



***Provider Workflow and
Dynamic Documentation
Superuser Guide***

November 2016

Crossings Healthcare Solutions
367 South Gulph Road
King of Prussia, PA 19406-0958
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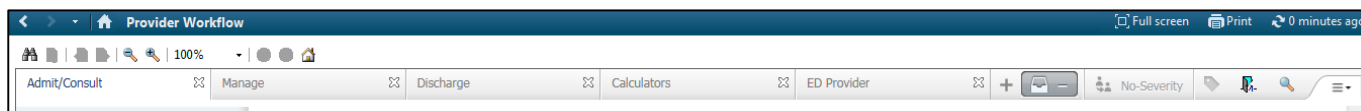
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The Provider Workflow & Dynamic Documentation Notes

The Provider Workflow assists the physician with their daily workflow. It allows the provider to review patient data and documents, place orders from one location, and provide an efficient and structured way to document from the beginning to the end of the patient stay.

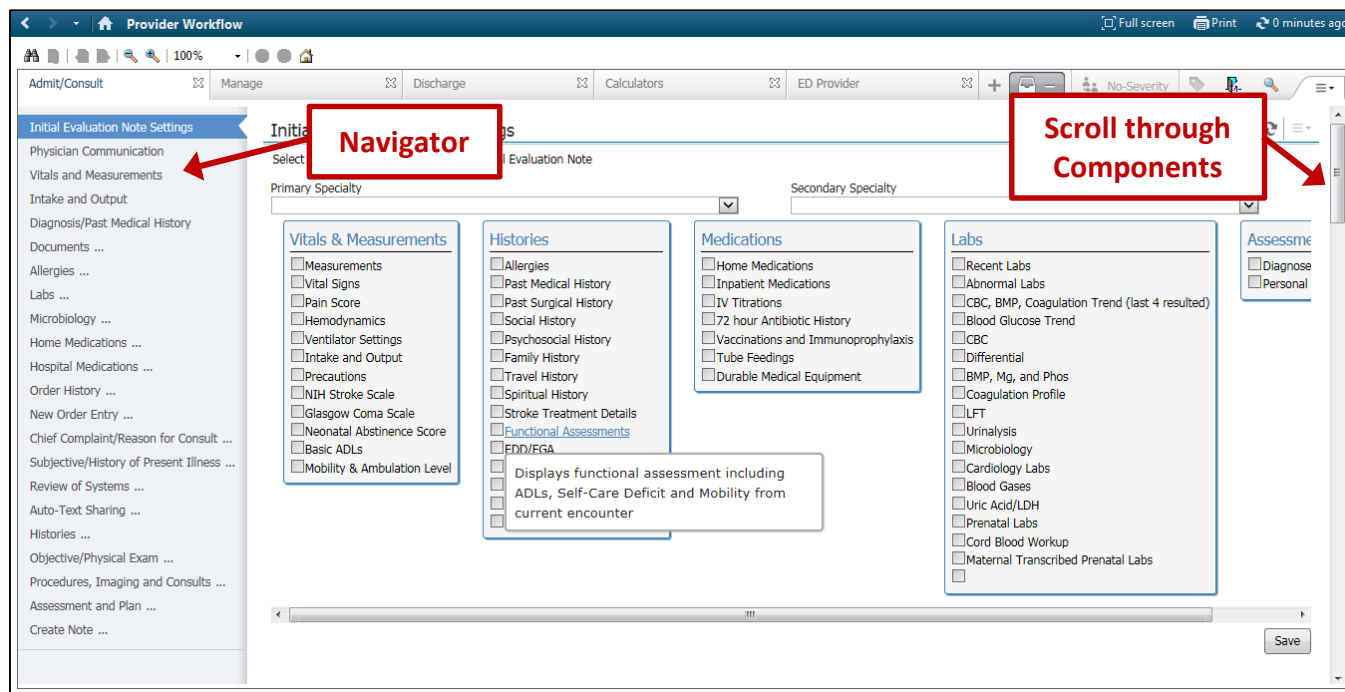
The provider is able to utilize free text boxes to document History of Present Illness (HPI), Review of Systems (ROS), and Physical Exam. Additionally, integrated functionality allows Physician Communication to be seen and documented in Physician Handoff and Provider Workflow.

After the provider completes their review and work on the chart, they can capture the necessary portions of documentation for the care they are providing directly within their workflow. The Provider Workflow consists of four tabs or Views



- The **Admit/Consult** view is used to generate an H&P or Consultation note.
- The **Manage** view is used for creating a Daily Progress/SOAP note.
- The **Discharge** view is used for the Discharge Summary.
- The Calculator Tab provides various clinical calculators.

Within each view, the provider is able to scroll down through the components in the main window, or they can click the desired component in the Navigator to jump to that specific component.



The components can be rearranged to best match a provider’s workflow by simply dragging and dropping them to the desired location in the Navigator. This will change the order of the component in the input window as well.

Admit/Consult Tab

The Admit/Consult tab of the Provider Workflow will be used to generate an Admission History and Physical, or a Consult note. The tab consists of the following components:

Initial Evaluation Note Settings

This component allows you to customize which data elements will be pulling into the H&P or Initial Consultation note. These data elements will populate into predefined sections of the note. This component is present on all tabs. The selections are set per the user on their respective tabs and will not have to be addressed every time a note is created.

Initial Evaluation Note Settings Admin Mode

Select templates to be included in the Initial Evaluation Note

Primary Specialty Secondary Specialty

Vitals & Measurements

- Measurements
- Vital Signs
- Pain Score
- Hemodynamics
- Ventilator Settings
- Intake and Output
- Precautions
- NIH Stroke Scale
- Glasgow Coma Scale
- Neonatal Abstinence Score
- Basic ADLs
- Mobility & Ambulation Level

Histories

- Allergies
- Past Medical History
- Past Surgical History
- Social History
- Psychosocial History
- Family History
- Travel History
- Spiritual History
- Stroke Treatment Details
- Functional Assessments
- EDD/EGA
- Antepartum Risk Factors
- Pregnancy History
- Delivery Information
- Neonatal Delivery Information

Medications

- Home Medications
- Inpatient Medications
- IV Titrations
- 72 hour Antibiotic History
- Vaccinations and Immunoprophylaxis
- Tube Feedings
- Durable Medical Equipment

Labs

- Recent Labs
- Abnormal Labs
- CBC, BMP, Coagulation Trend (last 4 resulted)
- Blood Glucose Trend
- CBC
- Differential
- BMP, Mg, and Phos
- Coagulation Profile
- LFT
- Urinalysis
- Microbiology
- Cardiology Labs
- Blood Gases
- Uric Acid/LDH
- Prenatal Labs
- Cord Blood Workup
- Maternal Transcribed Prenatal Labs
-

Assessments

- Diagnoses
- Personal Order History

Save

1. If the provider chooses, they can select the appropriate specialty under Primary Specialty.
 - a. If necessary, a secondary specialty can be selected.
2. Click the boxes next to the appropriate smart templates to be included in the note.
 - b. Hovering over the blue titles will show a description of the included data.
 - c. Clicking the blue title will show a preview of the data to be displayed in the note
3. Once all the needed elements are selected, click Save. The entire component will collapse and save the settings for all future notes on the Admit/Consult tab. The selections can be updated anytime in the future by clicking update.
 - d. The other tabs can be saved in the same manner.

Physician Communication

Physician Communication has three tabs- Order Renewal, Quality, and Communication.

- Order Renewal- Any medication orders that have expired or will be expiring in the near future will display on this tab. The provider can allow the order to expire by selecting the first check box (E) or they can renew the order by selecting the second check box (R.) After selections have been made, they must be signed by selecting Submit.
- Quality- Continuous orders such as Central Lines and Urinary Catheters are displayed on this tab. The provider can discontinue the order by selecting the first check box (D) or they can document a reason for

continuation by selecting the second check box (C) and choosing a reason for continuation from the dropdown selections. After selections have been made, they must be signed by selecting Submit.

- Communication- This tab allows for simple communication of non-urgent items amongst the care team. A nurse can add a communication and it will display face-up on this tab for all providers.
 - If the item will not be addressed by the provider, they can select the first check box (I) to ignore. If they will be addressing it, the second check box (A) can be selected to acknowledge. Ignoring an item only applies to the user making the selection, while Acknowledging an item does so for all users.
 - Items that have been Ignored/Acknowledged can be viewed by expanding the +, and can be reactivated by selecting the arrow.
 - Providers can add new communications by selecting +Add New Communication. This will open a form where the provider can enter the communication, then select the check mark in the upper left corner to sign.

Allergies

The Allergies component pulls directly from nursing or previous documentation. Allergy information details are displayed showing reaction, severity, onset, and source of the information. Additional allergies can be added by clicking the quick add button. **+** The Allergies header is also a hyperlink to the Allergies tab.

Vitals and Measurements

Vitals and Measurements pull in from nursing documentation. Look back options allow the provider to control the amount of data they see. Providers can change the look-back criteria in the upper right hand corner of the component (Last 1 days, Last 1 months, etc.)



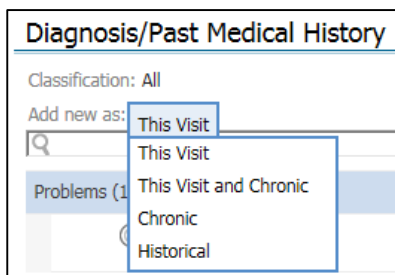
The Vitals and Measurements header is a hyperlink to the Vital Signs Tab.

Intake and Output

The I&O section pulls any information documented on a patient's Intake and Output.

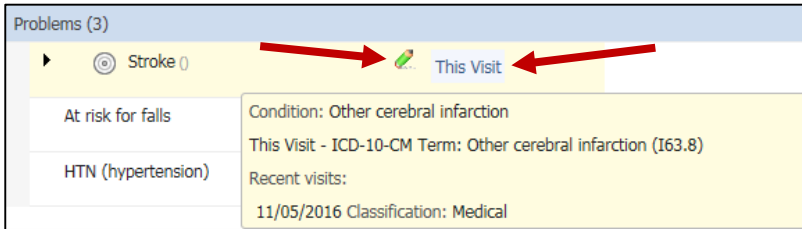
Diagnosis/Past Medical History

This component pulls in documented diagnoses (This Visit), problems (Chronic), and past medical history (Historical) that have been documented on the patient. New diagnoses or Problems can be added as Historical, Chronic, or This Visit. The default for this component is This Visit, but can be changed by clicking This Visit above the search box field and selecting the appropriate filter.

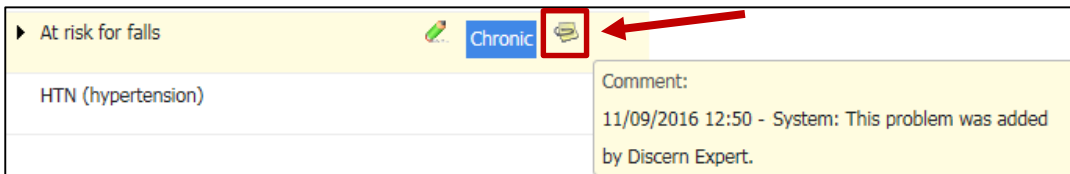


1. To enter a new diagnosis or problem, type the term into the search box (located above the Problems list with the magnifying glass).

2. Select the appropriate diagnosis or problem.
3. An existing diagnosis can be modified by clicking the pencil icon next to the diagnosis.
4. The status of the diagnosis can also be changed by clicking the status (i.e. This Visit) and changing it to the appropriate status.



5. Some problems listed will come from either Nursing documentation or Clinical Decision Support in the system. To see a comment, place the mouse over yellow paper with clip icon.



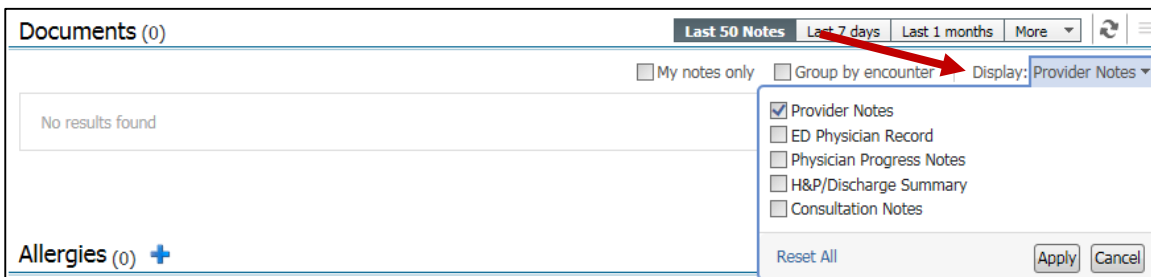
6. To show the Historical Problems on the same Problems list, click [Show Historical \(0\)](#), located on the right side of the screen.

The Diagnosis/Past Medical History Header is also a hyperlink to the Problems/Diagnosis tab, where changes/additions can also be made.

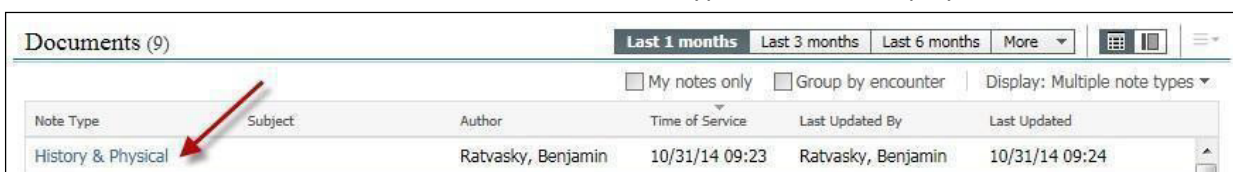
Documents

The Documents component displays documents from the patient's chart. Click the selected note to view it. Providers can change the look back criteria, as well as filter to view only their notes or group by encounter. The layout can be changed so providers can view the content of the note from within the tab.

1. To change the filter, click the field next to Display.

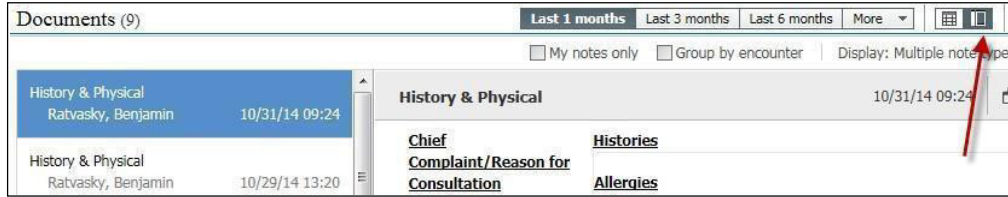


2. Check the boxes to add to the documents displayed, or uncheck to remove them.
3. Click **Apply**.
4. To view the document, click the blue link under the note type, which will display the document.



5. Documents can be previewed rather than opened.
 - a. Click the preview button located in the right corner next to the look back tabs.

- b. Providers can scroll down on the left side to select the document they want to preview, and it will display on the right.



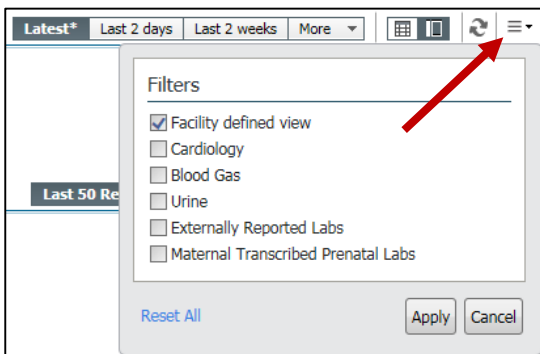
Labs

The Lab component displays the patient’s resulted labs. Primary labs are the default filter, but the filter can be modified. Providers can also change the look-back criteria as well. (Last 2 days, Last 1 months, etc.) The Labs header is a hyperlink to the Laboratory Tab, as well.



The Filters control what is displayed the component. To change the filter settings:

1. Click the filter icon in the right side of the screen (three horizontal lines with an arrow next to them).
2. Select Filters.

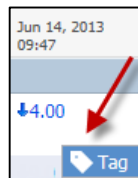


3. Check the box to add the lab results to the display, or uncheck it to remove them.
4. Click Apply.

Lab results can also be individually “tagged.” Providers can “tag” individual lab results to have them included in the Note. This would normally be done on abnormal results, or results over 24 hours old. Labs are the only individual values that can be tagged directly from Provider Workflow.

To tag a lab:

1. Click the lab to be tagged.
2. Right-click and select Tag.



Microbiology

This component displays resulted labs, pathology, and microbiology from the patient’s chart. Providers can also change the look-back criteria as well. (Last 2 days, Last 1 months, etc.)

Home Medications

The Home Medications component displays documented home medications, including last dose taken and patient’s compliance information. Clicking the Home Medications header will take the provider to the Medication

List. Click Document Medication by Hx button to document the home medications. Alternatively, the Meds History can be completed using the hyperlink in the Hospital Medications component.

Hospital Medications

The Hospital Medications component displays all active medications broken down by Scheduled, Continuous, PRN, etc. The status of the Meds History and Admission Med Reconciliation can be viewed as well. A green check mark will display if the history and/or reconciliation is complete.



Admission medication reconciliations can be completed from this component by clicking the Admission hyperlink. The link will open up to the selection reconciliation. Providers can add new orders or prescriptions and modify existing orders to complete the reconciliation.

NOTE: It is the recommended workflow to complete the Admission Medication Reconciliation before placing any orders on the patient.

Clicking the Hospital Medications header will take the provider to the Medication List.

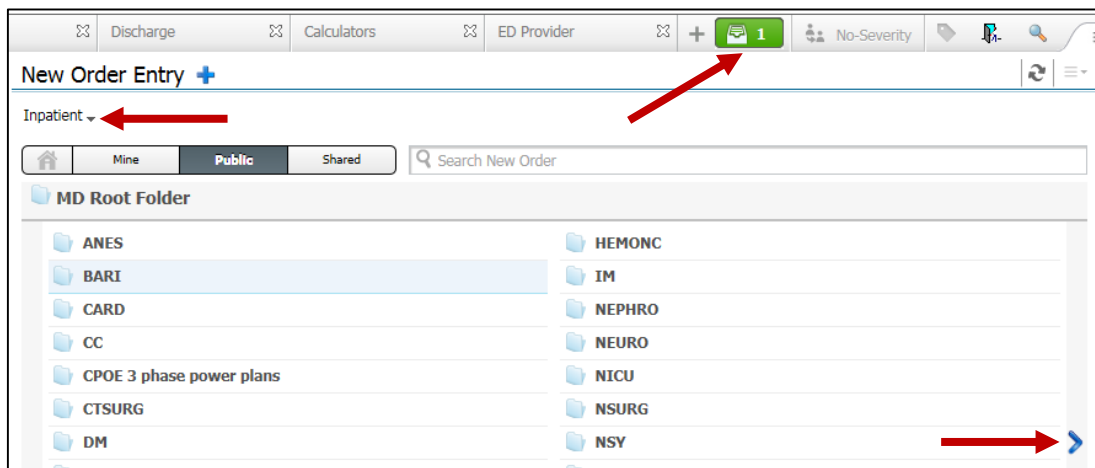
Order History

The Order History component displays a complete reverse chronological history of all orders in 24-hour increments. It includes order modifications, which provider performed these modifications, and how long ago they were performed. Placing the mouse over an order will display additional order information. The look back time can be modified to display additional orders by clicking the **More** hyperlink, next to the time frame.


New Order Entry

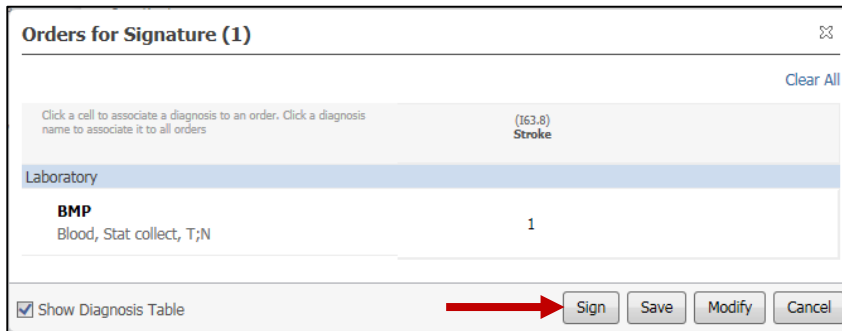
The New Order Entry component allows providers to add individual orders and PowerPlans to the orders scratch pad while remaining on the Provider Workflow page. Orders can be added by searching the catalog or accessing existing folders (personal favorites, public folders, or favorite folders of other users). These orders will be placed into the green Orders for Signature “Shopping Cart” awaiting the provider’s signature.

A Provider can change the order status from Inpatient to Prescription by clicking the down arrow after Inpatient. Clicking the arrow to the right will display the next series of folders. Clicking any folder will display orders within that category.



To complete placing the orders:

1. Click the green folder 
2. Modify any orders and Sign. Any missing details will display. Complete accordingly.



Chief Complaint/Reason for Consult

This component allows the provider to document the chief complaint. To enter the data:

1. Click the Chief Complaint/Reason for Consult.
2. The documentation section becomes available and the text can be modified.
3. Click Sign

Subjective/History of Present Illness

This is a free-text section. The provider may type or use voice dictation to enter the documentation. Auto text is not recommended in this section as documentation varies for each individual patient.

Review of Systems (ROS)

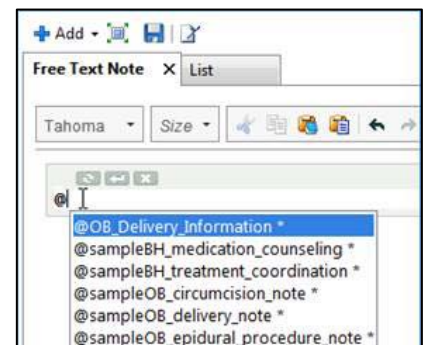
Review of Systems is a free-text component used to document the required elements for the patients. This component also allows for Auto Text functionality or voice dictation.

Auto Text

Another feature of Dynamic Documentation is the ability to create Auto Text. This provides a timesaving way for providers to enter text they use repeatedly without having to retype. This is available in any Cerner Free-Text Component, such as Review of System (ROS) or Subjective/History of Present Illness, where the Manage Auto Text toolbar is available.

There are several system level auto-texts available to all providers. These are designated with an @ in front of the description. (Example: @samplers)


NOTE: Auto Texts MUST be reviewed and modified to ensure accuracy.

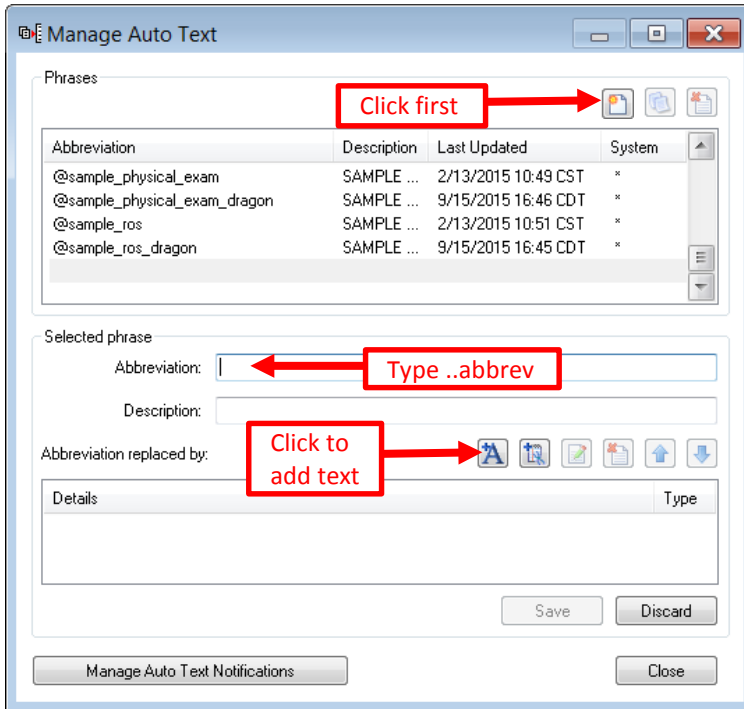



To create an Auto Text: (for class go into Review of Systems under the Admit/Consult tab)

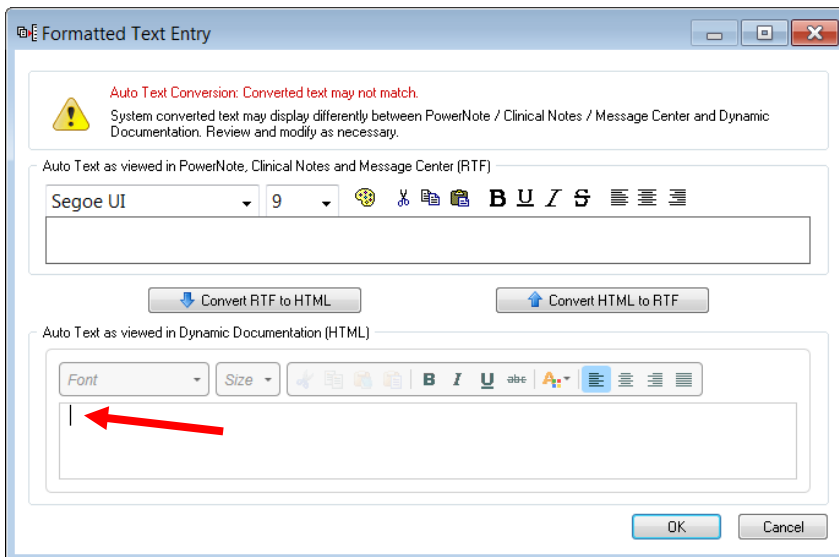
1. Highlight or CTL+A, the desired text to be used in your auto text
2. Click the copy icon on the auto-text toolbar, or CTRL+C, or right-click and copy.
3. Click the Manage Auto Text button in the toolbar




4. Click the New Phrase button 
5. Add an abbreviation to call the Auto Text.
 - a. We recommend using something starting with a double period (such as ..ROS) which will keep the provider's own Auto Text at the top of the list, and will prevent the auto text from accidentally being inserted while typing.
 - b. **Note:** The Auto Text abbreviations are case sensitive.



6. Enter a description for the Auto Text, if desired.
7. Click the Add Text button  to add the desired text.
8. Either paste (Ctrl+V or right-click and paste) the copied text or type the desired text into the lower window.




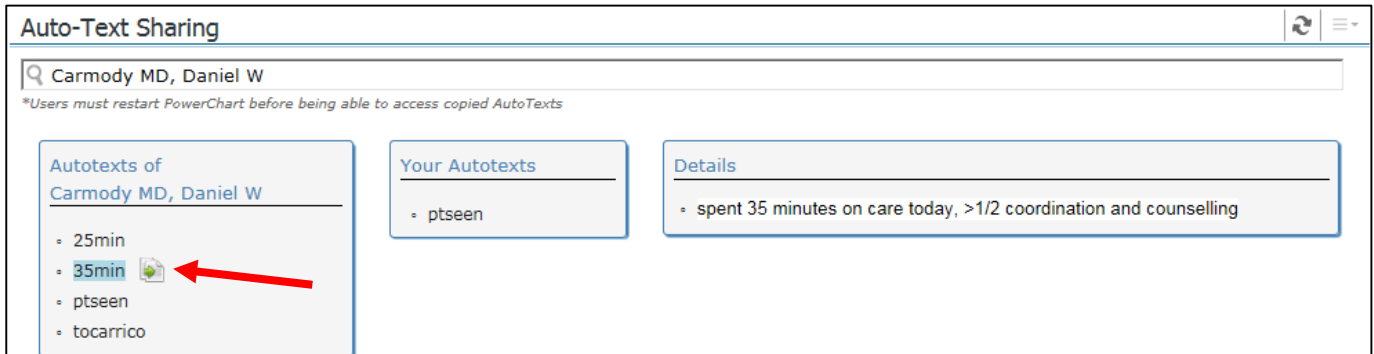
9. Click  to copy up to the top window.
10. Click OK.
11. Click Save.
12. Click Close to exit out of the Manage Auto Text screen.

To use an Auto Text in one of the free-text components, simply type the abbreviation to bring up the auto-text.

1. Typing in “..” will bring up a list of the entire provider’s auto texts or typing “@” will bring up the Corporate list.
2. Double-Click the auto text to be used.

Auto-Text Sharing

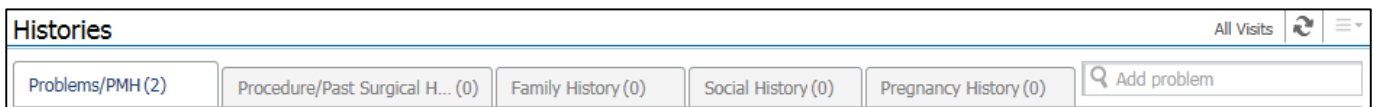
Similar to the Shared orders option, Auto-text can be shared amongst providers. Enter the provider’s name in the search field. Select the Auto-text to review on the left. The details will be seen on the right. Click the  icon to add it to your Auto-texts in the center.



Histories

This component displays any documentation completed in the Histories tab. This includes the Problems/PMH, Procedural/Past Surgical History, Family, Social, and Pregnancy History (on female patients). Click each tab to view the information.

- Past medical history can be modified by right-clicking on an individual problem.
- On the Procedure/Past Surgical History tab, hovering over a documented procedure will display more details. Additional procedures can be added by using the search box in the upper right hand corner.
- The Histories header is also a hyperlink that will take you to the Histories tab.



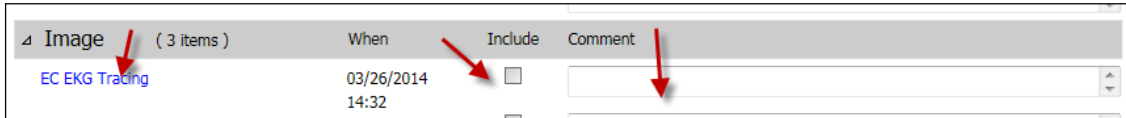
Objective/Physical Exam

This is another component where the provider can free-text or dictate their notes. It is recommended that Auto Text be used for this component. By using an Auto Text and modifying it to reflect the clinical situation, the provider can ensure that documentation is complete in order to meet the Joint Commission Guidelines.

Procedures, Imaging and Consults

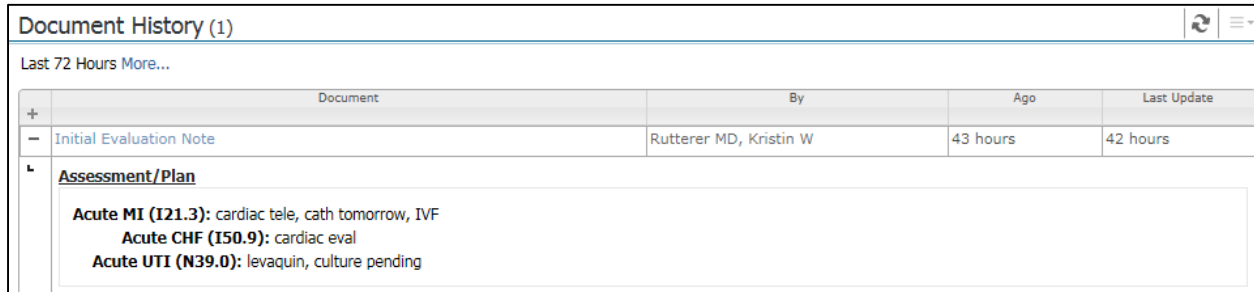
This component displays imaging studies, procedures performed and consults obtained during this visit. A free text comment box is available next to each title to allow the provider to comment on the study. Any comments entered in the box are automatically saved and carried throughout the hospital course up to discharge. Documentation can also be copied and pasted into the comments field (For example, the impression portion of the radiology study can be included). A check box allows the provider to pull relevant studies and comments into

their note. The “Include” check box is user specific and the comments section is shared and seen by all users. Providers can click the name of the test to view the report.



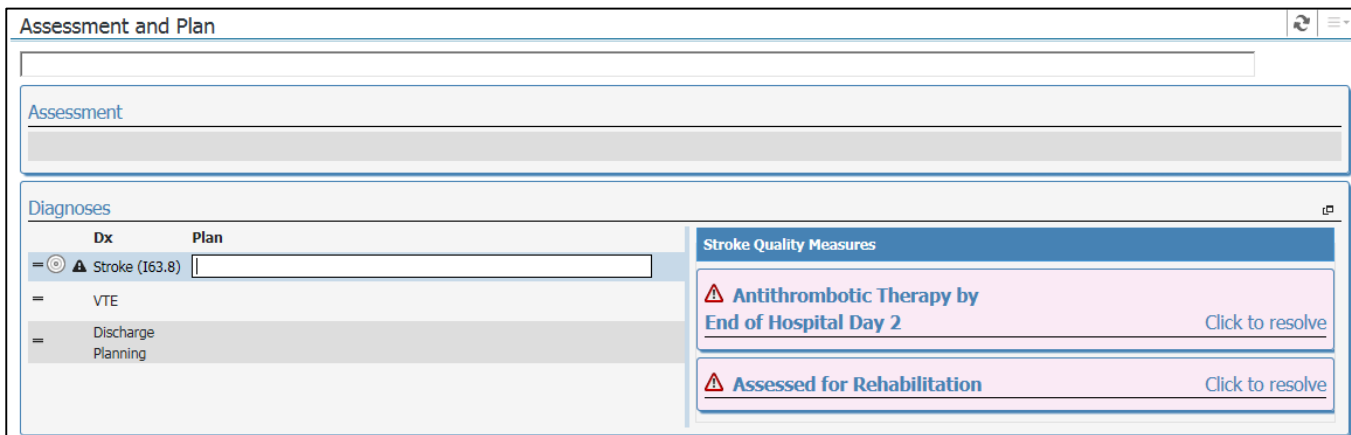
Document History

Document History displays the Assessment and Plan portion of any notes generated via Dynamic Documentation or Power Note. Provider Workflow The Assessment and Plan section can be viewed or collapsed by using the plus icon. The look-back can be increased in 24-hour increments by selecting the **More** hyperlink.



Assessment and Plan

The Assessment and Plan (A&P) component displays all active diagnoses from the patient’s diagnosis list. There is a free-text Assessment area, as well as a free-text Plan area to the right of each diagnosis. Only diagnoses that have a documented Plan will pull into the Assessment and Plan portion of the provider’s note. If a particular diagnosis does not fall under that provider’s care, they can simply leave the Plan blank and it will not be included in their note.



A face-up icon will indicate if a Quality Measure is associated with a diagnosis. The Quality Measures can be addressed from here, as discussed below.

Each provider’s documentation within the A&P carries forward from day to day, allowing them update yesterday’s plan rather than having to re-document it entirely. All documentation within the free-text Assessment and Plan areas automatically saves. The provider does not need to save or submit.

Additional diagnoses can be added using the search field at the top of the component. This will add the diagnosis to the patient’s diagnosis list, which will be visible by all care providers. Diagnoses can be more specified using the

Specification icon. They can be modified by clicking the hyperlinked diagnosis name. Incorrect diagnoses can be deleted by hovering over and clicking the 'x'

- **Note:** This will delete any Plans that may have been documented on the diagnosis by other users, and should be used with caution.

Diagnoses can be sorted by clicking on the horizontal line and dragging/dropping. Diagnosis sorting is saved at the user level. The order in which the user sorts the diagnoses within the A&P applies to them only.

Selecting the System Based Assessment and Plan icon allows the user to include body systems in their A&P, which can also be sorted using the drag and drop functionality. Body systems are added at the user level- it will not add them to other users' A&Ps.

Quality Measures

When a diagnosis has associated Quality Measures, clicking the free-text Plan area will open a side panel. The functionality varies based on the Quality Measures, but each follows the same principals. The provider can place an order or document a contraindication as appropriate for each measure. When a measure is unsatisfied, the side cards will display red. Once they have been satisfied, the side cards turn green. The system will recognize if a patient already has the appropriate orders to satisfy a measure, if they have an allergy to a certain medication, or if they otherwise do not qualify due to age or other factors. This information is displayed in the measures to provide decision support.

Chest Pain, AMI Quality Measures has four associated measures: ACEI or ARB for LVSD, Beta-Blocker Ordered, Aspirin Ordered, and Statin Ordered.

- ACEI or ARB for LVSD:
 - Last Documented EF- if there is an ejection fraction documented on the patient, it will appear here. The paper icon with a blue + can be clicked to document an EF. An ejection fraction of 40% or higher will satisfy this measure.
 - Echocardiogram Report-if there is an Echo report documented on this patient, it will display as a hyperlink for viewing.
 - Place order for Echo- this box can be used to place an order for an echocardiogram.
 - Place new order - this box can be used to place an order for an ACEI or ARB.
 - Select reason for not ordering- this drop down can be used if there is a contraindication for an ACEI or ARB.
- Beta-Blocker Ordered:
 - Place new order - this box can be used to place an order for a Beta Blocker
 - Select reason for not ordering - this drop down can be used if there is a contraindication for a Beta Blocker
- Aspirin Ordered:
 - Place new order - this box can be used to place an order for Aspirin
 - Select reason for not ordering - this drop down can be used if there is a contraindication for Aspirin
- Statin Ordered:
 - The box opens and ways to address to the quality measure appear. If there is an LDL resulted on the patient and it is above 100, the measure will be satisfied.
 - Place order for LDL - this box can be used to place an order for an LDL lab
 - Place new order - this box can be used to place an order for a Statin
 - Select reason for not ordering - this drop down can be used if there is a contraindication for a Statin

CHF Quality Measures has one associated measure: ACEI or ARB for LVSD.

- ACEI or ARB for LVSD
 - Last Documented EF- if there is an ejection fraction documented on the patient, it will appear here. The paper icon with a blue + can be clicked to document an EF. An ejection fraction of 40% or higher will satisfy this measure.
 - Echocardiogram Report-if there is an Echo report documented on this patient, it will display as a hyperlink for viewing.
 - Place order for Echo- this box can be used to place an order for an echocardiogram.
 - Place new order - this box can be used to place an order for an ACEI or ARB.
 - Select reason for not ordering- this drop down can be used if there is a contraindication for an ACEI or ARB.


Stroke Quality Measures has three associated measures: Antithrombotic Therapy by end of Hospital Day 2, Anticoagulation Therapy for A-Fib/Flutter, and Assessed for Rehabilitation.

- Antithrombotic Therapy by end of Hospital Day 2
 - Place new order- this box can be used to place an order for an antithrombotic medication.
 - Select reason for not ordering- this drop down can be used if there is a contraindication for an antithrombotic.
- Anticoagulation Therapy for A-Fib/Flutter (patient must have a diagnosis of A-Fib/Flutter for this measure to appear)
 - Place new order- this box can be used to place an order for an anticoagulant medication.
 - Select reason for not ordering- this drop down can be used if there is a contraindication for an anticoagulant.
- Assessed for Rehabilitation
 - Place new order - this box can be used to order a rehabilitation (PT or OT) treatment or evaluation.

If a patient qualifies for VTE Prophylaxis, a line will display within the A&P for VTE. The system accounts for multiple factors including other diagnoses, existing orders and lab values to determine what options are displayed. If VTE Prophylaxis has been satisfied, the card will display the satisfaction details. If VTE Prophylaxis has not been satisfied, the provider has the ability to order prophylaxis or document a cotraindication, similar the the other measures.

Creating the Dynamic Documentation Note

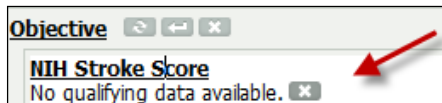
When the provider is done documenting on the Provider Workflow, click the “Create Note” button. The appropriate note template is automatically opened. The various sections of the Note are pulled in from the already documented components in the Provider Workflow as well as the users note settings selections. All sections in the note can be documented on, modified, and even removed completely.

1. To add information to the Note:
 - a. Click the  icon to insert the cursor for free-texting.
 - b. Type or copy and paste the information into the section of the Note, where the information is to be added.

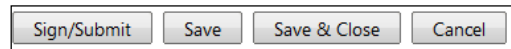


2. To remove a section of the note:

- a. Click the “x” next to the section to be removed.

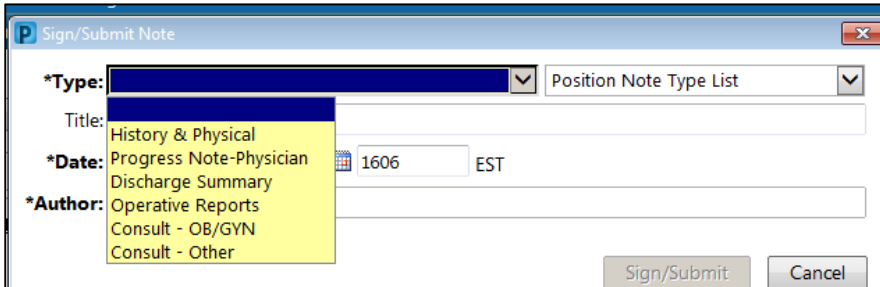


3. Once the note is reviewed and completed, click Sign/Submit.



- a. If the provider has not yet completed the Note, click Save.

4. Select the correct type of Note. The Admit/Consult Tab is used for both History and Physical, and Consult Notes.

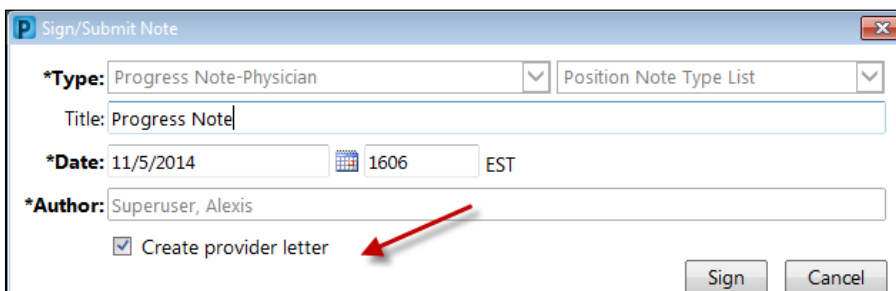


5. Add an appropriate title for the Note, if desired.
6. Click Sign.

Any unsigned Notes will appear in the provider’s Inbox in the Message Center to remind them to complete the note.

Provider Letter

The Provider Letter functionality is used when a provider wants to forward their note to providers outside the hospital. When a provider signs/submits their note, the Note Type selection window opens. At the bottom of this window, there is a “Create Provider Letter” check box. Selecting this and clicking “Sign” will bring up the provider letter window. The provider can then select recipients for their Note.



The provider will complete this form with the appropriate responses.

1. Select the appropriate provider
 - a. To save the provider as a favorite, Click the star in front of their name
2. Select the correct Mode.
 - a. If Mail is chosen, the note will need to be forwarded to the facility HIM message center for printing and mailing. The Forward for Print field will be highlighted in yellow and must be completed. The facility “HIM to print” bucket will have to be selected.
 - b. For training, use another provider.
3. Click OK to complete the recipient process.
4. Next, determine which sections of the note to include in the letter.
 - a. Click Add Results and select any test results to include.

- b. Click Browse Documents.
 - c. Either select Attach Full Document or highlight the area to include then select Attach Text Selection.
 - d. Click OK when all selections are made.
5. Click OK to complete the Provider Letter process.

Recipient: CERNER, CERNER

Subject: Provider Letter Save As: Provider Letter

Transition of Care Browse Documents

Tahoma 12

Chief Complaint/Reason for Consultation
C/O SOB

History of Present Illness

Review of Systems

Objective
NIH Stroke Score
No qualifying data available.

Physical Exam

Assessment/Plan

Histories

Immunizations

Medications

Results

Result Name	<input checked="" type="checkbox"/> Current Result	Date	<input checked="" type="checkbox"/> Previous Result	Date	Normal Range
Other Results Available To Include					
CL Cath Lab Order	<input checked="" type="checkbox"/>	6/14/2013			
Universal Protocols/TimeOut - Text	<input checked="" type="checkbox"/>	6/14/2013			
Cardiac Cath Report	<input checked="" type="checkbox"/>	6/17/2013	<input checked="" type="checkbox"/>	6/14/2013	
General Assessments	<input checked="" type="checkbox"/>	6/14/2013	<input checked="" type="checkbox"/>	6/14/2013	

OK Cancel Preview

Manage Tab

This View is very similar to the Admit/Consult View and utilizes many of the same components but will be used when providers want to generate a Progress Note. Similar to the Admit/Consult View, when the provider is done documenting on the MPage they will click the 'Create Note' button.

Discharge Tab

The Discharge Tab of the Provider Workflow is used to generate a Discharge Summary Note.

Discharge Note Settings

This component allows you to customize which data elements will be pulling into the Discharge note. These data elements will populate into predefined sections of the note. The selections will stick with the user on their respective tabs and will not have to be addressed every time a note is created.

1. If the provider chooses, they can select the appropriate specialty under Primary Specialty.
 - e. If necessary, a secondary specialty can be selected.
4. Click the boxes next to the appropriate smart templates to be included in the note.
 - f. Hovering over the blue titles will show a description of the included data.
 - g. Clicking the blue title will show a preview of the data to be displayed in the note
5. Once all the needed elements are selected, click Save. The entire component will collapse and save the settings for all future notes on the Admit/Consult tab. The selections can be updated anytime in the future by clicking update.

Vitals and Measurements

The Vitals and Measurements component pulls information directly from nursing documentation. Providers can change the look-back criteria in the upper right hand corner of the component (Last 1 days, Last 1 months, etc.)

Intake and Output

The I&O section pulls any information documented by nursing on a patients Intake and Output. Look back options can be changed to allow the provider the control the amount of data that is presented.

Documents

The Documents component displays notes entered by various providers. Clicking the light blue title of the note will open the document for viewing. Review the Admit/Consult Tab section for more information about this component.

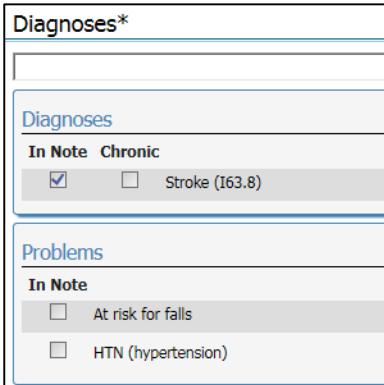
Labs/Microbiology

These components pull resulted labs and microbiology from the patient's chart. Providers can change the look-back criteria as well. (Last 2 days, Last 1 months, etc.)

Diagnoses

The Diagnoses component in the Discharge tab displays the patient's active diagnoses and problems. All diagnoses are pre-selected to go into the note but can easily be unselected by unchecking the box. They follow the same sort order that the provider established in the Admission tab A&P.

Active Diagnoses are listed at the top with Chronic Problems listed below. To include a diagnosis in the Chronic Problems list for future visits, check the box under Chronic for the diagnosis.



Diagnoses*	
Diagnoses	
In Note	Chronic
<input checked="" type="checkbox"/>	<input type="checkbox"/>
Stroke (I63.8)	
Problems	
In Note	
<input type="checkbox"/>	At risk for falls
<input type="checkbox"/>	HTN (hypertension)

Diagnoses can be modified if needed, for example, changing a working diagnosis to a discharge diagnosis.

1. Click the Diagnosis name. The Modify Diagnosis window appears.
2. Click the down arrow for the Type box and select the appropriate Type.
3. Make any other changes as necessary. Click OK.

Diagnoses can also be added to the list.

1. Type the diagnosis in the search box at the top of the component.
2. Select the appropriate diagnosis from the list.
3. The diagnosis is added automatically included in the note as indicated by the checked box under In Note.

The Problems list may contain items that are nursing related or are entered by the system based on nursing documentation. A problem or diagnosis can be excluded from the note by unchecking it.

Pending Results

The Pending Results component shows outstanding Laboratory or Radiology orders that are not complete for this encounter and automatically pulls into the Discharge Note.

Procedures, Imaging and Consults

This component displays imaging studies, procedures performed and consults obtained during this visit. A free text comment box is available next to each title to allow the provider to comment on the study. Documentation can also be copied and pasted into the comments field (For example, the impression portion of the radiology study can be included). A check box allows the provider to pull relevant studies and comments into their note. The “Include” check box is user specific but the comments section is shared and seen by all users. Providers can click the name of the test to view the report.

Medication Reconciliation

The Medication Reconciliation displays Home Medications and Prescriptions. Providers can complete Discharge Medication Reconciliation by using the Discharge Medication Reconciliation hyperlink. The Discharge Medication Reconciliation includes columns for continuing, discontinuing, and converting meds to prescription.

- The provider can also add new prescriptions by using the Add button. 

When the Discharge Medication Reconciliation is complete, the new prescriptions and continued home medications are displayed within the component. This information will automatically be included in the note and the patient’s discharge instructions.

Quality Measures

The Discharge Quality Measures functions similarly to the QMs within the Admission tab A&P. All orders are placed as prescriptions when using the Discharge tab, instead of inpatient orders on the Admit/Consult tab.

The screenshot shows a window titled "Quality Measures" with a sub-header "Stroke Quality Measures". It contains three items:

- Discharged on Antithrombotic Therapy** (Warning icon): Includes a "Click to resolve" link, a "Place new prescription:" text box, and a "Select reason for not prescribing:" dropdown menu with a "Submit" button.
- Discharged on Anticoagulation Therapy** (Success icon): Includes a "Click to resolve" link and the text "Anticoagulant Contraindication".
- Statin Prescribed at Discharge** (Warning icon): Includes a "Click to resolve" link.

Discharge Orders

The Discharge Orders component displays Diet, Activity, Wound Care, and Code Status order details. Each order will display current inpatient order details if they exist at the time of discharge. Providers can choose to include the current order details into their note by clicking the down arrow. This adds it to the free text box where they can add any additional information if need be. If they do not wish to use the current order details then they can just free text their desired instructions.

This component will show you if a Discharge Order has already been placed. If not, you can order it from this page by clicking the Discharge Order box and then the Make New Orders button.

The Discharge Orders entered will automatically pull into the provider’s note and the patient’s Discharge Instructions as appropriate.


The screenshot shows a form titled "Discharge Orders*":

- Diet**: "Current Order(s):" with a dropdown menu showing "Room Service Appropriate".
- Activity**: A text input field.
- Wound Care**: A text input field.
- Code Status**: A text input field.
- Additional Orders:** Includes a checkbox for "Discharge Order" and a "Make New Orders" button.

Follow-up/ Discharge Instructions

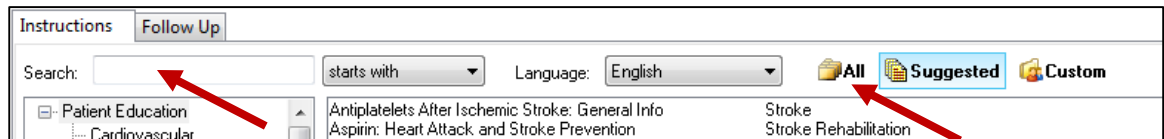
Providers can utilize the Quick Add button to enter Follow-up & Discharge Instructions. This information will pull into the provider's Discharge Note as well as the patient's discharge documentation.

To add Follow Up instructions:

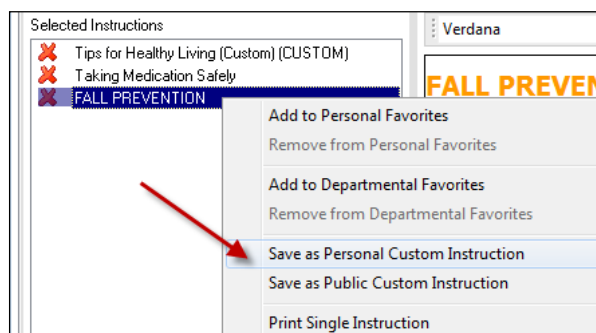
6. Click the Quick Add icon 
7. Complete the provider field with the provider with whom the patient will be following up.
 - a. Type in the first few letters of the providers last name
 - b. Click the binoculars to search, if needed
 - c. Select the correct provider
 - d. The providers name and address populates
 - i. The address can be modified if need by clicking the address box and making any necessary changes.
8. Complete the When section for when the patient should follow up with the provider.
9. Under Comment, double-click any of the predefined comments to select or free text in comments.
 - a. Any predefined comments can be modified by clicking in the Edit Comments field and making changes as needed.

To add Patient Education instructions to send home with the patient, click the Instructions tab.

1. The system will suggest instructions based upon the patient's active diagnoses.
 - a. Double-Click an instruction to select it.
2. To search for an instruction:
 - a. Change the folder type to All.



- b. Type the requested document in the search field.
 - c. Double-Click the desired instruction to select.
3. Make any modifications to any documents as necessary. Customized documents can be saved:
 - a. Right-Click the document name under Selected Instructions
 - b. Select Save as Personal Custom Instruction.
 - c. Customize the title name and click OK.



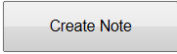
4. Click Sign in the bottom right hand corner of the window to complete the process.

Hospital Course

The Hospital Course is a free-text component. It is always on the Discharge tab, but can also be customized into the other tabs. Documentation in Hospital Course is shared amongst all users. It will continue to save until the Discharge Summary is generated. This allows all providers caring for the patient to contribute to the Hospital Course throughout the patient's stay. At the time of discharge, a clear picture of the care provided is available for the discharging provider.

Creating the Dynamic Documentation Note

Physicians should use the Create Note button at the bottom right of the MPage when done documenting in the Discharge Tab.

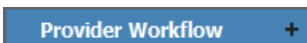
1. Click the  button at the end of the Discharge Tab section.
2. Review the entire note and make any changes, additions, or deletions as necessary.
3. Click Sign/Submit at the bottom right hand portion of the screen.
4. Select the correct Note type.
 - a. For the Discharge View Physicians should only use the 'Discharge Summary' Note Type.
5. Enter a title (optional)
6. Adjust the date or time if required.
7. Click Sign to complete.

The Discharge Summary is completed and filed appropriately. The document can be searched for under Notes in the TOC.

NOTE: A Dynamic Documentation note cannot be seen by other users until the note is Signed and Submitted.

Dynamic Documentation

A document may also be created by clicking the + next to Provider Workflow on the TOC.



ED Provider Tab

The ED Provider tab will link directly to the ED Note template. ED providers can drag this tab to the left so that becomes their default view.

OB Provider Workflow

All OB providers will have the OB Provider Workflow. In addition to the components above, the OB Provider Workflow has Birth Plans, Delivery Summary, EDD Maintenance, Fetal Monitoring, Obstetric Antepartum Risk Factors, and Pregnancy Overview. It is important to note that a pregnancy must be added in order to see all components on the OB Provider Workflow.

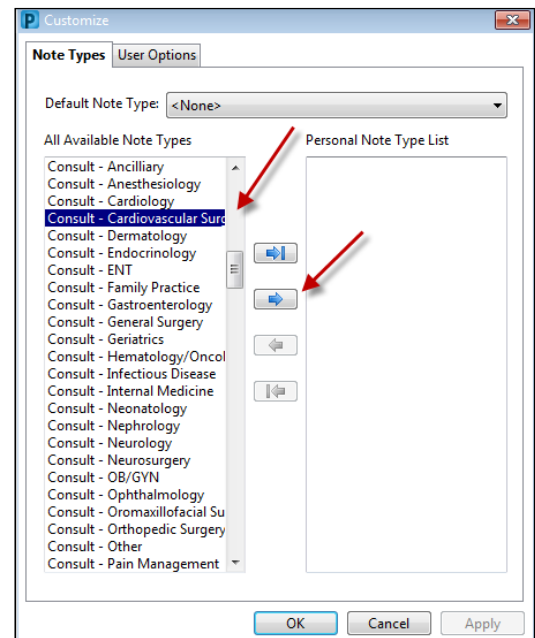
Personal Note Type Lists

When creating documentation in Cerner, it is essential to select the right note type for the document, as this determines where the note will be filed in the system. Example: If an H & P is filed as a Progress Note type, it will be difficult to find the document. If HIM (Health Information Management) is unable to find the document, a deficiency may be erroneously assigned to the provider for the completion of the missing document.

The note type is specified when the document is being signed. It is recommended that providers create a personal list of frequently used note types.

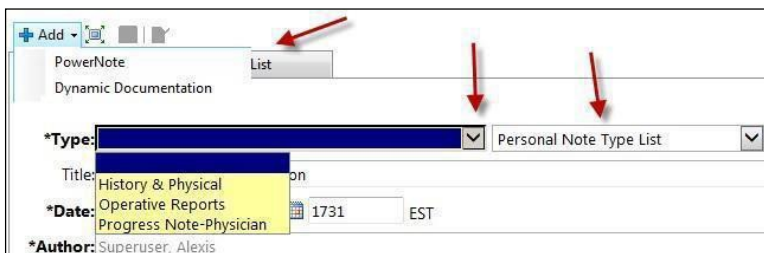
To set up a Personal Note Type list, to include only what the provider needs:

1. Click on the + next to Provider Workflow on the TOC.
2. Click View, located along the very top left of the screen, and select Customize.
3. Click the desired note types in the available column on left. It is important to confirm the appropriate note types with HIM prior to making your selections.
4. Click the blue arrow (without a line) to add the note types to the Personal Note Type list.
5. Click Apply when done.
6. Click OK.



To see the newly created Personal Note Type List:

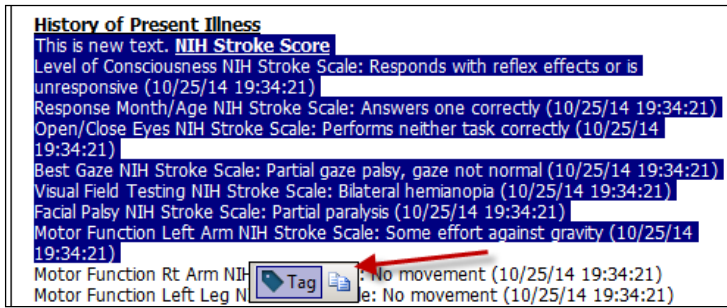
1. Click the arrow next to Add and select Dynamic Documentation.
2. Change the Note Type filter to Personal Note Type List.
3. Click Type to view the personal note type list. This will now be the default view for the provider.



Tagging

Tagging allows a provider to “tag” certain data elements that they want to include in their note. This function is currently limited to lab results and free text at this time. Tagged items are held on a clipboard until they are inserted into a note, with the exception of labs, which are automatically inserted into the “Results” section of the note.

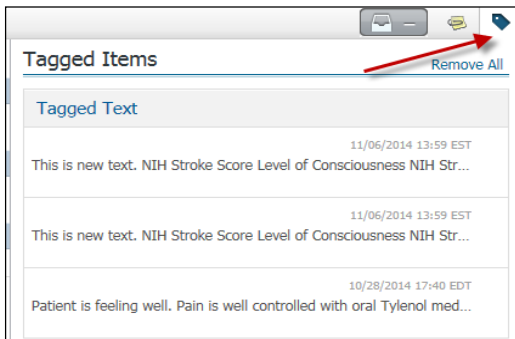
1. To tag text:
 - a. Highlight the section in an opened document to be tagged.
 - b. Click Tag.



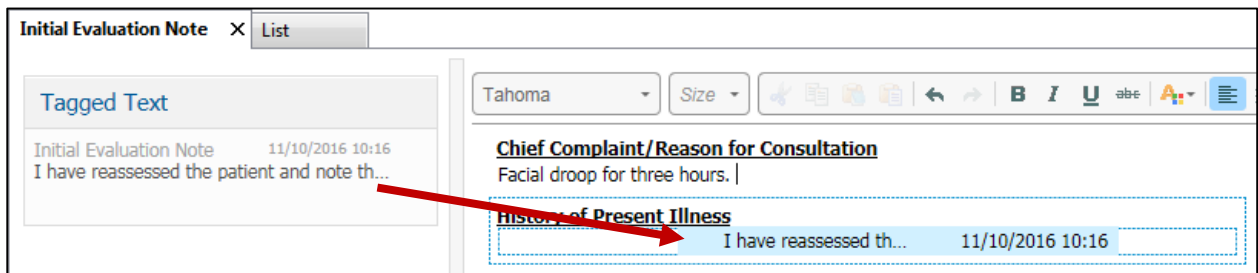
2. To Tag a lab result:
 - a. Right-click the desired result and click Tag.



3. To see all the tagged items, Click the blue tag in the right hand corner of the screen.



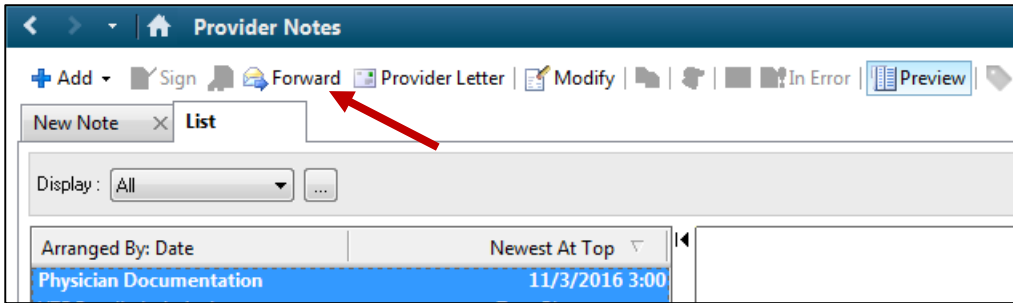
4. To insert the tagged items into a note, click Create Note
 - a. The tagged labs will auto populate in the “Results” section of the H&P/Consult, SOAP and Discharge Notes.
 - b. The tagged text will appear on the left hand side of the screen.
 - i. To insert the tagged document into the Note, click the tagged section and drag it to the desired area of the note. Make sure to “drop” it in the appropriate blue box.



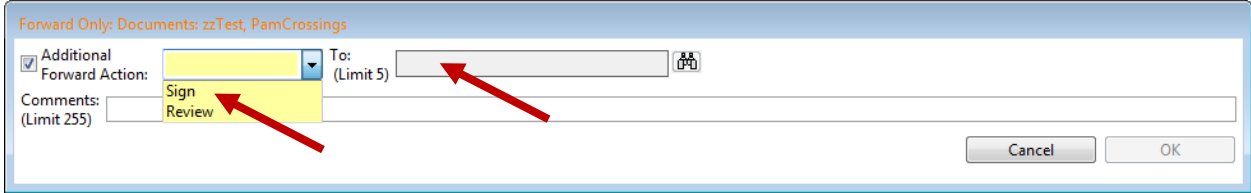
Forwarding a Document for Signature

After a document is completed and signed by a Resident or Mid-Level Provider, it MUST be forwarded on to the endorsing provider. To forward the document to the provider’s Message Center for approval:

1. Select Provider Notes from the TOC.
2. Select the document to forward.
3. Click Forward.



4. Select Sign from the Additional Forward Action.
5. Assign the appropriate provider.
6. Click OK when done.



Additional Components Available for Customization

Order Profile

The Order Profile component displays all active orders, in order of their clinical category. The filters can be grouped by clinical category and order type. You can also choose what type of orders to show (All Active Orders, All Orders, All Active Medications, All Active Non-Medications, Suspended Orders, Completed Orders, and All Inactive Orders)

Order Profile (8)								Selected visit	Refresh	Menu
For a complete list of Home Medications please refer to the Home Medications component.										
<input type="checkbox"/> Pending Orders (0) Group by: Clinical Category Show: All Active Orders										
Type	Order	Start	Status	Status Updated	Ordering Provider					
Non Categorized (5)										
<input type="checkbox"/>	Admission History	NOW	11/05/16 13:23	Ordered	11/05/16 13:23	System, System				
<input type="checkbox"/>	Admission Physical Assessment	NOW	11/05/16 13:23	Ordered	11/05/16 13:23	System, System				
<input type="checkbox"/>	Heart Failure Quality Measures	11/05/16 13:36:39	11/05/16 13:36	Ordered	11/05/16 13:36	System, System				
<input type="checkbox"/>	Stroke Quality Measures	11/05/16 13:23:25	11/05/16 13:23	Ordered	11/05/16 13:23	System, System				
<input type="checkbox"/>	VTE Quality Measures	11/05/16 13:23:02	11/05/16 13:23	Ordered	11/05/16 13:23	System, System				
Nursing (2)										
<input type="checkbox"/>	Initiate Mechanical VTE Prophylaxis	11/05/16 13:32:15	11/05/16 13:32	Ordered	11/05/16 13:32	System, System				
<input type="checkbox"/>	Weight - Extended Stay	11/10/16 3:00:00, q5day	11/10/16 03:00	Ordered	11/05/16 13:23	System, System				
Diet (1)										
<input type="checkbox"/>	Diet Cardiac	Room Service Appropriate, 11/09/16 15:22:00	11/09/16 15:22	Ordered	11/09/16 15:23	Test, Adam				

The provider can choose to cancel/discontinue orders directly from the profile.

1. Click the order(s) to be discontinued.
2. The Cancel\DC becomes available. Click to discontinue.

Type	Order	Start			
Non Categorized (5)					
<input type="checkbox"/>	Admission History	NOW	11/05/16 13:23		
<input type="checkbox"/>	Admission Physical Assessment	NOW	11/05/16 13:23		
<input type="checkbox"/>	Heart Failure Quality Measures	11/05/16 13:36:39	11/05/16 13:36		
<input type="checkbox"/>	Stroke Quality Measures	11/05/16 13:23:25	11/05/16 13:23		
<input type="checkbox"/>	VTE Quality Measures	11/05/16 13:23:02	11/05/16 13:23		
Nursing (2)					
<input type="checkbox"/>	Initiate Mechanical VTE Prophylaxis	11/05/16 13:32:15	11/05/16 13:32		
<input checked="" type="checkbox"/>	Weight - Extended Stay	11/10/16 3:00:00, q5day	11/10/16 03:00		
Diet (1)					
<input type="checkbox"/>	Diet Cardiac	Room Service Appropriate, 11/09/16 15:22:00	11/09/16 15:22		

Cancel/DC Clear

Weight - Extended Stay
11/10/16 3:00:00, q5day

Dose	Route	Frequency
--	--	q5day

Type	Status	Last Status Update
Inpatient	Ordered	11/05/16 13:23

Ordering Physician	Start	Stop
System, System	11/10/16 03:00	--

3. The order is placed in the shopping cart to be discontinued. Click the green folder.
4. Click Sign to complete the transaction.

Orders for Signature (1) Clear All

Click a cell to associate a diagnosis to an order. Click a diagnosis name to associate it to all orders	(163.8) Stroke	(148.91) New onset a-fib
---	-------------------	-----------------------------

Nursing

~~Weight - Extended Stay~~
11/10/16 3:00:00, q5day

Show Diagnosis Table

Sign Save Modify Cancel

PowerForm Search

The PowerForm component allows providers to search for and document PowerForms through the MPage. Providers also have the ability to flag PowerForms as favorites, making them easily accessible. To ensure that these data elements are pulled into the note, the provider will need to select the corresponding Smart Template from the Smart Template tool.

To search for a PowerForm:

1. Type at least three letters of the form being searched, i.e. “str” for Stroke.
2. A list of forms displays. Select the appropriate form.

3. The PowerForm selected opens up for documentation.
4. The provider will complete the necessary documentation, and then click the green check mark in the top left hand corner to sign.
5. To save a PowerForm as a favorite, click the ★ next to the PowerForm name.
6. Once the screen is refreshed, the favorite PowerForms will display.

Neonatal Discharge Data

This component displays discharge data for a neonatal patient.

Patient Information

The Patient Information component displays Admission Diagnosis, Discharge Location, and Primary Care Physician, as well as the Attending Physician.

Care Team

The Care Team lists the providers that have a relationship established with the patient

Role/Relationship	Contact	Phone	Service	Team
Cross-Visits				
Primary Care Physician	Test, Physannounce	--	--	--

Misc. Histories

This component displays documented responses from various nursing forms.

	Result	Author	Date/Time
4 Results (7)			
Patient Has New Onset TIA/Stroke	No	Milburn, Lisa	11/02/16 13:30
Tobacco Use	Patient Denies; Never Smoked	Milburn, Lisa	11/02/16 13:30
CAGE Questionnaire Score	0	Milburn, Lisa	11/02/16 13:30
Living Situation	Home Independently	Milburn, Lisa	11/02/16 13:30
Religious/Spiritual Needs	No	Milburn, Lisa	11/02/16 13:30
Patient Concerned for Personal Safety	No	Milburn, Lisa	11/02/16 13:30
Signs of Abuse or Neglect	No	Milburn, Lisa	11/02/16 13:30

Pathology

This component displays any Pathology Reports for the patient. It allows the user to change the look back filter.

Scales and Assessments

The provider can view documented scales and assessments and access the NIH Stroke Assessment form for documentation from this component.

Scales and Assessments		Selected visit: Selected visit Last 1 days Last 1 weeks More		
	NIH Stroke Assessment		Nov 7, 2016	
	Nov 9, 2016	09:54	09:29	19:22 14:02
NIH Stroke Scale Score	5	16	11 ▲	11

Vaccinations and Prophylaxis

This component displays immunization history, if any, on a patient.

Vaccinations and Immunoprophylaxis (1)		
Vaccine	Last Admin Date	Patient Age
influenza SEASONAL virus vaccine	11/09/16	76yrs 9m

influenza SEASONAL virus vaccine

► Nov 9, 2016 (76yrs 9m)
alfuira0.5i