This user guide was developed jointly by the North Carolina Health Information Exchange Authority (NC HIEA) and SAS Institute to assist NC HealthConnex Clinical Portal users in navigating the system. See contact information below for the primary points of contact in your organization as well as the NC HIEA Business Office.

Contact Details:

Participating Organization: ________________________________

Participant Account Administrator (PAA) Name: ________________________________

Participant Account Administrator (PAA) Phone/Email: ________________________________

NC HIEA Business Office:

For questions relating to this user guide, please call 919-754-6912 or email hiea@nc.gov.
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INTRODUCTION

Welcome

Welcome to the North Carolina Health Information Exchange Authority (NC HIEA) and the state-designated health information exchange (HIE), NC HealthConnex. Your participation in NC HealthConnex will enable you and other participating organizations to:

- Save time and reduce paperwork,
- Facilitate more informed treatment decision-making,
- Improve care coordination, and
- Enable better health outcomes.

Purpose

The North Carolina Health Information Exchange Authority (NC HIEA) operates NC HealthConnex to provide a secure and integrated view of a patient’s longitudinal health record. Our mission is to link all health care providers across North Carolina to improve health care quality and outcomes.

This document is intended as a guide for all users to provide basic Clinical Portal navigation information for NC HealthConnex. For an up-to-date list of participating organizations, visit the NC HealthConnex website to see Who’s Connected.

What is the NC HealthConnex Clinical Portal?

The NC HealthConnex Clinical Portal is a secure, standardized electronic system through which providers can share important patient health information. The use of this system promotes the exchange and analysis of patient health information from many disparate electronic health record (EHR) systems throughout North Carolina in a consolidated and efficient manner.

Once logged in, clinicians can view a patient’s medical history including allergies, medications, problem lists, procedures, lab results, radiology reports, immunization history, and other important information from providers across the state that have seen the patient—even if those providers are not part of the same practice or health system. The NC HIEA does not require providers to use an EHR or to purchase special software to be able to leverage the NC HealthConnex Clinical Portal, as it is a web-based application.

Basic functions of the NC HealthConnex Clinical Portal include:

- Search for patients,
- View demographic and clinical information,
- Download or print patient information to include in a patient record, and
- Send messages and patient records to, and receive messages from, other providers.

The NC HealthConnex Clinical Portal offers its users access to:

- Direct Secure Messaging, which allows providers to securely exchange patient information via a HIPAA (Health Insurance Portability and Accountability Act)
compliant email system, and access to the NC HealthConnex provider directory (containing 20,000+ provider addresses), and

- Patient records from other HIEs and systems nationwide via eHealth Exchange, which queries other state, intra-state and national HIEs, including the Veterans Health Administration HIE, for any available records upon patient search by a user.

The NC HIEA is working to expand its service offerings to improve the tangible value of statewide HIE to providers across North Carolina. There are many projects currently under development that will be added to the NC HealthConnex infrastructure as they are completed, including access to the North Carolina Controlled Substances Reporting System (CSRS) and electronic orders and results with the North Carolina State Laboratory of Public Health. For more information on our services, visit the Services section of the NC HealthConnex website.

Role-Based Permissions

Access to the NC HealthConnex Clinical Portal is granted to clinicians and other users that provide patient care in a variety of settings, including offices, clinics, emergency departments, hospitals and others.

The Clinical Portal is configured with various views and functionality that end users can access based on appropriateness to their role(s) and responsibilities in the patient care process per HIPAA. Not all views need to be accessed by all users, and access is based on sensitivity of information and relevance to the user.

A full list of the types of Clinical Portal functionality and information accessible to each user group role is provided below.

<table>
<thead>
<tr>
<th>Clinical Portal Functionality</th>
<th>HS_Clinician</th>
<th>HS_Clerical</th>
<th>HS_PAA</th>
<th>HS_Clinician + HS_PAA</th>
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<tr>
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<td>Search for Patients</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>View Recent Patients</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break the Privacy Seal</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>View Demographics</td>
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</tr>
</tbody>
</table>
CLINICAL PORTAL USER INTERFACE

The NC HealthConnex Clinical Portal user interface refers to the menus, icons, buttons and other user information on the various screens that help a user interact with the application.

Menus

Depending on where a user is within the Clinical Portal, one of three different menu bars will appear at the top of the screen to aid the user in navigation to other screens.

- **Main Menu:** This refers to the primary menu that will display at the top left of the screen upon logging in to the Clinical Portal/while on the Clinical Portal Home Page (also the Patient Search screen). This menu displays links to the following views:
  - **Patient Search:** This link returns a user to the Patient Search screen, which is the default home screen upon login.
  - **Messages:** This link takes a user to their Messaging Center inbox and allows the user to send, receive, delete and organize their Direct Secure Messages (DSM).
  - **Clinician Tools:** This link allows a user to create patient lists and take actions directly from those lists (such as send a message about that patient or view a patient summary). It also allows a user to tag patients with one of three common patient-provider relationships.
  - **My Account:** This link takes you to your user profile, where you can update your password and other account details.
  - **Logout:** This link logs you out of the Clinical Portal.
  - **Help:** This link opens a new window or tab on the user’s web browser to the Training & Tools section of the NC HIEA website. Here a user may access Clinical Portal video tutorials, get help with Clinical Portal credentials, and find other tools and information related to the Clinical Portal.

The **Main Menu** is shown below.

- **Patient View Menu:** This refers to a secondary menu that will display at the top right of the screen when a specific patient record is open. This menu displays links to all the Main Menu views, and one additional view:
  - **View Summary:** This link takes you to a patient summary report, containing patient demographics, allergies, medications, encounters, diagnoses and laboratory results consolidated from multiple patient data sources connected to NC HealthConnex. From this screen, a user may download, print or send to another Clinical Portal user or health care provider a patient summary, in various formats (see the Reports section of this User Guide).

The **Patient View Menu** is shown below.
• **Limited View Menu**: This refers to a tertiary menu that will display at the top left of the screen when in the Messages or Clinician Tools views. This menu will simply navigate a user back to the Clinical Portal Home Page (also the Patient Search screen) or allow a user to **log out** of the application, and is shown below.

---

**Buttons**

When navigating the clinical information within a patient record, a user should note the following buttons/icons and their functions:

- **A blue ellipsis icon**, often seen under a column titled "Details," indicates that more information may be available. Simply click on the icon to open a windowlet at right or a new pop-up window with this information. To close a windowlet, click the **X** in the upper right-hand corner, or click again the blue ellipsis icon next to the original row of data. To close a new pop-up window, click the **X** in the upper right-hand corner of the window.

- **A dark arrow icon** at the bottom of a list of information indicates that additional entries exist. The number to the left of the arrow indicates which page of entries the user is currently viewing. A user may click the arrow icons at the bottom of a list to navigate between pages of entries.

**Working in Windowlets**

Many links and buttons within the patient record screens of the Clinical Portal will open windowlets to the right of the screen. These windowlets may be navigated by adjusting (moving) or scrolling (up and down) various gray scroll bars. The gray scroll bars may appear on any side of the windowlet (top, bottom, right or left).

- **To make a windowlet larger** for better viewing of the information therein, click, hold and drag on a gray scroll bar to expand it in the desired direction.

- **To make a windowlet smaller** for better side-by-side viewing with the original information on the main screen, click, hold and drag on a gray scroll bar to minimize it in the desired direction.

**Logging In to Clinical Portal**

This section explains how to log in to the NC HealthConnex Clinical Portal, and information about password requirements.

To log in to the Clinical Portal, copy and paste the NC HealthConnex Clinical Portal URL ([https://portal.nchealthconnex.net](https://portal.nchealthconnex.net)) or type it into an Internet browser, such as Microsoft® Internet Explorer or Mozilla® Firefox®. Once you have entered the URL, the login screen is displayed, as shown below.
A username and password are required to gain access to the application. To obtain a username and password, contact your organization's Participant Account Administrator (PAA).

First-Time Log In

To log in for the first time, a user will enter the username and temporary password as assigned by their organization's PAA upon account creation. Once a user has entered the username and temporary password, the system will prompt the user to change the password and enter a challenge question and answer that may be used to update a forgotten password later, as shown below.

---

**Note:** A user may change their password and challenge question and answer at any time in the **Account** tab in the **My Account** section of the Clinical Portal.
Forgotten Password

If a user enters an incorrect password, s/he is notified that “Login Failed” and a *Forgot Password?* box appears, as shown below. When clicked, the box allows a user to answer their challenge question. If answered correctly, the user will receive an email at the email address linked to their Clinical Portal account with a temporary password, with which the user can reset their password from the login screen.

If a user attempts to log in five times with an incorrect username and/or password, the user will be prompted to enter the answer to the challenge question they set up on first-time log in, as shown below.

Upon entering the correct answer to the challenge question, the user will receive an email to the email account on file with NC HealthConnex with a temporary password.

If incorrect information is entered, the system may lock the user’s account, and the user must contact their organization’s PAA to unlock the account.
Security Requirements

To keep NC HealthConnex secure from unauthorized access, the NC HIEA has implemented the following system security requirements relative to user accounts and passwords:

- A user must reset his/her password every 90 days,
- Passwords must contain a minimum of eight characters including a mix of uppercase, lowercase, and special characters,
- When resetting a password, a user’s past four passwords may not be repeated, and
- A user’s account will become inactive if the user has not logged in for 45 days.

If a user has trouble logging in or changing a password, s/he should contact their organization’s PAA.

Accepting the Disclaimer

Each time a user successfully logs in to the NC HealthConnex Clinical Portal, s/he must agree to a standard disclaimer to gain access to the application. The user must read and select the Accept button within 20 minutes, or the user will be automatically logged out and returned to the login page. The disclaimer information to which a user must agree upon every log in is shown below.
Clinical Portal Home Page

The Clinical Portal home page, which defaults to the **Patient Search** view, appears when a user logs in to NC HealthConnex. This view contains the **Main Menu** at the top left of the display, where a user can click links to navigate to other sections within the Clinical Portal or log out. The **Patient Search** box appears at the left of the display, providing quick access to search for a patient.

A **Recent Patients** list appears at the center of the display, allowing a user to view demographic data of up to 20 recently viewed patients in alphabetical order and access their clinical records with a single click on the **Patient Name**. Note that the user must have opened (and not just searched) the patient record previously for that patient to appear in the **Recent Patients** list. The **Recent Patients** list displays name, gender, and date of birth for each patient.

For more information on the **Patient Search** view and accessing clinical records, see the **Patient Search** and **Viewing Patient Information** sections of this User Guide.

Logging Out of Clinical Portal

The **Logout** button is used to exit the NC HealthConnex Clinical Portal. The **Logout** button is accessible from all views within the Clinical Portal and is located at the far right of all three menu bars, as shown below.

It is important to use the **Logout** button as opposed to clicking on the **X** button of the browser. The **Logout** button will log the user out of the application and close the session. If the logout function is not used, the session will remain active for 20 minutes without user activity before the **Automatic Logout** feature is activated. The **Automatic Logout** feature is a security measure to protect patient data in NC HealthConnex from unauthorized users who may share or access a user’s computer.

**Note:** To protect patient data, a user is automatically logged out of the Clinical Portal after **20 minutes** of inactivity.
EDIT ACCOUNT DETAILS AND SPECIFY SYSTEM PREFERENCES

The **My Account** screen is the central location for changing account details like contact information, as well as some of the ways in which a user interacts with the NC HealthConnex Clinical Portal.

To access and edit this information, select the **My Account** link from either the **Main Menu** or the **Patient View Menu**, as shown below.

Clicking on the **My Account** tab will produce a pop-up window where a user may access and edit the information within the **Account** and **Preferences** tabs, as shown below.

### Account

The personal information in the **Account** tab may be edited as desired; however, the **First Name**, **Last Name**, and **E-mail** fields are required, as indicated by the asterisk (*). Note that these required fields will be pre-populated by the NC HIEA during account setup.

Fields available for edit/update on the **Account** tab, as shown above, include:

- **Basic Demographics:**
  - First Name (may only be edited by the NC HealthConnex Help Desk)
  - Last Name (may only be edited by the NC HealthConnex Help Desk)
  - Description (indicate the type of address; for example, “Work”)
  - Street
  - City
  - State
• Zip
• Telephone
• Use (select the type of telephone line from the drop-down menu)
• Mobile
• Fax
• Pager
• E-mail (this will be pre-populated, but may be edited)
• Location (indicate the type of email account; for example, “Work”)
• **Account Security:**
  • Current Password (this will be pre-populated and hidden)
  • New Password (enter a new password if desired)
  • Confirm Password (enter a new password a second time in this field to reset)
  • Challenge Question (this will be pre-populated, but may be edited)
  • Challenge Answer (this will be pre-populated, but may be edited)
• **Provider Identifiers:**
  • Identifier (may only be edited by the NC HealthConnex Help Desk)
  • Assigned By (may only be edited by the NC HealthConnex Help Desk)

After making edits to account information, a user should click the **Save Account** button at the bottom of the window to save all changes, as shown below.

![Account Information Screen](image)

**Note:** Some fields may only be edited by the NC HealthConnex Help Desk. To make changes to these fields, contact your PAA.
Preferences

The Preferences tab of the My Account pop-up window allows the user to configure some system settings. Fields available for edit/update on the Preferences tab include:

- **Default Patient Report**: the user may use the drop-down menu to select either the regular or expanded patient summary view.
- **Contract Search Results**: the user may enter a number of patients to limit the results returned by a search when there are many matches.
- **Hide Patient Search Criteria**: the default view upon patient search keeps the search entry/criteria section visible at left, with a list of search results returned at the right. By selecting “Yes” from the drop-down menu, the search entry/criteria section at the left of the screen will disappear when search results are returned. This feature may be helpful if the user is viewing this information on a small screen or mobile device.
- **List Type** and **My List**: please disregard these fields as they do not have any functionality tied to them and will be removed in a future system release.

The Preferences screen is shown below. After making edits to account information, a user should click the Save Preferences button at the bottom of the window to save all changes.
PATIENT SEARCH

The Patient Search screen in the NC HealthConnex Clinical Portal allows a user to search for patient records by entering medical record identifiers or demographic information.

Search by Medical Record Number

Every organization assigns medical record numbers (MRNs) to patients. A patient that has received care from multiple organizations may have more than one assigned MRN. A user may search for a patient by any MRN, and the assigning facility for that MRN, and see the patient’s records from all systems sharing data with NC HealthConnex.

- To search by MRN, key in an EHR ID and select an Assigned By entity name from the drop-down menu, as shown below. Then click Search.

Search by Demographic Information

Patients may also be searched by entering at least two fields of demographic information. Search results will appear with the closest match at the top of the list, followed by additional possible matches based on phonetically similar names and other partially matching criteria.

- To search by demographic information, key in both a Last Name and either a First Name or a Date of Birth. Then click Search, as shown below.
Note: If the search returns too many results, add additional search criteria (such as Middle Name) to filter the results and return a refined list of patients. The search algorithm will return results that are a close match; for example, a search may return results for different spellings of the searched name.

Search Results

Search results will include the following information for any matched patient(s):

- **Identifiers:**
  - The **Master Patient ID** will be displayed upon initial search under the **Identifiers** column next to the patient name. This ID is assigned by NC HealthConnex.
  - Clicking the + icon to the left of the **Master Patient ID** will expand the entry and list any **Organization-Specific Patient IDs**, along with attached records, in rows below. Note, these IDs are assigned by the EHRs at the organizations that contributed the specific records.

- **Name**
- **Gender**
- **Date of Birth**
- **Address**

Search results will appear as shown below.

From a search result, a Clinical Portal user may click on the **Patient Name** to the right of the **Master Patient ID** to open the record, as shown below.
Note: If there is any restriction on the information stored for the patient selected, a pop-up window explaining that the information is restricted will display (for example, if the patient has opted out of having their information shared via NC HealthConnex, or if the user’s access level does not permit viewing of clinical data).

Patient Privacy and Opt Out

The standard patient consent model implemented in NC HealthConnex, as stated in the North Carolina Health Information Exchange Act, is “Opt Out.” This means that patient data is by default opted in to being shared via NC HealthConnex unless a patient explicitly requests to opt out of having their information shared.

If a patient searched has opted out of having their information shared via NC HealthConnex, a Clinical Portal user may only see a Master Patient ID (no Organization-Specific Patient IDs). Clicking on the Patient Name will result in a message barring access to the patient record, as shown below.

NC HIEA Opt Out Policy

Patients have the right to opt out of having their information shared between providers through the HIE. If a patient chooses to opt out, they are required to complete a form and mail it to the NC HIEA Business Office. Opting out of having their information shared via NC HealthConnex will not adversely affect patient treatment by any physician and patients cannot be discriminated against if they decide to opt out. Patients may also use the form to rescind a previous opt out if they change their mind.

The primary opt-out process is for a HIE Administrator/Privacy Officer to manually change a patient’s status in the NC HealthConnex Clinical Portal.
**Note:** Even if a patient has opted out of having their information shared via the HIE, their clinical data from participating health care entities will continue to be submitted to the NC HealthConnex data repository. The HIE’s privacy and consent permissions simply hide an opted-out patient’s clinical data from all HIE users’ view.

---

**Break the Seal**

To access a patient record, a Clinical Portal user must have an established relationship with a patient. If a data-driven relationship exists (meaning the user, if a clinician, or user’s facility has previously seen the patient and their contributed records for that patient are present in the HIE), a user will be able to click a patient name and access the patient record instantly.

If a user does not have a prior data-driven relationship with a patient, the user may “Break the Seal” to receive temporary access to view a patient record. To gain temporary access, a user must:

1. Search for and select the patient record by clicking on the **Patient Name**. This will prompt the “Declare Patient Relationship” pop-up window, as shown below.

   ![Patient Search](image)

   ![Declare Patient Relationship](image)

   **To access a patient record, a Clinical Portal user must have an established relationship with a patient, or else declare their reason to view the record to gain temporary access.**
2. Select a reason to view the record from the drop-down list of options.

![Declare Patient Relationship](image)

3. After selecting an option, select the **Declare Relationship** button to open the patient record.

![Declare Patient Relationship](image)

Permission to view a patient record for a patient with whom the user does not have a data-driven relationship is temporary. This means that if a user returns to the **Patient Search** screen or another area of the Clinical Portal after viewing a record, s/he will need to repeat the “Break the Seal” process to access the record again or take actions relative to that patient from the **Clinician Tools** screen.

**Note:** All instances of “Break the Seal” are logged and subject to audit.
VIEWING PATIENT INFORMATION

Within the NC HealthConnex Clinical Portal, a user may access patient information received from various organizations participating with NC HealthConnex.

When a patient record is opened, this information is presented at the top of the patient record, through quick reference alert icons, and via tabs at the left of the **Patient View** screen that allow a user to view an aggregated clinical summary and drill down to specific types of clinical data, like medications and diagnoses.

Demographic Information

When a patient record is opened, the patient’s **Name, Age, Date of Birth, Address** and **Phone Number** appear across the top of the screen under the **Patient View Menu**, as shown below.

Additional demographic information is available by clicking the **Patient Demographic** quick reference icon to the right of the main patient demographic information pictured above (see the **Quick Reference/Alert Icons** section of this User Guide below).

Quick Reference/Alert Icons

To the right of the main patient demographic information displayed on the **Patient View** screen, icons (as relevant) give the user a quick visual flag for, and one-click access to, important clinical information. Hovering over each icon will also provide some information. Examples include:

- **Abnormal Results**: hovering over this icon displays information on abnormal test results, as shown below.

- **Alias Names Exist**: clicking on this icon opens a pop-up window with information on any historical/alternative names for the patient—for example, maiden names—as shown below.
- **Ongoing Patient Alerts**: clicking on this icon opens a pop-up window with more information on any important ongoing patient alerts providers should know about, as shown below.

![Patient Alerts Icon]

**DEMO, JANE M**

Female • 76 Years (1942-03-29) • 123 UNKNOWN LN, RALEIGH, NC 27565 • +1 (555) 1331123

<table>
<thead>
<tr>
<th>PATIENT ALERTS</th>
<th>MESSAGE</th>
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<tr>
<td>Other Directive</td>
<td>Patient has advance directives. For more information, please contact FirstHealth of the Carolinas 555 Memorial Drive PO Box 3000 PINEHURST, NC 28374</td>
<td>Active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Patient Demographic**: clicking on this icon opens a pop-up window with full demographic information and a few key clinical notes for the patient, as shown below.

![Demographic Icon]

**DEMO, JANE M**

Female • 76 Years (1942-03-29) • 123 UNKNOWN LN, RALEIGH, NC 27565 • +1 (555) 1331123

<table>
<thead>
<tr>
<th>PATIENT DETAILS</th>
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<td>Gutierrez, Chantry</td>
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</table>

- **Patient has Allergies**: clicking on this icon opens a pop-up window with information on allergies and adverse reactions, including date and source of this information, as shown below.

![Allergies Icon]

**DEMO, JANE M**

Female • 76 Years (1942-03-29) • 123 UNKNOWN LN, RALEIGH, NC 27565 • +1 (555) 1331123

<table>
<thead>
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<th>CATEGORY</th>
<th>ALLERGEN</th>
<th>NATURE OF REACTION</th>
<th>SEVERITY</th>
<th>ONSET DATE AND DESCRIPTION</th>
<th>STATUS</th>
<th>LAST UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Propensity to adverse reactions to drug</td>
<td>Vancomycin</td>
<td>Other (See Comments)</td>
<td>04/12/2018</td>
<td>Active</td>
<td>04/12/2018 00:00, RQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propensity to adverse reactions</td>
<td>Benzalkonium Chloride</td>
<td>Rash</td>
<td>09/24/2013</td>
<td>Active</td>
<td>09/24/2013 00:00, RQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propensity to adverse reactions</td>
<td>Warfarin</td>
<td>Nausea Only</td>
<td>09/24/2013</td>
<td>Active</td>
<td>09/24/2013 00:00, RQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propensity to adverse reactions</td>
<td>Lisinopril</td>
<td></td>
<td>05/10/2011</td>
<td>Active</td>
<td>05/10/2011 00:00, RQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propensity to adverse reactions</td>
<td>Sulfis (Sulfonamide Antibiotics)</td>
<td></td>
<td>05/10/2011</td>
<td>Active</td>
<td>05/10/2011 00:00, RQ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note**: These icons will only appear where relevant to the patient. For example, the **Patient has Allergies** icon will not display for a patient with no documented allergies.
Clinical Information

Below the main patient demographic information and quick reference/alert icons displayed on the Patient View screen, a patient record is presented in the following ways, navigable by tabs on the left side of the screen and icons within each screen (see the Clinical Portal User Interface section of this User Guide for a description of icon/button functions):

- **Summary**: the top tab and default page upon opening a patient record, the Summary screen includes a single, aggregated record that lists the most recent information received for an individual patient by the HIE. This information is categorized into the following lists: Allergies, Medications, Diagnoses, Documents, General Lab Results and Other Results and Notes.
- **Allergies & Alerts**: the second tab from the top, the Allergies & Alerts screen includes a list of known patient allergens, nature of the allergic reaction, severity level, date of onset, status and source/time of the data. This screen also displays important Patient Alerts for providers, such as the direction: “Do Not Resuscitate.”
- **Encounters**: the third tab from the top, the Encounters screen presents a list of patient encounters in reverse chronological order (most recent at the top), including relevant dates, type of encounter, facility name, relevant department and/or attending physician treating the patient, the local (treating facility) MRN and encounter number, and if available, insurance information.
- **Medications**: the fourth tab from the top, the Medications screen presents two lists of medications: Recent Medications (no end date provided) and Historical Medications (end date provided). Each list contains the order name, dose, drug route and start date for each medication, where that information was made available to the HIE.
- **History**: the fifth tab from the top, the History screen presents information on a patient’s family, social and medical history including type of information (e.g., “family” may describe a family history of a certain condition, or “social” may describe smoking status), a description, onset date, comments, and source/time of the data.
- **Conditions**: the sixth tab from the top, the Conditions screen presents three lists: Diagnoses, Present Illness, and Past Illness. The Diagnoses list contains patient diagnoses, including diagnosis type, description, code, status, diagnosis date, and source/time of the data. The Present Illness and Past Illness lists contain description, onset date, end date (if past illness), problem, status, and source/time of the data.
- **Procedures/Results**: the seventh tab from the top, the Procedures/Results screen presents three lists: Procedures, General Lab Results, and Other Results and Notes. The Procedures list contains operation, procedure date, care provider, operation code, and source/time of the data. The General Lab Results list contains order item, a link to a cumulative list of results for that order item, and individual results (a hyperlinked date/time that may be clicked for each full result information). The Other Results and Notes list contains description, status, results (a hyperlink that may be clicked for full result information) and results date.
- **Vaccinations**: the eighth tab from the top, the Vaccinations screen presents a list of vaccinations administered, including the order name, dose, drug route and start date.
- **Documents**: the ninth tab from the top, the Documents screen presents any documents received by the HIE, including the document name (a hyperlink that may be clicked to view document details or the full document, depending on document type), clinician, document type, activity date, and source/time of the data.

*Note: Though NC HealthConnex shares information with the NC Immunization Registry, all vaccinations currently presented in the Clinical Portal are as received from local EHR systems only.*
**Note:** All information in the clinical tabs described in this section is:

1. **Presented in reverse chronological order,** with the most recently received data at the top of each list. The data lists are not subject to sort, filter or search functionality.

2. **View-only.** To send a patient record to another provider, see the [Messaging](#) section of this User Guide. To download or print a patient record, see the [Reports](#) section of this User Guide.

3. **Exactly as received from local EHR systems,** meaning that some data fields may be blank or contain information displayed in a variety of different ways based on how it was formatted in the source system.

4. **May require a “Refresh” to present the most up-to-date information.** If a user sees “Awaiting results from:” text below the Patient View Menu, s/he should click the Refresh button, as shown below, to ensure the most recent data from all data sources is presented.

The nine clinical tabs are shown below.

<table>
<thead>
<tr>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies &amp; Alerts</td>
</tr>
<tr>
<td>Encounters</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>History</td>
</tr>
<tr>
<td>Conditions</td>
</tr>
<tr>
<td>Procedures/Results</td>
</tr>
<tr>
<td>Vaccinations</td>
</tr>
<tr>
<td>Documents</td>
</tr>
</tbody>
</table>

**Sections of the patient record which have no data populated are indicated by grayed out tab text, as shown at left.**

To arrive at the Patient View screen and navigate through the clinical tabs:

- Search for a patient record using Patient Search, or choose a patient from the Recent Patients list or a list within Clinician Tools.
- Select the patient for whom you wish to view the Patient Summary by clicking the Patient Name.

**Summary**

The Summary is a snapshot of the most recent components of a patient’s aggregated record. It is the first screen a Clinical Portal user sees when a patient’s name is selected from the results.
of a search or a user’s list, and displays six abbreviated lists of information: Allergies, Medications, Diagnoses, Documents, General Lab Results and Other Results and Notes. (Full lists of information for each category may be found by navigating through the tabs at left or by clicking the arrows at the bottom of each list.) Some of the fields within each section and information entry may be blank, as data is not always sent/received from the source system.

The **Summary** screen is shown below.

![Summary Screen](image)

Data inputs that appear as blue, underlined hyperlinks—such as a document or lab result—may be clicked to open a new window with additional information, as shown below.

![Document and Lab Result Details](image)
Additional information on a row of data on the Summary screen may be accessed by clicking on a blue ellipsis icon at the left of the row or a dark arrow icon at the bottom of the row, where available. The information will appear either as a windowlet at right or a new pop-up screen.

Allergies and Alerts

The Allergies & Alerts screen lists the patient’s recorded allergies and any important patient alerts.

- The Allergies and Adverse Reactions list includes any documented allergen, the nature of the patient’s reaction following contact with the allergenic substance or event, the severity level, the recorded date of onset, the status, and the date/time/facility/sender of the update, where that information was made available to the HIE, for each allergy.

- The Patient Alerts list includes important alerts for providers, such as the direction: “Do Not Resuscitate.” This list includes the type of alert, the alert message, the status, the date the alert was entered, and the facility/sender of the information for each alert.

Some of these fields may be blank, as data is not always sent/received from the source system.

The Allergies & Alerts screen is shown below.

To view additional information about an entry on the Allergies and Adverse Reactions list (such as a provider's comments), click on the blue ellipsis icon at the left of the row and a pop-up window will appear, as shown below.
Encounters

The **Encounters** screen displays a list of a patient’s encounters with care providers. The list includes the encounter start and end dates, the type of encounter, the facility name, the relevant department and/or attending physician treating the patient (with contact information), the local (treating facility) MRN and encounter number, and insurance information for each encounter.

Some of these fields may be blank, as data is not always sent/received from the source system.

The **Encounters** screen is shown below.

Attending physician names appear as blue, underlined hyperlinks and may be clicked to open a windowlet at right with contact information for the physician, as shown below.
Note: Attending Physician information is typically only sent to the HIE for emergency and inpatient events for ease of follow-up by a patient's care team.

Insurance information, if made available to the HIE, may be accessed by clicking on the blue ellipse icon. A windowlet containing insurance plan and account details will appear at right, as shown below.

Medications

The Medications screen lists recent and historical medications prescribed for the patient.

- The Recent Medications list contains the order name, the prescribed dose, and the drug route and start date, where that information was made available to the HIE, for each medication.

- The Historical Medications list contains the order name, the prescribed dose, and the drug route and “ordered on” date, where that information was made available to the HIE, for each medication.

Some of these fields may be blank, as data is not always sent/received from the source system. The Medications screen is shown below.
Additional details for each medication prescription—such as order status, ordering clinician or number of refills, if made available to the HIE—may be accessed by clicking on the blue ellipsis icon. A windowlet containing the information will appear at right, as shown below.

**History**

The **History** screen presents information on a patient’s family, social and medical history. This list includes the type of information (e.g., “family” may describe a family history of a certain condition, or “social” may describe smoking status), the description, the onset date, any comments, and the date/time/facility/sender of the update, where that information was made available to the HIE, for each entry.

Some of these fields may be blank, as data is not always sent/received from the source system.

The **History** screen is shown below.
Additional details for each history entry—such as the family member who carries the family history of a condition or the duration of an issue/condition, if made available to the HIE—may be accessed by clicking on the blue ellipsis icon. A windowlet containing the information will appear at right, as shown below.

Conditions

The Conditions screen provides information on a patient’s diagnoses and any present and past illnesses.

- The Diagnoses list contains patient diagnoses, including the diagnosis type, the description, the code, the status, the diagnosis date, and the date/time/facility/sender of the update, where that information was made available to the HIE, for each diagnosis.
- The Present Illness and Past Illness list entries contain the description, the onset date, the end date (if past illness), the problem, the status, and the date/time/facility/sender.
of the update, where that information was made available to the HIE, for each illness. Some of these fields may be blank, as data is not always sent/received from the source system.

The **Conditions** screen is shown below.

Additional details for each diagnosis (e.g., notes) may be accessed by clicking on the blue **ellipsis** icon. A pop-up window containing the information will appear, as shown below.

### Procedures and Results

The **Procedures/Results** screen provides information on a patient's procedures, general lab results and other types of results and notes.

- The **Procedures** list contains the procedure, the procedure date, the care provider, the
operation code, and the date/time/facility/sender of the update, where that information was made available to the HIE, for each procedure.

- The **General Lab Results** list contains the order item, a link to a cumulative list of results for that order item, and any individual result(s) (hyperlinked date(s)/time(s) that may be clicked for each full result information) for each lab result.

- The **Other Results and Notes** list contains information for other types of results (e.g., pathology or radiology), or related provider notes. This list includes the description, the status, the results (a hyperlink that may be clicked for full result information), and the results date for each entry.

For quick reference, note that any **red text** that appears within the Procedures/Results screens and pop-up windows/windowlets indicates a result or test item that is abnormal or outside of normal range (e.g., a result lower or higher than the provided reference range).

Some of these fields may be blank, as data is not always sent/received from the source system.

The **Procedures/Results** screen is shown below.

![Procedures/Results Screen](image)

**General Lab Results** may be viewed cumulatively or individually.

To view side-by-side cumulative results for a lab results order item, click the blue “View” hyperlink in the Cumulative column and a pop-up window will appear, as shown below. This pop-up window will display rows of individual test items, each of which include a reference range, units of measure, and columns of results from different dates/times, as noted. A **C** icon represents a Corrected result, and a **F** icon represents a Final result. Hovering over an individual result will show the result, reference range and unit description for quick reference, as shown below.
Additionally, any individual result from the cumulative results window may be viewed in more detail by clicking the individual result value hyperlink in the desired date/time result column. This will open a new pop-up window, as shown below.
To view individual results for a lab results order item, click the hyperlinked date(s)/time(s) under the result number column and a pop-up window will appear, as shown below. This pop-up window will display rows of individual test items for the result, each of which include a flag (e.g., Normal, Low, High), a lab value, units of measure, a reference range, a lab value status (Corrected or Final), and any comments, sensitivities, or message flags. As with the cumulative view, a icon represents a Corrected result, and a icon represents a Final result.

Note that each test item is itself a hyperlink that may be clicked to open a pop-up window including additional notes or other information, as shown below.
From the individual result detail window, blue underlined hyperlinks toward the top allow a user to navigate between results (Previous Result, Next Result), view Order Details in a new pop-up window (including the ordering clinician and other information) or switch to the Cumulative view.

The Order Details pop-up screen may contain additional detail about the order where provided—such as order status, comments, or text instructions—as shown below.
In the **Other Results and Notes** table, below **General Lab Results**, additional details for each entry in the table (e.g., ordering clinician, notes, etc.) may be accessed by clicking on the **blue ellipsis icon** in that row within the Details column or the “Results” blue hyperlink in that row within the Results column. A windowlet at right or a pop-up screen containing the information will appear, as shown below.

![Image of the Other Results and Notes table](image)

### Vaccinations

The **Vaccinations** screen provides information on a patient’s documented vaccinations, including the order name, dose, drug route and start date.

Some of these fields may be blank, as data is not always sent/received from the source system.

The **Vaccinations** screen is shown below.

![Image of the Vaccinations screen](image)

Additional details for each vaccination (e.g., ordering clinician or any comments or instructions) may be accessed by clicking on the **blue ellipsis icon** next to an entry. A windowlet containing the information will appear at right, as shown below.
**Note:** Though NC HealthConnex shares information with the NC Immunization Registry, all vaccinations currently presented in the Clinical Portal are as received from local EHR systems only.

### Documents

The **Documents** screen allows a user to view information on any documents received by the HIE, including a hyperlink that may be clicked to view document details or the full document itself (depending on the document type), the clinician, the document type, the activity date, and the date/time/facility/sender of the document, where that information was made available to the HIE.

Some of these fields may be blank, as data is not always sent/received from the source system. The **Documents** screen is shown below.
Additional details for each document (e.g., notes) may be accessed by clicking on the blue ellipsis icon next to the document name. A new pop-up window or a windowlet at right (depending on the document type) will appear containing the information, as shown below.

**Patient Information from Outside NC HealthConnex**

NC HealthConnex is a proud member of the nationwide eHealthExchange network. Active in all 50 states, the eHealth Exchange is the largest query-based, health information network in the country. It is the principal network that connects federal agencies and non-federal organizations, allowing them to work together to improve patient care and public health.

Through eHealthExchange, NC HealthConnex automatically queries external systems like our connected border-state statewide HIEs (in Virginia, Tennessee, Georgia and South Carolina) and the nationwide Veterans Health Information Exchange (VHIE) for available patient records when a patient is searched in the Clinical Portal. Any results from these and other connected systems through eHealthExchange will be returned and stored as documents in the **Documents** tab, and identifiable as such by viewing the facility information (displayed within a row in the **Facility** column, or by clicking on the blue ellipsis icon for more details). When searching a patient, a user may see a temporary message appear in the upper right hand corner of the screen noting that the system is “awaiting information from” external systems.

**Note:** If a record for a patient doesn’t already exist in NC HealthConnex, a search for that patient through our eHealthExchange partners will not be successful. A patient must have at least one prior record contributed by a NC HealthConnex participating organization to return and display external information in the patient record.
Timeline View

The Timeline View gives a Clinical Portal user an overall perspective of a patient’s episodic, chronological medical history using a visual representation of encounters and documents available for that patient over time. It also allows a user to filter the patient information shown in the various clinical tabs below by time period or by specific encounter.

To access Timeline View:

1. Search for and select a patient record (see instructions in the Patient Search section of this user guide) or select a patient from Recent Patients or another list in Clinician Tools.

2. Once the patient record is open, click the blue underlined view timeline hyperlink in the upper left of the screen, below the patient’s demographic information and above the clinical information navigation tabs, as shown below.

3. The timeline will appear as a gray bar where the view timeline hyperlink was. The gray bar will show dates at either end, indicating the earliest and latest information received for that patient. Above the gray bar, each thin navy blue line indicates a patient encounter where information is available for the corresponding time period. Each thin navy blue line has thin gold lines above and below it if the encounter is selected/included in the information displaying below; each thin navy blue line has thin light blue lines above and below it if the encounter is deselected/excluded from the information displaying below. At the right of the timeline, under the Quick Reference/Alert Icons, a timeline menu of three hyperlinks allows a user to include all encounters, deselect all encounters, or filter and isolate information from a specified time period and/or by encounter type. The timeline bar is shown below.

For quick reference, hovering over a navy blue encounter line will display an encounter number, admission date(s), episode type and department.
Filtering Patient Information by Time Period, Encounter Type or Episode

A user will find **Timeline View** most helpful when s/he is looking to filter patient information by time period, encounter type(s) or specific episode(s). A user may filter patient information in the patient **Summary** and other clinical information tabs in these ways:

- **Use the timeline menu hyperlinks to the right of the gray timeline bar to:**
  - **Select All:** clicking this hyperlink will include all of a patient’s encounters in the information displaying in the patient **Summary** below, and throughout the views as a user navigates the clinical information tabs at left.
  - **Deselect All:** clicking this hyperlink will exclude all of a patient’s encounters in the information displaying in the patient **Summary** below, and throughout the views as a user navigates the clinical information tabs at left. This is useful when a user wants to isolate a particular encounter by first deselecting all encounters, and then clicking individual encounter bars over the gray timeline bar as desired.

  ![Timeline View Example](image)

- **Adjust Preferences:** clicking the Preferences hyperlink will open a pop-up window with settings to allow a user to further customize the **Timeline View** by time period and encounter type(s) (to select multiple encounter types, click and hold the Control (“ctrl”) key while selecting the encounter types to include), as shown below. Note that a user may also un-check the “Enable Small Timeline” box to see slightly larger encounter bars, for easier clicking.

  ![Preferences Window](image)
When **view timeline** is clicked, all encounters for which the patient has had information sent to NC HealthConnex appear by default. A patient typically has multiple encounters displayed on the timeline. Information from specific episodes can be hidden or re-displayed in the below patient **Summary** screen and other screens accessible by the tabs at left by clicking on the episode (the thin **navy blue** line) in the timeline to deselect or select it.
REPORTS

The NC HealthConnex Clinical Portal provides two types of patient summary reports (Regular or Expanded) in three different formats (CCD, HTML or PDF) for viewing, printing and sharing. Once a patient record has been opened, these can be accessed from the patient Summary screen (or any of its sub-screens accessible by clicking the tabs at left) using the View Summary link in Patient View Menu bar at the top right of the screen, as shown below.

Once a user clicks View Summary, s/he will initially land on the default Patient Summary Report screen, as shown below. The data in this report will likely be too large to fit on the screen at one time; the browser scroll bar, page-down ("pg dn"), and page-up ("pg up") keys will allow the user to navigate the report and view all data.

To navigate back to the view-only patient record, click the Back to Viewer hyperlink at the top left of the screen, as shown below.
Report Types

There are two types of patient summary reports available for viewing, printing and sharing. These reports and their contents are as follow:

- **Patient Summary Report**: the default report upon clicking View Summary, this report shows patient demographics, allergies, medications, encounters, diagnoses and laboratory results.

- **Patient Summary Report (Expanded)**: this report shows more information, including patient demographics, allergies, alerts, advance directives, patient-clinician relationships, program memberships, encounters, appointments, diagnoses, medications, immunizations, laboratory results, radiology results, observations, procedures, physical exams, problems, history, documents, and sections for additional information about people and organizations related to the patient.

A user may select the preferred type of report from the **Report** drop-down menu at the top of the screen, as shown below.

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Report Formats

There are three report format options available to users: **Consolidated CDA CCD**, **Patient Summary (HTML)**, and **Patient Summary (PDF)**. A user may select the preferred format from the **View As** drop-down menu at the top of the screen, as shown below.

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Sharing a Report

A key feature of the NC HealthConnex Clinical Portal is the ability for users to proactively share patient information with other members of a patient's care team. To share a patient report with another health care provider with a Direct Secure Messaging mailbox:

1. Select the desired report type and format, per the instructions in the **Report Types** and **Report Formats** sections of this user guide, above. Then, click the **Send** button at the top of the screen, as shown below.
2. A pop-up window will appear confirming the user wishes to share the patient information with another party. Click Ok to continue.

3. A new message pop-up window will appear. Fill in all applicable fields, and filter the report as desired, per the Messaging section of this user guide. Then click Send at the bottom left, as shown below.

**Downloading or Printing a Report**

The patient summary reports described in the previous few pages are available for a Clinical Portal user to download or print for use during a patient encounter or addition to a local patient record.

To download or print a patient report, Patient Summary (PDF) is the recommended format
option. Once the report type (Regular or Expanded) is selected per the Report Types section of this user guide, use the “print” and “download” icons at the top right of the screen to take each action, as shown below.

Protecting Patient Health Information

Care must be taken to keep Protected Health Information (PHI) safe. Information downloaded to local systems or printed for office use may be accessed by unauthorized persons if care is not taken. This may happen if:

- The system is left in an insecure state; for example, a user leaves their computer unattended while logged into the Clinical Portal with a patient record or report open.
- A patient summary report is downloaded to a local system or printed for office use, and not properly encrypted, stored or filed to prevent unauthorized access by others.

To ensure PHI is not accessed by an unauthorized user:

- Always log out of the Clinical Portal at the end of your session. To do so, select the Logout button in the menu bar at the top of the screen. This action closes all open windows, message drafts and attachments automatically.
- Always check that all windows and tabs are closed before stepping away from your computer, as attachments or drafts may be open in separate windows in your browser.
- Follow all security guidelines recommended by your system administrator.

Please download and print patient reports with caution and remember it is your responsibility to safeguard patient data per the Health Insurance Portability and Accountability Act (HIPAA) and your contract with the NC Health Information Exchange Authority (NC HIEA).
CLINICIAN TOOLS

The Clinician Tools feature of the NC HealthConnex Clinical Portal allows a user to create and work patient lists, and tag patients with one of three common patient-provider relationships. Once a user creates a new list, s/he may take certain actions from that list quickly, such as messaging about the patient, downloading a patient summary, or copying the patient to another list.

To access Clinician Tools, click the Clinician Tools tab from the Main Menu or Patient View Menu bars, as shown below.

The Clinical Portal allows users to create patient lists based on their clinical and care management needs. This can be useful if a clinician or care manager would like to regularly track, for example, high-risk patients.

Once opened, the Clinician Tools main screen displays a user’s Recent Patients list, including patients for whom the user has recently viewed the patient record (clinical information). Patients are listed in alphabetical order. This list includes the patient name, date of birth, age, gender, primary care provider (PCP), PCP phone number, and three quick action icons at right.

The Clinician Tools main screen/Recent Patients list is shown below.

From the Clinician Tools main screen, a user may:

- **Work a patient list**, including:
  1. **View a patient record** by clicking on the patient name*,
  2. **Send a message about a patient** by clicking the envelope quick action icon at right,
  3. **Download a patient summary** by clicking the green download quick action icon at right, or
  4. **Copy a patient to another list** by clicking the lists quick action icon at right.

- **Create additional patient lists/access created patient lists** by clicking on the Lists button at the top left menu.

- **Tag patients with a patient-provider relationship** by clicking on the Relationships button at the top left menu.

Once a user creates a new list, s/he may take certain actions from that list quickly, such as messaging about the patient, downloading a patient summary, or copying the patient to another list.
**Note:** If a user does not have a data-driven relationship (organizational tie) with a patient, the user will have to break the privacy seal to view the patient record, as described in the *Break the Seal* section of this User Guide, and below in *Working Patient Lists*.

### Working Patient Lists

As described above, a user may take four main actions from any patient list within the **Clinician Tools** area of the Clinical Portal. These actions are described below.

1. **To view a patient record**, click on the patient name within a list. If the user has a data-driven relationship (organizational tie) with a patient (as described in the *Break the Seal* section of this User Guide), the record will open instantly, as shown below.

If a user does **not** have a data-driven relationship (organizational tie) with a patient, clicking on a patient name will yield a pop-up message, as shown below.

![Patient Record](image-url)
To continue to the patient record, click **Ok** to the above message, then proceed to break the seal for the patient by clicking the checkbox next to **Override Consent Policy** in the upper right hand corner of the screen, as shown below.

Once the **Override Consent Policy** box is checked, a **Reason** drop-down menu will appear at the top center of the screen, above the patient list. Select the appropriate reason to view the record from the list.

After a reason is selected, click the patient name again, and the record will open instantly.

2. **To send a message about a patient**, click on the envelope quick action icon at right within the row of patient information. If the user has a data-driven relationship (organizational tie) with a patient (as described in the **Break the Seal** section of this User Guide), a new message will open instantly. Once a recipient is entered in to the **Send To** field (as described in the **Composing Messages** section of this User Guide), the message will show an attached patient record, and the user may complete the remaining message fields and send the message, as shown below.
If a user does not have a data-driven relationship (organizational tie) with a patient, s/he must first break the privacy seal per the instructions on page 49 above.

3. **To download a patient summary**, click the green download quick action icon at right within the row of patient information. If the user has a data-driven relationship (organizational tie) with a patient (as described in the **Break the Seal** section of this User Guide), a new pop-up window will appear, allowing the user to customize* and download a patient report, as shown below.

For information on selecting a report type and format, see the **Reports** section of this User Guide. For information on filtering a report, see the **Attaching Patient Information to a Message** section of this User Guide.
Clicking **Download** opens a pop-up window allowing the user to open or save the file.

4. To copy a patient (or all patients) to another list, click the lists quick action icon at right within the row of patient information. If the user has a data-driven relationship (organizational tie) with a patient (as described in the *Break the Seal* section of this User Guide), a new pop-up window will appear, allowing the user to select the list* to which to add the patient, and whether they’d like to add only this patient or all patients in the current list. After selecting preferences, clicking **Copy** will copy the patient to the new list and confirm this action with a new pop-up window, as shown below.

*Note:* “Lists” are referred to as “Programs” in the NC HealthConnex Clinical Portal. Note also that patient lists created by way of assigning user-patient relationships are also considered “lists” in this scenario, and so a user may add a patient from any list to any user-patient relationship list (e.g., a user may add a patient from Recent Patients to their Primary relationship list).
Creating Additional Patient Lists

The NC HealthConnex Clinical Portal allows users to create patient lists based on their clinical and care management needs. This can be useful if a clinician or care manager would like to regularly track a group of patients—for example, high-risk patients, a group enrolled in a clinical trial, or those with specific chronic conditions.

To create a new patient list, first click on the **Lists** button at the top left menu of the **Clinician Tools** screen and select “add/edit lists...” from the **List** drop-down menu. Then click the **Add Program** button on the next screen, enter a name and description as prompted, and click **Save Program**, as shown below.
Once saved, the new patient list will appear in the list above, as shown below.

To edit an existing list, navigate back to the main Lists screen by clicking the button at the top left menu, and selecting the “add/edit lists...” from the List drop-down menu. Then, click the desired list name, edit the name and description as prompted, and click Save Program, as shown below.
To add a patient to a list, first click on the **Lists** button at the top left menu of the Clinician Tools screen and select the list name from the List drop-down menu. Then click the green plus sign icon 🔄 at the right of the screen, enter patient demographic or MRN information for the patient, and click **Search**. Finally, select the patient name from the results list to add the patient to your relationship list, as shown below.
As with the **Recent Patients** list, additional patient lists created by the user contain basic demographic information and allow quick access to messaging about the patient, downloading a patient summary and adding the patient to additional lists (see the **Working Patient Lists** section of this User Guide). In addition, a user may remove a patient from a list they create by clicking the icon at the right of the row of patient information.

## Tagging Patient Relationships

The NC HealthConnex Clinical Portal allows users to tag patients with one of three common patient-provider relationships based on their clinical/care relationship: Consulting, Primary and Referring. This can be useful if a clinician or care manager would like to regularly track one of these groups of patients—for example, patients for which a clinician is the referring provider, to ensure adequate follow-up after any care performed elsewhere.

Tagging a patient-provider relationship can be useful to track a group of patients—for example, patients for which a clinician is the referring provider, to ensure adequate follow-up after care performed elsewhere.

To tag a patient relationship, first click the button at the top left menu of the **Clinician Tools** screen and select a relationship type from the **Relationship** drop-down menu. Then click the **green plus sign icon** at the right of the screen, enter patient demographic or MRN information for the patient, and click **Search**. Finally, select the patient name from the results list to add the patient to your relationship list, as shown below.
To add a patient relationship:
- choose a relationship from the pull down menu
- click the Plus sign to search for and add a Patient.

Relationships with your patients:
- Patients added to "Primary" will by default show up in the "My List" tab.

Select a patient by clicking the patient name.

NOTE: Some records have been filtered due to Consent.
As with the **Recent Patients** list or additional patient lists created by the user, relationship lists contain basic demographic information and allow quick access to messaging about the patient, downloading a patient summary and adding the patient to additional lists (see the **Working Patient Lists** section of this User Guide). In addition, a user may remove a patient from a relationship list by clicking the ✗ icon at the right of the row of patient information.
MESSAGING

The messaging feature of the NC HealthConnex Clinical Portal allows users to send messages to and receive messages from any trusted Health Information Service Provider (HISP) Direct Secure Messaging (DSM) accounts registered with DirectTrust and within the NC HealthConnex Provider Directory.

This means users may share encrypted messages containing patient health information with other users within the NC HealthConnex Provider Directory only (not to/from standard e-mail accounts like Gmail or Yahoo).

Messaging Center User Interface

The Messaging Center looks much like a standard webmail application, with menu bars to the left and at the top, a list of messages at the middle/center of the screen, and a message viewing pane at the middle/bottom of the screen with Reply/Reply All/Forward buttons to the top right of the open message.

To access the Messaging Center, click the Messages tab from the Main Menu or Patient View Menu bars, as shown below.

A message row appears in bolded blue text when its contents are unviewed and un-bolded black text once viewed.

Messaging Menus

Two menus appear in the Messaging Center, at the left and the top of the screen. These menus display a user's folders for storing and organizing messages, and allow a user to take actions off of messages (such as moving or deleting messages), respectively. These menus and their contents/functions are shown below.
The menu bar at the left of the screen allows a user to compose a new message; view and work with messages in the Inbox, Sent, Deleted, and Drafts folders; or add a folder using the green plus sign icon.

The menu bar at the top of the screen allows a user to delete a message, mark a message (read or unread) from the drop-down menu, or move a message (to any standard or customized folder). To do this, a user must first select one or multiple messages from the list by clicking its checkbox.

Working with Folders

Folders enable users to manage their mailbox and organize messages so they can find them easily. There are two types of folders: standard system folders and user-defined folders.

The standard system folders may not be moved, renamed or deleted. These folders are always displayed at the top of the list of folders, and include:

- **Inbox**: this is the default folder displayed when the Messaging Center is opened and shows all received messages that have not been deleted or moved to another folder.
- **Sent**: this folder contains copies of all messages a user has sent, listed in reverse chronological order (most recent at the top).
- **Deleted**: this folder contains all messages deleted by a user, listed in reverse chronological order (most recent at the top). Deleted messages remain in this folder until a user selects and deletes the message permanently from this folder (and confirms the action in a pop-up window), after which point the message cannot be restored.
- **Drafts**: this folder contains any draft/unsent messages saved by the user. Any type of message may be saved as a draft, whether it is a new message, a forward, a reply, or a reply all message.

In addition to the standard system folders, a user may create and name their own folders for storing and organizing messages. An example of a user-defined folder may be “Referrals,” to store messages about patients referred to other providers, or “High-Risk,” to store messages about a provider’s high-risk patients. These user-defined folders appear below the list of standard folders in alphabetical order.

Note that a folder name is bolded when its contents are being displayed to the right.

To create a new user-defined folder, click the green plus sign icon below the standard system folders and enter the desired folder name as prompted in the pop-up window. Click Ok and the new folder will appear in alphabetical order within the list of user-defined folders, as shown below.
To rename or delete a user-defined folder, click the and icons, respectively, to the right of the folder name (see above right screenshot). Any contents of deleted folders will be moved to the Deleted folder; if there are messages a user wishes to save, s/he should move them from the Deleted folder to another folder.

Working with Messages

Sorting Messages

Messages within a folder may be sorted by clicking on their header titles. This will sort messages by date/time (Received column, with most recent first), subject name (Subject column, alphabetically), sender (Received From column, alphabetically), patient name (Patient Name column, alphabetically) or identifier (Identifier column, numerically). Clicking on the header a second time will sort the messages in the reverse order.

For example, to sort messages by date/time with the most recent messages at the top, click Received once, as shown below.

As another example, to sort messages by sender, in reverse alphabetical order, click Received From twice, as shown below.
Marking and Moving Messages

For better organization and usability, messages within any folder may be marked as Read or Unread, and moved from the Inbox to another folder, or between folders.

To mark a message Read or Unread, select the message by clicking the empty checkbox at the left of the message row, and select Read or Unread from the Mark as drop-down menu in the top menu bar, as shown below.

Once this action is taken, the message row will appear bolded (if marked Unread) or un-bolded (if marked Read).

To move a message between folders, select the message by clicking the empty checkbox at the left of the message row, and select the folder to which the message should be moved from the Move to drop-down menu in the top menu bar, as shown below.

Note that multiple messages may be marked or moved at once by selecting all desired message checkboxes at the left of the message row, and then taking the action to mark or move as described above.

Deleting Messages

Messages may be deleted from any folder by clicking the empty checkbox at the left of the message row, then clicking the Delete button in the top menu bar, as shown below.
Note that **multiple messages may be deleted at once** by selecting all desired message checkboxes at the left of the message row, and then clicking **Delete**, as described above.

**To permanently delete a message**, a user should select the message within the **Deleted** folder by clicking the empty checkbox at the left of the message row and clicking the **Delete** button in the top menu bar. This action will prompt a pop-up window asking the user to confirm they would like to permanently delete the message. By clicking **Ok**, the user agrees to permanently delete the message, after which point the message cannot be restored.

![OK to Permanently Delete?](image)

**Receiving and Viewing Messages and Attachments**

A user will receive new incoming messages in their **Inbox**, the default folder upon entering the **Messaging Center** that displays a list of messages at the middle/center of the screen, and a message viewing pane at the middle/bottom of the screen.

New, unread messages will display as **bolded** in the list. Once a user clicks on any part of the message row, the text in the row will be un-bolded, indicating the message has been opened, and the message body text, message delivery information, and/or attachment details will appear in the message viewing pane below the messages list.

If a **patient report** is attached, a user may toggle between the message body text itself (if any) and the patient report by using the tabs above the message viewing pane and below the messages list, as shown below.
If another type of document is attached from a sender’s local computer, clicking on the hyperlinked document name will open a new pop-up window asking the user to open or save the file, as shown below.
Composing Messages

A user may compose a new message from the Messaging Center, the View Summary page, or from a patient list within Clinician Tools.

If a user wishes to attach a patient report from the Clinical Portal to a message, s/he should initiate the message from the View Summary page, or from a patient list within Clinician Tools; see the Attaching Patient Information to a Message section of this User Guide below.

To compose a new message from the Messaging Center, a user will take the following steps.

1. Click the Compose button at the top of the left menu bar, and a new message pop-up window will appear, as shown below.
2. Enter a recipient into the **Send To...** field by either:

- **Searching the Provider Directory.** To search for a recipient address, click the **Send To...** button and key in recipient details to at least one of the available fields in the **Find Recipient** window, then select a recipient by clicking on a blue hyperlinked name in the results list, as shown below. Note that each search result will return a name, Clinical Portal user ID, description, ID number and assigning authority, and indication of whether the user is or is not a clinician, as this information is available.
OR

- **Typing the recipient’s last name into the **Send To**... field** (*only available if the user has sent a message to the recipient at least once before*). To use this quick option, start to type the recipient’s last name into the field directly. This action will prompt a drop-down menu directly below the **Send To**... field containing any prior recipient matching name(s), from which the user may click on the intended recipient and populate the field, as shown below.

![Image of Send To... field with a drop-down menu]

- To add additional recipients, repeat the steps above.

- **Note that once a recipient is successfully entered in to the **Send To**... field, the system recognizes the message as a Direct Secure Message and the **Delivery Policy** field defaults to “DSM Direct Delivery” and may not be changed. In addition, the **Patient**, **Message Type**, and **Reason** fields disappear. As the NC HealthConnex Clinical Portal is configured to send and receive messages only between Direct mailboxes, these additional fields do not apply to users.**

3. Enter any additional recipient(s) to be carbon-copied on the message into the **CC**... field by clicking the **CC**... button and repeating either of the bulleted instructions in step 2 above.

4. Type a subject into the **Subject** field and a message into the **Note** field, as shown below. **Note**, clicking the **Save Draft** button frequently will prevent losing a message mid-composition should the application time out during the drafting process.
5. If desired, add an attachment from the computer by first clicking the green plus sign icon, then clicking the Browse button in the Attach File pop-up window, locate the file from the computer’s local folders, and click Open, as shown below.
Finally, click the **Attach** button after confirming the filename above it represents the desired document.

If a user selects the wrong file or changes their mind, s/he may click the **Cancel** button or the X in the upper right of the **Attach File** window to cancel the attachment process.

6. Once all desired message fields are complete, click the **Send** button to send the message (a copy will be stored in the **Sent** folder), the **Save Draft** button to save it
for sending later (a copy will be stored in the Drafts folder), or the Cancel button to
discard the message (a copy will be stored in the Deleted folder). Note that once a
message has been sent, it cannot be recalled.

Attaching Patient Information to a Message

Should a user wish to attach patient information from the Clinical Portal to a message, s/he
should initiate the message from the View Summary page (once a patient records has been
opened) or from a patient list within Clinician Tools.

Initiating a message with a patient report attached from one of these two areas will also allow
a user to filter the report’s contents, select report type and format preferences or default to a
recipient’s preferences based on their Clinical Portal preference configurations, and preview a
copy of the report before sending.

To attach a patient report to a new message from the View Summary page:

1. Select a report format from the View As drop-down menu and a report type from the
   Report drop-down menu at the top of the screen, then click Send.

2. A pop-up window will appear to confirm the user is about to send the patient report;
click the Ok button to continue.

3. A new message window will appear. Complete the basic message fields (Send To..., CC..., Subject and Note) and any desired attachments from the local computer by
   following steps 2-5 in the Composing Messages section above.

4. If desired, filter the report’s contents by:
   • A unique encounter: click the Encounter drop-down menu and select the desired
     encounter based on the listed date, facility code, encounter type, and description,
     as shown below. Note, only one encounter may be selected using this option.
Other parameters, including period of time, data source, and inclusion/exclusion of specific data elements within the clinical categories listed (dependent on the report type): click the Filter... button, select the criteria as desired to fully customize the report to a recipient’s “need-to-know,” and click Apply Filters, as shown in the examples below. Use the Clear All or Select All checkboxes as needed to populate or de-populate all fields in a section.
5. If desired, select report type and format preferences or default to a recipient's preferences based on their Clinical Portal preference configurations. To do this, click the **Summary Options** blue hyperlink and select the desired options, as shown below.
6. If desired, preview the report about to be sent by clicking the Preview... button. A pop-up window will appear with the report as customized by the user in steps 4-5 above.

7. Once all desired message fields and patient information filtering are complete, click the Send button to send the message (a copy will be stored in the Sent folder), the Save Draft button to save it for sending later (a copy will be stored in the Drafts folder), or the Cancel button to discard the message (a copy will be stored in the Deleted folder). Note that once a message has been sent, it cannot be recalled.

Replying To and Forwarding Messages

Once a message within any folder is open in the message viewing pane at the middle/bottom of the screen, a user may use the quick action icons at the top right of the pane to reply to a sender, reply to all (if others were copied on the original message), or forward a message to another party. Hovering over each icon will display the associated action (Reply, Reply All, or Forward).
• To reply to the sender of a message, click the **Reply** quick action icon. A new message pop-up window will appear, addressed to the sender, with the original message and sent details in the body of the message, as shown below. Fill in the **Note** field and click **Send**.

![Reply to Sender](image1)

• To reply to the sender and all other parties copied on the original message, click the **Reply All** quick action icon. A new message pop-up window will appear with all parties copied and the original message and sent details in the body of the message, as shown below. Fill in the **Note** field and click **Send**.

![Reply All](image2)

**Note**: Users may receive messages from DSM accounts outside of the NC HealthConnex Provider Directory, but may not reply to those messages. This functionality will be available in a future system release.
• To forward a message to another party, click the Forward quick action icon. A new message pop-up window will appear with the original message and sent details in the body of the message, as shown below. Fill in the Send To..., CC.. (if applicable) and Note fields, and click Send.

![Forward message pop-up window](image)

**Working with Draft Messages**

Draft messages are messages that have been composed, but not yet sent. Drafts may be viewed, edited or sent from the Drafts folder tab in the left menu bar.

To edit and/or send a draft message:

1. Open the composed draft from the message list in the Drafts folder by double-clicking anywhere in the message details row. This will open the draft message, as shown below.

![Draft message editor](image)
2. Edit any of the basic message fields (Send To…, CC…, Subject and Note) and any desired attachments from the local computer by following steps 2-5 in the Composing Messages section of this User Guide, above. If a patient report is attached, filter, edit summary options, or preview, as desired, by following steps 4-6 in the Attaching Patient Information to a Message section of this User Guide, above.

3. Once all desired message fields and patient information filtering are complete, click the Send button to send the message (a copy will be stored in the Sent folder), the Save Draft button to save it for sending later (a copy will be stored in the Drafts folder), or the Cancel button to discard the message (a copy will be stored in the Deleted folder). Note that once a message has been sent, it cannot be recalled.

   Tip: clicking the Save Draft button frequently will prevent losing a message mid-composition should the application time out during the drafting process.
**TECHNICAL REQUIREMENTS**

The NC HealthConnex Clinical Portal is supported on various web browsers and mobile devices, as indicated below.

### Browsers

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<th>Chrome</th>
<th>Firefox</th>
<th>Internet Explorer</th>
<th>Microsoft Edge</th>
<th>Opera</th>
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### Mobile Devices* 

<table>
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<tr>
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<th>Firefox</th>
<th>Microsoft Edge</th>
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</tbody>
</table>

*Note: The Clinical Portal is generally supported on the latest version of each major platform’s default browser. To ensure the latest version is installed, check the Help>About Menu on your browser for information on whether the browser is up to date, or see options to download the latest version. If unsure, contact your organization’s system administrator. Proxy browsers (e.g., Opera Mini, Opera Mobile’s Turbo mode, UC Browser Mini, Amazon Silk, etc.) are not supported.*
HELP DESK

SAS® HIE Technical Support Communication Processes

All Participants of the NC Health Information Exchange Authority (NC HIEA) should designate one or two Participant Account Administrators (PAAs) for their organization who will have authority to utilize the SAS® HIE Technical Support Team and Help Desk.

PAAs should communicate their name and contact information to the SAS® HIE Technical Support Team at HIEsupport@sas.com, as well as future changes in administration so that contact information is kept up to date.

All end users from an organization should communicate any questions about usage of the Clinical Portal to their organization's PAA(s). The PAA(s) should first try to answer the questions for their end users. If the PAA(s) is unable to answer the question or has discovered an issue with the application, they should then direct questions, themselves, to the SAS® HIE Technical Support Team on behalf of their end users using one of four contact options as detailed in the Participant Account Administrator Reference Guide, available in the Training & Tools section of the NC HIEA website.
USER GUIDE CONTENT DISCLAIMER

The screenshots and presentations herein are intended as examples only and may differ from the actual screenshots and presentations generated by the released product in commercial production.
PARTNERS

About SAS Institute

The NC HiEA’s technical partner for delivering NC HealthConnex is SAS Institute.

Through innovative analytics, business intelligence and data management software and services, SAS helps customers at more than 80,000 sites make better decisions faster. Its world headquarters are based in Cary, North Carolina. SAS also operates the NC HiEA Technical Support Help Desk. For more information, visit SAS.com.

About InterSystems and J2 Interactive

The NC HealthConnex HIE Platform is powered by the InterSystems HealthShare product, and J2 Interactive is InterSystems’ integration partner.

InterSystems is the engine behind many important applications in health care, finance, government, and other sectors where lives and livelihoods are at stake. Founded in 1978, InterSystems is a privately held company headquartered in Cambridge, Massachusetts (USA), with offices worldwide, and its software products are used daily by millions of people in more than 80 countries. For more information, visit InterSystems.com.

J2 Interactive is an award-winning software development and IT consulting firm specializing in customized solutions for hospitals, labs, research institutions, and health information exchanges. For more information, visit J2Interactive.com.

About SES

NC HealthConnex Direct Secure Messaging is powered by Secure Exchange Solutions (SES).

SES sets the standard for seamless, scalable, secure connectivity across organizational boundaries. As an industry-leading health information technology provider, SES protects, streamlines and delivers sensitive and critical health care information while ensuring compliance and improving efficiency and quality. Hospitals, health systems, physicians, health plans and channel partners rely on SES for integrated secure communications that expand their reach and empower them to improve patient care. SES is a committed member of DirectTrust, helping healthcare stakeholders leverage standards-based communications to communicate across organizational boundaries. For more information, visit SecureExSolutions.com.

About DirectTrust

NC HealthConnex, in connection with SES, is part of the DirectTrust nationwide network.

DirectTrust is a collaborative non-profit association of 121 health IT and health care provider organizations to support secure, interoperable health information exchange via the Direct message protocols. DirectTrust has created a “trust framework” that makes it easy for health care professionals, health IT vendors and their patients/customers to communicate securely, with identity proofing and regardless of end-user application. Over 300 EHR and personal health record (PHR) vendors’ products, and over 50 HIEs, participate in the DirectTrust network, ensuring interoperability and security via Direct for exchange of health information.
to more than half the professionals in the U.S. health care system. For more information, visit DirectTrust.org.

About The North Carolina Department of Health and Human Services (NCDHHS)

The NC HIEA works closely with NCDHHS to support Medicaid and public health efficiencies.

The North Carolina Department of Health and Human Services (NCDHHS) manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens - children, elderly, disabled and low-income families. The Department works closely with health care professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders to make this happen. The Department is divided into 30 divisions and offices. NCDHHS divisions and offices fall under four broad service areas - health, human services, administrative, and support functions. NCDHHS also oversees 14 facilities: developmental centers, neuro-medical treatment centers, psychiatric hospitals, alcohol and drug abuse treatment centers, and two residential programs for children. For more information, visit NCDHHS.gov.