

eClinicalWorks Clinician Training Guide

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Part I. Login

Logging into Volunteer Computer (autoECW User)

- Windows Password: autoECW!@#
- Trainer Software
 - Username: trainer
 - Password: Password\$1

Logging into eClinicalWorks (eCW)

- Look for the eCW icon and double click to open the application
- Login with personal volunteer credentials
 - Change Password: Go to File>Change Password



My eCW username: _____

My eCW Password: _____

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Part II. Office Visit Screen (Clinician Schedule)

When clinicians login to eClinicalWorks, it will open to the Office Visit Screen, which displays the clinician's appointment schedule for the day:

[#1] Select the "P" radio button on the top left.

[#2] Select your name from the drop down list of clinicians. Make sure that the Facility and Appt. time are set appropriately or nothing will appear in your schedule.

Status [#6]

- Order of statuses: NUR, Ready for, SV (clinician), Done (clinician)
- Ready = patient is ready to be seen by clinician
- Change Status to SV (Start Visit)

**NOTE:

Clinicians can also access this Office Visit Screen by clicking on the "S" Jellybean located on the top right of the screen (the jellybean is the circle to the right of the S). This will be helpful when navigating back and forth between appointments:

Visit types [#3]

New Patients (NP), Physical (PHYS), Established Patient (ESTPT)

Reason [#4]

A general reason for the appointment that loads the template into the progress notes (e.g. PHYSICAL, PRIMARY CARE, WELL WOMAN EXAM).

Visit status [#5]

- **ARR** = Patient has arrived.
- **CHK** = Patient checked out at front desk.
- **PEN** = Patient has not checked in for appointment yet.

[#7]

Indicates that the nurse has taken vitals.

[#8] Double Click on the patient's name to enter the patient's chart.

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Part III. Prepping for a Patient

Section A. Patient Dashboard

Patient Language:

Identify if patient needs a translator.
If a translator is needed, please ask front office for an interpreter or use the language line (number found at Nurses Station).

Duck, Donald , 23 Y, M Info Hub Allergies Billing Alert

8600 Quicassin Road
Henrico, MA 23229
H:804-422-2600
M:804-555-5555
DOB:01/01/1995

Wt 04/25/18: 130 lbs.
Appt(L):05/08/18(MM)
Appt(N):07/24/18(MM)
PCP: Murchie,
Language: English
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: Donald Duck
Gr Bal: (\$135.00)

CLICK TO EDIT
wassup? 8/15/17

SECURE NOTES

Enable
Not web enabled

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

SF

Labs:
View Lab orders and results.

See pg. 5

DI:
View DI orders and results.

See pg. 6

Encounters:
View past progress notes.

See pg. 4

Patient Docs: contains scans of hospitalization records, discharge papers, external test results...etc.

See pg. 6

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Viewing Past Appointments

Click on “Encounters” in the Patient Dashboard (or the Encounters button in the Patient Hub).

View the Progress Notes from past appointments by double clicking into the row of the appointment.

Encounters

Providers/ Resources: [] All Encounters: []

Facility: [] All Service Dates: 05/30/2018 To: 05/30/2018

Diagnosis (ICD): [] Clear

Patient: **Test, Ginee**

	Date	Time	Type	Status	Provider	Resource	Facility	Reason	
<input type="checkbox"/>	06/17/201	04:45 PM	ESTPT	PEN	Hewitt, Benton E	Hewitt, Benton E	HEN	PRIMARY CARE	Crc
<input type="checkbox"/>	05/22/2018	12:30 PM	Eye	N/S	Estopinal, Christopher	Estopinal, Christopher	HEN		Crc
<input type="checkbox"/>	05/17/2018	03:41 PM	TEL		St. Germain, Mary K.		HEN	PHQ9	Crc
<input type="checkbox"/>	05/11/2018	10:30 AM	TIPS F/U	VOICEMSK	Bruzzese, Vivian	Bruzzese, Vivian	HEN		Crc
<input type="checkbox"/>	05/11/2018	08:00 AM	ESTPT	CHK	Hewitt, Benton E	Hewitt, Benton E	HEN	PHARMACY	Crc
<input type="checkbox"/>	05/04/2018	08:00 AM	TIPS F/U	CHK	Bruzzese, Vivian	Bruzzese, Vivian	HEN		Crc
<input type="checkbox"/>	05/03/2018	08:58 AM	TEL		St. Germain, Mary K.		HEN		Crc
<input type="checkbox"/>	05/02/2018	01:09 PM	TEL		St. Germain, Mary K.		HEN		Crc
<input type="checkbox"/>	05/02/2018	11:44 AM	ESTPT	CHK	Murchie, Michael S.	Murchie, Michael S.	HEN	PRIMARY CARE	Crc

Encounter(s) 9 Non Billable Visits: 1 NOS : 1

View Logs View Web View Print Fax View Appointment OK Cancel

View the locked progress note:

eClinicalWorks Viewer

Test, Ginee
 15 Y old Male, DOB: 01/01/2003
 Account Number: AB107050
 1234 Dulock Lane, Richmond, VA-23220
 Home: 804-625-9489
 Guarantor: Test, Ginee Insurance: CrossOver Uninsured
 PCP: Mary K. St. Germain
 Appointment Facility: Crossover Western Henrico

05/04/2018 TIPS Progress Note: Vivian Bruzzese, MD

Current Medications
Taking
 • Aspirin 81 MG Tablet Chewable 1 tablet Orally Once a day
 • Venlafaxine HCl 25 MG Tablet 1 tablet with food Orally Once a day
 • Claritin 5 MG Tablet Chewable 2 tablets Orally Once a day, stop date 06/01/2018
 • Ibuprofen 200 MG Tablet 1 tablet with food or milk as needed Orally

Vital Signs
 Smoker? (Y/N) n, BP 120/60 mm Hg, Pulse 60, Ht 68 in, Wt 125 lbs, BMI 19.00 index, Wt % 45.22 %, Ht % 56.89 %, BMI % 33.46 %, Wt-kg 56.7 kg, Ht-cm 172.72 cm.

Assessments
 1. General medical exam - Zoo.00
 2. Diabetes - E11.9
 3. Hypertension - I10
 4. Depression with anxiety - F41.8

Print

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Finding Test Results

Test results are generally in one of three places:

1. Labs
2. DI
3. Patient Documents

You can access these sections through the Patient Dashboard in the Progress Note or through the Patient Hub (see Part V. of this guide).

1—Labs

In Labs, a paperclip indicates that a result is present. Click on the paperclip to open up the results window.

LAB CATEGORIES	Show CC List	Show	Order Dt	Coll Dt	Result Dt	Labs	Reason	Result	Received	Reviewed
ALL	<input type="checkbox"/>	C	10/12/2017			Pap (thin prep) w/HP...			No	No
ANATOMIC PATH/C...	<input type="checkbox"/>	V	10/12/2017	10/12/2017	10/17/2017	CX-VAG CYTOLOGY (HR)	Received-Bon...		Yes	Yes
BILD	<input type="checkbox"/>	V	09/18/2017	09/18/2017	09/19/2017	T4, Free (Quiocasin)	Received-Bon...		Yes	Yes
BLOOD BANK	<input type="checkbox"/>	V								

Received: Indicates whether we have received the lab result.

Reviewed: Indicates whether the result has been reviewed by a staff clinician.

View In-House Lab results by double clicking on the lab order and viewing the yellow row in the center of the screen.

The screenshot shows a patient dashboard with the following sections:

- Patient:** Test Test, Test, DOB: 1/1/1979, Age: 39Y, Sex: F, Tel: 571-275-5868, Acct No: AB103709, WebEnabled: Yes, Elg Status: [blank].
- Lab Information:** Lab: Basic Metabolic Panel (8) (Quiocca), Order Date: 12/13/2017, Collection Date: 10/6/2016, Time: [blank]. Reason: [blank], Actual Fasting: Not Recorded, Ordered Fasting: [checkbox].
- Specimen:** Source: [blank], Description: [blank], Collection Volume: [blank], Units: [blank].
- Results:** Received: [checkbox], Date: 10/6/2016, Result: 6.2.
- Results Table:**

Order Date	Coll. Date	Calcium, S	Glucose, S	BUN	Potassium	Sodium, S	Chloride, S	Cre
12/13/2017	10/06/2016	6						
04/17/2017								
04/11/2017								
- Assessments:** 401.9 Elevated BP.
- Clinical Info:** [blank].

A red box highlights the yellow row in the Results table, and a red arrow points to it from a text box:

Find In-House Lab results recorded in the yellow line (that is the line that corresponds to that order).

2—DI (Diagnostic Imaging)

The DI window functions the same as the Labs window. View results by clicking on the paperclips.

However, oftentimes, DI results are scanned into our system and can be found in Patient Documents.

3—Patient Docs

Patient Docs contains any documents pertaining to the patient that have been scanned into eCW (Hospitalization records, Discharge papers, Cardiology test results...etc.). Check Patient Docs if you cannot find a test result in Labs or DI.

Use arrows to navigate through pages.

Patient Documents

Patient Test, Gingee

Refresh Search OCR Fax PtHub Print Ink MODI Multi Doc eCliniForms View

1 1 Page(s)

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC/Diff Ambiguous Default					
WBC	4.4		x10E3/uL	4.0 - 10.5	01
REC	4.83		x10E6/uL	4.10 - 5.60	01
Hemoglobin	14.5		g/dL	12.5 - 17.0	01
Hematocrit	41.7		%	36.0 - 50.0	01
MCV	86		fL	80 - 98	01
MCH	30.0		pg	27.0 - 34.0	01
MCHC	34.8		g/dL	32.0 - 36.0	01
RDW	13.5		%	11.7 - 15.0	01
Platelets	215		x10E3/uL	140 - 415	01
Neutrophils	42		%	40 - 74	01
Lymphs	47	High	%	14 - 46	01
Monocytes	7		%	4 - 13	01
Eos	3		%	0 - 7	01
Basos	1		%	0	01

Name Size (k)

Scan Options: Scan 1 Page(s) 100 DPI

Document Category: Scan Docs

View: FileView Settings Refresh

Description: Scanned By Labriny,Sarah Scanned On 2018-05-07

If there is a document in the folder, it will appear as a branch of that folder. Click on the document and it will appear in the viewer to the right.

Use the scroll bar to view the rest of the results.

Section B. Right Chart Panel

Right Chart Panel: Overview Tab

Located in the Right Chart Panel (on the right side of the patient progress notes) is the Overview tab, which includes the patient's problem list, current medications, allergies, immunizations, and therapeutic injections. This tab is a useful and efficient way to view patient information *without* leaving the progress notes.

The screenshot shows the 'Overview' tab of the Right Chart Panel for a patient named Mickey Mouse. The interface includes several sections: Global Alerts, Advance Directive, Problem List, Current Medications, Allergies, Immunizations, Therapeutic Injections, and Circle of Care. Callouts provide instructions on how to interact with these sections.

Click on "Overview in the Right Chart Panel"

The Problem List contains the patient's chronic conditions that have already been diagnosed.

Click on Blue arrows to move problem list diagnosis over into today's progress notes.

Click on plus sign to display more details about the immunization. A minus sign will appear with bullet points detailing the date of the vaccine and which dose it was in the series.

Scroll down to view Current Medication, Allergies, Immunizations, and Therapeutic Injections sections.

Problem List SNOMED	
Global Alerts	
Owes from past visit	
Eligibility Expiration	
Advance Directive	
Problem List	
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
R39.13	Splitting of urinary stream
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
Abrasion of foot, unspecified laterality, initial	

Current Medications		Stop Date
Refill Warfarin Sodium 10 MG Tablet		
Refill Lisinopril 20 MG Tablet		
Unknown Aspirin 500 MG Tablet		
Not-Taking Tylenol		03/05/2018
Start Metformin HCl 500 MG Tablet		

Immunizations			
BCG (90728)			
Cholera			
DTaP-Hib			
Hep B, adolescent or pediatric (11-19), 3 dose schedule			
Hep B, adolescent or pediatric (11-19), 3 dose schedule		12/12/2017	Dose-1

Right Chart Panel: DRTLA Tab

Located in the Right Chart Panel (on the right side of the patient progress notes) is the DRTLA tab, which stands for Documents, Referrals, Telephone Encounters, Labs, and Actions. This tab is a useful and efficient way to view both orders and results of patient labs, diagnostic images, and referrals *without* leaving the progress notes.

Click on "DRTLA" in the Right Chart Panel

Overview **DRTLA** History Order Sets Labs/DI

! Mouse, Mickey 50 Y, F as of 12/19/2017
Right Panel data last modified on: 11/22/2017 02:02 PM

Last 3 months

Labs All

Thyroxine (T4) Free, Direct, S (OB/HIV)	11/01/2017	
Hepatic Function Panel (Quioccasin)	11/01/2017	
Urinalysis (In-house)	11/01/2017	
Hemoglobin A1c (Quioccasin)	11/06/2017	

Diagnostic Imaging All

X ray : CHEST PA LATERAL (Bon Secours)	11/06/2017
MRI : Elbow, left (Bon Secours)	12/07/2017

Procedure All

Use the drop-down menu to select how far back you would like to view labs, diagnostic images, referrals...etc.

Date of lab order

Pink paper clips mean that an electronic result has been received. Click on the pink paper clip to view lab results. (Same for Diagnostic Images)

Telephone Encounters

Web Encounters

Referrals

50yo male with CKD stage IV due to obstructive uropathy and chronic NSAID use.	12/06/2017	0
50yo male with HTN referred for HTN control.	12/04/2017	0
50yo male referred for colonoscopy	12/04/2017	0
50yo male experiencing depressive symptoms	11/22/2017	0
50yo male diabetic with foot ulcers	11/22/2017	0
50yo male history of kidney stones. Recent hospitalization	11/22/2017	0

Scroll down to view Referrals section.

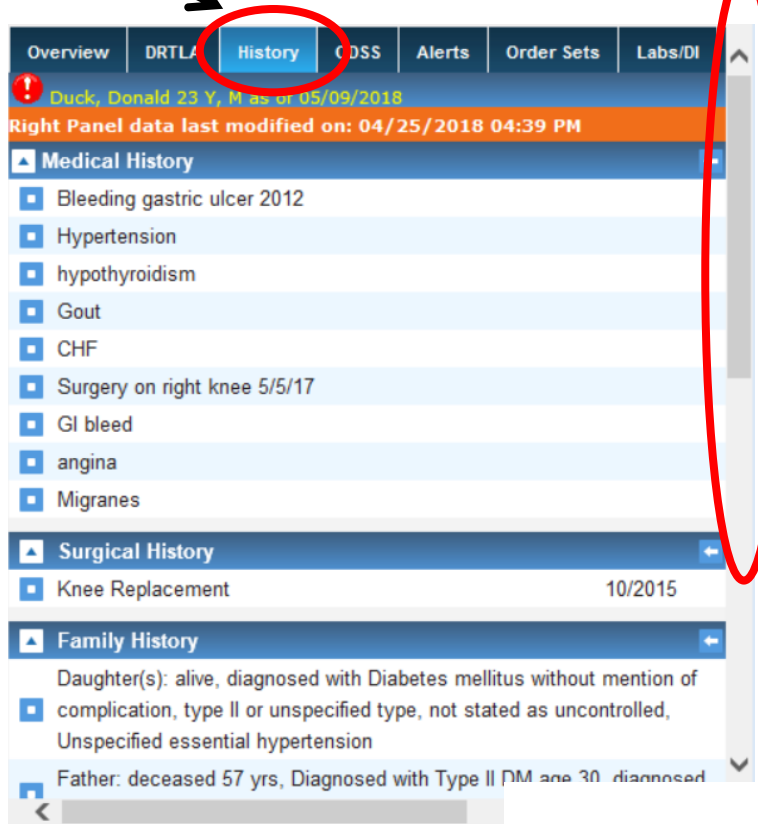
Date referral was made in eClinicalWorks

Click on the reason for the referral to view the "Outgoing Referral Window", where you will see a "specialty" field indicating what kind of specialist the patient has been referred to.

Right Chart Panel: History Tab

Located in the Right Chart Panel (on the right side of the patient progress notes) is the History tab, which includes the Review medical, gynecological, surgical, family, and social histories. This tab is a useful and efficient way to view patient information *without* leaving the progress notes.

Click on "History" in the Right Chart Panel



Scroll down to view Social History. (Gyn History will appear as a separate section for female patients.)

Part IV. Charting Workflow for a Typical Appointment

What Do I Fill Out?

Progress Note Sections

Nurse

Clinician

1. Chief Complaint		
2. HPI: Nurse Interview	2. HPI: -Clinician HPI [if new patient then also fill out: -PHQ-2 -Sexual History]	
3. Current Medication	} Review & Revise these sections	
4. Medical History		
5. Allergies		
6. *GYN History		
7. *Surgical History		
8. *Hospitalization History		
9. *Family History		
10. *Social History (2 folders) : ➤ Social History, General ➤ TOB/OB/Drugs		
11. Vitals		
		12. Examination
		13. Assessment
14. (Treatment: Nurses place standing orders <u>only</u>)	14. Treatment	
15. Immunizations: Administer immunizations (Nurses only place the standing order immunization: flu shot.)	15. Immunizations: Order Immunizations	
	16. Next Appointment	

* = only necessary to fill out for New Patient appointment

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Section A: Overview of Progress Note Navigation

Definition: **Progress Notes** are the equivalent of a patient’s paper chart for that appointment.

1. To enter the Progress Notes for a particular patient, double click on the patient’s name from the Office Visit Screen (S Jellybean).

	Visit Type	Appt Time	Patient Name	P/R	Reason
<input type="checkbox"/>	ESTPT	08:30 AM	Mouse, Mickey		PRIMARY CARE
<input type="checkbox"/>	ESTPT	08:45 AM	Mouse, Minnie		PRIMARY CARE
<input type="checkbox"/>	NP	09:00 AM	Duck, Donald		PHYSICAL

2. To open a section of the Progress Note, click on the corresponding blue hyperlink. The first Progress Note section that clinicians fill out (according to the “What Do I Fill Out?” chart above) is in HPI.

3.

Subjective:

Chief Complaint(s): ▾

chest congestion, cough, fever, headache.

HPI: ▾

Nurse Interview (at every visit)

Interpreter Used

Interpreter Used .

ER/Hosp/Urgent Care?

Since your last primary care visit, have you received care at an ER, hospital, or Urgent Care Facility? .

Travel History

Have you traveled outside of the country or been in contact with anyone who has in the last month? .

Medication Reconciliation

Med Rec Completed? .

Which prescriptions needed? ...

Adherence

Adherence? .

Rx Knowledge Assessment

Rx knowledge assessed? .

Communication Needs

Communication Needs .

Nurse Notes ..

Nurse Name ..

Clinician HPI

Interpreter used?

Intepreter Used? .

Are you seeing a non-CrossOver specialist?

Are you seeing a non-CrossOver specialist? .

Complaint 1 ..

Current Medication:

Taking

- Levothyroxine Sodium 25 MCG Tablet 1 tablet on an empty stomach in the morning Orally Once a day
- Insulin Glargine 100 UNIT/ML Solution 10 units Subcutaneous daily
- Insulin Aspart 100 UNIT/ML Solution 5 units Subcutaneous with meals
- Medication List reviewed and reconciled with the patient

Medical History:

Allergies/Intolerance:

La:

Gyn History:

OB History:

Surgical History:

Hospitalization:

Family History:

Social History:

ROS: ▾

Section B: HPI (History of Present Illness)

1. Click on the “Notes” box that corresponds to Complaint 1.

HPI (Gumdrop, Gingee - 05/22/2018 08:30 AM, ESTPT)

Pt. Info Encounter Physical Hub

Clinician HPI Show popup for c/o Order Categories

Clinician HPI Nurse Interview (at every visit)

c/o	denit	Symptom	Duration	Notes	Cl
		Complaint 1			X
		Complaint 2			X
		Complaint 3			X
		Complaint 4			X
		Complaint 5			X
		Low Back Pain-			X
		Cold Symptoms-			X
		Diabetes-			X
		Hypertension-			X
		Headache-			X
		Interpreter used?		Interpreter used? .	X

Denies All Clear All Custom

Notes Header Footer Browse... Spell check Clear

Find in

Vitals New Examination

2. This will open up a dialogue box in which you can free-text the “Subjective” of the SOAP note

HPI Notes

Free-form Structured

Options for Complaint 1 Delimiter , Dictate B U C Reset Font Clear Spell chk

Free-text notes here

Duration | | Days Weeks Months Years

Location/Radiation Onset Severity

Nature Aggravated by Relieved by

Associated Symptoms

Prev Custom OK Cancel Next >

Last Up

3. If the HPI question contains structured data, a new window with questions will appear. Click into the value field until a drop-down menu appears. Make your selection from the drop-down menu. Click into the *Notes* field to free-text additional notes about that question

HPI Notes

Free-form | **Structured**

Are you seeing a non-CrossOver specialist? Default Default for All Clear All

Name	Value	Notes
<input type="checkbox"/> Are you seeing a non-CrossC	Yes No	

< Prev Custom Close Next >

Section C: Review and Revise Sections

While the nurse completes the following sections, the clinician is responsible for reviewing and revising them as necessary:

- Current Medication
- Medical History and Allergies
- GYN History
- Surgical History & Hospitalization
- Family History
- Social History
- Vitals

Click on the blue hyperlinks on the Progress Notes to access these sections.

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Once you open a hyperlink, you can access other sections of the Progress Note by clicking on the picture icons located at the top of the hyperlinked screens. Hover over the picture icons to see which sections they represent:

The screenshot shows a software interface with a navigation bar at the top containing 'Pt. Info', 'Encounter', 'Physical', and 'Hub'. Below this is a toolbar with various icons. Red arrows point from callout boxes to specific icons: 'Medical History & Allergies' points to a red 'A' icon; 'Current Medication' points to a pill icon; 'Vitals' points to a stethoscope icon; 'Family History' points to a family icon; 'Social History' points to a person icon; and 'Surgical History & Hospitalization' points to a scalpel icon. Below the toolbar, the 'HPI' section is visible, showing a 'Clinician HPI' with a table containing a 'Complaint 1' entry.

c/o	deni	Symptom	Duration	Notes	Cl
		Complaint 1		.	X

1—Current Medication (Review and Revise as needed)

This section contains all medication the patient is supposed to be taking according to what was prescribed during their last visit. The nurse conducts medication reconciliation prior to the clinician interview with the patient.

Note: medication adherence questions are answered in the Nurse Interview in the “Adherence” area.

Medication Reconciliation

Pt. Info Encounter Physical Hub

Current Medication Past Rx History External Rx History Unreconciled Past Meds Add Medication Verified Rx Name Only

Drug Interaction Cancel

Apply Status from Prior Visit

T Taking N Not Taking D Discontinued U Unknown Status

Mark all as: T N U D

Medication	Start Date	Stop Date	Notes	Source	T	N	U	D
Aspirin Adult Low Dose 81 MG Tablet Delayed R...					<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tylenol 1 tab Oral				Michael, Murchie S.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ibuprofen 1 tab Oral				Michael, Murchie S.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maxalt-MLT 5 MG Tablet Disintegrating 1 table...	09/15/2017			Michael, Murchie S.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N Not Taking								
Atenolol 100 MG Tablet 1 tablet Orally Once a day					<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maxalt-MLT 10 MG Tablet Disintegrating 1 tabl...	09/15/2017			Michael, Murchie S.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin HCl 1000 MG Tablet 1 tablet with me...	01/18/2018			Murchie, Michael S.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lisinopril 10 MG Tablet 1 tablet Orally Once a day	02/13/2018			Murchie, Michael S.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinoulair 5 MG Tablet Chewable 2 tablets Oral...					<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chief Complaints Past Medical History

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2—Medical History & Allergies (Review and Revise as needed)

Add Medical History and Allergies as needed.

Past Medical History (Test, Test 2 - 04/24/2017 12:15 PM, DENT ESTPT) *

Pt. Info Encounter Physical Hub

Medical Hx Keyword ICD Pregnant BreastFeeding Hx Verified

No	History	ICD Code	FL
1	Essential hypertension	I10	<input checked="" type="checkbox"/>
2	Panic attacks	F41.0	<input checked="" type="checkbox"/>

Allergies N.K.D.A Allergies Verified

Agent/Substance	Reaction	Type	Status
peanut butter	anaphylaxis	Allergy	Active
sulfa	hives	Allergy	Active

- To add an allergy, click the “Add” button. Then, free-text allergies into Agent/Substance field, and in the type of reaction, type of allergy, and always mark the allergy as Active
- Check off NKDA if no known drug allergies.

Medication Reconciliation

3—GYN History (Review and Revise as needed)

Use the blue hyperlink to access this section.

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4—Surgical History & Hospitalization History

Add Surgical and Hospitalization History as needed. Use the “Add” button to add a new field.

The screenshot shows a software window titled "Surgical History (Duck, Daisy - 06/12/2018 02:00 PM, ESTPT)". The window has a navigation bar with "Pt. Info", "Encounter", "Physical", and "Hub". Below this is a toolbar with various icons. The main content area is divided into two sections: "Surgical Hx" and "Hospitalization".

Surgical Hx section:

- Buttons: Keyword, CPT, (with a plus icon), (with a minus icon), Denies Past Surgical Hx, Surgical Hx Verified

	Date (Mo/Yr)	Surgery
1	10/2015	knee replacement r. knee

Hospitalization section:

- Buttons: , (with a plus icon), (with a minus icon), Denies Past Hospitalization, Hospitalization Verified

	Date (Mo/Yr)	Reason
1	03/2013	pneumonia

At the bottom of the window, there are two navigation buttons: "Past Medical History" (with a left arrow) and "Family History" (with a right arrow).

5—Family History (Review and Revise as needed)

Use the blue hyperlink to access this section.

6—Social History (Review and Revise as needed)

Use the blue hyperlink to access this section.

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7—Vitals (Review and Revise as needed)

Use the blue hyperlink to access this section.

Date	*Smoker? (Y/N)	Resources/Advice t	*BP(mm Hg)	BP recheck	*Pulse	*Ht(in)	*Wt(lbs)	*BMI
04/24/2017								
04/17/2017								
04/13/2017								
03/31/2017								
03/30/2017								
03/29/2017								
03/28/2017								
01/03/2017								

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Section D: Examination

1. Click the green arrows to populate the default setting for a “normal” observation into the *Observation* field or click directly into the *Observation* field to free-text notes.

Field	Observation
GENERAL APPEARANCE:	in no acute distress, well developed, well nourished
HEAD:	normocephalic, atraumatic
EYES:	pupils equal, round, reactive to light and accommodation
EARS:	normal
NOSE:	nares patent, sinuses nontender bilaterally
ORAL CAVITY:	mucosa moist
THROAT:	clear
NECK/THYROID:	neck supple, full range of motion, no cervical lymphadenopathy
LYMPH NODES:	no palpable adenopathy
SKIN:	no suspicious lesions, warm and dry
HEART:	no murmurs, regular rate and rhythm, S1, S2 normal
LUNGS:	clear to auscultation bilaterally
BREAST EXAM:	
BREAST FINDINGS:	
CHEST:	
AROMPMN:	

Examination Notes

Free-form Structured

Options for EARS:

Delimiter , Dictate B U C Reset Font Clear Time stp Spell chk

Free-text here.

Click on the words on the left to automatically add them into the note. For example: auditory canal obscured with wax

Press Ok to return to the Examination screen.

Both EARS
LEFT EAR
RIGHT EAR
...
normal
not examined
auditory canal clear
hearing intact to whispered voice
tympanic membrane intact, clear
light reflex present
...
auditory canal obscured with wax
external canal inflamed
hearing diminished
...
tympanic membrane red
tympanic membrane perforated

< Prev Custom OK Cancel Next >

Section E: Assessments

Every part of the treatment plan in eClinicalWorks must be associated with a diagnosis code. The purpose of the Assessments screen is to pull up diagnosis ICD-10 codes so that treatment can be attached to the diagnoses. Use this screen to

1. Pull-up existing diagnoses
2. Put in new Diagnosis codes

1—Pulling-Up Existing Diagnoses

#1 Click on “Previous Assessments” radio button.

*Note: To select an Assessment/Dx code from the (chronic) Problem List, click the *Problem List* button.

#2 Select the diagnosis (single click).
The Diagnosis will move into the “Selected Assessments” section outlined below.

Assessments (Test, Gingee - 06/17/2018 04:45 PM, ESTPT)

Pt. Info Encounter Physical Hub

Switch To Classic Search

Previous Assessments

Problem List

Smart Search

Real Time

Did you mean?
-- No Suggestions --

Previous Assessments Map to ICD10 Default

10	Z00.00	General medical exam
10	F41.8	Depression with anxiety
10	F33.2	Severe episode of recurrent major depressive disorder, without psychotic feat
10	M25.561	Pain in right knee
10	M25.562	Pain in left knee
10	G89.29	Other chronic pain
10	I10	Hypertension

Selected Assessments

Axis	<input type="checkbox"/> PL	Code	Diagnosis	Specify	Notes	Risk	Cl
	<input type="checkbox"/>	M25.561	Pain in right knee				X
	<input type="checkbox"/>	M25.562	Pain in left knee				X
	<input checked="" type="checkbox"/>	G89.29	Other chronic pain				X

Notes

Axis 4 Axis 5

Examination Treatment

Last Updated on 2/18/19 by Sarah Labriny

2—Putting-In New Diagnoses

#1 To search for a new assessment, **ensure that you are assigning ICD-10 codes** by checking the *Use ICD10* box and type into the box on the left by wording of the assessment or by the code itself. Hit Enter on your keyboard. (DO NOT check the *Real Time* box.)

#2 Select the diagnosis (single click).

The Diagnosis will move into the “Selected Assessments” box outlined below.

*Note: Clicking on blue diagnoses will open up a new window of questions about the diagnosis in order to narrow it down to the most specific ICD- 10 code.

The screenshot shows the following data in the 'IMMO' table:

ICD-9	ICD-10	Diagnosis
784.0	R51	Headache
339.05	G44.059	Headache, short unilat neuralgiform, w/conjunctival injection/tearing
784.0	R51	Headache above the eye region
784.0	R51	Headache affecting lower half of face
784.0	R51	Headache around the eyes
339.20	G44.309+	Headache as late effect of brain injury
999.89	R51+	Headache as manifestation of blood transfusion reaction
339.89	G44.89	Headache associated with hormonal factors
339.82	G44.82	Headache associated with orgasm
339.82	G44.82	Headache associated with sexual activity

The 'Selected Assessments' table shows:

Axis	Code	Diagnosis	Specify	Notes	Risk	Clear
<input checked="" type="checkbox"/>	I20.0	Unstable angina				X
<input checked="" type="checkbox"/>	I10	Essential hypertension				X
<input type="checkbox"/>	L70.0	Acne vulgaris				X
<input type="checkbox"/>	R51	Headache, unspecified headache type				X

Problem List: Check off the box next to the ICD-10 code to add it to the Problem List (chronic conditions).

NOTE: the box does **NOT** need to be checked off in order for the diagnosis to appear in today’s notes.

(Optional): Remove an assessment selected at this encounter by first clicking on the diagnosis in “Selected Assessments” and then the *Remove* button

- (Optional): Manage the patient’s Problem List by clicking the *Problem List* button. Problems can be added or removed and added to *Medical Hx* from the *Problem List* window. If you see an ICD-9 code on a patient’s problem list, **YOU MUST UPDATE IT TO AN ICD-10 CODE!** Add the ICD-10 code and then delete the ICD-9 code.
- Click X to save and exit back to the Progress Note.

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Section F: Treatment

The Treatment screen is the main ordering hub for clinicians. From this screen, clinicians take treatment notes, order medication, labs, DI, and referrals. They also make notes about their treatment plan for the patient.

eClinicalWorks ties every order and note to a diagnosis (assessment). Therefore, it is important that you pay attention to the Assessment tabs.

The screenshot shows the eClinicalWorks Treatment screen for a patient named Test, Nugget, dated 05/31/2018 at 09:00 AM. The interface includes a top navigation bar with tabs for Pt. Info, Encounter, Physical, and Hub. Below this is a toolbar with various icons for actions like adding, removing, and generating history. The main area displays a list of current medications (Rx) with columns for Name, Strength, Formula, Take, Route, Frequency, Duration, Dispense, Refill, Authorization, AWP, and Stop Date. Below the medication list are sections for Labs, Diagnostic Imaging, and Procedures, each with a 'Browse...' button. At the bottom, there is a 'Notes' section with a 'Clinical Notes' tab highlighted in red. A red box surrounds the 'Clinical Notes' tab and the text 'TYPE TREATMENT NOTES HERE' with an arrow pointing to it. A callout box on the right contains the text: 'Record treatment plan notes in the "Clinical Notes" section. Make sure you are on the correct Assessment tab before you start taking notes.'

1—Medication [see separate guide on “Ordering and ePrescribing Medication in eCW”]

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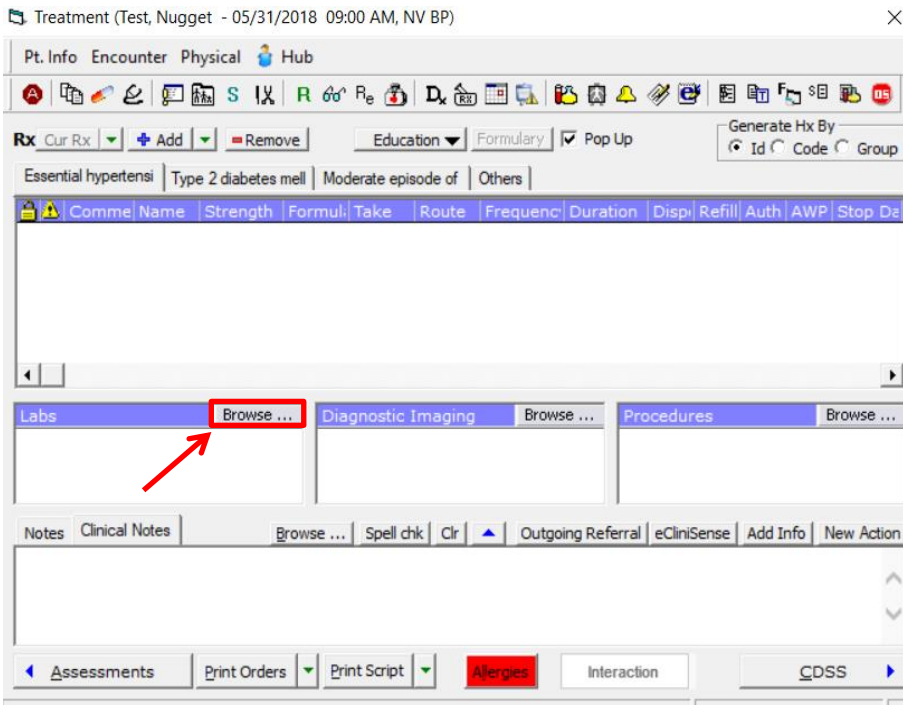
2—Ordering Labs (from the Treatment Screen)

Lab Ordering Policy:

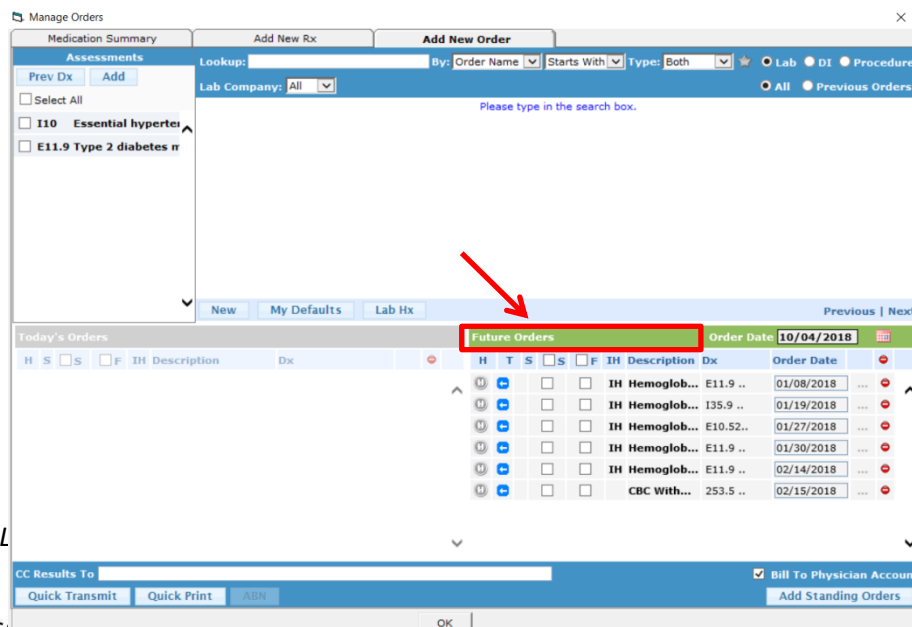
ALL labs should be ordered as **FUTURE ORDERS** (even if the hope is that they can be done same day).

The exception to this is that **In-house orders** that are being performed the same day should be put in **as same day**.

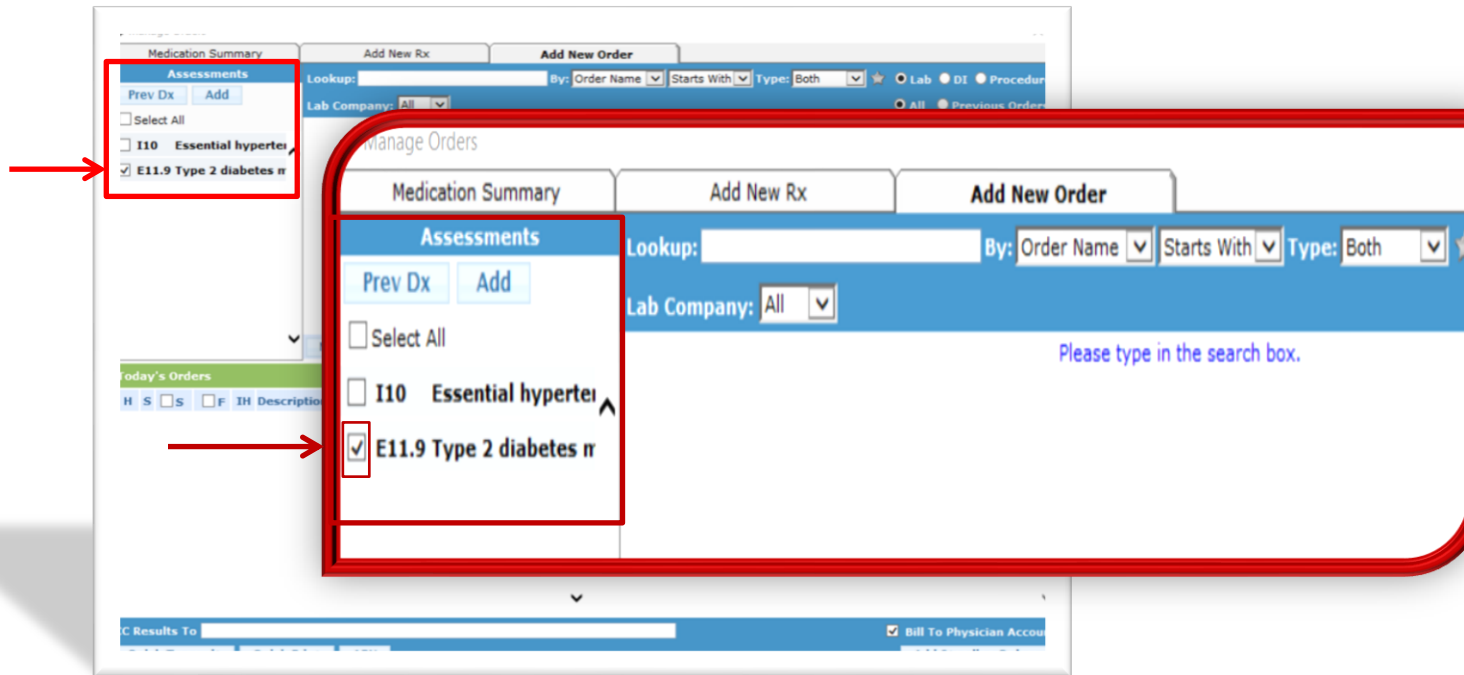
1. Click the “Browse” button next to Labs.



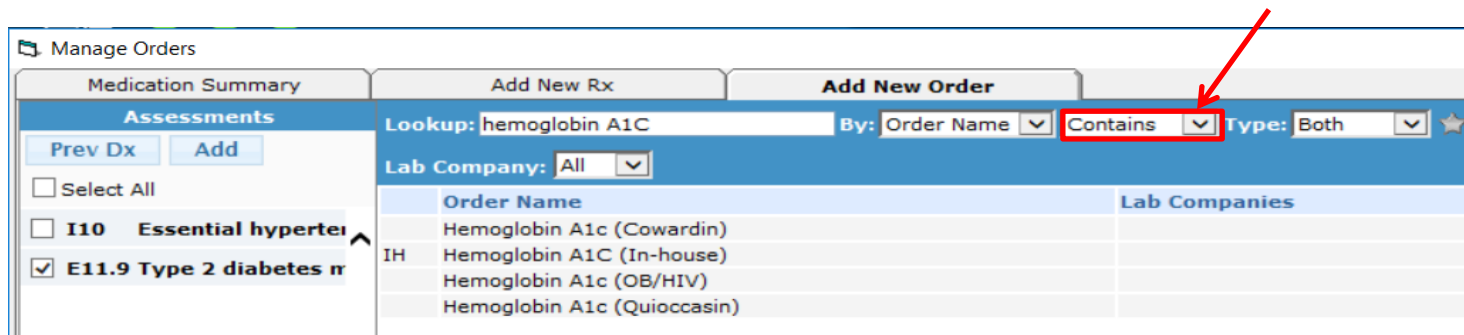
2. Select Future Orders



3. *****IMPORTANT:** Check off the box next to the Assessment/Dx code for which you are ordering.



4. Change the search criteria from "Starts with" to "Contains" (this makes the lab easier to find).



5. Type the name of the lab into the “Lookup” field. Select the lab by clicking on it. Select the In-House option if one exists, otherwise:
 - If you are at the **Henrico Clinic**: choose the “**Quiocassin**” option.
 - If you are at the **Cowardin Clinic**: choose the “**Cowardin**” option.

If both an In-House and location option exist, choose the In-House option.

The screenshot shows the 'Manage Orders' window with the following details:

- Lookup:** hemoglobin a1c
- Lab Companies:**

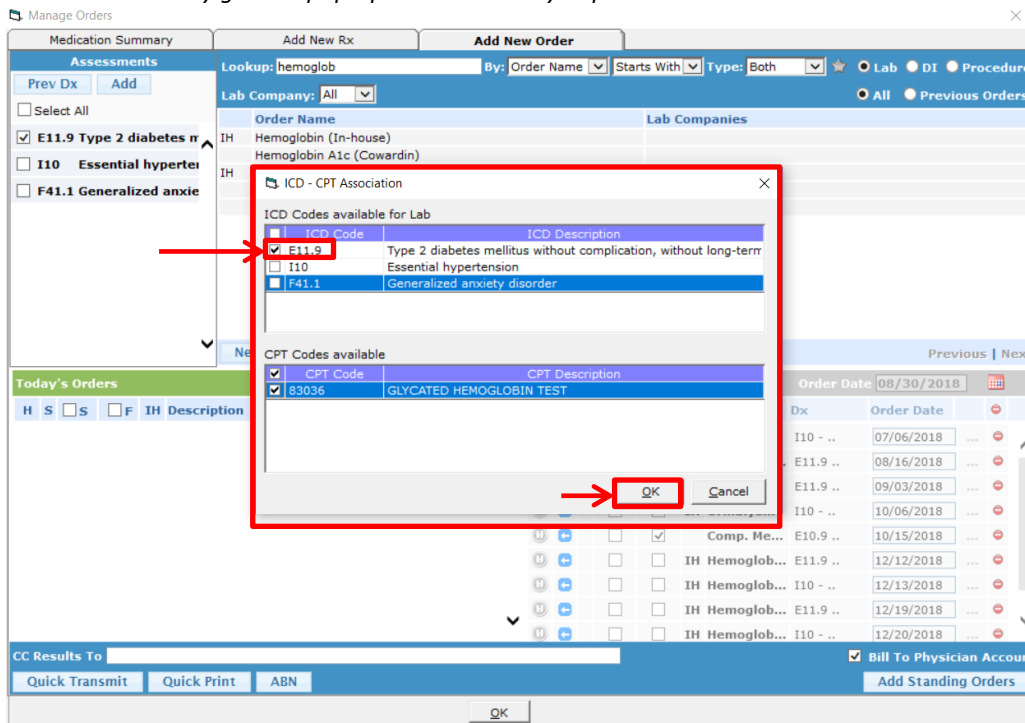
Order Name	Lab Companies
Hemoglobin A1c (Cowardin)	
IH Hemoglobin A1C (In-house)	
Hemoglobin A1c (OB/HIV)	
Hemoglobin A1c (Quiocassin)	
- Future Orders Table:**

H	T	S	S	F	IH	Description	Dx	Order Date
						CBC With...	253.5 ..	02/15/2018
					IH	Hemoglob...	E11.9 ..	10/04/2018

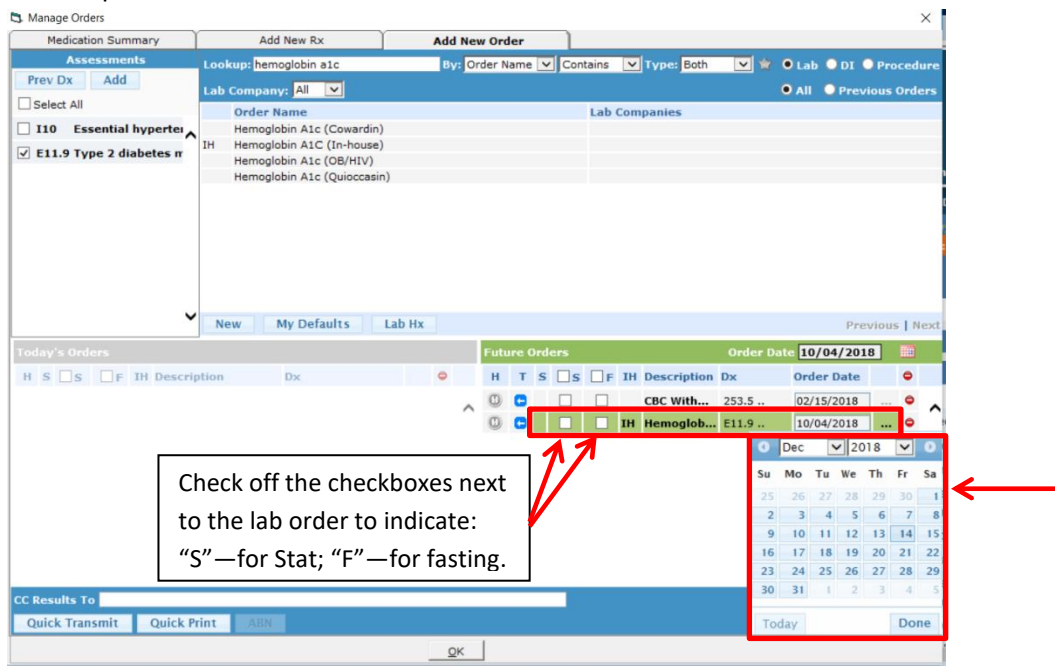
A text box with a red arrow pointing to the 'IH Hemoglob...' row in the 'Future Orders' table contains the text: "This will add the lab under “Future Orders”".

- The ICD-CPT Association box will appear. Check off the box next to the ICD-10 code for which you are placing the order. (If applicable, check off more than one.) Then, press Ok.

NOTE: You will only get this pop-up window when you place an In-House order.

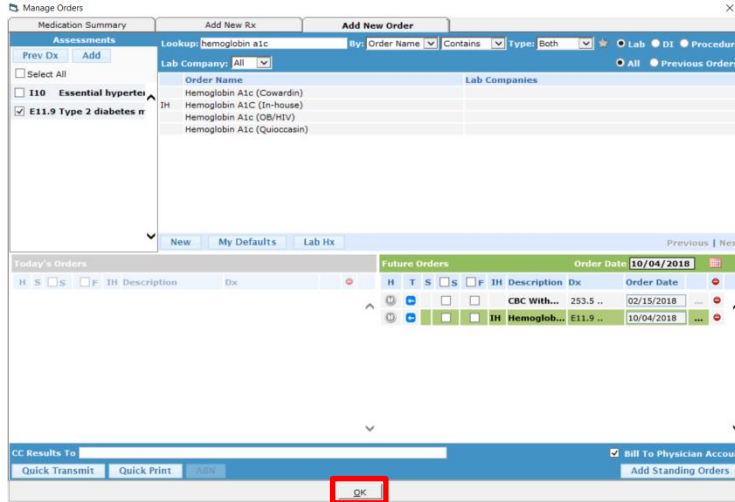


- Next, click on the date in the order date column and then use the calendar to select when you would like the patient to come back in for their lab.



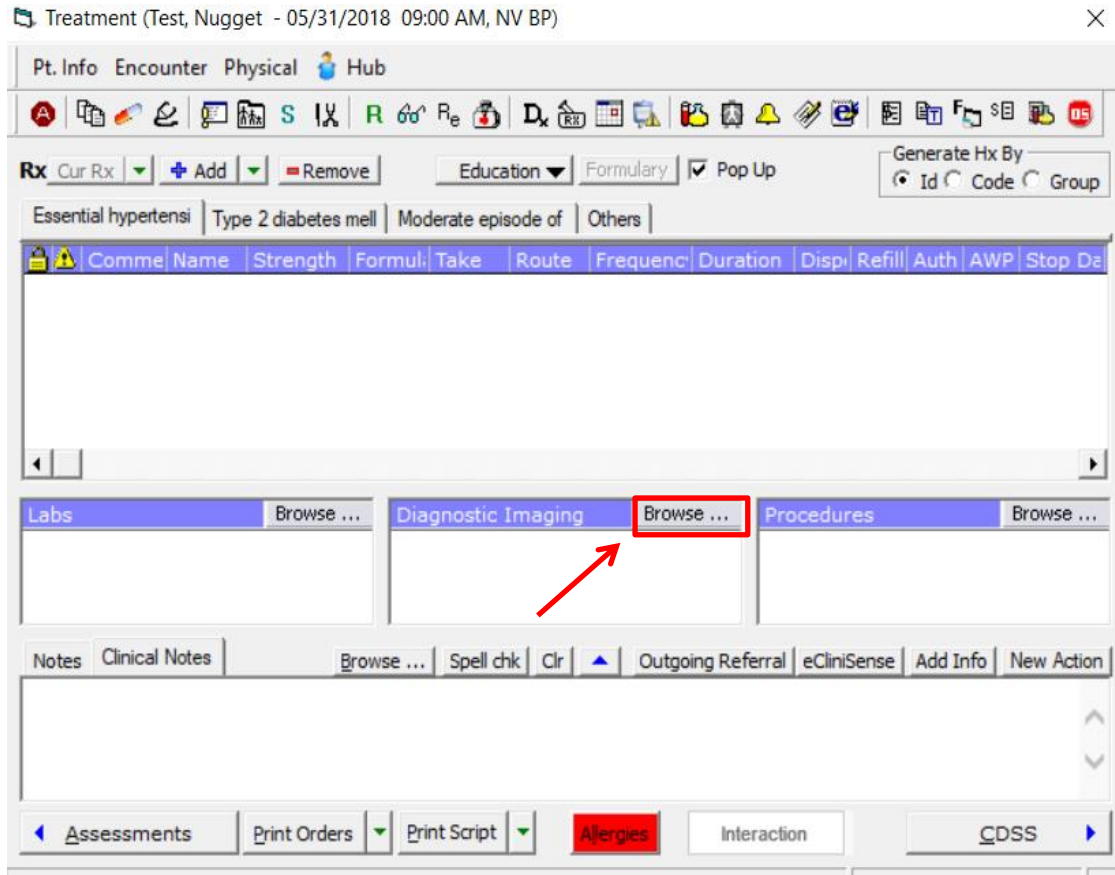
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8. Click "Ok" at the bottom to return to the Treatment screen.

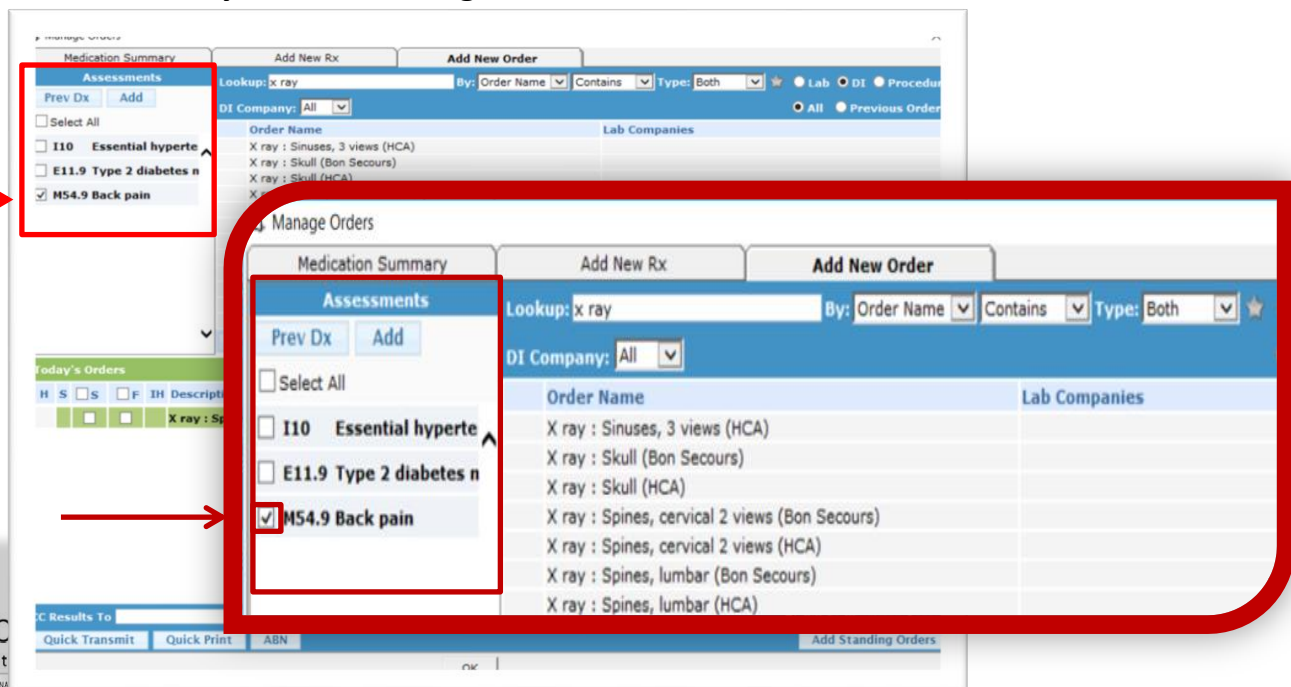


3—Ordering Diagnostic Imaging

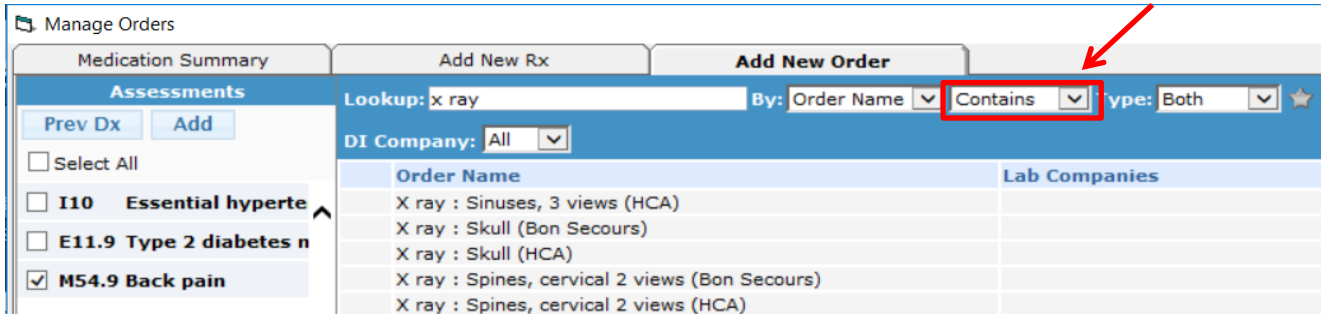
1. Click the “Browse” button next to Diagnostic Imaging.



2. *****IMPORTANT:** Check off the box next to the Assessment/Dx code for which you are ordering.

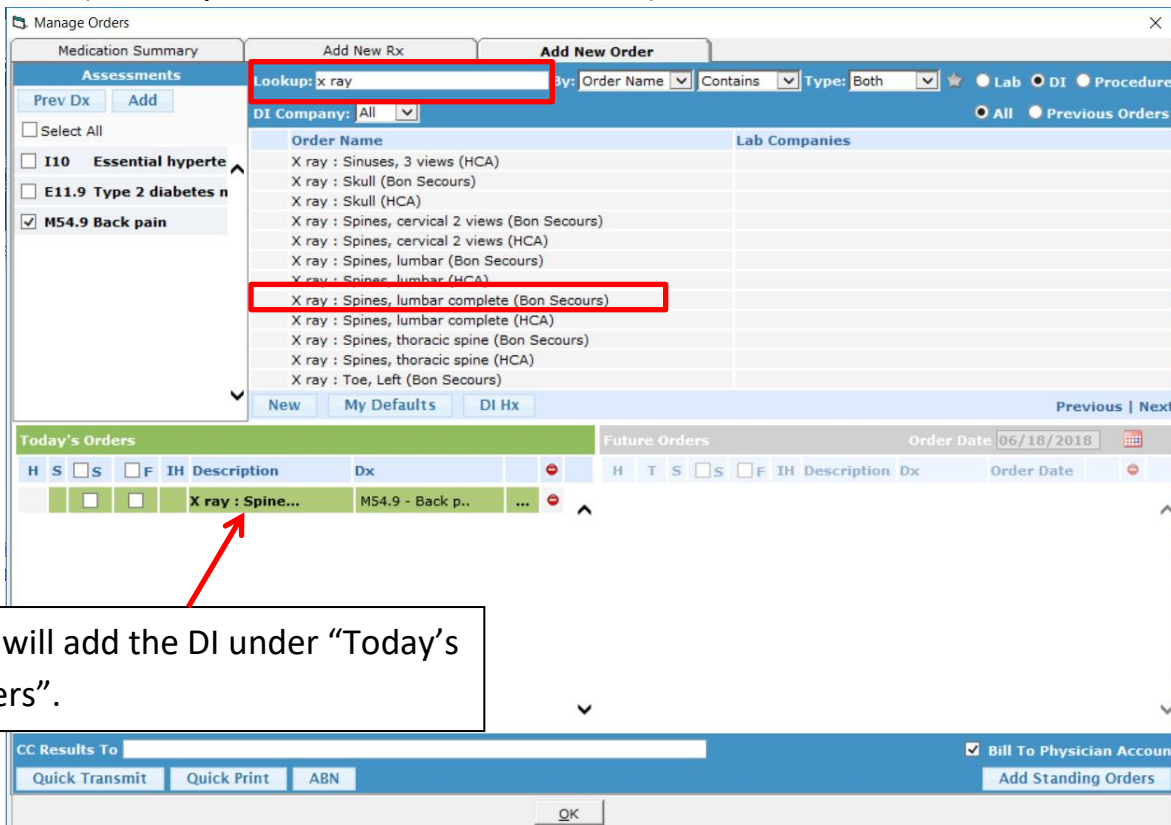


3. Change the search criteria from “Starts with” to “Contains” (this makes the order easier to find).



4. Type the name of the DI into the “Lookup” field. All DI orders start with one of the following: “Ultrasound”, “CT”, “MRI”, “X ray”. Select the DI by clicking it:

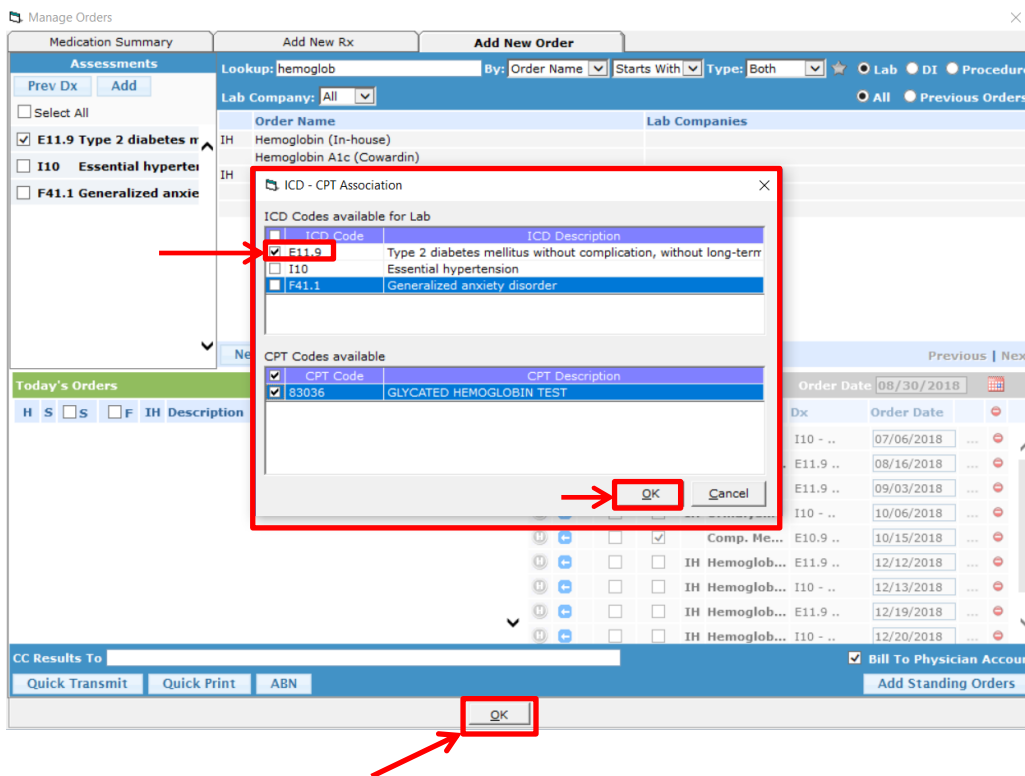
- If you are at the **Henrico Clinic**: choose the “**Bon Secours**” option.
 - If you are at the **Cowardin Clinic**: choose the “**HCA**” option.
- (The only In-House DI is Bladder Scan.)*



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5. Check off the box next to the ICD-10 code for which you are placing the order. (If applicable, check off more than one.) Then, press Ok.

NOTE: The **“ICD – CPT Association” window** below will pop up every time an order is placed that has a CPT code associated with it. Only In-House orders (labs, DI, procedures, and possibly immunizations/therapeutic injections) will have a CPT code associated with them. *This means that you will only get this pop-up window when you place an In-House order.*



6. Click “Ok” at the bottom to return to the Treatment screen.

4—Making Referrals

1. Fill out the back of the Check-Out Sheet as follows:

If the referral is a Routine Check-Up for Ophthalmology, Dental, or Well Woman exam:

DO NOT enter referral in eClinicalWorks. Simply mark next to the corresponding Routine Check-Up on the Check-Out sheet.

Otherwise:

It must be entered in eClinicalWorks (as seen below) AND marked on the check-out sheet.

Use the **“CrossOver In-House and Outside Referral Availability”** document to determine whether the referral is CrossOver (In-House) or Access Now. This document will automatically load as the last tab in Internet Explorer.

Routine Check-Ups and Referrals

Select Referral (s):

Routine Check Ups (Do not enter referral in eCW)

Ophthalmology (Diabetic due for eye exam: front desk schedules Eye Visit as patient checks out)

Ophthalmology/Optometry (Any other eye appt: front desk gives patient the phone number for eye clinic and asks patient to call for an appt; if it is urgent, provider sends eCW referral)

Well Woman Exam Dental Cleaning and Exam

Other In-House or Outside Specialty (Access Now) Referrals
 Note: Fast-track and urgent dental and eye referrals include newly diagnosed diabetics, TIPS, OB, urgent problems and pediatric patients. **Enter referral in eCW!**

CrossOver referral X-Rays (Bon Secours/Chippenham; CLINICIANS enter in eCW, fill out paper form, and give to patient!)

Access Now referral Other Imaging (CT, MRI, Mammo, U/S, Stress Test, etc.;)

The screenshot shows the 'Treatment' window for a patient named 'Test, Test 2' on 11/01/2017 at 10:03 AM. The 'Rx' tab is active, displaying a list of medications. A red box highlights the 'Essential hypertensi' entry. A red arrow points from this box to the 'Outgoing Referral' button in the bottom right corner of the window. Another red arrow points from the 'Outgoing Referral' button to a text box on the right side of the page.

Comme	Name	Strength	Form	Take	Route	Frequenc	Duration	Dispi	Refill	Auth	AWP	Stop Dd
Start	Lisinop	20 MG	Tablet	1 tablet	Orally	Once a d:	30 day(s)	30			32.11	

2. From within the Treatment window, click Assessment/Diagnosis tab for which you are writing a referral.

3. Then click the “Outgoing Referral” button. (Note: Although the button is called “Outgoing Referral”, it is used to make both In-House CrossOver referrals and Access Now referrals.)

Referral (Outgoing)

Patient: Test, Test 2 (AB103801) Sel Info Hub

Insurance: CrossOver Uninsured Sel Pt Ins POS 11

Ref From: Murchie, Michael Ref To: Provider: Specialty: Cardiac Surgery

Facility From: Crossover Western Henrico 4. Facility To: Auth Code: Auth Type: Start Date: 11/01/2017 Referral Date: 11/01/2017 End Date: 11/01/2018 Open Cases: 5. Assigned To: Referrals, Henrico

Appt Date: 11/01/2017 Unit Type: V (VISIT) Received Date: 11/01/2017 Status: Open Consult Pending Addressed

6. Priority: Routine

Diagnosis / Reason Visit Details Notes 8. Structured Data

Reason 7. Add Browse Remove

Sl. No	Description
1	34yr old patient with congestive heart failure

Diagnosis Previous Dx Add Remove Procedures Add Remove

Code Name Code Name

Scan Attachments (2) Logs OK Cancel Send Referral

(*Fill out the Outgoing Referral form according to the red asterisks)

4. Select the *Specialty* to which you are referring.

5. Select either “**Referrals, Cowardin**” or “**Referrals, Henrico**” in the *Assigned To* field according to the clinic at which you are serving.

6. Select the *Priority* of the referral in the corresponding field.

7. Under the *Diagnosis/Reason* tab, click the *Add* button and free-type the reason for referral and any special instructions. **If your explanation is too long for the first dialog box, use the add button (7) to add more dialog boxes** and finish your explanation in the next box(es). Otherwise, your description will get cut-off and the next provider will not be able to read your reason for the referral.

8. Click *Structured Data* button.

Diagnosis / Reason Visit Details Notes Structured Data

Name	Value	Notes
<input type="checkbox"/> Referral System 9.	In House Specialty at CrossOver Access Now	
<input type="checkbox"/> Outgoing Specialties	VCU	
<input type="checkbox"/> Priority of Referral	Bon Secours	
<input type="checkbox"/> Date sent	Other Community Resource	
<input type="checkbox"/> Approval date		
<input type="checkbox"/> Clinical consultation report rece		
<input type="checkbox"/> Attempt #1		
<input type="checkbox"/> Attempt #2		
<input type="checkbox"/> Attempt #3		
<input type="checkbox"/> Attempt #4		
<input type="checkbox"/> Attempt #5		
<input type="checkbox"/> Attempt #6		

Custom Default for All Clear All

Scan Attachments (2) 10. OK Cancel Send Referral

9. Double click in the *Value* column next to “**Referral System**” and a drop-down menu will appear. Select either “**In House Specialty at CrossOver**” OR “**Access Now**”. (Do not select bottom three options unless instructed to do so.)

10. Click the **OK** button. **DO NOT CLICK SEND REFERRAL!**

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Section G: Immunizations/Therapeutic Injections

Ordering an Immunization is 2-step Process:

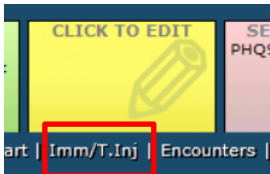
Step 1—Check Immunization Hx to make sure that the patient has not already received the immunization.

Step 2—Ordering Immunization

1—Checking immunization History

Click “Immunization” on the Patient Dashboard to view the patient’s Immunization History.

****DO NOT ORDER IMMUNIZATIONS FROM THIS SCREEN.****



2—Ordering Immunizations and Therapeutic Injections

1. After you have checked the patient’s Immunization/Th. Inj. History, Click the Immunizations or Therapeutic Injections link on the Progress Note under “Plan”:

Plan:

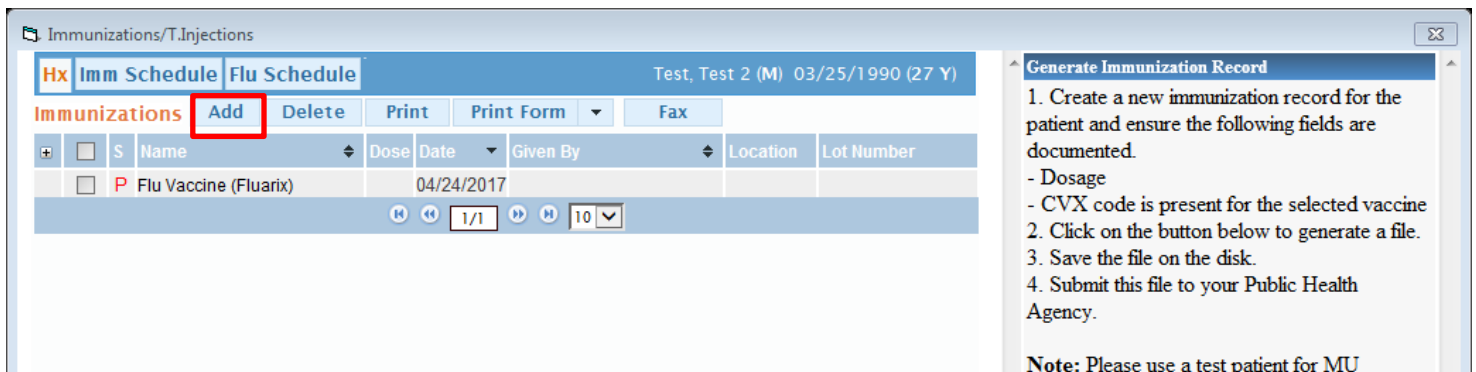
[Treatment:](#)

[Procedures:](#) ▼

[Immunizations:](#)

[Therapeutic Injections:](#)

2. Click *Add* next to *Immunizations* or *Therapeutic Injections* to add an order

A screenshot of a software interface for 'Immunizations/T.Injections'. The interface shows a patient's immunization history table. The table has columns for 'Name', 'Dose', 'Date', 'Given By', 'Location', and 'Lot Number'. A row is visible for 'Flu Vaccine (Fluarix)' on '04/24/2017'. Above the table, there are buttons for 'Add', 'Delete', 'Print', 'Print Form', and 'Fax'. The 'Add' button is highlighted with a red box. To the right of the table, there is a panel titled 'Generate Immunization Record' with instructions: '1. Create a new immunization record for the patient and ensure the following fields are documented. - Dosage - CVX code is present for the selected vaccine. 2. Click on the button below to generate a file. 3. Save the file on the disk. 4. Submit this file to your Public Health Agency. Note: Please use a test patient for MU'. The patient information at the top right of the screen is 'Test, Test 2 (M) 03/25/1990 (27 Y)'.

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3. Search for the order on the left side of the screen and select it
4. Select whether or not vaccination has been given in the past.
5. Associate it with an Assessment.
6. Press Ok. (The person who administers it will fill in the rest.)

Section H: Check-Out Sheet

Nurse visit: short 10-15 min visit with the nursing team for BP check, INR, DEPO, etc.

Lab visit: short 10-15 min visit with the nursing team to drawn lab.

*Indicate whether or not it is a fasting lab.

Patient Name _____ Date of Birth _____ Today's Date _____

Nursing Orders Prior to Check-Out

Blood draw

Instruct on insulin injections

Vaccine(s) _____

Nurse Visit

When? _____ Month(s) _____ Week(s)

BP check INR (fingerstick)

Depo in 3 months Other: _____

Lab Visit

When? _____ Month(s) _____ Week(s)

Fasting Non-fasting First Available

Regular Follow-Up Appointment

When? _____ Month(s) _____ Week(s)

Provider? _____ Any PCP

Other Front Office Items

Mental Health Resource Handout

Release of Information Form

VCC Application Information Sheet

Pharmacy Pickup

Provide info on bill counseling

Other: _____

Indicate when you would like the patient to return for a follow-up.

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Section I: Next Appointment

Assessments

P	CODE	Diagnosis	Specify	Notes
1	X	I20.0	Unstable angina	
2		F41.0	Panic attacks	
3		I10	Essential hypertension	
4		L70.0	Acne vulgaris	
5		R51	Headache, unspecified headache ty	
6		J41.0	Simple chronic bronchitis	

Procedure Codes

CPT	Tth No	Srvc	Name	Units	ICD1	ICD2	ICD3	ICD4	Notes
D0120			PERIODIC ORAL EXAMINATION	1.00					

Follow Up

6 Weeks

2-3 Ds 1 W 2 W 3 W

4 W 6 W 2 M 3 M

4 M 6 M 1 Y prn

Follow up N/A

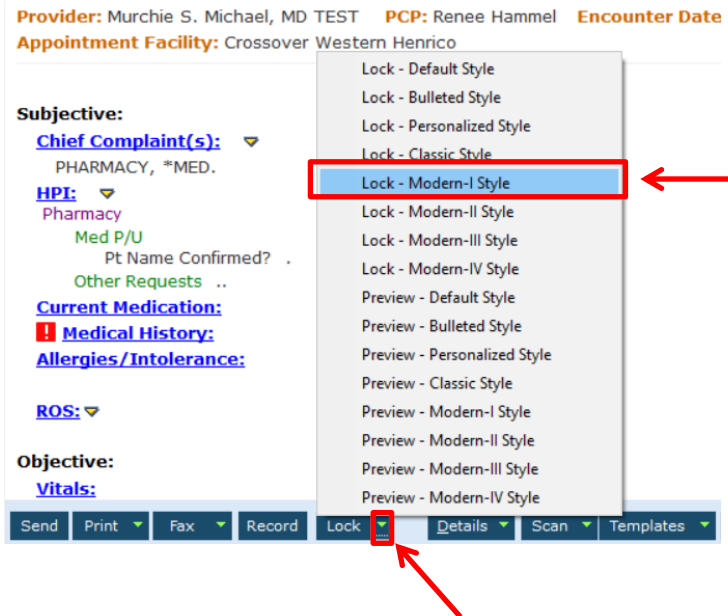
Disposition & Communication

CDSS Addl. Billing Data Confidential Note Close Done

- Enter the follow-up time frame in the *Follow Up* field or check the “Follow N/A” box if no follow up is needed.
 - IMPORTANT: Scribes and Medical Students must enter the appropriate signature in the Follow Up field:**
 - Scribe signature:** <Time Frame>, <Progress Note documented by scribe <First Name, Last Name>>
Example: 2 weeks, Progress Note documented by scribe Sarah Labriny
 - Medical Student signature:** <Time Frame>, <Seen and Examined by First Name, Last Name>
Example: 2 weeks, Seen and Examined by Sarah Labriny
 - Residents:** See *How to Co-Sign and Lock Progress Notes* guide to for finalizing Progress Notes
- Click *Close*

Section J: Locking the Progress Note

Click the caret next to Lock. Then select “Modern I Style”. This will lock the note, closing editing capabilities.



Documentation completed?

- Return to the schedule by clicking S jellybean
 - Change Floor Status by clicking into Status field and selecting “ALL DONE”

End of Shift

- **The Provider must lock their progress notes!**
 - You may do this either at the end of your shift for all appointments (recommended) or as you finish with each patient
 1. At the bottom of the Progress Note, select the arrow next to the *Lock* button
 2. Select “*Lock Modern I Style*”
 3. Upon prompt, click Yes to lock encounter
 4. Return to S jellybean and repeat for each progress note

Part V. Looking up a Patient



1. Lookup Patient using “Sherlock”

- Allows user to search for a patient by “last name, first name” or by DOB

Patient Lookup

Search Patient Include Appointment Facility

test by Name & by

All by ... All Facilities RTS

Pri	W	Name	DOB	Phone	Account No.	Last Appt Dt	Previous Name
1		Test,Test	10/09/1979	804-320-0801	AB103709	09/30/2016	
2		Test,Test 2	03/25/2009	804-320-0801	AB103801		
3	w	Test,VA M	10/11/1990	123-456-7890	1234567A	08/30/2016	

< Prev Next >

Patient Info

OK Cancel

Clicking here will take you to the Patient Hub

- This will take you to the Patient Hub. In the Patient Hub, users can access the same medical information they would find in the progress note including labs, DI, referrals, Patient Docs, Immunizations, Allergies and other sections described in the above guide in pages 3-6. (This is a secondary way to access those sections.)

Patient Hub (Test, Test)

Labs	DI	Procedures	Imm/T.Inj	Referrals	Allergies	CDSS	Alerts	Notes
Test, Test		Sel Info		Home: 804-320-0801				
1234 Diddle Street				Work:				
Henrico, VA-23233				Cell:				
DOB: 10/09/1979				Email:				
Age: 36 Y Sex: F				Insurance: CrossOver Uninsured				
Advance Directive:				PCP: Murchie, Michael				
WebEnabled: No				Rendering Pr:				
Messenger Enabled: Yes				Share				
Last vMsg:								
Account No: AB103709								
Patient Balance: \$0.00		Collection Status:		Labs 1 Tel Enc -				
Account Balance: \$0.00		Assigned To:		DI - Web Enc -				
				Referrals - Documents -				
				Actions - P2P -				
Last Appt: 09/30/2016 10:00 AM		Facility: Crossover Downtown						
Next Appt:		Facility:						
Bumped Appts: NONE		Case Manager Hx:						

New Appt	New Tel Enc	Print Label(s) v	Billing Alert	Patient Docs
Letters	Encounters	Medical Summ. v	Rx	Progress Notes
eClinForms	Devices v	Problem List	Medical Record	Send eMsg
Account Inquiry v	Guarantor Bal.	Consult Notes	Letter Logs	Fax Logs
Action v	Flowsheets	Messenger v	Billing Logs	PL 9 to 10
ePrescription Logs				

Close

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❖ **Logout of eCW**

To logout of eClinicalWorks, click the **X** in the top right corner of the eClinicalWorks window. When prompted, click Yes to close the application.

When you are finished with your shift, please **close all applications** and **SHUT DOWN your computer!**

😊 Thank you 😊

Computer Usage Guidelines



1. **Sign computers in and out.**

2. **Do NOT remove the chargers from the charging stations.**

If the computer is low on battery, use an extra charger located on the bottom of the computer rack.

3. **Do not leave your computer unattended with eClinicalWorks open.** Log out of eClinicalWorks if you walk away from your computer.

4. **Position computer so that patients cannot see your screen.** It is a HIPAA violation for patients to be able to see the eClinicalWorks application.

5. After shift:

- **Close all applications and SHUT DOWN computer.** (see how to guide on shutting down comp.)
- **PLUG COMPUTER INTO ITS ASSIGNED CHARGING STATION.**
(ex: PM2 → PM2)