Emergent Care Summary Training Guide

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v2.0

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Emergent Care Summary Training Guide

HEALTHeLINK

Table of Contents

1. Overview

HEALTHeLINK has developed an "Emergent Care Summary" that pulls specific data into a single document based on requirements developed by two emergency department (ED) providers.

This training guide contains instructions to access this document.

2. Help/Support

For more information or training on the emergent care summary, please contact the Help Desk.

For HEALTHeLINK™ Support

|	
24/7 Help Desk Support	**877.895.4724**
Local Help Desk Support	**716.842.6343**

Additional training materials are available at

www.wnyhealthelink.com/PhysiciansandStaff/TrainingVideos

3. Downloading an Emergent Care Summary Report

To download an emergent care summary:

1. Login into HEALTHeLINK through the HEALTHeCOMMUNITY Portal
2. Search for and access the desired patient
3. Click "Download Summary PDF" in the left hand navigation
    a. You cannot download an emergent care summary using the "Download Selected Items to PDF" option.
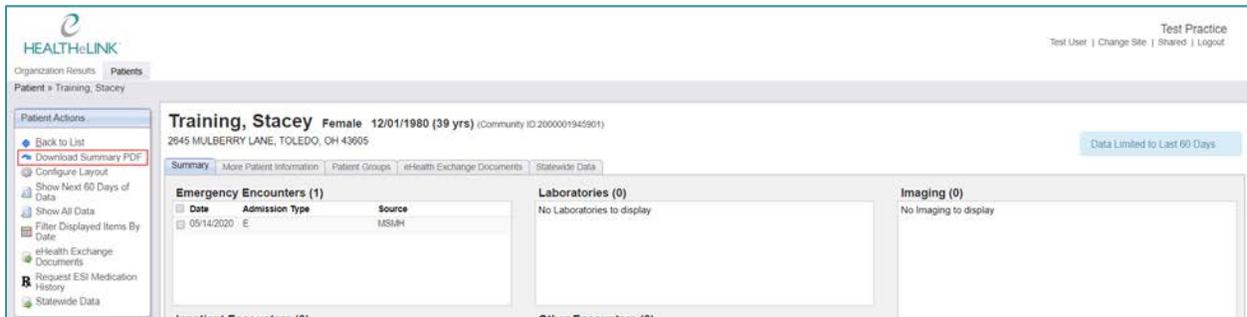
4. Select "Emergent Care Summary" from the dropdown
5. Enter a start and end date to limit the data to a specific range, if desired
    a. All relevant data will be in the report if no dates are selected
6. Check "Include Clinical Items Without Dates" box
    a. HEALTHeLINK recommends checking this box, as it includes data without a "received on date". Sections like *medications, allergies, and conditions* are common sections that may not have dates. This does not mean that there are never dates for these sections, but, for users that are interested in these sections, they should check the box.
7. Click [Download]

8. A new window will open with the generated PDF. From this window, you can view, save, or print the emergent care summary.
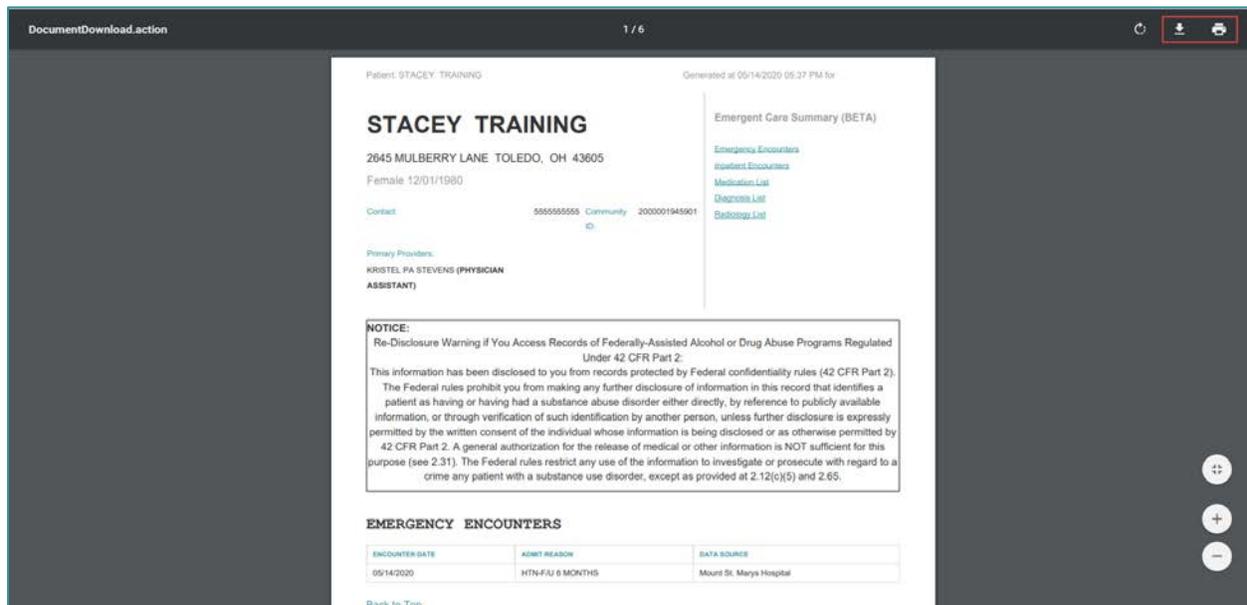
4. Emergent Care Summary Sections

1. **Patient Demographics**
   a. The demographics section contains patient name, address, gender, date of birth, phone number(s), and HEALTHeLINK global identifier. In addition to these fields, the demographics contain the specialists that the patient has been seen by and contains a table of contents of the sections that contain information.
   b. Primary providers are providers that come in on messages from data sources.
   c. The right hand side has a table of contents that contains a hyperlinked list of all the sections that were generated and had information. This means that there could be sections that are typically included in the document but are not displayed for a specific patient as no data exists.

2. **Emergency Encounters**
   a. This section contains the encounter date, admission reason/chief complaint, and the facility where the patient was seen.
   b. Encounter date is dependent on the source providing the correct information on each encounter message that is sent.
   c. Admit reason is sent in varying formats across sources, as well as, not sent at all in some cases. Blanks in this column represent an encounter message that did not contain an admit reason.

3. **Inpatient Encounters**
   a. This section contains the admission and discharge date, admission reason/chief complaint, and the facility where the patient was seen, as provided by the data source.
   b. Admission date/Discharge date is dependent on the source providing the correct information on each encounter message that is sent.

c. If encounter messages are sent in without admission or discharge dates, those fields we be defaulted to the message received on date. This issue shows up on the document as a negative encounter duration.

d. Admit reason is sent in varying formats across sources, as well as, not sent at all in some cases. Blanks in this column represent an encounter message that did not contain an admit reason.

4. **Medications**

   a. *Note: Medication information provided as is, and may not represent a comprehensive medication list. Surescripts reported filled medications will only be included if an ESI Medication History Query is performed prior to generating this document.*

   b. The medications section contains the status of the medication (current or prescribed), start and end dates, medication name, and last fill date.

   c. Medication status (prescribed/ordered) is dependent on EMR capabilities and user input to ensure accuracy. We know not all medications captured and sent to HEALTHeLINK will reflect 100% accuracy.

   d. Medication information is sent to us via practices, hospitals, and one pharmacy system. Surescript reported medications will only be included if any user has recently ran an ESI medication query for the current patient (ESI medications last 48 hours on the chart).

5. **Diagnosis**

   a. The diagnosis section contains diagnoses/conditions/problems, the reporting data source and, if available, the diagnosed on date.

   b. Without an actual date, the section could not be ordered chronologically, so they will default to received date order.

6. **Radiology**

   a. This section will contain all radiology studies performed, the data source, and date of study.

   b. The radiologist's report will be present within the HEALTHeLINK patient summary.