eClinicalWorks Clinician Training Guide

Outline

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    ii. Looking at Test Results
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IV. Charting Workflow for Typical Appointment
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  c. Review and Revise sections (Histories, Current Rx…etc.)
  d. Examination
  e. Assessment
  f. Treatment
    i. Medication
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    iii. Diagnostic Imaging
    iv. Referrals
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  i. Next Appointment
  j. Locking Progress Note
V. Looking Up a Patient

Part I. Login

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: _____

**Please contact Sarah Labriny if you have questions or concerns regarding eClinicalWorks at CrossOver Healthcare Ministry:

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Last Updated on 2/18/19 by Sarah Labriny

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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:

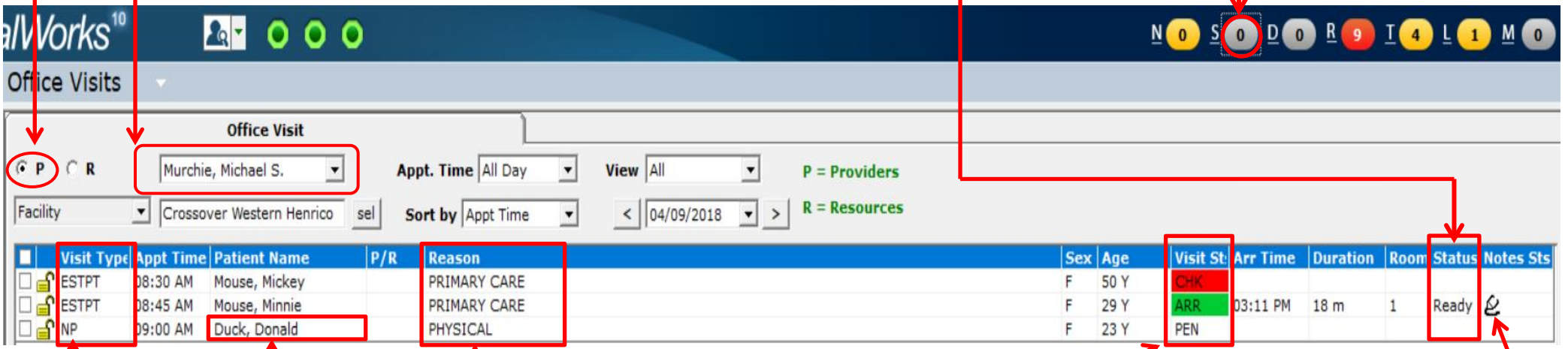
[#1] Select the "P" radio button on the top left.

[#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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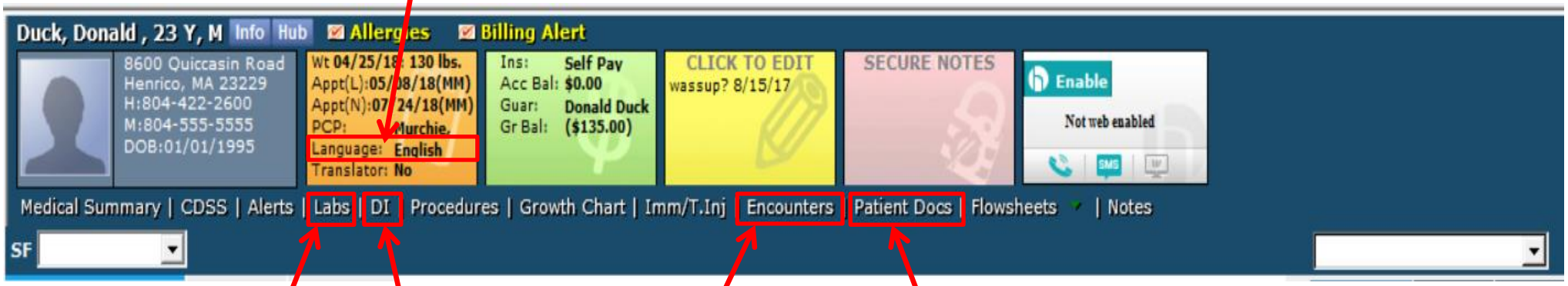
Part III. Prepping for a Patient

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).



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

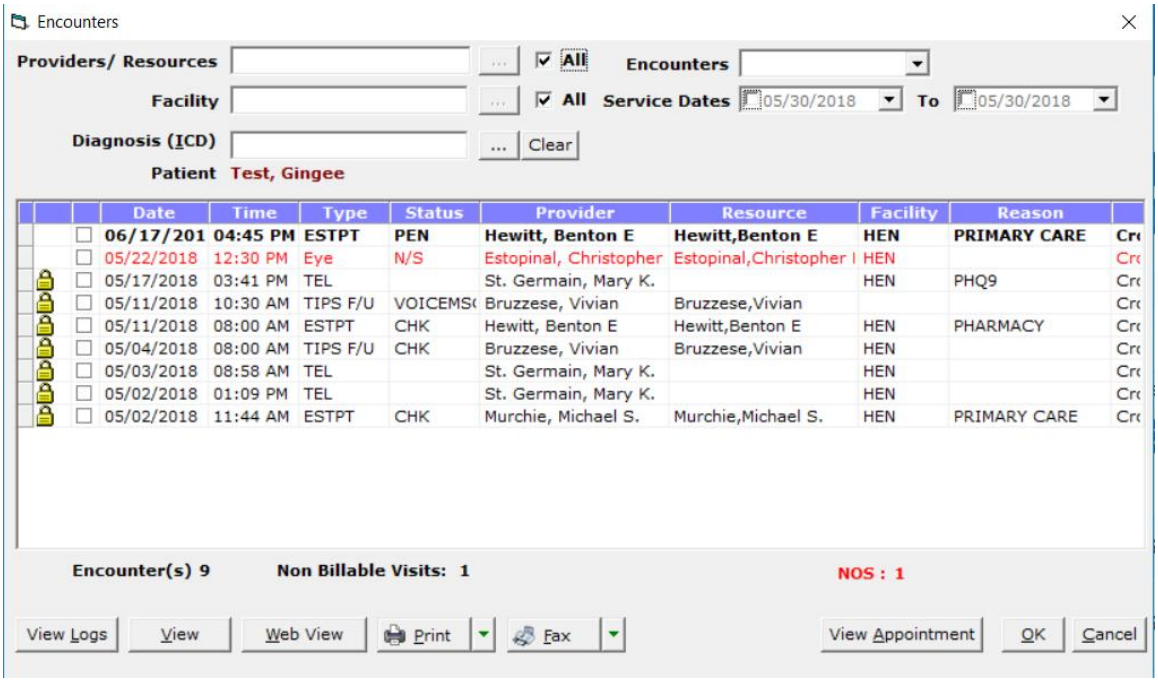
Patient Docs: contains scans of hospitalization records, discharge papers, external test results…etc.

See pg. 6

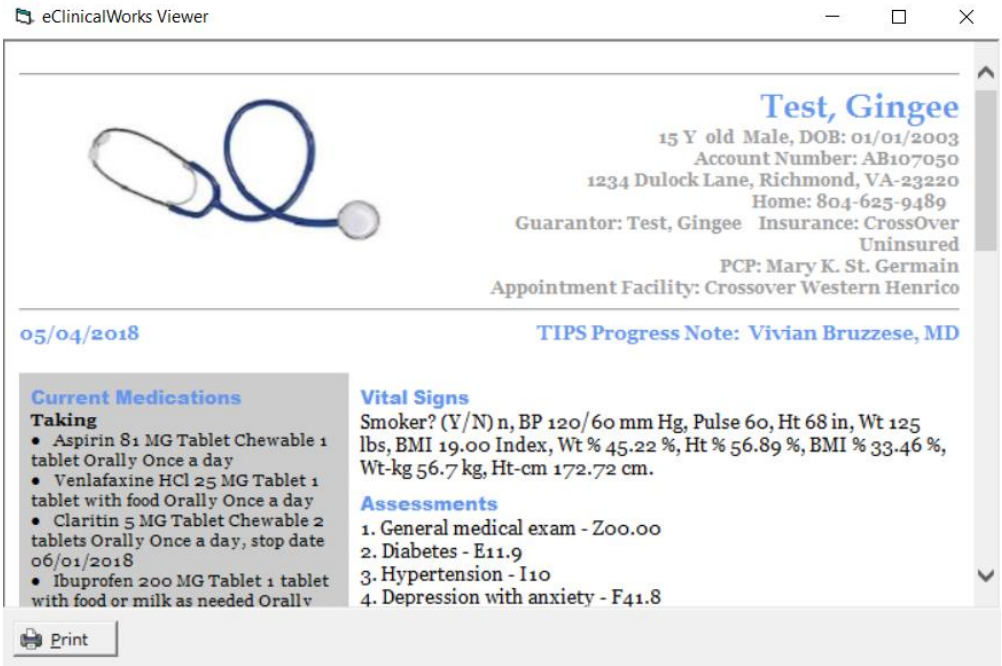
Viewing Past Appointments

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.



View the locked progress note:



Finding Test Results

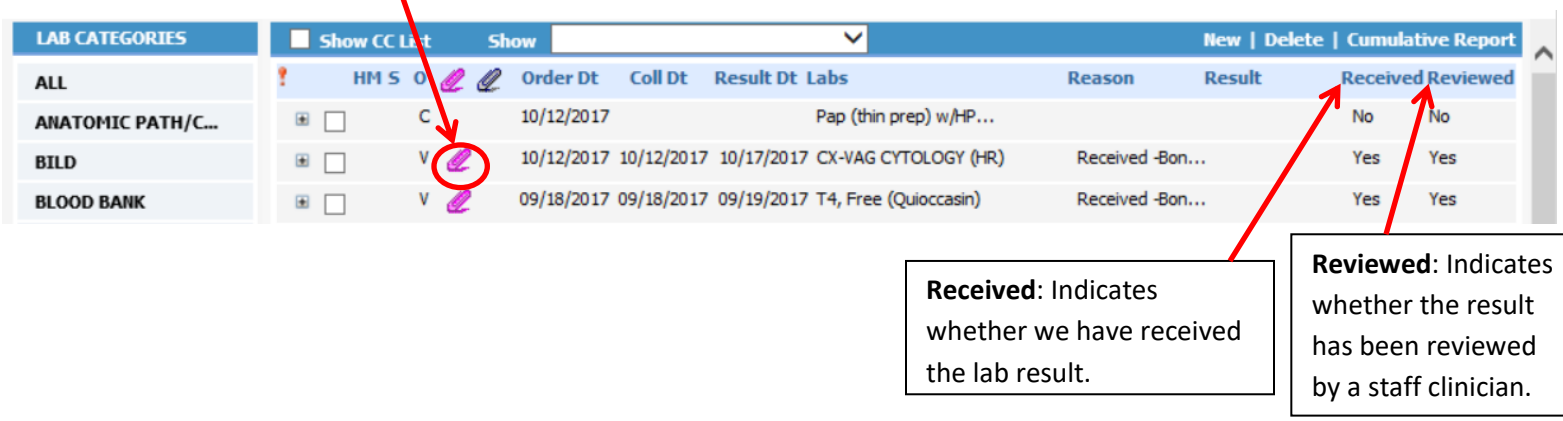
Test results are generally in one of three places:

1. Labs
2. DI
3. Patient Documents

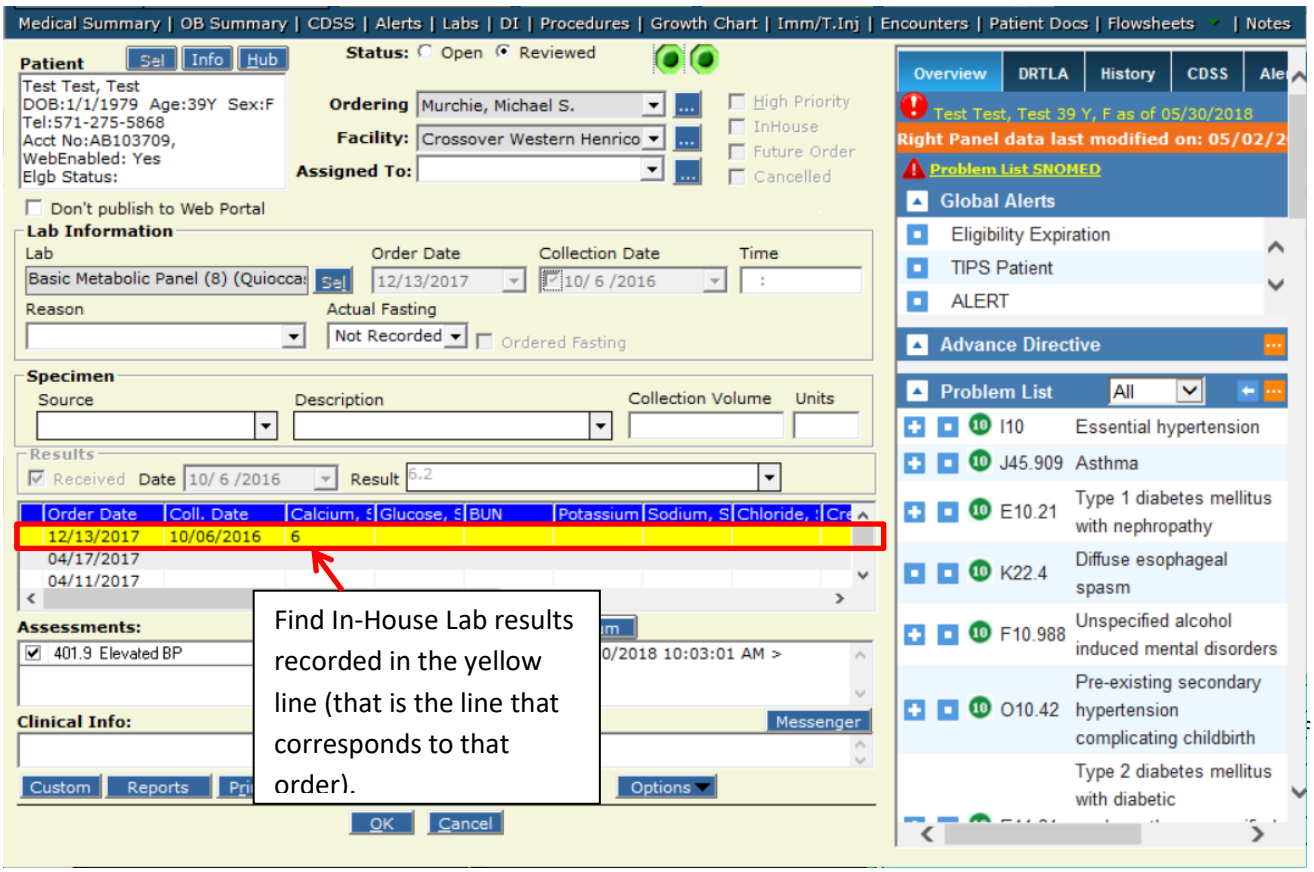
You can access these sections through the Patient Dashboard in the Progress Note or through the Patient Hub (see Part V. of this guide).

1—Labs

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



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



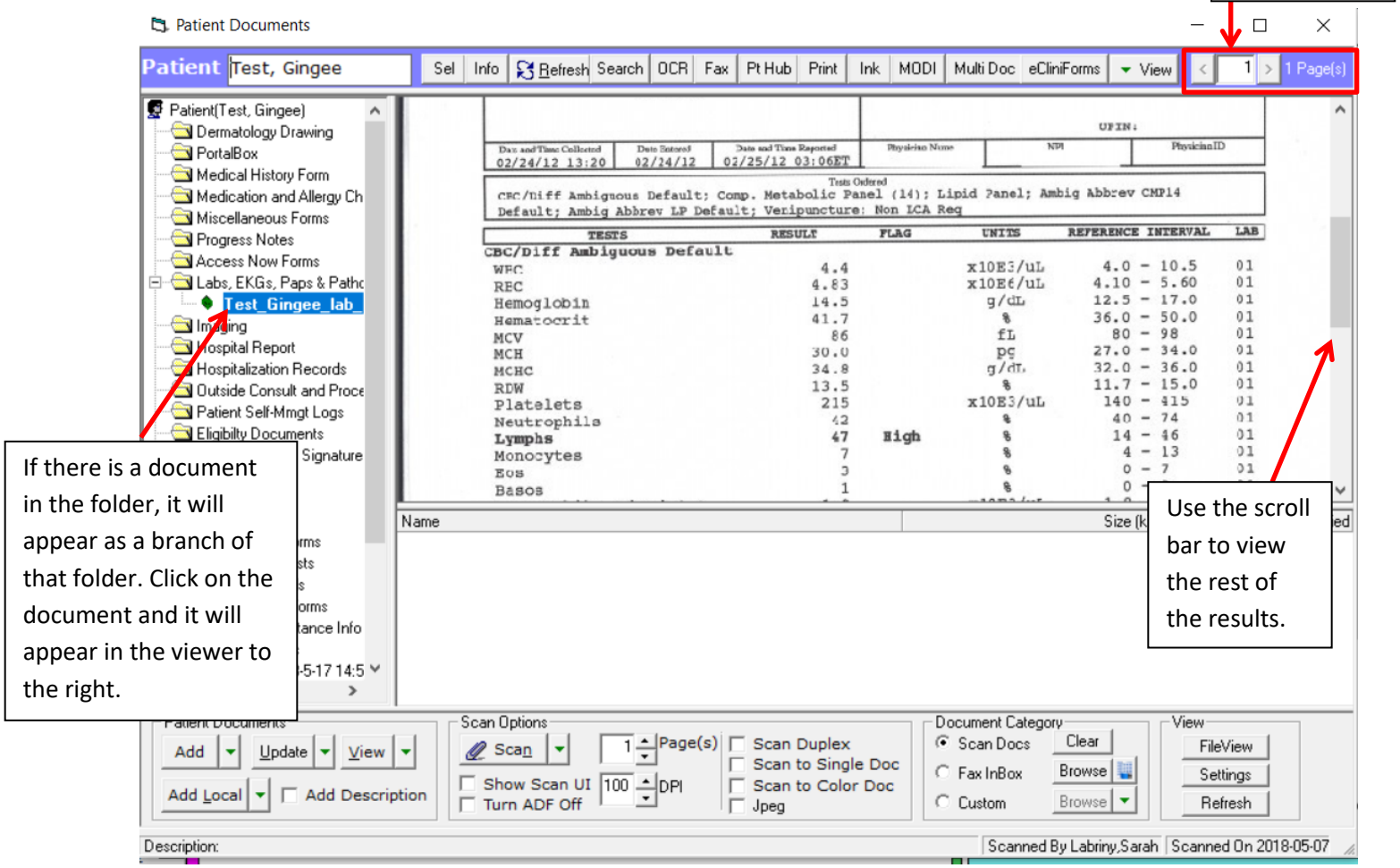
2—DI (Diagnostic Imaging)

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.



Section B. Right Chart Panel

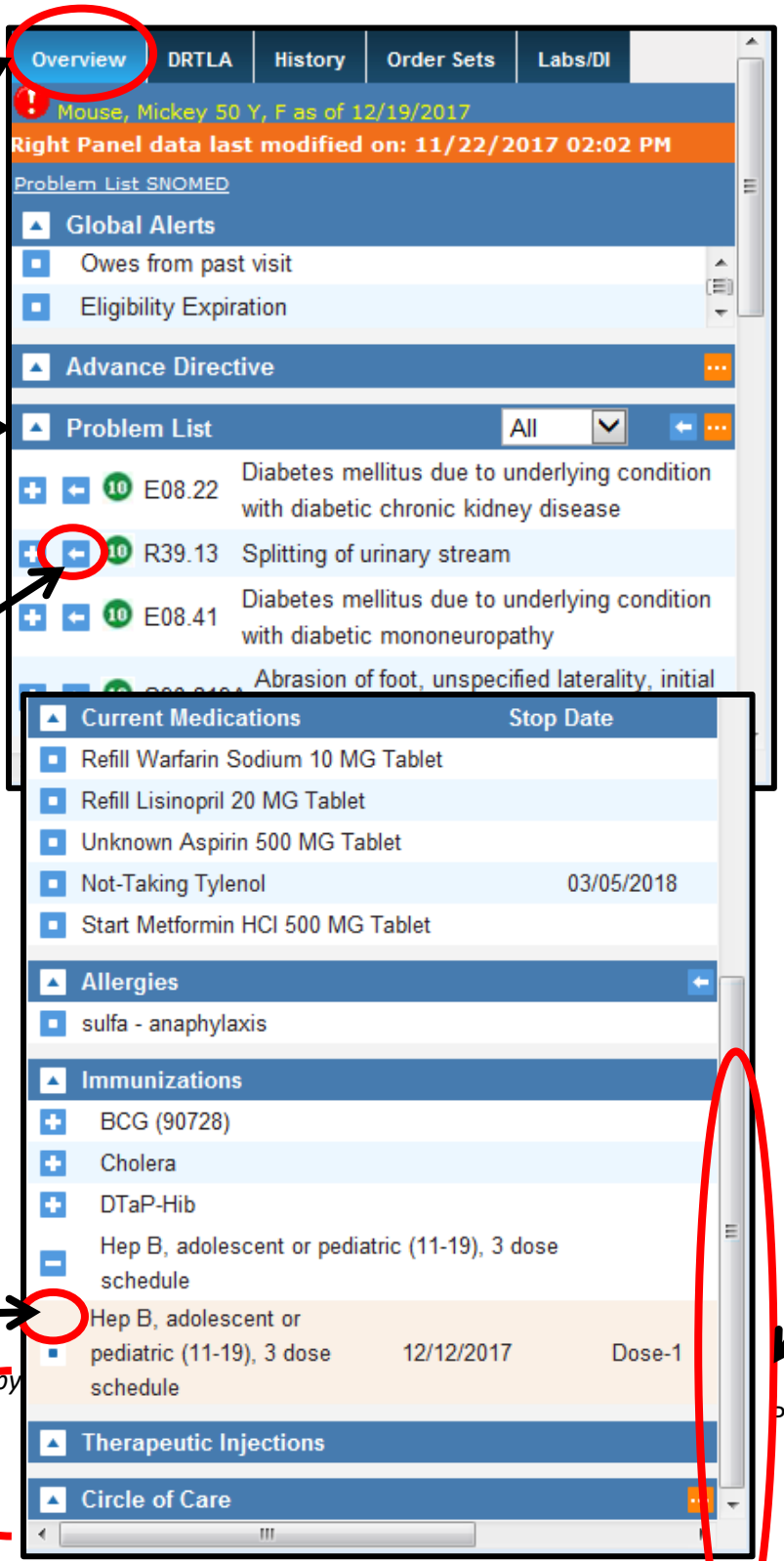
Right Chart Panel: Overview Tab

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.

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.



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

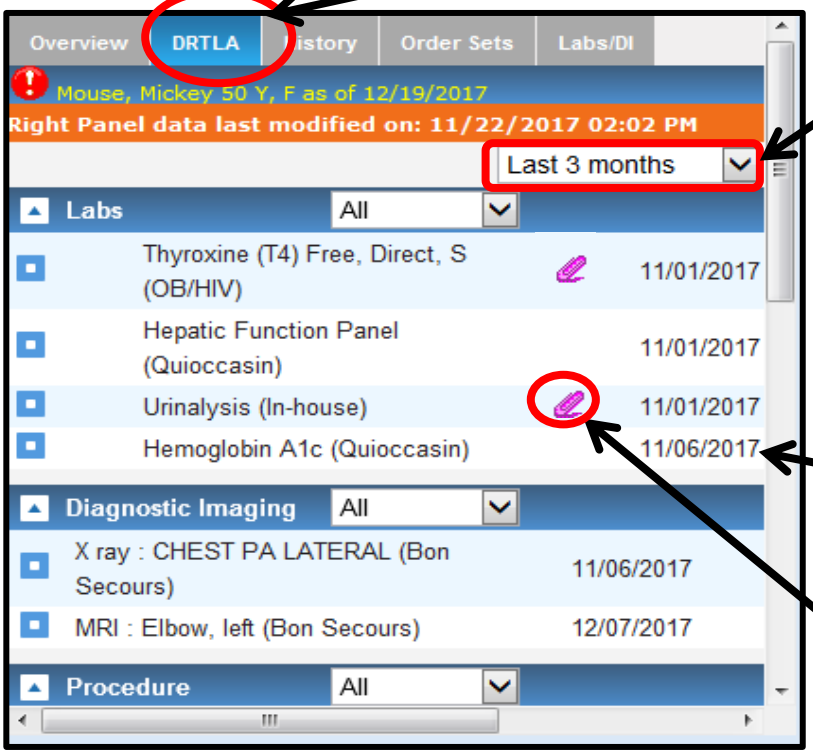
Click on plus sign to display more details about the immunization. A minus sign will appear with bullet points detailing the date of the vaccine and which dose it was in the series.

/18/19 by

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.

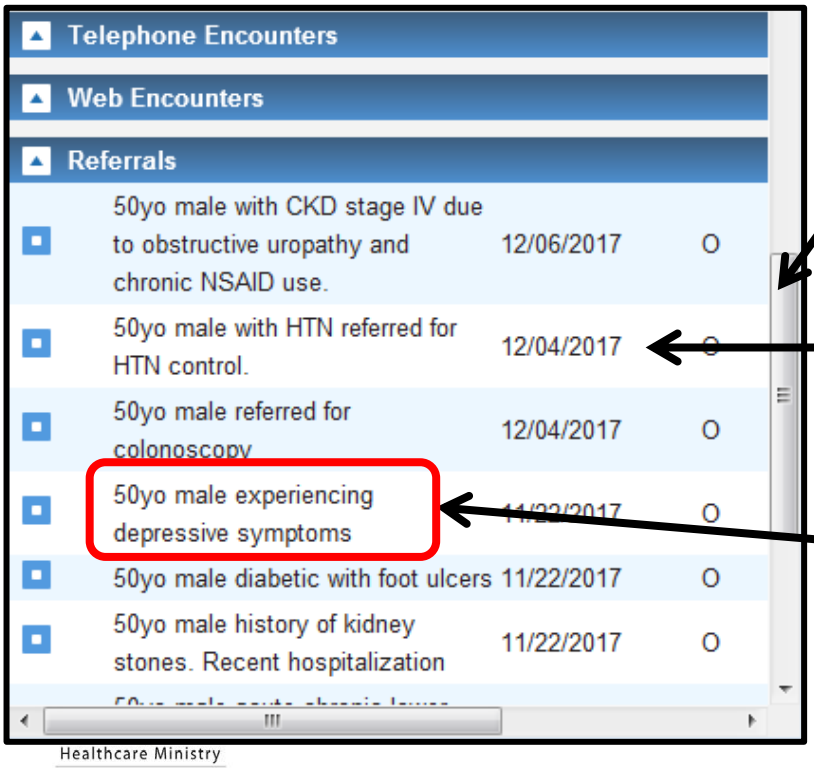
Click on "DRTLA" in the Right Chart Panel



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)



Scroll down to view Referrals section.

Date referral was made in eClinicalWorks

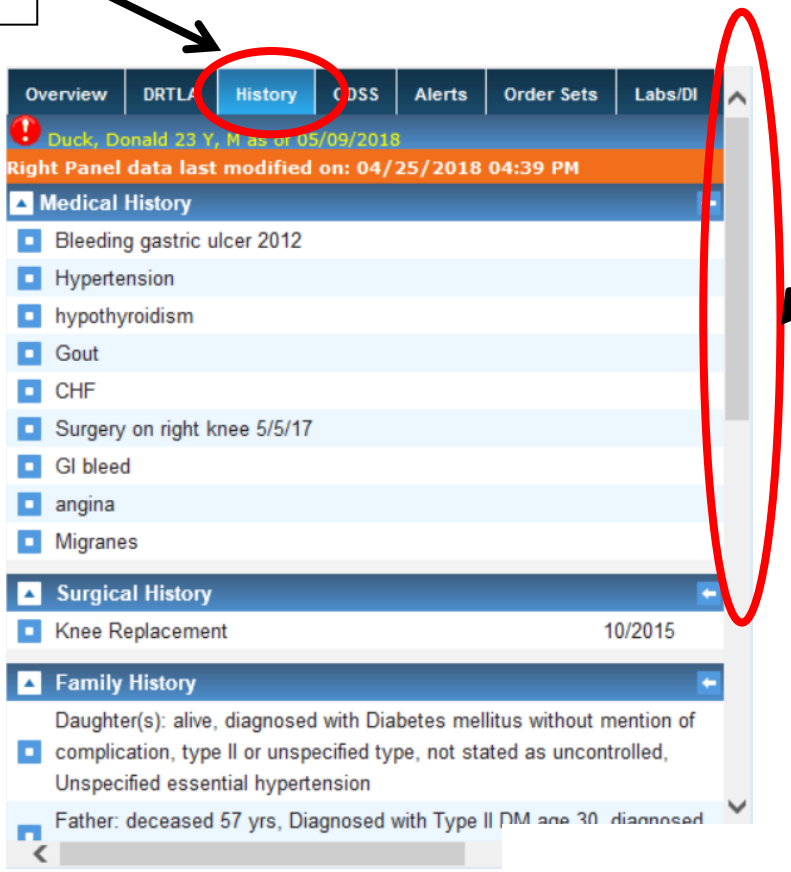
Click on the reason for the referral to view the "Outgoing Referral Window", where you will see a "specialty" field indicating what kind of specialist the patient has been referred to.

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 only)	14. Treatment
15. Immunizations: Administer immunizations (Nurses only place the standing order immunization: flu shot.)	15. Immunizations: Order Immunizations
	16. Next Appointment

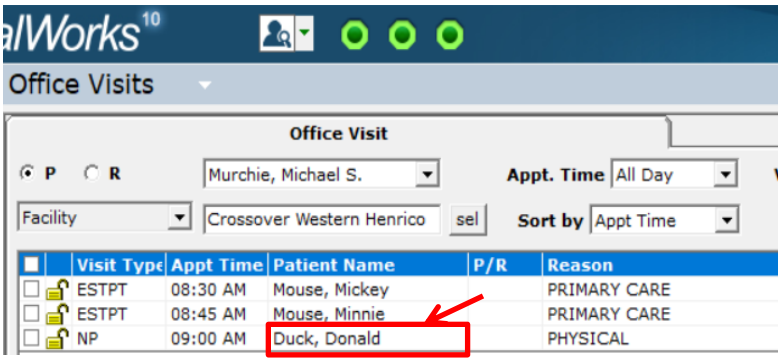
* = only necessary to fill out for New Patient appointment

Last Updated on 2/18/19 by Sarah Labriny

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).



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

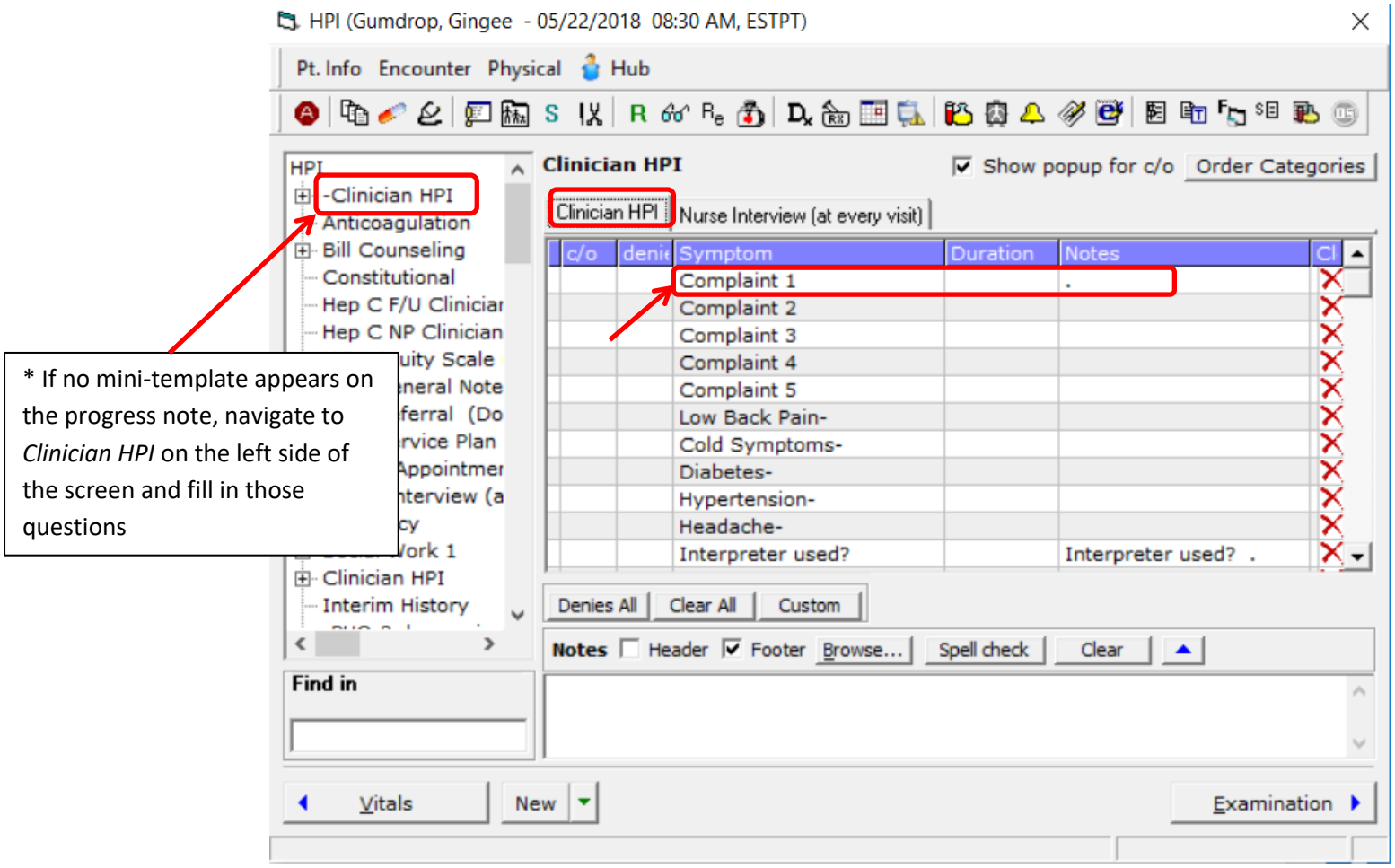
Medical History:
Allergies/Intolerance:

La

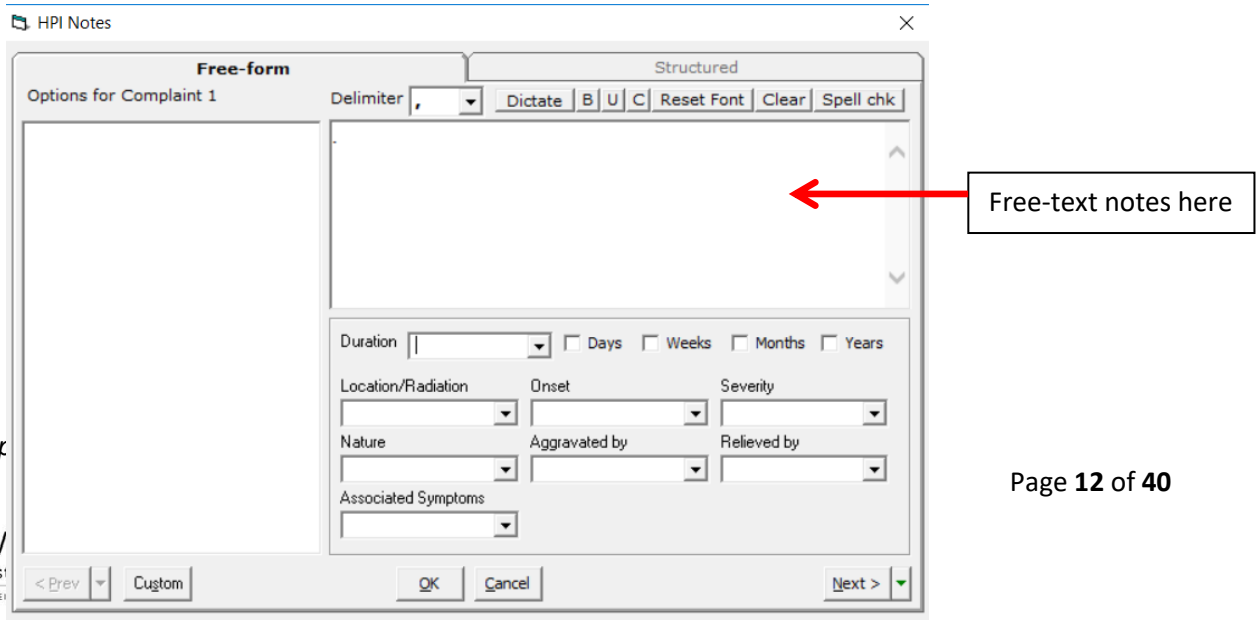
Gyn History:
OB History:
Surgical History:
Hospitalization:
Family History:
Social History:
ROS:

Section B: HPI (History of Present Illness)

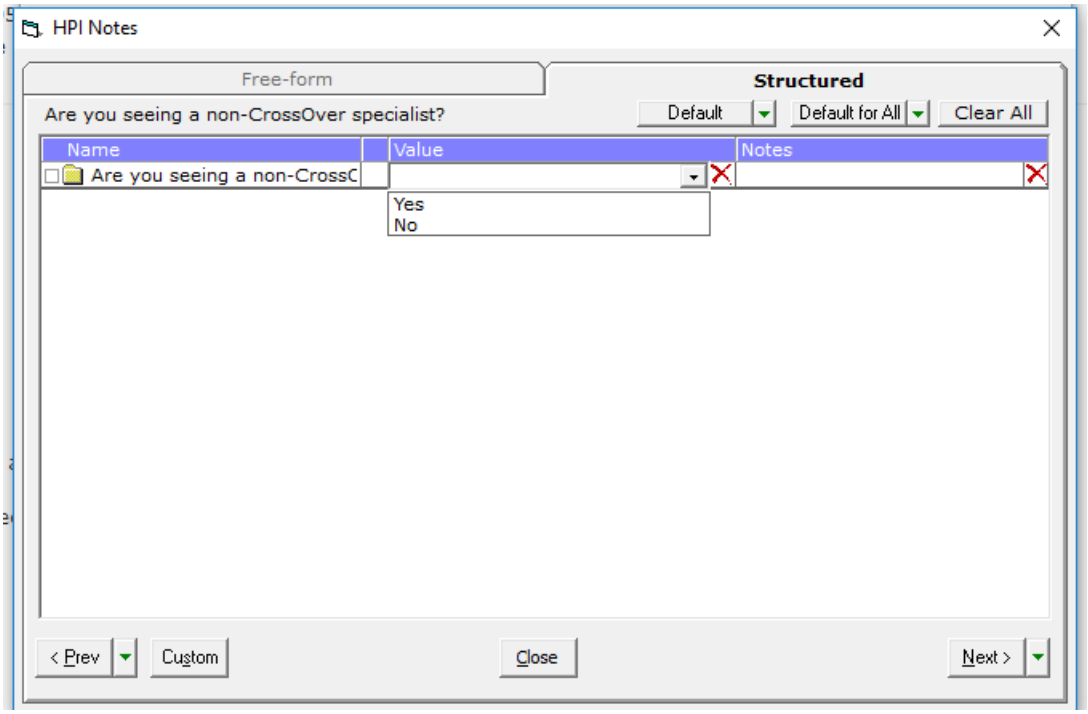
1. Click on the "Notes" box that corresponds to Complaint 1.



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



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



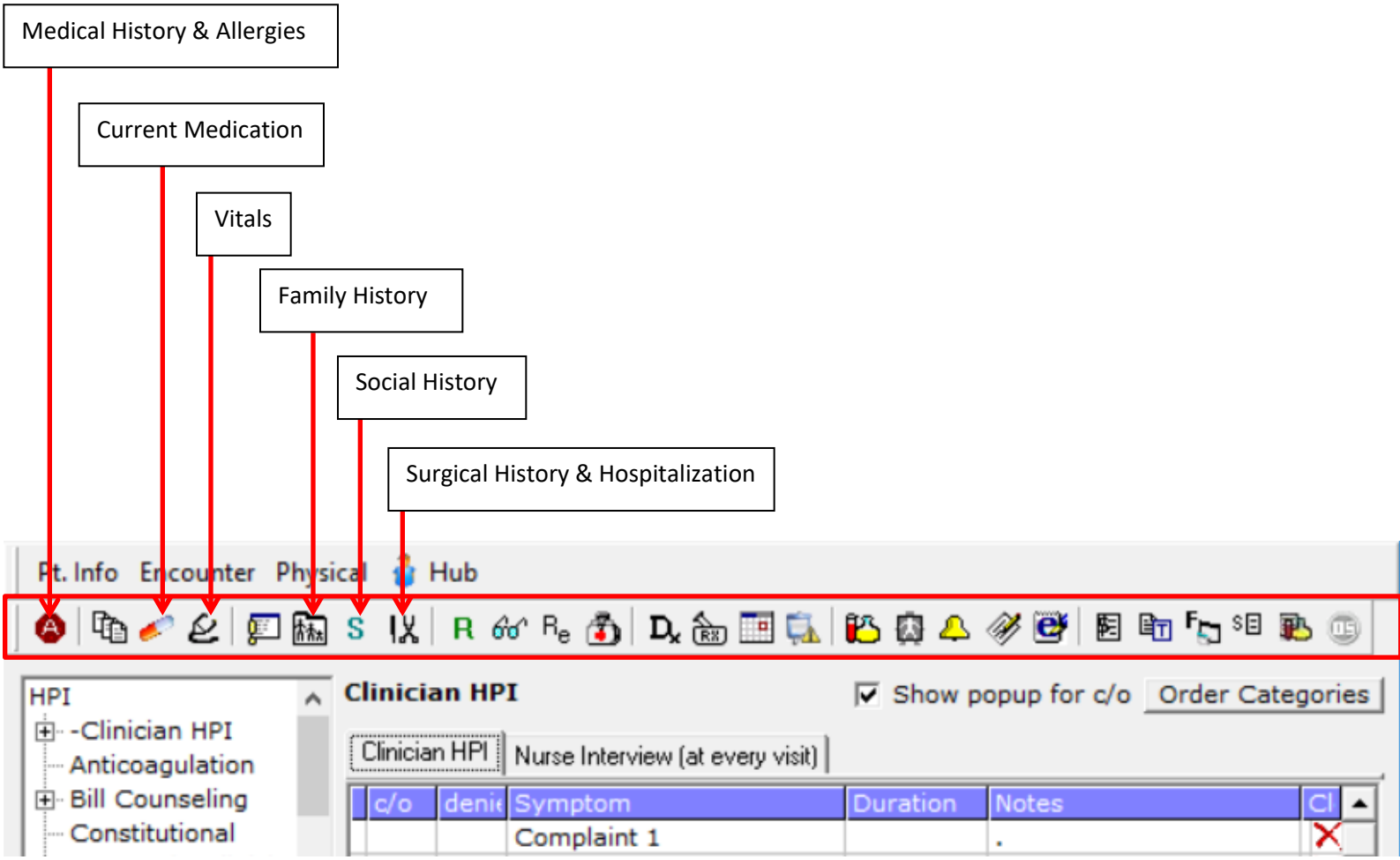
Section C: Review and Revise Sections

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.

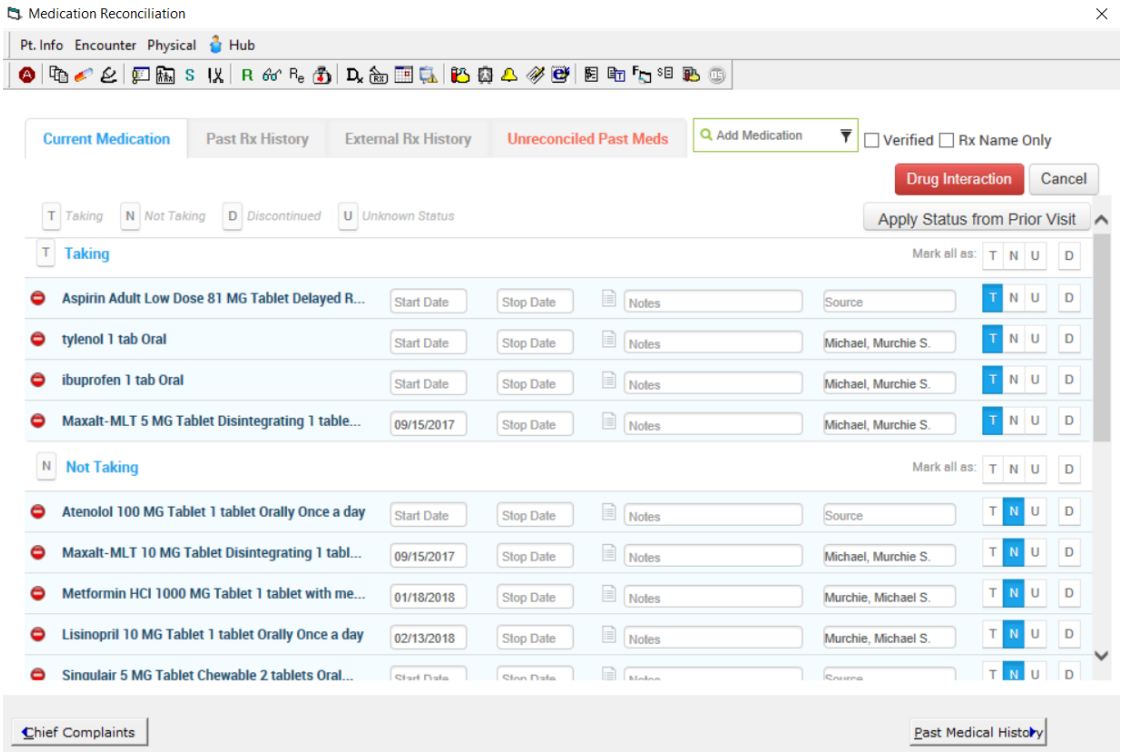
Once you open a hyperlink, you can access other sections of the Progress Note by clicking on the picture icons located at the top of the hyperlinked screens. Hover over the picture icons to see which sections they represent:



1—Current Medication (Review and Revise as needed)

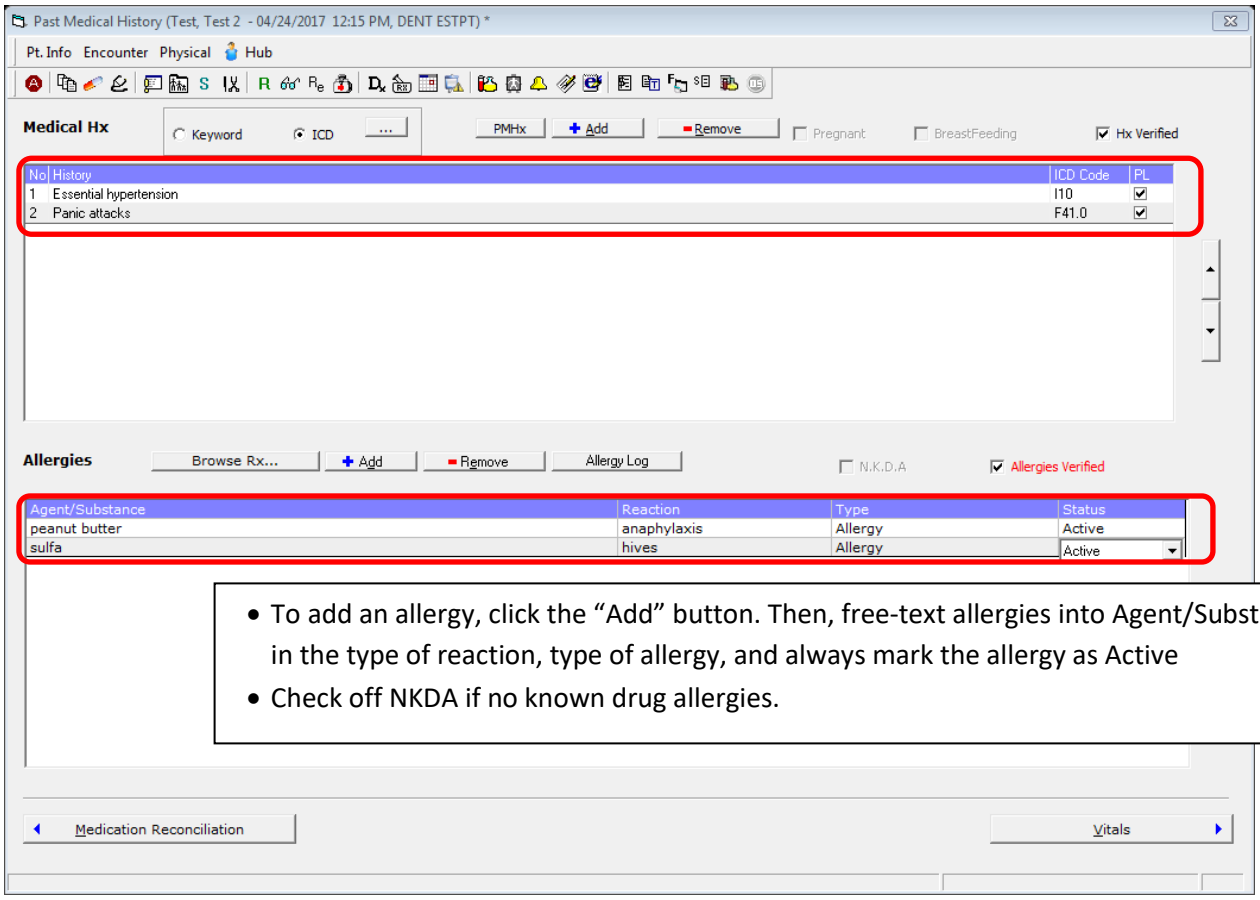
This section contains all medication the patient is supposed to be taking according to what was prescribed during their last visit. The nurse conducts medication reconciliation prior to the clinician interview with the patient.

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



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

Add Medical History and Allergies as needed.

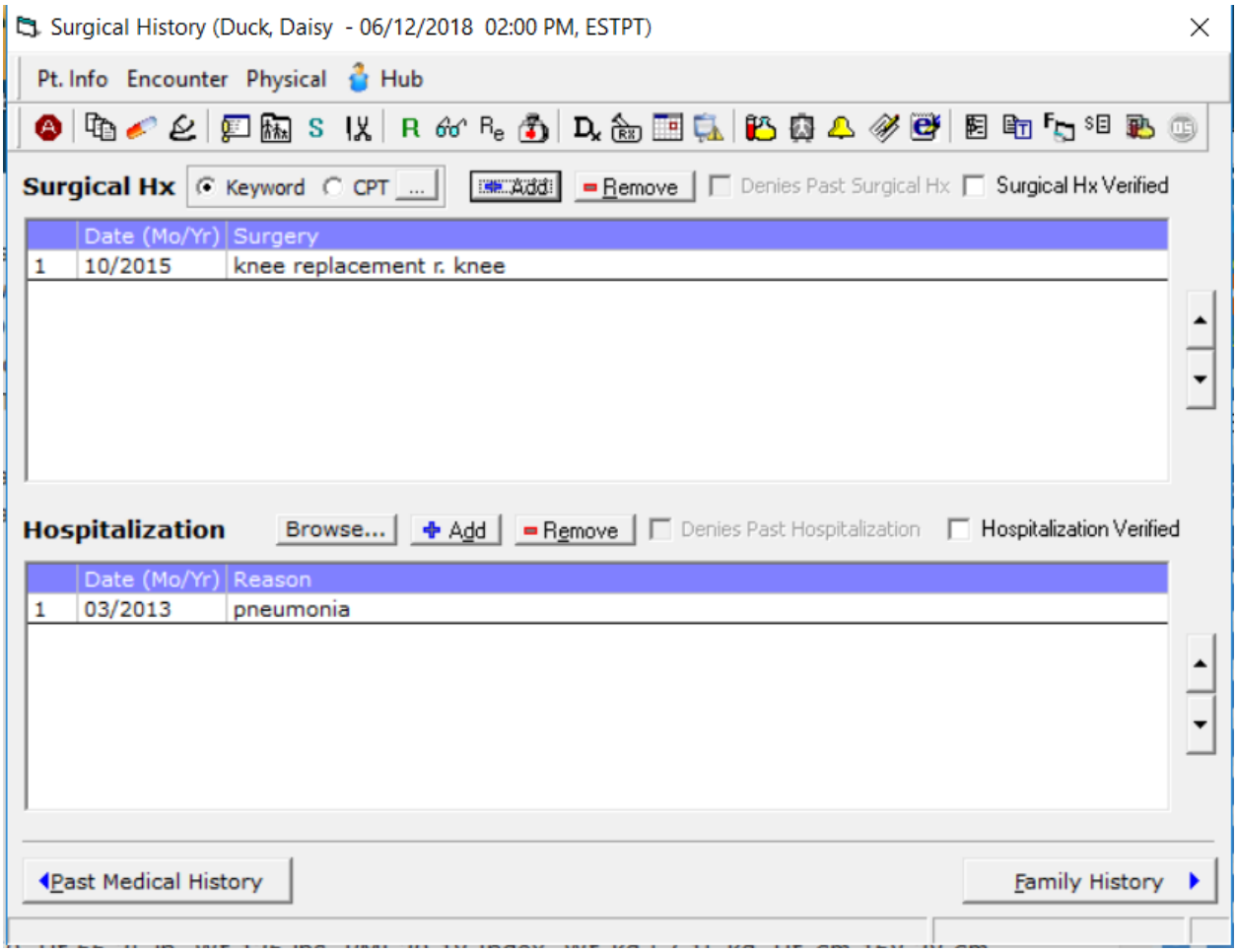


3—GYN History (Review and Revise as needed)

Use the blue hyperlink to access this section.

4—Surgical History & Hospitalization History

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



5—Family History (Review and Revise as needed)

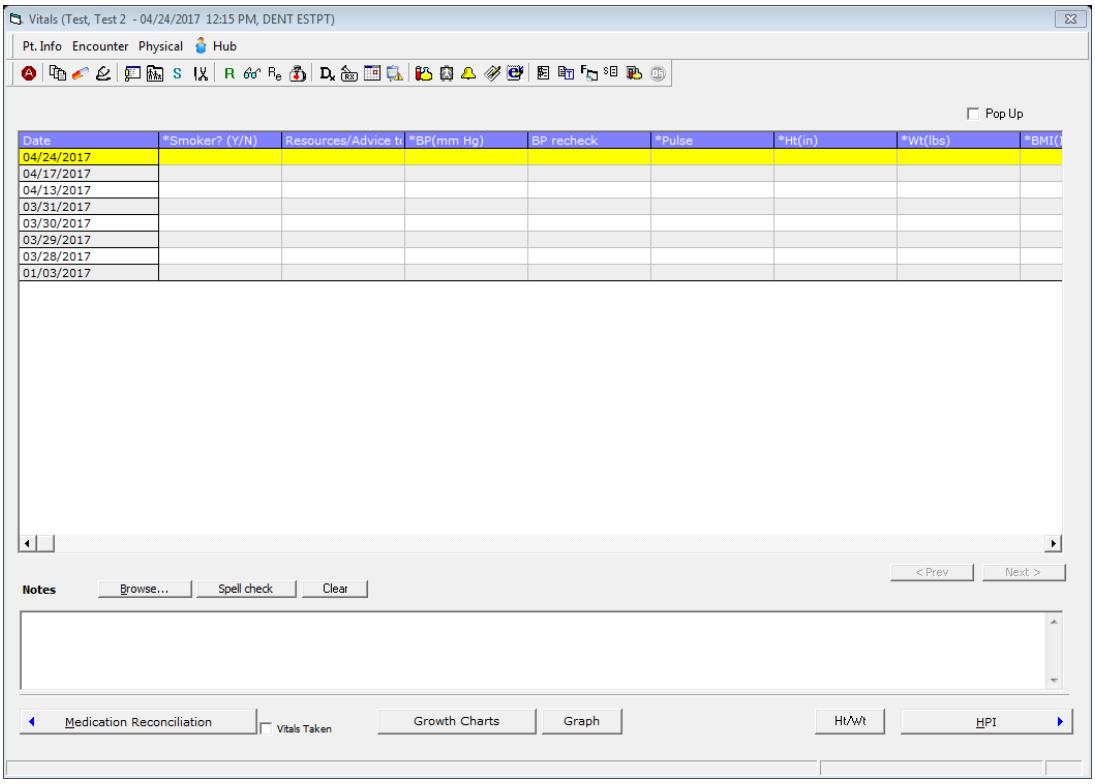
Use the blue hyperlink to access this section.

6—Social History (Review and Revise as needed)

Use the blue hyperlink to access this section.

7—Vitals (Review and Revise as needed)

Use the blue hyperlink to access this section.



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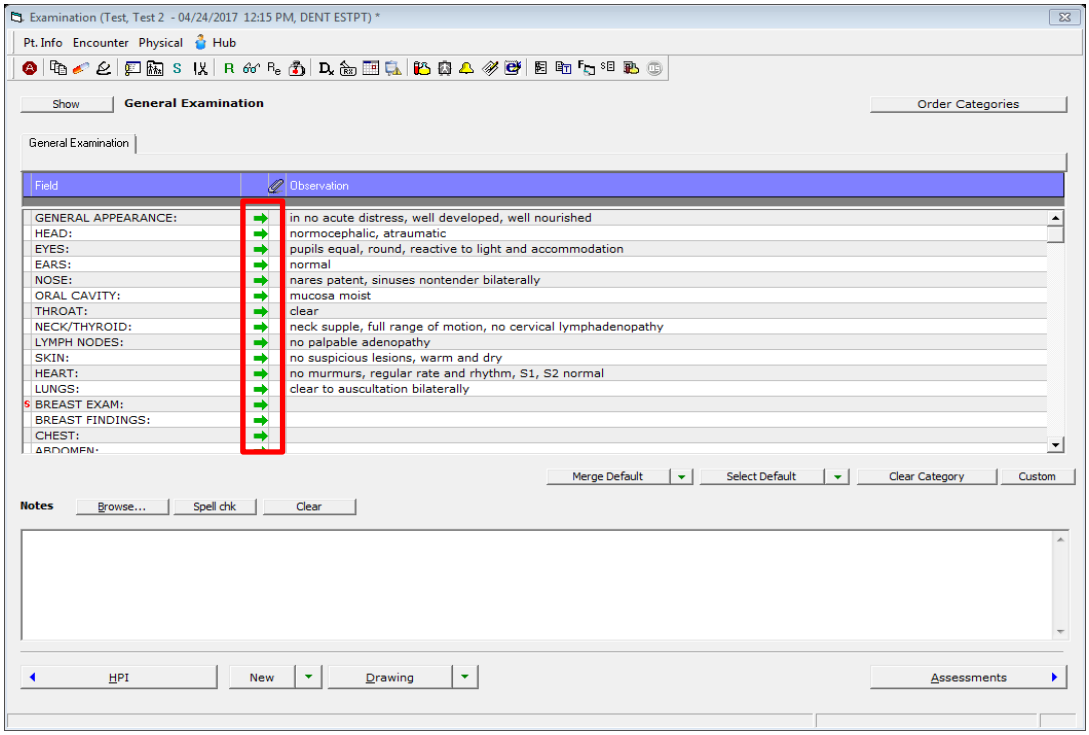
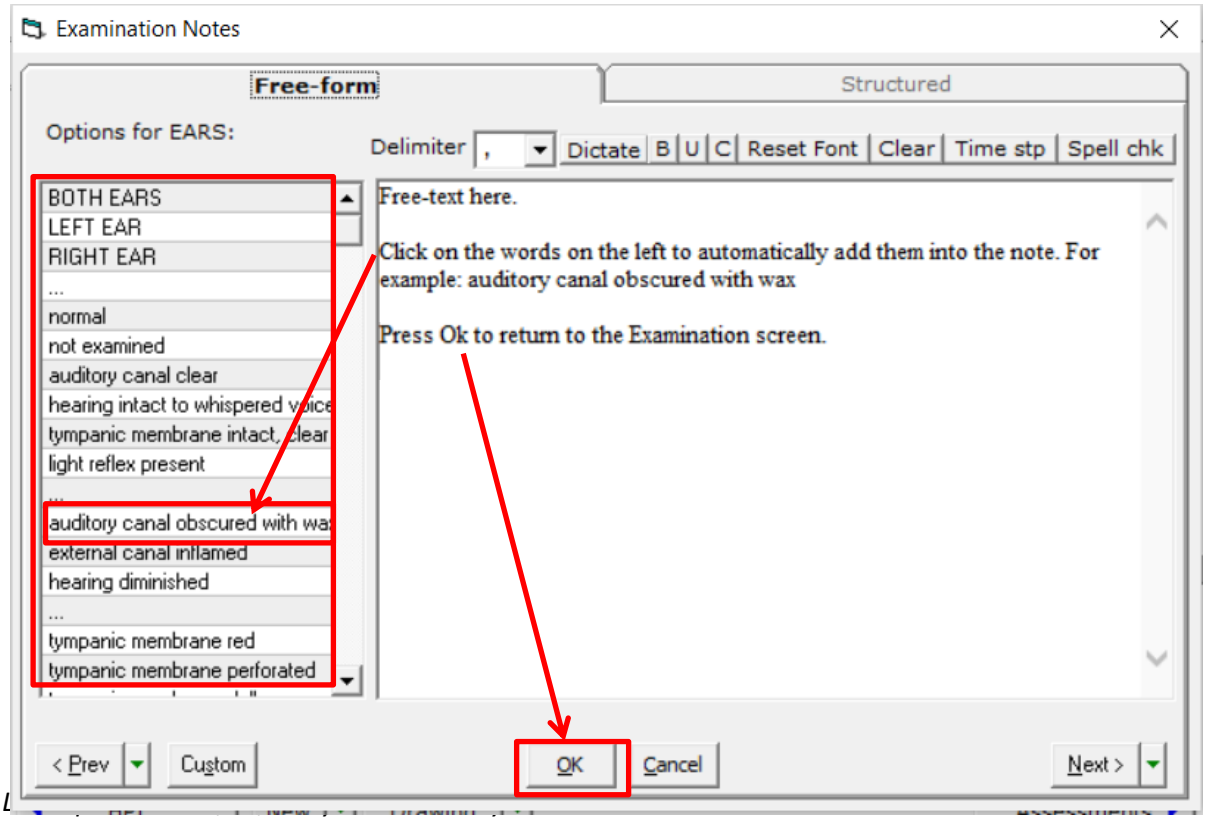
Section D: Examination

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.





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

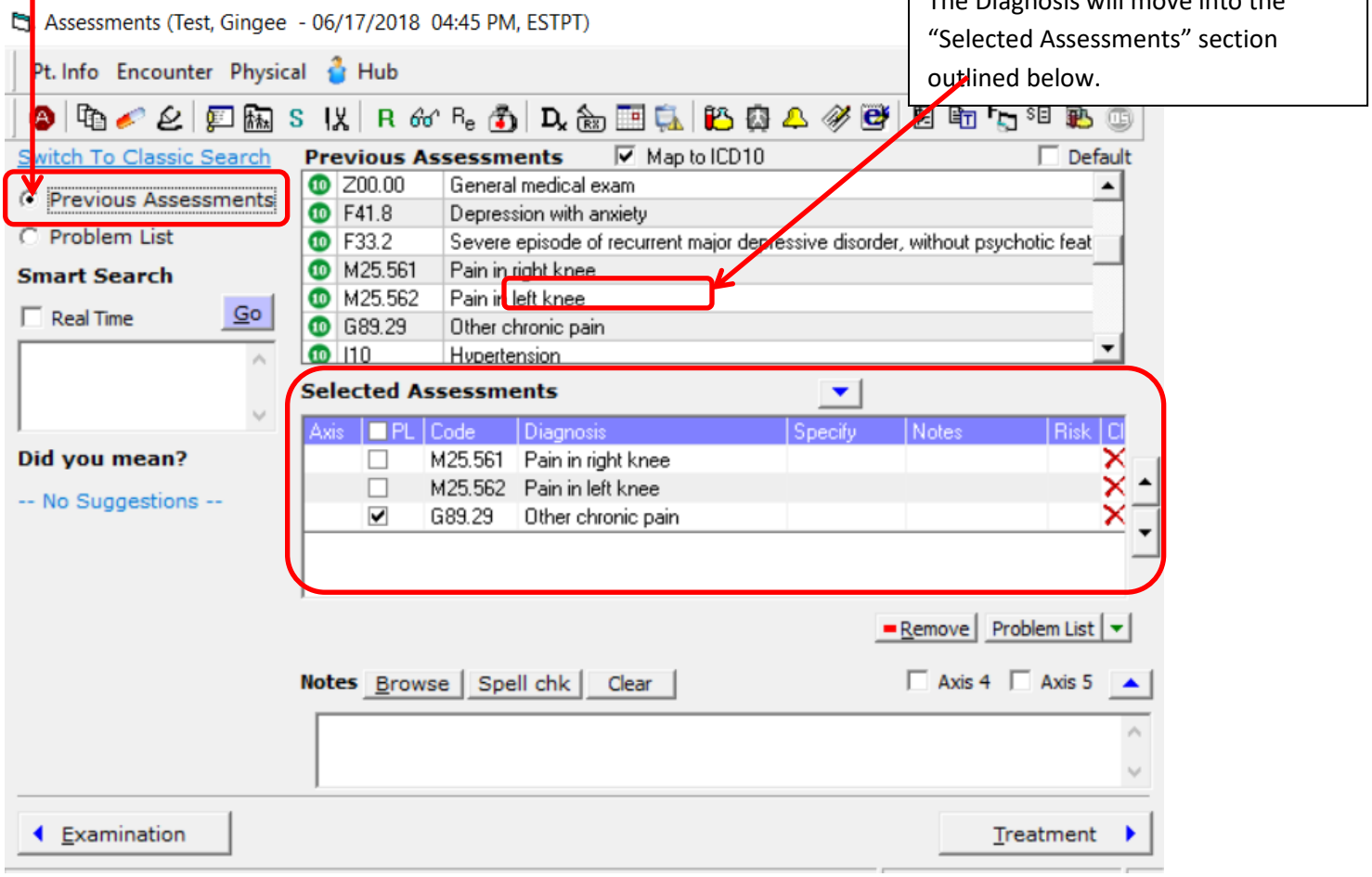
1. Pull-up existing diagnoses
2. Put in new Diagnosis codes

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.

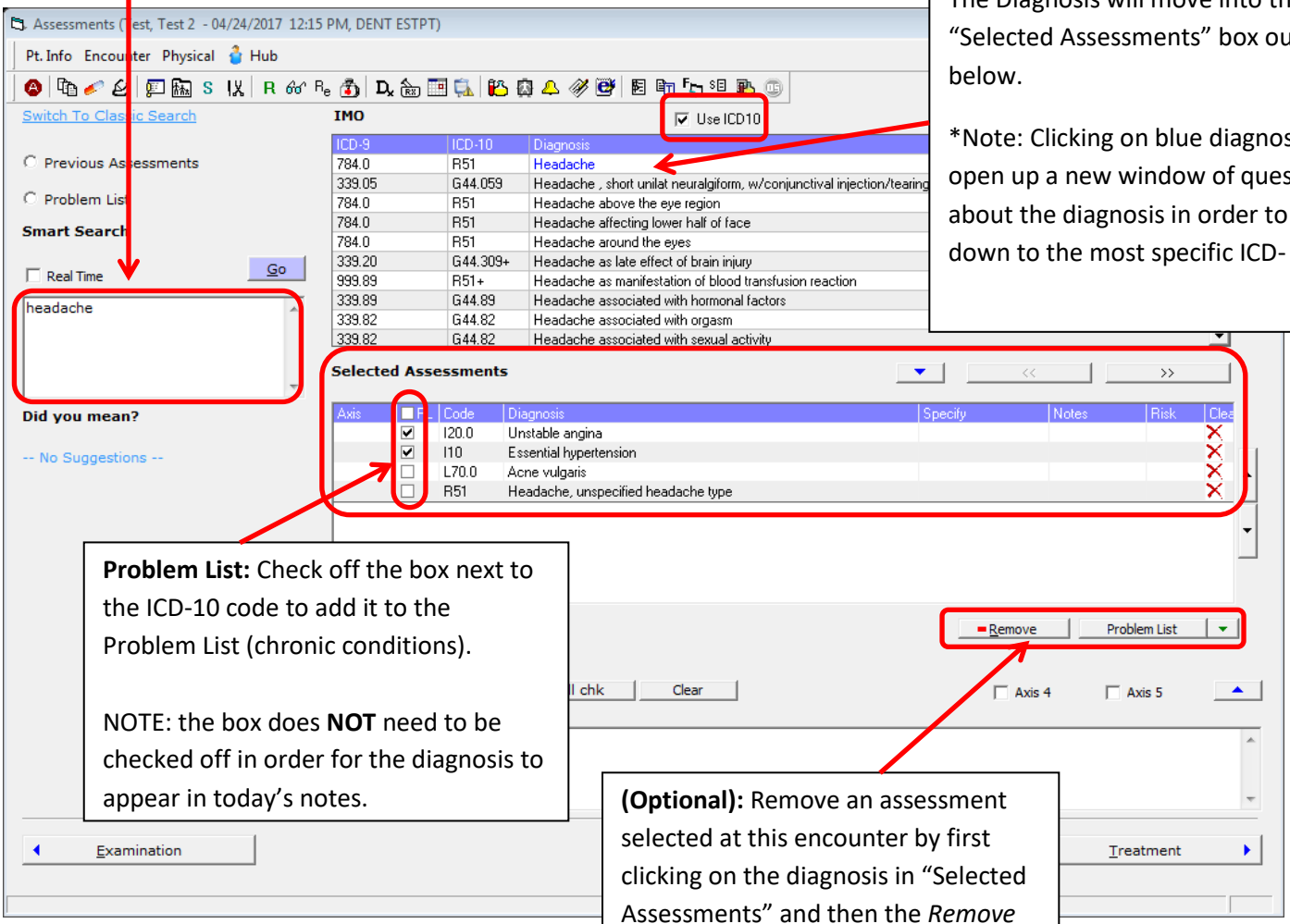


2—Putting-In New Diagnoses

#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.



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.

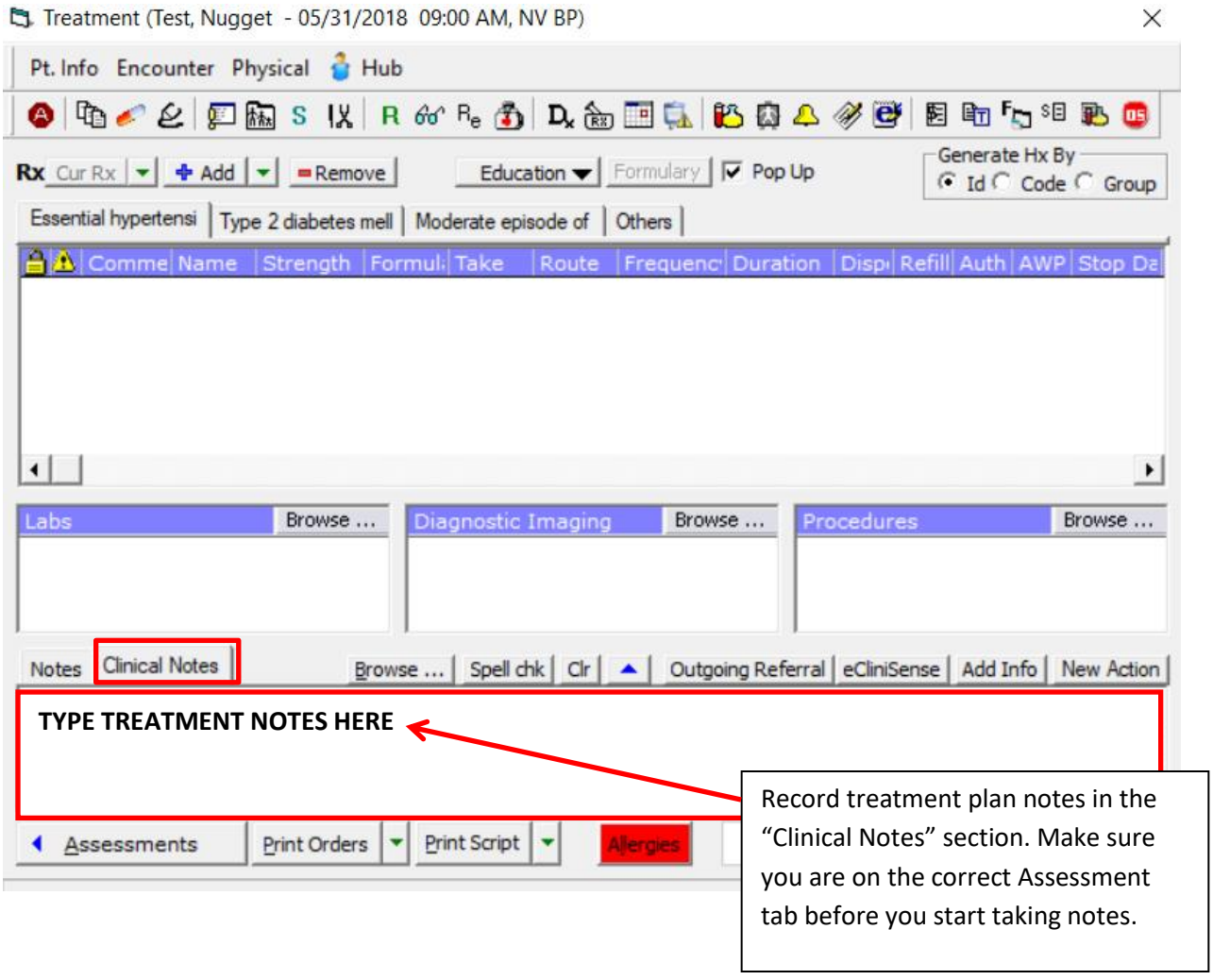
(Optional): Remove an assessment selected at this encounter by first clicking on the diagnosis in "Selected Assessments" and then the *Remove* button

- (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.

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.



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

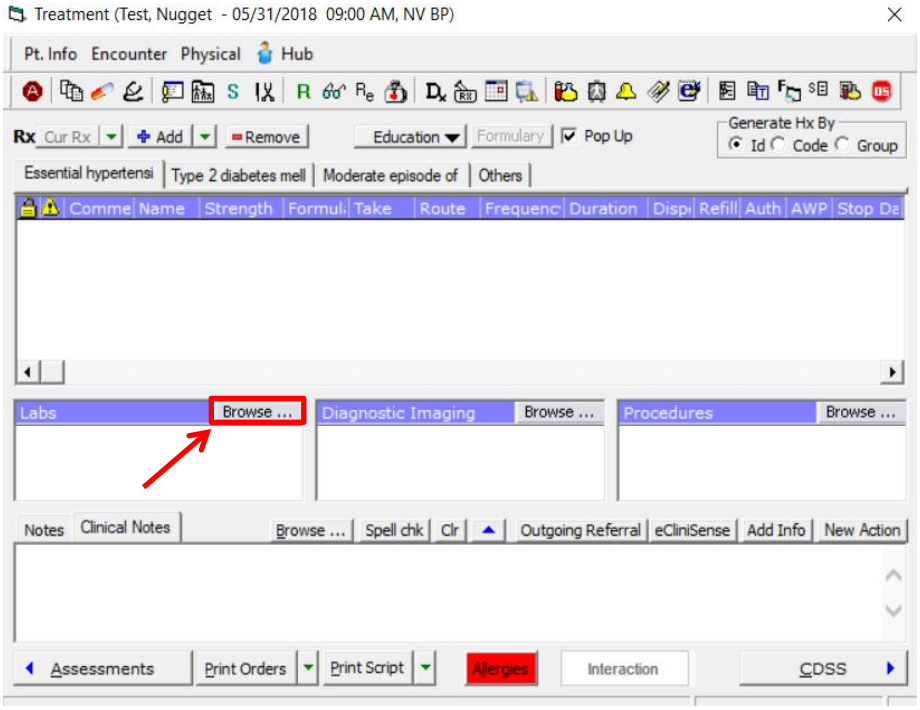
2—Ordering Labs (from the Treatment Screen)

Lab Ordering Policy:

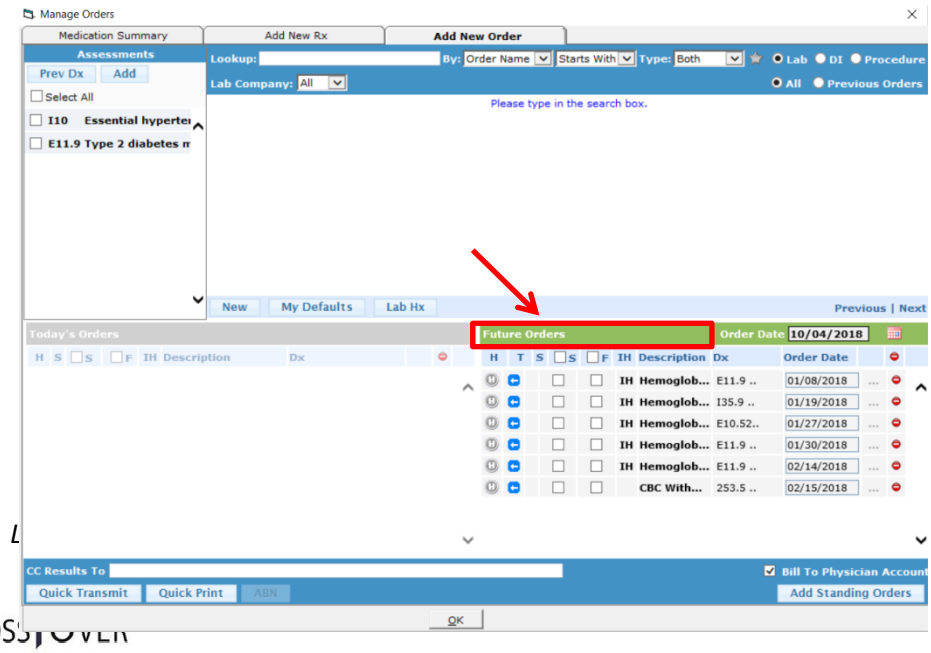
ALL labs should be ordered as FUTURE ORDERS (even if the hope is that they can be done same day).

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

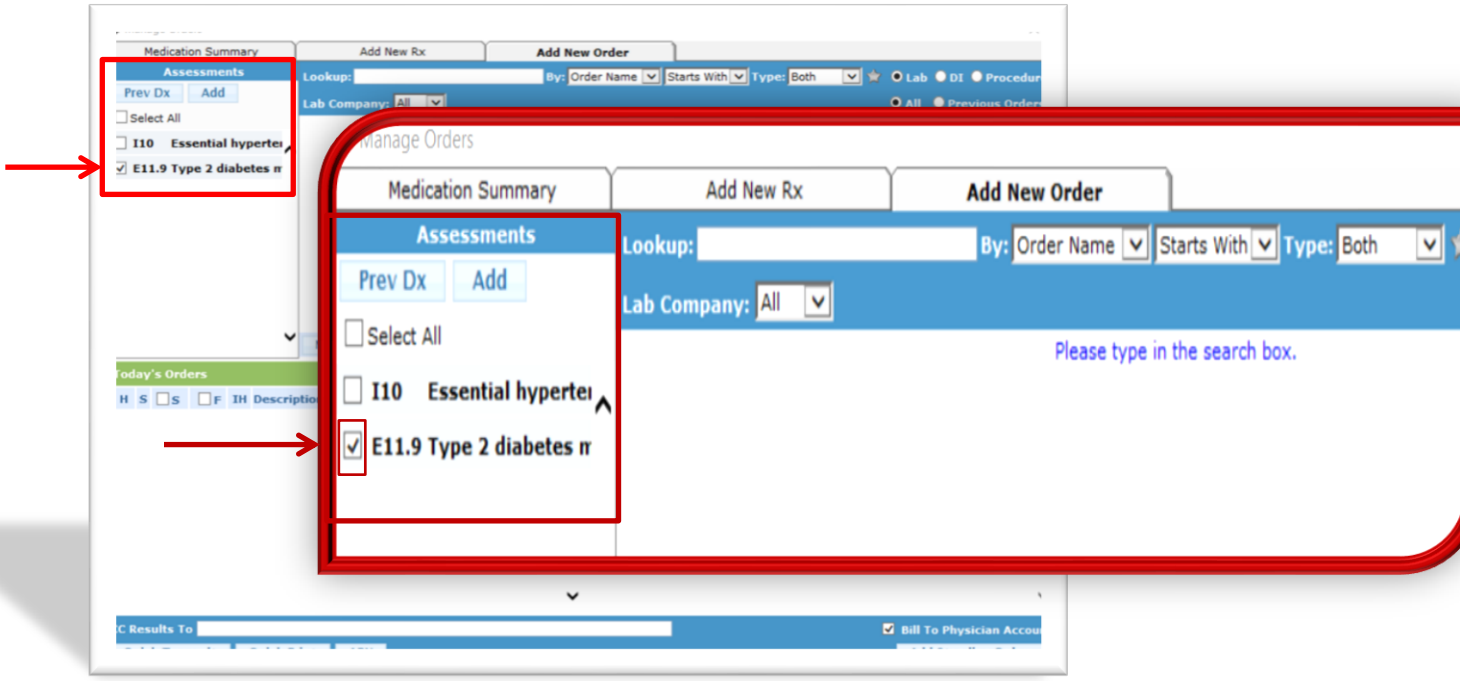
1. Click the "Browse" button next to Labs.



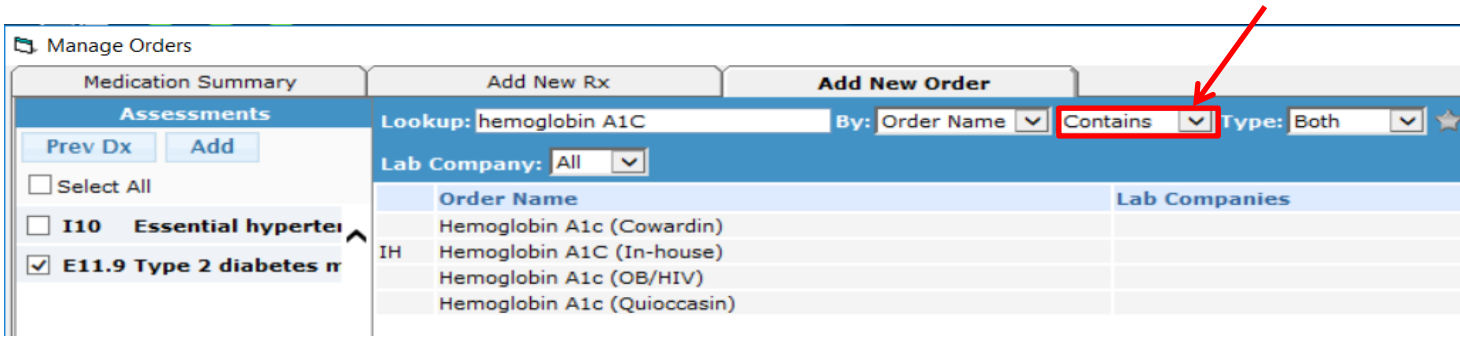
2. Select Future Orders



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



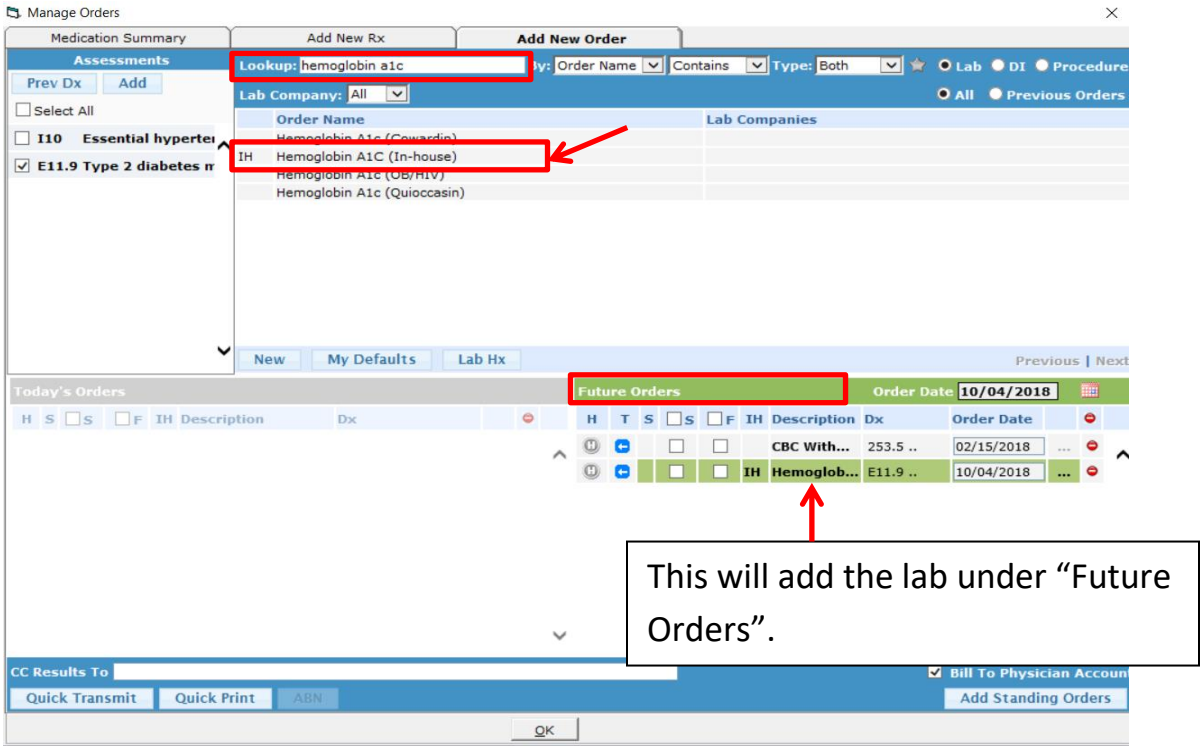
4. Change the search criteria from "Starts with" to "Contains" (this makes the lab easier to find).



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:

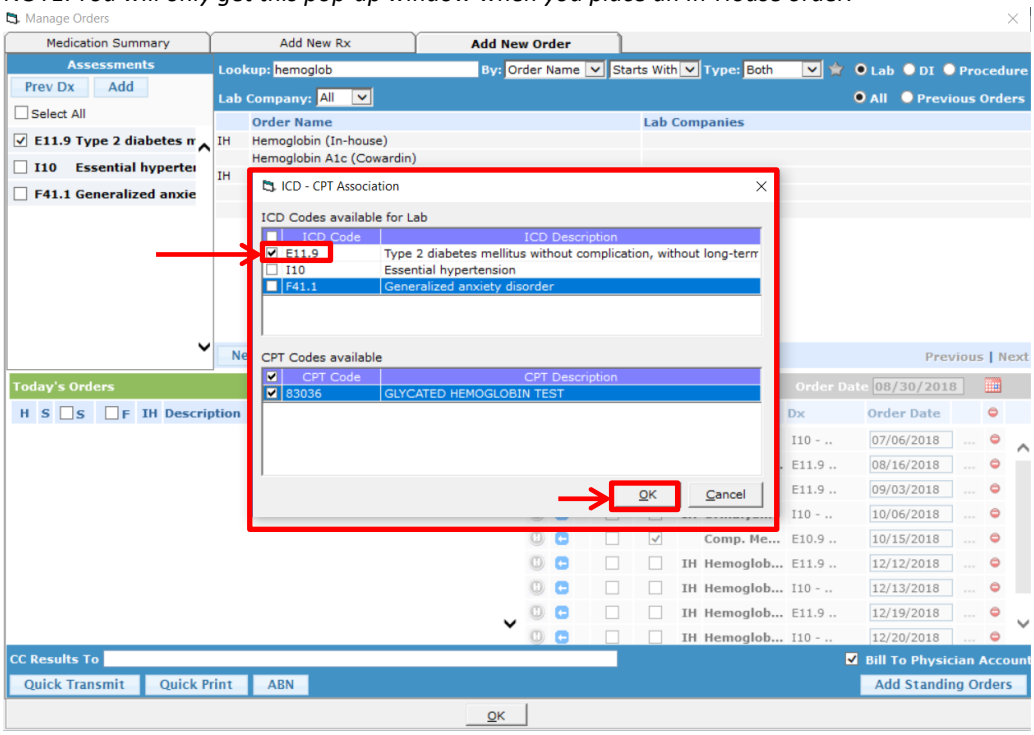
- If you are at the **Henrico Clinic**: choose the **"Quioccasin"** option.
- If you are at the **Cowardin Clinic**: choose the **"Cowardin"** option.

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

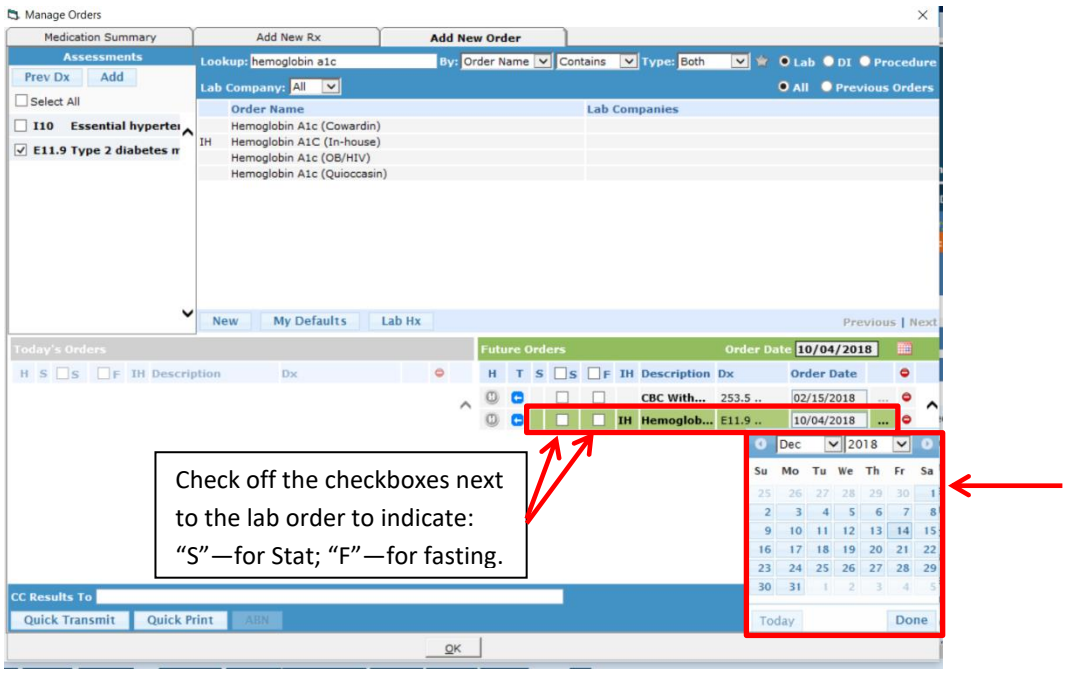


6. The ICD-CPT Association box will appear. Check off the box next to the ICD-10 code for which you are placing the order. (If applicable, check off more than one.) Then, press Ok.

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



7. 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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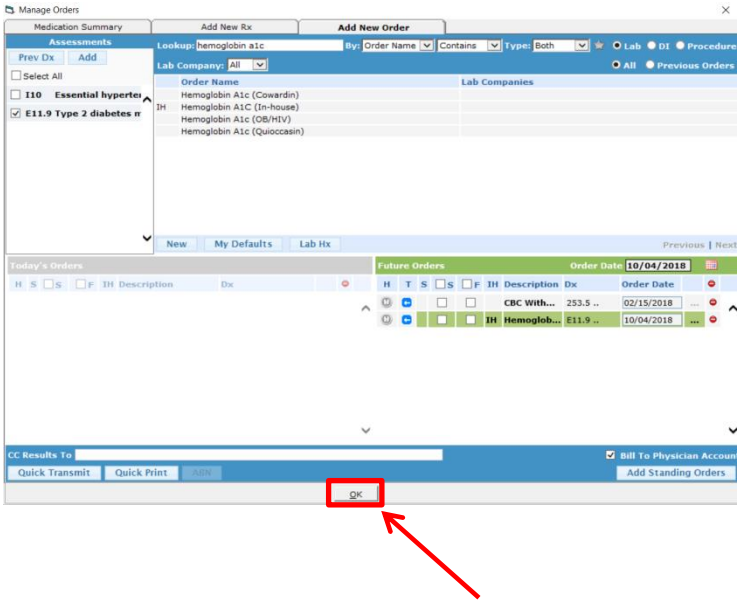
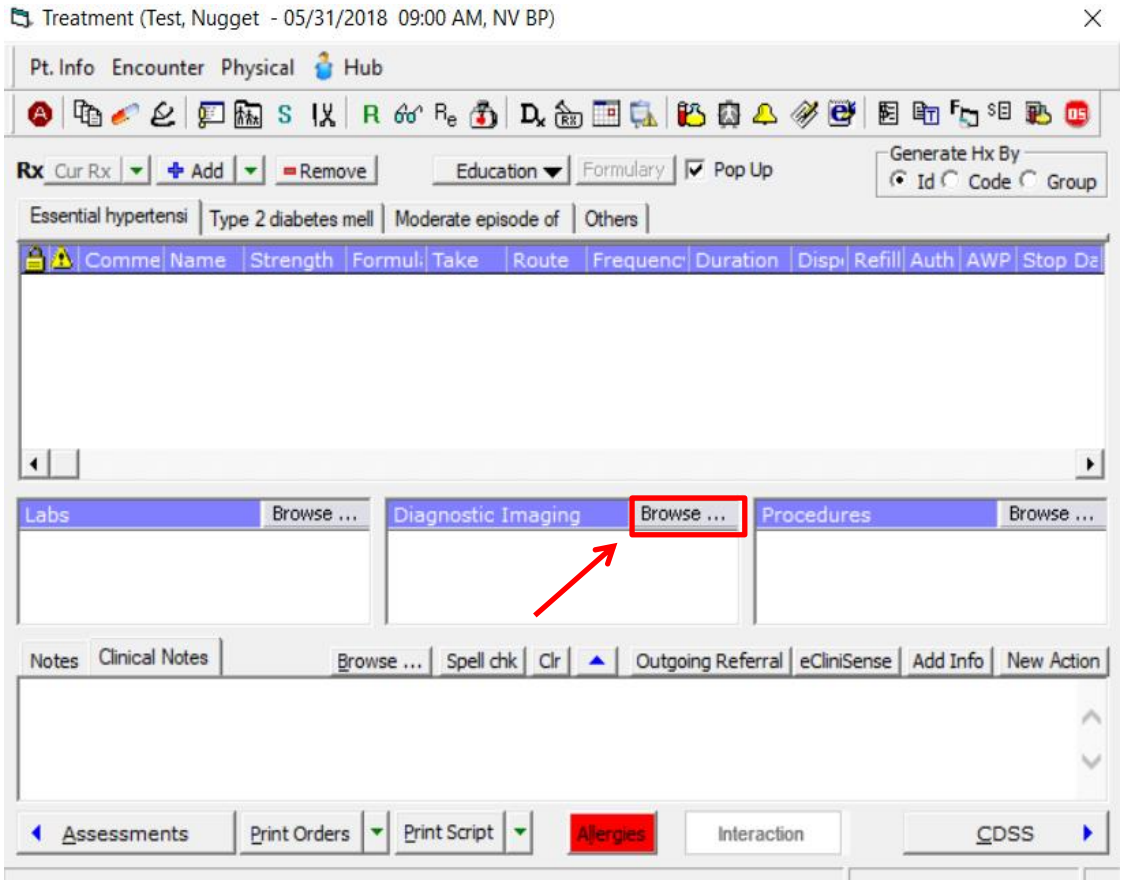
8. Click “Ok” at the bottom to return to the Treatment screen.

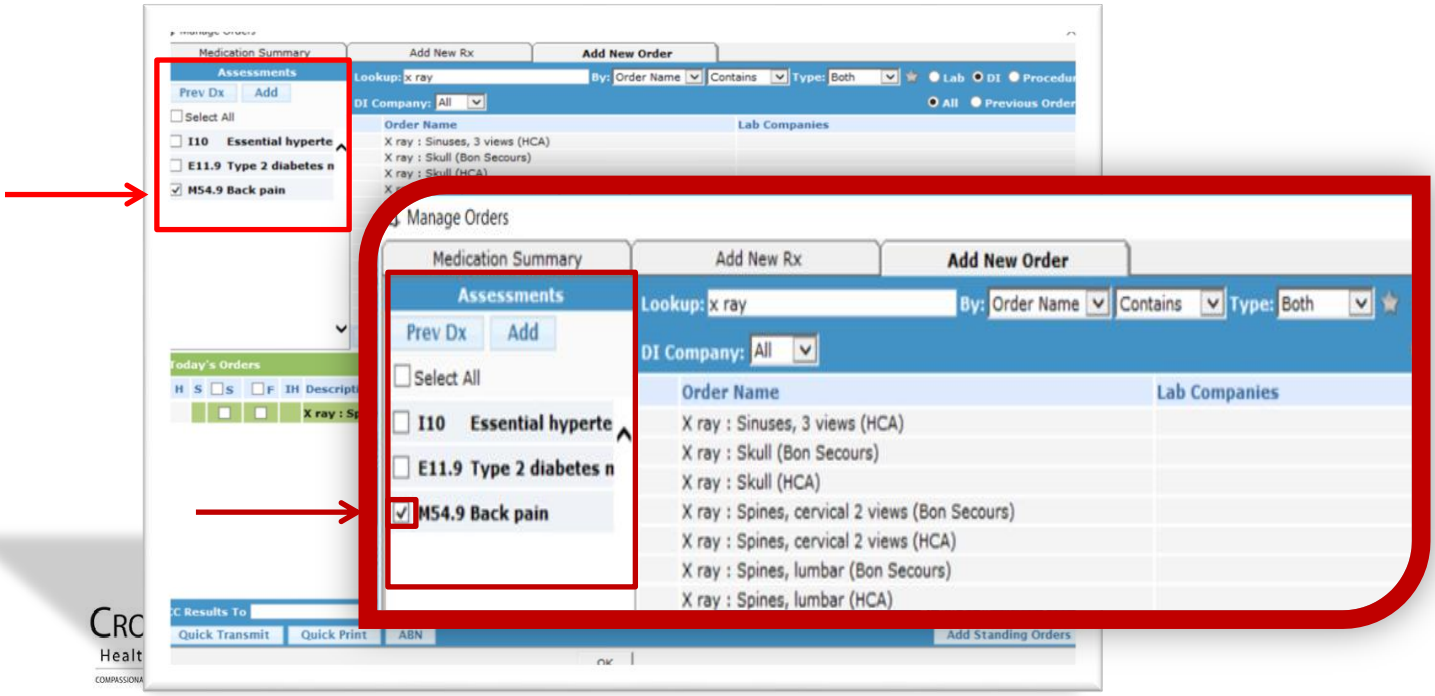


3—Ordering Diagnostic Imaging

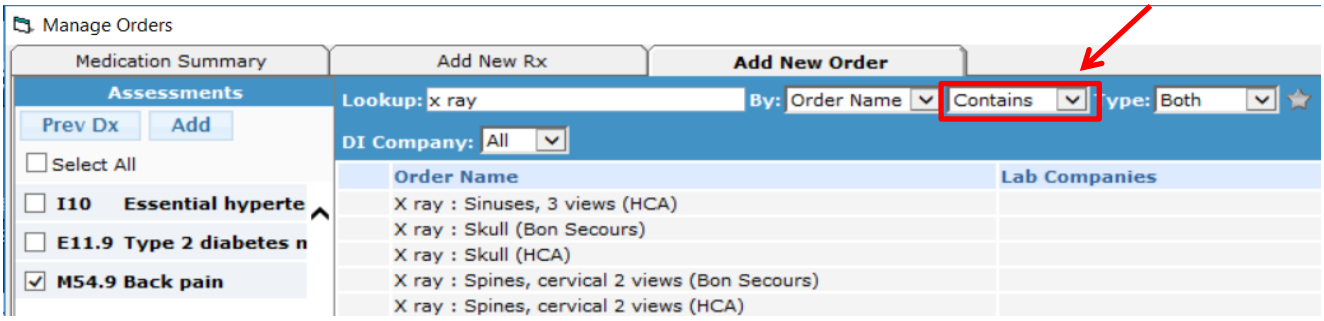
1. Click the “Browse” button next to Diagnostic Imaging.



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

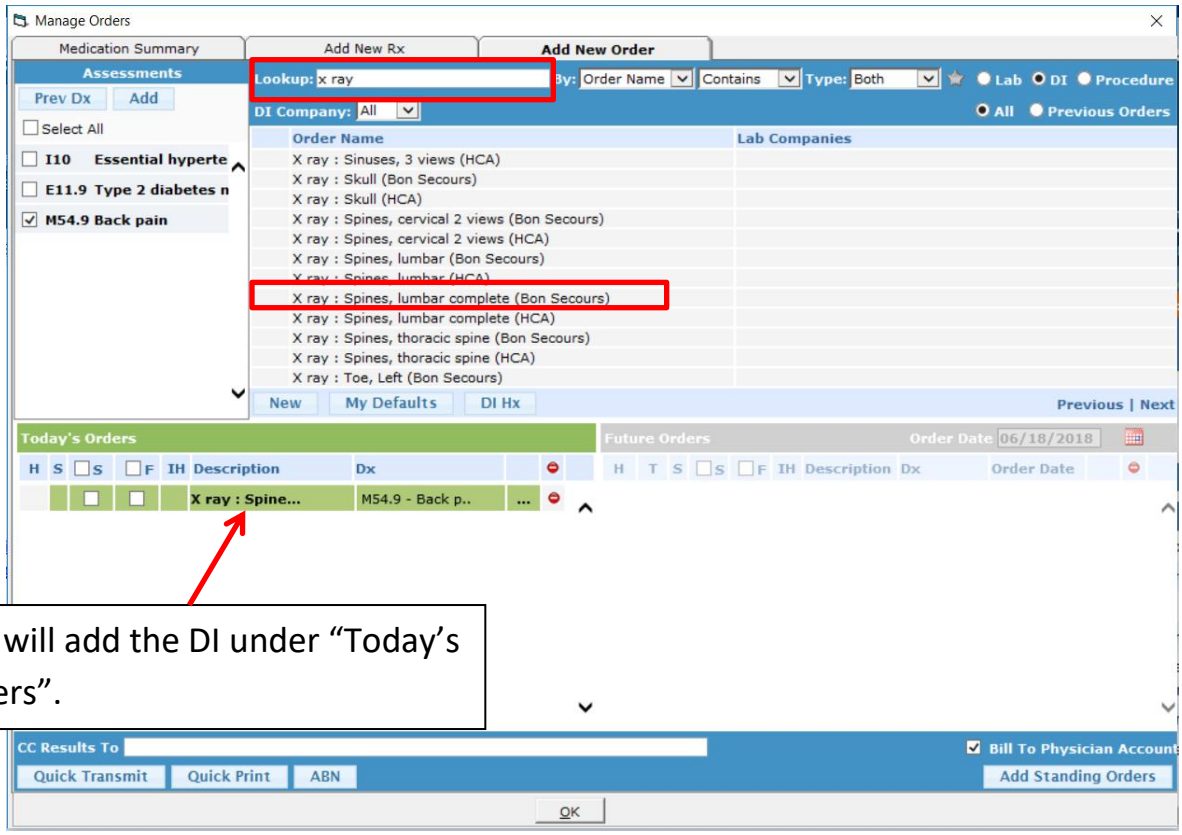


3. Change the search criteria from “Starts with” to “Contains” (this makes the order easier to find).



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:

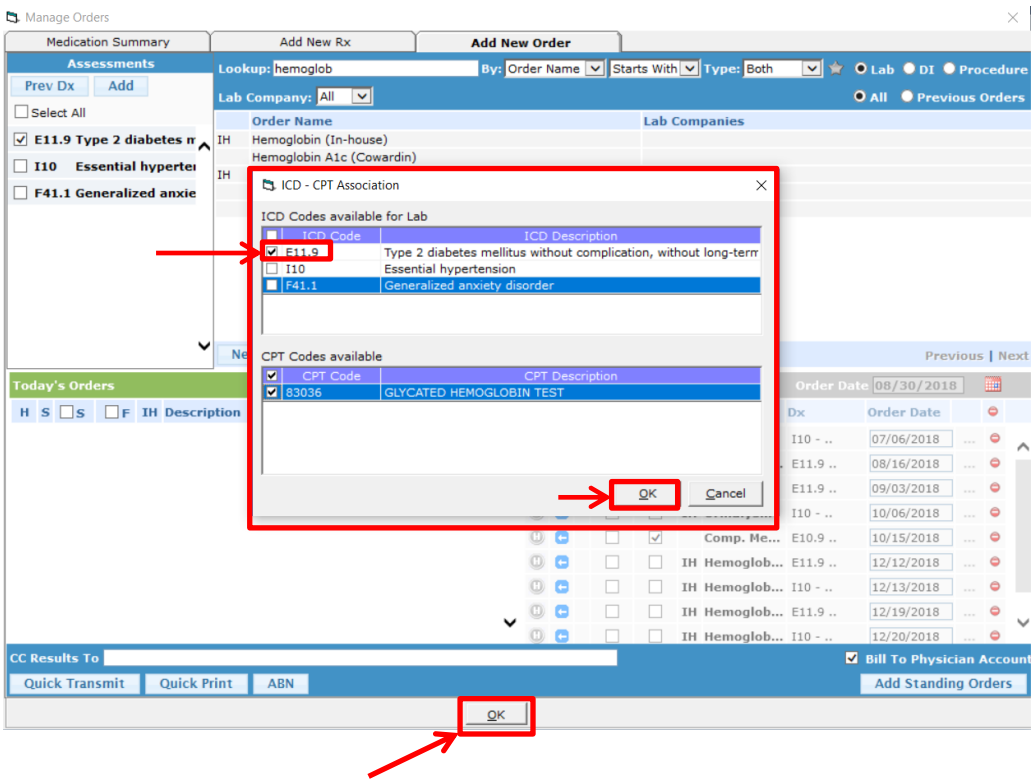
- If you are at the **Henrico Clinic**: choose the **“Bon Secours”** option.
- If you are at the **Cowardin Clinic**: choose the **“HCA”** option.
  (The only In-House DI is Bladder Scan.)



This will add the DI under “Today’s Orders”.

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

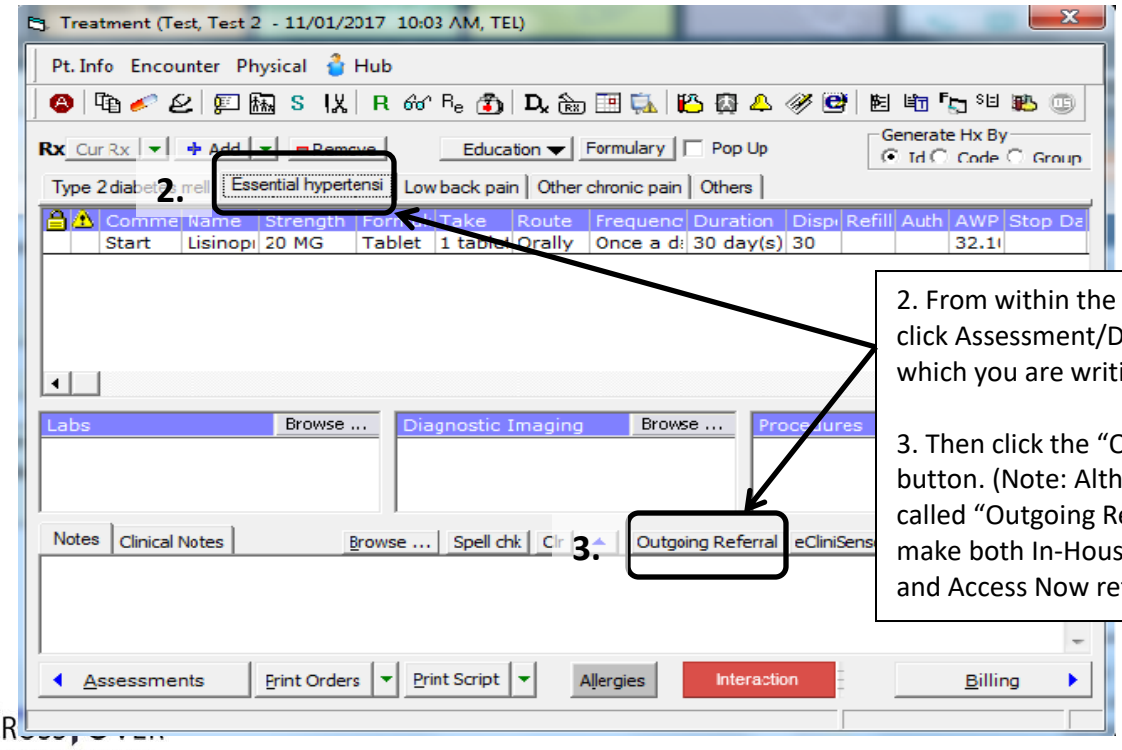
Note: Fast-track and urgent dental and eye referrals include newly diagnosed diabetics, TIPS, OB, urgent problems and pediatric patients. **Enter referral in eCW!**

____ CrossOver referral

____ Access Now referral

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

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



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.)

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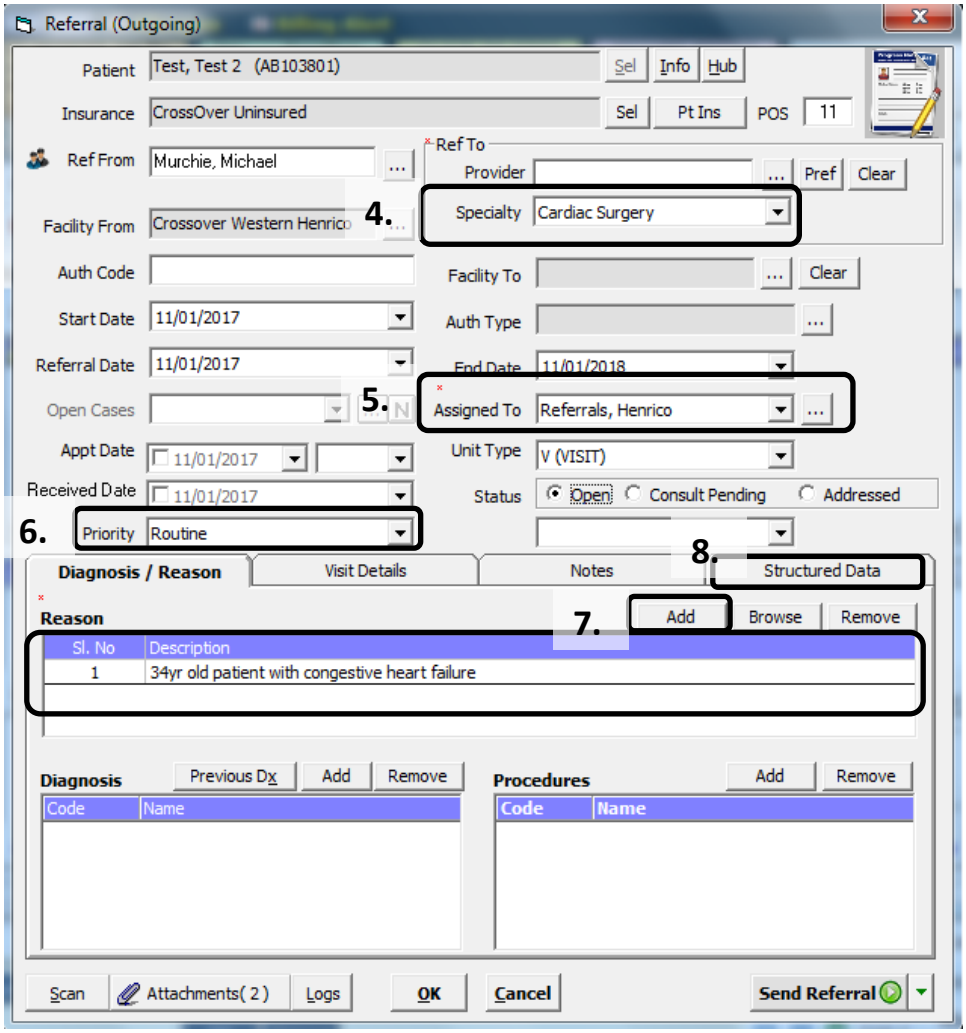


(*Fill out the Outgoing Referral form according to the red asterisks)

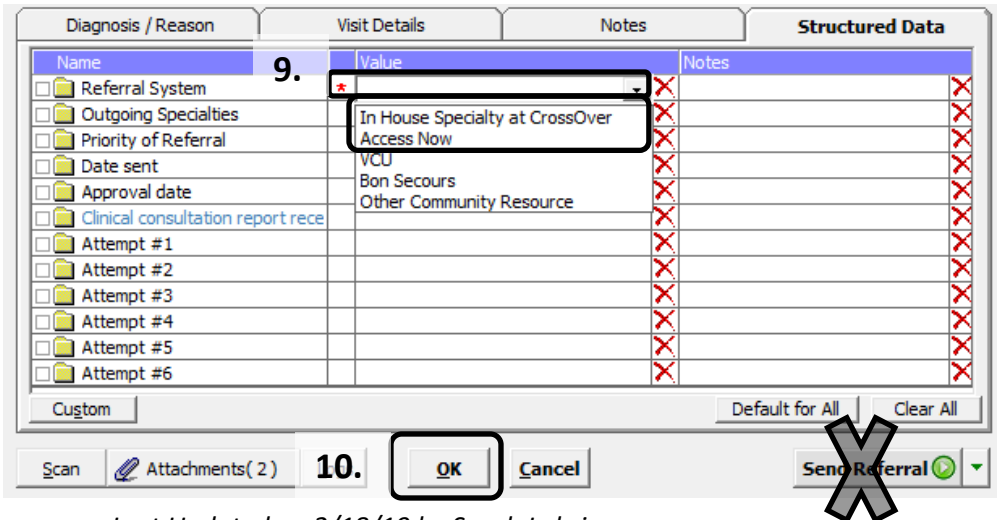
4. Select the *Specialty* to which you are referring.

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.



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. **<u>Click the *OK* button.</u> DO NOT CLICK SEND REFERRAL!**

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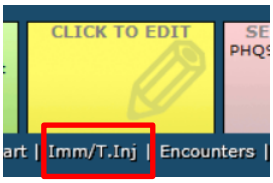
Section G: Immunizations/Therapeutic Injections

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

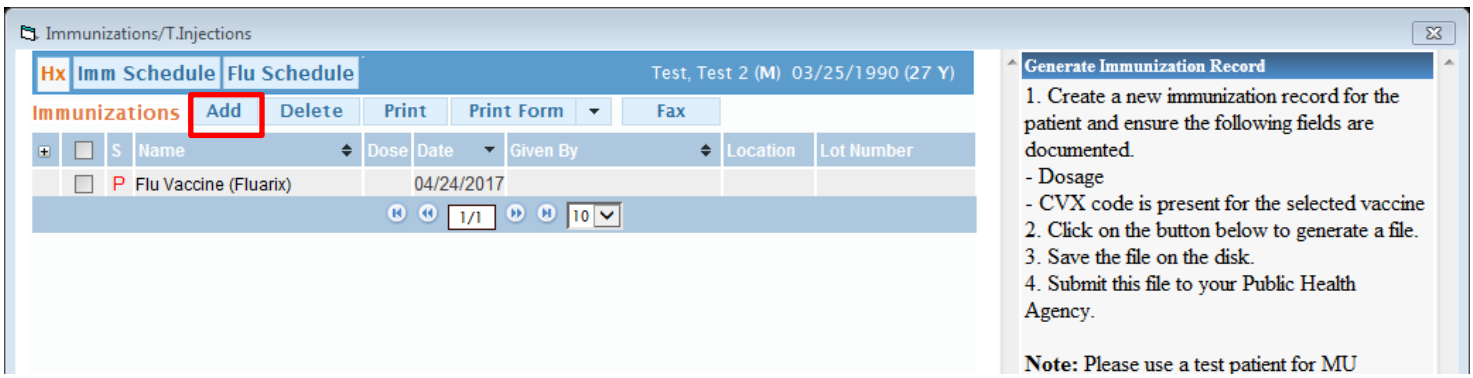
Click "Immunization" on the Patient Dashboard to view the patient's Immunization History.
****DO NOT ORDER IMMUNIZATIONS FROM THIS SCREEN.****



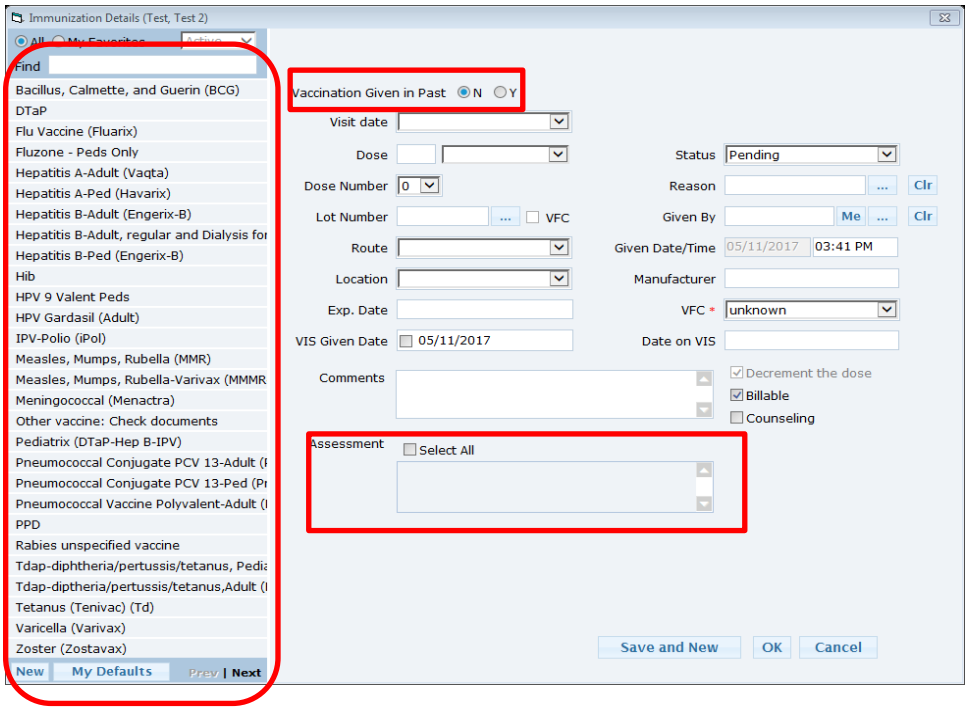
2—Ordering Immunizations and Therapeutic Injections

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":

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



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.)

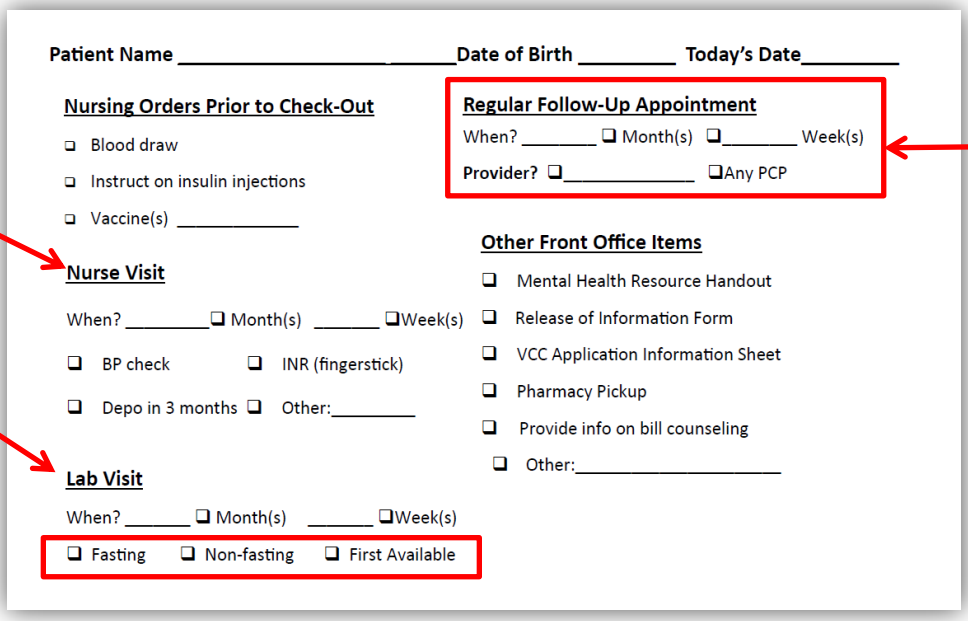


Section H: Check-Out Sheet

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

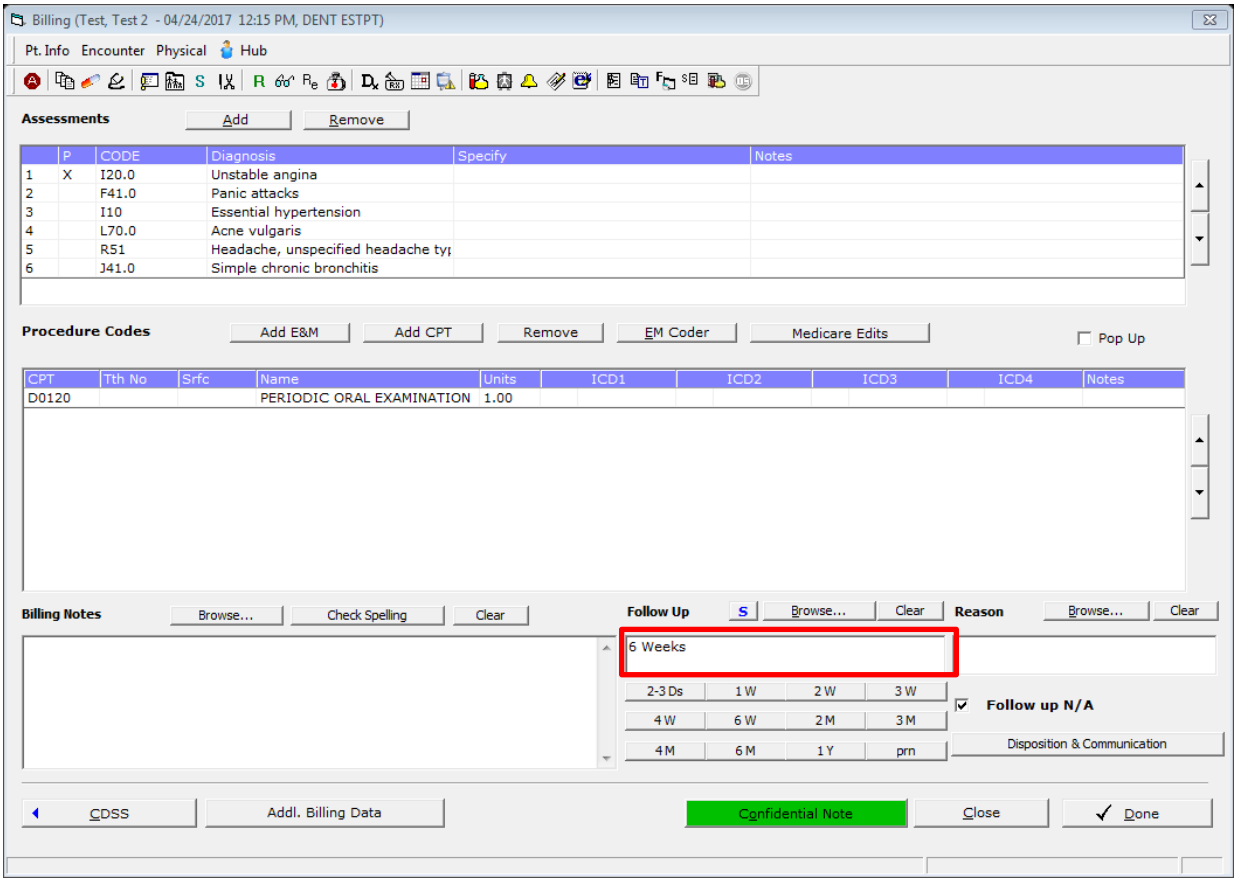
Lab visit: short 10-15 min visit with the nursing team to drawn lab.

*Indicate whether or not it is a fasting lab.



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

Section I: Next Appointment



- 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

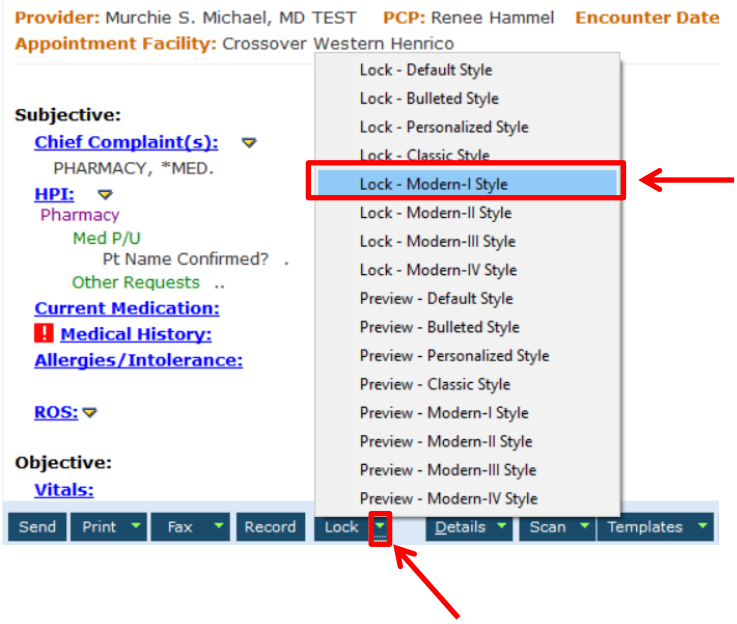
  ***Medical Student signature*:** <Time Frame>, <Seen and Examined by First Name, Last Name>

  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?

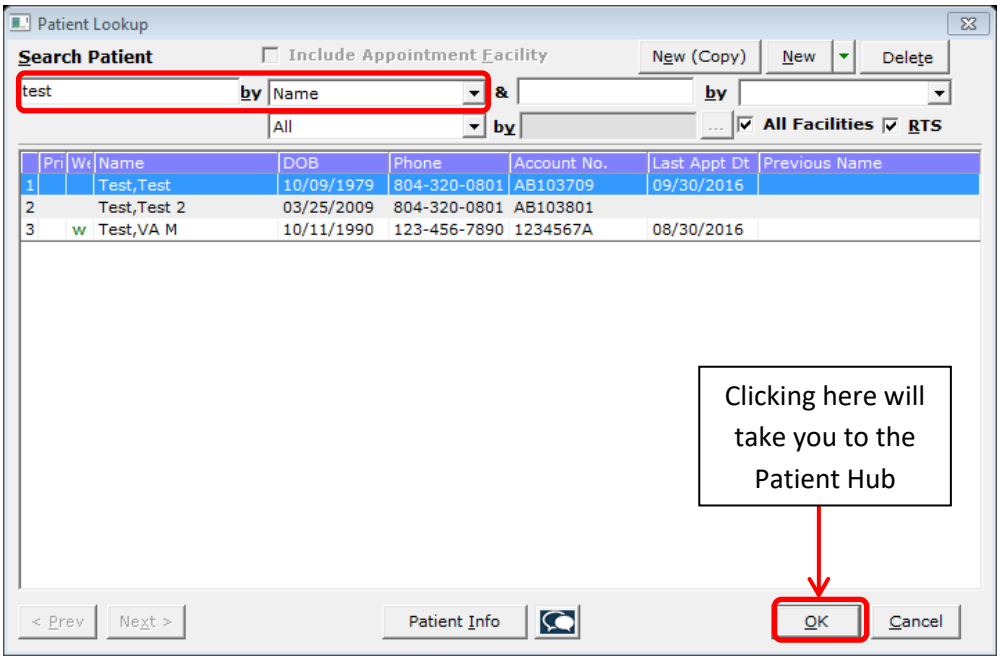
- Return to the schedule by clicking S jellybean
  - Change Floor Status by clicking into Status field and selecting *"ALL DONE"*

End of Shift

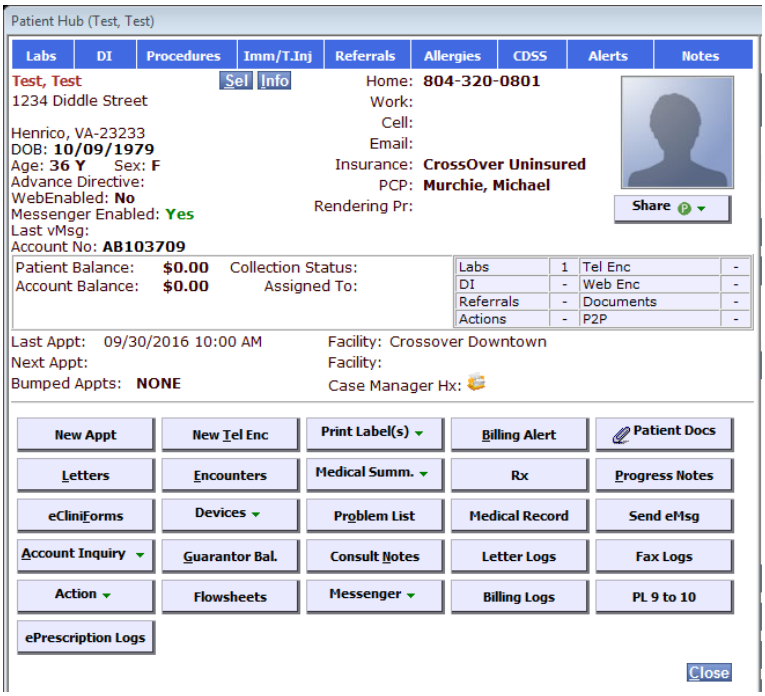
- **The Provider must lock their progress notes!**
  - You may do this either at the end of your shift for all appointments (recommended) or as you finish with each patient
    1. At the bottom of the Progress Note, select the arrow next to the *Lock* button
    2. Select "*Lock Modern I Style*"
    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



2. This will take you to the Patient Hub. In the Patient Hub, users can acces 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.)



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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 <u>patients cannot see your screen</u>.** It is a HIPAA violation for patients to be able to see the eClinicalWorks application.

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