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.

Focus Area	Best Practice Details
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 out 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.)*.

Focus Area	Best Practice Details

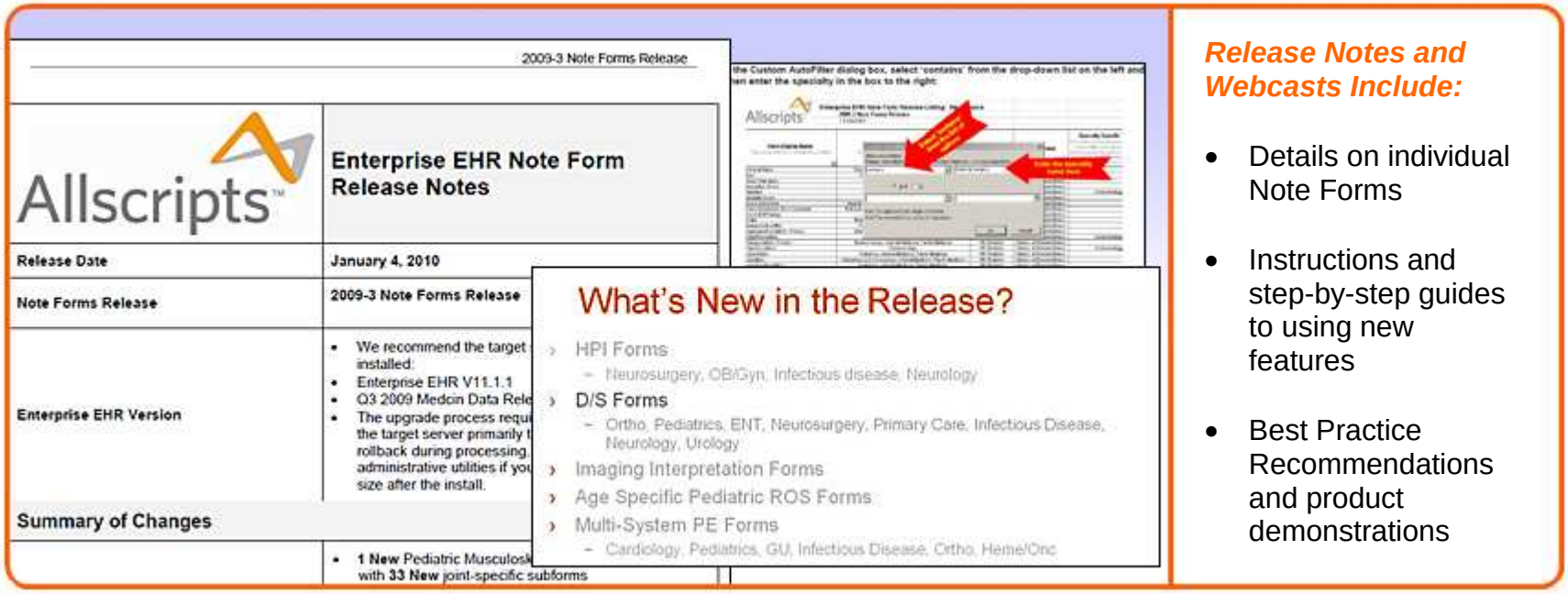
Version 11 Note Resources

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.



Release Notes and Webcasts Include:

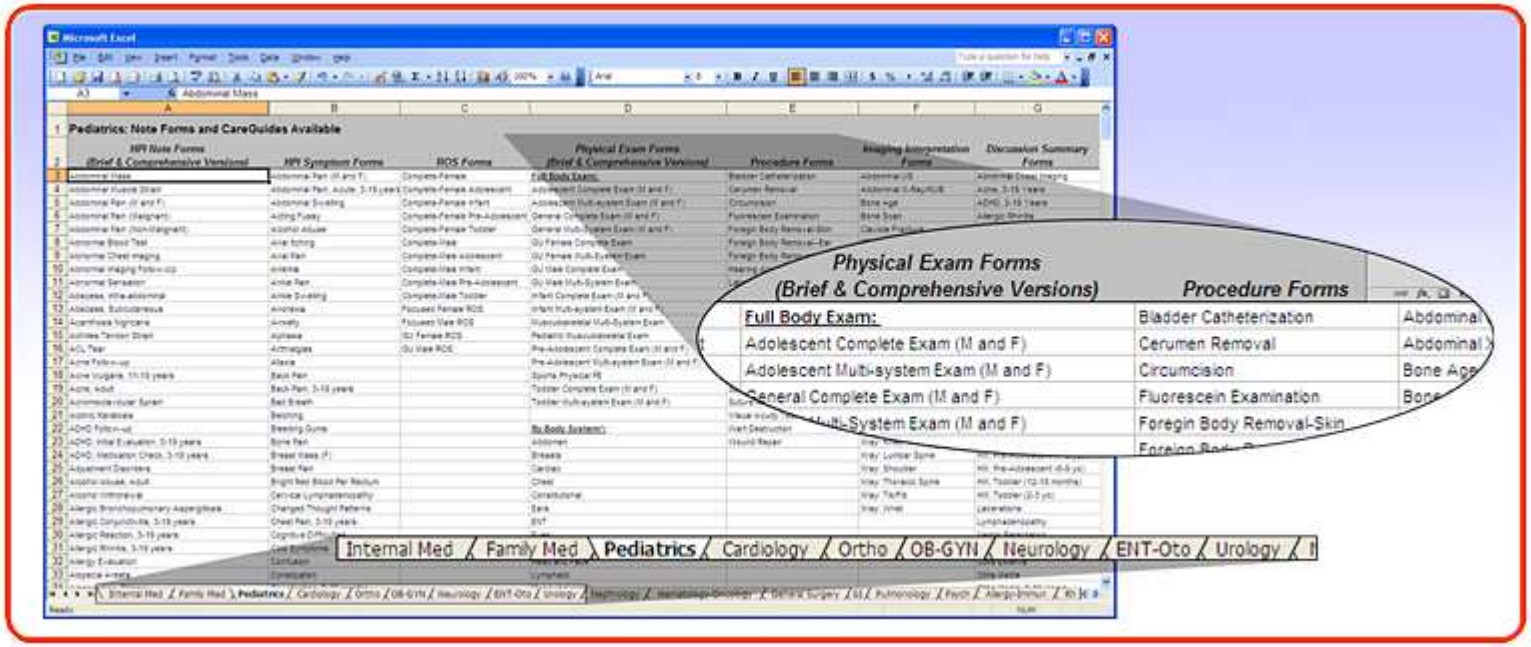
- Details on individual Note Forms
- Instructions and step-by-step guides to using new features
- Best Practice Recommendations and product demonstrations

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

Focus Area	Best Practice Details
Version 11 Note Resources	

‘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.



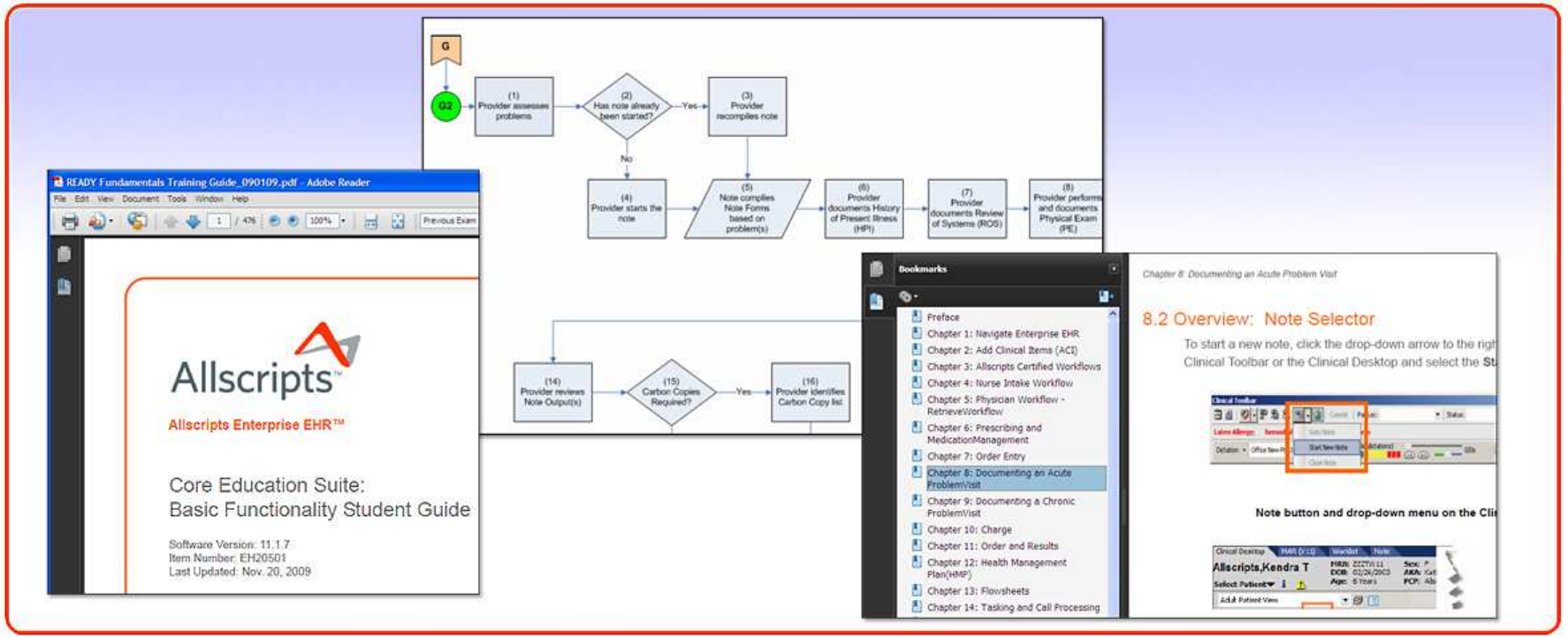
(You can find the spreadsheet on the Allscripts Knowledge Base, Article # 4861)

Focus Area	Best Practice Details
Version 11 Note Resources	

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).*



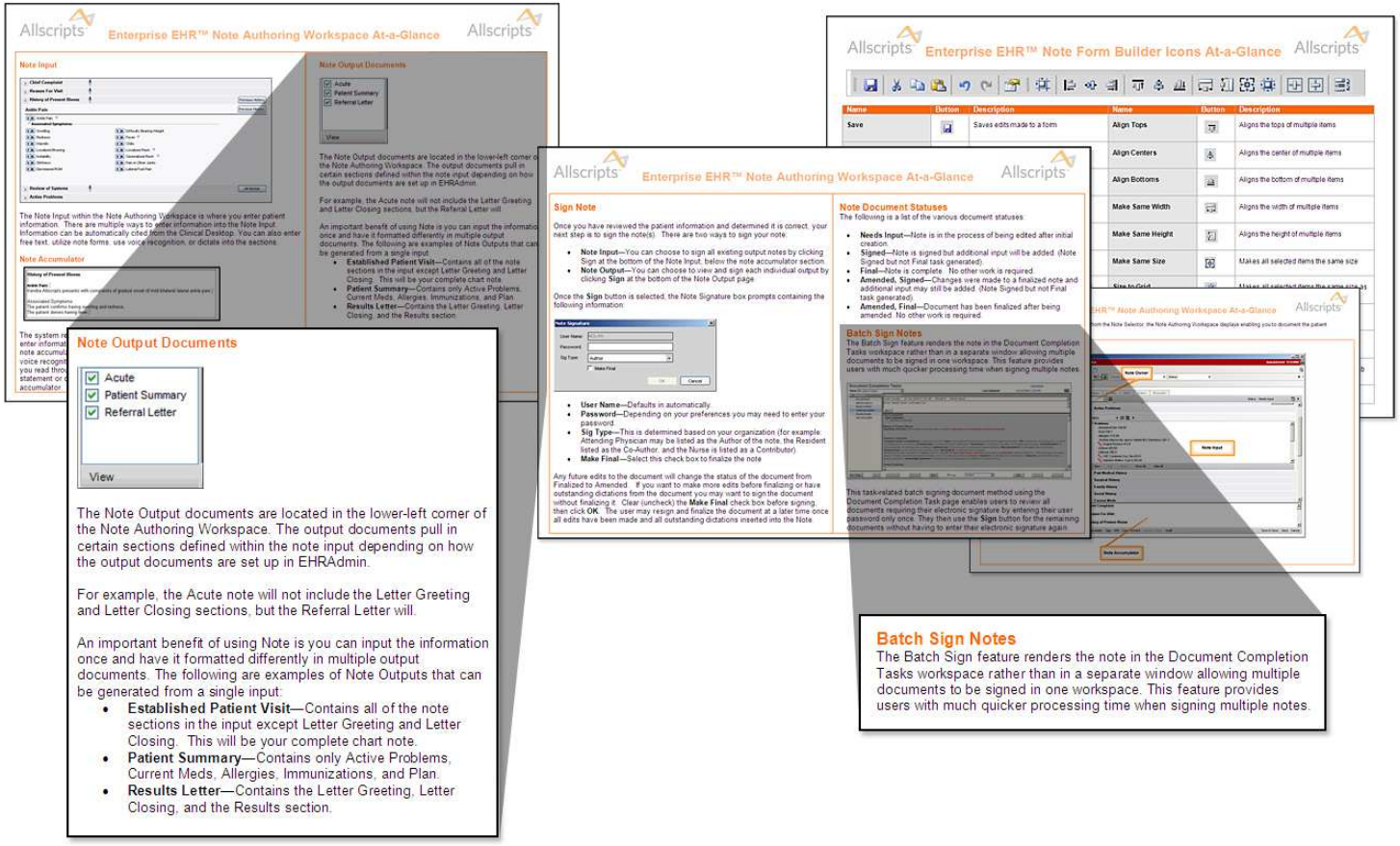
Focus Area	Best Practice Details

Version 11 Note Resources

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.



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

Focus Area	Best Practice Details
Version 11 Note Resources	

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.

Focus Area	Best Practice Details
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.

Focus Area	Best Practice Details
Suggested Note Form Utilization	

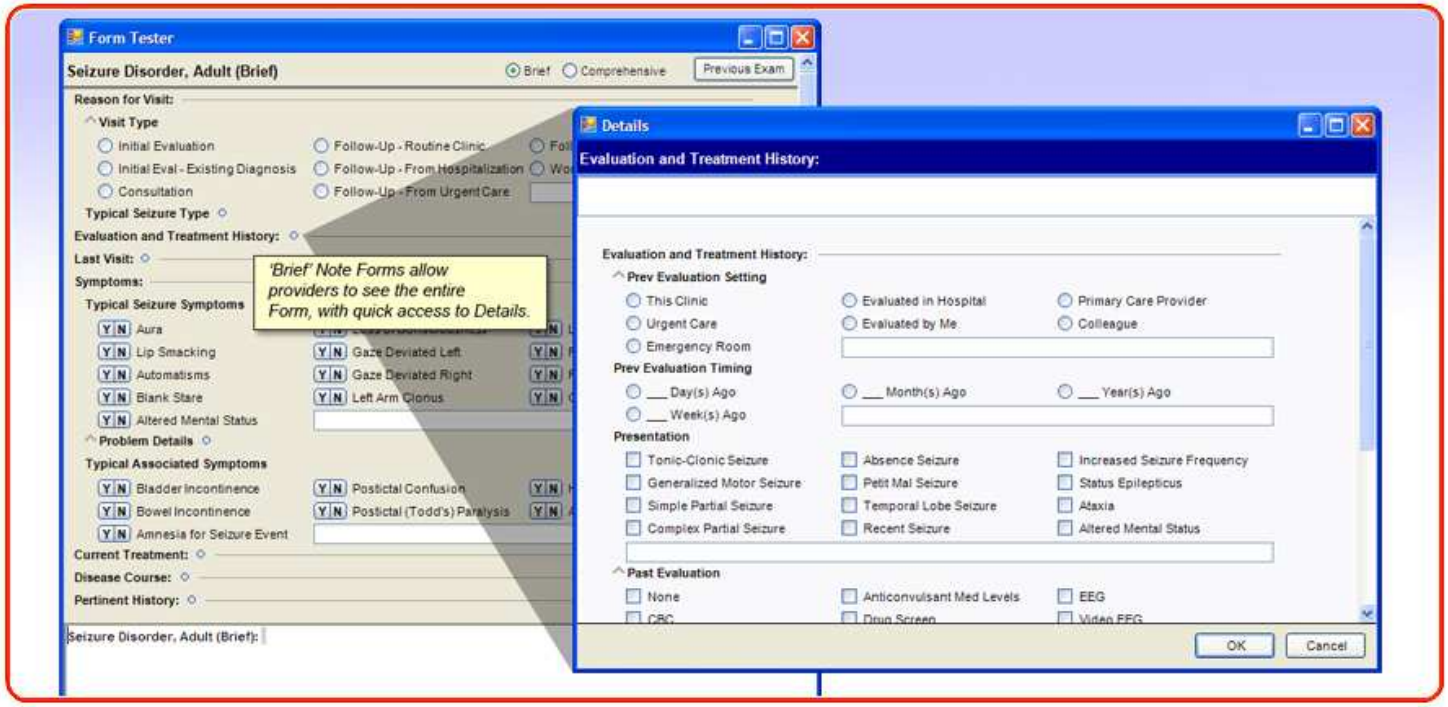
‘Brief’ HPI Note Forms

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.



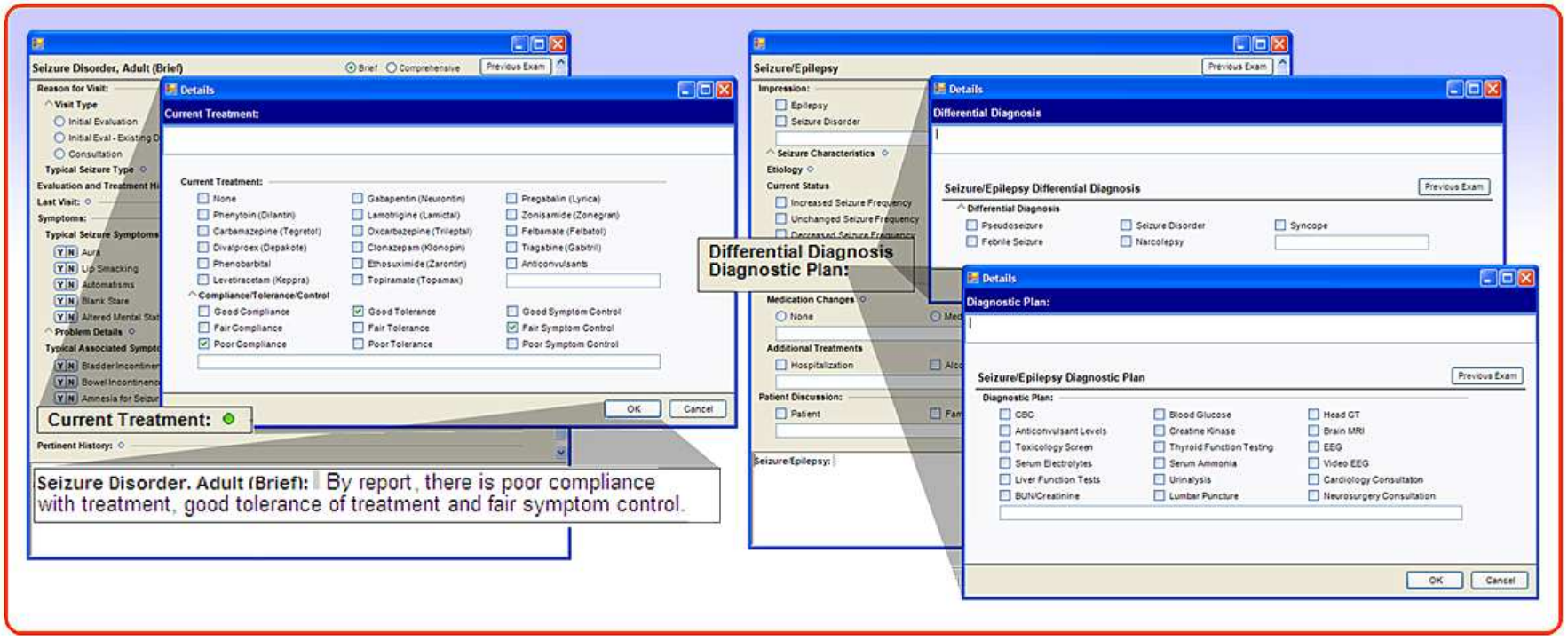
Focus Area	Best Practice Details
Suggested Note Form Utilization	

"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 where thinking at your next visit.)



Focus Area	Best Practice Details
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 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 your specific preferences and workflows.

Focus Area	Best Practice Details
Suggested Note Form Utilization	

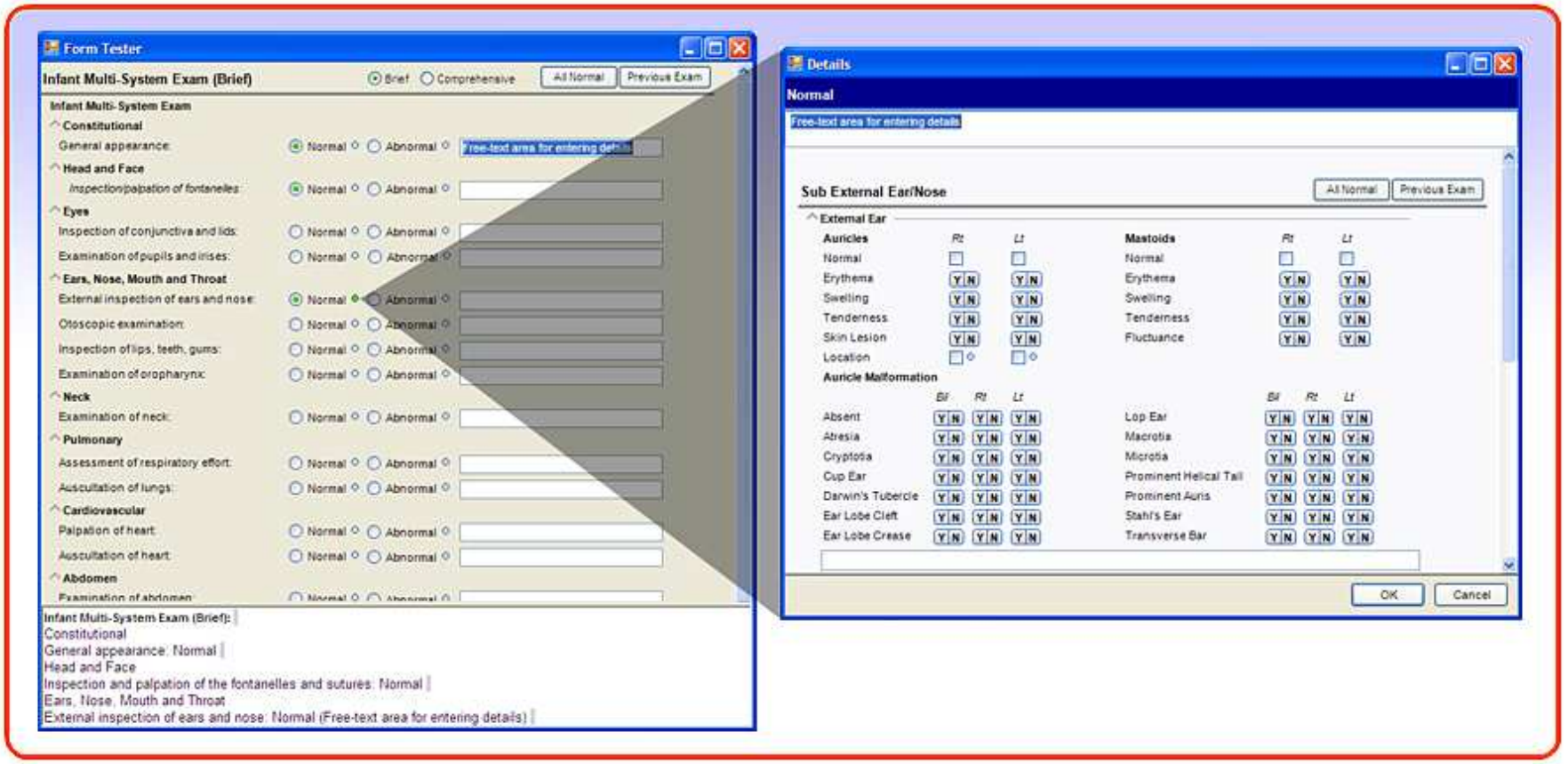
Multi-Symptom Full-Body Physical Exam (PE) Forms

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:*

E/M Benefits	All non-italicized control on these Note Form will give billing credit with few clicks *(see "Style" section below for details)*
Same Subform for Normal and Abnormal	By configuring the same data for 'Normal' and 'Abnormal', our Subforms support quick learning and consistency *('muscle memory')* for encounter documentation. The Subforms contain both pertinent positives and pertinent negatives.
Free-text Entry	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).
Brief and Comprehensive 'Views'	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 *(if enabled in your local system)* 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.
'Standard of Care Terminology' Support (Complete vs. Multi-system	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.
Customization of Allscripts-Delivered PE Multi-System Note Forms	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.

Focus Area	Best Practice Details
Suggested Note Form Utilization	

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



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

Focus Area	Best Practice Details
Suggested Note Form Utilization	

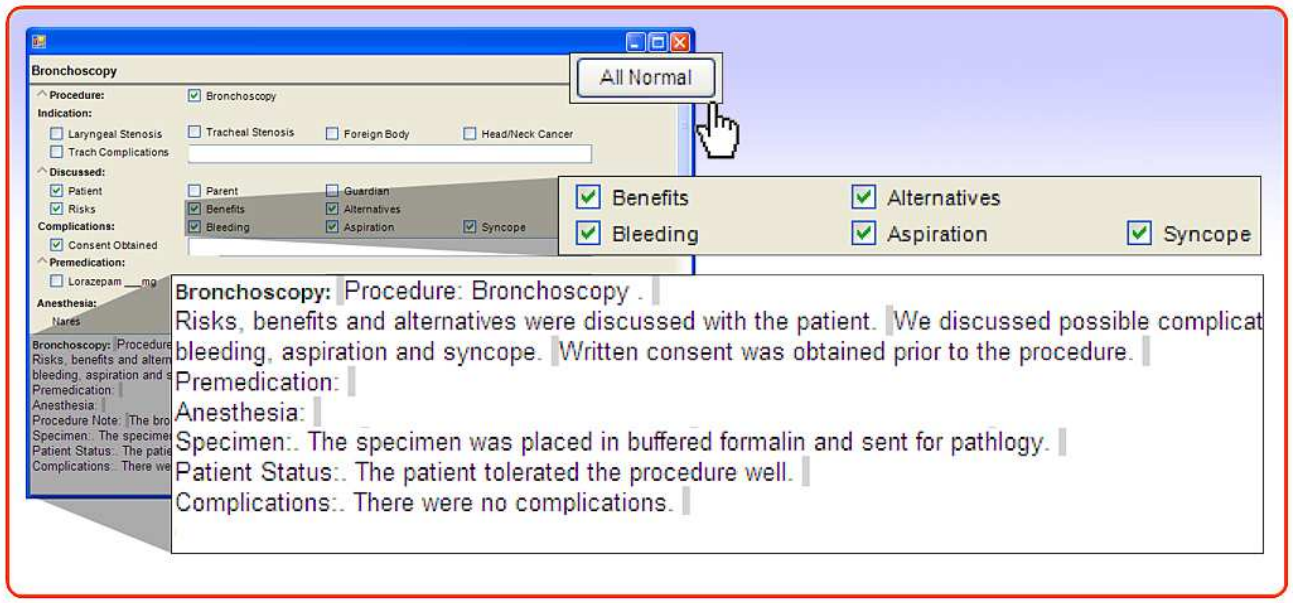
Procedure and Post-Op Note Forms

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.



Focus Area	Best Practice Details
Note Authoring Workspace QuickTips	

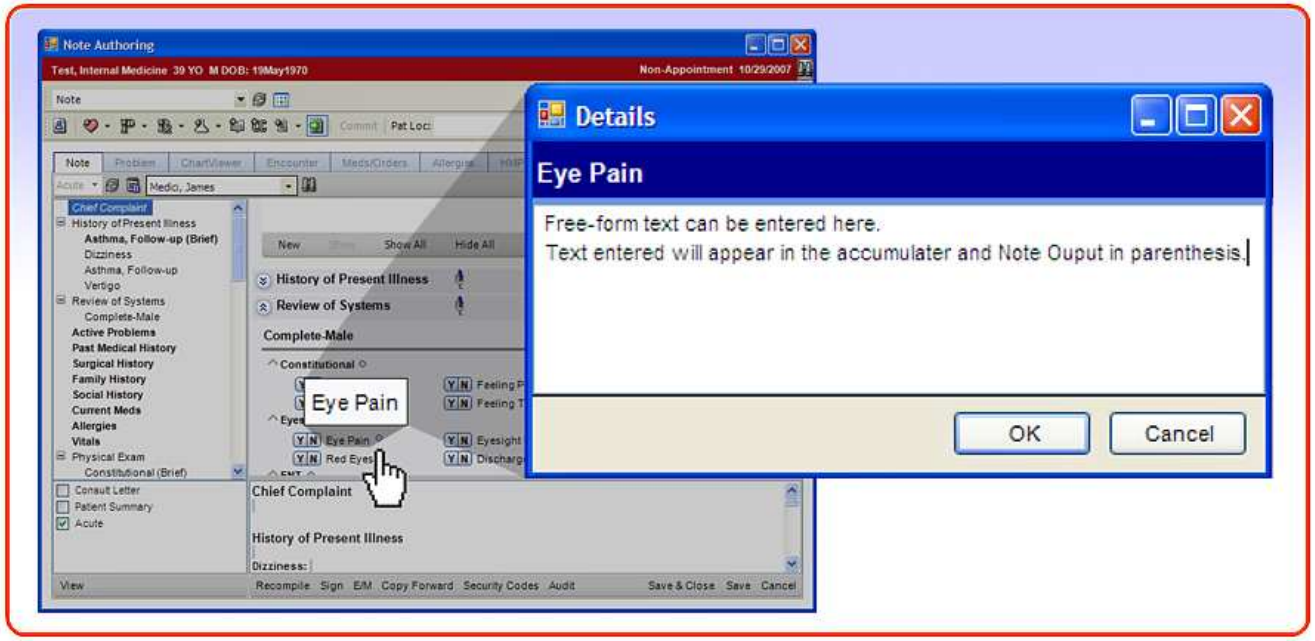
Double-Click for Free-Text Detail Form Controls

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)*



Focus Area	Best Practice Details
Note Authoring Workspace QuickTips	

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.

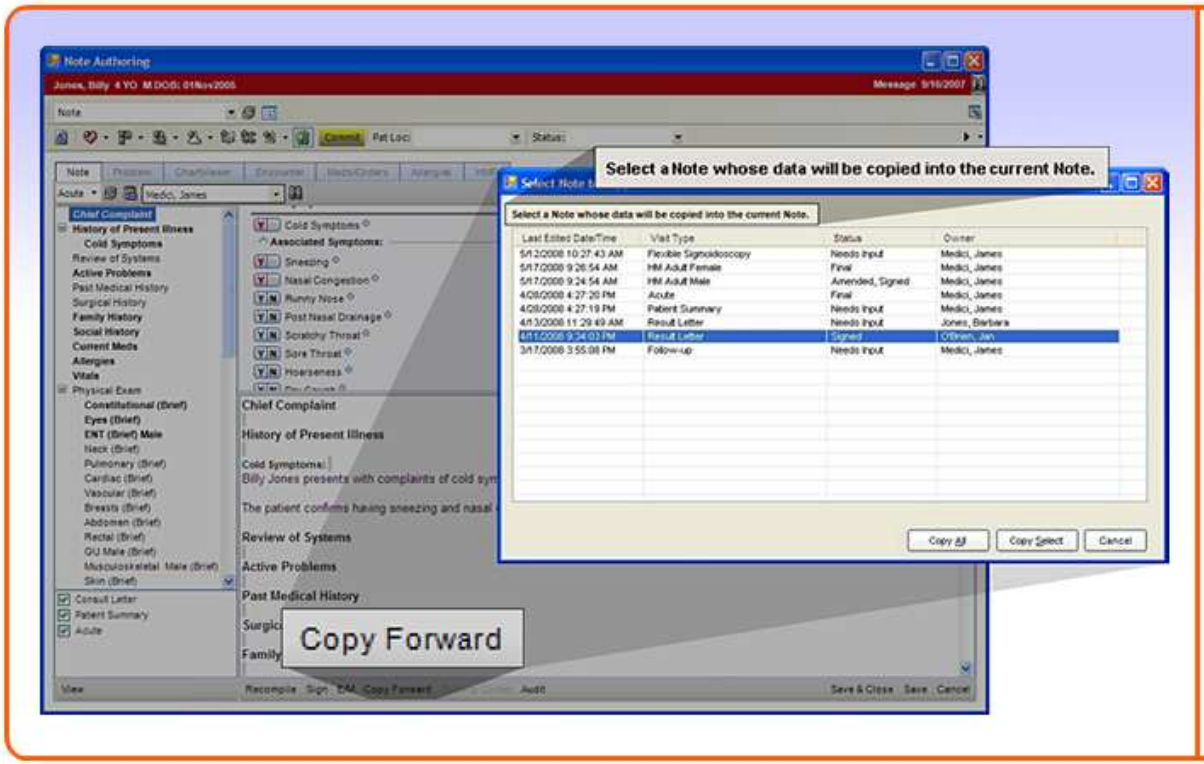
Focus Area	Best Practice Details
Note Authoring Workspace QuickTips	

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:

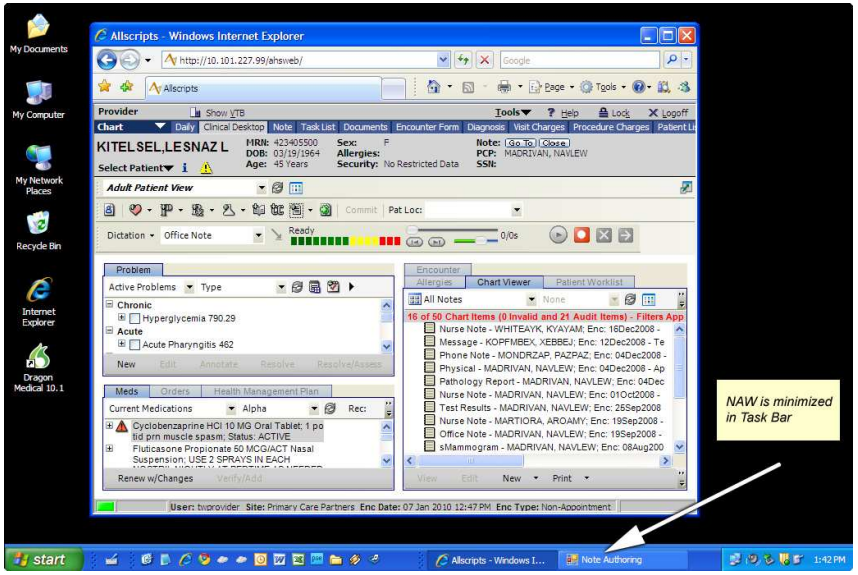
- **Copy Forward** allows the copying of encounter content to a Note with a different Note Form Type as the original Note - *as long as the Note Section (like HPI, PE) is present in both the source and the target Notes.* Also, the patient must be the same in both the source and the target.
- **Previous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

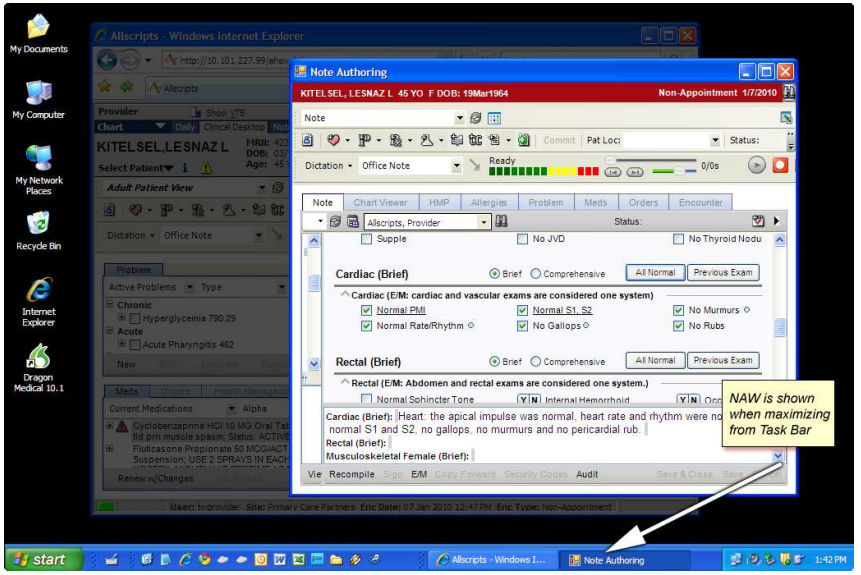
Focus Area	Best Practice Details
Note Authoring Workspace QuickTips	

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.





Focus Area	Best Practice Details
Note Admin and Setup	

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 form 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’

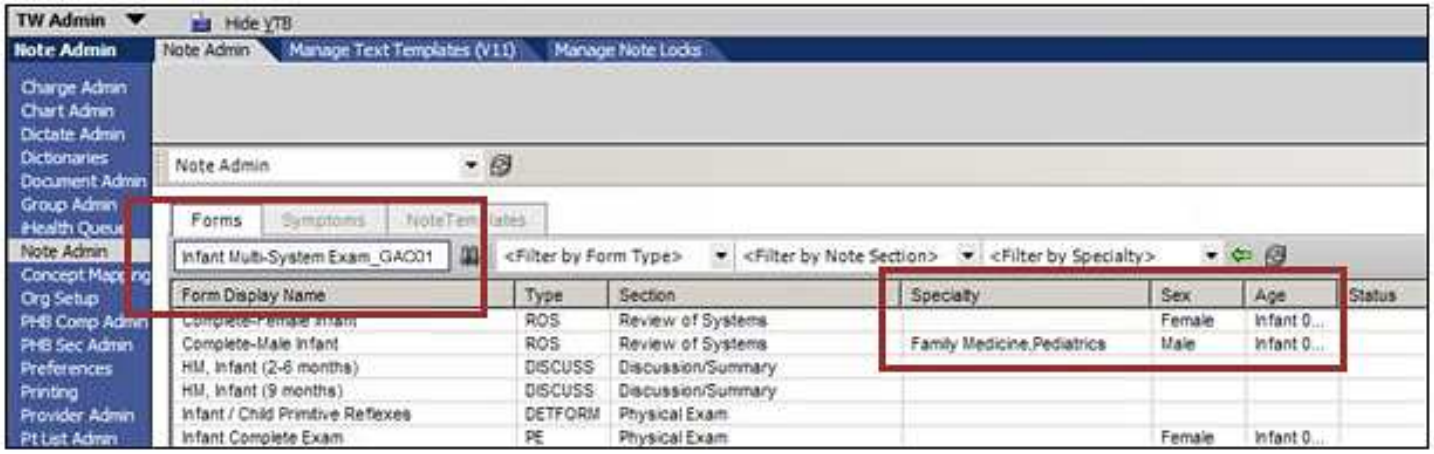
By following this step, you will ensure that Allscripts-generated updates to the Note Forms will not overwrite the Forms and Subforms that your organization edits.

Focus Area	Best Practice Details
Note Admin and Setup	

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.



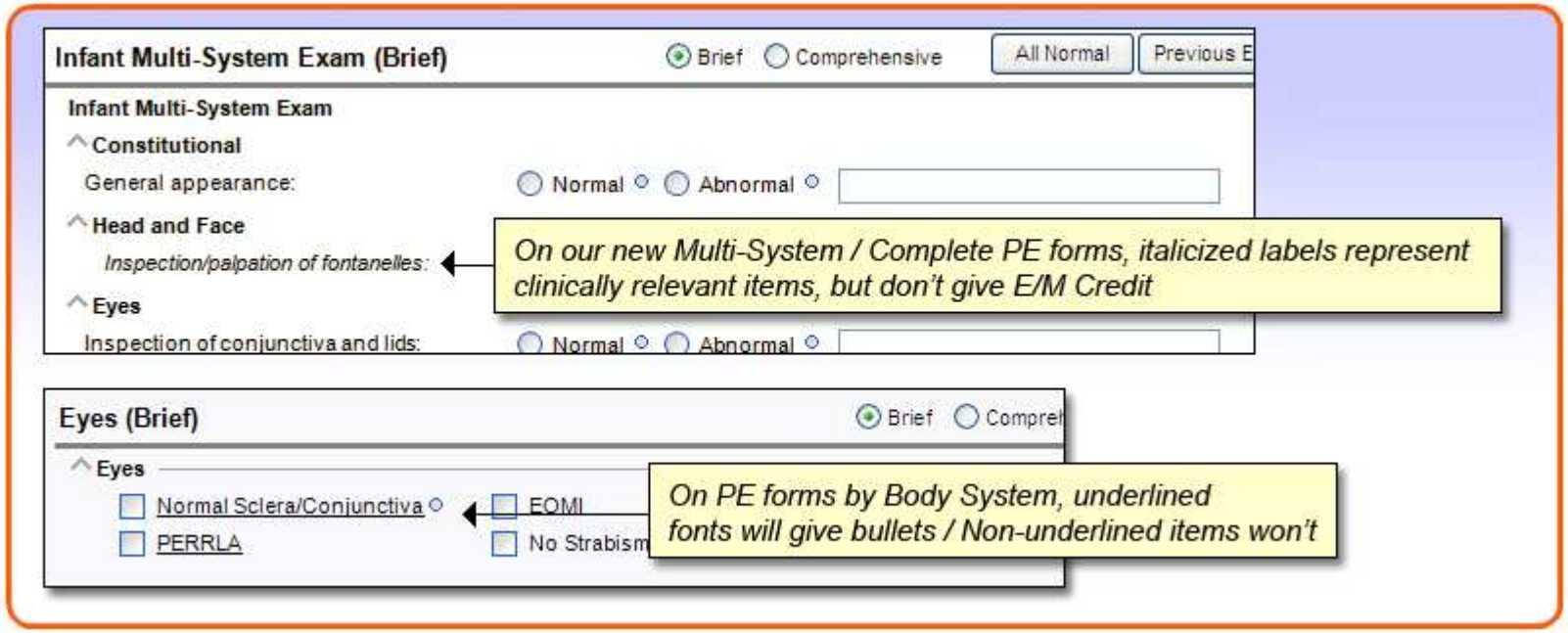
Focus Area	Best Practice Details
Style Guide Conventions	

Note Form Style Conventions

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

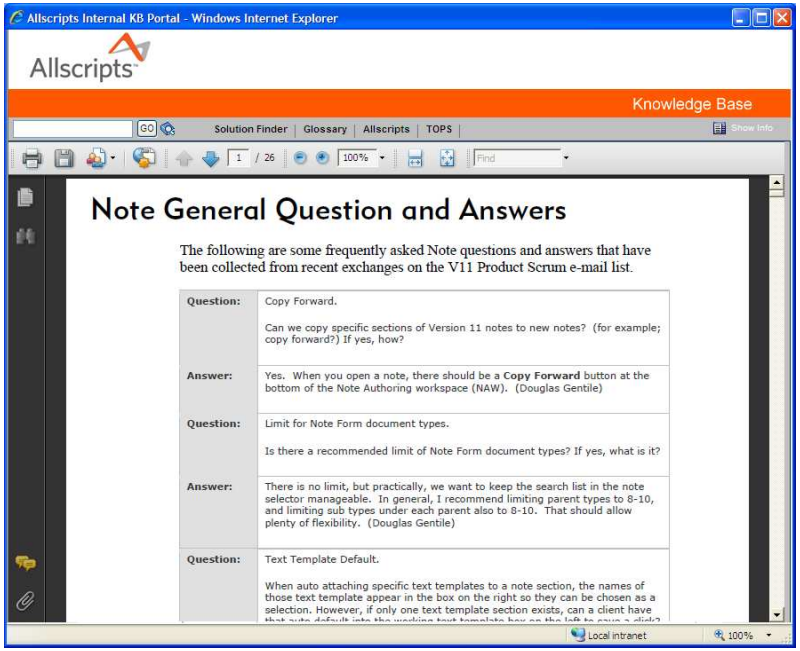
Examples Include:

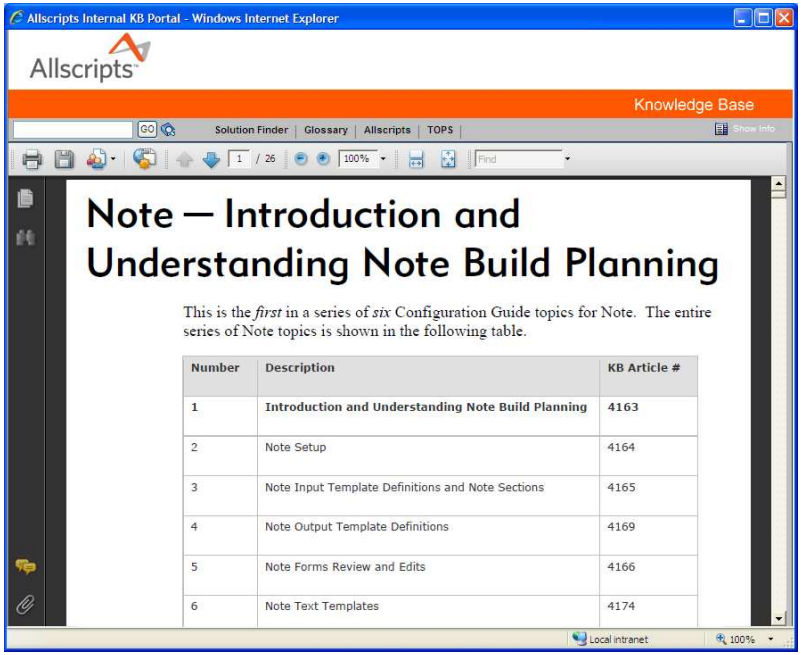
1. ***Italics*** — Items on our new Multi-System/Complete PE Note Forms deemed *clinically important*, but that don't give E/M coding credit
2. **Underline** — Items on PE Forms set up by body system (vs. Multi-System / Complete Forms) that provide E/M coding credit

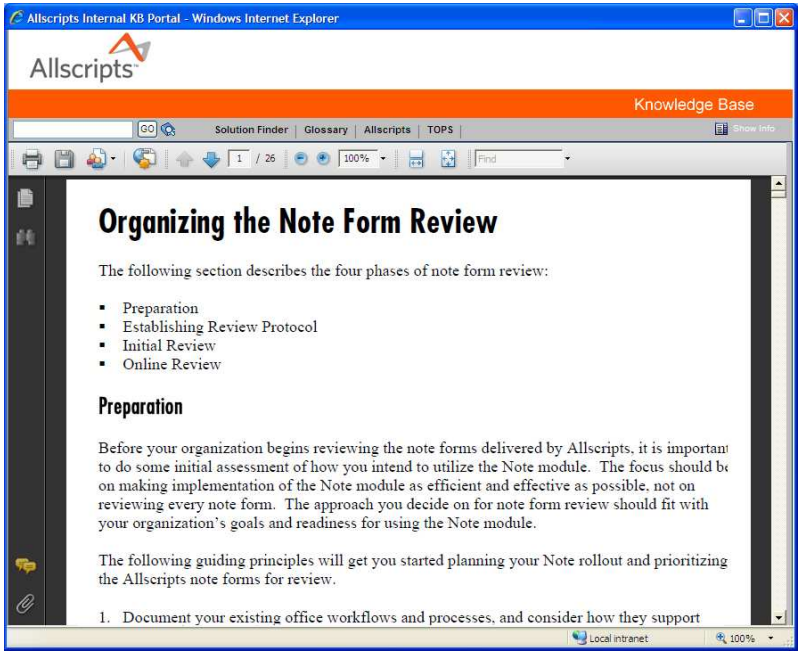


(You can find the Version 11 Note Style guide on the Allscripts Knowledge Base, Article # 3507)

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

Title and Location	Details
Note Questions and Answers **KP Article #** 4578 	**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

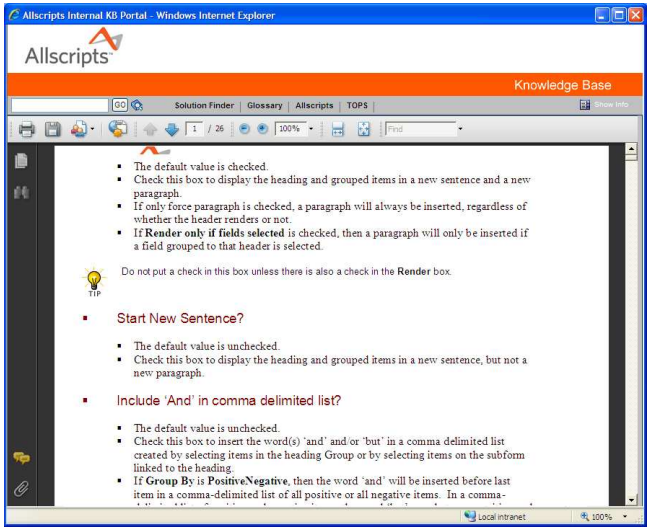
Title and Location	Details
Note Configuration Overview Series (.pdf) **KP Articles #** 4163, 4164, 4165, 4169, 4166, 4174 	**Overview:** These 6 documents provide a detailed look into V11 Configuration for Note. Although these are written for those users setting up Note Forms, it is suggested reading 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)

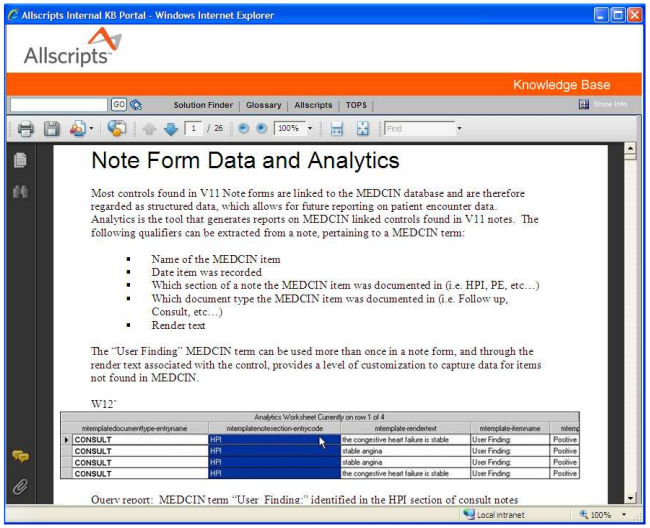
Title and Location	Details
Strategy for Reviewing Note Forms **KP Article #** 3489 	**Overview:** This document gives a great introduction into Best Practices surrounding getting started and establishing a successful Review Process for Note Forms specific to your organization.

Title and Location	Details

Creating and Editing Note Forms

KP Article # 3507



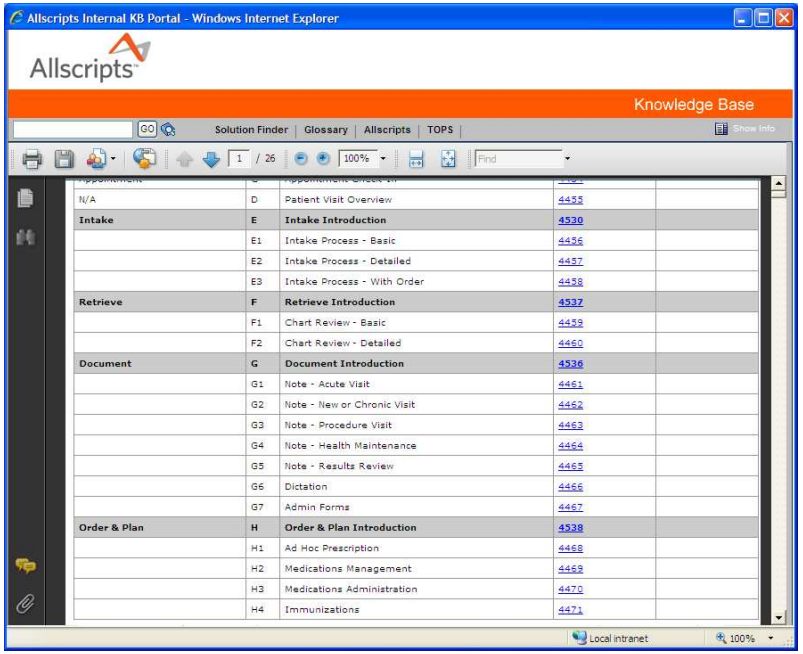


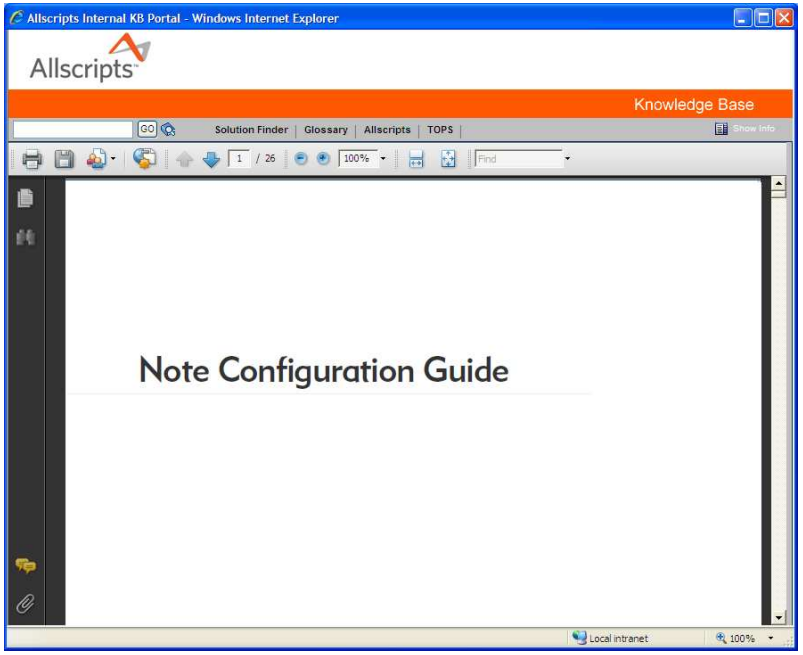
Overview:

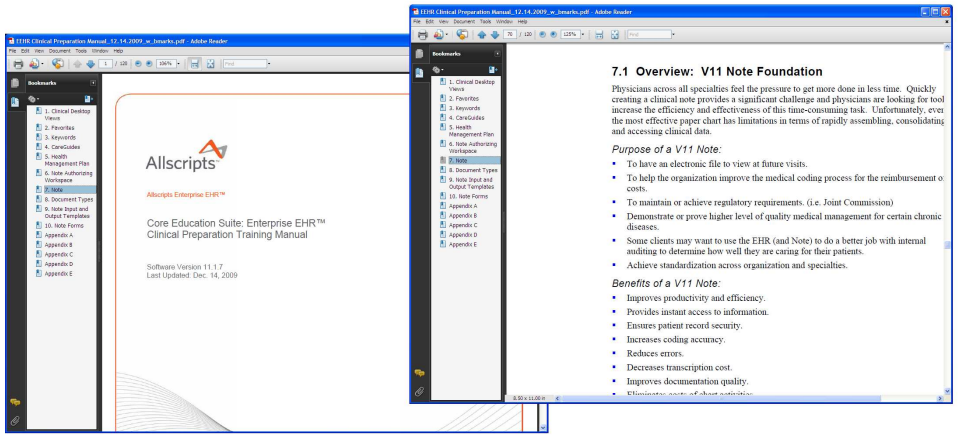
Detailed information for users responsible for the administration of Note Forms.

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

Title and Location	Details
Certified Workflows for Documentation **KP Article #** 4506 	**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

Title and Location	Details
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

Title and Location	Details
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)*.