AMEDD Guidance:
Core Nurse Skills for AHLTA

17 Aug 2006, Version 2.0

Note: This material, along with the associated How To information, is designed to facilitate transition to AHLTA and improve use by experience users. It is intended to augment the standard over-the-shoulder training and classroom training during initial implementation of AHLTA and help to facilitate the ongoing training of new personnel. The user should recognize that NOT ALL medication, consults, labs, and radiographic procedure are available in the training database. However, the practice of trying to reproduce notes in the training system can be very beneficial in training/learning how to efficiently and effectively perform your clinical documentation.

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Please refer to the "838 User's Guide" and "Using AHLTA Build 838 to Improve Outcomes" for additional information.

Introduction

Due to their broad scope of responsibility, nurses employ many AHLTA modules in their daily workflow. AHLTA has a vast assortment of functions and there is no way to teach (or learn) everything in one class. More class instruction is not the answer. The solution is to teach (learn) the skills that you need as a nurse to function effectively and efficiently. Skills can continue to grow and develop over time. This is true learning, not just exposure to the application.

This document will guide you through the basic skills needed to work effectively and efficiently in the outpatient setting using AHLTA. AMEDD Sustainment trainers are available at each MTF for ongoing support of learning.

The following areas have been shown to be necessary core skills. The order is the recommended order for teaching (learning) the skills. Within each area, clinical utility is also discussed. Learning will be most effective if the nurse has gone through the self-paced (guided) tutorial on AHLTA prior to training or has past experience.

1) Health History Module
    a) Set Up
    b) Healthcare review and reconciliation (updating information)
    c) Moving information into note
    d) How to configure Health History Module
2) Clinic Schedule (set up and review)
3) Signature Block and autocite preferences
4) Screening
5) Vital Signs
6) A/P
    a) Entry of immunizations
    b) Medications
    c) Procedure and other clinic specific codes
    d) Addresses wellness reminders
    e) Clinic Favorites
7) S/O Module (entering notes and screening, pulling up templates)
8) Telephone Consults
9) Immunizations Module

Only after the above has been mastered, should the nurse venture into other advanced functions within the application.

Health History Module

One of the great benefits of an EMR like AHLTA is the availability of patient information. The information is present and can be sorted. Unlike CHCS (Legacy), you can see multiple types of patient information at one time. The health history module gives you a

"dashboard" view of your patient status. Depending on your access roles, it also allows you to drill into detailed patient information. It is customizable to your preferences

Set up – The first time you use the health history module you will need to set up the areas that you wish to pull up. These should include at a minimum - allergies, medications, problems, vitals, and recent encounters. The health history module gives a display of information found in other folders in the patient record. These areas can also be accesses separately.

To setup:

1. Go to Health History item on left side of the screen.

2. The first time it is opened and any time you wish to modify, you will then need to select Tools from the top of the screen and then select Properties. Or you can use the Options button located to the right on the patient ID Bar.

3. A pop-up will appear that will allow for selection of the items you wish to include. Each box for the items selected can be moved to anywhere on the screen and resized as desired.

Resizing is done by clicking in the center of the box you wish to resize, then moving the black handles (or marks) up, down, left or right. You only need to get the boxes in the rough size you need. Then click on *align* to get the edges exact and looking "pretty."
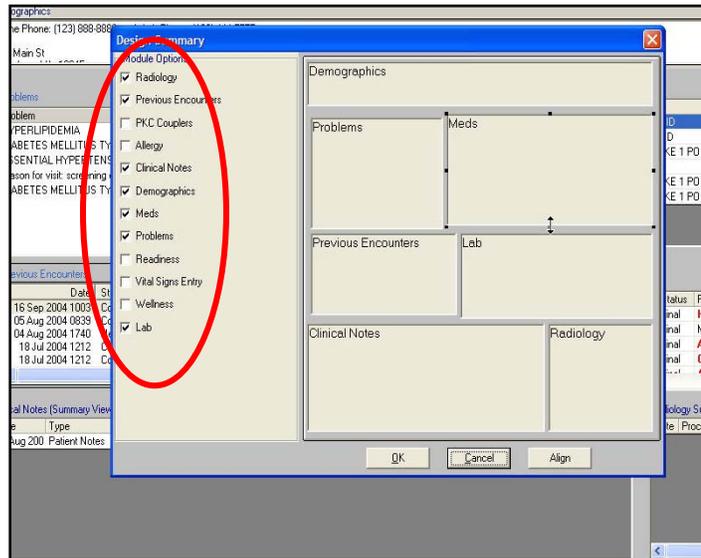
Each section on the screen can be used to access the full module.

Double click on the item (a specific previous encounter, for example) to access that module with the item double-clicked highlighted on the screen.

If you find you don't need a module, follow the same above steps to reconfigure as needed.

There will be a trade-off between the amount of information displayed and the time it takes to retrieve that information and display it. You will get the same expired medication notification when you display the medication module.

Health History Module Areas

1. **Problems** – Lists all the patient's recorded diagnoses. The problem list folder

also contains the patients list of previous procedures and family history. The diagnosis area is updated automatically whenever a new diagnosis is entered in the A/P module. The patient's problem list, procedure/surgical history, and family history can also be manually updated from

the problem list folder. By clicking on diagnosis on the problem list you can see previous encounters, labs, and other results associated with that diagnosis. This is the result of linking the orders and procedures to the diagnosis in the A/P section. In addition to adding item, the status of items can be changed from active, to inactive (resolved) or deleted (entered in error). The reason for any change should be documented but minor problems that resolved should be removed to keep the list from becoming cluttered. Local clinic rules should be established for who will be able to change the status of a diagnosis.

2. **Medication** – The medication module provides a list of all medications located in the patient's medication profile. This includes both active and

Meds	○ Inpt.	◉ Outpt.		
Last Filled	Medication Name		Sig	Status
Not Recorded	SIMVASTATIN (ZOCOR)--PO 20MG TAB		QD	Active
Not Recorded	METFORMIN (GLUCOPHAGE)--PO 500MG TAB		1 BID	Active
Not Recorded	LISINOPRIL (PRINIVIL/ZESTRIL)--PO 40MG T		1 QD	Active

expired medications. The list can be filtered by status (outpatient, inpatient, all). This usually should be set at Outpatient. The list can also be sorted by active or expired to facilitate rapid review. This is accomplished by clicking on the "Status" column header. This will allow the user to quickly review active medication use with the patient for reconciliation and compliance. Documentation of this will be addressed later.

In depth information regarding an individual medication can be viewed by double clicking on the desired medication. This function is similar to the review capability function of CHCS.

Allergies:	Iodine Containing Agents		Weight: 180 lbs / 81.65 kg
			15 Apr 2006
			BSA: 1.954 square meters
Age:	45yo Sex: M		Show Last Creatinine...

Details

	Medication Name	NDC
Medication :	LISINOPRIL (PRINIVIL/ZESTRIL)--PO 40MG T	No NDC

Sig: 1 QD

Status: **Active**   Order Number: **99990070-99990289**

Quantity:	30	Order Start Date: **04 May 2006**	
Refills:	6	Order Expiration Date: **Not Recorded**	Comment:
Refills Remaining:	6	Last Filled Date: **Not Recorded**	
Days of Supply:	**Not Recorded**	Event Date: **04 May 2006**	
Dispensing Location:	**CHCSII-T FACILTY**		
Clinic:		Ordering Provider: **PROVIDER, DAVID**	Close Detail

3. **Laboratory** – As with the Medication section, the health care team is able to review most recent lab results (indications for abnormal included) at a glance and enables moving a copy of that information directly into the patient's encounter.

Lab Results (All time periods)

Date Collected	Report Type	Report	Status	Results
01 May 2006 0000	Standard	Hemoglobin A1c	Final	Hemoglobin A1c => 7.5 => (H)
01 May 2006 0000	Standard	Microalbumin, urine	Final	Microalbumin => 17 =>
04 Mar 2006 0000	Standard	Urinalysis	Final	Acetest => Negative => , Appearance => Clear , Bilirubin => Negative , Blo
04 Mar 2006 0000	Standard	Lipid Panel Complete	Final	Cholesterol => 198 => , HDL => 42 , LDL => 123 , Risk Factor => 4.7 (H),
04 Mar 2006 0000	Standard	Chem 17	Final	Albumin => 4.4 => , Alk Phos => 88 , Anion Gap => 19 , AST => 28 , Bilirub

4. **Radiology** – This folder offers the same test result review as the above modules. The Radiology Summary lists information by date, procedure, result code, and with a special feature of AHLTA, by MTF.

| Radiology Summary | | | | | |
Event Date	Procedure	Ordering Provider	MTF	Status	Result Code
30-Dec-1899 0000	Sinus Series Report	Test User	CHCS II ITT	Complete	Minor Abnormality
30-Dec-1899 0000	Right Shoulder (AP Internal/External Rotation) Series Report	Test User	CHCS II ITT	Complete	Minor Abnormality
30-Dec-1899 0000	Chest PA And Lateral Series Report	Test User	CHCS II ITT	Complete	NORMAL

5. **Allergies** – This module includes the most up-to-date information gathered from CHCS as well as data entered by health care staff. This feature enables quick and easy review of specific patient information for confirmation and updating as needed. Double clicking anywhere in this area will open up the allergy module and allow editing or addition of new information.

Demographics	
Home Phone: (123)8888888	Work Phone: (123)4445555
233 Main St	
Anywhere, VA 12345	

Allergies	
Allergen	Reaction
Iodine Containing Agents	Rash

Vital Signs	
Date	Values
03 May 2006 0839	BP: 120/80, HR: 70, RR: 18, T: 98.6 °F,
02 May 2006 1740	BP: 178/98, HR: 88,
15 Apr 2006 1212	BP: 120/80, HR: 80, RR: 12,
15 Apr 2006 1212	BP: 135/85, HR: 88, RR: 12, T: 98.6 °F, HT: 5'8", WT: 180 lbs, BMI: 27.37, BSA: 1.954 square meters,

6. **Vital signs** – Review a historical record of the patient's vital signs. This is an excellent tool for monitoring prescribed blood pressure checks, monitoring weight gain or loss, and heart rates for patients on medications. Double clicking in this module will also allow graphing and printing of selected vitals.

7. **Clinical Notes** - Review notes regarding the patient entered outside the patient encounter. This is also where a copy of all consult results will be entered through CHCS.

Clinical Notes (Summary View)					
Date	Type	Status	Image	Clinician	Entered By
02 May 200	Patient Notes	Resolved		USER, TEST	USER, TES

8. **Wellness** - Review prevention items that are due for the patient.

9. **Readiness** - Review pertinent Readiness information.

Readiness Information				
Corrective Lenses Required:				
Glasses Received: -- Prescription:				
Contacts Received: -- Prescription:				
Protective Mask Received:				

Wellness (Due Reminders)

Type	Status	Earliest	Recommended
Regular Activity Counseling	Service Overdue		02 May 2006 0(
Blood Pressure Screen	Service Overdue		02 May 2006 0(
Anti-Tobacco Counseling	Service Overdue		02 May 2006 0(
Adequate Calcium Counseling	Service Overdue		02 May 2006 0(

10. **Previous encounters** – This module allows for the review of completed previous encounters and telephone consults.

Practice Recommendation

A. Open Health History Module as you enter the screening/exam room after greeting the patient.   While the module is loading begin to take vital signs or perform other necessary task. Loading the module will speed later information retrieval on the patient.

B. Moving test result information into your note: You can easily copy pertinent test results into the current encounter.

1. Double clicking on a test result will open the result.

2. Highlight the area that you would like to copy by clicking once and holding the mouse button, dragging the curser over the body of the text to be copied.

3. Right-click in the highlighted area, then select either:

a) Copy – places the selection on the clipboard; it can then be Pasted into the note

b) Copy To Note – copies the details directly into the S/O portion of the current patient encounter summary.

Note: An encounter must be open to use Copy To Note. Once copied, the details cannot be removed from the note, so ensure you only click Copy To Note once.

Clinic Schedule (Appointments)

The Appointments module in AHLTA allows for appointments to be checked-in and for walk-in appointments to be made. Scheduled appointment booking is still done in CHCSI. If AHLTA is unavailable, all orders will be placed in CHCS. You can set the filters in the Appointments module to show only those appointments you need to see. Click Change Selections and use the Search Selections window to filter appointments by clinic, provider, date and status. Once selections are made, set them as your default settings.
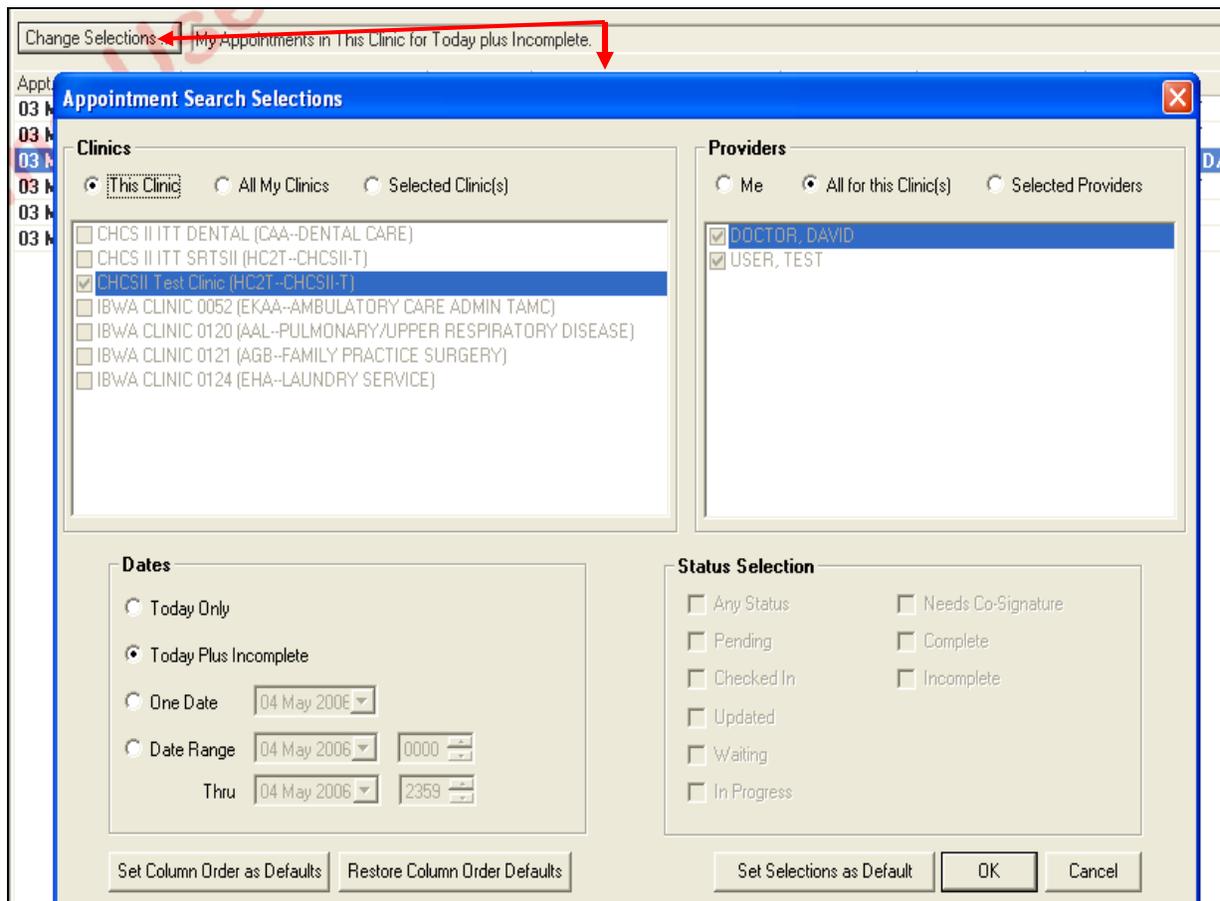
Signature Block and Autocite Set Up

Select any incomplete encounter and click on OK to open this encounter. When you are in the encounter screen, click on the Options button.

When the Encounter Summary Properties screen comes up, you can make your settings that will remain until changed (for all patients).

Set your signature block.

If you need to have your notes co-signed, enter in the provider's name that usually will co-sign your notes. This will provide a default person for co-signing but you will be able to change this before sending the encounter for co-signature

Set Autocite preference for Allergies only.
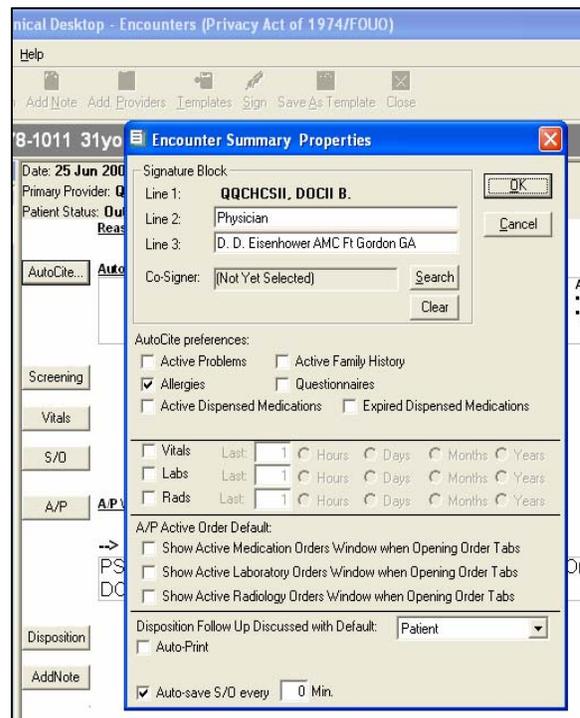
Do Not set your defaults to automatically include Lab and Rad values in your note. Check all three boxes under A/P Active Order Default, as this will speed seeing items in the A/P tab.

Encounter Documentation

The section below describes the core skills needed by nurses in their support of encounter documentation. For those nurses who generally write the S/O note and document diagnoses, note writing should be learned in the following sequence. An understanding of the functions is critical to the next step of learning. The A/P is usually the key area where medical diagnoses are listed, clinic procedures are coded, and patient education along with plan of care are conveyed.

Screening

The Screening module allows for the documentation of the reason for visit, injury and accident details, female specific information, and Wellness Reminders.

When screening a patient in your clinic, you may document the reason for visit in this module. As part of team documentation, it is recommended that most of documentation related to patient screening and intake be included on the AMEDD Screening AIM form discussed later. List only limited detail here. It is likely that there will be more than one patient complaint that needs to be documented. When choosing the main reason for visit, simply perform a search for the main symptom or complaint and choose from the items listed. Items may also be selected from the Clinic Favorite section.

A. Please note that some items are in all capital letters and others are not. If the Item is all caps that is a provider diagnosis. Nursing staff should choose the symptom driven items, or those in lower case, until a medical diagnosis is made.

B. If the patient needs a previous diagnosis addressed as well at this visit, you may choose from the Patient Problem List.
   1. Please note this also documents whether the complaint is "new vs. follow up". These can be changed and comments related to the complaint may be added here.

2. Adding Female Only Data

    A. The fields associated with Female Only Data display for female patients 12 years of age or older. If the patient is pregnant, the Last Menstrual Period and the Estimated DOB are required fields.

    B. In the encounter note, the estimated DOB is written as the EDC (Estimated Date of Confinement). This information, as well as the will then auto generate on every concurrent encounter from now on to allow for updating of information.

3. Verifying Allergies
    In every encounter, it is important to verify the patient's current allergies. The Screening module is the only module in the workflow where you can document the verification of patient allergies in the encounter note. To perform this action, click on the icon in the action bar indicating Verify Allergy. When you are taken to

the allergy module simply, check the box confirming that allergies were verified this encounter.
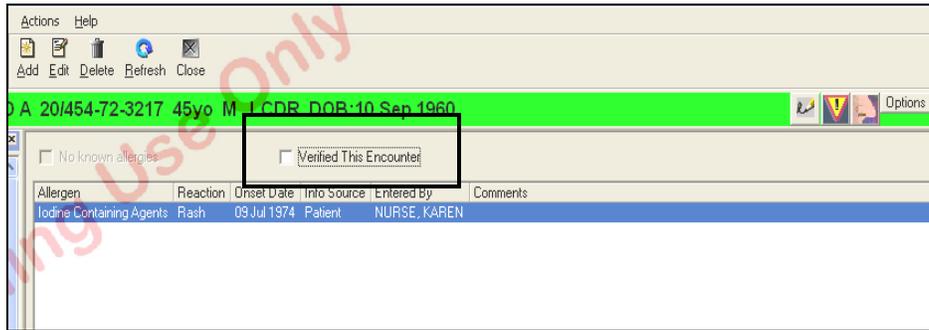
Using the "Add" button, you will also be able to enter a new allergy for the patient. There are two ways in AHLTA to enter allergies. First, a list of the top six allergens and reactions has been provided. These are accessed by using the pull downs next to those line items.
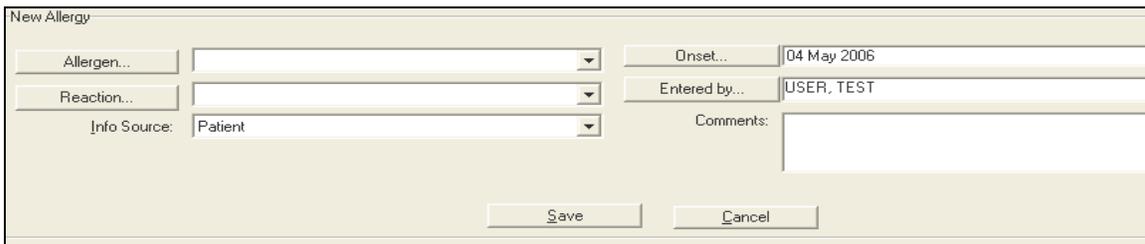
If the allergen or reaction is not listed in the quick list, it will be necessary to complete a search for those items. Clicking on the Allergen or Reaction toggle boxes will bring up a new search area. Be specific when searching for allergens, (most medications are listed under their generic name). When searching for reactions, if the reaction stated by the patient is not among the search results, you are able to enter the patient's statement into the comment section. This will result in the reaction area being populated with "Other: "and the comment.

4. Related to Injury/Accident
    A. If this is the FIRST visit related to an accident or injury (sprained ankle, automobile accident, and follow up examinations after ER visits) this area allows tracking of such events.

    1. Document the date of the injury itself.
    2. Check the most appropriate box to describe the event (see picture)
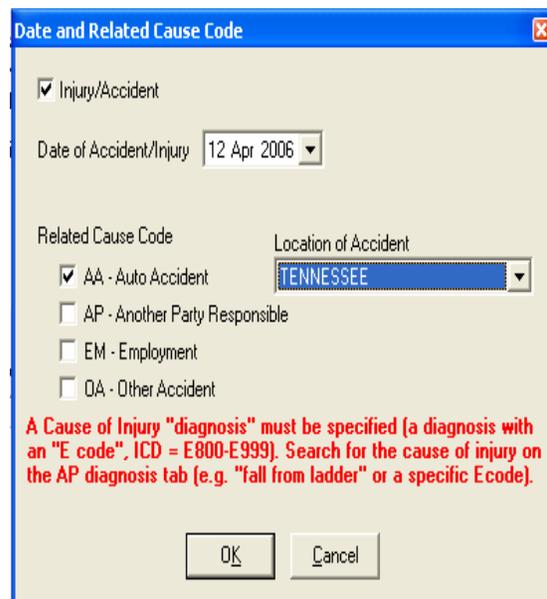
Vital Signs

The Vitals Sign module is pretty intuitive. You can document, view, edit, delete, and graph vital signs for a patient. The module contains two tabs: Review and Entry. The Entry tab allows vital signs to be entered under three different categories:

- Adult
- Obstetric (Female Only Patients)
- Pediatric

The default view is Adult, which displays Standard Vital Signs, Height/Weight, and Tobacco Use. Selecting either Obstetric or Pediatric brings up additional panels specific to their respective category (Urine dip stick and head circumference). This is accessed from the pull down in the top right corner.

Tobacco and alcohol once checked they cannot be unchecked; you must use the refresh button to uncheck if not asked. "Dot boxes" (ellipses boxes) allow modification of documentation for smoking cessation inquiries and potential alcohol abuse questions.

The following fields display once the appropriate checkbox is selected:

- Visual Acuity
- Oxygen Saturation
- Peak Flow

While entering vital signs you will notice several "dot boxes" (ellipses boxes). These can be utilized to modify the particular vital signs with more detailed information (arm blood pressure was taken in, weight with shoes or without, where pulse was taken, etc.)

When height and weight are entered you will also see that the program automatically calculates the BMI (Body Mass Index).

If you need to entry serial or multiple vital signs, this is done by entering the first set of vitals following by clicking the save button on the action bar and then entering the second set following the same action. This is useful for monitoring patients. You may also change the time that a set of vital signs were taken for more accurate documentation.

There is also a toggle box that will enable entering Orthostatic Blood Pressure checks.

Do not use the "Comment Box" on the vital sign tab for entering information about the patient visit. That information should be entered on the AMEDD General Screening AIM form.

A/P Module

The A/P module allows you to document your assessment of a patient's condition and the plan for treatment by entering diagnoses, procedures performed in clinic, patient instructions, and ordering consults, laboratory and radiology procedures, and medications.

You may find that due to your assigned tasks, you do not use all of the functionality in this module.

1. Documenting a Diagnosis / Procedure
   A. If the patient has been seen using AHLTA, their previous diagnoses can be seen by checking the Problem List button. Double-clicking on the items that appear in the window is the quickest way to add those diagnoses to the current encounter.
   B. When the provider has ordered a procedure for the patient, the nursing staff should be prepared to enter the procedure codes for those procedures as well as adding themselves as additional providers of care for coding purposes and work load capture. Lists of common procedures used in the clinic may be populated as follows:
      A. Clinic Favorites – This area should be preloaded with information that is specific to the clinic. The list should not exceed 15-20 items or it becomes cumbersome to use. The lists are those items that are MOST frequently used.
      B. Personal Favorites - If you wish to pre-position somewhat less common but frequent diagnoses that you use that are DIFFERENT from the clinic favorites, you should add them after finding them using the search method. The diagnosis is added by simply clicking on the button "add to favorites". This list also should not exceed 15-20.
      C. Search – The search function is much more robust than was present in CHCS. When searching for diagnoses for your patient, try to be as specific as possible. This specific diagnosis will be available to you in the patient problem list the next time you see the patient. The efficiency comes during future visits.
      D. Some common nursing procedures (with CPT or billing codes) are:
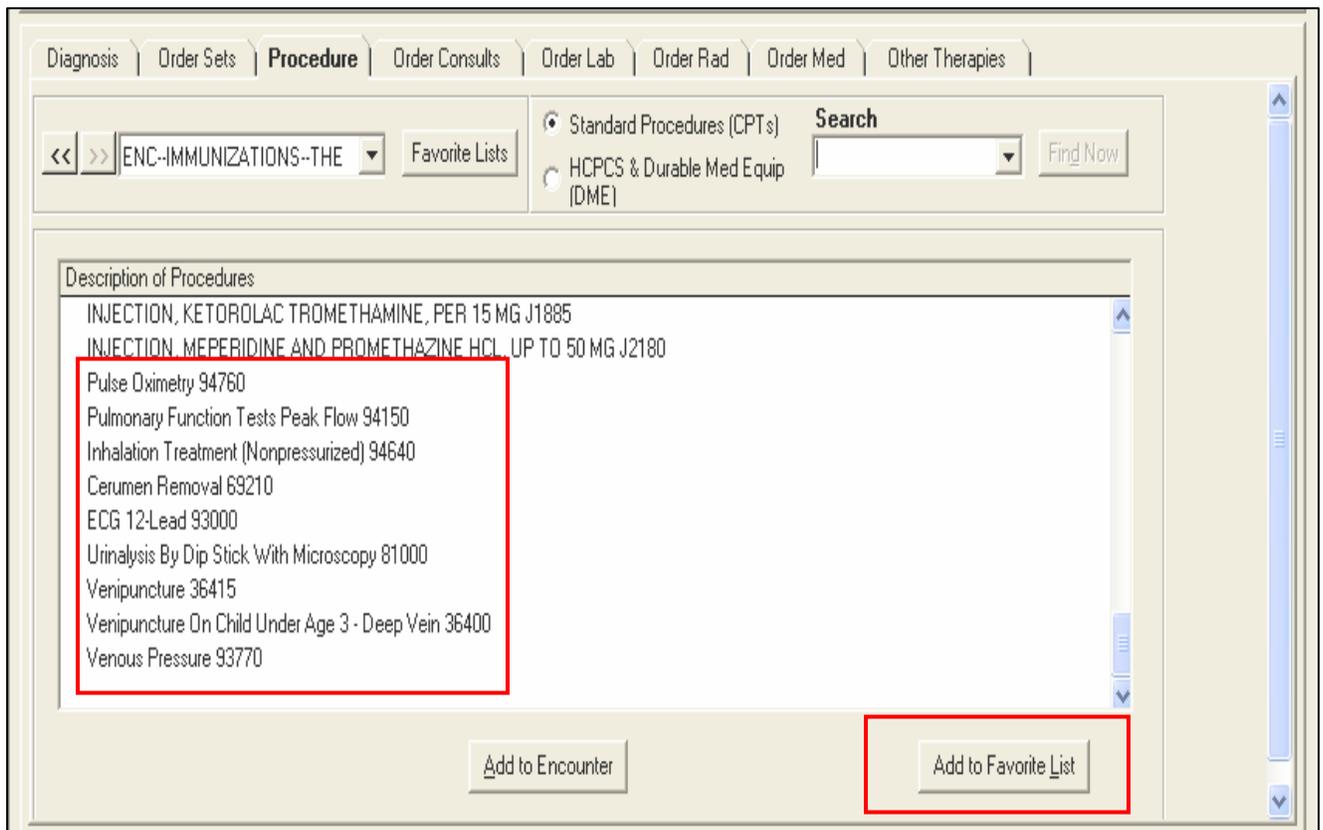
2. Associating Procedures with Diagnosis
    A. Procedures can be chosen from the clinic favorite list, which should be reviewed by your local coders and set up in the clinic for the most common procedures done locally (immunization, EKG, surgical, etc).
    B. If the diagnosis is known or the visit codes has been established by SOP, these items can be associated with a diagnosis by the nursing or technical support staff in the clinic when the procedure is performed. If the diagnosis is not known, the provider or person signing the encounter makes the association before signing the encounter.
    C. Remember to highlight a diagnosis before selecting the procedure so that the procedure/CPT is attached; this will also make it part of your note.
3. Use of the COMMENT/Plan box under the diagnosis.
    A. In this box you can list a follow-up plan, teaching, or whatever you usually include in your plan. The disposition module also has an area for follow-up care and you will need to decide how these areas work best for you.
    B. Note: The communication in the comment box will appear in the comment box on the Problem List. This gives you or other clinical team members a source of quick information when looking at the Problem List.
    C. To indicate the nursing involvement in the procedure, click once on the procedure that you have chosen. This will open a new window that will enable you to make yourself an "additional provider" by selecting your name and role. Remember to check the box by your name. Once this is completed once, or with the first entry, the window will automatically open for all subsequent procedure

entries. This action does NOT increase workload credit and should only be done as needed so that time is not wasted.
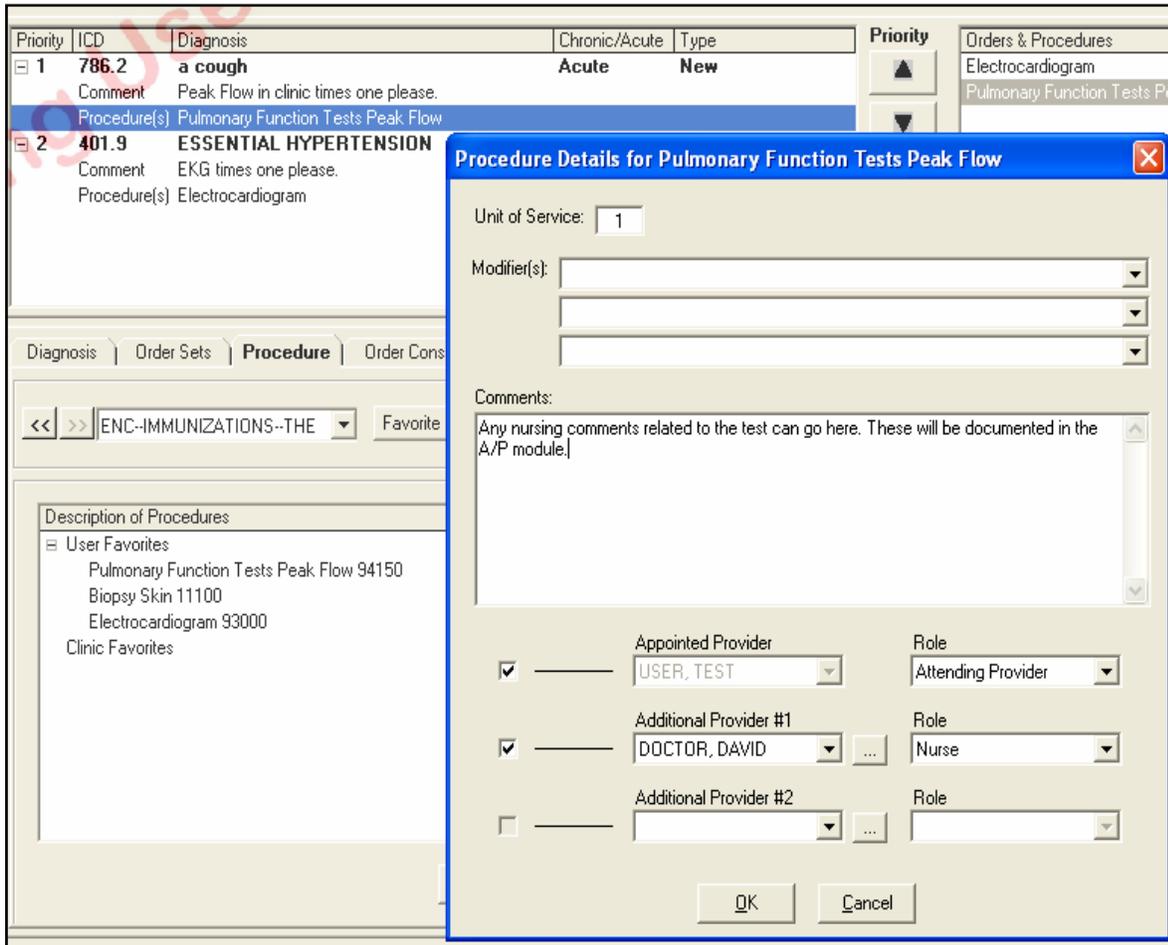
4. Ordering Labs, Rads, Meds and Consults (Role Dependent)
   A. The use of these functions is very similar to previous ordering in CHCS.
   B. The normal pharmacy and X-ray defaults that are in your Legacy system will appear.
   C. You should also make sure that the diagnosis that you are placing the order for is highlighted when you SUBMIT the order so that it will be linked in your note. This is just like writing your plan for the order on paper. The good news is writing the order also writes the note, unlike CHCS.
   D. If you are submitting an order under the name of a provider, an alert is sent to the provider requesting the order be co-signed. To verify the ordering provider, click More Detail on the order entry tabs.

Labs

The lab module is very intuitive with pull downs placed in key areas for ease of use. If the nurse is ordering for the provider, use the More/Less Detail button to ensure that the ordering provider is the correct provider.

By setting the Collection Priority, Collection Method, and Requesting Location, all of the requirements of entering an order into CHCS are met. This process replaces the need to print labs from CHCS.

There are certain labs that require additional information to be provided to the lab. When a specimen is ordered and the Lab Collection pop up appears, simply provide the information requested and the status will move to green. Providing the information saves processing time for the specimen in the lab.

Specimen Choices Completed

Choices for Collection Sample and Type

Collection Sample	Specimen-Type	Container
URINE/24HR	[USE TABLE]	24HR JUG

Search for specimen-type

Search keyword

URINE   Search

Results of specimen-type search

24 HR. URINE

Collection results for the order screen:

    SAMPLE: URINE/24HR
    CONTAINER: 24HR JUG

STATUS

OK

When entering orders for tissue samples for providers, a Tissue Exam Worksheet will appear.

1. Set the priority of the sample and ensure the requesting location is correct. Verify the ordering provider's name.

2. Enter a description for the container as labeled and indicate if it is frozen.

3. Clicking "Add" will move the specimen to the specimen list. This list may be modified or items may be deleted as needed.

4. Give a brief clinical history as indicated by the provider.

5. Submit the order.

Radiology

Ordering Radiology Tests is also intuitive and asks the same questions as CHCS. Ensure the ordering provider is correct by using the More/Less Detail button and ensure that the patient mobility status and the requesting location are correct.

Learning and Exercise
   A. Practicing placing common orders and procedures in the record.
   B. Use the coder for your clinic to insure that clinic favorites are accurate.
   C. Experiment with Order Sets which can be configured to allow more rapid entry of common orders to include education and other therapeutic items.
   D. You now have all the basic skills to use the A/P module. The goal is to write a completed A/P that you are happy with.

S/O Module: Templates and AIM Forms

The AMEDD has created an AIM form specifically for nurses: *Nursing--General—AMEDD* (See How To) and for Emergency Department Nursing to assist you with documentation. These and other forms have been designed by nurses for nurses. They will be continually improved with your feedback which can be submitted by checking the "?" on the last tab. There are many JCAHO requirements that are satisfied by using this AIM Form. Nurses are also allowed to document nursing observations with ease using this form.

With the fielding of AHLTA release 838.18, the AMEDD AHLTA office will be recommending the use of the AMEDD Screening A3 AIM Form. This form will allow the healthcare team to work more efficiently together. It will also help insure that issues such as medication reconciliation, master problem list updating, allergy verification, and military specific requirement are being met and can be tracked centrally. This will

decrease the burden of local chart auditing. The A3 screening form also allow a better means for the nursing staff to capture the patients reason for visit in the patient words along with allowing the provider to add to or edit what you enter as part of the team providing care to the patient. If using the form, you need not duplicate work on the screening tab.

Screening – 838 -- AMEDD: This form has been designed to allow the Nursing staff to be more fully integrated into the team documentation process. This process takes into consideration clinic workflows and the outcomes desired for documentation in determining who should write on or add to a patient's note. As with other AIM forms the tabs across the top of the AIM form guide the user to the appropriate areas. All Nursing staff involved with the screening process will choose the Screening/HPI/PMH tab to initiate the S/O note process and to aid in adding valuable JCAHO required information into the encounter data.

Reason for Visit: At least one of the six (6) reasons for visit should be checked and the information captured in the patient's words (narrative).

1. **Visit For**: This area allows the screener to use Free Text to capture the patients reason for visit.

2. **Follow-up Exam**: Allows the screener to document any patient concern regarding test results. This area also gives clues to the screener to copy results into the note itself.

3. **Consult visit**: Easy Access to information from the patient regarding which clinic and which provider has sent them for evaluation.

4. **Medication Refill**: This area is vital to the JCAHO required Medication Reconciliation Requirement and allows staff to properly document not only the review of medications, but any changes that need to be addressed by the provider.

5. **Other**: Additional problems of concern for this visit, reported by the patient, may be mentioned here.

6. **Visit for a Physical**: The small box icon allows for free text documentation. A convenient pull down has also been established with more frequent reasons for physicals listed. (see below)

Previous Hospitalizations, Previous ER Visits, And Prior Tests: If there is information provided by the patient that related to the current visit, it can be typed after the test already entered in the box.   As with other AIM forms, the MEDCIN terms also have specialized pull downs that will take the documenter directly to the Medcin Tree and offer a wide array of choices. You will have to decide if this is faster than typing. Both ways are appropriate, it is up to the user to choose which way is best for them. Remember to choose Y or N to indicate that particular history as well as the information review with the patient.

Patient Medical / Surgical History and Problem List: The items allow you to verify that the information was reviewed with the patient and updated in the appropriate areas of AHLTA. It will assist in meeting both specific JCAHO requirements and coding needs. You will notice the AIM form does NOT have pull down list as the information should be updated in the problem list or medication list so that it is available and easily seen in the future. Additional free text can be entered for clarity and further specification if desired.

Family Medical / Surgical History and Problem List, Patient Statistical Data:
There are many very important historical diagnoses that can affect patient care. This
information should be placed in the problem list module so that it is always available.
The AIM form will allow you to quickly indicate that the information has been reviewed
and updated. When the provider autocites the information into the encounter, they will
see the updated information.

Tobacco / Alcohol Screening: This area provides documentation regarding
patient information that was also captured in the Vital Signs and Screening Modules.
Documentation is included here to capture coding credit for that information.

Note: Remember to always Click Y or N to choose the documentation for that line item prior to writing free text or adding items from the Medcin tree. This will focus the program on that line item and ensure the date is properly entered and documented.

Note: Templates can be customized to allow documentation of information to similar detail.

Telephone Consults

There is no Telephone Consult Surrogate function in AHLTA. However, you can get around this by using the Change Selections option within the Telephone Consults module to view telephone consults that were entered with a different person as the provider.

1. Within the Telephone Consults module, click on the Change Selections button.

2. Within the Change Selections dialog box, select the provider(s) you are assisting.

Don't forget the time range. If the selections of All Outstanding or Today Plus Incomplete displays T-cons that have already been addressed (although not in AHLTA) you can change the date range to display current Pending T-cons.

1. Presently only providers can complete telephone consults in AHLTA, except for RNs who have the Nurse Wellness role. It is recommended that any RN who does telephone triage be considered to have this security role.

2. The act of selecting a telephone consult also opens up the patient's entire record. You can then use the Health History Module to review the patient's information while completing the telephone consult.

There are many situations in which creating a telephone consult for a provider would be an advantage. Patient concerns that need to be addressed by the provider, requests for refills on medications, and questions related to tests are common examples.

To create a T-Con, first you must be in the Telephone Consult Module. This module is located just under the Appointments Module on the Folder List.

You will notice there is a Change Selections button in the same location as in the Appointments Module as well. This allows the nurse or provider to select the telephone consults that they wish view within the clinic. This function takes the place of assigning a surrogate in CHCS. The Transfer button (blue arrows) on the action bar will allow the transferring of a T-Con from nurse to provider or from provider to provider.

To create a new T-Con, simply click the "New Telcon" button on the Action bar. This will open up a search module to select the correct patient. Once the patient has been found and loaded, entering the data for the T-Con is easy to follow.

1. Ensure the Assigned Clinic and the Provider(s) are correct using the pull downs.

2. Choose the correct appointment type.

3. T-Cons are always classified as Outpatient. Work load credit is dependant on the actions taken by the provider.

4. Check the call back number for accuracy and state the reason for the T-Con (5 words or less is best). Designate the correct urgency.

Any notes that the nurse wishes to add about the T-Con may be added in the Notes section. These notes will show on the T-Con when it is opened by the provider. Clicking the OK button will create the T-Con.

Telephone Consult lessons learned.

1. If a patient calls back with addition information or inquiries does a new T-Con have to be generated?

   No. By using the **Notes** button on the action bar (see below), additional notes can be added to an existing T-Con. This process will also give the provider access to the most current information when contacting the patient.

2. If I have created a T-Con and the patient's phone number is incorrect, do I cancel that T-Con and create a new one?

   No. The **Edit Phone #** (see below) button on the action bar will allow you to do this without even opening the T-Con already in place.

3. Can I use the T-Con module to enter information about the patient that needs to be addressed by the provider related to patient care?

   Yes. The T-Con module is an excellent way to give the provider information about their patient because it allows them to address the information and make changes to that patient's care on the spot if needed.

A Final Note

Hopefully now (and with some practice) you have the skills to more efficiently and effectively use AHLTA to document. Also you are better equipped to make help insure that health care outcomes are improved while speeding up clinical care through your greater involvement in clinical documentation and prevention. As with any new change, it will take time to become proficient and learn all the capabilities of AHLTA. The application will continue to be improved through user feedback and enhanced. This will require continued learning and changing of our clinical processes while focusing always on "Enhancing the Excellence of Military Healthcare".

Find, Load and Use AIM Forms

Finding and Loading AIM Forms *(see current list of AIM on AKO site)*
1. AIM forms are located in the S/O template list and are treated like S/O templates by AHLTA. Hence, they can only be loaded with an encounter loaded and the S/O module open.

2. The AIM forms are loaded in the enterprise folder and can be saved as a "link" into your favorites. Items in the enterprise folder have the owner listed as (Department of Defense). This will allow you to receive updated versions of the AIM forms automatically.

3. If you wish you can also set an AIM as your Default S/O template. (See "how to" on setting a Default Encounter Template.)

4. AIM forms can be identified by the icon indicated in the screenshot below:

5. AIM forms will always appear at the END of a list generated by the template search.

6. AIM forms can only be found if you use the search line located in the S/O template window itself and not from searches started by using the Search Button in the Action bar, as noted below:

If users want to add the AIM template to their list of favorite S/O templates, they may do so by RIGHT-CLICKING over the name of the AIM form and selecting the option "Add to Favorites." They should NOT use the option of saving them as one of their own templates, as this then saves the template as a new distinct template in the system. The major disadvantage of this is that when the AIM form is updated, you will not see the new version, but instead still see the old one. ***Using the "Add To Favorites"***

option actually is saving only a link, so you will always have the newest version available loaded. One quirk that has been seen in the live system is that it often takes 2-3 attempts to get the addition of the form to your favorites list. You will know it has "taken" when you see the template listed in your favorites, but the owner name still says, "Department of Defense."
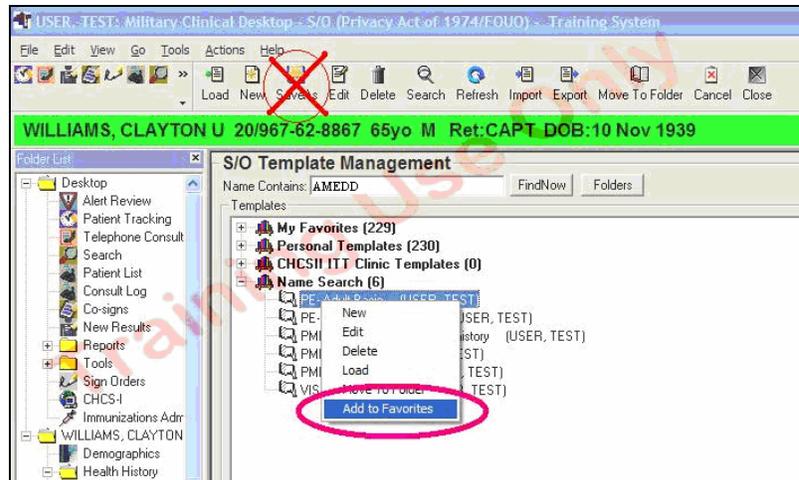
7. AMEDD Standard AIM templates will have either an Owner of the Department of Defense, or the local MTF. Ones with individual user names as owners are copies that were saved incorrectly as described in #7.

   Note: To locate all AMEDD AIM forms, enter *AMEDD* in the Name Contains field and click **Find Now**.

NOVEL Uses and Behaviors of AIM forms

1. When an AIM form is loaded into a particular encounter for a patient, each user after that will get the same AIM loaded when they open this encounter automatically, unless another AIM form is chosen. This can help with the clinic team working together to complete patient care documentation. The AIM chosen by the nurse during screening can be used by the provider to complete the note.

2. If copy forward is used on data from a previous encounter, the information that was copy forwarded will appear as a template. This is true if the encounter occurred using either a template or an AIM form. The items that were previously selected will appear as yellow. Once the items are accepted in the new note and the new AIM form is opened, all the responses will appear in the fields and boxes of the AIM form. This is true of any responses documented into the note prior to loading the AIM form as well. This is why it is a GOOD idea to load the same AIM form over the previous AIM form.

3. When copy forwarding an AIM, the user should open up the same AIM form as was used in the original encounter. This will actually appear to the user as a second template being loaded. The user then moves between the two S/O "templates" using the dropdown or arrows on the tool bar.

4. Miscellaneous Pointers
   A. Always click a button to include the item in the note before entering free text to ensure that the text will be included. If you don't, it may not "take" and appear as you expect.
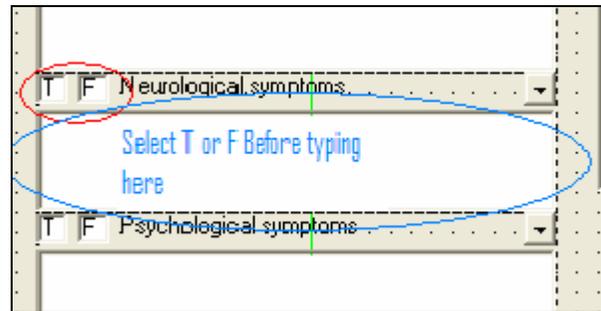
   B. If moving the cursor over a term reveals a question mark, a right click will open up the Medcin tree associated with that term.

   C. Left clicking on the button with a small empty box next to a term gives a free text box to enter details about that term/finding.

   D. Left Clicking a box that has a down arrow opens the Medcin tree associated with the term (just like the right mouse click on a question mark).

   E. To go from FORM view to NOTE view (the old Medcin note view), the toggle switch is in the upper right-hand corner. This is important to know, since if you want to add free text to an item found in a pick-list, you need to select the term, then move to the NOTE view, locate the term and then enter the free text associated with the term.

   F. Remember AIM forms are for S/O only.

   G. If you note a problem with the form or how the text emits, please use the e-mail link on the "Help" page that is launched by clicking the ? button

Using the Nursing--General--AMEDD Form

The Nursing--General--AMEDD form was developed to assist nurses with the common documentation tasks that are performed daily. The form contains multiple tabs. Not all tabs will be used for every encounter. Simply fill out the areas you need for individual encounters. The form itself contains helpful hints as to when additional steps are required based on a response to a question. Sometimes, documentation must also occur in other modules (allergies, A/P), as appropriate.

Note: For a complete list of current AIM forms, please visit AHLTA on Army Knowledge Online.

The Nursing--General--AMEDD form includes the following tabs:
Screening Questions
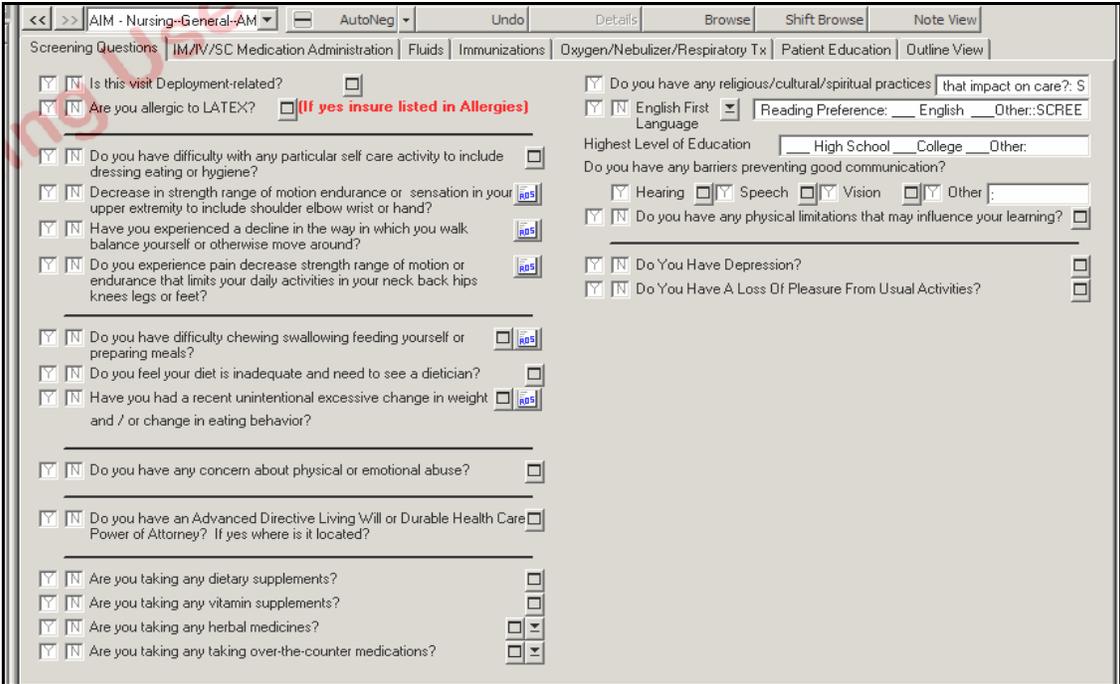
This portion of the Nursing AIM form will allow documentation of many JCAHO required elements of the patient encounter. These include latex allergy, self care issues, nutritional issues, advanced directives, issues of abuse, social/ learning disability issues, and depression.

IM/IV/SC Medication Administration

This tab of the Nursing AIM allows documentation of administration of medications into the S/O note. Placing information here will alleviate the need to use the comment box in the A/P Module. The A/P Module still must be completed for coding purposes and workload capture.

Fluids

Immunizations

Oxygen/Nebulizer/Respiratory Treatment

Patient Education

Example of a completed Nursing Note (S/O Note) using the Nursing AIM form:

S/O **SO Note** Written by USER, TEST @ 13 Apr 2006 0236 EST

History of present illness

The Patient is a 45 year old female. Source of patient information was patient.

" Not currently deployed for combat /deployment-related visit " No depression in the past two weeks " No anhedonia in the past two weeks

Allergies

No allergy to latex

Past medical/surgical history

Reported History:

Reported medications: Not taking OTC medications, no dietary supplements, and no vitamin supplements.

Legal documents on file for health care management: Health care proxy in chart: SCREEN -- Advanced Directive Living Will or Durable Health Care Power of Attorney. Document Location: Copy in Medical record

Personal history

Home environment: Native language English Reading Preference: ___ English ___Other: :SCREEN

Abuse / neglect: No abuse/neglect: SCREEN -- Concerns for physical or emotional abuse

Education: Educational level: grade __X_ High School ___College ___Other: : SCREEN

Functional status: No physical disability: SCREEN -- Physical Limitations influencing learning

Therapy

▪ Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record

▪ Administered ceftriaxone sodium + lidocaine was 250 mg (Ceftriaxone) Location: RUOQ Gluteal Route: IM

▪ No herbal medicines.
▪ The drug reactions/side effects are being monitored: Details-- Patient observed for 15 minutes and no adverse reactions noted

▪ Disposition - discharged home / released from clinic at: 1220

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Example of A/P module documentation in completed note:

<u>Therapy</u>
- Risks, benefits, and limitations discussed and understood Hard copy of signed document and statement of understanding filed in paper Outpatient Record

- Administered ceftriaxone sodium + lidocaine was 250 mg (Ceftriaxone) Location: RUOQ Gluteal Route: IM

- No herbal medicines.
- The drug reactions/side effects are being monitored: Details-- Patient observed for 15 minutes and no adverse reactions noted

- Disposition - discharged home / released from clinic at: 1220

<u>Counseling/Education</u>

- Patient education about an asthma action plan
- Patient education about asthma - peak flow monitor
- Patient education about asthma - metered dose inhaler
- Patient education about asthma - exposure to triggers
- Patient education about alcohol

<u>Practice Management</u>
    Intervention and counseling on cessation of tobacco use

A/P	A/P Written by USER, TEST @ 13 Apr 2006 0217 EST

1. a cough: Peak Flow in clinic times one please.

Procedure(s):	-Pulmonary Function Tests Peak Flow - Any nursing comments related to the test can go here. These will be documented in the A/P module.

2. ESSENTIAL HYPERTENSION: EKG times one please.

Procedure(s):	-Electrocardiogram

Disposition

AddNote

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Appendix A: Immunizations**

Documentation of Immunizations and Patient Flow

1. Perform preliminary documentation as guided by the Immunization AIM form or by personal template.

2. For Immunizations and PPD's referred by Provider, complete the following:
    A. Open the Immunizations module and document immunizations to be given and other information as directed in this portion of AHLTA (updating the vaccine history when possible).
    B. Ensure that patient's personal record is updated and that the VIS (vaccine information sheets) are provided for needed vaccines.
    C. Open A/P. (Note: This step is currently needed to get workload credit (RVUs) for immunizations. This is being corrected in build AHLTA Built 843 so that the dual entry can stop.)
        1) Under the Diagnosis tab, assign an ICD-9 code for each vaccine needed, if not done by the referring Provider.
        2) Under the Procedure tab, assign the CPT code for each vaccine given. This should be associated to the corresponding ICD-9 code.
        3) To document that you completed the procedure, click the procedure from the top box and add your name to the encounter and place a checkbox next to the procedure you completed.
            a. A word document can be pre-populated with "canned text" enabling the documentation of the five "nursing rights" of drug administration including the vaccine manufacturer and the expiration date of the dose. This can also be done using a free text template from the S/O module.
        4) Add the administration code for the vaccine from the Procedure tab.
            a. 90471 – The first immunization or a single immunization.
            b. 90472 – Used for each additional immunization. If giving more than one additional vaccine, select the procedure and change the units of service in the pop up box for all remaining vaccines.

3. If placing a PPD test, be sure to document in the comment box of the disposition, that the patient was instructed to return in 2-3 days.

4. Ensure the providers in the clinic do not sign the encounter before the nurse completes the immunization documentation. If they do sign the note, you will APPEND the encounter and the provider will have to sign the note again.

5. For Immunizations that are "walk-in's" – i.e. scheduled to get vaccinations based on CDC guidance (over the age of 2 years), school required vaccines, or presenting on a day other than the day of the wellness visit:
    A. Follow above procedure without change.
    B. In the Disposition module one of two things can occur:

1) The nurse can transfer the completed encounter to the patient's PCM or a designated provider for signing.
2) If the visit does not meet the criterion for a 99211 visit (office visit that does not require the provider to have direct contact with the patient), the nurse can complete the encounter using the 99499 E&M code.

6. For Therapeutic injections/Allergy therapy:
   A. Follow the above procedure without change.
   B. Complete the Disposition according to site guidance.

**For further details and information, please see the AMEDD AHLTA Immunizations Documentation Guide.