Providers Course 2 Participant Guide
Med Reconciliation & Discharge Process

Carolinas HealthCare System

CANOPY
ELECTRONIC MEDICAL RECORDS

Revised June 2012

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1. Enhanced Medication Reconciliation

Introduction

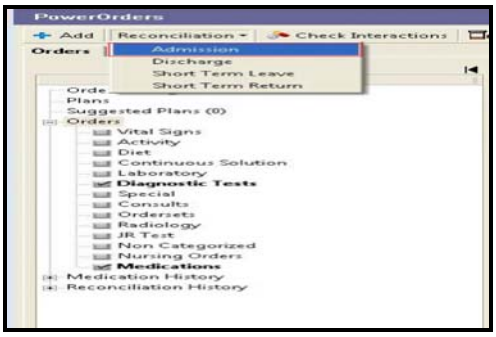
Enhanced Medication Reconciliation is the process of identifying the list of medications the patient is taking and using this list to provide correct medications at admission, transfer and discharge within PowerChart.

The components include:

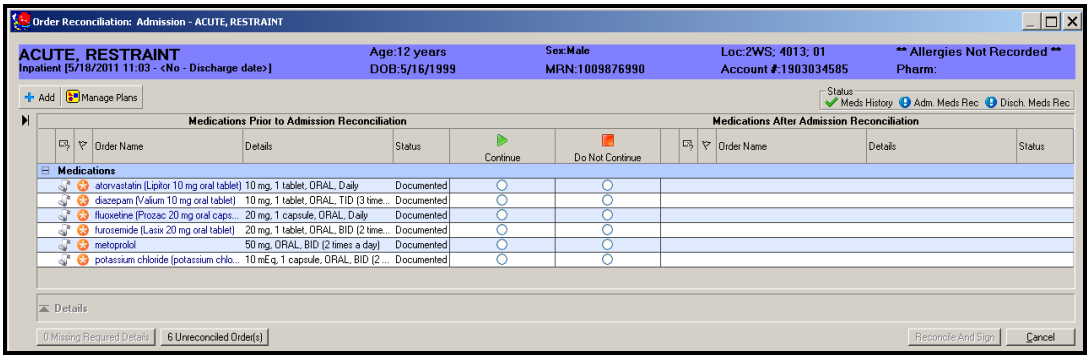
- Documented Medications by History
- Admission Medication Reconciliation
- Transfer Medication Reconciliation
- Discharge Medication Reconciliation
- Convert to Inpatient action
- Convert to Prescription action
- Therapeutic Alternatives Selection
- PowerPlan functionality

Admission Medication Reconciliation

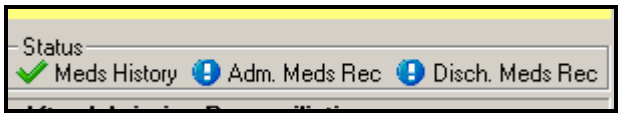
1. To perform **Admission Medication Reconciliation**, click the **Reconciliation** button in the profile of the Medication List or the PowerOrders component. Select **Admission** from the list.



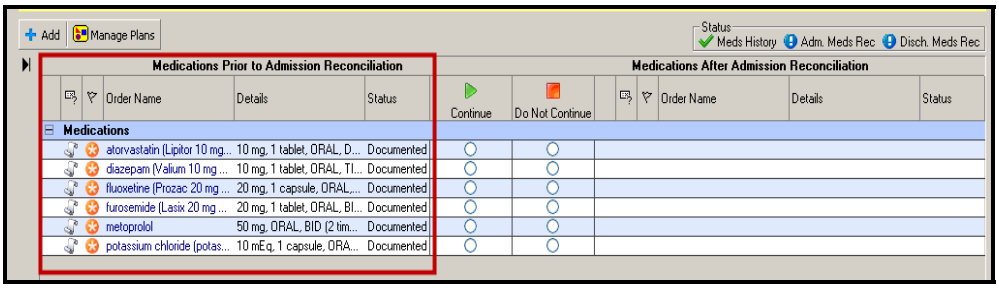
2. The **Order Reconciliation: Admission** window will open.



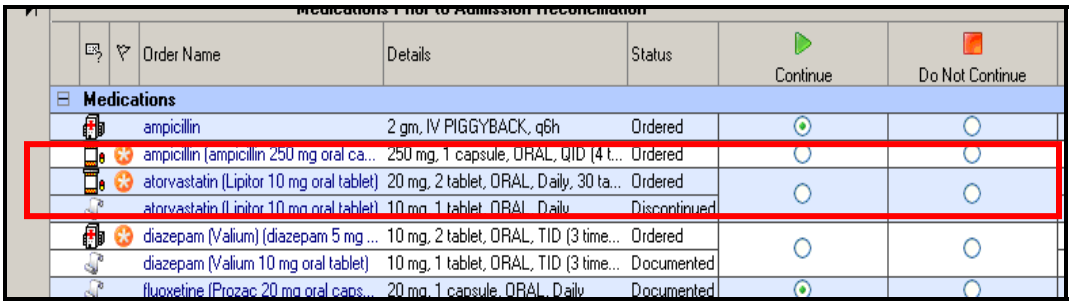
3. The **Status** indicates whether the **mediation history** has been completed. A **green** check means there are documented meds.



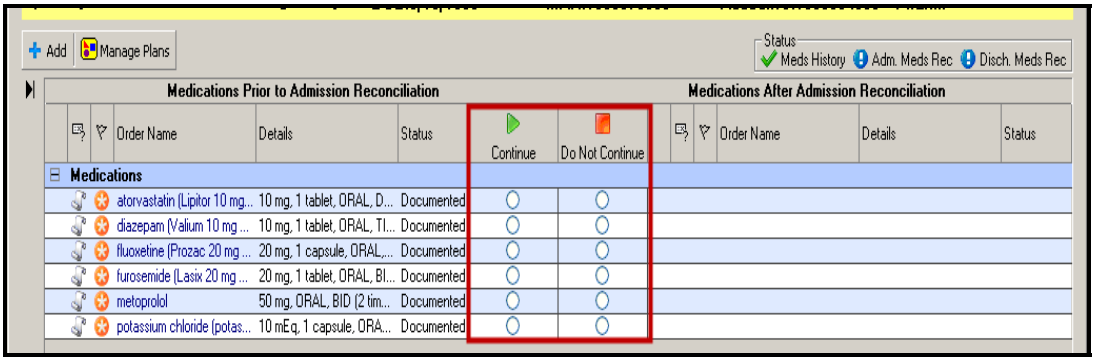
4. This section contains medications listed **prior to Admission Reconciliation**.



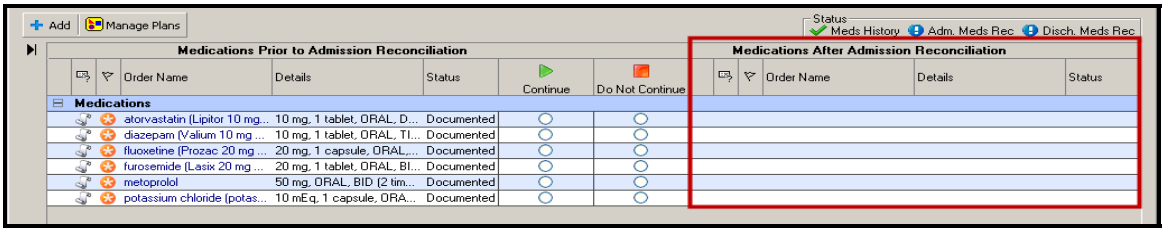
5. Orders may be grouped together. An **order group** consists of orders created by converting, copying, or reordering another order in the group. Each **order group** displays only one set of reconciliation options.
   - If an **order group** contains multiple inpatient and or outpatient orders, the reconciliation options are based on the inpatient order with the most recent start date and time.
   - If the **order group** contains no inpatient orders, the reconciliation options are based on the outpatient order with the most recent start date and time.



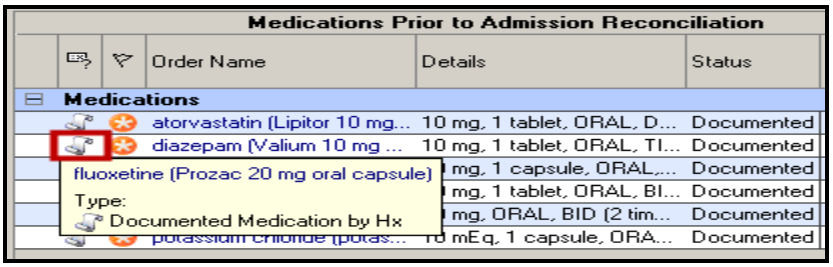
6. This section provides an option for each medication.
   - **Continue**
   - **Do Not Continue**



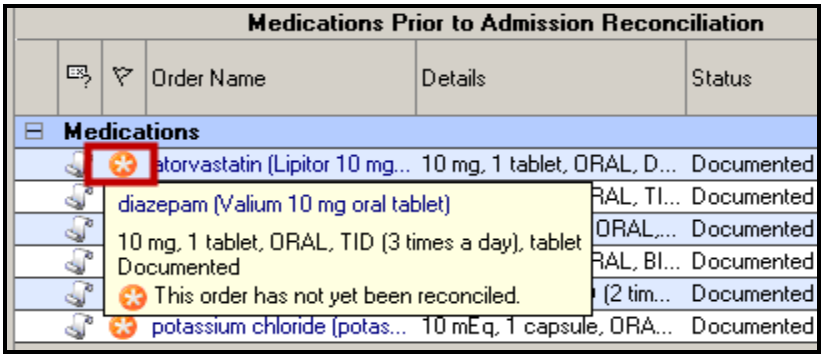
7. This section contains medications listed for the patient **After Admission Reconciliation**.



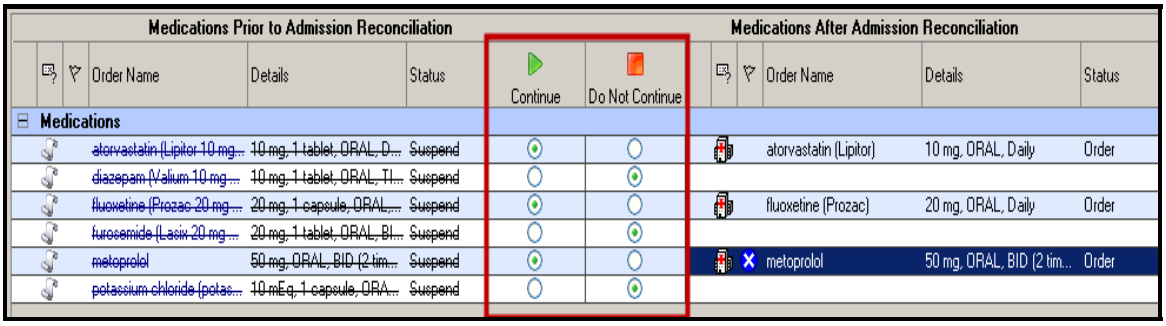
8. The **Scroll** icon indicates **Medications Documented by Hx**. A **Pill Bottle** icon represents **prescriptions** written in Cerner/PowerChart.



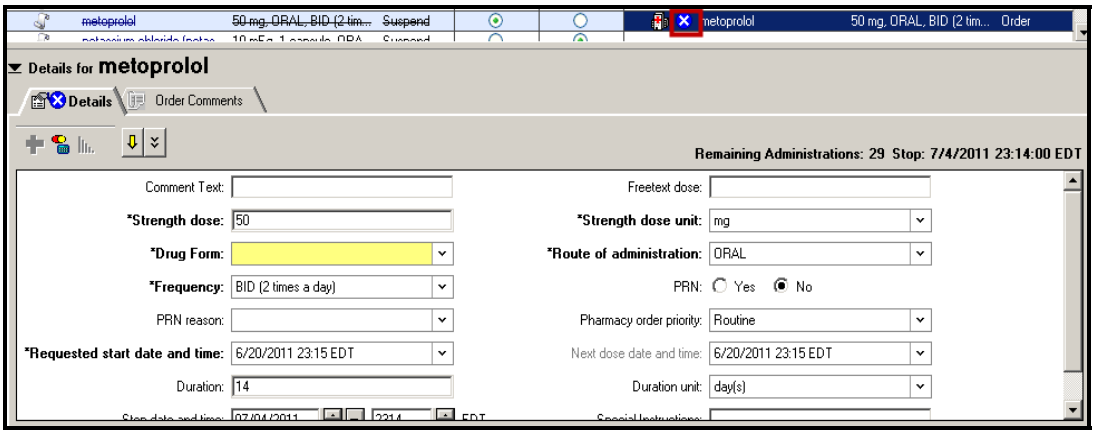
9. The **Orange Star** icon indicates the medication has not yet been reconciled.



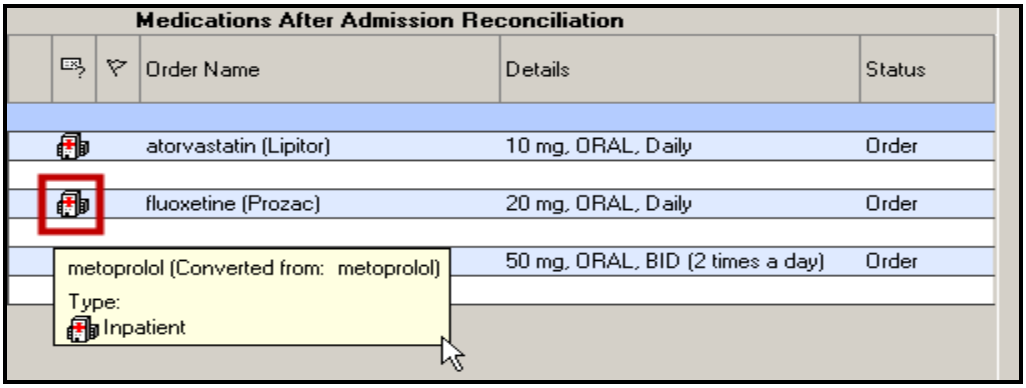
10. Select to **Continue** or **Do Not Continue** for each medication.
    - The **Continue** option will **Convert to Inpatient**
    - The **Do Not Continue** option will **suspend** the medication during admission medication reconciliation. These medications will be addressed at discharged.
    - To discontinue a home medication, select "Do Not Continue" by selecting the radio button for that home medication. **Suspend** should not be used for discontinuing a home medication while the patient is hospitalized.



11. Address required fields indicated by the icon. Required fields will be highlighted in yellow. Order details can be modified as necessary.



12. Medications that are **converted to an inpatient** medication will display the Inpatient icon.



13. Once all medications have been addressed, select the Reconcile and Sign icon

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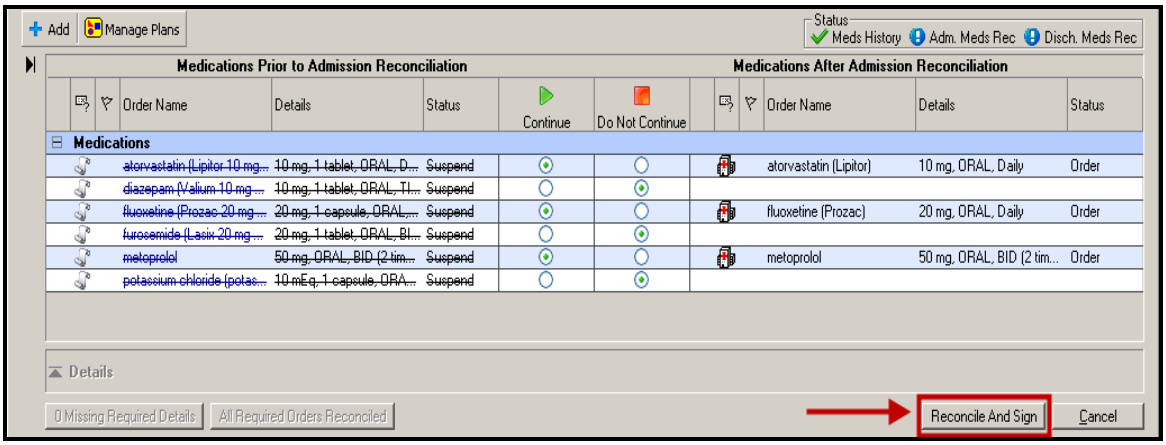
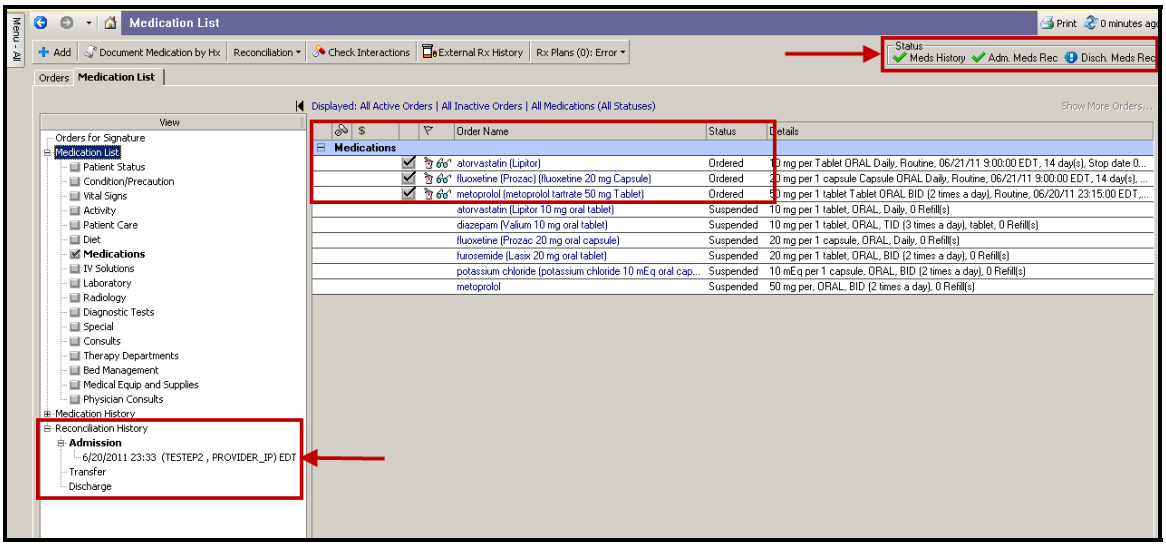


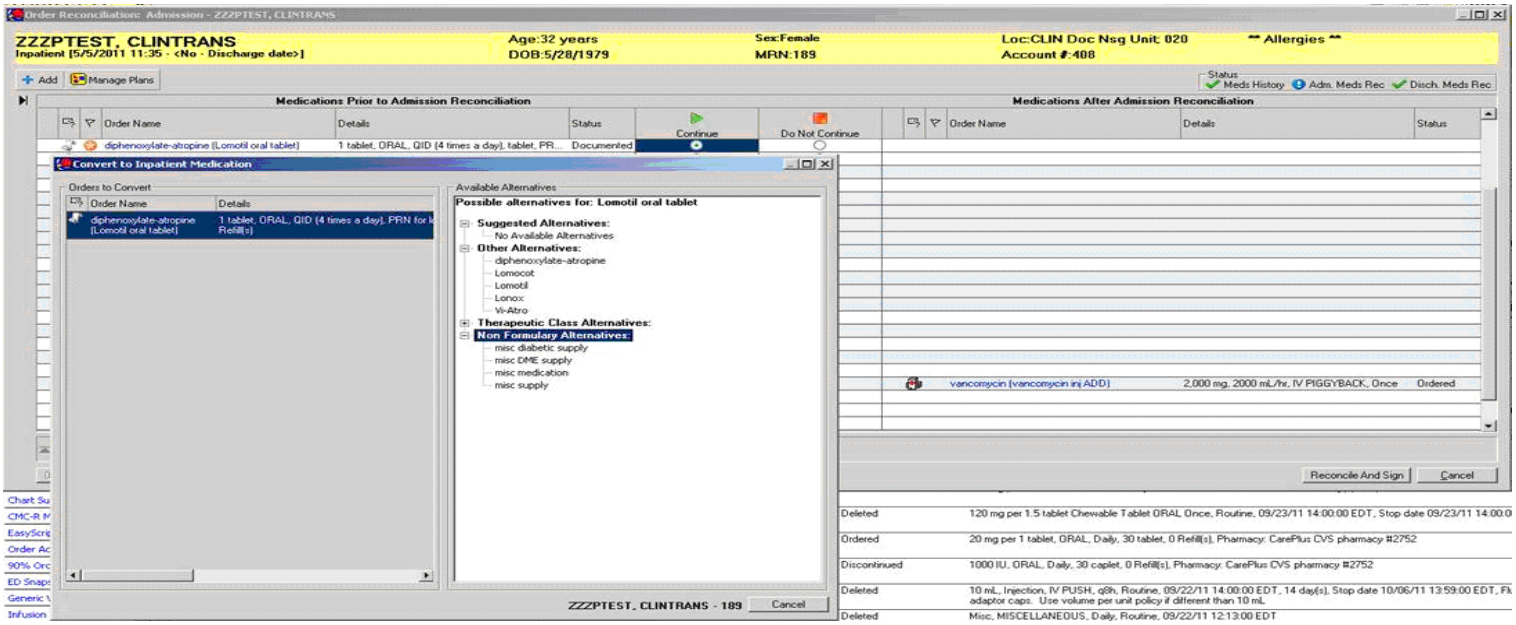
- The **Status** is updated indicating the **Adm Med Rec** is complete.
- The **Admission Reconciliation History** is updated with the date/time and user that performed the reconciliation.
- The **Orders Profile** is updated with the new inpatient medications.



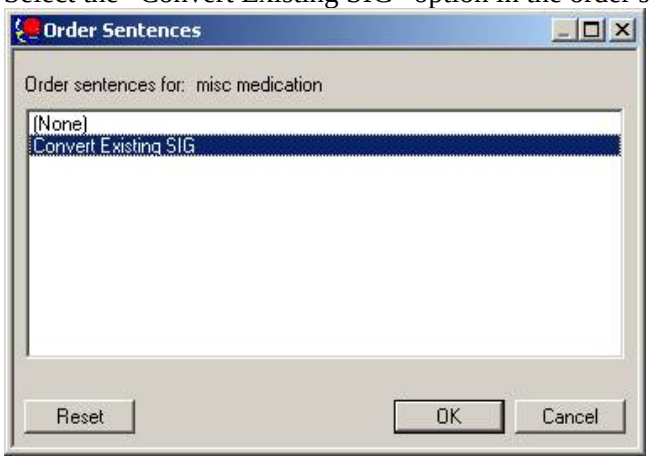
Admission Medication Reconciliation– Misc Med

- When performing medication reconciliation on admission, a scenario may arise when a home medication or prescription needs to be continued and the particular drug is not stocked at the facility. In this case, a therapeutic alternative needs to be ordered.
- Providers, who are unsure as to the appropriate alternative medication and dosage, can follow the steps below in order to have pharmacy identify and order the appropriate substitute.

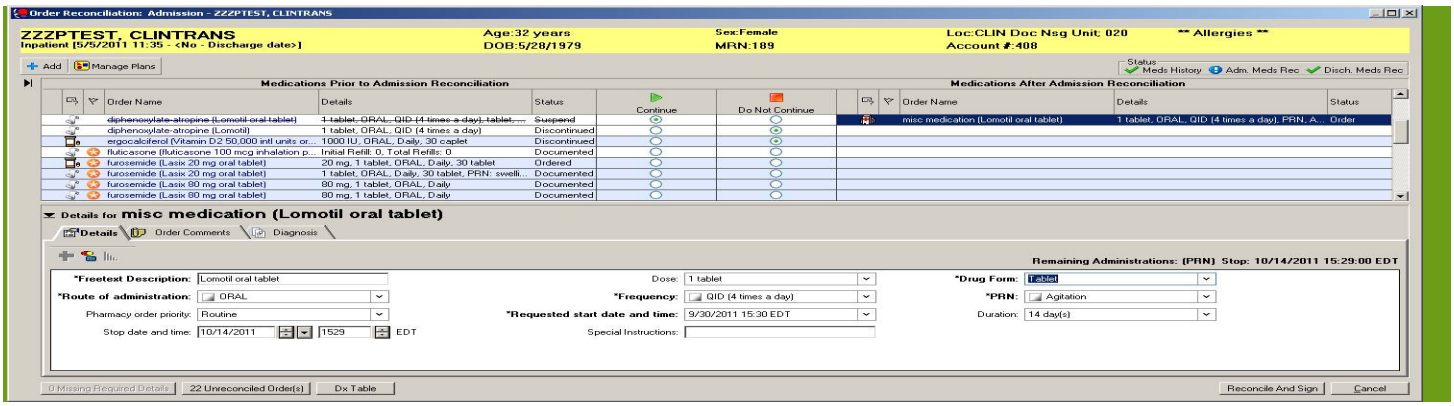
1. After selecting “Continue”, select “misc medication” in the Non Formulary Alternatives section.



2. Select the “Convert Existing SIG” option in the order sentence window.



3. In most cases, the order details will be carried over from the home medication or prescription to the inpatient order – fill out any missing order details and sign the order.

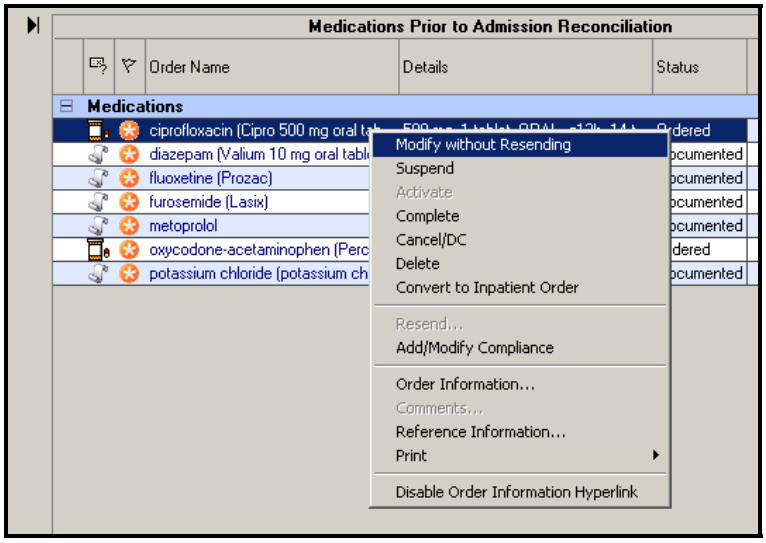


Actions On Medications From The Right-Click Menu

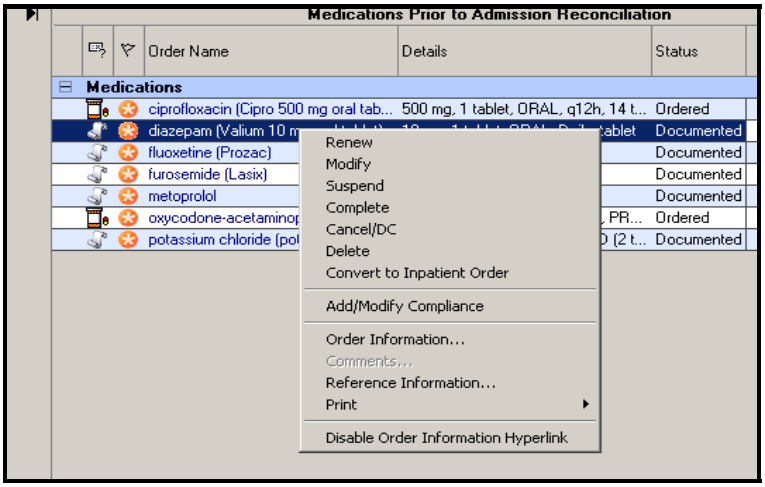
During the **Admission, Transfer or Discharge** reconciliation process the following actions on medications may be available from the right-click menu:

- **Renew:** The Renew action is initiated on the originating prescription to allow for renewal.
- **Modify without Resend:** The Modify action on the prescription allows you to select and alter details from the prescription and resend electronically.
- **Modify:** The system initiates a Modify action on the medication and you can select or alter details.
- **Copy:** The system generates the new (copy) order on a separate row from the originating order.
- **Cancel and Reorder**: The Cancel or Discontinue action is initiated on the originating medication. The Continue with Changes option is the default option. The system generates the new (copy) prescription on the same row as the originating medication.
- **Suspend:** The system initiates a Suspend action on the originating medication.
- **Resume:** The system initiates a Resume action on the medication and you can select or alter details.
- **Complete:** The system initiates a complete action on the originating medication.
- **Cancel/Discontinue:** The system initiates a Cancel or Discontinue action on the originating medication.
- **Delete:** The system initiates a Void action on the originating prescription and complete removes it from the system.
- **Convert to Inpatient:** This action converts a documented medication to an inpatient medication. This action is not available from the Discharge Medication Reconciliation window.
- **Convert to Prescription:** The system generates the new (convert) prescription on the same row as the originating medication.

Right click functionality on Admission for Prescription



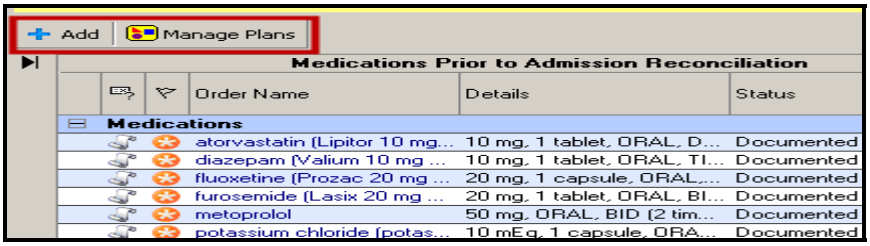
Right Click functionality on Admission for Documented Med by Hx



Adding Orders

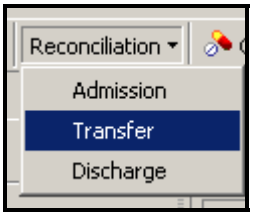
New medication orders can be added within the enhanced med reconciliation conversation as well.

- The **+Add** button opens the **Add Order** window to allow searching for medication orders.
- The **Manage Plans** button allows the management of **PowerPlans** that have been ordered.

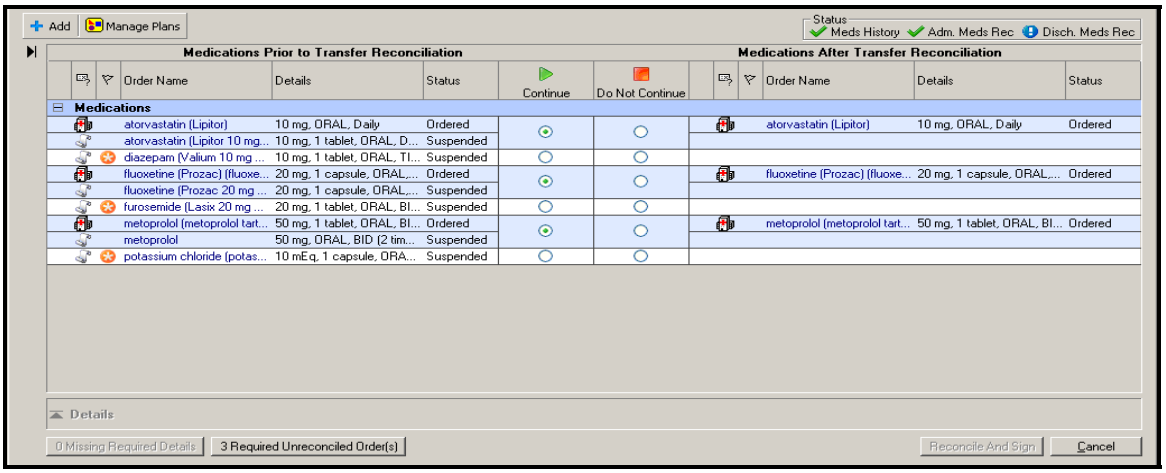


Transfer Medication Reconciliation

1. To perform **Transfer Medication Reconciliation**, click the **Reconciliation** button in the profile of the Medication List or the PowerOrders component. Select **Transfer** from the list.



2. The **Order Reconciliation: Transfer** window will open. **Inpatient medication will automatically default to continue**.



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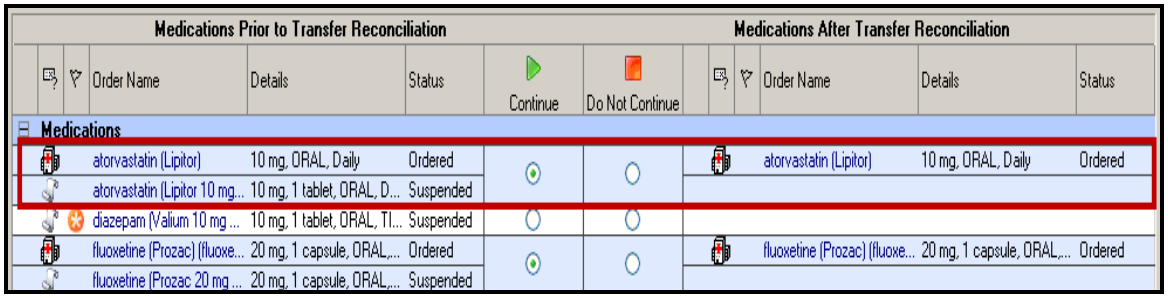
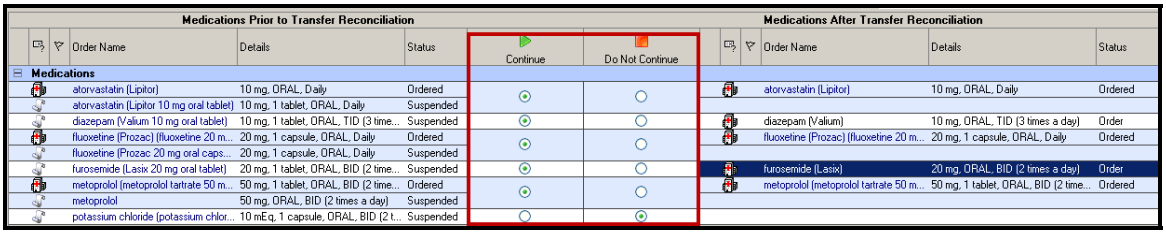


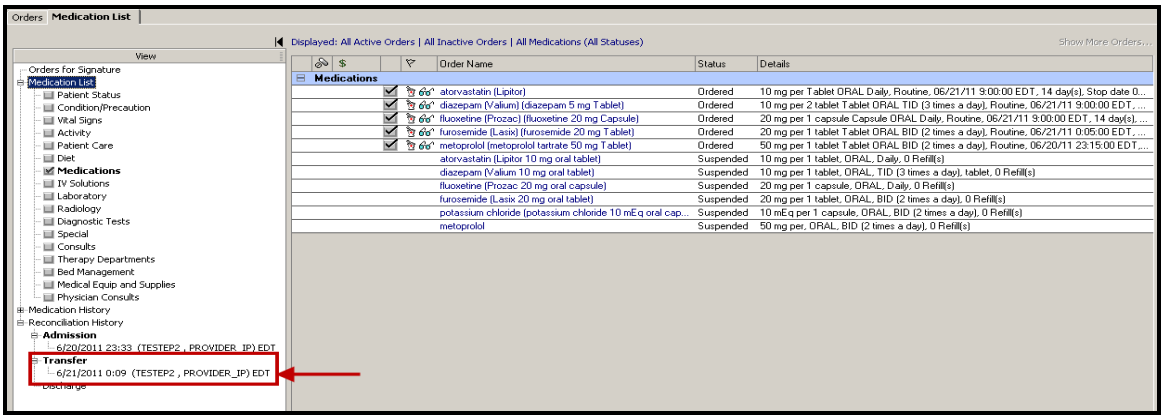
- If an **order group** contains multiple inpatient and or outpatient orders, the reconciliation options are based on the inpatient order with the most recent start date and time.
- If the **order group** contains no inpatient orders, the reconciliation options are based on the outpatient order with the most recent start date and time.

4. Select **Continue** or **Do Not Continue** for each order or order group. Address order details as needed.



5. Once all medications have been addressed, select the Reconcile and Sign icon.

6. The **Orders Profile** and the **Reconciliation History** will update.

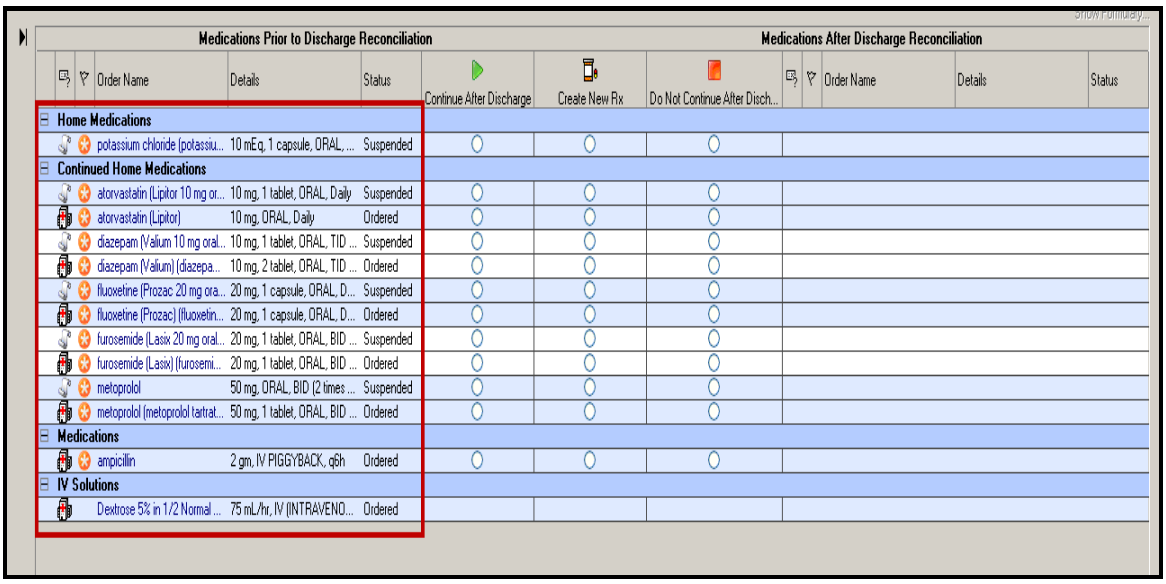


Discharge Medication Reconciliation

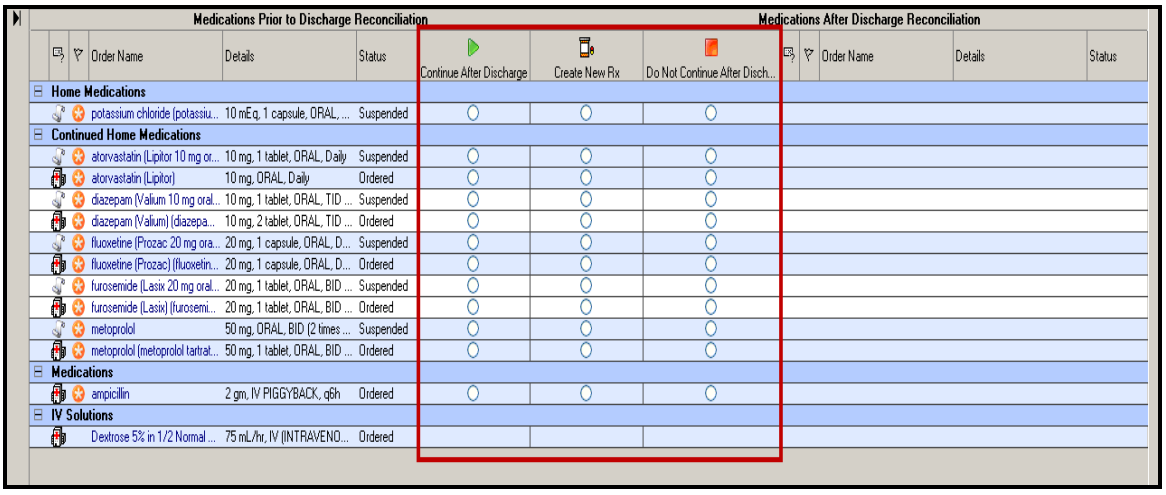
1. To perform **Discharge Medication Reconciliation**, click the **Reconciliation** button in the profile of the Medication List or the PowerOrders component. Select **Discharge** from the list.

2. The enhanced **Discharge Medication Reconciliation** can retrieve the following types of orders:
   - Active prescriptions across all encounters
   - Prescriptions inactivated within the past 24 hours from across all encounters
   - Active documented medications from across all encounters
   - Documented medications inactivated within the past 24 hours from across all encounters
   - Active ambulatory pharmacy orders from across all encounters
   - Ambulatory pharmacy orders inactivated within the past 24 hours from all encounters
   - Active inpatient pharmacy orders

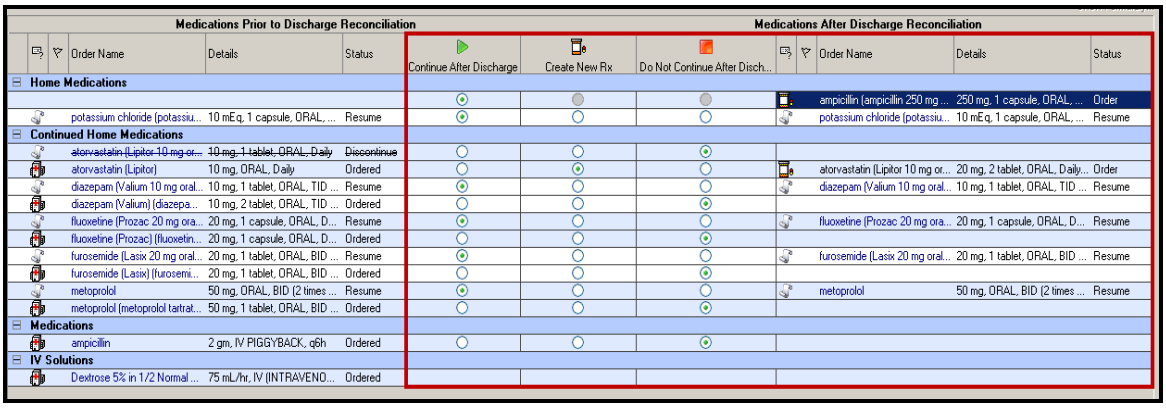
3. The **Order Reconciliation: Discharge** window will open. Orders are grouped in the following categories:
   - **Home Medications** (prescriptions and documented medications),
   - **Continued Home Medications** (documented medications continued on admission)
   - **Medications** (inpatient medication orders, ambulatory medication orders, intermittent orders, compound orders),
   - **IV Solutions** (continuous infusion orders such as titrateable infusions).



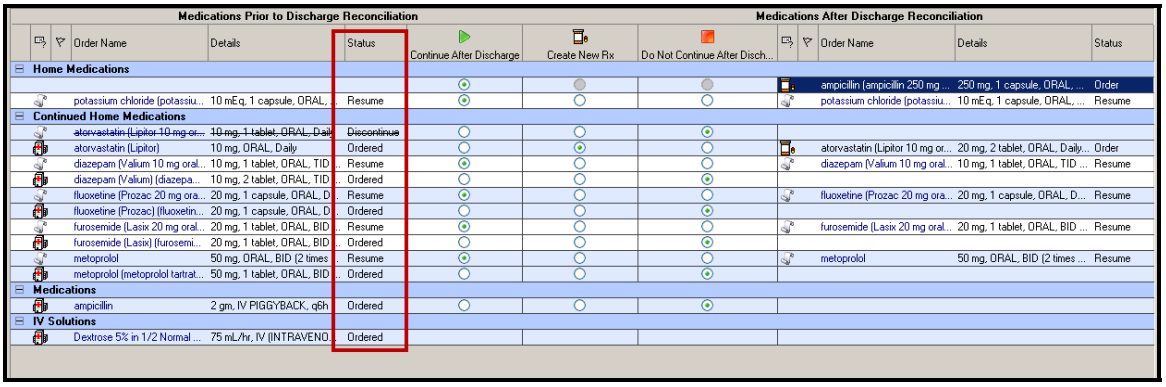
4. This section provides an option for each medication. Inpatient medications will default to **Do Not Continue**. Historical medication will default to **Continue after discharge**. This will allow the physicians to focus on addressing discharge medications that need to be created and/or modifying current prescriptions.
   - **Continue**
   - **Create New Rx**
   - **Do Not Continue**



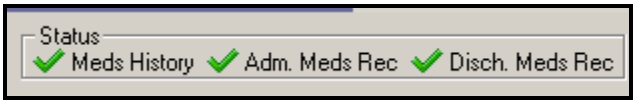
5. Select the appropriate action for each medication. Medications will now display in the **Medication after Discharge Reconciliation**.
   - New prescriptions will be indicated by the **Pill Bottle** icon.
   - Home medications that are continued will display with the **Scroll** icon.

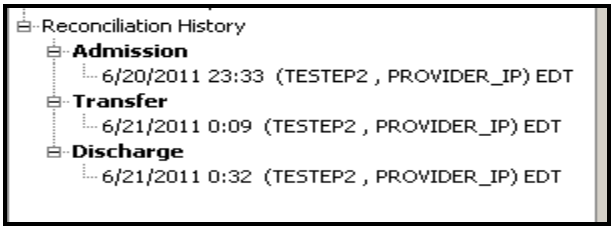


6. The Order Status will update according to the action that was take on the medication.



7. Upon signing the **Discharge Reconciliation**, the system commits all order and reconciliation actions to the database, updates the **Reconciliation History** with the actions taken and the date and time the user reconciled them, and updates the **Discharge Reconciliation Status** to Complete.
   - When the **Discharge Reconciliation** status is updated to Complete, it does not revert back to Incomplete if additional orders, prescriptions, or documented medications are added to the encounter.

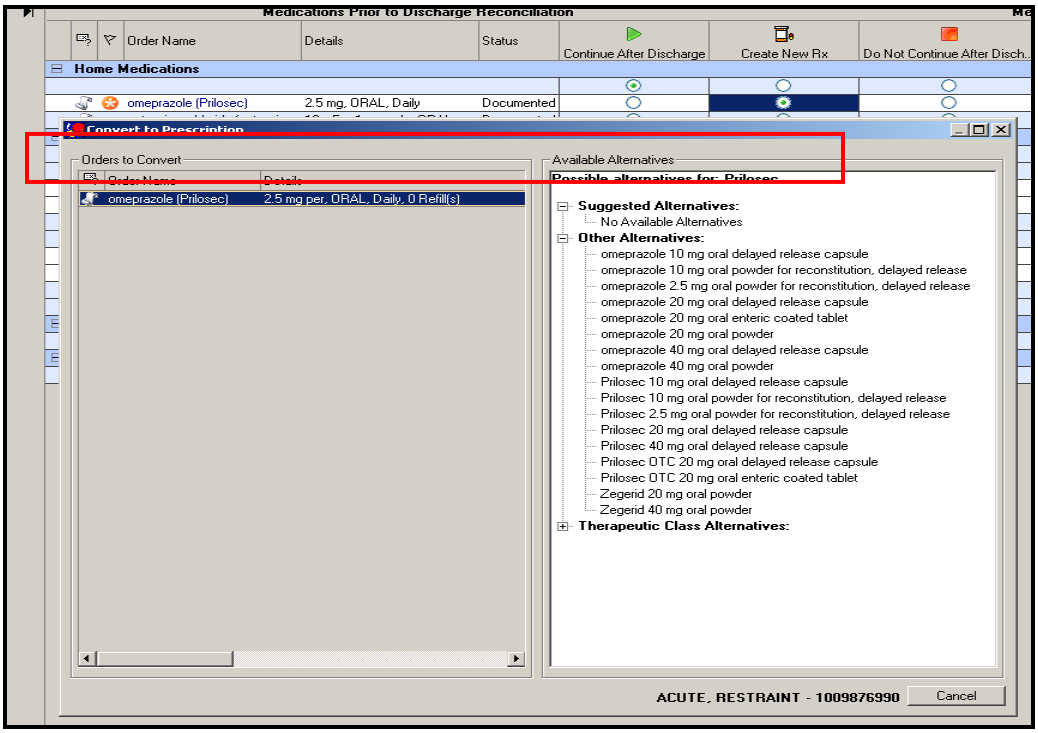




8. Available Alternatives

On **Convert to Inpatient Administration** or **Convert to Prescription**, the system may display a list of suggested therapeutic alternatives.

- The medication or medications displayed in this list partially match the converted from synonym but do not contain all three characteristics that make a complete match (mnemonic name, dose and form). The medications in the list are in the same catalog code of the converted from synonym.
- When a therapeutic alternative is selected from the list, the system displays the new selected mnemonic, the medication order sentences, and any decision support window if applicable.
- To remove the converted from medication from the conversion conversation, right-click the medication and select Remove from Conversation.



Discharge Process for Home, Rehab, LTAC and other Acute Facilities

Responsible Person	Tasks/Process
Provider	
Discharge To Home/Home Hospice/Pt Expired	

	Provider opens PowerNote –Discharge Summary EP 1. Enter Discharge Order –select disposition 2. Performs Medication Reconciliation from within PowerNote 3. Diet 4. Activities 5. Wound Care 6. Education & Follow-up 7. Discharge Diagnosis 8. Cause of Death (if applicable) **from Discharge Summary MPage** 9. Quality Measures – VTE and Stroke
	Provider Dictates Discharge Summary **Provider completes components in Discharge Process from Discharge Summary MPage** 1. Enter Discharge Diagnosis 2. Medication Reconciliation 3. Follow-up 4. Patient Education 5. D/C Process 6. Discharge Order – select disposition 7. Cause of Death (if applicable) 8. Quality Measures – VTE and Stroke
Discharge to Other Acute Facility/LTAC/Rehab Center	Same as Discharge to Home
Discharge to Skilled Nursing Facility	Same as Discharge to Home **Plus** Sign FL2 Form from CCM
Discharge to Jail	Same as Discharge to Home
Nurse	
Discharge To Home/Home Hospice/Pt Expired	Complete Depart Process Print Packet Get Signature on patient form Review Discharge information with Patient
Discharge to Other Acute Facility/LTAC/Rehab Center	Same as Discharge to Home **Plus** Print 72 hour Mar Summary Print CHS Condition/Transfer Summary Complete EMTALA Form – if applicable
Discharge to Skilled Nursing Facility	Same as Discharge to Home **Plus** Print 72 hour Mar Summary Print CHS Condition/Transfer Summary No signature required on the patient form
Discharge to Jail	Same as Discharge to Home **Plus** Print 72 hour Mar Summary
CCM	
Discharge To Home/Home Hospice/Pt Expired	Case Management completes any CCM Consults that are required prior to discharge

Discharge to Other Acute Facility/LTAC/Rehab Center	Case Management completes any CCM Consults that are required prior to discharge
Discharge to Skilled Nursing Facility	1. Case Management completes any CCM Consults that are required prior to discharge 2. Complete Patient Transfer Form 3. Confirm Chart Release Components 4. Copy of Face Sheet with family info 5. Patient code status/Golden Rod Form/ MOST Form 6. Prepare FL2 Form with PASARR Number
Discharge to Jail	Case Management completes any CCM Consults that are required prior to discharge
Medical Records	
Discharge To Home/Home Hospice/Pt Expired	No tasks
Discharge to Other Acute Facility/LTAC/Rehab Center	**Print the following items from the chart:** Discharge Summary Operative Reports Pathology MD Orders All Labs All Radiology Orders (CPOE) MAR Records Therapy Notes Progress Notes Medication Reconciliation Pharmacy Notes Special Diagnostics ED Notes History and Physical Cardiac Nursing Notes Consult Reports

2. RxWriter/ePrescribe

ePrescribe

ePrescribe is a routing functionality that sends prescriptions directly to the pharmacy computer system, bypassing printing methods such as faxing to the pharmacy or printing a prescription to be delivered by the patient.

- Allows the prescriber to access the patient's **External Rx History** and the patient's **Rx Plans**.
- Provides a secure, HIPAA compliant encoded communication link to and from *participating* pharmacies.
- **ePrescribe cannot be used to prescribe controlled substances.** DEA has not certified any transmitting or receiving system as meeting these security standards. The system will provide a print option for these medications.

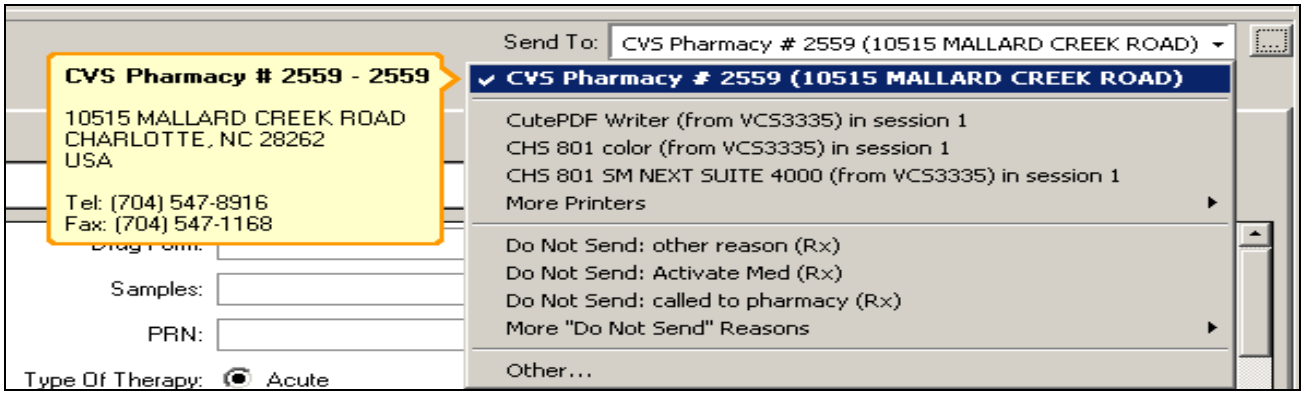
ePrescribe is integrated into **PowerChart** via the **Message Center** as well as **PowerOrders** and **Medication List**. Message Center will be utilized to handle routing errors.

Some of the benefits of ePrescribe include:

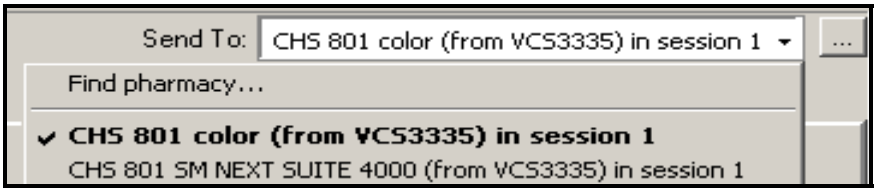
- Increased patient safety
- Increased efficiency for physicians and pharmacists
- Decreased wait time for patients getting a prescription filled
- Improved selection of medications due to the ability to access a patient's Rx Plans, thereby preventing prescriptions for medications not fully covered by a patient's plan
- Improved interactions checking with alerts to the prescriber using the Decision Support tool

To Send A Prescription Electronically

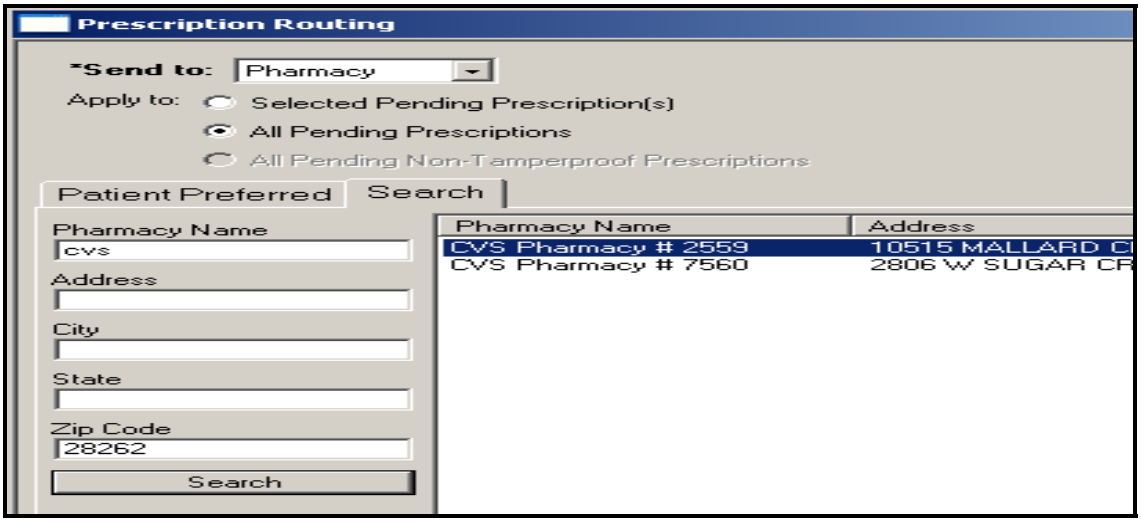
1. With the prescription open, click in the Send To: field.
2. If the patient has a preferred pharmacy it will appear here with mouse over contact information. When completing details about a new prescription, select the drop down arrow beside the pharmacy and hover over the pharmacy name in the drop down list. A pop-up window appears that contains the address and phone/fax number of the pharmacy.



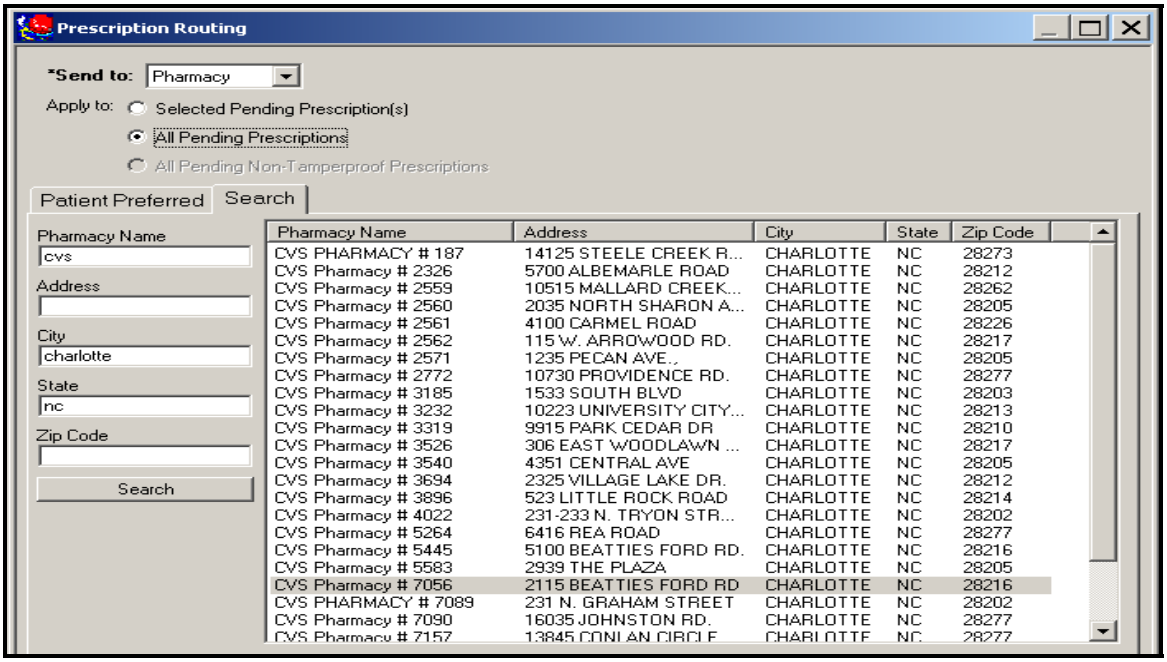
3. If there is no preferred pharmacy for the patient, then the pull-down menu of the Send To: field, will give a choice of Pharmacy.



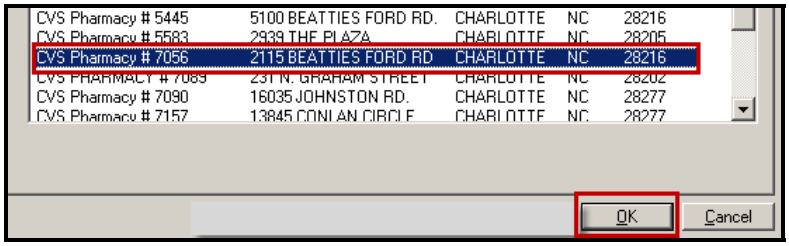
4. Click on Find pharmacy.
5. The **Prescription Routing** window will open. The city and state default in to the search fields based on the patient's demographic information.

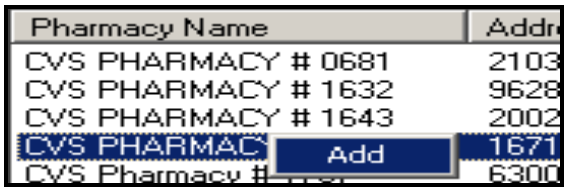


6. Type in pharmacy name and enough information to limit your search to 50.
7. The search results display all pharmacies.



8. Click on the desired pharmacy and select OK or Right click on desired pharmacy and click on Add

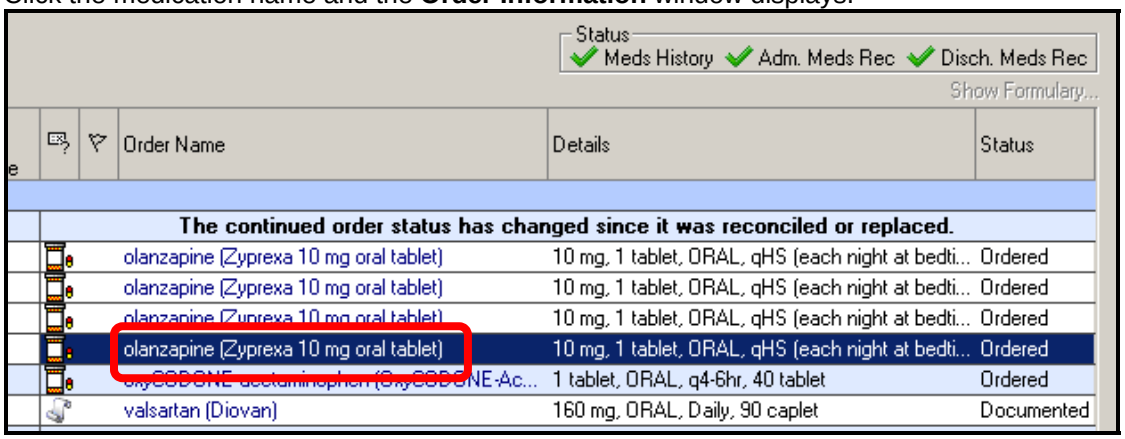




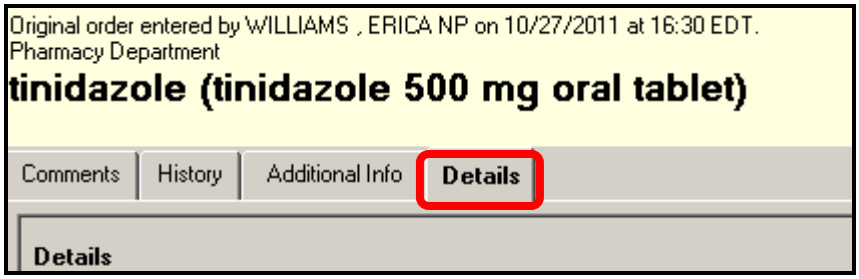
9. The pharmacy will now appear and remain on the patient as a preferred pharmacy.
10. At this point the prescription is ready to be signed which routes the prescription to the pharmacy.

Look-Up Pharmacy from Prior Prescriptions

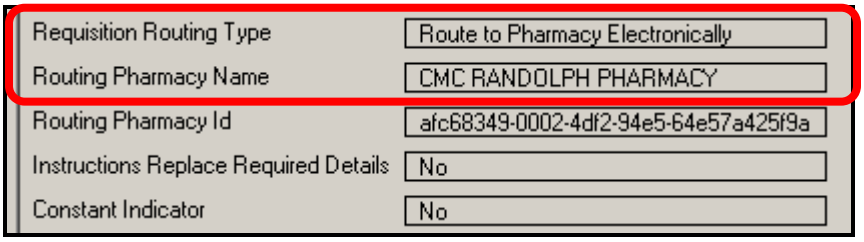
- The pharmacy from prior prescriptions can be viewed in at least two locations within PowerChart.
- Click the medication name and the **Order Information** window displays.



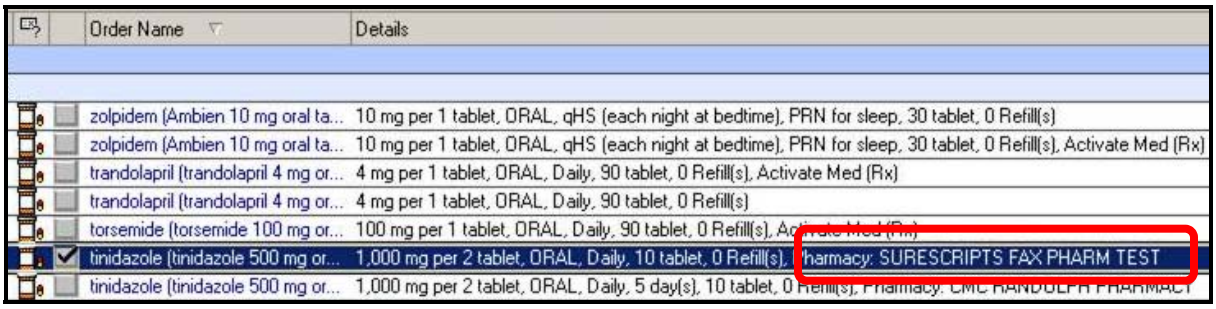
- Click the **Details** tab.



- If the prescription was routed to a Pharmacy, the **Requisition Routing Type** will look similar to below.



- The pharmacy is also located in the **Prescription** section of the **Medication List.** It is located to the right of the medication **Details.**



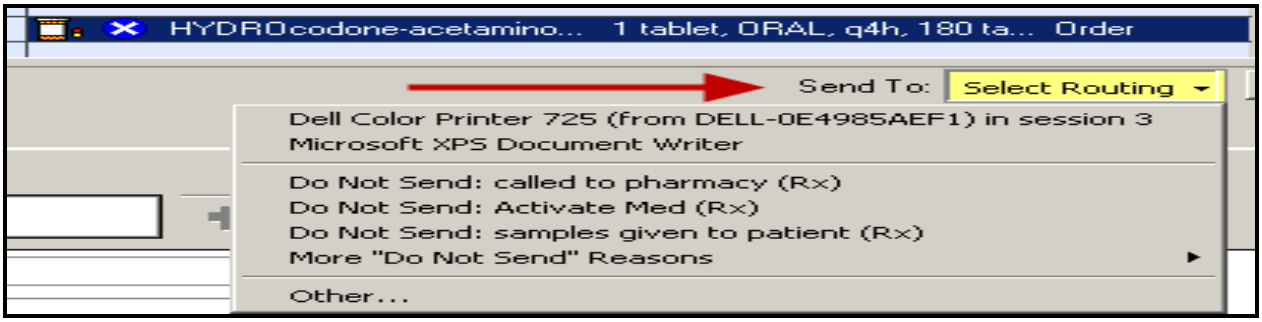
Patient Preferred Tab

1. It is the default tab when a primary pharmacy has been selected for the patient previously instead of the **Search** tab.
2. The most recently selected pharmacy will display at the top of the list. This same pharmacy will also default into the **Route** field of the prescription pad for future use.

3. This list is automatically updated when new prescriptions are sent

Sending To The Pharmacy Is Not An Available Option In The Following Situations:

1. Scheduled medications are excluded by DEA regulations. These prescriptions may be printed and the print option will default.

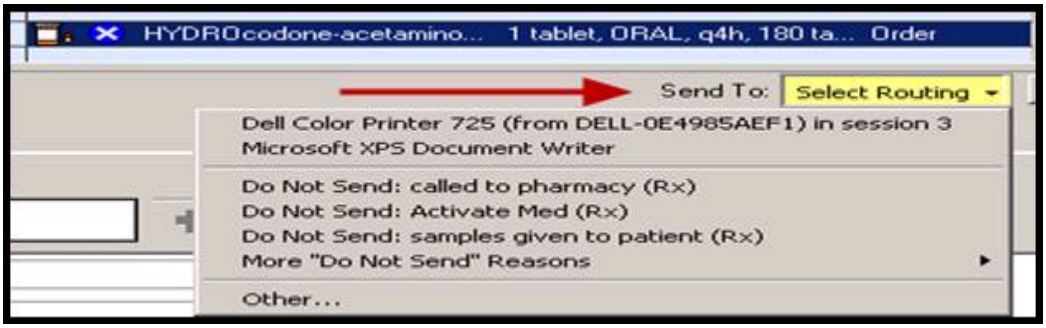


2. The ordering provider selected is not registered to send electronic prescriptions.

3. Critical patient demographics are missing such as last name, first name, date of birth or gender.
4. When entering multiple prescriptions at the same time, the Sent To: option defaults from the previous prescription for that inpatient.
5. If there is a mix of scheduled (controlled) medications and non-controlled medications, the non-controlled prescriptions can be sent electronically and the scheduled medications will be printed.

Printing a Prescription:

1. To print a prescription, select the printer from the menu.



2. **The printer used for prescription printing will have a Secure Rx label**

3. Labeled prescription printers will watermark the paper when the prescription prints

4. Provider designated computers (those with 22" monitor and Dragon Mic) will also have the **secure RX label** and will print to the labeled prescription printer.

ePrescribe Routing Errors

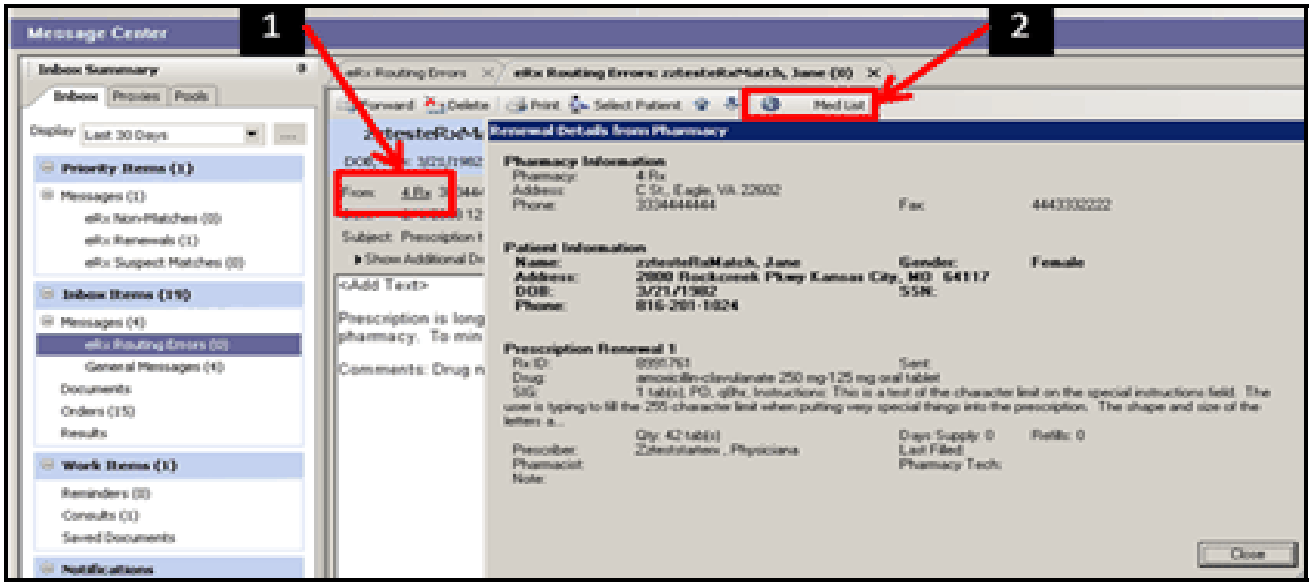
If the transmission of a prescription order to a pharmacy fails for any reason, a routing error message is sent to the ordering provider's Message Center.

Examples include:

- Prescription routing temporarily unavailable
- Unable to communicate with pharmacy
- Prescription too long for the pharmacy system

Within the routing error message the user can:

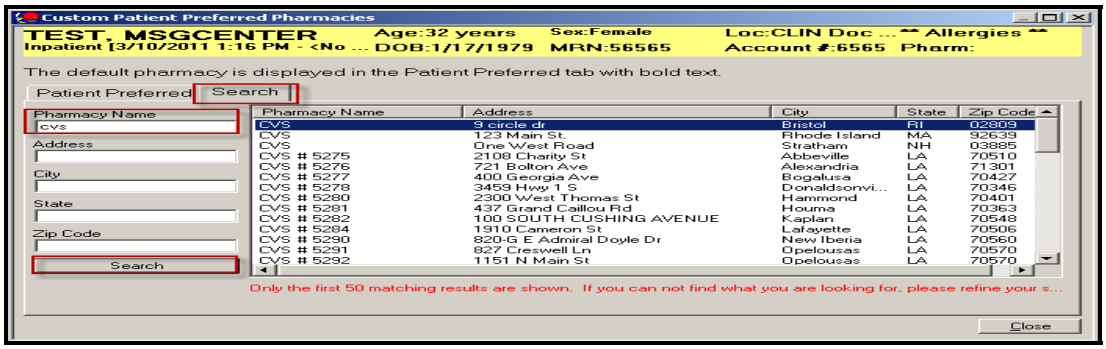
1. Click the pharmacy name hyperlink to view information about the pharmacy and the prescription to place a call to the pharmacy.
2. Click the Med List button to open the patient's Medication List and print the prescription to fax it to the pharmacy.
3. After the prescription is called or faxed to the pharmacy, a comment including the name of the prescription should be added to the message indicating what action was taken. Then the message should be saved to the patient's chart and deleted.



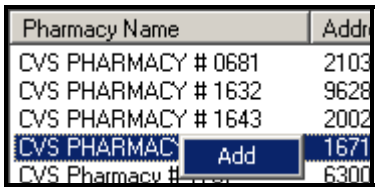
Patient Pharmacy Search

- Access Patient Pharmacy Search via the Patient Pharmacy icon on the Toolbar in the patient's chart.

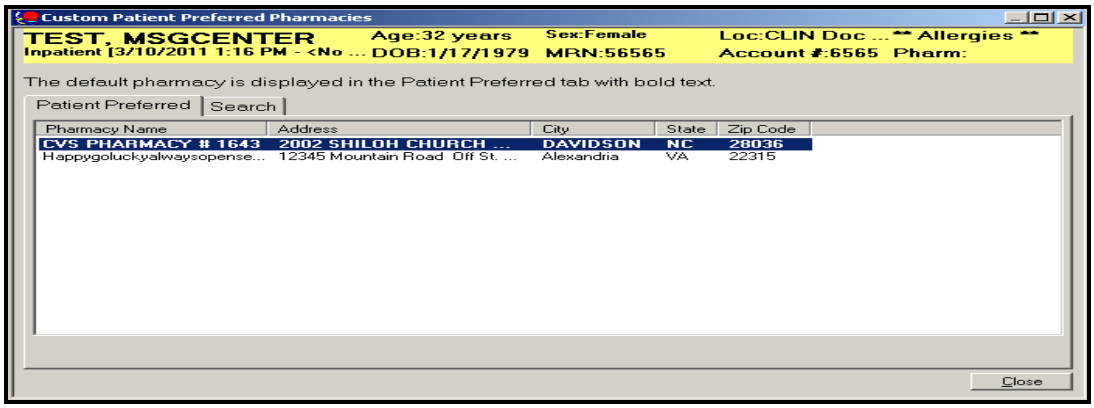
- The phone number can be found in at least two locations within PowerChart.
- Before beginning Discharge Med Rec, click the "**Patient Pharmacy**" icon then hovering over the name of the pharmacy. A pop-up window appears that contains the address and phone/fax number of the pharmacy.
- If patient has a preferred pharmacy in the system it will appear on the Patient Preferred tab.
- If empty, the search tab will open. Type in pharmacy name and enough information to limit your search to 50, and Click Search for pharmacies to display



4. Right click on desired pharmacy and click on Add

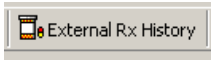


5. Pharmacy will now appear and remain on the Patient Preferred tab for access when writing electronic prescriptions.

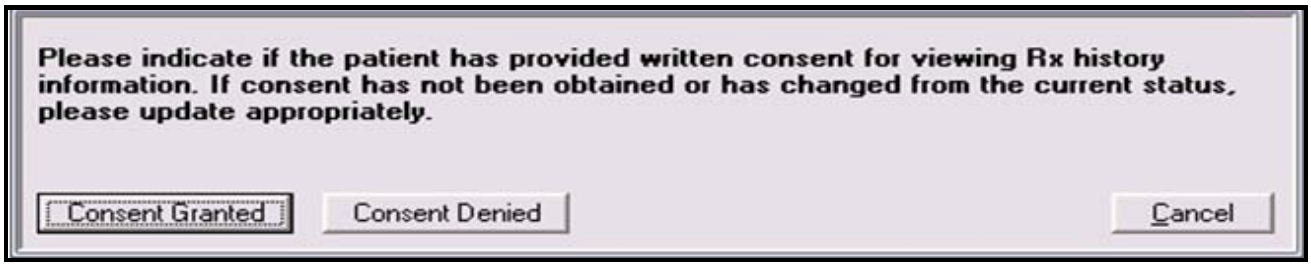


External Medication History

External Medication History is available through the Med List.

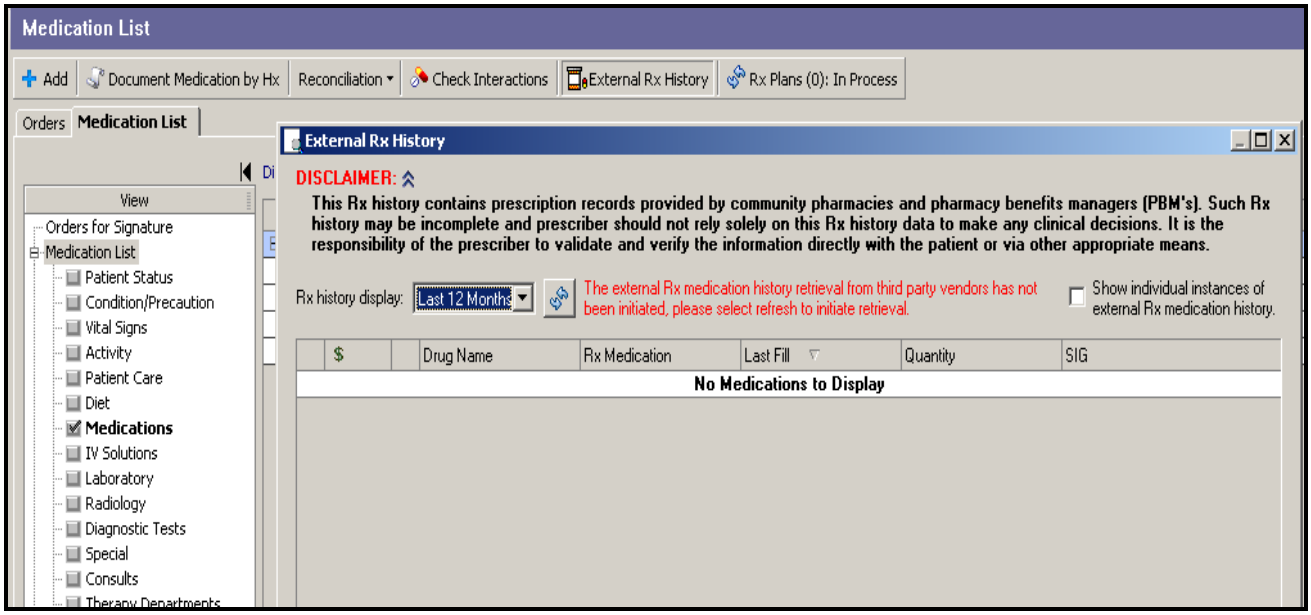
1. When selected it conducts a review of the patient's pharmacy events from the last 13 months of participating pharmacy prescription history for the patient.
2. It allows any prescriptions found to be converted to history or to prescription within PowerChart.
3. Click on the **External Rx History** button. 

4. The first window that will display is the **Rx History Patient Consent** dialog box. Select Consent Granted.

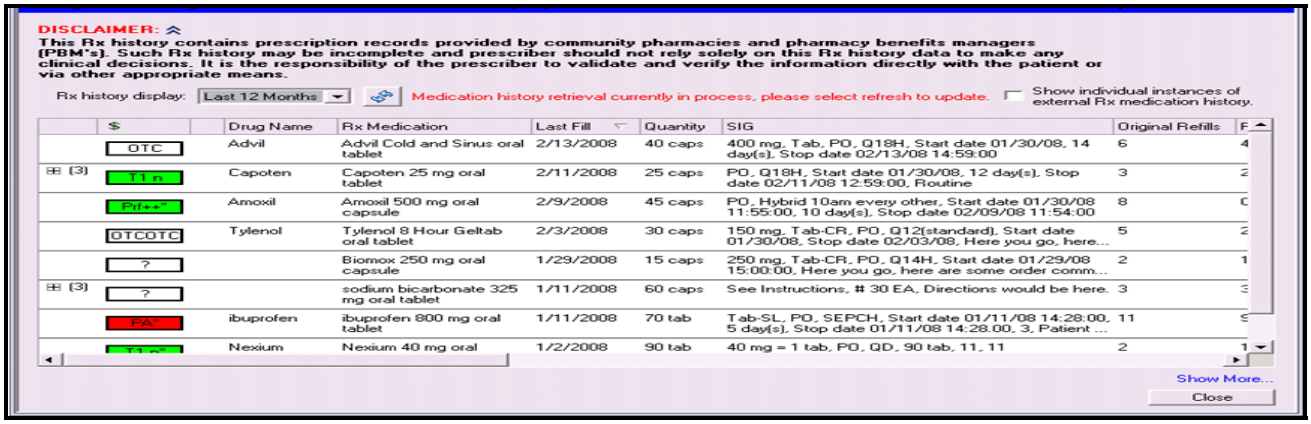


5. Once consent is granted and documented, the message will not pop up again for that patient. The user can go through the options menu again if he/she needs to update the patient consent status from granted to denied.
6. The default is the last 13 months. Other options are 3, 6, 18, 24 months, or show all.
7. The External Rx History window displays a list of the patient's prescriptions, including the Last Fill and Quantity. Note the disclaimer that the history may be incomplete.

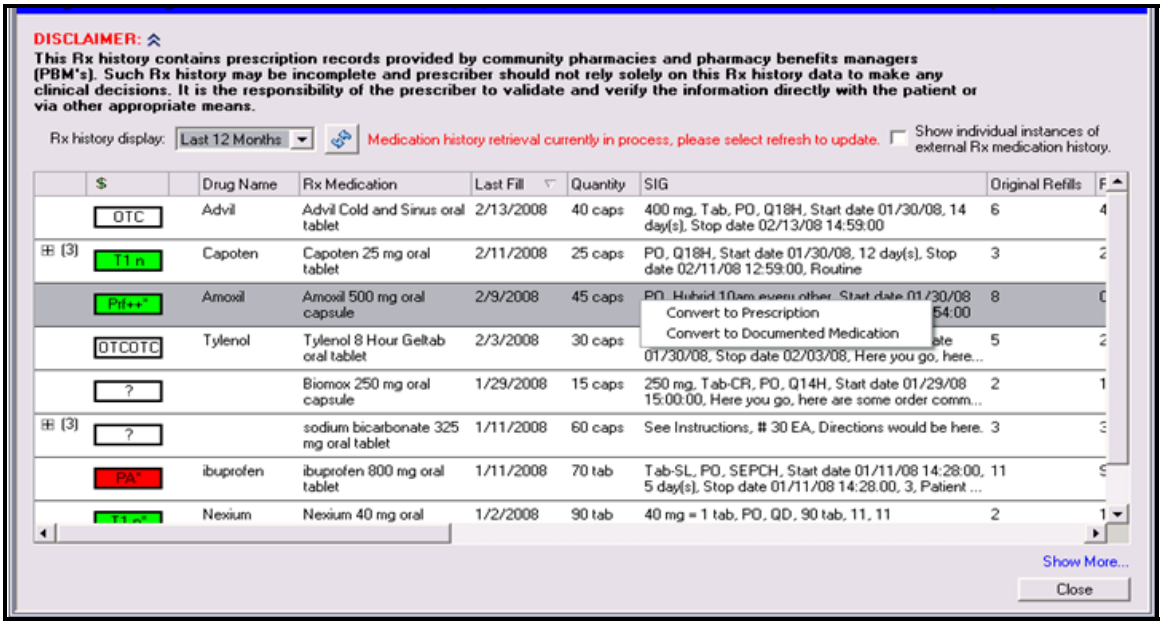
This is an example if no medications display.



This is an example if medications do display.



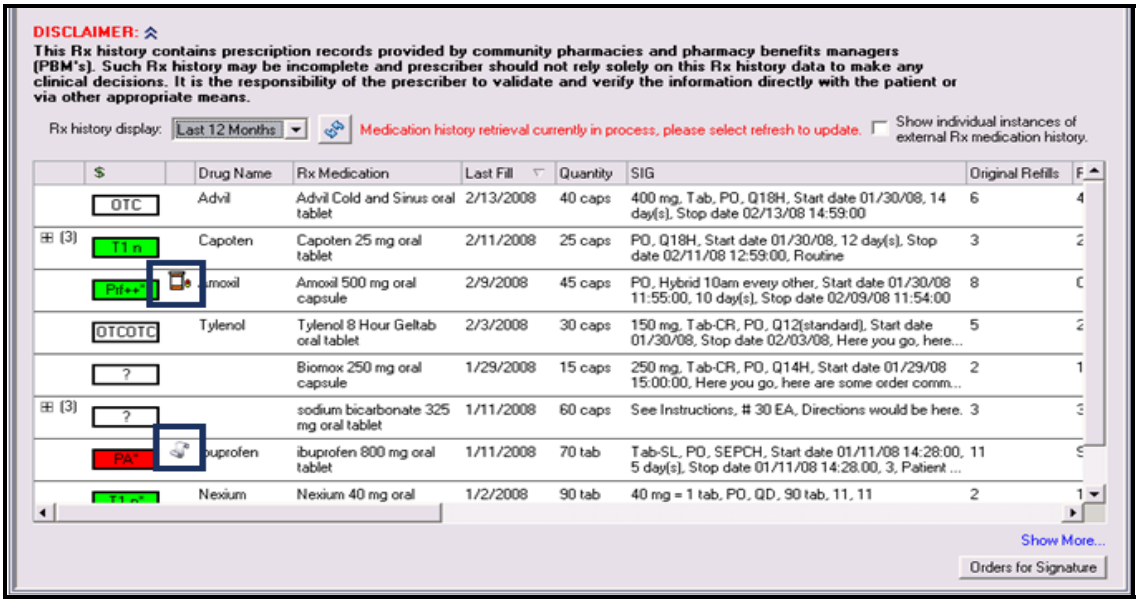
8. Right-clicking on a medication provides the option to convert external Rx history items to Prescriptions or Documented Medications.



9. **Convert to Prescription** opens the Rx Writer module and allows a prescription to be written by selecting an order sentence, modifying details, etc.

10. **Convert to Documented Medication** immediately adds the medication to the Medication List in a Documented Status.

11. Items that have been marked for converting will display the appropriate icon next to the medication name.

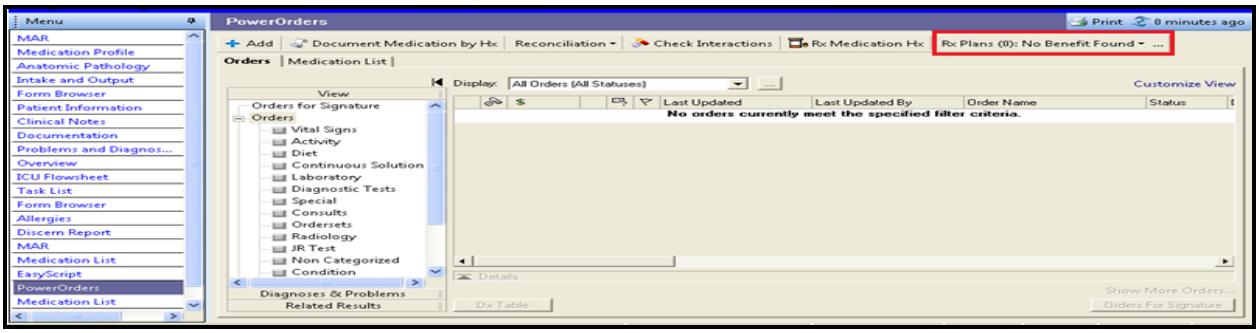


12. The user clicks the Orders for Signature button at the bottom to sign the orders and complete the process.

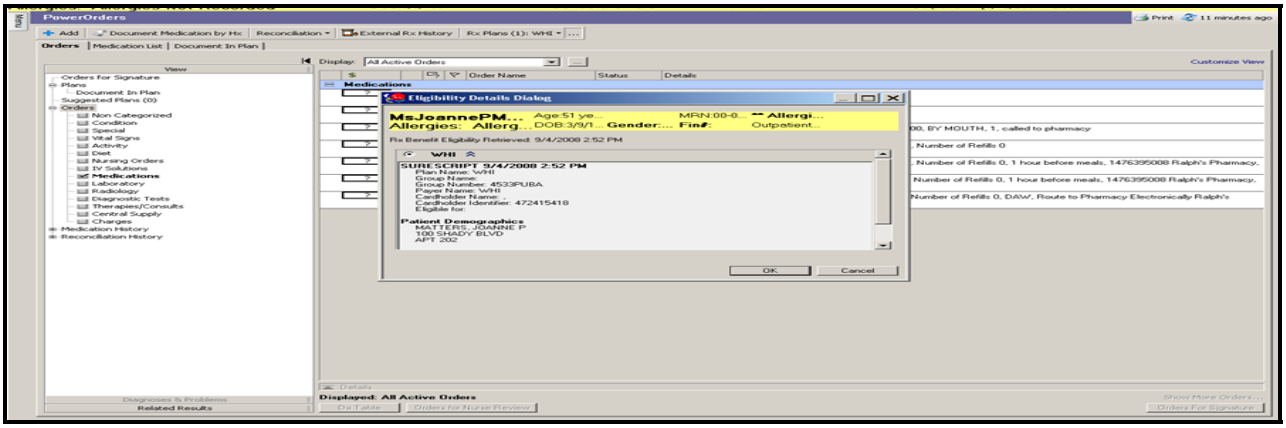
Eligibility

The Rx Plans feature allows the user to perform Rx benefit eligibility checking and determine the coverage for the desired medication (formulary checking).

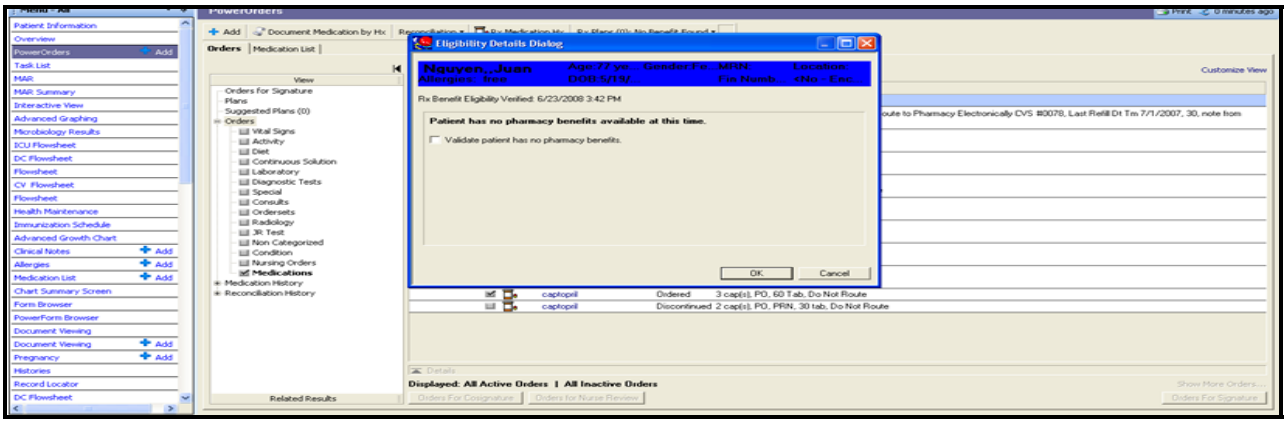
1. Once the eligibility checking has been performed, click on the **Rx Plans** control to pen the Eligibility Details dialog.



2. Eligible plans and details are displayed. If multiple plans are returned, the user can select the appropriate plan.



3. If there is no eligible health plan returned, the user has the ability to confirm that the patient does not have any pharmacy benefits if that is the case.

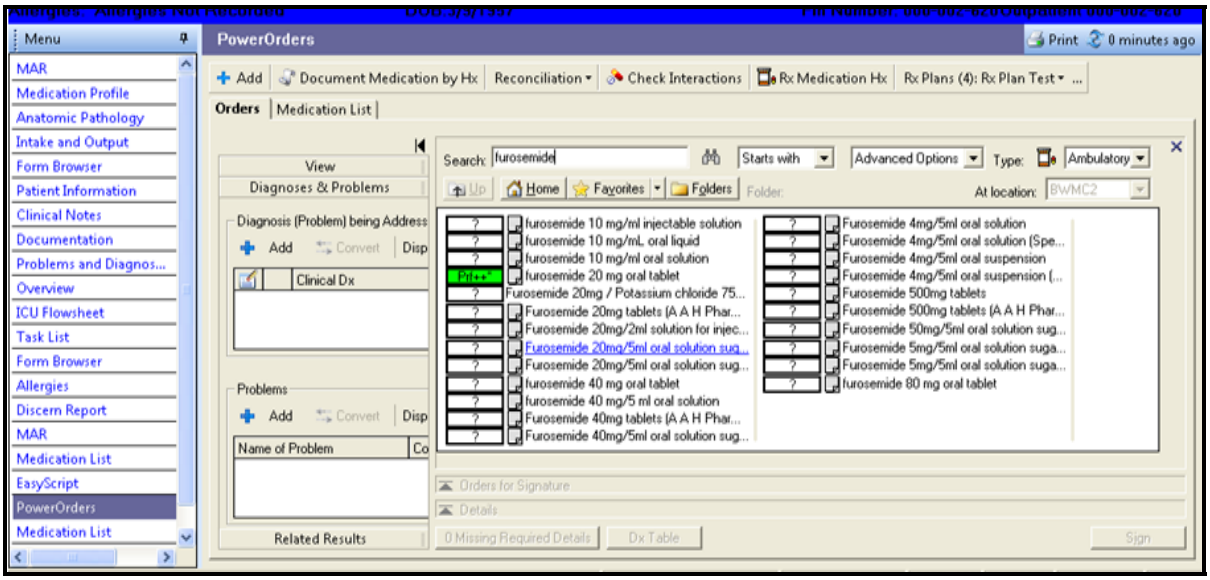


Benefits

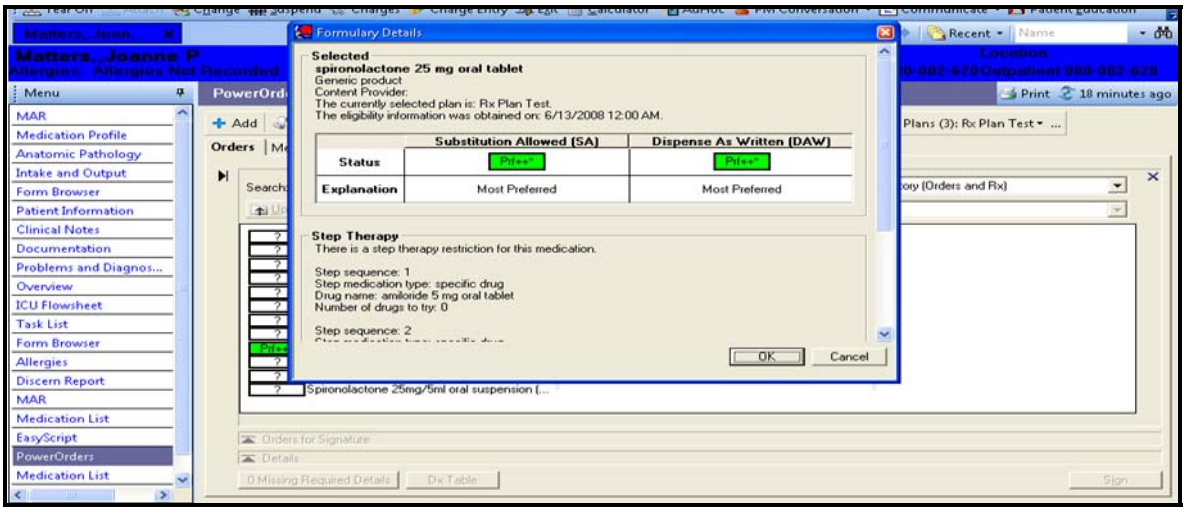
Formulary status provides information around the level of coverage for a specific drug.

- Level of preferences
- Copay
- Restrictions
- Alternatives
- Additional Reference Links

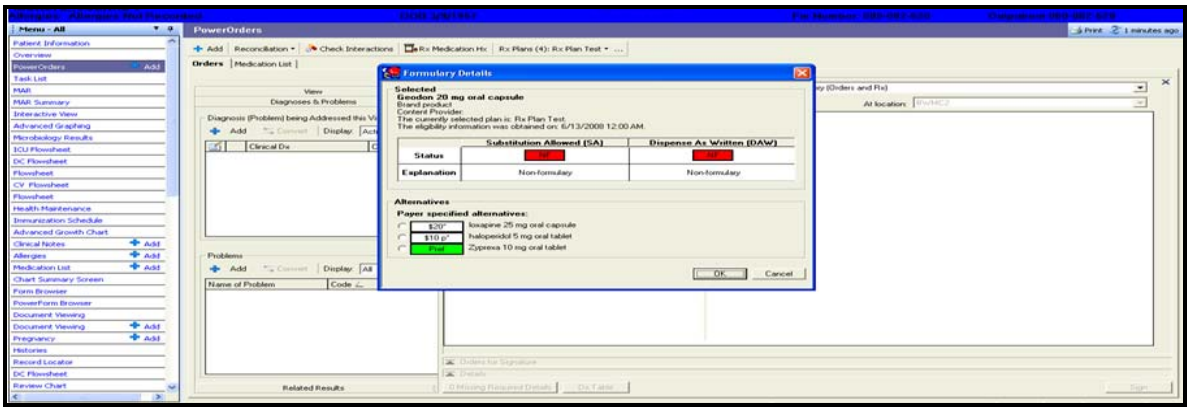
1. Formulary status icons will display for prescriptions and home medications on the order profile, and within the order search.



2. The color (green vs. red) and text within the icon provide the most critical information. Hover the mouse pointer over the icon for additional information, or click the icon to see the full formulary details.



3. Selecting the formulary details will also allow you to search for alternatives for non-formulary items.



4. The formulary status icon will update if necessary based on the Dispense as Written (DAW) selection.

3. Message Center

Message Center Overview

- The Message Center is a notification component of PowerChart that is used primarily by providers. Other clinicians using Message Center to communicate with providers includes: Nurses for certain renewal orders, Clinical Case Management, Wound Care, and Clinical Nutrition.
- For some providers Message Center is the default window when logging into PowerChart.
- The Message Center icon is located on the Toolbar

. Selecting it while in a patient's chart or anywhere else in PowerChart will take you to the Message Center. It contains all the folders available to the user. The number of folders will vary by user, as dictated by job function.

New Folders Message Center

Priority Items

- **eRx Routing Errors** – Any ePrescribe routing errors will be located in this folder. Examples: Prescription routing temporarily unavailable; Unable to communicate with Pharmacy; Prescription too long for the pharmacy system.

Inbox Items

- **Messages** – General messaging allows clinicians to communicate with the provider. Functions are similar to an e-mail. Clinical Case Management (CCM) can send template messages regarding CCM Discharge Plan Notification, CDMP Severity Complexity, and Physician Advisory Form. These messages are replacing CCM documentation on the paper progress note.
- **Med Student Orders** – Medical Student PowerPlan and Ad hoc orders will route to this folder for supervising provider co-signature. These orders are inactive until signed by the provider.
- **Renewals** – A notification will display so the provider is aware that a medication or restrictive restraint order is up for renewal. Triggers for renewals include: Stop Type, Stop Duration and Notification Period.
- **Proposed Orders** – Proposed Orders from Pharmacists, Nursing (Continue Urinary Catheter & Remove Urinary Catheter orders only), Wound Care, Clinical Case Management and Clinical Nutrition will route to this folder. The provider will have the option to Accept, Reject, or Accept with Modify a proposed order. The order is in a Proposed status (Not Activated) until the provider Accept or Accept with Modify and Sign the order. When signed by the provider, the order status changes to Ordered. At this time the order is activated. Reject and Sign will remove the order from the Order Profile in PowerChart.
- **Orders to Approve** – Orders placed with a designated communication type to be flagged/routed for co-signature. Example: CPOE Verbal, CPOE Phone, and CPOE Standing Orders. These orders are activated when entered by the clinician.

Work Items

- **Saved Documents** – Save PowerNotes or other documents that need to be completed and signed.

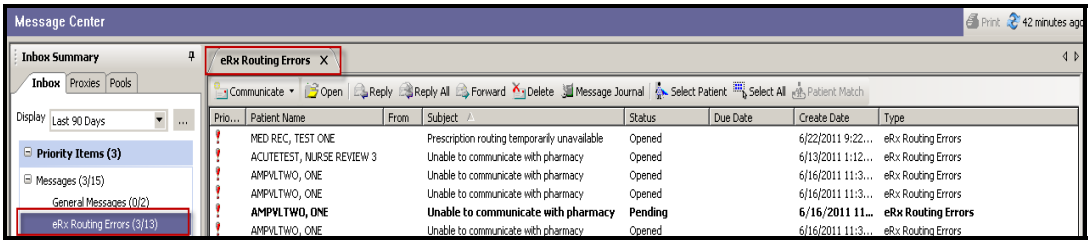
eRx Routing Errors

There are three common eRx Routing Errors Messages:

- "Prescription routing temporarily unavailable", - Connectivity, Communication Issues (usually with a particular pharmacy system)
- "Unable to communicate with the pharmacy". – Freestanding errors generated by pharmacies for a new prescription
- "Prescription too long for the pharmacy system" – Special Instructions/SIG is too long. The maximum character length of a prescription is 350 characters.

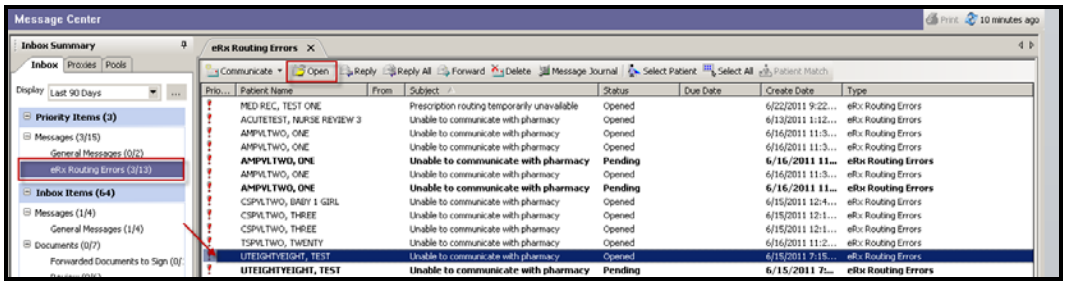
Open the Message

1. Select eRx Routing Errors menu under Priority Items on the Inbox tab. The eRx Routing Errors folder opens.

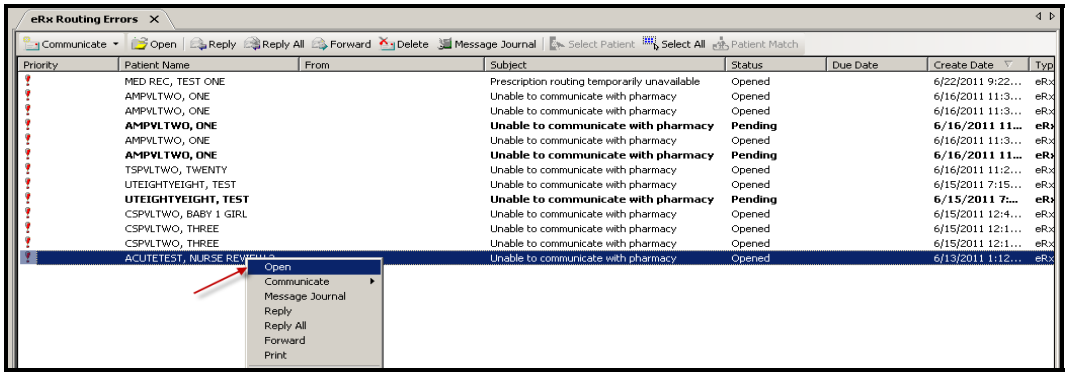


2. There are 2 ways to open a message:
   a. Double click on a message.
   b. Highlight a message and Click the Open folder icon

on the Message Options Bar.

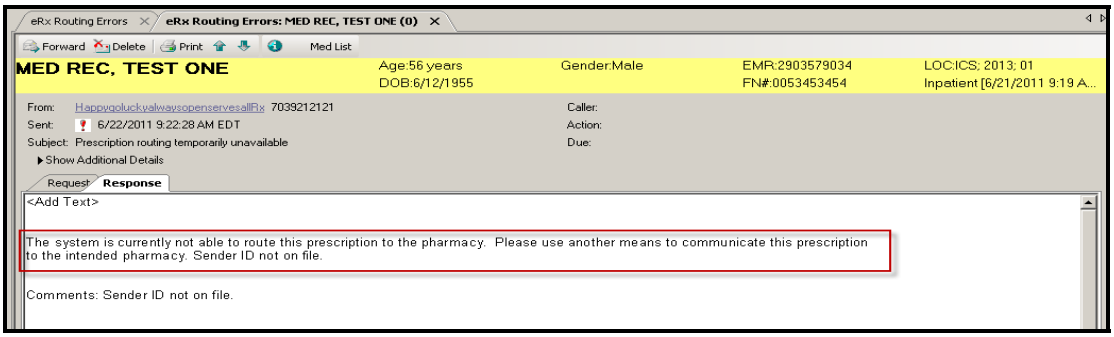


   c. Right click on the highlighted message and Select Open from the drop-down menu.

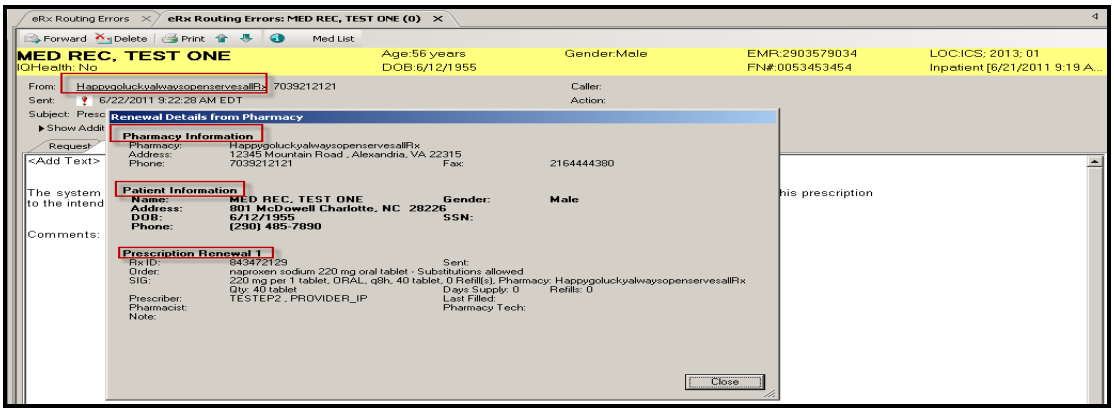


Contents of the Message

1. The eRX Routing Error message.



2. The Pharmacy hyperlink with the **Pharmacy Information**, **Patient Information** and **Order/Prescription Details.**

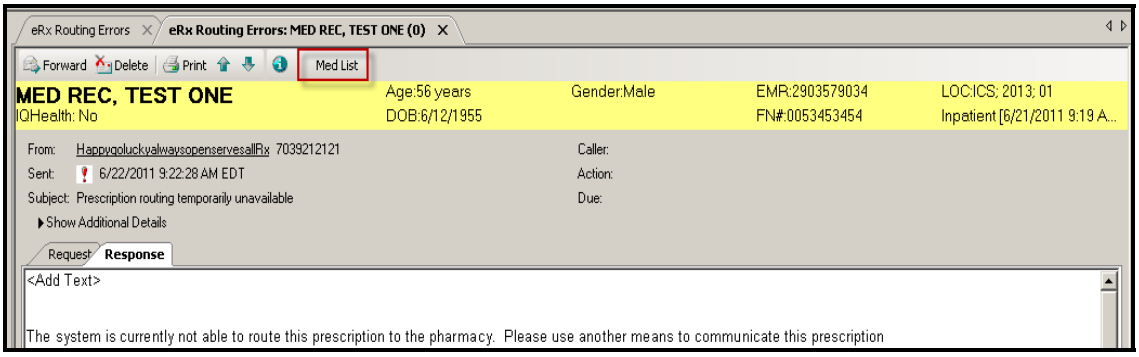


Responding to the eRx Routing Error Message

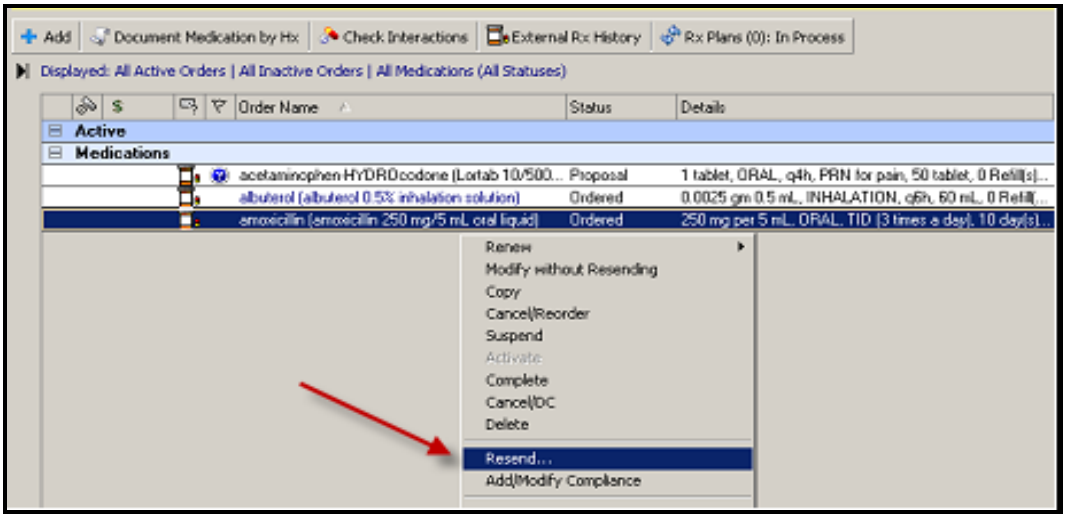
Resending the script back to the pharmacy will resolve the issue in many cases. However, if the second attempt results in another error, contact the pharmacy.

1. Identify the prescription from the order details (**Refer to above screenshot: naproxen sodium 220 mg per 1 tablet, oral, 20 tablets, refills 0.)**

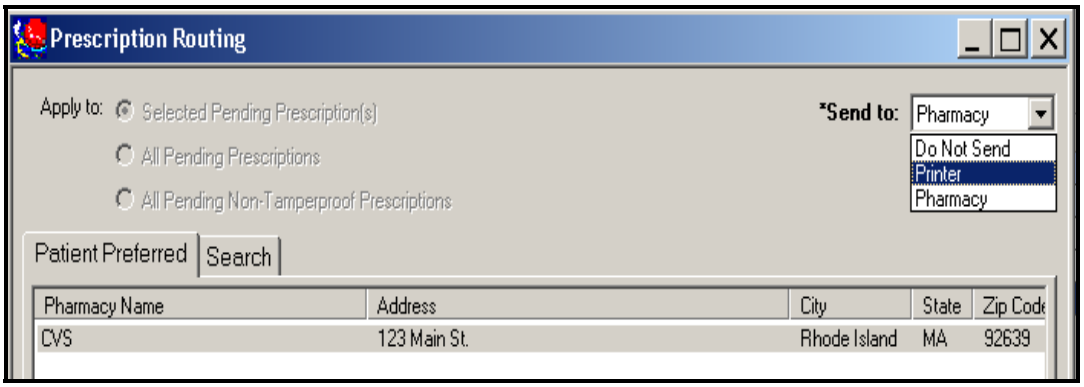
2. Launch Med List by click the Med List icon from the Message Options Bar.



3. Right-click on the Order and Select “Resend”. This will open the “Prescription Routing” window.



4. Change the Routing Option from “Pharmacy” to “Printer”.



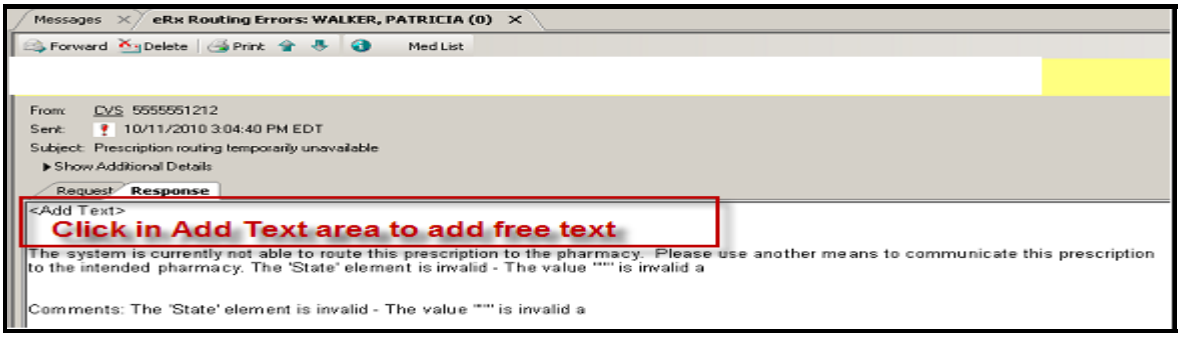
5. Print to:
    a. A designated Rx Tray Printer added as a favorite – Prints on Secure Paper
    b. A Window default printer – Prints on plain paper.

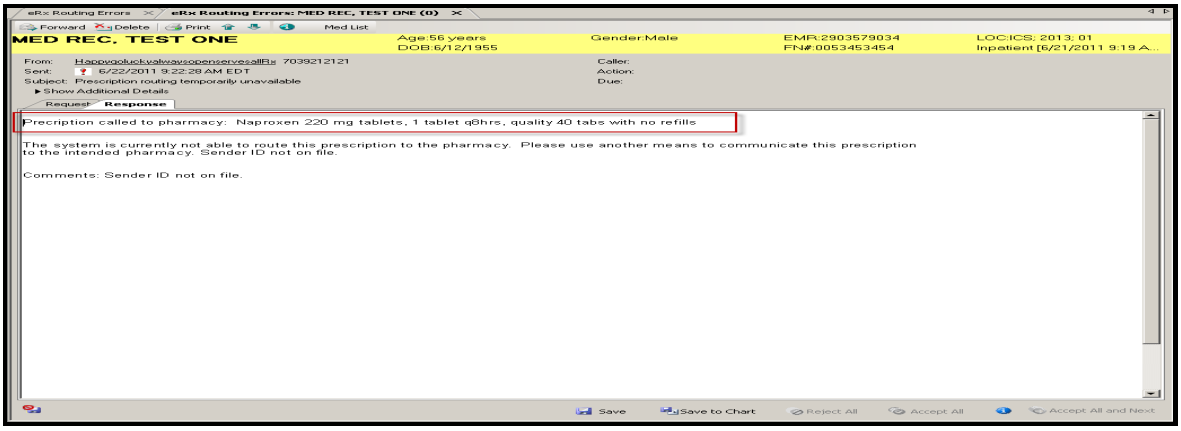
6. Manually fax printed prescription to pharmacy.
7. When appropriate, it is also acceptable to call the script into the pharmacy in place of a manual fax. Please document the method used to communicate the script information to the pharmacy and Save to patient’

Completing the Message

After the prescription is called or faxed to the pharmacy.

1. Highlight <Add Text> and free-text method of sending prescription to pharmacy (Call or Fax). Include the prescription details in the documentation



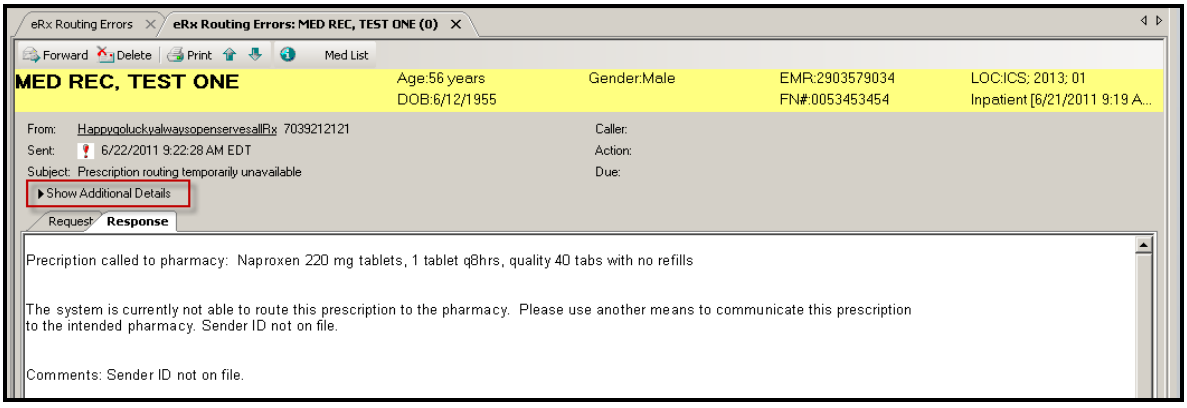


2. Then the message can be saved to the patient's chart.

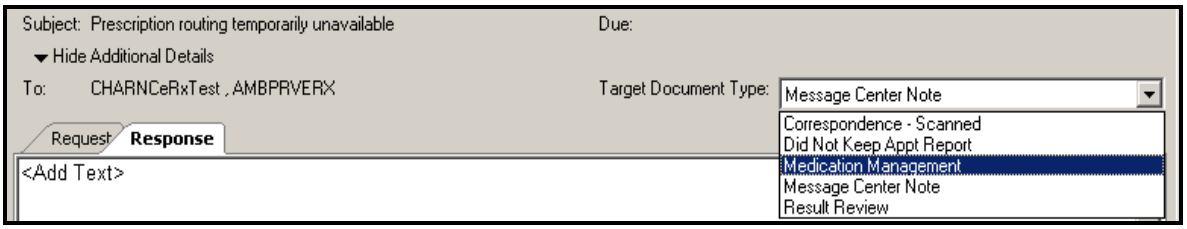
Saving Prescription Message to Chart

To save these actions to the patient's chart:

1. Click on "Show Additional Details" found under the Subject of the message.

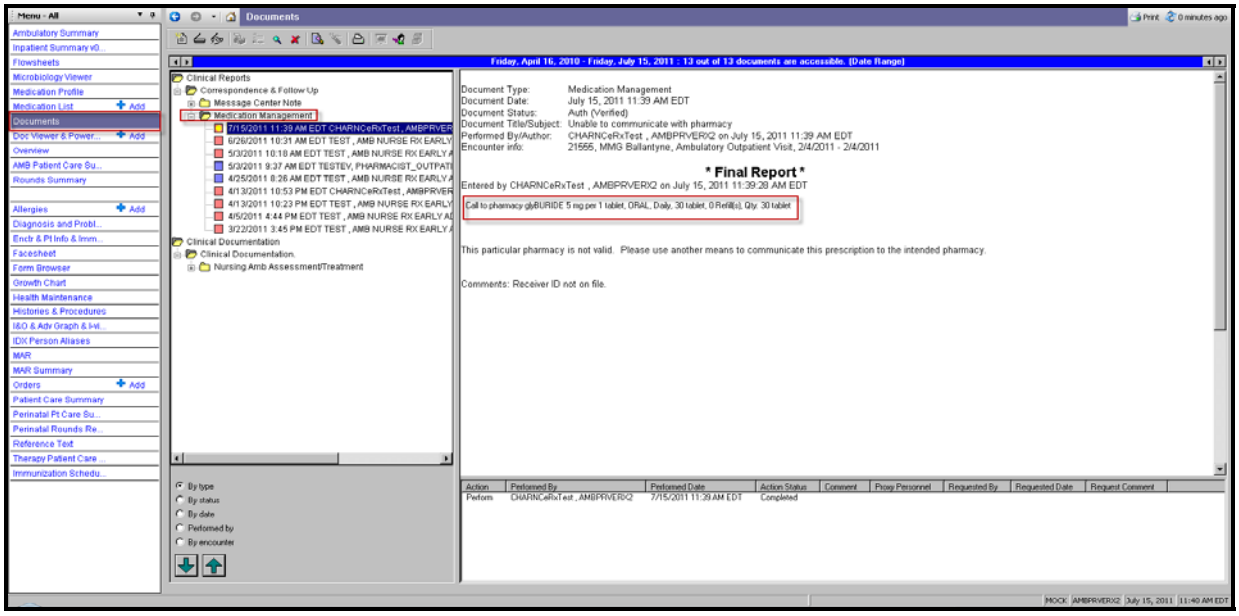


2. This will open addition details: Click the drop-down arrow to the right of "Target Document Type" and Select "Medication Management".



3. Use the "Save to Chart" action available at the bottom of the message.

4. The Message is saved under the Documents Menu in the "Medication Management" folder in PowerChart. Documents>Clinical Reports>Correspondence & Follow-up>Medication Management

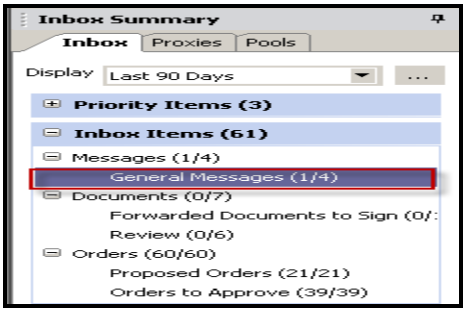


Messages

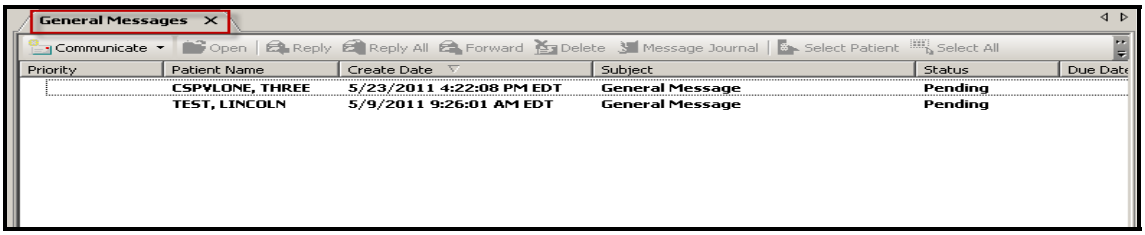
- General messaging allows clinicians to communicate with the provider.
- Functions are similar to an e-mail.
- Messages will replace several paper forms including
  1. "CCM Discharge Planning Notification" messages,
  2. "CDMP Severity-Complex Worksheet" (CCM CDI Audits)
  3. "Physician Advisory Form" messages to Dr. Fanning,

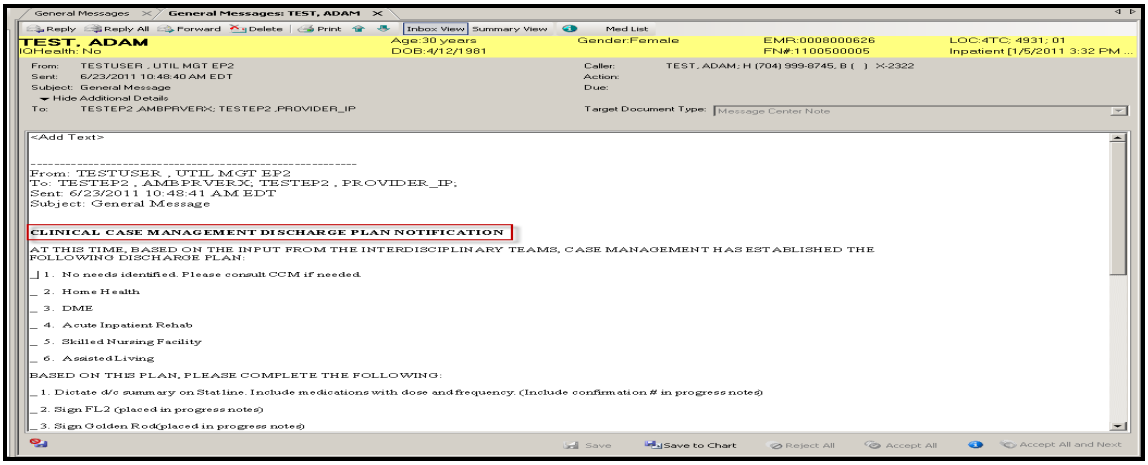
View General Messages

1. In the Message Center, click on the Message menu item under Inbox Items, and click General Messages.



2. In the content pane, **Double-click** on a **message** to open it. (Bolded messages indicate they haven't been viewed yet.)





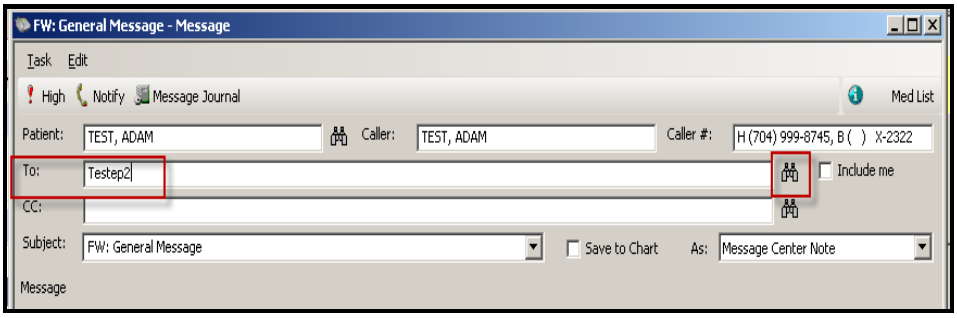
Reply or Forward a Message

1. Click the Reply icon

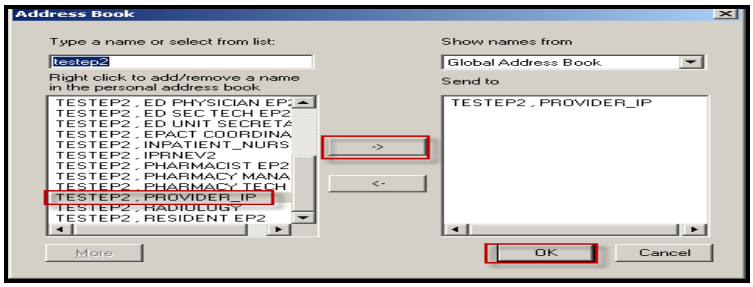
or Forward icon

at the top of the message, click in the message area and free text message.

2. To Search for provider: In the "To" box, enter the last name of the person that the message is being sent to and click on the **binoculars** on the right of the field**.**



3. This will open the address book and then the correct name can be chosen. **Click** on the name and move them to the "Send to" window on the right of the screen**.** Click OK.



4. Click the Send button

at the bottom of the message when message is complete.

Deleting Messages

Messages can only be deleted within the **Message Center Messages section**. To delete a message, click on the message and click on the Delete button. Once items are deleted from Message Center Messages, these items are stored in the Trash folder. Messages are not permanently deleted until they are deleted from the Trash. The system will automatically purge deleted messages over 30 days old.

Proposed Orders

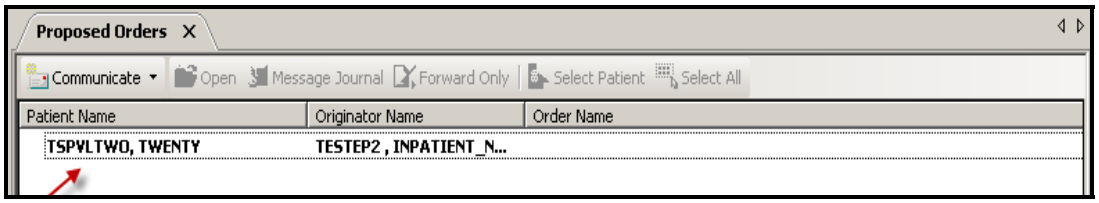
- Proposed Orders from Pharmacists, Nursing (Continue Urinary Catheter & Remove Urinary Catheter orders only), Wound Care, Clinical Case Management and Clinical Nutrition will route to this folder.
- The provider will have the option to Accept, Reject, or Accept with Modify a proposed order.

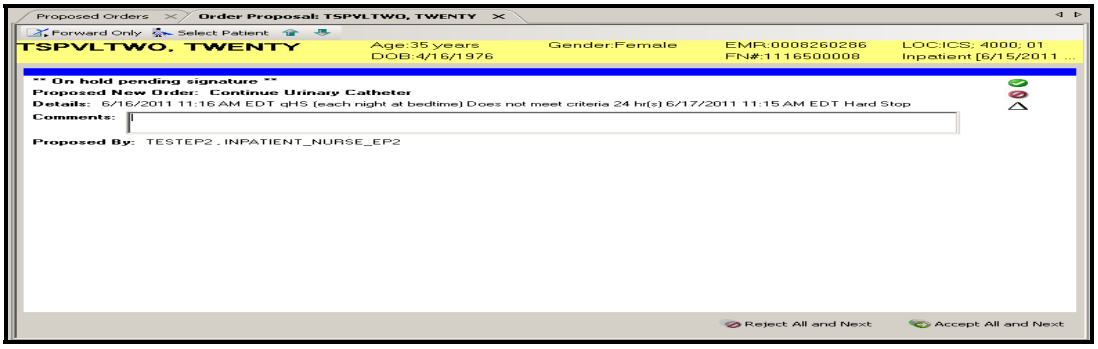
- The order is in a Proposed status (Not Activated) until the provider Accept or Accept with Modify and Sign the order. When signed by the provider, the order status changes to Ordered. At this time the order is activated.
- Reject and Sign will remove the order from the Order Profile in PowerChart.

View Proposed Orders

1. Click the Proposed Order under the Orders menu in Inbox Items.

2. In the content pane, **Double-click** on the **order** to open it.





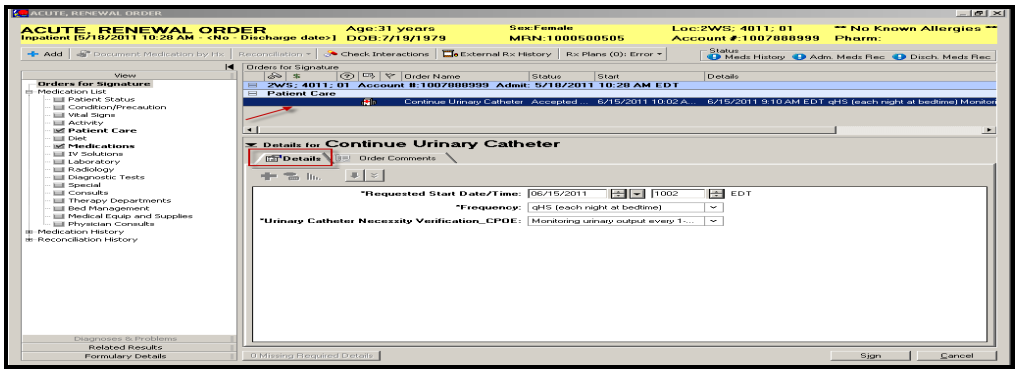
To Accept or Accept with Modify a Proposed Order

The Accept and Accept with Modify functionality are the same.

1. Click the Accept icon or the Accept Modify icon .

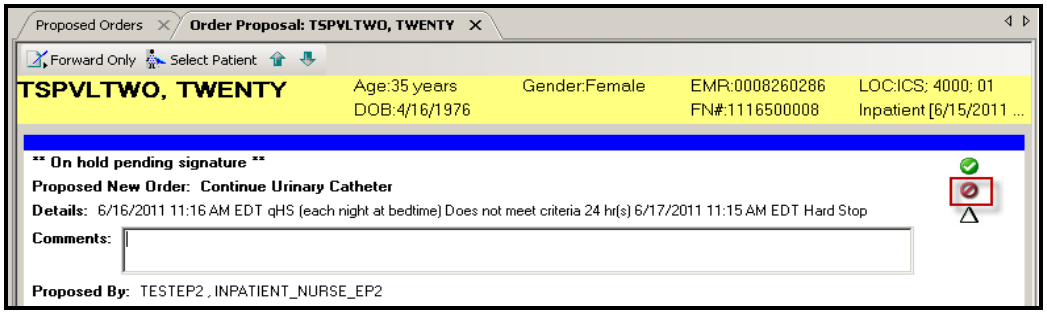
2. Enter Comments if needed, and click the Sign button.

3. The Order's Detail window opens in PowerChart. Modify order if needed and Click Sign. Once signed, the order goes to an ordered status.

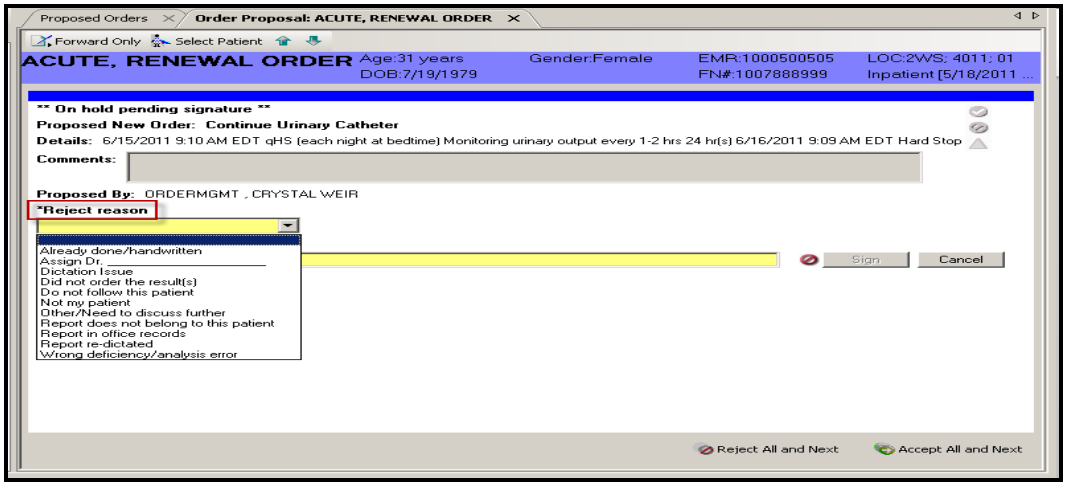


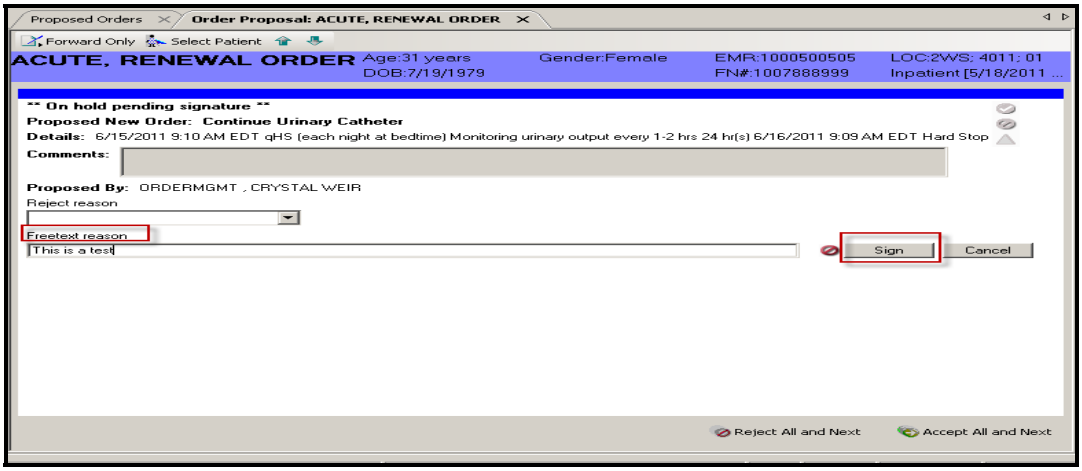
To Reject A Proposed Order

1. To Reject the proposed order, click the Reject icon and then click the Sign button.



2. A Reject Reason is required. You can pick a reason from the Reject reason drop-down menu or free text a reject reason. Click Sign and the proposed order will be removed from the order's profile.



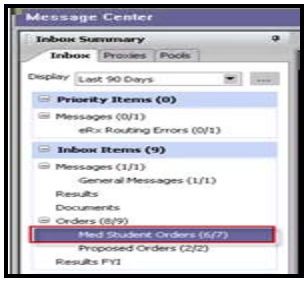


Med Student Orders

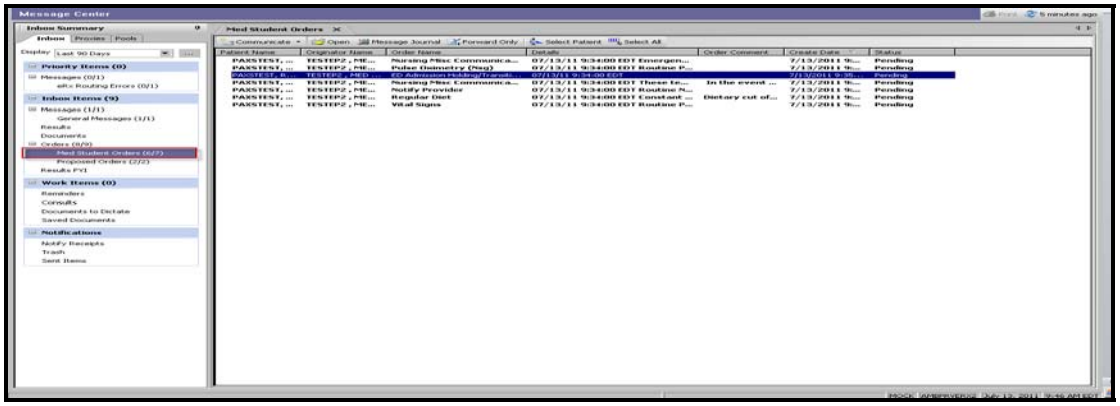
- Medical Student PowerPlan and Ad hoc orders will route to the Med Student Orders folder for supervising provider co-signature.
- These orders are inactive until signed by the provider.

Managing Med Student Orders In Message Center

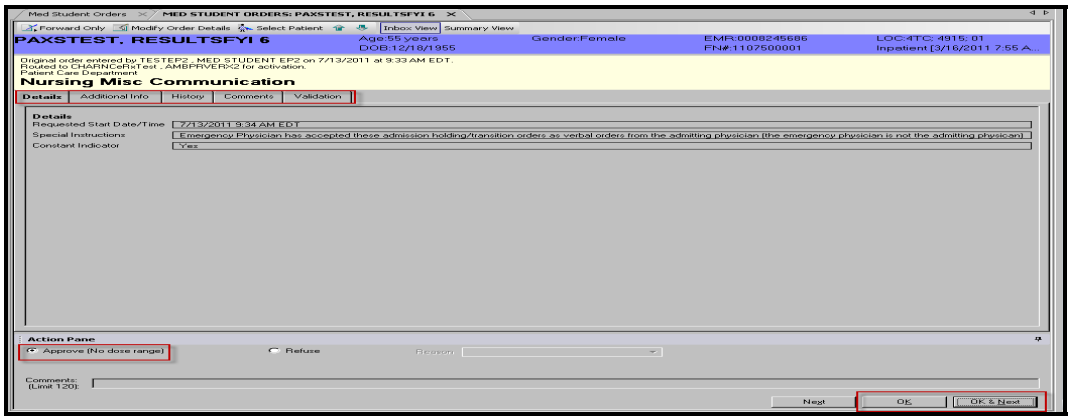
1. Click the Med Student Orders under the Inbox Items.



2. Select the med student order to review.

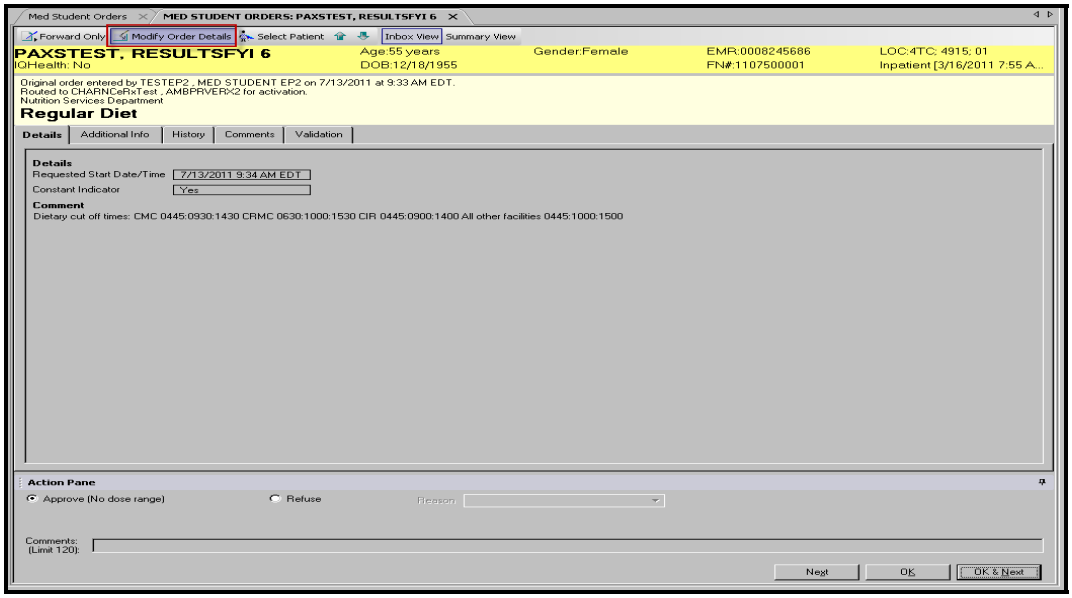


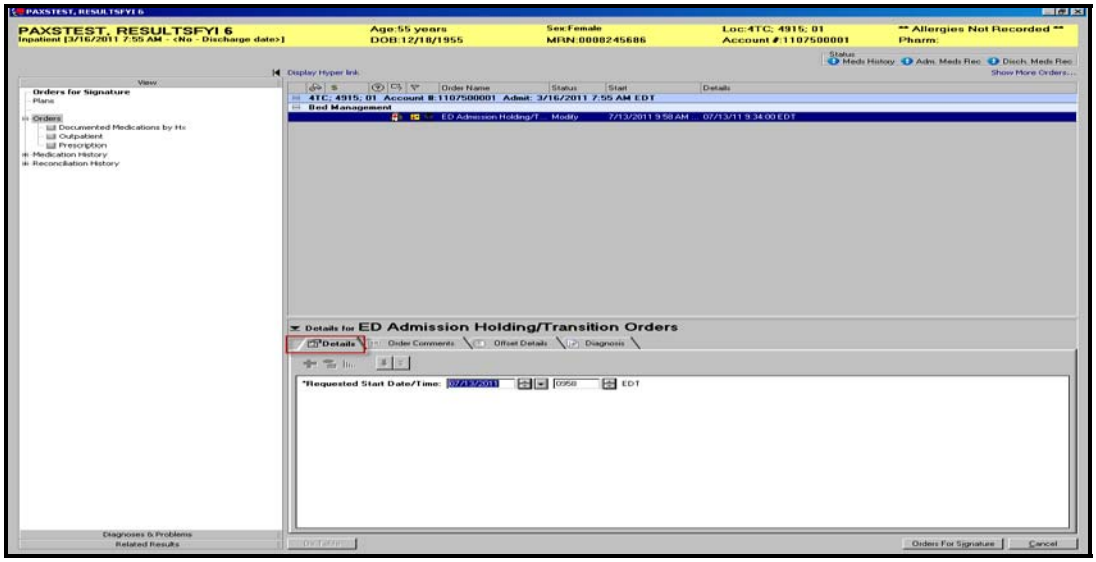
3. Double click the med student order to open the Action Pane. The Approve radio button is defaulted in. Click OK or OK & Next to approve and activate the order.



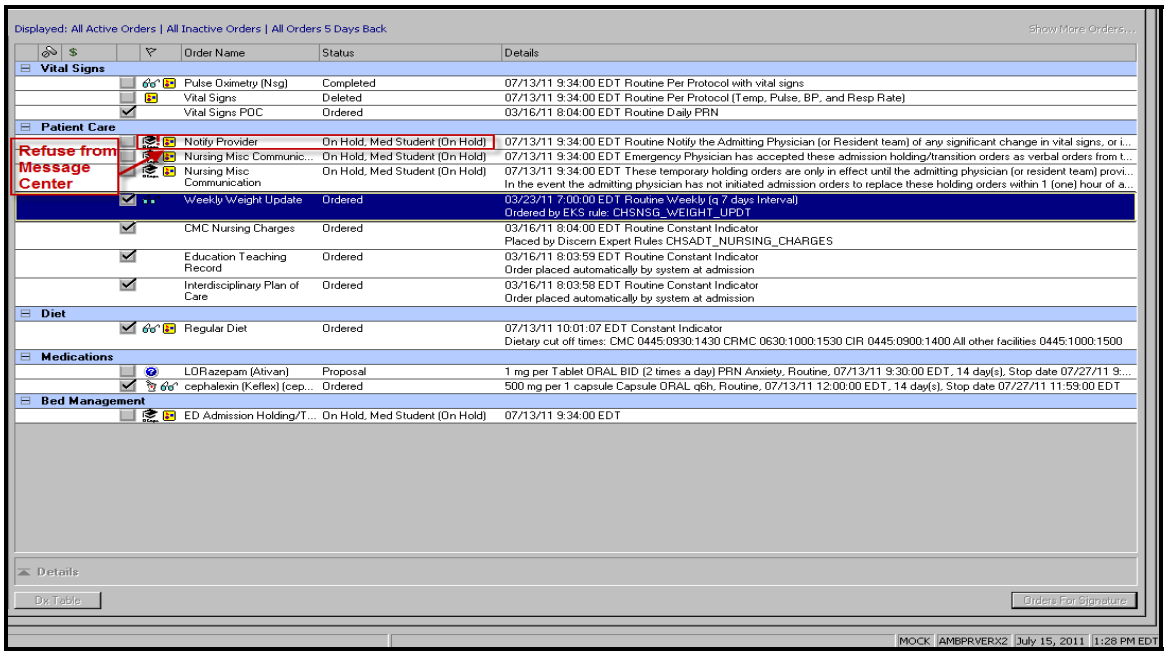
4. Click the Modify Order Details

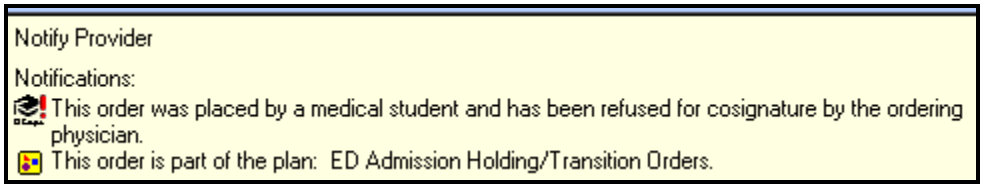
icon to open the order detail window. Modify details as needed and Click Sign to activate the order.





5. Click the Refuse radio button to refuse the med student order, and Select a reason for refusing the order by clicking the dropdown arrow to the right of "Reason" (required field). On the patient's Orders Profile, the order status shows On Hold Med Student and a red exclamation point is added to the Med Student icon .

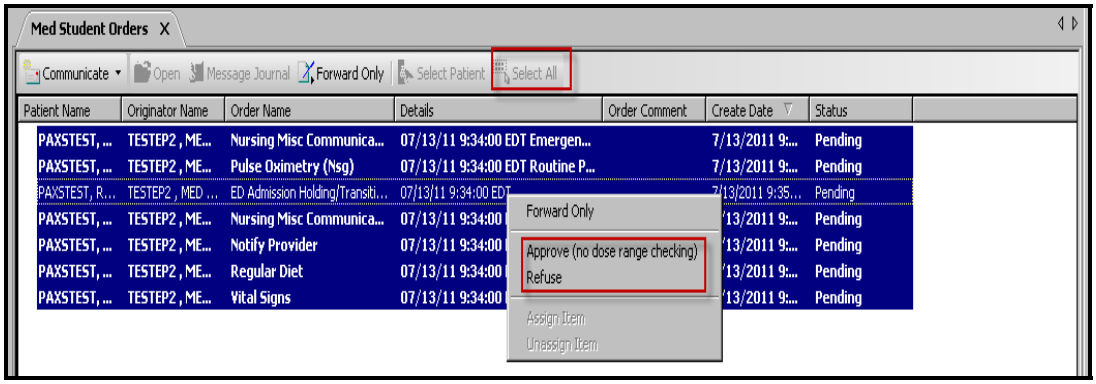




6. Click the Select All

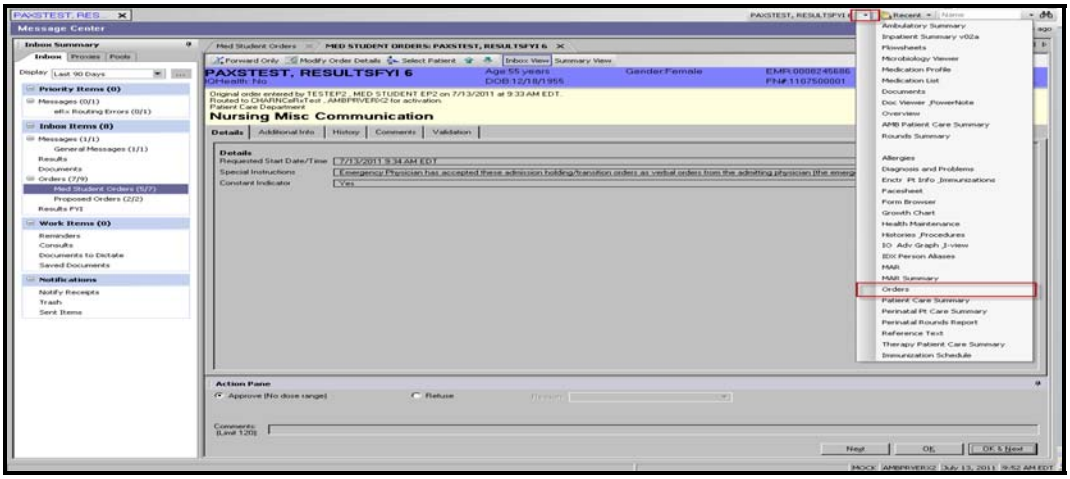
icon to highlight all Med Student orders, Right-click and Select Approve (no dose range checking) or Refuse to approve or refuse all med student orders within the window.

NOTE: THIS FUNCTIONALITY IS NOT A RECOMMENDED.

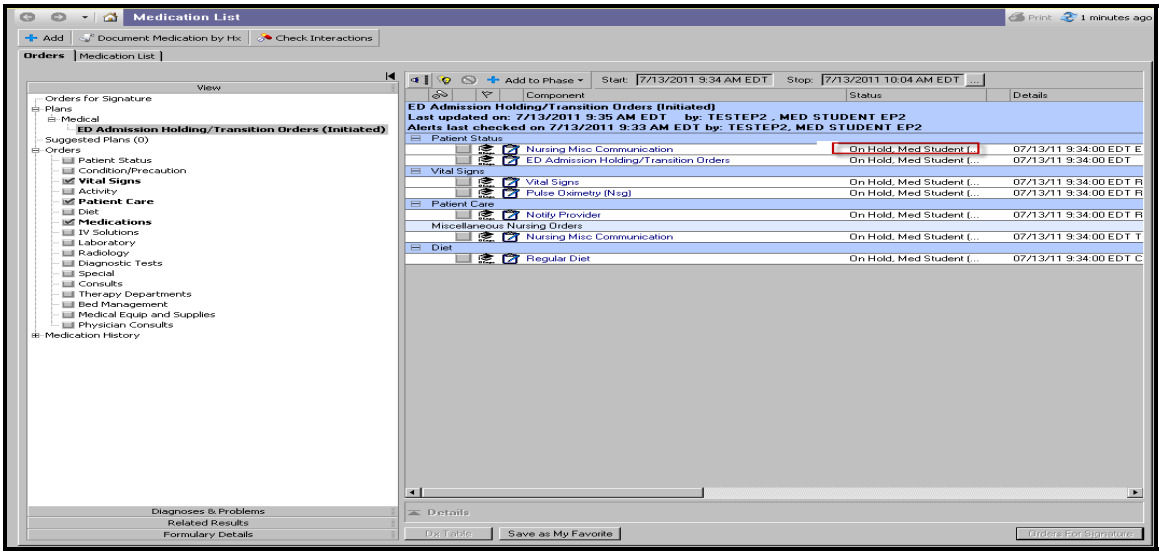


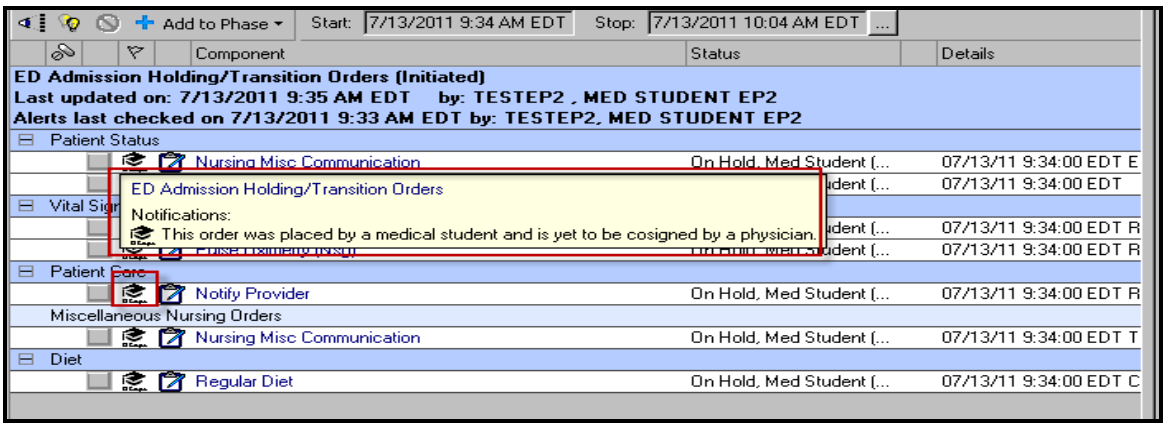
Managing Med Student Orders In PowerChart:

1. Click the drop down arrow to the right of the patient name above the message, and Select “Orders” from the dropdown menu.

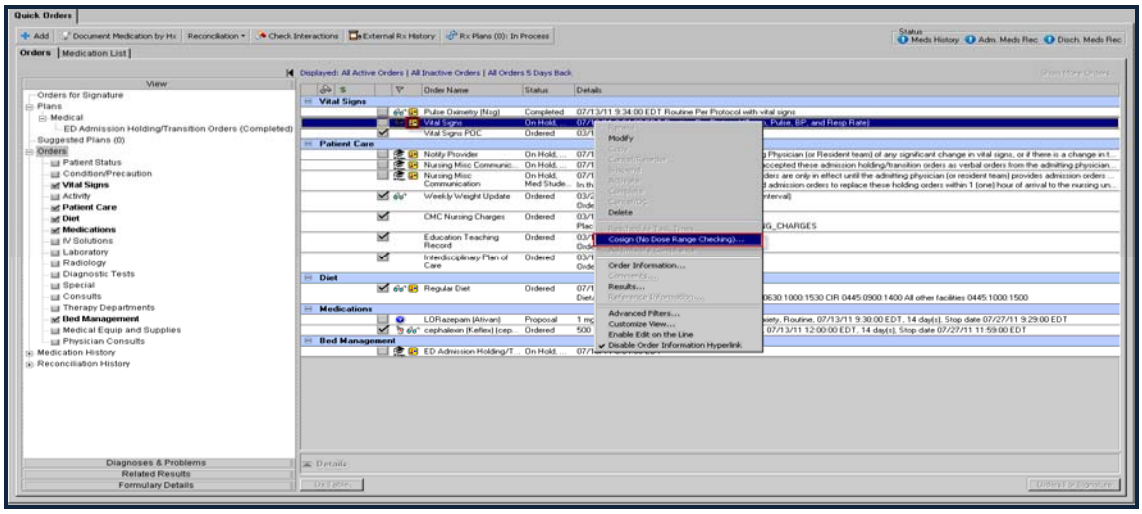


2. The patient’s Orders Profile window opens in PowerChart. The Med Student orders can be identfied by the Med Student order icon and an “On Hold Med Student” order Status.

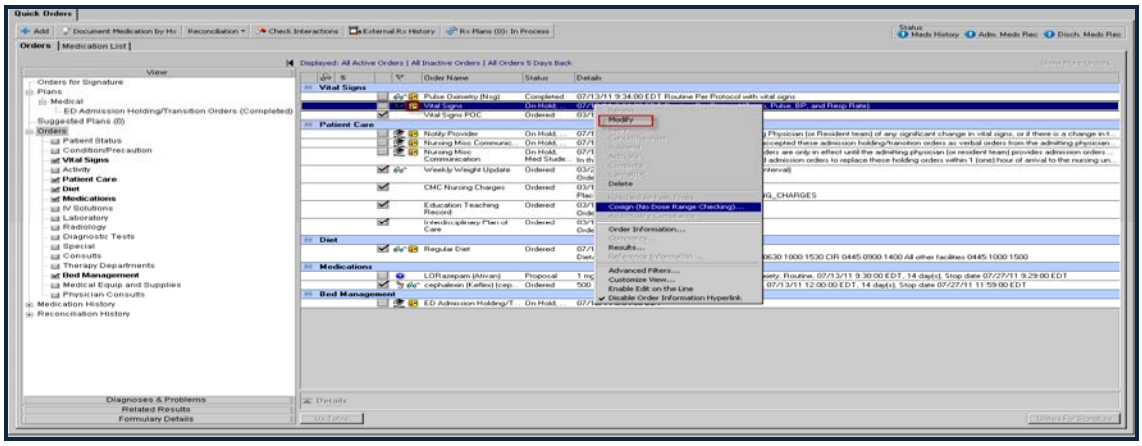




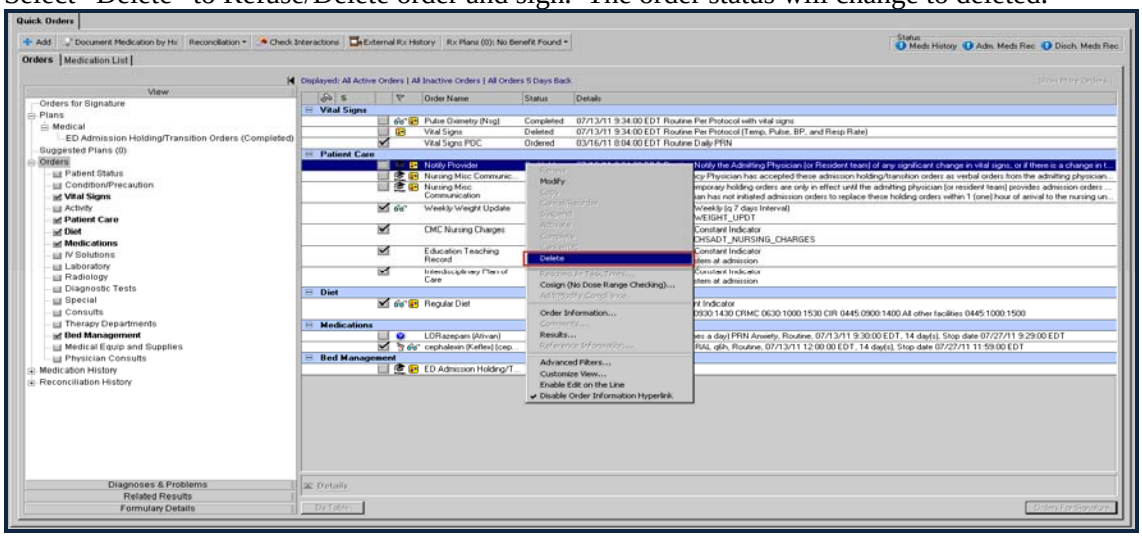
3. Right click on the On Hold Med Student order. From the menu:
    a. Select “Cosign (No DoseRange Checking)” to Approve and Activate the order.

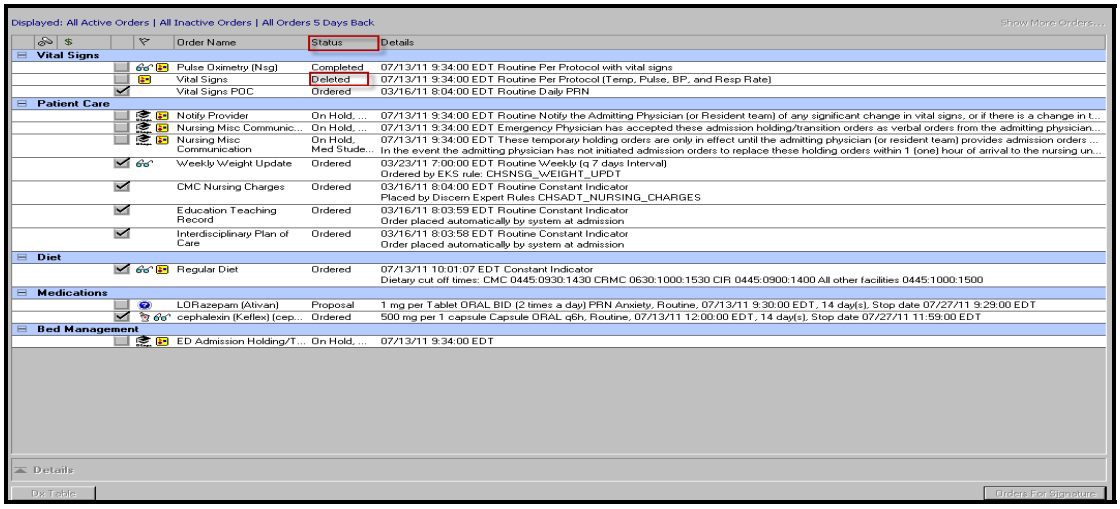


    b. Select “Modify” to open the order detail window make modifications and sign to activate the order.



    c. Select “Delete” to Refuse/Delete order and sign. The order status will change to deleted.



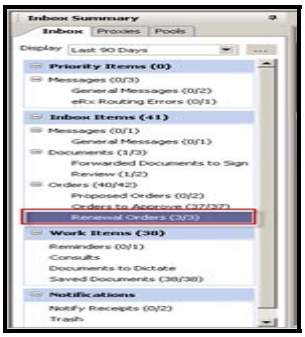


Renewals

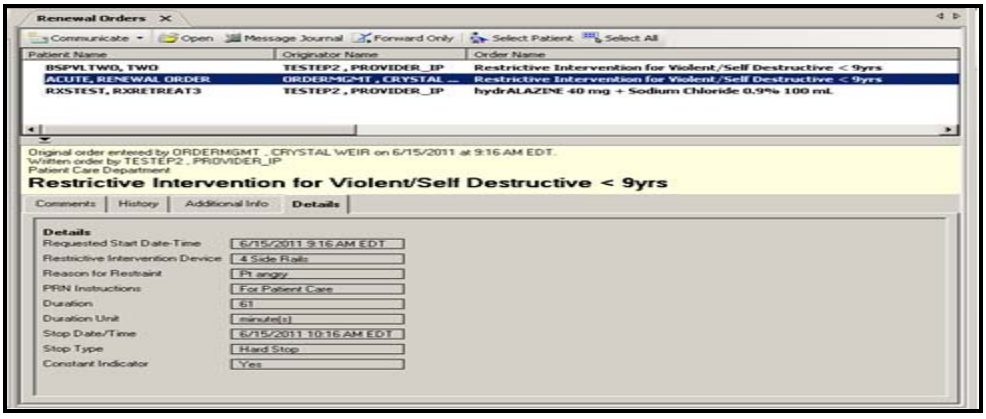
4. A notification will display so the provider is aware that a medication or restrictive restraint order is up for renewal.
5. Triggers for renewals include: Stop Type, Stop Duration and Notification Period.

Note: Suspended orders will not route for renewal and will discontinue at hard stop time/date.

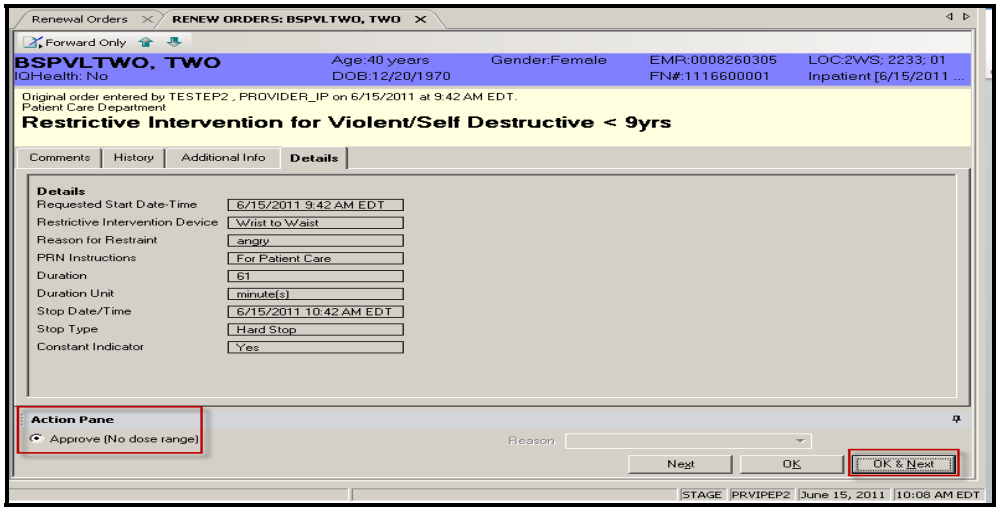
1. Click on Renewal Orders under the Inbox Items.



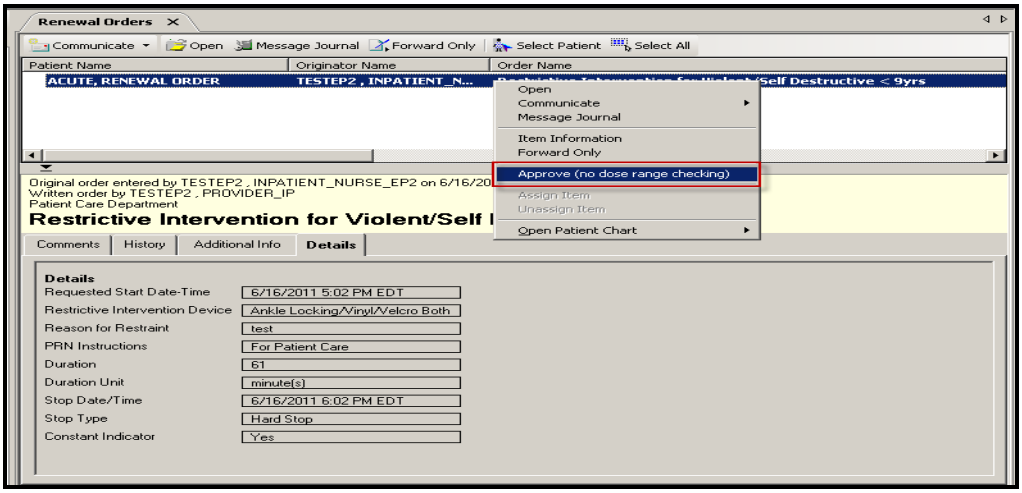
2. Select the renewal order to review order information.



3. Double click the renewal order to open the Action Pane. The Approve radio button is defaulted in. Click OK or OK & Next to renew the order.



4. A Right-Click on the renewal order opens a drop-down menu with the options below.

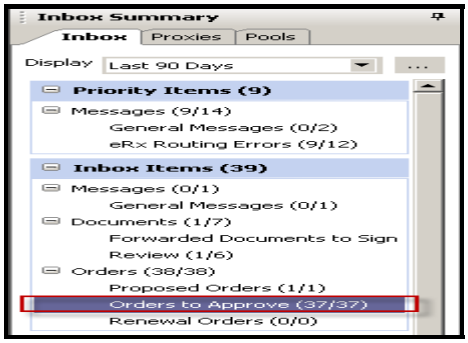


5. Renewal orders that are not addressed will automatically discontinue at the order's hard stop time/date.

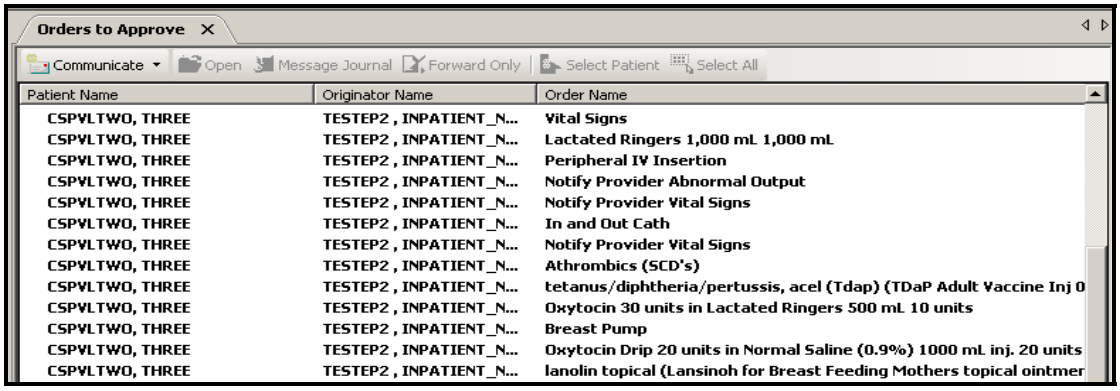
Orders To Approve

- Orders placed with a designated communication type to be flagged/routed for co-signature.
- Example: CPOE Verbal, CPOE Phone, and CPOE Standing Orders.
- These orders are activated when entered by the clinician.

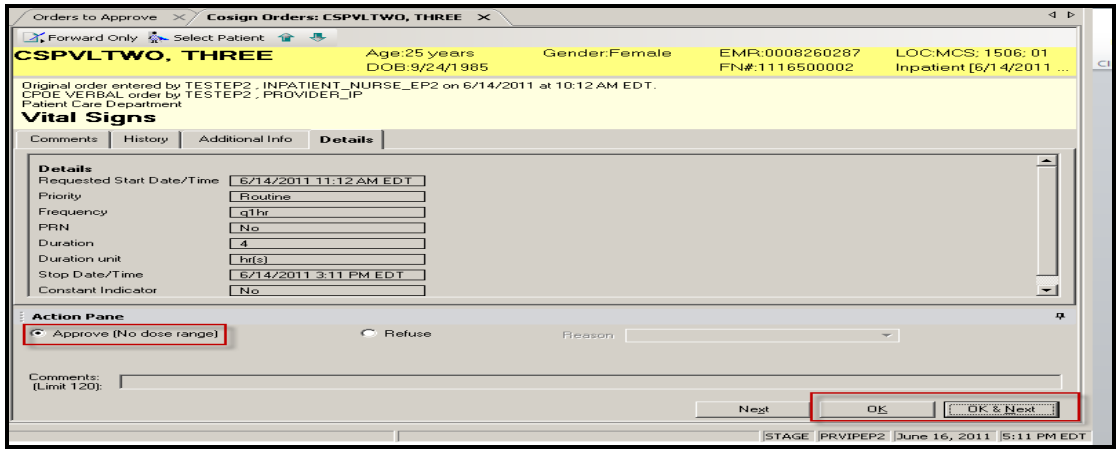
1. Click on the Orders to Approve item under the Inbox Items.



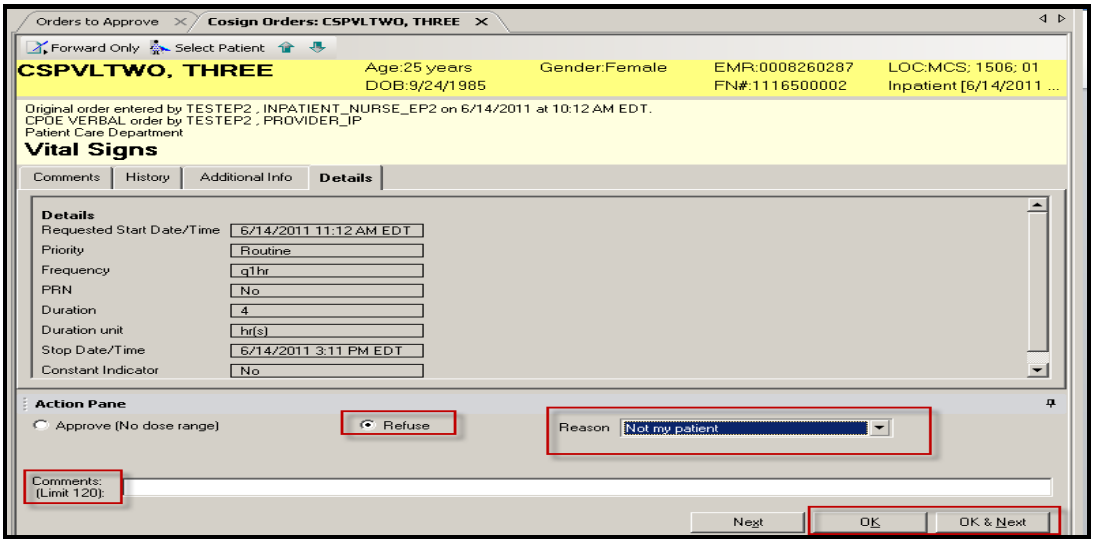
2. Double click the order to open the order detail window with Action Pane defaulted to Approve.



3. To Cosign the Order, click OK or OK & Next (if you have other orders to cosign).



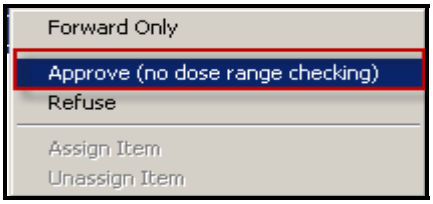
4. To Refuse a cosign order, Click the Refuse radio button and select a required reason for refusing to cosign the order. Freetext comments if needed. The refused cosign order is routed to medical records.



5. Select All is not recommended. Highlight the first order. Click the Select All button

. Right click and select Approve (no dose range) from drop-down menu. Click Refresh

to remove orders from folder.



Radiology Orders In Inbox

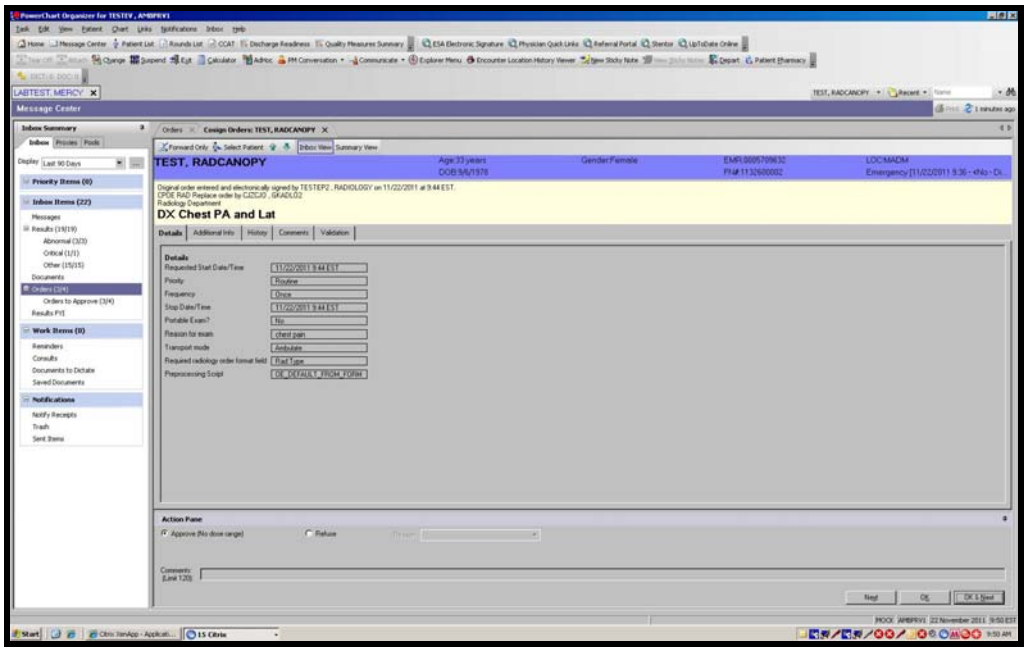
- Physicians will see Radiology orders requiring co-signature in the message center under a new communication type **"CPOE Rad Replace"**. **This communication type will be used to allow for physician sign off on orders that have been changed by a Radiology Technologist.** Radiology Technologists will be canceling and entering new orders for order placement issues that fall within the "Radiology Test Design" (i.e. DX Chest 1 View replaced with DX Chest 2 Views)

Any questions regarding this can be directed to the radiology departments at

Rad Dept. Contact Information:

Pineville….704-667-1200

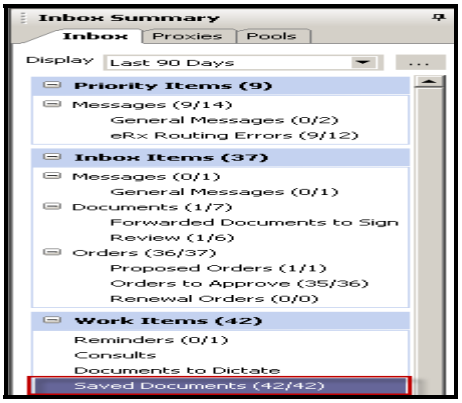
Mercy….704-304-5860



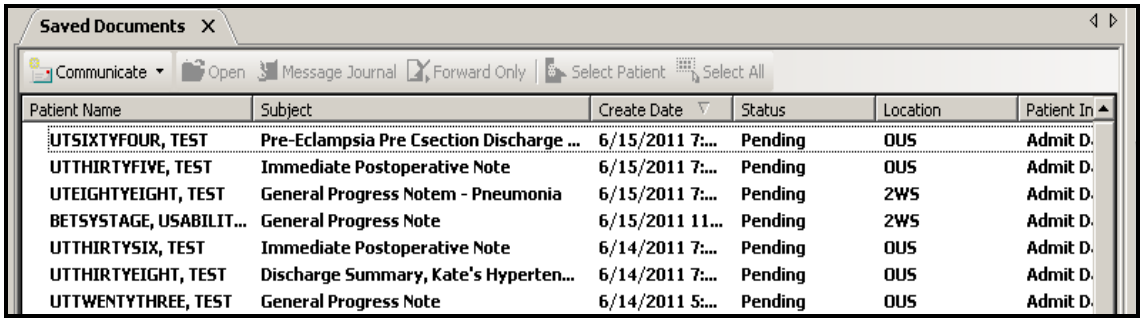
Saved Documents

Save PowerNotes or other documents that need to be completed and signed routes to the Save Documents folder.

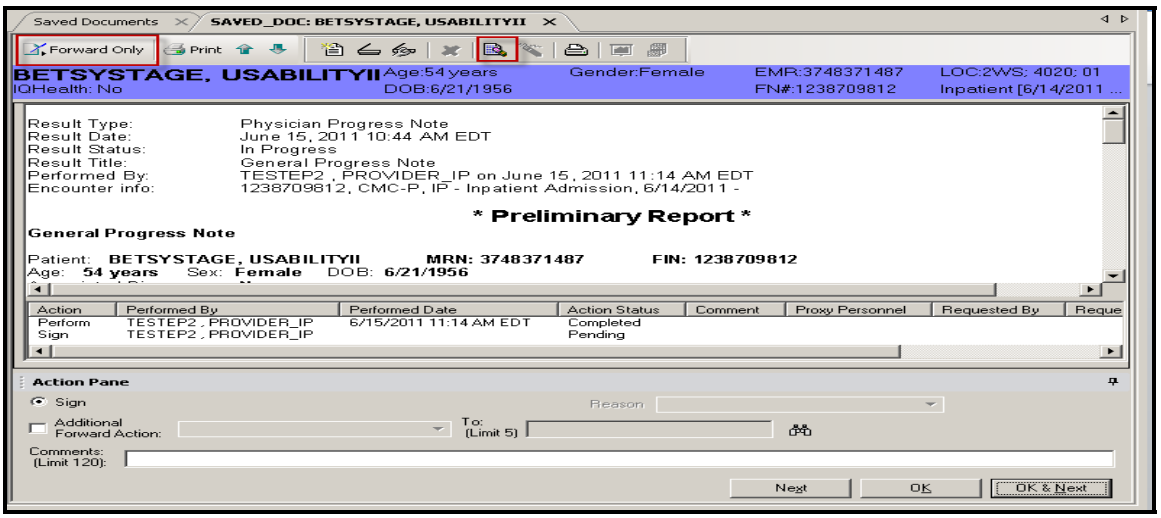
1. Click on the Saved Documents item under Work Items.



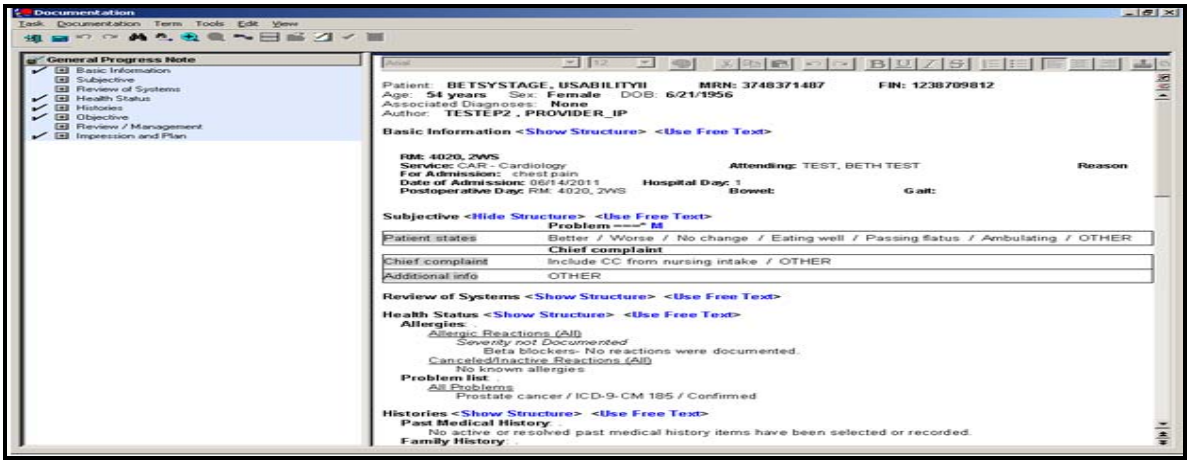
2. Double click the document to open.



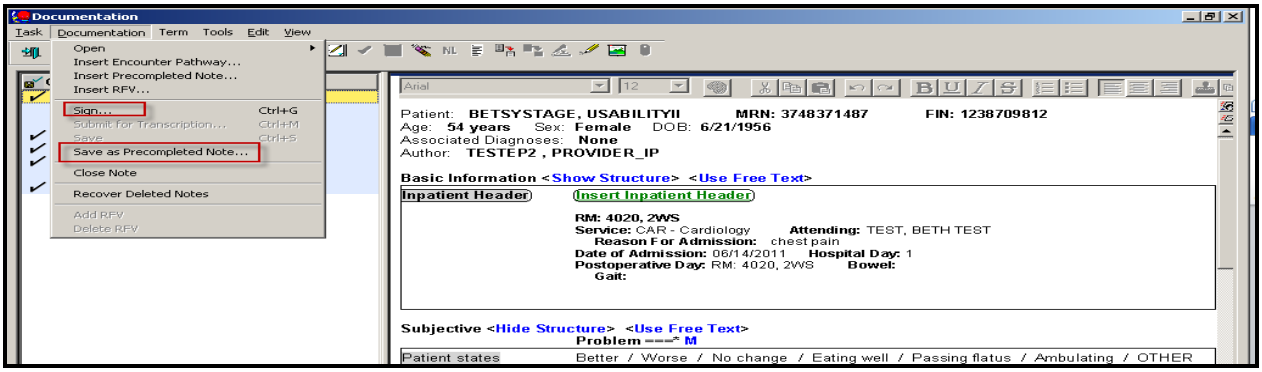
3. To Modify/Complete the PowerNote, click the Modify icon at the top of the document to open PowerNote. You can Forward a Saved Document by clicking the Forware Only button.



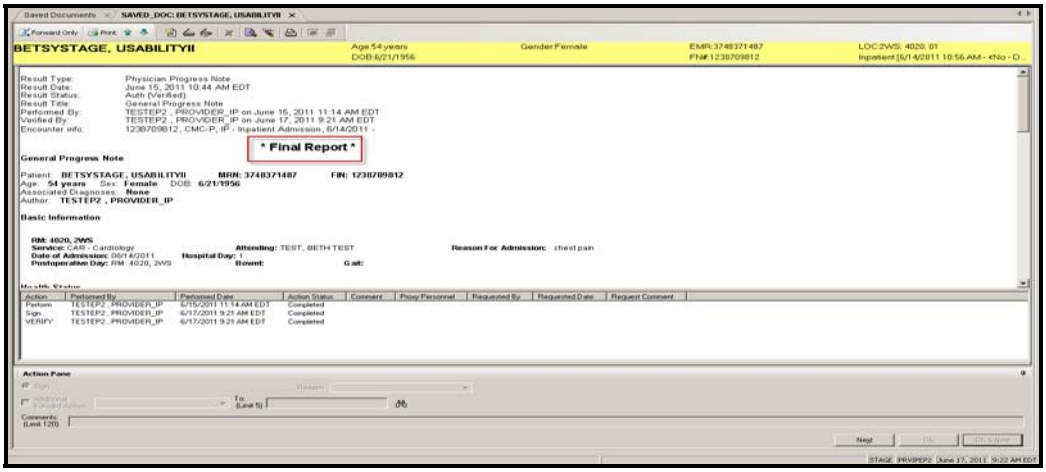
4. The PowerNote can be modified/completed by using the Navigation Pane. The check marks indicates areas of previous documentation.



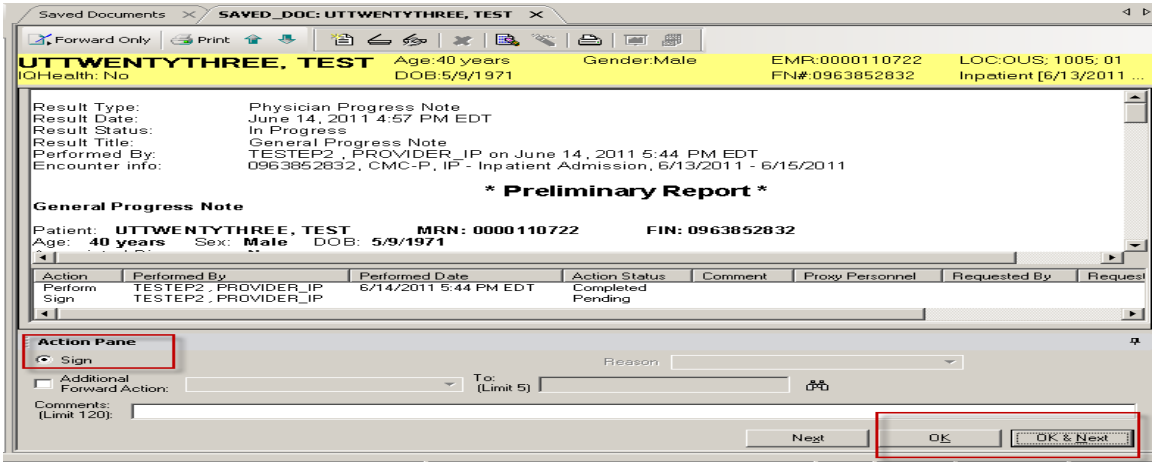
5. The PowerNote can be signed/finalized from this view. Click Documentation on the Menu Bar and Select Sign. You can also Save as Precompleted Note.



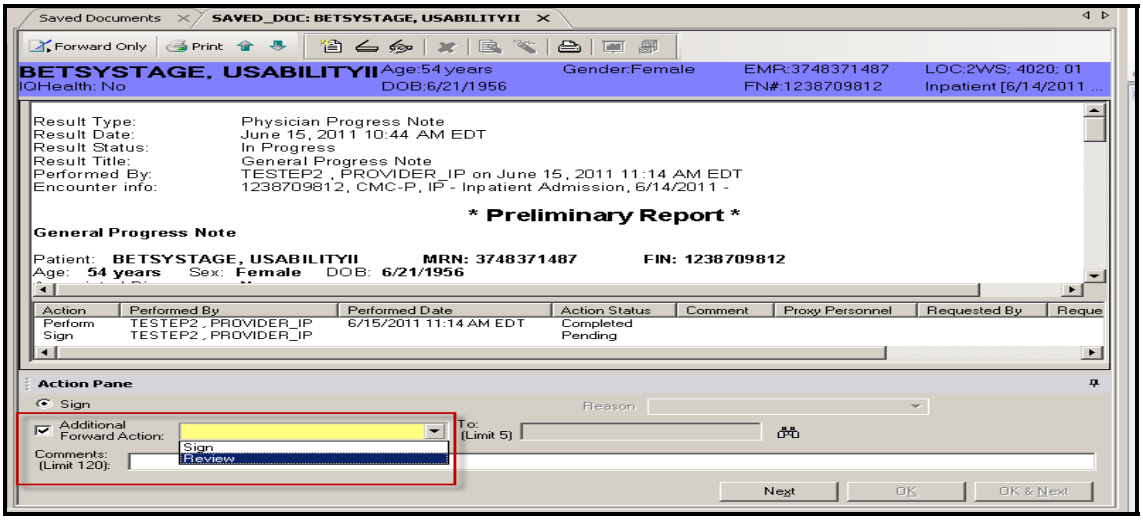
1. To close the document, click the Exit icon .
2. Once the PowerNote is Signed, the Preliminary Report becomes Final Report.

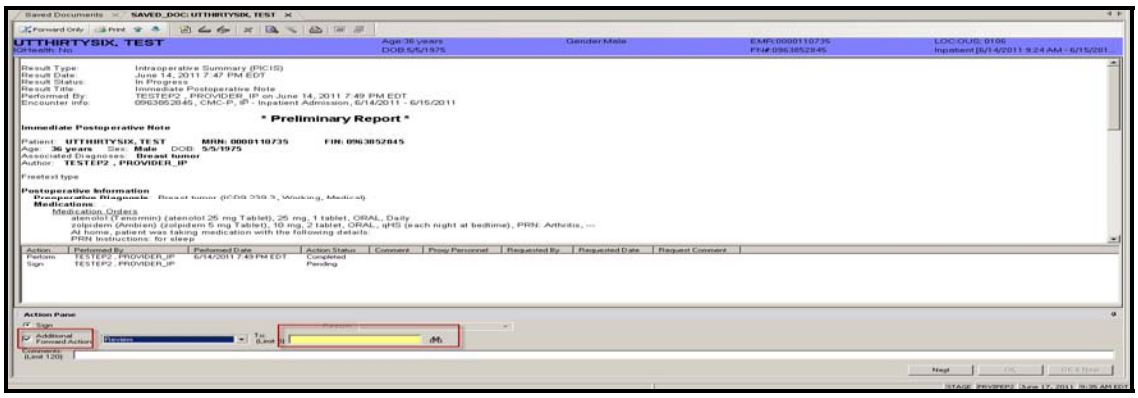


3. The Saved Powernote can be reviewed and signed without modifying. After reviewing the Saved Documents, if no modifications are needed Click OK.



4. To forward a Saved Document for Sign or Review, click the box next to “Additional Forward Action” in the Action Pane. Select Sign or Review and Search for the person by entering a few characters of the last name and Click the binoculars. Click OK to Send.





Key Notifications Toolbar

- The Key Notifications Toolbar alerts the provider when specific notifications are received in their Message Center Inbox.

- A maximum of three notifications can be displayed

- Key Notifications are beneficial in notifying providers of information that is time-sensitive in nature and/or actions that need to be taken.

- For CPOE, notifying providers of **order-related clinical activities** is key, as CHS will be rolling-out:
    - **Renewal Orders** – Time-Sensitive Orders Regarding Violent and/or Non Violent Restrictive Interventions, Urinary Catheter, that Must Be Reviewed & Signed in 24 Hours or Less (Depending on Clinical Situation)
    - **Proposed Orders** – Time-Sensitive Proposed Orders Request from Supporting Clinical Departments, Medical Students and/or Ambulatory Clinical Staff to a Supervising Physician (Before the Order Can Become Active for Clinical Activities)

- **Orders for Signature** – Time-Sensitive Orders That Must Be Signed within 48 Hours to Meet CMS and JCAHO Regulations.
- **Med Student Orders**—Time-Sensitive Orders That Are Not Active Until Signed by Supervising Provider.

- The Key Notification Toolbar displays on every patient chart.

- For **Acute Care Providers** the Key Notifications Toolbar includes:

- eRx Routing Errors
- Results
- Orders

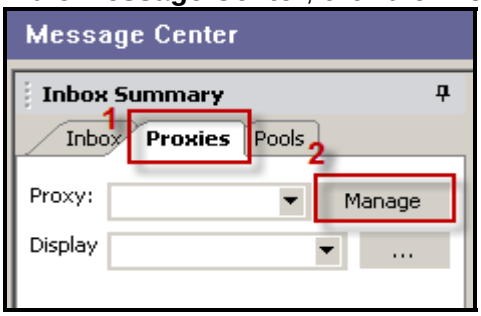
- For **Ambulatory/Acute (Hybrid) Provider** the Key Notifications Toolbar includes
:
- Documents to Sign
- Critical Results,
- Documents to Dictate

- For the **ED Provider** the Key Notifications Toolbar includes:
:
  - Documents to Sign
  - Orders
  - Document to Dictate

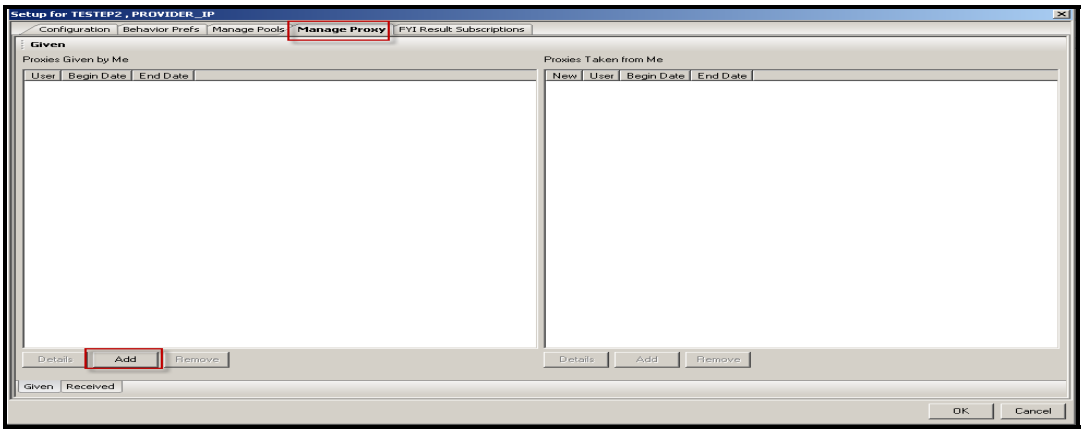
Message Center Inbox Proxy

- Granting proxy authorization enables another user or users to access your Inbox messages and review, sign, refuse, or forward messages as needed. When granting proxy authorization, specific Inbox folders can be selected for the proxy to view, and date ranges defined.
- Setting the **Proxy List Given by Me** is used to give permissions for others to see this PowerChart Message Center.

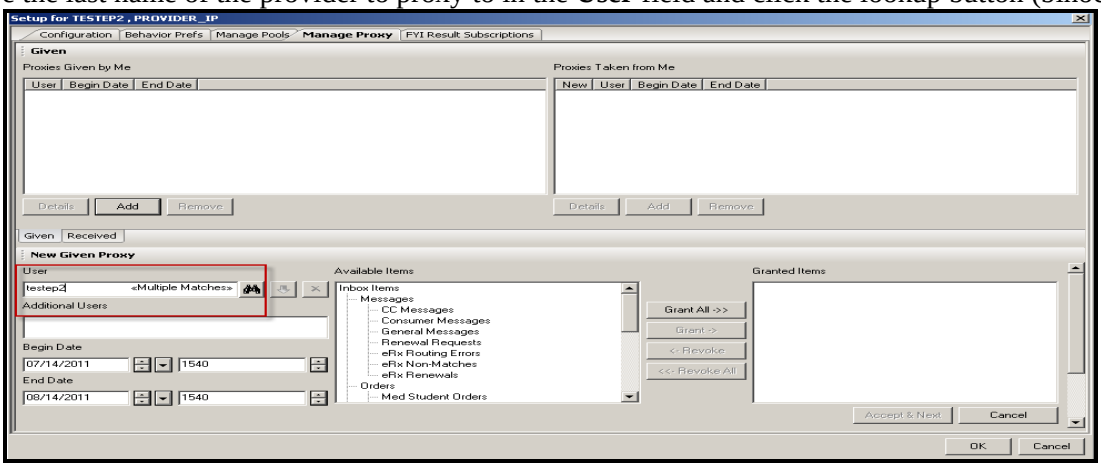
1. From the **Message Center**, click the **Proxies** tab, then click the **Manage** button.



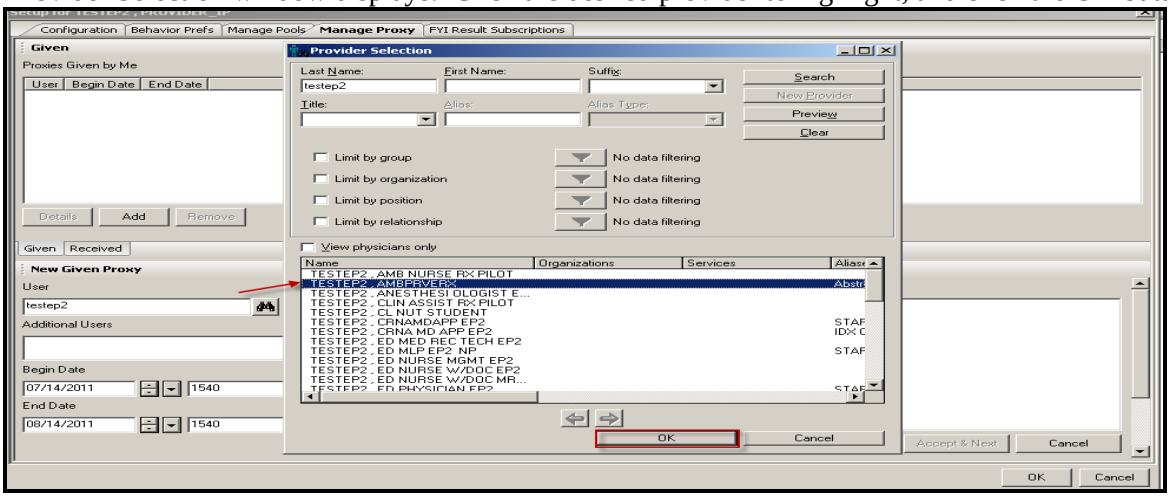
2. When the **Setup** dialogue box opens, the **Manage Proxy** tab should be active. Select the **Add** button.



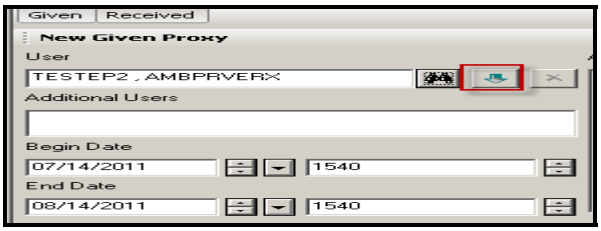
3. Type the last name of the provider to proxy to in the **User** field and click the lookup button (binoculars icon).



4. The Provider Selection window displays. Click the desired provider to highlight, and click the OK button.



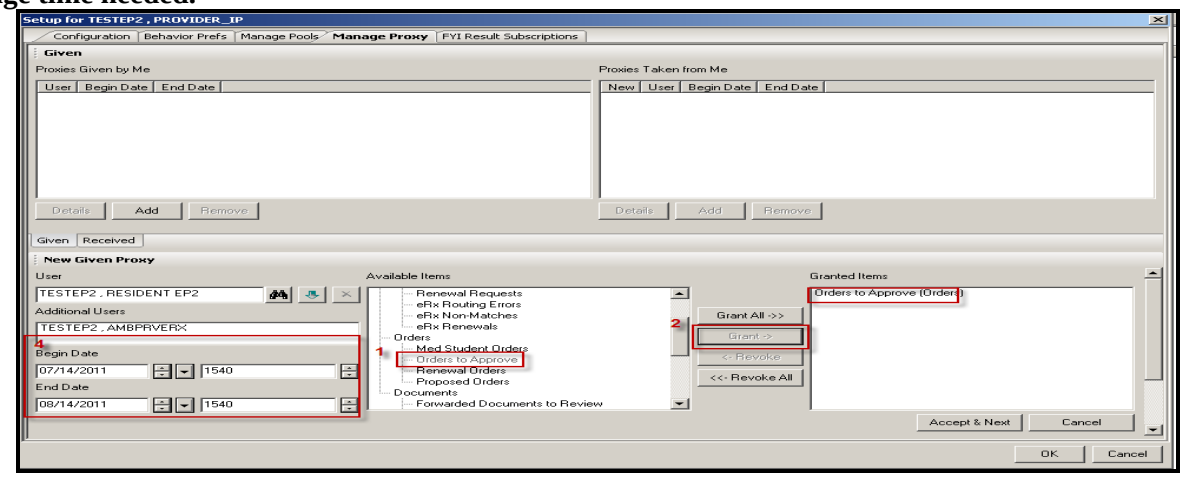
5. To add additional provider(s) click the green down arrow. This moves the selected provider to the Additional User field. Follow the steps outlined in **3 and 4** for each additional provider.



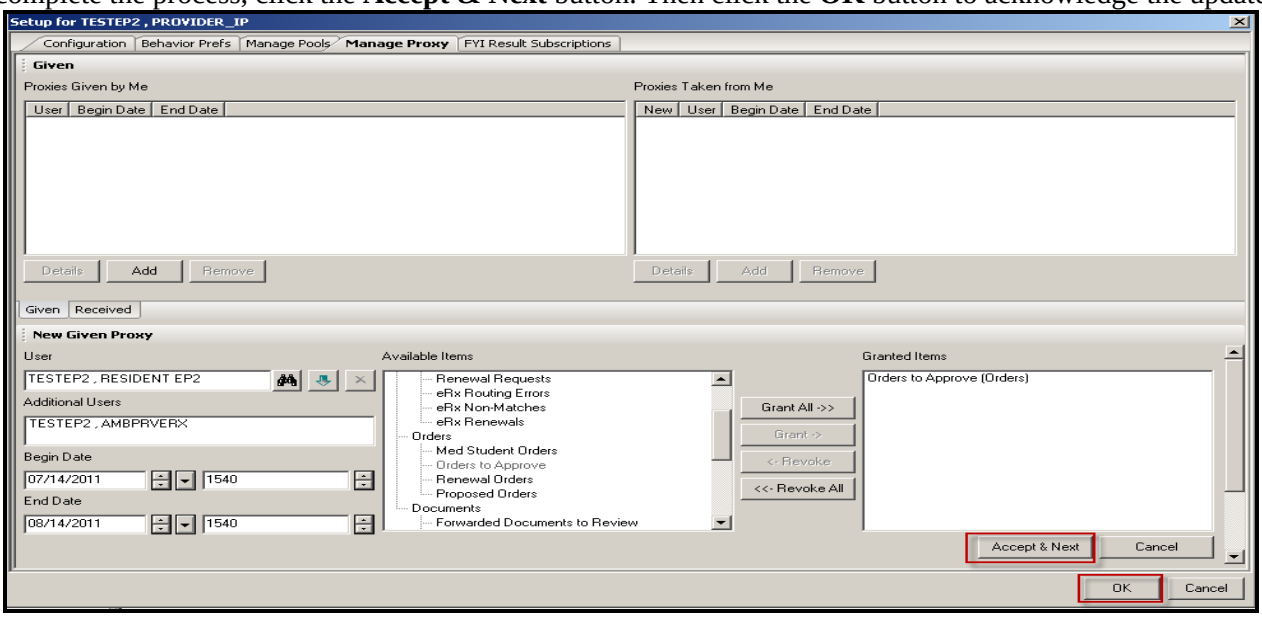
NOTE: Do not move the last user to the Additional Users field. The last user **must** remain in the User field in order for the Accept & Next button to remain active to complete the process (See Step 7)

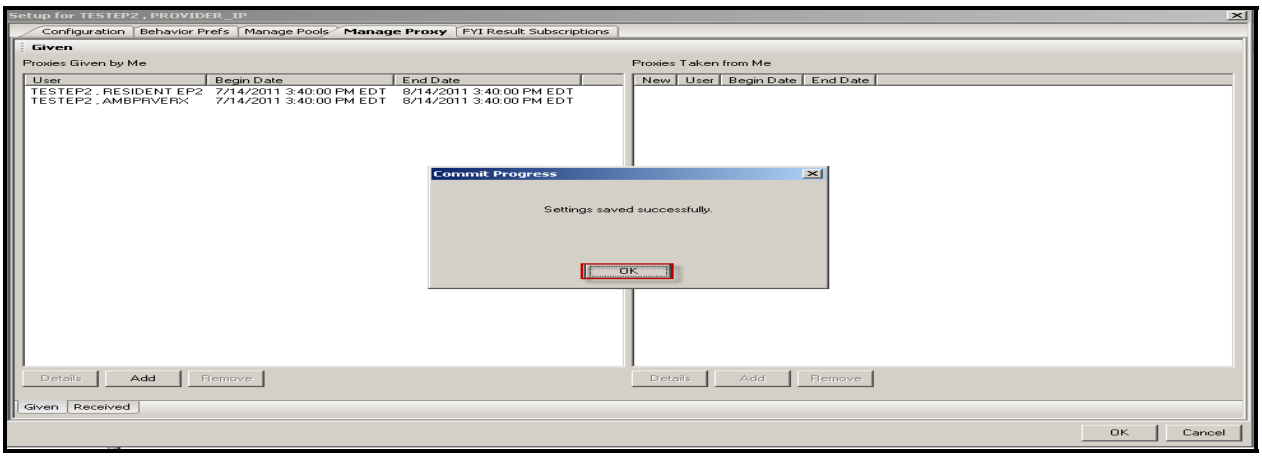
6. Select the **Inbox items to Proxy**. Grant the folder you want to proxy. If you want a colleague to be able to approve orders, choose your "Orders to Approve" folder. In this example, we will choose to proxy "Orders to Approve" for a Mid-Level provider. Under "Work Items" Click and highlight on "**Documents to Dictate**" then click the **Grant - >>** button. **Set the End Date Time filed**

Note: Set the least 10 years into the future for continuing access. Residents and Fellows set for just for the coverage time needed.



7. To complete the process, click the **Accept & Next** button. Then click the **OK** button to acknowledge the update.

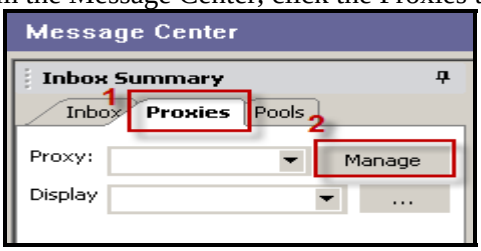




8. The user who was granted access will now have an entry in their Proxy list

9. Remove/Update Proxies Given by Me:

8. From the Message Center, click the Proxies tab, then click the Manage button.



9. When the Setup dialogue box opens, the Manage Proxy tab should be active.
10. Select the User to remove
11. Click the Remove button and OK to acknowledge the updates.

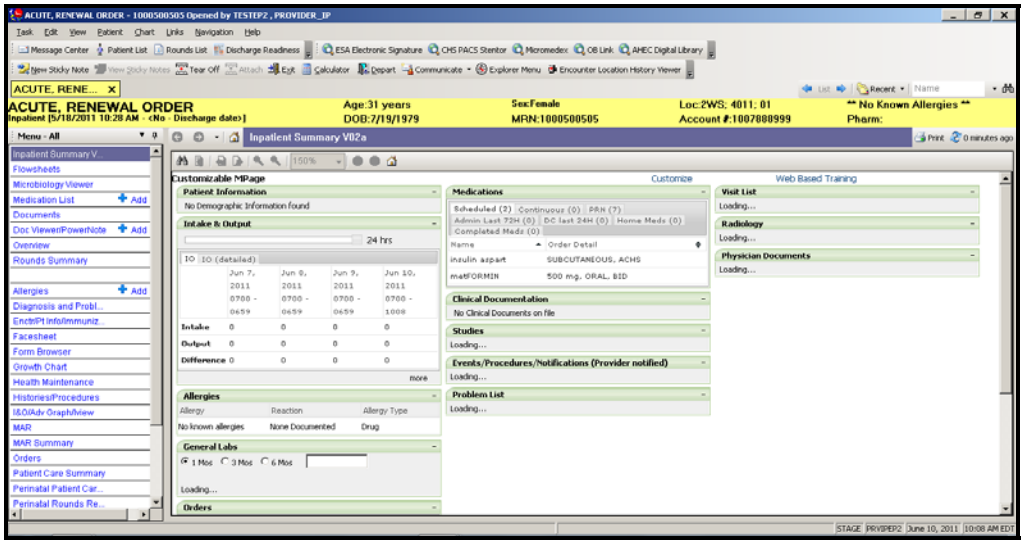
4. Problem List and Diagnosis

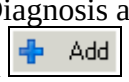
Introduction

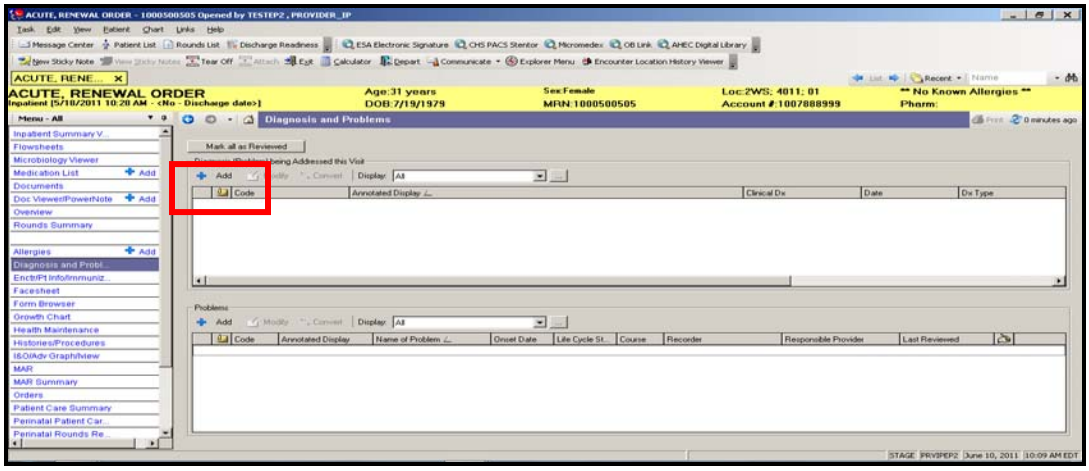
- The Diagnoses List is specific to an encounter. A provider can add a clinical diagnosis to the list. The Diagnosis list is encounter level information.
- The Problem List is patient level information viewable across all facilities and can be added by the provider and Infection Control.

Entering A Diagnosis

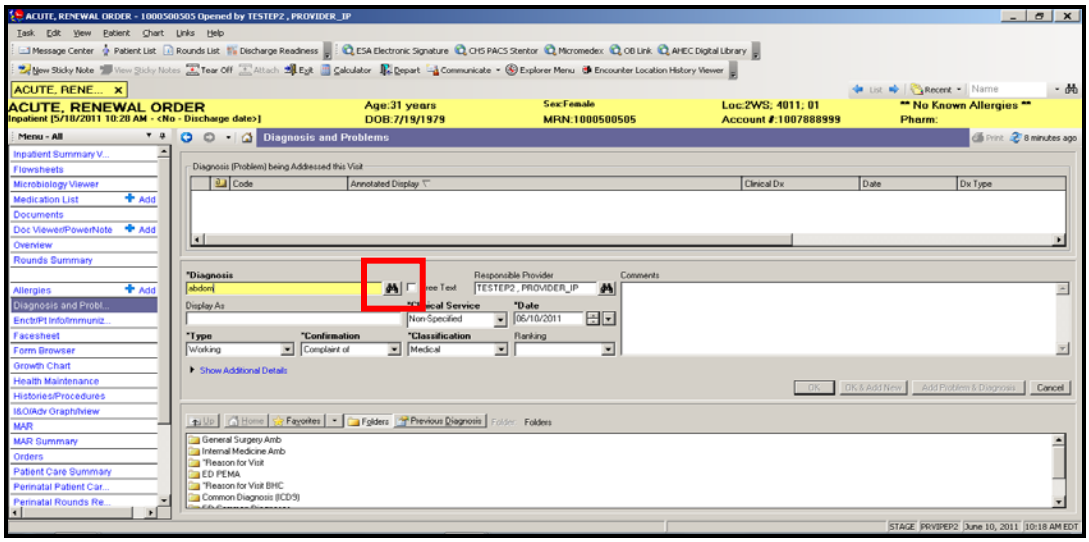
1. Open a patient chart.



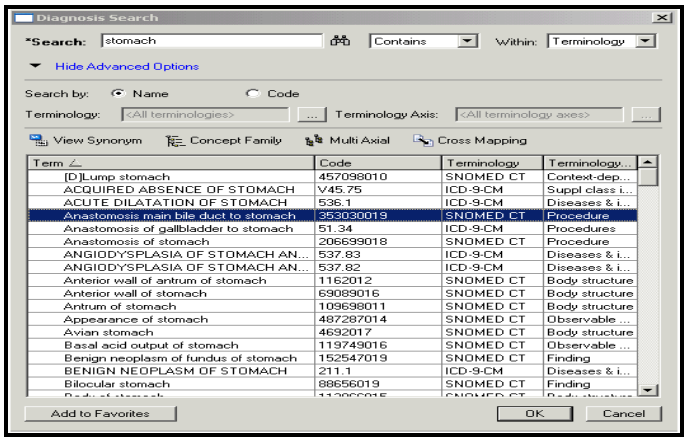
2. From the Navigator, select Diagnosis and Problems to open the Diagnosis and Problem entry window. Click the Add icon  to add a diagnosis (Problem being addressed this visit).



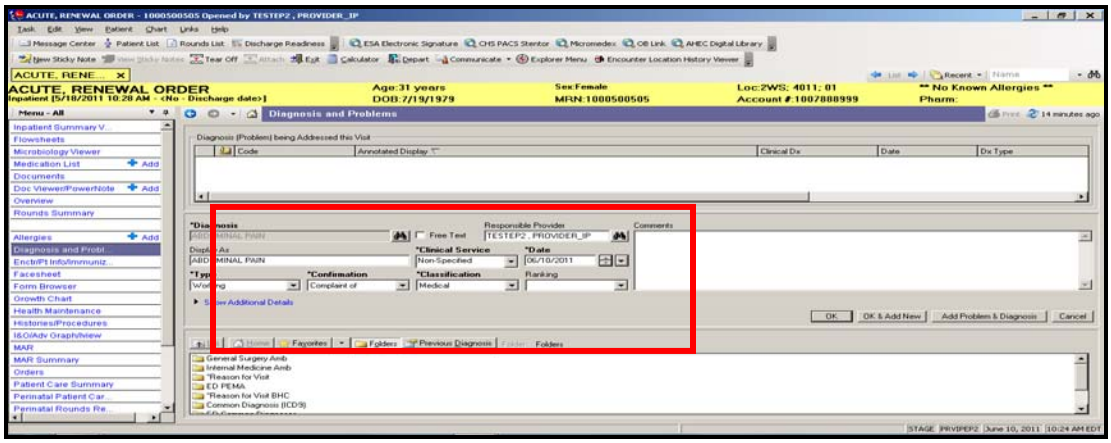
3. Begin typing in the diagnosis and click the Search button.

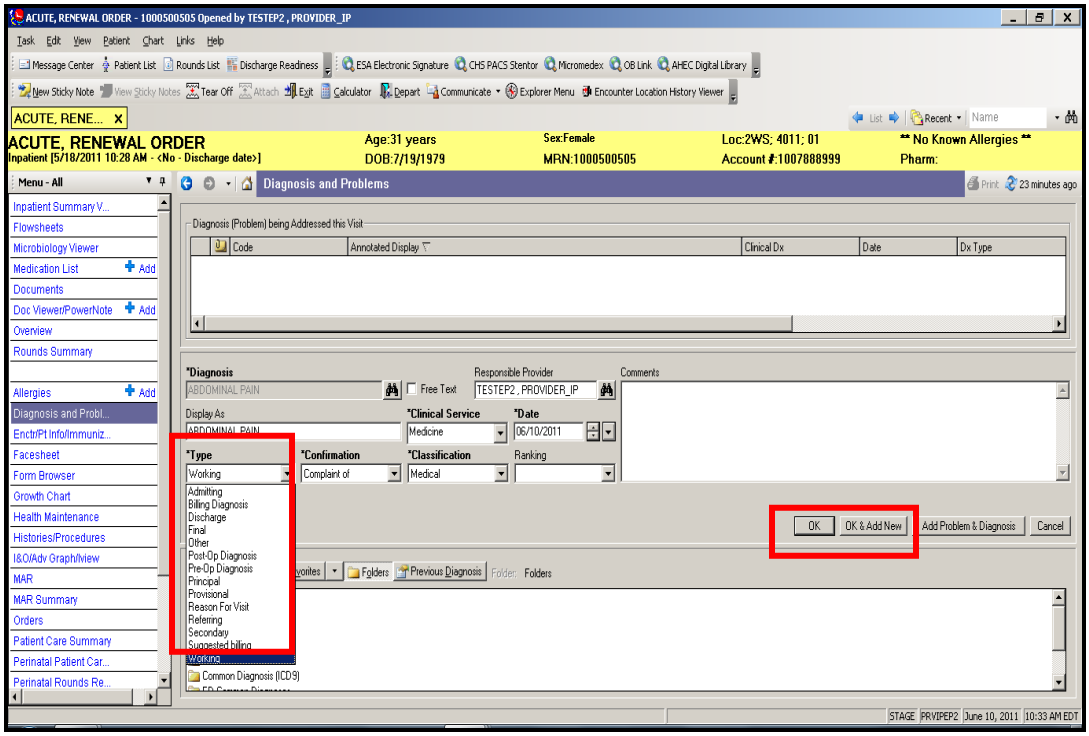


3. A nomenclature window will open. Select the diagnosis that is being addressed this visit.

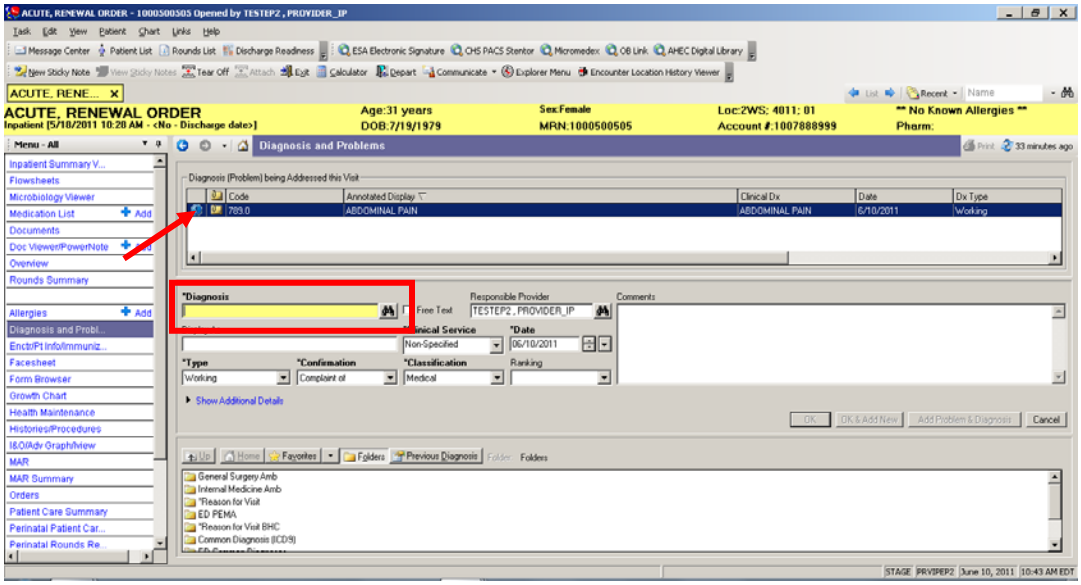


4. Using the drop down menus, further define the diagnosis as appropriate. When details are complete, click OK. Click OK to Add the diagnosis or OK & Add to add another diagnosis

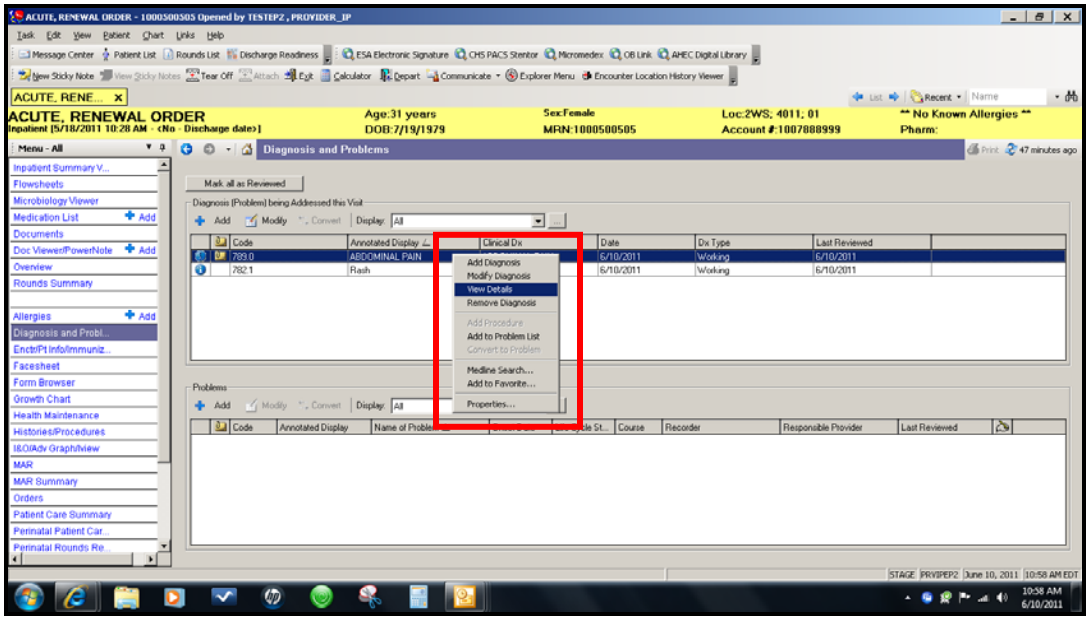




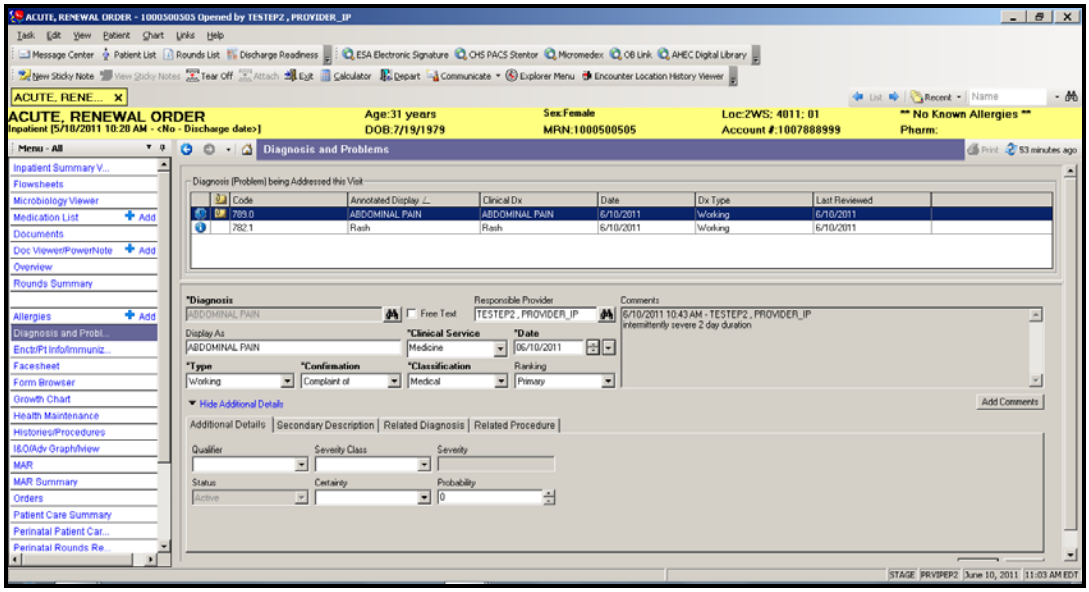
5. The primary diagnosis is charted and another entry can be entered.



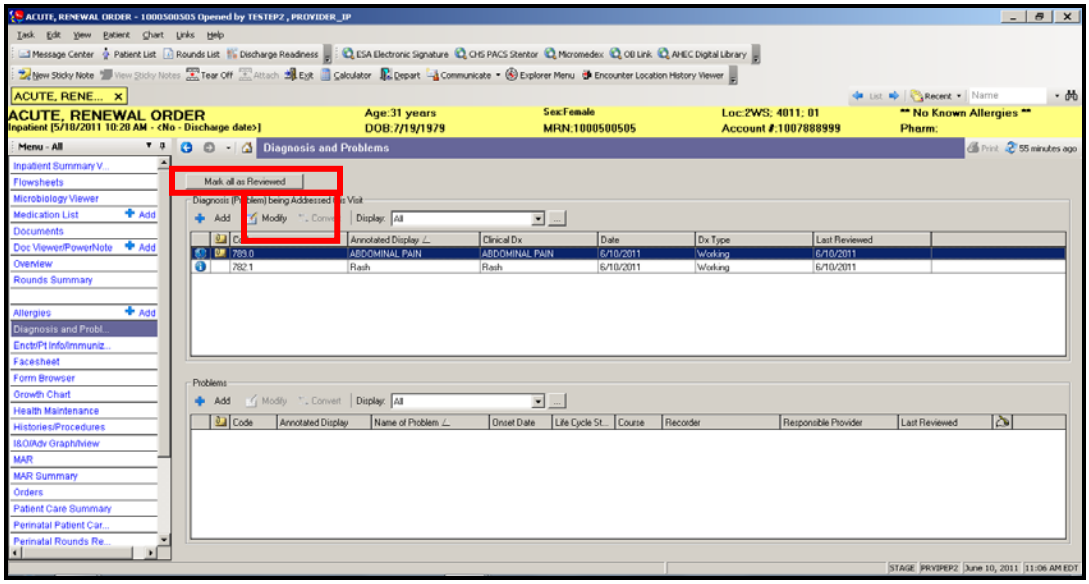
6. Right clicking on a diagnosis will open a menu that will enable options for additional activities within the Diagnosis list.



7. This is the view that opens when View Details is selected. If Modify is selected, fields are available to be changed.



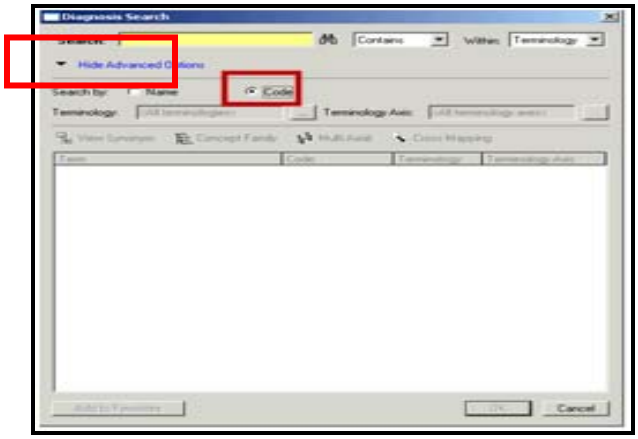
8. The Modify button can also be used to open the Modify window. The Mark as reviewed will record that the diagnosis was reviewed by the user.



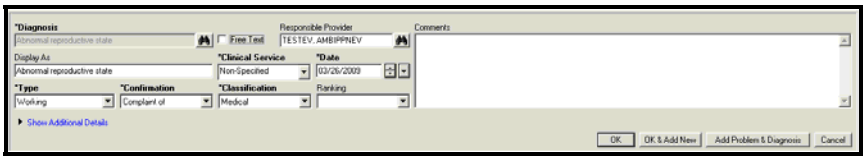
Diagnosis Search by Code

- If a user is familiar with diagnosis coding, a diagnosis can also be located using the diagnosis code. All codes containing the code number search criteria will display, in the same order the numbers were typed. Care must be taken to select the correct code.
- The decimal point must be used if the code number contains more than three numbers.

1. Complete all the previous steps as defined when searching by name, except click the Search by: **Code** radio button. **Note:** Click on the **Hide Advanced Options** to display the "Code" field

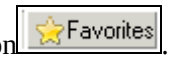


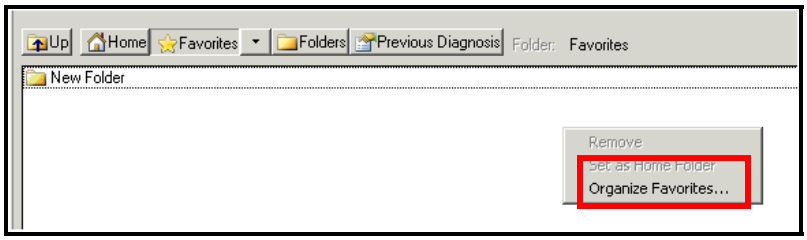
2. Continue adding the Diagnosis by after finding the code by click OK in the Diagnosis Search window and again in the final view.



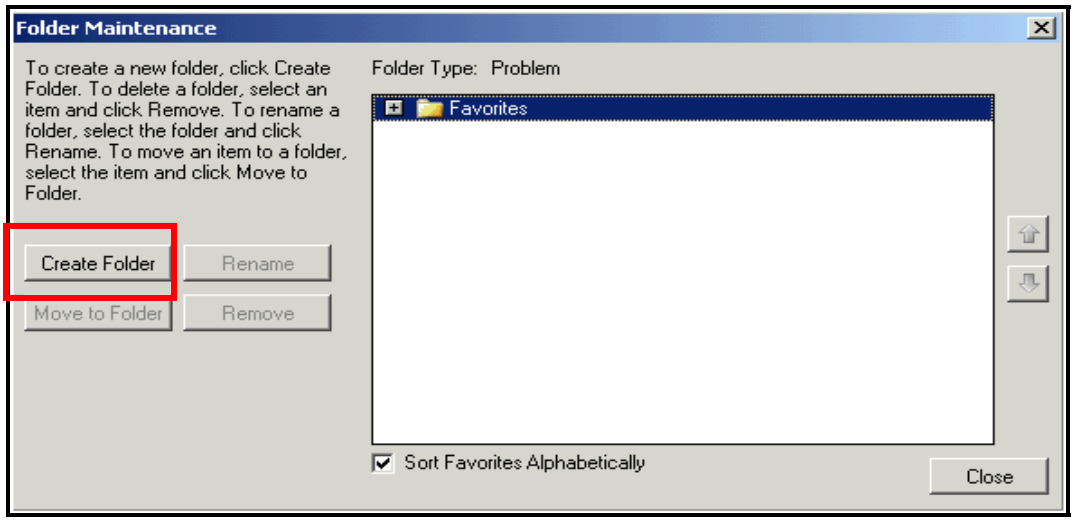
Creating Diagnosis Favorite Folders

- A Provider or Clinician can create a personal diagnosis folder to contain frequently used diagnoses to speed in diagnosis selection. More than one folder can be created, but each must have a unique folder name.

1. **Click** the Add button as if you were going to add a new diagnosis. Click the Favorites button  .
2. In the white space at the bottom, right-click and select Organize Favorites.

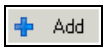


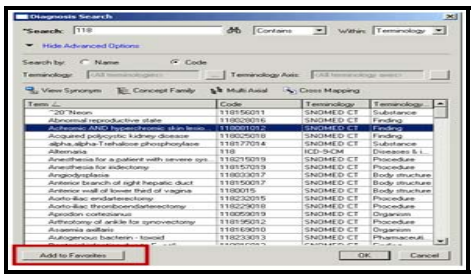
3. Click the **Create Folder** button, name your folder, and press enter on the keyboard.



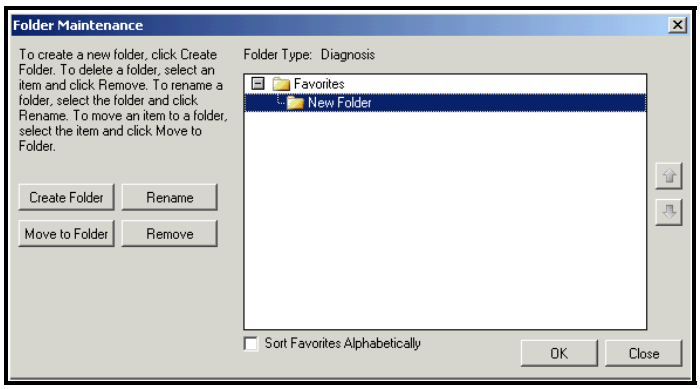
4. Click **Close**. The personal folder is now created.

Adding Diagnosis To Favorite Folder

1. **Open the Diagnosis Search dialog** box by click the Add  button in the diagnosis pane and then clicking the binoculars in the search view.
2. Perform either a Diagnosis Search by Text (Name) or Diagnosis Search by Code to locate a diagnosis.
3. Once the diagnosis has been located and highlighted, click the **Add to Favorites** button.

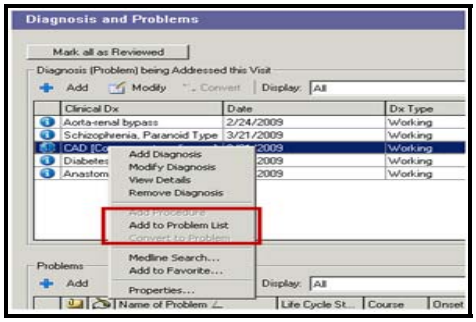


4. Select the folder to add the diagnosis to and click **OK**.



Moving A Diagnosis To The Problem List

1. Right-click on the diagnosis that is to become a new Problem, and select **Add to Problem List** from the dropdown menu.

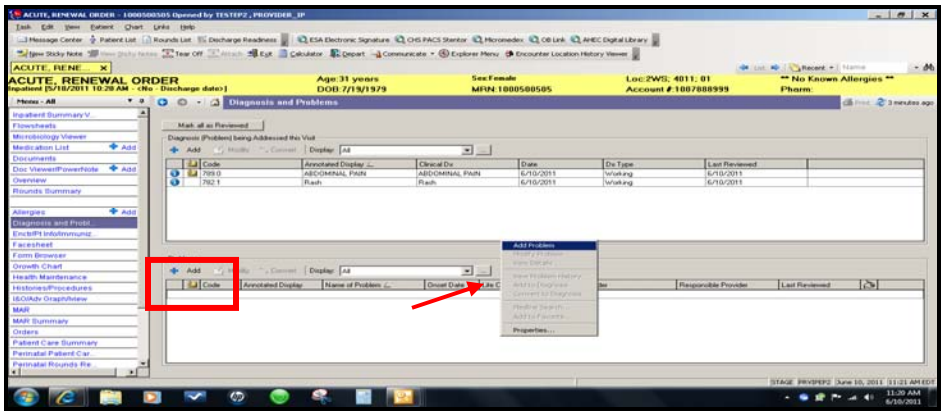


2. The Diagnosis will now be displayed in the Problem list.
3. Drag and Drop can be used to move a Diagnosis to the Problem list

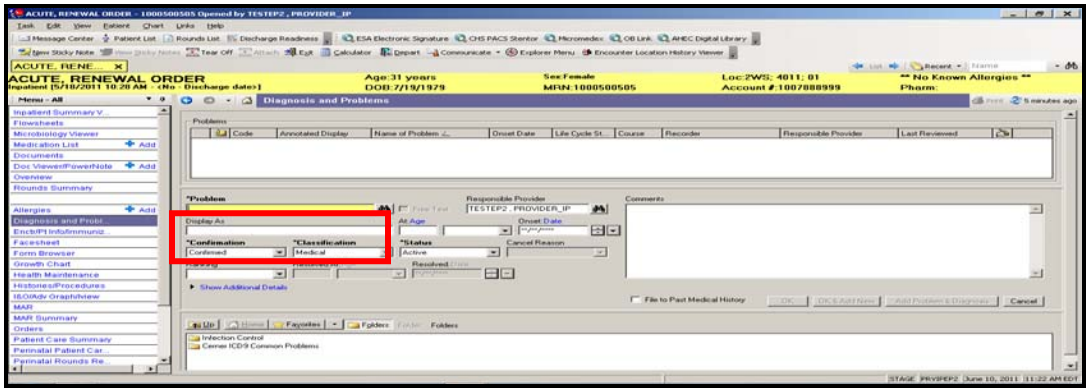
Entering A Problem

The functionality of the problem list is similar to the diagnosis list. The problem list will be used to enter chronic conditions.

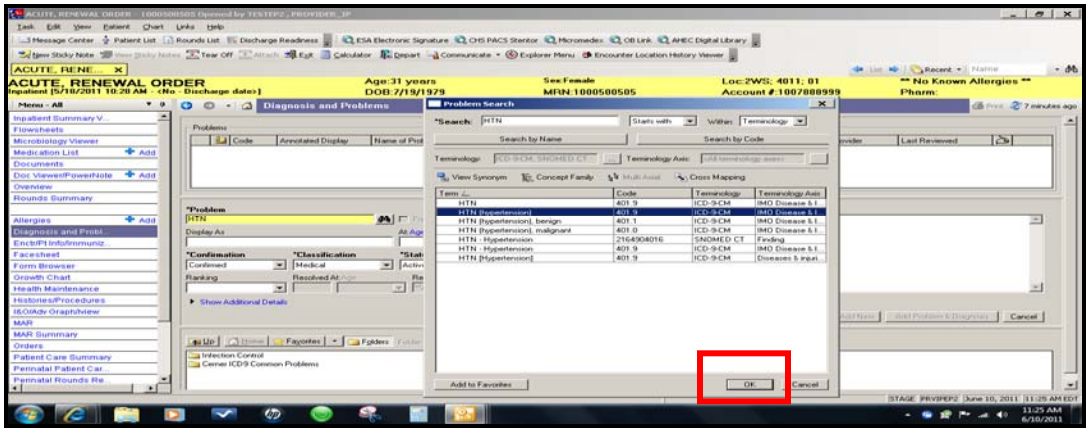
1. Click the Add button or right click anywhere in the problem list to open the problem window.



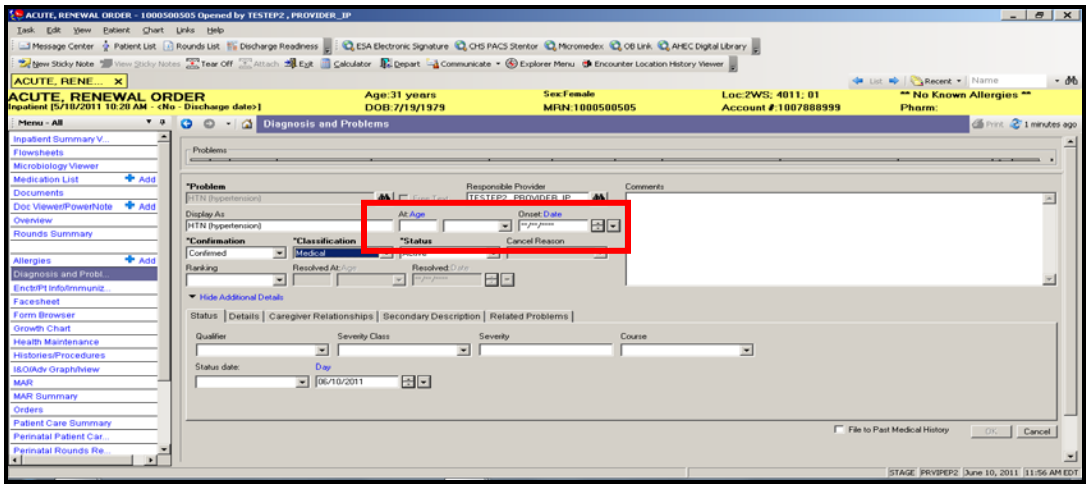
2. Begin typing in the Problem and click the Search binoculars .



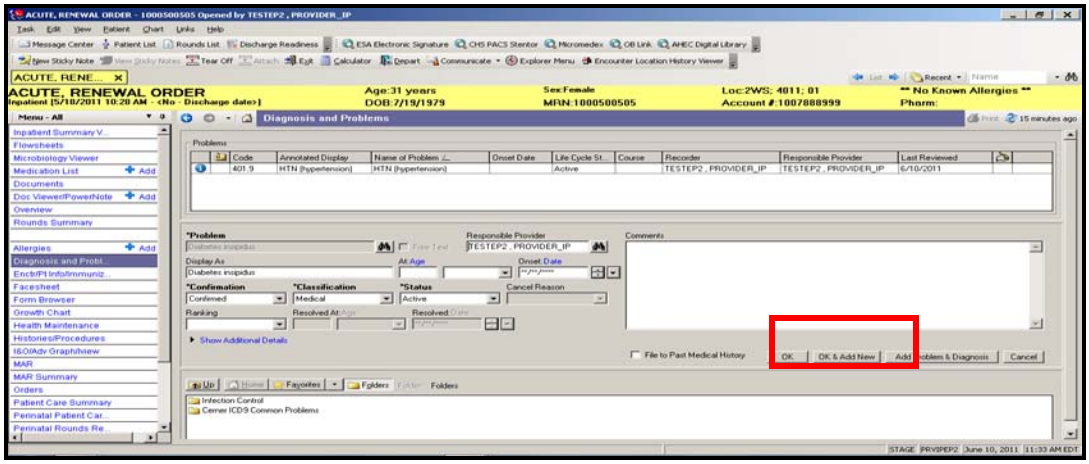
3. A nomenclature window will open. Select the problem that is being addressed this visit. Click OK.

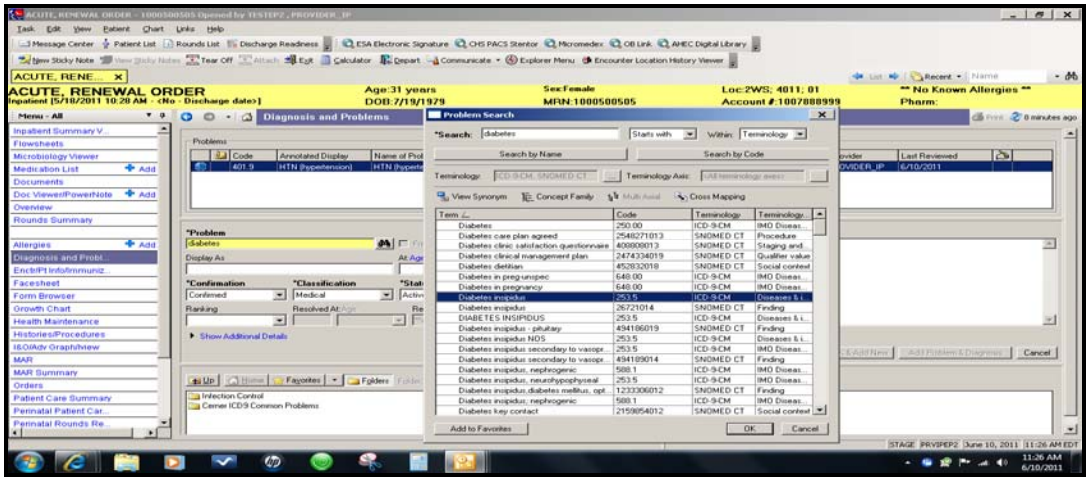


4. There are two unique fields for the problem list; At Age and Onset Date.

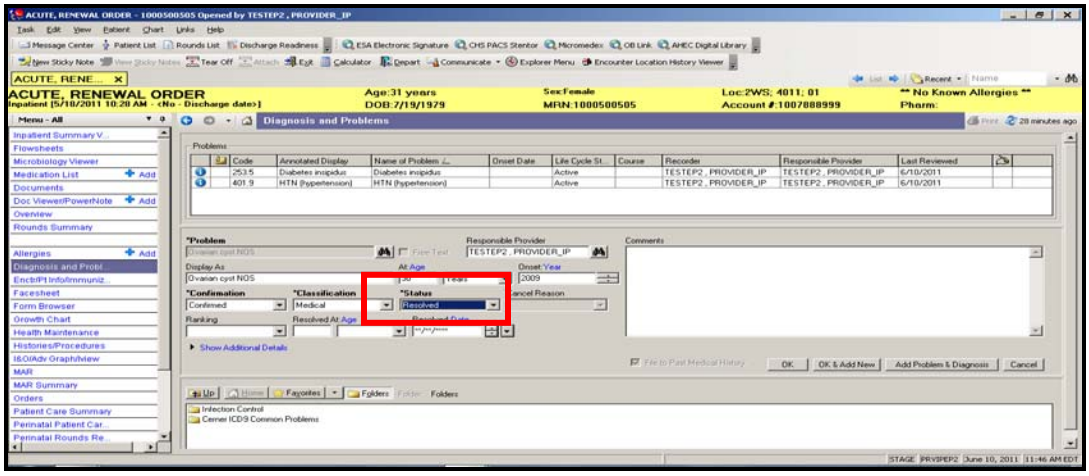


5. Complete details, and click OK. If another problem needs to be documented click the OK & Add New button, and the search window to open again





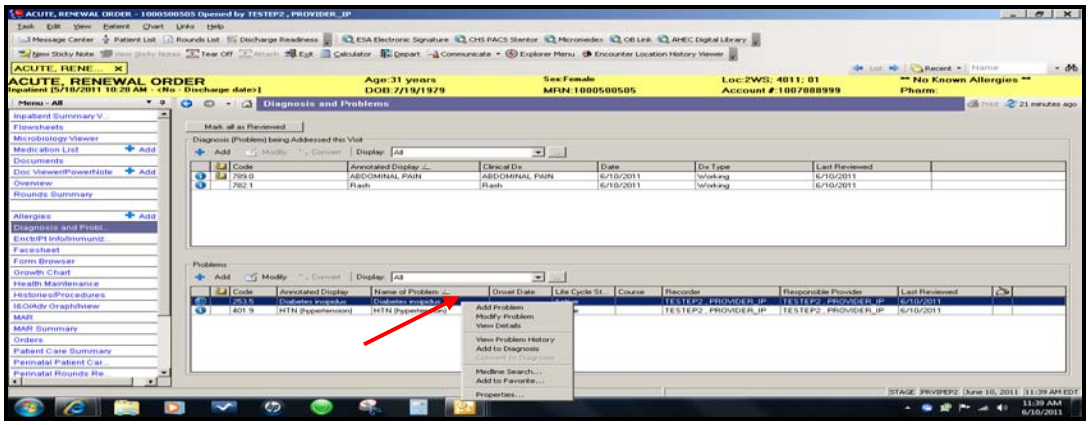
6. Historical problems can be added and document Status as resolved.



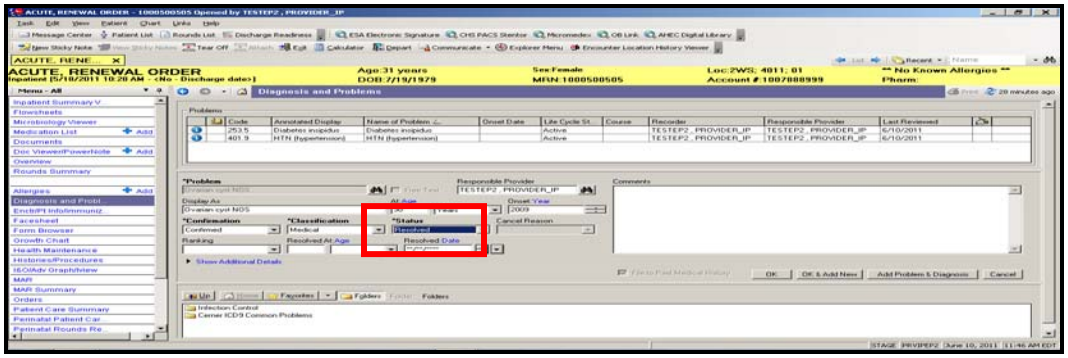
Activating/Inactivating Problem

- Users can activate/inactivate a person's problem if the problem comes out of remission. To activate the problem complete the following steps.

1. *Right click* the problem and select **Modify Problem** from the menu.



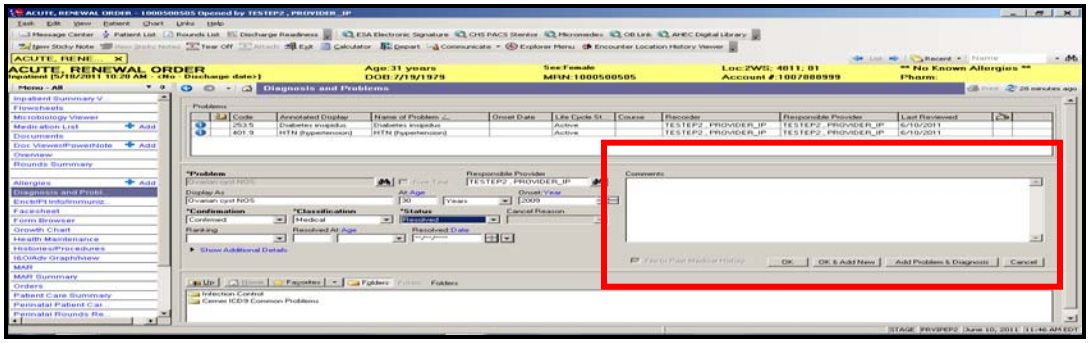
2. In the Status drop down select **Activate** or **Inactivate**.
3. Click OK. The problem is displayed in Problem Profile with the updated status.



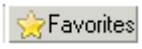
Adding Comment To Problems

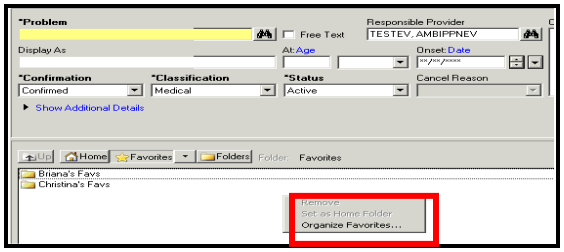
- If there is information about the person's problem that cannot be organized within Problem List's structured format, you can enter the information as a comment.

1. To add a comment from the Modify Problem or Add New Problem dialog box, enter comment information in the Comment field.
2. Enter the description or comment in the text box, and click **OK**.

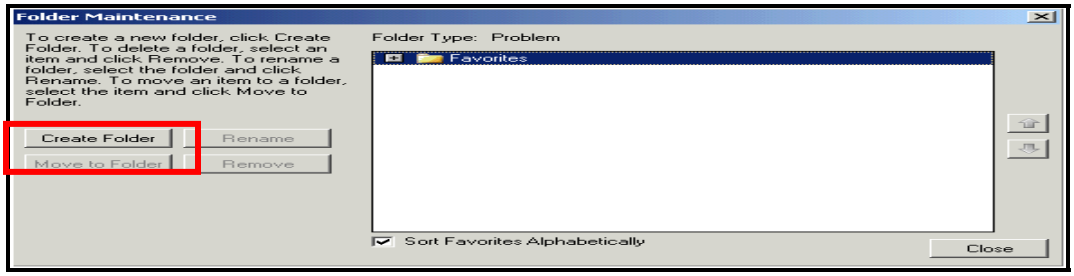


Adding Problems To My Favorite Folder

1. Users must first create a folder under My Favorites. In the Add Problem window, click the Favorites button  , and then *right click* in the white space and select Organize Favorites.



2. Highlight the favorite folder and click the **Create Folder** button.



3. Name the folder.
4. Next, after searching for the Problem, click and highlight the problem and then click the **Add to Favorites** button.
5. Select the folder to add the problem to and click OK.

5. Discharge Mpage and House Wide Depart Process

Introduction

Recognizing the challenges of discharge readiness and ensuring all items for discharge have been addressed and completed prior patient discharge, Cerner has developed two new *MPages* for improved visibility to readiness for discharge that work in conjunction with the Depart Process. The two new *MPages* are

- The Discharge Readiness Dashboard
- The Discharge Summary.

These *MPages* leverage current capabilities within PowerChart to better manage the items needed for discharge and provide face-visibility to key indicators throughout the process.

- The Discharge Readiness Dashboard is accessed from the Organizer level of *PowerChart*, and it provides a population-based view of key discharge activities, which allows clinicians to get a quick view of their patient's progress toward discharge.
- The Discharge Summary is accessed from a navigator tab within *PowerChart*, and it provides a patient-specific view of detailed information regarding the components pertinent to discharge.

The *House Wide Depart Process* organizes pertinent discharge instructions in one location of the record. The *MPAGES* are used to update the information that ultimately populates the discharge instructions that are created for the patient and other providers in the Depart Process. The Nurse will complete the Discharge worksheets, review and sign the discharge instructions by launching the Depart Process.

Learning Objectives

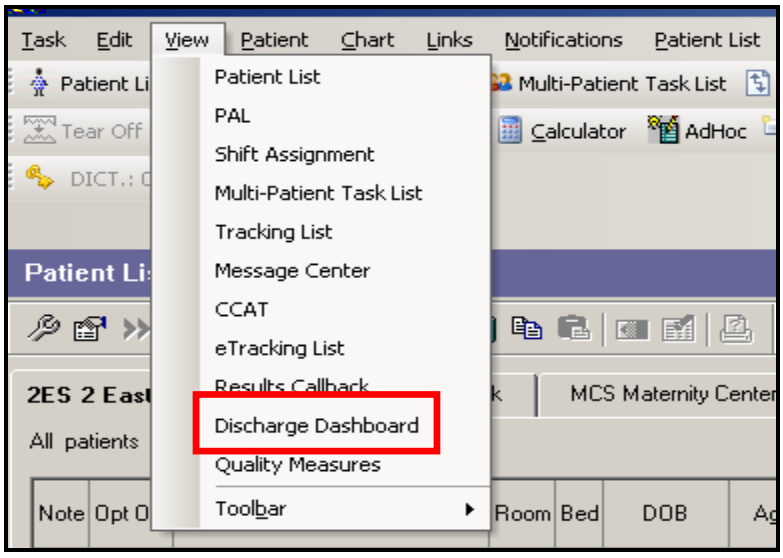
At the end of this course, you will be able to perform the following tasks.

- Understand and review the Discharge Readiness MPAGE
- Understand and review the Discharge Summary MPAGE
- Understand and complete the House Wide Depart Process to discharge a patient from the hospital
- Understand other clinicians roles in Depart Process
- Understand how the patient receives the printed discharge instructions

Discharge Readiness MPAGE

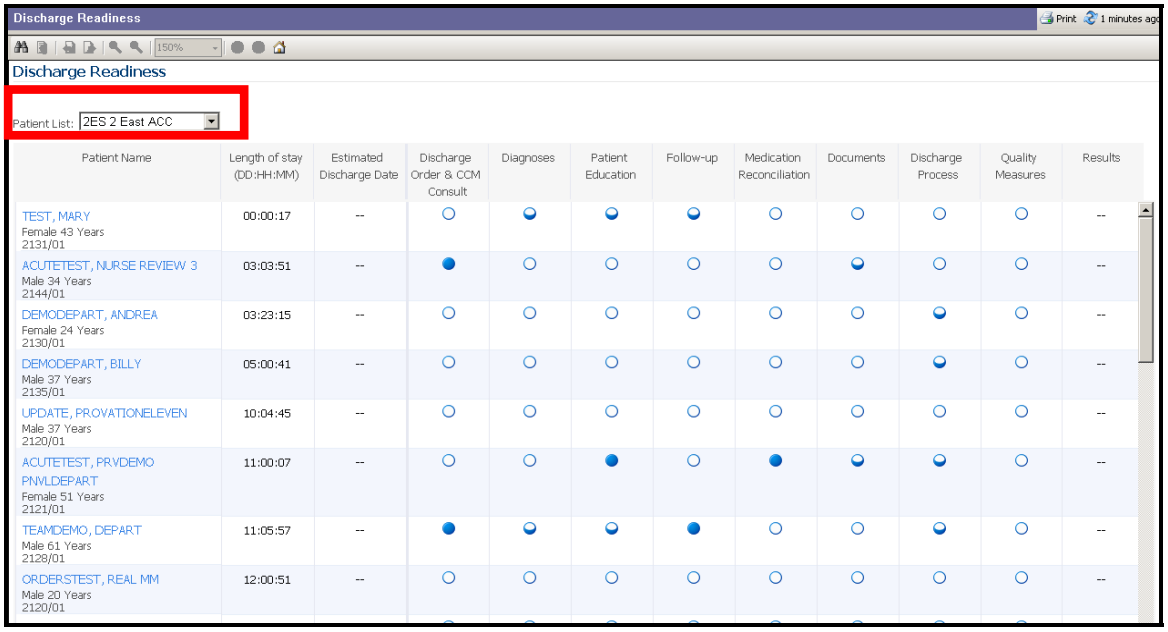
The Discharge Readiness Dashboard is accessed from the Organizer level of *PowerChart*. It provides a population-based view of key discharge activities, which allows providers and clinicians to get a quick view of their patient's progress toward discharge.

1. To access the Discharge Readiness MPAGE
   - Open *PowerChart*
   - On the tool bar, click on View
   - Select Discharge Dashboard.



2. The Discharge Readiness MPAGE leverages Patients Lists that are created in PowerChart such as:
   - Assignment
   - Location
   - Provider Group
   - Custom
   - Care Team
   - Medical Service

3. The MPAGE will always default to most recently used patient list.

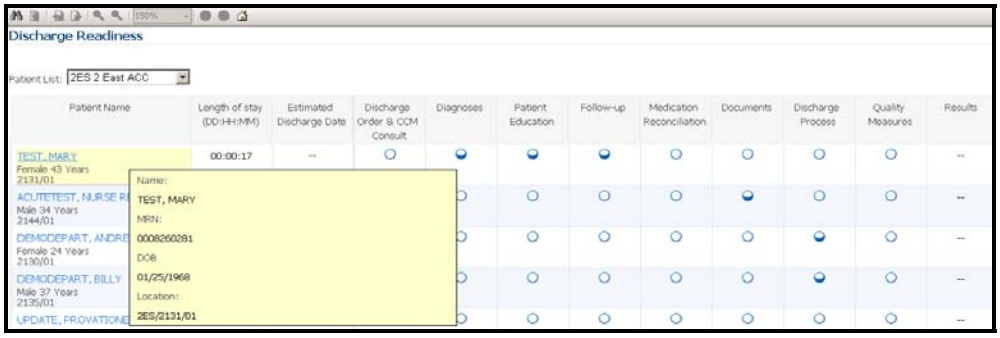


- Blue Circles that are empty indicate no activity has occurred in this section
- Blue Circles partially colored in indicate activity has occurred in this section but it does not mean it is necessarily completed.
- Blue Circles fully colored in indicate all activity for this component has been completed by all disciplines.
- Keep in Mind the Discharge Readiness MPAGE is a view only MPAGE.

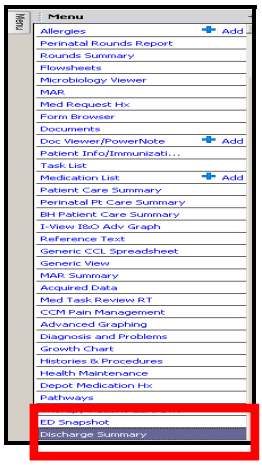
Discharge Summary MPAGE

The Discharge Summary MPAGE can be accessed from the Discharge Readiness MPAGE or via Navigator Tab within *PowerChart*, It provides a patient-specific view of detailed information regarding the components pertinent to discharge. The Discharge Summary MPAGE is a location of discharge information and not for the Dictated Discharge Summary.

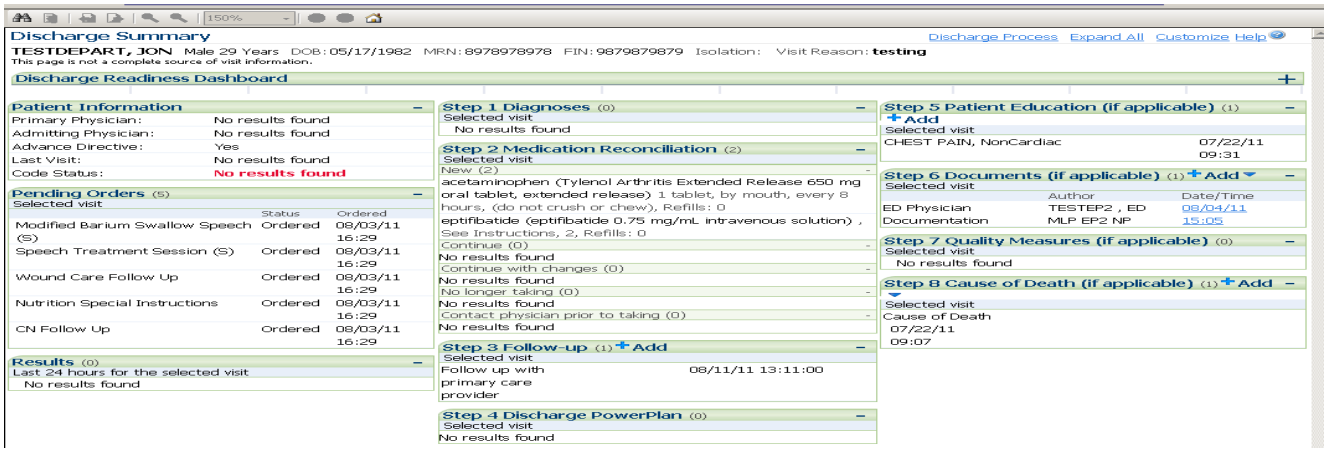
1. To access the Discharge Summary MPAGE from the Discharge Readiness MPAGE, **Double-click** on the patient's name.



2. To access the Discharge Summary MPAGE from a tab within *PowerChart*, Click on Discharge Summary Tab within the patients Chart



3. The Discharge Summary MPAGE opens



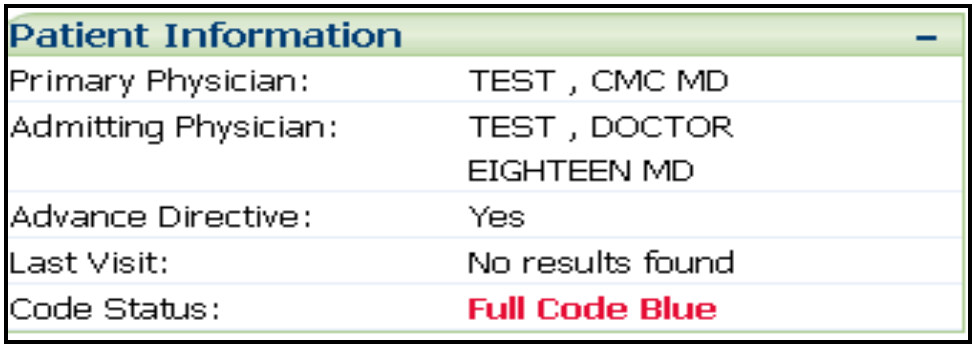
4. The Discharge Readiness Dashboard and the Discharge Summary MPAGES consists of the following components:

- Patient Information (Review Information)
- Pending Orders (Review Information)
- Results (Review Information)
- Diagnoses (Step 1 of the Discharge MPAGE that must be completed)
- Medication Reconciliation (Step 2 of the Discharge MPAGE that must be completed)
- Follow Up (Step 3 of the Discharge MPAGE that must be completed)
- Discharge PowerPlan (Step 4 of the Discharge MPAGE that must be completed)
- Patient Education (Step 5 of the Discharge MPAGE to be completed if applicable)
- Documents (Step 6 of the Discharge MPAGE to be completed if applicable)
- Quality Measures (Step 7 of the Discharge MPAGE to be completed if applicable)
- Cause of Death (Step 8 of the Discharge MPAGE to be completed if applicable)
-

5. The Discharge Summary MPAGE is actionable and provides more information and results as defined in each component. Some components provide the Provider the ability to complete the components from the Discharge Summary MPAGE.

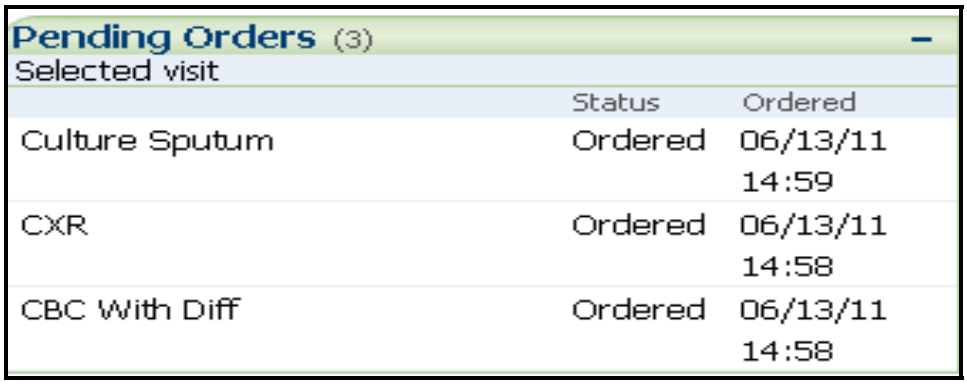
Patient Information Component

1. This component displays basic patient information such as
   - Primary Care Physician
   - Admitting Physician
   - Code Status
   - Advance Directive, etc.



Pending Orders

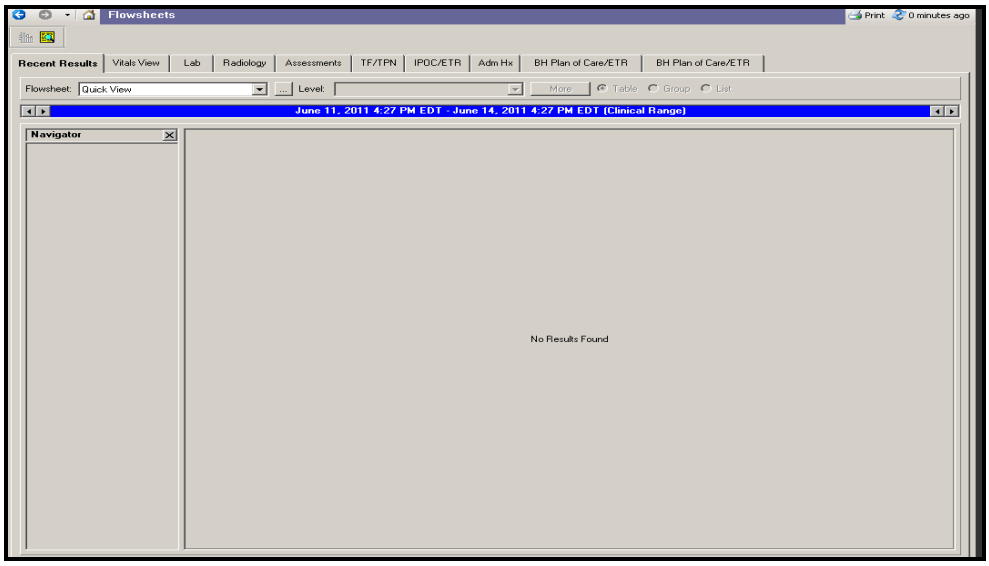
The Pending Orders component provides visibility to provider and clinicians of any outstanding non-med orders such as Lab, Radiology, Consults, etc...



Results

The Results component provides visibility to any Labs, Radiology or Cardiology results returned in last 24 hours (i.e., is physician aware of any critical results and should it impact physicians decision to discharge patient).

- Clicking on the word “Results” will launch into the “Flowsheets” Tab” in PowerChart.

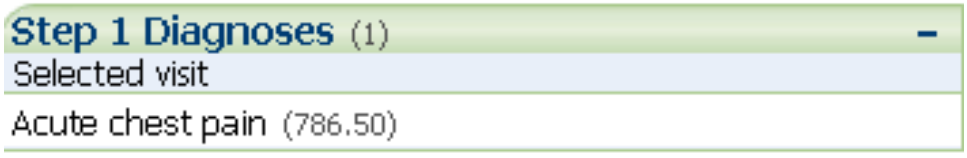


Diagnosis Component

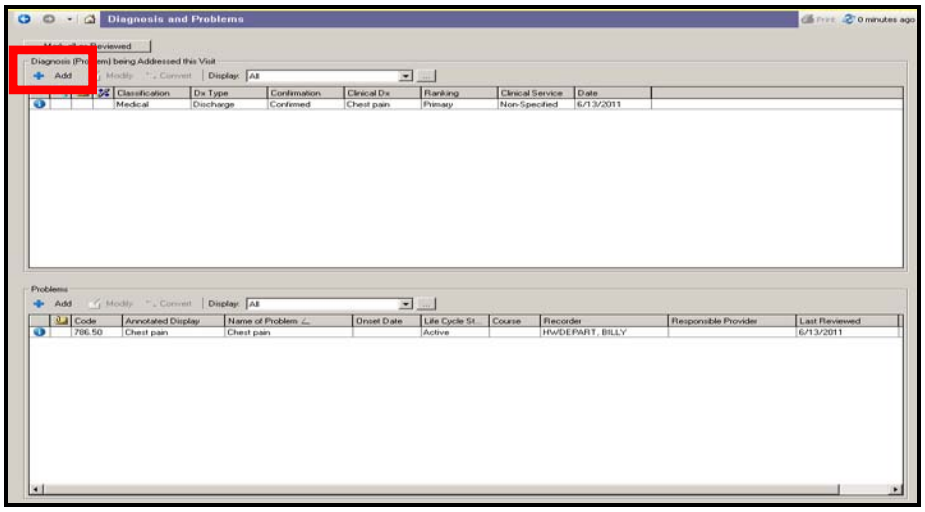
This component displays discharge diagnoses. If a Discharge Diagnosis has been entered, it will display within this component. If a Discharge Diagnosis has not been entered, the component will be blank. This is a required field.

To add a Diagnosis,

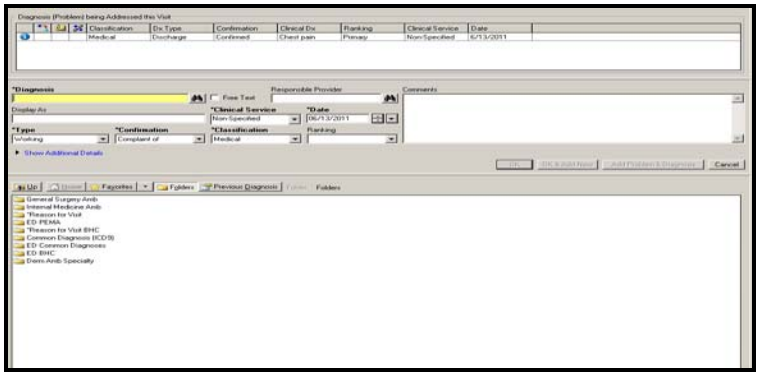
- click on the word “Diagnoses”
- this will launch to the Diagnosis and Problem window within PowerChart



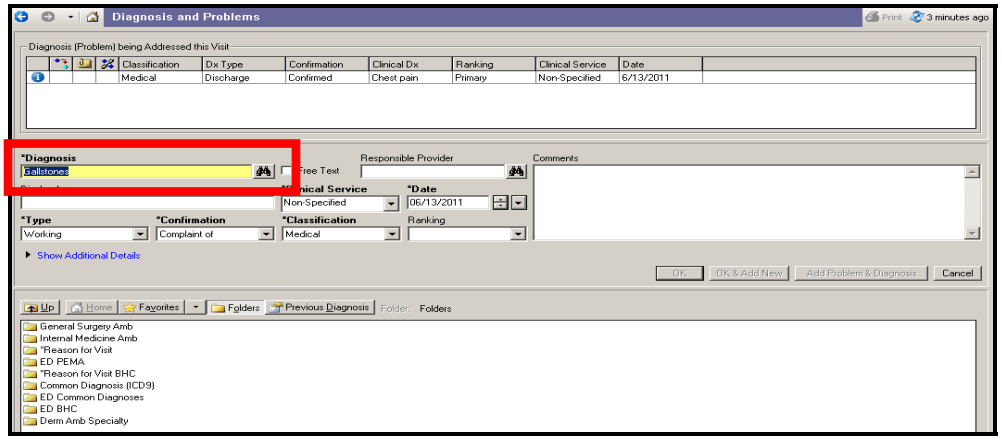
1. Click “**Add”** in the Diagnosis control box to enter the Discharge Diagnosis.



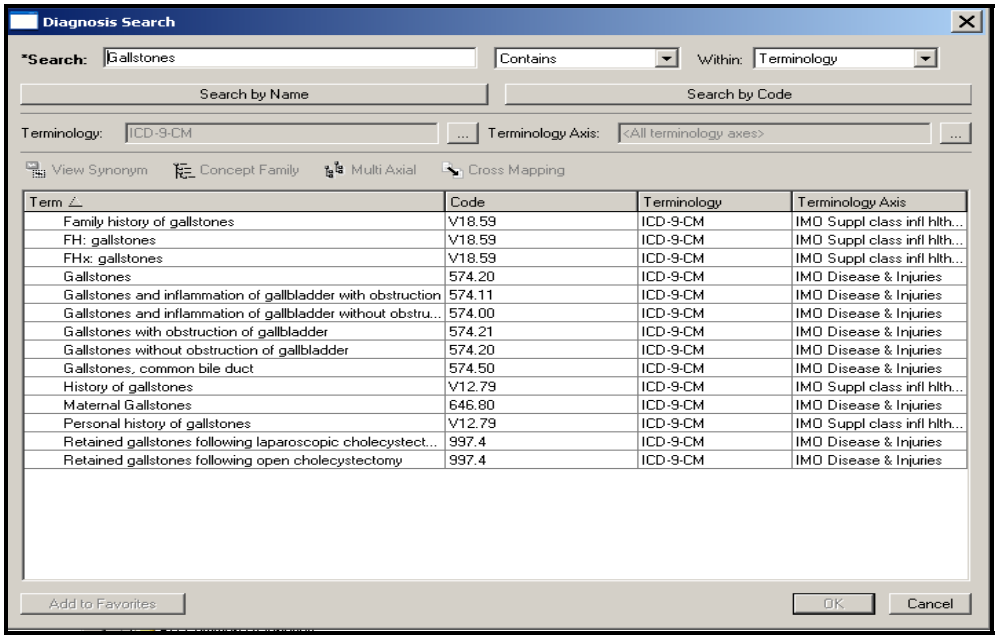
2. The Diagnosis Box then opens



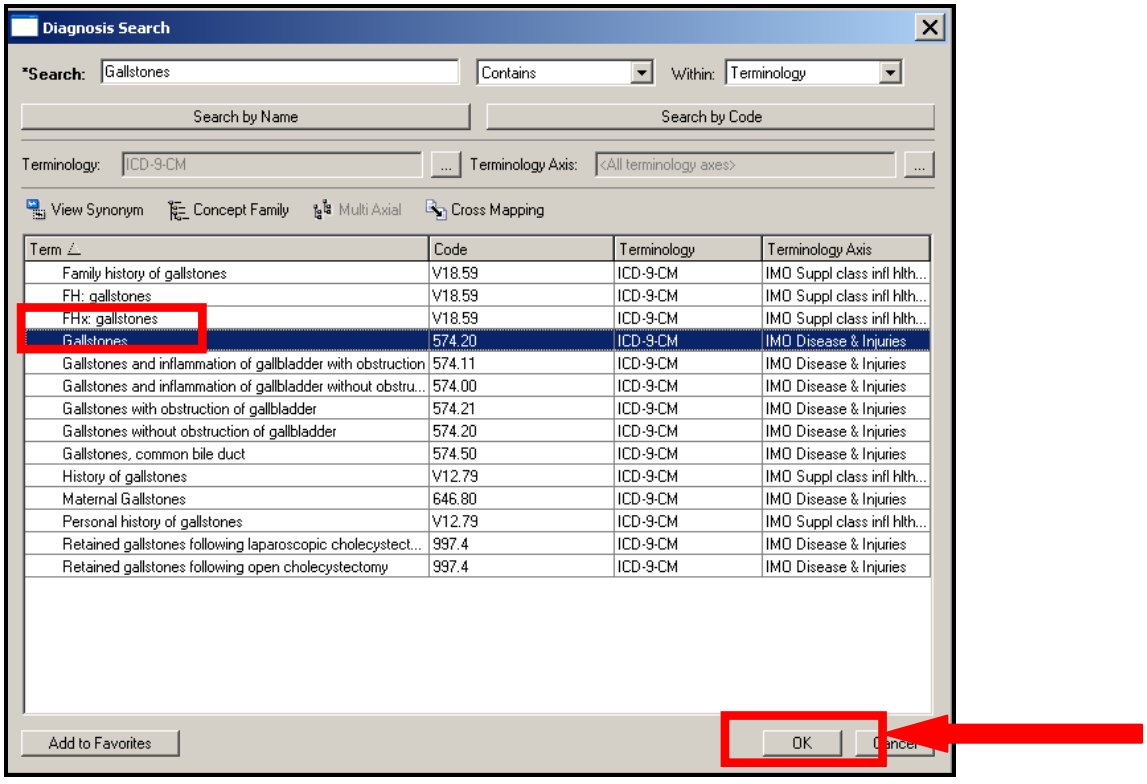
3. Type the name of the diagnosis in the Diagnosis field
4. Click the binoculars icon .



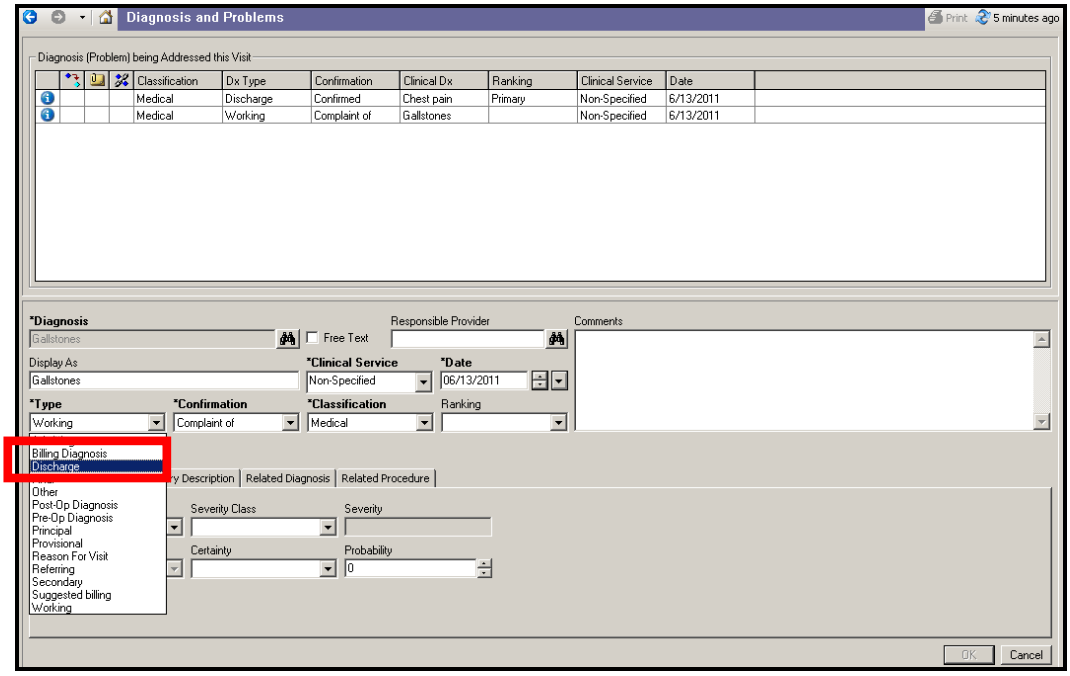
5. Search Results Return



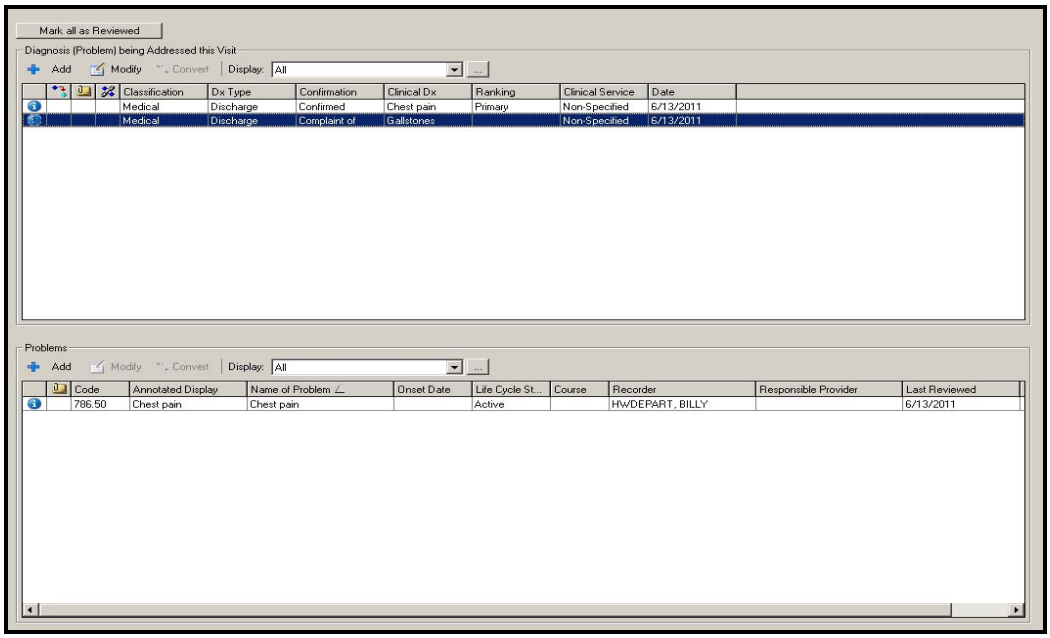
6. Click on appropriate choice and then click “ok” in the lower right hand corner



7. Complete the remainder fields and Choose Diagnosis Type of “Discharge”



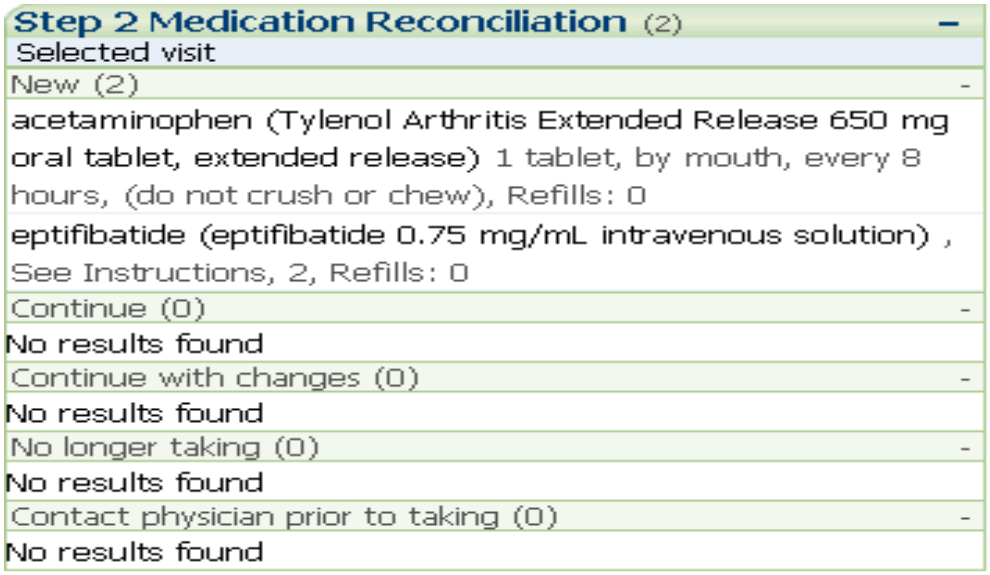
8. The Diagnosis now displays in the Diagnosis Box



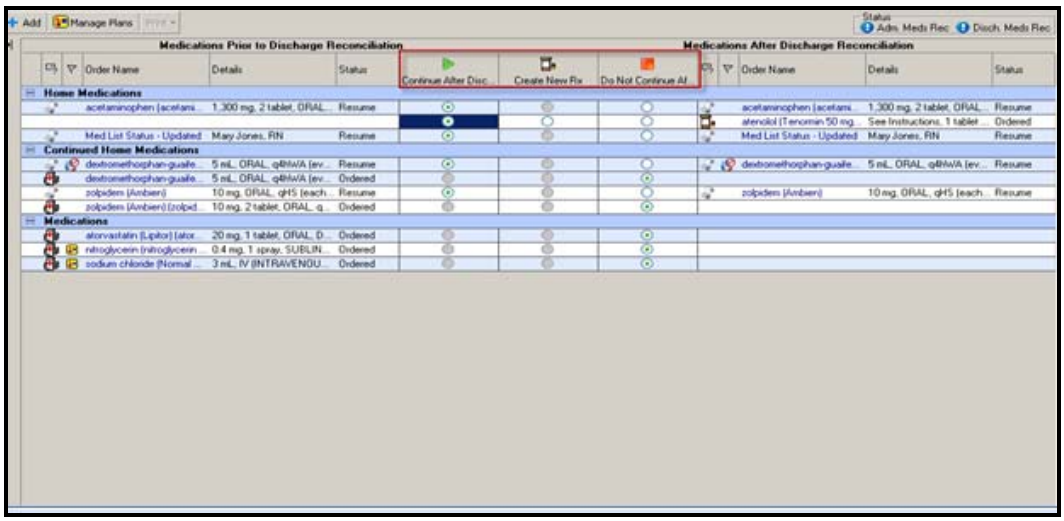
You can enter multiple discharge diagnoses. Follow steps outlined above to enter additional diagnosis.

Medication Reconciliation

The Medication Reconciliation component is a prompt for discharge reconciliation completion and provides visibility to medications on discharge. If medication reconciliation has occurred, information will be displayed and the Blue Circle will be fully colored in to indicate all activity for this component has been completed. If Medication Reconciliation has not been completed, it will be blank. This is a required field.

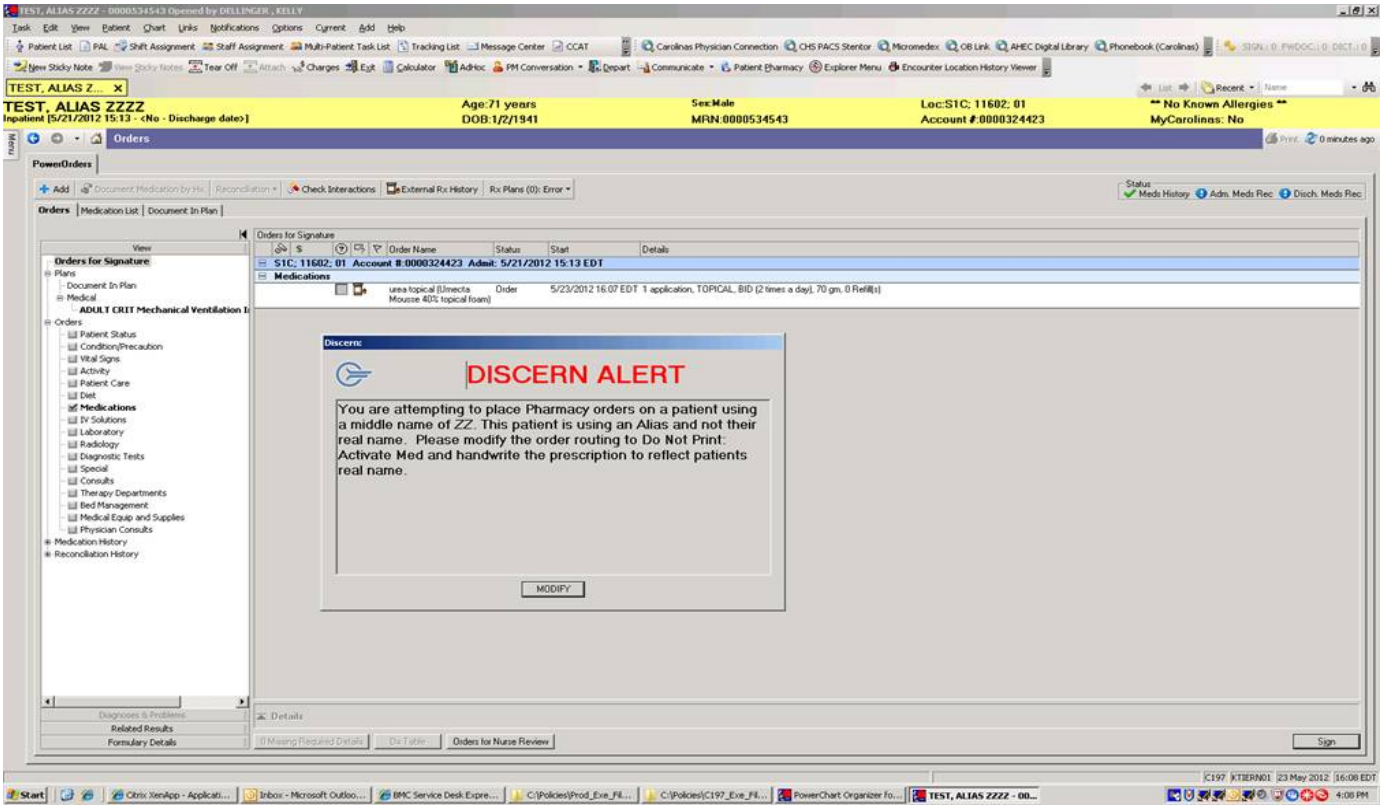


- Clicking on the title "Medication Reconciliation" will open the Medication Reconciliation window where you can complete this component.



Discharge Medication Reconciliation: Alias status

- **Prescriptions for Patients with Alias status**
  - If a provider attempts to e-prescribe or print a prescription for a patient with an Alias status, the provider will receive a discern alert as indicated in the screen shot below:



  - Select the modify option to alter details for the orderable. In the "Send to" field, select "Do Not Send: Activate Rx"

  - After completing the electronic discharge med reconciliation in Canopy following the above instructions, complete handwritten prescription(s)

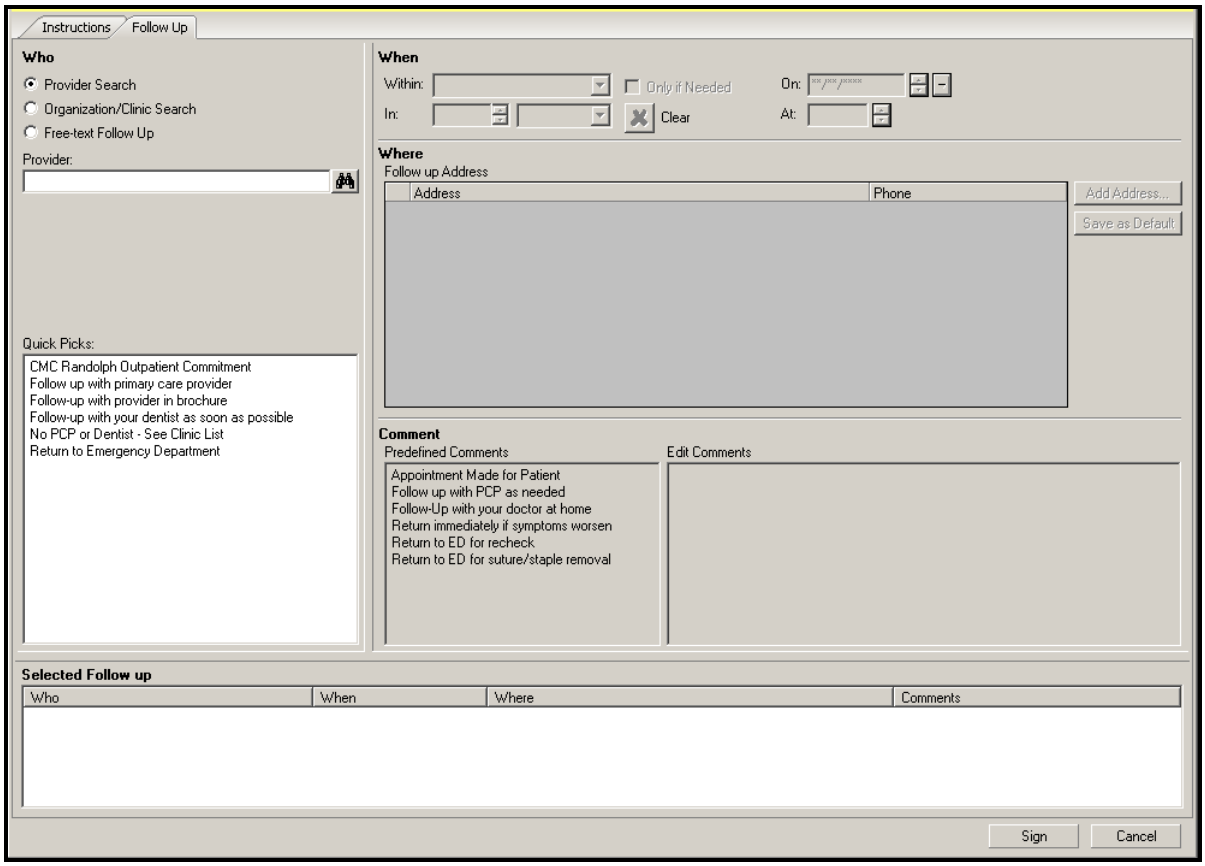
  - Note: The electronic discharge med reconciliation and handwritten prescriptions are required to complete this process.

Follow-Up

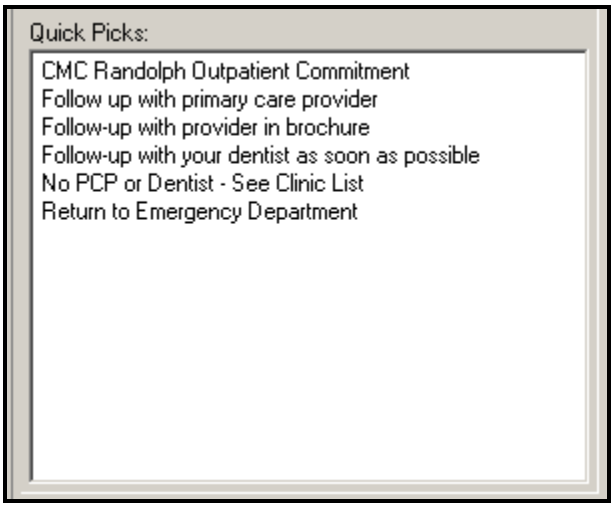
The Follow-Up component provides visibility of Follow-Up information entered for the patient. If other providers or clinicians have entered Follow-Up appointments and information it will display within the component. If no information has been entered, there will be no information displayed. The Follow-Up instructions action is intended for follow-up information that is scheduled for the patent within the organization or is non-specific. This is a required field.

1. To add Follow-Up Information, click on the +Add

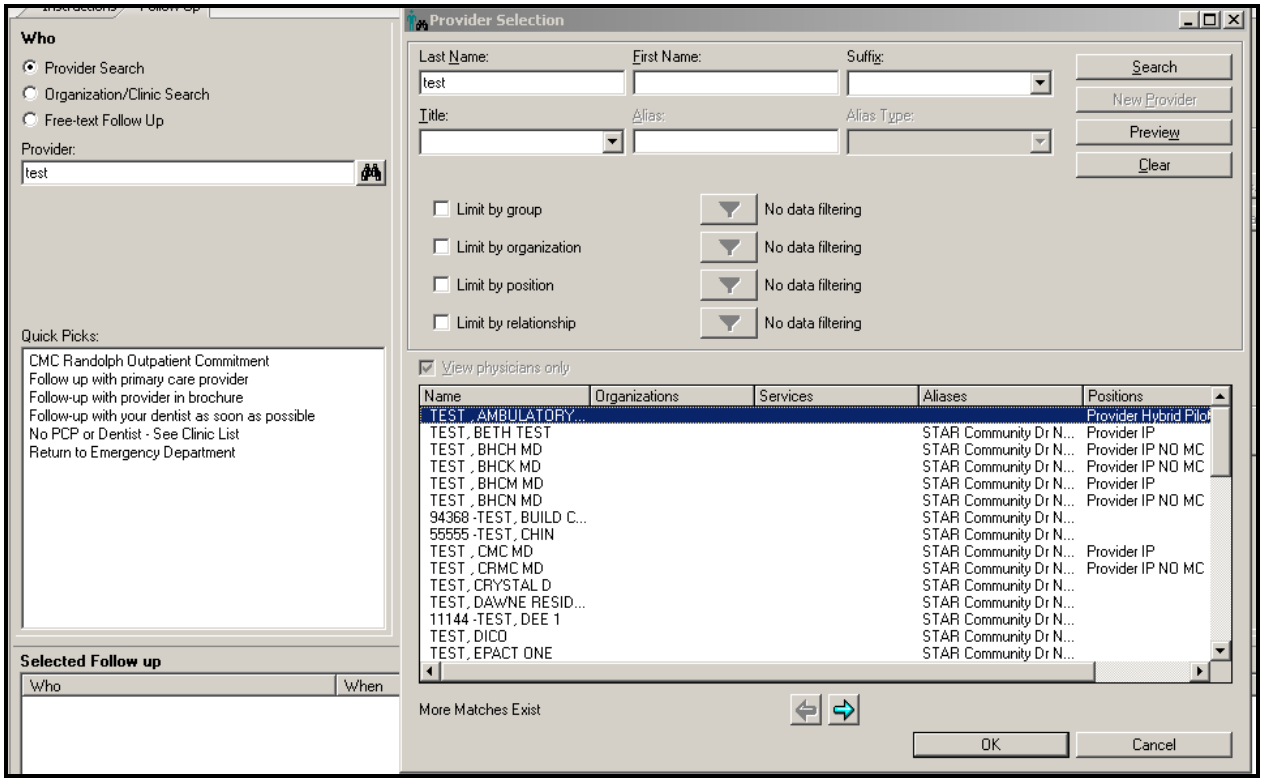
2. The **Follow-Up** Information window opens.



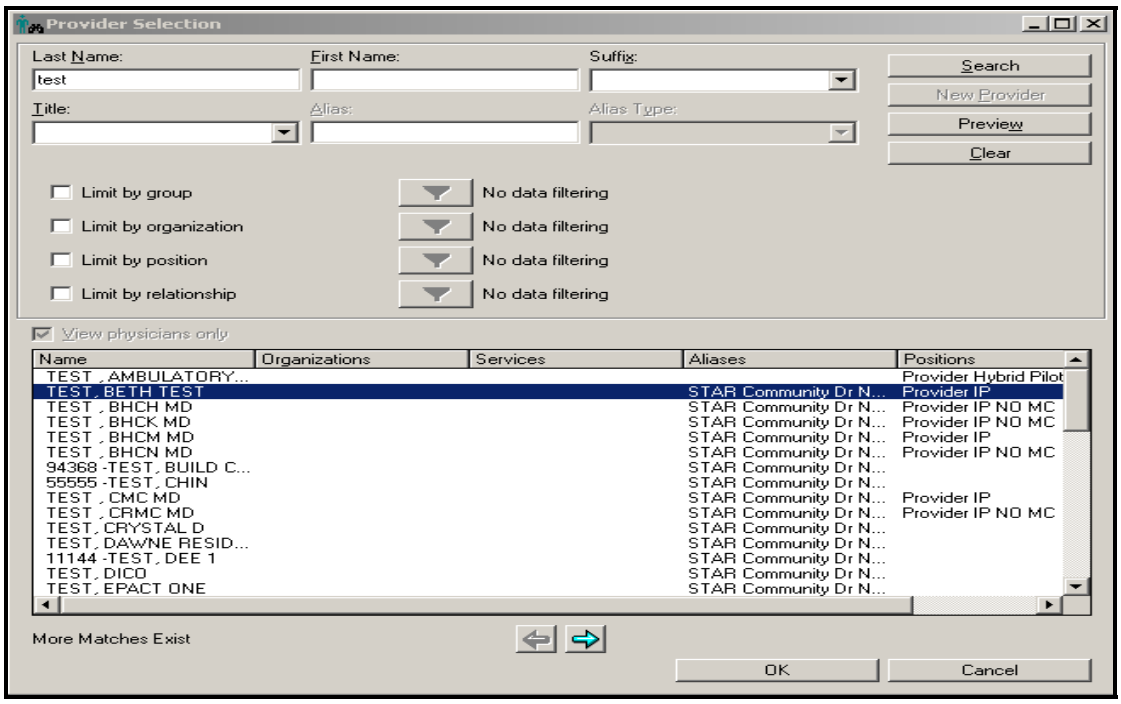
3. To select a **Quick Picks**, double-click the appropriate choice from the **Quick Picks** list.



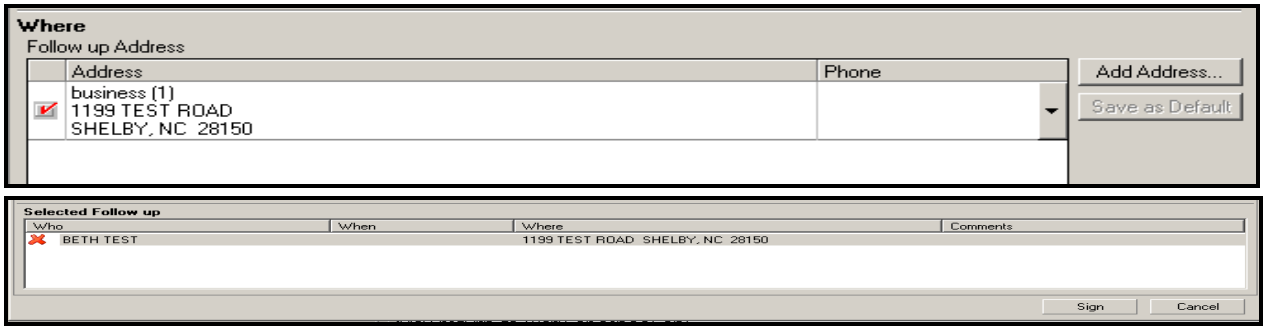
4. To select a follow-up Provider: Type the first few letters of the provider's last name and click the **Find (Binoculars)** button to the right of the Provider box to open the **Provider Selection** dialog box.



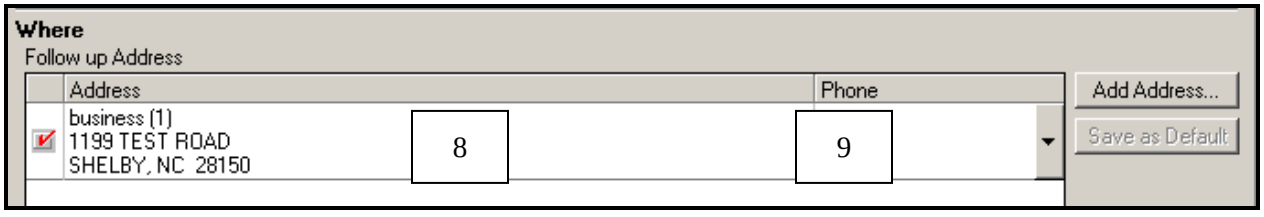
5. The **Provider Selection** box displays a list of Providers that you can double click on the name that you would like to select or click once to highlight the name and then **OK** to return to the **Follow-up** window.



6. The provider's address will display in the **Where** box and **Selected Follow-Up** box at the bottom of the screen. The business address will default in; you can make modifications as needed. If the physician's address is incorrect in the Follow-Up Section, please let a Canopy representative know or you may contact the Support Center at 704-446-6161 option 5.

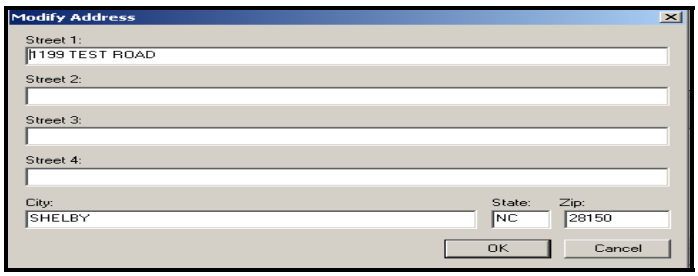


7. If a business address for the selected provider or organization is saved in the system, the address will be displayed automatically in the **Follow-Up Address** box.

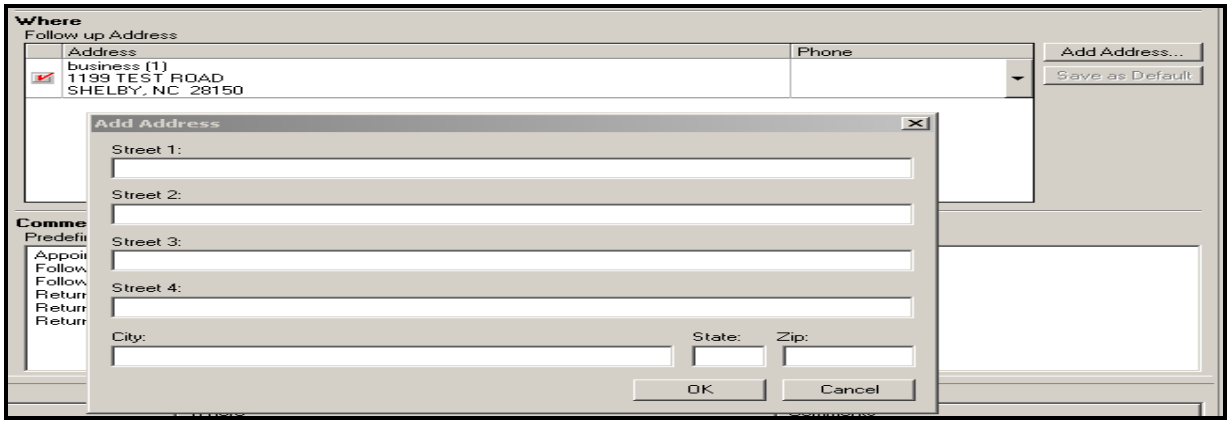


8. To modify a follow-up address, double-click the **Follow-Up Address** box and edit the information.

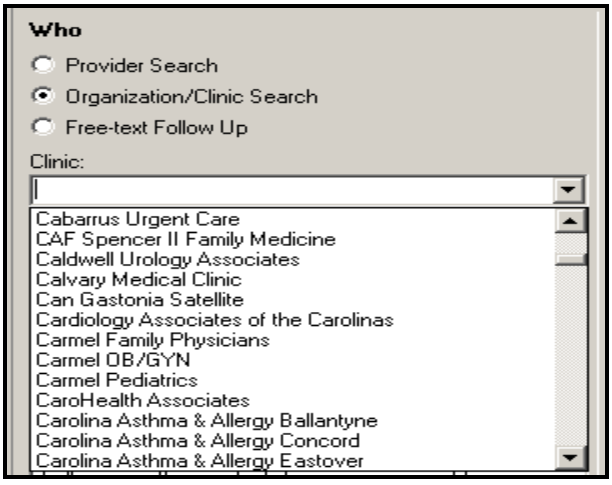
9. To modify a phone number, single-click in the **Phone** box and edit the information.



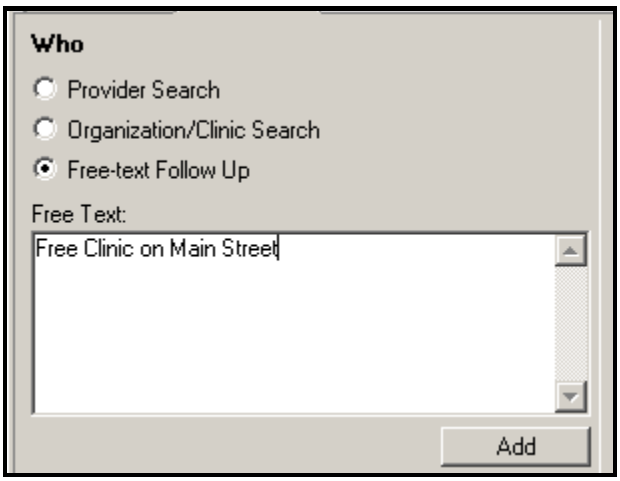
10. To add a new follow-up address for the instructions, click **Add Address** and type (Remember to uncheck the old address that is defaulted in)



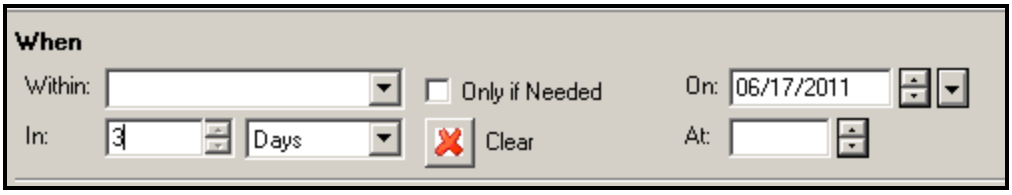
11. To select a follow-up organization or clinic instead of a follow-up provider, select **Organization/Clinic Search**. Select the clinic name from the Clinic menu.



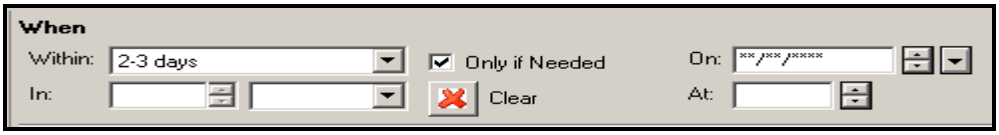
12. To enter **Free-text follow-up** instructions for providers or clinics not currently saved to the system, select **Free-Text Follow-Up**. Type the correct follow-up information, and click the **Add** button.

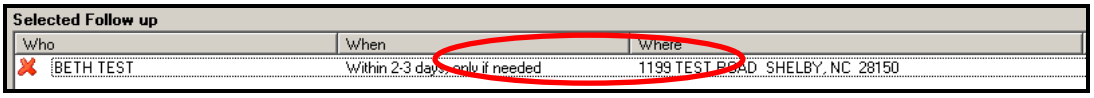


13. Use the **When** box to specify the time frame for the follow-up appointment. The **In** and **on** boxes allow selection of a specific date for the patient's follow-up appointment.

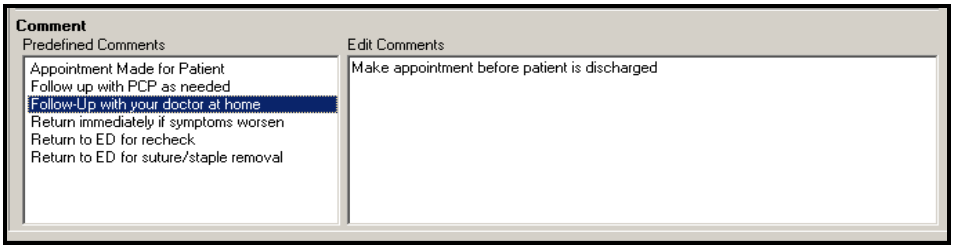


14. To set a time frame instead of a specific date for a follow-up appointment, select a date range from the **within** list. The option next to **only if needed** will add the text to the Follow-Up Information section if selected.

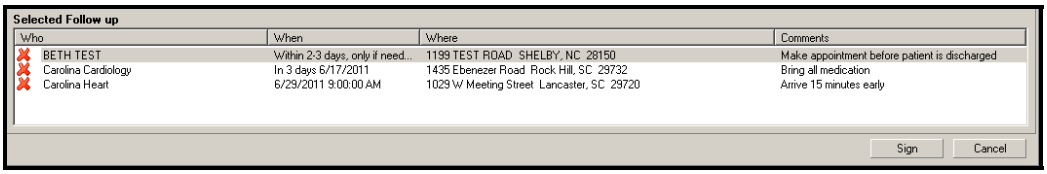




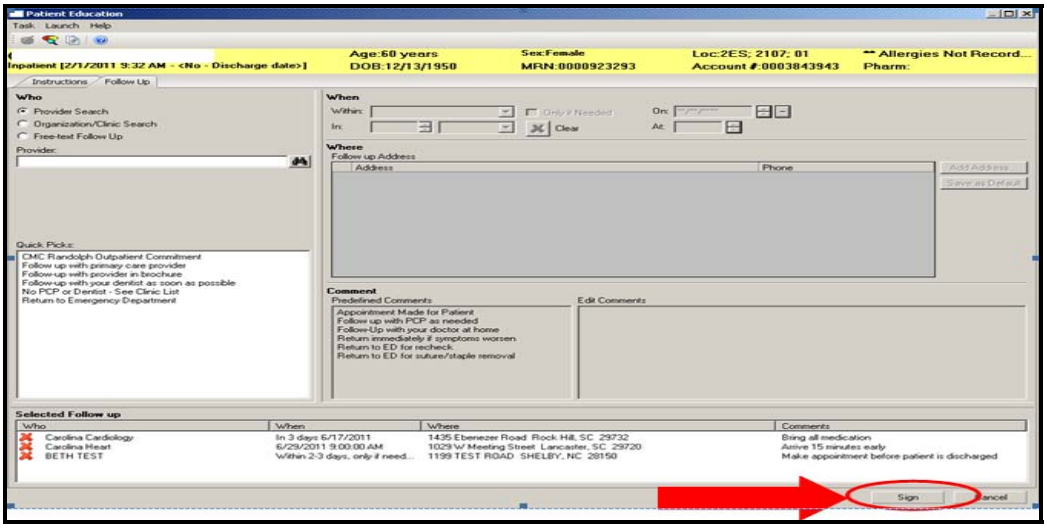
15. Add predefined follow-up comments by double-clicking a selection from the **Predefined Comments** list or typing comments into the **Edit Comments** box.



16. A summary of all follow-up instructions will display in the **Selected Follow up** window. Use the **red X** icon to delete any follow-up instructions that are no longer needed.



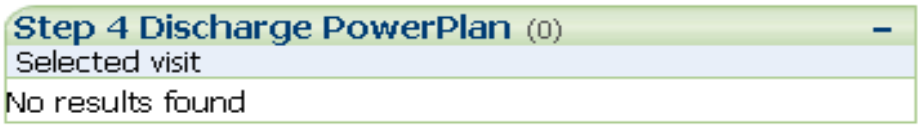
17. Click **Sign** to save your changes to the depart process.



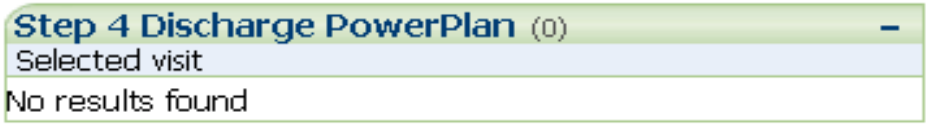
Discharge PowerPlan

The Discharge PowerPlans Component provides visibility to the provider as to whether or not the discharge orders have been placed. This provides visibility to all other clinicians as to whether or not the patient's discharge is imminent. This is a required field.

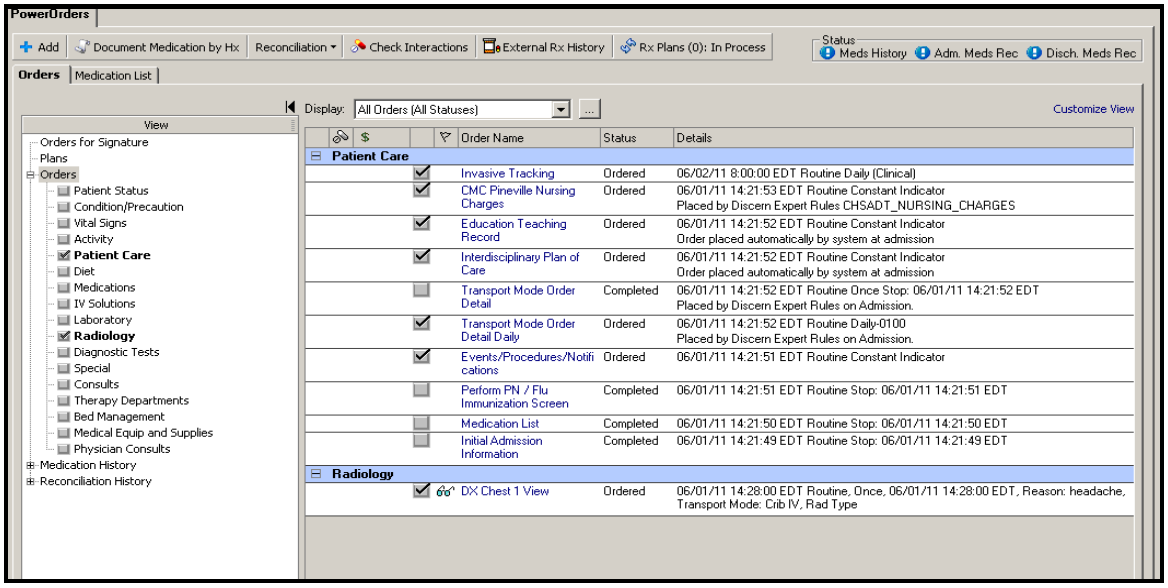
1. If Discharge PowerPlan has been placed, the orders from the PowerPlan will appear within this component. If there is no information it will return with “No results found”.

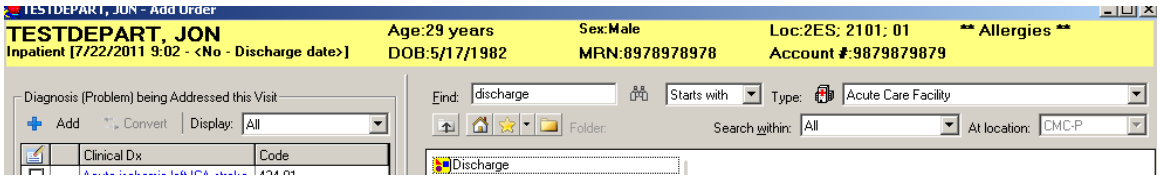


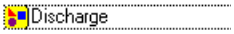
2. If the provider needs to place orders for discharge, clicking on the Title “Step 4 Discharge PowerPlan”. This will open to the PowerOrders Tab.

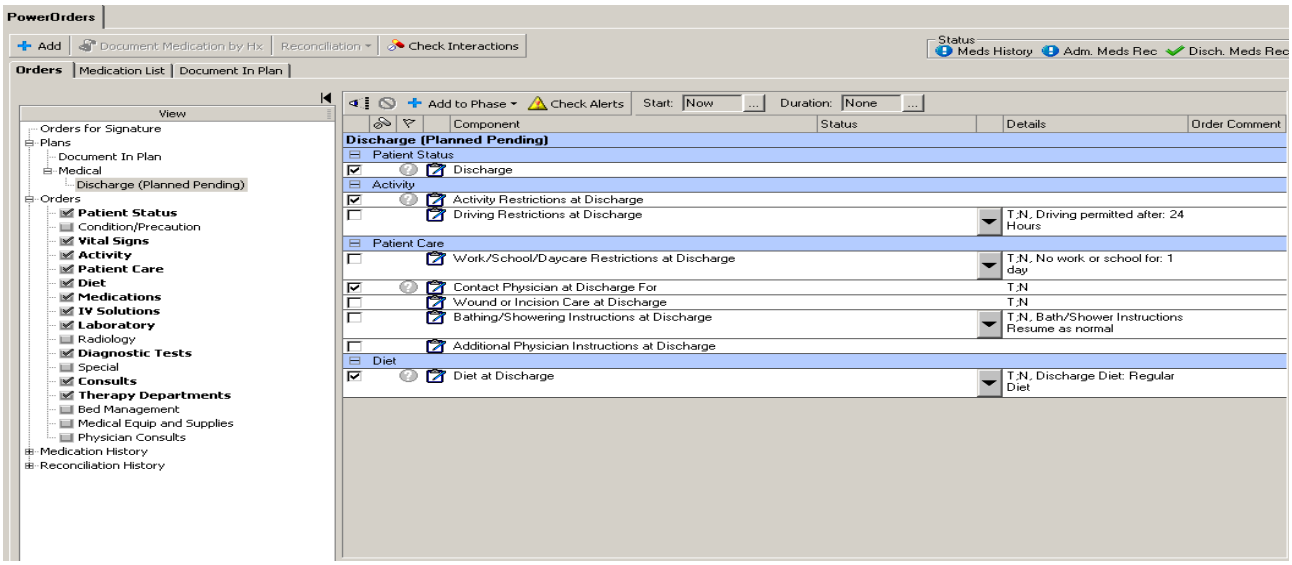


3. When the PowerOrders Tab opens, click on “+Add and search for Discharge”.





4. Select the Discharge PowerPlan ICON  and complete the order details as applicable. When the discharge order is placed the Nurse and Unit Secretary will receive tasks on their tasks list to complete their portions of the Depart Process for non-expired patients.



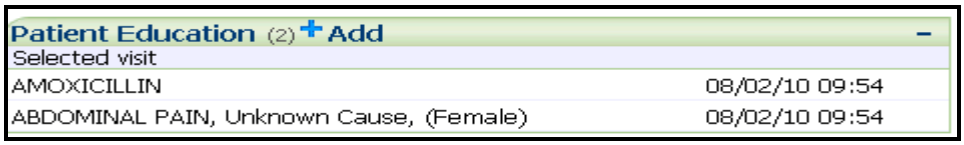
Patient Education

The Patient Education component provides visibility of patient education materials provided to patient. If no information has been entered, there will be no information displayed. Patient Education serves as a one-stop

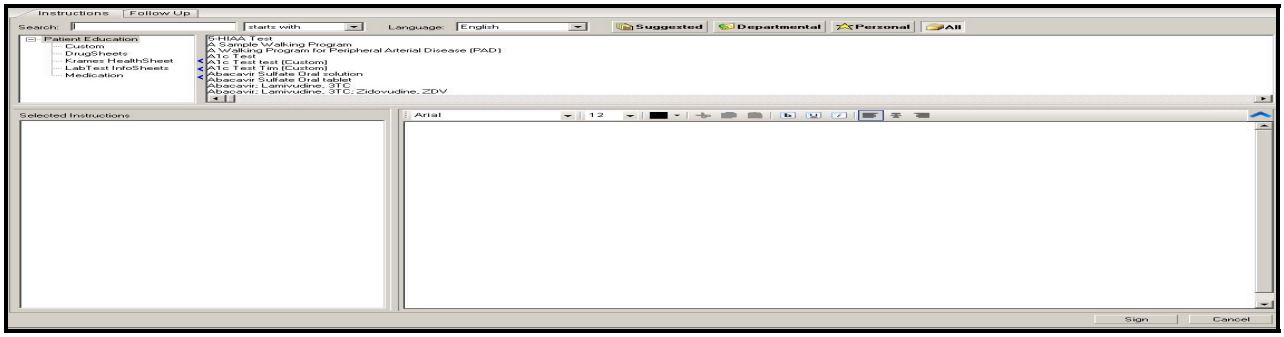
repository for patient education instructions such as discharge guidelines, specific disease process handouts, procedures, diet directives, and equipment information. Use Patient Education to select, view and save personalized patient education instructions. These instructions can then be saved to the patient's chart and imbedded automatically and printed upon discharge.

How to Open A Patient Education Module

1. To add patient education documents click on "+Add" to open the Patient Education Module.

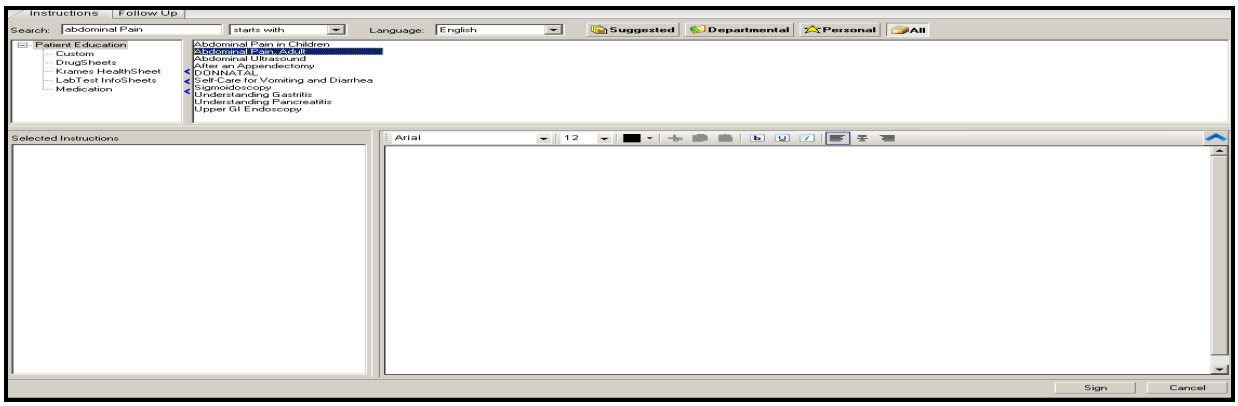


2. The Patient Education Information window opens

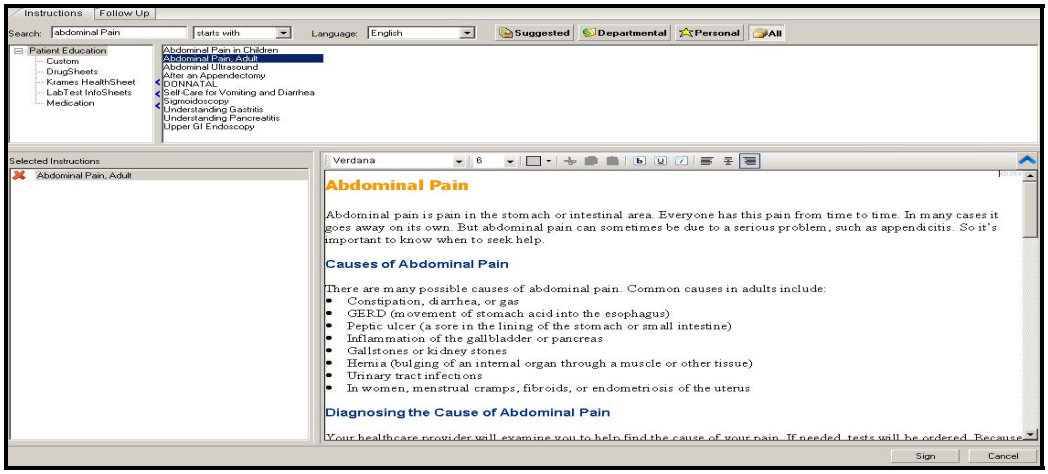


How To Add and Remove Patient Education

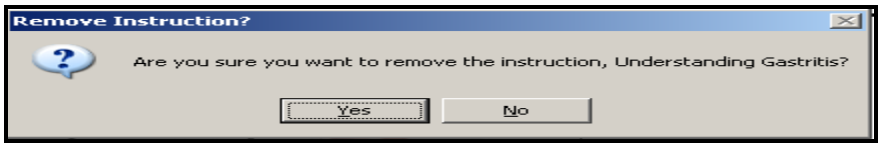
1. Type the diagnosis or condition in the **Search** field. The search results will begin to display in the results window. Type enough information to find the correct education documents. Select English or Spanish in the **Language** field.



2. **Double-click** the instruction in the top right window to add it to the **Selected Instructions** list; the content displays in the viewer to the right. This is what will be saved to the patients discharge instructions. Multiple instructions can be added.



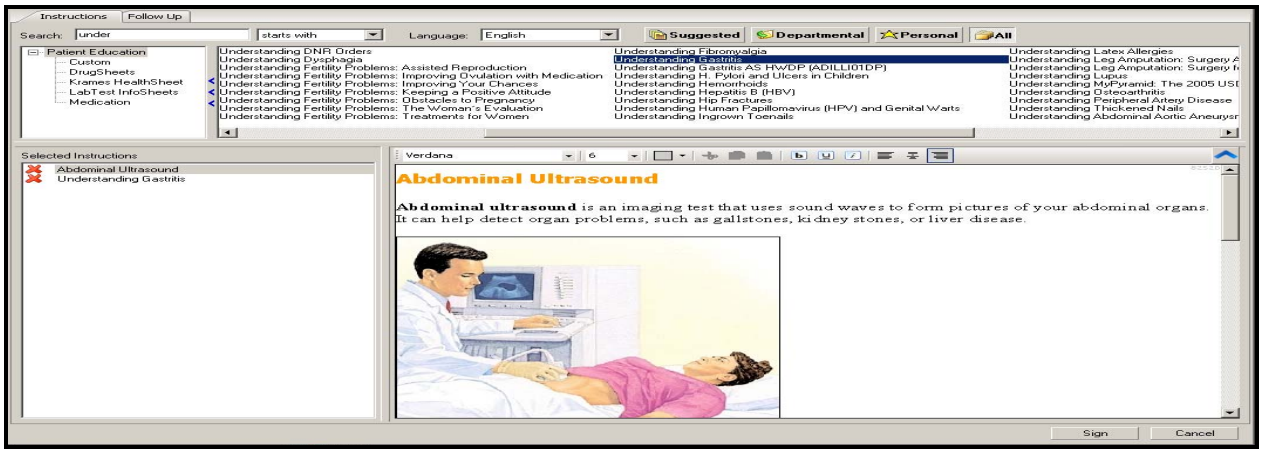
3. To remove an instruction click the **red X** button in the **Selected Instructions** box. You will receive a message box to confirm: Click **yes** to remove the instruction.



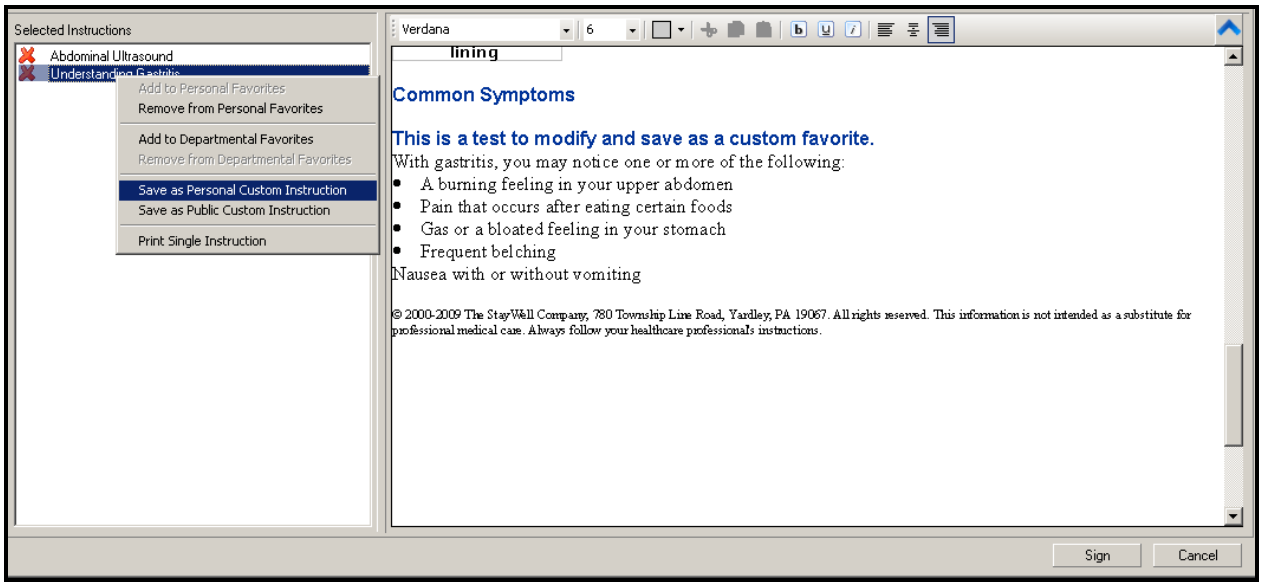
Modifying Discharge Instructions

The ability to modify standard patient education instructions to match patient needs is available in the Patient Education window. To edit patient education instructions, complete the following steps:

1. Select an instruction topic from the instruction list by selecting the instruction or search for a new instruction and add it to the selected list. The selected instruction should display to the right in the Text Editor.



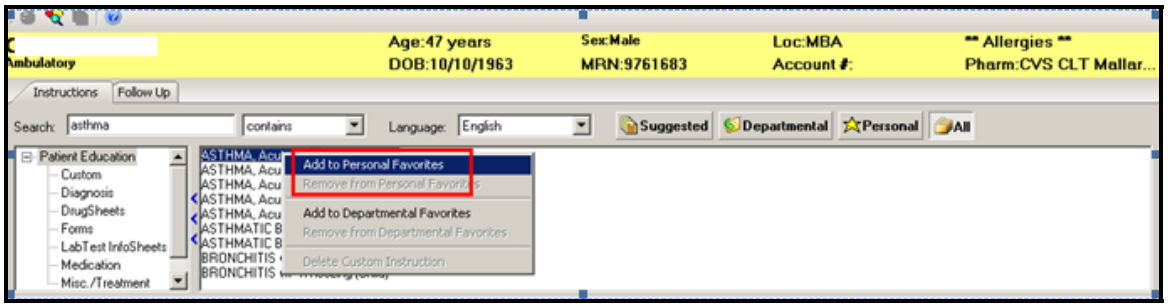
2. **Modify, add, or delete** text using the text editor. Normal word processing functions are available including copy, paste, cut, bold, italicize, and so on.
3. To Save the modify instructions as custom you can right click on the **Selected Instructions** and click on "**Save as Personal Custom Instruction**" Enter the name of the custom instruction and click **OK**.



Note: Modifying the instructions in the text editor does not make permanent changes to the instruction. The modified instructions will only display within this patient's chart.

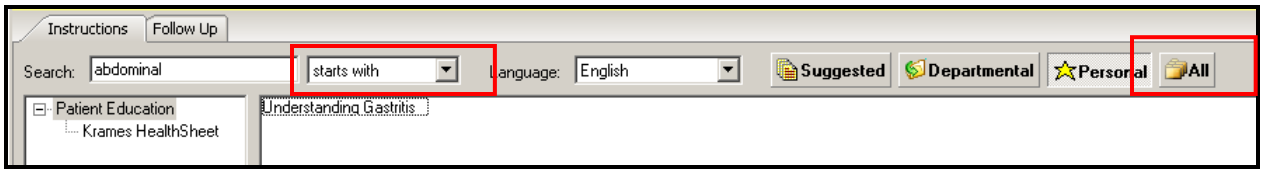
Saving and Deleting Personal Favorites

1. To add an instruction topic to the Personal Favorites:
   - Right-click the instruction in the results window. Click on **Add to Personal Favorites** in the right click menu**.**



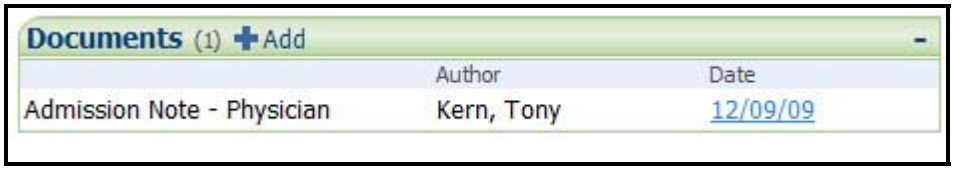
2. To remove an instruction topic from the Personal Favorites
   - Right-click the instruction. This can be done in the Instruction List window or in the Selected Instructions window.
   - Select Remove from Personal Favorites.

3. To view Personal Favorites
   - Click on **Personal** and it will display your favorites.

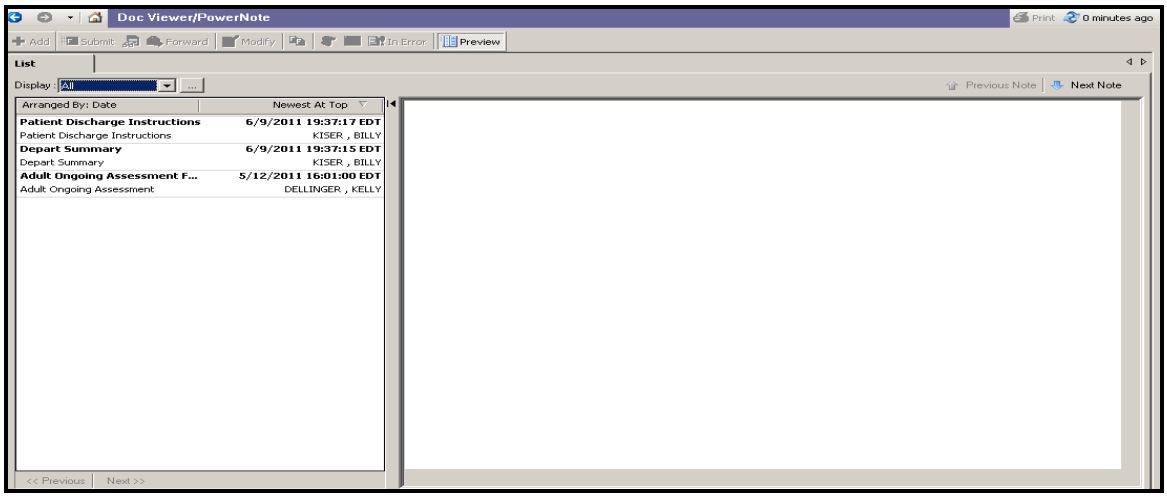


Documents

The Documents Component provides visibility to completed Physician Documentation Powernotes such as: Cardiology Reports, History and Physical, Physician Progress Notes, etc.



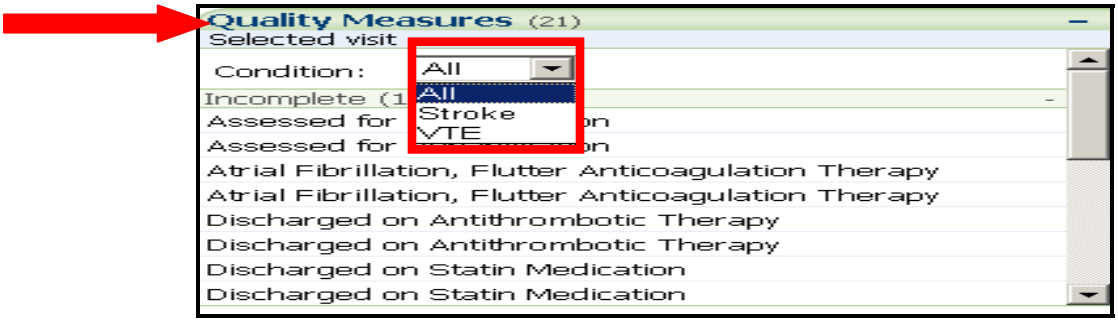
- Clicking on the Title **"Documents"** launches to the Document Viewer/PowerNote Window. Providers can access PowerNotes to Complete or View.



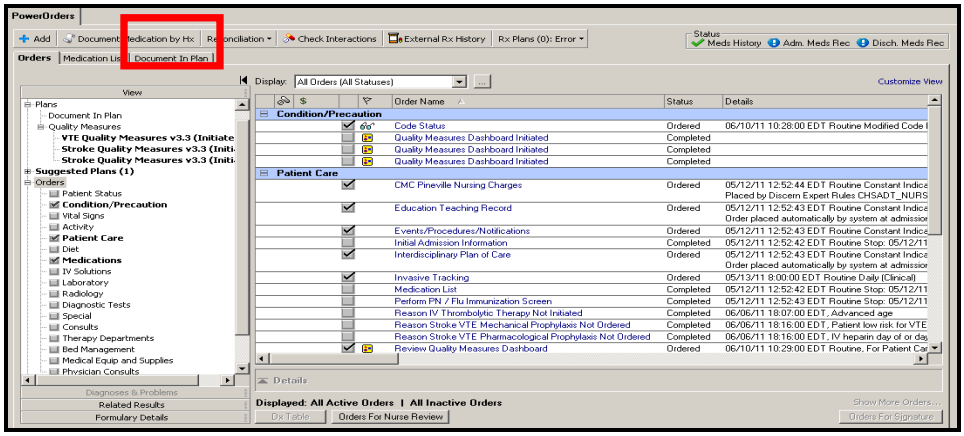
Quality Measures

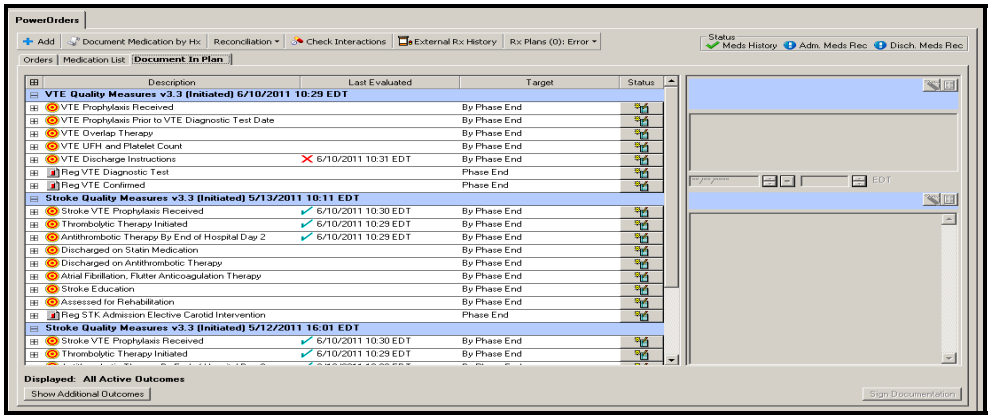
The Quality Measures component provides visibility to quality measures documented. If Quality Measures results have been documented, they will display within the component. If there is no information it will be blank. Currently we have two conditions available for viewing at CHS: Stroke and VTE.

1. Clicking on the title “Quality Measures” will launch into the Orders Profile.



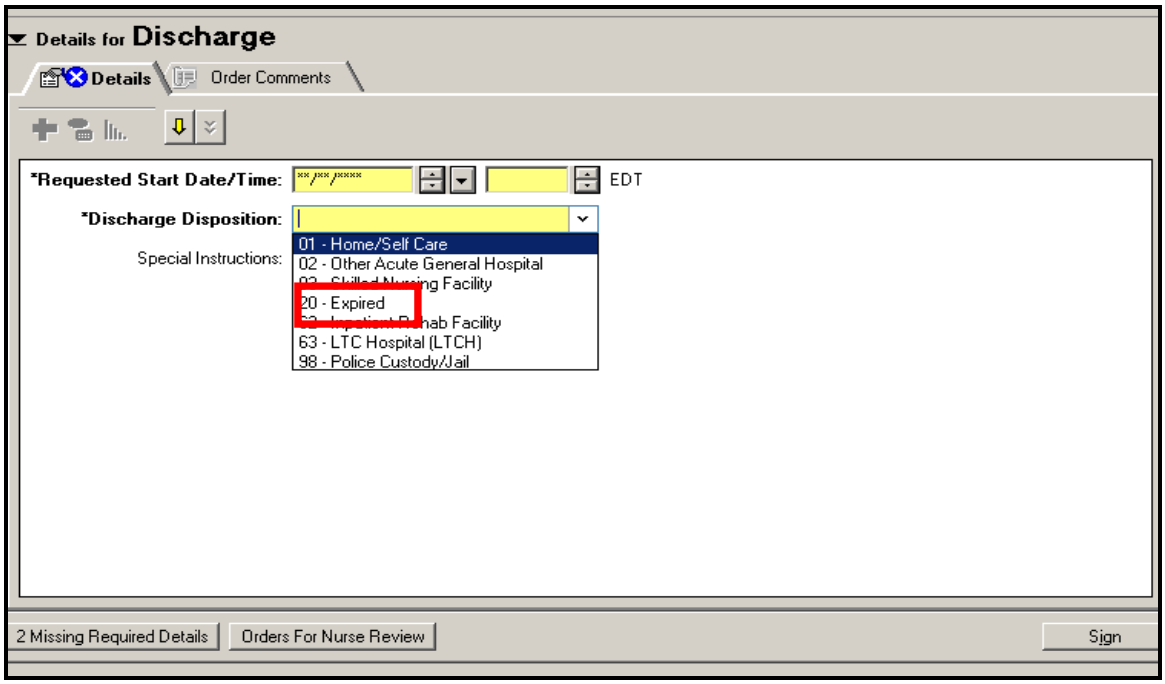
2. To view the Quality Measures PowerPlan, Click on “Document In Plan” Subtab

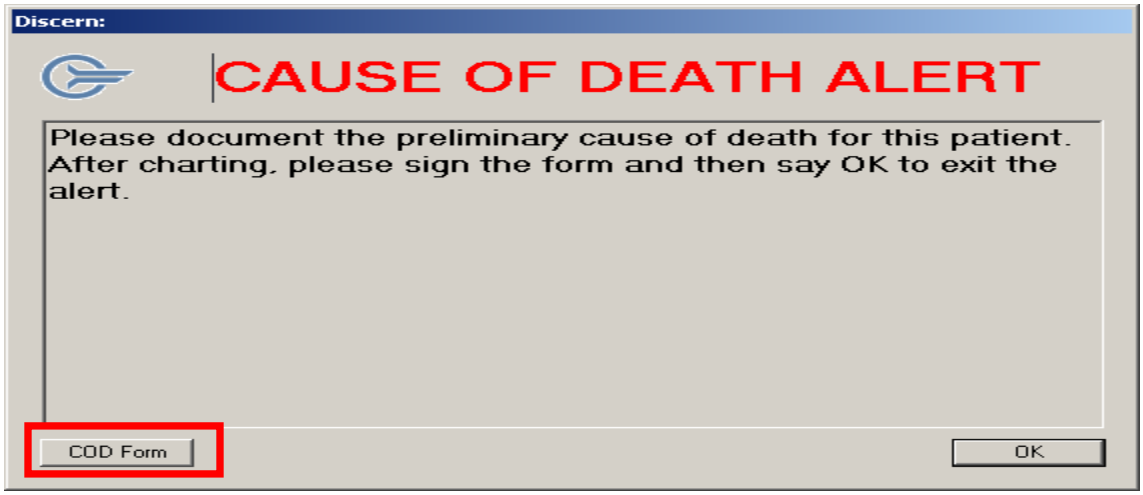




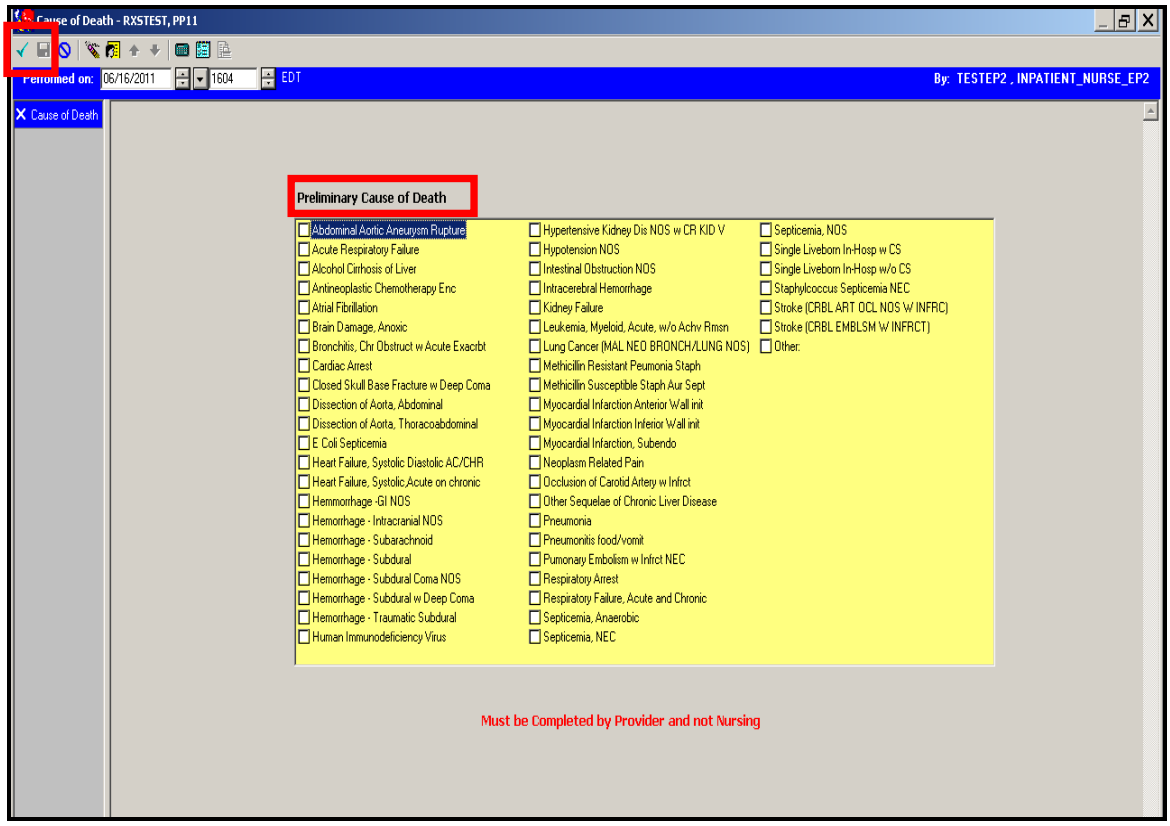
Cause of Death

1. If the patient expires during the course of hospitalization and the Discharge Disposition entered is “Expired” an alert will fire to remind the Provider to complete the Cause of Death Powerform.





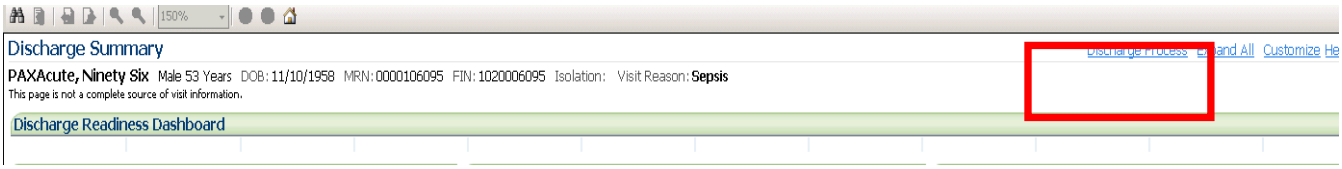
2. The provider will click on the “Death Form” in the alert, which will open the Form. The Provider will click on the response for the preliminary cause of death and click the Green Checkmark to sign the form.



Discharge Summary

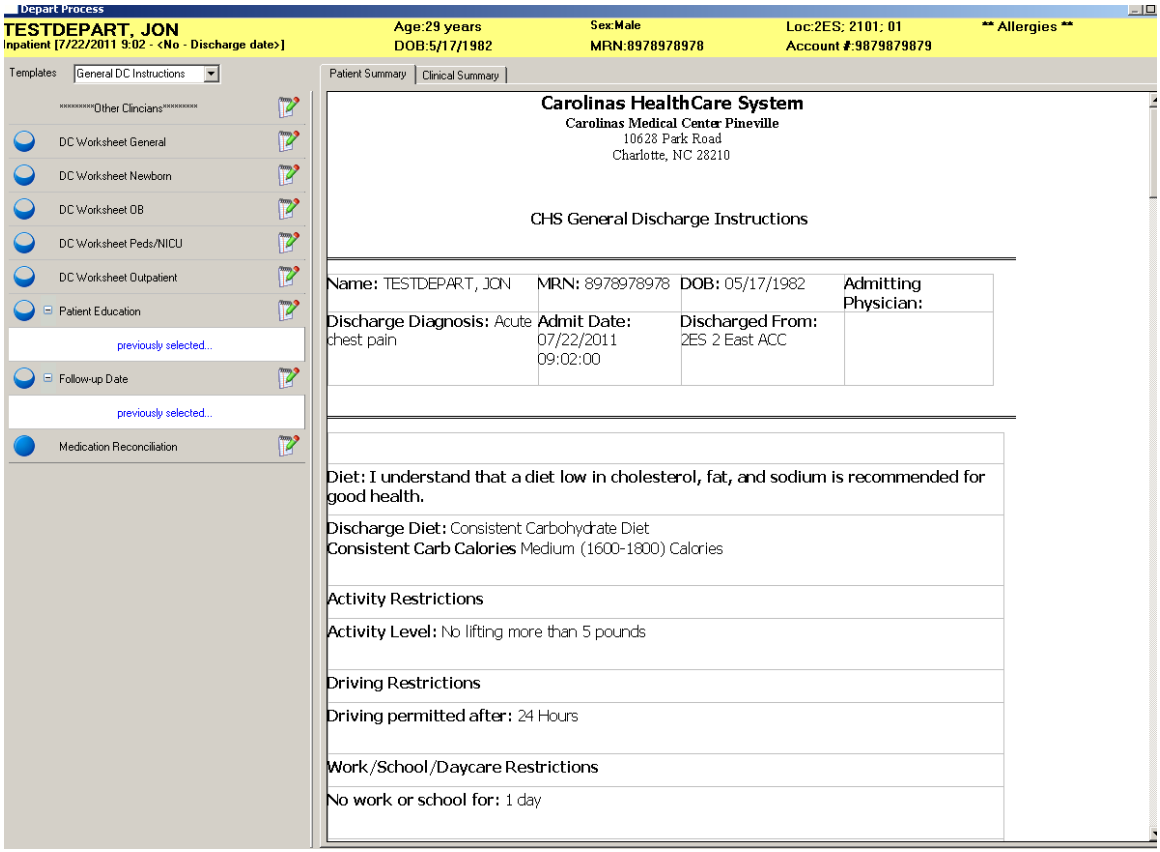
The Discharge Summary component provides visibility to the provider and other clinician’s documentation that has been completed from the Discharge Summary MPAGE and the Worksheets in the Depart Process. If information has been entered via Depart process, the information will display. If no information has been entered, there will be no information displayed.

1. To launch the Depart Process, click on the “Discharge Summary” hyperlink in the upper right hand corner of the screen.



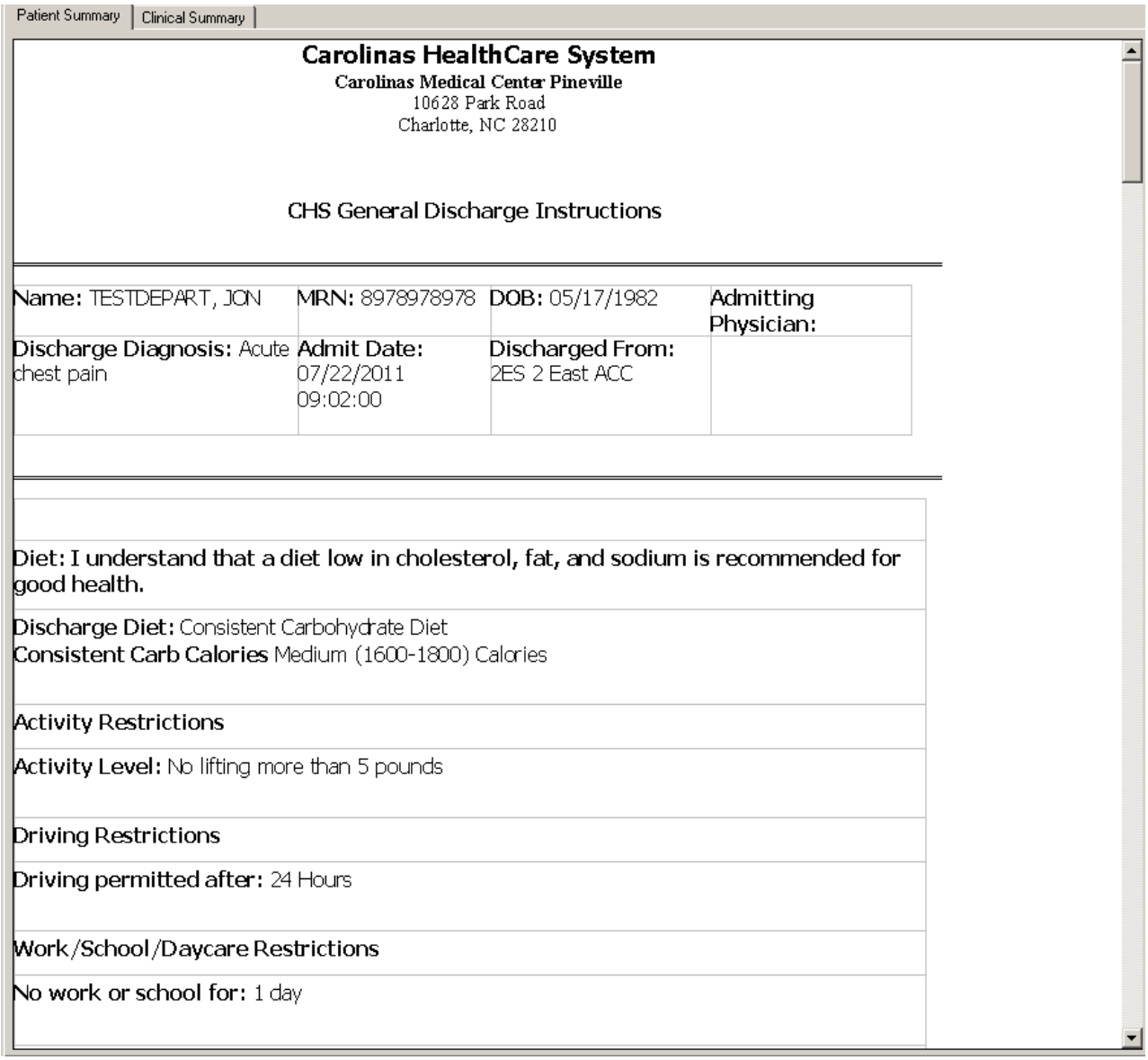
2. To launch the Depart Process, you can also click on the Depart Icon

in the toolbar.
3. The Depart Process Window will then display.



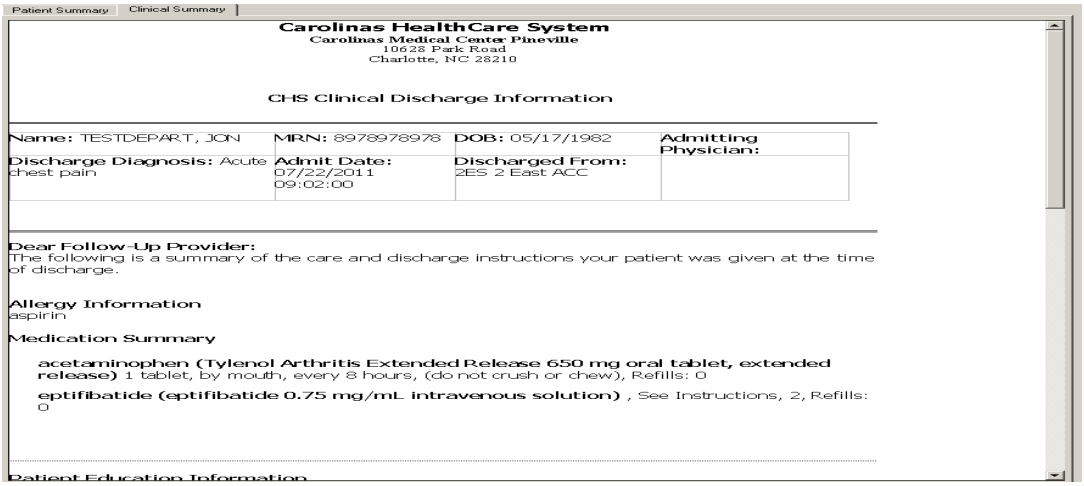
Patient Summary

The Patient Summary tab is the section that will be populated as items are completed from the Discharge Summary MPAGE as well as the Discharge Worksheet in the Navigator sections. The nurse will print the Patient Summary to give to the patient upon discharge.



Clinical Summary

The Clinical Summary tab is the section that will be populated as items are completed from the Discharge Summary MPAGE as well as the D/C Worksheets in the Navigator sections. The Provider may instruct the nurse to forward the Clinical Summary to another Providers Inbox in Message Center once all items have been completed (i.e. the Patient's Primary Care Physician, Referring Physicians, etc)


Patient Summary | Clinical Summary

Carolinas HealthCare System
Carolinas Medical Center Pineville
10628 Park Road
Charlotte, NC 28210

CHS Clinical Discharge Information

Name: TESTDEPART, JON	MRN: 8978978978	DOB: 05/17/1982	Admitting Physician:
Discharge Diagnosis: Acute chest pain	Admit Date: 07/22/2011 09:02:00	Discharged From: 2ES 2 East ACC	

Dear Follow-Up Provider:
The following is a summary of the care and discharge instructions your patient was given at the time of discharge.

Allergy Information
aspirin

Medication Summary

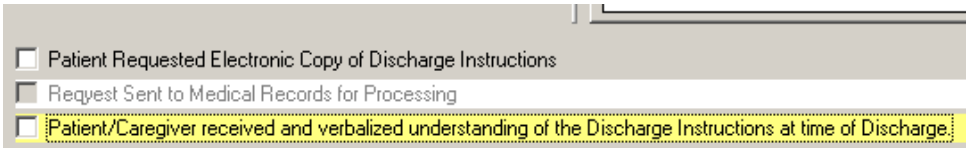
acetaminophen (Tylenol Arthritis Extended Release 650 mg oral tablet, extended release) 1 tablet, by mouth, every 8 hours, (do not crush or chew), Refills: 0

eptifibatide (eptifibatide 0.75 mg/mL intravenous solution) , See Instructions, 2, Refills: 0

Patient Education Information

Completion of the HWDP

1. The nurse will review the entire HWDP and complete the remaining Actions including:
   - Discharge Worksheet
   - Follow Up Appointment Date and Times
   - Additional Patient Education
2. They will confirm all items that were entered in both the Discharge Summary MPAGE and DC Worksheets from the Depart process display in the patient instructions template. They will then Print and Sign the Discharge Instructions.
3. Upon review of the instructions with the patient/caregiver, the nurse will place a check mark in the statement
   - Patient Requested Electronic Copy of Discharge Instructions (if patient requested)
   - Request Sent to Medical Records for Processing (if patient requested)
   - "Patient has received and verbalized an understanding of all discharge instructions given after review with the patient/caregiver(s)."


☐ Patient Requested Electronic Copy of Discharge Instructions
☐ Request Sent to Medical Records for Processing
☐ Patient/Caregiver received and verbalized understanding of the Discharge Instructions at time of Discharge.

• If all information has been entered and ready for the patient, the Nurse will click the **Print at D/C** button to print the discharge instructions and then click **Sign** to give to the patient upon discharge.

6. Social History

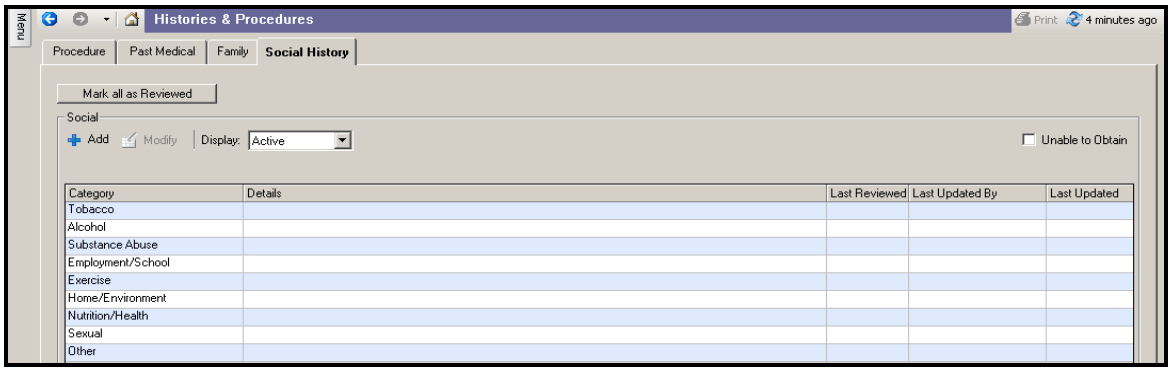
Social History

Patient social history information can be accessed via the Menu in the Organizer View. At this point, social history information can be:

- added (if the patient does not currently have social history information in the EMR),
- reviewed (if no social history information has changed), or
- modified (if information has changed since the patient's last visit).

Accessing Social History

1. Open your patient's chart and select Histories & Procedures from the Menu. Click the Social History Tab to view social history information for this patient.

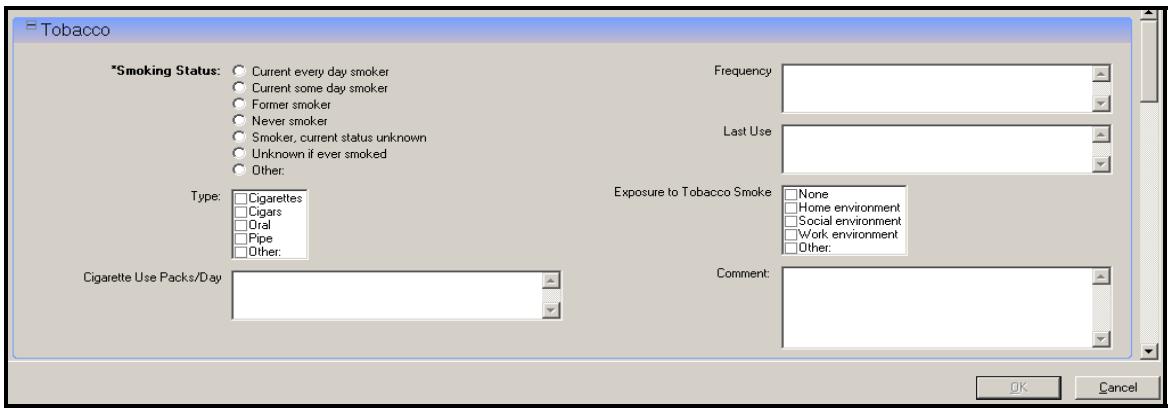


Note: This patient currently has no recorded social history information.

If you are unable to obtain information you can select the **Unable to Obtain** checkbox. The meaningful use requirement to assess the smoking status of this patient will NOT be met if this box is checked. This box is only available if there is no social history information charted for the patient.

2. **Adding new social history information:**

- Click the Add button and the social history control will open in the add mode. Tobacco, Alcohol, and Substance Abuse sections will default open.



- The remaining categories will display collapsed. These categories can be opened as needed by clicking the plus sign:

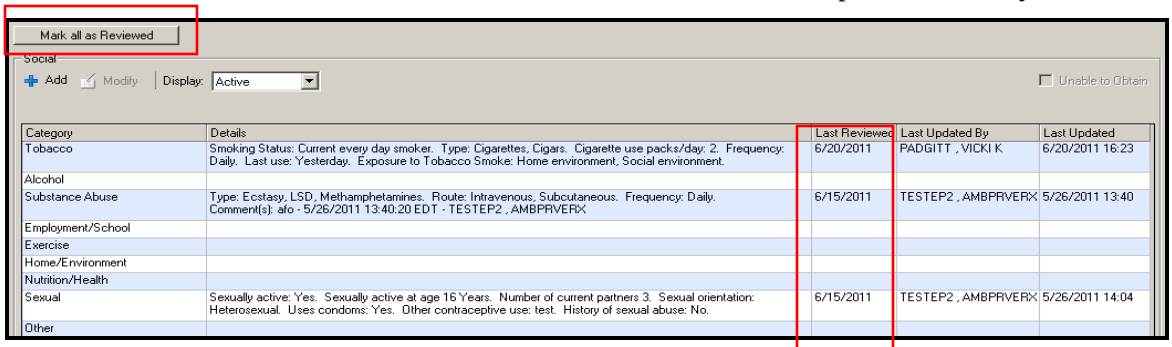
- Chart social history information as appropriate and click the OK button to sign.

Note: The **Add** mode should ONLY be used when nothing has been charted. If social history information is already present and you need to add to or change the existing data, use **Modify** (see step 4 below).

Note: The **Smoking Status** question appears bold and is preceded by an asterisk to indicate that it is a required field. Until this field is addressed, you will not be able to sign the social history section and the OK button will be dithered as in the screen shot above. Recording smoking status for patients 13 years or older is a meaningful use requirement.

3. Reviewing Social History Information

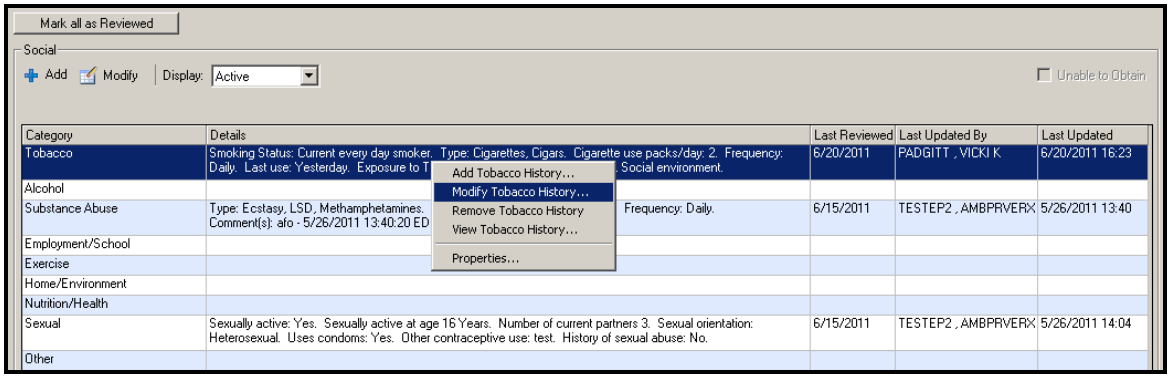
This patient has been admitted to the hospital, and social history information was already captured at a previous visit. Upon review with the patient, no information has changed. In this case, click the Mark all as Reviewed button, and the Last Reviewed column will update with today's date.



4. Updating Social History Information

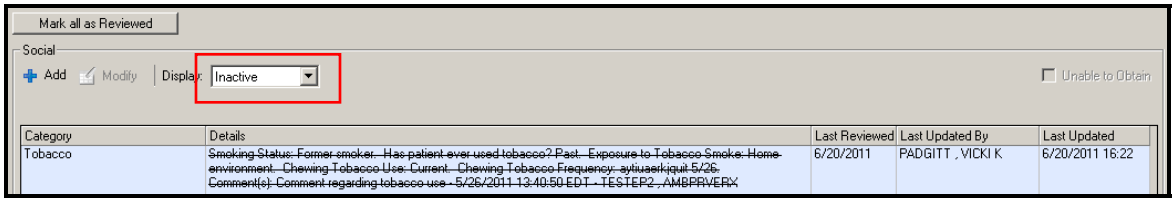
When social history information is already present but the information requires updating, it is important that you modify the existing information. You can modify by:

- Right-click the category you want to update and select **Modify _____ History…**.
- Click to highlight the category you want to update and click the Modify button.



5. Removing (uncharting) Social History Information

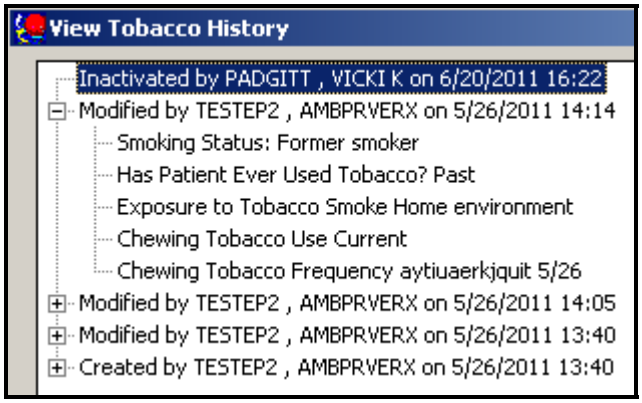
To remove information erroneously charted right-click the category you want to remove and select **Remove _____ History…**. The information will now appear as strike-through text as in the screen shot below:



The information is now inactive, and can be viewed by changing the Display to **Inactive**. Inactive information can also be displayed by right-clicking on a category and selecting **View _____ History…**.

6. Viewing History

The social history control captures a full audit trail of changes and additions. To access history, right-click and select **View _____ History…**.



7. Pulling Social History into PowerNotes

Previously charted Social History information can be pulled into PowerNotes as text.

Note: Social history can be modified from within the note, but changes will NOT write back to the Social History control and will ONLY be visible from within that note.

7. Quality Measures

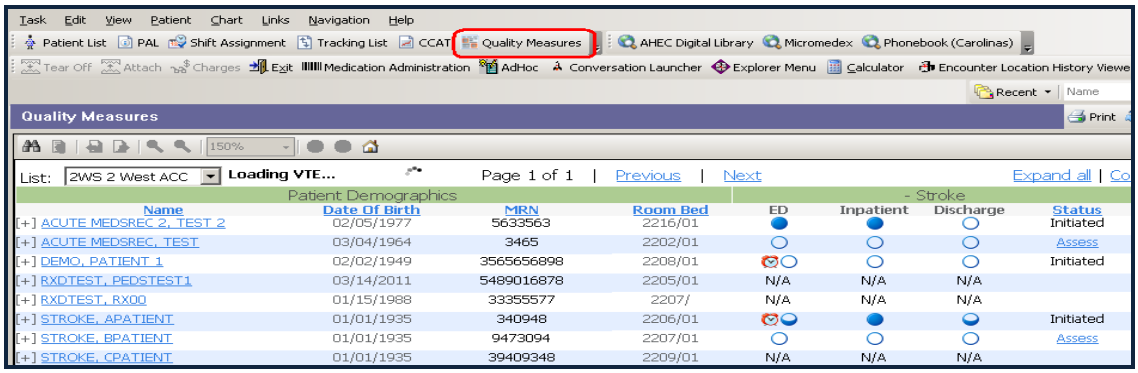
Quality Measures is integrated into the provider or clinician's daily workflow to reduce time reworking and documenting required measures retrospectively. The Quality Measures tool uses concurrent patient lists and pulls in clinical documentation from various aspects of the Electronic Health Record to assist with patient care management decisions to maximize real-time clinical effectiveness.

Benefits

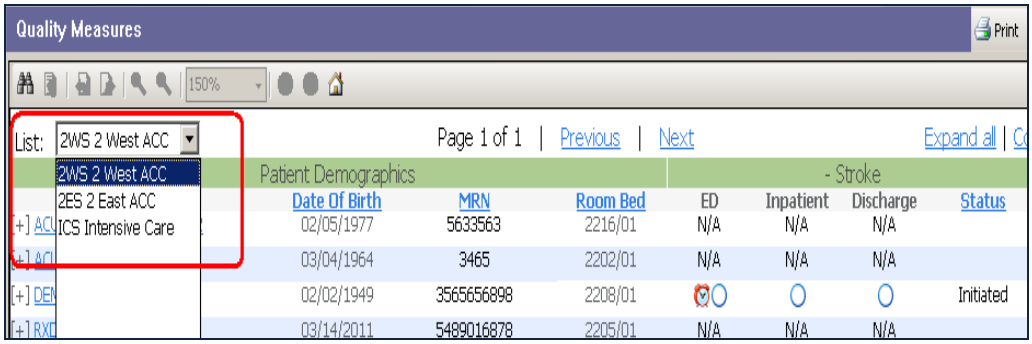
- Provider or Clinician can navigate to the Quality Measures Summary (mPage) for a concurrent snapshot and status of quality measures outcomes/goals.
- The goal is that the Quality Measures Dashboard will be automatically initiated when the Provider places the patient on the appropriate Evidence-Based Care PowerPlan.
- Alerts the Provider or Clinician when patients are identified as possible candidates for Quality Measures based on qualifiers such as relevant diagnoses, lab and radiology orders and results, medications, patient care orders, and clinical documentation.
- Time-sensitive Quality Measures are identified with a red alarm clock icon.
- Pulls in the most recent documentation from throughout the patient's Electronic Medical Record, reducing the need to navigate and search for documented Quality Measures data.
- Alerts the Provider or Clinician to measures that have not been completed on an identified Quality Measure patient.
- Quality Measures goals for Discharge display on the Provider's Discharge mPage, easing the discharge care management process.
- Reduces the instances of Providers and Clinicians having to notify patients of modified care plans post discharge.
- Reduces the Provider's need for dictating Addendums of required documentation after the patient has been discharged.
- Reduces the number of messages the Provider will receive in Message Center requesting additional documentation on patient records.
- Will be updated as new guidelines are adopted for appropriate care management.

Quality Measures Summary

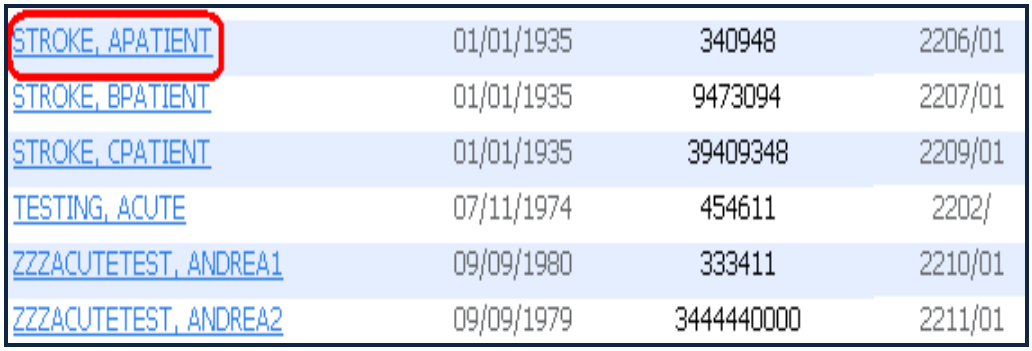
The **Quality Measures Summary** is an mPage designed to assist care providers with monitoring and maintenance of specific Quality Measure sets. The view is executed from the Organizer level in PowerChart by clicking on the Quality Measures icon from the tool bar. Once selected, all patients on the default or selected Patient List (or unit census) will be displayed.



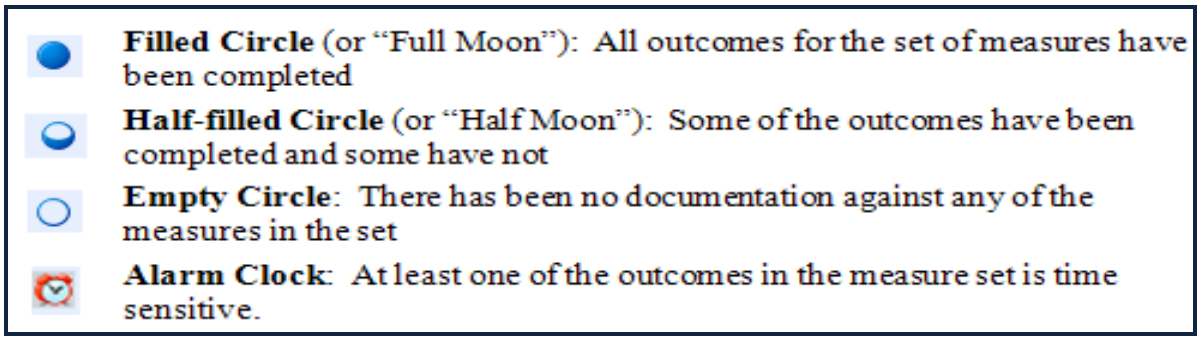
- The default is defined based on the location from where the list is being accessed. For example, a nurse accessing the Quality Measures Summary from a computer on the unit will see the Patient List (unit census) for only that unit. If multiple Patient Lists have been defined for the user, the **List** drop down menu on the Quality Measures Summary can be utilized to select the desired unit.



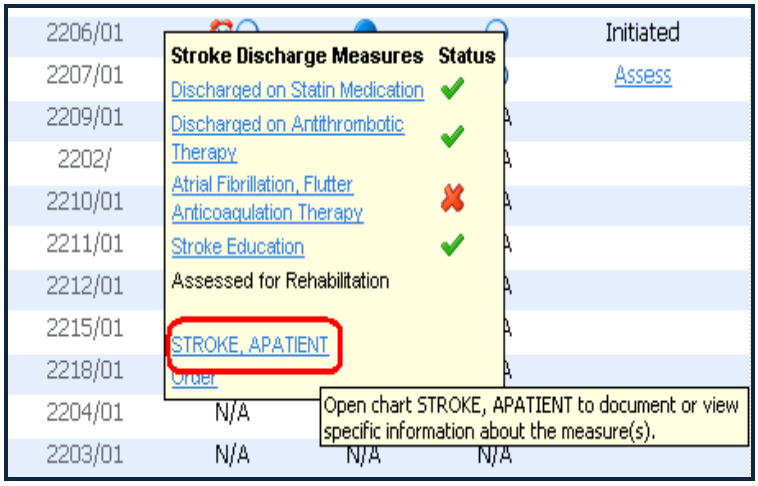
- From the Quality Measures Summary screen, clicking on the patient's name in the Name column will take you directly to that patient's chart.



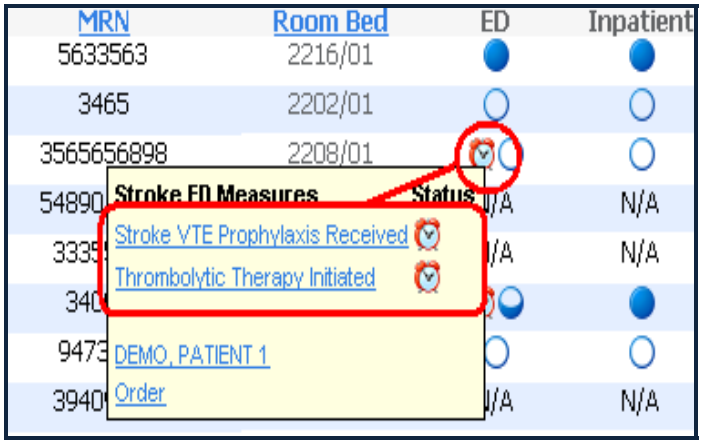
- Icons are used on the Quality Measures Summary to indicate the status of the individual measure or the group of measures in the set.



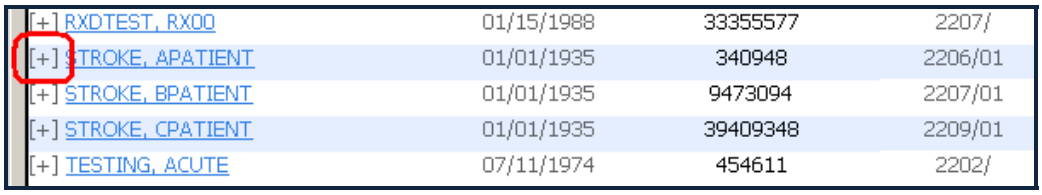
- **Hover** functionality allows you to view more specific information about the measure set by placing or "hovering" the mouse pointer over a specific item on the screen. In the screen print below, hovering over the half-filled circle in the ED column shows a list of criteria, the status (whether or not it has been met) and also provides a link to the patient's chart.



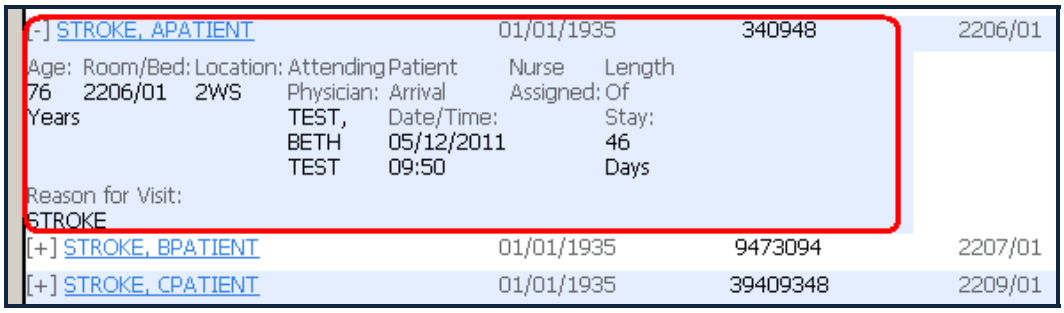
- A red alarm clock beside the status icon indicates that one of the measures is time sensitive and has not yet been completed. Hovering over the alarm clock icon will display exactly which one(s). Once all time sensitive measures have been completed, the alarm clock will no longer be displayed.



- Clicking the + sign beside the patient's name will open a view of the patient demographic information, which includes the



-

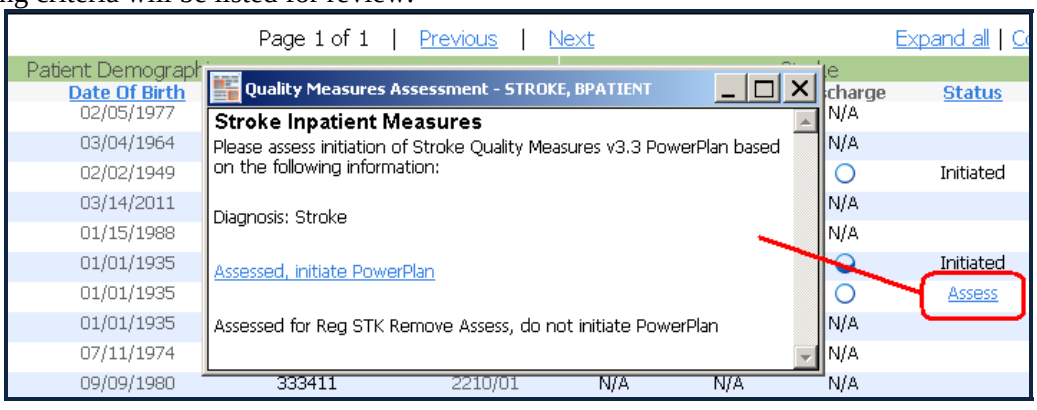


Assess Functionality

The **Assess** functionality on the Quality Measures Summary acts as a safety net to identify patients who might qualify for having a Quality Measures Dashboard (or Outcomes PowerPlan) initiated based on the direction of care and patient results.

- Assess functionality can be triggered based on the existence of specific criteria, such as:
  - Qualifying Problems or Diagnoses (example: CVA, Stroke)
  - Lab results (example: elevated troponin)
  - Clinical results (example: documented administration of warfarin)
  - Orders (example: Athrombics)

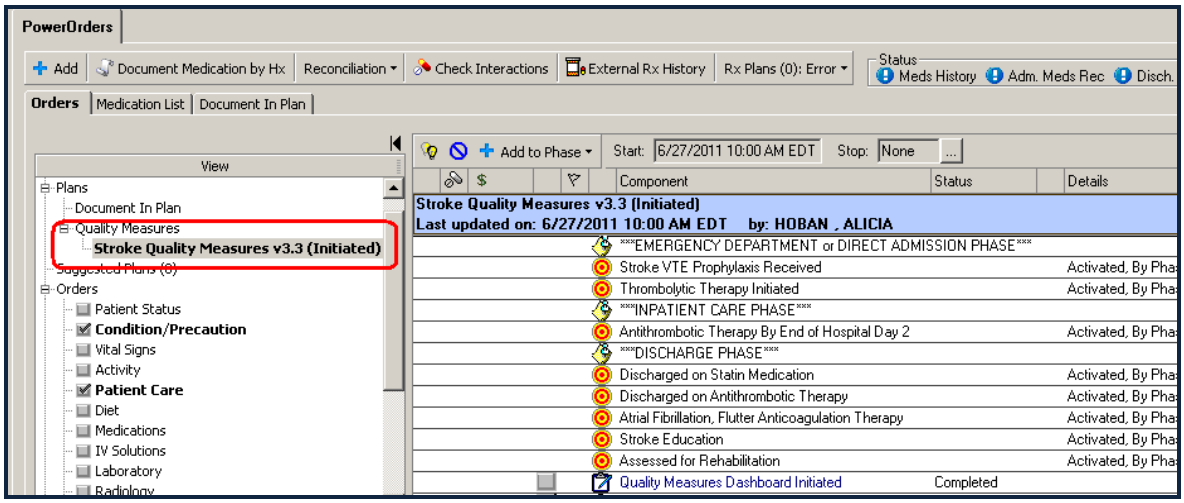
- Clicking on **Assess** in the **Status** column will open the Quality Measures Assessment window, where the qualifying criteria will be listed for review.



- Patients who may have met specific clinical criteria for a quality measure but do not have the Quality Measures Dashboard (or Outcomes PowerPlan) initiated for them are also identified.

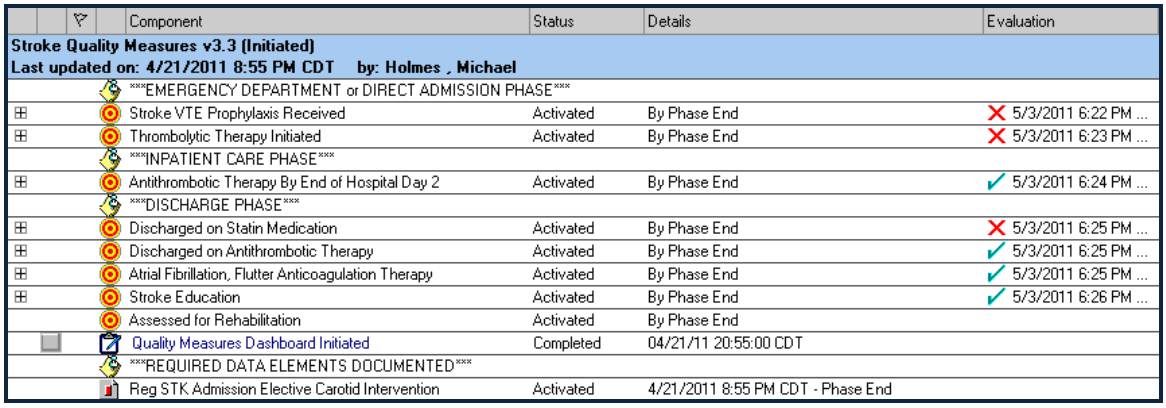
Quality Measures Dashboard (or Outcomes PowerPlan)

The **Quality Measures Dashboard** is initiated by entering the appropriate Quality Measures Outcomes PowerPlan. Once the Quality Measures Dashboard has been initiated, it will be displayed in the Navigator on the left side of the Orders screen in bold type under **Plans** > **Quality Measures** (as shown below).



Dashboard Component Overview

When the Quality Measures Dashboard is selected in the Navigator, the Dashboard components will be displayed in the Order profile area on the right side of the screen. If the Quality Measures Dashboard has been activated and charted on, the profile will display the patient's status for meeting the quality measures for that particular condition.



Plan buttons and icons are located in various places on the screen and provide easy access to Plan/Phase functions. Toolbar buttons access additional functionality.

Goal; Goal Chart In Plan. This icon denotes an outcome of the type Goal or Goal Chart In Plan.

Ordering the Quality Measures Outcomes PowerPlan

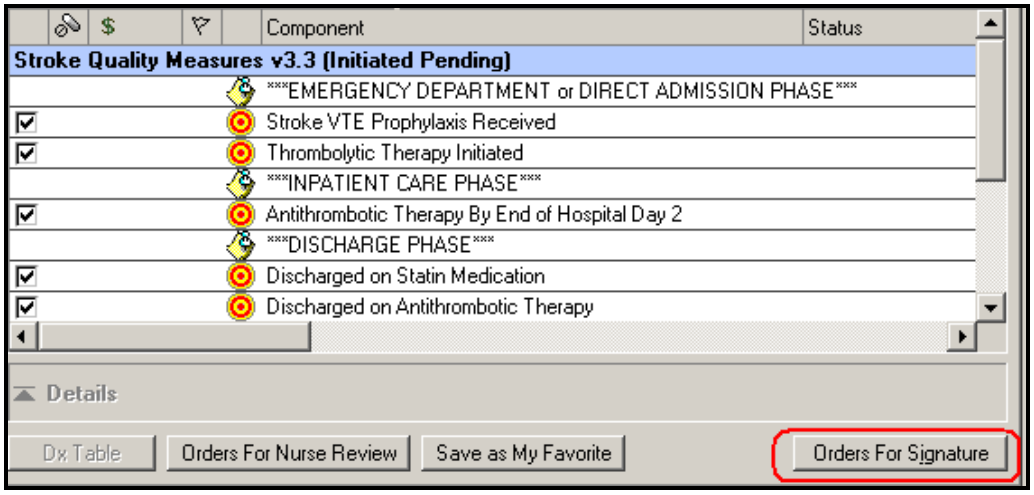
There are presently two Quality Measures Outcomes PowerPlans available:

- VTE Quality Measures v3.3
- Stroke Quality Measures v3.3

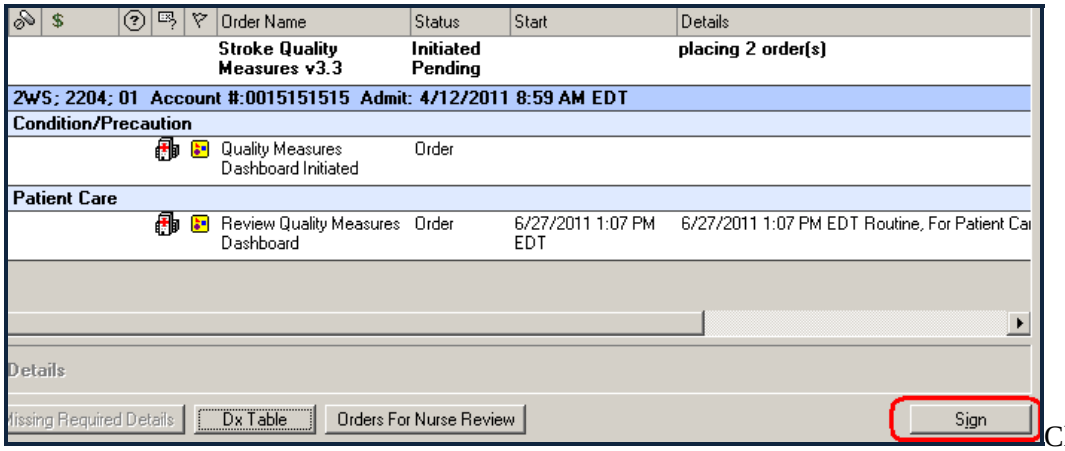
The Quality Measures Dashboard (or Outcomes PowerPlan) can be manually entered just as any other PowerPlan by using the +Add order functionality in PowerOrders.

1. Search for the appropriate plan. (NOTE: You can also locate by changing "Starts with" to "Contains" and entering the word "Quality".)

2. Once entered, the Quality Measures Dashboard components will display; click Orders for Signature.

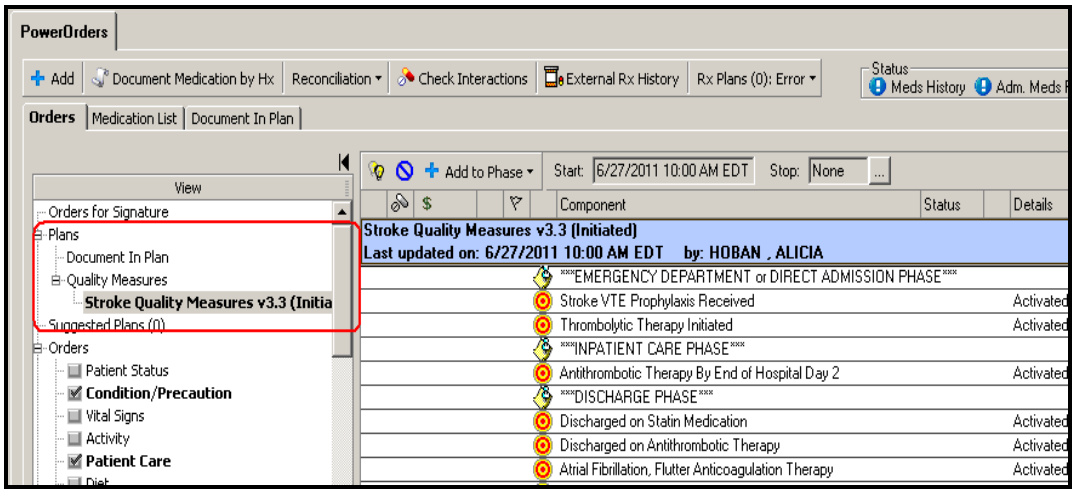


3. The Quality Measures Dashboard Initiated and Review Quality Measures Dashboard orders will display in the Order Profile. Complete any order details, then click Sign.

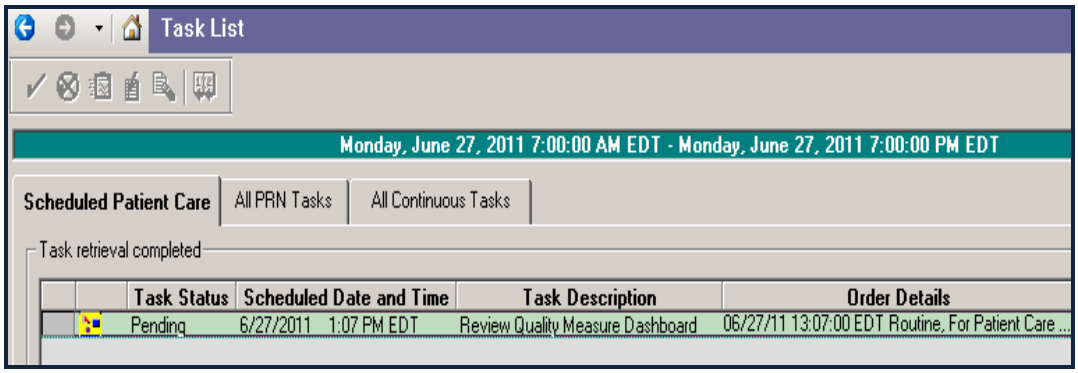


Click the Refresh button

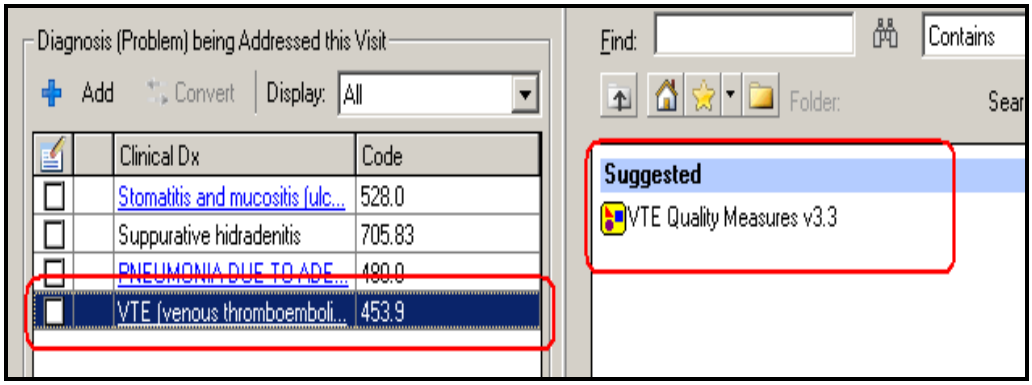
to refresh. The name of the Quality Measures Dashboard now appears in bold text in the Navigator pane under **Plans** > **Quality Measures**.



4. A task (shown below) is also created for nursing as a reminder to review the Quality Measures Dashboard.



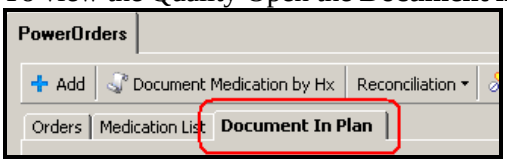
5. The Quality Measures Outcomes PowerPlan can also be entered via the Suggested plan link, which will display as a result of a qualifying Problem or a Diagnosis having been documented. The qualifying diagnosis will display as a blue hyperlink in the diagnosis pane on the +Add orders window. Clicking the link will display the suggested plans in the order panel to the right and the plan can be ordered by clicking to select it.



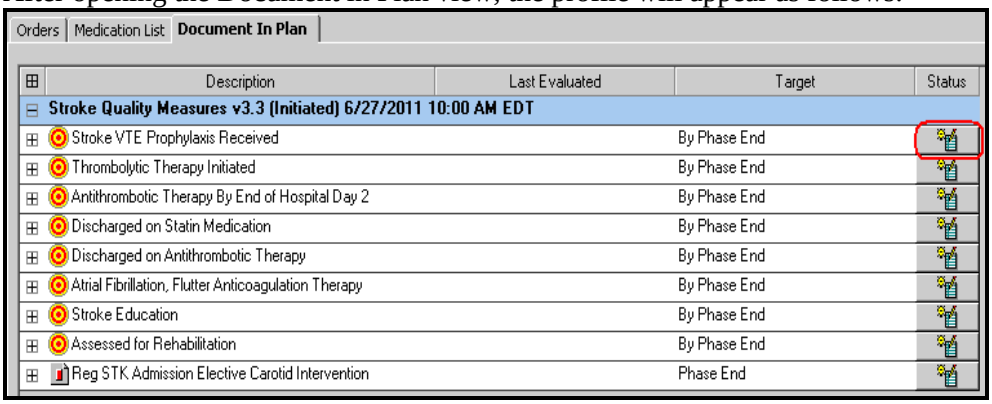
Accessing PowerForms from the Quality Measures Dashboard

Each of the outcomes within the Quality Measures Outcomes PowerPlan has an associated PowerForm that collects data documented within PowerChart (the forms can also be documented on directly, if needed). These PowerForms are accessed from the Quality Measures Dashboard.

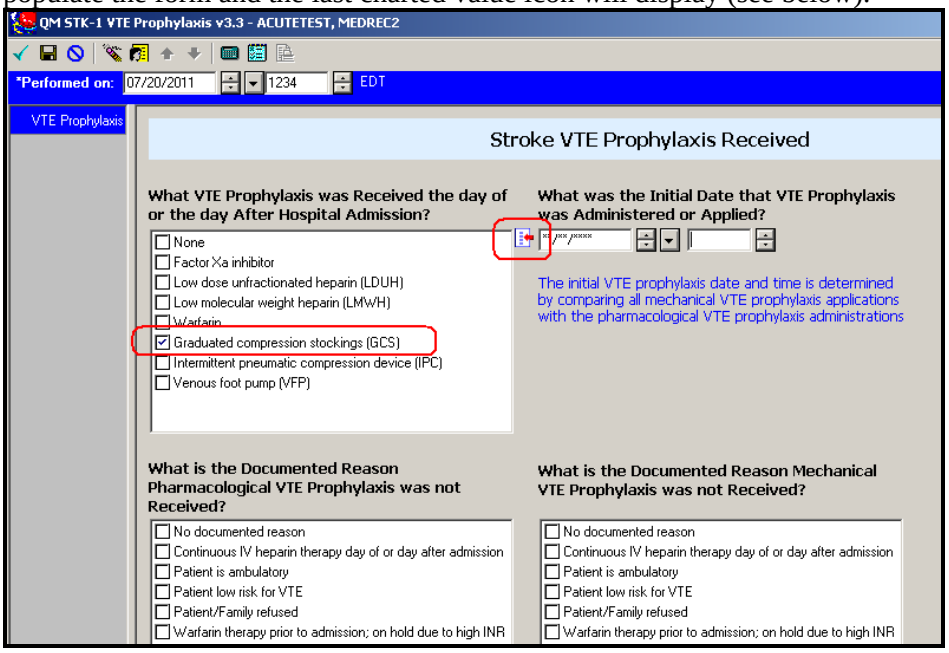
1. To view the Quality Open the **Document in Plan** view by selecting the tab for Document in Plan



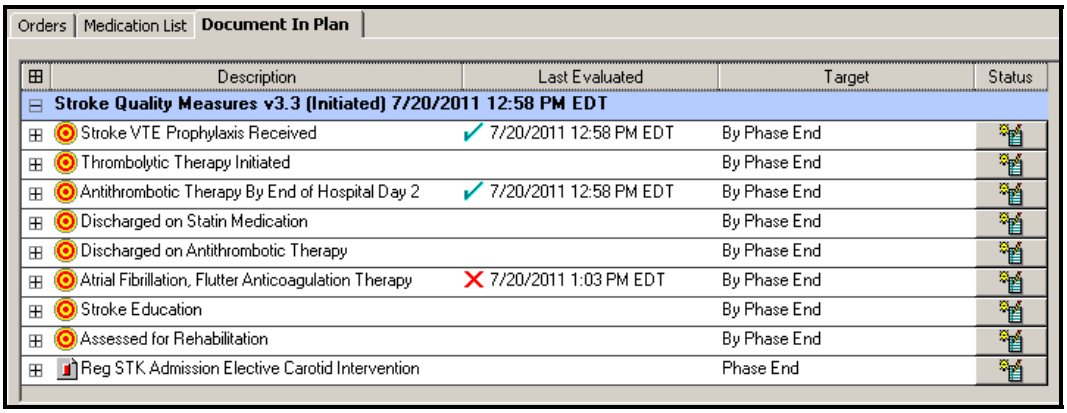
2. After opening the Document in Plan view, the profile will appear as follows:



3. Clicking the Charting icon in the **Status** column to the right of the outcome/goal (see above) will open the associated PowerForm. Any qualifying data that has been documented on the chart will populate the form and the last charted value icon will display (see below).



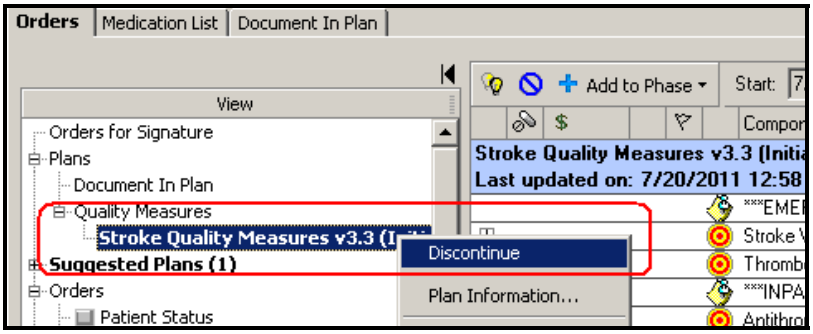
4. As outcomes/goals are met, the Quality Measures Dashboard will be updated with a green check. If an outcome/goal is not met, a red X will display.



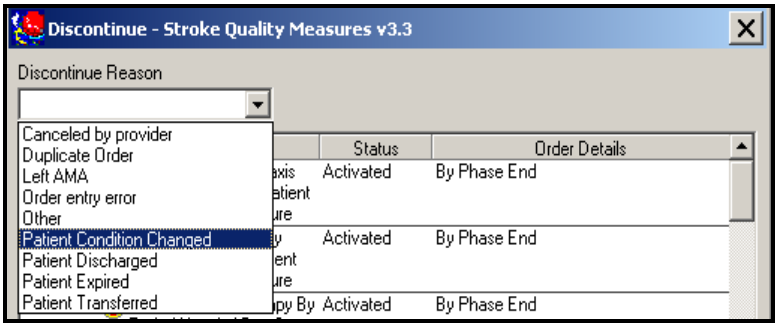
Discontinuing a Quality Measures Dashboard

If necessary, just as any other PowerPlan the Quality Measures Dashboard can be discontinued after it has been placed. For example, you may need to discontinue the Quality Measures Dashboard if it is determined that the patient does not meet the criteria for inclusion in the Quality Measure.

1. From the Navigator pane on the Orders tab, right-click on the appropriate Quality Measures Outcomes Plan and select **Discontinue**.



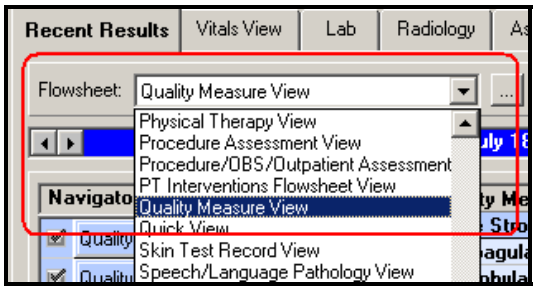
2. The Discontinue Dialog will appear. Select the appropriate Discontinue Reason from the drop down menu.

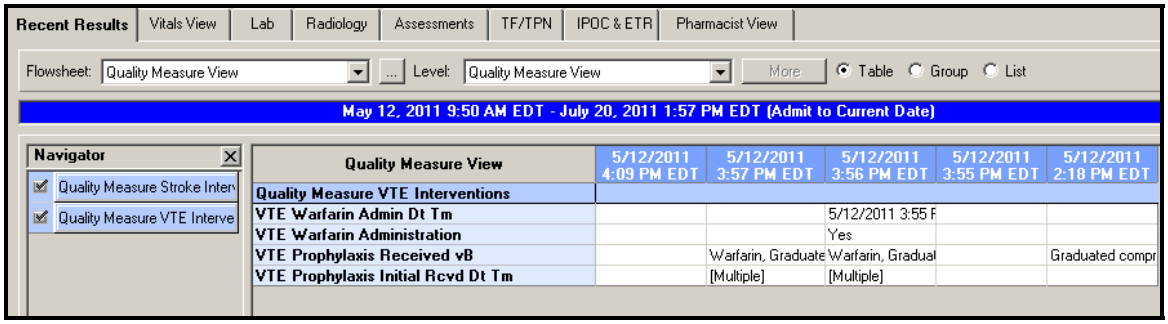


3. Click OK; and on the next two windows click Orders For Signature, then Sign.

Quality Measures View Flowsheet

Results documented for the Quality Measures Outcomes PowerPlan can be viewed from the Flowsheets menu, by selecting Quality Measures View from the Flowsheet drop down menu.


Recent Results
Vitals View
Lab
Radiology
Flowsheet:
Quality Measure View
Physical Therapy View
Procedure Assessment View
Procedure/OBS/Outpatient Assessment
PT Interventions Flowsheet View
Quality Measure View
Quick View
Skin Test Record View
Speech/Language Pathology View


Recent Results
Vitals View
Lab
Radiology
Assessments
TF/TPN
IPOC & ETR
Pharmacist View
Flowsheet:
Quality Measure View
Level:
Quality Measure View
More
Table
Group
List
May 12, 2011 9:50 AM EDT - July 20, 2011 1:57 PM EDT (Admit to Current Date)
Navigator
Quality Measure Stroke Interv
Quality Measure VTE Interve
Quality Measure View
5/12/2011 4:09 PM EDT
5/12/2011 3:57 PM EDT
5/12/2011 3:56 PM EDT
5/12/2011 3:55 PM EDT
5/12/2011 2:18 PM EDT
Quality Measure VTE Interventions
VTE Warfarin Admin Dt Tm
5/12/2011 3:55 F
VTE Warfarin Administration
Yes
VTE Prophylaxis Received vB
Warfarin, Graduate
Warfarin, Gradual
Graduated compr
VTE Prophylaxis Initial Rcvd Dt Tm
[Multiple]
[Multiple]

8. Downtime Process

Downtime Process

- Scheduled Downtimes will be announced via a Newsflash posted on the Physician Connection Page and within the Cerner Announcement Screen when Logging into the Application
- Unscheduled Downtimes will be notified via the Canopy Status Stoplight on the Synapse Intranet site and via an overhead page of a Computer Conference

Downtime Toolkit

1. Each Nursing Unit will be stocked with a downtime toolkit. In the event of a downtime the provider should contact the Unit Secretary or Nurse for needed information.

Paper Items located in the toolkit include

- Paper Progress Notes
- Single Order sheets
- Post Procedure Notes
- Medication Reconciliation Forms
- Discharge Forms
- Prescription Pads
- Restraint Order Documentation

2. Electronic tools available to assist are
    - Past results and charting can be viewed via the Cerner 24/7 View Only Database
    - Evidence Based Ordersets can be printed from the CareLine link located off of Synapse the CHS Intranet.
3. During the Downtime Unit Secretaries will fax the written Pharmacy Orders to the Pharmacy and direct the other written orders to the appropriate departments.
4. Paper MARS will be available.
5. Once the downtime is completed an overhead page will occur indicating the computer conference is completed. All orders which have not been completed or are in the future status will be entered into the system. Pharmacy will enter all pharmacy orders and Unit Secretaries will enter all other orders. The orders will not be entered as PowerPlans but as individual orders. The orders should be entered with a communication type of “Written” and no co-signature request should be generated to the ordering providers.

9. Addendum

ED to Acute Transfer Process

Clinician Responsible for Task	Task/Process
ED Provider	Determines if patient qualifies for possible admission and contacts the Admitting Provider. Enters electronically ***Admit/Change Patient Status*** order. The Admit/Change Patient Status order will include the admitting provider, location, accommodation code, etc.
Inpatient Provider	Makes decision to admit patient
Registration or Secretary	Change the patient type to IP/OBS and place in **ED Virtual Holding Unit** in STAR. If patient going to surgery change the patient type to OPP place in the surgery unit. Note: The ED Snapshot MPage will stop collecting ED orders and data once the patient is changed to an IP patient type. Registration will complete the admission paperwork and change the patient armband. If working from a MPTL, complete the task.
ED Provider and Inpatient Provider	Verify location change in patient's banner bar.

ED RN	Contacts Bed Management / House Supervisor to find inpatient bed for patient. Receives room assignment from bed management / house supervisor and places info in the comments field on the tracking board.
Clinician Responsible for Task	**Task/Process**

Admitting MD	Orders and PowerPlans should be entered when the patient arrives on the correct inpatient unit or placed in the correct inpatient bed. Place orders in a ***"planned"*** status unless must be ***"initiated"*** now. Able to enter inpatient orders while the patient is being held in the ED if the patient is in the ED Virtual Holding Unit. Use **Merge View** functionality when placing inpatient admit PowerPlans to display PowerPlan components with those already ordered for the patient and active on the Orders Profile. Enter Order Details for orders. **Discontinue** orders as needed. **Cancel/Reorder** any orders required for transfer of care which gives the user the ability to cancel an order and replace it with one that can contain the same order details or be modified. This allows the new admitting provider to be the ordering provider. The old order remains on the profile under a new status as well as the new. Use **Add Orders to Phase** (these orders will become part of the Powerplan). Able to perform **Admission Medication Reconciliation**. ED MD also has ability to enter ED Holding/Admit Orders PowerPlan. Must change the Provider on each order to the correct Admitting Provider. These orders will expire after 2 hours and should only be used if the IP provider is not available at all to give orders.

ED RN	Performs any pertinent orders in the ED while awaiting transfer. Completes documentation, enters and administers any stat/now admission med orders or stat/now orders. Completes patient care orders performed by right-clicking on the order and selecting complete.
ED RN	Gives report to receiving unit; completes Admit Conversation on Depart Process when patient leaves the ED.
Clinician Responsible for Task	Task/Process
Registration or Secretary	Transfers patient in STAR to the correct IP/OBS bed.
Admitting Provider	Initiate PowerPlans when patient arrives on IP unit if they are planned and have not been initiated. Perform Admission Medication Reconciliation if not yet completed.
Receiving Inpatient Nurse	Review patient's chart: Orders Profile, MAR Summary, ED Snapshot MPage and Inpatient Summary MPage. Initiates "planned" Admission PowerPlans not initiated by the provider Perform Orders for Nurse Review. Continue with Inpatient Admission Process.

Clinician Responsible for Task	Task/Process
Registration or Secretary	Transfers patient in STAR to the correct IP/OBS bed.
Admitting Provider	***Initiate*** PowerPlans when patient arrives on IP unit if they are planned and have not been initiated. Perform Admission Medication Reconciliation if not yet completed.
Receiving Inpatient Nurse	Review patient's chart: Orders Profile, MAR Summary, ED Snapshot MPage and Inpatient Summary MPage. ***Initiates*** "planned" Admission PowerPlans not initiated by the provider Perform **Orders for Nurse Review.** Continue with Inpatient Admission Process.

Surgery/PACU Transfer Process

Responsible Person	Tasks/Process
Attending	Enter General Patient Orders
Surgeon	Enter PreOp Phase of Multi-Phase Operative PowerPlan • When the surgeon enters the Pre-Op PowerPlan details, the future date/time or use of "offset" functionality can be used if the default of T;N is not appropriate • PowerPlan can be ***planned*** by the Surgeon and ***initiated*** by the Nurse at the appropriate time. • Use ***Add to Phase*** functionality If the provider is planning an outpatient procedure or wished to enter Pre-Op Orders prior to the patient's admission, the provider can call the **Pre-Admit Hotline** for a registered patient encounter. Once the patient encounter has been created the provider can enter the pre-op orders on the patient. These should be ***planned*** and ***initiated*** when the patient arrives for the outpatient procedure. When the patient departs the unit for surgery cancel/dc orders as needed.
Anesthesia	Enter Pre-Op Anesthesia orders.

Nurse	When the patient departs the unit for surgery cancel/dc orders indicated by the provider.
Patient arrives in Pre-Op Area	
Pre-Op Nurse	When the patient departs the PreOp Holding area the Pre-Op Nurse will cancel/dc the Pre-Op Phase of the Multi-Phase Operative PowerPlan (except for the pre-op antibiotic if to be given while in the OR).

Responsible Person	Tasks/Process
Patient in the OR for surgery	
Anesthesia	Enter PACU Anesthesia (pain management) orders and initiate the PowerPlan
PACU Nurse	Enter orders and able to initiate PACU PowerPlans (includes vitals, patient care orders, etc. commonly ordered in the PACU). • **PACU: ADULT Post Anesthesia Care Unit** • **PACU: ADULT ORTH Post Anesthesia Care Unit** • **PACU: PEDS Post Anesthesia Care Unit** Use ***Add to Phase*** functionality to indicate any Post-Op orders the provider would like to be fulfilled while the patient is in the PACU.
PACU Nurse	When the patient departs the PACU, cancel/dc the PACU Orders/PowerPlans. • A communication order within the PowerPlan will indicate to the nurse when it is appropriate for the PowerPlan to be canceled/dc'd.
Anesthesia	When the patient departs the PACU, cancel/dc the PACU Phase of the Anesthesia PowerPlan and orders.

Surgeon	Able to place the Post-Op Phase of the Multiphase Operartive PowerPlan in a ***planned*** status prior to surgery. Surgeon will ***initiate*** this phase of the plan when the patient arrives on the inpatient unit. • Nursing can ***initiate*** this phase of the PowePlan when the patient arrives on the unit per instructions from the Surgeon or per hospital policy. Address Medication Reconciliation post-operatively. All medications must be addressed during the Transfer Med Rec process.
Patient arrives on Nursing Unit	
Nurse	Patient Care continues for Post-Op patient. • Nurse ***initiates*** PowerPlans not initiated by the provider • Reviews chart in PowerChart • Performs Orders for Nurse Review

Case Management Message Templates

Phase II Case Management Message Templates

Messages will replace several paper forms including

1. "CCM Discharge Planning Notification" messages,
2. "CDMP Severity-Complex Worksheet" (CCM CDI Audits)
3. "Physician Advisory Form" messages to Dr. Fanning,

Templates have been made available to make it easier to document these.

1. CCM Discharge Plan Notification (blue sheet) – This is an FYI to the provider and will no longer be charted on paper.

CLINICAL CASE MANAGEMENT DISCHARGE PLAN NOTIFICATION

AT THIS TIME, BASED ON THE INPUT FROM THE INTERDISCIPLINARY TEAMS, CASE MANAGEMENT HAS ESTABLISHED THE FOLLOWING DISCHARGE PLAN:

_ 1. No needs identified. Please consult CCM if needed.

_ 2. Home Health

_ 3. DME

_ 4. Acute Inpatient Rehab

_ 5. Skilled Nursing Facility

_ 6. Assisted Living

BASED ON THIS PLAN, PLEASE COMPLETE THE FOLLOWING:

_ 1. Dictate d/c summary on Stat line. Include medications with dose and frequency. (Include confirmation # in progress notes)

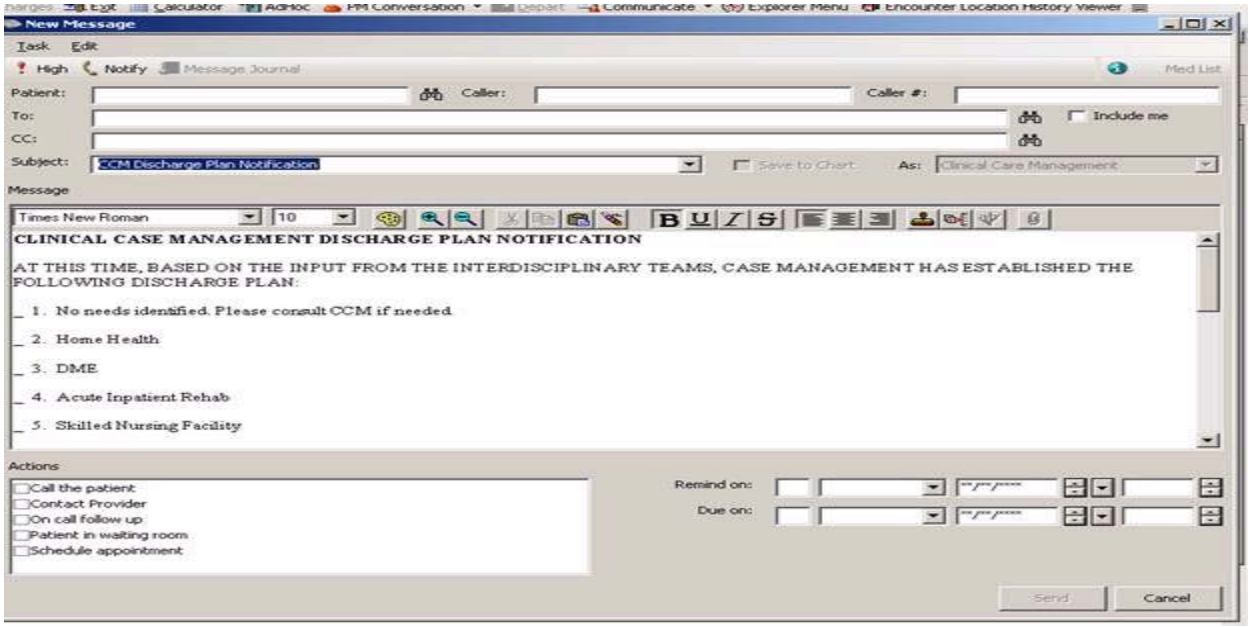
_ 2. Sign FL2 (placed in progress notes)

_ 3. Sign Golden Rod (placed in progress notes)

_ 4. Sign Wound Vac form (placed in progress notes)

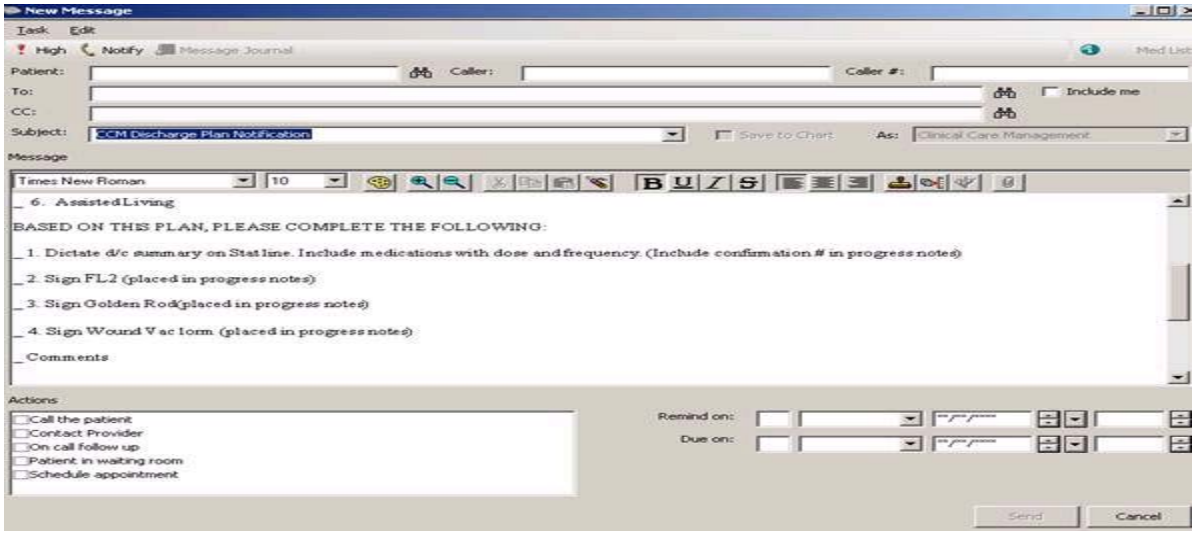
_ Comments

When creating a new message, change the subject to “CCM Discharge Plan Notification” and the template will automatically insert into the message’s body. Also notice the “As:” field automatically changes to “Clinical Care Management”. This message will be saved as that Note Type instead of “Message Center Note” which is the default for blank messages.



Remember to check “Save to Chart”.

If necessary you can set a reminder and/or a due date and you can use the Notify button to receive a notification either when the message is Opened or when it is overdue and not opened.

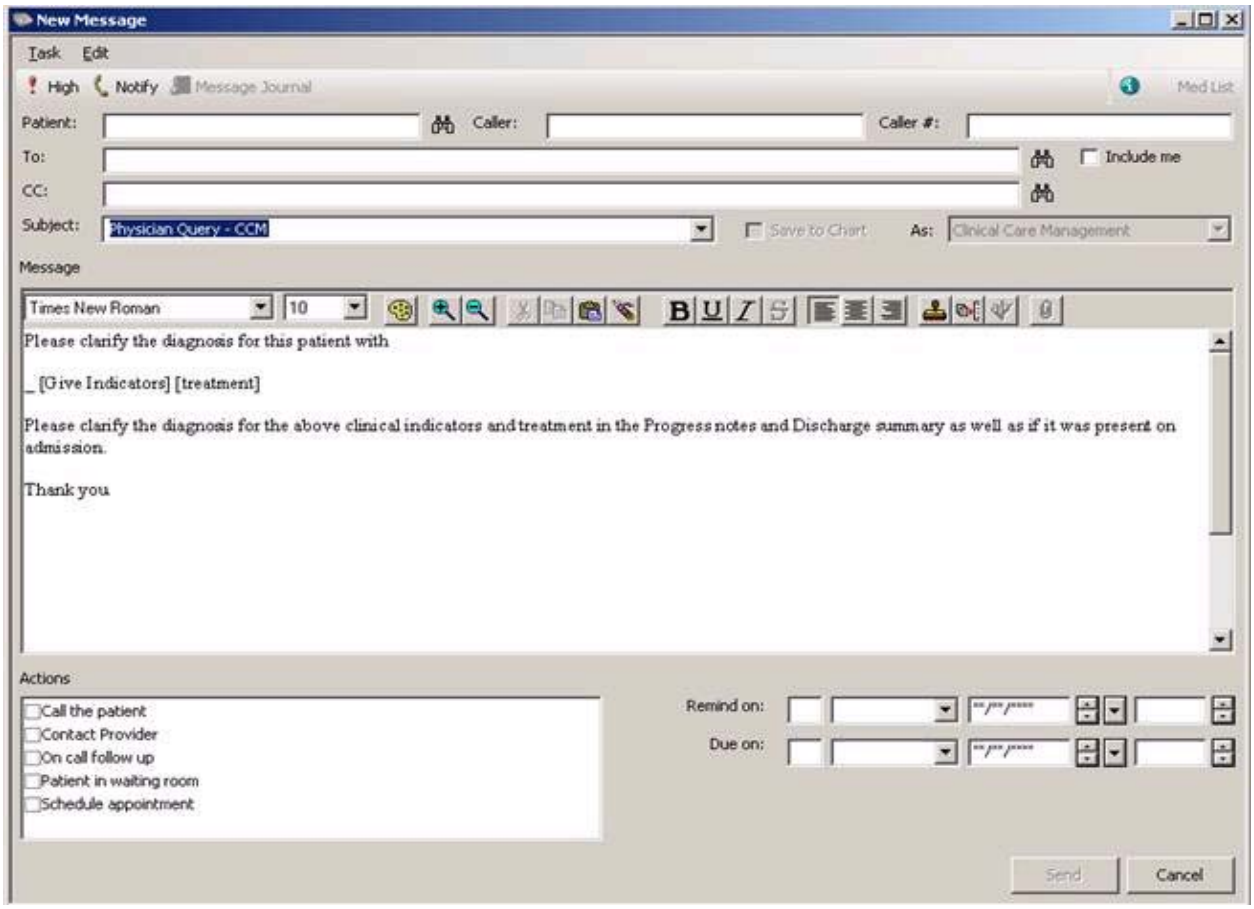


2. CCM CDI Audits (CDMP Severity Complexity) - The form currently prints from CDMP but staff still have to type out the entire question. Staff can send the provider a message with this information, the provider will enter the information into the PowerNote or update their dictated report and the staff can view the documents or powernotes as well as audit their sent messages to follow up with providers. Providers will be trained to respond "entered in PowerNote".

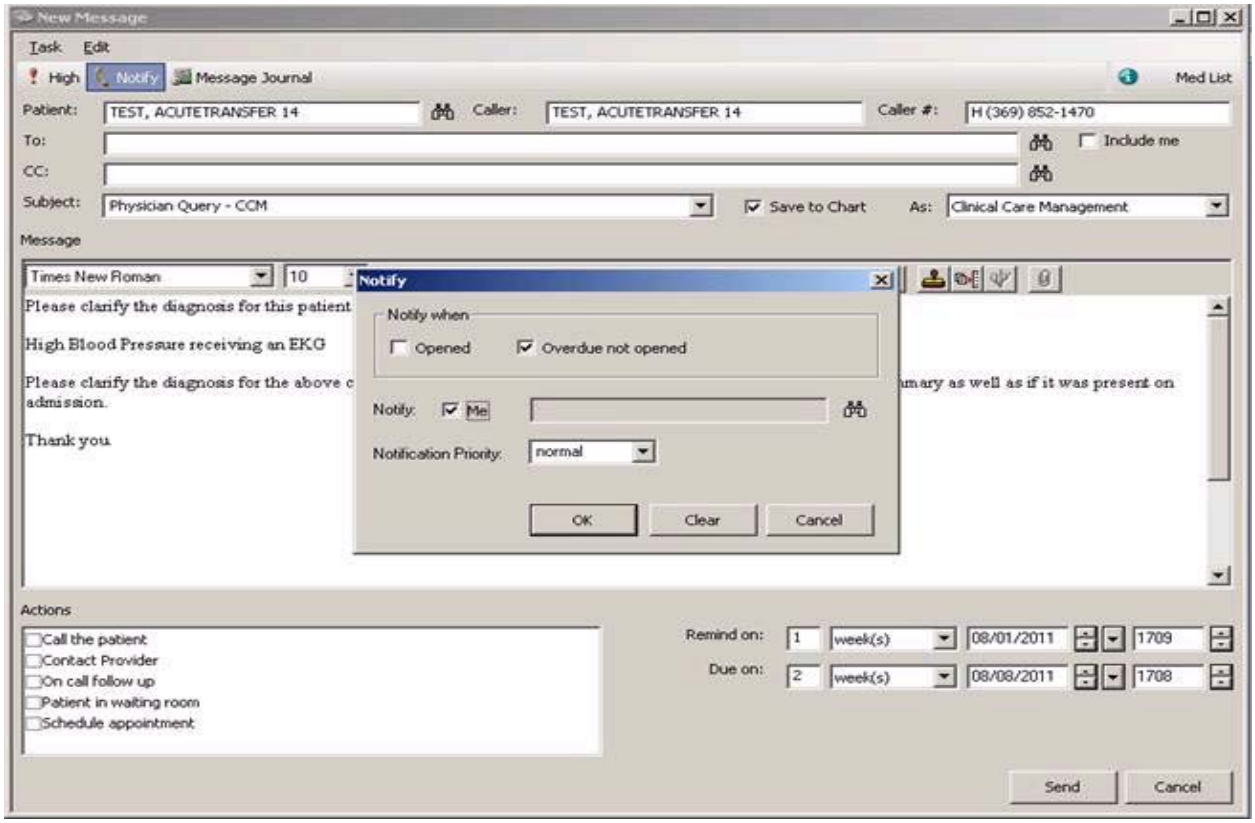
Please clarify if the patient has _

Please document the diagnosis in the Progress Note and Discharge Summary.

Thank you.



You need to enter the indications and treatments in the message where indicated.



3. Physician Advisor form – indicates patient to be admitted as inpatient or observation patient. Currently Dr. Fanning signs all of these and manually faxes back for CMC, Mercy, Pineville, university and some at NorthEast. May be able to use a template in Message Center for him to electronically sign.

Utilization Review Determination Form

Case Management Committee

MEDICARE ONLY

Section 1:

Reason for Physician Advisor Referral:

_ Does not meet screening criteria for admission. Date:

_ Does not meet screening criteria for continued stay. Dates:

_ Does not meet discharge screening criteria. Date:

Additional information:

_

Based on InterQual screening criteria, the patient's status meets: _ Inpatient _ Outpatient _ Observation status

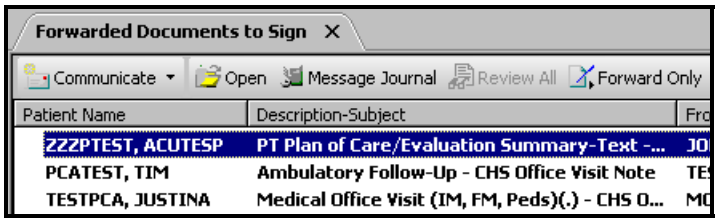
I have reviewed this case with the patient's treating physician, Dr. _ and the physician

_ agrees _ disagrees with this change in status. _ He/she is aware of the referral to the Physician Advisor and has been notified to contact the Case Management Department.

Rehab Plan of Care Review & Approval for Inpatient Medicare Observation Patients

- This process will enable physicians to electronically approve and sign the inpatient Medicare Observation Plan of Care certifications by using Message Center.

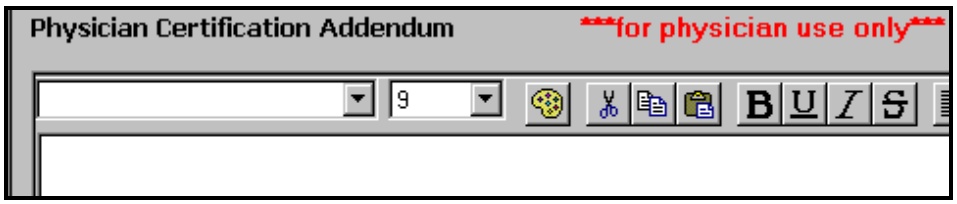
- PT, OT and Speech **Plan of Care** Certifications can be reviewed and signed through message center. These certifications will be in the **Forwarded Documents to Sign** folder.



- If modifications to the **Plan of Care** are **not** necessary then,
  -Sign and forward back to the therapist.

- If modifications to the **Plan of Care** are necessary then,
  -Right click within the document and select modify.
  -The Plan of Care PowerForm will open in modification mode.
  -Click on the Medicare Certification section.

- Enter any modifications in the Physician Certification Addendum box



- Choose the green checkmark to sign the form.
- Forward document back to the therapist.

Section 11:

As a physician advisor of the Case Management Committee, I _ have/have not discussed this case with the treating physician and determined that the patient status should be: _ Inpatient _ Outpatient _ Inpatient –bill Part B only _ Observation status.

Additional information:

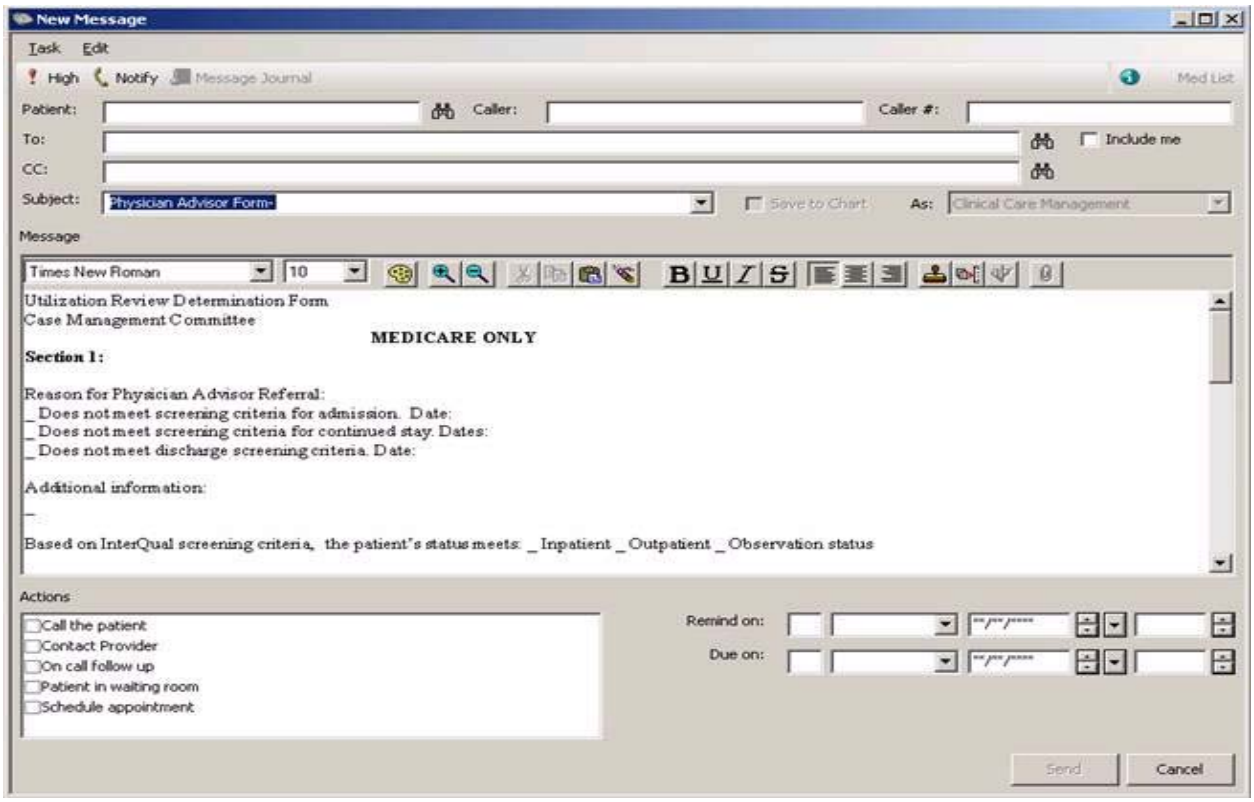
_

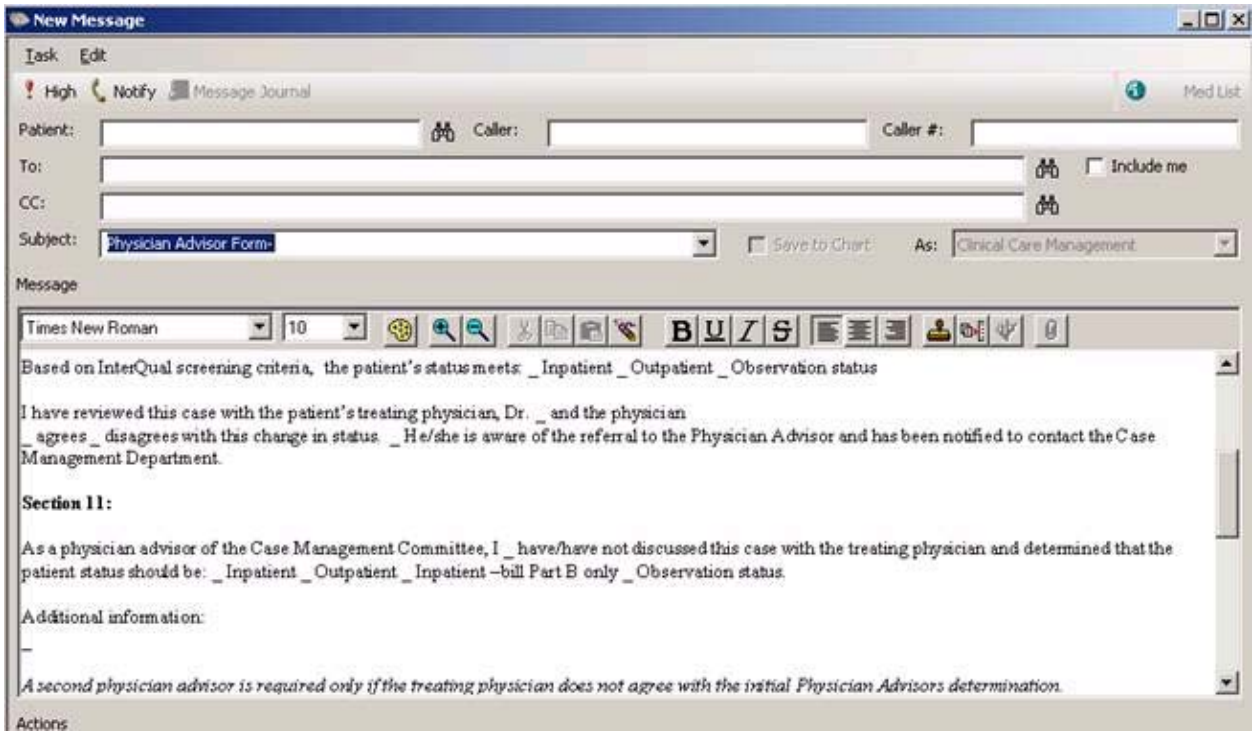
A second physician advisor is required only if the treating physician does not agree with the initial Physician Advisors determination.

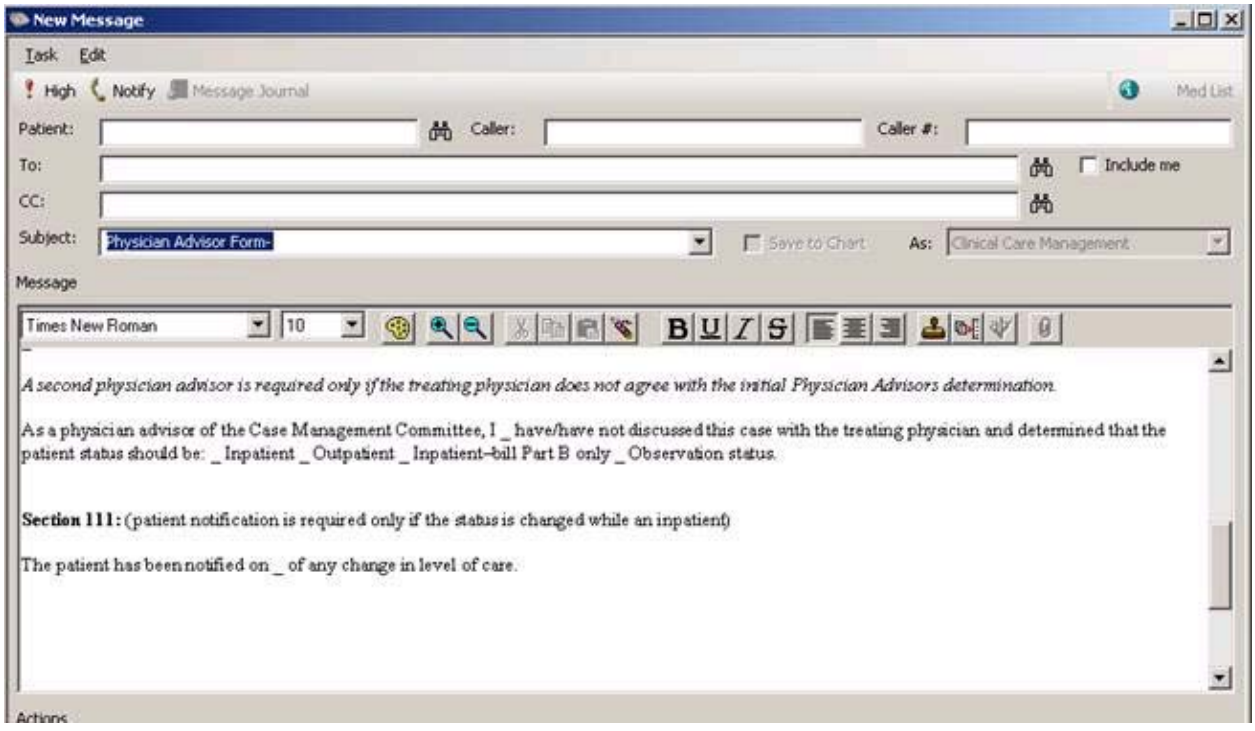
As a physician advisor of the Case Management Committee, I _ have/have not discussed this case with the treating physician and determined that the patient status should be: _ Inpatient _ Outpatient _ Inpatient–bill Part B only _ Observation status.

Section 111: (patient notification is required only if the status is changed while an inpatient)

The patient has been notified on _ of any change in level of care.




New Message
Task Edit
High Notify Message Journal Med List
Patient: Caller: Caller #:
To: Include me
CC:
Subject: Physician Advisor Form- Save to Chart As: Clinical Care Management
Message
Times New Roman 10
Based on InterQual screening criteria, the patient's status meets: _Inpatient _Outpatient _Observation status
I have reviewed this case with the patient's treating physician, Dr. _ and the physician
_ agrees _ disagrees with this change in status. _ He/she is aware of the referral to the Physician Advisor and has been notified to contact the Case Management Department.
Section 11:
As a physician advisor of the Case Management Committee, I _ have/have not discussed this case with the treating physician and determined that the patient status should be: _ Inpatient _ Outpatient _ Inpatient –bill Part B only _ Observation status.
Additional information:
_
A second physician advisor is required only if the treating physician does not agree with the initial Physician Advisors determination.
Actions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Message
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_
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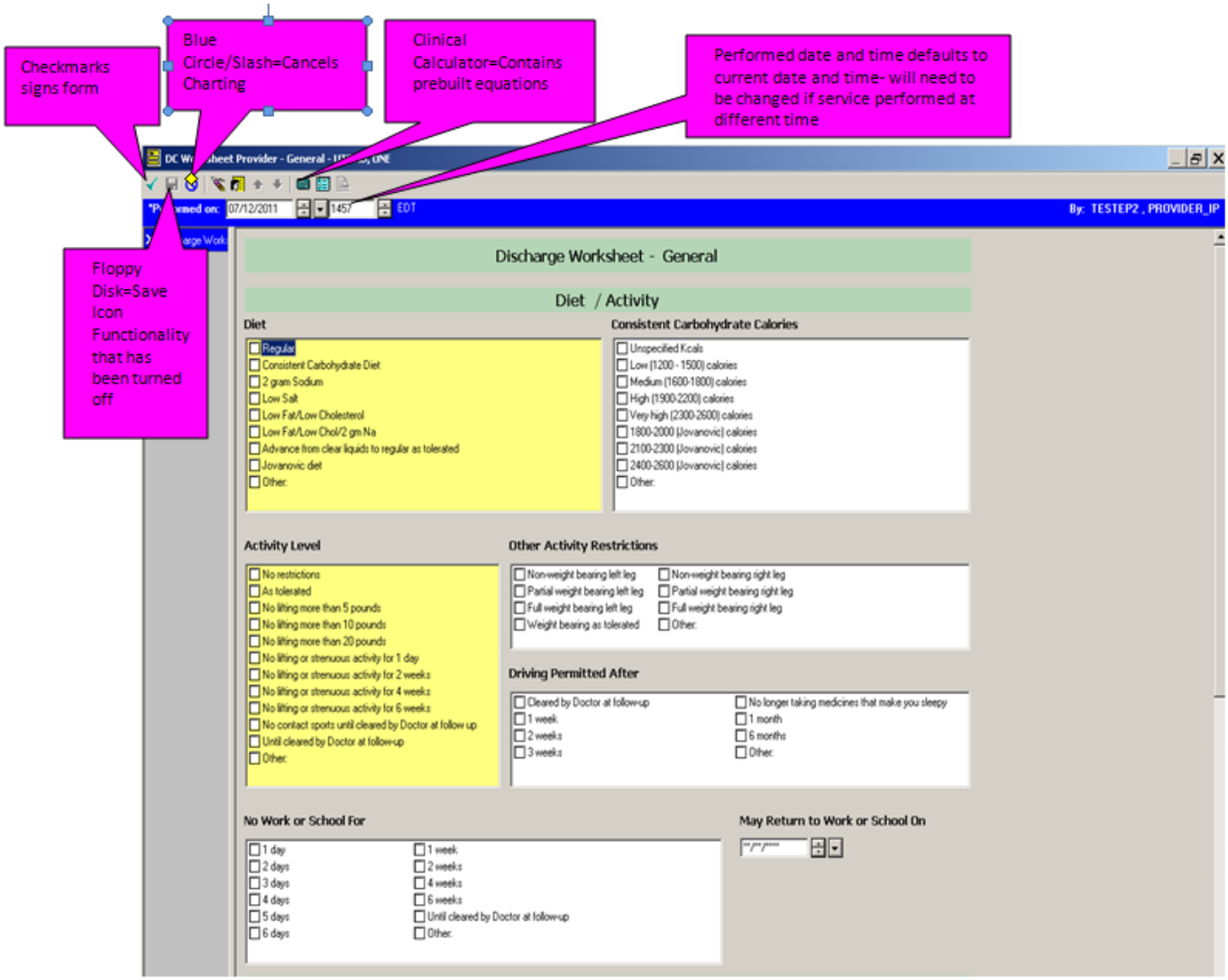
As a physician advisor of the Case Management Committee, I _ have/have not discussed this case with the treating physician and determined that the patient status should be: _ Inpatient _ Outpatient _ Inpatient–bill Part B only _ Observation status.
Section 111: (patient notification is required only if the status is changed while an inpatient)
The patient has been notified on _ of any change in level of care.
Actions

Anatomy of a PowerForm

The PowerForm is comprised of a list of sections on the left side of the screen and the documentation fields on the right.



Fields on the PowerForm

- The format of a field contains clues about the kind of information that can be charted.
  - **Date/time fields**

    A calendar is available for all date fields. Use the to display the pop up calendar.
    Can enter "T" (Today) to default to today's date in date field.
    Can enter "N" (Now) to default to the current time in the time field.
  - **Alpha fields** (single-select pick lists):

    Have a radio button next to each pick list item
    Only one option can be selected
    May have an "other" response option that will open a free text dialog box. (These allow a 255 character free text entry)
  - **Multi-alpha fields** (multi-select pick lists)

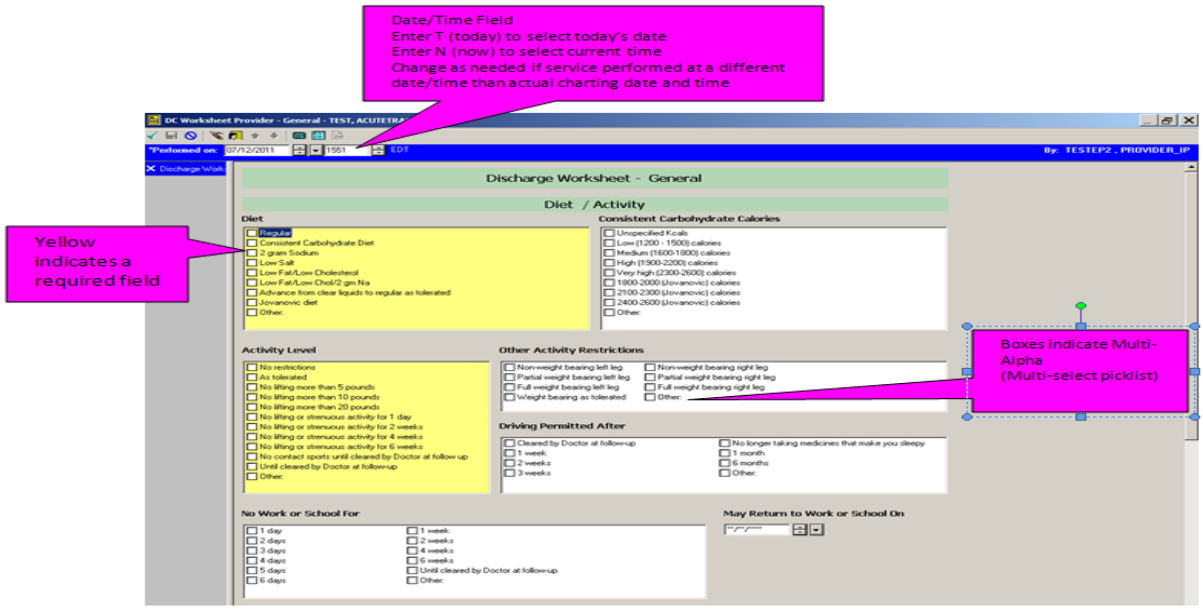
    Have a check box next to each pick list item
    Multiple options can usually be selected
    In some cases, if the first item is selected, no other available options can be selected (e.g., if "WNL" is the first item, a non-normal description cannot also be selected).
    May have an "other" response option that will open a free text dialog box. These allow a 255 character free text entry.
  - **Free text fields**

    Blank box for entering text; has a 255 character limit.
  - **Rich text fields**

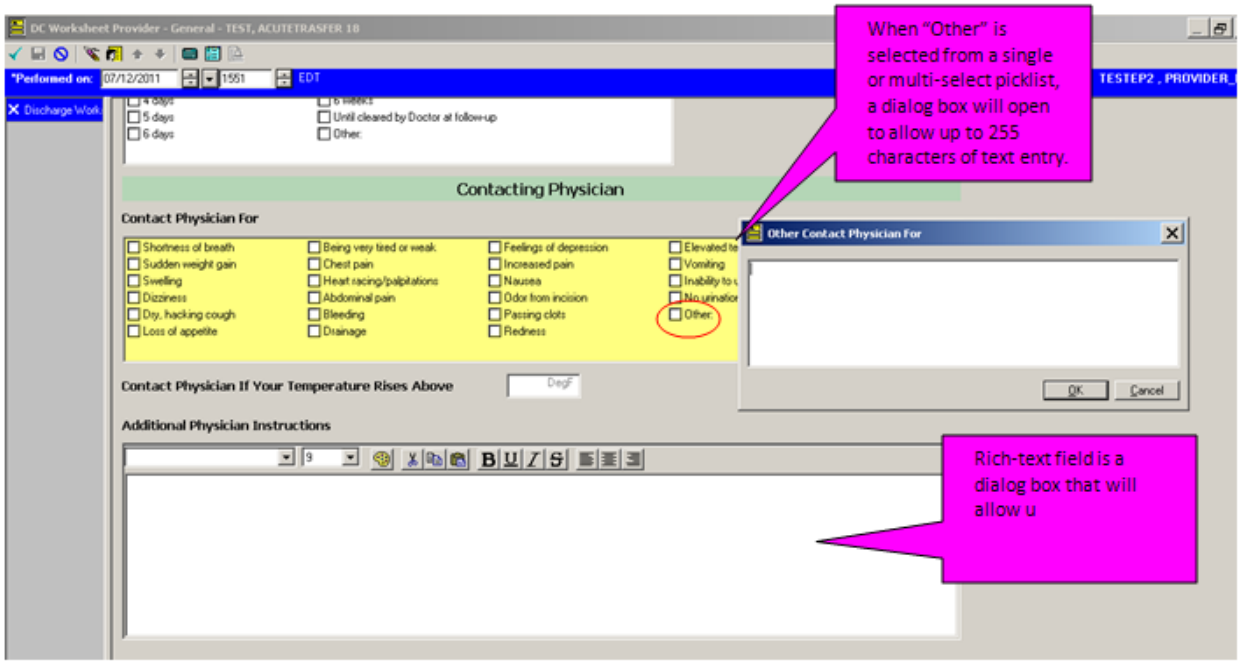
    Blank box for entering text; has no character limitations
  - **Required fields**

    Will show as yellow until a result or answer is entered.

Date/time, Multi-Alpha, Required Fields



"Rich-Text Fields and "Other" Fields on Multi-alpha Responses



- **Last Charted Value fields**

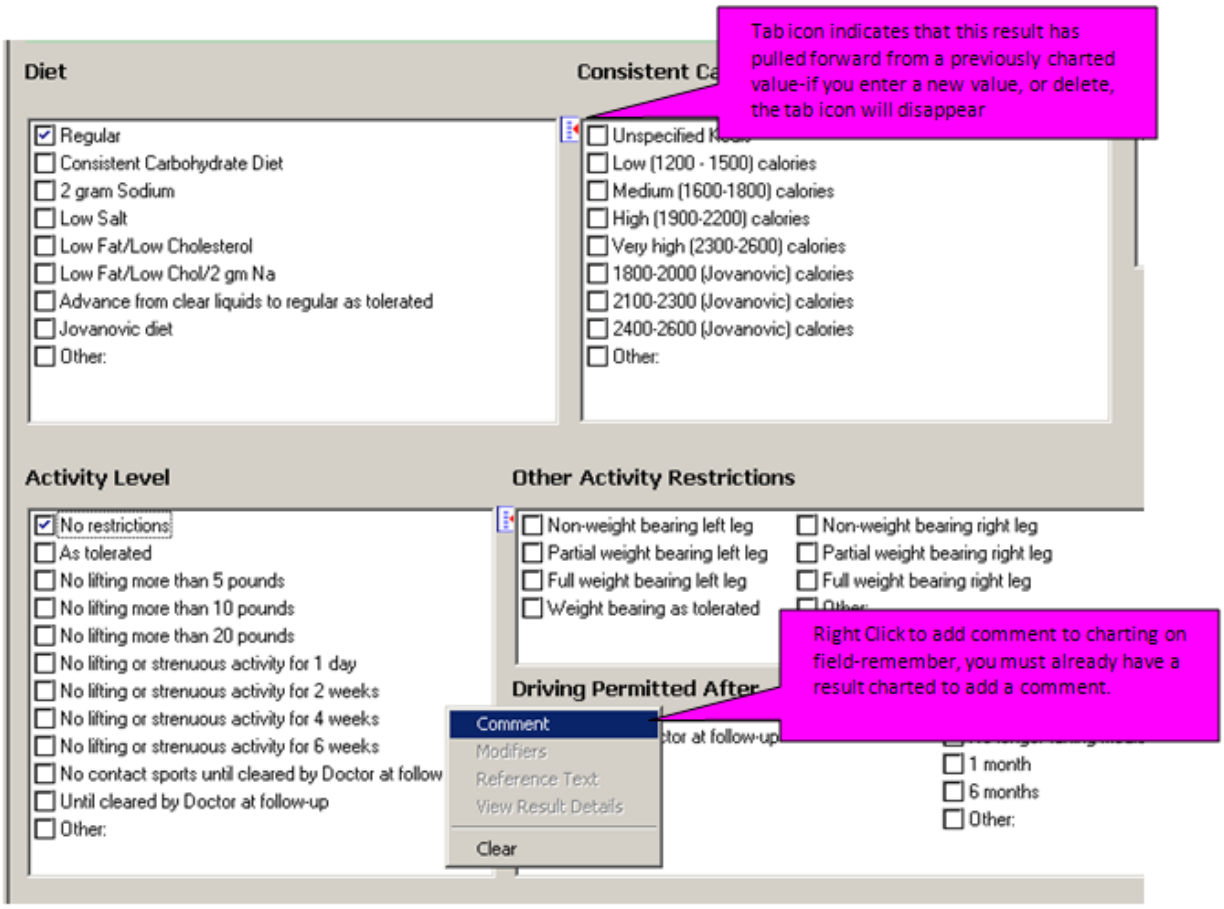
  Some fields may be set-up as "Last Charted Value". This means that information will be pulled forward from previous documentation.

  If a value has been pulled forward from previous charting, it will show a tab icon to the right of the field.

- **Comments**

Comments may be added to any field *that has a result charted* by right-clicking and selecting "Comment".

Comments never pull forward to a new instance of a form.

When a completed form is viewed in Form Browser, a green pushpin icon will display beside fields with comments. Click on this icon to view the comment.

Last Charted Values and Adding Comments