Ambulatory Clinical Intake Cerner Workbook
Ambulatory Clinical Staff

This self-guided workbook allows the Ambulatory Clinical Staff to practice common documentation using the optimized workflow. This complements PromisePoint simulations and instructor-led education.

Please note, the following scenario is designed to demonstrate the workflow and functionality of the new tools. It may not be inclusive of all Northern Light System and/or Hospital policies and procedures.

Patient Scenario:

35-year-old male presents for yearly physical, also has past medical history of hyperlipidemia, hypertension.

Table of Contents

Signing into Cerner Millennium

- From the Intranet page under **Quick Links** search for **Cerner Millennium – Train (New Hire)**.

  o Cerner Millennium Train is where you can practice on training patients.

- Click the green plus sign to add **Cerner Millennium – Train (New Hire)** to your Quick Links.

- From Quick Links, click **Cerner Millennium – Train (New Hire)**.

- Click the **PowerChart** icon.

- Enter the username and password provided below (Behavioral Health are at the bottom).

Patients and Sign Ons

Password: train44ing

Sign On	Date	Resource	Patient
TRAMBRN40	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBA
TRAMBRN41	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBB
TRAMBRN42	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBC
TRAMBRN43	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBD
TRAMBRN44	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBE
TRAMBRN45	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBF
TRAMBRN46	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBG
TRAMBRN47	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBH
TRAMBRN48	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBI
TRAMBRN49	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBJ
TRAMBRN40	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBK
TRAMBRN41	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBL
TRAMBRN42	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBM

Sign On	Date	Resource	Patient
TRAMBRN43	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBN
TRAMBRN44	7/5/2022	Pauline Johnston, MD	TRAIN, AMBINWBO
TRAMBRN45	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBP
TRAMBRN46	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBQ
TRAMBRN47	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBR
TRAMBRN48	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBS
TRAMBRN49	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBT
TRAMBRN40	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBU
TRAMBRN41	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBV
TRAMBRN42	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBW
TRAMBRN43	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBX
TRAMBRN44	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBY
TRAMBRN45	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBZ
TRAMBRN46	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBAB
TRAMBRN47	7/6/2022	Pauline Johnston, MD	TRAIN, AMBINWBAC
TRACBHAMBMA4	7/6/2022	Sandra St. Germain, PMH-NP	TRAIN, AMBINWBAD
TRACBHAMBMA5	7/6/2022	Sandra St. Germain, PMH-NP	TRAIN, AMBINWBAE

Ambulatory PowerChart Overview

Adding Resources

- Use the **Patient's for:** drop down to choose the appropriate Provider schedule.

- Click a patient's name from the Ambulatory Organizer Schedule to enter the chart.
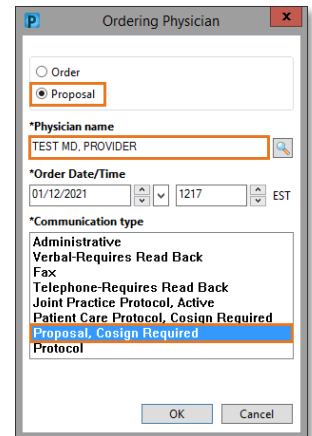
Patient Chart Review

Placing the AMB Joint Practice Protocol Order

- Clinical staff to propose the AMB Joint Practice Protocol order:
    o Navigate to the **Recommendations** component and click the **AMB Joint Practice Protocol** button under the Orders column.

Recommendation	Due	∧	Last Action	Recurrence	Source	Orders
▼ Active (2)						
AMB Joint Practice Protocol	In 12 months		Ordered (Today)	Every 1 YR	ZZ , AMB MA CERT P1	AMB Joint Practice Protocol

o In the Ordering Physician window:
- Select **Proposal.**
- Enter the ordering providers name in the **Physician Name** field.
- Select **Proposal, Cosign Required** as the Communication type.
- Select **OK**.
o Click the **Orders for Signature** tray.
o Click **Sign.**

Office Visit Workflow

Access Chart & Update Patient Location

- Update the patient's location on the Ambulatory Organizer. Select an exam room.
- From the **Ambulatory Organizer**, click the patient's name. The patient's chart opens on Ambulatory View.

Recommendations

- The **Recommendations** section provides suggestions for preventative measures for the patient based on their age, gender, and diagnoses.

Chief Complaint

- In the **Chief Complaint** field, enter: "Patient here for yearly physical exam. Patient also c/o low back pain that started 2 days ago."

- Click **Sign.**

Histories

- Social History will be updated within the intake form to allow the maintenance of the quality metrics located on the bottom of that section.

- All other histories will be updated via the Histories component on the Workflow MPage.

- Click the **Histories** heading in the Workflow MPage.

  o This will bring you to the Histories tab in the Menu to complete the other histories.
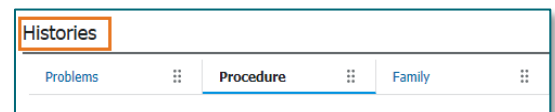
NOTE: You need to have one of the tabs other than Problems selected to have the link take you to the Histories section for updating and reviewing.

Procedure History

Review the procedures listed, if any, and ask the patient if they have had any procedures since their last visit.

- Documenting a Procedure

  o Click the +**Add** button.

    - In the **Procedure** search box, type **Knee Arthroplasty** and click the binoculars.

    - The Procedure Search box opens.

  o Select **Knee Arthroplasty** from the list and click **OK.**

  o In the **Provider** search box, enter **Copithorne, Peter.**

    - Use the magnifying glass to choose which provider if there are more than one with the same last name.

    - Select the provider's name from the list.

    - Click **OK.**

  o Select **Left** in for the **Laterality.**

  o Click the BLUE **date** and change it to **year.**

  o Enter a previous year for the procedure: 2014.

- In the **Location** field, click the binoculars and scroll to search for NL Maine Coast Hospital and select it.
  - Click **OK.**
- If there are more procedures to add, click **OK & Add New** to begin documenting the next procedure.
  - Click **OK** to add it to the list and get back to the **main screen.**
- Once the procedure list has been reviewed and updated as necessary, click **Mark as Reviewed** at the bottom of the component.

Family History

Review the patient's Family History listed and ask the patient if there have been any updates with family history since their last visit.

- **Documenting Family History**
  - Click the **Add** button.
  - Use the **Quick List search** icon (magnifying glass) to open the tool.
  - Select the **Search** tab.
  - Search for **Hypertension.**
  - Double-click to add to the **scratch pad** at the bottom.
  - Search for **Hypothyroidism.**
  - Double-click to add to the **scratch pad** at the bottom.
  - Click **OK** to get out of the search screen.
  - Click in the shaded column under the **father** to add a positive history of **Hypertension.**
  - Double-click the **plus** sign in the column to add more information about the condition.
  - Additional information can be documented here.
    - Document the father is **deceased** at age **66.**
  - Click in the shaded column under the **mother** to add a positive history of **Hypothyroidism.**
  - Click **OK.**

Allergies

- The patient reports having an allergy to Amoxicillin.
- To add **Amoxicillin** as an allergy, navigate to the **Allergies** component on the Workflow MPage.
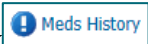
- In the search field type **Amoxicillin.**

  o The Search window displays search results.

- Select **Amoxicillin.**

- The Allergy window appears with fields to document allergy details.

- Click the **Severity** drop-down arrow and select **Mild.**

- Click the **Category** drop-down arrow and select **Drug**.

- Click the **Reaction(s)** field.

- Type **Hives.**

  o Select **Hives** from the list of options.

- In **Source**, select **Patient.**

  o If an onset date is known, this can be documented.

- Click **Save**.

- The allergy has been added. Click the **X** in the documentation box to close it.

- Once allergy review is completed, click **Complete Reconciliation**.

- After clicking **Complete Reconciliation**, the name, date, and time of the reconciliation will be displayed.

Medication List:

- From the **Home Medication** component, click the **Med History** [Meds History] hyperlink to the right of the component.

  o The **Document Medication by Hx** window opens.

- Review the patient's medications with the patient. We want to add that he is taking Aspirin 81 mg PO Daily to the patient's medication list.

- Click the **Add** button [Add] in the top left corner of the window.

- Type **Aspirin** in the Search field.

- Select **Aspirin 81 mg, Chew tab, PO, Daily, #100** order sentence.

- Review the details of the medication.

- Minimize the order details scratchpad by clicking the **collapse** icon.

- o Click the medication to view the medication details. Adjust the dose or frequency if the patient is taking the medication differently than the order sentence indicates.
- o Click the **Compliance** tab and indicate the last date and time of the dose and the status of the medication.
  - ▪ If additional medications are on the medication list, use the steps below to document the compliance:
    - ▪ Right-click one of the medications listed.
    - **HINT:** You can select multiple medications and modify details one time for all selected medications. Click the first medication then hold down the [CTRL] key and select the additional medications needed.
    - ▪ Select **Add/Modify Compliance**.
    - ▪ Click the **Status** drop-down arrow. Select **Still Taking.**
      - o Enter **date and time the last dose** was taken. If taken today, enter "T" to populate today's date.
- ▪ Click **Document History** once completed.
  - o You are returned to the Home Medications component on the Workflow MPage. You will notice a green checkmark now displays next to Meds History. `Status: ✔ Meds History`
  - o At the bottom of the **Home Medications** component, the **Document History:** section is updated from Incomplete to display the name, date, and time of the reconciliation being completed.

Problem List

Problems are reviewed and updated form the Problems component.

- ▪ From the Add As list, select **This Visit** or **Chronic**, or **This Visit and Chronic.**
  - o To change the status of a problem after it is created, click `☐ This Visit` | `✔ Chronic` **This Visit** or **Chronic** in the row for the problem.
- ▪ Enter a few characters of a problem name in the Problem Name search box.
  - o Type **Wellness Examination.**
  - o From the list, click **Wellness Examination (Z00.00).**
- ▪ Once the problem list review and updates has been completed, click **Mark as Reviewed.** `Review Incomplete | Mark as Reviewed`

Patient Intake

You will fill in the applicable fields and sections of this form that apply to your sites policy and processes. For the intent of training and demonstration purposes, you will complete the following in the Adult Ambulatory Intake Form.

- Click **Vital Signs** in the Ambulatory Nursing 2018 workflow navigator component.

- Click the **Add** drop-down arrow.

- Select **Adult Ambulatory Intake.**
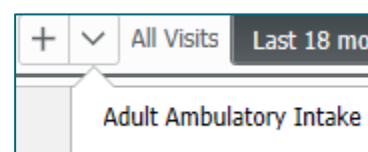
- The intake form displays defaulting to the ID Risk Screen section.

- Have you traveled within the past 6 weeks OR Have you had contact with an ill person who has traveled within the past 6 weeks? - Select **No.**

- Have you been hospitalized overnight outside of the US in the last 6 months? Select **No.**

- In the Risk Factors and Symptoms/MDRO Surveillance:

    o For Risk Factors for COVID-19: Select **No** to all questions.

- Click the **Summary ECD** tab, in the Patient Summary section:

    o In the **Vital Signs** and **Measurements** sections, chart the following:

        - Temperature: 37.2 C

        - Pulse Rate: 62 BPM

        - Respiratory Rate: 18 br/min

        - Systolic BP: 128 mmHg

        - Diastolic BP: 77 mmHg

        - Height/Length: 165 cm

        - Weight: 80 kg

        - SpO2: 95%

        - O2 Delivery: Room Air

- In the **Pain** section, enter the following:

    o Pain Present: **Yes, actual or suspected pain**

    o Numeric Pain Scale: **3**
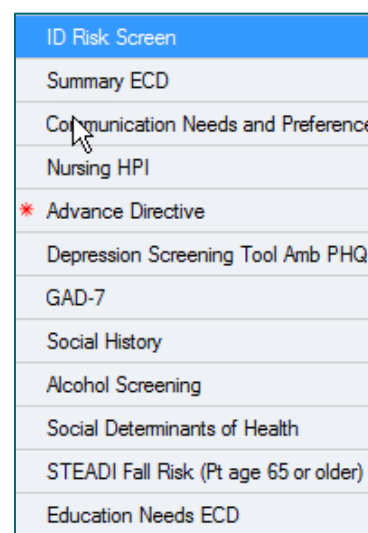
o   Primary Pain Location: **Lower Back**

Communication Needs and Preferences

- In the **Communication Needs and Preferences** section, enter the following:
  o   Preferred Spoken Language: **English**
  o   Preferred Written Language: **English**
  o   Preferred Mode of Communication: **Verbal**

Nursing HPI

- This is free text space for additional information not gathered in other areas of the chart.
  o   Enter the following: Patient reports feeling well overall health wise, up until 2 days ago where he began having lower back pain. He reports that he was helping "move a heavy appliance when it started."

Advance Directive

- Does Patient have an Advanced Directive: Select **Yes.**
  o   Based on the previous answer, conditional logic makes the **Location of Advanced Directive** available to chart and a required field: Select **Scanned into EMR.**

Depression Screening

- PHQ-2: Feeling down, depressed, hopeless – Not at all
- PHQ-2: Little Interest, pleasure in activities – Not at all
  o   Since the score was 0, no additional evaluation is needed at this time.

GAD-7

- Fill out this form if appropriate.

Social History

If the patient has been seen at another NLH Hospital or Ambulatory practice, the previously documented social history will be present and use the boxes at the bottom of the form to do **Social History Reviewed No Changes** after completing a review with the patient. Do **NOT** use the **Mark all as Reviewed.**

- Click the **Social History** tab.
  o   The **Tobacco, Electronic Cigarette/Vaping, Alcohol, Substance Use History**, and **Abuse/Neglect** are required categories to be completed.

- If no documentation exists, click the [+ Add] button to begin documenting in the Social History Tool.

  - In the **Tobacco** Section, select **Never (less than 100 in lifetime)**.

  - Scroll to the **Alcohol** section and select **Denies** in the Frequency drop-down menu.

  - Repeat this process for the remaining required categories that are to be documented on admission as mentioned above.

Social Determinants of Health

Document the following information:

  - Within the past 12 months we worried whether our food would run out before we got money to buy more? – **Never.**

  - Within the past 12 months the food we bought just didn't last and we didn't have money to get more? – **Never.**

STEADI Fall Risk (Pt age 65 or older)

- Fill out this form if appropriate

Education Needs ECD

- In the **Education Needs/Learning Style** section, enter the following:

  - Barriers to Learning: **None Evident**.

  - After you have completed documenting in the Intake Form, click the green checkmark ✔ to sign the form.

Interactive View and I&O (iView)

There are iView bands used in the Ambulatory setting to document different information. Ambulatory Assessment, Prior Authorization, Anticoagulation Therapy, and Thyroid Management are a few of the commonly used bands.

To add an iView Band:

- Adding in the Prior Authorization Band.

- In the patient's chart, go to **Interactive View and I&O**.

- To add navigator bands, from the top menu bar, go to **View>Layout>Navigator Bands**.
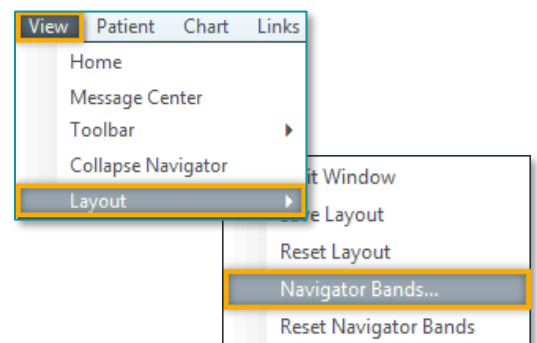
- The Navigator Documents window will display.
  - Highlight the desired band to add on the left under **Available Document Types** and use arrow to move to the right **Current Document Types.**
  - Use the up/down arrows on the right side of the window to move bands up or down within list.
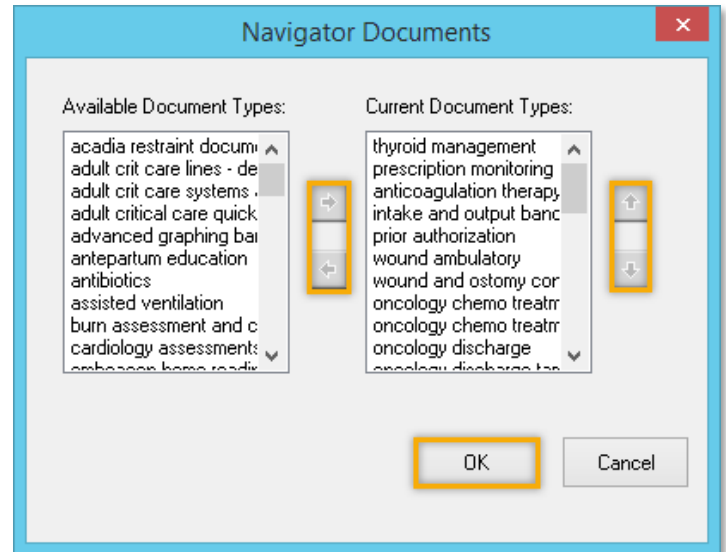
- Click **OK.**

- A **Changes to Navigator Bands** pop-up window will display suggesting to close application.
  - Click **OK.**
  - You **do *not* need to close** Millennium at this time for these changes to be made.
  - **Close the patient chart and reopen** to see the newly added band.
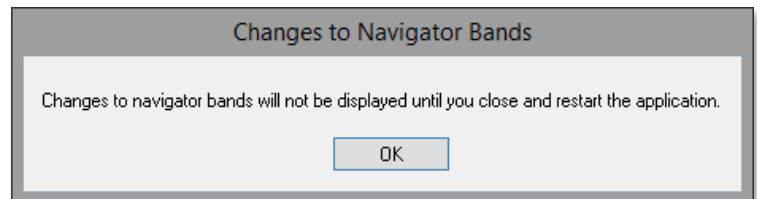
- In the **Vitals** component dropdown click **Ambulatory Assessment,** to go to iView.

Ambulatory Assessment

- Click **Intake ROS.**
- Double-click in the current time column in the gray banner for constitutional ROS.
- Click **Tab** on your keyboard to skip over otherwise negative.
- Click **No** for **Weight Change** greater than 10 pounds.
- Click **No** for **Fever.**
- Click **Yes** for **Fatigue.**
- Click **Yes** for **Difficulty Sleeping.**
- Click **No** for **Blood Transfusion.**
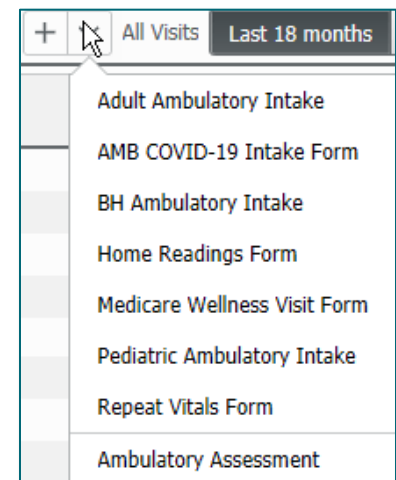
- Click into the white space to close the comment box.

- Double-click within the gray banner for **Genitourinary ROS** select **Otherwise Negative**.

- Click into the white space to close the comment box.

- Continue documenting in the fields for the remainder of the ROS sections. As a reminder, you can double-click in the ROS header as shown above or you can double-click within each cell.

Ad Hoc Charting

Document Outside Lab Results

- Search for your patient, using the **Patient Search** option(s).
  - Select an encounter from your location within 90 days before or after the current date.

- In the patient's chart, click the **AdHoc** button from the toolbar.

- Select the **Outside Labs** PowerForm and select **Chart**.

- Document the correct **Performed On**: Date and Location in which the labs are drawn.

- Locate the **Outside Labs – Coagulation** tab. Enter **2.9** in the Outside Lab – INR field.

- Click the green checkmark to sign the form.

For questions regarding process and/or policies prior to go-live, please reach out to a Super User or a local Clinical Informaticist.