In this document, I will explain how to complete a progress note in ECW 11. We start with the basic framework of a SOAP note. The chief complaint is pulled from the schedule - when this appointment was made, someone entered a reason, and this is pulled in as the chief complaint. The current medications are also pulled from the previous note. If there are any errors in the prior medication list, they will be pulled into this note as well, which is why reconciling medications is one of the most important steps in setting up a note properly.

In this visit, I clicked on “Chief Complaint” and changed the the complaint to “cough”. You can hit the “Browse...” button to see a long list of options, but I find it much easier to simply type in the chief complaint. You can add or remove lines in the complaint list by clicking on the appropriate button. The progress note navigation bar is highlighted in red – rather than clicking on the “x” and then opening the next section from the note, using the navigation icons is much more efficient.

Clicking on the “A” opens the allergy and medical history sections of the note:
To add a medical problem, you can free text into a new line after clicking “Add”, or you can use the ellipsis next to “ICD” to pull the diagnosis from the problem list or from a previous assessment. In this example, I used the ICD10 option, and pulled in the coronary artery disease diagnosis from the problem list. Note that this pulls the ICD10 code into the medical history as well.

Alternatively, you can select the keyword search a list of possible diagnoses (see the inset box to the right). I usually just choose “Add” and type in the medical problem I wish to add rather than using the keyword or ICD10 search engines. I also prefer to use the medical history as more than just a list – I prefer to add more descriptive information that helps me recall details quickly during a visit. In this case, when reviewing the history, I would delete the duplicate entry of hypertension. To remove an entry, just highlight it and click “Remove”.

To add a medication allergy, ALWAYS use the “Browse Rx...” button rather than the “Add” button. MedispanRx is a database of medications linked to NDC codes. This allows the allergy alert system to work properly. Just search for the medication and click on it to add it to the allergy list, and click “OK”.
Now add a reaction – I usually just type into the box because I like more detail a single word provides, but you can use the dropdown list if you wish. Also add the type of reaction, the status, how critical the reaction was, and ideally when the reaction occurred if the patient can provide a date. When you are all done reviewing/adding allergies, click on the box “Allergies verified” - this should be done at every visit.

If you try to add a nonstructured allergy, ECW will alert you to the fact that the drug allergy alert system will not be able to recognize this entry and it could result in serious patient injury. Some allergies have to be entered as nonstructured (like allergies to cats, or ragweed, or politics), but all drug allergies should be entered as structured data.

The picture of the capsule opens the screen in which medications are reconciled. Medications are listed as “T” for taking, “N” for not taking, “D” for discontinued, and “U” for unknown.
Two quick ways to update a medication list:

- “Apply Status from Prior Visit” – if the medication list got a bit messed up since the last visit (things happen in ECW), try clicking this button to revert the list to mirror that last visit.
- “Mark all as”: If some medications were listed as unknown or not taking at the last visit, but today the patient reports taking all the medications, just click on the “T”, and all medications will be associated with a “T”.

If a medication was discontinued since the last visit, mark it with a “D”, as I did with penicillin in this example. When writing time-limited prescriptions, try to remember to add a stop date so they don't end up living for months (or years) on the patient's medication list.

When you click on the “D”, the box to the right opens up. A glitch in multiple iterations of ECW results in this “Notes” section never being visible again – so don't bother writing anything here. If you choose allergy, intolerance, contraindication, or side effect, a reaction option opens. This will be added automatically to the allergy list for the patient. The reaction choices are limited, so I usually go back and modify this information in the allergy section.
If you do want to add a reason for discontinuing a medication that CAN be seen in the future, put the comment in the notes section shown above.

In the “Past Rx History” tab, you can review the medication list from any previous visit – just click on the “+” next to the date, and the medication list opens up. I have used this screen hundreds of times to:

• Find a medication that the patient reported he/she was still taking, but someone had discontinued it in error. In this example, if the patient is still taking metformin, all you need to do is hit the “T” and it will reappear on today's medication list.

• To reconstruct a medication list that has somehow disappeared, or has gotten really messed up. This can happen when the patient is seen by another provider who doesn't really understand ECW, and that provider added and deleted medications inappropriately, or the medication list was not reconciled at a prior visit and all medications are listed as “Unknown”.

You can change the filter from “Date” to “Medication” or to “Provider” - this can be helpful in the right circumstances.
You can also add medications to the list during reconciliation. Make sure to always use MedispanRx so the drug interaction program will work properly.

Suppose the patient's cough was seen elsewhere and a provider added clarithromycin. You can add this to the medication list in the current visit.

Clicking on the drug interaction icon opens the program that compares the list of structured medications to one another for significant interactions. Here it appropriately points out that naproxen is not a great choice of an analgesic in this patient taking Eliquis, and the clarithromycin plus sotalol has the potential for killing the patient – not good. Note that when we get to the prescribing area of this note, switching the drug interaction program to “New Drugs with active drugs” makes this software much more precise and useful. I also want to point out that the minus sign to the left of medications is active ONLY when a medication is first added to the medication list. So if you make an error when reconciling medications, you can delete the error at that moment. Once you close out of this screen, the minus icon is grayed out and the only way to remove a medication is by hitting the “D” button.
The last tab in the medication reconciliation screen I want to address is “External Rx History”. This is a very useful tab when you suspect medication noncompliance as the cause for an inadequate therapeutic response to a new medication. It is also a way to determine what the “new little blue pill” that another provider prescribed really is. This pulls data from pharmacy refills – as you can see from this list, it tracks all refills, including those of prescribers outside of ECW/Prima CARE (Dr. Haisman). It does occasionally miss refills, so if it is really important to know about a medication refill, it is best to call the pharmacy. But this screen can be really useful, and save a bit of frustration and polypharmacy when noncompliance is the problem.

At this point, if a template has not yet been imported for the note, I would suggest doing this. The template can be added at the start of this visit, or at any point during the visit.

At the bottom over the progress note is a panel of options – one of which is to choose a template for the visit. Clicking on the “Template” button opens the template screen.

Clicking on the little arrowhead next to “Templates” opens a list of options. “Set Default Options” and “Save Notes As Templates” will prove useful in the future. “Template List” opens a screen in which you can add and delete templates from your favorites list.
This is the template screen. The current filter is “Generic” and “All”. Once you set up your favorites, it will be much easier to quickly locate the template you wish to use. If you select “BDK FU general”, then click on “Add As Favorite”, this template will be added to your template favorites. Clicking on the magnifying glass will open a view of the template, allowing you to see what you are importing into the note. The panel at the right shows you which sections of the template will be added to the note. Selecting the “Set Default Options” shown at the bottom of the last page selects which of these areas you want included by default. I prefer to have HPI, ROS, exam, and treatment to be selected by default. Clicking on “Merge Template” will merge this into the note – meaning that if there is already something in the exam section, whatever is in the template will be added/merged with that data. If you click on the arrowhead next to this, you will see the option to “Copy Template”. Whenever ECW uses the word “copy”, it means that whatever your are selecting will write over the current data – what is there will now will be gone after you copy something over it. So be careful when you select the copy option in ECW. In some cases, this is what you want, but in other cases, it might not be exactly what you are looking for.

Patient specific templates (in the blue rectangle above) are like copy and paste on steroids. It provides you with a list of this patient's previous visits, and allows you to import the entire note (or selected portions of the note) into the current note. You can even choose another patient's note to import into the current visit. I find this to be too blunt of an instrument, but in some circumstances, it can be helpful.
OK, so now we have imported a template adding a little more structure to the note. The screen above shows the HPI section of the note. The HPI icon in the top navigation panel is highlighted by a red square. Note that other than the text in the HPI box, I am not seeing the rest of the HPI template. Click on the blue arrowhead, and you will see the entire HPI template. Remember this when the template information disappears – this has confused me more than a few times in the past.

Now the full HPI template is visible. Note that anything in the footer shows up below the HPI template, and anything in the header will show up in the note above the HPI template. “Clear All” clears the placeholders (the dashes highlighted by the red rectangle) as well as anything else in this “Notes” section to the right of the template section. “Clear” deletes everything in the lower “Notes” section. My preference when completing templates with placeholders is to “Clear All”, and then enter the data.
Clicking on “New Problems” in the “Interim History” (shown on the previous page) opens the screen to the left. If you have set up dictation, you can dictate into the box. There are some formatting options – bold, underline, color. Spell check is also an option. There are dropdown menus at the bottom of the box, but I have always preferred typing rather than clicking multiple times to populate the note. Click “Next” to move forward in the note.

Six Pcaretest takes her medications faithfully.

So this last screen (reason for skipping meds) I will leave blank...

and this portion of the template disappears from the note.

In most cases, I simply type into the HPI while I talk with the patient. Here I want to add another HPI template into this note.
After expanding “BDK”, I scrolled down to find “URI”, clicked on it, and the template (without placeholders) was pulled into the note.

Here I just want to point out that when you add multiple choices from the left panel, you can choose how to separate them – but commas, empty space, periods, semicolons, colons, or dashes.

The second way to add the URI template to this note is to go back to templates by clicking on the button at the bottom of the progress note.

In “My Favorites” - I clicked on “Next” a few times and found the URI template. Using the magnifying glass, I found that “CC” contained the words “BDK URI” - I don't want to import that, so I unchecked that box. Both “ROS” and “Treatment” sections are empty, so leaving these boxes checked makes no difference to what is imported. I don't want to copy over the rest of my note, so I will use “Merge Template” rather than “Copy Template”
Now you see that the URI template merged with the existing URI template - nothing was removed, so there are duplicate entries for what I already added from the other template.

Placeholders are necessary in templates – if they were not present, the template would be invisible in the note.

Note that simply clicking on “URI” and opening the template box gets rid of the duplicate entries.

Clicking the purple “URI” or any of the green elements in this template opens the box we have seen in the past few pages. Clicking on the placeholder opens the screen to the right.

Clicking on the circle next to a choice deletes the placeholder, replaces it with the selected choice, and drops you back into the note. Checking the square box allows you to choose multiple elements in this box and does not drop you back into the note. You can then hit “Next” to move down the line. The one annoyance here is that the placeholder remains as well – so when using this method, I simply select the placeholder and hit backspace or delete on the keyboard before checking off the boxes.
For “Nasal drainage”, I checked off the square boxes, but did not remove the placeholder, for “Cough” I clicked on the circle and was dropped back into the note. I then clicked on the placeholder for “Ear pain”, deleted the placeholder and checked of multiple boxes – and could then click “Next” to move to wheezing. In general, I prefer to open the larger box shown before, clear the placeholders, and then quickly enter the desired choices.

If you have many templates in a note, you can change the order in which they appear in the note if you wish.

Surgical history and medical hospitalization history are pretty straightforward. I have never used the Keyword/CPT search engines – just adding a date with a description of the procedure/hospital stay by free-text is simple. Moving the entry up or down (to reflect the correct time sequence) is possible using the arrows on the sides of the boxes.
I use the “Note” section (highlighted by the red square) of the family history most often. Hovering over the note makes the entry visible without opening up the note. The check boxes provide ECW with structured family history data – I don't find “Stroke” very helpful in the structured data portion of the family history, but having some structured data in family history is a quality indicator for some entities. So I put some structured data in my charts, but rely on the free-text note section for the useful information. You can add additional relatives using the “Add” button. You can remove these choices if you wish, but you cannot remove the standard choices coded in by ECW.

In the note section of the family history, you can select keywords from a list if you wish, but I find it easier and more useful to free-text into the box. A potential time-saver is to select multiple family members at the same time who have the same diagnosis. So if the patient's brother and paternal uncle both had melanoma, adding the paternal uncle in this screen (which is the brother's screen) will add melanoma to the uncle's note section as well. You can then add more specific details to each relative's note section as needed.

Here you can see the note that I added for the brother – and I checked off the box for cancer as well. The note section for the paternal uncle is also populated with “melanoma”.

- Father: deceased
- Migrated Family: deceased
- Mother: deceased
- Sister(s): alive
- Brother(s): alive
- Spouse
- Son(s)
Different providers/offices document social history in a wide variety of ways. I want to highlight just a few points. Anything written in the “Notes” section at the bottom is carried forward in all future notes – so add to this area sparingly. I have seen patients with a lot of stuff entered into this area – and when I see them 2 years after that data was entered, a good portion of it is wrong, and ends up in my note by default. So I either have erroneous information in my note, or I have to update/delete the information (that conflicts with the social history that I document elsewhere – a bit of an annoyance). The “S” seen to the left of the first two tobacco entries means that these link to smart forms. Click on the first one, and the following screen opens:

This form provides structured data that is used as a quality measure – so even if you document smoking history elsewhere, try to document this history with the smart form at least once a year – more often as appropriate. Smart forms are also available from the top left of the progress note, as shown in the screen to the far right.

In my office, we used the “BDK Social History” folder and the “BDK Prevention” folder to document social history as well as compliance with routine screening tests and immunizations (as ECW is not great at tracking these things – though it has improved significantly in the past few years in these areas).
The review of systems area in ECW is a bit overwhelming (I think there are about 60 folders). I use only the 3 BDK folders. You really can get by with one folder – as you can customize the choices very easily in the note as well as in the templates. Clicking on a problem that reports “Denies” once changes it to “Reports” in this ROS template. Click it again, and it will be blank. Any blank entry does not show up in the note. So ONE list of many choices could be used for all situations. Clicking “Clear Category” clears the current ROS completely. Clicking “Default per Category” selects the default choices for the current folder. Both the “All” buttons to the left affect ALL the folders – not particularly useful in my view. The “Notes” section at the bottom is pulled into all future notes – like similar sections in the family history and social history sections. I have NEVER added anything to this area, as it doesn't make sense to me that I would be able to predict the ROS for a future note. Clicking on the “Notes” section next to the ROS symptoms opens a box in which you can add details about the symptom – though I usually do this in the HPI.

The “Examination” area (NOT the “Physical Examination” area – this is a deprecated area in ECW that is still hanging around) follows all the same rules discussed before. You can format the text in the box if you wish (I never have). You can add choices from the list on the left by clicking on the entry, and it will be added with a comma separating it from other elements. You can free-text or dictate into the box, clear the box and start over, or spell check your entry. You can also time stamp your entry – which I have also never done.
I think the min-exam templates are extremely useful in cutting down on time spent charting. These are very easily created, and very easy to implement. The only requirement is that the exam area to be modified has to be empty to merge a mini-template into the note. In this case, I will import the neurologic exam into this note with one click. You can use the “Select Default” dropdown list as well – this copies over the entire note with the data.

EVERYTHING that is the exam will be wiped out. I usually use merge rather than select.

I created these templates with line breaks to make it easier to modify during the visit. If you want to get rid of all formatting (including line breaks), click on spell check. In ECW 11, this eliminates formatting (in ECW 11e, it does not eliminate formatting).

Another tool that can speed up documentation of your exam is to import an exam from a past visit and modify it to fit the current exam. Click on the arrowhead next to “Examination”, and the last 2 exams show up – you can filter by only your exams, and there is an option at the bottom of the page (not shown) to see 2 more past visits. Click on “Merge” to merge into the current exam, or “Copy” to copy over the current exam completely with the selection.
“Smart Search” is by far the easiest way to find the right ICD10 code for you assessment. If you find yourself in a screen that looks very different, you are likely in “Classic Search” - just switch back to “Smart Search”. I prefer real time searches, though when ECW gets very slow, it is quicker to uncheck this box and hit “Go” after entering your search word. Pay attention to RAF scores – the higher the RAF score, the more money Prima CARE gets to care for the patient in the managed care plans.

Notice that changing the diagnosis from alcohol abuse to alcohol dependence adds a significant value of 0.368 to the RAF score. Other diagnoses that I have neglected to code in the past EVERY year that carry significant RAF scores include morbid obesity, cerebral palsy, amputations, ileostomy in place, gastrostomy in place, and colostomy care.

Any diagnosis in blue needs further specificity – a box similar to the one on the left opens – click on the most accurate description of the problem and hit “OK”.

A simple time-saving tool is to use the problem list to populate the assessment. This is one good reason to keep the problem list accurate and succinct. “Previous Assessments” tends to be a long list of diagnoses – too long to be useful in general in my opinion.
“PL” stands for “Problem List”. A check mark in this box means either the problem is already on the problem list, OR that you have chosen a diagnosis that automatically populates the problem list. This last issue has resulted in problem list bloat in our charts – often, providers are not aware that they have added a problem to the problem list. For example, a diagnosis of paresthesia automatically populates the problem list, even though I personally would never add such a broad symptom to the problem list. If you uncheck the PL box in this screen – it doesn't matter – the problem populates the problem list as soon as the diagnosis is dropped into the assessment screen. If you DO want to add a problem to the problem list, checking the PL box will accomplish this.

In medical school and residency, I was taught to put the assessment under “Assessment” and the plan under “Plan”. Not so in ECW. Some providers do put their assessment in this screen, but anything added to the “Notes” area adjacent to the diagnosis is carried forward to all future notes. So another provider's assessment from 3 months ago magically ends up in my note when I choose the diagnosis of CAD. So please put both your assessment and plan in the “Treatment” section of ECW. Choosing the “Problem List” button opens up the problem list from the screen – so you can fix any inadvertent additions right here if you choose.

The “Treatment” screen has quite a few options, which I will address in the next few pages. You can refill current medications or add new medications, select patient education material to add the patient's Santovia page or print out at the visit, add labs and DI, enter a clinical assessment and plan as well as add notes for the patient to see on their health portal and on the patient summary page, print or fax orders, and print, fax, or escript prescriptions from this screen.
Let's start with the “Clinical Notes”. You can type or dictate into the text box, or you can click on “Browse” button (shown below) to access macros.

The first inset screen (called “Keywords” in the upper left of the screen) is what I call the browse box. I don't use the keywords shown in the left panel of that screen, but I do use macros. These are short text entries that you access by typing a shortcut name (here I am adding the “pain2” macro), then hitting both the control key and space bar at the same time. The third inset screen shows the results of adding that macro. One important caveat to the browse screen – unlike most other areas of ECW, hitting the “x” closes the screen without saving the text. In many areas of ECW, you can click “OK” or the “x” and the data is saved – here you must click “OK” for the new text to be saved. Configuring macros is discussed in other documents. The screens below show how to open the window to create or edit a macro. The bariatric macro was set up to be shared – so you can see this one.
To refill a current medication, click on “Cur Rx”.

In this example, I am refilling famotidine under the diagnosis of “Other”. You can click the “R” for refill, and edit the prescription later. Or you can choose “30” or “90” days and select the number of refills in the box at the top of the screen. “S” stops the medication, and “C” continues it without creating a prescription.

Clicking on the “H” opens a history screen for the medication.

Scrolling down allows you to see a list of prior encounters. Clicking on the “+” opens the medications from that encounter. Clicking on the blue “OV” opens a view of the encounter. This can help you to understand why a medication was started or stopped.

To start a new medication, you can simply change the tab from “Medication Summary” to “Add New Rx”, or you can click on the “Add” button from the treatment section (shown at the top of this page).
When prescribing medications, always make sure you are using “MedispanRx” - this makes sure that the NDC code is pulled with the medication, and allergy and drug interaction programs will work. At times, you may need to use other options in the “Type” dropdown – like “Custom” or “All” - this is especially true for diabetic supplies and durable medical equipment (like nebulizers, TENS units, etc.). If you have trouble finding a medication, try changing the search filter from “Starts With” to “Contains”. I prefer to see both the standard medication choices as well as my favorites, so I have “Both” selected by default (this option can be changed in your “My Settings” folder). Try to link medications to an appropriate diagnosis – in the left panel, you see the current assessments in this note, but you can add a diagnosis here if you need to.

The first 3 entries under naproxen are my favorites – with different doses, number to dispense, and number of refills (not seen here). To delete a favorite, click on the “x” in the yellow star. To make a medication your favorite, click on the “+” in the yellow star. Clicking on the “+” opens the inset screen. You can alter the instructions, duration, dispense quantity, and refills – then click “OK”, and this prescription is added to your favorites list.
In this case, I added a diagnosis of right knee contusion, and then added one of my favorite naproxen scripts to the note.

Clicking on the naproxen prescription above opens the “Rx Edit” screen – not my favorite screen in ECW. I dislike the keypads that are used for duration, dispense, and refills. You can free-text into the keypad box, but not into the yellow boxes. This increases the number of clicks when altering prescriptions. One caution: If I decide to change the number of pills to 20, but then go back and change the instructions to “1 tablet with food” - ECW will automatically change the dispense number to 60 (twice a day x 30 days). This can be particularly troublesome when prescribing opiates – 2 Percocet qid pm for pain for 5 days, #15, suddenly becomes #40 if you alter the instructions in any way after setting the number to dispense. Just be aware that altering the instructions can sometimes result in a change in number to dispense, and is easy to overlook.

To order a lab, either go to the new order tab in the prescription screen (shown above), or click on the “Browse” button in the treatment section of the note.
It is important to make sure all of your lab orders default to “Future Orders”, NOT “Today's Orders” - this is the way ECW interacts with the Prima CARE lab. If you find that “Today's Orders” is green and not gray, click on “My Defaults” and check the box “Set Default to Future Order”.

Use the “Lookup” screen to search for the lab you want to order. Typically, I search by “Order Name” and “Starts With”. If I can't find the lab, I change “Starts With” to “Contains”. You can add a diagnosis in this page if needed (by clicking on “Add” in the left panel).

Three functions that can really speed up lab ordering:

- Clicking on the star to open your lab favorites list
- Clicking on “Previous Orders” to see all previous lab orders for this patient
- Using a lab alias

Here I clicked on the star, and then just clicked on BMP, CBC, and UA. Searching for each of these labs without using my favorites would have taken more effort and time.
To manage your lab favorites, go to EMR → Labs, DI & Procedures → My Labs, DI & Procedures Favorites.

Click “Add” and the lab compendium appears – just select a lab you want to add (shown in the screen below) and click “OK”. To remove a lab favorite, check the box next to the lab and click “Remove”.

Clicking on “Previous Orders” (highlighted on the previous page) opens list of all past orders for this patient – in certain circumstances, this can be a useful tool to increase your efficiency.

I like to use lab aliases for certain diagnoses – for my typical fatty liver work-up and when ordering annual bariatric labs.

In the screen above, the fatty liver alias has been selected. Click on the labs you want to include in your work-up – this both speeds up ordering, and helps me to avoid omitting a lab needed to rule out one of the many causes of liver steatosis.
To view/update/create an alias, go to EMR → Labs, DI & Procedures → Labs & DI Alias.

Pick an alias to view, then click “Update”.

It is bad form to alter someone else's lab alias – but you are free to use any existing aliases that you like. To make your own alias, just click on “New”, open the lab compendium and add the labs you wish. An easy way to find your alias in the future is to preface the name with your initials.

You can change the date for all the lab orders by using the calendar at the top (you need to change the date PRIOR to ordering the labs). Once a lab is ordered, you can change the date for that individual lab by clicking on the date to the right of the lab order. You can delete all the labs for that date by clicking on the minus sign at the top, or delete individual labs by clicking on the minus sign to the right of the lab.

You can add a standing order by choosing the lab, then clicking “Add Standing Order”. Then choose how many times you want to order the lab, and at what interval. Then click “OK”.

Clicking on the ellipsis next to the lab opens a details screen where you can add notes for the lab (under “Notes” or “Clinical Notes” - the lab does not see text entered in “Internal Notes”). I add text here much more often when ordering diagnostic images than when ordering labs. You can also change the assessment linked to the lab in this screen.

Ordering a diagnostic image is very similar to ordering a lab – just change the screen to “DI”.

For some DI, you will need to change the DI company – in the case of an echo, change to cardiac testing.

If you can't find the DI anywhere, search using the filters “All” and “Contains”.
To send any prescriptions written during the visit, click on “ePrescribe Rx” at the bottom of the treatment screen.

I always click on “Show Preview Rx” - after being burned a few too many times by errors that I didn't see in the other views of the prescription writing process, this second look helps me to know EXACTLY what I am sending to the pharmacy.

When the naproxen prescription was dropped into the note, so long as your drug interaction default is set up as anything other than “None” (in My Settings), the system should have prompted you about any potential interactions. Clicking on the “Interactions” button here opens the interaction screen. Setting this to “New Drugs with active drugs” limits the information to the new prescriptions (my preference in this situation).

If you choose to send this in spite of the warnings, click on “Send Rx”.
OK, your note is written, labs/DI ordered, prescriptions written and sent – now for billing. Click on the calendar icon on the top navigation bar, then click on “Add E&M” (or, in some circumstances, click on “Add CPT”) and choose a billing code. Either free-text a follow-up interval or choose a selection from the buttons below the follow-up screen. Click “Done” - and send the patient to the front desk to be signed out.

Now, the most important function – locking your note. Until the note is locked, the visit cannot be billed. So, as the emails from Rich say every week - Lock Your Notes. Once a note is locked, it cannot be changed.

However, you can add an addendum to a locked note.

Brad Kney, MD
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