Cerner Basic Competencies

Perform a self-assessment of your Cerner competency with the list below. If you are not comfortable with completing the task listed, click on the task or a video to learn more, or contact your training resources for additional education.

ALL

1. Chart Review
   - Log in, locate a patient and choose the correct encounter
   - Navigate through Workflow Pages videos
   - Review and trend lab, radiology, micro, and pathology data
   - Quickly locate documents using Notes tab from menu

2. Message Center
   - Create, send and manage messages
   - How to forward results and reject results you don’t own
   - Create proxy and steal proxy from another provider
   - Sign and co-sign documents

   - Medication Reconciliation
   - Patient Education
   - Electronic Prescriptions

4. Orders
   - Place orders and Powerplans
   - Create favorite orders, use other users’ favorite orders and powerplans

5. Documentation
   - Add Problems and Diagnoses video and find specific (billable) diagnoses video
   - Add Family, Social, and Procedure histories
   - Tag text and labs video
   - Create a note (Dynamic Documentation and maybe PowerNote)
   - Use dictation using a microphone or your smartphone and create Dragon Templates
   - Document on the Workflow Pages
   - Take and insert a picture into a document, or find one not attached to a document video (Powernotes)
   - Change document types, titles and dates before and after signing video
   - Create and use dot-phrases
   - Add confidential documentation: diagnoses & notes video
   - Update PCP

Outpatient Only

- Review your daily schedule and look back/ahead
- Portal Messaging
- How to add standard and custom expectations in Health Maintenance
- How to satisfy and change expectations in Health Maintenance
OB Outpatient Basics
- Add and Close a pregnancy
- Use Antepartum Intake AdHoc form for a new OB visit
- Enter pregnancy history
- Enter outside prenatal labs
- Find pregnancy information on the OB Workflow video
- Change the EDD based on new dating info video
- Document on an OB visit card video
- Use OB .phrases
- Order routine pregnancy orders using AMB OBGYN Powerplans
- Use Women’s Health Quick Orders video
- Print prenatal record/Pregnancy Report
- Find Pregnancy Summary from a previous pregnancy in our system

OB Inpatient Basics
(all from OB outpatient plus:)
- Find the Tracking Shell and recognize Tracking Shell icons
- Launch a chart from the Tracking Shell
- Use the OB Inpatient Workflow video
- Document a Delivery Note using Powernotes video
- Place orders using OBGYN and PHA OBGYN Powerplans
- Find Partogram and document Labor Onset Date/Time in IView video
- Log in to Fetalink and review fetal monitoring

Surgery Basics
- Find and open a Preadmit encounter
- Enter pre-op orders for a scheduled surgery using a multiphase pre-op powerplan video
- Enter Pre-op orders for an inpatient surgery using a single phase pre-op from inpatient/ED Powerplan
- See the surgery schedule
- Use the appropriate post op Powerplan for your surgery
- Perform Admission Meds Rec on same day admits, Transfer Meds Rec on inpatients and Discharge Meds Rec on outpatient surgeries.

Inpatient Basics
- Find and use the Admit, Manage and Discharge MPages
- Prioritize Diagnoses
- Enter End of Life Wishes
- Document a medication history
- Use multiphase admit Powerplans
- View and select excluded orders from Powerplans, add orders to a phase and discontinue Powerplans
- Use Quick Orders Inpatient Medicine and ICU video
- Understand order frequencies
- Perform Admission, Transfer and Discharge reconciliations
- Assign Primary Contact
- Use I-Pass
- Add Patient Lists and add and remove patients from lists
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General Basics

1.1. How do I log into Cerner?

1.1.1. From Work?

1. Locate the Cerner PowerChart Icon on the desktop
2. Double-click the icon and wait for login screen to appear
3. Enter your username and password and click OK
4. Wait for Main Home Screen to appear
Toggle between Home screen, Message Center and Ambulatory Organizer.

The Home Screen includes the Message Center and the Ambulatory Organizer. You can toggle between a full screen Message Center and the full screen Ambulatory Organizer by selecting the button icons above the main screen.

1.2.1. From Home?
Download and install the correct version of Citrix Receiver or Citrix Workspace App for your device: https://www.citrix.com/downloads/
Go to this link and log in https://vchaca.cernerworks.com/Citrix/ProdWeb/

Then locate the Powerchart Icon and follow the steps above.

1.3. How do I see my patient schedule?

Answer:
1. From the My Day View, select the down arrow next to “Patients For: ”

2. Select Add Other option in the drop down menu
3. Type in your name (if your schedule does not automatically load) or the name of another provider and hit the enter key
4. Select the appropriate name until it highlights blue

```
Resources Search

Search for:

[Search]

Resources List:

[Resource List]

OK Cancel
```

5. Click the OK button
6. Select the “Patients for” drop down menu and click in the check box next to the provider name to add the resource – then click Apply to add the schedule

1.4. How do I understand what’s on my schedule?

Answer:

1. Color Status Bar

- **Light Blue** = Confirmed Appt.
- **Orange** = Seen by provider
- **Medium Blue** = Checked In
- **Dark Gray** = Checked Out
- **Green** = Seen by Nurse/MA/Student

2. Schedule

```
[Schedule]

1. Color Status Bar
2. Appointment Time
3. Patient name and demographics
```
4. Appt type
5. Textual Status
6. Visit Notes
   a. Click the dithered note icon to add a quick note about the visit to the schedule – This note does not map anywhere else
7. Add a resource schedule (Patient's for menu)
8. User Preference Menu

1.5. How do I open a patient chart?

Answer:

1. The best way to open a chart is from a schedule, patient list, tracking shell. This will ensure you are on the correct encounter.
2. If you need to open a chart without using one of these, locate the Patient Locator window on any screen
   a. The Recent drop-down remembers the last 5 patient charts viewed
   b. The drop-down next to the input window allows you to select between Patient Name and Medical Record number
   c. The Magnifying Glass performs the search (you can hit enter)

3. Type the last name or MR# in the input window and perform the search. Names are entered last name first (e.g. Doe, John)
   a. You cannot type a partial name in the window unless you use an asterisk “*” after the portion.

4. You must select the correct encounter (notice 2 encounters listed above) in order to insure the correct information will be available and that your orders will work.
5. Select OK to open the chart
6. Up to 4 charts can be open simultaneously, with differently colored banner bars differentiating each chart (Blue>Yellow>Green>Purple)
1.6. How do I establish a Provider-Patient Relationship?

**Answer:**

1. You will be asked to establish a relationship with any patient chart you access provided you have not established a relationship previously. The purpose of this function is to declare your purpose for accessing the chart so any information related to this patient is routed appropriately to you, if at all
   a. Your choices are:
      1) Inpatient Attending
      2) Non-Clinical Review
      3) Outpatient Primary Care Provider
      4) Outpatient Provider

2. Select OK after selecting a relationship (Relationship selection will be highlighted blue)
1.7. How do I understand the patient chart?

*Answer:*

1. Menu Buttons Toggle between different windows, such as Message Center and the Patient Schedule, allows access to Patient List creation, Ad-Hoc documentation, a calculator, and the Exit button.
2. The Banner Bar contains demographic information for the patient.
3. The Menu list contains the Table of Contents for the chart and can be pinned (always visible) or unpinned (hidden until hovered over).
4. The M-Page contains dynamically updated information organized in unique headers. It allows for direct data input, such as documentation, medications, orders, and allergies.

1.8. How do I modify a Provider-Patient Relationship?

*Answer:*

1. Select Patient Information from the Menu List.
2. Select the PPR Summary Tab

Right-Click over your name in the **Visit Relationships** window

Select the Available relationships to assign drop-down and modify your relationship. You can also select an end date/time for the existing or new relationship setting
1.9. How do I refresh my screen?

**Answer:**

1. Select the Cycle icon periodically to refresh the screen and send information to the computer servers – Makes the new information available to other users who may access the chart.
   a. Refresh often
   b. Refresh after new orders or significant alterations in the chart
   c. Refresh often
   d. Refresh often
   e. If all else fails, refresh...
1.10. How do I understand Favorites?

**Answer:**

1. Favorites are pre-set, pre-completed selections, which include specific details for your selection.
2. You may have favorites for Diagnoses, Problems, Allergies, Medications, Orders, etc. Your favorites are found by locating and selecting the star 🌟.
3. They are organized into predefined department folders, personal folders and for orders you can also search and use other people's favorites.
4. On the Workflow Order Entry Component you can select Mine (for the folders and orders you create), Departmental (for pre-set folders), or Shared (for other users).
5. The favorites can be organized into folders and recalled whenever needed to speed efficiency and enhance convenience.

![Diagram of Ambulatory Orders Root]

- **Home Folder** (where all the main folders are)
- **Individual Favorites** (you make them)
- **Move from Subfolder to Major**
- **This folder will also sometimes take you Home**
NOTE: the folders you see will be different based on what encounter type you are on (inpatient vs outpatient) and whether you are searching for In office/Meds as Rx, or Inpatient/Prescription so try changing those settings and check that you are on the correct encounter if you can not find what you expect.

1.10.1. How do I create a favorite?

**Answer:**

1. For Orders in the Workflow New Order Entry component:
   1. Select a tab that contains the folder in which you want to add an item as a favorite.
   2. Open the appropriate folder.
   3. Position the pointer over the order you want to add. If you see a gold star to the right of the item, it means this item has already been added to your favorites. If you see a gray star, the item has not been added as a favorite.
   4. Click the **gray star**. The system displays the Add Favorites dialog box.
   5. Select the folder you want from the list and click **Add**. The system adds the item to your Favorites folder, closes the Add Favorites dialog box, and displays a gold star icon when you position the pointer over the item row.

2. For orders with order details or for other favorites, initiate the order process or creation of Diagnosis, Problem, or Allergy
3. Add the desired details and then you may see **Add to Favorites** at the bottom left corner of the order window. You may click the button there
4. Prior to signing the order you may also right click to locate the Add to Favorites... menu choice

5. By selecting Add to Favorites..., you may create a new folder (Select New Folder button, type the name of the new Favorites folder (e.g. Pain, click enter to save the folder name, make sure the folder is highlighted with a single click) and save the favorite in that folder
6. You may also access your favorites directly from the M-Page.

7. In the Add order window, selecting the drop-down next the Favorites icon allows you to organize your favorites.
1.10.2. How do I move my favorite item to a different folder?

**Answer:**

1. Select Organize favorites from the drop down next to the Favorites icon and locate the item you wish to move.

2. Select the item by single-click and select **Move to Folder**.

3. Select the folder you wish to move the item to and select **OK**.
1.10.3. How do I move a favorite folder to a different folder?

**Answer:**

4. Select Organize favorites from the drop down next to the Favorites icon and follow the detail listed below:

- Click **Move to**
- Select the folder you want and click OK
- Verify the folder you want to move is in the right place
1.11. How do I create patient education?

1. Use the Workflow Patient Education component

2. Select the **Education** or **Medication Leaflets** tab. The system displays a list of education items or medication leaflets. If a This Visit problem or chronic problem has been documented for the patient, the Education tab displays suggested items in the This Visit Problems and Chronic Problems sections based on the associated problems and diagnoses.

3. Begin typing a term in the search box, and a list of materials matching the search term are displayed. You can also click **Favorites** next to the search box to see a list of favorite education items or medication leaflets, depending on which tab you selected. When searching in the Education tab, favorite items and favorite custom items are listed in the first section, non-favorite custom items are listed in the second section, and all other items are listed in the last section. Items in each section are listed in alphabetic order.

4. Select the item you want to add. The system adds the selected item to the **Added Education** box or the **Added Medication Leaflets** box.

5. To edit the educations: select an item from the **Added Education** box and click the **edit** icon. The system opens the *PowerChart* Patient Education window. Make the appropriate edits and click **Sign**. The system saves the changes, closes the window, and displays the Workflow Patient Education component.

1.12. How do I create a rounding/patient list?

**Answer:**

1. Use Patient List to build and view patient lists. Patient lists help you organize and easily access a large amount of patient data. You can view patient lists based on customized criteria, patient location, or your provider relationship. By building a variety of lists, you can group patients by logical categories and easily locate a patient’s chart rather than relying on a large single list. You can build up to 15 different patient lists. If additional lists are needed, your system administrator must modify the default setting. Some patient lists are populated automatically by the system while others must be built manually. In either case, you decide which lists you
want to be displayed. You can open a patient chart directly from a patient list, but you first must establish a relationship with the patient.
2. Patient Lists
   a. Some patient lists are maintained by the system that adds new admissions and removes
      transfers or discharges. You cannot add or remove patients to Location, Provider
      Group, and Medical Service list types.
   b. Building a Patient List - Organize patient charts in a way that is useful to you by
      building patient lists. You can update your patient lists quickly by adding and removing
      patients as often as you like.
   c. To begin building a patient list, open the Modify Patient Lists dialog box by selecting
      List Maintenance from the Patient List menu or by clicking .
   d. Click New to activate the patient list maintenance wizard.
   e. Select the type of patient list you want to build and click Next.

3. Several options are displayed on the left side of the dialog box, each representing a way to
   filter the patient list. When a filtering category is selected from the left side of the dialog box,
   you can select specific filtering options from the right side of the dialog box. These options
   differ depending on which filtering category is selected. Select the appropriate filters and
   enter a name for the list in the Name box. Note that, depending on which type of list you are
   creating, certain filters must be selected for you to proceed from this step.
   a. Click Finish to add the new name to the Available Lists box on the Modify Patient Lists
      dialog box.
   b. Move the list to the Active Lists box by selecting the new patient list in the Active Lists
      box and clicking . Active lists are displayed on the Patient List. You can modify the
      display order by selecting the list and clicking either or .
   c. Click OK to save your changes and return to the patient list.
   Note: If you want to add provider proxies to the selected list, click Next.
   d. Move the list to the Active Lists box by selecting the new patient list in the Active Lists
      box and clicking . Active lists are displayed on the Patient List. You can modify the
      display order by selecting the list and clicking either or .
   e. Click OK to save your changes and return to the patient list.
   Note: If you want to add patient filters or provider proxies to the selected list, click Next.
   f. Move the list to the Active Lists box by selecting the new patient list in the Active Lists
      box and clicking . Active lists are displayed on the Patient List. You can modify the
      display order by selecting the list and clicking either or .
   g. Click OK to save your changes and return to the patient list.

4. Removing a Patient List
a. To remove a patient list from the Patient List view, perform the following steps:

**Note:** Since the system updates Location and Relationship lists and populates them with appropriate patient names, these list type are regenerated once you add them to the Patient List view. A Custom list either can be removed or deleted, the latter being permanent.

b. Open the Modify Patient Lists dialog box by selecting List Maintenance from the Patient List menu or by clicking.

c. Select the list from the Active Lists box.

d. Move the selected list to the Available Lists box by clicking.

e. Click OK to return to the Patient Lists view.

5. Deleting a Patient List

a. You can delete patient lists that you no longer use. A deleted patient list is destroyed and must be reinstated to be used again. A Care Team list cannot be deleted. To delete a patient list, perform the following steps.

b. Open the Modify Patient Lists dialog box by selecting List Maintenance from the Patient List menu or by clicking.

c. Select the list from the Active Lists box.

d. Move the selected list to the Available Lists box by clicking.

e. Right-click the list in the Available Lists box and click Delete Patient List.

f. Click **Yes** on the Delete Patient List message.
g. Click OK on the Modify Patient Lists window to save the changes and return to the Patient List view.
Message Center

1.13. How do I Navigate the Message Center Inbox Summary?

**Answer:**

- **Inbox**: Your own inbox – contains general messages, eRx refills, documents to sign or co-sign, results to endorse, orders to approve or co-sign, tasks and reminders
- **Proxies**: Inbox for which you have proxy right (you can access someone else’s inbox)
- **Pools**: Common pooled inbox for which members subscribe

1.14. How do I understand Message Center icons?

**Answer:**

- **Communicate**: Creates a new message, reminder or consult.
- **Reply All**: Opens the item, enabling you to send a reply to the sender and all recipients of the original item.
- **Open**: Opens the selected notification.
- **Complete**: Marks the selected item as completed.
- **Message Journal**: Displays a list of phone messages, reminders, and consultations that have been documented for the selected patient.
- **Forward**: Opens the item, enabling you to add text and forward the item to another user.
- **Reply**: Opens the item, enabling you to send a reply to the sender.
- **Delete**: Deletes selected item.
1.15. How do I sign a document?

**Answer:**

1. Select the message under heading “Documents” in the Inbox Summary, indicating you have a document to sign
2. Open the message and locate the Action Pane at the bottom of the window
   
   ![Action Pane](image)

3. Select the Sign button and then click OK or OK and Next if there are more documents to sign
   
   If you refuse a document, you must state a reason. You can also forward the document to someone else to review or sign. You must complete the additional details to forward the document.

1.16. How do I endorse labs?

**Answer:**

1. Select the message under heading “Results” in the Inbox Summary, indicating you have a result to endorse
2. Open the message and locate the Action Pane at the bottom of the window
   
   ![Action Pane](image)

3. Select the Endorse button and then click OK or OK & Next if there are more results to endorse
   
   If you refuse a result, you must state a reason. You can also forward the result to someone else to review or endorse. You must complete the additional details to forward the document.
4. **NOTE:** the Additional Forward Action will remember your last settings, so make sure you unclick it for subsequent endorsements if you do not want to keep forwarding your results.
5. **NOTE:** DO NOT use this method to forward results to staff that are patients. USE the patient portal.

**How do I schedule a reminder?**

**Answer:**
1. Select Communicate from either the Message Center window or from within any patient chart in the menu buttons above the chart M-Page

2. Select Reminder and complete the details in the Reminder Pane, including recipient (check the Include Me box to send a reminder to yourself) and details in the text window. Remember, the text in the window is just a template and can be modified in any way prior to sending the reminder. Select High or Notify to mark the reminder as high priority or to provide receipt notification.

3. Complete detail including when you want the message to show up in the recipient inbox or when you want the request to be “due by.”

4. If a response is expected, you may check a pre-set response by selecting an item from the Actions box in the bottom of the pane. This will only place the text at the top of the message for the recipient to see.

1.17. How do I create a patient letter with results?

Answer:

5. Select Communicate from either within the result message in the Message Center window or from within any patient chart in the menu buttons above the chart M-Page
6. Select Letter and complete the details in the Create Letter Pane, including adding any text to the preset letter. Remember, the text in the window is just a template and can be modified in any way prior to printing the letter.

7. You may Launch Orders or add additional results to the letter prior to sending.

8. You may forward the letter to another individual by completing the detail in the action pane at the bottom of the screen. This action may be used to forward to an assistant for printing/sending.

1.18. How do I send messages to the patient in the Patient Portal
If the patient has a patient portal account or a secure email, select To Consumer to include the patient as a message recipient. You must select this check box for the patient to receive the message.

When you are endorsing results, you can send a message to the patient at the same time by selecting Consumer Message in the upper left.
1.19. Message Center Pools

1.19.1. How do I opt in a pool?

Answer:

1. Select the Pools Tab in the Inbox Summary
2. Click Manage
3. Select the pool you wish to Opt in
   The pool will highlight Blue
4. Click the Opt In > button, then click OK
5. If the Pool is “Controlled” you may be unable to Opt In and will need to contact a Pool Administrator

💡 To send a message to a pool, you must type “/p” in the recipient box. This will call up a window to allow you to select a pool as a recipient.

/p for pools

1.19.2. How do I find out who is in a pool?

Answer:

1. Select the Pools Tab in the Inbox Summary
2. Click Manage
3. Select the pool you wish to Opt in
   The pool will highlight Blue
4. Select the pool you wish to check
5. Select Details at the bottom of the window
6. The members of the pool are located in the left lower portion of the window

7. Click OK in the bottom right corner of the window after reviewing the information

1.20. Message Center Proxies

1.20.1. How do I establish a proxy?

Answer:

1. Select the Proxy Tab in the Inbox Summary
2. Click Manage
3. Click Add to Give Proxy to someone
4. You can also click Manage to manage any Proxies taken from you
5. Enter a name to give proxy and select the down arrow if you plan to give proxy to more than one person at a time. Remember, you must leave a name in the User box for the system to accept the request.

6. Select the items for which you wish to grant proxy and select Grant, or you may select Grant All to grant access to your entire Inbox.
7. You may also establish a length of the proxy
   a. Select a pre-determined length if you plan to give proxy for a short time
   b. Select a long length (years) if you plan to establish a long-term proxy
8. When items have been selected and moved to the Granted Items window, the Accept & Next button will activate and you can select it or select OK
9. You will automatically send a message to whomever you granted proxy, letting the individual(s) know proxy was granted

1.20.2. How do I check a proxy?

Answer:

1. Select the Proxy Tab in the Inbox Summary
2. Click Manage
3. Review which proxies were given or received, time frame for proxy, etc.
Orders

1.21. How do I document a home medication?

1. Select Meds History from the Medications component

2. Click + to add

3. You will see Document Medication by Hx as the Type (you can also choose this from any order dialog to document medication history)

Be sure the correct selection
1.22. How do I document compliance with a home medication?

**Answer:**

1. Open an admission, discharge, or outpatient reconciliation window or navigate to the Medication List.

2. Right click on the medications you wish to document compliance
   a. From the Medication list may select more than one medication if the compliance result is the same by using shift-key or CTRL-key functions.

3. Select the correct compliance result from the drop down list in the compliance frame at the bottom of the medication list window.

4. Click Reconcile and Sign when documented.
1.23. How do I prescribe a medication?

Answer:

1. Three ways to initiate ordering of medications:
   a. Search in the Search box on the New Order Entry component. Make sure the filter is set to Meds as Rx
   b. Click Add from your Meds Rec
   c. Click Add from Orders Menu List and verify Ambulatory – In Office (Meds in Office) is selected from the window drop-down in the upper right corner

2. Enter Medications on the Search window select the appropriate dose amount. The selection list will adjust as you type
4. You may select a diagnosis prior to ordering medications in the diagnosis and problems list to the left of the order window.

5. Add as many medications as needed and select Done when completed.
   1. You will notice medications added to your scratch pad below the order window as you add medications.

6. Complete the order detail and either select a pharmacy or select "Do Not Send:" with a reason.
Modify order

Select Pharmacy or click … to change

Click Sign to send the Rx
1.24. How do I create a medication favorite?

Answer:

1. Initiate order for medication
2. You may see **Add to Favorites** at the bottom left corner of the order window. You can click the button there
3. Prior to signing the order you may also hover your mouse cursor over the medication you want to add and right click to locate the **Add to Favorites**... menu choice

4. Complete process for adding to favorites

💡 You should create your favorites **before** signing orders to ensure problem-free favorites creation. If you complete all the details for the order and save to a favorite, all the order details will also save, including diagnosis detail. The recorded diagnosis may be added to your list if not already listed. If you choose not to save the diagnosis detail, you will want to create your favorites **before** completing the diagnosis detail of that order.
1.25. How do I establish/change a pharmacy?

Answer:

Select ellipsis (…) to call Send To: window

1. Select from patient preferred list or select Search Tab to search for a new pharmacy
2. Complete search detail and select Search
3. Select the appropriate result from the list and click OK
How do I refill prescriptions from the M-Page?

**Answer:**

1. Locate Home Medications on the M-Page
2. Select the medication you wish to refill
3. Select Renew to refill the medication
   a. Cancel/DC stops the medication during the medication course
   b. Complete, completes the course of medications
4. Edit any appropriate details
5. Select Apply
6. Sign the order
1.27. How do I understand Orders?

**Navigating Order Details**

1. **Tabs:** Use the tabs to navigate the order details.
   - **Details:** The default tab that displays the details of the order. When an order is updated in this tab, the update is also displayed in the Details column (#4 above) of the orders list.
   - **Order Comments:** Allows you to enter additional information about the order.
   - **Diagnoses:** Displays the diagnoses (problem) being addressed for the patient in the current visit.

2. **Status Column:** States the current status of the order in the orders list. The following statuses can be displayed:
   - **Order:** The order needs to be completed and signed.
   - **Processing:** The order has been signed, but the page has not been refreshed.
   - **Ordered:** The order had been successfully entered and signed.
   - **Incomplete:** The order has been entered, but the user has not supplied all necessary information.
   - **Completed:** The order has reached its defined stop date and time.
   - **Discontinued:** The order has been discontinued by a provider.
   - **Cancelled:** The order has been stopped by a provider.

3. **Missing Detail:** A yellow highlighted field indicates that this detail is required and must be completed before signing the order.

**Orders Icons**

- **Order Details Not Complete:** Indicates there are required details that have not been completed for the order set.
- **PowerPlan:** Indicates the orderable is part of a PowerPlan.
- **Clinical Calculator:** Opens the clinical calculator so you can make a calculation.
- **Dose Calculator:** Opens the dose calculator.
- **Nurse Review:** Indicates that nurse review is required.
- **Rx Verify Indicator:** Indicates that the order is subject to pharmacy review and has not yet been reviewed by a pharmacist.
- **Rx refusal Indicator:** Indicates that a pharmacist has rejected the order.
- **Taper Dosing:** Opens the taper dose tool.
- **Sliding Scale:** Opens the sliding scale dialog box.

1.28. How do I order from Folders/Favorites or other users?

Use the New Order Entry component. Select, Departmental or Shared.
Select folders and subfolders to find the folder you want and then select the orders you need.

Complete the following steps to locate a *PowerOrders* shared favorites folder:
1. Click the **Shared** tab.
2. Enter as much as you know of a provider's name in the search box.
3. Click **Search**. A list of potential matches is displayed.
4. Select the provider you want from the list. The shared favorite folders of the provider are displayed in the lower half of the component.
5. Add the selected order or plan. If you click **Add**, the order is added to the scratchpad or the Orders for Signature area where you can modify or sign the order.

1.29. **How do I understand special Order Prefixes?**

**Answer:**

1. Order Prefixes are special letter sequences to help you locate and narrow searches in the order catalog. Listed below are the special sequences you need to be aware of.
   a. Text entry will look something like

   RAD Chest will narrow search to all chest x-ray orders in radiology

<table>
<thead>
<tr>
<th>Diagnostic Studies</th>
<th>Labs</th>
<th>Special Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRD – Cardiology orders</td>
<td>SO – Send Out</td>
<td>Respiratory</td>
</tr>
<tr>
<td>RAD – Diag. X-Ray and Fluoro</td>
<td>LAB Panels</td>
<td>Blood Transfusion</td>
</tr>
<tr>
<td>IR – Interventional Rad</td>
<td>• Prenatal</td>
<td>EKG</td>
</tr>
<tr>
<td>RESPIRATORY – PFT's</td>
<td>• ER</td>
<td></td>
</tr>
<tr>
<td>MAM – Mammography</td>
<td>• DIC</td>
<td></td>
</tr>
<tr>
<td>ECHO – Echocardiology</td>
<td>• Sepsis</td>
<td></td>
</tr>
<tr>
<td>NM – Nuclear Medicine</td>
<td>• Mental Health</td>
<td></td>
</tr>
<tr>
<td>CT – CT Scan</td>
<td>• Needle Stick</td>
<td></td>
</tr>
</tbody>
</table>
1.30. How do I understand Powerplans (Order Sets)?

Answer:

1. Use pre-build ordersets and save time.
   a. Powerplans are ordered in the same way as any other order.

2. Select desired options, right click and select “Modify Planned Order” to edit order details, if necessary.
3. Click on “+ Add to Phase” to add any additional orders not present in the powerplan.
4. To save your customized powerplan, click on “Save as My Favorites” for future use.
5. Initiate the plan to start execution and sign the orders.
6. PowerPlan names contain prefix for easy search
   a. EMER – Emergency
   b. ICU – Intensive Care Unit
   c. MED – General Medicine
   d. OBGYN – OB/GYN
   e. SURG – Surgery
   f. SPPR – Special procedures
   g. PED - Pediatric
   h. PSYCH – Psychiatric
   i. PHA – Subphase (See next section for more info about Subphase)
1.30.1. How do I understand subphases?

Answer:

Subphase is a module (group of orders) that can be plugged into multiple powerplans. For example, instead of repeating orders for DVT Prophylaxis in multiple powerplans, it's logical to build a DVT Prophylaxis as a subphase (module) and link to the desired powerplans.

The subphase can be ordered as a powerplan by itself or as a part of another powerplan.

Caveat: Subphase can NOT be added to another powerplan at the time of ordering. Only a powerplan designer can add a subphase to a powerplan while in the design mode.

1.31. How do I use a dosage calculator?

Answer:

Right click on the medication order and select “Modify Planned Order”

Click on the icon containing medication capsule, Dosage calculator window is displayed.

Patient’s height, weight is populated from the chart.
Select the target dose and dosage calculator will compute actual dose.
Select rounding rules, adjustment, and algorithm if necessary.
Modify final dose (to override calculated dose) if necessary and click on “Apply dose” to return to PowerChart Order section.

1.32. How do I taper dosing?

Answer:

Scenario: Order prednisONE as follows

a. 10 mg daily x 3 doses, then
b. 5 mg daily x 3 doses, then
c. 1 mg daily x 3 days

Normally on the paper form, this order can be written as one sentence. However, in CERNER this taper dosing must be ordered as three separate orders with appropriate start date/time and order duration.

The following screen shots show how taper dosing is achieved by entering three separate orders with appropriate start date/time.

a. 10 mg daily x 3 doses (default start date time)
b. 5 mg daily x 3 doses, note that start date is set to July 4 (instead of Today; Now)
c. 1 mg daily x 3 doses. (Note that start date is set to July 7)

1.33. How do I do a Medication Reconciliation?

1.33.1. Types of Medication Reconciliations
Admit: required for admission to the hospital. You can convert home medications to inpatient medications with this reconciliation.
Outpatient: add, modify and discontinue home medications for all outpatient visits.
Transfer: all order reconciliation required for all transfers to a different level of care within the hospital.
Discharge: required at discharge to the hospital. You can convert inpatient medications to prescriptions and change home medications with this reconciliation.

1.33.2. Launch the Reconciliation
Choose the appropriate reconciliation from any medication component.

1.33.3. Understanding the Reconciliation Window
1. **Orders Prior to Reconciliation**: Content is organized by the following expandable and collapsible order types: Home Medications, Continued Home Medications, Medications, and Continuous Infusions.

2. **Order Type and Notification Icons**
   - **Prescriptions**: Indicates the order is a prescription.
   - **Home Medications**: Indicates the order is a home medication.
   - **Inpatient Medications**: Indicates the order is an inpatient medication.
   - **Ambulatory Medications**: Indicates the order is an ambulatory medication.
   - **Compliance**: Indicates a patient is not taking a medication or not taking the medication as prescribed.
   - **Unreconciled Order**: Indicates the order has not yet been reconciled.
   - **Order Details Not Complete**: Indicates there are required details that have not been completed for the medication.

3. **Medication Status**:
   - **Continue After Discharge**: Continues historical and prescription medications after discharge.
   - **Create New Rx**: Creates a new historical and prescription medication, and discontinues the original order.
   - **Do Not Continue After Discharge**: Discontinues the patient medication upon discharge.
   - **Orders After Reconciliation**: Content is organized by the following expandable order types: Home Medications, Continued Home Medications, Medications, and Continuous Infusions.

4. **Reconciliation Status Icons**
   - **No reconciliation has been started**.
   - **Reconciliation is completed**.
   - **Admission and Discharge reconciliation in process**.
   - **No orders are addressed on Reconcile and Plan**.
   - **All orders are reconciled on Reconcile and Plan**.
   - **Unreconciled Orders**: Orders that need to be reconciled.
   - **Continue Remaining Home Meds**: Continues all remaining historical medications.
   - **Do Not Continue Remaining Orders**: Discontinues all unreconciled orders.

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**Documenting Medication History With Historical Medications**

You can access the Historical Medication dialog box from PowerOrders or by clicking Medications from the Workflow MPages view.

1. Click **Document Medication by Hx.**
2. Click **Add.**
3. Enter the medication name in the search box.
   - **Note**: To document history on an active medication: right-click the medication, select an applicable action to document, and enter any required details or information. Continue to Step 7.
4. From the list, select the medication.
5. Click the **Compliance tab** to select the status and information source.
6. Enter the last dose date and time.
7. Click **Document History.**

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**Reconciling Medications**

You can access Medication Reconciliation from the Discharge Summary or through PowerOrders.

1. Click the **Orders tab** or the **Medications** component from the Workflow MPages view to access the reconciliation options.
2. Click **Reconciliation > Admission** to review defaulted medications. Check for compliance information, as needed.
3. For each Medication, select **Continue** or **Do Not Continue**.
   - **Note**: Right-click to select **Void, Cancel, DC, or Complete** to remove a medication.
4. Click **Unreconciled Orders**.
5. Click **Add or Manage Plans to add PowerPlans, as needed.**
6. Click the order details to update dose, route, frequency, and schedule.
7. Click **Sign.**

---

**Cross Encounter Transfer and Patient Discharge Report**

1. From the Orders tab, click **Reconciliation.**
2. Select **Cross Encounter Transfer.**
3. Select the appropriate reconciliation action for each orderable item.
4. Complete any required order details, or order comments.
5. Click **Plan or Transfer.**
6. Select the printer to print a report with the following information:
   - **Patient's Home Medications**: A list of the patient's active documented medications and prescriptions regardless of the selections.
   - **Recommended Medications**: A list of medications to be continued, and inpatient medications that are not continued and not included in the report.
   - **Recommended Non-Medications**: A list of all continued non-medication orderable items.
1.34. How do I understand the Workflow pages?

Navigating Workflow MPages Views (8.11)

1. **ViewPoint**: Displays a collection of MPages views, where each view is displayed as a tab in the ViewPoint, and presents you with the necessary information to complete a defined set of actions and common activities for your role and venue.

2. **View**: Provides you with a high-level view of information contained in the patient's chart to help you quickly understand the status of the patient, while allowing you to complete many self-directed actions from the view.

3. **ViewPoint Toolbar**: Allows you to perform actions that are not associated with a specific MPages view. See ViewPoint Toolbar on Page 2 for more information.

4. **Workflow View-Level Menu**: Allows you to perform various actions associated with the Workflow view. The following commands are available from the Workflow view-level menu:
   - **Components**: Allows you to show or hide components that have been configured for the view. From the Components list, select a component to display it in the Workflow view. Deselect a component to remove it from the Workflow view.
   - **Print Report**: Prints the current Workflow view.
   - **Clear Preferences**: Clears all personal preferences for the view.

5. **Workflow View**: Displays the Workflow components that have been defined for the view. The name of the Workflow view is displayed in a tab in the ViewPoint, or, if the view is not in a ViewPoint, in the blue heading below the demographics banner at the top of the view.

6. **Workflow Component**: Allows you to review patient results and take actions against those results. See Workflow MPages View Buttons and Icons on Page 2 for more information.

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**ViewPoint Toolbar**

- **Add View**: Adds a new facility-defined view to the ViewPoint.
- **Chart Search**: Allows you to search the patient's chart.
- **Discharge Process**: Generates the selected patient's departure summary.
  - **I-PASS**: Displays the patient's status. Select an I-PASS status to add and modify the illness severity, patient summary, situational awareness and planning comments, and actions for the patient. You can also select an I-PASS status to select a care team and update the Actions and Situational Awareness and Planning components to display information related to the selected care team.
  - **Orders for Signature**: Displays new pending orders, PowerPlans, and discontinuation orders for a patient and indicates the number of pending orders for signature. Click Orders for Signature to review, modify, and sign orders within any MPages view.
  - **Tagged Items List**: Displays a list of tagged results. You can tag one or more lab results in the Labs component to automatically populate the Lab Results section of a Dynamic Documentation note template or PowerChart while using an MPages ViewPoint. You can also tag highlighted text from the documents component. This feature allows you to limit the size of a documented note rather than including all results automatically.

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**Workflow MPages View Buttons and Icons**

- **Add**: Opens a dialog box or a section of the patient's chart where you can document additional information. For example, clicking the add button in the Allergies component opens the PowerChart Allergy Profile tab where you can document a patient's allergies.
  - **Additional Actions**: Displays a list of additional actions, PowerForms, or other items available in the component.
  - **Refresh**: Displays how much time has elapsed since the data in the component was last refreshed. Click this button to manually refresh the component information.

- **Component-Level Menu**: Displays additional filtering and display options for the component.
  - **Edit**: Allows you to edit information in the component.

- **Component Look Back Range**: Allows you to filter information in the component based on the selected time frame. For example, click the Last 24 Hours tab to display the appropriate patient information in the component for the last 24 hours.

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**Favorites**: Allows you to add or remove an item from your favorites.

**Flowsheet View**: Displays the component information in a date or time column when new results are charted.

**Gap Checking**: This indicator is displayed in the component heading when proper documentation is not complete for a component in the Admit or Discharge workflows. All components marked with the gap checking indicator must be satisfied to complete all required documentation within the workflow. For example, you must add at least one patient education item to satisfy the gap checking requirements in the Workflow Patient Education component.

**Ambulatory View**: Displays the selected component information in the latest and previous columns, which creates a consolidated view of results. This layout eliminates white space; however, a single column may contain results obtained on different dates or times.

**Loading**: This image is displayed when details for the component are loading. Once details finish loading, the image is no longer displayed.
1.35. **How do I document on the Workflow Pages?**

The Workflow Dynamic Documentation components allow you to automatically create documentation using free-text entry or structured documentation approaches. The following Workflow Dynamic Documentation components are available:

- Assessment and Plan
- Objective Physical Exam
- Hospital Course (multi-contributor)
- Patient Instructions (multi-contributor)
- Review of Systems
- Subjective History of Present Illness

Type or dictate in to these components and hit Save and the documentation will pull in to the appropriate place in a note.

1.36. **How do I review what has happened since the last visit?**

*Answer:*

1. Select the menu list item and review the information.
   a. Lab orders, documents, encounters, medications, and any orders since the last visit (or last recorded Date/Time Stamp) are listed
   b. You may review results directly on this page

1.37. **How do I review results?**

*Answer:*

*Easiest:*
1. Select the appropriate component from the Workflow Menu

2. If needed, change the filter for lookback

3. Or for the type of results (on some components)

4. Click on a result to see details in the side view, or graph numerical results
Alternative:

5. Select Results Review from the Menu List items
6. Select the appropriate view or the appropriate tab to view results more in depth

7. Use Graph or Seeker to graph results, or narrow results quickly to abnormals and critica

1.38. How do I review scanned documents?

Answer:

1. Scanned documents are found in the Notes section of the chart. You may access scanned
documents by selecting from the Menu List items
2. Use folders to navigate to stored content
1.39. How do I understand and document Problems and Diagnoses?

The following terms are important to understanding the Problem List component:

- **The This Visit status** represents a condition being addressed during the current patient visit or encounter. In the traditional Table of Contents view of Problems and Diagnoses, the This Visit status equates to the diagnosis (condition) being addressed this visit.
- **The Chronic status** represents an ongoing condition for a patient.
- **The Inactive status** represents a chronic condition that the patient is not currently experiencing.
- **The Historical status** represents a chronic condition with a resolved status, a This Visit status condition from a previous encounter, or both.

To access Problems and Diagnoses from the Workflow Summary, click **Consolidated Problems**.

The **This Visit** and **Chronic** status buttons are displayed with a dark gray background and a check mark when they have been selected and are applicable to the problem. Click on these buttons to change the status.

To add a problem:
1. From the Add New As list, select a **This Visit**, **Chronic**, or **This Visit and Chronic**. Note: You can change the status of the problem after it is created by clicking **This Visit** or **Chronic**.
2. Enter a few characters of a problem name in the Problem Name search box. The system displays a list of matching values.
3. From the list, select the problem you want. The problem is added to the Problem List component.

To document no chronic problems:
When no chronic problems are documented for a patient, the following message is displayed below the component heading in the Workflow Problem List component: **No chronic problems documented. Document No Chronic Problems or add a problem**. The **No Chronic Problems** text in the message is displayed as a link that allows you to document No Chronic Problems for the patient. Click **No Chronic Problems** in the message under the component heading. The system adds a row in the component that indicates that there are no chronic problems for the patient.

To view details, resolve, modify, specify, add comments, or launch the infobutton, click on the Problem and use the side pane:
1.40. How do I add an allergy?

Answer:

1. Select Add Allergy from Menu List or from M-Page
2. Review current allergies or select
3. Complete detail for Substance (e.g. Latex, penicillin, sulfa, etc.) in Add detail window
4. Complete detail for Reaction (e.g. rash, anaphylaxis, wheezing, etc.)
5. Enter free text data, if provided (unregistered reaction reported)

Complete Substance detail in the search window. Note Substance is selected...
Double-click selection and then replace text with reaction. Notice change in input choice.

Can also add Free Text.

Modify Severity.
Select Reaction and Click OK to accept. Can also select allergy from Catalog Tab.
Some logins will allow Substance AND Reaction data entry contiguously. You must also complete a category (drug, environment, etc.) prior to selecting OK.
Right-Click to modify or view details of the allergy

1.41. How do I create an allergy favorite?

Answer:

1. Right-click on selection to create favorite. You can organize into folders.
1.42. How do check for Drug-Allergy interactions?

Answer:

1. Select Reverse Allergy Check on the Add Allergy window.
2. Clinical Decision Support window will appear if allergy is present.
3. Complete detail for mCDS window and refresh afterwards to clear any allergy alerts.
1.43. How do I document a Family History?

**Answer:**

1. Click on Histories from the Histories component

2. Select the Family Tab and click

3. Complete detail in window (Right-Click to remove a finding)

- Click in blue column to add a positive finding
- Click in white column to add a negative finding
- Click (-) in first column add (-) across the entire family line
1.43.1. How do I add a new item to the Family History category?

Answer:

1. Sometimes the headers listed in the Family History detail do not include specific histories you may want to routinely take. In order to add a specific history, select the Magnifying glass next to the heading you wish to add detail.
2. Search for new element and double-click to add the element to a queue. Then click OK to add under the heading.

Check Persistence box to keep the element for all new
1.43.2. How do I add a Quick List item to a Family History?

**Answer:**

3. Sometimes the headers listed in the Family History detail do not include specific histories you may want to routinely take. In order to add a specific history, select the Magnifying glass next to the heading you wish to add detail.

4. Check Current Conditions Tab for new element and double-click to add the element to a queue. Then click OK to add under the heading or select Search Tab to search for a new element.
1.44. How do I document a Procedure History?

**Answer:**

1. Select Procedures from the Histories component
2. Type the procedure in to the search box. Choose an option from the dropdown. You can free text, but choosing a codified option is preferred. NOTE: use Procedures for invasive procedures, not health maintenance or basic imaging.

3. Complete details in window and click Save to document

1.45. How do I document a Social History?

**Answer:**

1. Click on Histories from the Histories component
2. Select the Social History Tab and click Add
3. Complete detail in window and click OK to document
   a. Double-click each category to add detail
   b. Tobacco history documentation is required for each patient as a Meaningful Use requirement

1.46. How do I create a Dynamic Document?

Answer:
To create a note from a template in a Workflow MPages view, click a note type in the Create Note section of the component list. You can also click Select Other Note to display a New Note tab in the Document Viewing component where you can select any available note type and template.
In Document Viewing, click the **Add** button. The New Note tab is displayed.

Select a Note Type, a Note Template and set the Date (if not today) and click OK.

A new note will open.

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**Navigating a Dynamic Documentation Note**

1. Toolbar: Use the toolbar to format text, to copy, cut, and paste text; to undo and redo actions; and to manage auto text.
2. Manage Auto Text: Click Manage Auto Text to create and manage auto text entries.
3. Sections: Allergies and Social History are examples of sections.
4. Subsections: Vitals & Lab

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**Signing a Dynamic Documentation Note**

1. With the note open, click **Sign/Submit**.
2. If the note has not been saved previously, you can change the note type at this time.
3. In the Document Title box, enter the title you want. The title defaults to the name of the template selected unless changed manually.
4. Click **Sign**. The note appears in the List tab of the Document Viewing window.
Opening a Dynamic Documentation Note

1. In the List tab, a list of documents, consistent with the filter, is displayed.
2. To narrow or change the filter, select Only in the Display box.
3. In the second box, select your filter.
4. Select appropriate descriptors for any other boxes displayed.
5. In the list of displayed documents, double-click the note you want to open. The selected note is opened in the editor.

Modifying an Existing Dynamic Documentation Note

1. Open an authenticated or modified Dynamic Documentation note in the document list.
2. Click the Modify toolbar button or right-click the preview pane and select Modify.
3. The note opens and positions your cursor in the Insert Addendum Here text box. Enter your addendum.
4. Click the X at the right side of a selection to strike through the entire selection. Highlight free text and click the strike through toolbar button to strike through portions of free text.
5. Click Sign/Submit.
1.47. How do I create a PowerNote?

**Answer:**

**Adding a PowerNote**

1. In Documentation tab, click *Add*.
2. Select a note type from the Type list.
3. Enter a title or leave the title box empty to have the system use the encounter pathway as the title.
4. Click the Encounter Pathway tab.
5. In the search box, enter a portion or all of the name of the encounter pathway you want.
6. Select *Starts With*, *Contains*, or *Exact Match* from the list next to the search box.
7. Click *Search*.
8. Select the encounter pathway you want.
9. Click *OK*.

**Navigating a PowerNote**

1. *Table of Contents*: Used to navigate throughout the levels of a PowerNote.
2. *Paragraph Heading*: Review of Systems and Chief Complaint are examples of paragraph headings.
3. *Sentence Name*: Constitutional, Eye, and ENMT are examples of sentence names.
4. *Term*: Negative and Fever are examples of terms.
**Viewing a PowerNote**

1. From the Existing tab in the New Note window, select the Current Encounter option.
2. Select Unsigned Notes Only if you want to view only those notes that have not yet been signed.
3. Select My Notes Only.
4. Click OK.

**Modifying an Existing PowerNote**

1. Open an authenticated or modified PowerNote in the Documentation tab.
2. Click the Modify toolbar button.
3. When prompted, select the whether you want to modify or correct the note.
   - Select the Correct Note option if you want to correct the content of the note. This opens the note in the PowerNote editor where you can use structured documentation to make changes to the document.
   - Select the Modify Note option if you want to add an addendum to the note. This opens the Clinical Notes editor.
4. Click OK.
1.48. How do I locate an AdHoc document/form?

Answer:

1. Select the AdHoc button  in the Menu Ribbon above the chart window

2. Navigate to the appropriate form or document and double click to select
3. Additional Assessments has a more comprehensive list of forms

Some form documentation is saved as notes, to view others, or make changes, go to Form Browser

In the Menu

1.48.1. How do I know which AdHoc forms are necessary for documentation?

Answer:

1. You can find recommended related forms by clicking on the drop down arrow on some components

2. Your location, specialty, and workflow will likely determine the appropriate form for documentation
   a. Adult Medicine
1.48.2. How do I document on an AdHoc Form?

**Answer:**

1. Select the form you wish to document with
2. Complete detail on form
3. Select:
   a. Green check mark to sign/document
   b. Disk icon to save
   c. Circle/slash to cancel charting
Some forms are actually multiple layered forms. You will notice a tab system along the left-hand side of the form. You can select a different form to view and document by selecting the appropriate menu item.

1.48.3. How do I complete Pediatric Health Maintenance?

**Answer:**

1. Select Pediatric Health Maintenance from AdHoc Charting folder
2. Review assessments completed by Nurse or assistant
3. Select appropriate age Health Maintenance form
4. Complete charting
5. Select:
   a. Green check mark to sign/document
   b. Disk icon to save
   c. Circle/slash to cancel charting

1.49. How do I view/understand immunizations?

**Answer:**

1. Select Immunizations Schedule from the Menu List
2. Review Immunization Schedule detail
   a. Pink items are due/overdue
   b. Yellow items are recommended, but not required
   c. Gray items are not due yet
3. Select History or AdHoc buttons to document immunization administration

**Answer:**

1. Select History or AdHoc to document Immunization administration

2. Complete detail for immunization administration and click Chart
1.50. How do I use Dragon Dictation?

1. Dragon Medical is a dictating device/program that allows you to enter text into any field that can be typed. Dragon Medical also has short cuts that will allow you pull up given commands or pre-programmed text. Works with programs like Word document, Cerner PowerChart, and even the Windows screen. VCMC and its affiliated Ambulatory Clinics have purchased a license to the software that can be used on all county machines – it is not tied to Cerner and cannot be accessed remotely like PowerChart can.

2. Dragon Icon – can change where bar is put or docked – side, bottom or top of screen

3. Next icon – turn mic on and off. Default for is for it to need to have a button pressed to dictate. There will be a slight half to 1 second delay between pressing the button and it starting to pick up what you're saying. To avoid corrupting the program's recognition of your speech (it learns from you), it is better to not have the option of being able to accidentally leave the Mic on when you leave the computer.

4. Next location -- volume bar, in yellow or in green or in red depending on how your volume is. Change the location or position of the microphone rather than your voice to get it in the green.

5. The little Dot, also known as the select and say indicator is green if you’re in a field that can be dictated but gray if it cannot.
Click on Dragon and then manage vocabularies. You can open new vocabularies that you can add or cycle between. We advise using base general large which will give you access to a bunch of nonmedical terms that you may use in e-mails or other correspondence. For your medical vocabulary, we advise selecting Internal Medicine or Emergency Department as these have the broadest/largest amount of medical vocabulary.

Click on open profiles to select a profile and vocabulary you want to use. You can also select the source as the microphone type to use.

It is very important that you save user files every once in a while so that it remembers the things you said and the shortcuts you’ve made. If you click on exit it will automatically do this but forced quits or timeslot office won’t save. The program learns from you and using Dragon more and more will make it work better and better for you.
Click on Words(1) function then View/Edit. This has a list of words that it knows, you can search for words to see if a particular word is already there. If they’re not there you can click on add (2) to put in a new word. You can also put it in spoken form (3) so that you can spell out how it is pronounced phoenetically. By clicking Train(4), you can teach the computer how you say that word. This is very important for putting in the names of physicians and places that may not be standard.
Click on train and then select go. This will allow you to train the recognition of your speech for this particular word. Do not push the dictate button on your device as it will automatically be listening for your dictation when you select go. We recommend that you do it 3 times with different inflections and at your normal talking speed. Click Done afterwards.
Click on help, sample commands which gives you access to a lot of standard verbal commands. The list will show up on your right side of your screen, if parts of it are not visible, simply drag the box to be bigger. The content of these commands will change depending on where your cursor is placed. For example if you are in a Word document you will be old to do certain things. If you are in a general screening you will be able to do other ones. You can also say “what can I say” to bring this up.

Please note the shortcuts available under editing and format as well as moving around as these will be things that you use fairly frequently.

***See the bottom of this document for a list of common commands

If there is a word that you were having difficulty with, it is being spelled differently than how you want to spell it. Say “select ___” (where ___ is that particular word) to highlight it; then click on spell that. Type in the word that you want, click on it in the list below, and then click on train to teach the 2 different words and how you pronounce them slightly differently.

Click on the word go and you will get to dictate for both words. When you have done this, select
the top word again and click for a total of 3 cycles so the computer can register the difference between the 2 words.

### 1.51. Shortcuts

If there is a particular body of text or way of stating things that you commonly use you can make a shortcut. First you need to select the phrase or sentence then say the words “make that a short cut”. This will bring up the box below that contains the desired text in it. Then you get to give it a **MyCommand Name** – this is what you will use to call it up when you are dictating. We recommend you put the word 'my—' in front of your command name to distinguish it from other things that you might say. Also make sure that you say “plain text” as this will check the box at the bottom right which will allow it to adjust the font to whatever note it is in. When you have done this just say “save”.

You can access your commands and shortcuts; click the **tools bar**, then **command browser**, then **user defined**. Double click on them to edit them. You will also have access to standard templates, it is advised that you do not edit these directly, rather make your own templates off of them.

**Brackets** are another great way too quickly do things. Templates will have standard bodies of text,
some of which will be in Brackets (eg. a standard adult exam or OB note). Dragon allows you to quickly highlight a body of text that is in brackets and decide if you want to dictate over it or accept it and move on to the next bracketed text. The next field button or command allows you to jump your highlight from one bracketed text to the next. If you want to keep the text in the brackets (and get rid of the brackets too), then use the accept default button or verbal command. You can also create your own templates with brackets in them.

In Dynamic documents, you can dictate freely into the free text areas, basically anywhere you can type. Sometimes there can be a glitch with Dragon... V sync means that your green button is on and that you can have access to all Dragons abilities. If the gray button is on in spite of you having your cursor in the field that means that you have been kicked out and you cannot do certain things like used shortcuts and brackets. The work around for this is to open the dictation box (just say “open dictation box”) and you can use your Dragon functions in that. When you are done say “transfer text” or hit the Transfer text button to bring it into where your cursor is in dynamic documents.

Dictate in to this
Transfer text
Advance to next field
Push to dictate button
Accept Default (accept what is bracketed)
Mouse scroll button
Left and Right click mouse buttons (there is also a Left click on the underside of the mic)

**Please note, this is the Power Mic II, the standard dictating device for the hospital. The clinics will be supplied with a simpler model call the Andrea ANC 300, which only has one button**
Some common Verbal Commands that you can give to Dragon to do; commands must be given quickly and with authority to be recognized by Dragon. Please note that the menu of Verbal commands will change depending on what program the cursor is in (e.g. Word document versus PowerChart)

**Searching the web (medical)**
- Search WebMD for *<words>*
- Search WebMD drugs for *<words>*
- Search WebMD conditions for *<words>*
- Search ICD9 for *<words>*
- Search ICD9 Procedures for *<words>*
- Search ICD9 drugs for *<words>*
- Search ICD9 dictionary for *<words>*
- Search ICD9 coding for *<words>*
- Search PubMed for *<words>*
- Search Uptodate for *<words>*

**Searching the web (general)**
- Search the web for *<words>*
- Search Google for *<words>*
- Search eBay for *<words>*
- Search YouTube for *<words>*
- Search Wikipedia for *<words>*
- Find a website about *<words>*
- Search videos for *<words>*
- Search news for *<words>*
- Search images for *<words>*
- Search products for *<words>*
- Search maps for *<words>*

**Microsoft Outlook Shortcuts**
- Send email to *<names>*
- Send email about *<subject>*
- Create an appointment with *<names>*

**Searching your desktop**
- search the computer for *<words>*
- search documents for *<words>*
- search bookmarks for *<words>*
- Find an e-mail about *<text>*

**Controlling the Microphone:**
- Go to sleep/Stop listening
- Wake up/Listen to me
- Microphone off

**Controlling Modes:**
- Start command mode
- Switch to numbers mode
- Spell mode off
- Dictation mode on

**Getting Help:**
- Give me help
• What can I say
• Display sample commands

**Improving accuracy**
• Open the Accuracy Center
• Edit vocabulary
• Export custom words
• Check audio settings

**Selecting and Correcting:**
• Select `<xyz>`
• Select again
• Select next `<n>` characters | words
• Select previous paragraph
• Select document
• Correct `<word(s)>`
• Select all
• Unselect that
• Correct that
• Spell `<characters>`

**Inserting Lines and Spaces:**
• New line
• New paragraph
• Press Enter
• Press Tab key | Tab

**Capitalizing:**
• Cap that
• Cap `<word>`
• All caps `<word>`
• All caps on
• No caps off

**Editing and Formatting Text:**
• Scratch that  ((gets rid of the last string of dictation you did, up till your last pause))
• Scratch that `<n>` times
• Delete line
• Delete last `<n>` words
• Delete that
• Backspace `<n>`
• Undo that  ((very helpful for undoing errors))
• Cut that
• Copy that
• Copy all to clipboard
• Paste it here
• Delete that
• Undo that

**Moving Around in Your Documents:**
• Move left `<n>` words | characters
• Move down `<n>` lines
• Go to end [of line]
• Go to top | bottom
• Page up | down
Creating Custom Auto Text

Select the Manage Auto Text icon

Click the + to add a new .phrase

Choose an abbreviation starting with "." and a description (if desired)

You can use any of the formatting tools to add formatting (bold, underline, font, size, color) to the text in your .phrase

Click on this icon to add chart elements to your .phrase

Use the search box, or scroll through the options. When you select a template it will show you what this template would bring in for THIS patient. Adding one of these elements will mean that it will include patient specific (and encounter specific when relevant) information in to your note.
Click on this icon to add a drop down selection to your note *NOTE* Drop down selections ONLY work in Dynamic Documentation

Click + to add each item and select the box if you do not want a default option

Click Create when you are done adding items for your drop list
Click Save when you are done with your .phrase. It is now ready to use.

When you use your new .phrase in a note, you can now select one of the options in the drop down

If you want to modify one of your already created .phrases to take advantage of the new features, or if you want to modify one of the shared .phrases for your own personal use, go ahead and find it when you open the Auto Text tool and select Modify, Duplicate or Delete. For shared .phrases, only Duplicate will be available – this will allow you to create your own version for your personal use (the ability to share .phrases with your friends, and enemies, will be coming, hopefully soon!)

You can then add formatting, drop lists and smart templates as desired.

**Tagging for Dynamic Documentation**

Tagging allows you to include copied text and lab results in your notes. This is particularly useful for tasks such as bringing in radiology reports into your documentation, as well as referencing consultant notes, giving credit to the document author with a time and date and document name and author stamp (as opposed to copying and pasting which did not have such a stamp). It is also very useful for bringing in individual lab results that are not captured by the .phrases or advanced templates (such as the Inpatient Progress Note).

1.52. **Tagging Text**

1. Preview any document you would like to include (this can be done from any of the various ways you can view a document).
2. Highlight the results you want to tag. The system displays the Tag button as a pop-up.
3. Click the Tag button or right-click and select Tag Selected. The system activates the Tagged Items List button on the Document Viewing toolbar at the top.

Note

Repeat this step until you have tagged every result you want to include in a note. You can go back and add more tagged items later if needed.
4. To view the list of results you tagged, click the Tagged Items List button on Document Viewing toolbar. The system displays the list of results you tagged.

5. If you want to remove an individual result from the list, position your pointer over the result row in the list you want to remove. The system displays the Delete button.

6. Click the Delete button. The system removes the result from the displayed list.

7. If you want to remove a complete section of results from the list, position your pointer over the result section header row in the list you want to remove. The system displays the Delete button.

8. Click the Delete button. The system removes the result section from the displayed list.

9. If you want to remove all results from the list, click the Remove All button at the top right of the list.

### 1.53 Tagging Labs

Tagging labs can only be done in the Workflow lab component. Remember, you can use the filters here to get all lab results.

1. Right-click a result in the Workflow view. The system displays the Tagging button as a pop-up.
2. Click the Tagging button. The system activates the Tagged Items List button on the ViewPoint toolbar at the top right.

3. To view the list of results you tagged, click the Tagged Items List button. The system displays the list of results you tagged.

   \[\text{Note}\]
   \[\text{Repeat this step until you have tagged every result you want to include in a note. You can go back and add more tagged items later if needed.}\]

4. If you want to remove an individual result from the list, position your pointer over the result row in the list you want to remove. The system displays the Delete button.
5. Click the Delete button. The system removes the result from the displayed list.
6. If you want to remove a complete section of results from the list, position your pointer over the result section header row in the list you want to remove. The system displays the Delete button.

7. Click the Delete button. The system removes the result section from the displayed list.
8. If you want to remove all results from the list, click the Remove All button at the top right of the list.

1.54. Adding Tagged Items to Your Note
When you create your Dyn Doc note, the labs you have tagged will automatically be pulled in to the Laboratory section of your note. If you add more tagged labs after your note was started, you can refresh the lab section and it will pull in the newly tagged labs. The tagged text items will be displayed to the left of your note. From the tagged items list you can click and drag tagged text to the location you want it in your note. Dotted lines appear in the note
indicating where the text lands when dropped. A heavy dotted line indicates exactly where the text
lands and if the text is hovered over a section heading the heavy line is displayed above the section
and the text drops into its own section above the heading. If the heavy line appears below the
section heading the text drops into that section.

Modify Note Type, Title, and Date
You can modify a note’s type, title, and/or date by modifying the original note (previously this required
copying, pasting and in-erroring). You can use this feature if, for example, you accidentally label your
operative note as a “Death Note.” Being specific and accurate in your note type, title and date helps
immensely when it comes to finding that important information later in the patient’s care.

Steps:
Select the note and click Modify

Click Note Details at the bottom:
Modify the note details and click OK (you only need to do this step if you haven’t signed the note yet).

The user will get a message confirming that a change to the note’s details is being made. Click Yes

In order to be able to click Sign/Submit, the user must enter an addendum

**Update PCP**
To update the PCP, select the drop down arrow on the PM Conversation tool, and select PCP Update.

Enter your location, click OK.
Enter the PCP’s name, click OK.

This will update the banner bar (and any reporting or messages that involve the PCP).
Cerner Health Maintenance

Health Maintenance allows you to access a list of one-time only or recurring tasks that are due during the visit. This allows for real-time notification of health screening, prevention, and management of diseases for patients based on age, risk factors, gender, documented conditions, and documented procedures.

The improvements in preventative care monitoring and the at-a-glance reminders can result in higher quality patient care, as well as increased revenue generation surrounding covered procedures that are recommended in Health Maintenance guidelines. Health Maintenance also gives you a general idea of how well a patient adheres to your recommendations.

You can access the Health Maintenance information in the Health Maintenance component on the Ambulatory Workflow or the Health Maintenance tab in the Menu.

1.55. Recommendation Qualification

There are three ways a Health Maintenance reminder can be associated to a patient: automatic qualification based on data recorded about the patient, manual assignment of a recommendation to a patient, and free text creation of a recommendation.

1.55.1. Automatic Qualification

The following items can be used in any combination to automatically qualify or disqualify a patient for a recommendation:

• Age
• Gender
1.55.2. Manual Recommendation Assignment

If a patient does not automatically qualify for a particular system-defined recommendation, a user can assign the recommendation manually using the Add function in Health Maintenance.

The Ad Hoc assign dialog box displays a list of recommendations, and allows selection of one or more items. The due date or frequency can be changed prior to assignment.

Currently assigned recommendations, including cancelled recommendations, are unavailable and cannot be selected. To re-assign a cancelled recommendation to a patient, the cancelled recommendation must be undone in the Recently Satisfied section.

1.55.2.1. Free Text Recommendation Assignment

To assign a recommendation to a patient that does not exist as a system built recommendation, select Add Free Text Expectation.
A frequency must be specified when adding free text recommendations. Only manual satisfiers (Done Elsewhere, Refuse, and Cancel) are available for free text recommendations.

Free text and manually added recommendations are displayed in *italics*.

1.56. **Satisfying a Recommendation**

Recommendations can be satisfied by actions taken in Health Maintenance or by documentation, results or orders that occur outside of Health Maintenance. A complete satisfaction history for any expectation for which the patient currently qualifies is displayed in the side panel for that recommendation.

The following types of satisfiers are available:

- Manual Satisfiers (Refuse, Postpone, Cancel, and Done Elsewhere)
- Orders (prescriptions or other orders)
- Procedures
1.56.1. Order Satisfiers
Orders, as Health Maintenance satisfiers, are typically used as pending satisfiers – meaning it will not completely satisfy the Health Maintenance expectation. Most order satisfiers in Health Maintenance are Laboratory and Radiology, so placing the order should not satisfy the expectation, as ordering a test/exam does not guarantee the patient will have it done. Most order satisfiers will be displayed for providers to select conveniently right from Health Maintenance.

Ex. AAA Screening
The US AORTA SONOGRAM ORDER is displayed for providers to select from Health Maintenance.

Once the order is clicked, it will show down in the Not Due/Historical section with a status of Ordered.

In some cases, orders will completely satisfy the expectation.
Example: Adult Wellness
Ordering the E&M code for a preventative visit will satisfy the expectation for the 1 year interval.

1.56.2. Result Satisfiers
Result satisfiers are documented clinical information, such as:
* Laboratory results
* Radiology reports
* Medications/Immunizations
* Fields in forms or Interactive View (I-View)
* Note types
* Forms

Results satisfiers will satisfy expectations for the given interval.

Example: Breast Cancer Screening
Once the completed mammography report exists in the chart, the screening shows as Satisfied in the Not Due/Historical tab.
1.56.3. Procedure Satisfiers

Procedure Satisfiers can be entered through the Procedure tab of the Histories component in the chart. Procedure satisfiers will completely satisfy the expectation for the given interval. You will need to use a cpt4 procedure to complete the expectation:

1.56.4. Manual Satisfiers

Manual satisfiers include satisfiers that the provider will select through Health Maintenance. They include Refused, Cancel Permanently, Done Elsewhere.

*Refused

Comments are optional, but encouraged to provide additional detail.
If an expectation is Refused, the due date will not change.

It will be the provider’s responsibility to update the due date manually.

*Cancel Permanently - Reasons and comments are optional, but you are encouraged to provide additional detail.

*Done Elsewhere - When a provider selects Done Elsewhere, you will be required to select a date that the expectation was completed. Comments are optional, but you are encouraged to provide additional detail. This will complete the expectation for the given interval.

1.57. Customizing Your Health Maintenance View

If you would like to customize your view or are responsible for only a portion of your patients’ health maintenance expectations (examples: diabetes provider, cardiologist, women’s health provider), you can customize the Workflow component view to only see the expectations that you provide care for. Click Manage Favorites.

You can select the recommendations you would like to see and then move them to the Favorites column. Then click Submit and select Show only Favorites.
You can also customize the time range for pending recommendations in the General Settings section.

1.58. To Undo a Satisfier or Cancelation
If you want to reinstate a previously canceled recommendation, or you need to unchart a manual satisfier, click on the Health Maintenance Header to go to the Health Maintenance tab in the Menu. Then go to the Recently Satisfied Expectations section and select Undo, the OK (you are encouraged to add a reason and comments).
AAA (Abdominal Aortic Aneurysm) Screening
Adult Wellness Screening
Adult Immunization - Tdap
Adult Immunization – Influenza
Adult Immunization – Pneumococcal 13-valent
Adult Immunization – Pneumococcal 23-valent
Alcohol Use Screening
Bone Density Screening
Breast Cancer Screening
BRCA-Related Cancer Risk Assessment
Cervical Cancer Screening
Chlamydia Screening
Colon Cancer Screening
Depression Screening (Adult)
Depression Screening (Adolescents)
Hepatitis C Screening
HIV Screening
Intimate Partner Violence Screening
Lipid Screening
Lung Cancer Screening
Prostate Cancer Screening
Skin Cancer Prevention
Statin Use for CVD Prevention
Well Child Screening – 2 – 18 Years

CAD Maintenance – Antiplatelet Agent Prescribed
CAD Maintenance – ACEi/ARB Prescribed
CAD Maintenance – Beta Blocker Prescribed
Diabetes Maintenance – HgbA1c
Diabetes Maintenance – Eye Exam
Diabetes Maintenance – Foot Exam
Diabetes Maintenance – Microalbumin/ Creatinine Ratio
Heart Failure Management – ACEI/ARB Prescribed
Heart Failure Management – Beta Blocker Prescribed
Highlighted satisfiers will be viewable “face up” from Health Maintenance.

### AAA (Abdominal Aortic Aneurysm) Screening

**Criteria**
- Male
- Ages 65-75
- Current Tobacco User (documented in Intake Form)
  
  OR Active or Resolved Problem of Tobacco Use / Tobacco User

**Interval**
Once

**Satisfiers**

ORDER:

US AORTA SONOGRAM

RESULT:

US AORTA SONOGRAM

MANUAL:

Cancel Permanently

Done Elsewhere

Refused

**Exclusions**
Patients with a condition of Abdominal Aortic Aneurysm in Problems List

---

### Adult Wellness Screening

**Criteria**
All patients age 18 and over

**Interval**
Yearly

**Satisfiers**

ORDER:

99385 Initial preventative new pt, ages 18-39

99385-25 Initial Comprehensive Preventive E&M new patient; 1

99386 Initial preventative new pt, ages 40-64

99386-25 initial Comprehensive Preventive E&M new patient; 4

99387 Initial preventive new pt, 65 and older

99387-25 Initial Comprehensive Preventive E&M new patient; 6

99395 Prev periodic visit est, ages 18-39

99395-25 Periodic Comprehensive Preventive E&M established p

99396 Prev periodic visit est, ages 40-64

99396-25 Periodic Comprehensive Preventive E&M established p

99397 Prev periodic visit est, 65 and older

99397-25 Periodic Comprehensive Preventive E&M established p

G0101 Cervical or vaginal cancer screening; pelvic and clini

G0402 IPPE new Medicare beneficiary

G0438 Annual wellness visit;initial visit

G0439 Annual wellness visit;sbsq visit

MANUAL:

Done Elsewhere

Refused

Cancel Permanently

**Exclusions**
### Adult Immunization - Tdap

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 19 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>10 Years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>(IMMUNIZATION) RESULT:</td>
</tr>
<tr>
<td></td>
<td>tetanus/diphth/pertuss (Tdap) adult/adolescent</td>
</tr>
<tr>
<td></td>
<td>tetanus/diphtheria/pertussis, acel(Tdap)</td>
</tr>
</tbody>
</table>

**MANUAL:**
- Done Elsewhere
- Refused
- Cancel Permanently

### Adult Immunization – Influenza

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients 6 months and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Seasonally (September 1 – March 30)</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>(IMMUNIZATION) RESULT:</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccine</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccine, Live</td>
</tr>
<tr>
<td></td>
<td>Influenza Vaccine High Dose</td>
</tr>
<tr>
<td></td>
<td>Influenza, NOS</td>
</tr>
<tr>
<td></td>
<td>Influenza Nasal, NOS</td>
</tr>
</tbody>
</table>

**MANUAL:**
- Influenza Contraindication Form
- Refused
- Cancel Permanently

### Adult Immunization – Pneumococcal 13-valent

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Once</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>(IMMUNIZATION) RESULT:</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal Vaccine 13-valent conjugate vaccine</td>
</tr>
</tbody>
</table>

**MANUAL:**
- Refused
- Cancel Permanently

Exclusions
### Adult Immunization – Pneumococcal 23-valent

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Once</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>(IMMUNIZATION) RESULT:</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal Vaccine 23-valent vaccine</td>
</tr>
<tr>
<td></td>
<td>MANUAL:</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Alcohol Use Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 12 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER:</td>
</tr>
<tr>
<td></td>
<td>99408 Alcohol and/or substance abuse structured screening and brief intervention; 15-30 min</td>
</tr>
<tr>
<td></td>
<td>99409 Alcohol and/or substance abuse structured screening and brief intervention; Greater than 30 min</td>
</tr>
<tr>
<td></td>
<td>MANUAL:</td>
</tr>
<tr>
<td></td>
<td>Annual Alcohol and Drug Screening Form</td>
</tr>
<tr>
<td></td>
<td>Alcohol Use Screening Performed Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Bone Density Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Women, Age 65 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Every four years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER:</td>
</tr>
<tr>
<td></td>
<td>DEXA Care Set</td>
</tr>
<tr>
<td></td>
<td>RESULT:</td>
</tr>
<tr>
<td></td>
<td>DEXA SKELET PERIP (RADIUS, WRIST, HEEL)</td>
</tr>
<tr>
<td></td>
<td>DEXA AXIAL_SKELET (HIPS, PELVIS, SPINE)</td>
</tr>
<tr>
<td></td>
<td>Bone Density Study</td>
</tr>
<tr>
<td></td>
<td>DXA Report</td>
</tr>
<tr>
<td></td>
<td>MANUAL</td>
</tr>
<tr>
<td></td>
<td>Bone Density Screening Done Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Breast Cancer Screening

<p>| Exclusions        | Patients with osteoporosis |</p>
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Women, age 50-75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Every two years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER: MAM DIGITAL MAMMO BILATE DIAG MAM DIGITAL MAMMO SCREENING MAM DIGITAL MAMMO UNILAT DIAG RESULT: Mammography Report MAM DIGITAL MAMMO BILATE DIAG MAM DIGITAL MAMMO SCREENING MAM DIGITAL MAMMO UNILAT DIAG MANUAL: Mammogram Performed Elsewhere Refused Cancel Permanently</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Bilateral Mastectomy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BRCA-Related Cancer Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
</tr>
<tr>
<td>Interval</td>
</tr>
<tr>
<td>Satisfiers</td>
</tr>
<tr>
<td>Exclusions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cervical Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
</tr>
<tr>
<td>Interval</td>
</tr>
<tr>
<td>Satisfiers</td>
</tr>
</tbody>
</table>
**HPV mRNA E6/E7-Quest**

**RESULT:**
Cytology Gyn Request w/Reflex HPV
Cytology Gyn Request w/ HPV
HPV mRNA E6/E7 Quest
Pap Smear Report
Gyn Cytology Report
HPV

**MANUAL:**
Pap Smear Performed Elsewhere
Refused
Cancel Permanently

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chlamydia Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
</tr>
<tr>
<td><strong>Interval</strong></td>
</tr>
</tbody>
</table>
| **Satisfiers** | ORDER:  
GC/Chlamyd Probe  
Chlamydia Amplified DNA Probe |
| **RESULT:** | Chlam Amp |
| **MANUAL:** | Not Sexually Active  
Cancel Permanently  
Done Elsewhere  
Refused |

| Exclusions |

<table>
<thead>
<tr>
<th>Colon Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
</tr>
<tr>
<td><strong>Interval</strong></td>
</tr>
</tbody>
</table>
| **Satisfiers** | ORDER:  
FIT-Clinic Order  
Fecal Globin By Immunochemistry-Quest |

| Exclusions |
RESULT:
Colonoscopy (note type)
Occult Blood Stool - Guaiac Test
Cologuard Result
Quest FIT Test Result
Fecal Glob Immnchem

MANUAL:
Occult Blood Stool – Guaiac Test Form
FIT POC Form
Occult Blood Stool Done Elsewhere
Colonoscopy Done Elsewhere
Flexible Sigmoidoscopy Performed Elsewhere
Cancel Permanently

PROCEDURE:
Colonoscopy Procedure
Colonoscopy
Colonoscopy through artificial stoma
Colonoscopy through stoma
Endoscopic examination of colon
Endoscopy of colon
Endoscopy of colon through artificial stoma
Fiberoptic colonoscopy through colostomy
Flexible colonoscopy
Flexible Sigmoidoscopy
Proctosigmoidoscope
Proctosigmoidoscopy through artificial stoma
Proctosigmoidoscopy through artificial stoma
Rigid Proctosigmoidoscopy
Sigmoidoscopy
Sigmoidoscopy through artificial stoma
Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
Colonoscopy, flexible; with biopsy, single or multiple
Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT MEETING CRITERIA FOR HIGH RISK
Adenoma(s) or other neoplasm detected during screening colonoscopy (SCADR)
Adenoma(s) or other neoplasm not detected during screening colonoscopy (SCADR)
Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report (End/Polyp)
Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
Colonoscopy through stoma; with decompression (for pathologic distension) (eg, volvulus, megacolon), including placement of decompression tube, when performed
Endoscope, retrograde imaging/illumination colonoscope device (implantable)
COLORECTAL CANCER SCREENING; ALTERNATIVE TO G0105, SCREENING COLONOSCOPY, BARIUM ENEMA.
Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers
Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
CT Colonography DX
COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL AT HIGH RISK
Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
Colonoscopy, flexible; with endoscopic mucosal resection
Computed tomographic (CT) colonography, screening, including image postprocessing
Colonoscopy, flexible; with directed submucosal injection(s), any substance
Colonoscopy, flexible; with control of bleeding, any method
Colonoscopy, flexible; with transendoscopic balloon dilation
Colonoscopy through stoma; with removal of foreign body(s)
Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
Colonoscopy through stoma; with biopsy, single or multiple
Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Colonoscopy, flexible; with removal of foreign body(s)
Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
Interval of 3 or more years since patient's last colonoscopy, documented (End/Poly)
Pre-procedure risk assessment and depth of insertion and quality of the bowel prep and complete description of polyp(s) found, including location of each polyp, size, number and gross morphology
Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid
Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
Colonoscopy through stoma; with removal of foreign body(s)
Colonoscopy through stoma; with control of bleeding, any method
Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colonoscopy through stoma; with endoscopic mucosal resection
Colonoscopy through stoma; with directed submucosal injection(s), any substance
Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)
Computed tomographic (CT) colonography, diagnostic, including non-contrast images
CT Colonography Screening
CT Colonography DX W/DYE

Exclusions

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 45 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Every three years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td></td>
</tr>
<tr>
<td>ORDER:</td>
<td>Hb A1c</td>
</tr>
<tr>
<td></td>
<td>Glucose Fasting</td>
</tr>
<tr>
<td></td>
<td>Glucose 2 Hour</td>
</tr>
<tr>
<td>RESULT:</td>
<td>Hgb A1c</td>
</tr>
<tr>
<td></td>
<td>Glucose 2 Hour</td>
</tr>
<tr>
<td></td>
<td>Glucose Fasting</td>
</tr>
<tr>
<td>MANUAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Screening Done Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Problem of diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 18 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td></td>
</tr>
<tr>
<td>MANUAL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression Screening Tool (PHQ-2/PHQ-9)</td>
</tr>
<tr>
<td></td>
<td>Edinburgh Postnatal Depression Screening</td>
</tr>
<tr>
<td></td>
<td>Depression Screening Exclusion</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
</tbody>
</table>

| Exclusions                |                          |

### Depression Screening (Adolescents)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 12 and 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>MANUAL: Depression Screening Tool (PHQ-2/PHQ-A) Edinburgh Postnatal Depression Screening Depression Screening Exclusion Refused</td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
</tr>
</tbody>
</table>

### Hepatitis C Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients born between 1945 and 1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Once</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER: Hepatitis C Antibody RESULT: Hep C Ab MANUAL: Done Elsewhere Refused Cancel Permanently</td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
</tr>
</tbody>
</table>

### HIV Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 15-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER: HIV 1-2 Ab/Ag EIA RESULT: HIV 1-2 Ab/Ag MANUAL: Done Elsewhere Refused Cancel Permanently</td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
</tr>
</tbody>
</table>
### Intimate Partner Violence Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Woman, Age 14-46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>MANUAL:</td>
</tr>
<tr>
<td></td>
<td>Intimate Partner Violence Screening Completed</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Lipid Screening

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients between the ages of 35-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Every five years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER:</td>
</tr>
<tr>
<td></td>
<td>Lipid Panel Plus</td>
</tr>
<tr>
<td></td>
<td>Lipid Panel</td>
</tr>
<tr>
<td></td>
<td>RESULT:</td>
</tr>
<tr>
<td></td>
<td>Cholesterol, Total</td>
</tr>
<tr>
<td></td>
<td>MANUAL:</td>
</tr>
<tr>
<td></td>
<td>Done Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Exclusions

- Problem of Hyperlipidemia, Statin on Medication List
### Exclusions

**Prostate Cancer Screening**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Men age 55-69</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER: PSA</td>
</tr>
<tr>
<td>MANUAL:</td>
<td>Prostate Exam Performed</td>
</tr>
<tr>
<td></td>
<td>PSA Performed Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Exclusions

**Skin Cancer Prevention**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients age 1 – 24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Every two years</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>MANUAL: Skin Cancer Counseling Performed</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Exclusions

**Well Child Screening – 2 – 18 Years**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Age 2–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers</td>
<td>ORDER:</td>
</tr>
<tr>
<td>99382 Initial preventative new pt, ages 1-4</td>
<td></td>
</tr>
<tr>
<td>99382-25 Initial Comprehensive Preventive E&amp;M new patient; age 1 through 4 years</td>
<td></td>
</tr>
<tr>
<td>99383 Initial preventative new pt, ages 5-11</td>
<td></td>
</tr>
<tr>
<td>99383-25 Initial Comprehensive Preventive E&amp;M new patient; age 5 through 11 years</td>
<td></td>
</tr>
<tr>
<td>99384 Initial preventative new pt, ages 12-17</td>
<td></td>
</tr>
<tr>
<td>99384-25 Initial Comprehensive Preventive E&amp;M new patient; age 12 through 17 years</td>
<td></td>
</tr>
<tr>
<td>99385 Initial preventative new pt, ages 18-39</td>
<td></td>
</tr>
<tr>
<td>99385-25 Initial Comprehensive Preventive E&amp;M new patient; age 18-39 years</td>
<td></td>
</tr>
<tr>
<td>99392 Prev periodic visit est, ages 1-4</td>
<td></td>
</tr>
<tr>
<td>99392-25 Periodic Comprehensive Preventive E&amp;M established patient; age 1 through 4 years</td>
<td></td>
</tr>
<tr>
<td>99393 Prev periodic visit est, ages 5-11</td>
<td></td>
</tr>
<tr>
<td>99393-25 Periodic Comprehensive Preventive E&amp;M established patient; age 5 through 11 years</td>
<td></td>
</tr>
</tbody>
</table>
**Cad Maintenance – Antiplatelet Agent Prescribed**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients with Coronary Artery Disease in their Problems List</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>When a medication in one of the drug classes below is ordered, the system will cancel this expectation, rather than satisfying it (Cerner design).</em></td>
</tr>
</tbody>
</table>

### Interval

<table>
<thead>
<tr>
<th>Satisfiers</th>
<th>Drug Classes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Platelet aggregation inhibitors</td>
</tr>
<tr>
<td></td>
<td>Glycoprotein platelet inhibitors</td>
</tr>
<tr>
<td></td>
<td>Protease-activated receptor-1 antagonists</td>
</tr>
</tbody>
</table>

**Manual:**
- Refused
- Cancel Permanently

### Exclusions

**Cad Maintenance – ACEi/ARB Prescribed**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients with Coronary Artery Disease in their Problems List</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>When a medication in one of the drug classes below is ordered, the system will cancel this expectation, rather than satisfying it (Cerner design).</em></td>
</tr>
</tbody>
</table>

### Interval

<table>
<thead>
<tr>
<th>Satisfiers</th>
<th>Drug classes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Angiotensin Converting Enzyme inhibitors (ACE inhibitors)</td>
</tr>
<tr>
<td></td>
<td>Angiotensin II receptor antagonists (ARBs)</td>
</tr>
<tr>
<td></td>
<td>ACE inhibitors with calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>ACE inhibitors with thiazides</td>
</tr>
<tr>
<td></td>
<td>Angiotensin II inhibitors with calcium channel blockers</td>
</tr>
<tr>
<td></td>
<td>Angiotensin II inhibitors with thiazides</td>
</tr>
</tbody>
</table>

**Manual:**
- ACEi/ARB Exclusion Form
- Refused
### CAD Maintenance – Beta Blocker Prescribed

**Criteria**
Patients with Coronary Artery Disease in their Problems List

*When a medication in one of the drug classes below is ordered, the system will cancel this expectation, rather than satisfying it (Cerner design).*

**Interval**

**Satisfiers**
Drug classes:
- Beta-Blockers with Calcium Channel Blockers
- Beta-Blockers with thiazides
- Beta-Blockers, cardioselective
- Beta-Blockers, non-cardioselective

**MANUAL:**
- BB Exclusion Form
- Refused
- Cancel Permanently

### Diabetes Maintenance – HgbA1c

**Criteria**
Patients with Diabetes in their Problems List

**Interval**
90 days

**Satisfiers**
ORDER:
- Hemoglobin A1c

RESULT:
- Hgb A1c

**MANUAL:**
- HgbA1c Done Elsewhere
- Refused
- Cancel Permanently

**Exclusions**
### Diabetes Maintenance – Eye Exam

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients with Diabetes in their Problems List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers ORDER:</td>
<td>Referral to Ophthalmology</td>
</tr>
<tr>
<td></td>
<td>Retinal Scan – Las Islas</td>
</tr>
<tr>
<td></td>
<td>Retinal Scan – Magnolia</td>
</tr>
<tr>
<td></td>
<td>Retinal Scan – Sierra Vista</td>
</tr>
</tbody>
</table>

RESULT:  
Diabetes Management-Eye Exam  

MANUAL:  
Diabetes Management-Eye Exam Form  
Eye Exam Done Elsewhere  
Refused  
Cancel Permanently  

### Exclusions

### Diabetes Maintenance – Foot Exam

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients with Diabetes in their Problems List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers MANUAL:</td>
<td>Diabetes Foot Exam Form</td>
</tr>
<tr>
<td></td>
<td>Foot Exam Done Elsewhere</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
</tr>
<tr>
<td></td>
<td>Cancel Permanently</td>
</tr>
</tbody>
</table>

### Exclusions

### Diabetes Maintenance – Microalbumin/ Creatinine Ratio

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Patients with Diabetes in their Problems List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interval</td>
<td>Yearly</td>
</tr>
<tr>
<td>Satisfiers ORDER:</td>
<td>Microalbumin/Creatinine Ratio</td>
</tr>
</tbody>
</table>

RESULT:  
Microalb/Creat Ratio  

MANUAL:  
Done Elsewhere  
Refused  
Cancel Permanently  

### Exclusions

### Heart Failure Management – ACEI/ARB Prescribed
| Criteria | Patients with Heart Failure in their Problems List  
*When a medication in one of the drug classes below is ordered, the system will cancel this expectation, rather than satisfying it (Cerner design). |
|----------|--------------------------------------------------|
| Interval | Drug classes:  
Angiotensin Converting Enzyme inhibitors (ACE inhibitors)  
Angiotensin II receptor antagonists (ARBs)  
ACE inhibitors with calcium channel blockers  
ACE inhibitors with thiazides  
Angiotensin II inhibitors with calcium channel blockers  
Angiotensin II inhibitors with thiazides  
MANUAL:  
ACEi/ARB Exclusion Form  
Refused  
Cancel Permanently  |
| Exclusions | Heart Failure Management – Beta Blocker Prescribed  
*When a medication in one of the drug classes below is ordered, the system will cancel this expectation, rather than satisfying it (Cerner design).  
MANUAL:  
BB Exclusion Form  
Refused  
Cancel Permanently |
OB/GYN Cerner Handbook

1. The Pregnancy Workflow

The Pregnancy Workflow is the flowsheet for the patient’s prenatal care. There are 2 versions, the OB Prenatal and OB Inpatient which are optimized for their respective location. You should be able to review all of their care relevant to their pregnancy care without navigating away from this screen.

Many of the components are common to other Workflow pages. There are a few components specific to OB. You should familiarize yourself with the information available on this page.

There are videos available that review each of these pages:

**OB Prenatal**
https://youtu.be/BpWWtz6iEzU?list=PL6psK6r4RFx0HT0sllnZVKDWe5BbwOSwB

**OB Inpatient**
https://youtu.be/-bLR5jO68?list=PL6psK6r4RFx0HT0sllnZVKDWe5BbwOSwB

1.60. Finding the OB Workflow Pages

You can use both of these pages as a tab on your Acute Workflow.

Click on the + to find the pages you do not have visible:

Select the view you want to use:

You can drag and drop the tabs of the Acute Workflow to where you want them.

Watch this video to view the customization of your Workflow tabs:
https://youtu.be/nePYKrTv9Lk?list=PL6psK6r4RFx2e0vg6gnQUhV_pkE8Mpxz2
1.61. **OB Specific Components**

1.61.1. **Overview**

You can view and document your prenatal visits in this component. You can use either the card view or the flowsheet view and toggle between the two with the icon in the upper right.

**Card View**

**Flowsheet View**
When you hover over the details in the box, you can view all of the historical information for that detail for the pregnancy (this is particularly useful for reviewing blood pressure and weight gain trends):

**Troubleshooting:** If the OB exam box does not appear make sure that you are using a Clinic encounter and that the blood pressure was recorded on the correct encounter.

### 1.61.3. Delivery Summary (OB Inpatient Page Only)

Details about the delivery will appear here:

### 1.61.4. Education and Counseling
OB education that is documented in Interactive View will populate this section.

### 1.61.5. Fetal Monitoring

The Fetal Monitoring tab will display the archived strips done in the hospital. If you click Show, it will launch a view-only version of Fetalink and you can review the archived strip:

![Fetal Monitoring Table](image)

<table>
<thead>
<tr>
<th>Initia</th>
<th>Complete</th>
<th>Fetal EGA</th>
<th>Reason for Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/02/13 08:00</td>
<td>04/03/13 03:35</td>
<td>33 Weeks 6 Days</td>
<td>done</td>
</tr>
</tbody>
</table>

### 1.61.6. Birth Plan

Birth plan requests are documented in Interactive View. If you click the + here, it will launch the birth plan form.

![Birth Plan Form](image)

No birth plans have been documented for this patient. Add a Birth Plan.

Here are the items that will display in this section if documented in this form:
1.61.7. Consolidated Problems

While this is not specific to the OB Workflow page, make sure to keep this section up to date and complete as it is the most useful way to convey important problems relating to the pregnancy between providers and between the outpatient and inpatient settings. Document dates of tubal and TOLAC forms in the comments section to make sure they can be easily retrieved on future visits and when the patient presents the hospital.

1.61.8. Prenatal Labs and Tests

Review prenatal labs here. They are separated by stage in pregnancy and the gestational age of the lab draw appears in the table.

You can also click on the lab and mark Decline when the patient declines a test:
Note: transcribed labs and HIV do not appear here, but you can find them in the Labs section. Not all of the labs will appear as “Ordered” when the order is placed, but the results will still appear if completed in our system.

1.62. Where do I find?

1.62.1.1. MSAFP results

Make sure your clinic scans these in as “Lab Report” then they will be viewable in the Documents section of the Pregnancy Workflow pages.

1.62.1.2. Ultrasounds Done in Clinic or Outside Facility

Make sure your clinic scans these in as “Ultrasound Report” then they will be viewable in the Diagnostics section of the Pregnancy Workflow pages.

1.63. The First Visit

1.63.1. Open the Pregnancy

Go to the OB Prenatal or OB Inpatient pages. You should see this at the top. Add a pregnancy by clicking where it says Add Pregnancy:

You will now see this window. You will need to enter an Onset Date. Typically the onset date will be the LMP. You can then choose to use this as the LMP date and it will be used for initial dating calculations. You can also specify the number of gestations if there are more than 1 (it will default to 1 gestation):
NOTE: if the patient does not know the LMP, pick a reasonable date in the past when the pregnancy might have begun for the Onset: Date field. Do not pick today’s date. This date is used to pull visits and clinical data in to the OB Workflow pages.

Next, enter a dating method. If you selected Use as LMP Date above, this will be completed already. If not, select a method. If you select Unknown, you can add an estimated due date.

The overview tab will now display the current pregnancy.

Troubleshooting: if the overview contains information about a pregnancy and you believe this is the first visit for this pregnancy, you will need to determine whether the information in the overview is from a previous pregnancy. If it is, you will need to CLOSE the prior pregnancy first, then add a new one. DO NOT make changes to the EDD until you have closed the pregnancy and added a new pregnancy (see section 1.5 on closing the pregnancy).

1.64. New OB Visit History and Physical (Outpatient)

To document the intake history, use the Antepartum Intake Form. If the Antepartum Intake form was started by your clinic staff, you can find it in the Form Browser:

Right click on it and select “Modify” to review and add your documentation as well"
If it was not already started, you can go to AdHoc charting on the banner bar (typically this form is started by the clinic CPSP/MA):

Choose the Antepartum Intake form

The advantages to using this form for your new OB visit are that it will contain the appropriate prompts for a complete history and the items in this form will populate to the Pregnancy Workflow (histories, genetic screen, pre-pregnancy weight) and the Pregnancy Report or Pregnancy Summary Document which is the printable version of the Pregnancy Workflow (including the Antepartum Note and the physical exam).

To save the documentation in the form, click the green check mark in the upper left hand corner.

1.64.1. Documenting the Pregnancy History

Go to Pregnancy History in the Antepartum Intake form, or to the Pregnancy tab in in the Histories section:
Click on the +Add button to add a prior pregnancy.

The record will be updated in the Gravida/Para box. DO NOT change the pregnancy count by entering numbers in to the Gravida/Para box (Add pregnancies ONLY by using the +Add button)

DO NOT CHANGE THE NUMBERS IN THIS BOX:

After you click on +Add, you can fill out the pregnancy details in this box:
To add information about a second twin, click on the + Add Baby icon:

You can then add the details for the additional baby:

Click OK, or OK & New until you are done adding all of the pregnancy history. The pregnancies will be viewable in the historical pregnancy table, and the count will be updated automatically in the pregnancy count box (again, do not edit the pregnancy count here).
If you need to make changes on the pregnancies you have documented, or if you need to delete a pregnancy you have recorded, click on the pregnancy within the table, then click modify:

It will bring up this box and you can make changes to the pregnancy here, or delete the pregnancy:

Troubleshooting: If the Gs and Ps are not correct in the Overview, try these tips:

Are the pregnancies documented in the Pregnancy History component? If not, then document them.

Is the gestational age documented for each pregnancy? If not, then modify the pregnancy to add the gestational age (an estimate is appropriate).

In some patients there may be an error with one or more of the pregnancies. If they are correctly documented, then you can try deleting the pregnancies and adding them again. If this does not correct the problem, please report it to the Helpdesk.

1.64.2. Transcribed Prenatal Labs

Labs that were done outside of the system (outside lab or transfer of care) can be documented in the Transcribed Prenatal Labs section on the Antepartum Intake form. When documented here, the labs will be available for review in the Labs section of the Pregnancy Workflow pages.
1.65. The OB Clinic Visit

View the OB clinic visit video here
https://youtu.be/BpWWtz6iEzU?list=PL6psK6r4RFx0HT0sllnZVKDWe5BbwOSwB

1.65.1. Documenting an OB Visit/Exam: Documenting on the Pregnancy Workflow Page

Document your prenatal visit directly on to the Workflow page by clicking Chart. The Chart button appears at the bottom of both the Card view and the Flowsheet view. When you are done adding results, sign with the green checkmark.

HINT 1: There is a 256 character limit for the comments section. For most OB patients, a short note in the comments section is adequate for the visit and you will not need a separate note. If you do need to complete a separate note, it is helpful to add the important details here and then create an OB clinic note (see below).
HINT 2: Your name will appear at the top of the card if you add visit comments, making it very easy to see who has been seeing the patient.

HINT 3: If you diagnose a patient with a multiple gestation, click where it says “Add Baby” to create an additional baby for documentation. ONLY do this ONCE.

1.65.2. Documenting in Interactive View (IView)

If you do not document on the day of your visit, to modify a result you have already charted, or to document Education and Counseling, you will need to document in IView.

You can access IView from the Pregnancy Workflow pages by clicking on Prenatal Visits

For an office visit, use the MD office visit section:

HINT: Double click on the colored box at the top of the column you are going to use for charting and then you can click enter or tab after completing each section and it will move to the next undocumented box in the column.
To modify a result you have already charted, right click on that result and select Modify.

Sign using the green checkmark in the left corner:

HINT 1: If you need to modify the gestational age on a card (e.g. if you perform an ultrasound that re-dates the pregnancy after the visit was started), navigate to Interactive View and document a new gestational age in any column that is more recent than the one already documented:

1.65.3. Documenting Education

Document OB education performed under the OB Education tab in IView:

1.65.4. EDD Maintenance

1.65.4.1. Adding New Dating Criteria
If you have a new piece of dating information and wish to add it to this section, click the + to add a new EDD calculation:

Then, you can add the new item here:

Once you have entered the new information, you can choose to use this method to calculate the EDD by clicking the box on the lower right:

Click OK when you are done.

**HINT 1**: use the comments box only for items relating to the EDD (other details relating to the pregnancy should probably go in the problem list).

**HINT 2**: for LMP calculations, you can select Show Additional Details and add details on the cycle length, the details on cycle length will adjust the EDD calculations accordingly.

---

1.65.4.2. Making Changes to an Existing EDD Calculation

To modify an existing EDD (e.g. if the patient tells you that she was mistaken about her LMP date), select “Modify EDD”

Do not use the modify function to change the calculation based on a new dating item.
1.66. Closing the Pregnancy

After the patient delivers, the pregnancy should be closed. Typically this is done by the postpartum nurse on discharge from the hospital. If the patient has an SAB, delivers outside of our system or if the pregnancy was not closed, you will need to close the pregnancy.

Go to Close Pregnancy on the Pregnancy Summary under Overview:

It will prompt you to enter the details of the pregnancy, which will now be part of the patients Pregnancy History:

Troubleshooting: if you have trouble closing the pregnancy, make sure you have entered the details for all of the babies in the pregnancy. If an additional baby was added in error, you will need to inactivate that baby first in Interactive View, then go back and close the pregnancy. If an additional baby was added, there will be more than one tab here:

1.67. Archived Pregnancy Summary

Once the pregnancy is closed you will no longer be able to view any of the pregnancy specific data in the Pregnancy Summary. You can review an archive of the Pregnancy Summary under Physician Documentation or Notes. It will be saved with the date that the pregnancy is closed.
HINT: this document is also viewable from the Pregnancy History section. Scroll to the right and you will see an icon in the column Summary under the closed pregnancy. Click on this and you can open and view the report from that pregnancy.

2. OB Notes

Most notes can be done using Powernotes, or Dynamic Docs depending on the provider preference. Delivery notes should only be done in Powernotes.

2.1. OB Admit/Clinic/TOLAC Notes

2.1.1. Dynamic Documentation

There are several .phrases that will give you entire note templates for many of the OB notes:

- obTOLACconsult *
- obTOLACintrapartumcklist *
- obTOLACreferralcklist *
- obadmithistoryphysical *
- obadmithistoryrepeatcsession *
- obclinicvisit *
They are designed to be added to a free text note and will contain all of the pertinent chart details for OB patients. It is not recommended to use the standard note templates as these do not contain information related to the pregnancy.

HINT: select a note from the menu of the OB Workflow pages to launch directly into the correct note type and label.

OB Inpatient:

[Image]

OB Prenatal:

[Image]

### 2.1.2. Powernotes

There are several shared precompleted OB admission notes designed for labor, repeat csection, general OB admits, TOLACs, and OB clinic visits. They will contain most of the charted elements relevant to an OB admission and are very easy to use. See section 2.2 for more information on how to use these notes.

<table>
<thead>
<tr>
<th>Title</th>
<th>Encounter pathway</th>
<th>Shared</th>
<th>Last changed by</th>
<th>Perform/Service Date/Time</th>
<th>Sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB Admit H&amp;P</td>
<td>Pretest Note *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>3/28/2017 17:22:02</td>
<td></td>
</tr>
<tr>
<td>OB Ané Discharge Summary</td>
<td>Pretest Note *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>5/27/2016 14:06:42</td>
<td></td>
</tr>
<tr>
<td>C/S Césaréen Delivery Note</td>
<td>C/S Césaréen Delivery Note</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>5/25/2017 19:43:31</td>
<td></td>
</tr>
<tr>
<td>OB Checklist TOLAC Referral</td>
<td>Pretest Note *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>5/24/2017 17:14:11</td>
<td></td>
</tr>
<tr>
<td>OB Clinic Vett</td>
<td>Pretest Note *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>11/11/2015 08:16:16</td>
<td></td>
</tr>
<tr>
<td>OB Clinic Vett Expanded</td>
<td>Pretest Note *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>11/11/2015 08:14:44</td>
<td></td>
</tr>
<tr>
<td>OB Fetal Well being bloody show</td>
<td>OB Fetal Well Being *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>12/20/2016 12:10:52</td>
<td></td>
</tr>
<tr>
<td>OB Fetal Well being decreased movements</td>
<td>OB Fetal Well Being *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>3/20/2014 09:51:20</td>
<td></td>
</tr>
<tr>
<td>OB Fetal Well being false labor</td>
<td>OB Fetal Well Being *</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>9/20/2014 09:46:36</td>
<td></td>
</tr>
<tr>
<td>OB Vaginal Delivery Note</td>
<td>OB Vaginal Delivery Note</td>
<td>Y</td>
<td>Brecht-Doocher, Aimée</td>
<td>5/25/2017 19:44:07</td>
<td></td>
</tr>
</tbody>
</table>

### 2.2. Powernotes Basics

#### 2.2.1. Add a Note

Click on Physician Documentation, click the down triangle next to the + Add and select Powernote.
You can now choose a template for your note. Encounter pathway lets you type and search for a template. Under the Catalog tab you can browse the available templates by discipline. Under Precompleted, you can select shared or personal precompleted notes.

2.2.2. Launching Your Powernote

After you find your desired note and click OK you will get this screen. Here you can select already charted items to bring in to your note. Click only the items that you want your note to contain.
HINT: In general it is best to select fewer items for a more readable note. Powernotes will save your preference for the next time you launch that note template.

2.2.3. Powernote Favorites

Save notes that you use frequently as your favorites for easy launching from the Summary pages. Click Add to Favorites before you launch the note.

![Favorite Notes Interface]

From the Workflow pages, you can now click on the downward triangle at the top of the Documents component and launch directly into that note (updates to your favorites in this drop down box often do not appear until the next time you log in).

2.2.4. Creating Precompleted Notes

You can customize your note templates by creating Precompleted notes. First launch the standard template you wish to use and make the changes you want to save for each note. Smart templates (like vital signs) that you include will be updated with the current values for the patient you are documenting on.

To save the note, find Documentation on the top line and then Save As Precompleted Note.

2.3. OBGYN Smart Templates

There are several smart templates to assist you in creating OBGYN notes. These are available for use in either Dynamic Documentation or Powernotes.

.obduedatecalcs will bring in the EGA/EDD and basis for the calculations
.obpreghistory will bring in the details from the pregnancy history
.obgravidapara will bring in the Gs and Ps documented in the pregnancy history
.obclinicvisit will bring in the info documented in Interactive View for the outpatient OB visit
.prenatal will bring in the prenatal labs (including the transcribed labs)
.labs.gyn will bring in many labs relevant to a gyn patient
.labs.std will bring in std screening labs

2.4. Delivery Notes

Use Powernotes for your delivery notes. There is a note for vaginal delivery and another for csection.

**STEP 1**
Allow the nurses to complete their documentation so that it will be included in your note.

**STEP 2**
Go to Physician Documentation to add a POWERNOTE.

![Powernote search interface]

Choose Precompleted and search for “delivery”
The new notes are called OB C/S Cesearean Delivery Note and OB Vaginal Delivery Note. The C/S note, if completed with the surgical details can be used as both the operative note and delivery summary.

![List of delivery notes]

Choose the appropriate note.

**STEP 3**
The first time you create each note, select all of the boxes on the pop up window (will be pre-selected if using the precompleted note)
Then click OK
You only have to do this ONCE, but you HAVE to do it ONCE.

STEP 4
You will need to do this EVERY time you use these notes.

**STEP 5**
Use the point and click documentation options for all of the portions included. This will allow what you put in your note to be retrieved for later data retrieval and reporting. You can add a narrative in each section, or at the end if desired. If all of the pertinent details are recorded as part of the point and click sections, a narrative note is not necessary for a vaginal delivery.

**NOTE**
There are a couple of places in the note where nursing documentation is pulled in: Indications for Csections, Maternal and Neonate complications will show the nursing documentation if completed below the section like this:
If this is complete, you do not need to select any of the options above for your note, it will be included in the text. If there are clinical discrepancies, please review with the nurse as inconsistencies in documentation are frequent medico-legal pitfalls.

The QBL will also pull in to the note:

```
<table>
<thead>
<tr>
<th>Quantitative Blood Loss</th>
<th>OTHER / QBL (ST)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quantitative Blood Loss: 750 (05/24/17 13:41:26)</td>
</tr>
</tbody>
</table>
```

If it is already documented, do not add it again. If it was not documented, it will appear like this:

```
| Repair | under local anesthetic / vaginal mucosa / | |
|---------|------------------------------------------|
| Quantitative Blood Loss | OTHER / QBL (ST) |
```

Click where it says “OTHER” to add the QBL.

**STEP 6**
Sign your note and go back to bed!

You can also watch the video here about creating these notes: https://youtu.be/gYg8tDLsV7s

**2.5. Fetal Well Being Powernote**
NSTs, BPPs and simple OB triages can be documented using the Fetal Well Being Powernote. There are a couple of shared pre-completed notes for common triage complaints, feel free to make more of your own.

For triage patients that are sent home by the RN, they will complete the Fetal Well Being Powernote and send it to the physician covering. When you receive these notes, you should review the note and the monitoring strip from the visit (see section 1.1.4 for an easy way to find and view the monitoring strip).

The note should contain the following in order to satisfy CMS requirements:

1. outcome of care
2. disposition
3. plan for follow up

**2.6. Discharge Summary**

Patients with minor or no complications who have been in the hospital for less than 48 hours regular inpatient or 72 hours for normal deliveries or normal newborns do not require a formal discharge summary. Instead the “final progress note” can be substituted for the discharge summary.

To fulfill CMS requirements, the note must contain the following:

1. Outcome of hospitalization
2. Disposition
3. Plan for follow up

**2.7. Postpartum Clinic Note**

To document a postpartum visit, use your favorite ambulatory clinic visit template (Dynamic Docs or Powernotes).
HINT: add the .obpreghistory smart template to your note to bring in the basic delivery info to your postpartum note.

### 2.8. Printing Prenatal Records
If you have a patient who is transferring care or traveling and would like to print out prenatal records, go to the Pregnancy Report in the Menu and then Print. This document includes all of the pregnancy specific information that is viewable on the Pregnancy Workflow.

![Pregnancy Summary](image1.png)

### 3. OB/GYN Orders

#### 3.1. Quick Orders

There is a Women’s Health Quick Orders tab that has many useful orders for your obgyn patients. The page has components for both the inpatient and outpatient settings. You can watch this video on using Quick Orders. [https://youtu.be/WgLMiodtBpg](https://youtu.be/WgLMiodtBpg)

You should familiarize yourself with the orders available on this page.
3.2. Powerplans

Ob/Gyn Powerplans start with OBGYN. Subphases start with PHA OBGYN.

HINT: use the OB powerplans preferentially for OB orders as there are rules attached to the ordersets to help suggest orders and certain orders (like Pitocin and magnesium) are specifically designed for the OB unit and will not work well if you use the standard orders.

3.3. Postpartum Orders
After delivery, discontinue the Labor and Delivery Admit Powerplan, and any other subphases or orders that you do not plan to continue after delivery. Then, perform a transfer order reconciliation.

For post vaginal delivery patients, place the postpartum orders and initiate these orders.

For post csections, follow the OR workflow and leave orders in a planned state.

**HINT 1**: for all individual orders placed during the antepartum stay, remember to Add to Phase so that they are discontinued along with the admission plan.

**HINT 2**: use postpartum and post csection orders only for postpartum patients because there are rules that fire off of these ordersets that do not apply to GYN patients.

### 3.4. OBGYN Order FAQs

How do I place an order for an amnioinfusion? Order the desired fluid and rate with a route of “Intrauteral”

### 4. Related Records

You can bring up baby’s chart from mom’s chart by clicking on Related Records:

### 5. OB Tracking Shell

Click onTracking Shell near the top of the screen.

This is what you will see:
You can hover over the items in the columns to see more details. Here you can see the details in the Allergies column:

Go through the columns to become familiar with what is available on the tracking shell.

Most of the columns (age, Gs and Ps, cervical exam) will populate automatically from documentation that you do elsewhere in the chart.

To Do and Notifications columns include icons for FSE, IUPC, and common labor diagnoses:
Anyone can add an icon by right clicking in the To Do, or Notifications box and it will bring up this screen, then, click on the appropriate boxes:

In the Comments column you can add a short free text comment that you want viewable on the labor board. This is typically where you would add the reason for admission (PTL, pyelo, IOL, etc). You can add a comment from any computer and it will be visible for everyone.

The VCMC or SP labor board is the de-identified view that will be available as the labor board with only the patient initials visible.
5.1. Launching the Chart from the Labor Board

You can launch any tab of the patient’s chart by right clicking on the patient from the labor board:

You should always launch the chart from the Tracking Shell in order to ensure you are working on the correct patient and the correct encounter/visit.

5.2. Reports/Birth Log
Launch the delivery log from the tracking shell, by clicking on Reports.

Then, choose which type of report you want to run:

You can specify a date range, and location (delivery location)

The Delivery Summary shows totals, multiples, c/s rates, VBACs, inductions, epidurals, lacerations and instrumented deliveries.
The Extractable Birth Log report is similar to the written birth log and has many, many fields. You can search within the report, or save the file and import it to Excel and can search and sort and work with the data.

6. Customizing IView Bands
You may want to customize what is visible in IView. To add or remove a section from what you see in IView, go to View, then Layout, then Navigator Bands.

Highlight the section on the left that you wish to add and then click the right arrow to add. Then click OK.

Highlight the item on the right side that you want to delete, click the left arrow, then OK to delete. Highlight the item on the right, then click the up or down arrow to change the order of the bands.

You will need to exit and restart Powerchart to view the changes in the IView bands.

7. Surgeries

7.1. Preop Visit

7.1.1. Preop Orders

Watch the Video instructions here: https://www.youtube.com/watch?v=JJaTN-9BS8I (5 minute video)
When you are ready to place your preop orders, they need to be placed on the PREADMIT encounter. This encounter will be created by pre-admitting when the surgery is scheduled. If you are doing the preop orders the same day you make the decision for surgery, you, or your clinic staff will need to call pre-admitting to have them create this encounter in order to enter preop orders.

7.1.1.1. Make sure you place the orders on the PREADMIT encounter (DO NOT use a PREREG or OUTPATIENT encounter).

To switch to the pre-admit encounter, click on the Loc in the Banner Bar.

Then click on your correct preadmit encounter in the list in the pop up window and click OK

You will now see Preadmit under the patient name.

HINT: if you open the chart from the surgery schedule, you will always get the correct encounter.

7.1.1.2. Place Preop Orders

Preop orders have 3 phases, Pre Admission Test, Day Before Surgery and Day of Surgery, click on each phase in the View column to enter orders for that phase. First enter the orders for the preop testing phase. The preop testing phase will initiate automatically when you sign the orders

3. Then enter the orders for the day before surgery phase. This phase contains the day of surgery medications per pharmacy request. If you want any medications that are not in the standard orderset, remember to Add to Phase.

These orders are left in a PLANNED state (do NOT Initiate).

4. Then, enter the orders for the day of surgery phase. These orders are left in a PLANNED state. You will need to put an admitting physician in the orders and the name of your procedure. If
you want to order any intraoperative medications (marcaine, pitressin, etc), add them to this phase. Select intraoperative orders from the surgery favorites folder (Folders->Surgery- >Medications).

5. CHECK ALERTS

6. Save your orders as a favorite so you have to make fewer modifications next time

7. SIGN the orders when you have completed all of the phases.

If you have done your orders correctly, they should look like this:

7.1.1.3. Preop Orders for Inpatients

Do not use the 2 phase preop orders for ED/Inpatient cases. Use SURG Pre-Op from Inpatient/ED or PHA OBGYN L&D Cesarean Orders to get the correct order formats for the hospital setting.

7.2. Day Of Surgery

7.2.1. Before the case

Review your H&P. Double click on the H&P to add an addendum. Add the H&P update. If you can not add the addendum to your document, you can create a free text document and place the update there (TIP: label it H&P update so HIM can find it easily)

7.2.2. After the Case

7.2.2.1. Outpatient Cases

1. Add Follow up and postop instructions
2. Make sure your patient has a discharge diagnosis
3. Add disposition and plan for follow up to your operative note and it will fulfill the requirements for a discharge summary on outpatient surgeries.

7.2.2.2. Post op Orders

7.2.2.2.1. Same Day Admits

1. Perform an Admission Reconciliation. DO NOT Discontinue the PACU orders.

2. Select a post op admit Powerplan
3. **Click** on each phase (Initiate in PACU and Leave Planned Until Floor) to review and select all orders. Place any time sensitive orders & orders you want completed in the PACU in the first phase.

4. **Sign** orders. The first phase will initiate automatically.

### 7.2.2.2.2. Inpatients

1. **Discontinue** any prior Powerplans/orders that are no longer needed. DO NOT discontinue the PACU orders.

2. **Perform** a Transfer Reconciliation. This step is REQUIRED.
   
   Reconcile ALL orders with this reconciliation, not just medications. Resume any previous medication orders that you want to continue after surgery (they will default to resume). DO NOT Discontinue the PACU orders.

3. If you are not changing many orders, **add** the Transfer to: order individually.

4. If you need to place a new plan, **select** your post op Powerplan (see above). Click on each phase to review and select all of the orders. Orders that you want completed in the PACU go in the first phase.

5. **Sign** orders. The first phase will initiate automatically.

### 7.2.2.2.3. Outpatients

1. Place any orders that you want to be carried out during PACU recovery – **sign**

2. **Place Discharge Orders for Home** - **sign**

3. **Perform a Discharge Reconciliation.** You can add discharge medications directly to the Discharge Reconciliation.
7.3. Viewing the Surgery Schedule

Click on Case Selection on the top of the screen:

From here you can view the upcoming (or past) case schedule. You can find cases within a date range, for a specific provider, or search by name or MRN:

Change the location of your search by clicking location:
Select your desired location in this box:

A checkbox next to the name means the patient has arrived:

<table>
<thead>
<tr>
<th>Checked In</th>
<th>Status</th>
<th>Person Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>03-Jun-2013 13:02</td>
<td>FORTYTHREE</td>
<td>INT-THREE</td>
</tr>
<tr>
<td>03-Jun-2013 12:25</td>
<td>FORTYTHREE</td>
<td>INT-THREE</td>
</tr>
<tr>
<td>03-Jun-2013 11:24</td>
<td>FORTYTHREE</td>
<td>INT-THREE</td>
</tr>
<tr>
<td></td>
<td>HAMPSTEAD</td>
<td>THOMAS TEST</td>
</tr>
</tbody>
</table>

8. Partogram

The Partogram is available under the Acute Workflow tabs on the Menu.

You will find it under the down arrow:

(While you are managing labor patients, you could drag and drop to the first position so that the Workflow will open to that page).

The Partogram gives you a graphical representation and summary of the patient’s vital signs and progress in labor.
The graphs will appear when a labor onset date and time are charted in Interactive View. The labor nurses should all know how to do this step.

9. Fetalink

9.1. Strip Review

You can open Fetalink from any computer with access to Cerner. Without logging in you will be able to view the active monitoring strips and scroll back to the beginning of that monitoring session.

In order to search for older strips, you will first need to sign in.

Then click Patient Archive to search for other monitoring sessions.

9.2. Fetalink Alarms

Physicians can also address alarms when appropriate. Here are some tips on how to address the alarms.
9.2.1. **What is Alarming?**
The strip of the patient that is causing the alarms is highlighted in red.

The vital sign triggering the alarm will be highlighted in yellow.

9.2.2. **Acknowledge the Alarm:**
Acknowledging the alarm will silence that alarm unless the reason for the alarm recurs in 30 secs or more.

Step 1 **Sign in!**
Step 2 Click green check mark

OR Click paperclip to add annotation, signing your annotation will acknowledge the alert

9.2.3. **Silencing the Alarm:**
Silencing will stop the alarm temporarily for that user only, but it will start again after 30 secs even if the reason for the alarm has resolved.

To silence the alarms, click the bell

9.2.4. **Set Alarm Thresholds for Individual Patients:**
Example: a patient with chorioamnionitis with an elevated FHR baseline being treated.

Step 1 **Sign in!**
Step 2 Open patient specific view.
Step 3 Click Patient Alerting

Step 4 Set desired custom values, then click OK.

These values will remain stored for the patient for this monitoring session, unless you go back and reset to defaults. This icon will appear under the patient’s name.

Cerner Mobile Apps

https://wiki.cerner.com/display/MHGRDC/PowerChart+Touch+Training+Documents

Clinical Images

Recommended workflow for adding clinical images in to notes uses the instructions in section 1.a, 2.b, and 3.a.

9.3. Capturing Clinical Images

9.3.1. Camera Capture or Powerchart Touch Apps
The easiest way to capture clinical images and load them into a patient’s chart is with Powerchart Touch or the Camera Capture app.

### 9.3.1.1. Get the Apps

Requires an iPhone, iPod or iPad with iOS 12 or greater or Android device with OS 4.4 or greater. Camera Capture is for images only and is available for iOS and Android. In Powerchart Touch you can review the patient chart, dictate notes and take photos and is available for iOS only.

- Download app from app store
- Request access code by using the Millennium+ link (log in with your Cerner Millennium username and password)
  https://cernercentral.com/device-access/tenants/8cf1bb66-7b18-4eaa-b641-538f19feb923/user/
- Look in your Clutter inbox, or log back in to the site for your code
- Contact Dr Brecht-Doscher or Dr Patterson with any questions

### 9.3.1.2. Use the App

Find the app on your phone

![App on Phone](image-url)
Log in using your Cerner Millennium login.

There are 3 ways to find a patient:

1. **Use your schedule:**

![Schedule View]

**Hint:** the app will display your schedule by default, but you can also add any schedule you would like to use by clicking on the schedule icon.
2. **Use a list:**
The lists you will have available are the same as the lists you see on the desktop. To select a different list, click on Lists.

**Hint:** there are lists available for VCMC and SPH ED patients and full hospital lists for both hospitals. Add these lists to your options on the desktop if you work in either of these settings.

1. **Use the Search to search for any patient**
Click on the patient

In Camera Capture this will take you directly to the camera. In Powerchart Touch, then go to the Media Gallery using the menu on the left, or by scrolling to that section

Then click on the camera icon.
Click on the camera button to take a photo
Click on the green checkmark to save the photo
Click on the red X to delete the photo and take another

You will be asked to choose a photo type. For clinical photos, choose Mobile Capture. For patient photos to be displayed on the banner bar, choose person photo. The name of the photo defaults to the date and time, you can replace this with whatever you prefer by typing in the name box.
9.3.2. Uploading Photos from a Camera

You can upload photos from any device. **Note: this method is not recommended** as it is significantly harder and requires that photos are stored on external devices in a manner consistent with privacy regulations and you will need a County issued device.

First, you will need to open a Powernote. Then click on the Insert Image icon.
Choose the Drawing Box

Select the file folder
Find your image on the local disks

Then select Open. You can annotate the photo and when you save your note, the image will appear in the note, and also in the Media Gallery.
9.4. Viewing Images

9.4.1. Powerchart Touch

Choose the Media Gallery in the menu on the upper left.

You can see the images, click on them to enlarge and enlarge on your device as you do with other photos. You can also take photos from here by clicking on the camera icon.

9.4.1.1. Workflow Pages

On the Workflow pages (Ambulatory, Admit and Manage), the component appears like this:
You can adjust the lookback to find older images by selecting one of the options at the top of the component (or under the More selection).

![Lookback Options]

You can enlarge the images within the component by sliding the Size scale.

When you select an image, you can select Review to view it within the component. Rename to add a more appropriate label to the image, or select View Selection to launch it in the Media Viewer (this will take a few seconds).

![Image Selection Options]

### 9.4.1.2. Summary Pages

On the Summary pages (ED, Ambulatory, Inpatient and ICU) it will appear collapsed by default.

![Summary Page]

Click the down arrow to expand.

If you plan to use the component frequently, you can also click the 3 horizontal lines and select Default Expanded:

![Default Expanded Selection]

Once expanded, you can also change the lookback to find older images by selecting the upside down blue triangle.
To expand the image, select the image, then, select the View Selection button to view the image in the Media Viewer.

### 9.4.1.3. Media Viewer

Launch the Media Viewer from either the Workflow or Summary pages as above. It may take a few seconds for the Media Viewer to load.
loaded, you can zoom in and out, enlarge and compare images on a split screen.

9.5. Inserting Images in to Notes

9.5.1. Dynamic Documentation
First, go to your favorite Workflow page and find the Media Gallery. Click on the image you want to place in your note and select Tag:

Tagged images will display a tag in the lower right corner

Open your note. You will notice the image in the tagged items area on the left. Drag and drop the image to where you want it to appear in the note.
You will see the image in your note:

**Physical Exam**
- **Vitals & Measurements**
  - **HT:** 90 cm

Images

In the Media Gallery, images that are included in notes will have a note icon in the lower right corner. If you click on that icon, it will display the note and you can click on the title and open that note:
Note 1: you can only tag images from the Workflow pages, not from the Summary pages, or directly from the Mobile app. You can create the note on the desktop, add your tagged images save the note and complete it in the Mobile app if desired, or dictate in to the text components in the app and then create the note on the desktop.

9.5.2. Powernotes

Select the Insert Image icon

Choose MultiMedia Manager to include one, or several images in your note. Select Drawing Box if you want to upload one image and add annotations.
If you choose Drawing Box, then select File and Include Image from MMM.

You will then see the MultiMedia Manager box.

Choose the photo you would like to include in your note and click Include.
9.6. Documenting in the Mobile Apps

Starting the HPI, RoS, PE, and A&P

1. Scroll to the bottom of the Chart Review view.
2. Tap in a component section (History of Present Illness, Review of Systems, Physical Exam, or Assessment and Plan).

<table>
<thead>
<tr>
<th>Subjective/HPI</th>
<th>Review of Systems</th>
<th>Objective/PE</th>
<th>Assessment/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dictating

1. Tap in a component.
2. Tap the Nuance button above the keyboard, and begin dictating.
3. To move to the next speech-enabled element, say go to next field.
4. When you are finished, tap the Nuance button again or say microphone off.
5. Tap Save for that component.

TIP: For a full list of commands, tap the Nuance button and say What can I say?

Creating a Note

1. Access the Document view, and tap the note template you want to use.
2. Enter the appropriate information and make any other modifications you want.
3. Tap Save to save the note as a draft.
4. Tap Sign to complete the note.
5. Enter the note title, note type, and the date and time of the note in the Details dialog box.
6. Tap Save/Sign.
9.7. Discharge Workflow AKA Doing Tomorrow’s Work Today (Inpatient Providers)

The Discharge Summary has now been replaced with the Discharge page, which is a Workflow page.

It contains 2 new components to help with the discharge process: Hospital Course and Discharge Instructions for Patient & PCP.

These are multi contributor free text components that persist throughout the inpatient encounter. They can be updated as new diagnoses are made or events occur that would be appropriate to include in a discharge note. They will pull in to the discharge note automatically. When they are updated regularly, it will mean that creation of the discharge note itself will be simple and fast (these components are also available on the Manage tab so you can update them there as the patient's course changes).

The red * next to a component represents a step of the discharge process that has not been completed.
If you are not sure what step that is, viewing that component will tell you:

(You can complete all of these steps without leaving the Discharge page)

When you have completed the steps needed prior to patient discharge, a green checkmark will appear.

Then, launch a discharge note, by clicking the note creator at the bottom:
If you have not completed the discharge diagnoses, medication reconciliation or patient education, you will get a popup reminder and will need to enter a reason for override in order to proceed.

The Discharge Note created will contain the text entered in the workflow page components. You can also use this component and note template for off service/transfer notes. The text will remain throughout the encounter.

**Care Teams**

**9.8. What are Care Teams?**
Cerner’s Care Teams is the place to keep track of all of the clinical and non-clinical people that are essential for the patient’s care. It is linked to the i-PASS and Physician Handoff to ensure good communication and continuity of care.
9.9. Viewing the Care Team

You can view the patient’s Care Team with the Workflow Component

Or by clicking on the Primary Contact field on the Banner Bar

You can view role, name, contact#, service and team:

You can assign Care Team members by clicking on “Add Care Team Member”

Here you can assign yourself or other providers as Care Team members for this visit or cross visit providers (for example, if you are the patient’s nephrologist or oncologist that follows the patient across hospitalizations). If you select yourself as a Cross Visits Provider, then you will stay listed as part of the care team until that relationship is removed using the Care Teams.

If you click on a provider name in this section, you can Modify, Make Primary or Remove.

If that person is the Primary Contact, you cannot Remove (you can never remove an existing Primary Contact without adding a new one), but you can Replace and change to a new Primary Contact. You can also see the rest of the providers associated with that team:
Modify will allow you to add a role so it is clear what role that person has in the patient’s care.

You can also assign non-providers (family and friends that are important for the patient’s care). This would be a good place to note a surrogate decision maker (there is not a specific relationship for that, but you can add a note to the name field).
NOTE: You may find several “Outpatient Primary Care Provider”s associated with a patient that are not correct. This option was poorly used and is now removed as an option for users to select. You will only be able to remove yourself if you are the person you are trying to remove. If there are other names listed here that are incorrect, please notify HCA.Helpdesk@ventura.org and they can be removed.

9.10. Managing Care Team Providers

It is important to keep Care Team provider assignments accurate and up to date in order to improve communication among the patient’s care team. In the past many people would assign themselves to one team and then continue to use that one role for primary contact assignments even when they had moved to another team (ie: intern starts on Medicine Team A and assigns themselves to Team A on July 1st, on their next rotation they are on surgery, but when they add themselves as the primary contact, they choose their name under Medicine Team A – that patient will now appear on the Medicine Team A list, not the surgery list). This will make the lists inaccurate and will be confusing for other members of the care team.

Complete the following steps to add and remove a provider to a medical service or medical service and team combination:

1. Select Manage Care Team Providers from the list at the upper-right of the window.

2. Select a service from the Medical Service list box and a team from the Team list box (optional) using the down arrow button (use the most specific combination whenever possible). A list of providers for the medical service you selected will display.
3. To add a provider, enter part of the provider name in the provider search box. Select a provider from the list of results.

4. To remove a provider click the **delete** icon to the right of the provider name.
5. To reactivate a removed provider, click the undo arrow to the right of the provider name in the Providers section of the window.

6. Click **Apply** to save all modifications (additions or removals) for the Care Teams and close the Manager Care Team Providers window. Note: If you fail to click **Apply**, any modifications you made are not saved to the database. If you prefer, you can make additional modifications before you click **Apply**.

   **9.11. Assigning Primary Contact**
   
   Click on the Primary Contact field to add or change the Primary Contact:
You can change multiple contacts at once by selecting multiple patients.

You can assign yourself as the Primary Contact. Be sure to assign the correct team (if you are no longer part of another team that appears here, you should remove yourself from that team – see Manage Care Team Providers above).

You can also assign someone else as the Primary Contact. Make sure you select the correct service/team!
**Admission Workflow**

See / interview the patient
Consider writing holding orders now if the plan is clear; consider steps 4-10 first if needing to organize thoughts prior to knowing what orders to write
Open Acute Workflow, “Admit” to write down HPI and ROS, saving them both frequently
Add Diagnoses (active “This Visit” issues) and Problems (‘past medical history’ or “Chronic” issues), and

9.12. **Number the Diagnoses in order of importance**

9.13. **Go to Histories tab to document Family, Procedure (can be done on Workflow component), and Social history including End of Life Wishes on EVERY PATIENT.**

This is critical to good patient care, and will carry through to other patient encounters
Missing any one item of Family History, Social History, Past Medical History or Review of Systems means that an admission isn't even billable at the lowest level; all elements are required.

confirming correct home med list (alternatively, can also discontinue medications by right clicking on the medication directly in the “Admission Medication Reconciliation” window); be sure that dose/route/frequency are accurately filled in to save time when converting meds to inpatient meds and for fast/accurate medication reconciliation at discharge

9.15. “Create Note” in acute workflow (bottom of the left sided column)
Document data in empty fields (Code Status [unless it has already been documented in Social History], PCP, Family Contact, Patient Pharmacy, Anticipated Needs on Discharge, Caregiver)
Go to “Patient Pharmacy” tab and find the patient’s preferred pharmacy and right click on it and “Add as Patient Preferred” – this will prevent wasting time hunting down that info at discharge
Finish documenting your physical exam and any EKG or radiologic interpretations via “Diagnostic Studies”. Fill in “Anticipated Needs at Discharge” and “Caregiver”.
In the “Disposition” section of each note clearly state whether the patient is a “full admission” or is on “observation” status. Write how many more days you expect the patient to require hospitalization and the major milestones which must be addressed before discharge (discharge planning starts before admission). A proper admission Disposition section might state:
“Disposition: Full admission with expected length of stay greater than two midnights. High risk of morbidity/mortality secondary to acute pancreatitis requiring IV narcotics and monitoring of respiratory status/blood oxygenation.”
Document your assessment and plan and “Sign” your note (if need to change order, refresh the Assessment and Plan and select Refresh Chart Data)

9.16. Perform “Admissions Medication Reconciliation”
Nurses and Pharmacy Techs cannot discontinue medications outside of exact duplicates which they may VOID. If a medication was intentionally discontinued by a physician, it is the admitting physician’s job to discontinue it from the medication list.

9.17. Write admission orders
Be sure to click on both the “Initiate in ED” phase and “Leave Planned Until Floor” phase. “Initiate in ED”, when signed, will initiate immediately.
“Leave Planned Until Floor” should have “Orders for Signature” clicked which will leave that phase in a planned state, to be initiated by nursing staff when the patient gets to the floor. “Leave Planned Until Floor” orders should be initiated within 4 hours of orders being placed, even if patient is still in ED (as a boarder). One time orders for ED, and medications that are time sensitive (i.e. antibiotics) should be Initiated immediately in ED.
See here for more details about writing orders

9.18. Clinical Tips for Admit Orders
Hold blood pressure medications if medical condition may also cause low BP (i.e. sepsis)
Watch for rebound HTN/tachycardia if holding clonidine or beta blocker
Consider ordering medications ad hoc which will soon have default hold parameters (i.e. hold AV nodal blockers for SBP < 105 or pulse < 60, non-AV nodal blockers for SBP < 110, with other nuances to come; these hold parameters will be listed in Special Instructions and may be manually changed if needed)
Hold diuretics for volume depleted patients
Avoid combining multiple nephrotoxic medications: ACE inhibitors/ ARBs, NSAIDs, vancomycin, piperacillin/tazobactam, aminoglycosides, acyclovir, IV contrast, diuretics
Consider parenteral anticoagulants over DOACs in hospitalized patients (see pharmacy website for flow sheet)
Caution with continuing anti-hypertensives, diuretics, anti-depressants in the ICU (SSRI + fentanyl = serotonin syndrome)
Ad hoc orders for AV nodal blocking agents will soon have default order sentences as follows: “Hold for SBP < 105 or pulse < 60. Call provider if ANY DOSES are held; for dialysis patients, hold if SBP < 135 if within 4 hours of dialysis” written in “Special Instructions”; continuation of those medications from an outpatient list will not have those same parameters, so they will need to be added (or order the medication ad hoc)
Ad hoc orders for NON-AV nodal blocking agents (including oral nitrates) will soon have default order sentences as follows: “Hold for SBP < 110. Call provider if TWO CONSECUTIVE doses are held; for dialysis patients, hold if SBP < 150 within 4 hours of dialysis” written in “Special Instructions”; continuation of those medications from an outpatient list will not have those same parameters, so they will need to be added (or order the medication ad hoc)
Nitroglycerine products that can quickly be discontinued (patches, paste, drips) will have default order sentences as follows: “Hold for SBP < 95”
Coming soon will be distinction of ACE inhibitors and Angiotensin Receptor Blockers for Hypertension (same parameters as above in “h”) or for Systolic Dysfunction (hold for SBP < 95)

9.19. Primary Contact/IPASS
On “Physician Handoff” page, click on “Primary Contact” and assign yourself as that contact if you are not already assigned as such
On “Physician Handoff”, complete the “I-PASS” prior to leaving the hospital as a sign out to the cross covering physicians

Transfer Workflow
From the “Orders” tab, click on ‘Reconciliation’ and then ‘Transfer’ and complete the All Orders “Transfer Reconciliation”. This is a REQUIRED on all step ups or step downs or change of location and from PACU back to the floor. Failure to complete the “Transfer Reconciliation” prior to ordering “Transfer to” will result in a pop-up message and an inability to sign the order until the “Transfer Reconciliation” is completed first
Write “Transfer to” order and complete appropriate details

Discharge Workflow
Go to “Acute Workflow” → “Discharge”
→ "Hospital Course" and “Discharge Instructions for Patient and PCP” and add significant details. Do this through the patient’s stay to save time at discharge. They will pull in to your discharge note.
→ “Patient Education” to pull in patient education materials for your patient
Ensure patient’s preferred language is chosen
Perform “Discharge Medication Reconciliation”
Note: this does not go into effect and does not change inpatient medications
Order “Discharge Orders to Home”
Be sure to include follow up appointments, discharge labs (ordered as “Future Order”, “Yes” with the actual lab if getting blood drawn in our system, ordered as free text under “Discharge Labs” and “Discharge

**Order Writing Details Inpatient**
Avoid telephone orders unless you’re driving or don’t have access to a computer

Keep up to date on signing unsigned Orders in your Message Center. You will be alerted to these orders by the “Orders” tab on your Toolbar

**9.20. Inpatient Powerplans**
Use Order Sets (“Powerplans”) whenever possible
Ordersets begin with prefixes depending on their function
PHA = Subphase: collections of orders for specific tasks like transfusion of blood, treatment of hypercalcemia, etc.
EMER = Emergency Department: usually has 1x orders (as the ED nurses don’t see anything more than x 1 orders in general), and labs will say “Nurse Collect”, “Yes” and therefore print lab labels on the label printers in the ED
MED = “Medicine”
ICU = “ICU”
OBGYN = OBGYN
LAB = lab
Utilize Use Med General Admit multiphase and ICU General Admit multiphase for almost all adult non-pregnant adult patients, except for Stroke /TIA (search the word Stroke in the orders pane, make sure that “Contains” is selected for Stroke-specific Powerplans)
“Multi-phase” ordersets have two (or more) parts that may be initiated at different times (MED General Admit Multi-Phase is the main plan, “Initiate in ED” and “Leave Planned Until Floor” are the phases of that parent plan in this example).

Initial phase of Admission Ordersets is initiated immediately when signed, and is bolded when signed to indicate that it has been initiated.

2nd and 3rd (and later) phases may either “Plan for Later” if the patient is in ED and the ED nurse does not need to see all of the floor orders, or “Initiate now” if they have already arrived to the floor.

If “Planned for Later”, those orders should be initiated within 4 hours even if the patient remains in the ED as an ED hold, but that does not always happen.

Clinicians may view the powerplans to see if the second phase has been initiated by looking at the Orders tab → View → Plans.

Bolded phases (Initiated) have been initiated.

Normal print phases (not bolded) (Planned) are waiting to be initiated and do not have any active orders.

If you would like to select additional orders from a Powerplan that has already been initiated:

Click on the Powerplan or phase where the order resides (i.e. above, click on “Initiate in ED (Initiated)”).

Click on the lightbulb icon above the orders.

Unselected orders will now appear.

Select the desired order and initiate it.

This is the workflow for daily renewal of restraints.

### 9.21. Special Instructions

If additional order details are needed (i.e. “hold Lactulose for > 4 soft BM’s/day”), place those orders in the “Special Instructions” field as those orders are the most face up for the nursing staff.

PRN orders for two medications for the same indication require a stepwise order clarification (e.g. Reglan 10mg IV Q6 hours PRN nausea/vomiting; Zofran 4mg IV Q6 hours PRN nausea/vomiting not controlled by Reglan).

### 9.22. PRN Orders

PRN orders for pain should have “mild pain”, “moderate pain” and “severe pain” all addressed (and may also have “breakthrough pain” addressed). Do not forget about an indication, and do not have more than one medication for one indication (though 1 Norco for “mild to moderate pain” and 2 Norco for “severe pain” is a valid order, 1 Norco for “mild pain” and 2 Norco for “severe pain” misses moderate pain and is not a valid order). NOTE: If the patient is admitted for an infection-related issue, please do NOT order acetaminophen or acetaminophen containing products (i.e. Vicodin, Norco, Percocet) as the PRN pain medication to avoid masking a fever!!

You cannot have two orders for the same indication – you must specify which to give first and which to give second. For IV drips in ICU (i.e. dexmedetomidine and propofol for RASS score), one must be written “Do not titrate” and the other may remain titratable.
9.23. Diet Orders
Diet orders that have more than one detail (i.e. dialysis diet + modified carbohydrate diet) should have one of the two diets ordered and then the second diet detail entered into “Special Instructions” (in general, “Special Instructions” is the best place to write any details as other fields will not be as readily visible to nursing).

9.24. Order Frequency
For the majority of medications, order “Daily, BID, TID, or QID” for administration frequency, administered by the following table so that patients receive the majority of their medications on a schedule and not haphazardly:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1000</td>
</tr>
<tr>
<td>BID</td>
<td>1000, 2200</td>
</tr>
<tr>
<td>TID</td>
<td>0600, 1400, 2200</td>
</tr>
<tr>
<td>QID</td>
<td>0600, 1200, 1800, 2200</td>
</tr>
</tbody>
</table>

Note: If a medication is ordered some time after the above times, it may not be administered till the next time (i.e. if BID medication is ordered at 1205, it’s most likely to be not given until 2200); if you’d like a dose to be given “Now”, consider changing “First Dose Priority” dropdown to “Now”.

Note: Enoxaparin Daily is administered at 0900, and Coumadin Daily is administered at 1400, by hospital convention.

Note: For antibiotics, therapeutic enoxaparin, esomeprazole for GI bleeders, and other medications that are dependent upon the time of the initial administration, order “q24h”, “q12h”, “q8h”, etc; be aware of the initial order time and when you want your next dose to begin.

Note: ‘unscheduled’ frequencies such as ‘post-HD’ or ‘pre-op’ will default to one-time doses only; more than one desired dose requires a Frequency.

9.25. Communication vs Task
Utilize “Communication Order” for orders you want to stay on the patient’s chart (i.e. strict Is and Os); utilize “Misc Nursing Task” for orders you want to go to the nurse’s task list (one-time orders like “call physician when family member arrives”).

Even if you verbally communicate with Social Services about a need (placement, equipment, etc), please also electronically place a “Consult to Social Services” with reason for the consult. Substance abuse counseling and homelessness are ordered as “Consult to Counselor” (Note: Do not place this order unless a patient is both willing and able to talk to a counselor about substance abstinence).

9.27. Quick Orders
Use “Quick Orders”, “Inpatient Medicine and ICU” tab for the following orders:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Columns 3 / 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrolyte repletion</td>
<td>Labs</td>
<td>Column 3 = billing codes</td>
</tr>
<tr>
<td>Powerplans by Organ System</td>
<td>Stat Labs</td>
<td>Column 4 = Ad hoc order entry</td>
</tr>
<tr>
<td>Critical Care Neurologic Meds*</td>
<td>Add on labs with reflex stat draw^</td>
<td></td>
</tr>
<tr>
<td>Nausea Meds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspepsia/ Acid Meds</td>
<td>Add on labs with reflex AM draw^</td>
<td></td>
</tr>
<tr>
<td>Constipation Meds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Meds (subcategories: IV once, oral)</td>
<td>AM Labs ordered</td>
<td></td>
</tr>
</tbody>
</table>
once, PRN, or scheduled) | AFTER midnight
---|---
Antihypertensives (subcategories start with PRN IV which includes hydralazine order with extended details) | AM Labs ordered Before midnight
Neurologic Meds | Timed studies
Miscellaneous Meds | Diagnostic studies

* = Critical Care Neurologic Meds includes one-time doses of sedatives and paralytics, extremely useful for the ICU

^ = Add on labs with either reflex stat draw or reflex AM draw reflects what to do if there is insufficient quantity of blood (or blood in the incorrect tube) to get the test performed.

9.28. Ordering Labs/Studies

HIV testing is better performed with the HIV 1-2 Ab/Ag EIA lab order. If high suspicion for HIV, order “HIV Stat” order but also await EIA order as well for confirmation. There is a program to offer all patients in ED an HIV test upon admission, ordered by the “LAB ER Panel”. If your patient opts out, there is “LAB ER Panel No HIV”

Use “Quick Orders”, “Inpatient Medicine and ICU” for daily labs/ stat labs (see prior page for details about Quick Orders)

“Send out” tests are sent to Quest and may take several days to result. (You can find a list of more common send out tests by placing a “QUEST” (starts with) order in Cerner; however, many other send out tests will not have a specific accompanying order in Cerner and will require a “QUEST Flexitest” order to be placed. Call the lab at x6037 and ask to speak to the “send out tech” for assistance with ordering these tests (alternatively, you can find the necessary details yourself on the Quest website; we use the San Juan Capistrano test location).

Note that it is the primary team’s responsibility (ie, yours!) to ensure that the appropriate micro and path studies (eg cultures, pathology specimens, etc) are ordered prior to a patient undergoing a procedure!

Utilize ordersets starting with “LAB Analysis –” for specimens

If “signing” the order when writing it, the labels will not print at the site of the procedure being performed (i.e. if happening in IR); Find the Powerplan Title in the View, right click, and select “Plan for Later”
9.29. Diabetes Orders Specifics

Subcutaneous Insulin Orders
Ordered via the PHA Adult SubQ Insulin PowerPlan
Located in the “Leave Planned Until Floor” section of the MED General Admit Multi-Phase Powerplan
May also be ordered ad hoc

Short acting insulin
For patients with mild hyperglycemia and well-controlled Hemoglobin A1C, consider correction dosing only
For patients with significant prandial hyperglycemia, consider both correction dosing and prandial dosing
usually don’t do prandial on admission orders unless patient with known prandial hyperglycemia issue

Correction dosing
Low-dose algorithm for normal weight patients (0-40 units of insulin daily)
Medium dose overweight/obese or high insulin requirements at home (41-80 units of insulin daily)
High-dose for overweight/obese or high insulin requirements at home (>80 units of insulin daily)
Very low-dose for patients with ESRD or very low weight
Must also choose whether the patient is eating (orders qAC + qHS insulin dosing) or NPO/tube feeds (orders q6 hour insulin dosing) when ordering correction algorithm

Prandial dosing
2 options (carbohydrate ratio dosing or fixed dosing)

RATIO DOSING:
Found in “PHA Adult SubQ Insulin” orderset under “insulin lispro – Breakfast”, “insulin lispro – Lunch”, and “insulin lispro – Dinner”
Gives set amount of insulin per grams of carbohydrate
1 unit per 30 grams carbohydrate is least strict, for thin patients or those with end stage renal disease
1 unit per 15 grams is standard for patients with average glucose tolerance
1 unit per 10, 7, or 5 grams should only be used if lower doses of insulin prove inadequate
At VCMC, each "modified carbohydrate" diet has 60 grams carbs -> 4 units.
OR... INSULIN-TO-CARB RATIO: 450/TDD = # grams covered by 1 Unit

FIXED DOSING:
much less preferred in the hospital due to variable PO intake and rapidly changing clinical status in the hospital
NOTE: Skilled nursing facilities do NOT use carbohydrate ratios and only do fixed dosing; do NOT send patients to skilled nursing on carb ratio dosing
Changing either correction dosing or prandial dosing requires the following steps:
Discontinue the specific orders no longer desired
Order a new “PHA Adult SubQ Insulin” PowerPlan
Unclick orders that are already active (hypoglycemia orders and when to check sugars)
Order new correction dosing or prandial dosing
NOTE: doing this differently (as in, discontinuing entire powerplan and reordering a new powerplan) creates an incessant number of orders (~22) to review for nursing staff, and this is not the preferred workflow for that reason
Changing patients from prandial correction dose (QAC + QHS administration) to NPO or tube feed correction dose (q 6 hours) requires the same re-ordering process as above
IV Insulin Orders
PHA Diabetes Type 1 IV Insulin Orders Using GlucoStabilizer NOT DKA NOT HHS
PHA Diabetes Type 2 IV Insulin Orders Using GlucoStabilizer NOT DKA NOT HHS
PHA DKA HHS IV Insulin Orders Using GlucoStabilizer
The above order sets makes you choose “modifier” under the order for the “Insulin Drip Regular 1 unit / ml” which generates the algorithm for amount of insulin given
0.01 should now be chosen for most patients; 0.02 was preferred in the past but resulted in too much hypoglycemia
Transition off of insulin infusions usually performed either in the morning or at night:
PHA Transition Intravenous to SubQ Insulin (Multi-phase Order)

9.30. Finding Information in Cerner
Workflow pages for the easiest review
Results Review for additional information
Change the date range as needed by right-clicking the dates
Watch for the “Show More Results” in the middle of the screen if you’re not seeing results you want to see (Cerner will only call up a certain number of results; if there are more results in that date range, you will need to click this button to see those data points)
Ins and Outs
Daily breakdown best seen in Workflow Pages⇒Manage⇒Intake and Output
Hourly breakdown best seen in Workflow Pages⇒ICU Dashboard⇒Vitals and Hemodynamics
(also has whole hospitalization balance in the top right corner)
Whole hospitalization breakdown of total in and total out best viewed via the .iosummary dot phrase in a note
.inoutreport and .iosummary both have ml/kg/hour calculations for urine output listed
Blood sugars
Range is listed on vital signs in your daily note
If vital signs are not listed in your note, use .Vitals24Hrs dot phrase in your note
.diabetes_inpatient will list all blood sugars for prior 48 hours
Change “Flowsheet” to “Diabetes Inpatient Flowsheet” for the best view (includes insulin administered, HbA1C, etc.)

MAR Summary
Organized by active Scheduled Meds (light blue), then PRN meds (green), then Continuous Infusions (light blue)
Medications that have been discontinued are greyed out
Date range may be changed to see other dates
Miscellaneous Information
Anticoagulation Flow Sheet is found under “Interactive View and Is and Os” and gives flowsheet information for anticoagulants and blood tests
Neuro checks are generally found under “Results Review”, “Assessments”

9.31. Documentation in Cerner

9.32. Notes

9.32.1. Admission notes
Select "Admission H&P” Note Template and “Admission Note-Physician” Type
Daily progress notes
Select “Inpatient Progress Note” Note Template and “Progress Note-Physician” Type
For ICU, consider selecting “Free Text Note” Note Template, then type .criticalcaresystemsnote
Discharge notes
Select “Discharge Note” Template
Select “Discharge Note” Type for two or less and “Discharge Summary” Type for three or more days in the hospital

9.32.2. Procedure notes
May select "Procedure Note” Template
May alternatively select “Free Text Note” and paste in specific procedures from the templates on the www.venturafamilymed.org website → Cerner → “Auto Text Dot-Phrases” (see “Make your own .phrases” below)
Also document procedures (i.e. lines, intubations, etc.) in the “Procedures” section of Histories, which will automatically pull into the Discharge Note Template significantly decreasing amount of time needed searching for procedures in documentation
9.32.3. Pulling Cerner data into your note
Data automatically gets pulled into templated notes
Highlighting anything in another note will usually lead
to a tag of that highlighted data and will bring up a separate window in other notes;
that data can then be clicked and dragged in your note, with a superscript and reference for where that information came from. This is extremely useful for copying HPI from the admission note into your discharge note.
If data is not pulled in automatically, data in Cerner is most effectively pulled into notes with .phrases

9.32.3.1. Miscellaneous admission data
.ro will bring in a templated review of systems which can then be modified
.meds_today will bring in medications administered today; .meds_yesterday will bring in
medications administered yesterday; extremely useful for HPIs
.socialhx and .familyhx bring in Social History and Family History respectively, useful if you've done updating
.criticalcaresystemsnote brings in a large systems-based template for ICU admissions, best placed in a “Free Text Note”

9.32.3.2. Vitals, Ins and Outs, and Blood Sugars POC
.vitals24Hrs lists most recent, minimum and maximum for vitals signs, point of care blood sugars,
and some invasive hemodynamics and is automatically brought in to the Inpatient Progress Note
.vitals lists most recently recorded vitals
.vitals-meas lists latest vitals, height, weight and pain score
.io_summary brings in total ins and total outs for last 3 days and for entire hospitalization
.inoutreport brings in each category of intake and output
.diabetes_inpatient lists the last 48 hours of blood sugars; .diabetes is more useful for outpatient

9.32.3.3. Lab data
.inptlabs will bring in lab data
.electrolytes will list most recent electrolytes and repletion methods
.healthmaintlabs brings in TSH, lipids, etc.
.bloodgases brings in ABGs (maybe not VBGs)
.micro (microbiology results) for cultures
.bodyfluidanalysis and .csfanalysis will bring in the respective data
.hivlabs brings in relevant data for HIV positive patients
.heplabs brings in labs relevant to hepatology
.labs.__ will bring in specific labs, including for endocrine, GYN, newborn, peds, renal, rheum, STD, tox_screen, ua, uds

9.32.3.4. Radiology data
There are multiple options for pulling in radiology studies (including EKGs) depending on what information you would like, and all begin with “.rad.”
.echo.ef lists most recent echo date and recorded EF

9.32.3.5. Medication data
.medlisthome and .medlisthosp bring in home med list and inpatient med lists respectively
.antibiotics brings in antibiotics administered during the current encounter and the dates administered
.fluids lists current active drips including IV fluids and IV infusions
.bloodproducts brings in administered blood products
9.32.3.6. **Diagnosis lists**

- `diagnoses-plan` lists diagnoses in number order with a space between diagnoses (most useful)
- `diagnoses` lists diagnoses with no spaces
- `diagnoses-orders` lists diagnoses with related orders

**Orders**

- `orders-today-provider` lists all orders placed today by the provider writing the note
- `orders-pend` lists pending orders not yet resulted

9.32.3.7. **Discharge .phrases**

- `dischargeorders` brings in a template for discharge orders (for placement at Skilled Nursing Facility for example)
- `dischargeshortstay` lists required components for discharge for patients hospitalized for < 48 hours
- `followup` lists follow up appointments
- `medlistpatient` inserts a patient friendly med list into your note in the patient’s preferred language (English or Spanish only) and translates the instructions in the freq/route/prn fields if necessary. Useful to print a list for a patient
- `opat` (Outpatient Antibiotic Therapy) when using the “OPAT Note” Document Type allows for multiple contributors (physician and social services and nursing and others) to see and edit the note as long as it is “saved” and not “signed”

9.32.3.8. **Miscellaneous .phrases**

- `asaclassification` brings in ASA Classification for surgeries
- `calc_saps2` brings in information regarding septic shock and disease severity, needs hourly urine output recorded
- `calc` phrases for ASCVD scores, has bled, CHA2DS2-VASc scores
- `sepsis` phrases for sepsis screen criteria
- `septicshockinitial` and `septicshockfollowup` list elements required to meet quality measures for septic shock; the follow up is required within 4 hours of the diagnosis of sepsis
- `hosp_score` for calculating readmission risk