Dynamic Documentation—An Introduction

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

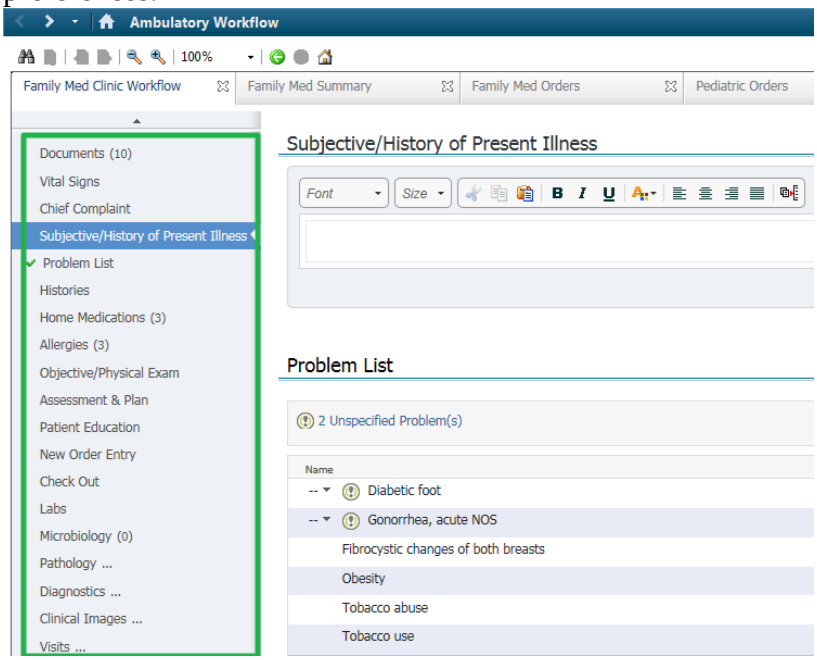
Dynamic Documentation, or DynDoc for short, is the current way to create notes in the Cerner Millennium EHR. It's the way most of our venues will create notes. (The older method, PowerNote, will still be used in a few venues, and wherever faculty instruct residents/students to use it.) Over time, PowerNote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

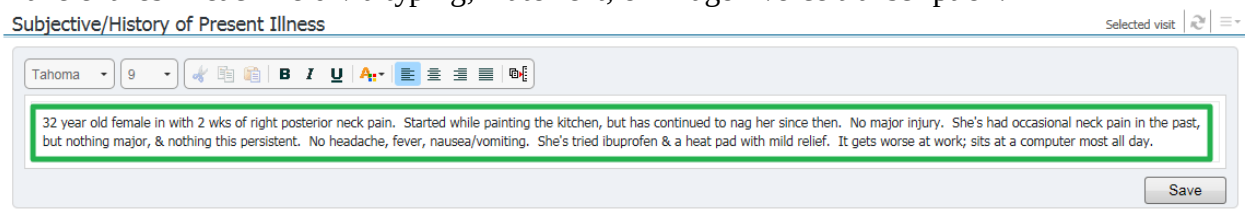
There are two ways to create a DynDoc. Neither is inherently better, and you can mix and match them.

METHOD 1

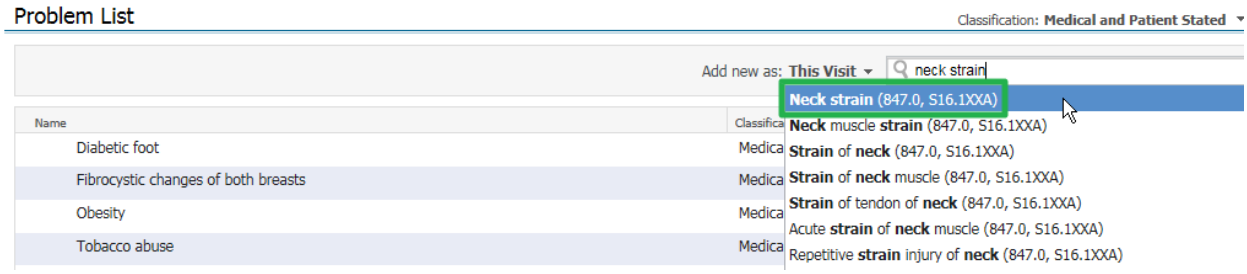
The first way is to work through a "workflow" tab, or MPage, putting your notes in various appropriate fields for the HPI, ROS, physical exam, assessment/plan, etc. You can use navigation on the left to move through these fields, and you can rearrange them to suit your preferences:



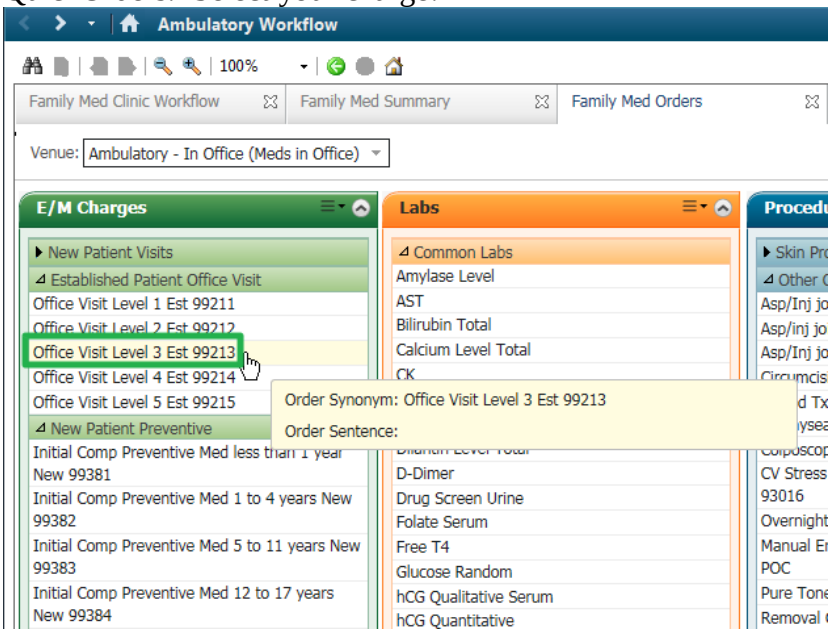
Make entries in each field via typing, AutoText, or Dragon voice transcription:



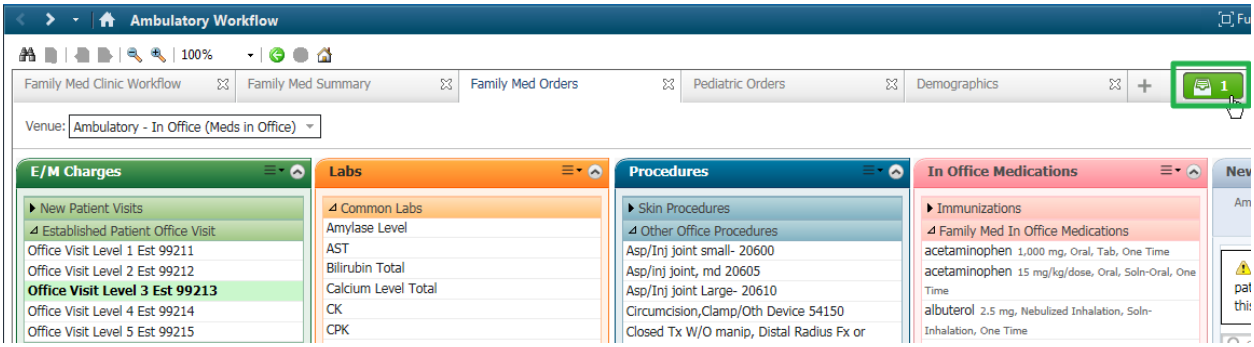
Update structured data as necessary. For example, select the billing diagnoses, add to the problem list, prescribe meds, etc.:



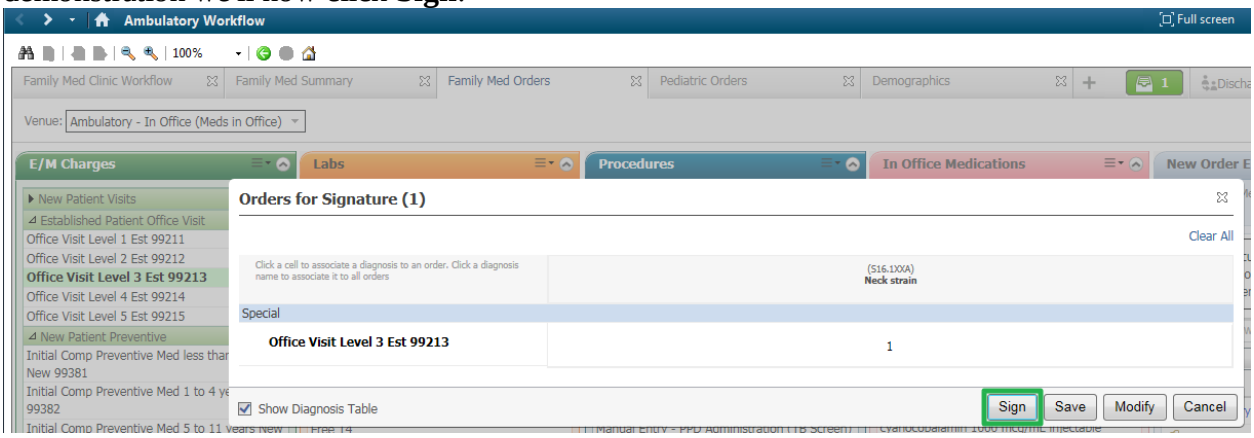
You may next want to select your encounter charge. The easiest way to do that is via QuickOrders. Select your charge:



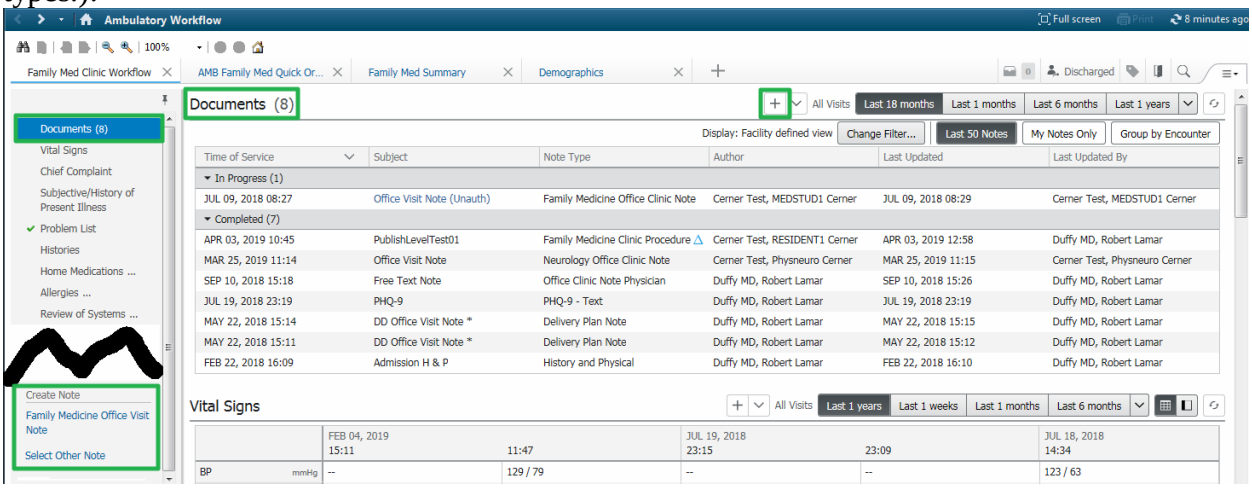
Then click the **Orders For Signature** "Checkout Cart" button to sign/modify your charge orders as needed:



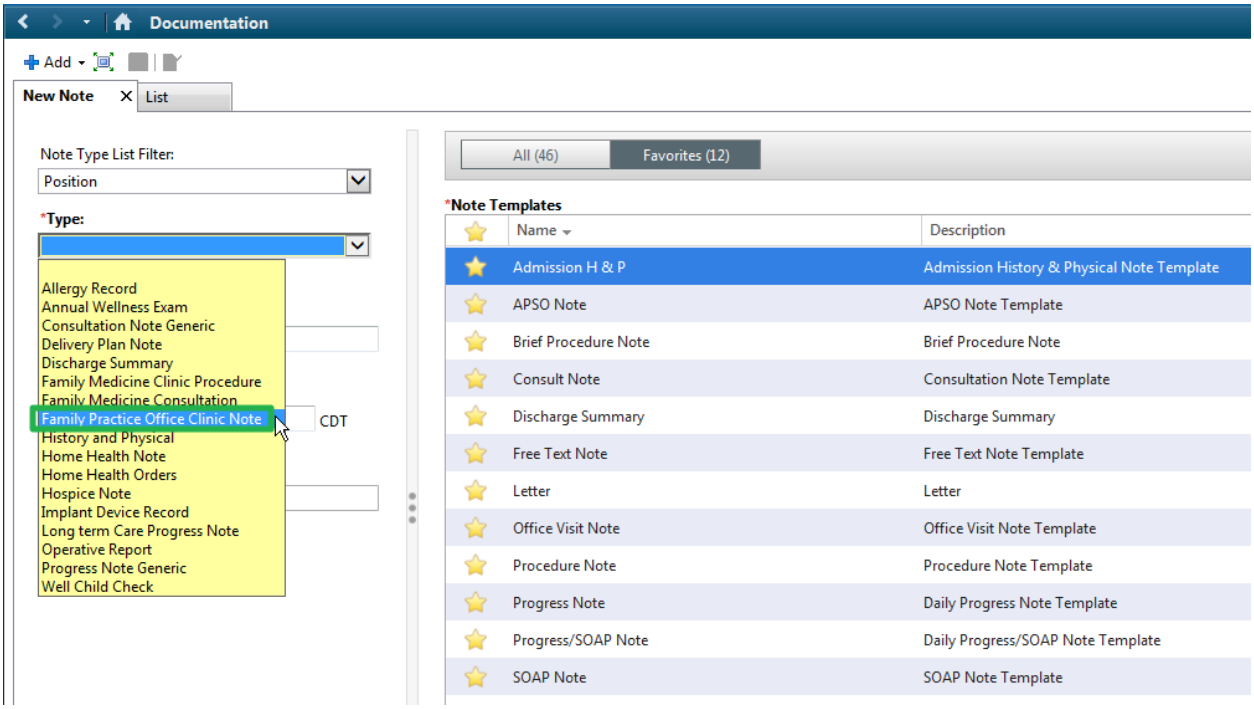
You can modify the charge order and associate with diagnoses as necessary. For this demonstration we'll now click **Sign**:



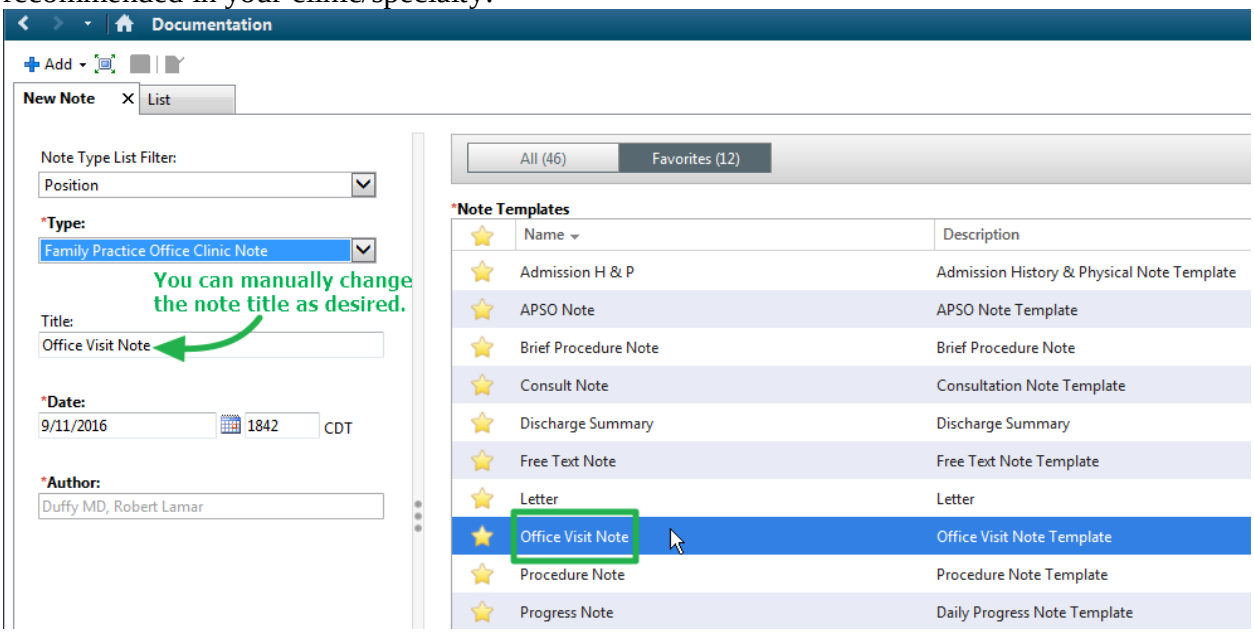
After doing that, you can create your note in a few ways, such as the **Documents + Sign**, or one of the options under Create Note at the bottom of the navigation. (Clicking Select Other Note is the same as clicking the **Documents + Sign**, and there are also shortcuts to other common note types.):



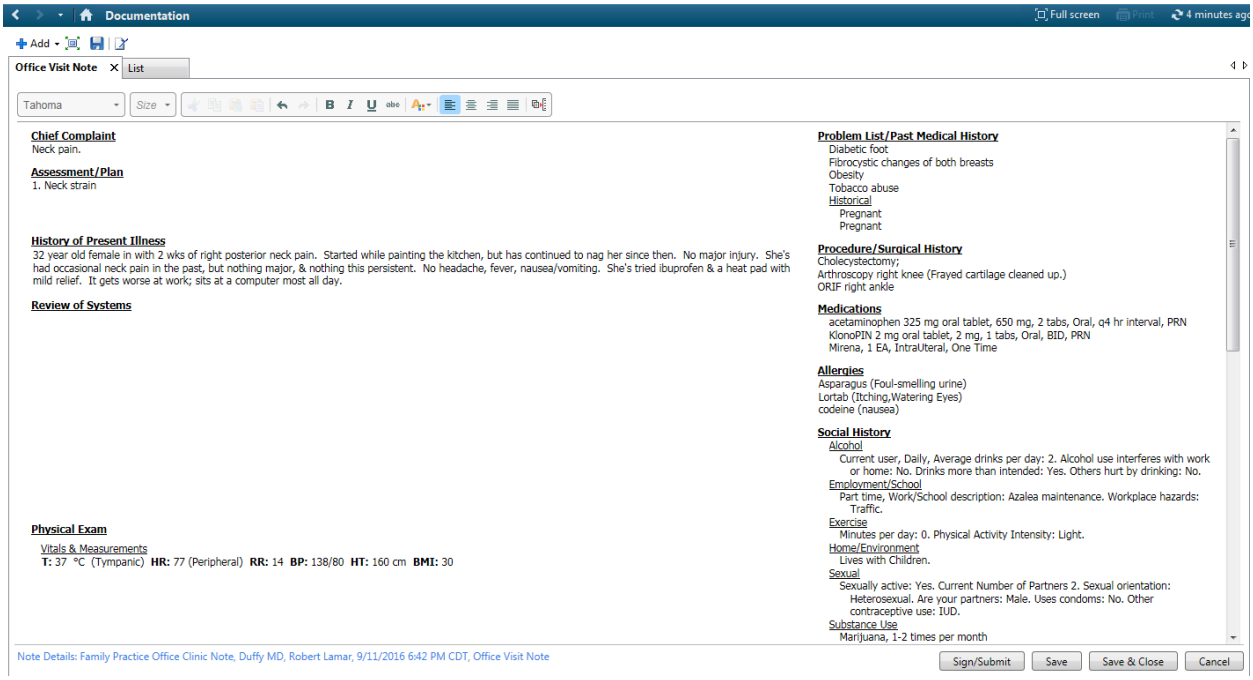
Select the **Note Type**:



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

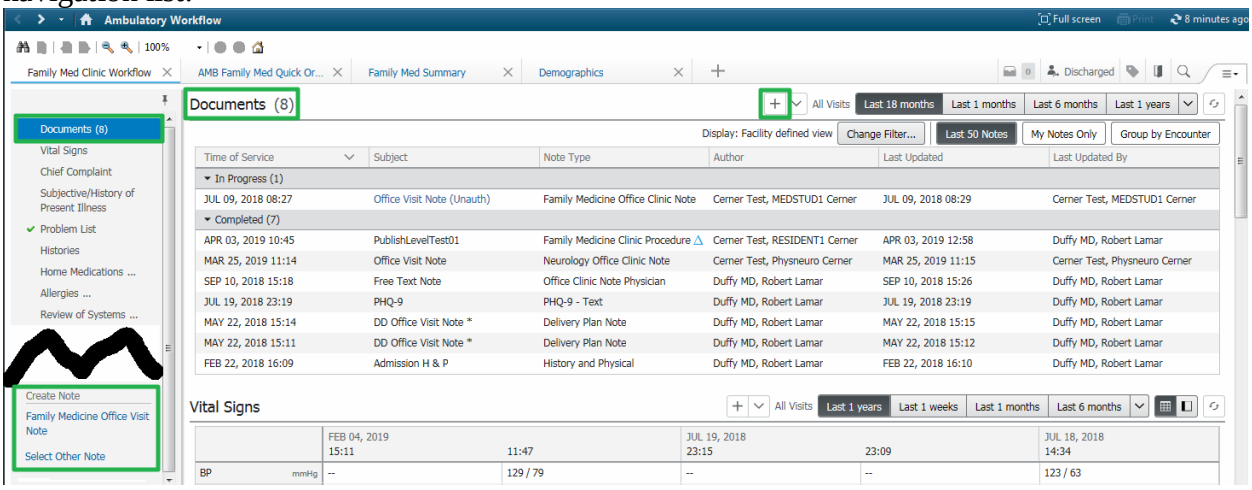


The note is created in the chosen format, combining the structured data elements, nurse-entered data, and your notes:

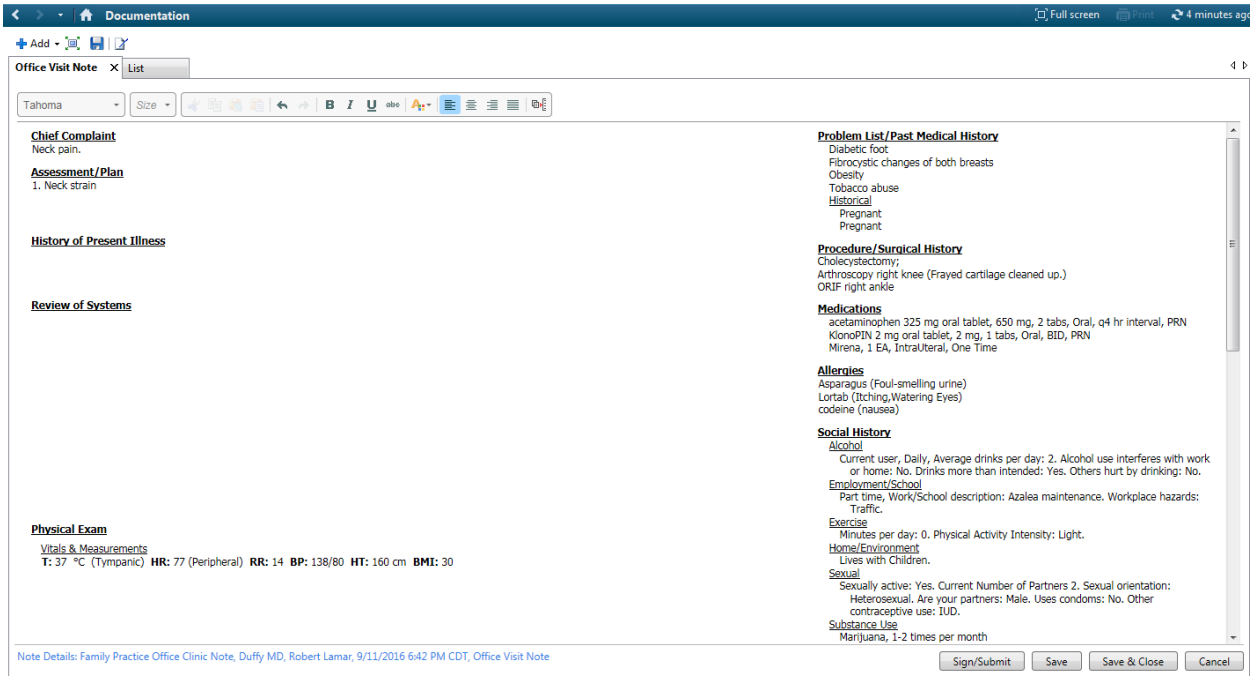


METHOD 2

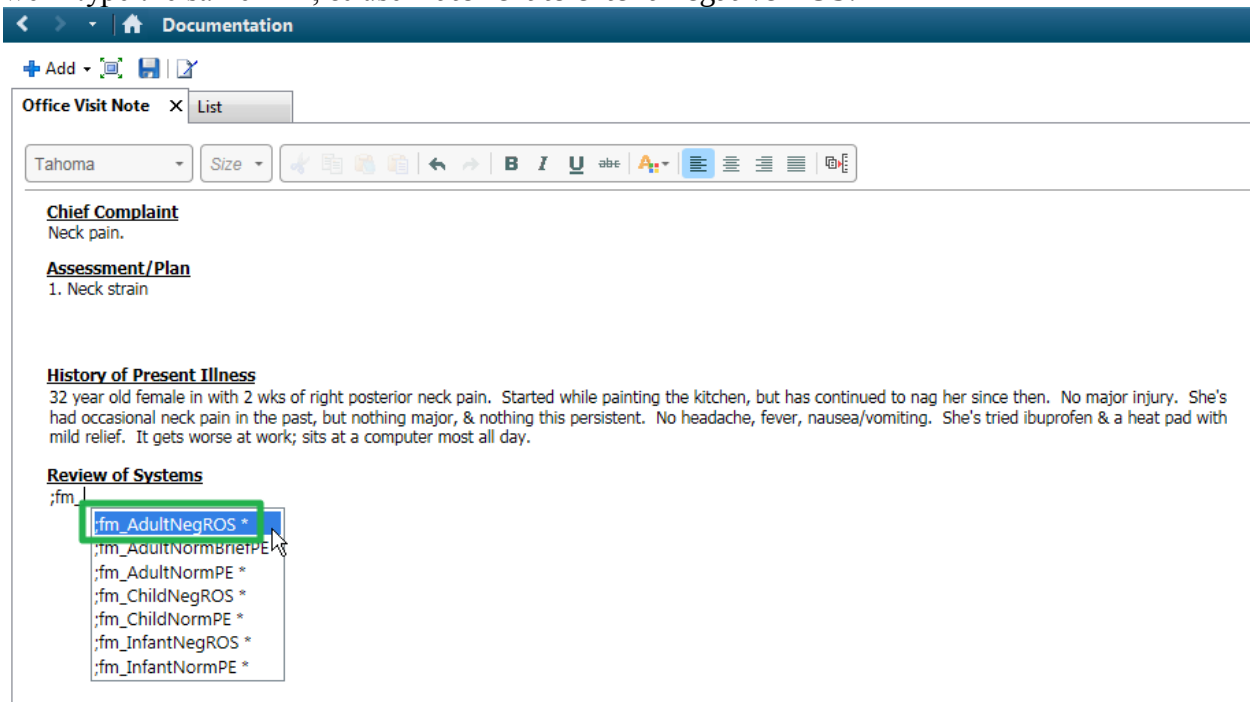
Now let's look at the other way to start a DynDoc. Instead of going through the fields in the workflow tab as above, go straight to creating the note via one of the appropriate links on navigation list:



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

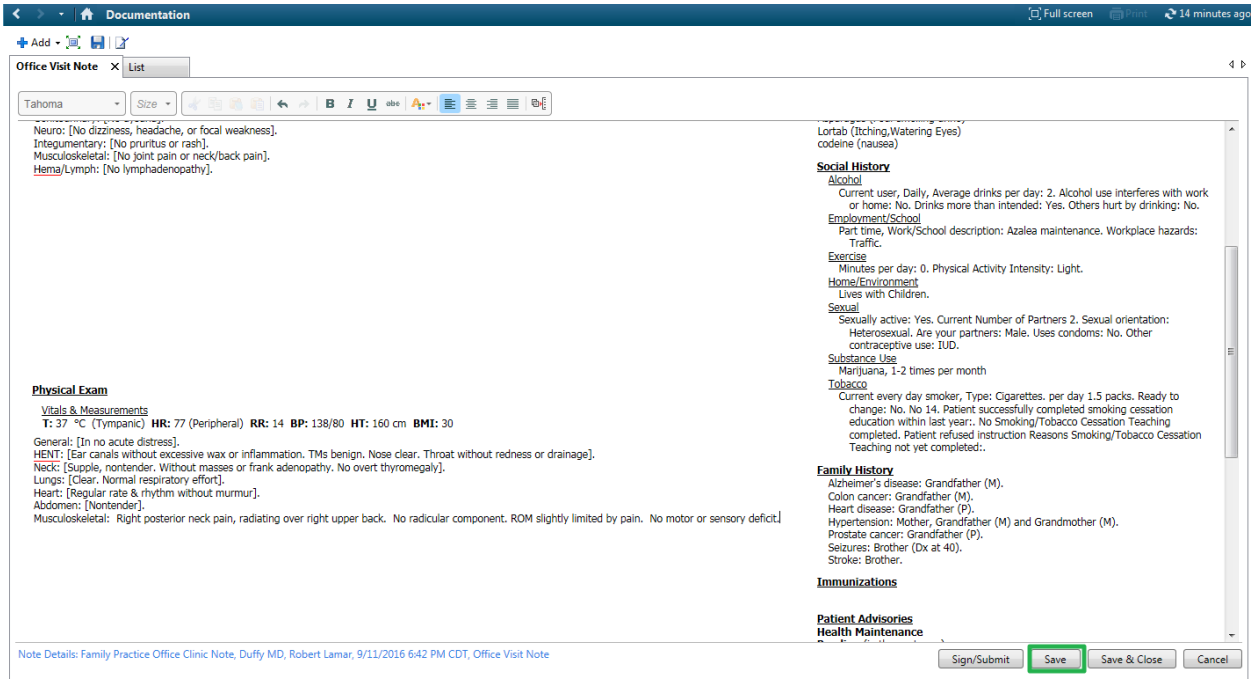


Your document is created, though this time there is no HPI, ROS, physical exam, or assessment/plan information, since you haven't entered it yet. But you can click into each section and enter it just like you did before, via typing, AutoText, or voice transcription. Here we'll type the same HPI, & use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

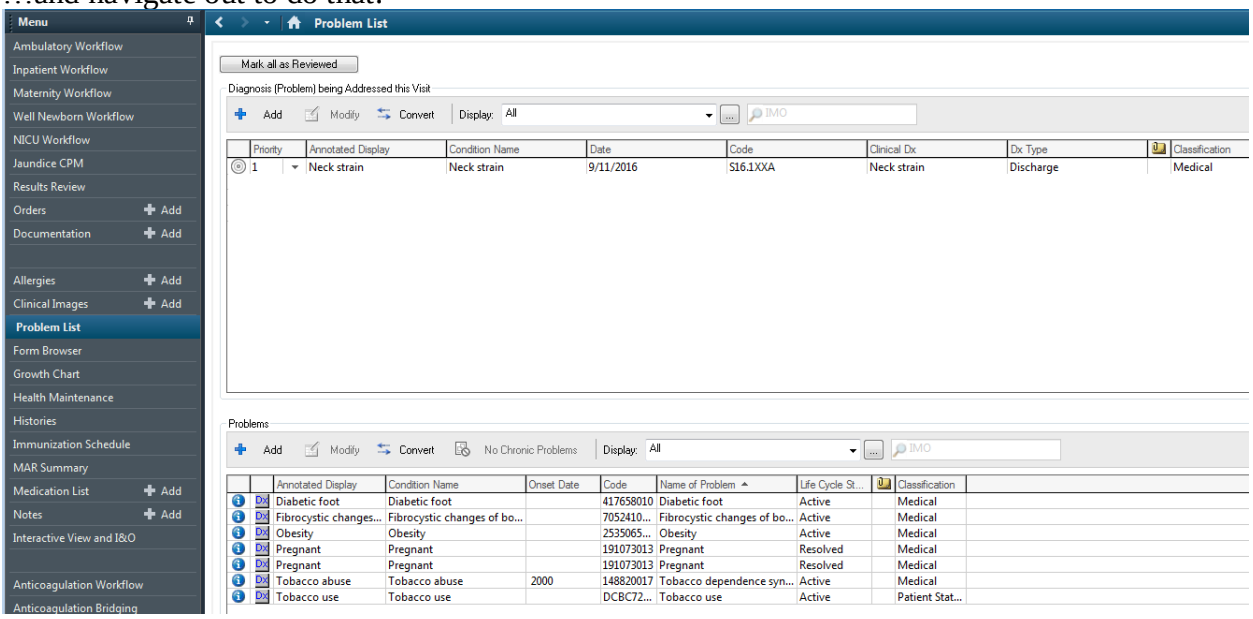


Complete other elements as necessary.

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

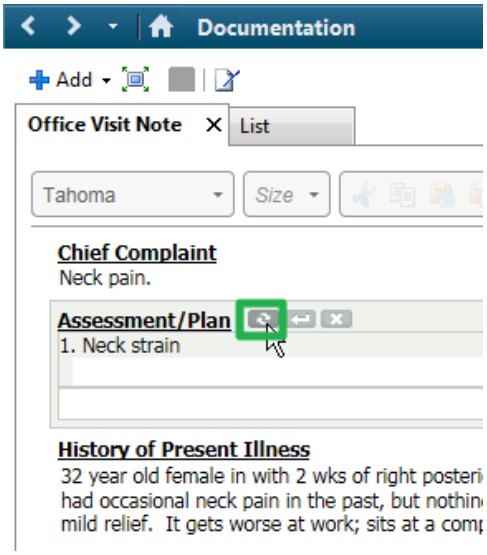


…and navigate out to do that:

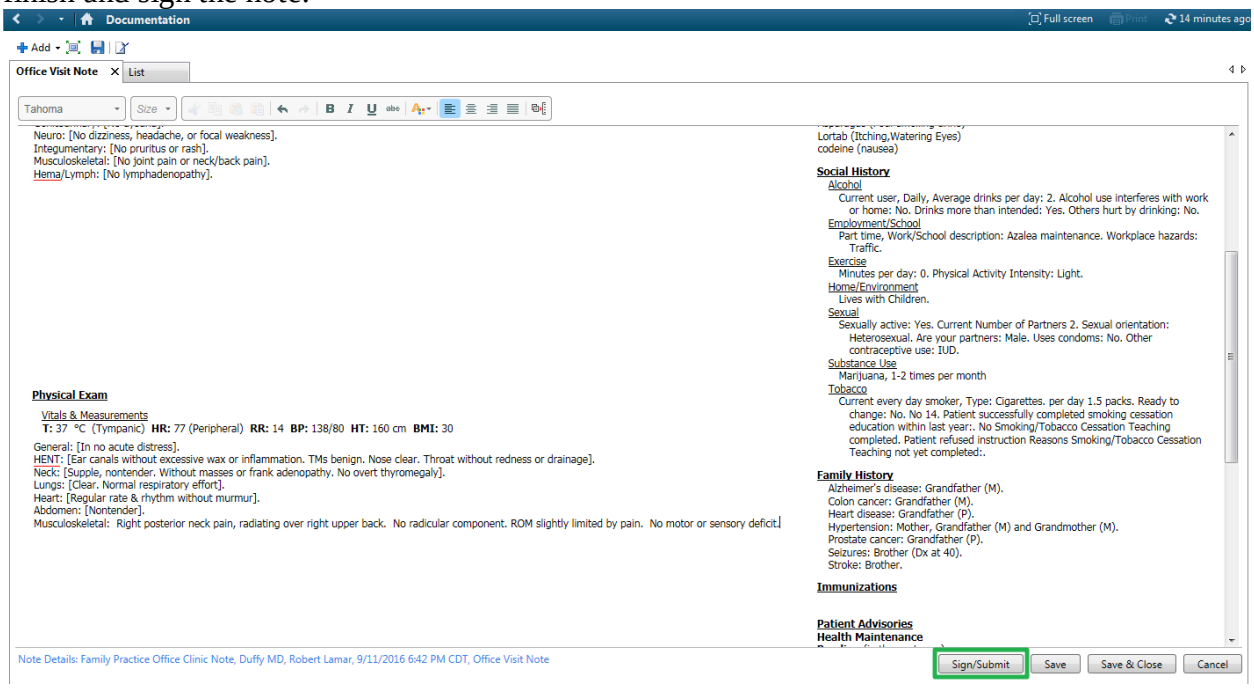


You may wish to select and sign your encounter charge at this time as well, as shown above.

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:



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



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. <u>This effectively does a</u>

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.