

# V11 Note Webcast Series

**Building Notes - Basics** 

Embrace the new world of healthcare







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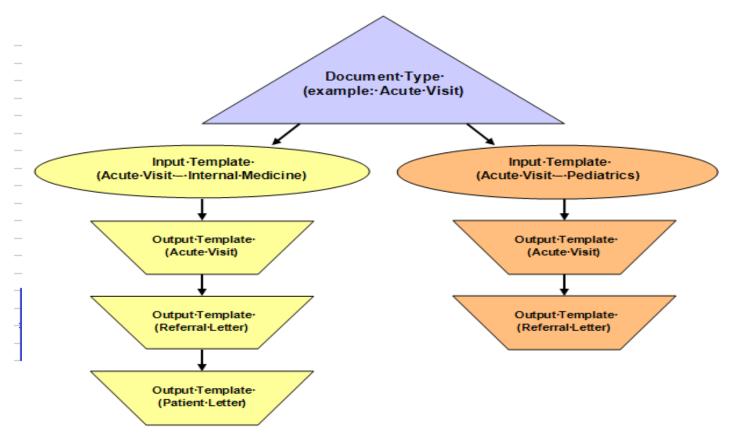
## Objectives:

- Document using a new Chief Complaint driven note
- Review the relationship between document types, input and output templates.
- Discuss and review the Document Type Dictionary.
- Locate and briefly discuss noteforms and text templates.
- Discuss and review a note input template and define the sections.
- Discuss and review an output template.
- Assign the new output template to a chart section.



# Document/Input/Output Relationship

\*\*Note that it is the output templates that get saved to the chart





# Document Type Dictionary

Dictionary: Document Type	<b>▼</b> 😥 🞹				
Code	∀	Name	7	Mnemonic	7
SNN		Sue's New Note		SNN	
☆ General Properties					
Required Finalization Authority		Manifestation: NOTEFORM ▼			
Required Owner Authority		Difficulty Factor: 1.0 ÷			
WorkFlow		Security Codes			
☆ General Properties II					
Display Note Icon on Sched	dule Prompt User to Ro	oute for Further Signature			
Include in Unsigned Notes I		-			
Auto CC	Is Letter				
Allow eReply to Patient	Prompt For Signa	ture Override			
Req Corr - Allow Invalidate	Only 🔲 Is Clinical Summa	ry			
↑ Note Properties					
General					
Description:					
☐ Is Sub Ty	pe Parent Form:	-			
Finalize N	lote on Save				
	1010 011 0410				
Note Visibility		Force Ammendment if:			
⊙ On Saving ○ On In	ital Signing C On Finaliza				
Note Task		Annotation Added			
Create Referring Provide	der Notification	Encounter Changed			
Create Patient Notificat	ion	Carbon Copy Added or Edited			
Create Review Covered	d Note Task on Finalization	Note Owner Changed			
Add Picklist Report	t Search				
report	- Scarcii				



# Document Type Dictionary Fields

#### **General Properties**

- <u>Required Finalization Authority</u>: Determines how much authority a user needs in order to finalize a note. (i.e. "Make final" box will either be available to check or not available. May change depending on Note Type that is being created.
- <u>Required Owner Authority:</u> Determines the level of security required to be the Note Owner
- Workflow: Always set at Electronic Signature
- <u>Manifestation</u>: Always set at NOTEFORM for notes. Will change for other document types.
- <u>Difficulty Factor:</u> Used with dictating providers only for the dictation level of difficulty due to factors like accent, subject matter or workflow. The values can be set between 1 and 9.9.
- <u>Security Codes:</u> Provides two options for adding security to the document. Option #1 is "doc change" code. Allows only the author to edit the document or a user who has the "document management" security code. Option #2 is "doc change shared" code. Allows a group of users within the same classification to edit each others documents when the code is part of the classification.





#### **General Properties II**

- <u>Display Note Icon on Schedule:</u> Should be checked for any note associated with a visit encounter. When viewing the schedule, the note icon will be unchecked if the note is not finalized or checked when signed and final. This is useful for providers and/or billing people to easily see when notes are done.
- <u>Include in Unsigned Notes Report:</u> Should be checked for "Dictate" type documents. An report of unsigned notes by user can be run from TWAdmin.
- Auto CC: Can be checked to allow a document type to be automatically carbon copied.
- Allow eReply to Patient: Used to reply to a patient on-line when checked.
- <u>Prompt User to Route for Further Signature:</u> Check this box if you want the system to send a co-sign note task after the note has been signed. This might be set for Nurse Notes, or a Physician Assistants notes.
- Is Result: Identifies in chart viewer that a scanned document is a result.
- <u>Is Letter:</u> Allows users to create letters with a greeting and a closing when checked. (V10 only)
- <u>Prompt for Signature Override:</u> Allows the user to over-ride the required signature authority when checked. Will prompt the signing user to identify a second person to co-sign the note by sending a co-sign note task. Typically used with Residents. Have used with diabetic educators in the past for their Diabetes notes.





#### **Note Properties**

- General Description: The display name of your note.
- <u>Is sub type:</u> Determines if the note should display under a parent type. For example: acute and chronic notes could be subtypes of Office Visits. Have also used Parent form of Procedures and other subtypes like I&D, Vasectomy etc...
- Finalize Note on Save: When checked, it places the note in a "final" status upon saving.
- Note Visibility: Selecting one of the options determines when the note is visible in Chart Viewer. Recommend making it visible upon saving.
- <u>Create Referring Provider Notification:</u> Creates a delegated task (i.e. task that is not seen in My Active Tasks) for the note owner indicating that the referring provider should be notified.
- <u>Create Patient Notification:</u> Will create a delegated task for the note owner indicating that the patient should be notified.
- <u>Create Review Covered Note Task on Finalization:</u> When a note is finalized by a covering physician a task is created for the appointment encounter provider to review the note.
- <u>Force Amendment if (any of the boxes are checked):</u> The note status will be "amended" if an annotation is added, the encounter is changed, a cc is added or edited and/or the note owner is changed.





#### **NoteForms**

- Provided as an easy way to enter structured data and render text in a clinical note.
- Highly configurable and can consist of Medcin (which appear on a note form as a Yes/No or Plus/Minus control, a check box, or in a group of radio buttons.), Text, Illustrations or Text Templates.
- Note that Medcin findings are considered discrete data and are therefore queryable. In 11.2 and higher and higher releases of Analytics- text controls are also queryable.
- Forms can be added to a note section by hitting the "add" button and then searching for the desired form.
- Can either keep it simple when searching to see more options or can also filter by form type, note type and/or specialty.





## Forms

Forms Symptoms NoteTe	mplates						
PH	hysical Exam	▼ <filter< th=""><th>by Note</th><th>Section&gt; ▼ <fil< th=""><th>ter by Specialt</th><th>y&gt; 🔽 🚨 🖛</th><th>8</th></fil<></th></filter<>	by Note	Section> ▼ <fil< th=""><th>ter by Specialt</th><th>y&gt; 🔽 🚨 🖛</th><th>8</th></fil<>	ter by Specialt	y> 🔽 🚨 🖛	8
Form Display Name Sex		Age	Туре	Section	Specialty	Created By	Date Created
Infant Pulmonary Exam		Infant 0	PE	Physical Exam	Family Medi	Allscripts Clinica	12/31/2006
Knee Exam Left			PE	Physical Exam		Allscripts Clinica	12/27/2006
Knee Exam Right	Unknown		PE	Physical Exam		Allscripts Clinica	12/27/2006
Knee Left			PE	Physical Exam		Allscripts Clinica	12/20/2006
Knee Right			PE	Physical Exam		Allscripts Clinica	12/20/2006
Liz Test Copy			PE	Physical Exam		Allscripts Clinica	11/15/2006
Lumbar Spine			PE	Physical Exam		Allscripts Clinica	12/18/2006
Lymphatics Exam			PE	Physical Exam		Allscripts Clinica	12/9/2006
Musculoskeletal			PE	Physical Exam		Allscripts Clinica	12/14/2006
*** Musculoskeletal test			PE	Physical Exam	Orthopedic	Allscripts Clinica	10/26/2010
Neck			PE	Physical Exam		Allscripts Clinica	12/14/2006
Neck Exam			PE	Physical Exam		Allscripts Clinica	12/18/2006
Neuro	Unknown	Adult >	PE	Physical Exam		Allscripts Clinica	12/14/2006
Neuro Exam	Unknown	Adult >	PE	Physical Exam		Allscripts Clinica	1/1/2007
Neuro Psych Exam			PE	Physical Exam		Allscripts Clinica	12/9/2006
Nose Exam	Unknown	Adult >	PE	Physical Exam		Allscripts Clinica	12/16/2006
Obstetrical Exam			PE	Physical Exam		Allscripts Clinica	11/8/2006
Oral Cavity Exam			PE	Physical Exam		Allscripts Clinica	12/10/2006
Ortho Hip-General			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/15/2006
Ortho Hip-Post Op			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/8/2006
Ortho Knee-General			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/5/2006
Ortho Knee-Post Op			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/6/2006
Ortho LE-Neuro			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Ortho LE-Vascular			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Ortho Shoulder-General			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Ortho Shoulder-Post Op			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Ortho UE-Neuro			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Ortho UE-Vascular			PE	Physical Exam	Orthopedic	Allscripts Clinica	12/11/2006
Pharynx Exam			PE	Physical Exam		Allscripts Clinica	12/6/2006
Pulmonary	Unknown	Adult >	PE	Physical Exam		Allscripts Clinica	12/14/2006
Pulmonary Exam	Unknown	Adult >	PE	Physical Exam		Allscripts Clinica	12/14/2006
Rectal Exam Female	Female		PE	Physical Exam		Allscripts Clinica	12/27/2006
Rectal Exam Male	Male		PE	Physical Exam		Allscripts Clinica	12/16/2006



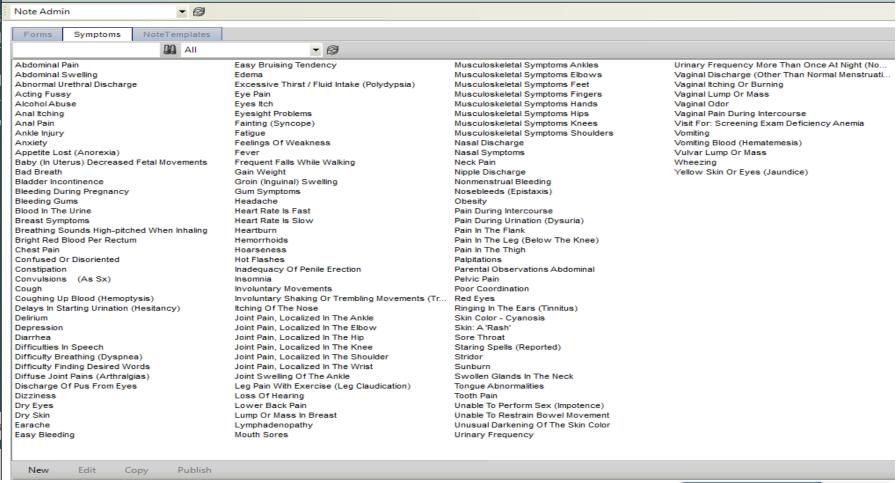
#### **Forms**

- There are three ways Allscripts allows you to utilize note forms:
  - Utilize Allscripts delivered content.
  - Review and edit Allscripts delivered content.
  - Build your own new forms (not recommended)
- There are five actions which can be performed within the Forms tab of Note Admin.
  - New allows you to create a brand new Note Form
  - Edit allows you to edit the original Note Form (Not recommended)
  - Copy allows you to copy the original Note Form and make edits
  - Properties displays the properties of the Note Form selected
  - Publish activates the edited Note Form for user access
    - Note: unpublished forms (not available to end users) are indicated by three astericks in front of the name.





#### Symptoms





## **Symptoms**

- These are detail forms that are associated with HPI: Symptom (parent forms). The details of these sub-forms are managed from this tab.
- Available in the ACI (add clinical item) under chief complaints.
- When HPI is set to "Auto Config" based upon Chief Complaint, the system pulls from these HPI:Symptom forms by adding the appropriate form to the HPI section of the note.



## **Text Templates**

Note Admin Manage Text Templates (V11) Manage Note Locks										
Manage Text Templates										
TW Module: Note(structured)										
Note Section:	-									
Specialty:	<b>-</b>									
Name	TW Module	Note Section	Specialty	Description						
		Note Section	Specialty	Description						
0-Newborn WCC	Note		Pediatrics	Sharkar Sak						
02 Mo Dev Milestones	Note		Pediatrics	Starter Set						
06 Mo Dev Milestones	Note		Pediatrics	Starter Set						
09 mo Dev Milestones 15 Mo Dev Milestones	Note		Pediatrics Pediatrics	Starter Set						
	Note			Starter Set						
18 Mo Dev Milestones	Note		Pediatrics	Starter Set						
1 MONTH 2 MONTH	Note Note		Pediatrics Pediatrics							
2 Yr Dev Milestones	Note		Pediatrics	Starter Set						
3 Yr Dev Milestones			Pediatrics							
	Note			Starter Set						
4 MONTH 6 MONTH	Note Note		Pediatrics Pediatrics							
6-7 Yr Dev Milestones			Pediatrics	Starter Set						
8-9 Yr Dev Milestones	Note Note		Pediatrics	Starter Set						
0-Newborn WCC	Note		Pediatrics	Starter Set						
04 Mo Dev Milestones	Note		Pediatrics	Starter Set						
1 Instructions	Note		Pediatrics	Starter Set						
More	Note		rediatrics							
More										
New <u>E</u> dit	Copy Delete	e E <u>x</u> port	I <u>m</u> port Content	Library View Security						



## **Text Templates**

- Located under Note Admin > Manage Text Templates
- Text templates are another way of documenting within a note. Buttons at bottom allow you to create/manage TTs similar to the way forms are managed.
- Not queryable
- Not captured by E/M coder
- Used in various Modules within EHR
- AHS provides Pre-delivered content and TTs can also be built from scratch relatively easily



## Input Templates

Note input templates control the note sections (HPI, ROS, Active Problems, Vitals, Assessment, Plan, etc.) that appear in the note and in what order. Note input templates also determine the autocite behavior for lists (Current Meds, Active Problems, Vitals, and Results) and the note forms that populate the note.



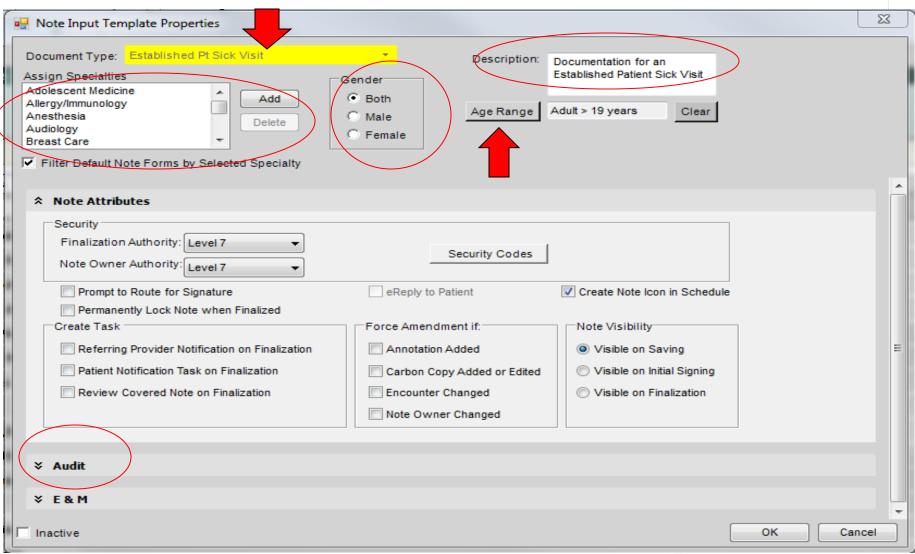
## Note Input Templates

Forms	Symptoms	NoteTemplates								
Document	Type Establishe	ed Pt Sick	Pt Sick Specialty: PEDIATRC			Age Range:	Pediatric 0-19 years			
Sections			<b>↑ Chief Complaint</b> ☐ Insert Dictation Placeholder							
Chief Com	plaint	Forms:								
Reason Fo	or Visit	*** Chief Comple	aint List ***	Add						
History of	Present Illness									
	f Systems	- 11		Delete						
Active Pro			Doloto							
Current M	eds									
Allergies Vitals		▼ Reason Fo	r Visit	Insert Dictation Placeholder						
Results/Da	ata		Present Illness	Insert Dictation Placeholder		✓ Previous His	story Auto-Config			
Physical E		▼ Review of	Systems	Insert Dictation Placeholder	✓ All Normal					
Assessme	ent	★ Active Pro	hlems	Insert Dictation Placeholder						
Plan				_						
	n/Summary	★ Current Me	eds	Insert Dictation Placeholder						
Letter Clos	_	★ Allergies		Insert Dictation Placeholder						
Signatures	-	<b>∀ Vitals</b>		Insert Dictation Placeholder						
		➤ Results/Delay	ata	Insert Dictation Placeholder						
		➤ Physical Ex	kam	Insert Dictation Placeholder	✓ All Normal	▼ Previous Ex	am 🗸 Auto-Config			
Add/Rem	nove Sections	* Assessme	nt	Insert Dictation Placeholder						
Output T	Templates	<b>≯ Plan</b>		Insert Dictation Placeholder						
▼ Establis	shed Pt Sick	* Discussion	/Summary	Insert Dictation Placeholder						
		★ Letter Gre	eting	Insert Dictation Placeholder						
	¥ Le	★ Letter Close	sing	Insert Dictation Placeholder						
		* Signatures	5							
New Out	put	Preview Prop	perties Save	Cancel New Input Search						



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#### E&M

•	Audit								
*	E&M								
	VE/MOBharbled	)							
	Ouidolines.	© 1997	C 1995		Setting:	Outpatient	* \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
	Exam Type:	General Multi	i-System (1997)	•	Service:	Prev Med Eval/Mgt			
	Patient Status:	C New	<ul><li>Established</li></ul>						
ľ									
<mark>°°</mark> )Ir	nactive							OK	Cancel



# Input Template Details

- **Gender:** Male/Female/Both (Example, if there's an OB Note, it would only be applicable to Female patients and therefore is only available to choose from when the patient in context is female.)
- Age: Using the OB Example, an age range could also be assigned to the input for adult patients 19-50 years old. These Age Ranges are predefined by AHS and cant be modified, so only assign this field if applicable (e.g. well child checks)
- Note Attributes (security): Please note that changes made here do not show up in the document type dictionary so the same changes will also need to be made there.
- Audit: Lists every event associated with the note input template.



# Input Template Details

#### **E&M**:

- The E/M Enable boxed must be checked in order for the patient's information recorded in the note to be captured by the coder.
- Remember that the setting and service should be applicable to the service and setting offered in your facility/clinic.
- ➤ Patient status can also be set here, but it can also be changed by clicking the E/M coder button from within the note.
- Example: Could set this to "Established" for Family and Internal Medicine specialties as this probably accounts for the majority of the patients seen.
- •Inactive: This box can be checked to inactive the note input. This makes is not available for the end user to select. It does not remove any inputs that are already in use.





## **Output Templates**

- Can have multiple outputs for every input
- Can change the text on each section or apply changes to all sections
- Can reorder and remove sections



## Litisha's Note Tips and Tricks

- Organizing the Doc Type Dictionary Before Building Input Templates
- Copying Note Templates
- Ensure that the input/output and document type details match.
- Enter comments on inputs for ease of finding template when ready to move via CMT
- Images on Note OutputsTWAdmin and Note Views
- Hiding the List Header
- Results Data Section Error
- Vitals Panel incorrect for end users
- Clinical Toolbar an Extension of the Clinical Desktop, not the note





# Things to Consider

- Remember that STANDARDIZATION is key. Align your note names with other document type (i.e. Scan and Unstructured). Determine what types of notes you will need across your organization as a whole, consider a good naming convention for ease of finding them in the Chart Viewer.
  - Note type examples include:
    - Acute, Chronic, Telephone, Refill/Renewal, Result Notes
    - New Pt, Established Pt Notes
    - Disease specific (i.e. Diabetes, COPD/Asthma) Notes
  - Note naming convention for multi-specialty orgs:
    - IM Renewal, FP Renewal, Peds Renewal, Derm Renewal etc...
  - Single Specialty with multiple sites:
    - Use clinic acronym as prefix: AO Phone, LO Phone, HO Phone





### **Additional Considerations**

- Remind your end users to ALWAYS read their note outputs to ensure clarity, prior to signing off of the note.
- The more documentation that is done within the note using Medcin, the more accurate E/M coder will be.
- Medcin IS discrete data and is therefore queryable
- In higher versions of Analytics using V11.2 or higher, text controls in addition to Medcin controls are reportable.



#### **Contact Information**

#### **Questions?**

#### **Questions:**

education@galenhealthcare.com Corporate: 888-Galen-44 Information

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http://wiki.galenhealthcare.com/Webcasts.

