Ambulatory Provider PowerChart Class Script for EHR Educators

Goals and Objectives

Goal: To give an overview of PowerChart functionality to new or identified providers.

Objectives: In a single (4 hour) course, introduce PowerChart concepts that will prepare the provider to use the EHR to deliver effective patient care.

By the end of this course, participants will be able to:

1. Navigate throughout the PowerChart toolbar icons, patient search, and manual refresh.
2. Utilize the Message Center for signing orders, reviewing results, and communicate via staff messages.
3. Use the AMB workflow to complete the Outpatient medication reconciliation and create an office note.
4. Place orders and charges using the QOC page.
5. Demonstrate basic Dragon Medical One use including dictation, vocabulary word creation, and Auto Text.

Content Outline

- **Instructor introduction**
  - Name, role, background.
  - Ask the provider's background.
- **Review agenda**
  - Log in to the TRAIN education domain.
  - Go through the Outline and practices.
  - Provision Providers for Electronically Prescribing Controlled Substances (EPCS).
  - Teach Dragon Medical One basics as needed.
- **Open Citrix Workspace**
  - Explain PowerChart app vs PowerChart-Dragon Medical One app.
  - Log in to TRAINB.

Basic Navigation

When you log into PowerChart, the program will open to this viewpoint or the ambulatory organizer. I want to take a couple of minutes and look at some basic navigation features on this page.

Icons - Tool Bar: Along the top of the screen, you will see the toolbar with a variety of icons.

Home: If you click on the home icon, it will bring you back to the ambulatory organizer. This is the page where you will find your schedule and a preview of the Message Center on the left-hand side.

Message Center: Moving across the toolbar is the Message Center icon. This is where you will cosign nursing orders and documents from mid-level providers, if necessary. I will come back to this section in a few minutes to further explore.

Copy Auto Text: Next, is the Copy Auto Text icon. Auto Text is sometimes called dot phrases in other EHR systems. This is where you go to make your own auto text, copy other providers' auto texts, or duplicate our public auto texts.

Resource Webpage: Returning to the toolbar, the next icon to discuss is the Resource Globe. If you click on this icon, it will take you to a webpage with a list of hyperlinks. I'll point out a few of the helpful ones.

- **Inteleconnect:** is our web-based image-viewing platform. You can use your Munson credentials to log in and see all your patients' imaging available through the PACS system. You can compare images side-by-side and use tools. Images are available in PowerChart, but you have to open up each report to see the associated image. When imaging is unavailable in PowerChart, you will need to come here to look at imaging.
- **LexiComp:** LexiComp is the Munson-approved drug manual.
- **MAPS** (MI Automated Prescription System) **and MCIR** (Michigan Immunization Record): MAPS and MCIR logins are here but the information is also available in the patient's chart.
    - Note: The MAPS link from this page will show a full history and the MAPS data in the chart will provide 2 years of history.
- **MHC Antibiogram:** The MHC antibiogram guidelines are available here. If you open the link a QR code is available to scan. We have also included this as a handout in your folder.

Return to PowerChart.

EHR website: The EHR website hyperlink is our department's website. This is a great resource for online documents and videos that help you to better understand and use PowerChart. When you are viewing this website, make sure to expand your page so you can see the full banner. You will click the Hospital and Ambulatory Provider link in the banner. Then along the side, you have categories to select different resources. The orientation section has the most used documents.

- **EHR Provider Website:** Show how to favorite the website from their web browser.
- **OPR Wave 2 Project Page:** Show the OPR Wave 2 project page on the EHR website and have providers favorite the website on their web browser.

UpToDate: Lastly is UpToDate, which is free to Munson employees. Once you have created a login, the program will run in the background and track potential CEUs.
Refresh Icon: PowerChart is a manual refresh system. It is recommended to refresh before and after any documentation or order entry. This will ensure you are viewing the most up-to-date information.

Exit Door: Finally, I want to point out the exit door button. It is recommended to exit the program via the door. This ensures all your personalizations are saved as well as officially logging you out of the system. If you use the red X in the upper right corner, then your personalizations may not be saved and your login is left running in the background for 72 hours. This could eventually lock you out of the system and you will have to call the Help Desk to regain access.

Any questions? Okay, let's take a closer look at a few icons we touched on already.

Copy Auto Text

The master icon for Auto Text. This will show your library of Auto Text (dot phrases) and allow you to copy other providers' auto text, make your own, and duplicate our public auto text.

Copy Another Provider's Auto Text: To copy another provider's auto text, search for their name in the search bar. [*Search for last name **Rawlin, Joseph** (TRAIN A); **Poole, Marshall** (TRAIN B)*]. A list of Dr. Rawlin's/Dr. Poole's auto texts will appear.

- **Preview:** If you click on one of the auto texts, you can preview it. [*A good example from Dr. Poole's list is: **mtp_D/C_PE_35***]. After reviewing the text, if it is one you would like to copy, click **Copy** and the system will allow you to rename the auto text.
- **My Abbreviation:** In the My Abbreviation area, it is recommended to use a period (aka dot) then your initials, and then the topic of the auto text. You are not allowed to use a space in the abbreviation, but you can use an underscore to make it more readable. Since we are in the training environment, I am going to pretend my initials are doc for doctor. So, I would change the abbreviation to: .doc_physical_exam.
- **My Description:** Then change the My Description section. There are no formatting rules for this section, so I am going to type: Physical Exam. Then click Copy to add it to my auto text list.
    - Renaming the selected auto text to your initials and description allows you to quickly pull up and use your auto text later when documenting.
- **My Auto Text Library:** If you look over in the My Auto Text Library section, you will see the text was copied to my list.

Make your own Auto Text: From this same window, you can also create your own Auto Text.

- Click on the manage auto text icon, under the My Auto Text Library header.
- Click the blue plus button.
- Add an abbreviation and description for your auto text.
    - Let's pretend that I am making an auto text for a pain scale and the location of the pain. I would write .doc_painscale_location for the abbreviation and Pain Scale & Location in the description.
    - Below is where I create my auto text. Let me demonstrate.
        - [*Type: The patient presents with_ pain in _ .].*
        - I will fill in the blanks of this statement by adding drop-down options.

- Highlight the underscore between with and pain in the statement and then click Create Drop Down. I'll add a 1-5 pain scale and click Create when I am done. This puts the drop-down options in the first blank. [*Demonstrate*]
- Now, highlight the underscore after pain and click the Create Drop Down icon. This time I'll add options for locations i.e. head, neck, back, left arm, & and right arm. If I choose Multiselect, it will allow me to select multiple options when using the drop-down. When I am done, I click Create and the drop-down is added to the second blank in my statement. [*Demonstrate*]
- Click Save when you are finished, and this auto text is added to your My Auto Text Library.

Public Auto Text: Another option is to copy public auto texts.

- Switch to the Public Phrases tab. You can see there are 152 pages of public phrases you can use.
- For example, let's search total and choose the Total Hip Arthroplasty auto text. When you select this from the list, it will show as a preview in the right pane.
- Click **duplicate** to copy the text.
- Rename the abbreviation and description like we did with the above examples.
- Here you have the option to edit the texts as needed before clicking Save.
- The auto text is now added to the My Phrases list.

Editing Auto Text: You can edit any of your auto text by clicking on one from your My Phrases list and then by clicking Edit.

Using Auto Text to pull in HPI: From the nursing intake form.
NOTE:

- *This still needs to be built in Train. In the real environment, if the providers have clinical staff entering a nursing HPI in their intake PowerForm, providers can use a specialty-specific dot phrase to pull in that HPR information in the note. For example, .pc_hpis_intake or .card_hpi_intake*
- *If you search, nursing HPI intake into the public phrase, you will see what examples are available in Train.*

Do you want to take a few minutes and explore making auto texts?
Let's return to our Ambulatory organizer. Click on the Home icon.

Ambulatory Organizer

The Ambulatory Organizer is the default landing page when you open PowerChart. The organizer is divided into 2 sections. On the left-hand side is a preview of the message center. The right section is your schedule.

Date: At the top of your schedule, you have filters. You can change it to view your schedule as a list, day, or week. You can also change the date to look forward and back in your schedule. This feature could be helpful when chart prepping.

Resource: When you open the ambulatory organizer in the real environment, your name will appear after Patients for:. Today we have it set up to view Dr. Rawlin's patient list in our training environment.

Information in the Organizer: From the schedule, essential information about the patient's appointment is displayed:

- **Appointment Time**
- **Name, Age, and Date of Birth (DOB)**
- **Patient Status:** This shows the progression of the patient's appointment status. For instance, when the patient arrives at their appointment or after the MA or nurse has finished their intake form.
- **Reason for Visit:** Derived from what the scheduler entered during the creation of the appointment.
- **Chief Complaint:** Listed if the clinical staff or the provider has already documented it.
- **Blue circle with a white I**: When you encounter a blue circle with a white "I" next to the birth sex on the organizer, it signifies that there is additional information related to the patient's social history. For instance, the patient might identify as a gender other than their assigned birth sex. Hovering over the icon will provide further details. Alternatively, you can access this information from the Histories component in the provider view.
- **Sticky notes:** When you encounter a sticky note in the notes column, it serves as informal communication between staff members. Sticky notes are not saved to the patient's chart. If the patient's appointment is moved to a different time or day, the note will not transfer to the new appointment time.
- **Opening a chart:** You can open a patient's chart right from the ambulatory organizer by clicking on the patient's name.

  NOTE: The Ambulatory organizer of PowerChart is unique—it automatically refreshes.

Remember, to return to the ambulatory organizer use the **HOME button** in the toolbar.

Patient Search

Patient Search: Another option for locating a patient in the system is by using the search bar. When you click on the magnifying glass, the program opens to a search screen. When searching for a patient, it is best to put in as many identifiers as possible.

- **Search Example:** For instance, if I enter **Cerned** in the Last name field, and T in the first name field and click search, the system warns me of the low search strength, if I continue, the system will give me more returns to sort through than if I would have made my search more accurate.
  - Upper section: The upper section lists all the patients that have Cerned, T in their name.
  - I also see that the MRNs (Medical Record Number or lifetime number) are listed with an alpha code. This alpha code indicates the facility and can be used to help identify the correct patient.
    - M is for Munson Medical Center, G for Grayling, P for Paul Oliver, C for Cadillac, and K for Kalkaska. These are all the facilities that use PowerChart. Gaylord, Manistee, and Charlevoix hospitals will be added to our system on September 9, 2024.
  - So, say I scroll down to find my patient: Tara. When I select her name, it opens the bottom portion of the search box. This shows me all the encounters that are in the system for Tara. Our system is a shared system, you will see both hospital and ambulatory encounters.
    - The encounters that start with an A are ambulatory encounters. The ambulatory encounters can include future visits.

        - Looking at the nursing unit will help identify the location, such as Munson Medical Center on floor A3 is an inpatient encounter. I would want to choose an ambulatory encounter that matches my clinic. **[*Do not open the chart, instead select Cancel*].**
    - You can open any encounter that you need to, you would just want to make sure that when it comes time to document, you are in the correct encounter.

Correct encounter: One of the best ways to ensure you are in the correct encounter, is if you select a patient from the ambulatory organizer.

Recent dropdown: Next to the search bar, there is a recent drop-down arrow. This will show you the last 5 patient charts you have accessed.

Any questions about the Ambulatory Organizer?

Message Center

Within the Ambulatory organizer, the left side of the screen is a preview of the message center. The message center can also be accessed by clicking on the icon in the toolbar. Essentially, the message center is the **email system of PowerChart**.

Overview:

- **Inbox:** The inbox tab is for items assigned to that provider who is logged in.
- **Proxy:** The proxy tab is where the provider can assign another person to monitor his/her message center when he/she will be off or on PTO. Practice managers will help with setting up proxies when needed.
- **Pools:** Pools are shared inboxes by a group of users that receive the same message. Each clinic will have their own clinical and clerical pools.
- **Single Click vs. Double Click**: Within the message center, if you single-click on an item, it will allow you to preview the item. If you double-click on an item, it will fully open and allow you to take action, if needed.

Results: The results folder will hold reports from tests, diagnostics, lab etc. that you have ordered. [show single click vs double click]

- **Scenario 1:** You might get a result in the folder that you need to just review. With that type of result, you would choose OK & Next or OK & Close to sign off that you reviewed the result. Do not click this now!
    - **OK & Close and OK & Next:** The OK portion of those options is your legal signature. Next will take you directly to the next item in the folder and close will close out the item.
    - **Next:** The Next icon does not sign the item, instead it just displays the next item in the folder.
- **Scenario 2:** There also may be a situation where a result is sent to the wrong provider. In this case, you could choose to refuse the result and fill in the reason for refusal. Do not do this now! There is a field to forward the message to the correct provider and to give additional comments. Once done, you would still need to sign off by choosing OK & Close or OK & Next.
- **Scenario 3:** Now let's say that after reading the result of the x-ray, you want to update the patient on the result and order a follow-up x-ray in 6 months. You can do all of this from the message center by creating an In-

Between visit or **a non-billable encounter**. An In-Between visit encounter, which always needs to be made when documenting patient information not related to a clinic visit.

- **Create:** Click on the drop-down arrow next to Create and select Staff Message. To note, if you just click on the word 'Create' itself, the system will default to creating a reminder.
- **Choose your clinic**: Munson Family Practice Center. This generates an In-Between visit encounter. Since I generated this message from a result, it will auto-populate the patient's name, the provider's name, and attach the result to the message.
- **To field:** In the To field, you will type in the recipient of the message. In most clinics, providers have access to pools of people rather than sending this message to one person.

  Demonstrate
  - Click on the binoculars next to the To field.
  - Change your search parameters to Pool instead of Personnel.
  - Search: **Munson Family Practice**. The pools for the practice will be displayed. Select **MunsonFamilyPractice Clinical Blue/Orange**.
  - **Favorite:** Right-click on MunsonFamilyPractice Clinical Blue/Orange to add the contact to your favorite list. This will allow you to use this pool without having to search for it each time you create a message.
  - Click Add then OK.
- **Include Me:** If this box is selected, the user will receive a copy of the message.
- **To consumer:** The To consumer sends the message to the patient's portal if they are enrolled.
- **High priority:** Select High if the message is important.
- **Notify:** A notify receipt can be set up.
  - If you click on this icon, you can set up a notify receipt when the message is opened or if the message isn't opened in a certain number of days. These notify receipts go to your Notify Receipts folder in your message center.
- **Subject:** Retitle the subject to be specific. It is recommended to use the approved initials of your clinic and a brief description of the subject of the message. For this message, type: **MFPC: chest X-ray result**
- **Save to chart:** This is preselected to save to the patient's chart.
- **Actions:** At the bottom of the screen, you will see actions. Do not use these options because they do not generate an action. Instead, use the message area to communicate the actions needed.
- **Message:** Fill in the message. Type: **Please call the patient with normal results. Repeat x-ray in 6 months.**
- **Add an order to the Message:** Next, I want to add the X-ray order to this message.
  - **Click launch orders**. This opens the orders section of PowerChart.
  - Click **Add** and type chest 2 v in the search bar. Select one of the options. You will be able to modify the order after selecting. You can add medication orders here as well, if needed, based on the result.
  - **Order details**:
    - **Missing Details:** At the bottom of the order, you'll notice two required details are absent. The blue circle with a white X icon indicates missing information.

- **Symptom:** The symptom box is highlighted in yellow. When dealing with an X-ray, a symptom must be included. Type "chest pain." Once completed, the blue circle disappears from the Details tab.
- **Diagnosis:** To associate the order with a diagnosis, click on the Diagnoses tab. Search for "chest pain" and select "chest pain (R07.9)." Now all the missing details are filled in.
- **Future Order:** If you want to schedule this order for 6 months from now:
  - In the Special Instructions, Notes to Scheduler, or Order Comments tab, type "to be done in 6 months." This statement will be added to the order details.
  - Alternatively, adjust the Start Date/Time to 6 months from now.
- **Sign:** Once the order details are complete, use the Sign button to attach the order to the message.

- Then **send** the message.
- **Sign the result:** It brings you back to the original result in your message center. Now you need to sign off on receiving this result by choosing OK & Close or OK & Next.

Any questions on how to use a Result to create an in-between encounter to document and communicate with members of the care team and patient?

Results FYI: Used for Primary Care. It is designed for PCP to allow subscription to specific sets of patient lab results, diagnostics, and documentation about their patients.

Orders: The Orders folder is broken up into cosign and proposed orders.

- **Cosign orders:** Cosign orders are typical nursing orders that in the clinic are usually per protocol. These orders can be acted upon without a provider's final signature, but still need your final signature in the chart. We have two cosign orders in our training environment. Double-click on the first order. Notice that when I have this order open there is a yellow action bar at the bottom of the screen.
  - Now you have the option to approve or refuse the order. If I refuse the order, I must give a reason. Maybe the reason is the order went to the wrong provider. Once you have made your selection, click OK & close or OK & Next to sign.
- **Proposed Orders:** In the ambulatory setting proposed orders are more frequently used than cosign orders. Proposed orders - cannot be acted upon until signed off by a provider. For this reason, they look a little different in the system. Double-click on a proposed order. On the right side, you have the icons for Accept, Reject, or Modify the order. Use the icons to select the appropriate action. If the order is completely incorrect, it is recommended to refuse the order and then place the correct order.
  - **Summary View**: A nice feature within the message center, is the ability to switch to summary view. This allows you to view the patient's chart that the message is about without having to leave the message center. So, you can click on summary view to look at what you need to reference in the patient's chart and then click inbox view to return to the message. [*Demonstrate*].
  - **Hyperlink to Patient's Chart**—Also, there is a link to the full chart next to the recent drop-down menu. Do not click on this for class purposes.

Documents: The document folder contains items to review and sign off on. Double-click to open the document. You have similar actions as before at the bottom of the screen. You can also **add an addendum** to the document by clicking the modify button. Click the Modify button. [*Demonstrate adding an addendum with the example below*].

- **Addendum:** Maybe you are supervising an APP, and you need to add a sentence to their document. You could do this with an addendum. I could write I agree with the findings in this report…and then click sign to add the addendum.
    - This addendum is now part of the report, and you can go on to the next document in your folder.

Messages

- **General Messages:** Just like the name suggests, the general messages folder will have general messages, but it will also contain Critical Lab Values.
    - Double-click on the **general message**. You can see that it is asking if you would like to see this patient for an urgent appointment. Using the reply feature at the top you can respond to this message just like you would to an email. You can click reply to the message.
    - The next message is a **critical lab value** message. The lab will first attempt to call the provider with critical lab value information and the lab will send a message to the message center. Your manager should have a process for handling this.

- **Renewal Request:** Double-click to open the Renewal request entered by a nurse.
    - **Request tab**: Select the request tab and fill in the information. The patient's preferred pharmacy will be listed if it has been entered into the chart.
    - **Response tab**: This is an area for a user to type a response if needed (ex. This has been completed). Once the request tab has been completed, the response tab will have the completed medication renewal listed.
    - If the request is wrong, reject the order and put in a new order for the medication.
    - **Important:** If a provider gets a renewal request for a controlled substance, the provider HAS to do the Opioid Review component before signing the renewal request. Use Summary view to do this. That way the provider doesn't have to leave message center. Background: providers are not doing the opioid review first, and it is getting flagged by quality measures.

Saved Documents: These are any notes that you have saved and have not signed. Think of this as your **to-do list**. When you are ready to complete the document, you will want to open the document within the patient's chart instead of completing the document in the message center.

Reminders: A provider may send a reminder to another staff member or to themselves. To create a reminder, click the drop-down arrow next to communicate in the toolbar and select Reminder. You may also save it to the patient's chart as a reminder.

Sent Items: The sent folder shows any sent or completed items from the Message Center.

Trash: The trash folder shows deleted items. You can restore a message back to a folder if it was accidentally deleted. [*Demonstrate as needed*].

Notify Receipts: The Notify Receipts folder is where the provider will receive notifications of the notify receipts they created.

Any questions on the message center?
Click on the home button to return to the ambulatory organizer.

Chart & Provider View Overview

Next, let's open a patient's chart from the Ambulatory Organizer. Click on the Home icon. I am going to open **Sage**. You open the patient indicated on your card.

HIPPA Compliance: The first time you open a patient's chart, you will be prompted to assign a relationship. This is a HIPPA compliance question. Do not worry too much about which relationship you pick; it will not affect the information you see in the chart. Note: NPs and PAs will have a midlevel provider option.

Overview of Patient's Chart: The chart opens to what we call provider view. Allow me a few minutes to give you an overview. This is where you will spend most of your time reviewing the patient's chart and completing your documentation.

- Providers can have **two charts open at once**.
- **Patient Demographic Bar:** At the very top is the patient demographic bar. It shows the patient's name, DOB, Age, birth sex, MRN, FIN, code status, and allergies. Some of the areas are links that you can click on to find out more information. For example, if you click on allergies. You can also click on the location number to change the encounter.
    - Have the providers switch to an encounter location that matches their specialty.
        - Ie: Urology= select Cadillac Urology (it might not be their clinic, but it matches their specialty. This allows return to clinic orders and charge assist to work.)
- If you see a small 'i' next to the patient's sex. This indicates there is more information in the Histories component. It could be the patient identifies as something other than their birth sex.
- **The refresh icon** is still in the upper right corner.
- The small **Home Icon** takes you back to the provider view when elsewhere in the chart.

Overview of Provider View:

- **MPages or Workflows** are tabs at the top.
    - **AMB Workflow:** We are currently in the AMB *Specialty* Workflow. This is going to be your main workflow for reviewing the patient's chart and creating your office note. I can change between workflows by clicking on the different tabs.
    - **AMB QOC:** Quick Order and Charges displays frequently used specialty-specific orders and charges face-up.
    - **Code Status:** The code status workflow. This shows you not only code status information but advance directives, power of attorney, and emergency contact information.
    - **Add/remove Workflows:** You can remove workflows from the list using the X icon. I can add workflows by using the + icon [*Demonstrate*]. I can also **rearrange** these workflows by clicking on a workflow and then dragging the workflow to where I want it.

- **Components**: The components are along the lefthand side of the screen. The components show you the information in the patient's chart. As you click on the different components, the information pulls to the top of the middle section of the screen.
    - **Filters:** Most components have filters you can apply to the information.
    - **Modifying Components:** You can **add and remove** components as needed by using the page menu icon (pancake stack) [*Demonstrate]*. You can also **drag and drop** components to rearrange them in any order.
    - **Refreshing Components:** I also have the option of **refreshing just a component** vs refreshing the whole system. It can be a time saver to only refresh a single component. In addition, if you refresh the whole screen, you are automatically sent to the top of the component list. [*Demonstrate what happens when you refresh the component vs the whole system*].
- **Contextual View/Pinned Free Text Components:** Contextual view is another name for split screen view. The free text boxes are locked to the right of your screen. These boxes are the building blocks for your note. This allows you to scroll through the patient's chart and at the same time build your note in the locked free text boxes.
- **Preset Note Templates:** At the bottom of the components list is a list of preset note templates specific to Munson and your specialty. Once you are done adding information to the free text boxes you can select a note template. Everything from the free text areas will **flow into your note automatically**. The system is designed so that you create your note in provider view and then at the very end select the template.
- **Blue Menu:** Finally, tucked away on your screen is the blue menu or the table of contents. This is typically the old way of accessing information in PowerChart. The information on this menu is all available in the provider view. Instead of having all the information on one screen, you have to click on each individual section of the chart to retrieve the information.

***Remember the only way the system will save your customizations is if you use the exit door to quit the system.**

Any questions about the provider view or the chart?

Workflow Components

Let's take a look at the components. I will review the most used components and the minimal required components for meaningful use.

Chief complaint: The chief complaint is a patient-stated reason for the visit. The component is a free text box and is typically entered by clinical staff during intake. Review, modify, or enter a chief complaint by clicking into the text box. Click sign to add a timestamp.

Problem list: The problem list is a shared list among hospital and ambulatory providers in the systems. For that reason, be careful when resolving a problem because it will get resolved on everyone's list. Problems can be both Chronic and This Visit.

- **This Visit problems:** All previous problems/diagnoses will be listed as chronic at the beginning of the visit. Providers can select from the chronic problems and make them also This Visit problems or a provider can search to add a new This Visit problem.

    - Complete words are not needed when searching. Be sure to search by the most specific word.
        - Example 1: If you are looking for a diagnosis for a right fracture of the tibia. Start typing: tib fra ri. Instead of starting your search with the word fracture
        - Example 2: Next add Atrial Fibrillation as a This Visit problem.
- **Specifying:** Next, specify all the selected This Visit problems. Atrial Fibrillation has an exclamation point next to it. This indicates that the diagnosis is not specific enough for billing.
    - Click on the exclamation point next to Atrial fibrillation. This will launch the diagnosis assistant. The assistant helps a provider choose a more specific type of atrial fibrillation. Work through the suggestions to find the correct diagnosis. For this example, choose **atypical** and click on **Save**. The atrial fibrillation is updated to **Atypical atrial flutter** and the exclamation mark is gone.
        - Note: To ensure accurate billing, double-check your billable diagnosis, click on the problem in the problem list and view the ICD-10 code for that problem. If that code wasn't intended, click Specified in the window to bring up the diagnosis assistant and potentially choose a different problem.
- **Prioritizing:** This Visit problems can be prioritized using the drop downs in the Priority column. The prioritized problems will appear in the Assessment and Plan component. With the example I used above, I am going to prioritize the Tibia fracture as 1 and Atrial fibrillation as 2.
    - Prioritizing your problems is crucial for Charge Assist to properly read and help determine the appropriate billing code for your note.
- Do not **resolve problems** because this is a shared list across the system. If the provider resolves a problem, it resolves it for all other providers. If you unselect this visit, the diagnosis goes away.
- All problems being addressed that visit need to be marked as This Visit problems, given a priority number, and documentation below each problem in the Assessment and Plan is required.

****Return to the PowerPoint slides to show how to Reconciliate Problems, Procedures, allergies, and immunizations.****

Histories: The Histories component provides information regarding a patient's problems, procedures, family, social, and pregnancy histories. If the information was collected outside of Cerner, it is scanned into the chart and needs to be reconciled. Clinical staff will attempt to reconcile this information with the patient. If they cannot, then the provider has the responsibility on what information is added to the chart. Make sure the component is reconciled by clicking reconciliation complete.

Allergies: This is another component that needs to be reconciled. Clinical staff will try to complete this but ultimately the provider is responsible for making sure the information is reconciled. Click Complete Reconciliation.

Home Medications: The outpatient home medication reconciliation needs to be completed at each visit. Normally, the clinical staff handles the medication history during intake, which is denoted by a green check mark next to the medication history. To complete the medication reconciliation process, simply click on the Outpatient hyperlink. You are only responsible for rectifying the medications that you prescribe and acknowledging the remaining medications.

- **Icons:**
    - **A white paper scroll** indicates a home medication.
    - **A pill bottle** Cerner prescribed home medication.
    - An **orange circle with a white star** is a medication that needs to be acknowledged or reconciled.

  - **Continue, Create New & Not Continue:** The columns in the middle allow you to continue medications using the green triangle, create a new prescription using the pill bottle, or not continue the medication using the red square.
- **Example:**
  - Let's pretend that you prescribed fexofenadine. Go ahead and continue fexofenadine.
  - **Creating a prescription:** If there is a home medication (white scroll) on the list that you want to create a prescription for use the center column [Demonstrate]. If the home medication is a Cerner-prescribed medication (pill bottle), right-click and renew the medication.
    - Be aware that there are medications, mostly cardiac meds, that will fire a duplicate order alert if the documented home med (white scroll) is not discontinued before prescribing. Within the duplicate medication alert, the med can be discontinued.
  - **Acknowledge Remaining Home Meds:** The rest of the medications are not prescribed by you, so you can acknowledge them by clicking the Acknowledge Remaining Home Meds icon.
  - **Reconcile And Sign:** Now click Reconcile And Sign to complete the form. There should be a green check next to Outpatient in the home medication component.

Patient Education: A provider may select "pre-made" education based on the This Visit problems on the problem list. Single-click on an item to include it. There is also the ability to favorite education using the star and modify education using the modify icon. One piece of educational material is required for meaningful use. Clinical staff can also able to add education.

Documents: Next is the documents component. This is where clinical documents can be reviewed in the patient's chart from both ambulatory and hospital settings.

- **Filters:** Filters can be used to narrow down what documents you can see.
- **Continuous Scrolling:** You can also enable continuous scrolling, which allows you to scroll through all notes without having to click on each note. Note: you cannot modify a note if you have enabled continuous scrolling.
- **Drag and drop:** One benefit of contextual view or split screen view is the ability to drag and drop information from one note to your note. PowerChart does not have a copy note forward option.
  - [*Demonstrate drag and drop function using the Review of Systems from the Primary Care Note*].
  - You can see as soon as I drag something into my note, it automatically gets a **footer** to indicate where the information came from. I can simply erase this footer or if I change something in the text, the footer will automatically be removed. There might be certain situations you will want to keep the footer.

Vital Signs & Labs: Vital signs and labs. By clicking on the name of the vital sign/lab it will show a trending graph. By clicking on a value, it will show norms. Most note templates will pull the most recent set of vital signs and labs into your note automatically. Lab results can be tagged. For instance, if you want to show a trend for one lab value over the course of the patient's stay, I can hold down the control key to tag multiple items at once to pull into my note [*Demonstrate*]. You cannot tag vital signs.

Diagnostic, Microbiology, and Pathology: These components will show you various reports. Click on the hyperlink to view the Chest 2V report. If there is an image associated with the report, you can go to the view image icon in the report. Our training environment does not have images. [show icon].

Tagging Function: Tagging information is PowerChart's copy-and-paste function. You cannot drag and drop items from an exterior window but instead, you can tag it. **Demonstrate**:

- Highlight the final impressions from the Chest 2V and click Tag.
- To view the tagged item, click on the tagged items icon. I can pull this into my note from here, or I can wait to add this tagged item to my note after I choose a template.

Opioid Review: This is the MAPS component. The first time you click into this component you will have to accept the terms of use. The MAPS score will be listed above the view report hyperlink in the real environment. You can click on the report to review it. The information includes opioid administration and documented prescriptions in the last 2 years. To view a full opioid history, use the MAPS link on the resource page. After reviewing this information, make sure the 'I certify that I have reviewed PDMP information' box is checked and that you clicked Mark as Reviewed. This will put your time-stamped signature in this component. [*Demonstrate*]

New Order Entry: In PowerChart, there are several ways to enter orders. One such option is the 'New Order Entry' component within Provider View. However, in the ambulatory setting, this component is mainly used to favorite orders or other provider's orders. Selected orders are collected in the Orders for Signature area. There are three primary tabs:

- **Home:** This tab displays commonly used orders specific to your discipline.
- **Mine:** Here, you can access your favorite orders.
- **Shared:** Use this tab to search for other provider's favorite orders.
- To add orders, simply click on as many as needed; they will accumulate in your 'Orders for Signature' inbox. To finalize, navigate to the inbox and sign off on the orders. Remember that modifications are possible using the 'Modify' button. Additionally, you can mark orders as favorites by clicking the star icon.

Recommendations: Provider-maintained list. This list is generated from age, birth sex, and any problems documented in the chart. To add a recommendation, click on the plus sign.

Patient Instruction: The Patient Instructions component allows the provider to free text instructions to a patient. This is a **multi-contributor** component. Contributors should identify their specialty after writing their instructions.

Example: Patient is non-weight bearing for 6 weeks on right leg. **RTL, MD**

Subjective, Review of Systems, Objective/Physical Exam, Assessment and Plan: these are free text boxes locked to the right side of the screen. This allows you to build your note as you review the chart. You can re-organize the order of these boxes using the arrow icon. [*Demonstrate as needed.*]. Free text component where the provider can type, use Auto-Texts (dot phrases) or Dragon Medical One.

Free Text and Auto Text quick keys: Remember, in free text boxes you can use your dragon dictation, tagging/dragging and dropping, and auto-text to fill out the box. I want to show you a couple of quick keys to use with auto text.

- **Demonstrate: F9** will tab through drop-downs.
  - Example: **.doc_ROS_dropdown**
- **Demonstrate: F3** will tab through underscores.
  - Example: **.doc_ROS_blank**

- **History of Present Illness from the clinical intake form.** If providers have clinical staff entering a nursing HPI in their clinical intake, providers need to use the specialty-specific auto text to pull in the HPI.
    - For example: .pc_hpi_intake or .card_hpi_intake

There are other components on the list based on your specialty, but we have covered the main components you will need to know.

Any questions on the workflow components?

Orders

The QOC (Quick Orders and Charges) page shows the most commonly used orders for your specialty. The orders are all face up for you to see. The orders selected from the QOC page all collect in the Orders for Signature area [*Show the Orders for Signature icon*]. Before you generate your note, you will want to place your orders so they will be associated with your diagnoses. Find and click on the MPage at the top of the provider view.

Quick Order Preferences: You can use the page menu to customize this page.

- Drag and drop
- There are three icons across the top of the Quick Orders MPage.
    - Ambulatory- In Office Orders
    - Ambulatory (Meds as Rx)

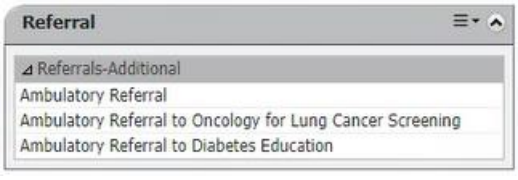
**Remember the only way the system will save your customizations is if you use the exit door to quit the system.*

Placing Orders: You can click on as many orders as you want. You can also use the Search New Order bar to search for orders not listed face up.

- **Orders to be done in the clinic: select the appropriate order with CPT code.**
- **Orders to be done at the hospital: select the appropriate order with no CPT code.**

Let's look at a couple of examples of placing orders.

- **Example Group 1:** Let's put in a Return to Clinic order, an Ambulatory Referral order, and a medication order. Find those orders and click on each of them.
    - *Demonstrate adding:*
        - Return to Clinic – choose the appropriate timeframe
        - Ambulatory Referral
        - Lasix (40 mg oral capsule), 2 Cap each dose, Oral, BID



- **Click on the Orders for Signature icon**. Here you will see the orders you selected. You will want to make sure that each order is associated with at least one problem. You can click on the grid to

change the associations. An order can be associated with more than one problem. [Demonstrate the process for associating orders to a problem.]

- **Modify:** You can modify any order before signing by selecting the Modify button. This will bring you to the main order section of PowerChart. Some orders will have to be modified before the system will allow you to sign the order because the order may have required details.
- **Sign:** Select Sign to sign the orders. Because the orders I chose have missing details, I am automatically redirected to the main order section of PowerChart.
    - **Return to Clinic order:** I see that the order has a blue circle with a white X next to it. This indicates more details are needed before I can sign off on the orders.
        - **Missing Required Details:** Double-click on the order sentence to view the order details. The yellow fields are mandatory. For a Return to Clinic order, I have to indicate appointment type from the drop-down.
            - **Choose:** an option
            - Now all required details should be completed for that order.
    - **Ambulatory Referral order:** Again, I see the blue circle with the white X next to the order.
        - **Missing Required Details:** Double-click on the order sentence to view the order details. For an ambulatory referral order, I have to indicate the Medical Service and the Referral Reason.
            - **Choose:** Cardiology for the service and put in Shortness of Breath for the reason.
            - Now all the required details should be completed for that order.
    - **Medication Lasix:** Now let's look at the Lasix order that was selected. Double-click on the order sentence to view the order details.
        - **Modify the order:** Fill in the required yellow fields. Remember the Send To drop-down allows you to eprescribe to the patient's pharmacy.
    - **Sign:** click sign once you have all the order details correct and the orders are placed.
- **Example Group 2:** Let's look at a few more examples. Let's place a lab order and an X-ray order. With these types of orders, you will problem want to schedule them for the future.
    - *Demonstrate adding:*
        - Lipid Panel
        - Hand MIN 3V LT
- **Click on the Orders for Signature icon**. Here you will see the orders you selected. Again, you will need to associate each order with at least one problem. [Demonstrate]
- **Sign:** Select Sign to sign the orders. Because the orders I chose have missing details, I am automatically redirected to the main order section of PowerChart.
    - **Lab: Lipid Panel:**
        - **Missing Required Details:** Double-click on the order sentence to view the order details.
            - **Fill in the Future Date to Have Drawn date:** to indicate that it is a future order
            - Now all required details should be completed for that order.
    - **X-ray: Hand MIN 3V LT:**
        - **Missing Required Details:** Double-click on the order sentence to view the order details. Fill in the symptom.
        - **Designate the order as a future order:**
            - In the Special instructions, Notes to Scheduler, or in the Order Comments write, "to be completed in 3 months." This will add the statement to the order sentence and designate this order as a future order.
    - **Sign:** click sign once you have all the order details correct and the orders are placed.

Favoriting Orders: You can favorite orders to have quick access to them.

- **Example:**
  - Click on the Basic Metabolic Panel from the Labs section.
  - Click on the Orders for Signature icon.
  - Click Modify Details. This will bring you to the order section of PowerChart in the blue menu. Modify the order as needed.
  - Right-click on the order details and click Add to Favorites.
  - Click on the Favorites folder and select New Folder. Create a sub folder titled Labs.
  - Make sure the Labs folder is selected and click OK to add the order as a favorite.
  - Click on Cancel to return to the QOC page.
  - The favorited order should be in your Mine folder.

Practice: Have the providers practice ordering at least 3 more orders. Then navigate back to the AMB Workflow.

Would you like to try any of these steps?
Return to AMB Workflow.

Dynamic Documentation

Once your orders are signed and associated with a problem, you will see the orders attached to the problem in the assessment and plan section of your note. Next, it is time to generate your note.

Choose a Note Template: The available note templates are listed below the component section. Remember, anything that you have entered into the text boxes on the right-hand side of your screen will flow into the note type you choose. [*Make sure you have information in the free-text boxes then demonstrate choosing a note template.].*

- **Dynamic Documentation Note**
  - **Edit functions**: Within the note, you still have the ability to edit. You can also use dragon dictation from this screen, type, or use auto text. There are three symbols when hovering in the note. (Hover by the Vitals in class).
    - **Refresh**: Refresh the details to a more updated set of vital signs.
    - **Arrow**: Will add a line of free text.
    - **Remove**: Will remove the section/subsection
  - **Tagged items:** Any unused tagged items will be listed on the right side of the screen. You can pull these items into your note.
  - **Returning to provider view**: If you need to return to provider view use the back arrow. To return to your note, use the forward arrow. Be aware that if you click the note template hyperlink a second time, it will generate a second note. [*Demonstrate as needed*].
    - Another option is to use the drop-down next to the forward back arrows and select between provider view and documentation. [*Demonstrate as needed*].
  - **Refreshing a section**: If you add something in a free text box in provider view and then return to your note template, use the refresh icon to update the section. [*Demonstrate as needed*].
  - **Save the note:** Notes can be saved and completed at a later time. When saved, the note will appear as 'In Progress' within the Documents component. To finalize the note, simply click on the hyperlink.

Remember, in the Message Center, the 'Saved Documents' section will display a list of your unsigned notes.

- **Sign/submit/forward note**: When you are ready to sign your note, click Sign/Submit. A screen will pop up to allow you to forward your note to another provider to sign or review.
  - **Example**: Let's send this note to our test physician.
  - Type in Test to the search bar.
  - Select Test MD, Physician from the list and then click OK.
  - You have the option to send the document for review or to send the document to be signed. Click Review.
  - You can favorite this physician by clicking the star icon next to their name. This might be helpful if you commonly send your notes to a certain provider.
  - Click Sign.

- **Charge assist:** After clicking sign/submit charge assist will populate.
  - **Type of visit:** Select the visit type. [*Choose Office Visit Established Patient*].
  - **Choose complexity:** Next, choose the complexity of the visit and click Assign.
  - **Pick Note:** Use the Select Note hyperlink to choose your note and click OK. Charge Assist will read your note and tell you if the charges submitted match the documentation in your note. Charge assist may agree with the selected charges or recommend charging less or more.
  - **Modifiers:** Modifiers can be added at the bottom of this section.
  - **Problem List: Do not uncheck the problems listed.**
  - **Submit:** when done click Submit. Then you can close out of Charge Entry.
- **Modifying the note**: To modify a note, click on the note from the Documents component.
  - At the top you will have the option to Modify. Click Modify.
  - You can add an Addendum to the note or Revise the note.
  - **Revise:** Select Revise and click OK. Add or modify the note as needed and then click sign. After refreshing the Documents component, the note now has a small blue triangle next to the note type. This indicates that the document has been modified.
  - If additional charges are being added or changed, then resubmit your charges through charge assist.

Any questions?

****Return to the PowerPoint Slide to complete the remaining slides (Launch support, class eval, continuing education credit, etc.)****

If providers need more practice, try the following:

- Sending a message to clinical staff
- Writing a note and then modifying the note
- Add more orders
- Practice tagging items
- Create an auto text and use it in a note