

eClinicalWorks

Business Analysis Department



EMR - I

Kentucky Department for Public Health

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BUSINESS ANALYSIS DEPARTMENT - CREATED FOR KENTUCKY DEPARTMENT FOR PUBLIC HEALTH

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Overview of the System

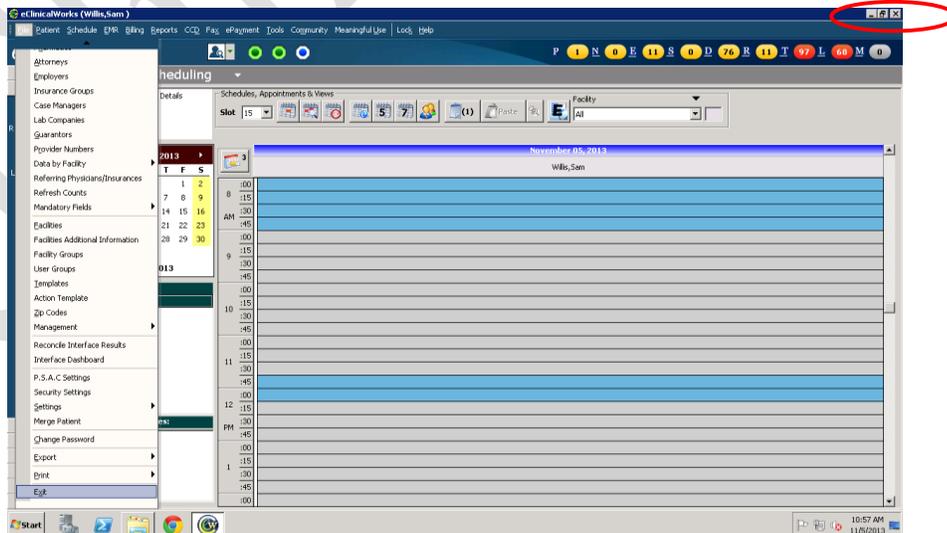
Logging in/out of eClinicalWorks

1. To log into eClinicalWorks, double click on the eClinicalWorks icon on your desktop. Enter your login ID and password (case sensitive) and click on “Log In.”

Note: Make sure you are in the correct environment. Hover over the icon or click on the icon once on desktop to determine the environment.



2. You can click on the ‘X’ button on the top right corner of the screen (to close the window) and log out as well.



Menu Bar and Navigation Panel

1. The options on the top of the screen are called 'Menus' and together they make up the 'Menu Bar'.
 - a. **File Menu** allows you to refresh counts and change passwords as well as user settings and computer settings.
 - b. **Patient Menu** allows you to lookup the desired patient, create new patient and perform basic operations for the patient.
 - c. **Schedule Menu** allows you to set & block provider/resource's schedule.
 - d. **EMR Menu** allows Administrators to customize the EMR System (Alerts, Labs, DIs, Order Sets, etc.)
 - e. **Billing Menu** allows Administrators to customize the Billing System (Organize/Group ICDs, CPTs, Enable Billing Options, etc.).
 - f. **Reports Menu** allows you to run EBO (End of Day Reports).
 - g. **CCD Menu** allows you to Export/Import CCD information (Not in use currently).
 - h. **Meaningful Use Menu** allows you to access Meaningful Use Reports.
 - i. **Fax, Tools and Community Menus** allow the you to perform additional administrative settings.
 - j. **Lock Menu** allows you to lock the current work station.
 - k. **Help Menu** allows you to navigate to support website and view current system information.

2. The Navigation Band on the left-side of the screen allows you to navigate to different parts of the system. Several of these features can also be accessed through the Quick Launch buttons/Jellybeans.
 - a. **Admin Band** allows you to make changes to the system dictionary (Visit Types, Visit Status, Visit Durations, etc.). Access to the Admin Band is restricted to the System Administrators.
 - b. **Practice Band** allows you to access various scheduling screens (Resource Schedule, Provider and Resource Schedules) and other short cuts (Progress Note, Out of Office, Telephone Encounter, Office Visit screen, etc.).
 - c. **Registry Band** allows Administrators to access recalling system of the application (Lookup Encounter, Patient Recall, etc.).
 - d. **Referral Band** allows you to access the referral module (Outgoing/Incoming).
 - e. **Message Band** allows you to access the internal messaging system. You can send/receive messages from the messaging feature.
 - f. **Documents Band** allows you to access documents module. This includes; Patient documents, Faxes (Inbox & Outbox), eCliniForms, etc.

- g. **Billing Band** allows you to access the billing modules. This includes; Encounters, Claims, Payments, ERAs, Batches, etc.

The screenshot displays the eClinicalWorks interface for user Willis, Sam. The interface includes a menu bar at the top with options like File, Patient, Schedule, EMR, Billing, Reports, CCD, Fax, ePayment, Tools, Community, Meaningful Use, Lock, and Help. A navigation band on the left lists various modules: Admin, Practice, Resource Scheduling, Laredo, Maricruz, Willis, Felecia, Willis, Sam, Office Visits, Allergy Shots, Lab, CCMR, Registry, Referrals, Messages, Documents, and Billing. The main area shows a single provider schedule for Tuesday, November 05, 2013, with a time slot from 9 am to 4 pm. A calendar on the right shows the month of November 2013, with the 5th highlighted in blue. A table at the bottom right lists reminders with columns for Time, Patient Name, and Phone No.

Annotations in the image include:

- Menu bar**: Points to the top navigation menu.
- Quick Launch Keys/Jellybeans**: Points to the row of colored circular icons.
- Show/Hide buttons/Olives**: Points to the three small circular icons in the top navigation bar.
- Navigation Band / Panel**: Points to the left sidebar menu.
- Single provider schedule**: Points to the main schedule grid.

Patient Look-up

Patient Look-up Screen and Lookup Options

- When you click on the patient lookup button, the 'Patient Lookup' screen opens up, which gives you a list of all the patients in the system arranged alphabetically by their last name.



- The patients can be searched using a combination of different search options such as Name, SSN, DOB, Account No, Phone No, Subscriber No, Previous Name or Home/Work/Cell Phone, Medical Record Number, Guarantor Name and by their default appointment facility.

Legend:

- W – Indicates that the patient is web-enabled (patient portal)
- ! – indicates that there is a billing alert for this patient.
- Color – indicates that there is a global alert for this patient.
- V – Indicates that the patient is enabled for eClinical Messenger

Real Time Search will dynamically modify the list of patients as the characters are being typed.

by	Name	Account No.	Last Appt Dt	Prev Name
W	Asaro, Amber	1234 9303	12/27/2010	
	Asaro, Amber OB	1234 9367	12/28/2010	
W	Bhat, Sameer	1722 9348	12/22/2010	
W	Black, Angel	0000 9324	12/04/2010	
W	Brown, James	508-445-6798 9306	12/04/2010	
W	Bush, Rose	232-432-5443 9342	12/04/2010	
W	Carpenter, Bonnie	000-000-0000 9345	11/02/2010	
W	Clark, Kelly	935-943-9359 9335	10/19/2010	
!	Curran, Jeff P	561-703-0241 9118	12/15/2010	
!	Curran, Martha M	561-703-1234 9119	12/01/2010	
	Curran, Shennen	561-703-1234 9120	05/14/2010	Pending with error 2/1
W	Darren, Gary	555-555-5591 92	12/01/2010	Medicare Post 185 1/1
W	Darren, Lori	555-555-5590 91	11/01/2010	
	G1, Test	121-212-1212 9366		
	G2, Test	123-456-7890 123456		
	Gandhi, Jinesh			
W	Gandhi, Rohan	508-628-7262 9360	11/18/2010	
W	Gonzales, Mary	508-234-3235 9311	10/19/2010	

- The Patient Lookup button also includes a drop-down list that provides quick access to a list of the last five patients whose 'Hub' screen has been viewed. This feature is available to all users. Click on the green drop-down arrow to the right of the patient lookup button to access patient records viewed recently. Including the links to Patient Lookup, Quick Registration, and Insurance by provider lookup.



Patient Demographics

The Patient Information (Demographics) screen can also be accessed by selecting a patient in the “Lookup” screen and then clicking on the “Patient Info” button at the bottom of the screen.

Personal Info

Account No 9446 Prefix [v] PCP Jones, Mary

Last Name Test Suffix [v] Referring Provider Jones, Mary

First Name 0410 MI [v] Rendering Provider/Primary Care Giver Willis, Sam

Previous Name [v]

Address Line 1 Erwr Date Of Birth (mm/dd/yyyy) 03/03/1985 Age: 28Y

Address Line 2 Erwr Gestational Age [v]

City Erwr [v] validate Sex [v] Male Transgender

State df Zip 232343 Country US Social Security [v]

Home Phone 334-324-2342 Cell No 234-234-2342 Employer Name [v] Parent Info [v] Clear

Work Phone 234-234-2342 Ext [v] Emp Status [v] (None Selected)

(statements will be addressed to responsible party) Student Status [v] (None Selected)

Responsible Party* Select Set Emergency Contact Family Hub Select Remove

Name Test, 0410 Emergency Contact [v]

Relation 1 Self - patient is the insured Acct Balance 0.00 Details Gr. Bal

Last Appt 11/05/2013 08:45 AM Patient 0.00 Acc Inquiry

Insurances IE New Case

Sliding Fee Schedule Fee Schedule Master Fee Schedule [v] Self Pay Add Update Remove

Name	State	Subscriber No	Rel Insured	Co Pay	Group No

Release of Information [v] Y [v]

Rx History Consent [v] U [v] Scan

Signature Date / /

Advance Directive [v]

Additional Info [v] Alert Misc Info Options P.S.A.C ePHX Updates OK Cancel

PCP is the patient's true Primary Care Provider. If they don't have one, there is a No PCP option. There is also an FQHC PCP option - if they select this, they must choose the FQHC in demo structured data. Rendering Provider is the assigned LHD provider

Mandatory fields are indicated by a red asterisk. You cannot save a patient record if a mandatory field is blank.

Financially responsible party (Patient Statements will be generated under this person's name and address). If services warrant a statement.

Patient Insurance(s) information: If there are no insurance(s) for the patient, the 'Self Pay' check box must be checked. **Please refer to the billing workbook for unique billing insurance scenarios.**

This button provides access to additional demographics fields such as additional emergency contacts and patient's pharmacy information. As well as additional mandatory demographics, including structured data questions.

Validates patient address

Address Validator

Address Validation (for Martha Curran)

Exact address is not found as entered. Correction is suggested.

Select one address from these alternatives:

Entered Address:

2 Technology Drive, Westborough, MA, 1581, US

Suggested Address:

- 2 TECHNOLOGY DR, WESTBORO, MA, 01581-1727, US
- 2 TECHNOLOGY DR, WEST PEABODY, MA, 01960-7907, US
- 2 TECHNOLOGY DR, WEST BRATTLEBORO, VT, 05301-9180, US
- 2 TECHNOLOGY DR, WEST PEABODY, MA, 01960-7977, US

Apply Cancel

Address Validation service provided by UPS

Additional information such as additional contact, patient billing address, employer address, patient’s picture, email, race, ethnicity, language, Default Facility, Default Lab and DI Company, Pharmacy details, Circle of Care etc., can be added/modified by clicking on the “Additional Information” button.

NOTE: If the patient doesn't have an email id, it could be marked as 'Not Provided'.

NOTE: If the patient doesn't have an email id, it could be marked as 'Not Provided'.

ADDING THE RESPONSIBLE PARTY:

1. Click on the 'Select' button on the 'Responsible Party' section of the demographics screen.
2. Choose the 'type' of the responsible party – if it is “Another Patient” or “Guarantor”, you must click on the “Sel” button corresponding to that field to choose the person’s name. Clicking on the “Sel” button will take to the corresponding ‘Lookup’ screen.

Note: Both ‘Another Patient’ and ‘Guarantor’ are financially responsible, but a ‘Guarantor’ is not a current patient of the LHD.

3. If the responsible party is not “Self”, you must also choose the appropriate “Relation” code by clicking on the browse button



ADDING THE INSURANCE DETAILS:

ID	Name	Address Line 1	City	State	Zip	Tel
10	Aetna	2332 Pearl St	Shrewsbury	MA	01582	555-555-
2	Anthem	834 Sapphire Lane	Boston	MA	02118	554-555-
3	BCBS	23 Pearl St	Shrewsbury	MA	01582	555-555-
4	Cigna	565 Diamond Ave	Westborough	MA	01581	555-555-
5	Commercial	2 Coral Road	Westborough	MA	01581	555-555-
6	CommPaper	222 Emerald Place	Shrewsbury	MA	01582	555-555-
7	Humana	787 Ruby Lane	Shrewsbury	MA	01582	555-555-
8	Kaiser	7878 Coral Road	Westborough	MA	01581	555-555-
9	Medicaid	110 Ruby Lane	Shrewsbury	MA	01582	555-555-
5	Medicare	45 Diamond Ave	Westborough	MA	01581	555-555-
16	Pacificare	954 Pearl St	Shrewsbury	MA	01582	555-555-
1	RXHUB					
2	Surescripts	DO NOT DELETE USED BY ELIGI!				
15	TuftsHealthPlan	278 Major Ave	Boston	MA	02118	554-555-
3	UNITED Healthcare	1 Ins Drive	Orlando	FL	33123	407-740-
14	UnitedHealthCare	45 Emerald Place	Shrewsbury	MA	01582	555-555-
9	WC	458 Major Ave	Boston	MA	02118	554-555-

Patient - Insurance Detail(Curran, Jeff P)

Insurance Address: UNITED Healthcare
 1 Ins Drive
 Orlando, FL-33123
 Tel: 407-740-2312, Fax: 407-740-2333
 E-Mail: support@ur.com
 Payor Id: 12345678 Medigap Id:

Source of Payment: ... ANSI-Commercial Insurance Co
 Insurance class for reports: ... ANSI-Commercial
 Coverage Dates (mm/dd/yyyy): 01/01/2009 to 12/31/2020

Primary
 Secondary
 Tertiary
 Terminated

Subscriber	Additional Information	Notes
Subscriber No 9485938-83745	Co-Pay 25.00 \$	
Insured's Name Curran, Jeff P	Patient Relationship to Insured 1 Self - patient is the insured	
Group No 394539853	Group Name eCW united	
Medicaid ID Number []	Supplemental Insurance Indicator <input type="checkbox"/>	
Insured's Alternate Name Last Name: [] First Name: [] MI: []		
Patient's Alternate Name Last Name: [] First Name: [] MI: []		

1. Click on the "Add" button in the 'Insurances' section. Then search for the appropriate insurance on the 'Lookup' screen that pops-up, select the correct insurance and click the 'Ok' button.
2. Enter the subscriber number and copayment details.
3. Choose the insurance 'designation' appropriately (i.e., primary, secondary, tertiary).
4. Make sure the insurance holder's name is selected in the "Insured's Name" field. In some cases, this can be different from the patient's responsible party name.

Patient Hub

Patient hub provides quick, single point access to all information (Clinical and Account) related to a patient.

The screenshot shows the 'Patient Hub' window for 'Test, Alex'. The interface includes a top navigation bar with tabs for Labs, DI, Procedures, Imm/T.Inj, Referrals, Allergies, CDSS, Alerts, and Notes. The main content area is divided into several sections:

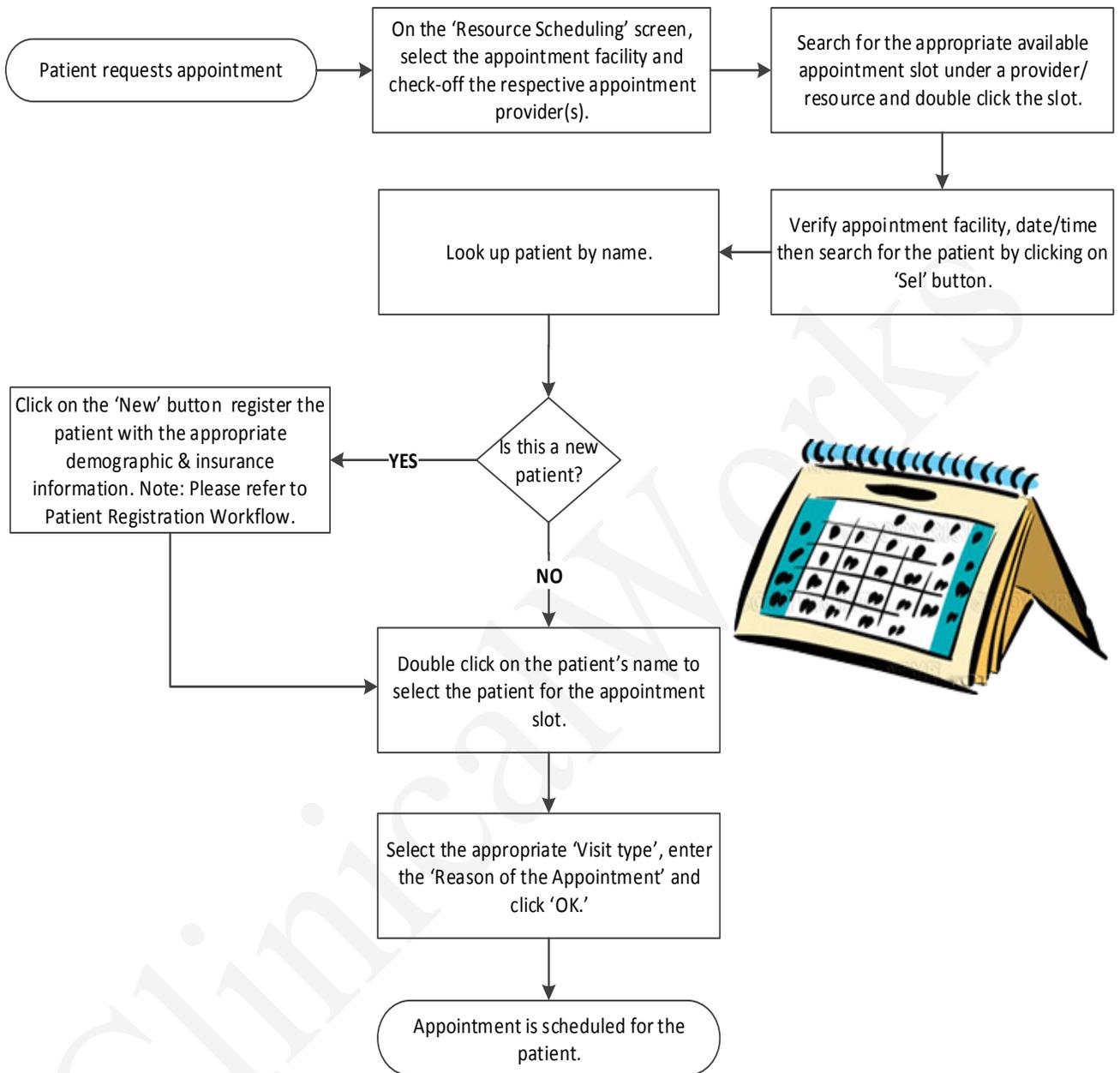
- 1. Toolbar:** A horizontal bar at the top with tabs for Labs, DI, Procedures, Imm/T.Inj, Referrals, Allergies, CDSS, Alerts, and Notes.
- 2. Patient Information:** A section containing patient details such as name, address (395 MAIN STREET, FRANKLIN, MA-02038), DOB (01/01/1970), age (43 Y), sex (M), insurance (Aetna), and account number (9300). It also shows financial information like Patient Balance (\$5.00) and Account Balance (\$155.00).
- 3. Chart Panel:** A vertical panel on the right side containing sections for Global Alerts, Advance Directive, Problem List (with items like 'Chest pain, other' and 'Shortness of breath'), Medication Summary (listing '1-Step Pregnancy', '12 Hour Nasal Spray', and '2nd Skin Moist Burn 2"x3"'), and Allergies (listing '1-Step Pregnancy', '12 Hour Decongestant', '12 Hour Nasal', and '14-Count Warmer').
- 4. Hub Buttons:** A grid of buttons in the center providing quick access to various functions: New Appt, New Tel Enc, Print Label(s), Billing Alert, Patient Docs, Letters, Encounters, Medical Summary, Rx, Progress Notes, eClimForms, Devices, Problem List, Medical Record, Send eMsg, Account Inquiry, Guarantor Bal., Consult Notes, Letter Logs, Fax Logs, Action, Flowsheets, Messenger, Billing Logs, and ePrescription Logs.

- 1. Toolbar:** Provides access to a comprehensive list of the patient's test results, immunizations, referrals, allergies, alerts, and notes.
- 2. Patient Information:** A snapshot of patient information, including the last and next visits.
- 3. Chart Panel:** Displays a quick reference of the patient's Progress Notes window-giving the provider easy access to the patient's history and other information, such as current medications, allergies, alerts, and immunizations.
- 4. Hub buttons:** The Hub buttons provide quick access to medical records of a patient. Perform frequent office tasks using these buttons, such as scheduling a new appointment, logging a phone call, or sending a message or letter.

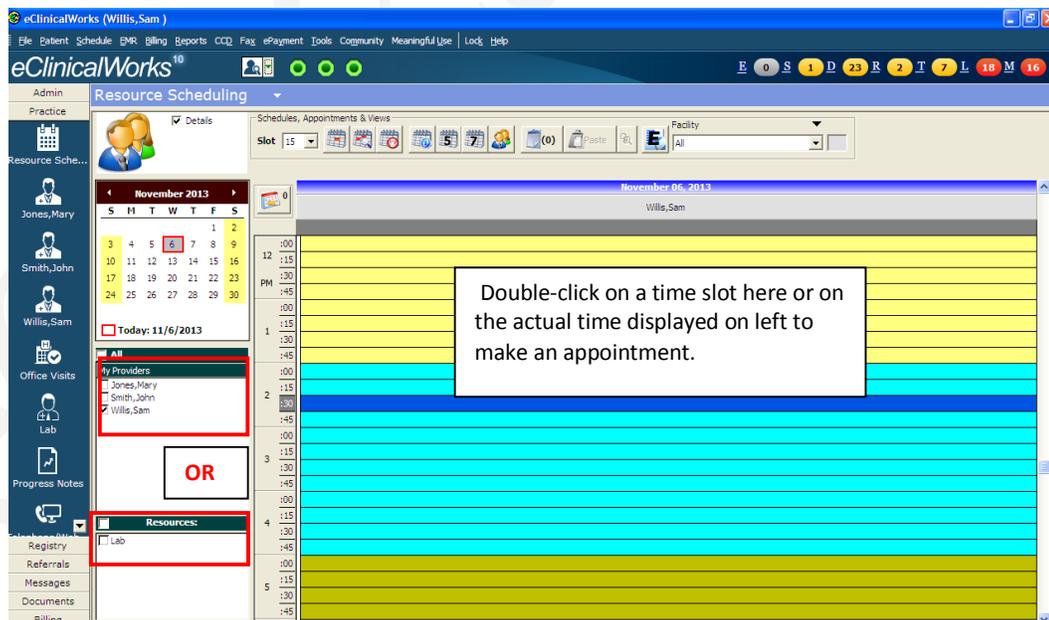
Scheduling Appointments

Scheduling Patient Appointments

The flowchart below illustrates the recommended workflow for scheduling patient appointments, for new and established patients.



1. If the patient is a 'New' patient (i.e., patient does not exist in your 'Lookup' database), the patient must be registered in the system as explained in the *Patient Registration* section. In addition to the "mandatory" fields defined, capture as much information as possible during the patient registration process.
2. If patient is an established patient (i.e., patient does exist in the 'Lookup' database), then verify the patient's demographic information (name, address, phone number and insurance information) to make sure they are up to date.
3. Once the registration or patient verification process is complete, close out of the 'Lookup' screen. The next step to scheduling a visit is to open the "Resource Schedule" for the respective provider / resource and visually search for an open appointment slot for the requested date and time. Multiple appointment schedules can be opened up side-by-side to check for appointment availability. Alternatively, the *Appointment Search and Multiple Appointment Booking* feature can also be used for searching open / available slots.
4. To begin the appointment scheduling process, select the provider or resource first. Based on their working hours in the respective facility, double-click on the desired appointment slot or on the time for that appointment slot and that would open up the "Appointment" screen (or) if you are using the *Appointment Search and Multiple Appointment Booking* feature, select the desired appointment slot and click on the "Schedule" button.



The steps for scheduling an appointment are explained below:

1. First, the respective patient has to be selected. Click on the “Sel” button to select the patient for whom the appointment needs to be scheduled. Search for the patient in the “Lookup” screen by entering the appropriate search parameters (i.e., Name, DOB, etc.)
2. Then the type of visit the patient is coming for needs to be chosen appropriately.
The Visit Status should be left as ‘Pending’ until the patient checks in.
3. Select the appropriate reason by clicking on the “drop down arrow” button and picking a relevant option.
4. A general note is just a section where front office can write down general notes for themselves. It only remains on the schedule.

The screenshot shows an appointment form with the following fields and callouts:

- Callout 1:** Points to the Patient field containing "Test, Liz M" and the "Sel" button.
- Callout 2:** Points to the Visit Type dropdown menu, which is currently set to "Dent 01353 (Sealant Rel)".
- Callout 3:** Points to the Reason dropdown menu, which is currently set to "Dental".
- Callout 4:** Points to the General Notes text area.

Other visible fields include Facility (068068.001:Lewis County Health Department), Date (10/7/2016), Provider (Gammon, Lisa), Resource (Gammon, Lisa), Start Time (9:00 AM), End Time (9:15 AM), and a Co-pay section with a checked box for "Change co-pay for this visit" and a value of 0.00.

1. Select a patient by clicking on the "Sel" button.

2. Choose a respective Visit Type for the appointment from the drop-down menu.

3. Choose the reason for visit by either selecting a reason from the drop-down menu or by directly typing it in.

4. Enter any general notes/reminders regarding the appointment here.

The table below shows all the available options for visit types and their corresponding reasons.

Visit Type Codes (Description)	Visit Reasons
--------------------------------	---------------

COUNS (Counseling)	Adult
Dent D0190 (Dental Screening Only)	Dental
Dent D1206 (Dental Varnish)	Family Planning
Dent D1351 (Dental Sealant)	KWCSP
Dent Prev (Preventive Dental)	Peds
EXAM-PREV (Preventive Exam)	Peds Car Seat
EXAM-PROB (Problem Exam)	Pregnancy Test
F/U (Follow Up Visit)	Prenatal
IMM (Immunization)	Resupply
LAB (Lab)	STD
MISC (Miscellaneous)	TB
WIC-BFCnsl (WIC Breastfeeding Counseling)	
WIC-BFGrp (WIC Breastfeeding Education Group)	
WIC-Breast (WIC Breastpump Issuance)	
WIC-Crt/Re (WIC Certification/recertification)	
WIC-Iss (WIC Benefit Issuance)	
WIC-NE (WIC Nutrition Education)	
WIC-NCGrp (WIC Nutrition Education Group)	
WIC-NEGrpP (WIC Nutrition Education Group Paraprofessional)	
WIC-NEPara (WIC Nutrition Education Paraprofessional)	
WIC-PkgCsl (WIC Food Package Change with Counseling)	
WIC-VOC (VOC)	

Appointment Search and Multiple Appointment Booking

Open appointment slots can also be searched for using the “Appointment search and multiple appointment booking” feature. Once the desired appointment slot(s) are found, this feature can also be used for scheduling single, multiple or group visits for patients.

This feature can be accessed by clicking on the  button from the ‘Resource Scheduling’ screen. Alternatively, it can also be accessed by clicking on the “Find” button on the appointment screen.



Click on the ‘Find’ button on the top of the Resource Schedule to open the ‘Appointment Search & Multiple Appointment Booking’ screen.

You can search for providers / resources by facility or under all facilities. To choose a facility, click on the “Sel” button. Check off “All” to search under all facilities.

The screenshot shows the 'Appointment Search & Multiple Appointment Booking' window. Key elements include:

- Facility:** TQC:Test QC
- Patient:** Test, P (DOB: 9/8/1987, Age: 23Y, Sex: M)
- Date:** 10/10/2010
- Time and Visit Info:** From 8:00 AM to 12:00 PM, Visit Type: NP (New Patient)
- Find Available Slots:** Includes a checkbox for 'Exclude booked slots' (checked) and a 'Find' button.
- Available Slots Table:**

Date	Provider/Resource	Location	Visit Type
Wednesday, November 17, 2010 at 8:00 AM	With Willis, Sam, Multi	At Test QC	NP
Wednesday, November 24, 2010 at 8:00 AM	With Willis, Sam, Multi	At Test QC	NP
Wednesday, December 1, 2010 at 8:00 AM	With Willis, Sam, Multi	At Test QC	NP
Tuesday, December 7, 2010 at 8:00 AM	With Willis, Sam, Multi	At Test QC	NP
Wednesday, December 29, 2010 at 8:00 AM	With Willis, Sam, Multi	At Test QC	NP
- Buttons:** 'Prev', 'Next', 'Schedule Multiple', 'Schedule', and 'Cancel'.

Search for the Provider / Resource under whom the visit needs to be scheduled by typing in the name. Select the appropriate name(s) from the list below. Make sure both the check boxes are checked off.

If you want to see the providers / resources for a selected facility only, then choose the appropriate Facility and then check off this option.

Choose a date, day and time preference for the appointment. Then select the appropriate 'visit type'.

Specify the search options for available appointment slots and click on the "Find" button. **Note: If you do not wish to double book, make sure the 'Exclude booked slots' option is checked.**

Search results can be sorted by 'Appointment time' or 'Provider / resource name'.

Select the desired appointment slot and click on the 'Schedule' button to schedule the appointment. If multiple appointments have to be scheduled consecutively, select the desired appointment slots and click on the "Schedule Multiple" button.

The "Next" buttons can be used to see the next set of available appointments and the "Prev" button takes you to the previous page.

Scheduling Recurring Visits

'Recurring visits' feature can be used to schedule multiple follow-up visits for the same patient. Please note that all visits scheduled will have the same 'visit type' code. This feature will be used for Directly Observed Therapy visits in the Tuberculosis program.



To schedule a recurring visit for a patient, click on the  button on the top of the 'Appointment' screen:

- 1) The 'start time', 'end time' and 'duration' cannot be modified from the original appointment. This will be automatically populated based on the visit type chosen for the original appointment.
- 2) Choose the 'Recurrence pattern' in weeks (i.e., appointment to be repeated once a week or 2 weeks or 3 weeks, etc.).
- 3) Choose the day of the week when the appointment has to be scheduled.
- 4) Specify the start and end of the recurrence pattern.
- 5) Click 'Save' to schedule the appointments based on the recurrence pattern chosen. The system will automatically schedule the respective appointments and display a confirmation message.

The screenshot shows the 'Appointment on Friday, January 07, 2011' window. The 'Appointment Recurrence' dialog box is open, showing the following details:

- Appointment time:** Start: 8:00 AM, End: 8:10 AM, Duration: 10 mins.
- Recurrence Pattern:** Weekly. Recur every 1 week(s) on: (highlighted with a red box).
- Day Selection:** Sunday, Monday, Tuesday, Wednesday, Thursday, Friday (checked), Saturday.
- Range of Recurrence:** Start: 01/07/2011, End after 10 occurrences, End by: 01/07/2011.

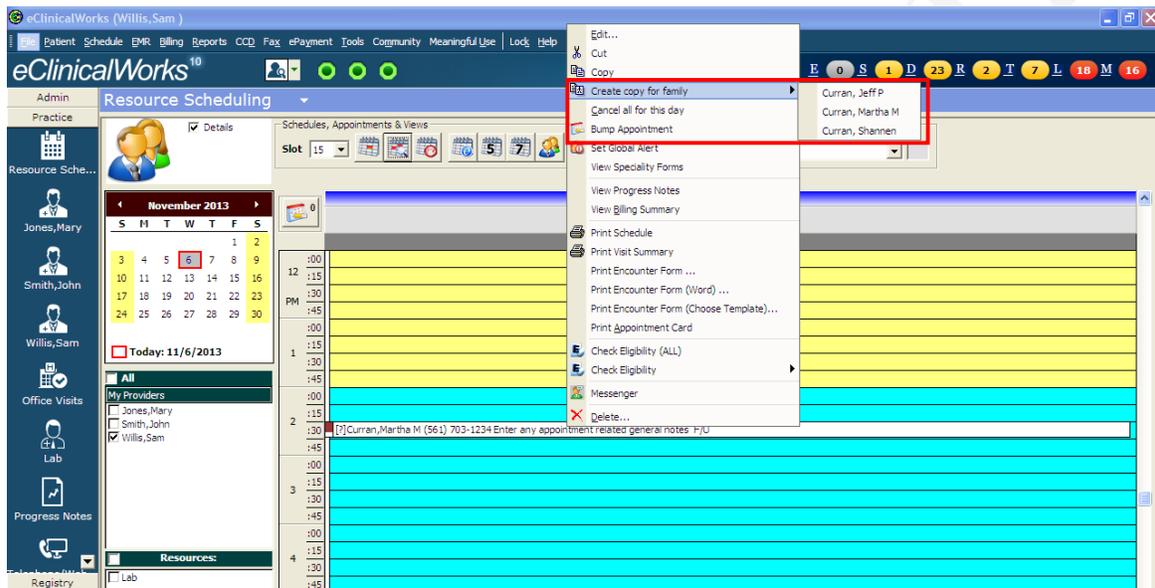
The background appointment form shows:

- Facility: WMA:Clinton Medical Associates
- Date: 1/7/2011
- Provider: Willis, Sam
- Resource: Willis, Sam
- Start Time: 8:00 AM
- End Time: 8:10 AM
- Patient: G1, Test
- DOB: 01/01/1970
- Visit Type: FAJ (Follow Up Visit)

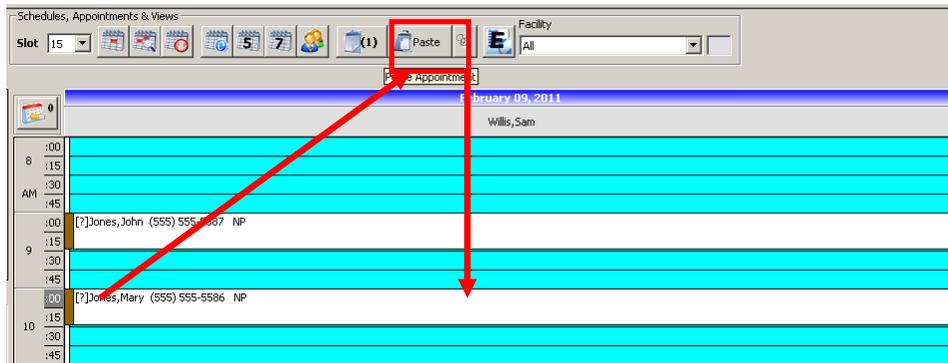
Scheduling Appointments for Family Members

Appointments can be easily scheduled for multiple patients connected through the same “Responsible Party” (or Guarantor) using the ‘Create copy for family’ option.

1. Schedule the appointment for the first member in the family, from the ‘Resource Scheduling’ screen.
2. Right-click on the appointment and click on “Create copy for family” option. You will see a list of all the members in the family.



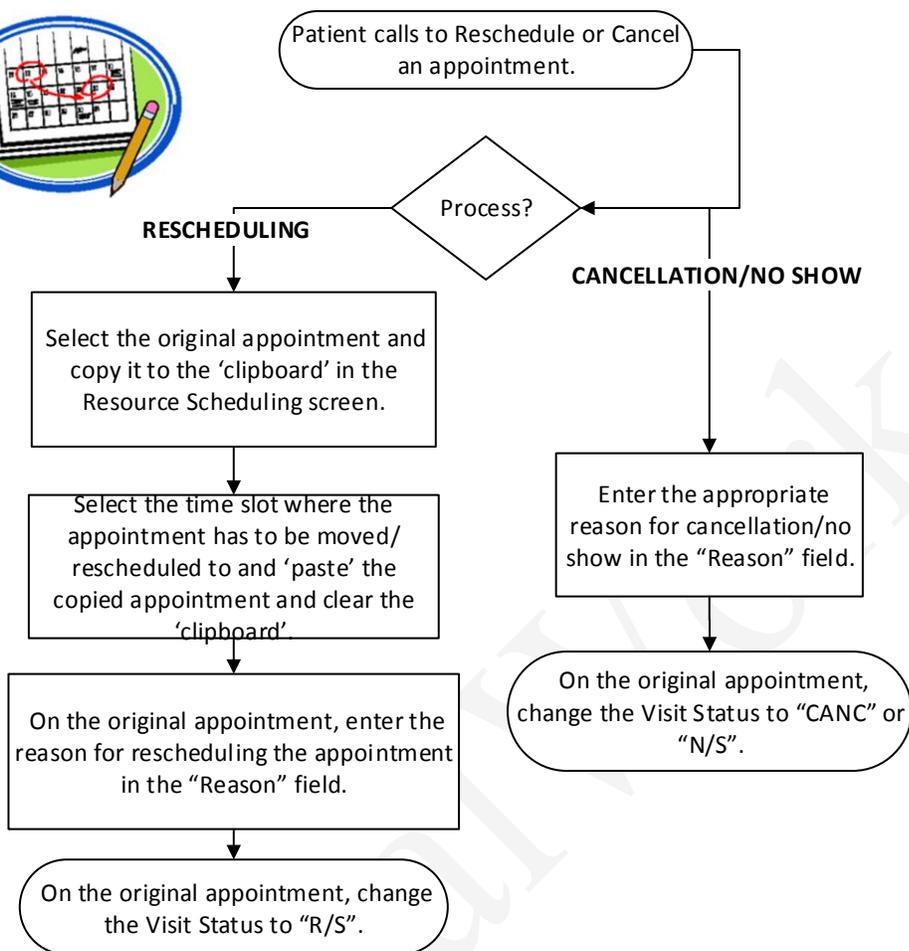
3. Click on the family member for whom the appointment has to be scheduled.
4. The system will create a similar appointment for this family member and place it in the ‘Appointment clipboard’.
5. Select the desired day, date and time when you want this appointment to be scheduled and “Paste” the appointment from the clipboard. Once the appointment is ‘pasted’, you can double-click on it and modify as necessary.



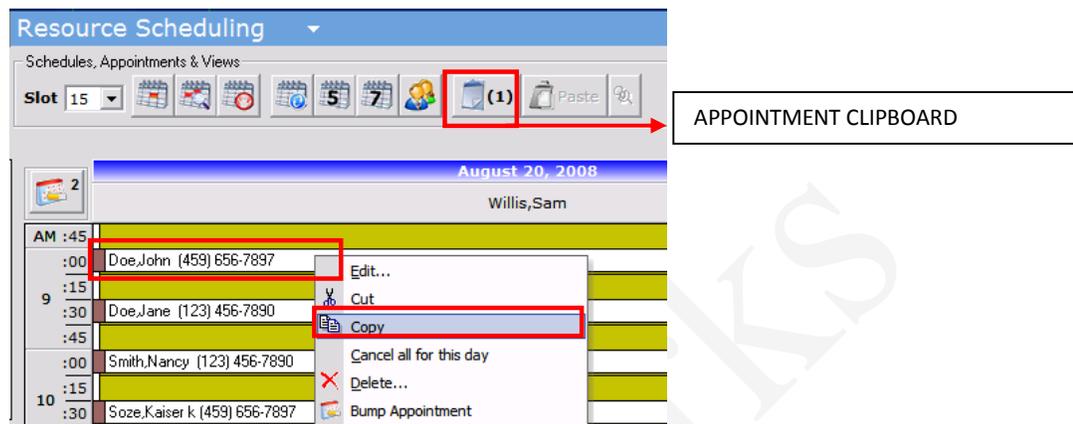
- Repeat steps 2 through 5 to schedule similar appointments for other family members as well.

Rescheduling Appointments

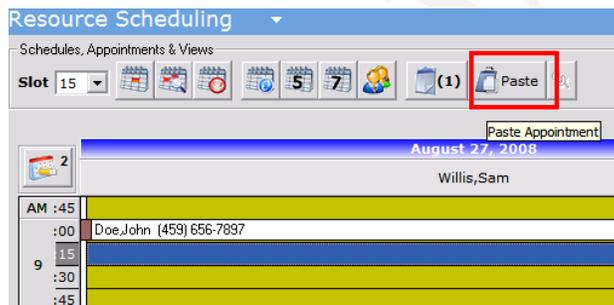
The flowchart below illustrates the recommended processes for rescheduling and cancelling scheduled visits.



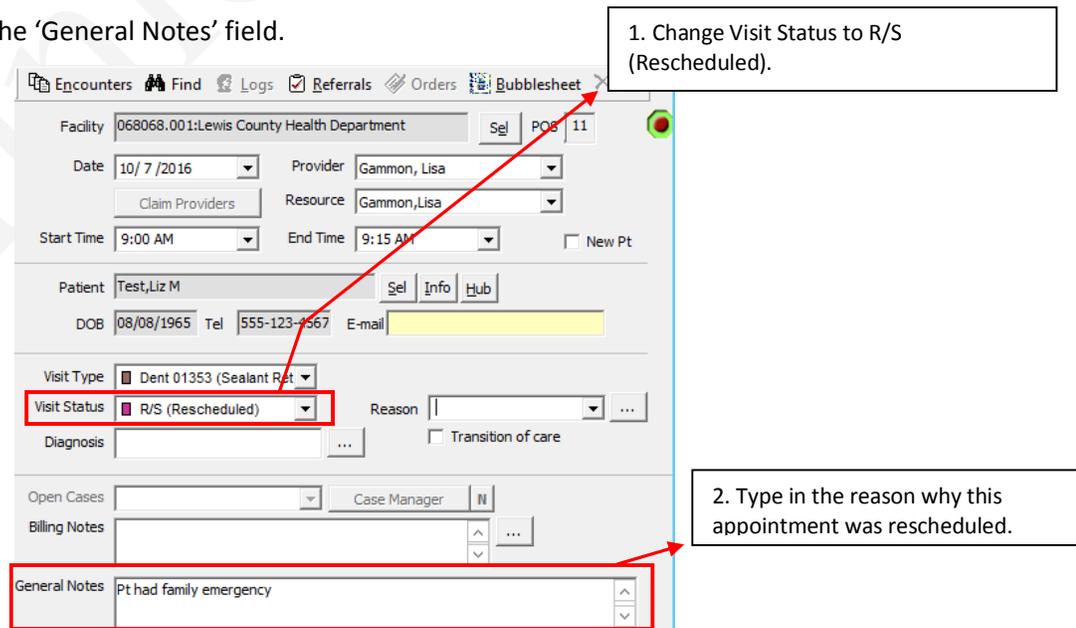
- From the 'Resource Scheduling' screen, right-click on the scheduled appointment and copy it to the Appointment Clipboard.



- Click on the appointment slot where the appointment needs to be rescheduled to and 'Paste' the appointment by clicking on that respective button.



- Go back to the original appointment, choose the 'Visit Status' as 'R/S' (or Rescheduled) and type in the reason for rescheduling in the 'General Notes' field.



Cancellations and No-shows

Appointments can be cancelled or marked off as 'no-shows' by simply choosing the appropriate 'Visit Status' code on the appointment screen.

The screenshot shows the appointment screen for a patient named Liz M. Test. The appointment is scheduled for 10/7/2016 at 9:00 AM, with provider Lisa Gammon. The 'Visit Status' dropdown menu is open, showing options like 'R/S (Rescheduled)', 'CANC (Cancelled)', and 'N/S (No-Show)'. The 'General Notes' section contains the text 'Pt unable to come.'.

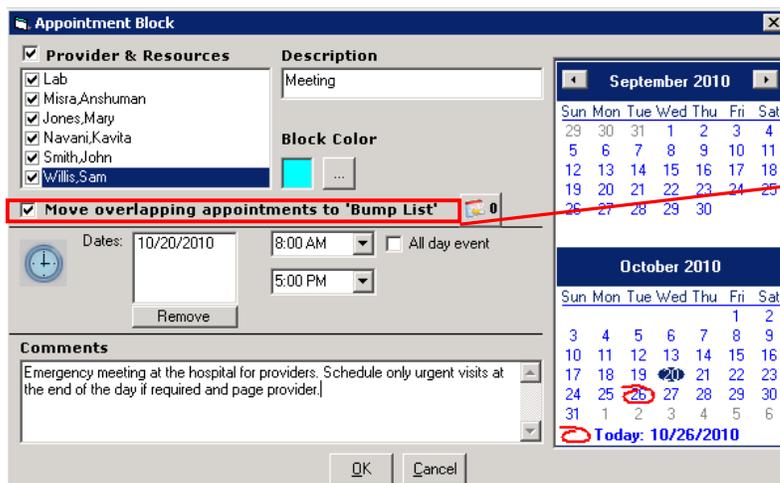
Some of the recommended steps while cancelling or marking off an appointment as 'no-show' are:

1. Always put in a reason for the cancellation in the 'General Notes' section of the appointment screen. This makes it easy to track why the appointment was cancelled for a patient.
2. If you have permissions to delete appointments, *do not delete* a cancelled or a no-show appointment as you will not be able to run a 'cancelled' or 'no-show' report on the system.
3. If any charges are associated with the appointment (copayments or self-pay payments), the appointment *cannot* be cancelled. The payment collected will have to be deleted or re-allocated to another visit before the appointment is cancelled. Contact the LHD billing supervisor to do so.

Bumping Appointments

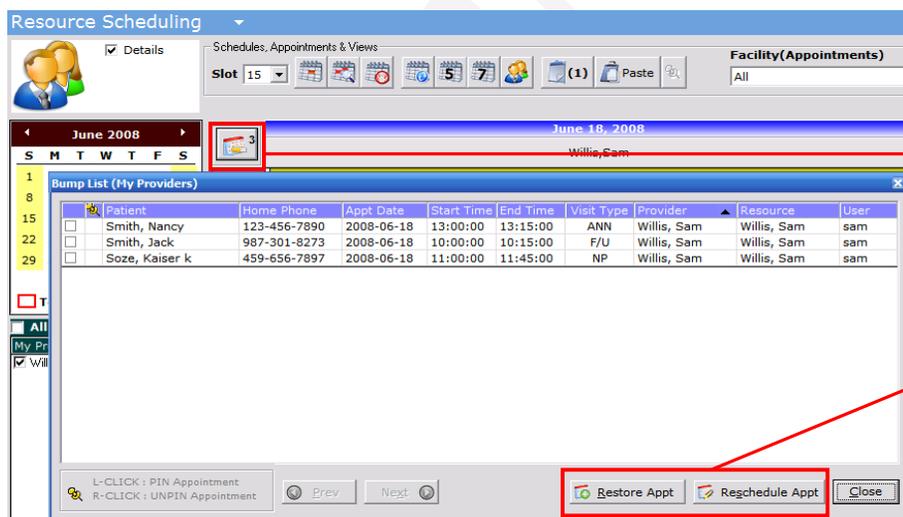
The 'Bump Appointment' feature can be used to create a 'Bump list' that would contain all scheduled patients who the provider/resource was unable to see during a particular day.

1. All appointments on a particular day can be transferred on to the Bump list and the whole day can be blocked for a provider/resource using the Block Hours feature.



This option has to be checked off in the Appointment Block screen to simultaneously block the entire schedule and transfer all patients in the schedule to the Bump List.

2. Individual appointments can also be put in the Bump List by right clicking on the appointment and choosing the 'Bump Appointment' option.
3. The Bump List can be seen by clicking on the Bump Appointments icon on the Resource Schedule screen. Appointments from the bump list can then be rescheduled as required.



The 'Bump Appointments' button on the Resource Schedule screen.

These buttons can be used to either restore the appointment(s) back on the schedule or to re-schedule the appointment(s) to a different date.

Introduction to eClinicalWorks EMR

The Office Visit Window

Basic patient check in/checkout process

1. The providers, Nurse and the MA will be using the 'Office Visits' screen to access the schedule for a particular day. This screen can be accessed by clicking on the 'Office Visits' icon under the 'Practice' section of the left navigation band or by clicking on the "S" Jellybean.

Use filter options to pull up a provider's or resource's schedule for a particular day.

APPT. TYPE	APPT. TIME	PROVIDER	RESOURCE	SEX	AGE	STATUS	ARR. TIME	DURATION	JOIN	STATUS	Notes	Sts
IFU	09:00 AM	Bennett, Janice	SW	F	43 Y	PEN						
CON 20	09:40 AM	Jones, John	SW	M	29 Y	PEN						
OV	11:00 AM	Darren, Lori	SW	F	34 Y	ARR	04:12 PM	2 m			✓	
NP	02:00 PM	Kumar, Raj	SW	M	43 Y	ARR	04:12 PM	2 m				

Visit status column – PEN denotes a pending visit, ARR denotes that the patient has arrived i.e., the front-desk has checked the patient in.

Arrival Time and Duration columns are updated automatically by the system once the patient checks-in at the front desk.

2. When the front desk staff checks the patient in, that will automatically be indicated on the Office Visits screen on the 'Visit Status' column – where the visit status code will change from 'PEN' or Pending to 'ARR' or Arrived.
3. If the patient's appointment is for a 'Nurse/MA Only' visit, the Nurse will check the patient into a room, complete the visit, check-out the patient from the exam room and send the patient over to the front desk. If it is a provider visit, the Nurse will check the patient into a room, complete the Nurse Assessment process before the provider sees the patient and then indicate to the provider that the patient is **Ready to be seen**, by changing the status code on the Office Visits screen.

The screenshot shows the 'Office Visits' application interface. At the top, there are filters for Facility, Date, and Sort by. Below is a table of visits with columns for Visit Type, Appt Time, Patient Name, P/R, Reason, Sex, Age, Visit St, Arr. Time, Duration, Room, Status, and Notes. A red box highlights a row for 'Bennett, Janice' at 09:00 AM. A callout box labeled '1. Select the patient.' points to this row. In the bottom left, a callout box labeled '2. Click on the Check In/ out button.' points to the 'Check In/Out' button in the toolbar. A pop-up 'Encounter' form is open, showing patient details for 'Bennett, Janice'. A callout box labeled '3. Click on the "Check In" checkbox to clock the time when the patient was checked into an exam room.' points to the 'Check In' checkbox. Another callout box labeled '4. Type in the exam room number where the patient is checked in.' points to the 'Room No' field. A final callout box labeled '5. Choose a "Status" code and click on the "OK" button.' points to the 'Status' dropdown and 'OK' button.

4. To document the provider or Nurse/MA assessment on the patient’s chart, the provider or Nurse will select the patient and either double-click on the patient’s name or click on the “View Progress Notes” button at the bottom left-hand side corner of the office visits screen to open up the patient’s ‘Progress Note’ for that encounter/visit.
5. Once the documentation is complete, the patient will be checked out of the room either by a Nurse/MA or the provider, again by selecting the patient and clicking on the “Check In/Out” button and then checking off the “Check Out” check box. Once the check-out is complete, the patient will go to the front desk to complete the Check-Out process.

Progress Note Overview

The progress note of the patient contains 3 major sections.

- Patient Dashboard
- Patient Chart Panel
- Patient S.O.A.P Note

Patient Dashboard

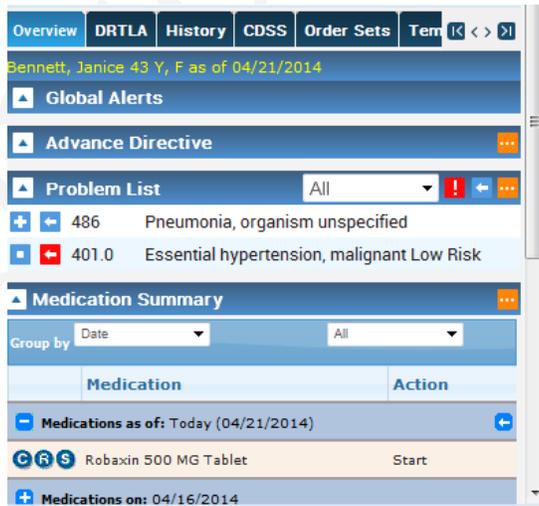


Patient Information and picture.

Patient’s insurance details, account balance, PCP, first and last appointment. There is a sticky note where any non-chart info can be added and used for documenting any important information about the patient. Menu bar gives a summary of all the data entered such as medical summary, list of labs, diagnostic images, procedures etc.

Patient Chart Panel

- The patient’s chart panel is the storage panel of all the previously entered information such as current medications, histories, allergies, immunizations etc.



Patient’s SOAP note

- Patient’s S.O.A.P note contains the Subjective, Objective, Assessment, Plan and Billing Data sections.

Documenting on a Progress Note: Subjective and Objective Information

Typically, during the nurse assessment of a patient, the nurse/MA will enter information in the following sections of the patient's progress note:

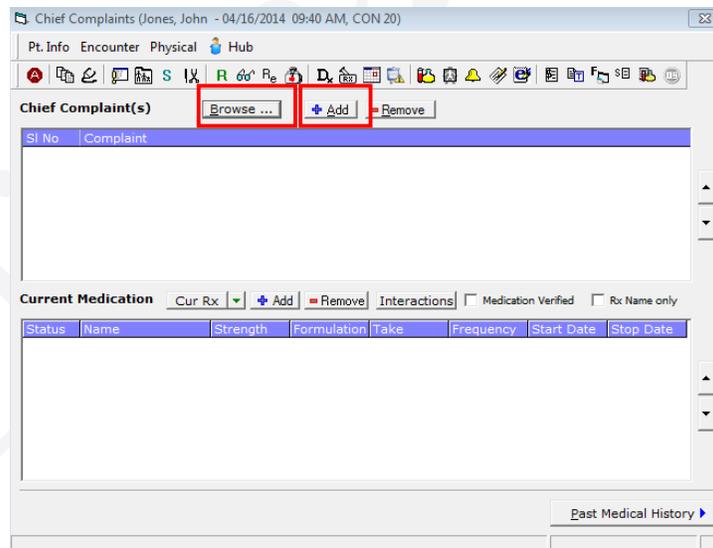
1. Chief Complaints
2. HPI
3. Current Medications
4. Allergies
5. Vitals

However, depending on the type/nature of the visit, additional information must be entered as required (for e.g.: the 'history' sections).

Entering relevant information in the four sections listed above are explained in detail, with screenshots below:

Chief Complaints

- From the patient's progress note, click on "Chief Complaints". The following window opens.



- The 'reason for visit' entered in the appointment screen will automatically show up as the patient's 'chief complaint'.
- Click on "Browse" or "Add" to add/change a chief complaint on the patient's chart.
- If you use "Add" to enter a complaint, the keyword/complaint must be typed in. The "Browse" button displays a standard 'pick-list' of complaints to choose from.

History of Present Illness (HPI)

- From the Progress Notes, click on 'HPI'. The following window opens:

Click an HPI category on the left and the corresponding items will show up on the right hand side.

To document the HPI, click on 'Notes' to bring up 'Notes' box.

Allows you to 'Denies' or 'Clear' all options.

c/o	denies	Symptom	Duration	Notes	Cl
X		Chest pain		Do You Have Freckles Ye	
	X	The complaints are reporte		friend	
	X	The patient is complaining			
	X	The chest pain began	1-2		
	X	The chest pain is describec			
	X	The chest pain occurs			
	X	The chest pain is located	back		
	X	The chest pain is worsenec			
		The chest pain is relieved l			
		Investigational studies that			
		There is known vascular di			

- Click an HPI category on the left side and the symptoms belonging to that category on the right side of the screen.
- Click the box in the "c/o" or "denies" column to mark the symptom that a patient 'complains of' or 'denies'.
- If the "show popup for c/o" is checked, the Notes section will automatically pop up. If show popup is not checked, then you will have to manually click on the "NOTES" section to get the option list.
- Click on a phrase to add it to the description area, or type in your own notes related to that symptom.
- Click on the blue arrow to expand the Notes section to cover more of the window. It will hide the structured data and allow a user to free type the HPI documentation.

Current Medications

- From the patient's progress note, click on "Current Medications". The following window opens.

- Click on the "Current Medications" hyperlink from the progress note to display the "Medication Reconciliation" window with the patient's medication information.
- New medications on the patient's record can be added by typing in the name in the 'Add Medication' box.
- Each medication added to the patients current list can be designated as 'Taking (T)', 'Not Taking (N)', 'Discontinued (D)', and 'Unknown Status (U)'.
- Medications can also be selected by clicking on the "Past Rx History". Here, you can sort the list by Prescribing provider, by the prescription date or by the prescription name.
- "Rx Name Only" check box can be utilized to remove the Strength, Formulation and Take.
- After the current medication list is built for the patient, check off the "Medication Verified" checkbox to

indicate to the provider that this is the most updated list. Verified

Past Medical History

- From the progress notes, click on “Medical History”. The following window opens.

Past Medical History (Bennett, Janice - 03/31/2014 11:20 AM, Dental) *

Pt. Info Encounter Physical Hub

Medical Hx Keyword ICD ... PMHx Pregnant BreastFeeding Hx Verified

No	History	ICD Code	PL
1	Detached Retina-left eye		
2	cataracts		
3	Abdominal pain		
4	abscess		
5	abnormal chest x-ray		
6	abnormal CT abdomen		
7	abnormal CT chest		

Allergies N.K.D.A Allergies Verified

Structured/N	Agent/Substance	Reaction	Type	Status
Structured	Keflex			
Structured	12 Hour Nasal Spray			
Structured	A & D			
Structured	7 Series BP Monitor/Upper Arm			
Structured	8 Hour Pain Reliever			

Chief Complaints Surgical History

- Three ways to add medical history:
 - Select “Keyword” or “ICD” and click on the ellipsis “...” to search by the respective option.
 - Click “PMHx” to add medical history from previously documented history.
 - Click “Add” to add a medical history on the patient’s chart.
- If you use “Add” to enter a medical history, a new line is added where you can free type the patient’s medical history. Using the ellipsis “...” button shows a general list of keywords or ICD that can be chosen for the patient.
- Medical history gets carried forward from visit to visit and history information from the previous visit is automatically displayed on the progress note.
- Check off the “History Verified” check box once you have updated the list.

Allergies

- From the patient's progress note, click on "Allergies/Intolerance". The following window opens (window also shared by "Medical History").

The screenshot shows the 'Allergies' section of a medical history window. The window title is 'Past Medical History (Bennett, Janice - 03/31/2014 11:20 AM, Dental) *'. The 'Allergies' section includes buttons for 'Browse Rx...', '+ Add', '- Remove', and 'Allergy Log'. There are checkboxes for 'N.K.D.A' and 'Allergies Verified'. Below these are two tables: 'Medical Hx' and 'Allergies'.

No	History	ICD Code	PL
1	Detached Retina-left eye		
2	cataracts		
3	Abdominal pain		
4	abscess		
5	abnormal chest x-ray		
6	abnormal CT abdomen		
7	abnormal CT chest		

Structured/N	Agent/Substance	Reaction	Type	Status
Structured	Keflex			
Structured	12 Hour Nasal Spray			
Structured	A & D			
Structured	7 Series BP Monitor/Upper Arm			
Structured	8 Hour Pain Reliever			

- To add a drug allergy or intolerance, click on the "Browse Rx" button, search for the drug and then choose the drug by clicking on it. By selecting the drug allergy from the "Browse Rx", you are adding a "structured" allergy. This allows the system to check for drug interactions.
- Click on "Add" to add a non-drug allergy/intolerance to the patient's chart. Choose the type of the substance to be added as "Non-structured". The "non-structured" option lets you type in a custom drug or substance and "non-structured" allergies do not check for drug interactions.
- The 'reaction' that the patient would experience to the substance added can be chosen from the drop-down list or manually typed in appropriately. The 'type' can also be chosen.
- If a patient denies any allergies, then click on the 'N.K.D.A' checkbox. (No Known Drug Allergies).
- The allergy log allows you to see who entered the allergy information.
- Click on "Allergies verified" once you have verified the allergies with the patient.

OB History

From the Progress notes, click OB History. The OB/GYN History window opens. The OB pane lists an established list of symptoms and the Notes section allows for keyword and free-text entry.

Denies H/O	Symptom	Notes
X	Periods :	
X	Sexual activity	
	Last pap smear date	10/10/2010
	Last mammogram date	11/01/2010
X	Abnormal pap smear	
	LMP	
X	STD	
X	Birth control	

Symptom	Notes
Total pregnancies	
Total living children	
Stillbirth(s)	
Miscarriage(s)	
Abortion(s)	
C section(s)	
Pregnancy # 1:	
Pregnancy # 2:	

GYN History

- From the progress note, click on "GYN History". The following window opens. The GYN pane lists all symptoms that can either be denied by the patient or applied to the "GYN History". The "Notes" section allows for keyword and free-text entry.

Surgical and Hospitalizations History

- From the patient's progress note, click on "Surgical History". The following window opens (window also shared by hospitalization).

Surgical Hx Keyword CPT ... Denies Past Surgical Hx Surgical Hx Verified

	Date (Mo/Yr)	Surgery
1	1965	appendectomy
2	2007	cataract removal
3	1998	cataract-lens implants
4	2007	left BKA
5	1985	fingers amputation
6	1990	AICD

Hospitalization Denies Past Hospitalization Hospitalization Verified

	Date (Mo/Yr)	Reason
1	2009	anaphylaxis
2		abdominal pain
3		atrial fibrillation
4		appendicitis
5		asthma exacerbation

- Two ways to add Surgical History:
 - Select "Keyword" or "ICD" and click on the ellipsis "..." to search by the respective option.
 - Click "Add" to add surgical history on the patient's chart.
- Click on "Browse" or "Add" to either add or update a new hospitalization.
- If you use "Add" to enter the history, a new line is added where you can free type the patient's medical history. The "Browse" button shows a general list of histories or reasons of hospitalization that can be chosen for the patient.
- When a patient has no surgical history or hospitalization then click on "Denies Past Surgical History" or "Denies Past Hospitalization".
- Check off the "Verified" check box once you have updated the list.

Family History

- From the patient's progress note, click on "Family History". The following window opens.

Family History (Test, Letters A - 03/23/2016 11:00 AM, EXAM- PREV)

Pt. Info Encounter Physical Hub

Copy/Merge Add Remove Customize Non-Contributory Family History Verified

Members	Status	YOB	Age	Note	CVD	Cance	DM	ATOD	HIV//HTN	Ment	TB	Other
Father	▼			...	<input type="checkbox"/>							
Other	▼			...	<input type="checkbox"/>							
Mother	▼			...	<input type="checkbox"/>							
Grandparents	▼			...	<input type="checkbox"/>							
Siblings	▼			...	<input type="checkbox"/>							
Children	▼			...	<input type="checkbox"/>							

Siblings Brothers Sisters Healthy

Children Sons Daughters Healthy

Notes Browse Clear

Surgical History Social History

- Under "Status" dropdown choose the options between "alive", "deceased", "unknown" or a blank field.
- Enter the birth year in the YOB field. This will automatically calculate the age.
- If a family member has a condition not listed as one of the checkboxes, click on the "..." buttons under the notes column to open the keyword window. Click on a known family condition from the left pane to add it to the Selected Category in the center pane or free type directly in the selected category pane. You can select multiple relatives on the right pane to that are known to have the conditions.
- Check off "Non-Contributory" if the family history is not relevant to this visit.
- The "Copy/Merge" option is available only for patients with the same guarantor.
- Check off the "Family History Verified" check box once you have updated the list.

Social History

- From the patient's progress note, click on "Social history". The following window opens:

Social History (Test, Letters A - 03/23/2016 11:00 AM, EXAM- PREV)

Pt. Info Encounter Physical Hub

Copy/Merge Social History Verified

Social History

- AAP Bright Futu
- Abuse/Neglect/A
- Dental History
- Diet/Exercise
- Foreign Birth
- Foreign Travel c
- HIV/AIDS Risk
- Incarceration
- Long-Term Care
- Mental Health
- Minor Services
- Occupation
- Homeless
- Tobacco Counse

Social Info	Options	Details
\$ Pregnancy Smoking Asses:		
\$ ASK - Tobacco use status:		
\$ ADVISE:		
\$ ACTION:		

Notes Browse ... Clear Select Default Clear All

Family History Custom ROS

- The folders on the left-hand side of the screen are called "Categories". When you select a category, the corresponding questions / items in that category will display on the right-hand side of the screen.
- Information can be added by clicking the "Details" field for that particular item. (Detailed Answer).
- The blue "S" identifies the item is built with Structured Data items. The red "S" identifies that the item is built with Structured Data items with Mandatory fields involved.
- Check off the "Social History verified" check-box once you are done.

Review of Systems (ROS)

- From the patient's progress note, click on ROS. The following window opens.

ROS (Darren, Lori - 04/16/2014 11:00 AM, AV - Femal)

Pt. Info Encounter Physical Hub

Review Of Systems

- CARDIOLOGY
- CONSTITUTIONAL
- DERMATOLOGY
- ENDOCRINOLOGY
- ENT
- FEMALE REPRODUCTIVE
- GASTROENTEROLOGY
- MALE REPRODUCTIVE
- MUSCULOSKELETAL
- NEUROLOGY
- SKIN

CARDIOLOGY

Symptom	Presence	Notes
Patient denies	→	
Patient complaining of	→	
Change in exercise toler	→	
Chest pain	→	
Chest pain while asleep	→	
Chest pain while awake	→	
Claudication	→	
Cold extremities	→	
Color changes of extrem	→	
Cough	→	
Cyanosis	→	

Default for All Clear All Default per Category Clear Category

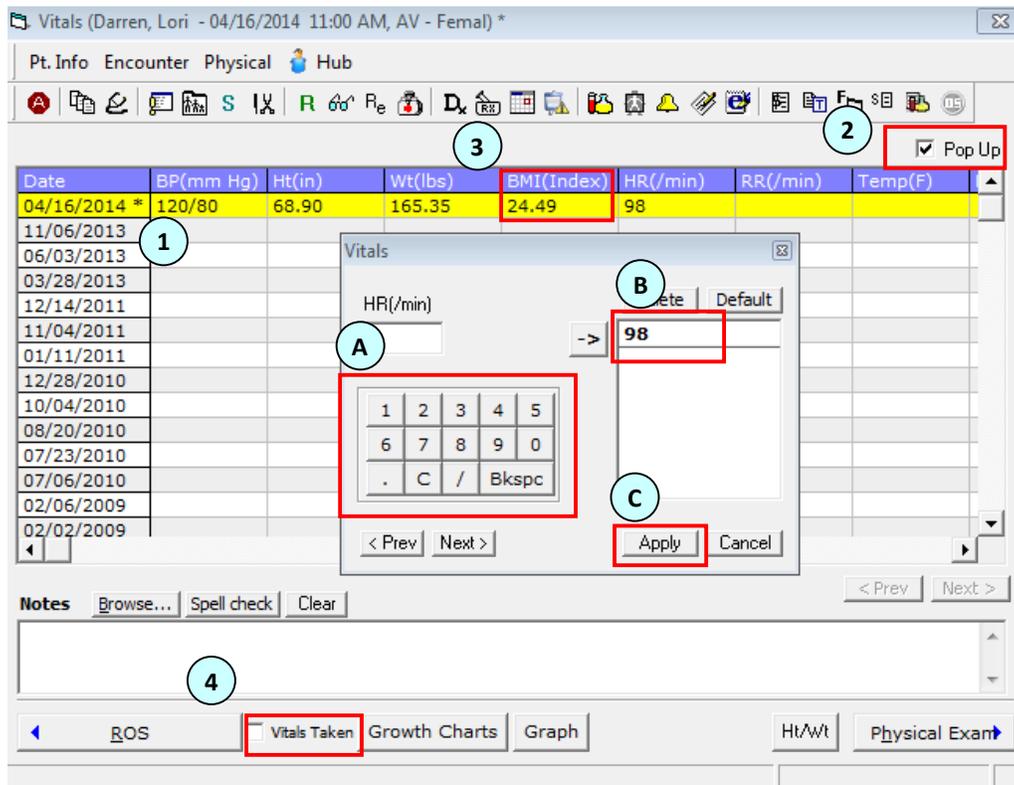
Notes Browse ... Clear Spell Check

Social History Custom Vitals

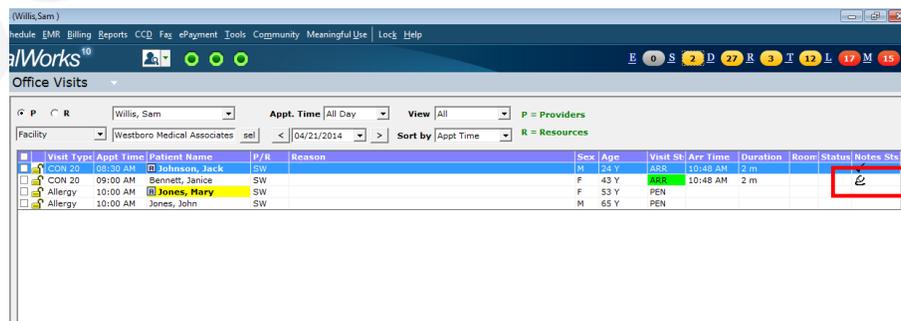
- To add additional notes to each symptom, simply click on the "Notes" cell corresponding to that symptom and type-in or select the notes keywords as required.

Vitals

- From the progress note, click on “Vitals”. The following window opens:



- The “Vitals” screen displays vitals for all visits for a patient. The row highlighted in yellow is the current visit.
- If the “pop-up” check-box is checked, the vital signs must be entered using the on-screen keypad by following steps A-C outlined in the screenshot. Otherwise, the vitals can be typed in by simply pointing and clicking in the respective yellow colored cell.
- BMI is automatically calculated depending on the patient’s weight and height.
- Check the “Vitals taken” check-box to document that vitals were taken during that visit. Doing this will also add a picture of a stethoscope in the “Notes Sts” column in the Office Visits screen.



Examination

- From the Progress Notes, click on 'Examination'. The following window will open.

Click an Examination category on the left and the corresponding items will show up on the right hand side.

To document the Examination, click on 'Observation' to bring up 'Notes' box.

Examination

- Click an Examination/Physical Examination category on the left side and the items (questions) belonging to that category appears on the right side of the screen.
- To document, click on the 'Observation' column to bring up 'Examination Notes' box.
- If desired, drawings/pictures can be attached using the 'Drawing' button.

Structured Data Column in Different Sections

In several sections of the Progress Notes, such as HPI, Examination, and Preventive Medicine, Social History, and Procedures, you will see a structured data column, which indicates if the notes field associated with the item is structured. A blue **S** indicates that the item is structured and a red **S** in the column indicates that the item is structured and mandatory.

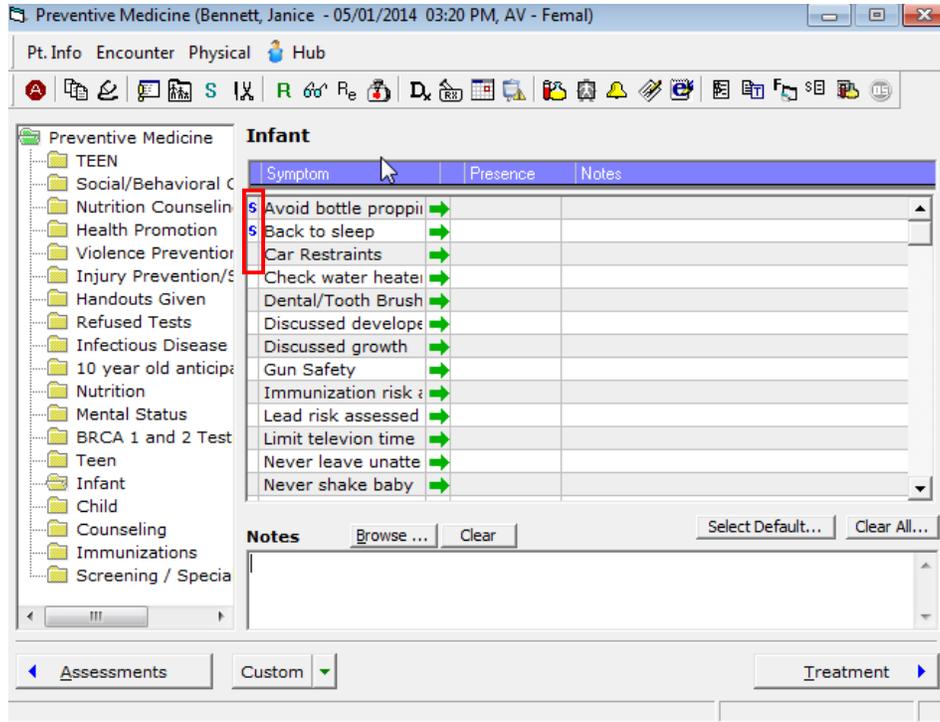
HPI:

c/o	denit	Symptom	Duration	Notes	Cl
S		Chest pain			X
S		The complaints are reported			X
		The patient is complaining			X
		The chest pain began			X
		The chest pain is described			X
		The chest pain occurs			X
		The chest pain is located			X
		The chest pain is worsened			X
		The chest pain is relieved by			X
		Investigational studies that			X
		There is known vascular disease			X

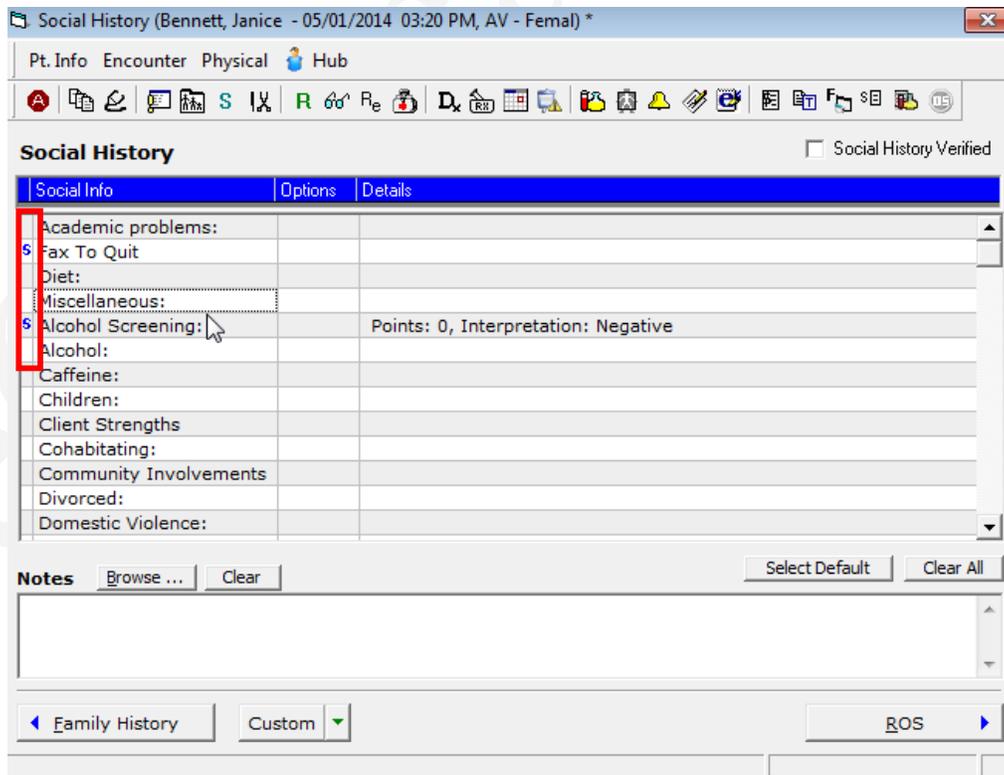
Examination:

Field	Observation
S GENERAL APPEARANCE	→
S FACE:	→
S HEENT:	→
ORAL CAVITY:	→
NECK:	→
HEART:	→
CHEST:	→
LUNGS:	→
ABDOMEN:	→
NEUROLOGIC EXAM:	→

Preventive Medicine:



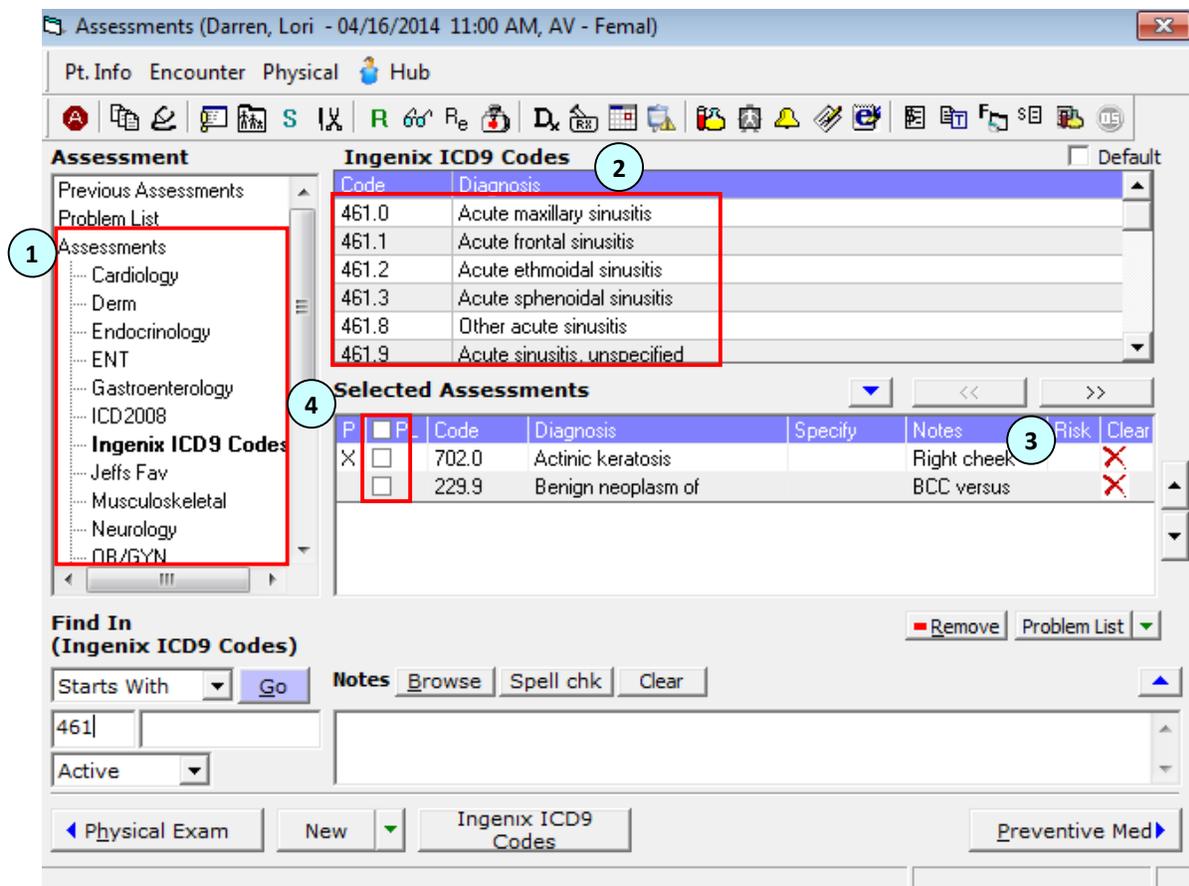
Social History:



Documenting the Assessments

Entering the Diagnosis and Diagnosis Codes

- From the progress notes, click on “Assessment”. The following window opens.



- Assessments can be searched by the diagnosis code or the name. They can be searched by first selecting one of the three options from the drop-down list: “starts –with”, “Contains”, “All words”.
- Once we find the assessment, highlight it to select it. Once selected, it goes into the selected assessment list for that patient.
- “Notes” section next to the diagnosis selected can be used to write the notes for that specific diagnosis whereas the notes section on the bottom is common to all the diagnoses.
- Any diagnosis which needs to be added to the problem list can be added from here by checking the ‘PL’ column. This allows the addition of the diagnosis codes to the right panel (in your progress note), which will allow you to select that diagnosis from there if the patient comes back for a follow up. It can also be selected from the problem list category on the assessment window.

Building the Problem List

The screenshot displays the 'Assessments' window for a patient named Darren, Lori. The window is titled 'Assessments (Darren, Lori - 04/16/2014 11:00 AM, AV - Femal)'. The interface includes a navigation pane on the left with 'Problem List' selected. The main area is divided into two sections: 'Ingenix ICD9 Codes' and 'Selected Assessments'. The 'Ingenix ICD9 Codes' section shows a list of codes and diagnoses, with 461.0 (Acute maxillary sinusitis) selected. The 'Selected Assessments' section shows a table with columns for 'P', 'PL', 'Code', 'Diagnosis', 'Specify', 'Notes', 'Risk', and 'Clear'. Two entries are visible: '702.0 Actinic keratosis' and '229.9 Benign neoplasm of', both with checkboxes for 'PL' and 'Risk'. Below this is a 'Find In (Ingenix ICD9 Codes)' section with a search box containing '461' and a 'Go' button. At the bottom, there are buttons for 'Physical Exam', 'New', 'Ingenix ICD9 Codes', and 'Preventive Med'.

To modify the existing problem list or to update the 'work-up' status of a medical problem, simply click on the ellipsis button (or the button with three dots) next to the "Problem list" heading on the patient's chart panel and that would open up the 'Problem list' window with the patient's history.

- Click on the desired column to choose enter the information for each medical problem.
- Click on the 'View Log' button to view the history of who added/updated/deleted the problem list of the patient.
- Click on 'Copy to Medical Hx' to copy problem list to the patients' medical history.

Problem List

Patient :

Problem List

Dx Type: All Dx Clinical Status: All No known problems

Type	Code	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical St	Added On	Modified On	Modified By	Resolved
	702.0	Actinic keratosis		Right ct		...	confirmed		04/16/201	04/16/2014	Willis, Sam	
	229.9	Benign neoplasn		BCC ve		...	confirmed		04/16/201	04/16/2014	Willis, Sam	
	789.37	Abdominal or pe					confirmed		04/16/201	04/16/2014	Willis, Sam	
	524.51	Abnormal jaw cl					confirmed		04/16/201	04/16/2014	Willis, Sam	
	756.82	Accessory muscl					confirmed		04/16/201	04/16/2014	Willis, Sam	

- If the patient does not have any problems, "No Known Problems" needs to be checked off.

Problem List

Patient :

Problem List

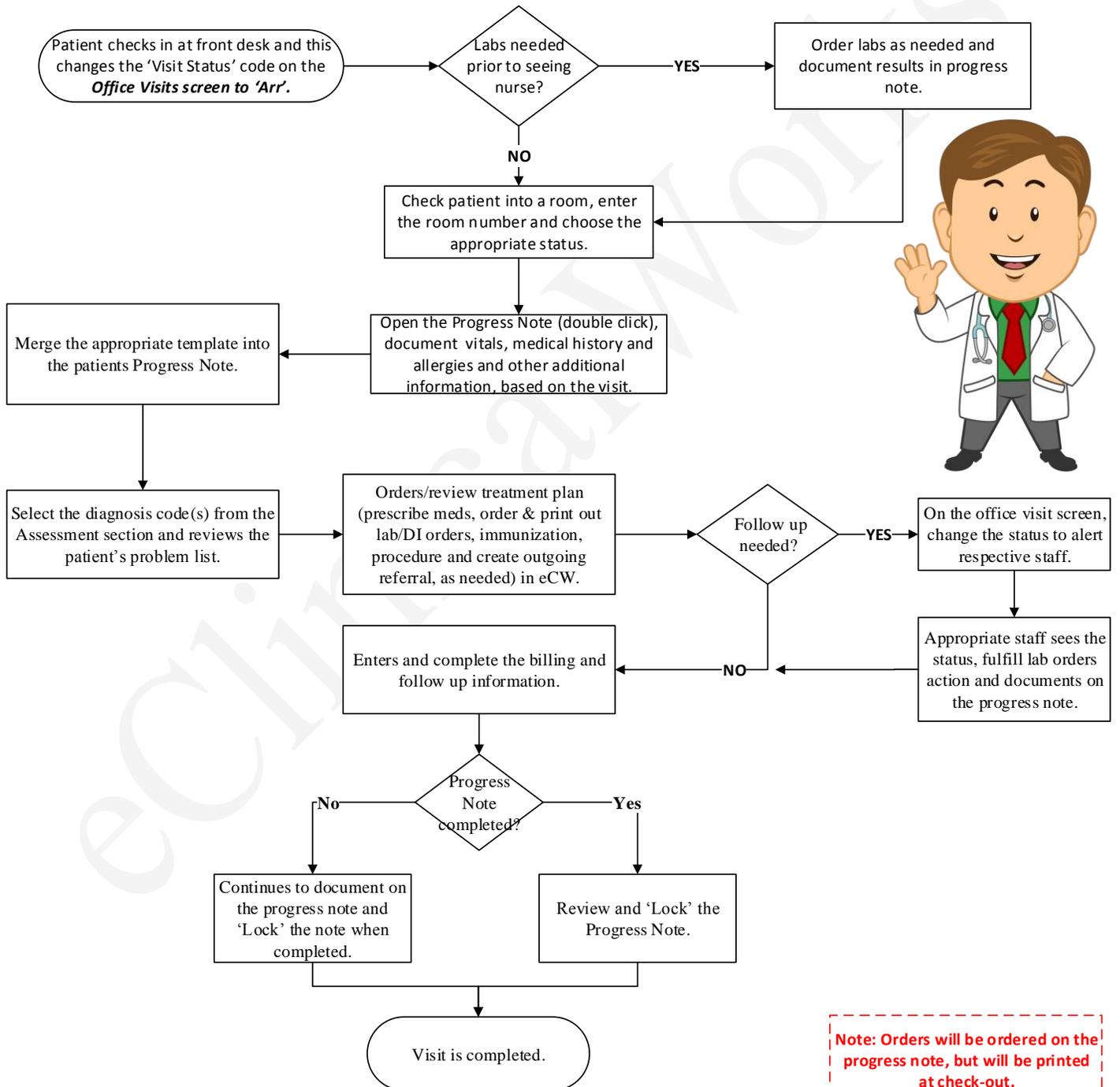
Dx Type: All Dx Clinical Status: All No known problems

Type	Code	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical St	Added On	Modified On	Modified By	Resolved
	702.0	Actinic keratosis		Right ct		...	confirmed		04/16/201	04/16/2014	Willis, Sam	
	229.9	Benign neoplasn		BCC ve		...	confirmed		04/16/201	04/16/2014	Willis, Sam	
	789.37	Abdominal or pe					confirmed		04/16/201	04/16/2014	Willis, Sam	
	524.51	Abnormal jaw cl					confirmed		04/16/201	04/16/2014	Willis, Sam	
	756.82	Accessory muscl					confirmed		04/16/201	04/16/2014	Willis, Sam	

Clinical Workflows

Provider Workflow

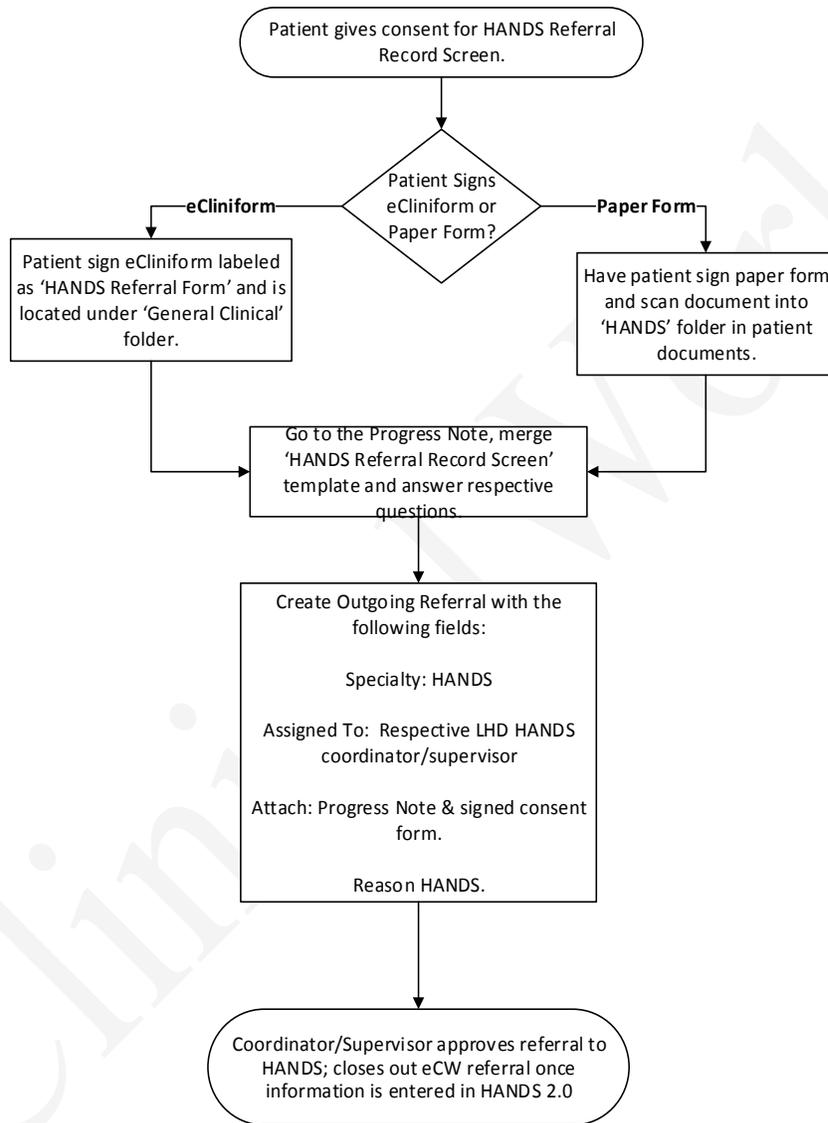
The flowchart below illustrates the provider workflow to document a patient's visit in eClinicalWorks.



Note: Orders will be ordered on the progress note, but will be printed at check-out.

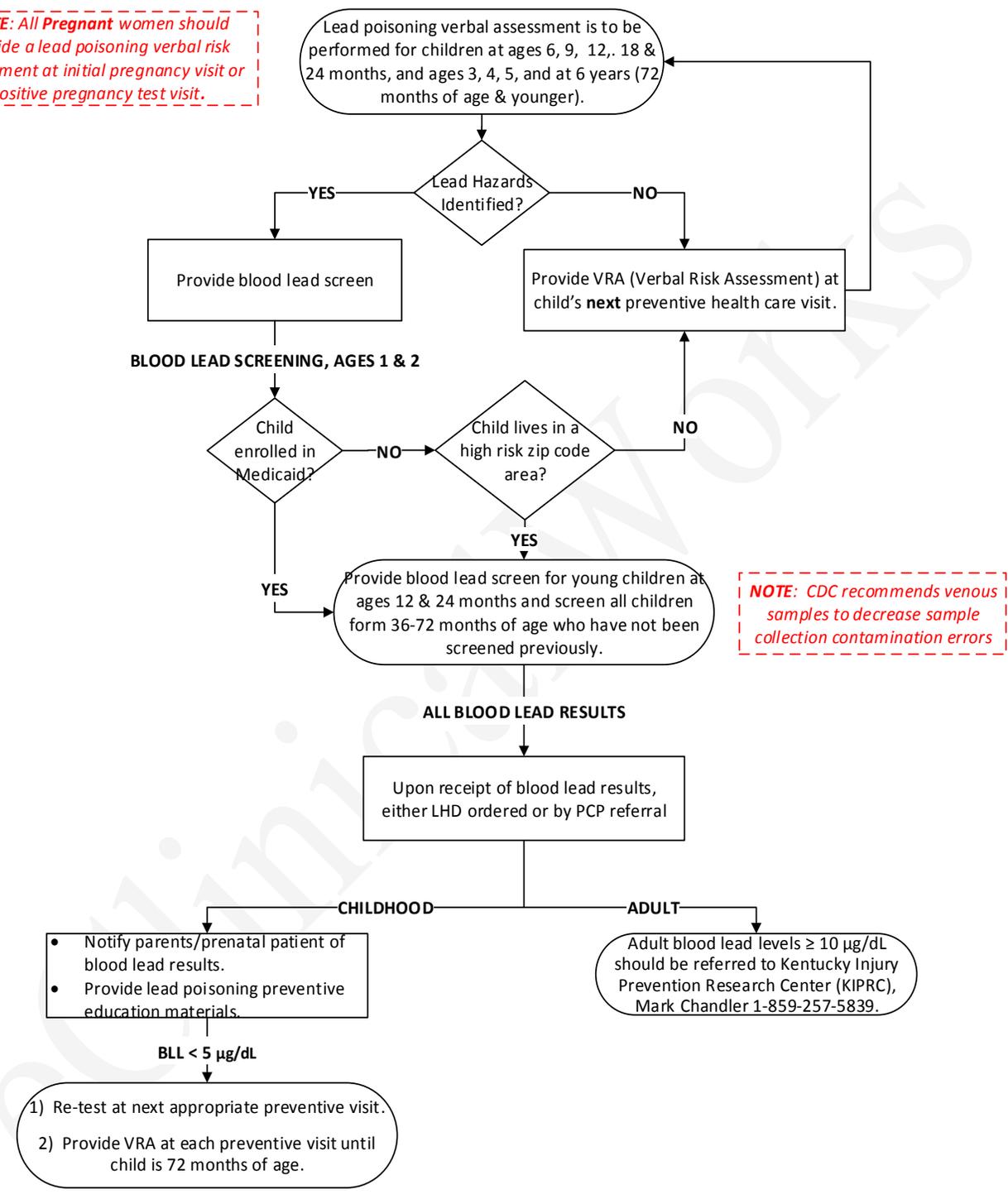
Program Workflows

HANDS

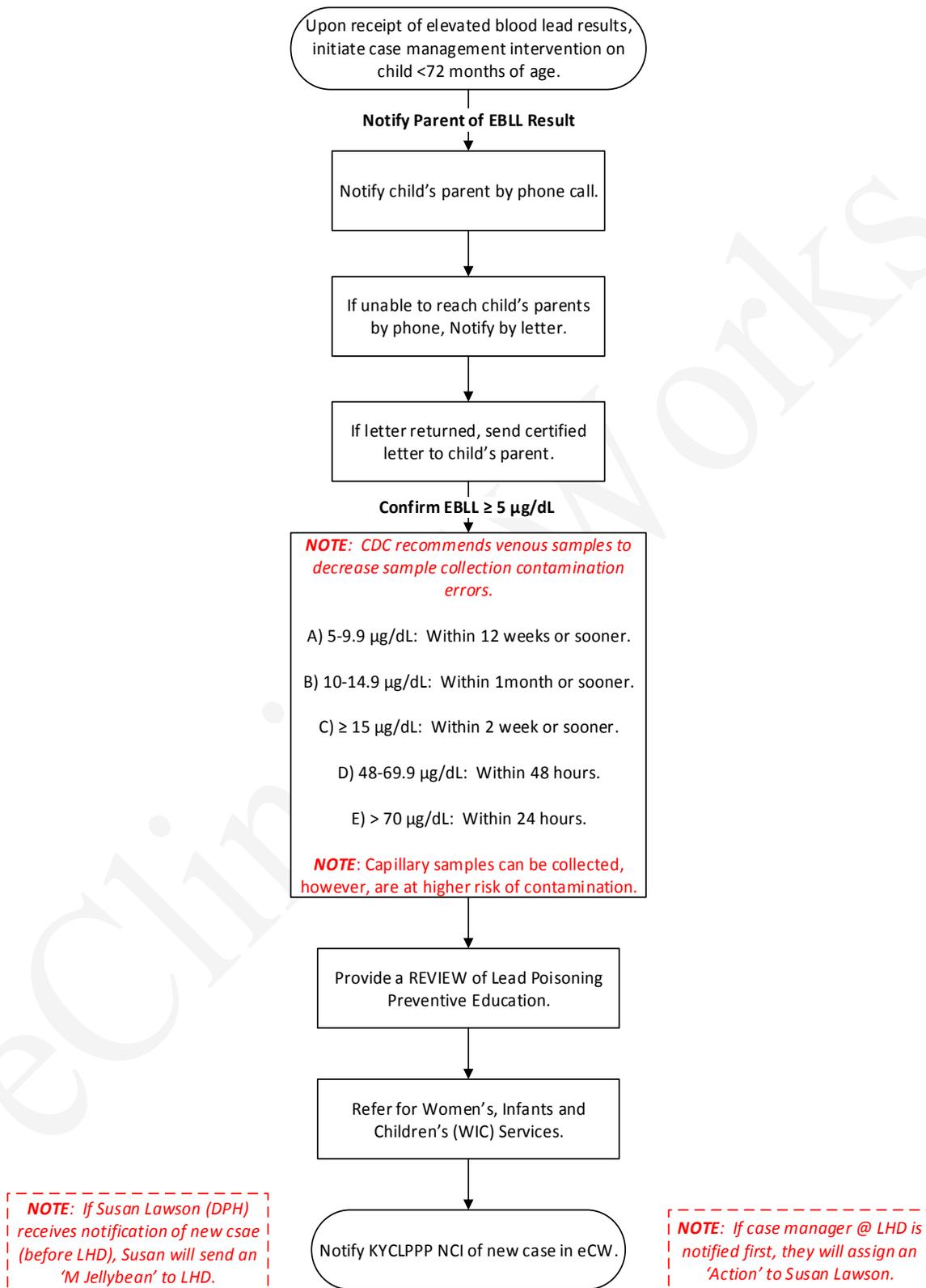


LEAD POISONING PREVENTION SCREENING GUIDE

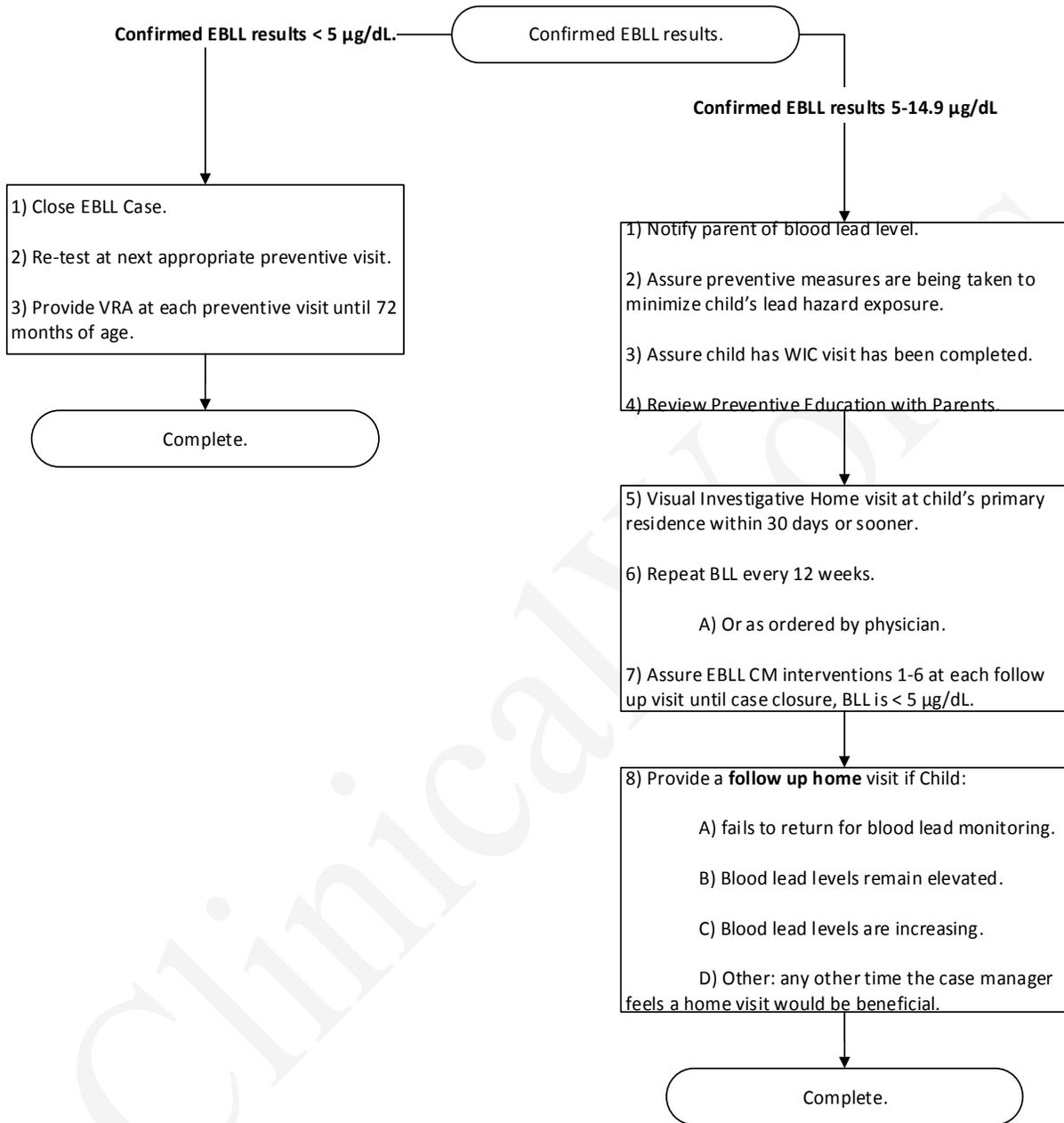
NOTE: All **Pregnant** women should provide a lead poisoning verbal risk assessment at initial pregnancy visit or positive pregnancy test visit.



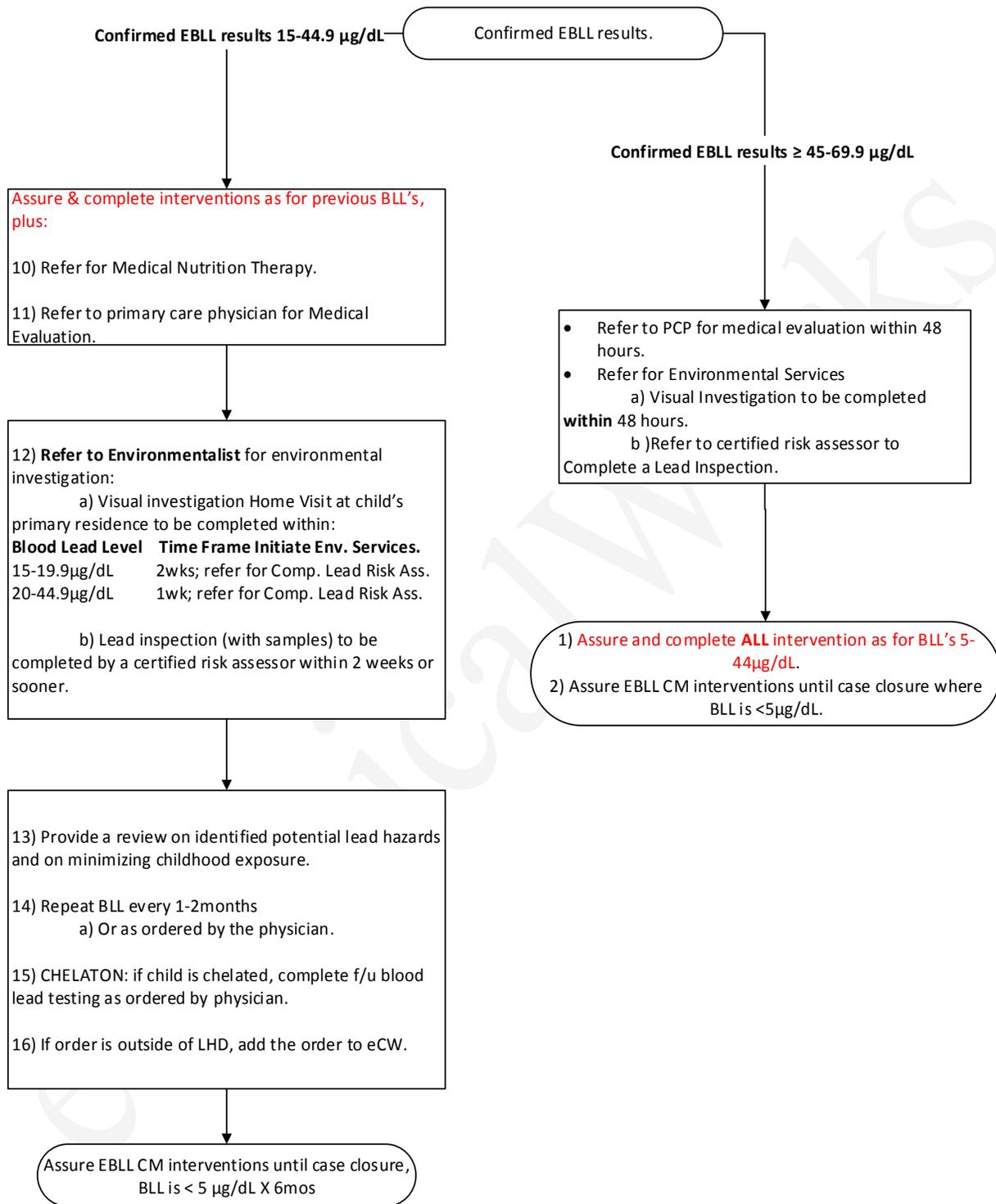
ELEVATED BLOOD LEAD RESULTS (EBLL ≥ 5)



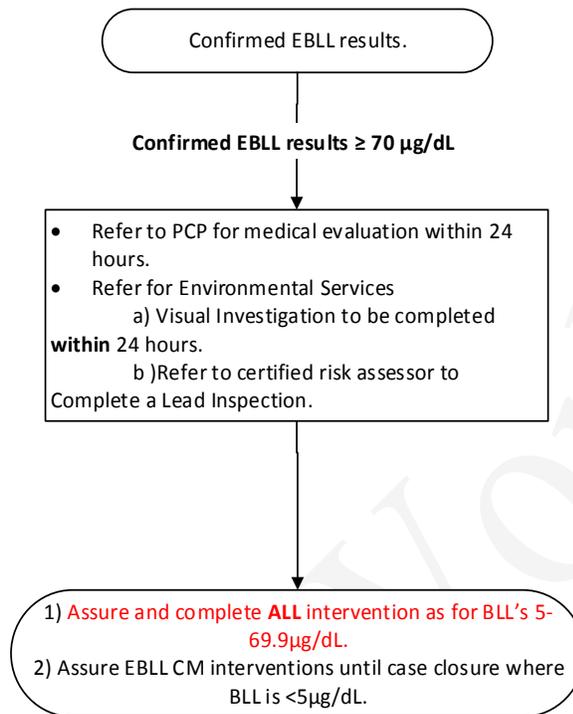
INTERVENTION FOR CONFIRMED BLL RESULTS



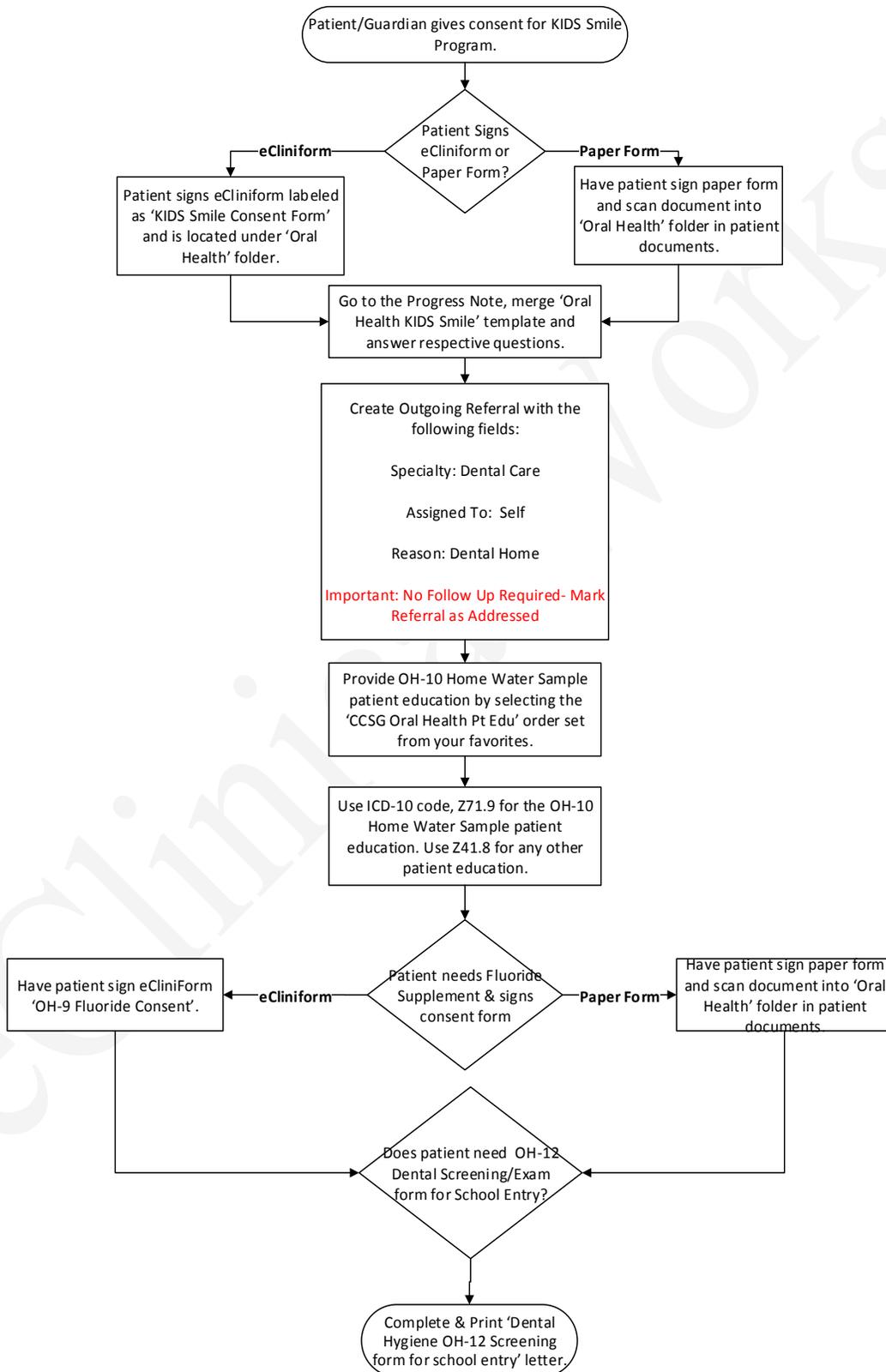
INTERVENTION FOR CONFIRMED BLL RESULTS (continued)



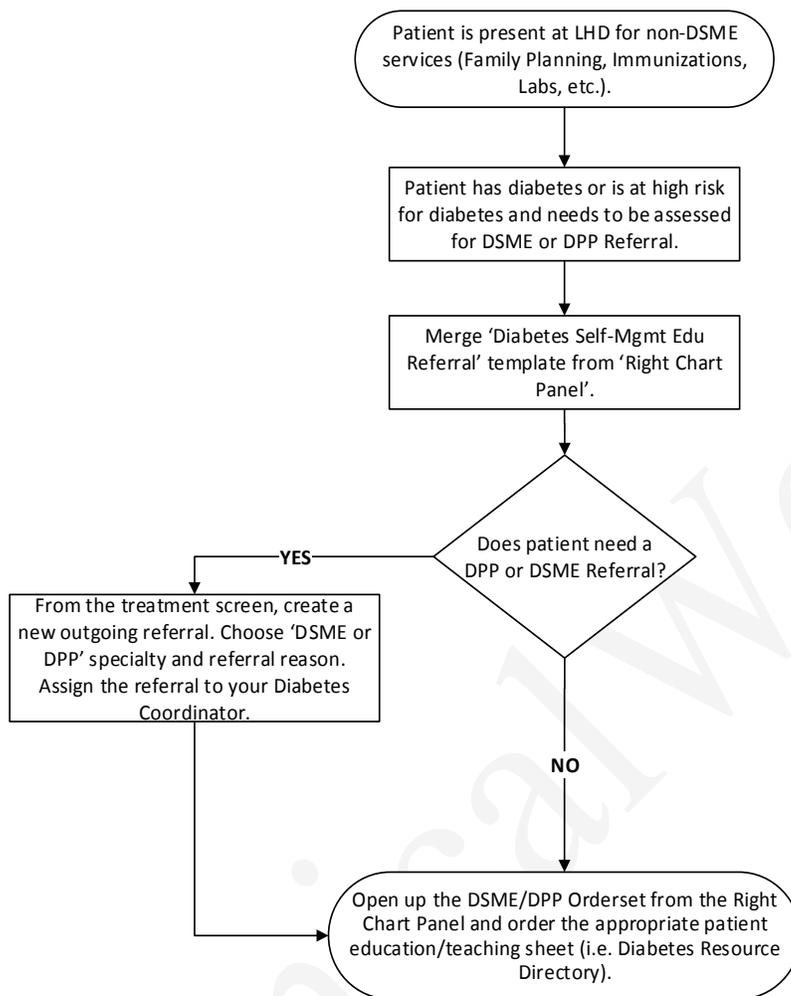
INTERVENTION FOR CONFIRMED BLL RESULTS (continued)



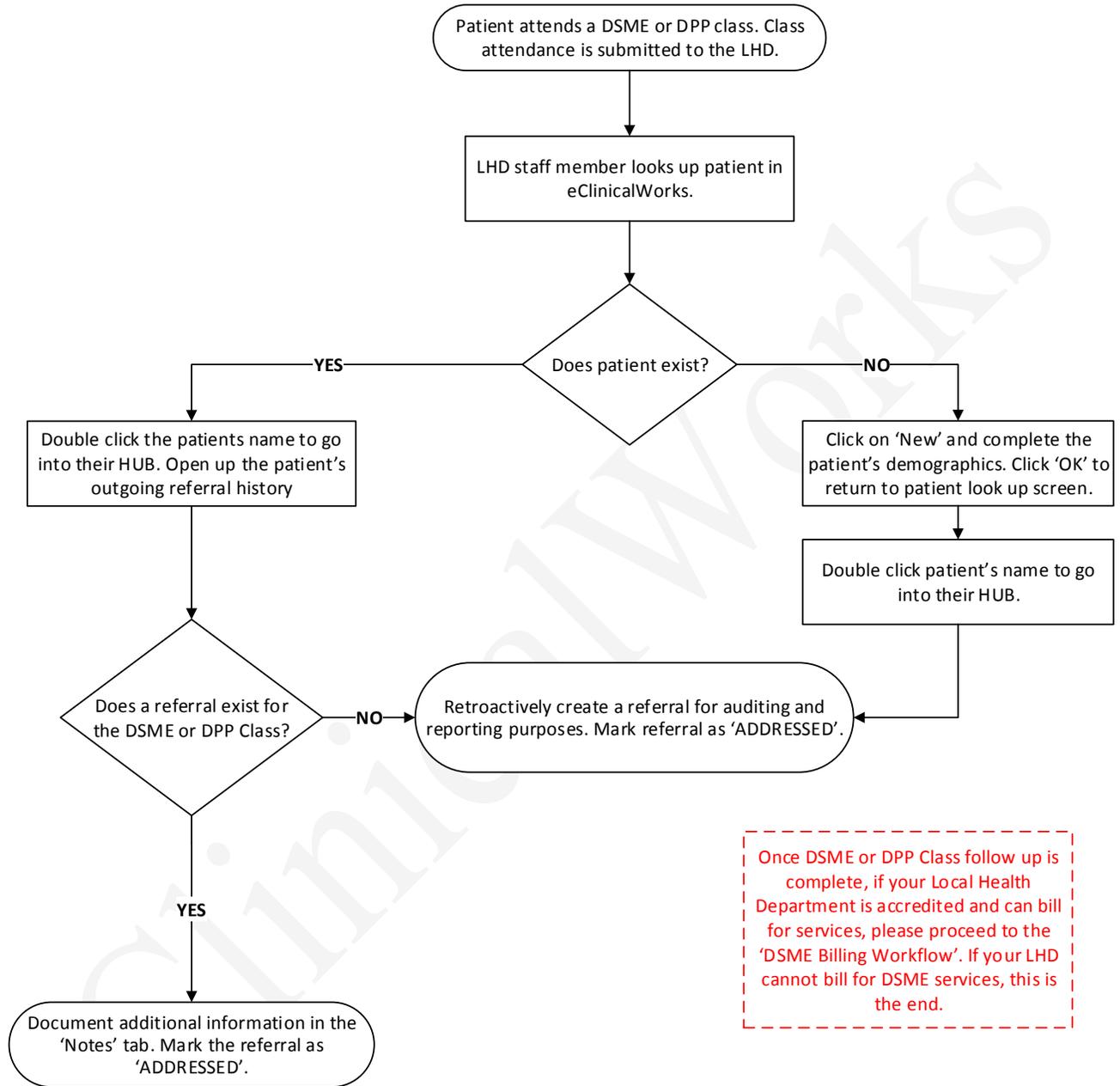
Oral Health Workflow



Referral for DSME or DPP Group Classes



DSME or DPP Class Follow Up



Billing for DSME Classes

Note: This should only be completed by an accredited Local Health Department providing DSME Services.

Note: This should also only be done after all referral follow up has been completed (whether or not the referral originated with the LHD or not.)

