

Allscripts TouchWorks 11.4.1 – Clinical Exchange Documents and Clinical Summary Notes

Empowering Extraordinary Patient Care





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Embrace the new world of healthcare	GALEN	Annu Constructions Annu Construction
	The webcast will begin momentarily	Attendees: Tracy Kimble
PROFESSIONAL Services Project Assessment Galen can leverage its extensive EHR experience to agree the condition of your EHB relieut. Drawing	Implementation Services Galen's keen understanding of EHR functionality and technical infrastructure uniquely positions it to positively	
on its history of leading successful EHR deployments, Galen will identify areas of weakness to mitigate risk and put the project back on track.	impact every aspect of the EHR implementation process. Review and Document Current State Workflows Evaluate Decision Requirements	
Evaluate Current State Review Organizational Goals Create Road Map to Success	Develop Future State Design Connecting Community Healthcare	▼ 2 Q&A
Project Management Galen provides project management solutions to help ensure your EHR rollout success. Galen will provide your organization with the experience necessary to identify, reduce and derivative project risks.	Galen understands the challenges that come with extending your EHR to physicians outside of your organization. Whether you're taking advantage of Stark Relaxation or just trying to provide a way for community physicians to get a complete view of their patients, Galen one have the second the second Toather way on one	
Implementation Management Resource Management Project Plan Design and Execution Site Preparation	review your unique situation and help structure an EHR that creates a seamless community connection.	
	vitalcenter	Ask: All Panelists
		Select a participant in the ack menu first and type your question here. There is a 256 character limit.





Introduction

Crystal Vervaecke

- Senior Consultant with Galen Healthcare Solutions
 - > Over 20 years in healthcare including 11 years of EHR experience
 - Galen Touchworks EHR Certified

Steve Skiff

- Consultant with Galen Healthcare Solutions
 - > 13 years of Healthcare IT Experience with 10 years of EHR experience
 - Galen Touchworks EHR Certified





Agenda

- > Overview/Definition
- > Options
- Considerations
- ➢ Setup
- ≻ Demo





Definition of a Clinical Summary

A Clinical Summary as an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the following:

- ✓ Patient name
- ✓ Sex
- ✓ DOB
- ✓ Race
- ✓ Ethnicity
- ✓ Preferred Language
- ✓ Smoking Status
- Problems: Current Problem List and any diagnosis specifically related to the office visit as separate fields
- Medications
- ✓ Medication allergies.
- ✓ Lab Test(s)
- Lab value(s)/result(s):
- Vital Signs (Height, Weight, Blood Pressure, BMI) taken during the visit or other recent vital signs

- ✓ Care plan field(s), including Goals and Instructions:
- ✓ Procedure
- ✓ Care Team Members
- ✓ The provider's name and office contact information
- ✓ Date and location of visit
- ✓ Reason for visit: The diagnosis related to the office visit should be expressed in the "reason for the patients visit" field
- Immunizations and/or medications administered during the visit
- ✓ Diagnostic Tests Pending: Refers to diagnostic tests that have been performed and results are not back
- ✓ Future scheduled tests: Test that have been schedule but not yet performed
- ✓ Clinical Instructions: Care instructions for the patient that are specific to the visit Future appointments
- ✓ Referrals to other providers
- ✓ Recommended Patient Decision Aids:





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Stage 2 Final Rule Requirements

Clinical summaries provided to patient or patient-authorized representatives within 1 business day for more than 50% of office visits.



Core Objective 🖌 Menu Objective

Numerator: The number of office visits in the denominator where the patient is provided a clinical summary within 1 business day

Denominator: The number of office visits conducted by the eligible professionals (EP) during the EHR reporting period (RP).

Exclusion: Any EP who does not have office visits during the RP.

Objective is shared across Eligible Professionals: Objective must be recorded during the reporting period:

Prerequisites

Requires: Clinical Summary functionality Availability: Prior to v11.2: 🗸 Enhanced v11.4.1: 🗸 Prior to v11.2:
VII.4.1: OR: v11 Note Availability:





Allscripts Delivers 4 Pre-defined Formats for the Clinical Summary

Allscripts Clinical Summary-RTF: Due to certain limitations in the CCDA template, Allscripts delivers the Allscripts Clinical Summary-RTF template. This template includes information or formats that are not supported by CCDA templates.

Allscripts Clinical Summary-CCDA: The Allscripts Clinical Summary-CCDA template meets all CCDA requirements for Meaningful Use Stage 2.

Allscripts Summary of Care (SOC): A summary of care is a document that is delivered in CCDA format that is used for referral and transition of care workflows. A summary of care provides more detailed information not in the clinical summary about the issues requiring the referral or transition of care to the provider receiving the referral. Sending a summary of care document electronically as part of a referral workflow is a requirement for Meaningful Use Stage 2. There can only be one active enterprise version of a summary of care at anytime since the version will be shared amongst all users, regardless of site and/or specialty.

Allscripts CCD: A CCD includes the patient's entire chart. A CCD can be sent to Allscripts Patient Portal[™] or another third party electronically. A CCD is a document used to exchange clinical information electronically, enabling clinicians to share patient information across locations and disparate systems. It is not usually printed. There can only be one active enterprise version of a summary of care at any time since the version will be shared amongst all users, regardless of site and/or specialty.





				Allscripts
Section	RTF	CCDA	SOC	CCD
Patient Details	Х	Х	Х	X
Reason For Visit	Х	Х	Х	X
Chief Complaint	Х	Х	Х	X
Functional & Cognitive Status	Х	Х	Х	X
Assessments	Х	Х		
Treatment Plans	Х	Х	Х	X
Interventions	Х	Х	Х	X
Instructions		Х	Х	X
Vital Signs	Х	Х	Х	X
Medications	Х	Х	Х	X
Medications Administered		Х	Х	X
Problems	Х	Х	Х	X
Allergies	Х	Х	Х	X
Results	Х	Х	Х	X
Past Medical History	Х	Х	Х	X
Procedures		Х	Х	X
Surgical History	Х			
Immunization Hx	Х	Х	Х	Х
Family History			Х	X

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Client Defined Manual Process

• V11 Note output

If the organization has v11 Note users, we recommend that they create a clinical summary output that is flagged as "Is Clinical Summary." The user can define the sections they want to appear in the clinical summary and the format of the clinical summary. At a minimum, it will need to include: Problem List, Diagnostic Test Results, Medication List and Medication Allergy List.

- □ As part of the user note documentation, they will be automatically creating a clinical summary document to give to the patient at the end of the visit.
- □ Using a v11 note allows the user to use additional customization to the look and feel of the clinical summary document that is given to the patient.

• V10 Note output

If the organization has users that create a v10 note as a part of their office visit, they feel comfortable giving that note to their patient, and the note includes the minimum clinical summary sections (See "CCDA Templates Delivered By Allscripts" section in this document), they can flag this as a "Clinical Summary Document" in the Dictionary.





Follow these setup sets for any clinical summary type:

- > Build an appropriate **print template** for the user Clinical Summaries to print on.
- ➢ Go to TWAdmin>Document Admin >Print Templates- create a print template to use
- > Verify **auto-print defaults** are established for those users that will be printing the clinical summary.
- Verify Chart-Edit and Chart-Print security codes are assigned to any user that will be producing a clinical summary.
- Verify "Can CS Invalid" security code is assigned to any user that needs the ability to invalidate a clinical summary.
- Verify that "Patient Profile- Edit" and "Patient Profile-View" security codes are assigned to any user that needs the ability to update the patient's preferred communication method for producing a clinical summary.
- Flag any appointment types that should be excluded from the denominator that should not be considered an office visits. Go to TWAdmin> Dictionaries>Appointment Type Dictionary>Exclude from Stimulus Reporting.



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Demonstration





Considerations

- Who, what, when, where, and how?
 - What type of Clinical Summary will you use?
 - Who will generate this Clinical Summary?
 - Where will this Clinical Summary be provided?
 - When will this clinical summary be generated?
 - How will you generate the clinical summary?
- Users who generate
- Generate from Daily Schedule and/or Encounter Summary
- Where to generate: Auto-Print Defaults
- Headers can be customized for Document
 - Less of a header (Site/Org Logo and Date/Time) for RTF/CED
 - More of a header (Site/Org Logo, Date/Time, Patient Info, and Encounter) for v10/v11 Structured Note Output





Q&A

Question Review

- Submit further questions to <u>education@galenhealthcare.com</u>
- Visit <u>http://galenhealthcare.com/calendar/</u> for future webcasts
- Slides and Q&A will be posted at <u>http://wiki.galenhealthcare.com/Clinical Exchange Documents and Clinical Summary</u> <u>Notes</u>





Thank you for joining us today, for additional assistance....

You can contact us through our website at www.galenhealthcare.com

