

~ November 27, 2019 ~

The following is a compilation of all flash items from Wave 1 through Wave 3 Fall 2019 Go-Lives. Please take a moment to review the answers to questions that have come up during rounding from affected end-users. Also reviewed are updates on any outstanding issues.

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## Frequently Asked Questions

### When should I use a Non-Patient Quick Reg encounter or an In-Between Visit encounter?

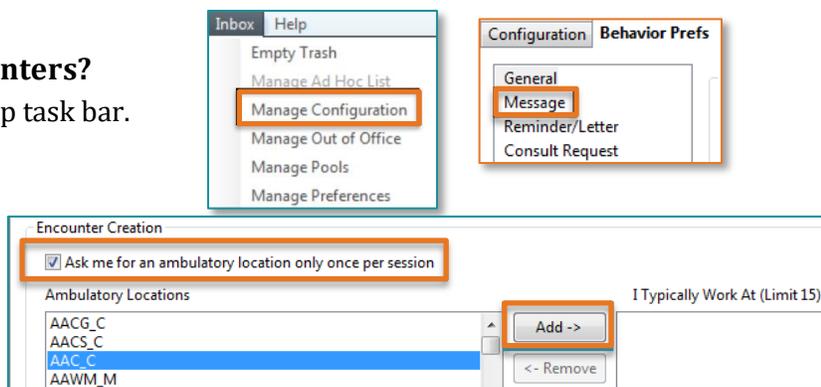
- A non-patient quick reg should now only be used in instances where there isn't an encounter specific to your location and you need to scan documents into the EHR.
- For all other needs, including placing orders prior to an appointment, an in-between visit encounter should be used.
- The workflow on how to create an in-between encounter can be found [here](#).

### What is an In-Between Encounter?

- An in-between encounter is used to place orders or important information in the Electronic Health Record, for a patient who is not currently in the office for a visit.
- Some examples of when an In-Between encounter could be used are in the case of a patient calling for a prescription renewal, a sick note, a referral request, or some other reason not connected with a current visit.

### How do I set my location for In-Between encounters?

- From **Message Center**, click **Inbox** from the top task bar.
- Select **Manage Configuration**.
- Click the **Behavior Prefs** tab.
- Select **Message**
- In Encounter Location, select the location(s) you work in and add to the left column.
- If working in multiple locations, uncheck the box under **Encounter Creation**.

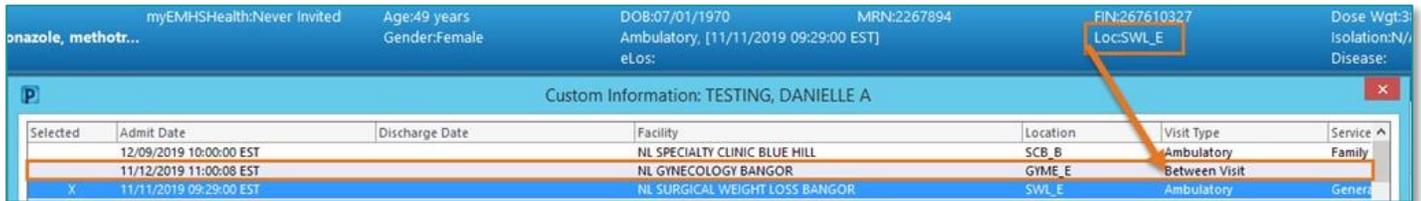


**NOTE:** Leaving the box checked will cause all messages from that day to go to the original location selected.

- The location will populate based on your In-Between encounter and can result in orders and/or scripts not being able to go through.

### Why can't I see in-between encounters when searching for the patient?

- Between visit encounters can only be seen from the LOC hyperlink in the banner bar of the chart and will not be seen in the encounter pane of the search window as it is a FIN-less encounter.
- Between visit encounters should only be used for phone messaging and/or placing orders for patient between visits, or in preparation for a new patient visit.



### How do I place orders from a message that didn't originate from my practice?

- A [detailed workflow](#) and a [video walkthrough](#) explaining how to manage and place orders from a message sent to you from another location are available by clicking the links.

### Where can I find the new practice names?

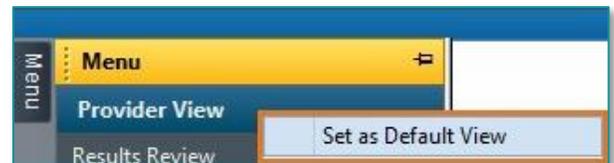
- A complete list of Wave 1 practices and their new rebranded names can be found on the CI portal [here](#).

### What is my new practice location acronym?

- A complete list of rebranded names and acronyms can be found [here](#).

### How do I change my default view when I open a patient's chart?

- From the "dark side" menu, right click on what you prefer the chart to open to and select **Set as Default View**.
- Remember to use the Exit button to close out of PowerChart to save your preference changes. 



### How does an NP/PA set their specialty specific Viewpoint?

- These specialty specific **Viewpoints** can be selected using the **MyExperience** tool within **Cerner PowerChart**.
- The **MyExperience** tool is available from the toolbar in **Cerner PowerChart**.
  - To change your specialty specific **Viewpoint**, select the appropriate specialty for your role from the list in the column on the right.
  - To change your default organizer view (the first page that opens when accessing **Cerner PowerChart**), select the desired page from the list on the left.
- Click **Save**.
  - Your view should now be updated based on your selections.



### Why can't I associate my patient to a room location on the Ambulatory Organizer?

- Patients cannot be assigned to a room location until, or after, the time of the patient's appointment.
- Cerner is working on a correction package for this, though the timeframe for the fix is unknown at this time.



### How do I see old records from Centricity or Allscripts?

- The Health Data Archive is available through PowerChart using the **Historical Records View** tab from the Menu. Further instructions on how to use it can be found [here](#).

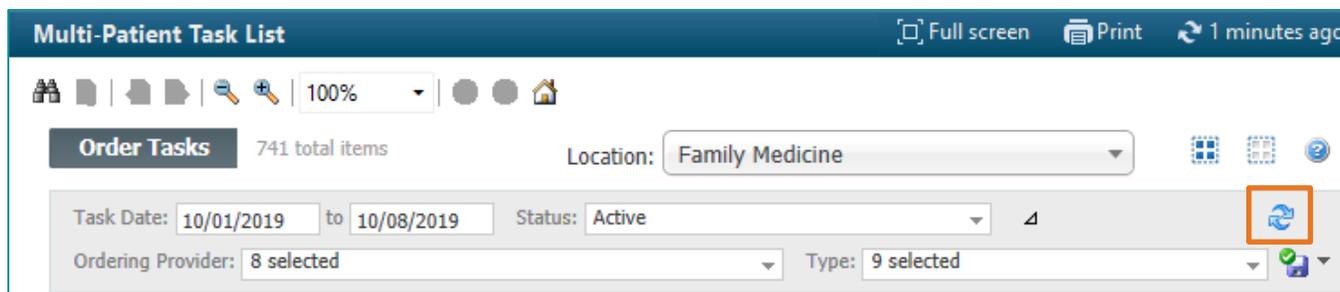
### How do I find my Multi-Patient Task List (MPTL)?

- Task list names are directly related to your facility/practice name. With the new name branding/facility breakout that occurred in conjunction with your go-live, your name now begins with NL...



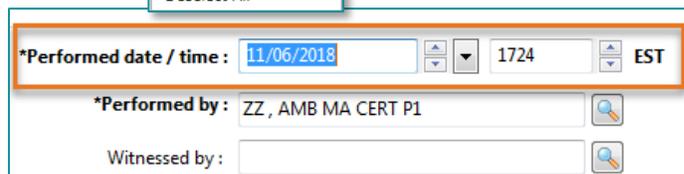
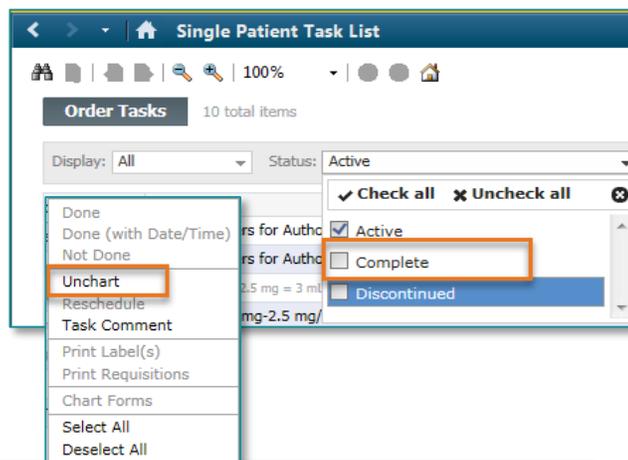
### Which Refresh Button should I use in the Multi Patient Task List after setting filters?

- The small refresh button on the MPTL page should be used to refresh after setting filters.
  - The "Minutes Ago" refresh button will refresh the entire page and filter settings will reset to default.



### Correcting the Date of an In-Office Medication

- When needed, medication documentation (e.g., date) can be corrected.
- Open the **Single Patient Task List**.
- Change the **Status** filter to include **Completed**.
- Right-click the medication and select **Unchart**.
- At the prompt, enter the reason.
- The medication will reappear on the **Task List**.
- Re-chart the medication with all correct information.
- Be certain to change the administration date, if needed

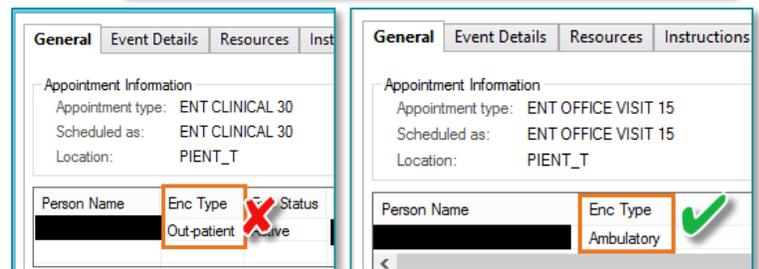
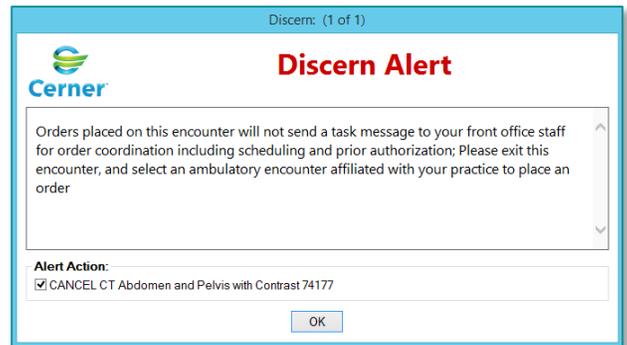


### How do I address tasks on the MPTL that aren't due for 6 months or more?

- For the workflow of managing tasks on the multi-patient task list for immediate or future action, please refer to the associated flyer, [Managing the MPTL](#).

### Why do I get an alert that says my orders won't go to the task list?

- Providers may be seeing a Discern Alert that looks like the screenshot to the right.
- This is due to the encounter type the patient is registered to being **Outpatient** rather than **Ambulatory**.
- At the practice level, the only way for staff to change the encounter to Ambulatory is to cancel the appointment/encounter and reschedule and create a new encounter. However, the registration department does have the ability to update the existing encounter from outpatient to ambulatory.



### Why is the EDD not displaying on the Pregnancy Card?

- In order for the EDD to appropriately display on the pregnancy card, the Pregnancy needs to be added from the workflow page **prior** to documenting vitals or intake information.
- A flyer containing this workflow is available from this [link](#), and on [PromisePoint](#).

### Why is my Last Menstrual Period not displaying on the Antepartum Record?

- When the last menstrual period isn't documented in the correct location, it will not display on the Antepartum record. This documentation should be entered in either Interactive View and I & O, the Ambulatory Comprehensive Intake Form, or the Ambulatory Quick Intake Form from the OB/GYN History band to ensure proper functionality.
- The last menstrual period is viewable in the EDD Maintenance Component.

### Where do I enter Antepartum Risk Factors?

- From the Risk Factors component, click the drop down and select the Antepartum Risk Factors option.
- Complete the form as appropriate.
  - The risk factors selected would then display in the Risk Factors component.



Risk Factor	Added By	Date Added
Previous shoulder dystocia delivered	TRAIN, PHYSWH1	November 19, 2019
Group B Streptococcus	TRAIN, PHYSWH1	November 19, 2019
Diabetes, gestational, type A1	TRAIN, PHYSWH1	November 19, 2019

**IMPORTANT:** Antepartum Risk Factors entered in the Risk Factors component do not automatically update the Problem List component. If it is appropriate for the Risk Factor to also be shown on the patient's Problem List, it will also need to be entered in the Problem List component. With future optimization, these Risk Factors will be linked to the Problem List and will resolve with the resolution of the pregnancy.

### How do I modify the Estimated Date of Delivery?

- This would be updated via the EDD Maintenance Component.
- If the date of the LMP was entered incorrectly, select Modify EDD within the EDD Maintenance Component, update the Date of Onset field as appropriate.
- Save your changes.
- These will be reflected in the Pregnancy Overview and the EDD Maintenance component.
  - If documentation has already been completed by the nursing staff this will update with the next visit.
  - The correct EGA will be reflected in the pregnancy overview.

**EDD Maintenance (1)**

EDD	EDD Method
✓ 06/08/2020 <span style="border: 1px solid orange; padding: 2px;">Modify EDD</span>	Last Menstrual Period (09/02/2019)

**Modify EDD Maintenance**

Method: Last Menstrual Period

Date of Method: 08/28/2019

Confirmation: Confirmed  Final  Initial

EDD: 06/03/2020

EGA: 11 weeks 6 days

Pregnancy Visit Information		
Date of Visit	11/19/19	09/02/19
Gestational Age	11w0d	--
Fundal Height	--	--

**Pregnancy Overview**

Current Pregnancy | Contact Info

EDD	06/02/20 (Authoritative)
EGA	12 Weeks, 0 Days
Gravida/Parity	G1,P0(0,0,0,0)
Multiple Fetuses	No, Singleton
Feeding Plan	--

### How Should I be Documenting Pregnancy Visit Information?

- The Pregnancy Visit Information can only be documented in the Pregnancy Card on the day of service.
- Information such as fetal movement, presentation, symptoms can be documented by the clinical staff.
  - If the nurse has information that isn't captured in Interactive View and I & O regarding this visit, they should utilize the Chief Complaint Component.
- Comments can only be documented one time and is intended for the provider to be the author of this documentation.
- If documentation needs to be added to by the provider or needs to be completed after the date of service, this can be done via Interactive View and I & O in the OB Provider Documentation band.
  - Documentation can be completed in the Antepartum Note section and there is a limit of 255 characters.
  - If this is an initial or complicated visit, Dynamic Documentation would then be utilized.

### Where do I document JW Medication Waste?

- The JW Medication Waste Form is located in **AdHoc** in the **Ambulatory** folder.
- This Form can be used to document both the amount of medication administered and the amount wasted.

NOTE: The documentation of waste is a CMS requirement for certain medications in areas without Pharmacy Review.

The screenshot shows a web-based form titled "JW Medication Waste Documentation". At the top, it displays the date and time: "Performed on: 10/02/2019 1556 EDT". The form has several input fields: "Medication Given", "Medication Dose", "Medication Waste", and "Medication Given Date/Time". There are also two sets of radio button options for "Unit of Measure", one for administered medication and one for wasted medication. The options include mg, mcg, gm, units, million units (MU), intl\_Units, mL, EA, and Other. A tooltip indicates "Right click to view medication list".

### How do I document that a weight was not taken this visit?

- In the **Measurements** section of the **Intake Form**, the reason why the weight was not taken can be selected from the **BMI Exclusion** dropdown.
- Be sure to document the exclusion if the **Weight** field is left blank.

The screenshot shows the "Vital Signs" and "Measurements" sections of a form. The "Measurements" section includes fields for "Height/Length Measured" (90 cm, 2 ft 11 Inch), "Weight" (kg), "Wheelchair Weight" (kg), "BSA", "Body Mass Index Measured", and "Ideal Body Weight" (-11 kg). A "BMI Exclusion" dropdown menu is highlighted with an orange box, showing options: "Patient refused", "Not clinically indicated for this visit", and "Unable to Obtain due to patient condition".

### How do I change the due date of a recommendation?

- Select on the Recommendation you need to update and click Modify.
- Click on the calendar icon to view the calendar.
- Click on the month hyperlink to open a list of months.
- Click on the year hyperlink to open a list of years.
- Select appropriate month, day and year then click Save.

The screenshot shows the 'Recommendations' window with a 'Modify' button highlighted. The 'Depression Screening Adolescent' recommendation is selected. The 'Due' field is set to 'Today' (10/31/2019). A calendar icon is clicked, opening a month/year selector. The year '2019' is selected, and the month 'October' is selected. The calendar shows the date '31' selected.

### How do I document bilateral blood pressures?

- The bilateral blood pressure section has been added to the following intake forms:
  - Ambulatory Comprehensive Intake Form
  - Ambulatory Pediatric Intake Form
  - Ambulatory Quick Intake Form
  - Antepartum Intake Form
- More information on how to create a personal level auto text to pull in this smart template can be found [here](#).

### How do I update the date in a charge order, or task that drops a charge, to reflect the DOS?

#### ➤ For charge orders:

- As a **provider** – use the calendar icon in the order details tab to select the date that reflects the date of service.
- As an **MA/RN** – there are 2 places you will need to change the date: in the **Ordering Physician** window AND in the **order details**.

#### ➤ For tasks that drop charges (i.e. meds and POC):

- Select Done in the task icon of the SPTL
- In the Performed date/time field, use the calendar icon to select the date that reflects the date of service the med was administered or POC performed.

The screenshots show the 'Ordering Physician' window with the 'Order Date/Time' field set to 11/22/2019. Below it, the 'Charting for: TESTING, DANIELLE A' window shows the 'influenza virus vaccine, inactivated' task. The 'Performed date / time' field is set to 11/22/2019. A calendar icon is used to select the date.

### When I give an injection, do I need to also place a charge order?

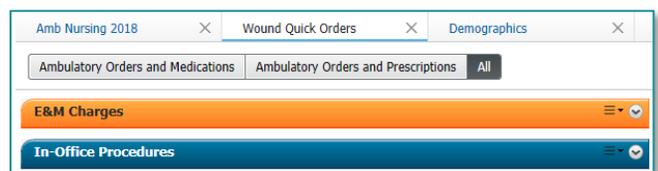
- For any medications given in office with a route of Subcutaneous, Intramuscular, IV, or IVP – an additional administration charge order is not necessary.
  - Completion of the medication task on the task list will drop the med charge and alert coding to manually enter the admin charge.
- For medications administered via any other route than listed above (i.e. intra-articular, bladder instillation etc.) – the appropriate administration procedure charge order is necessary to enter to drop that charge.
  - Completion of the medication task on the task list will drop the med charge only.

### How can I see if a Note or Charge has been completed on my patient?

- Information related to the Status of Notes and Charges for a patient’s visit is available from the Open Items Tab of the Ambulatory Organizer. Please see this [flyer](#) for more details on the Open Items Tab.

### How do I charge for a Nurse/MA Only Visit?

- For each Nurse/MA Only visit, an associated charge order must be placed at the end of the visit. This order should come from the E&M Charges and/or the In-Office Procedures component of the Quick Orders page based on the nature of the visit.

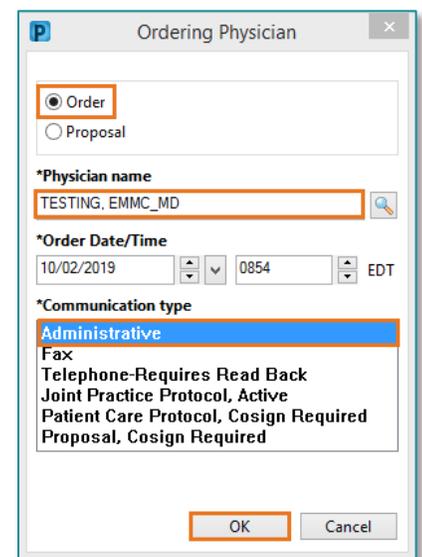


**STEP 1:** Ensure you are on the patient’s chart and on the correct encounter/location prior to commencing any documentation/placing orders.

**STEP 2:** Navigate to the Quick Order Page

**STEP 3:** Select the appropriate charge order for the nature of the visit from the **E&M Charges** and/or **In-Office Procedures** component.

- STEP 4:** In the Ordering Physician window:
- Select the **Order** option
  - Enter attending **physician’s name**
  - Select the **Administrative** communication type
  - Click **OK**



**STEP 5:** Select the Orders for Signature Tray.

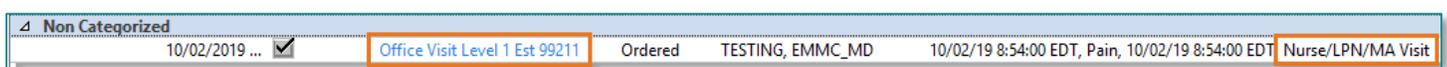
**STEP 6:** Associate the appropriate **diagnosis** if available and click **Sign**.

**STEP 7:** Within the order scratchpad, select **Yes** in the **Nurse/LPN/MA Visit** field.



**STEP 8:** Click Sign.

**NOTE:** This order will not route to the providers message center and does not need to be co-signed. It will appear in the Order profile under Non-Categorized and show as a Nurse/LPN/MA Visit.



- Click [here](#) to access the flyer on **Documenting a Nurse Only Visit**.

### When do I need to document a Nurse/MA Only Visit Note?

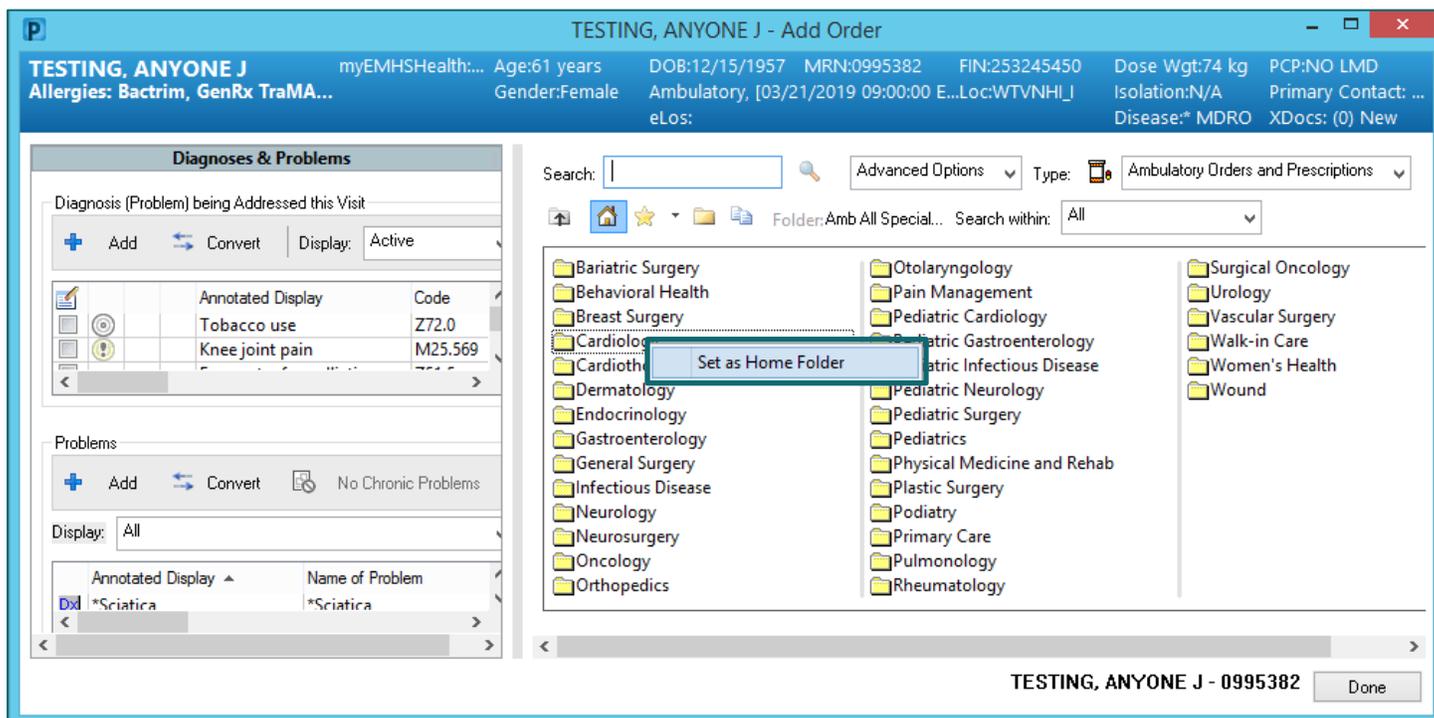
- Nurse/MA only visit notes should be used when any assessments and interventions are provided (i.e. wound dressing change, suture/staple removal etc.)
- Nurse/MA visits for immunizations or medication administration only do not need an associated nursing note as that will be documented from the medication task on the MAR.

### For outreach clinics, which encounter should Orders and Documentation occur on?

- Each outreach clinic has 2 encounters; one for the location where the patient is physically being seen for facility fees, and a second one specific to the providers home location for the professional fees.
- All orders and documentation should occur on the encounter with the facility location specific to where the patient is physically present.
  - This will allow for all nursing documentation that occurs with the patient to flow into the providers note.

### How can an NP/PA set a Specialty in the Add Orders Search Window?

- Since the NP/PA position is not specific to a specialty, the Add Orders Search Window from the Orders Profile is set up initially to display all specialty folders.



- To set one of these Specialty Folders and the Home Folder, simply right-click the desired folder and click the Set as Home Folder. This specialty folder will now display open when this window is launched in the future.

**REMINDER:** Be sure to exit PowerChart by clicking the Exit door to ensure this preference is saved to your account. 

### Why can't I propose a prescription medication from the Quick Orders page?

- Due to privileges associated to security positions, staff in an ABROE role/position are unable to propose prescriptions off of the quick orders page and must use the Orders Profile instead.
  - Staff in a MA, Certified MA, or RN/LPN position are able to propose prescriptions from the Quick Orders page.

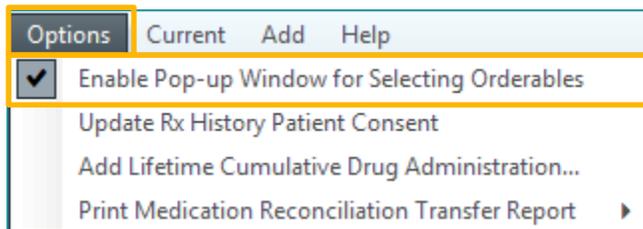
### What is the difference between Ambulatory Orders and Medications vs. Ambulatory Orders and Prescriptions?

- Ambulatory Orders and Medications should be used only for orders and/or medication being performed/administered in the office during the visit.
- Ambulatory Orders and Prescriptions should be used when placing a future order and any prescription medications.
- From the quick orders page these options are available in the New Order Entry component.
- From the +Add orders screen, these options are available from the Type dropdown.

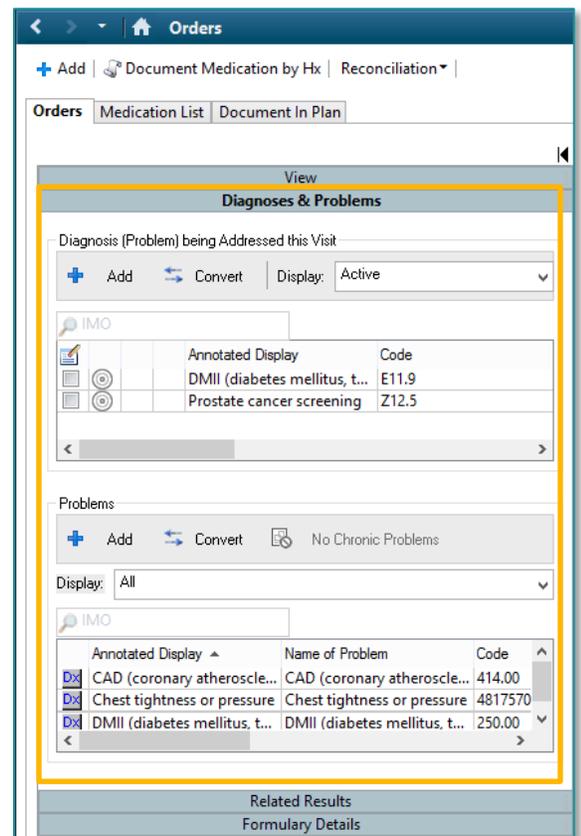


### How do I activate Diagnoses and Problems functionality from the Orders Profile?

- From the Orders Profile, click the Options menu item from the top of the page.
  - From the Options menu, deselect the "Enable Pop-up Window for Selecting Orderables" option.



- The checkmark should no longer be visible next to the "Enable Pop-up Window for Selecting Orderables" option.
- The Diagnoses and Problems section is now available to be used.
  - The tab will assist in the process for Adding and Managing Diagnoses and Problems from the Orders Profile.



## Do I use electronic charge orders or a fee ticket for my outreach clinics?

- There is not a standard answer for this question, and it is dependent on the nature of the contract between facilities. The following outlines each various scenario:
  - For providers performing an outreach clinic in which they are billing a professional fee only, providers will:**
    - Enter charges on a paper fee ticket which will be brought back with them to their “home” office location for manual batch charge entry.
    - All other orders will continue to be placed electronically via the QO page.
  - For providers performing an outreach clinic in which they are billing for a professional fee, but the MO they are rendering services at bill the facility fee the provider will:**
    - Enter a charge electronically for the facility fee to drop, **AND** use the paper fee ticket for the “home” location to bill the professional fee.
    - All other orders will continue to be placed electronically via the QO page.
  - For providers performing an outreach clinic in which they are completely contracted with that MO in which services are rendered at, providers will:**
    - Enter all orders (charges, follow-ups and testing) electronically and no paper fee ticket will be utilized.

## Do I have to do a Medication Reconciliation on every patient?

- Medication Reconciliation must be done on **every** patient at each provider visit, regardless if you are managing any medications or not. Med Rec is a Meaningful Use requirement and must be performed on every face to face patient visit with a provider.
  - Follow the steps in this [video](#) on how to complete med rec when not managing medications.
  - A Quick Reference Guide for completing Medication Reconciliation is also available on [PromisePoint](#).

## Why can't I see the Outpatient Med Rec Link after Importing Outside Records?

- When attempting to access and complete an Outpatient Medication Reconciliation, there is the ability to view and import the patient's medication history from outside sources.
- When in the view below, clicking on Return to Review will allow the provider to access the link to the Outpatient Medication Reconciliation tool.

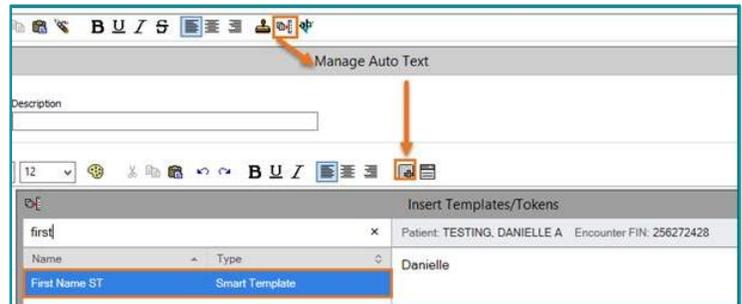
The screenshot shows the 'Home Medications' interface. At the top right, there is a link for 'All Visits' with a refresh icon. A purple warning banner states: 'You are viewing unverified data from outside sources. Interaction checking and Clinical Decision Support are not available until data is added to local record.' A 'Return to Review' button is highlighted with an orange border. Below the warning, an information banner reads: 'Information. I am providing care to this patient and have either (1) obtained the patient's verbal permission to access the patient's complete medication history or (2) determined that access to the patient's medication history is necessary for patient treatment and'. To the right of this banner are 'Consent Granted' and 'Consent Denied' buttons. Below the information banner are filters for 'Last 6 months', 'Last 12 months', 'Last 2 years', and 'Lifetime'. At the bottom, there is a table header with columns: 'Medication', 'Mismatches Ide...', 'Compliance', 'Originating Source', 'Last Modified D...', and 'Actions'. A dropdown menu is open showing 'Unverified Data from Outside Sources (3)'.

### How do I reconcile orders when results are received from an Outside NLH location?

- Reconciling orders is very important to maintain an accurate report of outstanding orders for a patient.
- The workflow on managing these varies and is highly dependent on the order details and whether you see **OUTSIDE EMHS** or **TAMC** (or any of the other NLH facilities).
- Please follow the workflow described in this [flyer](#) to appropriately reconcile testing orders performed outside of the NLH system.

### Can I pull in the patients first name only into an auto text?

- Yes! A new smart template has been created and is now available for use.
- It is not a system level auto text but can be pulled into a personal level auto text from the Insert Templates/Tokens icon.

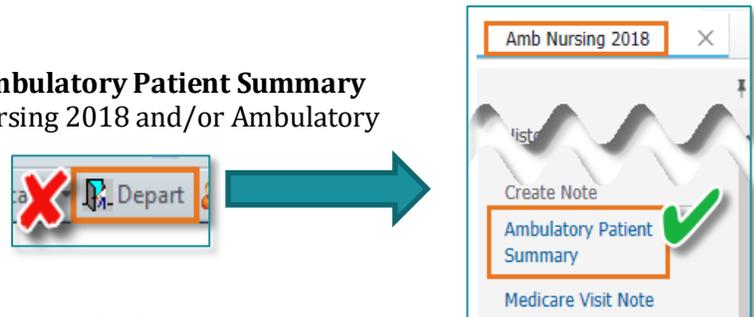


### How can I use Auto Text in my Nursing HPI?

- Click [here](#) to access the flyer outlining the workflow for **Using Auto Text in PowerForms**.

### Where is the Depart button?

- The Depart button has been replaced by the **Ambulatory Patient Summary** found in the Create Note section of the Amb nursing 2018 and/or Ambulatory 2018 workflow pages.



### Why is my name printing on order requisitions or Ambulatory Visit Summaries?

- Any document printed from within the electronic health record will print with a stamp of the user, date & time. This is functioning as designed by Cerner and there is no way to remove this.

### How will I know a patient has chosen that labs be done out of system from the Ambulatory Visit Summary?

- In the “Please Complete the Following” section, you will see within the details for those lab orders the statement “Performed Outside of EMHS”. This indicates that these labs have been ordered to be completed outside of the Northern Light Health system.
- Furthermore, a requisition will print at the time the order is placed, and then you can verify that this has been provided to the patient.

#### Please Complete the Following

CBC with Differential, BLOOD, Routine, Order for Future Visit, \*Est. Start: 10/22/19, **PERFORMED OUTSIDE OF EMHS**, ONCE, Cellulitis, 10/22/19 12:18:00 EDT, 87320695  
Lipid Profile with Reflex, BLOOD, Routine, Order for Future Visit, \*Est. Start: 10/22/19, ONCE, Cellulitis, 10/22/19 12:18:00 EDT, 87320695

**How do I document bilateral blood pressures?**

- The bilateral blood pressure section has been added to the following intake forms:
  - **Ambulatory Comprehensive Intake Form**
  - **Ambulatory Pediatric Intake Form**
  - **Ambulatory Quick Intake Form**
  - **Antepartum Intake Form**
- More information on how to create a personal level auto text to pull in this smart template can be found [here](#).

**Do I need to place a referral to another provider within my practice?**

- If you are referring to another provider in your practice, that is the same specialty, you do not need to place a Referral Order. Instead, you would use the AMB Follow-Up Appointment Order and indicate within those order details whom you would like the patient to see.
- If you work in a practice with multiple specialties under one roof and need your patient to see a provider in a specialty other than yours, then a Referral Order should be placed.

**What Worklists do I need for Referral Management?**

- It is recommended that multiple worklists be created based on the referral status.
  - The table to the right shows the referral status and suggested worklist titles:
- Click [here](#) to access a flyer with additional information on how to create Referral Management Worklists.

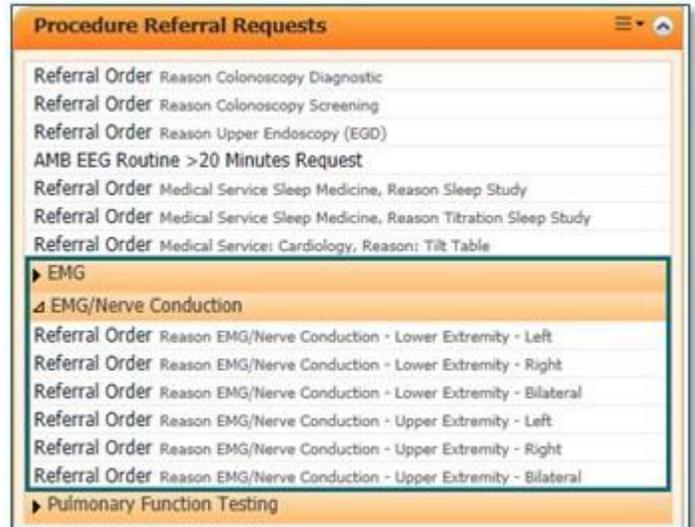
OUTBOUND		INBOUND	
Suggested Title	Outbound Worklists (Referring Practice) Statuses	Suggested Title	Inbound Worklists (Receiving Practice) Statuses
Outgoing-New	Not Started Prepare Send	Incoming-New	Pending Pending Reschedule
Outgoing-Rejected	Rejected	Incoming-Rejected	Rejected
Outgoing-On Hold	On Hold	Incoming-On Hold	On Hold
Outgoing-Tracking	Pending Sent Accepted Pending Reschedule	Incoming-Accepted	Accepted
Outgoing-Scheduled	Scheduled	Incoming-Scheduled	Scheduled
Outgoing-Attended	Attended	Incoming-Attended	Attended
Outgoing-Historical	Cancelled Closed Completed	Incoming-Historical	Cancelled Closed Completed
**Outgoing-Lookup	All Statuses	**Incoming-Lookup	All Statuses
** Due to line limitations and load times, lookup should only be used when patients are inquiring about the status of their referral			

**How do I document bilateral blood pressures?**

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### Why are orders that used to go to the task list now going to Referral Management?

- Orders for procedures/testing to be done outside of your practice by a different specialty/provider other than yourself, now go through referral management.
  - For example, an order placed for AMB EMG/Nerve Conduction prior to go-live went to the task list. This is now a Referral Order and will go to your Referral Management outgoing worklist.
  - These AMB orders, if previously on your quick order page, were replaced with Referral Orders.
- Other examples of AMB prefix orders now Referral Orders are: Colonoscopies, EGD's, Sleep Studies, and PFT's.
- Only if you/your practice is the performer of these tests/procedures, would you continue to use the AMB prefix orderable.



### Why aren't all my referrals in Referral Management?

- Any referrals placed prior to your practices' go-live date will still live on the Multi-Patient Task List (MPTL) and will need to continue to be worked on from that location until completed.
- Any referrals placed on, or after, your practices' go-live date will now appear in the Referral Management tool and be managed from that tool.

### How do I update the Priority on a Referral Order?

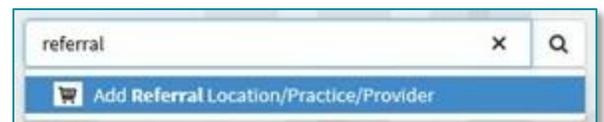
- In some cases, it is appropriate to change the priority of a referral case from "Urgent" to "Routine" based on review by clinical staff member recommendations and or practice policy. Please see [flyer](#) for details.

### How do I request a Location/Practice/Provider to be added to Referral Management?

- To decrease reliance on the "Misc. Provider" Refer to option and add Refer from practices to the Referral Management dictionary, it is required the user log a Service Now ticket to add the referral location/practice/provider

- To Log the ServiceNow Ticket

- Navigate to the ServiceNow portal from the Intranet page.
- In the Search field, type Referral.
- Select the Add Referral Location/Practice/Provider option.
- Fill out the form, ensuring that the required fields are satisfied.
- Click Submit.



## Important Reminders

### Controlled Substance AutoText Update

- On October 30<sup>th</sup>, the smart template was corrected and updated and the existing system level auto text, /controlledsubstance\*, will now pull in pill count comments appropriately.

### Ambulatory Visit Workflows

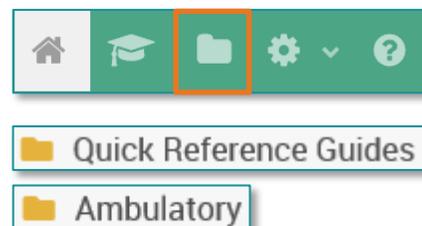
- Workflows can be accessed on the CI portal for both [clinical staff intake](#) and [provider visit](#).

### Message Center Tips and Tricks Job Aid

- Message Center tips and tricks for communicating to other providers, patients and/or staff are included in this [PowerPoint presentation](#).

### Available Educational Flyers

- Educational flyers and videos can be found on the [CI Portal](#).
- Additionally, Quick Reference Guides (QRGs) correlated from the e-courses can be found in [PromisePoint](#).
  - From PromisePoint's opening dashboard, click the Resources Folder near the top of the screen.
  - Click the Quick Reference Guide Folder.
  - Then click the Ambulatory Folder.
  - A list of QRG's will now be available.



/cont

[/controlledsubstance \\*](#)  
[/controlledsubstance\\_MAT \\*](#)

**Controlled Substance**  
Last Medication Contract Date: 05/01/19 (10/30/19 10:20:00)  
Date of last Urine Drug Screen: 08/07/19 (10/30/19 10:20:00)  
UDS Results as Expected: Yes (10/30/19 10:20:00)  
Date of Last Pill Count: 04/16/19 (10/30/19 10:20:00)  
Pill Count as Expected: Yes (10/30/19 10:20:00)  
PMP Review Date: 08/07/19 (10/30/19 10:20:00)  
PMP Provider Attestation: Yes (10/30/19 10:20:00)  
Morphine Milligram Equivalent Dose: 45 (10/30/19 10:20:00)

Pill Count Comments

10/30/19 10:20:00  
Pill count comments will appear here

### Entering charge orders after the date of service

- Entering charge orders after the DOS is not advised as coders are reviewing notes and charges the day after services are rendered.
- Entering a late charge order may result in duplicate charges for the patient.

### Referral Location Change

- As a reminder, the only referral location for Wound & Ostomy care, Edema, and Vascular Care, is the referral location of **NL Vascular Care Bangor**.
- This is the only location and it's used for all 3 specialties.

### Completing the Outside Labs PowerForm

- Whenever lab data from external locations is being entered into the chart, the Outside Labs PowerForm needs to be filled out with these results.
- This will allow these results to populate to the flowsheet, providing a more comprehensive overview of the patient's lab profile and greater documentation efficiency. Labs entered this way can be tagged for use in Dynamic Documentation and trended over time.
- The Outside Labs PowerForm is available from the AdHoc Menu within the patient's chart.

### Patient Visit Summary

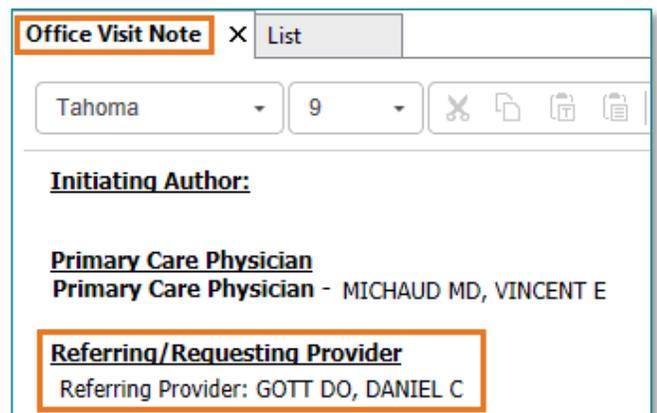
- As a result of the Maine State Law for the patient’s Right to Shop, effective 01/01/2018, this law requires healthcare entities to provide a written **“right to shop”** notice to patients with private health insurance coverage when these patients are being referred (or a recommendation is made for a referral) for non-emergency, outpatient physical or occupational therapy, radiology or imaging services, lab services, or infusion therapy services. To comply with this new legislation, beginning on or before January 1, 2018, EMHS will include a written notice on all Patient Visit Summaries in the electronic health record. This notice, along with an appropriate description of the recommended or referred service, will meet the written notice requirements of this new law.
- If a referral is made and the patient has private health insurance, the provider **MUST** print a Patient Visit Summary and provide it to the patient – the patient cannot “decline” printing of the material. If the patient then chooses not to read it or throw the Patient Visit Summary away, that is beyond our control; however, the law clearly states we must provide “written notification.”

**NOTE:** It is acceptable to email the Patient Visit Summary directly to the patient or post it to their portal if they prefer electronic delivery. This method meets the requirement of “written notification” and complies with the law. Signing the Patient Visit Summary will automatically post it to the patient’s portal if they are active.

- For additional information regarding the Right to Shop law, please see the attached [Memo](#) and [FAQ Sheet](#).

### Referring Provider field in Intake forms and Office Notes

- On Thursday, October 17, the Referring Provider field was added to the following intake forms:
  - Ambulatory Comprehensive Intake Form
  - Ambulatory Pediatric Intake Form
  - Ambulatory Quick Intake Form
  - Antepartum Intake Form
  - Medicare Wellness Visit Form
- So long as this information is filled out in the intake form, the referring providers name will auto populate the Dynamic Documentation note template, just beneath the Primary Care Provider:



### Ensure you’re on the correct encounter for your location.

- Once in the patient’s chart, double check the banner bar to ensure you’re on the correct location/encounter prior to commencing any documentation or placing orders.



### Encounters must be registered as Ambulatory, and not Outpatient.

- It is important for practices to look ahead at their schedules to identify patients that may have been previously registered as an **Outpatient** and update the registration to Ambulatory. This negatively affects the viewable orders on the Quick Orders pages and ability to place the order and have it fall on the MPTL.

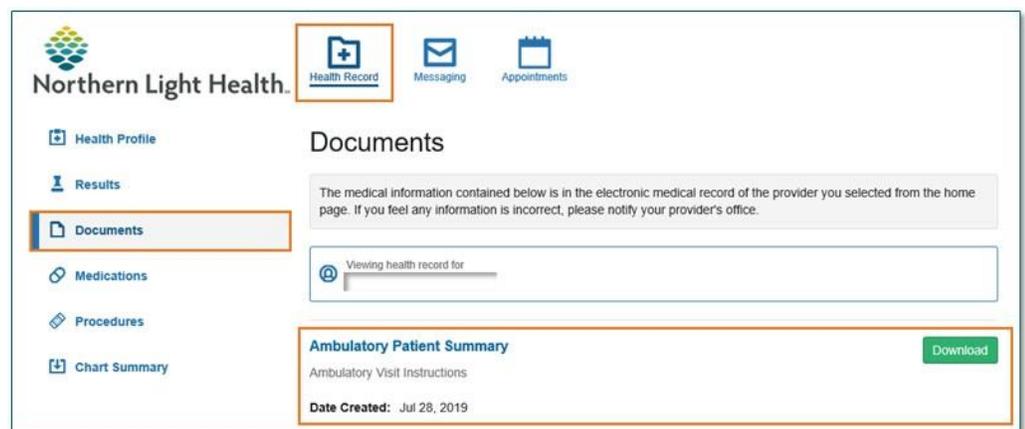
## Changes to Facility Org Structure

- In anticipation of Ambulatory Wave 3 go-live on Monday, 11/11/2019, Information Systems (IS) will be making changes to the Facility Org Structure within Cerner. Most of this change will be automated and completed in the background with minimal impact to users.
- Please note, this change affects specific EMMC specialty clinics (Rheumatology and Anemia Clinics) in a unique way. The [Facility Breakout Impact Wave 3 EMMC \(Anemia Clinic\)](#) flyer highlights those differences. All other locations should review the [Facility Breakout Impact Wave 3 EMMC version](#).
- The [Facility Breakout Impact Document For Referrals Management](#) includes the rebranded names and new location codes of **ALL** ambulatory locations from **Phase 1** and **Phase 2**, as well as highlights the potential impact to Referral Management requests and worklists.

## Ambulatory Patient Summary on the Patient Portal

- If a patient is **active** on the patient portal that their **Ambulatory Patient Summary** will automatically be viewable in the portal?
- Indication that the patient is registered on the Patient Portal is seen in the banner bar.
- When you click **Sign/Submit**, and then **Sign & Print** or **Sign** in the Ambulatory Visit Instructions – that document is immediately viewable electronically to the patient on their portal under **Health Record > Documents**.
- Patients can download the document to view it as needed.

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## Placing Charge Orders

- When placing orders, it is important to make sure the date listed in the order details is reflective of the date of the service.
- If placing an order late, it will require updating that default date when placing the order. Refer to Frequently Asked Question on how to update the date in the order details.
- This also applies to when tasks are charted late. It is important to always correct the date to match the date the service was provided.
- When the date is not set to accurately reflect the Date of Service, it will display with the incorrect date on the CDCC report used to post charges and charge entry staff/coding has to research. We are planning to automate the processes associated with charge posting soon, so we need to make sure that the order entry is being entered correctly to avoid having to do corrections, delaying billing, and potential claim denials.
- When finalizing your note, post your quick orders for charges. Do not go back and add after the fact. The coders capture these occurrences of not placing an order or missing one or more orders through the 'Provider Feedback report'.

## Known Issues

### **Why can't I preview/attach scanned documents in Referral Management?**

- Current Cerner functionality does not have the capability to preview scanned documents – and in turn if these are attached to a referral, generates a blank page to the recipient.

### **Why isn't the Ambulatory Visit Summary printing the scheduled follow-up appointment?**

- When printing the Ambulatory Visit Summary, these should populate under the Scheduled Future Appointments section of the summary printed at the end of the visit once these have been scheduled.
  - This is a known issue that this is happening for some locations. We are currently working on a resolution.

### **Please do not delete items from the CDCC report on the W: Drive.**

- Items can be moved to the archive folder when complete, but please do not delete items on the CDCC report in the W: drive.
  - If changes are needed, a copy of the CDCC report must be saved to the local desktop at which point the data may be manipulated from there and deleted from the desktop as needed.