



MyCareCorner

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bear no responsibility for attestation information submitted by the client.

Chapter 2 Overview

The MyCareCorner is an add-on application that allows patients to view their patient record online at MyCareCorner.net.

Chapter 3 Registering for MyCareCorner

MyCareCorner provides patients with access to their electronic health record. There are several options for registering for MyCareCorner: Email Registration, Printed Instructions and Self registration.

3.1 Email Registration

A patient may receive an email inviting them to register for MyCareCorner. For patients to receive the email, their email address will need to be populated on the profile. MyCareCorner links will only be sent if there is an account and the status is not "sent" or "pending".

The email sent to the patient will include a hyperlink to access MyCareCorner, as well as instructions on how to access the account. The email invite will expire 30 days after being sent to the patient. A new email invite will need to be resent if the patient does not access prior to the invite expiring. An email may be added to the patient's account by accessing the [Portal Management](#)⁸ screen or the following locations:

- Select **Hospital Base Menu > Profile Listing** > Select Patient > Enter the patient's email within the **Email** field.
- Select **Hospital Base Menu > Profile Listing** > Select Patient > Create New Visit > Ok > Enter the patient's email within the **Email** field.

If a patient has registered on MyCareCorner, upon discharge of any subsequent visits, a reminder email will be sent stating, ***There have been updates to your Patient Portal account.*** The update email will satisfy the MU Timely Access stat.

Resource

This document is an instruction sheet for patients on how to register for a MyCareCorner account.

- [Registering in MyCareCorner](#).

3.2 Printed Registration

A patient may also register by receiving the invitation for MyCareCorner in a PDF format that may be printed. To print the invitation, go to the Portal Management screen from the patient's account and select **Print**. The patient will then register following the section on *Using the Printed Invitation* within the [Registering in MyCareCorner](#) document.

NOTE: For more information on the Portal Management screen, see [Portal Management within Thrive](#).⁸

Chapter 4 MyCareCorner

MyCareCorner provides all the tools a patient needs to manage their health independently or in collaboration with their healthcare professional. Unlike static portals, MyCareCorner brings health data to life and promotes a collaborative approach to care. The following document can be customized for the facility and distributed as patient education material:

1. Select the link: [Patient Guide to Using MyCareCorner](#)
2. Download the PDF document to the PC.
3. Open the document in Adobe Acrobat.
4. Insert the facility logo.
5. Save and use to distribute to patients.

4.1 Adding Family Members to a Registered Account

Additional family members (spouse, children, and/or parents) may be added to a registered MyCareCorner account once a healthcare provider (hospital or clinic) provides the family member with an email or a printed copy of the registration invitation for MyCareCorner. The following document can be customized for the facility and used to be distributed as patient education materials:

1. Select the link: [Adding a Family Member to a Registered Account](#)
2. Download the PDF document to the PC.
3. Open the document in Adobe Acrobat.
4. Insert the facility logo.
5. Save and use to distribute to patients.

4.2 Sharing a Patient Record with Another MCC User

The **Share Record** option in MyCareCorner allows a patient to share their health record with other people, such as a spouse, parent, or children. Sharing their record allows person whom they shared it with to view and update their health information, depending on the level of access the patient gave them. Access can be changed or removed at any time. The following document can be customized for the facility and used to be distributed as patient education material:

1. Select the link: [Sharing My Record in MyCareCorner](#)
2. Download the PDF document to the PC.

3. Open the document in Adobe Acrobat.
4. Insert the facility logo.
5. Save and use to distribute to patients.

Chapter 5 CSA Tool

The CSA Tool is the facility administrator tool to manage patient accounts within MyCareCorner for patients at the facility. This tool gives facilities the ability to locate and manage patient accounts in MyCareCorner.

5.1 Age of Majority Workflow

The Age of Majority is the automatic removal process of a minor's patient recording from the parent account in MyCareCorner once the patient reaches the "age of account decoupling" within the CSA tool. This age is defined by the facility. Accounts that are eligible for the automatic decouple are accounts that have been linked through the registration process by accepting an invite for a minor or using the Create New Record within a parent or guardian's existing account. See [Adding Additional Family Members to Your MCC Account](#) for more information on linking. The decoupling process will happen in the following steps:

Step 1: 15 days prior the parent (or guardian) will receive a notification about the upcoming disconnect. They will receive the following email:

On <date>, the portal link between [PROFILE NAME] and [EMAIL ADDRESS] will be automatically deactivated. This is to comply with the HIPAA Privacy Rule and state law, which allows individuals of this age to consent to their own health care treatment. This change will not affect access for any previous health care visits, and will only affect visits from <date> forward.

Step 2: On the day of the disconnect the parent (or guardian) will receive the following email:

Our records indicate that you currently have access to healthcare records for the above-named child. According to state law, that individual has reached an age where he/she is now able to provide his/her own consent for one or more types of healthcare treatment. Under federal and state law, because the individual is now able to provide his/her own consent, that individual's medical information becomes private and confidential, and can no longer be shared without his/her written authorization.

Access to all of the child's previously entered healthcare information will still be available to you, but all future healthcare information will be restricted to the patient only.

[Child'sFirstName LastInitial] may continue to benefit from using the portal, with full access to his/her medical history by obtaining a personal invitation code from the practice and establishing his/her own personal login.

The decoupling process runs daily at 9 pm (PT) and will decouple any patients who will reach the age of majority on the following day. When the guardian receives the above emails there is nothing to stop the process and the patient must wait until the decoupling occurs to re-register.

Step 3: Within TruBridge EHR, when the decoupling event occurs the patient's email address will be removed from their profile and their registration status on the Portal Management screen will display as Decoupled. A new registration invite will not automatically be sent to the patient that was decoupled due to the email being removed. Once an email is entered on the account or a new visit is created with an email address a new invite will be sent.

NOTE: There are 2 options to review patient decoupling status in more detail. The first is on the individual patient by reviewing their [Portal History Status](#)^[8] from the Portal Management screen. The second option is running the [Age of Majority Decouple Log](#)^[24] from the report dashboard.

Step 4: Once the new invitation is sent to the decoupled patient, they may register a new account within MyCareCorner. After the patient's account is created, they have the option to grant access to the parent via sharing their record. See [Sharing Your Record in MyCareCorner](#) for more information.

Chapter 6 Portal Management within Thrive

The Portal Management screen is available to assist the facility in monitoring the registration process for the patient within MyCareCorner. This screen may be accessed via the following paths:

- From Charts: Select **Patient Chart > Health Information Resource > Portal Management**
- From System Menu: Select **System Menu > Patient Account > Census > Misc Options > Portal Reset**
- From MP-EHR: Select **Patient Charting > Patient Portal**

Name	Date of Birth	Invitation Status	Registration Sta...	Patient UUID	Invite Expiration	Decouple Date/Time
Mulder Fox William	11/30/1964	Not Sent	Not Registered			

Portal Management

The patient's email address for the selected visit will display within the **Email** field. This field may be edited as needed. If any changes are made to the Email field, **Update Email Address** should be selected to save the modifications to the patient's email within the visit.

The Portal Management screen may be filtered by the following options:

- **Name**: Displays the profile name of the selected patient or profile name.
- **Date of Birth**: Displays the patient's date of birth.
- **Invitation Status**: Displays the following status for the invitation that was sent to the patient:
 - **Not Sent**: Email Invitation has not been sent to the patient.
 - **Pending**: Email Invitation has been sent, but the patient is not registered within MyCareCorner.
 - **Complete**: Email Invitation has been sent and the patient is registered within MyCareCorner.
- **Registration Status**: Displays the following status of the patient's registration within MyCareCorner.
 - **Not Registered**: Displays when the patient does not have an active account within MyCareCorner.
 - **Registered**: Displays when the patient has an active account within MyCareCorner.
 - **Decoupled**: Displays when the account has been decoupled via the Age of Majority Decouple or the patient deleted their MyCareCorner account. When this displays, the patient needs to register a new account for MyCareCorner. In an Age Of Majority event, the email address is removed from the profile. Once an email is entered on the account or on a new visit, a new invite should be sent. When a manual deletion of a MyCareCorner account event has occurred, a new invitation will automatically be sent to the email listed on the account. The user will then be able to re-register for MyCareCorner.

- **Patient UUID:** Displays the ID that links the patient's information between Thrive and MyCareCorner.
- **Invite Expiration:** Displays the expiration date of the generated invitation. MyCareCorner registration invitations will expire 30 days after original generation.
- **Decouple Date/Time:** Displays the date and time the account was decoupled.

Each patient record will display on its own line and are selectable to enable the following options on the action bar:

- **Back Arrow:** When selected, the Health Information Resource screen will display.
- **Send/Resend:** Allows the MyCareCorner invitation to be sent or resent to the patient's email address. This option is enabled when a valid email address is available on the selected visit or profile.
 - If the Invitation Status is Not Sent this option will display as Send. When Send is selected an invitation for MyCareCorner Registration will be sent to the email on the visit or profile.
 - If the Invitation Status is Pending this option will display as Resend. When Resend is selected the invitation for MyCareCorner Registration will be resent to the email on the visit or profile.
- **Print:** Displays the invitation for MyCareCorner Registration in a PDF format that may be printed for the patient.
- **Portal Registration:** This option is enabled when the patient does not have a registered account for MyCareCorner. If selected, MyCareCorner.net will display with the embedded invitation code allowing the user to register the patient at bedside.
- **Portal Login:** Allows MyCareCorner.net to display, and the patient may log into their registered MyCareCorner account.
- **Launch CSA:** Allows the CSA Tool to display. This option is enabled when the patient has a registered account for MyCareCorner. The CSA tool is the facility's administrative tool for MyCareCorner. Please see the [CSA Tool](#) for more information.
- **Update Email Address:** Allows any modifications made to the patient's email address to be saved. This option is enabled when the user makes any modifications to the **Email** field within the visit. Once selected, the email address will update on the visit and/or profile. An invitation will be automatically sent to the patient's email address if the invite is not in "sent/pending" status.
- **Portal Status History:** Displays the Portal Status History screen that houses an audit log of the patient's decouple history and status of invitations sent. When selected the screen will display a grid with the following columns:
 - **Date/Time:** Displays the date/time from the Audit Log when the event occurred.
 - **Action:** Displays the following actions performed with MyCareCorner:
 - **Age of Majority Decoupled:** Displays when a decouple event occurs via the automatic age of majority decouple as set up in the CSA tool for the facility.

- **User Decoupled:** Displays when a decouple event occurs when the patient deletes their MyCareCorner account from MyCareCorner.
- **Admin Decouple:** Displays when a decouple event occurs by the administrator manually decoupling the user via the CSA tool.
- **Invitation Generated:** Displays each time an invitation is generated and sent to a patient.
- **Registered:** Displays when the patients registration is complete within MyCareCorner.

Chapter 7 Information Submissions


Information Submissions is an add-on application and is only available if the user is logged into TruBridge. If purchased, patients or authorized representatives will have the ability to upload documents from within MyCareCorner. Once a document has been uploaded, it may then be linked to an account from within TruBridge EHR.

7.1 Accessing Information Submissions

There are several launch points within Thrive that will allow access to Information Submissions.

From the Person Profile: Select Hospital Base Menu > Profile Listing > Patient Name > Information Submissions

From the Communication Application: Select Charts > Patient Account > Communication > Information Submissions

The paths above will then display the [Document Queue](#)  screen.

7.2 Document Queue

The Document Queue screen is used to import documents that were sent from the patient's or authorized representative's MyCareCorner account.

The following options are available within the action bar:

- **Back Arrow:** Allows the user to return to the previous screen.
- **View:** Displays the uploaded document. This option is enabled when a document is selected.
- **View Document Queue - All:** Displays all documents associated with the person profile. When this option is selected the option **View Document Queue - Match** will display.
- **View Document Queue - Match:** Displays all uploaded documents that have not been imported to a visit on the person profile. When this option is selected the option **View Document Queue - All** will display.
- **Archive:** Stores uploaded documents that will not be imported. This option is enabled when a document is selected and it has not been imported.
- **Import:** Allows the selected document to be imported and linked to an account. This option is enabled when a document is selected and it has not been imported.
- **Restore:** Allows archived documents to be restored and imported to an account. This option is enabled when an archived document is selected.
- **View History:** Displays a log of all user who have viewed the selected document. This option is enabled when a document is selected.

Select Hospital Base Menu > Profile Listing > Patient Name > Information Submissions

Document Queue

PATIENT DETAIL:

First Name: OLIVER
 Middle Name: R
 Last Name: ROTH
 Suffix:
 Previous Name:
 Date of Birth: 06/28/1985
 Sex: M
 Address 1: 604 OAK RIDGE CT W
 Address 2:
 City: DAPHNE
 State: AL
 Zip Code: 36526
 Home: 1234567
 Business:
 Mobile:

DOCUMENT LIST

Sent Date	Time	Image Title	Visit
01/06/2017	11:38	Patient Information Submission	

Information Submission - Document Queue

Documents available to import will display with the sent date and time that the patient or authorized representative sent the document via MyCareCorner along with the Image Title: Patient Information Submission. The Visit will display as blank until it is imported.

To import a document:

1. Select the **Patient Information Submission** document from the queue that will be imported to the patient's account.
2. Select **Import**.

Select Information Submissions > Patient Information Submission Document > Import

CHARTS » ROTH OLIVER R (DISCHGD) » COMMUNICATION

ROTH OLIVER R MR#: 971286 ACCOUNT#: E0000554 DOB: 06/28/1985 Sex: M Current Weight: 0 lbs 0.00 kg 0.00 g
 AGE: 31 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g
 RM: N/A Diagnosis: Allergies: No Known Drug Allergies

Import Cancel View

Document Import

Edit Document Title: [Select an image title](#)
 Select Visit for Import: [E0000554 ROTH OLIVER R](#)
 Service Dates: 01/05/2017 - 01/05/2017
 Stay Type: E.R.
 Sub Type:
 Service Code: EMERGENCY ROOM

ROTH OLIVER R (00004567)

Information Submissions - Import Document

The Document Queue screen will display the Document Title, Visit Number, Service Date (Admit date - Discharge Date), Stay Type, Sub Type and Service Code. The Document Title and Visit number may be edited. If Information Submissions is accessed from the Person Profile, the visit number will need to be addressed. If Information Submissions is accessed from the Communication application, the current visit the user has selected will auto-populate within the Select Visit for Import field.

The Document Title and Visit must be selected prior to importing the document.

3. Select the **Magnifying Glass** icon to choose the image title.

Select **Information Submissions > Patient Information Submission Document > Import > Select an Image Title**

CHARTS » ROTH OLIVER R (DISCHGD) » COMMUNICATION

ROTH OLIVER R MR#: 971286 ACCOUNT#: E0000554 DOB: 06/28/1985 Sex: M Current Weight: 0 lbs 0.00 kg 0.00 g
 AGE: 31 CrCl: N/A Height: 0.00 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0 lbs 0.00 kg 0.00 g
 RM: N/A Diagnosis: Allergies: No Known Drug Allergies

Charts

ROTH OLIVER R (DISCHGD)

- Alerts
- Lab Results
- Problem List
- Vitals
- Allergies
- Medication Reconciliation
- Prescription Entry
- Patient Immunization History
- Patient Education Document...
- PACS Images
- Order Chronology
- Transcriptions
- Clinical History
- Reports and Attachments
- Order Entry
- MAR
- Documentation
- Health History
- Health Information Resource
- Temporary Registration
- Plan of Care
- Communication**
- Charges
- Location Maintenance
- Demographics
- Visit History
- Patient Summary

Image Titles

Search:

Title	Ac...	Health Information
ABN	Y	
Advanced Directives	Y	
ARTERIAL BLOOD GASES	Y	
CBC	Y	
Chartlink Photo	Y	
COMPLETE METABOLIC PROFILE	N	
Documentation Photos	Y	
DRIVERS LICENSE	Y	
EKG	Y	
ESIGN CONSULTATION	Y	
FACESHEET	Y	
History & Physical	Y	
INITIAL PHYSICAL ASSESSMENT	Y	
INSURANCE CARD	Y	
LABORATORY	Y	
LIVING WILL	Y	
MP-EMR Patient Image	Y	
NEW ESIGN	Y	
New Test Image	N	
ORDER RESULTS	Y	
ORGAN DONOR	Y	
PAST MEDICAL HISTORY	Y	
PATIENT PHONE CONVERSATION	Y	
PATIENT PROGRESS NOTES	Y	
Physician Order	Y	
Physician's Order	Y	
PRE-ADMIT TESTING	Y	
SIGNED TERMS AGREEMENT	Y	
UPLOAD IMAGE	N	
UPLOADED IMAGE	N	
URINALYSIS	Y	
WOUND	Y	
WOUND PHOTOS	Y	

ROTH OLIVER R (00004567)

Information Submissions - Image Titles

4. Once an Image title has been selected, select the **Magnifying Glass** next to the visit number if Information Submissions was accessed from the Person Profile.

Select **Information Submissions > Patient Information Submission Document > Import > Select Visit for Import: Magnifying Glass**

SYSTEM MENU » SYSTEM MENU

ROTH OLIVER R AGE: 31 DOB: 06/28/1985 Sex: M Profile: 00004567

Visit List

Visit Number	Admit Date	Discharge D...	Stay Type	Sub Type	Service Code
E0000554	01/05/2017	01/05/2017	E.R.		38
E0000504	12/02/2016	12/02/2016	E.R.		EMERGENCY ROOM

Visit List


5. Select the visit. All visits will display for the selected Person Profile, even if the visit has not been discharged from within Thrive. Once the visit has been chosen, select **OK**.

6. Select **Import**.

When a document has been imported it will Display with the Image Title that was selected and the visit number it was associated with in the Document Queue. It will also place a copy of the document within Electronic File Management with the document origin of Pt Info Sub.

Select **Information Submissions > Patient Information Submission Document > Import**

SYSTEM MENU > SYSTEM MENU



ROTH OLIVER R AGE: 31 DOB: 06/28/1985 Sex: M Profile: 00004567

View

View Document Queue - Match

Archive

Import

Restore

View History

Document Queue

PATIENT DETAIL

First Name: OLIVER

Middle Name: R

Last Name: ROTH

Suffix:

Previous Name:

Date of Birth: 06/28/1985

Sex: M

Address 1: 604 OAK RIDGE CT W

Address 2:

City: DAPHNE

State: AL

Zip Code: 36526

Home: 1234567

Business:

Mobile:

DOCUMENT LIST

Sent Date: 01/06/2017 Time: 11:38

Image Title: Information Submission

Visit: E0000554

Document Queue

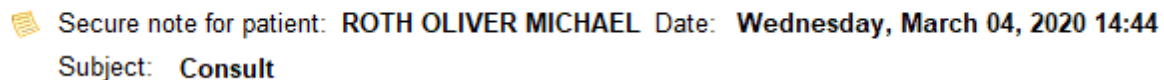
Chapter 8 Homescreen Notifications

Secure messages and attachments are able to be viewed from the Homescreen. The task type **SecurePatientMessage2** may be added to a specific folder so the user only sees notifications when a secure message is received from the patient portal to the provider. This notification is automatically set up within the personal inbox.

The following information will display within the Homescreen Alert:

- **Secure note for patient:** Displays the patient's name.
- **Date:** Displays the date and time the message was sent.
- **Subject:** Displays the text entered as the subject of the secure message.

Select Home



Secure note for patient: **ROTH OLIVER MICHAEL** Date: **Wednesday, March 04, 2020 14:44**
Subject: **Consult**

Homescreen Secure Message

When a notification displays on the homescreen, select the secure note. The Secure Note screen will display with the following options:

- **Back Arrow:** When selected, the Homescreen will display.
- **Reply:** Allows the replied message to be sent to the patient in MyCareCorner. This option becomes enabled when text has been entered within the Message field. Once this option has been selected, this will also acknowledge the message and remove the new message notification from the Homescreen and the Message Inbox in the Communication Application.
- **View Attachment:** When a message has been selected from the Homescreen and it has an attachment available, the View Attachment option becomes enabled. Once selected, the attachment will display within in a PDF document. The attachment will also display within the Document Queue and will be viewable until the document is attached to a visit following the current document queue process. Please see [Document Queue](#)¹¹ for additional Information.
- **Acknowledge:** When a message has been selected from the Homescreen, the Acknowledge option will become enabled. Once selected, the selected message will no longer display on the user's homescreen and the message subject and date/time will no longer display in bold within the Message Inbox in the Communication Application.
- **Open Chart:** Allows the patient's chart, from the visit number selected within the Visit drop down, to display. This option becomes enabled when a visit is selected within the Visit drop down.

The Secure Message screen will display the following information:

- **Visit:** The drop down will display all visits associated with the patient's profile and defaults to the most recent visit. If the message was sent from a previous visit, then the visit number originally associated with the message will display.
- **To:** This field displays the patient name that the message is being sent to.
 - **Patient check box:** Displays the name of the patient the message is being sent to. This check box defaults as checked.
 - **Authorized Rep check box:** Displays when the patient's account has an Authorized Rep on their account. This will display the Profile name of the Authorized Rep. If the check box is selected, the Authorized Rep's name will display in the To field.
 - **Clinically Relevant:** The check box will default as selected and should be unchecked if the message is not clinically relevant. This check box counts toward Promoting Interoperability (Stage 3) for sending clinically relevant messages from the provider to the patient.
- **Subject:** This displays the original subject that the user is replying to. This is a free text field and the subject may be modified if applicable.
- **Message:** This is a free text field for the user to enter the reply message to the patient.
- **Replying To:** Displays the previous message that the user is replying to.
 - **From:** Displays the name of who sent the message.
 - **Sent:** Displays the date and time the message was sent.
 - **To:** Displays the name of the user that the message was sent to.
 - **Subject:** Displays the subject of the message.
 - **Message:** Displays the content of the message.

Select Home > Secure Message Notification

HOME
Home

Home X

Reply View Attachment Acknowledge Open Chart

Visit: 360987

To:
☒ OLIVER ROTH (Patient) ☒ Clinically Relevant

Subject:
Referral Request

Message:

Replying To:
From: Oliver Roth
Sent: 08/20/2020 13:47
To: Mary Ruckart
Subject: Referral Request

Just following up to see if an appointment has been scheduled.

From: Mary Ruckart
Sent: 08/10/2020 14:28
To: Oliver Roth
Subject: Referral Request

Good Afternoon Oliver,

We are still waiting back for your appointment approval from the Cardiologist group. I will update you as soon as we receive the date and time.

Homescreen Secure Message

Chapter 9 Exclusions

9.1 Overview

Effective April 5, 2021, the [Information Blocking](#) rule prohibits any action or practice that interferes with the access, exchange, or use of an individual's electronic health information (EHI). There are [eight exceptions](#) when interference with the access, exchange or use of an individual's EHI would not be considered Information Blocking. To avoid non-compliance, and potential non-compliance penalties, Healthcare providers should ensure that suppression of any patient EHI meets one of the documented exceptions. Questions concerning the Information Blocking rule, and the eight exceptions, may be answered on the ONC's [FAQ](#) web page.

The Patient Summary or Referral/Transition of Care documents may be excluded from the Patient Portal for the patient and/or Authorized Representative. This may be done from the Consent/Privacy Settings screen by selecting either **Patient** or **Authorized Representative** under the statement, *"The following selections will exclude data from selected user on Portal and Patient-facing API's"*. The following paths will allow access to the Consent/Privacy Settings screen:

- Select Hospital Base Menu > Patient Account > Census > Stay Tab > Consent/Privacy Settings
- Select Hospital Base Menu > Patient Account > Medical Records > Print Electronic Record > Account Number > Consent/Privacy Settings
- Select Patient Chart > Reports and Attachments Icon > Medical Record Option > Consent/Privacy Settings
- Select Patient Chart > Demographics > Consent/Privacy

← Update + Care Team Event Notification

Patient Consent/Privacy Settings

Consent/Privacy Notice: ☒ Date: 6/11/2014 X

Med History Consent:

The following selections will exclude data from selected user on Portal and Patient-facing APIs:

Patient: ☐

HIE Shared Data: Date:

Patient Event Notification: Date:

Data Sensitivity Level: Date:

Protect Immunization Data: Date:

Participate in CAHPS survey: ☐

Chronic Care Management Program: ☐ Participating ☐ Participation Declined ☒ Not Addressed Date:

Citizenship:

Patient Consent/Privacy Settings

For additional information on the Patient Consent/Privacy Settings screen please see the [Registration User Guide](#).

When Patient or Authorized Representative is selected, the visit will not display in the MyCareCorner.

9.2 **Converted Rules**

The Patient Portal Exclusions table is now named the Converted Rules table. This table is display only and will list any exclusions that were previously created prior to the creation of the Exclusion Table.

***NOTE:** This table is for reference only. All exclusions will now look to the Exclusion Table.*

Select Hospital Base Menu > Master Selection > Business Office Tables > Table Maintenance > HIM > Converted Rules

EditAddRemoveDefault CheckedDefault UncheckedDelete

Converted API and Patient Portal Exclusions

Total: 1

Loaded Facility-Specific Preferences for 0001 EVIDENT COMMUNITY HOSPITAL

Reference Lab Patients

Default value is ☒

Filter Method:

☐ Show records that match ANY of the selected criteria

☒ Show records that match ALL of the selected criteria

Converted API and Patient Portal Exclusions

9.3 Exclusions Table

Exclusions may be set up to automatically exclude visits, images, transcriptions, problems, care team members, procedures and lab results from the patient, authorized representation and/or CCDA. Each exclusion type may be broad or specific (i.e. only excluding patients within a particular age range). Exclusions may be applied to the patient (via Patient Portal), Authorized Representative (via Patient Portal), CCDA or any combination of the three. Options to release the exclusions via Medical Records, or to make the unavailable for release, are also available from the patient's chart. Please see the chapter Exclusion Table within [Table Maintenance - HIM](#) User Guide for more information on setting up exclusions.

NOTE: Portal exclusions could constitute information blocking.

9.4 Chart Level Exclusion

Exclusions set up and applied to a patient's account may be viewed at the chart level in the Patient Medical Summaries - Exclusions Edit screen. Exclusions may be also be manually setup and/or released from this screen.

NOTE: Portal exclusions could constitute information blocking.

Select a Type to display a listing of all item names for the type along with the date the item was added. If an item has been excluded, an 'X' will display in the CCDA, Portal/Api and/or Authorized Rep column to designate where it was excluded from.

- Select Thrive UX > Charts > Select Patient > Health Information Resource > Patient Medical Summaries > Edit Exclusions
- Select Hospital Base Menu > Patient Account > Medical Records > Print Electronic Record > Account Number > Patient Medical Summaries > Edit Exclusions

Type	Name	Date	CCDA	Portal/Api	Authorized Rep	Reason
Visit (1)	HIV	09/09/2019	X	X	X	
Care Team (2)	HCG URINE PREGNANCY T...	09/09/2019	X	X	X	

Patient Medical Summaries - Exclusions Edit

To edit an exclusion, select an item to open the Exclude From panel. This will display options for CCDA, Portal/Api and Authorized Rep. These options may be selected or deselected, as needed,

to exclude or release information pertaining to the selected item. An Exclusion Reason may also be added, but is not required. If any changes are made, select **Save** on the action bar.

Select Thrive UX > Charts > Select Patient > Health Information Resource > Patient Medical Summaries > Edit Exclusions > Select Type > Select Name

JOHNSON ELLEN E

MR#: 000411 ACCOUNT#: 358168 DOB: 02/09/2003 Sex: Female Current Weight: 0.00 kg 0.0 g

AGE: 16Y CrCl: N/A Height: 0 inches BMI: 0 kg/m2 BSA: 0.00 m2 Admit Weight: 0.00 kg 0.0 g

RM: N/A Diagnosis: Pregnant - urine test confirms Allergies: No Known Drug Allergies

Save Refresh Release All

Patient Medical Summaries - Exclusions Edit

Type

Visit (1)

Care Team (2)

Image (2)

Problem (1)

Procedure (0)

Result (2)

Medical Record Transcrip...

Ancillary Transcription (0)

Name	Date	CCDA	Portal/Api	Authorized Rep	Reason
HIV	09/09/2019		X	X	
HCG URINE PREGNANCY T...	09/09/2019		X	X	

EXCLUDE FROM

☐ CCDA ☒ Portal/Api ☒ Authorized Rep

Exclusion Reason

Patient Medical Summaries - Exclusions Edit

There is also an option to release all exclusions on a visit by selecting **Release All** on the action bar. The only exclusions that will not be released are the ones with 'Unavailable for Release' selected in the Exclusion Table.

NOTE: Exclusions set as 'Unavailable for Release' may only be released if the exclusion is deleted in the Exclusion Table.

Chapter 10 Reports

10.1 Age of Majority Decouple Log

The Age of Majority Decouple Log will log emails that were removed from Profiles when an age of majority event occurs.

How to Print

1. Select **Report Dashboard**

2. Select **Age of Majority Decouple Log**

3. Select printing parameters:

- **Facility:** Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)
- **Decoupled Date Range:** Enter the date range to be audited.
- **Include Cover Sheet:** Select this option to include a Cover Sheet with the report.
- **Safe Mode:** Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a ?. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.
- **Output Format:** Use the drop-down box to select one of the following report Format options:
 - PDF
 - CSV
 - HTML

4. Select **Run Report** to display the report in the selected output format.

Description and Usage

When a patient reaches the age of majority and their account decouples from MyCareCorner, the email is removed from their Patient Profile. The Age of Majority Decouple Log will allow users at the facility to see a list of the emails removed, as well as the patient name, profile number, and date/time the Age of Majority decouple occurred. The output of the report will display in the order of the decouple date/time with the first to the most recent.

Age of Majority Decouple Log

07/19/2023 13:51		EVIDENT COMMUNITY HOSPITAL Age Of Majority Decouple Log <small>Document was generated by the Thrive EHR Software</small>		1 <small>age_of_majority_log.template</small>
Profile Name	Profile Number	Profile Email	Decouple Date/Time	
SMITH SALLY	6136	psmaurin+sallysmith@gmail.com	03/23/2023 05:12:04	

Listed below is an explanation of each column:

- **Profile Name:** Displays the name of the profile that was decoupled with the Age of Majority event.
- **Profile Number:** Displays the profile number that was decoupled with the Age of Majority event.
- **Profile Email:** Displays the email that was removed with the Age of Majority event.
- **Decouple Date/time:** Displays the date/time the decouple event occurred. For example, the date and time when the email was removed.

10.2 Patient Portal Access Report

The Patient Portal Audit Log is used to track all activity within the Patient Portal.

How to Print

1. Select **Report Dashboard**.
2. Select **Patient Portal Access Report**.
3. Select printing parameters:
 - **Facility:** Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)
 - **User:** Enter the name of the patient or authorized representative being audited. Leave this field blank to run for all users.
 - **User Type:** Enter **P** to audit a patient or enter **AR** to audit an authorized representative. Leave this field blank to run for both patients and authorized representatives.
 - **Date Range:** Enter the date range to be audited.
 - **Patient:** Enter the patients name to be audited. Leave this field blank to run for all patients.
 - **Visit ID:** Enter the patients visit number to be audited. Leave this field blank to run for all visits.
 - **Admitting Physician:** Enter the admitting physicians last name to be audited. Leave this field blank to run for all admitting physicians.
 - **Action:** Enter the action to be audited, such as view, download or transmit etc. Leave this field blank to run for all actions.
 - **Data Accessed:** Enter in the data accessed to be audited. Leave this field blank to run for all data.
 - **Include Cover Sheet:** Select this option to include a Cover Sheet with the report.
 - **Safe Mode:** Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a ?. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.
 - **Output Format:** Use the drop-down box to select one of the following report Format options:
 - **HTML**
 - **PDF**

- XML
- CSV
- MAPLIST
- TXT

4. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Patient Portal Access Report is used to track all activity within the Patient Portal. It will show if the patient or authorized representative viewed, downloaded, or transmitted the patient summary.

NOTE: In order to access the Audit Logs, the users login or role will need access to the System Utility application.

Patient Portal Access Report

06/01/2017 13:35		Evident Community Hospital Patient Portal Access Report Document was generated by the Thrive EHR Software 05/01/2017 - 06/01/2017			1 patient_portal_audit_log.template
Portal Login: 3276 05/16/2017 09:24:39	P/AR: P Action: View	Patient: MERRITT ADAM DELANE Data Accessed: Christy Gomez	Patient Visit ID: 359111	Attending Physician: 3115	
Portal Login: 3276 05/16/2017 09:24:43	P/AR: P Action: Reply	Patient: MERRITT ADAM DELANE Data Accessed: Christy Gomez	Patient Visit ID: 359111	Attending Physician: 3115	
Portal Login: 3276 05/16/2017 09:25:38	P/AR: P Action: View	Patient: MERRITT ADAM DELANE Data Accessed: Christy Gomez	Patient Visit ID: 359111	Attending Physician: 3115	
Portal Login: 3764 05/18/2017 17:58:04	P/AR: P Action: View	Patient: SMALL MATT MCKAY Data Accessed: Clinical Information	Patient Visit ID: 20001284	Attending Physician: 999999	
Portal Login: 3764 05/19/2017 07:58:26	P/AR: P Action: View	Patient: SMALL MATT MCKAY Data Accessed: Clinical Information	Patient Visit ID: 20001284	Attending Physician: 999999	
Portal Login: 4281 05/22/2017 11:36:37	P/AR: P Action: View	Patient: DARENSBOURG MARY BOWSE Data Accessed: Clinical Information	Patient Visit ID: 359138	Attending Physician: 1904	

Listed below is an explanation of each column:

- **Portal Login:** The ID of the patient or authorized representative who accessed the visit in the patient portal.
- **P/AR:** P will display if a patient accessed the patient portal. AR will display if the authorized representative accessed the patient portal.
- **Patient:** The name on the visit that was accessed in the patient portal.
- **Patient Visit ID :** The visit number that was accessed in the patient portal.
- **Attending Physician:** The physician number of the admitting physician on the visit that was accessed in the patient portal.
- **Date:** The date the visit was accessed in the patient portal.
- **Time:** The time the visit was accessed in the patient portal.

- **Action:** The action that was taken on the visit in the patient portal. The different options for the column are: View, Download, Transmit, Secure Message, API or OBP (Online Bill Pay).
- **Data Accessed:** The data that was accessed in the patient portal.

10.3 Patient Portal Exclusion Report

The Patient Portal Exclusion Report will identify patient accounts that have been automatically or manually excluded from the Patient Portal.

How to Print

1. Select **Report Dashboard**

2. Select **Patient Portal Exclusion Report**

3. Select **Select**

4. Select the desired report sequence.

5. Select printing parameters:

- **Facility:** Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)
- **Discharge Date Range:** Enter in a discharge date range for when excluded visits were discharged.
- **Visit ID:** Enter a patient's account number to pull to the report. Leave this field blank to pull all visits.
- **Stay Type:** Enter a stay type to pull patient accounts for a particular stay type. Leave this field blank to pull all stay types.
- **Service Code:** Enter a service code to pull patient accounts for a particular service code. Leave this field blank to pull all stay types.
- **Admitting Physician:** Enter an admitting physician number to pull patient accounts for a particular physician. Leave this field blank to pull all admitting physicians.
- **Exclusion Method:** Enter an **A** to display patient accounts that were automatically excluded from the Patient Portal, or enter an **M** to display patient accounts that were manually excluded from the Patient Portal. Leave this field blank to pull all excluded patient accounts.
- **Include Cover Sheet:** Select this option to include a Cover Sheet with the report.
- **Safe Mode:** Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a ?. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.
- **Output Format:** Use the drop-down box to select one of the following report Format options:
 - PDF
 - XML
 - CSV
 - HTML
 - MAPLIST
 - TXT

6. Select **Run Report** to display the report in the selected output format

Description and Usage

The Patient Portal provides the patient the ability to access clinical information associated with a visit. Throughout the system, there are multiple ways to exclude the clinical information from the Patient Portal. These exclusions may be done either manually or automatically. This report will identify those accounts that have been excluded within a discharge date range and will also display how the account was excluded.

Patient Portal Exclusion Report

05/24/2016 15:48		Evident Community Hospital Patient Portal Exclusion Report 05/20/2016 - 05/20/2016				1 mr_patient_portal_exclusion_log.template		
Acct Number	Patient Name	Physician Number	Physician Name	Stay Type	Service Code	Disch Date	Disch Time	Exclusion Method (A/M)
20000562	REED GRACE ELLEN	10000	Baxter J	2	LA	05/20/2016	10:30	A

Listed below is an explanation of each column.

- **Acct Number:** Patient account number.
- **Patient Name:** Patient name
- **Physician Number:** Admitting physician number on the excluded patient account.
- **Physician Name:** Admitting physician name on the excluded patient account.
- **Stay Type:** Stay type of the excluded patient account.
- **Service Code:** Service code of the excluded patient account.
- **Disch Date:** The discharge date of the excluded patient account.
- **Disch Time:** The discharge time of the excluded patient account.
- **Exclusion Method (A/M):** This column will display an "A" if the patient account was automatically excluded from the patient portal or "M" if the patient account was excluded manually from the patient portal.

10.4 Visits with Exclusions by Physician

The Visits with Exclusions by Physician report will give a listing of visits that have exclusions on them.

How to Print

1. Select **Report Dashboard**

2. Select **Visits with Exclusions by Physician**

3. Select **Run**

4. Select printing parameters:

- **Facility:** Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)
- **Physician Number:** Select a physician to only display visits pertaining to the physician. This field may be left blank.
- **Sort:** The report may be sorted by Visit Number, Patient Name, Admit Date and Discharge Date. A secondary sort is also available to sort by Ascending or Descending order.

5. The action bar options are as follows:

- **Run Report:** Select this option to run the report once all parameters have been selected.
- **PDF:** Select this option to display the report in a PDF format.
- **Reset:** Select this option to reset the parameters for the report.
- **All Visits:** Select this option to display all visits with exclusions.

Description and Usage

The Visits with Exclusions by Physician report will give a listing of visits that have exclusions on them. This report may be filtered by Facility and Physician to narrow the listing. An 'All Visits' option is also available to get a listing of all visits with exclusions. Once the results display on the screen, a patient may be selected to be taken to the Patient Medical Summaries - Exclusions Edit screen. From here, any exclusions may be released or added to the CCDA, Patient/Api or Authorized Representative.

Visits with Exclusions by Physician

Run Report	PDF	Reset	All Visits
------------	-----	-------	------------

Visits with Exclusions by Physician		
EVIDENT COMMUNITY HOSPITAL	Physician Number:	All Visits With Exclusions
Sort: Patient Name	<input checked="" type="radio"/> Ascending <input type="radio"/> Descending	
BEECH DAVIS SANDERS (357932)	Admitted: 12/15/2016	Discharged: 12/15/2016
JOHNSON ELLEN E (358168)	Admitted: 09/09/2019	Discharged: 09/09/2019
JOHNSON ROBERT LEVER (357856)	Admitted:	Discharged:
REED GRACE ELLEN (358002)	Admitted: 12/19/2016	Discharged: 12/19/2016
SMITH ELLA KATHERINE (357814)	Admitted: 05/16/2014	Discharged: 10/28/2016

Total number of visits with exclusions	5
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Listed below is an explanation of each column.

- **Patient Name/Visit Number:** The patient name and visit number with an exclusion. Double-click on the patients name to be taken to the Patient Medical Summaries - Exclusions Edit screen.
- **Admitted:** The admit date of the patient.
- **Discharged:** The discharge date of the patient.