

June 2025 Release Notes

Version 3.51

Prepare Now: Configure document settings for future release of all documents to patient portal

Changes are coming to **Admin > Document Types** to help practices control which documents are shared with patients and caregivers through the patient portals.

NOTE: These settings will be available immediately for configuration, but the full functionality will not be activated until July 26, 2025.

Updates to Admin > Document Types

See key details on the Document Types table Feature

The table in **Admin > Document Types** now includes more information at a glance. There is no need to click “**Edit**” to view key details.

New columns include:

- Document Type
- Chart Display Location
- Result Definition
- Release to Patient Portal
- Display Mode
- Review Category
- Review Required
- Visible in Attaching
- Visible in Document Filters
- Modified By
- Modified Date

Manage Document Type Definitions

Document Type Name	Document Type	Owner Practice	Chart Display Location	Result Definition	Release to Patient Portal	Display Mode	Review Category	Review Required	Visible in Attaching	Visible in Document Filters	Modified By	Modified Date
aaa	CCDA	Onc Hem of MSH	Patient Results	1,1,1-Trichloroethane measurement (procedure)		Image Viewer Mode	Other Documents	Yes	Yes	Yes	zDpdash zzP	05/07/2025 21:39
Advance directives declaration		EMR Master	Demographics, Intake			Clinical Note Mode	Imaging	Yes	No	Yes	The Lynx Keeper	02/17/2017 17:20
Advance directives declaration migrated		EMR Master	Patient Documents			Clinical Note Mode	Other Documents	No	No	Yes	ETL Interface	11/07/2015 18:51
Advanced Directives		Onc Hem of MSH	Demographics, Intake			Image Viewer Mode	Other Documents	Yes	Yes	Yes	G2 MD103	06/20/2016 16:53
Alert management note-CV	Care Management Integration	EMR Master	Patient Documents		Automatically	Clinical Note Mode	Other Documents	Yes	Yes	Yes	Disha Physician	05/16/2025 19:23
Automatically With Review chart alert		Onc Hem of MSH	Patient Documents		Automatically			Yes	Yes	Yes	Disha Physician	05/12/2025 11:07
Automatically WO Review test		Onc Hem of MSH	Patient Documents		Automatically			No	Yes	Yes	Disha Physician	04/30/2025 15:12
Biomarker requisition	Biomarker Requisition	EMR Master	Patient Documents		Automatically	Image Viewer Mode		Yes	Yes	Yes	Disha Physician	05/16/2025 19:24
Bone density reports		Onc Hem of MSH	Patient Documents		Automatically	Image Viewer Mode	Imaging	No	Yes	Yes	onc hem	05/09/2025 12:10

Action Required: Configure document sharing settings by July 25, 2025

Practices must review and update their document type settings in **Admin > Document Types** by **July 25, 2025**.

Starting **July 26, 2025**, the system will begin using these settings to determine which documents are shared with patients and caregivers via the patient portals.

Step 1: Ensure documents appear in the Documents tab of the patient’s chart

To be eligible for portal sharing, a document must first appear in the **Documents tab** of the patient’s chart.

When adding or editing a document type, **set the Chart Display Location to Patient Documents** for any document type you want to be considered for portal release (callout 1).

Document Type Definition Detail * required

Document Type Name * aaa

Document Type CCDA

Owning Practice Onc Hem of MSH

Preferences

1 Chart Display Location Patient Documents

Release to Patient Portal Automatically

Display Mode Image Viewer Mode

Review Category Other Documents

Review Required

Capture Accept/Deny Status

Visible in attaching list

Visible in document filtering list

SAVE CANCEL

Step 2: Configure portal sharing behavior

Two key fields control how documents are shared from the patient's chart to the portal:

1. Release to Patient Portal (callout 1)
 - a. Automatically (default): Document is released immediately.
 - b. Hold Until Reviewed: Document is held until reviewed.
 - c. Never: Document is never released.
 - i. If "Never" is selected, a reason must be entered to remain compliant with the Cures Act.
2. Review Required (callout 2)
 - a. Unchecked by default.
 - b. Check this box to require a review before the document is released.

Document Type Definition Detail * required

Document Type Name * aaa

Document Type CCDA

Owning Practice Onc Hem of MSH

Preferences

Chart Display Location Patient Documents

1 Release to Patient Portal Automatically

Display Mode Image Viewer Mode

Review Category Other Documents

2 Review Required

Capture Accept/Deny Status

Visible in attaching list

Visible in document filtering list

SAVE CANCEL

How these settings work together

Document release from the Documents tab of the patient chart will be controlled by the “Release to Patient Portal” and “Review Required” settings, as well as the “Do not release results until review” chart alert:

Release to Patient Portal	Review Required	“Do not release until review” chart alert	Result
Automatically	Unchecked	Inactive	Released to portal
Automatically	Unchecked	Active	Not released to portal
Automatically	Checked	Inactive	Released to portal
Automatically	Checked	Active	Requires review before release
Hold Until Reviewed	Unchecked	Inactive	Not released to portal
Hold Until Reviewed	Unchecked	Active	Not released to

Release to Patient Portal	Review Required	“Do not release until review” chart alert	Result
			portal
Hold Until Reviewed	Checked	Inactive	Requires review before release
Hold Until Reviewed	Checked	Active	Requires review before release
Never	Any	Any	Not released to portal

Orders Queue Enhancements

We’re making several improvements to the Orders Queue to streamline performance, improve reliability, and reduce workflow disruptions.

Retirement of the Orders Queue Legacy

To optimize overall system performance, we’re removing the **Orders Queue Legacy**. This eliminates the need for background processes that maintained two queues, reducing system delays and potential disruptions.

NOTE: Users can continue to leverage the filter for the Orders Queue Legacy “Processed” status in Orders Queue > Filters > Queue Status.

Smarter order status handling

We’ve refined the rules that determine when an order’s status resets in the Orders Queue to help preserve accurate order status tracking and minimize unnecessary rework.

Going forward:

- Editing C1s from the patient’s **Flowsheet** or **Order History** tab will no longer reset an order’s queue statuses to “**Not Started**”.
- Opening an order from the **Flowsheet** or **Order History** tab and clicking **Save & Sign** without making any changes will no longer reset the order’s queue statuses to “**Not Started**”.

See the number of patients, not orders

You’ll now see the **number of patients** (instead of the number of orders) that match your current filter criteria displayed in the far-left column of the Orders Queue (callout 1). This change boosts queue performance, as retrieving the patient count is much faster than counting individual orders.

The screenshot displays the iKnowMed Orders Queue interface. On the left, a 'FILTERS' section shows '54 Patients' with a callout '1' indicating the patient count. Below this is a list of patients with their names, MRNs, and DOBs. The main area shows a patient profile for 'Wvshmc, Vcawar (F)' with a 'MESSAGE' button and contact information. On the right, the 'Update Selected Orders' section shows a table with columns for Location Type, Perform Location, Perform Date, Queue Task, Update Status, and Queue Note. Below this, a 'Basic chemistry panel' is displayed with associated problem, ordered date, and instructions.

More reliable order display

We’ve improved a background process to more efficiently apply the default “**Not Started**” status to orders. This reduces the chance of orders being missing from the queue, especially during times of high system activity. You’ll now see orders appear in the queue more consistently, as expected.

Medications and Allergies full integration with Ontada Health e-Registration

Starting **Thursday, June 26, 2025**, the "**Pending**" status that was introduced in the **Medications** and **Allergies** tabs of the patient chart will become fully functional. This enhancement allows practice staff to electronically review, reconcile, and verify patient-submitted updates, eliminating the need for manual data entry.

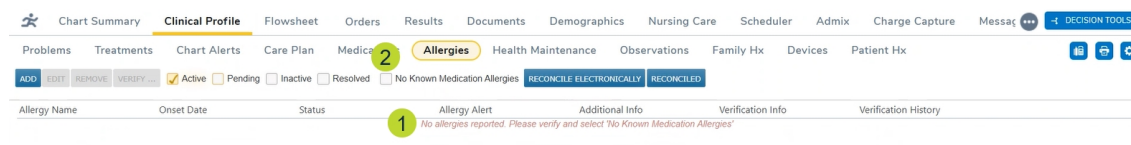
How it works

Patients without reported medications or allergies

If a patient has not reported any medications or allergies through Ontada Health e-Registration, the **Medications** and **Allergies** tabs in their chart will display a message indicating that no information was submitted (see callout 1 for example).

This message will prompt staff to **confirm** that the patient has no known medications or allergies. To document this in the chart, simply **check the box** labeled "**No Known Medication Allergies**" or "**No Known External Medications**" (see callouts 2 for example) and click the **Yes** button.

Once selected, this information will be saved to the patient's chart, ensuring accurate and complete documentation.

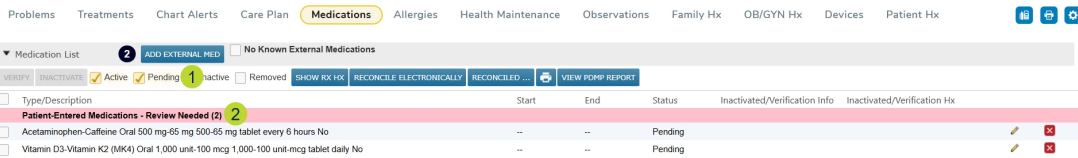


Patients with reported medications or allergies

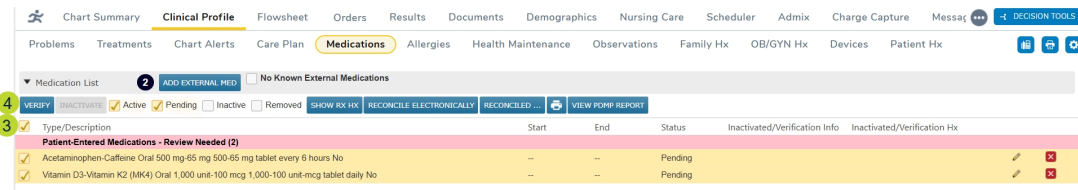
When a patient completes the **Medications & Allergies** section of the e-Registration form, their responses will automatically populate the **Medications** and **Allergies** tabs in their chart. These entries will appear with a "**Pending**" status until reviewed by practice staff.

To review and reconcile pending medications:

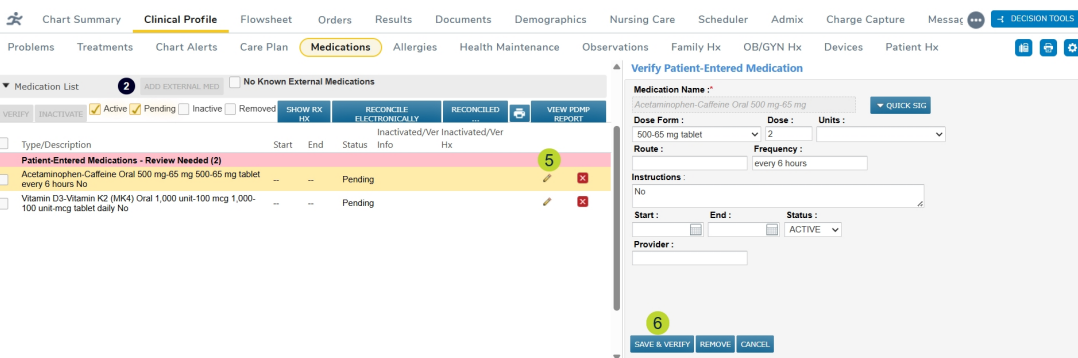
1. Open the patient's chart and navigate to **Clinical Profile > Medications**.
2. The **Pending** status box will be checked automatically (callout 1).
3. An alert will appear in the table to notify you that items need to be reviewed (callout 2).



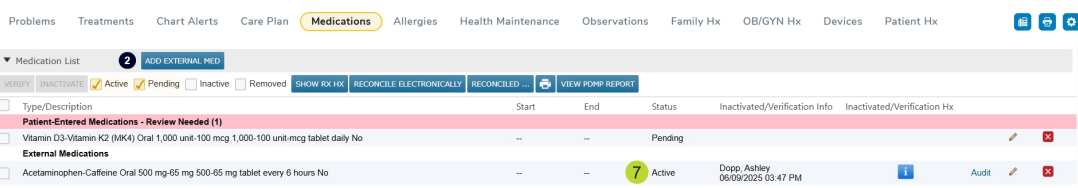
- If you wish to verify all items (including removals) in bulk, check the select all box or check the box next to each of the desired items (callout 3).
- Click the **Verify** button above the table to enact all patient-reported changes (callout 4).



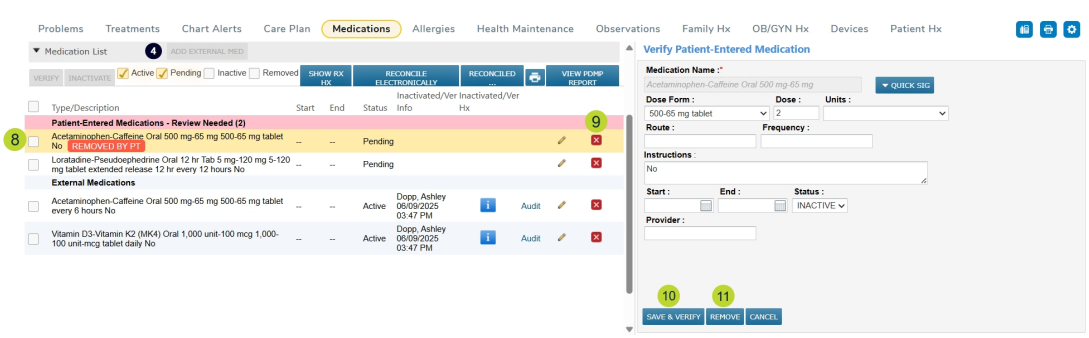
- If you need to review or update any pending items **before verifying them**, click the edit icon (callout 5).
- After confirming or updating the information, click **Save & Verify** (callout 6).



- The status of the item will change to **Active** (callout 7).



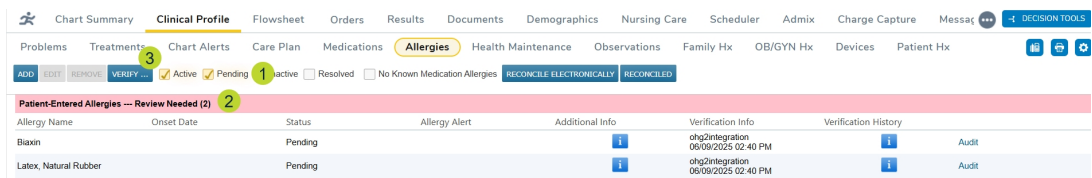
- Removed items will be marked with a red **REMOVED BY PT** badge (callout 8).
- You may click the red box to remove item (callout 9) or open the item to view the details before clicking **Save & Verify** or **Remove** to remove it from the patient's chart (callouts 10-11).



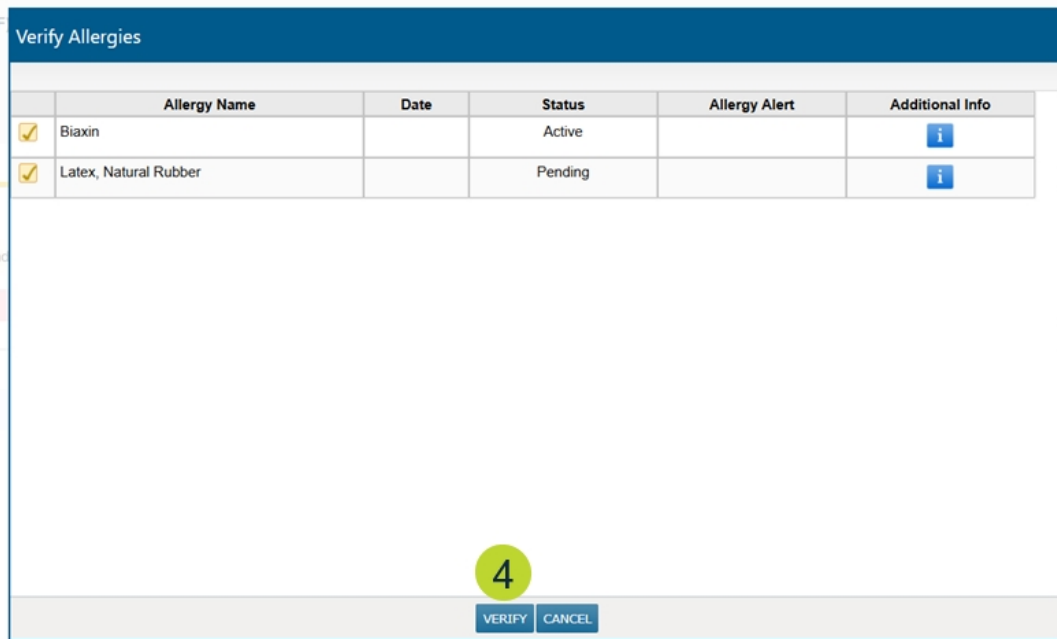
NOTE: Only external medications can be updated or removed in the Medications tab. For practice prescribed medications, you must continue to update or discontinue the prescription in the patient’s Flowsheet. Then, remove medication from pending status using the red box in the medications tab.

To review and reconcile pending allergies:

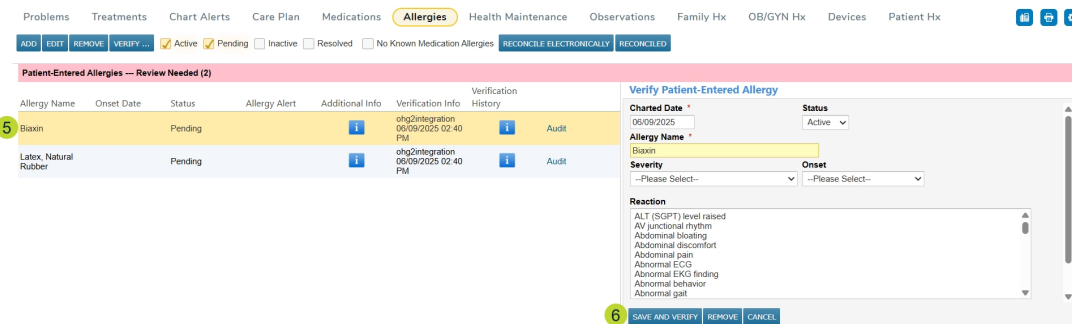
1. Open the patient’s chart and navigate to **Clinical Profile > Allergies**.
2. The **Pending** status box will be checked automatically (callout 1).
3. An alert will appear in the table to notify you that items need to be reviewed (callout 2).
4. If you wish to verify pending items (including removals) in bulk, click the **Verify** button above the table (callout 3).



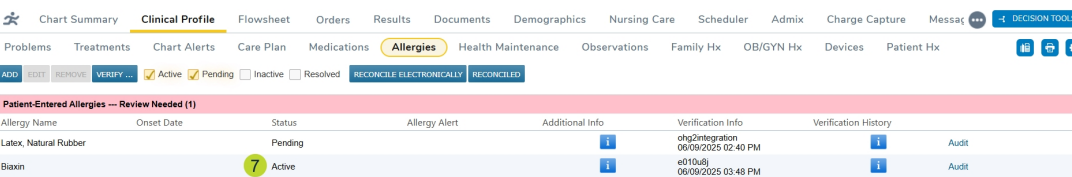
5. A window will appear where you can review all the changes. If it looks correct, click the **Verify** button to enact all patient-reported changes (callout 4).



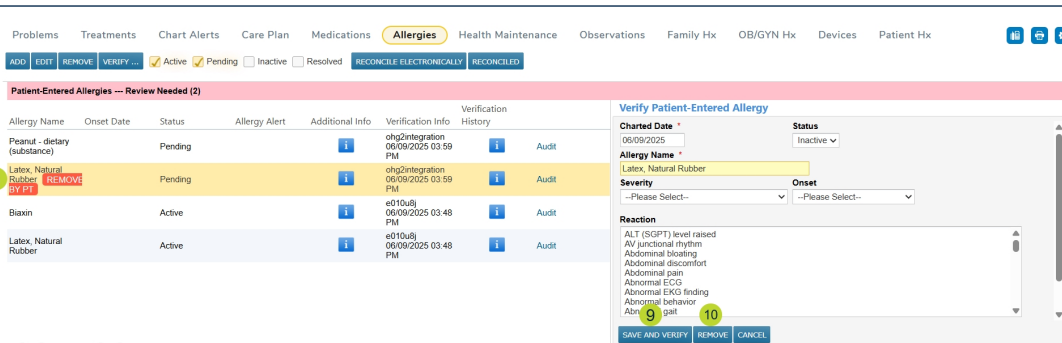
- If need you need to review or update any pending items **before verifying them**, click on the item (callout 5).
- After confirming or updating the information, click **Save and Verify** (callout 6).



- The status of the item will change to **Active** (callout 7).



- Removed items will be marked with a red **REMOVED BY PT** badge (callout 8).
- Click on the item to view the details before clicking **Save and Verify** or **Remove** to remove it from the patient's chart (callouts 9-10).



Enhanced visibility Medically Integrated Dispensing (MID) prescriptions

To provide greater transparency into a patient’s treatment journey, we’ve added new data points for electronic prescriptions filled by MID AccessPro, a medically integrated dispensing pharmacy tool.

The following dates will now be displayed in both the **Flowsheet** and the **Order History** tab:

- Prescribed Date
- Dispense Date
- Delivery Date
- Pill in Patient Date

These additions offer deeper insight into what the patient is being treated with and when the medication reaches them, supporting more informed clinical decisions and streamlined care coordination.

Acetaminophen Oral
required

Options for Occurrence	Date Ordered 02/26/2025
• Edit order	Details
• Move Order	Acetaminophen Oral
• Print	Acetaminophen Oral 325 mg capsule
• Renew Order	2 capsule orally once. Dispense: 30 Capsule Refills: 0 Duration: 15 days Allow Substitution
• Discontinue (D/C)	Associated Problem(s): Colon cancer *
• Remove	Medically Integrated Dispensing
• Print Rx	Prescribed Date: 02/26/2025
• Audit History	Dispense Date: 02/25/2025
	Delivery Date: 02/26/2025
	Pill in Patient Date: 02/26/2025

CLOSE

New e-prescribing end user license agreement prompt

Upon logging in after this release, all users from eRx-enabled practices, regardless of whether they have e-Prescribing or non-prescribing capabilities, will be required to review and accept a new end user license agreement from NewCrop.

While users may close the agreement to continue working, the prompt will reappear at each subsequent login until the agreement is marked as reviewed. Accepting the agreement is required to prevent the pop-up from recurring and to ensure continued access to e-prescribing features.

Alpha Oncology
Central Region-Boulder Clinic - 06/09/2025

Search Patient Name or ID

Worklist Queues Manage

E-Prescribing Agreement

To continue using the e-prescribing feature in iKnowMed G2, please review and agree to the End User License Agreement below. This notification will close permanently only after you have agreed to these terms. For any questions, please contact your practice administrator.

V3 INDEPENDENT ASSOCIATE AGREEMENT

THIS INDEPENDENT ASSOCIATE AGREEMENT (this "Agreement") is entered into effective as of the _____, 2024 (the "Effective Date") by and between [CUSTOMER NAME], having its principal place of business at [CUSTOMER ADDRESS] ("Associate"), and NewCrop, LLC, a Texas company having its principal place of business at 1800 Bering Drive, Suite 600, Houston, Texas 77057 ("NewCrop").

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REVIEW & ACCEPT CLOSE

ePRO Enrollment Tracking in VBC Care Plan

We're adding a new **ePRO Enrollment** section to the **Program Tracking** area of the VBC Care Plan to help practices track electronically reported patient outcomes, a key component of the Enhancing Oncology Model (EOM) program.

How to document ePRO Enrollment

1. Open a patient's chart and navigate to **Clinical Profile > Care Plan**.
2. Create a new or open an existing **VBC Care Plan**.
3. Click the **Program Tracking** section and scroll to the new **ePRO Enrollment** subsection (callouts 1-2).
4. Select an enrollment status – accepted, declined, or ineligible (callout 3).
5. Add a date for the selection by clicking in the field or on the calendar icon (callout 4).
6. If you need to remove a selection, click "**Clear**" (callout 5).

7. Once a selection and date are entered, this information will automatically appear in the **Overview** section of the care plan under **Program Tracking** (callout 6).
8. Be sure to save your changes to add this information to the care plan.

The image displays two overlapping screenshots of the 'Value Based Care Plan' form. The top screenshot shows the 'Form' tab with a list of services and callouts 1 through 5. Callout 1 points to 'Program Tracking' in the list. Callout 2 points to the 'ePRO Enrollment' section. Callout 3 points to the 'Accepted, Enrollment Date' field. Callout 4 points to the date input field. Callout 5 points to the 'Declined, Declined Date' field. The bottom screenshot shows the 'Overview' tab with callout 6 pointing to the 'ePRO Enrollment' section in the 'Program Tracking' area.

Enhancements to CCDA export

The **CCDA** will be updated to improve the clarity and completeness of shared patient information.

Date of Death field

A new **Date of Death** field will appear in the CCDA if a patient status is set to **“Deceased”** and a date of death is recorded in the patient’s chart (callout 1).

Additional Care Team details

The **Care Team** field will include the credentials, role, Member ID/NPI number, and practice address and phone number for the patient’s attending provider (callout 2).

View Report

EOM, Test Patient Summary CCD

1 Patient	Test EOM	Sex	Female
Date of birth	January 10, 1992		
Date of Death	June 2, 2025	Ethnicity	Unknown
Race	Unknown		
Languages	Unknown code	Patient IDs	TestEOM123 2.16.840.1.113883.3.623
Contact info			
Document Id	PatientSummaryCCD_EOM_20250609_0616_18.801 2.16.840.1.113883.3.623		
Document Created:	June 9, 2025, 06:16:18, MST		
2 Care Team	ZZVagdevi ZZNamburu of Onc Hem of MSH Role: Attending Physician Member ID: 12345 Address: 123 Mission Street 6th Floor San Francisco, CA 94105 Tel (Work Place): (510) 402-6077		
Author	Ashley Dopp, Onc Hem of MSH		
Contact info	123 Mission Street 6th Floor San Francisco, CA 94105		
Encounter Id	fcaaa939-d56e-4bb7-9b35-9778867818e4		
Encounter Date	at May 2, 2025		
Encounter Location	San Francisco Medical Oncology, Unit 1594 Box, Abilene, TX - 79603		
Informant	ZZVagdevi ZZNamburu of Onc Hem of MSH		
Contact info			
Document maintained by	McKesson Specialty Health		
Contact info	10101 Woodloch Forest The Woodlands, TX 77380, USA Tel (Work Place): 800 381 2637		

Table of Contents

- Assessment and Plan
- Allergies and Adverse Reactions
- Care Plan
- Reason for Visit
- Mental Status
- Encounters
- Functional Status
- Goals
- HealthConcerns

[PRINT](#) [CLOSE](#)

Export Patient Referral Note

The **Release of Information** widget on the **Chart Summary** tab of the patient's chart will include a new **Export Patient Referral Note (CCDA)** option (callout 3). This file shows what an external partner would see if the CCDA were shared with them.

Test EOM (B3 / F) | DOB: 01/10/1992 | MRN: TestEOM123 | Attending: ZZNamburu, ZZVagdevi | Dx: Colon cancer | HT/Wt/BSA: - / - / - | Allergies: Undefined

Chart Summary | Clinical Profile | Flowsheet | Orders | Results | Documents | Demographics | Nursing Care | Scheduler | Admix | Charge Capture | Messages | **DECISION TOOLS**

Default View | Interval Summary

Release of Information

Options:

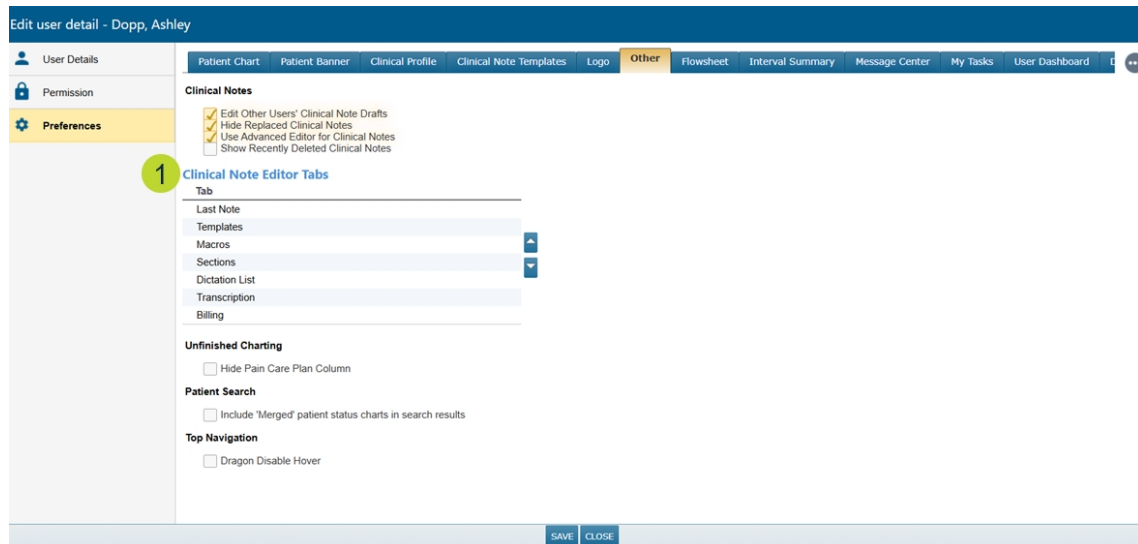
- Print Patient Record (1-year)
- Export Patient Record (1-year) File (CCDA)
- Export Patient Record File (CCDA)
- 3** Export Patient Referral Note File (CCDA)
- Record Other Release of Patient Information

Organize tabs when documenting clinical notes

You can now **rearrange the tabs** in the clinical note editor, giving you more control over how these tabs display when creating a clinical note. This is especially helpful if you use features like **AI Scribe** as you can now choose whether the **AI Scribe** or **Last Note** tab appears first or set any order that works best for you.

How to customize your tab order:

1. Go to **User > Preferences**.
2. Select the **Other** tab.
3. In the **Clinical Note Editor Tabs** section, use the arrows to move tabs into your preferred order (callout 1).
4. Save your changes.



Fixes (A-Z)

Admin > Practice Preferences

Previously, clicking the Save button on the Order Preferences tab (even without making any changes) would unintentionally deselect the Practice Logo / Letterhead checkbox on the General Settings tab within Practice Preferences.

With this fix, saving from the Order Preferences tab will no longer affect the Practice Logo / Letterhead setting. Clinical notes generated after saving preferences will retain the selected logo as expected.

Fixes (A-Z)

Worklist Queues > eRx Message

Previously, some APPs and supporting clinicians were unable to approve or deny renewals on behalf of a physician in the eRx Message queue. This functionality has now been restored, and APPs and other supporting clinicians can approve or deny renewals as expected.