Dear Providers,

Via Christi is replacing multiple existing electronic health records (EHR) with a single, integrated EHR. The single EHR, called OneChart, will improve patient outcomes by reducing errors and unnecessary care. This will help make Via Christi the best place to receive care and the best place to practice.

- OneChart will help us reduce unnecessary care and errors that result from hand-offs between health care providers, poor legibility and delay in the ordering process.
- With OneChart, clinicians will have access to the best practice standards of care.
- OneChart offers clinicians quick, easy access to our patients’ latest medical information.
- OneChart will help meet our patients’ service expectations by allowing them to use our new website portal to manage their health care.
- OneChart is based on the latest technology and leverages years of EHR experience.

This booklet contains the main functionalities needed to navigate, use and optimize the features of OneChart. More information, tools and educational videos can be found at viachristi.org/onechart
WHY ONECHART?

OneChart is a system that provides integration of clinical information between Via Christi’s outpatient and inpatient settings.

No handwriting to decipher, no orders to transcribe

OneChart will reduce the number of repeat tests.

CPOE drastically reduces turnaround times for Laboratory, Pharmacy and Radiology.

OneChart allows direct electronic prescribing to pharmacies.

OneChart provides clinical decision support (CDS), drug and allergy checks and access to evidence-based medicine.

Remote access to records will improve patient care and improve physician satisfaction.

OneChart allows physicians to save favorite content to streamline their workflows.

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Navigating the ambulatory organizer

1. **Color Status Bar** indicates the status of the appointment.
2. **Appointment Time** column displays the appointment time.
3. **Patient** column displays the patient name, age and gender.
4. **Appointment Details** column displays the appointment type.
5. **Status** column displays the status of the appointment and the patient’s location.
6. **Notes** column displays reason for visit and chief complaint data, as well as temporary comments.
7. Select **Patients for:** menu to view providers to be displayed.
8. Select **User Preference** menu to view **Note Reminder** or **View Order Reminder** tasks to be displayed in the **My Day** and **Open Items** views.
9. **My Day** view displays today’s appointments for up to five providers. If only one provider is currently displayed, then a timeline is available to the far right side which mimics **Calendar** view behavior.
1. **Calendar** view displays a single provider’s schedule for a day or a week interval.

2. **Open Items** view displays unfinished tasks for a single provider, from yesterday through the past seven days.

3. **Patient** column displays the patient name, age and gender.

4. **Appointment Details** column displays the appointment type.

5. **Notes** column displays reason for visit and chief complaint data, as well as temporary comments.

6. **Outstanding Actions** column displays outstanding items (Note Not Started, Note Saved, or Charge Not Started).

7. Select **Patients for:** menu to view providers to be displayed.

8. Select **User Preference** menu to view **Note Reminder** or **View Order Reminder** tasks to be displayed in the My Day and Open Items views.
9. Select Schedule view controls to change the Calendar view.

Color status bar

- Light blue indicates a confirmed appointment
- Dark gray indicates the appointment has been checked out
- Orange indicates a Seen by physician, mid-level provider or resident has taken place
- Green indicates a Seen by nurse or medical student has been triggered or selected to flip automatically when certain actions (such as signing a note with a specific note type) occur. This can also be manually changed by the user by selecting the status and choosing Seen by [a position]
- Medium blue indicates a checked-in appointment
- White indicates a No Show or Canceled appointment (Canceled appointments are displayed if the system administrator has configured them to display)

Selecting providers to be displayed

1. From the My Day view, select the Add Other option in the Patients for: menu
2. Search for and select the name of another resource
3. Click the box to the left of the name to indicate you want to see their appointment details at this time

4. Click **Apply**

5. To prevent a resource from being displayed, remove the check mark and click **Apply**

6. To remove a resource from this menu, select the gray X to the far right, then click **Apply**

**Manually changing patient location**

1. From the **My Day** view, click the patient appointment location

2. Select a new location from the menu

**Adding a temporary comment**

1. From the **My Day** view, click the gray **Note** icon

2. Enter the temporary comment in the **Comments** box

3. To view the temporary comment, click the **Note** icon
Opening a patient chart

1. Click on the patient’s name in the **My Day** view, **Calendar** view or the **Open Items** view. The patient’s chart opens.

2. Selecting the reminder tasks in the **My Day** view or the **Open Items** view will open the portion of the chart the system administrator has set up to open. For example, this could be **PowerOrders** for a charge item and **Clinical Notes** or **Document Viewing** for a note item.

Completing open items

1. From the **Open Items** view, position the pointer over the **Note Not Started**, **Note Saved** or **Charge Not Started** item and select the text.

2. Complete the outstanding action.

Manually completing open items

1. Position the mouse pointer over the reminder task icon to display a check box.

2. Click the check box to complete the reminder task.

3. Click the check box again to unsatisfy the reminder task in case you accidentally selected the wrong one.
Message Center

Navigating the Inbox Summary

**Inbox** Your own inbox

**Proxies** Inboxes for which you have proxy rights

**Pools** Pool inboxes

1. Click a folder to display the items in that category
2. Double-click the item to view it
Message Center icons

**Communicate**
Creates a new message, reminder or consult

**Open**
Opens the selected notification

**Message Journal**
Displays a list of phone messages, reminders and consults that have been documented for the selected patient

**Reply**
Opens the item, enabling you to send a reply to the sender

**Reply All**
Opens the item, enabling you to send a reply to the sender and all recipients of the original item

**Complete**
Marks the selected item as completed

**Forward**
Opens the item, enabling you to add text and forward the item to another user

**Delete**
Deletes selected item

Signing documents or results

1. Open and read the message
2. Review the notification and select **Save** or **Endorse**
3. Click **OK** or **OK & Next**
Replies to a message
1. Open and read the message
2. Click **Reply** or **Reply All** as appropriate
3. Compose the message
4. Select any additional messaging options. Click **Send**

Approving refill requests
1. Double-click the appropriate folder in the **Inbox Summary**
2. Double-click the request to open it
3. Review the request
4. Click **Accept All** or **Accept All and Next** to approve the request
1. **Consolidated Problem** Modify or add problems and diagnoses
2. **Home Medications** All active home medications documented for the patient
3. **Procedures** Patient’s past procedures and details
4. **Documents** Preview patient documents and add precompleted notes
5. **Vital Signs** View and update vital sign details
6. **Diagnostics** Radiology-related clinical results for the patient
7. **New Order Entry** Add orderables and **PowerPlans**
8. **Labs** Lab-related clinical results for the patient
Adding a new diagnosis, problem or past medical history

1. Expand the component by clicking the Expand and Collapse button.

2. Click Add New and select a new problem or diagnosis.

3. From the list, select This Visit, This Visit and Active, Active or Historical.

4. In the search box, enter the item. Up to 10 closest matches are displayed.

5. Select a term. Depending on your selection, the following actions occur:
   a. This Visit: The condition is added to the This Visit section as a diagnosis.
   b. This Visit and Active: The condition is added to the This Visit section as a diagnosis and to the Active section as an active problem.
   c. Active: The condition is added to the Active section as an active problem.
   d. Historical: The condition is added to the Historical section as a resolved problem.
Perform resolve, inactive and cancel actions

1. From the list in the Consolidated Problems component, open the Component menu by clicking the menu button on the header

2. Select Resolve, Inactivate or Cancel. The status of the problem is updated and it is removed from the Active list

3. Select a condition from one of the sub-sections

4. Select a problem in the Active section for the condition, then select an action from the list

5. To return to the summary, click the back arrow at the top left portion of the screen

Modifying a diagnosis

1. Expand the appropriate section containing the diagnosis you want

2. Position your pointer over the condition name and a pencil icon is displayed if the diagnosis can be modified

3. Click the pencil. The Modify Diagnosis or Modify Problem window is displayed

4. Complete the necessary details
Navigating order details

When the details of an order are updated in the Details tab, the update is also displayed in the Details column of the Orders list.
PowerOrders icons

- **Order Details Not Complete**
  Indicates there are required details that have not been completed for the orderset

- **PowerPlan**
  Indicates the orderable is part of a PowerPlan

- **Clinical Calculator**
  Launches the clinical calculator so you can make a calculation

- **Dose Calculator**
  Launches the dose calculator

- **Inpatient Orders**
  This icon represents tasks or medications that have been ordered for the patient while in the hospital

- **Nurse Review**
  Indicates that nurse review is required

- **Sliding Scale**
  Opens the sliding scale dialog box

- **Rx Verify Indicator**
  Indicates that the order is subject to Pharmacy review and has not yet been reviewed by a pharmacist

- **Rx Refusal Indicator**
  Indicates that a pharmacist has rejected the order

- **Ambulatory Order**
  Denotes that this order is an ambulatory order

Adding an order using PowerOrders

1. Click **Add**
2. In the search box, enter the name of the order you are searching for

3. Select **Starts With** or **Contains** if necessary to broaden the search criteria

4. Select the order from returned results

5. Select appropriate order sentence if prompted or modify the order from the **Details** tab

6. To complete order, click **Sign**

### Modifying an order using PowerOrders

1. Select the order to modify
2. Right-click the order and select **Modify**
3. Modify the order details
4. Click **Orders for Signature**

### Canceling an order using PowerOrders

1. Select the order you want to cancel
2. Deselect the check box next to the order you wish to discontinue, or right-click and select **Cancel/DC**
3. Modify the date and time in the details pane
4. Click **Orders for Signature** to complete canceling the order

**PowerPlans**

**Navigating PowerPlans**

1. **Plans** Includes all ordersets in an initiated, planned and discontinued state
2. **Orders** View orders by clinical category

![Diagram of PowerPlans interface](image-url)
PowerPlans Icons

**Merge View**
Displays the orderset components with those orders previously placed and active on the patient

**Initiate Plan or Phase**
Initiates the selected orderset or phase

**View Excluded Components**
Displays items that were not previously ordered in an initiated orderset

**Discontinue**
Opens the Discontinue dialog box so that you can discontinue the orderset or phase

**Plan Comment**
Adds a note to the orderset or phase

**Add to Phase**
Allows you to add an additional order or a prescription to an orderset or phase

**Filter Phase Components**
Allows you to view only selected items in the orderset or phase

Planning an orderset

1. Click Add
2. In the search box, enter the name of the orderset you are searching for
3. Select **Starts With** or **Contains** if necessary to broaden the search criteria
4. Select the orderset from the returned results
5. Select the orders you want to include and deselect those you do not
6. Modify the associated order sentences if necessary by clicking
7. Click **Orders for Signature** to place the orderset in a planned state.

8. Click **Sign**

**Removing an orderset**

1. Select the orderset you want to remove.

2. Right-click and select **Remove — Only plans with a Planned status can be removed**

**Adding an order to an orderset**

1. Select the appropriate phase of the **PowerPlan**

2. Click **Add to Phase** from the plans toolbar and select **Add Order**

3. Search and select the order you want
4. Click **OK**
5. Click **Sign**

**Discontinuing an orderset or phase**

1. Select the orderset you want to discontinue.
2. Right-click and select **Discontinue** or click the **Discontinue** button — *Only orders that have been initiated can be discontinued*
3. Select any orders you want to keep
4. Click **OK**

**Ordering excluded components**

1. Select the orderset you want to view excluded orders for
2. Click **View Excluded Components**
3. Select the check box next to the component you want to order
4. Click **Sign**
Navigating a PowerNote

1. **Table of Contents** Used to navigate throughout the levels of a PowerNote

2. **Paragraph Heading** Review of Systems and Chief Complaint are examples of paragraph headings

3. **Sentence Name** Constitutional, Eye and ENMT are examples of sentence names

4. **Term** Negative and Fever are examples of terms

Adding a PowerNote

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

**Viewing a PowerNote**

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

**Modifying an existing PowerNote**

1. Open an authenticated or modified **PowerNote** in the **Documentation** tab
2. Click the Modify toolbar button

3. When prompted, select whether you want to modify or correct the note
   a. Select the Correct Note option if you want to correct the content of the note. This opens the note in the **PowerNote** editor where you can use structured documentation to make changes to the document.
   b. Select the Modify Note option if you want to add an addendum to the note. This opens the **Clinical Notes** editor.

4. Click **OK**

**Copying an existing note**

1. Click the Existing tab. Make any applicable existing note filters
2. Select the note you want to copy
3. Select the **Copy to new note** checkbox and click **OK**
4. From the Paragraphs to Copy window, select the appropriate checkboxes for the paragraphs you want to copy
5. Click **OK**
6. The Auto Populate Document window opens, select the patient data you want to auto populate into the note and click **OK** to open the copied note in **PowerNote**
Signing a PowerNote

1. With the note open, click **Sign/Submit**

2. If the note has not been saved previously, you can change the note type at this time

3. You can also change the title or date if needed

4. Click **OK** to sign the note
Dynamic Documentation

Navigating a Dynamic Documentation note

1. **Toolbar** Use the toolbar to format text; to copy, cut and paste text; to undo and redo actions; and to manage autotext

2. **Manage Autotext** Click Manage Auto text to create and manage auto text entries

3. **Sections** Allergies and Social History are examples of sections

4. **Subsections** Vitals & Measurements is an example of a subsection

Adding a Dynamic Documentation note

1. In Document Viewing, click Add

2. Select a note type from the Type list
3. Enter a title
4. Define the service date and time
5. Double-click a reference template from the bottom of the page. A new note opens
6. Add and edit text to complete the note

**Signing a Dynamic Documentation note**

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

**Opening a Dynamic Documentation note**

1. In the **List** tab, a list of documents, consistent with the filter, is displayed
2. To narrow or change the filter, select **Only** in the **Display** box
3. In the second box, select your filter

4. Select appropriate descriptors for any other boxes displayed

5. In the list of displayed documents, double-click the note you want to open. The selected note is opened in the editor

**Modifying an existing Dynamic Documentation note**

1. Open an authenticated or modified *Dynamic Documentation* note in the document list

2. Click the **Modify Toolbar** button or right-click the preview pane and select **Modify**

3. The note opens and positions your cursor in the **Insert Addendum Here** text box. Enter your addendum

4. Click the X at the right side of a selection to strike through the entire selection. Highlight free text and click the **Strike Through Toolbar** button to strike through portions of free text
5. Click **Sign/Submit**

**Cerner ePrescribe**

**Navigating Cerner ePrescribe**

1. **Tabs** Navigate between **Orders**, **Medication List**, and **Document in Plan** tabs

2. **Search Box** Search by order name

3. **Type** The order type

4. **Details, Order Comments, Diagnosis** Enter details, comments and view the linked diagnosis

5. **Send To List** Select the order recipient
Cerner ePrescribe buttons

**External Rx History**
Viewable outside prescriptions for a patient

**Check Interactions**
Check current medications with ordering medications for any adverse reactions

**Medication History**
Displays previous medication

**Rx Plan**
A patient’s third party insurance. Prescription insurance can be added and selected

Placing a medication order

1. Click the **Orders** tab
2. Click **Add**
3. Enter the orderable in the **Find** box
4. Click **Search**
5. When finished, click **Done**
Renewing a prescription

1. From the **Orders Profile** tab, select the prescription to renew
2. Right-click and select one of the **Renew** sub-menu options
3. Complete the order details
4. Click **Orders for Signature**

Routing a prescription to a Pharmacy

1. Select an order, then click **Send To**
2. Select the appropriate routing type from the **Send To** list
3. Click **Find Pharmacy**
4. From the **Search** tab, enter the pharmacy information in the search parameters
5. Click **Search**
6. Select the appropriate pharmacy and click **OK**
Routing a prescription to a printer

1. Select an order, then click **Send To**
2. Select the appropriate routing type from the **Send To** list
3. Select the printer to which you want to route
4. If the wanted printer is not displayed in the **Sent To** list, click **Other**
5. Select the appropriate printer and click **OK**

Modifying prescriptions

1. Click **Replace △** and select **Same Medication, Different Dose or Formulation**
2. Modify any order details, such as dose, route and frequency
3. Click **Sign**
Exiting OneChart properly

It is very important to use the **Exit door icon** on the toolbar to sign off of OneChart instead of clicking the **X** in the upper-right hand corner of the screen. Failing to do so may cause any newly created preferences to be lost.

Understanding and creating favorites

Favorites are pre-set, pre-completed selections, which include specific details for your selection.

You may have favorites for diagnoses, problems, allergies, medications, orders, etc. Your favorites are found by locating and selecting the star 🌟 that is visible on order entry windows.

The favorites can be organized into folders and recalled whenever needed to speed efficiency and enhance convenience.

1. To add a favorite, go to the **Orders** section of the **Navigation** pane on the left side of the screen:
2. Search for the lab test, radiology study, procedure, charge code or medication you wish to add as a favorite

3. Change anything desired, such as the reason for exam on radiology orders or the desired sig on medications

4. Right-click the order itself and choose Add To Favorites

5. Choose the Favorites folder in which you would like the new order to be placed. You may also create a new folder
6. You can use favorites from multiple places, including the **New Order Entry** area of the **Ambulatory Summary**

Creating and managing autotext

1. Select the **Manage Autotext** icon from within any **Text Entry** window
2. Select the icon to create new autotext
3. Enter the abbreviation phrase name. The phrase should begin with a period or slash (. or /)
4. Enter a full description for the autotext
5. Select **Add text** for autotext phrase
6. Enter text or paste from a document (such as from Microsoft Word)
7. Select **Save**
8. The autotext can now be used in most freetext areas of the chart
Adding others to Personal Address Book

1. Open a message within the **Message Center**

2. Click the **Binoculars** icon next to the **To:** field

3. In the window that pops up, type the name of the person you wish to add to your address book

4. Select and right-click the person’s name after it is found

5. Choose **Add to Personal Address Book**

6. To view users in your personal address book, change the drop-down menu from **Global Address Book** to **Personal Address Book**
Creating a family history QuickList

1. Go to the family history area by clicking the Histories navigation menu item

2. Click the magnifying glass next to the QuickList item

3. In the window that pops up, double-click any of the items in the Current Conditions tab to add them to the QuickList

4. To find additional conditions, click the Search tab and search for the condition you wish to add

5. Click OK to save these selections

Opting in a messaging pool

1. Select the Pools tab in the Inbox Summary
2. Click Manage
3. Select the pool you wish to opt in. The pool will highlight blue
4. Click the Opt In > button and click OK

Determining who is in a messaging pool

1. Select Details at the bottom of the window
2. The members of the pool are located in the left lower portion of the window
Determining if a patient is signed up for portal

In the patient information area at the top of the screen, look for the Patient Portal indicator. If it says Yes, they are already a portal user.

Signing up a patient for the patient portal

1. Click the down-arrow next to the PM Conversation button at the top of the screen and choose Patient Portal Registration

2. Under the Patient Portal Registration drop-down, choose Yes and generate invitation

3. Type the patient’s email address in the appropriate field

4. Ask the patient for a four-digit PIN

5. Click OK
Saving Patient Education favorites

1. Click the **Patient Education** button in the toolbar at the top of the screen.

2. Search for the education item desired.

3. Right-click the education material and choose to **Add to Personal Favorites**.

4. To choose personal favorites in the future, click the **Personal** button in the **Patient Education** area.
Customizing Ambulatory Summary

Changing the order/layout of Ambulatory Summary sections ("widgets")

1. Click the far right drop-down menu and choose **Drag and Drop**

2. Left-click and hold, dragging any of the widgets wherever desired

Changing the color of widgets

1. Click the upper-right button of any widget, select color theme and drag the mouse to the desired color
Creating document filters

1. Click the **Documentation** link from the left side of the screen

2. Choose the ellipsis next to the **Display** option

3. In the **Advanced Filters** window that pops up, you may select various items to create new filters so that various documents may be shown instead of the entire list

4. Once these are selected, click **Save As** and name the filter

Some suggested filters to give an idea of the functionality

   a. **My Documents** Click the **Binoculars** icon next to **Select the Document author**. Search for yourself in the list of users that pops up.

   b. **Clinic Notes** Check the **Office/Clinic Notes** selection from the left side of the screen under **Select the Document Types you want to see**
c. Last 30 Days Enter the number 30 and select days under the area titled Select How Far Back to get Documents

Adding custom links in toolbar

How to modify the order of the Action toolbar

1. Click on the drop-down arrow at the end of the toolbar
2. Select Add or Remove Buttons
3. Select Customize

4. A Customize Tool Bars window will appear with instructions on how to modify the toolbar

5. If you click Add, you can add a link to another website; this will show up in the toolbar at the top of the screen
6. Adjust the **Action** toolbar to include the following icons:
   a. Communicate
   b. Patient Pharmacy
   c. Patient Education
   d. Depart
   e. Exit

### Setting the default menu to Ambulatory

1. On the **Navigation** menu, click on the black, down arrow to display the available menus

   ![Menu - All](image)

2. Select **Set as Default** and locate **Ambulatory** menu from that list, click on **Ambulatory**

   ![Set as Default](image)

3. Right-click the **Ambulatory Summary** item after it appears and choose to **Set as Default**
Setting the order folder default

This setting allows one click access to the department folders

1. From **Menu** – select and click on **Add**

2. **Add Order** window opens. Set filter to **Ambulatory-In Office (meds in office)**

3. Select the **Folder** icon, and the list of specialties will appear

4. Locate appropriate specialty list; click on appropriate specialty

5. List of locations appears. Right-click on appropriate location, click on **Set as Home Folder**
6. When set, each time the **Orders Add +** appears the department home folders will appear

![Image of folder icons](image)

**Adding a proxy**

1. Select the **Proxy** tab in the **Inbox Summary**

![Inbox Summary](image)

2. Click **Manage**

3. Click **Add** to **Give Proxy** to someone

4. You can also click **Manage** to manage any **Proxies** taken from you
5. Enter a name to give proxy and select the down arrow if you plan to give proxy to more than one person at a time. Remember, you must leave a name in the **User** box for the system to accept the request.

6. Select the items for which you wish to grant proxy and select **Grant**, or you may select **Grant All** to grant access to your entire Inbox.

**Setting a default printer for prescription printing**

1. Create a medication order
2. In the **Routing** window, select **Find Printer**
3. Make sure the **Default** is set to **Selected Pending Prescriptions** and **Always treat my personal default output destination as the default**
4. From the **Output Devices** tab, search for **Clinic** on left
5. Select the location, on the right — locate printer number, right-click and **Set as Default**
Changing order of Medication list and Orders list

Both the Medication and Order lists will need to be customized to the Recommended Settings for Outpatient Providers.

1. **To customize view** Select from menu. From the tool bar — Select: Current then Customize View to open the Customize View window

![](image1.png)

**Note:** This action is used to customize both the Medications and Orders lists

2. **Column Display in Medication List** Add items from Available columns and sort in the order illustrated below: Selected Columns and Group & Sort Orders need to be set

![](image2.png)

**Selected Columns**
- Type
- Notifications
- Start
- Order Name
- Details
- Ordering Physician
- Status
- Compliance Status
- Compliance Comments
- Stop
- Last Updated
3. Set the **Display to All Active Medications** (located on top of the **Medication** list) — Left-click on blue text at the top of the **Medication** list

4. **Advanced Filter window displays** Set to All Active Medications:

5. **Column Display in Orders List** Add items from Available columns and sort in the order illustrated below: **Selected Columns** and **Group & Sort Orders** need to be set

**Selected Columns**

- Type
- Notifications
- Start
- Order Name
- Details
- Ordering Physician
- Status
- Stop
- Last Updated
- Last Updated by
6. Set the display to **All Active Orders** (located at the top of the order list) — Left-click on the blue text at the top of the orders page

7. **Advanced Filter window displays** Set to **All Active Non-Medications**

### Suggested clinic workflow

Use of an electronic patient record requires some thought about workflow around data entry and patient care. Information must be as complete as possible to allow for adequate capture of interventions on any patient encounter. A suggested workflow is as follows:

1. Arrive at clinic location
2. Log into computer
3. Check messages, results, reminders and refills *(Message Center)*
4. Check schedule and make any notes on patients prior to starting day
5. Review chart of patient before or during patient intake *(Ambulatory Summary)*
6. Enter/update problems, diagnoses, allergies and maybe historical information *(Ambulatory Summary)*
7. Interview and examine patient/perform procedure
8. Complete any orders for labs, radiology, referrals and point of care testing (Ambulatory Summary or Quick Orders)
9. Order follow-up visit and billing (Ambulatory Summary or Quick Orders)
10. Document visit using DD, PowerNote or AdHoc documentation (Admit | Clinic and Documentation)

**Reviewing results**

1. Select Results Review from the Menu List items

![Results Review]

2. Select the appropriate view or the appropriate tab to view results more in depth

![Lab Results Window]

3. To graph results, select a lab test and then choose the graphing button on the upper left-hand corner of the lab results window

![Graphing Button]

4. The Ambulatory View will give a snapshot of all items over time in a patient’s chart. To see more information about an item, double-click its text.
Creating a patient letter

1. Select **Communicate** from either within the **Message Center** window or from within any patient chart in the toolbar buttons:

2. Select **Patient Letter** and complete the details in the **Create Letter** pane, including choosing a subject.

3. To insert results, choose the **Add Results** button on the right side of the screen. In the window that pops up, select any items you wish to be inserted into the letter.

4. Autotext can be used in the body of the letter.

5. Additional orders can be placed on the patient prior to sending the letter by choosing **Launch Orders**.

6. The letter can be previewed by clicking the **Preview** button at the bottom right corner of the screen.
7. You may forward the letter to another individual by completing the detail in the **Action** pane at the bottom of the screen.

**Scheduling a reminder**

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

![Communicate Menu](image)

2. Select **Reminder** and complete the details in the **Reminder** pane, including recipient (check the **Include Me** box to send a reminder to yourself) and details in the text window.

3. Select **High** or **Notify** to mark the reminder as high priority or to provide receipt notification.

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

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

**Adding a modifier code**

From the orders screen, there is a **CPT Modifier** field in the **details** tab.

1. Select the appropriate charge code from the **Orders** section of the **Ambulatory Summary** or from **Quick Orders**.
2. Click the **Orders to be signed** button
3. Choose the **Modify** button

![Sign, Save, Modify, Cancel buttons]

4. Double-click the order to be modified
5. Choose the appropriate CPT Modifier from the menu and then **Sign** the order

![Orders for Signature](image)

**Refreshing the screen**

So that multiple people can be in the chart at the same time, Cerner requires that screens be manually refreshed. This will save and update any information that has changed since the last time the page was refreshed.

Refreshing should be done after any new orders or significant alterations are made to the chart.

To refresh, click the **Refresh** button in the upper-right hand side of each screen. It will display the number of minutes it has been since the last refresh: ![31 minutes ago]

Remember to refresh often.
Patient alerts

OneChart allows you to view and document special alerts about a patient. Upon opening the chart of a patient with an alert, a pop-up box will display the specific alert(s).

Additionally, alerts can be viewed on the **Ambulatory Summary MPage** in the **Summary** area:
To document an alert, click the button. This will take you to a screen that will allow entry of administrative or clinical alerts. Note that Other is a choice for both types. Click the green check mark in the upper left hand corner of the screen to save the alert.

Using Patient Education

1. Click the Patient Education button in the toolbar at the top of the screen.
2. The Patient Education area will suggest educational material based on any diagnoses that have been entered. Alternatively, favorite or departmental topics can be chosen.
3. To search for an educational topic, the search field can be used.
4. Once an educational topic is found, double-click it to view the contents.
5. If changes are desired to an educational topic, these can be made directly in the document itself.

6. To save the modified educational material, right-click the information in the Selected Instructions area on the left. You may choose to Save as Personal Custom Instruction or Save as Public Custom Instruction. Choosing to save as public instruction will allow for sharing with other users.

**NOTE:** Saving educational material for later use and not using the suggested files will not count toward Meaningful Use Patient Education requirements.
Changing a patient’s pharmacy

Any pharmacy that has been added to the patient’s preferred list will be accessible from the medication ordering screen by using the down-arrow next to Send To. If a patient wishes to use another pharmacy not already in his or her list:

1. From the Medication Ordering screen, choose the ellipsis from the upper-right corner (next to the patient’s pharmacy).

2. From the screen that pops up, you can either choose any pharmacy the patient has previously used or click the Search tab to find another pharmacy.
Using the Dosage Calculator

1. Select the Dosage Calculator icon from the Medication Order screen

2. The patient’s height and weight are populated from the chart

3. Select the target dose and Dosage Calculator will compute actual dose

4. Select rounding rules, adjustment and algorithm if necessary

5. Modify final dose (to override calculated dose) if necessary and click on Apply dose to return to the Order screen
Adding Health Maintenance items

1. Select **Health Maintenance** from the **Menu List**

2. Select **+ Add** next to **Pending Expectations**. Health maintenance items are known as “expectations” in OneChart

3. Select expectations to track and remind
4. Complete detail to add expectations, then click **OK** to accept

5. You may alter expectation due dates or frequencies by selecting the items (in blue) corresponding to the expectation
6. From the list of health maintenance items, you can document that they are complete, refused, postponed, etc. by clicking the appropriate text beneath each item.

How to send a message to a patient on the portal

1. Within the **Message Center**, click the **Communicate** button.
2. Search for a patient and then click the **To consumer** checkbox. This will send the message to the patient.

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**How to send to a preceptor with DD**

1. Create the **DD** note. In the **Assessment/Plan** section, click the **Insert Free Text** button.

2. Go to the free text line and type “.res” to see the possible options for **Precepting**. Choose **discussed**, **present for exam** or **present for procedure** to enter the level of precepting.
3. Click the **Sign/Submit** button

4. Choose the appropriate **Type** and click **Sign**

5. In the top of the **Documentation** window that appears, click the **Forward** button

6. Choose **Sign** and choose the appropriate preceptor; then click **OK**
How to precept a resident/advanced practice provider in DD – Residency

1. Within the **Message Center**, go to **Documents** and select the document in question that needs to be precepted

2. Right-click the document, choose **Open Patient Chart** and then **Documentation**
3. Choose **Physician (Office/Clinic Only)** in the pop-up window that opens

![Assign a Relationship window]

4. Open the note that needs to be precepted by double-clicking it in the list

5. Go to the bottom of the document where it says **Insert Addendum Here**

6. Type “.pre” to display the options for the level of precepting

7. Choose the appropriate level of precepting (reviewed, discussed, present in the room or present for preceptor)

![Options for level of precepting]

8. Click the **Sign/Submit** button
How to precept a resident/advanced practice provider in DD – Non-Residency

1. Within the **Message Center**, go to **Documents** and select the document in question that needs to be precepted

2. Double-click the item to open

3. To add an addendum (preceptor statement), click the **Modify** button at the top of the screen. This will open the note and place the cursor in the addendum place; you can then add the .pre phrase appropriate for the level of precepting

4. In the **Action** pane at the bottom of the screen, click either **OK & Close** if this is the only document to be signed or **OK & Next** to sign the document and open the next one
Saving and modifying an orderset

1. From the **Order Entry** area, search for an existing orderset (for example, “well” will bring up the well adult/child ordersets that are pre-built in the system.

![Image of Order Entry screen]

2. Check any of the orders that you would like to be pre-checked in the future.

3. Click the **Add to Phase** button and choose **Add Order** to add an additional order to the orderset.

![Image of Add to Phase screen]

4. Search for the order desired and pre-check it if desired.

5. Click the **Save as My Favorite** button at the bottom of the screen and name the new orderset.

6. From now on, the orderset will be found under **My Plan Favorites** in the **New Order Entry** widget on the **Ambulatory Summary** or the **Quick Orders MPage**.

7. Ordersets need to be **Initiated**, not just signed, unless the orders are not to be carried out until the future.
Refusing an incorrectly assigned document

1. Double-click the document in the **Message Center** inbox
2. Click the **Refuse** button under **Action** and choose a reason
3. Choose to forward the document to Word Processing

**NOTE:** If you know to whom the message should be sent, instead of refusing it, simply forward the document to them directly by clicking the **Forward** button.

Sending referrals

1. Select the order **Internal Referral** or **External Specialty Referral** in the **New Order Entry** area based on where the patient is being referred
2. This referral order will go to the clinic task list; the person is responsible for handling referrals in each clinic will be able to view this and set up the referral
3. The referral orders can be added to your favorites with details already saved

Creating a work/school excuse

1. Create the text of the work/school note as an autotext or Dragon-saved phrase (see how-to file about how to create an autotext)
2. Click the **Communicate** button from the top toolbar and choose **Patient Letter**
3. In the **Patient Message** section of the window, insert the autotext or saved Dragon phrase

**Note:** This will be addressed **TO** the patient, so the autotext should reflect this
Note: The patient’s first name is all that will be displayed on the document. If the full name or DOB are desired, they will need to be added manually.

4. In the Action pane at the bottom of the screen, you may choose to Print Now or forward the note to someone else to print.

5. Click OK or Preview (to see the note first)

**Sending a message to portal with lab results attached**

1. Open Message Center and access the Results section. Select the lab results you would like to include in the message and select Create.
2. Include any additional message you would like to convey to the patient in the body and select **Send**