

Dynamic Documentation—An Introduction

This document includes minor updates to reflect the appearance and functionality of MPage 6.9.

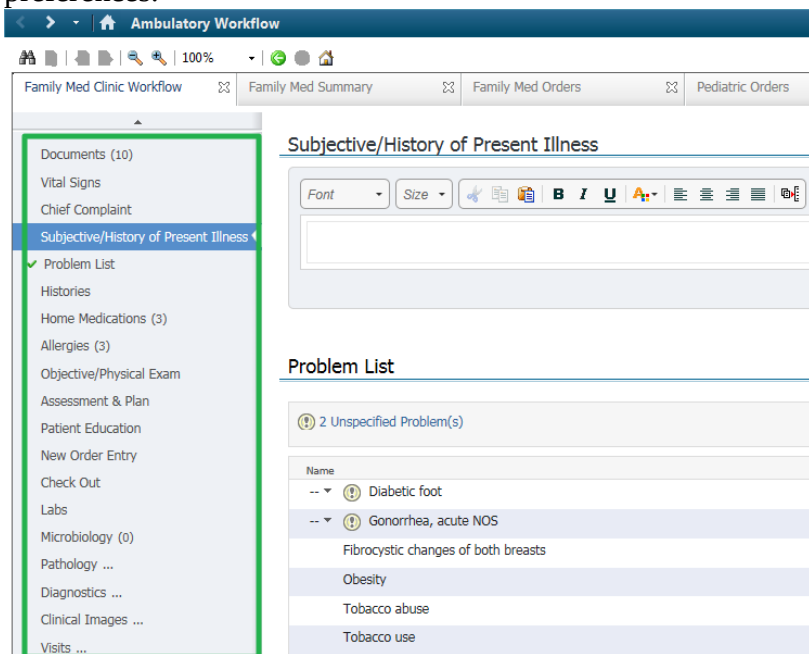
Dynamic Documentation, or DynDoc for short, is the current way to create notes in the Cerner Millennium EHR. It's the way most of our venues will create notes. (The older method, PowerNote, will still be used in a few venues, and wherever faculty instruct residents/students to use it.) Over time, PowerNote will gradually be phased out, while DynDoc will be further developed.

DynDoc allows you to combine the “structured data” elements of the medical record—things like med list, allergy list, problem list, etc.—with the “today’s encounter” aspects of the note, like the HPI, ROS, physical exam, and assessment/plan, in a way that looks less like the point-and-click medical note used in PowerNote and older EHRs. It creates a note that is more readable, and, for many commonly used notes, concisely places the “today” parts of the note in one column on the left, with the “structured data” parts of the note on the right. DynDoc uses document templates specific to your needs at the time, be that an outpatient clinic note, an H&P, operative note, discharge summary, or other type of note.

There are two ways to create a DynDoc. Neither is inherently better, and you can mix and match them.

METHOD 1

The first way is to work through a “workflow” tab, or MPage, putting your notes in various appropriate fields for the HPI, ROS, physical exam, assessment/plan, etc. You can use navigation on the left to move through these fields, and you can rearrange them to suit your preferences:



Make entries in each field via typing, AutoText, or Dragon voice transcription:

Subjective/History of Present Illness Selected visit

Tahoma 9

32 year old female in with 2 wks of right posterior neck pain. Started while painting the kitchen, but has continued to nag her since then. No major injury. She's had occasional neck pain in the past, but nothing major, & nothing this persistent. No headache, fever, nausea/vomiting. She's tried ibuprofen & a heat pad with mild relief. It gets worse at work; sits at a computer most all day.

Save

Update structured data as necessary. For example, select the billing diagnoses, add to the problem list, prescribe meds, etc.:

Problem List Classification: Medical and Patient Stated

Add new as: This Visit

Neck strain (847.0, S16.1XXA)

Neck muscle strain (847.0, S16.1XXA)

Strain of neck (847.0, S16.1XXA)

Strain of neck muscle (847.0, S16.1XXA)

Strain of tendon of neck (847.0, S16.1XXA)

Acute strain of neck muscle (847.0, S16.1XXA)

Repetitive strain injury of neck (847.0, S16.1XXA)

Name	Classification
Diabetic foot	Medica
Fibrocystic changes of both breasts	Medica
Obesity	Medica
Tobacco abuse	Medica

You may next want to select your encounter charge. The easiest way to do that is via QuickOrders. Select your charge:

Ambulatory Workflow

Family Med Clinic Workflow | Family Med Summary | Family Med Orders

Venue: Ambulatory - In Office (Meds in Office)

E/M Charges	Labs	Procedures
New Patient Visits Established Patient Office Visit Office Visit Level 1 Est 99211 Office Visit Level 2 Est 99212 Office Visit Level 3 Est 99213 Office Visit Level 4 Est 99214 Office Visit Level 5 Est 99215 New Patient Preventive Initial Comp Preventive Med less than 1 year New 99381 Initial Comp Preventive Med 1 to 4 years New 99382 Initial Comp Preventive Med 5 to 11 years New 99383 Initial Comp Preventive Med 12 to 17 years New 99384	Common Labs Amylase Level AST Bilirubin Total Calcium Level Total CK D-Dimer Drug Screen Urine Folate Serum Free T4 Glucose Random hCG Qualitative Serum hCG Quantitative	Skin Procedures Other Asp/Inj jo Asp/inj jo Asp/Inj jo Circumcis d Tx lysee Colposcop CV Stress 93016 Overnight Manual Er POC Pure Tone Removal

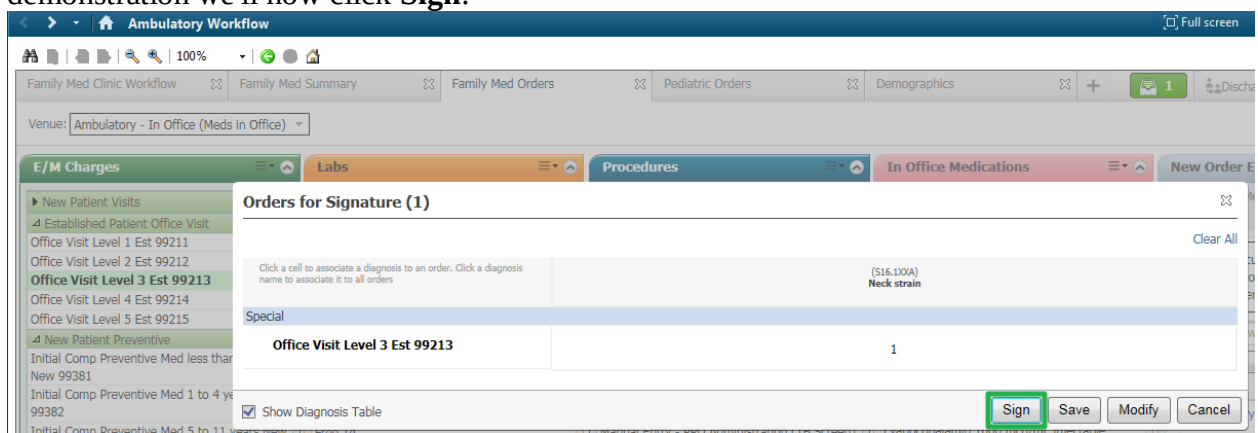
Order Synonym: Office Visit Level 3 Est 99213

Order Sentence:

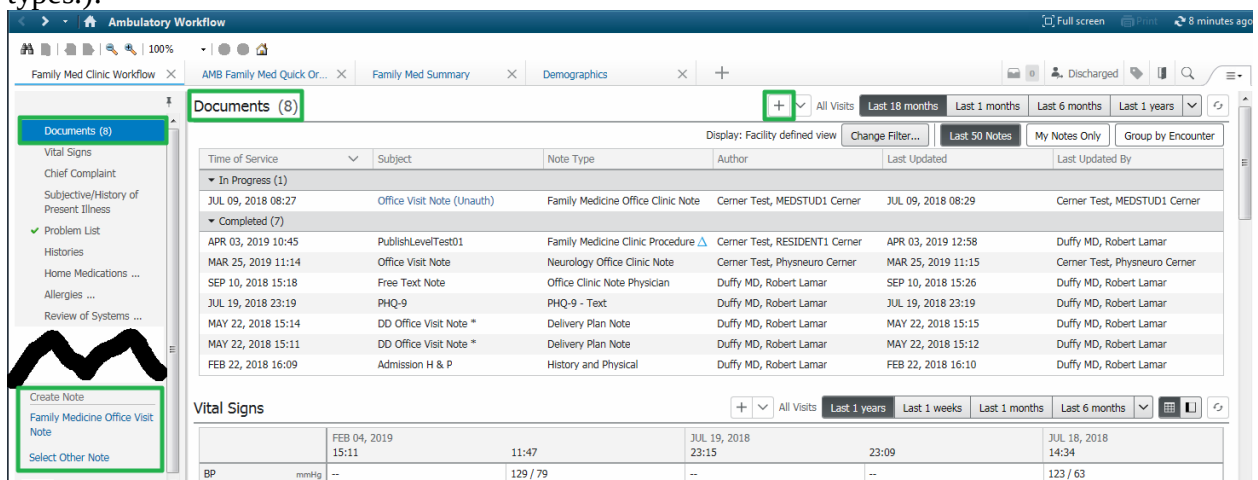
Then click the **Orders For Signature** "Checkout Cart" button to sign/modify your charge orders as needed:



You can modify the charge order and associate with diagnoses as necessary. For this demonstration we'll now click **Sign**:



After doing that, you can create your note in a few ways, such as the **Documents + Sign**, or one of the options under Create Note at the bottom of the navigation. (Clicking Select Other Note is the same as clicking the **Documents + Sign**, and there are also shortcuts to other common note types.):



Select the **Note Type**:

Documentation

+ Add - [Icons]

New Note X List

Note Type List Filter:
Position

*Type:

- Allergy Record
- Annual Wellness Exam
- Consultation Note Generic
- Delivery Plan Note
- Discharge Summary
- Family Medicine Clinic Procedure
- Family Medicine Consultation
- Family Practice Office Clinic Note
- History and Physical
- Home Health Note
- Home Health Orders
- Hospice Note
- Implant Device Record
- Long term Care Progress Note
- Operative Report
- Progress Note Generic
- Well Child Check

CDT

*Note Templates

Name	Description
Admission H & P	Admission History & Physical Note Template
APSO Note	APSO Note Template
Brief Procedure Note	Brief Procedure Note
Consult Note	Consultation Note Template
Discharge Summary	Discharge Summary
Free Text Note	Free Text Note Template
Letter	Letter
Office Visit Note	Office Visit Note Template
Procedure Note	Procedure Note Template
Progress Note	Daily Progress Note Template
Progress/SOAP Note	Daily Progress/SOAP Note Template
SOAP Note	SOAP Note Template

Double-click your desired template. You can also type whatever note title you prefer, or as recommended in your clinic/specialty:

Documentation

+ Add - [Icons]

New Note X List

Note Type List Filter:
Position

*Type:
Family Practice Office Clinic Note

Title:
Office Visit Note

*Date:
9/11/2016 1842 CDT

*Author:
Duffy MD, Robert Lamar

*Note Templates

Name	Description
Admission H & P	Admission History & Physical Note Template
APSO Note	APSO Note Template
Brief Procedure Note	Brief Procedure Note
Consult Note	Consultation Note Template
Discharge Summary	Discharge Summary
Free Text Note	Free Text Note Template
Letter	Letter
Office Visit Note	Office Visit Note Template
Procedure Note	Procedure Note Template
Progress Note	Daily Progress Note Template

You can manually change the note title as desired.

The note is created in the chosen format, combining the structured data elements, nurse-entered data, and your notes:

Documentation

Office Visit Note

Tahoma

Chief Complaint
Neck pain.

Assessment/Plan
1. Neck strain

History of Present Illness
32 year old female in with 2 wks of right posterior neck pain. Started while painting the kitchen, but has continued to nag her since then. No major injury. She's had occasional neck pain in the past, but nothing major, & nothing this persistent. No headache, fever, nausea/vomiting. She's tried ibuprofen & a heat pad with mild relief. It gets worse at work; sits at a computer most all day.

Review of Systems

Physical Exam
Vitals & Measurements
T: 37 °C (Tympanic) HR: 77 (Peripheral) RR: 14 BP: 138/80 HT: 160 cm BMI: 30

Problem List/Past Medical History
Diabetic foot
Fibrocystic changes of both breasts
Obesity
Tobacco abuse
Historical
Pregnant
Pregnant

Procedure/Surgical History
Cholecystectomy
Arthroscopy right knee (Frayed cartilage cleaned up.)
ORIF right ankle

Medications
acetaminophen 325 mg oral tablet, 650 mg, 2 tabs, Oral, q4 hr interval, PRN
Klonopin 2 mg oral tablet, 2 mg, 1 tabs, Oral, BID, PRN
Mirena, 1 EA, IntraUteral, One Time

Allergies
Asparagus (Foul-smelling urine)
Lortab (itching, watering eyes)
codeine (nausea)

Social History
Alcohol
Current user, Daily, Average drinks per day: 2. Alcohol use interferes with work or home: No. Drinks more than intended: Yes. Others hurt by drinking: No.
Employment/School
Part time, Work/School description: Azalea maintenance. Workplace hazards: Traffic.
Exercise
Minutes per day: 0. Physical Activity Intensity: Light.
Home/Environment
Lives with Children.
Sexual
Sexually active: Yes. Current Number of Partners 2. Sexual orientation: Heterosexual. Are your partners: Male. Uses condoms: No. Other contraceptive use: IUD.
Substance Use
Marijuana, 1-2 times per month

Note Details: Family Practice Office Clinic Note, Duffy MD, Robert Lamar, 9/11/2016 6:42 PM CDT, Office Visit Note

Sign/Submit Save Save & Close Cancel

METHOD 2

Now let's look at the other way to start a DynDoc. Instead of going through the fields in the workflow tab as above, go straight to creating the note via one of the appropriate links on navigation list:

Ambulatory Workflow

Family Med Clinic Workflow

Documents (8)

Time of Service Subject Note Type Author Last Updated Last Updated By

▼ In Progress (1)

JUL 09, 2018 08:27 Office Visit Note (Unauth) Family Medicine Office Clinic Note Cerner Test, MEDSTUD1 Cerner JUL 09, 2018 08:29 Cerner Test, MEDSTUD1 Cerner

▼ Completed (7)

APR 03, 2019 10:45 PublishLevelTest01 Family Medicine Clinic Procedure Cerner Test, RESIDENT1 Cerner APR 03, 2019 12:58 Duffy MD, Robert Lamar

MAR 25, 2019 11:14 Office Visit Note Neurology Office Clinic Note Cerner Test, Physneuro Cerner MAR 25, 2019 11:15 Cerner Test, Physneuro Cerner

SEP 10, 2018 15:18 Free Text Note Office Clinic Note Physician Duffy MD, Robert Lamar SEP 10, 2018 15:26 Duffy MD, Robert Lamar

JUL 19, 2018 23:19 PHQ-9 PHQ-9 - Text Duffy MD, Robert Lamar JUL 19, 2018 23:19 Duffy MD, Robert Lamar

MAY 22, 2018 15:14 DD Office Visit Note * Delivery Plan Note Duffy MD, Robert Lamar MAY 22, 2018 15:15 Duffy MD, Robert Lamar

MAY 22, 2018 15:11 DD Office Visit Note * Delivery Plan Note Duffy MD, Robert Lamar MAY 22, 2018 15:12 Duffy MD, Robert Lamar

FEB 22, 2018 16:09 Admission H & P History and Physical Duffy MD, Robert Lamar FEB 22, 2018 16:10 Duffy MD, Robert Lamar

Vital Signs

BP mmHg -- 129 / 79 -- 123 / 63

Select your Note Type and Template; we'll use the same choices as above, resulting in:

Documentation

Office Visit Note

Tahoma

Chief Complaint
Neck pain.

Assessment/Plan
1. Neck strain

History of Present Illness

Review of Systems

Physical Exam

Vitals & Measurements
T: 37 °C (Tympanic) HR: 77 (Peripheral) RR: 14 BP: 138/80 HT: 160 cm BMI: 30

Problem List/Past Medical History
Diabetic foot
Fibrocystic changes of both breasts
Obesity
Tobacco abuse
Historical
Pregnant
Pregnant

Procedure/Surgical History
Cholecystectomy
Arthroscopy right knee (Frayed cartilage cleaned up.)
ORIF right ankle

Medications
acetaminophen 325 mg oral tablet, 650 mg, 2 tabs, Oral, q4 hr interval, PRN
Klonopin 2 mg oral tablet, 2 mg, 1 tabs, Oral, BID, PRN
Mirena, 1 EA, IntraUteral, One Time

Allergies
Asparagus (Foul-smelling urine)
Lortab (Itching, Watering Eyes)
codeine (nausea)

Social History
Alcohol
Current user, Daily, Average drinks per day: 2. Alcohol use interferes with work or home: No. Drinks more than intended: Yes. Others hurt by drinking: No.
Employment/School
Part time, Work/School description: Azalea maintenance. Workplace hazards: Traffic.
Exercise
Minutes per day: 0. Physical Activity Intensity: Light.
Home/Environment
Lives with Children.
Sexual
Sexually active: Yes. Current Number of Partners 2. Sexual orientation: Heterosexual. Are your partners: Male. Uses condoms: No. Other contraceptive use: IUD.
Substance Use
Marijuana, 1-2 times per month

Note Details: Family Practice Office Clinic Note, Duffy MD, Robert Lamar, 9/11/2016 6:42 PM CDT, Office Visit Note

Sign/Submit Save Save & Close Cancel

Your document is created, though this time there is no HPI, ROS, physical exam, or assessment/plan information, since you haven't entered it yet. But you can click into each section and enter it just like you did before, via typing, AutoText, or voice transcription. Here we'll type the same HPI, & use AutoText to enter a negative ROS:

Documentation

Office Visit Note

Tahoma

Chief Complaint
Neck pain.

Assessment/Plan
1. Neck strain

History of Present Illness
32 year old female in with 2 wks of right posterior neck pain. Started while painting the kitchen, but has continued to nag her since then. No major injury. She's had occasional neck pain in the past, but nothing major, & nothing this persistent. No headache, fever, nausea/vomiting. She's tried ibuprofen & a heat pad with mild relief. It gets worse at work; sits at a computer most all day.

Review of Systems
;fm_

fm_AdultNegROS *
;fm_AdultNormBrierPE *
;fm_AdultNormPE *
;fm_ChildNegROS *
;fm_ChildNormPE *
;fm_InfantNegROS *
;fm_InfantNormPE *

Complete other elements as necessary.

If you have structured data to change, tests to order, etc, you can save the note:

Documentation

Office Visit Note

Tahoma

Neuro: [No dizziness, headache, or focal weakness].
Integumentary: [No pruritus or rash].
Musculoskeletal: [No joint pain or neck/back pain].
Hema/Lymph: [No lymphadenopathy].

Physical Exam

Vitals & Measurements
T: 37 °C (Tympanic) HR: 77 (Peripheral) RR: 14 BP: 138/80 HT: 160 cm BMI: 30

General: [In no acute distress].
HEENT: [Ear canals without excessive wax or inflammation. TM's benign. Nose clear. Throat without redness or drainage].
Neck: [Supple, nontender. Without masses or frank adenopathy. No overt thyromegaly].
Lungs: [Clear. Normal respiratory effort].
Heart: [Regular rate & rhythm without murmur].
Abdomen: [Nontender].
Musculoskeletal: Right posterior neck pain, radiating over right upper back. No radicular component. ROM slightly limited by pain. No motor or sensory deficit.]

Lortab (itching, watering eyes)
codeine (nausea)

Social History

Alcohol
Current user, Daily, Average drinks per day: 2. Alcohol use interferes with work or home: No. Drinks more than intended: Yes. Others hurt by drinking: No.

Employment/School
Part time, Work/School description: Azalea maintenance. Workplace hazards: Traffic.

Exercise
Minutes per day: 0. Physical Activity Intensity: Light.

Home/Environment
Lives with Children.

Sexual
Sexually active: Yes. Current Number of Partners 2. Sexual orientation: Heterosexual. Are your partners: Male. Uses condoms: No. Other contraceptive use: IUD.

Substance Use
Marijuana, 1-2 times per month

Tobacco
Current every day smoker, Type: Cigarettes, per day 1.5 packs. Ready to change: No. No 14. Patient successfully completed smoking cessation education within last year: No. No Smoking/Tobacco Cessation Teaching completed. Patient refused instruction Reasons Smoking/Tobacco Cessation Teaching not yet completed:..

Family History
Alzheimer's disease: Grandfather (M).
Colon cancer: Grandfather (M).
Heart disease: Grandfather (P).
Hypertension: Mother, Grandfather (M) and Grandmother (M).
Prostate cancer: Grandfather (P).
Seizures: Brother (Dx at 40).
Stroke: Brother.

Immunizations

Patient Advisories
Health Maintenance

Note Details: Family Practice Office Clinic Note, Duffy MD, Robert Lamar, 9/11/2016 6:42 PM CDT, Office Visit Note

Sign/Submit Save Save & Close Cancel

...and navigate out to do that:

Menu

Ambulatory Workflow

Inpatient Workflow

Maternity Workflow

Well Newborn Workflow

NICU Workflow

Jaundice CPM

Results Review

Orders + Add

Documentation + Add

Allergies + Add

Clinical Images + Add

Problem List

Form Browser

Growth Chart

Health Maintenance

Histories

Immunization Schedule

MAR Summary

Medication List + Add

Notes + Add

Interactive View and I&O

Anticoagulation Workflow

Anticoagulation Bridging

Problem List

Mark all as Reviewed

Diagnosis (Problem) being Addressed this Visit

+ Add Modify Convert Display: All

Priority	Annotated Display	Condition Name	Date	Code	Clinical Dx	Dx Type	Classification
1	Neck strain	Neck strain	9/11/2016	S16.1XXA	Neck strain	Discharge	Medical

Problems

+ Add Modify Convert No Chronic Problems Display: All

	Annotated Display	Condition Name	Onset Date	Code	Name of Problem	Life Cycle St...	Classification
1	Diabetic foot	Diabetic foot		417658010	Diabetic foot	Active	Medical
1	Fibrocystic changes...	Fibrocystic changes of bo...		7052410...	Fibrocystic changes of bo...	Active	Medical
1	Obesity	Obesity		2535065...	Obesity	Active	Medical
1	Pregnant	Pregnant		191073013	Pregnant	Resolved	Medical
1	Pregnant	Pregnant		191073013	Pregnant	Resolved	Medical
1	Tobacco abuse	Tobacco abuse	2000	148820017	Tobacco dependence syn...	Active	Medical
1	Tobacco use	Tobacco use		DCB72...	Tobacco use	Active	Patient Stat...

You may wish to select and sign your encounter charge at this time as well, as shown above.

Return to your note. If you've updated any sections, click that section's **Refresh** button to update that part of the note to include your new entries:

Documentation

+ Add

Office Visit Note X List

Tahoma Size

Chief Complaint
Neck pain.

Assessment/Plan    
1. Neck strain

History of Present Illness
32 year old female in with 2 wks of right posteri
had occasional neck pain in the past, but nothin
mild relief. It gets worse at work; sits at a comp

Whichever way you've done it, by this point the notes are the same. Click **Sign & Submit** to finish and sign the note:

Documentation Full screen Post 14 minutes ago

+ Add

Office Visit Note X List

Tahoma Size

Neuro: [No dizziness, headache, or focal weakness].
Integumentary: [No pruritus or rash].
Musculoskeletal: [No joint pain or neck/back pain].
Hema/Lymph: [No lymphadenopathy].

Physical Exam
Vitals & Measurements
T: 37 °C (Tympanic) HR: 77 (Peripheral) RR: 14 BP: 138/80 HT: 160 cm BMI: 30
General: [In no acute distress].
HEENT: [Ear canals without excessive wax or inflammation. TMs benign. Nose clear. Throat without redness or drainage].
Neck: [Supple, nontender. Without masses or frank adenopathy. No overt thyromegaly].
Lungs: [Clear. Normal respiratory effort].
Heart: [Regular rate & rhythm without murmur].
Abdomen: [Nontender].
Musculoskeletal: Right posterior neck pain, radiating over right upper back. No radicular component. ROM slightly limited by pain. No motor or sensory deficit.]

Lortab (Ibuprofen/Watermark Eyes)
codeine (nausea)

Social History
Alcohol
Current user, Daily, Average drinks per day: 2. Alcohol use interferes with work or home: No. Drinks more than intended: Yes. Others hurt by drinking: No.
Employment/School
Part time, Work/School description: Azalea maintenance. Workplace hazards: Traffic.
Exercise
Minutes per day: 0. Physical Activity Intensity: Light.
Home/Environment
Lives with Children.
Sexual
Sexually active: Yes. Current Number of Partners 2. Sexual orientation: Heterosexual. Are your partners: Male. Uses condoms: No. Other contraceptive use: IUD.
Substance Use
Marijuana, 1-2 times per month
Tobacco
Current every day smoker, Type: Cigarettes, per day 1.5 packs. Ready to change: No. No 14. Patient successfully completed smoking cessation education within last year. No Smoking/Tobacco Cessation Teaching completed. Patient refused instruction Reasons Smoking/Tobacco Cessation Teaching not yet completed.:

Family History
Alzheimer's disease: Grandfather (M).
Colon cancer: Grandfather (M).
Heart disease: Grandfather (P).
Hypertension: Mother, Grandfather (M) and Grandmother (M).
Prostate cancer: Grandfather (P).
Seizures: Brother (Dx at 40).
Stroke: Brother.

Immunizations

Patient Advisories
Health Maintenance

Note Details: Family Practice Office Clinic Note, Duffy MD, Robert Lamar, 9/11/2016 6:42 PM CDT, Office Visit Note

Sign/Submit Save Save & Close Cancel

So when would you choose one method over the other?

- If you're going to complete your note immediately after the visit, it doesn't really matter. Use whichever one you prefer.
- But if you plan to complete your note at a later time, always create the note before you close the chart. Whatever content has been entered thus far by you or the staff will be included, and you can return later to fill in the remaining areas, then sign your note. This effectively does a

snapshot of that content, especially test results, vital signs, etc, as of the moment you saw the patient. If you don't do this, then create your note hours to days later, the note will contain all data *as of that moment*. *This could be potentially confusing* if the patient has had a visit with another provider in the interim, or several more hours of vital signs and test results have appeared since you performed the encounter.

A couple other tips:

- Once you generate the document, the corresponding fields on the workflow tab have been “used” and go blank. (This is so you could use it to generate another note later, e.g., creating several progress notes on the same day.) Once you’ve generated the document, directly edit the document.
- Once you generate the document, don’t refresh the entire document, or you may overwrite information you’ve entered. Just refresh individual sections as desired.
- Some people may like working directly with the document from the start, since this gives you an immediate preview of the document. You know exactly how the finished product will look as you’re creating it, which may be a comfortable and preferable workflow for many users, compared to entering data on the workflow tabs and waiting till the end to see how it will be rendered.