V11 Note Webcast Series

Building Notes - Basics

Embrace the new world of healthcare

Objectives:
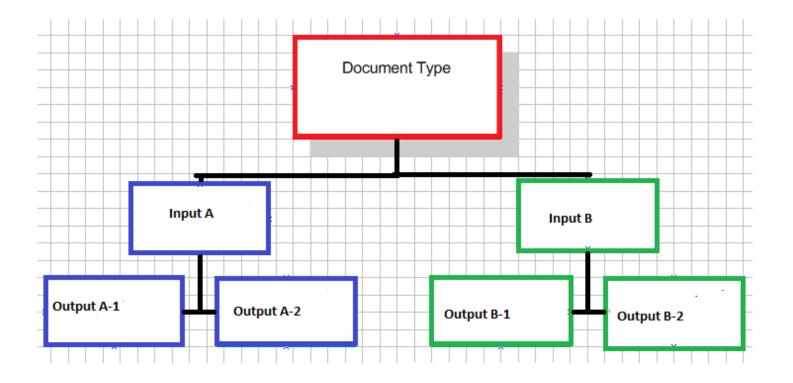
- **Review the relationship between document types, input and output templates.**

- **Discuss and review the Document Type Dictionary.**

- **Locate and briefly discuss forms and text templates.**

- **Create a note input template and define the sections.**

- **Create an output template.**

- **Assign the new output template to a chart section.**

- **Document using a new Chief Complaint driven note.**

Document/Input/Output Relationship

**Note that it is the <u>output</u> templates that get saved to the chart

Document Type Dictionary Fields

General Properties

- *Required Finalization Authority*: 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.

- *Required Owner Authority:* Determines the level of security required to be the Note Owner

- *Workflow:* Always set at Electronic Signature

- *Manifestation:* Always set at NOTEFORM for notes. Will change for other document types.

- *Difficulty Factor:* 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.

- *Security Codes:* 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

- *Display Note Icon on Schedule:* **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.**

- *Include in Unsigned Notes Report:* **Should only 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.**

- *Prompt User to Route for Further Signature:* **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.**

- *Is Letter:* **Allows users to create letters with a greeting and a closing when checked. (V10 only)**

- *Prompt for Signature Override:* **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.**

- *Is sub type:* **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.**

- *Create Referring Provider Notification:* **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.**

- *Create Patient Notification:* **Will create a delegated task for the note owner indicating that the patient should be notified.**

- *Create Review Covered Note Task on Finalization:* **When a note is finalized by a covering physician a task is created for the appointment encounter provider to review the note.**

- *Force Amendment if (any of the boxes are checked):* **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.**

Forms

- **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.**

- **Forms can be added to a note section by hitting the "add" button (from within the note section) 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

- **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.

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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

- **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 auto-cite behavior for lists (Current Meds, Active Problems, Vitals, and**
- **Results) and the note forms that populate the note.**

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**

Things to Consider

- **Before building any notes, 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, Existing Pt Notes
    - Disease specific (i.e. Diabetes, COPD/Asthma) Notes
  - Note naming convention for multi-specialty orgs:
    - IM Renewal , FP Renewal, Cardiology Renewal, Derm Renewal etc…
  - Single Specialty with multiple sites:
    - Use clinic acronym as prefix: GW Phone, GS Phone, APW Phone

Additional Considerations

- **Remind your end users to ALWAYS read their note outputs to ensure clarity, prior to signing off of the note.**

- **V10 clients - Noteforms can replace your current text templates, however unless Medcin is used to develop the forms it will not be reportable.**

- **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**

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Questions?

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