1) **Results Inbox** (Top right hand corner under your name)
   - Notification of new events or results such as ADTs from the hospital
   - The inbox is custom to what the user wants to see and is maintained by the user
   - All users by default have it turned on but can turn off through preferences tab

2) **Patient Search**
   - Use the patient search bar to locate your patients by social security number, medical record number, date of birth or name.
   - When searching by name, search: last name, first name

3) **Access Additional Records**
   - No results available does NOT mean no results available. Access to records is based on the user’s role and previous association with the patient. Providers are automatically associated with patients when they order tests, are cc’d on results or write notes in the hospital.
   - As a user who is not the patient’s provider, you are required to select the reason for completing an expanded search from the drop-down box.

4) **Encounters**
   Contains two parts 1) Problem List and 2) Encounter History

   **Problem List**
   - Displays all problems identified on each source ADT and corresponding ICD-10 Codes.
   - “No records to display” means no data was sent by the data contributors. It does NOT mean the patient has no problems.

   **Encounter History**
   - Displays a history of all the encounters the patient has had with the CHR data contributors since contributor started sending data
   - Can click on encounter to see studies completed during visit (except HPH encounters).

5) **Results**
   - Able to view results of “Final” status/electronically signed notes.
   - Results are filterable by check box or search box.

   **Specific Results include:**
   - Lab Results
   - Pathology Reports
• Radiology Imaging Reports
• Cardiac Studies – EKG, ECHO, Stress Test
• Transcription Reports (varies by sending facility) – History and Physicals, Discharge Summaries, ED Provider Notes, Consult Notes, Procedure Notes, Operative Reports, Hospitalist Progress Note, Orthopedic Progress Note, etc.
• **DATA GAPS:** Physician documentation from **HHSC West Hawaii Region** facilities when PDoc is used.

6) **Medication and Medication Query**
   • The medication feature is used for viewing allergies reported by the patient, medication fill history over past 12 months in the US, and medication alerts such as non-compliance.
   • If you plan to run a medication history query for a patient, HHIE recommends that users do so first as it can take 1-3 minutes to complete.
   • Users can navigate away from the medication query page while it runs and even look up another patient while the query continues running.
   • Medication queries provide 12 months of medication history across the United States.
   • Single patient can only be queried once every 24 hours

7) **Documents – Continuity of Care Documents**
   • The ‘Find External Documents’ button will create a query to receive a Continuity of Care Document (CCD) that may be available on-demand from the following data sources: **Hawaii Pacific Health, Veterans Administration**, and in the near future **DOD**.
   • CCDs will be listed (without the need to query) from the following data sources: **FQHCs** (Malama I Ke Ola), **Elation providers** (Eugene Lee, Scott Miscovich, Madamba) and in the near future **eClinicalWorks providers**.

8) **Create a Care Summary**
   • This tab allows you to create an exportable copy of the full patient record similar in content to the current Meaningful Use Transition of Care Summary providers are receiving from hospitals
   • Creates exportable CCD in XML format
   • Very comprehensive

9) **Profile and Face Sheets**
   • This tab provides access to both patient Demographics and exportable Face Sheets.
   • Face Sheets contain basic information about the patient encounters and provides easy recognition of how, where and why the patient has accessed care. They can be downloaded and attached to the user’s EHR or printed.