

eClinicalWorks

Business Analysis Department



EMR III

Kentucky Department for Public Health

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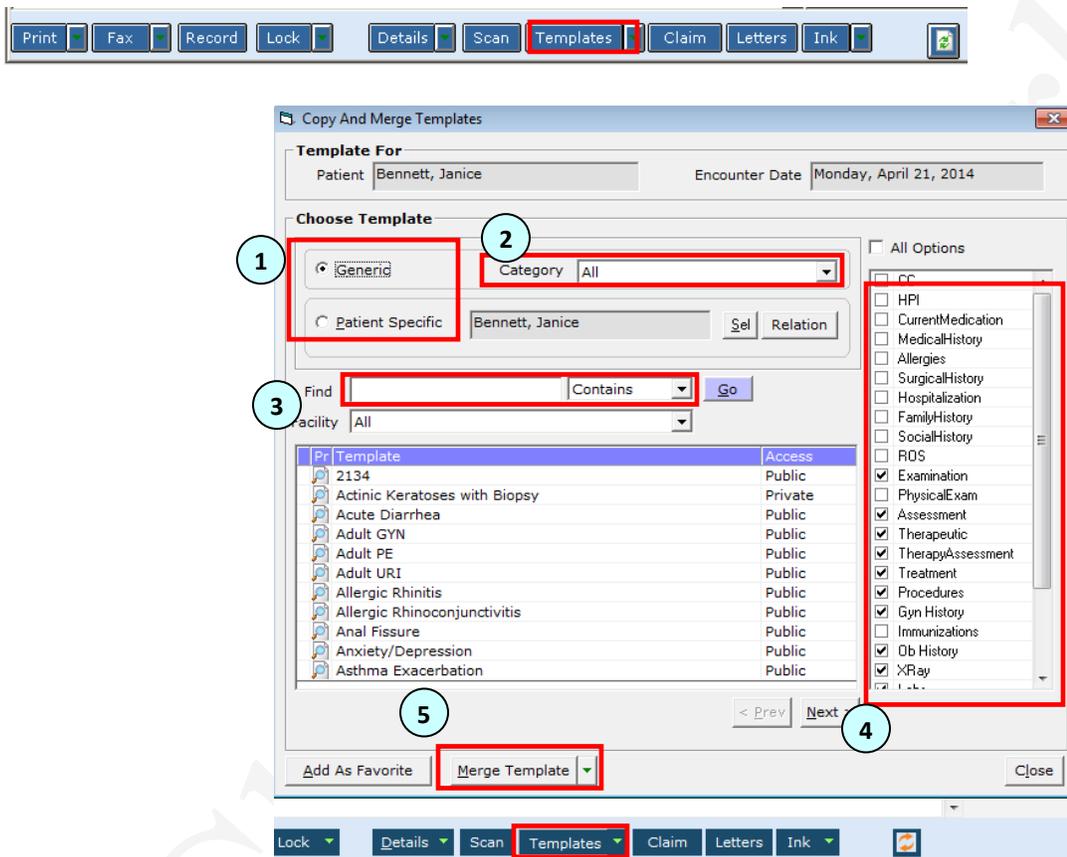
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eClinicalWorks

Advance EMR Feature

Progress Notes Templates - Using Progress Notes Templates

Patient-specific templates and generic templates can be copied/merged from the “Templates” screen obtained by clicking on the “Templates” button at the bottom of the progress note.

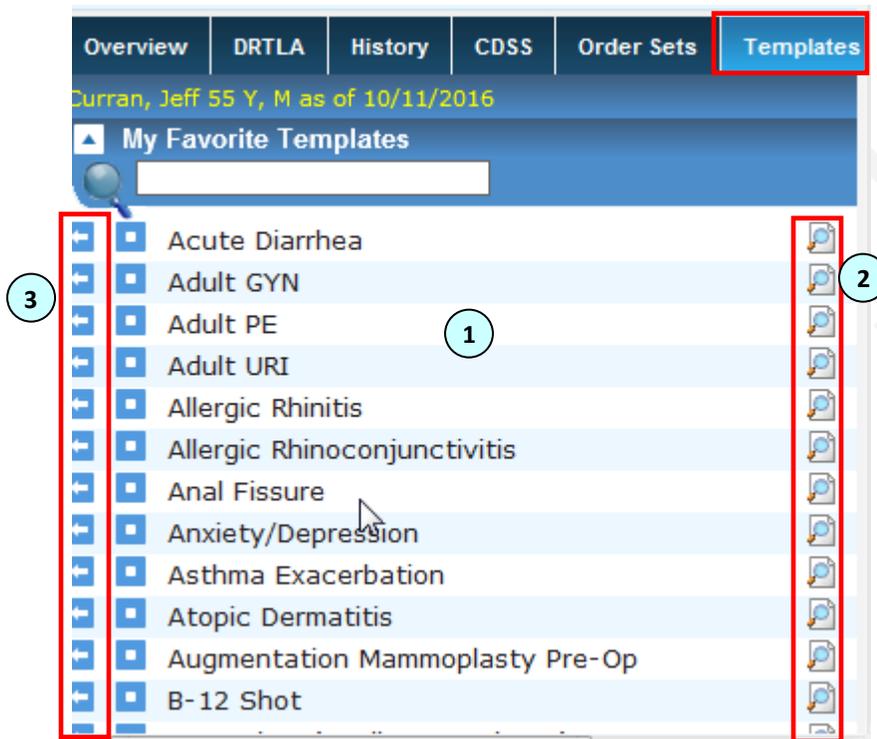


1. Choose the Template Type, Generic or Patient Specific.
2. Choose the Template Categories, All/Favorite.
3. The desired template can be searched from the list using the “Find” box.
4. The different sections of the progress note template that need to be copied or merged can be chosen as required.
5. Clicking on the “Merge template” will insert the information from the selected template into the current progress note.

Note: Clicking on the green arrow next to the “Merge template” button will give you a “Copy template” option. The ‘copy’ option will overwrite the current progress note with the information on the selected template.

Merging Templates from the Right Chart Panel

Favorites templates can be merged from the right chart panel by clicking on the “Templates” tab.



6. Choose the Template from the favorite list.
7. The magnifying symbol, allows the user to view the information in the template.
8. Clicking on the arrow will “Merge” the template and insert the information from the selected template into the current progress note.

Note: Clicking Using Templates from the Right Chart Panel allows the user to only “Merge” the template.

Progress Notes

Lab, Larry , 31 Y, M Set Info Hub R

	Boca Raton, FL H:561-750-4753 DOB:01/01/1983	<input checked="" type="checkbox"/> Allergies <input checked="" type="checkbox"/> Billing Alert	Appt(L):03/24/14(SW) PCP: Willis, Sam Language: Translator: No	Ins: Aetna Acc Bal: \$0.00 Guar: Larry Gr Bal: \$0.00 Ref: Charles, Ren: Willis, Sam	CLICK TO EDIT	SECURE NOTES
--	--	--	---	---	---------------	--------------

Medical Summary | CDSS | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient Docs | Flowsheets | Notes

SF

[Progress Notes](#) Scribe Orders

ADDRESS: , 714 Lab Lane, Boca Raton, FL 33433
Account Number: 9122
Encounter Date: 03/24/2014 **Provider:** Sam Willis, MD
Appointment Facility: Westboro Medical Associates

Subjective:
Chief Complaint(s):
HPI:
Diabetes Mellitus
31 year old male presents with c/o Insulin Dependent Diabetes Mellitus.
The patient is complaining of _____. The patient has been diagnosed with _____. The diet that the patient has been following is _____. Efforts at weight loss have been _____. The frequency of exercise that the patient achieves is _____. The frequency of the monitoring schedule is _____. Hypoglycemic episodes are _____. The most recent fasting blood sugar result was on _____. The results of the last HbA1c are _____. Blood glucose results are evaluated _____. Overall blood glucose levels _____. The insulin regimen is described as _____. The microalbumin has _____. The kidney function is _____. The feet _____. Diabetes education has _____. Side effects of the medications include _____. Compliance with the medical regimen has been _____. Impediments to compliance with the medical regimen has been _____.

Current Medication:

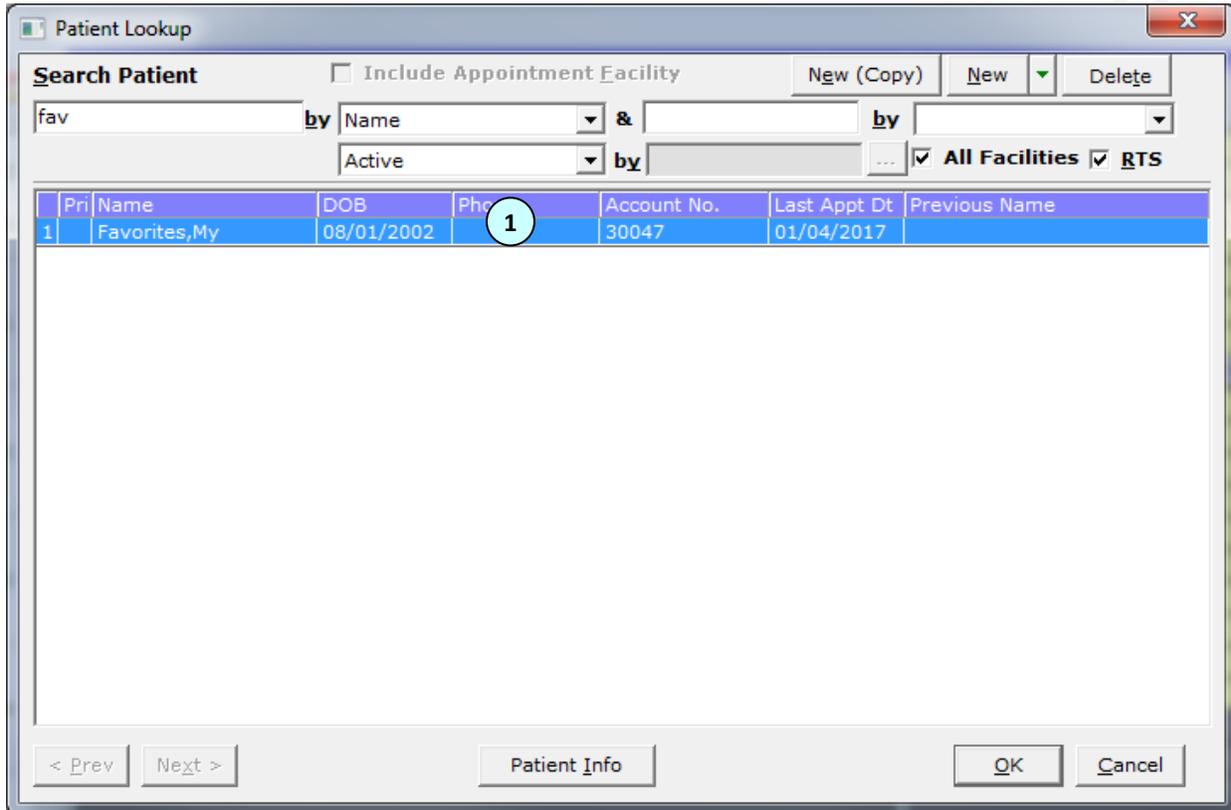
Send Print Fax Record Lock Details Scan Templates Claim Letters Ink

Merged Progress Note (Example)

Adding Favorite Templates

Favorite templates can be added by clicking on the “Templates” button at the bottom of the progress note.

1. From the patient look up window, search for the ‘patient’ labeled as ‘My Favorites’ and go to a progress note.
2. From the progress note click on ‘Templates’ button on the bottom.



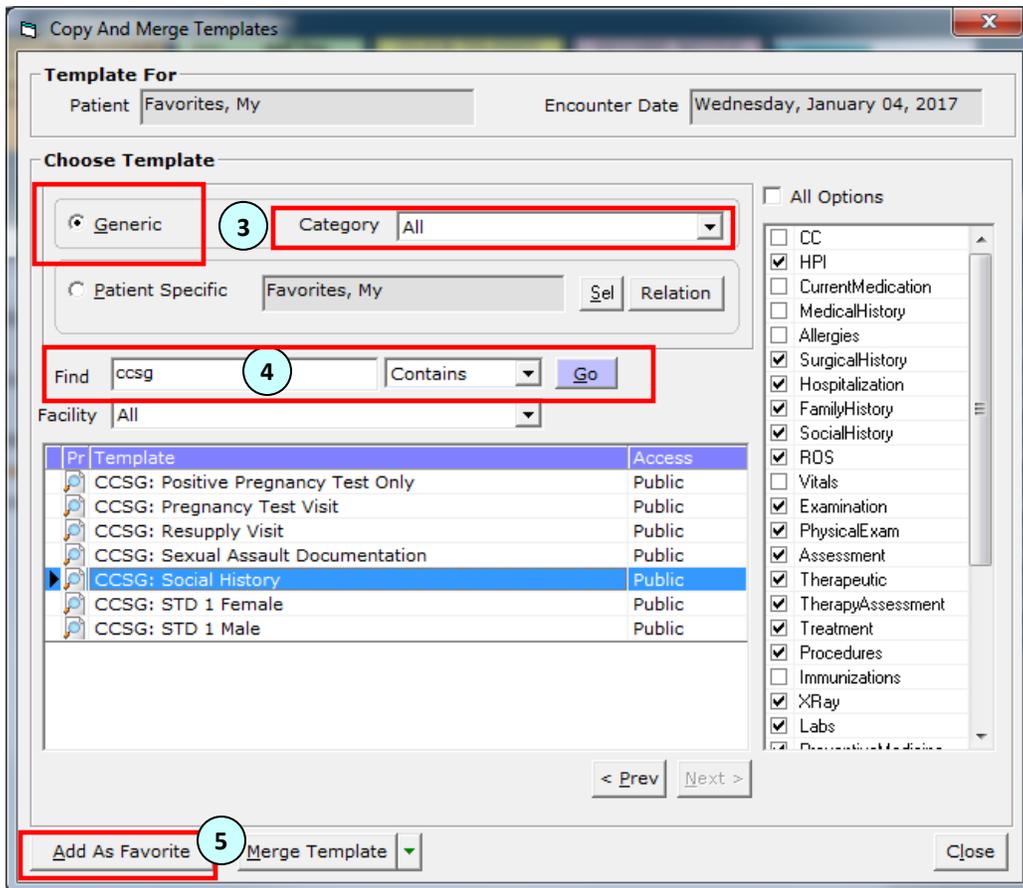
The screenshot shows the 'Patient Lookup' window. The search criteria are 'fav' by Name, Active, and All Facilities. The search results table is as follows:

Pri	Name	DOB	Pho	Account No.	Last Appt Dt	Previous Name
1	Favorites,My	08/01/2002	1	30047	01/04/2017	

Buttons at the bottom of the window include '< Prev', 'Next >', 'Patient Info', 'OK', and 'Cancel'.



The screenshot shows a toolbar with the following buttons: Print, Fax, Record, Lock, Details, Scan, Templates (highlighted with a red box and a circled '2'), Claim, Letters, Ink, and a trash icon.



3. Choose the Template Type as Generic & Category as 'All'.
4. Search for 'CCSG' in the 'Find' box to pull up all the CCSG templates. The Social History template will be saved on page 2.
5. Select the desired template and click 'Add As Favorite'. This will add the template to the users favorite list.
6. Once saved, user can exit out of the patient 'My Favorites'.

Below is a list of templates that have been created for Kentucky Department for Public Health.

eCW Template Name	DPH Form Name (if applicable)
Tobacco Counseling Sheet	N/A - Health Promotion Branch requirements
HANDS Referral Record Screen	N/A - Early Childhood Development Branch requirements
Diabetes Self-Mgmt Edu Referral	N/A - Diabetes Prevention and Control Program Requirements
HCV Infection Risk Assessment	HCV 2
Health Equity Questionnaire	E Clinical Works Health Equity Module-ayeditis (4)
CCSG: Adult Initial H&P- Female	H&P 13 Initial (Adult)
CCSG: Adult Initial H&P- Male	H&P 13 Initial (Adult)
CCSG: Adult Interval H&B- Female	H&P 14 Interval (Adult)
CCSG: Adult Interval H&B- Male	H&P 14 Interval (Adult)
CCSG: Domestic Violence Documentation	DV/SA-1 Domestic Violence/Sexual Assault Documentation Form
CCSG: Sexual Assault Documentaion	DV/SA-1 Domestic Violence/Sexual Assault Documentation Form
CCSG: Peds Initial H&P- Female	H&P 13 Initial (Pediatric)
CCSG: Peds Initial H&P- Male	H&P 13 Initial (Pediatric)
CCSG: Peds Interval H&P- Female	H&P 14 Interval (Pediatric)
CCSG: Peds Interval H&P- Male	H&P 14 Interval (Pediatric)
CCSG: Resupply Visit Form	BC-1 Resupply Visit Form
CCSG: Pregnancy Test Visit	PT-1 Pregnancy Test Visit Form
CCSG: Positive Pregnancy Test Only	PT-1 Pregnancy Test Visit Form
CCSG: Negative Pregnancy Test Only	PT-1 Pregnancy Test Visit Form
CCSG: STD 1 Female	STD-1 Sexual History and Physical Exam Form

CCSG: STD 1 Male	STD-1 Sexual History and Physical Exam Form
CCSG: Immunization Only Visit	GR208 & Barren River IMM-1
Dental- Preventive Adult High Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult High Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Low Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Low Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Moderate Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Adult Moderate Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child High Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child High Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Low Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Low Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Moderate Risk Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Child Moderate Risk Normal Findings	N/A - Dental Hygiene Program Requirements
Dental- Preventive Visit	N/A - Dental Hygiene Program Requirements
Dental- Screening Only	N/A - Dental Hygiene Program Requirements
Dental- Varnish Only Visit	N/A - Dental Hygiene Program Requirements

Dental- Varnish Only Visit Codes Abnormal Findings	N/A - Dental Hygiene Program Requirements
Dental- Varnish Only Visit Codes Normal Findings	N/A - Dental Hygiene Program Requirements
Dental-Sealant Only Visit	N/A - Dental Hygiene Program Requirements
EBLL- BLL>25	KCLPPP Case Management Follow Up Report Form
EBLL- Education	KCLPPP Case Management Follow Up Report Form
EBLL- Environmental	KCLPPP Case Management Follow Up Report Form
EBLL- Follow-Up	KCLPPP Case Management Follow Up Report Form
EBLL- Referrals	KCLPPP Case Management Follow Up Report Form
TB H&P-13	TB H&P-13 TB Clinic Initial Health Assessment/History/Exam
TB-1 Infection Form	TB-1 Infection Form
TB-4 Risk Assessment	TB-4 TB Risk Assessment Form
TB-17 DOT Initial Phase	TB-17a DOT Record Initial
TB-17 DOT Continuation Phase	TB-17b DOT Record Continuation
TB-20 TB Clinic Follow-up	TB-20 TB Clinic Follow-up Visit
Oral Health KIDS Smile	OH-11 KIDS Smile (personal record)
KWCSP - Breast Screening	ACH-58 Cancer Screening Form
KWCSP Cervical Cancer Screening	ACH-58 Cancer Screening Form
Bright Futures Well Child 2-5 days	Bright Futures Infancy Core Tools
Bright Futures Well Child 1 month	Bright Futures Infancy Core Tools
Bright Futures Well Child 2 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 4 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 6 months	Bright Futures Infancy Core Tools

Bright Futures Well Child 9 months	Bright Futures Infancy Core Tools
Bright Futures Well Child 12 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 15 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 18 months	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 2 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 2.5 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 3 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 4 years	Bright Futures Early Childhood Core Tools
Bright Futures Well Child 5 to 6 years	Bright Futures Middle Childhood Core Tools
Bright Futures Well Child 7 to 8 years	Bright Futures Middle Childhood Core Tools
Bright Futures Well Child 9 to 10 years	Bright Futures Middle Childhood Core Tools
Bright Futures Well Child 11 to 14 years	Bright Futures Adolescence Core Tools
Bright Futures Well Child 15 to 21 years	Bright Futures Adolescence Core Tools
School Health: Burns	GR207
School Health: Ear, Nose, and Throat	GR202
School Health: Head Check	GR205
School Health: Head Injury	GR206
School Health: Headache	GR204
School Health: Immunization	GR208
School Health: Insect Bite/Sting	GR209
School Health: Negative Pregnancy	GR203
School Health: Psychotropic Med/Assess	GR201
School Health: Asthma/Respiratory Assessment	GR210
School Health: GI Assessment	GR211
School Health: Tracheotomy Care	GR212
School Health: Skin Irritations	GR213
School Health: Wounds	GR214

School Health: Eye Assessment	GR215
School Health: Nose Bleed	GR216
School Health: Screenings	GR217
School Health: Gastrostomy Care/Feeding	GR218
School Health: Catheterization	GR219
School Health: Hypo-Hyperglycemic Assessment	GR222
School Health: Seizure	GR223
School Health: Muscle/Bone/Joint Pain or Injury	GR225
School Health: Menstrual Cramps	GR227
School Health: Oral Assessment	GR228
School Health: Heat Exposure	GR230
MNT-Adult	MNT-Adult
MNT-Pediatric	MNT-Pediatric
MNT-Diabetes	MNT-Diabetes
MNT-Gestational Diabetes	MNT-Gestational Diabetes
MNT-Renal	MNT-Renal
MNT-Follow-Up	MNT-Follow UP

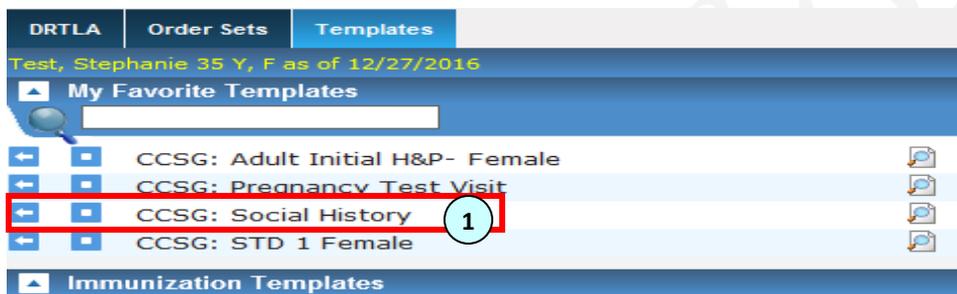
Templates- First Time Patients in eClinicalWorks

For patients that are being seen in eCW for the first time, the 'CCSG: Social History' template will need to be merged into the patient's progress note.

From the right chart panel:

1. Select the template labeled 'CCSG: Social History' and click the arrow.
2. This will *merge* in the contents of the template into the progress note.

Note: All social history questions have been removed from all the CCSG templates, except the CCSG template labeled as 'CCSG: Social History'.



Social History:

Abuse/Neglect/Violence

Concerns

- Fear of harm? Yes/No
- Pressure to have sex? Yes/No
- Daily needs met? Yes/No
- Forced sexual contact? Yes/No
- Fear of verbal/physical abuse? Yes/No
- Sex for money or drugs? Yes/No

2

Dental History

Dental Health

- Do you brush your teeth daily? Yes/No
- Do you floss daily? Yes/No
- Do you visit the dentist every 6 months? Yes/No

Diet/Exercise

Weight

- Do you have concerns about your weight? Yes/No

Exercise

- How often do you exercise? {...}

Diet

- Which foods do you eat daily? {...}

Mental Health

Mental History

- In the past 90 days have you been diagnosed with depression? Yes/No
- In the past 90 days have you had thoughts of harming yourself or others? Yes/No

Tobacco Counseling Sheet

Pregnancy Smoking Assessment

- Are you pregnant or have you ever been pregnant? Yes/No

ASK - Tobacco use status

- Are you a: {...}

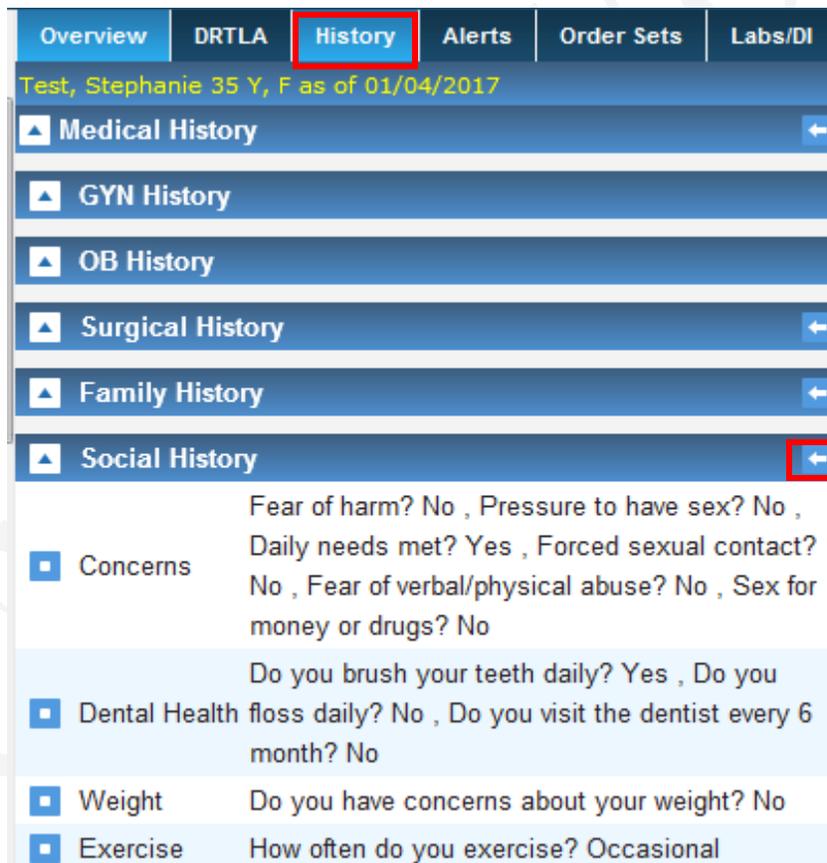
Note: The 'CCSG: Social History' template needs to be merged one time, regardless of the number of services provided.

Templates- Returning Patients in eClinicalWorks

For returning patients being seen in eClinicalWorks, the 'CCSG: Social History' information needs to be populated into the respective progress note. However, since the patient is returning, there is no need to use the template (as mentioned above), instead the user will use the 'History' tab on the Right Chart Panel.

From the Right Chart Panel:

1. Click on the 'History' tab.
2. User will have access to all the social history questions that were entered in the past.
3. Click the arrow to the right to merge in the information and update as necessary.



The screenshot displays the 'History' tab in the Right Chart Panel. The patient information is 'Test, Stephanie 35 Y, F as of 01/04/2017'. The 'Social History' section is expanded, showing the following questions and answers:

Section	Question	Answer
Concerns	Fear of harm? No , Pressure to have sex? No , Daily needs met? Yes , Forced sexual contact? No , Fear of verbal/physical abuse? No , Sex for money or drugs? No	
Dental Health	Do you brush your teeth daily? Yes , Do you floss daily? No , Do you visit the dentist every 6 month? No	
Weight	Do you have concerns about your weight? No	
Exercise	How often do you exercise? Occasional	

Note: Once information has been merged and updated, the updated information will save into the right chart panel.

Order Sets - Using Order Sets from the Progress notes

You can access order sets from the Order Sets tab of the Chart Panel to the right of the Progress Note.

To access an order set from the Chart Panel:

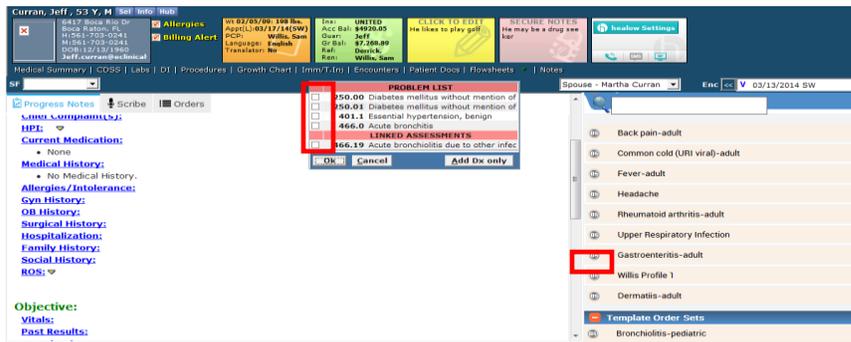
If certain order sets are added to a provider's 'favorites' list or associated with a progress note template, they will be available in the patient's chart panel (on the right), under the "OS" tab.

Note: The 'OS' tab must be enabled from the "Show/Hide" tab under File -> Settings -> My settings for every individual provider/staff member.

1. To order from a 'favorites' order set, click on the "OS" button corresponding to the order set and the respective 'trigger' diagnosis codes for that order set will pop-up.
2. Click on the desired diagnosis/assessment code and click on the "Ok" button; the appropriate order set window will open and the desired elements can be ordered from the Order set. **Note:** Choose Dx from 'Linked Assessments'- **NOT** the patient problem list.
3. If desired, a user can choose linked assessments and click on the button "Add Dx Only" to add assessments to the progress note and not have the Order Set appear.

The screenshot shows the eClinicalWorks interface. At the top, there's a patient header for 'Lab, Larry, 31 Y, M'. Below that, there's a 'PROBLEM LIST' and 'LINKED ASSESSMENTS' section. The 'LINKED ASSESSMENTS' section lists several codes: 460 Acute nasopharyngitis (common cold), 461.9 Acute sinusitis, unspecified, 462 Acute pharyngitis, 465.9 Acute upper respiratory infections of, and 466.0 Acute bronchitis. A pop-up window titled 'My Favorite Order Sets' is open on the right, showing a list of order sets: Back pain-adult, Common cold (URI viral)-adult, Fever-adult, Headache, Rheumatoid arthritis-adult, Upper Respiratory Infection, Gastroenteritis-adult, Willis Profile 1, and Dermatitis-adult. A red box highlights the 'Fever-adult' order set. A red box highlights the 'Add Dx only' button. A red box also highlights the 'OK' button in the pop-up window. Circled numbers 1, 2, and 3 indicate the steps: 1. Click on the 'Fever-adult' order set. 2. Click on the 'OK' button. 3. Click on the 'Add Dx only' button.

4. Order sets associated with progress note templates will show up under the "Template order sets" section when that respective template is copied or merged for the visit. The order set can be applied to the note by following a process like the one illustrated in steps 1 and 2 above.



Below is a list of order sets that have been created for Kentucky Department for Public Health.

eCW Order Set Name
CCSG: Well Child Pt Edu – Infancy (0mo-11mo)
CCSG: Well Child Pt Edu – Early Childhood (12mo-4yr)
CCSG: Well Child Pt Edu – Middle Childhood (5yr-10yr)
CCSG: Well Child Pt Edu – Adolescence (11yr-21yr)
CCSG Domestic Violence Pt Edu
CCSG Family Planning
CCSG General Pt Edu
CCSG HIV Pt Edu
CCSG Immunizations
CCSG Lead Pt Edu
CCSG Oral Health Pt Edu
CCSG Points to Remember Pt Edu
CCSG Prenatal Pt Edu
CCSG Sterilization Pt Edu
CCSG Tobacco Pt Edu
Diabetes Patient Resources
Hepatitis C Virus Teaching Sheets

Assigned To on Order Sets Window for Labs, Diagnostic Imaging, and Procedures

Assign labs, diagnostic imaging, and procedures using the “Assigned To” drop-down /More (...) when ordering from the Order Sets window:

The screenshot displays three sections of the 'Assigned To' dropdown menu, each with a red box highlighting the section title and the 'Assigned To' field.

Labs

Description	Lab Company
<input type="checkbox"/> CBC With Differential/Platelet	-
<input type="checkbox"/> 1-Methyl-histidine,Qn,CSF	ACL,Generic,PNINbound
<input type="checkbox"/> 17-Hydroxycorticosteroids, Ur	ACL,Generic,PNINbound
<input type="checkbox"/> 17-Ketogenic and Ketosteroids	ACL,ACL,Generic,PNINbound,Res...
<input type="checkbox"/> Lipid Panel	-
<input type="checkbox"/> Lipids, Total, Serum	-
<input type="checkbox"/> testRoss	-

Diagnostic Imaging

Description	DI Company
<input checked="" type="checkbox"/> Mammogram	-
<input type="checkbox"/> Bladder scan	-
<input type="checkbox"/> CT Scan : Biopsy Bone	-

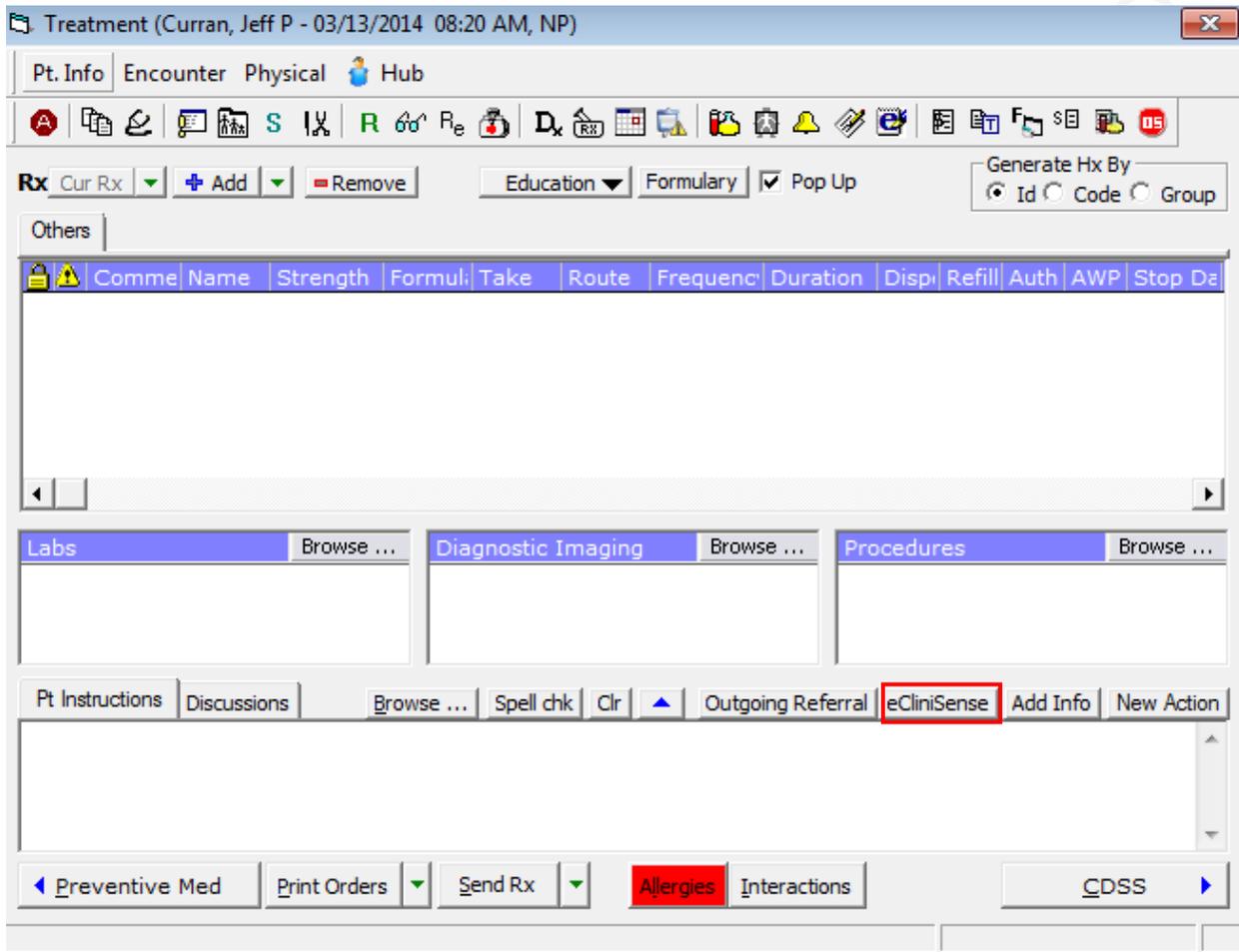
Procedures

Description

Using eCliniSense

eCliniSense allows clinicians to access the previously ordered treatment items for a diagnosis. Depending on the options you select the system can compile the most commonly ordered treatment items from across the database/State and display them in the eCliniSense window.

To use eCliniSense, from the Treatment Screen:



7. Click on the eCliniSense Button.
8. Select the Assessment Code from the drop-down option.
9. Select the option under the 'Generate Hx By' option to generate the eCliniSense information.
 - a. ID – Information will be generated for the specific ICD-10 name.
 - b. Code - Information will be generated for the ICD-10 code (Ex: E119).
 - c. Group – Information will be generated for the whole ICD-10 group (Ex: E119).
10. Select the 'Patient Specific' box if you would like to generate the eCliniSense information based on the patient.

Patient Dashboard Options

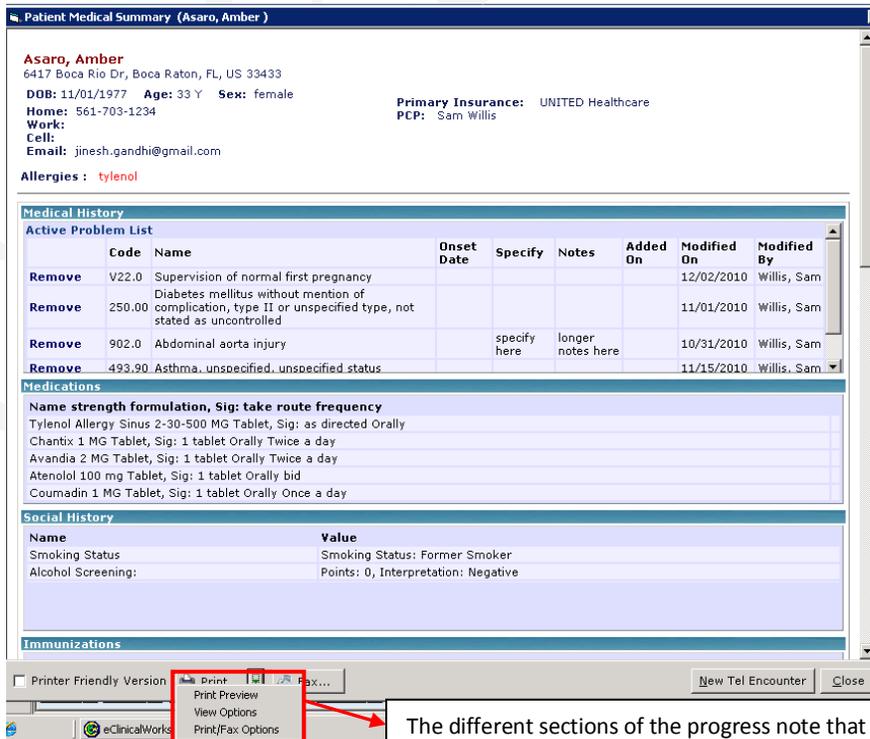
Accessing the Patient's Demographics Information and Hub

- The Patient Dashboard displays basic patient information.
- You can access detailed patient demographics by clicking on the 'Info' button.
- The Hub can be accessed by clicking on the 'Hub' button.



Printing/Faxing Medical Summary

- The 'Medical Summary' button is available on the patient's dashboard at the top of the progress note. Click on the medical summary button to display the summary of all the visits and information entered about the patient.
- The medical summary can also be accessed from the Patient Hub.



The different sections of the progress note that need to be printed or faxed can be chosen from the print/fax options.

Viewing/Printing Patient Encounters

- The patient's list of encounters can be viewed from the 'Encounters' button in the patient hub.
- It can also be viewed/printed from the 'Encounters' button available on the patient dashboard in the progress notes.

Check the box next to the encounter. Click on the print button to print the corresponding progress note. Click on the view button to view the corresponding progress note

	Date	Time	Type	Status	Provider	Resource	Facility	Reason
<input type="checkbox"/>	04/16/2014	09:00 AM	F/U	PEN	Willis, Sam	Willis, Sam	WMA	
<input type="checkbox"/>	03/31/2014	11:20 AM	Dental	PEN	Willis, Sam	Willis, Sam	WMA	
<input type="checkbox"/>	03/19/2014	08:49 PM			Jones, Mary	Jones, Mary	WMA	
<input type="checkbox"/>	03/19/2014	08:49 PM			Jones, Mary	Jones, Mary	WMA	
<input type="checkbox"/>	02/24/2014	10:20 AM	OV	PEN	Willis, Sam	Willis, Sam	WMA	
<input type="checkbox"/>	03/28/2013	09:30 AM	ESTPT	PEN	Jones, Mary	Jones, Mary	WMA	allergies

24 Encounter(s) Non Billable Visits: 0

View Logs View Web View Print Fax

Viewing/Printing/Faxing Patient's Scanned Documents

- To view/print/fax the patient's scanned documents, click on the 'Patient Docs' button in the patient hub. The left side of the window will show you the attached documents and the respective folders. The right side of the window will show you the preview of the document that is being clicked. To print/fax the documents click on the 'print' and 'fax' button on the top panel of the patient documents screen.

Note: Lab/DI reports can be faxed by selecting the documents from the patient documents folder and click 'Fax'.

The screenshot displays the eClinicalWorks Patient Hub for Martha M. Curran. The top section contains patient demographics and contact information. A red box highlights the 'Patient Docs' button in the navigation bar. Below this, the 'Patient Documents' window is open, showing a hierarchical list of document folders. A red box highlights the 'Patient Documents' folder in the left-hand pane. The top panel of the 'Patient Documents' window features several action buttons, with 'Multi Doc' highlighted by a red box.

- To print/fax multiple patient documents, click on the 'Multi Doc' button in the top panel of the patient documents screen.
- Click on the document on the left side and then click on the 'add' button and accumulate all the documents that need to be printed or faxed.

Viewing/Updating/Printing Patient's Flowsheets

- To view/update/print a patient's Flowsheet, click on the Flowsheet button in the dash board of the progress note.



- Another way to go to the patient's Flowsheet is to click on the 'Flowsheets' button in the patient hub.

Can change the view of the flowsheet to "graphical view".

Can enter notes for patient on flowsheet.

The yellow colored rows automatically flow from the already associated items from the progress notes. However, the white colored rows are available to free text.

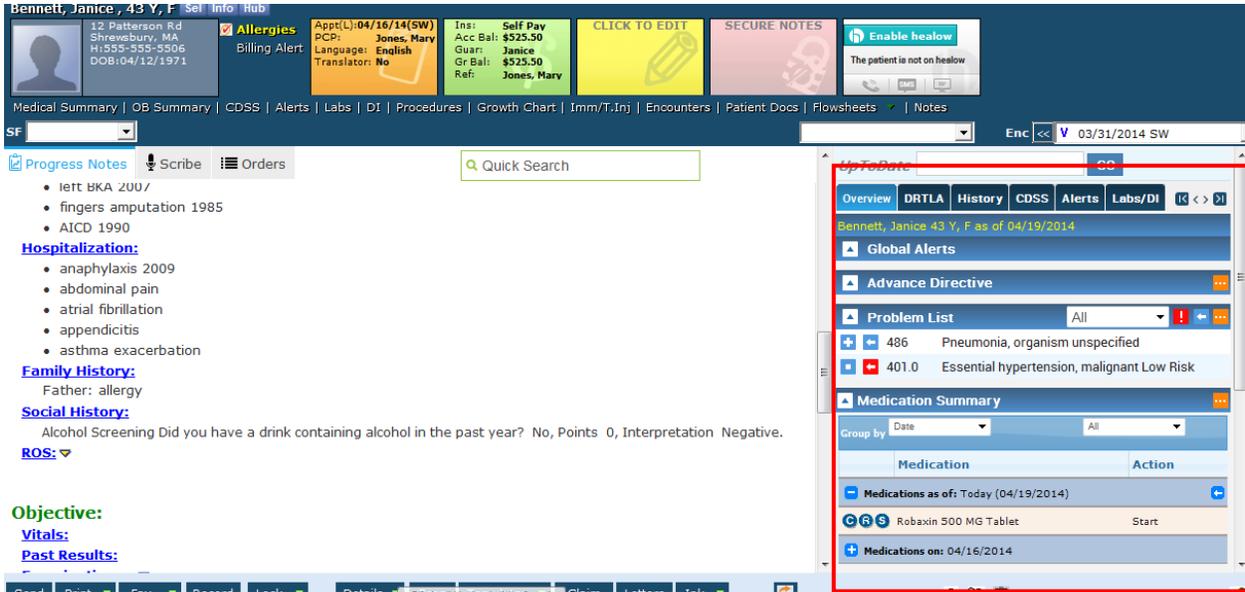
After entering/updating the flowsheet, it needs to be saved. Click on the 'save' button to save the flow sheet and click on the 'lock' button to lock the flow sheet after editing.

Can Print, Fax or Export the flowsheet.

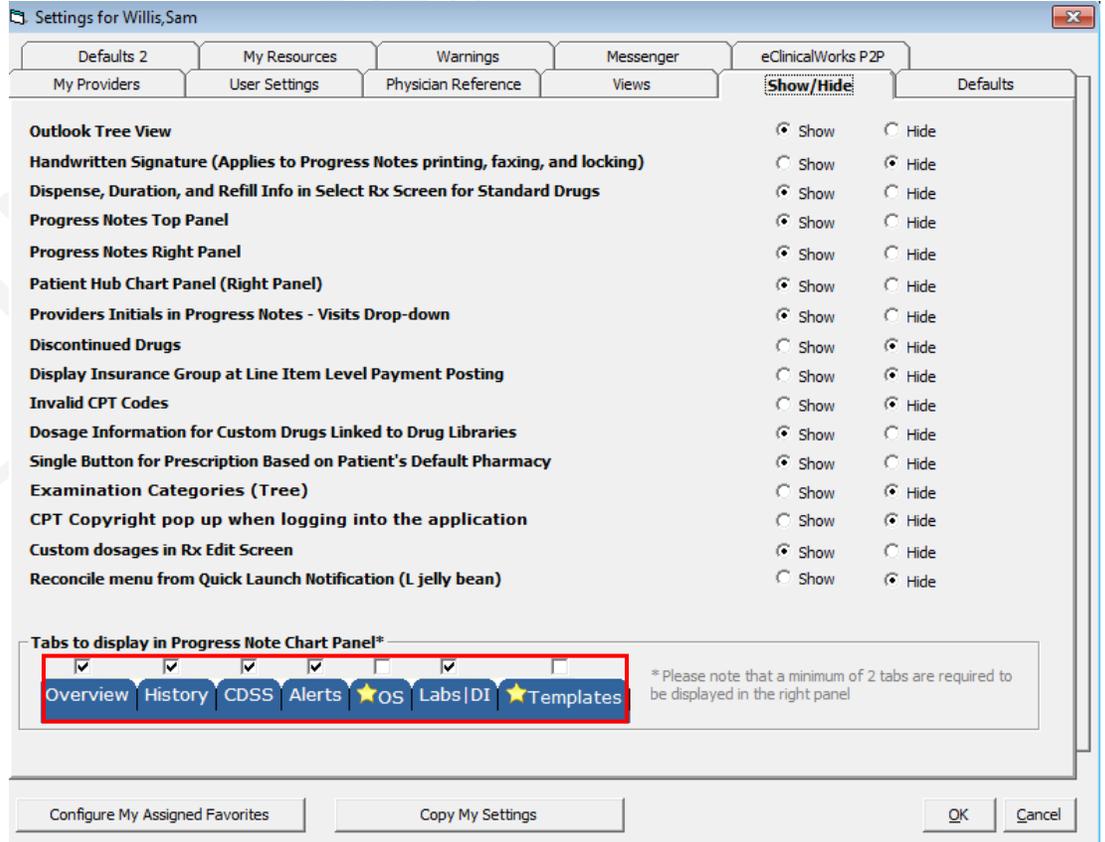
Patient Chart Panel Options

Accessing and Customizing the Patient Chart Panel

The Patient Chart Panel can be accessed through the Progress Note.



Patient Chart Panel options can be customized through 'My Settings' (File->Settings->My Settings and click on the 'Show/Hide' tab).



The image displays three side-by-side screenshots of the eClinicalWorks interface for a patient named Bennett, Janice 43 Y, F as of 04/19/2014. Each screenshot shows a different tab selected in the top navigation bar.

- Left Screenshot (Global Alerts):** Shows the 'Global Alerts' tab. It includes sections for 'Advance Directive', 'Problem List' (with 2 items: Pneumonia, organism unspecified and Essential hypertension, malignant Low Risk), and 'Medication Summary' (with 1 item: Robaxin 500 MG Tablet).
- Middle Screenshot (Medical History):** Shows the 'Medical History' tab. It lists various conditions such as Detached Retina-left eye, cataracts, Abdominal pain, abscess, abnormal chest x-ray, abnormal CT abdomen, and abnormal CT chest.
- Right Screenshot (CDSS Alerts):** Shows the 'CDSS Alerts' tab. It lists alerts like Body Mass Index, BP control in HTN (140/90), Depression screening, Patients see assigned PCG, Sexual history taken, and Smoking status. A 'Practice Created Alerts' section shows '[Dx] diabetes (HEMOGLOBIN A1C)' on 04/19/2014. A 'Registry Alerts' section states 'There are no over due alerts today for this patient.'

Different tabs for Chart Panel (Overview, History, CDSS, Favorite Template and OS)

This screenshot shows the 'Order Sets' tab selected in the top navigation bar for a patient named Curran, Martha 40 Y, F as of 04/19/2014. The main content area is titled 'My Favorite Order Sets' and lists several medical conditions with corresponding icons:

- Back pain-adult
- Common cold (URI viral)-adult
- Fever-adult
- Headache
- Rheumatoid arthritis-adult
- Upper Respiratory Infection
- Gastroenteritis-adult
- Willis Profile 1
- Dermatitis-adult

This screenshot shows the 'Template' tab selected in the top navigation bar for a patient named Curran, Martha 40 Y, F as of 04/19/2014. The main content area is titled 'My Favorite Templates' and lists various medical conditions with corresponding icons:

- Acute Diarrhea
- Adult GYN
- Adult PE
- Adult URI
- Allergic Rhinitis
- Allergic Rhinoconjunctivitis
- Anal Fissure
- Anxiety/Depression
- Asthma Exacerbation
- Atopic Dermatitis
- Augmentation Mammoplasty Pre-Op
- B-12 Shot
- R-12 Shot (Medicare Patients)

Patient Specific Alerts

Patient Specific Alerts allow clinicians to add clinical reminders to the individual patient's profile according to the alert type (Lab/DI/Immunization/Procedure/Billing and Others).

1. To create a patient specific alert click on the "Alerts" option from the patient hub or the patient dashboard and then click on Add in the patient specific alert section. The Patient specific alert window opens.

The screenshot displays the 'Patient Specific Alert' window for patient Bennett, Janice. The window is titled 'Patient: Bennett, Janice' and 'Add New Alerts'. It features a 'Alert Type' section with radio buttons for 'Labs', 'D.I', 'Imm / T.Inj', 'Proc.', 'Billing', and 'Other', where 'Other' is selected. Below this is a 'Name' field with a 'Sel' button. There are fields for 'Description' and 'Addl Entities' with an 'Add' button. The 'Recall After' section has radio buttons for 'Day(s)', 'Month(s)', 'Week(s)', and 'Year(s)', with 'Month(s)' selected. A 'Due Date' dropdown is set to '4 /19/2014'. At the bottom of the window are 'OK' and 'Cancel' buttons. In the background, the main interface shows a table of 'Generic/Dx/Rx Alerts' and a table of 'Patient Specific Alerts' with columns for Alert, Last Done, Due Date, Result, and Notes. The 'Add' button in the Patient Specific Alerts table is highlighted with a red box.

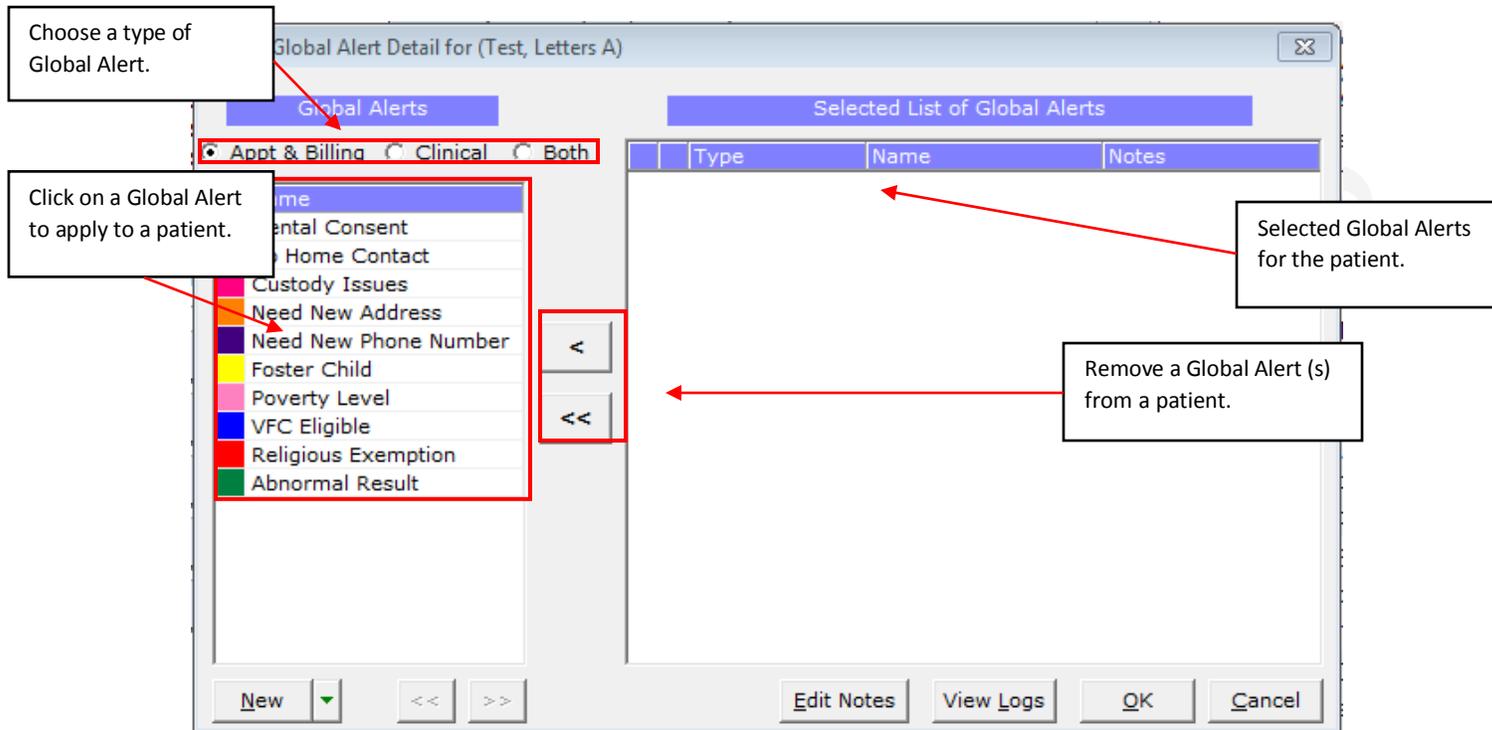
2. Use the drop down list and select one of the options to set up a patient specific alert. You can customize the due date using the "recall after" field. This creates a patient specific alert on the patient.
3. Once the patient gets that order done, the alert needs to be manually suppressed from the alert window.
4. Patient Specific as well as Generic alerts can be recalled using the patient recall feature under the recall band.

- Patient Specific and Generic Alerts can be found by clicking on the 'Alerts' button.
- To suppress the alert, click on the desired alert and click 'Suppress' and enter the 'Remind next on' information and the note.
- The alert can be permanently suppressed by selecting the alert and clicking on the 'Never Remind' button.

The screenshot displays a medical software interface with a patient profile on the left and an 'Alerts' window on the right. The patient profile for Bennett, Janice, 43 Y, F, includes contact information, insurance details, and a 'Subjective' section with a chief complaint of Diabetes Mellitus. The 'Alerts' window shows a table of 'Generic/Dx/Rx Alerts' with one alert selected: 'Dx (2:0) HEMOGLOBIN A1 3 months'. A 'Suppress' dialog box is open over this alert, allowing the user to specify a 'Remind next on' date and time, and add notes. The dialog box also features a grid for selecting frequency intervals (1W, 2W, 3W, 4W, 6W, 2M, 3M, 4M, 6M, 1Y, 2Y, 3Y) and 'OK' and 'Cancel' buttons. Below the dialog, the 'Patient Specific Alerts' section shows a table with one entry: 'Hgb A1c with MBC' with a last done date of 02/26/2014 and a due date of 05/06/2014. The 'Due Only' checkbox is checked.

Global Alerts

Global Alerts are established to alert staff members of important information related to the patient. Global alerts allow staff members to see this information quickly and in a number of areas within the system.



These alerts will pop-up on the screen whenever the patient's appointment is created\modified on the Resource Schedule to alert the front desk staff. The associated colors of the global alert will show up in the patient look up screen and also in the right chart panel. The Notes can also be customized with patient specific information associated with each Global alert.

CDSS Measures

Clinical Decision Support System alerts can be turned on from the “Views” tab in the File -> Settings -> My settings screen. CDSS measures are based on age, gender, and diagnosis.

- The CDSS alerts for a patient can be monitored by clicking on the ‘CDSS’ option in the patient dashboard. All ‘non-compliant’ CDSS alerts (i.e., alerts for which the numerator criteria is not satisfied) show up on the patient chart panel.
- If any of the CDSS alerts in the chart panel are linked with an order set, it is indicated by a ‘+’ symbol before the alert name. Clicking on the ‘+’ symbol shows the order set associated with that alert.
- The order set can be applied to the patient’s progress note by either clicking on the ‘OS’ button or by clicking on the arrow button, if it is a quick order set. For quick order sets, in addition to applying the order set, a status for the order can also be chosen.

Click on the CDSS option to see all CDSS alerts set for patient.

All CDSS alerts with the patient’s status are displayed on the CDSS

All non-compliant CDSS alerts (aka the alerts in red in the CDSS screen) show up on the Chart Panel.

Order sets linked with a CDSS alert show up if the ‘+’ symbol is clicked. To apply a quick order set, click on the arrow button (or if it is a normal order set, click the OS button).

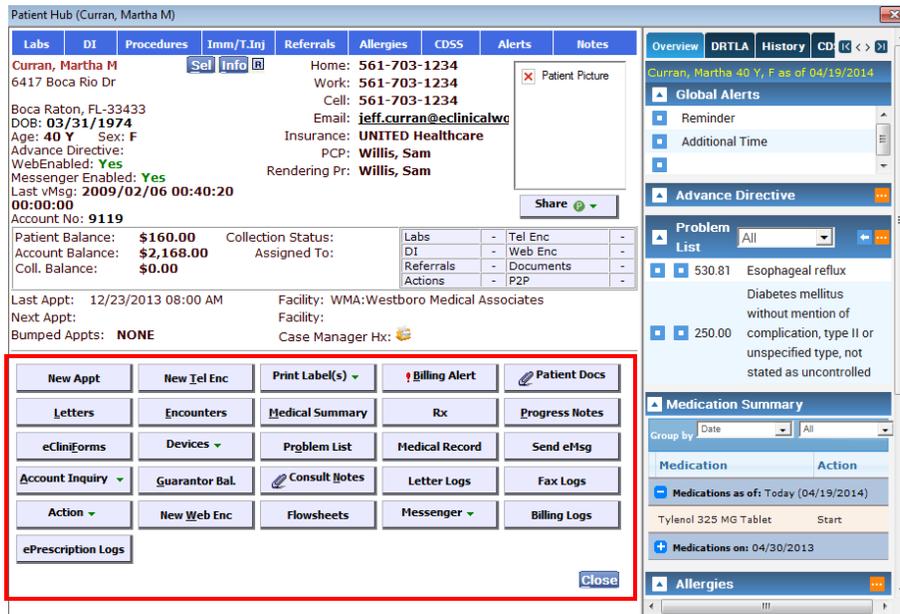
Measure Name	Last Done	Fq	Due Date	Status	Orders
Body Mass Index	24 M 04/19/2014				
BP control in HTN (140/90)	12 M 04/19/2014				Hypertensior
Depression screening	12 M 04/19/2014				
Patients see assigned PCG	12 M 04/19/2014				
Sexual history taken	12 M 04/19/2014				
Smoking status	12 M 04/19/2014				Asthma-adul
Alcohol use screening	03/31/2014 12 M 03/11/2015				
Breast cancer screening	04/19/2014 24 M 04/19/2016				

Dx Practice Alerts	Status
diabetes (HEMOGLOBIN A1C)	3 M 04/19/2014

Patient Specific Practice Alerts	Last Done	Due Date	Status
1-Methyl-histidine,Qn,CSF	02/26/2014	02/27/2014	
Hgb A1c with MBG Estimation	02/26/2014	05/06/2014	

Miscellaneous Features

Patient Hub



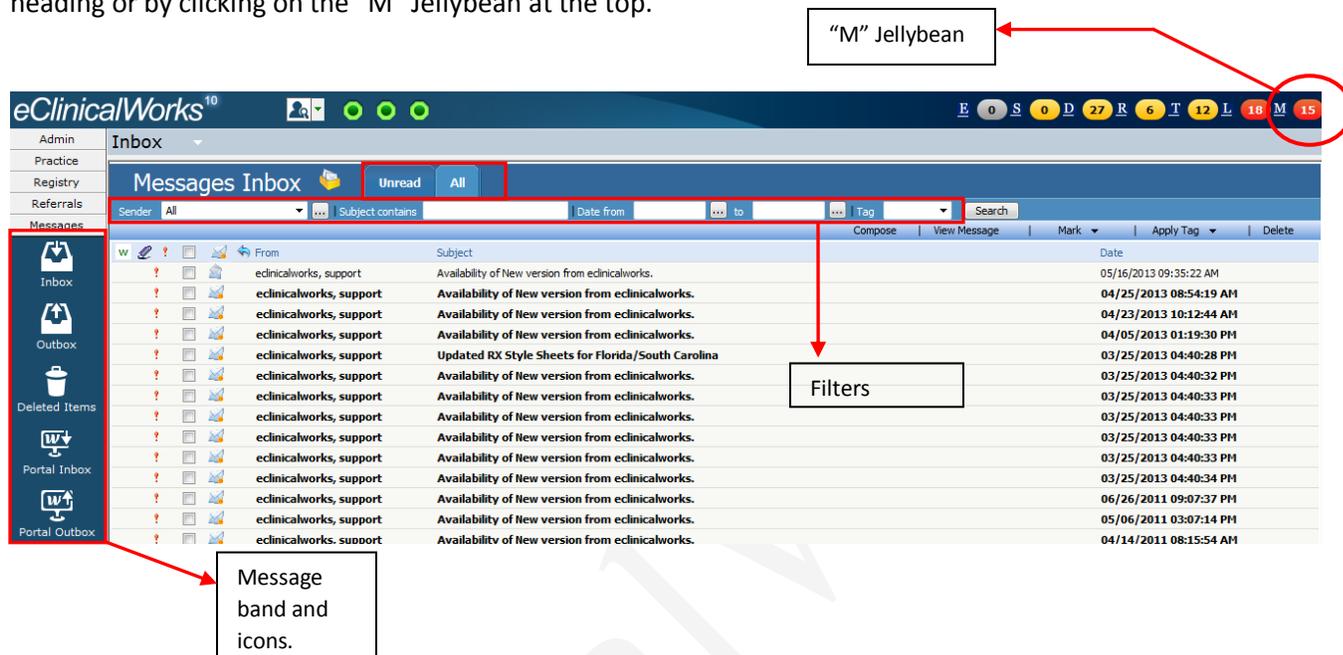
The main panel on the Hub consists of buttons that allow access to various sections of the EMR. Some of the more frequently used buttons are listed below:

- (1) New Tel Enc – Creates a new Telephone Encounter used for documenting phone conversations with patients and medication refill requests.
- (2) Patient Docs – Allows access to the patient’s Documents section that consist of any scanned or faxed documents stored in appropriate folders as well as archived documents from the patient’s previous medical record.
- (3) Rx – Allows access to a summary of all the medications (historical and current) that have been documented for the patient.
- (4) Medical Summary – Provides a summary of the patient’s medical record that can be faxed to a hospital or consulting physician for reference.
- (5) Progress Notes – Provides access to the patient’s progress notes.
- (6) Medical Records – Provides access to the central repository of all of the patient’s progress notes, scanned documents, faxed documents, lab and radiology reports.
- (7) Account Inquiry – Provides access to a detailed overview of the patient / guarantor’s account and balance information.

Messaging

The Messaging feature in eClinicalWorks allows users to send and receive messages internally.

Messages in eClinicalWorks can be accessed in two ways: from the navigation band under the “Messages” heading or by clicking on the “M” Jellybean at the top.

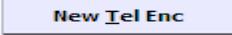


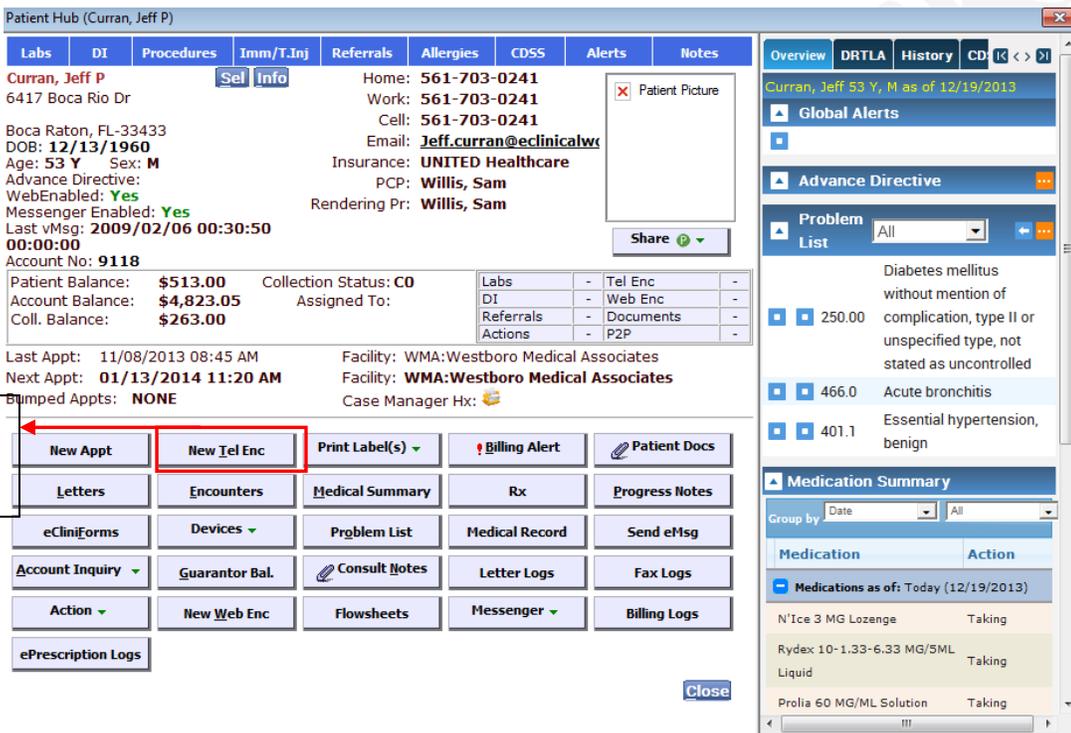
1. The messages band provides access to incoming messages, lets you send messages and provides a way to delete old messages.
2. The number displayed on the 'M' jellybean corresponds to the number of unread messages in your inbox.
3. Clicking on the 'M' letter will also give you options to access the inbox or outbox.
4. Users can compose a new message by clicking on 'Compose' or the 'Create New Message' button.

NOTE: This feature is not used for any clinical documentation for a patient. The clinical documentation regarding a patient needs to be done through telephone encounter. Information regarding a patient that is assigned to a user can be looked up by other users in the event that the assigned to user is out of office. Messages, however, are between the sender and the recipient.

Telephone Encounters

Providers and staff can document telephone conversations he/she had with the patient using the telephone encounter feature. Once documented, the telephone encounter can be assigned to different staff members in the clinic for further action if needed. (Telephone Encounter Examples: medication refill request, message for the provider, lab result request, etc.).

Telephone encounters can be created in several different ways. The easiest recommended way is to create it by clicking on the “New Tel Enc” button  in the patient ‘hub’.



Patient Hub (Curran, Jeff P)

Labs	DI	Procedures	Imm/T.Inj	Referrals	Allergies	CDSS	Alerts	Notes
Curran, Jeff P 6417 Boca Rio Dr Boca Raton, FL-33433 DOB: 12/13/1960 Age: 53 Y Sex: M Advance Directive: WebEnabled: Yes Messenger Enabled: Yes Last vMsg: 2009/02/06 00:30:50 00:00:00 Account No: 9118				Home: 561-703-0241 Work: 561-703-0241 Cell: 561-703-0241 Email: Jeff.curran@eclinicalw Insurance: UNITED Healthcare PCP: Willis, Sam Rendering Pr: Willis, Sam		Patient Picture Share		
Patient Balance:	\$513.00	Collection Status:	CO	Labs	-	Tel Enc	-	
Account Balance:	\$4,823.05	Assigned To:		DI	-	Web Enc	-	
Coll. Balance:	\$263.00			Referrals	-	Documents	-	
				Actions	-	P2P	-	

Last Appt: 11/08/2013 08:45 AM Facility: WMA:Westboro Medical Associates
Next Appt: **01/13/2014 11:20 AM** Facility: **WMA:Westboro Medical Associates**
Bumped Appts: **NONE** Case Manager Hx:

New Appt	New Tel Enc	Print Label(s) v	Billing Alert	Patient Docs
Letters	Encounters	Medical Summary	Rx	Progress Notes
eClniForms	Devices v	Problem List	Medical Record	Send eMsg
Account Inquiry v	Guarantor Bal.	Consult Notes	Letter Logs	Fax Logs
Action v	New Web Enc	Flowsheets	Messenger v	Billing Logs
ePrescription Logs				

Allows you to create a new telephone encounter.

Close

Overview DRTL History CD: [K < > X]

Curran, Jeff 53 Y, M as of 12/19/2013

Global Alerts

Advance Directive

Problem List All

- 250.00 Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- 466.0 Acute bronchitis
- 401.1 Essential hypertension, benign

Medication Summary

Group by Date All

Medication	Action
N'Ice 3 MG Lozenge	Taking
Rydex 10-1.33-6.33 MG/5ML Liquid	Taking
Prolia 60 MG/ML Solution	Taking

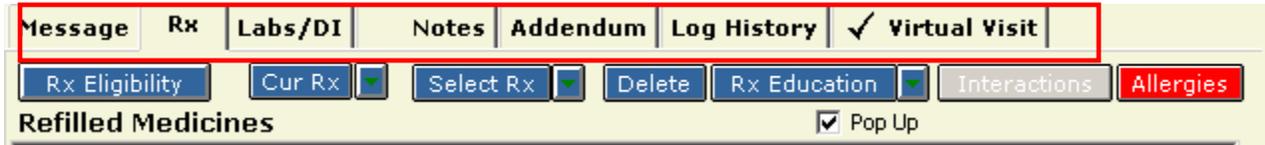
The screenshot shows the 'Telephone Encounter' window with the following fields and sections highlighted by numbered callouts:

- 1:** 'Answered by' field (Willis, Sam), 'Date' (12/19/2013), 'Time' (11:59 AM), and 'High Priority' checkbox.
- 2:** 'Patient' section containing name (Curran, Jeff P), DOB, Age, Sex, Tel, Acct No, and Elgb Status.
- 3:** 'Caller' field (Jeff).
- 4:** 'Reason' field (Needs call back from MD).
- 5:** 'Message' text area containing: 'Jeff call to discuss his symptoms with Dr. Willis. Please call patient back.'
- 6:** 'Action Taken' section containing: 'Willis,Sam 12/19/2013 12:01:45 PM > Call and spoke to Jeff.'
- 7:** 'AssignedTo' field (Willis, Sam).
- 8:** Window title bar and close buttons.
- 9:** 'Status' section with radio buttons for 'Open', 'Addressed', and 'Addressed and Docs Reviewed'.

1. The “answered by” field will be populated with the name of the person who creates the telephone encounter. The date and time are also automatically documented.
2. If the telephone encounter is created from the patient’s hub, the patient’s name and demographic details (including the provider name) will be populated automatically.
3. The name of the caller can be documented under the ‘Caller’ section. (Example; Mom, Wife, etc.).
4. The reason for the call can be chosen from the respective drop-down or also typed in.
5. The actual message can be typed in the “message” section.
6. The follow-up action taken for the issue can be documented in the respective section.
7. The telephone encounter thus created can be assigned to a provider or staff member appropriately.
8. For issue which requires immediate attention, staff can check off the ‘High Priority’ check box. This will trigger the Jellybean to turn ‘Red’.
9. Once the issue is addressed or taken care of, the telephone encounter can be ‘closed’ by selecting the “Addressed” option.

Different Tabs in the Telephone Encounter (Overview)

In addition to the message tab, the telephone encounter also comes with additional tabs where each tab's functionality is explained below:



'Rx' tab – Provides access to the patient's current medications, Rx history and allows providers to refill the selected medications.

'Labs/DI' tab – Provides access to the patient's Labs/DIs and the results.

'Notes' tab – Allows provider/staff to document additional notes.

'Addendum' tab – Allows provider/staff to add an addendum to the addressed (locked) telephone encounter.

'Log History' tab – Provides access to the history of the telephone encounter.

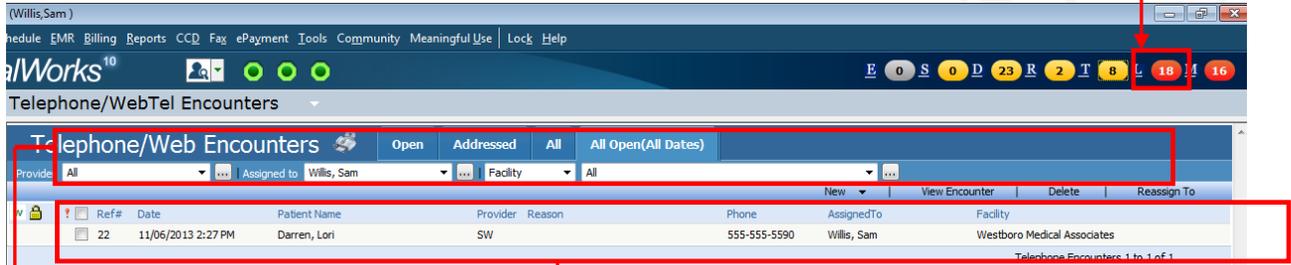
'Virtual Visit' tab – Provides access to the virtual progress note.

NOTE: *The telephone encounter is strongly recommended to document any phone messages which need to be a part of the patient's medical records, including, front office, clinical or billing related phone calls.*

Looking Up the Assigned Telephone Encounters

The assigned telephone encounter will show up in the 'T' jelly bean (the number reflects the amount of telephone encounters that have been assigned to the user). The active (open) telephone encounters are found under the 'Open', 'All' and 'All Open (All Dates)' tab.

Allows you to see how many telephone encounters have been assigned to you.



Filters: Allows you to view desired telephone encounters.

Telephone encounter

If you are assigned a 'High Priority' telephone encounter, the 'T' jelly bean will turn red.

Once the telephone encounter is addressed, it is moved to the 'Addressed' tab.

Medication refill process using a telephone encounter

- The patient's primary pharmacy can be selected on the "Additional Information" screen within the patient's demographics. It can be changed/modified, if required, for a single telephone encounter.
- Medication requests can be typed in the message section and the status of the medication can be checked using the right chart panel.

The screenshot shows the 'Telephone Encounter' window for patient Lyndsey Blurton. The 'Additional Information' section is highlighted with a red box, showing the 'Pharmacy' dropdown set to 'eRX Pharmacy (P)'. The 'Message' section contains the text 'Lipitor 10 MG, refill requested'. The 'Medication Summary' panel on the right is also highlighted with a red box, showing a list of medications including Lipitor 10 MG Tablet, Tylenol 325 MG Tablet, and Nicorette 4 MG Gum.

The patient's preferred pharmacy will show up automatically. It can be changed for an instance by clicking on the "..." button. The "E" symbol indicates that the pharmacy is "e-prescribe" enabled (medications can be sent electronically).

The history of the patient's updated 'Current Medications' list will show up in the 'Chart Panel'.

1. The respective medication can be chosen from the Rx tab of the Telephone Encounter.
2. The number of refills to be given can be entered appropriately by clicking the 'Cur Rx' button on the Rx tab of the Telephone Encounter.

The 'Manage Orders' window displays a 'Medication Summary' for the patient. It includes a table with columns for Medication, Action, Dur., D, R, and Source StopDt. The table lists current medications as of 10/29/2013: Lipitor 10 MG Tablet (Refill, SW), Tylenol 325 MG Tablet (Taking, SW), and Nicorette 4 MG Gum (Taking, SW). It also shows historical medication orders for 10/29/2013, 10/28/2013, and 10/15/2013.

Click on the "Rx" tab to open the medication refills screen. Clicking on the "Cur Rx" button will open the current medications list window. The number of refills can then be typed in as required.

3. Once the number of approved refills are typed in, the prescription for the patient can be:
 - (a) Printed out on prescription paper.
 - (b) Faxed electronically to the patient's pharmacy.
 - (c) E-prescribed (electronically prescribed) to the pharmacy.

Actions

You can create a new action from the 'Review Actions' window that can be accessed from the 'T' jellybean or by clicking the 'New Action' button on the 'Patient Hub'. You can assign an action to a staff member.

The screenshot shows the 'Actions' form with the following fields and options:

- Action** (tab highlighted in red)
- Name *
- Action Type
- Subject *
- Assigned To *
- Facility: Westboro Medical Associates
- Start Date: Wed, 05/14/2014 12:00:00 AM
- Due Date: Wed, 05/14/2014 12:00:00 AM
- Status *
- Priority: Normal
- Created By: Willis, Sam
- Creation Date: 05/14/2014 03:31 PM
- Notes
- Recurrence Pattern: Frequency, Hour(s), Day(s), Week(s), Month(s), Year(s)
- Range of recurrence: No end date, End after, End by
- Buttons: Merge Template, OK, Cancel

- 1) Actions can be filtered using their status by clicking on one of the following tabs in the Review Actions window: All, Open, All Open (All Dates), All Open (As of Today) Addressed and Cancelled.

The screenshot shows the 'Review Actions' window with the following elements:

- Navigation tabs: All, Open, All Open (All Dates), All Open (As of Today), Addressed, Cancelled (All tab highlighted in red)
- Filters: Assigned to, Willis, Sam; Facility; All; Patient
- Table with columns: Date, Status, Assigned To, Action Type, Subject, Created By, Start Date, Facility
- Buttons: New Action, View Action, Reassign To (highlighted in red)
- Red box with '12' in the top left corner

Date	Status	Assigned To	Action Type	Subject	Created By	Start Date	Facility
09/17/2013 12:00	Not Started	Willis, Sam	General -	General -	WILLIS, SAM	09/17/2013	
09/29/2013 05:26	Not Started	Willis, Sam	Scheduling	Schedule Surgery	Willis, Sam	09/27/2013	Westborough Medical Associates
11/01/2013 02:42	Not Started	Willis, Sam	Scheduling	Schedule Surgery	Willis, Sam	09/29/2013	Westborough Medical Associates
11/02/2013 11:08 AM	Not Started	Willis, Sam	Scheduling	Schedule Surgery	Willis, Sam	09/30/2013	Westborough Medical Associates

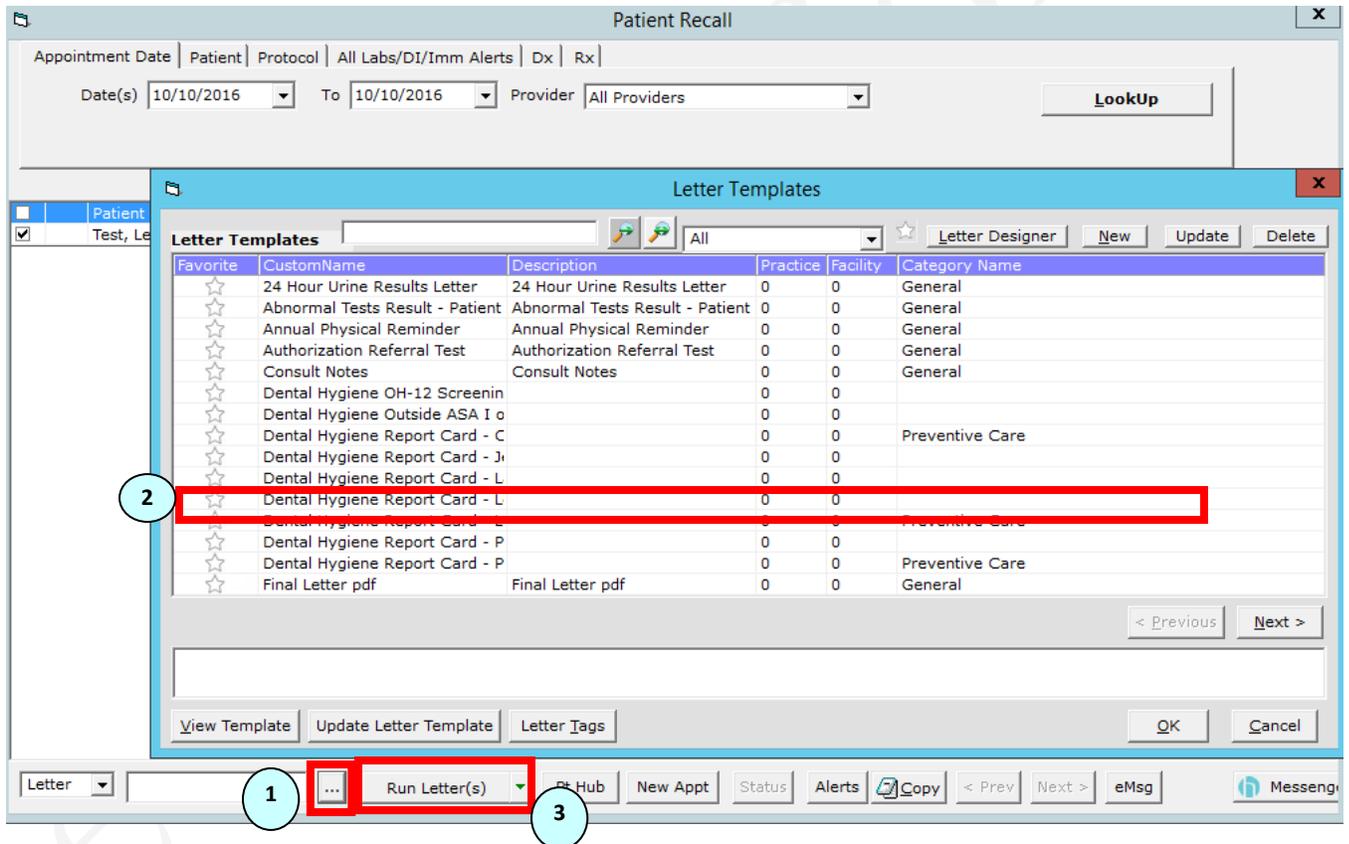
- 2) Multiple actions can now be reassigned at once by checking the box(es) next to all actions you want to reassign and clicking the Reassign To link in the upper-right corner of the window.

Letters

Generating and printing letters for a patient

Letter templates for commonly generated patient-specific letters can be set up as Microsoft® Word documents in eClinicalWorks. Once these letter templates are set up they can be printed for an individual patient by clicking on the “Letters” button from the patient’s Hub or clicking on “Letters” from the patient’s progress note and then following three simple steps as outlined below:

1. Click on the “Letter” [...] button at the bottom left of the screen
2. Choose the letter template that has to be printed out for the patient.
3. Click on the “Run Letters” button to generate the letter for the patient as a Microsoft® Word document that can be printed out as required.



NOTE: All letters have been created using tags that work from the progress note.

Documents – Scanning Documents and Working with Scanned Documents

eClinicalWorks comes with a document management feature which allows:

- Staff to scan patient documents into the system and attach the documents to the electronic chart (consent forms, lab results, consult reports, etc.).
- External entities to fax documents directly into the EMR system. The document will be faxed electronically into the system and the staff will be able to attach the document to the patient's electronic chart.

Scanning

1. The eClinicalWorks scanning module can be accessed by clicking on the “Patient Documents” icon under the “Documents” band in the left navigation panel or from the Patient Hub.

Select the patient for whom the documents need to be scanned.

Patient Document folders where scanned documents are stored.

Scanning settings.

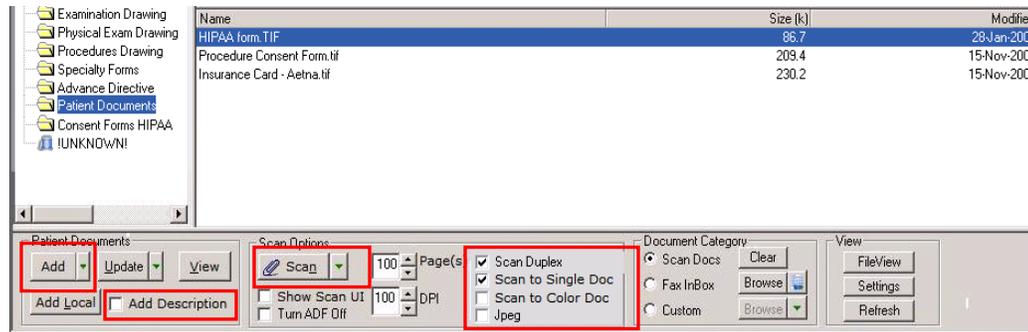
This number signifies the number of documents assigned to a user.

SCAN BUCKET: Scanned documents will be temporarily stored here. Users can then select the documents and add them into the right folder.

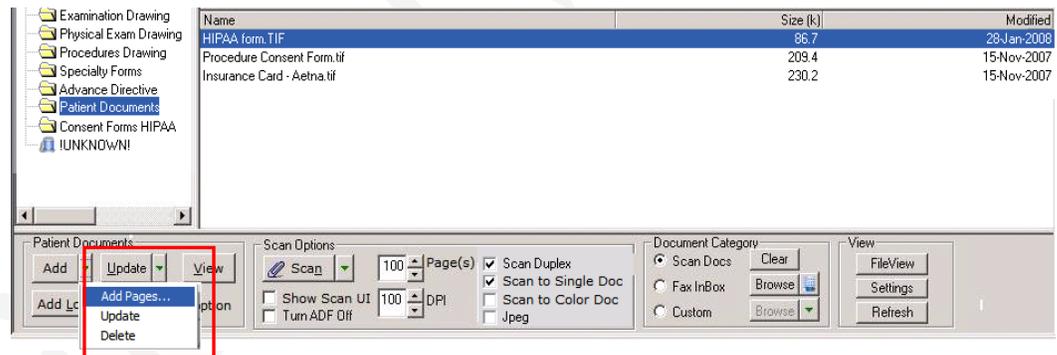
The screenshot shows the eClinicalWorks interface. The top navigation bar includes 'Patient Documents' and a user notification '0 D 26 R 3 T 12 L 17'. The left navigation panel has a 'Documents' band with a 'Patient Documents' icon. The main content area displays a patient's chart for 'Curran, Jeff P' with a list of document folders and a preview of an anatomical diagram. The bottom section contains 'Scan Options' and 'Document Category' controls.

2. After feeding the document into the scanner in the appropriate way, the number of pages can be specified if necessary and then clicking on the ‘Scan’ button will scan in the document and place it on the ‘Scan Bucket’.
3. The scanned documents can then be moved into the respective patient folder by following a simple 3-step process:
 - (i) Select the scanned document.
 - (ii) Select the folder where it needs to be added into.
 - (iii) Click on the ‘Add’ button (Make sure that ‘Add Description’ is checked off).

- Two-sided scanning can be done by checking off the “Scan Duplex” option prior to clicking on the ‘Scan’ button. Multi-page scanning can be accomplished by checking off the “Scan to Single Doc’ option prior to clicking on the ‘Scan’ button. (Please see screenshot on next page).



- To add certain pages only from the scanned document onto the patient’s folders, the “Add Pages” option that shows up when the green arrow right next to the “Add” button is clicked on can be used. This is typically useful when a faxed document has to be added on to the patient’s folder without the cover sheet.



- The “Add Local” button located right below the “Add” button can be used to add any ‘local’ files (i.e., files from your computer) on to one of the patient folders.
- By checking off the ‘Add Description’ check box before clicking on the ‘Add’ button, this allows staff to rename the scanned document, add additional notes as well as assign the document to other staff member in the practice.

Allows the staff to rename the document.

Allows the staff to review the document/mark the document as high priority.

Allows the staff to timestamp and add additional notes.

Allows the staff to assign the document to another staff member.

Allows the staff to attach the document to a lab/DI order or a progress note.

NOTE: The recommended naming convention to be followed when adding scanned documents into the respective folders is to “YYYY/MM/DD; County; NameOfDocument”. For example, if you are scanning a lab result that was received on the 1st of April, 2011, the scanned document should be named as ‘2011/04/01; CBC Result’. This recommended naming convention makes it easy to sort the documents in chronological order.

Working with Assigned Documents

Assigned documents can be viewed in the 'D' jellybean. The number in the jellybean indicates the amount of documents a particular user has to review. A red jellybean indicates that there is a 'High Priority' document in the inbox. The high priority document has an '!' in front.

Allows you to see how many documents have been assigned to you.

Scan Date	Patient Name	Custom Name	Assigned To	Description	Facility
11/17/2015	TestAetna6, Sheila	face	Willis, Sam		
11/17/2015	test, testDev B	BackViewLeftArm	Willis, Sam		
11/10/2015	Curran, Jeff P	PerioChart 11/10/2015 14:44:7	Willis, Sam	Snapshot of patient's perio chart	
08/17/2015	Jones, Jennie	BackViewLeftArm	Willis, Sam		
05/22/2013	Jones, Raul	boy1	Willis, Sam		
02/28/2013	Darren, Gary	CatScan	Willis, Sam		
10/06/2011	Jones, John	FrontViewLeftEar	Willis, Sam		
10/06/2011	Patel, Raj	Eyes	Willis, Sam		
10/06/2011	Jones, Maude	BackViewWholebody	Willis, Sam		
05/10/2011	Johnson, Jack	BottomNose	Willis, Sam		
02/25/2011	Jones, Mary	face	Willis, Sam		
02/21/2011	Johnson, Jack	face front view	Willis, Sam		
01/11/2011	Darren, Gary	face	Willis, Sam		
12/28/2010	Darren, Lori	Eyes	Willis, Sam		
12/10/2010	Darren, Gary	Eyes2	Willis, Sam		
12/10/2010	Jones, Jennie	hands	Willis, Sam		
11/22/2010	Curran, Jeff P	BackViewWholebody	Willis, Sam		
10/04/2010	Darren, Lori	Eyes2	Willis, Sam		
08/20/2010	Lab, Larry	face front view	Willis, Sam		
07/23/2010	Darren, Lori	FaceFront	Willis, Sam		
02/04/2009	Curran, Jeff P	Cardio ECG Strips 001.jpg	Willis, Sam		

Filters: Allows you to search for documents with a status.

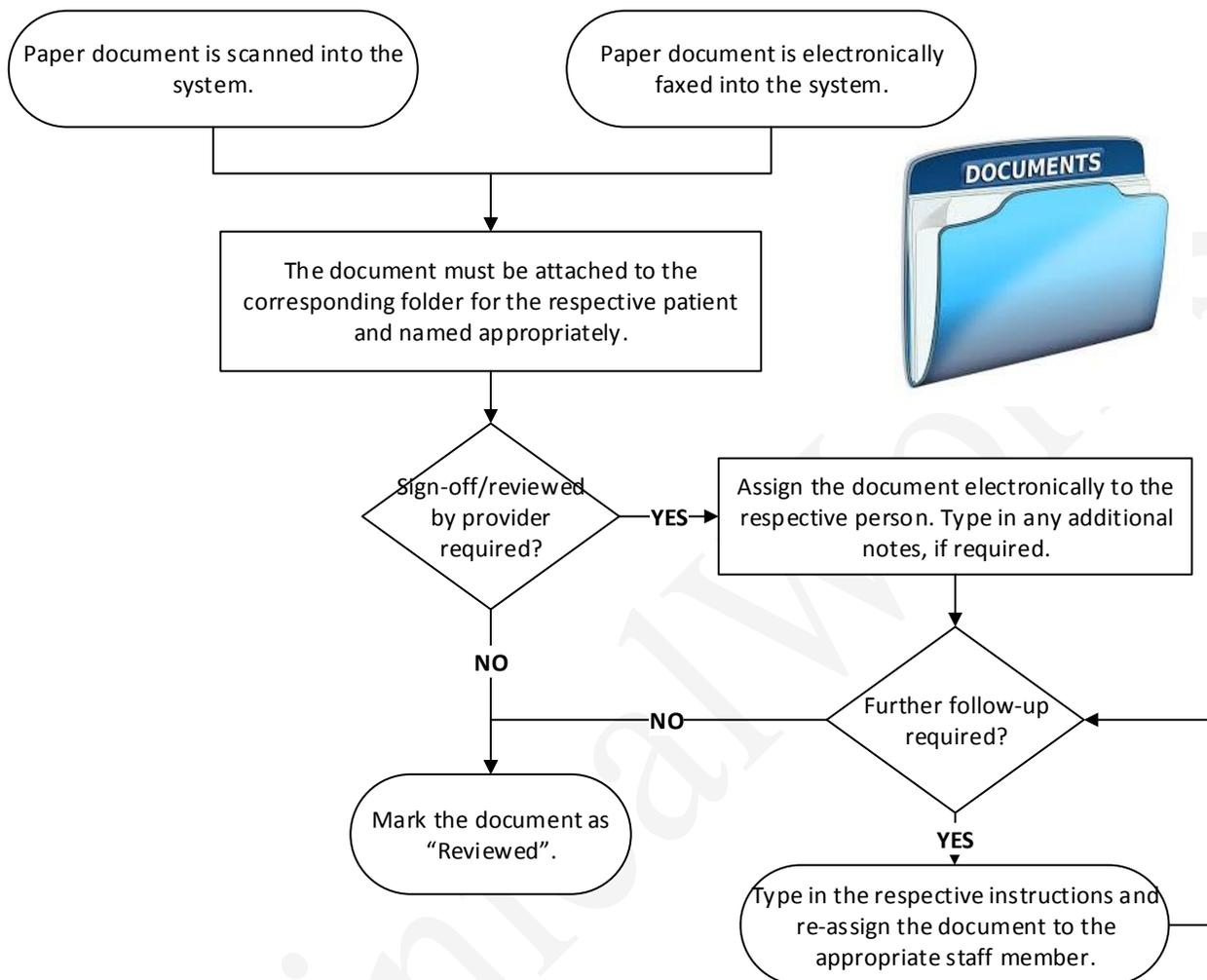
Document list.
'!' indicates a high priority document.

When clicking on a document from the document list, users can view the document as well as add additional notes under the 'Description' section, draw/sign on the document using the 'Ink Edit' button, reassign the document to another user, or mark the document as 'Reviewed'.

The screenshot displays the 'Document Details' window in eClinicalWorks. The interface includes a document ID field (9271 443BB88A-ED6E-FE42-B69A-94EBD928A239), a 'Description' text area, a 'Tag' field, a 'Scanned By' dropdown (Willis, Sam), and a 'Scanned Date' dropdown (4/19/2014). On the right, the 'Progress Notes' section contains 'Options' (Reviewed, Reviewed Doc and Lab, High Priority), 'Assigned To' (Willis, Sam), and a 'Facility' dropdown. A large image of a human eye is shown in the center, with a red circle highlighting a specific area. At the bottom, a navigation bar includes buttons for 'Next', 'Next(R)', 'Progress Notes', 'Patient Hub', 'Ink Edit', 'Refresh', 'OCR', 'OK', and 'Cancel'. Red callout boxes provide the following explanations:

- Top Left:** Allows the user to timestamp and add additional notes. (Points to the 'Time Stamp' button and the 'Description' field.)
- Top Right:** Allows the provider/staff to review the document/mark the document as high priority. (Points to the 'Options' section.)
- Middle Right:** Allows the user to assign the document to another staff member. (Points to the 'Assigned To' dropdown.)
- Bottom Left:** Allows the user to attach the document to a lab/DI order or a progress note. (Points to the 'Attached To' field.)
- Bottom Center:** Shortcuts – Open Progress Notes, Patient Hub, allows provider to draw/sign on the document, etc. (Points to the 'Progress Notes', 'Patient Hub', and 'Ink Edit' buttons.)

The below workflow illustrates the management of documents that are scanned into the system and that are faxed into the system.



Receiving Lab/DI Results Without an Interface

1. Lab and Diagnostic Imaging results can come back through an interface, as printed copies, or can be faxed electronically to eClinicalWorks.

If results come back as printed copies or hard copies, they must be scanned into the system. If they are electronically faxed into eClinicalWorks, you will be able to view the document from the “Fax Inbox” section. These respective documents must then be put into the appropriate folders in the “Patient Documents” section.

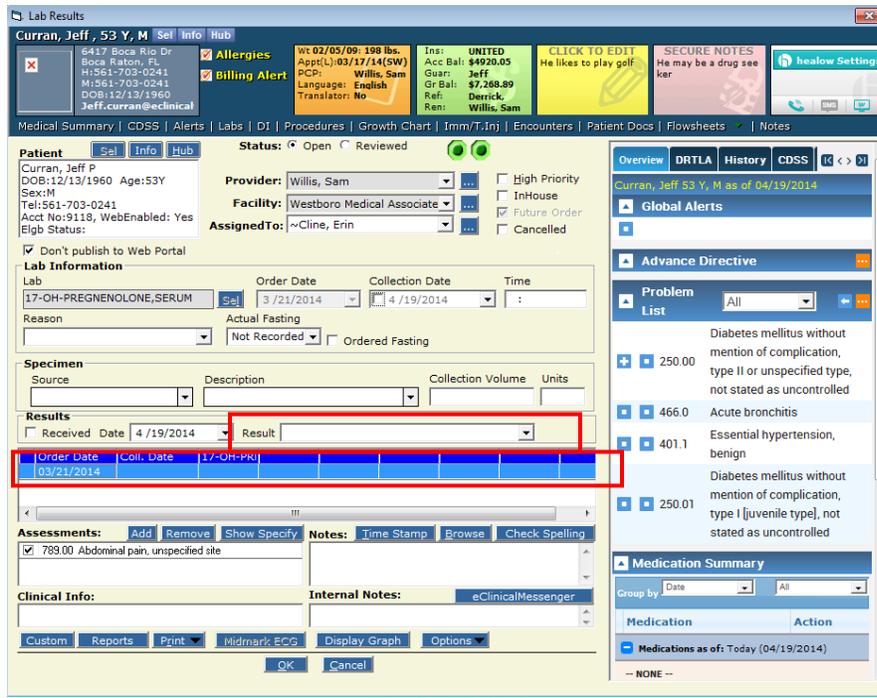
2. Once the lab report is added to the appropriate folder in the Patient Documents section, it must be linked with the corresponding lab or diagnostic imaging order. This can be done by clicking on the ellipsis button (the button with three dots) next to the “Attached to” option and then selecting the appropriate lab or DI order from the patient’s list of orders.

Note: If there are multiple orders for the same lab, make sure the report is linked to the correct lab order by looking at the date of the order.

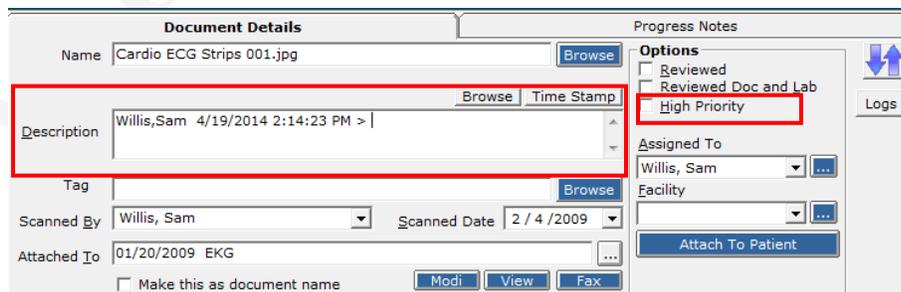
The screenshot displays the eClinicalWorks interface. At the top, a patient summary for Jeff Curran, 53 Y, M, is shown with various alerts and settings. Below this, the 'Document Details' section is visible, showing a document named 'Cardio ECG Strips 001.jpg' with fields for description, tag, scanned by (Willis, Sam), scanned date (2/4/2009), and attached to (01/20/2009 EKG). A red box highlights the ellipsis button next to the 'Attached to' field. Below the document details, a 'Labs' window is open, displaying a table of lab orders. A red box highlights the order for '17-OH-PROGESTERONE, S...' on 03/21/2014. A callout box with an arrow points to this order, stating: 'Double click on the respective order to open the “Results” screen where you can enter the “Result” of the lab/DI, for tracking purposes.'

LAB CATEGORIES	HM	S	O	W	Order Date	Coll Date	Result Date	Labs	Reason	Result	Received	Reviewed
ALL												
ANATOMIC PATH/C...												
BLOOD BANK												
BLOOD GASES												
CHEMISTRY												
COAGULATION												
GENETICS												
HEMATOLOGY												
HEMATOLOGY/COAG...												
IMMUNOLOGY												
IMMUNOLOGY RAST												

- To be able to track the results of the lab/DI, when you select the lab/DI to attach it to the scanned report, simply double click on the respective lab/DI order to open up the “Results” screen. On this screen you can select the appropriate description of the result from the corresponding drop-down option and enter discrete result data in the yellow attribute fields.

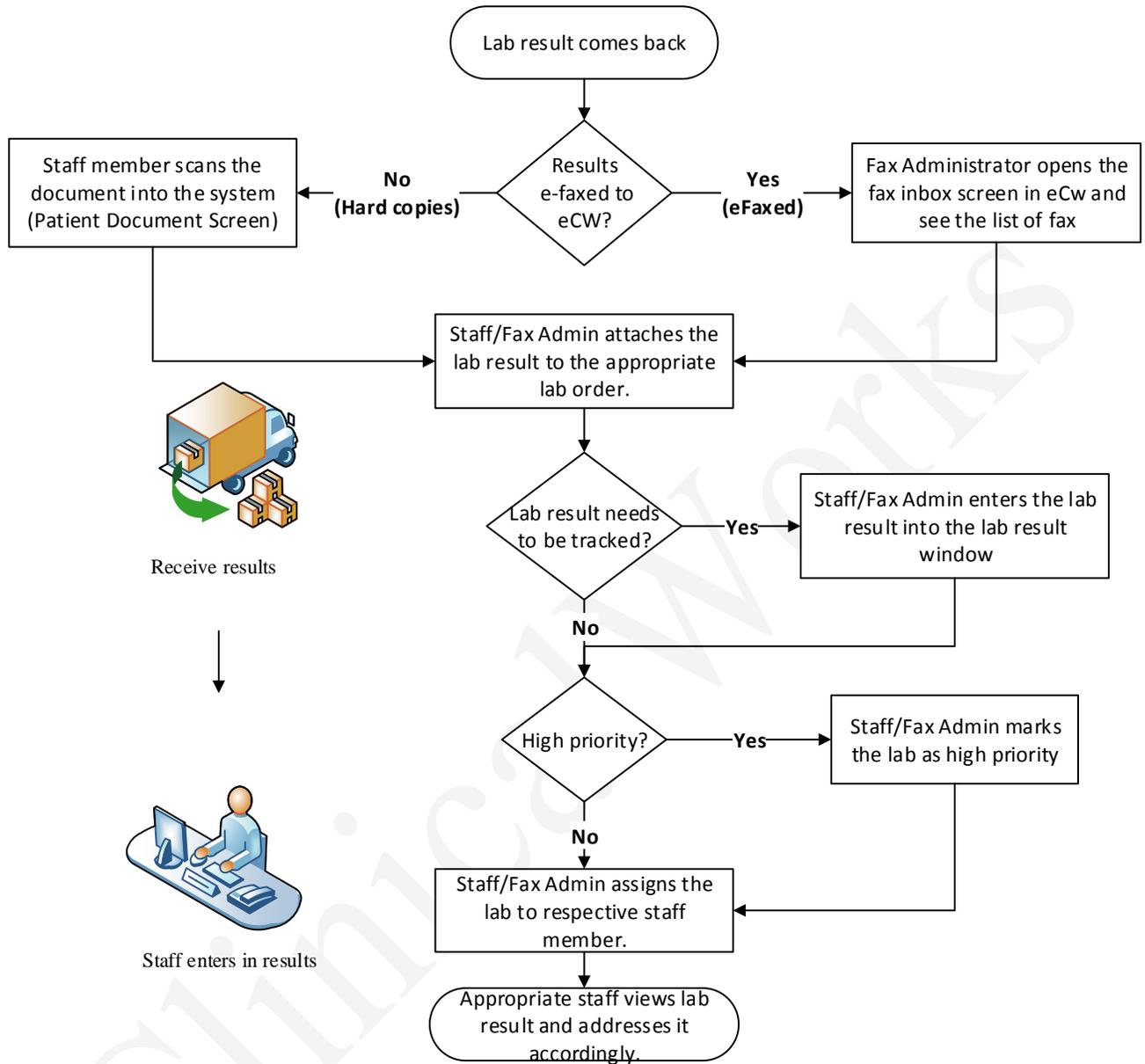


- Once the lab/DI report is linked with the corresponding lab/DI order, you can then assign the result to the provider for review. If this is a high priority lab order, you can check off the “High Priority” option on the Document Details screen.
- The provider will get these lab results in his/her ‘D’ jellybean. They can open the document and write their comments/ notes in the “Description” section. Please make sure to “Time stamp” in the description section whenever a note/comment is entered.

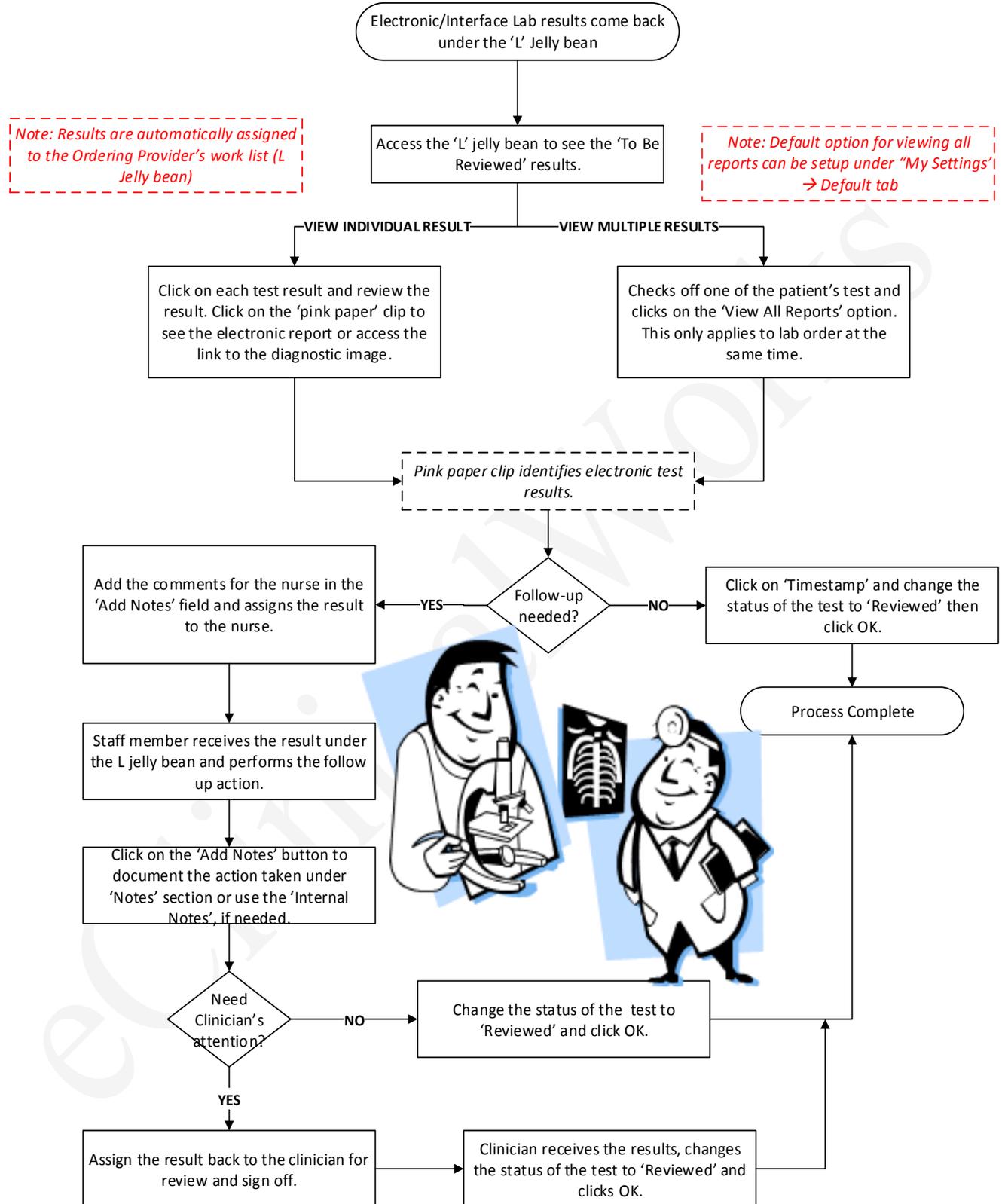


- Once the report has been reviewed the provider can check off the “Reviewed Doc and Lab” option, if the report is linked with the appropriate lab/DI or click on the “Reviewed” option if the report is not linked with the appropriate order.

The below workflow illustrates when the practice receives results from labs and diagnostic imaging.



The below workflow illustrates the lab/DI process with a bi-directional interface.



Electronic Faxing & eClinicalWorks

Incoming Faxes

As introduced in the previous section, eClinicalWorks includes a document management feature which allows external entities to fax the document directly into eClinicalWorks. The document then can be attached to the patient's electronic chart.

1. The Fax inbox can be accessed either by clicking on the "Fax Inbox" icon in the "Documents" band, by choosing the "Fax Inbox" option in the 'Patient Documents' screen or by clicking on the letter 'D' of the jelly bean.

The screenshot displays the eClinicalWorks interface. On the left sidebar, under the 'Documents' band, the 'Fax Inbox' icon is circled in red. A callout box with a red arrow points to this icon, containing the text: "Click on fax inbox here to access electronic faxes." In the main content area, the 'Patient Documents' screen is visible. At the bottom of this screen, the 'Document Category' dropdown menu is open, and 'Fax Inbox' is selected and circled in red. A callout box with a red arrow points to this selection, containing the text: "Users can also view faxes by selecting Fax Inbox here." The interface also shows a list of patient documents with file names like ~D\FE8CE0590A578C7D4.TMP and ~D\FAA7C0B285F64E9C0.TMP.

2. Attaching received faxes into the respective patient's folder can be done by simply selecting the fax document, selecting the folder where it needs to be added and then clicking on the "Add" button (similar to the process followed for attaching scanned documents).
Similarly, individual pages from the received fax can be added to a particular folder by using the "Add Pages" option, under the "Add" button (similar to Step 9 above).

Outgoing Faxes

eClinicalWorks allows users to electronically fax documents from the application. Users can access the fax feature by clicking on the 'Fax' button from various sections of the application (Ex. Progress Notes, Patient Documents, Lab/DI Order, etc.). Once the document(s) is faxed out, users can monitor the status of the outgoing faxes through the 'Fax Outbox' screen.

1. The fax 'outbox' is where all the faxes that were sent out electronically from eClinicalWorks are listed.

The fax outbox can be used to monitor the following information:

- (A) The number of faxes sent out by a user / provider / facility.
- (B) The number of faxes sent out by date.
- (C) The status of each fax that was sent out (completed/pending/failed).
- (D) The date and time when the fax was sent.
- (E) The destination fax number and name.

Click on fax outbox icon to see the overall fax logs.

Sent By	Provider	Patient	To Name	Fax No	Fax Status	Sent Date
Lavin, John	*ecwDaytona, Sp	Test, Fax		5084750843	Completed	10/09/2008 10:53:00
venkataraman, ve	*ecwSpoke, Spok	Test, Fax	testfax	3016385454	Completed	10/09/2008 11:49:00
Chandran, Bimal	*ecwSpoke, Spok	Test, Fax	Testing.....jane	231-757-9284	Completed	10/09/2008 11:56:00
Chandran, Bimal	*ecwSpoke, Spok	Test, Fax	Test fax 2 Jane	2317579284	Completed	10/09/2008 11:55:00
Chandran, Bimal	*ecwSpoke, Spok	Test, Fax	Test fax ...Jane ^_^	2317579284	Completed	10/09/2008 11:56:00
Chandran, Bimal	*ecwSpoke, Spok	Test, Fax	Test Rashid	732-889-1551	Completed	10/09/2008 12:03:00
Kumar, Satish	*ecwSpoke, Spok	Test, Fax	Test Shyam	4787452915	Completed	10/09/2008 12:20:00
Dahibawkar, Girish	*ecwSpoke, Spok	Test, Fax	testecw	3524830822	Completed	10/09/2008 12:33:00
Kumar, Satish	*ecwSpoke, Spok	Test, Fax	Kapil Fax	2127405554	Completed	10/09/2008 12:58:00
Rajpal, Kapil	*ecwSpoke, Spok	Test, Fax	Test Fax Kapil	2127405554	Completed	10/09/2008 13:07:00
Kumar, Satish	*ecwSpoke, Spok	Test, Fax	Kapil	2127405554	Completed	10/09/2008 13:18:00
Dhyani, Vivek	*ecwSpoke, Spok	Test, Fax	Kapil Fax	2127405554	Completed	10/09/2008 13:18:00
Chandran, Bimal	*ecwSpoke, Spok	Test, Fax	Test DR	9738222393	Completed	10/09/2008 13:18:00
Zagade, Hitesh	*ecwSpoke, Spok	Test, Fax	Test fax	9739128340	Completed	10/09/2008 13:27:00
Zagade, Hitesh	*ecwSpoke, Spok	Test, Fax	Test Fax	9739128340	Completed	10/09/2008 13:38:00
Rajpal, Kapil	*ecwSpoke, Spok	Test, Fax	Test Fax Kapil	2127405554	Completed	10/09/2008 13:38:00
Zagade, Hitesh	*ecwSpoke, Spok	Test, Fax	Test Fax	9739128340	Completed	10/09/2008 13:38:00
Kumar, Satish	*ecwSpoke, Spok	Test, Fax	Kapil	2127405554	Completed	10/09/2008 14:07:00
Lavin, John		Test, faxed		5084750843	Completed	10/09/2008 14:10:00
Prabhu, Rohit	*ecwSpoke, Spok	Test, Fax	Test fax	406-345-2604	Completed	10/09/2008 14:10:00
Talekar, Parag	*ecwSpoke, Spok	Test, Fax	test	2124962133	Failed	
Talekar, Parag	*ecwSpoke, Spok	Test, Fax	t2	2134962133	Completed	
Talekar, Parag	*ecwSpoke, Spok	Test, Fax		2124962133	Completed	
Talekar, Parag	*ecwSpoke, Spok	Test, Fax	t3	2124962133	Completed	10/09/2008 14:14:00
Shetty, Roshan	*ecwSpoke, Spok	Test, Fax	TEST-DMN-FAX	2626434721	Completed	
Zagade, Hitesh	*ecwSpoke, Spok	Test, Fax	Test fax	9492484587	Completed	10/09/2008 15:25:00
Zagade, Hitesh	*ecwSpoke, Spok	Test, Fax	Test Fax 1	9492484587	Completed	10/09/2008 15:27:00

2. The individual patient fax logs can be viewed by clicking on the "Fax Logs" button from the patient's Hub.

Receiving an Electronic Rx Refill Request

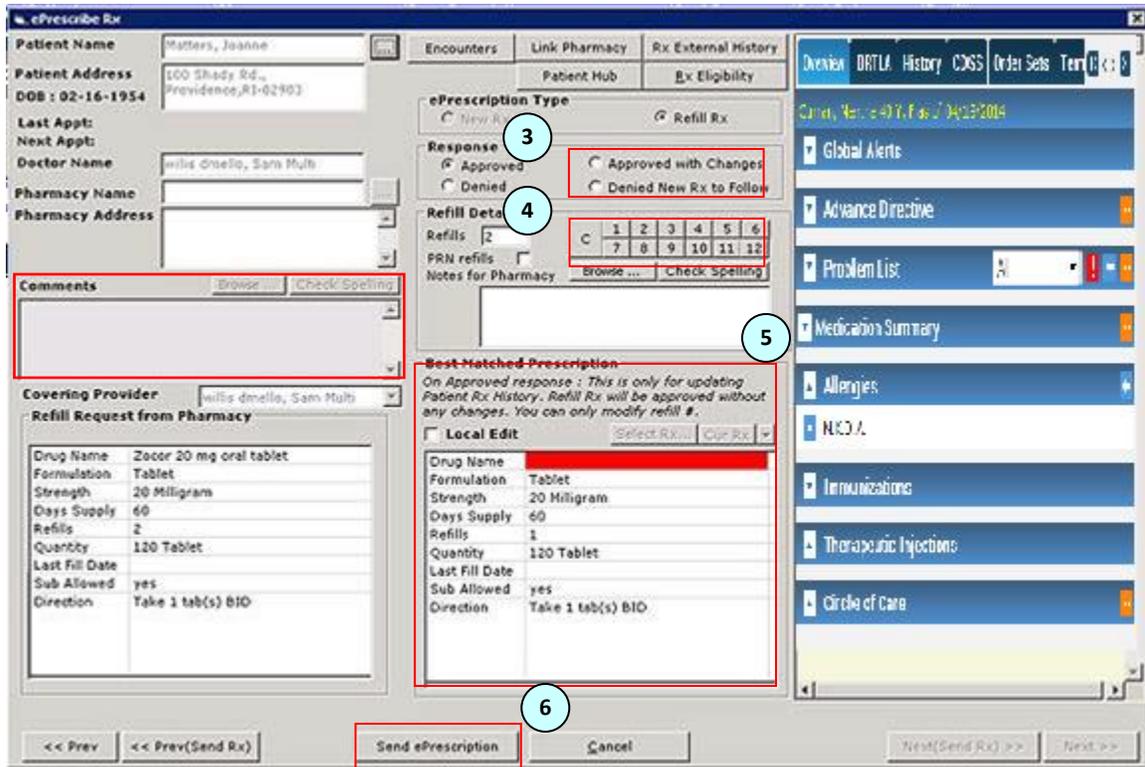
In addition to sending the Rx refill request via fax and telephone messages, Pharmacies can send the electronic refill request directly into eClinicalWorks. Once received, the 'E' jellybean of the provider will increase. The provider can respond to the eRequest by:

The screenshot shows the eClinicalWorks interface. At the top right, a toolbar contains several icons, including a red box labeled '1' around the 'E' jellybean icon. Below the toolbar, the 'ePrescriptions' window is open, showing a dropdown menu for 'Provider' set to 'Willis, Sam A'. Below this is a table with the following data:

Type	Status	Provider	Patient	Pharmacy	Drug Description	Sent By
Refill Request	Success	Willis, Sam	Tucker, Debra	TEST XML4 Pharmacy	VICODIN ES TABLET	
Refill Request	Success	Willis, Sam	Tucker, Debra	TEST XML4 Pharmacy	VICODIN ES TABLET	

A red box labeled '2' highlights the table area. At the bottom of the window, there is a 'Refresh' button.

1. Click on the 'E' Jellybean.
2. Select the refill request (double click).
3. From the ePrescribe Rx Window, select the action you would like to take:
 - a. Select 'Approved' to approve the refill request.
 - b. Select 'Denied' to deny the refill request.
 - c. Select 'Approved with Changes' to indicate that the request is approved with specified changes.
 - d. Select 'Denied New Rx to Follow' to indicate that the request is denied and that a new drug will be prescribed.
 - e. Select 'Approved with Changes' if making changes to refill prescription before approving it.



4. If you approved or denied the refill request, provide details for the refill in the 'Refill Details' pane:

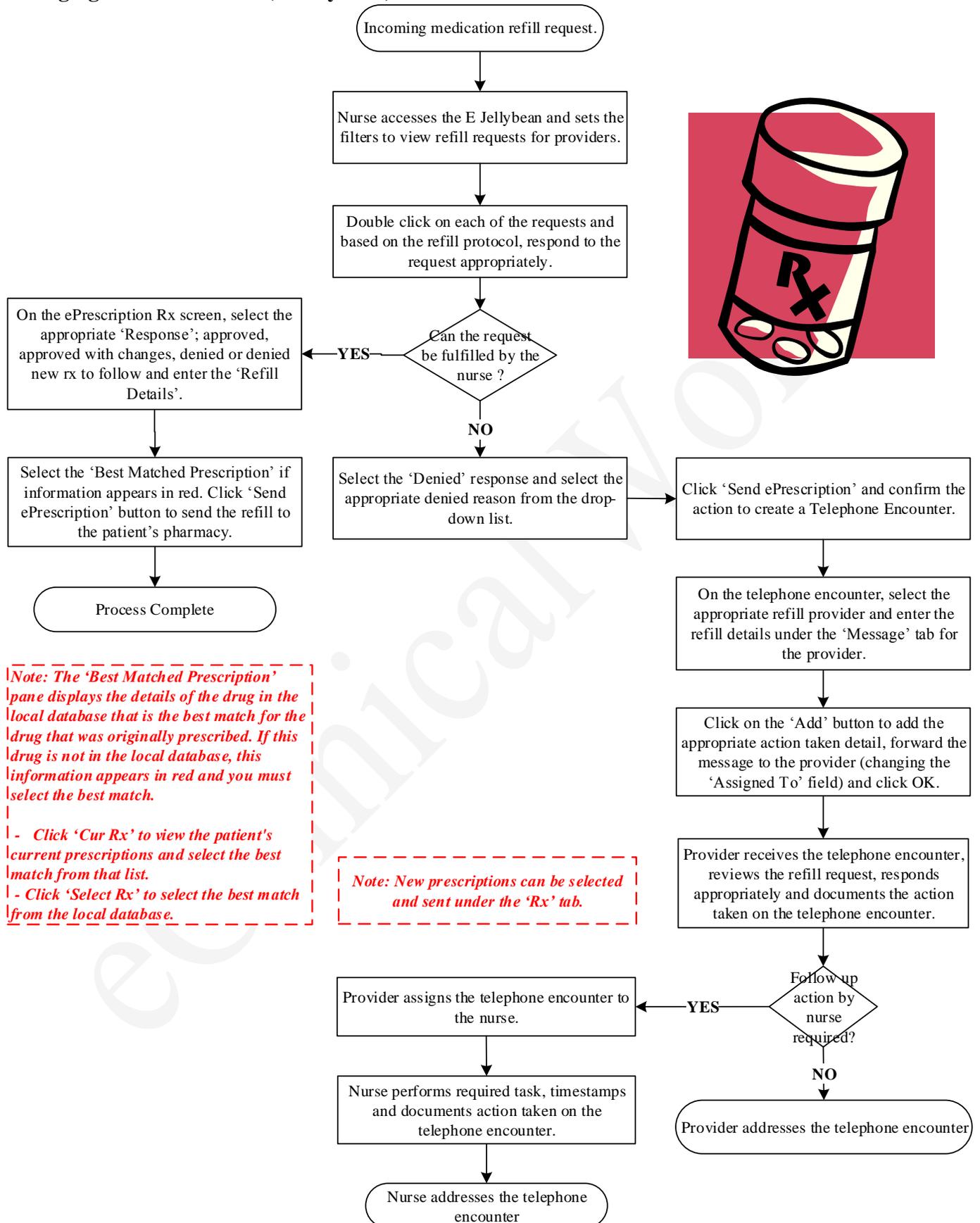
- Click the number buttons to specify the number of refills allowed or enter the number in the field.
- Click the 'C' button to clear the field.
- Enter notes in free text to accompany the response in the Notes field.
- Enter notes to accompany the denial in the Notes field.

5. The 'Best Matched Prescription' pane displays the details of the drug in the local database that is the best match for the drug that was originally prescribed. If this drug is not in the local database, this information appears in red and select the best match:

- Click 'Select Rx' to search for and select the best match from the local database.
- Click 'Cur Rx' to view the patient's current prescriptions and select the best match from that list.

6. Click 'Send ePrescription' to send the refill.

Managing Electronic Refill (E Jellybean)



Receiving an Electronic Lab Result

Once the practice is live with the lab interface and once the lab company/hospital processes the lab, the result can be sent electronically into eClinicalWorks. Clinicians can view the electronic lab result by:

1. Clicking on the 'L' Jellybean.
2. Select the desired lab.

Order Date	Call Date	Result Date	Patient	Labs/Imaging/Procedures	Reason	Result	Assigned To
02/05/2009	02/05/2009	02/05/2009	Curran, Jeff P	TSH	Diagnosis Related	Normal	Willis, Sam
02/01/2009	02/03/2009	02/03/2009	Lab, Larry	SPIRO	Diagnosis Related	Normal	Willis, Sam
02/01/2009	02/03/2009	02/03/2009	Lab, Larry	holter	Diagnosis Related	Normal	Willis, Sam
01/22/2009	01/26/2009	01/26/2009	Curran, Jeff P	URIC ACID	screening	Normal	Willis, Sam
01/22/2009	01/28/2009	01/28/2009	Curran, Jeff P	Upper gastrointestinal (UGI) series	Diagnosis Related	See Attached Report	Willis, Sam
01/22/2009	01/27/2009	01/27/2009	Jones, Raul	PSA,TOTAL	Screening	Normal	Willis, Sam
01/21/2009	01/27/2009	01/27/2009	Johnson, Jack	CBC	Patient Request	See Attached Report	Willis, Sam
01/21/2009	01/28/2009	01/28/2009	Johnson, Jack	Urinalysis, Routine	Screening	Normal	Willis, Sam
01/20/2009	01/20/2009	01/20/2009	Curran, Jeff P	URINALYSIS,COMPLETE	Screening	Normal except for tr bid	Willis, Sam
01/20/2009	02/03/2009	02/03/2009	Curran, Jeff P	EKG	Screening	Normal	Willis, Sam
01/16/2009	01/15/2009	01/15/2009	Lab, Larry	CBC (INCLUDES DIFF,PLT)	Requisition Printed: Quest	LOW WBC, HIGH Hgb	Willis, Sam
01/16/2009	01/15/2009	01/15/2009	Lab, Larry	GLUCOSE TOLERANCE,6HR	Requisition Printed: Quest	Low	Willis, Sam
01/16/2009	01/15/2009	01/15/2009	Lab, Larry	AMYLASE,SERUM	Requisition Printed: Quest	Normal	Willis, Sam
12/30/2008	01/08/2009	01/15/2009	Lab, Larry	URINALYSIS,MACROSCOPIC	Requisition Printed: Quest	Abnormal	Willis, Sam
12/30/2008	01/08/2009	01/15/2009	Lab, Larry	BASIC METAB PANEL W/EGFR	Requisition Printed: Quest	HIGH K+	Willis, Sam
11/21/2008	11/21/2008	01/15/2009	Lab, Larry	LIPID PROFILE	screening	Normal	Willis, Sam

3. Clinicians can view the lab attributes under the Result section.
4. Clinicians can click on the Pink Paper Clip to open the actual report (sent by lab company/hospital).
5. Additional comments can be added under the Notes Section if needed (Notes, Clinical Info and Internal Notes).
6. Assign Lab result to another user by changing the Assigned To dropdown if Follow Up needed.
7. Clinicians can mark the lab as reviewed by clicking on the 'Reviewed' option.

Lab Results

Patient Sel Info Hub

Curran, Jeff P
 DOB:12/13/1960 Age:53Y
 Sex:M
 Tel:561-703-0241
 Acct No:9118, WebEnabled: Yes
 Elgb Status:

Status: Open Reviewed

Provider: Willis, Sam

Facility: Westboro Medical Associate

AssignedTo: Willis, Sam

High Priority
 InHouse
 Future Order
 Cancelled

Don't publish to Web Portal

Lab Information

Lab: TSH Sel Order Date: 2 / 5 / 2009 Collection Date: 2 / 5 / 2009 Time: :
 Reason: Diagnosis Related Actual Fasting: Not Recorded Ordered Fasting

Specimen

Source: Description: Collection Volume: Units:

Results

Received Date: 2 / 5 / 2009 Result: Normal

Order Date	Coll. Date	TSH					
02/05/2009	02/05/2009	2.5					
04/22/2010	03/14/2010						

Assessments: Show Specify

250.00 Diabetes mellitus without mention of complicat
 466.0 Acute bronchitis
 401.1 Essential hypertension, benign

Clinical Info:

Notes: Time Stamp Browse Check Spelling

Internal Notes: eClinicalMessenger

Custom Reports Print Midmark ECG Display Graph Options

OK Cancel Next (R) Next

Lab Result

FINAL RESULT

clinton medical associates
323 lake street
Westborough, MA 01581
978-896-5214

PHYSICIAN INFORMATION		PATIENT INFORMATION	
Requesting:	Willis 8.0.100, Sam	Name:	Test, Larry
Ordering:	Clinton, Raj	DOB:	09/04/1965
		Sex:	male
		Tel:	878-787-8788

REPORT DETAILS		REPORT DATES	
Name:	Amylase, Serum	Order:	04/22/2010
Accession ID:	12345	Collection:	12/15/2009 19:28:00
Lab Ref Id:	26189	Report:	04/22/2010 15:33:00

NAME	VALUE	REF RANGE
F Amylase, Serum	85	31-124 U/L

ADDITIONAL NOTES

PERFORMING LAB: LabCorp EDI Testing, 3060 S Church Street, Burlington, NC - 272150000, Phone - 3365845171, Director - Testing

Patient: Test, Larry DOB: 09/04/1965

Print Fax Patient Hub Cancel

Lab Report from Lab Company/Hospital

In addition, all labs ordered for the patient can be viewed together by clicking on the desired patient, clicking the 'View' button, and selecting the desired option.

The screenshot shows the eClinicalWorks interface with a list of lab orders. The 'View All Reports' dropdown menu is highlighted, showing options: 'By Visit', 'By Patient (Unreviewed)', and 'By Patient (All)'. The lab order list includes columns for Order, Date, Col Date, Result Date, Patient, Labo, Reason, Diagnosis Related, and Patient Letter.

Order	Date	Col Date	Result Date	Patient	Labo	Reason	Diagnosis Related	Patient Letter	Result	Order To
C	02/05/2009	02/05/2009	02/05/2009	Curran, Jeff P	TSH	Screening	Normal	Normal	Willis, Sam	Willis, Sam
C	02/01/2009		02/03/2009	Lab, Larry	BKG	Diagnosis Related	Normal	Normal	Willis, Sam	Willis, Sam
C	01/27/2009	01/26/2009	01/26/2009	Curran, Jeff P	IRIC ACT	screening	Normal	Normal	Willis, Sam	Willis, Sam
C	01/23/2009	01/27/2009	01/27/2009	Jones, Rau	PSA, TOTAL	Screening	Normal	Normal	Willis, Sam	Willis, Sam
C	01/21/2009	01/27/2009	01/27/2009	Johnson, Jack	CBC	Patient Request	See Attached Report	See Attached Report	Willis, Sam	Willis, Sam
C	01/21/2009	01/28/2009	01/28/2009	Johnson, Jack	Urinalysis, Routine	Screening	Normal	Normal	Willis, Sam	Willis, Sam
C	01/20/2009	01/20/2009	01/20/2009	Curran, Jeff P	URINALYSIS, COMPLETE	Screening	Normal except for tr bld	Normal	Willis, Sam	Willis, Sam
C	01/20/2009	02/03/2009	02/03/2009	Curran, Jeff P	BKG	Screening	Normal	Normal	Willis, Sam	Willis, Sam
C	01/16/2009	01/15/2009	01/15/2009	Lab, Larry	CBC (INCLUDES DIFF, P-T)	Requisition Printed: Quest	LOW WBC, HIGH Hgb	Low	Willis, Sam	Willis, Sam
C	01/16/2009	01/15/2009	01/15/2009	Lab, Larry	GLUCOSE TOLERANCE, 2HR	Requisition Printed: Quest	Low	Low	Willis, Sam	Willis, Sam
C	01/16/2009	01/15/2009	01/15/2009	Lab, Larry	AMYLASE, SERUM	Requisition Printed: Quest	Normal	Normal	Willis, Sam	Willis, Sam
C	12/30/2008	01/08/2009	01/15/2009	Lab, Larry	URINALYSIS MAKROSCOPIC	Requisition Printed: Quest	Anormal	Anormal	Willis, Sam	Willis, Sam
C	12/30/2008	01/08/2009	01/15/2009	Lab, Larry	BASIC METAB PANEL, W/EGR	Requisition Printed: Quest	HIGH K1	Normal	Willis, Sam	Willis, Sam
V	11/21/2008	11/21/2008	01/15/2009	Lab, Larry	LIPID PROFILE	screening	Normal	Normal	Willis, Sam	Willis, Sam

Appendix A: Notices

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