Ambulatory Provider Documentation Training

Course Agenda

TOPIC	DEMO	Min
Welcome and Introductions • Introduction of Trainer • Ground Rules – Setting the Overall Expectations • Learning Objectives • Review of Agenda • Additional Resources and Materials		
MMODAL (IF APPLICABLE)		
Log In	Your log in is the same as the computer log in.	
Set Up	Click Begin and enter your hospital email address and pick your security question.	
Calibrate Microphone	• Profile training will then begin to provide a quick introduction to MModal as well as introduce the system to the users unique speech patterns to better provide speech recognition • Select Begin and use the push the record button on your microphone to begin dictating a series of short paragraphs • Once profile training is complete, select Finish	
Speech Recognition	• **Dictionary:** For terms that the system has trouble identifying, adding the terms to the dictionary can be beneficial	
Using MModal	• Select a free-text area • Hold down the record button • Dictate information	
CERNER		
ACTIVITIES: 1. Login 2. Discuss Security and Confidentiality 3. Automatically displays the Ambulatory Organizer and Message Center.		

Message Center
• Results
• Orders
• Documents
• Messages
• Saved Documents
• Reminders
 	
Ambulatory Organizer
• Selecting Resources
	Message Center
	• **Results:** display in Message Center as normal, abnormal or critical.
	• **Messages:** Send message to another classmate. Open received message and reply. Delete message.
	• Demonstrate selection of Message Templates and various elements associated with each.
	   o General Message
	   o Phone Message
	   o Physician Office Clinic Message	

- Organizer Views
- Patient Tracking
- Patient Status
- Patient Search
- Declaring a relationship
- Notes

Proxy
- Assigning
- Managing

Pools
- Opting in to a Pool
  o Assigning Yourself to a Message
  o Responding to a Message Within a Pool
  o Deleting a Message

  o Medication Refill Message
  o Referral Message
- Search for Patient's name in the Caller and Phone Contact information section of the message.
- **Reminders:** Set reminder for 1 minute from now. Click refresh. Open reminder and delete.

Ambulatory Organizer
- **Selecting Resources:** Search for your provider.
- **Organizer views:**
  o Day View
  o Calendar View (Look Ahead)
  o Open Items (For Physicians)
- Seen by
- Color coding
- **Patient Status:** How to change Patient Status under Status in Day View.
- **Patient Search:**
  o Ambulatory Organizer
  o Recent Patients/ Search
- **Notes:** Can add notes about why the patient is being seen
- **Proxy:** Providers may grant inbox privileges to a staff member to give them visibility to certain types of information.
- **Pools:** Pools are group of people who will have access to a group/on-call message center – explain how to work from pools and address items in the pools.

ACTIVITIES**:**
1. Open patients chart by left clicking on patient's name in any view.
2. Open a specific tab by right clicking on the patient's name and select the tab you want to open to.

Chart Elements
- Banner Bar
- Patient Chart Overview
- Toolbar Overview
- Refresh Button

Banner Bar:
- Identify demographic data available in the banner bar, including patient location.

Refresh Button:
- The Refresh button only refreshes the screen you are on.

Home Menu (Dark Menu)
- Ambulatory View
- Inpatient View
- Results Review
- Orders
- Documentation
- Allergies
- Clinical Media
- Diagnoses & Problems
- Form Browser

• Growth Chart • Recommendations • Histories • MAR Summary • Medication List • Patient Information (Patient Face Sheet) • Visit Summary • Flow Sheet • Outside Records • DM Viewer		
Ambulatory View • Clinic Tab	• **Chief Complaint:** Enter text in the free text space. • **Documents:** Open a previous progress note. • **Diagnostics:** Click on the test to see the report. If the test is imaging, show how to link into PACs. • **Allergies:** Add an allergy to Bactrim that started in 2010. • **Problem List:** Add a problem and prioritize as number 1 problem. • **Forms:** Single click to open the intake form and review. • **Patient Education:** Add patient education specific education. Modify the education to add specific instructions. • **New Order Entry:** Enter an order for a urine specimen to be collected for now and enter an order for lab work to be completed at the lab. • **Check Out:** Make sure there are green check marks on each item for a successful check out process. • **Follow Up:** Enter a follow up so the patient returns in 6 months. • **Clinic Note:** After documenting in the free text spaces for HPI, ROS, PE, and Plan, click on the create note section. Once you click on the note you want, all the information will fall into the note template. Review the note and then click Sign/Submit.	
• Orders	• Select what you want, click on the shopping cart, assign a diagnosis, and click sign. • Modify the order from this page.	
• Charges	• Select what you want, click on the shopping cart, assign a diagnosis, and click sign. • Modify the order from this page.	
Signing vs Saving	• **Signing:** Documentation is signed to the chart. Everyone can see your documentation. • **Saving:** Documentation is not signed to the chart. You are the only person who can see it.	
Medication Hx Documentation • External Rx History • Updating compliance • Adding new Removing	**Document Home Medications** • 5 mg of Ambien daily at bedtime that the patient actually takes on a prn basis • Coumadin 3mg every M, W, F as prescribed. • Symbicort (80-4.5 mcg) inhaler 2 puffs BID, that is used as prescribed by their PCP.	

Add Patient Preferred Pharmacy • Reviewing Patient Preferred Pharmacy • Adding Patient Preferred Pharmacy • Setting local pharmacy as default	• Click on the preferred pharmacy icon in the gray upper toolbar. Search for the city or zip code. Select the correct pharmacy.	

Letters
    • Provider Letter
    • Patient Letter
	Provider Letter
	• Click on Communicate in the toolbar at the top of the screen.
	• Select Provider Letter
	• Enter action items / fields / dot phrase
	• Submit
	Patient Letter
	• Click on Communicate in the toolbar at the top of the screen.
	• Subject- select document type (Results, Patient Letter, School Excuse, TOC, Work Release)
	• Edit patient message
	• Add results as necessary
	• Preview / Print
	• Ok	

Ambulatory Provider Documentation Training Agenda

Southeast HEALTH

Provider
Quick Guide

Table of Contents

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Accessing Patients in Power Chart
Creating Patient Lists: Location, Relationship, etc.

Inpatient charts can be accessed via your Patient List.

1. *Click* [Patient List] *on the toolbar*
2. From the Patient List screen, click the [icon] **List Maintenance** icon.
3. Click **New** (located at bottom of window).
4. Select appropriate **type** of patient list that you wish to create (i.e. **Location**, **Custom, etc.**).
5. Click **Next**.
6. To create a location list, click the [+] to the left of   **Locations**. Scroll down to Southeast Hospital.
7. Click on the [+] to the left of Southeast Hospital, repeat, and select the patient care unit [icon]you wish to view.
8. Check the box to the left of your [icon] selection.
9. Select your Patient List preferences and enter a name for the list at the bottom of the Pane
10. Click **Finish**.
11. Move the list from Available to the Active Lists box by selecting the list from the left panee and clicking the right arrow button [icon].
12. You can modify the order of the lists using the up arrow button [icon] and down arrow button [icon]
13. Click **OK**.

To create a **Relationship list**, follow steps a-e as described previously, but click the [+] to the left of **Visit Relationships,** and instead of Locations, and check the box to the left of your relationship. The recommendation is Admitting Physician, Attending Physician, and Consulting Physician. Click **Finish.**

Custom Lists must be manually updated by adding or deleting patients from the list. Patients will not populate the list based on Admission, Discharge or relationship criteria.

Custom Lists are created by following steps a through d as described previously, but you MUST enter a **name** for the list prior to clicking **Finish.**

Add patients to a custom list by Right clicking on a patient name from a location or relationship list, and select **Add to a Patient List**.
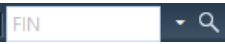
Remove patient from a custom list by right clicking on the name and selecting *Remove Patient from List* -OR- click [Add person] [icons] [Remove person] on the Patient List toolbar.

Additional Filters can be applied to any list type:
a. Highlight the filter type in the left column (e.g.Encounter Types)
b. Click on the appropriate filter(s) that display in the right column (i.e. Inpatient, Observation).
c. Activate the list with steps 11 & 12, as for location list creation, above.

Patient Search

Access to patient charts that are not on the provider's patient list will require a patient search.

1. Enter the patient's name or FIN in the patient search field [FIN ▾ 🔍] (located at the upper right of screen).
2. Click magnifying glass to search. Patient(s) will display.
3. Lower portion of window displays patient encounters.
4. Select **correct patient <u>and</u> correct encounter**. Double-click appropriate encounter.

Provider will be prompted to declare a relationship to patient when entering patient.'s chart the first time.

Revisiting Recently Accessed Charts

To return to one of the last five accessed patient charts, click on the drop down arrow to the right of [Recent ▾](upper right corner) and click on the patient's name to open chart.
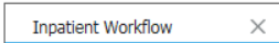
Workflow View/mPage

*(Workflow mPage is the default view when opening a patient chart.)*

1. Select Customize [🏷 ⚑ 🔍 ☰▾] on the upper right corner of the Summary page to configure the Page to your preferences. You can: Drag and drop headers, Expand/Collapse and change colors of widget categories as you wish..
2. Hover over any content/result item to display details.
3. Click on the word(s) in the header to open link to detailed patient data (e.g. Labs, Allergies, etc.).
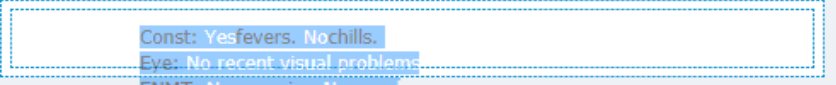4. Select ➕ to enter orders, allergies, diagnoses, etc.

REMINDER: The Workflow Page is Designed to increase your efficiency by guiding you through <u>both</u> *Review of existing* **-and-** *Inclusion of new* results and observations as you work through the categories of data.
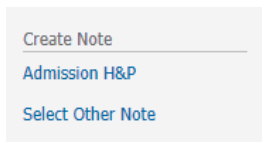
Navigate to the Workflow mpage to review the chart and begin documentation [Inpatient Workflow ✕]

This view will allow you to review the nursing documentation, labs, results, and begin your note.

1. To tag items from a clinical note highlight desired text and select 'Tag' [🏷 Tag]
2. To tag labs select the lab and click 'Tag'. [🏷 Tag]

3. To split your workflow mpage screen and move the freetext sections to the right of the screen click the split screen icon

4. To drag your text over to the freetext sections Once the screen is split, highlight the desired text and click the drag text icon.

5. You will then be able to drop the text intot he desired fieldof your note by dropping it wthin the dotted lines:

   Const: Yesfevers. Nochills.
   Eye: No recent visual problems

6. When you have completed your documentation on the workflow mpage, you can navigate to the bottom of the workflow menu and select your note type.

   Create Note

   Admission H&P

   Select Other Note

   Insert text, auto-text, etc.

   Refresh this section   Remove this section from Note

   Review of Systems

Creating Personal Auto Text

1. Click the Manage Auto Text icon and the Manage Auto Text screen opens.

2. Click on the New Phrase icon and the Abbreviation and Description boxes become active.

3. The icon to write a New Phrase is in the left hand corner of the Manage Auto Text Box

4. When the icon is clicked on, the Abbreviation and Description boxes become active.

5. At this point a symbol is chosen so the text can be retrieved.

6. You can use the "/" or a "." or

7. You can also use a symbol of your choice, e.g. ^.

8. It is important to put an identifying phrase after the symbol so you know what it is such as ^ *Test Phrase.*   This allows the user to retrieve the text and know what information it contains.

9. In the Abbreviation text box, differentiate the Personal Created Auto Text from the System-generated Auto Text by re-naming the Abbreviation field.

10. For example, enter ".rosCompleteDr.Kettner"

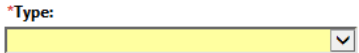11. Type or paste in any needed information and click **Save**.

Clinical Documents

1. Navigate to the Documents header on the Workflow Page, or Documentation on the Menu.
2. Double-click on the desired document to view.

Viewing Notes

1. Open a patient's chart from Patient List.
2. Click the Documentation section from the dark menu.
3. To change the criteria click on ⬚ icon. From there, filter what documentation you want to see.
4. Click apply.
5. Double click on the notes to display Notes on the right side of the screen.
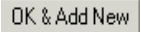6. Click the X in the upper right hand corner of the note to close.

Creating Notes

1. To create a note, click ✚ Add .
2. If you have a drop down arrow next to add, click that and select the type of note you want (either Power Note or Dynamic Note)
3. Choose the note type. *Type: [dropdown]
4. Make sure the note is titled correctly. If not, change the title. Title: Progress Note
5. Select the note template. Click OK.
6. Document the note.

Allergies

1. Click on **Allergies/Intolerances** from the Inpatient Summary Page or the Menu.
2. To add a new allergy, click + Add.
3. Select the appropriate Type of response by clicking on the drop down arrow (i.e. Allergy, Side Effect, Intolerance, etc…).
4. Enter the allergen in the *Substance field, and then click the binoculars.
5. Double-click on the substance from the substance search list.
6. Type the patient's Reaction, and then click the binoculars.
7. Double-click on the reaction from the reaction search list.
8. Complete additional information as appropriate, and then click OK or OK & Add New.
9. To modify or cancel an allergy, right-click on the allergy, then select Modify or Cancel.
10. Change fields as appropriate to modify or enter a *Reason to cancel, and then click OK.
11. After reviewing patient's allergies, select **Mark All as Reviewed**.
12. NKA can be indicated by selecting ⚙ (located in the allergy profile window). NKA is only available if no allergies have been documented.

Diagnosis & Problems List

1. Click Diagnosis & Problems from the Inpatient Summary Page, or the Menu.
2. In the Diagnosis pane, click ✚ Add. If adding a Problem, click ✚ Add in the bottom pane. The search window opens.
3. Enter the diagnosis or the code in the yellow search field. Click the 🔍 search icon.
4. Select the appropriate diagnosis from the list and click OK.
5. Update the *Type of diagnosis (Admitting, Discharge, Pre-op). (Discharge is the default type)
6. When all fields have been reviewed and updated, click [OK] or [OK & Add New] to add another diagnosis.

Converting a Problem to a Diagnosis

To convert a problem to a diagnosis, right click on the appropriate problem, and select **Convert to Diagnosis**. The problem will be added to the diagnosis list.

Home Medications

1. Within the orders section of the chart, select External Rx History from the tool bar. Verify that consent has been obtained (this is almost always obtained by Admissions staff), then select how many months of Rx history to display. The longer timeframe you chose, the longer the search will take. If the patient utilizes a pharmacy that participates in SureScripts, you will be able to review their home medications that have been filled utilizing their health insurance.
2. Right click on the medication to Convert to a Documented Medication.
3. When complete, click Close.
4. If additional home meds need to be entered, select Document Medication by Hx from the toolbar at top of screen, then select ✚ Add.
5. A Search window will open. Type the name of medication in the find field. The search will start after 3-4 letters are entered, like a Google search
6. Select the medication and complete order details.
7. Once completed, click on **Document History** (located at bottom right of screen).
8. You will not be able to complete the Discharge MedRec if the External Rx History has not been completed.

Histories Reviewing / Adding

1. Open a patient's chart from from Ambulatory Organizer or your Patient List.
2. Click on the **Histories** tab on the menu list.
3. Click on **Procedures** tab to review and / or document procedures / surgeries.
4. To add Procedure, select the **Add (+ Add)** button.
5. Click on binoculars search icon.
6. Select appropriate diagnosis / procedure term from the list that appears.
7. Click on **OK.** Complete additional fields if known.

*NOTE: The only required field (yellow) is the Past Medical or Procedure name.*

8. Click **OK** or **OK** & **Add New** (to continue documenting additional diagnoses or procedures).
9. Click **Family tab** and enter Family History as appropriate. Mark all as reviewed.

MAR Summary (Medication Administration Record)
Select **MAR Summary** from the Menu list (on the left). This displays medications ordered/administered, specific to patient's current encounter.

Medication Reconciliation

1. Reconciliation is found within the toolbar located on the orders section of the chart.
2. Click on Reconciliation.
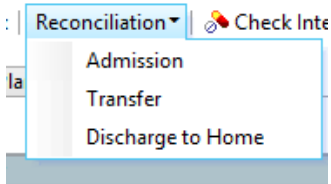
3. Select and complete the appropriate med rec process.

- *Admission Reconciliation allows you to convert documented* **External Rx History** *to inpatient orders.*
- *Discharge Reconciliation will default to the* **External Rx History** *as the medicines to continue after discharge.*

4. When completed, click Reconcile and Sign. (bottom right corner)

iView/I & O

1. Select Iview/I&O header from the Workflow Summary.
2. Select the Intake And Output band to view fluid balances. Top portion of window displays today's and yesterday's intake, output, and balance. Scroll up/down and left/right to view more data. Twenty-four (24) hour totals are 0700–0659.
3. Right-click on the blue date bar (located at top of page) to change viewing options, such as date range or hours per column.

Orders

Individual Order Entry

1. From the Inpatient Summary page, click on the located on the New Order Entry header. This takes you to the orders search box.
2. Type the order in the Find field. Select appropriate order. Click Done.
3. Complete order details, then click Sign (located in the lower right of your screen). Indicates missing order detail(s). Yellow fields or a bolded *field name preceded by an asterisk (*) are mandatory. After finishing all required fields, remember to Refresh your screen. (upper right corner)

Cancel/Reorder (for modifying an existing order, such as changing a medication dose)

1. Right click on the order. Select Cancel and Reorder then complete the appropriate order details. Click Orders for Signature, and then click Sign.
2. Copy an Order (such as getting a repeat CBC)
3. To copy a previous order, right click on the order and select COPY.
4. Make appropriate changes within the order details window (i.e. date). Click on Orders for Signature, and then click Sign.

Using PowerPlans

1. From the Inpatient Summary page or the menu, click on the ✚ located on the New Order Entry header. This takes you to the orders search box.
2. Type the specialty abbreviation in the Find field.
3. Click the desired PowerPlan, then click Done. The plan is now added to the order profile, but is incomplete.
4. To complete, select or deselect the components of the PowerPlan that you wish to order.
5. Modifications to order details can be made by right
6. clicking on the order sentence, then select
7. Modify Planned Order.
8. To view only selected orders, single-click the Filter button. Remember to un-click the filter button.

9. Click on the Merge View button (located on the orders screen) to see the orders in the powerplan displayed next to orders that have been previously ordered. Merge View only works when a powerplan in the View window is selected.
10. After completing all orders/details within the PowerPlan, select Sign. Refresh your screen. This places the PowerPlan in a Planned status. Orders will not be acted upon in the planned state.
11. Orders become active when the PowerPlan is initiated. The provider needs to Initiate (lower right corner) a PowerPlan when you have seen the new patient and are satisfied that the orders are complete.

Adding a PowerPlan to Favorites

1. From the Inpatient Summary page, or the Menu, select New Order Entry ✚.
2. Follow steps 2-5 (from page 13) to configure the PowerPlan as you prefer to have it.
3. Add new single order lines to the PowerPlan if you prefer, by clicking on the Add to PowerPlan button (upper left) and complete any required fields.
4. Prior to signing your PowerPlan, select Save as My Favorite (lower left corner).
5. Rename the PowerPlan (e.g. Dr Ballard's Tetraplegia Adm Order PP) if you choose, and then click OK.
6. To retrieve a saved PowerPlan, click ✚ Add (as if entering an order), then select the My Favorite Plans folder from the lower panel.
7. To organize favorites, click on the drop down arrowhead next to the yellow star.
8. Click Organize Favorites. Follow instructions provided on the screen.

Discharge Process

1. Update discharge diagnosis listed if necessary.
2. Review outstanding orders; DC unneeded orders prior to discharge as appropriate
3. Complete Medication Reconciliation if not already done.

*Note: You must complete step 3 **BEFORE** step 4 in order for it to pull in to your Discharge Documentation automatically.*

4. Click the Discharge tab on the Workflow Summary mPage
5. View patient's Discharge Readiness and Quality Measures status.
6. Click the Place Discharge Order header and select Discharge Patient order below then click Order button. or click on the ✚ Add button and search for the correct discharge order.
7. From the Discharge mPage, click the ✚ on the Follow Up header to add provider follow up instructions. Click OK.
8. Click the ✚ on the Patient Education header to add patient education instructions, then click OK.
9. Review and update the remaining items in the discharge menu/workflow.
10. Enter the Discharge Review of Systems at this time if appropriate.
11. If all depart activities are satisfied, create the Discharge Summary note.

Message Center

Message Center displays upon logging in.

1. To access Message Center from a patient chart or from your patient list, click [Message Center] in the tool bar.
2. Inbox Summary includes three categories:
      i. Inbox Items- Results, Results FYI, Orders (orders for co-signature and proposed orders), Documents (for signature) and Messages.
      ii. Work Items- Saved Documents, Anticipated Documents, Reminders and Paper Based Documents.
      iii. Notifications- Notify Receipts, Trash and Sent Items.

Results FYI: Review, Sign or Refuse
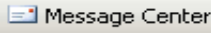
1. Navigate to the Results FYI section of the Inbox Summary.
2. Double-click on the result to view result details. Use Action Pane (located at the bottom of screen) to Endorse or Refuse.
3. Refuse- Select reason for refusal. Additional Forward Action is Review. Additional comments may be entered. Refused results are sent to HIM, REFUSAL INBOX (Health Information Management).
4. Click OK or OK & Next to sign and move to the next Results item.
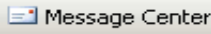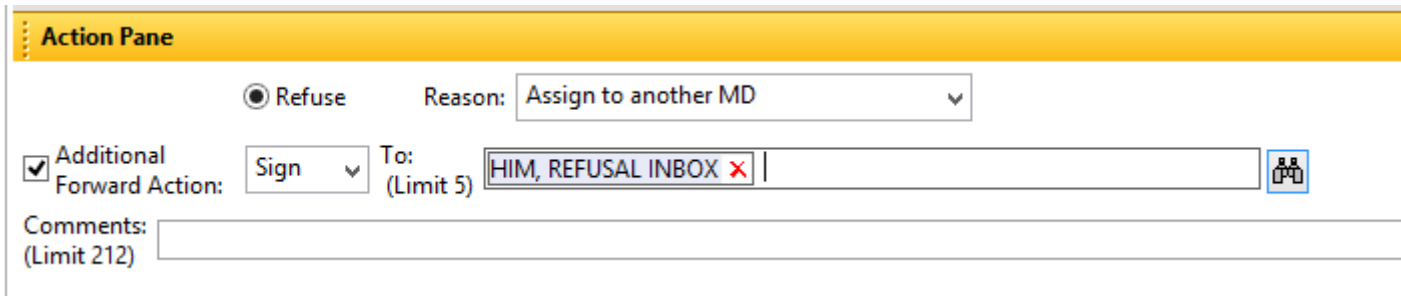
Anticipated Documents

To Create

1. Go to your Message Center. Message Center
2. Click on Anticipated Documents.
3. There will be a list of documents that need to be finished. Under the Subject heading will be the type of note that needs to be finished.
4. Right click on the patients name and you will be able to open the patient chart and access Documentation.
5. Document the note needed that is written below the Subject heading.

To Sign

1. Click on Anticipated Documents in your Message Center. Message Center
2. Double click the note that needs to be signed.
3. Scroll until you see yellow provider signature box.
4. Click inside the Yellow provider signature box. When you do so, it will outline the box in a blue stripped box
5. Click ok & close or ok & next which ever applies to your need.

To Refuse

1. Click on Anticipated Documents in your Message Center. Message Center
2. Open the document.
3. At the bottom of the screen there is the Action Pane.
4. Select the reason you are refusing the anticipated document.
5. Additional Forward Action is Sign.
6. Search for HIM, REFUSAL INBOX and send the anticipated document to HIM. Do not forward to other providers.
7. Click ok & close or ok & next which ever applies to your need.

Cosign Orders (Verbal/Telephone)

1. Navigate to the Cosign Orders section of the Inbox.
2. Double-click on the order to view order details. Use Action Pane (located at the bottom of screen) to Approve or Refuse.
3. Refuse- Select a reason for refusal (*mandatory). Additional Forward Action is Review. Additional comments may be entered. Refused orders are sent to HIM, REFUSAL INBOX (Health Information Management).
4. Click OK or OK & Next to sign and move to the next Order.

Proposed Orders
1. Navigate to the Proposed Orders section of the Inbox Summary.
2. Double-click on the order to view order details.
3. Select the appropriate action: Approve, Reject , or Modify.
4. If modifications are necessary, click Modify (white triangle located to the right of the order).
5. Make the necessary modifications and click **Sign.**
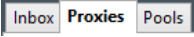
Messages: Creating a New Message
1. Click the Communicate icon (located at the upper left of the Messages pane).
2. If you choose, enter the patient's name in the Patient field, and then click the binoculars.
3. Select the patient and the correct encounter, then click **OK.**
4. Enter the recipient(s) in the To: and CC: fields. To include yourself, check Include me.
5. Compose message.
6. If you entered a patient's name, you have the option to save the message to the patient's chart by checking **Save to Chart.**
7. Actions- Check appropriate box (es).
8. You have the option to set a Remind on or Due on date/time for the message.
9. Click **Send.**

Messages: Reply, Forward or Delete
1. Double-click on the message to open. Select Reply, Reply All, Forward, or Delete.
2. If not deleting message, compose your response.
3. Actions- Check appropriate box (es).
4. You have the option to set a Remind on or Due on date/time for the message.
5. Click Send.

Proxies: Granting
1. Click the Proxies tab located in the Inbox Summary.
2. Click Manage.
3. Select the Given tab (located at the bottom of screen), then click **Add.**
4. Type the recipient in the User search field.
5. Specify Begin Date and End Date.
6. Select Available Items to grant, then click Grant-> or click Grant All->>.
7. Click Accept & Next, then **OK.**
8. The provider that has received proxy will be notified via inbox message. The users displayed in Proxies Given by Me pane are authorizations that have been granted by me.

Proxies: Receiving/Viewing Another User's Inbox
1. Click the Proxies tab located in the Inbox Summary.
2. Within Proxies tab, select the sending provider from the drop down in the Proxy field. This allows you to access their inbox.
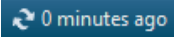
*The users displayed in the **Proxies Received by Me** pane are authorizations that you have received from other providers.*

Proxies: Removing Proxy Authority

1. Click the Proxies tab located in the Inbox Summary.
2. Click Manage.
3. Select the proxy that authority is to be removed.
4. Click Remove, and then click **OK.**

Helpful Hints

- **Refresh:** Displays the last time that the data on the current screen was updated. Click it frequently to refresh, and to avoid timing out. ⟳ 0 minutes ago

- To **Hide the Menu** (located on the left hand side of your screen), click the tack in the upper right corner on Menu line ⊞ Menu   ⊓

- To **Un-Hide the Menu**, click the Menu tab to view the menu. (upper left side). It will slide back if you move off it. To keep the **Menu** in view, click the tack again.

- To exit **PowerChart**, please utilize the ⊞Exit button in the tool bar. ("Use the **EXIT** door").

- Hover cursor over icons to see what they are for.

- "T:N" Enter "t" in a date field to get today's date.   Enter "n" in a time field for "now."

PowerChart Icons

✚ Add	Add Orders/Allergies		New Orders Review CareCompass
✚ Add to Phase ▾	Add Orders to a Plan		New Stat Orders Review CareCompass
⊘	Cancel PowerPlan/IPOC	↑👓	Orders for Review
	Customize IView	◎	Goal/Outcome IPOC
	Dynamic Group IView		PowerPlan/Plan of Care
…	Ellipsis Button		Pharmacy Verify Pending
	Exit Application	!	Pharmacy Rejected Order
⚠	High Risk Alerts		Physician Co-Sign Required
	Home/Documented Med	!	Physician Co-Sign Rejected
💡	Initiate PowerPlan/IPOC	◯	Quality Measures Icon
	Inpatient Order/Med		Reference Doc Available
◀	Merge PowerPlan View	!👓	Stat Order Review
✖	Missing Order Details	✔	Sign Documentation

Notes

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