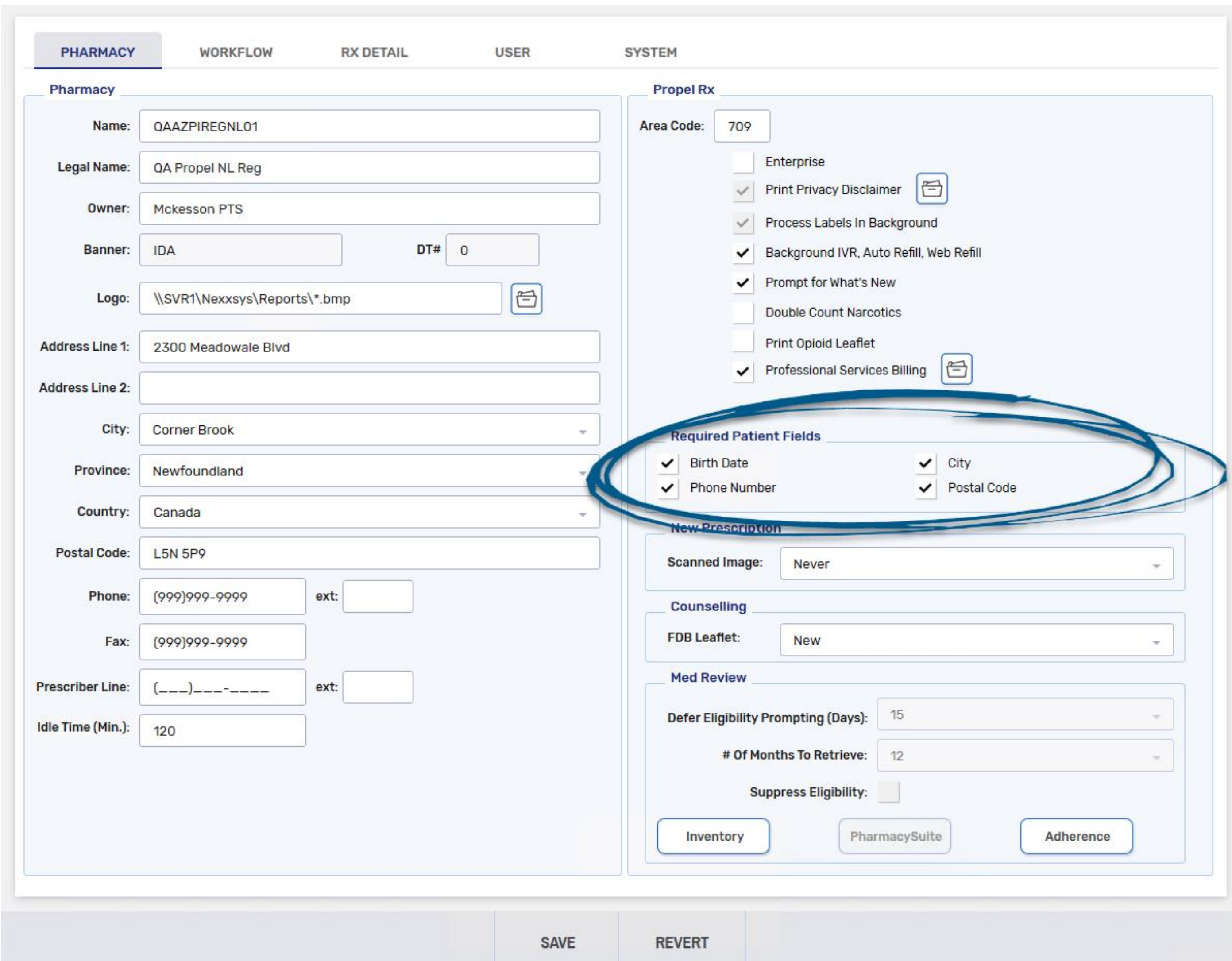


3. Once you are done viewing the change history, select **OK**.

Pharmacy Preferences

To comply with Client Registry (CR) preferences, ensure the following fields are selected as required in **More (...)** > **Pharmacy**:

- Birth Date
- Phone Number
- City
- Postal Code



Accessing a Patient’s EHR

The EHR-All Profile must be viewed with each new patient encounter or after a ‘break in service’ has occurred. A patient encounter is the duration to provide service to a patient, whereas a ‘break in service’ occurs when a period of inactivity occurs and/or if you begin activity with a different patient. The first time a dispense activity occurs for a patient, Propel Rx automatically requests and displays the patient’s EHR-All Profile. This ‘forced view’ of the Profile will not occur again until there is a ‘break in service.’

The ‘forced view’ of the patient’s EHR-Profile will also not occur when adding information to the following tabs:

- Clinical tab
- Notes tab

Under the Privacy, Confidentiality, and Access Principles and Guidelines for the Health Information Network (HIN), Newfoundland and Labrador operates under an ‘implied consent’ model for the collection, use, and disclosure of health information. Patient drug histories are accessible to authorized users of the Pharmacy Network for authorized purposes without a patient’s express consent.

However, privacy concerns require that pharmacies justify access to all patients’ health records on the EHR. You must provide a reason each time you request to view a patient’s EHR. An audit of these requests is recorded on the EHR and the Patient History tab.

Entering a Reason for Accessing the EHR

If this is the first time that the Patient Folder is being acted upon, or if there was a break in service, then Propel Rx forces a view of the patient’s EHR. You must also specify the reason for accessing the patient’s EHR.

When the Patient EHR Access Reason window opens, do the following:

1. From the dropdown menu, select a reason for accessing the patient’s EHR. The default reason is Patient Care.
2. *Optional*: Enter any comments in the **Comments** field.
3. Select **OK**.

Entering or Overriding Patient Consent

The HIN Principles and Guidelines provide individuals with the right to revoke consent for the use and disclosure of their health information. Patients may request that their health information be restricted from view within the Pharmacy Network. The 'masked' information is still subject to Drug Utilization Review for potential drug-to-drug interaction checking and may be accessed in specific circumstances (i.e., the mask may be overridden). When information is 'masked', it can only be viewed by supplying a keyword set by the patient, or by 'breaking the glass' (overriding consent).

If the patient's EHR Profile has been masked, you must have the patient's permission to access their EHR. The rules governing the retrieval of this information is limited to the following circumstances:

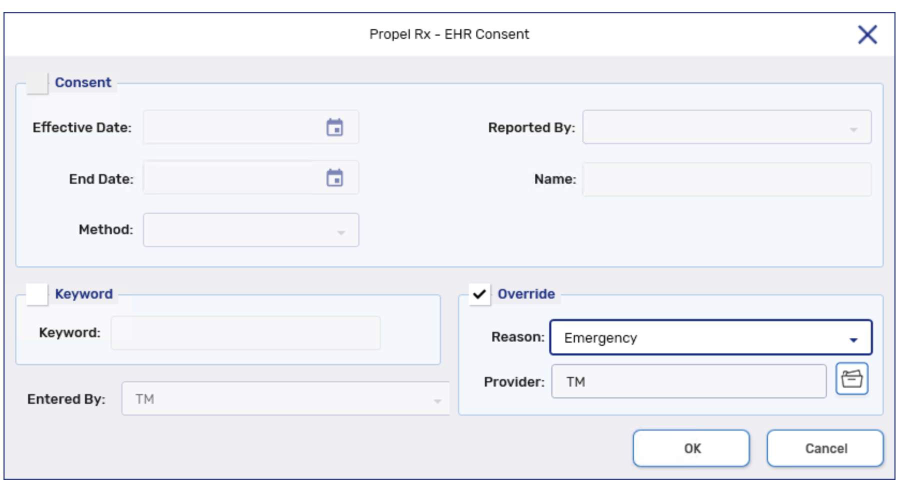
- Where express consent of the patient has been obtained. This means that the patient has provided permission, or has done so through a health professional, for a specified period.
- In emergency circumstances in which the patient is unable to provide consent.
- Where dangerous use of prescription drugs is suspected.

To enter or override consent:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select **Rx** > **Profile** > **EHR-All**. If the patient's EHR Profile is masked, the following Detected Issue appears:

Priority	Severity	Issue Type	Description
Error		A local business rule relating multiple elements has been violated	An error occurred - error details: Patient profile is keyword protected

4. Select **EHR Consent**. The EHR Consent window opens.
5. Select either the **Keyword** or **Override** checkbox.
   - If you selected **Keyword**, enter the patient's keyword.
   - If you selected **Override**, select a reason from the dropdown menu.



NOTE: If you select Override, the Provider is automatically populated with the Pharmacist user that is logged in or the Pharmacist user that is linked to the Technician user logged in. You can still change the Provider by selecting the expander button, however the logged in Pharmacist, or the linked Pharmacist will also be transmitted to the EHR.

6. Select **OK** to re-transmit the Profile request. Once accepted, the patient's EHR Profile is displayed.

ALERT: If a patient has lost/forgotten their keyword, they must contact Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006.

Searching for and Synchronizing a Patient

Newfoundland and Labrador pharmacies must thoroughly search the Client Registry (CR) to ensure a patient EHR Profile does not already exist prior to creating a new Profile.

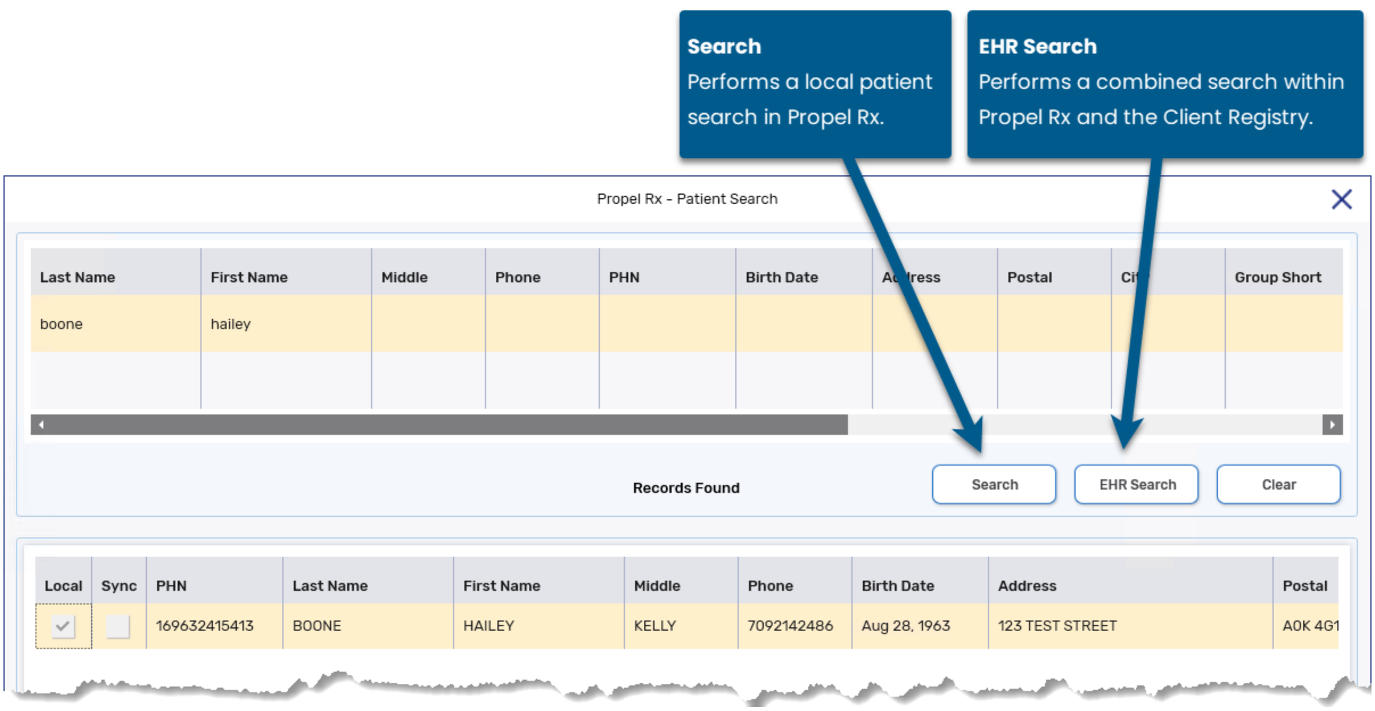
Patient Search Window

With EHR integration, you have 2 search options when searching for a patient: a local search or a combined search. In the Patient Search window:

- The **Search** button completes a local search within Propel Rx.
- The **EHR Search** button performs a combined search within Propel Rx and the Client Registry.

When EHR integrated pharmacies try to search for a patient, there are [4 possible scenarios] they may encounter. For each scenario, it is important to ensure that the Patient Folder is synchronized with the patient information on the Client Registry. For more information, see [Synchronization].

From the Patient Search window, Propel Rx users can identify which patients are local, synchronized, or neither, by reviewing the **Local** and **Sync** checkboxes. The sample patient below is a local patient that has yet to be synchronized with the Client Registry.



Search Criteria

When searching for a patient, it is ideal to use the patient's PHN. If the patient does not have or know their PHN, you can use a combined search.

A local search within Propel Rx can be done using any search criteria, as per existing functionality.

A combined search (EHR Search) of Propel Rx and the Client Registry must contain one of the following search combinations:

- Provincial Health Number (PHN)
- Last Name and First Name plus Date of Birth/Home Phone Number/Postal Code

NOTE: Wildcard character searches are not accepted (e.g., * % $).

Punctation

For all NAME fields, the only punctuation that is accepted when adding, updating, or searching for a Client Registry patient record are listed in the following table. All other punctuation, including quotation marks ("), asterisks (*), or forward slashes (/) are not permitted to be used.

Punctuation	Description
Hyphen [-]	When used in a combined name where appropriate. Example: MARY-ANN or COTTON-WILLIAMS
Apostrophe [']	Where appropriate. Example: O'REILLY
Period [.]	Where it is part of the name field. Example: ST. CLARE
Brackets [()]	Where it is part of the name field Example: ROBERT (BOB)

Babies and Neonates

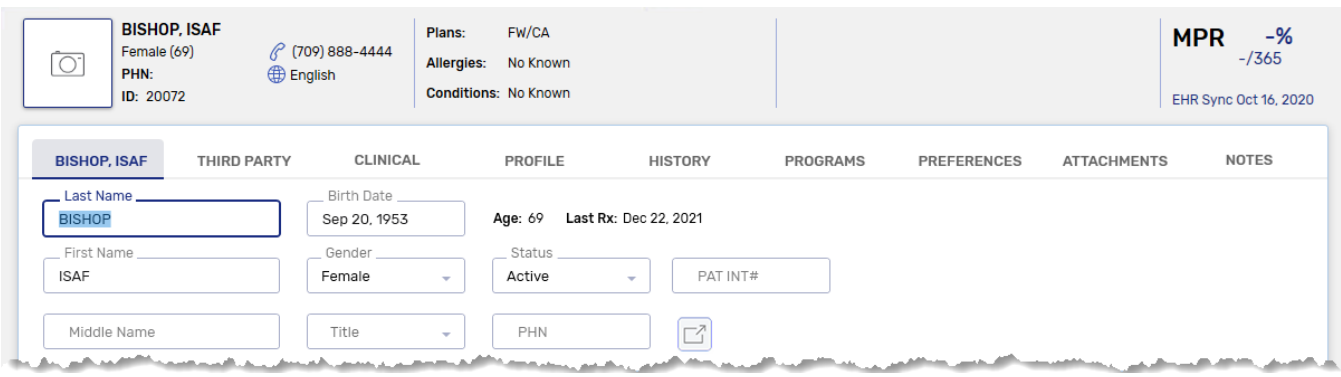
The First Name and Last Name are mandatory fields when creating a new Patient Folder for a newborn. The accepted practice as supported in Newfoundland and Labrador hospitals is to use "BB" (Baby Boy) or "BG" (Baby Girl) OF (mother's first name) as the first name of the unnamed newborn child.

Synchronization

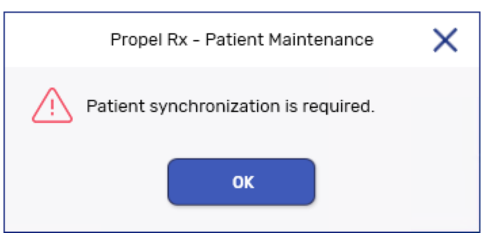
For any interaction to occur with the EHR, a patient's information in Propel Rx must be synchronized with the Client Registry. Synchronization ensures that the correct patient is selected and allows the patient information maintained on the Client Registry to be accurate.

In the top right section of the Patient Folder Main tab, below the patient's MPR, is an indication of the Patient Folder's synchronization status with the Client Registry.

- If the Patient Folder is not yet synchronized, it displays **EHR Not Sync'd**.
- If the Patient Folder has been synchronized, it displays **EHR Sync MM DD, YYYY**.
- If the Patient Folder is flagged as Facility, it displays **Facility Patient**.



It is imperative that every Patient Folder is synchronized prior to any interaction with the EHR. If a user attempts to transmit information to the EHR for a patient that has not been synchronized (e.g., fill a prescription, etc.), the following prompt appears:



Upon patient synchronization, the following patient fields are transmitted to the EHR:

- Last Name
- First Name
- Middle Name
- Status
- Birth Date
- Address Line 1
- Address Line 2
- City
- Province
- Postal Code
- Phone
- Country
- PHN
- Gender

NOTE: Any phone number extension entered in the Ext field is not transmitted to the EHR.

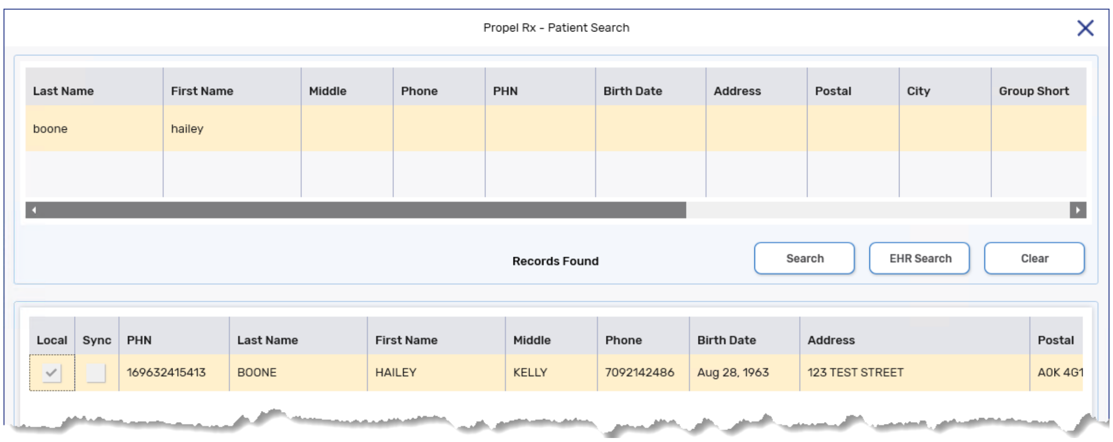
Search Scenarios

When EHR integrated pharmacies try to search for a patient, there are 4 possible scenarios they may encounter. For each scenario, it is important that the Patient Folder is synchronized with the patient information on the Client Registry.

Scenario 1: Existing Propel Rx Patient/Existing Client Registry Patient

You will encounter this scenario if the patient is an existing customer at your pharmacy and exists on the Client Registry.

1. Select the **Patient** button on the left navigation menu.
2. Enter the search criteria for the patient. You can search using the patient's first and last name or their PHN.
3. Select **Search**. The search results display matching local results.
4. Highlight the local patient record.



5. Select **OK**. The Patient Folder opens.
6. On the Main tab, select the **PHN Expander** button. The Patient Search – Client Registry window opens with the local patient information as the search criteria.
7. Highlight the matching result that displays.
8. Select **Compare**. The Patient Comparison window opens displaying the Local (Propel Rx) patient information and the Client Registry information.
9. Confirm the patient selected from the Client Registry matches the local record.
10. If required, information from the Client Registry can be saved locally by highlighting the applicable field(s) and selecting **Copy**. For more information on updating patient information in the Client Registry, see Patient Compare. Once information is copied over, a checkmark appears beside the field on the left.
11. Select **Update**.
12. Select **Save**.

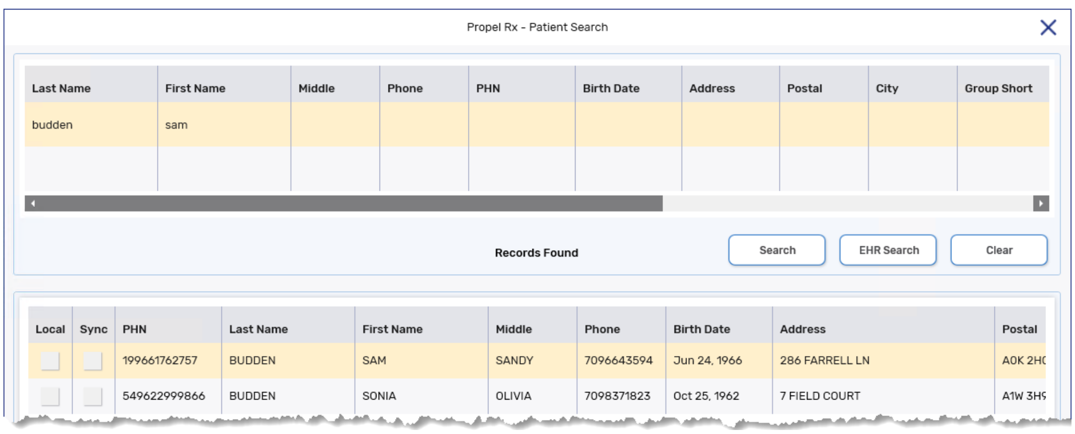
Propel Rx synchronizes the local record. The Patient Folder information bar is updated to indicate the Patient Folder was synced to the Client Registry and the date it occurred.

Scenario 2: New Propel Rx Patient/Existing Client Registry Patient

You will encounter this scenario if this is the first time the patient has come to your pharmacy, but not the first time they have received health care treatment from a Newfoundland and Labrador EHR integrated environment. This scenario will be used for a patient that exists in the Client Registry.

1. Select the **Patient** button on the left navigation menu.
2. Enter the search criteria for the patient. You can search using the patient's first and last name or their PHN.
3. Select **Search**. The search results indicate *No Records Found*.
4. Select **EHR Search**. The search results display an existing Client Registry record.
5. Highlight the existing Client Registry patient record.

NOTE: The **Local** and **Sync** checkboxes will be deselected, as shown with the highlighted record below.



6. Select **OK**. The Patient Folder is populated with the demographic information from the Client Registry.
7. If required, update any information in the Patient Folder.
8. Select **Save**.

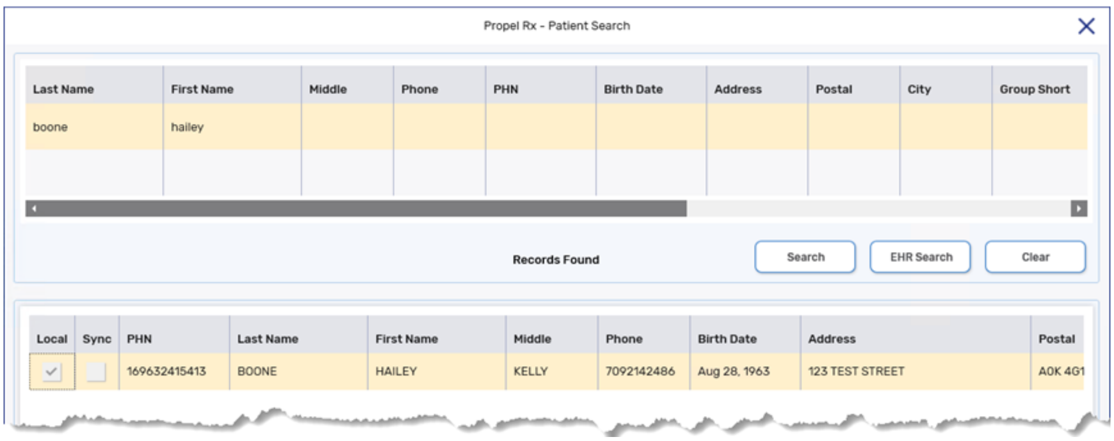
The Patient Folder is saved locally. The Patient Folder information bar is updated to indicate the Patient Folder was synced to the Client Registry and the date it occurred.

Scenario 3: Existing Propel Rx Patient/New Client Registry Patient

You will encounter this scenario if the patient is an existing customer at your pharmacy and is not currently in the Client Registry.

1. Select the **Patient** button on the left navigation menu.
2. Enter the search criteria for the patient. You can search using the patient's first and last name or their PHN.
3. Select **Search**. The search results display a local, non-synchronized record.
4. Highlight the local patient record.

NOTE: The **Sync** checkbox will be deselected, as shown with the highlighted record below.



5. Select **OK**. The Patient Folder opens.
6. On the Main tab, select the **PHN Expander** button . The Patient Search – Client Registry window opens with the local patient information as the search criteria.
7. Once the search is complete, select **Synchronize**.
8. Select **Save**.

The Patient Folder information bar is updated to indicate the Patient Folder was synced to the Client Registry and the date it occurred.

Scenario 4: New Propel Rx Patient/New Client Registry Patient

You will encounter this scenario if this is the first time the patient has come to your pharmacy and the first time they have received health care treatment from a Newfoundland and Labrador EHR integrated environment. This scenario will be used mostly when a patient is from out of province.

1. Select the **Patient** button on the left navigation menu.
2. Enter the search criteria for the patient. You can search using the patient's first and last name or their PHN.
3. Select **Search**. The search results indicate *No Records Found*.
4. Select **EHR Search**. The search results indicate *No Records Found*, or the results returned do not match the patient.

5. Select **New**. The Patient Folder opens.

> **NOTE:** Before selecting to add a new patient, it is imperative that you exhaust all search options.

6. Enter all related patient information for the new patient.
7. Select **Save**.
9. On the Main tab, select the **PHN Expander** button. The Patient Search – Client Registry window opens with the local patient information as the search criteria.
10. Once the search is complete, select **Synchronize**.
11. Select **Save**.

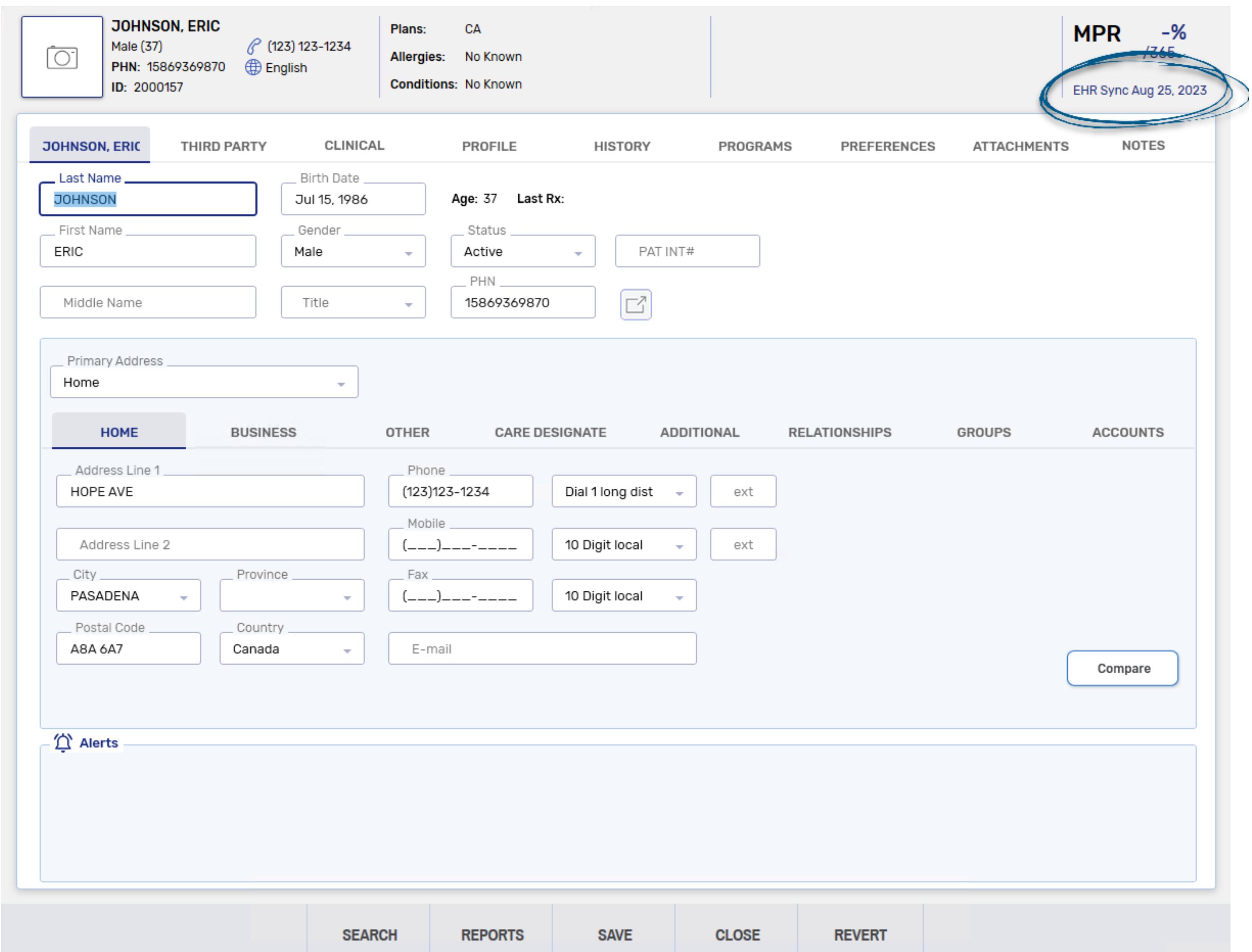
The Add Person message is sent to the Client Registry. Once the transmission is successful, the patient is saved and synchronized.

Patient Folder

Main Tab

Synchronization

An EHR Sync indicator displays on the information bar at the top of the Patient Folder. If a patient's local record has been synchronized with the Client Registry, **EHR Sync'd** appears at the top right along with the date the sync occurred. If a patient's local record is not synced, **EHR Not Sync'd** appears instead. It is imperative that every Patient Folder is synchronized prior to any interaction with the EHR.

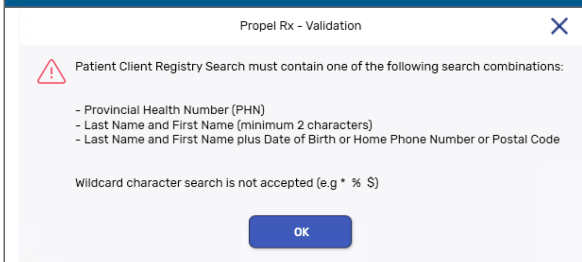
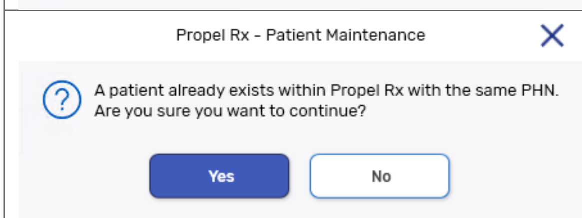
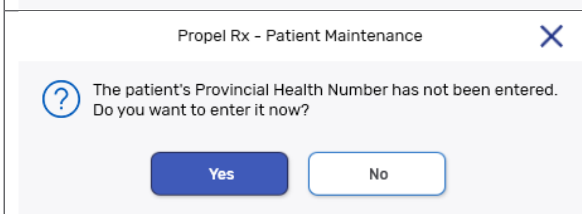
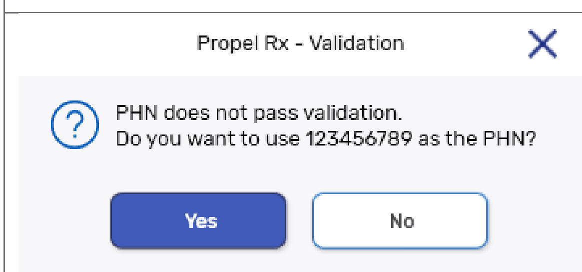


Once the patient has been synchronized, the PHN expander button is disabled. You can select **Compare** to validate the local information with the information on the Client Registry if needed.

PHN

The Personal Health Number (PHN) is a unique identification number assigned to a resident of a province. In Newfoundland and Labrador, this is called the Medical Care Plan (MCP) number, however, to maintain consistency, MCP is referred to as PHN throughout this User Guide.

Validations are performed when a PHN is entered in the Patient Folder PHN field. Refer to the table below for more information.

PHN Validation	Description
	The PHN field only permits the user to enter numeric or alphabetic characters. Other characters entered in this field (e.g., periods, hyphens, etc.) prompt this validation.
	The PHN is a unique identifier assigned to every patient. If the PHN field is populated with a PHN that already exists for another local patient in Propel Rx, this validation appears upon selecting **Save**.
	If the PHN field is left blank, this prompt appears upon selecting **Save**. This prompt only appears once. Upon making your selection, this prompt no longer appears for all future encounters with this Patient Folder.
	In Newfoundland and Labrador, the PHN is 10 digits. If a 10-digit number is not populated in the PHN field, this prompt appears upon selecting **Save**. A PHN that is not 10 digits may still be valid (e.g., out of province patient). Ensure to never use SPACES when entering a PHN.

Patient Compare

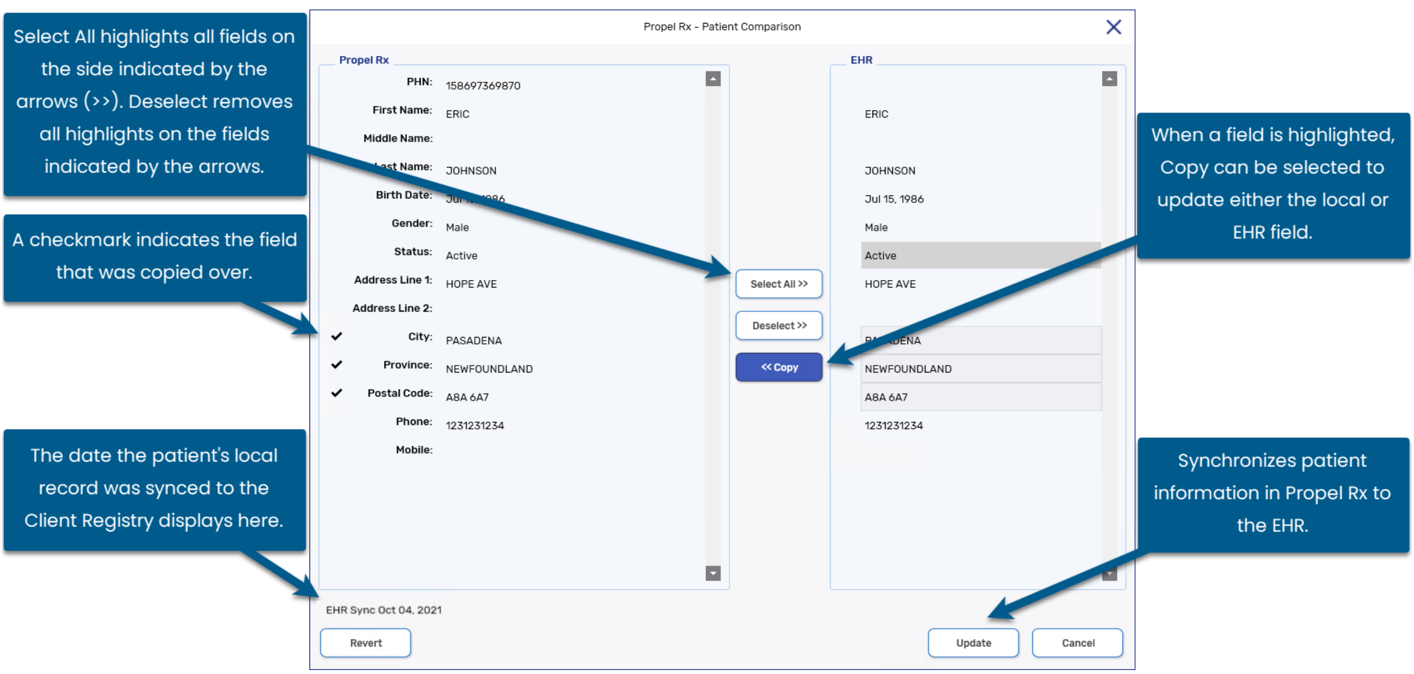
The Compare button allows you to compare the patient information in Propel Rx and the patient information on the Client Registry. If any of the information does not match, or something is missing, a user can update local information into the Client Registry, as well as apply Client Registry information locally into Propel Rx.

The Compare window can be invoked from the following 2 locations:

- Patient Folder (for synchronized patients only)
  - In the Patient Folder Main tab, select the **Compare** button located at the bottom.
  - Use the **Copy** button in the Compare window to update information from the Client Registry to Propel Rx, as well as from Propel Rx to the Client Registry.
- PHN Expander button (for non-synchronized patients)
  - In the Patient Folder Main tab, select the **PHN Expander** button. A search in the Client Registry is performed. If a search result is returned that matches, you must highlight the patient and select the Compare button at the bottom.
  - When the **Compare** button is selected through the **PHN Expander** button, you can only update information from the Client Registry to your local Propel Rx database.

You can only update information in one direction per transaction. Once a row is highlighted on one side, any highlighted rows on the other side become automatically deselected.

NOTE: When demographic information is updated in the Patient Folder Main tab, the information is transmitted to EHR automatically upon selecting **Save**.



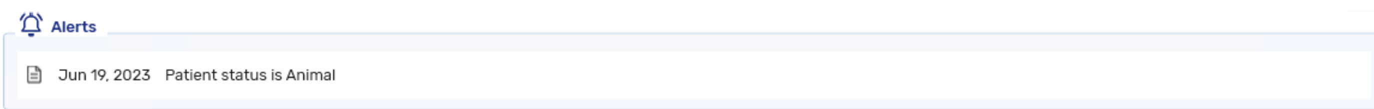
Patient Status

The **Animal** and **Out of Province** patient statuses are used more frequently in DIS enabled provinces. Animal is used to indicate that the Patient Folder is for a family pet. Out of Province is used to indicate that the Patient Folder is for a patient who is non-resident of Newfoundland and Labrador.

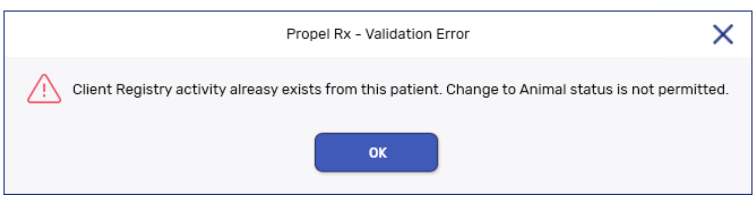
In Newfoundland and Labrador, when the patient status is Active, Deceased, Hospitalized, Obsolete, Out of Province, or Inactive:

- PHN is required
- Messages transmit to the EHR
- EHR buttons are enabled
- Patient History is updated if the patient status is changed

Animal patients are not associated with EHR functionality. When dispensing a prescription for an Animal, the Rx Detail – Alerts display the following Alert to ensure the dispensing pharmacist or technician is aware of the patient status.



When the patient status is updated, the change is recorded in the Patient Folder History tab. The status of a patient however, cannot be updated to Animal if Client Registry activity exists for that patient. The following validation prompt appears:



ALERT: The Animal patient status should not be used to bypass transmitting prescriptions to the EHR. All prescriptions must be transmitted to the EHR and any prescriptions that are not may be monitored or audited. Refer to EHR Network is Unavailable for how to manage transactions when the EHR is not available.

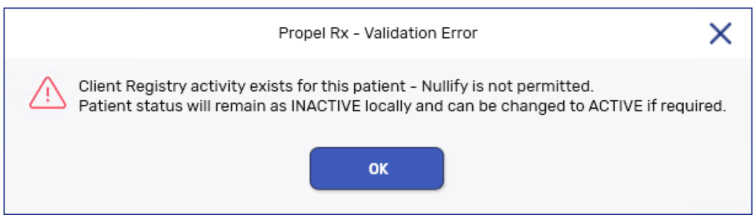
Nullifying a Patient

NLPN permits pharmacies to nullify synchronized Client Registry records. Nullifying a patient means that the Patient Folder was synchronized with the Client Registry in error. Nullifying a Client Registry patient is only permitted when the patient has had no activity with the EHR. Propel Rx initiates the nullify patient process when a synchronized patient status is changed to Inactive. When the nullify patient process is successful, **EHR Not Sync'd** appears in the Patient Folder information bar, the patient status is updated to **Inactive**, and a **Patient History** row is added.

Nullifying a patient is not permitted if:

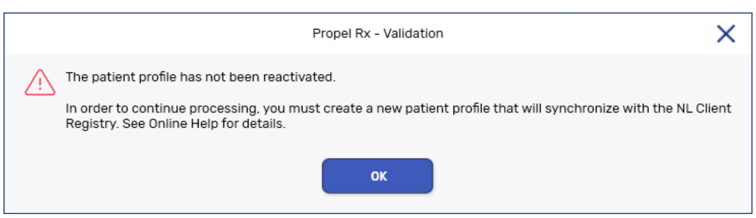
- The Patient Folder has never been synchronized;
- Clinical information or prescriptions have been transmitted to the EHR; or
- Any queries have been made for the patient.

When a synchronized patient status changes from Active to Inactive, Propel Rx validates if the Nullify action can be transmitted. If any EHR clinical or prescription history exists, the following validation displays:



The Patient Folder information bar still indicates **EHR Sync'd**. The patient status is changed to **Inactive** locally and a row is added to **Patient History**.

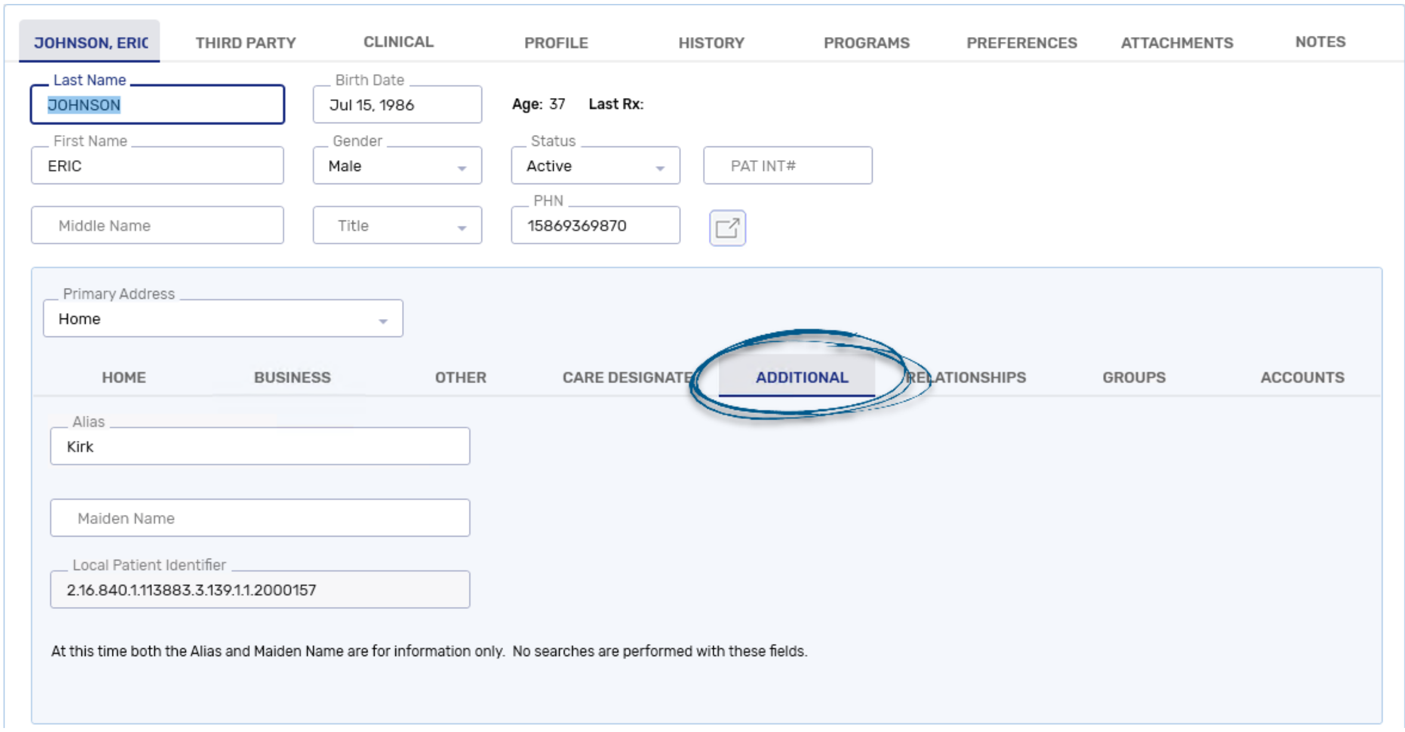
NOTE: If a patient was nullified in error, the patient CANNOT be reactivated as a previously nullified patient cannot be resynchronized. If attempting to reactivate a nullified patient, the following prompt displays:



A new Patient Folder must be created and synchronized to the EHR. To reduce confusion of which Patient Folder to use, the nullified Patient Folder can be merged with the new Patient Folder once the new Patient Folder is synchronized. For more information, see Merging Patients.

Additional Sub-Tab

In the Patient Folder Main tab, an Additional sub-tab is available.

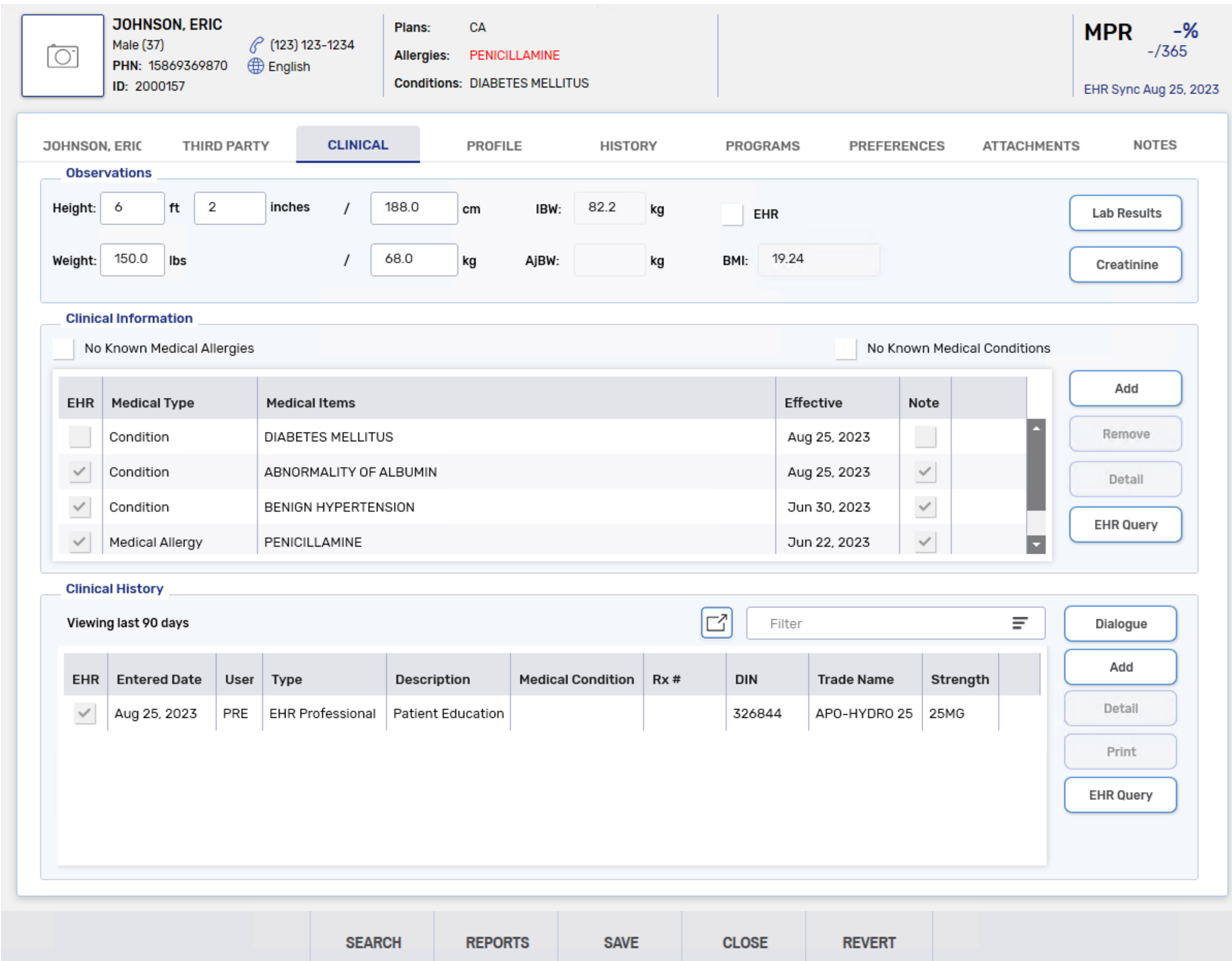


This tab contains the following information:

Alias	Use this field to enter any alias names your patient may go by (e.g., patient's first name is Robert but goes by Bob). This field is for informational purposes only; any information entered in this field is not transmitted to the EHR and does not appear anywhere (e.g., reports, labels, etc.). Furthermore, no searches are performed on the Client Registry using this field. If you find a patient on the Client Registry and add them locally, this field populates with their alias name on the EHR (if an alias exists).
Maiden Name	Use this field to enter a patient's maiden name. This field is for informational purposes only; any information entered in this field is not transmitted to the EHR and does not appear anywhere (e.g., reports, labels, etc.). Furthermore, no searches are performed on the Client Registry using this field.
Local Patient Identifier	This field is for informational purposes only. When troubleshooting with Newfoundland and Labrador DIS Support Team, this number may be required.

Patient Clinical Tab

The Clinical tab contains observations, clinical information, and clinical history that can be uploaded to the patient's EHR Profile.



Observations

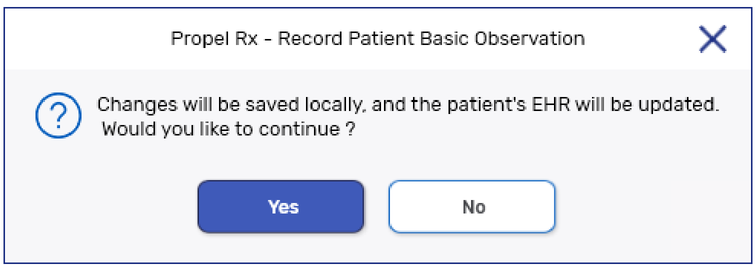
ADDING OBSERVATIONS

Basic patient observations (i.e., height, weight, lab results) are supported by the EHR. These fields can be maintained locally and transmitted to the patient's EHR.

To add observations to the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Height** field, enter the patient's height.
4. In the **Weight** field, enter the patient's weight.
5. Select the **EHR** checkbox. The following validation prompt displays.

NOTE: Both the Height and Weight fields must be populated for the EHR checkbox to be enabled.



6. Select **Yes** to the prompt.

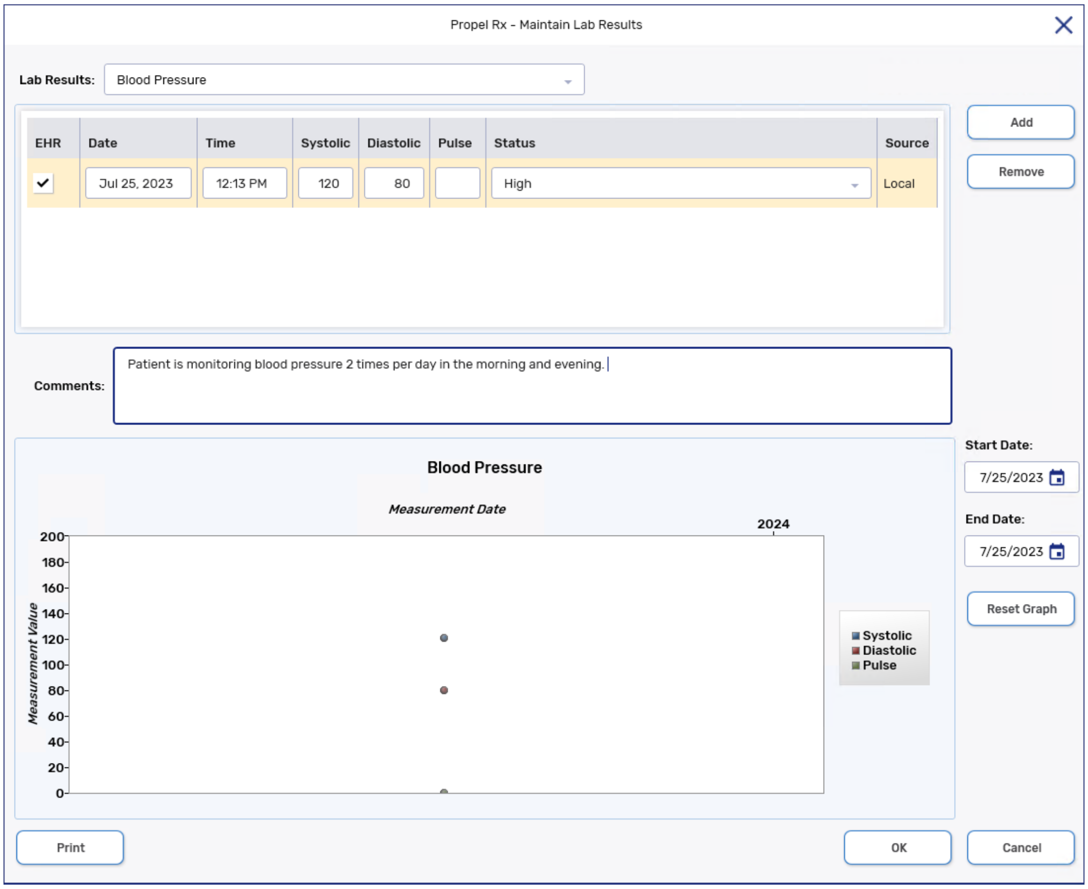
A processing message displays indicating the information is being transmitted to the EHR. When the height and weight observations have been successfully added, the processing window closes and the EHR checkbox is selected.

ADDING LAB RESULTS

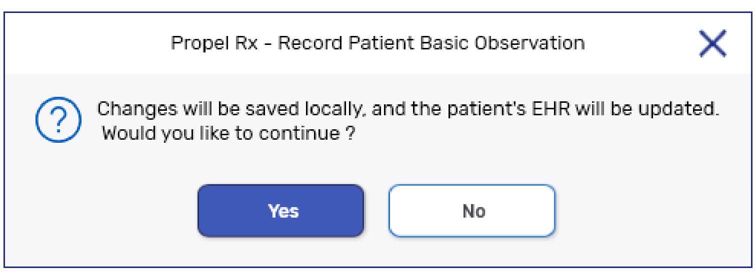
Lab results (i.e., blood glucose, blood pressure, body temperature, respiratory rate) can be added in Propel Rx and transmitted to the patient's EHR. These lab results will only be viewable in the DIS profile at other pharmacies; they will not be viewable in HEALTHeNL.

To add lab results to the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. Select **Lab Results**. The Maintain Lab Results window opens.
4. From the Lab Results dropdown list, select the type of lab result you want to add.
5. Select **Add**. A new row appears.



6. Enter the appropriate lab results/readings.
7. Select the **EHR** checkbox.
8. Select **OK**. The following validation prompt displays.



9. Select **Yes** to the prompt.

A processing message displays indicating the information is being transmitted to the EHR. When the lab results have been successfully added, the processing window closes.

RETRACTING OBSERVATIONS FROM THE EHR

It is possible to remove/retract Observations sent to the EHR from Propel Rx if they have not been viewed by a third party. The steps for this process vary depending on the information being removed.

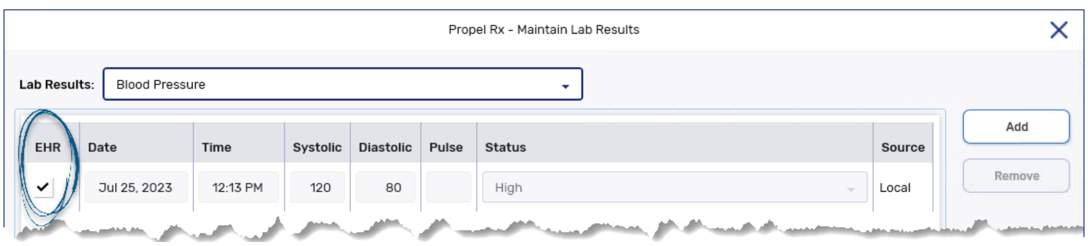
To retract height and weight demographics from the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Observations** section, deselect the **EHR** checkbox to remove the flag.

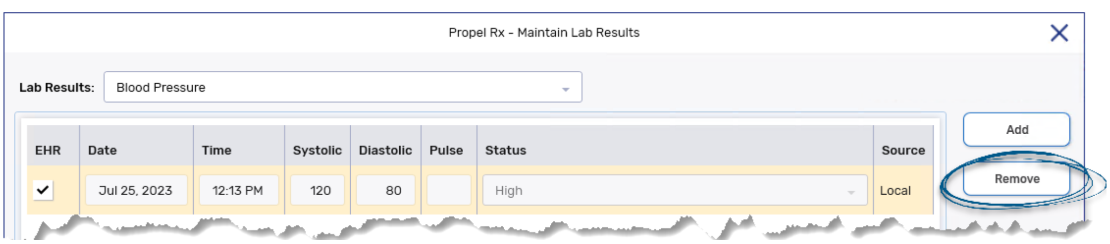
A processing message displays indicating the information is being retracted from the patient's EHR. Once the retraction is successful, the EHR checkbox no longer displays a checkmark.

To retract lab results from the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. Select **Lab Results**. The Maintain Lab Results window opens.
4. From the **Lab Results** dropdown, select the type of Lab Result you wish to retract.
5. Do one of the following:
    - If you want to maintain the record locally, deselect the **EHR** checkbox for the Lab Result entry.



    - If you want to remove the record both locally and on the EHR, highlight the Lab Result entry and then select **Remove**.



6. Select **OK**. A validation prompt asks if you want to save the changes locally and update the patient's EHR.
7. Select **Yes** to the prompt.

A processing message displays indicating the information is being retracted from the EHR. Once the retraction is successful, the EHR checkbox no longer displays a checkmark.

Clinical Information

VIEWING CLINICAL DETAILS

The **EHR Query** button allows you to access the patient's clinical results on their EHR and review what is currently on file to avoid duplicates. If the condition already exists on the patient's EHR, then it can be downloaded into your local system.

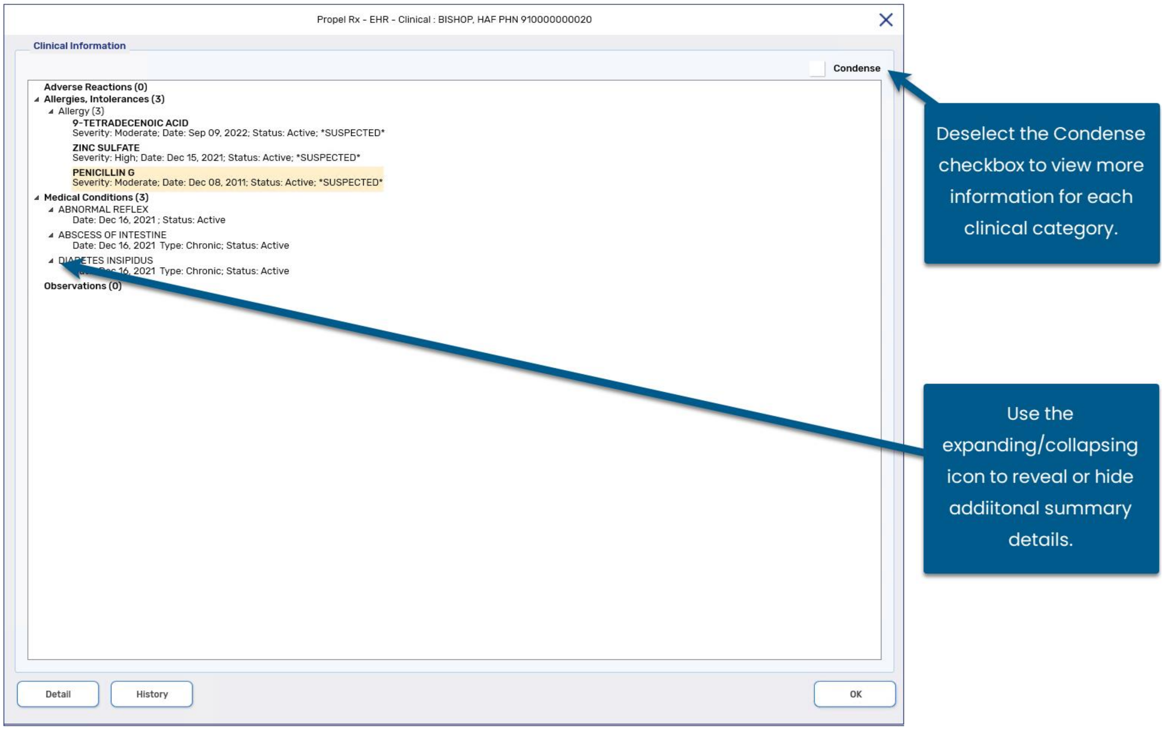
There are 2 **EHR Query** buttons in the Clinical tab. The **EHR Query** in the Clinical Information section only returns clinical results such as Allergies, Medical Conditions, and Reactions. The **EHR Query** in the Clinical History section only returns consultations such as Immunizations and EHR Professional Services.

When adding new clinical information, it is recommended that this information is always transmitted to the patient's EHR. By default, the **EHR** checkbox is selected for all observations and clinical information added. If you do not want the information transmitted to the patient's EHR, you can deselect the **EHR** checkbox.

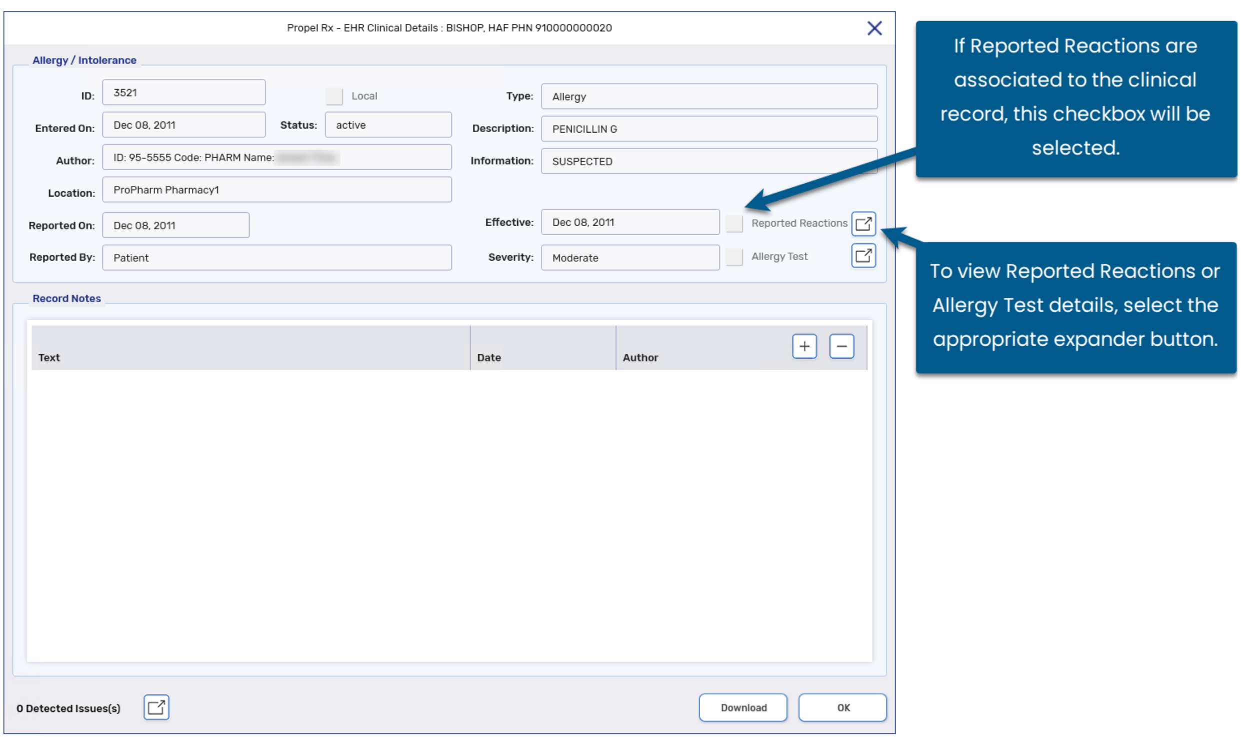
To view clinical details on a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. Select the **EHR Query** button in the Clinical Information section. The Patient EHR Access Reason window opens.

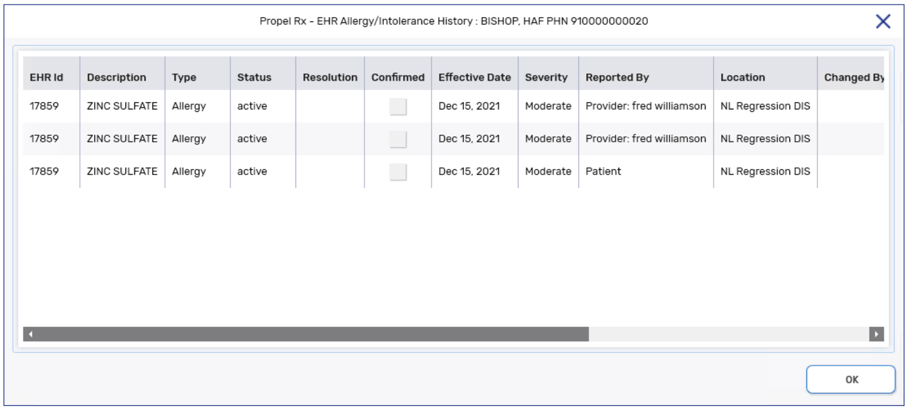
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR – Clinical window opens.



7. Expand a section to highlight the summary information for one of the documented records. This enables the **Detail** and **History** buttons.
8. To view the details of a record, select **Detail**. The EHR – Clinical window opens.
9. Select **OK** once you have finished reviewing the clinical details.



10. If you wish to view the history for the record, including when it was added and updates that were made, select **History**.



ADDING EXISTING CLINICAL INFORMATION TO THE EHR

The purpose of Clinical Information is to ensure that related Allergies, Intolerances, and Medical Conditions are kept on file for the patient. This clinical information is shared with the DIS and all healthcare professionals that are viewing the patient's EHR. Therefore, it is imperative that you keep this clinical information as up to date as possible.

It is necessary to update the EHR with local information as each pharmacy in Newfoundland and Labrador is the source system to the Client Registry. This information is also shared with all healthcare professionals.

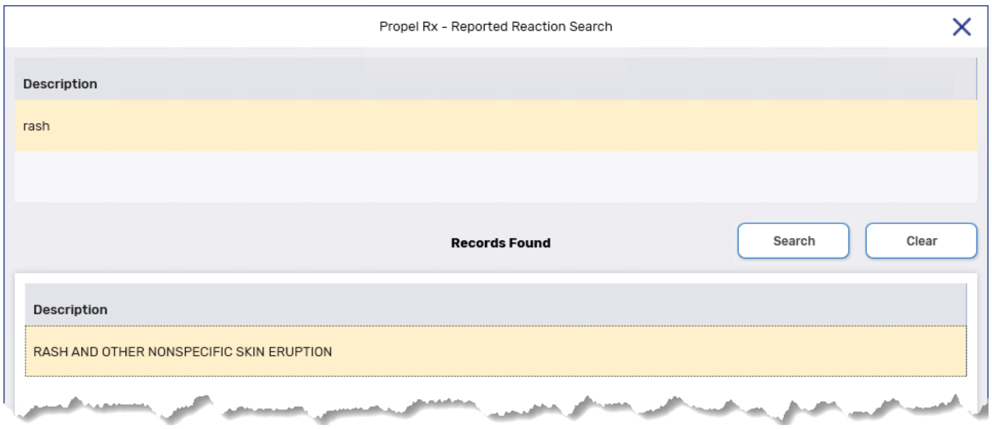
The following Medical Condition types can be uploaded to or downloaded from the EHR:

- Allergy Groups
- Medical Allergies
- Conditions
- Non-Medical Allergies
- Reactions

To add existing clinical information to a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical Information** section, highlight the local record that has not yet been uploaded to the EHR.

4. Select **Detail**. The Details window opens.
5. Select the **EHR** checkbox at the top.
6. To add a reaction for an Allergy, select the **Reactions** button.
    a. Select **Add**. The Reported Reaction Search window opens.
    b. Enter a description for the reaction at the top.
    c. Select **Search**. Matching reactions are displayed below.
    d. Highlight the appropriate reaction.



    e. Select **OK**.
7. To add a note, select **Add** in the **Notes** section.
    a. Enter the information for the note in the textbox.
    b. Ensure the **EHR** checkbox in the Notes section is selected if you wish to transmit the note to the EHR.
8. Select **OK**.
9. Select **Save**.

A processing message displays indicating the information is being transmitted to the EHR. Once the EHR has been updated with the local information, the **EHR** column in the Clinical Information section displays a checkmark.

ADDING NEW CLINICAL INFORMATION TO THE EHR

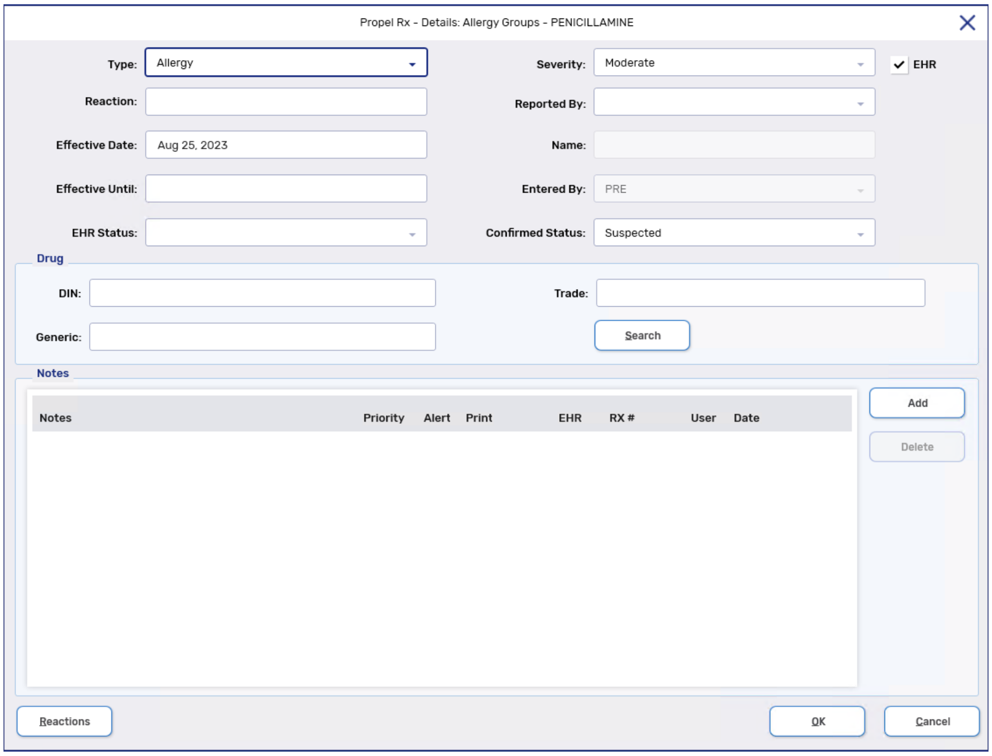
It is important to ensure all patient information is up to date. When asking existing patients for updated clinical information, any new Allergies, Intolerances, or Medical Conditions should be transmitted to the EHR.

NOTE: For a patient to have a complete and comprehensive EHR Profile, it is imperative that all clinical records are added to the EHR.

To add new clinical information to a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the Clinical Information section, select **Add**. The Medical Condition Search window opens.

4. In the **Description** column, enter your search criteria.
5. Select **Search**.
6. From the returned results, select the desired condition and then select **OK**. The Details window opens.

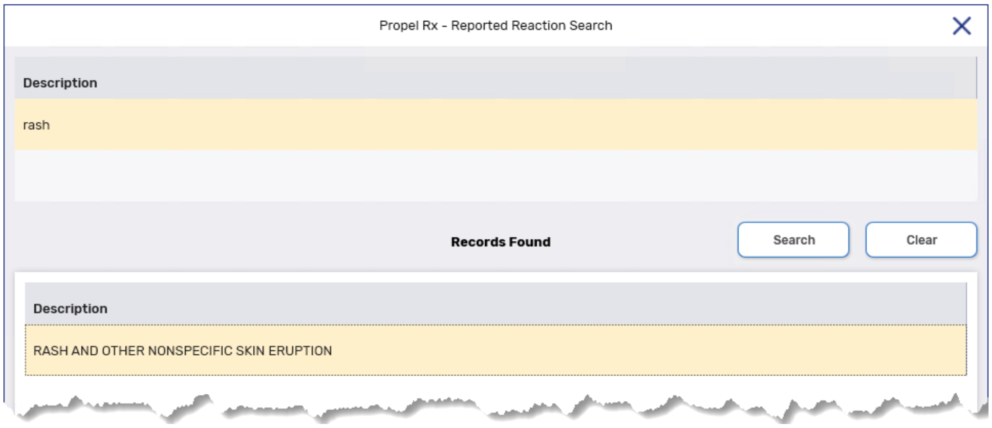


7. Enter the following details:
    - **Type**
    - **Severity**
    - **Reaction**
    - **Reported By**
    - **Confirmed Status** – for Allergies only to indicate whether it is suspected or confirmed
    - **EHR Status** – for Allergies and Conditions to indicate whether the patient still has the allergy/condition (Active) or is no longer afflicted (Completed)

    NOTE: If an Allergy/Condition is set to Completed, it cannot be changed back to Active. If the patient still has the allergy/condition, create a new record in the Patient Folder.

8. Ensure the **EHR** checkbox is selected.
9. To link a drug to the allergy or condition, enter the DIN, generic name, or trade name of the drug in the **Drug** section.
10. To add a reaction for an Allergy, select the **Reactions** button.
    a. Select **Add**. The Reported Reaction Search window opens.
    b. Enter a description for the reaction at the top.

c. Select **Search**. Matching reactions are displayed below.
d. Highlight the appropriate reaction.



e. Select **OK**.

10. To add notes, select the **Add** button in the **Notes** section.
    a. Enter the information for the note in the textbox.
    b. Ensure the **EHR** checkbox in the Notes section is selected if you wish to transmit the note to the EHR.
    c. For information on the different checkboxes for a note, see [Adding Notes to Clinical Information](#).
11. Select **OK**.
12. Select **Save**.

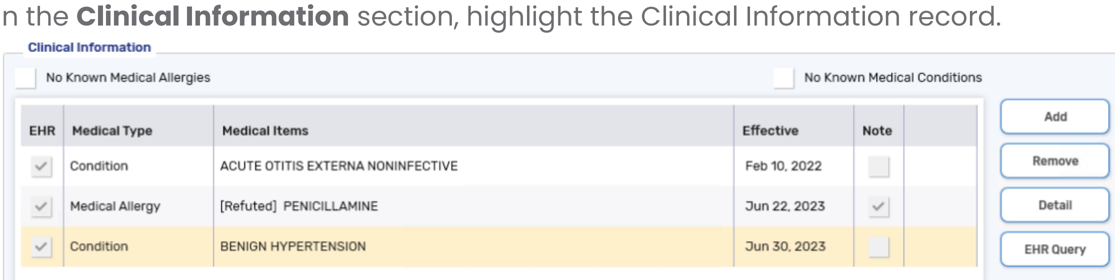
A processing message displays indicating the information is being transmitted to the EHR. Once the EHR has been updated with the local information, the **EHR** column in the Clinical Information section displays a checkmark.

ADDING NOTES TO CLINICAL INFORMATION

You can add notes to an existing Clinical Information record and transmit them to the EHR if needed. This can be done for records that are saved locally in Propel Rx or only exist on the EHR.

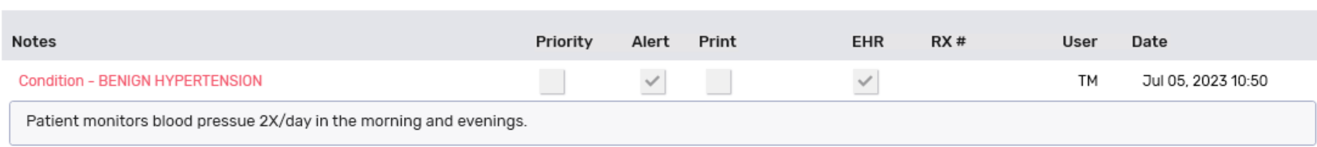
To add notes to an existing local Clinical Information record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical Information** section, highlight the Clinical Information record.



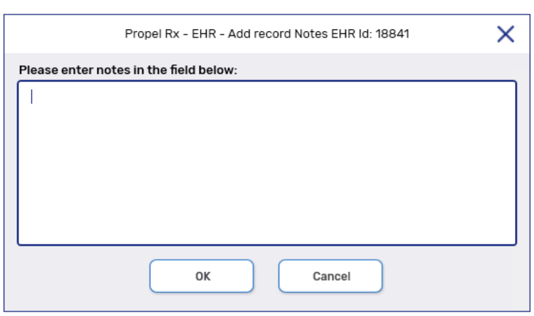
4. Select **Detail**. The Details window opens.
5. In the **Notes** section, select **Add**.
6. Enter information in the Notes textbox.
7. Select the following checkboxes if applicable:
   - **Priority** – if you want the note to pop up as an alert when opening the Patient Folder or processing a prescription in Rx Detail. If you already viewed the pop up when opening the Patient Folder, it does not display again in Rx Detail.
   - **Alert** – if you want the note to appear in the Rx Detail Alerts section when processing a prescription.
   - **Print** – if you want the note to print under the Notes/Alerts section of the half label or if Digital Workflow is enabled, appear in the Clinical Review Notes tab.
   - **EHR** – if you want to transmit the note to the EHR. By default, this checkbox is ON if the Clinical Information record has been transmitted to the EHR.
8. Select **OK**.
9. Select **Save** to transmit the note to the EHR.

A processing message displays indicating the information is being transmitted to the EHR. The Note checkbox displays a checkmark, and the note also displays in the **Patient Folder Notes** tab.



To add notes to an existing non-local Clinical Information record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical Information** section, select **EHR Query**. The EHR Access Reason window opens.
4. Select the reason for accessing the patient's EHR from the dropdown.
5. *Optional*: Enter any comments related to the access reason.
6. Select **OK**. The EHR – Clinical window opens.
7. Select the applicable record.
8. Select **Detail**. The EHR Clinical Details window opens.
9. In the **Record Notes** section, select the **Add** button . The Add Record Notes window opens.



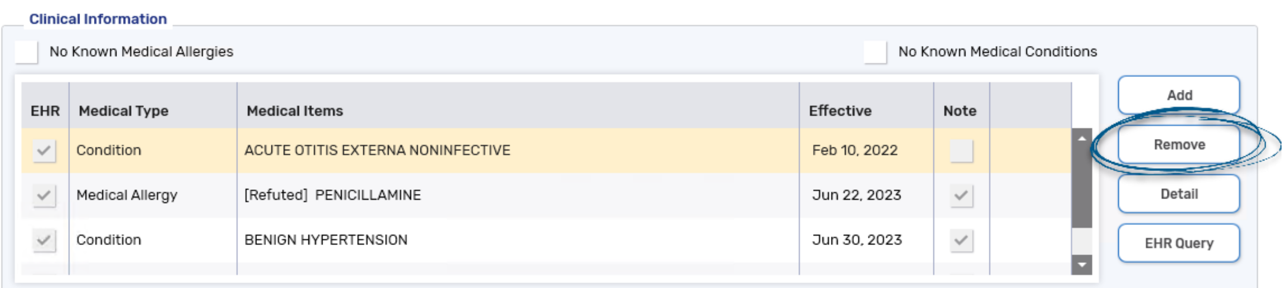
10. Enter your note in the text box.
11. Select **OK**. A processing message appears for the transmission of the note to the EHR. If the transmission was successful, the note appears in the Record Notes section.
12. Select **OK** to close the EHR Clinical Details window.
13. Select **OK** to close the EHR – Clinical window.

RETRACTING CLINICAL INFORMATION FROM THE EHR

It is possible to remove/retract Clinical Information sent to the EHR from Propel Rx.

To retract Clinical Information from the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical Information** section, highlight the record to be retracted.
4. Select **Remove**.



5. Select **Save**.

A processing message displays indicating the information is being retracted from the EHR. Once the retraction is successful, the record is removed from the Clinical Information grid and the action is recorded in the Patient History tab in Propel Rx.

NOTE: If you remove a Clinical Information record while the EHR Availability is set to No, it will be removed temporarily from the Patient Folder while the transaction is queued. When the transaction is later sent, if the send fails, the record is placed back on the Patient Folder.

The following records cannot be retracted from the EHR:

- Records that have been updated (e.g., adding a note is considered an update). You can retract the most recent update but not the record itself.
- Records that have been viewed by another pharmacy.
- Allergy records that have been refuted.

REFUTING AN ALLERGY ON THE EHR

The following Medical Condition types can be refuted on the EHR:

- Allergy Groups
- Medical Allergies
- Non-Medical Allergies

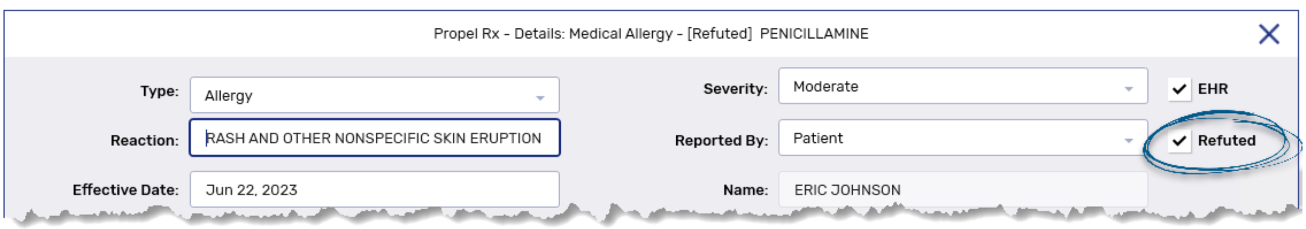
To refute an allergy on a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical Information** section, highlight the Allergy record.
4. Select **Detail**. The Details window opens.

NOTE: If the Allergy record is not local, download the record first into Propel Rx and then refute it. For more information, see Downloading Clinical Information from the EHR.

5. Select the **Refuted** checkbox.

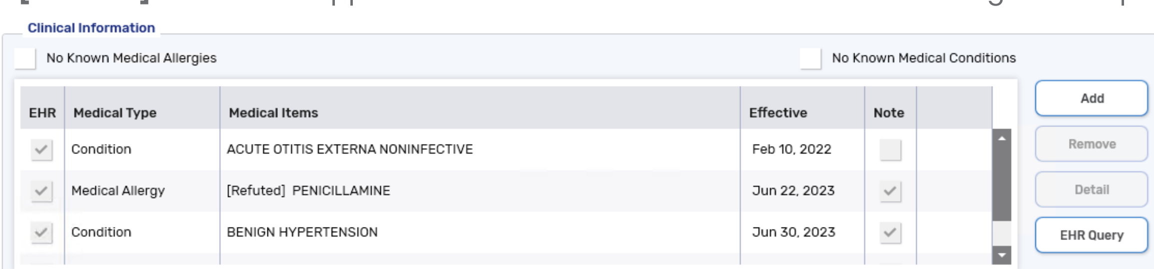
NOTE: The Refuted checkbox is only displayed once the Allergy record has been created and saved.



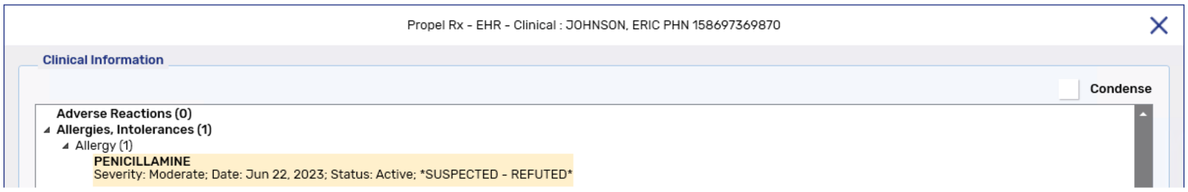
6. Select **OK**.
7. Select **Save**.

A processing message displays for the refute action. The following updates are made:

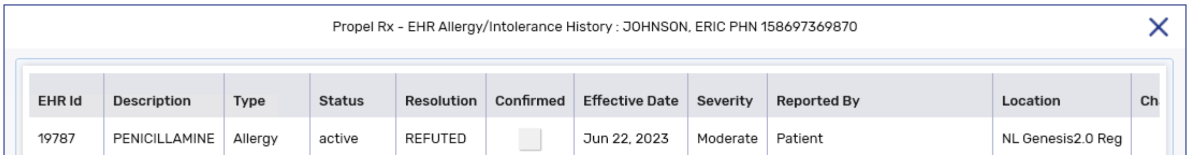
- A **[Refuted]** indicator is appended to the record in the Clinical Information grid in Propel Rx.



- When an EHR Query is performed from the Clinical Information section, the record is indicated as **REFUTED** in the EHR-Clinical window.



- If the history for the record is viewed from the EHR-Clinical window, a row appears with a Resolution of **REFUTED**.



DOWNLOADING CLINICAL INFORMATION FROM THE EHR

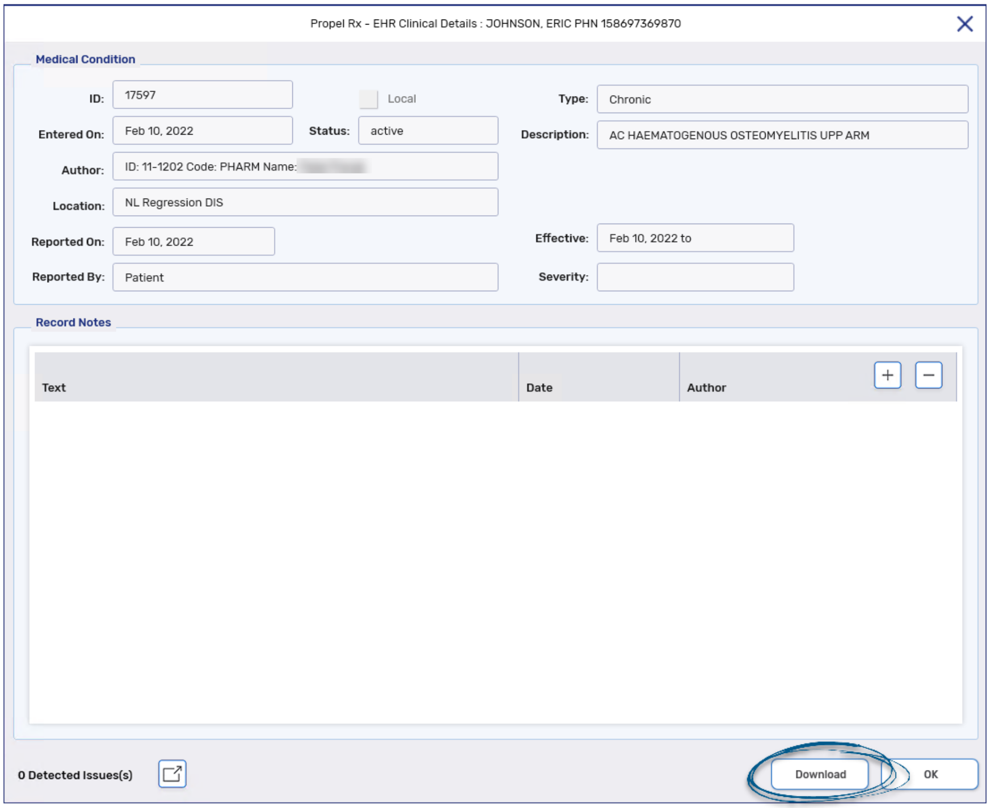
If there is Clinical Information on the patient's EHR that is not local, it can be downloaded into Propel Rx by selecting the Download button. The information is immediately transferred to the patient's Clinical tab in Propel Rx. The Download button is disabled for records that are flagged as Local.

To download Clinical Information from the patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. Select **EHR Query**. The Patient EHR Access Reason window opens.

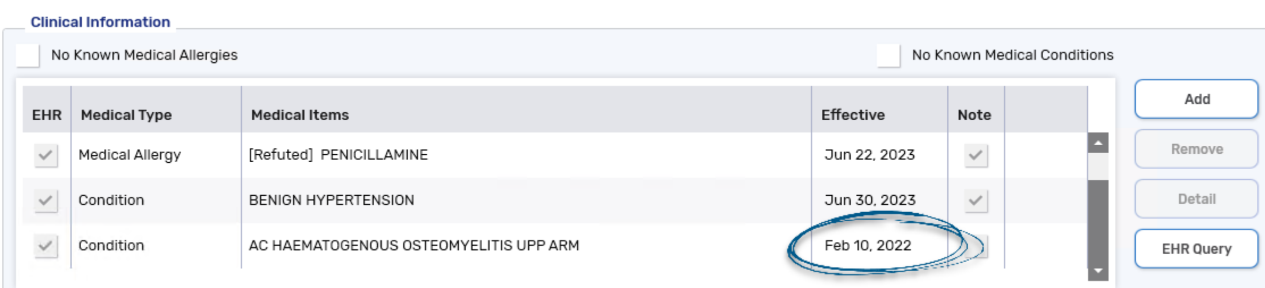
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR – Clinical window opens.
7. Highlight the desired Clinical Information record.
8. Select **Detail**. The EHR- Clinical Details window opens.
9. Select **Download**. The record is copied to the patient's local record.

NOTE: The EHR – Clinical window remains open in case additional Drug Allergy or Medical Conditions needs to be downloaded.



10. Select **OK**.
11. Select **Save**.

The record that was copied appears in the Clinical Information grid. The date that the record was added to the EHR is populated in the **Effective** column.



Clinical History

Immunizations and EHR Professional Services can be added from the Clinical History section and transmitted to the EHR.

VIEWING EHR PROFESSIONAL SERVICES

The EHR Query button in the Clinical History section allows a user to view all consultations on a patient's EHR before adding new records to the EHR unnecessarily.

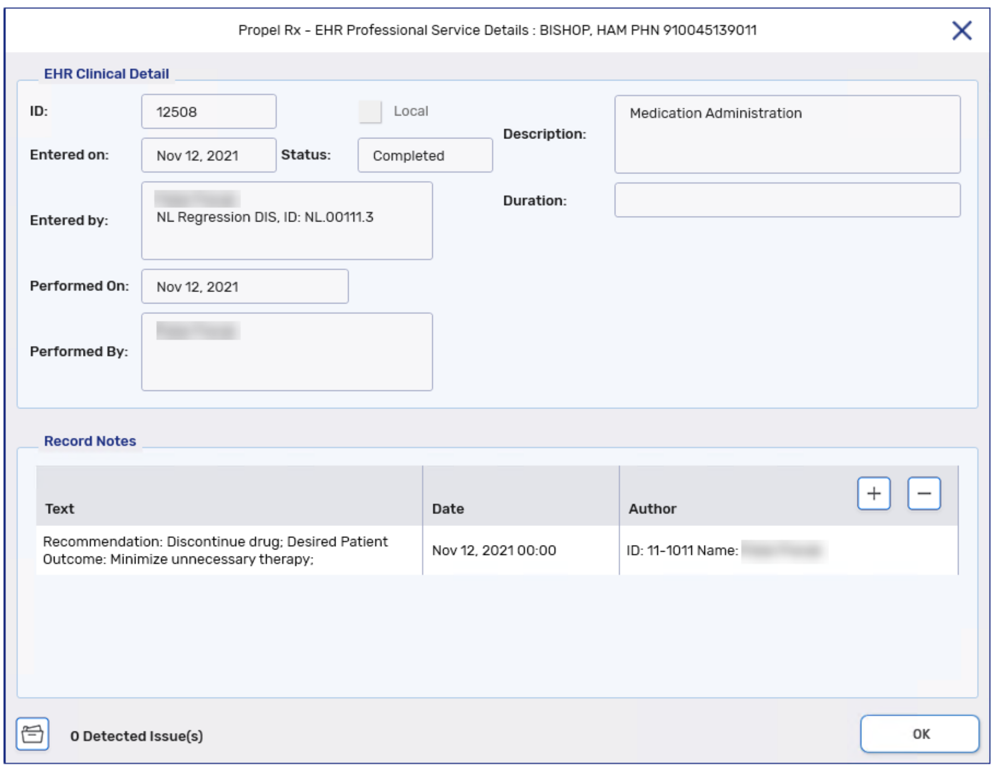
ALERT: The EHR Query button does not display any prescriptions, devices, other medications, or Clinical Information. Only consultations on the EHR are returned.

To view Professional Services on a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, select **EHR Query**. The EHR Access Reason window opens.
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR – Consultations window opens.

7. Choose to view in either a condensed or uncondensed mode by selecting/deselecting the **Condense** checkbox. By default, the checkbox is deselected (i.e., default view is uncondensed).
8. Use the expander buttons to reveal (▹) or hide (◢) additional summary details.
9. Highlight the summary information.
10. Select **Detail** to view more information.

11. Once you are done viewing the EHR, select **OK**.

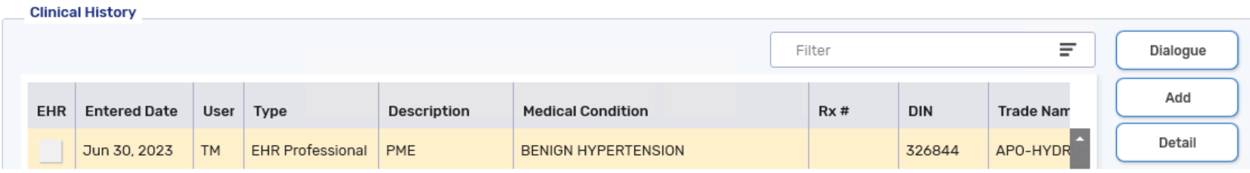


ADDING EXISTING PROFESSIONAL SERVICES TO THE EHR

To transmit an existing Professional Service in Propel Rx to a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, highlight the consultation you wish to transmit to the EHR.

NOTE: Only EHR Professional Services and Immunizations can be transmitted to the EHR.



4. Select **Detail**. The Clinical Notes window opens.
5. Select the **EHR** checkbox at the top.
6. Select **OK**.
7. Select **Save**.

A processing message displays to indicate the information is being transmitted to the EHR. Once the EHR has been updated with this local information, the **EHR** column in the Clinical History section displays a checkmark.

ADDING NEW PROFESSIONAL SERVICES TO THE EHR

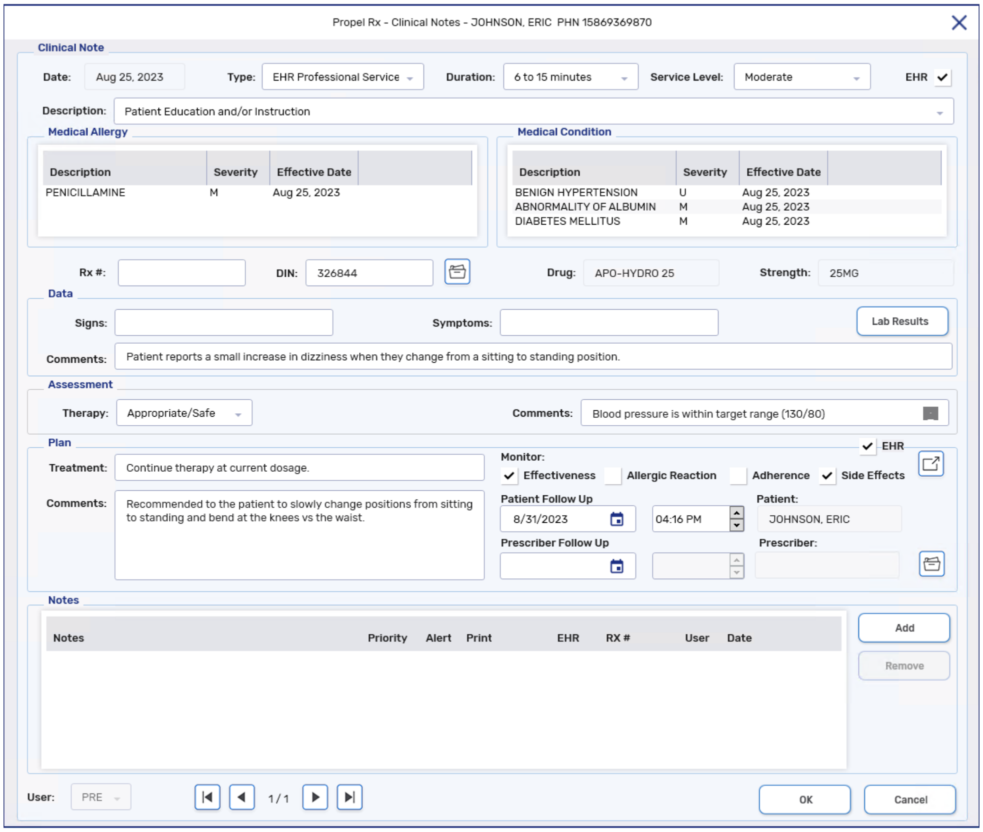
Only EHR Professional Services and Immunizations can be transmitted to the EHR from the Clinical History section.

To add a new Professional Service to a patient's EHR:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, select **Add**. The Clinical Notes window opens.
4. From the **Type** dropdown, select EHR Professional Service.
5. The **EHR** checkbox is selected by default. If you do not want to transmit the consultation to the EHR, deselect this checkbox.
6. *Optional*: Dropdown the **Duration** and **Service Level** fields and select the applicable options.
7. Dropdown the **Description** field and select the applicable description for the consultation.
8. Complete the **Data**, **Assessment**, and **Plan** sections.

NOTE: Information in the Data and Assessment sections are not transmitted to the EHR.

9. Select the **EHR** checkbox in the **Plan** section if you want to transmit information in this section to the EHR.
   - This checkbox is only available if the EHR checkbox at the top of the window is selected. By default, the EHR checkbox is OFF for the Plan.
   - Information entered in the Plan section is added as a Record Note for the consultation on the EHR.



10. To add notes, select the **Add** button in the **Notes** section.
    - Enter the information for the note in the textbox.
    - Ensure the **EHR** checkbox in the Notes section is selected if you wish to transmit the note to the EHR.
    - For information on the different checkboxes for a note, see Adding Notes for an EHR Professional Service.
11. Select **OK**.
12. Select **Save**.

A processing message displays to indicate the information is being transmitted to the EHR. Once the EHR has been updated with this local information, the **EHR** column in the Clinical History section displays a checkmark. If a Follow Up was entered, an entry is added to the Activities tile for the scheduled Follow Up date.

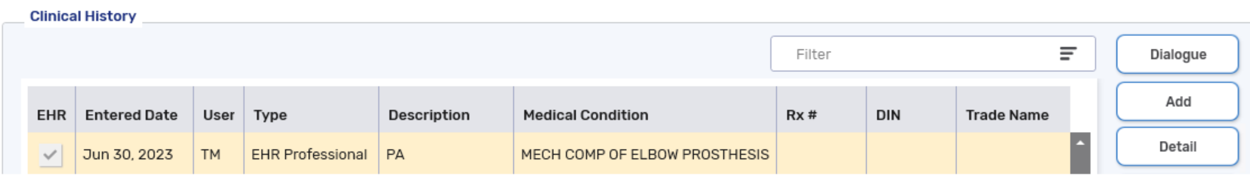
ADDING NOTES TO AN EHR PROFESSIONAL SERVICE

You can add notes to an existing EHR Professional Service record and transmit them to the EHR if needed. This can be done for records that are saved locally in Propel Rx or only exist on the EHR.

To add notes for a local EHR Professional Service record:

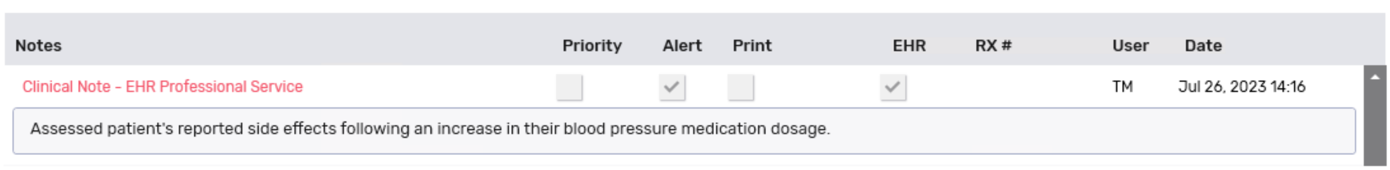
1. Open the **Patient Folder**.

2. Select the **Clinical** tab.
3. In the **Clinical History** section, highlight the EHR Professional Service record.



4. Select **Detail**. The Clinical Notes window opens.
5. In the **Notes** section, select **Add**.
6. Enter information in the Notes text box.
7. Select the following checkboxes if applicable:
    - **Priority** – if you want the note to pop up as an alert when opening the Patient Folder or processing a prescription in Rx Detail. If you already viewed the pop up when opening the Patient Folder, it does not display again in Rx Detail.
    - **Alert** – if you want the note to appear in the Rx Detail Alerts section when processing a prescription.
    - **Print** – if you want the note to print under the Notes/Alerts section of the half label or if Digital Workflow is enabled, appear in the Clinical Review Notes tab.
    - **EHR** – if you want to transmit the note to the EHR. By default, this checkbox is ON if the Clinical Information record has been transmitted to the EHR.
8. Select **OK**.
9. Select **Save**.

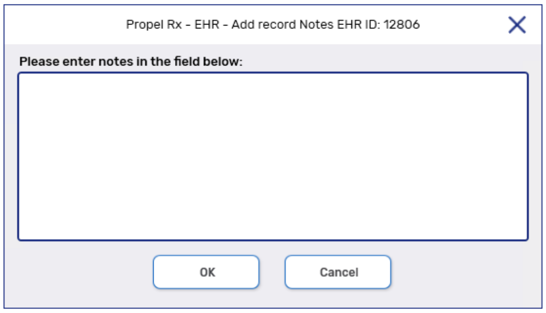
A processing message displays indicating the information is being transmitted to the EHR. The **Note** checkbox displays a checkmark, and the note also displays in the **Patient Folder Notes** tab with a Clinical Note – EHR Professional Service identifier.



To add notes to a non-local EHR Professional Service record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, select **EHR Query**. The EHR Access Reason window opens.
12. From the dropdown menu, select a reason for accessing the patient's EHR. The default reason is Patient Care.
13. *Optional*: Enter any comments in the **Comments** field.
14. Select **OK**. The EHR Patient Clinical History window opens.
15. Select the applicable EHR Professional Service record.
16. Select **Detail**. The EHR Professional Service Details window opens.

17. In the **Record Notes** section, select the **Add** button. The Add Record Notes window opens.



18. Enter your note in the text box.
19. Select **OK**. A processing message appears for the transmission of the note to the EHR. If the transmission was successful, the note appears in the Record Notes section.
20. Select **OK** to close the EHR Professional Service Details window.
21. Select **OK** to close the EHR Patient Clinical History window.

RETRACTING EHR PROFESSIONAL SERVICES

It is possible to retract/remove EHR Professional Services sent to the EHR from Propel Rx.

The following records cannot be retracted from the EHR:

- Records that have been updated (e.g., adding a note is considered an update). You can retract the most recent update but not the record itself.
- Records that have been viewed by another pharmacy.

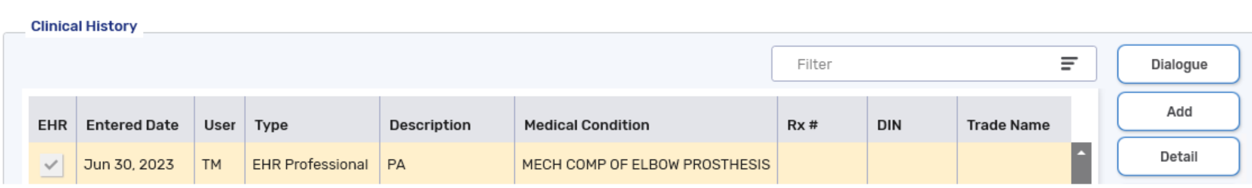
Smarter & Faster

Updating Unretractable Professional Service Records

If an EHR Professional Service record cannot be retracted, enter a note to convey additional information if needed.

To retract an EHR Professional Service record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, highlight the EHR Professional Service record to retract.



4. Select **Detail**. The Clinical Notes window opens.
5. Deselect the **EHR** checkbox at the top.

NOTE: When an EHR Professional Service is retracted from the EHR, Plan information for that record is retracted as well.

6. Select **OK**.
7. Select **Save**.

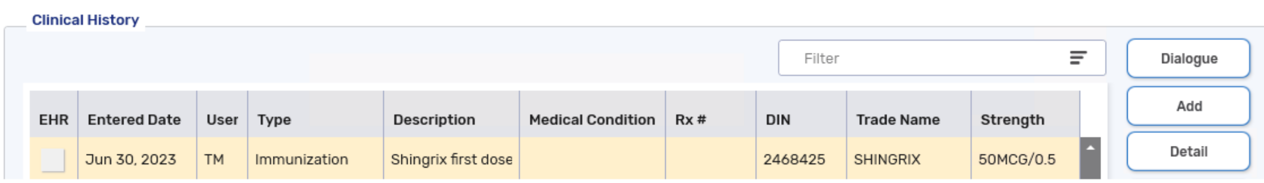
A processing message displays indicating the information is being retracted from the patient's EHR. If the removal of the EHR Professional Service record is successful, the **EHR** checkbox for the record is deselected in the Clinical History section.

ADDING EXISTING IMMUNIZATIONS TO THE EHR

To transmit an existing immunization record in Propel Rx to a patient's EHR:

1. Open the Patient Folder.
2. Select the Clinical tab.
3. In the **Clinical History** section, highlight the immunization you wish to transmit to the EHR.

NOTE: Only EHR Professional Services and Immunizations can be transmitted to the EHR.



4. Select **Detail**. The Clinical Notes - Immunization window opens.
5. Select the **EHR** checkbox at the top.
6. Select **OK**.
7. Select **Save**.

A processing message displays to indicate the information is being transmitted to the EHR. Once the EHR has been updated with this local information, the **EHR** column in the Clinical History section displays a checkmark.

ADDING NEW IMMUNIZATIONS TO THE EHR

To transmit a new immunization to a patient's EHR:

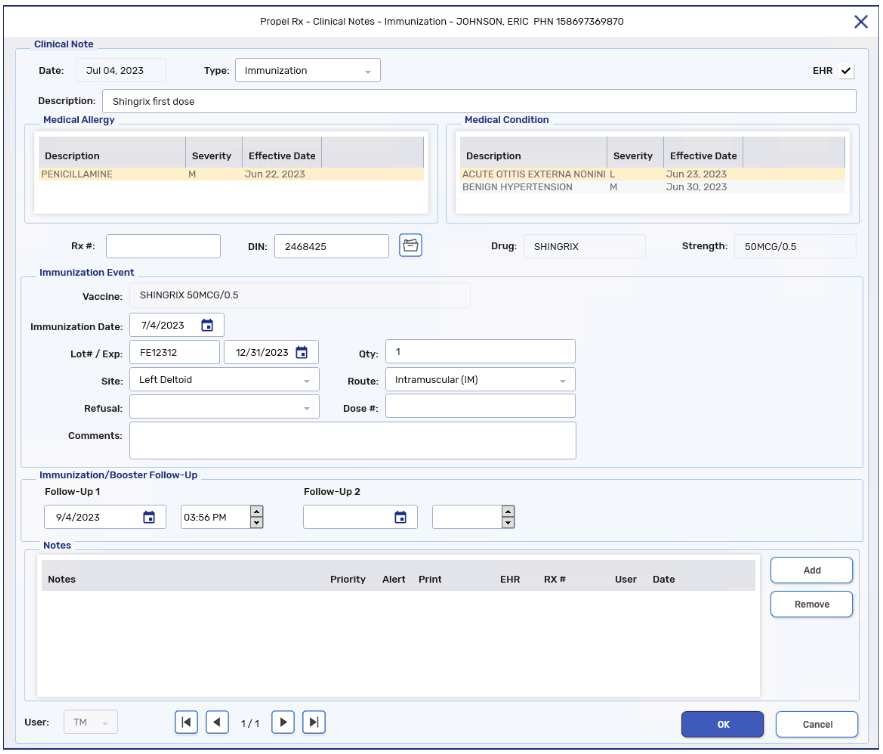
1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, select **Add**. The Clinical Notes – Immunization window opens.
4. From the **Type** dropdown list, select Immunization.
5. *Optional*: In the Description field, enter a description for the immunization. This displays in the Clinical History grid.
6. In the **Rx #** or **DIN** field, enter the prescription number or DIN associated to the immunization.

7. Complete the fields in the Immunization Event section. The following fields are required:
    - **Immunization Date**

    NOTE: Ensure you enter the correct date for the immunization. If you attempt to add an immunization with a future date, you will get the following Detected Issue:

Priority	Severity	Issue Type	Description
Error		A local business rule relating multiple elements has been violated	The specified Immunization Date is in future (600603)

    - **Lot#/Exp**
    - **Qty**
    - **Dose**
8. *Optional*: Enter a follow-up immunization date(s) in the **Immunization/Booster Follow-Up** section.



9. To add notes, select the **Add** button in the **Notes** section.
    - Enter the information for the note in the textbox.
    - Ensure the **EHR** checkbox in the Notes section is selected if you wish to transmit the note to the EHR.
    - For information on the different checkboxes for a note, see Adding Notes to an Immunization.
10. Select **OK**.
11. Select **Save**.

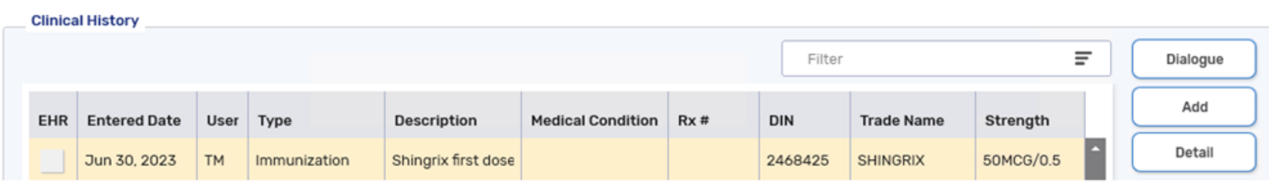
A processing message displays to indicate the information is being transmitted to the EHR. Once the EHR has been updated with this local information, the **EHR** column in the Clinical History section displays a checkmark. If a Follow Up was entered, an entry is added to the Activities tile for the scheduled Follow Up-date.

ADDING NOTES TO AN IMMUNIZATION

You can add notes to an existing Immunization record and transmit them to the EHR if needed. This can be done for records that are saved locally in Propel Rx or only exist on the EHR.

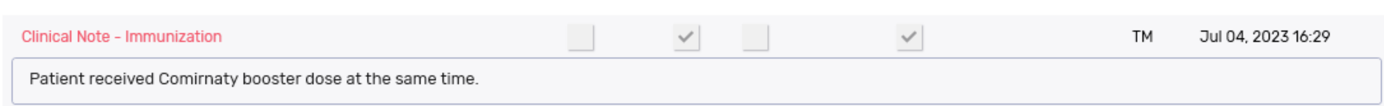
To add notes for a local Immunization record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, highlight the Immunization record.



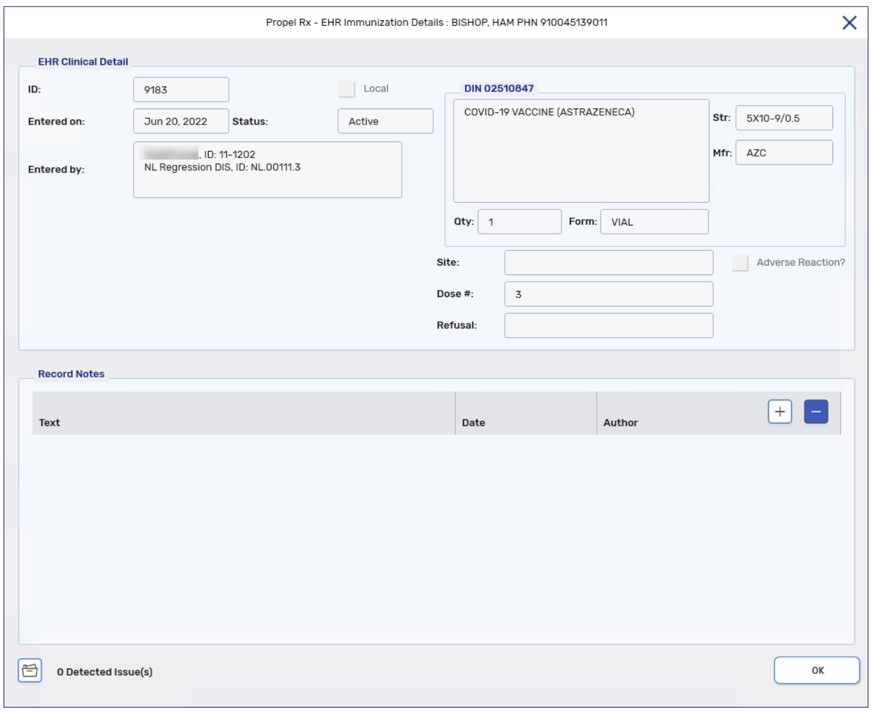
4. Select **Detail**. The Clinical Notes – Immunization window opens.
5. In the **Notes** section, select **Add**.
6. Enter information in the Notes text box.
7. Select the following checkboxes if applicable:
   - **Priority** – if you want the note to pop up as an alert when opening the Patient Folder or processing a prescription in Rx Detail. If you already viewed the pop up when opening the Patient Folder, it does not display again in Rx Detail.
   - **Alert** – if you want the note to appear in the Rx Detail Alerts section when processing a prescription.
   - **Print** – if you want the note to print under the Notes/Alerts section of the half label or if Digital Workflow is enabled, appear in the Clinical Review Notes tab.
   - **EHR** – if you want to transmit the note to the EHR. By default, this checkbox is ON if the Clinical Information record has been transmitted to the EHR.
8. Select **OK**.
9. Select **Save**.

A processing message displays indicating the information is being transmitted to the EHR. The **Note** checkbox displays a checkmark, and the note also displays in the **Patient Folder Notes** tab with a Clinical Note – Immunization identifier.

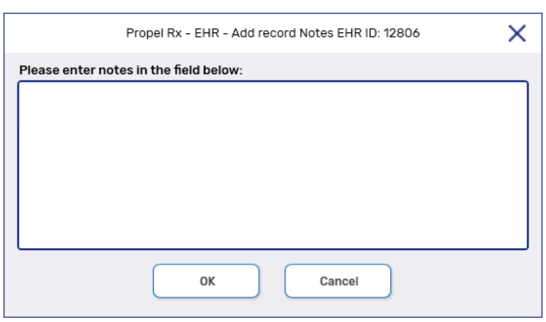


To add notes to a non-local Immunization record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, select **EHR Query**. The EHR Access Reason window opens.
4. From the dropdown menu, select a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR Patient Clinical History window opens.
7. Select the applicable Immunization record.
8. Select **Detail**. The EHR Immunization Details window opens.



9. In the **Record Notes** section, select the **Add** button. The Add Record Notes window opens.



10. Enter your note in the text box.
11. Select **OK**. A processing message appears for the transmission of the note to the EHR. If the transmission was successful, the note appears in the Record Notes section.

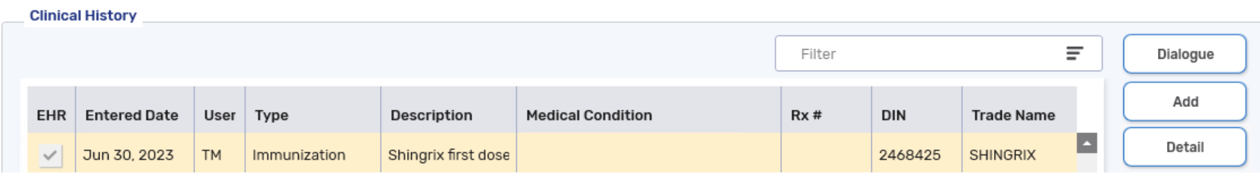
12. Select **OK** to close the EHR Immunization Details window.
13. Select **OK** to close the EHR Patient Clinical History window.

RETRACTING IMMUNIZATIONS

It is possible to retract/remove Immunizations sent to the EHR from Propel Rx.

To retract an Immunization record:

1. Open the **Patient Folder**.
2. Select the **Clinical** tab.
3. In the **Clinical History** section, highlight the Immunization record to retract.



4. Select **Detail**. The Clinical Notes window opens.
5. Deselect the **EHR** checkbox at the top.
6. Select **OK**.
7. Select **Save**.

A processing message displays indicating the information is being retracted from the patient's EHR. If the removal of the Immunization record is successful, the **EHR** checkbox for the record is deselected in the Clinical History section.

Patient Profile

A patient's local profile is displayed in the Patient Folder Profile tab. This only displays records that reside locally in Propel Rx.

Viewing a Patient EHR Profile

The Patient Medication Profile on the NLPN contains all medications and devices prescribed and dispensed to a particular patient registered in the provincial Client Registry. You must be logged into Propel Rx and have successfully completed a patient search to uniquely identify the patient in the NLPN.

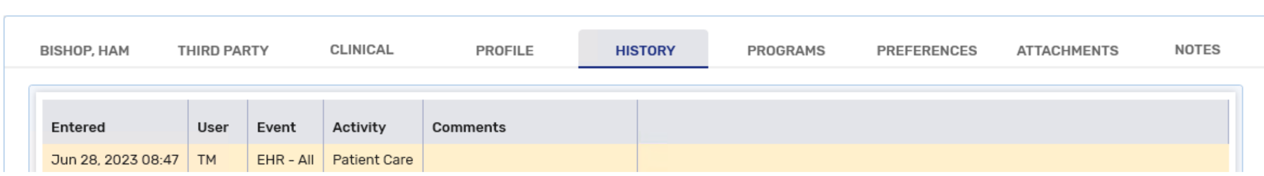
The EHR displays information in the following sections:

- **Clinical Information** – this information can be viewed from the Patient Folder Clinical tab. When viewing the patient's EHR Profile from the Patient Profile tab, the clinical information cannot be detailed or downloaded. For more information on the view from the Clinical tab, see Patient Clinical Tab.
- **Profile Information** – contains prescriptions categorized into (i) EHR only, (ii) EHR and Propel Rx, and (iii) Propel Rx only.

To view a patient's EHR from the Patient Profile tab:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select **Rx** > **Profile** > **EHR-All**. The Patient EHR Access Reason window opens.
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR - All window opens.
    - A summary of both clinical and prescription information is displayed.
    - The prescription information includes Prescriptions, Device Prescriptions, and Other Medications.
7. Once you are done viewing the patient's EHR, select **OK**.

The Patient History records the access to the patient's EHR as follows:



Entered	User	Event	Activity	Comments
Jun 28, 2023 08:47	TM	EHR - All	Patient Care	

Overview of the EHR – All Window

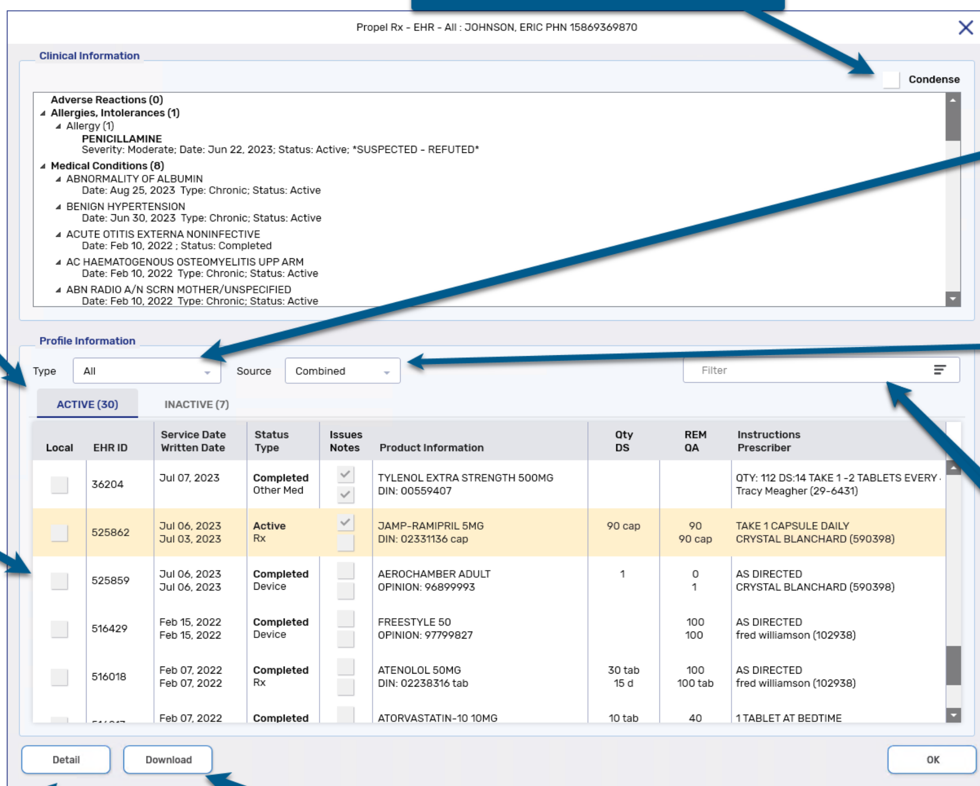
A patient's EHR – All Profile is broken into Clinical and Profile Information, as shown below.

- **Clinical Information** is a view-only section. Download is not permitted from this view.
- **Profile Information** can be viewed by both Type and Source.

Condense
Displays less detailed Clinical Information, allowing more information to be displayed on the screen.

Active/Inactive Tabs
Separates prescriptions based on Status. Aborted prescriptions display in the Inactive tab. All other prescriptions display in the Active tab.

The **Local** column indicates if the prescription is:
- Local Only
- EHR Only
- Local & EHR



Type
Allows view of:
-All Types
-Prescriptions (Rx)
-Device Prescriptions
-Other Medications

Source
Allows view of:
-Combined
-EHR
-Local Only

Filter
Allows prescriptions to be filtered by a field such as Type, Source, Product Information, Prescriber, EHR ID, and Instructions. When a filter is applied, both the Active and Inactive tabs are filtered.

Detail
Displays the details of the highlighted row, showing all related EHR information. If a prescription is local only, the Detail button is disabled.

Download
Permits your pharmacy to download a non-local prescription and dispense it at your pharmacy.

Overview of the EHR – Rx Details Window

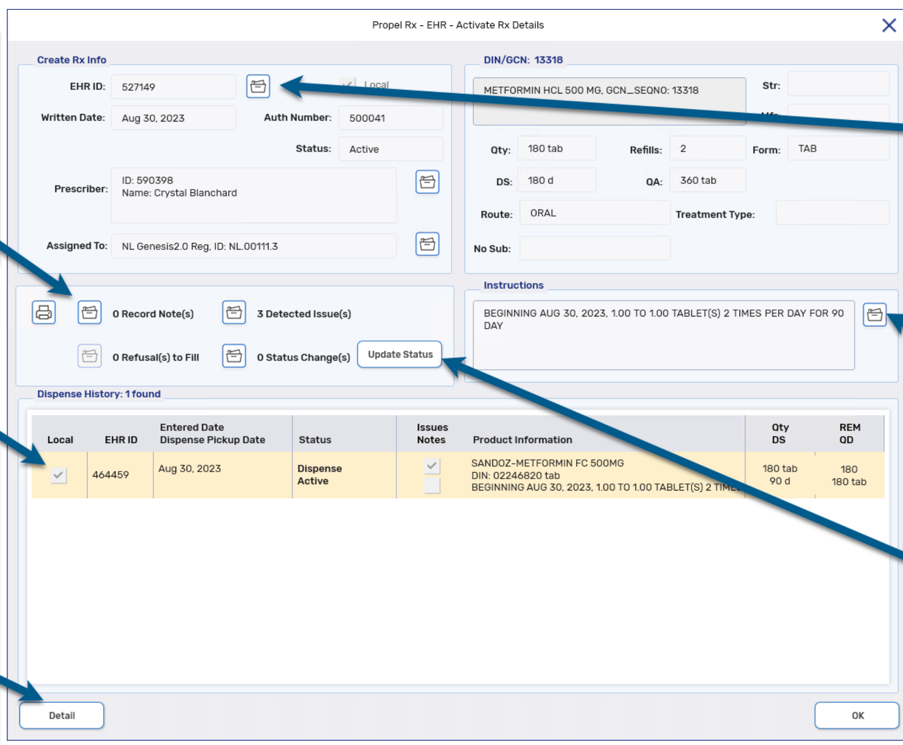
When viewing the **EHR – All** window, highlight a row and select Detail to view more information. The **EHR – Rx Details** window is broken up into 5 separate sections:

- **Create Rx Info** – this section is "how the prescriber wrote the prescription." Details such as Written Date, Prescriber, Status, and Assigned Pharmacy are displayed.
- **DIN/GCN** - this section outlines details of the prescription, including Quantity Authorized, Refills, Days Supply, Treatment Type, etc.
- **Instructions** – this section displays the instructions for the prescription.
- **Record Notes/Detected Issues/Refusals to Fill/Status Changes** – this section indicates if:
    - Notes were added for the prescription and transmitted to the EHR.
    - Detected Issues were returned by the EHR at the time of fill.
    - A Refusal to Fill was submitted.
    - The prescription status was changed.
- **Dispense History** – this section outlines each dispense as their own record. Additional information about each dispense can be detailed by highlighting the dispense and selecting Detail.

Folder Buttons
Select the folder button if the number beside the button is greater than 0 to display more information about notes, Detected Issues, status changes, or Refusals to Fill.

Local
Indicates if the record resides locally within Propel Rx.

Detail
Highlight a dispense and select Detail to view additional details regarding the dispense including who dispensed the prescription, Detected Issues, Record Notes, etc. The information that displays is similar to the top section of this window.



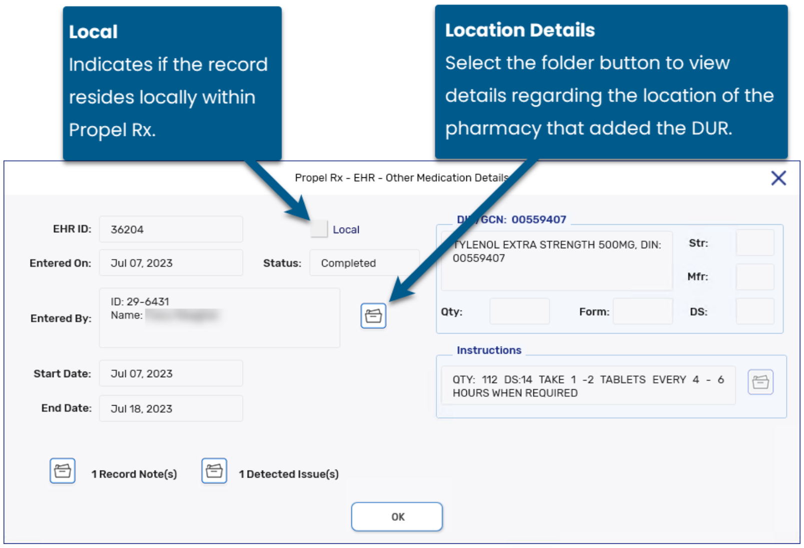
Additional Rx Information
Select the folder button to view additional details regarding the prescription (e.g., Rx Start Time/End Time, Previous Rx ID, Dispensable Status, etc.).

Additional Dosage Information
Select the folder button to view details regarding the instructions (e.g., supplemental instructions, etc.).

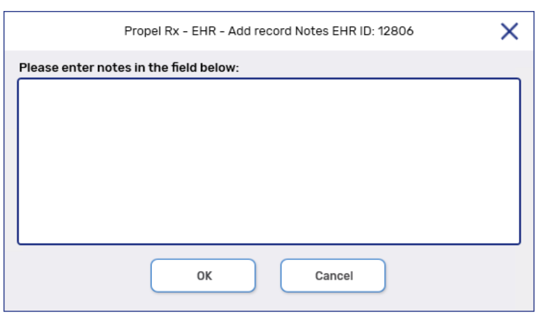
Update Status
Allows you to update the status of a local or non-local prescription to:
-Abort (Discontinue)
-Suspend
-Resume

Overview of the EHR – Other Medication Details Window

Other Medications are DUR Instructions used to record over the counter drugs, along with natural products, vitamins, or products dispensed out of province at another health facility. The **EHR – Other Medication Details** window displays the details as recorded on NLPN.



Record Notes only exist when a note is added to an Other Medication record. Users can add Record Notes to an Other Medication that is not local (i.e., added by another pharmacy). Users can add a Record Note by selecting the folder button followed by the add button. The Add record notes window opens allowing you to enter your notes for all health providers to view regarding the Other Medication.



Overview of the EHR – Device Details Window

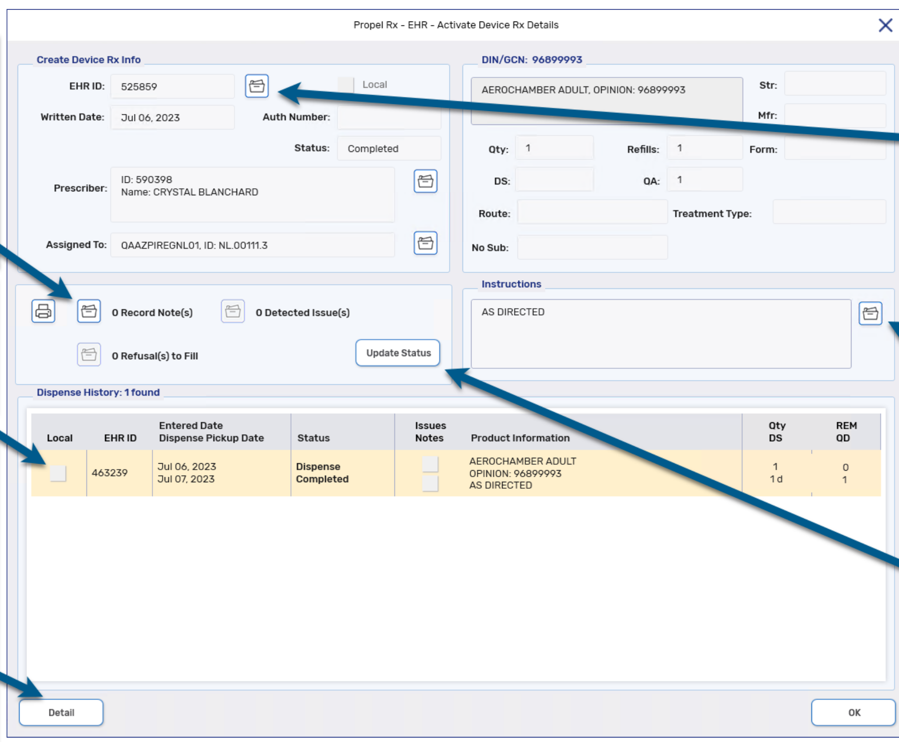
The following outlines the EHR – Device Rx Details window for the Create and Dispense of a Device. As with prescriptions, the Device Rx Details window is divided into 5 sections:

- **Create Rx Info** – this section is "how the prescriber wrote the prescription." Details such as Written Date, Prescriber, Status, and Assigned Pharmacy are displayed.
- **DIN/GCN** - this section outlines details of the prescription, including Quantity Authorized, Refills, Days Supply, Treatment Type, etc.
- **Instructions** – this section displays the instructions for the prescription.
- **Record Notes/Detected Issues/Refusals to Fill/Status Changes** – this section indicates if:
  - Notes were added for the prescription and transmitted to the EHR.
  - Detected Issues were returned by the EHR at the time of fill.
  - A Refusal to Fill was submitted.
- **Dispense History** – this section outlines each dispense as its own record. Additional information about each dispense can be viewed by highlighting the dispense and selecting Detail.

Folder Buttons
Select the folder button if the number beside the button is greater than 0 to display more information about notes, Detected Issues, or Refusals to Fill.

Local
Indicates if the record resides locally within Propel Rx.

Detail
Highlight a dispense and select Detail to view additional details regarding the dispense including who dispensed the prescription, Detected Issues, Record Notes, etc. The information that displays is similar to the top section of this window.



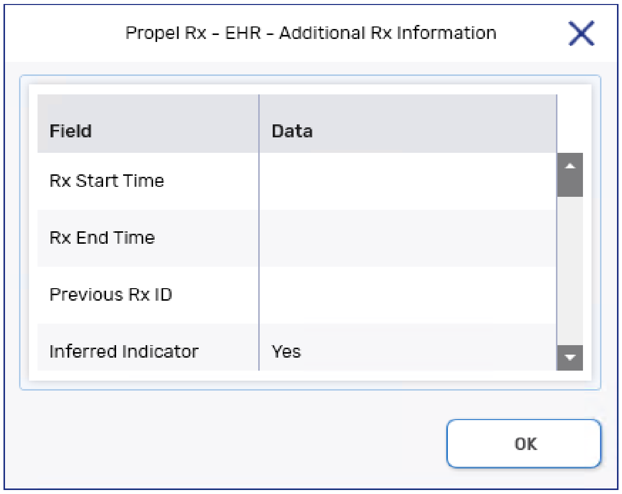
Additional Rx Information
Select the folder button to view additional details regarding the prescription (e.g., Rx Start Time/End Time, Previous Rx ID, Dispensable Status, etc.).

Additional Dosage Information
Select the folder button to view details regarding the instructions (e.g., supplemental instructions, etc.).

Update Status
Allows you to update the status of a local or non-local prescription to:
-Abort (Discontinue)
-Suspend
-Resume

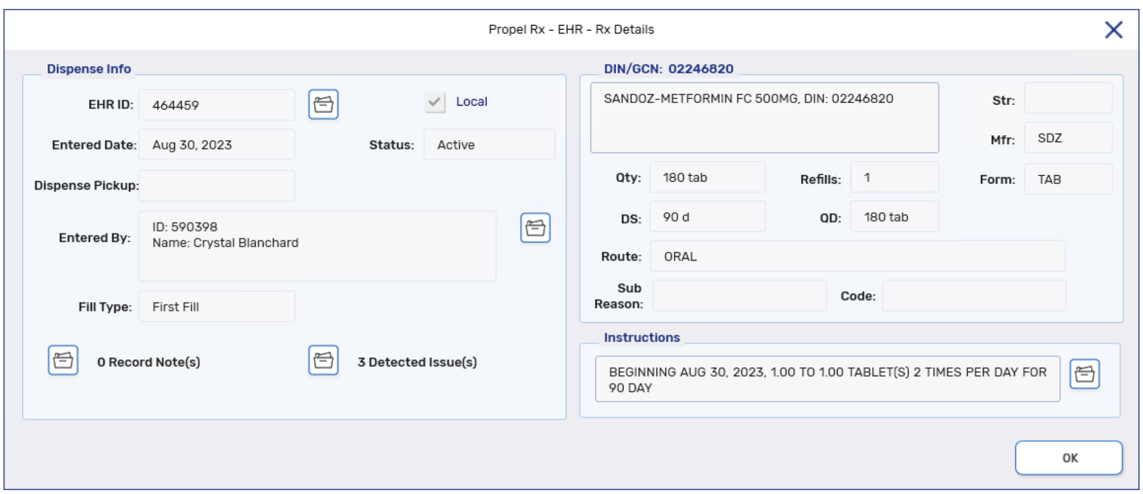
Sample Additional Rx Information Window

When the folder button beside the EHR ID is selected in the EHR – Rx Details or EHR – Device Details window, the Additional Rx information window opens. The window appears like the following:



Sample EHR – Rx Details Window

When a dispense is detailed from the EHR – Rx Details or EHR – Device Details window, the EHR – Rx Details window opens and appears like the following:



Updating a Prescription Status on the EHR

For non-local records, users can use the Update Status button to change the status of a non-local prescription (e.g., changing from Active to Aborted/Discontinued).

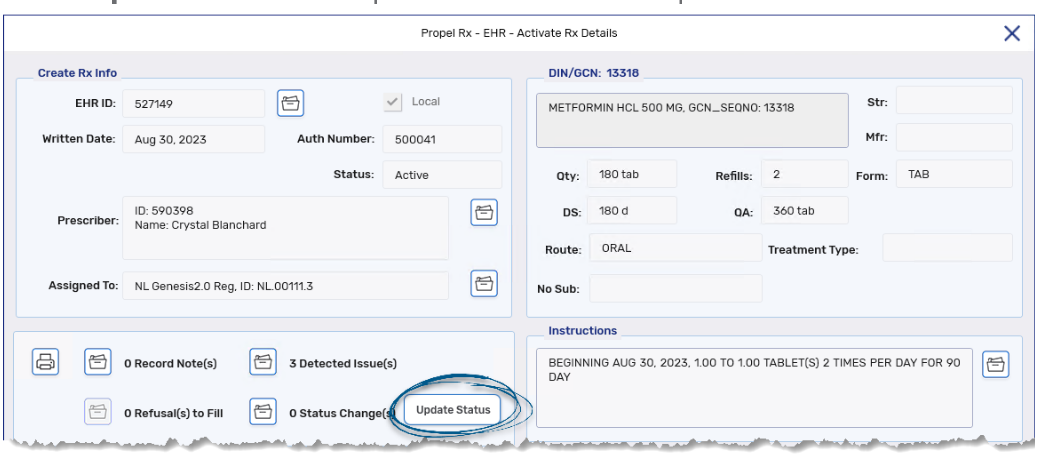
Smarter & Faster

Updating the Status of Local Records

If a prescription is found locally and on the EHR, update the status from the Patient Profile tab in Propel Rx. Prescription status changes from the Patient Profile are transmitted to the EHR. If the status is updated from the EHR Profile, the change is not reflected locally. This can lead to Detected Issues when attempting to refill the prescription.

To update the status of an EHR prescription:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select **Rx** > **Profile** > **EHR – All**. The Patient EHR Access Reason window opens.
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR - All window opens.
7. Highlight the desired record.
8. Select **Detail**.
9. Select **Update Status**. The Update Status window opens.

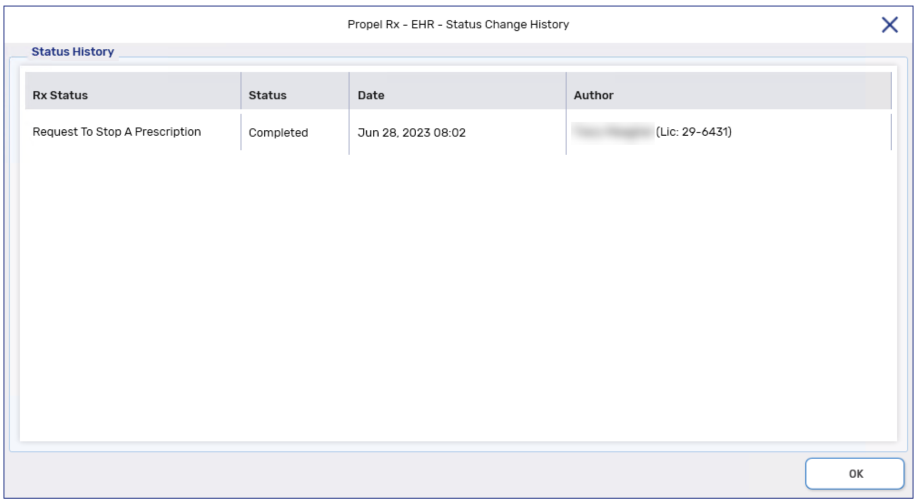


10. From the **Status** dropdown, select the status of the prescription. The following options are available:
    - Abort (Discontinue)
    - Suspend – the release date records the intended release date for the prescription. This date is recorded on the patient's EHR only.

- Resume

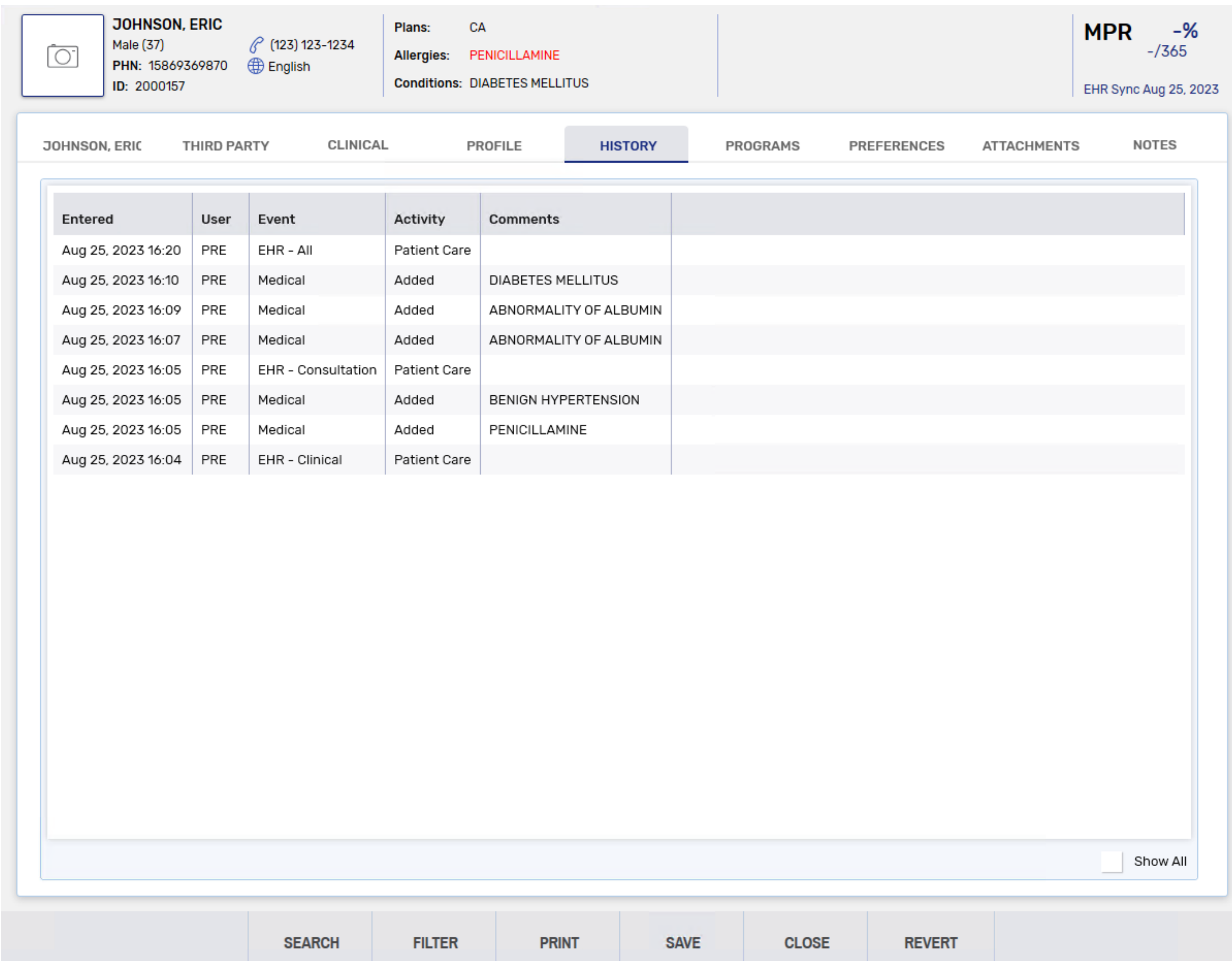
11. From the **Reason** dropdown list, select the reason for the status change.
12. *Optional*: In the **Notes** field, enter any comments about the status change.
13. Select **OK**.

The status change is recorded in the Status Change History window which can be accessed by selecting the folder button beside the Update Status button.



Patient History Tab

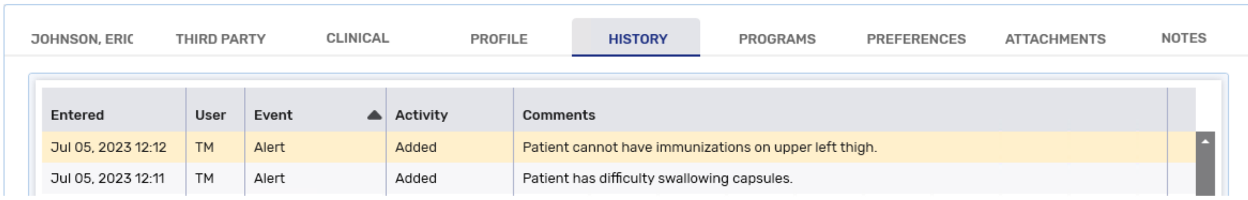
A patient's care history lists all events that have occurred for the patient. Events include modifications to the Patient Folder (e.g., adding notes) and prescription activities (e.g., filling, cancelling, or transferring a prescription). Each time a patient's EHR is viewed, an entry is created in this tab. For each event, the date, user, type of activity, and comments are displayed. By default, 1 year's worth of records are displayed. To view all History records, select the **Show All** checkbox.



ALERT: It is imperative that users log into Propel Rx with their own credentials and do not share their passwords. All activity sent to the EHR is done so with a user attached.

For each event that is recorded in the History tab, such as a dispense or a form, you can highlight the record and then select Detail to view more information about what occurred in the event. Certain events such as EHR access events cannot be detailed. Furthermore, you can use the action buttons along the bottom to sort and filter the entries in the History tab.

- To sort entries, select the header for the column you want to sort by. In the example below, the records are sorted in alphabetical order by Event.



- To filter entries, select Filter and enter the desired text to filter by.

Patient Notes Tab

Any notes added in the Patient Notes tab can be transmitted to a patient's EHR.

Viewing Notes on the EHR

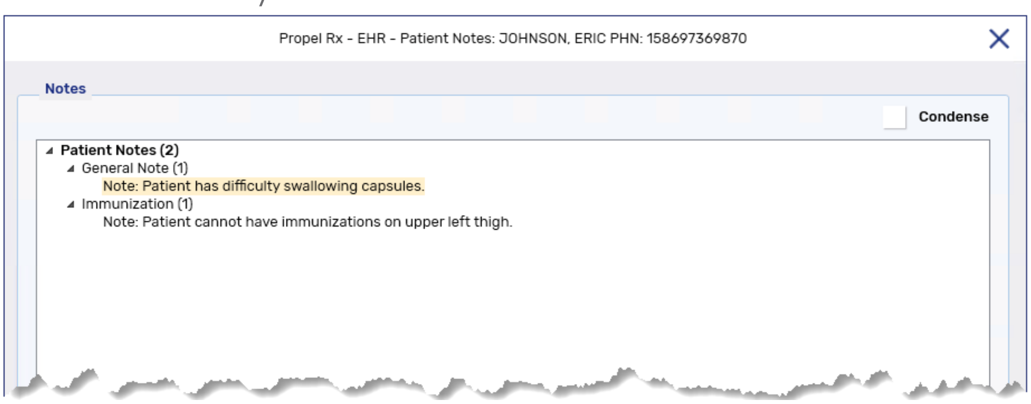
The EHR Query button in the Notes tab allows you to view all notes on a patient's EHR.

To view notes on a patient's EHR:

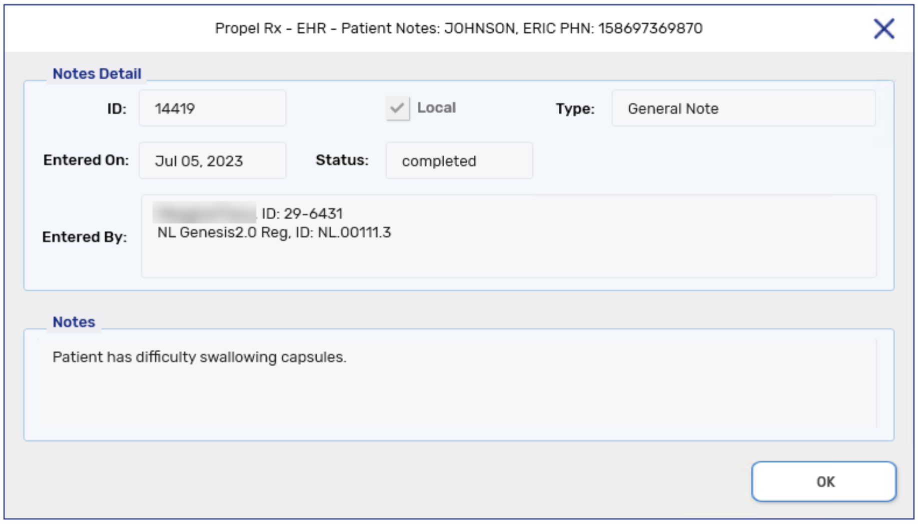
1. Open the **Patient Folder**.
2. Select the **Notes** tab.
3. Select **EHR Query**. The Patient EHR Access Reason window opens.
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR – Patient Notes window opens.

ALERT: The EHR Query initiated from the Patient Notes tab only returns Patient Notes. There are no prescriptions, devices, other medications, clinical information, or consultations displayed.

7. Choose to view in either a condensed or uncondensed mode by selecting the **Condense** checkbox. Uncondensed is the default view.
8. Use the expander buttons to reveal ( ) or hide ( ) additional summary view details.
9. Select the summary details for a record.



10. Select **Detail** to view more information.



11. Select **OK** to close the EHR – Patient Notes window.

Adding Notes to the EHR

A patient note can be added to a patient's EHR if the dispense identifies relevant information through an encounter with the patient. This includes information such as:

- Compliance issues
- Difficulty swallowing medication
- Smoking status
- Notation regarding family history

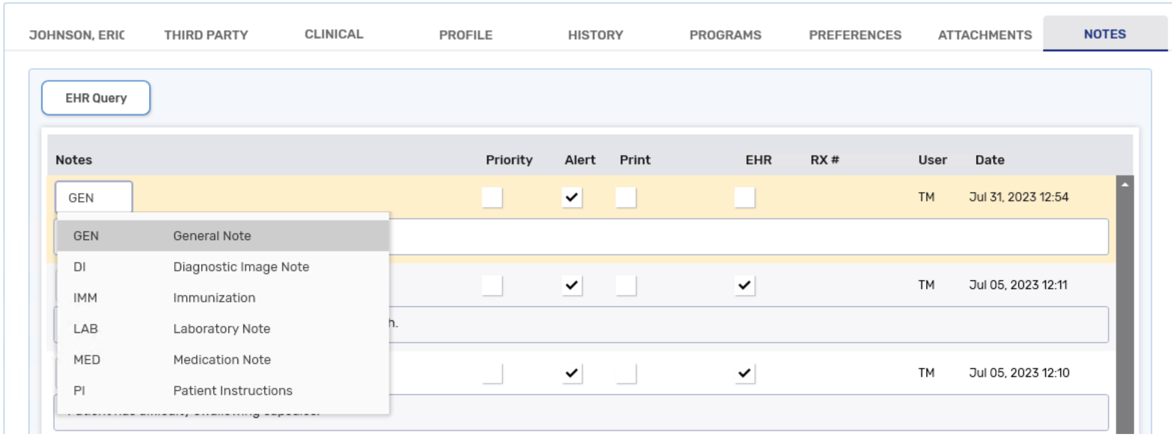
Patient notes are added locally. If you want to transmit a note to the patient's EHR, you must select the EHR checkbox. A validation prompt displays to confirm whether you would like to add the note to the EHR.

ALERT: It is recommended that only clinically relevant patient notes are transmitted to the EHR. Patient notes such as *'Deliveries to Side Door'* or *'Do not cash cheques'* should not be transmitted to the EHR.

Once a note is transmitted to the EHR, you cannot edit it. If a correction needs to be made, you can delete or retract the note from the EHR. For more information, see Retracting Notes from the EHR.

To add a patient note:

1. Open the **Patient Folder**.
2. Select the **Notes** tab.
3. Select **Add** located at the bottom. A new patient note row appears.
4. From the dropdown menu, select the type of note you are entering.



5. Enter your note text.
6. If the note should be added to the patient's EHR, select the **EHR** checkbox. By default, the **EHR** checkbox is not selected.
    - If you select the **EHR** checkbox, a validation prompt displays to confirm that you would like to save the note to the patient's EHR. Select **Yes** to continue.
7. Select **Save**.

If the EHR checkbox was selected, a processing message displays indicating the information is being transmitted to the patient's EHR.

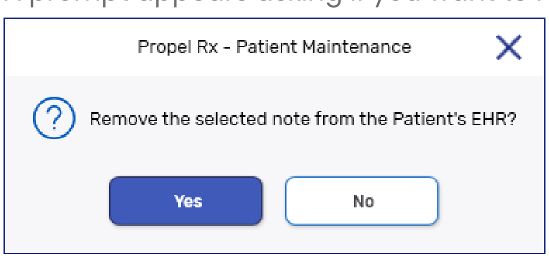
Retracting Notes from the EHR

If a note was added to a patient's EHR, you can retract the note from the EHR if needed. You cannot retract notes that were added from the Patient Folder Clinical tab from the Notes tab.

To delete a patient note:

1. Open the **Patient Folder**.
2. Select the **Notes** tab.
3. Do one of the following:
    - If you want to remove the note from Propel Rx and the EHR, highlight the note and select **Delete**.
    - If you want to retract the note from the EHR but keep it locally in Propel Rx, deselect the **EHR** checkbox for the note.

   A prompt appears asking if you want to remove the selected note from the EHR.



4. Select **Yes**.

5. Select **Save**.

If the note was previously transmitted to the EHR, a processing message displays indicating the information is being retracted from the patient's EHR. If the note was viewed by another user, the following Detected Issue appears for your information. Select **OK**.

Priority	Severity	Issue Type	Description
Warning		A local business rule relating multiple elements has been violated	The system indicates that this patient note may have been viewed by another provider before being recalled (600703)

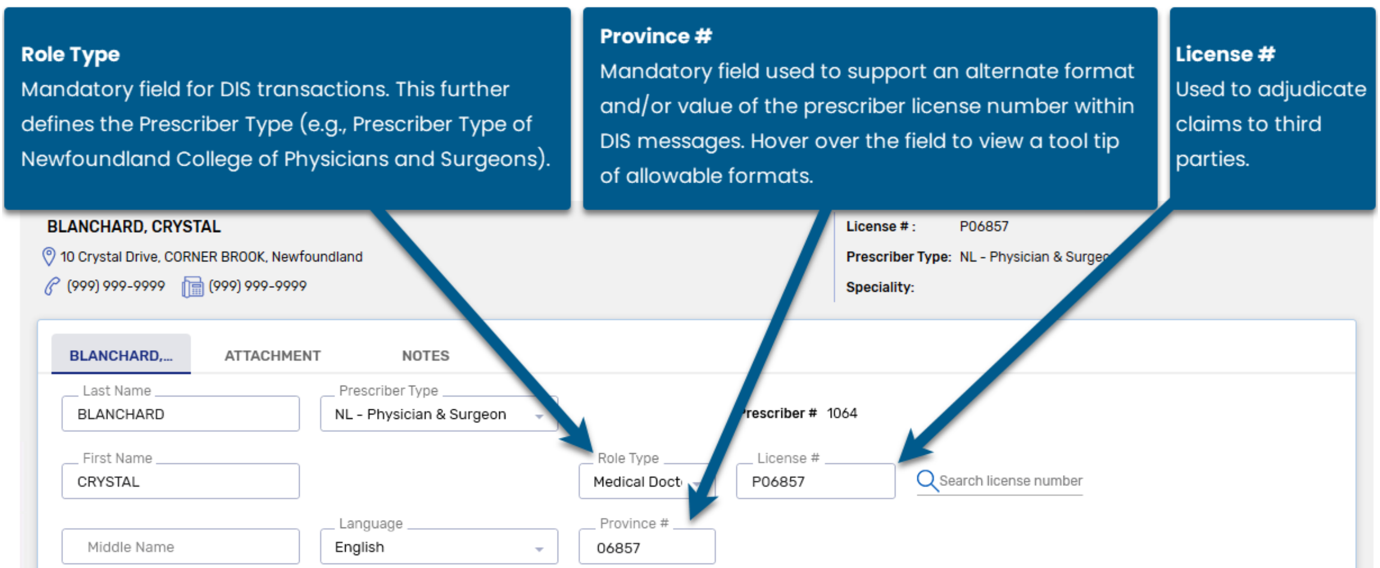
The note is retracted from the EHR. If **Delete** was selected, the note is also removed from Propel Rx.

Prescriber Folder

The Prescriber Folder allows you to add new or update existing healthcare professional records (e.g., physicians, nurse practitioners, pharmacists, optometrists, etc.) in Propel Rx.

Role Type and Province

The **Province #** value must be specified in a specific format based on the Role Type. The **Province #** is different than the **License #**.



Role Type	Sample License # for Adjudication	Sample Province # for EHR Transmissions
NL Medical Doctor	P09876 The letter P, F, R, L, or M should already be populated.	09876
NL Pharmacist	67142 Remove the hyphen from the Province #.	67-142
NL Registered Nurse and Registered Nurse Practitioner	N94678 Remove the first digit from the Province # and replace with N9.	14678
NL Dentist	D88908 Remove the first 2 digits and add D8; then remove the last 3 digits.	018909121

Any Out of Province Doctor	License number	00000
NL Optometrist	Number as provided by the Newfoundland and Labrador Health Services Service Desk	1234 Same as License #
Midwife	Number as provided by the Newfoundland and Labrador Health Services Service Desk	MW-5

MD Match

When adding new prescribers to your prescriber database, the MD Match button in the Prescriber Search window allows you to search a provincial database of doctors. For each doctor, this database contains an address, license number, and at least one phone number.

NOTE: MD Match is not integrated with the EHR.

If a prescriber cannot be located via MD Match, search the applicable provincial college registry.

TIP: Click on the magnifying glass beside the **License #** field to open the Newfoundland and Labrador College of Physicians and Surgeons Physician Search in your browser.

To use MD Match to locate a doctor:

1. Select the **Prescriber** navigator button on the left. The Prescriber Search window opens.
2. Enter in the prescriber search criteria.
3. Select **Search**.
4. If the doctor is not found, select the **MD Match** button at the bottom. The Master Doctor Search window opens. The search criteria are displayed.
5. Select **Search**.
6. Highlight the correct doctor from the search results.
7. Select **OK**. The Prescriber Folder opens.
8. If required, update the prescriber's information including **Role Type**, **Province #**, and **Address** fields.
9. Select **Save**.

Drug Folder

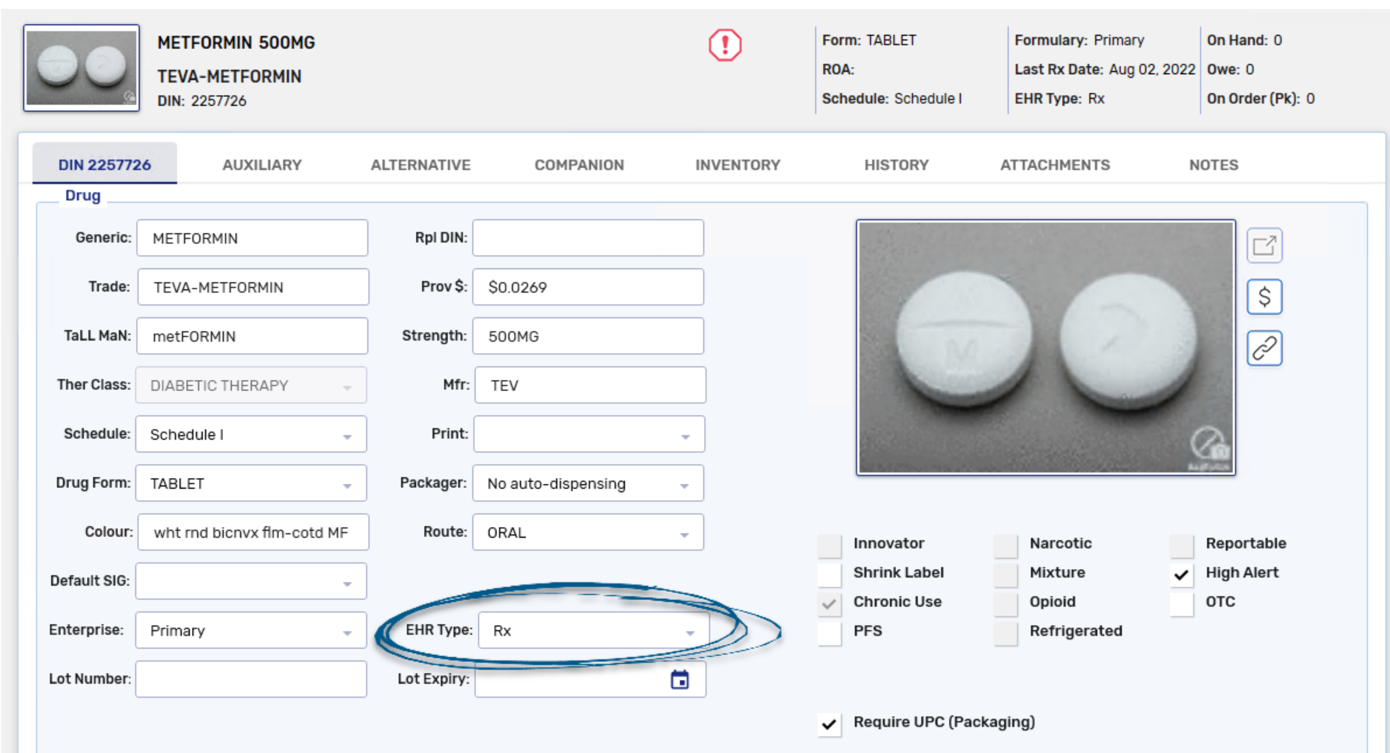
The Drug Folder contains fields that are submitted to the EHR with each prescription filled.

Main Tab

EHR Type

The EHR Type determines if the drug is submitted using the Prescription message, Device message, or not submitted at all.

- **Rx** – Prescription messages are used.
- **Device** – Device messages are used.
- **Non-EHR** – Prescriptions for these types are not transmitted to the EHR.

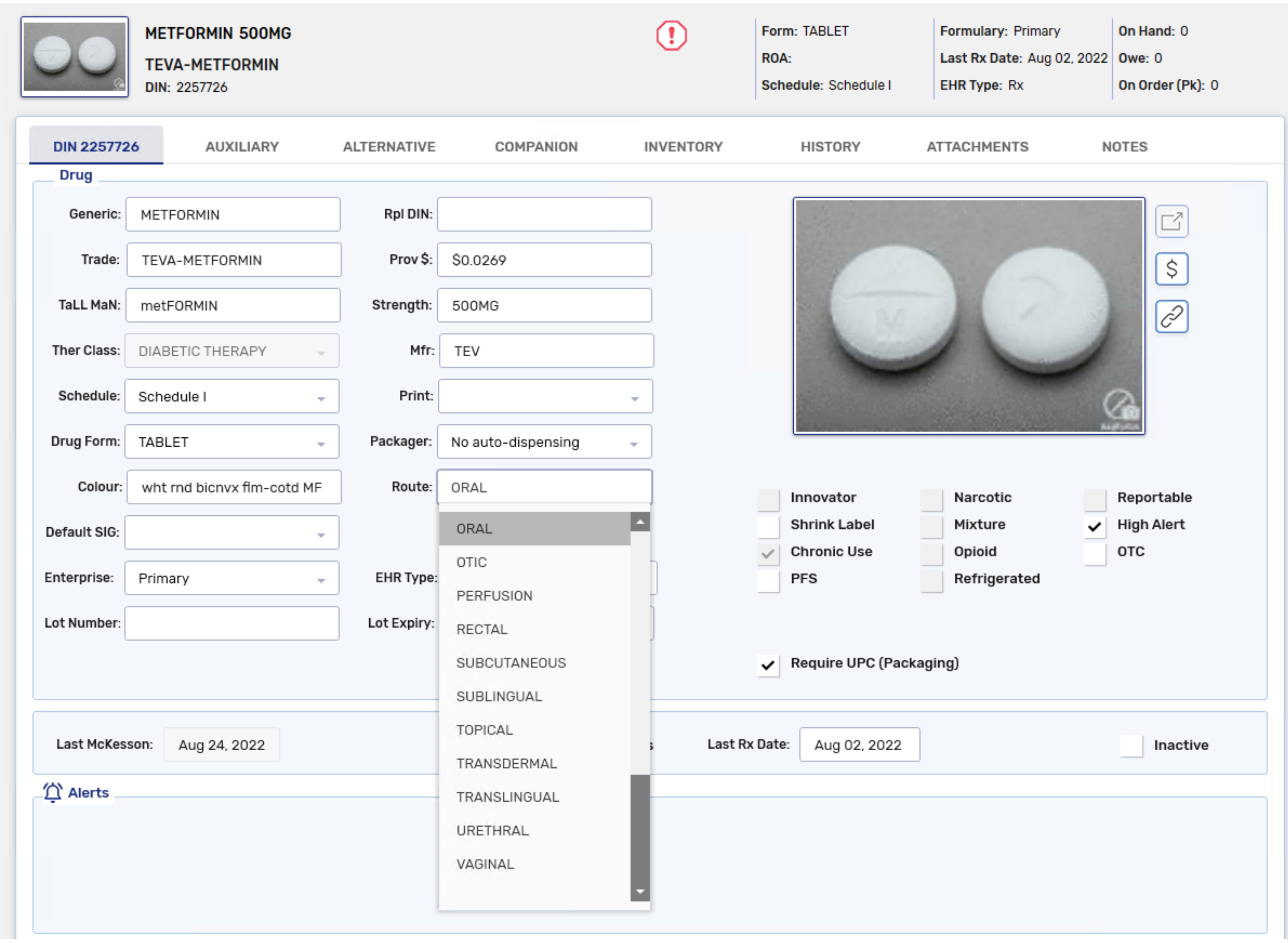


ALERT: The **EHR Type** of Non-EHR should only be used for service fees. If a product cannot be found on the product list (i.e., DIN, NPN, OPINION, PIN), call the Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006 to request it to be added.

When the EHR Type is Device, the EHR DIN/PIN and Type field (located in the Alternative tab) must be populated. For more information, see EHR DIN/PIN and Type.

Route

A product's Route of Administration (Route) is transmitted within the DIS Prescription message.



To modify the Route in the Drug Folder:

1. Open the **Drug Folder**.
2. In the Drug Folder **Main** tab, select the **Route** from the dropdown list.
3. Select a value that is appropriate for the drug (e.g., Oral).

   NOTE: Avoid using Miscellaneous as the Route.

4. For freeform drugs, ensure the **EHR Type**, **EHR DIN/PIN**, and **Type** are populated correctly. For more information, see EHR Type and EHR DIN/PIN and Type.
5. Select **Save**.

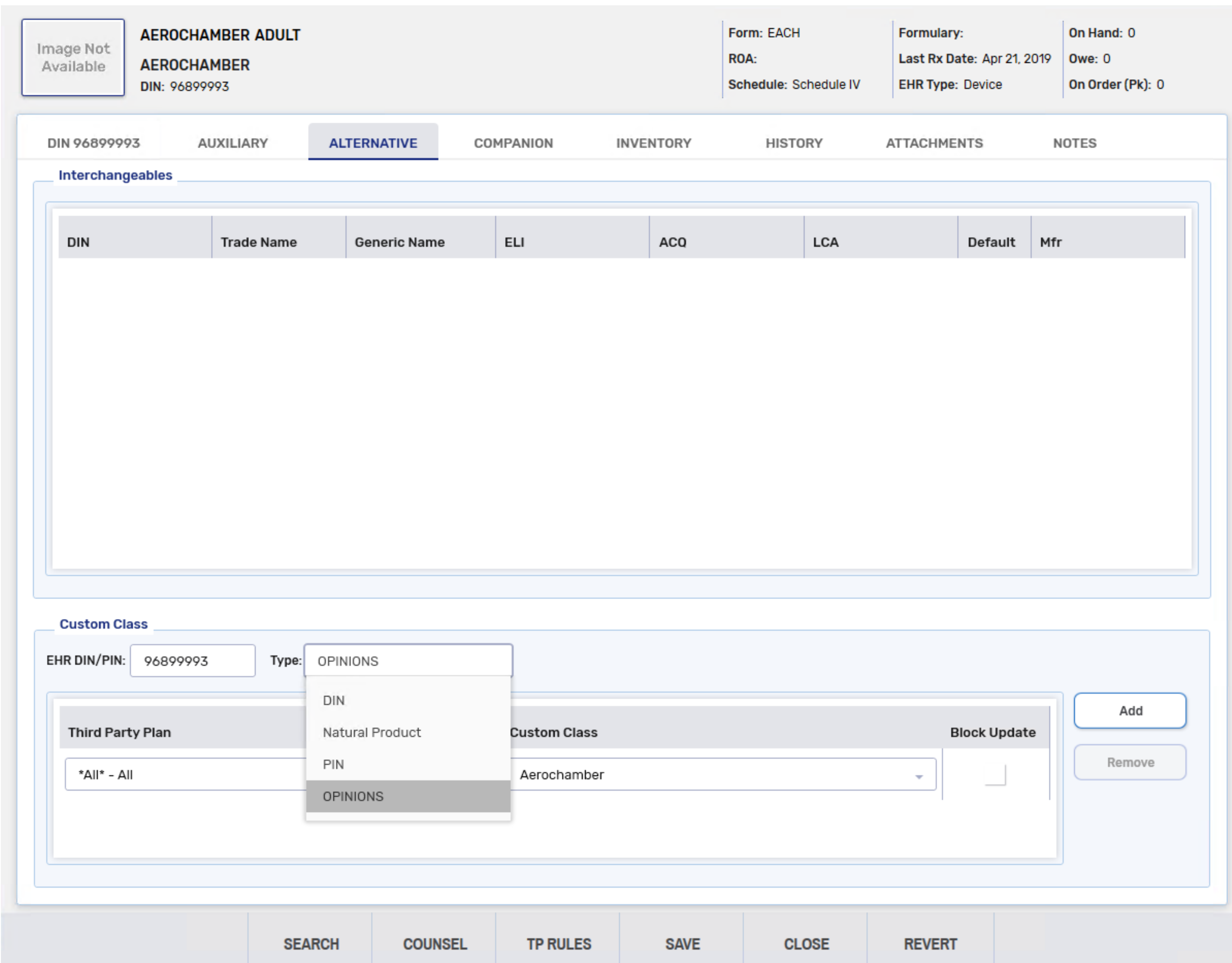
Alternatives Tab

EHR DIN/PIN and Type

The EHR DIN/PIN and Type fields provide a means to submit an alternative DIN/PIN to NLPN only. For drugs with an EHR Type of Device, these fields must be populated, and the Type is always OPINIONS.

The Type dropdown consists of the following:

- **DIN** – used when the EHR Type is Rx and the product has a valid DIN.
- **Natural Product** – used when the EHR Type is Rx and the product has a Natural Product Number (NPN).
- **PIN** – used when the EHR Type is Rx but the product is identified on the NL PIN list.
- **OPINIONS** – used only when the EHR Type is Device.



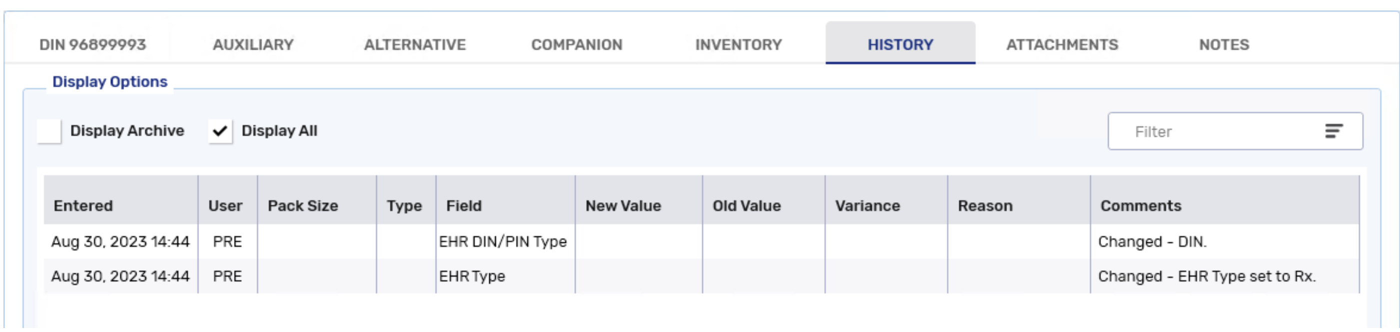
To add or update the EHR DIN/PIN and Type from the Drug Alternative tab:

1. Open the **Drug Folder**.
2. Select the **Alternative** tab.
3. Enter the recognized DIN/PIN/NPN value for the drug in the **EHR DIN/PIN** field.
4. Select the corresponding type from the **EHR Type** dropdown list (i.e., DIN, Natural Product, PIN, OPINIONS).
5. Select **Save**.

If a product cannot be found on the product list (i.e., DIN, NPN, OPINION, PIN), call the Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006 to request that it is added to the Newfoundland and Labrador PIN list. Ensure you have the information on hand prior to contacting the Service Desk, including the proper spelling of the component, brand name, label name, and the drug form. Please note that items added to the NLPN PIN list during this call are not subject to DUR checks.

History Tab

The History tab records when the EHR Type, EHR DIN/PIN, or Type have been changed. The date entered, user, and event are recorded for reference.



Mixtures Folder

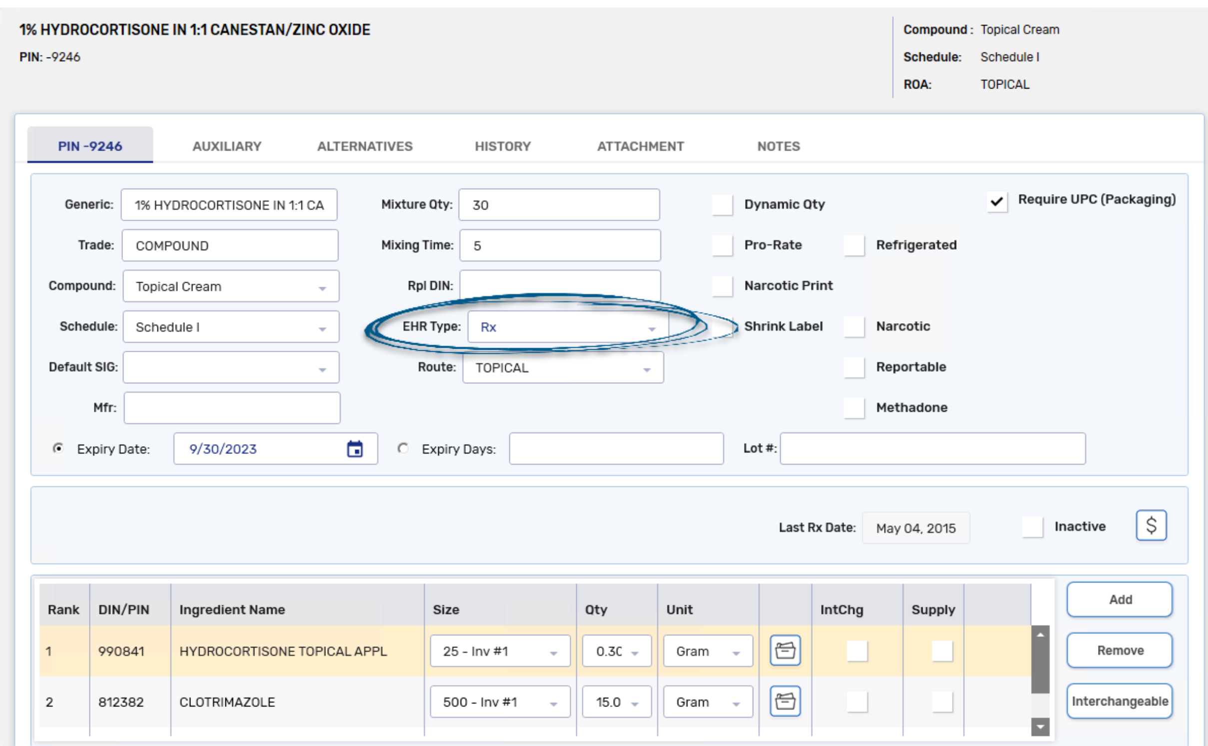
The Mixture Folder contains fields that are submitted to the EHR with each prescription filled. All ingredient names in a mixture prescription are sent over as part of the description, however on the EHR Profile, only the Generic mixture name and Rank 1 ingredient information (name, DIN, quantity, unit) are displayed.

Main Tab

EHR Type

The EHR Type selection determines if the drug is submitted using the Prescription message, the Device message, or not submitted at all.

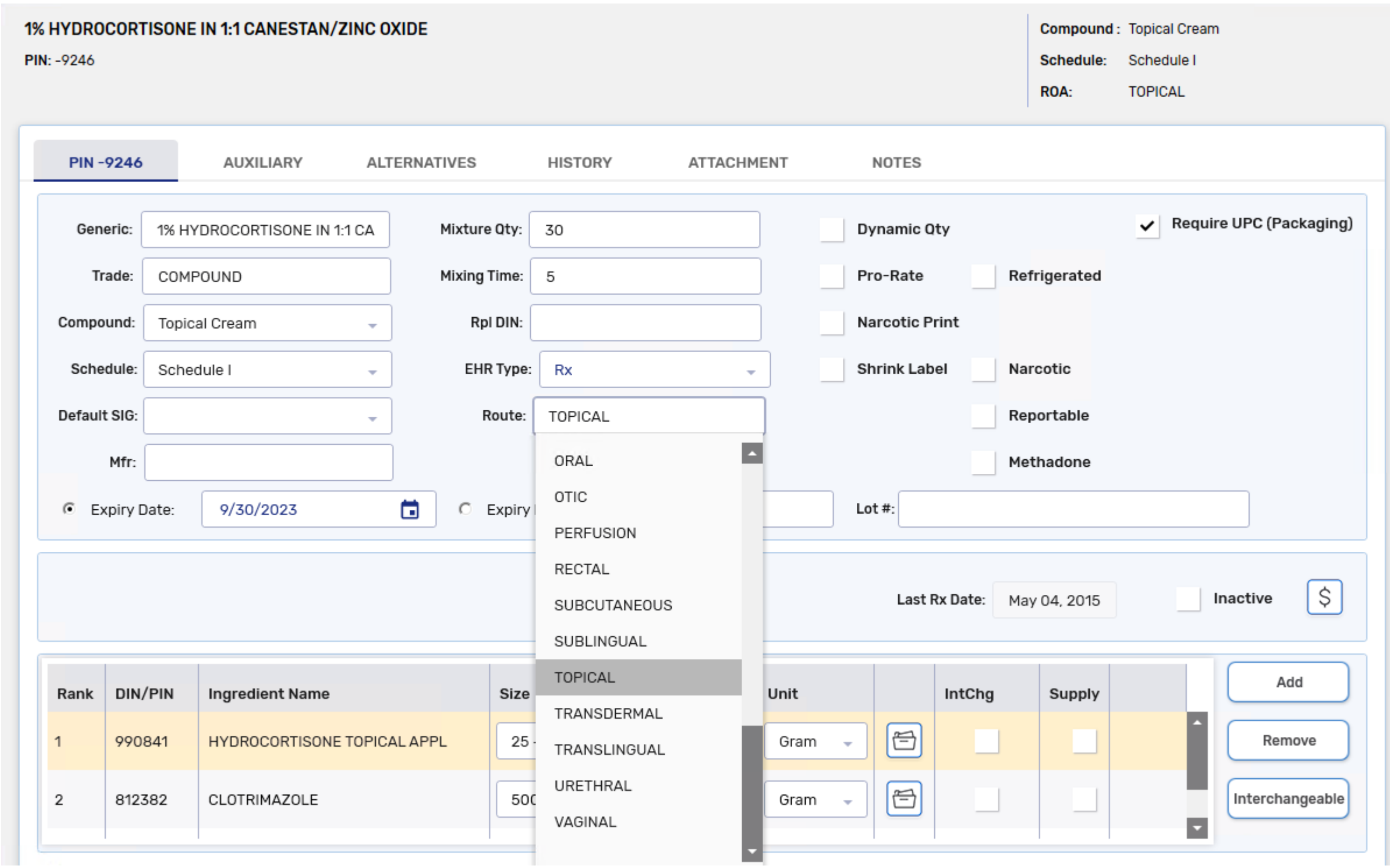
- **Rx** – Prescription messages are used.
- **Device** – Device messages are used.
- **Non-EHR** – Prescriptions for these types are not transmitted to the EHR.



ALERT: The EHR Type of Non-EHR should only be used for service fees. If a product cannot be found on the product list (i.e., DIN, NPN, OPINION, PIN), call the Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006 to request it to be added.

Route

A mixture's Route of Administration (Route) is transmitted within the DIS Prescription message.



To modify the Route in the Mixture Folder:

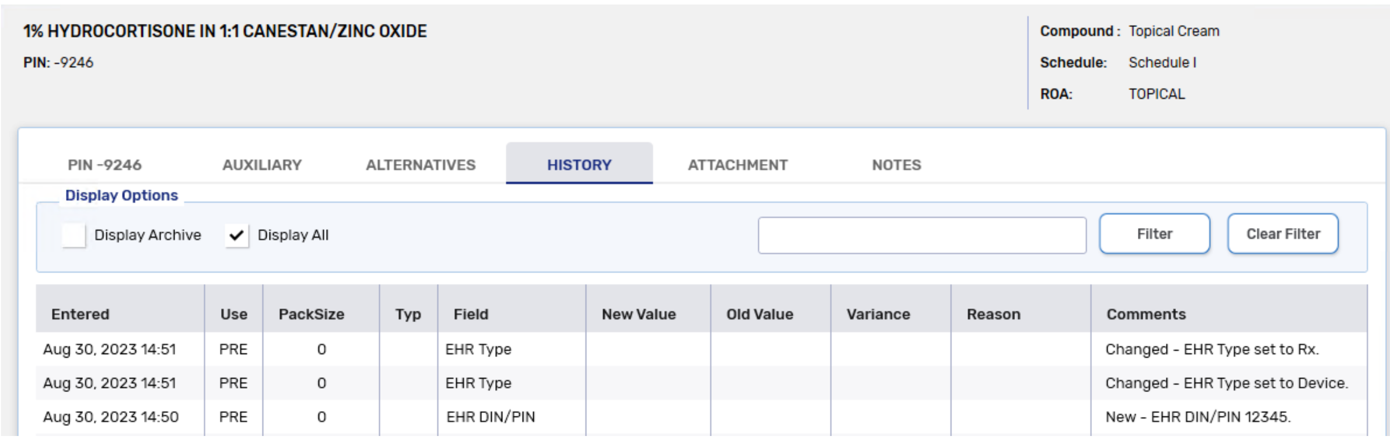
1. Open the **Mixture Folder**.
2. In the Mixture Folder **Main** tab, select the **Route** from the dropdown list.
3. Select a value that is appropriate for the mixture (e.g., Topical).

   NOTE: Avoid using "Miscellaneous" or "Injection" as the Route.

4. For freeform drug ingredients, ensure the **EHR Type**, **EHR DIN/PIN**, and **Type** are populated correctly. For more information, see EHR Type and EHR DIN/PIN and Type.
5. Select **Save**.

History Tab

The **History** tab in the Mixture Folder records when the **EHR Type**, **EHR DIN/PIN**, or **Type** have changed. The date entered, user, and event are recorded for reference.



Entered	Use	PackSize	Typ	Field	New Value	Old Value	Variance	Reason	Comments
Aug 30, 2023 14:51	PRE	0		EHR Type					Changed - EHR Type set to Rx.
Aug 30, 2023 14:51	PRE	0		EHR Type					Changed - EHR Type set to Device.
Aug 30, 2023 14:50	PRE	0		EHR DIN/PIN					New - EHR DIN/PIN 12345.

Methadone

Methadone prescriptions can be filled using the number of milligrams or millilitres being dispensed to the patient. This can be accomplished using one of the pre-existing methadone Drug Folders or creating a dynamic quantity Mixture Folder.

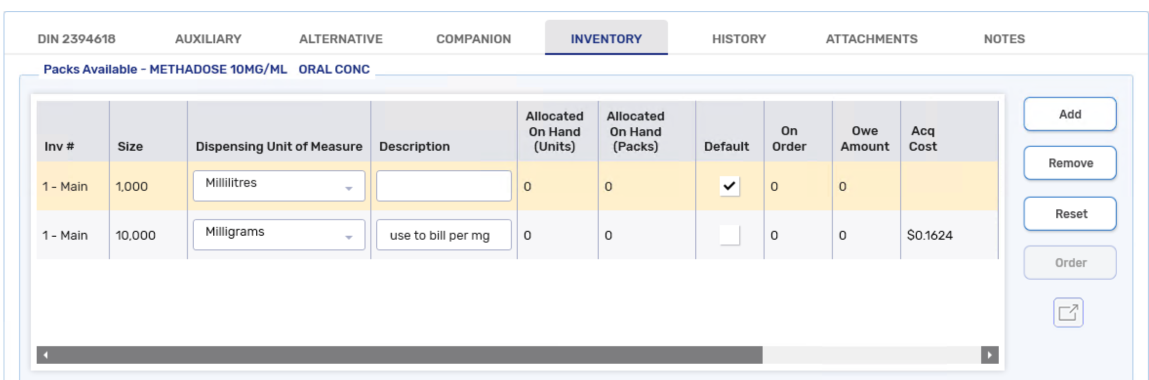
Methadone Drug Folder

When using a methadone Drug Folder to fill methadone prescriptions, the unit of measure must be specified in the Drug Folder. This only needs to be set up once for the Drug Folder you intend to use. If you are using a methadone Mixture Folder to fill prescriptions, the unit of measure does <u>not</u> need to be specified in the methadone Drug Folder.

To specify the unit of measure in a methadone Drug Folder:

1. Open the methadone **Drug Folder**.
2. In the **Inventory** tab, dropdown the **Dispensing Unit of Measure** for one of the pack sizes.
3. Select **Millilitres** or **Milligrams**.

TIP: Select **Milligrams** if the description for the pack size is “use to bill per mg.” Select **Millilitres** if the pack size reflects the actual volume of the bottle. In the example below, Methadose 10mg/mL comes in a 1,000mL bottle so the 1,000 pack size is set to a Dispensing Unit of Measure of Millilitres. The 10,000 pack size has a Milligrams Dispensing Unit of Measure.

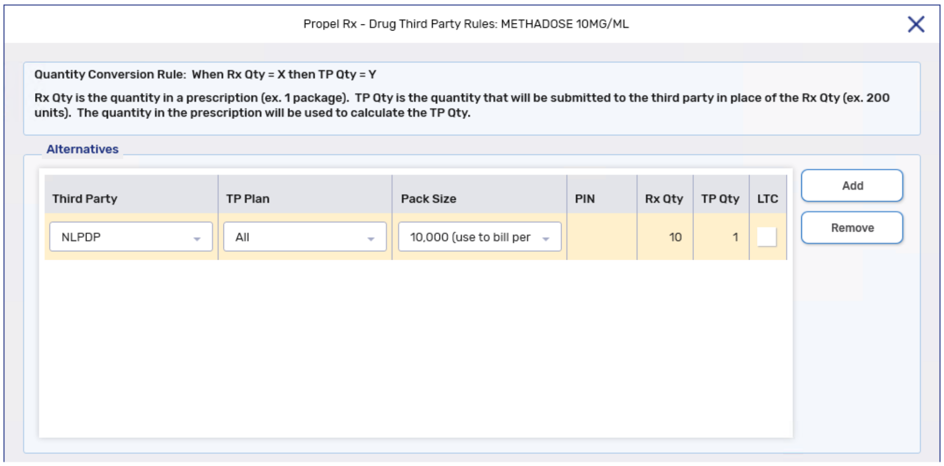


4. Repeat steps 2 – 3 for the remaining pack sizes.
5. Ensure the pack size you want to use for dispensing methadone is flagged as **Default**.
6. Select **Save**.

If you choose to fill prescriptions by the number of milligrams of methadone dispensed (i.e., **Dispensing Unit of Measure = Milligrams**), you may need to enter **TP Rules** to adjudicate quantities in millilitres for applicable third parties.

To enter a TP Rule:

1. Open the methadone **Drug Folder**.
2. Select the **Main** tab.
3. Select **TP Rules**.
4. Select **Add**.
5. Select the **Third Party** and **TP Plan** that requires methadone to be adjudicated in millilitres.
6. Select the milligram **Pack Size** used for filling prescriptions.
7. In the **Rx Qty** field, enter 10. In the **TP Qty** field, enter 1.



8. Select **OK**.
9. Select **Save**.

Methadone Dynamic Quantity Mixture Folder

A dynamic quantity mixture allows you to dispense variable quantities of methadone and fill prescriptions using the number of milligrams being dispensed to the patient. If you choose to create a dynamic quantity methadone mixture, you may need to create a freeform Drug for the ingredients in the mixture (e.g., Distilled Water, Tang, or preferred diluent).

For these products to be accepted by the DIS, it is imperative that the EHR DIN/PIN and Type are set according to the Newfoundland and Labrador Health Services PIN list in the individual ingredient Drug Folders and Mixture Folder. For more information, see EHR DIN/PIN and Type for Drugs and EHR DIN/PIN and Type for Mixtures.

Some third parties require claims to be submitted by the number of millilitres dispensed for methadone. When filling methadone prescriptions, enter the appropriate **TP Qty** in the **Rx Detail Third Party** tab for the third parties that require adjudication by the number of millilitres.

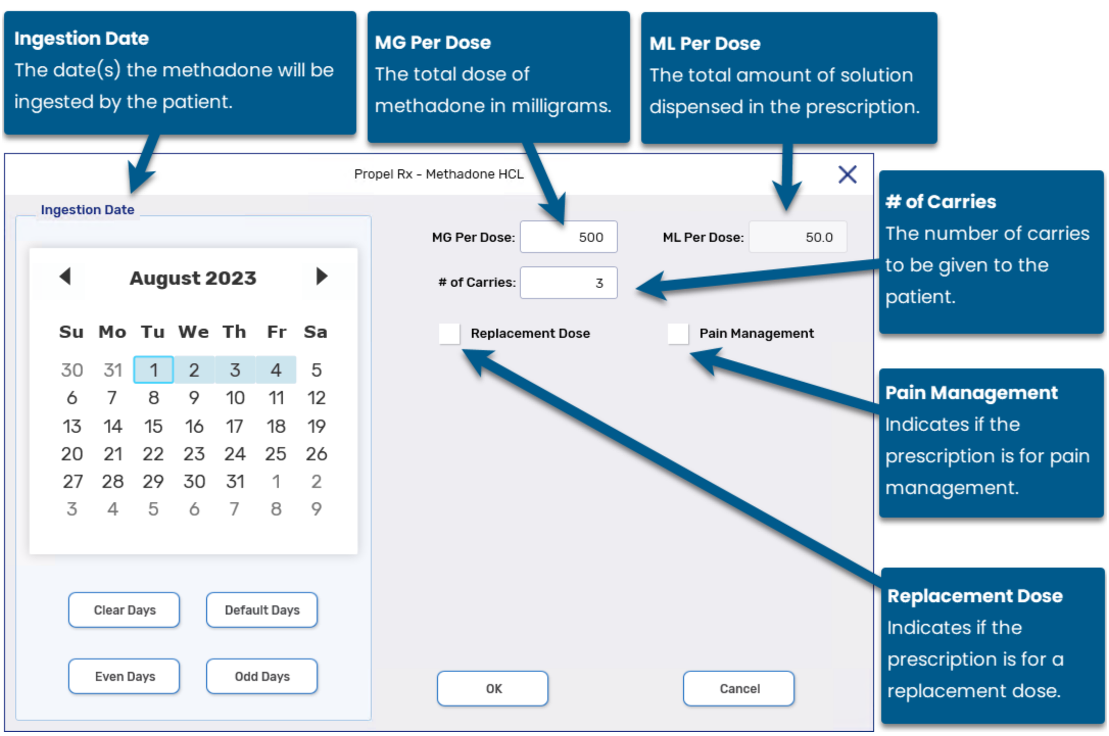
Entering Methadone Details

The Methadone window allows you to enter carries and the ingestion date for each prescription. Depending on whether you use a methadone Drug Folder or Mixture Folder to fill prescriptions, the window may look different. However, the same fields can be found in both windows.

Methadone carries generate a billing for each ingestion date. Many third parties in the province of Newfoundland and Labrador do not reimburse for these claims billed under the same date. If you choose to dispense the full quantity of today's dose and the carries, ensure the **Prescription SIG** is clearly outlined.

To open the Methadone window:

1. Open a methadone prescription in **Rx Detail**.
2. Select **Rx** > **Methadone**.

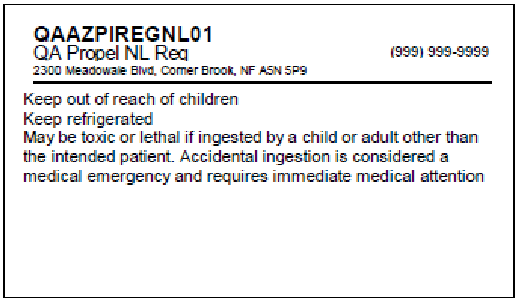


NOTE: If carries are entered in the Methadone window, the prescriptions are filled automatically once you select **OK**. One prescription is generated for each methadone dose within the same Audit History.

Methadone Prescription Labels

Methadone Supplementary Label

A methadone supplementary label, as shown below, prints for each methadone dose.

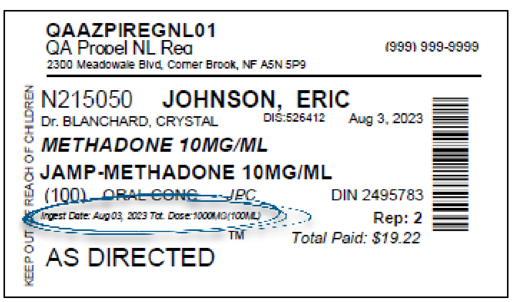


If you are using a methadone Drug Folder to fill methadone prescriptions, you have the option to suppress the printing of this supplementary label in **More (...)** > **Pharmacy** > **Rx Detail** > **Label Preferences** > **Methadone supp label**.

Methadone Vial Label

In Rx Detail, the **Labels** field indicates the number of vial labels that will print for each methadone dose. By default, methadone prescriptions filled using a methadone Drug Folder print one vial label per dose.

The quantity, ingest date, and total dose (in milligrams and millilitres) prints on each vial label.



Methadone Half Label Hard Copy

The methadone ingestion date and dose in milligrams and millilitres for the prescription print on the half label hard copy. When the prescription is a Refill or ReAuth, the hard copy also indicates the amount of methadone in milligrams that was dispensed in the last prescription (Last Dose or LD).

RX#: N215050 (W) NEW
JOHNSON, ERIC
HOPE AVE, PASADENA, NF, A8A 6A7 (123) 123-1234 LAN: English
DOB: Jul 15, 1986 Age: 37 Gender: M PHN: 158697369870 AD

Dr. BLANCHARD, CRYSTAL Lic: [P06857]
10 Crystal Drive, CORNER BROOK, NF (999) 999-9999 F: (999) 999-9999

METHADONE 10MG/ML
JAMP-METHADONE 10MG/ML
(100) CON JPC DIN: 2495783 PIN: 2495783
HIGH ALERT OPIOID Item#:
LOT: EXP:

AS DIRECTED

AU: N215050 QA: 300 QD: 100 DS: 1 Rep: 2
Qty Packaged: 100 Qty Owed: 0
Fill Date: Aug 03, 2023 Time: Aug, 03 2023 10:34 AM Last Fill:
Interval: 0 Rx Expiry: Aug 02, 2024
Tot. Dose: 1,000MG (100ML) Ingest Date: Aug 03, 2023

New Price: $19.22 Old Price: $0.00 C: $11.25 M: $0.00 F: $7.97 T: $19.22
TP: CA CA $19.22 COP: $19.22 DED: $0.00 WAV: $0.00
GP: 41.47% $7.97

DE	PKG	TECH	CLIN

TM

Methadone e-File Copy

The methadone ingestion date and dose in milligrams and millilitres for the prescription display on the e-File copy.

Rx #: 215056 REFILL Trace #:

Patient	Prescriber
ERIC JOHNSON PHN: 158697369870 Gender: Male DOB: Jul 15, 1986 AGE: 37 HOPE AVE, PASADENA, Newfoundland, A8A 6A7 Phone #: (123) 123-1234	CRYSTAL BLANCHARD License #: P06857 10 Crystal Drive, CORNER BROOK, Newfoundland, A5N 5P9 Phone #: (999) 999-9999 Fax #: (999) 999-9999

Prescription	Billing
1000.0 METHADONE 10MG/ML SOLUTION 0 METHADONE 10MG/ML SOLUTION AS DIRECTED DIN: -1251 PIN: 2495783 Rep: 0 Auth # : 215055 QA2000.00 QD: 2000.00 Days: 1 Fill Date: Aug 8, 2023 Last Dispensed: Aug 8, 2023 Rx Expiry Date: Interval Days: 0 Int. Code : Mixing Time: 5 Ingest Date: Aug 09, 2023 Tot. Dose: 1000.00MG (100.00ML)	New Price: $23.58 C: $11.62 Old Price: $23.58 F: $11.96 COP: $23.58 T: $23.58 Markup: $0.00 DED: $0.00 GP: 50.72% $11.96 CA : $23.58 TP Paid: $0.00 Bill Code: CA

Methadone Prescriptions in Workflow

When packaging and validating methadone prescriptions with carries in Digital Workflow, you can group methadone carries. This allows you to package and validate all methadone carries together. To do this, turn the Group Methadone Carries preference ON.

To turn on the Group Methadone Carries preference:

1. Select **More (...)** > **Pharmacy**.
2. Select the **Workflow** tab.
3. Dropdown the **Group Methadone Carries** field and select **ON**.
4. Select **Save**.

NOTE: You must clear all existing methadone prescriptions in Workflow to change this preference.

Packaging Methadone Carries

When **Group Methadone Carries** is ON, processing one methadone prescription within the carries group from the Packaging queue opens the first filled methadone prescription within the group. The packaging for this prescription applies to all carries. Once you have finished packaging the prescription, the prescription and carries move to the next Workflow step.

Validating Methadone Carries

When **Group Methadone Carries** is ON, processing one methadone prescription within the carries group from the Technical Validation or Clinical Review queue opens the first filled methadone prescription within the group. The validation for this prescription applies to all carries.

Completing Dialogue for Methadone Carries

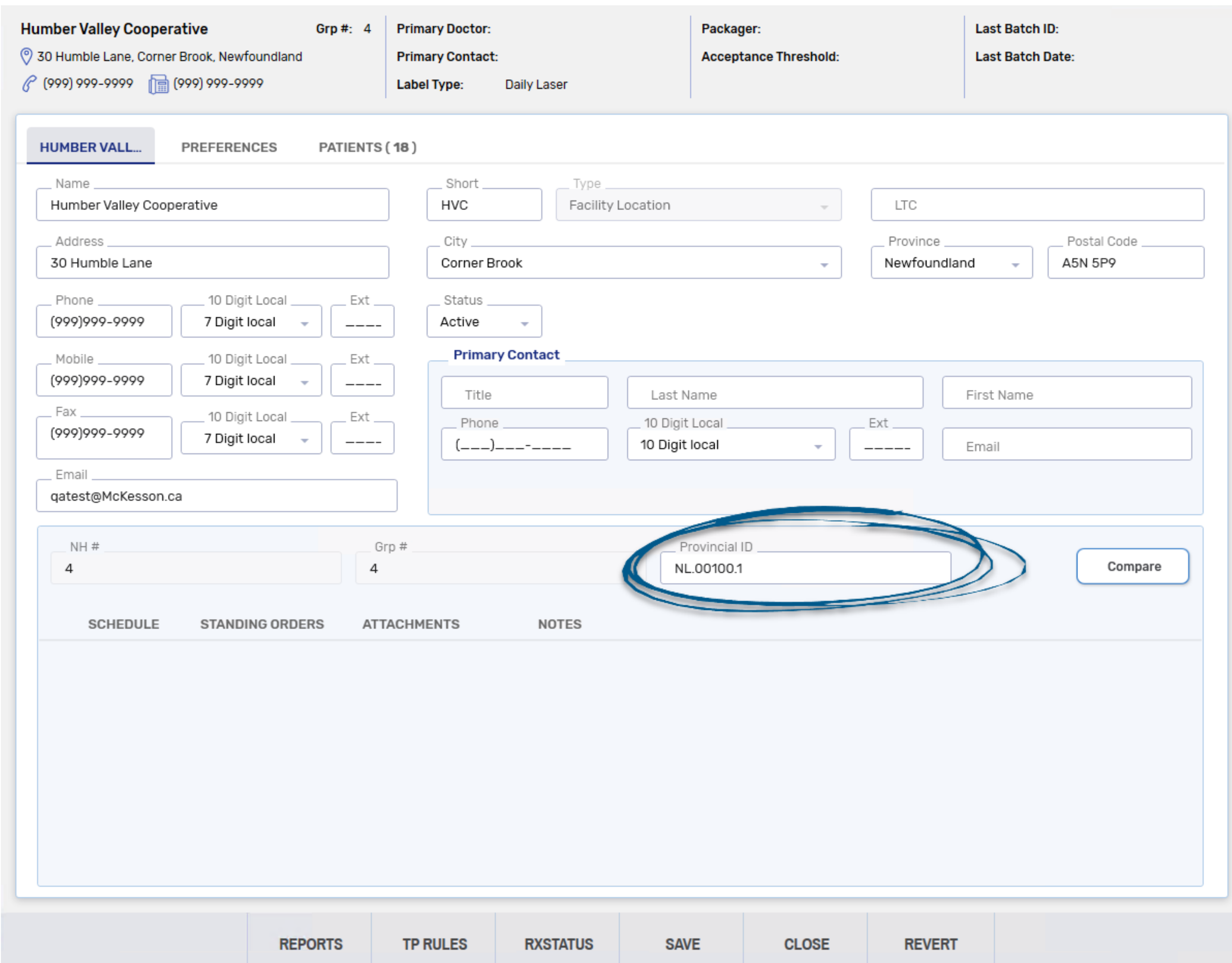
When **Group Methadone Carries** is ON, Dialogue for a witness dose is applied to the carries as follows:

- When **E-Dialogue** is set to **New** in More (...) > Pharmacy > Workflow, Dialogue is only done on the witness dose and no dialogue details are recorded for the carries in the Patient Folder Clinical tab or e-File copies.
- When **E-Dialogue** is set to **All**, Dialogue for the witness dose is copied over to the carries prescriptions and appear as separate rows in the Patient Folder Clinical tab and on the e-File copies for the carries.

Group Folder

All locations authorized to provide or receive services are identified uniquely by Newfoundland and Labrador's Location Registry. This includes group facilities such as Nursing Homes, Doctor Offices, and/or Clinics. To process Emergency, Ward Stock or Office Supply prescriptions, it is necessary to create a Group that matches this location, and a Facility Patient is then created for the corresponding facility.

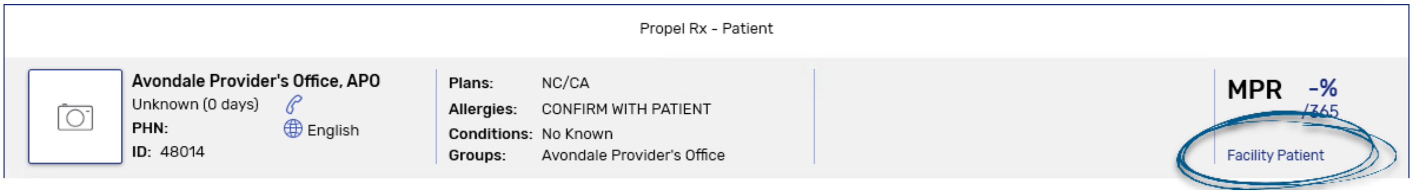
The **Provincial ID** field indicates the unique identifier assigned to the facility by NLPN.



Facility Patient

A Facility Patient is used to fill bulk stock or ward stock prescriptions for the facility. Facility Patients do not require synchronization, and EHR Profiles are not displayed. The prescriptions are still transmitted to the EHR but they are linked to the Group, instead of a specific patient.

A Facility Patient is automatically added when a Group is added from the Location Registry search. A Facility Patient indicator appears in the information bar at the top of the Patient Folder.



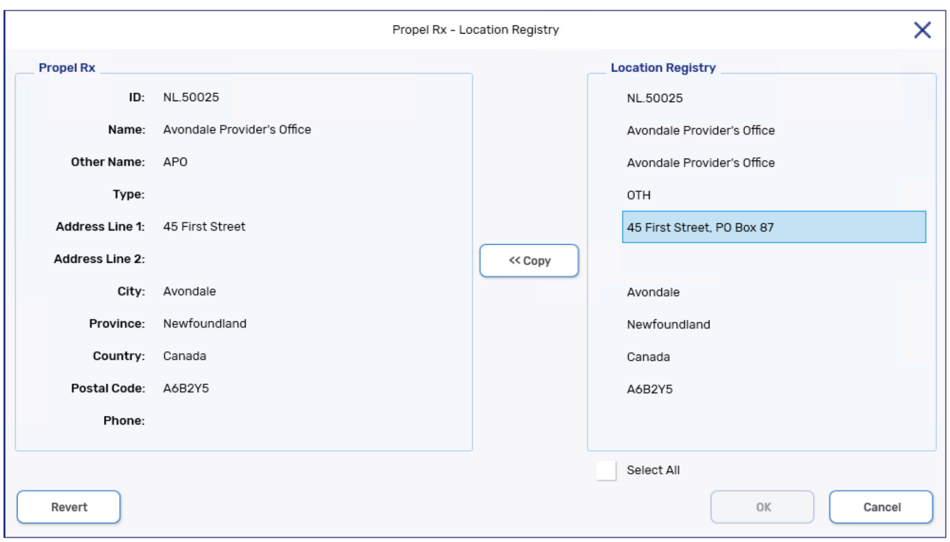
The Facility Patient's Birth Date is populated with the current system date, and the Gender is entered as 'Unknown.'

ALERT: Even though there may be multiple Facility Patients for a facility, all Facility Patients must have the same Provincial ID populated in the PHN field.

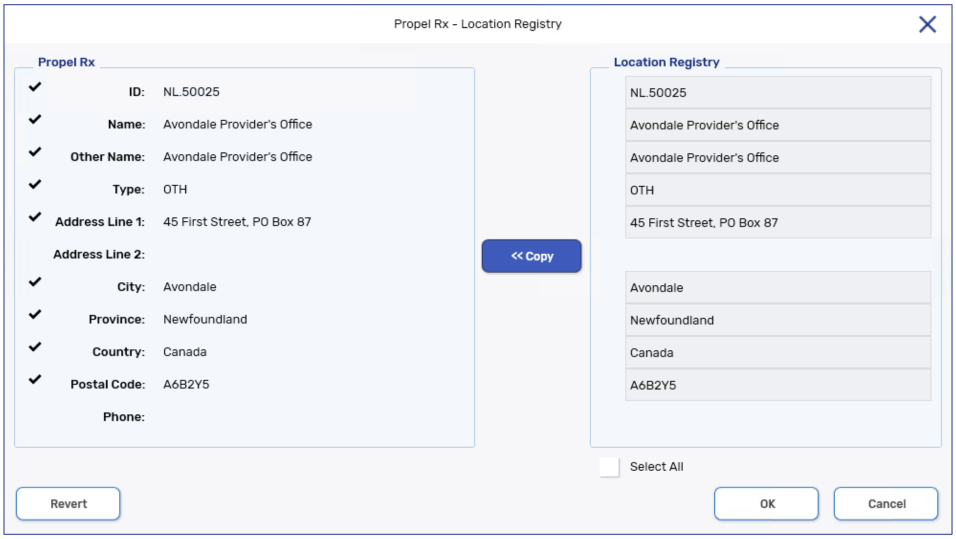
Updating an Existing Group/Facility Patient

To update an existing Group/Facility Patient:

1. Select the **Batch Manager** navigator button on the left.
2. Select the **Groups** tab.
3. Select the applicable group.
4. Select **Detail**. The Group Folder opens.
5. Select **Compare**. The Location Registry window opens.



6. On the right side, highlight the fields you want to copy over from the Location Registry.
   - You can quickly select all fields by selecting the Select All checkbox.
   - Information can only be copied one-way from the EHR to Propel Rx.
7. Select **Copy**. A checkmark appears beside the fields that were copied over from the Location Registry.



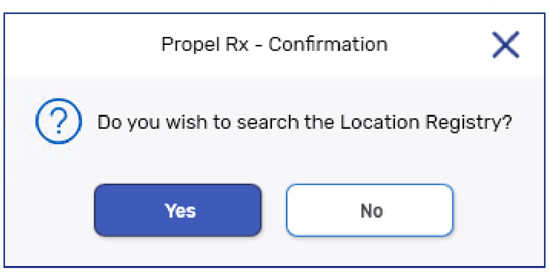
8. Select **OK**.
9. Select **Save**.

ALERT: Any errors with the Location Registry information should be reported to the Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006.

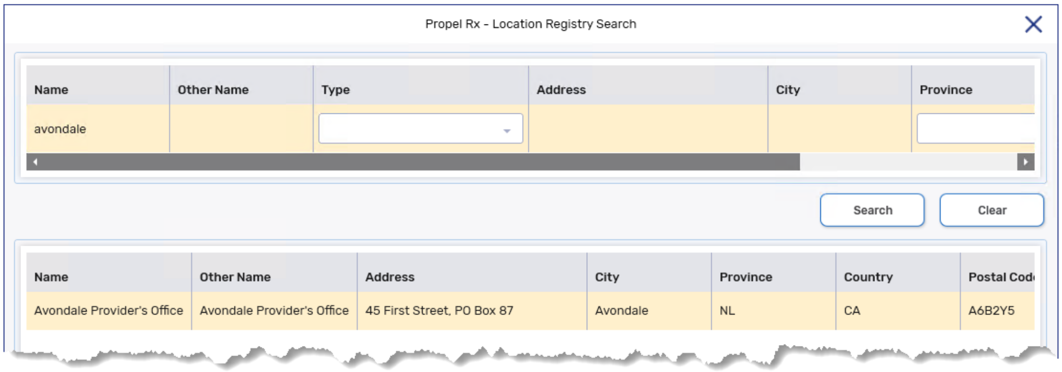
Creating a New Group/Facility Patient

To create a new Group/Facility Patient:

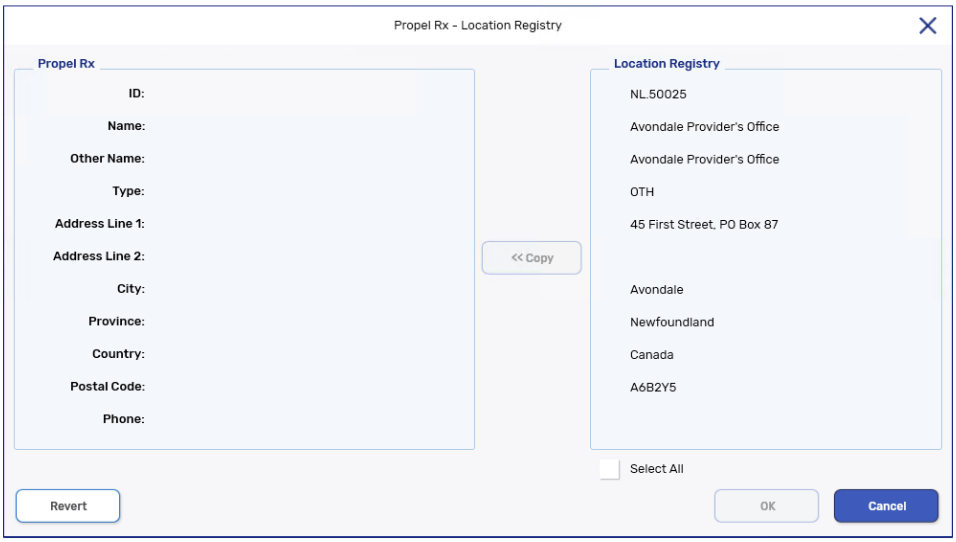
1. Select the **Batch Manager** navigator button  on the left.
2. Select the **Groups** tab.
3. Select **New**. A prompt appears asking if you want to search the Location Registry.



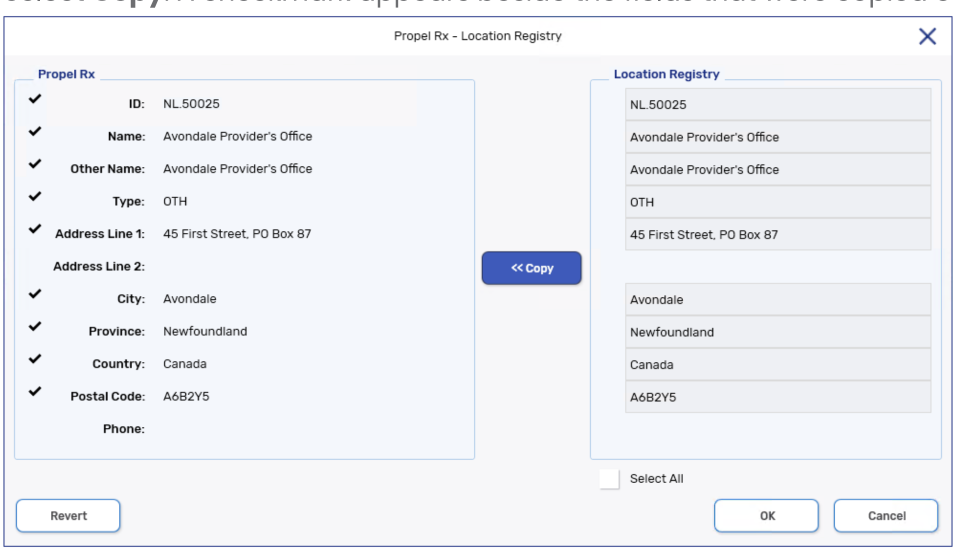
4. Select **Yes**. The Location Registry window opens.
5. If necessary, refine your search criteria.
6. Select **Search**. The Location Registry Search results are displayed.



7. Select the corresponding record.
8. Select **OK**. An additional window opens for you to copy information from the Client Registry.



9. Highlight the information on the right side that you want to carry over to Propel Rx.
   - You can select the **Select All** checkbox to quickly highlight all fields.
10. Select **Copy**. A checkmark appears beside the fields that were copied over to Propel Rx.



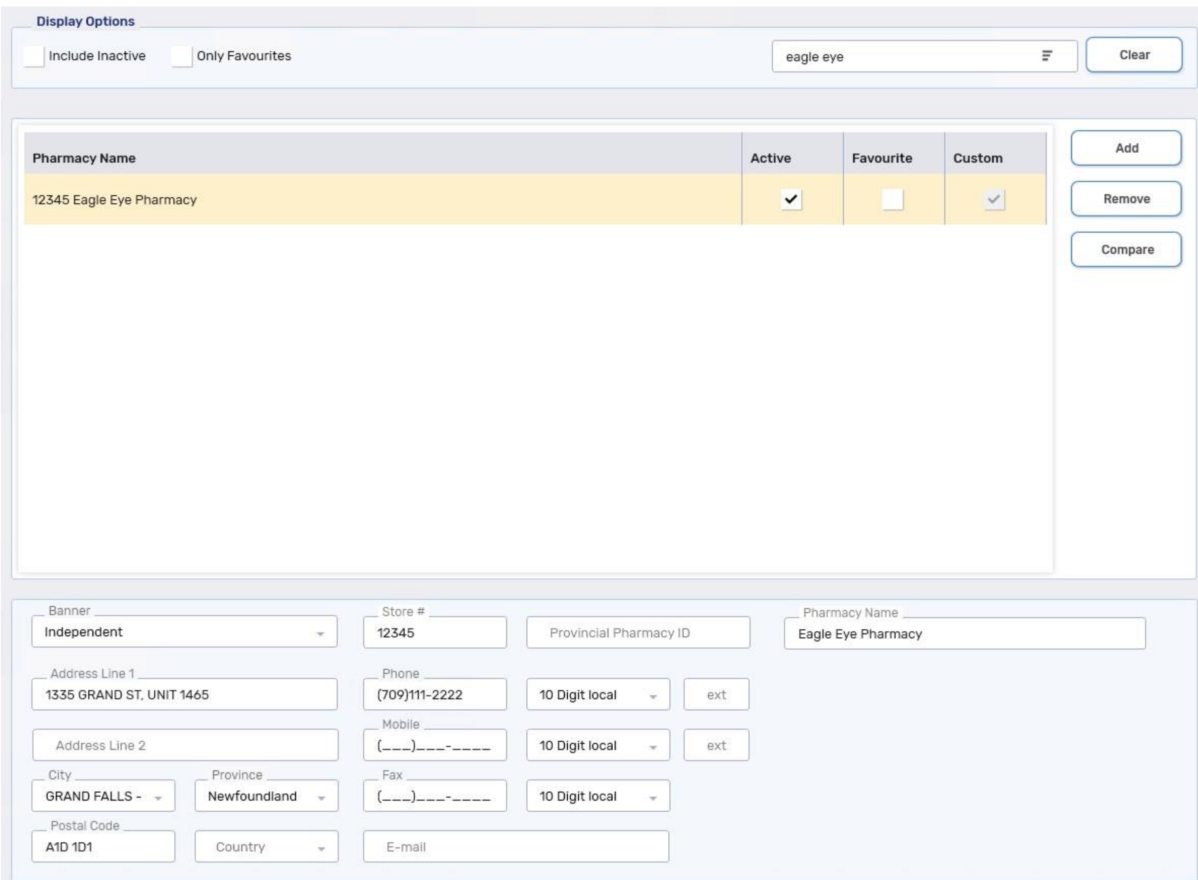
11. Select **OK**. The Group Folder is populated with the information that was copied over from the Location Registry including the Provincial ID.
12. Update any additional information such as **Type**, **Status**, **Short**, **Phone**, **Mobile**, **Fax**, and/or **Email**.
13. Select **Save**.

Other Pharmacy

All locations authorized to provide or receive services are identified uniquely by NLPN. Each pharmacy is assigned a unique location identifier which must be used when performing a prescription transfer. The Provincial Pharmacy ID field indicates the unique identifier assigned to the pharmacy by the NLPN.

Filtering the Other Pharmacy List

The Other Pharmacy window has a Filter field, allowing you to filter the list of other pharmacies by pharmacy name or any part of the address.



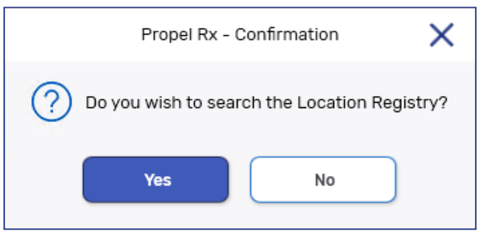
To filter the Other Pharmacy list:

1. Select **More (...)** > **List Maint**.
2. From the dropdown list, select **Other Pharmacy**. The Other Pharmacy window opens.
3. In the **Filter** field at the top, enter your filter criteria and then press Enter. Your list of Other Pharmacies is filtered, displaying the results that match your filter criteria.
   - To remove any filter criteria you may have entered, select **Clear**.

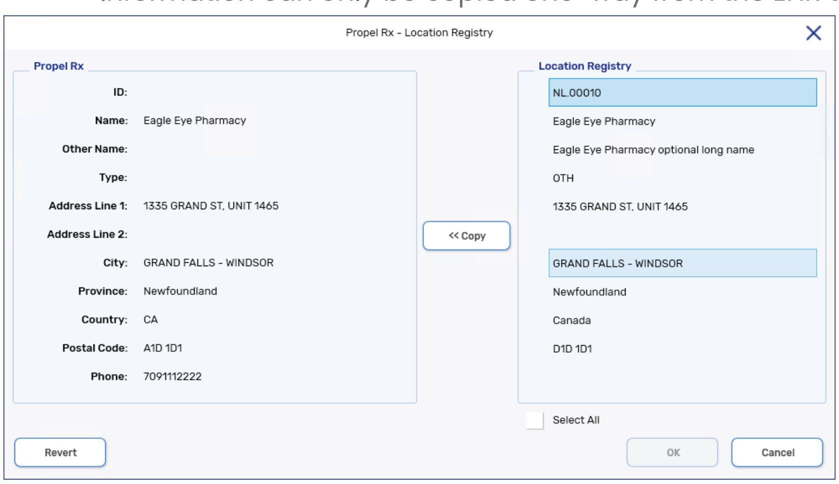
Comparing an Existing Pharmacy

To compare an existing Other Pharmacy to the Location Registry:

1. Select **More (...)** > **List Maint**.
2. From the dropdown list, select **Other Pharmacy**. The Other Pharmacy window opens.
3. Select a pharmacy.
4. Select **Compare**.
    - If the Provincial ID is blank in Propel Rx, a prompt appears asking if you want to search the Location Registry.
    - If the Provincial ID was populated in Propel Rx, skip to step 9.
5. Select **Yes** to the prompt. The Location Registry Search window opens with information from Propel Rx pre-populated in the search fields.



6. Select **Search**.
7. Highlight the matching pharmacy record.
8. Select **OK**. The Location Registry window opens.
9. On the right side, highlight the fields you want to copy over from the Location Registry to Propel Rx.
    - You can quickly select all fields by selecting the **Select All** checkbox.
    - Information can only be copied one-way from the EHR to Propel Rx.

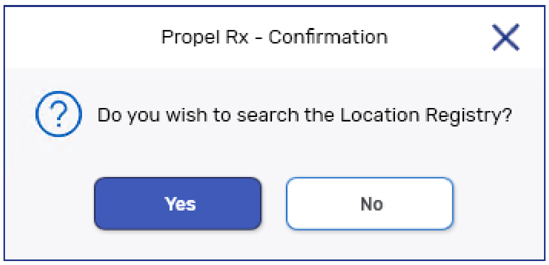


10. Select **Copy**. A checkmark appears beside the fields that have been copied over from the Location Registry.
11. Select **OK**.
12. Select **Save**.

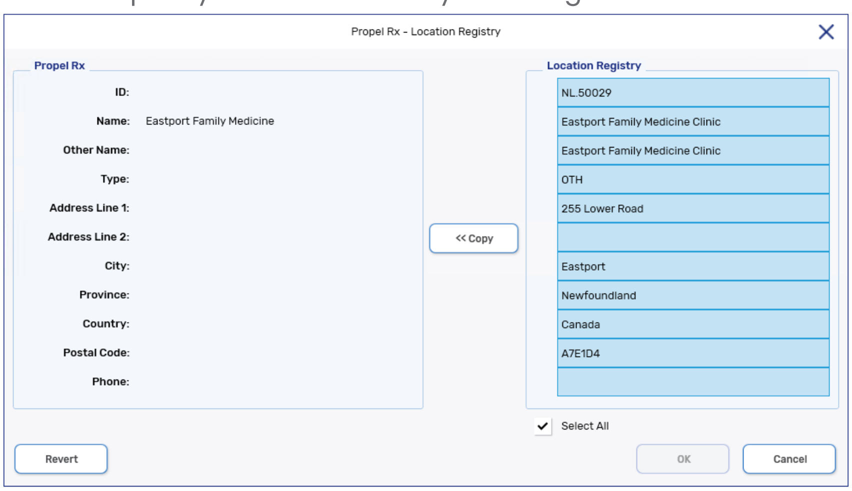
Searching for a New Other Pharmacy

To search for a Provincial ID of a new Other Pharmacy record:

1. Select **More (...)** > **List Maint**.
2. From the dropdown list, select **Other Pharmacy**. The Other Pharmacy window opens.
3. Select **Add**. A new row appears.
4. Enter the desired pharmacy name.
5. Select **Compare**. A prompt appears asking if you want to search the Location Registry.
6. Select **Yes**.



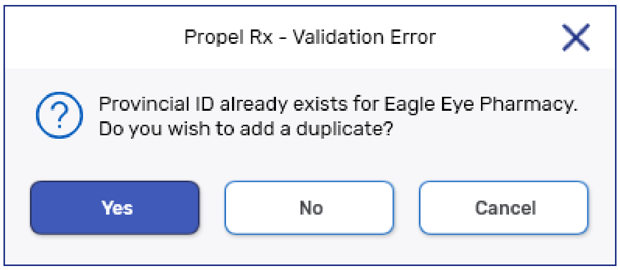
7. Enter your search criteria.
8. Select **Search**.
9. Once the desired results are returned, highlight the appropriate record.
10. Select **OK**. Another window opens for you to copy information from the Location Registry to Propel Rx.
11. On the right side, highlight the fields you want to copy over from the Location Registry to Propel Rx. You can quickly select all fields by selecting the **Select All** checkbox.



12. Select **Copy**. A checkmark appears beside the fields that have been copied over from the Location Registry.
13. Select **OK**. The Other Pharmacy record is populated with information copied over from the Location Registry.
14. Update any additional information as needed.
15. Select **Save**.

Duplicate Provincial Pharmacy ID

Each pharmacy in Newfoundland and Labrador has a unique identifier. For pharmacies that are out of province or not in the Newfoundland and Labrador DIS Index, it is necessary to use a standard Provincial Pharmacy ID (i.e., NL.00000 for out of province). The following validation is displayed if you attempt to save an Other Pharmacy record with a Provincial Pharmacy ID already saved for another Pharmacy:



Select **Yes** to the prompt. The Other Pharmacy record is saved using the same Provincial Pharmacy ID.

Filling a Prescription

All prescriptions **must** be added to the patient's EHR before it can be submitted online to third party payers for payment. The EHR captures all prescriptions, including cash prescriptions. Prescriptions for Animals however are not transmitted to the EHR. A prescription may also be downloaded from the patient's EHR and then filled or transcribed from a written paper prescription and then filled.

ALERT: The **EHR-All** Profile must be viewed with each new patient encounter or after a 'break in service' has occurred. For more information, see Accessing a Patient's EHR.

EHR Tab

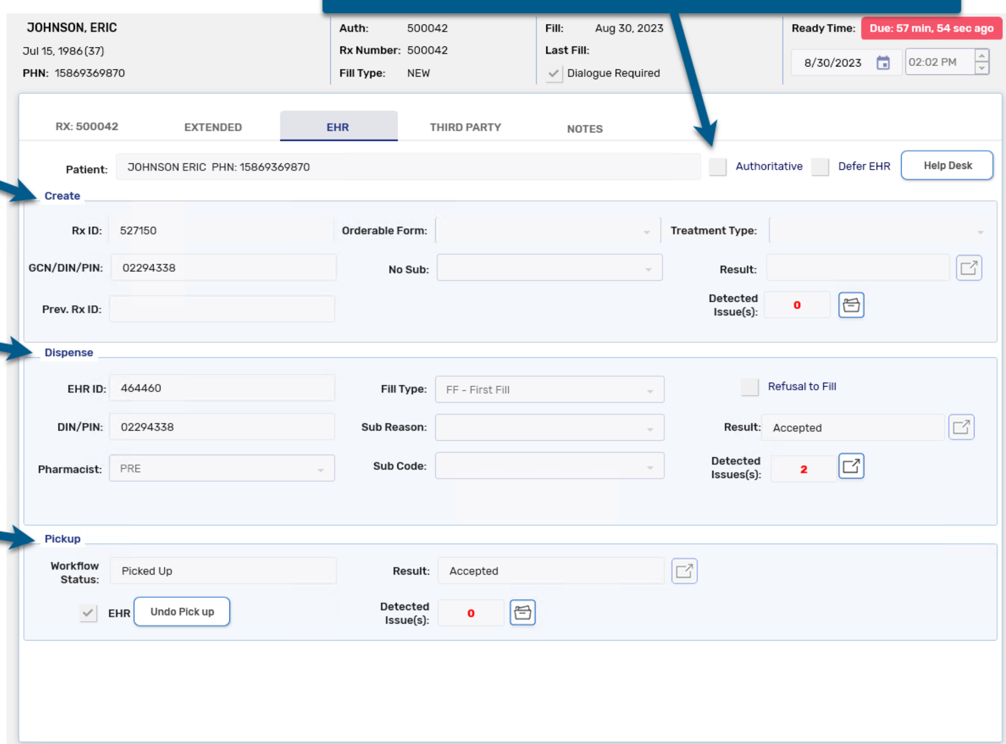
The **Rx Detail EHR** tab indicates the EHR information associated with 3 Prescription messages: Create (or Create Device), Dispense (or Dispense Device), and Pickup.

Authoritative
This checkbox indicates if the Rx is authoritative. If a pharmacist is prescribing medication and they wish to identify that the Rx originates from their pharmacy (as it was prescribed by the pharmacist), they can select this checkbox when dispensing. All other prescriptions are non-authoritative (e.g., paper Rx).

Create or **Create Device**
Contains information pertaining to the drug or device prescription, as it was prescribed.

Dispense or **Dispense Device**
Contains information pertaining to the fill of the drug or device prescription.

Pickup
Contains information pertaining to the pickup of the drug or device prescription.



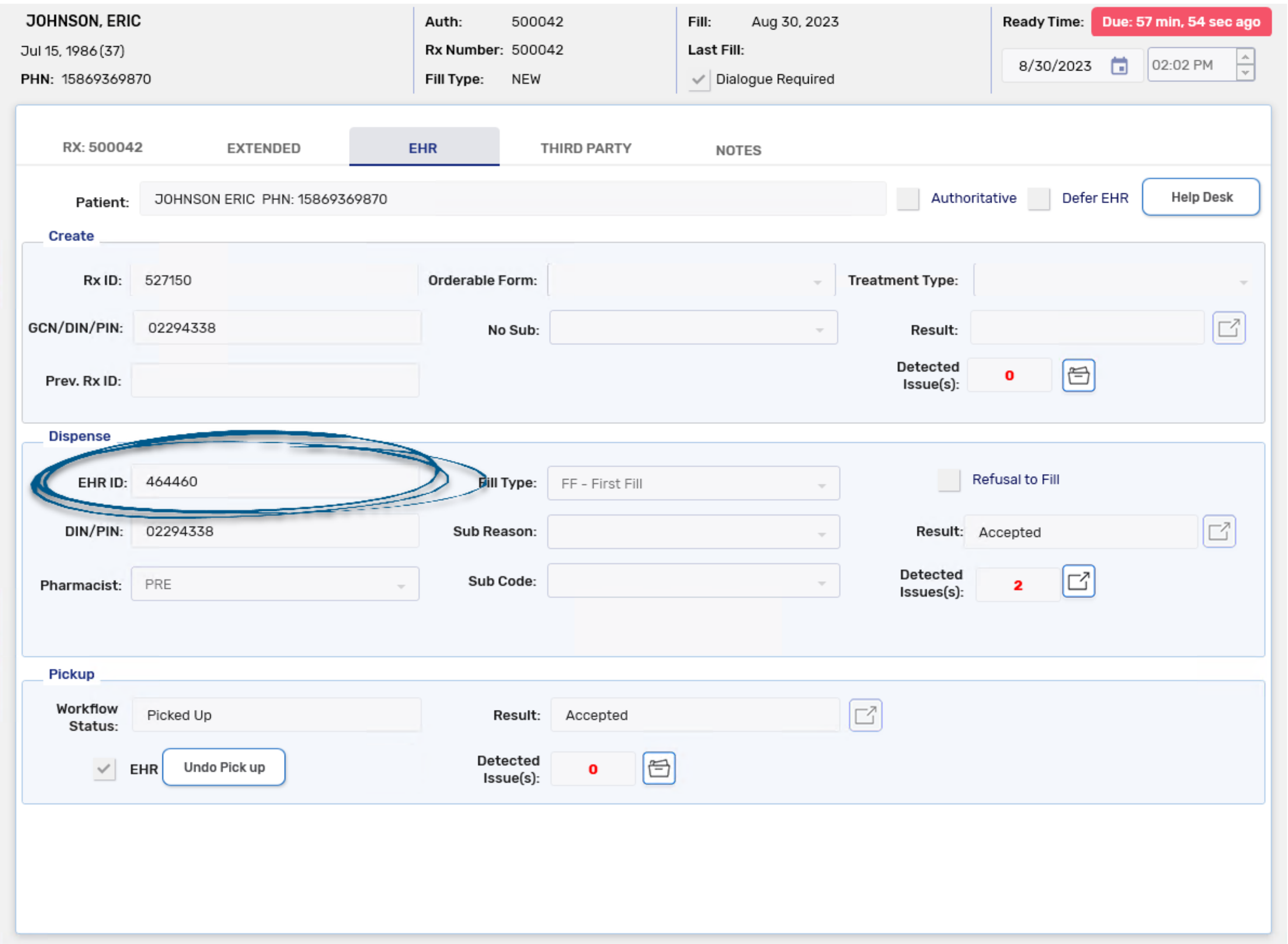
Filling a Prescription Using Fill and Queue Buttons

When a paper prescription is transcribed and filled, Propel Rx transmits the Dispense Prescription message to the EHR. This updates the prescription on the patient's EHR with the dispense information.

To fill or refill a drug or device prescription:

1. Open the incomplete prescription in **Rx Detail**.
2. Enter any required information in the Main tab of Rx Detail.
3. Once done, select **Fill** or **Queue**. The DIS Record Dispense message is transmitted to the EHR.

For filled devices, both the Create Device and Dispense Device DIS messages are transmitted. The Dispense (or Dispense Device) section shows the EHR ID of the dispensed prescription.



The patient's local Profile displays a prescription status of **Complete** (**COM**).

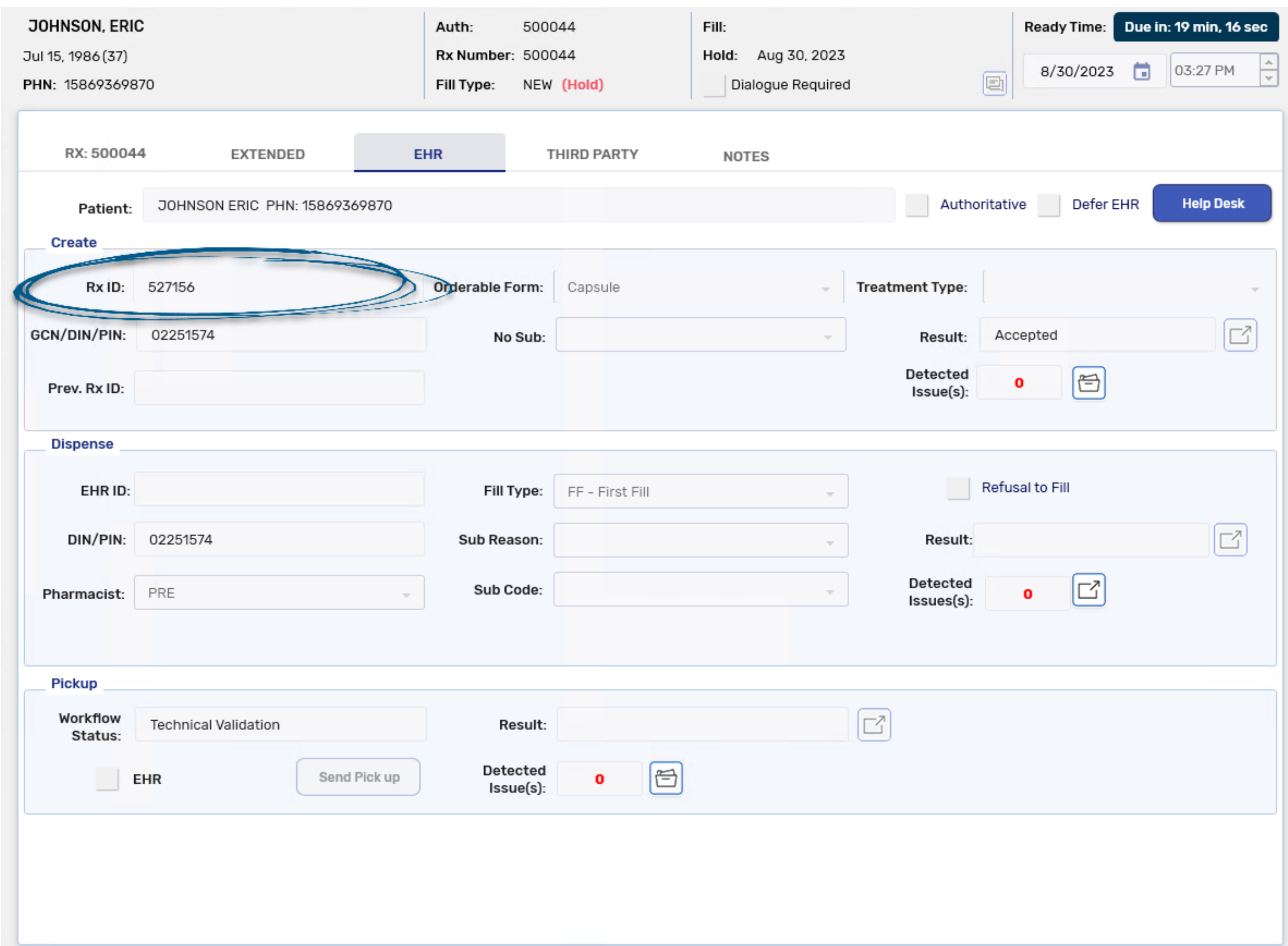
Placing a Prescription on Hold

When a paper prescription is transcribed and put on Hold for a patient, Propel Rx transmits the prescription to the patient's EHR. This is called 'creating the activate' with the EHR. The prescription is logged for dispensing later.

To place a prescription on Hold:

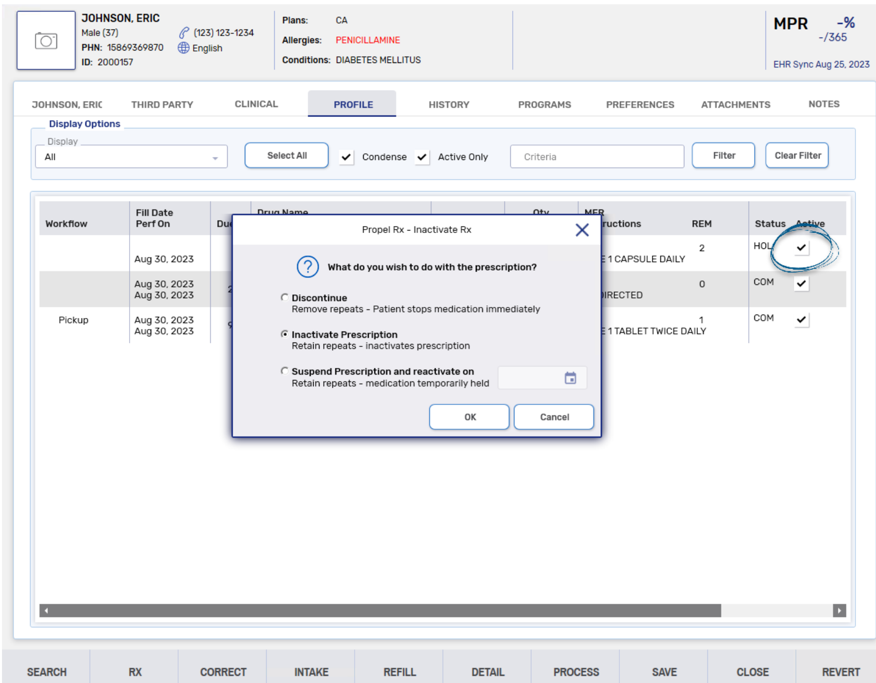
1. Select the **Intake** button from the Workbench or Patient Profile.
2. Enter the **Patient**, **Prescriber**, **Drug**, **Qty Auth**, **Qty**, **SIG**, and **DS**.
3. Select **Process**. The prescription opens in Rx Detail.
4. Select **Hold**.

The prescription is transmitted to the EHR, however, the *Dispense* details are only transmitted once the prescription is filled. The *Create* section displays the Rx ID of the prescription on Hold as shown in the example below. The Patient Profile in Propel Rx displays the prescription with a status of **Hold** (**HOL**).

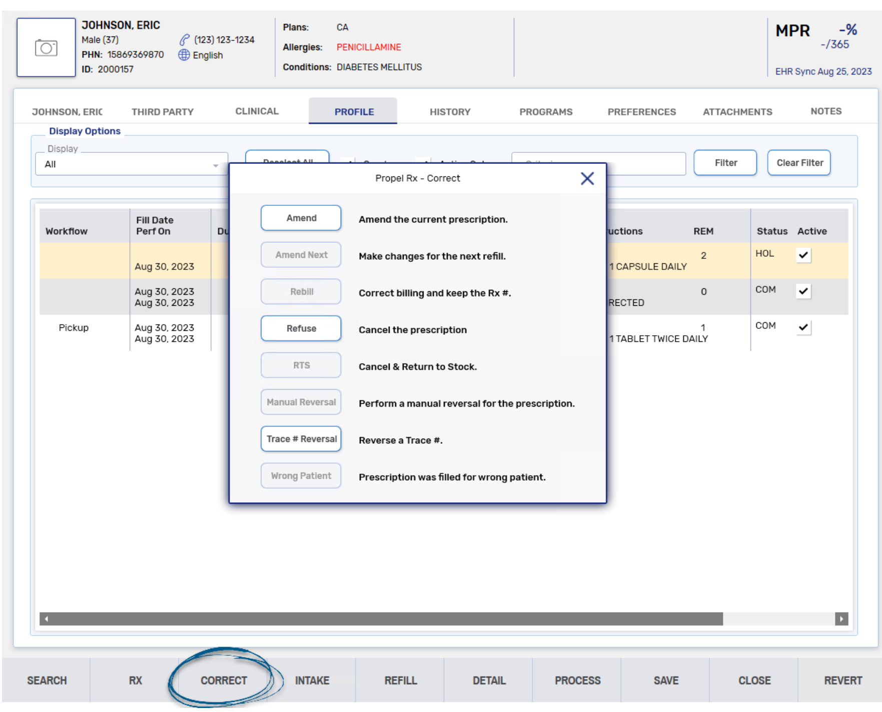


When a prescription is placed on Hold, it is recorded as an Activate on the patient's EHR Profile. If you need to correct the prescription, you must do one of the following:

- Inactivate the prescription by deselecting the **Active** checkbox, and then select the **Inactivate Prescription** option as shown below.



- Remove the first Hold by highlighting the prescription and selecting **Correct** > **Refuse**. Then proceed to create a new prescription with the correct information.

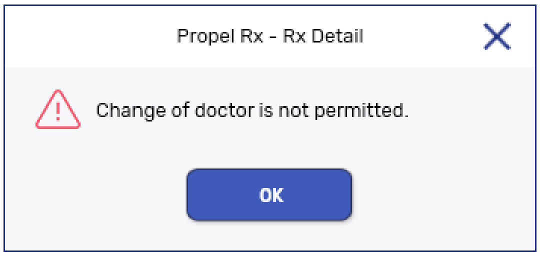


Changing the Prescriber/SIG/Drug for Refill Prescriptions

When a prescription has been recorded on the patient's EHR Profile, you will not be permitted to change the prescriber, instructions, or drug (to a non-interchangeable).

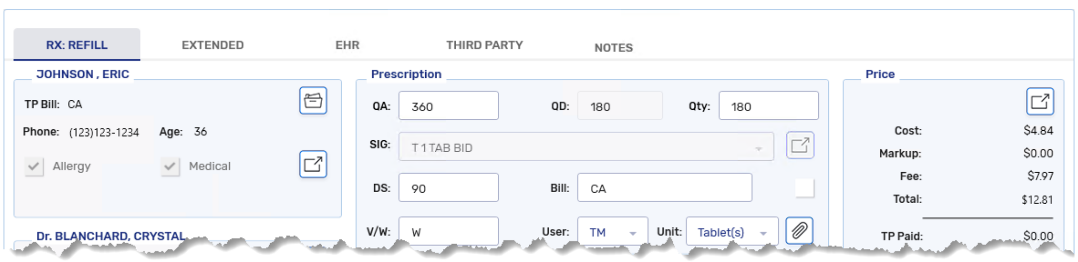
Changing the Prescriber

When refilling a prescription, a change of prescriber is not permitted. If a change of prescriber is required, a new authorization is required. If you attempt to change the prescriber within a refill prescription, the following validation is displayed:



Changing the Instructions

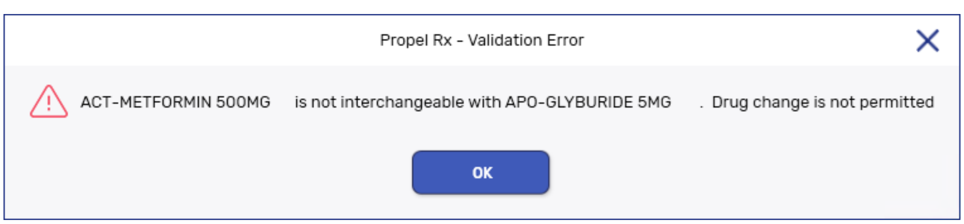
When refilling a prescription that is recorded on the EHR, a change of instructions is not permitted, and the SIG field is disabled for editing. If a change of instructions is required, a new authorization is required.



A change of instructions is permitted for prescriptions that were not transmitted to the EHR (e.g., prescriptions for Animals).

Changing the Drug

Change of drug is not permitted when the Activate message for the prescription has been recorded on the patient's EHR Profile (unless the drug is an interchangeable). If you attempt to change the drug, a validation prompt like the following appears:



Using the Additional Instructions Function

When longer instructions are required for a prescription than can fit in the Rx Detail SIG field, you can use the Additional Instructions function. Instructions entered in the Additional Instruction Label window are transmitted to the EHR and print on a separate vial label from the instructions entered in the Rx Detail SIG field.

To use the Additional Instructions function:

1. Open the incomplete prescription in Rx Detail.
2. Select **Rx** > **Add'l Instructions**. The Additional Instruction Label window opens.
3. Enter the instructions in the Additional Text section.

4. Select **OK**.
5. Continue to fill the prescription as usual.

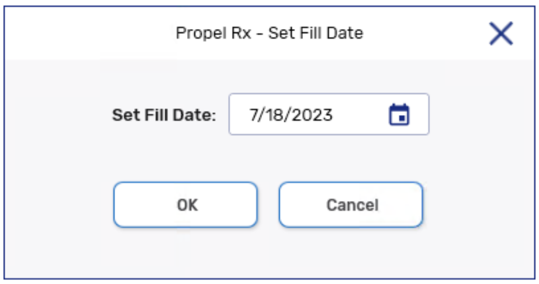
Using the Set Fill Date Function

The **Set Fill Date** function allows you to enter a Fill Date that is different from the current system date. This overrides the current system date, providing the ability to backdate prescriptions. The modified Fill Date is transmitted with the online claim and used as the prescription's Fill Date during adjudication. The Set Fill Date is also recorded on the patient's EHR.

When Set Fill Date is used for a new prescription or new authorization, the Written Rx Date in the Rx Detail Extended tab is updated with the same date.

To use the Set Fill Date function:

1. Open the incomplete prescription in Rx Detail.
2. Select **Rx** > **Set Fill Date**. The Set Fill Date window opens.



3. Enter a date that is before today's date.
4. Select **OK**.
5. Continue to fill the prescription as usual.

Once the prescription has been filled, the Fill Date cannot be modified. The Fill Date shown on the Patient Profile and Audit History in Propel Rx reflects the Fill Date used for the prescription. The Performed On Date reflects the system date on which the prescription was filled.

ALERT: Set Fill Date **must not** be used if you are placing the prescription on Hold. If you rebill a prescription, you cannot use Set Fill Date; you must refuse the prescription and refill it for the feature to be available.

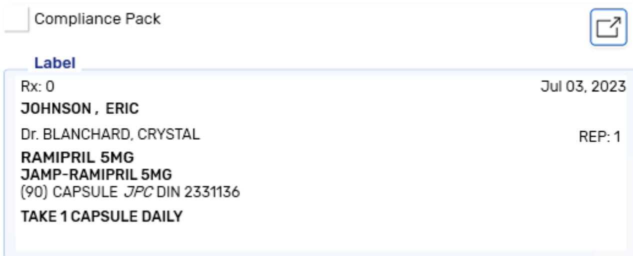
Entering Route of Administration

Route of Administration (Route) is a mandatory field for all drug or mixture prescriptions. Propel Rx populates the Administration Details Route field based on the Route information within the Drug or Mixture Folder. If the Route is blank, you are required to select a value.

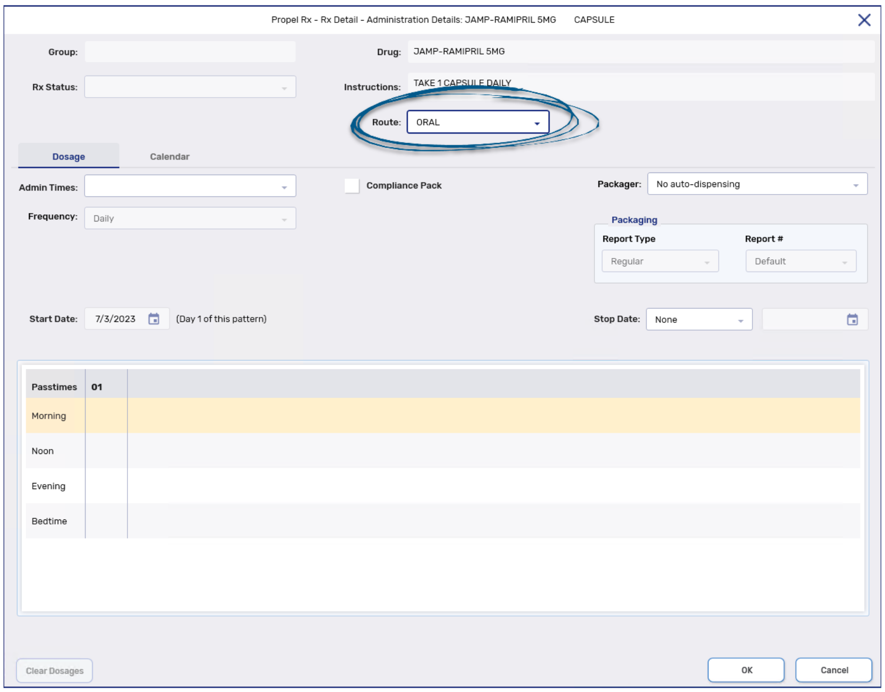
To enter a Route for a prescription:

1. Open the incomplete prescription in Rx Detail.

2. Select the expander button located above the SIG preview section. The Administration Details window opens.



3. Select an option from the **Route** dropdown menu.

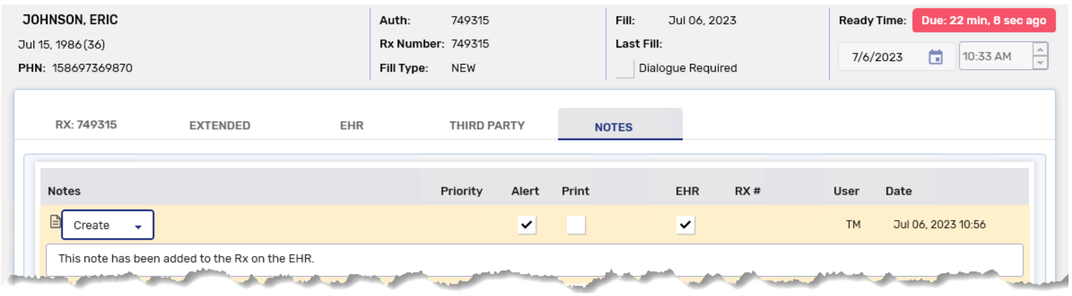


4. Select **OK**.
5. Continue to fill the prescription as usual.

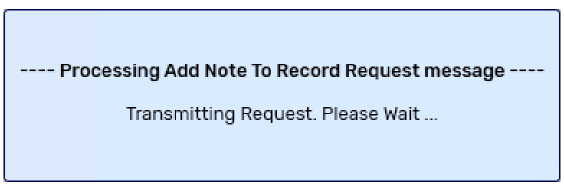
ALERT: The prescription Route list is a more comprehensive list than the Drug/Mixture Route list. Drug/Mixture Routes of Injection or Miscellaneous cannot be mapped to a prescription Route and always require manual intervention.

Adding a Prescription Note to the EHR

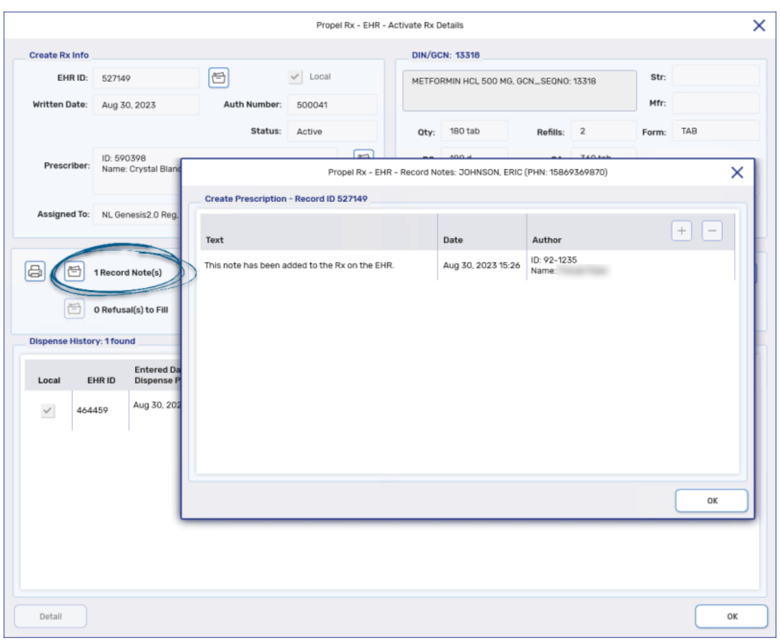
When adding a note to a prescription, you must determine if the note should be added to the patient's EHR Profile. If it is determined that the note should exist on the patient's EHR Profile for other healthcare professionals to view, select the EHR checkbox to transmit the note to the EHR. Once the **EHR** checkbox is selected, a dropdown is available for you to choose whether to attach the note to the Create or Dispense.



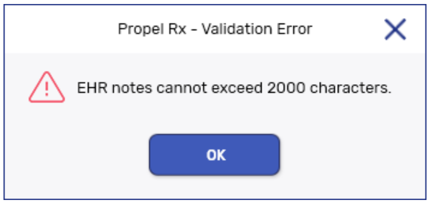
In the above example, the note was added to a completed prescription. After selecting the EHR checkbox and the Create option, you can select OK to transmit the note to the EHR. A processing message displays for the transmission.



Once the prescription note is added, you can view it by selecting the prescription from the patient's EHR Profile and selecting the folder button that indicates Record Note(s), as shown below.



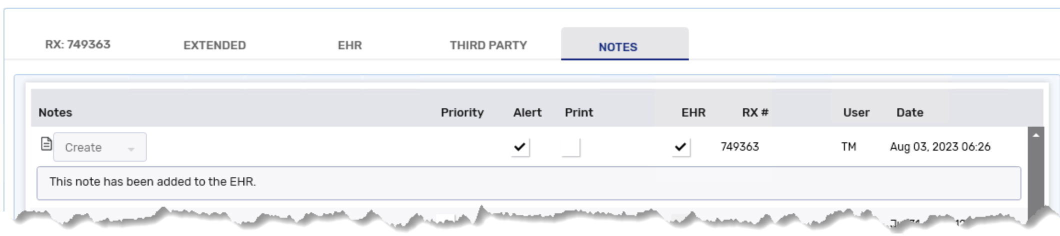
If a note longer than 2000 characters is attempted to be added, the following prompt displays:



Retracting a Prescription Note from the EHR

To retract a prescription note from the EHR:

1. Open the completed prescription in **Rx Detail**.
2. Select the **Notes** tab.



3. Do one of the following:
   - If you want to remove the note from Propel Rx and the EHR, highlight the note and then select **Delete**.
   - If you want to remove the note from the EHR but keep it locally in Propel Rx, uncheck the **EHR** checkbox for the note.
4. Select **OK**.

A processing message displays indicating the information is being retracted from the EHR.

If you attempt to retract a prescription note that has already been viewed by another healthcare professional, a Detected Issue appears indicating the prescription event is no longer retractable.

If the prescription note cannot be retracted due to other reasons, you may receive the following Detected Issue:

Priority	Severity	Issue Type	Description
Error		The specified element did not pass business-rule validation	The given event cannot be retracted as it is not the most recent event logged against the Rx (703715)

Maintaining Prescription Audit History

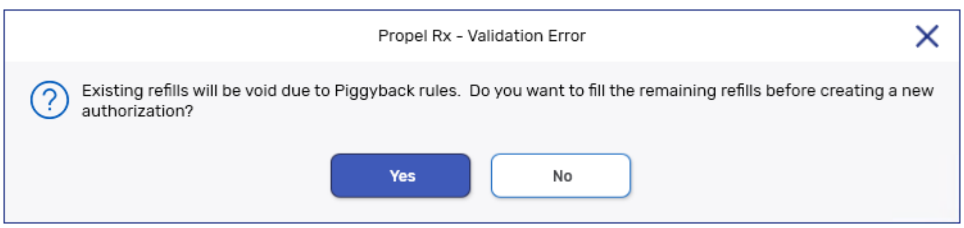
A prescription's Audit History lists the refill history for the prescription, including the original prescription and any subsequent refills and reauthorizations. When refilling a prescription, the prescription's Audit History and/or the patient's EHR Profile should be verified to determine when the prescription was last filled.

If the patient has refills remaining for a drug that was previously dispensed, you should refill the prescription and remove the previous refills to maintain an accurate Audit History. Propel Rx automatically creates a new authorization number for the reauthorized prescription.

ALERT: In the patient's EHR Profile, these prescriptions are linked by the *Previous Rx ID*, which is visible in the Rx Detail EHR tab.

To create a new authorization from an existing prescription:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Highlight the prescription currently on the Profile that still has refills.
4. Select **Refill**. The prescription opens in Rx Detail.
5. In the **QA** field, enter 0.
6. Press **TAB** on your keyboard. This changes the Fill Type from a Refill to a ReAuth.
7. Enter the new **QA**, **Qty**, and remaining prescription information in Rx Detail.
8. Select **Fill**. A piggyback prompt appears asking if you want to fill the remaining refills.



9. Select **No**.

An Abort message is transmitted to the EHR for the previous authorization. After the Abort message has been transmitted, the Create and Dispense for the new authorization are transmitted. This process links the Previous Rx ID with the new prescription presented today. The prescription's Audit History clearly demonstrates the Workflow process for this new authorization.

Filling Stock Supply Prescriptions

Stock Supplies, which are also referred to as ‘ward stock’ or ‘stock transfer’ (to another pharmacy), or ‘office use meds’, are medications that are dispensed to a facility instead of a specific patient.

NOTE: While you can send Stock Supply prescriptions to the DIS, it is not required and no longer recommended. The steps below outline how to send Stock Supply prescriptions to the DIS. If you wish to bypass the DIS, you can fill these prescriptions using an Animal patient status.

Stock Supply prescriptions can be recorded under the Facility Patients (refer to Group Folder). For a Stock Supply, the prescription information section of Rx Detail displays **Stock Supply**. The Dispense section of the EHR tab also displays **Stock Supply**.

To fill a Stock Supply:

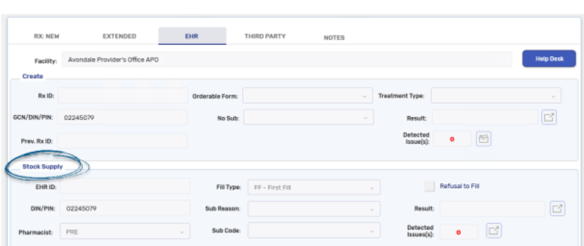
1. Open the **Patient Folder** for the Facility Patient.
2. Select the **Profile** tab.
3. Select **Intake**.
4. Enter the prescription information in the Intake window.
5. Select **Process**. The prescription opens in Rx Detail.

   NOTE: No EHR Profile information is displayed as the prescription is linked to a Facility and not an actual patient. The EHR-All button from the Patient Profile is also disabled.

6. Ensure the **QA**, **Qty**, **SIG**, and **DS** are appropriate. If using this prescription for billing to the Group, ensure the prescription price is correct.
7. Select **Fill**.

   NOTE: Stock Supply prescriptions cannot be deferred.

The **EHR** tab of the prescription displays **Stock Supply** in the **Dispense** section as shown below.



The prescription is recorded on the EHR and the patient’s local Profile is updated.

Deferring Prescriptions to the EHR

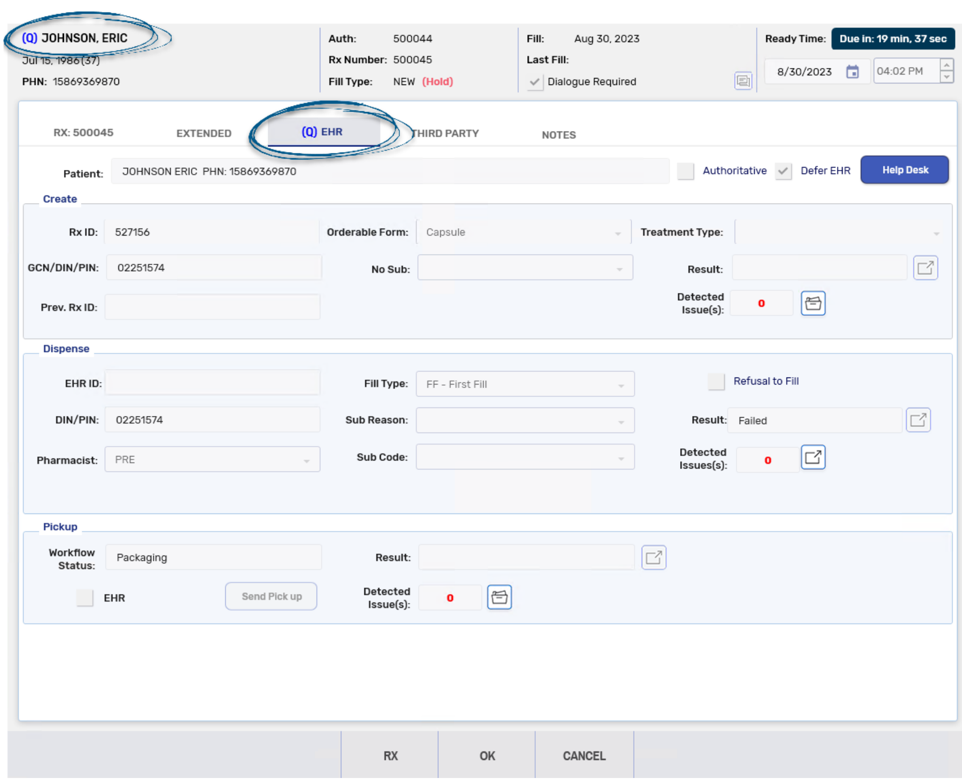
Users may be required to process a prescription for a waiting patient; however, the drug or device may not be recognized by the provincial EHR yet. The drug or device will be added to the EHR eventually; however, you still need to be able to process the prescription. For this purpose, you can use the **Defer EHR** functionality.

Defer EHR functionality applies to prescription processing only. This functionality allows you to temporarily bypass the EHR for Rx and Device transactions but adjudicate to the third parties. The Deferred prescriptions are added to the EHR Queue and you are responsible for sending the applicable EHR transactions at the appropriate time.

A **Defer EHR** checkbox is available in the **Rx Detail EHR** tab.

Any future EHR transactions associated with the prescription (e.g., Record Notes, Dispense Pickup, Undo, Reversals, etc.) are added to the **EHR Queue** and have an EHR Queue Status of **Deferred** until the Deferred prescription is processed.

The Deferred prescription as shown below is indicated with a **[Q]** indicator in Rx Detail. A **[Q]** indicator also displays on the Patient Folder information bar when the patient has transactions currently in the EHR Queue. This acts as a reminder for you to deal with the pending prescriptions.



Refilling Deferred EHR Prescriptions

When the **Defer EHR** checkbox is turned ON for the previous prescription, refills also have the Defer EHR checkbox turned ON until the previous record is submitted successfully to the EHR. It is imperative that users are reviewing the **EHR Queue** daily.

Therefore, when you attempt to refill a prescription that has 1 or more associated transaction(s) to the current prescription in the **EHR Queue**, the **Defer EHR** checkbox is ON automatically and cannot be modified.

Reauthorizing Deferred EHR Prescriptions

When the **Defer EHR** checkbox is turned ON for the previous prescription, reauthorized prescriptions also have the **Defer EHR** checkbox turned ON until the previous record is submitted successfully to the EHR.

Therefore, when you attempt to reauthorize a prescription that has 1 or more associated transaction(s) to the current prescription in the **EHR Queue**, the **Defer EHR** checkbox is ON automatically and cannot be modified.

Once submitted, the reauthorized prescription is flagged as **Deferred** (**Defer EHR** = ON). The related EHR transaction(s) for the prescription are added to the **EHR Queue** tile on the Workbench when you select **Hold**, **Queue**, or **Fill**. The EHR Queue Status for all related EHR transactions are set to **Deferred** until you send the transaction(s) to the EHR.

Correcting a Prescription

The Correct function allows you to fix an error(s) on a processed prescription (e.g., wrong quantity, drug, instructions). When a prescription is corrected, the corresponding DIS message is attempted for the retraction or removal from the EHR.

NOTE: In certain instances, you cannot correct a prescription such as a change in SIG or quantity of the prescription. In these scenarios, the original prescription must be discontinued and resubmitted.

Amend Allows you to make changes to a processed prescription without impact to billing.

Amend Next Disabled for eHealth provinces.

Rebill Allows you to cancel a prescription, correct it, and then fill the prescription in one step using the same authorization number and same Fill Date (e.g., incorrect quantity authorized).

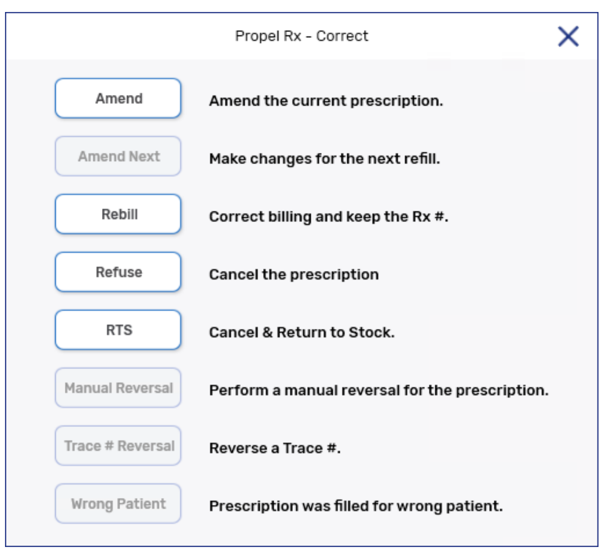
Refuse Allows you to cancel the prescription (e.g., prescription filled in error).

RTS Allows you to cancel the prescription. RTS allows you to enter the prescription numbers by scanning privacy labels.

Manual Reversal Allows you to reverse a prescription without adjudication of the reversal online.

Trace # Reversal Allows you to reverse a claim from a third party using a unique trace number.

Wrong Patient Disabled for eHealth provinces.



Rebilling a Prescription

In Newfoundland and Labrador, rebills for an Other Medication (DUR) or a prescription that is placed on Hold is not permitted. All other prescriptions can be rebilled.

To rebill a filled prescription:

1. From the **Patient Profile** or **Workbench**, highlight the completed prescription.
2. Select **Correct**. The Correct window opens.
3. Select **Rebill**. A prompt appears.

4. Select **Yes**.

Propel Rx reverses the third party claim and then reverses the EHR transaction on the patient's EHR Profile with the correct rebilled information.

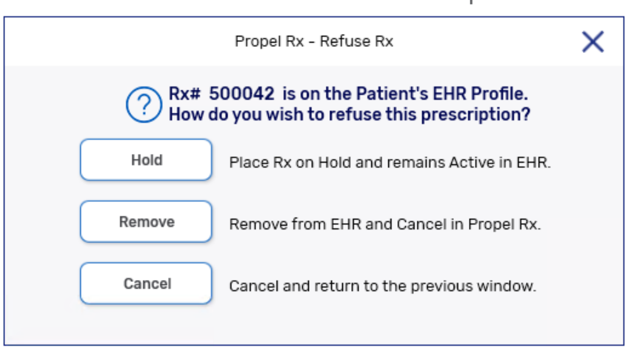
Rebilling a Discontinued Prescription

If a prescription is Discontinued and located on the EHR, you cannot make any changes to the billing (e.g., Correct > Rebill).

To correct the billing information, you must refuse the Discontinued prescription, and create a new prescription with the correct billing information.

To rebill a Discontinued prescription:

1. From the **Patient Profile**, highlight the Discontinued prescription.
2. Select **Correct** > **Refuse**. A validation prompt appears.
3. Select **Yes**. The Refuse Rx window opens.



4. Select **Remove**.
5. Create a new prescription for the same patient using the correct billing information.
6. Select **Fill**.
7. Discontinue the new prescription you just created.

NOTE: It is your pharmacy's responsibility to ensure that all Third Party billing is correct, including claim reversals, and that all documentation is in place in case there is any type of audit performed.

Refusing a Prescription

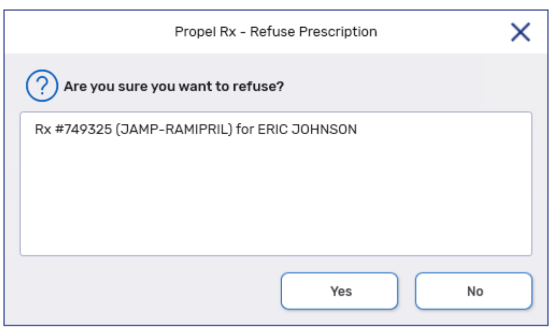
When refusing the first fill of a prescription, the Hold button is available.

When refusing a prescription, if a Pickup was completed previously, a retract of the Pickup is done as well and a record of the removal is included in the Audit History for the prescription.

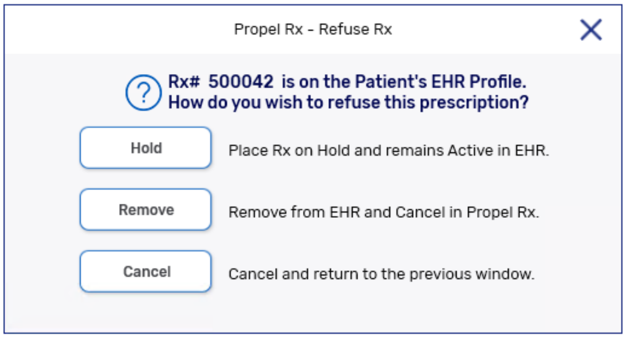
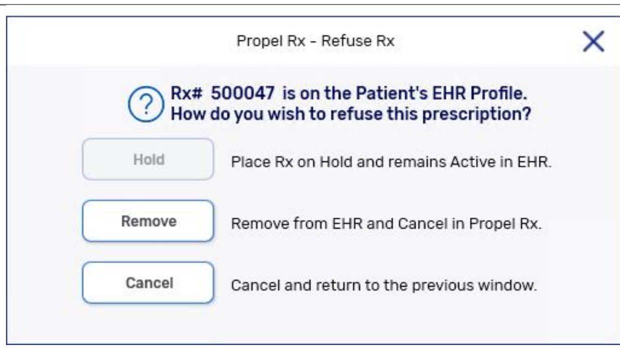
In Newfoundland and Labrador, you cannot refuse an Other Medication (DUR) prescription. However, you can remove the DUR using the Remove functionality in Audit History. For more information, see Retracting a DUR from the EHR. All other prescriptions can be refused.

To refuse a filled prescription:

1. From the **Patient Profile** or **Workbench**, highlight the prescription.
2. Select **Correct**. The Correct window opens.
3. Select **Refuse**. A validation prompt appears.



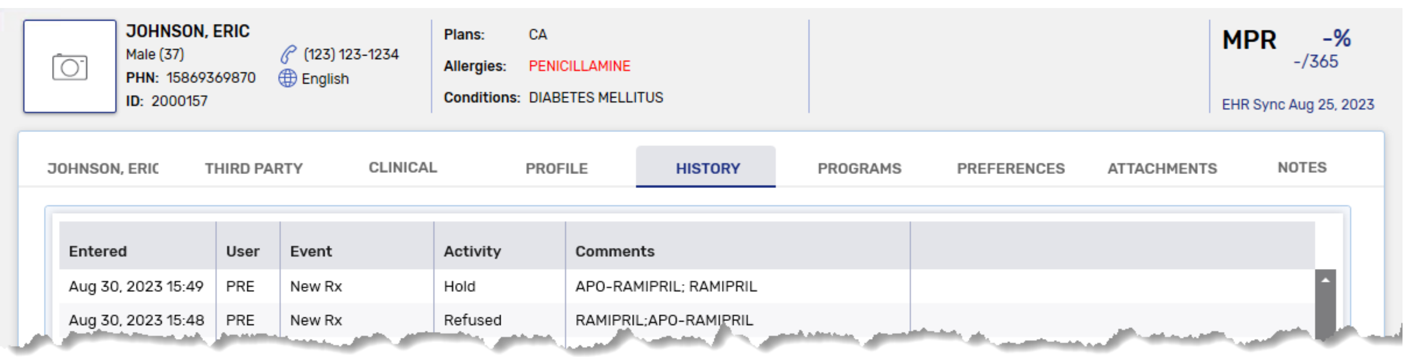
4. Select **Yes**. The Refuse Rx window opens. Depending on the prescription scenario, the buttons that are visible in the window vary, as indicated in the chart below.

Prescription Scenario	Prompt	Options/Actions
First fill of an inferred prescription		• **Hold**: Reverses the claim from the Third Party and EHR. The prescription is marked with a *Cancelled* status locally and the Create record still exists on the patient's EHR Profile. If a Pickup was completed, it is also reversed. The prescription can be refilled again later. All subsequent fills will be dispensed using the same Rx ID. • **Remove**: Reverses the claim from the Third Party and EHR. The prescription is removed from the patient's local Profile and EHR Profile. • **Cancel**: Exits with no changes.
Refill of a prescription	No prompt is displayed	• Reverses the claim from the Third Party and EHR. The prescription is marked with a *Cancelled* status locally and no record of the refill exists on the patient's EHR Profile. The prescription can be refilled again later. If a Pickup was completed, it is also reversed.
Prescription is on Hold		• **Remove**: Removes the prescription from the patient's local Profile and EHR Profile. The prescription can be filled again later. • **Cancel**: Exits with no changes.

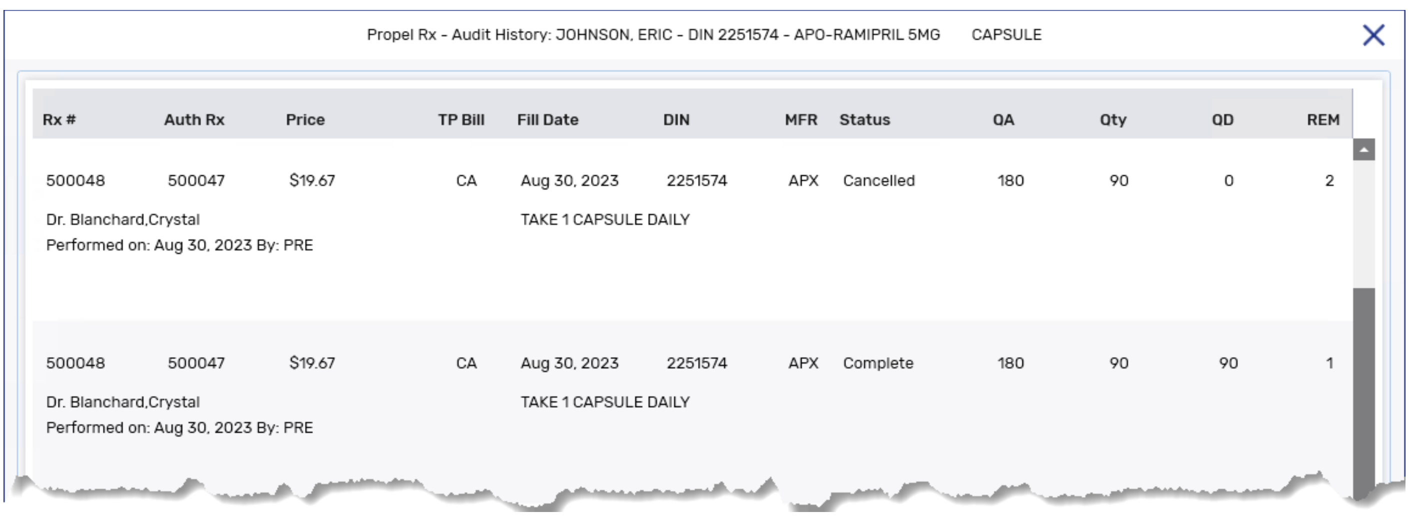
Prescription on file prior to EHR activation	No prompt is displayed	• Reverses the claim from the Third Party. The prescription is marked with a Cancelled status locally and no record of the fill exists on the patient's EHR Profile.

NOTE: In the case where a prescription is put on Hold (Create), and then that prescription is refilled (Dispense), you must correct and refuse both transactions. To remove the prescription from the EHR Profile, you must first refuse the Dispense and then refuse the Create.

All successful prescription refusals are recorded in the Patient Folder History tab, as shown below.



The Audit History for the prescription also accurately tracks the refusal, as shown below.



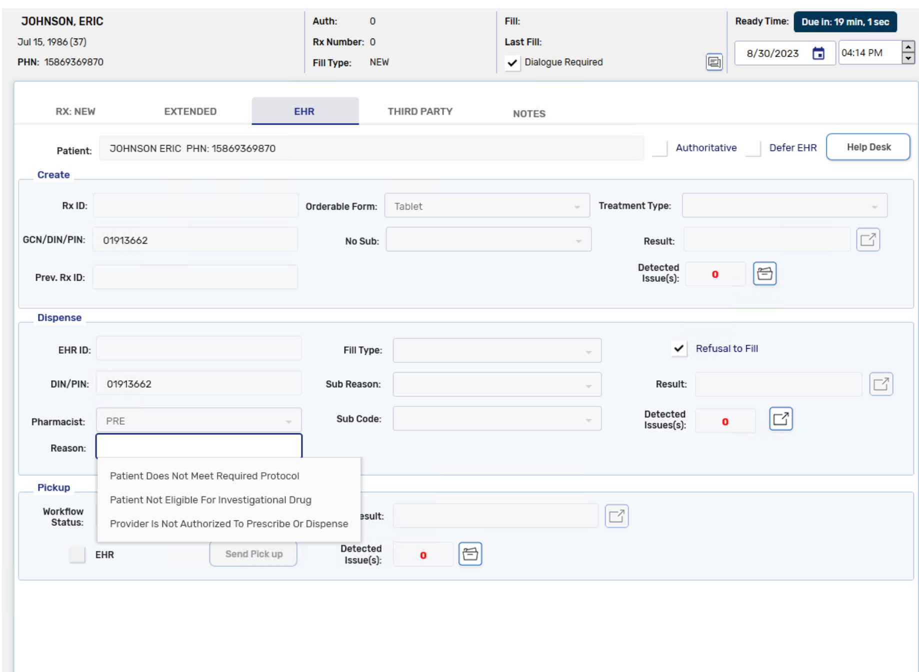
If for any reason, the retract message is unsuccessful, you are presented with a Detected Issue explaining the retraction could not be completed.

Refusing to Fill a Prescription

A healthcare professional should use their professional judgement to determine whether a prescription should not be filled. The **Refusal to Fill** message updates the patient's Profile with the **Refusal** indicator to advise healthcare professionals that a prescription was presented to your pharmacy, and in your professional judgement, you decided not to complete the dispense.

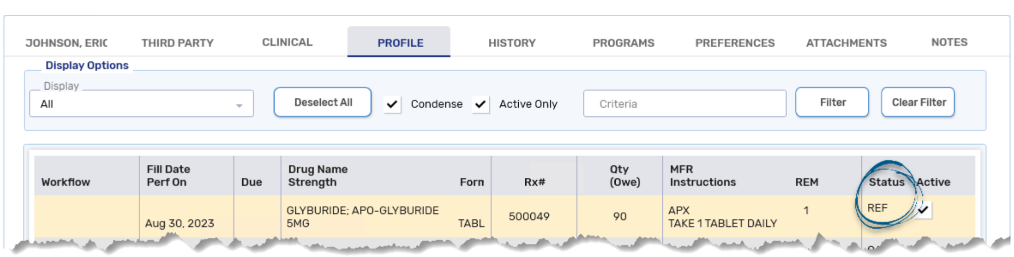
To complete a **Refusal to Fill** transaction:

1. Open the incomplete prescription in **Rx Detail**.
2. Enter any required information in the **Main** tab of Rx Detail.
3. Select the **EHR** tab.
4. Select the **Refusal to Fill** checkbox.

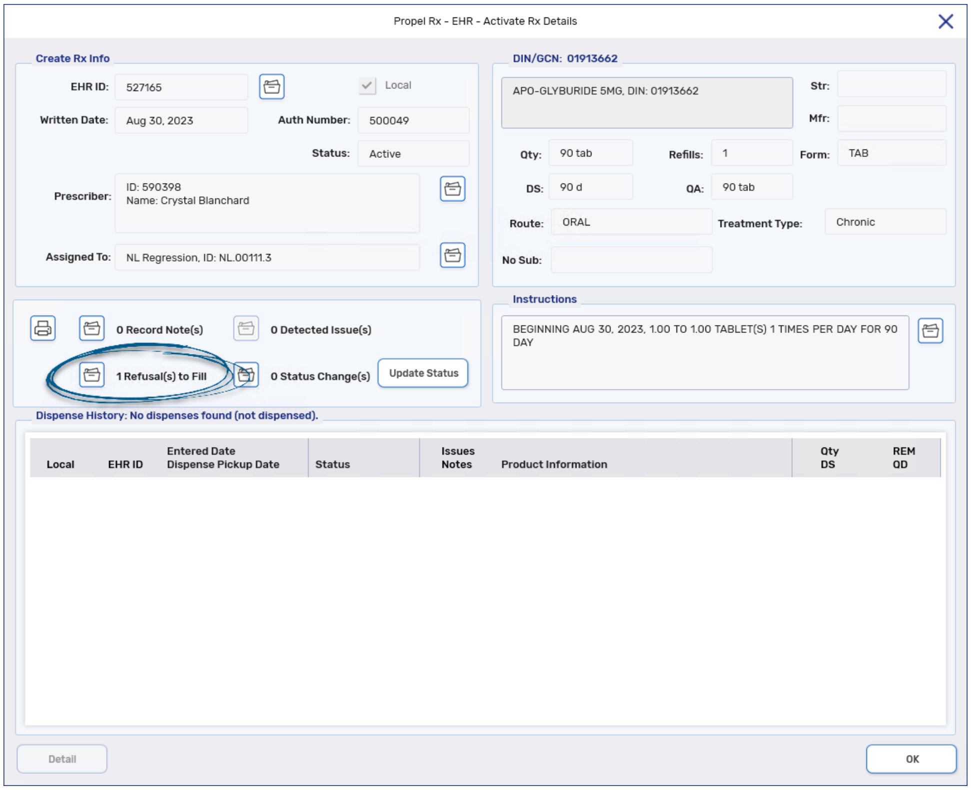


5. Select a **Reason** from the dropdown list.
6. Select **Fill** to submit the Refusal to Fill to the EHR.

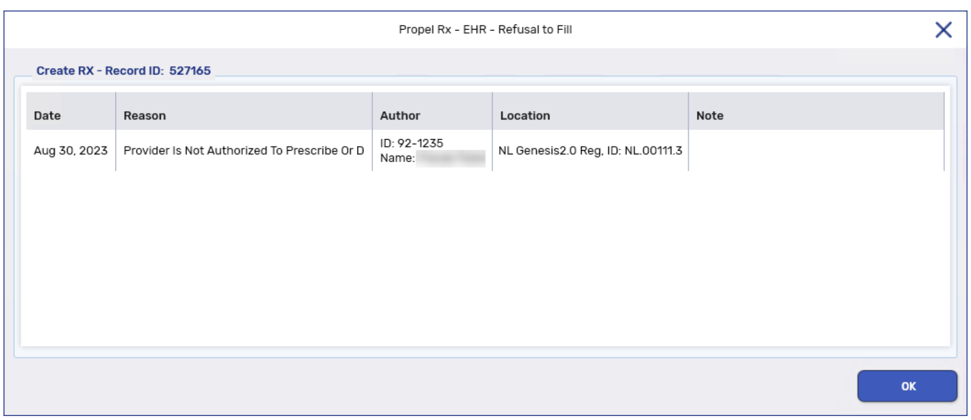
When a Refusal to Fill is completed, a claim is not sent for adjudication, and the prescription status displays as **REF** on the patient's local Profile.



You can view the Refusal to Fill information on the patient's EHR profile by selecting the folder button next to **Refusal(s) to Fill**.



The details displayed for the Refusal to Fill appear like the following window.



Inactivating a Prescription

Inactivating a Prescription from Propel Rx

After a prescription is processed on a patient's Profile, it is flagged as active. If the patient is no longer actively taking a medication, the prescription should be inactivated. It is important that you inactivate the drugs that a patient is not currently taking. This makes their Profile more accurate in Propel Rx and the EHR and allows for more efficient medication reviews.

A notes function allows you to document the reason for inactivating a prescription. The note is visible from the following locations:

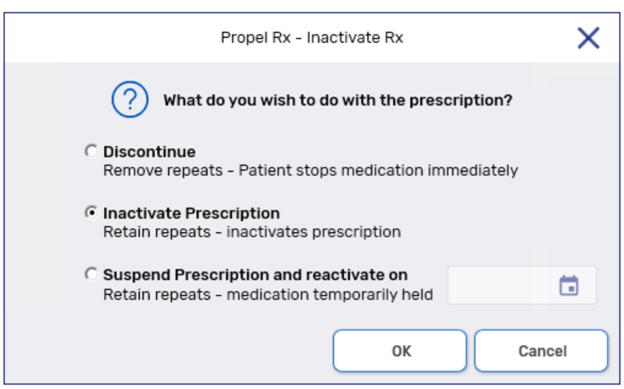
- Rx Detail Notes tab when the prescription is detailed.
- EHR Profile if the note was transmitted to the DIS.

Updating the Status of Local Records

If a prescription is found locally and on the EHR, update the status from the Patient Profile tab in Propel Rx. Prescription status changes from the Patient Profile are transmitted to the EHR. If the status is updated from the EHR Profile, the change is not reflected locally. This can lead to Detected Issues when attempting to refill the prescription.

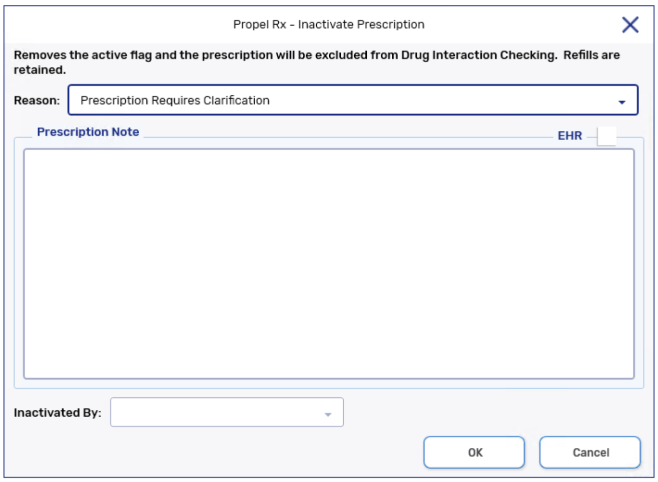
To inactivate a prescription from Propel Rx:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Uncheck the **Active** checkbox for the prescription that needs to be inactivated. The Inactivate Rx window opens.
4. Select the appropriate option.



- **Discontinue** – patient will no longer take the medication, effective immediately. Repeats are removed. Prescription is aborted on the EHR.
- **Inactivate** – patient is not currently taking medication but may resume later. Repeats are retained. Prescription is suspended on the EHR.
- **Suspend** – patient will stop the medication for a specific period and then resume on an optional chosen date. Repeats are retained. Prescription is suspended on the EHR. On the resume date, the prescription status will change back to active in Propel Rx and the EHR.

5. Select **OK**. The Inactivate Prescription window opens.
6. Select an appropriate reason from the dropdown menu.



7. *Optional*: Enter any notes for the inactivation. Select the **EHR** checkbox if you want the note to be transmitted to the EHR.
8. Select who (i.e., Agent, Patient, Provider) initiated the inactivation process.
9. Select **OK**.

A processing message displays for the suspend or abort and closes upon successful completion of the message to the EHR. The prescription is flagged as inactive on the Patient Profile in Propel Rx with one of the following indicators:

- Discontinued = *D*
- Inactivated = *I*
- Suspended = *S*

Resuming a Suspended Prescription from Propel Rx

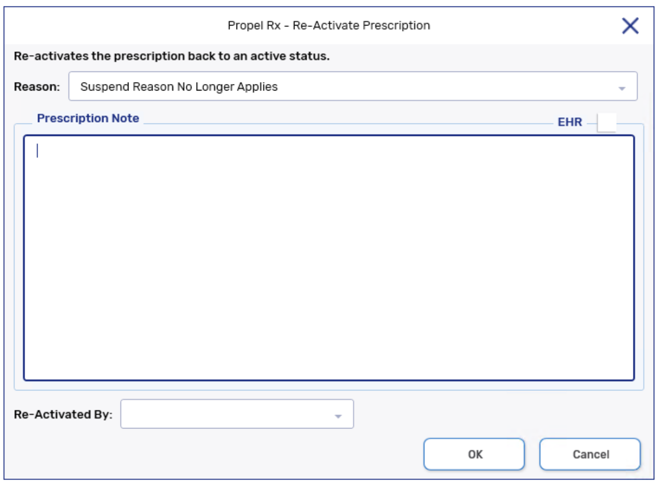
If a suspended prescription is found locally, you can reactivate it from Propel Rx which will update its status on the EHR. If a resume date was specified when the prescription was inactivated, the prescription will be automatically reactivated on the chosen date; however, you can still manually resume the prescription earlier if needed.

NOTE: You can only resume inactivated or suspended prescriptions in Propel Rx. You cannot resume a discontinued prescription.

If the prescription is not local (i.e., on the EHR), you can resume it from the EHR Profile by following the steps in Updating a Prescription Status on the EHR.

To resume a suspended prescription from Propel Rx:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the **Active** checkbox for the prescription that needs to be resumed. The Re-Activate Prescription window opens.
4. Dropdown the **Reason** field and select the appropriate option.



5. *Optional*: Enter any notes for the reactivation. Select the **EHR** checkbox if you want the note to be transmitted to the EHR.
6. Select who (i.e., Agent, Patient, Provider) initiated the reactivation process.
7. Select **OK**.

A processing message displays for the resume and closes upon successful completion of the message to the EHR. The prescription is flagged as active on the Patient Profile in Propel Rx.

Transferring a Prescription

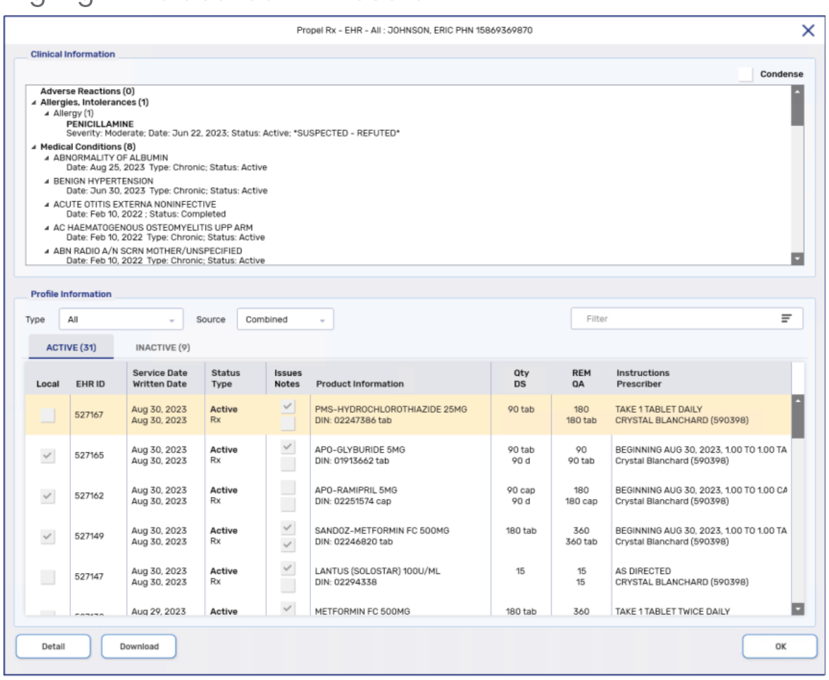
Transferring In a Prescription

The Download button is used to transfer in a prescription from a patient's EHR. This is performed if the prescription has been e-prescribed or if the prescription has been transferred to your pharmacy. If the prescription is on the patient's EHR, this means the originating pharmacy is connected to the EHR or the prescriber added the prescription to the EHR. The Download button is available from the EHR-All window.

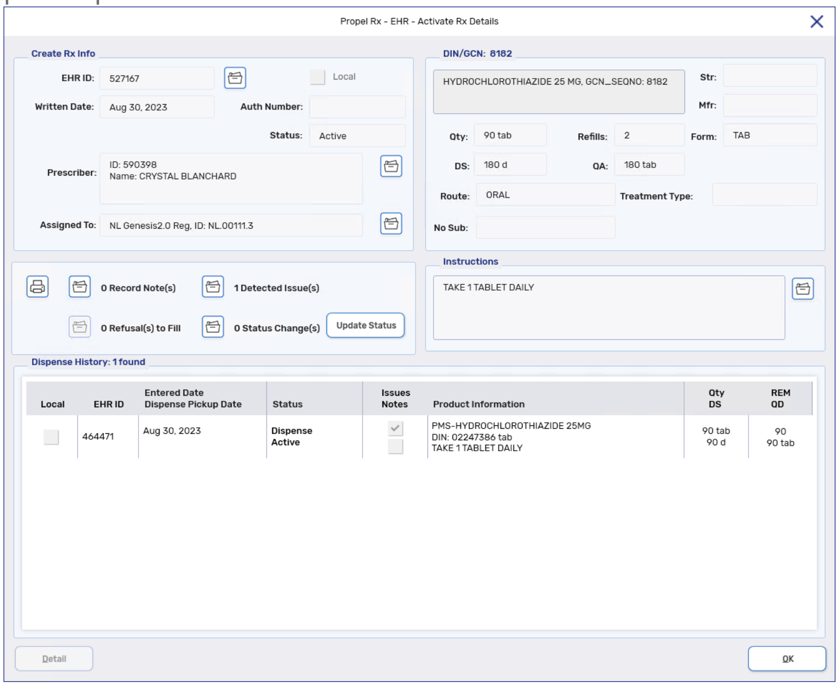
If the prescription was added to the EHR by another pharmacy, the originating pharmacy must assign dispensing authority to your pharmacy before a download can occur. Once this process is complete, your pharmacy can download and dispense against it.

To download a prescription:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select **Rx** > **Profile** > **EHR-All**. The Patient EHR Access Reason window opens.
4. From the dropdown menu, enter a reason for accessing the patient's EHR. The default reason is Patient Care.
5. *Optional*: Enter any comments in the **Comments** field.
6. Select **OK**. The EHR - All window opens.
7. Highlight the desired EHR record.

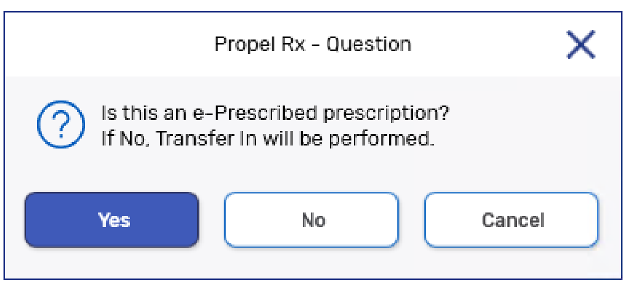


8. Select **Detail**. The EHR – Rx Details window opens. The deselected Local checkbox indicates the prescription is not local.



ALERT: It is recommended that the *Create* and *Dispense* details of a selected prescription are reviewed prior to selecting **Download**. This ensures that the correct prescription has been selected and for prescription transfers, provide an opportunity to confirm the information from the transferring pharmacy.

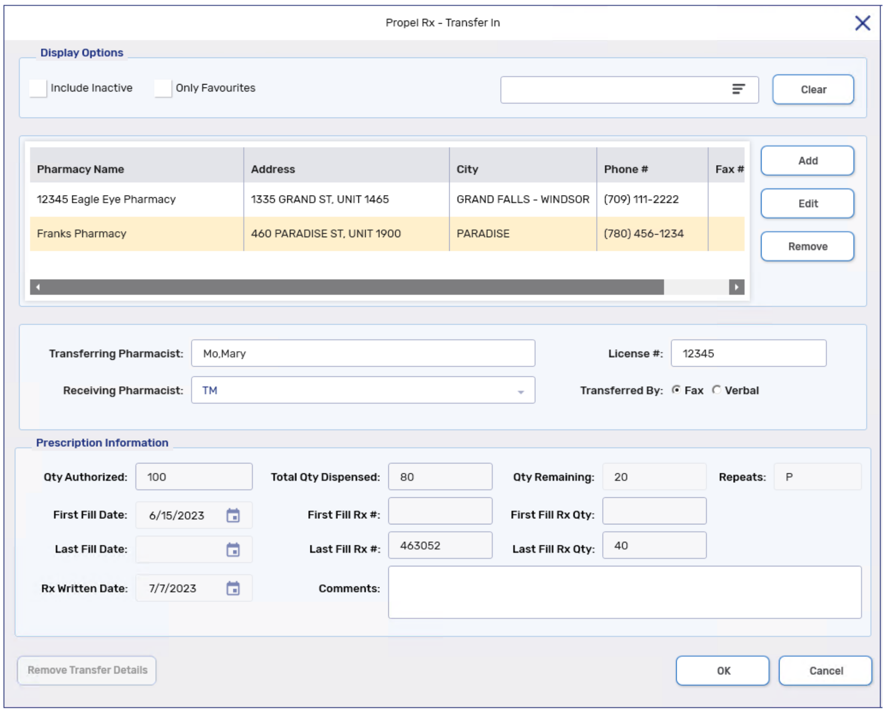
9. Select **OK**.
10. Select **Download**. A prompt displays.



11. Select **No**. All prescriptions in Newfoundland and Labrador are created and assigned to a pharmacy. The Ready Time window opens.
12. Enter a Ready Time.
13. Select **OK**. The Drug and Mixture Search window opens.
14. Select the appropriate drug and then select **OK**. The Prescriber Search window opens.
15. Search for and select the appropriate prescriber. The Transfer In window displays. The values that are returned with the Download message are populated.
16. Select the transferring pharmacy.

NOTE: If the pharmacy is not in the dropdown list, select **Add** to open the Other Pharmacy window to add a new pharmacy (refer to Other Pharmacy for more information). If the pharmacy is missing the Provincial Pharmacy ID, select **Edit** to add it from the Other Pharmacy window.

17. Enter the **Transferring Pharmacist**. The license number is optional.
18. Dropdown the **Receiving Pharmacist** field and select the appropriate user, if not already selected.
19. Review the details in the **Prescription Information** section and add any comments that are relevant to the prescription.



20. Select **OK**. The prescription opens in Rx Detail and displays the downloaded information.
21. Verify all information in Rx Detail and select either **Fill** or **Hold**.

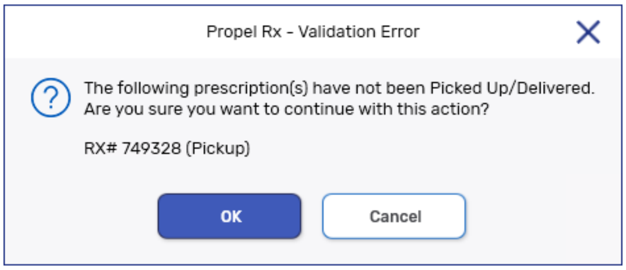
ALERT: It is expected that the proper transfer protocol of calling the originating pharmacy occurs and the prescription must be transferred electronically by the transferring pharmacy before it can be downloaded to your pharmacy. Refer to Transferring Out a Prescription for more information on the transfer out process.

Transferring Out a Prescription

The Transfer Out function is used to transfer the ownership of a prescription from your pharmacy to another pharmacy. When an EHR prescription is transferred, the corresponding DIS message is transmitted to NLPN.

The Transfer Out **must** be completed as soon as possible by the transferring pharmacy. Failing to do so prevents the receiving pharmacy from successfully downloading and dispensing the EHR prescription(s).

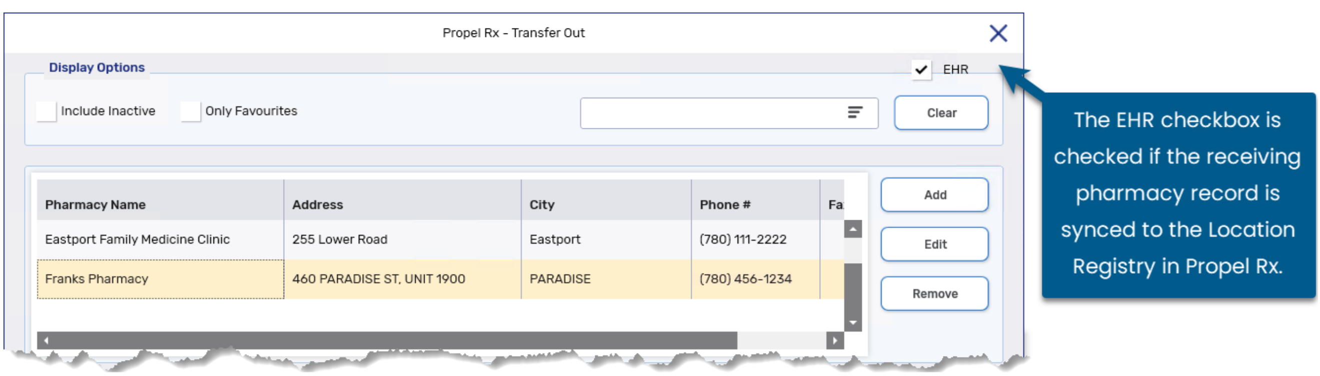
You cannot transfer a prescription if it has not completed Workflow. If a prescription is Waiting for Pick Up/Delivery, a warning appears asking if you want to continue with the transfer.



To transfer out a prescription:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Highlight the prescription(s).
4. Select **Rx** > **Transfer**. The Audit History for the first prescription appears. This can be used to provide the other pharmacy with information about the prescription.
5. Select **OK**. The Transfer Out window opens.
6. Select the receiving pharmacy.

   NOTE: If the pharmacy is not in the dropdown list, select **Add** to open the Other Pharmacy window to add a new pharmacy (refer to Other Pharmacy for more information). If the pharmacy is missing the Provincial Pharmacy ID, select **Edit** to add it from the Other Pharmacy window.



7. Complete the remaining Transfer Out fields as usual.
8. Select **OK**. The Transfer Report window opens.
9. Select the **Fax** and/or **Print** checkboxes.
10. Select **OK**. The Prescription Transfer Report is faxed and/or prints.

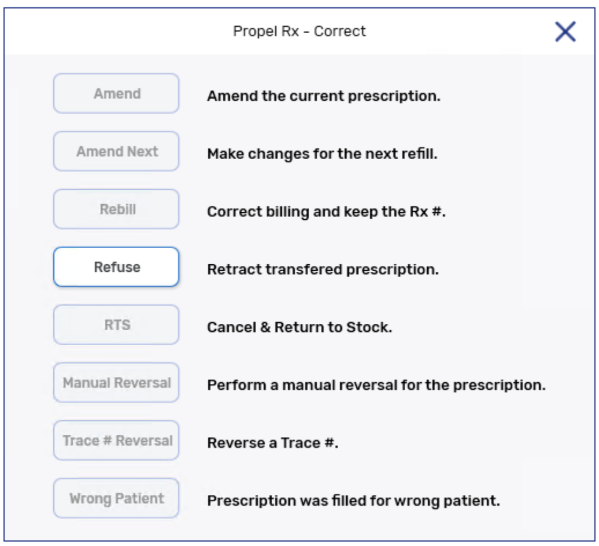
A processing transfer message displays and closes upon successful completion of the Transfer message to the EHR. The prescription is marked as **Transferred** (**TRN**) on the Patient Profile in Propel Rx.

Cancelling a Transfer Out

If a prescription was transferred out in error, the transfer can be cancelled. When this action is performed, the prescription repeats are restored in Propel Rx and a message is sent to the EHR to reassign dispensing authority for the prescription back to your pharmacy.

To cancel a transfer out:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Highlight the transferred out prescription.
4. Select **Correct**. The Correct window opens.



5. Select **Refuse**. The Refuse Prescription window opens.
6. Select **Yes**. The following occurs:
    - The status of the prescription is updated locally from Transferred (TRN) to the previous status prior to the transfer.
    - The repeats are restored on the prescription.
    - The dispensing authority for the prescription on the EHR is reassigned to your pharmacy.

DUR (Other Medication)

DURs (Other Medications) are non-prescription medications, such as over the counter drugs, natural health products, prescriber drug samples, etc.

Adding a DUR to the EHR

For DUR purposes, the Pharmacy Network requires that non-prescription medications are added to a patient's EHR Profile. In Propel Rx, this is accomplished using the **Add DUR** and **Refill DUR** functions.

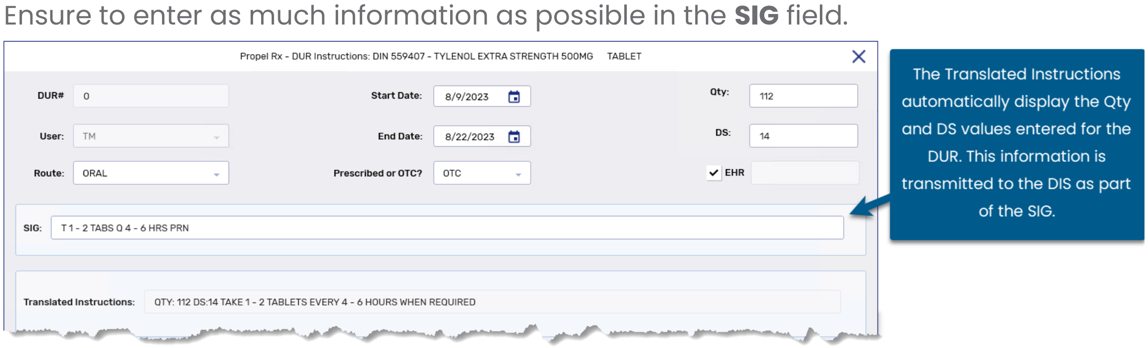
ALERT: As per NLPB Standards of Practice, acetaminophen with codeine is recorded on the Patient Profile as a prescription with the pharmacist as the prescriber.

To add a DUR to the EHR:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select **Rx** > **Add DUR**. The Drug and Mixture Search window opens.
4. Enter the desired search criteria and then select the appropriate drug. Interaction checking occurs. Either the Interaction Summary window opens or a prompt indicates that no interactions exist.
5. Depending on which window appears, select **Accept** or **OK**. The DUR Instructions window opens.
6. Depending on the EHR Type in the Drug or Mixture Folder, the **EHR** checkbox may be selected. If you do not want the DUR transmitted to the EHR, deselect the **EHR** checkbox.
7. Select the appropriate **Route** if it's not already specified.

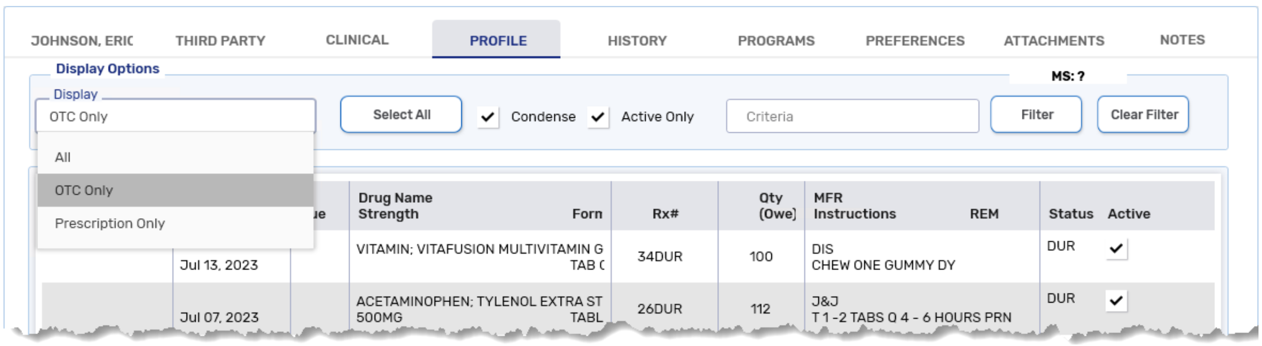
   NOTE: The Route of administration is required. Propel Rx populates the route based on the route information in the Drug or Mixture Folder.

8. Enter the **Start** and **End Date**.
9. Specify whether the medication was prescribed or OTC.
10. Enter the **Quantity** and **Days Supply**. These values are automatically added to the translated instructions which are sent to the EHR.
11. Ensure to enter as much information as possible in the **SIG** field.



12. To add notes to the DUR, select the **Add** button in the **Notes** section.
    a. Enter the information for the note in the textbox.
    b. Ensure the **EHR** checkbox in the Notes section is selected if you wish to transmit the note to the EHR.
13. Select **OK**. The DUR is added to the Patient Profile and transmitted to the EHR if the EHR checkbox was flagged ON.

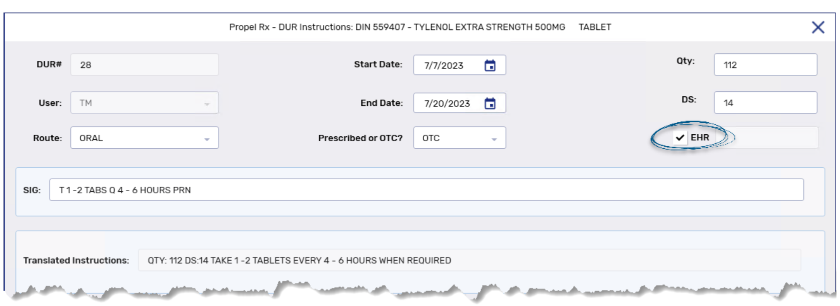
TIP: To filter for Other Medications on the Patient Profile in Propel Rx, dropdown the **Display** field and select **OTC Only**. Refer to Overview of the EHR - Other Medication Details Window to see how the Other Medication record appears on the EHR.



Adding an Existing DUR to the EHR

To add an existing DUR to the EHR:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the DUR.
4. Select **Detail**. The DUR Instructions window opens.
5. Select the **EHR** checkbox.



6. Select **OK**.

A processing message appears for the transmission of the DUR to the EHR.

Updating a DUR on the EHR

If a DUR is found locally, you can transmit updates for certain fields (e.g., Start/End Date, adding a note) to the EHR.

To update a DUR on the EHR:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the DUR.
4. Select **Detail**. The DUR Instructions window opens.
5. Enter or modify any necessary information in the window.
6. To add notes to the DUR, select the **Add** button in the **Notes** section.
   a. Enter information in the Notes textbox.
   b. Select the **EHR** checkbox if you want to transmit the note to the EHR.
7. Select **OK**.

A processing message appears for the transmission of the update to the EHR.

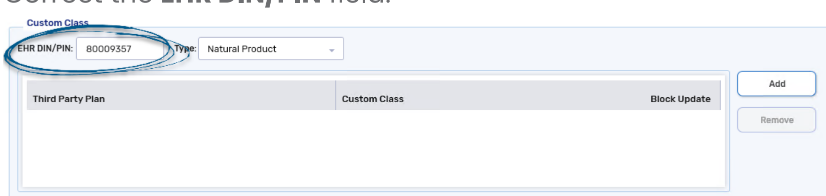
Resolving a DUR with an Invalid DIN

In the scenario where a DUR has an invalid DIN, the claim is rejected by the DIS and the DUR is saved locally for you to correct the drug and resubmit to the patient's EHR Profile. The following Detected Issue is also returned:

Priority	Severity	Issue Type	Description
Error		The specified element did not pass business-rule validation	An invalid drug code was submitted: 00980706 (701402)

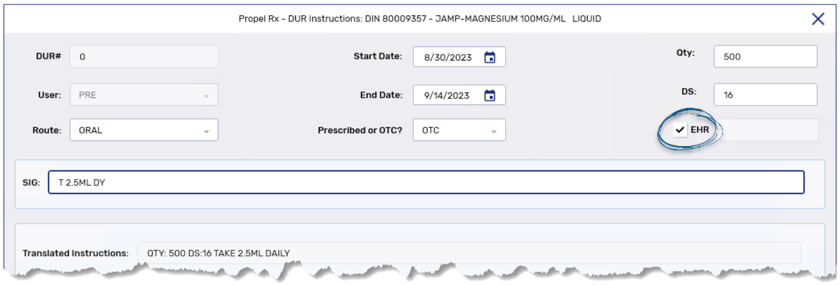
To resolve this Detected Issue:

1. When the Detected Issue is received, select **Cancel** to exit the window. The DUR is saved locally on the patient's Profile in Propel Rx.
2. Open the **Drug Folder** for the DIN you submitted above.
3. Select the **Alternative** tab.
4. Correct the **EHR DIN/PIN** field.



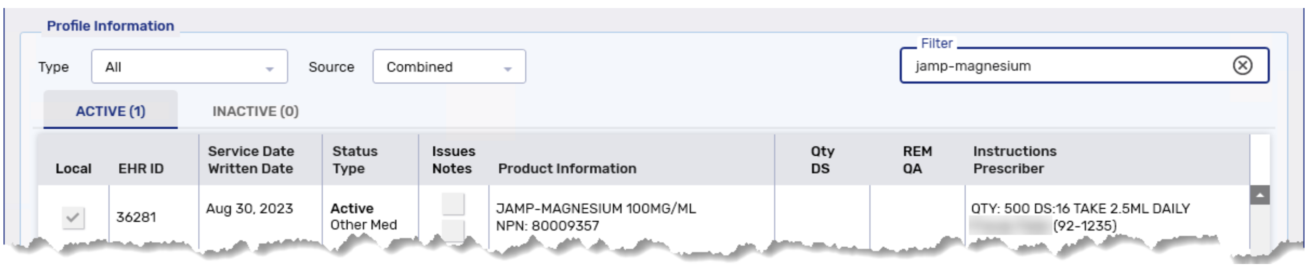
5. Select **Save**.

6. Open the **Patient Folder**.
7. Select the **Profile** tab.
8. Select the DUR.
9. Select **Detail**. The DUR Instructions window opens.
10. Select the **EHR** checkbox.



11. Select **OK**.

A processing message appears for the transmission of the DUR to the EHR. The patient's EHR Profile is updated with the DUR as shown below.

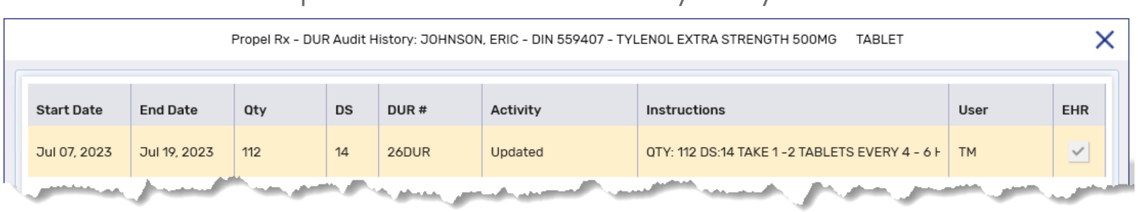


Retracting a DUR from the EHR

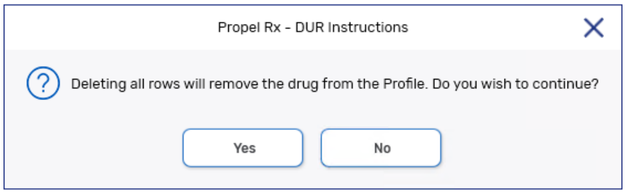
If a DUR was transmitted to the EHR in error, you may retract it from the EHR.

To retract a DUR from the EHR:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the DUR.
4. Select **Rx** > **Audit History**. The DUR Audit History window opens.
5. Select one or more dispenses from the Audit History that you want to retract.



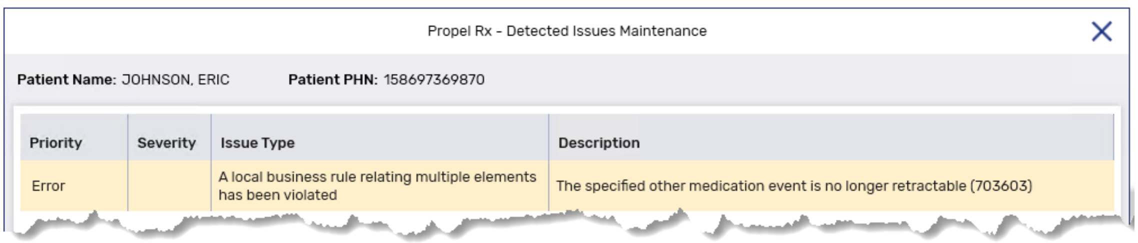
6. Select **Remove**. A prompt appears asking if you want to continue.



7. Select **Yes**.

A processing message appears indicating the information is being retracted from the EHR.

- If the retraction was successful, the DUR is removed from the Patient Profile and the EHR.
- If a Detected Issue was returned indicating the event is no longer retractable, the DUR is not removed from the EHR nor the Patient Profile in Propel Rx. You can add a note to convey additional information about the DUR if needed. For more information, see Updating a DUR on the EHR. You can also change the status of the DUR to Inactive. For more information, see Changing the status of a DUR to Inactive.

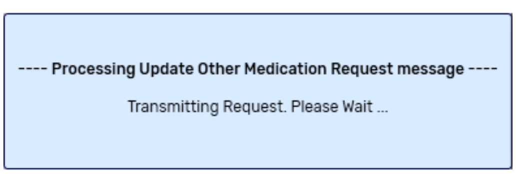


Changing the Status of a DUR to Inactive

If a patient is no longer taking a DUR, you can change the status of the DUR to **Inactive**. This changes the status of the DUR to Inactive in Propel Rx and Completed on the EHR.

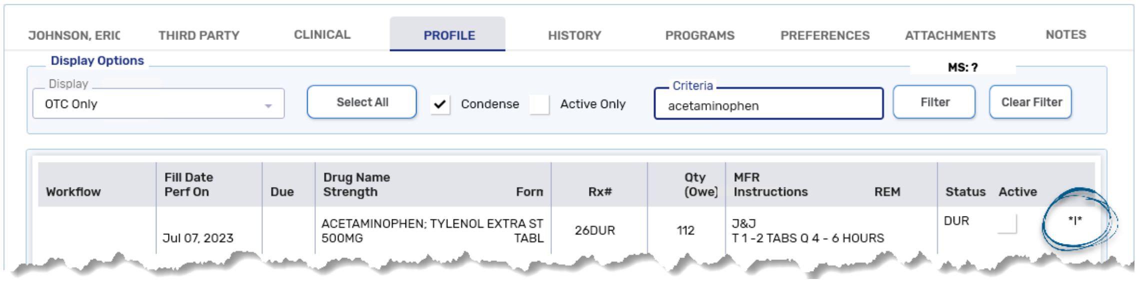
To change the status of a DUR to Inactive:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Deselect the **Active** checkbox for the DUR you wish to inactivate. The following message appears.

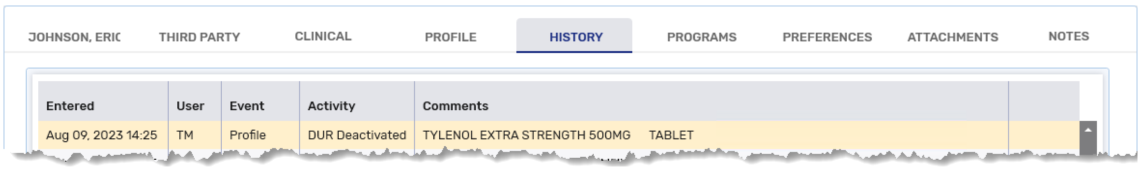


4. Once the message disappears, select **Save**.

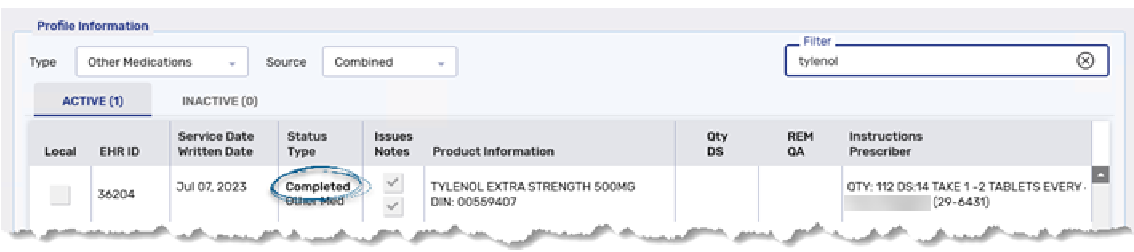
The DUR is inactivated and has an ***I*** indicator displayed beside it on the Patient Profile in Propel Rx.



The Patient Folder History tab also displays an Activity indicating the DUR was inactivated.



On the EHR Profile, the DUR can be found under the Active tab with a Completed status.



Batch Processing

Batching allows prescriptions to be dispensed as a group and processed without direct user intervention. Batching can be performed for Compliance Pack and any regular retail and/or non-retail prescriptions.

As DIS does not accept password caching, batches must be run during the day. If a batch is scheduled to run overnight, the prescriptions will fail to send to the EHR.

ALERT: During batch processing, the EHR Profile mandatory display may be ignored, but all messages returned by the EHR are retained within Propel Rx and the pharmacist can review the Detected Issues in a stand-alone Patient Profile transaction.

Batch functionality performs all current Propel Rx functionality including the following:

EHR Profile display is not required for batch prescriptions.	EHR Profile Preferences from More (...) > Pharmacy > Rx Detail are not applicable for batched prescriptions. The EHR Profile can be viewed manually by highlighting one or more prescriptions in the Batch Profile window and selecting **Profile**.
Detected Issues can be viewed from a completed Batch Profile.	All Detected Issues are saved within Propel Rx, allowing you to go back to the Batch ID at any time to view the issues. If Detected Issues are returned for a prescription, a Detected Issue indicator appears on the prescription row in the Batch Profile window. Select the folder button to view the Detected Issues. Only **Error** Detected Issues can be managed. All **Warning** and **Information** Detected Issues are for informational purposes only. Please review this information and use your professional judgement to correct them. A rebill or cancellation may be required.
A Rejected, Pending, or Failed CeRx is treated in the same manner in the Batch Profile window as a rejected CPhA transaction is handled in current functionality.	The claim is displayed in the Batch Profile window as **Incomplete** or **Pending** if the transaction was not successful. You must Detail the transaction from the Batch Profile, correct the prescription, and then select **OK**. It would be best to open the prescription in Rx Detail and view the EHR tab to determine what evaluation is needed. Once all corrections have been made, highlight the Incomplete/Pending prescriptions from the Batch Profile and then select **Submit**.

Non-Synchronized Patients

All patients must be synchronized before any DIS messages can be transmitted.

To synchronize a patient from the Batch Profile window, do one of the following:

- *Recommended*: Detail the prescription and synchronize the patient from the Patient Folder.
- Remove the prescription from the batch, synchronize the patient, and reschedule the batch.
- Synchronize the patient and resubmit the prescription within the batch.

Detected Issues

Any Detected Issues returned with the DIS Prescription message are visible from the Detected Issue(s) folder within the Batch Profile window. Refer to Detected Issues and Issue Management for more information on how to manage Detected Issues. While any user can view Detected Issues, only a Pharmacist user can manage them. The Issue Management portion of the Detected Issues window is only visible to Pharmacist users. A Pharmacy Technician only has access to the OK and Cancel buttons which close the Detected Issues window.

To view the Detected Issues from the Batch Profile window:

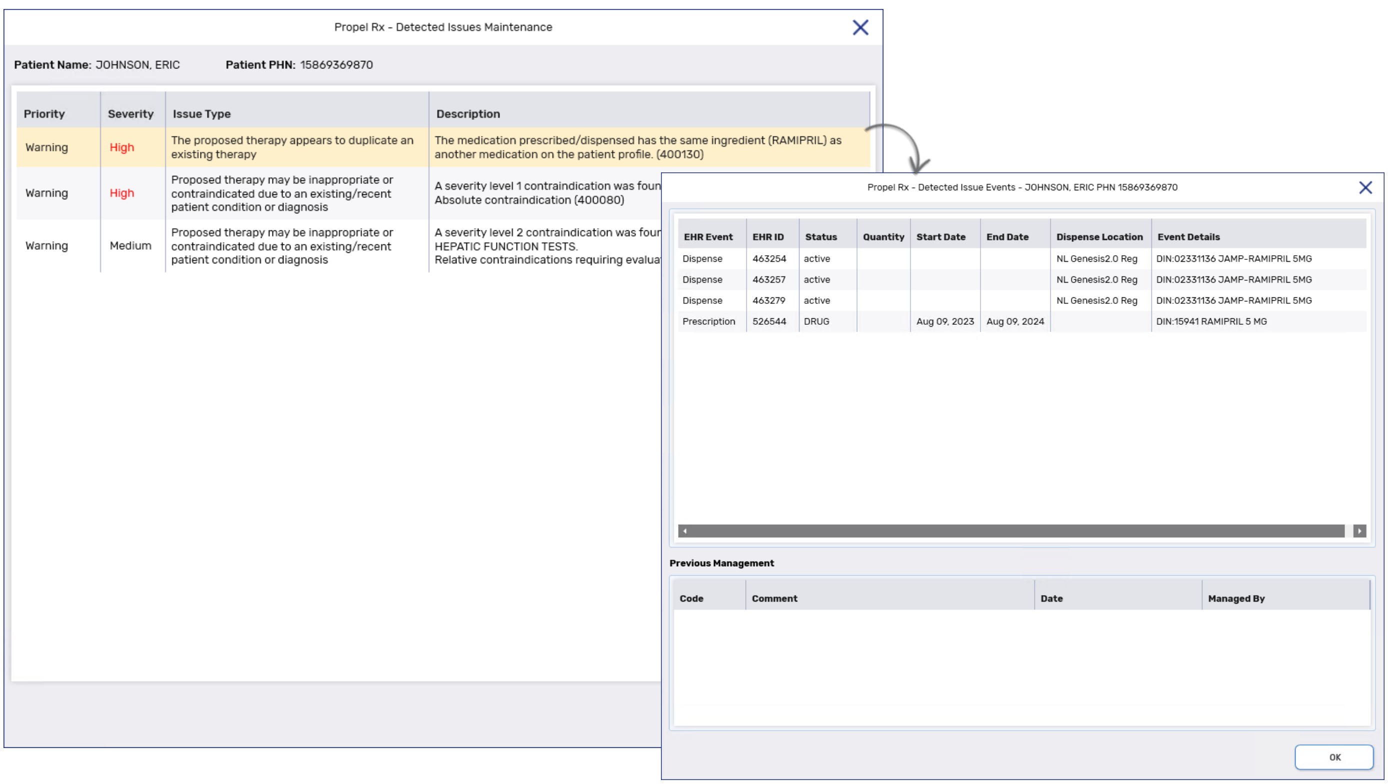
1. Select the Detected Issue(s) folder button .
2. Select **Cancel** or **OK** to close the Detected Issues window.

Detected Issues and Issue Management

The Drug Utilization Review (DUR) component of the Pharmacy Network is a rules-based, data driven function that performs up to 22 separate DUR checks against the accumulated medication history of a patient. DUR is performed in the Pharmacy Network when:

- A Prescription request is submitted
- A Dispense request is submitted
- A prescription is reactivated
- A Record Other Medication request is submitted

If DIS detects an issue with a transaction, whether it is an inquiry or the receipt of information, it may return a Detected Issue to alert the user to a potential error, discrepancy, or matters that may be of concern. Detected Issues have an associated **Priority** (Error, Warning, Information) and **Severity**. Detected Issues are sorted by Priority and then by Severity.



When you double-click on a Detected Issue in the Detected Issues Maintenance window, additional information is displayed including the events (e.g., prescriptions, allergies) which caused the Detected Issue, as well as any previous Issue Managements that were recorded.

Viewing Detected Issues

If a Detected Issue is returned with a message response, Propel Rx displays the details within the Detected Issues window. This allows you to view and manage issues on an ongoing basis, clear any outstanding issues, as well as be notified of potential problems.

The Issue Type and Description of these Detected Issues are generated by NLPN. The following chart displays the various Detected Issue priorities that your pharmacy may encounter:

Priority	Description
Error	The request could not be processed successfully and has been rejected because of a problem. The message requires immediate action to continue. Errors always display before Warnings and Information. There are two types of Errors: • Rejected with <u>no ability</u> to add an Issue Management (e.g., the ID specified for the prescriber is not valid). • Rejected with <u>ability</u> to add an Issue Management (e.g., submitted dispense has the same ingredient as an existing active prescription on the Pharmacy Network).
Warning	The request was successfully processed and transmitted to the EHR, but it was processed differently than the requester had asked, or an anomaly was encountered of which the requester should be aware. The message does not require immediate action to continue (e.g., drug is known to interact with another active drug). You may add an Issue Management, but it is not required.
Information	The request was successfully processed and there were no issues. However, a piece of information is being returned that may be of interest. The message does not require immediate action to continue (e.g., fill too soon). You may add an Issue Management, but it is not required.

Once a Detected Issue has been reviewed or managed, it can be viewed again later. To view a Detected Issue later:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the prescription you want to view Detected Issues for.
4. Select **Detail**. The prescription opens in Rx Detail.
5. Select the **EHR** tab.
6. In the applicable **Create**, **Dispense**, and/or **Pickup** sections, select the expander button beside the Detected Issue(s) field to view the Detected Issues. The Detected Issues Maintenance window opens.

7. Double-click on the row. The Detected Issue Events window opens displaying additional information about the Detected Issue.

Managing Detected Issues

Pharmacy staff are alerted of any Detected Issues that may arise from activating and dispensing prescriptions. It may be necessary to manage the issue to advise and communicate to the EHR that some mitigating actions were taken. While any authorized pharmacy user can view Detected Issues, **only a Pharmacist user can manage Detected Issues**. For non-Pharmacist users, the Issue Management section of the Detected Issues window is not visible.

When a Detected Issue window appears without an **Issue Management** section for a Pharmacist user, then the Detected Issues are only displayed for informational purposes. Usually, this is a result of an EHR Query. In some cases, Detected Issues are presented but do not require Issue Management.

NOTE: When managing Detected Issues from the EHR Queue for a masked patient, you must access the patient's EHR consent and enter consent or override to manage the issue and resubmit the transaction to the EHR.

Managing a Detected Issue from the Detected Issues Window

To manage a Detected Issue from the Detected Issues window, do the following:

- If the Issue <u>cannot</u> be managed (e.g., DIN is invalid), select **Cancel** and return to Rx Detail to make the correction before submitting again.
- If the Issue <u>does not require</u> management, select **OK**. Propel Rx continues processing the transaction. You may add an Issue Management later if you wish by following the steps in [Managing a Detected Issue for an Accepted Dispense](#).
- If the Issue <u>requires management</u>, select **Add** from the Issue Management section. An Issue Management row is added.
    a. Use your professional judgement to select an appropriate Issue Management code from the dropdown list.

    b. *Optional*: To document additional comments about the Issue Management, enter text in the **Comment** field.
    c. Select **OK** to retransmit the DIS message with the Issue Management.

Once a Detected Issue has been reviewed or managed, it may be viewed again later. For more information, see Viewing Detected Issues.

Managing a Detected Issue for an Accepted Dispense

The DIS may accept a Dispense message but return a Detected Issue for informational purposes. Although it is not necessary, your pharmacy can still add an Issue Management to the prescription.

To manage a Detected Issue for a dispense that was accepted by the EHR:

1. Ensure a Pharmacist user is logged into Propel Rx.
2. Open the prescription in **Rx Detail**.
3. Select the **EHR** tab. The Dispense section indicates the prescription was accepted.

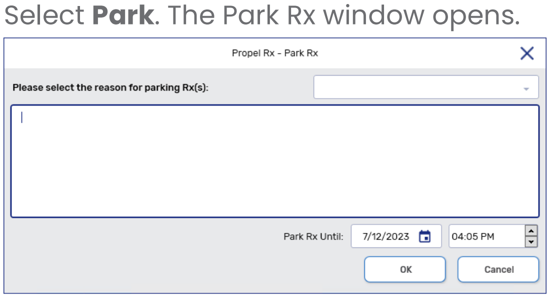
4. Select the expander button beside the Detected Issue(s) field.
5. Select **Add**.
6. Select an appropriate Issue Management.
7. Select **OK**.

Managing a Detected Issue when a Pharmacy Technician is Logged In

Any authorized pharmacy user can view the Detected Issues returned for a prescription, however only a Pharmacist user can manage the Detected Issues. If a prescription is rejected and can be resolved by adding an Issue Management, you must log off as the Pharmacy Technician user and log back in as the Pharmacist user to manage it.

To manage a Detected Issue when logged in as a Pharmacy Technician user:

1. Exit the Detected Issues Maintenance window.
2. Select **Park**. The Park Rx window opens.



3. Select a reason and enter any necessary comments for parking the prescription.
4. Select **OK**. The prescription is placed on the Parked Rx tile.
5. Log off as the Pharmacy Technician user and log back in as the Pharmacist user in Propel Rx.

6. Select the **Parked Rx** tile.
7. Select the prescription.
8. Select **Process**. The prescription opens in Rx Detail.
9. Select the **EHR** tab.
10. Select the expander button beside the Detected Issue(s) field.
11. Select **Add**.
12. Enter the appropriate Issue Management.
13. Select **OK** to re-submit the prescription to the EHR.

Common Detected Issues

Review the common Detected Issues below for more information on how to manage them.

Prescribing Provider is Not Valid

Cannot add an Issue Management – This error indicates that the **Province #** for the submitted prescriber is incorrect. To resolve this Detected Issue, verify that the provincial ID entered in the **Prescriber Folder Province #** field is correct. Refer to Prescriber Folder for more information. If incorrect, enter the correct provincial ID, and resubmit the prescription to EHR.

Priority	Severity	Issue Type	Description
Error		The specified element did not pass business-rule validation	The ID specified for the Prescribing Provider is not valid. Please verify the provider ID and resubmit. (701504)

Given Event Cannot be Retracted

Cannot add an Issue Management – This error indicates that the record on the patient's EHR Profile cannot be removed. If additional information needs to be conveyed for the record, a note should be entered and transmitted to the patient's EHR Profile.

Priority	Severity	Issue Type	Description
Error		A local business rule relating multiple elements has been violated	The specified adverse reaction event is not retractable (600411)

Prescription Transfers

Cannot add an Issue Management – This error indicates that the transferring pharmacy has not yet completed the transfer process on their dispensary system. In this example, you are requesting to transfer in a prescription, however, the prescription is not yet flagged eligible to be dispensed by your pharmacy (i.e., the prescription has not yet been assigned to your pharmacy). To resolve this Detected Issue, you must contact the transferring pharmacy and request they select your pharmacy as the pharmacy the prescription is transferred to.

Priority	Severity	Issue Type	Description
Error		The specified element did not pass business-rule validation	This prescription is assigned to a different service location (701612)

Potential Duplicate Existing Therapy

Can add an Issue Management – This warning indicates that the medication being dispensed already exists on the patient's EHR Profile. This Detected Issue appears for informational purposes only. If determined that you want to continue with the current (duplicate) prescription, no further action is required, however you can add an Issue Management if you wish from the Rx Detail EHR tab. For more information, see Managing a Detected Issue for an Accepted Dispense.

Priority	Severity	Issue Type	Description
Warning	High	The proposed therapy appears to duplicate an existing therapy	The medication prescribed/dispensed has the same ingredient (ACETAMINOPHEN) as another medication on the patient profile. (400130)

User Specified in Created By is Not Authorized

Cannot add an Issue Management – This error indicates that a user is attempting to submit a message to the EHR (e.g., updating an EHR password, sending a prescription dispense) but cannot as they have an invalid license number entered in the Security window. To resolve this Detected Issue, validate the license number entered for the user in the Security window (More > Security). If incorrect, enter the correct license number and resubmit the transaction.

Priority	Severity	Issue Type	Description
Error		A local business rule relating multiple elements has been violated	NL1523;The user specified in "Created By" is not authorized to work at the location specified in "Created At". - Author's LicenseID: root=2.16.840.1.113883.4.261, extension=29-64311 and LocationID: root=2.16.840.1.113883.4.267, extension=NL.00111.3 - Transaction ID: 050E4500-B0EC-4F2A-B4FC-4D8D8F1EFCDF

Drug is Known to Interact With an Existing or Recent Drug Therapy

Can add an Issue Management – The following warning indicates that the drug being dispensed may interact with another drug the patient is actively taking. This Detected Issue appears for informational purposes only.

After reviewing the prescription and the drugs the patient is currently taking, if you determine the drug is okay for the patient, no further action is required. You can still add an Issue Management if you wish from the Rx Detail EHR tab, but it is not required. For more information, see Managing a Detected Issue for an Accepted Dispense.

Priority	Severity	Issue Type	Description
Warning	Medium	Proposed therapy may interact with an existing or recent drug therapy	A drug to drug interaction was found between SELECTED ANTICOAGULANTS (VIT K ANTAGONISTS)/NSAIDS. INCREASED EFFECT OF THE FORMER DRUG. Severe Interaction: Action is required to reduce the risk of severe adverse interaction. Clinical Effects Code: INF Reference Code: MTCR (400050)

Drug May be Inappropriate or Contraindicated Due to an Existing Condition or Diagnosis

Can add an Issue Management – The following warning appears when the drug being dispensed is not recommended due to an existing condition the patient may have (e.g., medical condition or allergy). This Detected Issue appears for informational purposes only. After reviewing the prescription, if you determine the drug is okay for the patient, no further action is required. You can still add an Issue Management if you wish from the Rx Detail EHR tab, but it is not required. For more information, see Managing a Detected Issue for an Accepted Dispense.

Priority	Severity	Issue Type	Description
Warning	High	Proposed therapy may be inappropriate or contraindicated due to an existing/recent patient condition or diagnosis	A severity level 1 contraindication was found between COUMARIN ANTICOAG./ INCREASED RISK OF BLEEDING DUE TO COAGULATION DISORDER. Absolute contraindication (400080)

Patient Profile is Keyword Protected

Cannot add an Issue Management – The following warning appears when the patient's EHR Profile has been masked. To view the patient's EHR, you must supply a keyword set by the patient, or 'break the glass' (override consent). For more information, see Entering or Overriding Patient Consent.

Priority	Severity	Issue Type	Description
Error		A local business rule relating multiple elements has been violated	An error occurred - error details: Patient profile is keyword protected

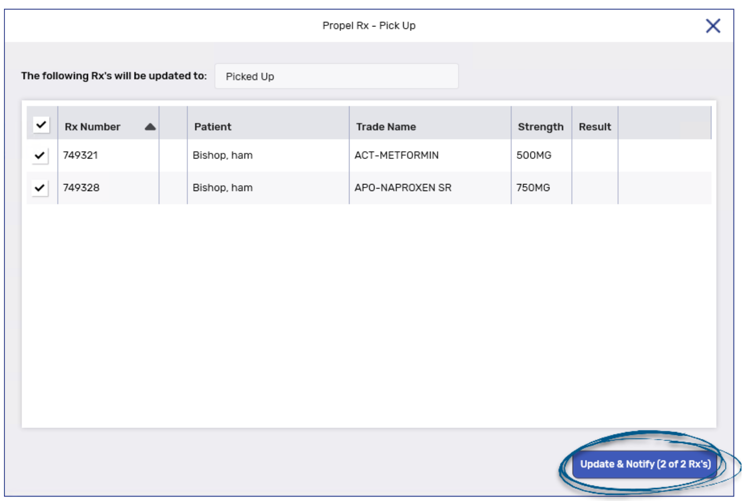
Modifying Workflow Status

A prescription's Workflow status can be modified to Picked Up manually or via POS integration.

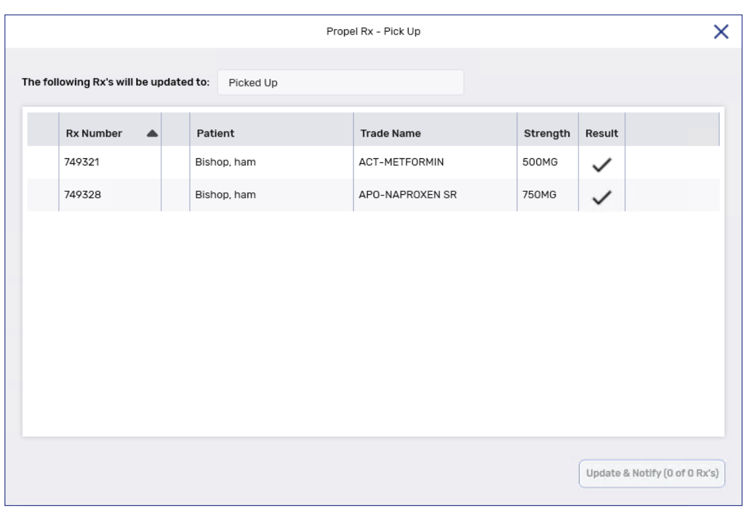
Changing the Pickup Status Manually

To manually modify the prescription Workflow status to Picked Up from the Pick Up/Delivery tile:

1. On the Workbench, select the **Pick Up/Delivery** tile.
2. Select the prescription(s) whose Pickup status you wish to change.
3. Select **Pick Up**. The Pick Up window opens.
4. Select **Update & Notify** to submit the Pick Up messages to the EHR.



Once the Pick Up message has been successfully transmitted to the EHR, the Result column is populated with a checkmark.



Changing the Pickup Status Through POS Integration

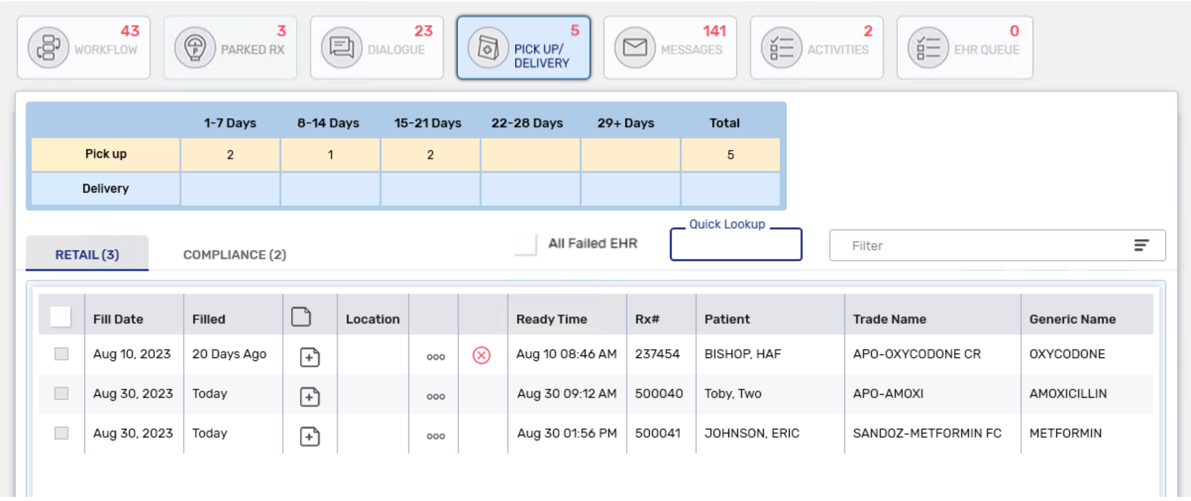
When the **Dispense Pickup** preference is set to POS Integration, the Pickup message is sent upon scanning the prescription at the POS till. Any prescription not scanned remains in the Pick Up/Delivery tile and the Dispense Pickup remains blank on the EHR until the prescription is marked as Picked Up.

Resending a Failed Pickup Message

When a DIS Pickup message fails, the prescription remains in the Pick Up/Delivery tile with a red x icon . By default, Propel Rx displays the last 60 days worth of prescriptions waiting for pick up in the Pick Up/Delivery tile. However, you can select the **All Failed EHR** checkbox to display all prescriptions that failed to be picked up on the EHR regardless of timeframe, in addition to the last 60 days worth of prescriptions waiting for pick up.

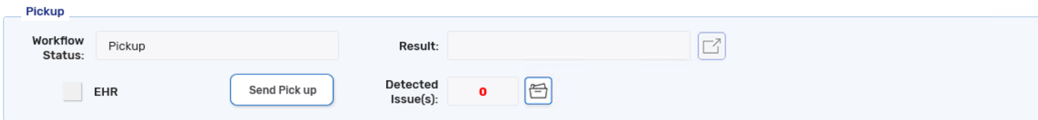
NOTE: The counter on the Pick Up/Delivery tile will always reflect the number of prescriptions waiting for pick up in the last 60 days, regardless if the All Failed EHR checkbox is selected.

It is necessary to review the prescription and attempt to resolve the reason for the failed Pickup to remove the prescription from the Pick Up/Delivery tile.



To resend a failed Pickup message for a prescription:

1. On the Workbench, select the **Pick Up/Delivery** tile.
2. Select the prescription.
3. Select **Detail**. The prescription opens in Rx Detail.
4. Select the **EHR** tab.
5. From the **Pickup** section, review the Detected Issues or failure messages if any.
6. Select **Send Pick Up** in the Pickup section. Propel Rx attempts to send the Pickup message again.



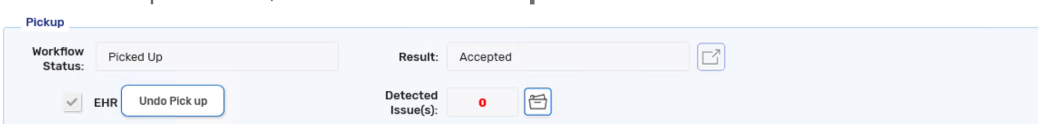
A processing message appears indicating the information is being sent to the EHR. If the Pickup message is successfully transmitted, the Workflow status is updated to Picked Up and the EHR checkbox is selected.

Retracting a Pickup Message

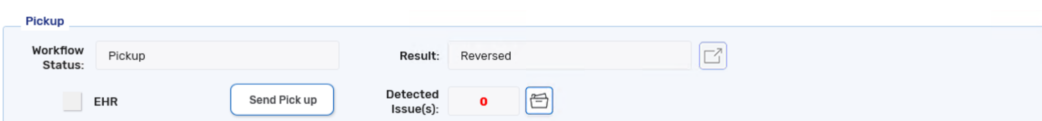
If a Pickup message was sent in error, you can retract the Pickup from the EHR.

To retract a Pickup message:

1. Open the **Patient Folder**.
2. Select the **Profile** tab.
3. Select the prescription.
4. Select **Detail**. The prescription opens in Rx Detail.
5. Select the **EHR** tab.
6. In the Pickup section, select **Undo Pick up**.



A processing message appears indicating the information is being retracted from the EHR. If the retraction is successful, the Workflow status is updated to Pickup and the Result indicates the transaction was Reversed.



Correcting an Issue Management Activity

Activities can be created for scheduled prescription changes (e.g., prescriptions with scheduled stop dates). These changes are automatically transmitted to the NLPN on the effective date. If during transmission, a Detected Issue is encountered, the Activities tile lists these with an Activity of Issue Management. The Comments indicate the patient's name, prescription number, trade name of the drug, strength, and form.

Corrective action must be taken for these Issue Management activities as they may prevent a prescription from being filled successfully.

To manage this type of issue from the Workbench:

1. Select the **Activities** tile.
2. Select any row with an **Issue Management** Activity.
3. Select **Complete**. A Detected Issues window opens displaying details of what stopped the message.
4. Depending on the Priority and Severity of the issue, you will need to make the appropriate changes to the prescription on the patient's Profile. For more information, see Managing Detected Issues.
5. Select **OK**. The status of the Activity changes to Complete.

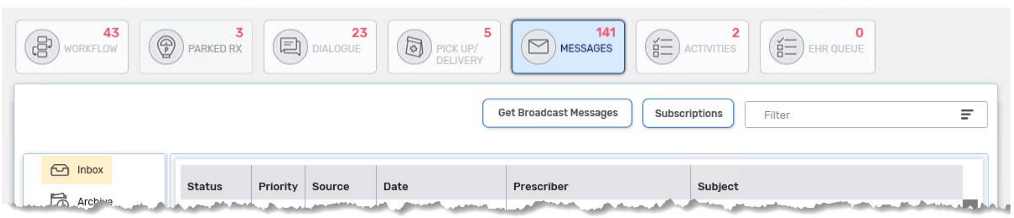
Messages Tile

The Messages tile allows you to receive important electronic communications such as drug recalls, program updates, and formulary information. The Inbox is used to instantly communicate important Propel Rx notices. The Broadcast Messages window is used to communicate NLPN messages.

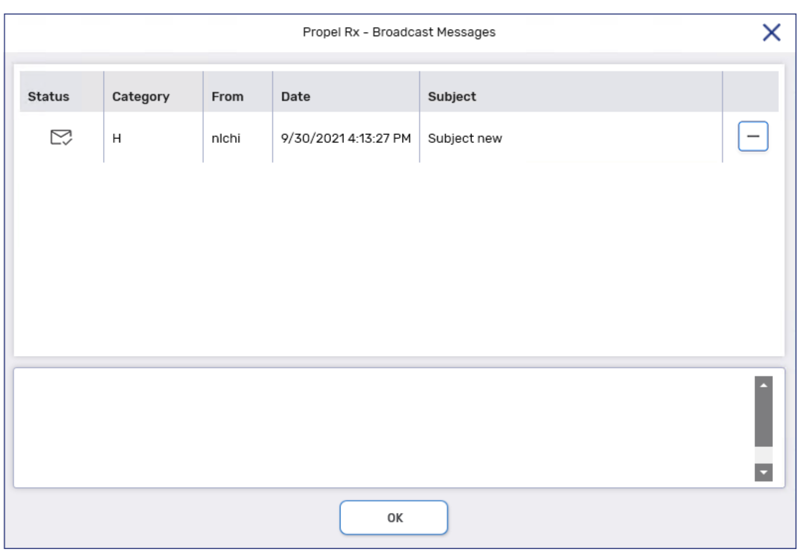
Broadcast Messages Window

To view broadcast messages:

1. Select the **Messages** tile on the Workbench.
2. Select **Get Broadcast Messages**.



   Propel Rx checks if there are any broadcast messages to view for the logged in user and displays a prompt indicating if there are any new messages in the queue.
3. Select **OK** to the prompt. The Broadcast Messages window opens. The window is split into two sections:
   - The top view contains the list of messages. Unread messages are displayed in bold. Once a message is read, you can delete it by selecting the minus button.
   - The bottom view displays a preview of the message. When a single message is selected, the detailed message text appears in this section. If multiple messages are selected, no detailed message text appears in this section.

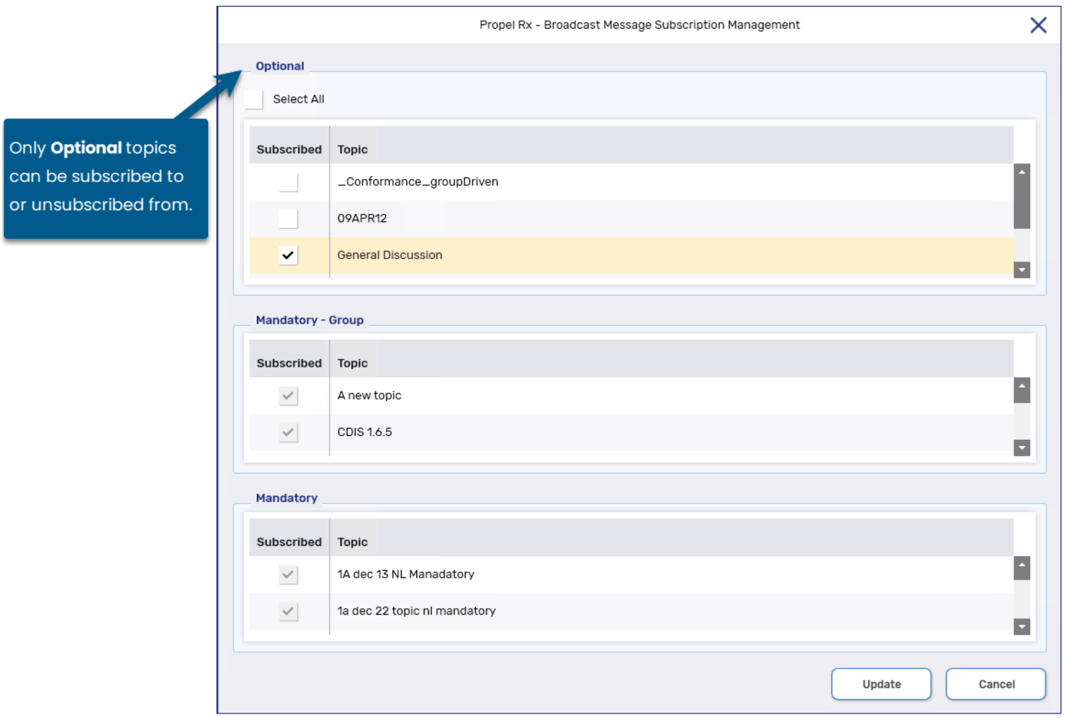


Subscriptions

The Subscriptions button on the Messages tile returns a list of broadcast message topics you are currently subscribed to and allows you to manage which broadcast messages you wish to receive. The Subscriptions request is initiated for the logged in user.

To view and manage your broadcast message subscriptions:

1. Select the **Messages** tile on the Workbench.
2. Select **Subscriptions**. The Broadcast Message Subscription Management window opens.
3. Subscribed topics are indicated with a checkmark. To change the subscription status of an Optional topic, select the **Subscribed** checkbox.



4. Select **Update**.

ALERT: If the network is down, subscription update requests are not added to the EHR Queue. If you need to update your subscriptions, do so once the network is back up.

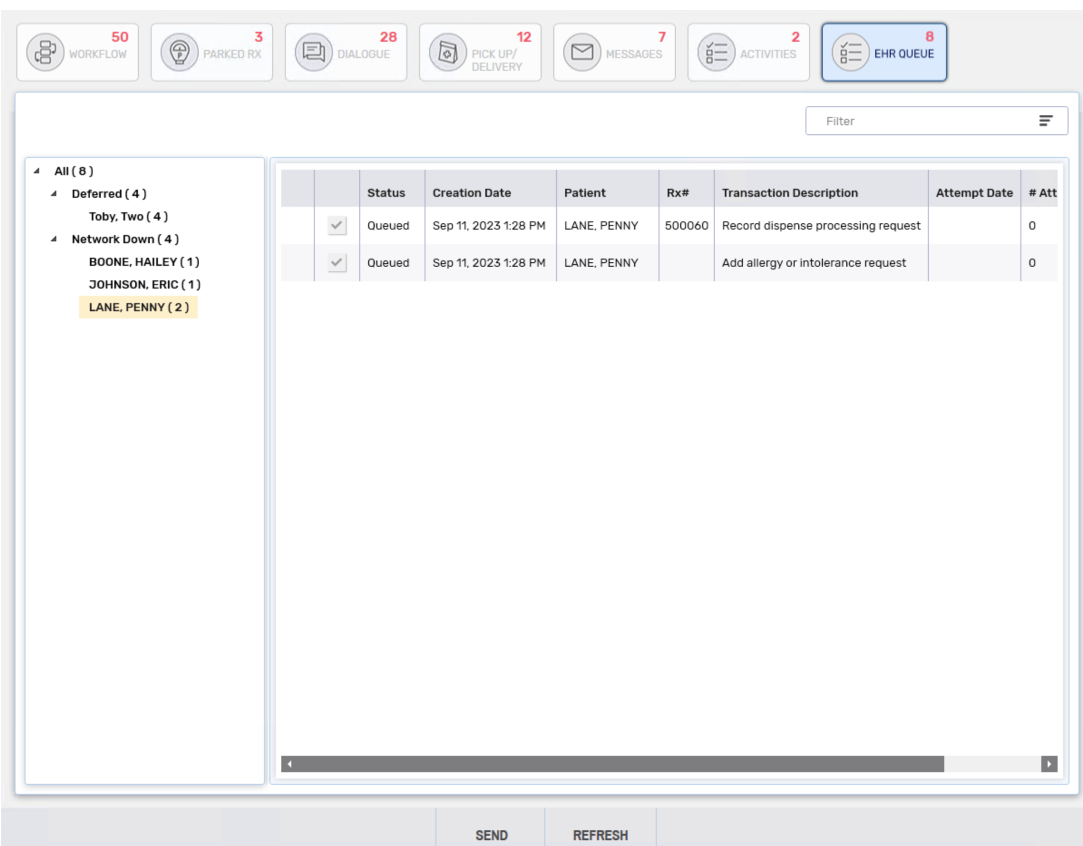
EHR Queue Tile

The purpose of an EHR Queue is to allow you to continue to service your patients and process prescriptions even if the EHR is temporarily unavailable. This tile manages any transactions (e.g., prescription, pickup, clinical requests) that could not be processed due to EHR Network unavailability.

One of the main advantages of the EHR Queue is there is no interruption of service to your patients when the EHR is unavailable. Prescriptions are successfully adjudicated, and a label set with correct pricing information is printed.

ALERT: Each pharmacy is responsible for ensuring that any failed or rejected EHR Queue transactions are resolved each day.

When NLPN is down, claims are queued in order of creation. If a patient has any EHR Queued transactions, then all subsequent transactions are queued and processed in order. No new claims for a particular patient can be sent to NLPN until all queued claims for that patient have been sent. A prior queued claim may have an impact on the results of another claim that is sent down (e.g., an Allergy Add request must be sent before more dispenses are sent because that may affect the outcomes of DUR processing for those subsequent dispenses).



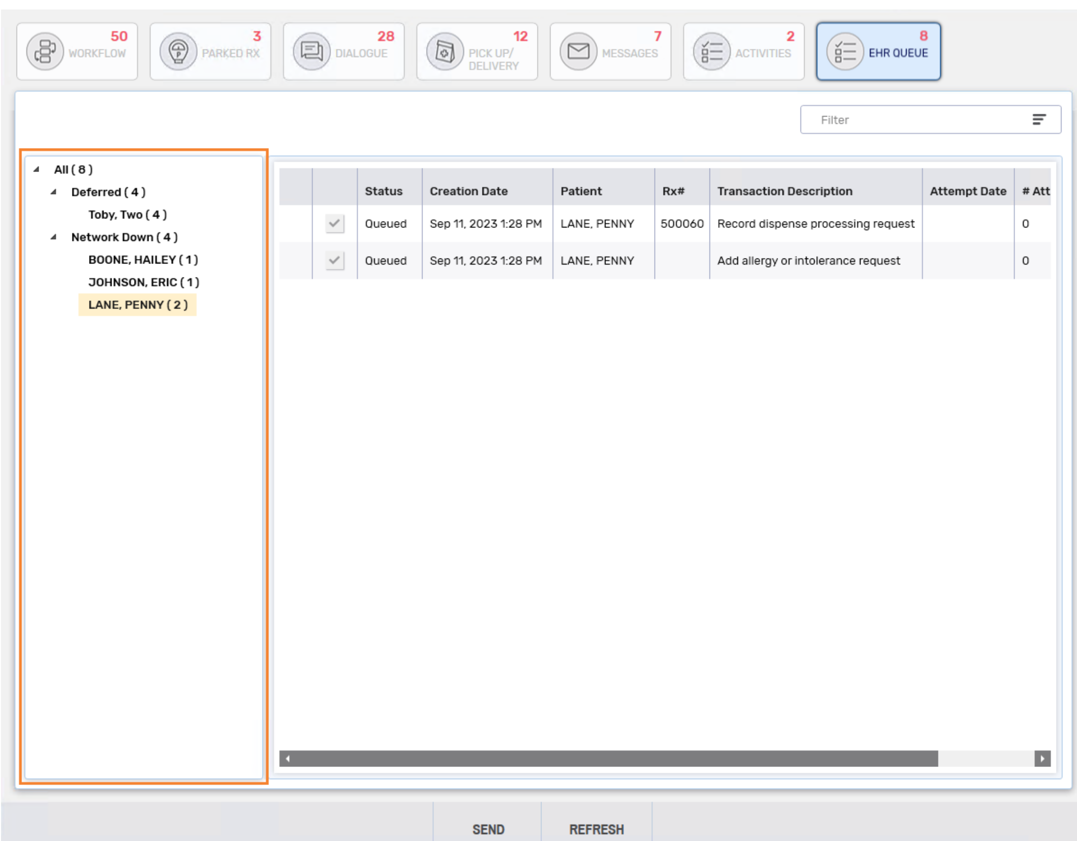
The EHR Queue tile displays a counter which indicates how many transactions reside in the EHR Queue. Within the tile, there are two sections: a transaction summary tree view and a detailed view of the queued transactions. The background colour of the text changes to yellow when the focus has been placed on that view.

Transaction Summary View

The Transaction Summary tree view is the left section of the EHR Queue tile. This view lists all EHR Queue transactions which can be expanded or collapsed to view the following:

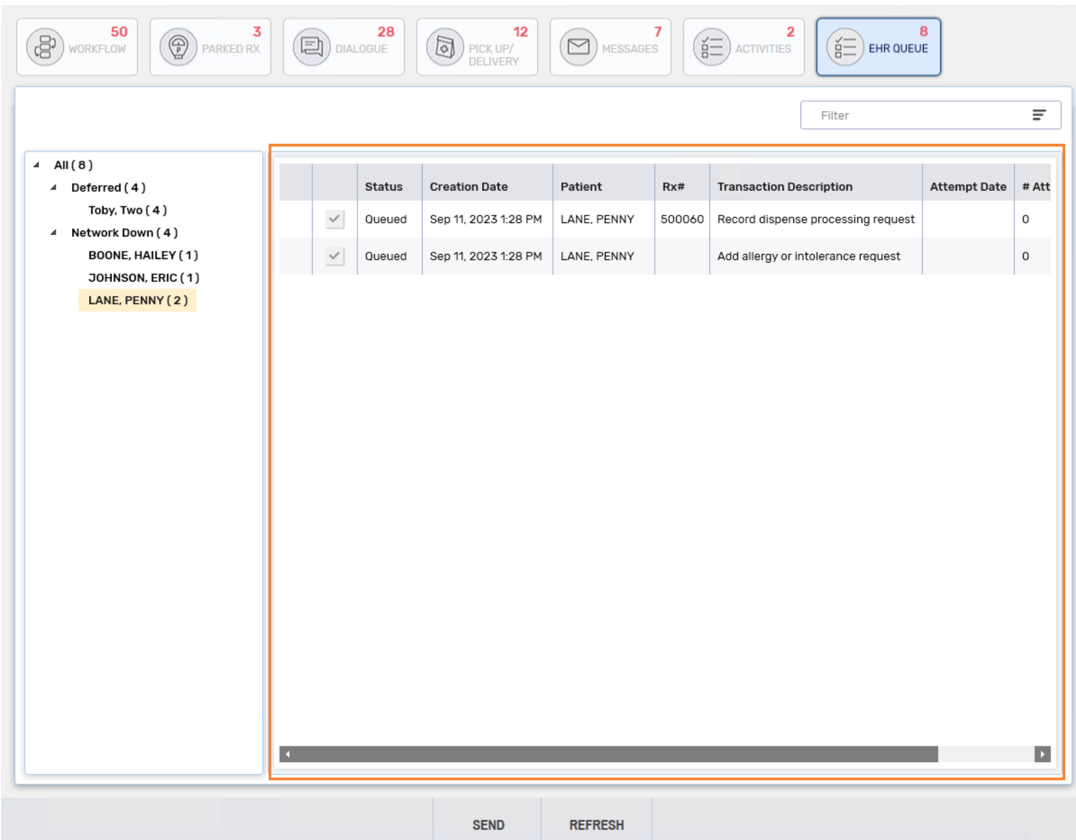
- **All transactions** – displays all transactions in the EHR Queue. This is a read-only view. To action a transaction, a queue type (i.e., Deferred, Network Down) or patient must be selected.
- **Deferred** – displays all transactions that were deferred for EHR submission.
- **Network Down** – displays all transactions that were added to the EHR Queue due to the EHR network being unavailable/unreachable.
- **Patient** – displays all transactions for the patient in the EHR Queue that were either Deferred or added due to a Network Down scenario.

Transactions are organized by creation date in ascending order. A counter beside each row indicates the number of transactions for that type or patient.



Detailed Transactions View

The Detailed Transactions view is the section to the right of the EHR Queue tile. The Detailed Transactions view lists all the EHR transactions that have been queued for a selected patient or queue type. Each row represents a detailed view for each transaction.



Refer to the table below for a description of each column in the Detailed Transactions grid.

Column	Description
Issues/Errors	A folder button allows you to view the details of the issue or error when a transaction has a status of Failed or Rejected. • Selecting this button displays the Detected Issues Maintenance window for Rejected transactions or a message prompt for Failed transactions. • If the Patient Folder is not synced, the folder button is outlined in red. When selected, it opens the Patient Folder for you to sync the patient. No transactions can be sent for a patient until they are synced.
Checkbox	The checkbox indicates which transactions are selected for sending.

	- If multiple transactions are associated with a prescription (e.g., Activate, Dispense, Pickup), upon selecting the checkbox for one transaction, the other transactions are automatically selected. Similarly, if the checkbox is deselected for a transaction, all associated transactions are also deselected. - For Deferred prescriptions, the checkboxes are defaulted OFF and editable. For Network Down transactions, the checkboxes are ON and disabled. This is a safeguard to prevent transactions from being sent to the EHR in the wrong order.
Status	The current transmission status of the EHR Queued transaction. ***Queued*** – Message is waiting to be sent. ***Started*** – Message is currently being sent. ***Rejected*** – Message is rejected by the EHR with Detected Issues. You must attempt to manage the Issue(s). ***Failed (Network still down)*** – Message transmitted unsuccessfully after a predefined number of attempts. ***Not Sync*** – Patient is not synchronized with the Client Registry. ***Deferred*** – Message was deferred and has not yet been sent.
Creation Date	The date and time that the EHR Queued transaction was originally created.
Patient	The name of the patient with EHR Queued transactions.
Rx #	The prescription number for the transaction.
Transaction Description	The EHR Queued transaction description.
Attempt Date	The actual date and time that the transaction was submitted.
# Attempts	When the EHR Queued transaction is submitted, a counter keeps track of the total number of attempts and the current attempt number.
Initials	Each EHR Queued transaction has a user associated with it. This is the actual user that created the EHR transaction.

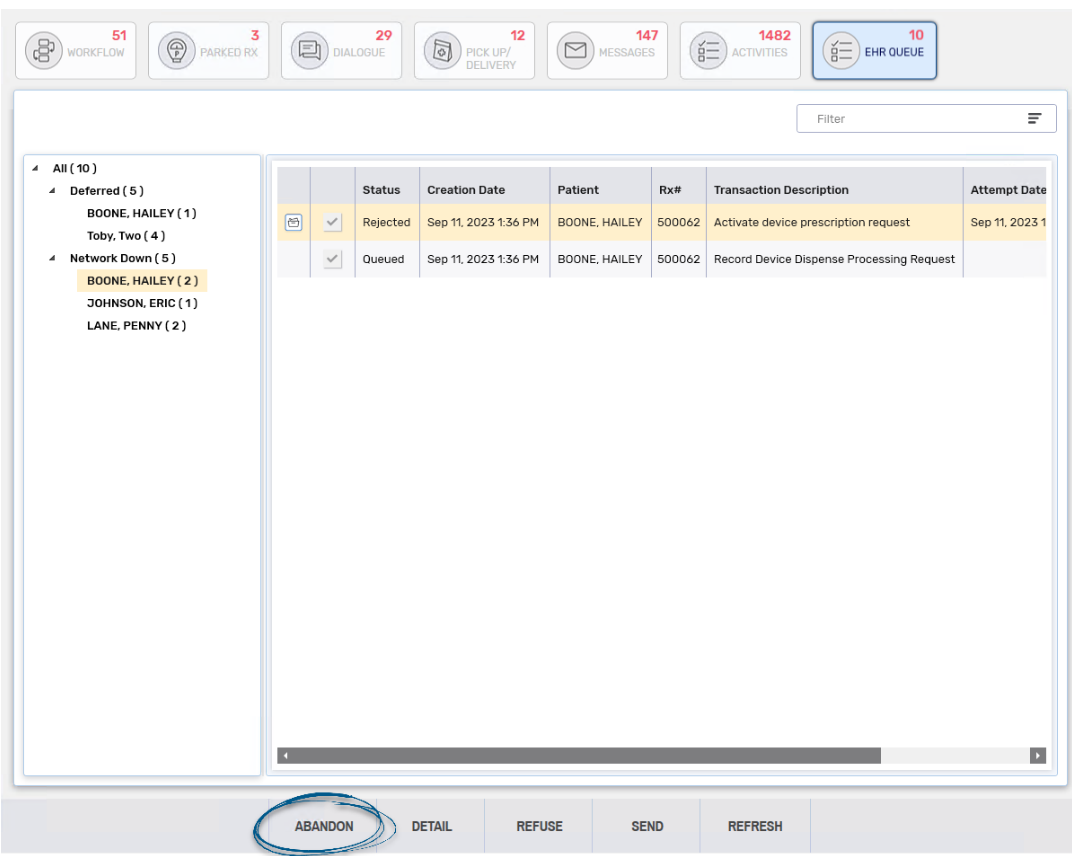
EHR Queue Buttons/Fields

Button	Description
Send	Sends the selected transactions to the EHR. • The Send button is enabled if the selected row(s) have an EHR Queue status of Rejected, Failed, Queued, or Deferred. The button is hidden for all other statuses. • Selecting Send transitions the status of the first EHR Queued transaction to Queued for the checkmarked transactions for the patient or queue type. Transactions are sent in order by creation date. For the Network Down queue, all transactions are automatically and must be selected for sending. • The # Attempts counter is reset. After 5 failed attempts, a prompt appears indicating the number of transactions that have been cancelled, rejected, or abandoned. These transactions remain in the EHR Queue. • If a Detected Issue is returned for a transaction, it must be managed and sent successfully before the next selected transaction is sent. Similarly, if the network is still down when a transaction is sent, a prompt indicates this, and the remaining selected transactions are not sent. • A prompt indicates how many transactions were successfully sent.
Filter	Allows you to enter a description to filter for specific transactions.
Refresh	Refreshes the EHR Queue view.
Detail	Opens Rx Detail as read-only. No changes can be made from this view. • Activate, Dispense, Pickup, or Refusal to Fill transactions can be detailed. • If changes must be made, open the applicable folder (e.g., Patient, Prescriber, Drug) to make the necessary changes.
Refuse	Refuses the prescription. This can be an Activate, Dispense, or Refusal to Fill transaction. • For Ward Stock dispenses, refusals are local only as they cannot be retracted from the EHR. • Once the dispense has been transmitted, the retraction is sent. • The order that transactions are sent are based on the creation date and the timestamp. If one transaction fails, downstream associated transactions are not sent.
Abandon	Allows you to remove a transaction from the EHR Queue. This button should only be used if every option has been exhausted to correct the prescription.

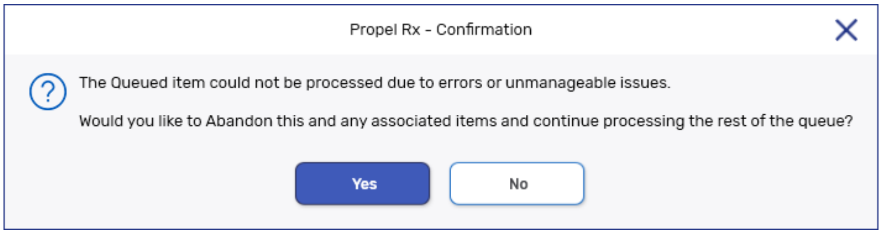
	• The Abandon button is enabled if the selected transaction has an EHR Queue status of Failed or Rejected. • If a Detected Issue is returned that is not manageable, a prompt appears upon sending the transaction which provides the option to abandon the transaction. • A reason must be entered for abandoning a transaction. This is recorded in the Patient Folder History tab. • Any associated transactions (e.g., Pickup, Reversal, Undo) are also abandoned. • If a prescription must be abandoned, ensure the prescription is refused and resubmitted.

Abandon Button

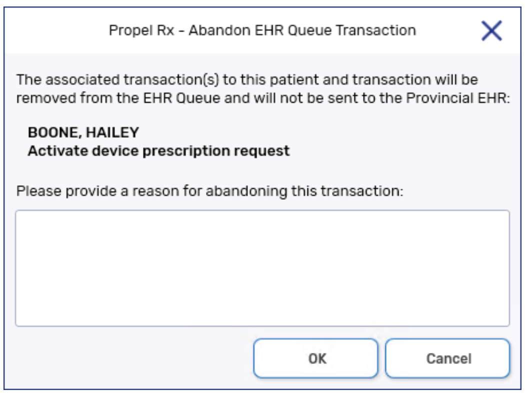
An Abandon button is available in the EHR Queue. By selecting the Abandon button, you can remove the transaction from the EHR Queue. This button may be required if, for whatever reason, the claim cannot be corrected and submitted to the EHR through the normal process. Only Rejected or Failed transactions can be abandoned.



NOTE: If a Detected Issue is returned that cannot be managed when sending transactions from the EHR Queue, a prompt appears indicating this and gives you the option to abandon the transaction. If **Yes** is selected, the Abandon EHR Queue Transaction window opens for you to enter a reason. If **No** is selected, you are returned to the EHR Queue tile and any remaining selected transactions from the EHR Queue are not sent to the EHR.



If a transaction is abandoned, you are required to enter a reason (maximum 280 characters). This entry is tracked in the **Patient Folder History** tab in the **Comments** column.



The Abandon button is not available for Deferred prescriptions as the claim has not been processed and submitted to the EHR. The Abandon button should only be used if every option has been exhausted to correct the prescription.

ALERT: When using the Abandon button, it is the pharmacy's responsibility to go back to the patient's Profile to reverse any financial adjudication and correct the prescription. Pharmacies in Newfoundland and Labrador, by law, must ensure the patient's EHR Profile is accurate and up to date.

EHR Network is Unavailable

When a transaction fails to send to the EHR, Propel Rx attempts to resend. After a maximum number of retries, the following prompt appears, and the transaction is placed in the EHR Queue:

In a batch, if the first prescription fails to send to the EHR, subsequent prescriptions are automatically added to the Network Down queue in the EHR Queue tile.

If a patient has a transaction in the EHR Queue, a blue Q indicator appears in the following locations:

- Patient Folder information bar beside the patient name
- On the Rx Detail EHR tab if the transaction was for a prescription
- Beside the EHR checkbox for non-prescription transactions (e.g., notes, lab results, DUR)

NOTE: When the network is down, you can add clinical records locally, but you will need to send them from the EHR Queue tile when the network is back up.

When the connection to the EHR is lost, or the network is down, you should first confirm that the EHR is down by contacting the Newfoundland and Labrador Health Services Service Desk at 1-877-752-6006.

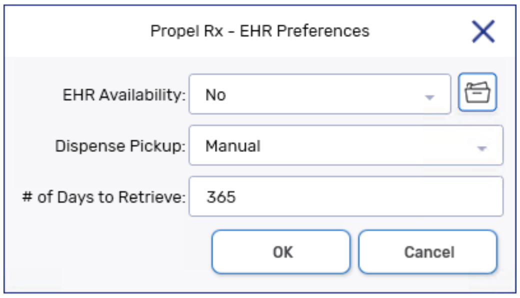
If the network is unavailable, you have the following options:

- Set the EHR Availability to No
- Continue Filling Prescriptions
- Stop Filling Prescriptions
- Park Prescriptions

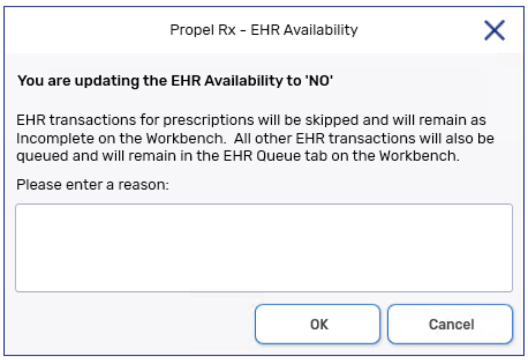
Set the EHR Availability to No

If the EHR Network is down for an extended period, you may choose to set the EHR Availability to No. When the EHR Availability is changed, the EHR Availability window prompts the user to enter a reason for changing this preference.

1. Select **More** (...) > **EHR** > **Preferences**.
2. Select **No** from the EHR Availability dropdown list. The EHR Availability window opens.



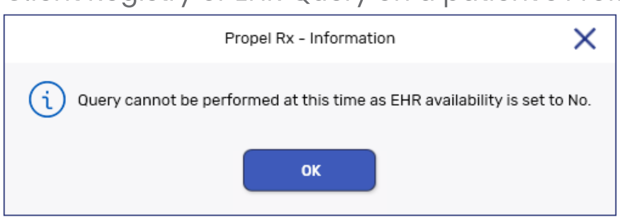
3. Enter the reason for changing the EHR Availability. The reason can be viewed later by selecting the folder button in the EHR Preferences window.



4. Select **OK**.

When the EHR Availability is set to No, the following occurs:

- Any transactions (e.g., processed prescriptions, new allergies, etc.) are automatically added to the EHR Queue tile, except for merges; merges cannot be completed if the network is unavailable.
- The following prompt appears when you attempt to perform a query (e.g., patient search on the Client Registry or EHR Query on a patient's Profile):



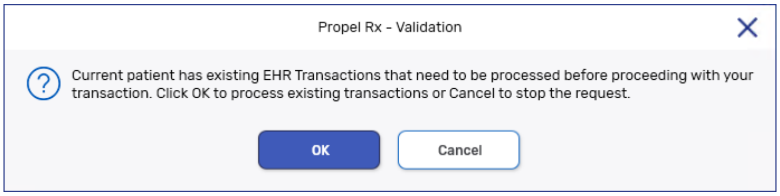
- If you remove an allergy, it is removed temporarily from the Patient Folder while the transaction is queued. If the transaction cannot be sent successfully, the record is placed back on the Patient Folder.

Continue Filling Prescriptions

When the connection to the EHR is lost or the network is down, you may choose to continue to fill prescriptions and attempt to connect to the EHR with each transaction (i.e., leave the EHR Availability as Yes).

When a transaction fails to send to the EHR, subsequent transactions for the same patient are automatically placed in the EHR Queue. Propel Rx does not attempt to connect to the EHR again until a prescription is filled for a different patient, or another prescription is filled for the same patient after a break in service (e.g., navigate to another Profile and return).

If transactions already exist in the EHR Queue for the patient, upon attempting to send another transaction, the following prompt appears:



- Select **OK** to process the existing transactions in chronological order. If the network is still down, a prompt appears advising this.
- Select **Cancel** to not send the transactions, including the current transaction, to the EHR.

Stop Filling Prescriptions

You may choose to stop filling prescriptions until the connection to the EHR is restored (i.e., ask the patient to wait until the connection is restored).

Park Prescriptions

You may choose to fill a prescription until it reaches the **Rx Detail** window and then select **Park**. The prescription is then moved to the Parked Rx tile on the Workbench. At this point, the label cannot be printed.

When the network is restored, the prescription can be processed from the Parked Rx tile and submitted to the EHR and third parties for payment. The label set can then be printed to be filed with the prescription.

Sending Transactions When the Network is Restored

When the EHR network is restored, you can proceed to upload the transactions from the EHR Queue.

TIP: Open another instance of Propel Rx to send queued transactions so you can continue to fill prescriptions on your current session.

To send EHR Queued transactions:

1. If the EHR Availability was previously set to No, complete steps a – e below:
   a. Select **More** (...) > **EHR** > **Preferences**.
   b. Dropdown the **EHR Availability** field and select **Yes**. The EHR Availability window opens.
   c. Enter a reason for changing the Availability.
   d. Select **OK** to close the EHR Availability window.

   e. Select **OK** to close the EHR Preferences window.

2. Select the **EHR Queue** tile on the Workbench.
3. Select the applicable row from the tree view on the left.
   - If you want to send all Deferred or Network Down transactions, select the **Deferred** or **Network Down** row.
   - If you want to send transactions for a specific patient, select the applicable patient row.
4. On the Detailed Transaction view to the right, select the checkboxes for the transactions you wish to send.

   NOTE: Network Down transactions are automatically selected for sending from the Network Down queue. This is to ensure the transactions are sent in the appropriate order.

5. Select **Send**. Propel Rx sends the transactions in order by creation date.
   - If a Detected Issue is returned for a transaction, it must be managed before subsequent transactions can be sent. If the Detected Issue is unmanageable, a prompt gives you the option to abandon the transaction.
   - If a transaction fails to send after 5 attempts, a prompt appears indicating the number of transactions that were cancelled, rejected, or abandoned. These transactions remain in the EHR Queue.
   - The number of successful transactions that were sent are returned in a prompt.

Resolving Failed/Rejected EHR Transactions

When a transaction is not successfully transmitted to the EHR, the transaction remains in the EHR Queue tile, and the status will be one of the following:

- **Failed** – the EHR network was unavailable.
- **Rejected** – the transaction was rejected due to an error that must be resolved prior to resubmission.
- **Deferred** – prescription was selected to temporarily bypass the EHR and has yet to be submitted.
- **Queued** – transaction is waiting to connect to the EHR network to be sent.

To resolve a failed/rejected EHR transaction:

1. From the Workbench, select the **EHR Queue** tile.
2. Highlight the transaction you wish to view.
3. Select the folder button next to the transaction you wish to view. The Detected Issues window appears with the error.
4. Resolve the error or enter an Issue Management. Refer to the table below for more information on how to action different issues/statuses in the EHR Queue.

What is the issue/status of the transaction	What does it mean?	What actions should I take?
Not Sync	The Patient Folder is not synced to the Client Registry.	Select the red folder button to open the Patient Folder and then proceed to synchronize the patient. Once synced, the transactions in the queue change to a Queued status.
Queued	The message is waiting to be sent.	Propel Rx sends the transactions in the appropriate order if more than one is being submitted. No action is required now.
Failed	The message was sent to the EHR but failed or a maximum number of attempts for the message was reached.	Send the transaction once the EHR connection is restored.
Rejected	The message was rejected by the DIS with a Detected Issue.	Correct the data or use Issue Management. For more information, see Detected Issues and Issue Management.
Started	The message is being sent.	No action is required now.
Deferred	The prescription was deferred in Rx Detail and has not been sent.	Send the transaction.

5. Select **OK**.
6. Select **Send**.
7. Ensure the claim is transmitted by checking the EHR Queue tile and ensuring the transaction is no longer there.

Reports

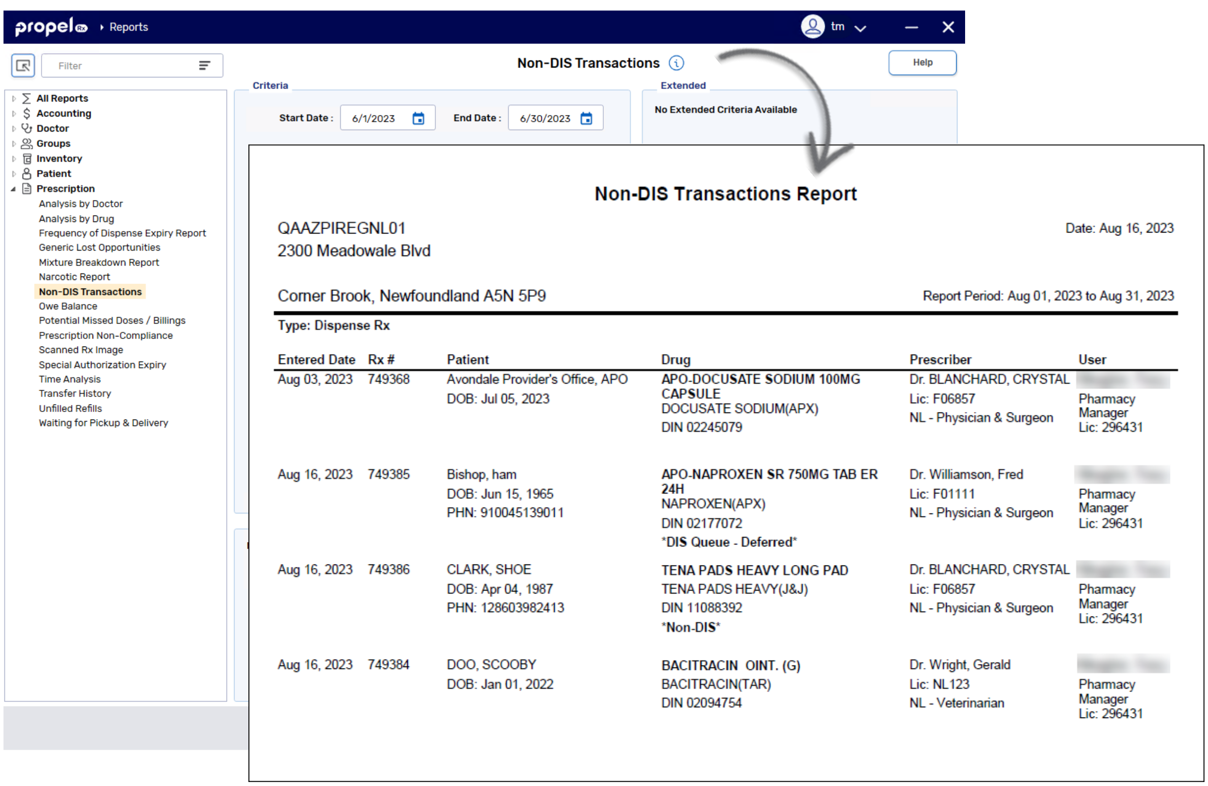
Propel Rx permits you to run reports that can assist you with managing your patients. Not all users have access to run these reports. See Setting Up Report Access for more information.

Non-DIS Transactions Report

The Non-DIS Transactions report lists all the prescriptions that were either placed on hold or filled but not transmitted to the EHR. This includes prescriptions for patients with an Animal status as well as DUR records that were added to the Patient Profile but not transmitted to the EHR. This report should be reviewed weekly to evaluate if there are any prescriptions which should have been sent but were not.

To run the Non-DIS Transactions report:

1. Select **More (...) Reports** > **Propel Rx Reports**.
2. Dropdown **Prescription** from the side menu.
3. Select the **Non-DIS Transactions** report.
4. In the **Start Date** field, enter the start date for the prescriptions you wish to view.
5. In the **End Date** field, enter the end date for the prescriptions you wish to view.



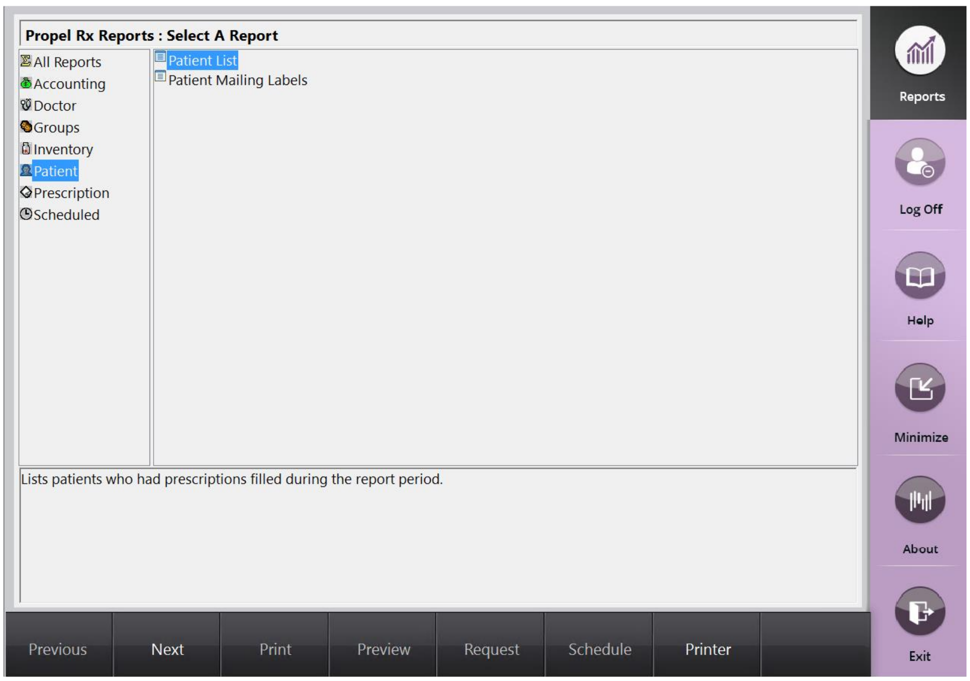
6. Select **Preview**.

Patient List Report

You can generate the Patient List report to view all your patients that currently do not have a PHN on file.

To run the Patient List report:

1. Select **More** (...) > **Reports** > **Propel Rx Reports**.
2. Select **Patient** from the side menu.
3. Select the **Patient List** report.



4. Select **Next**.
5. In the **Start Date** field, enter the start date for the patients you wish to view.
6. In the **End Date** field, enter the end date for the patients you wish to view.
7. Enter in any other filter criteria for the report.
8. Select **Preview**.

Merge

Propel Rx gives you the ability to merge Patient Folders.

Merging Patients

When a patient merge is performed, one Patient Folder is removed from the database and the other is retained. The Patient Folder for the patient who is retained will include all the information from the patient that was removed. It is imperative that your pharmacy validates that the Patient Folders should in fact be merged prior to merging them.

The Patient Merge window is separated into two sections: **Target** and **Remove**. **Target** contains the information for the Patient Folder that will remain and into which all other Patient Folder data will be merged. **Remove** contains the information for the Patient Folder which will be merged into the Target Patient Folder.

Only Pharmacist users are permitted to merge patients. It is imperative to keep your patient records accurate and up to date. Avoid duplicates and ensure prior to synchronizing any patients that you confirm the patient is not in Propel Rx more than once.

To merge two Patient Folders:

1. Select **More** (**...**) > **Merge** > **Patient**. The Patient Merge window opens.
2. In the **Target** section, enter all or part of the name of the patient you wish to keep.
3. Select **Search** or the folder button.
4. From the results returned, select the correct patient.
5. Select **OK**.
6. In the **Remove** section, enter all or part of the name of the patient you wish to remove from the database.
7. Select **Search** or the folder button.
8. From the results returned, select the correct patient.
9. Select **OK**.
10. Verify that the **Target** and **Remove** patients are correct and then select **OK**. A validation prompt appears to confirm the merge.
11. Select **Yes**.

Propel Rx performs the merging of the two Patient Folders. Depending on the size of the Patient Folders, the merge can take a few minutes to complete. Once the merge is successful, a prompt appears indicating the merge was successful.

NOTE: If the Target patient is not synchronized and the Remove patient is synchronized, a prompt displays indicating that the Target patient must be synchronized to complete the merge.

ALERT: Merging is not possible when the EHR is down or if the EHR Availability is set to No. You must wait for the EHR to be available again before attempting to perform a merge.

Unmerging a Patient

If you have completed a patient merge in error, contact the PTS Customer Care team at 1-800-387-6093 option 2 and request an unmerge of the Patient Folders. You will be required to identify the target patient's name, birth date, gender, and address information.

Newfoundland and Labrador Health Services Service Desk

If you detect an issue with the EHR, contact the Newfoundland and Labrador Health Services Service Desk to report the issue. The Service Desk provides assistance for all technical and business calls.

You can contact the Newfoundland and Labrador Health Services Service Desk at the following:

- Telephone: 1-877-752-6006 or 709-752-6006
- Email: service@nlchi.nl.ca

You must provide the following details when you contact the Service Desk:

- PID #
- Contact name
- Contact phone number
- Description of the problem

Helpful Links

Website	Details
Pharmacy Network Information	Additional information about the Newfoundland and Labrador Pharmacy Network (NLPN).
Pharmacy Network Newsletters	Updates of NLPN policies and procedures communicated via the Pharmacy Network Newsletters. Issued by the Centre and available on the Pharmacy Network website. Pharmacy staff must use the updated Pharmacy Network User Guide material. Notification of updates will be sent via the Pharmacy Network Newsletter and will be available online. The Pharmacy Network Newsletter is initiated by the Centre to: • Announce changes to Pharmacy Network policies and procedures • Clarify existing policies • Announce new features of the system • Report on progress and other newsworthy items related to the Pharmacy Network
Newfoundland and Labrador Personal Health Information Act	A complete copy of the Personal Health Information Act.
Newfoundland and Labrador Pharmacy Board	More information regarding NLPB Pharmacy Standards of Practice and/or the Newfoundland and Labrador Pharmacy Act.

Pharmacist Password Agreement Pharmacy Assistant/Technician Student Password Agreement Technician Password Agreement	A copy of the Newfoundland and Labrador Pharmacy Network Password Agreement that must be signed by all Pharmacy Network users.
Pharmacy Network Education Site	All pharmacists, pharmacy assistants, technicians, and pharmacy students must successfully complete the Pharmacy Network Education as the first step to obtaining a username and password for the Pharmacy Network. Completing the Pharmacy Network Education is mandatory, and all users must achieve a passing mark of at least 70% on the Pharmacy Network Education test.
College of Physicians and Surgeons of Newfoundland and Labrador – Physician Search	Searchable database for the College of Physicians and Surgeons of Newfoundland and Labrador.
OPINIONS	A web-based database that assigns Product Identification Numbers (PINs) to products, which are usually devices that do not have DINs. Any products associated with this database will be identified with an EHR Type of Device for submission to NLPN. Examples of products in this database are diabetic test strips and insulin pump supplies.
Health Canada - Natural Health Products Database	Health Canada maintains a list of licensed Natural Health Products which have been issued a Natural Product Number (NPN). Examples of products in this database may include Glucosamine Chondroitin, Ginkgo Biloba, and Slow-K.
NLPN PIN List	The NLPN PIN list has been created by the Centre to facilitate the submission of clinical information to the Pharmacy Network for items that do not have a DIN, NPN, or OPINIONS PIN.

Notes

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pts@mckesson.ca

pharmacytechnologysolutions.ca

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