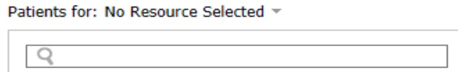
MarshallHealth

PowerChart Ambulatory
Pocket Guide

PowerChart Ambulatory©
Non-Provider Pocket Guide

Ambulatory Organizer – Schedule View

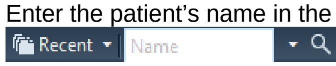
1. The organizer will default to the **My Day** schedule.
2. To locate additional providers or resources click directly on **Patients for:**



   a. Search for the additional resource:

   b. Click on the patient name to open the chart.

Whenever possible patient charts should be opened from the schedule. This ensures documentation is captured on the correct encounter/FIN. Access to patient charts that are not on the schedule will require a patient search.

a. Enter the patient's name in the patient search field 

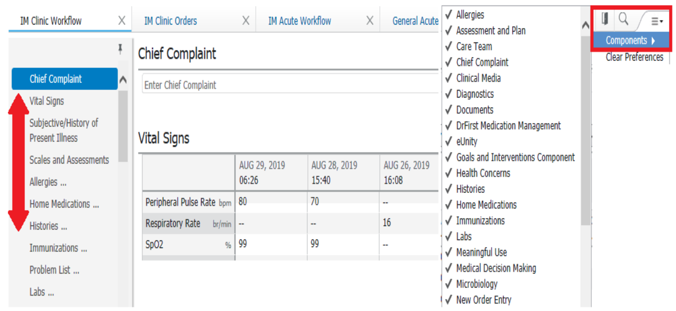
(upper right).
b. Click **Enter** to display matching patients on top.
c. Lower portion of window displays patient encounters.
d. **Select correct patient <u>and</u> correct encounter FIN**.
e. Click **OK** to open the chart to the appropriate visit .

* *You will be prompted to declare a relationship.*

Workflow Views/mPages

Each specialty has it's own tabs for workflows and quick orders. Additional specialty tabs may be added, and the tabs rearranged by dragging and dropping left to right.

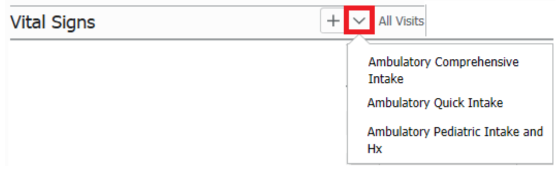
The workflow views contain the following components where patient data can be reviewed and added



Workflow components can be removed from the list by uncheking the components ≡▾ in the upper right corner and/or rearranged by priority top to bottom on the list using the Drag and Drop method.

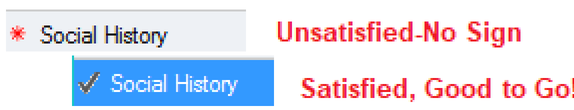
Workflow and Quick Orders Pages

1. Click the Workflow tab to Review all available information with the patient.
2. Click the dropdown Arrow next to Vitals to open Intake forms.



Intake PowerForm – **General Guidelines**

- Some tabs or fields are ‘conditional’; A pertainant positive answer (e.g. “*yes*” –to **Pain?)** will open areas for entry of additional detail (e.g. pain location, numeric value, etc.)
- Orange Asterisks indicate a Required field (field has yellow background) exists in that section. You cannot sign the form without addressing the required fields.



Intake Components

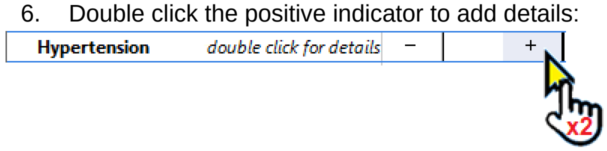
1. Enter the Chief Complaint
2. Enter Vitals, Height, and Weight Dosing
3. Risk Assessment – Pain, Depression Screening
4. Social History – Includes Tobacco use – contains

   ** Required components* (PowerForm can NOT be signed without addressing these elements).

To satisfy review requirement for subsequent visits, **right-click**, select **Modify**, then click the **OK** button.

5. 

Family History
6. Double click the positive indicator to add details:



Medications

1. Select **Meds** and Review all documented meds..
2. **Document compliance** by right clicking on highlighted medication(s) in the profile view.
3. Select **Add/Modify Compliance,** add comment if necessary
4. If medication course is completed (e.g. antibiotic) right click medication and select **Complete**.
5. Click **Sign.**
6. If additional home meds need to be added; select the **Document Medication by Hx** tab at the top left.
7. Select **Add** at top of screen **(+Add).**
8. Search window will open, search for the medication
9. Select the appropriate medication and complete known order details (dose, route, frequency).
10. Select **Compliance** tab and document compliance
11. Click **Document History**. The view will return to the Medication List.
12. Click **Document Medication by Hx** at the lower right
13. If there are **No known home medications** or you are **unable to obtain information on compliance**, click **Document Medication by Hx**. Select **No Known Home Medications** or **Unable to obtain** from checkboxes at the top of the screen.
14. Click **Document Hx** (bottom left of screen).

Allergies- Adding/Modifying/Reviewing

1. Select **Allergy** from Workflow view or Menu
2. Click **+ Add**
3. Enter the first few letters of the allergy in the ***Substance** field and click the binoculars to **Search**.
4. Double click the allergy from the list to select.

5. Search for the ***Reaction** symptoms.
6. Complete ***Category** and ***Type** fields as appropriate
7. Click **OK**.
8. To modify or Cancel an allergy entry, right click the item in the Profile view.
9. Select **Modify** or **Cancel**
10. Add or change fields as appropriate and click **OK.**
11. Select **Mark all as Reviewed** at the top of the screen to indicate review of allergies.

Procedure History– Reviewing/Adding

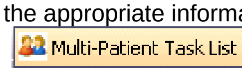
1. Select **Procedures** from workflow view or menu.
2. To document review of existing procedures click **Mark all as reviewed** button.
3. To add a procedure select the **Add (+ Add)** button.
4. Enter **procedure name** and Click the binoculars.
5. Select appropriate SNOMED procedure term from the list that appears.
6. Click on **OK.** Complete additional fields if known.
7. Click **OK** or **OK & Add New** (to continue documenting additional procedures).

Problem List

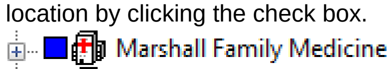
1. Select **Problems** from workflow
2. Review the active problems list and mark each as **This Visit and/or Chronic**
3. To add a new problems enter the term, CPT or ICD 10 in the **Add Problem** Search field.
   The list of matching terms/codes will appear .
4. Click **OK**.
   **Only Physicians should be entering diagnosis.*

Setting up the Multi-patient Task list

To display patient lists with your departmental tasks only, the Multi-patient Task list should first be configured to display the appropriate information.

1. Click 

 on the organizer toolbar.
2. It is necessary to set display options to pull in the proper information.
3. Right click on the words **Assigned Tasks** on the Gray information bar.
4. Click **Customize Patient View**.
5. On the Time Frames tab select the period to display (Recommend 1 week back and 1 day forward):
6. On the Patient List tab click locate the department location by clicking the check box.

7. Click OK to display the tasks for the selected area.
8. Right click the task and select Chart Details…
9. Fill out the PowerForm and Sign using the green checkmark in the upper left corner.

To see tasks for a single patient, open that patient chart and click on the Activities and Interventions tab of the Table of Contents.

Ad Hoc Charting-Documenting/Modifying/Uncharting

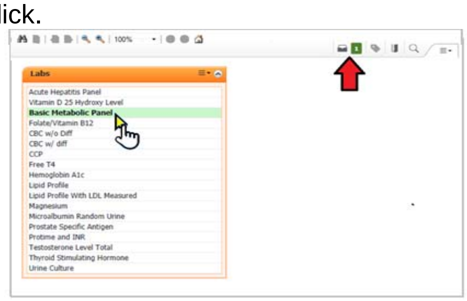
1. Select **AdHoc** icon from the toolbar to document an assessment, procedure, POC test result, record/transcribe labs, etc.
2. **Folders** will appear which contain forms for specific documentation/Specialty areas.
3. **Click Intake/Assessment** folder to display various intake documentation forms.
4. Select the forms needed for visit (can multi-select).
5. Select **Chart on the lower right of the pane.**
6. Reminder: Indicates **required** field (yellow fields).
7. **Sign** forms upon completion by clicking on at the top left of form.
8. To modify a completed form: Click the **Form Browser** tab on the Table of Contents and locate the desired form. Right-Click the form and select **Modify.**
9. Edit documentation and **Sign** .
10. To **Unchart** a form completed: Click the **Form Browser** tab on the Menu list. Right-Click the form and select **Unchart.**
11. Enter the reason for Uncharting in the unchart dialog area and **Sign** the comment.

Many forms are associated to note templates that will pull data into the provider visit note. Examples include the Medicare Annual Wellness Assessment form and Developmental Milestones forms.

Placing Orders from the Quick Orders Page

Prior to entering orders, it is recommended that a diagnosis be recorded by the responsible provider to which orders can be associated. Alternatively, non-provider staff may enter a reason for visit or chief complaint as a “working diagnosis” so that orders can be entered, signed, and routed to the responsible provider for co-signature.

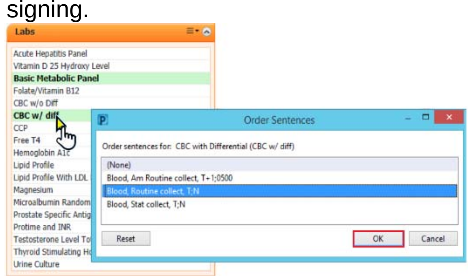
1. Click on the Quick Orders tab at the top of the Workflow View.
2. Locate the order within the desired category and click on it to select.
3. Click **OK.**
4. At the top right of the Quick Orders Page you will note a “recipe box”  with a number to its right. This is the Orders for Signature indicator. The number will increase for every additional order you click.



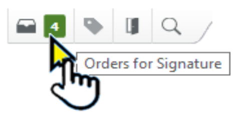
Addressing Order Details

1. Orders that have recommended sentences may prompt the user to select details such as status (Stat, Routine, Timed Study), or for Medications Dose, Route, Frequency, etc.)

2. Select the appropriate order sentence if it is available, otherwise, select (None) and modify order specifics as part of the review process prior to signing.



3. When all orders have been selected click the **Orders for Signature** indicator:

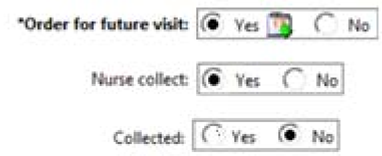


4. Orders with the  icon have missing required details that must be addressed.

5. **Sign** the order.

Lab Orders

*Specimen type (Blood, Sputum, CSF, etc.)
*Collection Priority (Stat, Routine, TS, etc.)
*Specimen source (body site)
*Requested **Start** Date/Time: Defaults current date/time, change if appropriate
* All orders will default to **Future** Status
If a Nurse will collect the specimen the order details must reflect the following:



Imaging Orders

*Requested Start Date/Time: Defaults current date/time, change as appropriate

*Reason for Exam: this is not necessarily the same as diagnosis, but gives the imaging team better information regarding what views should be captured.

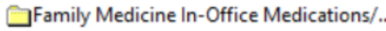
*All orders will default to **Future** Status

Medications/Immunizations Given in Clinic

1. Select **Quick Orders** mPage
2. Your common departmental meds may be listed beneath these categories or click **New Order Entry** to open the order profle and search.

- or -

3. **Make sure you are selecting *In-Office or Rx***



vs.

4. Select the correct order/sentence from the list or Search for the orderable.
5. Enter the ordering provider and communication type. If additional medications required, follow steps 3-4.
6. Click **Done** to close the order entry window.
7. Complete order details. Indicates missing detail.
8. Yellow arrows link to individual missing details
9. **Sign** the order(s).
10. Order will be listed as ***Processing***, click **Refresh.**
11. Access **Activities and Interventions** from the Table of Contents or MPTL from toolbar to display tasks.

In-Office Medication Administration

1. Click the 

toolbar button
2. Click the **Next** button to bypass wristband scan
3. **Scan** the medication/immunization barcode
4. **Click** the checkbox next to the medication


5. Provide a **Reason** the wristband was not scanned.
6. **Scan** the medication/immunization barcode
7. ***Make sure to select the administration charge!***
8. Complete administration details and **Sign**.
9. **Refresh**. Task will be complete and drop off list.

Immunization by History Documentation

1. Select **Immunizations** on the workflow
2. Click the Import button on the lower right to update the list from HealtheRegistries.
3. Click **View Forecast** to see what is **Due, upcoming, or** to **Document History.**
4. Click the **Document History** button.
5. Choose appropriate vaccinations from the list by clicking **Select**
6. Enter the administration date, if known.
7. Enter the **Source** of Historical Info from the drop down list.
8. Enter the Product & Details if known and Comments if appropriate.
9. Click **Submit**
10. Immunizations to be administered in the clinic will follow the medication administration process.

Obtaining External Prescription-Document Meds by Hx

Dr. First is accessible from the Ambulatory Workflow M Page and can be used to populate the documented medications by history, which is required prior to performing the provider performing Medication Reconciliation.

This application queries national insurance and pharmacy databases based on last name, first name, date of birth, gender and zip code as these are standard EHR connecting requirements.

External medication history is stored and queried in the EHR and can be added to the patient's active medication list as current medications.

1. From the Ambulatory Workflow M Page, click the component ***DrFirst.***
2. Click the view (3, 6, or 12 mo.) that you want to retrieve, then click **Document History**.
3. DrFirst will then retrieve the data.
4. There is a component in Dr. First that displays any existing medication that exists in Cerner. The external medications can be converted to Prescriptions or to Documented Medications by right clicking on the appropriate medication.

Converting an external med to a documented med:

1. Once the action is selected the user is prompted to sign the order into the legal chart: Orders for Signature
2. The documented medication will be displayed in the orders profile.
3. Click the **Sign** button to commit the historical medication to the record.

Converting an external or documented Med to a Rx::

1. When the convert to prescription option is selected the user is prompted to select an appropriate SIG:
2. Click **OK** when the appropriate dose, route, frequency and dispense amount have been selected.
3. The Prescription order will display in the orders profile with the missing details icon displaying if any additional information is required:
4. When a provider with an established Surescripts' number enters a prescription they will have the option to send the prescription electronically:
5. -OR- to select a printer associated with the computer they are logged into.
6. When all details have been addressed click **Sign.**
7. **Any failed Rx transmissions will be returned to the departmental eRx pool**

Renewing Prescriptions

Rx must be in **Ordered** status on the medication list or order tab to prescribe.

1. Right click the prescription to be renewed on the medications list.
2. Select **Renew** and choose the supply and # refills.
3. Verify pharmacy routing with patient.
4. Click **Orders for Signature** (lower right of screen).
5. Click **Sign** (lower right of screen).
6. **Refresh** screen. Medication selected for refill will be in complete status, renewed medication will be in ordered status.

Converting Documented Meds by Hx to Prescriptions

1. Medications that are **Documented by History** can be converted to active prescriptions.
2. Right click and select **Convert to Prescription.**
3. Continue from step 6 – **Prescription – Ordering.**

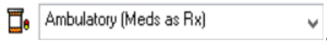
Converting Meds to New Prescriptions

1. Medication orders in the **completed or discontinued** status can be converted to an active prescription .
2. Right click completed or discontinued medication
3. Select **copy.**
4. Continue from step 6 in **Prescription – Ordering**.

Order Favorites

1. Select **Orders (+Add)** on the menu list.
2. Search for an order or medication.
3. Right click order and select **Add to Favorites.**
4. To save orders with the order details – enter the order details, before signing the order, right click the order and select **Add to Favorites**.
5. Select the **Favorites** icon to verify.
6. **Allergy substance, reaction and Problem/Diagnosis favorites** can be saved by selecting then clicking **Select to Favorites** –after the search action.
7. To Organize Favorites, Click the drop down next to the yellow star icon
8. Click **Organize Favorites.** Use screen instructions.

Prescriptions and DME – Ordering

1. Select **Orders (+Add)** on the menu.
2. Change **Type** of order to **Prescription**
   

   .
3. Enter prescription name or DME in the Search field
4. List will appear with medication/DME name and medication name with different order sentences.
5. Click the **order** requested by provider.
6. Enter the **Ordering Provider** and **Communication Type**. Click **OK.**
7. Click **Done** to close the order entry window.
8. Complete order details by clicking the specific order detail being addressed. Choices will be listed in **Detail Values** window or enter free text value.
9. 

   Routing choices are **Do Not Send, Printer, Pharmacy (fax**).
10. Select **Do Not Send** if calling in prescription
11. Select **Pharmacy** if Auto Faxing prescription.
12. Select **Printer** when printing in clinic. Printer displayed is default printer for user.
13. Printer can be changed by clicking on  and selecting printer destination.
14. **Sign** the order(s) (lower right of screen).
    Note: Prescriptions and DME supplies printed must be signed by provider.

Messaging, Proxies and Pools

To start a message, click **Communicate** on the tool bar.

Messaging – Create New Message

1. If within the correct patient's chart, Click the **Communicate** icon .
2. If outside the patient's chart enter the patient's last name in the **Patient** field and **Click** the binoculars.
3. Select the patient and click **OK.**
4. Enter any message recipient(s) in the **TO** and **CC** boxes. To include yourself as a recipient click **Include Me.**
5. The **SAVE TO CHART** field will default.
6. Select a Template in the Subject dropdown if desired, or free text a message **Subject**.
7. Messages will default to **Save as**: Phone messages. Select a different folder to save to if needed.
8. Free text or use auto text to populate the message.
9. Select any additional messaging/reminder options.
10. Click **Send.**

Messaging – Replying or Forwarding

1. Open a message and click **Reply** to sender or **Reply All** to include all message recipients.
2. Compose the response or insert auto text.
3. Set a reminder or due date as necessary.
4. Select any additional messaging options and **Send**.
5. To Forward a message, click the **Forward** icon and proceed with steps 2-4 above.

Proxy – Granting

1. Click the **Proxy** tab in the **Inbox Summary**.
2. Click **Manage** button.
3. Click **Given** button at bottom of screen, then **Add.**
4. Select any recipient from the **User** Search.
5. Select **Begin** and **End** dates.
6. Select **Available Items** to Grant.
7. Click **Accept & New.**
8. The users displayed in the **Proxies Given by Me** pane are authorizations you have granted others.

Proxy – Viewing Another User's Inbox

1. In order to view another user's Inbox, you must have proxy rights to do so
2. Click the **Proxy** tab in the **Inbox Summary.**
3. From the **Proxy** list, select the Inbox you would like to access
4. Work in the proxy's Inbox as if it were your own
5. To review an item and leave for the original owner, **close** the item. Do not sign, refuse or forward.

Opt in to Pools

1. Click the **Pools** tab in the **Inbox Summary**.
2. Click **Manage** button.
3. Scroll through the list of available pools and highlight those to opt in to <Ctrl + Click>
4. Click the **Opt In** button between the Available and Member Pools panes to opt in to the pool.
5. The pools are available in the Pools drop down of your inbox.

Referral Management

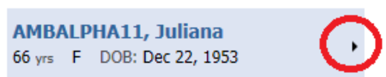
1. Click 

on the toolbar. The first time you access the queue you will need set up the **Originating** and/**or Receiving** worklist; thereafter they will be available in the list selection dropdown.
2. To set up a list for your department's referrals, click 

3. Click **Add**
4. Enter a **Name** for the list (e.g. FM Outbound Referrals).
5. Locate your department within the **Available Locations** [**Referred From** Location Required]
6. Check the box next to the correct **location.**
7. Select the **Medical Service** for your department
8. Select the **Statuses** you wish to see in this list type
9. Click **Save**

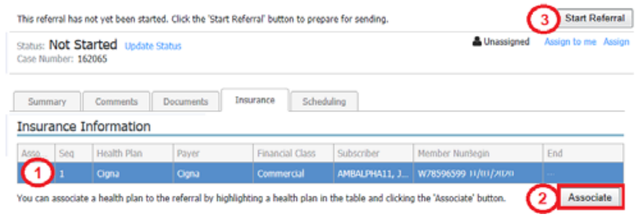
<u>**Send a Referral Request**</u>

1. To open the referral, click the arrow on the right margin:



2. Review the **Summary** Tab
3. **Make sure** the **Refer To Provider** <or> **Location** is populated. If missing, the **Generate** button will not be available to route the referral when ready.
4. Click the **Insurance** tab to continue.

1. Click the insurance line to highlight
2. Click **Associate** to link the insurance to the referral



3. Click the **Start Referral** button.
4. If all requirements are satisfied the **Generate** button will be enabled.
5. The **Transition of Care** document will be compiled.
6. Click the **Send** button.
7. The referral will be in a **Pending** status until acted upon by the Receiving Department

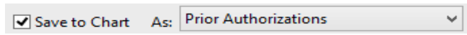
<u>Receiving Referral Requests</u>

1. Open the referral item as previously illustrated.
2. Click **Accept** or Reject.
3. Notify scheduler of the request or they can schedule it from the CPM referral queue.
4. When the appointment is made it can be associated to the request by highlighting the appointment and clicking the **Associate** button.

5. The Status is updated to **Scheduled**, (also visible to the Originating department) indicating the patient should be contacted with appointment details.

Prior Authorization – Nurse Workflow

1. **Order for Procedure/Exam/Test is placed**
2. Open Procedure Request message in Clinical Pool.
   a. If nurse obtains insurance authorization proceed to step .
   b. If Pre-Cert resource will obtain authorization data, nurse will change the message **Save As** Dropdown and **Forward** the Request to Prior Auth Resource.



3. The resource obtaining authorization data will fill in the Prior Auth message template and copy (Ctrl C).
4. Locate the procedure request in the appropriate  Win32 Auth queue.
5. Right click the correct request and select **Modify…**
6. Click the **Details** tab
7. Scroll down to the **Authorization comments…**
8. Paste the Authorization Data copied in step 4 (Ctrl V)
9. If Pre-Cert completes template, reply to nurse/pool with authorization data.
10. Nurse or Pre-Cert resource will move request to appropriate scheduling queue in Win32 (Right click request in queue>**Move**)
11. **Forward** scheduling request to appropriate team
12. When nurse/pool receives Scheduled **Reply**, contact Patient and document in the message>**Save** to Chart
13. **Delete** the message.

Notes

First Line of Support: SuperUser
Name: ______________________
Extension: __________________