Health ePractice
Electronic Medical Record
Physician Companion

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ST. JOHN HEALTHPARTNERS
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 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
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]

   1. TRAINING TOOLS
      Virtual role-based learning modules and companions that will introduce you to basic eClinicalWorks functionality and workflows to prepare you for the Electronic World of Medical Records.
      TO BEGIN SELECT YOUR ROLE:

      ![Role Buttons]

      2. PHYSICIAN / MID-LEVEL
      OFFICE MANAGER
      CLINICAL
      CLERICAL

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

   ![Web-Based Training Modules]

   Introduction to Windows
   Accessing eClinicalWorks
   OVERVIEW
   Office Visit Schedule
   Patient Look-up
   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?

eClinicalWorks Train Environment

1. From your Start Menu select the Run... option.

2. The Run activity window displays. In the Open: field type in the following: MSTSC and click the OK button.

3. The Remote Desktop Connection activity window displays. In the Computer: field type in the following: `Asp12.eclinicalweb.com:9328` and click the Connect button.
How Do I Access?

4. The “Log On to Windows” activity window displays.

5. Input the User name: and Password: that was provided to you by your Implementation Coordinator.

![Log On to Windows window]

6. eClinicalWorks Log-In screen displays.

![eClinicalWorks Log-In screen]

7. Type in your **GENERIC login ID** and **Password** provided by the Implementation Coordinator.

8. Click on the **log in** button.
Basic eClinicalWorks Navigation

Section II: How to Guides

How do I log into eClinicalWorks Production Environment?

1. Double-Click on the icon located on the desktop.
2. eClinicalWorks login screen appears.
3. Type in your login ID and password as appropriate.
4. Click on the button.

How do I log out of eClinicalWorks?

There are two ways to log out of eClinicalWorks

1. Click on and select EXIT from the drop down menu.
   OR
2. Click on the in the upper left hand corner of the screen.
Basic eClinicalWorks Navigation

**Basic Navigation Tools**

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

![Image of eClinicalWorks window with navigation elements](image)

**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.
Basic eClinicalWorks Navigation

**Patient Look-Up and Patient Hub Overview**

1. You can look up a patient by clicking on the Patient Lookup Icon.
2. The Patient Lookup activity window opens which gives you a list of all the patients in the system arranged alphabetically by their last name.

![Patient Lookup Activity Window](image1.png)

3. Patients can be searched by using a combination of different search options such as; Name, SSN, DOB, Account No./Medical Record No., Phone No., Subscriber No., Previous Name or Home, Work, and Cell phone. Patients can also be filtered by their default appointment facility.

4. When a patient is selected the Patient Hub will display.

5. The Patient Hub provides a convenient, single point of access to all information available in a patient's record.

![Patient Hub Overview](image2.png)
Basic eClinicalWorks Navigation

Quick Launch Task Buttons Overview

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.
Basic eClinicalWorks Navigation

Office Visit Schedule Overview
Office Visit view is the designated workspace for Physicians and clinical staff. This workspace displays all scheduled appointments and distinguishes patients that have completed the arrival process, and are ready to be seen by the Physician.

1. **P/R Radio Buttons:** Enables to view Provider or Resource patients.
2. **Appointment Time and Date:** Defaults to the current date and enables the user to sort the schedule by using Morning, Afternoon, or All Day selection.
3. **Sort By:** Enables the user to sort patients by appt. time, patient name, or visit status.
4. **Visit Status:** Indicates if the patient has arrived for their appointment
5. **Room:** Indicates the exam room the patient is in.
6. **Status:** Current status of the patient’s visit
7. **Button Bar:** Displays the following options: Progress Notes, Check In/Out, Billing Data, Refresh, View Orders, Lock Progress Notes (drop down displays several Template options), and eCliniForms.
Basic eClinicalWorks Navigation

*Update a patient’s status code and enter a exam room identifier in the Office Visit Screen*

1. Select the patient from the schedule.
2. Click on the **Check In/Out** button.

3. The Encounter Activity window displays.
4. Click in the Check In box.
5. The Time In field will populate the time.
6. Click in the Room No field and enter patient room number.
7. Click on the **OK** button.
8. The patient’s arrival time, room number and status will appear on the Office Visit schedule.
Basic eClinicalWorks Navigation

Accessing the Patient’s Visit

1. To open a patient’s visit, double-click on the patient’s name from the office visits screen.

2. The patient’s visit opens in the Progress Notes view. All clinical documentation will be completed in this view.
Basic eClinicalWorks Navigation

Progress Note Overview
The progress note of the patient contains 3 major sections:
1. Patient Dashboard
2. Patient Chart Panel
3. Patient S.O.A.P. Note

Patient Dashboard
The patient dashboard displays:
1. The patient’s picture with demographic information.
2. The patient’s insurance details, account balance, PCP, first and last appointment.
3. A sticky note panel and secure notes (Physician to Physician) panel that can be used for documenting any important non-chart information about the patient.
4. Advance Directive shows the code entered by the front office in the demographics section.
5. The menu bar gives a summary of all the data entered such as medical summary, list of labs, DI, procedures etc.,

Patient Chart Panel
The patient’s chart panel is the storage panel of all the previously entered information such as:
Problem List, Current Medication Summary, Allergies, Immunizations, History, Comprehensive Summary of the Patient’s Test Results, Telephone Encounters, Web Encounters, and Clinical Decision Support System that includes PCMH Alerts.
Subjective and Objective Documentation

Documenting a Chief Complaint

1. In Progress Note click on Chief Complaint(s):

2. Chief Complaints activity window will display.

3. To add a chief complaint click on the browse button.

4. In the “Find:” field type in the name of the complaint.
5. Select the appropriate complaint from the list.

6. Click **Ok** button.

7. The chief complaint is added. Click **X** to close.

8. Chief Complaint entry will appear on the Progress Note.
Subjective and Objective Documentation

**Current Medication Documentation**

1. From the patient’s progress note, click on “Current Medications”.

2. The Current Medications Activity window will display.
   **Note:** this window is also shared by chief complaints.

3. To document a current medication click on the **Add** button.

![](image1.png)

4. The RX Select activity window displays.

5. In the Find field, type the medication name.

6. The medication name will appear in the left hand column and the strength(s) appear in the right column.

7. Select the appropriate strength of the medication and it will populate under the Selected RX area.

8. Repeat steps five through seven to add another medication.

9. To complete this documentation click on the **OK** button.
Subjective and Objective Documentation

10. The Current Medication window displays with the added medication.

11. Document the Medications have been verified by clicking on the Medication Verified box.

   ![Current Medication Window]

   **Current Medication**
   - **Name**: Omeprazole
   - **Dose**: 40 mg
   - **Route**: by mouth
   - **Frequency**: Once a day

Documenting Past Medical History

1. From the Progress Notes, click on “Medical History”

2. Click on the “Browse” or “Add” Button to add Medical History documentation to the patient’s chart.

   ![Past Medical History Window]

   **Past Medical History**
   - **History**
     1. High Blood Pressure
     2. High Cholesterol

3. Once documentation of Past Medical History has been completed, make sure to indicate the history has been verified by clicking on the History Verified box.

   ![Past Medical History Window]

   **History Verified**

   **NOTE**: The “Browse” button shows a general list of keywords that can be selected for the patient’s Medical History. The “Add” button allows you to free-text the history as opposed to selecting from a list. Past Medical History gets carried forward from visit to visit and history information from the previous visit is automatically displayed on the Progress Note.
Documenting Allergies

1. Select Allergies/Intolerance from the Progress Note
2. The Allergies activity window displays (this window is also shared by Past Medical History).
3. To indicate the patient has No Known Drug Allergies (NKDA) click in the box next to NKDA.
4. To search for a drug allergy, click on the `Browse Rx...` button.
5. In the Find field, search for the name of the drug allergy.
6. Select the appropriate allergy by clicking on the allergy name. The name will populate in the Selected RX field.
7. Click on the `OK` button.
Subjective and Objective Documentation

8. To search for a Environmental or Food Allergy click on the [Add] button.

9. In the Structured/Non Structured field click on the drop-down menu arrow.

10. Select Non Structured from the menu.

11. A warning will appear indicating if you free-text in the field it will be excluded from automated drug-allergy testing. Click [OK].

12. Click in the Agent/Substance field.

13. Click on the drop-down menu arrow and select the allergy from the list.

14. Click in the Reaction box.

15. Click on the drop down menu arrow and select the appropriate reaction.

16. Mark the allergies as verified by clicking in the Allergies Verified box.
Documenting Surgical and Hospitalizations History

1. From the patient’s progress note, click on “Surgical History”. The following window opens:

2. Click on “Browse” or “Add” button to either add or update a new surgical history or hospitalization.

3. When a patient has no surgical history or hospitalization, you can click on “Denies Past Surgical History” or “Denies Past Hospitalization”.

4. Once documentation of Surgical History / Hospitalizations have been completed, make sure to indicate the components have been verified by clicking on both the Surgical History Verified and Hospitalization Verified boxes.
Subjective and Objective Documentation

Documenting Family History

1. From the patient’s progress note, click on “Family History”. The following window opens:

2. Under “Status” click in the field box to indicate a status of “Alive”, “Deceased”, or “Unknown”.

3. Click in the DOB field and enter a birth year. This will automatically calculate the age of the family member.

4. Click in the notes column to open the keyword window.

5. Select condition from the left pane to add it to the Selected Category in the center pane.

6. Select the relative on the right pane that are known to have the condition.

NOTE: You can select multiple relatives that have the condition by pressing the control key on the keyboard and holding it down while selecting the family member with the mouse.
Subjective and Objective Documentation

*Documenting Vital Signs*

1. In the progress note click on “Vitals”.

2. Vitals intake activity window will display.

3. Click in first field box (in this instance: *HR*) and type value.

4. Use the tab key to move to following fields and continue typing values in appropriate fields. (Note: BMI will auto-calculate for you)

5. When you have completed entering vitals, click on the red “X” to close the window.

6. The vitals documentation will appear in the progress note time stamped with the date, time, and name of the individual who documented the information.
Subjective and Objective Documentation

Accessing the Initial Visit Smart Form

1. In progress note, click on the drop down menu arrow in the Smart Form (SF) field.

2. Select Initial Visit from the drop down menu.

3. The Initial Visit smart form displays.

4. Fill in the appropriate information provided by the patient by using the drop down menus (if provided) or clicking in the box by the selection.

   NOTE: You do not need to complete all of the fields to move forward.

5. Click on the \textbf{Save & Next >>} button to move to save the information that you documented and move to the next screen.
Subjective and Objective Documentation

6. The Tobacco Control form displays.

7. Depending on what you select under the Are you a: field, options will appear for specific documentation pertaining to the choice selected.

8. After completion, click on the Save & Next >> button.

9. The Alcohol Misuse/Abuse form displays.

10. Depending on what you select under: Did you have a drink containing alcohol in the past year? More questions will appear for specific documentation.

11. At the completion of the form, you will receive a point value. This value will be used to select the interpretation of the form, Positive or Negative.

12. Once the form is completed click on the Save & Next >> button.

13. The Depression Screening form displays.

14. Complete the form as appropriate.

15. Click on the Save button to complete the Initial Visit Smart Form.
16. A pop-up activity window will display stating that the Form Data Saved Successfully.

17. Click on the **OK** button.

18. You will return back to the Progress Note.
Subjective and Objective Documentation

Documenting History of Present Illness (HPI)

1. From the progress note, click on the HPI link, and the following window displays:

2. Click on a HPI category on the left side panel and the symptoms belonging to that category appear on the right side panel of the screen.

3. Click on the box in the “c/o” or “denies” column to mark the symptom that a patient ‘complains of’ or ‘denies’.

4. If the “show pop-up for c/o” box is checked, when we select c/o for that symptom an option list will pop up, giving you one-click access to common phrases that apply to the symptom.

5. Click on the Notes field to add a description or type in your own notes related to that symptom.

6. Close out of the HPI activity window by clicking on the .

7. All HPI documentation appears in the progress note.
Subjective and Objective Documentation

Documenting Review of Symptoms (ROS)

1. From the patient’s progress note, click on ROS. The following window opens:

2. If the patient complains of a symptom, click once in the “Presence” column to display “No,” click again to display “Yes” or leave blank (no response or not asked).

3. Click on “Default for All” to select the predefined defaults for all body systems/categories defined for ROS. “Clear All” changes the observations back to blank.

4. Click on “Default per Category” to select the predefined default answers for all body systems/categories defined for ROS. “Clear Category” changes all the observations in the selected category to blank.

5. 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.
Progress Note Documentation

Documenting the Assessment

1. From the progress note, click on “Assessment”. The following window opens:

2. Assessment can be searched by 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”.

3. Once you locate the assessment, highlight it to select it. Once selected, it goes into the selected assessment list for that patient.

4. “Notes” section next to the selected diagnosis can be used to write the notes for that specific diagnosis, whereas the notes section on the bottom is common to all diagnoses.

5. Any diagnosis which needs to be added to the problem list can be added from here by checking the box adjacent to the diagnosis. 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.

6. “Previous Assessment” gives the list of all the diagnosis given to this patient in the past. It also contains the list of the diagnoses added to the problem list.
Documenting the Treatment Plan

1. From the progress note, click on “Treatment”; the following window displays:

2. Patient assessments made in the assessment section appear as individual tabs on the Treatment window. The individual tabs allow the physician to specifically address each symptom.

ePrescribing/Refilling Medications

1. Click on the ‘tab’ corresponding to the diagnosis for which medications need to be prescribed or refilled.

2. To refill patients’ current medications, click on the “Cur Rx” button, select the meds that need to be refilled and simply type in the number of refills in the “refills” column.

3. To document whether the patient was asked to increase/decrease/stop the current dose, click on the “comment” column and choose the respective comment.
Progress Note Documentation

4. To prescribe a new medication, click on the “Add” button and choose a new medication from the ‘drug dictionary’. Once the medication is chosen and when you click on ‘Ok’, the dosage details can be modified back on the ‘Treatment’ screen.

5. The medications can then be printed or faxed or electronically prescribed to the patient’s pharmacy by clicking on either the “Print” button (to print on prescription paper) or the green arrow next to the “Print” button (to fax or e-scribe).

Orders

1. In the Lab/Diagnostic Imaging/Procedures section, click on “Browse” to open either option as needed

2. Select the Lab, DI or Procedure radio button

3. Using the Dx list on the left side of the window, order
4. To select labs/DI for a time in the future, click on the “Future Orders”, ‘Look up’ box, choose the appropriate Order. Select the appropriate date.

5. Standing Orders for labs can be ordered by clicking on the “Add Standing Orders” button.

**Medication Summary**

1. Select the Assessments from the left hand side
2. Click on C to continue, R to Refill with the numbers indicated the refill amount, or S to Stop the medication
3. To ‘Add New Rx’:
4. Type in the medication in the “Find” field

**Outgoing Referral**

1. The outgoing referral button on the treatment screen opens the window where you can enter information for creating a referral.

2. Enter the information into the fields and then print the referral or assign it to someone who takes care of it at the practice

3. The referral can be sent through P2P network as well
**Immunizations/Injections**

1. From the progress notes, click on “Immunizations”. The Injections/Immunization window opens for the patient. Click on “Add” button to add an immunization.

2. Use the “Find” field to locate the immunization from the list in the left pane. Once located, select the desired immunization by simply clicking on it.

3. After selecting the immunization, document the other required fields on the “Immunizations” screen (such as “given by,” dosage details, location, etc).
Reviewing Past Order Results

1. The previously ordered labs are available on the labs/DI section on the right side chart panel of the patient.
2. If the results are already marked off as “reviewed” by the provider, the lab appears in a normal size. If it has not yet been reviewed, the lab name appears in bold text.
3. There is a blue arrow next to the lab name. Clicking on this blue arrow will move the lab result to the current progress notes under the “past results” section.

Documenting Procedures

1. From the progress notes, click on “Procedure” heading, choose the respective procedure that was done for the patient and that needs to be documented.
2. Type in the respective notes as required.
3. The “Default per category” can be set so as to populate default notes for each “category” (or sub-heading) within the selected procedure.

**Preventive Medicine**

1. The preventive medicine is used to document the necessary counseling given to the patient.

2. The categories are available on the left side and the items under the categories are in the right side.

3. There is also a miscellaneous notes section in the bottom of the section.
**Billing and Follow-up Information**

*Entering the billing codes and follow-up details*

From the progress notes, click on “Visit code” to open the “Billing” window.

1. The “Assessment” section will have all the diagnosis added by the provider. The provider can also add diagnosis from here.
2. “Procedure Codes” section will have all the procedure codes and also the E&M (or Visit) Code.
3. There are two ways to enter the E&M Code:
   - Provider can enter the E&M (Office Visit) code by clicking on the ‘Add E&M’ button.
   - eClinicalWorks has the E&M calculator which can be found under the “EM Coder” button.
     - “Chart based EM coder” – will calculate an appropriate visit code based on the amount of information that has been documented on the progress note.
     - “Time based EM coder” – will calculate the visit code based on the face-time the provider chooses (depending on how much face time was actually spent).
4. If the provider wants to put in some notes for the biller, those can be typed in the “billing notes” section.

5. A follow-up appointment with respective details can be entered in the “Follow-up” section. The details entered here will be displayed in the “Appointment” screen and can be seen by the receptionist during the check-out process.

6. “Done” indicates to the billing department that the note is ready to be billed, whereas “Close” means that the provider will still work on the note and might enter additional billing information.
Printing/Faxing the progress note in different format styles:

Printing the progress note in different styles
Click on the small green arrow next to the “Print” button in the bottom of the progress notes and choose the style of printing. Printing ‘Labs’, ‘Diagnostic Imaging’, as well as ‘Procedure’ is possible by clicking on the “Print” option below:

Faxing the progress note in different styles:
Click on the green arrow next to the “Fax” button, then choose the ‘style’. Once the ‘fax’ window opens, enter the fax number and click on the “Send Fax” button.
Progress Note Documentation

Printing/Faxing a Consult Note/Report

Faxing Consult Notes/Report:
Click on the green arrow next to the “fax” button and choose the “Fax Consult Notes” option.

![Diagram of faxing process with instructions]

Choose consult report/consult request depending if it is an outgoing referral note/incoming referral note.

Allows you to specify the recipient(s)

Allows you to save the document in the specified folder

Allows you to preview the document
Progress Note Documentation

Printing Consult Notes/Reports:

Click on the green arrow next to the “Print” button, choose the “Consult Notes” and choose the “Print Using letter” option to print the consult note/report in a pre-loaded letter format. The Provider can also print using the “HTML’ version by selecting “Print Using html”.

![Image of the software interface showing consultation notes and print options]

- Current Medication: Vicodin 5-500 MG 1 tablet as needed for pain every 6 hrs
- Medical History:
- Allergies/Intolerance:
- Gyn History:
- OB History:
- Surgical History:
- Hospitalization:
- Family History:
- Social History:
- ROS:

Objective:

Consult Notes: Print Using Letter
Print Using html
Progress Note Documentation

Printing the After Visit Summary

Printing Patient Visit Summary and Modifying It

To modify/add notes to the visit summary: Check the boxes next to items to include in the printing of visit summary.

To type some additional notes along with the visit summary, simply click on the bottom part screen and type in any personalized notes, if required.
**Progress Note Documentation**

**Locking a progress note**

To lock the progress note, click on the green arrow next to the “Lock” button at the bottom of the screen and choose a ‘style’ to lock the note.
Assigning a progress note to another provider (Overview)

1. To assign a progress note to another provider, click on the green arrow next to the “Details” button at the bottom of the screen and select “Change Assign to”

2. Select the provider that you would like to assign the progress note to.

3. Type any comments under the ‘Note’ section and click ‘OK’. (Optional – To lock a progress note and assign to another provider, click on the ‘Lock’ or green arrow next to the ‘Lock’ to select a style for the progress note and click ‘OK’, the progress notes will be assigned to the selected provider in a ‘Locked’ progress note mode)
Progress Note Customization Tools

**Progress Note Short-Cuts**

**Patient Chart Panel**

The patient’s history and allergy information can be populated on the current progress note from previously entered information, by simply clicking on the respective ‘blue arrow’ icons on the patient chart panel.

![Diagram of patient chart panel]

**Using the ‘caret’ options**

1. The following sections of the progress note: HPI, ROS, Examination, Physical Examination, Assessment and Treatment can be populated from previously entered information by clicking on the ‘caret’ option (yellow inverted triangle) next to the respective headings.

2. The “copy” button will replace existing information with the selected information, while the “Merge” button will append the selected information to the already existing data in that section.
Progress Note Customization Tools

Using the ‘notes’ drop-down

1. For the HPI, Examination and Physical Examination sections, the notes that are already entered for the various symptoms can be modified by directly clicking on the respective notes keyword and choosing the alternate option from the drop down window that pops up.

- **HPI:**
  - **Diabetes:**
    - **HbA1c:**
      - **Current Medication:**
        - **Medical History:**
          - **Allergies/Intolerance:**
            - **Surgical History:**
              - **Hospitalization:**
                - **Family History:**
                  - **Social History:**
                    - **ROS:**

- **Objective:**
  - **Vitals:**

- **DIABETES F/U**
  - **DOB:**
    - **BMI:**
      - **Current Weight:**
        - **BMI:**
          - **Compliance:**
            - **Current Medication:**
              - **HbA1c:**
                - **Current Medication:**
                  - **Medical History:**
                    - **Allergies/Intolerance:**
                      - **Surgical History:**
                        - **Hospitalization:**
                          - **Family History:**
                            - **Social History:**
                              - **ROS:**

- **DIABETES F/U**
  - **DOB:**
    - **BMI:**
      - **Current Weight:**
        - **BMI:**
          - **Compliance:**
            - **Current Medication:**
              - **HbA1c:**
                - **Current Medication:**
                  - **Medical History:**
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                      - **Surgical History:**
                        - **Hospitalization:**
                          - **Family History:**
                            - **Social History:**
                              - **ROS:**

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                - **Current Medication:**
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                        - **Hospitalization:**
                          - **Family History:**
                            - **Social History:**
                              - **ROS:**

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                            - **Social History:**
                              - **ROS:**
Progress Note Customization Tools

Creating Progress Note Templates

1. A progress notes template can be created by clicking on File->Templates, or green arrow next to ‘Templates’->‘Template List’ (if in progress notes).

2. Click on the ‘New’ from the ‘Template List’ window.

→ Note: Template List windows displays all the templates that have been loaded/created in the system.
3. Type in the name of the template, description, (Optional) – Associate Facility, Visit Type, Category, and associate with Order Sets.
4. Select if this will be a ‘Private’ template or a ‘Public’ template.
5. Click ‘OK’—A blank progress notes will show up and administrator can start building desired content of the progress note template.
**Using Progress Notes Templates**

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

2. The template category (i.e., private/public/favorites) can be chosen using the respective drop down option.

3. The required template can be searched from the list using the “Find” box.

4. The different sections of the progress note template that need to be copied or merged can be chosen as required.

5. Clicking on the “Merge template” will insert the information from the selected template into the current progress note. Clicking on the green arrow next to the “Merge template” button will give you a “Copy template” option. *The ‘copy’ option will overwrite the current progress note with the information on the selected template.*
Creating Order Sets

To create a new order set, click on the EMR menu on the top and then click on “Order Set Administration”.

1. Click on ‘New’ to create a new Order Sets
2. Type in the name of the Order Sets (description)
3. Type in the desired measures (Optional)
4. Indicate if this is a ‘Quick Order Sets’
5. Click ‘OK’.
6. Click ‘Update’ to add the triggered diagnosis, linked diagnosis, and the items (elements) into the Order Sets

➤ NOTE: Click on the ‘Browse’ button in the corresponding section (Rx, Labs, Procedures, etc) to add it.

7. Close out from the window. The Order Set is saved.
Using eCliniforms and Specialty Forms (If Applicable)

1. To use eCliniforms, click on the ‘Ink’ button at the bottom of the screen which will open the eCliniform screen. Choose the form and click on the ‘Ink Doc’ and this will open the screen for inking. Mark the necessary details and click on the ‘floppy disk’ symbol to save the changes made.

2. This document will be available for reference under the ‘Chart Documents’ folder in the patient documents.

3. To use Specialty Forms, click on the arrow next to the ‘Ink” button in the bottom of the screen and choose the ‘specialty form’ option. Enter or type in the data as required and click on the ‘Save’ in the bottom of the screen and this automatically will get saved in the “Specialty forms folder” in the patient documents.
Generic Alerts

1. 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.

2. Generic Alerts can be accessed from the Patient Hub. It can also be viewed from the patient dashboard. It can also be accessed from the patient right panel.

3. These alerts would automatically be suppressed once the conditions are satisfied (e.g.: a lab result is received).

4. You can also manually suppress the generic alerts by clicking the ‘Last Done’ button or the “Suppress’ button.
Alerts and Recalls and Registry

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.

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

1. 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.

2. Global Alerts can be created from the patient hub, from the demographics and by choosing the ‘Global Alerts’ option under EMR>Alerts.

3. 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.
Alerts and Recalls and Registry

Patient Recall

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

2. Recall lists can be run for patients based on appointment dates, patient-specific protocols (or alerts) and generic protocols (or alerts).

3. Once the required search fields or ‘filters’ are chosen appropriately, the ‘Lookup’ button must be clicked on to get the desired recall list

4. Respective letters can be printed out for a patient/all patients in the recall list by using the “Run Letters” button.
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)

![Registry Feature Diagram]

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