



Allscripts Enterprise EHR

## Clinical Content Team Best Practice Guide: **Version 11 Note**

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# Allscripts Enterprise EHR

## Version 11 Note Resources and Best Practices

The goal of this document is to compile a broad range of resources, Tips/Tricks and Best Practice Recommendations from the Allscripts Clinical Content Team for the EEHR V11 Note Module.

*Main themes include:*

- > Getting Started on Version 11 Note
- > Introduction to Clinical Team Resources (*Webcasts, Release Notes, Quick Self-Study Series*)
- > Note Authoring Design Intent, QuickTips and Best Practices
- > Further Reading and Educational Materials for a 'Deeper Dive'



### *Clinical Team Best Practice Recommendation*

Throughout this document, the icon to the left indicates our Clinical Content Team has given a Best Practice recommendation.

By following these tips, your organization's experience with Version 11 Note will support optimal system performance, streamline your documentation and billing processes, and increase Provider adoption.

## Overview

**Clinical Team Best Practice Recommendations: Getting Started with Version 11 Note****> START LITE!**

Version 11 Note has been designed to support rich functionality and configurability. However, it takes users time to become comfortable with all of the features that V11 Note offers. With that we strongly recommend that you begin your organization's V11 Note experience by configuring with a 'Note-lite' approach that includes only the Physical Exam, Review of Systems, Procedure, and Post-Op note sections – the Note Forms for these sections are the easiest to customize, the most standardized, and are elegantly integrated with E/M 97 billing guidelines.

Try these sections for a few months and let your providers get used to the navigation, billing interaction and output formats – then roll out more forms like HPI and Discussion Summary. During this initial 'Note-lite' period, users can dictate, use Dragon or type the other parts of the Note until the group is ready to add in the use of the remaining note form sections like HPI and Discussion/Summary.

By following this Best Practice and adding features via an iterative strategy, you will find that provider adoption in your organization will be increased dramatically.

**> AVOID THE 'TYRANNY OF THE EMPTY FORM'**

Providers are trained to be complete and comprehensive when documenting an encounter. Aside from billing and legal concerns, the Note is essentially about communication – to colleagues, the patient - as well to serve as a quick reminder for future visits.

When starting out with Version 11 Note, you might feel like you need to click a lot of the Note Form controls. However, while documenting a visit via the EHR, we suggest that you only select the Form Controls that communicate the details about the case as quickly and easily as possible – *be concise and don't document anything more than that*. Any items that you do not select will not become part of your note output.

In addition, Clinical Team-delivered Note Forms released in 2009-2010 have been integrated with E/M Coding Guidelines – so EEHR charge will send the bullets to ensure correct billing without requiring extra clicks.

**> LEVERAGE FREE-FORM TEXT AND DETAILED SUBFORMS**

Version 11 Note has been designed to allow expedited encounter documentation with few clicks, on a single page-view.

However, since every encounter has a "story", it's not possible to include every scenario on a structured form. So we designed the system with the 80/20 rule in mind – providing concise clinical content on the main form for 80% of encounters, with quick access to comprehensive views, detailed Subforms and free-text areas with a single click (If we shot for 100%, the Forms would be so long they would be unusable). There are tips throughout this document on how to access these free-form text inputs while authoring your Notes (*Double-clicking on controls, Subform areas, etc.*).

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## Release Notes and Webcasts

Our Clinical Content Team publishes new and revised content on a quarterly basis. You can find detailed information about the release content in the Release Notes and recorded Webcasts provided by members of our Clinical Content Team.

These documents are great resources if you want a quick overview of the new content available in a Note Form Release – as well as the personal touch provided by the video webcasts and real-time demonstrations from our Clinical Leaders.

Most importantly, these resources also provide best practice recommendations regarding system performance and workflows from our Clinical Content Team – providers who understand the challenges and daily situations faced by our clients.

2009-3 Note Forms Release	
	<b>Enterprise EHR Note Form Release Notes</b>
<b>Release Date</b>	January 4, 2010
<b>Note Forms Release</b>	2009-3 Note Forms Release
<b>Enterprise EHR Version</b>	<ul style="list-style-type: none"> <li>We recommend the target installed.</li> <li>Enterprise EHR V11.1.1</li> <li>Q3 2009 Medicin Data Release</li> <li>The upgrade process requires the target server primarily to rollback during processing, administrative utilities if you size after the install.</li> </ul>
<b>Summary of Changes</b>	<ul style="list-style-type: none"> <li>1 New Pediatric Musculoskeletal with 33 New joint-specific subforms</li> </ul>

**What's New in the Release?**

- > HPI Forms
  - Neurosurgery, OB/Gyn, Infectious Disease, Neurology
- > D/S Forms
  - Ortho, Pediatrics, ENT, Neurosurgery, Primary Care, Infectious Disease, Neurology, Urology
- > Imaging Interpretation Forms
- > Age Specific Pediatric ROS Forms
- > Multi-System PE Forms
  - Cardiology, Pediatrics, GU, Infectious Disease, Ortho, Heme/Onc

**Release Notes and Webcasts Include:**

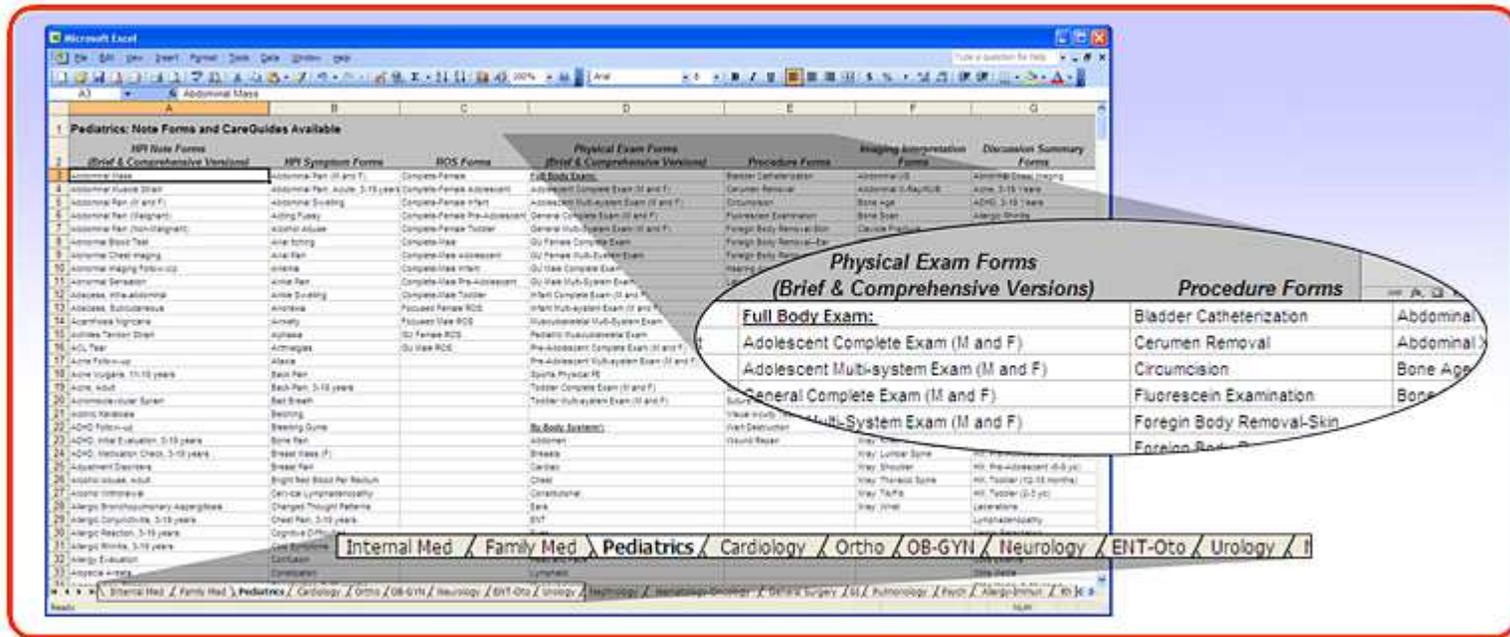
- Details on individual Note Forms
- Instructions and step-by-step guides to using new features
- Best Practice Recommendations and product demonstrations

*(You can find these documents on the Allscripts Knowledge Base)*

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## 'Content By Specialty' Spreadsheet

The 'Content By Specialty' Spreadsheet provides a list of Note Forms and Care Guides grouped by specialty. This spreadsheet is a very handy tool when you want to quickly review the content available with a Note Form Release relevant to your practice.



(You can find the spreadsheet on the Allscripts Knowledge Base, Article # 4861)

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## READY Certified Workflows and Training Materials

We suggest that you review the READY training materials available to EEHR clients. These documents illustrate the Certified Workflows our READY teams have pulled together from commonly-held industry best practices.

Although your organization's workflows might deviate from the Certified Workflows, this documentation offers many tips that you can leverage and complement training during and after your initial Go-Live (*See last section for Knowledge Base Article #'s*).

The composite image illustrates the READY Certified Workflows and training materials. It includes:

- Flowchart:** A process flow starting with 'G2' (Go-Live) leading to 'Provider assesses problems'. A decision diamond asks 'Has note already been started?'. If 'Yes', the provider 'recompiles note'. If 'No', the provider 'starts the note'. This leads to a parallelogram 'Note Form' based on problem(s), followed by 'Provider documents History of Present Illness (HPI)', 'Provider documents Review of Systems (ROS)', and 'Provider performs and documents Physical Exam (PE)'. A second decision diamond asks 'Carbon Copies Required?'. If 'Yes', the provider 'identifies Carbon Copy list'. If 'No', the provider 'reviews Note Output(s)'. The flowchart is marked with a 'G' icon.
- PDF Document:** 'READY Fundamentals Training Guide\_090109.pdf' in Adobe Reader. The cover features the Allscripts logo and 'Allscripts Enterprise EHR™'. The title is 'Core Education Suite: Basic Functionality Student Guide'. Metadata includes 'Software Version: 11.1.7', 'Item Number: EH20501', and 'Last Updated: Nov. 20, 2009'.
- Software Interface:** A screenshot of the Allscripts clinical toolbar showing a 'Start New Note' button highlighted with a red box. Below it, a patient list table is visible with columns for 'Name', 'MRN', 'DOB', 'Age', 'Sex', and 'PCP'. The patient 'Allscripts, Kendra T' is highlighted.
- Training Slide:** 'Chapter 8: Documenting an Acute Problem Visit'. Section '8.2 Overview: Note Selector' explains that to start a new note, the user should click the drop-down arrow to the right of the Clinical Toolbar or the Clinical Desktop and select the 'Start New Note' button.

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## READY 'Cheat Sheets' and 'At-A-Glance' Quick Guides

Our Educational Services team has provided a number of Quick Reference cards which give a high-level description of common workflows and tips for documenting an encounter with Version 11 Note.

It is the goal of these materials to keep the information short and easily accessible, on one page – providing just the right information in a concise, portable format. We suggest keeping these cheat sheets around the office for quick reference.

**Note Authoring Workspace At-a-Glance (Note Input and Note Output Documents)**

The Note Input within the Note Authoring Workspace is where you enter patient information. There are multiple ways to enter information into the Note Input: information can be automatically cited from the Clinical Desktop. You can also enter free text, utilize note forms, use voice dictation, or dictate into the sections.

The Note Output documents are located in the lower-left corner of the Note Authoring Workspace. The output documents pull in certain sections defined within the note input, depending on how the output documents are set up in EHRAdmin.

For example, the Acute note will not include the Letter Greeting and Letter Closing sections, but the Referral Letter will.

An important benefit of using Note is you can input the information once and have it formatted differently in multiple output documents. The following are examples of Note Outputs that can be generated from a single input:

- Established Patient Visit**—Contains all of the note sections in the input except Letter Greeting and Letter Closing. This will be your complete chart note.
- Patient Summary**—Contains only Active Problems, Current Meds, Allergies, Immunizations, and Plan.
- Results Letter**—Contains the Letter Greeting, Letter Closing, and the Results section.

**Note Authoring Workspace At-a-Glance (Sign Note)**

Once you have reviewed the patient information and determined it is correct, your next step is to sign the notes). There are two ways to sign your note:

- Note Input**—You can choose to sign all existing output notes by clicking Sign at the bottom of the Note Input, below the note accumulator section.
- Note Output**—You can choose to sign each individual output by clicking Sign at the bottom of the Note Output page.

Once the Sign button is selected, the Note Signature box prompts containing the following information:

- User Name**—Defaults in automatically.
- Password**—Depending on your preferences you may need to enter your password.
- Sig Type**—This is determined based on your organization (for example, Attending Physician may be listed as the Author of the note, the Resident listed as the Co-Author, and the Nurse is listed as a Contributor).
- Make Final**—Select this check box to finalize the note.

Any future edits to the document will change the status of the document from Finalized to Amended. If you want to make more edits before finalizing or have outstanding dictations from the document you may want to sign the document without finalizing. Clear (uncheck) the **Make Final** check box before signing, then click OK. The user may resign and finalize the document at a later time once all edits have been made and all outstanding dictations entered into the Note.

**Note Authoring Workspace At-a-Glance (Note Document Statuses)**

The following is a list of the various document statuses:

- Needs Input**—Note is in the process of being edited after initial creation.
- Signed**—Note is signed but additional input will be added (Note Signed but not Final task generated).
- Final**—Note is complete. No other work is required.
- Amended, Signed**—Changes were made to a finalized note and additional input may still be added (Note Signed but not Final task generated).
- Amended, Final**—Document has been finalized after being amended. No other work is required.

**Note Authoring Workspace At-a-Glance (Batch Sign Notes)**

The Batch Sign feature renders the note in the Document Completion Tasks workspace rather than in a separate window allowing multiple documents to be signed in one workspace. This feature provides users with much quicker processing time when signing multiple notes.

**Note Form Builder Icons At-a-Glance**

Name	Icon	Description	Name	Icon	Description
Save	[Save Icon]	Saves edits made to a form	Align Tops	[Align Tops Icon]	Aligns the tops of multiple items
Align Centers	[Align Centers Icon]	Aligns the center of multiple items	Align Bottoms	[Align Bottoms Icon]	Aligns the bottom of multiple items
Align Bottoms	[Align Bottoms Icon]	Aligns the bottom of multiple items	Make Same Width	[Make Same Width Icon]	Aligns the width of multiple items
Make Same Height	[Make Same Height Icon]	Aligns the height of multiple items	Make Same Size	[Make Same Size Icon]	Makes all selected items the same size
Size to Grid	[Size to Grid Icon]	Makes all selected items the same size to the grid			

(Contact your Account Manager or Allscripts Academy Representative for more information)

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## Internal Discussion Sessions



### *Clinical Team Best Practice Recommendation*

We have often noticed (*during Provider visits, interviews, demos and user group sessions, etc.*) that many times the best sources for information are your peers and colleagues within your organization.

When a group of providers get together for even a small amount of time to discuss challenges and describe personal workflows, we have consistently witnessed participants walk away with one or two “tricks” that dramatically increase daily productivity and product satisfaction.

Although we realize it’s sometimes challenging to find the time, we suggest that you schedule regular sessions among the users of EEHR within your organization to discuss daily workflows – we are confident that the time invested during this exercise will provide sufficient ROI as your organization matures with the use of the EHR.

Note Admin  
and Setup**Auto-Configuration**

Note Forms may be configured to participate in **Auto-Configuration** for certain sections of the note input template (HPI and PE). Note Forms will automatically be inserted into the HPI and Physical Exam sections of the Note Input Template based on the Chief Complaint, an Assessed Problem, or a combination of both.

'Chief Complaint' is based on a dictionary of Medcin symptoms that have HPI Symptom Forms developed and available in the user's server. Selecting an item from Chief Complaint will bring in any available HPI Symptom Forms to that visit's Input Template. Assessing a problem will bring in an HPI Problem Form for that visit's Input Template.

In order for auto-configuration to occur, the Chief Complaint must be selected or a Problem assessed prior to launching a new Note. If additional Chief Complaints or Assessed Problems are added after the Note is opened, the user must click the Recompile action button at the bottom of the Note Authoring Workspace to bring in additional forms (*or click on the appropriate Note section of the NAW's left-hand Table of Contents and select 'New From Top or Bottom' to bring in a new Note Form.*)

**Clinical Team Best Practice Recommendation**

Since each instance of Auto-configuration has performance implications, the Allscripts clinical team recommends that you limit Auto-configuration to the HPI section.

We recommend that you have Auto-Configuration turned off for Physical Exams (PE) – instead default the Multi-System / Complete PE forms (described below) into your input templates.

Also, we recommend you ensure that your Favorites/Quick Lists include the Problems to which your HPI forms (*Rx and Problem*) are linked – so that when you select an item from Favorites, it will auto-config in the expected HPI form.

Following these best practices will help insure that your Note Forms load quickly and present a simplified/streamlined UI when starting to use V11 Notes – while leveraging the content provided by Allscripts.

Suggested  
Note Form  
Utilization

## 'Brief' HPI Note Forms

We have received feedback from users that it's helpful to see the entire length of a Note Form when documenting encounters.

To address this, we have developed a 'Brief' version of the HPI Note Forms.

These brief HPI Note Forms contain all of the same information as their comprehensive counterparts, but are structured to provide much of the information on Subforms (*vs. scrolling through a long page to view all elements*).

This approach gives the user a view that is easy to review the entire Form at-a-glance – with access to details when required via a single click.

The screenshot displays a software interface for testing forms. The main window is titled 'Form Tester' and shows a form for 'Seizure Disorder, Adult (Brief)'. The form is divided into several sections, including 'Reason for Visit', 'Typical Seizure Type', 'Evaluation and Treatment History', 'Symptoms', 'Problem Details', 'Current Treatment', 'Disease Course', and 'Pertinent History'. A 'Details' subform is open over the main form, showing a detailed view of the 'Evaluation and Treatment History' section. A callout box with a yellow background and black text points to the 'Details' subform, stating: "'Brief' Note Forms allow providers to see the entire Form, with quick access to Details.'

The 'Seizure Disorder, Adult (Brief)' form includes the following sections:

- Reason for Visit:**
  - Visit Type:** Initial Evaluation, Initial Eval - Existing Diagnosis, Consultation, Follow-Up - Routine Clinic, Follow-Up - From Hospitalization, Follow-Up - From Urgent Care.
  - Typical Seizure Type:** (Dropdown menu)
- Evaluation and Treatment History:** (Dropdown menu)
- Last Visit:** (Dropdown menu)
- Symptoms:**
  - Typical Seizure Symptoms:** Aura, Lip Smacking, Automatism, Blank Stare, Altered Mental Status, Gaze Deviated Left, Gaze Deviated Right, Left Arm Clonus.
  - Typical Associated Symptoms:** Bladder Incontinence, Bowel Incontinence, Amnesia for Seizure Event, Postictal Confusion, Postictal (Todd's) Paralysis.
- Problem Details:** (Dropdown menu)
- Current Treatment:** (Dropdown menu)
- Disease Course:** (Dropdown menu)
- Pertinent History:** (Dropdown menu)

The 'Details' subform shows the following sections:

- Evaluation and Treatment History:**
  - Prev Evaluation Setting:** This Clinic, Urgent Care, Emergency Room, Evaluated in Hospital, Evaluated by Me, Primary Care Provider, Colleague.
  - Prev Evaluation Timing:** \_\_\_ Day(s) Ago, \_\_\_ Week(s) Ago, \_\_\_ Month(s) Ago, \_\_\_ Year(s) Ago.
  - Presentation:** Tonic-Clonic Seizure, Generalized Motor Seizure, Simple Partial Seizure, Complex Partial Seizure, Absence Seizure, Petit Mal Seizure, Temporal Lobe Seizure, Recent Seizure, Increased Seizure Frequency, Status Epilepticus, Ataxia, Altered Mental Status.
  - Past Evaluation:** None, CBC, Anticonvulsant Med Levels, Drug Screen, EEG, Video EEG.

Suggested  
Note Form  
Utilization

## “Brief” HPI and Discussion/Summary Note Forms

*Clinical Team Best Practice Recommendation*

We suggest users leverage the areas in the HPI and D/S Forms that provide a place to **document your thinking at the time of the encounter** (for example: Medication compliance and tolerance information, differential diagnoses, diagnostic plans, etc.)

(Please note that these sections are not meant to duplicate Rx and Assessment lists – they don’t promote Problems or create Orders. And, remember – these areas are not required...they are there for you to use if you want to refer back to what you were thinking at your next visit.)

**Seizure Disorder, Adult (Brief)**

Reason for Visit:  Initial Evaluation  Initial Eval - Existing  Consultation

Typical Seizure Type

Last Visit:

Symptoms:

Typical Seizure Symptoms

Aura  Lip Smacking  Automatism  Blank Stare  Altered Mental Status  Problem Details  Bladder Incontinence  Bowel Incontinence  Amnesia for Seizure

Current Treatment:

<input type="checkbox"/> None	<input type="checkbox"/> Gabapentin (Neurontin)	<input type="checkbox"/> Pregabalin (Lyrica)
<input type="checkbox"/> Phenytoin (Dilantin)	<input type="checkbox"/> Lamotrigine (Lamictal)	<input type="checkbox"/> Zonisamide (Zonegran)
<input type="checkbox"/> Carbamazepine (Tegretol)	<input type="checkbox"/> Oxcarbazepine (Trileptal)	<input type="checkbox"/> Felbamate (Felbatol)
<input type="checkbox"/> Divalproex (Depakote)	<input type="checkbox"/> Clonazepam (Klonopin)	<input type="checkbox"/> Tiagabine (Gabitril)
<input type="checkbox"/> Phenobarbital	<input type="checkbox"/> Ethosuximide (Zarontin)	<input type="checkbox"/> Anticonvulsants
<input type="checkbox"/> Levetiracetam (Keppra)	<input type="checkbox"/> Topiramate (Topamax)	

Compliance/Tolerance/Control

<input type="checkbox"/> Good Compliance	<input type="checkbox"/> Good Tolerance	<input type="checkbox"/> Good Symptom Control
<input type="checkbox"/> Fair Compliance	<input type="checkbox"/> Fair Tolerance	<input type="checkbox"/> Fair Symptom Control
<input checked="" type="checkbox"/> Poor Compliance	<input type="checkbox"/> Poor Tolerance	<input type="checkbox"/> Poor Symptom Control

Pertinent History:

Seizure Disorder, Adult (Brief): By report, there is poor compliance with treatment, good tolerance of treatment and fair symptom control.

**Seizure/Epilepsy**

Impression:

Epilepsy  Seizure Disorder

Seizure Characteristics

Etiology

Current Status

Increased Seizure Frequency  Unchanged Seizure Frequency  Decreased Seizure Frequency

Medication Changes

None  Med  Other

Additional Treatments

Hospitalization  Alcohol

Patient Discussion:

Patient  Family

Seizure/Epilepsy:

**Seizure/Epilepsy Differential Diagnosis**

Differential Diagnosis

Pseudo-seizure  Seizure Disorder  Syncope  Febrile Seizure  Narcolepsy

**Seizure/Epilepsy Diagnostic Plan**

Diagnostic Plan:

<input type="checkbox"/> CBC	<input type="checkbox"/> Blood Glucose	<input type="checkbox"/> Head CT
<input type="checkbox"/> Anticonvulsant Levels	<input type="checkbox"/> Creatine Kinase	<input type="checkbox"/> Brain MRI
<input type="checkbox"/> Toxicology Screen	<input type="checkbox"/> Thyroid Function Testing	<input type="checkbox"/> EEG
<input type="checkbox"/> Serum Electrolytes	<input type="checkbox"/> Serum Ammonia	<input type="checkbox"/> Video EEG
<input type="checkbox"/> Liver Function Tests	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Cardiology Consultation
<input type="checkbox"/> BUN/Creatinine	<input type="checkbox"/> Lumbar Puncture	<input type="checkbox"/> Neurosurgery Consultation

Suggested  
Note Form  
Utilization

## Using Focused / Complete ROS Forms



### *Clinical Team Best Practice Recommendation*

In response to Provider Advisory Board (PAB) recommendations, we have made the following revisions in order to differentiate our Review of Systems (ROS) Note Forms.

We suggest the use of these forms in the following manner:

- > **Complete** – Appropriate for new patients
- > **Focused** (formerly known as 'Extended') – Appropriate for acute and follow-up visits

Allscripts delivers these forms in such a way that customization can be done efficiently at the organizational-level by starting with the Complete ROS and deleting any items that do not pertain to your specific preferences and workflows.

Suggested  
Note Form  
Utilization**Multi-Symptom Full-Body Physical Exam (PE) Forms**

For the past year, our Clinical Content Team has been focused on creating Note Forms that facilitate efficient encounter documentation. The result is our new set of full-body PE Exam Note Forms which are easy to use (since multiple body systems are included) and are based on 97 E/M Coding Guidelines. *Highlights Include:*

<b>E/M Benefits</b>	All non-italicized control on these Note Form will give billing credit with few clicks (see “Style” section below for details)
<b>Same Subform for Normal and Abnormal</b>	By configuring the same data for ‘Normal’ and ‘Abnormal’, our Subforms support quick learning and consistency ( <i>‘muscle memory’</i> ) for encounter documentation. The Subforms contain both pertinent positives and pertinent negatives.
<b>Free-text Entry</b>	Since all encounters are unique, our Note Forms support multiple options for free text entry. These include entering text directly into the accumulator wherever you see a grey bar, or within the Note Form itself in a text box - or by double clicking on any control (which renders the entered text in parenthesis next to that control).
<b>Brief and Comprehensive ‘Views’</b>	Brief Note Form versions support quick entry for acute and follow-up visits; Comprehensive versions support efficient documentation for Health Maintenance and Consult visits. In both cases, the user can take advantage of the ‘All Normal’ button ( <i>if enabled in your local system</i> ) and document ‘by exception’. The controls that are defaulted to participate in ‘All Normal’ are preset on delivered Note Forms, but can be easily modified at a client’s organizational level.
<b>‘Standard of Care Terminology’ Support (Complete vs. Multi-system)</b>	We have provided options to allow you to decide the verbosity of your Note Output for a specific encounter. The Multi-system exams render ‘Normal’ when selected verses the Complete exams which render a brief description (for example “S1, S2, no murmurs”); both of these options are appropriate from a legal and billing standpoint.
<b>Customization of Allscripts-Delivered PE Multi-System Note Forms</b>	Organizational-level customization can be done efficiently by starting with the more comprehensive version of the PE Note Forms and deleting out the items that do not pertain.

Suggested Note Form Utilization

## Multi-Symptom Full-Body Physical Exam (PE) Forms, cont.

The screenshot displays two overlapping windows from a medical software application. The primary window, titled 'Form Tester', shows a 'Brief' version of an 'Infant Multi-System Exam'. It includes sections for Constitutional, Head and Face, Eyes, Ears, Nose, Mouth and Throat, Neck, Pulmonary, Cardiovascular, and Abdomen. Each section has radio buttons for 'Normal' or 'Abnormal' and a text field for details. The 'Ears, Nose, Mouth and Throat' section is currently selected, with 'Normal' chosen for 'External inspection of ears and nose'. A secondary window, titled 'Details', provides a more granular view of the 'Sub External Ear/Nose' examination. It features a table for 'External Ear' with columns for 'Rt' and 'Lt' for various conditions like Auricles, Mastoids, Erythema, Swelling, Tenderness, and Skin Lesion. Below this is a section for 'Auricle Malformation' with columns for 'Bif', 'Rt', and 'Lt' for conditions such as Absent, Atresia, Cryptotia, Cup Ear, Darwin's Tubercle, Ear Lobe Cleft, Ear Lobe Crease, Lop Ear, Macrotia, Microtia, Prominent Helical Tail, Prominent Auris, Stahl's Ear, and Transverse Bar. Both windows have 'All Normal' and 'Previous Exam' buttons and 'OK'/'Cancel' buttons at the bottom.

(Example of an Allscripts-delivered Multi-System Full-Body PE Note Form)

Suggested  
Note Form  
Utilization

## Procedure and Post-Op Note Forms

Our Procedure and Post-Op Note Forms provide easy and quick documentation through the use of the 'All Normal' button (*remember, Allscripts delivers these preset but your organization has the ability to determine what should be included as 'All Normal' and whether or not 'All Normal' is a feature available to the providers in that organization*). The Post-Op Notes are set up in a 'SOAP' Note format for ease of use and documentation, given that billing for these visits tend to fall under the 'global surgical fee'.

If a procedure is performed in a consistent manner most of the time, you can pre-select the defaults to display automatically when the Form is initially loaded (then, you can select/deselect the exception items appropriate for the specific visit). In addition, these Forms support the use of the Double-click Free Text control (described above and below) and typing comments directly into the accumulator.

These Forms include consistent formatting to support ease-of-use -- including Discussion, Consent and Time-out, Finding, Post-procedure and Follow-up areas. Also, we have attempted to keep the Note Form short and concise by using Subforms to provide optional details.

By adopting these Note Forms, your Procedure-based workflows and Post-Op visits will require very few clicks to complete the documentation in most cases.

The screenshot displays the 'Bronchoscopy' form in the Allscripts EHR system. The form is structured as follows:

- Procedure:**  Bronchoscopy
- Indication:**
  - Laryngeal Stenosis
  - Tracheal Stenosis
  - Foreign Body
  - Head/Neck Cancer
  - Trach Complications
- Discussed:**
  - Patient
  - Risks
  - Parent
  - Guardian
  - Benefits
  - Alternatives
  - Bleeding
  - Aspiration
  - Syncope
- Complications:**
  - Consent Obtained
  - Lorazepam \_\_\_ mg
  - Anesthesia: Nares
- Premedication:**
  - Lorazepam \_\_\_ mg

A tooltip for the 'All Normal' button shows the following generated SOAP note text:

```

Bronchoscopy: Procedure: Bronchoscopy .
Risks, benefits and alternatives were discussed with the patient. We discussed possible complicat
bleeding, aspiration and syncope. Written consent was obtained prior to the procedure.
Premedication:
Anesthesia:
Specimen: The specimen was placed in buffered formalin and sent for pathology.
Patient Status: The patient tolerated the procedure well.
Complications: There were no complications.
  
```

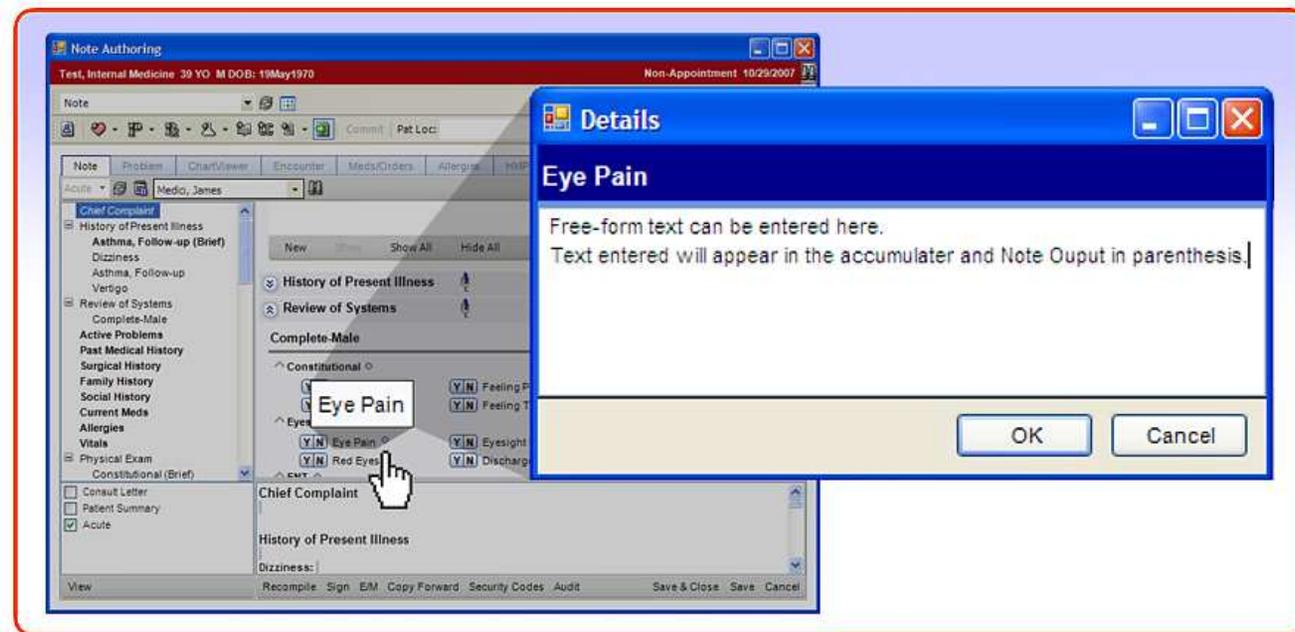
## Double-Click for Free-Text Detail Form Controls

We have heard from our providers that they require the ability to enter free text – above and beyond the Medcin-linked point-and-click documentation provided by our Note Forms.

In response, we've added the ability to launch a free-form text detail form for Note Medcin and text-field controls simply by double-clicking on the label in the Note Authoring Workspace (*this feature is available in Version 11.1.6 and above*). The information that you enter will render in parentheses following the rendered text from that specific control (*see graphic below*).

The user also has the options noted above for entering free text - which includes typing directly into the accumulator wherever a grey bar appears and entering free text into text boxes on the main Note Form.

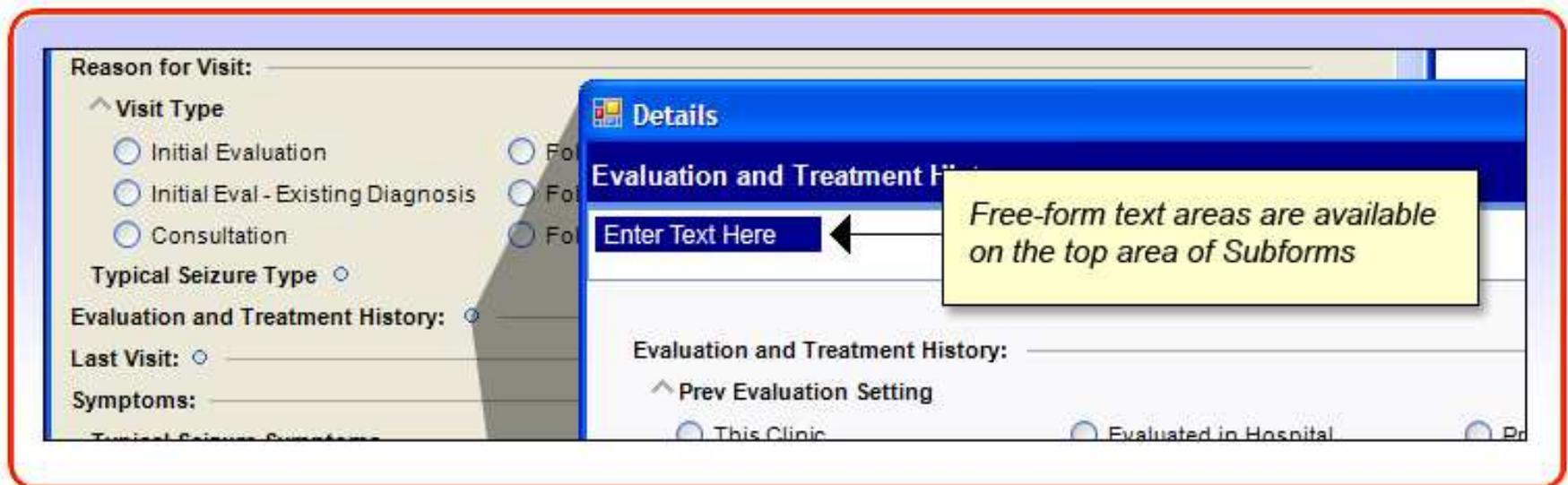
**Please note:** In all cases, any free-text that's entered will be for informational purposes only (won't be added to E/M coder for billing purposes)



## Free-Text Areas on Subforms

In addition to the Double-Click functionality described above, we have added free-text areas on the top of Allscripts-delivered Subforms to complement the structured nature of the main Note Form.

The cursor is automatically placed in the field when the form is loaded.



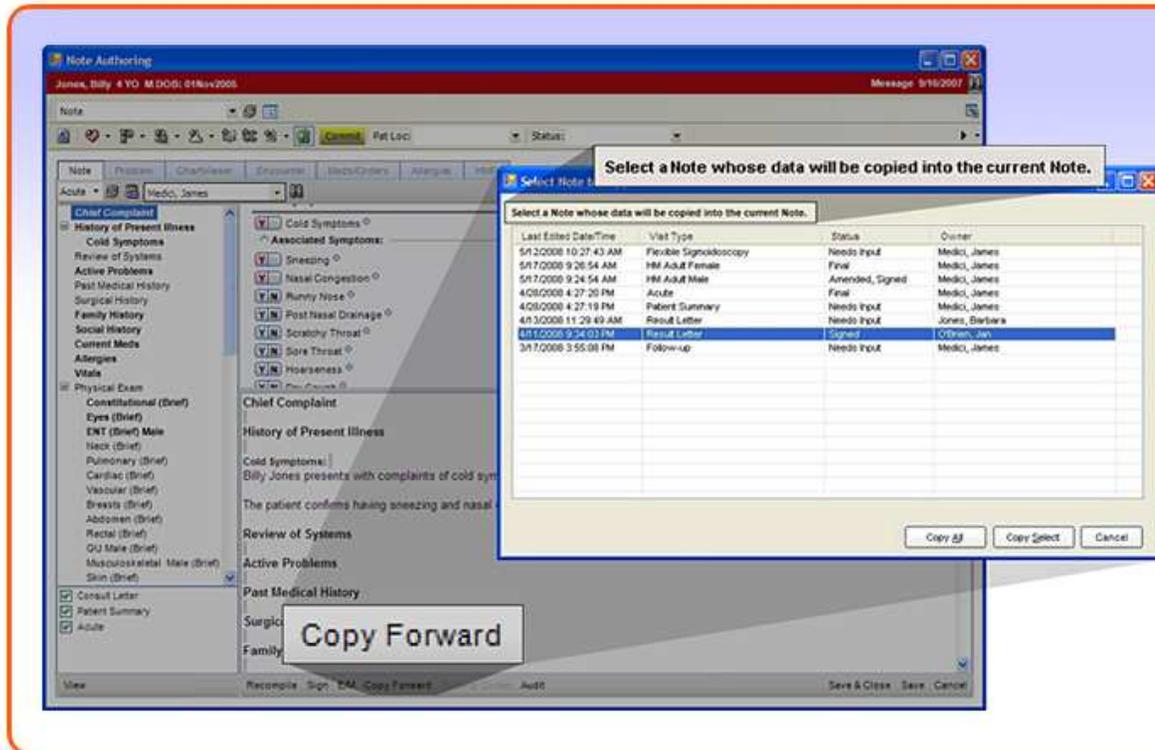
Note  
Authoring  
Workspace  
QuickTips

## Copy Forward

**Copy Forward** is a great feature that enables Providers to copy entire Note contents (OR specific Note sections – like HPI or Physical Exam) from an existing Note to a new Note. This feature allows Providers to **easily view the previous visit's findings** and bring forward content from the previous visit into the new Note (think of a chronic patient who gets the same exam every visit – good example would be a monthly diabetic foot exam. The Provider can 'Copy Forward' the findings from the last encounter and document the visit 'by exception' with a few clicks – and all E/M Billing Information is brought forward as well).

## Previous History / Previous Exam

The **Previous History** and **Previous Exam** features also allow providers to pull Note content from the specific patient's last encounter with a single click. Like Copy Forward, these features can improve efficiency by bringing forward data from the last visit that serves as a reminder of previous pertinent findings. With these features, Providers also gain time-savings by not having to navigate to Chart Viewer to find a previous and relevant Note to be reminded about prior findings.



*Important details to remember when using these features:*

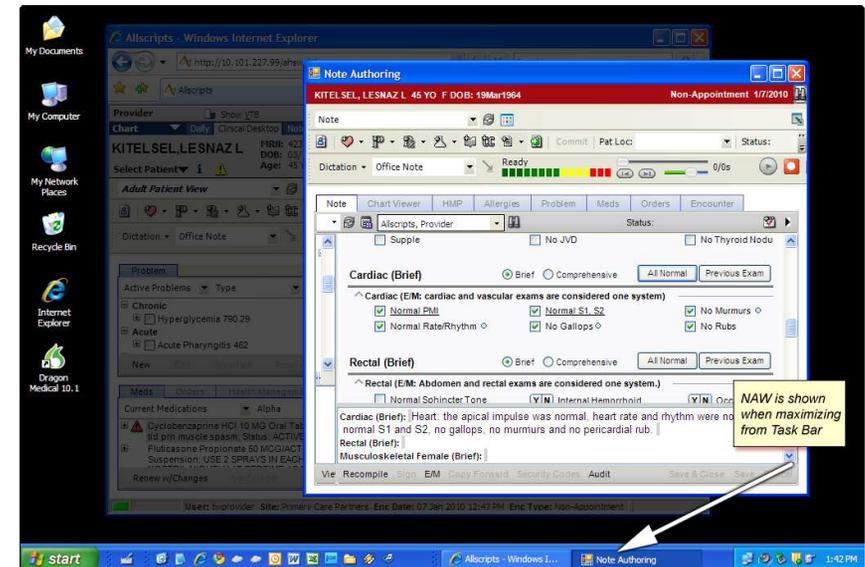
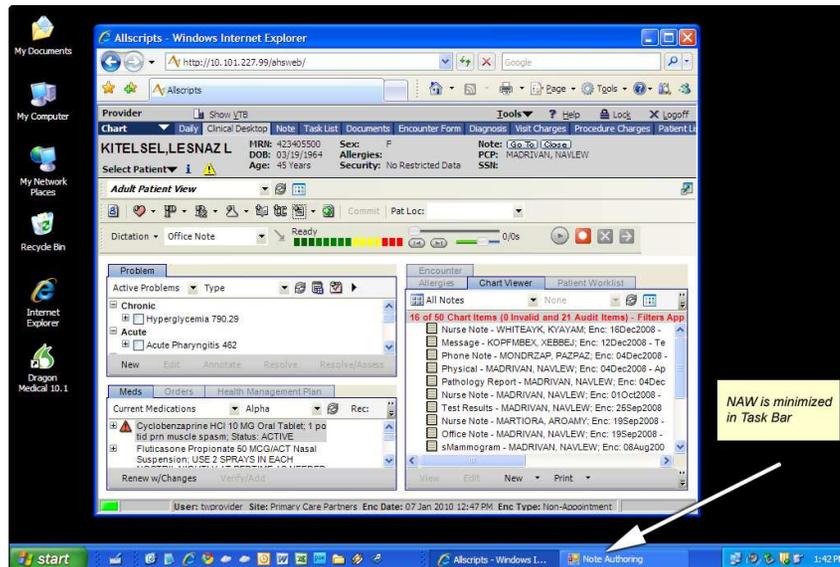
- > **Copy Forward** allows the copying of encounter content to a Note with a different Note Form Type as the original Note - as long as the Note Section (like HPI, PE) is present in both the source and the target Notes. Also, the patient must be the same in both the source and the target.
- > **Previous History / Previous Exam** is supported when the source and target Notes are the same Note Form Type, same Patient and same Provider.

## Note Authoring Workspace QuickTips

### Note Authoring Workspace (NAW) is Minimized

New V11 Note users often don't realize that the NAW launches in a new window (*a 'pop-up'*). These users sometimes think that the NAW is closed, or has inadvertently 'vanished' – when it is actually minimized and accessible from the desktop's bottom task bar (as illustrated below).

This intentional design allows Providers to switch between the Clinical Desktop and the NAW easily – while keeping the Note in context.



## Creating Your Own Note Forms ('Copy' vs. 'Save')

Since Note Form use and rendering directly reflects the uniqueness of a given practice, its providers and patients, we expect that eventually, many users will want to customize some of their Note Forms.

We recommend waiting until Providers have documented with V11 Note Forms before much customization is done - as what a Provider thinks they might want before live exposure to our Note Forms is often very different from what they ultimately want once they have become familiar with documenting their patients and getting used to the features and tricks of the V11 Note Product.



### *Clinical Team Best Practice Recommendation*

- > Start your Note Form with an Allscripts Clinical Content Team-produced form
- > Don't manipulate and 'Save' – Instead Copy and 'Save'

**By following this step, you will ensure that Allscripts-generated updates to the Note Forms will not overwrite the Forms and Subforms that your organization edits.**

## Recommended Naming Conventions for New and Allscripts-delivered Note Forms



### Clinical Team Best Practice Recommendation

- > Append your initials or some other indicator to the Note Form 'Display Name' – *this will allow for easy searching once the editing is complete (example: Infant Multi-System Exam\_GAC01)*
- > Use the 'Specialty' property only if there is another Form in your library with the same name, same Note type and same Note section (*and same sex and age if applicable*) that is used for another specialty or all other specialties.
- > Use 'Age Range' and 'Sex' if you plan on defining Note Inputs for specific Visit Types.

TW Admin Hide YTB

Note Admin Manage Text Templates (V1.1) Manage Note Locks

Note Admin

Forms Symptoms NoteForm Dates

Infant Multi-System Exam\_GAC01 <Filter by Form Type> <Filter by Note Section> <Filter by Specialty>

Form Display Name	Type	Section	Specialty	Sex	Age	Status
Complete-Female Infant	ROS	Review of Systems		Female	Infant 0...	
Complete-Male Infant	ROS	Review of Systems	Family Medicine, Pediatrics	Male	Infant 0...	
HM, Infant (2-6 months)	DISCUSS	Discussion/Summary				
HM, Infant (9 months)	DISCUSS	Discussion/Summary				
Infant / Child Primitive Reflexes	DETFORM	Physical Exam				
Infant Complete Exam	PE	Physical Exam		Female	Infant 0...	

Style Guide  
Conventions

## Note Form Style Conventions

You will find certain fonts and styles used in the Note Forms delivered by our Clinical Content Team.

Examples Include:

1. ***Italics*** — Items on our new Multi-System/Complete PE Note Forms deemed *clinically important*, but that don't give E/M coding credit
2. **Underline** — Items on PE Forms set up by body system (vs. Multi-System / Complete Forms) that provide E/M coding credit

The image shows two screenshots of medical note forms. The top screenshot is titled "Infant Multi-System Exam (Brief)" and shows a form with sections for "Constitutional", "Head and Face", and "Eyes". The "Eyes" section includes the text "Inspection of conjunctiva and lids:" followed by radio buttons for "Normal" and "Abnormal". A yellow callout box with an arrow pointing to the text "Inspection of conjunctiva and lids:" contains the text: "On our new Multi-System / Complete PE forms, italicized labels represent clinically relevant items, but don't give E/M Credit".

The bottom screenshot is titled "Eyes (Brief)" and shows a form with a section for "Eyes" containing checkboxes for "Normal Sclera/Conjunctiva", "EOMI", "No Strabismus", and "PERRLA". A yellow callout box with an arrow pointing to the "Normal Sclera/Conjunctiva" checkbox contains the text: "On PE forms by Body System, underlined fonts will give bullets / Non-underlined items won't".

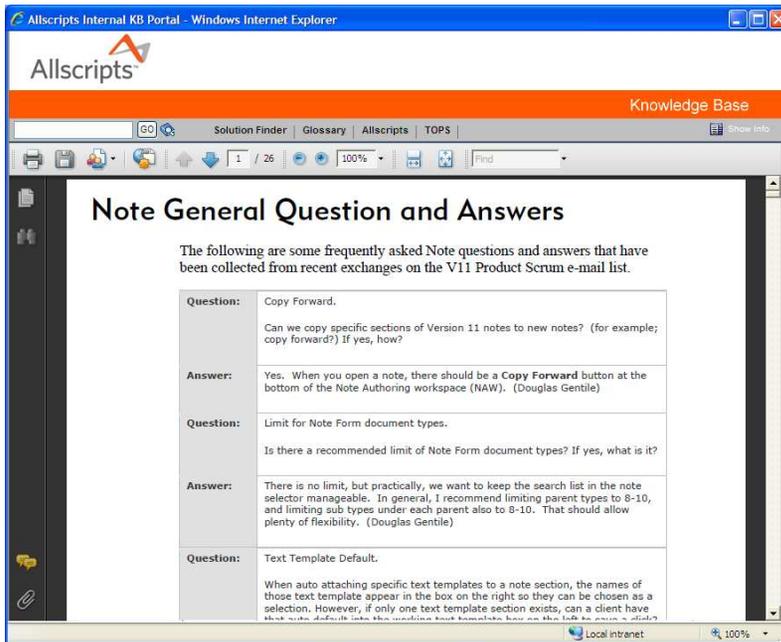
(You can find the Version 11 Note Style guide on the Allscripts Knowledge Base, Article # 3507)

# Further Reading and Educational Materials for a 'Deeper Dive'

## Title and Location

### Note Questions and Answers

KP Article # 4578



## Details

### Overview:

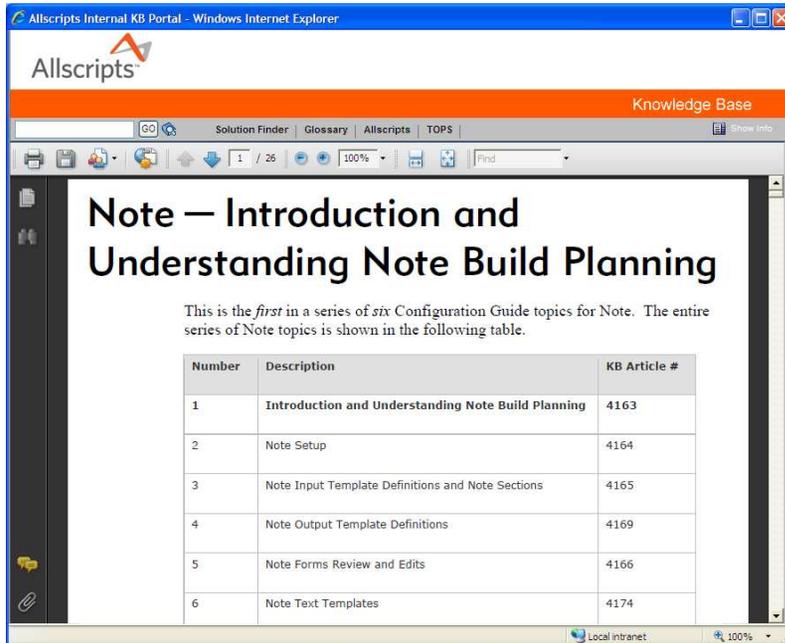
This document compiles common Version 11 FAQ's answered by our Subject Matter Experts (SME's):

### Topics Include:

- > General Note Questions
- > Note input and note output templates
- > Note forms
- > Note text templates

## Note Configuration Overview Series (.pdf)

KP Articles # 4163, 4164, 4165, 4169, 4166, 4174



### Overview:

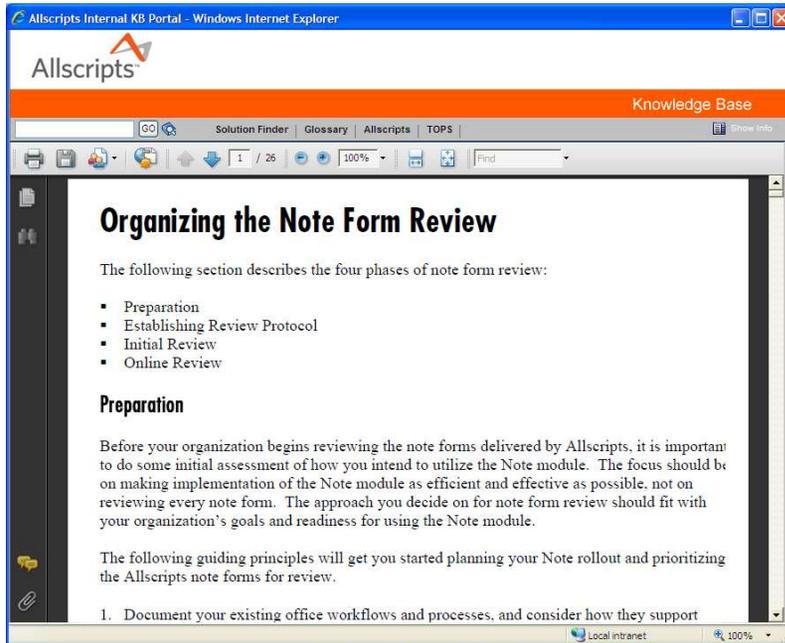
These 6 documents provide a detailed look into V11 Configuration for Note.

Although these are written for those users setting up Note Forms, it is suggested reading as a good overview for those just getting started with V11 Note:

- > Introduction and Understanding Note Build Planning (4163)
- > Note Setup (4164)
- > Note Input Template Definitions and Note Sections (4165)
- > Note Output Template Definitions (4169)
- > Note Forms Review and Edits (4166)
- > Note Text Templates (4174)

## Strategy for Reviewing Note Forms

KP Article # 3489

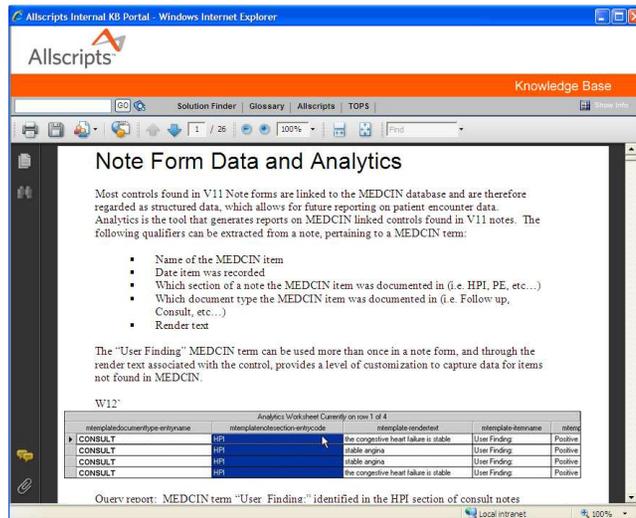
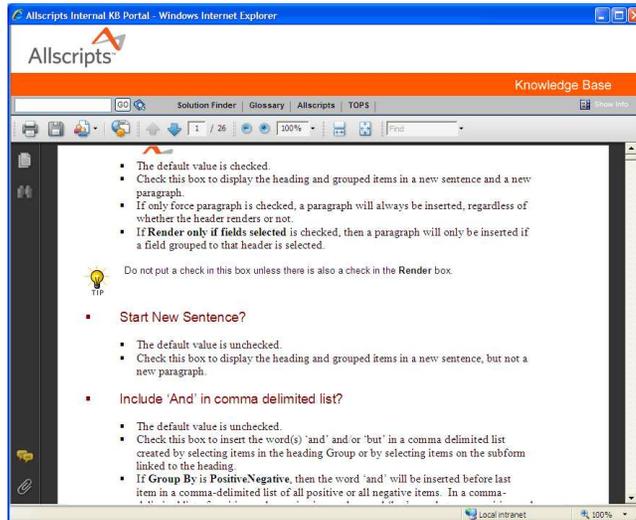


### Overview:

This document gives a great introduction into Best Practices surrounding getting started and establishing a successful Review Process for Note Forms specific to your organization.

## Creating and Editing Note Forms

KP Article # 3507



## Overview:

Detailed information for users responsible for the administration of Note Forms.

*Information includes:*

- > Note Admin Workspace Overview
- > Form Details and Best Practices
- > MEDCIN Field Details and Coverage Information
- > Text Field Details
- > Subform Details
- > E/M Coder Details
- > Note Form Data and Analytics

## Certified Workflows for Documentation

KP Article # 4506

The screenshot shows a web browser window titled "Allscripts Internal KB Portal - Windows Internet Explorer". The page displays a "Knowledge Base" section with a search bar and navigation tabs. Below the search bar is a table listing various workflow categories and their corresponding article numbers.

Category	Sub-Category	Article Title	Article ID
N/A		Appointment Overview	4455
	D	Patient Visit Overview	4455
<b>Intake</b>	<b>E</b>	<b>Intake Introduction</b>	<b>4530</b>
	E1	Intake Process - Basic	4456
	E2	Intake Process - Detailed	4457
	E3	Intake Process - With Order	4458
<b>Retrieve</b>	<b>F</b>	<b>Retrieve Introduction</b>	<b>4537</b>
	F1	Chart Review - Basic	4459
	F2	Chart Review - Detailed	4460
<b>Document</b>	<b>G</b>	<b>Document Introduction</b>	<b>4538</b>
	G1	Note - Acute Visit	4461
	G2	Note - New or Chronic Visit	4462
	G3	Note - Procedure Visit	4463
	G4	Note - Health Maintenance	4464
	G5	Note - Results Review	4465
	G6	Dictation	4466
	G7	Admin Forms	4467
<b>Order &amp; Plan</b>	<b>H</b>	<b>Order &amp; Plan Introduction</b>	<b>4538</b>
	H1	Ad Hoc Prescription	4468
	H2	Medications Management	4469
	H3	Medications Administration	4470
	H4	Immunizations	4471

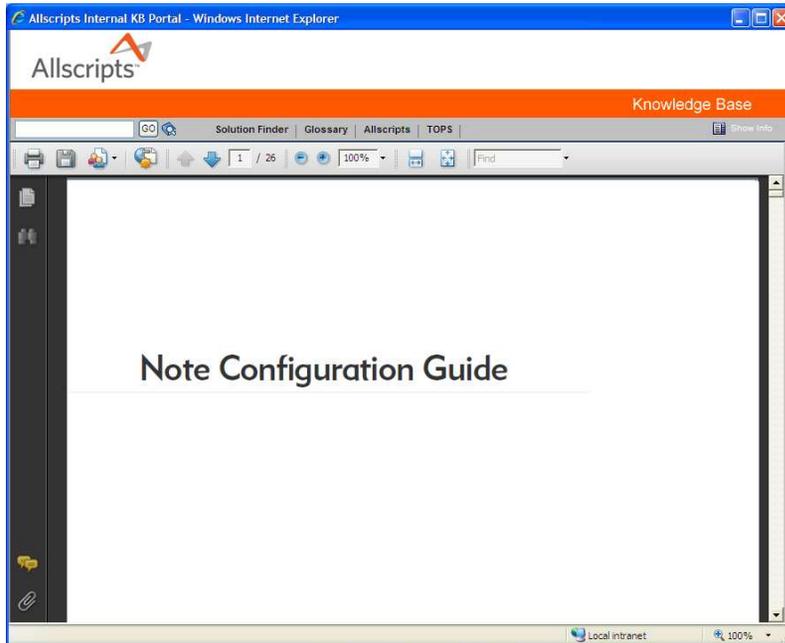
### Overview:

This document provides links to Allscripts Document Certified Workflows:

- (G) Document Introduction
- (G1) Note – Acute Visit
- (G2) Note – New or Chronic Visit
- (G3) Note – Procedure Visit
- (G4) Note – Health Maintenance
- (G5) Note – Results Review

## Note Configuration Guide

KP Article # 4577



### Overview:

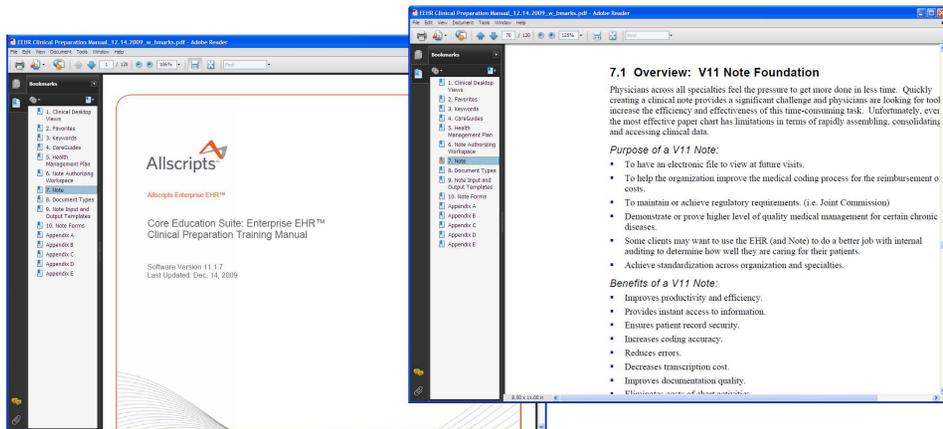
This guide is a comprehensive reference defining all aspects of configuring the Note module. It contains an overview of each component of Note and detailed Note configuration and administration information.

*Topics discussed include:*

- > Introduction and understanding note build planning
- > Note setup
- > Note input template definitions and note sections
- > Note output template definitions
- > Note form review and edits
- > Note text templates

## Enterprise EHR Clinical Preparation Guide and Classroom Training

Contact your Account Manager or Allscripts Academy Representative for more information



### Overview:

Learn strategic and Best Practice methods for reviewing and editing clinical data which is delivered with Enterprise EHR™, such as Favorites, CareGuides and Note Forms.

Learn how to customize and configure clinical workspaces for specific medical practices and specialties (*including the Clinical Desktop and the Note Authoring Workspace*).