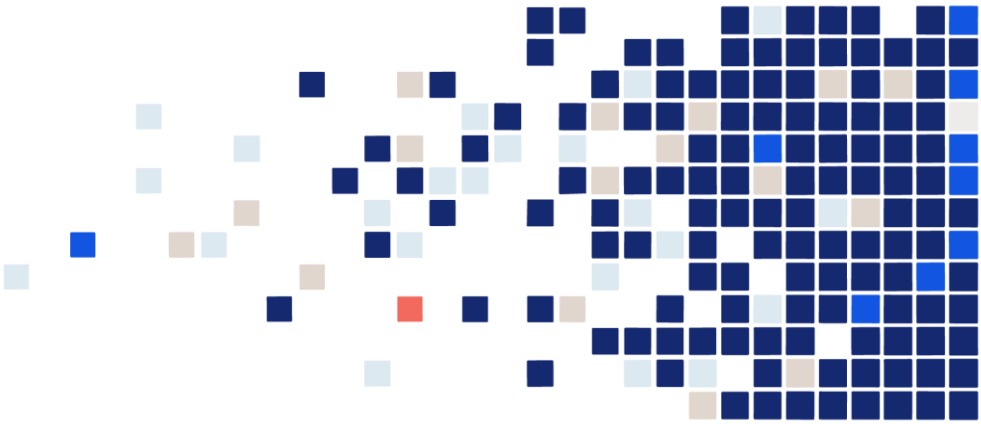
Manifest MEDEX

MX Access

USER GUIDE



Manifest MEDEX

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1. MX Access Homepage

MX Access provides deep longitudinal health information from across California. To access MX Access, click the **Access** icon in the menu located on the left side of the screen.

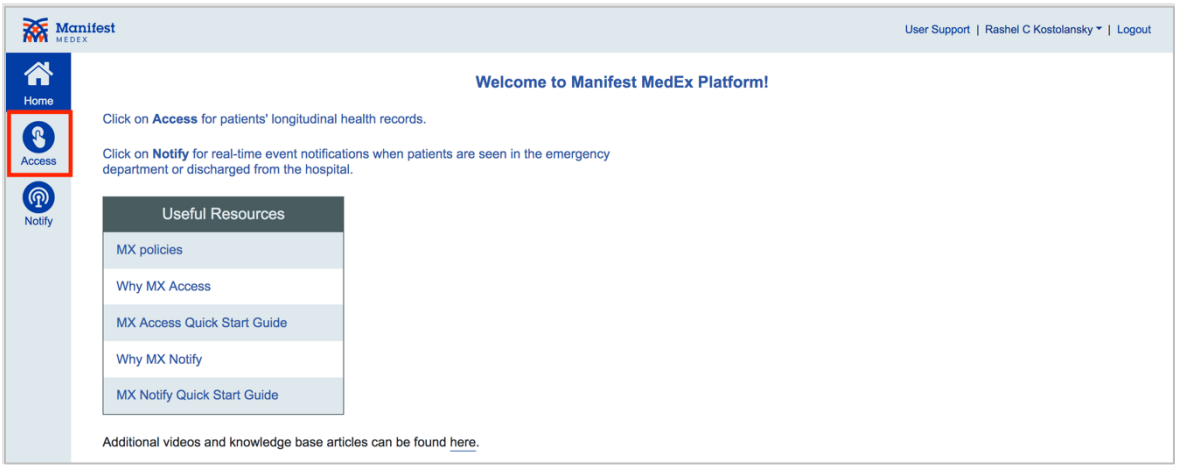


Figure 1: MX Access

You will be directed to the Access **Homepage** that displays the patient search screen and a **Recent Patients** tab. You can search for a patient using their demographics or their MRN/facility. Payer and ACO/IPA users should search for patients using demographics or Patient ID.

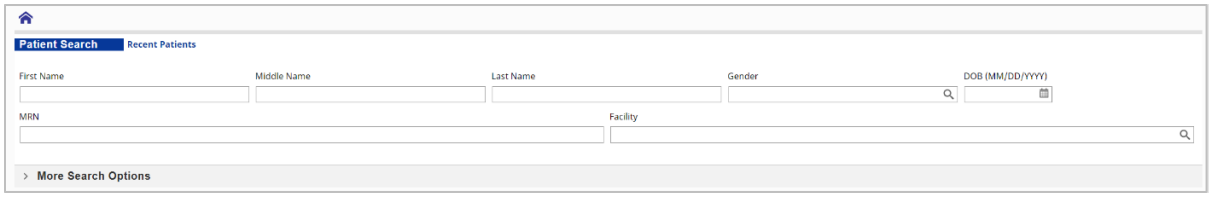


Figure 2: MX Access Homepage

*Note: If you choose to enter the patient's **Name** and the **MRN/facility**, the system will default to display the results based on the **MRN/facility**.*

a. Searching for a Patient Using Demographics

The minimum search criteria for demographics are the patient's **First Name** (at least 2 characters) and the patient's **Last Name** (at least 2 characters). To make sure the

system locates the right patient, we recommend you include as much information as possible. The fields available for data entry are: First Name, Middle Name, Last Name, Gender, and Date of Birth (DOB). To enter additional information, click **More Search Options**, where you can add: Street, City, State, Zip, and Social Security Number (SSN).

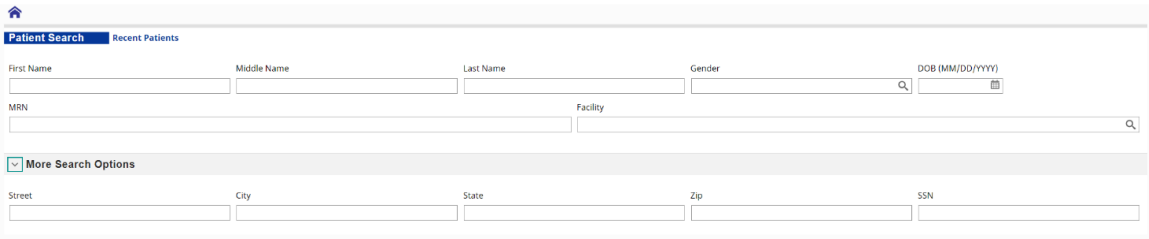


Figure 3: Patient Demographic Search

If the minimum search criteria are not entered, the system will return an error message listing the search requirements.

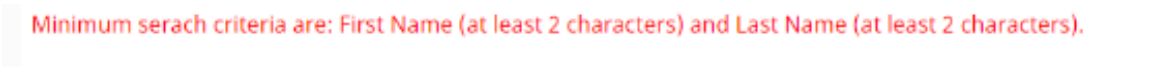


Figure 4: Patient Demographic Search Error

b. Searching for a Patient Using MRN/Facility

Searching for a patient using **MRN** requires adding the associated facility name in the **Facility** field. You can click on the magnifying glass to see the list of facility names or start typing the facility name within the field to find the facility of interest.

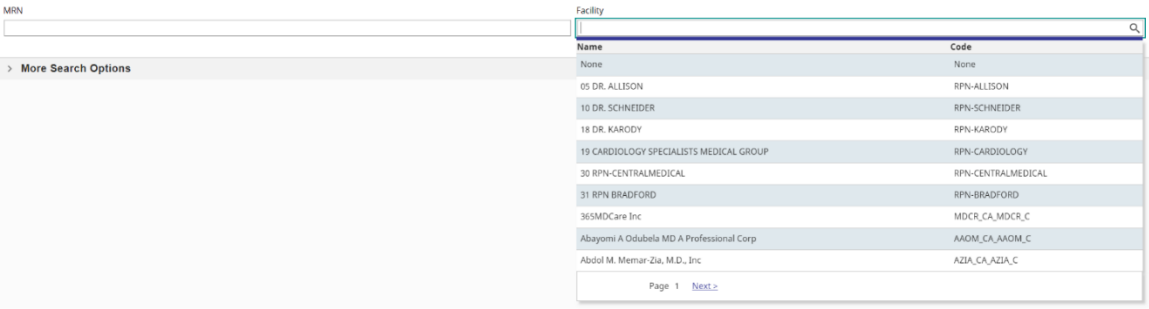


Figure 5: Facility List

If you try to search for a patient using only the MRN or only the facility, an error message will appear.

Choose a facility when entering an MRN.

Figure 6: MRN Patient Search Error

c. Recent Patients

MX Access contains a **Recent Patients** tab that is automatically populated with a list of your 20 most recently viewed patient records. The patients are organized in reverse chronological order. Once the maximum number of patients is listed, the oldest viewed patient is dropped from the bottom of the list, and the newest is added to the top. The **Recent Patients** tab displays the patient's Last Name, First Name, DOB, Age, Gender, Primary Care Provider (PCP), and PCP Phone. From the **Homepage**, click the **Recent Patients** tab, locate your patient, and click on their name.

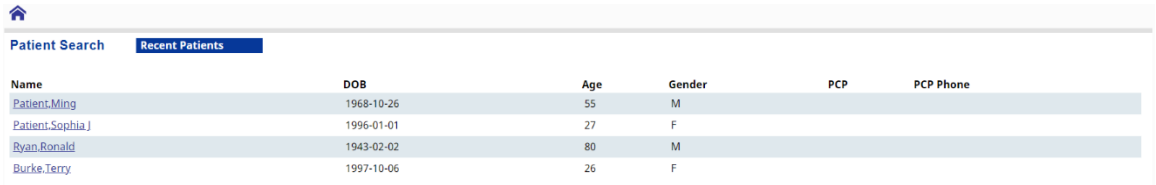


Figure 7: Recent Patients Tab

2. Patient Search Results

Search results will be displayed under the search criteria. The search results will include the patient:

- **Identifier**: Patient MRN/facility
- **Name**: Patient's last name and first name
- **Gender**: Patient's sex indicated by **F** or **M**
- **DOB**: Patient's date of birth
- **Address**: Patient's most recent address
- **Info Types**: The type of information included in the medical record.
  Note: The icons are shown at the MRN level and will only be displayed when clicking the expand button next to the patient's identifier.

- **Consent Status**: Patient is opted-in or opted-out

a. Search Results Using a Patient's Demographics

Searching for a patient using demographics will result in up to 50 patients being returned.

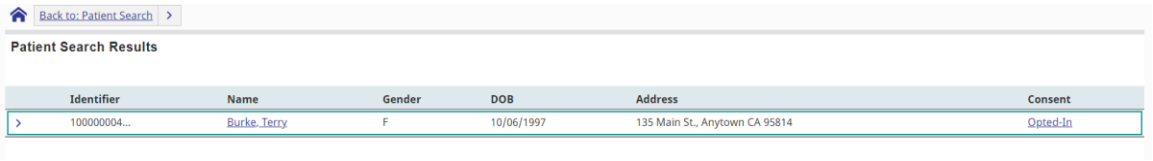


Figure 8: Demographic Search Result

b. Search Results Using a Patient's MRN/Facility

When you search for a patient using their MRN and Facility, the system will return an exact match. If an exact match cannot be found, the system will display **No matches found!**

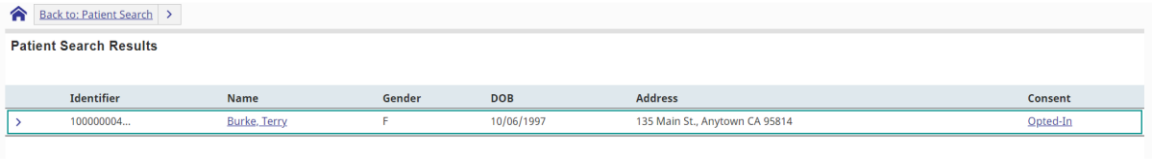
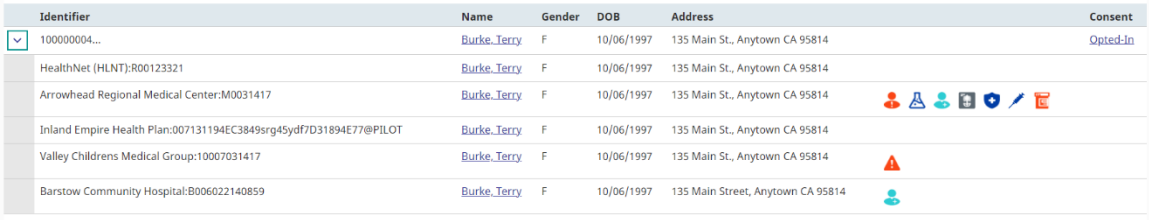


Figure 9: MRN Search Result

c. Patient Identifiers

Search results include a patient's full longitudinal record as well as a list of all data sources. To see all data sources included, click on the expand/minimize icon › next to the patient's **Identifier**. A list of MRNs and facilities will be displayed on the screen. You can choose to view the patient's full medical record or view data from one source at a time.



Identifier	Name	Gender	DOB	Address	Consent
100000004...	Burke, Terry	F	10/06/1997	135 Main St., Anytown CA 95814	Opted-In
HealthNet (HLNT):R00123321	Burke, Terry	F	10/06/1997	135 Main St., Anytown CA 95814	
Arrowhead Regional Medical Center:M0031417	Burke, Terry	F	10/06/1997	135 Main St., Anytown CA 95814	
Inland Empire Health Plan:007131194EC3849srg45ydf7D31894E77@PILOT	Burke, Terry	F	10/06/1997	135 Main St., Anytown CA 95814	
Valley Childrens Medical Group:10007031417	Burke, Terry	F	10/06/1997	135 Main St., Anytown CA 95814	
Barstow Community Hospital:B006022140859	Burke, Terry	F	10/06/1997	135 Main Street, Anytown CA 95814	

Figure 10: Patient Identifiers

d. Info Type Icons

Search results illustrate the type of information available in the medical record using icons. Each data source will list the type of information it contributed to the longitudinal medical record. You can hover over the icons to see what they represent.

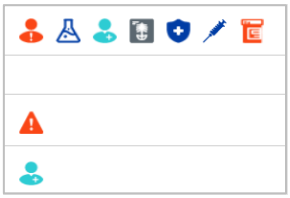


Figure 11: Info Types

You will see one or more of the following icons:

- Allergy
- Documents
- Diagnoses
- Medical History
- Lab Results
- Medications
- Problems
- Radiology Results
- Vaccinations

e. Consent Status

California is an opt-out state, meaning all patients are opted-in by default. However, patients can choose to opt out of the network. If a patient has opted out, you will see that noted under **Consent** on the far right of the screen. If the patient has opted out, you can search for the patient, but you will not be able to access their medical record.

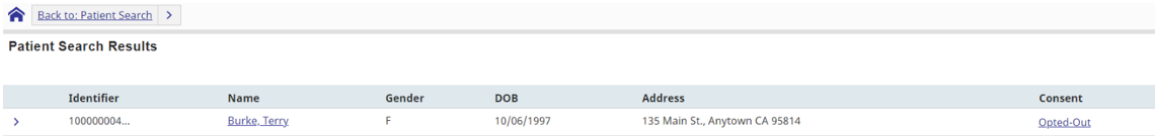


Figure 12: Consent Status

Patients can request to change their consent status by submitting a form on the MX website.

f. Choosing to View a Patient's Full Medical Record

To select a patient's comprehensive medical record (i.e., one that includes data from all sources), click on the patient's name in the search results.

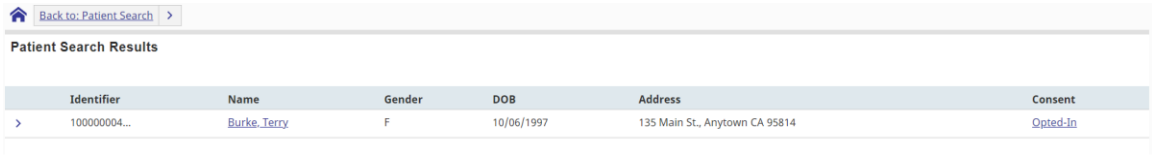


Figure 13: Full Medical Record

g. Choosing a Data Source

To select one specific data source, click on the name next to the **Identifier** of interest.

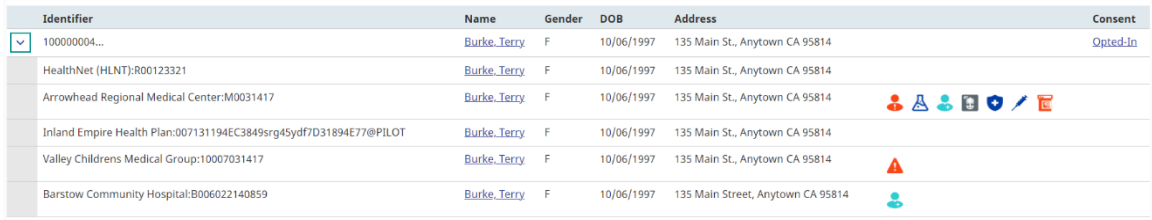


Figure 14: View Selected Patient Record

h. Choosing a Patient from the Recent Patients Tab

When a patient is added to the **Recent Patients** tab, the system will add the patient's full longitudinal record regardless of whether you choose to view only one data source. To view one data source, you will need to search for the patient again and select the data source of interest.

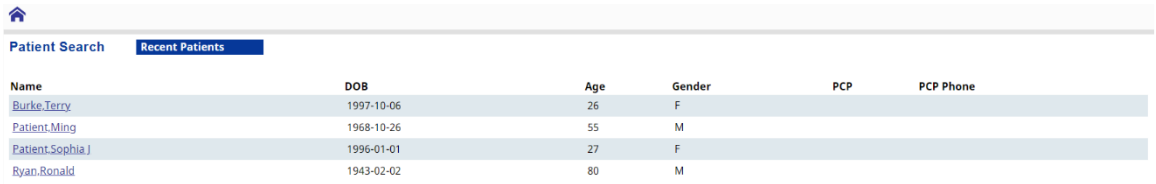


Figure 15: Selecting Recent Patient Record

3. Patient Summary

The Patient Summary page gives you a brief overview of the patient's allergies, medications, problems & diagnoses, procedures, laboratory results, and encounters. Each section on this page can be sorted by key information using a primary and secondary selection.

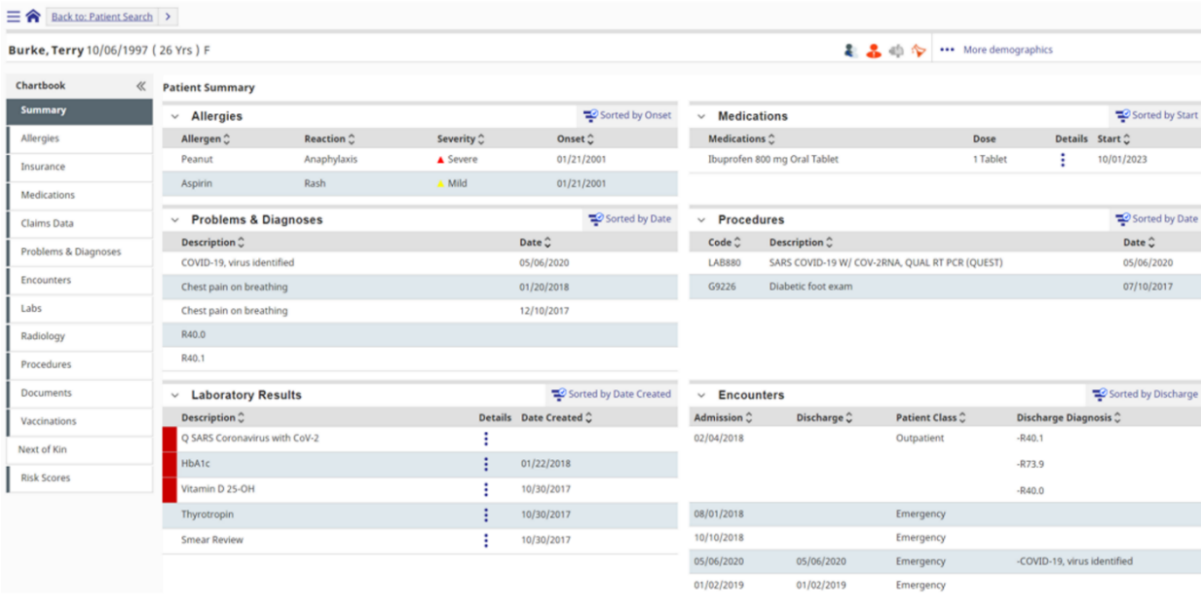


Figure 16: Patient Summary

a. Alert Icons

MX Access displays alert icons at the top of a patient's record if there is crucial information to note, such as abnormal lab results or allergies. Hover over the icon to see what it represents.



Figure 17: Alert Icons

Click on the icon to see a slide out bar with more icon selection options.

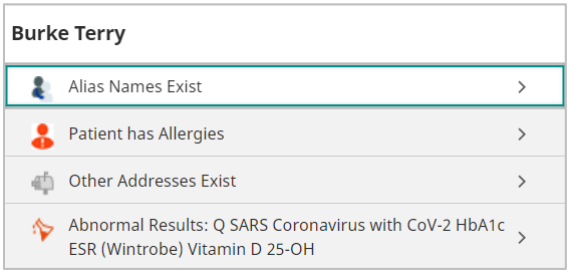


Figure 18: Slide out List of Alert Icons

You may see one or more of the following icons:

- Alias: Indicates that the patient goes by more than one name (e.g., Terry and Theresa).
- Allergy: Will be displayed when the patient has one or more recorded allergies.
- Other Address: Will be displayed when the patient has additional addresses.
- Abnormal Results: Will be displayed when the patient has abnormal test results.
- Deceased: Will be displayed when the patient is deceased.

- COVID-19: Will be displayed when the patient has had a positive COVID-19 lab result.

When a patient is deceased, the date of death will be displayed on the screen.



Figure 19: Deceased Patient

When a patient has received a positive COVID-19 lab result within the past 90 days, a COVID-19 Positive banner will be displayed on the screen. After 90 days, the banner will no longer be displayed, but the COVID-19 icon will remain.



Figure 20: COVID-19 Positive Banner

Click on the icon within the slide-out bar to be taken to the appropriate page.



Figure 21: Selecting an Icon on the Slide Out List

b. More Demographics

The patient summary page displays a patient's last name, first name, DOB, age, and sex on the top left side of the screen. You can see more demographics by clicking **More Demographics** on the top right side of the screen.



Figure 22: Patient Demographics

The additional information displayed may include address, MRNs, phone numbers, email, race, language, marital status, religion, ethnicity, SSN, driver's license, mother's maiden name, insurance, and PCP. To hide the information, click **Less Demographics.**



Figure 23: More Demographics

i. Full Medical Record Demographics

The full medical record lists demographics from the most recently updated data source. If there are additional addresses or alias names for the patient, they will be shown in **Alert Icons**.

ii. Data Source Demographics

Viewing a specific data source will list the demographics of that data source. If another data source contains the patient's most recently updated address, it will be shown in **Alert Icons**.

iii. Sexual Orientation and Gender Identity (SOGI)

Users can access and view SOGI data by clicking on the **More Demographics** section within the Patient-Name banner in the top right corner of the page.



Figure 24: Access More Demographics

Once demographics have been expanded, the SOGI data will appear in the bottom left-hand corner of the patient demographics profile. The SOGI data points, if available, include:

- Sexual Orientation

- Gender Identity
- Sex Assigned at Birth

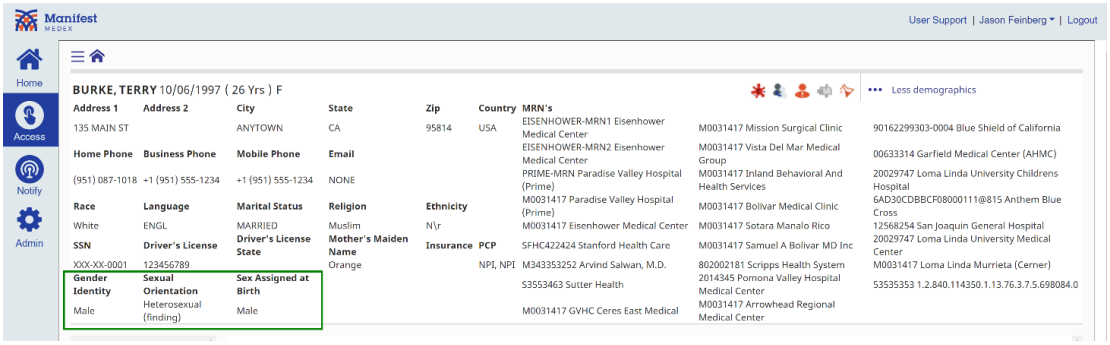


Figure 25: SOGI Data

c. Patient Summary Report

View the patient's medical record in various standard reports such as consolidated clinical document architecture (CCDA), discharge summary, and patient summaries. To view the patient summary report, click on the three dots on the right side of the screen and select **Patient Reports** at the top of the slide out screen.

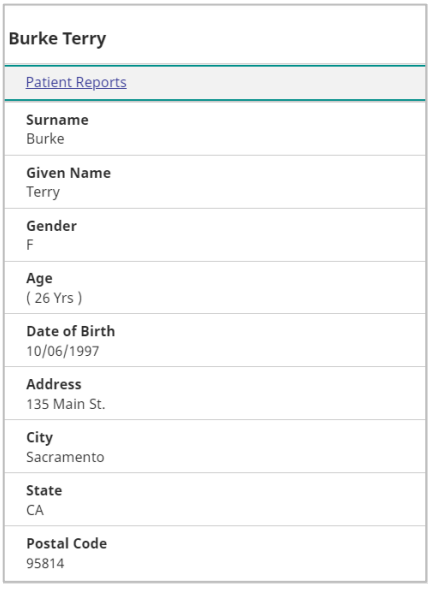


Figure 26: Patient Reports

Patient Summary (HTML) is the default report shown. This report includes patient demographics, allergies, medications, encounters, diagnoses, laboratory results, observations, procedures, social history, care teams, patient goals, health concerns, devices, and procedure-specific devices.

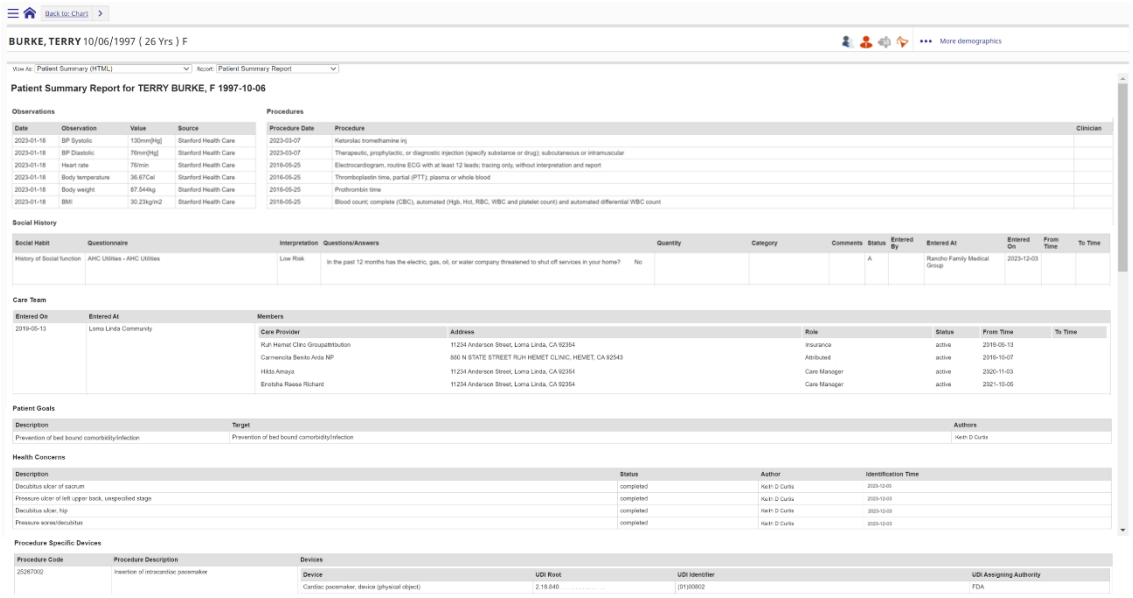


Figure 27: Patient Summary Report HTML

To view this report in an expanded view, click the **Report** dropdown menu and select **Patient Summary Report (Expanded).** The expanded report includes patient demographics, allergies, alerts, advance directives, patient-clinician relationship, program memberships, encounters, appointment, diagnoses, medications, immunizations, laboratory results, radiology results, observations, procedures, physical exams, problems, history, documents, death information, and additional information about people and organizations e.g., emergency contacts and providers.



Figure 28: Patient Summary Report Expanded

To view the report in a different format, click the **View As** dropdown menu.

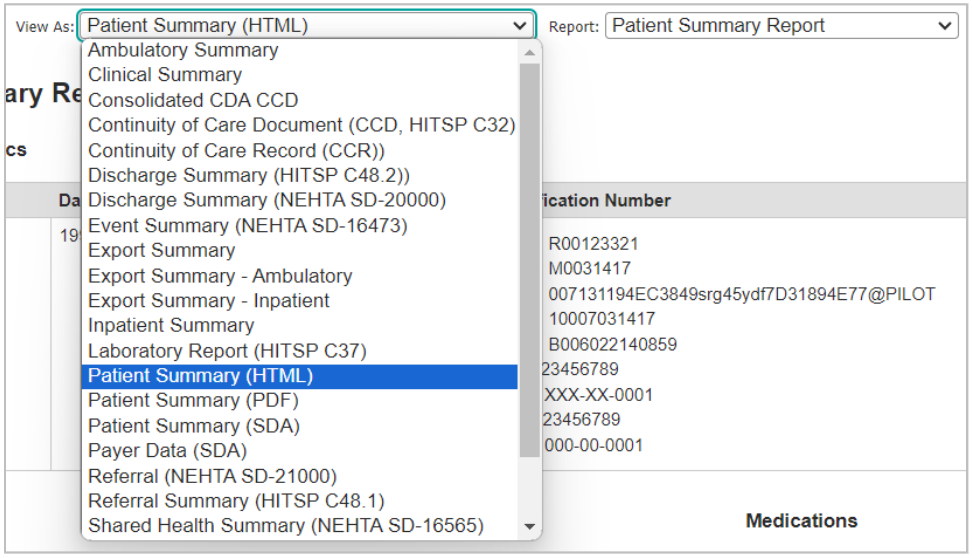


Figure 29: View As

You can view the report in the following formats:

- Ambulatory Summary
- Clinical Summary
- Consolidated CDA CCD
- Continuity of Care Document (CCD, HITSP C32)
- Continuity of Care Record (CCR)
- Discharge Summary (HITSP C48.2)
- Discharge Summary (NEHTA SD-20000)
- Event Summary (NEHTA SD-16473)
- Export Summary
- Export Summary – Ambulatory
- Export Summary – Inpatient
- Inpatient Summary
- Laboratory Report (HITSP C37)
- Patient Summary (HTML)
- Patient Summary (PDF)
- Patient Summary (SDA)
- Payer Data (SDA)

- Referral (NEHTA SD-21000)
- Referral Summary (HITSP C48.1)
- Shared Health Summary (NEHTA SD-16565)
- Transition of Care/Referral – Ambulatory
- Transition of Care/Referral – Inpatient
- Transition of Care/Referral Summary

d. Printing or Downloading a Patient's Summary Page

You can print or download a patient's summary report. To print or download, click the **View As** dropdown menu and select **Patient Summary (PDF)**. The PDF will appear on the screen. Click the **Download** or **Print** icon.

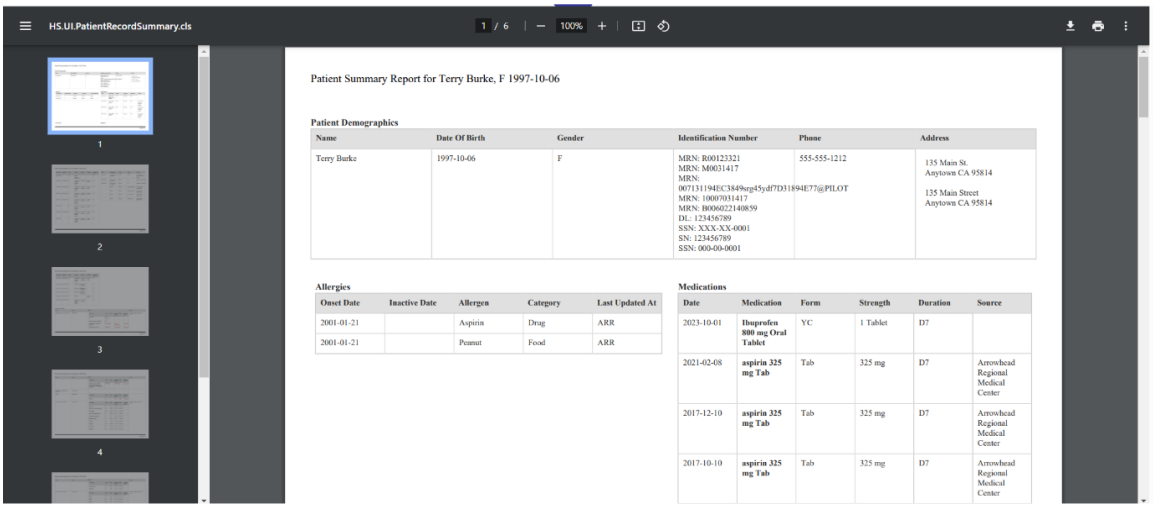


Figure 30: Patient Summary PDF

To return to the previous page, click on **Back to: Chart** at the top left-side of the screen or click on the arrow to select "Chart" which will bring you to the last visited page in the patient chart.

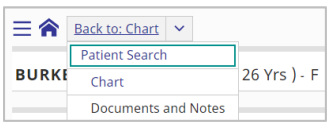


Figure 31: Summary Report Exit

4. Selecting Tabs

The patient record is divided by summary, allergies, insurance, medications, problems & diagnoses, encounters, lab results, radiology results, procedures, documents, vaccinations, next of kin, risk score, and vit. To see more details about any of these items, click on the tab of interest located on the left side of the screen.

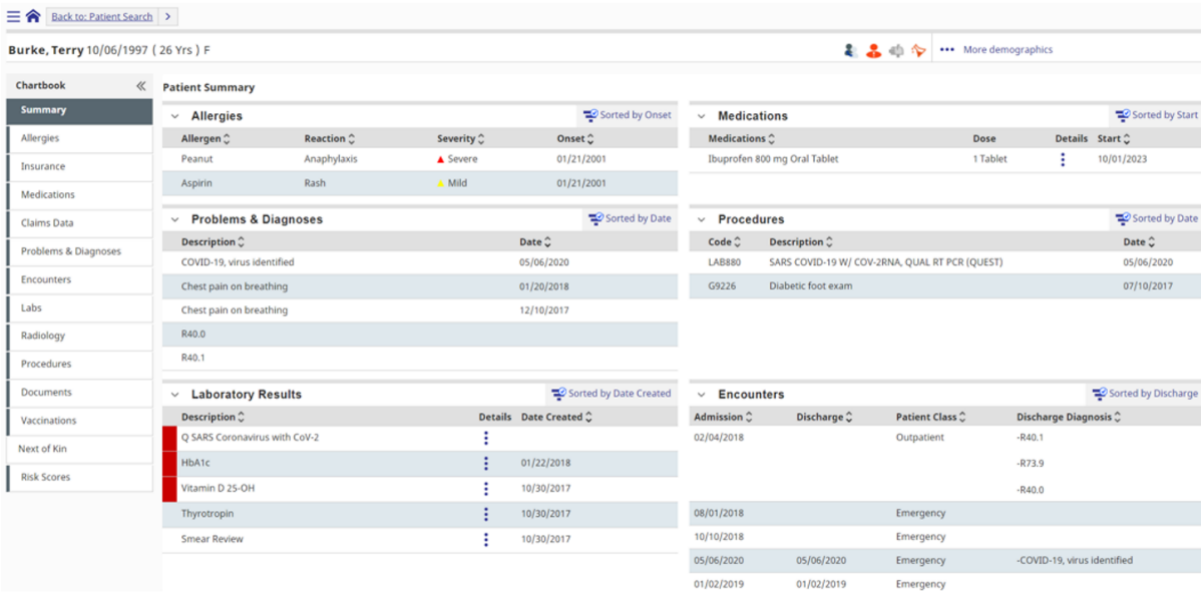


Figure 32: Selecting Tabs

Tabs that contain patient data will have a gray line on the left side of the tab. Tabs without data will remain white.



Figure 33: Tabs with Data

To display more data across the screen, you can collapse the chartbook tabs located on the left side of the screen. Simply click on the collapse button to hide the tabs or click on the expand button to display the tabs.

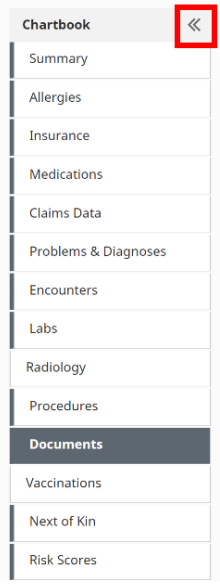


Figure 34: Hiding Tabs

a. Allergies

Click the **Allergies** tab to view the list of recorded allergies. The tab includes allergy:

- **Type**: The type of allergy. In this column you will see animal, drug, environment, food, pollen, plant allergy, or miscellaneous.
- **Allergen**: The name of the allergen (e.g., aspirin, peanuts)
- **Severity**: The severity of the allergen. In this column you will see mild, moderate, severe, or unknown.
- **Reaction**: The allergic patient's reaction/symptoms if they are exposed to the allergen
- **Onset Date**: The date for which the allergic reaction occurred
- **Resolved On**: The date for which the patient was cured of the symptoms
- **Status**: Whether the patient is still allergic. In this column you will see active or inactive.
- **Reporting Entity**: The organization that reported the allergy
- **Last Updated**: The date of latest update as it relates to the allergy

The severity of the allergic reaction will be indicated by a **Mild** or **Severe** icon.



Figure 35: Allergies

Within the Allergy tab, you can sort data by primary and secondary fields. The default sort in the allergy tab is *Onset Date,* and you can change the sort order by clicking on **Sorted by Onset Date.**



Figure 36: Sorted by Onset Date

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

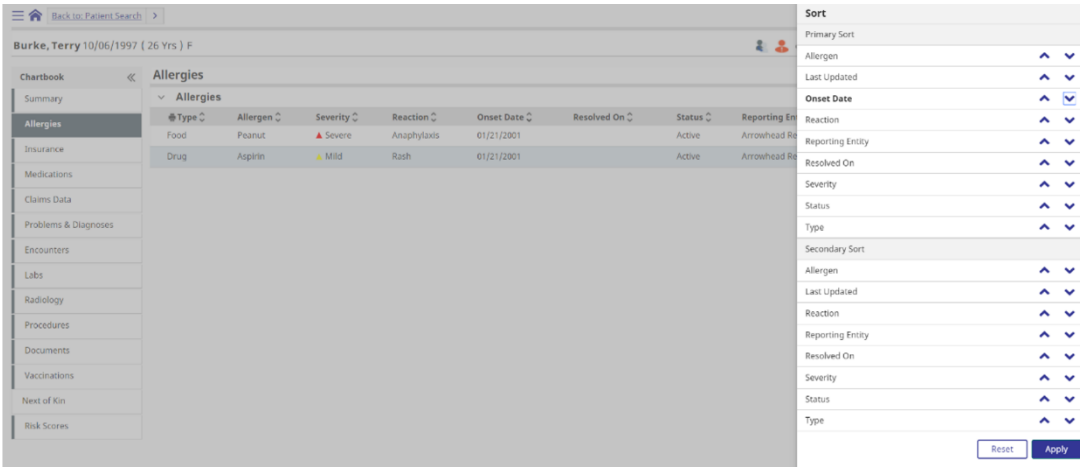


Figure 37: Allergies Sorted by Options

You can search within the allergy tab by entering at least one character in the search box and clicking enter. The system will search for all results within the tab. Search results will be highlighted in yellow.

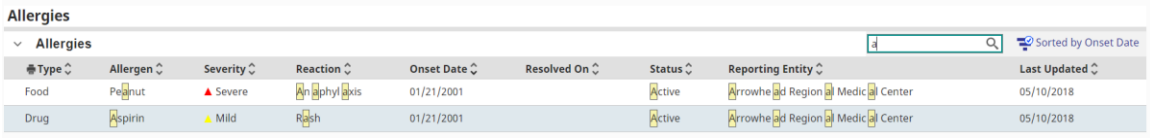


Figure 38: Allergies Search Box

b. Insurance

Click the **Insurance** tab to view a list of the patient's insurance coverage(s). Tables include Active Eligibility, Inactive Eligibility, Active Enhanced Care Management (ECM), and Historical Enhanced Care Management (ECM). The Eligibility tables include:

- **Insurance Name**: The name of the insurance company
- **Type**: The type of claim. In this column you will see Med (Medical) or Rx (prescription).
- **Group Name**: The name of the insurance group (e.g., Cal Choice)
- **Policy Number**: The unique member ID for the policyholder
- **Plan**: The type of plan. In this column you will see exclusive provider organization, health maintenance organization, preferred provider organization, or other.
- **Start Date**: The date for which the insurance coverage started
- **End Date**: The date for which the insurance coverage ended
- **Relationship**: The relationship of the patient to the policyholder

The Enhanced Care Management (ECM) tables include:

- **ECM Eligible/Previously ECM Eligible**: An ECM table that displays whether the patient is currently eligible or was previously eligible
- **ECM Provider Name**: The name of the ECM provider, if the patient is assigned to a provider

- **ECM Provider National Provide Identifier (NPI)**: The NPI of the ECM provider, if the patient is assigned to a provider
- **Start Date:** The date the patient became eligible for ECM
- **End Date:** The date the patient's ECM eligibility expired
- **Insurance Name:** The name of the insurance company that provided the ECM data

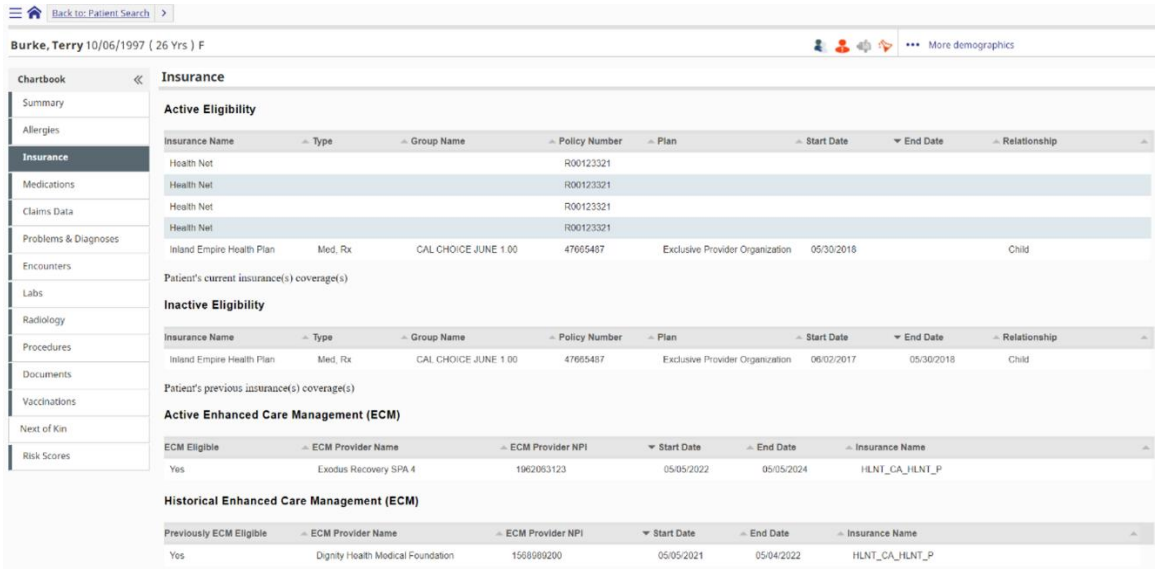


Figure 39: Insurance

c. Medications

Prescribed and filled medications are included in the patient's summary page. If medications have been prescribed or filled within the last 90 days, they will appear under **Recent Medications**. Medications older than 90 days can be found under **Historical Medications**. Click the **Medications** tab to view recent and historical medications. You can filter the medications by **All Meds**, **Clinically Sourced Meds** (clinical data), or **Claims Sourced Meds** (claims data). The tab includes:

- **Medication**: The name of the medication (e.g., Aspirin)
- **Prescribed/Filled**: Whether the medication was prescribed or filled

- **Status**: Whether the medication is new or a refill. For clinical data, you will see V – verified or D – discontinued. For claims data, you will see CP – New Claim Paid or RP – Refill Claim Paid.
- **Form, Dose**: The amount of medication prescribed (e.g., 325 mg). This column will only include clinically-sourced data.
- **Sig/Instructions**: Instructions on how to take the medications (e.g., once a day). This column will only include clinically-sourced data.
- **Route**: The method of how the medication should be taken (e.g., oral). This column will only include clinically-sourced data.
- **Start**: The date the patient is prescribed the medication (clinical data). *Note: If this field has a date populated, and the source is claims data, it will display the same date that is displayed in the* ***Fill Date.***
- **Prescribed by**: The name of the physician who prescribed the medication. Hover over the name to see the specialty of the physician who prescribed the medication
- **Pharmacy**: The pharmacy that filled the prescription. This column will only include claims-sourced data.
- **Fill Date**: The date the medication was filled. This column will only include claims-sourced data.
- **Quantity Dispensed**: The total amount of dispensed medication
- **Days Supply**: The amount of days the supply of dispensed medication will last. This column will only include claims-sourced data.
- **Source:** Whether the data is claims-sourced or clinical-sourced

Within the Medications tab there is the ability to sort data by primary and secondary fields. The default sort in the Medications tab is *Start,* and you can change the sort order by clicking on **Sorted by Start**.

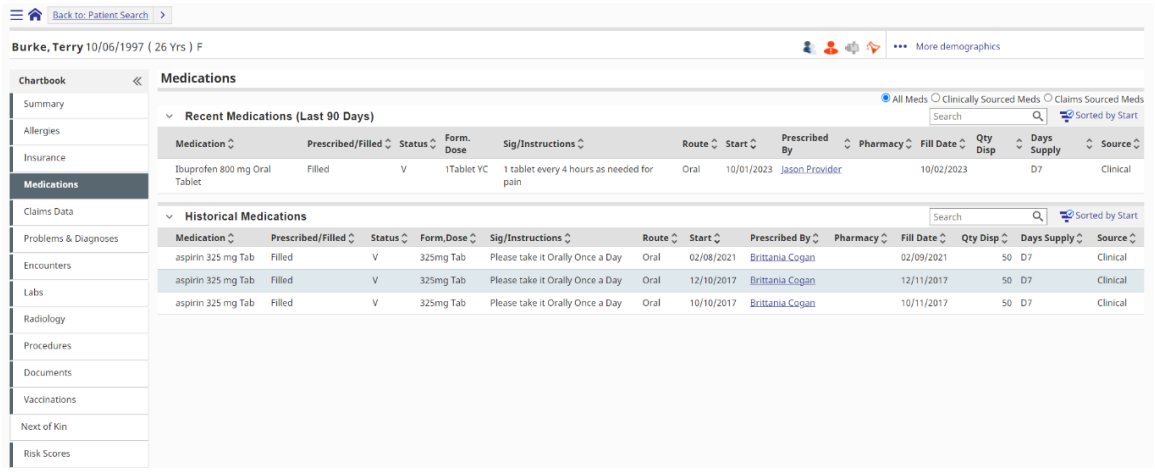


Figure 40: Medications

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

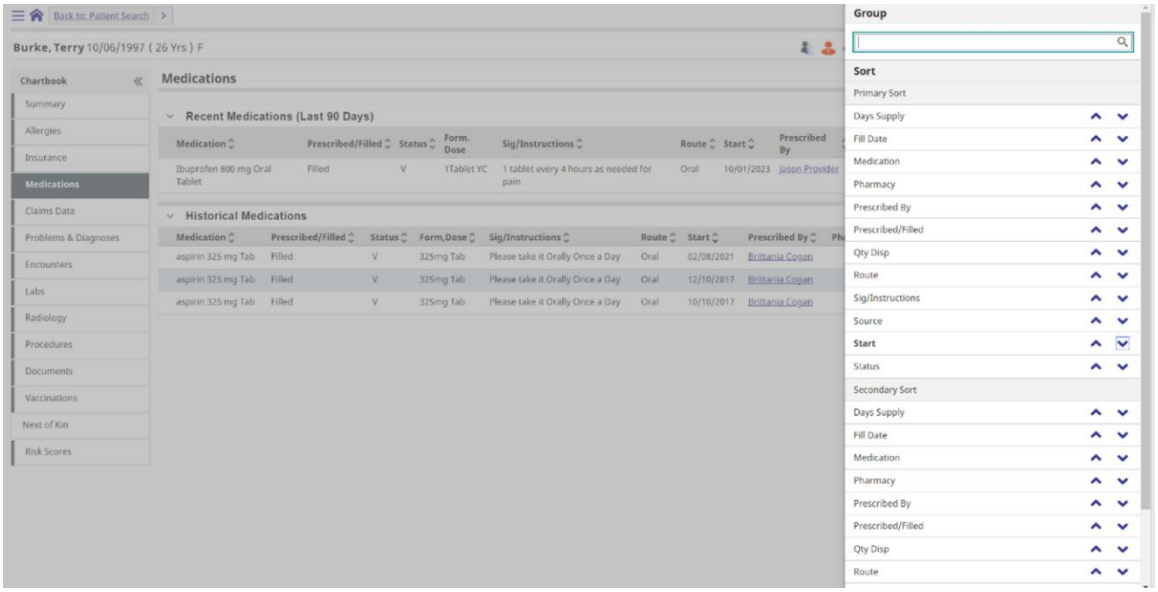


Figure 41: Medications Sort Options

Two search boxes are available in the Medications tab, one for the Recent Medications table and the other for the Historical Medications table. You can search within either table by entering at least one character in the search box and clicking enter. Search results will be highlighted in yellow.

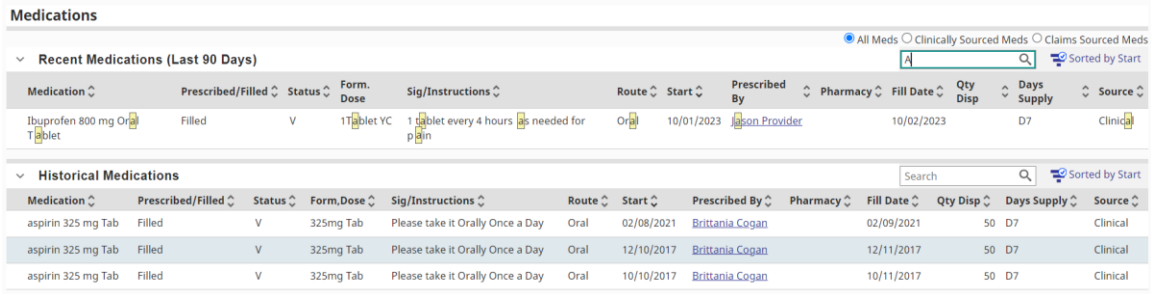


Figure 42: Medications Search Boxes

d. Problems & Diagnoses

To view patient diagnoses with past and present problems, click the **Problems & Diagnoses** tab. You can filter the diagnoses by **All Diagnoses**, **Clinically-Sourced Diagnoses Only**, or **Claims-Sourced Diagnoses Only** by selecting the radio button located at the top right side of the screen. This tab includes:

- **Description**: A description of the problem or diagnosis (e.g., Type 2 diabetes mellitus with unspecified complications)
- **Status**: The status of the diagnosis. For clinical data, you will see active or inactive, and for claims data, you will see final.
- **ICD code**: The code associated with the particular disease/diagnosis
- **Type**: The type of diagnosis. For clinical data, you will see F (final), W (working), A (admitting), or O (other). For claims data, you will see claims principal (primary diagnosis), claims admission (admitting diagnosis), or claims other (all other diagnoses).
- **Encounter/Claims #**: The number of the encounter given by the organization
- **Encounter Date**: The date the encounter took place for the problem or diagnosis
- **Last Updated**: The date of the latest update as it relates to the diagnosis
- **Reporting Entity**: The organization that reported the problem or diagnosis

- **Source**: Whether the problem or diagnosis was clinical or claims data
- **Diagnosis Date**: The diagnosis date of a present or past problem
- **Resolved On**: The date the present or past problem was resolved on

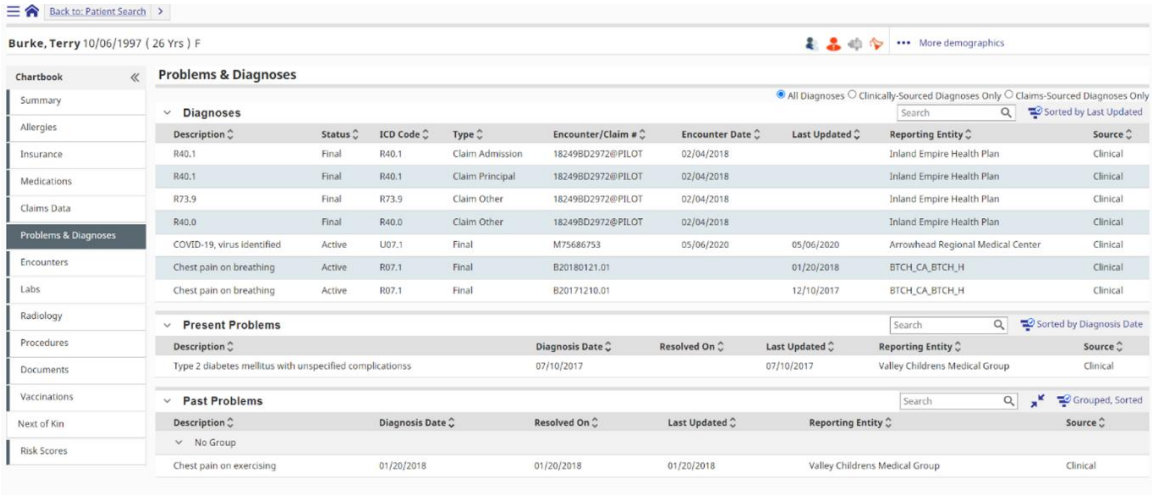


Figure 43: Problems & Diagnoses

Within the Problems & Diagnoses tab you can sort data by primary and secondary fields. The default sort in the Diagnoses table is *Last Updated,* and the default sort in the Past and Present Problems is *Diagnosis Date*. You can change the sort order by clicking on **Sorted by Last Updated/Sorted by Diagnosis Date**.

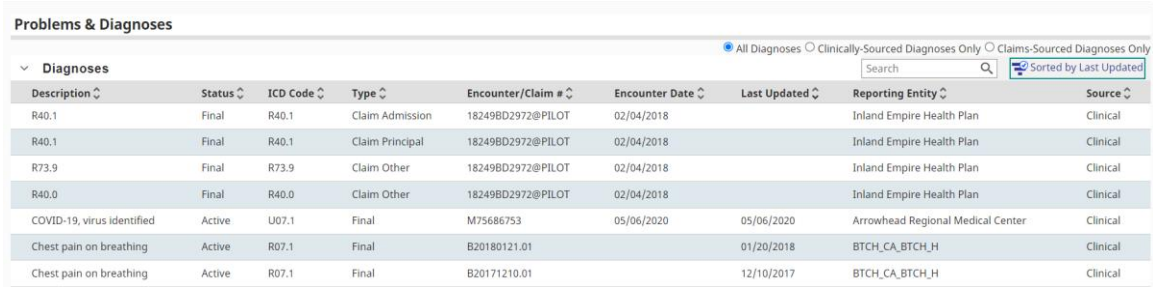


Figure 44: Problems & Diagnoses Sorted by Last Updated

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date)

or click on the ⌄ icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

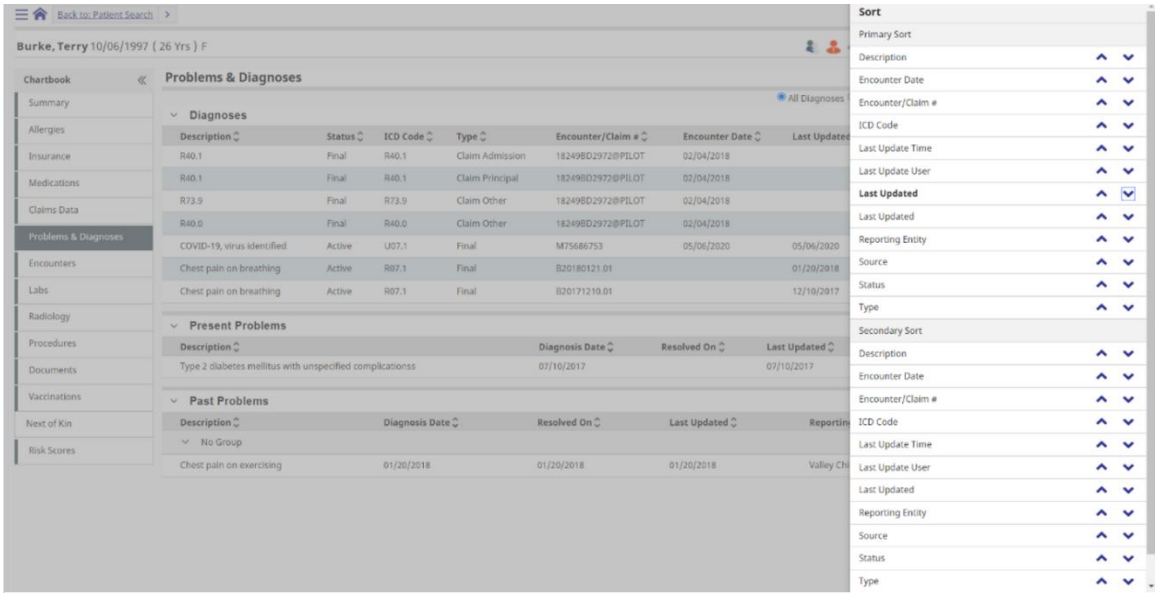


Figure 45: Problems & Diagnoses Sort Options

Three search boxes are available in the Problems & Diagnoses tab: one for the Diagnoses table, another for the Present Problems table, and a third for the Past Problems table. You can search within any table by entering at least one character in the search box and clicking enter. Search results will be highlighted in yellow.

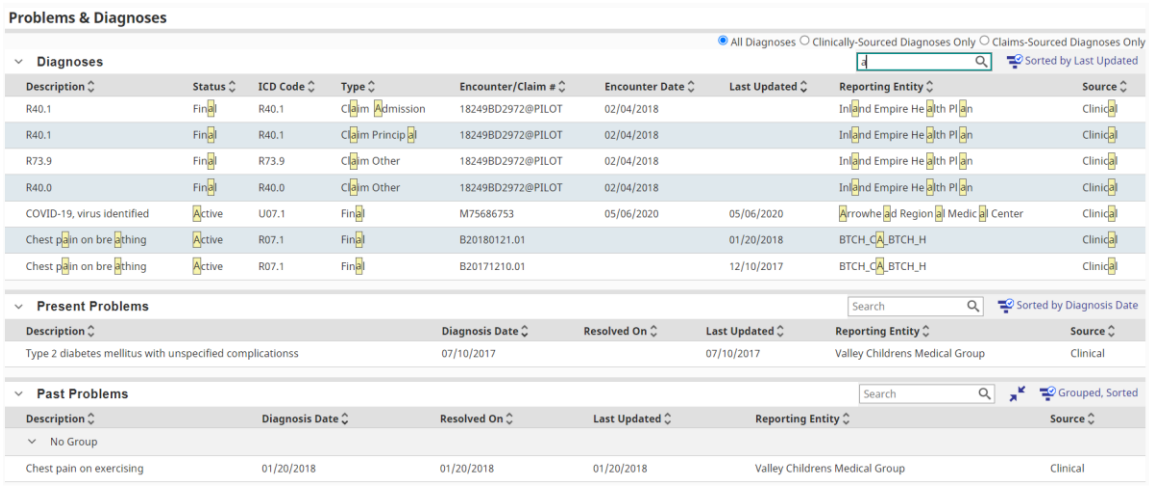


Figure 46: Problems & Diagnoses Search Boxes

e. Encounters

To view inpatient and outpatient details, click the **Encounters** tab. The encounters are organized by **Hospital and Emergency Department (ED)** visits and **Outpatient** visits. You can filter the encounters by **All Encounters**, **Clinically-Sourced Encounters Only**, or **Claims-Sourced Encounters Only** by selecting the radio button located at the top right side of the screen. The tab includes the following columns in the two tables:

Hospital and ED:

- **Admission Date**: The date the patient was admitted to the facility
- **Discharge Date**: The date the patient was discharged from the facility where they were admitted
- **Patient Class**: The type of encounter. This column will include clinically-sourced data only and you will see inpatient or emergency displayed.
- **Hospital Service**: The location of where the patient is treated. This will include clinically-sourced data only.
- **Reporting Entity**: The organization that reported the encounter
- **Clinician**: The name of the physician who treated the patient
- **Discharge Diagnosis**: The diagnosis the patient had upon discharge
- **Discharge Disposition**: Where the patient was discharged to (e.g., discharged to home)
- **Source**: Whether the problem or diagnosis was clinical or claims data
- **Insurance**: Insurance information provided during the encounter. Click on the details icon ⋮ to see the insurance details
- **Encounter/Claim #**: The number assigned to the particular encounter

Outpatient:

- **Date of Service:** The date of the outpatient encounter
- **Specialty**: The specialty of the outpatient service provided
- **Service Provided**: The service provided during an outpatient visit

- **Diagnosis**: The diagnosis given during the outpatient visit
- **Reporting Entity**: The organization that reported the encounter
- **Clinician**: The name of the physician who treated the patient
- **Source**: Whether the problem or diagnosis was clinical or claims data
- **Insurance**: Insurance information provided during the encounter. Click on the details icon ⋮ to see the insurance details.
- **Encounter/Claim #**: The number assigned to the particular encounter

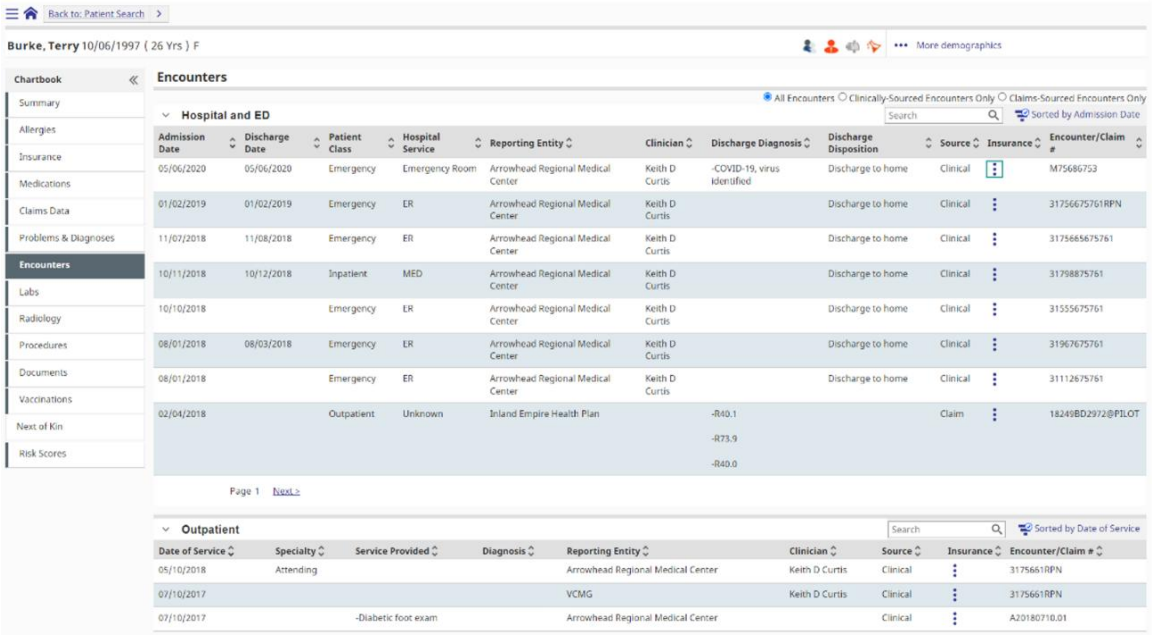


Figure 47: Encounters

Within the Encounters tab, you can group data by clicking on the “Sorted by” button on the top right side of the screen and entering text in the “Group” field. The Hospital and ED table allows grouping by Patient Class and Reporting Entity. The Outpatient data allows grouping by Reporting Entity.

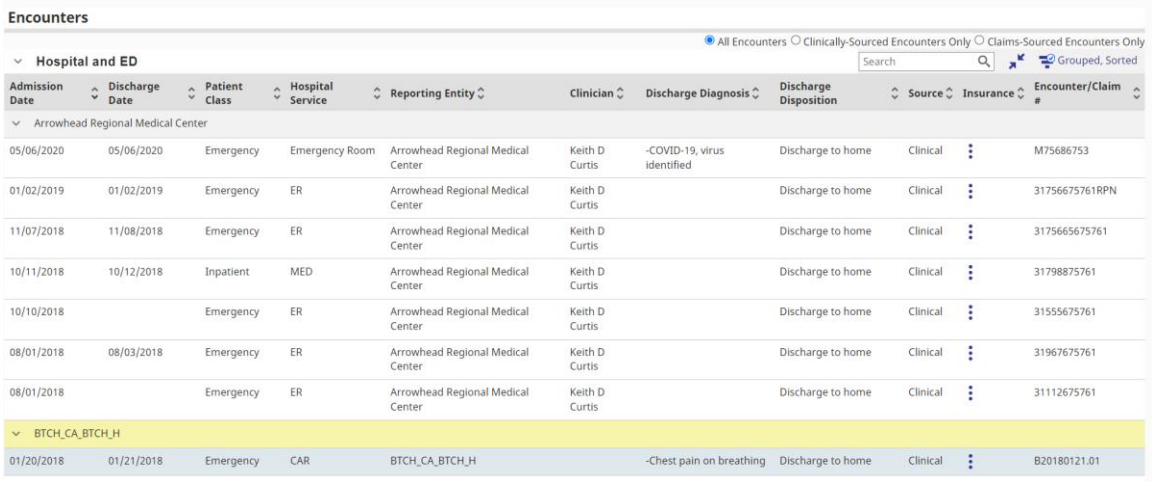


Figure 48: Encounters Grouping

Additionally, within the Encounters tab you can sort data within each table by primary and secondary fields. The default sort in the Hospital and ED table is *Admission Date* and in the Outpatient table is *Date of Service.* You can change the sort order by clicking on **Sorted by Admission Date/Date of Service**.

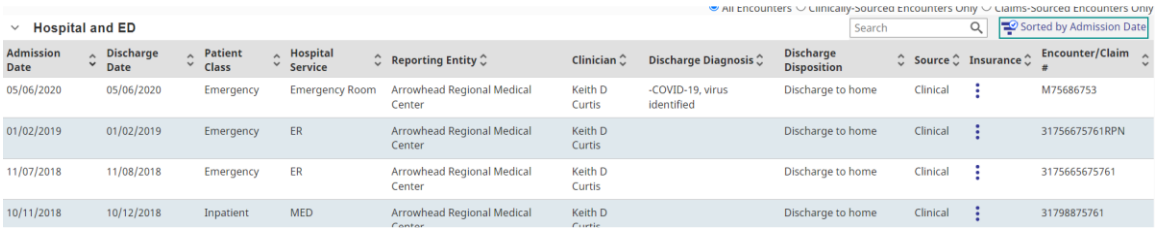


Figure 49: Encounters Sorted by Admission Date/Date of Service

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

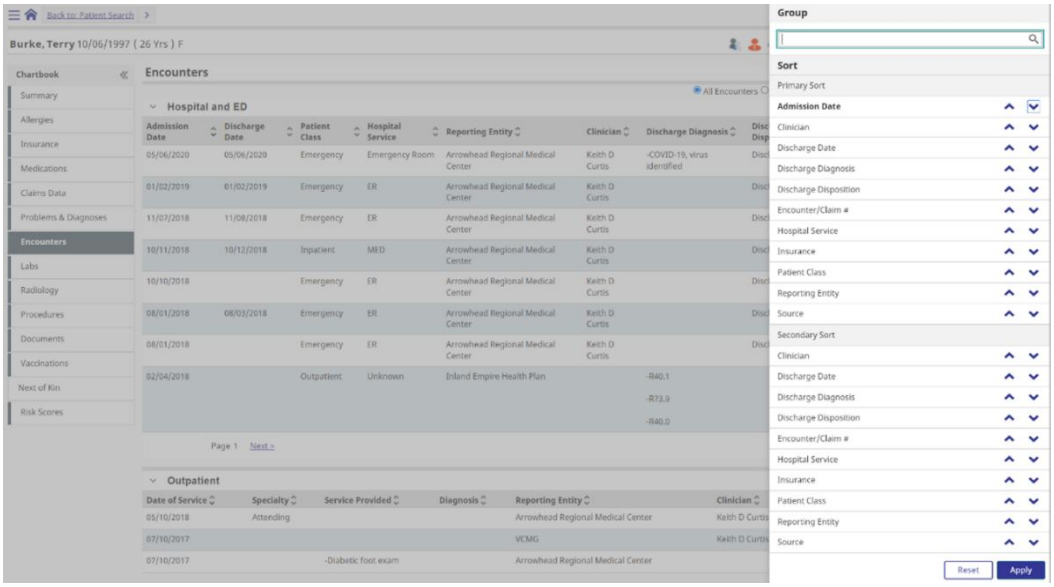


Figure 50: Encounters Sort Options

Two search boxes are available in the Encounters tab, one for the Hospital and ED table and the other for the Outpatient table. You can search within either table by entering at least one character in the search box and clicking enter. Search results will be highlighted in yellow.

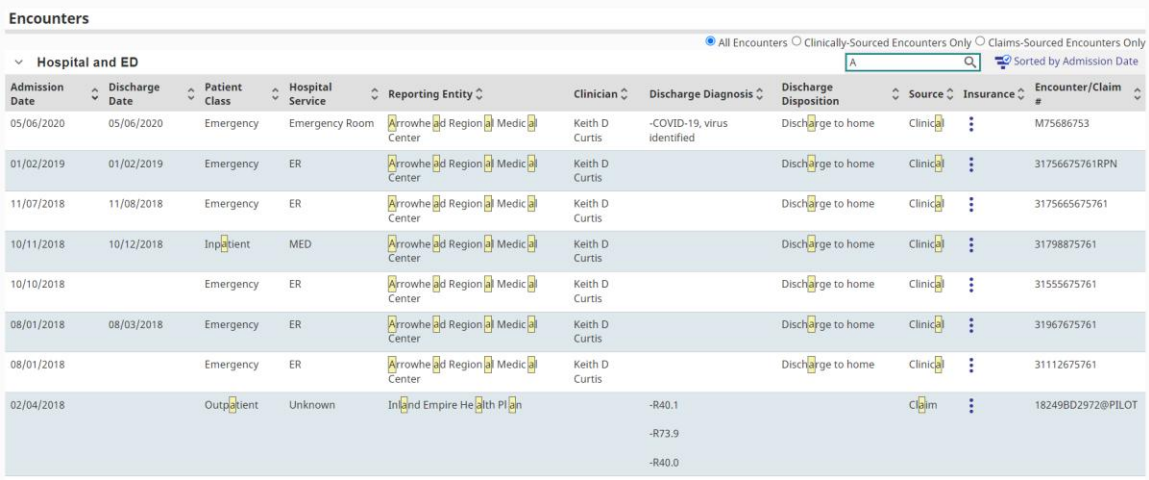


Figure 51: Encounters Search Boxes

f. Labs

View and compare laboratory orders and test results individually or side by side by clicking on the **Labs** tab. Two tables are available within the Labs tab, Laboratory Results – Tabular View and Lab Results Table [Across All Episodes].

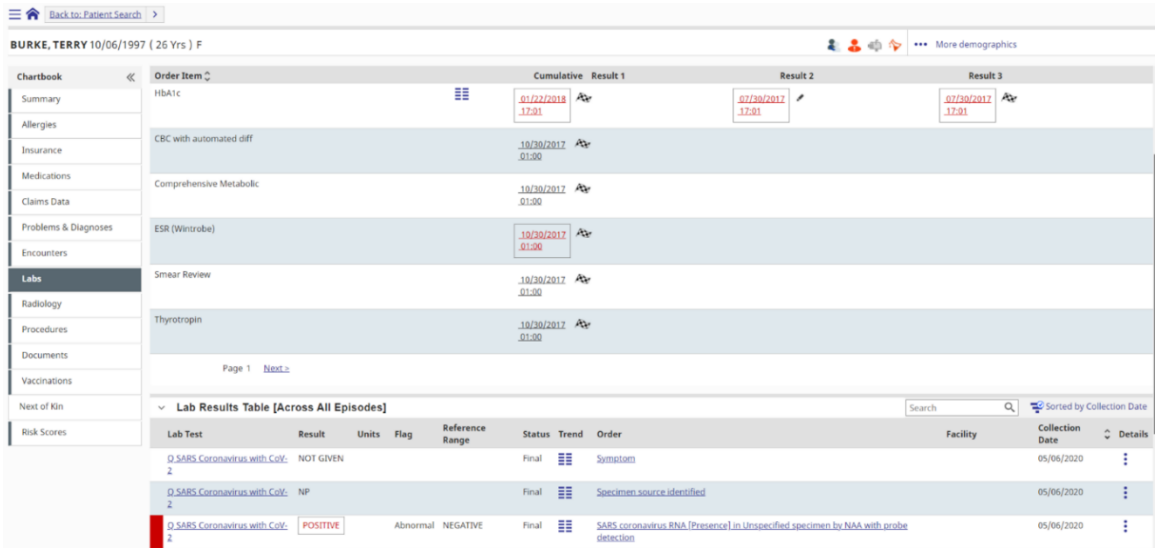


Figure 52: Laboratory Results

In the Laboratory Results – Tabular View, the Lab Order Item will be displayed with the Result Date, and a cumulative view option. A flag is shown next to finalized lab results. A pencil is shown next to results that have been corrected. Results in red indicate abnormal results.

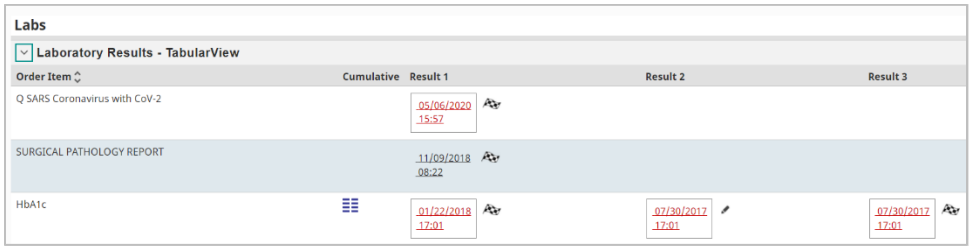


Figure 53: Laboratory Order

To see the results of a lab order, click on the date to the right of the **Order Item**. The following details will be displayed on the screen:

- **Patient**: Name of patient
- **MRN**: Patient MRNs (this is the full list of MRNs associated with the patient's medical record)
- **DOB**: Patient date of birth
- **Order Start Date & Time**: Date and time of lab order
- **Ordering Clinician**: Clinician who ordered the lab
- **Specimen**: Sample
- **Specimen Collection Date & Time**: Date and time of sample collection
- **Specimen Received Date & Time**: Date and time of sample received
- **Results Date & Time**: Date and time of results
- **Results Status**: The status of finding the test values with "Final" or "Correction to Results". In this column will see either final or correction to results.
- **Placer ID**: The unique identifier for a lab order that links the orders placed with the results
- **Last Updated At**: The facility that was the last one to update the lab result
- **Age at Time of Test**: Patient age at the time of test
- **Test Item**: The name of the test
- **Abnormality/Flag**: Indicates if a result is abnormal by displaying normal, low, or high
- **Value**: The test's numerical value
- **Units**: The units of the test
- **Reference Range**: The normal range of the test results
- **Test Item Status**: The status of the test (e.g., final)
- **Comments**: Comments related to the test
- **Sensitivities**: Sensitivities to the test
- **Observation Time**: The date and time the test took place
- **Performed At**: The location where the test was performed

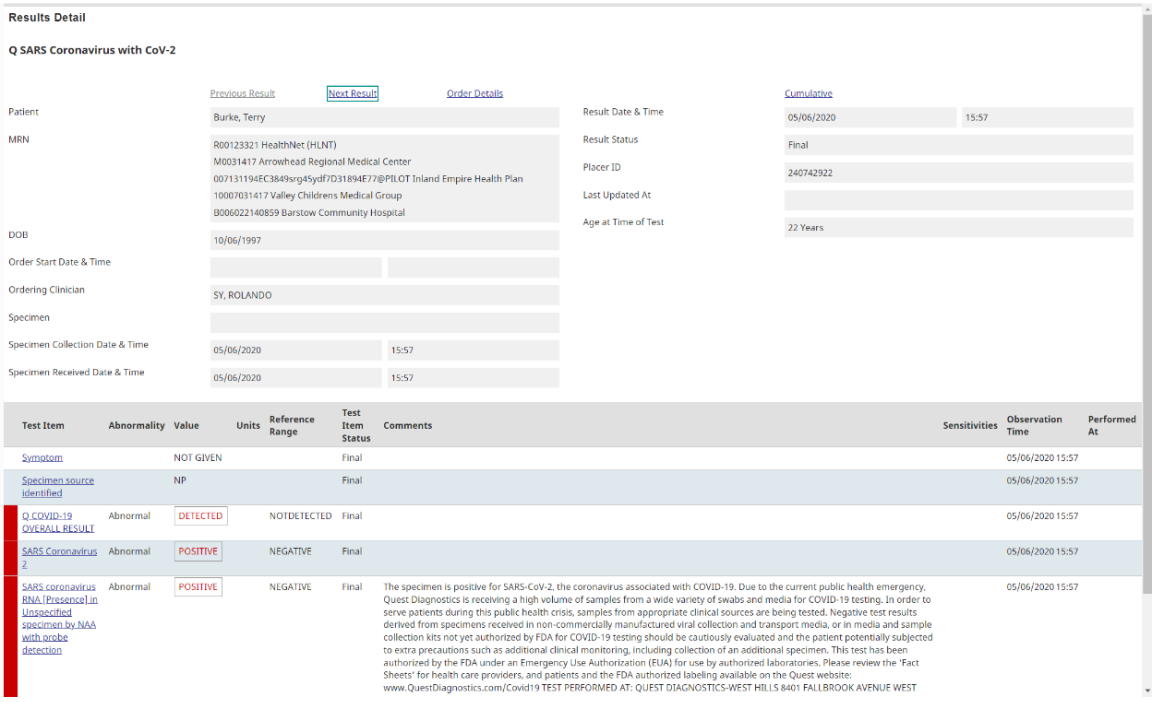


Figure 54: Laboratory Order Item

When a test has been run multiple times, test dates will be listed next to one another.

You can compare test results side-by-side by clicking the **Cumulative View** icon .

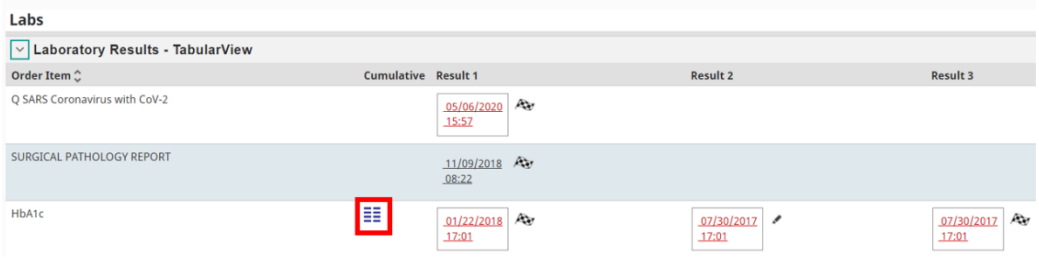


Figure 55: Comparing Results

All test results will be displayed on the screen. The results include:

- **Test Items**: The name of the test
- **Reference Range**: The normal numerical range of test results
- **Units**: The units of the test
- **Date**: The date the test was completed

Graph the results to easily identify trends and changes over time by clicking **Cumulative Graph**.

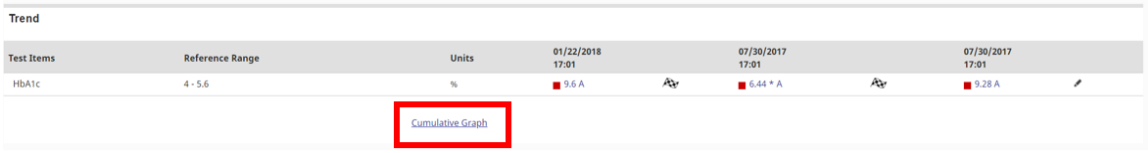


Figure 56: Cumulative Results

Graph details will be listed above the graph.

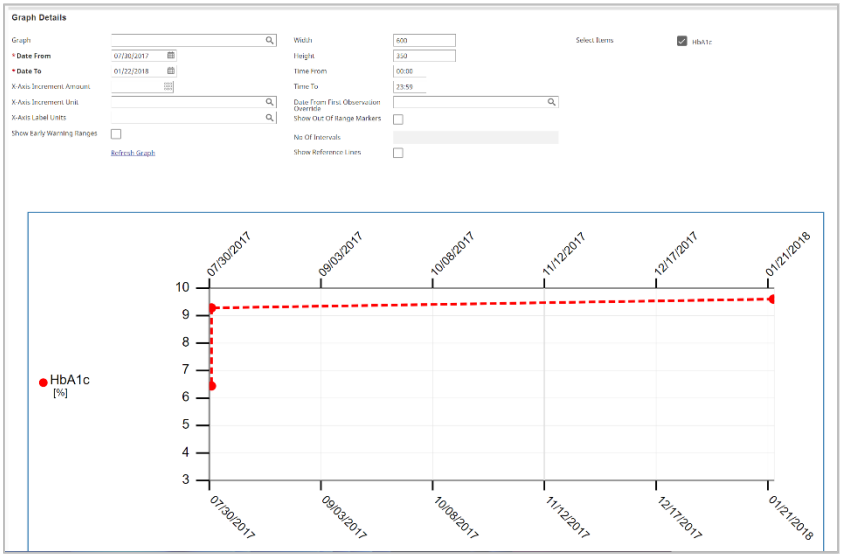


Figure 57: Cumulative Graph

To go back to the Lab Tab, click on the **Back to: Chart** button on the left side of the screen. Under the Tabular View, a second table is displayed “Lab Results Table (Across All Episodes).” The following details are displayed:

- **Lab Test**: The name of lab test
- **Result**: The result of the lab test
- **Units**: The units of the result
- **Flag**: An indicator of whether the results were normal, low, or high
- **Reference Range**: The normal reference range of the lab results

- **Status**: The status of the lab results
- **Trend**: An option that allows you to see details of all associated lab results
- **Order**: The order associated with the lab test
- **Facility**: The location where the test was performed
- **Collection Date**: The date the lab order sample was collected
- **Details**: Additional details related to the lab test

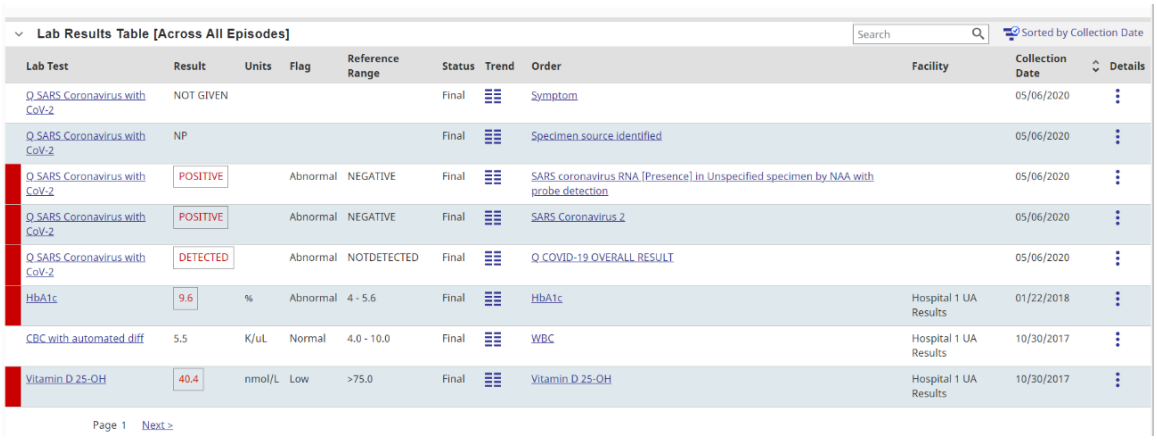


Figure 58: Lab Results [Across All Episodes]

To review trends in the lab results, click on **Trend**. This will open a new window with details of all associated labs.

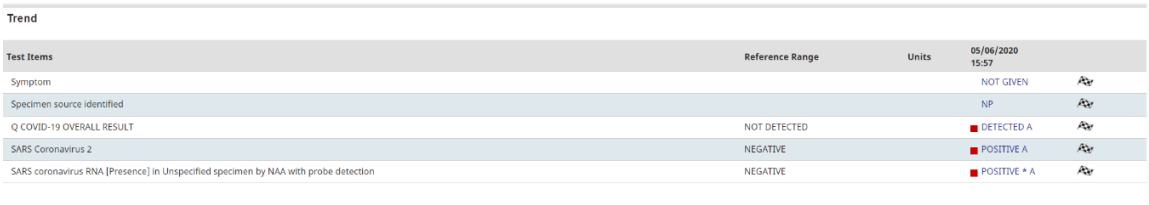


Figure 59: Lab Results [Across All Episodes] Trend

To review test item details, click on **Details**. Details include:

- **Episode Hospital**: Location where lab was completed
- **Test Item Code**: Code of the lab completed
- **Test Item**: The name of the test
- **Value**: The test's numerical value

- **Reference Range**: The normal numerical range of test results
- **Units**: The units of the test (e.g., fL, m/u, %)
- **Test Items Status**: The status of finding the test values with “Final” or “Correction to results.” In this column will see either final or correction to results.
- **Comments**: Comments from the provider

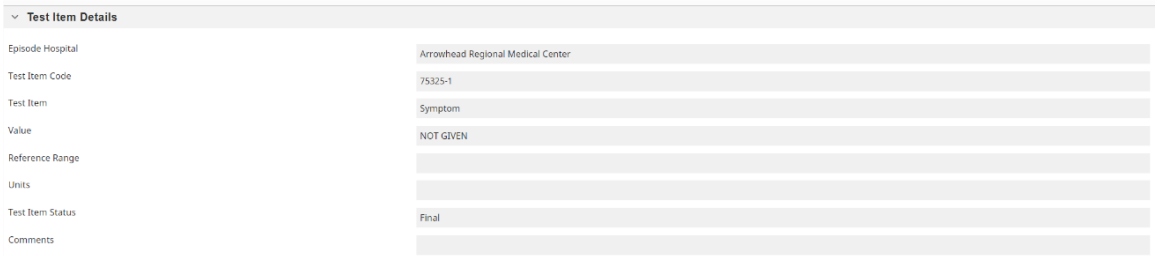


Figure 60: Lab Results [Across All Episodes] Details

You can expect to find the following types of documents in the **Labs** tab:

- Anatomic Pathology – Interfaces Only
- Blood Bank – Interfaces Only
- Blood Gases
- Blood Bank
- Chemistry
- Cytopathology
- Hematology
- Immunology
- Laboratory
- Microbiology
- Mycology
- Outside Lab
- Pathology
- Surgical Pathology
- Serology
- Toxicology

- Urinalysis

Within the Labs tab there is the ability to sort data by a primary field. The default sort in the Lab Results Across All Episodes table is *Collection Date.* You can change the sort order by clicking on **Sorted by Collection Date**.

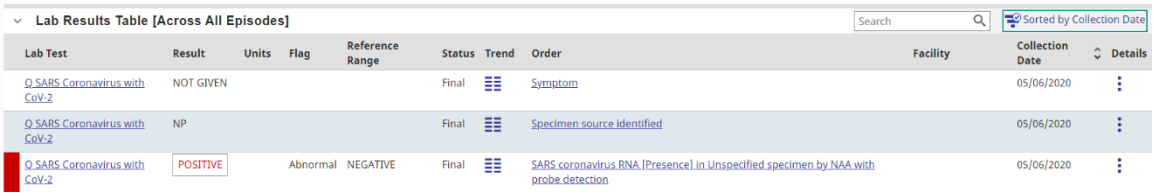


Figure 61: Lab Results [Across All Episodes] Sorted by Collection Date

To select a new sort order, click on the ^ icon to sort **Collection Order** in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort it in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

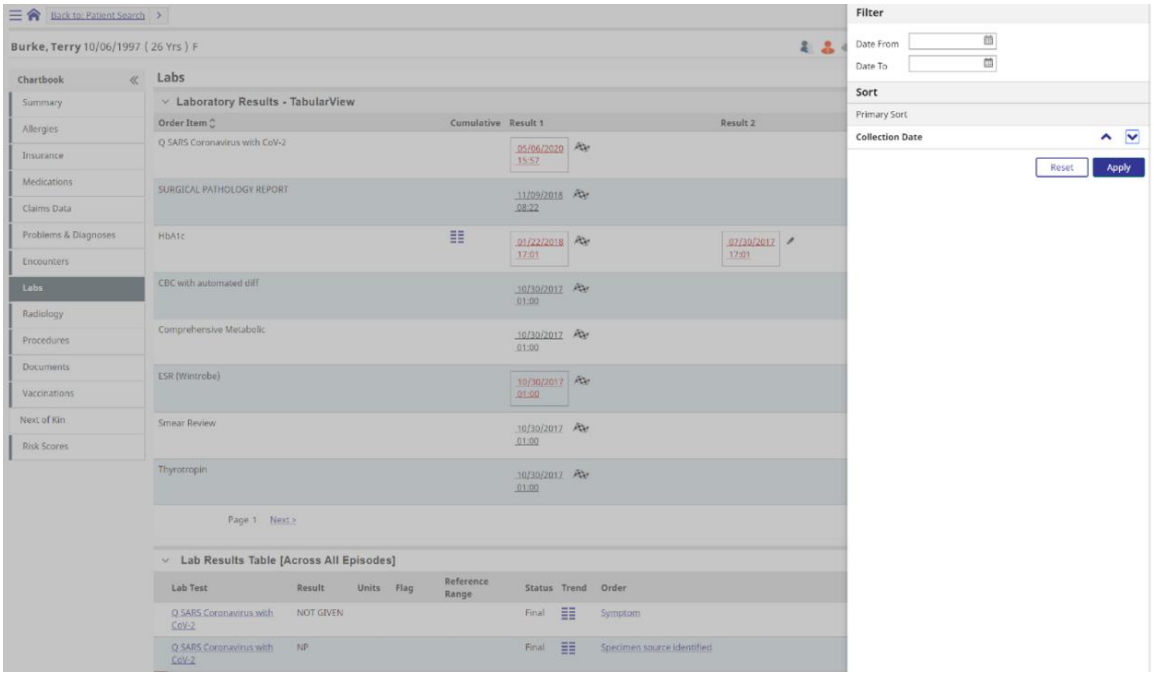


Figure 62: Lab Results [Across All Episodes] Sort Option

Additionally, to filter lab data displayed in this table, select a **Date From** and **Date To** by entering dates in both fields and clicking **Apply**. The filtered data will now be displayed in the table according to the dates entered in the filter.

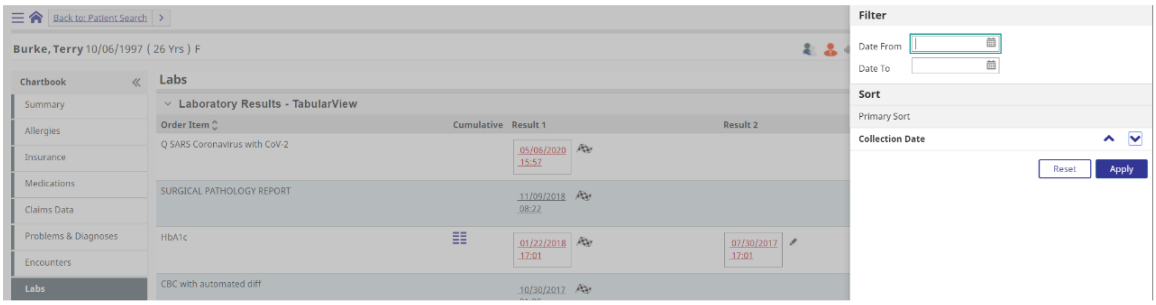


Figure 63: Lab Results [Across All Episodes] Date Filter

You can search within the Lab Results Table [Across All Episodes] table by entering at least one character in the search box and clicking enter. Search results will be highlighted in yellow.

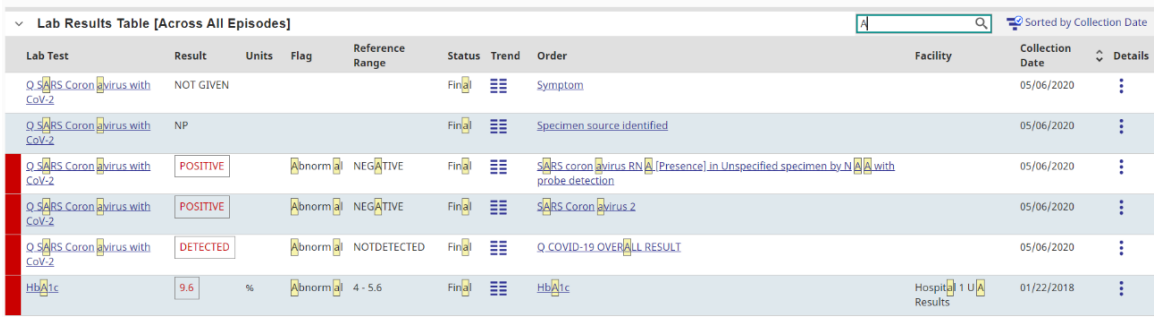


Figure 64: Lab Results [Across All Episodes] Search Box

To print an individual lab result, select the desired lab result to open the lab results screen, then click **Print** at the top.

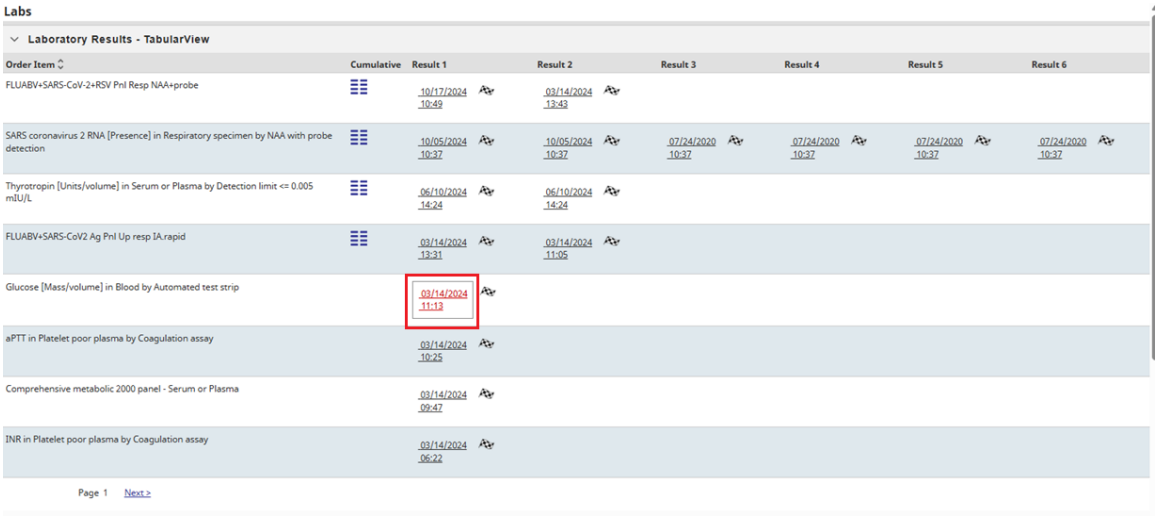


Figure 65: Printing a single lab result

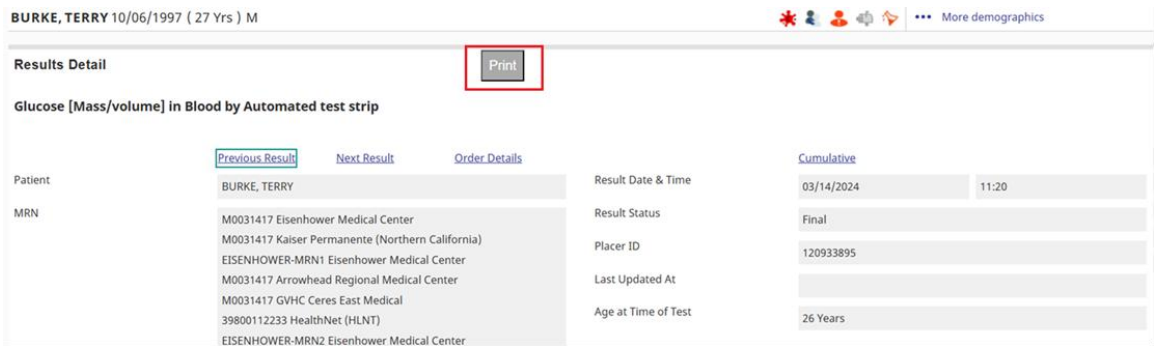


Figure 66: Printing a single lab result

g. Radiology

To see a list of your patient's radiology results, click the **Radiology** tab. The results will include:

- **Description**: The radiology procedure the patient was given (e.g. x-ray)
- **Details**: Additional details about the report including: history, comparison, technique, findings, impression, and dictated by. See the description of additional details below.
- **Date**: The date the radiology procedure was administered to the patient
- **Status**: The status of the radiology test. In this column you will see either final or corrected

- **Reporting Entity**: The organization that reported the radiology result

To see more information, click the **Details** icon ⋮.

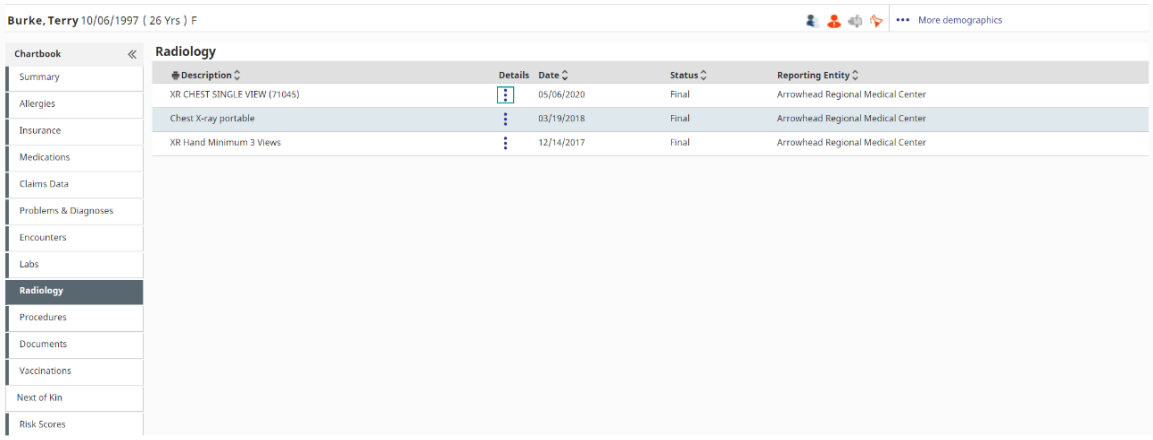


Figure 67: Radiology Results

Additional radiology details will appear on the screen. Details may include:

- **Specimen Collection Date & Time**: The date and time the radiology order took place
- **Ordering Clinician**: The clinician that ordered the radiology test
- **Date Created**: The date the test result was created
- **Result Status**: The status of the results. In this column you will see either final or correction to results.
- **Filler Number**: The number of the test result
- **Last Updated Facility**: The facility that last updated the results
- **Age at Time of Test**: The age of the patient at the time of the test
- **Facility Details:** Facility name, number, and address
- **Clinician Details**: Clinician notes or comments
- **Procedure**: A description of the test that was completed
- **Findings**: A description of the test findings
- **Patient Name**: The name of the patient undergoing the test

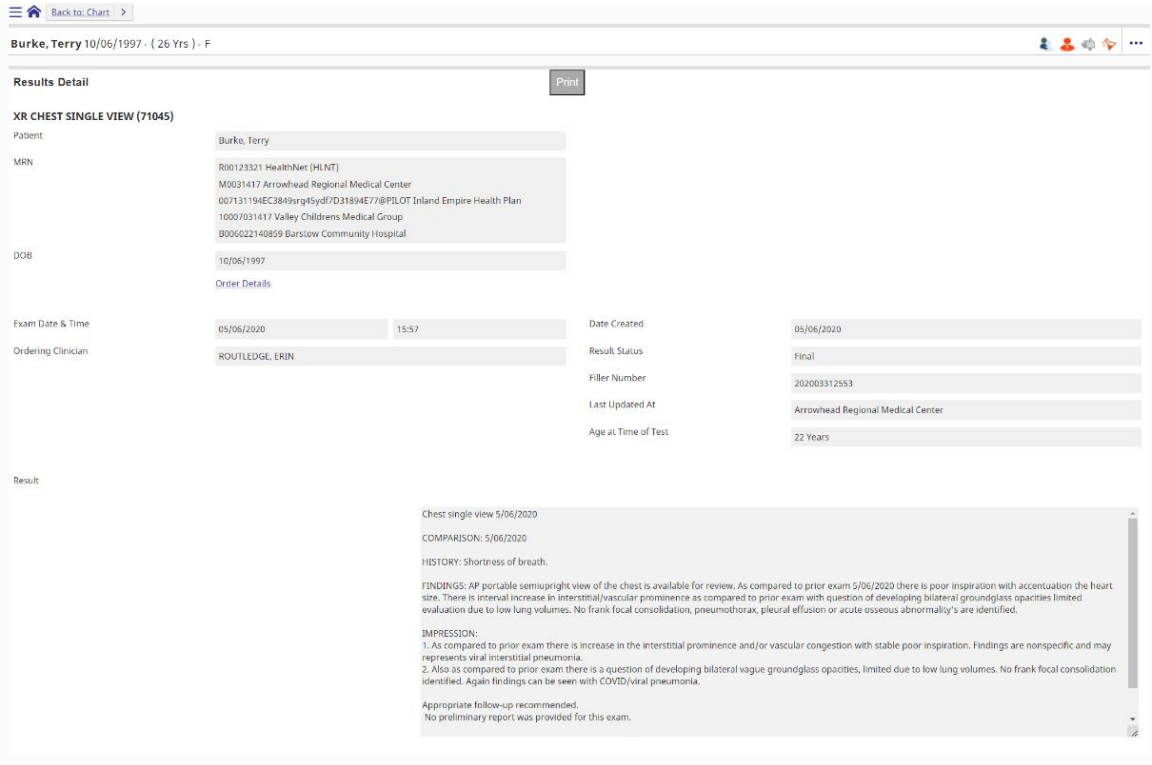


Figure 68: Radiology Document

You can also choose to view the order details and leave out the findings by clicking on **Order Details**.

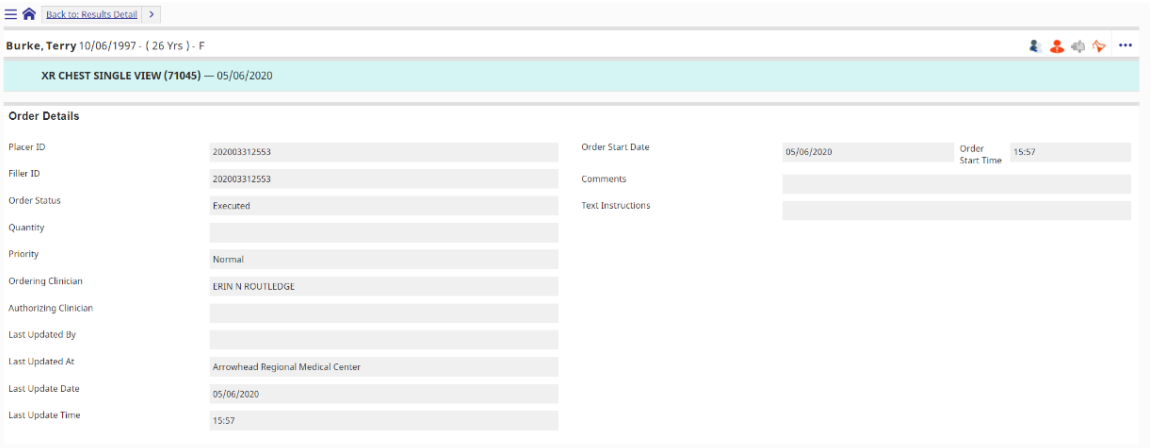


Figure 69: Radiology Order Details

You can expect to find the following types of documents in the **Radiology** tab:

- CT Scan
- Cardiac Catheterization
- Cardiac Ultrasound
- Electrocardiac
- Electroneuro
- Diagnostic Imaging
- Nuclear Magnetic Resonance
- Nuclear Medicine Scan
- OB Ultrasound
- Radiology
- Radiology Ultrasound

h. Procedures

To view a list of your patient's procedures, click the **Procedures** tab. You can filter the procedures by **All Procedures**, **Clinically-Sourced Procedures Only**, or **Claims-Sourced Procedures Only** by selecting the radio button located at the top right side of the screen. The tab includes:

- **Procedure Code**: The code of the procedure given to the patient
- **Procedure Description**: Details of the procedure given to the patient (e.g., diabetic foot exam)
- **Date**: Date for when the procedure was performed on the patient
- **Procedure Provider**: The name of the provider who performed the procedure on the patient
- **Reporting Entity**: The organization that reported the procedure
- **Last updated**: The date of the latest update as it relates to the procedure
- **Source**: Data type (clinical or claims)

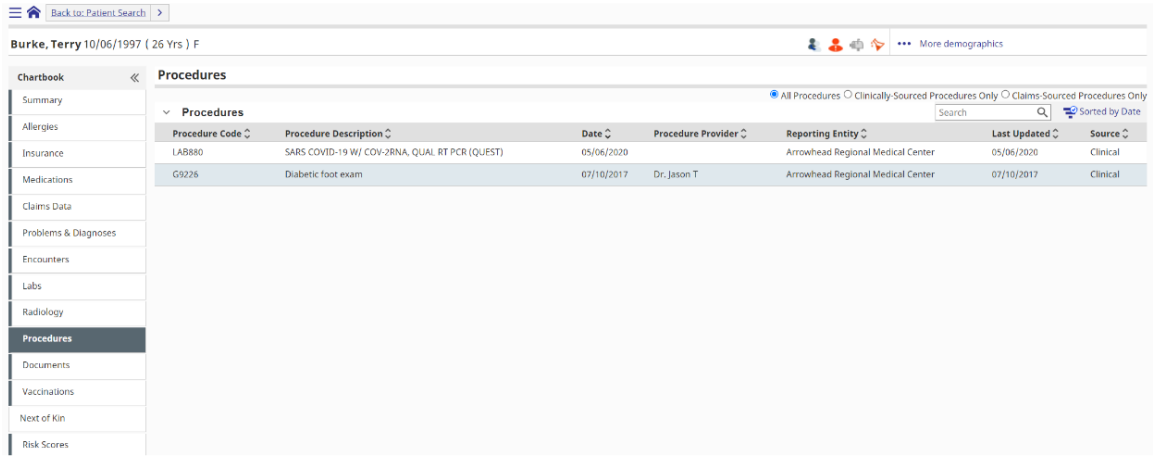


Figure 70: Procedures

Within the Procedures tab, you can group data by the Procedure Description and Reporting Entity by clicking on “Grouping by” button in the top right side of the screen and adding text in the “Group” field.



Figure 71: Procedures Grouping

Additionally, within the Procedures tab you can sort data by primary and secondary fields. The default sort in the Procedures tab is *Date.* You can change the sort order by clicking on **Sorted by Date**.



Figure 72: Procedures Sorted by Date

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date)

or click on the icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

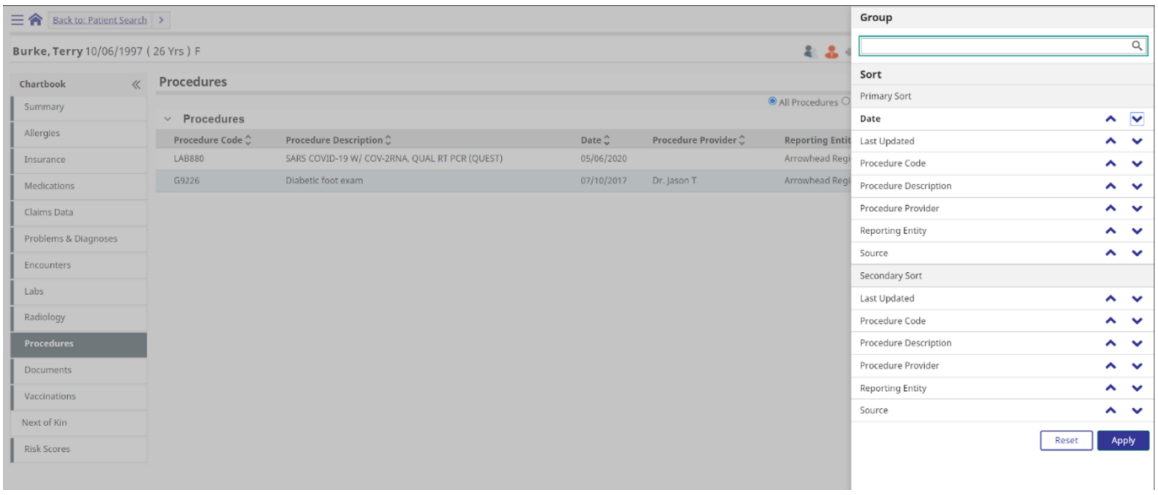


Figure 73: Procedures Sort Options

You can search within the Procedures tab by entering at least one character in the search box and clicking enter. The system will search for all results within the tab. Search results will be highlighted in yellow.



Figure 74: Procedures Search Box

i. Documents

Documents not included in the **Labs** or **Radiology** tabs can be found in the **Documents** tab. The document tab includes:

- **Document Name**: The name of the document (e.g., Discharge Summary)
- **Doc Type**: The type of the document (e.g., transcribed document, ED referral)
- **Details**: Click on details to see the document
- **Document Date**: The date the document was produced

- **Clinician**: The name of the clinician who produced the document
- **Reporting Entity**: The organization that reported the information in the document
- **Last Updated**: The date of the latest update as it relates to the document

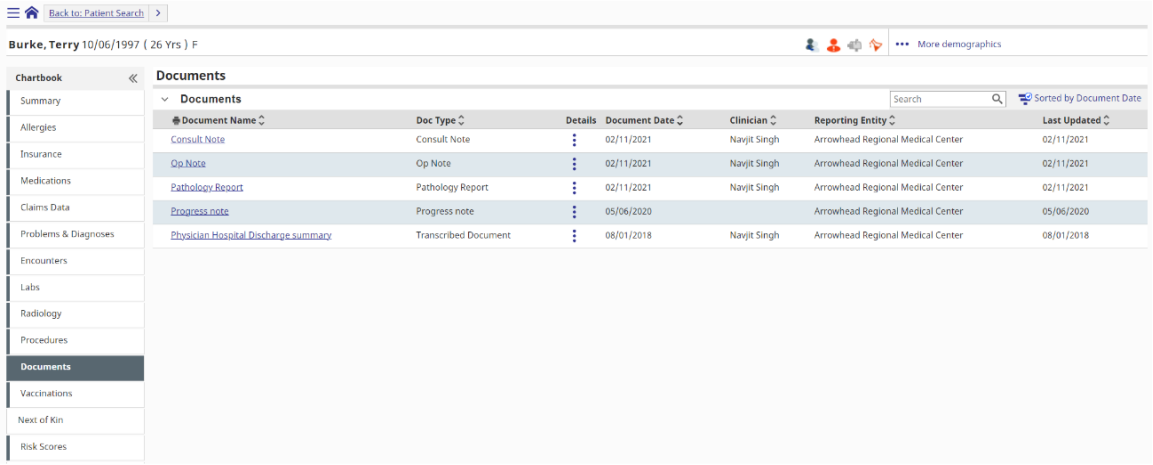


Figure 75: Documents

To see the document details, click the **Document Name**. Details include:

- **Patient:** Name of patient
- **MRN:** Medical record numbers of patient
- **DOB:** Patient DOB
- **Clinician**: The name of the clinician who produced the document
- **Doc Type**: The type of document (e.g., transcribed document, ED referral)
- **Document**: The name of the document
- **External ID**: The numerical ID of the document
- **Status**: The status of the document. In this field you will see “Final” or “Correction to result.”
- **Notes**: The notes describing the document details (e.g., patient problems, discharge instructions, history of illness)
- **Encounter Date**: The date of the encounter
- **Transcription Date:** The date the document was produced
- **Signed Date**: The date the document was signed
- **Last Updated**: The date the document was last updated

- **Download/Print**: A button that allows you to download or print the document details

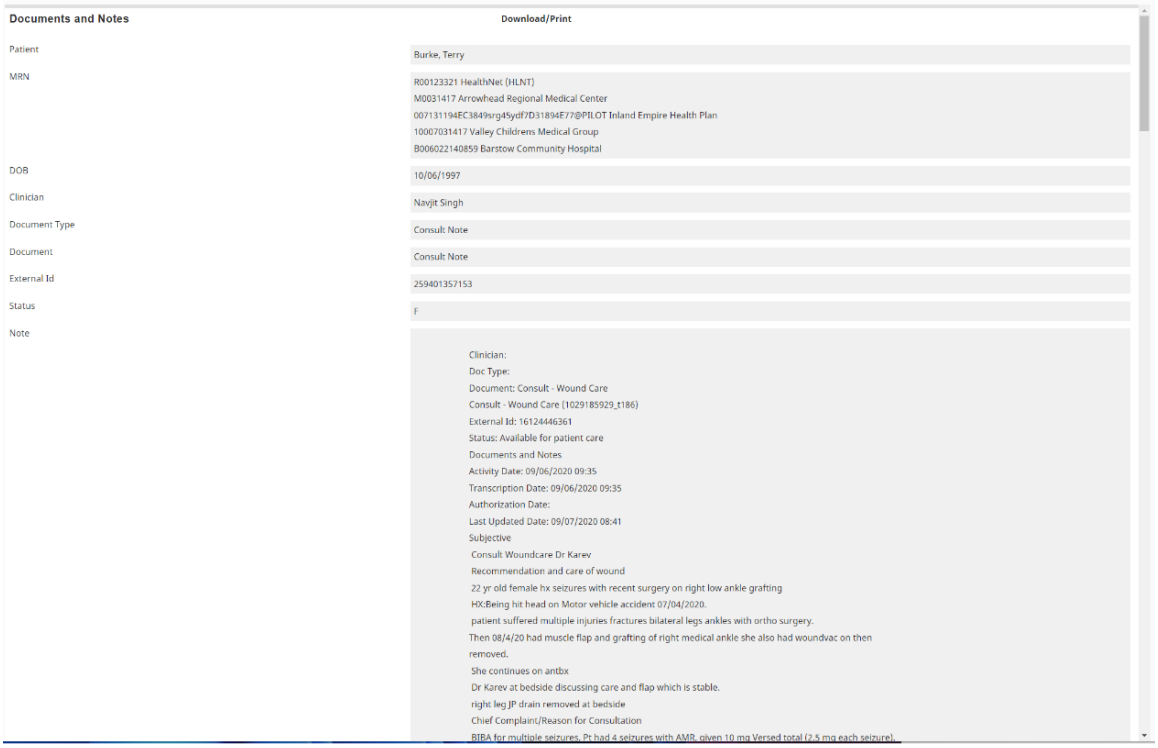


Figure 76: Document Details

To see additional document details, click on the ⋮ icon. Details include:

- **Patient:** Name of patient
- **MRN:** Medical record number of patient
- **DOB:** Patient DOB
- **Clinician**: The name of the clinician who produced the document
- **Doc Type**: The type of document (e.g., transcribed document, ED referral)
- **Document**: The name of the document
- **External ID**: The numerical ID of the document
- **Status**: The status of the document. In this field you will see “Final” or “Correction to Result.”

- **Notes**: The notes describing the document details (e.g., patient problems, discharge instructions, history of illness)
- **Encounter Date**: The date of the encounter
- **Transcription Date:** The date the document was completed
- **Signed Date**: The date the document was signed
- **Last Updated**: The date the document was last updated
- **Download/Print**: Clicking on this button allows you to download or print the document

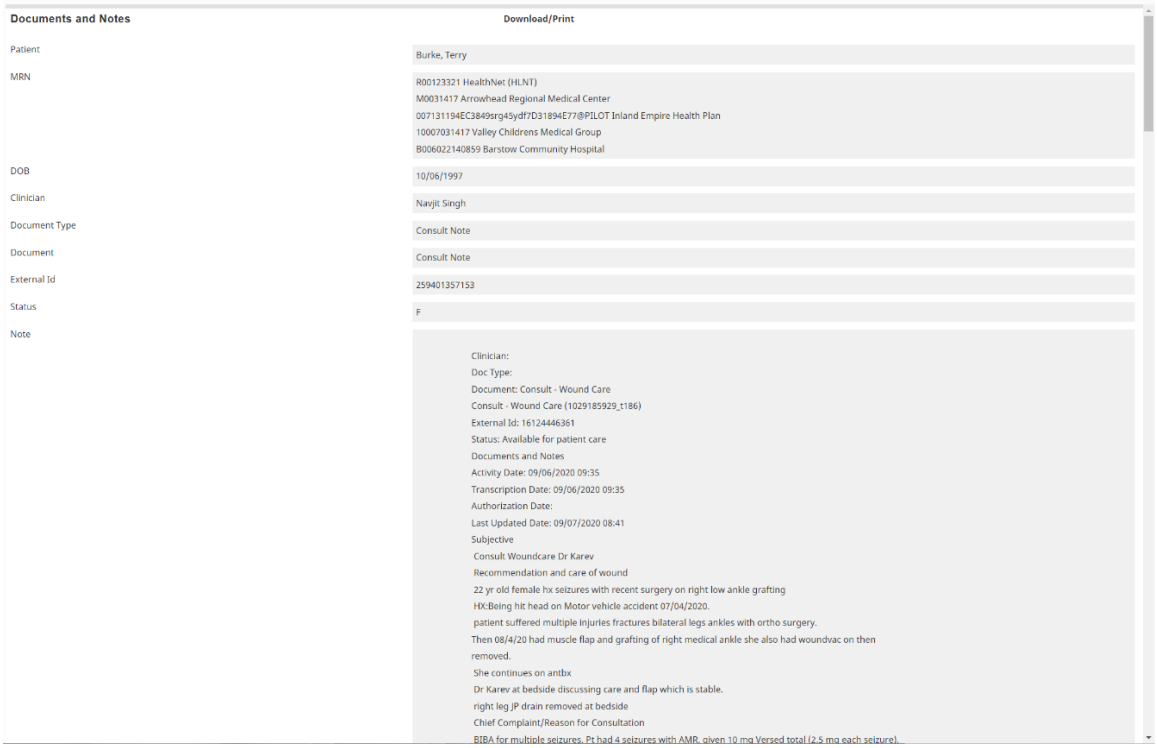


Figure 77: Additional Document Details

Note: If the document is a CCD, clicking on the document name will display the CCD document and clicking on the document details icon will display the details related to the CCD, such as type of document and activity/transcript dates, but not the actual CCD.

You can expect to find the following types of documents in the **Documents** tab:

- CCDA
- Patient Discharge Summary
- Nursing Service Measures
- Physician Note
- Physical Therapy
- All other documents not included in the **Radiology** or **Labs** tab

Within the Documents tab there is the ability to sort data by primary and secondary fields. The default sort in the Documents tab is *Document Date.* You can change the sort order by clicking on **Sorted by Document Date**.

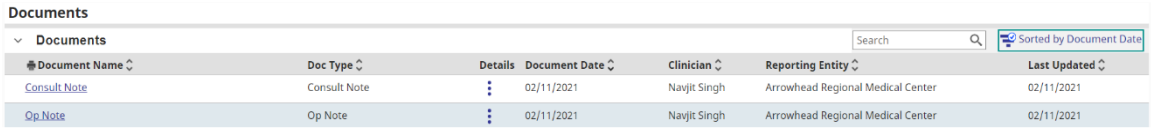


Figure 78: Document Sorted by Date

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the ⌄ icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

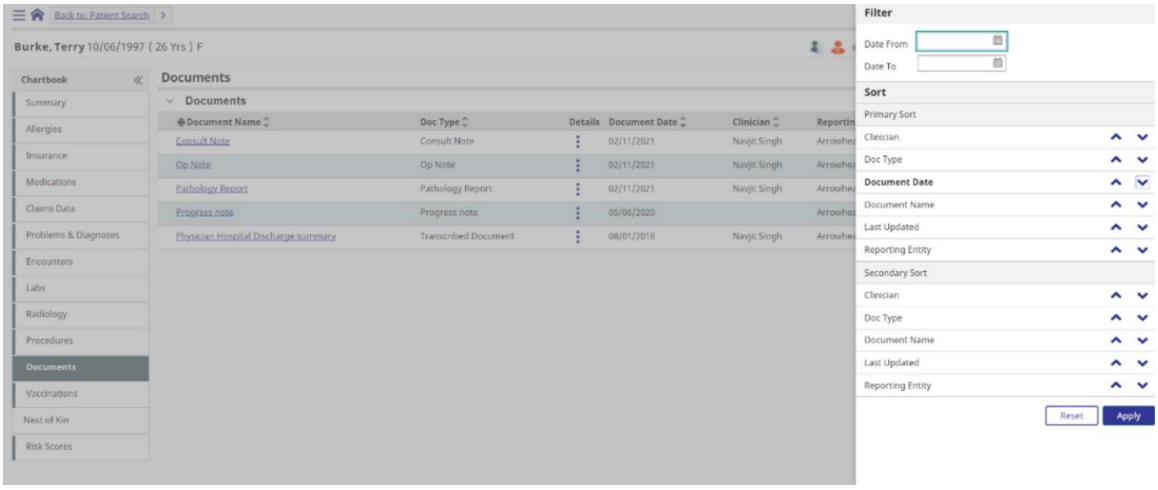


Figure 79: Document Sort Option

Additionally, to filter documents displayed in this table, select a **Date From** and **Date To** by entering dates in both fields and clicking **Apply**. The filtered documents will now be displayed in the table according to the dates entered in the filter.



Figure 80: Document Filtered Dates

You can search within the documents tab by entering at least one character in the search box and clicking enter. The system will search for all results within the tab. Search results will be highlighted in yellow.

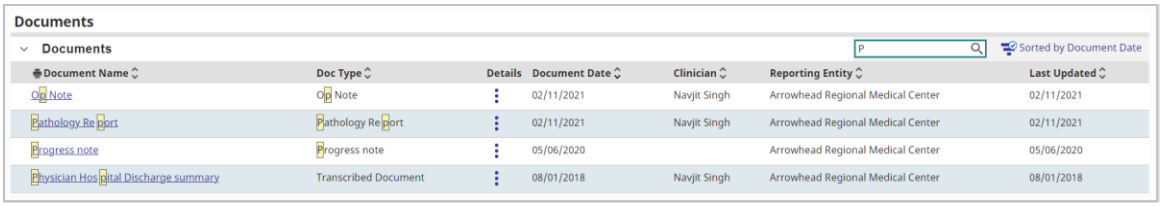


Figure 81: Document Search Box

j. Vaccinations

To view a list of patient vaccinations, click the **Vaccinations** tab. This tab includes:

- **Vaccine**: The name of the vaccination given to the patient
- **Details**: View additional information related to the vaccination (e.g., priority)
- **Date Administered**: The date when the vaccination was given to the patient
- **Amount**: The dosage or quantity of the vaccination (e.g., .75 milliliters)
- **Order Notes**: Notes about the vaccine order
- **Reporting Entity**: The organization that reported the vaccination
- **Lot Number**: The number of the vaccination
- **Last Updated**: The date of the last update to the vaccination

Within the Vaccinations tab you can sort data by primary and secondary fields. The default sort in the Vaccinations tab is Last Updated**.** You can change the sort order by clicking on **Sorted by Last Updated**.

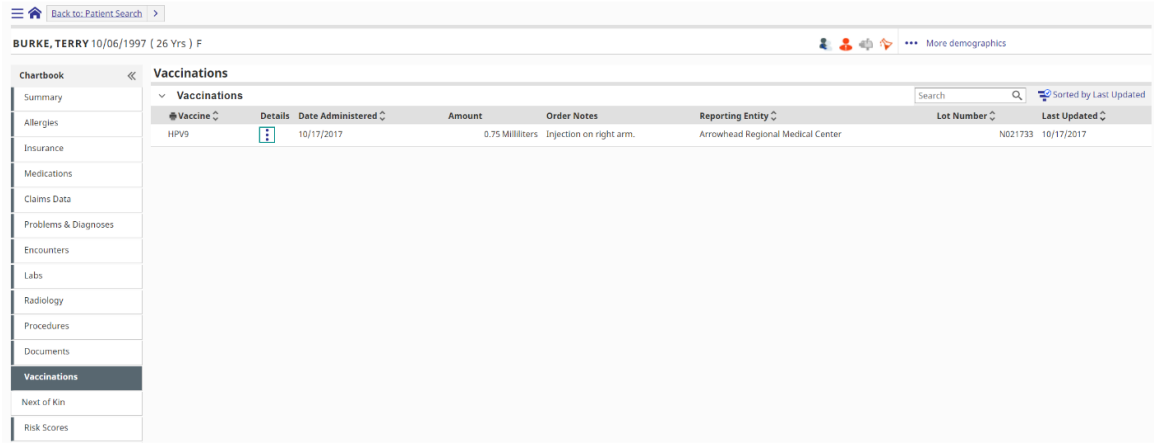


Figure 82: Vaccinations Sorted by Last Updated

To select a new sort order, choose from the list of available options displayed on the right side of the screen. One primary sort and one secondary sort can be selected. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

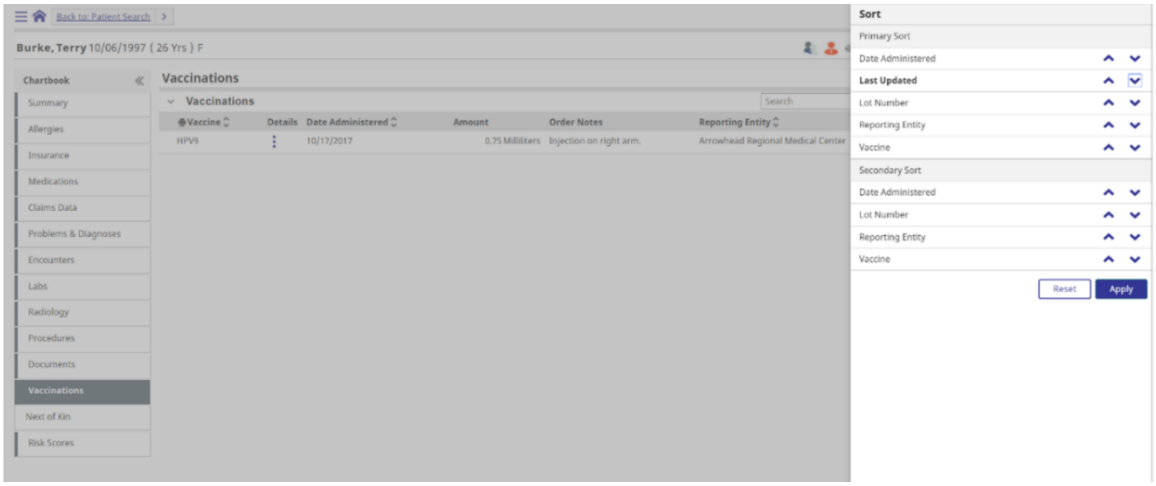


Figure 83: Vaccinations Sort Options

You can search within the vaccinations tab by entering at least one character in the search box and clicking enter. The system will search for all results within the tab. Search results will be highlighted in yellow.

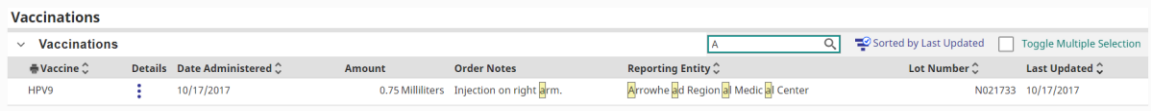


Figure 84: Vaccinations Search Box

To see details for a specific vaccination, click the **Details** icon ⋮. The vaccination details include:

- **Patient:** Name of patient
- **MRN:** The MRNs associated with the patient
- **DOB:** The patient's date of birth
- **Order Number**: The order number of the vaccination
- **Order Status**: The status of the order (e.g., verified)
- **Priority**: The priority of the vaccination (e.g., low, normal, high)
- **Ordering Clinician**: The clinician who ordered the vaccination
- **Authorizing Clinician**: The clinician that authorized the vaccination
- **Number of Refills**: The number of refills for the vaccination
- **Route**: The route of the vaccination (e.g., intramuscular)

- **Order Start Date and Time**: The order start date and time of the vaccination
- **Order End Date and Time**: The order stop date and time of the vaccination
- **Dose / Form**: The dose form
- **Units**: The units of the vaccination
- **Frequency**: The frequency of the vaccination
- **Duration**: The duration of the vaccination
- **Comments**: Comments about the vaccination
- **Text Instructions**: Text instruction about the vaccination

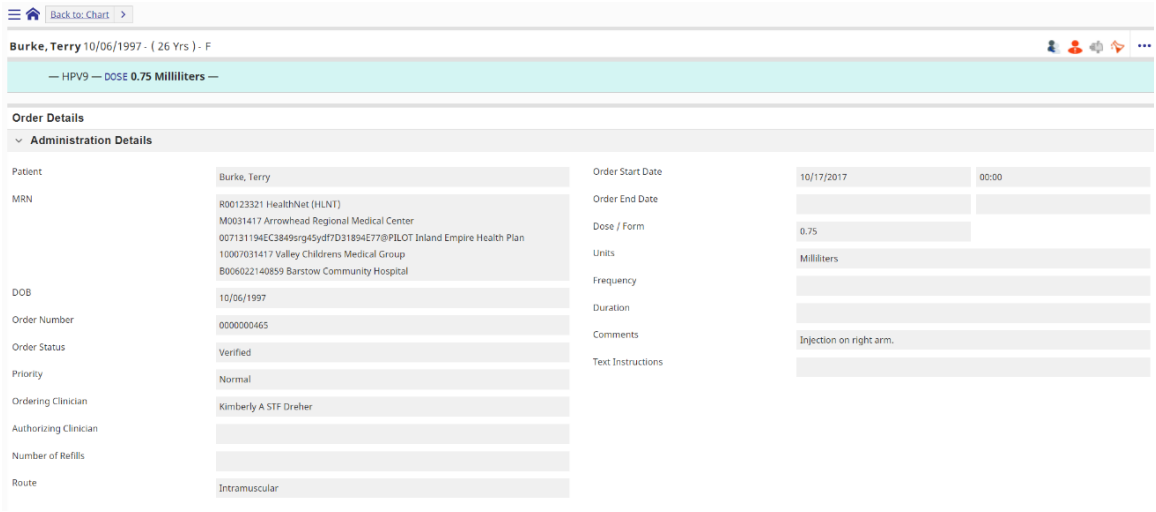


Figure 85: Vaccination Details

k. Next of Kin

Patients can have family members listed as their contacts or **Next of Kin**. To see a list of a patient's contacts, click **Next of Kin**. Patient contact information includes relationship, contact type, first name, last name, address, city, state, zip code, country, and phone number.

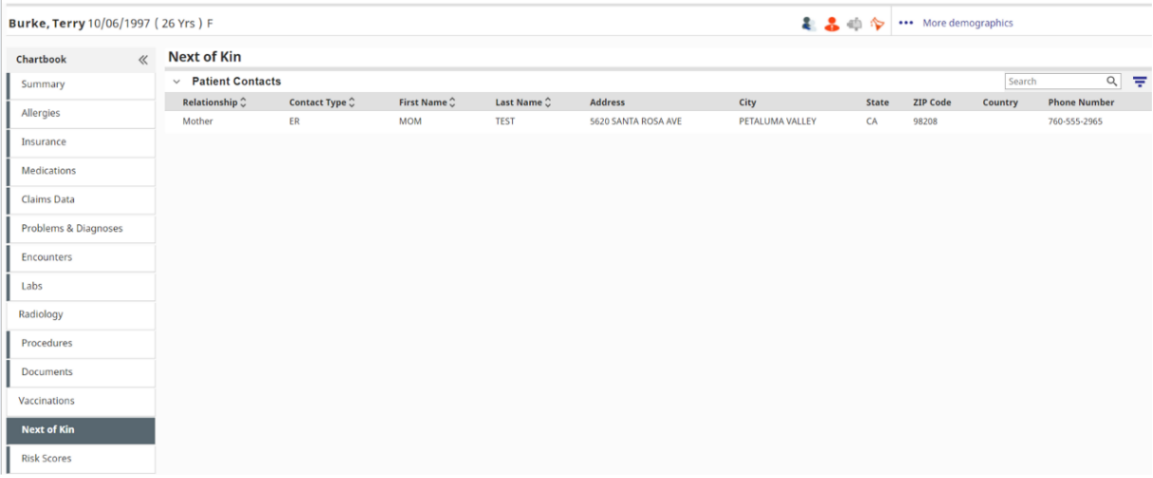


Figure 86: Next of Kin

Within the Next of Kin tab you can sort data by a primary field. There currently is no default sort set in this tab. You can change the sort order by clicking on the **Sorted by** icon.



Figure 87: Next of Kin Sorted by Icon

Clicking on **Sorted by** icon allows you to sort by a primary field. To select a new sort order, choose from the list of available options displayed on the right side of the screen. Click on the ^ icon to sort in ascending order (e.g., from a to z or earliest date to latest date) or click on the v icon to sort in descending order (e.g., from z to a or latest date to earliest date) and click **Apply**. To reset the sort changes to the original sort, click on **Reset**.

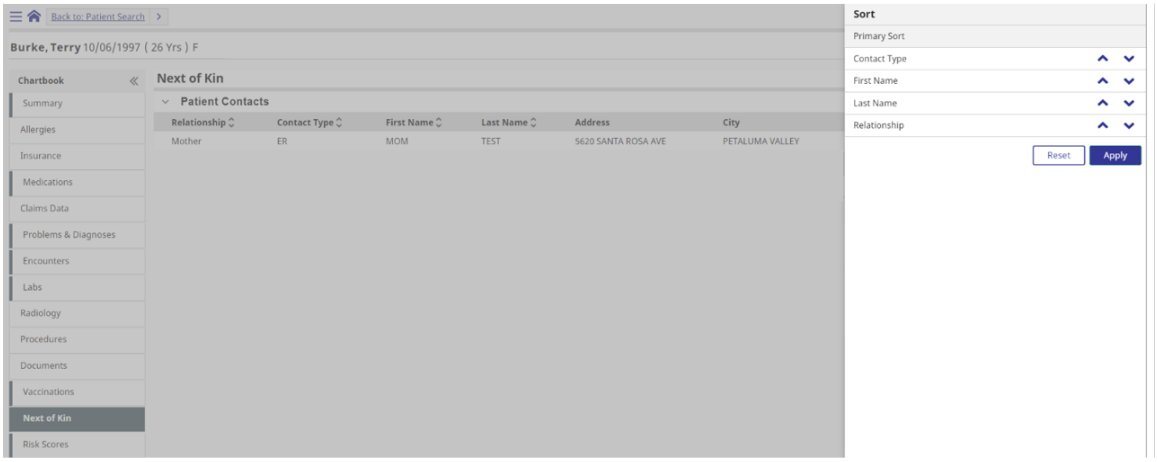


Figure 88: Next of Kin Sort Options

You can search within the Next of Kin tab by entering at least one character in the search box and clicking enter. The system will search for all results within the tab. Search results will be highlighted in yellow.

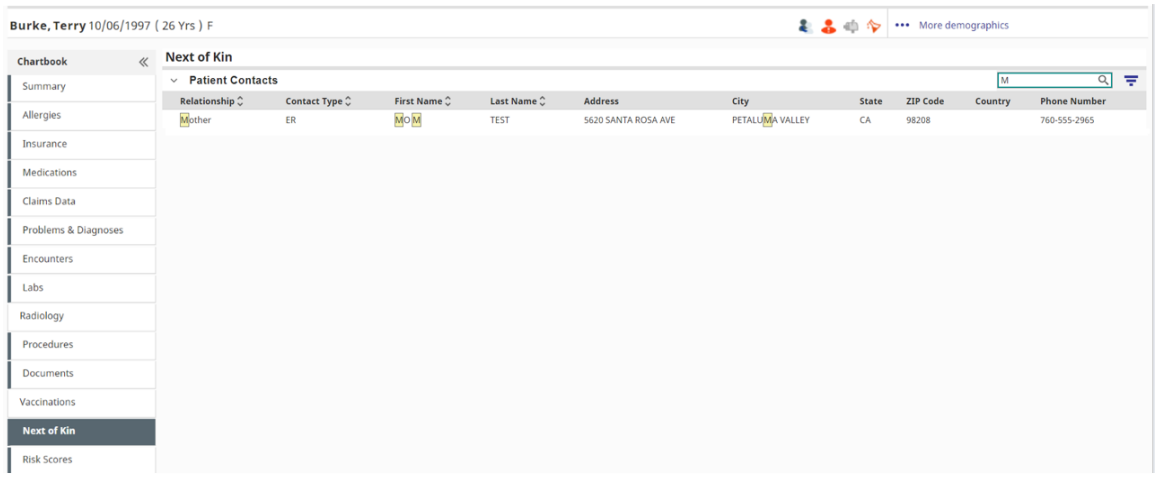


Figure 89: Next of Kin Search Box

I. Risk Score

The Risk Score for patients who are Inland Empire Health Plan (IEHP) members will displayed in this tab when available. IEHP Member Risk Scores include:

- **Risk Score**: The risk associated with the individual member compared to 1, where 1 is defined as an average risk based off a large external reference population.
- **Chronic Condition Count**: The number of chronic conditions identified for the member. A Chronic Condition is an alteration in the structure or function of the body that is likely to last longer than twelve months and is likely to have a negative impact on the health or functional status.
- **Probability of High Total Cost**: The likelihood that the member will have costs in the top 5% of the population in the following 12 months.
- **Probability of Persistent High User**: The probability that the member will be in the top 20% of users for two consecutive years.
- **CM Risk Stratification**: Risk Stratification of IEHP Membership based on Care Coordination, Diagnosis Based Markers, and Risk Modeling.

There are three different forms of risk score values for IEHP Risk Scores:

- **Risk Score** and **Chronic Condition Coun**t have a minimum value/start range of 0, and there are no maximum values/end ranges.
- The **Probability of High Total Cost** and the **Probability of Persistent High Users** will display numerical values between 0.00 to .99. If a patient has 0.95 displayed next to the probability of high total cost, that means the patient is 95% likely to be in the top 5 percent of the total high cost for IEHP in the next 12 months.
- **CM Risk Stratification** will display high, rising, medium, and low risk.

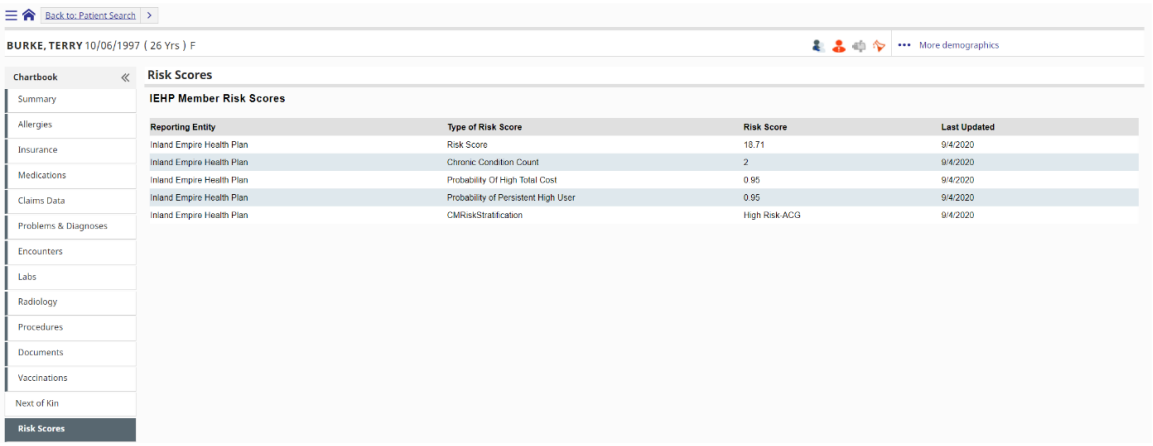


Figure 90: Risk Scores

m. Social Drivers of Health (SDOH)

The SDOH tab includes six tables that consolidate an individual's social history information into a single, easy-to-access location. The six tables include:

- **SDOH Problems**: Coded social diagnoses and identified social problems. SDOH Problems include a social need category which can include any of the following, but is not limited to: food insecurity, housing instability, homelessness, transportation insecurity, utility insecurity, financial insecurity, poverty, social isolation, lack of social connection, education, literacy, employment, occupational insecurity, intimate partner violence, safety, legal, justice system involvement, stress, and digital access.
- **Social History**: Structured SDOH screening results and questionnaire responses (e.g., PRAPARE, etc.). To view the individual's complete questionnaire, click on the link in the "Questionnaire" column. You can also print or save the questionnaire as a PDF.
- **Patient Goals:** Individual-level goals which are created based on identified SDOH Problems and/or clinical goals.
- **Health Concerns**: A health-related matter that is directly or indirectly related to a social driver of health that may require attention, intervention, or management.
- **SDOH Interventions:** Services and actions taken by an individual's care team to address identified social needs, beyond formal referrals. SDOH Interventions

include a social need category which can include any of the following but is not limited to: food insecurity, housing instability, homelessness, transportation insecurity, utility insecurity, financial insecurity, poverty, social isolations, lack of social connection, education, literacy, employment, occupational insecurity, intimate partner violence, safety, legal, justice system involvement, stress, digital access, and literacy.

- **Referrals**: SDOH referrals that include the name of who sent the referral, the date it was sent, the organization the referral came from, along with any related SDOH codes.

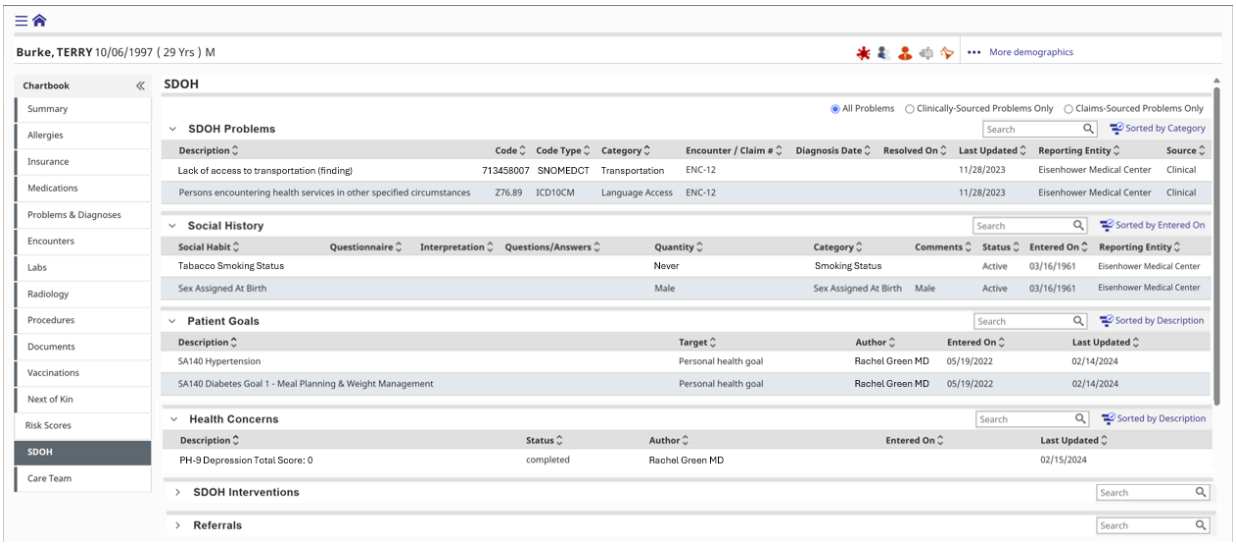


Figure 91: SDOH

n. Care Team

The Care Team tab lists those involved in an individual's care coordination and transitions of care, including PCPs and community partners.

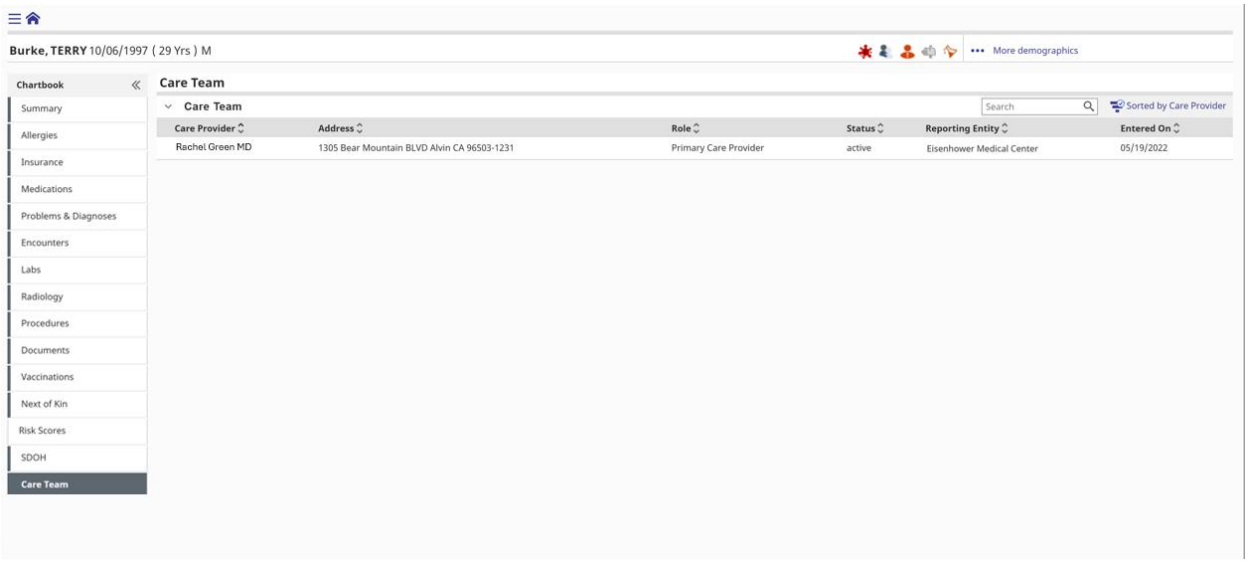


Figure 92: Care Team

Should you have additional questions about MX Access, please contact our MX Support Team at support@manifestmedex.org