

# 08.31.2023 • RELEASE REPORT

PIMSY Plan	PIMSY Department	PIMSY Screen	PIMSY Platform	Type	Release Notes
Prime Professional Platinum	Medical Records	Notes	Provider Portal	Enhancement	We have updated the note interface for Progress and Assessment notes in the Provider Portal. Please see below to read more on these exciting changes.

*See next page for more detail*



## Progress / Assessment Note Updated UI

- We have updated the UI for Progress and Assessment Notes in the Provider Portal. Here, the Notes window features a clean layout that utilizes collapsible panels for the *Basic Details*, *Forms*, and *Session Notes* sections. Simply click on the blue panel to hide or reveal a section.
- At the top of the notes window, client and note information can be located, as well as options to review and/or release the note.

**Assessment Note**

Save Copy Delete Print

Note #	Name	Gender	DOB	Age	Service Date Time	Billing Code
1-C-10939-15794	Andrews, Grace	Female	12/01/1998	24	08/31/2023   09:00 AM	(4000F)Tobacco Counseling- 100.00ur N/A-125569

Substance Usage Medications Diagnosis Goal Add Services Reference Team Misc.Q & A Tracking

Allow Release Released for Review Reviewed Released

**Basic Details**

Service Date \* 08/31/2023 Start Time \* 9:00 AM End Time \* 10:00 AM Duration 60 Primary Billing Code \* (4000F)Tobacco Counseling- 100.00ur N/A-125569

Performed By System Administrator QP \*\*\*N/A\*\*\* Location Code \* (11) Office

Division Haywood Division Note Type \* BIRP Location Type \* Clinic

☒ Inpatient ☐ Face to face ☐ Collateral Note

Discharged 12/31/1999

**Note Tags**  
Billing: Copay Waiver, Edit

**Client Tags**  
Billing: Outstanding Invoice, Dispositions: Release Info, Pronouns: She/Her, Edit

**SAL Tags**  
Info: Co-Pay, Tracking: Checked In, Edit

> Forms  
> Session Note

- To view areas such as Substance Usage, Medications, and Goals, select one of the bubbles below the client and note information to view a slide out of that section.

## Top Panel and Slide Outs

- When creating a new note, please ensure to save the note so a note number is created. Once saved, and a note number is generated, you can proceed with making edits to the note.
- To access areas such as Substance Usage, Medications, diagnosis, etc., click one of the blue bubbles below the client and note information. A slide-out for that section will appear from the right side of the note window.

The top panel displays client and note information for Grace Andrews (Note # 1-C-10939-15794). Below this information is a row of blue bubbles for navigating to different sections: Substance Usage, Medications, Diagnosis, Goal, Add Services, Reference, Team, and Misc.Q & A Tracking. To the right of these bubbles are checkboxes for 'Allow Release', 'Released for Review', 'Reviewed', and 'Released', along with 'Save', 'Copy', 'Delete', and 'Print' buttons.

The 'Medications' slide-out window is shown, featuring a table of current medications:

Action	Rx Code	Medication	Dosage	Quantity	Refills	Instructions	Active	Note #	NDC Co
	687045	Adderall	5mg	30	2	2x/day	<input checked="" type="checkbox"/>	1-C-10939-15794	
	N/A	Acidophilus/Bifidus	2	45		One per day	<input checked="" type="checkbox"/>	1-C-10939-15794	
	N/A	Prozac	20mg	30	2	1/day	<input checked="" type="checkbox"/>	1-C-10939-15794	

- The Goals/Treatment Plan area can be accessed from this area as well. The Treatment Plans and Goals area utilizes the collapsible accordion section just like on the main note page. Click to view or hide the goal and need panels. Like the PIMSY desktop application, Primary, Secondary, and Tertiary plans can be selected, as well as Plan Types, and Divisions.

The 'Goal' slide-out window displays a treatment plan for 'NEED Plan1: Chemical Dependence - Withdrawal (Psychopharmacology)'. It includes a goal statement, an objective, and an intervention plan. The intervention plan details the administration of objective addiction and withdrawal severity rating instruments (e.g., ASI, CIWA-Ar) and the evaluation of results.

Below the intervention plan, there is a list of 'Actions' with a checkbox for 'Worked On In Session'. To the right, a list of 'NEED Plan1' items is shown, including Substance abuse, Chemical Dependence - Withdrawal (Psychopharmacology), Impulsivity (Rehabilitation), Substance Intoxication/Withdrawal (Addiction 5e), and Substance-Induced Disorders (Addiction 5e).

## Basic Details Panel

- The Basic Details panel for Notes has been improved by being structured into a more comprehensive layout. Here, items such as *Performed By*, *Division*, *Start / End Time*, and *Note Type* can be viewed and/or edited. Additionally, commentary for Client tags has been updated.

Basic Details

Service Date \*  
08/31/2023

Start Time \*  
9:00 AM

End Time \*  
10:00 AM

Duration  
60

Primary Billing Code \*  
(4000F)Tobacco Counseling- 100.00ur N/A-125569

Performed By  
System Administrator

QP  
Main Therapist

Location Code \*  
(11) Office

Division  
Haywood Division

Note Type \*  
BIRP

Location Type \*  
Clinic

☒ Inpatient ☐ Face to face ☐ Collateral Note

Discharged  
12/31/1999

Note Tags  
Billing  
Copay Waiver Edit

Client Tags  
Billing  
Outstanding Invoice Dispositions  
Release Info Pronouns  
She/Her Edit

SAL Tags  
Info  
Co-Pay Tracking  
Checked In Edit

Client Tags

Comment

System Administrator | 08/30/2023 | 2:45 PM

Client has been late last three sessions

System Administrator | 08/31/2023 | 2:20 PM

Client arrived on time for today's appointment.

Enter Comment...

Save

- When creating comments for Client tags, a timestamp will be applied for when the comment was created and by whom. To create a comment, type in the blank text field and then click Save.

## Forms Panel

- Q&A's can be accessed by revealing the Forms Panel. Here, any Q&A's that have current active answers will be highlighted in green. Selecting a Q&A will open the Q&A.

The screenshot displays the PAISLY assessment interface. On the left, a sidebar shows a list of forms under the 'Select Forms' dropdown. The main panel shows the 'Forms' section with a 'Medical History' dropdown. A yellow arrow points from the 'Medical History' dropdown in the main panel to the 'Medical History' option in the sidebar dropdown menu.

**Select Forms Dropdown Menu:**

- Select Forms
- Assessment Note Tracking Misc. Q&A
- My Test Assessment with Permissions
- BHI Assessment
- Family History
- Assessment Form
- Client Vitals x
- System Exam x
- Socia History x
- Psych. History
- Mood Template
- Medical History

**Main Panel Forms Section:**

Basic Details

Forms

Medical History

paistry

☐ Show Previous Answers  
☒ Current Note

Search answers...

Print Report

Title: 1-C-10939-15794

Date: 8/31/2023

**\* Perinatal History**

N/A

Hide Answers

Answer	Remarks	Active	Title	Date	Edited By	Edited
N/A		<input checked="" type="checkbox"/>	1-C-10939-15794	8/31/2023 9:00:00 AM	System Administrator, LCSW	8/31/2023 2:46:58 PM

**\* Gestation Complications**

☐ Yes ☒ No ☐ N/A

Remarks

Show Answers

This screenshot shows a close-up of the 'Admin. Save' button and the release status options.

Admin. Save Copy Delete Print

☐ Allow Release ☐ Released for Review ☐ Reviewed ☒ Released

- For users with the profile rule *Note Modify Admin Save Button*, an *Admin Save* button will appear in place of the *Save* button if the note is released.

## Session Note Panel

- The Session Note Panel houses the narrative field. This was previously the top narrative field of the note form. Please note that the header labels may appear differently for each site.

The screenshot shows the 'Session Note' panel. At the top, there is a header bar with a dropdown arrow and the text 'Session Note'. Below this, there are two tabs: 'Chief Complaint' (which is active and underlined) and 'Plan'. The main area is a large, empty text field for the narrative. At the bottom left, there is a toggle switch labeled 'OFF Dictation'. At the bottom right, there are two buttons: 'Answers' and 'Add template'.

## Additional Changes

- We have included the option to convert Progress Notes to Assessment Notes. This can be found by going to the Reference tab under the client and note details. A slide-out will appear on the right with various options that can be saved. Click the blue *Change to Assessment Note* button to initiate the conversion.

The screenshot shows a 'Reference' tab slide-out. On the left, there is a sidebar with a 'Progress Note' checkbox and a table of client information. The table has columns for Note #, Name, Gender, and DOB. The first row shows Note # 1-C-10939-15798, Name Andrews, Grace, Gender Female, and DOB 12/01/1998. Below the table are buttons for Goal, Add Services, Reference (which is highlighted), Team, and Misc.Q & A Track. The main area of the slide-out is titled 'Reference' and contains a blue button labeled 'Change To Assessment Note' (highlighted with a yellow box). To the right of this button are 'Close' and 'Save' buttons. Below the button, there are several form fields: 'Service location' (a dropdown menu with 'Haywood Office' selected), 'Service location If School' (a dropdown menu with '\*\*\*N/A\*\*\*' selected), 'Service location If "Other"' (a text field), 'Location Name' (a text field with '101 West Main St'), 'Address' (a text field), 'City' (a text field with 'Washington'), 'State' (a dropdown menu with 'District of Columbia' selected), and 'Zip' (a text field with '44444'). At the bottom, there is a section titled 'Common Clinical Document' with a 'Register With FHIR API' button and a 'Send to FHIR API' button.