Health ePractice
Electronic Medical Record
Office Manager Companion

www.health-epractice.org

A PASSION for HEALING
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How Do I Access?

Section I: How Do I Access?

St. John HealthPartner Website

1. In Windows Internet Explorer address bar type: health-epractice.org
2. St. John HealthPartners Website will display.
3. On the main tool bar hover over Health ePractice to display a drop-down menu.
4. From the drop-down menu hover over Practice Tools to display a drop-down menu.
5. From the drop-down menu click on eClinicalWorks (PM/EMR)
6. You have arrived at eClinicalWorks (PM/EMR) Practice Tools Home Page

Office Manager Companion
eClinicalWorks
How Do I Access?

**Web-Based Training (WBT) Modules**

1. On the eClinicalWorks (PM/EMR) Practice Tools Home page scroll down to the Training Tools area.
2. Select your appropriate role by clicking on the role button.
   
   ![Training Tools](image)

   **TO BEGIN SELECT YOUR ROLE:**
   
   - [Physician/Mid-Level]
   - [Office Manager]
   - [Clinical]
   - [Clerical]

3. A list of mandatory WBT Modules display for the role you selected.
4. Click on the name of any module to open the content.

![Web-Based Training Modules](image)

- Introduction to Windows
- Accessing eClinicalWorks
- Overview
- Office Visit Schedule
- Patient Lookup
- Patient Hub
- Quick Launch Task Buttons
- Progress Note
- Progress Note Right Chart Panel
- Progress Note Bottom Toolbar Buttons
- Using It All Together
  - Day One — New Patient Appointment
  - Day One — Established Patient Appointment
  - Day One — Telephone Encounter
  - Day One — Refill Encounter
  - Proficiency Assessment
How Do I Access?

Log In/Out of eClinicalWorks

1. To log into eClinicalWorks double-click on the eClinicalWorks icon located on your desktop.

2. Enter your login ID and password (case sensitive) and click on “Log In.”

3. To log off of eClinicalWorks go to File and select Exit from the drop-down menu or you can click on the ‘X’ button on the top right corner.

Remember to log out of eClinicalWorks when you leave your workstation unattended.
Basic eClinicalWorks Navigation

Section II: How To Guides

Basic Navigation Tools

eClinicalWorks application window has five standard navigation elements. These elements appear in Resource Schedule, Office Visit, and Progress Note workspace.

Element Details

1. **The Menu Bar:**
   Consists of the File, Patient, Schedule, EMR, Billing, Reports, CCD, Fax, Tools, Community, Lock Workstation, and Help drop down menus. Depending on your security, these menus can be used for basic functionality throughout the application.

2. **Patient Look-up Icon:**
   Launches the patient search activity window. When a patient is selected the Patient Hub displays. Clicking the down-arrow displays the last five (5) Progress Notes accessed.

3. **Toggle Buttons (Olive Buttons):**
   Enables the user to show or hide application elements.

4. **Quick Launch Dashboard Taskbar (Jellybeans):**
   Shortcut buttons to access items needing attention. The shortcut buttons also indicate the urgency and number of pending document reviews, and unread messages.

5. **Bands and Left Navigation Pane:**
   Provides access to functionality granted to the user by their security settings.
1. The Resource Scheduling screen is the best screen for appointments to be schedule or moved around for providers/resources and it can be accessed from the “Practice” band.

2. Provider and resource schedules can be seen for a 5-day period or a 7-day period consecutively by clicking on the respective icons on the top.

3. Time blocks on the schedule for a provider or resource can also be created similarly.

4. Single or Multiple appointments can be easily scheduled by clicking on the respective icons on the top. This is the same screen the front office will be using to check in and check out patients.
Basic eClinicalWorks Navigation

Quick Launch Task Bar

1. **E Menu**: The total number of e-prescriptions refill requests received and transmission errors displays on the button. Click to open the e-prescriptions window to review all e-prescriptions.

2. **S Menu**: Provides links to the Office Visits, Resource Schedule, and Progress Note windows. The number next to the “S” also indicates the number of patients marked as arrived. This number only displays for the providers and not for any other staff member; other staff members will see this number change from “0”.

3. **D Menu**: Provides the option of going directly to the Fax Inbox or Fax Outbox windows. The number next to “D” indicates the number of documents assigned to the logged in staff member. Click the button to open the Review Document window.

4. **R Menu**: Provides links to the Incoming Referrals or Outgoing Referrals windows. The total number of referrals assigned to the logged-on user displays in parentheses next to each link. The number next to the “R” indicates the number of combined incoming and outgoing referrals. Click the button that has the number to open the Outgoing Referrals window, or click the “R” itself, which will give you a drop down menu and from there you can select Incoming or Outgoing Referrals.

5. **T Menu**: Provides links to the Telephone/Web Encounters window, which includes new telephone and web encounters. The total number of encounters assigned to the user who is logged in will be displayed in parentheses next to each category. The number next to the “T” indicates the combined number of open telephone, web encounters and action items assigned to you. Click the button to open the Telephone/Web window.

6. **L Menu**: The L menu opens the labs and imaging window. The labs/imaging window opens directly to the To Be Reviewed Tab. The total number of labs and imaging assigned to the logged in user will display in parentheses next to each category. The number next to the “L” indicates the combined number of labs and imaging.

7. **M Menu**: Provides links to the Inbox, Outbox, or Deleted Messages windows, and includes a link to the Create New Message window. The number next to the “M” indicates the number of new messages in the inbox for the logged-in user. Also, by clicking on the letter “M” you can choose to view the Inbox, Outbox, Deleted Messages and even Create New Messages.
Creation and Block Provider/Resource Schedules

Creating a Provider/Resource Schedule

To set working hours for Provider/Resource, click on Schedule > Working Hours and Resource Availability

1. Select whether a provider’s schedule or a resource’s schedule needs to be built.
2. Select the appropriate provider or resource’s name from the drop-down list.
3. Click on the “Add” button and define the Working hours name (i.e. Master Schedule, Winter Schedule, etc.) and date range (i.e. for how long it will be applicable)
4. Click on the “Add” button and define the days, the working hours for each day and the facility where the provider/resource will have patients scheduled on that particular day.
5. This step is optional and can be used to create visit type rules, by clicking on the “Add” button, specifying the visit type, the duration for which the rule has to be applied for each day and the number of visits allowed.
6. Recurring schedules for providers/resources can be built by clicking on the “Recurrence” button in the ‘Working Hours date range’ screen (Step 3) and entering the appropriate information.
Creation and Block Provider/Resource Schedules

Blocking a Provider/Resource Schedule

The ‘Block hours’ options can be used to block the provider/resource hours when the provider will not be available to see a patient during his/her working hours.

To block the provider’s schedule;
1. Click on the ‘Block’ Icon from the ‘Resource Schedule’ screen
2. Select the Provider(s)/Resource(s) that you would like to block from the list
3. Enter the description using the description box (Ex: Christmas, Surgery at Hospital, etc) and choose the block color (the chosen color will be displayed on the Resource Schedule screen)
4. Select the Start Date/Time and End Date/Time. Use the ‘All Day Event’ to indicate that the Provider/Resource will not be available for the entire day.
5. (Optional) – Comments can be entered as needed
Patient Look-up

Patient Look-up Overview

Patient Look-Up Screen allows the user to:

- Search for the desired patient
- Register new patients
- Access patient’s demographics and hub

1. 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.

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

3. The Patient Lookup button also includes a drop-down list that provides quick access to a list of the last five patients whose Progress Notes have 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.

4. Select the desired patient by clicking on the patient’s name. Click the “Patient Info” button to view patient demographic information. After selecting the patient either click on the “OK” button, or simply double-click on the patient’s name, to access the patient hub (if you have access).

Patient Information (Demographics) screen

Patient Hub

The buttons (including the ones on the top of the screen) on a patient’s hub can be used to retrieve any information regarding the patient as well as to do any task related to the patient.
Patient Look-up

Patient Registration

The overview of the patient registration process is illustrated using a flow chart diagram below:
Patient Look-up

Patient Demographics

1. The patient information (Demographics) screen can also be accessed by clicking on the “Info” or “Demographics” button, in the different screens within eCW.

2. The mandatory fields can be configured by the practice administrator. However, some of the fields (such as Name, DOB and Sex) are absolutely required and these cannot be configured.
3. Additional information such as additional contact, patient’s physical address, patient’s picture, race and ethnicity details, language spoken, pharmacy details, etc., can be added/modified by clicking on the “Additional Information” button. In addition, if the patient is no longer with the practice, the patient can be marked as inactive. If the patient has passed away, the patient can be marked as deceased.
Patient Look-up

Patient Hub

Patient Hub is a centralized place where patient information can be found. In addition, different tasks can be done for the patient through the patient hub. Patient Hub can be accessed from different parts of the program.

1. Patient Hub can be accessed by:
   a. From ‘Patient Lookup’ screen
      i. select the desired patient and click ‘OK’
      ii. Double click on the patient’s name
   b. From a different screen in the program
      i. Click on the ‘Hub’ or ‘Patient Hub’ button

2. Patient Hub displays on the screen:

   From the patient lookup screen

   From the Chart Panel
Patient Look-up

Displays patient information.

Allows user to access patient’s information and perform tasks for the patient.
Scheduling Appointments

Scheduling Patient Appointments

1. Staff can create an appointment for a patient by opening the ‘Resource Schedule’ screen, select the date and the desired provider from the list, and double clicking on the desired time on the appointment screen.

![Resource Schedule Screen](image)

Double-click on a time slot here or on the actual time displayed on left to make an appointment.
2. Once the ‘Appointment’ screen opens, the basic appointment information will be displayed on the window (Facility, Provider/Resource, Start Time).

3. Staff can select the patient by clicking on the ‘Sel’ button. This allows the user to search for the patient from the patient lookup screen.

4. Once the patient is selected, the user can select the visit from the ‘Visit Type’ drop down. This tells everyone the type of visit that the patient is coming in for (New Patient, Established Patient, etc.).

5. Once completed, staff should leave the ‘Visit Status’ as ‘PEN (Pending)’ as this is the appointment status indicator (Pending, Arrived, Check Out, etc.).

6. The patient’s chief complaint can be entered under the ‘General Note’ field and any notes which need to go to the biller can be put under billing notes.
### Scheduling Appointments

**Rescheduling Appointments**

For appointments that need to be rescheduled to another day, a two-step process has to be followed:

1. The visit status on the actual appointment has to be selected as ‘R/S’ and the reason for rescheduling has to be typed in the ‘General Notes’ field.

2. The appointment now has to be re-created on the date when it needs to be rescheduled. This can be done by double clicking on the new date/time or copy the original appointment and paste it on the new time slot. (please note that if you follow the ‘Copy’ route, make sure to remove the General Note from the reschedule reason, as it will be copied to the new appointment as well).
Scheduling Appointments

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.

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.
Scheduling Appointments

In addition to changing the Visit Status of the Cancelled and Reschedule appointments, it is recommended that the receptionist enters the reason in the General Notes Box. This allows other staff members to the reasons as well.
Scheduling Appointments

Copying/Cutting and Pasting Appointments

1. An appointment can be copied or cut by right clicking on the appointment.
2. The appointment is now put on the ‘Appointment Clipboard’
3. From the resource scheduling, ‘Left Click’ on a new time and click ‘Paste’
4. The appointment is now copied/moved to a new time.

The ‘Appointment Clipboard’ and ‘Paste’ icon.
Scheduling Appointments

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 onto the “Bump list” and the whole day can be blocked for a Provider/Resource using “Block Hours” feature.

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 Scheduling screen. Appointments from the bump list can then be rescheduled as required.

Office Manager Companion
eClinicalWorks
Scheduling Appointments

Generating and Verifying Incoming Referrals (If Applicable)

For patients who need a referral in order to be seen by the provider. Secretary/staff can create and document “Incoming Referral” in eClinicalWorks.

1. Incoming referrals can be created for a patient by clicking on the “Referral” button on the ‘Appointment’ screen or by going to the patient’s Hub and clicking on the “Referrals” button.
2. The details of the referral can then be documented on the ‘Incoming Referrals’ screen, as required (Referral From, Referral To, Auth Code, Start-End Date, Reason, Diagnosis, etc).
3. Incoming referrals can be linked to the appointment by clicking on the ‘Visit Details’ tab.
Workman’s Comp/MVA Visits

If the patient’s appointment is not going to be billed under the Medical Insurance such as Workman’s Compensation / Motor Vehicle Accident (MVA), the visit that will be covered by an insurance which is different from the patient’s primary insurance, the appropriate additional insurance has to be added in the “Patient Information” screen and then this insurance has to be associated with the appointment.

(a) Add the Work. Comp. insurance without “designation”, i.e., ‘Primary’, ‘Secondary’ or ‘Tertiary’ status in the ‘Insurance’ section of the “Patient Information” screen.

*Note: Click “Yes” for any warning messages that may display as a result of this step.*
Patient Check-In

(b) For Practices that will be using the Claim Data Feature: Click on the “Claim Data” button on the Appointment screen and from the Claim Data screen remove all other insurances except the Work Comp. insurance. This change will be applicable for the current visit only.

(c) For Practices that will be using the ‘Case Management’ Feature: Click on the “N” button on the Appointment screen and from the Case Detail screen, remove all other insurances except the Workman’s comp/MVA Insurance. This change will be applicable for the current visit only.
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.

2. After feeding the document in the scanner in the appropriate way (top down, back-side facing towards you), 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’.

2. The scanned documents can then be moved into the respective patient folder by following a simple 3-step process:
   1. Select the scanned document
   2. Select the folder where it needs to be added into
   3. Click on the ‘Add’ button (make sure that ‘Add Description’ is checked off)
Patient Check - In

4. 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.

5. To add certain pages only from the scanned document into 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 into the patient’s folder without the cover sheet.

6. The “Add Local” button located right below the “Add” button can be used to add any ‘local’ files (i.e., files from your computer) into one of the patient folders.

7. 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 members in the practice.
The recommended naming convention to be followed when adding scanned documents into the respective folders is to “YYY/MM/DD – NameOfDocument”. For example, if you are scanning a lab result that was received on the 10th of August, 2009, the scanned document should be named as ‘2010/06/10 – CBC Result’. This recommended naming convention makes it easy to sort the documents in chronological order.
Linking the visit with the Incoming Referrals (If Applicable)

For patients who need a referral in order to be seen by the provider. Secretary/staff can link the (created) referral to the appointment by:

1. Click on the “Referral” button on the ‘Appointment’ screen.
2. Select the desired referral and click on the ‘Update’ button.
3. Click on the ‘Visit Details’ tab
4. Select the encounter date from the drop down.

Click on the drop-down arrow and select the appropriate visit date that this referral has to be linked to.
Patient Check - In

eClinicalForm (Overview)

Paper forms that providers/patients need to sign and are not available in the EMR system (some insurance/facility requires their unique paper forms) can be uploaded as ‘eCliniForms’. eCliniForms can be accessed under the ‘Documents’ band. eCliniForms can be ‘inked’ using the Stylus from the tablet or the Signature Pad.

1. To use the eCliniForm, select the desired eCliniForm from the list and click ‘Ink Doc’ button

2. Once the document is loaded, provider/staff/patient can ink the document

3. Once completed, provider/staff can save the document to the patient’s chart by clicking on the ‘Attached To Patient’ button or the ‘Disk’ icon

(This depends on where you accessed the eCliniForm)
a. If you access the eCliniForm from the ‘Documents’ band, you can select the ‘Attached To Patient’ option, select the folder where you want to save the document and rename the document.

b. If you access the eCliniForm from other parts of the application such as Appointment Screen, Progress Note, you can click on the Disk icon and the document will be saved to the corresponding folder with the standard naming convention.
Patient Check – In

Bubble Sheets

Use the Bubble Sheet wizard to create, modify and delete bubble sheets.

To create a standard Bubble Sheet

1. From the EMR menu, select Bubble Sheet Designer option.

The bubble sheet wizard opens:

2. Click Create New Bubble Sheet document option

The document name text box displays:
3. Enter a name for the bubble sheet and click the Next > button

The Design document window opens:

4. Single click a folder to open it
   – Some folders contain sub-folders; double click any folder with a (+) to open it.
5. Double click an item (pink icon) to add it to the bubble sheet
   – Each item you select appears in the list in the right pane.
   – Select an item more than once to ask several questions on the same topic
6. Edit each item to create a question for your bubble sheet:
   Double click an item
   ♦ or
   Select an item from the list in the right pane and click the Edit Row button.
   ♦ The edit question window opens
7. Create questions and options for the bubble sheet based on the selected item using the following features

<table>
<thead>
<tr>
<th>Feature</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heading</td>
<td>This field groups related questions. The default name comes from the subjective sections of the Progress Notes. You can change this heading to rename your groups of questions.</td>
</tr>
<tr>
<td>Question</td>
<td>Enter a question for the item (topic) you selected. If you selected the same item more than once, you can create related questions for each one.</td>
</tr>
<tr>
<td>Options</td>
<td>Enter the answers from which patients can select on the bubble sheet. Separate these options with commas.</td>
</tr>
<tr>
<td>Selection</td>
<td>Click either the Single or Multiple radio button to indicate the number of answers the patient can mark and then click Save button.</td>
</tr>
</tbody>
</table>

Note: Include negative response options so questions are not left without a response. For example, if you ask: What pet are in your home?, include an option for None.
Patient Check – In

8. To use structured data in a bubble sheet:
   a. In the tree view on the left, double click a folder to open it:
      - The blue folders contain the questions with answer options saved as structured data.
      - Some folders contain sub-folders. Double click any folder with a (+) to open it:

   b. Double click an item in a blue folder to add a related question to the bubble sheet. The selected item appears in the list in the right pane and the edit question window opens. The responses in the Options field are not editable and the radio buttons for the selection options are disabled.
Patient Check – In

9. Use the Up and Down arrows on the far right to reorder your questions, if necessary.
10. Click the Delete Row button to remove an item or question.
11. Click the Delete Page button to remove a page of items.
12. Click the Generate Document button when you have finished adding and editing items.
The Notepad© editor opens and displays the selected items along with the category titles. Notepad provides providers some basic formatting or to save it as a .doc file and format the document using Microsoft© Word:

13. Click the Finish button to save the file

14. Print the document
**Patient Check - Out**

**Collecting Copays and Payments**

1. Copay can be collected by clicking on the ‘Charge Details’ button and ‘Copay’ (from the appointment screen)

2. Document the payment information on the Payment Screen, amount, check number and memo if applicable. Once completed, receipt can be printed by clicking on the ‘Receipt’ button at the bottom left hand corner of the screen.
3. Additional Notes can be documented in the “Memo” section
Patient Check - Out

Printing Out Visit Summary

Once the provider is done with the patient, visit summary can be printed out by:

1. Right click on the appointment and select ‘Print Visit Summary’ from the resource scheduling screen
2. Select the desired options and click on the ‘Print Preview’ button

Note: Visit summary can also be printed by the provider/nurse from the progress note
Miscellaneous Features

Messaging

Messaging feature in eClinicalWorks allows staff and providers 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” button on 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’ button corresponds to the number of unread messages in your inbox.
3. Clicking on the ‘M’ letter will give options to access the inbox or outbox.
4. User can compose a new message by clicking on ‘Compose’ or ‘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 encounters.
**Telephone Encounters**

Providers and staff can document telephone conversation he/she had with the patient using the telephone encounter feature. Once documented, the telephone encounter can be assigned to a different staff member in the practice for further action if needed. (Telephone Encounter Example; Medication Refill request, Message for the Provider, Lab result request, etc.)

Telephone Encounters can be created several ways in eClinicalWorks. The easiest (and recommended) way to create a telephone encounter is through ‘New Tel Enc’ button from the patient hub.
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.

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.

The name of the caller can be documented under the “Caller” section. (Example: Mom, Wife, etc.)

The reason for the call can be chosen from the respective drop-down or also typed in.

The actual message can be typed in the “Message”: section.

The follow-up action taken for the issue can be documented in the respective section. The eClinicalMessenger could be utilized as well as the Reply to Patient button.

The telephone encounter thus created can be assigned to a provider or staff member appropriately.

For issues which require immediate attention, staff can check off the ‘High Priority’ check box. This will trigger the Jellybean to turn ‘Red’

Once the issue is addressed or taken care of, the telephone encounter can be ‘closed’ by selecting the “Addressed” option.
Miscellaneous Features

Actions
Action feature allows user to create and assign task to different staff members in the system.

1. Actions can be created either from the patient Hub or by clicking on the ‘T’ alphabet on the top right corner of the screen.

2. Actions thus created can be assigned to a respective staff member with a message and certain attachments, set a respective status code and can also be made to recur repeatedly over a period of time, if required.
Miscellaneous Features

Alerts/Recalls

Generic Alerts

Generic alerts can be set for all patients seen by a provider or in a particular facility. These alerts can be set from the EMR>Alerts option.

Generic Alerts can be accessed from the Patient Hub. They can also be viewed from the patient dashboard or be accessed form the patient right panel.

• These alerts would automatically be suppressed once the conditions are satisfied (e.g. a lab result is received).
• You can also manually suppress the generic alerts by clicking the ‘Last Done’ button or the “Suppress” button.
Miscellaneous Features

Alerts/Recalls

Patient Specific Alerts

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” under the patient specific alert. The Patient specific alert window opens.

![Alert Window]

2. Use the drop down list and select one of the options to set up a patient specific alert. You can also select the “recall after” and the due date changes. 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.
Global Alerts can be established by the physician 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.

- Global Alerts can be created from the patient hub, from the demographics and by choosing the ‘Global Alerts’ option under EMR>Alerts.
- These alerts will pop-up on the screen whenever the patient’s name is clicked on from the ‘Lookup’ screen as well as when an appointment is created/modified for the patient.
Miscellaneous Features

Alerts/Recalls

Patient Recall

Recall Feature can be accessed from the Navigation Band under Recall -> patient recall

- Recall lists can be run for patients based on appointment dates, patient-specific protocols (or alerts) and generic protocols (or alerts).
- Once the required search fields or ‘filters’ are chosen appropriately, the ‘Lookup’ button must be clicked on to get the desired recall list.
- Respective letters can be printed out for a patient/all patients in the recall list by using the “Run Letters” button.
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 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
Miscellaneous Features

**Document Management**
eClinicalWorks comes with a document management features which allows:
- Staff to scan the patient’s document into the system and attaches the document to the electronic chart (consent forms, lab result, 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.

   ![Scanning Module Image]

   - Select the patient to for whom the documents need to be scanned in.
   - Patient Document folders where scanned documents are stored.
   - Scanning settings

   ![Scan Bucket Image]

   - SCN Bucket. Scanned documents will be temporarily stored here.
   - Users can then select the documents and add them into the right folder.

   1. After feeding the document in the scanner in the appropriate way (top down, back-side facing towards you), 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’.

   2. The scanned documents can then be moved into the respective patient folder by following a simple 3-step process:
      1. Select the scanned document
      2. Select the folder where it needs to be added into
      3. Click on the ‘Add’ button (make sure that ‘Add Description’ is checked off)
4. 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.

5. To add certain pages only from the scanned document into 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 in to the patient’s folder without the cover sheet.

6. The “Add Local” button located right below the “Add” button can be used to add any ‘local’ files (i.e., files from your computer) in to one of the patient folders.

7. 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 members in the practice.
The recommended naming convention to be followed when adding scanned documents into the respective folders is “YYY/MM/DD – NameOfDocument”. For example, if you are scanning a lab result that was received on the 10th of August, 2009, the scanned document should be named as ‘2009/08/10 – 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 on the ‘D’ dashboard taskbar. The number on the dashboard indicates the amount of documents a particular staff member has to review. Red dashboard taskbar indicates that there is a ‘High Priority’ document in the inbox. The high priority document has an “!” in front.

- Filters: Allows you to view desired documents with different status
- Document list: “!” indicates a high priority document
- Allows you to see how many documents have been assigned to you
Miscellaneous Features

When clicking on a document from the document list, Provider/Staff 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 a particular staff member or mark the document as ‘Reviewed’.

Allows the provider/staff to timestamp and add additional notes

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

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

Allows the provider/staff to assign the document to another staff

Shortcuts – Open Progress Notes, Patient Hub. Allows provider to draw/sign on the document, etc.
**Miscellaneous Features**

*eClinicalWorks Electronic Faxing*

*Incoming Faxes*

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

1. Prior to receiving the faxed document, the practice administrator had to map the eCW application on every local computer to the fax inbox by typing the fax inbox folder’s location on the “Local Settings” screen. The ‘Local Settings’ window can be accessed through the “File” menu, “Settings” option and clicking on the “Local Settings” option.

2. Once completed, the Fax inbox can be assessed either by clicking on the “Fax Inbox” icon in the “Documents” band or by choosing the “Fax Inbox” option in the ‘Patient Documents’ screen. Accessing the fax inbox from patient documents is more efficient because the user can immediately attach the fax to a patient record after reviewing it from this section.

![Image of fax inbox access in eClinicalWorks]

Users can also view faxes by selecting Fax Inbox here.

Click on fax inbox here to access electronic faxes.
eClinicalWorks Electronic Faxing

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 5 above).

Outgoing Faxes

eClinicalWorks allows users to electronically fax documents from the application. User can use the fax feature by clicking on the ‘Fax’ button from various section of the application (Ex. Progress notes, Patient Documents, Lab/DI Order, etc). Once the document(s) is faxed out, user can monitor the status of the (sent out) faxes through ‘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

2. The individual patient fax logs can be viewed by clicking on the “Fax Logs” button from the patient’s Hub.
Reports

Running Registry Reports

Registry feature can be accessed by clicking on the ‘Registry’ icon. To run a registry report:
1. Select the desired tab and set the values
2. Click on ‘Run New’ button
3. (Optional) – To narrow down the search, select other tabs and set values and Click ‘Run Subset’
4. The data can be exported into Notepad/Excl by clicking ‘Copy’ button at the bottom of the screen
5. Registry Queries can be saved by clicking on ‘Save Queries’ button. Enter the desired name, associate with a flowsheet (optional) and input ‘Report Criteria’ (Optional)

Note: Registry feature can be accessed by 1 staff member at a time. To release the session, click ‘Release Lock’
Reports

View Billing Summary

- The billing summary can be printed from Reports > Billing Summary > View billing summary.
- No shows will not show on the summary, so if there is a charge for no showing then the no shows can be viewed through Reports > EMR > Cancelled visits. Same goes for cancelled appointments.
- If there is no diagnosis documented on the progress note, then on the billing summary the appointment will show but it will not have any ICD-9 codes or CPT codes for billing purposes.
- The billing summary can be printed at the end of the day by provider and then given to the outside billing company to drop the claims.
Reports

Cancelled Visits/No-Show

The cancelled visit/no-show report can be run from the Reports menu > EMR > Cancelled Visits

Set the report parameters by physician and date range.

This report will state whether the appointment was a no-show or cancelled. This is the report to be used to charge no-show fees.
Telephone Encounters

Routing Phone Messages to Staff

Training Scenario
Mary Clark handles triage at your practice and one of her many responsibilities is to manage the phone messages. She is currently using “sticky notes” to route messages to staff members – help to show her a more effective way to route messages.

1. To create a telephone encounter for a patient, click Lookup and search for the patient in the Patient Lookup window.
2. Once you’ve located the patient, click OK to open the Patient Hub.
3. Click New Telephone Encounter (New Tel Enc)
   The Telephone Encounter window displays.
4. Select a provider from the provider drop-down list.
5. Use the reason drop-down list to select a reason for the call.
6. Depending on the reason for the call:
   • Select the Message tab to enter a message from the patient into the message field.
   • Select the RX tab if the call relates to prescriptions
   • Select the Virtual Visit tab and choose a provider
7. Once the patient’s message or information has been entered into the related fields, assign the encounter to the appropriate staff member by using the Assigned To drop-down list. Click OK to save the encounter and return to the Patient Hub.

Searching for Patient Appointments

Training Scenario
Donald Hound calls to reschedule his next appointment. He knows the date, but he is not sure of the exact time of the appointment. How can you find his future appointments if he doesn’t know all the information?

1. From the menu, click the Patient Lookup.
   The Patient Lookup window displays. Find Donald Hound in the list.
2. Click on Donald Hound’s name to highlight it, and then click OK.
   The Patient Hub displays with all of the patient’s information. The hub displays Donald’s next scheduled visit date and time in bolded text.
3. To see more appointment information, click Encounters on the Patient Hub.
   The Encounters window displays with a complete list of Donald’s encounters. Use the Encounters drop-down list in the top right corner to sort by encounter type.
Telephone Encounters

Patient Calls for their Test Results

Training Scenario
Crystal Cougar calls the office to find out about her lab test results from her visit 4 days ago. Your front office staff logs the call information. It is 4pm, and nurse Jane is reviewing the current day call log.

Front Office Staff Logs Call:
1. Click the Lookup button
2. Find, Cougar, Crystal, and then click OK.
   The Patient Hub opens
3. Click the New Tel Enc button
4. Complete the Telephone Encounter form, making sure the reason for the call is to check results.
5. Assign the telephone encounter to yourself (for training purposes only)
   The completed form is now accessible from the “T jellybean” on the main window.

Patient Calls to Request a Rx Refill

Training Scenario
Crystal Cougar calls the office to request a refill of her Lipitor prescription. Your front office staff logs the refill request from the phone call.

1. Click the Lookup button
2. Find, Cougar, Crystal, and then click OK
   The Patient Hub opens
3. Click the New Tel Enc button
4. Complete the Telephone Encounter form making sure the reason is RX refill Request
5. Select the “Rx” tab
6. Click the Cur Rx button to select the Lipitor medication; click OK
7. Assign the telephone encounter to yourself (for training purposes only)
   The completed form is accessible from the “T jellybean” on the main window
**Telephone Encounters**

*Patient Calls to Request a Copy of their Medical Record*

**Training Scenario**
Crystal Cougar calls the office to request a copy of her medical record. Your front office triage staff logs the request from the phone call, and routes it to the clinical staff for processing.

1. Click the Lookup button
2. Find, Cougar, Crystal, and then click OK.
   The patient hub opens
3. Click the New Tel Enc button
4. Complete the Telephone encounter form, making sure the reason for the call is a request for the medical record.
5. Assign the telephone encounter to yourself (for training purposes only)
6. Click on the “T jellybean” from the quick launch task bar
   The telephone encounter window opens listing the encounters that match the selection criteria.
7. Verify that the status drop-down is displaying All Open (All Dates); change the status if required.
8. Double click the encounter for Mrs. Cougar with the reason ‘request medical record’.
9. Read the message entered
10. Click the Patient Hub button.
    The patient hub opens
11. Click the Medical Record button
12. Click the Encounters tab.
13. Check the box(es) next to the date(s) that you would like print or click the top box to select all the encounters to be printed.
14. Click the Print button
Scheduling

A New Patient Calls for an Appointment

Training Scenario
Annie just moved to town and needs an annual physical for the job she is starting in two weeks. She calls your practice for an appointment. Your front office staff schedules her for a new patient, annual exam visit 7 days from today. She would like to see a female physician or female nurse practitioner.

1. Click Resource Schedule and click the box for each provider to see their availability for new patients.
2. Select the date (7 days from today) from the calendar of an available female provider.
3. Click Sel.
4. The patient lookup window opens.
5. Enter your last name, Annie in the Patient Search field to ensure the patient is not in the system already.
6. Click New
   The Patient Information window opens
7. Complete the required demographics fields, and click OK when done.
   The fields with red asterisks are required. Your practice may require other fields to be complete too.
8. Click OK at the Patient Lookup window.
9. At the Appointment window, continue making the appointment and click OK when done.
Scheduling

New Patient but Family Member is Already a Patient

Training Scenario
Mrs. Cougar calls to schedule an appointment for her son, John Cougar. Since, Crystal Cougar is already a patient at the practice, create an account for John Cougar using his sister’s account information.

1. Click Lookup
2. Search for , Cougar, John, be sure he doesn’t exist in the system already
3. If not, search for Cougar, Crystal; select her
4. Select the New (copy)
5. Complete the Copy Patient Demographics window with John Cougar’s information, and then click OK.
6. At the Patient Information window, enter John Cougar’s social security number and any other information required by your practice.
7. Click OK
8. At the Patient Lookup window, select John Cougar and click OK
9. At the Patient Hub, click the New Appt button and continue to schedule this patient for an appointment.

Managing Appointment No Shows

Training Scenario
It’s the end of the day, and Donald Hound didn’t appear for his scheduled appointment or call to cancel. Your practice has a policy to send a warning letter to patients after two No Shows. You’d like to search Donald Hound’s past scheduling history regarding No Shows and Cancelled appointments to determine if you should send him a letter.

1. From the menu, click Patient Lookup
2. Click on Donald Hound’s name to highlight it and then click OK
3. Click the Encounters button on the Patient Hub
4. To send a letter to Mr. Hound, close the Encounters window and return to the Hub
5. Click Letters
6. Select the (...) button next to letters in the bottom left of the window
7. Select Letter/Missed Appointment letter from the list
8. Select Run Letter button
Check - Out

Printing a Visit Summary for a Patient

Training Scenario
While checking out, Crystal Cougar requests a printed summary of today’s visit.

1. From the Resource Schedule window, find Crystal Cougar’s appointment and right-click on it
2. Select Print Visit Summary

Printing an Appointment Card

Training Scenario
While checking out, Crystal Cougar, makes a follow up appointment and you need to print her an appointment card.

1. From the Resource Schedule window, find Crystal Cougar’s appointment and right-click on it.
2. Select Print Appointment Card
   A list for all future appointments for Crystal Cougar prints
Check – Out

Reviewing Orders before Checking Out

Training Scenario
Crystal Cougar just finished her visit with the doctor, and after her visit she stops at the reception desk to check out. The receptionist wants to ensure that Crystal has all of the doctors orders before she leaves the office.

1. From the scheduling window, double-click on the patient’s appointment. The appointment window opens with the patient’s information displayed.

2. From the menu, click Orders
The patient orders window displays with all Labs, Imaging, Prescriptions, Immunizations, and Referral information for the patient.
Check - In

Insurance Change at Check – In

**Training Scenario**
Crystal Cougar walks in to set up an appointment for today and lets you know that her primary insurance company has changed from BCBS to Aetna. Your front office staff removes BCBS from her account and adds Aetna to the account.

1. Double click on the Resource Schedule in the time slot desired for Mrs. Cougar. The appointment window opens up.
2. Click the “Sel” button. The patient lookup window opens.
3. Type, Cougar, Crystal in the name search box.
4. Select Cougar, Crystal from the list; click ok.
5. Enter in the patients visit type and reason.
6. Select the Info button next to the patients name. The patient info window opens.
7. Double-click on the BCBS insurance row to open the Patient-Insurance Detail window.
8. Click terminated and enter dates in the Coverage Dates fields.
9. Click OK.
10. Click Add to add Aetna as Crystal Cougar’s primary insurance. An “X” appears next to BCBS to show it’s an inactive insurance policy.
11. Select Aetna, and click OK.
12. Click Primary and enter the subscriber number.
13. Click OK when done. At the patient information window, Aetna insurance shows on the list with a P indicator for primary insurance.
14. At the Visit Status field, select Check – In
Setting up Physician’s Working Hours

The Doctor is In – On Her Day Off

Training Scenario
Dr. Jones usually has Thursdays as her day off. Next Thursday, May 18, she will be seeing patients to catch up with her case load. You want to open up her schedule so that the receptionist can schedule appointments.

The Front Office Adjusts the Doctor’s Schedule

1. From the schedule menu, click Working Hours. The Working Hours window opens.
2. From the Date Range pane, click Add. The Working Hours Date Range opens.
3. Enter the Working Hours information. Enter a description: In on Thursday Enter Thursday’s date for both dates.
4. From the middle pane, click Add to open the Add Working Hours dialog.
5. Enter the information for Thursday’s work day.
6. In the Date Range pane, move the entry in on Thursday to the top of the schedule so that it takes precedence.
Setting up Physician’s Working Hours

Set up Time Slots for Sick Visits and Well Visits

Training Scenario
To make appointment scheduling more efficient, the doctors have agreed to an hourly schedule where there are two Sick Visits of 15 minutes each, followed by one Well Visit of 30 minutes. Use the Rule Sets to accommodate this scheduling pattern.

A rule set can be associated with a visit type
1. From the Schedule menu, click Working Hours. The Working Hours window opens.
2. Click the Rule Sets button to open the Rule Set Configuration window.
3. Click the New button
4. Enter a name for the Rule Set in the Set ID field.
5. Click OK.
6. Select the new Rule Set and click the Add button.
7. Select a Visit Type from the drop-down list.
8. Enter the maximum number of visits allowed for the time interval. If more than “1” is entered, this allows multiple visits in the same time slot without the system considering them overbooking.

Apply the Rule Set to the Schedule
1. Select one of the pediatricians from the Provider(s) drop-down list.
2. Select a date range.
3. Select the Day of Week/Hours combination from the middle pane, and click the Update button.
4. Select a Rule Set from the drop-down list.
Multiple rule sets can be applied to a Day of Week/Hours combination.
Messaging

Sending Messages within the Practice

Training Scenario
You could stand in the hallways and shout, “Staff meeting on Thursday at 3:00!” But there is a better way to keep everyone in the loop. – Use the messaging system.

1. From the Messages band, click Outbox.
2. Click the Compose button to display the Send Message window.
3. Enter the message information in the following fields:
   - From: automatically enters the name of the person who is logged on.
   - Priority: Choose from Emergent, Urgent, or Routine.
   - To: click the “Sel” button and choose one or more recipients from the Receivers List.
4. Click OK to close the Receivers List.
5. On the Subject line, type a short description.
6. In the Message area, type the message.
7. Click the Send button when the message is complete.
Setting up Patient Alerts

Creating a Global Alert

Training Scenario
Crystal Cougar is a patient in your office and she is also hearing impaired. You would like to note this in the chart for future reference for your office staff members to be aware.

1. From the Patients Hub select the Billing Alerts button
2. The alerts window opens
3. Select the Global Alerts tab
4. Select the ‘Set Global Alerts’ button
5. Choose a pre-made global alert from the left pane
6. Toggle between the available lists by selecting the radio buttons
7. Select OK
8. The Global alert is now added to the patients account and will pop-up when a user attempts to open up this patient.