The goal of this lesson is to give you a lean review of things you need to know to get up & running in Unity. Other lessons will provide more detail, but whether you have been through training & want a refresher before Go Live, or you would like an overview before you start training, you should find this useful. This presentation focuses primarily on PowerChart, the application that will be most-utilized by medical-surgical providers.
Desktop Orientation

Here’s what you’re looking at, & how to find your way around on the chart.
When you first log on, you’ll see a Home screen. It may have different appearances, but often you’ll see your daily schedule & some of your Message Center inbox.
At the top you will see a **Windows Menu**...

...and a **Toolbar**.

The appearances can vary by specialty, content you are viewing, & personal preferences.
Many of the items on the menu & toolbar are things you won’t use very often, or that you have other ways to access within your workflow. You can learn what they are by clicking on them, but they’ll be discussed when pertinent in other lessons. Here are a few you’ll use commonly.

**Home:** Return to Home screen.

**Message Center:** Open Message Center.

**Physician Handoff:** Open rounding list & I-PASS handoff tool.

**MyExperience:** Used by residents & students to flex specialty.

**Recent:** Dropdown list of recent encounters.

**Search:** Patient search box.

**Refresh:** Refreshes contents of displayed screen.

**Exit:** Safely close Unity.
When viewing your appointment list you can change provider or date as necessary.

Clicking a patient’s name opens the chart.
When the patient’s chart is open, you’ll see a splash of useful information at the top in the **Banner Bar**.

Hovering over an item often displays more information.

Clicking on items may open it for further review & entry. This is a quick way to open **Allergies**, for example.
When documenting a patient encounter, be it an involved hospital admission or a brief office visit, you’re basically doing two types of activities:

1. Documenting/updating/reviewing **structured data**—the things that make up the patient’s medical history & span across encounters. This includes the past medical, surgical, family, & social histories, along with the med list & allergy list. Reviewing old notes & test results would fall into this category as well.

2. Documenting **encounter-specific data**—the things you see, hear, do, & think during the encounter. Present illness/subjective history, review of systems, physical exam, assessment (billing diagnosis), plans, & orders fall into this category.

The emphasis varies, of course, depending upon venue, specialty, patient type, etc. Let’s look at how these two types of activities are performed in Unity.
Here we have a patient’s chart open. It is shown on a wide computer screen so that we see the full width, though on smaller screens you may choose to collapse some of these elements. While the appearance changes somewhat to accommodate appropriate content for various specialties, or inpatient vs outpatient venues, there are a number of common elements.
At the far left is something labeled the **Menu**, though its actual name is the **Table of Contents**. The Table of Contents can be thought of as the “big” navigation bar. It is often presented as an “older” part of the Cerner EHR, but don’t let that discourage you from using it—it is often the simplest way to get where you need to be & do what you need to do.
Much of the Table of Contents lets you view & record structured data (problem list, meds, allergies, & medical/surgical/social/family histories). It also gives you a way to place orders & view test results & prior documents.
Items toward the bottom of the Table of Contents generally include optional/niche functionalities or less commonly-used tools.
The top few lines provide “viewpoints” for you to document & perform clinical activities. These differ among specialties. Many providers have at least an Ambulatory & an Inpatient viewpoint. Some have additional viewpoints, as illustrated here. Others may have only one viewpoint that presents all of the workflow tools.
When you click on one of these viewpoints, the right side of the screen displays several workflow tabs, also referred to as mPages. These tabs are designed to be a rapid & efficient way to perform the majority of your work.
There are four general types of mPages. Here you see a Workflow mPage. This is where most providers will spend the bulk of their time reviewing & documenting data. The emphasis here is the encounter-specific aspect of your documentation, though historical/structured data elements can be recorded as well.

On an outpatient encounter you’ll see workflow mPages geared toward a clinic encounter. On an inpatient encounter you may see separate mPages for admission, rounding, discharge, or for adult vs. pediatric patients. You can also rearrange the elements displayed to meet your workflow preferences.
A second type of tab is the **Summary mPage**. This summarizes many elements of the chart on one screen. You may see separate mPages for adults vs. children, & clinical vs. demographic data. You can rearrange elements & specify color preferences.

To some the Summary mPages may seem busy & cluttered; others may find at least parts of them useful. Remember that everything you see here can be found on the Table of Contents in a presentation that you may find more appealing, so use whichever you like.
A third type of tab are **Quick Orders mPages**. These present orders that are frequently used in your specialty. You may see separate mPages for adults vs. children, & for orders vs. charges. Again, you can rearrange elements & specify color preferences.
Lastly, you may also sometimes see other mPages that present specialty workflow or tools.
When on a Workflow mPage you’ll notice another navigation bar in addition to the Table of Contents. You can drag elements up & down on this mPage navigation bar to suit your workflow.
When screen space is at a premium, you may not want to display both the Table of Contents & the mPage navigation bar. You can click the thumback on the Table of Contents to collapse it. (On some small-screen devices this happens automatically.) Hovering over it will always bring it back as needed.
So how do you use these tools to document an encounter? While the workflow will differ depending upon the venue, the basic approach can be summarized as:

1. **Staff and/or provider records & updates structured data.** The staff may also record chief complaint, vital signs, & perform point-of-care tests.


3. **Staff completes wrap-up tasks** (further point-of-care tests, injections, follow-up scheduling, etc.).
Cerner provides two ways to create encounter documents.

1. **Dynamic Documentation (or DynDoc for short).** This is the newer method, & the one that the majority of our providers will use. Document templates automatically bring in most structured data, so that the provider only adds the newly-created encounter-specific data.

2. **PowerNote.** This is the older method. Notes are created in a point-and-click fashion. Only a minority of our providers will use this method, but for some specialties or encounter types this remains the recommended method. You will be told in your training if & when you should use PowerNote.

With both methods you have to ability to utilize AutoText (user-defined text you use on a frequent basis) & Dragon voice transcription.
Dynamic Documentation (DynDoc) Users

You have a number of options, but here are some recommendations to get you started. The following example uses an outpatient encounter, but an inpatient H&P, progress note, or discharge summary works in a similar fashion. You might perform many of the actions before, while, or after you see the patient.
Open the patient’s chart. Much of the data review & entry can be performed via the **Workflow mPage** or the **Table of Contents**. The Workflow mPage is designed to be lean & fast; the Table of Contents often provides access to the greatest degree of detail. You will probably find a mix & match workflow that suits your preferences.

Note these forward, backward, & breadcrumb carats. These work like the forward & backward buttons on an Internet browser. They come in handy when you’re going back & forth between mPages & the Table of Contents.
You may wish to start by glancing at notes from previous visits. Many are visible on the mPage, but often this is a “short list” specific to your specialty.

Table of Contents | Documentation is an alternative that shows all documents, though you may have to wade through staff documentation you’re not interested in at the moment.
Reviewing vital signs & chief complaint recorded by staff might be your next stop. These are nicely displayed on the Workflow mPage. You can add repeat vital signs using the dropdown arrow for Vital Signs, & update the Chief Complaint if necessary.
Next you might want to review the Problem List. The Problem List is actually used by Cerner for two different things. The first is as a “problem list proper”—to list historical problems. The second is to record today’s billing diagnoses. Obviously, these are things you might do at two different times on the encounter. At this point we want to review the “problem list proper.”
On the mPage the Problem List component looks like this. When the **Chronic** button is flagged, that indicates an item on the actual Problem List. (When **This Visit** is flagged, that means it is a billing diagnosis from this encounter.)

You have a search box to add new items to the Problem List; just make sure you select **Add new as Chronic** from the dropdown arrow.
On the Table of Contents the Problem List looks like this. The “problem list proper” is at the bottom, where you also see a search box to add to it. (The billing diagnosis list for the encounter is at the top.)
This Histories component on the mPage allows you to review procedure (surgery), family, social, & pregnancy history details, each in its own tab. The ability to enter new data here is somewhat limited, however. Clicking on the Histories heading will take you to Histories on the Table of Contents.
Here you also see each type of history in its own tab, but there is an **Add** button that allows you to make new entries in a pretty intuitive fashion.
The Home Medications list displays nicely on the workflow mPage. In this example your staff has already reviewed the medication history with the patient for you to look over.
Allergies also display on the mPage. You can click **Complete Reconciliation** to acknowledge that you've reviewed them.

If you need to add further allergies, click the **Allergies** heading or the + **sign**; these take you to **Allergies** on the Table of Contents.
Here you can add more allergies, or remove/resolve/update incorrect entries.
You can view previous lab & radiology results via several tabs on the mPage navigation.

You have options to select the time frame you wish to view.
Test results are displayed on the Table of Contents by going to **Results Review**. You have a number of tabs to display different types of information, & options for the date range you wish to see.
While that took a little while to demonstrate, it only takes a minute or two to do. Now it’s time to see the patient.
For illustration purposes I’ve placed the **Chief Complaint, Subjective, Review of Systems, Objective, & Assessment and Plan** components next to each other on the mPage navigation bar.
These are the 5 fields where you will make textual entries specific to today's encounter, & have them appear in your visit note.
You might enter or update all or part of the Chief Complaint, Subjective, & Review of Systems fields while in the room with the patient.

When you make an entry you'll see a **Sign** or **Save** button below the field.
You might make your physical exam entry a bit later.
When it comes to Assessment and Plan let’s pause for a moment. Here is where the second use of the Problem List comes into play. You now want to enter your Assessments, or billing diagnoses for the encounter.
Change the **Add new as dropdown** to **This Visit**.
Start to type your desired diagnosis in the search field, then click on it when it appears.
If this were something worthy of being added to the Problem List, e.g., a new diagnosis of hypertension, you could click the **Chronic** button to use it as both a billing diagnosis for this encounter & to add it to the problem list. (We don't need to do that here.)
You can also easily search for your billing diagnosis on the Table of Contents Problem List tab. While Cerner is a little loose with the term “problem,” the billing diagnoses are at the top, & the problem list is at the bottom.

In other words:
Top list = Billing Diagnoses = “This Visit” on mPage
Bottom list = Problem List = “Chronic” on mPage
To search for your billing diagnosis, start to type in the search box & click on your desired result as it appears.

You can use the Convert buttons to add a billing diagnosis to the problem list, or vice versa.
With the diagnoses chosen, let’s return to the **Assessment and Plan** field on the workflow mPage. This gives you a spot to enter text to further explain the diagnosis & document your plans. You can do that via typing, Dragon speech recognition, or AutoText.
With assessment & plan documented, we need to place some orders. Understand that in Unity, “order” is a very broad term. In addition to things like diagnostic studies you intuitively think of as orders, medication prescriptions & charges are also orders. The first place to look for orders is a Quick Orders page. These can have different names depending upon specialty or inpatient vs outpatient setting. In this example, we'll go to the Family Med Orders tab.
Explore the available listings, expanding & collapsing sections as necessary. First we’ll add a **Comprehensive Metabolic Panel** by clicking on that item.

Add a charge for a Level 3 office visit.

And we’ll place our **Clinic Follow-Up** visit order.
Of course, you won't find every order you need on Quick Orders. For others you can perform a search from here as well. Let's add our terbinafine prescription. Many searches work like an Internet search engine, where you can type partial entries & see matches in real time. We'll type **terbin 250** to locate terbinafine 250 mg tablet. Select the best match you see. Don't worry if it isn't exactly what you want; you'll adjust the details in a minute.
That search will often find what you want, but if you need to do a more detailed search, you can do so by clicking the **New Order Entry + sign**.

That's the same as clicking **Orders + Add** on the Table of Contents.
Those open the full order search engine.
While we’re talking about order searches, an important tip to remember is **Less Is More**. Start with brief pieces of the terms you’re looking for to see the broadest list of results. If the list is too broad, type a little more.

For example, if you type out the full term “comprehensive metabolic panel,” you’ll see just two results.

But due to variations in the way orders may be abbreviated or truncated, if you type “comp met pan” you’ll find a 3rd result—the LabCorp order for the test.
But in most cases, as in our example, you can do most of your ordering through the Quick Orders mPage. After selecting all your orders, you’ll see the checkout cart icon has turned green, displaying the number of orders you’ve queued up. Click on that.
You’ll have an opportunity to associate orders with diagnoses; all of the billing diagnoses you’ve selected display here. Click under the diagnosis for each line to associate it with the order.

Then click **Modify**.
You may encounter popups offering order sentences. Pick the one closest to what you want, or none, then click **OK**.
Your orders display. You’ll be notified if there are details to complete through the Blue X & the Missing Required Details. And you should probably review orders anyway to see if there are any changes you want to make.
Click an order to modify it. For terbinafine we’ll specify an acute med of 90 days duration, 30 tabs with 2 refills.
We’ll say more about **Favorites** later, but for now note that, after you’ve specified these details, if this is an order you expect to use frequently, this is the best time to save it as a Favorite. **Right-click** the order & select **Add To Favorites**.
There is another lesson that discusses Favorites in more detail, but for now click **OK** to save the Favorite.
The required detail on the follow-up order is the time frame. Use the available boxes to specify that.

### Details for Clinic Follow-Up

<table>
<thead>
<tr>
<th>Details</th>
<th>Order Comments</th>
<th>Diagnoses</th>
</tr>
</thead>
</table>

- **Requested Start Date/Time:** 09/08/2017 14:49 CDT
- **Requested Appointment Time:** Other - Specify in Comments
- **Scheduling Location:** Next Available
- **Future Order:** Other - Specify in Comments
- **Special Instructions:** Appt w/ me in 80-90 days.
When all details have been addressed, click **Sign**.
Before you leave the orders, notice the Orders For Cosignature button. If this is active (not grayed-out), there are orders that have been placed by your staff that you need to cosign. Click this.
You see all orders in need of cosignature by all providers. You can select one, several, or all, then click **Cosign**.

<table>
<thead>
<tr>
<th>Order</th>
<th>Action Dat...</th>
<th>Entered By</th>
<th>Order Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>10/20/2017 4:54:35 PM CDT</td>
<td>Bacon, Heather M</td>
<td>Lipid Panel (LC)</td>
</tr>
<tr>
<td>✓</td>
<td>10/20/2017 4:54:35 PM ...</td>
<td>Bacon, Heather M</td>
<td>Microalbumin, Random ...</td>
</tr>
<tr>
<td>✓</td>
<td>10/20/2017 4:54:35 PM ...</td>
<td>Bacon, Heather M</td>
<td>Urine Culture, Routine (LC)</td>
</tr>
<tr>
<td>✓</td>
<td>10/20/2017 4:54:35 PM ...</td>
<td>Bacon, Heather M</td>
<td>Comp. Metabolic P...</td>
</tr>
<tr>
<td>✓</td>
<td>10/20/2017 4:54:35 PM ...</td>
<td>Bacon, Heather M</td>
<td>CBC With Differential.../...complications</td>
</tr>
</tbody>
</table>

This comes in handy to cosign all verbal & standing orders performed on your behalf during the visit. On an inpatient encounter this is also a good way for today’s attending to cosign orders submitted to a covering attending from the previous day, such as admission orders.
Now navigate back to the Workflow mPage & look at **Patient Education**. You’ll see suggestions for the patient’s billing diagnoses & chronic problems. Select appropriate materials. They can be edited then printed by you or your staff.
One last thing to do before you let the patient go is to do a final review of the med list. On an inpatient encounter this would be the Discharge medication reconciliation. On a clinic encounter, the analog is the Outpatient reconciliation. On the Home Medications component, click **Outpatient**.
Reconcile the med list. Click the **Stop** bullet for those you wish to discontinue.

Click the **Continue** bullet for those meds from others you wish to acknowledge but not prescribe yourself, or to continue meds you’ve previously prescribed.
If you wish to generate a prescription for a historical med, e.g., to refill a med given elsewhere, click the Rx (prescription bottle) bullet.
Clicking on the med in the right column will display the prescription details. Modify as desired.
Click **+Add** to prescribe a new med. For example, if we hadn’t ordered the terbinafine earlier, we could have done that here. You might wish to use this step as the spot where you generate all your prescriptions.

When everything has been addressed, click **Sign**.
With all of that done, it is time to generate your note. You can begin by clicking the Documents + sign on the mPage, or Documentation + Add on the Table of Contents.
The bottom of the mPage Navigation Bar also gives you access to documentation. **Select Other Note** takes you to the same place as the above links. You’ll also often see one or more links to directly create common documents.
Select Document Type, & modify the Title if necessary. Then double-click the desired Note Template. You’ll see common options, like Office Visit Note, Admission H&P, Discharge Summary, etc.
The note generates. Depending upon the note template you’ve selected, a summary of structured data often appears on the right, while the items specific to this visit are often on the left.

If you hover over any section, you’ll see a gray X that allows you to delete it if you don’t want it included.
Notice that these encounter-specific fields...
...are the same as the mPage fields we made entries in earlier.
Also understand that you can click into these fields & make further entries via typing, AutoText, or Dragon transcription.
This provides you a great deal of flexibility as to how & when you create your documentation:

• Make all your entries on the mPage fields, & all you have to do here is a quick review & sign.
• Make no entries at all on the mPage fields. You can make them here just as easily, & you instantly see what your note will look like.
• Mix & match the approaches. You might make quick notes on the mPage fields while you’re seeing the patient, then flesh out the note further here.
If you need to make more structured data entries (a historical item, additional order, etc.) after creating the note, you can do that. For example, say you remember the patient told you about a new allergy. Use the Table of Contents to Add an allergy.
Make your entry, click **OK**, then use the back carat to return to your document.
Back in your document, hover over the section you updated & click the **Refresh** button.

The update appears.
When the note is done, click **Sign/Submit**.
Residents & students will search for an attending to cosign, then click **Sign**. (Attendings will just click **Sign**.)
And remember, while this example illustrated an outpatient encounter, an inpatient encounter works in largely the same fashion. There are mPages to facilitate admission, rounding, & discharge, & they include some components more pertinent to a hospital visit, like fluid I&Os & inpatient med lists.
PowerNote Users

Much of the workflow for PowerNote users is the same as illustrated above for DynDoc users. Entering structured data, placing orders, & dropping charges can all be done as shown above.

The major difference is how you create your note.
Recall the **Subjective, Review of Systems, Objective, & Assessment and Plan** mPage fields used to feed entries into DynDoc notes.
These do not feed into PowerNotes. So do not make entries in these fields if you’re going to be creating a PowerNote; it’s just a waste of your time. mPages are still a convenient way to enter structured data, review information, look for Quick Orders, etc., but they won’t help you enter encounter-specific data into PowerNotes.
After entering/updating structured data, placing orders, & performing other activities necessary for the encounter, to create a PowerNote, go to **Documentation** in any of the ways seen before.
Specialties that routinely use PowerNote will be taken directly to PowerNote. Specialties that usually use DynDoc will need to click the **dropdown arrow** next to the **+Add button** to select PowerNote.
There are several ways to begin a PowerNote, & the details are covered in other lessons. One basic way is to perform a search, then select the most appropriate note template you find in the results.
PowerNote is a mostly point-and-click approach to creating notes, & initially the choices may appear overwhelming. Remember, you don’t have to touch everything you see. Just use the parts to do the documentation you would normally do.
Clicking items within the template sometimes automatically inserts that item from the chart, or takes you to that area of the chart to review & select the item.
Other sections give you the opportunity to click your way through the documentation, as seen here for the physical exam.
Anywhere you see **Use Free Text** or **OTHER** gives you a chance to type, dictate, or AutoText your entry.
This process becomes quicker as you familiarize yourself with the handful of document templates you’ll use, & there are ways to speed the process along, using **macros** & **precompleted notes**. Other lessons go further into these details.

When done you’ll click **Sign/Submit** to sign the note (forwarding for cosignature if necessary).
Message Center

Everyone will use Message Center every day to communicate with other users, & to review/sign off test results & documents. Other lessons go into more details, but here are the basics.
You can always click **Message Center** on the toolbar to open Message Center.

Folders with various categories of items (messages, documents, results, etc.) appear on the left. Expand & click on subfolders as necessary.
Clicking an item will usually show a preview of it at the bottom.

Click Open to fully view & sign off the item.
The appearance will vary a bit by content, but to endorse/sign off items, click **OK & Close** (or **OK & Next** to sign & move to the next item).
Attendings signing off resident/student notes, instead of clicking **OK & Close**, will click the **Modify** button at the top to further review the note & add a co-signature attestation.
To send a message to another user about the patient, click *Communicate* on the toolbar & select *Message*. 
Search for your recipient, add a subject line, then type your message. You can save to the chart if appropriate. Then click **Send**.

To: Molokhia MD, Ehab A

CC: 

Subject: Mutual patient

Message:

Please see my note from today about our mutual patient.
Other Tips

Here are a few other tips to make your life easier in Unity.
Favorites

- There are opportunities to save “Favorites” everywhere you turn in Unity: Orders, historical entries, allergies, document types, patient education, & message recipients, just to name a few.

- You see these opportunities to create Favorites as “Add to Favorites” buttons, stars, or options on a right-click menu.

- Favorites can be very helpful, so take a moment to create them on the fly as you’re doing your initial encounters in Unity.

- But don’t go overboard. The ideal item to save as a Favorite is something that was difficult or time-consuming to find, & that you’ll use often. E.G., if you can locate an order in 5 seconds on a Quick Orders page or a search, why save it as a Favorite?

- Cerner leaves a bit to be desired when it comes to Favorites folder structure. There is another lesson that goes into further detail, but for the moment remember two things: 1) Favorites on an inpatient encounter are different from Favorites on an outpatient encounter, & 2) It is best to save Favorite orders, with any personal modifications, right before signing the order—not when you’re searching for the order.
PowerPlans

• Order sets are called **PowerPlans** in Unity. When you search for orders, you can recognize them by this “pizza box” icon.

• Especially in the inpatient setting, always think PowerPlan first. Are you admitting a patient? Need to start vasopressors? Treating an infection? Planning a procedure? There is probably a PowerPlan that includes most all orders you’ll need, including best practice recommendations, that will save you a lot of work.

• After you’ve opened a PowerPlan & selected the items you need, remember you can save these as Favorites as well.
AutoText

- AutoText is a phrase that you can insert into your documentation (DynDoc or PowerNote) by typing a short abbreviation. These can be huge time-savers for things you say frequently in your daily work. Frequently-used patient plans/instructions & procedure notes are good examples.

- There are stock Cerner AutoTexts; these have abbreviations that start with a period (sometimes called “dot phrases.”)

- There are USA-specific AutoTexts, & department-specific AutoTexts; these have abbreviations that start with specific special characters. A list of the special characters for each department is available on our training page.

- You can create your own AutoText as well. Taking a moment to create them on the fly as you do your initial encounters will save you a ton of time on future encounters.
Message Center

• Clearing your inbox every day will make your life a whole lot easier.

• Some things you can sign off at a glance in Message Center. Other times you’ll need to open the chart to get some context & decide upon further action. It’s easy to open the chart from the message. And remember if you sign off the item on the chart, it drops out of Message Center as well.

• There is no need to create a letter to discuss a patient with another USA provider. Send a message instead; it could be as brief as “Thanks for the referral; please see my note from today.”

• You can send Reminders to yourself or others that show up in the future. If something needs doing in 6 weeks, this is an excellent way to make sure it doesn’t get forgotten.
Documentation

- Try to do as much of your encounter documentation as possible in real time before moving on to the next patient. As you become more familiar with the system, this may be easier than you think.

- Even if you can't fully create a note, do as much as you can, then **Save** the note. You can come back & finish it later, & **Message Center** will show you a list of saved documents you need to complete.

- In fact, even if you don't make any entries at all, create & save a note before you move on to the next patient. This captures a snapshot of the vital signs, point-of-care tests, & other available data at the time of the encounter. This can save you a lot of confusion if the patient sees another provider before you come back to your note.
Charges

• When we go live, there will not be a coding assistant in Unity. One will become available a few months later, but initially everyone will need to manually choose billing codes.

• Most common encounter charges can be found on Quick Orders or Charges mPages—clinic visits, hospital admission, rounds, consult, & discharges, & many procedures are listed.

• For other charges, use Order Search. Orders that drop professional charges usually include the CPT code in the name. In fact, if you know the CPT code for the charge, you can search for that. This comes particularly in handy for procedures.

• Consider modifiers. Adding modifiers will be a new workflow to many USA providers. Particularly think about modifiers when a resident sees a Medicare patient; when a well-child visit is done on a Medicaid patient; & when a procedure is done on the same day as an E&M code. There is another lesson that goes into more detail about modifiers.
Conclusion

This is by no means everything you need to know about our Cerner electronic health record. It is a very deep program. No EHR is perfect, & all will forever be a work in progress. But this should help you get your feet wet.

More details can be found in Unity lessons in HealthStream. There are probably lessons above & beyond what you’ve been assigned. You can locate most of these by searching for Unity USA Provider.

Other learning materials & work aids can be found on our Unity intranet site at http://hos.usouthal.edu/unity/clinical.aspx.