EAST TENNESSEE STATE UNIVERSITY

QUILLEN ETSU PHYSICIANS

Module 5: Notes

Provider Training Module
Allscripts Touchworks EHR

Quillen **EHR** Team
Phone: (423) 282-6122, Option 1

June 2020

MODULE INSTRUCTIONS

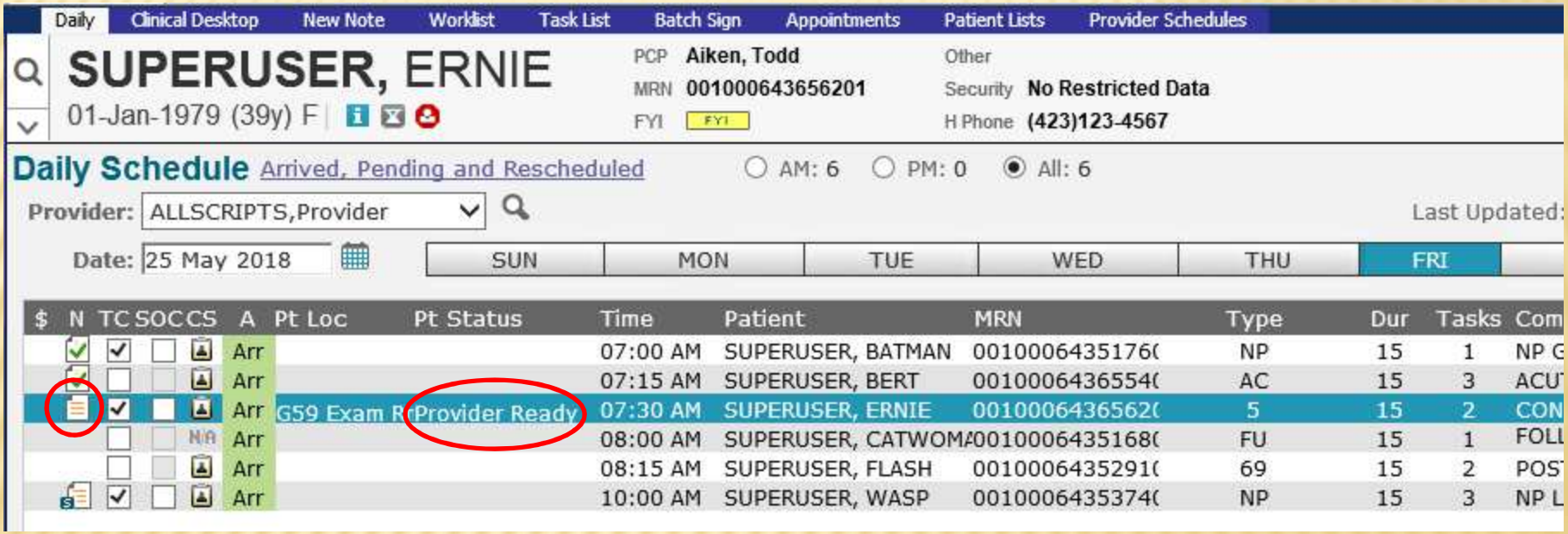
There are a total of 5 modules that need to be completed prior to the on-site training. It is REQUIRED that you complete all of the modules PRIOR to training.

These modules are intended to serve two purposes: as an introduction to the system, and as a reference. The modules are very detailed. As such, we don't expect you to retain all of the information in the slides before training; however, we encourage you to print the PDFs, as you will be able to refer back to them as you begin to use the system.

Training will consist mainly of mock practice sessions, so a basic knowledge of the system prior to training is essential. If you have any problems completing these modules, please contact the EHR team. (Contact info is on Slide 1 of each module).

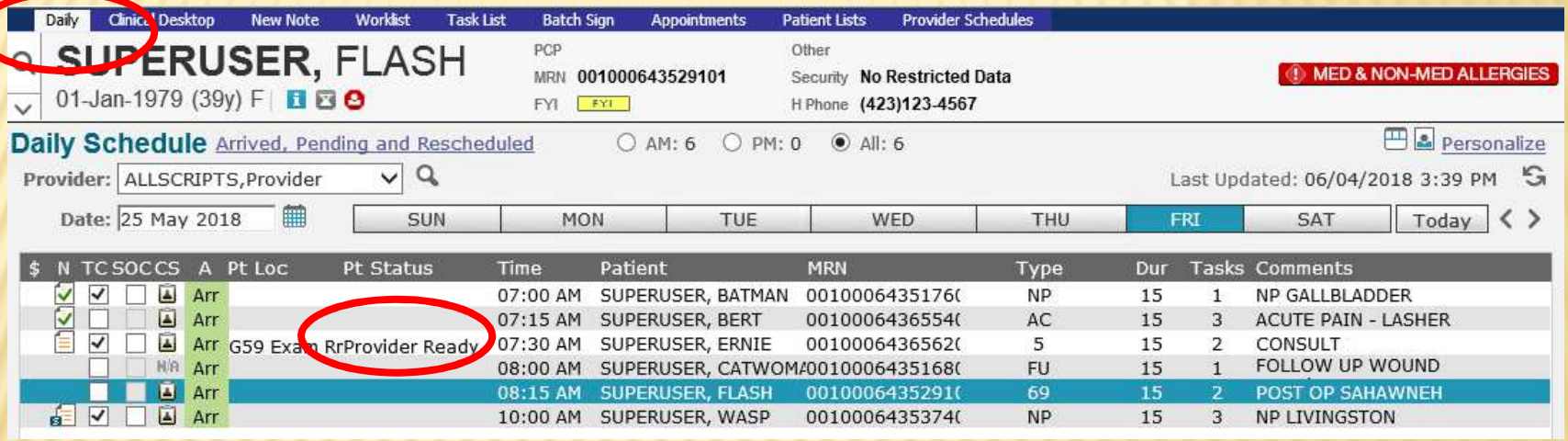
OPENING A NOTE STARTED BY NURSE

In most of the clinics, your nurse will start your note for you. She/he will open the note, put in the chief complaint and possibly a reason for visit, and then save and close the note. Once the note has been started, it will appear on your Daily Schedule with a "note" icon in the "N" field. To begin documentation on your patient, **make sure** that the Pt Status is set to **Provider Ready**, and then **double click the note icon** to open your note in "edit" mode. (Slide 7 shows you the "edit" mode)

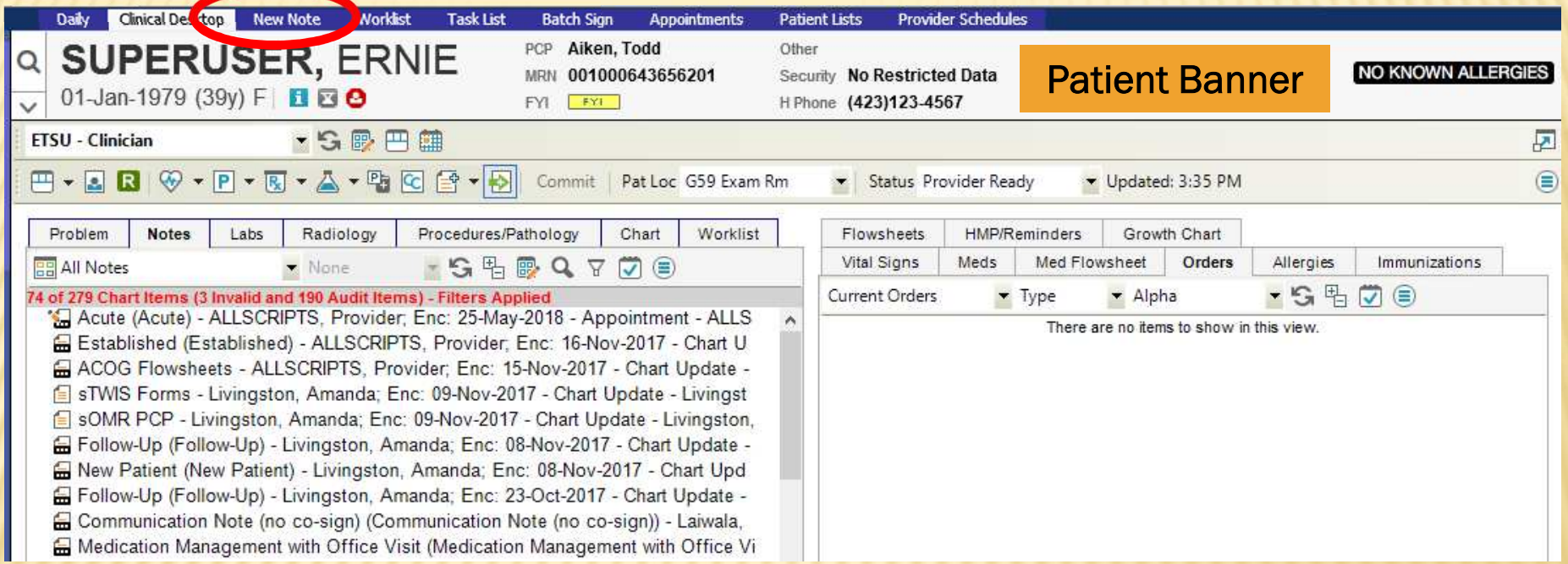


STARTING YOUR OWN NOTE

If your nurse does not start your note for you, once he/she changes the status to **Provider Ready**, double click on the patient's name. This takes you to the Clinical Desktop.



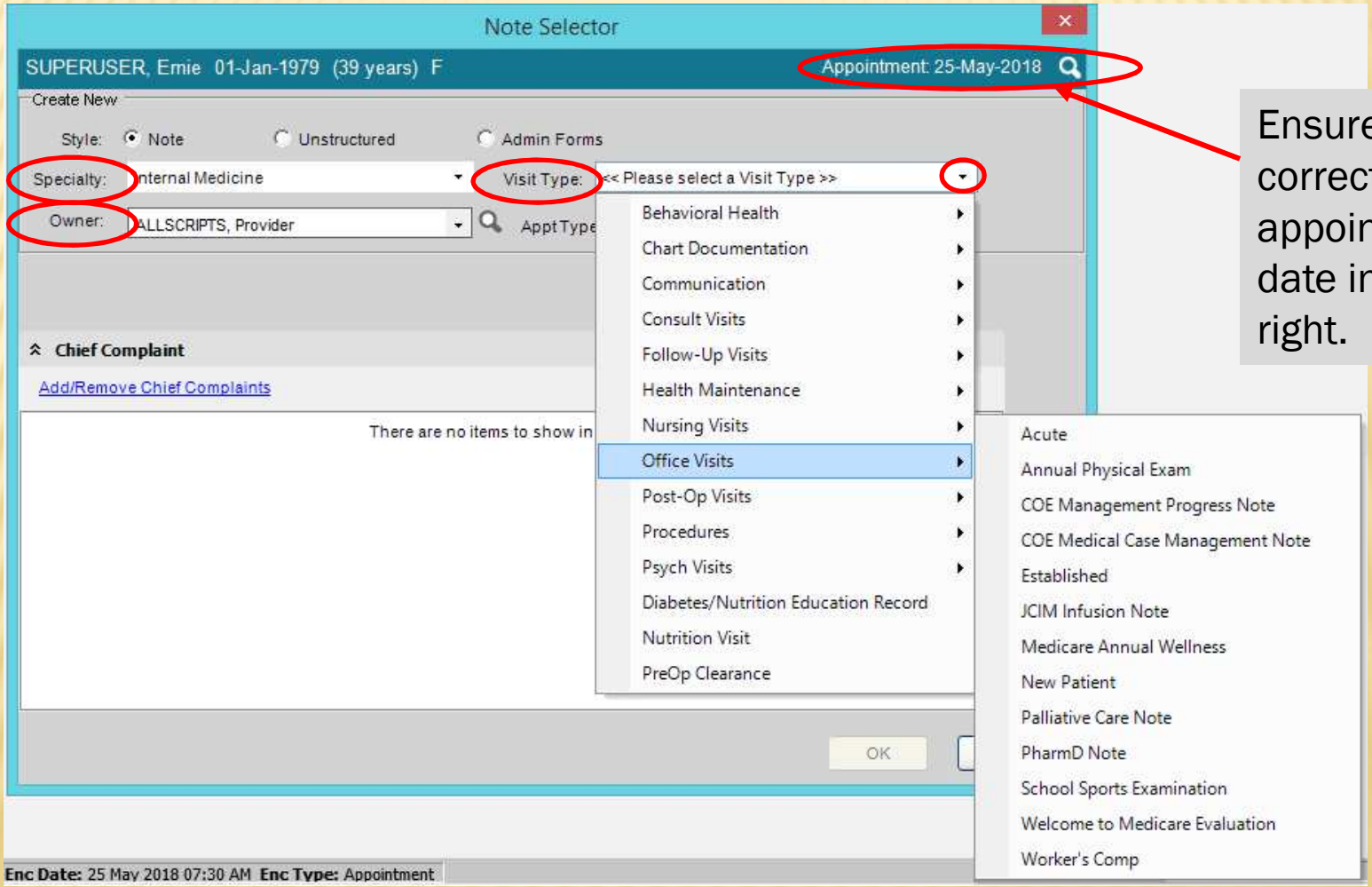
NEW NOTE TAB



Make sure the patient's name is in the **Patient Banner**, and then click on the **New Note** tab

NOTE SELECTOR

The Note Selector screen allows you to choose the type of note you are going to create. Click the drop down next to **Visit Type** and choose the note type. We suggest you talk to your preceptor about what note type to choose.



Ensure that correct appointment date in upper right.

NOTE IN "EDIT" MODE

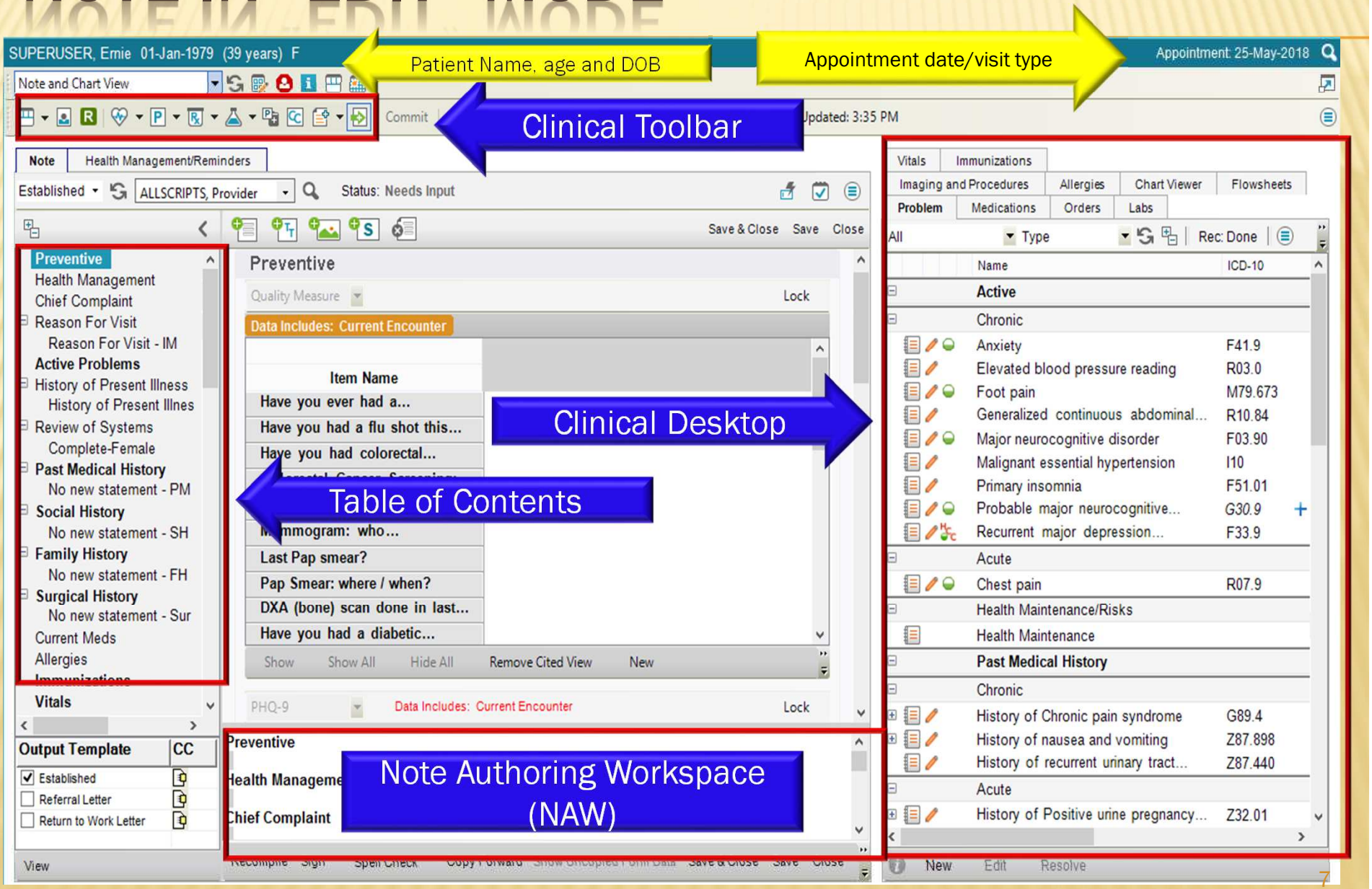
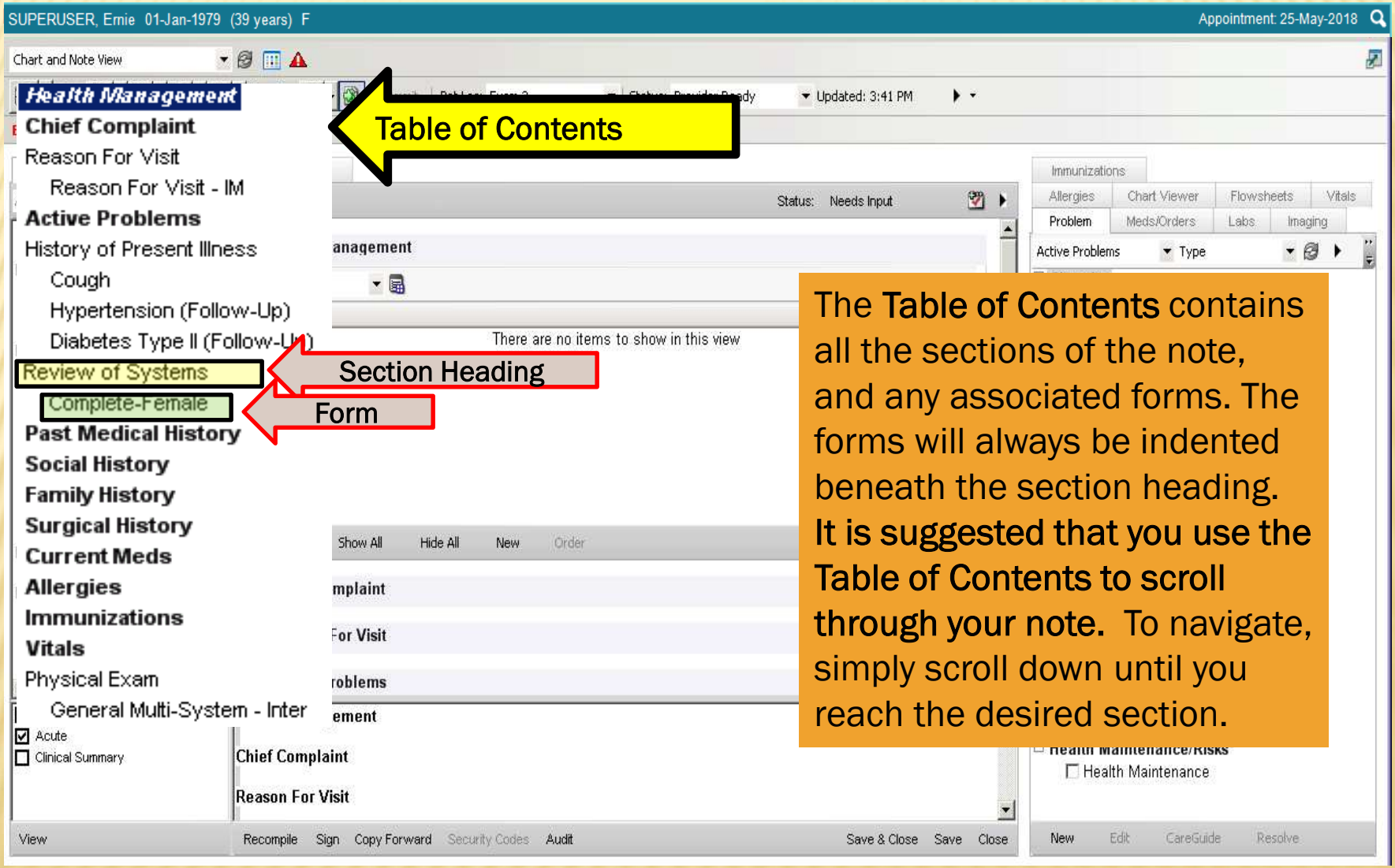


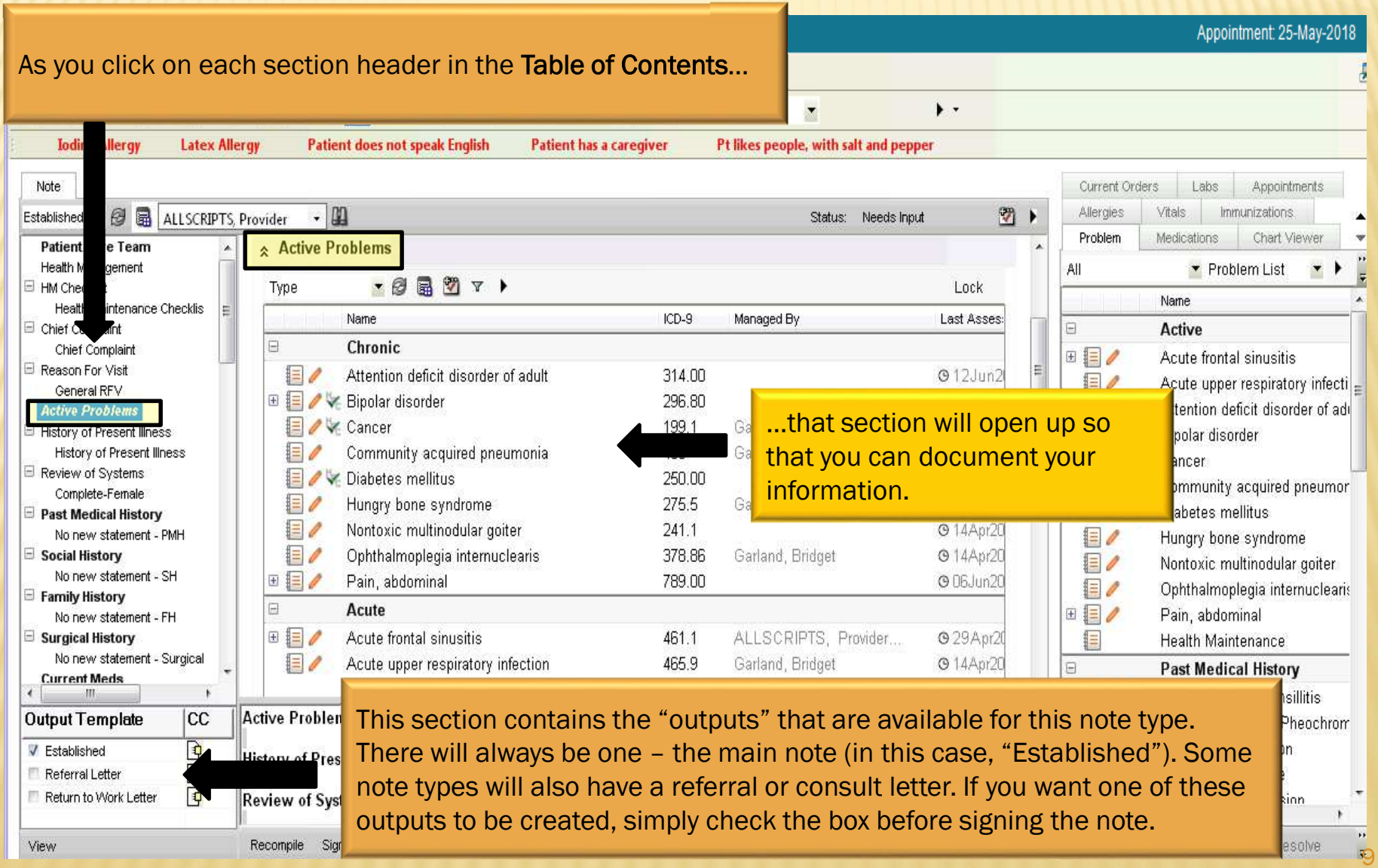
TABLE OF CONTENTS



The **Table of Contents** contains all the sections of the note, and any associated forms. The forms will always be indented beneath the section heading. **It is suggested that you use the Table of Contents to scroll through your note.** To navigate, simply scroll down until you reach the desired section.

TABLE OF CONTENTS

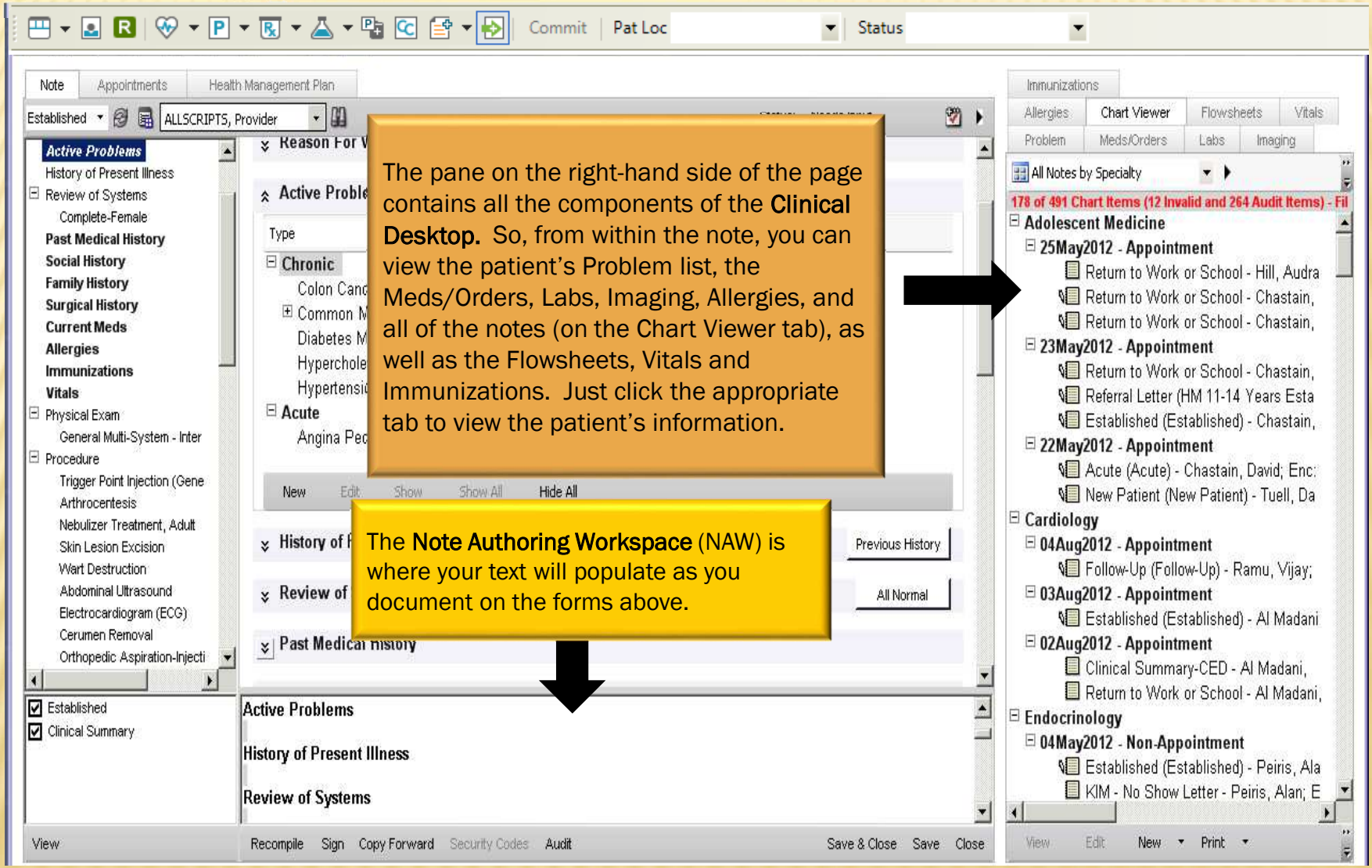
As you click on each section header in the **Table of Contents**…



…that section will open up so that you can document your information.

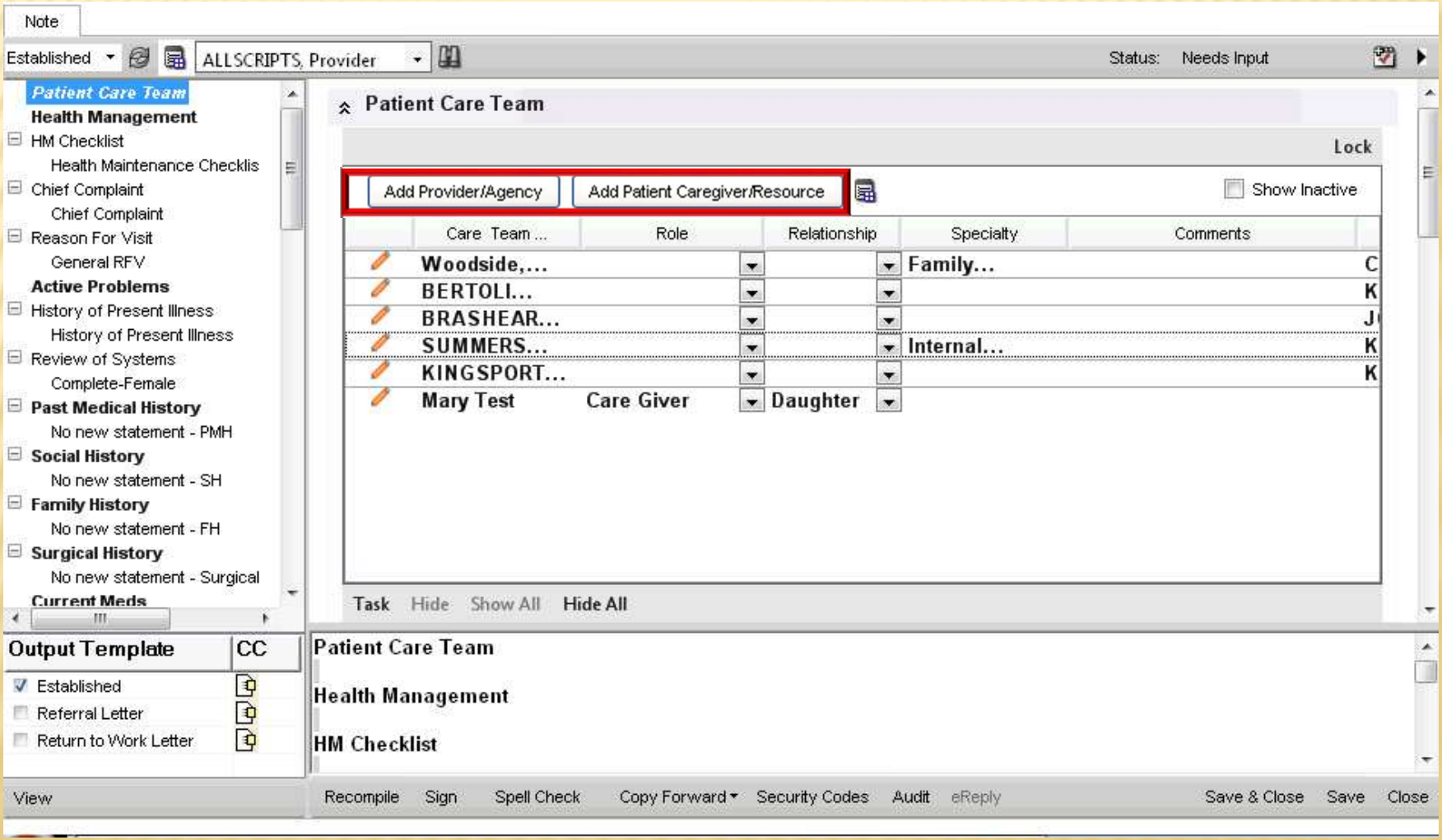
This section contains the "outputs" that are available for this note type. There will always be one – the main note (in this case, "Established"). Some note types will also have a referral or consult letter. If you want one of these outputs to be created, simply check the box before signing the note.

CLINICAL DESKTOP/NAW

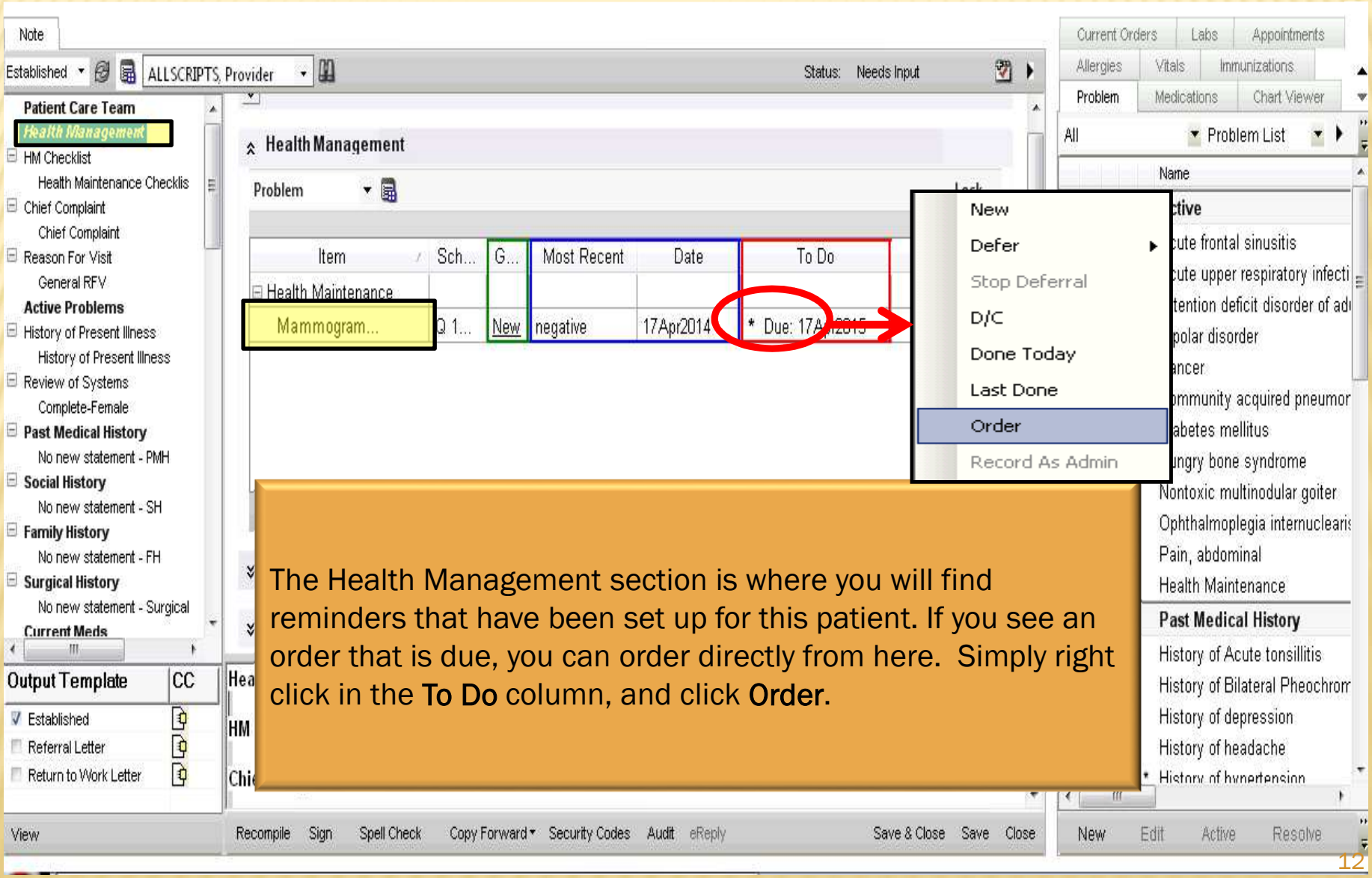


NOTE SECTIONS – PATIENT CARE TEAM

The Patient Care Team is a section where clinical staff can enter members of the patient's care team – other physicians, home health companies, and even family members/caregivers.

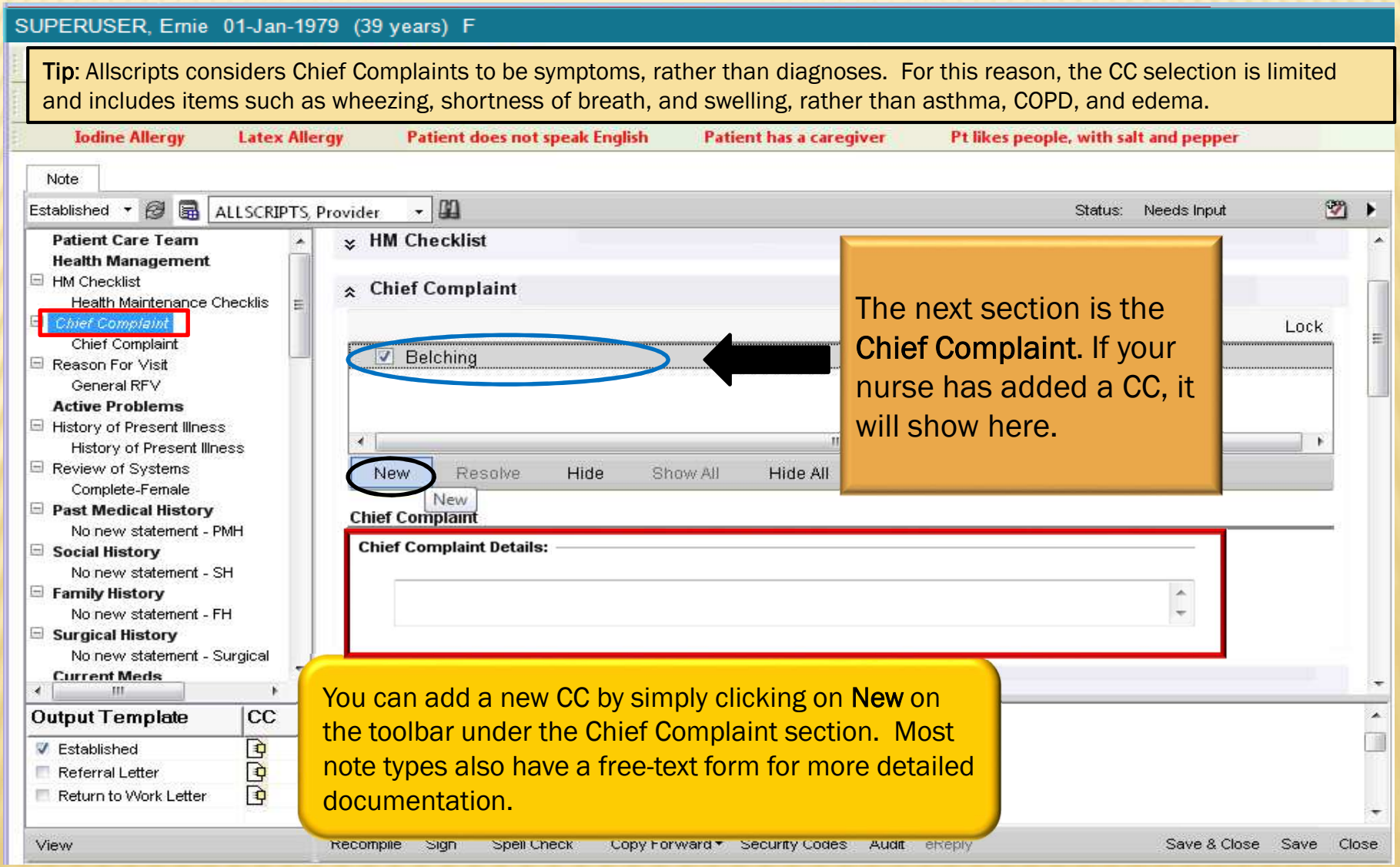


NOTE SECTIONS – HEALTH MANAGEMENT

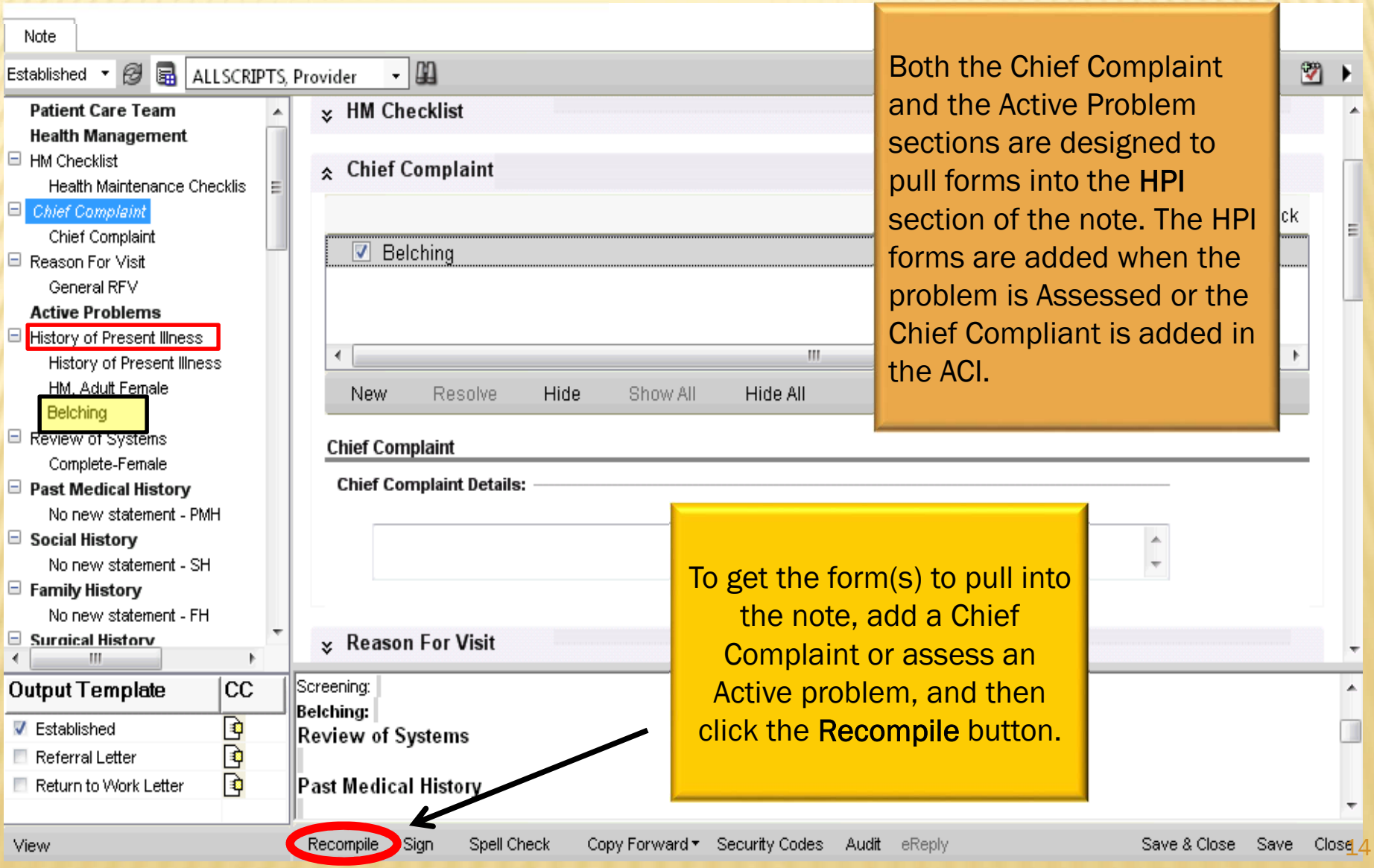


The Health Management section is where you will find reminders that have been set up for this patient. If you see an order that is due, you can order directly from here. Simply right click in the **To Do** column, and click **Order**.

NOTE SECTIONS – CHIEF COMPLAINT



HPI NOTE FORMS



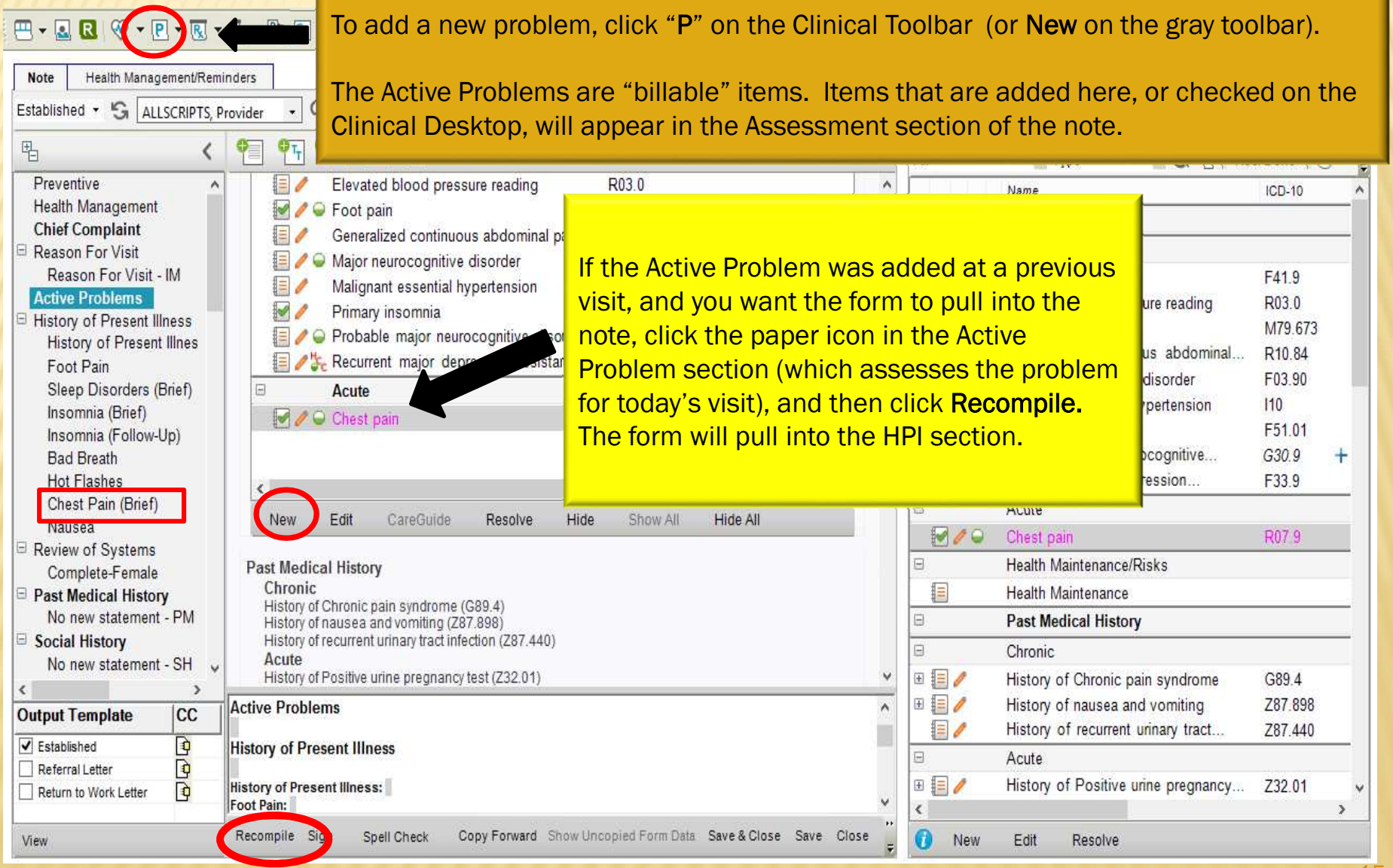
Both the Chief Complaint and the Active Problem sections are designed to pull forms into the **HPI** section of the note. The HPI forms are added when the problem is Assessed or the Chief Compliant is added in the ACI.

To get the form(s) to pull into the note, add a Chief Complaint or assess an Active problem, and then click the **Recompile** button.

FORMS

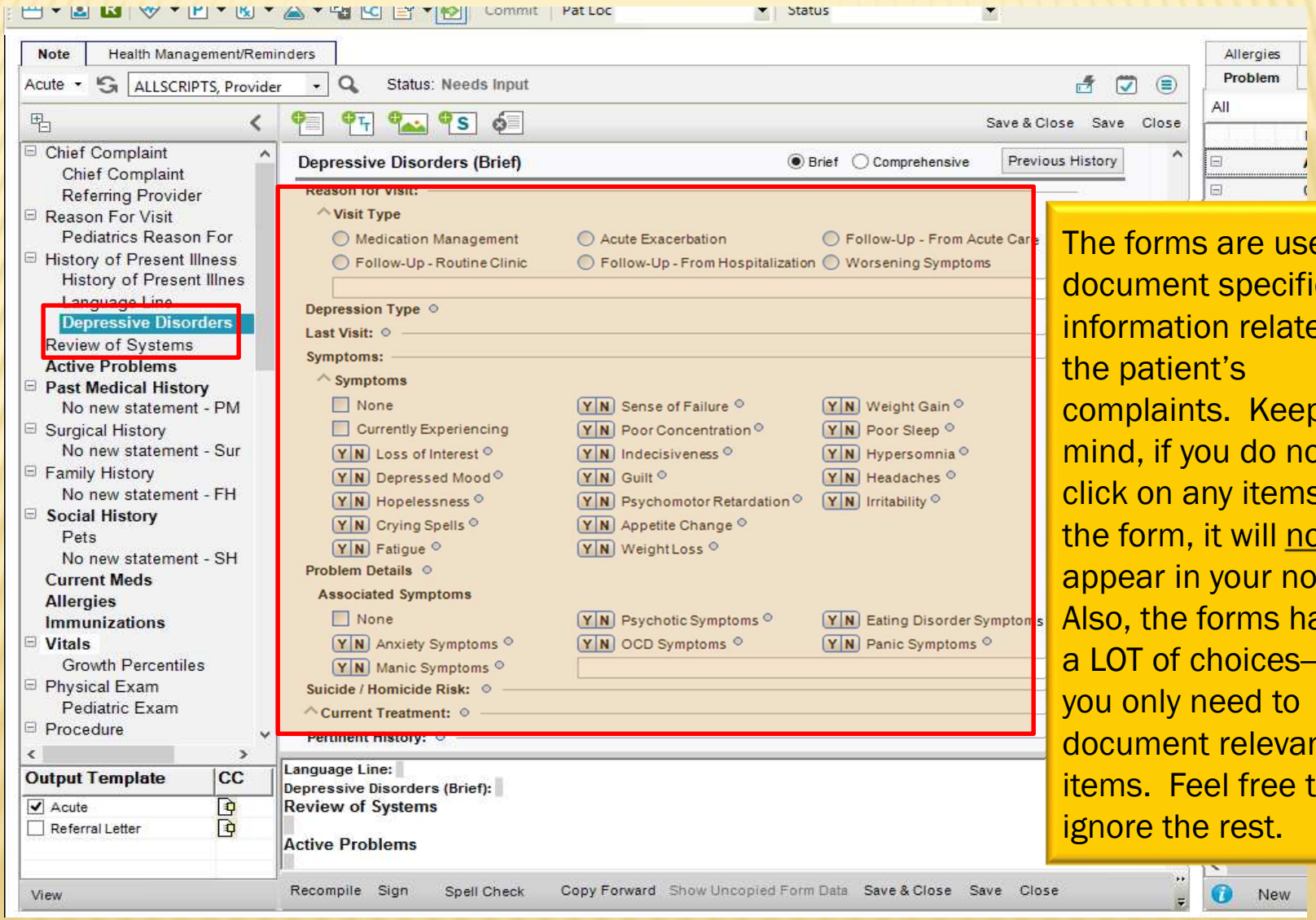
To add a new problem, click "**P**" on the Clinical Toolbar (or **New** on the gray toolbar).

The Active Problems are "billable" items. Items that are added here, or checked on the Clinical Desktop, will appear in the Assessment section of the note.



If the Active Problem was added at a previous visit, and you want the form to pull into the note, click the paper icon in the Active Problem section (which assesses the problem for today's visit), and then click **Recompile.** The form will pull into the HPI section.

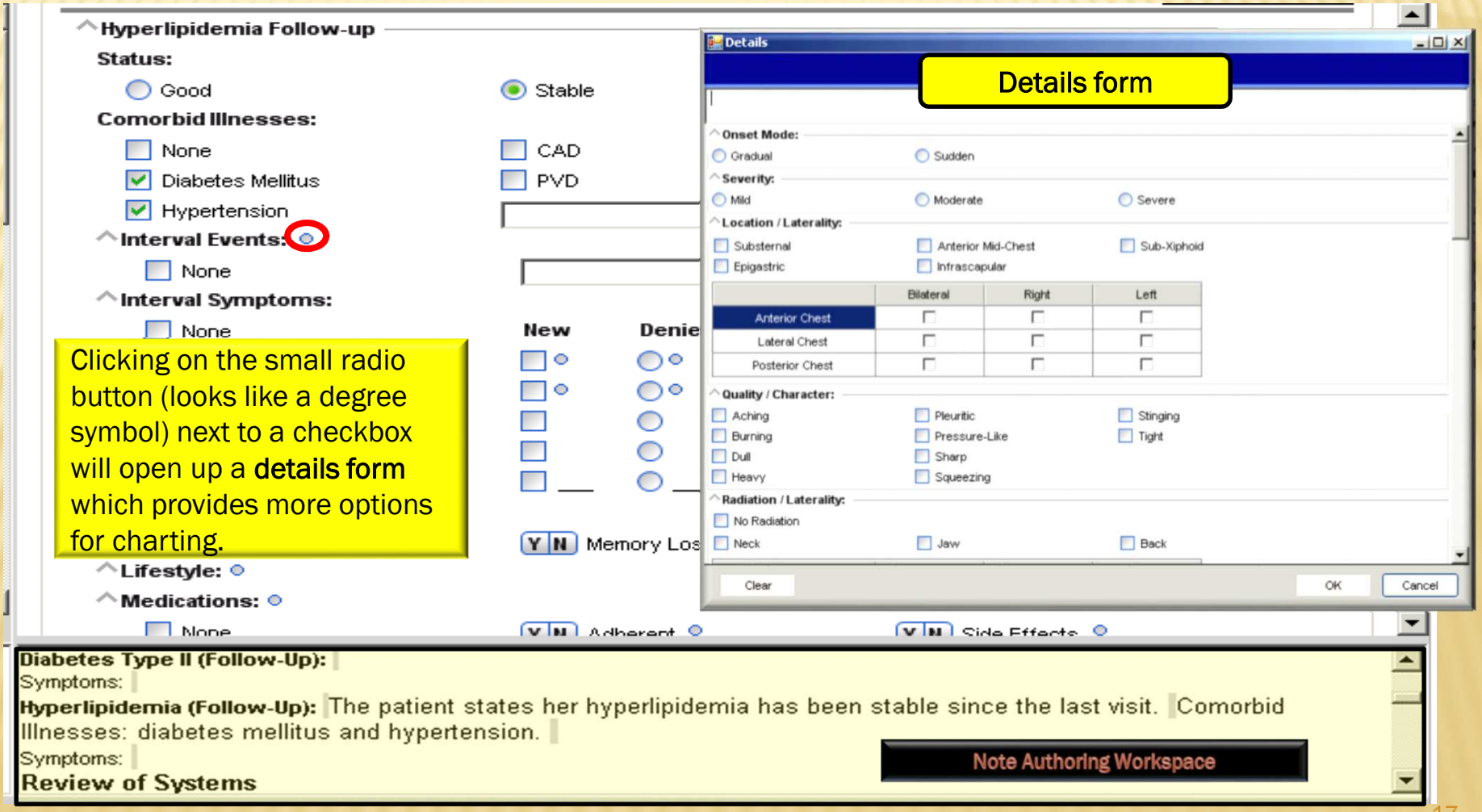
FORMS



The forms are used to document specific information related to the patient's complaints. Keep in mind, if you do not click on any items on the form, it will not appear in your note. Also, the forms have a LOT of choices—but you only need to document relevant items. Feel free to ignore the rest.

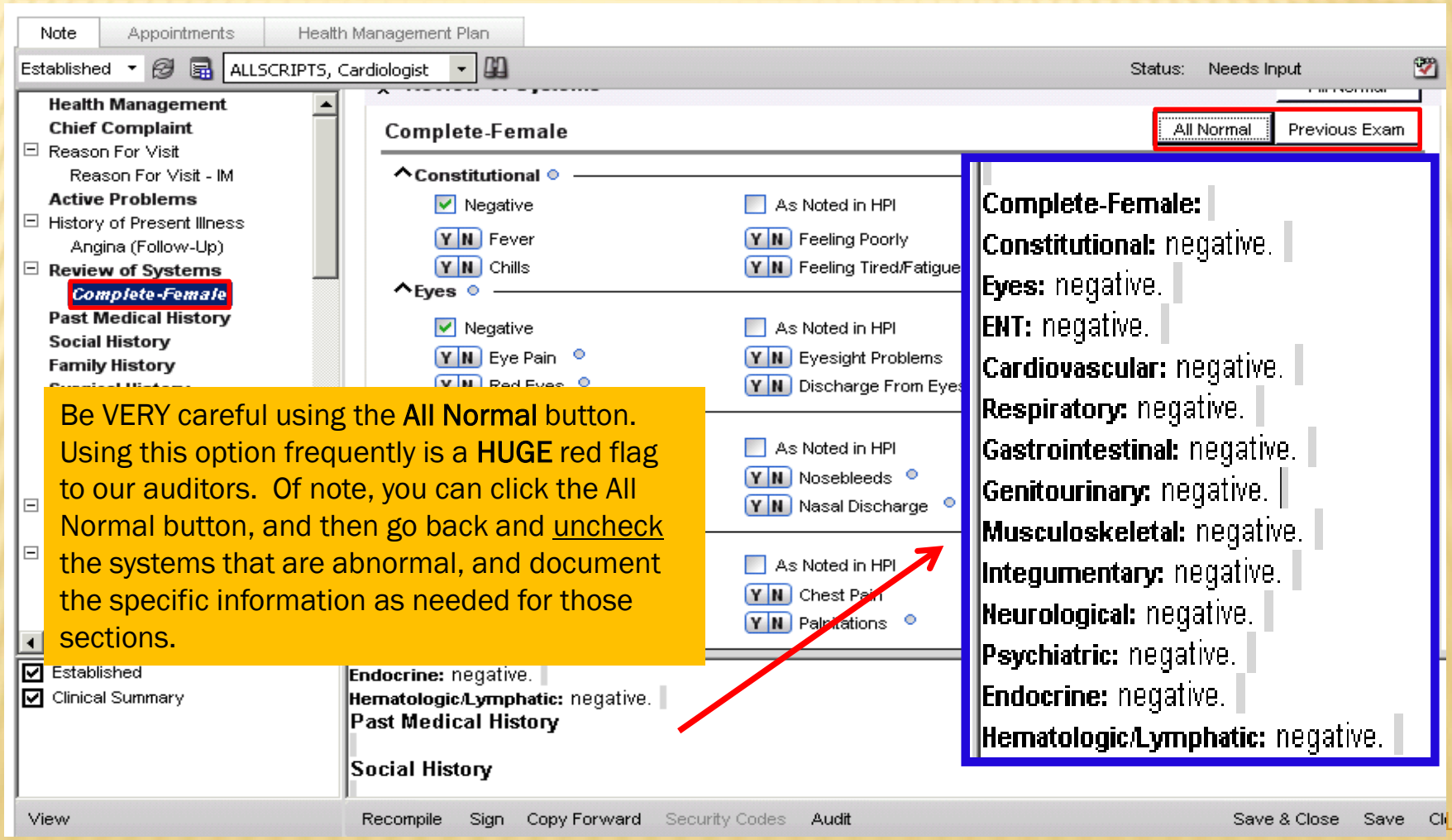
FORMS

Clicking the boxes on the forms will populate the text at the bottom of the page (called the Note Authoring Workspace).

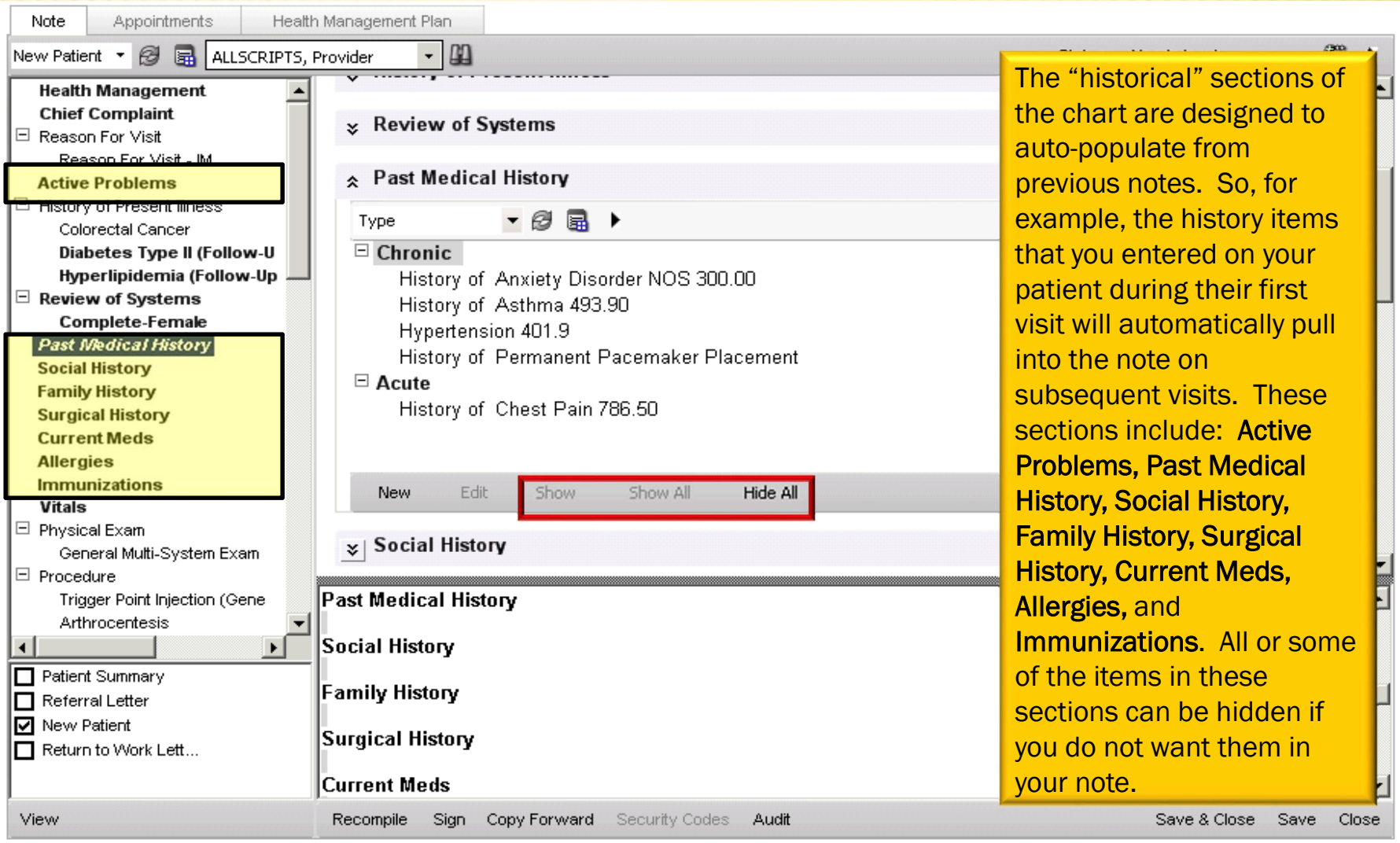


FORMS

Some of the forms will have an **All Normal** and/or **Previous Exam** option. Clicking the All Normal button will populate negative/normal text for ALL of the systems. The Previous Exam button will pull in all items from the last exam.



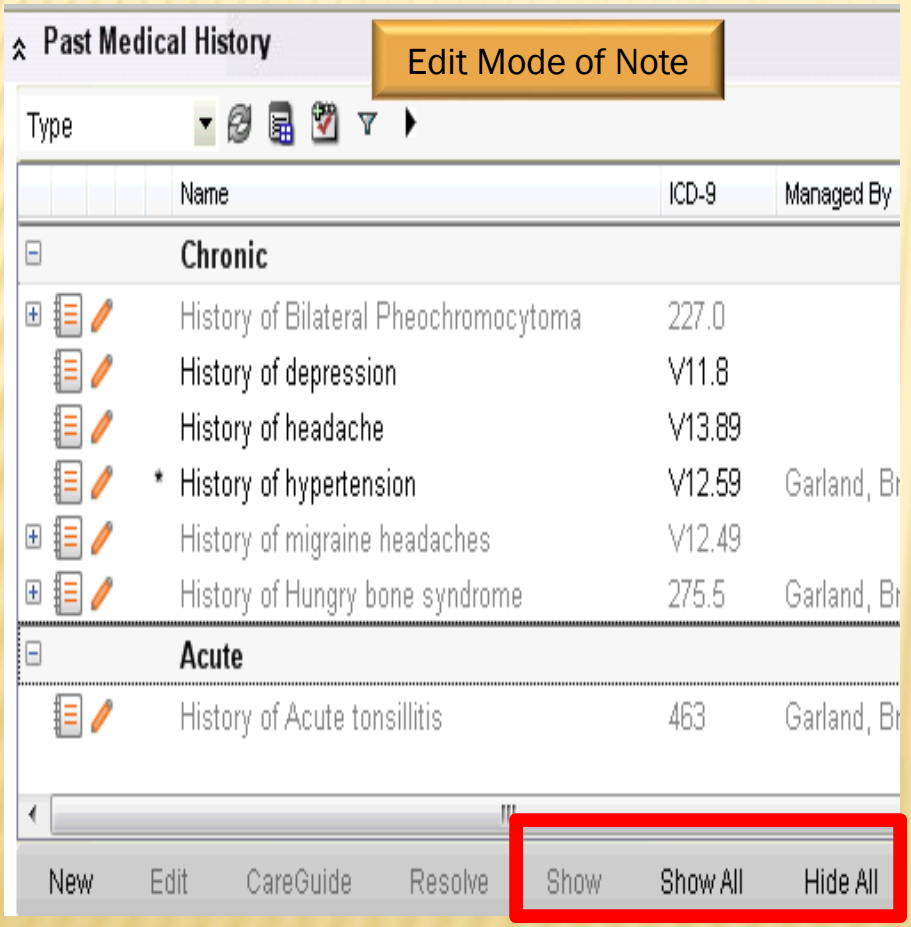
HISTORY SECTIONS

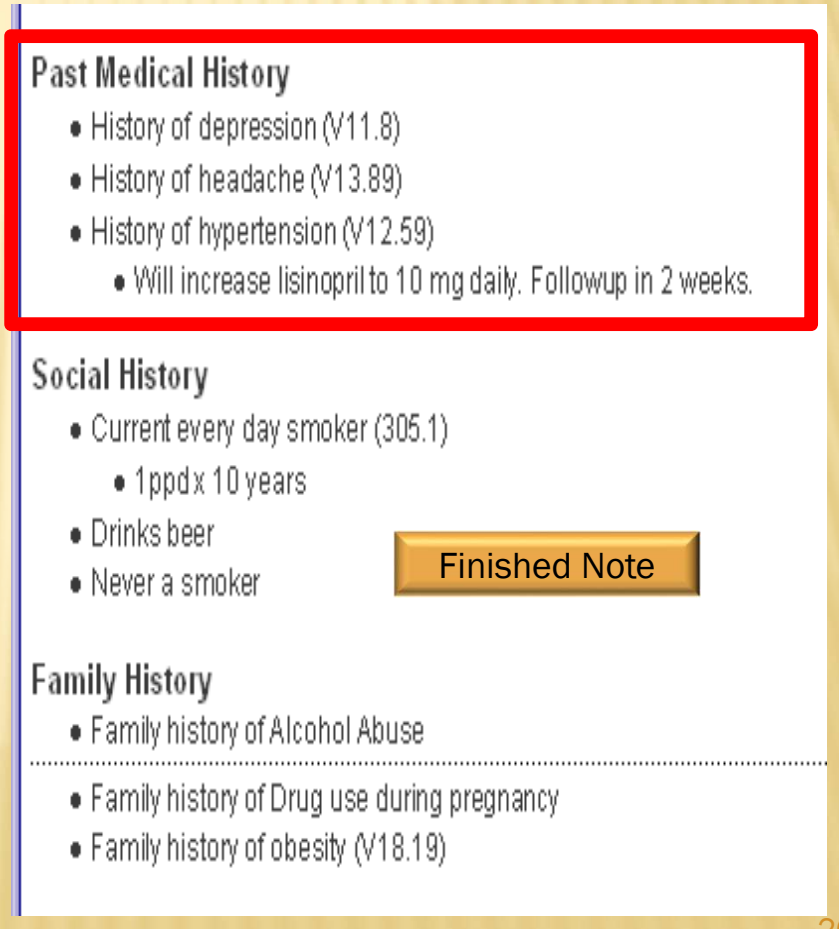


The "historical" sections of the chart are designed to auto-populate from previous notes. So, for example, the history items that you entered on your patient during their first visit will automatically pull into the note on subsequent visits. These sections include: **Active Problems, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies,** and **Immunizations.** All or some of the items in these sections can be hidden if you do not want them in your note.

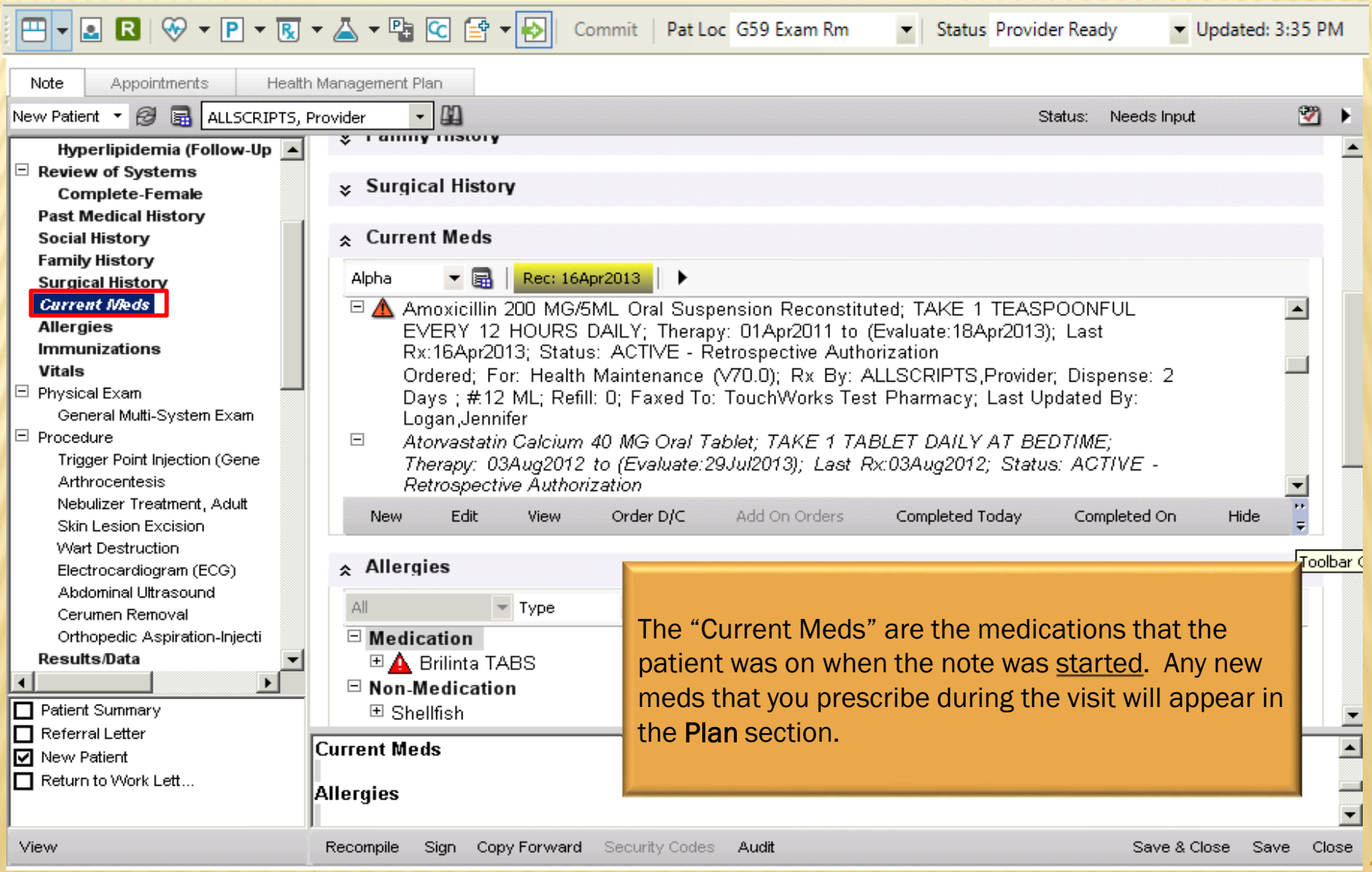
HIDING ITEMS

Use the "Show," "Show All," "Hide," and "Hide All" options to pull only relevant items into your note. If the items are **grayed out**, they are hidden. If they are **black**, they will appear in your note. In this example, I've clicked on 3 items, and then clicked "show." Only those items will appear in my finished note. It does not erase them from the patient's chart, however. The next time you open a note, all items will pull in.



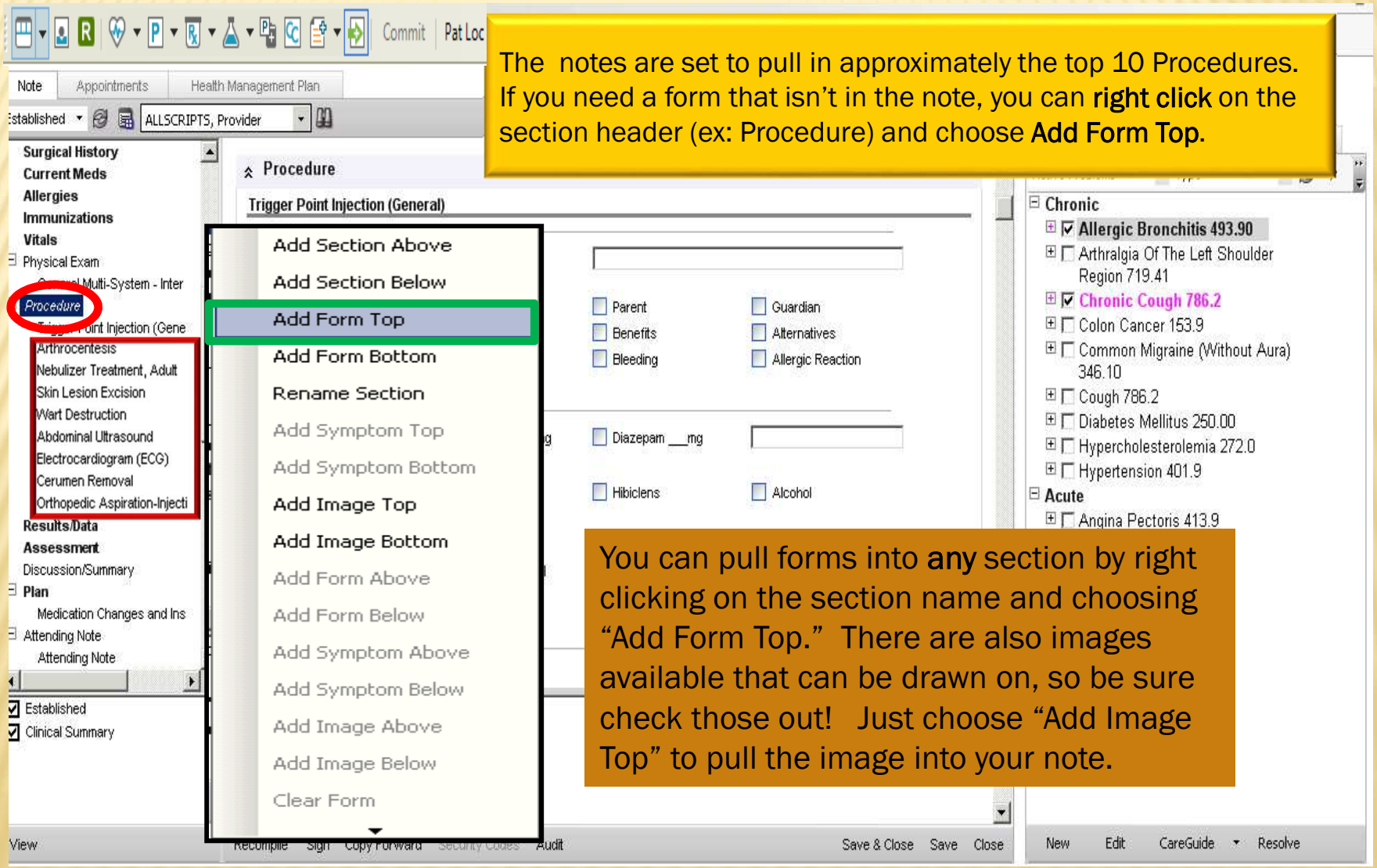


NOTE SECTIONS – CURRENT MEDS



The "Current Meds" are the medications that the patient was on when the note was started. Any new meds that you prescribe during the visit will appear in the **Plan** section.

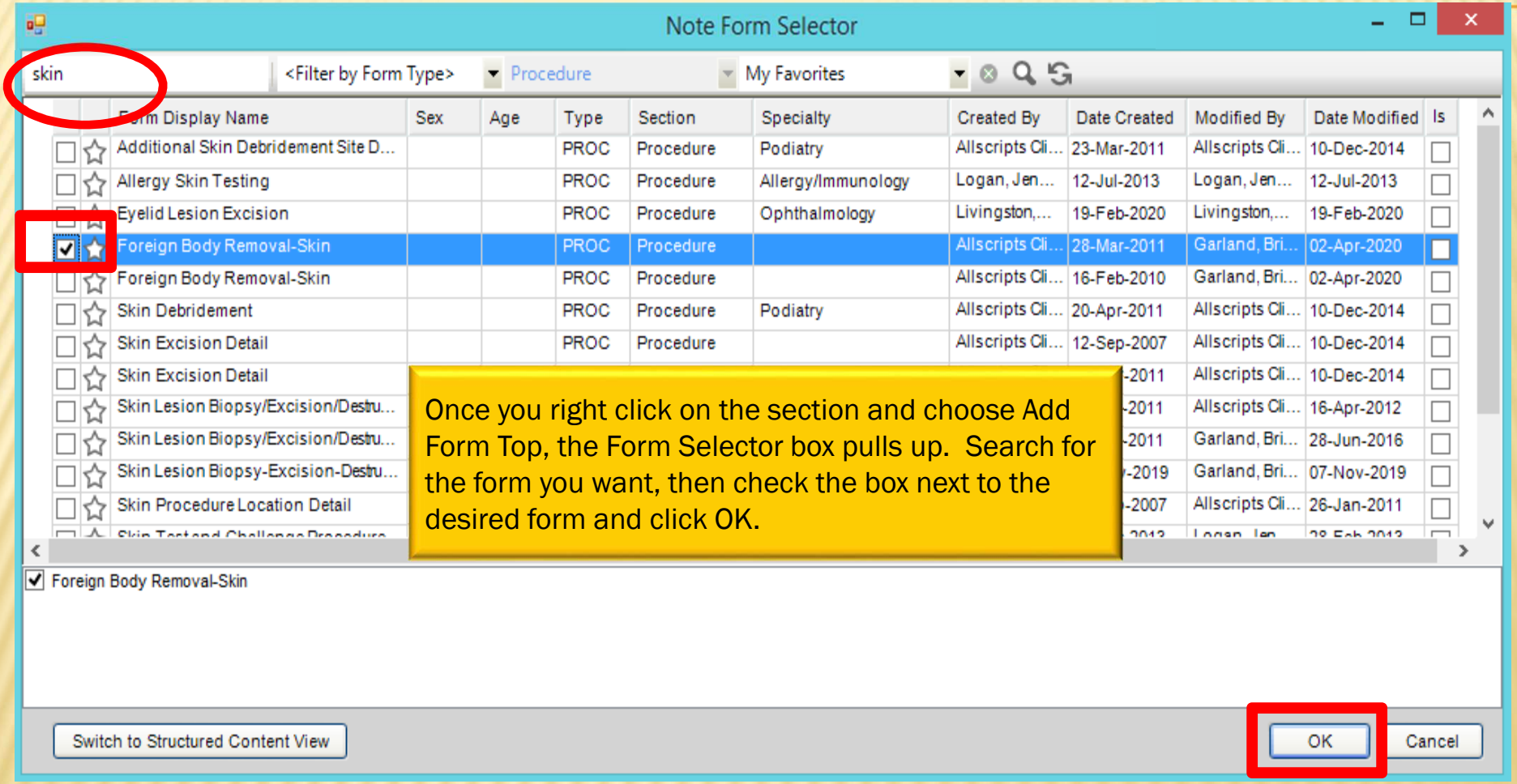
NOTE SECTIONS – PROCEDURES



The notes are set to pull in approximately the top 10 Procedures. If you need a form that isn't in the note, you can **right click** on the section header (ex: Procedure) and choose **Add Form Top**.

You can pull forms into **any** section by right clicking on the section name and choosing "Add Form Top." There are also images available that can be drawn on, so be sure check those out! Just choose "Add Image Top" to pull the image into your note.

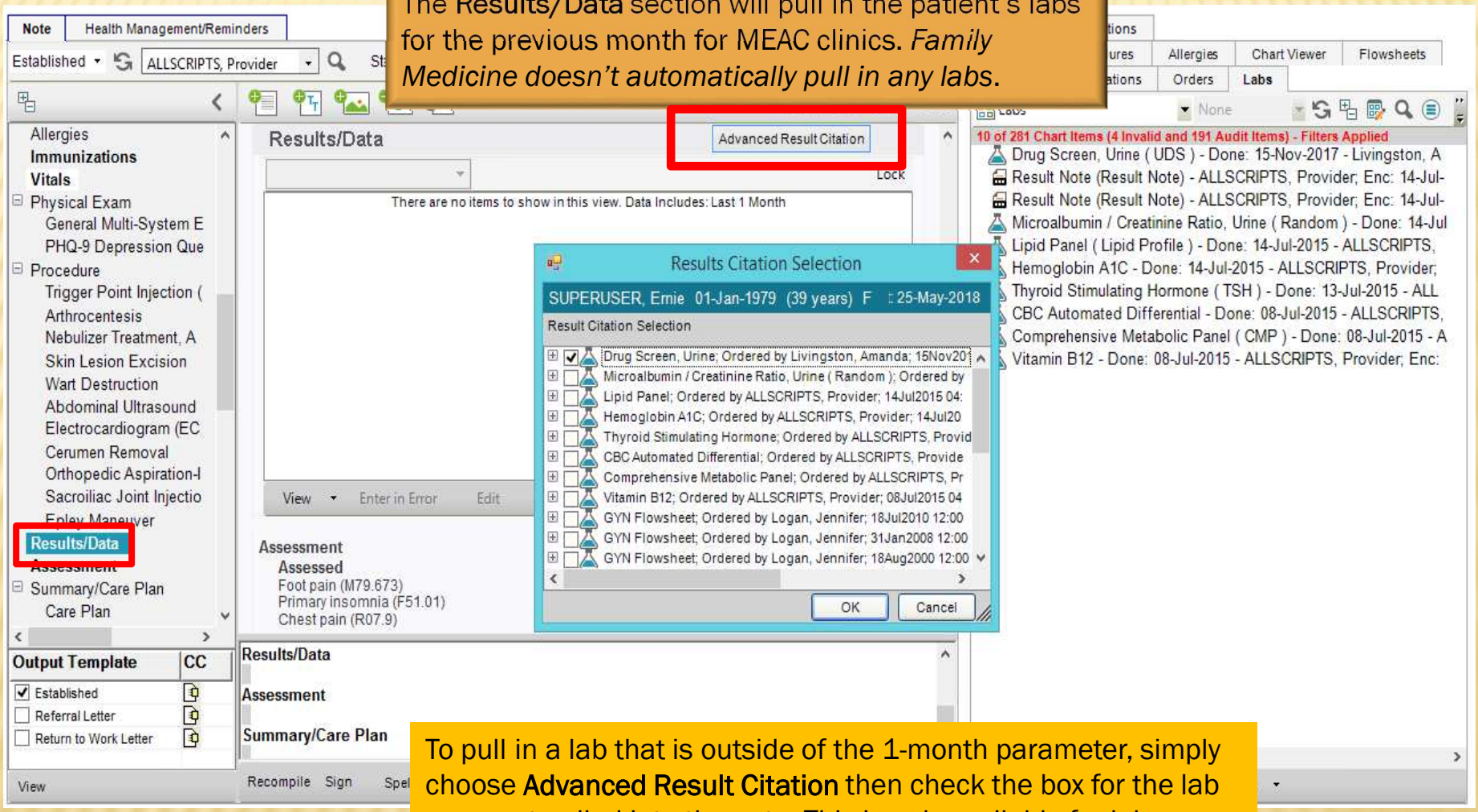
NOTE SECTIONS – PROCEDURES



Once you right click on the section and choose Add Form Top, the Form Selector box pulls up. Search for the form you want, then check the box next to the desired form and click OK.

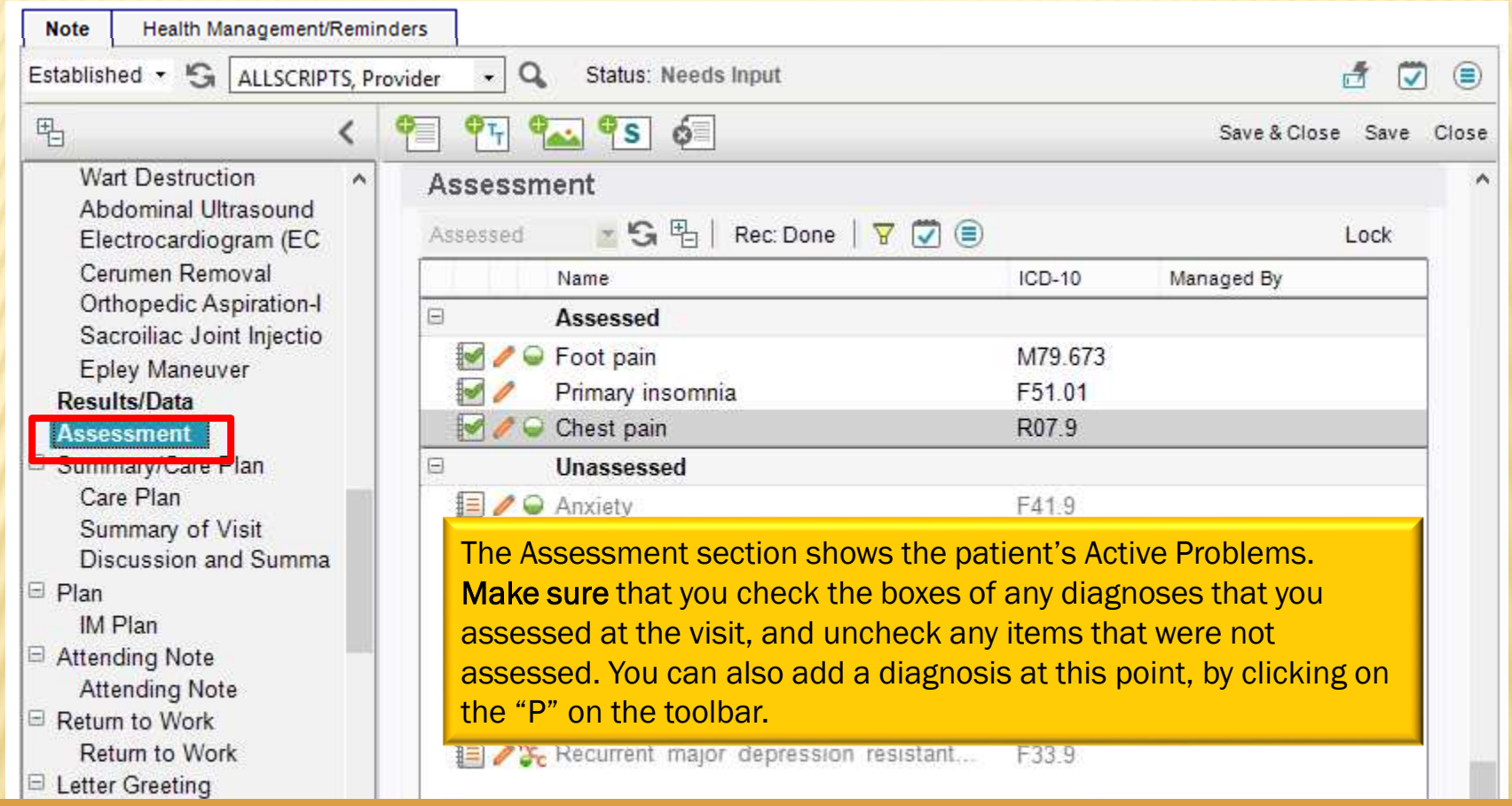
NOTE SECTIONS – RESULTS/DATA

The **Results/Data** section will pull in the patient's labs for the previous month for MEAC clinics. *Family Medicine doesn't automatically pull in any labs.*



To pull in a lab that is outside of the 1-month parameter, simply choose **Advanced Result Citation** then check the box for the lab you want pulled into the note. This is only available for labs completed by ETSU laboratory.

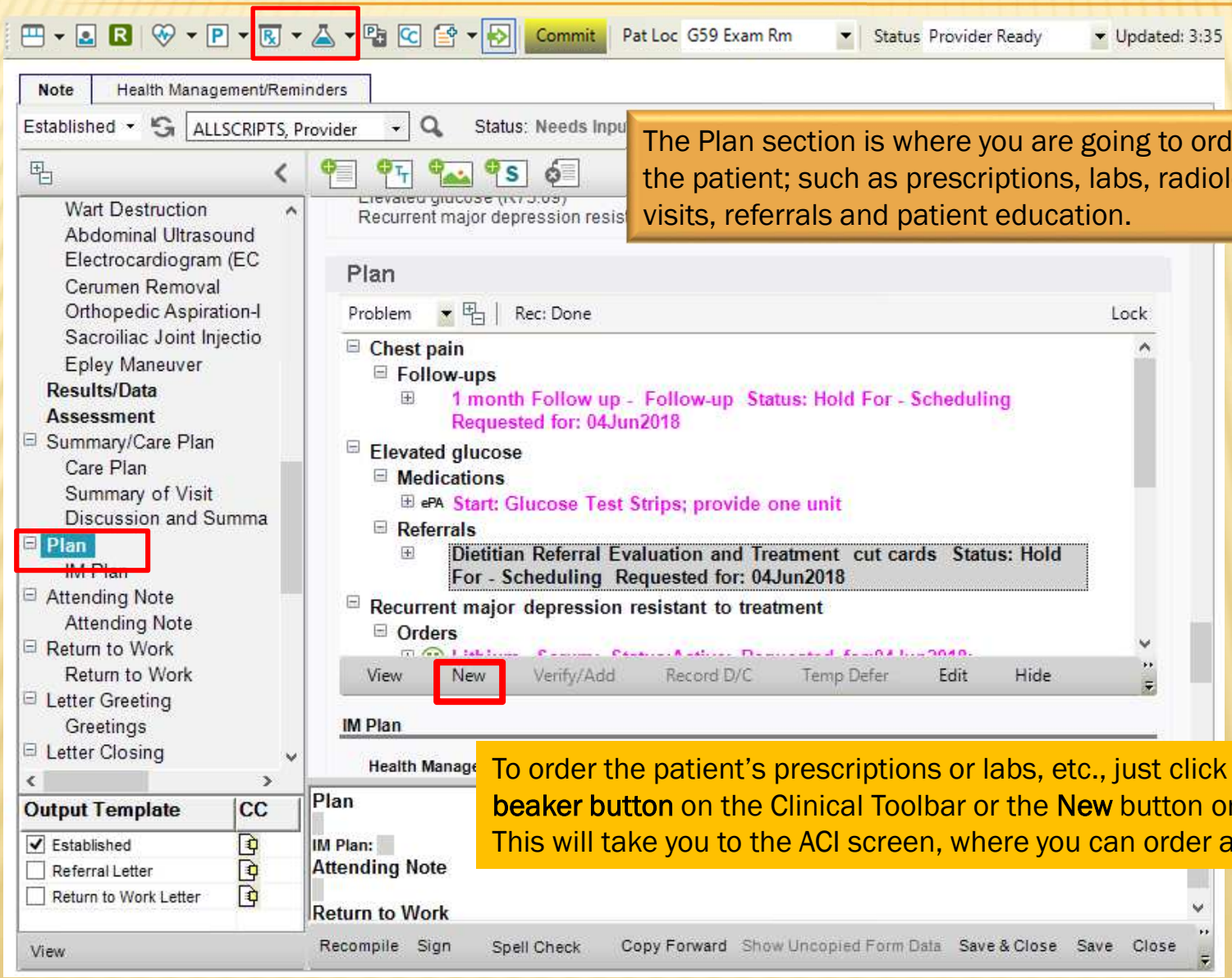
NOTE SECTIONS – ASSESSMENT



The Assessment section shows the patient's Active Problems. **Make sure** that you check the boxes of any diagnoses that you assessed at the visit, and uncheck any items that were not assessed. You can also add a diagnosis at this point, by clicking on the "P" on the toolbar.

It's **really** important for billing purposes that the items you assessed are placed in order of importance. To do this, simply click on the item you need to move and drag it into place. Currently, we are still utilizing superbills, so the assessed problems in your note need to match the problems you list on the encounter form (superbill). The order also needs to match.

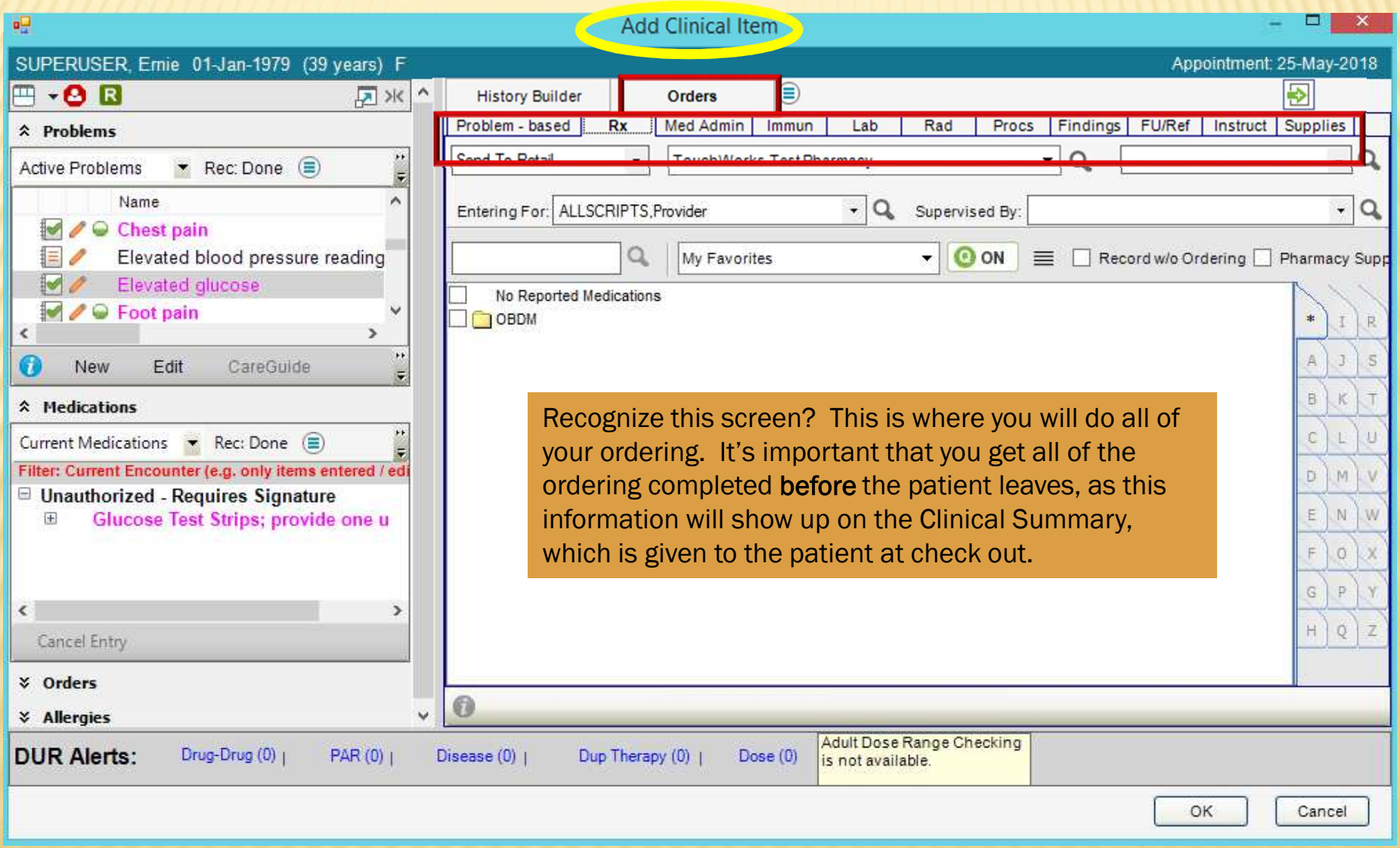
NOTE SECTIONS – PLAN



The Plan section is where you are going to order all the items for the patient; such as prescriptions, labs, radiology, follow-up visits, referrals and patient education.

To order the patient's prescriptions or labs, etc., just click on the **Rx** or **beaker button** on the Clinical Toolbar or the **New** button on the gray toolbar. This will take you to the ACI screen, where you can order all of the items.

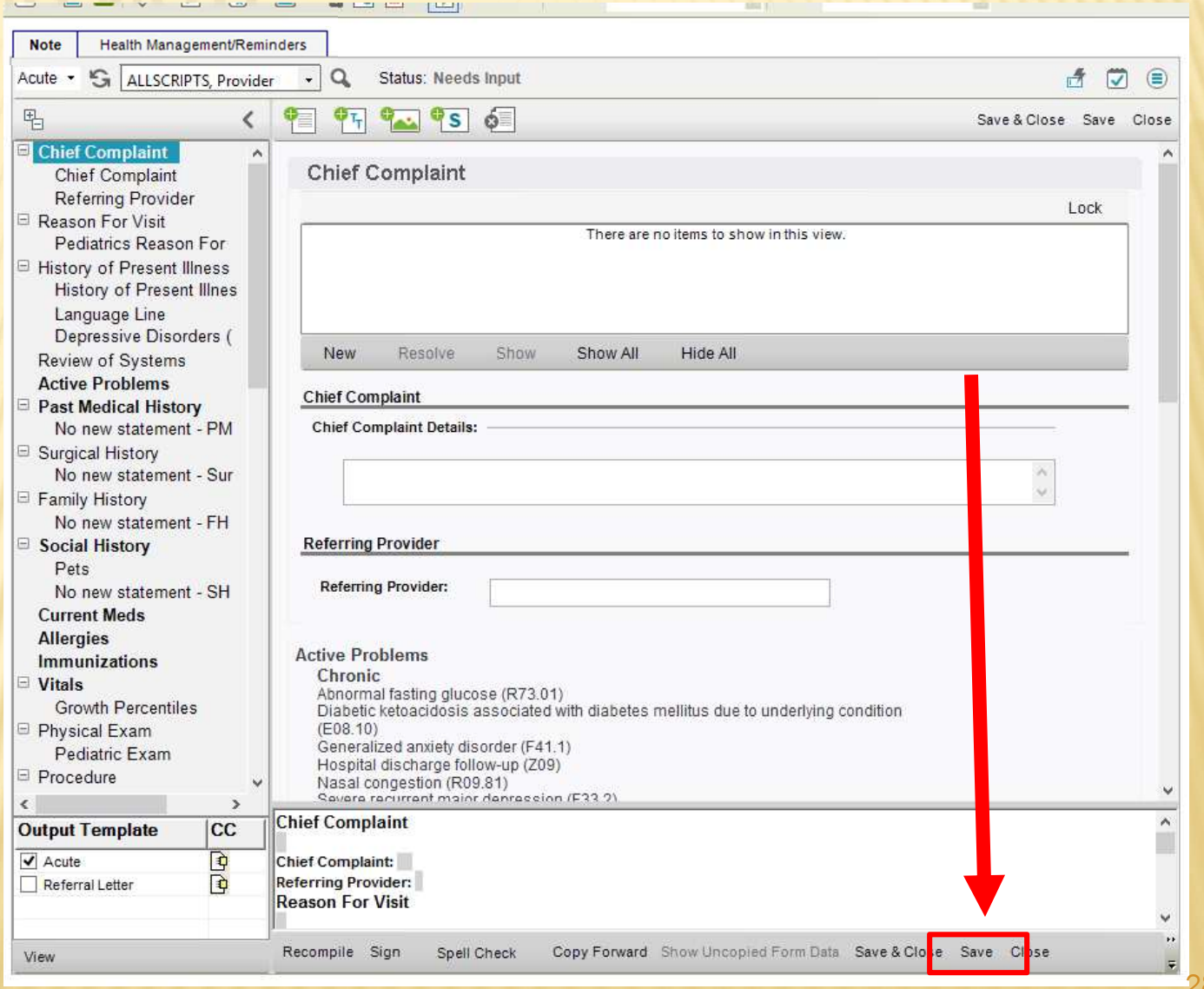
NOTE SECTIONS – ORDERING



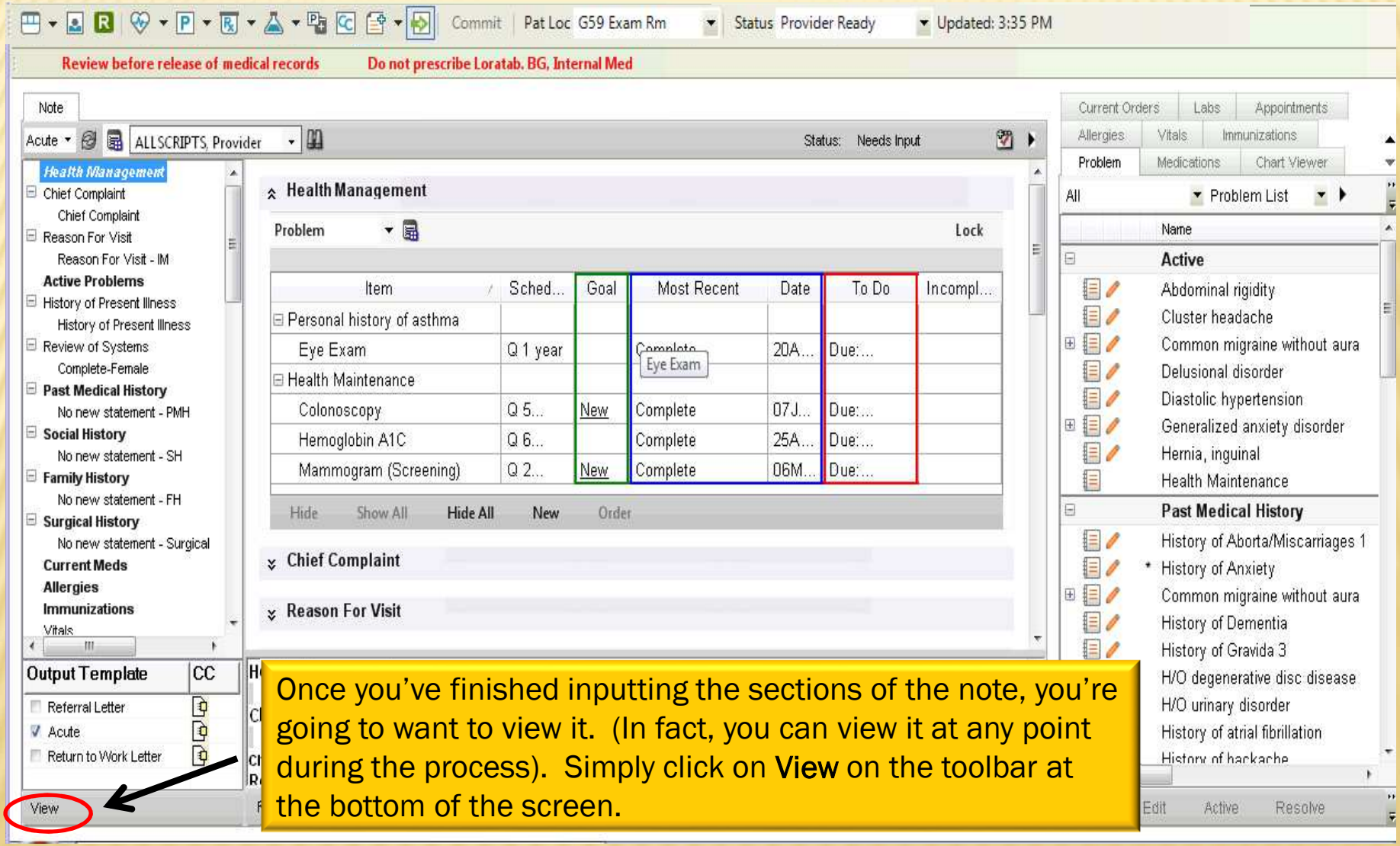
Recognize this screen? This is where you will do all of your ordering. It's important that you get all of the ordering completed **before** the patient leaves, as this information will show up on the Clinical Summary, which is given to the patient at check out.

SAVE YOUR NOTE

It is important to save your note often when working. This will create iterations that can be retrieved by the EHR team in case the note crashes or you lose internet connectivity.

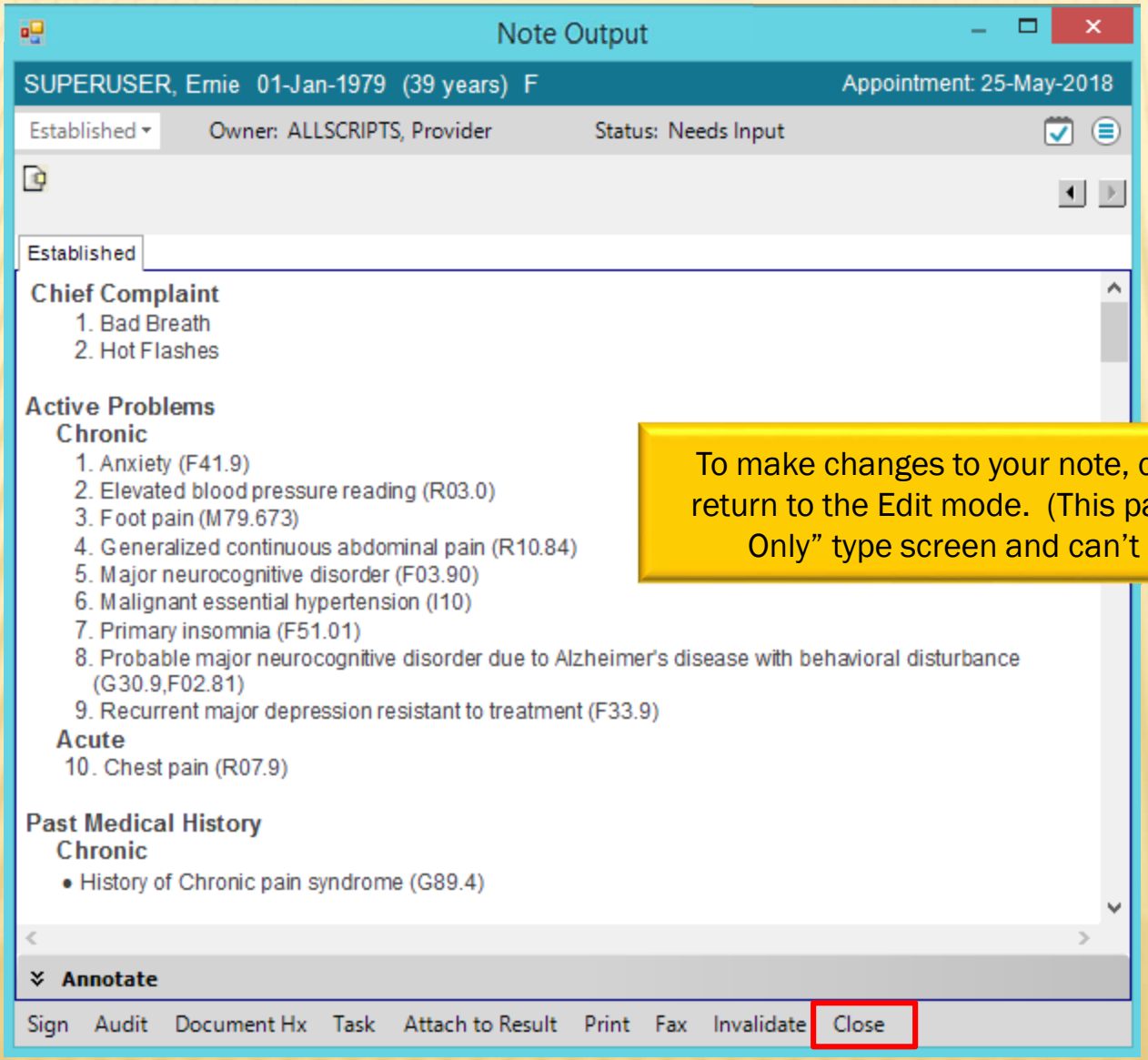


VIEWING YOUR NOTE



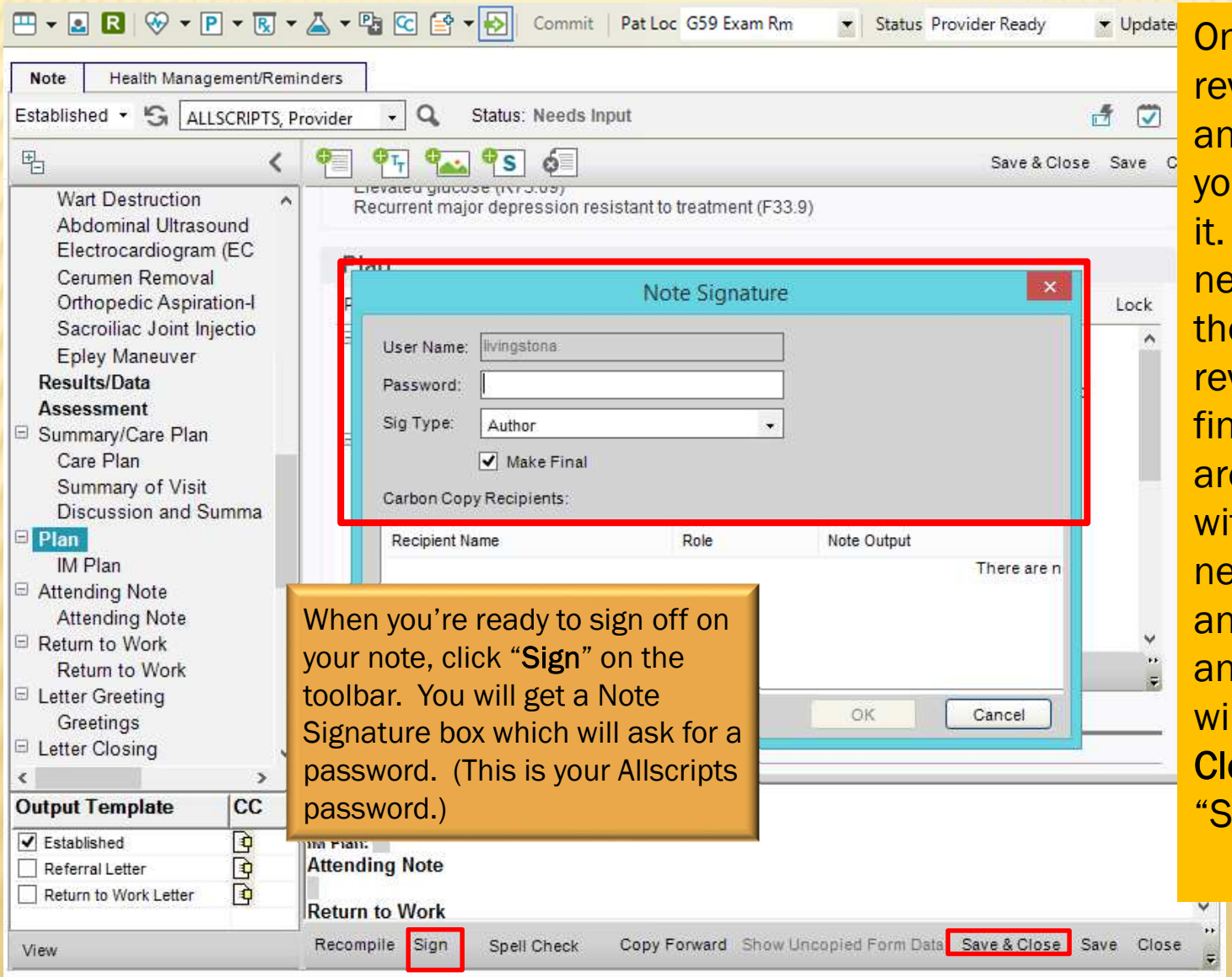
Once you've finished inputting the sections of the note, you're going to want to view it. (In fact, you can view it at any point during the process). Simply click on **View** on the toolbar at the bottom of the screen.

VIEWING YOUR NOTE



To make changes to your note, click **Close** and return to the Edit mode. (This page is a "Read-Only" type screen and can't be edited.)

SIGNING YOUR NOTE

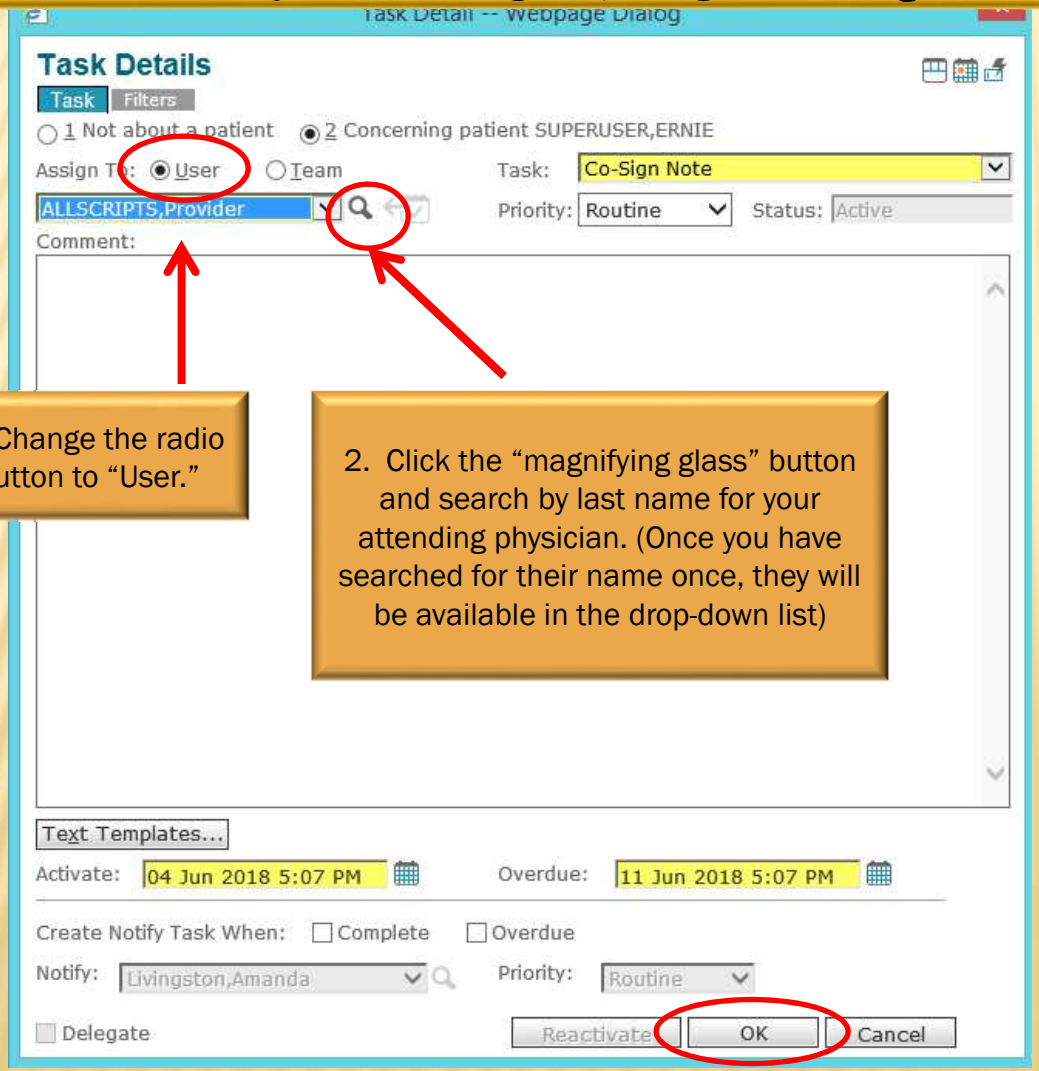


When you're ready to sign off on your note, click "**Sign**" on the toolbar. You will get a Note Signature box which will ask for a password. (This is your Allscripts password.)

Once you've finished reviewing your note, and it's complete, you will want to sign it. Residents will need to send it to their preceptor for review and finalization. If you are NOT finished with the note, but need to get out of it and go on to another patient, you will click "**Save & Close**," instead of "Sign."

CO-SIGN NOTE TASK

Once you click OK on the Signature Box, residents (and nurses, if they are creating a note that needs to be finalized by an attending MD) will get a **Co-Sign Note** task.

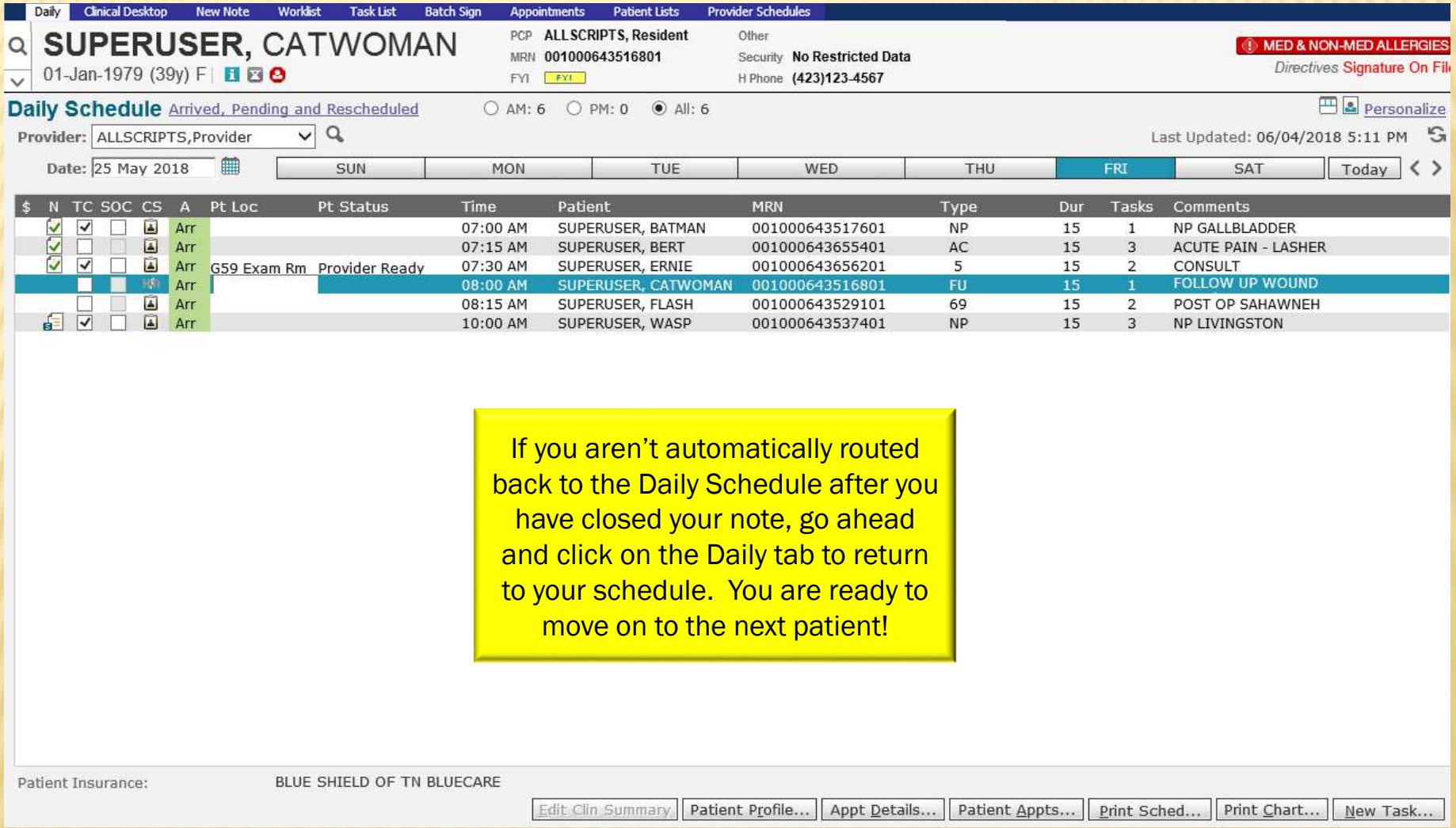


1. Change the radio button to "User."

2. Click the "magnifying glass" button and search by last name for your attending physician. (Once you have searched for their name once, they will be available in the drop-down list)

After you have put your **attending physician's** name in the Assign To: field, click OK. There is no need to type anything in the Comment section. (When your attending double clicks on this task, it will take him/her directly into the note to be signed and finalized.)

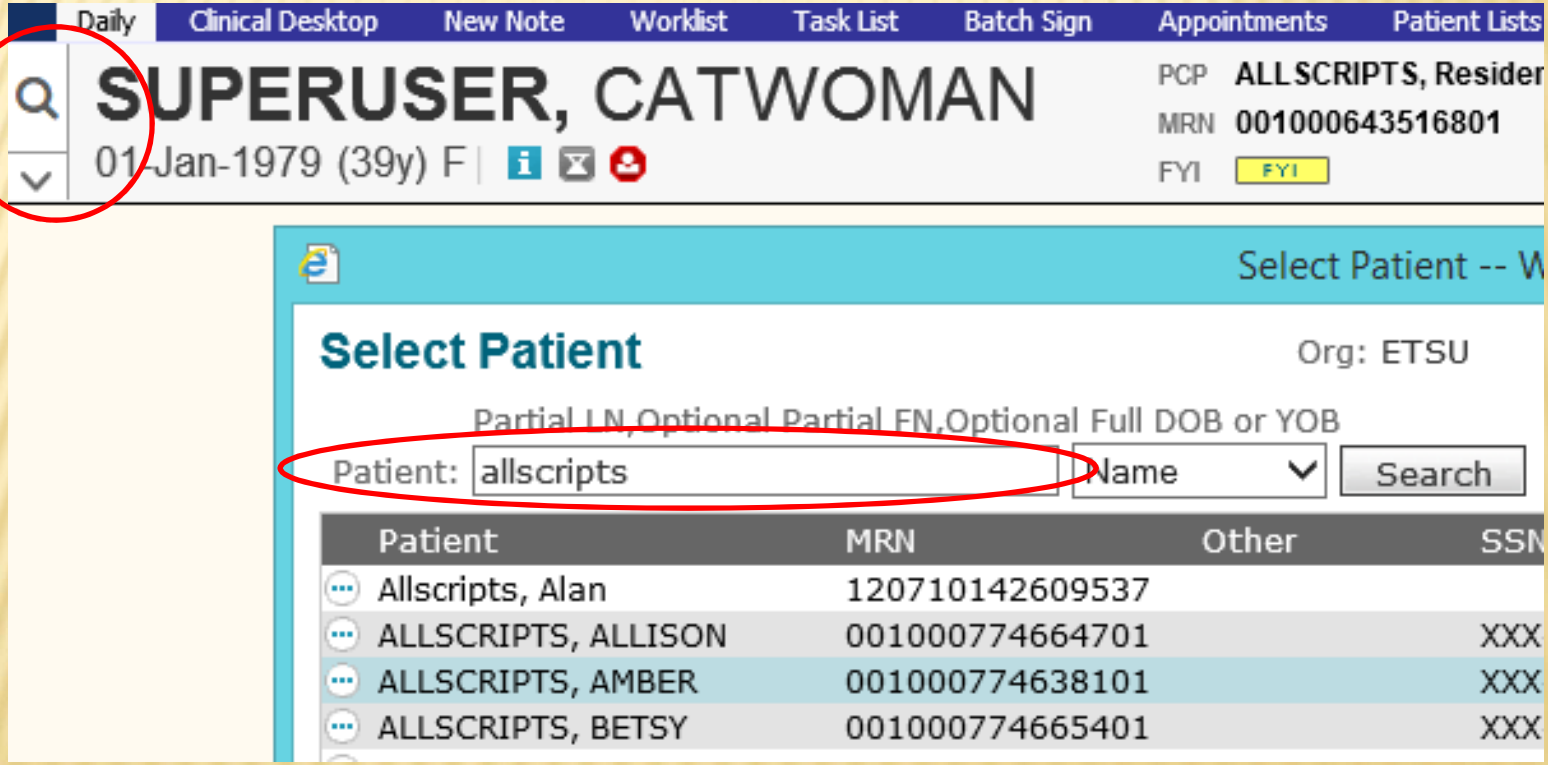
RETURN TO DAILY SCHEDULE



If you aren't automatically routed back to the Daily Schedule after you have closed your note, go ahead and click on the Daily tab to return to your schedule. You are ready to move on to the next patient!

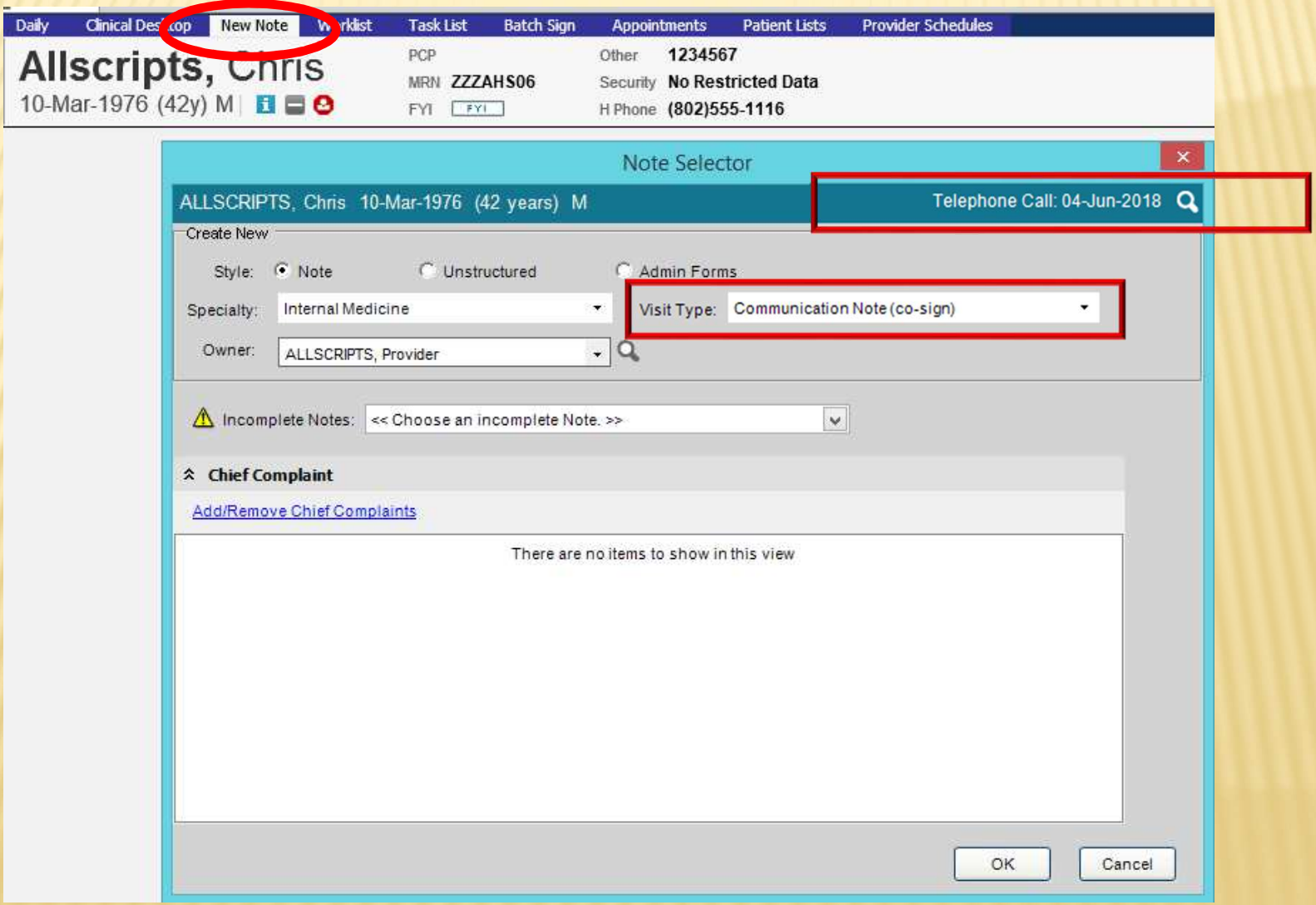
STARTING A NOTE

Most of the time, you will be doing notes on patients who are on your schedule. But, from time to time, you'll want to create a telephone note on a patient who isn't on your schedule. To document a note in this situation, click on the "magnifying glass." A "Select Patient" box will appear. Search for your patient by **Last Name, First Name** or **DOB**. Click Search. Highlight the patient's name and click OK.

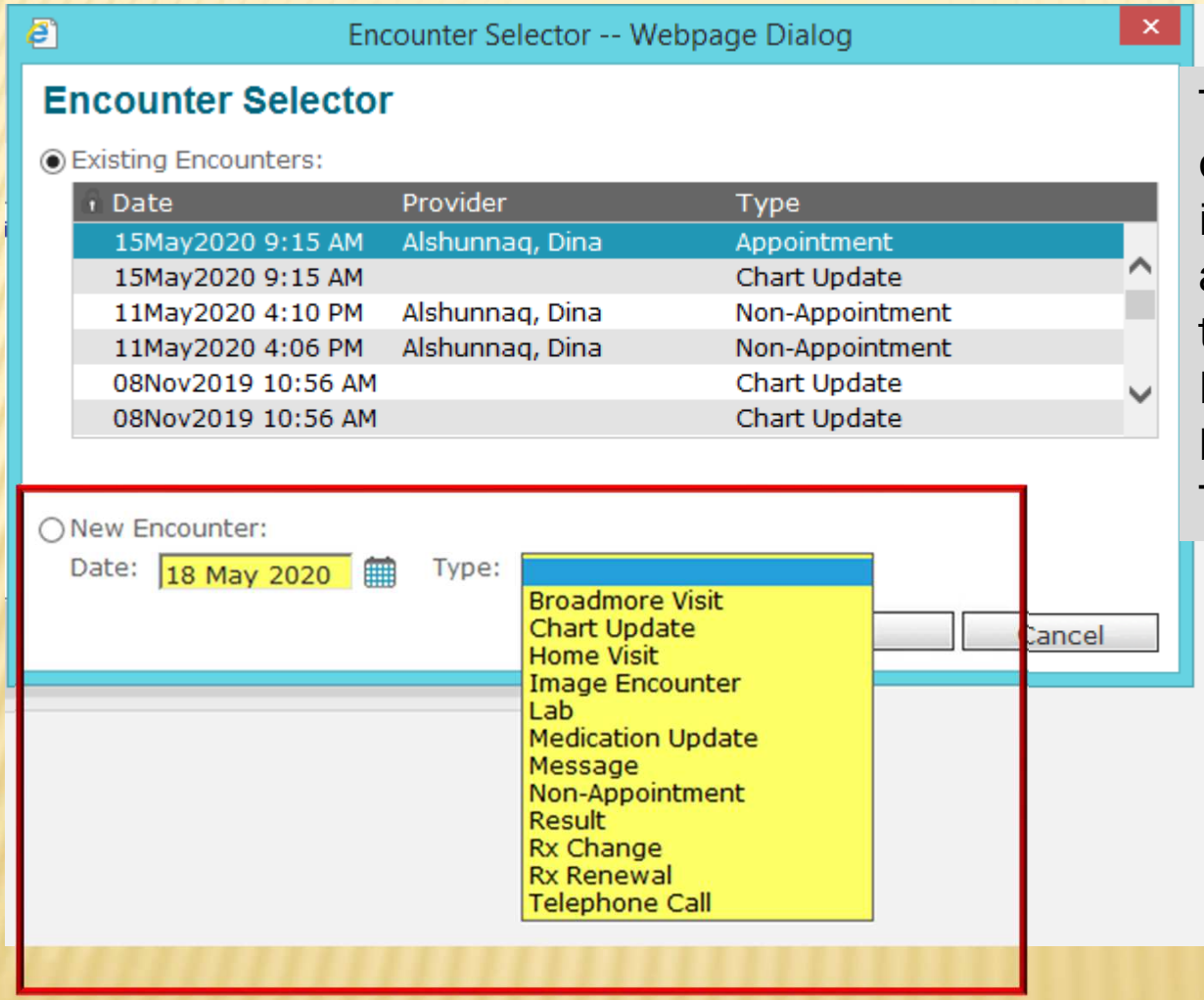


NEW NOTE TAB

Once the patient is in the Banner, click on the New Note tab. Choose your Visit Type. Click OK.



ENCOUNTER SELECTOR



The Encounter Selector opens when the note isn't attached to an appointment, like a telephone call. Click New Encounter radio button and choose a Type.

MACROS

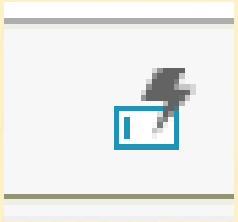
A macro is a shortcut that you create that when entered into the system will automatically expand into a larger phrase or series of phrases. A macro can be used to automatically enter simple, repetitive phrases including commonly used sentences and instructions in your documentation.

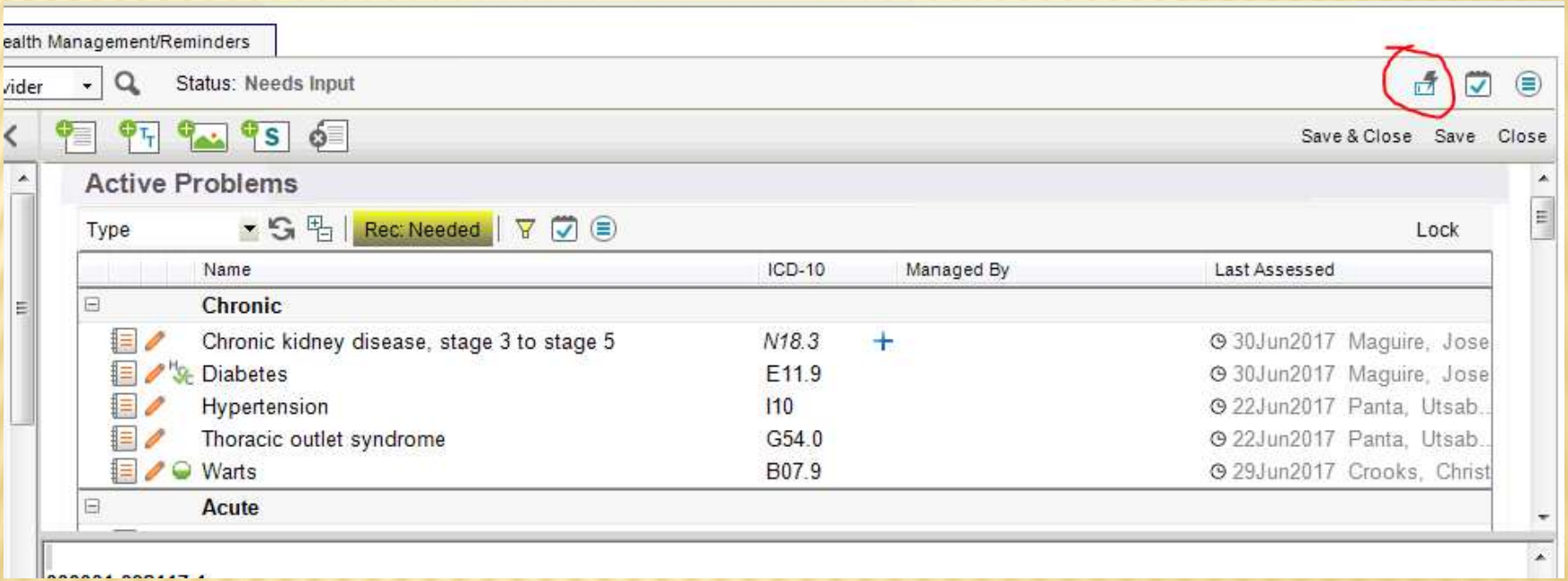
Macros that are inserted without editing may contain elements that were not asked or examined during the specific patient encounter. Physicians need to be certain that the medical record accurately reflects the patient encounter.

More documentation does not equal a higher E/M level. E/M levels are determined by the nature of the presenting complaint, History, Physical Exam and Medical Decision Making. Evaluation and treatment must be medically necessary and appropriate. *(from https://www.acep.org/Clinical---Practice-Management/EMR-EHR-FAQ/)*

HOW TO CREATE A MACRO

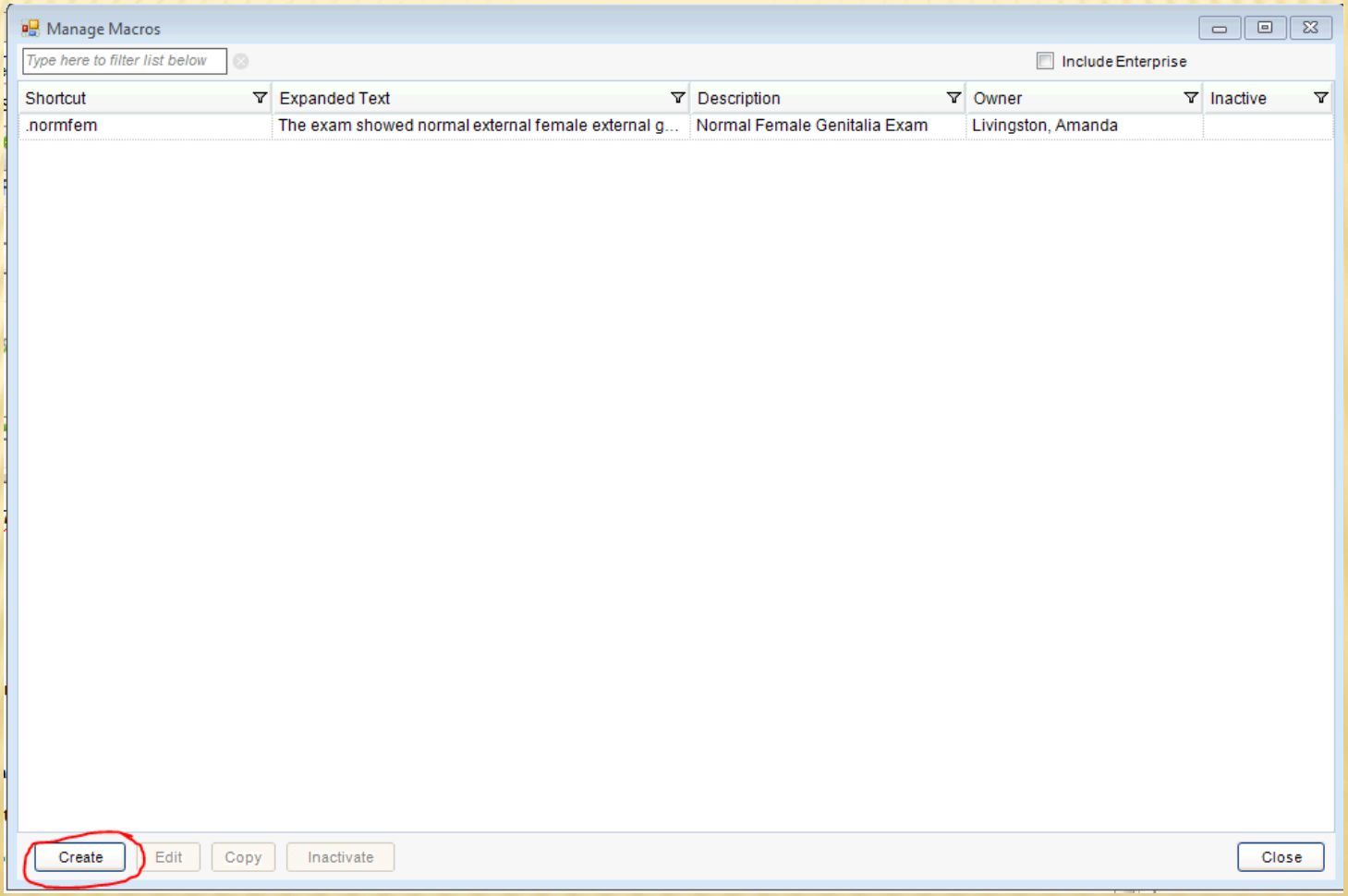
Click the macro button.



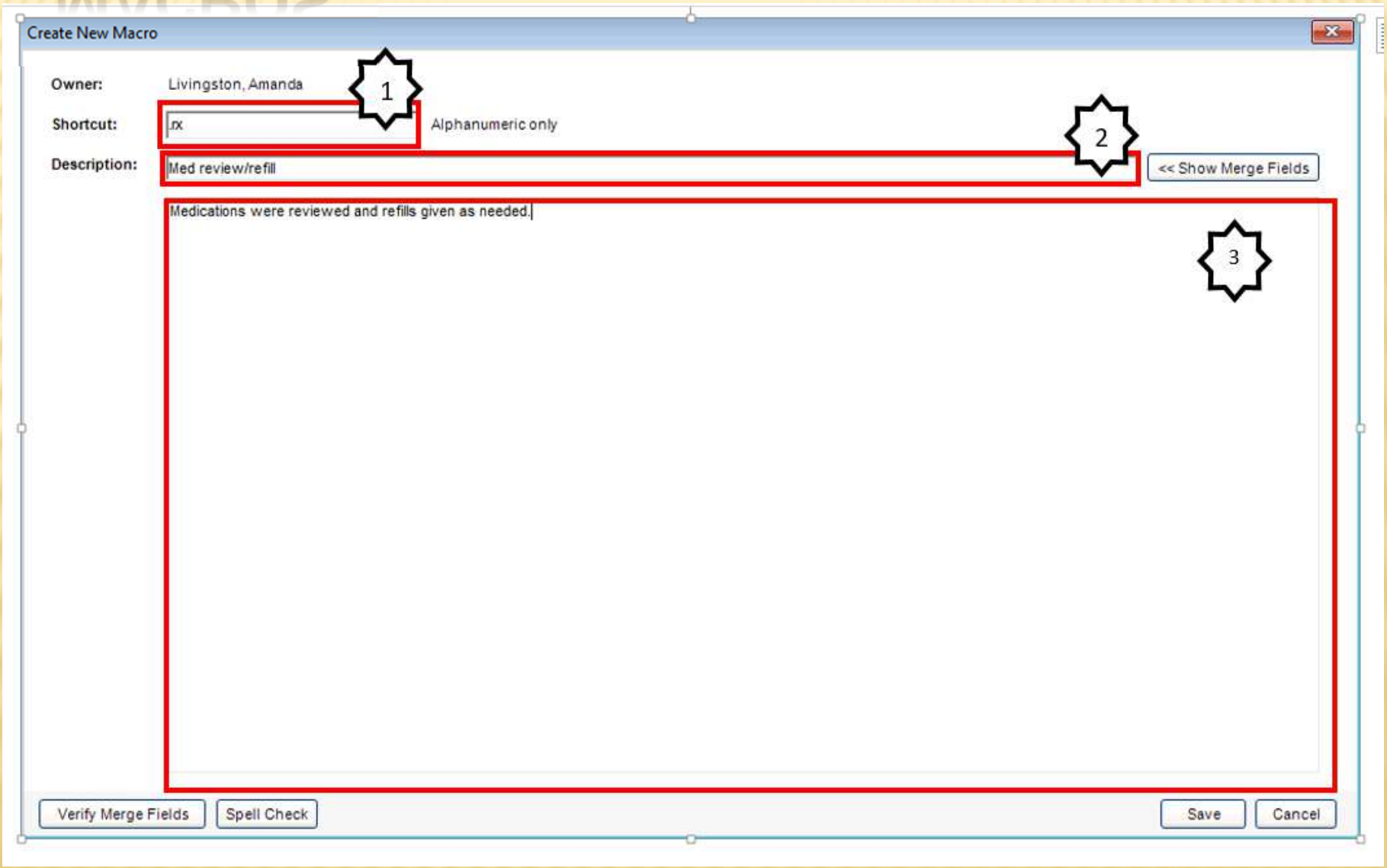


MACRO CREATION

A Macros Edit box will appear for you to begin creating. Click Create.



MACROS


Create New Macro
Owner:
Livingston, Amanda
1
Shortcut:
.rx
Alphanumeric only
2
Description:
Med review/refill
<< Show Merge Fields
Medications were reviewed and refills given as needed.
3
Verify Merge Fields
Spell Check
Save
Cancel

MACRO COMPONENTS

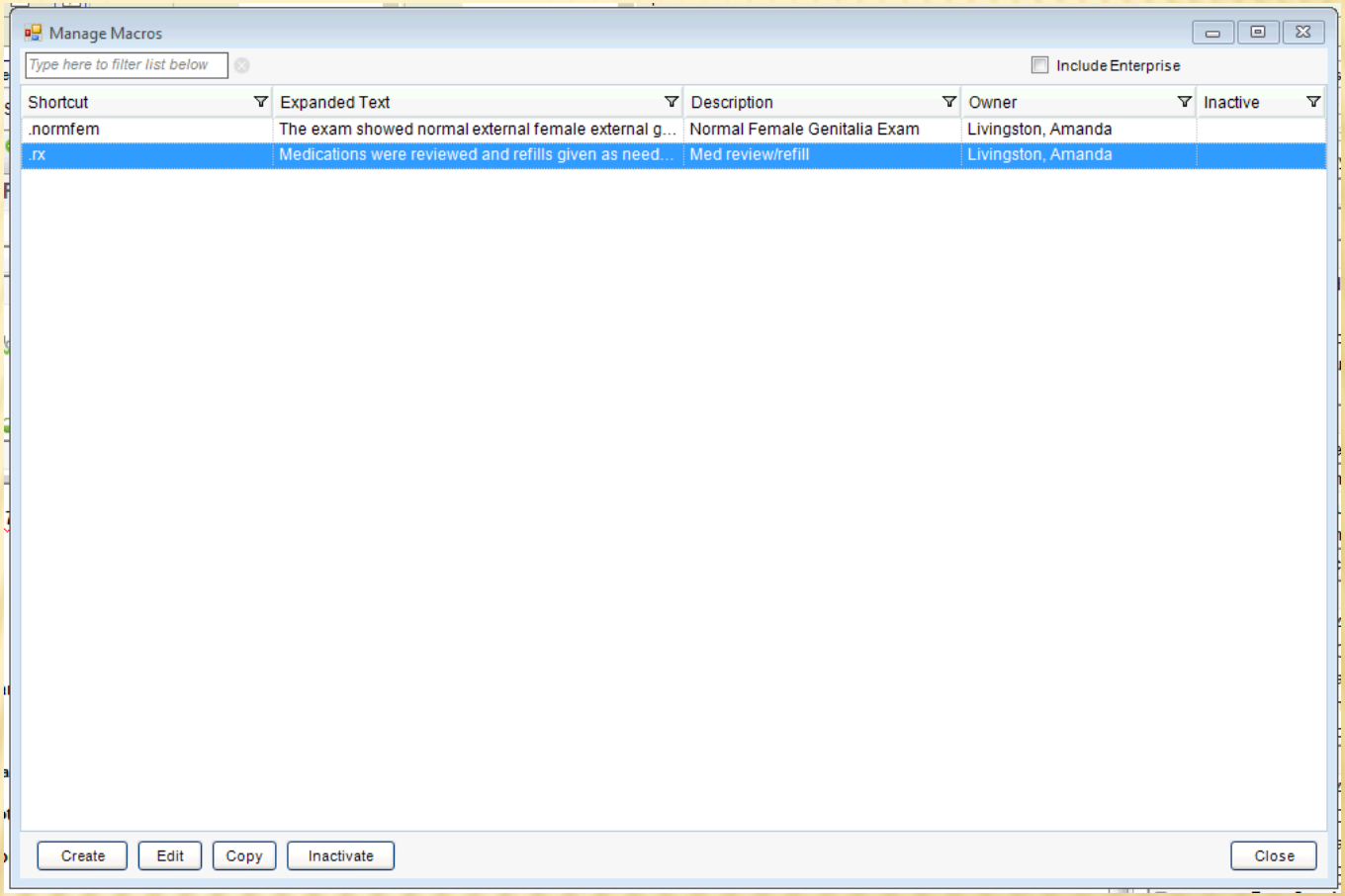
1. **Shortcut** will allow you to put in your short phrase for your macro.

2. **Description** will explain what the macro is for.

3. Information placed into the text field will be distributed in the area your macro is placed.

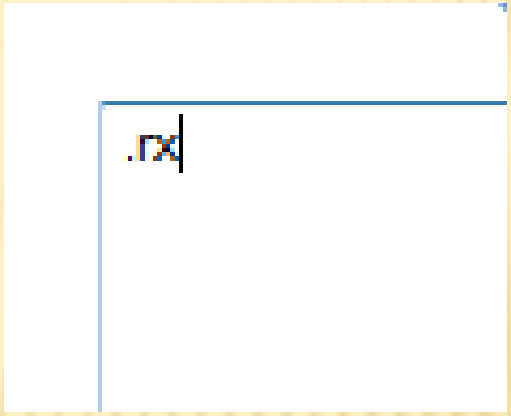
SAVE YOUR MACRO

Save your macro. The new macro will be added to your Manage Macros list. From this window, you can Create, Edit, and Inactivate. They are not removed easily from the system.



TO ADD MACRO IN ALLSCRIPTS

To add, just type whatever your shortcut name is wherever you want your macro to populate. Be sure to begin with the period. Enter the macro shortcut. Then click the enter key on your keyboard.



Medications were reviewed and refills given as needed.

You have now completed all of the required modules for Allscripts EHR 17.1 training. Please be sure to complete the quiz by following the link beneath the modules.