Northern Light Health

From the Office of Clinical Informatics

Cerner Millennium
Rehab Lymphedema Workflow

May 12, 2020

On June 15, 2020, the Rehab Optimization project will be implemented, transferring documentation that is occurring on paper or in other systems to electronic documentation within Cerner Millennium. This optimization streamlines workflow and makes documentation easily accessible to providers and other clinical staff. This flyer will outline the new workflow for the Physical, and Occupational Therapist who perform Lymphedema treatment.

Workflow for PT/OT/SLP

- **The patient has been checked into the Outpatient Rehab Clinic.**
- **Evaluation, Daily Notes,** and the **Discharge Summary** documentation forms will be accessed from the **Adhoc folder.**
- **When a Progress Note is nearing being due, the therapist receives an alert and when the Progress Note is due, a task will go to the MPTL for the Progress Note documentation.**

NOTE: Documentation of charges occurs within the Evaluation, Daily Note, Progress Note, and Discharge Summary forms.

Adhoc Folder Structure

- Each Therapy discipline will only see their own Note types in Adhoc.

Documenting a Task from the MPTL

- **Double-click** the desired task to open up the documentation form.
- If all of the required documentation fields have been completed, the task on the MPTL will have a green check mark and have a status of **Complete.**

- **Refresh** the MPTL by clicking the **minutes ago button** to remove the task from the MPTL.
- Forms that do not have all required fields documented will go to the MPTL with a status of **In-Process.**
  - Clicking on an **In-Process task** will open the previously started form.

Evaluation Forms

Key information about the Evaluation form is listed below.

- Locate the **Lymphedema Evaluation form** in the **IRF Therapy** (defaulted open) or in the **Outpatient Therapy** folder in **Adhoc.**

NOTE: DO NOT open the Lymphedema Measurements or the Wound section before the measurements or wound is documented in Interactive View and I & O (iView). This documentation comes into the form in a template. The templates will not pull in data if the sections for Lymphedema Measurements or Wound are not first documented in iView.

- Document the required fields and those sections that are applicable to the patient.
- In the **Assessment** section**, Evaluation Complexity** will populate **Low, Moderate, or High Complexity** based on documentation in the **Evaluation.**
    - Documentation fields that contribute to the calculation are:
        - **Examination of Body Systems** – located in the **Assessment** section.
        - **Clinical Decision Making** – located in the **Assessment** section.
        - **History of Comorbidities/Personal Factors Impacting Plan of Care** – located in the **Past Medical History, Problems, and Diagnosis** section.
        - **Presentation of Characteristics** – located in the **Subjective** section.
            - **OT** does not have this documentation field.
    - If the **Evaluation Complexity** calculation differs from what the therapist has documented, the therapist should review the documentation fields that contribute to the calculation and adjust as needed.
- **Documenting a Problem**
    - Locate and open the **Past Medical History, Problems, and Diagnosis** section.
    - Use the **IMO search** field for entering a **new Problem.**
        - Right-click the newly added Problem to add details such as **Age** or **Date of Onset**.
    - Click **+ Add** to search for Problems that do not come up in IMO Search.
    - Problems should be added if the problem for which the patient is being seen for is not on the **Problem list**, and when the patient reports a new problem.

NOTE: Therapists do NOT add a Problem under Diagnosis (Problem) being Addressed this Visit.

- **Pain Screening-Primary**
    - If Pain education is given to the patient, document **Yes.**
    - Document **Not appropriate at this time** if Pain education is not being given to the patient.
- **Coordination of Care**
    - Use this section to document who care of the patient was coordinated with.
- **Hybrid Time Based Charges** and **Time Spent with Patient sections**
    - Refer to the **Rehab Therapy Charge** flyer for detailed information on documenting charges.
- **Additional Information**
    - Document in this free text box information that does not have a discreet documentation field.
- Click the **SAVE disc icon** to save the **Evaluation** form.
- Close the **Adhoc** Charting window.

- Navigate to **Interactive View and I&O** in the **Menu** (Table of Contents).

Documenting Lymphedema Measurements

Key information about documenting Lymphedema Measurements will be listed here.

- Click **Interactive View and I&O** on the **Menu**.
- Locate and click the **Lymphedema** iView band.
- Select the applicable Lymphedema site for documentation.

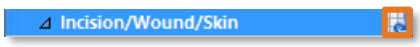
NOTE: **There are subsections for Unaffected Baseline Measurements, and Affected Baseline Measurements. Be careful to document the measurements in the correct section.**

- **Measurement Interval** must be documented in order for the **Volume Calculations** to work.
- Document the **Location** and the measured **Circumference** at the designated measurement Interval.
  - The first measurement will be A and the measurements will proceed up the alphabet.
  - **Volumes** will be A to B, B to C, C to D, etc. A **Total Volume** will also be calculated.
- iView documentation is signed by clicking the **green sign icon**.

Documenting Wounds

Wound documentation takes place in the **Rehab Wound View** iView band.

- **Incision/Wound/Skin Dynamic Group**
  - Click the **Incision/Wound/Skin** dynamic group grid to open the label.



  - The **Label** is where the wound location is documented.
  - Each wound requires its own **Incision/Wound/Skin** dynamic group.
  - In **Abnormality Type**, select the type of wound.
  - Documentation fields will open based on the selection in Abnormality Type.
  - If a wound is healed, **Inactivate the dynamic group** by right-clicking the label and select **Inactivate**. The documentation fields will turn gray and documentation cannot occur within that dynamic group.
  - iView documentation is signed by clicking the **green sign icon.**
  - Now that the iView documentation is complete, the information needs to be pulled into the saved form.

Completing a Saved Form

- Navigate to **Form Browser**.
- Locate the form that has been saved.
- Right-click and select **Modify**. The saved form opens.

- Click in the **Lymphedema Measurements** section to pull in documentation from iView. Documentation from iView displays in the template.
- Click in the **Wound** section to pull in documentation from iView. Documentation from the dynamic group displays in the template.
- Sign the form by clicking the green sign icon.

Changing Documentation Time

- If documentation is not occurring at the time of the assessment, right-click in the **Time EDT** box and select **Insert Date/Time**. This will allow for the documentation to be documented with the time the assessment occurred.
- Enter the appropriate **Date** and **Time**. A new documentation column will open.

Daily Note Forms

- Locate the **Lymphedema Daily Note** in the **Outpatient Therapy** or the **IRF Therapy** folder in **Adhoc**.

NOTE: **The documentation notes content is the same in both the Outpatient Therapy and IRF folders.**

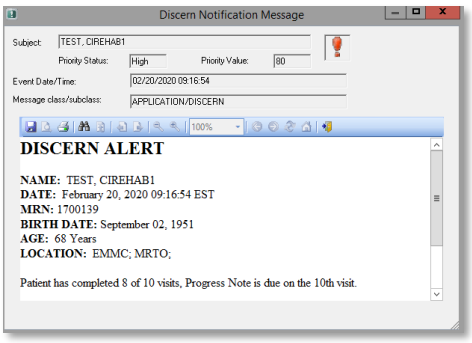
- **Document the required fields and those sections that are applicable to the patient.**

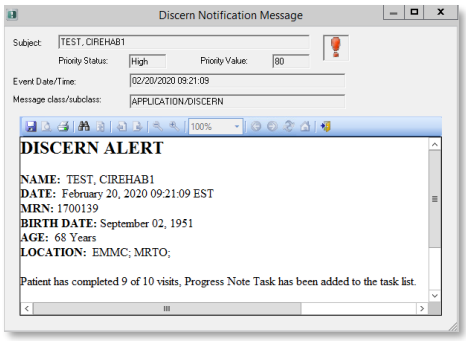
NOTE: **Certain documentation from the Evaluation form will pull forward to the Daily Note. Click in the documented sections to pull in data from the Evaluation.**

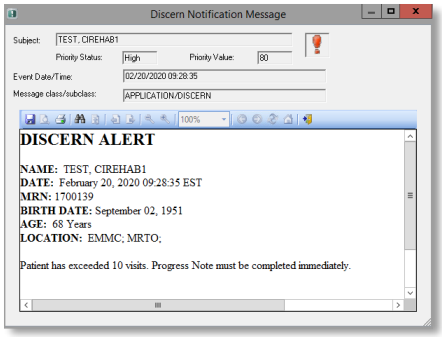
Progress Note Forms

- Progress Notes are accessed from the **Outpatient Therapy** and the **IRF Therapy** folders in **Adhoc.**
- **On the 8th visit**, on chart open, the therapist will receive a pop-up **Discern Alert** reminding the therapist that a **Progress Note** is due on the 10th visit.
- **On the 9th visit**, on chart open, the therapist will receive a pop-up Discern Alert reminding the patient that the Progress Note is due on the 10th visit.
    - The **Progress Note task** will go to the MPTL on the 9th visit.

- **On the 10th visit,** if the Progress Note has not been completed, on chart open, the therapist will receive a pop-up Discern Alert stating the Progress Note is due immediately. This alert will continue to fire until the Progress Note is completed.







- In the **Assessment** section, document **Progress Note Complete.**
  - Documenting the Progress Note is complete, resets the counter so alerts will fire for the next Progress Note.

Documenting Cancelled/Missed Units

- If the patient arrives late, is too fatigued to continue the treatment, or misses part of their therapy session due to another reason, the number of **Missed Units** and the **Reason** are documented at the bottom of the **Time Spent with Patient** section located in each of the documentation forms.
- If the patient misses an entire therapy session, document in the **Missed Therapy Minutes form** for your discipline located in **Adhoc.**

Discharge Summary Forms

- The Discharge Summary forms are NOT tasked to the MPTL.
- On the patients last visit, the therapist will access the **Discharge Summary** form from the **Outpatient Therapy or IRF Therapy folder** in **Adhoc.**
- Documentation from the **Lymphedema Daily Note** and **Lymphedema Progress Note** will pull forward to the **Discharge Summary** form.
  - Click in each previously documented sections to pull data forward into the Discharge Summary.
- If the patient is **discharged from therapy** because they have stopped coming, or have exceeded the number of allowed missed sessions, the **Discharge Summary** form should be documented based on the last visit.
  - The therapist would indicate the number of **Missed Units** in the **Cancelled/Missed Time** subsection of **Time Spent with Patient.**

NOTE: **Any form that does not have all required fields documented will fire a task to the MPTL even though the form was not originally tasked to the MPTL. These tasks will be found on the Physical and Occupational Tx tab, and Speech Language Pathology tab.**

Student Documentation

- After a student therapist completes a documentation form, the licensed therapist will get a task on the **MPTL** for the form with a Status of **Pending Validation**.
- The student's documentation forms will display in **Form Browser** with a status of **(In-Process)**.
- The licensed therapist will double-click the task to open the student's documentation.
- The documentation should be reviewed. The therapist is required to document something in the note in order to sign the form.
- After the licensed therapist signs the form, in **Form Browser** the status of the form will display as **(Auth (Verified))**.

Saving a Note

- If a therapist is working on a documentation form and is not able to complete it in one sitting, the form should be **Saved** rather than signed.
- Click the **Save Disc icon** next to the Sign icon.
- If the saved note has **required fields that have not been documented** yet, navigate to the MPTL and click the task to open the previously started note.
    - In **Form Browser**, this note would have a **red tile** and have a status of **(In-Progress)**.
- To complete a saved note that had **all required fields documented**, navigate to **Form Browser** and locate the saved form.
    - In **Form Browser**, this note would have a **blue tile** and a status of **(In-Progress).**
    - Right-click the form and select **Modify** form.
    - Once the form is completed, click the **Sign icon.**
    - The status in **Form Browser** will update to **(Auth (Verified))**.