

Notes Setup and Support Guide

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Your Responsibilities for Safe Use

This documentation will help guide you through the available software configuration options so you can decide the right configuration for your organization. Of course, safe and compliant use of the software in any configuration requires you and your users to use good judgment and perform certain responsibilities, including each of the following: enter and read information accurately and completely; be responsible for configuration decisions; ensure compliance with laws and regulations relevant for your organization; confirm the accuracy of critically important medical information (e.g., allergies, medications, results), just as you would with paper records; actively report suspected errors in the software to both Epic and affected personnel; thoroughly test the software to ensure it's accurate before using it; and use the software only according to standards of good medical practice. You also are responsible for training your personnel and other users to perform these responsibilities. Not performing any of these responsibilities may compromise patient safety or your compliance with applicable requirements.

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Notes Setup and Support Guide

Notes are often the best way for a clinician to communicate information about a patient. Clinicians can use notes to document everything from a patient's social history to current procedures and diagnoses, and clinicians might refer to notes for years in order to plan a patient's care.

Clinicians can create, view, and edit notes in the Notes activity and note navigator sections. This guide also includes information about setting up and configuring notes features, such as cosigning and sharing.

Clinicians can also create notes in the NoteWriter. For information about setting up and configuring the NoteWriter, refer to the [NoteWriter Setup and Support Guide](#).

Across your organization

The entire notes structure is stored in the Notes (HNO) master file. This ensures that clinicians can experience a consistent set of features and see a more familiar interface as they work with notes across applications.

However, not all features are or should be available in all applications. Feature sets control which notes features are available to clinicians, such as the ability to cosign notes or copy previous notes. Default feature sets differ based on encounter type. For example, a clinician who treats a patient in the hospital uses different notes features than a clinician who treats a patient in an office visit.

In the Foundation System

Notes feature sets are fully configured in the Foundation System.

Notes Setup: Essentials

In this section, we'll cover everything you need to do to start using notes. This includes what you need to do to make note types available to clinicians in the Notes activity and note navigator sections.

Determine If Your Organization Uses Web-Based Notes

 Starting in February 2022



Notes are web-based by default in the Hyperdrive client. If you are on the Classic client, read below to determine if your organization uses web-based notes.

In order to use web-based notes features on the Classic client, your organization must have the UCN Web Notes feature license. If you are not sure whether you have this license, contact your Epic representative and mention SLG 3550868.

Make Note Types Available to Clinicians

The Notes activity allows clinicians to edit and view existing notes and to create new notes. To make note types available to clinicians, you need to set up their profile settings to give clinicians the ability to view and create notes of those types in the Notes activity.

Notes are organized into tabs based on note type. Tabs can include more than one note type. For example, both ED notes and ED provider notes appear on the Emergency tab. Carefully consider how you plan to organize note types into tabs, and which tabs you make available to each clinician group.

Keep in mind that certain note types are high in volume. To minimize loading time, assign these notes to their own tab. For example, the Progress Notes tab should only show Progress Notes. Clinicians can always use the All Notes tab to see these notes alongside other note types.

The [Foundation System hosted environment](#) has already set up several note tabs for clinicians. To review the suggested note tabs, log in as a user and open the Notes activity. Below is a list of users whose note types could be a good starting point.

- Attending Physician Inpatient (IPMD)
- Nurse Inpatient (IPRN)
- Physician Resident/Fellow (RESMD)
- Attending Physician Emergency (EDMD)
- Nurse Emergency (EDRN)
- Nurse Family Medicine (FAMRN)
- Physician Family Medicine (FAMMD)

The screenshot shows the Notes module interface. At the top, there's a toolbar with various icons for creating new notes, filtering, loading all notes, and managing note types like Progress, Consult, Procedure, H&P, D/C Summary, ED, OR, Assessments, Amb Notes, Other, and Incomplete. A red box highlights the 'Incomplete' tab. Below the toolbar, a message says 'Number of notes shown: 33 out of 34 based on filters. More to load.' and 'There are new updates. Sort by new notes.'

The main area displays a list of notes from different clinicians:

- Loren Landry, CRT** Progress Notes: Respiratory Therapist, Date of Service: 01/19 2:34 PM, File Time: 02/06 1:40 PM, Signed.
- Pat Cooper, M.D.** Progress Notes: Physician Medicine, Date of Service: 01/19 12:30 PM, File Time: 01/19 7:22 PM.
- Loren Landry, CRT** Procedures: Respiratory ... Date of Service: 01/19 10:20 AM, Respiratory, File Time: 01/19 6:59 PM.
- Tori Savage, RN** Progress Notes: Registered N..., Date of Service: 01/19 9:45 AM, Wound Care, File Time: 01/19 6:54 PM.
- Chris Pinderski, M.D.** Progress Notes: Physician Surgery, Date of Service: 01/19 9:42 AM, File Time: 01/19 6:46 PM.
- Pat Cooper, M.D.** Progress Notes: Physician Medicine, Date of Service: 01/19 9:00 AM, File Time: 01/19 6:38 PM.
- Sean Armstrong, M.D.** Progress Notes: Physician Orthopedics, Date of Service: 01/19 6:48 AM, File Time: 02/06 1:29 PM.
- Loren Landry, CRT** Progress Notes: Respiratory ... Date of Service: 01/18 8:30 PM, Respiratory, File Time: 01/19 5:36 PM.
- Kim Harker, RN** Progress Notes: Registered N..., Date of Service: 01/18 8:00 PM, General Nursing, File Time: 01/19 5:28 PM.

Below the notes, there's a section for **Patient Assessment / Evaluation** with details about mental status, level of activity, respiratory pattern, and breath sounds. There are also sections for **Labs and Vitals** (Leukocytes, Hemoglobin, Hematocrit, Platelets) and **Indications** (Clinical Indications for therapy: medicated aerosol therapy: airway inflammation and/or edema). A **Plan:** section is also present.

Determine Which Note Types to Use

The note types that you make available to your clinicians will depend on the clinician's role and on the needs of your organization. The commonly used note types are:

- 1-Progress Notes
- 2-Consults
- 3-Procedures
- 4-H&P
- 5-Discharge Summary
- 6-ED Notes
- 8-ED Triage Notes
- 10-OR Nursing
- 19-ED Provider Notes
- 42-Lactation Note

Review the list of available note types in the Type (I INP 5010) category list and determine the note types that your clinicians will use. Then, follow the steps in the topics below to make them available to clinicians.

You can also create custom note types if the available note types don't meet your needs.

Create Custom Note Types

If clinicians in your organization have a unique workflow that requires a note type not provided by Epic, you can create a custom note type and add it to a tab. Depending on the needs of your organization, you might also need to create a new tab to show the note type in the Notes activity.

Make sure to notify your HIM and Professional Billing analysts if you create any new note types, as notes-based deficiencies are tracked by specific note type.

Add a New Note Type to the Type Category List

1. Follow the path Epic button > Admin > General Admin > Category List Maintenance.
2. Enter INP in the Database field and 5010 in the Item field.
3. Enter an ID for your note type outside the Epic release range of 1 to 99999.
4. Enter a title, abbreviation, and synonyms for your note type as appropriate:
 - Title: Enter the name of the note type as you want it to appear in Hyperspace.
 - Synonyms: If users might search for the note type using terms other than the name in the title field, enter those terms as synonyms.
 - Abbreviations: Abbreviations are for display only and aren't searchable.
5. Starting in February 2024, click Pend to add your note type to the list. In previous versions, click Go.
6. Click Save to save your changes to the category list.

Determine Which Notes Tabs to Use

A note type has to be linked to a tab for clinicians to use it. Epic provides several tab records in the Foundation System. For example, in the facility profile, configuration record 100000000-IP Notes Configuration includes the following tabs:

- 3040000004-IP Progress Notes Tab
- 102-IP Consult Notes Tab
- 103-IP Procedure Notes Tab
- 104-IP H&P Notes Tab
- 3040010500-IP Discharge Summaries Tab
- 3040010600-IP ED Notes Tab
- 3040000008-IP Advance Care Planning Notes Tab
- 3040000001-IP Plan of Care Tab
- 1070000052-OR Periop Tab
- 3040000005-IP Events Documentation Tab
- 3040000007-IP Med Student Tab
- 1141000-CCM Payer Review Notes
- 1141001-IP Additional Notes
- 3040000011-IP Transfer Center Note Tab
- 1050000002-RIS MR Safety Analysis Tab

You can also create custom tabs if the available tabs don't meet your needs.

Default Tabs

Note that there are tabs that appear by default, without any set up on your end:

- All Notes: Shows all notes that have been signed and that are present on other tabs.
- Incomplete: Shows all unsigned notes.
- Transcription: Shows unauthenticated transcriptions. Refer to the [Change Where Transcriptions Appear in the Notes Activity](#) topic of this document for information about changing where unauthenticated transcriptions appear in the Notes activity.

Link Note Types to Existing and Custom Tabs

After identifying existing and/or creating new note types for your clinicians, link them to the appropriate tab records. Tab records correspond to the tabs you see in the Notes activity. These tab records are attached to the clinician's profile via a Notes Activity Configuration (HFN) master file. If you've determined your clinicians need a custom tab, you can create a new tab record and link note types at the same time.



You can define default note types for tabs. Refer to the [Specify Default Note Types for Tabs in the Notes Activity](#) topic below for details.

1. Access the Notes Activity Configuration master file.
 - In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations.
 - In OpTime Text, follow the path Perioperative Charting > Clinical Administration > Notes, Text Templates > Notes Activity Configurations.
2. Open an existing tab record or create a new record.
 - If creating a new record, enter a name.
 - At the Would you like to create a new Configuration? prompt, enter Yes.
 - At the Record ID prompt, enter a record ID in the customer range (above 10,000).
 - At the Record Name prompt, press ENTER.
 - At the Record Type prompt, enter Tab record and press ENTER.
3. Go to the Notes Activity Tab Details screen.
 - If this is a new record, enter a name for your note tab in the Display Name field.
4. In the Note Types field, enter the notes you want to appear on this tab. Press F7 to insert an additional note type.

Add Tabs to the Notes Activity

To see a tab in the Notes activity, add it to a Notes Activity Configuration record and link that configuration record to the clinician's profile. If this is your first time setting up the Notes activity for clinicians, or if you created custom tabs, create a new configuration record by following the steps below. If a configuration record is already set up for the clinician, you can add additional tabs to the existing record.

Epic releases two standard notes configuration records, 100-IP Standard Notes Configuration and 200-OR Standard Notes Configuration, that you can review in the [Foundation System hosted environment](#).

Create a Configuration Record

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations (HFN).
2. Create a new configuration record.
3. In the Record Type field (I HFN 100), enter Configuration Record.

4. On the Notes Activity Configuration Record screen, list the tab records that you want to appear in the Notes activity in the Available Tabs field (I HFN 150). You can press F8 to edit one of the listed tab records.

Attach the Configuration Record to a Profile

1. Open a profile record in Clinical Administration or OpTime Text.
2. Select Note, Letter, Transcription.
3. On the Notes Activity Settings screen, enter a notes configuration record in the Notes activity configuration field (I LPR 948). This field is set to 100-IP Standard Notes Configuration for EpicCare Inpatient users in the Foundation System.

Specify Default Note Types for Tabs in the Notes Activity

You can specify a certain note type to open by default when a user creates a new note from a given tab in the Notes activity. This option is particularly beneficial for tabs that allow more than one note type to be created, because if no default note type is set for those tabs, the user needs to manually choose the type they want.

You can specify a default note type for a given tab either in the tab record itself, or in a Notes activity configuration record that contains the tab. If a tab has default note types set at both levels, the value at the configuration record level takes precedence.

Be aware that you cannot specify default note types for the All Notes or Incomplete tabs.

To be able to specify default note types for tabs in the Notes activity, you must have the UCN Default Note Type license, which is included in the standard EpicCare Inpatient license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

Set a Default Note Type in a Tab Record



You can use the Build Wizard in Hyperspace to set default note types for multiple tabs at once. To get started, open the Build Wizard and search for feature 10000038-Assign Default Note Types to Tabs (application: EpicCare Inpatient). Note that the Build Wizard can be used to set default note types only at the tab record level and not at the configuration record level.

If you need to change these settings after running the Build Wizard, complete these steps:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations (HFN) and open the tab record you want to update.
2. Go to the Notes Activity Tab Details screen.
3. In the Default Note Type (I HFN 135) field, add your default note type.

Set Default Note Types for Tabs in a Configuration Record

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations (HFN) and open the configuration record you want to update.
2. Go to the Available tabs screen.
3. Find the tabs you want to add default note types to, and add values in the corresponding rows in the Default Note Type (I HFN 151) field.

Allow Clinicians to Write Different Note Types in One Place

 Starting in February 2025

You can make multiple note types available for clinicians to choose from in a single navigator section or in the Notes sidebar for an outpatient encounter. This option allows a clinician to write multiple notes of different types in one encounter or have a single note with a different type from encounter to encounter, without switching tabs or workspaces to write a note of a different type.

After you enable this option, clinicians can change the note type from the note editor or start a note of a given type using speed buttons. For example, if you set note types of Progress, Procedure, and H&P in a navigator, your clinicians can see these note types in the Notes sidebar activity in the Note Type field.

Work with your operational managers to determine which note types to add. We recommend that you specify the additional note types in profile (LPR) records. Note that, because this setting affects standard note navigator sections in all contexts, we recommend against configuring this setting in the system-level profile. Additional configuration options are available for complex and unique scenarios (for example, to specify note types that should be available for only a specific navigator). Refer to the [Write Different Note Types in One Place](#) topic for more information. If you configure these options in records other than profile records, including menu (E2U), activity (E2N), navigator (LVN), and navigator configuration records (VCN), that setup overrides your profile-level configuration unless the Additional Notes Type parameter is blank in those records. The note type you list in the Note Type field of your record is the note type that appears by default when a clinician opens a note without applying a specific note template.

After enabling multiple note types, users can create speed buttons specific to the note type. The buttons appear in the toolbar based on the type of note a clinician has open for editing. If there is no note open for editing, speed buttons for all note types appear. Additionally, if a clinician changes the note type for a note they have open, the speed button selection changes to show speed buttons for the new note type.

NoteWriter templates aren't supported when you enable multiple note types. Instead, we recommend that you create default note speed buttons so clinicians can start a note from a specified SmartText. Refer to the [Set Default Note Speed Buttons at the Profile Level](#) topic for more information. Clicking Create Note creates a note that is defined as the primary note type in the record.



Use the Build Wizard in Hyperspace to update or create records to allow multiple note types in the activity. To get started, open the Build Wizard and search for feature 16570-Notes Navigator Multiple Note Types Setup (application: EpicCare Ambulatory).

To manually enable multiple note type configuration in the profile (LPR), complete the following steps:

1. In Clinical Administration, open the profile you want to modify (Management Options > Profiles (LPR)) and select Note, Trans, Communication.
2. On the Notes General Settings - 5 screen, in the Additional navigator note types (I LPR 49322) field, enter any note type you want to enable within the Notes sidebar activity. Starting in November 2025, August 2025 with special update E11500381, May 2025 with special update E11406281, and February 2025 with special update E11310803, you can configure up to 10 additional note types in the Notes sidebar.
In August 2025 and earlier versions without special updates, up to six additional note types are supported.

For more complex and unique scenarios, you can manually enable multiple note types for a specific navigator or the Notes sidebar activity. Note that configuration in records other than the profile overrides configuration at the profile level unless the Additional Notes Type parameter is blank in those records.

To implement this feature in the Visit Navigator:

1. In Clinical Administration, go to Navigators > Dup Configuration and open the record you want to duplicate.
 - a. For an edit-only navigator configuration, create a copy of configuration 218-MR_CHARTING_MULTIPLE_EDITONLY.
 - b. For a non-edit only navigator configuration, create a copy of configuration 118-MR_CHARTING_MULTIPLE.
2. On the Parameters screen in your configuration record, in the Additional Note Types (I VCN 10020) field, enter any additional note types you want to enable within the Notes sidebar activity.
3. In Clinical Administration, go to Navigators > Dup Navigator and open the record you want to duplicate.
 - a. For an edit-only navigator, create a copy of navigator section 218-SEC_CHARTING_MULTIPLE_EDITONLY.
 - b. For a non-edit only navigator, create a copy of navigator section 118-SEC_CHARTING_MULTIPLE.
4. Open your copied navigator section and enter your copied configuration record in the Default Configuration (I LVN 1070) field.
5. Link the navigator records to your topic or section records that is linked to your navigator template. Refer to the [Navigators: Strategy & Setup](#) topic for more information.

To implement this feature in the Notes sidebar activity:

1. Access Chronicles and enter E2N to open the Activity master file. Select Enter Data > Duplicate activity, and copy 23411_NOTES_SIDEBAR.
2. Access Chronicles and enter E2U to open the Menu master file. Select Enter Data > Duplicate menu, and copy 23407-MR_IT_SB_NOTE.
3. On the Parameters screen in your menu, in the Additional Note Types (I E2U 2020) field, enter any additional note types you want to enable within the Notes sidebar activity.
4. Link the copied menu record to the copied activity record. Refer to the [Activities and Menus: Strategy & Setup](#) topic for more information.
5. Link the copied menu record to the appropriate Workflow Engine rule. Refer to the [Workflow Engine Rules: Strategy & Setup](#) topic for more information.

Change Where Transcriptions Appear in the Notes Activity

By default, unauthenticated transcriptions appear on the Transcriptions tab of the Notes activity. If you want unauthenticated transcriptions to be separated by note type, you can configure them to appear on the same tab that shows notes of its type.

1. In Clinical Administration, access EMR System Definitions and go to Note, Trans, Communication.
2. On the Transcription & Dictation Settings screen, enter Transcription tab in the Notes tab to display unauthenticated transcriptions field.

Change the Time Frame for Notes Tabs

By default, note tabs include notes from the last 72 hours. By increasing or decreasing the time frame, you can show more or fewer notes. For example, if a patient has had multiple procedures performed over the course of a week-long hospital stay, it would benefit clinicians to be able to quickly see all procedure notes related to that stay. In this scenario, you might increase the time frame of the Procedure note tab to include all relevant notes.

For example you might want to configure a tab that tends to contain many notes, such as Progress Notes, to use a shorter time frame to reduce loading times.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations and open the tab record.
2. On the Notes Activity Tab Details screen, enter a time range in the Loading Time Range field.

Automatically Include Text and SmartTools in New Notes

You can use a SmartText as a note template to make documenting more efficient for clinicians and ensure that they meet basic documentation requirements for a note type. You can automatically include free text, like bolded headings, and SmartTools, like SmartLinks or SmartLists, when a clinician creates a new note. After creating SmartTexts for this purpose, you must associate them with note types.

In EpicCare Inpatient, OpTime, and Anesthesia, you can create multiple SmartText note templates for a note type so that a physician has different documentation options depending on the patient. For example, you might create two progress note templates, one for adults and one for pediatric patients. The physician can then choose the appropriate template when he creates a progress note. You can configure the appropriate template to appear automatically based on the service the clinician selects.

In EpicCare Ambulatory and ASAP, it is also possible to create multiple note templates per note type, but Epic recommends that you create one all-inclusive note template and associate that template with the Progress note type.

Create Note Templates

1. In Hyperspace, create a new SmartText (search: SmartText).
2. In the text preview field, add the SmartTools and free text that should appear when a clinician creates a new note.
3. On the Restrictions card, give the template a functional type of IP Charting (for use in EpicCare Inpatient, ASAP, OpTime, and Anesthesia encounters) or MR Charting (for use in EpicCare Ambulatory encounters).
4. When the template is complete, select the Released checkbox and click Accept.

Associate a Note Template with a Note Type

1. In Clinical Administration, open a profile record and select Note, Letter, Transcription.
2. Go to the Default Note Templates screen.
3. In the Note Type (I LPR 46040) field, enter the note type you want to associate with a note template.
4. In the Default Note Template (I LPR 46045) field, enter your SmartText.

Automatically Populate Service-Specific Note Templates

You can configure a service-specific note template to appear instead of the note type's default note template when a clinician selects a service in Hyperspace. This is useful for clinicians who might select a different service on a per-patient basis and need to include different information based on their service or when clinicians in the same department are on different services.

To configure a note template to appear when a clinician selects a specific service, add a rule to your standard note template for each service that has a service-specific SmartText:

1. Create a rule (search: Rule Editor) in the Patient context using property 42509-Current Note Service with the Value field set to the hospital service for which you want a specific note template to appear.

2. Open your note template (search: SmartText) and open the Overrides card.
3. In the Rule Column, add the rule you created.
4. In the Override SmartText column, enter the note template associated with the service.

Make Note Navigator Sections Available to Clinicians

Many Epic-released navigators, such as the Admission or Rounding navigator, already include note navigator sections. However, you might need to add note navigator sections to custom navigators to accommodate workflows within your organization.

There are several available note navigator sections that you can add to your navigators:

Section Name	Description
118-Sec_Charting_Multiple	This outpatient progress notes section allows clinicians to create and edit multiple progress notes for a single encounter.
124-Sec_Doc_Tel_New	This documentation section allows clinicians to create and edit multiple telephone encounter notes for a single encounter.
125-Charting_Mult_DxNORD	This progress notes section allows clinicians to create and edit multiple progress notes for a single encounter. In addition, this section allows them to drag and drop diagnoses and orders into notes.
126-Sec_PT_Instr RTF	This patient instructions section allows clinicians to document patient instructions. Clinicians can copy previous instructions by clicking Copy Previous on the note toolbar. They can also print out the notes entered in this section and give them to their patients.
127-Sec_Procedure_Notes	<p>This procedure notes section allows clinicians to document and review procedure notes. They can result orders, enter preoperative and postoperative diagnoses, and link procedures to a patient's surgical history from within the navigator.</p> <p>This section supports the entry of multiple notes in a single encounter.</p>
1405-Sec_MR_Linked_Perfs	<p>This outpatient procedures performed section allows clinicians to document and review procedure notes.</p> <p>Physicians or specialists can use this section to select an order, document the order's performables, and assign charges for the order.</p> <p>This navigator section must be used in conjunction with all of the following outpatient navigator sections:</p> <ul style="list-style-type: none"> • Orders Needing Results/Charges (1404-SEC_MR_ORDERABLES_OP) section. • Orders Needing Results (1418-SEC_MR_ORDERABLES_OP) section. • Charge Capture (1417-SEC_MR_LINKED_CHARGES) section. <p>For performable and chargeable linking to function, this section must appear either between the Orders Needing Results/Charges section and the Charge Capture section or after the Orders Needing Results section.</p>

Section Name	Description
1406-Sec_IP_Linked_Perfs	<p>This inpatient procedures performed section allows clinicians to document and review procedure notes.</p> <p>Physicians or specialists can use this section to select an order, document the order's performables, and assign charges for the order.</p> <p>This navigator section must be used in conjunction with all of the following inpatient navigator sections:</p> <ul style="list-style-type: none"> • Orders Needing Results/Charges (1421-SEC_IP_ORDERABLES_OP) section. • Orders Needing Results (1425-SEC_IP_ORDERABLES_OP) section. • Charge Capture (1423-SEC_IP_LINKED_CHARGES) section. <p>For performable and chargeable linking to function, this section must appear either between the Orders Needing Results/Charges section and the Charge Capture section or after the Orders Needing Results section.</p>
27032-ER_Notes	<p>This ED notes section allows clinicians to document notes about a patient's visit to the emergency department. Notes recorded in this section appear on the ED Notes tab in the Notes activity.</p>
34112-Sec_Discharge_Notes	<p>This discharge notes section allows clinicians to document and review discharge notes for the patient.</p>
34203-Sec_IP_Progress_Notes	<p>This inpatient progress notes section allows clinicians to document and review progress notes for the patient.</p>
34302-Sec_IP_Transcription_Link	<p>This transcription section contains a link that opens the Transcriptions tab of the Notes activity. This section uses navigator configuration record 34302-IP My Transcriptions Link to configure the link.</p> <p>The section appears only when a patient has transcriptions for his current encounter. If you would like this section to appear even when there are no transcriptions, duplicate the released navigator section and remove extension 34164-IP My Transcription Nav Filter from the Filter PP field on the Section Setup screen.</p>
34500-Sec_HP_Notes	<p>This H&P notes section allows clinicians to document and view H&P notes for the patient.</p>
34501-Sec_IP_HP_Notelist	<p>This H&P interval notes section allows clinicians to document the H&P note that is required before a surgery can be performed. You can configure the settings on the H&P Interval Settings screen of the profile to determine how which notes appear:</p> <ul style="list-style-type: none"> • In the "Number of days to search for valid notes" (I LPR 46050) field, enter the number of calendar days back to search for notes written prior to the admission. For example, enter 30 or leave the field blank to search for notes written thirty calendar days prior to

Section Name	Description
	<p>the admission.</p> <ul style="list-style-type: none"> In the Note Type field, enter the note types that you want to appear in the section and enter values in the "Show Notes Of This Type From The Current Encounter?" and "Show Notes Of This Type From Past Encounters?" fields to configure whether notes of that type from a current or past encounters appear. <p>The section also shows H&P notes attached to the current admission, as well as notes written prior to admission. Using this section, surgeons can write an interval H&P note directly from a previous H&P note.</p> <p>When a clinician opens this section, existing H&P notes from the current admission appear under the Notes attached to current encounter header. If a note was written within 30 calendar days prior to the patient's admission, it appears under the Notes from past 30 days header. Any scanned transcripts also appear in this section. Note that clinicians can add interval notes to scanned transcripts only if the documents are attached to the current encounter.</p> <p>If an H&P note requires a cosignature, the Cosign icon appears alongside the note in the navigator section. Clinicians cannot cosign these notes directly in the section, and instead must open the note in the Notes activity.</p> <p>Surgeons can use the Add Interval button to create a copy of a note (if the note is not from the current encounter), along with a new interval note where the surgeon can document any updates, as well as state that the original note has been reviewed and is valid. Upon accepting the note, the duplicated note appears above the corresponding interval note in the section. Shared and pended H&P notes do not have an Add Interval button.</p> <p>Starting in November 2022, notes from outside organizations also appear in the section. These external notes use the same profile settings as internal notes to determine which notes should appear. When an interval note is added to an external note, a copy of the external notes is created and linked to the current admission.</p> <p>Starting in February 2024, you can control what columns appear in the H&P Interval notes section by adding them in the H&P Additional Information (I LPR 46067). These columns include Author Provider Type, Note Department, and Author Service. Clinicians can search for notes faster with these column options as it provides them more information without having to search through each individual note.</p>
34517-Sec_Transfer_Notes	This transfer notes section allows clinicians to document and review progress notes for the patient.
52010-Sec_OR_Surgeon_Notes	This surgeon notes section allows clinicians to document and view surgical notes for the patient.

Section Name	Description
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For information about customizing a note navigator section, refer to the [Customize Note Navigator Sections](#) topic.

To add a note navigator section listed above to a custom navigator, refer to the [Collect Sections into Topics](#) topic and follow the steps to add the section to a topic contained in your navigator's template.

Determine Which Services a Clinician Can Select

Determine Available Note Services at the Profile Level

You can determine at the profile level which services clinicians can select for notes. By setting the list of allowed services at the profile level, you don't need to maintain individual lists of allowed services in each provider record.

You can enter a list of services in the Allowed services (I LPR 34751) field in profiles. Note the following:

- If the Allowed services field is left blank and the Method for default service field in the profile is set to any value other than 1-Use the provider record, the clinician can select any service from the Clinical Service (I ECT 34886) category list for notes.
 - If the Allowed services field is left blank and the Method for default service field in the profile is set to 1- Use the provider record and the clinician has allowed services in his provider record, he can select any service from the Allowed Services field in his provider record for notes. If he does not have allowed services in his provider record, he cannot select a service for notes.
1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription.
 2. Go to the Notes General Settings - 2 screen.
 3. In the Allowed services field, enter services that clinicians can select for notes.

Set a Default Service for Notes That Is Different from the Default ADT Service

You can set a default service for notes that is different from your default service for ADT accommodations. This feature is helpful if your organization uses different services for ADT accommodations and notes.

1. In Clinical Administration, follow the path Users, Providers > Providers (SER).
2. Open a provider record.
3. Go to the Inpatient Provider Information 2 screen.
4. In the Default Clinical Service (I SER 34700) field, enter a service from the Clinical Service (I ECT 34886) category list.

Change How the Default Service for Notes Is Determined

When a clinician creates a new note and has not yet entered a service anywhere in Hyperspace, the default service for the note is the service specified in the Default Clinical Service (I SER 34700) field in their provider record. At the profile level, you can configure the system to instead use any of the following as the default service:

- The service listed in the Default clinical service (I DEP 24110) item of the author's login department record
- An extension record that determines the default service based on given criteria
- No default service

When the service field is visible to clinicians, they can manually change the service when writing a note in the

Notes activity or a note navigator section.

You can configure clinician profile settings to determine the default service for new notes, ED narrator notes, transcriptions, and the Problem-Oriented Charting navigator section. Before doing so, there must be at least one service in the Default Clinical Service (I SER 34700) field. Refer to the [Set a Default Service for Notes That Is Different from the Default ADT Service](#) topic for more information for more information about that setting.

To configure a default service for a specific profile:

1. In Clinical Administration, open a profile record and select Note, Letter, Transcription.
2. Access the Notes General Settings - 2 screen.
3. In the Method for default service (I LPR 34750) field, enter the method by which the system should determine the default service to use for notes written by users with this profile. The default value and Foundation System setting is set to 3-Use extension.
4. In the Respect default service method (I LPR 34756) field, enter the option that matches the desired behavior for your organization. Be sure to consider how the Respect default service method (I LPR 34756) field interacts with the Method for default service (I LPR 34750) field. You can set the Respect default service method field to either of the following options, with these considerations:
 - 1-Yes. The default service always respects the method specified in the Method for default service (I LPR 34750) field.
 - 0-No or blank. The note service respects the Respect default service method field the first time the clinician uses a tool that makes use of the Service field. After that, the default service becomes the service the clinician last selected.
5. If you entered Use an extension in step 3, enter the extension record in the Service extension (I LPR 34760) field.
6. Exit the profile record.

If you want to hide the Service field completely so that clinicians can't change the service when writing a note:

1. In Clinical Administration, select EMR System Definitions > Note, Trans, Communication.
2. On the Inpatient Notes General Options screen, enter Yes in the Hide service (I LSD 34448) field.

Set a Default Service for Notes Based on the Service Specified in a Previous Note

If you've set the Respect default service method (I LPR 34756) item to Yes or set profile variable UCN_USE_OLD_SERVICE_DEFAULTING (34100) to 1-True to use the settings in a clinician's profile to determine the default service for notes, you can use an extension to make selection of service for notes more intuitive for clinicians who frequently switch their service, such as residents.

With this feature, these clinicians need to check and optionally change the default service of their notes only once per patient encounter, instead of checking and manually changing the note service each time they write a note. If the clinician already wrote a note for an encounter or admission, the extension record uses that note's service as the default service for future notes written by the clinician in that encounter. If the clinician didn't specify a service for the previous note or hasn't written a note for the encounter or admission, you can choose to:

- Use the service specified in the Default Clinical Service (I SER 34700) field of the provider record.
- Use the service specified in the Default Clinical Service (I DEP 24110) field of the author's login department.

- Starting in November 2023, use the service specified in the Default Clinical Service (I SER 34700) field of the provider record, and if that is not set, then use the service specified in the Default Clinical Service (I DEP 24110) field of the author's login department.
- Leave the field blank. This is the default value.

When a clinician specifies a service for the first time in an encounter, the new default value won't take effect until he closes and reopens the workspace.

You need to duplicate and modify extension 88888-IP Default Note Service from Previous Note only if you want a default service to be used for notes without a service specified. If you want to use the extension as released, which leaves the service blank if the clinician hasn't previously specified a service, skip to step 3.

1. In Chronicles, duplicate extension 88888.
2. Open your duplicate record and enter a value for the fifth parameter.
 - Enter 2 to use the value in the Default Clinical Service field of the provider record.
 - Enter 3 to use the service specified in the author's login department.
 - Starting in August 2023, enter 4 to use the service specified in the provider record, and use the service specified in the author's login department if the provider record is not set.
 - Enter 1 to leave the service field blank.
3. In Clinical Administration, open a profile record and select Note, Letter, Transcription. Go to the Notes General Settings - 2 screen.
4. Enter 3-Use an extension in the Method for Default Service field.
5. Enter extension 88888 or your copy in the Service extension field.

Set Default Service for Notes Based on Encounter Team Specialty

If you've set the Respect default service method (I LPR 34756) field to Yes and the Method for default service (I LPR 34750) field to 3-Use an extension, or set profile variable UCN_USE_OLD_SERVICE_DEFAULTING (34100) to 1-True to use the settings in a clinician's profile to determine the default service for notes, you can use an extension to make selection of service for notes more intuitive for clinicians who need to frequently switch their service based on what specialty they use on the patient's Treatment Team.

Duplicate and modify extension 96868-DBC Default Note Service from Care Team to set a default service for notes based on the clinician's encounter Treatment Team specialty.

1. In Hyperspace, open the Extension activity (search: Extension) and create a new record copying extension 96868.
2. In the fifth parameter, enter an interface general table that maps Provider Specialty to Author Service for your organization.
3. In the sixth parameter, you can choose to enter one of the following fallback options when a service cannot be derived from clinician specialty on the Treatment Team. If this parameter is left blank, no service is defaulted in:
 - 1-Provider Service: Use the service from the provider record (I SER 34700).
 - 2-Department Service: Use the service from the department record (I DEP 24110).
 - 3-Provider Specialty: Use the provider's specialty from the encounter treatment team as the service. If used, the category must exist in both the specialty category list (R SER 1050) and the clinical service category list (R ECT 34886).

- 4-Last Used Service: Use the service from the previous note written for the current encounter.
4. To add this extension to a Profile (LPR) record:
 - a. In Clinical Administration, go to Management Options > Profiles (LPR).
 - b. On the Notes General Settings-2 screen, enter the extension into the Service Extension (I LPR 34760) field.

Associate Notes With Consult and Procedure Orders

Clinicians can write consult or procedure notes to associate their documentation with a specific order. When a clinician associates a note with a consult or procedure order, the order is automatically marked complete. Alternatively, a clinician can quickly create and complete a new order by adding it to his consult or procedure note.

After a procedure is resulted via this workflow, it appears in Chart Review with a status of Final result. After the procedure is final, you can't edit the procedure or associated diagnoses, but you can edit the procedure note.

Ensure that Clinicians Document Only Appropriate Consult and Procedure Orders

All clinicians with the Procedures tab in the Notes activity can create procedure notes. However, you should complete the steps below to ensure that they document notes only for appropriate orders. To do this, specify the order types for which clinicians can write consult and procedure notes in the clinician's profile and optionally configure an extension that can filter additional orders.

You can also prevent an order from being automatically completed when a clinician with a certain provider type writes a note for the order. This setting is useful when multiple clinicians will document on the same order.

1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription > Consult and Procedure Notes screen.
2. To determine the consult orders for which a clinician can write consult notes, fill out either or both of the fields below. Note that if you enter values in both fields, an order must fulfill both conditions to appear to clinicians:
 - In the Consult note order types (I LPR 35171) field, enter order types.
 - In the Consult note filter extension (I LPR 35176) field, enter an extension. To find the available extensions, view the help text for the Consult note filter extension item in your clinicians' profiles.
 - i. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open your profile.
 - ii. Go to the Consult and Procedure Notes screen.
 - iii. In the Consult note filter extension field (I LPR 35176), press Shift+F5 to view the help text for this item and see a list of available extensions.
 - If you want to see a more detailed list of available extensions, follow the instructions in the [Find Extensions of a Specified Type](#) topic to search for extensions of the IP Procedure Note Filter type.
 - iv. Add your desired extension to the Consult note filter extension field.
3. To determine the procedure orders for which a clinician can write procedure notes, enter values in the following fields. If you enter values in all fields, an order must fulfill all conditions for a clinician to be able to document a procedure note on it.

- In the Procedure note order types (I LPR 35170) field, enter order types.
- In the Procedure note filter extension (I LPR 35175) field, enter an extension. To find the available extensions, follow steps i through iv in number 2 above for the Procedure note filter extension item.
- The Search inactive procedures in procedure notes (I LPR 35184) field is available starting in August 2025, May 2025 with special updates E11403140 and E11403142, February 2025 with special updates E11308383 and E11308401, and November 2024 with special updates E11212581 and E11212596. Enter 1-Yes or leave blank to allow lookup of inactive procedures in non-NoteWriter procedure notes or enter 0-No to prevent lookup of clinically inactive procedures.

Prevent Orders from Being Completed When Certain Clinicians Document Them

You can prevent an order from being automatically completed when a clinician with a certain provider type writes a note for the order. This setting is useful when multiple clinicians will document on the same order.

1. In EMR System Definitions, follow the path Note, Trans, Communication > Consult and Procedure Notes screen.
2. Enter provider types in the Provider Types that Cannot Complete Consult or Procedure Orders from Notes field.

Prevent Completed Orders from Appearing for Consult and Procedure Notes

You might have certain orders that can be completed either by a physician associating them with a consult or procedure note or by another role who doesn't write consult or procedure notes. You can prevent consult and procedure orders that are completed, but don't have a note, from appearing in the list of orders for which a clinician can write a note.

For example, you might want to configure this feature if nurses can complete certain procedure orders by completing a task, and physicians can complete the same type of task by writing a procedure note. That way, the physician can't unintentionally associate his note with an order that has already been completed by the nurse, and he has to search through fewer procedure orders to find the one he wants to document on.

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) > open a profile > Note, Letter, Transcription > Consult and Procedure Notes screen.
2. To configure this feature for procedures, enter extension 49233-ED Filter Completed Procedures in the Procedure note filter extension (I LPR 35175) field.
3. To configure this feature for consults, enter extension 49233 in the Consult note filter extension (I LPR 35176) field.

Automatically Create Procedure Performed Notes for Interventional Cardiology Studies

 Starting in February 2025

 November 2024 with SU E11204270

 August 2024 with SU E11109550

 May 2024 with SU E10913811

! Before implementing this feature, talk to your Epic representative and mention SLG 9519253 to see if this is a good fit for your organization. Automatically creating notes can lead to an excess of notes and is not recommended for every organization.

You can configure finalized interventional cardiology studies to appear in the Notes tab in Chart Review allowing users to see the result text and a link to the final report. This is beneficial for clinicians from specialties who work primarily from the Notes tab; for example, a physician in the ED can skim the patient's notes and see that they had a percutaneous coronary intervention (PCI) yesterday.

These notes are also available in the Notes activity starting in May 2025, in February 2025 with special update E11305293, in November 2024 with special update E11210218, and in August 2024 with special update E11112953. To show Procedure Performed notes in their own Notes tab, refer to the [Make Note Types Available to Clinicians](#) topic.

Invasive Cardiologist Cupid, MD	Performed Procedure
Physician	Signed
Cardiology	
Date of Service: 12/18/2024 9:41 AM	
Procedure Orders	
Cardiac catheterization [1065737] ordered by Invasive Cardiologist Cupid, MD at 12/18/24 0933	
Procedures	
PERC CORONARY INTERVENTION	
LEFT HEART CATH [CATH27]	
Signed	
This note indicates that the following procedure has been performed:	
Percutaneous coronary intervention, Left heart cath	
<p> Admission (Pending) on 12/18/2024</p>	
Conclusion	
<ul style="list-style-type: none"> • Prox LAD to Mid LAD lesion is 80% stenosed. Prox LAD to Mid LAD reduced to 0% stenosed. 	
<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Follow-up within a few weeks after the procedure to assess recovery and adjust medications if necessary. 2. Resume regular visits with your cardiologist to monitor heart health, manage risk factors, and adjust treatment plans as needed. 3. Referral to a cardiac rehab program for exercise and education. 	
<p>These recommendations and follow-up steps are essential to ensuring the stent remains effective and for promoting overall cardiovascular health.</p>	

To configure which procedures create notes when signed, complete these steps:

1. In Hyperspace, open Imaging System Definitions (RDF 1).
2. Go to the Chart Review tab and add the desired interventional cardiology result report types to the Procedures to Appear in Chart Review Notes (I RDF 1450) field.



Interventional cardiology result report types are in the range 56000-56999, except 56590. For more information about result report types, check out the [Configure the Result Report Type for Imaging Procedures](#) topic.

Determine which report is used in the Notes tab of Chart Review so you can update it:

1. In Clinical Administration, go to Management Options > Profiles (LPR) > Note, Letter, Transcription and open profile 1.
2. On the Notes Chart Review Options screen, identify the report in the Inpatient notes & transcription (I LPR 34201) field.
 - o If it's report 52290-Chart Review Notes Report, navigate to the Reports (LRP) master file and make a copy.
 - o If it's a custom report, you can update that record and don't need to make a new copy.

Notes created from invasive cardiology studies use information found in print group [70228-CV Conclusion](#) or a copy, which appear in the result report. To ensure the result text formatting matches your custom print group, use the [Print Group Search Report Template](#) to check if you are using a copy of print group 70228. If you are, follow these steps:

1. Open a copy of wrapper print group [70234-CV Conclusion Note Wrapper](#) in text.
2. In parameter 3-Result Print Group ID, replace 70228-CV Conclusion with your copy.

Finally, add the wrapper print group to your custom Notes report:

1. In your copy of the report, navigate to the Additional Print Group Configuration screen.
2. Set the Action (I LRP 8110) field to 2-Add second column print group.
3. In the Print Group (I LRP 8100) column, add 70234-CV Conclusion Note Wrapper or your copy.

Automatically Create Generic Orders for Procedure Notes

Clinicians can associate orders with their documentation while writing procedure notes, but they aren't required to associate an order with each procedure note. You can ensure that each procedure note has an associated order by configuring the system to automatically create a generic order and associate it with the note when a clinician signs it. For example, this ensures that all procedure notes appear on Procedures tab in Chart Review, because only procedure notes that have associated orders appear on this tab. These orders are not sent through order transmittal.

You can also use a utility to associate generic orders with procedure notes that have already been signed without associated orders. To run the utility, contact your Epic representative and mention parent SLG 894661.

Note that neither the configuration described below nor the utility apply to procedure documentation notes documented in the NoteWriter. If clinicians document in the text of a procedure documentation NoteWriter note without selecting a procedure on the Procedures tab, the note is not automatically associated with a generic order.

1. In Clinical Administration, select Management Options > Edit System Definitions > Note, Trans, Communication and access the Notes and Orders screen.
2. Enter 1 or 2 in the Unlinked Procedure Note Behavior? field. If you enter 1, procedures are created for each procedure entered in the Procedure Name list. If you set this field to 2, one generic procedure is created for the note.
3. Enter a procedure record to use as your generic procedure for procedure notes in the Generic Procedure to Create field.
4. Enter 1 or 2 in the Select Authorizing Provider Based On? field. If you enter 1, the provider who created the note is used as the authorizing provider. If you enter 2, a generic provider is used.
5. If you entered 2 in Select Authorizing Provider Based On? field, enter a generic provider in the Generic Authorizing Provider field.
6. Enter 1 in the Auto Created Order Charging Behavior? field if you want the system to send charges for the generic order using normal charging logic. If you leave this field blank, charges are not sent.

Remind Clinicians to Add Procedures to Surgical History When They Write Procedure Notes

Help ensure accurate patient history by making it easier for a clinician to add a procedure to a patient's surgical history when he writes a corresponding procedure note. You can configure the system to automatically select the Add To History check box in the note editor when a clinician writes a procedure note so that the procedure is added to the patient's surgical history when the clinician signs the note.

To use this feature, you must create groupers to group the procedures that should be automatically added to a patient's surgical history, and then add those groupers to one or more profiles.

Create Grouper (VCG) Records

1. In Hyperspace, select Epic button > Tools > Management Console > Concept Related > Edit Grouper Record.
2. Create a new grouper record.
3. Enter EAP in the Master file field.
4. Enter General in the Type field.
5. List the procedure (EAP) records that you want to group on the General Info tab.
6. Click Accept.

Add Grouper Records to a Clinician's Profile

1. In Clinical Administration, open the profile that you want to edit.
2. Follow the path Procedure, Scheduling, Task > General Options.
3. On the Procedure Grouper screen, list the IDs of the grouper records you created in the Procedure Grouper Automatically Included In Surgical HX field.

Help Clinicians Choose the Right Orders When Adding Procedures to a Note

You can help ensure that clinicians select the right order when adding procedures to their notes by allowing them to select only orders on a preference list. When you configure this feature, the Database List tab doesn't appear when clinicians search for a procedure order to add to their notes. Instead, only the Preference List tab appears, which likely has fewer and more relevant procedures.

For example, consider a case where you've built several chest tube orders, including several intended for nursing care of a chest tube. If you configure a clinician's profile so that only orders on his preference list are available when he searches for a chest tube procedure order, you can ensure that he adds and documents on the appropriate order.

Before you enable this feature, you should create a preference list with appropriate procedure orders and add it to one of the following fields in a profile record:

- Inpatient procedure preference list (I LPR 17070). This preference list is used for inpatient, hospital outpatient visit (HOV), emergency, surgical, and anesthesia contexts.
- Outpatient procedure preference list (I LPR 17071). This preference list is used for outpatient and telephone contexts. To use this field, you must have the OP Procedure Documentation Pref List license, which is included in the standard EpicCare Inpatient license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

If clinicians don't have a preference list entered in one of these fields, they'll be able to document only procedures that have already been ordered for the patient, and they won't be able to add additional procedure orders from within the note. Refer to [Create a System Preference List for Orderable Items](#) topic for information about creating a preference list.

To configure a profile so that only the Preference List tab appears:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) > open a profile > Note, Letter, Transcription > Consult and Procedure Notes screen.
2. Enter 1-Yes in the Remove database list from procedure notes (I LPR 35188) field.

Show the Specialty Linked to Orders

⌚ Starting in November 2022

⭐ May 2022 by SUs E10212042 and C10212041-HSWeb

⭐ February 2022 by SUs E10115400 and C10115399-HSWeb

You can help clinicians select the correct order in procedure and consult notes by showing the specialty linked to the order. This is especially useful if you use a generic Physician Consult order in which the ordering user specifies the specialty the consult should go to.

The screenshot shows the 'Edit Note' interface. At the top, there are tabs for 'Manage Orders', 'Sidebar Summary', and 'Edit Note'. Below these are sections for 'My Note', 'Note Details' (Date of Service: 8/18/2022, 03:24 AM), and 'Consult Orders'. Under 'Consult Orders', there are two entries for 'PHYSICIAN CONSULT'. The first entry has 'Nephrology' highlighted with a red box. The second entry has 'Cardiology'. Both entries show the date '08/18/22' and time '0323'.

	<input type="checkbox"/> My Specialty	<input type="checkbox"/> Associated Orders
PHYSICIAN CONSULT	Nephrology	08/18/22 0323
PHYSICIAN CONSULT	Cardiology	08/18/22 0323

1. In Clinical Administration, follow the path Management Options > Profiles > Note, Letter, Transcription.
2. Go to the Consult and Procedure Notes - 2 screen.
3. Set the Show Specialty column in order list? (I LPR 35183) item to Yes.

Require Clinicians to Attach Orders Before Signing Procedure Notes or Consult Notes

You can help ensure that procedure and consult orders are completed by requiring clinicians to attach orders before signing procedure notes or consult notes. For procedure notes, this is particularly useful if you already use a close encounter extension 8850-Check for Unlinked Outpatient Procedure Notes to check that procedure notes created in the NoteWriter have an attached order.

If you create generic orders for procedure notes if a clinician hasn't already associated one before signing the note, that generic order fulfills this requirement. Refer to the [Automatically Create Generic Orders for Procedure Notes](#) topic for more information.

Before completing this setup, make sure you've completed the setup in the [Associate Notes With Consult and Procedure Orders](#) topic so that clinicians can associate notes with orders.

1. In Clinical Administration, open a profile and go to the Consult and Procedure Notes - 2 screen.
2. For procedure notes, enter Yes in the Require attached orders to sign procedure notes (I LPR 35181) field.
3. For consult notes, enter Yes in the Require attached orders to sign consult notes (I LPR 35182) field.

Add Information About Multiple Procedures in the Same Admission to a Note

You can create a SmartLink that allows clinicians to add procedural information from multiple procedures or surgeries that take place during the same admission to a note. For example, clinicians can use this SmartLink in discharge summary notes and post-operative notes to include information from several surgeries in a comprehensive summary of the patient's stay.

To create this SmartLink, you need to create a custom copy of wrapper SmartLink 40042-ORMULTI and configure it as needed. Then you need to add the wrapper to a SmartText and specify the SmartLinks that it should include.

Wrapper SmartLink 40042 includes three standard parameters, which you can configure in the SmartLink Editor after duplicating the SmartLink. You can use these parameters to specify whether the SmartLink pulls in procedural information from Radiant, Cupid, OpTime, or all three. You can also exclude certain logs based on their statuses.

Note the following limitations of SmartLink 40042:

- If you include more than 20 SmartLinks in one wrapper, errors can occur. If this many SmartLinks are needed, use multiple wrappers instead.
- If you include more complex SmartLinks, such as those that pull in implant or specimen tables, include very few other SmartLinks and do not enter captions for the table SmartLinks.
- This SmartLink is designed for use with OpTime SmartLinks that have an ID between 40000 and 40085, such as 40001-ORPROCAL. Other SmartLinks might not work as expected when added to SmartLink 40042. However, this SmartLink can still be used to show data in non-OpTime contexts, such as in inpatient notes.
- Custom SmartLinks created prior to 2010 cannot be used in this SmartLink.

For more information about available SmartLinks, refer to the [Search for Information About SmartLinks in Your System](#) topic.

SmartLink 40042 has three configurable parameters:

- 1-delim. Required. Determines what appears between the information for each procedure, to differentiate them in blocks for optimal readability. As released, a string of dashes appears between procedures.
- 2-loctype. Required. Determines the type of procedural information to include.
 - Enter null ("") to show both procedural (Radiant and Cupid) and surgical (OpTime) information. As released, this parameter is set to null, and both surgical and procedural information from all three products appears.
 - Enter 0 to show only surgical information documented in OpTime.
 - Enter 1 to show only procedural information documented in Cupid.
 - Enter 2 to show procedural information documented in Radiant.
- 3-filterStatus. Optional. Determines which logs are excluded from the list, based on their statuses. Enter a caret-delimited list of statuses from the Status (I ORL 510) item. As released, voided cases are filtered from the list.

Create a Custom Copy of the Wrapper SmartLink

1. In Hyperspace, follow the path Epic button > Tools > SmartTool Editors > SmartLink and open SmartLink 40042.
2. Click Save As to duplicate the SmartLink.
3. Select the SmartLink tab and configure the parameters as needed in the SmartLink code field. For example:
 - To show only surgical information, change the "" in the second parameter to "0".
 - To exclude information from voided, completed, or canceled logs, instead of only voided logs, replace the "4" in the third parameter with "4^5^6".
4. Enter contexts as appropriate for your needs. For example:
 - If clinicians will use the SmartLink in post-op notes, add OR Log Entry PostOp Notes.
 - If clinicians will use the SmartLink in discharge summary notes, add IP Discharge Summary.
5. Select the Active check box to activate your SmartLink.

Add Your SmartLink to a SmartText

1. In Hyperspace, follow the path Epic button > Tools > SmartTool Editors > SmartText and open or create a SmartText.
2. In the text preview field, add your copy of SmartLink 40042 by typing
@ORMULTI[caption1^mnemonic1,caption2^mnemonic2@]. For example, you might enter @ORMULTI[Log ID^LOGID,Operating Room^OR,OR Location^ORLOC@]. This would show the SmartLinks with the LOGID, OR, and ORLOC mnemonics in the note with the captions "Log ID," "Operating Room," and "OR Location."

Let Clinicians Add Post-Procedure Diagnoses as Visit Diagnoses

Clinicians might want to add post-procedure diagnoses to the visit diagnoses list directly from a procedure note. When you give clinicians the ability to add their post-procedure diagnoses from a procedure note, by default they can also specify a post-procedure diagnosis as the primary visit diagnosis.

When you perform the following setup, when a clinician adds a post-procedure diagnosis in a procedure note and signs or pends the note, the post-procedure diagnosis is added automatically to the visit diagnoses list and is

included as a visit diagnosis for billing. The clinician clicks the Primary column to the left of a post-procedure diagnosis to mark it as the primary visit diagnosis. You can prevent clinicians from marking diagnoses as the primary visit diagnosis from procedure notes if your organization requires clinicians to mark the primary diagnosis only from the Visit Diagnoses list.

When the patient already has visit diagnoses listed, the post-procedure diagnoses are added to the list and do not overwrite the previously entered diagnoses.

When a visit diagnosis is already marked as the primary visit diagnosis and a clinician marks a post-procedure diagnosis as the primary diagnosis in a procedure note, the post-procedure visit diagnosis replaces the visit diagnosis as the primary visit diagnosis. The original primary diagnosis remains on the visit diagnosis list as an ordinary visit diagnosis.

The top screenshot shows a 'Diagnoses' section with a 'Both' tab selected. A specific diagnosis, 'Broken wrist, left, closed, initial encounter', is highlighted with a red box. The bottom screenshot shows a 'Visit Diagnoses' list with the same diagnosis listed, along with its ICD-10-CM code, S62.102A.

1. In Clinical Administration, follow the path Management Options > Profiles > Note, Letter, Transcription.
2. Access the Consult and Procedure Notes screen.
3. Enter Yes in the Update encounter dx from post-procedure dx (I LPR 35185) field to save post-procedure diagnoses as visit diagnoses. By default, entering Yes in this field also allows clinicians to select a post-procedure diagnosis as a primary visit diagnosis.
4. If you don't want clinicians to be able to select a post-procedure diagnosis as a primary visit diagnosis, enter No in the Select primary dx from post-procedure dx (I LPR 35186) field.

Allow Clinicians to Document and Review Advance Care Planning Notes

You can allow clinicians to document and review information about advance care planning in the Notes activity or in print group [45538-Advance Care Planning Notes - All Encounters](#) by using the advance care planning note type. You can also include other note types that include advance care planning information in the print group.

You can integrate review and documentation of advance care planning (ACP) notes into advance care planning workflows by adding an ACP Notes navigator topic to a navigator or an activity, such as the Advance Care Planning activity used by clinicians in long term care facilities.

For example, the following roles can document or review ACP notes using one of these tools:

- Primary care physicians
- Clinicians working in the ICU
- Clinicians working in long-term care facilities
- Case managers
- Social workers
- HIM staff

All Notes Progress Consults Procedures H&P Discharge Emergency Plan of Care ACP Events Med Student Incomplete

2 of 2 notes displayed. All loaded.

Author Name	Author Type	Service	Status	Type	Date of Service	File Time
Chris Miller, MD	Physician	Urgent Care	Signed	ACP (Advance)	04/08/2015 1:41 PM	04/08/2015 1:41 PM
Bridget Brune, MD	Physician	Family Medicine	Signed	ACP (Advance)	02/13/2015 10:22 AM	02/13/2015 10:30 AM

Bridget Brune, MD Physician Signed Family Medicine ACP (Advance Care Planning) 2/13/2015 10:22 AM

Ben Avery and I discussed his advance directive today. He brought an updated copy in for review, which I have submitted.

Manual Template Copied

A clinician reviews his patient's ACP notes in the Notes activity

Advance Care Planning Notes [Create ACP Note](#)

Date of Service	Author	Author Type	Status
04/08/15 1237	Dana Wade, MD	Physician	Signed

A clinician reviews his patient's ACP notes in the advance care planning notes print group

Filed Advance Care Planning Notes [Create ACP Note](#)

Advance Care Planning Notes [Create ACP Note](#)

Date of Service	Author	Author Type	Status
05/05/15 1957	Miller, Chris, MD	Physician	Signed
04/14/15 1956	Wade, Dana, MD	Physician	Signed

A case manager reviews a patient's ACP notes from the ACP Notes navigator section

Considerations

You can use both standalone notes with a type of advance care planning and sections within other notes. We expect that most organizations need to use both options: standalone notes for when patients meet clinicians or other users to primarily talk about advance care planning, and sections for when advance care planning is discussed alongside other health concerns, such as during a physical.

Allow Clinicians to Document and Review Advance Care Planning Information from the Notes Activity

Add a tab that shows ACP note types so clinicians can review these notes. Refer to the [Make Note Types Available](#)

to [Clinicians in the Notes Activity](#) topic for information about adding a tab to the Notes activity. If you use advance care planning note types other than 71-ACP (Advance Care Planning), you also need to add them to EMR System Definition:

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Note, Trans, Communication > Advance Care Planning Notes screen.
2. Enter your note types in the Custom ACP note types (I LSD 34071) field.

Show a List of Advance Care Planning Notes in a Report

To make print group [45538-Advance Care Planning Notes - All Encounters](#) available to clinicians, add report 44310-IP ACP Notes or another report that contains print group 45538, to an activity, such as Patient Lists or Summary. Refer to the print group's Data Handbook entry for information about configuring it.

We recommend completing additional setup below to include non-advance care planning notes in the report.

Include Other Types of Notes That Have Advance Care Planning Information in a Report

You can also include other types of notes that contain advance care planning information in the [45538-Advance Care Planning Notes - All Encounters](#) print group. This is useful because, sometimes, it makes the most sense for physicians to include advance care planning information as part of a broader note, rather than a separate one.

You need to mark the start and end of this section so when users expand notes in the print group, only content in the advance care planning section appears. To configure what part of these notes is treated as an advance care planning section, add SmartLinks to denote the start and end of the section to your note templates. You can use SmartLink 750-Prog Note Section ACP - Begin to start a section and 755-Prog Note Section ACP - End to end a section. If you want to customize the section header, refer to the next section.

Make sure that the section SmartLinks are only included when clinicians are actually documenting that information, unless they should document advance care planning information every time they use a particular note template. You can do this in one of two ways:

- Make the SmartLinks appear when clinicians indicate through a SmartList that they are documenting advance care planning information.
- Make the SmartLinks appear when clinicians add an advance care planning-related SmartPhrase to a note.

SmartLinks 750-Prog Note Section ACP - Begin and 755-Prog Note Section ACP - End create a collapsible section. Refer to the [Automatically Collapse Sections in a Note](#) topic for instructions.

Customize the Header of ACP Note Sections by Creating Custom SmartLinks

By default, the ACP note section has a header of Advance Care Planning. You can customize the title that appears to physicians and other clinicians above the ACP section in advance care planning notes by creating a category list, creating custom SmartLinks, and updating your configuration in EMR System Definitions (LSD):

1. In Hyperspace, open Category List Maintenance (search: Category List Maintenance) for Section SmartLink Title (I ECT 34550).
2. Add a category with the title that should appear.
3. Open SmartLink 750-Prog Note Section ACP - Begin. Click Save As to create a copy.
4. Change the Section Title parameter to the category list value you created.
5. Click Save.
6. Repeat steps 3 through 5 for SmartLink 755-Prog Note Section ACP - End.
7. In Clinical Administration, go to Management Options > Edit System Definitions (LSD) > Note, Trans,

Communication > Advance Care Planning Notes screen.

8. Enter the category list value you created in the Custom ACP section types (I LSD 34078) field.

Integrate Review and Documentation of ACP Notes into Workflows

To integrate review and documentation of ACP notes and notes containing ACP sections into advance care planning workflows, add navigator topic 44303-Topic_ACP_Notes to a template to a navigator or an activity. Refer to the [Collect Topics into a Template](#) topic for more information about adding a navigator topic to a template.

Allow Clinicians to Summarize the Admission in a Hospital Course Note

Hospital course notes allow clinicians to keep a running summary of the patient's admission that is eventually used as the start of their discharge summary.



If your organization uses problem-oriented charting, there are some additional options for documenting the hospital course within problem-level assessment & plan notes. Refer to the [Incorporate Hospital Course Notes into Problem-Oriented Charting](#) topic for details.

Draft Hospital Course Notes with Generative AI

Starting in November 2025

August 2025 by SU E11501363, E11500649, C11500649

May 2025 by SU E11407280, E11401947, C11401947

February 2025 by SU E11310914, E11310903, C11310903

Drafting hospital course notes with the help of generative AI can help clinicians more quickly summarize the admission to include in their discharge summaries. An AI-generated draft pulls together information from notes and events documented throughout the admission, giving clinicians a starting point for their note. Organizations that started using an early version of this feature reported that the drafts save time in note-writing—one clinician who timed writing a note with and without AI and found that starting with the AI-generated draft made writing the note take 40 seconds instead of around 4.5 minutes.

For more information about this option, refer to the [Draft Hospital Course Setup and Support Guide](#).

Use Service-Specific Hospital Course Notes

You can configure the system to have a single hospital course shared across all services that treat the patient, or you can allow each service to document their own hospital course. If you make your course notes service-specific, clinicians can add their own notes about the care they performed without seeing or adding to other clinicians' notes. This might be especially beneficial for specialists working alongside the hospitalist team who might find it difficult to coordinate on a shared hospital course. Service-specific course notes don't allow specialties to see what the primary team documented, and if there's a patient transfer, users might not have access to the course note from the previous team if they are from a different specialty.

If you want to use service-specific course notes:

1. In Text, open the Menu (E2U) master file.

2. Open Foundation System menu record 3040005001-IP_IT_SBAR_HOSPITAL_COURS or your copy of it.
3. Go to the Run Parameter screen and update parameter 2-Service-Specific? to 1-Yes.

Open Hospital Course Notes in the Sidebar

If you want clinicians to open their hospital course note in a sidebar so that they can navigate to other parts of the patient's chart with their note open, you need to decide whether to open it as a sidebar activity by default or to add a link that opens the sidebar to a report or to a navigator section.

To add hospital course notes as a sidebar activity that is open by default:

1. In Chronicles, open the Menu (E2U) master file and create or duplicate a menu record that represents the sidebar.
2. On the Menu Information screen of the new menu record, edit the items list to configure which activities appear as tabs in the sidebar. Include the note-editing sidebar activity (E2N) record 34061-IP_SIMPLE_ONEPERENC_NOTE_SBAR.
3. Add your sidebar menu into a workflow engine rule for your inpatient physician workspaces. Refer to the [Make Navigators and Activities Available to Users](#) topic for more information.

To add a link to a report:

1. In Clinical Administration, go to Reports, Print Groups > Dup Print Groups and copy print group [45792-IP Banner – Generic Rule](#).
2. In your print group, set the fourth parameter to 34061. This is the ID for the note-editing sidebar activity (E2N) record IP_SIMPLE_ONEPERENC_NOTE_SBAR.
3. In the fifth parameter, enter the Note Type (I INP 5010) value of the hospital course note type that your organization uses and that you want to open for editing in the sidebar. If you want to allow each service to document their own course note instead of a single hospital course note that's shared across all services, enter two pipe-delimited pieces in this parameter and enter 1 in the second piece. For example, your parameter value could look like 12345|1.
4. Add your copy of print group 45792 to a report where you want the link to appear.

To add a link to a navigator:

1. In Clinical Administration, follow the path Navigators > Navigator Configurations (VCN) and create a new configuration record:
 - a. In the Apply to Section Type field, enter Activity Link.
 - b. Go to the Activity Link Settings screen.
 - c. In the Activity descriptor field, enter IP_SIMPLE_ONEPERENC_NOTE_SBAR.
 - d. Enter a caption for the link, such as Open hospital course note.
 - e. In the Run parameters field, enter the Note Type (I INP 5010) value of the hospital course note type that your organization uses and that you want to open for editing in the sidebar.
2. Create a new navigator section:
 - a. In the Type field, enter Activity Link.
 - b. In the Handler ProgID field, enter EIPVNSecHndlers{{CLIVER}}.IPVNAActivityLink.
 - c. In the Default Configuration field, enter the ID of the configuration record you created. If you want to allow each service to document their own course note instead of a single hospital course note that's shared across all services, enter two pipe-delimited pieces in this parameter and enter 1 in

the second piece. For example, your parameter value could look like 12345|1.

- d. Add your navigator section to a navigator. Refer to the [Collect Sections into Topics](#) topic for more information.

Include Hospital Course Notes in Discharge Summaries

After you've configured the options to allow clinicians to document in a hospital course note, update appropriate SmartTexts used for Discharge Summaries to pull in the hospital course using SmartLink 34032-Hospital Course Note (mnemonic: .HospCourseNote).

Allow Clinicians to Review Associated Notes Together

Save clinicians time and clicks by showing notes associated with the selected note in the Notes activity and Chart Review. When a clinician selects a note, notes that are considered associated based on settings you configure also appear. You can configure associated notes based on note service, provider type, and date of service. Note that unsigned and deleted notes don't appear, even when they meet the associated note criteria.

To show associated notes, configure one or more copies of extension 88821-IP Associated Note Filter that identify associated notes based on note service and author provider type. Then, associate each extension with a note type in EMR System Definitions. Note that if you configure this feature for the H&P, Interval H&P Note, or H&P (View-Only) note types, associated notes with any of the three H&P note types appear. For example, if you configure associated notes to appear for the H&P note type, when a clinician selects an H&P note, associated notes with a type of Interval H&P Note and H&P (View-Only) also appear if they meet the criteria in the extension.

To configure a copy of extension 88821:

1. In Chronicles, open the Extension (LPP) master file.
2. Go to Enter Data > Duplicate Extension and enter 88821.
3. Enter a unique ID for your extension based on your organization's numbering conventions. Epic recommends using a three-digit prefix for your application or specialty.
4. Enter a unique name for your extension.
5. Type Yes to duplicate the extension.
6. In Hyperspace, open your new copy:
 - Search: Extension
 - Path: Epic button > Admin > Master File Edit > Extension
7. Configure the parameters as desired:
 - To consider a note associated only if it has a certain service, enter a list of services in the Included Clinical Services field.
 - To consider a note associated if it has any service except certain specified services, enter a list of services to exclude in the Excluded Clinical Services field. This parameter is ignored if the Included Clinical Services field has values.
 - To consider a note associated only if it has the same service as the selected note, enter Yes in the Service must match field.
 - To consider a note associated only if the note's author has a certain provider type, enter a list of provider types in the Included Provider Types field.
 - To consider a note associated if the note's author has any provider type except certain specified provider types, enter a list of provider types to exclude in the Excluded Provider Types field. This

parameter is ignored if the Included Provider Types field has values.

8. Click Accept to save and close your record.

For example, if you're configuring associated notes for progress notes written by residents, you might enter Yes in the Service must match field and Physician in the Included Provider Types field to show only associated notes with the same service as the selected note written by an author with a provider type of Physician.

To associate an extension with a note type in EMR System Definitions:

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Note, Trans, Communication > Associated Notes screen.
2. If you want to show a divider to help clinicians distinguish where selected notes end and associated notes begin, enter 1-Yes in the Separate associated notes with a banner (I LSD 34239) field.
 - For example, if you're configuring associated notes for note types that tend to have enough documentation that clinicians need to scroll to review it all, you might want to enable this feature to help clinicians spot where the associated note begins while scrolling.
3. Enter a note type in the Note Type (I LSD 34235) column. You can enter the same note type multiple times in this column to associate it with multiple provider types or extensions.
 - Remember if you enter an H&P note type, associated notes with any of the Epic-released H&P note types appear.
4. If you want to limit the associated notes criteria to a specific provider type, enter it in the corresponding Provider Type (I LSD 34236) field. The system will show associated notes only if a note has the configured note type and its author has the configured provider type.
 - Note that this field is different than the provider types you might have entered when configuring your copy of extension 88821. The provider type you enter here applies to the selected note, while the provider types you entered in the extension apply to the notes associated with the selected note.
5. Enter the number of days back and forward the system should search for associated notes, based on the selected note's date of service. The maximum number of days you can search is 5. If blank, the system searches only for associated notes with a date of service on the same day as the selected note's date of service.
6. Enter your copy of extension 88821 in the Linking Extension field.
7. Click Accept to save and close your record.

For example, if you're configuring associated notes for progress notes written by residents, enter 1-Progress Notes in the Note Type field, Resident in the Provider Type field, and 1 in the Date Range field (or leave it blank).

To validate this build:

1. Log in to Hyperspace as a clinician who reviews notes for which you've configured associated notes.
2. In the Notes activity or Chart Review, select a note for which associated notes should appear. Remember, that the associated note won't appear if it's deleted or unsigned.
3. Verify that the expected associated note appears below the selected note.

Associate Notes with Flowsheet Documentation

Allowing clinicians to create notes directly from the Flowsheets activity and flowsheet navigator sections prevents them from having to enter notes as comments, which have a 60 character limit. Also, administrators no longer

have to create flowsheet rows with a row type of string, which were previously used to enter long comments.

When this feature is enabled, clinicians can right-click a single value, multiple selected values, or a column header in the Flowsheets activity and select New Note. When a clinician selects New Note, the Flowsheet Notes window opens in compact mode, which is a simplified version of the editor in the Notes activity. By clicking the Insert Data button, clinicians can copy data from flowsheets, which is more efficient than using SmartLinks to insert flowsheet data.

To allow clinicians to create notes from documentation flowsheets, you must add security points to Inpatient security classifications and configure settings in EMR System Definitions and profile records. You can also configure print groups of the type Doc Flowsheet to show flowsheet notes.

Clinicians must have Inpatient security point 280-Allow attaching Notes to Flowsheet Cells or EpicCare security point 336-Flowsheet Notes to create notes from the Flowsheets activity and flowsheet navigator sections. In addition, the icons that appear in documentation flowsheet column headers to indicate that a note is associated with one or more values in that column do not appear unless clinicians have one of these security points.

Specify the Default Date and Time for Flowsheet Notes

In EMR System Definitions, you specify the date and time that is used by default for notes created from documentation flowsheets.

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Flowsheet, Device Data Capture.
2. In the Flowsheet notes time/date default, enter one of the following values:
 - 1-Earliest. The date and time of the earliest selected column is used as the note's date and time.
 - 2-Latest. The date and time of the most recent selected column is used as the note's date and time.
 - 3-Now. The current date and time is used as the note's date and time. This is the default value.

Specify the Types of Notes Clinicians Can Create from Flowsheets

At the profile level, you must specify the types of notes that clinicians are allowed to create from documentation flowsheets. If a clinician has Inpatient security point 280-Allow Attaching Notes to Flowsheet Cells or EpicCare security point 336-Flowsheet Notes, but she does not have any note types specified in her associated profile, she can view flowsheet notes but she cannot create flowsheet notes.

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
2. Select Flowsheets and go to the Flowsheets - 3 screen.
3. In the Allowed note types for flowsheet notes (I LPR 34775) field, enter the types of notes clinicians are allowed to create from documentation flowsheets.

Show Notes in Flowsheet Print Groups

You can configure print groups of the type Doc Flowsheet, such as [46581-IP All Flowsheet Data \(Rich Text\)](#), to show notes that clinicians have associated with flowsheet data.

1. In Clinical Administration, follow the path Print Groups, Reports > Print Groups (LPG).
2. Open a copy of a print group of the type Doc Flowsheet.
3. Go to the Doc Flowsheet Print Group Configuration screen.
4. In the Flowsheet Notes field, enter one of the following values:
 - 0-Do not display flowsheet notes. Flowsheet notes do not appear.

- 1-Show hyperlink to note. Links appear that clinicians can click to access notes.
- 2-Show full note text. Each value with a note linked to it appears with a reference number. Clinicians can use the reference number to view the associated note at the bottom of the print group.

Allow Clinicians to Create H&P Notes from Outpatient SmartSets

To help clinicians document and file their History & Physical (H&P) notes when they see patients in outpatient encounters, you can add notes of note type H&P to your outpatient SmartSets.

Consider implementing this feature if you have clinicians, particularly specialists, who regularly use SmartSets during outpatient encounters where they perform History & Physical exams for upcoming procedures.

For example, Dr. Singh is a cardiothoracic surgeon who performs History & Physical exams two days a week at an outpatient cardiology clinic. She uses a cardiothoracic surgery general pre-operative SmartSet to place orders during the pre-op visit and would like to create an H&P note directly from the SmartSet.

You can create or use an existing H&P SmartText, and then add a SmartGroup containing the SmartText to your existing SmartSet or a new SmartSet.

H&P notes created from outpatient SmartSets can be viewed in Chart Review and the Inpatient Notes activity.

To create a SmartText to use in your H&P note, complete the setup instructions in the [SmartTexts](#) topic.

To add an H&P note to a SmartGroup:

1. In Hyperspace, open the SmartGroup Editor (search: SmartGroup; path: Epic button > Tools > Management Console > Decision Support > SmartGroup) and create a SmartGroup.
2. Select the Configuration form and click Add Item in the toolbar.
3. Select SmartText in the Item type menu and click Accept.
4. Enter your SmartText in the SmartText field.
5. Enter Inpatient Notes in the Filing Type field.
6. Enter H&P in the Note Type field.
7. Enter a display text.
8. Click Accept, and then click the Release button in the toolbar.
9. Click Save and Accept.

To add your SmartGroup to a SmartSet:

1. In Hyperspace, open the SmartSet Editor (search: SmartSet; path: Epic button > Tools > Management Console > Decision Support > SmartSet) and create or open an existing SmartSet.
2. Select the General Info form and enter any information necessary for your SmartSet.
3. Select the Configuration form, and then click Add Section in the toolbar.
4. Add a section display name and any additional information, and then click Accept.
5. Click Add SmartGroup in the toolbar. This button might be in the More menu on the right side of the toolbar.
6. Add your SmartGroup.

7. Click Release and Accept.

If you want your SmartSet to appear in specific specialties, departments, or encounter contexts, complete the setup instructions in the [Restrict SmartSets and Order Sets to Certain Contexts](#) topic.

Determine When Clinicians Can Write H&P Interval Notes

Many organizations interpret the CMS guidelines for H&P notes to mean that H&P interval notes shouldn't be created for a patient before the patient is admitted. To ensure that these guidelines are followed, the Add Interval button doesn't appear in the H&P Interval Note activity until the patient is admitted. By default, patients are considered to be admitted if they meet any of the following criteria:

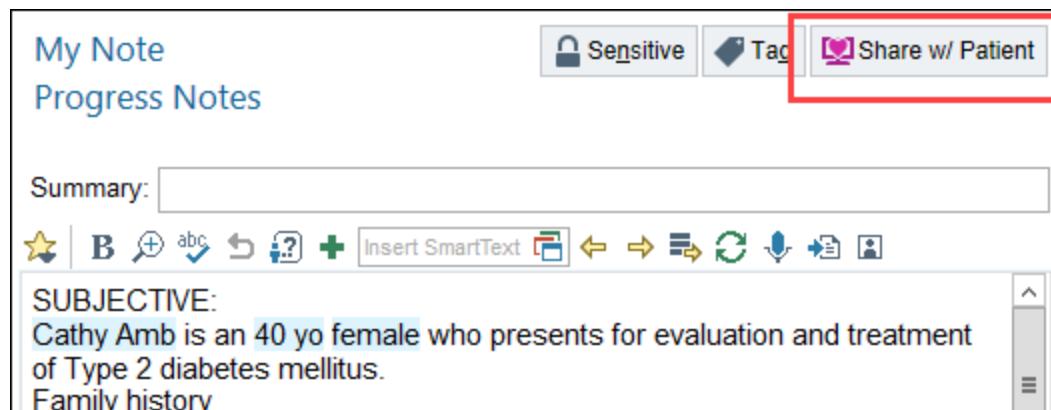
- They have a confirmed admission.
- They have a confirmed HOV.
- They have been marked In Pre-Procedure.
- They have been discharged.

Complete the following steps if you want to change the criteria used to determine whether a patient is admitted. The Add Interval button appears based on these criteria:

1. In Hyperspace, create a new Patient-context rule in the Rule Editor (search: Rule Editor). You can create a copy of rule 48090-OR Consider Patient Not Admitted for H&P Interval to get started.
2. Configure the rule to return true if the patient is not admitted based on your defined criteria.
3. In Clinical Administration, go to Management Options > Profiles (LPR) > Note, Letter, Transcription.
4. Go to the H&P Interval Settings screen.
5. In the Patient admission rule (I LPR 46066) field, enter your rule.

Determine Which Note Types Are Shared with Patients

Providing patients with access to physician-documented notes can positively impact patient-centered care and improve patient accountability. Research studies conducted by the non-profit OpenNotes organization show improvements in patient compliance with treatment due to the transparency provided by sharing notes, especially progress notes.



Shared notes are available to patients in MyChart when the note is signed. Starting in February 2021, and in November 2020 with special update E9504469, in August 2020 with special update E9408201, and in May 2020 with special update E9309488, notes written by clinicians whose profiles are configured to use one of the following Notes feature sets are automatically shared with patients in MyChart:

- 10-IP Default Features
- 11-AMB Default Features
- 12-HOV Default Features
- 13-ED Default Features
- 14-OR Default Features
- 15-TEL Default Features
- 16-AN Default Features
- 18-Specialty Plan of Care Default Feature

In previous versions, clinicians whose profiles are configured to use Notes feature set 11-Amb Default Features can manually share progress notes with patients by clicking the Share w/ Pt button in any note editor. Starting in August 2018, clinicians with Notes feature set 10-IP Default Features or 13-ED Default Features can manually share progress notes for ED visits and inpatient admissions with the Share w/Pt button. Notes created from SmartSets or the Flowsheets activity can also be shared. Your organization can add the Share w/ Pt button for additional note types, such as History and Physical Examination (H&P).

Starting with February 2021 or with the special updates listed below, notes are shared by default unless their note types are configured to be Allow sharing or Do not allow sharing in the Notes feature set. When set to Allow sharing, the Share w/ Pt button appears in the note type but isn't selected by default, but the clinician can select if appropriate. When specific note types are shared by default, clinicians can unselect the Share w/ Pt button to prevent the note from being shared in MyChart. Starting in November 2021, in August 2021 with SU E9801443, in May 2021 with SU E9705598, and in February 2021 with SU E9609595, this feature is also available in Haiku, Canto, and Rover. Note that if a clinician's feature set does not have the Sharing with patients feature enabled, then that clinician cannot share notes.

Starting with August 2021, you can further control whether a note is shared by default, allows sharing, or can't be shared based on specific criteria by configuring generic rules. For example, you might not want to share notes by default for adolescent patients and instead configure those notes to allow sharing.

In versions earlier than February 2021, notes are not shared by default unless you have one of the following special updates:

- November 2020 special updates E9503738, C9503738-Hyperspace, C9503738-EpicCare Link, and C9503738-HSWeb
- August 2020 special updates E9407610, C9407610-Hyperspace, C9407610-EpicCare Link, and C9407610-HSWeb
- May 2020 special updates E9309176, C9309176-Hyperspace, C9309176-EpicCare Link, and C9309176-HSWeb

Notes created in the Remote Client for home health and hospice are also automatically shared with patients starting in May 2021, February 2021 with special updates E9602352 and C9602352, November 2020 with special updates E9505993 and C9505993, and August 2020 with special updates E9409205 and C9409205. See [Create Notes on the Remote Client](#) for more information.



Contact your Epic representative and mention parent SLG 5798222 to determine the sharing status of your note types.

Prerequisites

Work with the MyChart analysts at your organization to complete the setup described in the [Share Clinicians' Notes with Patients in MyChart](#) topic.

Considerations

The following note types are meant to be patient-facing and appear to patients in the Notes tab of a past visit in MyChart, without needing to be individually shared:

- 23-Note to Patient via Portal
- 37-Patient Instructions

Starting in May 2024, the below discharge instructions no longer appear on the Notes tab.

- 61-Discharge Instr - Meds
- 62-Discharge Instr - Pharmacy
- 63-Discharge Instr - Activity
- 64-Discharge Instr - Diet
- 65-Discharge Instr - Appointments
- 66-Discharge Instr - Lab
- 67-Discharge Instr - Other Orders
- 68-Discharge Instr - Other Info
- A custom discharge instructions note type specified in the Allowed custom note types (I LSD 34047) field in the Discharge Instructions Note Types section of the Simplified Documentation Types screen in EMR System Definitions

Starting in November 2024 or in August 2024 with SU E11103101 or in May 2024 with SU E10908737, notes of type 37-Patient Instructions don't appear in the Notes tab, because they instead appear in the After Visit Summary.

To configure which note types are shared with patients by default:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations and open or create a Notes Feature Set.
2. On the Feature Set Configuration Record screen, verify that feature 18-Sharing with patients is present in the Features Enabled (I HFN 200) list. If it isn't in the feature set, add it.
3. Go to the Share with Patient Settings screen.
4. Enter your desired note type in the Note Type (I HFN 220) field. In the corresponding Shareable? (I HFN 221) field, enter one of the following values:
 - Allow sharing. The Share w/ Patient button appears in note editors in Hyperspace, and clinicians can click it to share notes of this type with patients. If notes are routed to In Basket, then QuickActions might be used on them. If a QuickAction is configured to share with the patient by default, then that setting will be respected when the QuickAction is executed. That is, the clinician would need to deselect the Share w/Patient button to prevent sharing the note. For more information related to QuickAction configuration, see the [Create QuickActions to Quickly Perform Common Tasks](#) topic.

- Share by default. The Share w/ Patient button appears in note editors in Hyperspace, and clinicians can unselect the button to prevent the note from being shared. This is the default value.
 - Do not allow sharing. Clinicians cannot share notes of this type.
5. If you want to change how certain notes are shared based on specific patient criteria, refer to the [Change a Note's Default Sharing Status Based on Patient Age or Other Specific Criteria](#) topic.
6. Result Notes will only respect the HFN settings when users have EpicCare Security Point 129-MyChart Lab Edit enabled. Without this security point enabled, Result Notes will automatically be blocked from sharing with the patient.

If you've created a new feature set, you'll also need to add it to a clinician profile. For more information, refer to the [Assign Feature Sets](#) topic.

If you configure notes to be shared by default or keep the default Shareable value of unlisted note types so they are shared by default, you can create a SmartPhrase for clinicians to document a reason if they choose not to share a note and use a close encounter validation check to remind them, as described in the [Prompt Users for a Reason When They Don't Share a Note](#) topic. It is possible for clinicians to set a preference to not share a certain note type, and you can hide this user setting as described in the [Hide the User Setting to Opt Out of Sharing Notes with Patients by Default](#) topic if you don't want clinicians to choose not sharing notes as their default preference.

In the Foundation System, we've configured feature sets 2100000011-Amb Features w/ Cosign and 2100000014-Amb Default Features w/ Open Notes to enable most note types for sharing and to share progress notes by default in the outpatient setting. We've also configured feature set 3041001-IP Default Features with Open Notes to allow clinicians to share progress notes with patients using MyChart Bedside. Refer to the [Show Clinicians' Notes in MyChart Bedside](#) topic for more information about how patients see these notes.

To see this configuration in the [Foundation Hosted environment](#), log in to Clinical Administration as your organization's project team member (AMBADM or IPADM).

Change a Note's Default Sharing Status Based on Patient Age or Other Specific Criteria

If you want to change the default sharing status of a note based on specific criteria, complete the following steps. For example, you might use this option so that all notes written for adolescent patients allow sharing but are not shared by default. Note that if you create multiple rules, the system uses the status for the first rule listed that returns True.

1. In Hyperspace, create a rule (search: Rule Editor) using a context of 8018-Share with Patient Default.
2. Add properties and logic so that the rule evaluates as True for scenarios where you want to use a different sharing status. For example, if you wanted to create a rule to limit based on patient age, you might use property 2221-Age: Visit. For details on working with rules, refer to the [Create or Edit a Rule](#) topic.
3. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations and open or create a Notes Feature Set.
4. On the second Share with Patient Settings screen, enter your rule in the Downgrade Rule (I HFN 226) field and the sharing status to use if that rule returns true in the Share Status (I HFN 227) field.

Update Share with Patient Settings for Custom Feature Sets

If you need to update share with patient settings for multiple feature sets, then you can use import specification HFN,1001-Share with Patient Settings to quickly complete this build. You can only update feature set records with a record type of 3-Feature Set Configuration using this specification.

Refer to the [Create a Custom Feature Set](#) topic for steps on how to create custom feature sets. Refer to the [Import Data into Chronicles](#) topic for steps on how to use a standard import specification.

This specification can be used only to change feature set items related to share with patient functionality. You can modify the following items with this specification:

Item ID	Item Name	Notes
.1	Record ID	You cannot create new records with this specification.
.2	Record Name	
5	Record Status	You cannot update deleted records with this specification.
200	Feature List	<p>You can export and import all features with this specification to ensure features in the record prior to the export are retained. This includes features that are not related to Sharing with Patient.</p> <p>For example, imagine that you export a Feature Set record that contains the cosigning feature. You can re-import that feature set record with the cosigning feature along with any other changes made in this item.</p>
220	Note Shared with Patient - Note Type	If any note type is not sharable, the import validation fails and logs an error. If any note type is duplicated, the import validation fails and logs an error.
221	Note Shared with Patient - Sharing Allowed	If there are more items in the Note Shared with Patient – Note Type (I HFN 220) item than there are in this item, the import validation fails and logs an error.
222	Disable User Level Opt Out of Share by Default	
223	Show Reason for Not Sharing Popup	
224	Show Reason for Not Sharing Text Field	
225	Hide MyChart Note Security in Hyperspace	

Update the Notes Activity Display Report

Because physicians can select multiple notes for review in the Notes activity, its display report requires unique configuration compared to other reports. While patient-level and encounter-level print groups can be added directly to your Notes activity display report (I LPR 34236), you cannot add note-level print groups directly to the report.

To add a note-level print group to the display report, you must add it to a copy of print group 45390-UCN Display Selected Notes. This print group uses the Display Print Groups parameter to define which note-specific print groups appear in the display report. Print group 45390 lists the following print groups in the parameter as released:

1. 45391-UCN Note Header
2. 45392-UCN Note Body
3. 50126-UCN Note Display Linked Notes
4. 45393-UCN Note Revision History
5. 45394-UCN Note Chart Correction History
6. 45395-UCN Note Routing History

To add a note-level print group to your display report:

1. In Chronicles, access the print group (LPG) master file.
2. Duplicate print group 45390-UCN Display Selected Notes.
3. In your copy, fast forward to the Parameters screen.
4. Select the Display Print Groups parameter and press F6 to edit it.
5. Add the note-level print group you want to show in the display report to the bottom of the parameter list and save your changes.

After you've updated your copy of print group 45390-UCN Display Selected Notes, you must add the print group to your Notes activity display report (I LPR 34236).

Notes Setup: Give Clinicians Notes Features

The topics in this section represent the many notes features, such as the ability to cosign notes, that you can make available to your clinicians. You'll make notes features available to clinicians by adding security points to their security classes and features to their feature sets. In some cases, you'll also need to configure additional settings in their profile records.

The features you choose to configure will depend on the workflows that your clinicians use. For example, you need to configure sensitive notes only if you have clinicians, such as psychiatrists, who write notes that should be visible only to certain clinicians.

Configure Feature Sets

Feature sets determine which notes features, such as the ability to cosign notes, are available to clinicians. Default feature sets differ based on encounter type. For example, a clinician who treats a patient in the hospital uses different notes features than a clinician who treats a patient in an office visit. You can assign a feature set to clinicians by adding it to a profile. Most feature sets are assigned to the system-level profile, but it is also possible to assign feature sets to department-level profiles.

Default feature sets represent recommended functionality, and therefore should provide access to all the notes-related features clinicians need in each encounter type. Default feature sets are available for the following encounter types:

- Inpatient: 10-IP Default Features
- Outpatient: 11-AMB Default Features
- Hospital outpatient departments: 12-HOV Default Features
- Emergency: 13-ED Default Features
- Surgery: 14-OR Default Features
- Telephone encounters: 15-TEL Default Features
- Anesthesia: 16-AN Default Features
- Specialty Plan of Care: 18-Specialty Plan of Care Default Features
- Dorothy and Comfort: 19-Home Health & Hospice Default Features

To investigate which notes features are available in a default feature set, open the Notes Activity Configuration (HFN) master file in Chronicles. Follow the path Enter Data > View Configuration and open one of the feature sets listed above. The notes features available appear in the Features Enabled list on the Feature Set Configuration Record screen.

You can also create custom feature sets for groups of users whose needs aren't met by the feature sets above. To allow clinicians to use a custom feature set, you must add features to that feature set, configure the available SmartText functional types, and add the feature set to a profile.

Create a Custom Feature Set

Default feature sets are designed to provide access to all the notes-related features clinicians need. However, you might encounter situations in which a clinician needs a unique feature set. For example, if physicians in a hospital outpatient department want notes to be signed at the close of an encounter, you would need to add the Sign when Signing Visit (February 2019 and earlier: Sign at close encounter) feature to your copy of the HOV Default Features feature set.

Be aware that some notes features are mutually exclusive. For example, a feature set can't contain the ability to share notes and the ability to sign a note at the close of an encounter. The available features are listed below, along with any mutually exclusive features.

Feature	Mutually Exclusive Features
Cosigning	
Sharing with clinicians	Make me the author (May 2024 and earlier) Sign when signing visit
Make me the author	Sharing with clinicians (May 2024 and earlier) Change author on edit
Hospital service field	
Note date/time	
Sensitivity	
Copy previous	
Copy/duplicate	
NoteWriter	
Tagging	
Sign when signing visit	Sharing with clinicians
Related encounters	
User revalidation	
Change author on edit	Make me the author
Chart correction	
Sharing with patients	
Note editor routing (starting in November 2023)	

1. In Chronicles, access the Notes Activity Configuration (HFN) master file.
2. Follow the path Enter Data > Duplicate Configuration, and duplicate one of the default feature sets.
3. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open your duplicate feature set.
4. On the Feature Set Configuration Record screen, add or remove features in the Features Enabled field.
Note that you can't add a feature that is mutually exclusive with another feature.

Assign Feature Sets

To allow clinicians to use a custom feature set, you must assign that feature set to an application context at the

profile level. Because the system looks at all profile levels when determining which features a clinician has access to, we recommend that you attach all feature sets to the system-level profile.

1. In Clinical Administration, go to Management Options > Profile > Note, Letter, Transcription and access the Notes Feature Set Configuration screen.
2. In the Application Context (I LPR 31400) field, enter an encounter context.
3. In the Feature Set (I LPR 31401) field, enter the feature set you want to associate with the encounter type listed in the Application Context field.
4. To assign a feature set to a department, access that department's profile and repeat steps 2 and 3.

Use SmartTexts in a Note

Configure Available SmartText Functional Types

In addition to notes features, feature sets also control which SmartText functional types are available in each application context. You can configure which functional types a clinician has access to based on which feature set he uses. For example, you can create a custom feature set to grant access to procedure SmartTexts in an ambulatory setting.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the SmartText Settings screen, enter the functional types of SmartTexts that are available when writing notes in the Default SmartText Functional Type field.
3. To narrow the list of searchable SmartTexts, enter the note types that should be available in the Note Type column and enter functional types that should be available in the SmartText Functional Type column.

Control Which SmartTexts and SmartLinks Medical Students Use in Their Notes

You can help medical students choose the right SmartTexts and SmartLinks when writing notes by reducing the amount of SmartTexts and SmartLinks available to them. When you add the IP Medical Student functional type to the note feature set used by your medical students and to appropriate SmartTexts or SmartLinks, medical students can use only SmartTexts and SmartLinks with that type when they write notes.

Note that, after you configure this feature, SmartTexts and SmartLinks with a type of IP NoteWriter continue to be available to medical students with access to the NoteWriter.

Add the functional type to the notes feature set used by your medical students:

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations > open the feature set.
2. Go to the SmartText Settings screen.
3. Enter 865-IP Medical Student in the Default SmartText Functional Type to restrict any note type that isn't overridden in the table below to the IP Medical Student functional type.
4. If you want to configure exceptions to the functional type for certain note types or if you didn't enter the medical student functional type in step 3, enter note types in the Note Type (I HFN 203) column and enter appropriate functional types in the corresponding SmartText Functional Type (I HFN 204) fields.

Add the functional type to a SmartText:

1. In Hyperspace, open the SmartText Editor (search: SmartText; path: Epic button > Tools > SmartTool Editors

- > SmartText).
2. Open or create a SmartText.
 3. Open the Restrictions card and enter 865-IP Medical Student in the Functional Type list.
 4. Make sure the Released check box is selected, and then click Accept.
- Add the functional type to a SmartLink:
1. In Hyperspace, open the SmartLink Editor (search: SmartLink; path: Epic button > Tools > SmartTool Editors > SmartLink).
 2. Open or create a SmartLink.
 3. Go to the SmartLink tab.
 4. Enter 865-IP Medical Student in the field next to the Add Context button, and then click Add Context.
 5. Make sure the Active check box is selected, and then click Accept.

Cosign Notes

You can give clinicians responsible for overseeing the documentation of other clinicians, such as attending physicians, the ability to cosign and attest notes written by the clinicians they supervise. This helps ensure that documentation is accurate and complete. If you require cosignature for certain note types or notes written by certain provider types, a cosigner must review and cosign before a note is considered signed.

To review how cosign requirements are set up in the Foundation System users, log in to the Foundation Hosted environment. Security settings control the cosign requirements for the nursing student, medical student, and resident users in the Foundation System.

Give Clinicians Access and Security to Cosign Notes

Clinicians must have the Cosigning feature in their feature set and must have either Inpatient security point 42-Notes Cosign or EpicCare security point 322-Can Cosign Others' Notes to be able to cosign notes. Additionally, in order for a clinician to be specified as the cosigner of a note, they must be able to receive In Basket messages of type 95-IP Cosign Note. Refer to the [Determine Which Message Types Users Can Send and Receive](#) topic for more information.

Note that the Cosigning feature causes the Cosign Required checkbox to appear by default when clinicians write or edit notes. Refer to the [Configure Cosign Requirements for Note Types](#) topic for information about how to remove this checkbox.

To add the Cosigning feature to a feature set:

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add 1-Cosigning to the Features Enabled field.

To update a security class:

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor).
2. Do either of the following:
 - o Open an Inpatient security class and set security point 42-Notes Cosign to Yes.
 - o Open an EpicCare security class and set security point 322-Can Cosign Others' Notes to Yes.

Configure Cosign Requirements for Note Types

Cosign requirements can be configured either in the security class or in the profile. Updating the security class allows you to require all notes that are written by particular users, such as medical students, to be cosigned without needing to set the requirement for each note type individually. Updating the profile allows you more flexibility to only require certain note types be cosigned or to allow users to decide whether a certain note needs to be cosigned. Regardless of which option you choose, to require or allow users to designate a cosigner for the note, you must configure the users' profile.

To update the security class to require all notes written by particular users to be cosigned, do either of the following:

- Open an EpicCare Inpatient security class (search: Security Class Editor) and set security point 28-Notes Cosign Required to Yes.
- Open an EpicCare security class (search: Security Class Editor) and set security point 323-Notes Require Cosign to Yes.

Considerations

If a user has one of these security points, the Cosign Required checkbox appears for all note types, even if the note type's Requirement is set to Unused in the profile as detailed below.

You can remove the Cosign Required checkbox from note types that should never be cosigned to ensure that clinicians can't select the checkbox by accident and to save room in the note editor. For example, this feature is useful for supervising clinicians who have the Cosigning feature in their feature set because they cosign others' notes. Because the Cosigning feature is used for both clinicians who cosign notes and clinicians whose notes require a cosignature, the Cosign Required checkbox appears for the supervising clinician by default. You can use this feature to remove the checkbox from all note types that the supervising clinician writes.

To update the profile to configure the cosign requirement for certain note types and to allow users to designate a cosigner for the note:

1. In Clinical Administration, open a profile.
2. Select Note, Letter, Transcription and go to the Notes Cosign Settings screen.
3. In the Cosign Requirements (I LPR 46000) section, list the note types that require cosignatures.
4. In the Requirement (I LPR 46010) field, enter one of the following:
 - Recommended. The Cosign Required checkbox is selected by default, but the note's author can clear it.
 - Required: The Cosign Required checkbox is selected by default, and the note's author can't clear it.
 - None. The Cosign Required checkbox appears in the note window, but it is not automatically selected. This is the default behavior.
 - Unused. The Cosign Required checkbox doesn't appear. If clinicians write notes that should never be cosigned, you can use this setting to prevent confusion by hiding the checkbox for those notes.
5. To require or allow users to designate a cosigner for the note, enter one of the following in the Forward to In Basket (I LPR 46020) field:
 - Required. The note's author must enter a cosigner.
 - Allowed. The note's author can enter a cosigner, but it is not required.

- Unused. The Cosigner field does not appear. This is the default behavior.
6. Enter Yes in the Default in cosigner? (I LPR 46030) field if you want the most recent cosigner to be entered in the Cosigner field by default.
 7. Starting in February 2024, the Cosigner role (I LPR 46032) field allows supervisors to be the default cosigner. If you leave this field blank, the most recent cosigner is used as the default cosigner. If providers typically have their supervisors cosign their notes, enter one of the following options.
 - 1-Encounter Supervising Provider. The supervisor who is specified when the provider logs in is the default cosigner.
 - 2-Supervisor for Current Provider. The supervisor specified in the Supervisor (I SER 1150) field in the provider's provider record is the default cosigner.
 - 3-ED Supervisor. The supervisor selected when the provider signs in to the ED is the default cosigner.

Make sure users for whom getting a cosignature is required have the Cosigning feature in their feature set, so that the Cosign Required checkbox appears:

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add 1-Cosigning to the Features Enabled (I HFN 200) field.

Configure the Cosign Method

You specify the methods by which clinicians can cosign notes documented by others, such as nurses or residents, at the system level and at individual profiles:

- Cosign only. With this option, clinicians can't include an attestation comment when cosigning a note.
- Cosign with attestation only. With this option, clinicians need to include an attestation comment when cosigning a note.
- Clinician choice to cosign or cosign with attestation. With this option, clinicians have buttons to either cosign or attest.

When configuring the cosign method, enter the most universally applicable method at the system level and configure overrides at the profile level. For example, if only notes of a certain type require an attestation, you can set the system-level cosign method to "cosign without attestation" and set a cosign method of "cosign with attestation" for the note type at the profile level.

To configure a cosign method at the system level:

1. In Clinical Administration, open EMR System Definitions.
2. Select Note, Trans, Communication and go to the Notes General Options - 2 screen.
3. In the Cosign method (I LSD 34009) field, enter:
 - 1-Cosign with attestation. This is the behavior when the field is left blank.
 - 2-Cosign without attestation.
 - 3-Both cosign with and without attestation.
 - 4-None. Use this option to disable cosigning at the system level and then enable it only in the appropriate profiles.

To configure a cosign method at the profile level:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
2. Go to Note, Letter, Transcription > Attestation Configuration Options - 2 screen.
3. If the cosign method should differ from the system-level setting, enter that method in the Default cosign method (I LPR 34231) field.
4. If the cosign method for certain note types differs, enter the note type in the Note Type (I LPR 34232) field and then enter the cosign method in the corresponding Cosign Method (I LPR 34233) field.

Ensure Clinicians Available for Cosign Are Authorized for the Service Area Where the Encounter Occurred

Starting in May 2024

You can restrict the list of cosigners available for a note to ensure the note is cosigned by a provider authorized for the service area where the encounter occurred. This might be useful, for example, for Connect organizations that want to limit cosigners to providers in their service area.

If you enable this feature, providers are available for selection if the Authorized All Service Areas (I EMP 5045) item in their user record is set to 1- Yes. If the provider is not authorized for all service areas, the system checks whether the encounter's service area is listed in the provider Service Area Authorization (I EMP 17700) item. If it is, the provider is available for selection as a cosigner.

To restrict the clinicians available for cosigning a note to those authorized for the appropriate service area:

1. In Clinical Administration, open the profile you want to edit (Management Options > Profiles (LPR)) and select Note, Letter, Transcription).
2. On the Notes Cosign Settings screen, enter Yes in the Restrict by Service Area? (I LPR 46033) field. When this field is blank, the default setting is No.

Set Preferred Authentication Method When Cosigning

Starting in May 2022

To set the preferred authentication method for notes, you must set the relevant Context and Primary Devices for a clinician in the Authentication Administration activity. To determine how to set the method by which clinicians revalidate their identity refer to the [Specify Authentication Rules Manually](#) topic.

Allow Clinicians to Edit Cosign-Required Notes

You can give clinicians the ability to edit cosign-required notes they have signed, without creating an addendum, as long as those notes haven't been cosigned yet. This feature allows anyone who has contributed to the note and anyone who can cosign the note to edit the note before it is cosigned. Changes are still tracked in the note's revision history.

1. In Clinical Administration, open EMR System Definitions.
2. Select Note, Trans, Communication and go to the Notes General Options - 2 screen.
3. Enter Yes in the Allow editing of cosigned-required notes? (I LSD 34028) field. When this field is blank, the default setting is No.
In the Foundation System, this field is set to Yes.

Considerations

When a provider with cosign security edits a note, the note loses its cosign requirement. If your system is not configured to automatically change a note's author to the editing clinician, and if the note's author does not have charging rules added to their profile, billing issues could occur because the note remains associated with the clinician who needs sign-off.

To ensure that the appropriate charges are filed when a clinician edits a note, we recommend that you enable the Change author on edit feature. For more information, refer to the [Change a Note's Author Automatically When a Clinician Edits a Note](#) topic.

Providers can edit cosign-required notes during attestation without removing the cosign requirement.

Allow Clinicians to Addend Attested Notes

By default, clinicians can't addend notes that have been attested. You can give clinicians a security point that lets them addend notes that have been attested. This ability is useful if the clinician later notices an error that should be corrected in a note. Clinicians with this security point can addend any attested notes, not just their own.

As with addenda to other notes, this can cause the author of the note to change. As an alternative, clinicians can edit the original note during attestation without becoming the author of the note.

To give clinicians the security point to addend any attested notes:

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor). Open an EpicCare security class.
2. Set security point 358-Can Addend Attested Notes to Yes.

Allow Clinicians to Cosign Any Note

You can give a clinician the ability to cosign or attest a note, even if that note doesn't require a cosignature. This feature is useful if attending physicians at your organization aren't required to cosign all resident notes of a certain type. For example, an attending physician might cosign a resident's daily progress note, but not a brief progress note that the resident writes later to document a change in the patient's condition.

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor). Open an EpicCare security class.
2. Set security point 357-Can Cosign Any Note to Yes.

Allow Users to Remove Another User's Cosignature from a Note

By default, a cosignature or attestation can be removed only by the clinician who cosigned or attested the note. You can give users, such as administrators, the ability to remove another user's cosignature or attestation from a note. This ability is useful for correcting a note that a clinician cosigned in error after that clinician has left the organization.

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor). Open an EpicCare security class.
2. Set security point 359-Can Remove Others' Notes Cosign to Yes.

Send In Basket Messages to Remind Clinicians to Cosign Notes

If you have configured a clinician's profile to require or allow him to enter a cosigner when he signs a note, you can automatically send an In Basket message to the clinician he specifies as his cosigner. This allows the clinician

to easily keep track of the notes that he must cosign.

1. In Hyperspace, follow the path Epic button > Admin > In Basket > Epic-wide Settings.
2. Select the Message Type Defaults form.
3. In a new row, enter IP Cosign Note in the Message Type column.
4. Enter 510 (IP NOTE COSIGN MSG) in the Definition column.
5. Enter the potential recipients of this type of message in the Registry column.
In the Foundation System, this field is set to 1-Staff.

To create deficiencies for cosign-required notes, refer to the [Create and Update Notes Deficiencies Automatically](#) topic.

Prior to May 2024, Chart Completion messages are not delayed. A cosign note deficiency message is sent to the Chart Completion folder and the Cosign Notes folder is sent a message for that same note. Starting May 2024, these deficiency messages are initially sent to only the Cosign Notes folder. The messages sent to the Chart Completion folder are delayed to reduce sending duplicate messages. Refer to the [Notify Providers of Deficiencies with In Basket Messages](#) topic to configure delaying In Basket deficiency messages.

Disable Command Buttons for Cosign Notes In Basket Messages

You can disable the Cosign, Edit, Attest, or Edit in Encounter buttons for Cosign Notes In Basket messages. For example, you could remove the Cosign and Edit buttons when coders send documentation queries that require physician attestation. That way, physicians can only click the Attest button. You specify the note types that this change applies to.

To configure this change, you need to identify which note types you want to disable actions for and what actions you want to disable.

1. Enter a list of note types in extension records.
 - a. In Chronicles, duplicate one or both of the following extension (LPP) records:
 - 3460-IB Enable Cosign Cmds. Use this extension to disable the Cosign, Attest, or Edit in Encounter buttons.
 - 3461-IB Enable Edit Cmd In Cosign Folder. Use this extension to disable the Edit Button.
 - b. In your copy, enter a list of note types in the Disabled Note Types parameter. Messages for these note types will not show the buttons that you configure in step 3.
2. In Chronicles, duplicate the In Basket Command (HIC) records for the button you want to disable:
 - Edit. 3450-IP Cosign Note Edit
 - Edit in Encounter. 3451-IP Cosign Note Edit In Enc
 - Attest. 3455-IP Cosign Note with Attestation
 - Cosign. 3460-IP Note Cosign
3. Add your extensions to the new command records. In Hyperspace, open your command records (search: Commands). On the Code form, enter your new extension in the Enable LPP (I HIC 955) field.
 - For your Edit button, enter your copy of extension 3461-IB Enable Edit Cmd In Cosign Folder.
 - For the Cosign, Attest, or Edit in Encounter buttons, use your copy of extension 3460-IB Enable Cosign Cmds.
4. Replace existing In Basket Command records with new ones for your Cosign Note Message Type.

- a. To create a copy of the Cosign Note message type, refer to the [Create a Custom Message Type](#) topic.
- b. Open your copy of Message Type Definition 510-IP Note Cosign Message (search: Message Type Definition). If you need to find your copy of 510, you can check Epic-wide Settings (search: Epic-wide Settings) to see the Definition associated with Message Type 95-IP Cosign Note.
- c. On the Command Buttons form, replace the Edit, Edit in Enc, Attest, or Cosign Command buttons with the ones you created in Step 3.

Determine the Behavior of In Basket's Encounter Button

When clinicians review notes in In Basket's Cosign Notes and Incomplete Notes folders, they can click Encounter to review a patient's chart and edit or attest to a selected note in the sidebar. Because clinicians at some organizations have a preference between editing and attesting to cosign-required notes, you can make their notes workflows more efficient by configuring the appropriate note editor to open every time a clinician clicks Encounter.

By default, clinicians with the appropriate security are prompted to choose between editing or attesting to a cosign-required note.

If a clinician can't edit a certain cosign-required note because they don't have the appropriate security, the encounter opens without opening the note, no matter which of the options you configure for your organization.

To determine the behavior of the Cosign Notes folder's Encounter button:

1. In Clinical Administration, follow the path Management Options > Edit System Definitions > Note, Trans, Communication.
2. Go to the Notes General Option - 2 screen.
3. In the IB Cosign Notes Encounter button action (I LSD 34091) field, enter one of the following:
 - 1-Prompt the user for an action (or leave the field blank). A window appears where clinicians decide whether to edit or attest to the selected note in the patient's encounter. Clinicians make this choice every time they click Encounter unless they save their preference by clicking Always Attest or Always Edit.
 - 2-Attest the note in the encounter. The patient's encounter always opens with the attestation editor in the sidebar.
 - 3-Edit the source note in the encounter. The patient's encounter always opens with the selected note open for editing in the sidebar.
 - 4-Launch the encounter without editing. The patient's encounter always opens without opening the selected note in the sidebar.

Show Removed and Previous Attestations

If users, such as administrators, need to review attestations that have been removed from a note or attestations to previous versions of a note, you can show these inactive attestations in a collapsible section below the note.

Depending on how you configure the profile, removed attestations or both removed and previous attestations appear in the Inactive Attestations section.

Note that the print groups below always show removed attestations in an expanded version of the Inactive Attestations section, but you can configure the profile setting so that they show both removed and previous attestations.

- [45417-UCN Revision History](#)
- [45911-IP Note Revision History](#)

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) > open a profile > Note, Letter, Transcription > Attestation Configuration Options - 1 screen.
2. Enter a value in the Show inactive attestations (I LPR 34230) field:
 - To show only removed attestations for the current version of the note in the Inactive Attestations section:
 - Enter 2-Show Collapsed to show them and collapse the section by default.
 - Enter 3-Show Expanded to expand the section by default.
 - To show removed attestations for both the current and previous versions of the note and attestations to previous versions in the Inactive Attestations section:
 - Enter 4-Show Related Collapsed to show them and collapse the section by default.
 - Enter 5-Show Related Expanded to expand the section by default.
 - Enter 1-Do Not Show or leave the field blank to hide the Inactive Attestations section completely.
 - Note that these settings affect the section that appears in the two revision history print groups differently. If you enter 2 or 3, the section is still always expanded in the history print groups. If you enter 4 or 5, removed attestations for both the current and previous versions of the note and attestations to previous versions appear in the section in the print groups. However, the section is still always expanded. If you enter 1, removed attestations to the current version of the note continue to appear in the section in the print groups.

Automatically Include SmartText in Attestations

You can configure a SmartText to appear automatically when a clinician creates an attestation. Including a SmartText helps ensure that attestations have similar structures and content and that they meet documentation requirements at your organization. You can create and assign different SmartTexts based on the note type of the note being attested.

1. Create or identify a SmartText to use for attested notes. Refer to the [Create and Edit a SmartText](#) topic for more information about building SmartTexts.
2. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
3. Go to Note, Letter, Transcription > Attestation Configuration Options - 1 screen.
4. Enter a note type and a SmartText that should appear for that type in the table.

Allow Clinicians to Update Date of Service Upon Attestation

If your organization requires that attending physicians attesting medical student documentation should update the note's date of service upon attestation, you can allow clinicians to update a note's date of service as part of their attestation workflows.

Clinicians must have the Note Date/Time feature in their feature set for the Date/Time fields to appear. They will not appear in cases where changing the date of service is inappropriate, such as when a note is linked to a case and must use the case's date and time as its date of service.

For more information on updating feature sets, refer to the [Configure Feature Sets](#) topic.

In the Foundation System, this workflow includes an attestation SmartText. To view this SmartText, log in to the Foundation Hosted environment and open SmartText 14010-Attending Not Present in the SmartText editor

(search: SmartText). For more information on setting a SmartText for a note type, refer to the [Automatically Include Text and SmartTools in New Notes](#) topic.

To enable the Date of Service fields for an attestation, identify the note types for which clinicians should be able to change the date of service during attestation. Then, enable the field for these note types:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) > open a profile > Note, Letter, Transcription > Attestation Configuration Options - 1 screen.
2. Enter a note type in the Note Type (I LPR 46035) field. If you've configured the profile to automatically include a SmartText for a note type, it'll already appear in the list.
3. Enter 1-Yes in the Update Service Date (I LPR 46037) field to show the Date of Service fields for attestations to notes of that type. If you leave the field blank or set it to 0-No, the Date of Service fields don't appear.

Prevent Clinicians from Editing the Original Note in Attestations



In the rare case that your organization determines that clinicians should not be able to edit the original note while they write an attestation, you can disable that option.

1. In Clinical Administration, follow the path Management Options > Profiles (LPR), and open a profile.
2. Select Note, Letter, Transcription, and go to the Attestation Configuration Options -1 screen.
3. Enter 1-Yes in the Disable edit during attestations? (I LPR 46039) field.

Create and View Sensitive Notes

In some scenarios, a clinician might want to restrict access to a note. Marking notes as sensitive ensures that only clinicians who need to see the notes can access them. For example, a nutritionist might not need access to a patient's psychiatric notes. When a psychiatric provider marks her notes as sensitive, the nutritionist cannot access them. You should work with your HIM team to determine which clinicians should have the ability to create sensitive notes and which clinicians should have the ability to view sensitive notes. By default, notes marked as sensitive are not sent to other organizations over Care Everywhere. Refer to the [Define Restricted Encounters, Departments, and Episodes for Care Everywhere](#) topic for the exceptions to restricting sensitive notes and encounters.

Considerations

HIM users can [Restrict Protected or Sensitive Information in Document Templates](#) to omit sensitive notes from a particular release of information if that is appropriate for the release request.

Records exchanged through Care Everywhere do not include notes marked as sensitive. However, if the note content is copied into another place in the patient's chart, the information might then be disclosed through Care Everywhere. Refer to the [Restricted Content](#) topic for more information.

Access to sensitive notes is determined by a hierarchy of rules. If there are no rules at one level, the system looks to the next level. When a rule is true, the clinician is granted access to the sensitive note. The system searches for rules in the following order:

- The provider record of the note's author
- The department record for the encounter department
- EMR System Definitions

You can use Epic-released rules to allow clinicians to access sensitive notes based on various factors, such as the provider's role, the note type, or the current workstation. You can also create custom rules to grant access to sensitive notes. If no rules are entered in any of the aforementioned fields, sensitive notes are visible to all users.

Give Clinicians the Sensitive Notes Feature

A clinician must have the Sensitivity feature in their feature set to create or view sensitive notes.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add 6-Sensitivity to the Features Enabled field.
3. If the feature set you updated isn't already listed in the clinician's profile, go to Management Options > Profiles (LPR) and open the clinician's profile.
4. Select Note, Letter Transcription. On the Notes Feature Set Configuration screen, enter a context in the Application Context (I LPR 31400) field and enter the feature set you customized in the corresponding Feature Set (I LPR 31401) field.

Allow Clinicians to Mark Notes Sensitive

You can give clinicians the ability to mark notes as sensitive by adding security points to their EpicCare security class.

EpicCare security point 173-Change Own Notes' Sensitive Status allows a clinician to mark only the notes he writes as sensitive. Security point 173 functions in three situations:

- When a clinician creates a new note, the Sensitive button appears in the note, and the clinician can select it to mark the note sensitive.
- When a clinician edits a note that he is the author of, the Sensitive button appears in the note, and the clinician can select it. If a clinician does not have this security point (or security point 174), the Sensitive button doesn't appear unless the note has already been marked as sensitive. In this case, the Sensitive button appears and is selected, but the clinician can't clear the selection.
- When a clinician edits an existing note that someone else is the author of and he has this security point but not security point 174, the Sensitive button appears in the note but the clinician can't clear the selection. However, if a clinician is able to mark himself as the author by selecting the Make me the author button, the Sensitive button is enabled and he can select it. If he clears the Make me the author button, the Sensitive button reverts to its previous state.

EpicCare security point 174-Change All Notes' Sensitive Status allows a clinician to mark all notes as sensitive. Security point 174 functions in two situations:

- When a clinician edits a new or existing note that he is the author of, the Sensitive button appears in the note and the clinician can select it to mark the note sensitive.
- When a clinician edits an existing note that someone else is the author of, the Sensitive button appears in the note and the clinician can select it to mark the note sensitive. If the clinician selects the button, the note indicates that he was the last person to edit it.

Note that to change the content of another person's unsigned note, a clinician must have EpicCare security point 170-Edit Others' Unsigned Notes.

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor). Open an EpicCare security class.

- Set security point 173 or 174 to Yes, as appropriate.

Allow Clinicians to View Sensitive Notes

Access to sensitive notes is determined by a hierarchy of rules. If there are no rules at one level, the system looks to the next level. When a rule is true, the clinician is granted access to the sensitive note. The system searches for rules in the following order:

- The system checks the provider record of the note's author. On the Sensitive Notes Rules screen, the Sensitive Clinical Notes Rules list (I SER 8201) determines the rules that apply to notes created by the provider. If this list contains any rules, the search stops after these rules are checked. If any rule is true, the current user is able to view the sensitive note. If there are rules listed and none of them are true, the current user is not able to view the sensitive note. If no rules are listed, the system moves on to check the encounter department record for listed rules.
- The system checks the department record for the encounter department. On the Sensitive Notes Rules screen, the Sensitive Clinical Notes Rules list (I DEP 17115) determines the rules that apply to notes created in this department. If this list contains any rules, the search stops after these rules are checked. If no rules are listed, the system moves on to EMR System Definitions to check for listed rules.
- The system checks EMR System Definitions. On the Sensitive Data Settings screen, the Sensitive clinical notes rules list (I LSD 1195) determines the rules that apply to notes created at the facility. However, this list is only checked if both the note author's provider and department records contain no rules.

Considerations

If no rules are entered in any of the aforementioned fields, sensitive notes are visible to all users.

The following rules are available to determine whether a clinician can view a sensitive note:

- 17000-Note Type Is Ambulatory Progress Note
- 17001-Current User Is Note Author
- 17002-Provider Type of Current User Is Physician
- 17003-Sign-on Department Is Department 1
- 17004-Current Provider's Dept Is Dept 1
- 17005-Current Provider's Specialty Is Allergy
- 17006-Current Provider Is a Care Team Member
- 17007-Current User Is Either Note Author or Proxy of Author
- 17008-Current Provider Is Current Patient PCP
- 17009-Note Type Is Telephone Encounter Documentation
- 34150-Note Type is Not 100000
- 34151-Note Author's Service Is Not 122
- 34152-Current User Has User Role
- 34153-Current User's Workstation Is Workstation 1

If these rules do not meet your organization's needs, you can copy existing records and create custom rules. Refer to the [Create or Edit a Rule](#) topic for information on creating custom rules.

Follow these steps to allow a specific clinician to view sensitive notes:

1. In Clinical Administration, open a provider record and access the Sensitive Notes Rules screen.
2. In the Sensitive Clinical Notes Rules list, enter one or more rules mentioned above, based on when the user should be able to view sensitive notes. For example, if you want the clinician to see sensitive notes that he wrote, enter rule 17001.

Follow these steps to allow all clinicians in a department to view sensitive notes:

1. In Clinical Administration, open the department record and access the Sensitive Notes Rules screen.
2. In the Sensitive Clinical Notes Rules list, enter one or more rules mentioned above, based on when clinicians should be able to view sensitive notes. For example, if you want clinicians to see sensitive notes that they wrote, enter rule 17001.

Follow these steps to allow all clinicians at a facility to view sensitive notes:

1. In Clinical Administration, open EMR system definitions and access the Sensitive Data Settings screen.
2. In the Clinical Notes list, enter one or more rules mentioned above, based on when clinicians should be able to view sensitive notes. For example, if you want clinicians to see sensitive notes that they wrote, enter rule 17001.

Automatically Mark Certain Notes Sensitive

You can assign a default sensitivity to notes with a certain type. This feature is useful if, for example, you want to make all psychiatric notes sensitive automatically. You set up this feature using a profile setting, so choose the profile record or records that you want to update before completing the following steps.

1. In Clinical Administration, open the profile record and go to the Notes General Settings - 1 screen.
2. In the Note Type field, enter the type of note that should be marked sensitive by default.
3. In the corresponding space in the Sensitive? field, enter Sensitive.

Configure Who Can See Routed Sensitive Notes

You can use reports 45407-IP Auto Routed Notes and 45408-IP Auto Routed Transcriptions and any routed copies of reports that contain print group [34502-IP Note Routing Attached Notes](#) to show clinicians information about routed notes. In some cases, you might want to restrict some users from seeing sensitive note information in these locations.

To ensure that only users with sensitive notes access can see sensitive note information in these reports, you can use the following rules to specify which clinicians should see sensitive notes and transcriptions that are routed to them:

- 34158-Note Author's Service Is Not Psychiatry
- 34159-Recipient Is Either Note Author or Proxy of Note Author
- 34160-Note Type Is Progress Note
- 34161-Recipient Is Note Author
- 34162-Provider Type of Recipient Is Physician
- 34163-Recipient's Dept Is the Specified Department
- 34164-Recipient's Specialty Is the Specified Specialty
- 34166-Recipient Is Referring Provider
- 34167-Recipient Is Patient's PCP
- 34168-Recipient Is Patient's Attending Provider

- 34169-Recipient Is Patient's Admitting Provider
- 34172-Recipient Is Treatment Team Member

You can also use the following properties to create custom rules:

- 42038-PCP
- 42041-Referring Provider
- 42042-Admitting Provider
- 42043-Attending Provider
- 42044-Treatment Team Members
- 42305-Last Edit User
- 42306-Automated Routing Recipients
- 42307-Note Author Linked Provide
 - Starting in May 2024, February 2024 with special updates C10800569 & E10800569, and November 2023 with special update C10703529 & E10703529, use property 42556-Note Author Linked Provider-Automatic Routing instead of this property in rules used to control routing sensitive notes.

These rules mimic sensitive note privileges for individual or groups of clinicians. For example, you can use rule 34162 to ensure that only providers with a provider type of Physician can see sensitive notes.

For more information about automatically routing notes and transcriptions, refer to the [Automatically Route Notes Transcriptions](#) topic.

1. In Hyperspace, follow the path Epic button > Tools > Rule Editor Tools > Rule Editor.
2. Duplicate the rule you want to use and configure your duplicate as desired. For example, to allow physicians to see routed sensitive notes, enter the following:
 - Property: Provider Type
 - Operator: =
 - Value (or Property): Physician
3. In Clinical Administration, open a provider record, department record, or EMR System Definitions and go to the Sensitive Notes Rules screen.
4. In the Sensitive Clinical Notes Auto-Routing Rules field, enter your rule.

Prevent Clinicians from Changing a Note's Sensitive Status

You might have some types of notes that should always be marked as sensitive. Although you can [mark the notes as sensitive by default](#), clinicians can still manually change the sensitive status if they have security to edit note sensitivity. To prevent clinicians from changing a note's sensitive status regardless of their security, you can disable the Sensitive button in the note editor.

Considerations

If you enable this feature, the Sensitive button is disabled for every clinician.

Interfaces of kind 11-Incoming Transcriptions respect this feature, which means that a transcription filed over an interface might be marked as sensitive or not sensitive regardless of the sensitivity flag in TXA-18. For example, if you disable the Sensitive button and a note type is marked as sensitive by default (I LPR 17017) but the interface message sensitivity flag is set to Usual Control (unrestricted), the note is still marked as sensitive.

To disable the Sensitive button in the note editor, complete the following steps:

1. In Clinical Administration, go to Management Options > Edit System Definitions (LSD) > All Screens.
2. Use Home + F9 to jump to the Sensitive Data Settings screen.
3. Set the Disable toggling note sensitivity (I LSD 1197) field to Yes. If you leave this field blank or set it to No, clinicians who have the [appropriate security](#) and the [Sensitive Notes feature](#) in their feature set can change a note's sensitivity.

Let Patients View Sensitive Notes in MyChart

By default, sensitive notes are hidden from patients and proxies in MyChart. You can allow patients and proxies to see sensitive notes in MyChart if those notes are marked to be shared with the patient.

Starting in August 2025, when patients and proxies view their notes on the Notes from Care Team tab in MyChart, they see any sensitive notes marked as Limited access. They can get further context from a banner above the notes list explaining that those notes are available to be viewed by fewer providers to protect their privacy. When they open a sensitive note, they see a similar banner explaining that this note can be viewed by fewer members of their care team for their privacy.

The screenshot shows the 'Notes from Care Team' section of the MyChart app. At the top, there is a red banner with the text: 'To protect your privacy, some notes have been marked for limited access. These notes can be viewed by fewer members of your care team.' Below the banner, there is a list of notes. The first note is highlighted with a red box around the 'Limited access' label. The note details are: 'Progress Notes' (Updated May 8, 2025, 9:17 AM) and 'Dr. B Ralston, MD'. The second note in the list is: 'Progress Notes' (Signed May 8, 2025, 9:10 AM) and 'Nurse Lawrence J'.

View of the Notes from Care Team tab from a visit with a note marked as sensitive. Above the notes list is a banner that reads, "To protect your privacy, some notes have been marked for limited access. These notes can be viewed by fewer members of your care team."

[← Notes from Care Team](#)

Progress Notes

Updated May 8, 2025



To protect your privacy, this note has been marked for limited access. This note can be viewed by fewer members of your care team.

Progress Notes by Dr. B Ralston, MD at 5/8/2025 9:17 AM

Subjective
Birdie Stokes is a 31 yo female who presents for Gender Affirming Care.
Patient expresses a desire to discuss options for gender affirming care, including hormone therapy and potential surgical interventions. They report feeling increasingly dysphoric and is seeking guidance on the next steps in their transition.

Objective
Patient appears well-groomed and in no acute distress. Vital signs are stable. Physical examination is unremarkable.

Assessment & Plan
Patient is a candidate for gender affirming care. Discussed hormone therapy options, including risks and benefits. Provided information on surgical options and referrals to specialists. Scheduled follow-up appointment in one month to monitor progress and address any concerns. Recommended mental health support and provided resources for counseling.

View of an individual note marked as sensitive. Above the note is a banner that reads, "To protect your privacy, this note has been marked for limited access. This note can be viewed by fewer members of your care team."

To enable patients and proxies to view sensitive notes in MyChart:

1. From the MyChart System Manager Menu, open the Clinical Note Sharing Options 1 screen.
2. In the Hide sensitive notes item (I WDF 346) enter 0-No.

For more information on hiding or showing notes in MyChart, review the [Limit How Notes Are Shared](#) topic in the [Appointments and Admissions in MyChart Setup and Support Guide](#).

Copy Notes

In some situations, clinicians might create several similar notes for a patient. For example, this might happen when a clinician needs to document the progress of a patient who routinely exhibits recurring symptoms. In these situations, he can save time by copying a previous note. To do this, he selects the note he wants to copy in the Notes activity and clicks Copy. The copied text then appears where the clinician's cursor is in the note editor window, and he can then edit and sign the note.

Occasionally, a clinician might want to document that a patient's condition hasn't changed. For example, this is useful for clinicians documenting daily progress notes for a long-term patient whose status is relatively stable. In these situations, a clinician can copy the full text of his previous note to a new note. To do this, he creates a new note and clicks Copy Prev. You can limit a clinician's ability to copy the previous note based on encounter and note status.

Give Clinicians the Copy/Duplicate and Copy Previous Features

Clinicians must have the Copy/Duplicate feature in their feature set in order to copy notes. They must have the Copy previous feature in their feature set in order to copy the previous note.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen:
 - Add Copy/Duplicate to the Features Enabled field to allow clinicians to copy notes.
 - Add Copy Previous to allow clinicians to copy the previous note.

Allow Clinicians to Copy Only Certain Notes

You can configure the system to allow clinicians to copy notes only if the note is from a related encounter or if the note is signed. This helps ensure that documentation from the copied note is relevant and accurate.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. Go to the Copy Previous Settings screen.
3. In the Encounters to search (I HFN 210) field:
 - Enter Previous encounters to allow clinicians to copy the previous note from any past encounter. This is the default behavior when the field is blank.
 - Enter This encounter and related encounters to allow clinicians to copy the previous note from only this encounter and related encounters.
4. In the Note status to search (I HFN 211) field:
 - Enter Signed and unsigned notes to allow clinicians to copy signed and unsigned previous notes. This is the default behavior when the field is blank.
 - Enter Signed notes only to allow clinicians to copy only signed previous notes.

Prevent Clinicians from Copying Notes

If your organization wants to ensure that clinicians consistently create situation-specific notes, you can disable note copying functionality at the system level.

By disabling copy functionality, you remove the following from the system:

- The Copy button from the activity toolbar of the Notes activity and note navigator sections
- The Copy Prev button from the note editor
- The Copy Previous Note button from the NoteWriter
- In February 2025 and earlier, the Copy Previous SmartBlock button from the NoteWriter

Clinicians also can't use Copy Previous Section SmartLinks to [copy sections of previous notes](#). To disable copy functionality, complete the following steps:

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communications.
2. On the Notes General Options - 3 screen, enter Yes in the Disable copy functionality (I LSD 34234) field.

Starting in May 2025, the disabling of Copy Previous SmartBlock is controlled by separate settings from the disabling of other note copying functionality. You can disable Copy Previous SmartBlock at the system level or disable it for only certain users.

To disable the Copy Previous SmartBlock button at the system level, complete the following steps:

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communications.
2. On the Notes General Options - 3 screen, enter Yes in the Disable copy SmartBlock functionality? (I LSD 33234) field.

To disable Copy Previous SmartBlock for only certain users so that other users can still copy previous SmartBlocks, disable Copy Previous SmartBlock at the note feature set level instead. Refer to the [Configure Feature Sets](#) topic for additional information about configuring and assigning note feature sets to users. To disable Copy Previous SmartBlock in a note feature set, complete the following steps:

1. In Clinical Administration, go to Management Options > Profile > Note, Letter, Transcription and access the Notes Feature Set Configuration screen.

2. Select the feature set you want to edit and press F8 to edit it.
3. On the Copy Previous Settings screen, enter Yes in the Disable Copy SmartBlock in NoteWriter? (I HFN 215) field to remove the Copy Previous SmartBlock button from NoteWriter.

Use Copy Previous to Copy from More Note Types

Changing the Copy From setting at a more specific level than the default overrides the default configuration for all note types listed in the table, causing the values above to be disregarded in favor of the newly specified note type(s).

Clinicians often use multiple types of notes to document the care they provide for patients. In some situations, clinicians might want to copy content from previous notes into a new note, such as when a patient presents for follow-up care. To help clinicians document these notes more efficiently, they can use Copy Previous to copy content from notes of a different type (I INP 5010) than the note they're writing. This includes notes created in the Notes activity, navigator sections, and NoteWriter. Note that this feature does not apply to the Copy button in the inpatient Notes activity.

For example, suppose a patient has surgical information that's documented in an H&P note. When the patient goes to his PCP for a follow-up visit, the PCP can use Copy Previous to add content from the H&P note into a progress note with a single click.

Encounters searched: All Encounters		Note status: Signed and unsigned notes							
Enc D...	Enc Type	Note Type	Date of Service	Status	Author	Author Type	Enc Provider	Department	Primary Diagn
11/07/2017	Office Visit	Progress Notes	11/7/2017 3:02 PM	Signed	LISKA, JACK	Physician	ROBERT SU...	JZL CENT FA...	
10/04/2016	Office Visit	H&P	10/4/2017 1:44 PM	Incomplete	LISKA, JACK	Physician	ROBERT SU...	CENT FA...	

Show only my notes 2 notes found, 2 years searched. [Remove Encounter Filters](#) [More](#)

[Add Text Only](#) [Accept](#) [Cancel](#)

By default, clinicians can copy from additional note types (I INP 5010) as summarized in the table below:

Note Type You're Writing	Note Types You Can Copy From
1-Progress Note	2-Consults, 3-Procedures, 4-H&P, 5-Discharge Summaries, 94-Group Note
2-Consults	1-Progress Note
3-Procedures	1-Progress Note
4-H&P	1-Progress Note
5-Discharge Summaries	1-Progress Note
37-Patient Instructions	1-Progress Note
94-Group Note	1-Progress Note

You can specify additional note types for which clinicians can use Copy Previous. You can also enter specific note types that clinicians can copy from when they write any of the note types listed above. Changing the Copy From setting at a more specific level than the default will override the default configuration for all note types listed in the table, causing the values above to be disregarded in favor of the newly specified note type(s).

There are additional considerations for how this feature works with anesthesia notes. The following note types are considered anesthesia notes:

- Anesthesia Preprocedure Evaluation
- Anesthesia Postprocedure Evaluation
- Anesthesia Procedure Note
- Any note type that's listed in the Single Copy Note Types (I LSD 89175) field or the Multiple Copy Note Types (I LSD 89176) field

When a clinician writes an anesthesia note and uses Copy Previous, she can copy from any of the following notes:

- Anesthesia note types (as defined above) that you specify. She can copy from only anesthesia notes that are related to the twelve most recent encounters of the type (I EPT 30) 53-Anesthesia Event Encounter. For example, if you specify that a clinician can also copy from Anesthesia Preprocedure Evaluation Notes when she writes Anesthesia Postprocedure Evaluation Notes, and she's previously written notes of either of those types in fifteen Anesthesia Event encounters, she can copy from only notes in the twelve most recent Anesthesia Event encounters. Note that the system also filters the anesthesia note types she can copy from based on the configuration of the Note status to search (I HFN 211) field.
- Non-anesthesia note types that you specify. She's not limited to copying from only recent notes of these types.
- Anesthesia clinicians with the default Anesthesia note feature set, 16-AN Default Features, can copy from Consult notes when they write Anesthesia Preprocedure Evaluation notes.

You can configure note feature sets (HFN) to specify all of the note types that clinicians can copy from when they're writing a certain type of note. You can also configure similar settings in EMR System Definitions. If you specify note types to copy from either in a note feature set or in EMR System Definitions, any default settings for that note type are overridden. For example, you can configure EMR System Definitions to specify that clinicians can copy from only other H&P notes when they write an H&P note.

You can use the Build Wizard in Hyperspace to configure note feature sets or EMR System Definitions to specify

which note types clinicians can copy from when they use Copy Previous. To get started, go to Epic button > Tools > Build Wizard and search for feature 170040-Copy Previous Across Note Types (application: EpicCare Ambulatory). Note that the Build Wizard doesn't configure note feature sets that are applied to fixed profiles, with the exception of the system-level profile.

If you need to tweak these settings after running the Build Wizard, or if you want to update a feature set that's applied to a fixed profile, complete the steps described in the following sections.

Configure Copy Previous for Additional Note Types in a Notes Feature Set

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations (HFN), and open a custom feature set for which you've enabled Copy Previous as described in the [Give Clinicians the Copy/Duplicate and Copy Previous Features](#) topic.
2. Go to the Copy Previous Settings screen.
3. In the Note Type (I HFN 230) field, enter a note type (I INP 5010) so that when clinicians write a note of this type, they can use Copy Previous to copy from additional note types.
4. In the Additional Note Type to Copy From (I HFN 231) field, enter an additional note type that clinicians can copy from when they write a note of the type that you listed in step 3.
5. Repeat steps 3 and 4 as needed. Note that you can enter the same note type multiple times in the Note Type (I HFN 230) field so when clinicians write that type of note, they can copy from multiple additional note types. For example, you might enter ED Notes multiple times in the Note Type (I HFN 230) field, and enter ED Triage Notes and ED Provider Notes on the corresponding lines in the Additional Note Type to Copy From (I HFN 231) field. Clinicians can then copy from both ED Triage Notes and ED Provider Notes when they write ED Notes.

Configure Copy Previous for Additional Note Types in EMR System Definitions

The following setup applies only when clinicians don't have Copy Previous settings (I HFN 230 and I HFN 231) configured in a notes feature set for the context in which they're writing a note.

Considerations

The EMR System Definitions settings don't apply to any profiles that use the default Anesthesia feature set, 16-AN Default Features. If you want the EMR System Definitions settings to apply to these profiles:

1. [Copy feature set](#) 16-AN Default Features and clear the Note Type (I HFN 230) and Additional Note Type to Copy From (I HFN 231) settings as described in the Configure Copy Previous for Additional Note Types in a Notes Feature Set section above.
2. [Assign the feature set](#) you created in step 1 to the system-level profile and any other profiles that are using the default Anesthesia feature set as needed.

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communication > Notes General Options - 3 screen.
2. In the Note Type (I LSD 6554) field, enter a note type (I INP 5010) so that when clinicians write a note of this type, they can use Copy Previous to copy from additional note types.
3. In the Additional Note Type to Copy From (I LSD 6555) field, enter an additional note type that clinicians can copy from when they write a note of the type that you listed in step 2.
4. Repeat steps 2 and 3 as needed. Note that you can enter the same note type multiple times in the Note Type (I LSD 6554) field so when clinicians write that type of note, they can copy from multiple additional

note types. For example, you might enter ED Notes multiple times in the Note Type (I LSD 6554) field, and enter ED Triage Notes and ED Provider Notes on the corresponding lines in the Additional Note Type to Copy From (I LSD 6555) field. Clinicians can then copy from both ED Triage Notes and ED Provider Notes when they write ED Notes.

Use SmartLinks to Copy Sections of Previous Notes

Some clinicians might write notes that contain a lot of duplicative text from previous encounters. For example, a patient might be seen several times over a short period in a rehab clinic. Portions of the note text from each visit might remain largely the same, such as the overall plan and goals of the rehab. Clinicians can use [Copy Previous](#) to copy a note from a previous encounter, but this requires the clinician to do one of the following to copy only a certain note section:

- Highlight the text in the Copy Note window and click Add Text Only.
- Copy the entire note and then manually delete the text that they don't want.

To help make it easier for clinicians to copy only the text they want, they can use Copy Previous Section SmartLinks to bring in a section from previous notes.

The following Copy Previous Section SmartLinks return a section from a previous note:

- 221-Last Visit Note Section - Subjective Text (mnemonic: .LASTVISITSUBJECTIVETEXT)
- 229-Last Visit Note Section - Objective Text (mnemonic: .LASTVISITOBJECTIVETEXT)
- 237-Last Visit Note Section - Assessment Text (mnemonic: .LASTVISITASSESSMENTTEXT)
- 238-Last Visit Note Section - Plan Text (mnemonic: .LASTVISITPLANTEXT)

These SmartLinks are similar to other SmartLinks that insert the text of a specific note section, such as SmartLink 701-Prog Note Section - Subjective text, except the SmartLinks listed above can return content from notes in a different encounter. For example, if a patient comes in for a physical therapy visit, the therapist can use SmartLink 238 to copy the plan section from his progress note written during the patient's last visit two weeks ago.

The SmartLinks use the section SmartLinks described in the [Automatically Collapse Sections in a Note](#) topic to define the portion of note text that is copied. For example, SmartLink 221 returns the text that's between SmartLink 700-Prog Note Section Subjective - Begin and whichever of the following is encountered first:

- An end section SmartLink like 705-Prog Note Subjective - End
- Another begin section SmartLink
- The end of the note

If a SmartLink can't find an appropriate section to copy text from, the text {There is no content from the last <section name> section.} appears, which ensures that clinicians have to edit or delete the text before they sign their note because of the braces.

When text is added to a note through a Copy Previous Section SmartLink, it's [attributed](#) in the same way as content that's brought in by using the [Copy Previous](#) functionality. This helps ensure that staff can investigate whether clinicians are using the SmartLinks appropriately in their notes.

Prerequisites

To use the Copy Previous Section SmartLinks, you must have the MR SmartLinks for Last Visit Note Sects license, which is included in the standard EpicCare Ambulatory license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

You also need to [give clinicians the Copy Previous feature](#) in their feature set.

Considerations

The Copy Previous Section SmartLinks are not intended to replace the [Copy Previous](#) feature. Instead, these SmartLinks are most useful in situations where all of the following are true:

- A patient is seen regularly across multiple visits.
- A clinician's note contains a section that they always want to copy across each visit without copying the entire note.
- The note section doesn't contain any SmartTools that must remain refreshable after they're copied.

When a note section is brought in by the Copy Previous Section SmartLinks, text from SmartTools is brought in only as text. This means that clinicians can't use NoteWriter to update copied text that was generated from a SmartBlock, refresh text generated from a SmartLink, or reselect the selections in a SmartList. For example, suppose the Objective section of the note from a patient's last visit includes a visit diagnosis SmartLink. If a clinician uses a Copy Previous Section SmartLink to copy that Objective section, her current note will show the visit diagnosis from the patient's last visit. As such, clinicians might not find these SmartLinks useful for copying note sections like an Objective section, which is most likely to contain SmartTool documentation.

Additionally, if the copied section contains a placeholder SmartLink for a partial dictation, that SmartLink is brought in as text and is not updated when the transcription is complete. The transcription text replaces the SmartLink only in the original note.

We recommend that you work with clinical leadership to determine for which clinicians this feature will be most helpful.

To allow clinicians to use the Copy Previous Section SmartLinks, you need to use section SmartLinks to define the specific sections (I ECT 34550) in their note templates that they can copy from.

Clinicians can use the Copy Previous Section SmartLinks as released to copy the following note sections (I ECT 34550):

- 1-Subjective
- 2-Objective
- 3-Assessment
- 4-Plan

You need to configure a copy of the SmartLinks if you want clinicians to copy from a different note section, or if you want to customize which notes the SmartLinks can copy from. By default, each SmartLink returns a section from the last progress note written by the current user in a prior encounter that occurred within 730 days of the current visit.

Refer to the sections below for instructions to define sections in note templates and for the available customization options for the SmartLinks.

Define Sections in Note Templates

You need to ensure that clinicians' note templates include section SmartLinks that define which section (I ECT 34550) the Copy Previous Section SmartLinks copy from. You can use the Epic-released SmartLinks listed below to indicate the Subjective, Objective, Assessment, and Plan sections of a note. If you want to indicate a different section, you can duplicate and customize an existing section SmartLink.

- 700-Prog Note Section Subjective - Begin (mnemonics: SUBJECTIVEBEGIN and SUBJECTIVE). This SmartLink indicates the beginning of the Subjective section.
- 710-Prog Note Section Objective - Begin (mnemonics: OBJECTIVEBEGIN and OBJECTIVE). This SmartLink indicates the beginning of the Objective section.
- 720-Prog Note Section Assessment - Begin (mnemonics: ASSESSMENTBEGIN and ASSESSMENT). This SmartLink indicates the beginning of the Assessment section.
- 730-Prog Note Section Plan - Begin (mnemonics: PLANBEGIN and PLAN). This SmartLink indicates the beginning of the Plan section.

Create a Custom Section SmartLink

Prerequisites

The following steps assume that you created a category value for the note section (I ECT 34550) that you want to copy from. Refer to the [Add a Value to a Category List](#) topic for more information about editing category lists.

1. In Hyperspace, go to the SmartLink Editor (search: SmartLink) and open a section SmartLink that you want to copy.
2. Click Save As, give your copy a new name, and click Accept.
3. On the General tab, enter a mnemonic.
4. Make sure that only unique synonyms are listed in the Synonyms table.
5. On the SmartLink tab, click the Default link.
6. Change the value in the SmartLink's title parameter to match the section (I ECT 34550) you want to define.
7. Click Accept.
8. If any contexts listed in the Available to Contexts section use code other than the default code, click the heading and edit the code to change the title parameter there, as well.
9. Select the Active checkbox and then click Accept.

Add Section SmartLinks to a Note Template

Prerequisites

You need Shared security points 11-Edit SmartText and 12-Release SmartText to create note templates.

If your note templates don't already include section SmartLinks, you can add them to existing or new note templates. Note that if you attempt to put one section SmartLink inside of another, the text in the sections won't appear as expected.

1. In Hyperspace go to the SmartText Editor (search: SmartText) and open an existing note template or create a new one.
2. On the General tab, add section SmartLinks by entering their mnemonics surrounded by at (@) signs. For

example, enter @SUBJECTIVE@ to add the Epic-released Subjective section SmartLink.

- When the template is complete, select the Released checkbox and click Accept.

If you added custom section SmartLinks to clinicians' note templates, complete the setup described in the next section to configure a copy of a Copy Previous Section SmartLink to use your custom section SmartLinks.

Configure a Copy of a Copy Previous Section SmartLink

By default, each Copy Previous Section SmartLink returns a section from the last progress note written by the current user in a prior encounter that occurred within 730 days of the current visit. You can customize the SmartLinks to copy a section from:

- Notes with a specific type (I INP 5010).
- Notes with a specific status.
- Only notes written by the current user.
- Only notes written by an author who has the same specialty as the current user.
- Only notes written in a certain encounter type (I EPT 30).
- Only notes written in the same department as the current user's login department.
- Notes that were written during [pre-charting](#).
- Notes that were written in any encounter that's linked to the same episode as the current encounter.

You can also change how many days in the past the SmartLinks look for a note to copy from, and the total number of notes the SmartLinks search.

Refer to the [Edit a SmartLink](#) topic for more information about configuring copies of SmartLinks.

Add a Copy Previous Section SmartLink to a Note Template

You can optionally add a Copy Previous Section SmartLink directly to a note template so clinicians don't have to manually insert them into their notes. For example, you might add SmartLink 221-Last Visit Note Section - Subjective Text (mnemonic: .LASTVISITSUBJECTIVETEXT) to rehab specialists' note templates because they almost always repeat the subjective section between a patient's visits.

Prerequisites

You need Shared security point 11-Edit SmartText and 12-Release SmartText to create note templates.

To add Copy Previous Section SmartLinks to a note template:

- In Hyperspace, go to the SmartText editor (search: SmartText) and open an existing note template or create one.
- On the General tab, add SmartLinks by entering their mnemonics surrounded by at (@) signs. We recommend that you add Copy Previous Section SmartLinks to a separate line than the corresponding beginning section SmartLink because of how the system inserts spaces around the text brought in by the SmartLinks. For example, to add SmartLink 221, we recommend that your template look as follows:
@SUBJECTIVE@
@LASTVISITSUBJECTIVETEXT@
- When the template is complete, select the Released checkbox and click Accept.

Share Notes with Other Clinicians

Shared notes allow multiple clinicians to collaborate on a single note. This is especially useful in departments where several care team members might contribute to the body of a note, such as a mental health unit. Shared notes appear on the Incomplete tab of the Notes activity and can be edited by all clinicians with the Sharing with clinicians feature.

To allow clinicians to share notes with other clinicians, you must have the UCN Shared Notes license, which is included in the standard EpicCare Ambulatory, EpicCare Inpatient, OpTime, or ASAP licenses. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

Give Clinicians the Security to Share Notes

Several security points control whether clinicians can create or view shared notes. To give a clinician the ability to share notes with other clinicians, you must give them either EpicCare Inpatient security point 161-Create Shared Notes or EpicCare security point 320-Can Create Shared Notes.

If you want your clinicians or other users to be able to view or edit other's shared notes, give them one of the following security points:

- EpicCare Inpatient security point 162-View Other Users' Shared Notes
- EpicCare Inpatient security point 163-View/Edit Other Users' Shared Notes
- EpicCare Inpatient security point 164-Administrative View/Edit Other Users' Pended and Shared Notes
- EpicCare security point 318-View Others' Shared Notes
- EpicCare security point 319-Edit Others' Shared Notes
- EpicCare security point 328-Unsigned Notes Admin Access

Note that the security points that give users the ability to view but not edit others' notes override higher levels of security. For example, if a user has security point 162-View Other Users' Shared Notes and security point 163-View/Edit Other Users' Shared Notes, that user can view but not edit other users' shared notes.

To add security points to security classes:

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor).
2. Do either of the following:
 - Open an EpicCare Inpatient security class and set security points 161, 162, 163, or 164 to Yes, as appropriate.
 - Open an EpicCare security class and set security points 318, 319, 320, or 328 to Yes, as appropriate.

Give Clinicians the Sharing with Clinicians Feature

Clinicians must have the Sharing with clinicians feature in their feature set in order to share notes.

Considerations

The Sharing with clinicians feature is mutually exclusive with the Sign when signing visit feature. In May 2024 and earlier, the Sharing with clinicians feature is mutually exclusive with the Make Me the Author feature.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add 2-Sharing with clinicians to the Features Enabled

field.

Choose Which Types of Notes Clinicians Can Share with Other Clinicians

You can configure the types of notes clinicians can share. This allows you to limit sharing to only notes that require collaboration among multiple providers.

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile > Notes General Settings - 3 screen.
2. Enter the types of notes clinicians should be able to share in the Allow sharing of note types (I LPR 49315) field.

Claim Authorship of Notes with the Make Me the Author Feature

When a clinician clicks Make Me the Author, he assumes authorship of that note, regardless of who created it. For example, a medical assistant can create a note and enter basic information and then a physician can later claim authorship and complete the note.

You can also show a message to a clinician when he clicks Make Me the Author that informs him of the ramifications of claiming authorship.

Give Clinicians the Make Me the Author Feature

Clinicians must have the Make Me the Author feature in their feature set and certain EpicCare security to claim authorship of notes. If you want them to be able to take ownership only of notes in certain departments, follow the steps in the [Allow Clinicians to Take Ownership Only of Notes in Certain Departments](#) section.

Considerations

The Make Me the Author feature is mutually exclusive with the Change author on edit feature. In May 2024 and earlier, it is mutually exclusive with the Sharing with clinicians feature.

To add the Make Me the Author feature to a feature set:

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add 3-Make me the author to the Features Enabled (I HFN 200) field.

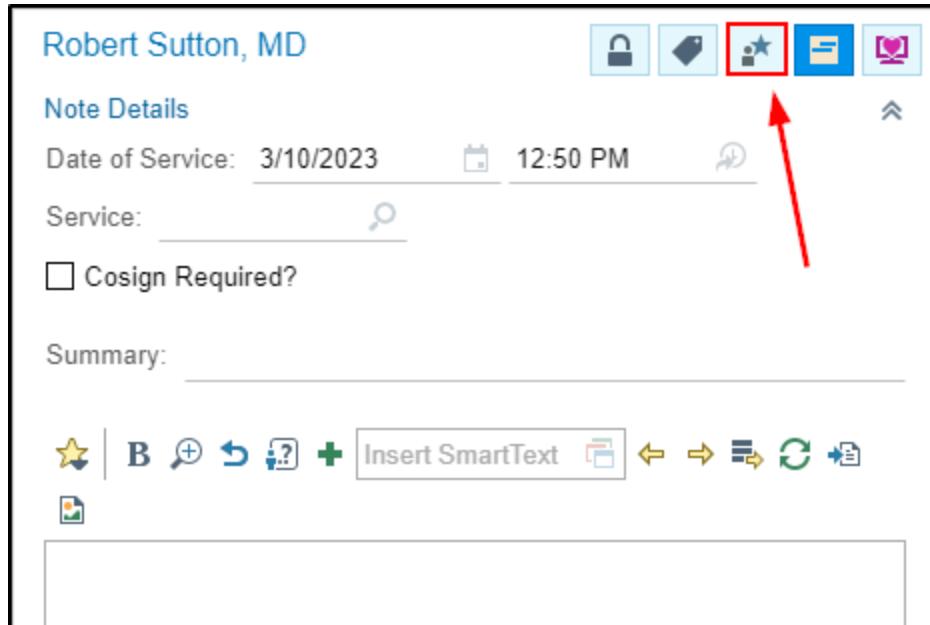
To update a security class:

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor).
2. Open an EpicCare or Inpatient security class and set the following security points to Yes:
 - EpicCare security point 170-Edit Others' Unsigned Notes
 - EpicCare security point 317-Edit Others' Incomplete Notes
 - EpicCare security point 417-Edit Others' Incomplete Telephone Documentation
 - Inpatient security point 288-View/Edit Other Users' Pended Notes
3. Make sure the following security points are set to No:
 - EpicCare security point 155-View Others' Incomplete Notes

- EpicCare security point 455-View Others' Incomplete Telephone Documentation
- Inpatient security point 287-View Other Users' Pended Notes

Starting in August 2024, clinicians can use Make Me the Author with shared notes and signed notes. To give clinicians access to edit shared notes, follow the steps in [Give Clinicians the Security to Share Notes](#) and [Give Clinicians the Sharing with Clinicians Feature](#). To give clinicians access to addend signed notes:

1. In Hyperspace, go to the Security Class Editor (search: Security Class Editor).
2. Set at least one of the following security points to Yes:
 - EpicCare security point 321-Can Addend Others' Notes
 - Inpatient security point 29-Notes Addendum



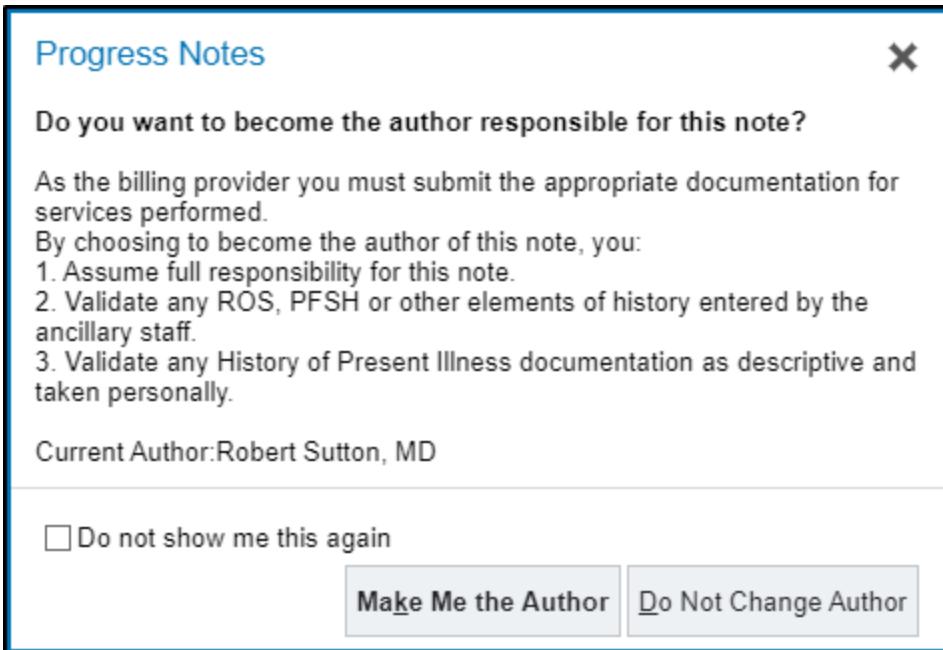
Clinicians can use the "Make Me the Author" button to claim authorship of a note.

Configure the Message and ToolTip that Appear When Clinicians Claim Authorship of a Note

You can show a message to a clinician when he clicks Make Me the Author that informs him of the ramifications of claiming authorship. You can configure the text of the message and the text of the tooltip that appears when a clinician places his mouse over the Make Me the Author button.

1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription > Make Me The Author Settings screen.
2. Configure the following fields as desired:
 - Show message when the author of a note changes? (I LPR 17013): Enter Yes to show a message. By default, this field is set to No, and no message appears.
 - Tooltip text to use for Make Me The Author button (I LPR 17014): Enter text that appears when a clinician places his mouse over the Make Me the Author button. By default, this field is blank, and no text appears.
 - Message to display when the author of a note is changed (I LPR 17009): Enter text that appears in

the message. By default, this field is blank, and no text appears.



Example of the message a clinician sees after selecting Make Me the Author.

After a clinician has seen the message that appears when he clicks Make me the author, he can suppress it by selecting the Don't show me again check box. If you want to cause the message to appear again for certain users or for all users even if they've suppressed the message, for example because you've updated the message and want all users to see it, you can run a utility.

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Undo Make Me Author Msg Suppression.
2. To show the message for specific users:
 - a. Select Specify Profile for which to undo Message Suppression.
 - b. Enter the profile number.
3. To show the message for all users, select Undo Message Suppression for all Users.

Allow Clinicians to Claim Authorship of Notes from In Basket

You can allow clinicians working in In Basket to quickly claim authorship of a note in an encounter linked to an In Basket message by clicking Make Me Author. If a clinician clicks Make Me Author in an In Basket message, a message prompts the clinician to confirm that she wants to claim authorship of the note. Note the following:

- The same restrictions that apply to the Make Me the Author workflow that clinicians complete directly in the patient's encounter apply to this In Basket workflow. For example, a clinician can't claim authorship of a note that has already been signed.
- A clinician can't use this button to claim authorship of multiple notes in a single encounter. To do this, she must open the encounter and claim authorship of the notes from the encounter.

Complete the following steps to add the button to a message type definition that includes linked encounters, such as 26-My Open Encounters or 90-CC'd Charts:

1. In Hyperspace, follow the path Epic button > Admin > In Basket > Message Type Definitions and open a copy of the message type definition you want to configure.

2. On the Command Buttons form, add button 1105-Make Me Author to the first available row in the Buttons table.

Show Error Messages when Users Can't Become the Author of a Note

You can configure the Make Me Author button to show error messages explaining why a user is unable to take authorship of a note instead of having the button be unavailable. When you use the Epic-released Make Me Author button (as described above), if conditions are not met for the current user to become the author of the note, the button is unavailable. If you create a copy of this button and remove extension 11052-HIC11051Enable extension from the Enable LPP (I HIC 955) field, users instead see an error message explaining why they can't become the author of the note.

Let Clinicians Take Authorship of Different Note Types in In Basket

By default, the Make Me Author button described above searches for a note type of 1-Progress Notes when the encounter type is 1-Ambulatory or for a note type of 5-Telephone when the encounter type is 36-Telephone Encounter. If you want the button to look to different note types in specific encounter types, you must create a copy of the Make Me Author button and associated records:

1. In Chronicles, open the Command (HIC) master file and duplicate command 1105-Make Me Author.
2. In Chronicles, open the Extension (LPP) master file and duplicate extension 11052-HIC11051Enable.
3. Open your duplicate extension and enter note types to look for in each type of encounter in the parameter. Refer to the parameter help text for how to properly format this value.
4. In Hyperspace, open your copy of the Make Me Author command (search: Commands).
5. Navigate to the Code form under General Settings and clear the Enable LPP (I HIC 955) field and replace it with your custom extension to apply your changes from step 3.

Change a Note's Author Automatically When a Clinician Edits a Note

Instead of having a clinician manually claim authorship of a note, you can automatically make certain clinicians the author of any notes that they edit. This ensures that notes accurately reflect a patient's current provider.

To automatically update a note's author when a clinician edits it, add the Change author on edit field to a clinician's feature set.

Considerations

The Change author on edit feature is mutually exclusive with the Make me the author feature.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open your duplicate feature set.
2. On the Feature Set Configuration Record screen, add Change author on edit to the Features Enabled (I HFN 200) field.

Choose Whether a Clinician Can Be the Author of a Note Based on the Original Author Type

⌚ Starting in February 2024

⭐ November 2023 by SU E10702629

 **August 2023 by SU E10607461**

 **May 2023 by SU E10513714**

 **February 2023 by SU E10416887**

You can configure whether a clinician automatically becomes the author of a note, is given the option of becoming the author, or does not have the option of becoming the author depending on who the original author is.

For example, you might want physicians to automatically become the author of notes started by a resident, have the option of becoming the author of notes started by a nurse, but not have the option to become the author of notes started by cardiologists. To make this possible, you'd configure an extension and then specify that extension in your physicians' profile record.

Follow the steps below to set up this feature:

1. In Chronicles, open the Extension (LPP) master file and duplicate extension 5928 MR-AutoAuthorType.
2. Open your copy and go to the Parameters screen.
3. In the AuthType parameter, enter the provider types for which the Make Me the Author button should not appear. In the example above, you'd enter Cardiologist in this parameter.
4. In the ifNotResult parameter, select the default behavior for provider types that are not listed in either AuthType or Preselect Providers.
 - Enter 0 if you want the editing provider to have the option to become the note author, but you do not want the editing provider to become the note author automatically.
 - Enter 1 if you want the editing provider to automatically become the note author.
5. In the Preselect Providers parameter, enter the editing provider type that should automatically be made the author of the note. In the example above, you would enter Resident in this parameter.
6. In Clinical Administration, select Management Options > Profiles and open the profile you want to modify.
7. Select Note, Letter, Transcription.
8. On the Notes General Settings - 1 screen, enter the type of note you want your extension to apply to in the Note Type (I LPR 17015) field.
9. In the corresponding Make Me Author Def Status Ext (I LPR 17016) field, enter your extension.

Allow Clinicians to Take Ownership Only of Notes in Certain Departments

Clinicians with EpicCare security point 170>Edit Others' Unsigned Notes can take ownership of notes written by other clinicians, including unsigned notes. You can use extension 5925-Make Me the Author-Encounter Dept Matches Provider Dept to limit this ability only to notes for encounters that occur in a department in which the clinician can be scheduled (I SER 40). For example, if a cardiologist can be scheduled only in a cardiology department, he can take ownership only of notes written for encounters in the cardiology department, but not in other departments, such as the ICU.

1. If desired, copy extension 5925 in Chronicles and configure the parameters. You need to make a copy only if you want to change the released behavior.
 - Display for Provider Department. Optional. Determines whether the Make Me the Author check box appears when the encounter takes place in a department in which the clinician can be scheduled. If this parameter is set to 1, as released, the check box appears and is selected by default. If this

parameter is null or 0, the check box appears but isn't selected. Set this parameter to 2 to hide the check box.

- Display for Other Department. Optional. Determines whether the Make Me the Author check box appears when the encounter does not take place in a department in which the clinician can be scheduled. As released, this parameter is set to 2, and the check box does not appear. If this parameter is null or set to 0, the check box appears and is cleared by default. If this parameter is set to 1, the check box appears and is selected by default.

2. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
3. Go to Note, Letter, Transcription > Notes General Settings - 1 screen.
4. Enter a note type in the Note Type (I LPR 17015) field.
5. Extension 5925 or your copy in the corresponding Make Me Author Def Status Ext (I LPR 17016) field.

Configure Make Me the Author for Signed Notes

Starting in August 2024

Clinicians with the security to edit signed notes can use Make Me the Author on signed notes. By default, a clinician must select Make Me the Author to take ownership of a signed note. You can optionally customize extensions if you want clinicians to take over authorship by default when they edit signed notes, or if you want to prevent them from taking over authorship of signed notes.

Select Make Me the Author by Default for Signed Notes

Clinicians with extension 5921-Make Me the Author - Default Yes have Make Me the Author selected by default only when editing unsigned notes.

To select Make Me the Author by default for signed notes:

1. Copy extension 5921 and set parameter 3-Enable For Signed Notes? to 1-Yes.
2. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
3. Go to Note, Letter, Transcription > Notes General Settings - 1 screen.
4. Enter a note type in the Note Type (I LPR 17015) field.
5. Enter your copy of extension 5921 in the corresponding Make Me Author Def Status Ext (I LPR 17016) field.

Hide Make Me the Author for Signed Notes

Clinicians with extension 5922-Make Me the Author - Default Hide have Make Me the Author completely hidden, even if it exists in their feature sets.

To hide Make Me the Author for only signed notes:

1. Copy extension 5922 and set parameter 3-Only Hide Signed Notes? to 1-Yes.
2. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
3. Go to Note, Letter, Transcription > Notes General Settings - 1 screen.
4. Enter a note type in the Note Type (I LPR 17015) field.
5. Enter your copy of extension 5922 in the corresponding Make Me Author Def Status Ext (I LPR 17016) field.

Route Notes

A clinician can route a note to share patient information contained in notes with other clinicians. You can allow clinicians to route notes to selected recipients from the Notes activity using In Basket messages, fax, or mail. To set up the routing notes using a fax feature, you must be using a third-party faxing vendor. Work with your HIM team to determine the appropriate methods and recipients for routing notes.

The Route button is added to the Notes activity toolbar by Inpatient security point 166-Notes Routing or EpicCare security point 327-Notes Activity Routing. Starting in November 2023 these security points also adds the Route button to the note editor, if the user also has 22-Note editor routing in their feature set (HFN). See [Review and Specify Routing Recipients within the Note Editor](#) below for more information on routing within the note editor.

When a clinician clicks Route in the Notes activity or the note editor, the options that are available depend on his routing setup. Although you don't need to be using the Communication Management navigator section to use the Route button, both features rely on the same settings. For additional information about configuring the Communication Management navigator section, refer to the [Set Up Communication Management](#) topic.

Allow Clinicians to Route Notes Through In Basket

Clinicians can send notes to other clinicians using In Basket messages.

1. In Hyperspace, follow the path Epic button > Admin > In Basket > Epic-wide Settings.
2. Enter the following on the Message Type Defaults screen:
 - In the Message Type column, enter IP ROUTING.
 - In the corresponding Definition column, enter 500-IP ROUTING.
 - In the corresponding Registry column, enter the potential recipients of this type of message (for example, 1-STAFF).
3. In Clinical Administration, select Management Options > Edit System Definitions > Note, Trans, Communication > Inpatient Notes General Options screen.
 - In the Notes routing report field, enter 34502-IP Notes Routing Report.
4. Page down to the Communication Management Setup- Routing screen.
 - In the Route Method column, enter In Basket.

Allow Clinicians to Route Notes to In Basket Classes

Starting in November 2021

If clinicians at your organization need to route notes to multiple providers, you can let them route notes to classes from the Notes activity. As the [Set Up Classes](#) topic explains, routing a note to a class is like sending an email to an email list: everyone in the class receives a copy of the same message. When you let clinicians route to classes, a green Class button appears in the window where they complete their routing workflows.

To make clinicians' In Basket management easier, many organizations prefer to route notes to pools. As the [Send Messages to Pools](#) topic explains, all members of a pool are treated as a single recipient, so one member can resolve an In Basket message for all members of the pool. This is why clinicians can route notes to pools but not to classes by default.

To let clinicians route notes to classes:

1. In Clinical Administration, follow the path Management Options > System Definitions > Note, Trans, Communication.

2. Go to the Notes General Options - 2 screen.
3. In the Enable routing to classifications (I LSD 34233) field, enter 1-Yes.

Allow Clinicians to Route Notes Through Faxes

Clinicians can send notes to other clinicians through faxes when In Basket messages aren't an option.

Prerequisites

Check with your Epic Client System Administrator (ECSA) or faxing administrator and make sure that your organization has set up integrated faxing, as described in the [Faxing Setup and Support Guide](#).

Complete the steps in the [Route Communications by Fax](#) topic to route notes as faxes using the Communication Management framework. To support notes routing, configure the following as part of your setup:

- In the Fax report field, enter a report such as:
 - 45400-IP Right Fax Report (Text)
 - 45401-IP Forward Advantage Fax Report (Rich Text)
 - 45402-IP Biscom Fax Report (Rich Text)
- In the Fax attachment folder field, enter the location of the folder where the attachment files will be stored and verify the fax server has read and write privileges.

Allow Clinicians to Route Notes Using Mail

You can allow clinicians to route notes to other clinicians through the mail when In Basket messages aren't an option.

1. In Clinical Administration, select Management Options > Edit System Definitions (EMR) > Note, Trans, Communication.
2. Page down to the Communication Management Setup - Routing screen.
 - In the Route Method column, enter Mail.
 - In the Behavior column, enter Server Handling.
 - In the Routing Extension column, enter extension record 14270-Commmgt Mail Routing or your copy
 - Page down to the Communication Management Setup-2 screen. In the Mail printer class field, enter a printer classification.
3. Exit EMR System Definitions and open the user record.
4. Page down to the Printer Classifications section.
 - In the printer classification field, enter the printer classification you set in System Definitions.
 - In the corresponding Remote Device field, enter the printer device name where you wish to send all mailed notes.
 - In the corresponding Ask field, enter No.
 - In the corresponding Option field, enter Remote.

Allow Clinicians to Route Notes Via a Third-Party System

 Starting in November 2024



If your organization participates in data exchange with a third party (for example, OntarioMD's Health Report Manager (HRM) system), you might have previously completed build to suppress other routing methods, such as fax, to prevent routing the same note multiple times. If so, you need to revert the routing suppression build before implementing this feature. To get started, contact your Epic representative and mention SLG 9108123.

Providers at your organization might subscribe to a third-party system to receive notes outside Epic. You can create a custom communication method for clinicians to route notes and transcriptions over an Outgoing Documentation interface to that third-party system. This method allows clinicians to route notes or transcriptions directly from Chart Review or the Notes activity.

To set this up at the system level:

1. Set up your Outgoing Documentation interface to send notes to your third-party system:
 - a. Use the Turbocharger activity to download an Outgoing Documentation (AIK 226) interface. Refer to the [Get New Interface Records in Your System](#) topic for more information. If you have an existing Outgoing Documentation interface, you can instead make a copy of it to use for notes routing, but you cannot use the same interface for notes routing and your existing integration.
 - b. Set profile variable ROUTING_MODE (6820) to 1-Routing mode on the interface.
 - c. For additional information about how to set up the interface, use the Interface Reference Guide Viewer in Hyperspace to view the Outgoing Documentation Interface Reference Guide - Routing Mode (quick jump code: Q20077#AID^20078J).
2. In Hyperspace, add a custom routing method to the Encounter Communication Sent - Method (I EPT 19742) category list. For detailed instructions about modifying category lists, refer to the [Modify a Category List's Values](#) topic.
3. In Clinical Administration, select Management Options > Edit System Definitions (EMR) > Note, Trans, Communication.
4. Go to the Interface Routing Method Configuration screen.
 - a. In the Routing Method (I LSD 5860) column, enter the custom method you created in step 2.
 - b. In the Notes (I LSD 5863) column, enter the Outgoing Documentation interface that you configured in step 1.
5. Page up to the Communication Management Setup - Routing screen.
 - a. In the Route Method (I LSD 5700) column, enter the custom method you created in step 2. When you do, the Behavior and Routing Extension columns are automatically populated.
 - b. In the Can Route Ext (I LSD 5730) column, enter extension 5860-Can Route to Interface.

Alternatively, you can configure routing methods for specific departments. To configure a third-party routing method for a specific department, complete the following steps:

1. Set up your Outgoing Documentation interface to send notes to your third-party system:
 - a. Use the Turbocharger activity to download an Outgoing Documentation (AIK 226) interface. Refer to the [Get New Interface Records in Your System](#) topic for more information. If you have an existing Outgoing Documentation interface you can instead make a copy of it to use for notes routing, but you cannot use the same interface for notes routing and your existing integration.
 - b. Set profile variable ROUTING_MODE (6820) to 1-Routing mode on the interface.

- c. For additional information about how to set up the interface, use the Interface Reference Guide Viewer in Hyperspace to view the Outgoing Documentation Interface Reference Guide - Routing Mode (quick jump code: Q20077#AID^20078J).
2. In Hyperspace, add a custom routing method to the Encounter Communication Sent - Method (I EPT 19742) category list. For detailed instructions about modifying category lists, refer to the [Modify a Category List's Values](#) topic.
 3. In Clinical Administration, select Management Options > Facility Structure > Departments/Units.
 4. Open the department you want to configure and go to the Communication Management Setup - 1 screen.
 5. In the Route Method (I DEP 17570) column, enter the custom method you created in step 2. When you do, the Behavior and Routing Extension columns are automatically populated.
 6. In the Can Route Ext (I DEP 17573) column, enter extension 5860-Can Route to Interface.

Once you complete your custom routing method configuration, update the communication preferences for any recipients in your system who will receive notes via a third party to use your new custom routing method. Refer to the [Provider Communication Preference Setup](#) topic for more information.

Restrict Routing Methods for Providers Who Meet Rule Criteria

You can automatically route note or transcription In Basket messages to providers only if they meet certain criteria defined in a rule, which gives you a more granular way of determining these recipients. For example, you can route these messages only to external or community providers who prefer to receive communication using mail or fax, rather than In Basket. Similarly, you can use this feature to suppress these messages for providers who would rather receive communication using In Basket.

If the rule evaluates to true for a given recipient, meaning a recipient satisfies the criteria for that rule, that provider does not receive the note or transcription message. If the rule evaluates to false, the provider receives the message. You can also define whether carbon copy recipients are evaluated by the rule.

First, you need to set up a rule (CER) that determines who is filtered out of automatic routing. You can use the Provider context for this rule. Starting in May 2024, you might instead decide to use the context of Automatic Note Routing - Provider, which allows you to use notes-specific properties such as filtering by note type, note service, and note sensitivity in the same rule as provider-specific properties. Refer to the [Create or Edit a Rule](#) topic for configuration steps. You can use any provider properties (HFP) in your rule, but the following might be most useful to automatic routing:

- 21466-Internal or External, which filters providers based on whether they're considered internal or external to your organization.
- 21478-Report Grouper 6 C, which filters providers based on whether they have a report grouper defined in the Grouper 6 (I SER 2905) field in their provider record. This grouper is used to find providers using the Provider Finder module in Call Management.
- 72031-Communication Preference, which filters providers based on their default communication preference set in the Communication Preference (I SER 8350) field in their provider record, such as mail, fax, or In Basket
- Starting in May 2024, 42553-Communication Preference – Automatic Note Routing, which filters providers based on the Update communication preference hierarchy? (I LSD 2163) field in EMR System Definitions. Refer to the [How it Works](#) topic for more information.
- Starting in May 2024, 42487-Automatic Note Routing Note ID, which contains all properties in the Clinical Notes context.

Next, you'll add your rule to a duplicate of either extension 88823 or 88824, depending on which type of message you want to route. Both extensions have the same configurable parameters.

1. In Chronicles, duplicate either:
 - a. Extension 88823 if you want to automatically route note messages.
 - b. Extension 88824 if you want to automatically route transcription messages.
2. In the first parameter of your duplicate extension, enter the ID of the rule you created.
3. In the second parameter, enter Yes to have the rule evaluated for carbon copy recipients of the message. Leave the parameter blank or enter No to ignore carbon copy recipients.
4. Open a profile (LPR) record to which you want to add your duplicate extension.
 - If you copied extension 88823, list your extension in the Routing extensions (I LPR 34908) field on the Auto Route Notes Configuration - 1 screen.
 - If you copied extension 88824, list your extension in the Routing extensions (I LPR 34899) field on the Auto Route Transcriptions Configuration - 1 screen.

Allow Clinicians to Route Notes to PCPs and Referring Providers with a Single Click

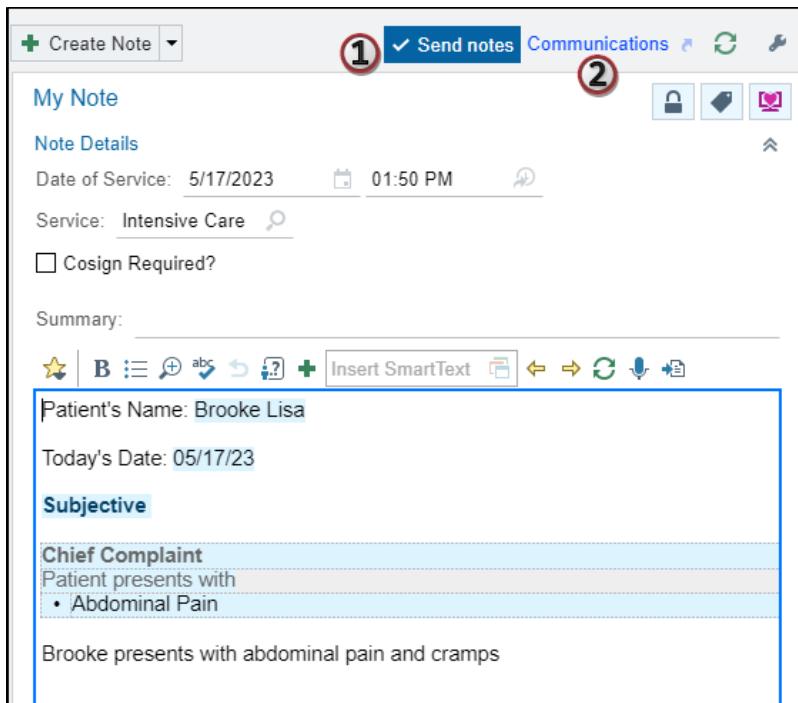
Specialists often need to send their notes back to a patient's PCP or a referring provider. For example, your organization might have a dermatologist who is regularly referred to by other providers. Most commonly, this workflow requires the provider to manually send the note as a letter or attachment from the Communication Management activity. Alternatively, the provider might go to the Chart Review Notes tab, select the note, and manually select recipients to route it to.

Either way, the provider has to take several steps to complete the workflow, which quickly adds up over the course of several patient visits. To help make this workflow more efficient for providers, you can enable them to send their notes to PCPs and referring providers with a single click.

You can set up a [quick communication](#) to automatically generate a letter that includes the provider's note. When a provider finishes writing her note, they can select a checkbox in the note editor to indicate that they want to send the note to recipients that you configure. The system then sends the letter when the visit is signed.

The provider can also click a link to open the Communication Management activity and preview the letter before it's sent and make changes as necessary. For example, the provider might want to send the letter to additional members of the patient's care team.

Note that the checkbox and link appear only in encounters that can be signed, such as office visits, but they don't appear in addendums. Also note that the checkbox and link appear only when there is at least one quick communication generated for the note as described below.



A physician uses a single click to have the note sent to the patient's PCP and referring provider when the visit is signed (1). The physician can optionally click a link to open the Communication Management activity and edit the communication as needed (2).

To set up the single-click routing workflow, you need to configure quick communications and configure notes navigator sections to show the checkbox.

Prerequisites

To use the single-click routing workflow, you must have the MR Quick Communications license, which is included in the standard EpicCare Ambulatory license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

Considerations

Because the checkbox and link appear only in encounters that can be signed, this feature is intended to be used only in outpatient contexts.

Configure the Quick Communications

As part of setting up the quick communications, you need to make several decisions, including:

- Whether the communication includes the notes in a letter or a report.
- Which note types are included.
- Whether the communications can include all providers' notes or only the encounter provider's notes.
- Whom the communications are sent to.
- Which encounter types and departments the communications are automatically created for.
- Whether the system creates the communications only when there are valid recipients.
- Whether the communications are automatically sent when the visit is signed.
- Whether the communications are available only for internal or external recipients.

You can use the Build Wizard in Hyperspace to configure the quick communications and make these decisions. To get started, open the Build Wizard (search: Build Wizard) and search for feature 170012-Send Notes to Providers with a Quick Click (application: EpicCare Ambulatory). Note that if you want to send the notes in a letter, you need to build the letter template as described in the next section before you run the Build Wizard.

If you need to tweak any settings after running the Build Wizard, refer to the following sections for manual setup instructions.



If you completed this setup and don't know why the checkbox doesn't appear as expected, refer to the [I'm not sure why the single-click routing checkbox doesn't appear as expected](#) topic for help troubleshooting.

Configure a Letter Template for the Communications

Epic recommends including the encounter provider's notes in a report, but you can optionally configure a letter template to include with the report, or configure a letter template to include the notes itself using SmartLink 89-NOTES - Progress Notes w/o Sensitive Notes (mnemonic: .PNOTES) or a copy. You might also use the following SmartLinks in your template to configure how the provider's signature appears:

- 941-My Patient Letter (mnemonic: .MYPATIENTLETTERLINK)
- 942-My Provider Letter (mnemonic: .MYPROVIDERLETTERLINK)

For more information about these SmartLinks and others available in your system, refer to the [Search for Information About SmartLinks in Your System](#) topic.



Note that your letter template needs to include SmartLink 89 or a copy of it. You must list all notes SmartLinks used in your letter templates in the SmartLinks containing note text (I LPR 10047) field. Letters that contain these SmartLinks are automatically set to wait for transcriptions instead of being sent when an encounter is closed if there are unresolved note dictations. For more information about this field, refer to the [Automatically Mark Letters Containing Dictated Notes as Waiting for Transcriptions](#) topic.

Refer to the [Create Letter Templates](#) topic for detailed instructions about creating letter templates.

Configure a Notes Report to Include with the Communications

Epic recommends including a notes report with the communications that contains the encounter provider's notes. The following table describes each type of record that's needed to configure a notes report. It also mentions several Epic-released records that you can use to help simplify the setup.

Type of Record	What it Controls	Epic-Released Record	Default E
Expanded notes extension (LPP)	<ul style="list-style-type: none"> Filters which notes in the print group are expanded or shown as a link based on: <ul style="list-style-type: none"> Whether the provider is considered a high-level provider (I LSD 3619 and I LPR 34257). The note type (I HNO 34034). Determines whether notes that are not expanded by default are completely hidden in the print group. 	14695-MR Expand Enc Prov Notes Extension	<ul style="list-style-type: none"> Expa Pati • Expa rega prov • Hide
Notes print group (LPG)	<ul style="list-style-type: none"> Determines which note types (I HNO 34044) can appear. Determines which note statuses can appear. Uses an expanded notes extension to determine which notes are expanded by default or shown as a link. 	54698-MR Encounter Provider Notes	<ul style="list-style-type: none"> Incl • Us Ext shov • Refe defa
Encounter notes report (LRP)	The communication includes this report as an attachment.	52300-MR Encounter Provider Notes	Includes p

Each type of record is entered in the record that appears below it in the table. That is, the expanded notes extension is entered in the notes print group, which in turn is entered in the encounter notes report. If you're okay with the behavior of the Epic-released records, you can skip to the next section and use those records when you set up the quick communications. Otherwise, duplicate the Epic-released records as needed and configure them according to their help text.

You can also use any reports that you already configured.



If your communications include reports that you want to be sent or not sent regardless of whether clinicians select the checkbox, list them in the Reports that do not contain note content (I LPR 10048) field. For more information about this field, refer to the [Automatically Mark Letters Containing Dictated Notes as Waiting for Transcriptions](#) topic.

Set Up the Default Recipients and Specify Which Encounter Types the Communications Are Created For

After you configure a letter template or notes report, follow the instructions in the [Set Up Quick Communications](#) topic to configure the communications. As part of this setup, you'll define the default recipients for the communications, such as the PCP and referring provider, and which encounter types the communications are created for. You can also specify whether the communications are sent automatically when the visit is signed or whether clinicians have to select the checkbox to send them. This can be configured either through the Build Wizard or through I LPR 47025.

Considerations

The default recipients that you define for the quick communications determine the caption of the checkbox in the note editor:

- If the patient's PCP is the only recipient, the caption says "Send to PCP."
- If the patient's referring provider is the only recipient, the caption says "Send to referring."
- If the patient's PCP and referring provider are the only recipients, the caption says "Send to PCP & referring."
- If the patient's care team or the patient are included as recipients, the caption says "Send Notes" regardless of whether the patient's PCP and referring provider are also included as recipients.
- If there are no recipients, the caption says "Send Notes."

Note that a patient must have a PCP or a referring provider before the quick communication is generated for the PCP or referring provider to be added as recipients. For example, if you specify that the patient's PCP should be a default recipient when you complete the setup described in the [Set Up Quick Communications](#) topic, the patient's PCP is added as a recipient only if they were defined in the Care Teams activity in a previous encounter or were listed as the patient's PCP when the appointment was scheduled. If a clinician adds a PCP for a patient during an encounter, that PCP isn't included as a default recipient for the notes sent from that encounter.

Also note that the system uses the quick communication settings from the encounter provider's profile, not the logged in user's profile.

Generate the Communications Only When There Are Internal or External Recipients

You might want the system to generate the communications only when there are internal or external recipients. For example, if your organization requires providers to send their notes only to referring providers outside of your organization, you can have the system generate the communications only if it finds valid external recipients.

You can use rules (CER records) to determine whether the system generates the communications. The following rules check for valid recipients for the communications:

- 16104-MR Has External PCP or Referring Provider. This rule returns True if the patient has a PCP or referring provider outside of your organization.
- 16105-MR Has Internal PCP or Referring Provider. This rule returns True if the patient has a PCP or referring provider in your organization.

Follow the instructions in the [Create Rules to Generate Communications Based on Patient or Encounter-Specific Criteria](#) topic to use these rules with your communications.

Show the Checkbox and Communications Link to Clinicians

By default, the checkbox and link to the Communications activity appear only for progress notes regardless of how you configure the quick communications. For clinicians to see the checkbox and link in other types of notes, you need to configure a parameter in your notes navigator sections. Alternatively, if you don't want the checkbox and link to appear for progress notes, you need to configure your progress notes navigator section to not include it.

If you are using [web-based notes](#), complete the following steps:

1. In Clinical Administration, go to Navigators > Navigator Configurations (VCN) and open a navigator

configuration record. Refer to the [Configure Sections](#) topic for more information.

2. Go to the Parameters screen and navigate to the Enable Send Notes? parameter.
3. Enter No to hide the checkbox and link or enter Yes to show the checkbox and link.

If you are using non-web-based notes, complete the following steps:

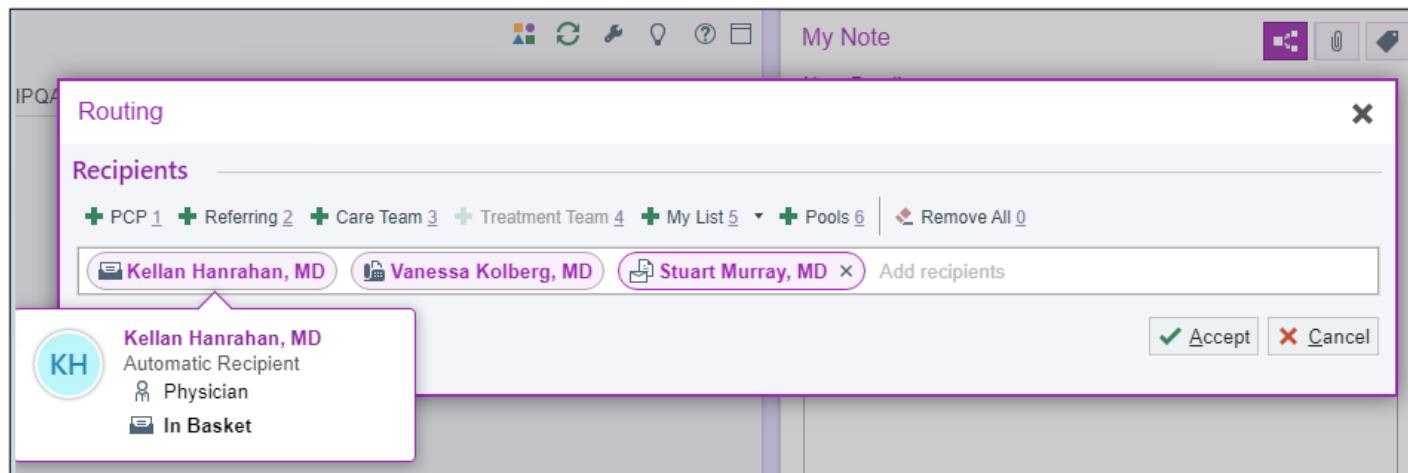
1. In Clinical Administration, go to Navigators > Navigators (LVN) and open a notes navigator section.
2. Go to the Section Setup screen.
3. In the HANDLER ProgID (I LVN 1020) field, add the EnableSendNotes parameter and set it to 1 to have the checkbox and link appear. Set this parameter to 0 to not have the checkbox and link appear.

For more information about configuring navigator section parameters, refer to the [How do I configure the Handler ProgID field?](#) topic.

Let Clinicians Review and Specify Routing Recipients from Their Notes

Starting in November 2023

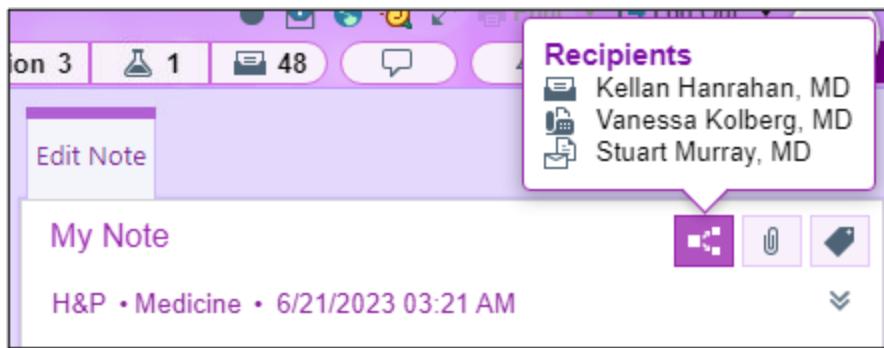
Providers can review and specify routing recipients for their notes directly from note editors. They can click the Routing button to add recipients manually, using quick buttons available in other routing workflows or using Provider Finder. Recipients added here will receive the note via their default routing method; recipient details cannot be edited from this window. Starting in November 2025, users can manually add up to 100 recipients.



The Routing button in the upper right portion of the note editor launches the Routing window.

Recipients added here receive the note using their preferred routing method by default. Starting in February 2024, clinicians can select alternate routing methods or addresses by clicking the recipient's name to open their details. Clinicians cannot edit automatic recipients from this window. Automatic recipients always use their default routing method.

After they add recipients, clinicians can quickly review this information hovering over the Routing button.



! The Routing button is available only for notes written in Hyperspace note editors (for example, the Notes sidebar, Notes navigator section, NoteWriter, and Narrator editors). Within those editors, the button is not available for any note types (I HNO 34033) set in the Custom SPOC Note Types (I LSD 35650) field in EMR System Definitions or for any of the following note types:

- 33-Subjective & Objective
- 38-Assessment & Plan
- 43-Committee Review
- 100-Dialysis Plan of Care Note
- 101-Home Health Plan of Care Certification
- 102-Home Health Plan of Care
- 93002-Hospice Plan of Care
- 93006-Hospice Non-Covered

Prerequisites

Clinicians must have either EpicCare Inpatient security point 166-Notes Routing or EpicCare security point 327-Notes Activity Routing to access the Routing button in clinical note editors. They also need feature 22-Note editor routing in the notes feature set (HFN) record for the Application Context in which they work. This feature is included in the Epic-released default feature set records for all Application Contexts, except:

- 8-Transplant (8-Committee Review in February 2025 and earlier)
- 9-Specialty Plan of Care
- 10-Home Health & Hospice

To enable routing from within the editor for custom feature set records, complete the following steps:

1. In Clinical Administration, go to Management Options > Profiles (LPR) and open the profile record in which you want to enable note editor routing.
2. Select Note, Letter, Transcription.
3. On the Notes Feature Set Configuration screen, locate the relevant Application Context (I LPR 31400) for your updates.
4. Open the feature set (HFN) record set in the Feature Set column (I LPR 31401) for the Application Context. You can open the feature set record directly by pressing F8 while in the Feature Set column.

5. In the feature set record, add 22-Note editor routing to the list of features enabled for users in that application context.

If the Application Context you're looking for is not shown on the Notes Feature Set Configuration screen, the Epic-released default feature set record is used for that context.

Hide the Preview of Automatic Routing Recipients



If the Auto-save interval (I LSD 34023) field in EMR System Definitions is set to 0, automatic recipients will not appear in the note editor and you can skip this setup.

If automatic routing is enabled for a clinician with access to the Routing button in the note editor, that clinician can preview the providers who will be automatic recipients for a note. When a clinician creates a note, or opens an existing note for editing, recipients that will receive the note automatically appear in the Routing window. They are indicated as automatic recipients within their recipient details.

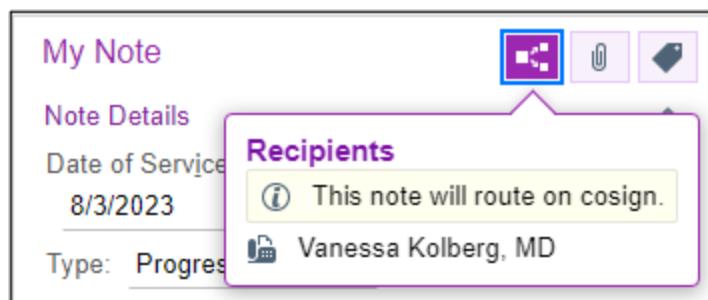
Clinicians can't edit the details for automatic recipients, nor can they remove those recipients. However, automatic recipients of a note can change depending on a variety of criteria, some of which can change as the clinician edits their note. To ensure the automatic recipient preview is as accurate as possible, the system recalculates a note's automatic recipients whenever a clinician:

- Changes a note's type or service.
- Changes a note's cosign requirement or assigned cosigner.
- Changes whether they are taking authorship of a note using Make Me the Author.
- Changes a note's sensitivity status.

Considerations

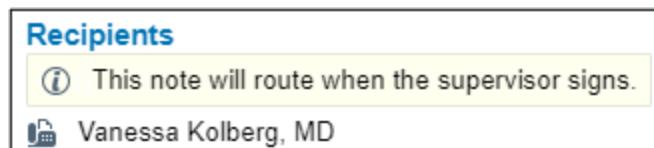
A clinician's Cosign logic (I LPR 34869) configuration affects what they see when hovering over the Routing button in a note editor.

If The Cosign logic field in the clinician's profile is left blank or set to 1-Route when a note is cosigned, and that clinician sees the automatic recipients preview in the Routing window and hover bubble, a banner appears in the hover bubble indicating that the note will be sent to the designated recipients when it is cosigned, not when it is signed.



If the Cosign logic field is set to 0-Route when a note is signed, and a clinician is cosigning a note, the routing button is disabled and the hover bubble will doesn't appear.

If a resident requires a second signature on their transcriptions, and the Transcription cosign logic (I LPR 34898) in their profile is left blank or set to 0-Route Available, 3-Route initial and When Available if Edited in Hyperspace, or 4-Route Available if Edited in Hyperspace, a banner appears in the Recipients hover bubble notifying them that any recipients added to the transcription will receive it when their supervisor has also signed it.



Refer to the [Transcription Alternatives to Cosign Workflows](#) topic for more information on the second signature workflow.

By default, clinicians with access to the Routing button in the note editor see the automatic recipient preview if they have automatic routing configured in their profile. To disable the automatic recipient preview for clinicians without removing access to the Routing button, complete the following steps:

1. In Clinical Administration, go to Management Options > Profiles (LPR) and open the profile record in which you want to hide the automatic recipient preview.
2. Select Note, Letter, Transcription.
3. If you want to hide the preview for notes, go to the Auto Route Notes Configuration - 1 screen and set the Show auto routing recipients (I LPR 34917) field to 1-Hide.
4. If you want to hide the preview for transcriptions, go to the Auto Route Transcriptions Configuration - 1 screen and set Show auto routing recipients (I LPR 34918) to 1-Hide.

Require Note Revalidation

When the User revalidation feature is enabled for notes, a clinician must enter his password, or other authentication method, each time he signs or cosigns a note. Notes revalidation ensures that notes are

signed only by the clinician who is currently logged in.

To require notes revalidation, clinicians must have the User revalidation feature in their feature set, and you must enable revalidation in EMR System Definitions.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open the feature set used by the clinicians who you want to revalidate notes.
2. On the Feature Set Configuration Record screen, add User revalidation to the Features Enabled field.
3. Access EMR System Definitions and go to Security, Patient Access.
4. On the Security Settings screen, enter 18-Notes in the Workflows Requiring Revalidation field.

Tag Notes

Note that prior to Epic 2018, the concept of tagging notes was called bookmarking.

Allow Clinicians to Tag Notes

A tag allows a clinician to quickly return to a significant note. When he clicks Tag in the note editor or the NoteWriter, he can choose which tag to assign to the note. The selected note then appears with a tag icon in Chart Review and the Notes activity. For example, you might create a tag called Suspected Abuse to add to any note that documents the clinician's suspicion that the patient is being abused. Then, in Chart Review, the clinician can filter on this tag to quickly view the number of times suspected abuse has been documented.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add Tagging to the Features Enabled field.

For more information about configuring tags in Chart Review, refer to the [Change How Clinicians Can Tag Notes in Chart Review](#) topic.

Prevent Clinicians from Tagging Notes

You can turn off tagging at the system level, which prevents clinicians from being able to add tags to notes.

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communications.
2. On the Notes General Options - 1 screen, enter Yes in the Disable tagging field.

See Information from Related Encounters

You can allow clinicians to view data from clinically related encounters alongside data entered in the current encounter. Any data not entered in the current encounter is available only for reference purposes and appears as read-only. Viewing information from related encounters is useful in situations where a patient comes in for many visits related to the same problem, and a clinician wants to track his progress.

You can set up logic to define related encounters on the Related Encounters screen in your profile record. After opening an encounter, you can also manually select related encounters from Patient Station. For more information about setting up related encounters, see the [Related Encounters Setup and Support Guide](#).

To see information from related encounters, clinicians must have the Related encounters feature in their feature set.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open

your duplicate feature set.

2. On the Feature Set Configuration Record screen, add Related encounters to the Features Enabled field.

View and Change a Note's Service

If your organization uses multiple services, such as geriatrics and pediatrics, you can configure the note editor window to show the Service field in the note editor. You can configure the system to select a default service automatically based on the service of the provider, the service of the login department, or a custom extension record. Clinicians can also manually enter a service in the note editor window.

Clinicians must have the Hospital service field feature in their feature set to see the Service field in the note editor.

Epic recommends setting the current login department as the default service to account for residents and other providers who do not have a service listed in the provider record. Your organization should review its department build to confirm that all virtual and clinic departments have a clinical service specified.

Considerations

If a clinician has made their own personalization settings for default note service, that overrides any default service set following the steps below. Refer to the [Determine Which Services a Clinician Can Select](#) topic for more information about note service default behavior.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add Hospital service field to the Features Enabled field.
3. Access a profile and go to Note, Letter, Transcription.
4. On the Notes General Settings - 2 screen, enter the method to use to assign a default service in the Method for default service (I LPR 34750) field:
 - Enter 1 to use the service associated with the current provider.
 - Enter 2 to use the service associated with the current login department.
 - Enter 3 to use an extension record.
5. If you chose to use an extension record, enter the extension record in the Service programming point field.

Change a Note's Date and Time of Service

You can make the Date of Service fields appear in the note editor, so that clinicians can manually change the note's date and time of service.

By default, the current date and time appear in the Date of Service field for inpatient notes and the encounter date and time appear by default for outpatient notes. The encounter date and appointment time also appears by default for HOV-context notes. You can also choose not to have a default date and time or to use the encounter date and time. The logic used to determine the encounter date and time varies by application as follows:

- EpicCare Inpatient and OpTime use the admission date and time. If the admission date and time are empty, they use the expected admission date and time. For a new note on a discharged patient, the discharge date and time are used.
- HOV uses the encounter date and appointment time. If the encounter date and appointment time are empty, the admission date and time are used. If the admission date and time are empty, the expected

admission date and time are used.

- ASAP uses the Grand Central arrival date and time.
- Anesthesia uses the current date and time.
- EpicCare Ambulatory uses the encounter date and appointment time. If no encounter date or appointment time is entered, this context uses the date and time the encounter was created.
- Telephone documentation contexts use the current date and time.

You can also override the default date and time logic for specific note types or for specific encounter types, which you might want to do for outpatient notes imported from a legacy system, for example.

Clinicians must have the Note date/time feature in their feature set to see a note's date and time of service in the note editor.

Considerations

Changing the default note date and time format changes how note date and time appear almost everywhere in Hyperspace, including the majority of notes-related print groups.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set.
2. On the Feature Set Configuration Record screen, add Note date/time to the Features Enabled (I HFN 200) field.

Change the Logic That Determines the Default Date and Time

To change the logic, you must define new logic in a feature set configuration record and assign the feature set to a profile record. If you are already using a custom feature set for the profile in which you want to define new logic, update that feature set record.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open a custom feature set or the feature set currently assigned to the profile you want to update.
2. On the General Notes Settings screen, enter the logic you want to use to determine a note's default date and time in the Default note date/time logic (I HFN 212) field.
3. To override the default date and time logic for specific note types, enter the note types you want to override in the Note Type (I HFN 213) column, and enter the logic you want to use in the Override Date/Time Logic (I HFN 214) column.
4. If you created a new custom feature set, add it to a profile record, such as a department or user-level profile:
 - a. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open the profile you want to update.
 - b. Select Notes, Trans, Communication.
 - c. On the Notes Feature Set Configuration screen, in the Application Context (I LPR 31400) field, enter an application context.
 - d. In the Feature Set (I LPR 31401) field, enter your custom feature set.

Change the Default Note Date and Time Format

1. In Clinical Administration, access profile settings and go to the Notes General Settings - 1 screen.
2. In the Format for date/time display field, choose how you want a note's date and time to appear in

Hyperspace.

- Enter 0 to use system default settings.
- Enter 1 to use the 12 hour format.
- Enter 2 to use the 24 hour format.

Change the Default Date and Time for Specific Encounter Types

You can configure your system to show the date a note was written instead of its encounter date in reports or navigator sections. This option is most likely to be helpful for outpatient notes imported from a legacy system that doesn't link the notes to a specific encounter, though you can also use it to show the date of service instead of the encounter date.

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communication > Notes Display Options - 2 screen.
2. In the Encounter Type (I LSD 34029) field, enter an encounter type (I EPT 30) for which you want to configure how the display date for notes appears. For any encounter types that you don't list in this field, the encounter date appears in reports, and the date a note was created appears in navigator sections.
3. In the Report Display (I LSD 98231) field, specify how you want the note display date to appear in reports for notes written in the encounter type you entered in step 2. Enter one of the following:
 - Enter 0 or leave this field blank to show the encounter date.
 - Enter 1 to show the date and time a note was created.
 - Enter 2 to show both the encounter date and the date and time a note was created.
 - Enter 3 to not show any date or time.
 - Enter 4 to show the note's date of service.
4. In the Nav Section Display (I LSD 98232) field, specify how you want the note display date to appear in navigator sections for notes written in the encounter type you entered in step 2. Enter one of the following:
 - Enter 0 to show the encounter date.
 - Enter 1 or leave this field blank to show the date and time a note was created.
 - Enter 2 to show both the encounter date and the date and time a note was created.
 - Enter 3 to not show any date or time.
 - Enter 4 to show the note's date of service.
5. Repeat steps 2-4 for additional encounter types as needed.

Note that the settings described above apply only in ambulatory contexts. Additionally, these settings can be overridden by the configuration of print groups that show notes. For example, print group [51009-Visit: Progress Notes \(Rich Text\)](#) shows the encounter date, regardless of how you configure the Report Display (I LSD 98231) field. If you want reports to show the date and time a note was created, we recommend that you review the print groups in the report to see whether you need to configure their parameters to not show the encounter date.

Hide a Note's Time of Service in Chart Review

Outside of ambulatory contexts, both a note's date and time of service appear in the Chart Review Notes tab. In some cases, you might want only a note's date of service to appear. For example, you might have notes that are transcribed by a third-party vendor that doesn't support filing a time of service, in which case the system shows a time of service of midnight. You can instead show only the note's date of service so an inaccurate time of service doesn't appear.

Prerequisites

This setup applies only to report 45895-IP Note Details (Rich Text), which is the report that appears by default in the Chart Review Notes tab, report 52290-Chart Review Notes Report, or copies of them. Refer to the [Show Notes Information](#) topic if you show a different report on the Chart Review Notes tab and need to switch to using report 52290, 45895, or a copy.

1. In Clinical Administration, go to Management Options > Profile > Note, Letter Transcription > Notes General Settings - 1 screen.
2. In the Date of Service Chart Review display (I LPR 34237) field, enter 1-Date only.

Note that this setting does not apply to ambulatory contexts because only the encounter date appears in those contexts. In addition, this setting can be overridden by the configuration of the Default note time display (I LSD 34038) field and by the configuration of print groups that show notes. For example, if you use report 52290 and have the Default note time display (I LSD 34038) field set to Creation Time, both a note's date of service and time of service appear regardless of how you configure the Date of Service Chart Review display (I LPR 34237) field.

Correct Misfiled Notes

You can allow clinicians to take corrective actions on notes that were erroneously filed to a patient's chart. There are many options to consider when enabling chart correction. For more information, see the [Chart Correction Workspace Setup and Support Guide](#).

Clinicians with the Chart correction feature in their feature set can flag notes as misfiled, remove the misfiled flag, and add chart correction comments when deleting a signed note.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open your custom feature set.
2. On the Feature Set Configuration Record screen, add Chart correction to the Features Enabled field.

Take Advantage of Advanced Note Features with Specialty Note Templates

To supply specialist providers with more specialty-specific advanced note writing features, we worked with Specialty Steering Boards to create Foundation System note templates for a variety of specialties. These templates make use of advanced note features that help clinicians write and review streamlined notes, helping to reduce note bloat.

Quick links (A) allow specialists to jump to relevant sections of the chart with one click, removing the need to click between different tabs to find a needed piece of information. These links are embedded in optional SmartLists that are removed when the specialist signs the note. SmartLinks such as Past Medical and Surgical History automatically pull in information under the Quick Review section, and that section is also removed when the note is signed, decreasing the length of the note while allowing specialists to quickly review important aspects of the patient's medical history while documenting.

The templates use rules to determine whether sections are hidden based on the patient the specialist is seeing. For example, in the Primary Care template, the Hunger Screening section is included in the Screening Results SmartList for only pediatric patients. Links to Synopsis views are also evaluated by rules and appear based on the patient's age or problem list and the specialty service they are receiving. For example, if a pediatric patient has a visit with their neurologist, the template includes a link to the Synopsis view designed for pediatric conditions as opposed to adult (B).

Create Note Neuro exam 1

My Note

Progress Notes • Neurology • 7/10/2025 10:54 AM

HPI Ped Neuro Exam Physical Exam

Subjective **A** Quick Links: [Last Note in Specialty Snapshot](#) (1)
Patient ID: Maggie Felix is a 9 y.o. female who presents for Seizures and Headache.
Today she is accompanied by parents.

Seizures
This is a chronic problem. The problem is associated with flashing lights. There have been no recent head injuries.

Objective **B** Quick Links: [Synopsis \(Peds\)](#) [Growth Chart](#) [Procedures](#) [Labs](#) [Imaging](#) [Results](#)
Review Media Trend Vitals
Avoid pulling in long tables of results. Comment on relevant results to support your medical decision making. (1)
BP 100/65 | Pulse 80 | Temp 37 °C (98.6 °F) | Ht 1.346 m (4' 5") | Wt 29.5 kg |
BMI 16.27 kg/m²
Growth percentiles: 50 %ile (Z= 0.00) based on CDC (Girls, 2-20 Years)
Stature-for-age data based on Stature recorded on 7/10/2025. 44 %ile (Z= -0.14) based on CDC (Girls, 2-20 Years) weight-for-age data using data from 7/10/2025.

Neurological Exam
Physical Exam

Quick Links [Full Problem List](#) (1)

Assessment & Plan Diagnoses
Epilepsy, focal

Orders:
levETIRacetam (Keppra) 250 MG tablet; Take 1 tablet by mouth in the

SmartLinks Sign on Accept

This screenshot shows a medical note for a 9-year-old female patient named Maggie Felix. The note is in 'edit mode'. The 'Subjective' section contains a brief history of her seizures and headache. The 'Objective' section includes vital signs (BP 100/65, Pulse 80, Temp 37 °C), growth data (CDC 50%ile for stature, 44%ile for weight), and a mention of her weight-for-age data. Treatment plans include a prescription for levETIRacetam (Keppra). The interface includes standard clinical tools like growth charts and imaging results.

A pediatric neurology note in edit mode

Signed
 Expand All Collapse All Expand All by Default

Subjective

Patient ID: Maggie Felix is a 9 y.o. female who presents for Seizures and Headache.
 Today she is accompanied by parents.

Seizures
 This is a chronic problem. Primary symptoms include seizures, light-headedness. The problem is associated with flashing lights. Associated symptoms include headaches. There have been no recent head injuries.

Objective

BP 100/65 | Pulse 80 | Temp 37 °C (98.6 °F) | Ht 1.346 m (4' 5") | Wt 29.5 kg | BMI 16.27 kg/m²
 Growth percentiles: 50 %ile (Z= 0.00) based on CDC (Girls, 2-20 Years)
 Stature-for-age data based on Stature recorded on 7/10/2025. 44 %ile (Z=-0.14) based on CDC (Girls, 2-20 Years) weight-for-age data using data from 7/10/2025.

Assessment & Plan

◆ Epilepsy, focal

Orders:

- levETIRacetam (Keppra) 250 MG tablet; Take 1 tablet by mouth in the morning and 1 tablet before bedtime.
- Ambulatory EEG; Once - Future

A signed pediatric neurology note viewed from Chart Review

In the Foundation System, we created several specialty-specific note templates that you can add as speed buttons for specialty providers. For more information, refer to the table below.



To make it easy for you to get this content, we created a Turbocharger package for these note templates. This is available to download for organizations in the United States from the Available Packages tab of the Turbocharger activity in Hyperspace. If your organization is outside the United States or you don't have automatic package delivery set up, contact your Epic representative and mention project 332270 to get the package. For information about mapping and importing this package, refer to the [332270-Updated Specialty Note Templates](#) topic.



Starting in May 2025, you can use the Build Wizard in Hyperspace to update the default note template speed buttons in profile records. Enter a department specialty to pull in all profiles associated with that specialty, allowing you to more easily identify a similar set of profiles to update.

To get started, open the Build Wizard (search: Build Wizard) and search for feature 41290-Set Default Note Speed Buttons in Profiles (application: EpicCare Ambulatory, EpicCare Inpatient). To manually set up default note template speed buttons in profiles, refer to the [Set Default Note Speed Buttons at the Profile Level](#) topic.

Specialty	Department Profile (LPR)	SmartText (ETX)
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Allergy and Immunology	110000001-ALG EMC DEPT 111000003-ALC PED DEPT	26982-ALG Progress Note (Advanced Navigation)
Audiology	2101111101-AUD EMC DEPT	27841-AUD Progress Note (Advanced Navigation)
Cardiology	1180000001-IP CARDIOVASCULAR DEPT	10983-CAR Physician
Dentistry	2800000010-WIS EMC DEPT 2800000016-WIS EMC PED DEPT	15471-WIS Dental Exam
Dermatology	1200000001-DER EMC DEPT 1200000003-DER PED DEPT	27834-DER New Consult Visit 27835-DER Follow-Up Visit
Developmental Medicine	1210000001-DEV EMC DEPT	27051-DEV Progress Note (Advanced Navigation)
Endocrinology	2030000001-END EMC DEPT	27860-Standard Diabetes Visit
Fertility & Embryology	7620000001-REI EMC DEPT	27058-REI Progress Note (Advanced Navigation note)
General Surgery	1260000001-SUR EMC DEPT	28012-OR General Surgery Progress Note
Genetics	1270000001-GNT EMC DEPT 1270000002-GNT PED DEPT	28070-GNT Visit Note
Geriatrics	1280000001-GER EMC DEPT	28040-GER Standard Visit Note
Gynecology	2070000001-GYN EMC DEPT	2101059101-Gyn Standard Visit
Infectious Disease	1370000001-INF EMC DEPT	11176-INF NoteWriter Template
Maternal Fetal Medicine	1021000-MFM EMC DEPT	27075-MFM Progress Note (Advanced Navigation)
Medical Oncology	1151000002-ONCBNC DEPT 1151000003-ONCBNC BMT DEPT 1151000009-ONCBNC GYNONC DEPT	14004-ONC Cancer Initial Visit 14003-ONC Cancer Follow Up 14806-ONC Cancer Off Treatment
Nephrology	1410000001-NEPH DEPT	28077-NEPH Adult Visit Note
Neurology	1420000001-NEU EMC DEPT	2100000005-NEU General Progress/Consult - Simple

Specialty	Department Profile (LPR)	SmartText (ETX)
Occupational Medicine	138000002-OCC MED PROFILE	28067-OM Standard Visit Note
Ophthalmology & Optometry	130000-OPH ADULT DEPT 130003-OPH PED DEPT 130004-OPH OPTOMETRY DEPT	15387-OPH Comprehensive Visit Note
Orthodontics	2800000017-WIS EMC ORTHO DEPT	27859-WIS Ortho Adjustment 27867-WIS Ortho Comprehensive Exam
Orthopaedic Surgery	1040000004-ORTHO GENERAL DEPT	140010-ORT Progress Note NoteWriter Template
Otolaryngology	1220000001-ENT EMC DEPT	27826-ENT Progress Note (Advanced Navigation)
Palliative Medicine	1920000001-PALL CARE EMC DEPT	27897-PAL Standard Visit Note
Pediatric Cardiology	1180000001-IP CARDIOVASCULAR DEPT	10983-CAR Physician
Pediatric Endocrinology	2030000002-END PED DEPT	27860-Standard Diabetes Visit
Pediatric General Surgery	1260000001-SUR EMC DEPT	28012-OR General Surgery Progress Note
Pediatric Nephrology	1410000002-NEPH PED DEPT	28078-NEPH Pediatric Visit Note
Pediatric Neurology	140000002-NEU PED DEPT	2100000030-NEU Ped General Progress/Consult
Pediatric Oncology	1151000007-ONCBN PED DEPT	15262-ONC Cancer Initial Visit PED 15382-ONC PEDS Cancer Follow Up 15430-ONC Cancer Off Treatment PED
Pediatric Otolaryngology	1220000002-ENT PED DEPT	27826-ENT Progress Note (Advanced Navigation)
Pediatric Pulmonology	1550000002-PUL PED DEPT	27971-PULM Visit Note
Pediatric Rheumatology	1580000002-RHU PED DEPT	27096-RHU Standard Visit Note (Advanced Navigation)
Physical Medicine & Rehab	1500000001-PM&R EMC DEPT 1500000002-PM&R PED DEPT	28228-PMR Standard Visit Note
Podiatry	7610000001-POD EMC DEPT	14720-POD Standard Visit Note

Specialty	Department Profile (LPR)	SmartText (ETX)
Primary Care	210002-FAM EMC DEPT	26716-Primary Care (Advanced Navigation)
Pulmonology	1550000001-PUL EMC DEPT	27971-PULM Visit Note
Rheumatology	1580000001-RHU EMC DEPT	27096-RHU Standard Visit Note (Advanced Navigation)
Urgent Care	10501116-EMC URGENT CARE	3600106292-UC AMB NoteWriter Template

Notes Setup: Remind or Warn Clinicians About Notes

This section describes several features you can use to remind your clinicians to perform important actions, such as sign notes or charge for notes.

Send In Basket Reminders When Notes Are Saved

You can automatically send an In Basket message when a clinician signs a new note or note addendum. This feature is not applicable to many organizations, but you might find it useful to serve the following functions:

- A supervising physician or nurse can receive a message when a supervised physician or nurse signs a note. The supervisor can review the note in the In Basket message.
- An HIM pool can receive a message if a note is signed or addended more than 72 hours after the patient departed the ED, the point at which the coder will have typically completed coding. The message serves as a prompt for the coder to review the coding.
- When a scribe signs or pends a note, a message can go to the attending provider. We recommend that you set this up using a deficiency instead so the message no longer appears after the note's signed. Refer to the [Send Attending Physicians an In Basket Message When a Scribe Shares a Procedure Note](#) topic for setup instructions.

You can set this up with a copy of extension record 49313-ED After Note File - Send In Basket Message in the profile of the person signing the note. The triggered message uses message type definition 4905-ED Note Accepted, which in turn uses message type 492-ED Note Accepted.

1. Duplicate extension record 49313.
2. Set the parameters in the duplicate record as appropriate.
3. Open your profile, select Note, Letter, Transcription and access the Notes General Settings - 2 screen.
4. In the Note saved extension field, enter your duplicate extension record.

Save Time by Letting Clinicians Open Notes in the NoteWriter Directly from Deficiencies

 Starting in November 2022

 May 2022 by SUs E10213530 and C10213530-HSWeb

 February 2022 by SUs E10116264 and C10116264-HSWeb

Clinicians can open existing incomplete notes in the NoteWriter from their note deficiencies with the Jump To button hyperlink, saving time and reducing clicks . This will be most helpful for note types other than 19-ED Provider Note. For example, you might want to configure your ED Attestation Note deficiency to open incomplete attestation notes directly in the NoteWriter.

To configure the Jump To button to open an existing incomplete note directly in the NoteWriter:

Specify an existing hyperlink to appear for an Attestation Note deficiency In Basket message:

1. In Hyperspace, open the deficiency type that should include the hyperlink (search: Deficiency Admin).
2. Go to the Status Settings form and find the status for which you want the hyperlink to appear.
3. In the Hyperlink Action (I DEF 65) column, specify the Attestation Note hyperlink.

If you need to create a new option to include as a hyperlink:

1. Open the Hyperlink Action (I DEF 65) category list (search: Category List Maintenance).
2. Enter an unused ID in the Add/Edit category field. Starting in February 2024, click the Add Category button. In previous versions, click Go.
3. Specify a title, abbreviation, and any applicable synonyms.
4. In the Action type field, select Activity. This opens the patient's chart and opens the specified activity.
 - Activity descriptor. Enter the descriptor (I E2N 30) ED_IP_NOTEWRITER_REDIRECTOR
 - Jump to an Inpatient activity from a surgery-linked deficiency? Click Yes.
 - Run parameters. Specify any parameters to control how the activity loads. There are two run parameters you might use, NoteType and MyNoteMode.
 - NoteType corresponds with the HNO type. To see a complete list of note types available in an environment, open the Note Types (I INP 5010) category list (search: Category List Maintenance).
 - MyNoteMode corresponds with the My Note behavior as specified in the My Note (I LPR 46026) field. 0=off, 1=one per user, 2=one per encounter.
 - You can specify either or both of these, such as NoteType=1234,MyNoteMode=1.
 - The note type specified needs to be set up as the NoteWriter note type.
 - There is an additional run parameter, SkipNWLaunch. When set to 1, this is used to directly open a note without going to the NoteWriter. For example, NoteType=1234,MyNoteMode=1,SkipNWLaunch=1
 - Tooltip. Enter the text to show when a user hovers over the hyperlink.

Remind Users to File Charges for Notes

You can help ensure that clinicians charge for clinical services documented in their notes in one of two ways:

- Configure a Charge Capture activity to appear automatically when a clinician signs a note that should have corresponding charges or marks it Sign when Signing Visit. Refer to the [Show a Charge Capture Window](#) topic for more information.
- Automatically generate placeholder charges to notify coders that a clinician has signed a note that a coder should evaluate for charges or marked it Sign when Signing Visit. Refer to the [Post Placeholder Charges](#) topic for more information.

Remind Surgeons to Link Notes Written in Non-Surgical Workspaces to Surgical Procedures

You can configure surgeons' profiles to require or recommend that they link certain notes composed in non-surgical contexts to surgical procedures. This makes all clinical information related to the surgical procedure more easily accessible for pre-op, day-of-surgery, and follow-up workflows.

When you require or recommend linking notes written in non-surgical contexts to surgical procedures, the Case ID field appears in the notes editor and surgeons can enter the case number associated with the note. You can

also configure the notes editor to show the Case ID field, but not require or recommend that surgeons complete the field.

1. In Clinical Administration, go to Management Options > Profiles and open a profile record.
2. Go to Note, Letter, Transcription > Notes-Surgery Linking Settings screen.
3. In the Note Type field, enter a type of note to require or recommend surgeons link to a case.
4. In the Requirement field, enter Require, Recommend, or None.

Warn Clinicians That Incomplete Notes Exist

Using In Basket message type 40-Incomplete Notes, you can show clinicians a warning message when they have notes that are marked as incomplete. You can choose to show the message when a clinician secures or exits Hyperspace, as well as when a clinician completes a note from In Basket that indicates that pended orders or medications exist.

1. In Clinical Administration, access a profile and go to Note, Letter, Transcription.
2. On the Incomplete Notes Functionality screen, enter Yes in one of the following fields, depending on when you want a message to appear:
 - In the When securing or exiting Hyperspace (I LPR 1607) field, enter Yes to show a message when a clinician secures or exits Hyperspace.
 - In the When pended orders exist (I LPR 1612) field, enter Yes to show a message when a clinician completes a note from In Basket and pended orders or medications exist.

Prior to May 2024, Chart Completion messages are not delayed. An incomplete note deficiency messages is sent to the Chart Completion folder and the Incomplete Notes folder is sent a message for that same note. Starting May 2024, these deficiency messages are initially sent to only the Incomplete Notes folder. The messages sent to the Chart Completion folder are delayed to reduce sending duplicate messages. Refer to the [Notify Providers of Deficiencies with In Basket Messages](#) topic to configure delaying In Basket deficiency messages.

Starting in August 2025, Incomplete Notes messages are automatically suppressed or retracted if a clinician has a 9-My Open Chart or 26-My Open Encounter message for that same encounter. Clinicians can instead resolve their outstanding documentation from the encounter message. To configure which encounter types receive My Open Chart and My Open Encounter messages, refer to the [All Recommendations by Message Type](#) topic.

Always Show a Warning When Clinicians Open Another User's Note for Editing

When a clinician with security to edit others' notes either right-clicks a note and then clicks Edit or Addend, or double-clicks a note to open it for editing, they see a message that prompts them to confirm that they want to edit the note. This message can be helpful for clinicians who are reviewing a long note and don't realize that it was written by someone else because the author's name appears in the note header. If a clinician doesn't want to see the message, they can select a checkbox so it doesn't appear again.

Edit Note



This note was written by Bernoulli, Shawn M, MD. Are you sure you want to edit it?

Do not show me this again

Yes

No

You can hide this checkbox from clinicians to ensure that they always see the warning message. For example, you might hide the checkbox if your compliance department mandates that clinicians acknowledge that they are editing someone else's note.

If you don't want clinicians to hide the message about editing or adding another user's note, you can prevent them from doing so by configuring your EMR System Definitions:

1. In Clinical Administration, go to Management Options > Edit System Definitions (LSD) > Note, Trans, Communication > Notes General Options - 1 screen.
2. In the Always show warnings when double clicking another's note? (I LSD 33201) field, enter 1-Yes. If you leave this field blank, clinicians can select the checkbox to hide the message.

Ensure Notes Are Formatted Correctly

Your organization might require clinicians' notes to be formatted in a certain way. For example, clinicians' notes might be sent over an interface that converts the notes to plain text and requires the notes to not exceed a certain character limit. To help ensure that notes are formatted correctly for these cases, you can show clinicians a warning when their notes aren't properly formatted.

When a clinician attempts to sign an improperly formatted note of a note type for which you've configured this feature, a message warns her that the note isn't formatted correctly and allows her to review the note. She might be required to modify her note before she can sign it depending on the exact formatting error. For example, if her note exceeds a character limit, she needs to reduce the content of her note before she can sign it.

Your note contains 32700 characters. This exceeds the maximum allowed length of 31500 characters.

Your note contains too many attachments.

Your note will lose its formatting.

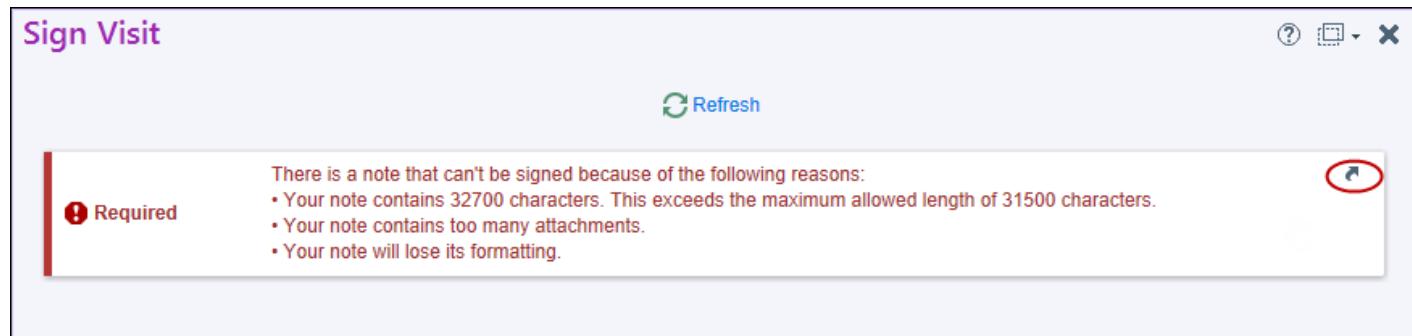
Your note is too long for message transmittal. Split this note into multiple notes.
Your note contains 8 URL attachments and 0 attached files. There is a 5 attachment limit.

Your text contains formatting that will be lost during message transmittal. This is your note text without formatting:
Subjective:
Blake New is a male 30 yo that presents today with:
@PRINCIPALPROBLEM@

Cancel

When a clinician attempts to close an encounter that includes an unsigned note for which you've configured note

validation, a message in the Sign Visit activity warns her about the note formatting and allows her to click a link to review and manually sign the note. Depending on the exact error in the formatting of her note, she can continue to close the encounter without reviewing and manually signing the note. Otherwise, she's prevented from closing the encounter.



Determine Which Note Types to Configure

Before you begin configuring this feature, identify the note types that need specific formatting and the profiles in which you'll configure these note types. When deciding which note types should have a specific formatting, keep the following caveats in mind:

- If you configure this feature for NoteWriter notes, clinicians might be unable to split their documentation into multiple notes to meet the formatting requirements, such as to avoid exceeding a character limit. You might need to configure different formatting requirements for these note types or educate clinicians about alternative methods of formatting their notes.
- If you configure this feature for a note type that generates placeholder charges when signed, multiple placeholder charges are generated if a clinician splits her documentation into multiple notes to meet the formatting requirements. You might need to educate clinicians about alternative methods of formatting their notes, educate charging staff about how to identify and handle multiple placeholder charges generated by this workflow, or update your charging workqueues to filter these additional charges out.

Warn Clinicians When Signing Notes or Encounters

You can use extensions of the type (I LPP 30) 34940-IP Notes Sign Validation to check notes when clinicians sign them or when clinicians sign encounters that have notes set to Sign when Signing Visit. To configure an extension:

1. In Chronicles, open the Extension (LPP) master file and either duplicate a released extension or open a custom extension for editing.
2. Go to the Parameters screen and configure the parameters as needed.

When you've configured all of the extensions you need, associate them with the appropriate note types in a profile record:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
2. Go to Note, Letter, Transcription > Notes Sign Validation screen.
3. Enter a note type in the Note Type (I LPR 34940) field.
4. In the corresponding Validation Extension (I LPR 34941) field, enter the extension that you configured. If you leave this field blank, the note type you entered in step 3 is removed.

Help Clinicians Include Key Details in Their Clinical

Documentation with Provider Nudges

 Starting in November 2025



To make it easier for you to get this content, we've updated the [HIM Potential Condition Templates](#) Turbocharger package to include provider nudges. This version of the package is available for download starting in November 2025 through May 2026. If your organization is signed up for automatic Turbocharger content updates, you can subscribe to receive updates automatically when they're available. For more information about automatically updated content, refer to the [Get Automatic Updates to Turbocharger Content](#) topic. For information about importing this package, refer to the [230174-HIM Potential Condition Templates](#) topic.

Considerations

Provider nudges appear only in inpatient encounters. For an option similar to nudges for outpatient encounters, refer to the [Let Physicians Know About Suspected Hierarchical Condition Category Diagnoses](#) topic.

Provider nudges remind providers to document relevant conditions for their patients, allowing for more accurate reimbursement and reduced CDI queries. If your organization does not have a CDI program, you can still use provider nudges to help providers maintain complete and accurate documentation for their patients.

Provider nudges use patient-context rules (CER) to identify patients who might have potential undocumented diagnoses. If a patient passes a rule, the relevant nudge appears in the To Do sidebar and in the Notes editor. Providers have a few different options to respond to the nudge. They can:

- Agree with the nudge by documenting a diagnosis. You set which diagnoses appear as response options for the nudge, but a provider can also choose their own diagnosis to respond to the nudge.
- Mark the nudge as Unable to Determine if they do not have enough evidence available to confirm or disagree with the nudge. You can disable this option for your organization or for a specific nudge if it is not appropriate.
- Disagree with the nudge if they do not think the patient has that condition. This feedback from providers can help you to refine the display rule for your nudge.

If a provider responds to the nudge, marks it as Unable to Determine, or disagrees with the nudge, it stops appearing to others. If a provider ignores a nudge, the nudge remains visible to other providers caring for the patient.

All Foundation System potential condition templates have a CDI priority weight of 10. When a nudge is appearing to a provider for a potential condition, the related potential condition template has a CDI priority weight of 0, because the active provider nudge is functionally similar to a sent query, which does not contribute to an account's CDI priority weight.

You can report on the effectiveness of your provider nudges using dashboard [38107-HIM CDI System Interventions](#).

Does a diagnosis explain the following clinical indicators?

(i) ^

[View evidence](#) ▾

Heart failure

Another Diagnosis

Unable to determine

Disagree

A nudge reminds a provider to review if the patient has heart failure.

Where providers see nudges depends on whether they're using Diagnosis-Aware Notes. In [Diagnosis-Aware Notes](#), SmartTools allow providers to manage and maintain a patient's problem list from directly within their note-writing workflows, so provider nudges appear within the Diagnosis-Aware Notes section of their note. Any diagnosis they select from a nudge is also added to the patient's Problem List.

For providers who don't use Diagnosis-Aware Notes, nudges appear in the CDI Suggestions window that opens from the bottom of their note. Without the use of Diagnosis-Aware Notes features, nudge response diagnoses are not added to the patient's problem list.

Considerations

Provider nudges use the same records as potential condition templates, so creating a provider nudge from an existing potential condition template can be easier than creating a provider nudge from scratch. For information on how to set up potential condition templates, refer to the [Help Clinical Documentation Improvement Users Find Potential Secondary Diagnosis Opportunities](#) topic.

For CDI specialists, provider nudges appear in the patient's Query Sidebar with the same evidence and diagnosis options as shown to providers, helping to keep everyone on the same page. CDI specialists can:

- Add evidence or edit response options. To do this, they turn the nudge into a regular query.
- If they see that condition is already supported, they can take care of it for the provider by marking it as Documented.
- Mark it as Disagree if the nudge is inappropriate.

Nudges marked Documented or Disagree no longer appear to providers.

Summary of How to Create a Provider Nudge

To create a nudge, at minimum, you must:

1. Have a potential condition template (LQT) record for the condition for which you want to nudge providers. You can update an existing potential condition template you already use, or you could make a new one to use for a nudge.
2. Set a display rule (CER) in the potential condition template to nudge providers.
3. Set the evidence you want to appear with the provider nudge.
4. Set the diagnosis response options in the potential condition template for the nudge.

While not required, you might want to:

1. Review and update the system-wide behavior for provider nudges.
2. Update behavior specific to that nudge in the potential condition template, such as which providers can see the nudge.

The following topics will walk you through these steps in detail.

AI Evidence in Provider Nudges

Starting in February 2026 and with November 2025 SUs E11604123 and E11604159, AI can help include note text data in nudges, rather than just discrete data like labs, medications, and flowsheets. Note evidence allows you to use nudges for more complex conditions because providers likely want to reference written indications for these conditions in addition to the discrete clinical data that can already be used as evidence.

The [HIM Potential Condition Templates](#) Turbocharger package includes malnutrition and pressure injury nudges with AI evidence.

CDI Nudges for Physicians with AI evidence are included in your Epic Generative AI Jump Start Cloud Infrastructure Package Pricing Agreement. If your organization has not yet signed that agreement and wants to enable this feature while paying usage-based costs, you can work with your Epic representative and mention SLG 10784958 to request a cost estimate.

Nudges with AI evidence are not trained to predict treatments or provide evidence-based decision support, and the provided text is not intended to diagnose, prescribe treatment, or serve as a substitute for clinical judgment. Any provider using nudges with AI evidence needs to be aware that they must fully review and verify that the nudge is accurate before accepting them.

Progress Notes by Tom Drew, Nutritionist 12/05/2025 13:57

"Nutrition Diagnosis (PES Statement) Moderate malnutrition in the context of chronic illness, related to reduced appetite and inadequate oral intake, as evidenced by 14% unintentional weight loss in 3 months, intake <75% of estimated needs for >1 month, and moderate muscle wasting on NFPE."

This evidence was identified by Generative AI. Not a replacement for clinical judgement and not intended for diagnosis, treatment, cure, mitigation, or prevention of a disease or condition.

Diagnoses

- Malnutrition
- Another Diagnosis
- Unable to determine
- Not my specialty
- Disagree

A provider sees a malnutrition nudge supported by AI-extracted evidence in the Diagnosis-Aware Notes section of their note, and they hover over the evidence to see the full quotation from the nutritionist's note.

Give Security to Users to Create Nudges

Starting in November 2025

Analysts either need Hospital Billing security point 141-Allow User to Access System Profile or Shared security point 99106-May Access Automated Nudge Configuration to create provider nudges and manage system-wide nudge behavior.

Hospital Billing security point 141 includes access to many other features, too, so if analysts don't need that broad security or you don't use Hospital Billing, but do need to configure nudges, use Shared security point 99106.

Determine System-Wide Behavior for Provider Nudges

Starting in November 2025

By default, provider nudges:

- Show a header of "Does a diagnosis explain the following clinical indicators?"
- Appear to all provider types listed in the Hospital Billing profile in the Default Codeable Provider Types (I SER 1040) field. By default, codeable provider types are Physicians, Nurse Anesthetist, Anesthesiologist, Midwife, Physician Assistant, Nurse Practitioner, Optometrist, Dentist, Osteopath, Resident, and Fellow.
- Appear in progress notes, consults, procedure notes, H&Ps, discharge summaries, ED notes, and ED provider notes.
- Include a response option of Unable to Determine.
- Use progress note as the note type when a provider responds with a new note from the To Do sidebar.

Because nudges appear in high-traffic, high-impact provider workflows, you might need to adjust these behaviors for your organization. If you want to adjust how nudges work for your organization, follow these steps:

1. In Hyperspace, open the Automated Nudge Settings activity.
2. To change the header text for all provider nudges, enter text in the Missing Diagnosis Nudge Header Text (I LSD 39503) field.
3. To limit which codeable providers can see nudges, set a user-context rule in the Recipient Filter Rule (I LSD 39506) field.
4. To override the types of notes in which nudges appear, enter note types in the Note Types to Include (I LSD 39505) field.
5. To remove the Unable to Determine option from nudges, select Yes in the Disable Unable to Determine Option (I LSD 39504) field.
6. To change the note type used when a provider selects Respond with New Note from a nudge in the To Do sidebar, specify a note type in the Default Response Type Note (I LSD 39060) field.

Configure Potential Condition Templates to Create Provider Nudges

Starting in November 2025

Provider nudges are built from [potential condition template](#) (LQT) records. To start using a nudge, you need to associate it with a condition and specify when it appears and how providers can respond to it. You'll also set up what evidence shows for the nudge for providers to review.

Associate a Condition

You must associate a provider nudge with a specific condition. The condition list is a released list (I HSD 2497) of relevant conditions, such as obesity or heart failure. Using a released list of conditions allows us to benchmark

usage and develop applicable enhancements in the future.

If you're updating an existing potential condition template, this is already set, and you can skip this step.

To set a condition for a provider nudge:

1. In Hyperspace, open the relevant record in the Potential Condition Template activity.
2. In the General form, enter the appropriate category from the Condition Mapping - Condition category list (I HSD 2497) in the Condition (I LQT 18034) field.

Specify the Display Rule

Providers see a nudge for a patient when that patient passes a display rule set to Nudge Provider. Display rules are patient-context rules you can use to identify patients who meet certain criteria related to that condition. Although you can update your existing potential condition template display rules to nudge providers, we recommend creating new, more specific display rules for nudges.

Limit nudges to only appear when you're relatively confident a provider will agree with the nudge, as doing so helps reduce the possibility that providers find nudges distracting rather than helpful.

For example, in the Foundation System, the Doc Review rule for Obesity identifies patients with a BMI of 35 or higher, while the provider nudge rule identifies patients with a BMI of 40 or higher. In this example, a nudge doesn't appear to a provider for a patient with a BMI of 37 but no other indicators of obesity because a provider might ignore or disagree with the nudge. A CDI specialist does see the potential condition node in Doc Review for that patient, so if they identify additional relevant clinical indicators for obesity, they can choose to query the provider.

Display Rule	Display Behavior
1 HIM Potential Condition of Anemia [3800000001]	Show Only in Doc Review [1]
2 HIM CDI Anemia Provider Nudge [118202]	Nudge Provider [3]
3	

A potential condition template set with a broader rule to show a potential condition node in Doc Review and a more specific rule to show the nudge directly to the provider.

To set a new Display Rule for a provider nudge:

1. In Hyperspace, open the relevant record in the Potential Condition Template activity.
2. In the General form, enter your new patient-context rule in a new row in Display Rule table.
3. Set the Display Behavior for that row to Nudge Provider.

Set Diagnosis Response Options

Each provider nudge must have at least one diagnosis response option set, but you can set as many diagnoses as responses as are appropriate for the nudge.

To agree with a provider nudge, providers must select one of the diagnosis responses provided or specify another diagnosis in response.

To set the specific diagnosis responses a provider can select to respond to a nudge:

1. In Hyperspace, open the relevant record in the Potential Condition Template activity.

2. On the Provider Nudges form, go to the first line in the Diagnosis Response Options table and:
 - a. Set the Code Set (I LQT 18047) for the diagnosis.
 - b. Enter the Code (I LQT 18048) for the diagnosis. If the code's preferred term is a calculator, the Is Calculator field is automatically set to Yes, allowing the provider to use a diagnosis calculator to select a more specific diagnosis.
 - c. If you want physicians to see a display-friendly name (for example, Obesity, unspecified instead of Obesity, unspecified [278.00.ICD-9-CM]), enter that text in the Display Name (I LQT 18050) field.
 - d. To set a custom response term instead of the preferred clinical term, use the Custom Term Response Option (I LQT 18045) field.
3. Repeat these steps for all the diagnosis responses you want to specify for the nudge.

Determine the Evidence that Appears

You have two options for setting up the evidence report for a nudge:

- Set up an evidence report that appears to both providers, in the View Evidence window, and CDI specialists, in potential conditions nodes in Doc Review.
- Set up an evidence SmartText that's specific to provider nudges and appears in the nudge itself.

To set the Evidence Report for a provider nudge if you want that evidence to appear in the View Evidence window and potential conditions nodes in Doc Review:

1. In Hyperspace, open the relevant record in the Potential Condition Template activity.
2. In the General form, enter a report into the Evidence Report (I LQT 18001) field.

To set the Evidence Report for a provider nudge if you want it to appear only in provider nudges:

1. In Hyperspace, open the relevant record in the Potential Condition Template activity.
2. In the Provider Nudges form, enter a 1-MR Charting context SmartText into the Evidence SmartText (I LQT 18038) field.

Optional Configuration

To explain why a provider is seeing a nudge, you can set a Reference SmartText (I LQT 18037) using a 1-MR Charting context SmartText. Providers can hover over the info icon in the nudge to view this context. For example, you might want to provide specific reference materials to explain why obesity might be an appropriate diagnosis for this patient.

You can also override certain system-wide settings for individual provider nudges on the Provider Nudges form. Specifically, you can:

- Disable the Unable to Determine option for a specific nudge by setting Disable Unable to Determine Option (I LQT 18039) to Yes.
- Limit which codeable providers see the nudge by applying a user-context rule in the Recipient Filter Rule (I LQT 18044) field.

Make It Easier for Clinicians to Include Key Details in Their Clinical Documentation Based on Common CDI Queries

 August 2025 and earlier

 Starting in May 2024



To make it easy for you to get this content, we've created a Turbocharger package for the rules, SmartText, and SmartLinks needed for this project. This is available to download for organizations in the United States, either from the top of this release note or from the Available Packages tab of the Turbocharger activity in Hyperspace. If your organization is outside the United States or you don't have automatic package delivery set up, contact your Epic representative and mention project 316516 to get the package. For information about mapping and importing this package, refer to the 316516-Proactively Reminder Providers to Include Relevant Information in their Notes topic.

To limit follow-up queries from clinical documentation specialists (CDS), enable clinicians to include information commonly needed for timely reimbursement when writing a patient's note by adding the Foundation System SmartLink 103405-HIM Provider Nudge SmartLink (mnemonic: .HIMPROVIDERNUDGE) to clinician's note templates. After you add the SmartLink into a provider note template, SmartTexts automatically pull in relevant information about commonly queried conditions, such as obesity, depression, heart failure, and malnutrition, to prevent queries from being sent to clinicians by clinical documentation specialists. For example, the SmartText for malnutrition pulls in information about the patient's BMI and the SmartText for depression pulls in information about the patient's depression related score. Based on this information, clinicians can evaluate the presence and severity of these conditions.

This clarification is intended to ensure accurate documentation and help reduce future manual queries. [See more.](#)

The patient's Body mass index is 37.76 kg/m². Based on this data the following accurately represents the patient's status: Obesity Type ▾

A clinician is directed to evaluate a patient's obesity type in SmartText 27131-HIM Provider Obesity Text. Once the clinician signs the note, the blue text disappears.

Have appropriate stakeholders review the CDI nudge content to confirm it aligns with organization needs. The Foundation System includes the following SmartTexts that you can use in note templates:

- 27021-HIM Provider Nudge
- 27131-HIM Provider Obesity Text
- 27171-HIM Provider Pediatric Obesity Text
- 27169-HIM Provider Depression Text
- 27170-HIM Provider Heart Failure Text
- 27174-HIM Provider Pancytopenia Text
- 27173-HIM Provider Pediatric Malnutrition Text
- 27172-HIM Provider Malnutrition Text

Document and Track Reasons Why Notes Are Not Shared with Patients

As described in the [Determine Which Note Types Are Shared with Patients](#) topic, your organization can configure note types to be shared with patients by default through MyChart. If a clinician does not want a certain note to be

visible to the patient, the clinician can deselect the Share w/ Pt button.

The following topics describe how you can prompt or require clinicians to document a reason when notes are not shared and how you can configure a report to track notes that are not shared and the documented reasons for not sharing.



Clinicians can use My Notes Settings to set a personal preference to not share notes for a certain note type by default. You can disable this preference setting by following the steps in the [Hide the User Setting to Opt Out of Sharing Notes with Patients by Default](#) topic. If you hide this setting, communicate to clinicians that their notes will now be shared by default, but they can still deselect the Share w/Pt button if there is a particular note that should not be shared. If you continue to allow users to set a preference to not share notes, let them know that they will now be prompted for a reason for each note, after you complete the tasks below.

Document Why a Note Is Not Shared

This section contains information about two different ways to prompt clinicians to document a reason when they choose not to share a note with the patient in MyChart.

- The first option is to configure a window to appear when clinicians choose not to share a note that was shared by default. This is our recommended option because it is a streamlined workflow that ensures users don't forget to document a reason.
- The second option is to configure a SmartPhrase where clinicians can document their reason for not sharing a note. You should use this option only if you don't yet have access to the Reason for Blocking window development.

Require Users to Document a Reason for Not Sharing a Note in a Window

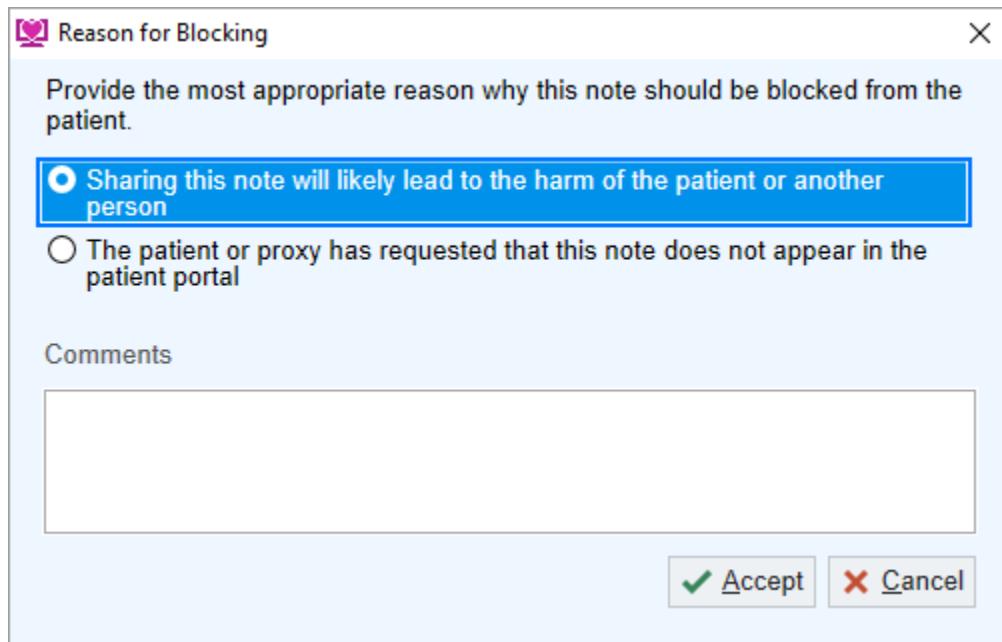
Starting in May 2021

February 2021 by SU E9601311, C9601311-HSWeb, E9600830, E9601038, C9601038-HSWeb, E9600800, E9600736, E9601153, C9601153-Hyperspace, C9601153-EpicCare Link, E9602352, C9602352-HomeHealth, E9601926



This is Epic's recommended option for all organizations.

You can require that clinicians document a reason when they choose to not to share a note with the patient by clicking the Share w/ Patient button. If you do so, when a clinician stops sharing a note that was shared by default, a window appears prompting the clinician to document a reason why she is choosing not to share the note with the patient. Refer to the [Determine Which Note Types Are Shared with Patients](#) topic for information on how to update which notes types are shared by default.



The Reason for Blocking window with two configured reasons.

You can customize the introductory message that appears in the window as well as the reasons a note can be blocked. If you don't set up any reasons, the window never appears. The window has a comment field to allow clinicians to enter additional details. If you don't want the comment field to appear, you can remove it. The reason for blocking and comment appear in the note editor and notes reports.

The reason for blocking and user comment appear on a closed note in the note editor.

If your organization prevents sensitive notes from appearing in MyChart using the Hide Sensitive Notes? (I WDF 346) field in Patient Access System Definitions, clinicians see the Reason for Blocking window when they mark a note that is shared by default as sensitive. If a note is not shared by default, then the window does not appear when a clinician marks the note as sensitive.

Define a List of Reasons for Blocking a Note

Update the Reason for Blocking (I HNO 17133) category list with the reasons that your clinical stakeholders and compliance teams identified. For details on updating category lists, refer to the [Add a Value to a Category List](#) topic.

Customize the Introductory Message

If you want to customize the introductory message on the Reason for Blocking window, complete the following steps:

1. In Clinical Administration, go to Management Options > Edit System Definitions > Notes, Trans Communication.
2. On the Share with Patient Settings Screen, enter the custom text you want to show in the window in the Message to display when prompting users to select a reason for blocking the note from the patient (I LSD 33200) field.

Disable the Comment Field

If you want to disable the comment field on the Reason for Blocking window, complete the following steps:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations (HFN), and open a custom feature set.
2. On the Share with Patient Settings screen, set Allow specifying free text reason for blocking (I HFN 224) to No.

Remove the Reason Documentation Requirement in a Feature Set

If you determine that clinicians who use a certain feature set should not be required to enter a reason for blocking, complete the following steps:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configuration (HFN) and open a custom feature set.
2. On the Share with Patient Settings screen, set Require a Reason for Blocking from the Patient (I HFN 223) to No.

Prompt Users to Document a Reason for Not Sharing a Note in a SmartPhrase



Using a SmartPhrase is no longer the recommended way to document a reason for not sharing a note in MyChart. It should be used only if you don't yet have access to the Reason for Blocking window development detailed above.

You can implement a SmartPhrase for clinicians to document their reason for not sharing a note and help clinicians remember to use it:

- In outpatient settings, you can add a close encounter validation check to make sure users document a reason.
- In inpatient settings, you can use a Reporting Workbench report to identify notes that are not shared without having a reason documented and follow up with those providers.



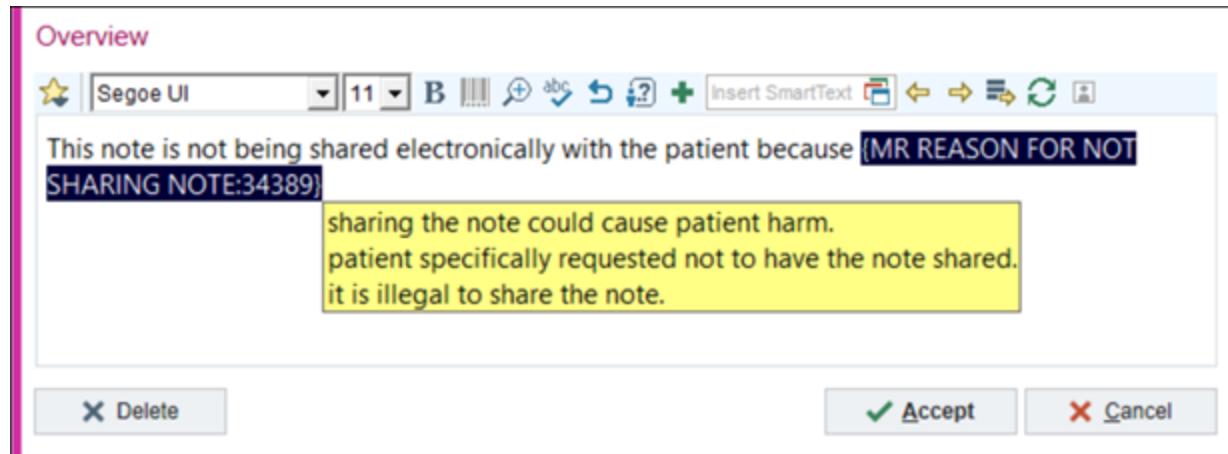
Starting in November 2019, if your organization is in the United States and a member of your EpicConnect team has completed the necessary EpicConnect setup, a Turbocharger package is available for download on the Available Packages tab of the Turbocharger activity (search: Turbocharger). Starting in August 2020, you can download the package from this topic. If your organization is outside the United States or you don't have automatic package delivery set up, contact your Epic representative and mention project 231792 to get the package. For information about mapping and importing the package, refer to the 231792-Prompt Users for a Reason for Not Sharing a Note topic.

All Settings: Create a SmartList and SmartPhrase

Make a SmartList with possible reasons:

1. Check with stakeholders at your organization to determine appropriate reasons for not sharing a note, such as the potential to cause patient harm.
2. Complete the steps in the [Create and Edit a SmartList](#) topic to create a SmartList with the reasons you determined. Use the following settings:
 - a. Select the Use Discrete Data checkbox.
 - b. In the Discrete Data section, enter SmartData element EPIC#31000205115-Workflow - MyChart - Reason for Not Sharing Note with Patient in the File Selected Choices To (I ELT 400) field. Enter a Context of Note.

Make a SmartPhrase that includes the SmartList you created. Refer to the [Create and Edit a System SmartPhrase](#) topic for more information.



Outpatient Settings: Prompt Users for a Reason When They Don't Share a Note

Complete the following tasks to configure a close encounter validation check for outpatient settings so that a message appears if a user un-selects to share a note with a patient without using the SmartList you created to document a reason. When a clinician uses the SmartList to indicate a reason, a SmartData element is filed when the note is signed so that the close encounter validation check doesn't appear.

Create Rule Properties

You need several properties for your rule. You might already have some of these properties in your system, and you can create the rest using the information below. Refer to the [Create or Edit a Property](#) topic for general information about working with properties.

Released Property	Details to Build Yourself
Property group 101554-C_UCN Linked Notes Available in the Foundation System	Context: Patient Concept: 19-Patient Group number: 20330 Count item: 20330
Property 101758-C_Linked Note Available in the Foundation System	Add to your property group Item: 20330-UCN – Linked Notes Data type: Numeric Related group: 20330 Network INI: HNO DAT resolution ext: 12002-Current DAT
Property 102454-C_Patient Sharing Available Available in the Foundation System	Add as a child of C_Linked Note Context: Note Item: 17132-Share with Patient Available Data type: Numeric Category: 101;ECT
Property 102455-C_Patient Shared? Available in the Foundation System	Add as a child of C_Linked Note Context: Note Item: 17131-Share with Patient Data type: Numeric Category: 101;ECT
Property 19140-SmartData Value	Add as a child of C_Linked Note Context: Note Function: Use code <code>\$\$NoteSDESearch^JEDREMCHK2</code> Select Multiple Response Data type: String Cache setting: Inherit From Context

Configure a Rule

Create a rule that applies if a clinician does not share a note and returns true only if a reason is documented. Use the following logic:

- Rule Context: Patient
- Property: C_Patient Sharing Available = 1-Yes
- Property C_Patient Shared? = 0-No
- Property: SmartData Value > SmartData Element EPIC#31000205115 = <blank>
- Property: Status <> Deleted
- Evaluation Logic: And

Refer to the [Create or Edit a Rule](#) topic for general information about working with rules.

Create a Close Encounter Validation Check

Configure a close encounter validation check to use the rule that you created:

1. Duplicate extension 34373-MR Rule Based Close Visit Validation.
2. In your copy of the extension, enter the rule you created in the third parameter.
3. Enter the message that you want to appear to the user in the fifth parameter, such as "Document a reason why the note was not shared."

Add your extension to the profile and encounter type where you want the message to appear, as described in the [Require Encounters to Meet Specific Criteria to Be Closed](#) topic.



If a clinician uses a SmartList to document a reason for not sharing a note, the clinician needs to save the note so that the SmartData element is filed. If a clinician selects for the note to be signed when the encounter is closed, the close encounter validation message still appears because the SmartData element hasn't yet been filed. Refer to the [Set a Default Action for New Notes at the Profile Level](#) topic for more information about configuring default actions for when notes are signed.

Inpatient Settings: Follow Up When a Reason Is Not Documented

Configure a report for inpatient settings to identify notes that clinicians chose not to share and where they did not document a reason using the SmartPhrase you configured, as described in the All Settings: Create a SmartList and SmartPhrase section above. The goal of this report is to be an actionable worklist that an administrator or compliance manager at your organization can use to follow up with clinicians and show them how to attest or create an addendum to their note to document the SmartPhrase. This report is similar to the report described in the [Track Notes Not Shared with Patients](#) topic but allows for more actionable outcomes by using the SmartData element as a criterion instead of a display column. When the clinician signs the note, the SmartData element is filed, and the note no longer appears on your report because a reason for not sharing the note has been documented.

To configure the report:

1. In the Analytics Catalog, search for template [34001-IP Notes Report Template](#) and create a new report.
2. In the Report Settings window, add new criteria with "And" logic based on the following:
 - Item: Share with Patient Available (I HNO 17132). Configure it to equal Yes.
 - Item: Share with Patient (I HNO 17131). Configure it to equal No.
 - Property: Note Context SmartData Element Search. Configure it to SmartData element EPIC#31000205115-Workflow - MyChart - Reason for Not Sharing Note with Patient does not exist.

3. Add other criteria based on how you want to filter your report, such as by date range or department.
4. Save and run your report.

If this is a new workflow for your organization, run the report and follow up on it daily to make sure that clinicians get used to allowing notes to be shared or documenting a reason if they choose not to share a note.

Track Notes Not Shared with Patients

This section describes three different options for configuring report template [34001-IP Notes Report Template](#) to report on notes that are not shared and the reasons for not sharing, depending on your setup.

Track Notes with a Blocking Reason Documented in the Reason for Blocking Window

 Starting in May 2021

 February 2021 by SUE9601926

If your organization configured a window where clinicians can document a reason for not sharing a note, as described in the [Require Users to Document a Reason for Not Sharing a Note in a Window](#) topic above, you can create a Reporting Workbench report that shows all notes where clinicians documented a blocking reason. By default, it returns results from the past week, but this is configurable.

Complete the following steps to configure the report:

1. In Hyperspace, go to the Analytics Catalog, search for template [34001-IP Notes Report Template](#), and create a new report. This template can be used for reporting in both inpatient and outpatient settings.
2. In the Report Settings window, add a new criterion for the Reason for Blocking (I HNO 17133) item.
3. Add other criteria based on how you want to filter your report, such as by department.
4. To show the reason a note was blocked, go to the Display form, click Add, and search for column 34767-Reason for Blocking Note. Select the column from the Available Columns list and add it to Selected Columns.
5. To show the comments from the Reason for Blocking window, repeat the process from step 4, but add column 34768-Reason for Blocking Note Additional Information.
6. Optionally, go to the Summary tab to add a visual display based on the data returned. For example, you might want a pie chart that breaks down the percentage of unshared notes by reason.
7. Save and run your report.

Plan to follow up on the report regularly to make sure that reasons are being documented as expected. You might want to add a component to an administrative or manager dashboard that shows the pie chart or other summary that you created so you can check daily on the reasons notes are not being shared and easily drill down to the details in Reporting Workbench. Refer to the [Streamline Build by Integrating Radar and Reporting Workbench](#) topic for more information about including Reporting Workbench report results in dashboards.

Track All Notes That Aren't Shared

You can create a Reporting Workbench report to show notes that clinicians have chosen not to share. The goal of this report is to help you see the overall percentage of notes that are not shared at your organization. You might use it as you identify trends with certain clinicians or note types that are more frequently not shared.

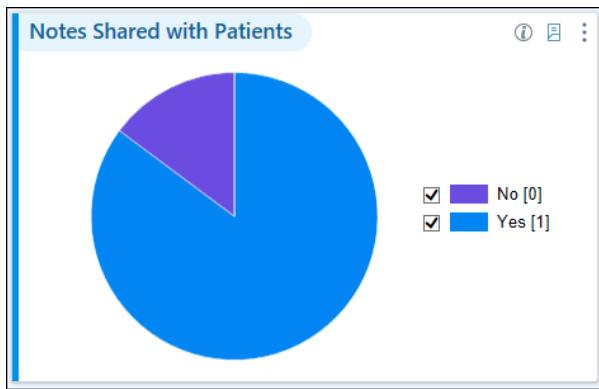
Complete the following steps to report on the percentage of notes that are not shared:

1. In Hyperspace, go to the Analytics Catalog, search for template [34001-IP Notes Report Template](#), and create a new report. Note that this template can be used for reporting in both inpatient and outpatient

settings.

2. In the Report Settings window, add a new criterion based on the Share with Patient Available (I HNO 17132) item and configure it to equal Yes.
3. Add other criteria based on how you want to filter your report, such as by date range or department.
4. On the Display tab, add a new column based on the Share with Patient (I HNO 17131) item.
5. Optionally, go to the Summary tab to add a visual display based on the Share with Patient column you created. For example, you might want a pie chart so you can see at a glance the percentage of notes where Share with Patient is set to No.
6. Save and run your report.

Plan to follow up on the report regularly to make sure that notes are being shared as expected. You might want to add a component to an administrative or manager dashboard that shows the pie chart or other summary that you created so you can check daily on the percentage of notes not being shared and easily drill down to the details in Reporting Workbench. Refer to the [Streamline Build by Integrating Radar and Reporting Workbench](#) topic for more information about including Reporting Workbench report results in dashboards.



Track Notes with a Blocking Reason Documented in a SmartPhrase

If your organization implements a SmartPhrase so that clinicians can document a reason for not sharing a note, as described in the [Prompt Users to Document a Reason for Not Sharing a Note in a SmartPhrase](#) topic, you can add a column to the report described in the [Track All Notes That Aren't Shared](#) section above. This can help you see the percentage of notes that are not shared and that have a reason documented, as well as spot check that reasons are being documented appropriately.

To add this information to your report:

- Duplicate extension (LPP) 35336-IP Note SmartData Element Value and configure the second parameter to SmartData element EPIC#31000205115-Workflow - MyChart - Reason for Not Sharing Note with Patient.
- Copy Reporting Workbench column 35336-IP Note - SmartData Element Value. In your copy of the column, enter the extension you created in the Text Ext field.
- Add your column to the report.

To make it easier to review the report results at a glance and follow up, you might want to create a grouped table or other summary. For example, the summary below shows notes that were not shared, the reason documented, and for how many notes each provider entered that reason.

Reason Not Shared

Reporting Period: 09/15/20 12:00 AM - 09/22/20 11:59 PM

Grouped by: [Shared with Patient](#), [Note SDE Value](#), [Note Author](#)

Total count of Note ID

Grand Total	44
No [0]	18
patient specifically requested not to have the note shared.	2
Adam Johnson, MD	1
Julian Jeffries, MD	1
sharing the note could cause patient harm	16
Kevin Lin, MD	3
Julian Jeffries, MD	4
Ben Anderson, MD	3
Kim Waverly, MD	1
Macie Maxwell, MD	2
Jianting Lee, MD	1
Brian Stenberg, MD	2
Yes [1] (1 subgroup)	26

Notes Setup: Bells & Whistles

In this section, we'll show you more configuration options for notes. They allow for further configuration of the behavior and appearance of notes.

Extract Billing Information When a Note Is Cosigned

To prompt patient billing extracts for patients with notes requiring a cosign, you can now add extensions that are triggered when a cosign-required note is completed with a cosign to profiles. For information on how to use extensions to configure patient billing extracts, refer to the [Send Patient Billing Extracts for Professional Services to Another Vendor](#) topic. To add an extension to a profile:

1. In Clinical Administration, open the profile record that should trigger extensions on cosign.
2. Go to the Notes General Settings-2 screen.
3. Enter an extension in the Note cosigned extension (I LPR 34357) field.

Automatically Route Notes

You can configure your system to automatically route notes to clinicians. When a note is automatically routed to clinicians, those clinicians receive notification by fax, mail, or an In Basket message. Work with your HIM team to determine the appropriate methods and recipients for routing notes.

Configure the System to Automatically Route Notes

1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription.
2. Go to the Auto Route Notes Configuration 1 screen.
3. In the Auto Route notes field, select Yes to enable automatic routing.
4. To determine Auto Routing behavior when signing cosign-required notes and cosigning notes:
 - a. In the Cosign logic (I LPR 34869) field, you can determine the logic used when automatically routing cosigned notes and notes requiring a cosign. If this field is set to 1-Route when a note is cosigned or is left blank, the note is routed when it is cosigned. You can instead set it to 0-Route when a note is signed or 2-Route when a note is signed and when it is cosigned.
 - b. Starting in August 2025, May 2025 with special updates E11403167 and E11403168, February 2025 with special updates E11308407 and E11308515, November 2024 with special updates E11212595 and E11212676, August 2024 with special updates E11113883 and E11113857, and May 2024 with special updates E10916114 and E10916124, you can configure the Cosign without attestation (I LPR 34964) field to suppress auto routing when the same user cosigns after making an addendum to a note. If you set this field to 0-Route based on Cosign Logic or leave the field blank, the note routes based on the Cosign logic (I LPR 34869) field. If you set the Cosign without attestation (I LPR 34964) field to 1-Suppress if same user cosigns after an addendum, then auto routing is suppressed when a user cosigns without an attestation on a note that does not require cosign after making an addendum on that note. Otherwise, it routes based on the Cosign logic (I LPR 34869) field.
5. To automatically route notes to an In Basket pool:
 - a. Enter 1 in the In Basket Pool logic field.
 - b. Enter an In Basket pool in the In Basket Pool field.
6. Enter provider types in the Allowed provider types field. Notes signed by the types of providers you enter here will be automatically routed. Notes signed by types of providers that aren't listed here will not be

automatically routed.

7. If you want notes automatically routed based on your In Basket distribution schemes, enter Yes in the Route to distribution scheme? field.
8. Go to the Auto Route Notes Configuration 2 screen.
9. In the Auto Route Report table, enter the following:
 - a. Enter one or more note types that you want automatically routed. For example, enter procedure note, progress note, or discharge summary.
 - b. Enter a report that you want the system to use when a note is automatically routed by fax. If you leave this field blank, the system uses the report specified in the Default notes report (I LSD 34847) field on the Auto Routing Configurations - 1 screen in EMR System Definitions. If this field is blank, the default report is 45407-IP Auto Routed Notes.
 - c. Enter a report that you want the system to use when a note is automatically routed by mail. If you leave this field blank, the system uses the report specified in the Default notes report (I LSD 34847) field on the Auto Routing Configurations - 1 screen in EMR System Definitions. If this field is blank, the default report is 45407-IP Auto Routed Notes.
 - d. Enter an In Basket message type that you want the system to use when automatically routing a transcription to In Basket. If you leave this field blank, the system uses the message type specified in the Default notes In Basket message type field on the Auto Routing Configurations - 1 Screen in EMR System Definitions. If this field is blank, the system uses message type 500-IP Routing.
 - e. Starting in August 2024, if you have set up custom routing methods as described in the [Route Communications by a Custom Fax or Mail Method](#) topic, press F6 to enter a report you want the system to use when a note is automatically routed by a custom method you specify. If you leave this field blank, the system uses the report specified in the Default notes report (I LSD 34847) field on the Auto Routing Configurations - 1 screen in EMR System Definitions. If this field is blank, the default report is 45407-IP Auto Routed Notes.
 - f. Starting in November 2024, [Allow Clinicians to Route Notes Via a Third-Party System](#) topic, press F6 to enter a report you want the system to use when a note is automatically routed by a custom method you specify. If you leave this field blank, the system uses the report specified in the Default notes report (I LSD 34847) field on the Auto Routing Configurations - 1 screen in EMR System Definitions. If this field is blank, the default report is 45407-IP Auto Routed Notes.
10. Go to the Auto Route Notes Configuration 3 screen.
11. For every note type you selected in the Auto Route Report table, select the recipients for those documents. Starting in November 2024, you can enter an extension you have set up as described in the [Use Extensions to Automatically Route to the Patient Care Team](#) topic in the Care Team extension field.

Specify a System-Wide Default Report for Automatic Routing

In profile records, you can enter a report that the system uses when automatically routing notes by mail or fax. However, you can also specify a report in EMR System Definitions. This setting is useful when:

- You want to simplify your configuration of automatic routing. For example, if you enter a report in EMR System Definitions, you might not need to specify a report in every user or department profile.
- You want to make sure that a report of your choosing is used when a note is automatically routed from a clinician whose profile does not have a report specified.
- You want to make sure that a report of your choosing is used when automatic routing isn't enabled in a clinician's profile, and clinicians are listed as CC recipients in a note. The system routes the note to those

recipients using the report you've entered in EMR System Definitions.

When no report is specified at either the profile or EMR System Definition levels, the system uses report 45407-IP Auto Routed Notes as a default for notes.

1. In Clinical Administration, access EMR System Definitions and select Note, Trans, Communication.
2. Go to the Auto Routing Configurations screen.
3. To specify a report for automatically routing notes, enter a report in the Default notes report field.

Use Extensions for More Flexible Automatic Routing of Notes

You can use extensions in conjunction with your automatic note routing configuration for more granularity in determining whether notes are automatically routed. When you enter one or more extensions in a field in your clinicians' profiles, notes are routed based on the settings in the extensions.

The extensions you enter must have a type of 34516-Note Auto Routing, such as the following Epic-released extensions:

- 88371-IP Note Notify EMR Provider, which prevents notes from being automatically routed to recipients who don't use clinical applications.
- 88375-IP Note Suppress Auto Routing Rule, which you can configure to prevent automatic routing when a rule evaluates as true.

For a complete list of extensions that you can use, configure a report from the [Extension Search Report Template](#):

1. In Hyperspace, open the Analytics Catalog.
2. Search for report template 34090.
3. Click New Report. The Report Settings window opens.
4. On the Criteria tab, configure the Extension type criterion to search for note auto routing extensions.
 - In the Relationship field, enter Equal to.
 - In the Extension Type field, enter 34516-Note Auto Routing.
5. Configure any other criteria as desired.
6. Click Run.

To configure an extension to route notes:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) > open a profile > 17 > Auto Route Notes Configuration - 1 screen.
2. Enter one or more extensions in the Routing extensions (I LPR 34908) field. If you enter more than one extension, a note is automatically routed only if it passes the logic configured in all of the extensions.

Use Extensions to Automatically Route Notes to the Patient Care Team



Care team members might want to receive important updates regarding their patient's health status. For example, a care team member might want to know that their patient was recently discharged and a clinician wrote a Discharge Summary note. You can use extensions to configure when the system should route a note automatically and which providers on a patient's care team should receive the note.

1. In Chronicles, duplicate extension 36347-IP Notes Automatic Routing to Care Team.
2. Open your copy and go to the Parameters screen.

3. In the Send All Active? parameter, enter 1-Yes if you want the system to automatically add all active members of the patient care team as recipients. Enter 0-No or leave this parameter blank if you want only certain members of the care team receive the note. If set you set the parameter to 1-Yes, no further configuration is necessary.
4. If you set the Send all Active parameter to 0-No or left the parameter blank, you must modify at least one of these two parameters:
 - In the Roles parameter, enter which care team roles (I EPT 80114) a provider should be in the patient care team to automatically receive the note. If all roles should receive the note, leave this field blank.
 - In the Specialties parameter, enter which care team specialties (I EPT 80101) a provider should be in the patient care team to automatically receive the note. If all specialties should receive the note, leave this field blank.
5. In the Use Spec and Service? parameter, enter 1-Yes if a provider should automatically receive the note only if their specialty listed in the Specialties parameter must also be mapped to a note service as described in the [Restrict Routing to Care Team Specialty by Note Service](#) topic. Enter 0-No or leave this parameter blank to ignore the mapping of specialty to service in EMR System Definitions.
6. In the Routing Filter Logic parameter, enter 1-AND or leave this parameter blank if both the role and specialty of a care team member must be listed in this extension for them automatically receive the note. Enter 2-OR if only one condition, role, or specialty listed in this extension is required for a care team member to automatically receive the note. This parameter is ignored if either the Roles or Specialties parameter is blank.
7. Close your copy of extension 36347-IP Notes Automatic Routing to Care Team to save your changes.
8. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
9. Select Note, Letter, Transcription and go to the Auto Route Notes Configuration – 3 screen.
10. For each appropriate note type, add your copy of extension 36347-IP Notes Automatic Routing to Care Team to the Care Team extension (I LPR 34957) field.

Restrict Routing to Care Team Specialty by Note Service

 Starting in November 2024

Care team members of certain specialties might be interested in receiving a note only when it is assigned to a particular clinical service. For example, an outpatient pulmonologist might want to see progress notes with an assigned service of Internal Medicine but doesn't need to see progress notes with a service of Orthopedics. To restrict which care team members of specific specialties receive notes automatically by the service of the note, do the following:

1. In Chronicles, duplicate extension 36347-IP Notes Automatic Routing to Care Team.
2. Open your copy and go to the Parameters screen.
3. Set the Send All Active? parameter to 0-No or leave the parameter blank.
4. In the Specialties parameter, set the care team specialties (I EPT 80101) that should receive routed copies of notes with only specific services.
5. Set the use Spec and Service? parameter to 1-Yes.
6. Close your extension and return to Clinical Administration.
7. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Note, Trans, Communication.

8. Go to the Auto Routing Configurations – 3 screen.
9. In the Care Team Specialty column, enter the specialties you set in the Specialties parameter of your copy of extension 36347-IP Notes Automatic Routing to Care Team.
10. In the Note Service column, enter the note service (I ECT 34886) that the corresponding specialty should receive. If care team members of a given specialty should automatically receive notes of multiple services, enter the specialty in a new row, add the additional service, and repeat for each applicable service.
11. Close EMR System Definitions and return to Clinical Administration.
12. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
13. Select Note, Letter, Transcription and go to the Auto Route Notes Configuration - 3 screen.
14. For each appropriate note type, add your copy of extension 36347-IP Notes Automatic Routing to Care Team to the Care Team extension (I LPR 34957) field.

If clinicians writing a note have your copy of extension 36347- IP Notes Automatic Routing to Care Team configured in their profile, the system refers to the table in EMR System Definition to check the specialties of any care team recipients. Recipients receive the note only if their specialty is mapped to the note's service.

If the recipient's specialty is not set in the table, or if it is set in the table without a corresponding service mapped to it, then the recipient will receive the note regardless of its service.

Prevent Clinicians from Opting Out of Automatic Routing to In Basket

Starting in May 2024

By default, clinicians can opt out of receiving In Basket messages for notes of specific note types they do not want automatically routed to them. You might want to ensure that all clinicians receive In Basket messages for notes set up for automatic routing. You can turn off notes automatic routing to In Basket preferences for all clinicians in EMR System Definitions.

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Note, Trans, Communication.
2. Go to the Auto Routing Configurations – 1 screen.
3. Set the Enable manual suppression for note types? (I LSD 35210) field to No.

Customize Note Navigator Sections

You can change the appearance and behavior of a notes navigator section by configuring parameters in a navigator configuration record (if you are using [web-based notes](#)) or entering parameters in a navigator record (if you are using non-web-based notes). Below is a list of parameters that can be used to configure any notes navigator section, along with the basic steps to add a parameter to the navigator record.

Note that in non-web-based notes, adding or modifying parameters in a navigator record involves editing the string of code found in the HANDLER ProgID field. Your navigator record might not function as expected or might not function at all if you introduce an error into this string of code.

Customize a Note Navigator Section

You can duplicate and modify the following note navigator sections:

- 103-Sec_Exam_Notes for nursing notes

- 118-Sec_Charting_Multiple to include multiple note sections in a single navigator
- 124-Sec_Doc_Tel_New for telephone encounter notes
- 125-Charting_Mult_Dxord to include multiple note sections in a single navigator
- 126-SEC_Pt_Instr RTF for patient instruction notes
- 128-SEC_H&P_Notes for H&P notes, intended for outpatient contexts
- 27032-ER_Notes for ED notes
- 34112-SEC_Discharge_Notes for discharge notes
- 34203-SEC_IP_Progress_Notes for progress notes
- 34500-SEC_HP_Notes for H&P notes, intended for inpatient contexts
- 34517-SEC_Transfer_Notes for transfer notes
- 52010-SEC_OR_Surgeon_Notes for OR surgeon notes

Note that if you replace navigator section descriptors after users have personalized the location of their navigator sections, it will result in the loss of those personalizations.

To configure a notes navigator section in [web-based notes](#), modify parameters in the section's associated navigator configuration record:

1. In Clinical Administration, go to Navigators > Navigator Configurations (VCN) and open a navigator configuration record. Refer to the [Configure Sections](#) topic for more information.
2. Go to the Parameters screen and update the parameter values as needed.

Note that this configuration method applies only to web-based notes navigator sections. A navigator section is web-based if the View Path (I LVN 1021) field contains one of the following as part of the path:

- Epic.Clinical.Ambulatory.Billing.Web.Views.OPCPerformablesBehavior
- Epic.Clinical.Anesthesia.Sections.Web.Views.Notes.ANNotesNavigatorBehavior
- Epic.Clinical.Anesthesia.Sections.Web.Views.Notes.ANNotesEditOnlyNavigatorBehavior
- Epic.Clinical.Common.Notes.Navigator.Web.Views.NotesNavigatorSectionBehavior
- Epic.Clinical.Common.Notes.Navigator.Web.Views.EditOnly.NotesNavigatorSectionEditOnlyBehavior
- Epic.Clinical.Obstetrics.NavigatorSections.PrenatalNotes
- Epic.Clinical.Emergency.Navigator.MyNote.Web.Views.MyNoteSectionBehavior
- Epic.Clinical.BehavioralHealth.Notes.Web.Views.GroupDocNavigatorSectionBehavior
- Epic.Clinical.BehavioralHealth.Notes.Web.Views.GroupDocNavigatorSectionEditOnlyBehavior

To configure a navigator section in non-web-based notes, add or modify parameters in the Handler ProgID code:

1. In Clinical Administration, go to Navigators > Navigators (LVN) and open a navigator section record.
2. On the Section Setup screen, put your cursor in the Handler ProgID field and press SHIFT+F3 to edit the field:
 - If the parameter already exists in the string, replace its value with the appropriate value.
 - If not, scroll to the end of the string and add a comma followed by the parameter name, an equals sign, and the value. For example, enter ",ShowMine=1" without the quotation marks to show only notes written by the clinician viewing the navigator section. Make sure that you don't add spaces

between parameters.

Configure Edit-Only Sections

Starting in February 2022

You can configure parameters in a menu (E2U) record that points to an edit-only notes section using a Section As Activity navigator. This option is more efficient for custom notes because you do not need to build navigator (LVN), activity (E2N), and navigator configuration (VCN) records to configure notes settings. Instead, simply duplicate the menu (E2U) associated with the notes section's activity (E2N) record.

Considerations

To use this option, you need to know which notes sections are edit-only and use the Section As Activity navigator. To determine whether the notes navigator you are using is edit-only, you can check your notes section record:

1. In Clinical Administration, go to Navigators > Navigators (LVN) and open your navigator section record.
2. On the Section Setup screen, if your navigator's View Path (I LVN 1021) field contains the following, it is an edit-only section:
 - Epic.Clinical.Common.Notes.Navigator.Web.Views.EditOnly.NotesNavigatorSectionEditOnlyBehavior

To determine whether the notes section you are using is configured for the Section As Activity navigator, check the navigator template:

1. In Clinical Administration, go to Navigators > Navigators (LVN) and open your navigator template.
2. On the Template Setup screen, check whether your Optimize Nav For (I LVN 306) field is set to Section As Activity.

To use this option, duplicate a released menu (E2U) that supports this feature and modify its parameters:

1. In Chronicles, access the Menu (E2U) master file and duplicate the menu you want to copy (Enter Data > Duplicate Menu). The following Epic-released menus point to an edit-only notes section in a Section As Activity navigator:
 - 23402-MR_MNU_TABGRP_NOTE
 - 23407-MR_IT_SB_NOTE
 - 23489-MR_IT_SB_TEL_DOC
 - 34841-MR_IT_SB_HP_NOTE
 - 49671-ER_ITM_PERMANENT_NOTE_SIDEBAR
 - 55850-MR_ITM_RAD_THERAPY_PROGRESS_NOTES_SB
 - 73163-OB_TB_DELNOTE
 - 88009-MR_TXP_ITM_SB_CR_NOTE
 - 89025-AN_IT_SB_PREOP_NOTE
2. Go to Create/Edit Menu and open your newly created custom menu.
3. On the Run Parameters screen, modify the notes parameters to your liking under the Value column. At this time, this option is supported for the following parameters in both [web-based](#) and non-web-based notes:

DefaultAction, NoteType, StartupNWTAB, UseDropdown. The following parameters are additionally supported through this option only if you are using [web-based notes](#): OneNotePerEncounter, ShowDeleted, and TimeRange. Refer to the information in the following sections for specific details on configuring each of these parameters.

Change the Note Type

You can change the note type that is assigned to a note created in a navigator section. For example, you might want to configure the system so that all notes created from an ED Notes navigator section have a type of ED Note.

If you are using [web-based notes](#): in the navigation configuration record, enter a category value from the Note Type (I INP 5010) category list in the Note Type parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",NoteType=#" without the quotation marks, where # is the ID of a note type. For example, enter ",NoteType=1" if you want all notes created in that section to be progress notes. You can find a list of note types in the Note - Type (I INP 5010) category list.

Specify a Default SmartText

If you have notes navigator sections where clinicians always document a specific kind of note, you can specify a default note template for that section.

If you are using [web-based notes](#): in the navigation configuration record, in the Default SmartText parameter, enter the SmartText ID.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",SmartText=#" without quotation marks in the Handler ProgID code, where # is the ID of the note template SmartText. For more information about creating note templates, refer to the [Automatically Include Text and SmartTools in New Notes](#) topic.

Show Only Notes Written by the Current Clinician

You can show only notes written by the clinician viewing the navigator section. This setting applies only to signed notes. Unsigned notes from all clinicians still appear.

If you are using [web-based notes](#): in the navigation configuration record, enter Yes in the Show Only My Notes? parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowMine=1" without the quotation marks.

Show Only Recent Notes

You can show only recently written notes in a navigator section. For example, you can choose to show only notes written in the last 24 or 48 hours. This can be useful if patients are likely to have many notes for their encounter, because loading many notes slows performance, and clinicians are often interested only in the patient's most recent information. Up to 48 hours will typically not cause slow performance.

If you are using [web-based notes](#): in the navigation configuration record, enter a number of hours to look back for notes in the Time Range parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",TimeRange=#" without the quotation marks, where # is the number of hours to look back for notes.

Give Clinicians the Option to See Old Notes



Available in the Hyperdrive client and with [web-based notes](#) in the Classic client.

If you've configured the Time Range parameter described in the [Show Only Recent Notes](#) topic, you can add a checkbox that allows clinicians to see older notes that have been filtered by the Time Range parameter. If the Time Range parameter is set to 0 or left blank, this parameter has no effect.

In the navigator configuration record, enter Yes in the Show Old Notes? parameter.

Show Notes as a Table

You can show the list of notes as a table, with only the text of the selected note below the table. This makes the notes navigator section look similar to the Notes activity and improves visibility and performance of the navigator section.

The screenshot shows the 'Progress Notes' screen. At the top, there are buttons for 'Create Note in NoteWriter' and 'Create Note'. Below this is a table titled 'All Progress Notes' with columns: Author, Service, Author Type, Status, File Time, and Date of Service. The table lists several notes from 'Song, Ruby, MD' and 'Qayyum, Noor, MD' across different dates and times. Below the table, there are buttons for 'Edit', 'Delete', 'Send to NoteReader', 'Tag', and 'Copy'. A detailed view of a note for 'Song, Ruby, MD' is shown, including fields for Author, Service, and Status, along with encounter and creation dates/times. The note text is displayed in sections: SUBJECTIVE (Diet: She reports vomiting), OBJECTIVE (Vital signs: (most recent): Pulse 60, temperature 98.5 °F (36.9 °C)), and ASSESSMENT & PLAN.

If you are using [web-based notes](#): in the navigation configuration record, enter Yes in the In Table Mode? parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",TableMode=1" without the quotation marks.

Define a Maximum Height for the Table Mode Note Text Report



Available in the Hyperdrive client and with [web-based notes](#) in the Classic client.

If you've enabled Table Mode, you can define a maximum height in pixels of the report that shows the note text below the table.

In the navigator configuration record, enter the number of pixels in the Max Note Height parameter.

Determine When Notes Navigator Sections Switch to a Table



Available in the Hyperdrive client and with [web-based notes](#) in the Classic client.

Navigator sections that show notes in a list automatically switch to a table when there are more than 10 notes to show. This dynamic switching between a list and a table ensures that clinicians can always see a quick glimpse of the notes on a patient's encounter, even when there are many, and ensures that clinicians can easily scroll through the navigators that contain these sections.

You can change the number of notes required for a given section to switch from a list to a table to match your clinicians' preferences. For example, clinicians at your organization might want a section to switch to a table when there are more than three notes. Similarly, you can configure a section to always appear as a list, no matter the number of notes that it shows.

In the Max Notes Until Table Mode parameter, in the navigator configuration record, enter the number of notes that can appear in the section before it switches from a list to a table. If you want the section to always appear as a list, enter 0. Note that this parameter has no effect if the Table Mode? parameter is set to Yes.

Show Notes in Shortened Form

You can show notes in a collapsed state with a link that a clinician can click to expand each note. The collapsed state shows the whole header and, depending on the formatting of the note, a few lines of note text. This feature is already enabled by default in the Patient Instructions note section, and only works in non-Edit Only navigators.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Use Short Form? parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",UseShortForm=1" without the quotation marks.

Choose Whether Clinicians Can Create NoteWriter and Non-NoteWriter Notes

By default, clinicians can create both non-NoteWriter and NoteWriter notes from a navigator section. You can allow clinicians to create only NoteWriter notes or only non-NoteWriter notes. For example, this might be useful when you want to encourage clinicians to complete certain types of documentation in the NoteWriter.

Considerations

Keep the following in mind when configuring NoteWriter access:

- NoteWriter isn't available in the Exam Notes section.
- NoteWriter automatically launches when physicians create or edit a note if their navigator configuration record has a value of 1 or 2 in the Launch NoteWriter automatically? parameter. Additionally, physicians must have a default NoteWriter template, which you configure in the NoteWriter Templates screen of a profile record.

If you use web-based notes as described in the [Determine If Your Organization Uses Web-Based Notes](#) topic, open the navigator configuration record and in the Launch NoteWriter automatically? parameter, enter:

- 0 to show only the Create Note button, which does not open NoteWriter automatically. Clinicians can open NoteWriter manually by inserting a SmartBlock into a note.
- 1 to show only the Create Note in NoteWriter button, which opens NoteWriter automatically. Note that for

this parameter to work, a default NoteWriter template needs to be defined on the NoteWriter Templates screen of a profile record.

- 2 to show both the Create Note and Create Note in NoteWriter buttons, letting clinicians decide which type of note to create. This is the default behavior. Note that for this parameter to fully work, a default NoteWriter template needs to be defined on the NoteWriter Templates screen of a profile record.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section:

- Enter ",NoteWriter=0" without the quotation marks to show only the Create Note button, which does not open NoteWriter automatically. Clinicians can launch NoteWriter manually by inserting a SmartBlock into a note.
- Enter ",NoteWriter=1" without the quotation marks to show only the Create Note in NoteWriter button, which opens NoteWriter automatically.
- Enter ",NoteWriter=2" without the quotation marks to show both the Create Note and Create Note in NoteWriter buttons, letting clinicians decide which type of note to create. This is the default behavior.

Choose Which SmartBlock Opens in NoteWriter

You can choose which SmartBlock opens when a user creates, edits, or addends a note in NoteWriter.

Considerations

NoteWriter isn't available in the Exam Notes section.

If you are using [web-based notes](#): in the navigator configuration record, with your cursor next to the NoteWriter Startup Option parameter, press F6. In the NoteWriter Startup SmartBlock field, enter:

- 0-None to prevent NoteWriter from opening automatically.
- 1-First SmartBlock to open the first SmartBlock in the note. This is the default behavior.
- 2-SmartBlock ID to open a specified SmartBlock automatically, if that SmartBlock is in the note. If the SmartBlock is not in the note, the first SmartBlock in the note opens automatically.
 - If you choose this option, you have to fill in the SmartBlock ID field. If you don't do this, then NoteWriter doesn't open automatically.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section:

- Enter ",StartupNWTAB=ENLARGED_VIEW_OF_NOTE" without the quotation marks to open the Note tab.
- Enter ",StartupNWTAB=LEFT_MOST_TAB" without the quotation marks to open the leftmost tab.
- Enter ",StartupNWTAB=HHSID_<ID#>" without the quotation marks, where <ID#> is the ID of the SmartBlock that you want to open. For example, enter ",StartupNWTAB=HHSID_147" to start on the Review of Systems tab.

Prompt Clinicians to Edit Incomplete Notes Instead of Creating New Ones

When a clinician tries to create a new note and he already has an incomplete note of that type, you can prompt him to edit his existing incomplete.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Check Incomplete Notes? parameter.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",CheckIncNotes=1" without the quotation marks.

Hide Deleted Notes by Default

You can choose to hide deleted notes by default. Clinicians can select a check box at the top of the section to show deleted notes.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Allow Hiding Deleted Notes? parameter to hide deleted notes.

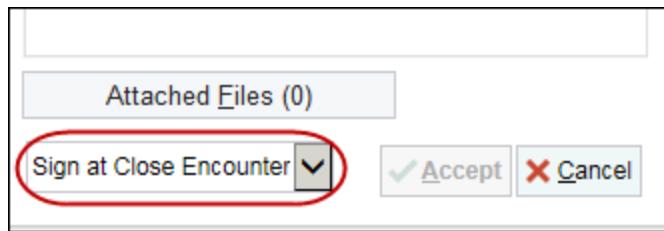
If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowDeleted=1" without the quotation marks to hide deleted notes.

Choose Whether a Note Actions Menu or Buttons Appear

You can configure a notes navigator section to use buttons or a note actions menu. When the navigator section uses a note actions menu, the note action selected in the menu is applied when the clinician closes the navigator section.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Use Drop-down? parameter to use the note actions menu. Enter No to use the buttons.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",UseDropDown=1" without the quotation marks to use the note actions menu. Enter ",UseDropdown=0" without the quotation marks to use the buttons.



A note actions menu

Change the Status That a Note Gets When Saved Automatically

If you have configured the notes navigator section to use a note actions menu instead of buttons, you can choose a default action to take on a note when it is saved automatically, such as when the system secures. This allows inpatient clinicians who need to navigate Hyperspace quickly, such as ED physicians, and outpatient clinicians who don't need to sign their notes until the end of the encounter to close the workspace or secure Hyperspace without having to choose an action to take on the note.

You can choose to mark the note to be signed when the encounter is closed, sign the note immediately, pend the note, or share the note with other clinicians. If the action you choose isn't allowed for a certain note, a message will appear asking the clinician to select an action. For example, if the default action is sign and the note has unresolved wildcards (**), a message appears.

Note that if a clinician has a default action specified for a note type on the Notes General Settings - 4 screen of his profile, that action is used for notes of that type, regardless of the note navigator settings.

If you are using [web-based notes](#): in the navigator configuration record, in the Default Action parameter, enter:

- 1-Pend to pend the note.

- 2-Sign when Signing Visit / Close Workspace to sign the note when the visit is signed or when the clinician exits the workspace. Only notes with a type of 36-Telephone Encounter or 70-Nursing Note are signed when the clinician exits the workspace. All other note types are signed when the clinician signs the visit.
- 3-Share to share the note. This does not share the note with the patient, but instead marks it as shared so other clinicians with the right security can act on your note. You must have the Share with Clinicians feature enabled in your Notes Feature Set for this option to take effect.
- 4-Sign to sign the note.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section:

- Enter ",DefaultAction=1" without the quotation marks to pend the note.
- Enter ",DefaultAction=2" without the quotation marks to sign the note at close encounter or when the clinician exits the workspace. Only notes with a type of 36-Telephone Encounter or 70-Nursing Note are signed when the clinician exits the workspace. All other note types are signed when the clinician signs the visit.
- Enter ",DefaultAction=3" without the quotation marks to share the note. This does not share the note with the patient, but instead marks it as shared so other clinicians with the right security can act on your note. You must have the Share with Clinicians feature enabled in your Notes Feature Set for this option to take effect.
- Enter ",DefaultAction=4" without the quotation marks to sign the note.

Add NoteWriter Templates to Existing Notes



This configuration option applies only to navigator sections that have the EditOnly parameter set to 0 or left blank and do not have a type of 3-Procedures.

Clinicians can add a NoteWriter template to an existing note by clicking a button. For example, a nurse might start a note as she rooms a patient, and that note doesn't contain any SmartBlocks. A clinician later clicks Edit in NoteWriter in his notes navigator section to add a template that contains a History of Present Illness (HPI) SmartBlock, which he can then document in NoteWriter. This can save the clinician time from having to manually insert a SmartText that contains the HPI SmartBlock.

When you configure the SmartBlock Insertion Location parameter (called NWActionNtsWOSB in November 2021 and earlier versions), notes navigator sections include an Edit in NoteWriter link or an Addend in NoteWriter link that adds a note template to either the beginning or the end of the note.

If you are using [web-based notes](#): in the navigator configuration record, in the SmartBlock Insertion Location parameter, enter:

- 0-Nowhere to prevent a template from being inserted automatically if a clinician clicks Edit in NoteWriter or Addend in NoteWriter. This is the default behavior.
- 1-At Beginning to insert the template at the beginning of the note.
- 2-At End to insert the template at the end of the note.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section:

- Enter ",NWActionNtsWOSB=AtFront" without the quotation marks if you want the template to be added to the beginning of the note.
- Enter ",NWActionNtsWOSB=AtEnd" without the quotation marks if you want the template to be added to

the end of the note.

Note that the templates are added only to notes that weren't originally created with NoteWriter. Also note that a default NoteWriter template (I LPR 46025) needs to be defined for the Edit in NoteWriter button to appear for a given note type, and the button can be used to add only that default template.

Change How Progress Notes Sections Open



This configuration option applies only to navigator sections that have the EditOnly parameter set to 0 or left blank.

When a clinician opens a notes section by clicking it in the navigator's table of contents or clicking the section header, the section attempts to open an existing or new note in the NoteWriter. If NoteWriter isn't enabled for that note, it opens the note in a non-NoteWriter editor. You can change how the navigator behaves when a clinician clicks the section header or progress notes link in the table of contents.

There are two related parameters you can use to determine this behavior.

If you are using [web-based notes](#): in the navigator configuration record, in the Section Edit Action parameter, enter:

- 0-Jump to section to go to the section but not open a note for editing. Instead the section opens in preview mode, showing any existing notes.
- 1-Create or edit in section to create or open an existing note in the section and not in NoteWriter. If the note type is NoteWriter only, then the note still opens in NoteWriter unless NoteWriter is disabled.
- 2-Create or edit in NoteWriter to create or open an existing note in NoteWriter, unless NoteWriter is disabled. If NoteWriter is not disabled, NoteWriter notes and existing notes containing NoteWriter templates open in NoteWriter by default.

In the Header on Click Action parameter, enter:

- 0-Create new to create a new note. This is the default behavior.
- 1-Edit Most Recent Existing to open the most recent note in that section for editing.

Note that if Section Edit Action is set to 0-Jump to section, this parameter has no effect. If Section Edit Action is set to any other value, this parameter behaves as expected.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, for the PreferSec Edit parameter:

- Enter ",PreferSecEdit=0" without the quotation marks to not open the section in editor mode. Instead, the section opens in preview mode, showing any existing notes.
- Enter ",PreferSecEdit=1" without the quotation marks to open or create a non-NoteWriter note whenever possible. A NoteWriter note still opens if the note type is configured to be NoteWriter-only.
- Enter ",PreferSecEdit=2" without the quotation marks or remove the parameter altogether to open an existing or new note in the NoteWriter, when possible.

For the OnClickAction parameter:

- Enter ",OnClickAction=0" without the quotation marks to create a new note.
- Enter ",OnClickAction=1" without the quotations marks to edit the most recent existing note.

Note that if ",PreferSecEdit=0" is already present in the HANDLER ProgID string, then this parameter has no

effect. If PreferSecEdit is set to any other value (or not set), then this parameter behaves as expected.

Prevent Users from Editing Signed Notes

By default, the ability to edit signed notes is determined by a user's security and feature set settings, but you can prevent all users from editing signed notes in specific notes navigator sections.

If you are using [web-based notes](#): in the navigator configuration record, enter No in the Edit Signed? parameter to prevent users from editing signed notes, regardless of their security.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",EditSigned=0" without the quotation marks to prevent users from editing signed notes, regardless of their security.

Remove the Link to the Notes Activity

By default, a link to the Notes activity appears in notes navigator sections, but you can disable it.

If you are using [web-based notes](#): in the navigator configuration record, in the Hide Go To Notes? parameter, enter Yes to hide the link.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",HideGotoNotes=1" without the quotation marks to hide the link.

Hide the Refresh Button

By default, a Refresh button appears in notes navigator sections, but you can disable it.

If you are using [web-based notes](#): in the navigator configuration record, in the Hide Refresh? parameter, enter Yes to hide the Refresh button.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",HideRefresh=1" without the quotation marks to hide the Refresh button.

Ignore the Maximum Number of Progress Notes Setting



This option applies only to progress note navigator sections.

You might have set the Maximum number of progress notes (I LPR 17003) item to limit the number of progress notes a user can create. You can set specific progress note navigators to ignore this setting, meaning that there is no limit to the number of progress notes that users can create in the section.

If you are using [web-based notes](#): in the navigator configuration record, in the Ignore Max Progress Notes Per User? parameter, enter Yes to let users create unlimited progress notes.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",IgnoreMaxPerUser=1" without the quotation marks to let users create unlimited progress notes.

Show Signed and Unsigned Notes in One List

By default, signed notes and unsigned notes appear in separate lists in notes navigator sections, but you can choose to show them together in one list.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Show Notes Merged? parameter to group signed and unsigned notes into one list.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowNotesMerged=1" without the quotation marks to group signed and unsigned notes into one list.

Show Reports Alongside Notes Without SmartBlocks

You can configure reports to appear in the main pane when a note without SmartBlocks is open in the sidebar. The reports to show are set in the Reports available in NoteWriter (I LPR 92000) item.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Show NoteWriter Report? parameter to show the report.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowNWReports=1" without the quotation marks to show the report.

Show Other Notes While Editing a Note



This option does not apply to edit-only navigator sections. A navigator section is edit-only if the View Path (I LVN 1021) contains Epic.Clinical.Common.Notes.Navigator.Web.Views.EditOnly.NotesNavigatorSectionEditOnlyBehavior.

By default, other notes are not shown when a note is open for editing in a navigator that is not edit-only, but you can configure the navigator section to show other notes below the note editor. Edit-only navigator sections always show other notes when a note is open for editing.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Show Other Notes When Editing? parameter to show other notes.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowPostEditContent=1" without the quotation marks to show other notes.

Prevent Users from Editing Transcription Notes

By default, the ability to edit transcription notes is determined by a user's security and feature set settings, but you can prevent all users from editing transcription notes in specific notes navigator sections.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Transcriptions Read Only? parameter to prevent all users from editing transcriptions, regardless of security.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",TransReadOnly=1" without the quotation marks to prevent all users from editing transcriptions, regardless of security.

Show the Note Attribution Widget

By default, the note attribution widget does not appear when viewing closed notes, but you can enable it.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Show Note Attribution? parameter to show the attribution widget.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShowNoteAttribution=1" without the quotation marks to show the attribution widget.

Automatically Collapse the Sidebar When NoteWriter Opens

By default, when you open a note in the sidebar and add a SmartBlock or NoteWriter template, the note stays open in the sidebar when NoteWriter opens. If a clinician wants NoteWriter to take up the full width of the navigator, you can set the sidebar to collapse when NoteWriter opens.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Hide Sidebar on Start? parameter to collapse the sidebar when NoteWriter opens.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",HideSidebarStart=1" without the quotation marks to collapse the sidebar when NoteWriter opens.

Limit Note Creation to One Per Encounter

If you want clinicians to create only one note of a certain type per encounter, set this parameter in the notes navigator section that has the specified note type. Note that Anesthesia pre-op notes are always restricted to one per encounter, and that ED Provider notes can be set to one note per user or one note per encounter in the profile. This parameter does not affect either of those settings.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the One Note Per Encounter? parameter to limit note creation.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ShareMode=0" without the quotation marks to limit note creation.

Show a Read-Only Report Instead of a Note in a Specific Situation

If there are certain situations where you want to show clinicians a read-only report in the notes navigator section instead of letting them act on a note, you can specify a report to show and use a generic rule to define the situations when the report appears. The report appears when the rule evaluates to False.

If you are using [web-based notes](#): in the navigator configuration record, navigate to the Single Report View parameter and press F6. In the Rule ID field, enter a generic rule. In the Report ID field, enter a report.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",ReportID=#", where # is the ID of a report, and "RuleID=#", where # is the ID of a generic rule. Do not include quotation marks in either parameter.

Hide Notes from Related Encounters



By default, if a user can see notes from related encounters, those notes appear in note navigator sections. You can configure navigator sections to show only notes from the current encounter. For more information about related encounters, refer to the [See Information from Related Encounters](#) topic. Note that if you choose to hide notes from related encounters in notes navigator sections, those notes still appear in other locations, such as the Inpatient Notes activity.

If you are using [web-based notes](#): in the navigator configuration record, enter Yes in the Disable Related Encounters? parameter to hide notes from related encounters.

If you are using non-web-based notes: in the Handler ProgID (I LVN 1020) field of the note navigator section, enter ",DisableRelEnc=1" without the quotation marks to hide notes from related encounters.

Disable the Notes Sidebar

The notes sidebar allows clinicians to continue to work on a note while they access other activities in Hyperspace. When a clinician clicks the pin button in a note navigator section, the note appears in a pane on the right side of the Hyperspace window. This allows clinicians to view relevant patient information and review results while composing the note.

The sidebar is enabled by default, but you can disable it in the profile record.

Considerations

The Notes sidebar works best with larger monitors, and is unavailable on monitors with a resolution less than 1280 pixels.

1. In Clinical Administration, access profile settings and go to the Notes General Settings - 2 screen.
2. In the Disable notes sidebar field, enter Yes to disable the notes sidebar.

Set a Default Action for New Notes at the Profile Level

You can set default actions for new notes written in the NoteWriter or in a note navigator section at the profile level. This feature is useful if your clinicians' note preferences differ by role or department. For example, you could make it so that new progress notes created by one group of clinicians have a default action of Sign when Signing Visit, but notes created by another group of clinicians have a default action of Sign.

You can set a default action for all notes and specific types of notes using fields in the profile record. When both a default action and a specific action are configured, the specific action overrides the default action.

Note that the system can't always use the default action you specify to save a note. For more information, refer to the [I'm not sure how the system automatically saves a note](#) topic.

Set a Default Action for All Notes

1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription.
2. Go to the Notes General Settings - 4 screen.
3. In the Default action for new notes field, enter the default action for new notes.

Set a Default Action for Specific Types of Notes

1. In Clinical Administration, open a profile and follow the path Note, Letter, Transcription.
2. Go to the Notes General Settings - 4 screen.
3. Enter a note type in the Note Type field.
4. Enter an action in the Default Action field.

Set Default Note Speed Buttons at the Profile Level

You can create default note speed buttons that clinicians can click to create a note that begins with a SmartText specified at the profile level. For example, you might want all nurses in a specific department to document nursing notes in the same format, so you could create a default nursing note speed button for those nurses. Clinicians can also use these speed buttons to add content to an existing note. By configuring note speed buttons in a profile, you ensure that a clinician has access to speed buttons without creating her own.

Note that these speed buttons are Ambulatory only and are available only in notes navigator sections and the

sidebar. They don't appear in the Notes activity. To configure default speed buttons in the Notes activity, refer to the [Set Default Speed Buttons in the Notes Activity](#) topic.

Prerequisites

To use note speed buttons, you must have the Notes Personalization license, which is included in the standard EpicCare Ambulatory license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

topic. To configure default speed buttons in a profile:

1. In Clinical Administration, open a profile.
2. Go to Note, Letter, Transcription.
3. In the Note Type (I LPR 46100) field on the Note Speed Buttons screen, enter the type of note from the Note Type (I INP 5010) category list that you want to be created when a clinician clicks the speed button. Clinicians can also use these speed buttons to add content to an existing note.
4. In the Caption (I LPR 46101) field, enter free text to specify the caption that appears on the button.
5. In the SmartText (I LPR 46102) field, enter the SmartText record that you want inserted in the note when a clinician clicks the speed button. For more information about creating SmartTexts, refer to the [Create and Edit a SmartText](#) topic.
6. Starting in August 2025, in the Service (I LPR 46103) field, you can optionally enter a service you want inserted in the note when a clinician clicks the speed button. Clinicians can only use allowed services. For more information about which services can be used refer to the [Determine Which Services a Clinician Can Select](#) topic in the [Notes Setup and Support Guide](#).
7. Repeat steps 3-6 for any additional speed buttons you want to create.



Starting in May 2025, you can use the Build Wizard in Hyperspace to update the default note template speed buttons in profiles. Find profiles by department specialty to efficiently identify a similar set of profiles to update.

To get started, open the Build Wizard (search: Build Wizard) and search for feature 41290-Set Default Note Speed Buttons in Profiles (application: EpicCare Ambulatory, EpicCare Inpatient).

In the Foundation System we've created several specialty-specific note speed buttons, which you can reference as a guide for your build. These templates make use of advanced note craft features that help clinicians write and review streamlined notes, helping to reduce note bloat.



To make it easy for you to get this content, we've created a Turbocharger package for the new note templates. This is available to download for organizations in the United States from the Available Packages tab of the Turbocharger activity in Hyperspace. If your organization is outside the United States or you don't have automatic package delivery set up, contact your Epic representative and mention project 332270 to get the package. For information about mapping and importing this package, refer to the [332270-Updated Specialty Note Templates](#) topic.

To check out one specialty's build in the Foundation System, log in to the [Foundation Hosted environment](#) as your

organization's rheumatology department physician (RHEUMMD). Open a patient's chart to the Notes sidebar. Review the available speed buttons. Try logging in as your organization's fertility department physician (REIMD) and open a patient's chart to the Notes sidebar. Notice that the available speed buttons differ. For more information on the specialty-specific speed button build in Foundation Systems refer to the [Specialty Note Templates](#) extra topic.

In the Foundation System, we've created several default HPI speed buttons for common chief complaints, which you can use as a guide for your build, and added them to many specialties' profiles.

To check out one specialty's build in the Foundation System, log in to the [Foundation Hosted environment](#) as your organization's emergency department physician (EDMD). Open a patient's chart to the NoteWriter. Create a new note and go to the HPI tab. Document note text using both the free-text Narrative section and the Forms section. Review the available speed buttons above the Narrative section. Try opening the chart of a patient who has a different chief complaint. Notice that the available speed buttons differ.

To configure default speed buttons in a profile and use the Foundation System build as a reference:

1. In Clinical Administration, go to Management Options > Profiles (LPR) and open a profile.
2. Go to Note, Letter, Transcription > HPI Speed Button Defaults.
3. In the Note Type (I LPR 46110) field, enter the note type with which you want to associate the speed button.
4. If you want the button to appear only when a patient has a certain chief complaint, enter that complaint in the Chief Complaint field. If you leave this field blank, the button always appears.
5. Enter a caption in the Caption (I LPR 46111) field to indicate the type of situation in which to use this speed button.
6. Enter a SmartText in the SmartText (I LPR 46112) field. For more information about creating SmartTexts, refer to the [Create and Edit a SmartText](#) topic in the [SmartTools Setup and Support Guide](#).

If you want to reference default speed button build in the Foundation System as you complete build in your system, log in to the [Foundation Hosted environment](#) as your organization's emergency department administrator (EDADM), go to Clinical Administration, and open profile 210002-FAM EMC Dept.

1. Use steps 1-6 above for this profile and any other profile you're interested in reviewing.
2. Go to the SmartText Editor (search: SmartText).
3. Open SmartText 1601062927-ED HPI Chest Pain Narrative, as an example.
4. On the Restrictions tab, notice that we added a functional type of IP NoteWriter. Any SmartText you want to use as a speed button requires this functional type.

Change Notes Activity Filter Options for Multiple Users

You can use the Update Notes Filter Settings utility to change whether deleted notes and notes written by clinicians with a specific author type appear in the Notes activity for multiple users. This allows you to quickly change filter options for multiple users instead of asking individual users to change their own filter options.

For example, when you create a new author type, users who filter the Notes activity by author type don't see notes written by authors of that type until you add it to the filter. You can use the new Update Notes Filter Settings utility to add the author type to the Notes activity filter for all users who should see notes written by an author of that type. You can also use the utility to change whether deleted notes appear.

Create a Subset

If you want to change a filter setting for only a subset of users, you must first create a subset. You can skip these steps if you have already saved a subset of users whose filter options should be changed.

1. In Chronicles, open the user (EMP) master file.
2. Choose a search option.
3. Enter All at the Users prompt.
4. If applicable, enter a contact number, date, or range of dates to search only specific contacts or enter All to search all contacts.
5. Choose whether to sort the results in numeric or alphabetical order.
6. Choose whether to include hidden records in your search results.
7. Enter one or more conditions.
8. Choose whether each condition should be true or false.
9. If applicable, choose whether all or a single contact is included in the search results for each user.
10. Choose a print format and print to screen.
11. Save the search results as a subset.

Change Whether Deleted Notes Appear for Users

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Update Notes Filter Settings.
2. Enter All or the name of your subset at the Users prompt.
3. Enter No to see a list of filter options that you can change:
4. Select Set Show deleted notes.
5. Choose either Show deleted notes or Hide deleted notes, as desired.
6. Select Complete changes to apply the changes to the users that you selected in step 2.

Change Whether Notes from Certain Author Types Appear for Users

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Update Notes Filter Settings.
2. Enter All or the name of your subset at the Users prompt.
3. If you want notes from all author types to appear in the Notes activity, enter Yes when prompted. Otherwise, enter No to see a list of filter options that you can change:
 - If you want notes written by authors with a certain author type to appear in the Notes activity, select Add a provider type to the users' filters. Note that if you apply this option to a user who doesn't filter notes in the Notes activity, there will be no change.
 - If you don't want notes written by authors with a certain author type to appear in the Notes activity, select Remove a provider type from the users' filters. Note that if you apply this option to a user who doesn't filter notes in the Notes activity, a filter that includes all author types except the one you specify will be automatically applied to their Notes activity.
 - To cancel changes that you made for a single author type, select Cancel changes regarding a certain provider type.
4. Select Complete changes to apply the changes to the users that you selected in step 2.

Allow Clinicians to Quickly Create a Note

The Fast Note activity allows clinicians to quickly create a new note. While the Notes activity allows clinicians to use many notes features in a convenient place, it might take several seconds to load, depending on how many notes a patient has. The Fast Notes activity is a simple note editor that clinicians can use to quickly create a single note without having to wait for the Notes activity to load.

The Fast Note activity opens either a new progress note or a pended note that the clinician previously created in the Fast Note activity. If a clinician wants to write a different type of note, they can change the note type using the Type field at the top of the window. After the clinician signs the note, they must addend it from the Notes activity or a note navigator section if they want to make changes.

To make the Fast Note activity available to clinicians, give them either EpicCare Inpatient security point 146-Fast Note or EpicCare security point 335-Fast Note.

You must also create or edit a Workflow Engine rule and do one of the following:

- Add a menu record that includes item 34555IP_IT_FastNote to the rule:
 - Add the menu item to the menu record. Refer to the [Group Activities Into Menus](#) topic for more information. Note that Epic-released menu 34900-IP_MT_Admission_Workspace includes the IP_IT_FastNote menu item.
 - Add the menu to the rule. Refer to the [Set Up Activity Tabs, the More Activities Menu, and Sidebar Activities](#) topic for more information.
- Add menu item 34555-IP_IT_FastNote to the rule. Follow the instructions in the [Set Up Activity Tabs, the More Activities Menu, and Sidebar Activities](#) topic and enter the Fast Note menu item in step 4.

Allow Clinicians to Write Note Summaries

Clinical notes can be dense, and the longer they get, the longer they can take to review. To help clinicians spotlight the big picture of each note, you can add a Summary field to clinical notes. We recommend enabling this field if your clinicians struggle with finding relevant information due to note bloat. If your organization has no need for note summaries, we recommend not creating work for clinicians who might find summaries redundant.

In the Summary field, clinicians can write a plain-text distillation of each note they write. Then, when searching for and reviewing notes, they can quickly determine which they need to read in greater detail. Summaries can also streamline communication between clinicians. When a primary care physician sees a patient who needs treatment from a specialist, for example, the PCP can write a blurb for the specialist in her note's summary.

Your clinicians can write summaries for most notes they write. They cannot write summaries for read-only notes or notes like S&O and A&P notes, which get incorporated into larger notes. Other examples of note types that do not support summaries include:

- 37-Patient Instructions
- Any note types specified in the Allowed Note Types for Discharge Instructions (I LSD 34047) and Allowed Note Types for Shared One-Per-Encounter Notes (I LSD 34076) fields

After your organization enables note summaries for all allowed note types, you can make summaries optional, recommended, or required for all notes or for specific note types. For example, if your clinicians tend to write long progress notes and brief consult notes, your organization can require summaries for progress notes but not for consult notes.

My Note

Type: Initial Assessme Service: Medicine

Date of Service: 9/27/2019 11:48 AM

Cosign Required

Summary:

<img

Considerations

- To use the Summary field, you must have the Clinical Note Summaries license, which is included in the standard EpicCare Inpatient license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.
- If you enable summaries for your organization and any of your clinicians use a third-party dictation tool to dictate their notes, you might need to update their configuration of the dictation tool to account for the Summary field's presence in the note editor. If you don't, clinicians might accidentally add their dictations to the Summary field instead of the note editor text box.

To make the Summary field available to your clinicians:

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Note, Trans, Communication.
2. Go to Notes General Options - 2.
3. Set Enable note summary (I LSD 34698) to Yes.

Set Note Summary Requirements

If you haven't already done so, determine which note types should require summaries at your organization. You can apply a default requirement to all notes and override it for specific note types. For example, you might recommend summaries by default, but require them for procedure notes.

To configure summary requirement settings:

1. In Clinical Administration, open a profile and go to Note, Letter, Transcription.
2. Go to Note Summary Settings.
3. Set the Default note summary requirement (S LPR 34753) field, which applies to all notes. Under Note Type and Note Summary Requirement, set the summary requirements needed for specific note types.

Configure the Summary Column in Chart Review

The Encounters and Notes tabs of Chart Review can contain many notes for a given patient. Because summaries can make review easier for clinicians, it helps to identify which notes include summaries. This section contains information on the Summary column, which you can add to the Encounters and Notes tabs to help clinicians find and preview note summaries.

Add a Summary Column to the Encounters Tab

In the Chart Review Encounters tab, you can add a Summary column that contains previews of each encounter's most relevant note summary. This is especially useful in contexts where a given encounter might contain several notes of various types. In these contexts, you can use note type and note time to configure which summaries represent the overall encounter.

For example, inpatient providers at your organization might prefer to see summaries only for the most recent progress note. In this case, the Summary column shows an icon or summary text to indicate when an inpatient encounter contains a progress note with a summary. Clinicians can hover over the indicator to quickly view the summary.

Chart Review

The screenshot shows the 'Chart Review' application with the 'Encounters' tab selected. At the top, there are tabs for Encounters, Labs, Imaging, Procedures, ECG, Other Orders, and Medications. Below the tabs are buttons for Preview, Refresh (8:42 AM), Select All, Deselect All, Review Selected, and Synop. There is also a section for Filters with a checked 'Default filter' option and filters for Me, Cardiology, Department, and Admissions. The main area displays a table with columns: Summary, When, Type, and With. The 'Summary' column contains icons representing different types of notes. The first three rows are highlighted with a red box around the 'Summary' column header and the first three rows.

Summary	When	Type	With
	06/19/2019	Office Visit	Me
	06/17/2019	Admission (Discharged)	Me
	06/05/2019	Admission (Discharged)	Me
	06/05/2019	Registration	

Before you begin, determine whether you want to the summary indicator to appear as text or as an icon.

To add summary previews to the Encounters tab:

1. In Chronicles, make a copy of extension 13363-ENC/Clinical Summary.
2. In your copied extension, go to the Parameters screen and complete the following parameters:
 - OP Notes to Search, IP Notes to Search, and ED Notes to Search. Configure these parameters to determine how the summary link functions for encounters in each of these contexts. Any unmentioned contexts follow the rules set in OP Notes to Search.
 - Allowed Note Types. Specify the eligible note types for each context's Summary column. For example, if you enter 1-Progress Notes while in IP Notes to Search, the summary indicator appears only when an inpatient encounter has a progress note containing a summary. If you leave this parameter blank, the Summary column indicates when a note of any type contains a summary. In this case, it previews the summary from the most recent note.
 - Most Recent Note Only? Enter Yes to search only the most recent note written for the encounter. Continuing the example above, if the most recent note is an H&P note or a progress note with no summary, no summary indicator appears in the Summary column.
 - Use File Time? Enter Yes to determine the most recent note based on each note's file time instead of the date of service.
 - Lookback Days. Specify how far back to search for summaries. If you enter 14 here, for example, and an encounter contains no relevant note summaries written within the last 14 days, then the Summary column for that encounter is empty.
3. In Chronicles, open your Chart Review Tab - Encounters template (LQT) and go to the Chart Review Column Information page.
 - Under Column Name, insert a new row and enter your organization's preferred name for the Summary column. You can also leave this field blank if you want to save space.
 - Under Extension, add your copy of extension 13363.
 - Under Type, indicate whether you want the summaries link to appear as an icon or as a string.

Add a Summary Column to the Notes Tab

In the Notes tab of Chart Review, you can add a Summary column that shows when a note contains a summary. If

a note contains a summary, an icon or a preview of the summary's text appears in the column. Clinicians can hover over the icon or text to quickly view the entire summary.

Before you add the Summary column to your Notes tab, decide whether you want summaries to appear as text or as icons. We recommend showing the summary as an icon because this reduces visual clutter and allows showing the note summary as well as the note preview. If you configure the summary to appear as text, it shows only content written in the [Summary field](#).

To add summary previews to the Notes tab:

1. In Chronicles, open your Chart Review Tab – Notes template (LQT) and go to the Chart Review Column Information screen.
2. Under Column Name, insert a new row and enter your organization's preferred name for the Summary column. You can also leave this field blank if you want to save space.
3. To show the summaries link as text:
 - In the Item field, enter 49.
 - In the Type field, enter String.
4. To show the summaries link as an icon:
 - In the extension field, enter extension 13359-Note/Clinical Summary Icon.
 - In the Type field, enter Icon.

Hide the Preview and Show Only Discrete Note Summaries

The Summary column shows a preview of the note text, in addition to the discrete note summary. The Summary column shows an icon for all notes with text, even if the note does not contain a discrete note summary.

If you want to hide the preview of the note text and show only the discrete note summaries:

1. In Chronicles, make a copy of extension 13359-Note/Clinical Summary Icon.
2. In your copied extension, go to the Parameters screen and set the Disable Generated Note Summary? parameter to Yes.
3. In Chronicles, open your Chart Review Tab – Notes template (LQT) and go to the Chart Review Column Information screen.
4. In your Summary column, change the extension to your copy of extension 13359.

Collapse Certain Information in Notes by Default

You can make it easier for clinicians to find what they're looking for in notes by collapsing certain information by default when clinicians review the note. There are two aspects of a note that you can configure to be collapsible:

- SmartLinks, such as a table listing the patient's allergies
- Sections in a note, such as the Subjective and Objective sections of a SOAP note

You can configure SmartLinks, sections, or both to be collapsed by default, depending on the needs of clinicians at your organization, and clinicians can save their own preferences. Clinicians can update their settings to choose whether they want all SmartLinks and sections or particular SmartLinks and sections to be expanded or collapsed by default. The ability to save preferences for SmartLinks is limited to web report viewers such as Chart Review and the IP_NOTES activity. If a user has saved preferences for SmartLinks, that setting is respected in both web and non-web activities. The options they choose are saved for them regardless of where they view a SmartLink or a section in Hyperspace.

- For example, a clinician can select the Expand All by Default checkbox to see all SmartLinks and sections expanded by default.
- A clinician can also choose whether an individual SmartLink or section is expanded or collapsed by default. For example, she could select the Collapse by Default checkbox next to a vitals SmartLink. Every time this SmartLink appears in a note, it's collapsed by default for this clinician.

For clinicians to use the user settings, you must have the Notes Personalization license, which is included in the standard ASAP, EpicCare Ambulatory, EpicCare Inpatient, and OpTime licenses. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.

Collapse SmartLinks in a Note by Default

You can collapse certain SmartLinks in a note to make it easier for clinicians to find the information they're looking for. For example, you might configure SmartLinks that show a patient's vitals to be collapsed because this information can be seen in other areas of the patient's chart. When reviewing a note, clinicians see summaries of collapsed SmartLinks. They can click a SmartLink summary to expand or collapse it. They can also click Expand All or Collapse All.



To identify notes that might benefit from using collapsible SmartLinks, you can create a Reporting Workbench report that shows the SmartText used by a note, the length of the note, and whether the note contains collapsible content. To find these notes, create a report column (search: Column Editor) by copying column 34198-Note ID. Change the Item field to 34906, which is the item containing the note's SmartText. Then, create a report from the [IP Notes Report Template](#). Make sure to include columns 33106-Note Contains Collapsible Content and 33105-Note Size (Total Character Count) along with the column you created.

For more information about creating and configuring Reporting Workbench reports, refer to the [Create a Report from a Report Template](#) topic.

The SmartLinks listed below are collapsed by default. You can make other SmartLinks collapsible by completing the steps below. SmartLinks must be refreshable to be collapsible.

- 1-ACTMed
- 8-Allergies - Table Format (starting in November 2023)
- 18-Medications - Current, Table
- 19-Medications - Current, Listed Continuously (starting in November 2023)
- 21-COPMeds
- 38-History - Family
- 77-Medication - Previous to This Encounter (starting in November 2023)
- 88-History - Past Medical History
- 90-Problem List (starting in November 2023)
- 93-History - Past Surgical History
- 94-Medications - Prior to Admission
- 102-SOC

- 104-Short Social Hx on File (starting in November 2023)
 - 105-SOCHx
 - 111-History - Tobacco Use (starting in November 2023)
 - 129-History - Past Medical History Pertinent Negatives (starting in November 2023)
 - 131-History - Past Surgical History Pertinent Negatives (starting in November 2023)
 - 132-Medications - Encounter
 - 136-Medications - Long-Term (starting in November 2023)
 - 137-Medications - Start of Encounter
 - 159-Medications - Current, Epic-Ordered, Table
 - 190-Vitals - Display Multiple Vitals
 - 34127-ResultRCNT - IP Recent Results
1. In Hyperspace, follow the path Epic button > Tools > SmartTool Editors > SmartLink.
 2. Open the SmartLink that you want to make collapsible.
 3. Click Save As, give your copy a new name, and click Accept.
 4. On the SmartLink tab, enter Collapsed by Default in the Collapsible field.
 5. If desired, enter text in the Collapsible summary field to customize the summary text that appears when the SmartLink is collapsed. If you leave this field blank, the first line of the SmartLink is used as the summary.
 6. Select the Active check box and then click Accept. When you add your SmartLink to a SmartText, the SmartLink doesn't appear collapsed in the SmartText Editor. View the note text as a clinician to verify that the SmartLink is collapsed.

Collapse Sections in a Note by Default

You can collapse certain sections of a note to make it easier for clinicians to find relevant information. For example, clinicians reviewing their notes often want to read the author's assessment and plan first. You can collapse the subjective and objective sections of a note so that clinicians don't have to scroll past them to find the Assessment and Plan sections. When reviewing their note, clinicians see the headings of collapsed sections. They can click a section heading to expand or collapse the section. They can also click Expand All or Collapse All.

Starting in November 2023, by default, all the sections in notes are collapsible and the Objective section is collapsed. These defaults can be changed at the system level and overridden for specific note types and context.

To change which sections are collapsed by default:

1. Make sure your note templates include sectioning SmartLinks. Refer to the [Add Sectioning SmartLinks to a Note](#) topic for more information.
2. Create a note display template that specifies which sections of a note are collapsible and whether they are collapsed by default. Refer to the [Create a Note Display Template to Define Section Collapsibility Settings](#) topic for more information.
3. Associate the note display template with a note type in EMR System Definitions. Starting in November 2023, you can also make the note display template a system-level default. Refer to the [Associate a Note Display Template with a Note Type](#) topic and [Change the Default Note Display Template at the System Level](#) topics for more information.

Add Sectioning SmartLinks to a Note

You can use the Epic-released SmartLinks listed below to indicate the Subjective, Objective, Assessment, and Plan sections of a note. If you want to use custom section SmartLinks, refer to the following section for information on how to create your own sectioning SmartLink.



In August 2023 and earlier, the following Epic-released SmartLinks are not collapsible by default. Follow the steps in the Create a Note Display Template section and the Associate a Note Display Template with a Note Type section to make them collapsible.

- 700-Prog Note Section Subjective - Begin. This SmartLink indicates the beginning of the Subjective section. Mnemonics: SUBJECTIVEBEGIN and SUBJECTIVE.
- 710-Prog Note Section Objective - Begin. This SmartLink indicates the beginning of the Objective section. Mnemonics: OBJECTIVEBEGIN and OBJECTIVE.
- 720-Prog Note Section Assessment - Begin. This SmartLink indicates the beginning of the Assessment section. Mnemonics: ASSESSMENTBEGIN and ASSESSMENT.
- 730-Prog Note Section Plan - Begin. This SmartLink indicates the beginning of the Plan section. Mnemonics: PLANBEGIN and PLAN.

Create a Custom Section SmartLink Title

If you want to create a section SmartLink with a custom title (for example, because you want to combine two sections into one), complete the following steps:

1. In Hyperspace, follow the path Epic button > Admin > General Admin > Category List Maintenance.
2. Enter ECT in the Database field and 34550 in the Item field.
3. Add a new category value with the title of your new section.
4. Save your changes.
5. In Hyperspace, follow the path Epic button > Tools > SmartTool Editors > SmartLink.
6. Open the SmartLink that you want to copy.
7. Click Save As, give your copy a new name, and click Accept.
8. On the General tab, enter a mnemonic.
9. Make sure that only unique synonyms are listed in the Synonyms table.
10. On the SmartLink tab, click the Default link.
11. Change the value in the SmartLink's Section Title parameter to the category you created.
12. Click Accept.



Do not set the Collapsible field on the SmartLink tab. That field is intended for SmartLinks that show information from the patient chart, such as vitals or surgical history.

Add Section SmartLinks to a Note Template

If your note templates don't already include section SmartLinks, you can add them to existing or new note templates.

You need Shared security point 11-Edit SmartText and 12-Release SmartText to create note templates.

1. In Hyperspace, follow the path Epic button > Tools > SmartTool Editors > SmartText.
2. Open an existing note template or create a new one.
3. On the General tab, add section SmartLinks by entering their mnemonics surrounded by at (@) signs. For example, enter @SUBJECTIVE@ to add the Epic-released collapsible Subjective section to the note.
4. When the template is complete, select the Released check box and click Accept.

Change the Default Note Display Template at the System Level

Starting November 2023

You can change a system-level default template that applies to all note types and contexts that don't have their own template record set. By default, if you use Epic's recommended template 20-Default Note Display Template, all section SmartLinks are collapsible, with Subjective, Assessment and Plan expanded by default and Objective collapsed by default. If you want to update the system default, do the following:

1. In Clinical Administration, open EMR System Definitions (Management Options > Edit System Definitions (LSD)) and Note, Trans, Communication.
2. On the Note Display Template Options screen, in the System Default Template (I LSD 35057) field, enter your preferred Note Display Template record.

To override the default template for specific note types or contexts, refer to the [Associate a Note Display Template with a Note Type](#) topic.

Create a Note Display Template to Define Section Collapsibility Settings

A note display template controls which section SmartLinks are collapsible and whether they are collapsed by default.

1. Access the Notes Activity Configuration master file:
 - In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations.
 - In OpTime Text, follow the path Perioperative Charting > Clinical Administration > Notes, Text Templates > Notes Activity Configurations.
2. Create a new configuration record.
3. In the Record Type (I HFN 100) field, enter Note Display Template.
4. On the Note Display Template - Collapsible screen, configure the following fields as necessary:
 - Default collapsible behavior (I HFN 301): enter either Collapsible and Collapsed or Collapsible and Expanded to make all sections collapsible unless their settings are overridden in the table below. Leave the field blank or set it to Not Collapsible to make all sections not collapsible unless their settings are overridden in the table below.
 - Note Sections (I HFN 310) and Collapsible (I HFN 311): Enter specific sections and collapsing behaviors to override the behavior listed in the Default collapsible behavior field. For example, if you entered Collapsible and Collapsed as the default behavior, you can give the Assessment and Plan sections a behavior of Collapsible and Expanded or Not Collapsible to make sure that clinicians see the content of those sections.
5. When you have finished editing your template, enter Yes in the Released (I HFN 300) field. Note display templates must be released before they can be associated with a note type.

Associate a Note Display Template with a Note Type

You associate note display templates with note types in EMR System Definitions. You can assign a different note display template for each patient context. For example, you can assign a template for an inpatient patient context and a different template for an outpatient patient context.

1. In EMR System Definitions, go to Note, Trans, Communication > Note Display Template Options screen.
2. Enter a type from the Note Type (INP 5010) category list in the Note Type field to associate it with a display template.
3. Enter a patient context and note display template in the Context and Display Template fields.
4. If applicable, in the Default Template field, enter a default note display template to use in contexts that don't have a note template specified below.

Reduce Note Bloat by Formatting Certain SmartLinks as Hover Bubbles

⌚ Starting in November 2024 for All Organizations

⌚ Starting in November 2023 for Early Adoption

To help clinicians reduce note bloat, you can use SmartLinks that allows clinicians to include information-dense SmartLinks such as patient medications, problems, allergies, or history in their note without pulling in the entire SmartLink content. Instead, a summary appears, and clinicians can hover over that summary to view the full SmartLink content in a hover bubble. The hover bubble appears throughout Hyperspace when they hover over any part of the summary sentence, including the icon. This helps clinicians complete review more quickly because they don't need to read through the details and might also improve note length reporting metrics.

How They Work

Hover bubble SmartLinks help limit the amount of content that initially appears when a note is written or reviewed. These SmartLinks are typically used for review within clinical notes and not to document medical decision making. The same content that would appear if the SmartLink were fully expanded appears when a clinician views the hover bubble for the SmartLink. Some other locations, including letters, EpicCare Link, and MyChart messages, show the content with the existing SmartLink formatting instead.

Appearance in Clinical Notes

When writing notes, the SmartLink content appears in the hover bubbles. Note that if clinicians writing notes want to pull the expanded SmartLink into the note, there is a right-click option to format these to the expanded view.

The screenshot shows the Epic EMR interface with the 'Notes' tab selected. A 'Current Medications' section is displayed, showing a list of medications with their respective details. A hovering bubble over one of the medication entries provides expanded information about the dosage and timing of the medication. The interface includes various icons for navigation and note creation.

Appearance in Chart Review and Happy Together Notes

When clinicians review notes from most locations within Hyperspace, including in Chart Review and Happy Together Notes, the hover bubble SmartLink content appears within hover bubbles.

The screenshot shows a medical chart interface. At the top, it displays the provider information: "Family Medicine, Physician, MD" with a "Physician" role, and the encounter date: "3/21/2024". To the right, there are links for "Progress Notes" (with a warning icon) and "Sign when Signing Visit". Below this, a section titled "Sign when Signing Visit" shows the patient's name: "Delilah Bard Rowan" and birthdate: "7/23/1970". A blue arrow points from the "Problem List" link in the "Background" section down to a expanded "Patient Active Problem List" box. This box contains the heading "Patient Active Problem List" and the timestamp "as of 4/15/2024 8:47 AM". It lists one diagnosis: "Iron deficiency anemia secondary to blood loss (chronic)", which is linked to its SNOMED CT(R) code: "Iron deficiency anemia due to blood loss".

Family Medicine, Physician, MD Physician
Encounter Date: 3/21/2024

Progress Notes Sign when Signing Visit

Sign when Signing Visit
Delilah Bard Rowan
7/23/1970

Admitting Provider: Physician Family Medicine
Primary Care Physician: Rowan, Lila, MD

Background
Current Medications [\[link\]](#), Past Medical History [\[link\]](#), Past Surgical History [\[link\]](#), Family History [\[link\]](#), Social History [\[link\]](#), Problem List [\[link\]](#), Allergies [\[link\]](#)

Patient Active Problem List
as of 4/15/2024 8:47 AM

Diagnosis	SNOMED CT(R)
• Iron deficiency anemia secondary to blood loss (chronic)	Iron deficiency anemia due to blood loss

Appearance in MyChart and AVS Reports

If these notes are viewed in MyChart or included in the AVS, the text of the SmartLink is expanded within the note.

Progress Notes

Lila Rowan, MD (Physician) • Family Practice

The patient's Allergies have been reviewed and confirmed

Allergies

Allergen

- Ferrous Sulfate
- Iodine
- Salicylic Acid

Reactions

Patient's Current Medications and this visit's Problem List as of 4/10/2025

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• Dimethicone 1.2 % GEL	apply externally.		
• Toremifene Citrate 60 MG TABS	Take 1 tablet by mouth every morning.		

No current facility-administered medications for this visit.

Patient Active Problem List

Diagnosis	SNOMED CT(R)
• Acute prostatitis	Acute prostatitis
• Actinic keratosis	Actinic keratosis

Medical History: Past Surgical History Past Medical History Family History

No past surgical history on file.

Past Medical History:

Diagnosis	Date
• Fracture, tibia	

Appearance in Classic Client, Mobile, Care Everywhere, and Interfaces

If the note is viewed by a clinician from other locations that don't support hover bubble SmartLinks, the SmartLinks appear with the summary sentence. For example, this format is used when notes are printed, viewed in the Classic client, viewed in Haiku, Canto, or Rover, or sent over Care Everywhere or an interface. Additionally, copying a previous note that contains hover bubbles to a location that does not support hover bubble SmartLinks —like letters—pulls in any hover bubble SmartLinks as non-refreshable content inline with the corresponding SmartLink.

mychart notes by Dr. Lila Rowan, MD at 4/10/2025 8:41 AM

The patient's Allergies have been reviewed and confirmed

Allergies

Allergen

Reactions

- Ferrous Sulfate
- Iodine
- Salicylic Acid

Patient's Current Medications and this visit's Problem List as of 4/10/2025

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• Dimethicone 1.2 % GEL	apply externally.		
• Toremifene Citrate 60 MG TABS	Take 1 tablet by mouth every morning.		

No current facility-administered medications for this visit.

Patient Active Problem List

Diagnosis	SNOMED CT(R)
• Acute prostatitis	Acute prostatitis
• Actinic keratosis	Actinic keratosis

Medical History: Past Surgical History Past Medical History Family History

No past surgical history on file.

Past Medical History:

Diagnosis	Date
• Fracture, tibia	
• Goiter (1)	
• Tonsillopharyngitis	

The patient's [Allergies] have been reviewed and confirmed

[Allergies]

Allergen Reactions

- Ferrous Sulfate
- Iodine
- Salicylic Acid

Patient's [Current Medications] and this visit's [Problem List] as of 4/10/2025

[Current Medications]

Current Outpatient Medications

Medication Sig Dispense Refill

- Dimethicone 1.2 % GEL apply externally.
- Toremifene Citrate 60 MG TABS Take 1 tablet by mouth every morning.

No current facility-administered medications for this visit.

[Problem List]

Patient Active Problem List

Diagnosis SNOMED CT(R)

- Acute prostatitis Acute prostatitis
- Actinic keratosis Actinic keratosis

Medical History: [Past Surgical History] [Past Medical History] [Family History]

Plain text hover bubble SmartLink content.

Adjust How Hover Bubble SmartLinks Appear

To have hover bubble SmartLinks appear inline as described in the [How They Work](#) topic you need to have the HBSL Interconnect queue and listeners. If you are using the Outgoing-Only Server Chronicles configured Interconnect instance as described in the [Create Chronicles Configured Instances](#) topic, you already have the HBSL queue and listeners setup and hover bubble SmartLinks will automatically appear inline.

If your organization is not using this instance you will need to manually create a new queue as described in the [Create an Interconnect Queue](#) topic to create the queue using the following settings:

- Mode: Synchronous
- Queue Type: HBSL

After creating the queue follow the steps in [Configure the Interconnect Instance to Receive Outgoing Requests](#) to configure the listeners on an existing Interconnect instance for the HBSL queue to see the inline formatting of hover bubble Smartlinks.

If you would prefer the content of hover bubble SmartLinks to appear at the bottom of printouts and reports, complete this setup:

1. In Clinical Administration, follow the path Management Options > Complete Configuration (HDF).
2. At the Configuration prompt, enter 1-Compiled Configuration.
3. Set the Inline hover bubble SmartLinks in printed documents (I HDF 20384) field to No.

Available Hover Bubble SmartLinks

The following SmartLinks are enabled as hover bubble SmartLinks. As part of your upgrade, any duplicates of these SmartLinks are also automatically converted to be hover bubble SmartLinks, but only if the duplicate SmartLink is enabled as collapsible (I HHS 320). To ensure that these SmartLinks display with an appropriate summary text within the note, the collapsible summary (I HHS 330) field must be set.

Medications

The following SmartLinks are automatically enabled as hover bubble SmartLinks:

- 1-TakMed – Medications Taking (mnemonic: .TakMed).
- 18-Medications - Current, Table (mnemonic: .CMed).
- 19-Medications - Current, Listed Continuously (mnemonic: .CMeds)
- 77-Medications - Previous to This Encounter (mnemonic: .Med)
- 94-Medications - Prior to Admission (mnemonic: .PTAMeds)
- 132-Medications - Encounter (mnemonic: .EncMed)
- 136-Medications - Long-Term (mnemonic: .LTMed)
- 137-Medications - Start of Encounter (mnemonic: .EncMedStart)
- 159-Medications - Current, Epic-Ordered, Table (mnemonic: .EpicMed)

The following SmartLinks are based on the same code but are not enabled as hover bubble SmartLinks automatically because of the workflows that they are typically used in.

- 915-Rounding Report Scheduled Meds (mnemonic: .RRSchMed)
- 916-Rounding Report PRN Meds (mnemonic: .RRPRNMeds)
- 917-Rounding Report IV Meds (mnemonic: .RRIVMedds)

Allergies

The following SmartLink is automatically enabled as a hover bubble SmartLink:

- 8-Allergies - Table Format (mnemonic: .Allergy)

Problem List

The following SmartLink is automatically enabled as a hover bubble SmartLink:

- 90-Problem List (mnemonic: .Prob)

History

The following SmartLinks are automatically enabled as hover bubble SmartLinks:

- 38-History - Family (mnemonic: .FamHx)
- 88- History - Past Medical History (mnemonic: .PMH)
- 93-History - Past Surgical History (mnemonic: .PSH)
- 104-SOCH - Social History (mnemonic: .SocH).

- 105-SOCHX - Social History (mnemonic: .SocHx).
- 111-History - Tobacco Use (mnemonic: .TobHx)
- 129-PNMH - Past Medical History Pertinent Negatives (mnemonic: .PNMH)
- 131-PNSH - Past Surgical History Pertinent Negatives (mnemonic: .PNSH).

Phenotypes

The following SmartLinks are automatically enabled as hover bubble SmartLinks:

- 65010-GNO Patient Phenotype Table Detailed (mnemonic: .PhenoTabDetail)
- 65011-GNO Patient Phenotype Table with Comments (mnemonic: .PhenoTabDetailComment)

Considerations for Benchmark Metrics

For notes that use hover bubble SmartLinks, there could be changes in metrics that use the length of note text to calculate a value using the Note Attr - Character Count (I HNO 34903) item. This item does not include text that appears in the hover bubble. For example, if the metric is counting what percentage of the note is copied content, the metric might now show that a smaller percentage of the note was copied.

The following metrics are affected by this change:

- [34088-Exec Notes Percent Voice Recognition Content](#)
- [34011-Notes Percent Copied Content](#)
- [34012-Notes Percent Author Content](#)

Enable Hover Bubble SmartLinks

Starting in May 2025, you can enable hover bubble SmartLinks by setting Enable hover bubble SmartLinks (I HDF 20383) to Yes. If you want to enable this feature in your system in February 2025 or an earlier version, contact your Epic representative and mention SLG 8083184.

You must complete this step before any other build or validation can be completed. After the feature is enabled, the released SmartLinks listed above are available to users automatically, but you can complete the following build in this topic to modify hover bubble SmartLinks that don't meet the needs of your organization.

Update Custom SmartLinks

If you use custom copies of any of the [Available Hover Bubble SmartLinks](#), and they do not show hover bubbles, complete the following steps.

1. Open the SmartLink Editor and open your custom SmartLinks.
2. On the SmartLink tab, set the Refreshable? field to Yes and set the Collapsible field to Collapsed by Default.
3. Enter a summary in the Collapsible summary field. This summary displays in the body of the note. For example, for a problem list SmartLink, you likely want to enter Problem List. This field must be set to ensure that an appropriate summary appears within the body of the notes for that SmartLink.
 - If no Collapsible summary is specified, you may encounter the following error message when the SmartLink is pulled into the note: {<SmartLink mnemonic>} cannot be used as a Hover Bubble SmartLink. Please report this to your administrator.} If you identify such an error, you can resolve it by entering a Collapsible summary.
4. Enable the SmartLink as a hover bubble SmartLink in the SmartLink editor in August 2024 or later or by using the Build Wizard.



To get started, open the Build Wizard (search: Build Wizard) and search for feature 170063-Hover Bubble SmartLink Configuration (application: EpicCare Ambulatory). If you need to disable a SmartLink or, starting in November 2025, override a SmartLink, you can also use the Build Wizard for that workflow. More details are available in the [Hover Bubble SmartLink Configuration](#) topic.

Validate SmartText Formatting

Your Epic representative can run a search to identify SmartTexts that use SmartLinks that now appear as hover bubble SmartLinks. If you plan to validate formatting and appearance of the new SmartLinks within specific SmartText, this can help you prioritize which SmartTexts you validate.

Mention SLG 8083184 when working with your Epic representative to run this search.

If you want to focus on the SmartTexts that are used the most, you can run a report using Reporting Workbench template [23000-SmartTool Usage Data](#) to identify the most used SmartTexts and cross-reference that list with the list of affected SmartTexts from the search. Run a report with the following criteria:

- Data Range = At least one month, but longer if you prefer
- Group By = SmartTool
- SmartTool Types = SmartText

After running the searches to determine affected records, these SmartText can be viewed within the SmartText Editor. Test these SmartTexts in note workflows with test patients to confirm that the formatting will still display as intended for these records.

Update Your Review All SmartLink

The Foundation System includes a SmartLink that allows clinicians to include a line in their note that attests that they reviewed patient information. This SmartLink uses various rules to check if each piece of information has been reviewed during the encounter and shows the relevant title only if that information was marked as reviewed.

I have reviewed: Tobacco | Allergies | Meds | Problems | Med Hx |
Surg Hx | OB Status | Fam Hx |

You can create a similar SmartLink that uses hover bubble SmartLinks to allow anyone reading the note to see the relevant information. The Foundation System includes two SmartLinks:

- 100533-AMB Mark As Reviewed This Encounter by Anyone. This SmartLink shows the types of information what were marked as reviewed by anyone.
- 100437-AMB Mark As Reviewed This Encounter by Provider. This SmartLink shows the types of information what were marked as reviewed by a physician or APP.

If you have these or similar SmartLinks in your system, you can create versions that use hover bubble SmartLinks by completing the following steps:

1. Open the SmartText used by the SmartLink. For example, the Foundation System uses SmartText 13160-AMB Mark As Reviewed This Encounter by Anyone and 12797-AMB Mark As Reviewed This Encounter by Provider.

2. These SmartTexts include a sequence of rules-based SmartLinks that check a rule and then call a SmartTool. Update the second mnemonic for each rules-based SmartLink to be the mnemonic for the appropriate hover bubble SmartLink. For example, for SmartText 13160, you might use the following (note that the rule IDs listed in the first parameter reference Foundation System rules and might be different in your system):

- @RULESMARTLINK(680931,TOBHX)@@RULESMARTLINK(680920,ALLERGY)@@RULESMARTLINK(680921,CMED)@@RULESMARTLINK(680924,PROB)@@RULESMARTLINK(680925,PMH)@@RULESMARTLINK(680926,PSH)@@RULESMARTLINK(680927,FAMHX)@@RULESMARTLINK(680930,SOCHX)@

Manual Build Instructions

If you do not currently use a SmartLink like this and want to build it from scratch, you can do so using the following instructions. Note that this task involves building multiple rules, SmartText, and other records. Reference the Foundation System for details on the records, but the section below lists the records and some basic details about them.

Note that before building a record, it's useful to first check if they exist in your system by looking up the record using the Community ID and by the record name (which you likely copied if you already manually created the record in your system).



You can look up a record by community ID in most record lookup windows using the format "CID.<community ID>." For example, for a rule record with the community ID of 12345678, you can open it in the Rule Editor by entering CID.12345678.

Build Rules

Create the following rules that check whether a specific type of information was marked as reviewed during the encounter by anyone. For details on creating a rule, refer to the [Create or Edit a Rule](#) topic.

FS Record ID	Community ID	Record Name	Rule Logic
680931	950256472	AMB Tobacco Review This Encounter by Anyone	(49250-ED Reminder - History Reviewed (Sections = 5-Tobacco)) = (1-Yes)
680920	950256463	AMB Allergies Review This Encounter by Anyone	(49195-ED Reminder - Allergies Reviewed) = 1 AND (100110-C_Allergy Status Review) ≠ (30-Unable to Assess)
680921	950256464	AMB Medications Review This Encounter by Anyone	(49370-ED Reminder - Medications Reviewed) = (1-Yes)
680924	950256467	AMB Problems Review This Encounter by Anyone	(49302-ED Reminder - Problem List Reviewed) = (1-Yes)
680925	950256468	AMB Medical History Review This Encounter by Anyone	(49205-ED Reminder - History Reviewed (Sections = 1-Medical)) = (1-Yes)
680926	950256469	AMB Surgical History Review This Encounter by Anyone	(49205-ED Reminder - History Reviewed (Sections = 2-Surgical)) = (1-Yes)
680927	950256470	AMB Family History Review This Encounter by Anyone	(49205-ED Reminder - History Reviewed (Sections = 9-Family)) = (1-Yes)
680930	950256471	AMB Social History Review This Encounter by Anyone	(49205-ED Reminder - History Reviewed (Sections = 8-Sexual Activity, 6-Alcohol, 7-Drug Use)) = (1-Yes)

If you prefer to use the SmartLink that checks if a provider marked the information as reviewed, build the following rules:

FS Record ID	Community ID	Record Name	Rule Logic
680906	950255764	AMB Tobacco Review This Encounter by Provider	(49250-ED Reminder - History Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner) (Sections = 5-Tobacco)) = (1-Yes)
680907	950255765	AMB Allergies	(49195-ED Reminder - Allergies Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-

FS Record ID	Community ID	Record Name	Rule Logic
		Review This Encounter by Provider	Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner)) = 1 AND (100110-C_Allergy Status Review) ≠ (30-Unable to Assess)
680908	950255766	AMB Medications Review This Encounter by Provider	(49370-ED Reminder - Medications Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner)) = (1-Yes)
680909	950255767	AMB Problems Review This Encounter by Provider	(49302-ED Reminder - Problem List Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner)) = (1-Yes)
680848	950255706	AMB Medical History Review This Encounter by Provider	(49205-ED Reminder - History Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner) (Sections = 1-Medical)) = (1-Yes)
680901	950255759	AMB Surgical History Review This Encounter by Provider	(49205-ED Reminder - History Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner) (Sections = 2-Surgical)) = (1-Yes)
680902	950255760	AMB Family History Review This Encounter by Provider	(49205-ED Reminder - History Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner) (Sections = 9-Family)) = (1-Yes)
680904	950255762	AMB Social History Review This Encounter by Provider	(49205-ED Reminder - History Reviewed (Provider Types = 4-Anesthesiologist, 108-Dentist, 116-Fellow, 5-Midwife, 102-Pharmacist, 1-Physician, 6-Physician Assistant, 105-Optometrist, 113-Resident, 9-Nurse Practitioner) (Sections = 8-Sexual Activity, 6-Alcohol, 7-Drug Use)) = (1-Yes)

Build a SmartText

Create a SmartText record with the following details. Note the following:

- You only need to create the SmartTexts that match the behavior you want.
- In the text below, the IDs in bold are the Foundation System ID. You must update that to the ID for the record in your system.

Record Name	SmartText Content	Restrictions
AMB Mark as Review This Encounter by Anyone	@RULESMARTLINK(680931 ,TOBHX)@, @RULESMARTLINK(680920 ,ALLERGY)@, @RULESMARTLINK(680921 ,CMED)@, @RULESMARTLINK(680924 ,PROB)@, @RULESMARTLINK(680925 ,PMH)@, @RULESMARTLINK(680926 ,PSH)@, @RULESMARTLINK(680927 ,FAMHX)@, @RULESMARTLINK(680930 ,SOCHX)@	Functional Type = 1-MR Charting, 800-IP Charting, 60-MR NoteWriter, 805-IP NoteWriter
AMB Mark as Review This Encounter by Provider	@RULESMARTLINK(680906 ,TOBHX)@, @RULESMARTLINK(680907 ,ALLERGY)@, @RULESMARTLINK(680908 ,CMED)@, @RULESMARTLINK(680909 ,PROB)@, @RULESMARTLINK(680848 ,PMH)@, @RULESMARTLINK(680901 ,PSH)@, @RULESMARTLINK(680902 ,FAMHX)@, @RULESMARTLINK(680904 ,SOCHX)@	Functional Type = 1-MR Charting, 800-IP Charting, 60-MR NoteWriter, 805-IP NoteWriter

Create the SmartLink

1. Create a new SmartLink record (search: SmartLink). Name it AMB Mark as Reviewed This Encounter and set the Type field to SmartText.
2. On the General tab, enter a Mnemonic, such as MARKALLHOVER.
3. Enter a short description, such as Information reviewed during encounter.
4. On the SmartText tab, set the SmartText record field to the SmartText you created.
5. You can pull through the contexts you entered on the SmartText record or enter 1-MR Charting, 800-IP Charting, 60-MR NoteWriter, 805-IP NoteWriter.
6. Mark the record as Active.

If you are creating both the Anyone and Provider versions of the SmartLink, complete the steps a second time for your additional SmartLink. Make sure to set unique mnemonics and descriptions to let users know which information is being pulled in.

Test the SmartLink

To test your SmartLink, open an encounter and mark various things as reviewed. Open a note and enter your SmartLink using the mnemonic you specified. Verify that it pulls in the right information and that you can view the information that was reviewed in a hover bubble.

Use SmartLink Editor to Update Hover Bubble SmartLinks

If an existing hover bubble SmartLink doesn't meet the needs of your organization, you can edit it. For example, you might want to change hover bubble SmartLinks to no longer display as a hover bubble. You can duplicate any of the released hover bubble SmartLinks and create custom versions to use instead. Refer to the [SmartLinks](#) topic for more details on editing SmartLinks.

Important SmartLink Editor Features Related to Hover Bubble SmartLinks

- To display with hover bubbles, SmartLinks must be configured as follows:
 - Refreshable: Yes (I HHS 100)
 - Collapsible: Collapsed by Default (I HHS 320)
 - Collapsible Summary: A value of your choosing (I HHS 330)
 - Display as Hover Bubble SmartLink: Yes (I HHS 54)
- The Display as Hover Bubble SmartLink setting appears only for SmartLinks that have a code template with Allow Hover Bubble (I E3N 390) set to Yes. The code templates of the SmartLinks in the [Available Hover Bubble SmartLinks](#) section are the only ones currently built to display as a hover bubble when inserted.

The screenshot shows the SmartLink editor interface for a SmartLink named 'IP SOCHX'. The 'Display as Hover Bubble SmartLink' checkbox is checked under 'User-Entered Parameters'. Other settings like 'Refreshable' and 'Collapsible Summary' are also visible.

Find SmartTools that Use a SmartLink

In the SmartLink editor, the Used-By section of any SmartLink includes all the SmartTools that reference the SmartLink's mnemonic. Refer to the [Determine What Records Use a SmartTool](#) section to determine which SmartTools are referencing a SmartLink, including our released hover bubble SmartLinks.

If you need to update many SmartTools referencing a SmartLink, your Epic representative can use the utility described in the [Use a Utility to Find and Replace SmartLinks or Free Text in SmartLists, SmartPhrases, and SmartTexts in Your System](#) topic.

Give Users Access to Insertion Personalization

There is an option to give users access to the Automatically expand hover bubble SmartLinks on insertion setting, which can be found in SmartTool Formatting Settings in Hyperspace. This user setting is accessible only when Disable hover bubble SmartLink insertion (I HDF 20382) is set to Yes. With this user setting enabled, hover bubble SmartLinks automatically expand upon insertion instead of pulling in with the hover bubble formatting. This setting applies when users insert new hover bubble SmartLinks using a dot phrase or template. Previously

inserted hover bubble SmartLinks are unaffected by this setting.

The screenshot shows the 'SmartTool Formatting Settings' dialog box with the 'Text Insertion' tab selected. It includes sections for 'On paste:' and 'On SmartTool insertion:'. Under 'On paste:', there are three radio buttons: 'Keep Source Formatting' (selected), 'Match Surrounding Text', and 'Prompt me each time' (checked). Below these is a checkbox for 'Show "Paste Text Only" option in right click menu'. Under 'On SmartTool insertion:', there are three radio buttons: 'Keep Source Formatting' (selected), 'Match Surrounding Text', and 'Prompt me each time' (checked). Below these is a checkbox for 'Automatically expand hover bubble SmartLinks on insertion' (unchecked) with an information icon (i).

Expand SmartLink Content in Reports

If you want hover bubble SmartLinks to be expanded by default when clinicians and other users view certain reports in Hyperspace, you can configure the SmartLinks to appear inline or as endnotes in these reports. This is helpful if these users frequently need to view the content of these SmartLinks.

To expand hover bubble SmartLinks by default:

1. In Chronicles, duplicate extension 13477-Note Hover Bubble SmartLink Display Mode. Change the value of the first parameter to 1-Inline or 2-Endnote to expand all hover bubble SmartLinks.
2. Open the report in which all hover bubble SmartLinks should be expanded. If it is an Epic-released report, create a copy.
3. Enter your copy of extension 13477 in the Add'l setup (I LRP 195) field.

Automatically Sign Notes at the Close of an Encounter

You can configure a feature set so that pended notes are automatically signed when the current encounter is closed. When a clinician clicks Sign when Signing Visit, the note is editable until the encounter is closed. This prevents clinicians from needing to manually sign pended notes, which saves documentation time when closing an encounter.

Clinicians must have the Sign when signing visit feature in their feature set in order to have the system automatically sign pended notes when an encounter is closed.

Considerations

The Sign when signing visit feature is mutually exclusive with the Sharing with clinicians feature.

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations, and open your duplicate feature set.
2. On the Feature Set Configuration Record screen, add Sign when signing visit to the Features Enabled field.

Automatically Save Notes Based on a Time Interval

You can configure EMR System Definitions so notes are saved automatically based on a time interval. The in-progress notes can then be recovered if something prevents clinicians from manually saving them. In February

2021, this setting does not apply to Anesthesia notes, L&D Delivery notes, or patient instructions. Starting in May 2021, it applies to procedure notes in the web-based procedure note activity for Anesthesia.

You can choose the time interval that controls when notes are automatically saved, and you can choose the message type used for sending automatically saved notes.

1. In Clinical Administration, select Management Options > Edit System Definitions > Note, Letter, Transcription and access the Notes General Options - 1 screen.
2. In the Auto-save interval (I LSD 34023) field, enter a length of time, in minutes, after which notes are saved. The minimum value is 2 minutes.
 - Starting in August 2018, if no value is specified, the system saves notes automatically every 5 minutes. If you want to disable auto-saving, enter a zero (0) and notes will not be saved automatically.
 - In versions prior to August 2018, if no value is specified, notes are not saved automatically.
3. Leave the Message type for timeout messages (I LSD 3165) field blank. Epic plans to deprecate this field in a future release, so we recommend that you leave it blank to use the default message type of 69-Timeout Message.

Automatically Save Notes When Editing Letters

When a clinician navigates away from an open note to a different activity, the note stays open and unsaved so that he can return to it and immediately continue documentation. If a clinician wants to pull the content of a note into a letter, he needs to save and close it first for its content to be included in the letter.

You can configure notes to save and close automatically when a user goes to edit a letter in the Communication Management or Letters activity, allowing them to add the note content to the letter without needing to manually save and close the note beforehand.

Note that this process might not be entirely automatic for your users if:

- Your system is configured to require user re-validation when signing notes.
- There is a wildcard in the note that would prevent the note from being signed manually.

Additionally, notes saved as a result of this workflow are signed if the note editor is configured to sign notes upon saving. Keep these considerations in mind when deciding whether to implement this feature.

To enable automatic saving and closing of notes when a user edits a letter in the Communication Management or Letters activity:

1. In Clinical Administration, go to Management Options > Edit System Definitions (LSD) > Note, Trans, Communication and access the Notes General Options - 1 screen.
2. In the Save note prior to editing a letter (I LSD 6553) field, enter 1-Yes.

Automatically Add a Signature When a Clinician Signs a Note

You can automatically add a signature when a clinician signs a note. This helps ensure that notes have signatures without requiring a clinician to enter a SmartPhrase or type the signature. You can also configure the signature to be encounter-specific so that clinicians who work in multiple contexts have appropriate signatures for each context.

To automatically add a signature to a note, you configure a copy of extension record 34260-IP Note After File - Append User Signature and add it to a clinician's profile. For clinicians who work in multiple contexts that require different signatures, you can build two separate copies of this extension record with different signature configurations and different encounter contexts and add them to the clinician's profile.

For example, consider a case where you've configured a signature that includes values that are relevant only in inpatient contexts, such as the name and phone number for the clinician's login department. For physicians who work in both inpatient and outpatient departments, you can configure the signature to appear only for notes written in an inpatient context or you can configure a different signature to appear when the physician writes a note in an ambulatory or HOV context.



Starting in August 2024, in May 2024 with special update E10904093, or in February 2024 with special update E10809186, the extension does not add a signature to type 33-Subjective & Objective or type 38-Assessment & Plan notes. These note types should not have their own signatures because they are often included within Diagnosis-Aware Notes or notes generated as part of problem-oriented charting.

Configure a Copy of Extension 34260

1. Open the Extension (LPP) master file in Chronicles.
2. Make a copy of extension 34260.
3. On the Parameters screen, enter contexts from the UCN - Application Contexts (I ECT 34234) category list in parameter 11-Application Context. For example, enter 1-Inpatient to configure the extension to add an automatic signature only for notes created in an inpatient context.
4. Configure the rest of the parameters as desired.
5. In Clinical Administration, add the extension to the Note saved extension (I LPR 34350) field on the Notes General Settings - 2 screen of a profile or follow the steps below to configure multiple versions of extension 34260 to be evaluated when a clinician saves a note.

Configure Multiple Versions of Extension 34260 for Different Note Contexts

1. Create multiple copies of extension 34260.
2. Open the Extension (LPP) master file in Chronicles.
3. Make a copy of extension 34175 and open it for editing.
4. List your extensions in the LPP Type 34510 List parameter.
5. Add your copy of extension 34175 to the Note saved extension (I LPR 34350) field on the Notes General Settings - 2 screen of a profile.

Automatically Print Reports When Notes Are Saved or Pended

If you are still using paper charts for partial documentation and want to add a printed notes report for a saved or pended note to the paper chart, you can use a duplicate of extension record 34288-IP After Note Filing Print Report. This allows clinicians to view the note in Hyperspace and in the paper chart.

1. In Clinical Administration, access your profile and select Note, Letter, Transcription.
2. Access the Notes General Settings - 2 screen.

- If you want the report to print after the note is saved, enter your duplicate of extension record 34288 in the Note saved extension (I LPR 34350) field.
- If you want the report to print after the note is pended, enter your duplicate of extension record 34288 in the Note pend extension (I LPR 34351) field.
- If you want the report to print after an attestation is signed, enter your duplicate of extension record 34288 in the Note attestation extension (I LPR 34352) field.

Automatically Add a Clinician to a Treatment Team When They Sign or Pend a Note

You can configure clinicians' profiles so that when they sign or pend a note for a patient, the note's author, the note's cosigner, or both are automatically added to the patient's treatment team. This configuration helps ensure that a patient's treatment team is up to date when clinicians don't have time to add themselves to treatment teams. Use extension 49311-ED After Note File Assign Treatment Team to configure the logic for assigning treatment team relationships.

How It Works

As released, the extension does not add clinicians to patient treatment teams. You must duplicate the extension and modify the parameters to fit the needs of your organization.



Several of the parameters in this extension have similar or identical names. Use the parameter help text to see whether a parameter applies to the note author or to cosigners.

Who Is Assigned to the Treatment Team

The Add Author? and Add Cosigner? parameters determine whether the author and cosigner are added to the treatment team. If you leave these parameters blank, as released, or set them to No, the author or cosigner respectively aren't added to the treatment team.

Which Treatment Team Relationship Is Used

The system uses a combination of parameters and system settings to determine which treatment team relationship to use:

1. Assuming the Add Author? parameter is set to Yes, the system uses the following logic to determine the author's treatment team relationship:
 - a. If the Allow Attending? author parameter is set to Yes, a note author can be assigned as the attending provider, but other parameters and settings determine whether that assignment is made.
 - b. To determine which relationship to use, the system first uses settings outside the extension to attempt to assign a treatment team relationship:
 - i. If the provider is currently signed into the department, then the current relationship is used.
 - ii. If the user has a provider (SER) record and a default treatment team relationship (I SER 2600) is specified, then that relationship is used.
 - iii. If the user has a provider record and is listed as a physician (I SER 1040) and is not a resident (I SER 1120), the system assigns a relationship of Attending Provider.
 - c. If a relationship hasn't been assigned and the As Attending Instead? author parameter is set to Yes, the author is assigned to the treatment team as the attending provider.

- d. If a relationship hasn't been assigned and a relationship is specified in the Add Author As parameter, that relationship is used.
2. Assuming the Add Cosigner? parameter is set to Yes, the system uses the following logic to assign a treatment team relationship:
 - a. If the As Attending Instead? cosigner parameter is set to Yes, the cosigner is assigned to the treatment team as the attending provider. If both the cosigner and the author would be added as attending providers, the system assigns the author.
 - b. If a relationship is specified in the Add Cosigner As parameter, that relationship is used.
 - c. If a relationship hasn't been assigned, the system uses settings outside the extension to attempt to assign a treatment team relationship:
 - i. If the provider is currently signed into the department, then the current relationship is used.
 - ii. If the user has a provider (SER) record and a default treatment team relationship (I SER 2600) is specified, then that relationship is used.
 - iii. If the user has a provider record and is listed as a physician (I SER 1040) and is not a resident (I SER 1120), the system assigns a relationship of Attending Provider.
 - d. If the Default As Attending parameter is set to Yes and a relationship hasn't been assigned, the cosigner is assigned to the treatment team as the attending provider.
 - e. If a relationship is specified in the Default Cosigner As parameter, that relationship is used.

If none of the conditions above are met, the extension doesn't assign a treatment team relationship to the author or cosigner.

Note that there are other parameters in this extension that affect its behavior. For example:

- The Note Types parameter determines which notes are evaluated. If you leave this parameter blank, as released, the extension logic is applied only to ED notes, ED Triage notes, and ED Provider notes.
- Starting in August 2025, if the Service to Specialty Table parameter is populated, the system assigns the provider to a role on the care team with a specialty based on the mapping between note service and specialty. The table specified in this parameter must be a general table using table specification 36008-Clinical Service to Specialty.

Refer to the extension's help text for information about other parameters.

Configure the Extension

To configure your extension and add it to a profile:

1. In Chronicles, make a copy of extension 49311.
2. Modify your duplicate's parameters.
3. In Clinical Administration, open a profile.
4. Access Notes, Letter, Transcription. Page down to the Inpatient Notes General Settings - 2 screen.
5. Add your modified extension to one or more of the following fields, as appropriate:
 - Note saved extension (I LPR 34350)
 - Note pend extension (I LPR 34351)
 - Note attestation extension (I LPR 34352)
 - Note cosign extension (I LPR 34357)

Automatically Replace Ambiguous Abbreviations in Notes

The Joint Commission on Accreditation of Healthcare Organizations has issued a list of dangerous abbreviations, acronyms, and symbols that account for medical errors that endanger patient safety. For example, the abbreviations QD (for daily) and QID (for four times a day) are often mistaken for each other. As part of The Joint Commission's National Patient Safety Goals, this "Do Not Use" list is a minimum set of dangerous abbreviations that must be avoided.

The Institute for Safe Medication Practices (ISMP) also suggests a list of error-prone abbreviations that you might want to consider avoiding as well to increase patient safety at your facility. For example, ISMP suggests avoiding the abbreviation D/C since it can mean either discontinue or discharge.

You can use the spell checker in Hyperspace to check for these ambiguous abbreviations and prompt users to substitute these abbreviations for more appropriate replacements. Note that the spell checker does not currently support the replacement of inappropriate symbols.

Give Users the Ambiguous Abbreviations Dictionary

Your organization might have already added the ambiguous abbreviations dictionary to your system as a system-wide dictionary. If not, or if you need to make it available to only a subset of users, refer to the Create a Supplementary Dictionary in May 2020 and Later Versions sub-topic of the [Create an Additional Dictionary](#) topic for instructions.

Configure the System to Automatically Replace Ambiguous Abbreviations as Users Type

To automatically replace ambiguous abbreviations as users type, you need SmartList 8051996-Ambiguous Abbreviation. This record is included in the Foundation System. Alternatively, you can use the Foundation System's ambiguous abbreviations dictionary (SPL) record 1000000000-Ambiguous Abbreviations.

Ensure that Users Have Auto Correct Enabled

To automatically replace ambiguous abbreviations, users must have the Auto correct words as you type option selected in their Spell Checker user options. You can use the Application Access menu (also known as the d ^EPIC menu) to search for users who don't have this option enabled:

1. From the Application Access menu, go to ApplCore > Spell Checker Utilities > Search User Options.
2. At the Users prompt, enter All.
3. At the Spell checker option prompt, enter 9-Auto correct words as you type.
4. At the Value prompt, enter No.
5. Press Enter at the and Spell checker option prompt.
6. At the Save the search results to a subset:
 - Enter Yes if you'd like to save a list of the users that the search finds for later reference. Enter a name and description for the subset and fill out the other prompts as desired.
 - Enter No if you don't want to save the list of users.
7. At the Are you sure you want to run the search prompt, enter Yes.

You can either save the subset and use the Edit User Options for Multiple Users utility to select the option or follow up with users who do not have this option enabled and instruct them how to turn it on.

To use the utility:

1. In text, open the Spell Checker Utilities menu again and select Edit User Options for Multiple Users.
2. At the Users prompt, enter Set followed by the name of your subset, such as Set Users Missing Auto Correct.
3. At the Spell checker option prompt, enter 9-Auto correct words as you type.
4. At the Value prompt, enter Yes.
5. Press Enter at the and Spell checker option prompt.
6. Enter Yes at the Are you sure you want to edit the selected users prompt.

To have users change their settings in Hyperspace, open the User Spell Check Settings (search: User Spell Check Settings) and select the Auto correct words as you type setting.

Ensure That Users You Add in the Future Have Auto Correct Enabled

To ensure that all users you add to your system in the future have the Auto correct words as you type option selected in their Spell Checker user options, select it in Spell Checker System Options:

1. In Hyperspace, select Epic button > Tools > Spell Checker > System Options.
2. On the General tab, select the Auto correct words as you type option.
3. Click Accept.

Pull Event Times into Notes

Configure an event's time to be pulled into an anesthesia note, saving anesthesiologists from having to look up this information when writing the note. You can configure the anesthesia event time or all case timing event times to automatically appear in the note. Documented intubation event times automatically appear in the released airway procedure note. You can also add a button to the note that pulls in the event time when clicked.

To pull in event times, you first need to configure a copy of an extension. To pull in anesthesia event times, configure a copy of extension 89076-AN Default Time from Event:

1. In Chronicles, access the Extension (LPP) master file.
2. Duplicate extension 89076 and configure its parameters as follows. To see how we've configured our copy of extension 89076 in the Foundation System, go to the [Foundation Hosted Text environment](#) and open extension 1128907601-AN File Airway Placement Time from Intubation/Airway Placed Event .
 - a. Anesthesia Event. Enter the anesthesia event whose start time should be pulled into the note.
 - b. First or Last? This parameter determines which event to use if there are multiple events of the given type documented. Enter 0-Last or leave this parameter blank to use the most recently documented event, or 1-First to use the earliest event.
 - c. SmartData Identifier. Enter the SmartData Identifier of the element that is set to the given time. The SmartData element should have a type of Instant.
 - d. Allow Override? Enter 0-No or leave this parameter blank to prevent the extension from overriding any existing data in the SmartData element. Enter 1-Yes to allow the extension to override existing data.

To pull in case timing event times, configure a copy of extension 89760-AN Default Time from Case Timing Event:

1. In Chronicles, access the Extension (LPP) master file.
2. Duplicate extension 89760 and configure its parameters as follows. To see how we've configured our copy

of extension 89760 in the Foundation System, go to the [Foundation Hosted Text environment](#) and open extension 89761-AN File Airway Placement Time from Intubation Case Timing Event.

- a. Case Timing Event. Enter the case timing event whose start time should be pulled into the note.
- b. SmartData Identifier. Enter the SmartData Identifier of the element that is set to the given time. The SmartData element should have a type of Instant.
- c. Allow Override? Enter 0-No or leave this parameter blank to prevent the extension from overriding any existing data in the SmartData element. Enter 1-Yes to allow the extension to override existing data.

To pull the event time into the note automatically, add the extension to a SmartForm:

1. In Hyperspace, open the SmartForm for the procedure that you want to pull the event time into in the SmartForm Designer (search: SmartForm Designer).
2. Open the Scripting tab and go to RootComponent > AfterDataLoaded.
3. Click Add Action.
4. Give your new action a type of Run Programming Point.
5. In the Programming point field, enter your copy of extension 89076 or extension 89760.

To instead create a button that pulls the event time into the note:

1. In Hyperspace, open the SmartForm for the procedure that you want to pull the event time into in the SmartForm Designer (search: SmartForm Designer).
2. Right-click and select Add > Command Button.
3. Select the button and click the Properties tab.
4. Enter a caption for the button in the Caption field.
5. Right-click the button and select Scripting.
6. Select Click and then click Add Action.
7. In the Type field, enter Run Programming Point.
8. In the Programming point field, enter your copy of extension 89076 or extension 89760.

Change the Color of Notes Written by Certain Clinicians

You can make notes written by certain types of providers stand out by changing the color of the line at the top their headers and around their provider photo when they're viewed from the Notes activity and note navigator sections. That way, clinicians can quickly determine which type of provider wrote a note.

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD).
2. Go to the Notes Display by Provider Type screen.
3. In the Provider Type field, enter a provider type that should have a different colored header.
4. In the corresponding Title Color field, enter the six-digit hexadecimal code for the color you want to use.
In the Foundation System, the following provider types are configured to have different colored headings:

Provider Type	Heading Line Color
Physician	E6E6FA
Registered Nurse	B0C4DE
Licensed Nurse	E0FFFF
Resident	98FB98
Midwife	FF34B5
Nurse Practitioner	FFE4E1
Medical Assistant	FF9142
Physician Assistant	FFE4E1

Use a Color or Background Image to Indicate a Note's Status

You can specify a color, background image, or both to appear in notes to indicate their status. By default, the following colors and images appear depending on note status:

Note Status	Status Color	Background Image
Shared & Unsigned	None	None
Incomplete	Gray	The word "Incomplete" appears as a watermark behind the note text
Addendum	None	None
Deleted	Gray	None

1. In Clinical Administration, go to Management Options > Edit System Definitions > Note, Trans, Communication.
2. Access the Notes Display Options - 1 screen.
3. Enter a color or image in the Color (I LSD 33023) or BG Image (I LSD 33024) fields for each note status. Leave these fields blank to use the default colors or image.
 - a. Enter a color value as a 6-digit hexadecimal RGB color. This means that the first two digits are for red, the second two digits are for green, and the last two digits are for blue. For example, enter FF0000 for bright red or 0000FF for deep blue.
 - b. Enter your background image file. Starting in August 2018, enter the file name of your image on your BLOB server. We recommend storing background images on the BLOB server so they appear correctly on all platforms. In Epic 2018 and earlier versions, enter the complete file path of the image you want to use, such as X:\picture\picture.jpg.
4. Enter a color in the Default status color (I LSD 33015) field. Leave this field blank to use the default color.

Disable Printing Notes from the Notes Activity

Encourage clinicians to print notes from Chart Review or the Summary report by disabling printing from the Notes activity. Chart Review or the Summary reports are set up to look better printed and fit more on a page.

You can disable printing from the Notes activity using profile variable IP_NOTES_DISABLE_PRINT (88021).

1. In Clinical Administration, follow the path Management Options > Complete Configuration (HDF).
2. At the Configuration prompt, enter 1-Compiled Configuration.
3. Access the Customer Specific Install Mnemonics screen and enter IP_NOTES_DISABLE_PRINT in the Mnemonics column.
4. Enter 1-True in the Code column.

Enable Image and File Attachments for Notes

Keep notes clean and easy to read by allowing clinicians to attach images and related files, such as PDFs, instead of inserting them into the text of the note.



When you enable this feature for a note type, a clinician writing a note of that type can click an Attached Files button to open the Edit Attachments window. From the window, he can select files associated with the encounter or browse to a file. He can also preview and remove files that he or another clinician previously attached. After he attaches a file, the Attached Files button updates its attachment count so that clinicians can determine how many attachments a note has without opening the Edit Attachments window. When enabling this feature, you can configure an attachment limit so that a note never has an excessive number of attached files.

To enable attachments for a note type, configure it in a profile:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile and go to the Insert Image Options for Letters and Notes screen.
2. Enter a note type in the Note Type (I LPR 34780) field.
3. In the corresponding Enable Attachments field, enter 1-Yes.
4. To limit the number of attachments a single note can have, enter a number in the corresponding Max Attachments field. If you leave this blank, the limit is 1000 files.

Further Configure Attachment Limits



This topic applies only to organizations in Denmark.

To count attachments that are embedded as links within the note when determining the number of attachments, configure a copy of extension 88606-IP Denmark Note Sign Validation:

1. Extension 88606 is also used to warn clinicians that a note will be converted to plain text and to prevent signing when the plain-text version of the note exceeds a certain character limit, as described in release note [470102-Configure a Character Limit for Notes Converted to Plain Text](#). If you already use a copy of extension 88606 in the Validation Extension (I LPR 34941) field for the note type for which you want to configure an attachment limit, open your existing copy and skip to step 5.
2. In Chronicles, open the Extension (LPP) master file and follow the path Enter Data > Duplicate Extension.
3. Enter 88606 at the Extension field.

4. Give your new extension a unique ID and name.
5. Open your extension for editing and go to the Parameters screen.
6. If you don't want to also enforce a character limit for a note, clear the value in the Maximum Length parameter. If you configured a copy of extension 88606 as described in release note 470102, you likely don't need to edit this parameter.
7. Verify that 1-Yes is entered in the Count Attachments parameter. This is the released value.

To configure an attachment file size limit:

1. In Clinical Administration, follow the path Management Options > Edit System Definitions (LSD) > Outgoing Interface Settings screen.
2. Enter a maximum file size, in bytes, in the Attachment size limit (I LSD 3415) field. If you leave this field blank, the default is 5242880 bytes, which translates to 5 MB.
3. Create or configure a copy of extension 88606 as described in the previous set of steps, if you haven't already.

If you created or configured a copy of extension 88606, associate it with note types in a profile:

1. In Clinical Administration, follow the path Management Options > Profiles (LPR) and open a profile.
2. Follow the path Note, Letter, Transcription > Notes Sign Validation.
3. Enter a note type in the Note Type (I LPR 34940) field.
4. In the corresponding Validation Extension (I LPR 34941) field, enter your copy of extension 88606. If you leave this field blank, the note type you entered in step 3 is removed.

Automatically Add Billing Modifiers for Visits with Residents When Clinicians Cosign Notes

Billing for residents requires modifiers to be added to the visit, but it can be easy for attending physicians to forget to add the modifiers when cosigning the resident's note. In certain specialties, when a resident of a certain tenure sees a patient without an attending physician present, modifier GE must be added. When the resident and the attending physician see a patient together, modifier GC must be added.

You can set up your system to automatically add one of these modifiers when a clinician cosigns a resident's note. When the attending physician clicks Attest from a resident's note or uses the Attest QuickAction in a Cosign - Chart In Basket message and selects an attestation statement from a SmartList, the system files data to a SmartData element. Then, the system uses rules to find charges for visits with the SmartData element set and adds the appropriate modifier to the charges.



To get you started, your Epic representative can help you move some of the records for this feature into your system. Contact your Epic representative and mention project 199700.

To set up this process in your system, complete the following steps:

1. Open the SmartText your clinicians use to attest to visits where the attending physician wasn't present. If you don't already have a SmartText like this, follow the steps in the [Create and Edit a SmartText](#) topic to create one. In the Foundation System, we use SmartText 14012-Primary Care Exception.
2. Select the Discrete Data Settings tab.

3. In the Discrete Data Settings table:
 - a. Enter SmartData element EPIC#31000115161-Workflow - Attestation - GE Modifier in the SmartData Element field.
 - b. Enter Encounter in the Context field.
 - c. Enter Yes in the Element Value field.
4. Open the SmartText your clinicians use to attest to visits where the attending physician was present. If you don't already have a SmartText like this, follow the steps in the [Create and Edit a SmartText](#) topic to create one. In the Foundation System, we use SmartText 14015-E&M Including Resident/Fellow.
5. Select the Discrete Data Settings tab.
6. In the Discrete Data Settings table:
 - a. Enter SmartData element EPIC#31000115160-Workflow - Attestation - GC Modifier in the SmartData Element field.
 - b. Enter Encounter in the Context field.
 - c. Enter Yes in the Element Value field.
7. If you haven't already added these SmartTexts to a SmartList so that clinicians can select one of them when they attest to a note or visit, follow the instructions in the [Create and Edit a SmartList](#) topic.
8. If you haven't already added the SmartList to an attestation SmartPhrase, follow the steps in the [Create and Edit a System SmartPhrase](#) topic to create a SmartPhrase and add your SmartList to it. To recreate the Foundation System build, add the @ME@ SmartLink after the SmartList to automatically pull in the attesting provider's name.
9. If you haven't already added the SmartPhrase to an In Basket attestation QuickAction, open the Attest Note QuickAction and add it (search: Manage QuickActions).
10. Work with your billing team to create or update an action in the Charge Handler to add the appropriate modifier to a visit. For step-by-step instructions, refer to the [Build Actions in the Charge Handler](#) topic. In the Foundation System, we have two actions for this purpose that you can use as a model:
 - Action 100076-Add GE Modifier uses rule 144694-Physician Attested Primary Care Exception to check whether the supervising provider attested that the encounter qualifies for the primary care exception. If so, the Charge Handler adds the GE modifier.
 - Action 100025-Add GC Modifier adds a GC modifier if the GE modifier wasn't added by the previous action.

Set Default Quick Sort Buttons for the Note List

By default, users have buttons available to sort the note list by date of service, note type, and service. Users can select any other sort option from the More menu, and can add and remove buttons by clicking the wrench icon to access user settings. You can customize the buttons that appear by default for a certain group of users to make sorting and finding notes even faster for users who don't change their own settings. For example, if physicians typically look for notes based on whether they were written by a physician or a nurse, you could add Author Type as a default button at the profile level for all physicians.

The screenshot shows a clinical notes interface. At the top, there are sorting options: 'Sort: Note Time' (highlighted in blue), 'Note Type', 'Service', and 'More'. Below this is a header bar with a user icon, the name 'Sam Clark, MD', the title 'Physician', and the specialty 'Surgery'. To the right of the name is a link to 'Progress Notes' and the timestamp 'Note Time: 02/06 10:42 AM'. Below the timestamp is 'File Time: 02/06 10:42 AM' and a small green square icon. Further down are links for 'Addendum' and 'Print'. The background of the note card is light blue.

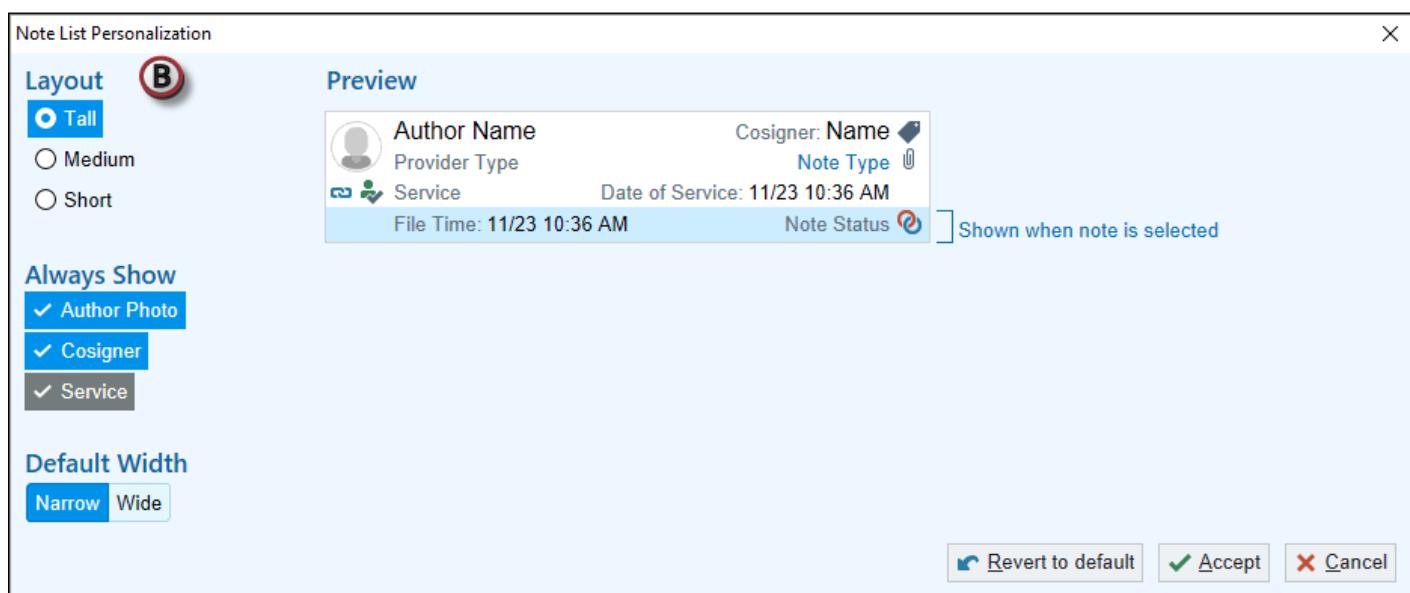
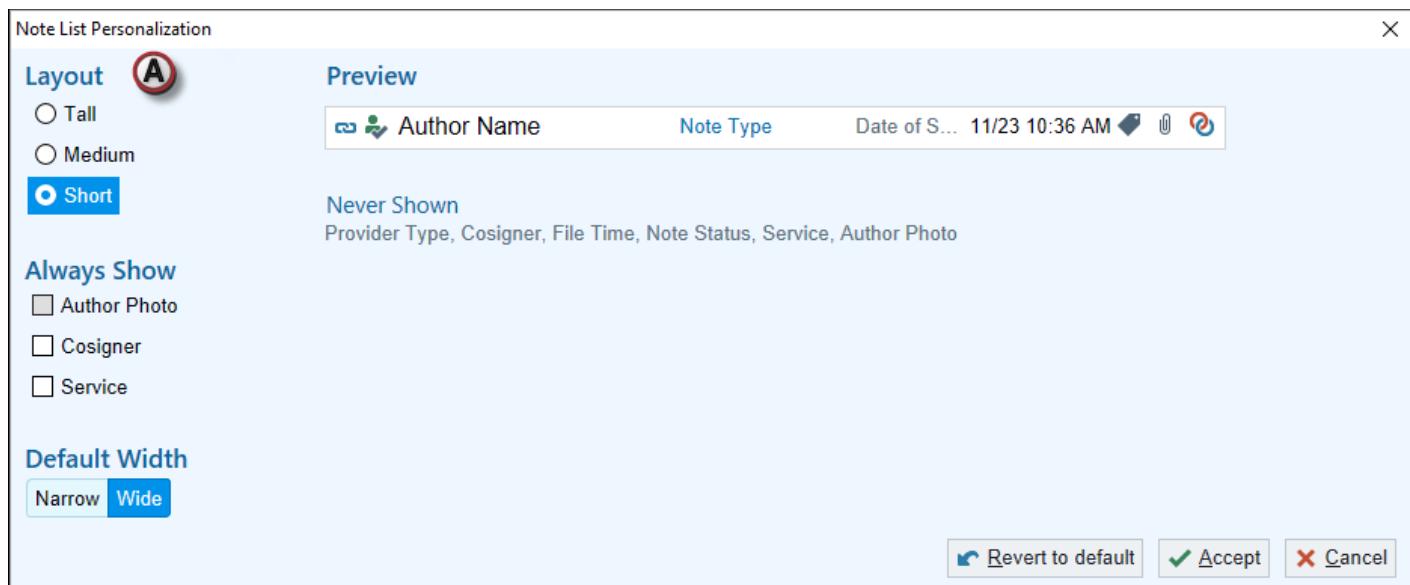
To update the default buttons for a profile:

1. In Clinical Administration, access a profile and select Note, Letter, Transcription.
2. Go to the Notes Activity Settings screen.
3. In the Quick sort buttons (I LPR 34507) field, enter the buttons you want to appear. Note that buttons appear in alphabetical order regardless of the order you enter them here.

Specify a Default Note List Layout for Users Who Haven't Selected a Layout

In the Notes activity, clinicians have the option to choose a note list layout to determine how much vertical space each note uses in the list, how much horizontal space the note list uses, and what details appear in the note list. Say one physician at your organization, Dr. A, wants to see as many notes on his screen as possible. He can choose the shortest layout height with a wide default width to show everything on one line and cut the scrolling he needs to do. Dr. B likes to be able to scan the note list to see the provider type, cosigner, and service for notes before she selects a note. She can choose a taller layout height and show those details in the note list.

To update note list layouts, you must have the Note List Personalization license, which is included in the standard Inpatient EMR license. If you're not sure whether you have this license, contact your Epic representative and mention parent SLG 3550868.



You can set a default note list layout at the profile level for any users who haven't selected a layout for themselves. You might do this to tweak the layout for all of a certain set of users after getting feedback from a few of those users that they never find it useful to see certain details, like the author's photo, in the note list. If any users with that profile have already selected a layout, your default layout doesn't override their preferences.

To specify a default layout for a profile:

1. Determine the HFN ID of the layout you want to specify as the default layout for a profile. To do so:
 - a. Turn on Report/HTML Assistance in Hyperspace.
 - b. Open the settings window in the Notes activity by clicking the wrench icon above the note list.
 - c. Select the options you want in your default layout. The HFN ID appears in the bottom left corner of the window.
2. In Clinical Administration, access a profile and select Note, Letter, Transcription.
3. Go to the Notes Activity Settings screen.
4. In the Note list layout (I LPR 34503) field, enter the ID you identified in step 1.

Set Default Speed Buttons in the Notes Activity

 Starting in August 2023

In the Notes activity, users can create personalized speed buttons to write notes with specific templates. You can set up default speed buttons at the profile level so that users have speed buttons already set up. You might do this if there are specific templates that you want users to use when writing notes, so that they can easily create notes with those templates.

To specify default speed buttons for a profile:

1. In Clinical Administration, access a profile and select Note, Letter, Transcription.
2. Go to the IP Notes Activity Speed Buttons screen.
3. In the Note Type (I LPR 46300) field, enter the note type of the note that the speed button should create.
4. In the Caption (I LPR 46301) field, enter the title of the speed button as it should appear in the Notes activity.
5. In the SmartText (I LPR 46302) field, enter the SmartText record that the speed button should use. For more information about creating SmartTexts, refer to the [Create and Edit a SmartText](#) topic.
6. Starting in August 2025, in the Service (I LPR 46303) field you can optionally enter a service you want inserted in the note when a clinician clicks the speed button. Clinicians can only use allowed services. For more information about which services can be used refer to the [Determine Which Services a Clinician Can Select](#) topic.
7. Repeat steps 3-6 for each default speed button you want to create.

Any modifications a clinician makes using the Add/Edit Speed Buttons window override the default settings in the profile. For example, consider the following scenario:

1. You configure default speed button A in a profile.
2. A clinician uses the wrench icon to add personal speed buttons B and C.
3. You replace speed button A in the profile with speed button D.

In this case, the clinician still sees buttons A, B, and C in addition to the new default button D. However, if the clinician never used the Add/Edit Speed Buttons window, then she sees only button D.

Hide Authentication Information in Note Reports

Several print groups, such as [54690-Note Report: Simple Chart Review Note \(Rich Text\)](#), show a note's authentication information in a format like "Last signed by: <author> at <Date and time>". In some cases, this information might not be accurate. For example, if an abstracted note was filed over a transcription interface that doesn't include authentication information, the system uses the date and time that the note was created as the date and time of the authentication. If the note wasn't authenticated when it was first created, the date that appears is inaccurate.

You can conditionally hide the note authentication information to ensure reports don't show inaccurate data. Continuing with the example above, you could have the authentication information hidden for any notes attached to an abstraction encounter.

To hide the authentication information, you need to:

- Create a rule that determines when to hide the information.

- Enter the rule in EMR System Definitions.

Create the Rule

Create a rule (CER) in the Clinical Notes context such that note attribution information is hidden when all of the rule criteria are met. For more information about creating rules, refer to the [Create or Edit a Rule](#) topic.



We recommend that your rule use only properties that check information directly related to the note, such as the note author or the encounter type. Properties that check other information might cause the rule to behave unexpectedly when you server-print or fax note reports.

For example, suppose you build your rule to hide attribution information when a user is logged in to a specific department. If a user faxes a report, the system might use the login department of a background user instead of the login department of the user who faxed the report, resulting in the note attribution information appearing when you didn't want it to.

Enter the Rule in EMR System Definitions

After you create your rule, complete the following steps to enter it in EMR System Definitions:

1. In Clinical Administration, go to Management Options > Edit System Definitions (LSD) > Note, Trans, Communication > Notes Display Options - 2 screen.
2. In the Suppress authentication rule (I LSD 98233) field, enter the rule you created.

Hide the User Setting to Opt Out of Sharing Notes with Patients by Default

If you configure certain types of notes to be shared with patients by default as described in the [Determine Which Note Types Are Shared with Patients](#) topic, clinicians can configure a user setting to opt out of having their notes shared with patients by default, which saves them time from having to manually clear the Share W/ Patient button each time they don't want to share a note.

You might want clinicians to have to clear the Share W/ Patient button to help ensure that most of their notes are shared. For example, you might have a regulatory requirement to share most of your organization's notes. To help enforce this, you can hide the user setting for clinicians to opt out of having their notes shared with patients by default:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations (HFN) and open a record of the type Feature Set Configuration.
2. Go to the Share with Patient Settings screen.
3. Set the Disable user-level opt out of share by default? (I HFN 222) field to Yes.

Add a Refresh Button in the Note Action Bar

The Refresh button in the note action bar makes refreshing SmartLinks quick and convenient for clinicians. This refresh button appears by default in ED encounters and for ED providers.

To use the refresh button in the note action bar, you must have the UCN_REFRESHBUTTON license, which is included in the standard EpicCare Ambulatory, EpicCare Inpatient, OpTime, ASAP, and Anesthesia licenses. If you're not sure whether you have any of these licenses, contact your Epic representative and mention parent SLG

To show the Refresh button in the note action toolbar in settings other than the ED:

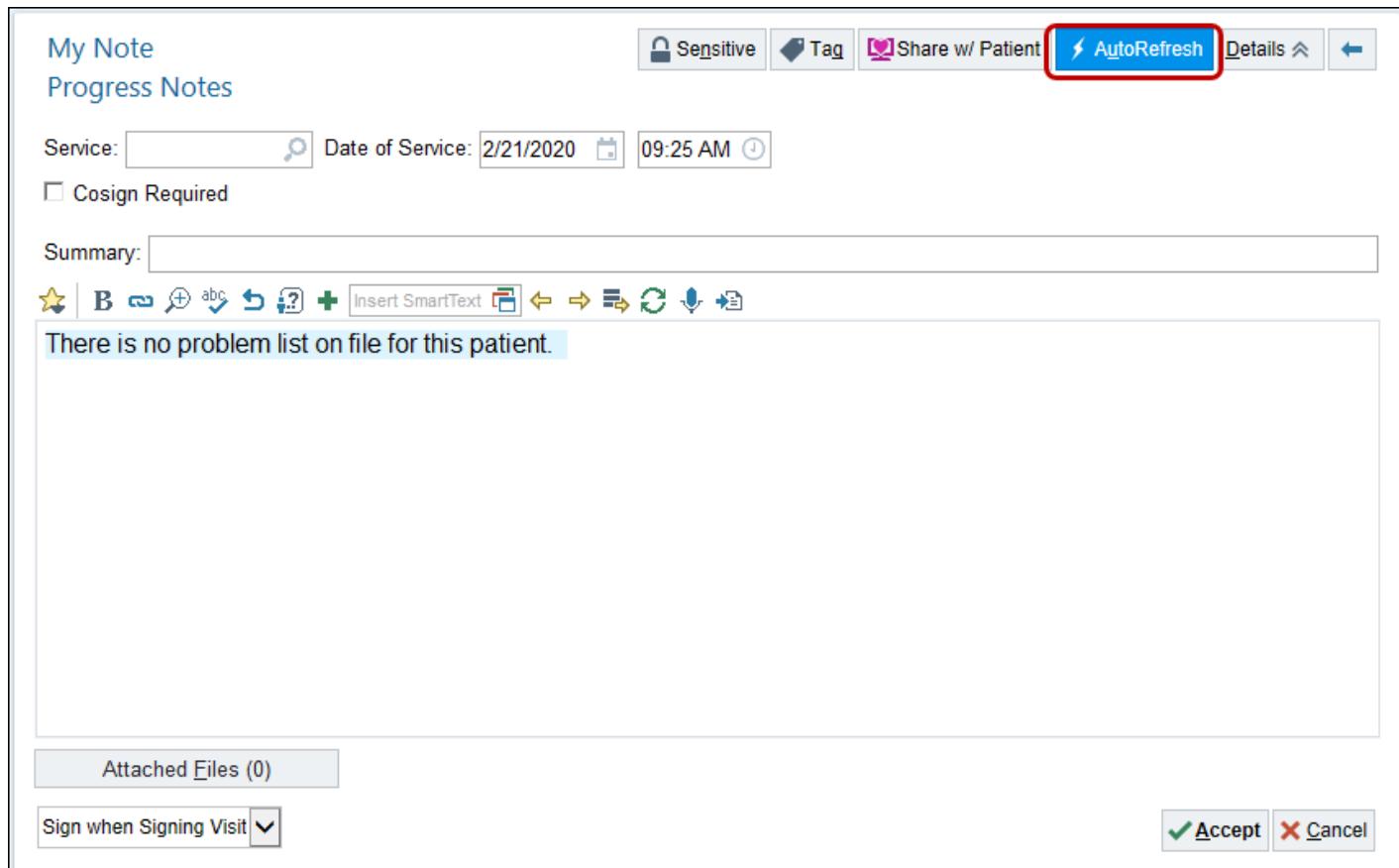
1. In Clinical Administration, open a profile record and select Note, Letter, Transcription.
2. Go to the Notes General Settings - 5 screen (August 2023 and earlier: Notes General Settings - 3 screen).
3. In the Show Refresh button? (I LPR 49314) field, enter 1-Yes.

Automatically Refresh SmartLinks When Notes Are Edited

When clinicians use SmartLinks in notes, they need to manually refresh them to keep the note content up to date. For example, suppose a clinician starts a progress note that contains a SmartLink to show the patient's Problem List problems. If he adds problems to the patient's chart, he has to remember to refresh the SmartLink so those problems appear in his note.

To help save clinicians clicks and ensure their notes stay up to date, you can give them the option to automatically refresh all SmartLinks in their notes. If you implement this feature, clinicians see an AutoRefresh button in their note editor. By clicking the button, clinicians elect to have all refreshable SmartLinks in their notes automatically refresh when:

- They open a note for editing.
- They close a note.
- They edit a note and then close the encounter workspace, regardless of whether the note is still open.



The screenshot shows the 'My Note' progress notes editor interface. At the top, there are several buttons: 'Sensitive', 'Tag', 'Share w/ Patient', and a blue 'AutoRefresh' button, which is highlighted with a red box. Below these are fields for 'Service' and 'Date of Service' (set to 2/21/2020 at 09:25 AM), and a checkbox for 'Cosign Required'. The main area is titled 'Summary:' and contains the text 'There is no problem list on file for this patient.' Below the summary is a toolbar with various icons for text formatting and SmartText insertion. At the bottom, there are buttons for 'Attached Files (0)', 'Sign when Signing Visit' (with a dropdown arrow), 'Accept' (with a green checkmark), and 'Cancel' (with a red X). The overall layout is clean and organized, typical of a medical software interface.

If a clinician enables automatically refreshing SmartLinks, that configuration applies to every note that they

write going forward, including different note types. For example, if the clinician clicks the AutoRefresh button in a progress note during an encounter with patient A, their SmartLinks continue to be refreshed automatically when they write an H&P note for patient B. The clinician can click the AutoRefresh button again to have the system stop automatically refreshing SmartLinks, but they have to click Undo or Cancel in the note editor to remove any content that was refreshed before they cleared the AutoRefresh button.

To help clinicians know whether SmartLinks in a note will be automatically refreshed, a lightning bolt icon and a message appear at the top of the note when it's closed for editing. A warning message also appears when a user first clicks AutoRefresh and again when they perform an action that will cause the SmartLinks to be refreshed. Users can select a checkbox in the warning message so they don't see it again.

The screenshot shows a software interface for managing medical notes. At the top, there are buttons for Edit, Delete, Tag, and Copy. A red box highlights a message: "This note will refresh SmartLinks when the workspace closes." Below this, the note details are shown: "Incomplete Progress Notes" by "Sasha Tash, MD" (Physician, Specialty: Family Practice), created on "2/21/2020 9:25 AM". Under the "Patient Active Problem List", it shows a diagnosis of "Diabetes mellitus" (SNOMED CT(R) code: Diabetes mellitus).

Considerations

There are several caveats to this feature, which makes it unsuitable for certain organizations. Read the following caveats to determine whether this feature is a good fit for your organization. Epic recommends against implementing this feature unless your organization is okay with every one of these caveats.

Performance Considerations

If you implement this feature, clinicians might notice that it takes longer for their notes to load, or longer for the notes to be saved after they sign them or close the chart, because SmartLinks are being refreshed. To help determine whether this performance degradation is acceptable for your organization, refer to the [Review Response Time Metrics](#) topic for information about using System Pulse Analytics to review your current performance metrics and work with your performance TS.

Notes Can Be Signed Without Final Content Review

If a clinician enables AutoRefresh and sets their note to Sign when Signing Visit, the SmartLinks in that note are refreshed after the clinician closes the encounter through the Sign Visit activity. This behavior means that a note can be updated and signed after a clinician last reviewed it. As such, you need to work with your compliance department to determine whether this behavior is appropriate for your organization, or develop a workflow to have clinicians open their note for editing to review it again before they sign the encounter.

SmartLinks aren't refreshed in notes that are already signed before an encounter is closed.

Automatically Refreshing SmartLinks Are Available Only in Ambulatory Contexts

The AutoRefresh button is available only for notes written in the ambulatory context. It doesn't appear in other contexts, such as telephone encounters, inpatient encounters, or hospital outpatient departments (HODs).

Considerations

Multi-User Workflows

When the AutoRefresh button is enabled, SmartLinks are refreshed regardless of who updated the data. For example, if one clinician adds a Problem List SmartLink and a different clinician updates the patient's Problem List, the SmartLink is updated with any problems added by the second clinician before the note is signed. This behavior might not be intuitive if the first clinician is unaware of the updates made by the other clinician.

SmartLinks Not Refreshed for Summary of Care Documents

If you configured an extension to send summary of care documents to referring providers or locations at the completion of a referral as described in the [Send Summary of Care Documents Automatically at the End of Office Visits or Inpatient Stays](#) topic, note that those documents might not contain up-to-date SmartLink content from clinicians' notes because the SmartLinks aren't automatically refreshed until after the documents are sent. However, letters and [Quick Communications](#) do contain up-to-date SmartLink content.

Additional Workflow Considerations

There are several other workflow considerations regarding automatically refreshing SmartLinks:

- SmartLinks are automatically refreshed only in notes that were edited. For example, if a clinician who enabled automatically refreshing SmartLinks opens an encounter with an existing note, but doesn't open the note before closing the encounter workspace, any SmartLinks in that note aren't refreshed.
- SmartLinks aren't refreshed automatically in patient instructions.
- SmartLinks aren't refreshed automatically when notes are edited in the My Incomplete Notes In Basket folder.
- SmartLinks aren't refreshed automatically when clinicians addend a previously signed note.
- If several SmartLinks are in a note with the AutoRefresh button enabled, there is no indication to clinicians which SmartLinks might have been automatically refreshed when they open the note for editing.
- CMS coding guidelines changes mean notes may not include many refreshable SmartLinks.
- If a clinician enables AutoRefresh for a note, they can only sign the note automatically at sign visit, not manually when saving the note.

If any of the caveats listed above make this feature unsuitable for your organization, you can alternatively add a Refresh button to the note editor toolbar to help make it easier for clinicians to manually refresh their note SmartLinks. For more information, refer to the [Add a Refresh Button in the Note Action Toolbar](#) topic.

If you're okay with all of the caveats listed above and want to implement this feature, complete the following setup to

- Configure an Interconnect queue to support automatically refreshing SmartLinks.
- Work with your Epic representative to enable automatically refreshing SmartLink.

Configure Interconnect

A synchronous Interconnect queue with a type of APPLCORE must be set up to use automatically refreshing SmartLinks. This queue is enabled as part of the Outgoing-Only [Chronicles-Configured Instances](#). If you have implemented that instance, verify the queue is running.

If you are not using the Outgoing-Only Chronicles-Configured instance, follow the instructions in [Create an Interconnect Queue](#) to create the queue using the following settings:

- Queue Name: APPLCORESYNC
- Descriptor: APPLCORESYNC
- Mode: Synchronous
- Queue Type: APPLCORE

After creating the queue, follow the steps in [Configure the Interconnect Instance to Receive Outgoing Requests](#) to configure the listeners on an existing Interconnect instance, then follow the steps in [Import Interconnect Configuration](#) to import the configuration into Kuiper and deploy it.

Enable Automatic Refreshing

Contact your Epic representative and mention parent SLG 3369576 to have your Epic representative perform the necessary setup to enable automatically refreshing SmartLinks.

Allow Clinicians to Cosign, Attest, Delete, or Edit Notes Based on Note Type or Provider Type or Specialty

You can allow clinicians to cosign, attest, delete, or edit only certain notes based on the note type, the author's provider type, or the author's provider specialty. This can allow certain clinicians to have targeted access to taking action on others' notes. For example, you might allow nurses to cosign nursing students' notes but not notes written by other types of users. Or, you might want to allow physicians to cosign most note types but require them to attest resident and med student notes instead of simply cosigning them.

You configure this behavior in profiles, and you do it using a structure of default settings and individual scenarios you want to override those defaults. You can specify an author provider type, author provider specialty, note type, or a combination of two or three of those criteria for each scenario. For example, in the case of nurses who should be allowed to cosign only notes written by nursing students, you'd set a default cosign setting of No and an override for author provider type of Nursing Student with a cosign setting of Yes. In an example where clinicians should be allowed to cosign most notes but required to attest a few specific note types, you'd set a default cosign setting of Yes and overrides for each note type with a cosign setting of No and an Attest setting of Yes.

Note Action Restriction Settings							
		Cosign		Attest		Delete	
Default:		No	No	No	No	Edit/Addendum	
Author	Author	Cosign	Attest	Delete	Edit/Addendum		
Prov Type	Prov Specialty	Note Type	Cosign	Attest	Delete	Edit/Addendum	
1. Nursing*			Yes	No	No	No	
2. []							

Use these profile settings to supplement clinicians' security to cosign, attest, delete, and edit notes so you can cover more detailed situations. If you don't configure these settings for a clinician's profile, the clinician's ability to cosign, attest, delete, and edit notes is controlled only by their security class. If these settings are set to Yes the user can take the associated action if they also have the appropriate security.

1. In Clinical Administration, open a profile and go to Note, Letter, Transcription > Note Action Restriction Settings screen.

2. In the Default Cosign (I LPR 49393), Attest (I LPR 49394), Delete (I LPR 49395), and Edit/Addendum (I LPR 49396) fields, specify the default allowed actions for clinicians.
3. Add a line for each scenario in which you want to override the default settings. Enter the author provider type (I LPR 49380), author provider specialty (I LPR 49381), note type (I LPR 49382), or a combination of two or three of those settings for each line. If you want to specify an author provider specialty or a note type for a line but not an author provider type, enter a dash (-) in the Author Prov Type field and then press Tab to access the other fields.
4. Complete the Cosign (I LPR 49383), Attest (I LPR 49384), Delete (I LPR 49385), and Edit/Addendum (I LPR 49386) field for each line you add. If you leave a field blank, a user's ability to complete the action is based on their security class configuration.

Restrict Specific Users from Taking Certain Note Actions

You can prevent specific clinicians from taking certain notes actions by configuring extension 34270-IP Notes-Restrict Action and adding it to a profile. For example, you can prevent certain users, like residents, from deleting notes that providers have cosigned if your organization considers a cosigned or signed note to be a necessary part of a patient's legal medical record. Similarly, you can prevent nurses from deleting H&P notes, which coders often depend on for billing.



You can also restrict clinicians from taking certain actions on notes based on note type or provider type or specialty. Refer to the [Allow Clinicians to Cosign, Attest, Delete, or Edit Notes Based on Note Type or Provider Type or Specialty](#) topic for more information.

To prevent clinicians from taking certain notes actions, first configure parameters in a copy of extension 34270 to specify it for a given use case. Then, add the extension to a profile.

1. In Chronicles, open the Extension (LPP) master file and make a copy of extension 34270-IP Notes-Restrict Action.
2. Go to the Parameters screen.
3. Configure the following parameters according to your organization's needs:
 - Restriction Display Message. Enter a message that appears to clinicians when they try to take a restricted action. If left blank, "Action restricted" appears.
 - Actions to Restrict. Specify the note actions to restrict.
 - Note Types to Restrict. Specify the note types to restrict.
 - Note Purposes to Restrict. Specify the note purposes to restrict.
 - Transcription Note Document Types. Specify the transcription document types to restrict.
 - Transcription Note Document Availability Statuses. Specify transcription document availability statuses to restrict.
 - Transcription Note Completion Statuses. Specify transcription completion statuses to restrict.
 - Note Author Provider Types to Restrict. Specify the provider types to restrict. If a clinician with a listed provider type is the author of the note, this parameter is ignored.
 - Note Statuses to Restrict. Specify note statuses to restrict.
 - Note Cosign Statuses to Restrict. Specify the cosign statuses that prevent specific clinicians from taking an action on a note. For example, you can prevent residents from deleting cosigned notes

that they didn't write.

4. Locate the Logic parameter.
5. Enter the numbers corresponding to the parameter that you configured in the previous step, including the logical relationship between each parameter. For example, to prevent nurses from deleting signed H&P notes that were written by a physician, enter 4&9&10. You don't need to list the Actions to Restrict parameter here.
6. In Clinical Administration, follow the path Management Options > Profiles and open a profile.
7. Go to Note, Letter, Transcription.
8. Go to the Notes General Settings - 2 screen.
9. In the Note action control extensions (I LPR 34355) field, enter your copy of extension 34270.

Make a Note Type Read-Only for Certain Clinicians



You can prevent clinicians from creating and editing notes of a specific note type by setting the note type to read-only in their profile. Clinicians can still cosign, attest, and delete these notes if they have the required security. For example, this might be helpful for an admitting physician who wants to review emergency department notes but has no reason to write them.

Considerations

Using this setting prevents clinicians from taking all actions related to writing this note type including signing, pending, and sharing. To prevent clinicians from taking individual actions for a note type instead of preventing all actions, refer to the [Note Behavior](#) topic. To limit the ability to delete, attest, or cosign the note type refer to the [Allow Clinicians to Cosign, Attest, Delete, or Edit Notes Based on Note Type or Provider Type or Specialty](#) topic.

To prevent clinicians from creating and editing notes of a specific note type, add the note type to the list of read-only note types:

1. In Clinical Administration, follow the path Management Options > Profiles and open a profile.
2. Go to Note, Letter, Transcription.
3. Go to the Notes General Settings - 3 screen.
4. In the Read-only note types (I LPR 49325) field, enter the note type you want to prevent clinicians from creating or editing.

Customize the Information Shown in Notes In Basket Messages



To help clinicians move through In Basket workflows like cosigning and completing notes more quickly and without having to switch to other activities like Chart Review, you can configure your notes-based messages to include notes-based print groups and reports.

You can add these print groups and reports to your notes-based messages only in Inpatient notes-based message

types, and Inpatient notes-based print groups and reports.

To customize the print groups and reports shown in your notes-based messages, create or copy a custom message type definition. For more information on doing so, refer to the [Create or Copy Message Types and Message Type Definitions](#) topic. You then need to link your message type definition to the message type, such as Incomplete Notes or Cosign Notes. Refer to the [Customize Message Reports to Show Relevant Information](#) topic for instructions.

Update the Shared with Patient Status for Multiple Notes



You can easily share a large set of previously blocked notes with patients by clicking Update Share with Patient in reports built from template [34001-IP Notes Report Template](#). This allows you to quickly share multiple notes at once, as opposed to manually reviewing and sharing each one individually. Using this feature, you can also block multiple notes that have been shared previously.

When someone at your organization, like an auditor or a physician, identifies a group of notes that have been blocked but should be shared, you can use this feature to share all of those notes in bulk. To do so, create a report from template 34001-IP Notes. After you run the report, you can select the notes that need to be shared and then click Update Share with Patient in the report toolbar. In the window that appears, you can choose either to block the selected notes or share them. The system notifies you if the action was successful.

To use the Update Share with Patient button in reports built from template 34001-IP Notes Report Template, you must have EpicCare security point 381-Can Bulk Update Share with Patient Setting for Notes in your EpicCare security class. For more information about updating a user security class, refer to the [Edit an Existing Security Class](#) topic.

Make sure the person responsible for auditing the shared status of notes knows about this feature so you can better coordinate which notes need to be shared or blocked.

Remind Clinicians to Include Sectioning SmartLinks in Notes



Sectioning Smartlinks are a useful tool to combat note bloat because they help clinicians organize note content efficiently into collapsible sections, allowing future reviewers to easily read a note. Using an extension (LPP), you can configure a message to show upon signing a note that reminds users to insert specified sectioning SmartLinks into the note. You can make sections required or recommended for different note types.

This feature might also be useful for specific scenarios where parts of a note are automatically sent to another provider. For example, organizations in Norway that send a Discharge Summary form that pulls information from certain note sections to patients' GPs can use this option to ensure notes contain the appropriate sections. To show the message and make sure notes written by providers contain the correct sectioning SmartLinks, configure an extension and list it in the appropriate profile.

How to set up the Extension

1. In Chronicles, navigate to the Extension (LPP) masterfile > Enter Data > Create/Edit Extension.
2. Create a new extension.
3. In your extension record, set the Type (I LPP 30) field to IP Notes Sign Validation
4. Set the Code Template (I LPP 1000) field to 175379 - MR Note Pre-Sign Validation - Sectioning SmartLinks.
5. On the Parameters screen, configure the parameters appropriately for your organization.
6. In Clinical Administration, open the appropriate profile (Management Options > Profiles (LPR)).
7. On the Notes Sign Validation screen, specify the Note Type (I LPR 34940) where you want to apply this extension, and link the extension record to it in the Validation Extension (I LPR 34941) column.

Show Last Note Times in Patient Lists or In Basket

The Last Note Date of Service and Last Note Time extensions can save users time by allowing them to see note information from Patient Lists or In Basket instead of having to go to the Notes activity to find this information. For example, they can see the date of service of the last filed note or when the last filed note was most recently edited.

You can specify whether to show only or to exclude:

- Certain note types
- Notes from the current user
- Notes from the current encounter
- Notes from the last x hours
- Notes from certain specialties
- Notes with certain statuses, such as Incomplete, Signed, or Deleted (starting in May 2023)
- Notes from certain services (starting in February 2025)

Complete these steps to show the file time or date of service for notes in the Patient Lists Last Note column:

1. Duplicate extension (LPP) 34563-IP Last Note Time or 36563-Last Note Date of Service and configure the parameters as desired. Refer to the [Duplicate and Modify an Extension](#) topic for instructions.
2. In Hyperspace, open the Column Editor and copy column 34563-IP Last Note Time or 34933-Last Note Date of Service.
3. Enter the duplicated extension in the Text ext field in your copy of the column. Use your copy of extension 34563-IP Last Note Time in your copy of column 34563-IP Last Note Time, or use your copy of extension 36563-Last Note Date of Service in your copy of column 34933-Last Note Date of Service.
4. In the My List Editor in Hyperspace, add the new column for Last Note Time or Last Note Date of Service. Refer to the [Give Clinicians Access to Columns in Patient Lists](#) topic for instructions.

Complete these steps to show the file time or date of service for notes for an In Basket message type:

1. Duplicate extension 89327-AN In Basket Last Note Time or 89627-AN In Basket Last Note Date of Service and configure the parameters as desired.
2. Duplicate and open the desired In Basket Message Type Definition, such as Cosign Notes, My Incomplete Notes, or Chart Completion. Refer to the [Create or Copy Message Types and Message Type Definitions](#) topic for instructions.
3. In the Message Type Definitions Listing Columns form, add a new column for Last Note Time or Last Note Date of Service.

4. Add the copied extension in the Extensions field.

Show OurPractice Advisories When Signing a Note or Marking a Note for Sign When Signing Visit

⌚ Starting in February 2024

You can use triggering action 49-Sign Note or Mark Note as Sign when Signing Visit to have OurPractice Advisories appear based on different note content criteria specified in the OurPractice Advisory record. When a clinician tries to sign the note or saves it as "Sign when signing visit," the system checks if note data like note type, service, or content like SmartData elements should trigger an OurPractice Advisory. If any of that information is present, the OurPractice Advisory is triggered.

Note that the OurPractice Advisories appear only when a clinician signs the note or saves it as "Sign when signing visit". The OurPractice Advisories don't appear when a clinician pends a note, edits a signed note and pends it, or shares a note.

For more information about configuring OurPractice Advisories, refer to the [Determine Basic Guidelines for Where and How Often OurPractice Advisories Appear](#) topic.

Allow More Note Types to be Copied between Birth Parents and Babies

⌚ Starting in February 2025

You can configure clinicians' profiles to allow them to copy notes of several different types between birth parents' and their babies' charts.

The screenshot shows the 'My Note' interface. At the top, there's a title 'My Note' and a row of icons: a blue square with a white grid, a blue tag-like icon, a yellow warning icon with an exclamation mark, and a blue icon with a computer monitor. Below this is a section titled 'Note Details' with fields for 'Date of Service' (11/19/2024), 'Time' (02:37 PM), 'Type' (Progress Notes), and 'Service'. There's also a checkbox for 'Cosign Required?' which is unchecked. Under 'Copy note to:', there are two checked checkboxes: 'Bartel, Lola (Birth Parent)' and 'Bartel, BabyBoy (3 days)'. A summary section is partially visible below. At the bottom is a toolbar with various icons: a star, a bold 'B', a magnifying glass, a checkmark, a blue arrow, a question mark, a green plus sign, 'Insert SmartText', and other standard document editing tools.

Clinicians can select checkboxes to copy their note in a patient's chart to the charts of the patient's birth parent and siblings linked to the patient's delivery, such as in the case of a twin delivery. The checkboxes can also be configured to be selected by default for certain note types.

Before you enable this feature for note types in addition to Lactation Notes, work with relevant clinical and legal or compliance stakeholders, such as L&D clinicians and members of your HIM, legal, and/or compliance teams, to determine which profiles and note types should be configured for copying notes between birth parents' and their babies' charts. Questions for stakeholder consideration include:

- What are the use cases at my organization for copying notes between birth parents and their babies?
- Which specialties and staff at my organization are involved in the care of birth parents and their babies? Which note types do they use now? What level of access do these users have to both birth parents' and babies' charts?
- What information does my organization consider appropriate to copy between charts, and what are the legal implications of copying that information?
- What implications does copying notes between birth parents and their babies have on my organization's strategy for complying with the Office of the National Coordinator's (ONC) [21st Century Cures Act](#) to prevent information blocking?

After you have feedback from these stakeholders, you're ready to complete the configuration described in this topic.

The following note types can be copied between birth parents and babies:

- 1-Progress Notes
- 2-Consults
- 35-L&D Delivery Note
- 36-Telephone Encounter
- 42-Lactation Note
- 70-Nursing Note
- Certain custom note types that do not have special behavior

You can also configure certain custom note types for copying between the charts of birth parents and their babies. We expect that you can configure most custom note types in this way, but some note types might have specific behavior that prevents them from being copied. For example, you cannot configure custom note types that support component-style discharge instructions. For this reason, we recommend testing custom note types thoroughly to ensure they behave as expected.

You can configure notes copied between the charts of birth parents and their babies to be stored on related outpatient encounters in their charts, if applicable. Starting in November 2025, August 2025 with special updates E11503557, E11503646, E11503647, and C11503647, and May 2025 with special updates E11411592, E11411690, E11411691, and C11411691, you can specify an encounter type to store notes when a relevant encounter does not exist. Otherwise, they are stored on Clinical Documentation Only encounters, which are sent through Care Everywhere as long as they have an undeleted, copied note stored in them. In documents generated by Care Everywhere, these encounters appear with a title of Birth Parent/Baby Shared Documentation.

The screenshot shows a software interface titled "Care Everywhere" with a navigation bar at the top. The "Documents" tab is selected. Below the navigation bar, there are buttons for "Preview", "Refresh (3:14 PM)", and "Review Selected". A "Filters" section includes a checked "Default filter" button and an unchecked "Patient Summaries" button. The main area displays a table with columns: Date, Type, Specialty, Providers, Source, Title, and Description. The table lists four entries under the heading "Today".

Date	Type	Specialty	Providers	Source	Title	Description
Today	Clinical Summary			✓ Community Practice		
Today	Admission	Obstetrics	Obstetrics-Gynecology, Physician	✓ Community Practice	Hospital Encounter Summary	
Today	Clinical Documentation Only	Obstetrics		✓ Community Practice	Birth Parent/Baby Shared Documentation	
Today	Office Visit	Obstetrics	Obstetrics-Gynecology, Physician	Community Practice		

Clinical Documentation Only encounters with undeleted, copied notes stored in them can be sent through Care Everywhere.

The following encounter types can store copied notes:

- 49-Lactation Encounter
- 76-Telemedicine
- 91-Home Care Visit
- 101-Office Visit
- Custom encounter types

To ensure that notes can only be copied to relevant encounters, such as well-baby visits that are scheduled for both the birth parent and their baby, the system can store a copied note on an outpatient encounter only if the encounter meets all of the following conditions:

- Its type is specified in one of the following places:
 - The Enabled outpatient encounter storage types (I LPR 29075) field.
 - Starting in November 2025, August 2025 with special updates E11503557, E11503646, E11503647, and C11503647, and May 2025 with special updates E11411592, E11411690, E11411691, and C11411691, the Encounter Type (I LPR 29074) field.
- It is on the same day as the encounter that contains the original note.
- It is in the same department as the encounter that contains the original note.
- It shares at least one care team member with the encounter that contains the original note.
- It is scheduled within one hour of the encounter that contains the original note.
- It is still open.

We recommend reviewing your strategy for complying with the Office of the National Coordinator's (ONC) [21st Century Cures Act](#) to determine whether any of the encounter types that can store copied notes, including Clinical Documentation Only encounters, are currently hidden from patients in MyChart, and whether they should instead be shown to comply with the [21st Century Cures Act](#). If you determine that certain encounter types are hidden that should instead be shown to patients in MyChart, refer to the [Configure the Appearance of Open and Past Encounters in MyChart](#) topic to adjust your settings. Work with your MyChart and compliance teams to make this change.



You can use the Build Wizard to update profiles to allow clinicians to copy notes of several different types between birth parents' and their babies' charts. To get started, open the Build Wizard (search: Build Wizard) and search for feature 150072-Support Birth Parent/Baby Note Copying for Additional Note Types (application: Stork). If you need adjust these settings, refer to the manual instructions below.

Follow these steps to allow clinicians to copy notes of types including Lactation Note between birth parents' and their babies' charts:

1. Determine which profiles you want to configure.
2. In Clinical Administration, go to Management Options > Profiles > the profile you want to configure.
3. Go to Specialties, Other Modules > Obstetrics. Page down to the Birth Parent/Baby Note Copying Settings screen.
4. In the Birth parent/baby note copy creation enabled? field (I LPR 29070), select Yes.
5. In the Note Type field (I LPR 29071), enter the note types you want to allow clinicians to copy between birth parents and babies. In your system-level profile, Lactation Note is the first note type set by default.
6. In the Maximum Baby Age (Days) field (I LPR 29072), enter the maximum age in days a baby can be for a clinician to copy a birth parent/baby note to their chart.
7. In the Selected by Default? Field (I LPR 29073), enter Yes if the checkbox to copy the note should be selected by default for that note type.
8. Starting in November 2025, August 2025 with special updates E11503557, E11503646, E11503647, and C11503647, and May 2025 with special updates E11411592, E11411690, E11411691, and C11411691, in the Encounter Type (I LPR 29074) field, enter the encounter type that should be created to store copied notes if an existing encounter that can be copied to does not exist.
9. In the Enabled outpatient encounter storage types field (I LPR 29075), list the outpatient encounter types that should store copied notes if a patient does not have an ongoing admission encounter.

Some information and functionality, such as note tags, are not copied between birth parents and their babies. Sensitive notes also cannot be copied. Copying notes between birth parents and their babies is not supported on mobile.

Remind Clinicians to Include SmartBlocks in Notes

Starting in August 2024

May 2024 by special update E10901009

February 2024 by special update E10806660

November 2023 by special update E10710568

SmartBlocks are a useful tool to help clinicians write notes quickly by clicking buttons rather than typing or dictating. To help make sure that clinicians include SmartBlocks as intended, you can configure your system to stop them from signing notes that don't contain the SmartBlocks you specify as required. If a clinician tries to sign a note that doesn't contain a required SmartBlock, a message appears that tells them what SmartBlock they need to add before they can sign the note. You can make a SmartBlock required or recommended for different note types.

To show the message and make sure notes written by providers contain the required SmartBlock complete the following steps:

1. In Chronicles, open the Extension (LPP) master file and duplicate extension 36559-IP Note Sign Validation - Note Contains SmartBlock.
2. On the Parameters screen, only Parameters 7 and 9 are essential for the validation check to work, but all the parameters below can be configured for your organization.
 - Parameter 7-SmartBlock ID: The SmartBlock that should be required in the note content. If you don't specify anything here, clinicians are always allowed to sign the note and an error is logged to the Error Log indicating that the extension needs to be updated.
 - Parameter 8-Validate Application Context: The application context relating to the patient's encounter (e.g. an Inpatient encounter or HOV encounter) that this requirement should apply. If application contexts are specified, the requirement applies only to those listed. If no application contexts are specified, the requirement applies in all contexts.
 - Parameter 9-Is Hard-Stop: Set this parameter to Yes to prevent clinicians from signing notes that don't include the specified SmartBlocks. Set this parameter to No or leave it blank to show a warning but give clinicians the option to edit the note before signing or continue with the current sign action.
 - Parameter 10-Primary Error Message: If a value is specified in this field, that value appears as the **bold** text in the error message. Otherwise, the text "Note is missing required documentation: (SmartBlock)" appears.
 - Parameter 11-Error Message Description: If a value is specified in this field, that value appears as the subtext in the error message. Otherwise, the text "Add (SmartBlock) to your note." appears.
 - Parameter 12-Include SmartTool Information: Set this parameter to 1 to show additional information in the error message about the SmartText or SmartPhrase first pulled into the note. If the first SmartTool is a SmartBlock or SmartLink, no additional information appears. If this parameter is set to 0 or left blank, no additional information appears.
3. In Clinical Administration, open the profile to which you want the sign note validation check to apply.
4. On the Notes Sign Validation screen, enter the note type for which the SmartBlocks should be required in the Note Type (I LPR 34940) column and enter the extension you configured in the Validation Extension (I LPR 34941) column.

Jump to More Types of Incomplete Notes From the Sign Visit Activity

 Starting in May 2025

 February 2025 by SU E11307819

Clinicians can directly open their incomplete notes from the Sign Visit activity with the Jump To button. Starting in August 2025, in May 2025 with special update E11403447, and in February 2025 with special update E11308614, the note types that you specify in the Additional Note Types (I LPR 49322) field automatically open in the Progress Notes sidebar when a clinician clicks the Jump To button.

By default, clinicians can go to the following note types:

- 1-Progress Notes

- 2-Consults
- 3-Procedures
- 4-H&P Notes
- 36-Telephone Documentation
- 37-Patient Instructions
- 38-Assessment and Plan Note
- 70-Nursing Notes
- 80-Radiation Planning Notes
- 81-Radiation Completion Notes
- 82-Radiation Therapy Simulation Directive
- 83-Radiation Treatment Planning Directive
- 84-Radiation Treatment Management
- 85-Radiation Treatment Summary
- 94-Group Note

If your organization uses other note types, you can allow clinicians to directly open incomplete notes of those types from the Sign Visit activity.

To allow clinicians to use the Jump To button for other note types:

1. In Clinical Administration, open a profile.
2. Go to the Notes Navigator Section Type Mapping screen.
3. In the Note Type (I LPR 49323) field, enter the note type you want to map.
 - a. Starting in August 2025, in May 2025 with special update E11402428, and in February 2025 with special update E11307819, you can configure all note types except for note types 37-Patient Instructions, 38-Assessment and Plan, and 94-Group Note.
4. In the Navigator Section Type (I LPR 49324) field, enter the navigator section type you want to link to the associated note type.

For information about creating custom note types and linking them to navigator sections, refer to the [Make Note Types Available to Clinicians](#) topic. Refer to the [Allow Clinicians to Write Different Note Types in One Place](#) topic for more information about enabling multiple note types in the Notes sidebar activity.

Preventing Automatic Note Creation When Opening the Notes Section

 **Starting in August 2025**

 **May 2025 by SU C11403913**

 **February 2025 by SU C11309174**

You can configure whether a new note is automatically created when a clinician first opens an edit-only note navigator section in an encounter. This automatic note creation might not be the right behavior if, for example, a clinician has multiple note types configured and the primary note type isn't the correct note type to use in most cases. Additionally, clinicians can always see all their note templates if you prevent automatic note creation.

When the Prevent auto note creation (I LPR 49326) field is set to No or left blank, new notes are created when a clinician first opens the Notes section. When this field is set to Yes, new notes aren't created in this case. Regardless of this setting, when a clinician first opens the Notes section in an encounter with one of their unsigned notes, that note still automatically opens.

To disable automatic note creation:

1. In Clinical Administration, open a profile.
2. Go to the Notes General Settings - 5 screen.
3. In the Prevent auto note creation (I LPR 49326) field, enter Yes.

Notes Utilities: Correct Existing Notes

This section describes how to use tools to correct errors, such as inaccurate note metadata and notes associated with the wrong patient, and to automatically clean up pended data after a patient is discharged.

Re-link Partial Dictations to Their Parent Note

⌚ Starting in November 2022

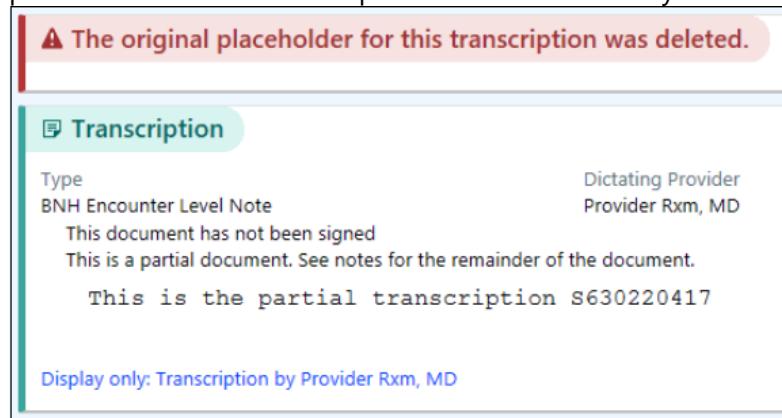
⭐ May 2022 by SU E10211035

⭐ February 2022 by SU E10114844

In rare circumstances, partial dictation files can become unlinked from their parent note. When this occurs, you can use the Repair Partial Dictation Links utility to re-link partial dictations to their parent note.

You can identify affected partial dictation files in the following ways:

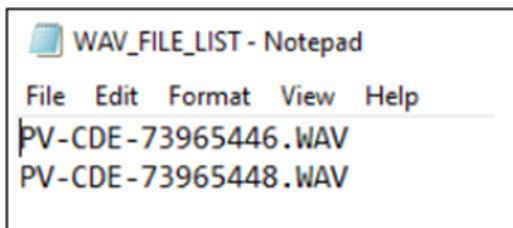
- If you use a Transcription Interface, error 6155 is logged in your EDI error queue.
- Regardless of whether your organization uses an interface, a banner appears in In Basket when a user authenticates a transcription to notify the user that the partial dictation cannot be merged back into the parent note. Users should report this error to an analyst.



Before you run the utility to re-link partial dictations, you need to find the partial dictation identifier. These identifiers start with PV- and end in .WAV. If you have installed May 2022 special update E10210512 or February 2022 special update E10114494, or if you use November 2022 or a later version, the identifier appears in the tooltip of the partial dictation SmartLink.

In other versions, you can find the identifier in the Note Rich Text (RTF) (I HNO 41) item, which you can view in the Record Viewer.

After you've found the identifier, compile a list of the unlinked partial dictation identifiers in a text file editor with one identifier per line. Save your document as a .txt file. It should look something like this:



Next, take the following steps to run the Repair Partial Dictation Links utility and re-link partial dictations to their notes:

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Repair Partial Dictation Links.
2. On the Utility Options - Screen 1 screen, enter select the Mode option and choose Fix Mode.
3. Select Continue to go to the next screen.
4. On the File Selection screen, set Input File to the path of the .txt file that contains your partial dictation identifiers.
5. Set Output File to a file path with a .txt file where the utility can print its report.
6. Select Continue to run the utility.
7. The report in the output file returns a status for each listed partial dictation identifier.

Regenerate Partial Dictation Metadata Files

Starting in February 2023

If your clinicians record partial dictations within Epic that are transcribed by a third-party vendor, you might occasionally find that the metadata files associated with the dictation are not generated, preventing the complete transcription from being filed correctly. When this occurs, you can use the Regenerate Partial Dictation Metadata utility to regenerate the file.

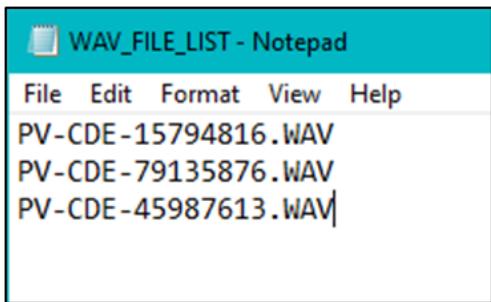
There are two main ways to determine whether you have missing metadata files, making it necessary for you to run this utility:

- The existence of partial dictation .WAV files over an hour old without corresponding metadata files is an indicator that the files were not generated. To view .WAV files:
 - a. In Clinical Administration, open your facility record and identify the external server configuration (E0A) record linked in the Duplicate Dictation Setting (I EAF 17703) field.
 - b. Open the external server configuration you identified in step 1 and check the Dictation Location (I E0A 55) field.
- The absence of expected completed transcriptions from the third-party vendor is another indicator of missing metadata files. Analyze the transcriptions your organization receives from its third-party vendor and if you notice there are files missing or you have not received a transcription for some time you may need to run this utility.

Before you run the utility, you need to create a text (.txt) file that lists the partial dictation identifiers. These identifiers start with PV- and end in .WAV. You can find the partial dictation identifier in one of two ways:

- Check the names of the .WAV files. The automatically generated file name of each .WAV file is the partial dictation identifier.
- Check SmartLink 20001-Partial Dictation Link. The identifier can be found in the tooltip or in the Partial Dictation Identifiers (I HNO 250/251) field.

After you have found the identifiers, compile a list of the partial dictations with missing metadata in a text file editor with one identifier per line. Save your document as a .txt file. It should look like this:



Next, run the Regenerate Partial Dictation Metadata utility:

1. Use one of the following paths:
 - Starting in August 2024, in Clinical Administration, go to Management Options > Utilities > Application Utilities > Clin Doc/Stork > Notes > Regen Partial Dictation Metadata.
 - In May 2024 and earlier, in Clinical Administration, go to Management Options > Utilities > Clin Doc/Stork > Notes > Regen Partial Dictation Metadata.
2. On the Run Setup screen:
 - a. Enter 1 to select the Mode option and choose 2-Fix Mode.
 - b. Enter 6 to specify an absolute file path to save the Exception file to.
 - c. Enter 7 to specify an absolute file path to save the Report file to.
 - d. Enter 8 to specify the file path of the .txt file containing the partial dictation identifiers.
3. Once you have verified all the information is correct enter 9 to continue.
4. At the prompt asking if you want to continue with the current settings input 'Yes' to run the utility.

Add a Service to Past Notes

You can use a utility to add a service to past notes. Having a service on past notes gives clinicians more context when they review those notes. For example, you could update all past notes that were written by providers with a cardiology specialty in an inpatient setting to have cardiology as the note's service.

Your Epic representative will need to run the utility, but you'll need to identify which sets of notes you want to update. You can update all notes or a certain group of notes to a specific service, or you can update the service of notes based on:

- The default service of the note's author.
- The specialty of the note's author, if the note was written in an inpatient setting. Starting in November 2022, this option is also available for notes written in an outpatient setting.
- The department where the encounter occurred, if the note was written in an outpatient setting.

Contact your Epic representative to run this utility and mention parent SLG 860583.

Change the Note Type of Signed Notes

You can use the Note Type Change tool to update the Note Type field in signed notes. This is helpful when:

- Clinicians sign notes with the wrong note type.
- An interface files transcriptions with the wrong note type.

To access the Note Type Change tool, users need Identity security point 2001-Note Type Change.

To use this tool to change note types:

1. In Hyperspace, open Chart Correction Tools (search: Chart Correction Tools).
2. In the Show tools that run on field, enter a filter of Notes.
3. Locate the Note Type Change tool. Click Start.

For more information about configuring the Note Type Change tool, refer to the [Determine How Chart Correction Tools Run](#) topic.

Change a Note's Author Provider Type

You can use the Change Author's Provider Type utility to change the provider type of filed notes. This utility allows you to quickly change a subset of notes filed with the wrong provider type instead of having to update each note individually.

For example, if a nurse practitioner's provider record is incorrectly set up with a provider type of nurse anesthetist, any notes she creates have the wrong provider type. You can use the Change Author's Provider Type utility to correct the provider type for all the notes she filed with a provider type of nurse anesthetist.

You can change the author provider type for an individual note or multiple notes. If you want to change many notes at one time, create a subset of notes.

As a precaution, run the utility in Report mode first to verify the changes you want to make and then run the utility in Commit mode to execute the changes.

Create a Subset of Notes to Update

1. In Chronicles, open the Notes (HNO) master file.
2. Follow the path Subsets > Create Subset.
3. At the Name for Subset prompt, enter a name.
4. At the Description prompt, enter a description.
5. At the Public? prompt, enter Yes or No. If you enter Yes, other administrators can use this subset.
6. At the Expiration Date prompt, enter a date.
7. At the Notes prompt, enter a note's record ID. The prompt reappears after you press Enter. Repeat this process for each note you want to add to your subset.
8. At the Contacts prompt, enter All and press Enter.

Run the Utility to Change the Provider Type

If you want to correct many notes at once, follow the steps in the [Create a Subset of Notes to Update](#) topic to create a subset.

1. In Clinical Administration, follow the path Management Options > Utilities > Application Utilities > Clin Doc/Stork > Notes > Change Author's Provider Type.
2. At the New Provider Type prompt, enter the provider type that you want to associate with the subset of notes and press Enter.
3. Enter 1 to run the utility in report mode.
4. Enter 1 to use the subset of notes you created or enter 2 to specify the IDs of individual notes.
5. At the Select the contact logic prompt, choose whether to change only the last contact, all contacts, or only the contacts specified in the subset.

6. Press Enter to start the utility. Notes that the utility can change are saved in the HNOPROVCHNG subset. Press Enter.
7. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
8. Enter a file path where the results should be saved. Press Enter to run the utility.
9. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
10. If desired, enter a reason for changing the provider type at the Reason prompt. This should be a valid chart correction reason.
11. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the provider type is changed.
12. Enter Yes to use the subset created when you ran the utility in report mode.
13. If desired, enter an email address and then enter the file path where the results should be saved. Press Enter to run the utility.

Change a Note's Author

The Change Note Author utility allows you to change the user (EMP) and provider (SER) associated with a note or subset of notes.

For example:

- If a clinician inadvertently logged in with the wrong user profile during her shift, you can use this new utility to quickly change the user and provider associated with all notes she wrote during that shift.
- If a clinician's user record was inadvertently associated with the wrong provider record, you can use this utility to change the provider associated with notes he wrote.

The Change Note Author utility has two options:

- Change EMP authorship for selected notes
- Change SER authorship only for selected notes

When the utility updates the EMP associated with a note, it always changes the note's SER to the record associated with the new EMP record. If you want to change only the EMP record, you can use the first option to change the EMP record, and then use the second option to change the SER record back to the desired value.

Create a Subset of Notes to Update

1. In Chronicles, open the Notes (HNO) master file.
2. Follow the path Subsets > Create Subset.
3. At the Name for Subset prompt, enter a name.
4. At the Description prompt, enter a description.
5. At the Public? prompt, enter Yes or No. If you enter Yes, other administrators can use this subset.
6. At the Expiration Date prompt, enter a date.
7. At the Notes prompt, enter a note's record ID. The prompt reappears after you press Enter. Repeat this process for each note you want to add to your subset.
8. At the Contacts prompt, enter All and press Enter.

Run the Utility to Change the User

If you want to correct many notes at once, follow the steps in the [Create a Subset of Notes to Update](#) topic to

create a subset.

1. In Clinical Administration, follow the path Management Options > Utilities > Application Utilities > Clin Doc/Stork > Notes > Change Note Author > Change EMP authorship.
2. At the User prompt, enter the EMP record that you want to replace. The utility will use this value to ensure that only notes with the desired EMP record are corrected, regardless of whether there are additional notes in the subset.
3. At the second User prompt, enter the EMP record that should replace the value you entered in step 2.
4. The utility displays the EMP you've chosen to replace and the EMP you've chosen to replace it with.
 - If the values are correct, enter Yes.
 - If not, enter No to go back and correct them.
5. Enter 1 to run the utility in report mode.
6. Enter 1 to change the EMP for a subset of notes or enter 2 to change the EMP for only one note.
7. Enter the subset or note ID.
8. Choose whether to change only the most recent contact of a note, all contacts, or only contacts specified in the subset.
9. Press Enter to start the utility.
10. Notes that the utility can change are saved in the HNOAUTHRCHNG subset. Press Enter.
11. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
12. Enter a file path where the results should be saved. Press Enter to run the utility.
13. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
14. If desired, enter a reason for changing the author at the Reason prompt. This should be a valid chart correction reason.
15. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the cosign requirement is changed.
16. Enter Yes to use the subset created when you ran the utility in report mode.
17. If desired, enter an email address and then enter the file path where the results should be saved. Press Enter to run the utility.

Run the Utility to Change Only the Provider

If you want to correct many notes at once, follow the steps in the [Create a Subset of Notes to Update](#) topic to create a subset.

1. In Clinical Administration, follow the path Management Options > Utilities > Application Utilities > Clin Doc/Stork > Notes > Change Note Author > Change SER authorship only.
2. At the Provider prompt, enter the SER that you want to add to notes.
3. Enter 1 to run the utility in report mode.
4. Enter 1 to change the SER for a subset of notes or enter 2 to change the SER for only one note.
5. Enter the subset or note ID.
6. Choose whether to change only the most recent contact of a note, all contacts, or only contacts specified in the subset.
7. Press Enter to start the utility.

8. Notes that the utility can change are saved in the HNOAUTHRCHNG subset. Press Enter.
9. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
10. Enter a file path where the results should be saved. Press Enter to run the utility.
11. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
12. If desired, enter a reason for changing the author at the Reason prompt. This should be a valid chart correction reason.
13. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the cosign requirement is changed.
14. Enter Yes to use the subset created when you ran the utility in report mode.
15. If desired, enter an email address and then enter the file path where the results should be saved. Press Enter to run the utility.

Change a Note's Cosign Requirement

We recommend using a chart correction tool in Hyperspace to change a note's cosign requirement instead of using the Clinical Administration utility described here. Refer to the [Determine How Chart Correction Tools Run](#) topic for more information about the Note Cosign Requirement Change tool.

You can use the Change Cosign Requirement utility to add or remove a cosign requirement for a single note or for a subset of notes. When you add a cosign requirement, the utility attempts to identify an appropriate cosigner, sends an In Basket message to the cosigner, and creates a deficiency for the note, if applicable. When you remove a cosign requirement, the utility attempts to retract In Basket messages sent to the former cosigner and deletes any associated deficiencies. The utility ignores any notes that have already been cosigned.

Note that this utility can repost any existing placeholder charges attached to the notes it changes and revert any coding changes to those notes.



If your organization has an [Outgoing Documentation Interface](#) set up, be aware that this utility triggers an interface message for each note that is changed. Interface configuration determines whether a message is sent or if the event is filtered out. Be sure to communicate your plans to run this utility with the EDI team so that they can determine how to handle the potential surge of messages.

Create a Subset of Notes to Update

1. In Chronicles, open the Notes (HNO) master file.
2. Follow the path Subsets > Create Subset. Enter a name and description for the subset.
3. At the Public? prompt, enter Yes or No. If you enter Yes, other administrators can use this subset.
4. At the Expiration Date prompt, enter a date.
5. At the Notes prompt, enter a note's record ID. The prompt reappears after you press Enter. Repeat this process for each note you want to add to your subset.
6. At the Contacts prompt, enter All and press Enter.

Run the Utility to Add a Cosign Requirement

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Change Cosign Requirement > Add Cosign Requirement.
2. Choose the method that the utility uses to determine who is responsible for cosigning the note:

- Enter 1-Select a user record to enter a single cosigner.
 - Enter 2-Select the staff provider in the note (HNO 1035) to use the provider recorded as the staff provider in the note. This option works only for transcriptions.
 - Enter 3-Select the attending provider for the visit to use the provider recorded as the attending provider for the encounter.
3. Enter 1-Run Utility in Report Mode.
 4. Choose whether to run the utility for a subset of notes or a single note:
 - Enter 1-Subset of HNO Records to run the utility for a subset of notes.
 - Enter 2-Individual HNO Records to run the utility for only a single note.
 5. Enter the subset or ID.
 6. Choose whether to change only the most recent contact of a note or all contacts.
 7. Press Enter to start the utility. Notes that the utility can change are saved in the HNOCOSIGNCHNG subset. Press Enter.
 8. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
 9. Enter a file path where the results should be saved.
 10. Press Enter to run the utility.
 11. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
 12. If desired, enter a reason for changing the cosign requirement at the Reason prompt. This should be a valid chart correction reason.
 13. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the cosign requirement is changed.
 14. Enter Yes to use the subset created when you ran the utility in report mode.
 15. If desired, enter an email address and then enter the file path where the results should be saved. Press Enter to run the utility.

Run the Utility to Remove a Cosign Requirement

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Change Cosign Requirement > Remove Cosign Requirement.
2. Enter 1-Run Utility in Report Mode.
3. Choose whether to run the utility for a subset of notes or an individual note.
4. Enter the subset or ID.
5. Choose whether to change only the most recent contact of a note or all contacts.
6. Press Enter to start the utility. Notes that the utility can change are saved in the HNOCOSIGNCHNG subset. Press Enter.
7. If desired, enter an email address to receive an email when the utility is done running.
8. Enter a file path where the results should be saved.
9. Press Enter to run the utility.
10. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
11. If desired, enter a reason for changing the cosign requirement at the Reason prompt. This should be a valid chart correction reason.

12. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the cosign requirement is changed.
13. Enter Yes to use the subset created when you ran the utility in report mode.
14. If desired, enter an email address and then enter the file path where the results should be saved. Press Enter to run the utility.

Remove or Reattach a Note in a Patient's Record

A deleted note remains a part of a patient's record and appears in certain areas of Hyperspace, such as Chart Review. You can use the Remove Patient Association utility in cases when it is appropriate to completely remove one or more notes from a patient's record, such as when a clinician accidentally documents in the wrong patient's chart. You can use the Reattach Patient utility to associate one or more notes with a patient's medical record after it has been removed using the Remove Patient Association utility.

You can remove or reattach individual or multiple notes in a patient's record. If you want to remove or reattach many notes at one time, create a subset of notes.

As a precaution, first run the utility in Report mode first to verify the changes you want to make and then run the utility in Commit mode to execute the changes.

To use the utility, you need to know the record ID of any notes you want to remove or reattach. To find a note's record ID:

1. In Hyperspace, open the note in the patient's chart.
2. Follow the path Epic button > Help > Session Information Report.
3. In the Session Information Report, click Show Report and Print Group IDs to turn on Report/HTML assistance.
4. Return to the note. The record ID of the note appears in the note header with the label HNO ID.

Create a Subset of Notes to Update

1. In Chronicles, open the Notes (HNO) master file.
2. Follow the path Subsets > Create Subset.
3. At the Name for Subset prompt, enter a name.
4. At the Description prompt, enter a description.
5. At the Public? prompt, enter Yes or No. If you enter Yes, other administrators can use this subset.
6. At the Expiration Date prompt, enter a date.
7. At the Notes prompt, enter a note's record ID. The prompt reappears after you press Enter. Repeat this process for each note you want to add to your subset.
8. At the Contacts prompt, enter All and press Enter.

Remove a Note from a Patient's Record

If you want to remove many notes at once, follow the steps in the [Create a Subset of Notes to Update](#) topic to create a subset.

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Deletion Utilities > Remove Patient Association.
2. Enter 1 to run the utility in report mode.

3. Enter 1 to use the subset of notes you created or enter 2 to specify the IDs of individual notes.
4. Press Enter to start the utility. Notes that the utility can change are saved in the HNODELUTIL subset. Press Enter.
5. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
6. Enter a file path where the results should be saved. Press Enter to run the utility.
7. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
8. If desired, enter a reason for removing the note at the Reason prompt. This should be a valid chart correction reason.
9. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the provider type is changed.
10. Enter Yes to use the subset created when you ran the utility in report mode.
11. If desired, enter an email address and then enter a file path where the results should be saved. Press Enter to run the utility.

Reattach a Note to a Patient's Record

If you want to reattach many notes at once and you haven't already created a subset, follow the steps in the [Create a Subset of Notes to Update](#) topic to create a subset.

1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc/Stork > Notes > Deletion Utilities > Reattach Patient.
2. Enter 1 to run the utility in report mode.
3. Enter 1 to use the subset of notes you created or enter 2 to specify the IDs of individual notes.
4. Press Enter to start the utility. Notes that the utility can change are saved in the HNODELUTIL subset. Press Enter.
5. If desired, enter an email address to receive an email when the utility is done running. Press Enter.
6. Enter a file path where the results should be saved. Press Enter to run the utility.
7. After you are satisfied with the results of the utility in report mode, run the utility in commit mode.
8. If desired, enter a reason for removing the note at the Reason prompt. This should be a valid chart correction reason.
9. If desired, enter a chart correction comment at the Comments prompt. This comment will appear in the chart correction record created when the provider type is changed.
10. Enter Yes to use the subset created when you ran the utility in report mode.
11. If desired, enter an email address and then enter a file path where the results should be saved. Press Enter to run the utility.

Delete Pended Inpatient Notes from Old Encounters

You can clean up patient records by deleting pended inpatient notes for patients who have been discharged. When pended notes for discharged patients are older than a certain number of days, they often won't or shouldn't be completed based on your facility's policies. Use a batch job to permanently delete these notes from the system so they no longer appear in Hyperspace. Note that this batch job doesn't delete transcriptions.

1. In Clinical Administration, follow the path Management Options > Utilities > Batch Menu > Job Enter/Edit.
2. Create a new batch job.

3. Enter 34300-IP Delete Incomplete Notes in the Template to use field.
4. Access the Single and Multiple Response Values screen.
5. Enter the number of days that pended notes can remain in a patient's chart after discharge in the Days Before Purge field. Any pended inpatient notes that are older than the number of days you specify will be deleted.
6. If you don't want to delete incomplete revisions, enter No in the Delete Incomplete Revisions field. Starting in May 2025, February 2025 with special update E11302072, and in November 2024 with special update E11207601, incomplete revisions created with chart correction workflows are excluded from the purge regardless of the setting on this field.
7. If you want to limit how far back the batch job searches for discharged patients with pended notes, enter a number of days in the Days Back To Delete field. For example, if you want to delete pended notes only for patients discharged in the last 6 months, enter 180. This value should be greater than the value entered in the Days Before Purge field. If this field is left blank, pended notes are deleted for all patients with discharges older than the number of days specified in the Days Before Purge field.
8. Starting in May 2024, if you want to delete incomplete shared notes, enter Yes in the Delete Incomplete Shared Notes field.
9. At the Batch Menu, select Batch Enter/Edit.
10. Create a new batch or open an existing batch.
11. Enter your batch job in the Job Name field of the table.
12. At the Batch Menu, select Run Enter/Edit.
13. Create a new batch run.
14. Enter the batch containing your batch job in the Batch Name field.
15. Schedule the run. See the [Define and Submit a Run](#) topic for more information.

Automatically Delete Pended Notes After Discharge

You can configure the system to automatically delete pended notes and incomplete revisions after a patient is discharged. This prevents clinicians from needing to manually delete incomplete notes that were never filed to the patient's chart, which saves clinicians time and reduces clutter in the Notes activity. Starting in May 2025, February 2025 with special update E11302072, and in November 2024 with special update E11207601, incomplete revisions created with chart correction workflows are excluded from the purge.

1. In Hyperspace, go to Epic button > Admin > Access Management > User Security. Create a generic user to be used as the default user for automatically deleting incomplete notes. You might already have such a user for automatically discontinuing orders or removing LDAs at discharge.
2. In Clinical Administration, access EMR System Definitions.
3. Select Admission, Hospital Outpatient and access the Discharge Actions - 1 screen.
 - If you want the system to delete all incomplete notes of all types, enter All in the Incomplete note types to delete (I LSD 11286) field.
 - If you want the system to delete incomplete notes of selected types, enter Selected Only in the Incomplete note types to delete field. Then, enter the selected note types in the If not all, specify note types (I LSD 11285) field.
4. By default, the system uses the value in the Allow deletion of shared notes (I LSD 34027) field on the Notes General Options - 2 screen of EMR System Definitions when deleting shared pended notes. Enter Yes in the

- Delete shared notes (I LSD 11287) field to override that setting when automatically deleting incomplete notes at discharge.
5. Navigate to the Discharge & Close Encounter screen of EMR System Definitions to have the system delete incomplete notes. In the Foundation System, incomplete notes are deleted with a delay time of 725 hours.
 - In the Action (Optional) (I LSD 11275) field, enter 2-Cancel Incomplete Notes.
 - Optionally enter a delay time. To change the delay time for all discharge actions, enter a time in the Delay (Default) (I LSD 11250) field. To change the delay time for canceling incomplete notes only, enter a time in the Delay Time in Hours (Optional) (I LSD 11276) field. This value overrides the value in the Delay (Default) (I LSD 11250) field.
 6. On the same screen, specify the generic user. You can do this in two ways:
 - Specify a user for all discharge actions. The user in the Discharge User (Default) (I LSD 11258) field applies to all discharge actions unless otherwise specified.
 - Specify a user for canceling incomplete notes only. To do this, enter 2-Cancel Incomplete Notes in the Action (Optional) (I LSD 11275) field. In the same line, enter a user in the Discharge User (Optional) (I LSD 11277) field.

Update Sensitivity for Past Notes

You can use a utility to mark a specific set of existing notes as sensitive. This utility is particularly useful if notes that were created before your organization implemented sensitive notes should be marked as sensitive or if a large group of notes that shouldn't be sensitive were marked as sensitive by mistake.

You can use the utility to mark notes as either sensitive or not sensitive taking the following criteria into account as needed:

- Department
- Department specialty
- Encounter type
- Chronicles subset

Before marking a set of notes as either sensitive or not sensitive you can run the utility in report mode to view a list of the notes that would be affected.

When you use the utility, an action of Note Metadata Change is logged in the Notes audit trail (I HNO 34040) for each affected note.

To run the utility, in Clinical Administration, follow the path Management Options > Utilities > Application Utilities > Clin Doc/Stork > Notes and select Mark Notes Sensitive/Not-Sensitive.

List Corrupted Notes by Patient

Very rarely, when clinicians are copying forward a previously written note for a patient, an element in the copied note causes Hyperspace to terminate unexpectedly. In these cases, the notes are still available in the system, but they are flagged such that they are no longer editable by the clinician.

We've created a utility that you can use when physicians contact you about notes that they can't edit. You can use this utility to look up notes by patient to find specific note IDs, save them to a subset to remove the flags from notes by group, or save them to a .csv file for further analysis.

In Clinical Administration, navigate to Management Options > Utilities > Application Utilities > Clin Doc/Stork >

1. Enter information to find the patient, and select the correct patient if several appear.
2. Corrupted notes in the patient's record appear in a list.
 - If you're looking for a specific note ID based on the patient's name, it will likely appear in this list.
3. If you want to save the results to a subset to unflag as a group, enter Yes.
 - You can use the Unmark Corrupt Notes utility to remove flags from a subset of notes rather than one note at a time.
4. If you want to save the results to a .csv file for further reference, enter Yes.

Reset Non-Production Notes Activity Settings

The Reset Notes Activity Cache button makes troubleshooting build and testing faster by quickly updating user settings that affect Notes behavior, so they are reflected in the system faster.

In the web-based Notes activity in non-production environments, this button is located on the Notes toolbar or under the More menu. When you make changes to user settings and want to test them right away, click the Reset Notes Activity Cache button, and then refresh the activity to see most changes immediately. Some changes might require you to close and reopen the activity instead of refreshing.

Notes Support: Reporting

This section describes several ways that you can report on and investigate note usage at your organization.

Reporting Index

You can use reports built from the [IP Notes Report Template](#) to report on notes, including reports that help you:

- Find blank notes.
- Find notes that need to be signed or cosigned.
- Report on copied content.
- Find notes with excessive amounts of copied content.

Report on Incomplete Note Statistics

You can report on your facility's incomplete note statistics using the Pended Notes utility, which can be helpful during or after implementing clinical documentation to track how and when notes are being marked as incomplete.

The utility creates an XML file that you can then open from Microsoft Excel. The file can include information about:

- Which types of providers marked notes as incomplete.
- What time each type of provider marked notes as incomplete.
- What note types were marked as incomplete.
- How many notes were marked as incomplete in each department.
- Which clinicians marked notes as incomplete and how many notes each clinician marked as incomplete.
- How many notes were marked as incomplete at specific times of the day.

To run the utility, follow these steps:

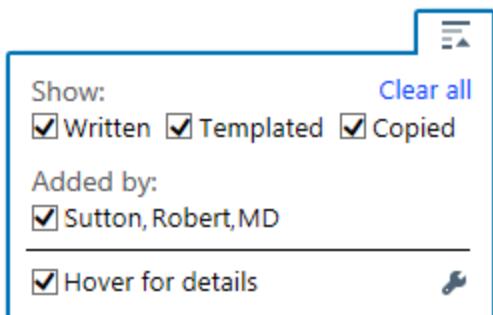
1. In Clinical Administration, follow the path Management Options > Application Utilities > Clin Doc > Notes > Pended Note Info.
2. Follow the search criteria prompts:
 - Choose the search criteria for patients from the following options:
 - Discharge date range
 - Admission date range
 - Currently admitted patients
 - Current patient department
 - Enter the remaining search criteria associated with each option
3. At the Save file to your computer? prompt, enter Yes if you want to save the report to your local computer. Enter No if you want to save the report to the drive on your Windows machine that is mapped to your Unix server.
4. At the File Name prompt, enter the full path and file name where you want to save your search results.

After the utility runs, the report appears in the folder you created.

Give Users Tools to Investigate Note Copying Behaviors

You can give managers, deficiency analysts, and coders several tools to use when investigating whether clinicians are using copied content appropriately in their notes:

- Attribution tools that allow them to see who added or changed content in the note, the method they used to add or change the content, and how much content they added or changed.



- Reports built using report model 34455-IP Note Copy History shows all notes with copied content.
- Reports built using report model 34456-IP Note Content Analysis shows only notes with copied content over a certain threshold.

For more information about configuring and using reports based on the report models, refer to the Report on Copied Notes and Find Notes with Excessive Amounts of Copied Content common uses topics within the Report Repository entry for report template [34001-IP Notes](#).

You can also enable attribution tools for assessment and plan (A&P) notes.

In version November 2021 and earlier, by default, users have a "simple" user interface that filters only on whether content was copied.

Considerations

We recommend that your organization involves your patient safety officer or equivalent roles in discussions about safe use of copy and paste in writing notes. Those discussions should include developing and implementing organizational or departmental policies around what constitutes appropriate use of copy and paste functionality, and how the organization will monitor the use of copy and paste in provider notes to update and reinforce those policies.

Some resources your organization can use to inform these discussions are:

- Characterizing the Source of Text in Electronic Health Record Progress Notes (external link: <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2629493>)
- ECRI Institute Health IT Safe Practices: Copy and Paste (external link: <https://www.ecri.org/HITPartnership/Pages/Safe-Practices.aspx>)

Modify a User's Starting Attribution Viewing Preferences

By default, unless otherwise configured in a profile by an analyst, the following settings are used until a user selects their own defaults in the note attribution widget (click wrench icon to open Default Filters):

- The note attribution widget is collapsed.
- To see content's attribution information when a user hovers the cursor over content, the user needs to

check the Hover for details filter.

- To deemphasize manually entered, copied, or template text, the user needs to apply attribution filter settings.

To configure the default settings, which hold for a user until they select their own defaults in the note attribution widget:

1. In Clinical Administration, go to Management Options > Profiles > Note, Letter, Transcription > Note Attribution screen.
2. To start the note attribution widget expanded when a user views a note, enter 0-No in the Collapse widget by default (I LPR 35054) field.
3. To allow a user to hover over content and see that content's attribution information, enter 1-Yes in the Enable tooltips by default (I LPR 35053) field.
4. To deemphasize content types by default, enter 0-No in the corresponding setting:
 - Show manual content (I LPR 35050)
 - Show template content (I LPR 35051)
 - Show copied content (I LPR 35052)

Enable Attribution Tools for Assessment and Plan Notes

To enable attribution tools for A&P notes, you'll need to configure the initialization parameters for the activity or navigator section that clinicians use to review A&P notes.

To configure an activity:

1. In Clinical Administration, follow the path Roles, Menus, Activities, etc. > Activities (E2N) and open the activity that contains A&P notes.
2. Enter InitParams=4^^^^^1 in the Control init parameters field.

To configure a navigator section:

1. In Clinical Administration, follow the path Navigators > Navigators (LVN) and open the section that contains A&P notes.
2. Add ",InitParams=4^^^^^1" without the quotation marks to the end of the code in the Handler ProgID field.

Notes Support: Common Issues

This section describes some common issues that you might encounter, along with possible solutions for addressing the issue.

I can't write a note of a specific note type.

Solution A

First, check that the user's profile has a Notes activity configuration record that contains the note type. To do this, first check the user's profile find their Notes activity configuration record:

1. In Clinical Administration, follow the path Management Options > Profiles and open the user's profile.
2. Go to Note, Letter, Transcription.
3. Go to the Notes Activity Settings screen.
4. In the Notes activity configuration (I LPR 948) field, find the Notes activity configuration record attached to the user's profile.

After you've found the user's Notes activity configuration record, follow these steps to confirm that the note type appears in their Notes activity configuration record:

1. In Clinical Administration, follow the path Notes, Text Templates > Notes Activity Configurations (HFN).
2. Open the Notes activity configuration record you found.
3. Go to the Available Tabs screen.
4. Press F8 to open each tab and check for the desired note type.

If the note type does not appear in the Notes activity configuration record, refer to the [Link Note Types to Existing and Custom Tabs](#) topic to add the note type to the Notes activity configuration record.

Solution B

If the note type is included in the user's Notes activity configuration record, check that the note type has allowed actions. Starting in November 2023, all actions of a note type can be restricted if the note type is set as read-only as described in the [Create a Read-Only Note Type](#) topic, which prevents users from writing or editing notes of that type.

In earlier versions, or if the note type is not set as read-only, the ability to write a note can be suppressed when the note type does not have any allowed actions. Follow these steps to determine if the note type cannot be written because all actions for the note type are suppressed:

1. In Clinical Administration, follow the path Management Options > Profiles and open the user's profile.
2. Go to Note, Letter, Transcription.
3. Go to the Notes General Settings - 3 screen. A note type cannot be written when all actions are limited for that note type, which is the case when all of the following are true:
 - The note type is not listed in the Allow sharing of Note Types? (I LPR 49315) field.
 - The Hide Sign button (I LPR 49310) field is set to Yes, or the note type is listed in the Hide Sign button for note types (I LPR 49311) field.
 - The Hide Pend button (I LPR 49312) field is set to Yes, or the note type is listed in the Hide Pend button for note types (I LPR 49313) field.

- For the Ambulatory context, the note type is listed in the Hide Sign when Signing Visit button for note types (I LPR 49317) field.

To allow a note type to be written, allow at least one action to be taken for the note type by allowing signing, pending, or sharing.

Considerations

If both the Hide Sign button (I LPR 49310) field and the Hide Pend button (I LPR 49312) fields are set to Yes for all note types, then the Create Notes button is hidden. You can make these profile setting changes to prevent users from creating notes.

I'm not sure what a note's status means.

A note's status is based on a category list in the Note Status (I HNO 17100) item. This status appears in Chart Review and in print groups, such as 54601-Note Report: Note Info (HTML). However, a note's status might appear differently in other areas of Hyperspace.

The table below describes the statuses that a note can have and how those statuses appear in different areas of Hyperspace.

Chart Review / Print Groups	Notes activity / Note navigator sections	Description
Incomplete	Incomplete	<p>This note isn't finished, and clinical decisions shouldn't be made based on its contents. An incomplete note can usually only be viewed and edited by its author. Users with certain security points can view incomplete notes written by other clinicians. For example, an attending physician might be able to view and edit an incomplete note written by a resident.</p> <p>A note has a status of Incomplete when a clinician:</p> <ul style="list-style-type: none"> Clicks Pend. Selects Pend on close in a note navigator section. <p>Transcriptions don't use the Incomplete status.</p>
Signed	Signed	<p>This note has been signed by a clinician with full privileges.</p> <p>A note has a status of signed when a clinician:</p> <ul style="list-style-type: none"> Clicks Sign. Selects Sign on close in a note navigator section.
Addendum	Addendum	This signed note was modified and signed again by a clinician with full privileges.

Chart Review / Print Groups	Notes activity / Note navigator sections	Description
		<p>A note has a status of Addendum when a clinician clicks Addend, and then:</p> <ul style="list-style-type: none"> • Clicks Sign. • Selects Sign on close in a note navigator section.
Cosign Needed	Cosign Needed	<p>This note is complete, but has been signed by a clinician without full privileges. A supervising clinician must cosign the note. Transcriptions that have been signed by a resident, but need to be cosigned by a supervising clinician also have this status.</p> <p>A note has a status of Cosign Needed after a clinician without full privileges, such as a resident:</p> <ul style="list-style-type: none"> • Clicks Sign. • Selects Sign on close in a note navigator section.
Cosign Needed Addendum	Cosign Needed Addendum	<p>This signed note was modified and signed by a clinician without full privileges. A supervising clinician must cosign the addendum.</p> <p>A note has a status of Cosign Needed Addendum after a clinician without full privileges, such as a resident, clicks Addend, and then:</p> <ul style="list-style-type: none"> • Clicks Sign. • Selects Sign on close in a note navigator section.
Shared	Shared	<p>This note has been sent to another clinician for further action. It isn't signed and might not be complete. This status is most often used when a clinician begins a note and then shares it with another clinician because it requires additional documentation by the second clinician.</p> <p>A note has a status of Shared when a clinician clicks Share. Transcriptions don't use the Shared status.</p>
Attested/Attested Addendum	Attested/Attested Addendum	<p>This note or addendum was cosigned with an attestation statement.</p> <p>A note has a status of Attested when a supervising clinician clicks Attest before clicking Sign. This can</p>

Chart Review / Print Groups	Notes activity / Note navigator sections	Description
		only be done in the Notes activity or in the Cosign Notes In Basket folder.
Incomplete Revision	Incomplete Revision	<p>This note is an incomplete addendum or edit.</p> <p>A note has a status of Incomplete Revision when a clinician clicks Addend or Edit and then:</p> <ul style="list-style-type: none"> • Clicks Pend. • Selects Pend on close in a note navigator section.
(No change) The note's status remains unchanged until the clinician pends or signs the note.	In Progress	<p>This status indicates that a clinician is currently adding an addendum to the note.</p> <p>A note has a status of In Progress when a clinician:</p> <ul style="list-style-type: none"> • Clicks Addend. • Clicks Edit.
Unsigned	Unsigned	This note is complete but hasn't been signed yet.
Unsigned	Sign when Signing Visit	This progress note is complete but hasn't been signed yet. This status indicates a note that will be signed when the encounter is closed.
Unsigned	Sign at Exiting of Workspace	This telephone documentation note is complete but hasn't been signed yet. This status indicates a note that will be signed when the workspace is closed.
Unsigned Transcription	Unsigned Transcription	This transcription is complete but hasn't been signed yet. This status also indicates a transcription that has been signed by a clinician without full privileges but won't be cosigned.
Deleted	Deleted	This note was deleted.

I'm not sure why a SmartText added from a SmartSet has a particular status.

When a clinician adds a SmartText from a SmartSet and a note of the same note type with a status of Incomplete, Sign when Signing Visit, or Signed already exists for the encounter or admission, the SmartText appears in the existing note and the note's status remains the same.

When a clinician creates a new note by selecting a checkbox to add a SmartText from a SmartSet, the note's status depends on four factors:

- Whether the clinician signs or pends the SmartSet.

- Whether the SmartText contains any unresolved wildcards or SmartLists.
- Whether there's a value entered in the Default action for new notes (I LPR 49320) field in the clinician's profile.
- Whether the clinician's notes feature set contains item 10-Sign when signing visit.

Let's walk through how these factors change the note's status:

- When the clinician signs the SmartSet and the SmartText contains no unresolved wildcards or SmartLists:
 - If a value is entered in the Default action for new notes field in the clinician's profile, the default action is applied to the note containing the SmartText.
 - If the Default action for new notes field is blank and the clinician's notes feature set contains item 10-Sign when signing visit, the note's status is Sign when signing visit.
 - If the Default action for new notes field is blank and the clinician's notes feature set doesn't contain item 10-Sign when signing visit, the note's status is Incomplete.
- When the clinician signs the SmartSet and the SmartText contains unresolved wildcards or SmartLists:
 - If the clinician's notes feature set contains item 10-Sign, the note's status is Sign when signing visit.
 - If the clinician's notes feature set doesn't contain item 10-Sign when signing visit, the note's status is Incomplete.
- When the clinician pends the SmartSet:
 - Starting in August 2024, the note's status is Pended.
 - In May 2024 or earlier, or if the clinician's profile settings are set to override SmartSet pending functionality as described in the [Give Users Access to SmartSet and Order Set Workflows](#) topic:
 - If the clinician's notes feature sets contains item 10-Sign when signing visit, the note's status is Sign when Signing Visit.
 - If the clinician's notes feature set doesn't contain item 10-Sign when signing visit, the note's status is Incomplete.

I'm not sure what a note action in the revision history audit trail means.

Solution

Note actions are stored in the IP Action Take on Note (I HNO 34040) item and can be viewed using print group 45419-UCN Revision History Audit Trail or a copy of it. The table below lists the note actions that can appear for a note and explains what each means.

Note Action	Description
Incomplete	The clinician pended the note.
Incomplete Revision	A clinician pended an addendum or pended an edit for a note that required a cosignature.
Unsigned	A clinician saved a note with a status of Sign when signing visit or saved an unsigned transcription.
Sign	The clinician signed the note. This action is recorded even when the note that the clinician signs requires a cosignature. This action is also recorded when a

Note Action	Description
	clinician saves his changes after editing a note that requires a cosignature.
Deleted	A user deleted the note after it had been signed.
Deleted Pended	A user deleted a pended addendum to a note, an unsigned transcription, a note saved with a status of Sign when signing visit, or a shared note when the Allow deletion of shared notes (I LSD 34027) field is set to 3-Accept and Delete.
Undelete	A user restored a transcription that was marked deleted, which is done using the Transcription Undeletion utility .
Hard Delete	The note was deleted and also removed from the patient's record. This occurs when a user deletes an incomplete note, a pended addendum to a note, or a shared note when the Allow deletion of shared notes (I LSD 34027) field is set to 1-Allow.
Addend	A clinician edited the note after it was signed.
Cosign	A clinician cosigned or attested to the note.
Share	A clinician shared the note.
Author Changed	The author of the note was changed. This occurs when: <ul style="list-style-type: none"> A clinician whose notes features include Change Author on Edit edited the note. A clinician whose notes features include Make Me the Author clicked the Make Me the Author button for the note.
Route	The note was routed, which occurs automatically based on the logic in the fields on the Auto Route Notes Configuration - 1 and Auto Route Notes Configuration - 2 screens of the profile or when a clinician selects a note in Chart Review or the Notes activity and clicks Route.
Transcription Merge	The transcription of a partial dictation was merged into its parent note.
Chart Correction	A user added a flag to indicate that the note was misfiled, removed an existing flag, or used the Note Redaction or Note Mover chart correction tools. Refer to the Determine How Chart Correction Tools Run topic for more information about chart correction tools.
Note Type Changed	A user changed the note's type, which can be done using: <ul style="list-style-type: none"> The Change Note Type utility in Clinical Administration. The Note Type Change chart correction tool.
Remove cosign/attestation	A clinician removed a cosignature or attestation from the note.
Note Metadata Change	A user changed metadata associated with the note using a utility. For example, he used the Change Author's Provider Type utility or one of the Deletion utilities.

Note Action	Description
Scanned	A user scanned a clinical note into the system.
Regenerate/Import Note Text	A note was repaired by a utility.
Addend/Edit Transcription	A signed note was edited, or a partial dictation was merged into a signed note.
Autopend	This action is not possible as of the conversion to the Unified Clinical Notes structure in Epic 2010. It is still present in the list to preserve backwards compatibility.
Authorize Transcription	This action is not possible as of the conversion to the Unified Clinical Notes structure in Epic 2010. It is still present in the list to preserve backwards compatibility.
Resident-Authorize Transcription	This action is not possible as of the conversion to the Unified Clinical Notes structure in Epic 2010. It is still present in the list to preserve backwards compatibility.
Refresh SmartLink	This action has been added to support future development, but is not yet available for use.

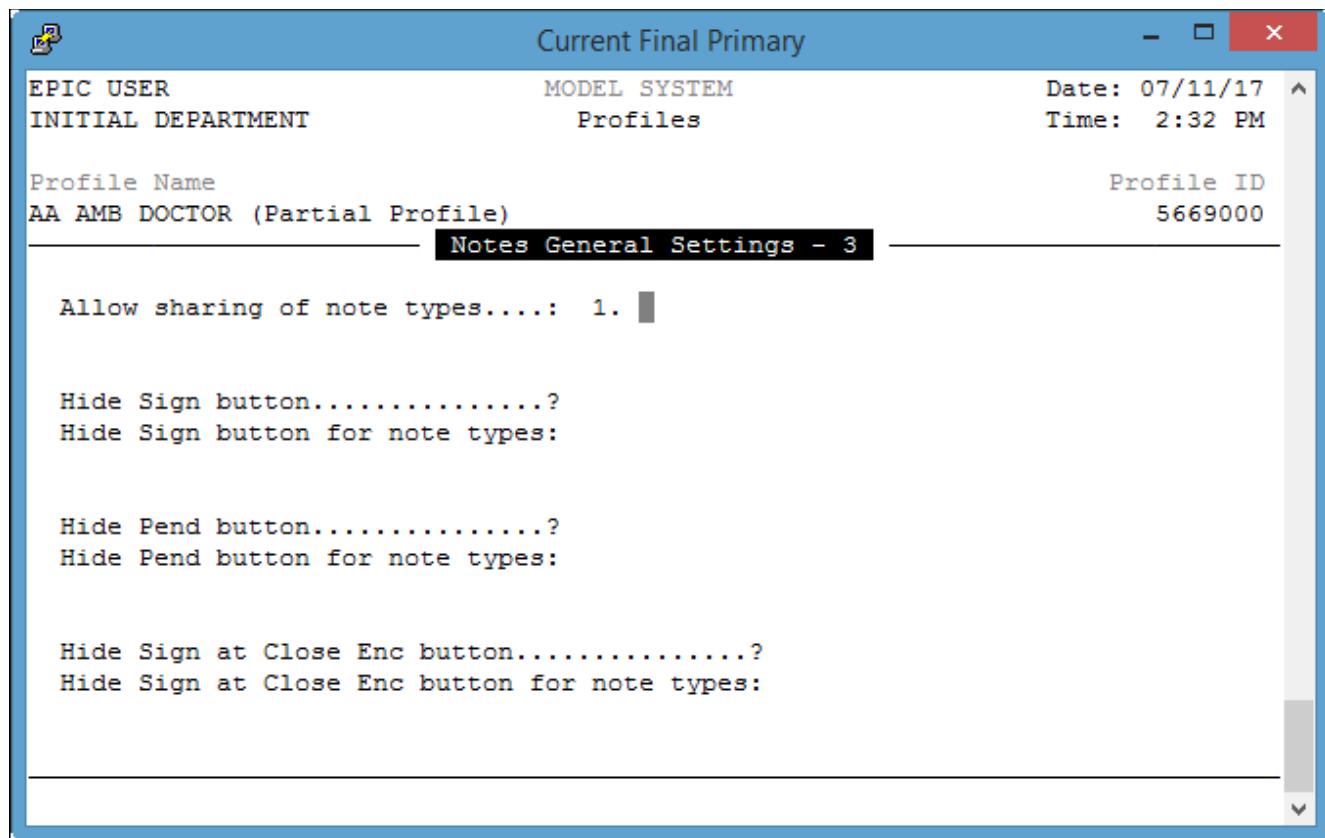
I'm not sure how the system automatically saves a note.

The system automatically saves notes in some cases. For example, notes are saved automatically when the system times out or when a user closes the system automatically, such as by scanning their badge or leaving the proximity of the workstation.

To automatically save a note, the system needs to use a specific action to save it. For example, the system might pend a note to save it, or set it to Sign when Signing Visit. Because not every action is available for every note, the system uses logic to determine which action to use. For example, if a user doesn't have the Sign when signing visit feature in her notes feature set, the system can't automatically save her note by setting it to Sign when Signing Visit.

The system is prevented from using certain actions to save notes based on these factors:

- The current status of a note
- The configuration of a user's notes feature set
- The configuration of the Notes General Settings – 3 screen in a user's profile:



- Scenario-specific restrictions listed below under Additional Restrictions.

The following table summarizes which default actions are allowed based on the note's current status:

Current Note Status	Allowed Actions for that Status
Signed or Incomplete Revision	Pend, Sign
Sign when Signing Visit/Workspace	Pend, Sign when Signing Visit/Sign at Close Workspace, Share, Sign
Shared with Other Clinicians	Share with Other Clinicians, Sign
Pended or New	Pend, Sign when Signing Visit/Sign at Close Workspace, Share, Sign

Additional Restrictions

There are also other restrictions for when the system can save a note by signing it or setting it to Sign when Signing Visit. If any of the following are true, the system is prevented from saving a note by setting it to Sign when Signing Visit and the note will be pended instead:

- The user requires note revalidation as described in the [Require Note Revalidation](#) topic.
- The encounter is already closed.
- The note doesn't have a type.
- The note is linked to a procedure order that is missing a required diagnosis association.
- The system is configured to show a Charge Capture window when notes are signed or marked Sign When Signing Visit, as described in the [Show a Charge Capture Window](#) topic.

- The note contains an Ambient SmartSection, as described in the [Add Sections for Generated Text to Your Note Templates](#) topic.
- The note requires a cosigner, inpatient service, case ID, or note summary and the required information is missing.
- The note allows explicitly setting the date of service and no date of service has been entered.

If any of the following is true, the system is prevented from saving a note by signing it and the note will be pended instead:

- The system was closed due to a system timeout, rather than being closed automatically by a badge scan or similar external action.
- The user requires note revalidation as described in the [Require Note Revalidation](#) topic.
- The encounter is already closed.
- The note doesn't have a type.
- The note was written in a notes navigator section that uses action buttons, as described in the [Choose Whether a Note Actions Menu or Buttons Appear](#) topic.
- The note contains unresolved variables, such as wildcards (***) or undocumented SmartLists.
- The note triggers a pre-sign validation extension, such as the extension described in the [Remind Clinicians to Include Sectioning SmartLinks in Notes](#) topic.
- The note is linked to a procedure order that is missing a required diagnosis association.
- The system is configured to show a Charge Capture window when notes are signed or marked Sign When Signing Visit, as described in the [Show a Charge Capture Window](#) topic.
- The note contains an Ambient SmartSection, as described in the [Add Sections for Generated Text to Your Note Templates](#) topic.
- The note requires a cosigner, inpatient service, case ID, or note summary and the required information is missing.
- The note allows explicitly setting the date of service and no date of service has been entered.

Configuring Default Actions

You can specify default actions for new notes as described in the [Set a Default Action for New Notes at the Profile Level](#) topic to help control which actions the system attempts to use to save a note. For example, you might specify that the system try to save new progress notes by setting them to Sign when Signing Visit.

The logic the system uses to determine which action to use to save a note is summarized as follows:

1. If a note is written in a navigator section that uses a note actions menu, the system attempts to save the note using the action that's currently set in the menu.
2. If the note can be saved with its current status, the system saves the note with that status.
3. If the default action for a note is allowed, the system saves the note using that action.
4. If the note was written in a navigator section that uses action buttons as described in the [Choose Whether a Note Actions Menu or Buttons Appear](#) topic, and a user attempts to manually close the workspace with the note open for editing, the system prompts the user to choose an action to save the note.
5. Notes are saved according to the first allowed action in the following list:

- a. Pend
 - b. Sign when Signing Visit
 - c. Share
 - d. Sign
6. If the note is currently shared with other clinicians, the system saves the note with that status. Otherwise, the note is pended.

To help illustrate this logic, consider the following example:

- A user opens a note for editing, and that note uses a note actions menu.
- The user sets the menu to Sign when Signing Visit and then leaves her workstation.

By step 1 in the logic above, the system saves her note by setting it to Sign when Signing Visit.

As another example, consider the following:

- A user creates a note in a navigator section that uses action buttons and then leaves her workstation.
- The Default action for new notes (I LPR 49320) field is set to Sign at Close Encounter.

Because the user isn't using the note actions menu, step 1 in the logic above doesn't apply. The note's current status is New, so step 2 also doesn't apply. Therefore, the system saves the note by setting it to Sign when Signing Visit by step 3.

An RTF note isn't appearing as expected.

The RTF standard requires a space between RTF control words and other content in a result or note that is received from an interface. The space is necessary for the text to be properly formatted and converted to plain text. In some scenarios, such as when an incoming orders interface with a certain configuration sends RTF notes or results, the interface can concatenate segments without a space. In these scenarios, the word appended to the RTF control word doesn't appear in the note or result.

Use the RichText Analyzer activity to identify instances where an RTF control word is concatenated with its following word, review possible separations, and preview the note with those separations made:

1. Make sure you have security point 99002-Access to RichText Analyzer in your Shared security class (search: Security Class Editor). It's activated in released security class 40001-Shared Administrator Security.
2. In Hyperspace, open the RichText Analyzer (search: RichText Analyzer).
3. Enter a patient, contact, and note or result (HNO) record to retrieve and press Load Record Content. If you don't have access to the record, you can break the glass to access it.
4. The invalid control words appear in the table on the top left and are highlighted in red in the RTF formatted content section. In the Possible Match field, select the correctly spaced word pair. If there are multiple ways in which the invalid control word can be separated such that the first word is a valid control word, all ways appear as possible matches.
5. If you know that a certain control word is valid in Epic but doesn't already appear in the table of invalid keywords, click Add to List to create a new record for the valid control word.
6. Click Display Adjusted HNO Preview to see how the matches specified would affect the result or note text.

I'm not sure why Invalid Note Attribution data errors are

logged.

If your organization deals with a high number of Invalid Note Attribution data errors, you can periodically log the RTF note along with the errors for troubleshooting purposes. An item in your compiled configuration allows you to specify an interval to wait between logging RTF. For example, you can set up your system to log RTF along with the first error in each six-hour interval.

1. In Clinical Administration, go to Management Options > Complete Configuration and open configuration 1.
2. Go to the RTF Validation Settings screen.
3. Set the Attribution error RTF logging interval (I HDF 2474) field to the number of hours to wait before logging RTF with the next invalid note attribution error.

Provider photos aren't appearing correctly.

When you upgrade to a version in which provider photos can appear in the Notes activity, if they aren't appearing correctly or at all, refer to the [Set Up Provider Photos](#) topic and make sure your organization has completed those steps.

Clinicians' notes take a long time to load because of warnings about sharing notes in MyChart.

If you enable clinicians to [share their notes with patients in MyChart](#), the system shows clinicians in the note editor when they share their note with a patient but the patient can't see it because they don't have security to view shared notes in MyChart. This information also appears in print groups that show notes, like print group [54690-Note Report: Simple Chart Review Note \(Rich Text\)](#).

By removing these warnings, you can mitigate performance degradation that can occur when a clinician opens her note.

To remove the warnings, complete the following steps:

1. In Clinical Administration, go to Notes, Text Templates > Notes Activity Configurations and open a Notes Feature Set that includes feature 18-Sharing with patients.
2. Go to the Share with Patient Settings screen.
3. In the Hide patient's MyChart Notes Security in Hyperspace? (I HFN 225) field:
 - Enter 1-Yes to remove the warnings.
 - Enter 2-Only Show In Editor to hide the warnings in print groups that show notes but keep them in the note editor. This option is helpful because the performance issues might occur only when a clinician tries to view a print group but not when they're using the note editor.

Clinicians frequently see errors about the system handling a mailbox message.

During certain workflows, clinicians might see an error message about the system being unable to handle a mailbox message. Although this message prevents the system from closing unexpectedly, it can make it difficult to troubleshoot the root cause of the issue. If clinicians repeatedly see this message, you can configure their workstation so the system does close instead of showing the message, which produces [DumpTruck files](#) that your Epic representative can use for troubleshooting.

To let the system close instead of showing the message, contact your Epic representative and mention parent SLG 4304745.

I'm not sure why the single-click routing checkbox doesn't appear as expected.

If you completed the setup described in the [Allow Clinicians to Route Notes to PCPs and Referring Providers with a Single Click](#) topic and are having trouble getting the checkbox to appear as expected, there are several things that you can check:

- If the checkbox doesn't appear:
 - Verify that the quick communication you set up appears in the Communication Management activity. The checkbox appears only if the quick communication was generated. If the quick communication wasn't generated, refer to the [Why Doesn't My Letter Appear in the Quick Communication Section?](#) topic to troubleshoot your quick communication build.
 - Verify that the note is a progress note, or that you completed the setup to show the checkbox for other types of notes as described in the Show the Checkbox and Communications Link to Clinicians section of the [Allow Clinicians to Route Notes to PCPs and Referring Providers with a Single Click](#) topic.
 - Verify that the encounter is of a type that can be closed, like an office visit. The checkbox doesn't appear in encounters that can't be closed. The checkbox also doesn't appear in an addendum.
 - Verify that if your quick communication includes a letter template, that letter template includes SmartLink 89-Notes - Progress Notes w/o Sensitive Notes (mnemonic: .PNOTES) or a copy of it. You must list all notes SmartLinks used in your letter template in the SmartLinks containing note text (I LPR 10047) field.
- If the checkbox caption doesn't say what you expect it to, verify that you set up the correct default recipients for the quick communication as described in the "Set Up the Default Recipients and Specify Which Encounter Types the Communications Are Created For" section of the [Allow Clinicians to Route Notes to PCPs and Referring Providers with a Single Click](#) topic.
 - If you set up the correct default recipients but the checkbox caption still doesn't say what you expect, verify that the default recipients have an active address (I SER 21120). For example, if you set up the patient's PCP as a default recipient, but the patient's PCP doesn't have an active address, then the checkbox caption doesn't say "Send to PCP".
- If the checkbox isn't selected by default and you want it to be, verify that you set up the quick communication to send by default. For more information, refer to the [Set Up the Default Recipients and Communications for Certain Encounter Types](#) topic.
- If the checkbox is disabled, check whether the quick communication has been edited or sent. Quick communications are generated only once per encounter, so if a clinician goes to the Communication Management activity to edit the communication before she selects or clears the checkbox, the checkbox becomes disabled in the note editor.

The changes I've made to Notes settings aren't appearing in Production right away.

Because Notes settings tend to change infrequently, the system updates Note configuration periodically. For example, if you create a new note type, it can take an hour or more for that note type to be available in

Production after you migrate your build from another environment.

If you're updating your Notes settings and want to test them right away, you can use a menu button in non-Production environments. For more information, refer to the [Reset Non-Production Notes Activity Settings](#) topic.

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